Behavioral Health Partnership Oversight Council
Operations Subcommittee

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Meeting Summary: March 9, 2007

Co-Chairs: Stephen Fahey & Lorna Grivois

Next meeting: Friday April 13 @ 1PM at VOI, Rocky Hill

CTBHP/VOI Report

Report highlights & Subcommittee discussion:

- BHP Rapid Response Team: Volume of outreach to individual providers has doubled.
- Batch process for web registrations: CTBHP/VOI has drafted a phone survey for high volume providers as to their readiness to engage in the process and requested SC volunteers to review the questions prior to the phone survey.
- Changes:
    - Effective **May 1, 2007,** no future dating for registration will be accepted. Completion of the outpatient registration must occur after the initial face-to-face session to effectuate tracking of access. This will be especially important as the Enhance Care Clinics begin, tracking timeliness of care access. Providers can still back date the registration form 21 days.
      Comments: clinics would like to future date OP registration for clients transitioning from a higher level of care to OP, which would allow some clinics to centralize their PA for OP services. Lori Szczygiel asked Wheeler clinic to get back to her for discussion of this.

    - Inpatient Psychiatric Bed Availability Roster: **July 1, 2007** real time bed tracking will begin through the ABsolute system for all CT psychiatric inpatient and several border hospitals outside CT and CT psychiatric Residential Treatment Facilities (PRTFs). Providers will have control over the bed availability system and will be able to edit their own site's bed availability based on a security code assigned to their user ID. Trainings on the use of the system will begin late April/May 2007. The bed information will be available to CTBHP/VOI; this avoids ED multiple phone calls to hospitals trying to place a patient; instead one call to CTBHP that will review the case for level of care authorization and identify appropriate available inpatient bed.

      Comment: suggestion to eventually add child EMPS, EDs and adult Mobile Crisis access to the bed availability system. CTBHP/VOI may have system demo available to SC at April 13 meeting. CTBHP/VOI will soon be contacting CT Hospital Association to discuss the process.

- Timeliness of Pre-cert (average time 15 minutes) & concurrent review (CCR) process (average 8-15 minutes) is improving related to 1) establishment of 4 teams in VOI, 2) provider familiarity with information required and now familiarity with the web registration screens and 3) VOI has modified the outpatient CCR form that will be on the VOI web site: www.CTBHP.org.

Comment: VOI was asked to review the timing of requesting authorization beyond 26 OP sessions for additional OP sessions. Providers can call before the 26 sessions have been completed; the remainder of the 26 sessions will not be lost with the new authorization. ***SC members suggested a "provider tutorial" to answer operational questions that have arisen.*** The SC was asked to identify issues & VOI will provide feasibility feedback at the April SC meeting.

- 2007 CTBHP/VOI utilization priorities were reviewed:
    - CTBHP/VOI Intensive Care Manager is on site at CCMC to manage ED delays and at hospital sites to help manage inpatient discharge delays. Family participation in this process varies by institution. May include hospital rounds meeting or the specific family meetings. Discharge delays reflect the flow of children and adults through the BH system influenced by the level of care provided and the right service at the right time.
    - Evaluation of the impact of foster care disruption on BH use,
    - Focus on intensive management of children under age 10 to determine when BH inpatient hospitalization can be diverted to community-based care.
    - Look at adult length of stay (LOS) in particular for those with co-occurring diagnoses; especially detox LOS that seems too short.

- Monthly "snap shot" look at discharge delay shows that for EDs, 60% of patient disposition is to inpatient units (expectation was stated at 28%) that may reflect the current inadequacy of community-based service access. Other factors also need to considered:
    - How aware are ED staff and residents of alternatives to inpatient care when evaluating the ED patient with BH needs.
    - How applicable have the ED/EMPS memorandum of understanding (MOU) been?
    - Hospital credentialing rules that don't allow certain activities of the ICM and EMPS staff for ED patients "stuck" in that site because of disposition barriers.

Outstanding BH Claims under managed care

Value Options has completed the outstanding claims process with Hall-Brooke and reached a tentative agreement with St. Francis Hospital.

BHP Claims data

- Continue to have about three-quarters of claims paid.
- The majority of denial reasons may be represented by a small number of providers that the Rapid Response Team then works with.
- Paul Piccione (DSS) will follow up on issue: multiple PAs are required when a practitioner provides services at a provider site other than what was in the original PA. CTBHP/VOI by contract report out by provider site.

Providers commented that the BHP system has more transparency, less barriers and more problem solving assistance than was experienced in the managed care delivery system.