OPEN MEETING MINUTES

Name of Governmental Body: DHS 31 Crisis Urgent Care and Observation Facilites ("CUCOFs") Advisory Committee			**Attending:** **DHS:** Ski Singh, Joanette Robertson, Brianne Zaborowske, Laurie Hintz, Allie Merfeld, Kathy Teske, Sarah Coyle, Pam Lano, Jenna Suleski, Heather Carlson, Gynger Steele **External:** Matthew Stanford, Bob Rohret, Mary Morse, David Stanley, Julie Owen, Mary Kay Battaglia, Pranav Shah, Michael Lappen, Kathy Markeland, Carrie Simon, Gordon Young, Jill Chaffee, David Wahlberg, Caty McDermott, Tom Diel, Heather Hainz, Richard Eaton, Emily Erickson
Date: 8/26/2024	Time Started: 9:00 AM	Time Ended: 1:00 PM	
Location: via Microsoft Teams			Presiding Officer: Brianne Zaborowske

Minutes

1. Welcome, Introductions
   - Review of first AC meeting (introduction, process for emergency and permanent rule writing, overview of crisis system)
2. Public Comments
   - No testimony or public comments
3. Developing a Crisis Facility (Bob Rohret, St. Croix County)
   - Focus on evolution of Minnesota's system of care and systemic reform – Medicaid expansion state which allows for integration and coordinated care between all health care.
   - IMD Facilities (over 16 bed facilities) could be eligible for Medicaid spending with an 1115 waiver
   - Consideration: How to develop facilities that do not function like a jail or space for detention but include therapeutic measures:
     - How do we do this even with involuntary clients who are on an emergency detention?
     - Consideration of isolation and restraints in the facilities.
     - How do we develop a facility that can provide therapeutic services while also managing potentially dangerous individuals who are brought to the facility against their will?
   - Discussion: Connection to resources and care coordination are a pivotal piece of developing and operating a crisis facility. Hospitals and law enforcement were large partners in this facility type and significant education occurred to ensure partnerships. Questions related to funding for start up costs in addition to sustainability of services. How do people move through the system if they require higher levels of care if they are involuntary to services- and who transports?
4. Admissions (DHS)
   - Review of a few areas of the rule – goals:
     - Considerations, opportunities, and challenges
     - Flag terms that need to be defined
     - Areas for discussion
   - Emphasis on rule writing needing to be applicable to all agencies throughout the state for minimum requirements
   - Act 249 must have services: 1.) accept voluntary and involuntary referrals for adults and, if applicable, youth; 2.) abstain from required medical screening; 3.) provide assessment for physical health, substance use, and mental health; 4.) provide suicide and violence risk assessments; 5.) provide medication management and therapeutic services; 6.) coordinate services for basic needs; 7.) provide safety and security for staff and patients; 8.) staffing

24/7 with telehealth; 9.) allow for voluntary and involuntary services and allow for conversion in the same setting to voluntary services

- Whiteboard Exercise:
    - Involuntary admissions: how does the ED get authorized?
    - Significant discussion regarding involuntary clients and what is the nature of "urgent care facility" services
- Discussion:
    - How are we defining admission? Seems like there are two roles/service lines for the facility- both urgent care triage and non-inpatient stabilization
    - Admission needs to be discussed and defined

5. Services (DHS)

- What are the different services being offered by CUCOF settings?
- Two different tracks of conceptualizing services: voluntary and involuntary
- Discussion:
    - Can these facilities realistically be a stand alone facility or is it more appropriate that they are co-located or part of a hospital/inpatient beds?
    - How do we sustain these facilities without funding and staffing connected to larger entities?
    - Some feel their communities could not obtain/sustain staffing for 24/7/365 facilities

6. Youth Crisis (Emily Erickson, DCF)

- Child welfare: CPS/Youth Justice focused- all youth needs may be broader
- There has been an increase in child welfare due to lack of behavioral health services needs being met in the community
- Youth involved in child welfare system may have multiple persons involved (county CPS, foster parents, court, etc)
- Recommendation to not create extra layers or hoops in order for youth in child welfare to access services they need. A child in need is a child in need
- Placement options will be a consideration when writing rule
- Discussion:
    - How do we navigate within both the child welfare and behavioral health systems? We need to look at both voluntary and involuntary for youth specific services. Are both voluntary and involuntary youth spaces locked/secured?

7. Operating a Crisis Facility (Dr. Julie Owen, MHEC)

- MHEC is a partnership between Milwaukee County and private hospitals
- Provides 24/7 psychiatric care and is licensed as a 124 hospital
- Provide both voluntary and involuntary services
- Private hospital (Aurora) is facility manager
- Discussion;
    - Conservations around care coordination and discharge planning- both large considerations for CUCOFs
    - How could staffing and operations be scaled to smaller communities/smaller facilities? Best ways to use telepsychiatry in more rural areas?