Behavioral Health Partnership Oversight Council

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Meeting Summary: May 9, 2007

Next meetings: Wednesday June 13, 2007 & July 11, 2007

Attendees: Jeffry Walter (Co-Chair), Mark Schaefer (DSS), Karen Andersson & Bert Plant (DCF), Laurie Van Der Heide (CTBHP/VO), Judith Meyers, Susan Walkama, Jean Hardy (Health Net), Heather Gates, Sharon Langer, Patrick Monahan, Elizabeth Collins, Barbara Parks Wolf (OPM), Anthony Del Mastro, Thomas Deasy (Comptroller's Office), Cristine Vogal (OHCA), Sherry Perlstein, Beresford Wilson, M. McCourt (leg. Staff).

Behavioral Health Partnership Oversight Council (BHP OC) April meeting summary was approved without change.

BHP OC Subcommittee Reports

DCF Advisory Subcommittee: Co-chairs: Heather Gates & Kathleen Carrier

The Subcommittee meets on the 3rd Tuesday of the month, interested participants welcomed. The May meeting will review the Juan F Exit plan. Ms. Gates noted that Emergency Dept. (ED) boarder issues bring attention to the importance of adequately funded in-home services such as IICAPS that can divert some children from the ED and/or hospital. Without state policy and appropriately financial support for community services the ED and hospital issues will continue.

Quality Management & Access Subcommittee Chair: Dr. Davis Gammon, Co-Chairs: Robert Franks & Paula Armbruster
Please review the May Subcommittee meeting summary.

BHP OC Quality SC 5-7-07.doc

Behavioral Health Partnership Reports

CTBHP/ValueOptions (VO) (Click on icon below to view full presentation)

BH Oversight Committee May 9 20(

Discussion/questions:

- There are approximately 175 child/adolescent beds in the 7 in-state psychiatric hospitals.
- The state contracts with 5 facilities to provide out-of-state psychiatric hospital care.
- There have been some changes in the psychiatric residential treatment facilities (PRTF): Wellspring is now a residential treatment facility (RTC) rather than a PRFT. Wheeler Clinic is no longer a PRFT as of 1/06. The PRFT is the highest level of residential care with 24 hour medical management.
- Historical trend data on DCF use of residential facilities in and out-of-state isn't available; BHP will be collecting data on current utilization of in-state and out-of-state RTC.
- Hospital discharge delay data trending began Jan.1, 2007 after training and testing data reliability. It is a critical benchmark for hospital service utilization and the BHP care delivery system. The delay days are calculated by: all inpatient days in a given quarter (denominator), the # of days flagged as delayed in that same quarter (numerator). The 1st Q07 shows that the state is purchasing **30% of inpatient care for non-acute, ready to be discharged patients.**
- Discharge delay reasons:
    - Primarily waiting for RTC. DCF wants to have consistent consultations with the discharging hospital, family and DCF to identify appropriate alternative services to institutional care and use UM data to guide funding based on sound clinical decisions. A Council family representative strongly supports this being implemented.
    - The low % awaiting community services (CBS) does not reflect the community experience: historically hospital discharge occurs before the CBS is in place.
    - The BHP OC Quality SC will be reviewing UM data and asking questions to clarify what is being measured vs. what else might be needed. The SC Co-Chairs and BHP could meet about this.

- Local area analysis of inpatient and PRTF identifies utilization (days/1000 clients), average length of stay, taking into consideration 'outliers' and discharge delay reasons that would identify potential future community service needs in an area.

- ED delays in the 3rd Q rose significantly with the greatest number of ED boarders (85 children) at CCMC during that time. Family representative suggested that data on ED boarder's residence and BH services prior to behavioral health-related ED visit would be informative. DCF is looking at this. (*See BHP "ED response plan" in BHP presentation below*.

    - The BHP OC Quality Management Subcommittee will be monitoring ED utilization and patient "boarding". Mr. Walter stressed the importance of hospital participation in this Subcomittee.
    - CT Hospital Assoc. (CHA) will be meeting with BHP about discharge issues and bed tracking process. The Governor is interested in how to best reduce ED stays. Before July the State can use the DPH system that includes pediatric beds. The hospitals haven't agreed to release hospital specific DPH data to the ASO.

BHP Agency Report

BHPOC Presentation 5-9-07 Final.ppt

- ✓ **DCF Expenditures for services managed by the CTBHP ASO** (slide 1, 2) were reviewed by Drs. Karen Andersson and Bert Plant as requested by the Council. Expenditures were based on SFY05 & 06 and projected SFY 07. Discussion/observations:
  - In-state and out-of-state residential expenditures are expected to decrease in SFY 07 because of 1) increase spending ($35M) for therapeutic group homes and 2) increased DCF budgeted total ASO-managed community expenditures (>$37M). **Karen Andersson will provide a list of therapeutic group homes by geographic area.**

- ✓ SFY 07 Rate increases: payment of adjusted claims June 2007.
- ✓ Decision regarding minimum duration (proposed 3 hour) requirement for Intensive Outpatient Program (IOP) is under review in the BHP agency Clinical Management Committee
- ✓ Effective with the 2nd May claims cycle, timely filing requirement for resubmission of a denied claim <u>will be extended from 60 to 120 days.</u>
  - *Comment:* Mr. Walter asked why BHP timely filing requirements differ from fee-for-service (FFS) – 365 days. DSS noted BHP is not a FFS program and that the filing times for BH claims is the same or higher than under managed care.
- ✓ Drs. Karen Andersson & Bert Plant (DCF) reviewed the BHP short term ED response plan developed in light of the extraordinary high 'seasonal' volume of BH-related ED and hospitalizations in the spring of 2007 (*see slides 7-14, click on icon above).*
  Comments:
  - Developing and maintaining available therapeutic community programs services with adequate capacity is a key strategy in reducing the ongoing BH emergency situation. Beresford Wilson (Family rep) emphasized the importance of :
    - Reducing the adverse impact of the DCF provider credentialing process (for flex funding) on diverse ethnic small provider groups. DCF responded that the agency is supporting these providers in meeting credentialing criteria.
    - Community level collaboration of EMPS, ED and system of care teams.
  - DCF is looking to more effective and efficient in using of "flex funds" that will improve ED diversions.
  - Suggested adaptation of the EMPS/hospital MOU as a template for other such relationships with hospitals that do not have child/adolescent BH services. DCF stated the EMPS teams/hospitals are revisiting the agreement formats.
  - As part of examining the recent crisis, it was suggested that BHP consider KidCare goals of managing care by progression through Levels of Care, looking beyond "flex funding".
  - ***DCF will provide further information of the diversion plan for CCMC in June and data on prior BH services to ED visit, for example who is cycling in and out of congregate care facilities. .***
- ✓ ***BHP will provide an update at the June 13th meeting on provider case management authorizations.*** BHP is monitoring out patient web-based registration information for case management; will assess the level of need for increased CTBHP/VO case management hours.