Behavioral Health Urgent Care & Crisis Stabilization Units
September 30, 2021
10:00 am – 11:00 am
Co-Chairs: Tim Marshall & Jeff Vanderploeg

1. **Welcome & Introductions [:02]**
   Jeff Vanderploeg opened the meeting and welcomed everyone.

2. **Overview of Workgroup Goals, Anticipated Deliverables, and Timeline [:03]**
   Tim Marshall encouraged participants to send additional notes electronically regarding the draft recommendations being reviewed today.

3. **Review Draft Recommendations for BHUC [:25]**
   Vanderploeg shared the draft Urgent Care model document which included a rationale for the need for urgent care in the state and critical model components informed by prior meetings of the workgroup, the broader literature and lessons from other states.

   A participant raised questions regarding potential challenges with the new level of care, in regard to funding sources, physical space, and time to implementation. The participant noted that the urgent care model will not provide a timely response to the immediate challenges being faced.

   Marshall acknowledged that there would be time needed to fully develop and implement a new level, but noted that this workgroup's deliverables and goals have been clear from the beginning. He mentioned that the standards of care are almost completed and that the document being shared with the group was created from comments that had occurred during the past workgroup meetings. Reimbursement rates, etc. will need to be worked out.

   A participant raised a question regarding what could be done in the short-term to address the immediate challenges and also recommended estimating the cost and available funds. They raised a concern regarding the timeline and expense of urgent care, and shared that they felt the legislature is eager to hear what will be the immediate response to the behavioral health crisis.

   Vanderploeg asked the group to consider which parts of the current model would work in an early phase of implementation and which parts would come later. It was noted that a physical site would be an item that would likely occur later down the road.

   Participants raised two major concerns: (1) youth being stuck in the ED, needing more rapid triage to get kids out; and (2) the need for an alternative to the ED for behavioral health crises. A participant suggested identifying some partnerships that are willing to start offering urgent care access as a creative and innovative solution to build on over time. The participant suggested that this could be achieved rapidly and then stepped up in the future. This type of work would need to be funded through a grant since there is not funding right away, and then potentially demonstrate the benefit for Medicaid funding.

   A participant noted that while reviewing the Crisis Stabilization Unit model parameters they struggled to see the difference between that model and inpatient hospitalization. They

recommended something that could be done more quickly to address the 1-7 days following an ED visit would be an IOP or a PHP model. It was noted that it's challenging finding available services for children that come into the ED. It was added that integration of medical records across hospitals and community providers is very important. Having to give referrals by phone, email and fax is very time consuming, and often delays care. The system would benefit from electronic referrals and an increased focus on the 1-7 days following the ED – these solutions would ease the burden on the patient and the clinical staff.

Marshall offered that these comments from participants would be added into the content of the documents. Marshall stated that this group needs to deliver some type of concrete plan around urgent care and crisis stabilization units, however in recognition of the concerns raised, there may be a need to create a spin off meeting to address short-term solutions to these urgent needs.

A participant noted that while urgent care and crisis stabilization units would be new for CT, they are not new models for other states, and this group could learn from what has been done already elsewhere. A participant requested via the chat function that the following be included in the model development documents: (1) Are there models in other states and how are they working, (2) Can we implement a model in CT, and if so, what are the challenges associated with implementing such a model in our state?

A participant questioned using PHP and IOP as an answer for the kids that are currently being seen in the ED, stating that they are very costly and that Medicaid reimbursement is very low. Another participant responded that the model is helpful in discharging kids to appropriate levels of care, but the reimbursement levels make it not work.

Another concern was raised regarding the low inpatient capacity and the need for access to refer children after they've been assessed. They noted that reimbursement rates were very low, and also that bed capacity should be added into the workgroup documents. The need for inpatient beds was referenced in both verbal and chat comments.

A participant asked what the driver behind 23 hours is [in an urgent care model] and what happens on that 24th hour? Where do children go at that point?

Marshall responded that the urgent care setting is intended to prevent an overnight stay. It is a setting that is easily accessible and the hope would be a 2-4 hour visit. The participants agreed that would be an ideal timeframe and noted that often times kids are not able to be seen and assessed within 23 hours in EDs. Some participants noted they would not want to see children in the urgent care for 23 hours and then sent to the ED. Yale added that even though they have a lot of beds, they still get full and then kids end up in the ED beyond 24 hours because they don't have a bed to find. It was questioned in the chat if, additionally, Medicaid definitions of inpatient/outpatient were also driving the 23 hour cap. Chat responses included that for Medicaid up to 23 hours should be paid for as ambulatory. Over 23 hours should be billed as inpatient, however, practically inpatient requires many regulatory approvals.

Marshall noted that by getting kids out of the ED and into behavioral health urgent care centers, children would be assessed more timely. He noted that it is an important piece that will help the system overall. If there were behavioral health urgent care centers in place, we

wouldn't have the current challenge of kids getting stuck in EDs with behavioral health needs. However, there would be an occasional need for youth showing up at an urgent care with very immediate risks to be sent to the ED, just as occasionally occurs with Mobile Crisis now.

A participant requested that the target population and level of acuity intended for the urgent care centers be clarified; the group needed to be clear what level of acuity is appropriate for urgent care vs. ED vs. outpatient. Vanderploeg responded that could be added to the document and that the target population would be youth that don't need to be in the ED but do need stabilization for a psychiatric evaluation. He also noted that it would be helpful to receive data from the EDs regarding the volume and acuity of the children coming in for behavioral health needs. Others emphasized in the chat that would be helpful. Yale offered that since October of 2020, they have averaged a 43% inpatient rate.

A participant shared that in Massachusetts the governor and legislature got involved to add extra beds and that led to additional funding in the state. Reimbursement is primarily an issue with Medicaid; the rates are far too low and do not cover costs.

4. **Begin Discussion of Crisis Stabilization Unit (CSU) Model Parameters [:25]**
   The group did not have time to discuss the CSU Model Parameters.

5. **Wrap-Up and Next Steps & Adjourn [:05]**
   The co-chairs stated that they would move forward with setting up an additional meeting to discuss immediate solutions and to gather as many ideas as possible. One additional question was asked regarding S-FIT and whether, when those close, that funding would be repurposed. Marshall responded that it has been planned that the funding would be put toward the Crisis Stabilization Units in order to work toward a full continuum of crisis services.

   A quick poll was taken to assess the interest in a second meeting time to discuss immediate needs. The interest of the group was confirmed and Marshall stated that they would look at the Calendar to identify additional dates & times for the meeting.

6. **Chat box:**
   All Chat Box questions were addressed during the discussion and are reflected in the minutes above.

Next meeting Dates:
October 28, 2021
November 18, 2021