Immediate Action Plan to
Enhance the Behavioral Health System for Children in Connecticut

October 8, 2014

Consistent with national trends, hospital emergency departments in Connecticut have seen annual increases in the number of youth presenting with behavioral health issues. These increases, partnered with seasonal patterns of increased utilization, have resulted in emergency department (ED) discharge delays, particularly during peak periods in the spring.

Public Act 13-178 required the Department of Children and Families (DCF) to develop a comprehensive, integrated plan to meet the mental, emotional, and behavioral health needs of all children in Connecticut. This long-term plan, released on October 1, 2014, includes recommendations that will fundamentally reform Connecticut's behavioral health system over a number of years. In order to jumpstart this process and provide relief now to the Connecticut children and families who have to navigate the children's mental health system, Governor Malloy has developed this action plan for immediate implementation.

The Governor's immediate action plan will quickly increase capacity in the system, including addressing the unique treatment needs of children with autism spectrum disorder and behavioral health challenges. By undertaking this capacity building now, we can ease the capacity issues faced by EDs, particularly during the spring peak period in 2015. These steps are not intended to replace or forestall action on DCF's recently completed long-term plan.

The package of initiatives uses evidence-based interventions, such as Wraparound Milwaukee which has proven positive outcomes integrating intensive care coordination and child and family teaming with clinical support to the child and family. Further long-term initiatives should also rely on evidence-based interventions.

The initiatives are funded with both existing and new or reallocated resources. Repurposing existing resources will allow current providers to reallocate efforts in slightly different ways with some additional funding to meet the needs outlined in the plan. For those initiatives that are being newly funded, providers, including existing providers, will have an opportunity to receive funding through a competitive procurement.

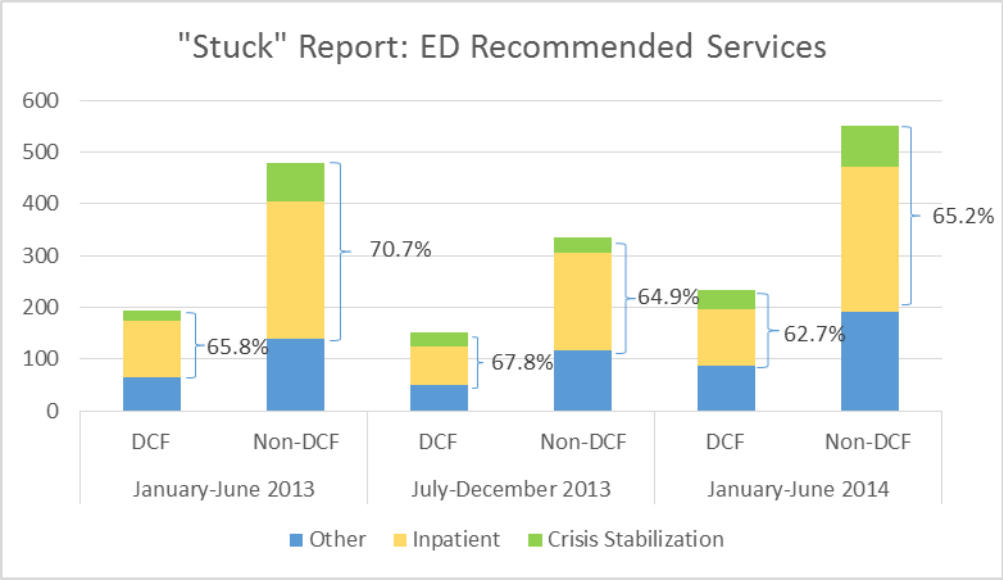
The Governor's recommendations rely on existing data[1] from the state's behavioral health system which help identify the causes of discharge delays and other "bottlenecks" that negatively impact the flow of the system. Two main factors emerged

[1] The data available for analysis were provided by ValueOptions, the state's administrative services organization (ASO) for the Behavioral Health Partnership (BHP). These data are limited to the HUSKY youth population only.

from this review: (1) the majority of youth "stuck" in an emergency department are waiting for crisis stabilization or inpatient beds; and (2) youth with autism spectrum disorder (ASD) are utilizing the ED for behavioral health services at a much higher rate than the total youth population.

Crisis Stabilization and PRTF Capacity:

In order to move HUSKY youth along to the behavioral health services that they need in a timely manner, ValueOptions, the state's administrative services organization (ASO) for the Behavioral Health Partnership (BHP), tracks HUSKY youth that are "stuck" in EDs and assists in their disposition planning[2]. "Stuck" is defined by ValueOptions as being in an ED for over eight hours after being medically cleared. Data from these reports show that consistently, for both DCF-involved youth[3] and non-DCF involved youth, the majority of those stuck are waiting for the recommended services of inpatient care or crisis stabilization beds.



As there are limited crisis stabilization beds in the state, it is clear that these data show there is a need for increased capacity in that area. Further investigation into discharge delays from inpatient units revealed that although discharge delays overall from inpatient units has steadily decreased over the past three years, the limited number of in-state Psychiatric Residential Treatment Facility (PRTF) beds are still causing delays. This can, in turn, cause further delays in the system, particularly for youth who are ready to transition to a lower level of care from inpatient. In order to ameliorate some

[2] These data are based on the ValueOptions Intensive Care Manager's daily ED calls and reflects the hospitals' self-report of "stuck" youth.

[3] DCF-involved youth refers to youth committed to DCF, in protective services, in the juvenile justice system, engaged in Voluntary Services, and Families with Service Needs (FWSN) cases.

of the ED discharge delays due to waiting for inpatient beds, increasing the PRTF bed capacity is also recommended.

Quarterly Inpatient Average Days in Delay by Reason Code (Excluding Inpatient Solnit Center)									
	Awaiting State Hospital			Awaiting PRTF			Awaiting RTC		
	Cases	*Total Days in Delay*	*Average Days in Delay for Discharges*	*Cases*	*Total Days in Delay*	*Average Days in Delay for Discharges*	*Cases*	*Total Days in Delay*	*Average Days in Delay for Discharges*
Q1 '11	11	87	7.9	14	136.0	9.7	14	301	21.5
Q2 '11	15	317	21.1	19	230.0	12.1	14	430	30.7
Q3 '11	15	266	17.7	18	284.0	15.8	13	181	13.9
Q4 '11	17	389	22.9	14	200.0	14.3	13	191	14.7
Q1 '12	9	231	25.7	21	265.0	12.6	10	170	17.0
Q2 '12	10	367	36.7	24	418.0	17.4	10	301	30.1
Q3 '12	12	308	25.7	15	177.0	11.8	11	168	15.3
Q4 '12	13	264	20.3	14	179.0	12.8	6	108	18.0
Q1 '13	8	212	24.2	18	202.0	14.1	8	103	22.1
Q2 '13	11	145	23.6	22	305.0	16.6	7	68	10.3
Q3 '13	9	170	26.0	30	561.0	22.2	8	110	14.2
Q4 '13	11	211	20.3	20	405.0	26.6	4	51	23.3
Q1 '14	6	72	13.6	17	154.0	13.3	3	125	43.7
Q2 '14	12	206	17.4	26	353.0	13.3	3	28	12.0

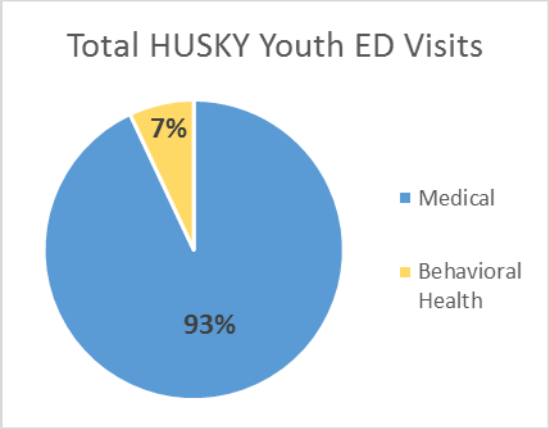
Source: ValueOptions Utilization Analysis – authorizations from ValueOptions CareConnect System

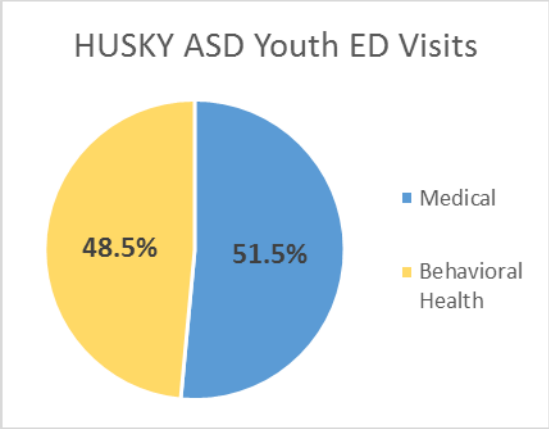
ASD Youth with Behavioral Health Needs:

Data show that there are high ED utilization rates for HUSKY youth with Autism Spectrum Disorder, compared to the total HUSKY population[4]. From January 1, 2013 to June 30, 2014, almost half of the total HUSKY youth ASD population had at least one ED visit – for a total of 2,998 visits. Of these 2,998 visits, 48.5% (1,453) were behavioral health related. Within the total HUSKY population, only 7% of ED visits were behavioral health related (see graphs on the following page).

In addition, the 1,453 behavioral health visits were utilized by only 651 individual youth with ASD. This population has unique needs and could be served more effectively with specialized services and treatment options.

[4] Value Options – Ad Hoc Report. Methodology: ValueOptions authorization database was queried for any diagnosis of ASD on Axis I and/or Axis II on any authorization for behavioral health services during the period of 1/1/13 and 6/30/14





Plan to Build Capacity in the Children's Behavioral Health System

1. **Expand Crisis Stabilization and Respite Beds.** Repurpose SAFE Homes currently funded by DCF to create crisis stabilization and respite beds. Due to a diminishing volume of children being removed from their family homes for child protective services reasons, over 70% of the state's 70 contracted SAFE home beds are now vacant. Increased clinical staffing will allow DCF to use these beds for two enhanced levels of care: The Short-term Family Integration Treatment (or S-FIT) crisis stabilization and Therapeutic Support Team (TST) respite care. A minority of currently contracted beds would continue to provide the SAFE home level of care and children that need traditional SAFE home care will still have access to beds when needed. S-FIT provides a short-term (up to 15-days) treatment setting for children with a rapidly deteriorating psychiatric condition, in order to reduce the risk of harm to self or others and to divert children from admission to higher levels of care. TST allows up to 30 days per year, per family, of respite care. Initially, these beds will be available only to DCF-involved children, but in the future, the agency will consider expansion of these services to other populations through a procurement process. This proposal would also increase the crisis stabilization beds available to non-DCF families by reserving DCF's currently contracted crisis stabilization beds for use solely by non-DCF families, further relieving overstays in Emergency Departments (EDs). DCF currently funds two 15-day stabilization units, operated by the Children's Center of Hamden (8 beds) and Wheeler Clinic (6 beds). These two programs currently accept both DCF and non-DCF families, through referrals from Emergency Mobile Psychiatric Services (EMPS) teams. They serve youth ages 7-18 in crisis who do not require inpatient care, but who would benefit from a brief respite while receiving intensive individual and family interventions. Of the children currently served by these two programs, although the ratio shifts, approximately 50% are DCF-involved and 50% are not involved with the Department. The proposed policy change will make all 14 beds available to non-DCF involved children.

Current SAFE home funding	*$ 7,549,370*
Additional Annualized Costs	*$ 1,020,647*
Total Expenditure	*$ 8,570,017*

2. **Enhance Psychiatric Residential Treatment Facility (PRTF) Capacity with a Statewide Medicaid Rate.** Create a statewide Medicaid rate for PRTF which will allow "any willing provider" to open a facility. The statewide rate of approximately $465/day should incentivize providers to open additional beds – existing rates range from $352-$366/day. DSS will prepare and submit a Medicaid State Plan Amendment by the end of September that sets a prospective rate retroactive to July 1, 2014 with no cost settlement. New beds would be available for children with behavioral health needs regardless of DCF involvement or payer.

   PRTFs provide psychiatric and other therapeutic services to children and youth in need of a structured residential setting while simultaneously preparing the child and family for ongoing treatment in the community. The average length of stay is 176 days and the level of care is less intensive than acute inpatient psychiatric hospitalization and more restrictive than residential or community-based treatment (such as partial hospitalization and home-based services).

   Cost of bringing existing providers up to new rate is approximately $1.6 million which is within the $1.8 million built into FY15 budget for this purpose. There are potential unbudgeted costs to the extent new beds are established.

3. **Expand community-based clinical services and in-home alternatives.** As included in the DCF FY15 budget, $2 million will be used by DCF to develop services to assist two high risk populations including: (1) those children with high acuity as evidenced by frequent contact with the ED and other high end supports, and (2) those children currently residing in congregate care settings. The funding will be used for Therapeutic Support Teams (TST) providing enhanced support and intensive care coordination. This model will apply key principles of Wraparound Milwaukee that have proven positive outcomes integrating intensive care coordination, child and family teaming with clinical support to the child and family. It is these principles and approach that were embedded into the Children's Behavioral Plan developed by DCF as required by Public Act 13-178.

   No additional funding necessary -- $2 million was appropriated in FY15. RFP is ready for release.

4. **Post EMPS Staff in Emergency Departments**. The Governor proposed, and in early September the legislative committees of cognizance approved, $160,282 in funding from the FFY 15 Community Mental Health Services Block Grant to be used to support out-posting of EMPS Crisis Intervention staff in emergency departments

of hospitals serving children in order to assist with overcrowding and overstays of children and youth 18 years of age and under. The funding will be used to support one FTE in the Connecticut Children's Medical Center (CCMC) and one part time position at another hospital plus some psychiatric consultation expenses. The clinicians will be responsive to any crisis situation, but will focus primarily on linking children and families to long term, appropriate treatment settings and will facilitate, when appropriate, the development of a Plan of Care.

Federal funding available from the FFY15 Community Mental Health Services Block Grant.

5. **Work with the Office of the Healthcare Advocate to enhance access to behavioral health treatment and settings for commercially-insured populations.**

   No state cost.

6. **Consider enhancing the Emergency Mobile Psychiatric Services (EMPS) Network.** Add more clinicians and extend the hours of this service. EMPS providers currently provide in-home emergency services to families – stabilizing the child or referring families to the ED if the situation requires that level of intervention. The proposal would increase the hours of service from 11 hours/day to 18 hours a day: 6:00 a.m. to 12 midnight. The call centers indicate that historically there have been very few calls made during the hours between midnight and 6:00 a.m. It is believed that the additional staffing and hours will enhance the current system and allow the providers to meet the majority of service needs.

Current EMPS Costs	*$10,590,993*
New Costs	*$ 3,000,000*
Total	*$13,590,993*

7. **Consider creating a community-based Behavioral Health Assessment Center (BHAC) as an alternative to hospital emergency rooms.** This short-term assessment center will provide an alternative to care in hospital emergency departments by providing a community-focused assessment and intervention. The Emergency Mobile Psychiatric Service (EMPS) network could serve as the gatekeeper and divert children from the emergency room when appropriate. When a child presents at an assessment center, there would be four main clinical paths for consideration: discharge to home, crisis stabilization, inpatient care, or psychiatric residential treatment facility care. Other states have created similar models to divert patients from EDs, offering specialized interventions that can assist this population. New Jersey operates a county-based network of such centers; some are attached to hospitals and others to community mental health centers. These smaller centers specialize in behavioral health issues, but retain the medical expertise to care for

potential physical health issues that may be causing the crisis. It is important that these centers be co-located with medical professionals so that medical clearances can be performed.

Option A: Private Provider	
Current Costs	*$0*
New Costs	*$4,000,000*
Total Costs	*$4,000,000*
Option B: State Operated	
Current DCF for On-call Staff at Solnit South	*$1,500,000*
New Costs	*$3,000,000*
Total Costs	*$4,500,000*

Plan to Address Unique Needs of Autism Spectrum Disorder

8. **Provide Specialized Supplemental Services for Children with Autism Spectrum Disorder (ASD).** DDS will establish 1-3 multi-disciplinary transition teams of specially trained practitioners to address the unique needs of children and youth with ASD receiving care in PRTFs and other settings. Focus will be on conducting an assessment of the individual as well as the home/school environment and making recommendations for successful transition out of the facility. Transition plans may include teaching and behavior management using evidence-based interventions which may be covered by a private insurer or Medicaid post discharge. After the initial startup, transition teams may also work with children in hospitals or children in their homes who are at risk for hospitalization. Up to $1 million in funding is available in the FY 15 budget to support services including therapy, treatment, and consultation by the team specialists. The team would provide services for children and youth with ASD in PRTFs, or at risk of needing that level of care, regardless of DCF involvement or payer. After best practices have been developed, we will determine if it is feasible to add this service to the Medicaid State Plan in order to receive reimbursement under Medicaid.

   No additional funding necessary -- $1 million was appropriated in FY15 for this and #4 below. Additional funding may be necessary to annualize in FY16.

9. **Develop an RFP for up to three specialized inpatient hospital beds for individuals experiencing the most acute and complex Autism Spectrum Disorder (ASD) and co-occurring psychiatric disorders.** There are a small number of individuals with clinically complex cases for whom intense behavioral challenges require hospitalization. A few of these individuals need highly specialized hospitalization out-of-state. An average of less than two Medicaid patients per day receives specialized, out-of-state treatment. These cases are poorly served in two ways: (1) there is no effective in-home behavioral intervention to prevent the need for

hospitalization or residential placement; and (2) there are few psychiatric hospital beds with specialized care for individuals with autism. DDS will implement a recommendation of the FY 13 Autism Feasibility Study to develop and fund a RFP for up to three specialized inpatient hospital beds for individuals experiencing the most acute and complex Autism Spectrum Disorder (ASD) and co-occurring psychiatric disorders.

No additional funding necessary in FY15. See #8 above.

10. **Provide In-Home Supports for High Need Children with ASD.** DDS will implement a recommendation of the FY 13 Autism Feasibility Study to create appropriate in-home care to divert children/youth ages 13-21 with ASD from inpatient and other residential settings. This in-home support pilot will assist adolescents who have autism and who are exhibiting severely challenging behaviors to remain in the community and live successfully at home with their families. Too often, lack of appropriate community support leads to visits to the ED and possibly out-of-home placement. The primary purpose of the pilot is to reduce the need for emergency room visits and/or hospitalization, and out-of-district or residential placement. The secondary purpose is to build connections to school, home and community and expand the circle of support for the child and his/her family. This pilot will serve 10 children ages 13-21 who have a diagnosis of ASD and present with severely challenging behaviors.

    No additional funding necessary – the pilot is funded for $300,000 in FY15.

11. **Ensure Medicaid Coverage for the treatment of ASD.** Governor Malloy has directed DSS and DDS to begin work on a plan to comply with a July 2014 bulletin from the federal Centers for Medicare and Medicaid Services (CMS) which explains that states must cover services for the treatment of individuals with ASD as part of the federal Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) requirements. DSS and DDS will explore a full range of treatment services for children on the spectrum, including coverage of evidence-based interventions for children under 21. DSS and DDS will present their initial thoughts during the next regular meeting of the Autism Spectrum Disorders Advisory Council on 10/22.

    Unknown, but likely significant, costs.