Behavioral Health Urgent Care & Crisis Stabilization Units
October 28, 2021
10:00 am – 11:00 am
Co-Chairs: Tim Marshall & Jeff Vanderploeg

Agenda:

1. **Welcome & Introductions [:02]**
   Jeff Vanderploeg welcomed the group to the 5th meeting. He informed the group the meeting would need to adjourn at 10:30am today due to an unexpected conflict for many of the members.

2. **Overview of Workgroup Goals, Anticipated Deliverables, and Timeline [:03]**
   The goals of the workgroup were reviewed.

3. **Review Draft Recommendations for BHUC [:25]**
   Vanderploeg shared the PowerPoint regarding the BHUC model design. These recommendations are based on the group's discussions. Carl brought up the increasing challenges to have staff available to provide care. The beds might be available but often times the staff is not available. Vanderploeg responded that the workforce challenges are critical to address, but that there were long standing challenges before the pandemic with use of the ED for behavioral health. The goal of the recommendations is to develop a model for a separate Urgent Care center with the understanding that this group is hopeful that staffing challenges can be overcome. It is important to note, however, that hiring will continue to be challenging.

   Vanderploeg noted the changes to the model document since the last time they reviewed it. Psychiatric assessment and ruling out medical concerns was added based on past conversations. One of the goals would be to provide that level of assessment. A participant mentioned that the ability to provide telehealth is beneficial there.

   Participants discussed the need to provide more detail in the model document, including what is included in intermediate levels of care and the need for respite care. Marshall noted that the best practice document that SAMHSA has put together does have respite and crisis stabilization as separate. CT will need to be clear on what it wants to be accomplished. Marshall noted he did not see crisis respite listed in the services identified for possible funding through 988 implementation. This group needs to be inclusive of it in the crisis array it recommends.

   The report will need to ensure there is an understanding by the audience with how urgent care fits in within the continuum of services, for example 211 and 988, crisis stabilization, EDs, crisis respite beds. Urgent care is to be a part of a crisis continuum of care. The group recommended that we have a clear description of the target population. It should be accessible to all levels of youth whose needs require the care regardless of system involvement, payer, acuity, etc. It's important that specialized competencies are included in the BHUC and provide intervention even if they are a risk to themselves. Urgent Care should be able to directly refer to inpatient. It will be important to have real time bed tracking as well.

   Participants raised questions regarding the feasibility of direct admit to inpatient from the BHUC. It was noted that it can happen, maybe not within 24 hours always, but there's nothing from preventing it from happening. It's a different model. There will need to be a culture shift in CT, but it does happen in other states. A participant questioned whether the BHUC could truly provide

services to *everyone* that did not have an immediate medical emergency. The model will need to clearly define who goes to the ED – there will likely be some children who are too acute for BHUC. Another participant discussed the need to ensure that out of pocket costs do not deter families from the BHUC and toward the ED.

The group added a few recommendations for the document in the chat:

- Clarify “inpatient” by using the term "inpatient psychiatric care".
- Multiple participants clarified that having children transported from an ED to a BHUC would not be allowable or desired.
- A participant offered the following BHUC services for inclusion: (1) assessment to develop level of care recommendations, including a focused mental health evaluation, assessment of immediate safety concerns (risk assessment) and further mental health needs; (2) Medication may be started, if indicated and urgently needed; (3) Safety planning; (4) Brief coping interventions for child and caregivers; (5) Family psychoeducation; (6) Referral and linkage services; (7) In person (home or clinic) or telephonic transitional care of significant duration to bridge to recommended treatment; (8) Communication with other care providers

4. **Begin Discussion of Crisis Stabilization Unit (CSU) Model Parameters [:25]**
   The group agreed to discuss this item at the November meeting.

5. **Wrap-Up and Next Steps & Adjourn [:05]**
   Tim Marshall ended the meeting informing the participants that the next meeting will need to focus on the Crisis stabilization recommendations. Once the changes have been made to the Urgent Care Recommendations they will be sent electronically and participants will be asked to respond virtually. Marshall encouraged groups to think beyond the workforce shortages etc., but to focus feedback on the specific model. The meeting was adjourned at 10:34am.

6. **Chat box:**
   Messages from the text box were incorporated into the minutes above.

Next meeting Dates:
November 18, 2021