Behavioral Health Partnership Oversight Council

Child/Adolescent Quality, Access & Policy Committee

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

Meeting Summary
Wednesday, October 21, 2015
2:00 – 4:00 p.m.
Value Options
Rocky Hill, CT

Next Meeting: November 20, 2015 @ 11:00 AM
at VO, Rocky Hill

Attendees: Sherry Perlstein (Co-Chair), Jeff Vanderploeg (Co-Chair), Karen Andersson (DCF), Kathleen Balestracci, Lois Berkowitz (DCF), Annie Calamari, Kenneth DiCepua, Erin Eickenhorst Fearn, Elizabeth Garrigan, Kim Haugabook, Dr. Irvin Jennings, Susan Kelly, Beth Klink, Mickey Kramer, Joan Narad, Kim Nelson, Steve Merz, Rebecca Neal, Heather Paluso, Ann Phelan, Donyale Pina, Dr. Robert Plant (VO), Heidi Pugliese, Maureen Reault, Kathy Schiessl, Sherrie Sharp, and Cynthia Wilson

Child and Adolescent Utilization Level of Care Data Q1 & Q2 -2015: Bert Plant, Ph.D., ValueOptions

ChildAdol10-21-15YouthSemi-AnnualRptPr

- Presentation reviewed utilization data by level of care (LOC) from Q1 and Q2 calendar year 2015; using primarily authorization data; Solnit divided out of most analyses because their utilization patterns tend to be very different than others programs
- Youth membership has continued to increase over time, but not as quickly as adult membership
- Quarterly membership growth among DCF-involved has been declining
- Substantial reduction in enrollment growth among youth in DCF voluntary services
- Inpatient admissions among DCF-involved youth are lower than in past years
- Inpatient average length of stay (ALOS) is at its lowest rate in last two years
- For the first time, non-DCF ALOS among 3-12 year olds is slightly longer than ALOS among DCF-involved youth, primarily because the rate among DCF-involved youth has greatly decreased, whereas ALSO among non-DCF youth is about the same over the same timeframe)

- Among 13-17 year olds, there is still longer ALOS for youth with DCF-involvement than among youth without DCF involvement
- Among 3-17 year olds at "Big 7" hospitals only, there has been a slight reduction in ALOS from 12.0 to 10.8 days over last couple of years
- Inpatient discharge delay
    - Gradual reduction in last couple of years in terms of percentage of days spent in delay status. The percentage of total days in delay status is currently under 10%, down from a high of 36%.
    - It tends to be that kids in delay status are waiting for another service, most likely PRTF
    - An increase in ALOS at Solnit, especially among non-court ordered youth. Decrease in ALOS over last few quarters among the court-ordered youth to Solnit. Most court-ordered youth are sent there for evaluation
    - It's possible that youth that are court-ordered to Solnit make up a larger percentage of Solnit discharges during school months
    - It was suggested that it might be helpful to look at hospital data both in-state and in border states, by home town of the child to determine the degree to which youngsters from communities without hospital beds are being hospitalized outside their own communities.
    - It was also suggested that looking at whether access to in-home and intermediate level of care services is correlated to hospitalization rates
- Community PRTF
    - There are three across the state
    - Any willing provider can open a PRTF, but they are required to have a school on grounds
    - PRTFs may experience discharge delay because there is not enough collaboration between PRTF and the family/school/community to ensure they're all prepared for that young person to be discharged
    - There are some barriers to opening a PRTF including reimbursement structures, requirement for having a school, and CMS restrictions on billing other services while a youth is in a PRTF.
- PRTF: Number of admissions on the decline; discharge delay days was rising until Q4FY15
    - There was a request from QAP members to see that data by age and by gender
- Service delivery to youth with ASD
    - Total of 84 youth served in first two quarters
    - Increases in total number of youth admitted , especially for behavioral assessments, plan of care, and service delivery
    - Most kids served are non-DCF. DCF-involved youth with autism are served in other programs but it's expected that DCF-involved youth will gradually transition over to the Medicaid autism program
    - It would be helpful to examine our workforce development to determine whether we have sufficient well-trained providers that can provide autism services. Bert noted that Massachusetts (per capita) has more qualified providers than CT. One member suggested that might be because Mass. has better rates?

    - Provider enrollment has been an issue since the program started. Given the prevalence rates there may be up to 8,000 kids in need of autism services. Number of youth served so far is very low. There is a need to support providers in getting credentialed to provide these services.
- Residential Treatment
    - Admissions to out of state RTCs has gone up (4 and 5 admissions in past two quarters), but these are very small N's which limits ability to interpret.
    - ALOS is longer but highly variable from quarter to quarter among those in out of state RTC; ALOS has increased slightly in recent quarters among those in in-state RTCs
- One member commented that it would be very helpful to bring together utilization data with expenditures data, to examine where resources are going relative to utilization
    - SAMHSA grants are becoming available to support states' efforts to look closely at new fiscal and reimbursement strategies
- Another member noted that utilization is interesting and important, but not the same as looking at the outcomes of care

Expansion of EMPS Hours of Mobility: Karen Andersson (DCF)

- EMPS expansion was part of the children's BH Plan
- Karen Andersson reported that EMPS will receive an additional $2.5 million; DCF will be meeting with each of the six primary providers to discuss specific allocations
- There will be a base increase among all providers, with additional increases based on recent performance on a variety of indicators
- Hours will be extended to include mobility from 6am – 8am, but will not be expanded past current 10pm end point. Appreciation was expressed to DCF for responsiveness to concerns raised by council members, families and providers, regarding the original proposal to increase the nighttime hours rather than the morning hour. It was noted that mobility starting at 6am will enable EMPS to be responsive to families needing help with school refusal.

New Business and Announcements

- A question was raised regarding the specific goals for this committee or the Council as a whole. The suggestion that goals be established will be brought to the Council's Executive Committee for consideration
- Due to the state holiday on 11/11, the Council will be meeting on 11/18/2015. This will supplant the Committee's meeting time. The committee chairs will consult with the state agencies to determine a November meeting time and agenda and will notify the members.

***NOTE: New Meeting Date and Time: November 20, 2015 @ 11:00 AM**
4th Floor, Huntington Conference Room, VO in Rocky Hill