Tow Youth Justice Institute
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Q&A Unanswered Questions and Questions that Needed Follow Up from the November 13th TCB Meeting.

The two presentations listed below are posted on the TCB page on the CGA website.

Presentation 1: UCC and Mobile Crisis Data Spotlight

Presenters: Kellie Randall, AVP of Quality Improvement at CHDI, Amy Samela, VP of Residential Programs, The Village for Families and Children & Erin Saylor Chief Operating Officer, Child and Family Agency

Question 1: In regard to the hospital-based Yale program, do you have a sense of timing as to when that will be completed?

Yann Poncin's follow up: As a recap, we have implemented programmatic changes that align with the future services in the dedicated UCC space, and we currently use flexed space out of and within the current PED to provide a distinct experience for families with behavioral health needs. The future dedicated space itself involves the movement of five other services. These services are not "pick up and go"; they require specific designs to accommodate their needs (regulatory, administrative, or clinical requirements), hence the challenged timeline.

The new spaces and movements are now in process, with the demolitions beginning this month. The UCC space will be cleared over the following months, and the build-out will start in April 2025. There is a conservative estimate of six months to build out the space, with the anticipation of being able to complete it sooner

Question 2: What is the highest and best optimal delivery of a UCC services, what case load number should you be hitting and the increment of time if possible?

Presenter Follow up: We aim to be available for all youth experiencing a mental health crisis when they need it with minimal wait. We want to ensure that we have the appropriate staffing model to meet the community's need, so families can immediately access services and receive the ongoing care required to mitigate their symptoms. At this time, we are still assessing the needs in each of our community and, based on our collective years

of experience, know that it will vary based on the season and health of the state at any given time.

Question 3: It would be very helpful for us if you had data not just on how many people you saw, but at what hours of the day. I noticed a lot of your referrals tend to be during daytime, so looking at that 24/7 and if there is a different sweet spot that is more practical and a right sized approach.

Presenter Follow up:

- For the 3 Community sites, the general time frame for admissions is 10am-8pm
- Wellmore, is open 24/7 which ensures that families can access the service when they determine it most convenient and most necessary.

The next page provides a chart of Community UCC episode arrival times from January-October 2024

UCC Episodes by Arrival Time – January-October 2024

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	
0:00-0:59	1	6	2	2	4	1	0	**16**
1:00-1:59	0	0	1	1	0	0	0	**2**
2:00-2:59	0	0	0	1	0	0	0	**1**
3:00-3:59	0	1	0	0	0	0	0	**1**
4:00-4:59	1	0	0	0	0	0	0	**1**
5:00-5:59	0	0	0	0	0	0	0	**0**
6:00-6:59	0	0	0	0	0	0	0	**0**
7:00-7:59	0	0	0	0	1	1	0	**2**
8:00-8:59	1	5	8	7	7	5	0	**33**
9:00-9:59	0	15	15	12	11	16	1	**70**
10:00-10:59	1	16	20	18	23	15	1	**94**
11:00-11:59	2	21	20	20	18	20	5	**106**
12:00-12:59	2	27	17	20	28	27	2	**123**
13:00-13:59	2	22	20	29	26	16	3	**118**
14:00-14:59	1	27	15	20	25	8	6	**102**
15:00-15:59	0	12	17	22	30	22	4	**107**
16:00-16:59	0	23	19	22	23	20	1	**108**
17:00-17:59	2	22	19	15	22	13	3	**96**
18:00-18:59	0	17	15	10	15	15	1	**73**
19:00-19:59	1	12	16	6	14	11	3	**63**
20:00-20:59	1	9	14	9	7	3	2	**45**
21:00-21:59	1	6	3	6	3	2	3	**24**
22:00-22:59	3	2	4	3	6	0	0	**18**
23:00-23:59	0	0	1	0	0	0	0	**1**
	19	**243**	**226**	**223**	**263**	**195**	**35**	**1204**

53% of UCC episodes have begun on weekdays between 11:00 a.m. and 5:00 p.m. 91% of UCC episodes began on weekdays between 8:00 a.m. and 9:00 p.m. Note: only one agency is open 24 hours a day, and all agencies began with weekday/daytime hours and have expanded over time.

Question 7: Could you provide a breakdown between Medicaid and Commercial insurance and what is the status of bundle payments within insurances as compared? If you could provide commercial even in aggregate, it would be helpful.

Presenter Follow up: We are now supplying this information to DCF on a monthly basis. On average it is about 52 (Medicaid) /48 (commercial) split. Commercial insurance pays only for one code and does not support the length or depth of our work adequately at this time.

Question 8: You mentioned that in Connecting to care, that you're referring and when you're referring you are being faced with long waitlists. When you're referring, where are you referring to?

Presenter Follow up: As part of the discharge plan, the discharge planner makes all the necessary referrals as recommended by the family and the treatment team. Based on the time of the day, these appointments/referrals might be made the following day. If the next level of service isn't available, the treatment team will identify a concurrent level of service. For example, if a youth is waiting for IICAPS but there is a waitlist, the youth might then be seen at ECC but meet twice a week until the higher level is available. Additionally, the teams have also partnered with Mobile Crisis to help bridge youth and family until the next level of care is available. If this happens, the family and the program call together and set up their next mobile visit.

Question 9: If you're not able to get a referral done within a timely matter, what is happening to that person? Are you assuming that level of care or is that person floating in the community on their own?

Presenter Follow up: We believe that Connect to Care is one of the outcomes we are looking for at the UCC and therefore would never intentionally leave a family/youth without a provider when they leave the UCC. As part of the aftercare work, the discharge planner is calling the family to ensure follow-up with that next service. If the family comes across any barriers, then the UCC staff will work to identify an alternative option.

Question 10: You mentioned that you have staffing issues, I was wondering if you have that currently and how often do you have turnover in your places?

Presenter Follow up:

- Hiring a complement of staff has been the challenge to open up 7 days a week. It has been challenging to find staff who want to work throughout the weekend. Difficult positions to hire are nursing, clinical and psychiatry.
- We have also found it difficult to staff a program that requires staffing ratios that require staff to be "frozen" when their peers call out. This isn't standard practice in many therapy positions, so clinicians often opt for other roles that they have more autonomy over their schedule.
- Lastly, hiring staff into a program that does not have stable on-going funding is very challenging. It's the nature of non-profit, grant funded programming but the level of instability of this vital service has made staff feel very insecure in their positions in an equally unstable economy when there is a workforce shortage, and they have options to go elsewhere. We're hopeful that a commitment to ongoing funding will mitigate our staffing challenges.
- While Wellmore has been open 24/7 since early January, the issues raised above have been true for us in an ongoing way. We are open for the times that families need us, however, maintaining this results in a complicated balancing act.

Question 11: The length of stay, how long are children staying in urgent care?

Presenter Follow up: It averages around 3.5 hours.

Question 12: What kind of data is being collected around connecting to care so that we know it isn't going to turn into the emergency room situation where if they can't connect to care, then we need to know exactly where and what is needed.

- As part of our d/c data, we know what programs the youth are going to. Families are also being provided aftercare services so if there any barriers, the team can identify a secondary program or bridge service.

Question 13: Another issue I think is important is, are you getting any state assistant from your marketing?

Presenter Follow up: The programs are covering all of the media ad campaigns using any vacancy/unspent money.

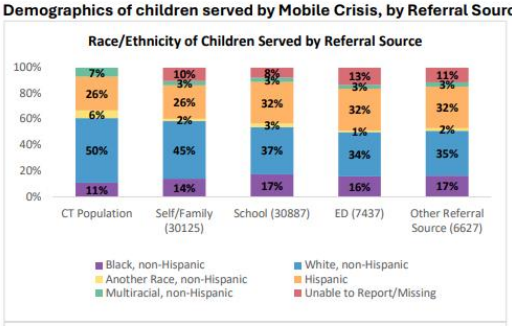
Question 14: Is mobile crisis serving as a stop gap? A bridge?

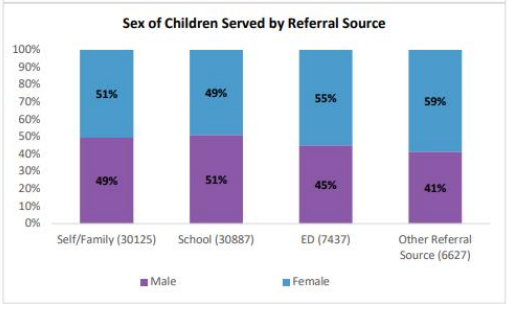
Presenter Follow up: Mobile crisis refers to youth at the UCC and the UCC is utilizing Mobile Crisis as a bridge service only when needed. Use of Mobile Crisis helps to support families as they seek to connect to care for more complicated clinical presentations; while the UCC can provide phone support or invite a return to the UCC, mobile crisis can do an assessment in the home if families agree

Question 15: With regard to mobile crisis utilization, you talked about cohorts coming from the community, family, and schools, is there a way of drilling down to understand or look at the profile of the kids that are coming from each of those buckets? So that we can better understand the needs of those kids coming from those schools? And understand the population's need? Is that data available?

Presenter Follow up: We do look at certain differences by referral source; the next two pages provide an overview of demographics and primary presenting problem by referral source for Mobile Crisis.

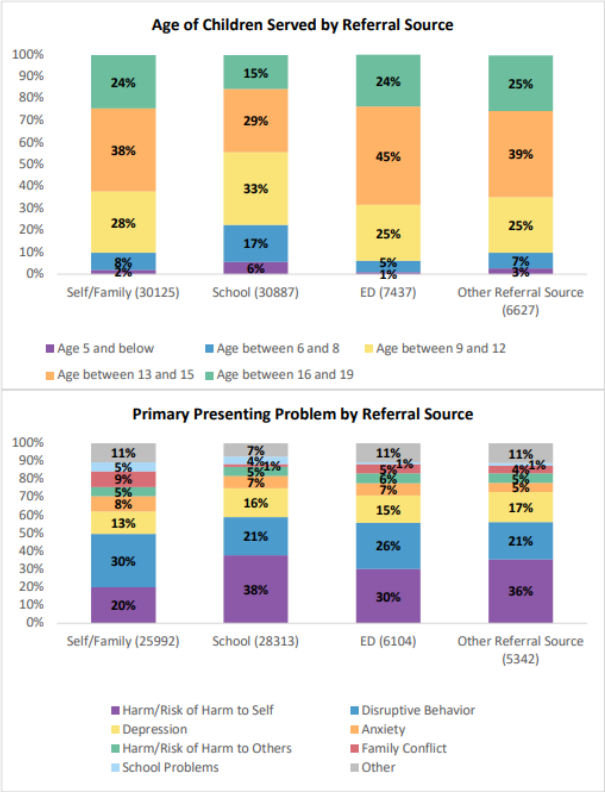
Demographics of children served by Mobile Crisis, by Referral Source – FY2019-FY2024





Mobile Crisis Summary:

- The racial/ethnic breakdown of Self/Family referrals is closest to the CT population, referring Black children at slightly higher rates and White children at slightly lower rates.
- School, ED, and other non-family referrals all had similar demographic breakdowns – all referring Black and Hispanic youth at higher rates than both the CT population and self/family referrals.
- Both Self/Family and Schools refer males and females at similar rates



Mobile Crisis Summary:

- *Schools refer children 8 and under and children age 9-12 at higher rates than all other referral sources.*
- *Self/family, EDs, and all other non-family referral sources refer higher rates of adolescents. Self/family referrals have the lowest rate of harm/risk of harm to self and the highest rate of disruptive behavior.*

- *All non-family referral sources, but schools to the greatest extent, have higher rates of referral for harm/risk of harm to self*

Question 16: If you collect any numbers on whether any referrals are coming from school-based health centers at all, and whether there's mental health capacity within those school-based health center if a referral comes from one.

Presenter Follow up:

- At the time, that data was not collected re: SBHC
- UCCs have since added this to their entry questions, but it is unclear if families will even understand the difference and how accurate this would even be. Additionally, we are looking into if it would be feasible to collect SBHC as a referral source for Mobile Crisis as well.
- Another piece of this is that SBHC are not a common finding in schools. You have pockets where it may be available, but at least in some areas, it is very scattered.

Question 17: Are we capturing race and ethnicity data, or are we capturing data from zip code? Because one of the things that were heard from national colleagues where urgent care centers have been implemented is that at times disparities in access persist where people who have greater psychosocial complexity might be racialized, higher degree of DCF custody still end up in emergency departments instead of urgent care centers.

Presenter Follow up: We do collect race and ethnicity data as well as 5-digit zip code. We routinely compare to the overall CT child population, but it is certainly worth comparing it to those served in the ED to whatever extent that data is available.

Presentation 2: Data Spotlight: Carleon/ CTBHP

Presenters: Carrie Bourdon, CEO CTBHP & Jackie Cook, Regional Network Manager, CT BH

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Question 1: On page 'Youth Ages 3 to 7 Behavioral Health Return Visits' and then prior to that 'Connect to care', I was wondering if the degree of return visits were related to the length of time it took to connect to care?

Presenter Follow up: This is not readily available. Exploring this question further would require additional discussion and likely a focused study.

Question 2: One of the things we see sometimes is kids in the emergency room and recommended for inpatient or a higher level of care and the recommendation changes. I wonder to what extent the data captures those changes in recommendations and it's a sort of question with regard to the ED stuff, but even the sort of psychiatric residential treatment facilities, the discharge where kids are waiting for group homes. Does the data capture the changes for initial recommendations for inpatient or group home to something that's a lower level of care primarily because we couldn't get that and things change over time

Presenter Follow up: The data is based on the last captured reason.

Question 3: My first question has to do the return visits in the ED and if you don't have this now, if you could report back to this, it would be helpful. Do you break out by Neuro-developmental, intellectual disability or ASD on the return visit question? The other part of the question has to do with the PRTFs and length of stay with the same question, folks with neuro-developmental disorders and what would their length of stay be in comparison to others as well as that would have workforce implications as well as workforce competency implications?"

Presenter Follow up: This data is not readily available, however Carelon could produce this for a future meeting.

Question 4: The other part of that question is the 30-day returns, so if we could also factor in the 30-day returns.

Presenter Follow up: This is not readily available. Exploring this question further would require additional discussion and likely a focused study.

Question 5: How do we capture similar data for that cohort of kids who are commercially insured or uninsured, who are still accessing care or need care? I know that the CT Hospital Association has been collecting daily data on ED utilization that does capture the entire population, is there a mechanism that we can capture that data and marry it with some of this data so that we can get a more comprehensive look for the total population of children that need emergency care

Presenter Follow up: CT BHP does not have data for commercially insured youth.

Question 6: The time frames are different in almost every slide, in January 2019 to June 2024, and then you go to the next page its June 2022 to Sept 2024, and then as you go through each one, it is hard to compare the information to see a trend. The other question is you stated, 'the data that was captured by DCF' and I was kind of confused. Is the data captured by DCF different from your data? It should be the same, shouldn't it?

Presenter Follow up: The timeframes vary based on the specific measure/dashboard. For example, claims based reports require a claims lag to allow providers to bill before we can assess the data. ED stuck on the other hand, is a self-reported measure by the ED and therefore is available in more real-time.

Question 7: Isn't this all DCF status since you were contracted through DCF to provide this data to us, correct?

Presenter Follow up: Not all Medicaid youth are DCF-involved, so there are non-DCF involved HUSKY Health youth captured in the report.

Question 8: One thing I found interesting is that you do ages three to seventeen, then you change that. Is that because of access to the actual data or historical data that you were using. On one you have ages six to seventeen and then in the beginning you have three to seventeen, so is it by the definition of the population, that DCF is involved with or is it because there was no data.

Presenter Follow up: The age variation is based on the measure/level of care being reviewed. For example, PRTF is available for youth ages 6 and older so 3- to 5-year-olds would not be included in the measure.

Question 9: Can you clarify DCF status, do you mean any DCF involvement or kids who are committed to DCF?

Presenter Follow up: Any DCF involvement (i.e., not restricted to DCF-Committed)

Question 10: I wanted to clarify, are there kids who stay in a PRTF over 600 days?

Presenter Follow Up: No, the 600 days was cumulative across all youth on overstay.