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/medicaid

Meeting Summary: May 18, 2007

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

Next meeting June 15, 2007 @ 12:30 PM at CTBHP/VO

BHP Program Data *(See report below presented to BHP OC 5/11/07)*

BH Oversight Committee May 9 20

Inpatient and ED service authorization data was reviewed (*see data from report above)*:

	Inpatient			**PRTF**		
	Q3 06	***Q4 06***	***Q1 07***	***Q3 06***	***Q4 06***	***Q1 07***
# of Cases	791	929	736	91	87	83
Total days	15,528	16,171	16,453	6,425	5,881	5,334
ALOS	24.5	26.7	25.2	105.4	138.8	195
% days delayed	NA	NA	30%	NA	NA	2.5%

Discussion ensued about the **1st Q07** data. Highlights include:

Inpatient vs. PRTF:

- The average length of stay (ALOS) for ***PRTF*** increased from 175 to almost 200 days while the **inpatient** remained flat (pg 4).
- 30% of the inpatient hospitalization days, based on medical necessity guidelines are delayed discharge days (about 5000) that could be reduced if there were more intensive community-based (CB) services available.
    - DSS noted the 10B7 report: of 570 discharges in 1st Q07, 88 were delayed discharges; 191 children admitted in that Q stayed through the quarter.
    - The percentage of discharge delays is an important marker for how well the BHP program is doing, over time, in improving availability of and access to CB services.
- Reports on hospital days/1000 by local area and discharge delays, being provided to the community collaboratives, can identify local planning needs. In the future it would be helpful to track 1) hospital days/1000 members and intermediate level of care utilization by local area and 2) penetration rate of BH services by local area.
- Reasons for inpatient, PRTF and residential treatment care (RTC) discharge delays were reviewed. As has been seen in past quarters, 'awaiting placement' remains the top reason for 1st

Q07 discharge delay reasons.

ED discharge delays:

- There has been a gradual increase in ED discharge delays since 3rd Q06: average days increased in 1st Q07 to about 2.7 days compared to 3rd Q06 (2.2 days).
- CCMC had experienced the highest number of delays in 1st Q07 compared to other hospitals: about 45 children/adolescents in 1st Q07 compared to 6 in 3rd Q06.
    - More than 57% of children delayed in the ED in 1st Q07 were living at home with family.
    - Of those children "stuck" in the ED (90), 72% (65) were DCF involved.
    - One-third of ED-delayed children were 12 years or younger.
    - 68% of those seen in the ED in the reporting quarter were admitted to inpatient care.

Descriptive data on ED delays suggest that Emergency Mobile Psychiatric Services (EMPS) use as consultants and available CB services would divert ED visits/delays and some inpatient dispositions.

The Subcommittee identified the need for the State Department of Education to be involved in the BHP work. A pilot was suggested that would include Enhanced Care Clinics, EMPS, school-based health centers (SBHC), local primary care providers and area Education departments as partners in the process of managing child/adolescent BH referrals.

BHP outlined next steps in data analysis for July to QA SC and Council:

- ✓ Community-based service use
- ✓ RTC capacity, use over the past 5 years
- ✓ % of DCF children involvement in levels of services
- ✓ Outpatient registration data reports.