Behavioral Health Partnership Oversight Council

Child/Adolescent Quality, Access & Policy Committee

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Co-Chairs: Steve Girelli & Jeff Vanderploeg
Meeting Summary
Wednesday, November 20, 2019
2:00 – 4:00 p.m.

Next Committee Meeting Date: Wednesday, December 18, 2019 at 2:00 PM at Beacon Health Options in the Hartford Conference Room (Third (3rd) Floor in Rocky Hill, CT

Attendees: *Dr. Steve Girelli (Co-Chair), Dr. Jeff Vanderploeg (Co-Chair), Dr. Lois Berkowitz (DCF), Carrie Bourdon (Beacon), Annie Calamari, Michelle Chase, Melissa Deasy, Ken DiCapua, Tammy Freeberg, Irvin Jennings, Beth Klink, Kenneth Layones (Beacon), Thais Ortolaza, Kelly Phenix, Dr. Sandrine Pirard (Beacon), Bert Plant (Beacon), Kathy Schiessl, Tara Scrivano, Erika Sharillo (Beacon), and Dr. Stephney Springer (DCF)*

Introductions

Co-Chair Steve Girelli convened the meeting at 2:00 PM and introductions were made.

Comments and Discussion from the October Meeting

- There was a request to obtain the website address from an earlier (possibly September) CAQAP presentation that introduced members to a data dashboard on children.

Statewide Crisis Services- *Improving Care & Throughput in Emergency Crisis and Acute Treatment Services* -Bert Plant, PhD (Beacon), Erika Sharillo, LCSW (Beacon), Sandrine Pirard, MD (Beacon), Carrie Bourdon, LCSW (Beacon), Tim Marshall (DCF), Kellie Randall, PhD (CHDI), Aleece Kelly (CHDI)

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Perspective on Emergency Departments

- Good throughput occurs when families can access crisis services when they need it, are discharged on time with a plan, and connect to the next service, all without preventable delays.
- This presentation takes a system-level approach, describing how multiple programs fit together, rather than examining just one program at a time.

- Rising prevalence (total number of children with behavioral health (BH) needs) and rising acuity (intensity of their BH needs) each contribute to more pressure on the BH system.
- Over the last 10-20 years, indicators of BH acuity (e.g., emergency department (ED) visits) (e.g., suicide) are on the rise. CT statistics are rising too, but not as quickly as national data.
- There was an approximately 7% increase in child/adolescent visits to the ED for BH concerns (BHED visits) from 2016 to 2018.
- Two other indicators tracked are: 1) the percentage of youth who are connected to another service within seven days of a BHED visit, and 2) within 30 days of a BHED visit.
- A member noted that there are certain towns and schools that still do not use Mobile Crisis
- Inpatient utilization rates have been lower over the last few years, which may be related to few inpatient beds overall. In addition, hospitals EDs with their own inpatient units tend to have higher rates of admitting youth from the ED to inpatient.
- BHED stuck rates (youth who remain in the ED 8 or more hours after medical clearance) were higher in 2019 than in 2018. Even though more youth are getting ED stuck, for youth that do get ED stuck, they tend to be stuck for less time.
- A member noted that increases in BHED visits and stuck rates, may be related to members having trouble with non-emergency medical transportation, missing routine appointments, getting discharged from that treatment, having a crisis, and entering the ED.
- Children with DCF involvement (all types of DCF involvement, not just DCF commitment or placement) tend to experience higher rates of BHED visits, and higher rates of BHED stuck status, than children without DCF involvement.
- A member asked about the relatively low ED connection to care rates and whether efforts there could yield significant system improvements. Presenters indicated that these rates may understate actual connections to follow-up care as they only include a connection to a Medicaid-funded service that they can "see" in the data. Other grant-funded or private service connections may be made as well, which may not appear in their data.

<u>Perspective on Inpatient Hospitalizations</u>

- Inpatient average lengths of stay have increased slightly from 2017 to 2019, but there is a lot of variability among the state's inpatient providers.
- Beacon has a performance target to manage inpatient hospitals to reduce discharge delays. Since the partnership started, the rates of inpatient discharge delay have been reduced by 72%.
- Some providers have closed their child/adolescent BH inpatient and psychiatric residential treatment facility (PRTF) units. Some new PRTF beds have opened in 2019 and a few more will open in 2020; however, there's still a net loss of inpatient and PRTF beds over the last few years.

Perspective on Mobile Crisis Intervention Services

- Mobile Crisis is accessible to all youth across the state, and responds to homes, schools, and community locations to prevent ED visits, and also responds to children in the ED to help with throughput out of the ED and into community-based care.
- There has been about 65% growth in Mobile Crisis episode volume from FY2011 to FY2019, but despite this growth, providers have maintained high mobility (93% in FY2019) and rapid response times (87% of responses in under 45 minutes; median response time of 29 minutes).
- A member asked about the clinical model used in Mobile Crisis. Presenters responded that clinicians are trained in the Roberts seven-stage model of crisis intervention, and in the Mary Grealish model and approach to crisis stabilization. This is supplemented by additional trainings in trauma-informed, strengths-based crisis planning, and other relevant skills.
- Most children (about 85%) served by Mobile Crisis are not DCF-involved. Only 20% of youth served by Mobile Crisis had visited an ED for behavioral health reasons in the prior 6 months.
- About 40% of children served by Mobile Crisis are referred to outpatient services, and 13% are referred back to an existing provider.
- Schools (46% of all referrals), families (35%), and EDs (10%) are the most common referrers.
- Many Mobile Crisis episodes to the ED result in youth being diverted from an inpatient stay. Mobile Crisis is also being used to respond to schools to prevent BHED visits, but there is additional opportunity in that area.
- Studies show that Mobile Crisis reduces the cost of inpatient visits and reduces BHED visit rates.
- Beacon provides a number of interventions in EDs and involving other levels of care in order to alleviate pressure on EDs and inpatient units.
- There are a number of alternative strategies that can be used in EDs, inpatient units, PRTFs, and in the community. Some of these things are being done in parts of CT's system. There are some new approaches that are not being used in CT (e.g., BH Urgent Care, Crisis Now referral with GPS tracking and real-time provider appointment scheduling, and School-Based Clinic Crisis Services).
- A member noted that even outpatient services, IICAPS, and other services are in place that likely prevents ED visits and inpatient admissions. Presenters noted that this varies by provider, with some doing this well, and others not responding to crises after-hours.

CAQAP Generating Solutions and Recommendations

1. Initiate a policy and process that ensures a child with a BHED visit receives various follow-ups (e.g., texts, hand-written cards), and trauma-informed assessment and linkage to intervention.
2. Targeted outreach, pressure, and incentives for schools that are not using Mobile Crisis and have high rates of BHED referrals.
3. Make it more difficult for providers to end treatment based on missed appointments (given that missed appointments are often related to transportation barriers).
4. Provide education to schools, and enhance school-based health services, to raise their capacity to prevent and address crises.

5. There is a need to develop an acuity measure to be used in EDs to inform referral decision-making and response to treatment. A parallel measure could be developed for schools and community settings. Members recommended ensuring these tools are designed to protect against implicit racial/ethnic bias, and monitored for bias as they are rolled out.
6. Work with inpatient providers to do better discharge planning at the initiation of treatment.

New Business and Adjournment

Co-Chair Steve Girelli thanked everyone for the presentations and adjourned the meeting at 3:45 PM.

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