Short Term Solutions to Behavioral Health ED Volume
October 21, 2021
10:00 am – 11:00 am
Co-Chairs: Tim Marshall & Jeff Vanderploeg

1. **Welcome & Introductions [:02]**
   Jeff Vanderploeg reminded everyone that the meeting is being recorded and asked for everyone to introduce themselves in the chat.

2. **Overview of Workgroup Goals, Anticipated Deliverables, and Timeline [:03]**
   Tim Marshall informed the participants that the workgroup recommendations have been sent via email. Today's meeting will be a review of those documents, and see if anything needed to be added.

3. **Presentation of Workgroup Recommendations [:45]**
   A slide presentation of the recommendations from the workgroup was shared. Recommendations addressing each of the following five areas were discussed: (1) preventing youth from visiting the ED who don't need to be there; (2) facilitating timely discharge from the ED to community based care; (3) facilitating timely inpatient admissions; (4) timely discharge from inpatient to community based care; and (5) process and policy changes that can support these solutions.

   The recommendation report reflects the comprehensive work of the group, inclusive of discussions held at each meeting. The slides demonstrate the prioritization of the group's recommendations within each area per responses to a survey sent to the workgroup members. The survey was sent to 45 people, and 27 responded. There was a separate survey sent to family and consumer group, and they are currently at 93 responses. The results of that survey will be sent out to the group once the information is compiled.

   A participant asked who has already received or will receive the documents. Marshall responded that the report went out to this workgroup, the Children's Behavioral Health Implementation Advisory Board and Tri-chairs, the 12 commissioners, a smaller inter-agency workgroup, inclusive of 5 commissioners and members of the Governor's office and OPM. All documents are public can be shared with additional individuals such as executive staff members.

   Recommendations as Prioritized per Survey Responses (shared via slides)

   I. Preventing youth from Unnecessary ED Visits
      1. Expand the use of Mobile Crisis to triage youth to serve as an alternative to the EDs; (educate, incentivize, and create accountability structures for schools and police to expand their use of Mobile Crisis).
      2. Expedite implementation of one or more behavioral health urgent care center programs (or something similar) and collect pilot data.
      3. Engage SDE and schools to ensure federal funding for SEL/student mental health are being used as intended to meet student mental health needs. Provide mental health technical assistance, oversight, review, and transparency of school district plans with respect to addressing social-emotional learning and mental health services.

4. Use HRSA or other available resources to expand ACCESS Mental Health; consider having ACCESS Mental Health clinicians use a caseload carrying model.
5. Pilot a paramedicine model including use of an ambulance-type service that allows transport of children to a home or community site.

II. Facilitating Timely Discharges from the ED to Community-Based Care

1. Increase reimbursement rates for the intensive home-based services that are currently underfunded.
2. Increase reimbursement rates to acute and intermediate levels of care.
3. Expand utilization of Mobile Crisis to bridge youth in EDs and inpatient beds to appropriate community-based levels of care.
4. Deploy Mobile Crisis clinicians to EDs to conduct evaluations of incoming BH ED youth visits (i.e., the Mobile Crisis ED facility liaison position).
5. Expedite the newly developed DSS RFP for the Intensive Transition Care Managers program.

III. Facilitating Timely Inpatient Admissions

1. Explore the use of technology for real time service and bed capacity availability, e.g. Behavioral Health Link, Open Bed, Unite Us etc. The platform would track youth needing placement (including relevant information for special populations) as well as availability of care (inpatient and PRTF beds as well as intermediate levels of care).
2. Dramatically increase reimbursement rates for inpatient and PRTF and actively recruit sites who might have unused additional bed capacity.
3. Increase respite bed capacity.
4. Streamline referral and admission processes and paperwork to PRTF and inpatient settings.
5. Establish a process utilizing daily emails to immediately stand up a centralized system for tracking acute bed availability, referral and dispositions information.
6. Strengthen congregate care model as a resource for therapeutic residential services.
7. Allow community-based providers to provide emergency assessments on inpatient campuses.

IV. Facilitating Timely Discharges from Inpatient to Community-Based Care

1. Increase reimbursement rates to community-based intermediate levels of care.
2. Increase reimbursement rates for the intensive home-based services that are currently underfunded.
3. Utilize Mobile Crisis as a bridge to next level of care.
4. Develop a clinic service for bridging medication management and therapy.

V. Related Policy and Process Changes

1. Develop specialized capacity at acute and intermediate levels of care to meet the needs of children with serious intellectual and developmental disabilities.
2. Consider changes to existing provider licenses to allow other clinical services to provide services outside the clinic setting, including sufficient reimbursement for in-home services.

3. Consider any possible process improvements within the ED to expedite discharges (e.g., reconsider policy for having a psychiatric evaluation for every child, ensure policies allow for Mobile Crisis to be onsite.
4. Add workforce capacity by expediting licensing process including availability of licensing exams and extension of the Governor's Executive Order regarding licensing.
5. Propose legislation requiring schools to utilize Mobile Crisis as an alternative to the ED.
6. Offer comprehensive training and workforce development opportunities to all staff working in acute and intermediate levels of care for handling treating children with mild to moderate intellectual and developmental disabilities.
7. The CT Hospital Association and member hospitals, utilize their Incident Command System for children's behavioral health crisis and seasonal increases as needed.

[Note that the minutes below reflect the discussion held during the slide presentation].
The goal was to stay true to the integrity of this workgroup. The goal was not to say these recommendations are the only right solutions.

A participant asked about federal dollars to expand ACCESS Mental Health. In the chat a participant noted that this was not an expansion for ACCESS MH CT, but a restoration of original staffing/service. It was also noted in the chat that it would be really helpful to have a real time accounting of the ARPA authorized expenditures specific to children's mental health. Marshall stated it did occur very recently, there are a lot of proposals that are in progress or need to be completed. Many contracts are currently in the works.

Participants discussed the need to know the data regarding length of bed stays in EDs and the reasons for those stays. A participant commented that the internal data for March 2021 shows it was a little bit higher than March 2019, but that boarding increased by 350%. A big part of the delay was kids not being able to get to other levels of care (inpatient/outpatient). Delays in ED discharge due to delays in inpatient discharge were echoed in the chat. The availability of timely data is important.

A participant emphasized the recommendations for Mobile Crisis to support triaging of children in EDs and helping to bridge them into and out of the ED, as well as to divert more kids from coming in. There was an additional discussion regarding DCF-involved children disproportionately having multiple episodes of care at EDs. While DCF-involved children do not reflect a high proportion of overall ED BH visits, Medicaid data identifies DCF involvement as being a risk factor for ED discharge delay. It was noted that in NJ Mobile Crisis goes out for new foster care placements to make the connection to Mobile Crisis for the foster families, and it may be something worth exploring for CT.

A participant noted that for some models of intermediate care, increasing capacity is sometimes more important than increasing rates - there are other limitations that effect availability. E.g., many of these models are closed, grant funded, fee based, or a combination.

A participant noted how important it is to keep follow up care as a part of the Mobile Crisis model even though it is more and more challenging as volume rises. As the use of Mobile Crisis has increased the part that makes the model works is getting comprised.

There was a discussion among participants regarding the recommendation around an electronic platform for real time bed tracking. A participant raised a concern that a real time data system will never be fully accurate because it does not show kids who are waiting in the ED for an inpatient bed. A bed could show up as available, but there's already a child in the ED who needs that bed. Discharges put up on the board but there's already 3 kids waiting. There was a discussion that the platform would track a variety of service placement and would be important to serve the system at large. In the chat, a participant offered that it makes the system wide issues transparent for all key players. Is patient flow impacted due to staffing issues, increase in acuity of patient presentation, lack of availability in appropriate programs, etc.? There was agreement among workgroup members regarding this benefit. Marshall offered that it is important to keep collecting data so we can have a better idea of the needs for the system to do better in the future.

Participants highlighted the need for PRTF and respite (both crisis respite but also planned respite), noting respite is a very valuable tool.

A participant raised the need to ensure the recommendations are transparent and written in lay terms to be accessible by the public including families. Vanderploeg agreed that accountability with recommendations is important and they will share the findings from the family and community survey that was sent out once results are received later in the week.

A participant questioned the recommendation regarding the hospitals' policies for children to have psychiatric evaluations – it is not necessarily a policy for hospitals, but could be a medical liability not to do it. It was acknowledged that recommendation needed to be reconsidered and/or reworded.

To summarize the recommendations Marshall noted that there are a lot of efforts underway, and that the challenges in CT are very complex. None of these recommendations by itself would be a solution. Many things need to happen concurrently and have a domino effect. We need to continue to have short, intermediate and long term goals to have sustainable change.

A participant asked whether building off the enhanced care clinics is being considered. The group noted this as an additional area to consider.

4. **Wrap-Up and Next Steps & Adjourn [:10]**
   Vanderploeg suggested that the next meeting would be used to go over the results of the family survey. A request was made to also provide any updates on decisions made at the agency commissioners meeting.

Next meeting Dates:
Nov. 4th 10:00-11:00 a.m.

Chat Box: Chat comments have been integrated into the meeting minutes.