Complex Case Report Summary

Public Act 25-89, Sec. 5

Statute Language

Sec. 5. (a) The Secretary of the Office of Policy and Management, in consultation with the Governor's Kids Cabinet, shall establish a working group to examine the feasibility of an interagency complex case team for young adults ages seventeen to twenty-two with intellectual or developmental disabilities, including autism spectrum disorder, who (1) may have co-occurring mental or behavioral health needs, (2) are in urgent need of community placement or agency services, and (3) qualify for support from more than one state agency.

Report due by 2/1/26 and to report on:

(1) findings on the necessity of creating a formalized process to address long hospital stays for such

young adults and safe discharges with community supports

(2) summary of best practices identified in other states,

(3) recommendations concerning state appropriations necessary to operationalize any recommended process

(4) recommendations regarding a referral process for complex case team management

(5) proposed legislation to implement any recommended process

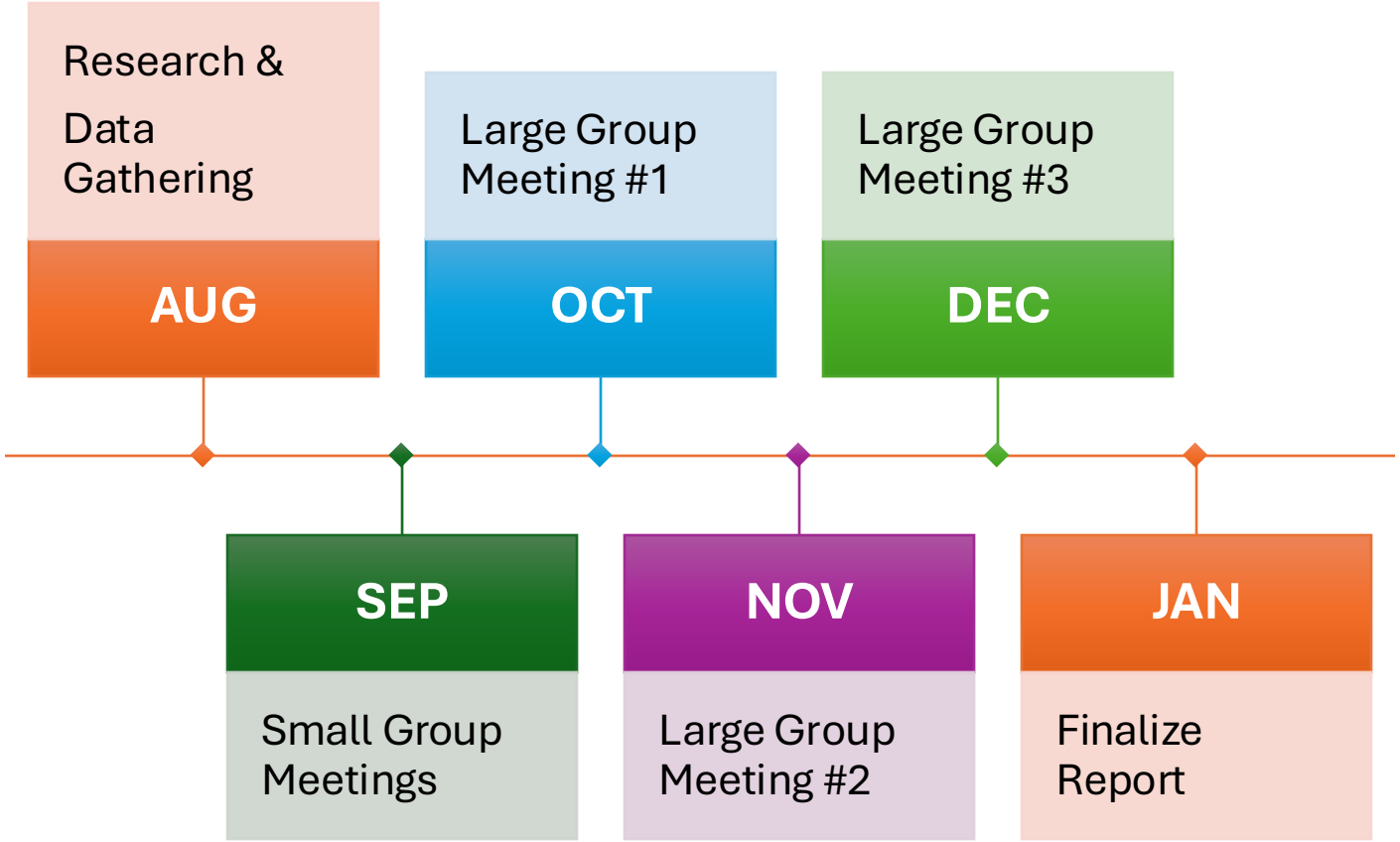
Goals Identified in Statute

Establish a working group to;

- Assess the feasibility of establishing a formalized interagency Complex Care Team to address:
  - Prolonged hospitalization
  - Safe discharge planning
  - Resource allocation and referral processes
  - Service coordination and agency of authority when eligibility criteria crosses multiple state agencies
  - Immediate community placement for high-need youth and access issues

- Identify the ideal structure of an interagency complex care team
- Conduct a fiscal cost analysis for the state to implement an interagency complex care team and potential for cost savings
- Recommend a sustainable legislative and funding framework

Project Timeline



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Defining Complex Cases in CT

Younger adults (ages 17–22) with intellectual and/or developmental disabilities (I/DD), including autism, who also experience co-occurring mental or behavioral health needs, face significant barriers in accessing timely and appropriate community-based placements and services. These individuals often require support from multiple state agencies but are at times left in prolonged hospital stays or other inappropriate settings due to the lack of a coordinated interagency response system and sufficient community-based capacity. This can result in delayed discharges, service gaps, increased healthcare costs, and sub-optimal long-term outcomes for the person.

State Models: Keys to Success

Agency collaboration and shared values to find solutions that improve the system for youth with complex needs.

Leadership Support (Executive Branch)

Statutory authority and resources to implement recommendations for the state's vision

OhioRISE

Specific Managed Care Program for youth with complex behavioral health needs combined with a 1915(c) waiver

Oversight through Dept of Medicaid and Governor's Children First Cabinet that includes relevant state agencies.

Serves all children in OH despite family income.

The program is currently serving 52,000 children and has reduced ED visits, psychiatric hospital stays, length of stay, and out-of-state placements.

Prior to implementation they utilized an Interagency Team that received referrals and had a $4M operating budget to assist counties with complex cases.

Pennsylvania's Blueprint for Complex Cases

A bulletin was released prioritizing complex cases in the state.

Staff positions were added to the Office of the Secretary to develop the Statewide Blueprint and provide TA to counties.

The Secretary's staff do not have a budget to support case specific needs, they provide policy suggestions, resources and technical assistance to implement the work outlined in the blueprint.

NJ Systems of Care

NJ is using an ASO to implement their systems of care under the Department of Children and Families.

The ASO is a single point of access to their array of services that includes; behavioral health, substance use, and intellectual and developmental disability services for youth and families statewide.

They utilized a SAMHSA grant to develop a concept for their integrated system of care.

Massachusetts

- Developed an Interagency Review Team for Complex Cases
- The team reviews complex cases where an individual is waiting in a hospital emergency department, a medical bed, at home or other location and is in urgent need of a placement.
- The team is comprised of state agencies; the co-chairs will determine a solution when there is a lack of consensus among agencies on appropriate supports or eligibility.
- The team is provided funding to assist with additional testing and/or temporary solutions to placement.

Recommendation #1

- ***Formalize a higher-level review process for complex cases in Connecticut.***
- State agencies will use a current review process and formalize though an MOU
  - DMHAS
  - DDS
  - DCF
  - SDE
- Agencies will convene to determine operations which includes
  - Meeting frequency
  - Additional membership
  - Referral criteria and process
  - Timelines for review and determination
  - Process for communicating joint decision and follow up with OPM
  - Process for dispute resolution

Recommendation #2

- ***Close gaps in the behavioral health system for young adults with ID/D who are not being transitioned to the DMHAS YAS program.***
- DCF has made some proactive changes to licensing requirements, which will allow some individuals with ID/D to remain in VCM past age 18, when determined appropriate for their ongoing treatment needs.
- Next Steps
  - Use higher-level review data to determine the treatment needs vs long term placement needs of this population. Determine if a budget is required to support the work of the review committee.
  - Work alongside TCB to ensure this population is considered in discussions around transforming the behavioral health system for children.
  - Build clinical capacity in autism and intellectual disability across the entire behavioral health system to decrease the need for long-term out of home placements.
  - Align system supports to decrease disruption for those who are receiving special education services through the school year in which they turn 22 years old.

Recommendation #3

- ***Build additional infrastructure to address behavioral health system gaps for young adults (14-21) with ID/D who require residential treatment.***

- Build capacity by developing a PRTF model that can meet the treatment needs of this cohort.

Questions

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