Behavioral Health Partnership Oversight Council

ADULT Quality Management & Access Committee-

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Co-Chairs: Elizabeth Collins & Howard Drescher

Attendees: *Meeting Chair: Howard Drescher*

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- ***Update on DMHAS Intermediate Care Beds - Jennifer Hutchinson***

St. Vincent Hospital currently has 5 patients/16 beds total. The Level of Care (LOC) guideline was approved by PAG Committee at the 4-20-11 meeting. DMHAS will continue to work with the hospital on operational issues. Providers can access beds by a phone to DMHAS first: Lee Swearigen at 860-418-6936; she works with Sue Graham, DMHAS. Referrals for this level of care can come from EDs and hospitals. The facility would discuss the request for admission first with DMHAS for appropriateness of admission and then contact VO for prior authorization (PA). Natchaug hospital, which is grant funded through DMHAS, can accept some of these clients if they are in that geographic area.

- A client does not have to initially be linked to a Local Mental Health Authority (LMHA) but will be linked with LMHA through DMHAS. The hospital care plan will reflect the need for an intermediate acute care hospital service. The expected length of stay (LOS) is ~ 45 days.
- Payers for this service are Medicare, Medicaid and DMHAS grants for clients not entitled to one of these public health programs.
- *Can clients be probated into this level of institutional care*? Yes, as these are acute level beds.

- ***ValueOptions Report: Overview of the BHP Performance Initiatives - Deb Struzinski***

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ValueOptions presented a program overview of the Provider & Analysis & Reporting (PAR) status that is part of the CTBHP quality improvement process (*click icon above to view presentation):*

- *(Slide 3)* PAR phase 1: collaborative work with DSS, DCF, VO, providers and consumers to develop goals and processes to meet these goals.
- *(Slide 4*) CTBHP & VO created provider work groups to identify & identify strategies to overcome barriers to achieving PAR goals.

- *(Slides 7-9)* The first Provider Pay for Performance (P4P) initiative began in 2008. to expedited change. Used pending available funds thru DSS.
- *(Slide 10)* snap shot of first program and impact on discharge delay days (beyond medically necessity) that creates a thru put barrier in the system. *(Slides 11-12)* Progress resulting from the Pediatric Psychiatric Inpatient PARs program: 32% reduction of average length of stay (ALOS), discharge delay days (DD) days were reduced by 50% in CY 2010 and total LOS was reduced by 17% while hospital readmission rates have continued to decline.

Committee comments/questions included:

- *What is the process in choosing and identifying a performance incentive program?* VO does a lit review on issues as well as outreaches to VO national data base. VO's primary focus in developing any P4P initiative is the State's provider experience with that P4P area in order to develop processes and expected outcomes. Providers initially met the goal; now the focus is on maintenance data, moving toward quality with input from parents (parent engagement) of hospitalized children.
- National data: inpatient ALOS is ~ 6 days; however states have different community based (CB) programs. CT has made progress from the initial 45 day ALOS.
- Dr. Herrick noted: Some of states' LOS is driven by state law and system delivery model (i.e. capitated managed care). Colorado savings from reduced inpatient LOS was put back into the community provider system. VO noted CT savings on the inpatient side was spent on expanding the BH ambulatory care services.
- HUSKY adult inpatient LOS has been ~ 5.8 days – since 2006, this has been consistently shorter than children's LOS. This HUSKY sub-population's shorter LOS may be related to clients that are less vulnerable than children and the HUSKY adults generally have available housing. CTBHP instituted a hospital "by pass" program (hospital can avoid at least one concurrent review (CCR) to reduce the administrative burden for the facility and VO.
- ED stays for the 'new' Medicaid adult population is creeping up. In some cases a hospital may hold a patient in ED until their hospital bed available. VO will need to look at this. Also been requests for extended LOS in inpatient detox units, in part related to the facility's decision to wait for that hospital's IOP slot to become available. VO will also be tracking this and look at readmissions to the detox facility.
- VO talking with agencies about performance targets. Looking at home health utilization with home care agencies, evaluating 2010 service utilization data. VO will work with Home Care agencies to develop performance targets when VO's performance target language is finalized.
- Strategies for successful PARs: ***collaboration*** with VO, state agencies, (i.e. regional DCF office) and providers to solve the problem LOS: acute medically necessary days and DD days. DCF clients historically and continue to be at higher risk for > LOS. CTBHP goal is to determine what contributes to this - the acute lOS vs. DD LOS - and then apply interventions per case. VO said problem solving is always a collaborative process with thoughtful consideration to approaches that maintain care, quality and safety. Early treatment planning and focal treatment plans with families are critical to this process. Open discussion with providers on PARS data provides an opportunity to share strategies on how to achieve successes, reach PARs goal. Lori Szczygiel (VO) said family engagement is critical in

hospital quality initiatives and making the transitional connection to Community based services CBS). Family peer support assists in client/family transition from inpatient to CBS.

- VO works with inpatient units on discharge plans and is aware of inpatient unit time constraints to make the discharge plan, therefore VO Intensive Case Managers (ICM) work with the facility to build/execute the plan. ValueOptions ICM staff – 8 for adults, 12 staff for children. Case load could be 30-40/ICM. It varies: the ICM staff may work with a facility for a time period to achieve goals in PARS, then step back to provide ICM to specific clients.
- More challenges with adults: ASO works with DMHAS, LMHA and providers to identify where there are gaps in discharge services/geographic area. Care coordination helps people to transition to Community services. DMHAS, VO provide care coordination and assign VO's ICMs for complicated needs patient: ICM staff will follow a client to community to make sure they are connected to care and ties together other CB resources needed by the client.
- VO can assess utilization patterns (i.e. frequency of detox admissions with the same discharge plans that need to be revised to reduce relapse into inpatient services).
- Home health perspective: Kym Nystrom found VO very helpful to this industry, providing education so important to staff to learn more about CTBHP "recovery" approach.
    - NE HC: inpatient clients are connected to home care by the LMHA. Often these clients have both MH and multiple medical problems that require a range of home services and medication management. Home care goals include incremental skill building to allow the client to manage their medical regime in the home and connect them to social networks and support.
    - VO will look at providers' prescription of home care LOS patterns and discuss what works best for this patient.

- Kara Spinner (All About You Home Care) noted concerns related to the consequences of reducing hours in the home and difficulty going back to original hours if problems develop. VO said the home care agency is given a specific number of units on PA that can be renewed as needed; the home care agency determines how units used. VO said their responsibility is to ensure the member gets services at the level they need. If the client experiences a worsening of status, requests for episodic inpatient care or upgrade services is reasonable. For some CTBHP members, planned episodic short hospital admissions may avert crises.

➢ ***Future Geo-Access report***

Committee discussed parameters of such a report

- VO will do the report as part of their contract. VO has the provider profile from Medicaid provider network (CTMAP) but this may not be up to date. VO plans to run a claims- paid report for every provider listed in the CTMAP network that will identify providers still seeing Medicaid CTMAP clients. Then overlay the CBHP population density by area with active participating provider number by area to identify 'network capacity'. ***First baseline 2011 report will available in September.*** It was suggested that once the baseline network capacity data is known, VO can look at baseline data, identify capacity issues and compare readmissions per client density/provider numbers (area network capacity).
- HUSKY claims filing lag is 120 days, Medicaid FFS 365 days. VO biostatician will mine

DSS data warehouse for the geo access report.

- Children transitioning to the adult system creates challenges early work being done with agencies and VO. Challenging clients in home health care.
- ***Discussion on levels of care to focus on for future meetings***

- There are no intermediate services for adult patients that are not safe to be discharged from inpatient care to the community, yet the patient doesn't meet "medically necessity" for continue hospital stay. Intermediate acute care beds may be appropriate for some of these patients.
- Clients fragile for community living may be stable in the hospital. What is missing is:
  - One-to-one services in the community. Insurance doesn't pay for this, although some patients were provided this thru DMHAS grants (discretionary discharge funds) when funds can be shifted to this service; this is more difficult to do now with budget constraints. This type of care suggest some success outcomes in maintaining clients in the community.
  - There is no outpatient "commitment" to ensure compliance with treatment (i.e. take medications, participate in outpatient services).
  - How can these innovative experiences eventually become part of treatment options that may avoid hospitalization/readmissions? Lori Szczygiel suggested these types of analyses can be helpful to make the case for other treatment options. The Committee can track trend data around adult discharge delays and quantify what 3 elements contribute to stalled discharges. VO offered that their ICM staff can discuss specific difficult cases with the hospital.
- Medicaid dollars vs. grant dollars in system need to be identified when making changes.
- Legal liability issues often drive inpatient care, while this level of care may not be best option for successful treatment and management.
- Committee can continue to look at ethical areas that impact level of care for clients.

Other Issues: none were raised.

Future meetings:

- ✓ June 7 meeting: in **3rd floor, 3D suite. All meetings at VO will be on the 3rd floor beginning Monday May 9, 2011.**
- ✓ June agenda items will include:
  - Vo phone status report
  - VO performance targets, performance standards
  - Discuss quality metrics. Medicine has quality standards, clinical pathways (i.e. managing CHF). *Are there standards/clinical pathways for adult Mental Health care*? There is some federal work in this area: Steven Moore (VO) will look at this and share with the Committee.
  - Committee will decide on summer meeting dates.