Behavioral Health Partnership Oversight Council

Child/Adolescent Quality, Access & Policy Committee

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Co-Chairs: Hal Gibber, Sherry Perlstein & Jeff Vanderploeg

Meeting Summary
Wednesday, May 20, 2015
2:00 – 4:00 p.m.
Value Options
Rocky Hill, CT

Next Meeting: Wednesday, June 17, 2015 @ 2:00 PM at VO, Rocky Hill

Attendees: Sherry Perlstein (Co-Chair), Jeff Vanderploeg (Co-Chair), Karen Andersson (DCF), Dr. Kathleen Balestracci, Sarah Becker, Lois Berkowitz (DCF), Carrie Bourdon, Rick Calvert, Frank Fortunati, Steve Girelli, Susan Kelley, Dan Lyga, Ebony McDaniel-Gladding, Kim Nelson, Dr. Robert Plant (VO), Maureen Reault, and Kathy Schiessl

Review of 2013 Inpatient Data: Bert Plant, Ph.D., ValueOptions

- Discussed findings from study of 2013 inpatient claims data, which were reviewed as part of the 2014 CT Behavioral Health Partnership (CTBHP) performance targets (see attached presentation)
- In 2013, less than 1% of all Medicaid-enrolled youth used inpatient hospitalization services for behavioral health, whereas 20.3% of all Medicaid-enrolled youth used any behavioral health service
- Inpatient hospitalization most common among adolescents (13-17 years old)
- Youth enrolled in DCF Voluntary Services have significantly higher representation among users of inpatient services as compared to their overall representation in the Medicaid population
- The percentage is very low for youth in inpatient settings who are identified as diagnosed with a substance use/abuse condition
    - The group believed these numbers were significantly lower than the true prevalence among the youth population at large, or among those who use inpatient care
    - Questions arose as to whether substance use is being properly assessed and identified
    - The belief among group members is that a strong bifurcation in practice continues to exist between mental health and substance abuse providers,

whereby mental health providers tend to "miss" substance use concerns, and substance use providers tend to "miss" mental health concerns
    - There is a significant gap and opportunity for policy to increase the number of youth who are screened for substance use conditions and referred to appropriate care, and to enhance the degree to which substance use and mental health providers better integrate care
- There were questions raised as to whether youth have the right to keep confidential their alcohol or drug use when disclosed in the context of mental health treatment
- Rates of health conditions among this population also appeared to be much lower than known prevalence rates, suggesting the need to examine dataset limitations in these fields and/or data quality concerns
- Examined claims filed to fill prescriptions for psychotropic medications following an index inpatient visit, along with the class of those psychotropic medications
    - Prompted request to examine how this rate may change compared to filled prescriptions prior to the inpatient visit
    - It was also suggested that the short length of inpatient stays does not provide sufficient time to fully determine the need for multiple medications that youngsters may be taking while in the hospital. This frequently requires psychiatrists in community settings to make significant changes to medications when the child is in a less secure environment.
- Members discussed how many families and other referrers continue to advance the belief that inpatient and residential care are the "gold standards" for treatment, even when potentially more appropriate, more effective, and less costly treatment options are available
    - Highlighted the need for more education to parents and the community
- It was suggested that in-patient and ED hospital providers meet with community providers to identify issues and develop strategies to improve the transition of children into hospital care and back to the community.

Distribution of Re-investment in Community-Based Mental Health Programs and Child Protective Services Programs: Cindy Butterfield and Judith Jordan, DCF

- Reviewed DCF budget line items from State Fiscal Year (SFY) 2011 until SFY2015 (as of January 31, 2015)
    - Budget line items were categorized into the following groups: Community-Based Behavioral Health; Child Protective Services-Administrative; Child Protective Services-Community; Child Protective Services-Out of Home; Juvenile Justice-Community; Juvenile Justice-Out of Home; Congregate Care
- Cumulative changes in funding were reviewed for specific programs and services, for broad categories above, and in total across each SFY
- **Total reductions in congregate care during this timeframe totaled $71,920,649**
- **Total increases in the following spending categories totaled $51,037,487**; **of that amount $13.5 million went to behavioral health services**

- Members and presenters discussed various processes and factors that strongly influence decision-making related to behavioral health expenditures
- A few members raised significant concerns over the increases in the number of youth presenting to Child Guidance Clinics/Outpatient Clinics for Children (OPCCs), the increasing acuity of the youth presenting at this level of care, and the lack of increases in funding for this service category relative to other services. It was noted that there have been no increases in grants to outpatient despite the high increase in utilization. Those dollars that have been invested in outpatient have been specific to the implementation of Evidence Based Treatments, not to expansion of capacity.
- It was noted that recommendations in the report presented by Bert Plant on ECC and Outpatient will continue to be looked at through the Counsel and working groups with a one to two year implementation timeframe.
- Members recommended that the QAP Subcommittee and Oversight Council strongly advocate for increased funding at the outpatient level of care to support provider efforts to more immediately meet the increased demand for services and high acuity level
    - Some members recommended strategic enhancements to CGC/OPCC services that would improve the quality and effectiveness of that level of care. This would include an evaluation of quality and outcomes at the CGC/OPCC level of care.
    - Members noted the recent finding that outpatient care was identified as a protective factor for repeat use of inpatient care among Medicaid-enrolled youth.
    - Members suggested mining existing data and collecting new data to report on caseloads, indicators of clinical acuity, reductions in hospitalizations, functional outcomes (e.g., school functioning), and clinical outcomes.
    - DCF representatives noted a barrier for increasing funds to outpatient/CGC level of care, in that it is very difficult to move funds from a fee for service program into grant funds.
- It was also requested that the OPCC Needs Assessment report commissioned by DCF, or the draft presentation made by Dr. Jane Ungemack, from UCONN, be made available to the Counsel. It was noted that the State Agencies have agreed to integrate her findings with the recommendations made in the VO report presented by Bert Plant.

<u>Quality, Access, and Policy Recommendations</u>

- **Substance Use Treatment**
    - Increase the number of youth who are screened for substance use conditions and referred to appropriate care, and enhance the degree to which substance use and mental health providers integrate care
- **Parent and Community Education**
    - Provide education to parents on appropriate use of residential and inpatient levels of care, the importance of providing services while maintaining youth in their homes and communities, and managing the chronicity of certain behavioral health conditions.

- **Funding for Outpatient Level of care**
    - Develop a strategy for enhancements to outpatient care that draws from recent findings and recommendations, improves the overall quality of outpatient care, and consistently measures service quality, outcomes, and cost savings

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