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: November 16, 2007

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

Next Meeting: Friday December 14, 2007 @ 1 PM at CTBHP/VO

CTBHP/VO Utilization Data: Laurie Van Der Heide *(Click on icon below to view presentation)*

Quality & Access 11_07.ppt

Discussion:

Inpatient data

- ✓ Data presented (*see attachment above*) had separation of RiverView Hospital (RVH) and private psychiatric hospital utilization for calendar year quarters (i.e. 1Q07 = Jan-Mar, 2Q07 = Apr-June, 3Q07=July-Sept). SC discussion highlights of presentation:
  - o In **3Q07** (a low inpatient service demand time period) both general hospitals and RVH had reductions in admissions; however average length of stay (ALOS) increased for both. General hospitals average about 1000 admissions/year and may discharge children more slowly during the period when there is less demand for beds and less pressure for discharge; benefits to the child/family as well as maintaining hospital census levels and financial stability.
  - o The **3Q07** represents the most accurate data measuring DCF RVH acute vs. discharge delay days. CTBHP/VO began RVH management July 2007. Prior quarters did not capture the full LOS (prior authorization date vs. actual admission date that was used for 3Q07); RVH **3Q07** ALOS was about 6 months.
  - o DCF private psychiatric hospital stays were longer than for non-DCF children. At RVH both DCF children and non-DCF children had longer ALOS compared to private hospitals. RiverView was described as an "intermediate" acute hospital in that the severity of patients' illnesses requires longer hospitalizations.
  - o Page 7 of slide presentation - Non-DCF *delay* ALOS doubled from 2Q07 to 3Q07. This may be caused by child/youth waiting for DCF voluntary services status determination and then post-discharge treatment (i.e. RTC). CTBHP/VO will be doing an audit to determine the reasons for the increased delays.

Subcommittee comments/recommendations:

Emergency Department (ED) Utilization

- ✓ The number of members in the ED delay tracking status per month (pg 8) shows a higher number in 3Q07 compared to 3Q06.

- ✓ Average LOS in ED (all) dropped from 3 days to 1.5- 1 day in June & July. This was thought to be related to available pediatric psychiatric inpatient hospital capacity in the summer. However the ALOS jumped back to 2.5 days in August & Sept.
- ✓ Diversion rates to *community services* for children delayed in all EDs peaked at 47% in 2Q07, dropping to 37% in 3Q07. CTBHP/VO had an active presence at CCMC in the 2nd Q 2007. CCMC percentage of ED pediatric psychiatric patients admitted inpatient climbed after June when CTBHP/VO was not as intensively involved with CCMC to about 50% in July while outpatient disposition flatted out to 30% beginning in July. The impact of the CCMC/IOL CARES unit, opened mid October, may be seen in the 4Q07.

- ✓ Subcommittee recommended:
  - Apply the same scale for data report graphs where possible.
  - **C*ontinue to separate*** RVH utilization data from general/private hospital data in reports going forward given the significant differences in ALOS and delays.
  - Systematically identify utilization by ***race and ethnicity*** and ***subpopulations:***
    - Identify discharge delays by ***age.*** Youth ages 17 years and over transitioning to Cedar Crest under DMHAS experience hospital discharge delays because Cedar Crest beds are often full. Dr. Schaefer stated that institutional capacity problems for non-HUSKY adults are being evaluated by Commissioner Vogel (OHCA) and the Secretary of OPM.
    - ***Developmentally Disabled (DD) population***: about 25% of RVH admissions have developmental needs in addition to behavioral health conditions. RVH had a special unit for these patients; however this unit was closed because the need decreased. These patients are now admitted to appropriate RVH units.
    - ***Juvenile Justice/DCF*** client BH service utilization.
  - Request data on all CCMC pediatric psychiatric ED patients: identify the number of children referred to the CARES unit and of these, the number admitted inpatient.
  - CTBHP/VO determine (perhaps by sampling) the hospital Region 5 pediatric psychiatric children are admitted. (*CTBHP/VO will be evaluating Region 5 services in the LADP and DCF regional offices in Region 5 are also collecting data on service needs in Region 5).*
  - Of children discharged from EDs to community level services, identify service utilization patterns prior to and after ED discharge including repeat ED visits or re-hospitalizations.

<u>*Concurrent Reviews (CCRs)*</u>

Mark Schaeffer described the time goals for OP registrations (15-20 minutes) and CCRs (10 minutes) versus 45' and 30' respectively as the actual average time. The Mercer audit identified 'inadequate documentation' on questions for medical necessity, adequacy of discharge plan, family involvement and client strength based assessments. CTBHP/VO staff work diligently to significantly improve the audit recommended areas, which will be reflected in the January Mercer audit. The unintended consequence of audit compliance was increased CCR time and lower staff moral.

Subcommittee comments:

- ✓ Time inefficiencies related to CCR narrative entry and level of provider preparedness takes away from direct patient care time.
- ✓ SC requested a ***copy of the full forms***, including the drop downs, ***for review prior to the next meeting.*** CTBHP/VO is moving away from micromanagement of the program after the initial implementation year. The Chair requests more discussion on essential data elements required for the various levels of care. Family/consumer input is essential to the review.
- ✓ ***Dr. Gammon requested Mercer participate by phone at the Dec. 14th meeting*** to discuss the audit results and basis of required elements/documentation for the CCRs.

IICAPS Performance Report Indicators

Jeffery Walter, Co-Chair of the BHP OC, requested this Subcommittee make recommendations for the performance measurement of IICAPS programs. Recommendations will also come from the DCF Advisory Subcommittee.

Kristin Holdt, IICAPS services, discussed some of the measures collected on IICAPS families that include pre and post measures such as the Ohio scales, service utilization 6 months prior to and during participation in the program, the ALOS in the program (about 6 months), disposition of patient post IICAPS. The program is working with the BHP agencies to obtain behavioral health service data after IICAPS discharge. Subcommittee comments:

- Beresford Wilson asked if underlying problems are captured (i.e. abuse) and addressed in the program. Ms. Holdt stated the program focuses on identified problems and attempts to alleviate them by treatment completion.
- Recommend data on service "wait times" (defined as time from referral to IICAPS to treatment) by region and race/ethnicity.
- Dr. Gammon asked that an outline of the items collected by IICAPS and others recommended by DCF SC be sent to this Subcommittee.

Addendum: email from Dr. Gammon to Kristin Holdt & emailed to SC members:
As I recall the discussion, the Subcommittee hoped that several areas might be addressed. Of particular importance to the SC seemed to be:

A. Service Access: referrals by pertinent demographics (i.e. race/ethnicity, age, location/region, etc) and other factors impacting access such as delay/waitlist and referral origin.

B. Clinical Description: diagnosis, stressors, GAF, classification under IDEA, if available, and any other pertinents that would help characterize the populations at this level that the OHIO or your other instruments might provide

C. Outcome: the change measures from the OHIO and other pertinents

Dr. Larcen's seemed to be asking for discharge data that would shed light into a critical area...treatment plan completion. If other data shedding light on this and other process-related issues were available, it might be useful to consider its presentation,

Other

Dr. Gammon stated he met with Speaker Amann and Senator Gayle Slossberg to discuss the challenges the education system encounters in dealing with behavioral health problems in the schools. The legislators are interested in creating a work group of educators and Council members to address these important issues.

CTBHP Performance Measurement Project discussion was deferred to the Dec. meeting. Dr. Schaefer provided the CTBHP web link for the Program performance indicators.

http://www.ctbhp.com/provider/performance.htm