Behavioral Health Urgent Care & Crisis Stabilization Units
August 19, 2021
10:00 am – 11:00 am
Co-Chairs: Tim Marshall & Jeff Vanderploeg

1. **Welcome & Introductions [:02]**

Jeff Vanderploeg introduced himself and Co-Chair Tim Marshall. He indicated that this meeting was rescheduled from late July, and notified participants that the meeting was being recorded and that the recording would be saved on the www.plan4children.org website along with meeting minutes.

2. **Overview of Workgroup Goals, Anticipated Deliverables, and Timeline [:03]**

Tim Marshall briefly reviewed workgroup goals established at the outset of the process. He pointed out that recommendations for a Connecticut BH Urgent Care (BHUC) model had been discussed in the Children's Behavioral Health Plan and the state is now moving toward implementation. Marshall also noted that this model was an important part of federal initiatives focused on the crisis continuum of care, and was also related to the planned implementation of a 9-8-8 system.

3. **Facilitated Discussion of BHUC DRAFT Model Parameters [:45]**

Jeff Vanderploeg reviewed a draft document of BHUC model parameters that had been distributed to the workgroup prior to the meeting. He solicited feedback and input from workgroup members along each dimension of the model. One participant noted that it was difficult to understand where the state's Mobile Crisis service for children fit in to the BHUC concept, as well as how BHUC related to other parts of the continuum. Marshall indicated that Mobile Crisis was anticipated to serve as a main "gatekeeper" for the BHUC. Vanderploeg noted that a new section of the document may be needed that clearly articulates where the BHUC fits with other system components such as Mobile Crisis, EDs, PRTF, and other levels of care.

Another participant stated that the references in the document to the role of Emergency Departments was good, but that there are other points of access into the system that should be reflected as well, including primary care physicians, schools, and first responders. Other participants validated the idea that multiple pathways and referrers into BHUC would be ideal, but that clear triage and decision-making protocols would be needed to ensure that youth and families were referred to the right option. Participants further underscored the importance of educating the whole system about the availability of the BHUC and how to access it. Vanderploeg indicated that a section on "Outreach and Education" could be included in the model document, and that the concept of a "no reject" policy for BHUC was important to its optimal functioning.

A participant believed that a BHUC should be at least as well positioned to address the needs of youth at imminent risk of harm to self or others as a general ED; therefore, the participant recommended that the group consider including youth at imminent risk of harm to self or others as a target population of BHUCs. The participant further noted that general medical EDs were best for youth in need of medical treatments other than behavioral health and encouraged the workgroup to carefully consider which youth were appropriate for the BHUC level of care, and who should be making those triage decisions. Participants noted that medical screening at the door, conducted by nurse practitioners or physician's assistants, have been used in other locations. Others noted that legislation may be needed to allow some referrers to send youth directly to a BHUC rather than to an ED.

Participants then discussed the physical location of a BHUC. Participants noted that a BHUC, at minimum, should be adjacent to a hospital and have strong bi-directional flow of patients based on their needs. Other participants, however, noted the strong potential for community-based providers to deliver services in a BHUC

even if the BHUC was physically located on hospital property. Furthermore, integrated models of adult and youth BHUC were raised as being potential money savers; however, other participants noted that the needs of adults and children with behavioral health conditions were very different and co-mingling those services in one site may not be advisable.

In the area of training, participants noted that first responders would need a lot of training or they would continue to send everyone to the ED. Training/workforce development, marketing, and legislation were identified as very important elements to successfully launching a BHUC model. Other participants noted that some police departments viewed themselves as very competent in addressing behavioral health concerns, and that some police departments were adding social workers to their staff.

Discharging clients within the 23-hour design of the BHUC was raised as a concern. Participants stated that required COVID testing and difficulties accessing other levels of care in the community may make a discharge within 23 hours very difficult. Others noted the specific need to ensure BHUCs could address the needs of youth with Autism as well as intellectual and developmental disabilities. Participants supported training of all BHUC staff to ensure they could address the clinical needs of what was likely to be a very diverse group of youth.

4. Wrap-Up, Next Steps, and Adjournment [:10]

Tim Marshall thanked participants for a productive meeting and noted that presenters from Bellevue and Northwell-LIJ were scheduled to present on their models at the next meeting on August 26. He then asked participants what future workgroup meetings should focus on. Responses included:

- Continue revisiting the model description document, particularly the goals of the BHUC model.
- Talk more about licensing and accreditation requirements (DPH, DSS, DCF, other)
- Presentations by other states operating successful models

5. Chat box

From Laine Taylor to Everyone: 10:17 AM
I had the same question, but I would recommend that the focus would be with injury that requires immediate medical attention

From Frank Fortunati to Everyone: 10:18 AM
I agree with Jason's comments

From Carl Schiessl, CHA to Everyone: 10:19 AM
Yes, I do too. Thank you. Great discussion.

From Laine Taylor to Everyone: 10:20 AM
per the weapons point... individuals in police custody who need eval, should go to ED as well

From Carl Schiessl, CHA to Everyone: 10:22 AM
I just sent a consumer guidance developed by the DPH Quality of Care Advisory Committee in 2015 in an effort to inform and educate consumers on where to go in the event there is a medical need as among EDs, urgent care centers, and retail clinics.

From Tammy Freeberg to Everyone: 10:27 AM
I believe that there was legislation a few years ago that makes it possible, but I agree that training and other "stuff" will need to be in place to actually make it happen.

From Frank Fortunati to Everyone: 10:28 AM
Totally agree with that!. This center should also be a resource for kids that come to the ED first. That is consistent with the "no wrong door" access.

From KramerM to Everyone: 10:40 AM
I agree with Jason,

From Howard Sovronsky to Everyone: 10:41 AM
I agree that this should be seperate

From Jason Malia to Everyone: 10:41 AM
I worry about this as well. 23 hours is a short time line. Hopeful that the system can work that quickly

From Carl Schiessl, CHA to Everyone: 10:42 AM
Is the 23-hour issue related to reimbursement for services?

From Steven Rogers to Everyone: 10:43 AM
yes

From G Steck/Wellmore to Everyone: 10:43 AM
I thought so too Carl. Under Medicaid I think this is the case, no?

From Carl Schiessl, CHA to Everyone: 10:43 AM
That's what I was thinking.

From C. A. Gonzalez, MD, CCGC to Everyone: 10:44 AM
23+ hours in an ED setting can be nightmarish, but in an ideal BHCU, that would not be the case

From Amy Evison to Everyone: 10:46 AM
How would children be cohorted by age and development? Teens with young children would be a challenge due to how differently their behaviors and risk presents itself.

From Tammy Freeberg to Everyone: 10:47 AM
I think that the question of whether the stabilization unit is an integral component of Connecticut's urgent care model, rather than a separate program, is almost more important than the hospital vs community based setting question.

From Laine Taylor to Everyone: 10:51 AM
I agree, Mickey. Children with ASD and IDD will arrive to the centers regardless. We need to provide facilities and staff who are ready to support those children appropriately.

From Jason Malia to Everyone: 10:51 AM
Is Urgent Care covered the same as an ED bill from Medicaid? I think this is important to ensure the copay or bill would not be more in the urgent care model.

From KramerM to Everyone: 10:53 AM
Thank you!

From Carl Schiessl, CHA to Everyone: 10:53 AM
Great discussion. I'm afraid I must depart at 10:59 to participate in a call with DPH. Thank you.

From Laine Taylor to Everyone: 10:53 AM
A population who would best be served, even for assessment for MH issues are those with complex medical co-morbidities or severe eating disorder with medical complications

From C. A. Gonzalez, MD, CCGC to Everyone: 10:55 AM
might be good to revisit the document, especially in re goals

From C. A. Gonzalez, MD, CCGC to Everyone: 10:59 AM
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i might not make it to next week's meeting. will it be recorded and available later?

From Elisabeth Cannata - Wheeler to Everyone: 10:59 AM
yes to revisiting the document...also as we talk about this continuity between levels/programming, I think we should spend a little time discussing the family engagement and support aspects...that is often where there is a lot of tension in transition - where parents not feeling safe - and additional implications when there are children in foster care