Behavioral Health Assessment Centers & Urgent Care
July 1, 2021
10:00 am – 11:00 am
Co-Chairs: Tim Marshall & Jeff Vanderploeg

Proposed Workgroup Goals:

1. Review current federal and state initiatives to expand the crisis care continuum
2. Review and define core components of the crisis continuum (services and infrastructure)
3. Review literature and expertise for Connecticut's consideration in future system development
4. Make recommendations to Children's Behavioral Health Plan Implementation Advisory Board and the 12 state Department Commissioners for further follow-up and implementation

Anticipated Workgroup Duration
Monthly; up to 6 meetings

Materials to be distributed to Workgroup:

1. *Crisis Services: Meeting Needs, Saving Lives* (SAMHSA)
2. *National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit* (SAMHSA)
3. Excerpt from SAMHSA Guidelines on Core Services and Best Practices (SAMHSA)
4. *Emergency Department Use by Connecticut Children and Youth with Behavioral Health Conditions* (Child Health & Development Institute & Beacon Health Options)
5. *A Matter of Public Health and Safety: How States Can Support Local Crisis Systems (*Justice Center, Council of State Governments)

Meeting Objectives:

1. Review national best practices in crisis behavioral health services and supports
2. Review existing components, and gaps, in Connecticut's behavioral health crisis continuum
3. Plan out future workgroup meeting agendas, objectives, topics, materials
4. Identify workgroup co-chairs

Agenda:

1. **Welcome & Introductions**

   Jeff Vanderploeg welcomed participants and asked them to introduce themselves using the chat function.

2. **Overview of Workgroup Goals, Anticipated Deliverables, and Timeline**

   Jeff and Tim Marshall shared an overview of the workgroup goals, deliverables, and timelines. Tim then provided background and context on national and state funding and service system enhancement efforts.

3. **Discussion of National Best Practice Documents and Future Crisis Continuum, Comparison to Connecticut's System**

   a. Service and Infrastructure Components:
      i. Statewide Call Center: 9-8-8 real-time appointments, closed-loop referral system
      ii. mobile crisis,

iii. urgent care (23-hour),
iv. Crisis Stabilization and intensive assessment center (14-day),
v. inpatient,
vi. PRTF

A participant asked for details about the Department's plan for locations of the urgent care and assessment centers. Tim responded that there have been only very preliminary discussions to date but no decisions have been made on siting these new service settings. He noted that a public-private partnership will be needed for these services settings, as well as other areas of children's behavioral health service delivery.

Tim noted that this workgroup will refer to the 23-hour setting as "behavioral health urgent care" and the 1-14 day setting as "behavioral health assessment centers." Another participant noted that less than 50% of patients at their emergency department setting are discharged in 23 hours or less, which may complicate the 23-hour model being contemplated. Tim responded that this would be further explored in the next segment.

Tim noted that the SAMHSA Crisis Best Practice Toolkit had been widely distributed to states and may be helpful for guiding Connecticut's efforts, and summarized major themes from this report. He noted that the report identifies three core components of a crisis continuum: 1) call center (likely to be 9-8-8 when implemented by July 2022); 2) 24/7 mobile crisis; 3) 23-hour behavioral health urgent care. He added that Connecticut views assessment centers (1-14 day), inpatient beds, and psychiatric residential treatment facilities (PRTF) as being other important components of the crisis continuum. Tim said that throughput would be greatly improved by integrating these service components, and that workforce development would be needed to address the needs of a variety of presenting concerns and diagnoses.

Tim said the vision was to offer the 23-hour urgent care center as an alternative to the general medical emergency department, and that Mobile Crisis would provide an important linkage to this level of care. A participant noted that in previous work experience in California, an urgent care model was implemented at their facility that allowed police and ambulances to refer, rather than relying only on walk-ins. In addition, he noted that Mobile Crisis must have information about the whole system in order to most efficiently link to the appropriate level of care. A participant noted that value based payment approaches may have the potential to further incentivize utilization of these new levels of care, and that it feels that Connecticut is on the verge of aligning resources to address the behavioral health ED issue in Connecticut. Another participant noted that real-time bed tracking real-time appoints is another important infrastructure component worth considering in Connecticut.

A participant asked about the plan for what would occur clinically for youth in a 23-hour setting. Tim indicated that the focus should be to ensure crisis stabilization and initial assessment as quickly as possible in these settings, and then achieve linkage to ongoing care. There were several other comments offered in the chat box that were recorded to help inform the crafting of future meeting agendas.

4. **Identify agenda for subsequent meetings: Data, best practice approaches, resources, or presentations**

Tim indicated that he and Jeff would convene to review meeting notes and craft future agenda items.

5. Co-Chair Volunteers

There was not sufficient time for this agenda item. Participants are invited to contact Tim and Jeff if they are interested in co-facilitating future meetings.

6. Adjourn

The meeting was adjourned at 11:00 a.m.