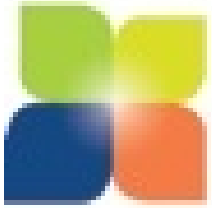


Connecticut BHP

Supporting Health and Recovery

Bending the Institutional Cost Curve: Lessons Learned & Opportunities

April 13, 2011

Where Did We Start?

Behavioral Health Partnership Legislation – July 1, 2005

- Expanding individualized, family-centered and community-based services;
- Maximizing federal revenue to fund behavioral health services;
- **Reducing unnecessary use of institutional and residential services for children and adults**;
- Capturing and investing enhanced federal revenue and savings derived from reduced residential services and increased community-based services for HUSKY Plan Parts A and B recipients
- Improving administrative oversight and efficiencies; and
- **Monitoring individual outcomes and provider performance**, **taking into consideration the acuity of the patients served by each provider, and overall program performance**.

Where Did We Start?

Behavioral Health Partnership Legislation – July 1, 2005

Two Key Provisions of Legislation relating to Access and Use of Inpatient Care:

The ASO shall provide or arrange for on-site assistance for the appropriate placement of:

- Children with Behavioral Health Diagnoses who are held in an Emergency Department for more than 48 Hours
- Children who are on inpatient units more than five days longer than medically necessary – Discharge Delay.

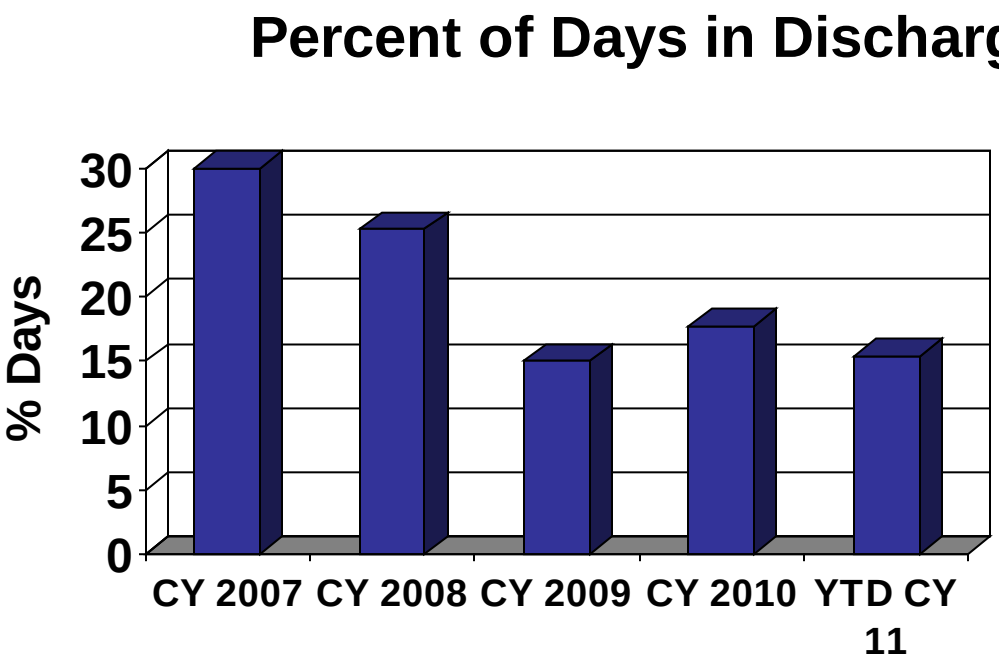
Why were these provisions needed?

- Between 30-40% of all inpatient days for children were due to Discharge Delays awaiting placement in state funded placements, including residential, group home, specialized foster care, or state hospitals.
- Hundreds of children every year where awaiting admission to inpatient beds and were held in Emergency Departments more than 48 hours. Over 400 children “stuck” in ED’s an average of 2.4 days during 2007.

What Did we Do?

- ✓ **BHP Oversight Council** – Forum for Providers, Family Advocates, Legislators, State Agencies and ASO
- ✓ **Quality Data Monitoring** – issues of Discharge Delay and Children Stuck in ED's regularly reported to Council and its committees.
- ✓ **Access to outpatient care improved** – Enhanced Care Clinics Fall 2007
- ✓ **Access to intensive in-home care improved** – IICAPS converted to fee for service.
- ✓ **Intensive Case Managers** assigned to each inpatient facility and focused on those children and families needing access to community care.
- ✓ **ASO and DCF focused on matching referrals** to residential and group home placements – improved tracking of referrals and matching. Standardized assessment tools used to determine level of care needed and available resources. Best match. Regular meetings to accelerate decision making.
- ✓ **Provider Profiling and Reporting** to better understand how providers are improving performance – un-blinded to enhance our collaboration and learning from each other. Use of best practices.
- ✓ **Established an Inpatient Workgroup** with clinical and administrative leaders from all 8 hospitals that provide child and adolescent inpatient care.
- ✓ **Pay for Performance Incentives** established with providers to focus on discharge delays and overall improvement in length of stay. 1% of inpatient funding set up as pool.

What were the Results?



Nearly a 50% reduction in Discharge Delay Days Realized since 2007

Slight increase in 2010 over 2009 – reduced capacity of residential treatment – First Quarter 2011 back to 2009 levels.

Largest increase in out-of-state hospitals. Children with MR/PDD key group.

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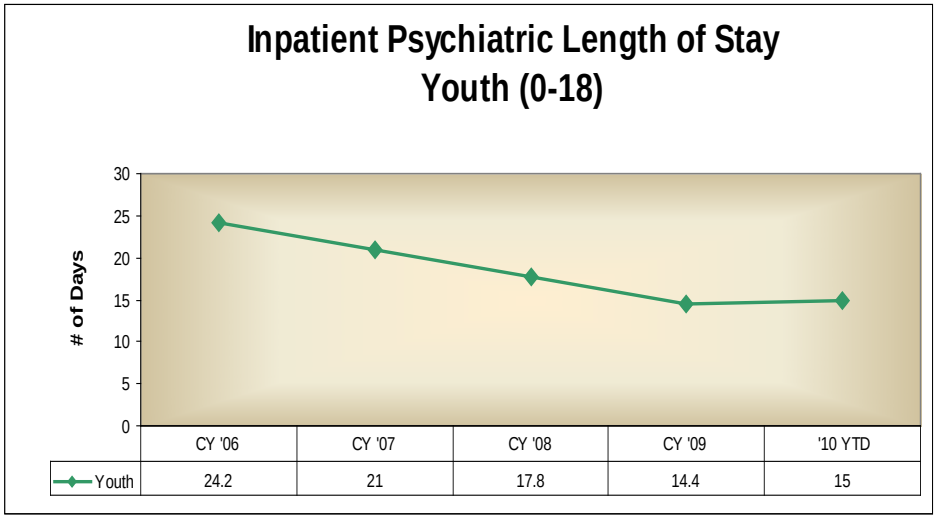
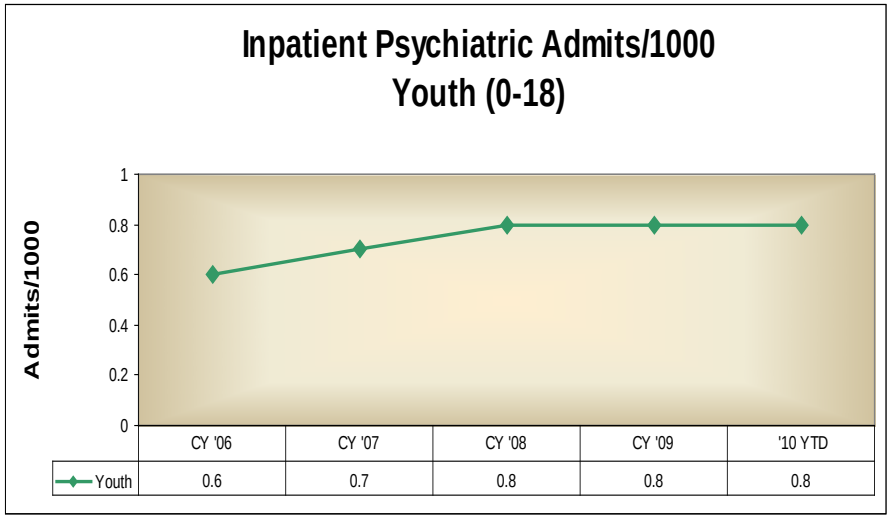
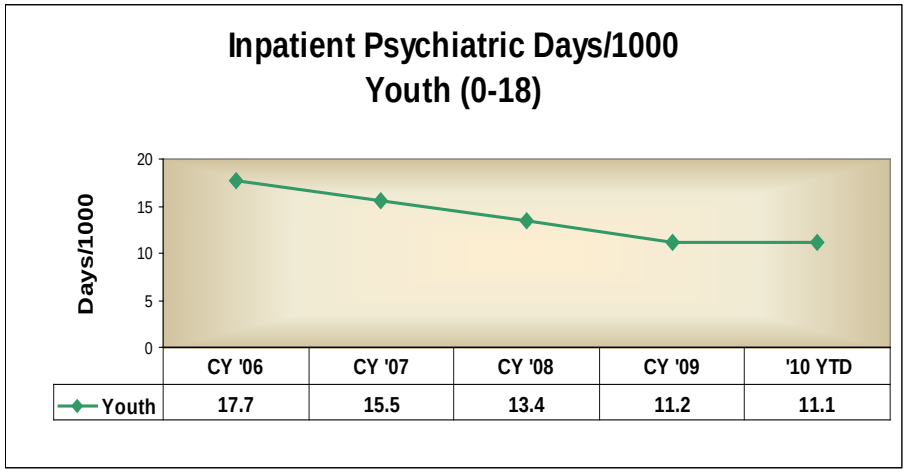
What were the Results?







- ✓Length of Stay reduced 37%
- ✓Improved Access – increase admissions
- ✓Reduced # of Days per 1,000 members
- ✓ED Delays reduced significantly
- ✓Readmissions – 30 Day readmissions
  Reduced from 16.7% in 2008 to 12.6% in CY 2010

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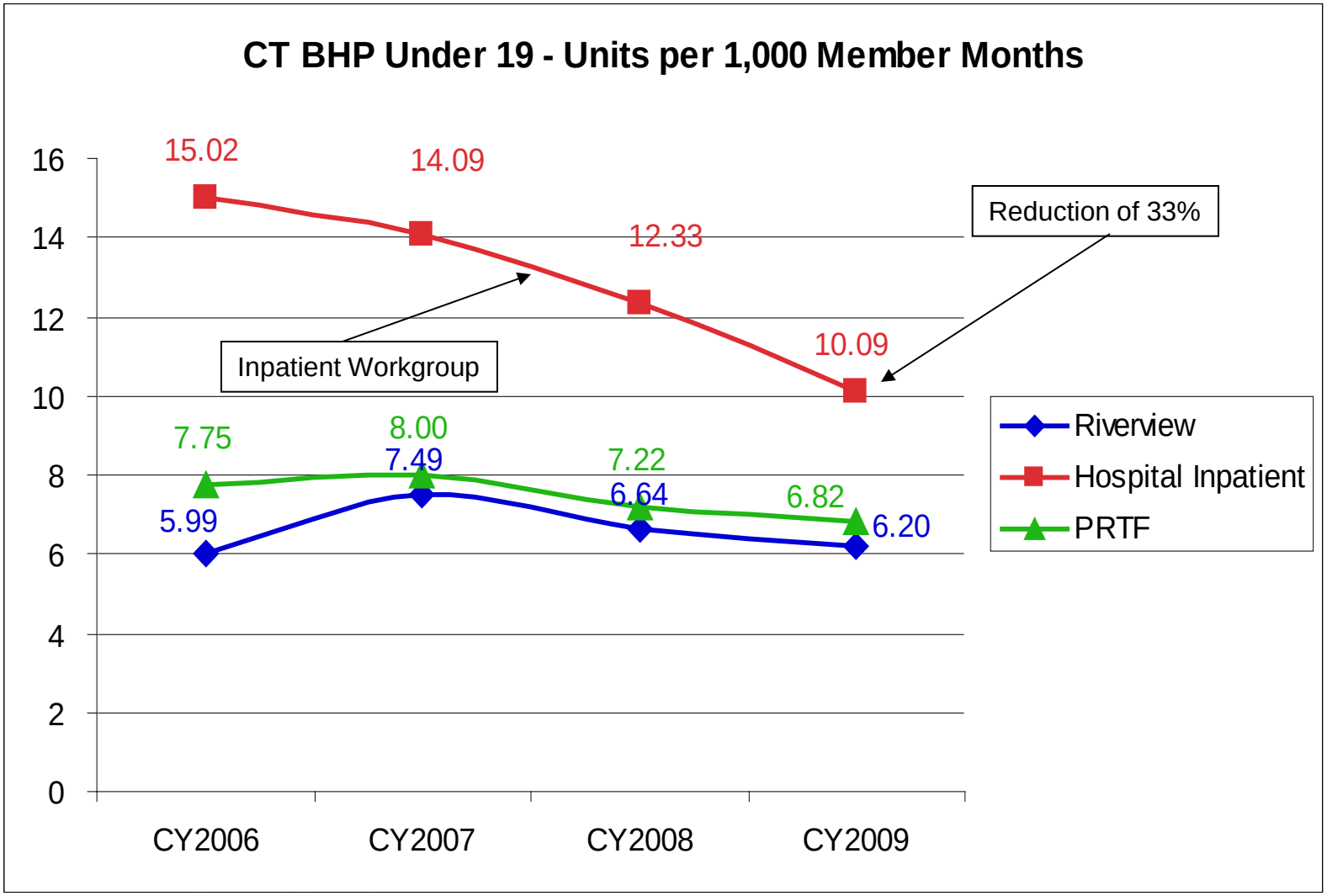
CT BHP Under 19 Utilization

Inpatient Psychiatric



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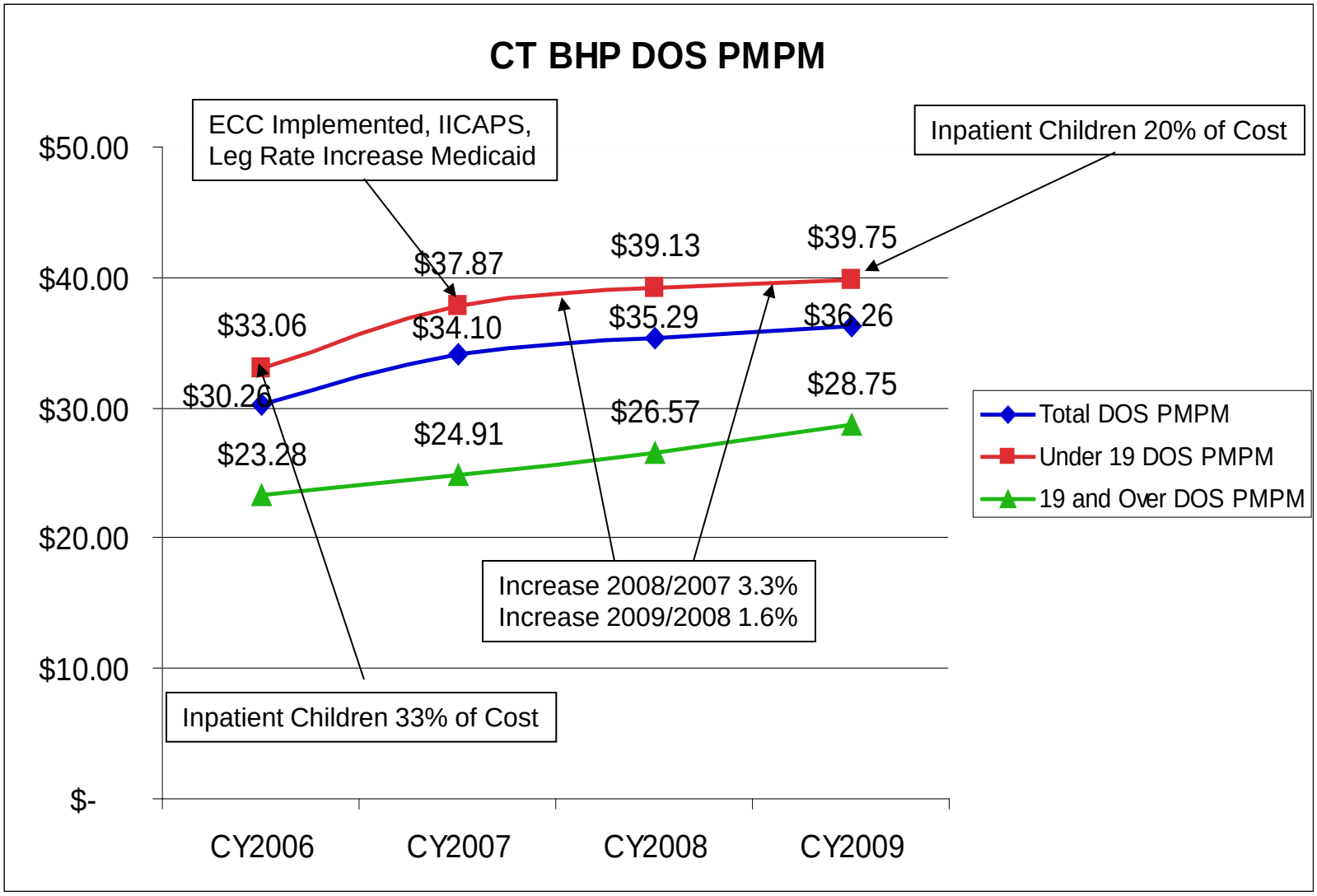
Bending the Cost Curve



Lessons Learned & Opportunities

- ✓ **Focus and Collaboration Works** – Use of data, focused attention from all aspects of the system – Providers, DCF, ASO can produce measurable results
- ✓ **Access to community based programs –** Outpatient (ECC), IICAPS, group homes, specialized foster care all make a difference in reducing institutional costs.
- ✓ **Pay for Performance Programs –** Can be embraced by providers and help to focus attention on key performance issues.
- ✓ **Improved Outcomes** – Can help to bend the "cost curve".
- ✓ **Family collaboration crucial –** Next iterations of the will focus on family communication, engagement and development of wrap-around discharge plans and crisis plans.
- ✓ **Data Makes a Difference.** Providing data to providers, DCF and ASO can help to improve performance. Quarterly review of data and real time web access to data enables providers to benchmark performance and focus on performance improvement activities.
- ✓ **The savings have been reinvested in expanded community access.**
- ✓ **Future focus will be on outcomes and readmissions.**
- ✓ **Need to address under-funding of inpatient care.** Lowest ratio of covered cost.