Connecticut BHP
Supporting Health and Recovery

Behavioral Health Partnership Oversight Council
September 11, 2013

CT BHP Quality Management Program Initiatives

Overarching Goals of the CT Behavioral Health Partnership Quality Management Program

- Continuously improve care and service provision
  - Use data to identify areas for improvement, key indicators, high-risk individuals/populations
  - Ensure measures are valid, reliable, comparable
  - Design interventions to address areas in need of improvement and re-measure following the interventions to assess impact
- Quality Management (QM) Program has been in place since 2006

QM Initiatives

- Provider Analysis and Reporting Program
- Clinical Bypass Program
- Clinical studies
- Intensive Case Management Pilots

Provider Analysis & Reporting (PAR) Program

A vital strategy used to:

- Shape and adapt the delivery and outcomes of the CT behavioral health system of care
- Improve quality and access to care
- Evaluate provider performance individually, as a group across a level of care, and as part of a system of care
- Compare performance with both locally-informed and industry-wide utilization and quality measures

How a PAR Program is Established

- Identify specific behavioral health level of care (e.g., Adult Psychiatric Inpatient Hospitals or Psychiatric Residential Treatment Facilities (PRTF) for youth)
- Establish work groups with providers to co-create measures and set goals and targets
- Create a profile with and for the providers
- Regional Network Managers meet individually with providers to deliver performance feedback and obtain information re barriers encountered
- Discuss strategies to effectuate change and improve the quality of the care

Current PAR Programs

- Enhanced Care Clinics
- Pediatric and Adult Psychiatric Inpatient Hospitals
- Psychiatric Residential Treatment Facilities (PRTFs)
- Emergency Departments (EDs)
- Therapeutic Group Homes
- Residential Treatment Centers (RTCs)
- Home Health Care

Home Health PARS Program

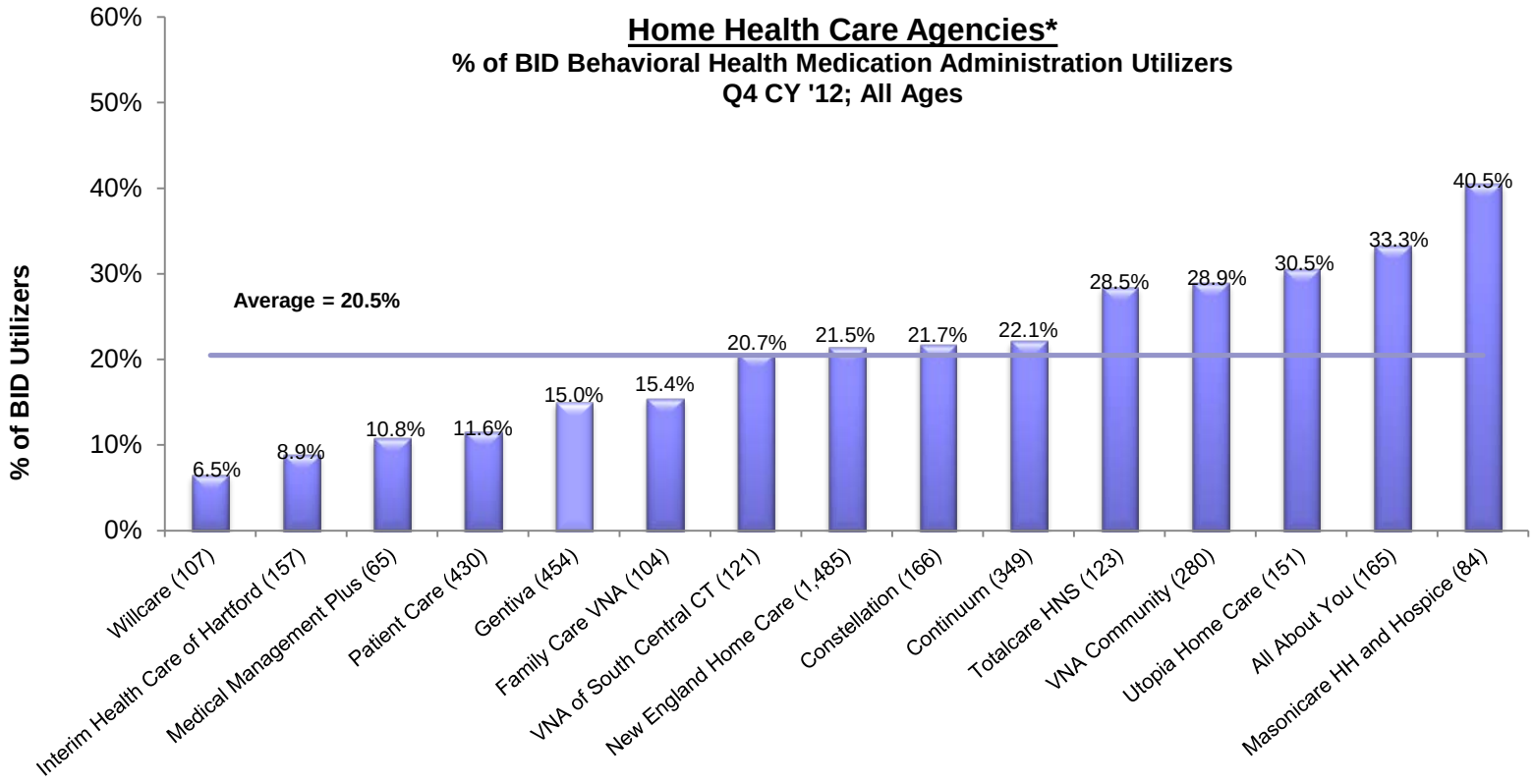
- CT Home Health (HH) Agencies providing behavioral health medication administration services to at least 75 individuals per quarter are included
- As of Q4 2012, the PARs HH providers served 88.5% of all individuals utilizing HH medication administration services

Home Health PARs Indicators

By provider and aggregate statewide:

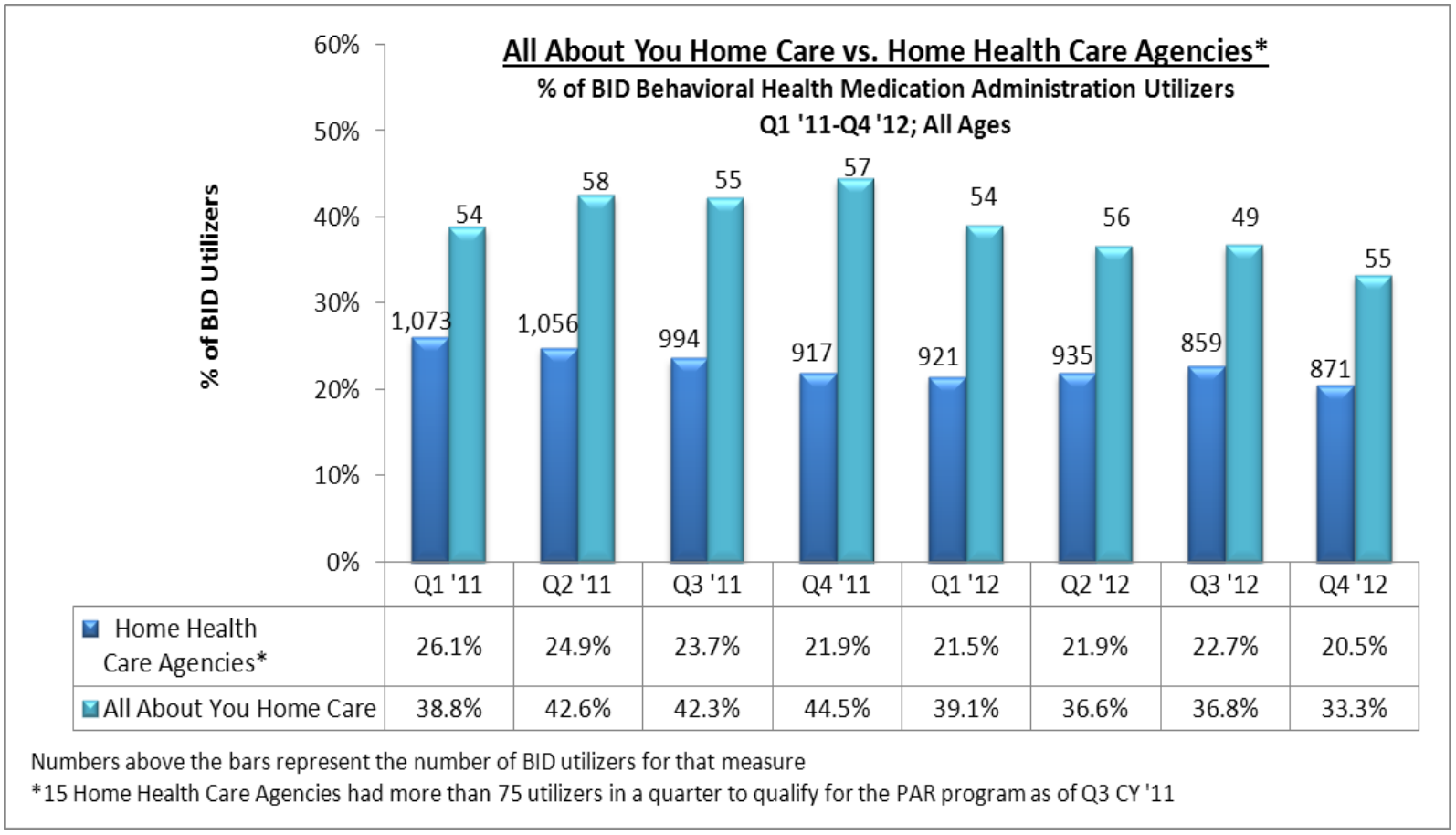
- % of utilizers receiving twice a day (BID) medication administration services
- % of utilizers receiving once a day (QD) medication administration services
- % of BID and QD utilizers with evidence of skill transfer
- % of utilizers with an ED visit during the quarter
- % of utilizers with an Inpatient admission during the quarter

Variation between HH Agencies in % individuals with BID services



Number in parentheses represents the total utilizers for that quarter
*15 Home Health Care Agencies had more than 75 utilizers in a quarter to qualify for the PAR program as of Q3 CY '11

Statewide and HH Agency decrease in % of individuals with BID services over time



Numbers above the bars represent the number of BID utilizers for that measure

*15 Home Health Care Agencies had more than 75 utilizers in a quarter to qualify for the PAR program as of Q3 CY '11

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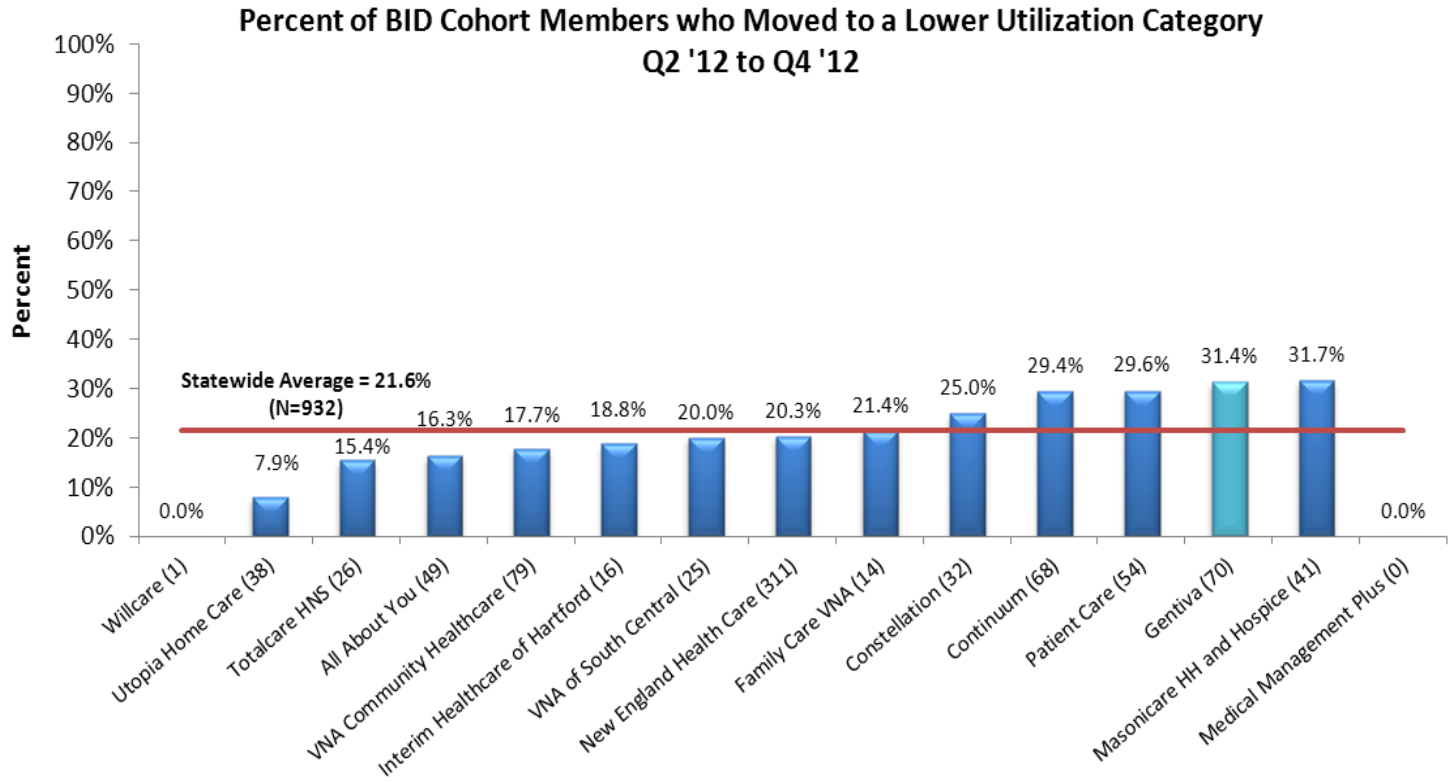
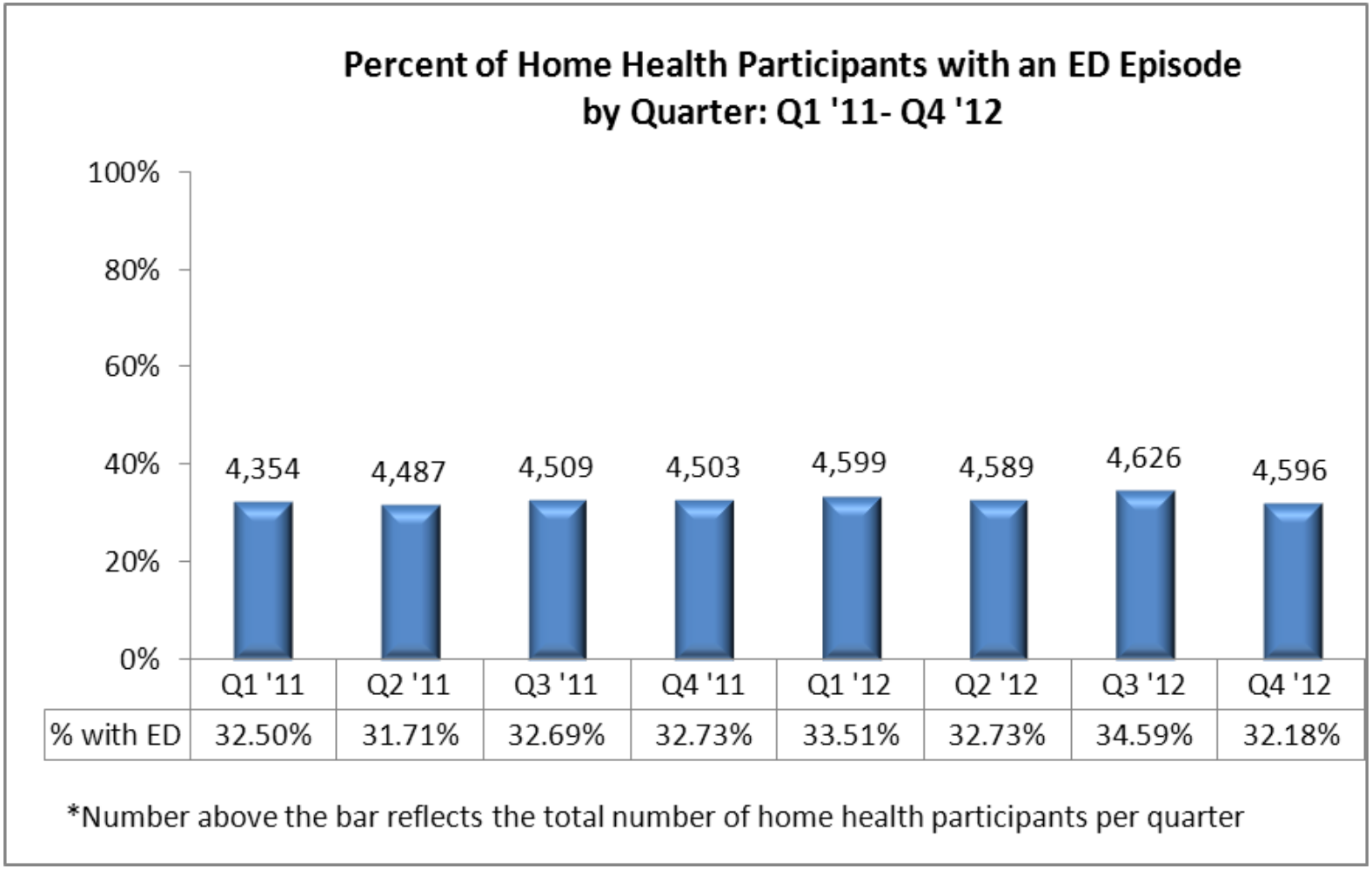
% of BID HH utilizers with evidence of skill transfer

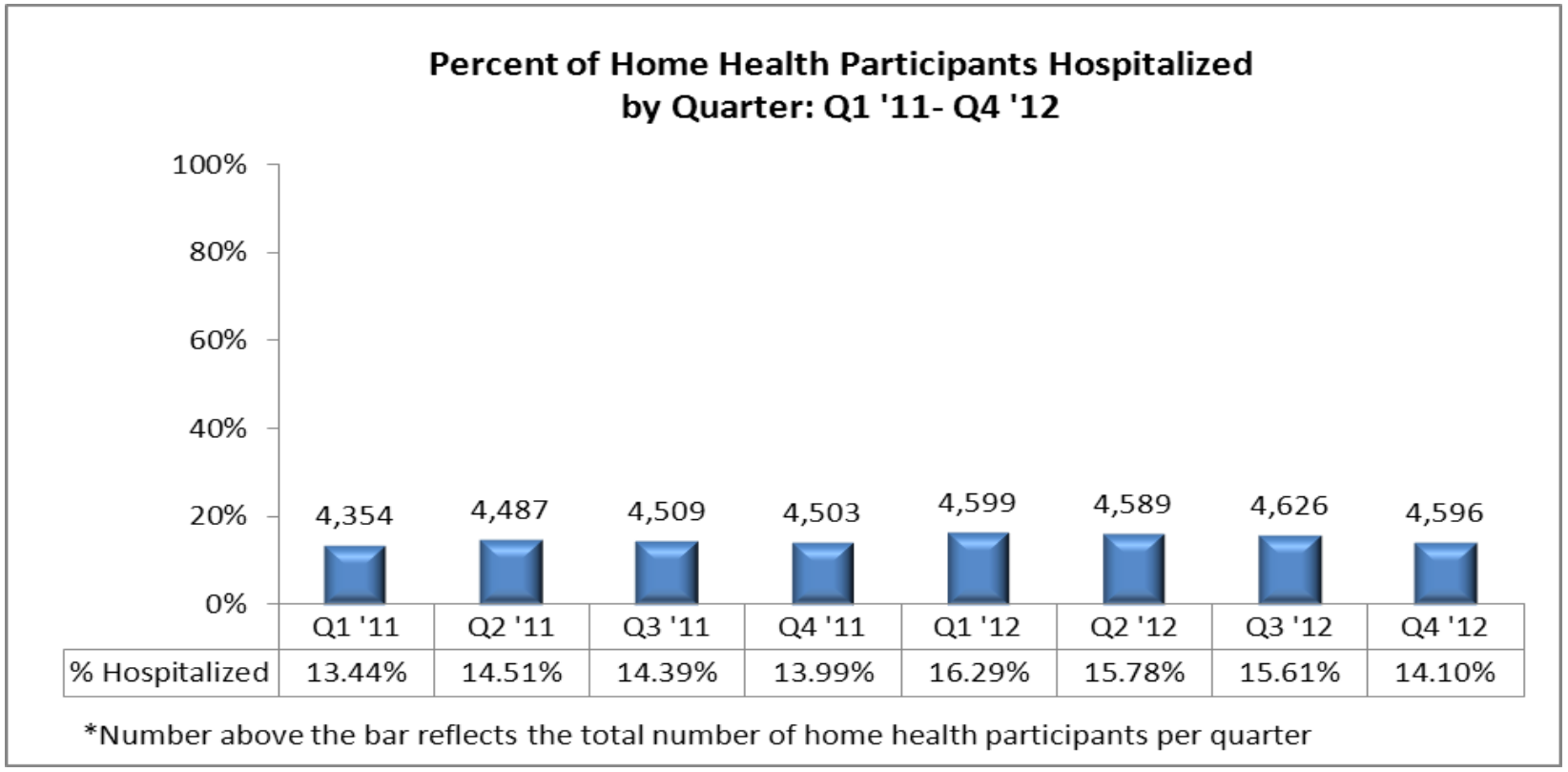


Number in parentheses represents the total BID utilizers for Q2 '12 excluding those who: became deceased, changed providers, went inpatient for over 21 days, received no home health services, or were ineligible for over 21 days in Q4 '12

% of HH utilizers with an ED visit during the quarter



% of HH utilizers with an Inpatient admission during the quarter



	Q1 '11	Q2 '11	Q3 '11	Q4 '11	Q1 '12	Q2 '12	Q3 '12	Q4 '12
% Hospitalized	13.44%	14.51%	14.39%	13.99%	16.29%	15.78%	15.61%	14.10%

*Number above the bar reflects the total number of home health participants per quarter

Clinical Bypass Programs

- Shortens administrative time spent reviewing the care of individuals with routine needs, frees up time for challenging situations that require additional consultation/support
- Programs currently in place for Adult & Child Hospitals and IICAPS providers
- Current Eligibility Criteria:
    - Length of Stay
    - Readmission Rate within 7 days
- Moving to Case-Mix Adjusted performance targets for Adult Inpatient Hospitals

Clinical Studies

Annually:

- Two Adult clinical studies
- One Youth clinical study

Studies frequently continue over several years

Examples of studies conducted:

Disruption rates of youth in foster care

Improvement in rate of follow-up for youth in foster care identified as needing behavioral health services

Autism Feasibility Project

Clinical Studies: IOP Services

Adult study ongoing since 2012

During 2012:

- Developed claims-based reports to identify intensity and duration of use of Intensive Outpatient (IOP) services
- Integrated DSS Medicaid claims data with DMHAS funded service and episode data sets (provider reported) to capture all IOP treatment
- Integrated DMHAS National Outcomes Measurement data with claims data to move towards ability to measure outcomes
- Identified patterns of utilization

Early Findings

What happens to IOP utilizers following treatment?
Within 180 days of discharge from IOP:

- Slightly more than 10% received no further treatment
- Of those who received further treatment:
  - 64.0% received outpatient treatment
  - 21.1% received an intermediate level of care treatment
  - 14.9% were admitted to a higher LOC

Readmission to IOP treatment:

- 61.9% had no readmissions to IOP
- Of those readmitted to IOP:
  - 2.6% were readmitted to IOP within 7 days
  - 14.0% were readmitted to IOP between 8-30 days
  - 12.4% were readmitted between 31-90 days
  - 9.0% were readmitted between 91-180 days

IOP Study Next Steps

- Nearly 25% of the episodes of IOP were for 3 or fewer visits;
  - Need to determine what level of intensity and duration of services constitutes IOP treatment
  - Examine the relationship between number of IOP visits and the next treatment received and readmission rate
- Move to multivariate analyses of predictors of use and outcome of IOP treatment
  - This will allow us to examine the relationships between characteristics of the individuals using IOP services and patterns of utilization and outcomes

Intensive Case Management (ICM) Pilot Programs

Historically, the ICM model has been a“brokering” model

- ICM works with providers and state agencies to facilitate discharge planning and connection to the next level of care
- ICM authorizes needed care for individuals
- ICM facilitates crisis prevention planning
- Peers work directly with individuals

ICM Broker Model Impact on Youth

Youth with an ICM assignment had **18.6% more days in a confined setting** during the 6 months following assignment than they did before ICM assignment.

They spent:

- 77.8% **fewer days in Acute Care Inpatient** facilities in the 6 months following assignment and
- 21.1% **more days in Solnit** (State Hospital for CT youth) in the 6 months following assignment
- 58.4% **more days in Psychiatric Residential Treatment Facilities** (PRTF) in the 6 months following assignment
- 189.3% **more days in Residential Treatment Care** in the 6 months following assignment
- The findings are positive in that youth identified for the program were historically “stuck” and not receiving the care that was needed for on going stability

ICM Broker Model Impact on Adults

Adults with an ICM assignment had **72.7% fewer days in a confined setting and 10.5% more days in the community** during the 6 months following assignment than they did before ICM assignment. They spent:

- 73.5% **fewer days in Inpatient** facilities in the 6 months following assignment and
- 69.2% **fewer days in Inpatient Detox** facilities in the 6 months following assignment
- The average length of stay for Inpatient days prior to the ICM assignment was 9.02 days compared to 7.53 days post the ICM assignment
- The range of Inpatient days prior to the ICM assignment was 2 to 92 days compared to 1 to 50 days post the ICM assignment
- The findings are positive in that adults referred to the ICM program came from a variety of sources and were identified as not effectively utilizing community resources

ICM Pilot Projects Underway

St. Francis Hospital: Face to Face Model involving an ICM and a Peer

Goal: Improve connect-to-care following discharge, decrease readmission rates

Home Health Pilot Project: Face to Face Model involving an ICM and a Peer

Goal: Decrease frequency of medication administration visits, connect individuals to community services, social groups

Questions/Comments