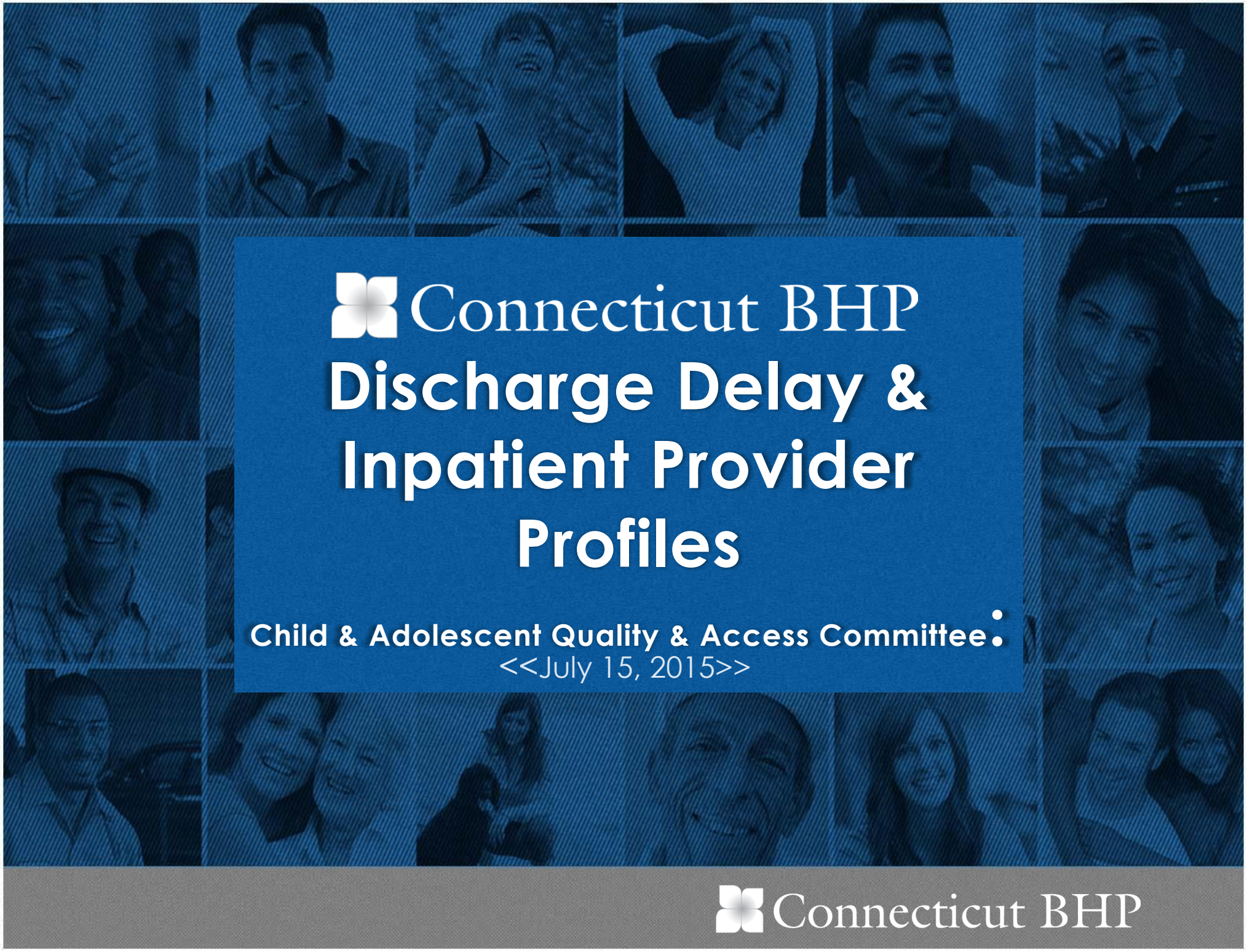


Connecticut BHP

Discharge Delay & Inpatient Provider Profiles

Child & Adolescent Quality & Access Committee:

<<July 15, 2015>>

Connecticut BHP

Acknowledgements

Overview of Contents

- Inpatient Discharge Delay: Authorization Data
- 2013 Behavioral Health (BH) Inpatient Provider Profiles: Claims Data
  - BH Inpatient Admissions from the Emergency Department
  - BH Observation Bed Admissions
  - Connection to Care After Discharge
  - Readmission Rates by Diagnosis
- Next Steps

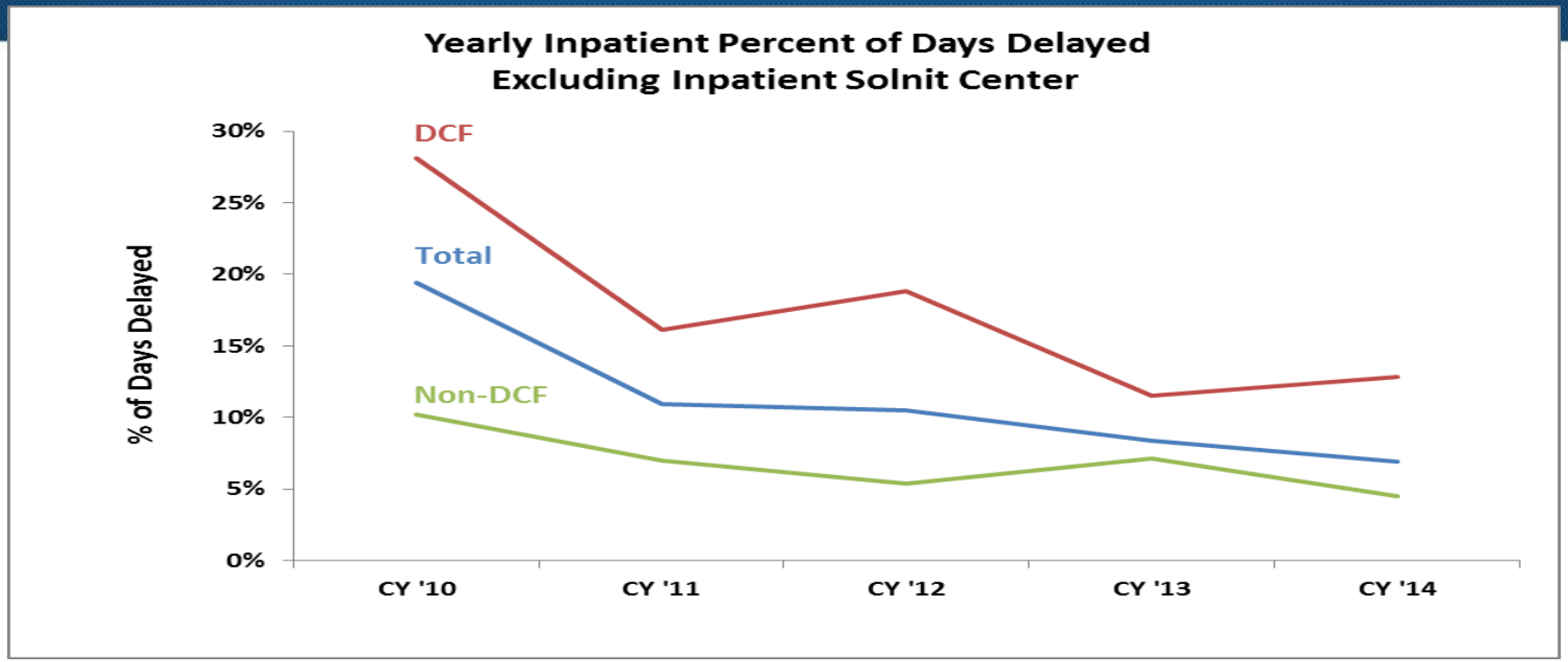
Acute Psychiatric Inpatient: Discharge Delay

- **Discharge Delay Defined:**

Days spent in the hospital awaiting the behavioral health service (level of care) necessary for the youth to be discharged. The youth is ready to leave the hospital as soon as the service is available.

- **Measures:**
- Percent of Inpatient Days Delayed
- Differences in Discharge Delay between DCF-Involved and Non-DCF-Involved Youth
- Level of Care Awaited

Percent of Acute Psychiatric Days Delayed



During 2014, Youth utilized 36,133 Acute Inpatient (IP) days.

- **DCF-Involved youth used 10,095 days (27.9%) of all IP days**
- **Non-DCF-Involved youth used 26,038 days (72.1%)**

A total of 2,476 (6.9%)of the IP days utilized by youth were spent in discharge delay status

- **DCF-Involved youth had 1,285 (12.7%) of their IP days delayed**
- **Non-DCF-Involved youth had 1,191 (4.6%) of their IP days delayed**

% Discharge Delay decreased from 20% to 6.9% from 2010 to 2014

Behavioral Health Services Awaited by Youth in Discharge Delay

CTBH12087: Quarterly Inpatient Average Days in Delay by Reason Code

Excluding Inpatient Solnit Center

		CY '12	CY '13	CY '14
Awaiting State Hospital	Delayed Discharges	37	32	31
	Total Delay Days for Discharges	1,267	744	697
	Average Delay Days for Discharges	34.2	23.3	22.5
Awaiting PRTF	Delayed Discharges	57	72	66
	Total Delay Days for Discharges	1,058	1,441	926
	Average Delay Days for Discharges	18.6	20.0	14.0
Awaiting RTC	Delayed Discharges	32	23	9
	Total Delay Days for Discharges	748	382	202
	Average Delay Days for Discharges	23.4	16.6	22.4

Nearly 75% of discharge delay days were spent awaiting:

- Psychiatric Residential Treatment Facilities (PRTF; youth ≤13 years old)
- Solnit inpatient beds OR
- Residential Treatment (RTC)

INPATIENT PROVIDER PROFILE MEASURES 2013 CLAIMS-BASED

THE BASICS

Medicaid Members
- **Youth ages 3-17**

Includes all youth Medicaid members in volume Information

Excludes youth who are dually eligible for Medicaid and Medicare for measures involving connect to care and readmission rates

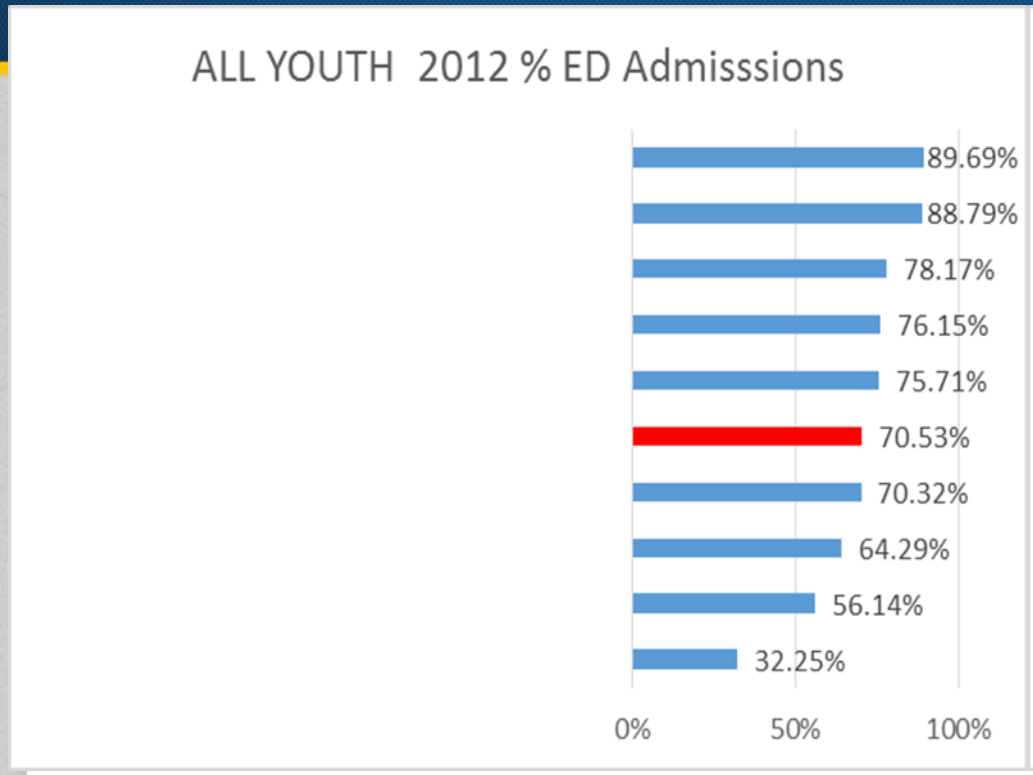
For youth, all measures based on Medicaid claims data from 2012 & 2013

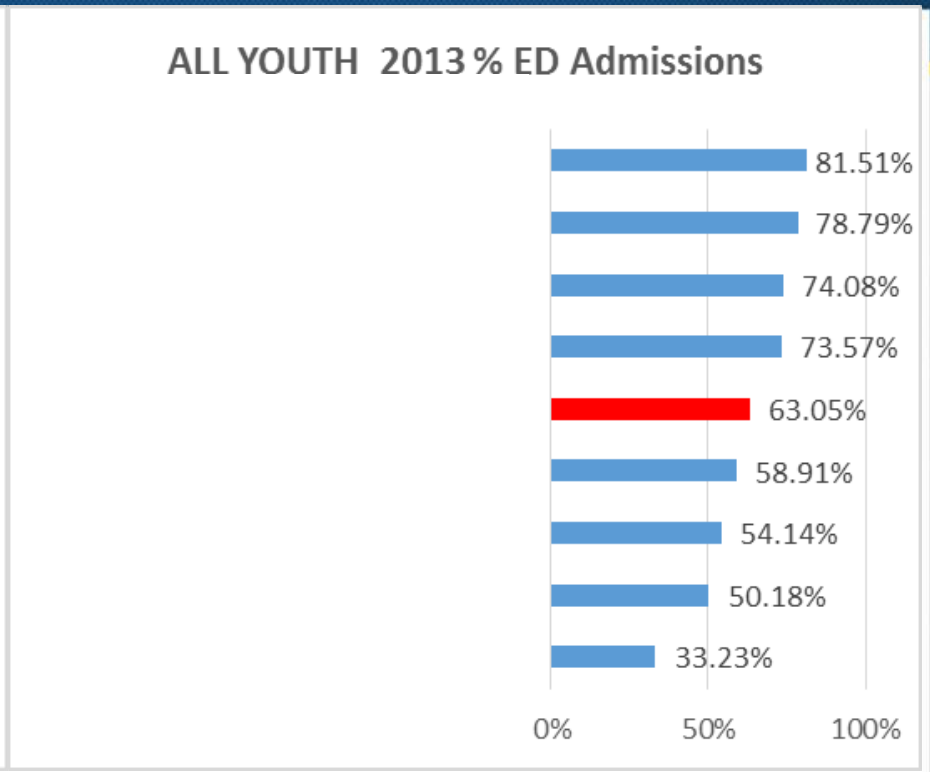
Use of Descriptive Statistics

BH Inpatient Admissions from the Emergency Department

The rate with which youth were admitted to an Inpatient Acute Hospital bed from the ED, as opposed to a Direct Admission or an admission from an Observation Bed

% of Inpatient BH Admissions from the ED



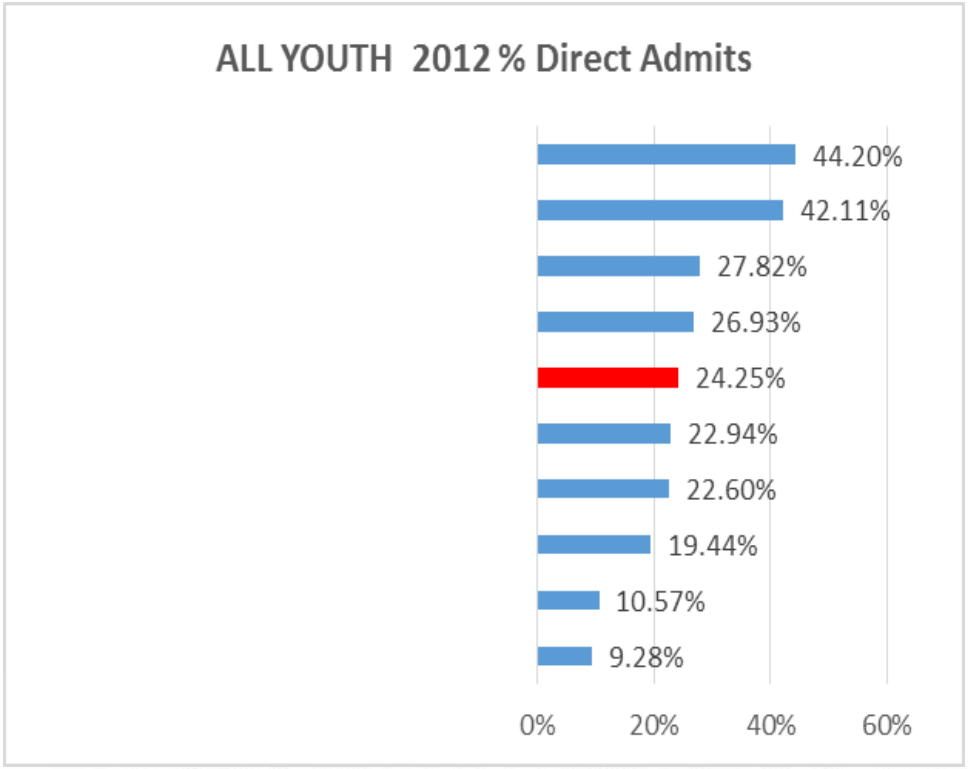


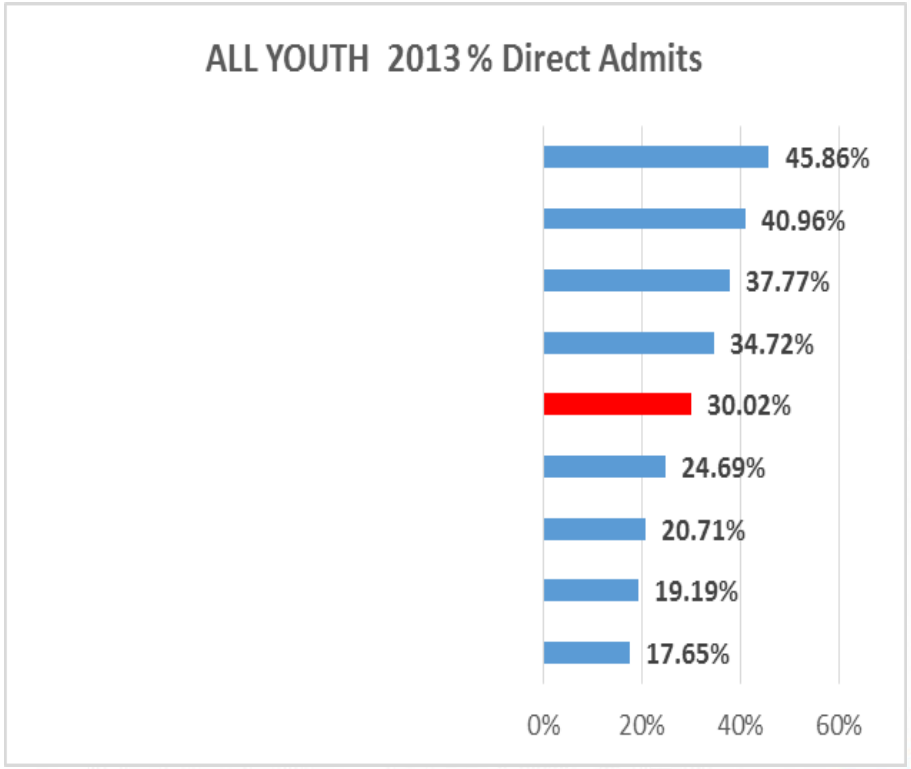
The percentage of inpatient admissions from the ED decreased significantly ($p<0.001$) from 2012 to 2013.

- **Children between 6 and 12 years old were less likely to be admitted from the ED**
- **Adolescents 13 to 17 years old were more likely to be admitted from the ED**

% of Inpatient BH Admissions that are Direct Admissions

- Direct admissions increased significantly from 2012 to 2013 and accounted for nearly all of the admissions to acute psychiatric hospitals not accounted for by admissions from the ED.
- As more BH IP beds are filled via transfer from within the hospital or community system of care, more youth may be delayed in the ED waiting for IP admission
- Admissions to IP from Observation Beds was infrequent though expected to increase as hospitals add BH Observation Beds for youth





Youth Observation Bed Utilization

A claims-based measure of the volume of Observation Bed stays of youth with a behavioral health diagnosis in any position on the claim

- Not including CCMC, the volume of Observation Bed stays for youth in CT hospitals was low, though increasing at some hospitals
- 2013 volume by hospital ranged from 0 to 48 admissions
- From 2012 to 2013, observation bed use nearly doubled; 64 admissions during 2012 and 110 during 2013
- CCMC CARES volume was stable between 2012 and 2013 (~800 admissions)
- Nearly 60% of Youth Observation Bed stays had a primary Medical Diagnosis and a secondary Mental Health Diagnosis

Connection to Care Following Discharge from Inpatient Hospitalization

Goal: Using the HEDIS Ambulatory Follow-up Measure as a template, develop an expanded measure of percent of youth who Connect to Care within 7 and 30 days post discharge from:

- Acute Psychiatric Hospital
- State Psychiatric Hospital

- Include members with MH and SA diagnoses
- Expands services that count as connections to care to include residential rehab services

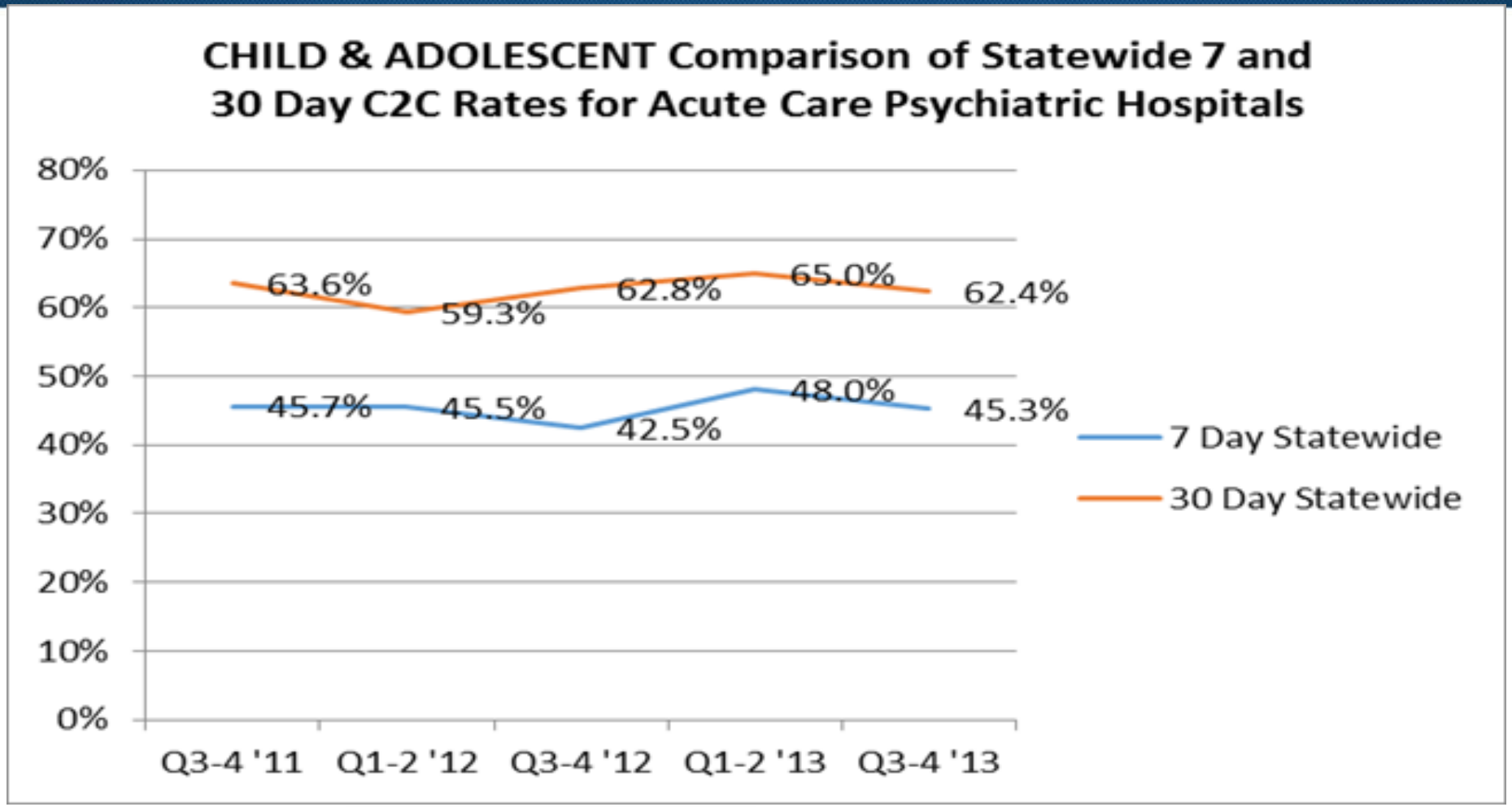
Connection To Care

Importance: Inpatient stabilization is only first step

- Maintain and extend improvement post discharge
- Prevent hospital admission and readmissions
- Transition phase is critical
- Connection to BH services within 7 Days is industry benchmark

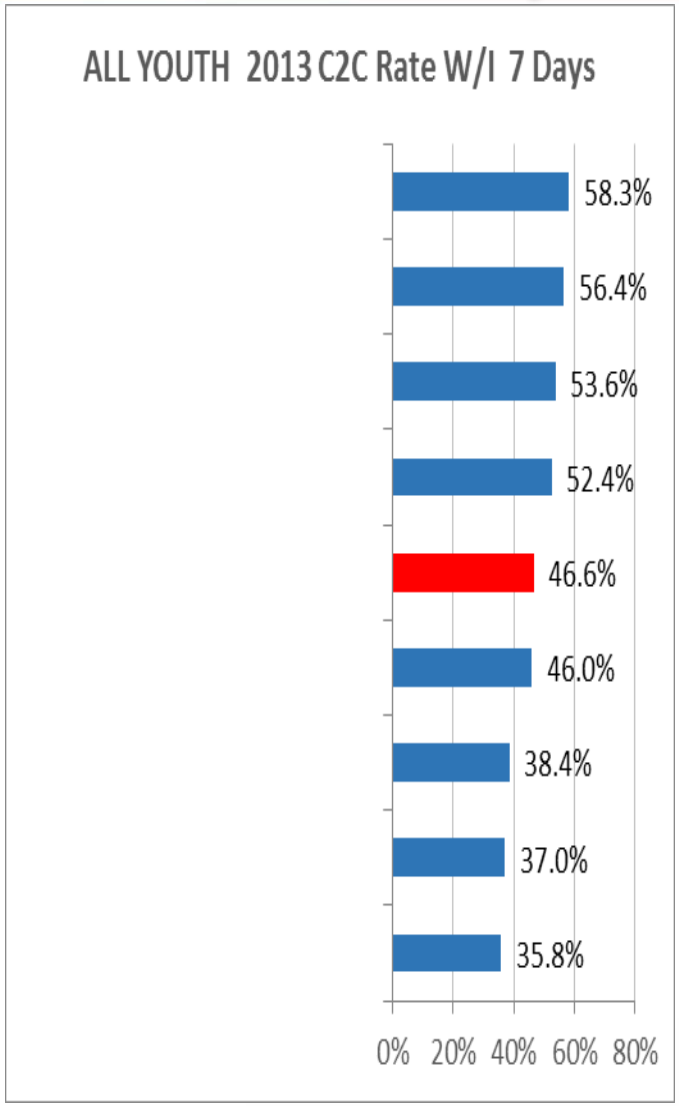
Please Note: Connect to Care (C2C) rates may be higher than reported as services provided by DCF flex funds are not included.

Statewide Youth Acute Psychiatric Hospital C2C Rates



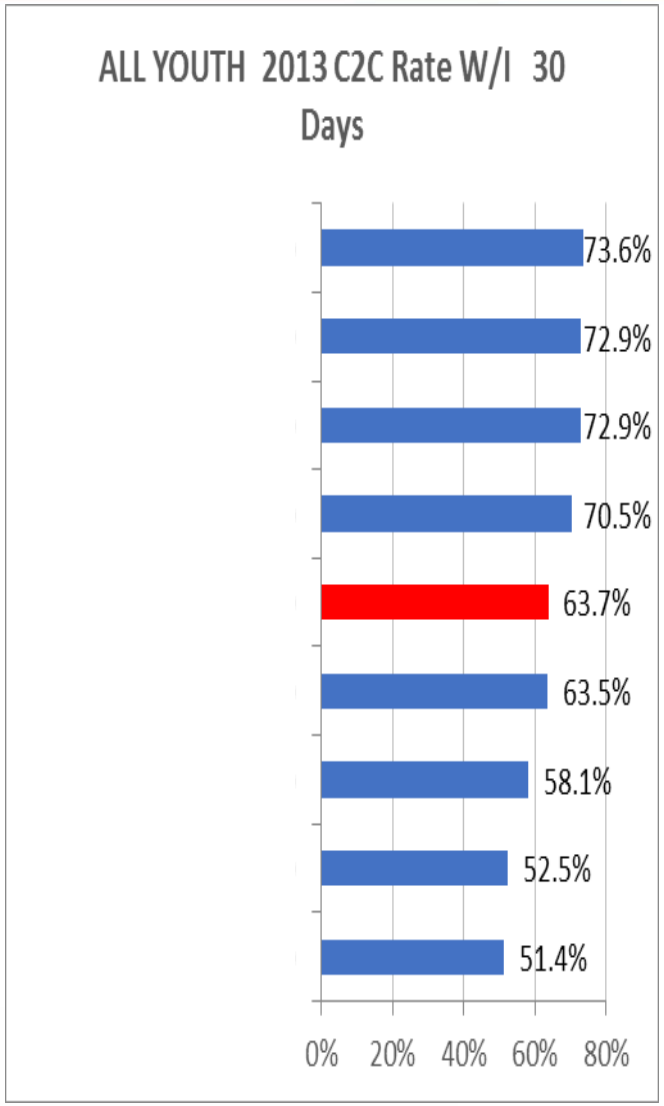
Statewide rates over multiple 6 month increments demonstrate flat performance

Comparison of 2013 7 and 30 Day C2C Rates for Acute Psychiatric Hospitals: All Youth



Statewide Average 7 Day C2C Rates:
2012: 44.1%
2013: 46.6%

Statewide Average 30 Day C2C Rates:
2012: 60.9%
2013: 63.7%



Acute Care Hospitals 7 & 30 DAY C2C RATES 2012 – 2013 ALL YOUTH

Acute Care Hospitals

7 Day C2C Rates:

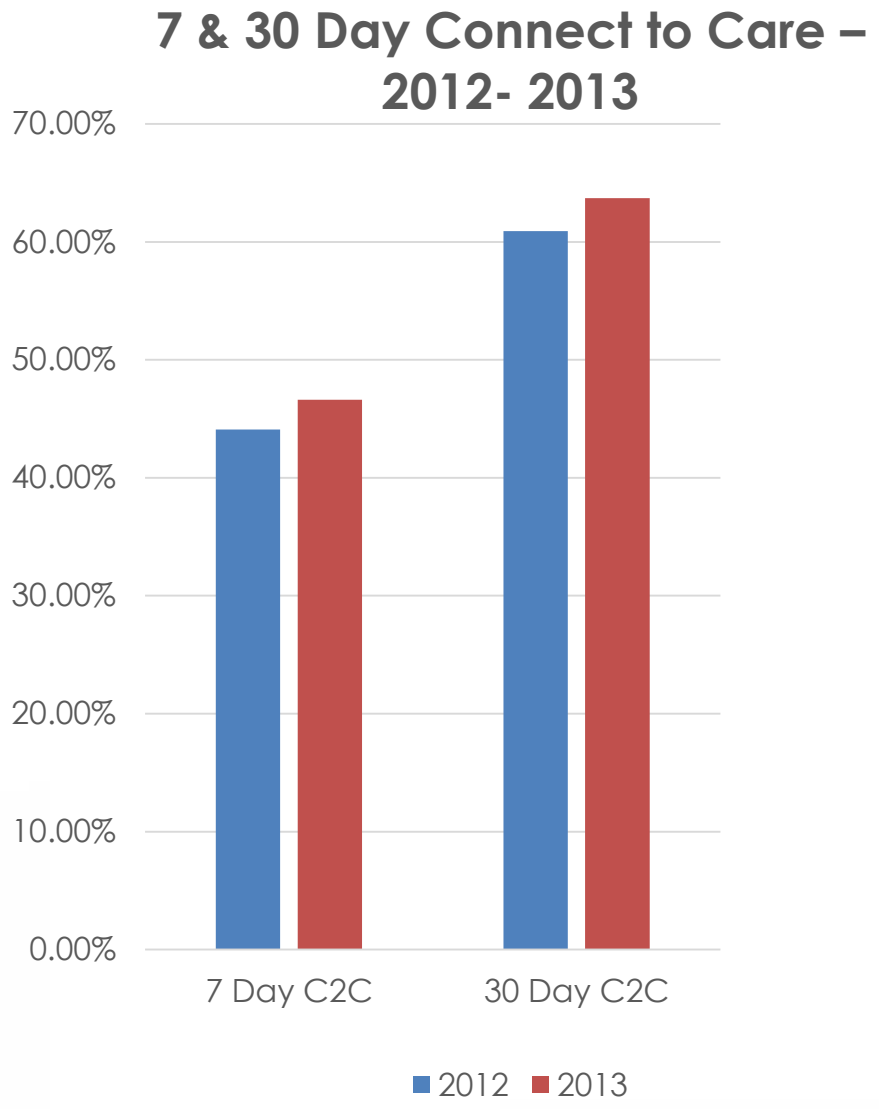
2012: 44.1%

2013: 46.6%

30 Day C2C Rates:

2012: 60.9%

2013: 63.7%



Youth Inpatient Readmission Rates and Diagnoses

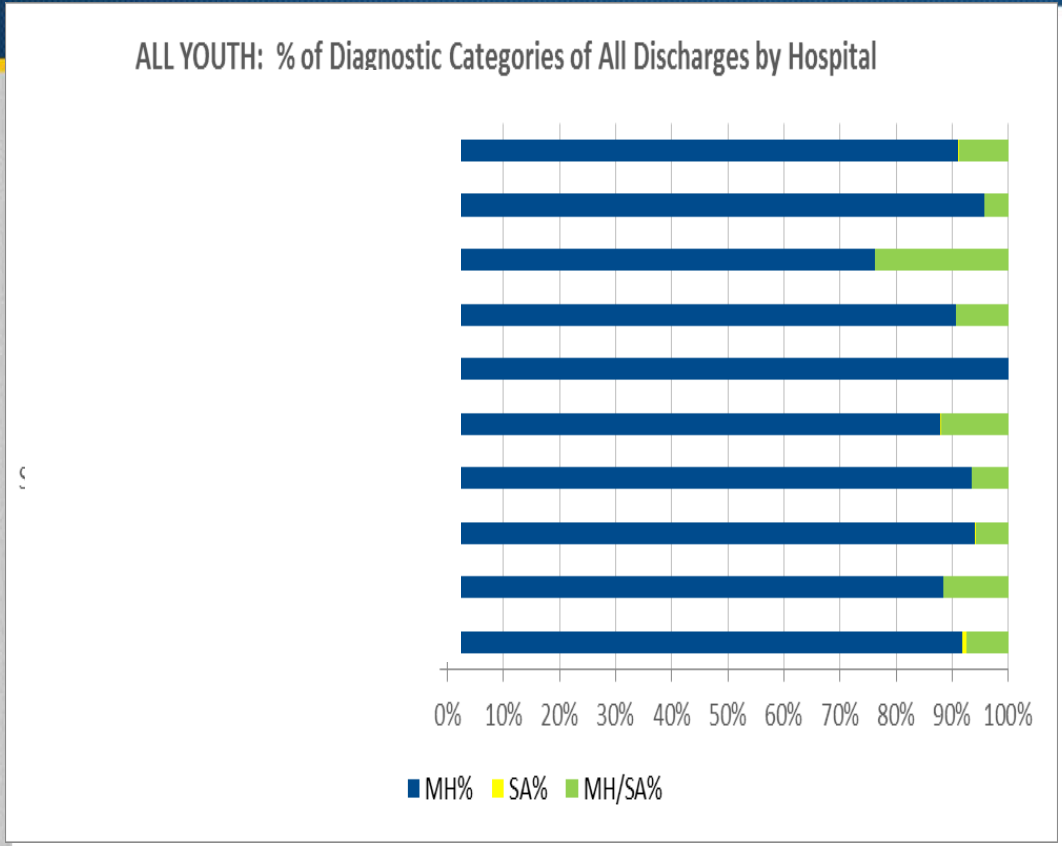
Importance of Readmission Rates:

- Increase costs of healthcare
- Considered Preventable in many instances
- Result in penalties to hospitals with high rates

Diagnostic patterns related to readmission:

- In a recent study (2014), 2 of the top 4 diagnoses related to IP readmission for Medicaid members were Mood Disorders and Schizophrenia (Hines, Barret, Jiang and Steiner, 2014).
- Alcohol and Substance Use Disorders were 5th and 10th respectively

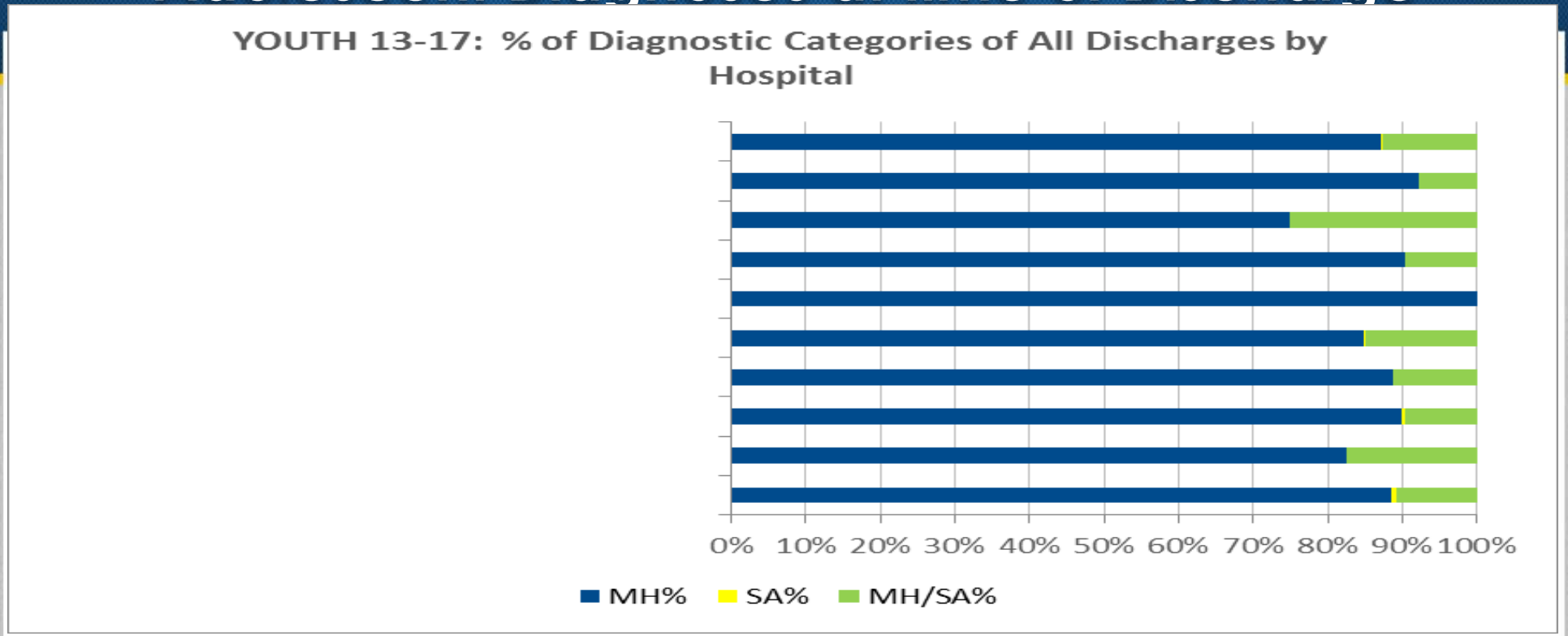
Hospital Diagnostic Patterns: Youth Diagnoses at time of Discharge



Youth discharge diagnoses were categorized as MH Only, SA Only, or MH/SA

- Over 92% of youth IP Discharges had an MH Only Index diagnosis
- 6.8% of youth IP discharges had an MH/SA Index diagnosis
- 0.2% of youth IP Discharges had an SA Only diagnosis
- **Low rates of MH/SA diagnoses raise concern that co-occurring diagnoses are being missed, particularly for the adolescent population**

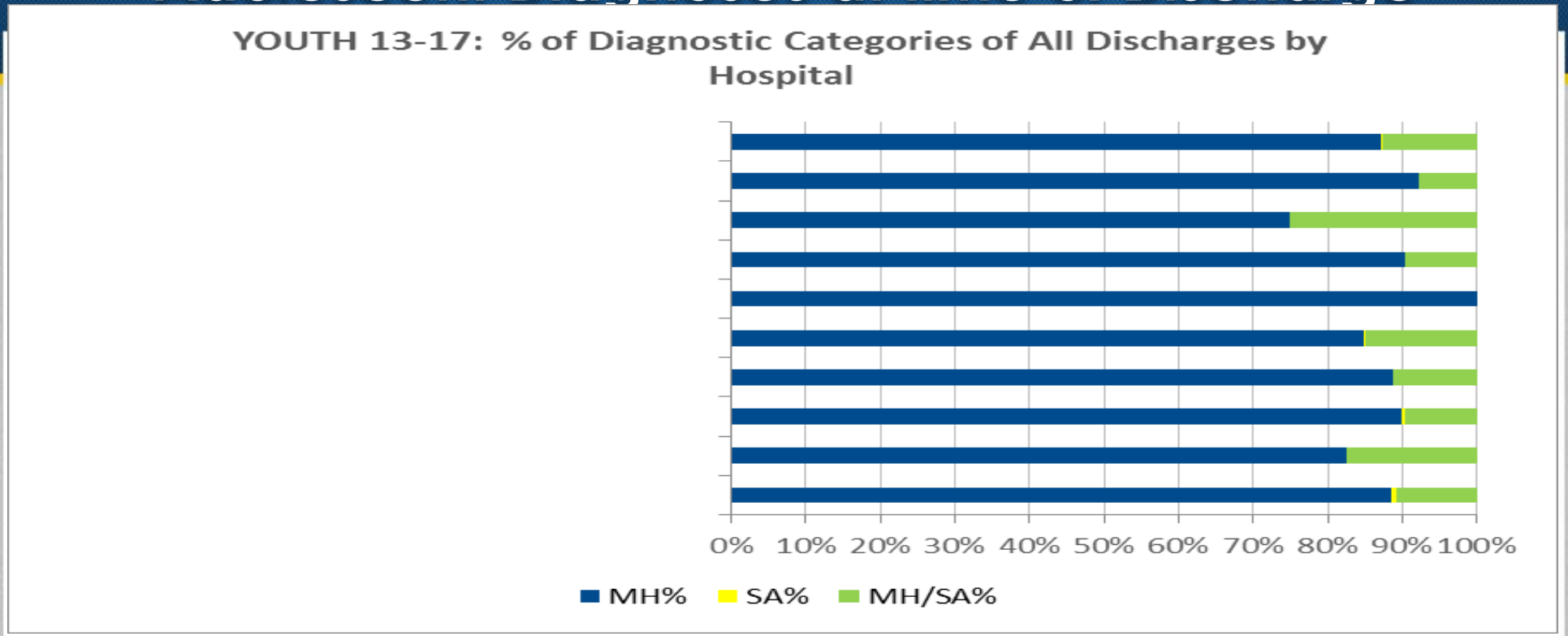
Hospital Diagnostic Patterns: Adolescent Diagnoses at time of Discharge



Among hospitalized adolescents, **statewide** diagnostic patterns were as follows:

- 87.0% were diagnosed with MH Only
- 12.7% were diagnosed with MH/SA
- 0.3% were diagnosed with SA Only

Hospital Diagnostic Patterns: Adolescent Diagnoses at time of Discharge

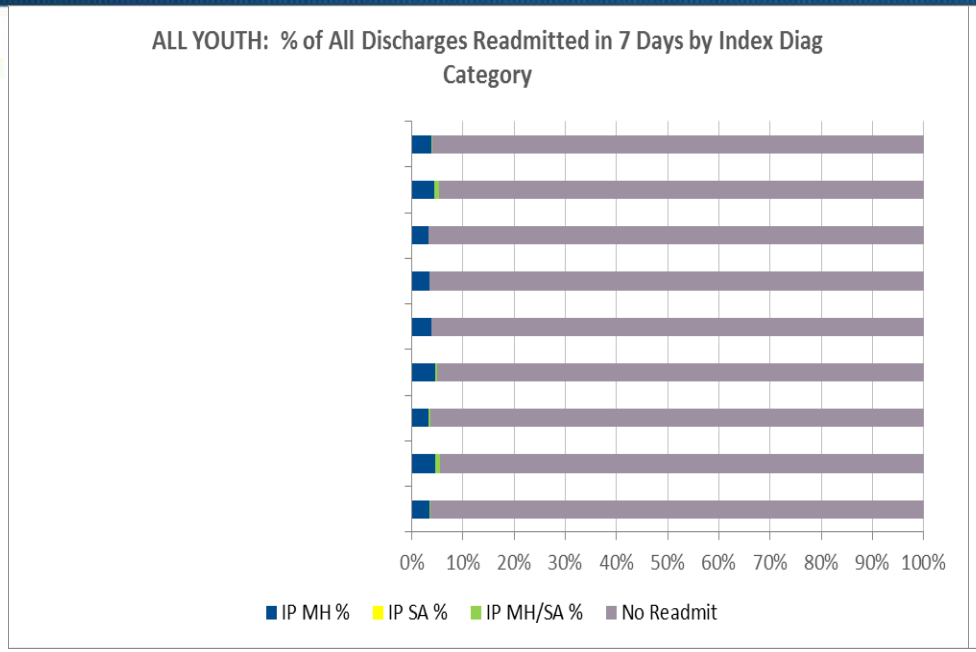


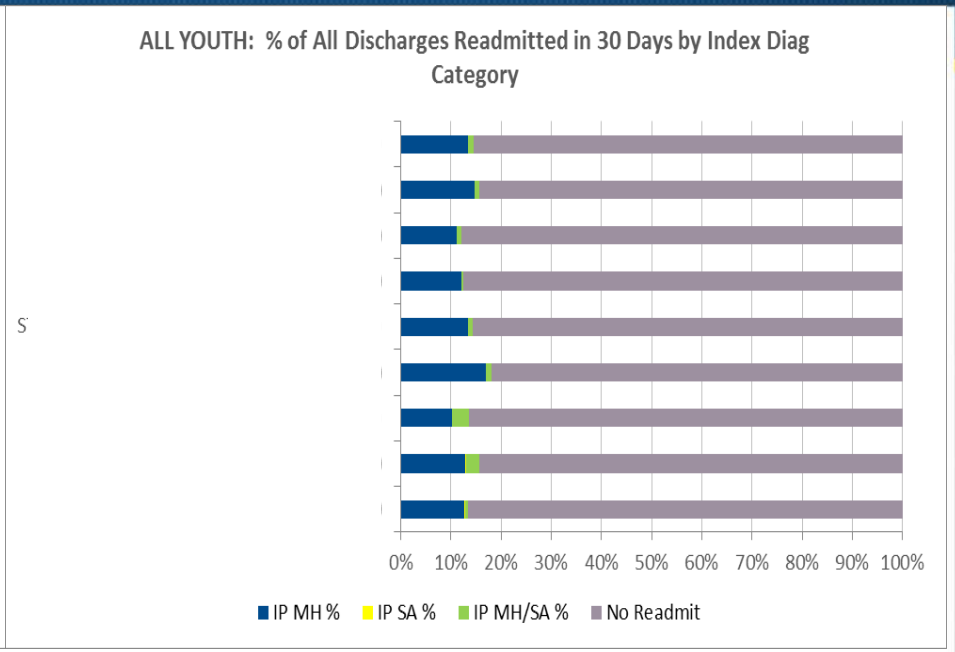
There was **wide variation among the hospitals** with regard to diagnostic patterns for adolescents:

- MH only: 75.0% (N=220) to 100% (N= 183)
- MH/SA: 0% (N= 183) to 25.0% (N= 220)

There appear to be hospital specific patterns of diagnosis

% of Discharges Readmitted within 7 and 30 Days by Index Diagnosis





The **statewide average 7 Day Readmit** rate for all youth discharged was **4.1%**

The statewide 7 Day Readmission rate for youth diagnosed with:

- **MH Only** during the index episode was **4.2%** (178/4,230)
- **SA Only** during index episode was **11.1%** (1/9)
- **MH/SA** during the index episode was **3.2%** (13/410)

The **statewide average 30 Day Readmit** rate for all youth discharged was **14.5%**

The statewide 30 Day Readmission rate for Youth diagnosed with:

- **MH Only** during the index episode was **14.7%** (620/4,230)
- **SA Only** during the index episode was **33.3%** (3/9)
- **MH/SA** during the index episode was **12.0%** (49/410)

Agreement Between Index and Readmission Diagnosis: 30 Days

Of the 620 youth readmitted within 30 Days from the Index MH Cohort:

- 596 (96.1%) had an MH Only diagnosis on readmission
- 24 (3.9%) were re-diagnosed with an MH/SA diagnosis on readmission

Of the 49 youth readmitted within 30 Days from the Index MH/SA Cohort:

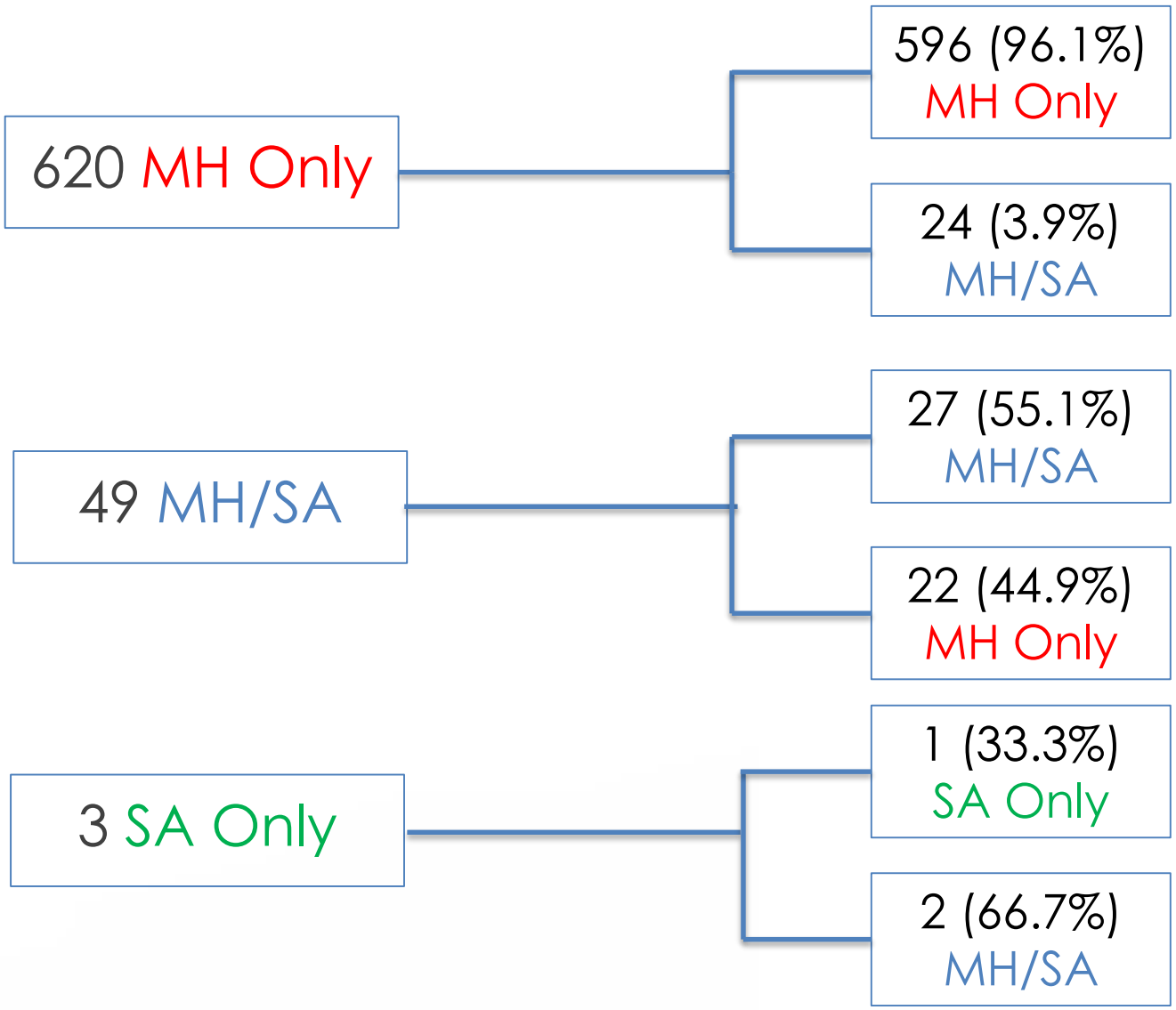
- 27 (55.1%) were readmitted with an MH/SA diagnosis
- 22 (44.9%) were re-diagnosed with an MH Only diagnosis on readmission

Of the 3 youth readmitted within 30 Days from the Index SA Only Cohort:

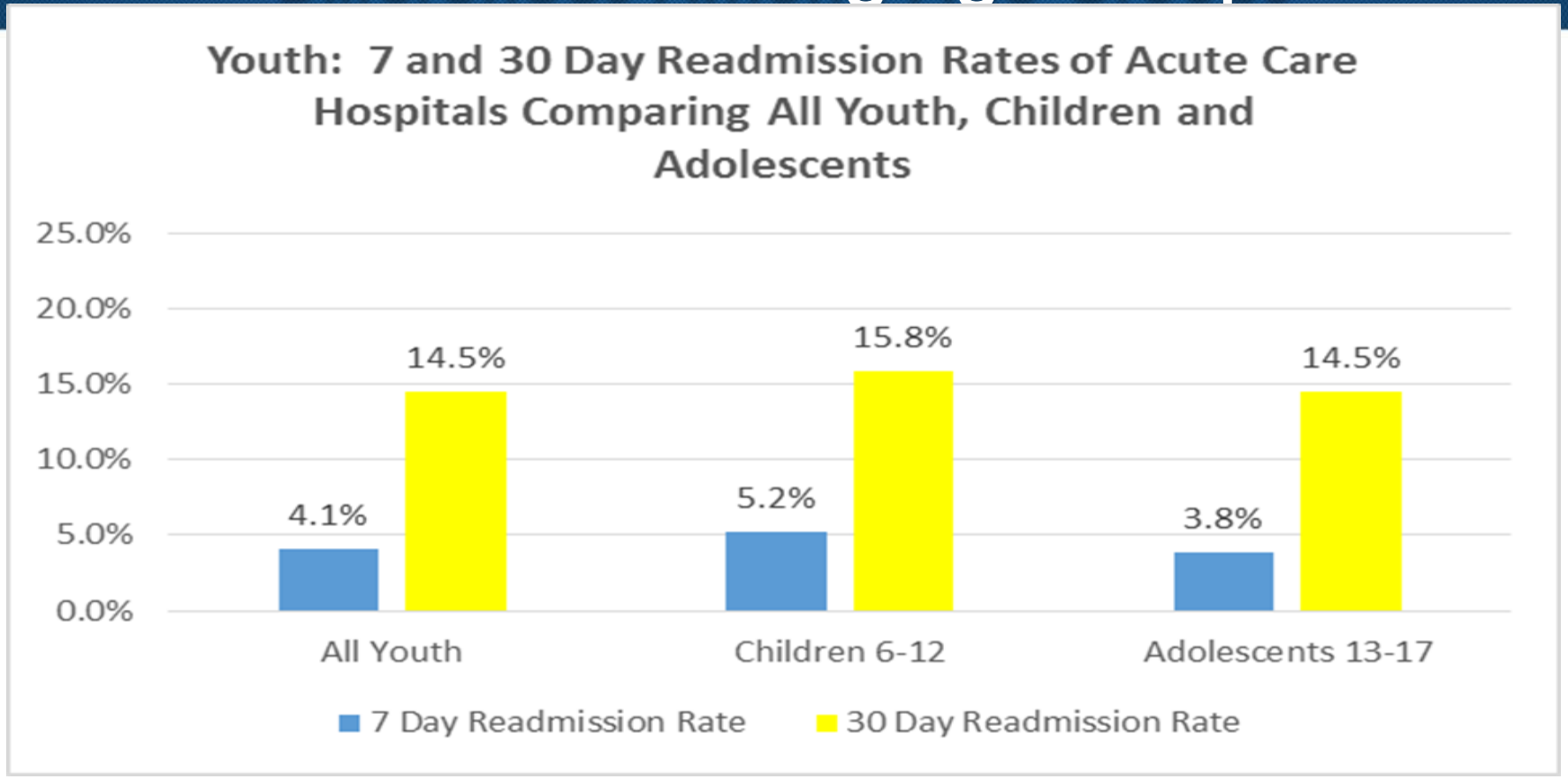
- 1 (33.3%) was readmitted with an SA Only diagnosis
- 2 (66.7%) were readmitted with an MH/SA diagnosis

Co-Occurring MH/SA diagnoses, absent during the Index Admission, were sometimes identified on readmission

Agreement Between Index and Readmission Diagnosis: 30 Days



Youth 7 & 30 Day Readmission Rates: Differences Among Age Groups



Significant differences:
7 Day Readmission Rates
- Adolescents and Children
- All youth and adolescents
- All youth and children

Significant differences:
30 Day Readmission Rates
- All youth and children

Provider Profiles: Observations

- The significant decreases in the rate of admissions from the ED to acute psychiatric hospitals may be impacting delays in the ED
- Not including CCMC, the volume of **Observation Bed** stays for youth in CT hospitals was low, though increasing at some hospitals

DECREASE ADMISSIONS FROM ED → ? → ED DELAY

Provider Profiles: Observations

- More than 50% of youth hospitalized in acute psychiatric hospitals had no evidence of follow-up BH care within 7 days

>50%

No Follow-up at 7 Days

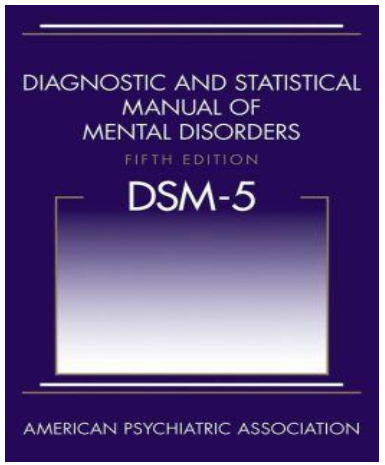
- More than 35% of youth had no evidence of follow-up BH care within 30 days of discharge

>35%

No Follow-up at 30 Days

Provider Profiles: Observations

- Possible under-identification of Co-Occurring MH/SA diagnoses during inpatient hospitalization may result in inadequate discharge planning and readmission
- There appears to be hospital-specific effects with regard to BH diagnosis with wide variation in the rate of identification of co-occurring MH and SA issues. This finding was accentuated among diagnostic patterns of hospitals treating adults.



Questions/Comments