Behavioral Health Partnership Oversight Council

Quality Management & Access Subcommittee

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Meeting Summary: July 20, 2007

Next meeting: Friday September 21, 2007 At 1 PM at CTBHP/VO, Rocky Hill
Chair: Dr. Davis Gammon Co-Chairs – Paula Armbruster & Robert Franks

CTBHP Data 1st & 2nd Quarters 2007 *(Click on icon below to view data report)*

QA SubCommittee
July 20 2007 (5).ppt

Discussion of presentation by level of care:

Inpatient Services

- ✓ Inpatient data for inpatient psychiatric facility (IPF), inpatient medical unit (IPM) and observation beds (23 hours, very small number) includes Riverview data. Riverview data will be separated from the data as previously recommended by the SC. Of 180-190 hospital admissions, 50-60 cases are in Riverview hospital.
- ✓ DCF status impacts discharge delay days:
  - o Children < 12 years that are DCF-involved have delayed discharge due to foster care placement wait. SC commented there needs to be a place other than an inpatient facility for young children to "wait" for community living placement while receiving BH services.
  - o Hospital discharge delay is also attributed to residential care admission delays.
  - o DCF children's delayed days are higher (25 – 31 days) than non-DCF children (14-13.3). The DCF delay-days were higher in Q2 07 compared to Q1 07 whereas the non-DCF delayed days were actually lower in Q2 07 than in Q1 -07.
  - o "Acute" LOS for delayed cases is higher for DCF clients; some of the non-DCF cases may be in DCF process for receiving DCF services such as voluntary services.

- ✓ All states have hospital discharge delays: CT is ahead in that the CTBHP/VO has clearly defined and measured acute inpatient care by medical necessity and delayed stays. CTBHP/CT continues to work to reliably distinguish acute care versus discharge delay.

*CTBHP response to inpatient discharge delay (**see outline in document above**)*

- ✓ CTBHP/VO has implemented discharge delay strategies that include 3 weekly rounds with child psychiatrist focusing on 1) cases that are inpatient > 10 days, 2) current discharge delay cases, VO System Managers bring discharge delay data to regional weekly meetings, audit all delayed cases and sample outlier cases (inpatient > 10 days) to determine if the case was reviewed in rounds or should be in a discharge delay status.

- ✓ DCF now reviews daily all DCF children in delay status, determining what discharge services are needed from the hospital/VO perspective as well as the DCF area office perspective. DCF determines if there is a discharge plan, is it reasonable and are there alternative services that are available to the family that would facilitate hospital discharge. This review has been in place 6 weeks so it is too early to evaluate impact. DCF does not have a policy for Area Office staff to visit the DCF inpatient child – resource issue.

- ✓ ValueOptions outlined 3 goals to reduce discharge delays (***see detail in above document).*** Comments:

    - Some hospitals begin work on discharge disposition on admission and do refer cases that have delay potential to hospital case management and CTBHP/VO intensive care management (ICM). CTBHP/VO has trained their care managers on potential discharge delay indicators that they use as prompts for the hospital to address a patient's potential discharge delay.
    - Riverview Hospital discharge evaluation often focuses on the child/family problems rather than strengths of the child/family/foster family unit; the case can be daunting for entities to accept the child on discharge when strengths are not included.
    - Hospital discharge "best practices" relies on communication among all stakeholders to drive the implementation of the strategy.

- ✓ It is important to analyze issues related to hospital discharge delays: implicit in this process are the broader behavioral health system issues. Need to evaluate how delays and interventions relate to the overall system of care and coordination of that system. DSS observed that some initiatives are in place, but we do need to look at interventions that will make the spring 2008 service access and level of care transitions better than the 2007 experience.

*CCMC **(See background, interventions and impact on CCMC ED delays)***

Children's Medical Center (CCMC) in Hartford saw an increasing trend in children delayed in the hospital's emergency department (ED) during January through March 2007. The BHP response plan was implemented April 13th and its positive impact was attributed to onsite Wheeler Clinic EMPS successful collaboration with CCMC staff, CTBHP/VO onsite support that included after hours and weekend staffing and the responsiveness of area providers in accepting ED patients into their programs. Impact:

- While the pediatric psychiatric ED admission numbers remained at 150-200/month, the average length of discharge delays dropped below 2 days in May and June 2007.

- The percent of ED pediatric psychiatric patient admitted to inpatient services dropped from 40% to 30% with the most dramatic drop seen after the April intervention began. The intervention ended in June and the inpatient ED admits went back up to 35% in June. The increase may be relate to the end of the intervention, as well as other factors such as more open hospital beds in June that affect triage strategies.
- Beginning October 2007 a ***6 bed Harford "Cares Unit***" will open for short (1.8-3 days stays) for ED patients to be evaluated for appropriate disposition to behavioral services in the community or institution.

CTBHP/VO is working on desktop provider profiling that will provide information to understand provider practices and collaboratively identify practices appropriate to that provider that would, for example, reduce hospital discharge delays. Can look at variability in case mix per provider, relations with DCF Area Offices, available stabilization services at the community level and future geo access of community services and gaps in service availability. Comments:

- The SC suggested a break-out of out-of-state facilities and Riverview profiles.
- What is lacking is knowledge of long term community diversion service capacity, increased use of such available services while expanding services in local areas that have service gaps.

Next meeting topics:
Robert Franks, Co-Chair, outlined topics for the September 21 meeting:

- Look at available pre-ED diversion strategies such as the role of schools in pediatric psychiatric issues and EMPS services. Important to look at school's collaboration with programs such as EMPS and Enhanced Care Clinics in the context of school policies for "zero tolerance".
- Data:
  Hospital data:
  - Look at length of stay by age/DCF, non-DCF involvement by child's area of residence and hospital geographic area.
  - Hospital discharge delays: identify patient demographics, developmental/other co-morbidities, disruptive out-of-home placement.

ED data: look at where the child was prior to the ED visit (i.e. home, school, group home, etc). This is available from CCMC and Yale ED data. It was suggested this demographic be included in future ED data by area.

Intermediate level of care: Q2 07, LOS for PHP, IOP, EDT, profile modeling, outlier characteristics.

- Analysis of regional trends for EMPS services.
- DCF update on daily review of DCF-involved children's hospital discharge delays.