Behavioral Health Urgent Care & Crisis Stabilization Units
November 18, 2021
10:00 am – 11:00 am
Co-Chairs: Tim Marshall & Jeff Vanderploeg

Meeting Minutes:

1. **Welcome & Introductions [:02]**
   Jeff Vanderploeg reviewed the workgroup goals, and mentioned that there would be a discussion regarding additional meetings and next steps at the end of the meeting.

2. **Overview of Workgroup Goals, Anticipated Deliverables, and Timeline [:03]**
   Tim Marshall reviewed the goals for the workgroup, and discussed that the workgroup was charged with developing models for the two levels of care (referred to by this workgroup as BHUC and CSU, but having many different names across the country). These are not short-term solutions but are necessary to have a sustainable approach to addressing the need. He recommended to the workgroup that they take another review of SAMHSA's best practices. Per best practices, Mobile Crisis in the state should be a hub to connect to all levels of care including the crisis continuum. Marshall recommended providers keep an eye on procurements from DCF to address shorter-term implementation strategies. Priority is to get something out as soon as possible. Today's meeting would primarily be focused on the CSU model.

   A participant asked if respite care would be addressed.
   Vanderploeg answered that this group was charged with two levels of care (23-hour urgent care and 1-14 day crisis stabilization units). Respite is relevant to crisis-orientated services, but this group would not be able to take on respite beyond what is currently being talked about. If it's something that continues to be of interest then an additional space would need to be explored that is dedicated to that.

   Marshall referred the group to the 988 Coalition plans including federal guidance on how to fund the crisis continuum. There is federal guidance on crisis services that could be paid for through telecom. If the state chooses that route – to add a cell phone tax - crisis stabilization would be qualified to be paid. Crisis respite was not among what could be paid for with the tax. We are monitoring states across the country with 988, and many states have passed such legislation. In CT we have not heard a discussion about that. SAMSHA is stepping up with funding infrastructure for suicide hotlines being directed into the 988 system.

3. **Discuss Crisis Stabilization Unit (CSU) Model Parameters [:25]**
   Vanderploeg shared a PowerPoint to review the CSU model, including differentiation from inpatient care. CSU is intended to be a short term bedded unit, a community-based unit that is unlocked. This level of care is intended for youth who do not require a higher level of care, staffing would be less intensive including peer specialists. The activities of the CSU would look similar to the urgent care but over a more extended period of time with a quick return to home, school or community. CSU can be a step down from inpatient, but also a step up from lower levels of care. Mobile crisis could make a direct referral to crisis stabilization.

   A participant asked about the difference from S-FIT (Short-Term Family Integrated Treatment).
   Marshall gave a brief overview of the history of S-FIT as a result of a state fiscal crisis, the crisis continuum was never fully built, and S-FIT reflected an attempt by the state to combine a

respite and crisis stabilization service into a hybrid approach. It unfortunately never fully worked, and utilization was very low.

The proposed CSU model would focus on de-escalating clinical acuity and/or distress for children who do not require inpatient. The model would then provide evaluation and assessment for children and maintain them in the least restrictive setting appropriate to their clinical needs. It would also increase connect-to care rates, prevent or reduce admissions/re-admissions to EDs, inpatient psychiatric hospitalization, and PRTF.

Vanderploeg encouraged the group to look into each of the categories of the model and identify what additional information might be needed for each section.

A participant asked if there was a way to join the efforts with Mobile Crisis in regard to developing the training and core competencies.
Vanderploeg answered that yes, as the state continues to roll out the 988 and crisis stabilization continuum, cross training would make sense.

A participant asked if there are current spaces that could be converted to do this model and noted that otherwise it would take millions of dollars to create a new site.
Marshall answered that yes – the first step would be a request for qualifications to identify who out there is willing and able to provide these services and the potential sites, and then a RFP.

A participant asked if there is a reimbursement model for this level of care?
Marshall noted that there is not yet one in CT, however, it appears there could be some Medicaid codes that would apply. Currently talking with DSS for codes as alternatives to the ED, and working to get a sense of what components would be covered under Medicaid. It is intended that there would be reimbursement for many services, and not the intent that state dollars would fully fund these levels of care.

A participant asked if S-FIT physical space or clinical staffing could be used to transition into the CSU model.
Marshall offered that when thinking about the services, a number of places may have some space or could be willing to implement these services. Request for qualifications will identify who would be willing and active. Some sites may be open to this and some might not. Marshall also noted comments in the chat box regarding what may be included in the report in regard to identifying sites: "Add 'Applicable Regulatory Requirements to both facility approval and site operation'. We may also wish to include 'Service Areas,' meaning where would these sites be located in CT and how large an area would they serve? Under "funding approaches," perhaps include 'capital and operating expenses.' Also include 'reimbursement models for services rendered.'

A participant asked about capacity for the CSUs in the chat.
Marshall added that the goal isn't to have large buildings with floors of beds, but somewhere around 6-10 beds. Even if money was no object, being community-based, home-like, sub-acute care, we wouldn't want to build anything overwhelming. The timeline is looking like 1-2 years pending funding and authorization. It will take some work to get this going. The work that this group is discussing has been in discussion since 2014, the pandemic hit and the need was magnified. We already knew about the seasonal challenges the ED's face.

A participant raised concerns regarding staffing and the restrictive aspect the staffing shortage places on new potential services, and also requested that training requirements be vetted.
Regarding staffing concerns, it's been made clear in testimony to the legislature and in other arenas that there is a great need to invest in the behavioral health workforce. Providers need increases in rates in order to be able to pay staff and also need to be able to offer loan repayments, etc. to incentivize recruitment and retention of staff.

A participant asked if the model would be fully state funded or only Medicaid funded.
Marshall reiterated that the goal is for these levels of care to be available to all children regardless of insurance status. We'll need to be able to find a way to work with both commercially insured and Medicaid. One of the challenges that Newtown pointed out was that even those who have the means often can't get access to treatment.

A participant asked for clarification that the length of stay would remain at 14 days (stating there are challenges with shorter LOS).
It was confirmed that it is intended that this model have a 1-14 day length of stay.

A participant raised concerns in the chat regarding staffing and competencies — that "de-escalation" would require a variety of competencies and skills and readiness and that less intensive staffing may not be advisable.
Marshall noted the strengths found nationally in having a model that combines the medical model with a peer and community-based model. In suicide prevention work, peers and survivors often share stories regarding the benefits of peer support.

A participant noted in the chat the need also to prepare for children with ID/DD needs.

4. **Wrap-Up and Adjourn [:05]**
   There was agreement that the group had more to discuss. The draft report will be sent out electronically to the group before the next meeting. The last meeting will be in December, and the group will be able to finish the report electronically to submit mid-December. There was a request to see the document a week in advance and a request to see group comments, and the use of google docs was offered.

   Carl Schiessl offered that the Children's Behavioral Health Plan Implementation Advisory Board has scheduled meetings for December 6 and January 24 and can reserve time for updates or discussion at these meetings.

5. **Chat Box**
   Note that comments from the chat box were included in the minutes above.

Next Meeting Date:
December 7, 2021 1:00pm-2:00pm