Connecticut
Medicaid Managed Care Council
Behavioral Health Subcommittee

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MEETING SUMMARY

MARCH 15, 2000

Chair: Eva Bunnell Co-Chair: Jeffery Walter

Behavioral Health Outcomes Study Pre and Post Managed Care

Paula Armbruster, Director of the outpatient Yale Child Studies Center clinic, presented data comparing pre-post managed care demographic characteristics and functional outcomes on children seen in the YCSC. The following summarizes the demographics:

Demographics	**Pre-managed Care (N=201)**	**Post-managed Care (N = 475)**	**Statistical Significance**
Age: 5-11	63.6%	64.1%	N.S
12-18	36.4%	35.9%	
Gender: Male	56.7%	59.2%	N.S
Female	43.3%	40.8%	
Ethnicity:*			N.S
Non- Minority	33.8%	28.2%	
Minority	66.2%	71.8%	
Caregiver: single	64.3%	50.2%	0.001

parent			
Two parents	30.4%	30.7%	
Demographics	Pre- MC	Post MC	Stat. Significance
Caregiver; Other	5.4%	19.1%	
Payment source: Insurance	21.9%	22.5%	0.001
Medicaid	62.7%	75.0%	
Unknown	15.4%	2.5%	
Residence: New Haven	59.1%	76.2%	0.001
Other	40.9%	23.8%	

- Caregivers: other includes relative/guardian, DCF guardianship
- Medicaid includes Medicaid, no insurance, grant, no charge.
- Corrected data on ethnicity; the percentage of minority clients exceeds that of non- minority clients.

Pre-Managed Care Post-Managed Care

	Mean (SD)	Statistical Significance	Mean (SD)	Statistical Significance
CGAS:Evaluation	49.1 (9.7)	p<0.0001	47.1 (8.0)	p<0.0001
Discharge	53.3 (10.9)	p<0.0001	51.4 (9.5)	p<0.0001
GAF: Evaluation	54.2 (8.6)	p<0.0001	52.1 (7.6)	p<0.0001
Average # sessions	35.3		15.5	0.0001*****
Average # months	8.7		6.5	0.0480*

seen				
Average #sessions/month	5.7		3.2	0.0001*

- CGAS: lowest level of functioning scored 1-100.

- GAF: highest level of functioning, with 70 and above indicating normal function.

- *Statistical significance based on the Wilcox rank-sum test

Ms. Armbruster summarized the observations from the study:

- There was a shift in caregivers, with more children in Other (DCF) category in the managed care period (post MC).

- There was a decrease in the 'unknown' insurance category, suggesting more children were insured in the Post MC period.

- More children from New Haven were served in the Post MC period, reflecting the impact of school-based mental health programs. There was greater congruence in the referral diagnosis and evaluation diagnosis in the Post MC period, suggesting greater provider sensitivity to differential diagnoses.

- There was no statistically significant difference in the functional ratings of children before and after treatment between the Pre and post MC periods, despite the significant reduction of average number of session per child.

- The average functional level, both on evaluation and discharge, (GAF 54 – 58) revealed persistent moderate impairment that raised the following points of discussion:

    - The mental health provider's task may be to maintain or prevent deterioration of the child's functional level, given the level of impairment at evaluation and crises that may occur during therapy.

    - The average impairment level seen at evaluation suggests the need for earlier identification of 'at-risk' children and secondary preventive interventions that would prevent the level of

functional impairment now seen in the outpatient setting.

- Alternative interventions need to be considered, as psychodynamic models do not seem to be associated with more than a flat improvement in functional level (10 points pre-post treatment).

Discussion in the subcommittee highlighted the following issues

- Family assessment of treatment is an important outcome measure, however it is difficult to obtain this, especially in light of the overall 35% dropout rate. Yale has attempted to get these measures over the last few sessions, or through family outreach with a post measurement payment to the family.

- YCSC plans to do a follow-up study to assess differences in outcomes for children with higher evaluation GAF scores versus those with lower scores.

- Alternative interventions may be needed for children with lower pretreatment GAF scores as their environment is more difficult that those with higher scores. Alternative treatment may include:

    - Meeting social needs through after school programs, adult mentoring, creative learning experiences.

    - Cognitive behavioral therapy models that include prescribed protocols within finite time limits. Changing

models from psychodynamic model to a cognitive behavioral therapy model requires refocusing therapist training that better prepares them to treat children with social/behavioral health needs. There are preferred practice models for 12 children's mental health diagnoses used by Alan Kazdin at Yale. The discharge forms may, in the future include alternative treatment approaches.

- The entry low GAF scores emphasize the need to identify the 'at risk' child earlier and provide interventions before they reach this lower functioning level.

Other Issues

1) Psychiatric inpatient reinsurance payments to MCOs from DSS have been delayed, necessitating PRO BH to hold on provider payments until the money is received from the State. The other plans stated they are paying the hospitals at the present time. James Gaito (DSS) will bring this to the attention of the Financial Management department within DSS and Council staff will inform the Chair of the Medicaid Council, Sen. Toni Harp, of the problem. Under the reinsurance contract, the hospital readmission rates have decreased by 10%. The number of children staying beyond 15 days inpatient has increased. Currently PRO has 35-40 children inpatient beyond clinical necessity.

2) A steering group that will work with the researcher during the BH outcomes study will be reorganized, with representatives from MCO, providers, agencies and Medicaid Council. The goal is to begin the study by July 1,2000.

3) Future focus of the subcommittee with include:

- Continued work by the Priority working group with the subcommittee on the identified issues.

- Assess the status of the SBHC mental health contracts with MCO.

- Assess the coordination of mental health and primary care services in the HUSKY program

- Identify the best practices in children's mental health, including treatment and administrative practices.

Jeffery Walter suggested that the full subcommittee could begin meeting every other month as work continues in the working groups. **The next meeting will be on Wednesday April 19 at 1 PM in LOB RM 1A.** The agenda will include a report on the Governor's MH commission, a report and discussion with David Parrella on the legislative BH study and report from DCF and Dawn Henschel on the transition of youth from DCF to DMHAS.

BH Outcomes Work Group Summary

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The group reviewed the discharge form, recommended changes that will be included in the form. The form is complete, with the exception of several remaining questions that the researcher needs to be consulted about.

The MCOs, providers and agencies on the steering committee will develop the training tools needed for the study orientation phase and meet throughout the study period with research staff.

	MCO	Provider
Pre-Study MCO/provider Orientation	• Organize provider training with trade assoc. • *Notify providers via mail with training dates* • *Trade Assoc to reinforce training attendance with their providers.* • Provide training with the researcher, identifying that all clinics, group practices and individual providers have participated	• Ensure clinic, practice staff attend/receive training in the study.
Pre-treatment (OTR) data	• Blacken the patient name	• Complete the OTR

	from the form • Review the OTR for data completeness • *Mail incomplete forms back to the provider for further information.* • Enter this in the MCO tracking system • Mail *completed* OTR(S) to the researcher weekly	*before the* 3 visit for each new OP family. • *Mail or* fax the completed form to the MCO within one week of completion. • *Complete data on forms returned by MCO and mail or fax back to MCO.*
Discharge data	• Blacken client name from form • Review form for data completeness • Identify that a OTR for this client was sent to Yale. • *Review form for data completeness, return incomplete forms to*	• Complete the form at the end of Rx, or at any time treatment is prematurely ended because of client withdrawal or referral to more intensive Rx setting. • *Mail or f*ax discharge form to the

	provider. • Send form(s) to researcher weekly. • Use internal tracking system to pay provider for completed OTR/discharge form. • Notify providers when study N reached.	MCO within one week of discharge • *Add missing information to forms sent back by MCO, return to MCO within a week.*	

Next steps:

• MCO and provider trade association estimate the time factor for study, based on functions agreed upon in the grid. MCOs estimate $ amount for pre-post forms for providers.

• Steering group to meet with Alan Kazdin to finalize the discharge form and study protocol.

• Develop training protocols and materials for MCO internal staff and providers.

• Contract completion: 1) DSS/MCO 2) DSS/researcher.