



## Behavioral Health Partnership Oversight Council

### Quality Management & Access Subcommittee

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[www.cga.ct.gov/ph/BHPOC](http://www.cga.ct.gov/ph/BHPOC)

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### Meeting Summary: Jan. 18, 2008

Chair: Dr. Davis Gammon Co-Chair: Robert Franks

*Next meetings: Friday Feb. 15 and March 14<sup>th</sup>, 2008*

**EMPS Re-Design: DCF** (Click on icon below to view presentation – full report at [www.chdi.org](http://www.chdi.org))

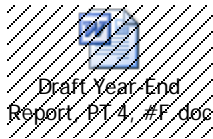


EMPS for ASO-Q&A  
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Discussion related to above presentation by Dr. Bert Plant (DCF) included the following points:

- Potential of \$11M for EMPS system improvement pending OPM's decision.
- As part of supporting short diversionary and short term intervention roles of EMPS, the program needs to better define linkage of services and ensure more timely linkage to services.
- There is a need to increase the availability and utilization of DCF "Crisis stabilization units". Currently there are two sites in Hamden and Wheeler clinic with a total of 16 beds. The CCMC/IOL CARES unit is not classified as a crisis stabilization unit.
- DCF is considering expanding EMPS *mobile* services from 7 PM to 10 PM and supplementing coverage with on-call staff for off-hours.
- Several states have moved away from using 1-800 numbers, choosing to simplify how residents can contact EMPS in an emergency by using a statewide call center such as CT's 211 numbers. A state wide call center versus provider based center is controversial in that:
  - Some providers are unhappy in what is viewed as a step outside their relationship with the community by adding in another step (211) for people to contact EMPS.
  - Family perspective on recommendations: having a consistently applied definition of a 'crisis' and an easily remembered crisis number such as 211.
- A report recommendation was made that para-professionals could assist in helping families make timely connections to care. Currently it may take more than 6 weeks to connect an EMPS client to services outside EMPS. A primary cause of service connection delay is delayed access to psychiatry (M.D. & APRN) for medication evaluation/ prescribing. (*This type of service has been identified as inadequately available in broader discussions related to the BHP program as well.*)
- DCF expects to complete the EMPS re-procurement by the end of SFY 08 and anticipates phasing in the revised EMPS program.

**CTBHP/VO: Foster Care Disruption Report** (*Click on icon below to view summary of report*)



- Of the 1000 children removed from their home July – Dec. 2006, 70% went to foster care, 30% to relative care.
- Between 25% and 47% of youth placed in foster care experienced a care disruption between their first placement and May 1, 2007. For youth in relative care/special study, the rate of disruption was from 9% to 12%, depending on the definition of disruption.
- There are multiple definitions of “disruptions”: this study used both the federal definition of any movement vs. planned or unplanned movement.
- Study found that youth who had authorized BH services 6 months *before* foster placement were more apt to experience placement disruption than those without BH services prior to placement. Those that received BH services after foster placement also had higher disruption placements. Youth placed with relative caregivers were less likely to receive BH services after the placement.
- Foster family focus groups identified specific needs that involve ‘coaching’ to manage the child’s behaviors. Focusing on foster family actual needs may help in foster family recruitment and reduce the loss of foster family participation.
- CTBHP/VO will complete their work on this study, identify those at high risk for placement disruption and propose a working model to BHP as CY 2008 target performance.

Next meeting, Friday Feb. 15 at 1 PM at CTBHP/VO will include LOS and discharge trends as agenda items.

The March SC meeting was moved to **March 14<sup>th</sup>** since March 21 is a state holiday.