Behavioral Health Urgent Care & Crisis Stabilization Units
December 7, 2021
1:00 pm – 2:00 pm
Co-Chairs: Tim Marshall & Jeff Vanderploeg

Meeting Minutes:

1. **Welcome & Introductions:**
   The chairs reminded the group that today's main goal was to finalizing the workgroup recommendations and get final feedback.

2. **Overview of Workgroup Goals, Anticipated Deliverables, and Timeline:**
   Tim Marshall summarized the three original workgroups with the added fourth workgroup [the Short-Term Solutions to ED Volume Workgroup]. There has been vocal expression from this workgroup and others that participants would like to further the discussions. This group was tasked with putting recommendations around a CT based urgent care and crisis stabilization units. It's important to note that across the country different states use different terminology for these types of care.

3. **Discuss Crisis Stabilization Unit (CSU) Model Parameters:**
   The CSU model document was distributed prior to the meeting via email as well as through a google doc for individuals to give real time feedback. Very little feedback was received.

   A participant from Yale New Haven Hospital raised concern with prioritizing investment in the CSU at this time. Investing in ways to get youth back into their homes and communities should be higher prioritized. Supporting building and staffing 24/7 is very expensive and labor intensive. A lot of components of the CSU are very similar to how Yale New Haven currently runs their inpatient units. There was a comment in the chat that their recollection was that CSU was not in the original charge for the workgroup.

   Marshall clarified that this workgroup was always charged with developing both levels of care (the behavioral health urgent care and the CSU model). This group is not making recommendations about which items will be funded or not funded. The funding is at the legislative level. This group was tasked with developing the two levels of care. The report will include a broader system context. Proposing a CSU does not preclude enhanced investment in other parts of the system.

   A participant asked is it possible for both to be done. There is a limited amount of funding, creating these additional settings is costly.
   A community-based sub-acute unlocked facility is different than an inpatient level of care. From the beginning of the workgroup there have been two levels of care to be focused on. There are similarities but also major differences to subacute vs. acute models. The goal of the workgroup was if money was not an object what type of model would this group recommend.

   A participant asked what type of kids will be going to these facilities? Is this a child in crisis and/or a family in crisis?
   There is evidence around the country that this type of model is useful. With the additional options the child might be able to avoid the ED all together. CSUs and urgent care centers don't have to have a specific population but it would be important to have a targeted level of care. There was a request in the chat to see existing admission criteria for each of these levels of care, and one to have a grid of all current levels of care and criteria as well what the future would look like with those criteria as a visual in the report.

   A participant suggested adding a line of sub-acute vs acute; defining the difference would assist with identifying appropriate youth.
   The group discussed decisions on levels of care, including referrals to PRTF. The difference between a child with a sub-acute level of care is a youth that is ready to be in the community with 24/7 supports as they are prepared to be transitioned back into the community at the home level. Sometimes PRTF is referred to when the family

isn't stable enough to house the child in a stable and safe environment. Beacon has developed eligibility criteria for PRTF, and there are some areas where the levels of care are similar. A participant added the link in the chat: [https://www.ctbhp.com/providers/pdfs/Child_BHP_Level_of_Care_Guidelines.pdf]. There are guidelines, but final decisions are made between the medical doctors.

A participant asked for clarity around what happened to S-FIT?
The level we are currently discussing is referred to as short term residential or crisis residential. Those pieces have been put forward as well. The biggest challenge with the S-FIT facilities was that most of the beds were open most of the time. The department if trying to be more efficient with tax payer dollars.

There was a discussion in the chat regarding hospitals' challenges with finding S-FITs availability. Providers offered their current S-FIT availability into the chat.

Marshall asked the group if there was any specific parts of the model that people wanted to discuss. We've heard that adding language around target population and level of care is important. If there are areas of the report where clarity can be added, that can be added in the next draft and we will look for your feedback.

A participant suggested adding language in the report to identify challenges.
How do we staff it, how do we figure out where to put these units? The participant didn't feel comfortable stating a recommendation unless it is carefully worded, such as "we've identified this as a model and here are some of the opportunities and challenges that have been identified for implementing in the state of CT". The participant requested that the report acknowledge the practical needs of the project and how do we figure out how to pay for. There was clarification that this group was not tasked with determining how the levels of care would be paid for. A participant added in the chat the concern that COVID relief funding is one-time funding.

It would be good for us to know what did and didn't work in S-FIT to inform how to help develop this new program.

The key is to be sure to have different ways to stabilize children in crisis. Mobile Crisis becomes a key part of puzzle. The more we are able to utilize Mobile Crisis the better. These recommendations are consistent with SAMSHA's crisis models of care.

4. **Finalize Recommendations & Next Steps**
   Marshall outlined the next steps. This group is finalizing the written report for the 23 hour and the crisis stabilization unit; those two things will be put forward in system recommendations that this group has discussed. The short-term solutions document has been finalized and sent to everyone. The data integration and the alternative payment recommendations have been finalized this week as well. We gave a short presentation at the Children's BH Advisory Board meeting. It makes sense to have a follow up routine meeting to review all the pieces.

5. **Chat Box:**
   Note that the comments in the chat box have been integrated into the minutes.