September 9, 2021

Director Michelle Barnes, Colorado Department of Human Services
Director Kim Bimstefer, Colorado Health Care Policy and Financing
CC: Governor Jared Polis

Directors Barnes and Bimestefer:

As we have discussed, Colorado's system to serve our highest acuity children is failing. Not only are there not enough therapeutic/psychiatric services and treatment beds available to match children's needs across all of the highest levels of care, but there also exists little accountability to ensure facilities are programmatically able to meet the needs of higher acuity children they are licensed to serve. As shared with you in CHSDA's September Executive Committee meeting, the devastating impact of the current crisis involves children that are inappropriately placed in dangerous stopgap settings without treatment or qualified staff support, unnecessarily sent out of state, and stuck in emergency rooms or hospitals well beyond their eligible date of discharge.

While this crisis is being felt across all areas of the state today, it has been years in the making and earlier measures have not been sufficient to shift the course of the emergency. As a follow up to the discussion between CHSDA, CDHS, and HCPF executive leadership last week and recognizing that other stakeholders have had recent conversations with the Governor's office, CHSDA, in this letter, is expanding on the multifaceted crisis that county directors of human services and their staff are facing on a daily basis to place children and youth with the highest acuity needs. We thank you for the thought and energy that went into the CDHS action plan outlining the departments' various efforts to address parts of the issue and HCPF's efforts to find immediate placements for children in limbo, but we are compelled to provide additional context from the counties' perspectives and identify additional gaps and solutions to consider. CHSDA urges you to take immediate, wide-ranging and resource-intensive action to match the complexity and volume of these challenges.

Services and treatment placements for the highest acuity children are so limited that efforts to locate a facility that has an open treatment bed and can meet the needs of the child involve an exhaustive, lengthy effort pursuing dozens of providers. Met by denial after denial, these cases rarely find timely or local resolutions and as a result children bounce in and out of inappropriate types of care with changes to their medication and long waits for clinical evaluation and support. The delays and inefficiency resulting from a lack of bed space across multiple levels of care further adds to the trauma, destabilization and acuity of the child involved. Creative Solutions, Centralized Staffing, Transfer Center staffing processes, as well as, direct outreach to CDHS and HCPF leadership, are similar in their attempts and failings to solve barriers to finding appropriate placements, despite intensive collaboration across many partners. Even with all hands on deck across our organizations to match needs with existing treatment providers, the crisis persists. The capacity to match the need simply doesn't exist and more often than not the private provider refrain is that a child/youth is "too acute" to meet admission criteria.

It is not uncommon for residential facilities that are licensed to serve higher acuity youth with complex needs to have exclusionary criteria. This leaves a persistent gap in the availability of placements for children/youth that may have one or more of the following presenting factors: a history of running, high physical aggression, intensive mental health needs, self-harm, history of legal charges, sexually predatory or offending behaviors, substance use, intellectual or developmental disabilities, including autism, and/or co-occurring chronic physical health challenges. The gap is even larger for children younger in age. The few facilities that accept children outside of other facilities' exclusionary criteria are chronically maxed out and report long wait lists. County departments of human services are encountering situations where child welfare staff have had to stay overnight in county offices or hotels because there was nowhere else for the child to go. This is unacceptable.

In addition, the lack of step down and long-term residential treatment centers for children/youth eligible for discharge from emergency room and inpatient hospitalization increasingly leads to costly, out of state placements that are much farther away from a child's family. Counties have been told that the majority of children/youth placed out of state do not look different than those placed in-state at existing placements, but without clear real-time data the challenge is even harder to define and advocate around. There are no mechanisms to hold facilities accountable for prioritizing out-of-state children over local residents or rejecting admission due to staffing/programmatic criteria. In addition, the system of payers is overwhelmingly complicated to navigate and acts as another contributing barrier to finding appropriate placements in a timely manner. While we have no interest in placing children in facilities that are unequipped to serve them, we do want to ensure that those that are licensed for this high level of care are prepared to and do accept these children.

We are currently in urgent need of more treatment bed capacity in psychiatric residential treatment facilities for in-state residents, longer term residential treatment centers and residential step-down options after inpatient hospitalization. Several providers within the already limited landscape on the high-end of the continuum have closed permanently in the last few years. The need for more capacity also extends on both ends of the continuum: to inpatient and psychiatric hospitalization settings on the high-end and in-home community services to support step down options on the other end. It goes without saying that children and youth should, whenever safely possible, receive treatment services in the home with family and/or with kin to prevent out-of-home placement. The need outlined in this letter is a reflection of the behavioral health crisis for children and youth with the most acute needs, when children and families are in significant crisis at the high-end of the treatment system, cannot receive treatment safely in the home and have experienced multiple failed placements.

At the end of June 2021, there were over 4,200 children in out-of-home placement across the state. CHSDA recently surveyed counties on the number of children/youth in county custody and in high-acuity placements. Point in time responses from 36 of 64 counties (including all of the Big 11 counties), revealed:

- 26 children/youth currently in the hospital
- 24 children/youth in a residential facility out of state
- 91 children/youth in need of residential placements (not also included in the hospital count)
- 69 children/youth in county custody on the run

This problem extends well beyond the child welfare system. While these numbers don't reflect additional placements in systems outside of county custody (including RAE/Medicaid and private pay) we know the challenge involves even more children and youth than are represented in county-custody numbers alone.

Counties urge you to review the host of considerations outlined below as possible solutions, both in the short-term and long-term. These take into account and build on CDHS' recent action plan that outlines problems and associated action steps:

- Counties urge the state to make available more funding immediately to create additional residential treatment beds to meet the need of high acuity children/youth within the coming weeks. Per SB21-137, Colorado is utilizing stimulus dollars to contract for 15-20 no eject/reject residential provider beds reserved for the most acute children/youth by November 2021. HCPF is also pursuing an approach to utilize stimulus dollars to recruit providers with specialized programming, but the timeline is unclear and will not help with the immediate short-term crisis. The number of beds coming online in the short-term is grossly insufficient to meet the current, immediate need.

- As of July 1, 2021, Colorado increased the daily rate for Psychiatric Residential Treatment Facilities to $750/day in an effort to make Colorado rates competitive with out-of-state provider rates and disincentive a current provider practice of filling beds with out-of-state children. However, what complementary provisions in licensing or monitoring would ensure Colorado residents are prioritized locally? Can the state consider paying to keep open beds available to in-state residents, among other strategies? Can the state incentivize facilities who serve Colorado residents?

- Colorado expects to have 70 additional Psychiatric Residential Treatment Facility beds across three new providers as a result of existing facilities shifting their license type, but it will take some time for providers to staff up and admit children and youth. With these new PRTF facilities, what measures can be taken, or what changes in licensing or monitoring can be made, to close the loophole that occurs with existing PRTFs when a youth meets the acuity for PRTF level of care and meets the medical necessity criteria, but does not meet the facility's programmatic criteria (staffing, equipment, etc.). Without further accountability and stricter programmatic requirements, the fear is that these additional beds will fail to close the gap in need as a result of exclusionary criteria. Can the state do more to align a PRTF's programmatic criteria with the licensing criteria?

- We recommend CDHS create and track CStat numbers and strengthen contractual requirements for data reporting for providers across levels of care, including: admission and re-entry denials, discharge due to level of acuity, sufficient notice of discharge, number of in-state and out-of-state children/youth served, length of stay, and permanency outcomes. In addition, it is critical that contract requirements for providers include participation in creative solutions and/or other staffing processes to identify timely placements for high acuity children. Tracking outcomes across all levels of care that contribute to the revolving door of failed placements is essential to move efforts toward solutions.

- While CDHS is in the beginning stages of developing a process and reporting mechanism to better track out-of-state placements across systems and OBH is in the process of contracting for a vendor to build a "bed tracking" database for in-patient facilities that will start with Substance Use Disorder (SUD) providers, these efforts will take some time to have a positive effect on the system. What better data sharing processes can close this gap in the short-term?

- Colorado's screening tool for the detention continuum at time of arrest includes two levels in the continuum that do not exist today: staff secure and shelter. Changes to detention criteria per SB19-108 and SB21-071 are shifting the demands and needs across the continuum. Requirements of SB19-108, in

combination with congregate care requirements and admission standards for treatment under Family First, have left every jurisdiction concerned about the lack of residential placements to meet the need of youth in either or both delinquency and dependent and neglect cases, when placements with family or kin are not possible. Counties urge state leadership across the delinquency, commitment, and child welfare systems to be equal partners in identifying solutions, managing placement arrangements for high-acuity children/youth, and committing funds.

- This crisis reflects the challenges of a larger behavioral health system that have not met the needs of these children/youth earlier in their lives. CHSDA urges all parties to continue to invest in community-based, evidence-based, and accessible behavioral health services targeted to children and youth throughout the state. Part of the implementation of the comprehensive safety net system for behavioral health (SB19-222 plan) involves identifying behavioral health services each community must have access to in each region of the state. Success on this metric, however, is several years away while Colorado families are in crisis each day. Counties urge timely implementation of prevention services specific to behavioral health services and swift action to implement recommendations from the Delivery of Child Welfare Taskforce's Medicaid Subcommittee.

Without significant and timely action this crisis will only continue to intensify. We need treatment bed capacity to serve the needs of children and youth that are often excluded by provider admission criteria. We need more capacity in psychiatric residential treatment facilities for younger children and adolescents, longer term residential treatment centers, residential treatment step-down options after inpatient hospitalization, and residential substance use disorder treatment facilities for youth. There is no way to overstate how this crisis is affecting dozens of Colorado children and families every day across the state. Each new day without swift recourse to address the lack of high-acuity treatment options will continue to create safety concerns for children, youth, families and county caseworkers. Thank you for the opportunity to provide comments on behalf of our membership. We look forward to the actions ahead to ensure Colorado's children and youth treatment needs can be met in-state.

Sincerely,

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