DEPARTMENT OF HUMAN SERVICES

Memo

Date: **March 14, 2018**

To: **Members of the Senate Human Services Reform Finance and Policy Committee**

From: **Dan Kitzberger, Legislative Director for Direct Care and Treatment**

RE: Update on Priority Admission Law at Anoka Metro Regional Treatment Center (AMRTC), also known as "the 48-Hour Law"

In 2013, changes were made to the Civil Commitment Act (MS 253B.10, Subd. 1b), which require the commissioner of human services to prioritize the admission of the following individuals from county jail into a state-operated treatment facility:

(1) ordered confined in a state hospital for an examination under Minnesota Rules of Criminal Procedure, rules 20.01, subdivision 4, paragraph (a), and 20.02, subdivision 2;

(2) under civil commitment for competency treatment and continuing supervision under Minnesota Rules of Criminal Procedure, rule 20.01, subdivision 7;

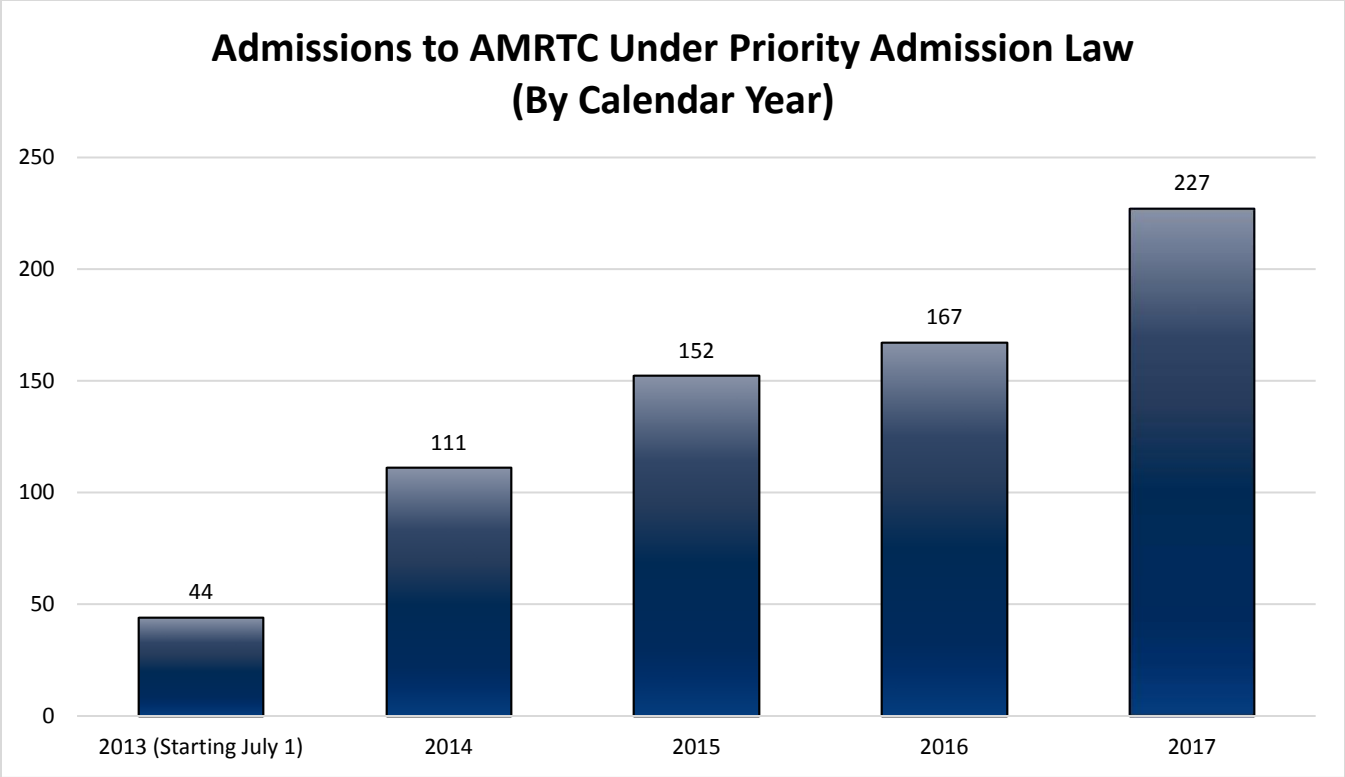
(3) found not guilty by reason of mental illness under Minnesota Rules of Criminal Procedure, rule 20.02, subdivision 8, and under civil commitment or are ordered to be detained in a state hospital or other facility pending completion of the civil commitment proceedings; or

(4) committed under this chapter to the commissioner after dismissal of the patient's criminal charges.

As the legislature has instructed, Direct Care and Treatment (DCT) has prioritized admissions of such individuals to AMRTC. When a medically appropriate bed is available, the admission occurs within 48 hours of our receiving the order for commitment unless there is a delay in transportation. In the event that a medically appropriate bed is not immediately available, regardless of their location prior to admission, individuals are placed on a waiting list. Patients from county jails who meet the criteria above are prioritized over patients from other locations, such as community-based hospitals and emergency departments.

"48-Hour Law" Priority Admissions

The number of patient transfers from county jails under the priority admission law continues to increase every year (see graph below). Currently, more than half of the beds at AMRTC are occupied by patients from county jails. In addition, the directive to prioritize the admission of these patient over others requires us to keep several beds available in anticipation of court orders for recent or pending hearings. Of all DHS-operated direct care facilities, AMRTC accepts the vast majority of patients under priority admission law because it serves those with the highest acuity.



Other Factors Impacting Patient Census

In addition to the priority admission law, it is also important to consider a variety of factors that impact census on any given day, and over time. The census at AMRTC is evaluated and adjusted daily based on the level of patient acuity and capacity. Daily census has been down somewhat in FY18. There are a few key reasons, some of which are unique circumstances, while some are longer-term, which contribute to this:

Ligature Risk Remediation

Direct Care and Treatment (DCT) has spent $1.3 million at AMRTC to comply with new Center for Medicare and Medicaid Services (CMS) safety and accreditation standards that aim to reduce the risk that patients may harm themselves by hanging. The standards require all psychiatric and acute care hospitals nationwide to remove potential ligature points in bathrooms, bedrooms or closets, including hooks, railings, and door handles. Noncompliance would put the facility's license in jeopardy with federal regulators, so the work was not optional and had to get underway quickly. AMRTC is well ahead of other hospitals in the completion of this work and is preparing for additional work that will take place this summer.

At AMRTC, we replaced existing toilets, sink fixtures, and restroom doors with safer products that meet the new standards. We also installed sensors on bedroom doors that can detect even slight increases in weight.
The work, which has required us to systematically close patient care units and move patients to other wings, began in late October of 2017 and took several months to complete the first phase. A second phase to remove ligature dangers in the ceilings is soon underway. This will result in periodic patient care unit closures as well.

Increased Patient Acuity

Constant use of Intensive Care Areas (ICA) for high-acuity patients who benefit from a low stimulation environment and must have 2-to-1 staffing has also impacted census. Every ICA we use effectively takes four other beds offline, based on staffing and physical plant capacity. Currently, three ICAs are in use, which means 12 other beds are unavailable. For the last several months, we have required three or four ICAs continuously.

Temporarily-Reduced Clinical Capacity

When two long-term psychiatrists left in October, AMRTC went several months with no directly employed psychiatrists, except for the medical director. All other care was provided by contracted physicians, most of whom worked no more than a month or two or only very sporadically. Care was also provided by employed mid-level providers, who do not have the same level of training or experience as a psychiatrist in treating the patient population at AMRTC. During this period, we've also lost nurses and other key staff.

We hope you find this information useful. If you have questions or would like additional information, please contact Dan Kitzberger at 651-431-3783 or daniel.kitzberger@state.mn.us.