Behavioral Health Partnership Oversight Council

HUSKY Quality Management, Access & Safety Committee

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Chair: Dr. Davis Gammon
Co-Chair: Robert Franks
Meeting summary: April 15, 2011

Next meeting: Friday May 20, 2011 @ 1 PM at VO, Rocky Hill

Residential Treatment Center (RTC): In- state & Out-of-state (OOS) Utilization

YOUTH IN
RESIDENTIAL TREATI

Today's presentation *(click icon above to view presentation)* includes the data given to the DCF Commissioner to assist her in planning a strategy to bring children back to in state RTCs.

Report is a snap shot of children & youth in RTCs 2-14-2011 that compares characteristics of the in-state and out-of-state (OOS) populations in order to identify resources needed in CT to bring OOS clients back to in-state RTC services.

- *(Slide 2)* 624 children/youth in RTCs - 56% are in (OOS) facilities; this number has been slowly increasing. The State needs to determine how to decrease the number of OOS RTC clients.
- In-state there are 14 RTCs with ~ 360 total bed capacity; these beds are not all filled in- state because of the complex needs of some youth that currently are sent to OOS facilities.
- (Slides 9-11) VO noted that identifying kids by DSM IV diagnostic category is not that helpful in identifying in-state client service needs.

Descriptors: *(slides 3-8)*

- More males are OOS, even when diagnostic tier is considered. Placement in OOS facilities makes it difficult for parents/caregivers to travel to see the child and participate in treatment and discharge treatment planning.
- Age – there is intent in CT not to place young children <12 years of age in RTC care: but 10.6% of this age group is placed in OOS RTCs compared to 5.5% placed in in- state facilities.
- *(Slide 5)* More 13-16 year old children/youth are placed in-state while 17 % more youth in this age group are admitted to OOS facilities.

- *(slide 6)* CT data does not show race/ethnicity differences in placement in-state or OOS facilities. VO noted there is limited national information on disparities in RTCs – just beginning to gather this information.
- *(Slides 7-8)* DCF status of children in RTCs: there are more DCF children in OOS care which maybe related to diagnosis tier rather than DCF status per se.
- Juvenile Justice children/youth: more are in-state RTCs than OOS that suggests that CT has resources to treat most JJ clients in-state (vs. clients with certain diagnoses (i.e. MR/PPD) that tend to be managed OOS).
- DCF Voluntary Services budget reduction can impact commercially insured children's access to RTC as commercial carriers do not provide coverage for any/some RTC services (underinsured children that families apply for voluntary services for such services). The cost for these children's care is passed onto the State.

Diagnostic categories (slides 9-10): The slides examine DSM IV diagnosis vs "diagnostic tier" as predictors of placement in-state vs. OOS. Tier provides better prediction, as noted and identifies groups that are differentially placed out of state.

Comment:

- Since diagnostic information is <u>not</u> that helpful in identifying reasons for increased OOS placement, VO looked at diagnostic tiers & how they are matched to a particular RTC: for some a diagnosis within a tier (i.e. fire starting) will drive placement to OOS.
- OOS placement may be driven to some degree by severity/acuity of youth's behavior: in-state facilities may be more risk adverse in accepting youth with high acuity needs.
- A 2nd admission to an OOS facility may occur by default, when the client has not done well at a suitable in state facility.
- Once a youth reaches age 17, he/she is more likely to be placed to out of state for complex reasons of policy.

Slides 11-12 describe in state RTC BH treatment offered. VO would like to work with RTCs to identify and support their strengths for treating certain types of youth and provide support to RTCs to enhance facility capacity treat a broader range of clients.

VO has been doing UM for in-state RTC for DCF over the past 2 years; it is now working with OOS facilities in a similar manner noting that 15-20 OOS RTCs are longer lengths of stay than may be optimal.

(Slides 13-15) **<u>Permanency plans</u>** (PP):

Data from DCF Link system: In-state facilities are less likely to have PPs than OOS (slide 13). (Caveat: there may be permanency plans in place that VO was not aware). Slide 14 presents a break down by age, but requires cautious interpretation (small cell and incomplete ascertainment of PPs).

(*Slide 16)* shows that child welfare children with 3 or more placement disruptions are more likely to be placed in OOS RTCs.

The DCF Commissioner will use the data to identify the common characteristics of kids in OOS placement to determine how to best bring them home. The impact of child welfare placement disruption on the child/youth's behavioral health status and the family's unmet needs will be looked at more closely as part of the strategies to reduce reliance on RTC placements.

Next Meeting: May, 20th: agenda items include:

- RTC performance incentives
- Identifying and organizing ongoing agenda items for future meetings