# Behavioral Health Partnership Oversight Council

## Quality Management, Access & Safety Subcommittee

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***Chair: Dr. Davis Gammon***
***Co-Chairs: Robert Franks & Melody Nelson***

**Meeting Summary: May 15, 2009**
*Submitted by Agnes Halarewicz,Dir. QA, ValueOptions*
***Next meeting: Friday June 19, 2009 At 1 PM at CTBHP/VO, Rocky Hill***

**1. Welcome and introductions**

*Attendees: Dr. Mark Schaefer (DSS), Dr. Karen Andersson (DCF), Dr. Lois Berkowitz (DCF), Dr. Davis Gammon, Laurie Szczygiel (CT BHP/VO), Dr. Laurie Van Der Heide (CT BHP/VO); Ann Phelan (CT BHP/VO), Dr. Steven Kant,( CT BHP/VO), Agnes Halarewicz, (CT BHP/VO); David Klein, Susan O'Connell, Dr.Bob Franks (CHDI) Beth Klinc (YNHH).*

**2. Review of the newly created CT BHP presentation calendar.**
There were no requested changes or additions.

2009 Agenda.xls

**3. Review and discussion of CT BHP Presentation on High Utilizers**.

CT BHP High Utilizers.ppt

The goal of this Performance Target was to increase the time in community of the sub population of CT BHP members identified as High Utilizers. High Utilizers (HU) are defined as members, aged 0 up to and including 18 years old, with 4 or more inpatient admissions within a six-month period. The Performance Target could be achieved by either decreasing the number of members identified as High Utilizers or by decreasing the average time each of the High Utilizers spent in inpatient during the reporting year (2008).

Key to the CT BHP intervention to increase time in the community is the assignment of an Intensive Care Manager (ICM) to every HU identified member in order to assist with all aspects of continuity of care. (see slideshow).

Highlighted points:

Outcomes

- ✓ Number of HU increased to 55 in 2008 from baseline of 44 in 2007. The average number of inpatient days utilized by each High Utilizer also increased. These outcomes are not in sync with other utilization outcomes which show a **decrease** in:
  - DCF children admitted
  - ALOS across the system
  - Discharge Delay days

- ✓ ICMs positively impacted system through-put, but did not appear to directly impact the rate of admission.
- ✓ Overall, the HUs represent a disproportionate amount of admits and days for their cohort size- 3.2% of inpatient users, including a disproportionate number of adolescents – 80% compared to 60% in general user population. Additionally the majority of the HUs came from the community not from congregate care. The HU cohort during 2008 did turnover with only 8 members identified as HUs during 2007 continuing to remain as HUs in 2008.

Literature review suggests that

- ➢ Multiple inpatient admissions are not always a reflection of failure
- ➢ More challenging children are now being treated in communities, often leading to increased use of inpatient settings
- ➢ Best 'cure' for HU may be the use of residential services.

Questions & Discussion:

- ➢ The Committee discussed whether the number and average time in the hospital of High Utilizers serves as an appropriate proxy for effectiveness of the ICM program, particularly in light of the extraordinary success of that team with decreasing Discharge Delays. Given the goal of improving access and treating children within the community, and understanding the fact that the phenomena of HUs is not likely to ever disappear, what is the "acceptable" number of HUs, i.e. how many would be considered "too many"?
- ➢ What is the ICM value added to the system of care? What are alternative outcome measures for ICM effectiveness (discharge delay, through put)?
- ➢ Discussion ensued regarding the need to improve access to "bridge" services between inpatient and other levels of care and return home. Fewer than expected HU members had IICAPS in place at discharge. However, it is possible that DCF's Special Funds were utilized to cover home based services, in which case those services would not be reflected in CT BHP database.
- ➢ Per CT BHP, the reviewed HU cohort represents a very small number of members with significant clinical challenges. Next steps include not having them serve as proxy for

effectiveness of ICM Team but as population to examine more closely. Further follow up of the cohort, particularly in terms of what happened to them after they are no longer identified as HUs and focus on characteristics of individual cases, may help to identify additional significant variables. The data collected is valuable and should be utilized further.

- The ultimate goal of community placement at all cost should be re-evaluated as some members could have potentially been placed in residential facilities earlier, without multiple hospitalizations.
- Dr. Schaefer provided a background of how this Performance Target was developed.

Follow up:

- CT BHP will re-group internally as a result of the discussion.
- In the Fall, CT BHP will provide a follow up on the 55 HUs.

**4. Review of CT BHP 2008 Quality Management Program Evaluation**

CT BHP 2008 QM Program Evaluation.d

- Review of key accomplishments (*inserted from 2008 QM Program Evaluation*).
  - Increased the reporting of Quality of Care issues by CT BHP staff by more than 500% necessitating weekly meetings of the Quality of Care Committee and a revised protocol for the investigation and handling of the issues identified.
  - Improved the coordination and communication of trend information that results from the CT BHP identified Quality of Care issues with the DCF Quality Management Department.
  - Revised the administration of the Member Satisfaction Survey to improve its validity so that members are surveyed within a month of receiving services
  - Met all Member and Provider Telephone Access standards
  - Finalized a retrospective data analysis comparing the behavioral health utilization patterns of children and adolescents who disrupt out of foster care placement with those who do not disrupt
  - Implemented a quality improvement activity with two DCF Area Offices to identify children newly placed in foster care with a history of behavioral health issues to improve the timeliness of services and potentially decrease disruption
  - Completed a literature review regarding the characteristics of foster parents that may be related to disruption patterns
  - Implemented a quality improvement activity that addresses improved identification of members with post partum depression and connection to behavioral health services when necessary
  - Implemented the Provider Analysis and Reporting programs for child and adolescent inpatient, PRTF, and ECCs

- Implemented two Pay for Performance initiatives including one for child and adolescent inpatient and one for PRTFs

- Adult inpatient ALOS increased by 1 day; CT BHP will be outreaching to hospitals to identify possible causes for the increase.
- Discussion focused on best ways to take advantage of the large amount of data collected by CT BHP, including possible further analysis and potential exploratory studies that could be conducted before it becomes outdated. CT BHP is open to the possibility of sharing its reports with a larger audience. Further discussion/ additional meetings regarding this issue are necessary to decide how to appropriately target the audience, such as academic sites and foundations, and to identify current reports that could be made more interactive without having to be re-done in multiple ways.

- Discussion regarding reports produced by CT BHP: the committee is interested in reviewing a set of Quarterly reports (agreed upon Q4'08/Annual and Q1'09 reports).

**Next Meeting Agenda items:**

1. Review and discuss CT BHP reports.