To: Cross-Agency Executive Sponsor Working Group
From: Colorado Human Services Directors Association (CHSDA)
Date: December 1, 2022
Re: Solution-Focused Proposals to Address the Continuum Capacity Crisis

Having children languish in a hospital or detention setting for months at a time, stay overnight in county offices or hotels for days or weeks with caseworkers in an unsafe environment and without access to treatment, or unnecessarily sent to a facility out of state far from their families because no other facilities in state will admit them, is unacceptable for Colorado's child welfare practice. The ongoing continuum capacity crisis in Colorado requires urgency, shared accountability, and creative solutions from all stakeholders. To that end, Colorado County Departments of Human Services and CHSDA would like to share the list below with the newly formed Cross-Agency Executive Sponsor Working Group that will begin meeting in December 2022.

This working list includes a starting place for additional solution-focused proposals to bring to the table for cross-agency prioritization. It was generated with County Directors through CHSDA's Children and Families Subcommittee, CHSDA's Executive Committee, and County Directors regional groups. While Directors have considered over 30 proposals to date, the list below reflects only the items that have the most consensus across counties to move forward and prioritize at this time. Counties will continue to review proposals and may send additional ideas with consensus to the Cross-Agency group as the work continues.

1. **A formal data request across partners that will enable the cross-agency group and stakeholders to assess the scope of the problem and refine solutions in an ongoing way.** The data request includes, but is not limited to the following information that can be made available if cross-agency partners prioritize staff capacity to compile this information:
    a. Data on the total number of all Colorado children and youth placed in out-of-state residential facilities. While CDHS is able to pull this data for children in county custody, the data would be stronger if it was presented alongside HCPF data on children that are not in county custody. The analysis should include, but is not limited to the following: detailed information of the ages of children placed out of state, the location of the out of state provider and type of provider, a brief summary of reasons why the children could not be placed in Colorado facilities, and a brief summary of what the out-of-state facility was able to provide that was not available in Colorado.
    b. An analysis of how many children and youth from other states are in Colorado residential facilities, in order to assess whether raising the daily medicaid rate paid to Psychiatric Residential Treatment Facilities (PRTFs) is successfully incentivizing Colorado PRTF providers to take Colorado children and youth. If Colorado is still experiencing this scenario, prioritize exploration into resolving these challenges.
    c. Summary data from the BHA on the independent assessments completed to date, including: how many children/youth go to the level of care recommended by the assessment and how many do not, where children/youth go when they do not go to the level of care recommended by the assessment and why, and de-identified data from the Child and Adolescent Needs and Strengths tool that can provide insight into the

behavioral health needs of children entering residential treatment, in order to both ensure QRTP programming is built to address treatment needs and inform upstream behavioral health investments that can prevent the need for residential placement.

d. Data collection on behalf of CAFCA that reports out on provider denials of referrals received in a standardized and ongoing way (#s and reasons why). In September 2022, Providers at a CAFCA Brainstorm Work Session said that the screen outs happening the most are: children/youth that have a charge involving a gun or weapon (other criminal charges), and/or assaultive behavior. It is critical that this information go beyond anecdotal report outs to capture the scope of the behaviors providers aren't equipped to take in an ongoing way and where the gaps are.
e. A complete analysis of all licensed residential facilities that have closed over the last five years (Jeff hills-aurora, Tennyson, Mt St Vincent Home, Hilltop, Turning Point, ROP, etc.), accompanied by a narrative on the population they used to take and the number of residential beds lost to provide detail on lost capacity specific to children with complex needs.
f. Data on the utilization of Laradon and the high-acuity bed pilots at PRTF and QRTP providers that are contracted with CDHS, including: the number of applications received, how many children/youth were eligible, reasons why children referred were not eligible, how many have been and are on the waitlist, how many have been served, outcomes upon discharge and several months post discharge, where the children and youth went that were not eligible for placement or did not stay on the waitlist, etc. These beds are often the last stop before Colorado children and youth go out of state.
g. Data from the DCW Placement Support Request Form- since inception to present- profiles/categories of children with complex needs that require additional support to locate placement.
h. Data from all Creative Solutions meetings with state partners- since inception to present- profiles/categories of children with complex needs that require additional support to locate placement.
i. Data from the counties on the number of children and youth in county custody stuck in county offices, hotels, or hospitals as stopgap settings. CHSDA can provide this information monthly.
j. Data from all hospitals on the total number of children and youth "stuck" in emergency department, inpatient, or psych hospital settings past medical necessity.
k. Data on the total number of youth in detention past when they are determined to be releasable (ages, reasons why), as well as, an analysis of the detention bed cap and its impact on emergency releases requiring placement.
l. Additional data collected through the SB21-071 performance standards on crossover youth that can be incorporated into the ongoing data analysis of children and youth in stopgap settings so we're incorporating any complicating factors from the delinquency side. Specifically, we want to look at where children and youth are going post the reduction in detention beds and Family First reforms.
m. Data on the number of open beds at QRTP providers across the state at points in time.

2. **Add needed clarification and make it possible so that the state crisis system can prioritize and respond to children and youth in crisis, in or returning to, residential facilities so providers are able to stabilize children, maintain them in the placement, or accept them back from hospital discharge**. In addition and related to this proposal, prioritize funding to expand adolescent crisis resolution teams across the state so all children and families have

access to this additional support in crisis. Currently, Crisis Resolution Teams in limited areas support families with children who are experiencing behavioral health challenges and would benefit from intensive, short-term (up to 42 days), in-home services and linkage to ongoing supports. The pilot only requires ASOs to serve one area per region at this time and only 19 of 64 counties are included in the service areas. Data on the pilot should be made available to inform any additional legislation and funding required for this work to be expanded.

3. **A robust messaging effort with judicial and delinquency judges and court partners about the continuum capacity crisis and reasons why court-orders for children and youth to enter stopgap settings in county offices and hotels without medication-certified and treatment staff are unsafe**. While some counties have ongoing open communication with their judges, magistrates, and District Attorneys, other jurisdictions are facing an ongoing crisis where the court increasingly orders a child or youth into an unsafe stopgap setting. This messaging effort will require leadership, prioritization, and support from cross-agency stakeholders.

4. **A robust messaging effort with hospital staff and leadership about the continuum capacity crisis, the tireless efforts of county and state support staff to locate appropriate placements for children with complex behaviors, and a new approach that relies on the crisis system when a family feels unsafe and unsupported bringing a child home from the hospital as opposed to defaulting inappropriately to the child welfare system and considering these scenarios abandonment and neglect.** While counties and Children's hospital staff through the state's HCPF, RAEs, CDHS, and County Collaborative (HRCC) hospital discharge subcommittee have been at the table, participation across all hospitals is needed to strengthen communication, hospital discharge planning and support for families in crisis. For example, representatives from HCPF, CDHS, counties, and hospital staff created a resource in 2021 titled, "Hospital Discharge Roles & Responsibilities." Where this effort has stalled and a critical next step is willingness across hospitals to review and endorse the resource through a regulatory lens and with consensus from the hospital association. There are significant opportunities to improve hospital discharge planning for children with complex needs, but all stakeholders to be partners at the table to advance this work.

5. **Significantly reduce the amount of time that county caseworkers spend on locating a single placement that is willing to accept a child or youth with complex behaviors by 1) fast-tracking the bed tracker functionality for residential facilities that accept children and youth and 2) streamlining/standardizing the application process with providers so counties do not have to fill out dozens of different application packets for one child**.

6. **Prioritize conversations right now about accountability and quality treatment programming within the entire continuum, especially within the existing residential providers in our state**. All agencies need to consider how to have a coordinated approach with residential providers on this area of need and how to make TA available to support this shift. We are not going to have an impact if we only focus on increasing provider rates or bed capacity without quality treatment and outcomes in tandem.

7. **Incentivize providers to take children and youth with the most complex behaviors** using general fund dollars. Maintain the investment of funding for providers to take children with complex needs before ARPA dollars run out, by exploring how to structure and create an

incentivize pool that providers can opt-in to in order to serve eligible populations that require more intensive staffing and clinical support.

8. **Prioritize and fast-track expansion of residential and family-like setting capacity in the continuum for children and youth with complex needs**. The separate high-acuity residential bed and family-like setting pilots that have been able to staff up to date are not sufficient to meet the demand across Colorado. These efforts not only need sustained funding, but additional funding to meet the demand above and beyond current capacity. The data collection effort above should inform this strategy.

9. **Explore the impact of the detention bed cap on the continuum crisis and instances when the cap causes emergency releases that impact the child welfare system**. This could include a deep dive into strategies across the country to reduce the use of juvenile detention in an equitable way and implement a more family-based community model for children and youth, like the juvenile detention alternative (JDAI), while in the meantime, ensuring the system is resourced to handle current needs. Children and youth that are alleged of high-level crimes or have a history of significant assaultive behaviors are coming to counties for emergency placement due to the detention bed cap and providers are not equipped to accept this population.

10. **Support efforts to advocate for funding the forthcoming actuarial analysis for updating residential provider rates that accept and treat children and youth with complex behaviors**.

11. **Explore if the BHA could host a pool of contracted clinical and specialized staff that would be able to support residential providers upon admittance of a child or youth with complex needs, if their milieu and staffing is not already sufficient.** Given that our ability to expand the capacity of our continuum and our ability to enhance the quality of treatment within the continuum for children/youth with complex needs are both limited by workforce shortages, this idea aims to address the workforce shortage in the short-term instead of waiting for all providers to be appropriately staffed to treat all behaviors. This team could fill the gap that occurs when providers are missing staff to address particular behavioral and treatment domain needs. Having the team be hosted by a state agency could address the liability and regulation concerns that providers have in accepting outside staff into their facilities and allow for targeted higher pay to recruit clinicians quickly and retain them for this purpose.

12. **Support funding for CDHS' idea to create a statewide training academy that can provide foundational and specialized training to new and veteran 24/7 direct care staff at providers that would increase staff ability to support children and youth with complex needs**.

Thank you in advance for your consideration of these ideas. Counties remain committed to generating potential solutions and coming to the table to collaborate with stakeholders around this significant crisis.