Children's Behavioral Health Plan Implementation
Behavioral Health Urgent Care and Crisis Stabilization Unit Workgroup Report

EXECUTIVE SUMMARY

Prior to the COVID-19 pandemic, high numbers of youth with behavioral health conditions were presenting to hospital emergency departments (ED) seeking evaluation and treatment. Since the pandemic, these numbers have continued to climb, frequently overwhelming the capacity of EDs. Workforce shortages and high demand at other levels of care, along with longstanding underfunding across several levels of care in the children's behavioral health service array, have only compounded the crisis. For Connecticut to implement a sustainable solution, the state will need to fully invest in two new levels of care to support children who can be safely cared for in community-based settings. These include a 23-hour setting to receive, triage, stabilize and assess children in crisis (referred to below as a behavioral health urgent care) with a linkage to a short-term (1-14 day) sub-acute facility with 12-16 beds for children who need additional time for stabilization (referred to below as a crisis stabilization unit).

In order for these two levels of care to be successful, it is necessary that the state simultaneously attend to needs throughout the continuum of behavioral health services including the following: (1) Invest in the behavioral health workforce, including ensuring reimbursement rates are sufficient across all levels of care; (2) Enhance and standardize the models of practice and expand service availability for intermediate levels of care; (3) Strengthen and increase utilization of the Enhanced Care Clinics; (4) Enhance and expand Mobile Crisis Intervention Services; (4) Make better use of available technology for real-time tracking of needs and services; (5) Increase inpatient bed capacity; and (6) Enhance the model of practice for psychiatric residential treatment facilities (PRTF) and increase beds as needed.

The above findings reflect the work of the Behavioral Health Urgent Care (BHUC) and Crisis Stabilization Unit (CSU) Workgroup (workgroup) consistent with the original intent of the state's Behavioral Health Plan for Children approved in 2014. Following the workgroup's review of literature and best practices in implementing a crisis continuum, and in recognition of the gaps in the state's existing children's behavioral health care system, the workgroup developed the following three recommendations[1]:

<u>Recommendation 1:</u> Fully fund and implement one or more sites each of the behavioral health urgent care and crisis stabilization units per the models outlined by the workgroup.

<u>Recommendation 2:</u> Evaluate implementation, revise the models as indicated, and replicate to meet the state's need for the behavioral health urgent care and crisis stabilization unit levels of care.

<u>Recommendation 3:</u> Address the needs (identified above) across the children's behavioral health system to support the optimal functioning of the behavioral health urgent care centers and crisis stabilization units.

[1] The workgroup participants are listed in Attachment 3. The workgroup reached consensus on many of the issues raised in regard to need as well as the recommended BHUC and CSU model components included in this report. That does not mean, however, that each workgroup participant explicitly endorsed each of the report's recommendations. Through a process of intensive review and open debate, the included set of recommendations emerged.

I. Background

Connecticut's Behavioral Health Plan for Children was a part of the legislative response to the Sandy Hook tragedy and was developed with extensive input from families, providers, state agencies, researchers, community members, and other stakeholders. It was approved by the Connecticut General Assembly in 2014 and has provided a blueprint to ensure that the state's behavioral health system and its services promote well-being and meet the mental, emotional, and behavioral health needs for all children in the state. More recently DCF identified the need and opportunity for collaboration among stakeholders to *further* support implementation of the goals of the Plan and provide recommendations to its Implementation Advisory Board. Workgroups were established to support these efforts, including the Behavioral Health Urgent Care (BHUC) and Crisis Stabilization Unit (CSU) Workgroup (workgroup).

The workgroup was comprised of stakeholders from hospitals, community-based provider agencies, child and family advocacy organizations, the state's behavioral health partnership, and state agencies (Department of Mental Health and Addiction Services (DMHAS), the Office of the Child Advocate (OCA), as well as DCF). The workgroup was tasked with accomplishing the following four 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
    a. 23-hour crisis stabilization setting
    b. 1-14 day sub-acute crisis stabilization and assessment centers
4. Make recommendations to the Children's Behavioral Health Plan Implementation Advisory Board and the twelve state Department Commissioners for further follow-up and implementation

The subsequent sections of the report provide additional information on the workgroup's processes and achievements, rationale for the proposed levels of care, workgroup recommendations for consideration by the Advisory Board and the twelve state Department Commissioners/Administrators, and next steps. The specifics for each of the proposed models are included as attachments to this report.

II. Workgroup Process and Accomplishments

<u>Review of Current Initiatives and Best Practices</u>

The workgroup collaborated across a total of seven meetings held between June and December, 2021. They addressed the first two goals of the workgroup through a series of discussions regarding national best practices for the crisis continuum of care. The SAMHSA Crisis Best Practice Toolkit has been widely distributed to and utilized by states and was highlighted as being helpful for guiding Connecticut's efforts.[2] The toolkit identifies the following core components of a crisis continuum: (1) regional crisis call center; (2) crisis mobile team response; and (3) crisis receiving and stabilizing facilities. In Connecticut, the call center is operated by United Way 2-1-1, which functions as both the call center for Mobile Crisis and the National Suicide Prevention Lifeline and will also serve as the 9-8-8 call center when implemented in July 2022. Connecticut also has a robust crisis response team, with youth Mobile Crisis providing statewide coverage and responding to over 15,000 crisis episodes each year.

The state falls short, however, in meeting the third core component of the continuum, the crisis receiving and stabilizing facilities. The SAMHSA document identifies these "23-hour facilities" (not overnight) as offering individuals "no wrong door" access to mental health and substance use services,

[2] Substance Abuse and Mental Health Services Administration (SAMHSA) (2020). National Guidelines for Behavioral Health Crisis Care - A Best Practice Toolkit: Knowledge Informing Transformation.

with availability for walk-in, as well as emergency vehicle (ambulance and police) drop off.[3] These facilities operate 24/7/365 and are staffed to triage youth, quickly identify if there are critical medical needs, and support stabilization regardless of the individual's behavioral health presenting problem, diagnosis, or disability.

In addition to having a facility to address the immediate crisis, it is also recommended that a crisis continuum include availability of beds for short-term stay to support individuals who cannot maintain stabilization within the 23 hour period, but can voluntarily be evaluated and stabilized in an unlocked facility. The state's current gap in these two levels of care results in many youth using the ED unnecessarily for behavioral health needs, resulting in delays in ED discharge, and challenges with throughput across the system.

The Need for Additional Levels of Crisis Care

As referenced above, with limited options for crisis receiving facilities and the longstanding under-funding of parts of the children's behavioral health system, many children experiencing a behavioral health crisis are brought to an ED for evaluation and treatment. National research and state data strongly suggest:

1. The volume of visits to hospital EDs among youth with behavioral health concerns is rising;
2. Clinical acuity, intensity, and complexity of needs among those youth is rising;
3. Staffing for behavioral health (and other disciplines) is stretched thin in hospitals as well as across the behavioral health continuum of care;
4. Youth with behavioral health needs can experience significant wait times in EDs before receiving services beyond observation;
5. EDs vary significantly in the presence of staff with behavioral health expertise and their capacity to provide adequate behavioral health evaluation or intervention;
6. Most youth who present to an ED with a behavioral health need are not subsequently admitted to an inpatient hospital, suggesting that their needs could be addressed in the community;
7. Many youth are not able to de-escalate from crisis and fully stabilize within a one-day timeframe, but also do not necessarily require inpatient care;
8. EDs vary significantly in their familiarity with the behavioral health continuum of care and in their ability to connect youth to ongoing services appropriate to the child's needs.

As a result of these factors, youth who present to EDs with a behavioral health need and their families can experience additional trauma, stress, and increased acuity *stemming from the ED experience itself*. Many of these factors have only been exacerbated since the onset of the COVID-19 pandemic. Alternative settings such as BHUC and CSU have the capacity to meet the needs of youth with behavioral health crises and quickly connect them with the appropriate level of care, and are therefore vital to resolving the challenges that are currently facing the state's behavioral health system. A brief introduction to each model appears below with more specifics included as attachments. Note that during the course of the workgroup meetings, in recognition of the longer timeframe required for implementation of a BHUC and/or CSU, and the growing number of youth presenting to the ED with behavioral health needs, additional meetings were held specifically to discuss viable short-term solutions to the crisis at hand, and a separate report containing those urgent recommendations was developed.

[3] Note that implementation of ambulance drop off in Connecticut will require regulatory changes.

BHUC

A BHUC in Connecticut will offer capacity to provide crisis stabilization, evaluation and assessment, and linkages to longer-term care for youth with behavioral health concerns. This new service would be brief (less than 24 hours), provided in a safe and calming setting, and staffed with well-trained cross-disciplinary behavioral health professionals with expertise in addressing the needs of youth experiencing a behavioral health crisis and connecting them to ongoing care.

This 23-hour setting is consistent with national best practices, and is utilized in many other states and municipalities (e.g., Arizona, California (San Diego), North Carolina (Guilford County)) as well as in other countries (e.g., Canada and the United Kingdom). Other terms for this level of care include crisis receiving and stabilization facilities, crisis stabilization units, community crisis centers, etc. Many youth in crisis who present to EDs but do not require inpatient care could be safely cared for in a BHUC, with good outcomes, and potentially at a lower cost.

CSU

A CSU, also known as a sub-acute bed, crisis residential facility, or short-term residential facility, is another element of a full continuum of crisis-oriented services as described in SAMHSA's best practice toolkit. It is a short-term (up to 14 days) community-based residential facility (unlocked, home-like setting) for youth who do *not* require inpatient care, but are also not ready to return to the community without further stabilization services. This option will support throughput in the system and allow youth who are not stabilized within a one-day timeframe to be cared for in a less restrictive environment that can successfully prepare them for return to home and community. CSU services frequently include treatment and close collaboration with families and schools.

Model Components

The workgroup identified the key components of the BHUC and CSU models, aligned with national best practices. The components included, for each level of care, identification of the goals, setting and physical space, target population and acuity, referral and acceptance process, staffing, services, training and competencies, length of stay, and discharge and connect-to care. The full recommended BHUC and CSU models are included in attachments to this document (beginning on pages 9 and 13, respectively).

Funding Considerations

For both models, building a new facility, or renovating an existing one, will add significantly to overall costs, and therefore consideration of existing sites is recommended. Many of the services to be provided by the BHUC and CSU models are already Medicaid reimbursable; however, in order to implement the full models for all children regardless of insurance type or status, robust funding, including a combination of grant funds and a fee-for service rate, is likely to be necessary. Consideration of incorporating these levels of care into an alternative payment method (APM) (e.g., "value-based payment") could be beneficial in achieving cost savings. APM models frequently include a goal of reducing general medical ED volume, which these levels of care are designed to address.

In addition to funding the BHUC and CSU models, it is critical that the state make significant investments in the expansion and retention of the behavioral health workforce. Workforce shortages, only exacerbated by the pandemic, continue to impact all levels of care, and therefore have implications for any service delivery recommendations. Investments must include raising reimbursement rates for levels of care and types of services that remain underfunded so that agencies have the resources to appropriately pay clinicians. The state should also consider offering loan forgiveness programs, tuition reimbursement, and other incentives to recruit clinicians into the workforce and retain them in children's community-based service delivery.

Crisis Care within the Continuum of Services

The workgroup strongly and consistently recommended that BHUC and CSU development must be considered within the broader context of the state's children's behavioral health service system. Workgroup members agreed that the transition across services must be seamless; especially the transition from BHUCs to higher levels of care (e.g., CSU, inpatient psychiatric hospitalization), but also transitions from crisis receiving facilities to lower levels of care. BHUCs will be part of a subset of acute and sub-acute crisis-oriented services within the full behavioral health service array. These are inclusive of, but not exclusive to, the following services, some of which are in existence and others are yet to be launched:

- 9-8-8 and/or 2-1-1 Behavioral Health Crisis Call Center
- Mobile Crisis Intervention Services
- 23-hour crisis stabilization setting (e.g. behavioral health urgent care)
- Short-Term (1-14 day) 24-hour settings (e.g., crisis stabilization unit)
- Emergency Departments
- Inpatient Psychiatric Hospitalization
- Psychiatry Residential Treatment Facilities (PRTF)
- Crisis Respite Beds

Delineations across target populations and settings for acute, sub-acute and intermediate levels of care are briefly identified in the table below.

Level of Care	**Program Type**	**Target Population**	**Setting/Length of Stay**
Acute	Inpatient	Highly acute: Imminent risk to self or others; recent history of serious injury to self or others; gravely disabled; recent significant destruction of property	24-hour care; hospital setting; locked facility LOS up to 30 days
Sub-Acute	Crisis Stabilization Unit	Sub-acute: Cannot fully stabilize within 24 hours but can be stabilized within community-based setting/unlocked facility; voluntarily admitted by self *and* family; once stabilized can safely return to home, school and community	24-hour care; home-like setting (can be community-based); unlocked facility LOS up to 14 days
	Psychiatric Residential Treatment Facility	Sub-acute: Can be stabilized within community-based residential setting that offers all services the child may need including schooling; typically longer-term (30 or more days) with simultaneous preparation to return to community	24-hour care; community-based; unlocked facility LOS up to 120 days
Intermediate	Partial Hospitalization Program	Safely able to stay in home/community setting; does not require overnight supervision/24-hour care; symptoms require ongoing diagnostic work or medication monitoring	Community or hospital-based setting ≥4 hrs/day; 5 days/wk LOS up to 4 weeks
	Intensive Outpatient Program	Safely able to stay in home/community setting; does not require overnight supervision/24-hour care; symptoms do not require diagnostic work, but may require medication management	Community-based setting ≥3 hrs/day; 2-5 days/wk LOS up to 6 weeks
	Extended Day Treatment Program	Safely able to stay in home/community setting; does not require overnight supervision/24-hour care; symptoms are persistent in nature but do not require diagnostic work; can rely primarily on recreational therapeutic services	Community-based setting ≥3 hrs/day; 2-5 days/wk LOS up to 6 months

From a systems perspective, the development of new crisis care settings will impact, and will be impacted by, the full continuum of care. Together with additional enhancements as described below, the addition of BHUCs and CSUs is expected to improve throughput across the behavioral health continuum of services. **Accordingly, the workgroup identified the following needs in the children's behavioral health system that must be addressed to achieve optimal functioning of the proposed new levels of care.**

1. **Invest in the behavioral health workforce**. An insufficient workforce was cited as a significant challenge that is affecting all levels of care and has been exacerbated since the outset of the COVID-19 pandemic. The State must enhance rates and grant funds and also consider other financial incentives such as loan forgiveness and tuition reimbursement in order to attract and retain a behavioral health workforce that is sufficient to meet the need.
2. **Enhance the model of practice and expand intermediate levels of care**. Youth with needs that are too significant for routine outpatient care, as well as youth stepping down from higher levels of care (e.g., inpatient, PRTF, CSU), are in need of enhancements at the "intermediate" level of care. The workgroup recommends enhancing and standardizing the model of practice as well as expanding the service capacity among intensive center-based models including Intensive Outpatient Programs, Partial Hospitalization Programs, and Extended Day Treatment as well as intensive in-home services.
3. **Strengthen and increase use of Enhanced Care Clinics.** Enhanced care clinics serve children and adults with behavioral health needs, accept "walk-ins," and offer timely screening, triaging, and evaluation. There is a need to identify opportunities to increase utilization and capacity of ECCs to meet the needs of children with mild to moderate acuity, providing youth with timely evaluation and connections to longer-term services.
4. **Enhance Mobile Crisis Intervention Services**. Mobile Crisis is a critical service within the continuum of care, and is envisioned to play a significant role in diverting youth from the ED, assessing and identifying appropriate levels of care, and helping ensure timely discharges from the ED to community-based care. Resources to Mobile Crisis should be expanded in order to support its role as a central hub and coordination center with the ability to facilitate referrals to all levels of the crisis continuum of care.
5. **Make better use of available technology for real-time tracking of needs and services.** Technology is needed to track, in real time, behavioral health ED volume, inpatient bed availability, and other levels of care critical to system throughput (e.g., PRTF, intermediate levels of care, BHUC and CSU when implemented). Connecticut should invest in a technological platform with these capabilities in order to ensure transparent tracking of needs and services.
6. **Increase inpatient bed capacity**. There was strong consensus among workgroup members that Connecticut has too few inpatient beds for children and adolescents, and that reimbursement rates for inpatient hospitalization are insufficient. This shortage significantly contributes to ED throughput issues and impacts multiple other elements of the service array. However, with other services fully funded and utilized, the need for additional inpatient beds may decrease. Once BHUCs, CSUs, and other services are implemented, inpatient bed capacity and need should be monitored and reassessed.
7. **Increase psychiatric residential treatment facility (PRTF) bed capacity and enhance the model of practice**. The workgroup cited a shortage of PRTF beds for children and adolescents with the most significant needs. The workgroup recommends enhancement of the PRTF model of practice to further align with national best practices. The workgroup discussed making all needed service enhancements, then reassessing the adequacy of PRTF bed capacity and availability, in particular for special populations including children with intellectual and developmental disabilities.

III. Workgroup Recommendations[4]

The BHUC and CSU Workgroup arrived at the following recommendations to present to the Children's Behavioral Health Plan Implementation Advisory Board and the twelve state Department Commissioners for further follow-up and implementation.

Recommendation 1: Fully fund and implement one or more sites each of the behavioral health urgent care and crisis stabilization units per the models outlined by the workgroup.

Recommendation 2: Evaluate implementation, revise the models as indicated, and replicate to meet the state's need for the behavioral health urgent care and crisis stabilization unit levels of care.

Recommendation 3: Address the following needs across the children's behavioral health system to support the optimal functioning of the behavioral health urgent care centers and crisis stabilization units:

a. Invest in the behavioral health workforce;
b. Enhance the model of practice and expand intermediate levels of care;
c. Strengthen and increase use of Enhanced Care Clinics;
d. Enhance Mobile Crisis Intervention Services;
e. Make better use of available technology for real-time tracking of needs and services;
f. Increase inpatient bed capacity; and
g. Increase psychiatric residential treatment facility (PRTF) bed capacity and enhance the model of practice.

IV. Next Steps and Considerations

Given the efforts invested by the workgroup in developing the recommended levels of care, as well as the existence of similar models in other states, Connecticut is well-primed for the timely release of funding for BHUC and CSU sites. Given that implementation is dependent on availability of appropriate sites, the state may consider taking a first step of soliciting request for qualifications from the community to identify potential locations within a high need geographic area before seeking proposals for implementation.

Given that the workgroup recommended simultaneous planning efforts for the development of a BHUC and a CSU, it is recommended they be developed within the same geographic area. The state should consider whether the BHUC and CSU should be operated by the same provider, on the same site, or if a formal partnership agreement between the two settings in close proximity would be sufficient. The CSU model as recommended in the attachment is proposed as having separate units by age and also specific needs (separate units for ages 5-12, ages 13 and up, and for children with intellectual disabilities, development disabilities, or autism spectrum disorders). It is important to note that the CSU level of care is often available for an adult population and this may be considered in Connecticut as well. Accordingly, the state may want to consider a lifespan model with clearly separated physical spaces and developmentally appropriate models of care, in order to be more efficient in investing in the administrative infrastructure costs. It should be noted, however, that the safety concerns (and comfort

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[4] The workgroup participants are listed in Attachment 3. The workgroup reached consensus on many of the issues raised in regard to need as well as the recommended BHUC and CSU model components included in this report. That does not mean, however, that each workgroup participant explicitly endorsed each of the report's recommendations. Through a process of intensive review and open debate, the included set of recommendations emerged.

for children and parents) related to unlocked child and adult units within the same facility would need to be fully addressed. Those challenges may outweigh the efficiency of a shared location.

In addition to design considerations, the state must address barriers to implementation. First, to appropriately address unnecessary behavioral health ED visits, regulatory changes that allow emergency transport by ambulance or police directly to BHUCs are needed. Second, currently ED visits are not reimbursable if the child is subsequently admitted to an inpatient unit. The State should ensure that BHUCs and CSUs can bill for their services even if the youth is subsequently referred to an inpatient setting.

Implementation of the workgroup's three recommendations will improve Connecticut's children's behavioral health system by improving throughput, reducing utilization of higher cost options for behavioral health care, and better aligning the state with national best practices. Most importantly, it will offer families and other referral sources an appropriate setting for children with behavioral health crises that will support their needs and lead to improved behavioral health outcomes for children.

Attachment 1: Recommended Behavioral Health Urgent Care Model

BHUC Goals

The workgroup identified a number of relevant goals for the BHUC level of care:

- Reduce utilization of general medical EDs and inpatient hospitalization for mental health or substance use concerns (particularly for high-risk groups including youth with intellectual/developmental disabilities, Autism, other conditions and risk factors).
- Stabilize crisis; de-escalate clinical acuity and/or distress.
- Provide psychiatric assessment and rule out medical concerns requiring ED transport.
- Triage behavioral health needs and acuity and maintain youth in the least restrictive setting appropriate to their needs.
- Provide continuous observation and supervision (for less than 24 hours) for children, adolescents, or emerging adults who do not require a higher level of care.
- Increase connect-to-care rates (i.e., connection to the clinically appropriate behavioral health service following BHUC, which may include an existing provider)
- Prevent or reduce re-admission to EDs or inpatient hospitalization following BHUC.

BHUC Setting

Consistent with national examples and best practices, Connecticut can place BHUCs within community-based organizations, with a requirement for strong community-hospital partnerships. There are several important considerations and challenges to address:

- There are likely to be high facility costs for BHUCs, and physical space may be a significant challenge. In order to ensure the resources invested in securing the appropriate location, facilities, property, and space results in actualizing this new level of care, there will need to be a strong partnership and collaboration between the private providers/hospitals and the state.
- Collaborate with DPH and other regulatory bodies to ensure an expedited licensing, accreditation, and regulatory approval process.
- The workgroup envisions that it will be rare for BHUCs to need to transport to a general medical ED, doing so only in the event of a medical/physical health need or in cases where the child's risk of harm to self or others or grave psychiatric disability cannot be successfully addressed within the BHUC setting. There should be protocols in place to ensure that BHUCs can safely transport to an ED in these situations without placing the burden of transport on families.

Physical Space

The workgroup's overall recommendations in this area include:

- BHUC's should be comfortable and inviting to families, supporting the overarching goal of crisis de-escalation. The physical environment of a BHUC should strike a noticeable contrast to a general medical ED setting, including calming and warm colors, comfortable furniture, safety features, and other characteristics.
- BHUCs should be designed with school referrals and first responders in mind.
- BHUCs should be geographically located within the areas of highest need, and should be close enough to hospitals with EDs and inpatient beds to support bi-directional flow.
- BHUCs should be strategically located geographically so that all residents in the state are able to travel to a BHUC within one hour.

Target Population

BHUCs should be accessible to all youth who are appropriate for this level of care regardless of system involvement, payer, diagnosis, or disability status. The workgroup recommends that:

- BHUCs accept youth across all diagnostic categories and other clinical presentations including youth with intellectual and developmental disabilities or other complex clinical conditions with

moderate to high levels of acuity. BHUCs should have the staff training and expertise to address the needs of a diagnostically diverse population.

- Exclusions due to a child being "too acute" should be rare for a BHUC. Youth at risk of harm to self/others should be accepted given that BHUCs are being designed with specialized behavioral health expertise that does not exist at most general medical ED settings. There may be occasions where the BHUC cannot safely de-escalate and stabilize a child who is acutely dangerous to self or others or is gravely disabled, and a direct referral to an ED will be needed (see below for requirements related to this triaging). The workgroup recommended careful attention to delineating the characteristics of youth appropriate for BHUC from those who require transport to the ED for evaluation.
- BHUCs should accept youth regardless of insurance status/type of insurance. Most services should be reimbursable by Medicaid and commercial insurers, and together with DCF and other grant funding, will afford all children who need BHUC services to be able to access it.

<u>Referral and Acceptance to BHUC</u>

The workgroup recognized that the most common referrers to BHUC are likely to include:

- 9-8-8 and/or 2-1-1 Crisis Call Center
- Youth/Family walk-ins
- Mobile Crisis
- Ambulance, Police, Fire
- Schools
- Primary Care Physicians

The workgroup had a number of recommendations related to referral and acceptance.

- BHUCs should provide "no-wrong-door" access to youth in need of mental health and substance use care, regardless of referral source.
- BHUC contracts should allow providers to staff sites with individuals who have the capacity and required competencies to serve children with varying diagnoses, disabilities and other conditions.
- BHUCs must be able to quickly identify and triage youth who are in need of medical treatment or who cannot safely be in the BHUC due to imminent risk to self or others, or grave psychiatric disability, and coordinate timely transport to the nearest ED location. Clear protocols for billing in these circumstances are needed, in order to determine whether EDs, BHUCs, or both settings submit for reimbursement.
- Although medical screening may be conducted primarily in person, emergency telehealth may also be considered for supporting medical screening.
- Connecticut should consider one or more decision-making algorithms to guide hospital EDs, BHUCs, police, and community gatekeepers and referrers (e.g., 9-8-8, Mobile Crisis, 9-1-1, 2-1-1) in making BHUC referrals. The goal should be to ensure that the most clinically appropriate referral is made, without unnecessary steps that would be inefficient, duplicative, and disruptive to families and providers.
- Ensure marketing materials, outreach, education, and protocols target all potential referrers to BHUC (see list of referrers above).
- BHUCs should establish and maintain collaborative partnerships and/or memoranda of understanding with referrers into BHUC, as well as the most common levels of care and service providers utilized upon discharge from BHUC.
- To appropriately divert unnecessary behavioral health ED visits, it will be necessary to make regulatory changes that allow emergency transport by ambulance or police directly to BHUCs.

Staffing

BHUCs will be staffed at all times (24/7/365) with a multidisciplinary team capable of meeting the needs of children, adolescents, and emerging adults experiencing behavioral health crisis in the community. Staffing considerations should include the following:

- Child/adolescent psychiatrists and/or psychiatric nurse practitioners/APRN (telehealth as needed)
- Licensed and credentialed mental health clinicians capable of completing effective and comprehensive crisis assessments. This should include Behavioral Specialists with experience with ID/DD populations, given their current disproportionate representation among youth that visit EDs for behavioral health concerns.
- BA-level staff to support non-clinical care and supervision of children.
- Admission and discharge planning staff.
- Parent/Caregiver and young adult peers with lived experience relating to behavioral health challenges.
- Current workforce challenges may require creativity, particularly to ensure an adequate number of prescribers. Consider establishing formal partnerships with psychiatry fellowship programs to create rotations in BHUC settings.
- Provide appropriate in-service training for all BHUC staff, as well as cross-training that occurs alongside key community referrers and partners.

Services

- Although medical clearance is not required prior to BHUC referral and utilization, BHUC staff should have the ability to assess whether an individual's condition requires medical attention in a hospital or referral to a dedicated detoxification or withdrawal management program.
- Screen for suicide risk and complete comprehensive suicide risk assessments and suicide prevention and safety plans.
- Screen for violence risk and complete more comprehensive violence risk assessments and planning when clinically indicated.
- Assessment to determine appropriate level of care.
- Transportation to support flow between BHUCs and EDs, as well as to CSUs and inpatient hospitals as needed (BHUC to arrange ED transport by ambulance when needed in the event of a medical/physical health need or in cases where the child cannot safely be stabilized within the BHUC). Any barriers to ambulance transport from BHUCs to EDs will need to be addressed.
- Formalized relationship with intensive support programs/beds (e.g., Crisis Stabilization Units, inpatient hospitalization). However, the workgroup strongly urges decision-makers to ensure that BHUCs are implemented as part of a comprehensive system enhancement; specifically an increase in inpatient beds and intermediate level of care availability.
- Include real-time bed and appointment tracking and registry system (in collaboration with 9-8-8/2-1-1 and Mobile Crisis services) to support efficient connection, referral and direct placement to needed services.
- Coordinate connections to ongoing care across the entire service array. If BHUCs are located within a community-based organization, it would be helpful for that organization to have a full service array.
- Coordinate communication with DCF and other service systems as relevant.

Training/Core Competencies

The workgroup recommended cross-training involving BHUC staff and community referrers. Furthermore, since the BHUC will be a cross-diagnostic setting, it will be critical to ensure the multi-disciplinary team has expertise and skills in the following areas, at minimum:

- Crisis Stabilization/de-escalation
- Mental health
- Substance use
- Intellectually and Development Disabilities and Autism Spectrum Disorders
- Screening and Assessment
- Medical clearance
- Culturally and Linguistically Appropriate Service (CLAS) Standards
- Referral and Linkage to community-based care (and hospital level of care, as needed)

Length of Stay

- Maximum length of stay of less than 24 hours
- Average length of stay of approximately 4 hours or less.

Discharge and Connect-to Care

- Discharge planning from any level of care is generally reliant on the availability of needed services. As such, the workgroup recommends analysis of all elements of the service continuum and expansion of overall capacity where needed. Note that the State is also investigating the development of CSUs that will offer a 1-14 day setting for youth that need additional stabilization and assessment, which will be a critical service category for youth that have not yet achieved clinical stability in BHUC.
- BHUCs are designed to complete crisis stabilization and assessment in less than 24 hours, so that children's length of stay at a BHUC is always less than one day. Prior to the 24-hour mark, the child will be provided not just with a referral to, but with an appointment for, their next placement or service. BHUCs will refer clients to the least restrictive level of care most appropriate to their clinical needs. BHUC providers may not shift responsibility for this to the family, law enforcement, mobile responders, or other providers. It will be critical for BHUCs and other providers across the continuum to build strong relationships and establish clear expectations to facilitate timely transitions to the next level of care.
- The workgroup recommends that BHUCs have admission rights, or at least strong capacity for referral and linkage, to the rest of the acute crisis continuum of services, including EDs, inpatient psychiatric services, PRTF, Crisis Stabilization Units, and Crisis Respite services.
- Furthermore, the group recommends that BHUCs should have the capacity to make direct referrals, or at least strong capacity for referral and linkage to intermediate levels of care (e.g., Intensive Outpatient Programs, Partial Hospitalization Programs, Extended Day Treatment, intensive in-home services).
- Use of an electronic platform for real-time appointments and bed tracking will be used.

Attachment 2: Recommended Crisis Stabilization Unit Model

<u>CSU Goals</u>

The workgroup has identified the following goals for the CSU level of care:

1. Reduce utilization of (and reduce discharge delays from) general medical EDs and inpatient hospitalization by increasing the availability of clinically-appropriate services, thereby improving throughput of the overall system.
2. De-escalate children with moderate or high clinical acuity and/or distress who do *not* require inpatient care, but do require a longer period than the ED provides to achieve stabilization (up to 14 days).
3. Following de-escalation, provide evaluation and assessment for children, adolescents and emerging adults with a warm hand-off to ongoing services.
4. Maintain youth in the least restrictive setting appropriate to their clinical needs.
5. Increase connect-to care rates (connection to the clinically appropriate behavioral health service following CSU, which may include an existing provider).
6. Prevent or reduce admission/re-admission to BHUCs, EDs, inpatient psychiatric hospitals, and Psychiatric Residential Treatment Facilities (PRTFs).

<u>CSU Setting and Physical Space</u>

Nationally there are examples of this level of care being placed within community-based organizations, and with a requirement for strong community-hospital partnerships. There are several important considerations and challenges to address:

- Consider in site selection the potential benefit of having physical proximity to (or co-location with) a behavioral health urgent care center and/or inpatient unit.
- It is expected that a CSU facility would house 12 to 16 beds.
- CSUs should be geographically located within the areas of highest need, and should have the ability to accept referrals from, and refer to, hospitals with EDs and inpatient beds in a timely manner.
- CSUs should contain separate units according to age group and certain needs. Units for ages 5 to 12 should be separate from those over age 12. A separate unit with staff with specialized expertise should also be available for children with intellectual disabilities (ID), developmental disabilities (DD), and autism spectrum disorders (ASD). The need for separation by sex and gender identity may be considered as well.
- Consider whether administrative efficiency could be achieved by siting CSUs within lifespan organizations, which could allow for safely servicing children and adults.
- Physical space for CSUs will be a challenge. In order to secure an appropriate location, facilities, property and space for this new level of care, there will need to be a strong partnership and collaboration between the private providers/hospitals and the state. Collaborate with DPH and other regulatory bodies to ensure timeliness of licensing, accreditation, and regulatory approvals.
- There should be protocols in place to ensure bi-directional flow between hospital EDs, BHUCs (when implemented), CSU settings, and inpatient units.
- Unlike many other residential and inpatient programs, CSUs are unlocked facilities. Due consideration should be given to ensuring separate space is available for youth of varying ages, sexes, gender identities, and/or gender expressions.
- The design of the unit should be “home-like” and welcoming; furniture and décor should be conducive to de-escalation, stabilization and recovery.

Target Population

CSUs should be accessible to all youth who require this level of care regardless of system involvement, payer, diagnosis, or disability status. The workgroup recommends that the following activities take place after a clinical and psychiatric evaluation:

- CSUs will accept youth ages 5-21 who are willing to be admitted *voluntarily.* Note that the guardian's consent must be voluntary for this level of care, and the youth must be able to be safely cared for in an unlocked facility. As noted above, separate units should be maintained by age groups. Continuity of services for transitional age youth will be supported through collaboration between DCF and DMHAS.
- CSUs accept youth across all diagnostic categories and other clinical presentations including youth with ID, DD, ASD or other complex clinical conditions. CSUs must have the staff training and expertise to address the needs of a diagnostically diverse population. As noted above, a separate unit for children with ID, DD and ASD should be maintained to appropriately meet the needs of these children.
- CSUs should accept youth regardless of insurance status/type of insurance. Many of the services are expected to be reimbursable by Medicaid and commercial insurers, and together with DCF and other grant funding, must afford access to all children who need CSU services.
- CSU will accept children who are evaluated as sub-acute; that is, the child's functioning is significantly impaired, but acuity does not require inpatient hospitalization. Among other considerations, criteria for admission could include:
    - High risk of hospitalization/re-hospitalization or ED use
    - High likelihood of continued substance abuse, but not for significant withdrawal symptoms
    - Symptoms are significantly interfering with child's functioning in home/community; behaviors have recently escalated
    - High risk behaviors are likely to lead to harm to self or others, but can likely be avoided through appropriate supervision
- Exclusions would include:
    - Child is acutely dangerous to self or others
    - Child is gravely disabled
    - Child is at very high risk of going AWOL
- Children referred to the CSU cannot be stabilized without 24 hour observation and stabilization services and cannot safely be maintained at home. The individual home environment, including the availability and capacity of the parent/caregiver to provide oversight and maintain safety should be considered in addition to the child's acuity.
- The safety of children referred to the CSU could not be maintained in a lower/intermediate level of care.

Referral and Acceptance to CSU

The workgroup recognized that the most common referrers to CSUs are likely to include: Mobile Crisis, BHUC, EDs, and other services along the behavioral health continuum of care. The workgroup had a number of recommendations related to referral and acceptance including:

- An evaluation by Mobile Crisis, a behavioral health urgent care (or similar service), or an ED must precede admission to a CSU.
- CSUs should be accessible to all youth regardless of system involvement or payer.
- CSU contracts should allow providers to staff sites with individuals who have the capacity and required competencies to serve children with varying diagnoses, disabilities and other conditions.

- CSUs should establish and maintain collaborative partnerships and/or memoranda of understanding with referrers to CSUs, as well as the most common levels of care and service providers referred to upon discharge from the CSU.

Funding Approaches

- Building a new facility, or renovation of an existing facility, will add significantly to overall costs. Opportunities to repurpose existing sites should be considered as much as possible.
- Robust funding, including a combination of grant funds and a fee-for service rate, is likely to be necessary to ensure that CSUs have the capacity to implement the full model for all children in the state who need this level of care.
- Many of the services provided by the CSU are Medicaid billable; CSU providers should ensure that reimbursement from Medicaid and private insurance is maximized.

Staffing

CSUs will be staffed at all times (24/7/365) with a multidisciplinary team capable of meeting the needs of youth in need of stabilization. Staff should include:

- Licensed and credentialed mental health clinicians capable of completing effective and comprehensive evaluations, de-escalating, stabilizing and providing treatment. This should include Behavioral Specialists with experience with ID/DD populations.
- A child psychiatrist or advanced practice registered nurse must be available to prescribe and administer medications.
- Registered nurses for medical assessment and coordination with primary or specialty care regarding co-occurring medical conditions.
- BA-level staff to support non-clinical care and supervision of children.
- Admission and discharge planning staff.
- It is expected that CSUs utilize parent/caregiver and young adult peers with lived experience relating to behavioral health challenges to offer additional support to licensed clinicians.
- Current workforce challenges may require creativity, particularly to ensure an adequate number of prescribers. Consider establishing formal partnerships with psychiatry fellowship and nurse practitioner programs to create rotations in CSU settings.
- Provide appropriate in-service training for all CSU staff, as well as cross-training that occurs alongside key community referrers and partners.

Services

In addition to de-escalation and stabilization services, CSUs provide tailored treatment programs that focus on the specific needs of the child to maintain stabilization and prepare them to return to their home environment, school, and community.

- Comprehensive evaluation and diagnostic formulation.
- Brief physical examination.
- De-escalation and stabilization are expected to be needed periodically throughout the length of stay. Should a child's stabilization significantly decline and the child become an imminent risk to self or others, plans for transportation to an ED or inpatient hospital must be in place.
- Group and individual evidence-based treatments.
- Varied recreational therapy and program activities that focus on supporting the child in returning to the community prepared with the skills needed to prevent future escalation, in coordination with the child's support system, school, etc.
- Engagement with families/caregivers in the child's treatment plans, crisis and safety plan, and in preparation for the child's return to the home environment. Coordination with DCF as relevant.

- CSUs must have coordinated connections to ongoing care across the entire service array. Integrating CSUs within community-based organizations that offer a full service array is the preferred approach.

Training/Core Competencies

The workgroup recommended cross-training involving CSU staff and community referrers, such as Mobile Crisis and behavioral health urgent care clinicians. Furthermore, since the BHUC will be a cross-diagnostic setting, it will be critical to ensure clinical expertise and skills in the following areas, at minimum:

- Crisis stabilization/de-escalation
- Mental health
- Substance use
- Trauma-informed care inclusive of training on racial and urban trauma
- Intellectual and Developmental Disabilities and Autism Spectrum Disorders
- Screening and Assessment, for common behavioral health conditions and trauma
- Culturally and Linguistically Appropriate Service (CLAS) Standards
- Referral and Linkage to community-based care (and hospital level of care, as needed)

Average Length of Stay

- Maximum length of stay 14 days

Discharge and Connect-to Care

- The workgroup recommends there be strong capacity for referral and linkages across levels of care, with ease of admission (with the receiving facility's approval) from BHUCs to CSUs and from BHUCs/CSUs to the rest of the sub-acute and acute continuum of services, including inpatient psychiatric services, PRTF, and Crisis Respite services.
- Furthermore, the group recommends that CSUs should have the capacity to make direct referrals, or at least strong capacity for referral and linkage to intermediate levels of care (e.g., Intensive Outpatient Programs, Partial Hospitalization Programs, Extended Day Treatment, intensive in-home services) which are likely to be the next level of service following discharge from the CSU.
- High fidelity Wraparound care coordination services are also likely to benefit many families whose children are discharging from a CSU. Relationships with agencies offering care coordination is important.
- Use of an electronic platform for real-time appointments and bed tracking will be used.

Attachment 3: Workgroup Participants

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