Short Term Solutions to Behavioral Health ED Volume
October 14, 2021
9:00 am – 10:00 am
Co-Chairs: Tim Marshall & Jeff Vanderploeg

1. **Welcome & Introductions [:02]**
   Jeff Vanderploeg overviewed the workgroup goals and outlined the agenda.

2. **Overview of Workgroup Goals, Anticipated Deliverables, and Timeline [:03]**
   Tim Marshall introduced Jennifer Jencks and also noted that Carl Schiessl would give a brief update.

   Carl Schiessl from the CT Hospital Association provided an update on the hospitals' response to ED volume. Hospitals reengaged the Incident Command Structure regarding the volume of children with behavioral health needs in the EDs. The hospitals have been able to achieve patient transfers primarily from Connecticut Children's and Yale to other hospitals. CHA has been reporting daily to the state of CT to make sure the state is aware of what is going on in real time. Representatives from Children's and Yale emphasized the collaboration. Schiessl reported they hope to use this experience to understand better how to respond to crisis in real time as a system.

   Participants asked about the involvement of community-based providers. Schiessl responded that they were trying to respond to the immediate crisis, but in the future it would be important to engage the community based providers.

   A participant noted in the chat that it would be very helpful to have some data regarding admissions to ED: age, region, school district, referral/admission source, whether the family touched mobile crisis.

3. **Presentation from Jennifer Jencks on Lessons from Rhode Island [:25]**
   Jennifer Jencks gave a presentation regarding her experience in Rhode Island. She is currently the COO of the Children's Center in Hamden, but presented to the workgroup based on her experience overseeing behavioral health services at a hospital in Rhode Island. Her presentation included the following practices that have the possibility to inform Connecticut's solutions to its current challenges.

   1. To centralize reporting of bed availability in RI, each hospital sent an email every morning detailing how many beds were available. An email went back out each afternoon to all relevant parties that offered hospital availability across the state.
      a. A participant asked if special populations or specific needs were noted in the emails (e.g., ASD or ID) as that is sometimes where the challenges with placement come in. Jencks responded that specific needs were noted.
      b. A hospital noted that the challenge comes when there are multiple children with the same specific needs and not enough specialized staff to support them.
      c. A participant recommended a google spreadsheet for tracking.
      d. A participant referenced DMHAS' online tracking system.
      e. Jencks also noted in the chat later that in RI, evals and placement typically occurred within 4 hrs.

2. While RI no longer had Mobile Crisis services, they did have a dedicated phone line for behavioral health crisis in communities and schools. One difference from CT Mobile Crisis was the use of a screener *by schools* to triage youth before placing a call, avoiding sending children to the ED unnecessarily.

3. The use of an electronic referral program was also very beneficial in RI. The platform called Unite Us worked was effective for electronic referrals for behavioral health, but also for basic needs, and medical needs.
    a. Participants commented that there is some use of Unite Us already in Connecticut. It was also mentioned that it can take into account who has been waiting the longest, the needs and location of the family, etc. There are other similar platforms in other states as well, e.g., Behavioral Link in GA.
    b. It was noted, also, that moving kids out of inpatient is a challenge also. Access to lower levels of care is important as well. And, in the chat, that it would be important to know how many inpatient and PRTF discharge delays there are. Care coordination can support these efforts as well.
    c. Concerns were noted in the chat regarding the time it takes to admit to PRTF.
    d. Piloting an urgent care was confirmed as a solution being considered.
    e. A concern regarding private residential facilities with children from out-of-state bringing youth to EDs was raised.

4. Finally, a bridge clinic model, providing medication management and basic services while other referrals come into place helped as well.

There was a brief discussion (including chat comments regarding the status of kids still in EDs). Yale reported it had 13 youth in its EDs, 8 of them requiring hospitalization; their child unit is already one over census, and their adolescent unit full. CT Children's reported having 26 BH patients stuck in the ED and that they are developing a more robust real time internal data reporting system but we really need statewide data to support it. It was also noted that the same concerns are in adult units now.

A participant raised a question in the chat about the DSS RFP regarding care coordination and it was reported that it is now moving forward.

4. Brief Recap and Group Prioritization of Recommendations from October 7th [:25]

The chairs had planned to do a series of polls to allow the workgroup to prioritize the recommendations discussed to date. However, due to a lack of time, it was decided a survey would be sent to the workgroup members allowing them to rank the recommendations. It was asked that the workgroup members, in ranking the recommendations, consider the cost, political will, how long will it take to implement and how many youth can be impacted by the solution.

5. Wrap-Up and Next Steps & Adjourn [:05]

The meeting was adjourned at 10am. An email will be sent containing a survey for participants to complete.

<u>Next meeting Dates</u>:
Oct. 21st 10:00-11:00 a.m.
Nov. 4th 10:00-11:00 a.m.