

Bulletin

July 25, 2006

Minnesota Department of Human Services □ P.O. Box 64981 □ St. Paul, MN 55164-0981

OF INTEREST TO

- County Directors
- Social Services Supervisors and Staff
- Pre-petition Screeners
- Adult MH Case Mgmt. Supervisors
- Community MH Centers
- Contracted MH Case Mgmt. Providers
- Adult MH Initiatives
- Local MH Advisory Council Chairs
- Intensive Residential Treatment Programs
- County Attorneys
- District Court Judges and Administrators

ACTION/DUE DATE

Please become immediately familiar with these changes to contract language as they pertain to existing Psychiatric Inpatient Services in Community Hospitals.

EXPIRATION DATE

12/31/2007

DHS amends contracts for Extended Psychiatric Inpatient Services in Community Hospitals

TOPIC

DHS is amending contracts for extended psychiatric inpatient services in community hospitals, also known as the “contract bed program” or “contract beds”. Specific changes pertain to criteria for voluntary hospitalization, deletion of language previously preventing re-admission (on 45-day contract) within 15 days of discharge, and requirement that hospitals provide notice of DHS appeal rights.

Also, extensions to the 45-day limit of service may now be made based upon medical necessity.

This bulletin replaces #05-53-01.

PURPOSE

To inform counties and providers of amendments and changes to existing contractual language, as well as clarification of commitment issues.

CONTACT

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SIGNED

WES KOOISTRA
Assistant Commissioner
Chemical and Mental Health Services

Background

Effective July 1, 2002 the State Legislature (Minnesota Statutes, section 256.9693) directed DHS to expand community-based psychiatric inpatient services statewide, in anticipation of the reduction in Regional Treatment Centers (RTCs) throughout the state. DHS published requests for proposals (RFP) on November 15, 2002 and on July 19, 2004. To date, DHS administers contracts with 16 community hospitals for payment of inpatient psychiatric services for up to 45 days over and above acute admissions for Medical Assistance (MA) recipients. This includes 8 non-metro hospitals, which also receive grants for persons who are dually eligible for MA and Medicare, or are uninsured. DHS anticipates the addition of new hospital contracts in the upcoming months.

Since the original contracts were written, a number of concerns have arisen that have required clarification and amendment to the language within those agreements. Specifically, issues that are being addressed at this time include:

- In order to access funding under these contracts as a voluntary patient, previous requirements regarding physician documentation in support of civil commitment, as well as language requiring a pre-petition screening has been deleted. Language directing the contractor to obtain a release of information has been added. This new process supercedes the process identified in the original contracts and outlined in previous bulletin (#05-53-01).
- The 2005 Legislature enacted language in Minnesota Statutes, section 256.9693, which allows for care to be paid under the Medical Assistance (MA) contracts for more than the 45 days referenced in the current contracts; "The commissioner may authorize additional days beyond 45 based on an individual review of medical necessity." It is intended that individuals needing acute extended psychiatric inpatient care past 45 days will be served at the community hospitals whenever possible.

Consequently, the extension of care past 45 days in the MA contracts renders clause 4.3.1 of the current contract, regarding a 15 day gap between discharge and readmission, to be unnecessary and it has been removed.

Since it is expected that transfers to state-operated facilities will be rare, community hospitals no longer have to routinely send patient documentation to State Operated Services (SOS). DHS strongly encourages continued dialogue and communication between local care providers and community mental health centers, regional mental health initiatives, counties, and SOS in order to better access available resources including Adult Rehabilitative Mental Health Services (ARMHS), Intensive Residential Treatment Services (IRTS), Assertive Community Treatment (ACT), and the 16-bed Community Behavioral Health Hospitals (CBHHs) being developed throughout the state.

- Further information regarding the CBHHs is available on the DHS website at: http://www.dhs.state.mn.us/main/groups/disabilities/documents/pub/DHS_id_000087.hcsp

Or by contacting SOS Adult Mental Health Central Pre-Admission (CPA) at: (763-548-2337 or 1-866-966-2337). Additional information regarding the referral process for admitting individuals to adult mental health SOS facilities can be found in DHS Bulletin #06-76-01.

- At the request of community mental health advocates, contract hospitals are required to notify prospective patients (under the contracts) that they have appeal rights under Minnesota Statutes § 256.045. Additional questions regarding patient rights can be directed to the Office of the Ombudsman for Mental Health and Developmental Disabilities at: (651-296-3848 or 1-800-657-3506), or: <http://www.ombudmhm.state.mn.us/>
- Changes in the process to access Minnesota Health Care Programs using the State Medical Review Team (SMRT) include the requirement that SMRT comply with all five (5) steps of the Social Security Administration (SSA) process using DHS forms 4565 and 4566 as outlined in previous bulletin (#06-21-01). Hospital requests for MA using an expedited SMRT process may be routed through SOS CPA. Questions regarding this specific process can be directed to SOS CPA (763-548-2337), or to Michael Landgren at DHS (651-431-2251). Additional questions regarding SMRT can be directed to the SMRT Hotline at: (651-431-2493).
- Legislation was recently passed that includes an amendment that allows a provider of mental health care and treatment to disclose health record information about a patient to a family member or caretaker. Information is limited to diagnosis, admission notes, name/dosage of medications prescribed, potential side effects of medication, potential consequences of failure to take medication as directed, and summary of discharge plan. A provider may refuse to disclose information if it is determined that disclosure may be detrimental to the physical or mental health of the patient, or is likely to cause the patient to inflict self-harm or harm to others.

Legal References

Minnesota Statutes, section 256.9693

Action Requested

Counties, Case Managers, ACT Teams, Pre-petition Screeners, County Attorneys, District Court Judges and Administrators, and care providers are encouraged to become familiar with these changes and amendments.

Questions and Answers

Contract Specifics

1. What is the purpose of these contracts?

There are two types of contracts; both having a goal of providing statewide availability of psychiatric inpatient services for up to 45 days, for recipients of MA, individuals dually eligible under MA and Medicare, and uninsured individuals. Care beyond 45 days, based on an individualized review of medical necessity, may be allowed on a prospective basis.

The MA contract covers MA fee-for-service recipients, while the grant contract covers uninsured and underinsured individuals who do not qualify under the MA contract. A key “underinsured” group is the MA-Medicare dual eligible patients.

Individuals from many areas of the state currently have to travel long distances to access acute inpatient psychiatric care and sometimes encounter waiting lists. DHS intends for these contracts to result in more appropriate services becoming available closer to the patient’s home community. From the patient’s standpoint, the purpose is to facilitate a return to community living as soon as possible.

2. Which hospitals have special MA contracts with DHS to provide extended psychiatric inpatient services?

Allina, including:

- Abbott Northwestern Hospital (Minneapolis)

- Mercy Hospital (Coon Rapids)

- United Hospital (St. Paul)

- Cambridge Medical Center

- New Ulm Medical Center

- Owatonna Hospital

University of Minnesota Medical Center - Fairview (Minneapolis)

Fairview Southdale Hospital (Edina)

Hennepin County Medical Center (Minneapolis)

HealthEast-St. Joseph's Hospital (St. Paul)

Regions Hospital (St. Paul)

Miller-Dwan Medical Center (Duluth)

Northwest Medical Center (Thief River Falls)

Fairview University Medical Center - Mesabi (Hibbing)

St. Cloud Hospital

Worthington Regional Hospital

Appendix B provides a list of phone numbers for each hospital for questions relating to patient admissions.

DHS is working on contracts with other hospitals in addition to those listed above. For an updated listing of hospitals, please check the DHS website, at:

http://www.dhs.state.mn.us/main/groups/disabilities/documents/pub/DHS_id_003494.hcsp

3. Which hospitals have special grant contracts with DHS to provide extended psychiatric inpatient services for the uninsured and under insured who do not qualify for the MA contract?

Allina: Cambridge Medical Center,

New Ulm Medical Center

Owatonna Hospital

Miller-Dwan Medical Center (Duluth)

Fairview University Medical Center - Mesabi (Hibbing)

Northwest Medical Center (Thief River Falls)

St. Cloud Hospital

Worthington Regional Hospital

DHS will contract with other hospitals in addition to those listed above if additional funding is available.

4. Does each hospital have a specific service area?

Although each hospital has a primary service area, the MA contract can be used to fund eligible patients from throughout the state. For the grant contracts, only patients outside the 7-county metro area are currently eligible to be funded. Please contact the hospitals in your area for additional information.

5. Why is the 7-county metro area excluded from the grant contract?

The grant contracts are subsidized through money saved from the closure of the SOS-operated Regional Treatment Centers throughout the state. Anoka Metro RTC (AMRTC) is not currently being restructured into community services, as is the case with the non-metro RTCs.

Consequently, there are no RTC savings to reinvest for grant contracts in the metro region at this time.

Eligibility

6. Who is eligible to receive services under these contracts?

Funding under the MA contract is for MA eligible adults meeting all of the criteria in # 1 - 6 and one of the criteria in #7:

1. age 18 years or older, or attaining 18 years during the contract stay;
2. not under a 72-hour or court ordered hold;
3. not in a prepaid health plan;

4. not dually eligible for MA and Medicare, unless the patient has exhausted Medicare inpatient psychiatric benefits;
5. persons whose county of financial responsibility is in Minnesota, unless otherwise approved by DHS;
6. persons who need psychiatric inpatient services beyond what is normally available under the MA diagnostic-related (DRG) payment; and
7. the need for psychiatric inpatient services must be documented in at least one of the following ways:
 - a. a judicial commitment under Minnesota Statutes, Chapter 253B as mentally ill;
 - b. a revocation of a provisional discharge;
 - c. a stayed commitment; or
 - d. a voluntary admission: there must be clear documentation by the attending physician in the patients' hospital record that continued psychiatric inpatient hospitalization is needed for treatment completion, and the patient is capable of giving informed consent for voluntary treatment or has a substitute decision maker who will consent to the treatment. The attending physician must determine if a voluntary hospitalization is appropriate, and that it is consistent with the definition of medically necessary care in Minnesota Statutes, section 62Q.53, subdivision 2. The hospital must work in consultation with the county, to the extent that the patient consents, to determine if there are less restrictive alternatives available; or
 - e. a continuance of a commitment proceeding, with inpatient services stipulated as part of the condition of the continuance.

The criteria for coverage under the grant contract is the same as above, except:

- a. Recipient cannot be covered under the MA contract; and
- b. Recipient county of financial responsibility is any Minnesota county, except the 7-county metro area (Anoka, Hennepin, Carver, Scott, Ramsey, Washington, and Dakota Counties).

7. A client is not MA-eligible now, but is potentially MA-eligible. Can s/he be served under the MA contract?

MA can pay for medical bills accrued up to three months prior to MA application. Probably the most common method for these clients to establish MA eligibility is to apply for certification of disability through the State Medical Review Team (SMRT). Contract hospitals may use an expedited SMRT process by sending necessary information by way of SOS Central Pre-Admission, or they may use the earlier procedure and contact the county human services financial worker for details. General information about SMRT is available on the DHS website at:

http://www.dhs.state.mn.us/main/groups/county_access/documents/pub/dhs_id_018432.hcsp#P2425_173428

If a client is not MA-eligible at the time of admission, the hospital needs to decide whether to serve the individual and take the risk that the person might not become MA-eligible or to refer the individual to an SOS facility. Prompt action by the county to facilitate the individual's MA application is critical in these situations.

8. Can a voluntary patient receive services under these contracts?

Yes, under the following conditions:

A person otherwise eligible for services under the contracts, and who voluntarily consents to treatment in lieu of commitment, can be served through this program. There must be clear documentation by the attending physician in the patient's hospital record that continued psychiatric inpatient hospitalization is needed for treatment completion and that the patient is capable of giving informed consent for voluntary treatment or has a substitute decision maker who will consent to the treatment (see item 7d under Question #6 above and Appendix A to this bulletin).

9. What kind of documentation is required for an individual to qualify for contract bed services as voluntary (in lieu of commitment)?

See Appendix A.

10. Why are individuals with pre-paid health plan coverage excluded from these contracts?

Under legislation passed in 2001, similar services should be available from the individual's health plan. Hospitals need to work out payment arrangements with each health plan. For additional information, see DHS Bulletin #02-53-12.

Data Privacy

11. Will federal HIPAA regulations affect the hospital's ability to share patient data?

A Notice of Privacy Practices must be provided to patients. Hospitals contracting with DHS for the provision of extended inpatient psychiatric services enter into a Business Associate Agreement, making the contract hospitals business associates and allows for the sharing of data.

12. Are hospitals allowed to share patient data without the patient's consent?

If the patient is under a commitment or other type of court order, patient consent is not required since the Commitment Act requires this data to be shared with appropriate staff in the court, the county, and the state. If the patient is not under court order, the hospital should ask the patient to complete a release of information to share information with counties and other providers. Whether or not patient consent is required, the hospitals must inform all patients that private data about them will be shared with the state and the counties for purposes of treatment planning and payment.

13. Can family members or caregivers obtain patient information?

Yes, as a result of recent legislative amendments (to Minnesota Statutes, section 144.335), it is now easier for family members and caregivers to get patient information under certain conditions. A provider of mental health care may disclose recorded information to a patient's family or caregiver if:

- a. The request for information is in writing;
- b. The family member or other individual lives with, provides care for, or is directly involved in monitoring the treatment of the patient;
- c. The involvement under clause (b) is verified by the patient's mental health care provider, attending physician, or a person other than the person requesting the information, and it is documented in the patient's medical record;
- d. Before the disclosure the patient is informed in writing of the request, the name of the person requesting information, the reason for the request, and the specific information being requested;
- e. The patient agrees to the disclosure, does not object to the disclosure, or is unable to consent or object, and the patient's decision or inability to decide is documented in the medical record; and
- f. The disclosure is determined to be necessary to assist in the provision of care or monitoring of the patient's treatment.

Information disclosed under this law is limited to diagnosis, admission/discharge data (including discharge summary), and medication information (name/dosage of medications prescribed, potential side effects, and potential consequences of failure to take medication as prescribed). A provider may still determine that it would be detrimental to the physical or mental health of a patient to disclose information, and can refuse the request. The formal consent to release information, as well as emergency releases, can still be used.

Collaboration with Counties

14. Are hospitals required to coordinate services with counties?

Yes, these contracts include a number of provisions to this effect, including a requirement that the hospital notify the county within 24 hours after beginning contract bed services, provide weekly updates to the county, involve the county's designated case manager or ACT team in treatment and discharge planning, and have quarterly administrative meetings with counties and SOS/DHS to review the status of the contract and assure that mutual responsibilities under the contract are being met.

15. Do hospitals need to have a formal agreement with counties pertaining to roles and responsibilities?

These contracts do require hospitals to collaborate with counties on many levels:
Patient treatment planning, discharge planning, follow-up and aftercare;
Issues surrounding Provisional Discharges;
Contract bed utilization;
Contract bed service review.

Additionally, these contracts require that hospitals meet regularly with counties and DHS staff to address the issues above, as well as, to improve collaborative relationships and patient care. Consequently, counties are urged to discuss the need for formal agreements with hospitals in

their area. At a minimum, counties should establish a formal meeting schedule with the appropriate hospitals.

16. Are counties expected to facilitate discharge planning?

Yes, DHS expects counties to carry out their case management role as the designated agency under the Commitment Act. Mental Health Case Managers or ACT teams should be involved in treatment team review meetings and in discharge planning activities including the development of provisional discharge criteria. The average length of stay under existing contracts has been about 23 days (FY 2005). Therefore, beginning discharge planning at admission is essential in order for patients to be discharged in a timely fashion and have appropriate discharge options. Under the contract, patients may not be discharged to homeless shelters or to the street.

Commitments and Holds

17. If the person is committed, how should the commitment read?

According to Minnesota Statutes, section. 253B.09, subdivision 1 (c), “If the commitment as mentally ill, chemically dependent, or mentally retarded is to a service facility provided by the commissioner of human services, the court shall order the commitment to the commissioner. The commissioner shall designate the placement of the person to the court.”

DHS considers contract bed hospitals to be, “a service facility provided by the commissioner of human services.” Commitments of individuals meeting eligibility criteria for the contract beds should be ordered to the commissioner of human services. Committing an individual to a specific hospital or SOS facility is not consistent with Minnesota Statutes, section 253B.09, subdivision 1 (c). In addition, it can create problems and delays in placing and/or transferring the individual resulting in the need to have commitment orders amended if the listed facilities cannot accept the individual or need to transfer the individual. Commitment of an individual to the commissioner of human services will allow DHS to make appropriate and efficient placement of the person whether it be a contract bed or an SOS facility.

The above provision does not apply if the facility is not operated by DHS or not funded through a DHS extended psychiatric services contract.

The law requires courts to use the least restrictive, most appropriate alternative to meet each individual’s needs. This may include facilities such as Intensive Residential Treatment (IRTS) facilities or other programs which are typically not under a direct contract with DHS. If the facility is not operated by DHS or not under a direct contract with DHS, it should be specified in the commitment order.

18. If a client is “committed to the commissioner” and placed in a contract hospital do they automatically go to the top of the list for possible RTC admission?

For clients who are committed to the Commissioner of Human Services (for both the contract bed program and the SOS facilities), every effort will be made to “transfer” the client as quickly

as possible. Communication should occur between the contract bed hospital and SOS Central Pre-Admission (Greater Minnesota 1-866-966-2337; Twin Cities Metro Area 763-548-2337) as soon as it appears that a transfer of care may be needed. If law enforcement transportation is required, advanced preparations may need to be made.

However, note that these contracts expect that participating hospitals will treat patients until they are ready for discharge to the community; “transfers” to AMRTC should be the exception.

19. Does eligibility for these contracts include patients who are under a continuance of a commitment proceeding?

Yes, if inpatient services are stipulated as part of the condition of the continuance.

20. If a Provisional Discharge is revoked, must the person be returned to an SOS facility?

No. The Commitment Act states that the designated agency (county case manager or ACT team) may revoke a provisional discharge if: the patient has violated material conditions of the provisional discharge, and the violation creates the need to return the patient to a more restrictive setting, or there is a serious likelihood that the safety of the patient or others will be jeopardized.

The Commitment Act also states that a person can be returned to any other treatment facility which consents to receive the patient (this can include the community hospitals DHS has contracted with). Please see Commitment Act Minn. Stat. §253B.15 for the full content of the provisional discharge revocation criteria. Note that the treating physician may assess the patient on the same day as commitment and if s/he does not agree that the person needs inpatient hospitalization, may provisionally discharge the patient again that same day. It is always best for the case manager or ACT team, and the treatment team to work together when deciding the need for a revocation. All less restrictive alternatives should be explored first.

21. Who is responsible for hold orders?

These contracts do not cover hold orders, except for the situation described in Question #23. Under state laws (Minnesota Statutes, section 253B.045, subdivision 2 and section 256G.08), counties are the payers of last resort for hold orders. Hospitals are required to bill the individual’s health coverage first for medically necessary inpatient hospital stays (see Minnesota Statutes, section 256.969, subdivision 21 and section 253B.045, subdivision 2). Most hospitals have been able to demonstrate medical necessity for hold orders.

We recognize that the DRG payment which a hospital would normally receive for a hold order may be less than the cost of the stay, especially in the case of court-ordered holds, which may sometimes go for weeks. We encourage counties and hospitals to work with their local courts and county attorneys to streamline commitment procedures and reduce lengthy court holds. Hospitals and counties may also want to consider the expedited voluntary (in lieu of commitment) procedures described elsewhere in this bulletin as an alternative to a court hold and/or commitment for certain patients.

There are situations where the patient has no health coverage or the health coverage does not include the cost of a hold order, in which case the county of financial responsibility will end up being liable for payment.

As stated in Minnesota Statutes, section 256G.02, subdivision 4, The “county of financial responsibility” refers to the county in which the person resides at the time of confinement or, if the person resides in an excluded time facility offering care (e.g. foster home, group home, board and lodging facility, or intensive residential treatment facility) the county in which the individual last resided immediately before entering the facility. If the individual has no residence in this state, the county which initiated the confinement will retain responsibility. When there is a dispute as to which county is the actual county of financial responsibility, the county charged for the cost of confinement where the hold order occurred should pay, pending a final determination by DHS, which has the statutory authority to resolve disputes according to M.S.256G.09.

22. Can a hospital expect payment from a county for a hold order without a county hold order contract?

We strongly recommend that all hospitals negotiate a hold order contract with their host county. Without a contract, there is no basis to establish a hold order rate, to define health plan versus county versus patient responsibility, to assure appropriate notification to the county, etc. A host county contract can define all of these terms for all responsible counties who may have a patient at that hospital. If a hold order contract has not been negotiated, and there is no health coverage, a county may still be responsible, but it is very difficult to work out the specifics of the county's liability on an after-the-fact basis.

Minnesota Statutes, section 256G.08, subdivision 1 states “In cases of voluntary admission or commitment to state or other institutions, the committing county shall initially pay for all costs. This includes the expenses of the taking into custody, confinement, emergency holds under sections 253B.05, subdivision 1 and 2, and 253B.07, examination, commitment, conveyance to the place of detention, rehearing, and hearings under section 253B.092, including hearings held under that section which are venued outside the county of commitment”. Please see DHS Bulletin #06-85-01 for further information regarding financial responsibility disputes between counties.

23. What happens if a person has met the criteria for voluntary treatment (in lieu of commitment), decides they no longer want treatment, but the physician determines a hold order is appropriate? Who pays for the subsequent hold period prior to commitment?

These contracts cover continual hospitalization, including the initial voluntary treatment (in lieu of commitment), a subsequent hold period (if necessary prior to commitment), and commitment (if necessary). Contract coverage does not end if the person needs to be switched from voluntary to involuntary status.

Coordination with State Operated Services

24. If a voluntary patient requires a “transfer” to an SOS facility, do they have to be “committed” to access an SOS-managed bed?

Committed individuals, so long as the commitment reads “commitment to the commissioner”, take priority for admission in an SOS-operated facility. However, patients who are voluntary (in lieu of commitment) may be admitted to an SOS facility, depending upon availability/capacity, and at the discretion of SOS treatment professionals. The community hospital which requests a transfer of a patient to an SOS facility should be prepared to provide justification of why a transfer is necessary. Please see Bulletin #06-76-01 for further detail.

25. What procedure(s) regarding consultation on medication or other psychiatric treatments should hospitals follow when a person who is mentally ill and dangerous (MI & D) is admitted?

For individuals who are committed as mentally ill and dangerous, it is important that all persons and agencies involved in the client's aftercare be familiar with the conditions of the provisional discharge. Most orders include a condition that requires consultation with the State Operated Services Forensic Medical Director prior to any medication change. SOS continues to be involved with clients placed in the community because of ongoing risk management issues. SOS has extensive experience with the client including medication histories and responses to changes in medications.

Contact Dr. Jennifer Service at the Minnesota Security Hospital at 507-931-7872 for questions regarding medication changes. Notice regarding an MI&D client's hospitalization in the community should be immediately reported to Bill Gallagher, Special Review Board Coordinator, 651-431-3680.

Discharge Planning

26. Who determines the length of stay and discharge criteria?

Under the Commitment Act, the hospital treatment team decides when someone is ready for discharge. However, discharge planning must begin at admission, or ideally, pre-admission. Discharge planning must be a mutual effort between the hospital and the designated agency representative (usually the case manager or ACT team).

27. Is there any flexibility for patients to stay longer than 45 days?

Yes, extensions in the MA contract bed program beyond 45 days will be considered, based on medical necessity and CDMI approval; approval of extensions beyond 45 days will need to be prospective (not retrospective).

SPECIAL NEEDS

This information is available in other forms to people with disabilities by contacting DHS at 651-582-1990 (voice), or through the Minnesota Relay Service at 1-800-627-3529 (TTY), 711, or 1-877-627-3848 (speech-to-speech relay service).

**PROTOCOL FOR VOLUNTARY HOSPITALIZATION
(In Lieu of Commitment) TO EXTENDED
PSYCHIATRIC INPATIENT CONTRACT BEDS**

Following is the protocol for accessing funding for voluntary hospitalization to Extended Inpatient Psychiatric Contract Beds. Patients who agree to voluntary treatment, and meet the following criteria may be served in the contract beds as voluntary patients in lieu of commitment:

1. A physician must clearly document in the patient's hospital record that continued psychiatric inpatient hospitalization is needed for treatment completion (beyond an acute care stabilization), and the patient is capable of giving informed consent for voluntary treatment (or has a substitute decision maker who will consent to treatment), and;
2. The attending physician must determine if voluntary hospitalization is appropriate, and that it is consistent with the definition of medically necessary care in Minnesota Statutes 62Q.53, Subd. 2., and;
3. The hospital must work in consultation with the county, to the extent that the patient consents, to determine if there is a less restrictive alternative available, and;
4. Contractors should ask prospective patients to sign a consent for the release of medical information for the purpose of:
 - (a.) County evaluation of less restrictive alternatives to inpatient hospitalization, if appropriate, and;
 - (b.) Service coordination with the county and other providers for continued treatment and discharge planning, and;
 - (c.) For utilization review management.

Voluntary patients may limit the type of information that is shared and the agencies or individuals with whom that information is shared.

Appendix B

Hospitals with Contracts for Extended Psychiatric Inpatient Services

Hospital Name	City	Contract Type	Phone Numbers for Admissions and Program Info
Abbott Northwestern Medical Center	Minneapolis	MA	Mary Larson, LICSW: 612-863-5394 Ruth Fransen, Utilization Mgmt. Specialist: 612-863-7667 Karen Wendt, Manager: 612-863-9172 Jodi Rucker, Director: 612-863-8737
Cambridge Medical Center	Cambridge	MA and Grant	Dawn Sederberg, Triage Nurse (M-F): 763-689-7824 – 651-339-8849 (pager) Donna Krzmarzick, BHS Director: 763-689-7957
Univ. of MN Medical Center-Fairview	Minneapolis	MA	For bed availability, to admit a patient etc. call Central Intake at 612-672-6600 For information about clinical program etc. or status of a specific patient, call Marlene Burr, Manager Clinical Systems: 612-273-4534
Fairview Southdale Hospital	Edina	MA	Pat Murphy, Program Director: 612-273-6272
Fairview-Univ. Medical Center-Mesabi	Hibbing	MA and Grant	Craig Stevens, Dir. of Clinical Services: 218-749-2881
Hennepin County Medical Center	Minneapolis	MA	John Gray, Nursing Supervisor: 612-873-2299 Joanne Hall, Behav. CBU Administrator: 612-873-3364
Mercy Hospital	Coon Rapids	MA	Wendy Emerson, UR Specialist: 763-236-7507 Karin Lucas, Director: 763-236-8603
Miller-Dwan Medical Center	Duluth	MA and Grant	Richard Paul, Director: 218-786-1262 Kari Rengo, UR Specialist: 218-786-2809 Colleen Baggs, Nurse Manager: 218-786-1902
New Ulm Medical Center	New Ulm	MA and Grant	Steve Schneider, Manager of BH: 507-233-1210; 507-252-4172 (pager) Kay Witt, Assistant Manager of BH: 507-233-1293
Northwest Medical Center	Thief River Falls	MA and Grant	Maggie Kaste: 218 683-4341
Owatonna Hospital	Owatonna	MA and Grant	Mary Jacobsen, BHS Manager: 507-455-7647
Regions Hospital	St. Paul	MA	Tom Geskermann, V.P./ BH: 651-254-3988 Michael Trangle, M.D., Assoc. Med. Dir./ BH: 651-254-2734 Cindy St. George, Director BH Programming: 651-254-9269
St. Cloud Hospital	St. Cloud	MA and Grant	Steve Vincent, Director of BHS: 320-255-5777 Deb Stueve, Dept. Director: 320-251-2700., ext. 53201 Sonya Wieber, Quality and Performance Analyst: 320-255-5777
St. Joseph's Hospital	St. Paul	MA	Joe Clubb, Director of Behavioral Care: 651-232-3256
United Hospital	St. Paul	MA	Susan Tabor, Director: 651-241-8639 or 651-241-8565; 612-534-2245 (pager) Kathleen Tuenge, BHS Case Mgr. Leader: 651-241-8658
Worthington Regional Hospital	Worthington	MA and Grant	Melvin Platt, Chief Executive Officer: 507-372-2941 Behavioral Health Unit: 507-372-3273