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: ***Oct. 16, 2009***
Next meeting: Friday Nov. 20, 2009 @ 1 PM at VO, Rocky Hill

CTBHP/VO report on Residential Treatment Centers (RTC): 24 month utilization


VO RTC EXECUTIVE SUMMARY 09.doc


BHPOC Presentation 10-14-09 Final.ppt

The RTC utilization analysis report is part of CTBHP/ValueOptions's Performance Target 10 – a DCF RTC 'rightsizing initiative' based on analysis of RTC utilization data and summary recommendations that would assist DCF in developing a specific plan to resize RTC in Ct. Key presentation/discussion points included the following (*Click on 1st icon for report summary, 2nd icon for the analysis data.)*

- Since Dec. 2007 there has been a 40% decrease in the number of beds used by DCF in CT. Noted that the number of DCF licensed RTC beds is greater than those available to DCF. The reduction is attributed to program closures and increased use of community level services such as IICAPS, intensive home-based services.
- *Slides 6-13* show demographic and diagnostic detail of populations in RTCs. As youth in RTC settings start to dip in 2Q08, the average capacity rises during the same time period.
- *Slides 16 – 18* provide utilization for youth 0-12 years. Younger children's average length of stay (ALOS) is 29% longer than the 13-18 age group (this is supported by literature).
- Complex psychiatric youth with serious behavioral symptoms have extensive LOS. The LOS varies by facility related to RTC program and case mix of youth.
- *Slides 19-23* show in-state vs. out-of state RTC trends.
    - In-state admissions have decreased while OOS admits remain fairly constant, suggesting a need to look at in-state treatment capacity for some of the current OOS residential clients.
    - There has been a 7% decrease in OOS ALOS from CY 08 – year to date 09 compared to 12% reduction for in-state ALOS.
    - Discharge delay days per youth are 200 days. (*See slides 31-35 for ALOS by gender,*

diagnosis.). Mr. Walter observed that patients in RTC, PRTFs and Riverview hospital seem to be waiting for similar type of discharge placements (i.e. DCF group homes or RTC) which contribute to 'gridlock' in the behavioral health continuum of services.

- Initial outcomes following in-state RTC discharge (*see slides 36-43)* showed that of the 94 youth who had no record of CTBHP authorization following in-state RTC discharge in CY08 59 (63%) had 'unfavorable outcomes' that included no participation in referred treatment (AMA), placed in correctional facility, detention/CJTS, had no discharge plan on record. Discussion and suggestions of how to improve outcomes for these youth included:
    - Earlier connection with family/youth during RTC stay,
    - Work with DCF youth advisory board and family advocacy group to identify concrete steps to achieve goal of family engagement.
    - Improvement for OOS youth is challenging because of distance from their community, lack of family unit, severity of psychiatric diagnosis.
    - Bring the State Dept of Education and DCF together in a discussion of how to facilitate thoughtful planning of a youth's re-entry into the education system when they return to their community.
    - Ensure planned transition/established treatment goals with communication between RTC and community provider, encourage reimbursed appointments with community provider prior to RTC discharge.

PRTF Profiles: CTBHP/VO

There was time for a brief review of Psychiatric Residential Treatment Facility (PRTF) profile that used 'facility C" compared to ALL PRTF providers (59 beds), on admissions, ALOS, use of inpatient facility admits (these inpatient days are counted in the total PRTF days and next authorized level of care 7 – 30 days after PRTF discharge for facility c compared to all PRTFs. About 41% of dicharges had no PA for services within 7 days of discharge; however this dropped to 12% by 30 days. One reason for the delay within 7 days is that the next level of care provider can submit PA data later than when services actually began. There is concern that ~ 11% of youth in PRTF services had no identifiable next level of care authorization by 30 days post discharge. Home-based services accounted for ~ 40% of the next level of care post discharge and ~ 20% had admits to inpatient care.

November meeting will be devoted to review of the PA registration data and recommendations for revisions.