Behavioral Health Partnership Oversight Council

Quality Management & Access Subcommittee

Legislative Office Building Room 3000, Hartford CT 06106
(860) 240-0321 Info Line (860) 240-8329 FAX (860) 240-5306
www.cga.ct.gov/ph/BHPOC

Meeting Summary: May 7, 2007

Chair: Dr. Davis Gammon Co-Chairs – Paula Armbruster & Robert Franks

Next meeting: Friday May 18th at 11:30 – 1 PM at ValueOptions, Rocky Hill

BHP Report

Dr. Mark Schaefer (DSS) summarized status of key initiatives:

- Performance measure project (PMP) (with BHP & HSRI): latest version of the performance quality indicators that have been refined over the past four months is on the CTBHP web site: www.CTBHP.com BHP expects to begin this project in the Fall, 2007.

- Enhanced Care Clinics (ECCs) status: 29 letters of agreement have been completed, representing 29 ECCS and 100 service sites that provide child and adult services. One change was made to have secondary sites have emergency walk-in unless it is a small site. Timelines:

    - September 07: ECC meet timeliness of access criteria
    - January 2008: ECC would meet primary care/BH coordination of care.
    - Other ECC criteria would be phased in as appropriate thereafter with BHPOC input.

- Mercer quality analysis report is expected ready for review by the QA SC in June.

ValueOptions Report

QA SubCommittee
May 7 2007 (4).ppt

Focus of the discussion was on Emergency Dept. (ED) and inpatient & PRTF utilization and discharge delays.

ED Utilization

- ✓ Children's psychiatric ED utilization has, over the past four years, increased in excess of medical ED use. During these 4 years Medicaid children's volume increased by 30,000; however the tendency to rely on the ED for emergency/urgent BH problems may account for the disproportionate increase in BH ED use. ***(see second report on children's BH ED use by CHDI at www.chdi.org.)*** Reasons for this need to/will be further explored.
- ✓ ED use patterns vary by region/hospital. For example, the Children's Medical Center (CCMC) has been recently experiencing their highest pediatric psychiatry ED volume while

Midstate and St. Francis have experience volume reductions.

- ✓ During the last week CCMC had record numbers of ED "boarders". The BHP agencies took the following actions:
  - o Onsite ASO Intensive case management and system managers that work with CCMC after hours to support disposition from the ED.
  - o Use diversion where appropriate through co-locating Emergency Mobile Psychiatric (EMPS) teams at CCMC and St. Mary's that work with families to look at alternative care.
  - o DCF is working with providers that deliver intermediate level services such as intensive home services, partial hospital and extended day treatment programs to 'flex' their existing capacity to meet intermittent increase service needs that could allow for inpatient diversion.
  - o Longer term initiatives that will address delay issues include full implementation of the ECC emergency walk-in services and increase in EMPS teams/hours.
  - o Expanding CT agency out-of-state facility agreements for specialty services. Currently Stony Lodge and Four Winds Hospital in NY, Bradley Memorial in RI, Kids Peace in PA and occasionally Brattleboro Retreat in VT are in use. The need to do this for children with behavioral, developmental and medical diagnoses raises the question of CT's need to create a developmental disability unit to provide services with in the state. State agencies will need to consider this.

- ✓ During ED/hospital discharge delay upswings, questions about the adequacy of inpatient psychiatric bed capacity often resurface. The Office of Health Care Access study on child and adolescent psychiatric bed capacity can be found on the agency web site: www.ct.gov/ohca

- ✓ The epidemiology of the pediatric psychiatric crises, though less acute than Massachusetts, remains somewhat elusive.

- ✓ Future ED utilization reports should include ED use/MM and the number of children/adolescents that present to the ED; the latter would require several data sets, including CHIME data and HUSKY MCO data, since admissions through the ED are not recorded as an ED visit.

Inpatient & PRTF utilization
A slide set with descriptive data on inpatient and PRTF utilization data was reviewed and discussed at the SC meeting in preparation for its presentation at the BHP OC meeting 05/09/2007. Dr. Schaefer expressed the wish that the primary task of the QM & A SC become the critical review and analysis of BHP performance data as they become available. The SC concurred.

- ✓ While inpatient use has not shown significant changes, it is worrisome that the discharge delay days are 23% (about 5000 days) of the total inpatient (inpatient and PRTF). Of the total inpatient days, 16-17,000 (77%) are inpatient service days compared to 4800 days (22%) for PRTFs. It was suggested that future reports separate the inpatient and residential utilization data.
- ✓ Total inpatient days and percent of discharge delay day trends are a critical metric of the

impact of the system change over time.

- ✓ Regional data is difficult to evaluate because of the small numbers/region.
- ✓ Wait times for residential placement continues to be cited as the primary discharge delay reason. Dr. Andersson stated that assumptions such as long inpatient stays require residential placement can be challenged when the inpatient facility, DCF team and family look at alternative care beyond residential care.
- ✓ Leaving a child/adolescent in an acute institutional setting beyond discharge can lead to "treatment freeze" while placement barriers are addressed. Consider creating protocols for acute vs. subacute care.

The discussion related to the presentation emphasizes the importance of the BHP OC and Subcommittee formulating questions related to the data. The May 18th meeting of the SC will be devoted to advancing this discussion.