2016

DMHAS Psychiatric Services Study Report

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Introduction

In Section 356 of Public Act 15-5 of the June Special Session, the Connecticut Legislature directed the Connecticut Department of Mental Health and Addiction Services (DMHAS) to study the adequacy of psychiatric services in the state, in collaboration with other state agencies, hospitals, providers, and other stakeholders, and ultimately submit a report to the Legislature by January 1, 2017. Legislators requested that this report examine inpatient and outpatient services, as well as make recommendations regarding state needs, costs, and funding sources for services in the adult and child mental health systems. Based on this legislative charge, this report focuses solely on mental health services within the state.

The impetus for the legislative mandate grew out of ongoing concerns that have been the focus of study in Connecticut over the past ten to fifteen years. Various reports in Connecticut have identified inadequate inpatient services for children and adults, gaps in high intensity community services, and fragmentation related to mental health funding and service delivery in Connecticut. These concerns have previously been documented in the Connecticut Blue Ribbon Commission on Mental Health (2000), Mental Health Transformation Report, and the Office of Health Care Access' Report to Examine Hospital Inpatient Behavioral Health Bed Capacity for Children (2006). Issues identified in these Connecticut reports often mirrored those that have been observed on the national level.

This report examines how the system can better manage current psychiatric beds and looks at what community resources are essential to lessening the demand for inpatient services. A comprehensive community system that has a broad range of services to divert individuals from inpatient care coupled with a broad spectrum of discharge options is essential to addressing deficiencies in the system. The demand for inpatient care is integrally linked to the strength of the community system.

Information in this report has been gathered from a broad range of stakeholders. DMHAS was informed by statewide forums that have been held with providers, advocates, and family members over the past year. Regional focus groups have been held with providers as the state has grappled with budget cuts and the need for system redesign and innovation. Regional planning groups contributed to the report by formally surveying their communities and provided valuable information regarding mental health needs that are of local and statewide concern. The Connecticut Hospital Association, through their behavioral health leadership, provided information about the contributions hospitals make along with their observations about system needs. The report incorporated information from a number of state agencies including the Department of Children and Families, the Department of Public Health and their Office of Health Care Access, and the Department of Social Services.

The data presented in this report include a range of information related to Connecticut's mental health service system, and provide a core set of facts about the system. The report includes data about inpatient and residential bed capacity in Connecticut; diversionary services, such as crisis and respite programs; and, additional community services including Assertive Community Treatment (ACT) and similar programs. Connecticut has a long tradition focused on recovery and a life in the community.

The report is being prepared against a backdrop of significant changes on the national and state level that are likely to influence mental health funding and service delivery. The recent Presidential election may bring changes to Medicaid as the nation grapples with universal health care. On the state level, Connecticut's new economic reality is forcing state agencies to rethink their missions and critical priorities. In light of this backdrop most of the report findings and recommendations are focused on better managing existing resources

and the development of low cost innovations that can address issues identified in this report. A small number of recommendations will be presented which can only be implemented if new funding is identified in the future.

Background and National Trends in Mental Health Service Delivery

The publicly funded mental health system across the country has been undergoing significant transition. A number of factors have been influencing the national and state landscapes. The Great Recession, introduction of the Affordable Care Act, mental health parity, and continued reductions in publicly funded inpatient psychiatric beds are just some of the factors impacting mental health service delivery across the country. The Great Recession has caused huge deficits in many states which have led to reductions in the mental health service delivery system. At the same time the Affordable Care Act (ACA) and mental health parity are expected to increase the number of individuals who now have insurance or have more equitable mental health benefits making them more likely to seek out treatment. Those factors are more recent in nature but others, such as deinstitutionalization, began many years ago and have continued to impact the present.

Various groups have highlighted the reductions in publicly funded inpatient psychiatric beds. The Treatment Advocacy Center (TAC) in a 2012 report titled "*No Room at the Inn*" (Fuller et al.) and an updated 2016 report *Going, Going, Gone* (Fuller et al.) described these reductions and the impact they were having on mental health systems across the country. The TAC 2016 report indicated that publicly funded beds had decreased from a high of 337 beds per 100,000 population in the 1950's to 11.7 beds per 100,000 in 2016 (Fuller et al. 2016 p.2) While there may be some disagreements about the precise numbers, what cannot be disputed is the fact that publicly funded inpatient psychiatric beds have reduced dramatically over the past six decades. The TAC report shows that the trend has continued since 2010 when data was first gathered for their report. They recently reported that approximately 6,000 additional publicly funded beds had been lost since 2010. (Fuller et al 2016 p.7). It is interesting to note that this report showed that Connecticut had the 6th highest bed per capita rate in the country at 17 beds per 100,000 people.

Various studies have shown that several factors have influenced this trend. The original impetus came from the deinstitutionalization movement which accurately advocated that many people who were being "warehoused" in state hospitals could live and flourish in the community. However, the success of deinstitutionalization is closely tied to the degree to which states invest in community support services. A comprehensive community mental health system that includes residential, diversionary services and intensive supports like assertive community treatment, and medication management are necessary ingredients if individuals are to successfully recover in the community. Many states that have closed psychiatric hospitals have not re-invested these savings back into community services. Even in states where there may have been significant investment in community mental health services, the Great Recession has led to major cuts in state general funds devoted to behavioral health as states have dealt with containing severe budget shortfalls. The slow financial recovery in many states is placing additional pressure on community mental health services.

At the same time, many states across the country have seen their remaining general psychiatric beds eroded by increased demand for forensic inpatient psychiatric services. The TAC reports that approximately half of the 11.7 beds per 100,000 populations are now occupied by forensic patients (Fuller et al 2016 p.2). While the degree to which forensic beds have eroded beds that were allocated for the civil population has not been precisely quantified, it is clear that in many states the demand for forensic beds has had a major impact on bed availability. The reductions in bed capacity and increased forensic demand have led states to create wait lists for inpatient psychiatric services. States have reported that this increases the number of individuals who are waiting in hospital Emergency Departments (ED's), on community inpatient units, or in jails. Severe budget shortfalls, reduced or eroded bed capacity, and reductions in community mental health support services have led many to

question the adequacy of our mental health services. The most recent TAC report describes a phenomenon called Emergency Department (ED) Boarding where ED's will hold difficult patients in the ED even if a bed is available on a hospital's psychiatric unit. This is done to pressure state authorities to admit these patients. While the degree to which this may be happening in Connecticut has not been quantified, it is likely that this is occurring here as well. The ED Boarding may be used when no reimbursement exists or hospitals fear that patients fall into one of the difficult to discharge categories described below. Another phenomenon has been observed on the national level. Geller and others have written that many hospitals now retain a group of difficult to discharge patients. (Fisher, Geller, Pandiani 2009) Geller referenced a Massachusetts study conducted in 2008 which found that a number of patients had significant discharge barriers including complex medical conditions, inappropriate behaviors difficult to manage in the community, and problematic sexual behaviors that may place patients and others in the community at risk (Meyerhoff, Smith, Schieffer 2008). Geller's article separately described how many correctional systems recognized that certain inmates remained sexually dangerous even after completing their sentences. Certain states have committed these individuals to psychiatric hospitals as a means of protecting the public after completion of their sentence. These individuals are then becoming part of a long-stay population with significant discharge barriers (Fisher, Geller, Pandiani, 2009). This phenomenon is important because over time, these complex patients place increasing pressure on existing psychiatric beds. If one assumes that each year the number of these individuals grows, this means a smaller portion of beds are turning over each year, further reducing available bed capacity.

One final factor relates to the fragmentation that exists within the mental health service delivery system. Multiple public and private funding streams finance mental health. The funding array includes Medicare and Medicaid, Federal Block Grants, State General Funds, and private insurance. Consumers often have to navigate an array of state and local providers with differing eligibility criteria. Supportive services that are essential for recovery like housing and employment may operate in separate bureaucracies, further complicating the coordination of care for persons with mental illness. Financial benefits that may be available to persons with mental illness like Social Security Disability Income (SSDI) or Aid to Families with Dependent Children sit under different state or federal agencies as well.

Interestingly, many of the national trends that have been described have not been observed in Connecticut. Connecticut has not seen large reductions in state-operated bed capacity nor has Connecticut seen beds eroded significantly as a result of increased forensic demands. Factors that have been evident in Connecticut will be discussed below.

Trends Influencing Connecticut's Mental Health System

The Connecticut Legislature's charge to evaluate the adequacy of our mental health services was prompted in part, by factors in Connecticut that were similar to those identified on the national level. At various times in the last 20 years, Connecticut has studied mental health service delivery. This has included the Connecticut Blue Ribbon Commission on Mental Health (2000) and the more recently the Mental Health Transformation Initiative which was funded from 2005 through 2010 sought to build on recommendations of the New Freedom Commission Report. Some of the national trends described earlier were reported in these earlier studies.

Deinstitutionalization and Reductions in Publicly Funded Psychiatric Beds

Connecticut has long been a leader in the deinstitutionalization movement. Like much of the country, Connecticut had large numbers of persons with mental illness housed in state hospitals. In the early 1950's, Connecticut had over 9,000 individuals residing in three large state hospitals; Connecticut Valley Hospital,

Fairfield Hills, and Norwich State Hospital. During the 60's and 70's state hospital populations began to decline. In the early 1980's Governor O'Neill's Blue Ribbon Commission on Mental Health served as an impetus for the development of a community support system. This began the most extensive period of community mental health service development for adults in Connecticut history. Dozens of new programs were established including case management, psychosocial rehabilitation, vocational, emergency crisis intervention and residential programs. DMHAS' predecessor agency, the Department of Mental Health (DMH) established a statewide network of Local Mental Health Authorities (LMHAs) that had clinical and administrative accountability for the care of all poor people with serious psychiatric disabilities within a geographic area. (Connecticut Blue Ribbon Commission on Mental Health 2000)

By the mid-1990s, the community system was considered to be sufficiently strong to permit closure of two of Connecticut's three large state-operated psychiatric hospitals. Following the national trend to shut down these facilities, Fairfield Hills Hospital closed in 1995, followed by Norwich Hospital in 1996. Concurrently, a variety of new community programs were established specifically for the patients being discharged. Others were expanded. The state contracted with several general hospitals and a private psychiatric hospital for acute inpatient psychiatric services. Some patients who could not be placed in community programs were transferred to Connecticut Valley Hospital (CVH), which expanded its bed capacity to accommodate them.

Most recently, Connecticut closed Cedar Ridge Hospital in July 2010. Cedar Ridge was serving approximately 100 patients before the closure. The closure resulted in a net loss of approximately 20 beds as some patients were transferred to CVH, beds were increased at Greater Bridgeport, and intermediate beds were purchased at St. Vincent's Hospital in Bridgeport. Today's state-operated bed capacity is the same as it was in 1997, 550 beds. Unlike other states, Connecticut has not seen significant bed reductions over the past 20 years.

Forensics and Bed Availability

Connecticut also differs from national trends in that beds for civil patients have not been significantly eroded by increased demand for inpatient forensic psychiatric services. In 1997 Connecticut had 213 forensic beds and currently has 232 of these beds, a 10 % increase. During the period from 1997 to the present, bed capacity for forensics has fluctuated rising at one point to 269 in 2001 and then dipping to the current capacity of 232. However, forensic patients that are referred for competency evaluations do compete for beds that may be reserved for civil patients. This occurs when a patient is found to be incompetent and non-restorable. These patients may be evaluated in a community setting but then require hospitalization, ultimately becoming civil patients. These patients then compete for available beds within the state system. In the past year, Community Forensics staff have conducted a record number of community evaluations, between 550 and 600 last year. It is estimated that approximately 200 of these patients who were evaluated in the community will require an inpatient bed and cannot be diverted. A portion of these patients will be found to be incompetent and non-restorable.

Forensic patients impact bed availability because certain forensic patients require a lengthy discharge process. A number of forensic patients at CVH are under the jurisdiction of the state's Psychiatric Security Review Board (PSRB). These are individuals that have been found "Not Guilty by Reason of Insanity" (NGRI). The discharge plans for these patients often moves slowly in increments as the PSRB must monitor, review and approve discharge plans. Individuals that are found to be NGRI may have prolonged periods of transition as the patient gradually increases their time in the community. The normal route may include day visits to a program, overnight visitations that increase over time, and finally discharge and community placement which could unfold over a period of a year or longer. Patients under the jurisdiction of the PSRB often face community barriers because their discharge plans are available to the public and communities often oppose discharges to their communities that involve PSRB patients. Communities are often concerned about risks associated with

these clients. The community opposition may delay these transitions resulting in fewer beds being available for new admissions.

Access to State Beds and Wait List

While bed capacity has not changed significantly, it can be difficult for private hospital psychiatric units and emergency departments to access state beds for patients who may require longer-term care. Connecticut has maintained a wait list for a number of years in order to track and prioritize requests for state-operated beds. Private hospitals refer those individuals that they believe will require a state bed, and DMHAS records and tracks the information until the patient is either accepted to a state bed or has an alternative disposition. While the clinical profile of who is referred to the wait list varies, these individuals often lack insurance or may not meet medical necessity criteria, may have histories of violent or criminal behavior, and may have serious medical conditions in addition to serious mental illness. Hospitals may have some familiarity with these individuals and may perceive that significant discharge barriers exist. The average wait time for a state bed has increased significantly over the past 5 years, increasing from an average wait of 18 days in FY 12 to 27 days in FY 16. The wait list will be discussed later in the report, but there are individuals who wait in a lower level of clinical care then needed for a state bed to become available.

Current Economic Climate and Access to Community Services

Hospitals also express that they are unable to access community services that might divert individuals from inpatient stays or reduce the lengths of stay. This issue is one that may become more critical in the next several years as grants provided to community mental health services are reduced as a result of declining state revenues and increased deficits.

State agencies have been evaluating how they will manage significant budget reductions and have been involved in processes to clarify essential core services. These potential cuts would likely have some impact on diversionary services like crisis or respite and they may also impact what services are available to support discharge or step-down from inpatient psychiatric care.

Affordable Care Act and Medicaid Expansion

Mental health and substance abuse services in Connecticut have been heavily influenced by the implementation of the Affordable Care Act (ACA). Connecticut was among the first states to create a state option to provide coverage to childless adults with incomes of 133% of the federal poverty level (FPL). These individuals were previously receiving a Medicaid-like benefit through the State Administered General Assistance (SAGA) Program. They became eligible for Medicaid in April 2010 and the program was called the Low Income Adults (LIA) program. Effective January 1, 2014, Connecticut took advantage of Medicaid expansion. At that time, Connecticut expanded Medicaid to all individuals not eligible for Medicare under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 138% FPL. The state was eligible for enhanced federal matching payments for these newly eligible beneficiaries. These changes, along with the implementation of Connecticut's Health Exchange, Access Health CT, expanded the number of individuals who were eligible for Medicaid or subsidies through the Health Exchange. Access Health CT has been instrumental in reducing the number of individuals in Connecticut who were uninsured. It was estimated in September 2015 that approximately 137,000 individuals were uninsured in Connecticut, approximately 4% of the state's population.

The Medicaid expansion under ACA means that more Connecticut residents are covered by insurance and therefore eligible for mental health and substance abuse services. While the increased coverage is good for Connecticut citizens, this may place increased pressure on providers within the state as mental health and substance abuse services become more accessible. It is important to recognize that the recent election may destabilize the mental health and substance abuse system. While some aspects of the ACA may remain, the

elimination of ACA has the potential to increase the number of uninsured in the state making increased numbers more dependent on the state's safety net at a time when Connecticut's economy is incapable of paying for service needs that were previously covered by Medicaid.

Overview of the Connecticut's Mental Health Service System

Mental health services in Connecticut are delivered or managed by a number of state agencies. The Departments of Social Services (DSS), Children and Families (DCF), Correction (DOC), Mental Health and Addiction Services (DMHAS), and the Court Support Services Division (CSSD) all have some role in mental health service delivery. The state's mental health authority is DMHAS. Children's mental health services are managed by the Department of Children and Families. DSS is the state's Medicaid authority and they manage the behavioral health aspects of that program in collaboration with DMHAS and DCF. Each of the other entities listed above have specific target populations such as inmates, or those persons that are court involved.

The Department of Mental Health and Addiction Services (DMHAS) promotes and administers comprehensive, recovery-oriented services in the areas of mental health treatment and substance abuse prevention and treatment throughout Connecticut. The mission of the Department of Mental Health and Addiction Services (DMHAS) is to improve the quality of life for Connecticut residents by providing an integrated network of comprehensive, effective and efficient mental health and addiction services that foster self-sufficiency, dignity and respect. The Department has a budget of approximately $700 million, employs over 3,200 staff statewide, and treats over 110,000 Connecticut citizens annually in both our mental health and addiction service system. When one considers solely the mental health portion of the DMHAS service system, over 57,000 unduplicated clients were served in the DMHAS mental health treatment system in FY 16.

While the Department's prevention services are available to all Connecticut citizens, its mandate is to serve adults (over 18 years of age) with psychiatric or substance use disorders, or both, who lack the financial means to obtain such services on their own. The Department manages a comprehensive array of state-operated or funded mental health and addiction treatment services. DMHAS also provides collaborative programs for individuals with special needs, such as persons with HIV/AIDS infection, people in the criminal justice system, those with problem gambling disorders, pregnant women using substances, persons with traumatic brain injury or hearing impairment, those with co-occurring substance abuse and mental illness, and special populations transitioning out of the Department of Children and Families. The Department has also developed programs with other state agencies through collaborative contracting mechanisms.

DMHAS is the mental health and substance abuse authority for the state of Connecticut. The agency operates six Local Mental Health Authorities (LMHAs) and funds seven others operated by private non-profit agencies. These LMHA's are responsible for coordinating mental health care for individuals residing in these communities. Each LMHA manages a comprehensive community mental health system that includes a broad spectrum of services including crisis and respite, jail diversion, a range of residential programs, medication management and outpatient counseling, and specialized housing and employment services. Over 100 providers deliver mental health services through DMHAS' funded or operated mental health system.

Certain services in the DMHAS mental health system are especially relevant to this study. This includes inpatient, residential, diversionary services, and intensive community supports. Most of the services that DMHAS "purchases" through grants are services that are not reimbursable meaning Medicaid, Medicare, and other insurers do not include these services in their core benefit packages. This includes inpatient services, residential, mobile crisis and respite, intensive case management and recovery support services focused on employment and housing. The Department operates four inpatient psychiatric treatment facilities with an overall

capacity of approximately 550 psychiatric beds. Just over 230 of these beds are allocated for the forensic population at Connecticut Valley Hospital. Inpatient and substance abuse residential programs are provided in Hartford and in Middletown. DMHAS also contracts with two private hospitals for intermediate level of care beds. These beds are located at 4 hospital locations in Hartford, Bridgeport, New Haven, and Middletown. Several of these facilities provide transitional units, high intensity residential services for individuals that no longer meet the criteria for inpatient care, but still require a high degree of staff supervision and structure.

Diversionary services are a critical component in a mental health system. This typically refers to programs like mobile crisis, brief care and respite, and jail diversion. These services are designed to intervene, often in an emergency, in order to evaluate and rapidly treat an individual in order to divert them from inpatient hospitalization. Respite programs offer short-term beds, supervision, and supportive programming in an effort to stabilize an individual whose psychiatric condition may be deteriorating. Jail diversion programs operate in a similar manner, but are focused on individuals that have been arrested. These programs are designed to divert persons with mental illness from the criminal justice system. While not specifically focused on diverting individuals from hospitalization, diversion from criminal justice into a range of community support helps to maintain these individuals in the community.

Residential services are critically needed services when a patient is ready to be returned to the community. They are also essential supports for those individuals that require a high degree of structure in order to be maintained in the community. DMHAS offers a comprehensive array of residential options with varying degrees of supervision and support. This continuum includes group homes, intensive residential programs, supervised apartments, and case management supports for individuals that are living within scattered site apartments in the community.

Connecticut's mental health services for children are managed and delivered through another state agency, the Department of Children and Families (DCF). Issues related to children' services will be discussed in a separate section of the report.

DMHAS has also developed a unique interagency collaboration with the Departments of Social Services and Correction and the Office of Policy and Management to develop a contract with a privately operated nursing home that would accept referrals for individuals who met nursing home level of care but were difficult to place because of past risky behaviors. 60 West began accepting patients in April 2013 and currently serves over 70 patients. This creative venture has allowed DMHAS to discharge or divert patients from inpatient settings to a more appropriate level of care thus freeing up beds in the state-run hospital system.

The DOC provides behavioral health services to inmates through the UCONN Health Center's Correctional Managed Health Care (CMHC). Their 2016 annual report (UCONN Health Correctional Managed Health Care Annual Report, July 1, 2015) indicates that the CMHC provides Connecticut's inmate population with comprehensive mental health assessment and treatment modalities. The annual report indicated that CMHC social workers, psychologists, and psychiatric nurse clinicians provided over 187,000 visits that included 20,579 suicide assessments. There were almost 20,000 visits to psychiatrists and almost 18,000 to Advanced Practice Registered Nurses. Fifteen DOC facilities provide outpatient mental health services; ten of the fifteen correctional facilities have inpatient mental health infirmaries; four facilities offer supportive congregate housing; six facilities offer specialized sex offender services including York Correctional Institution for women. The mental health department is comprised of 10 Psychiatrists, 14 Psychologists, 7 mental health Nurse Practitioners, 64 Social Workers, and 20 Professional Counselors (as of June 2016).

Mental Health needs of veterans in Connecticut are served through the Connecticut Veteran's Administration Healthcare system in West Haven.

DSS and Medicaid and Affordable Care Act in CT

Medicaid is one of the largest funders of mental health services in Connecticut. The state's Medicaid authority, DSS, funds a range of mental health services including Outpatient, Intensive Outpatient, Partial Hospitalization and Inpatient services. In addition to the core services offered under the state's Medicaid program, DSS collaborates with DMHAS to provide specialized services under several Medicaid waivers including the Home and Community Based Waiver (HCB), the Acquired Brain Injury (ABI) Waiver, and Medicaid Rehab Option (MRO) Group Home program. The MRO Group Home Program provides reimbursement to private providers that are offering intensive residential services to Medicaid eligible clients.

The CT Behavioral Health Partnership (BHP) is a Partnership that consists of the Department of Children and Families (DCF), the Department of Social Services (DSS), the Department of Mental Health and Addiction Services (DMHAS), Beacon Health Options and a legislatively mandated Oversight Council. Expanded in 2011 to include DMHAS, the contract is designed to create an integrated behavioral health service system for our members: Connecticut's Medicaid populations, including children, families, and childless adults who are enrolled in HUSKY Health and DCF Limited Benefit programs.

DSS and DMHAS have collaborated to provide targeted case management services (TCM) and most recently DMHAS has implemented Behavioral Health Homes (BHH), an innovative program designed to better integrate behavioral health and physical health. Fourteen providers offer integrated care to high-need individuals within these agencies. TCM and BHH services are delivered by providers in the DMHAS system and qualify for Medicaid reimbursement which returns to the state's General Fund, unlike other Medicaid covered services where providers directly receive payment for the service they provide.

Financing of Mental Health Services in Connecticut

Public mental health services are financed through a number of mechanisms that include state, federal, and private funding. These sources including state General Fund appropriations, Medicaid, Medicare, commercial insurance and federal grants. The state's General Funds support a comprehensive array of mental health programs in DMHAS, DCF, the Department of Correction, and in the Court Support Services Division of the Judicial Branch. In addition, municipalities support mental health services (e.g., school social workers or school psychologists) in local school systems. DMHAS and DCF also receive funding from the federal government in the form of block grants. The largest block grant is the Community Mental Health Services Block Grant which provides Connecticut more than $4.5 million per year. Federal funding also supports services that are administered by the Veteran's Administration.

Many community services in Connecticut are funded through state general funds, typically through grants to mental health providers within the state. These grants support a comprehensive array of community services including mobile crisis, respite, residential, assertive community treatment, case management, social rehabilitation, and a variety of employment and housing supports. DMHAS grant dollars largely support services that cannot be reimbursed by Medicaid or Medicare. These services are augmented by Medicaid funding for mental health services, including Outpatient, Intensive Outpatient, and Partial Hospitalization. DSS currently funds these services using a fee-for service methodology. Qualified providers receive a fee for the service they provide.

There was a significant change made to the way inpatient psychiatric services were reimbursed by Medicaid in 2015. Prior to that time, inpatient psychiatric services were paid for through a complicated reconciliation

process. Based on that methodology, general hospitals complained that they would lose money if patients had lengths of stay in excess of approximately 15 days. It was believed that hospitals would avoid admitting patients that might surpass that length of stay and instead refer those patients to a state bed. Beginning in January 2015, DSS established per diem rates for any hospitals in Connecticut that provided inpatient psychiatric services. They no longer use the reconciliation process and general hospitals receive payment for each day of service provided the patient meets medical necessity criteria. While this change has been beneficial to private hospitals, there are some clients who are admitted for inpatient psychiatric services and at some point no longer meet medical necessity criteria and cannot be discharged for any number of reasons. This places the hospitals in the position of bearing the cost for these patients. This concept of medical necessity governs the quantity and length of treatment for outpatient and inpatient services.

DMHAS funds inpatient psychiatric services, acting as the payor of last resort for the needy individuals in the State. Where possible, DMHAS bills insurers for these services. However, federal law makes many of the individuals served within the state hospital ineligible for reimbursement due to what is called the IMD exclusion. The Medicaid Institutions for Mental Diseases (IMD) prohibits the use of Medicaid funds for care provided in mental health facilities larger than 16 beds. This Medicaid exclusion was originally put in place as a means to reinforce the state's role as the primary payor for inpatient mental health services. DMHAS does receive funding for the "disproportionate share" of the Medicaid and uninsured patients they serve in their inpatient facilities. These disproportionate share payments provide DMHAS with approximately $70 million in funding for the care of these individuals that are under the IMD exclusion.

DMHAS contracts with several hospitals for intermediate care beds for those individuals that may require care for lengths of stay between1 to 90 days. St. Vincent's Hospital receives funding annually which is expected to support individuals that are uninsured or do not meet medical necessity criteria. DMHAS also funds 3 beds at Natchaug Hospital. This contract was developed after the closing of Norwich Hospital and was intended to provide community beds in that area. Similarly, St. Vincent's contract was initiated after the consolidation of Cedar Ridge Hospital in 2011. While most of the Cedar Ridge beds were consolidated at CVH or Greater Bridgeport, some additional bed capacity was purchased through this contract.

State-Operated Inpatient Services in New England

When evaluating the adequacy of Connecticut's bed capacity, it is important to evaluate how Connecticut compares to the rest of the country and other New England states. A similar study which was conducted several years ago in Colorado (NRI, Inc. et.al.,2015) compared that state's per capita bed rate (per 100,000 citizens) to an "average" of a grouping of Western states. These rates were calculated to determine if Colorado exceeded this average. That study then presented information about the number of beds needed to equal that average and the costs associated with building those beds. A per capita bed rate is developed by calculating the total number of beds that are operated by the state and dividing them by the state's census. That number is then multiplied by 100,000 in order to determine the bed rate per 100,000 population.

Interestingly, the literature on this topic does not contain any scientifically validated information about what is considered to be the appropriate per capita bed rate to effectively manage demand for publicly run inpatient psychiatric beds. The TAC Report "No Room at the Inn" (Fuller et al), developed a benchmark through a consensus group of psychiatrists. They concluded that a state needed 50 beds per 100,000 citizens but this estimate has never been tested or more thoroughly researched. At the time of their first study in 2012 the national per capita bed rate was 14.1. One state had a per capita bed rate of 39 but no other state in the country had more than 29 beds per 100,000 population. Connecticut ranked tenth in the country in that report. An

update to that report shows that Connecticut has the sixth highest per capita bed rate in the country with 17 beds, still far below the benchmark of 50 set by TAC.

The tables below show how Connecticut compares to the other New England states. The tables show the per capita beds rates by using information supplied to DMHAS by each of the New England states. A simple survey was sent to all of the New England states in 2016 asking them to confirm the number of beds they operate and the number of replacement beds they contract for with private hospitals. The states were also asked to further specify the number of beds allocated for forensic patients and the number of beds specifically allocated for children. They were also asked to specify if oversight of forensic patients was managed by the state mental health authority or by another state agency such as Department of Corrections.

It is often difficult to normalize data between states because some state mental health authorities operate forensic beds and others have those beds managed by the state's Department of Correction (DOC). This is true in New England where several states have forensic beds which are managed by DOC. Massachusetts and New Hampshire follow that model. Connecticut has forensic beds which are managed by the state's mental health authority and Maine has a hybrid model where some beds fall under the state's mental health authority and some beds actually are managed by the state DOC. Vermont does not specifically set aside beds for forensics but any of their state-run or contracted beds can be used for forensic patients. No data was available for Rhode Island.

Table 1 below shows the data in two ways. One column looks solely at those beds that are under the direct management and control of the state's mental health authority and then builds a per capita rate using that state's civilian census for 2015. A second column in the table adds in the forensic beds that are run by DOC. Connecticut surpasses the New England per capita bed rate by almost 4 beds (17 to 12.8) when just looking at beds under the authority of the state mental health agency. When the forensic beds that are managed under DOC are added in, Connecticut still surpasses the New England average, but by a smaller margin, approximately 2.5 beds (17 to 15.4). Connecticut's per capita bed rate is still well below the rate put forth by TAC. Based on a population of approximately 3.5 million, Connecticut would need to create an additional 1,100 beds in order to meet the bed rates recommended by the TAC. New England as a whole would have to develop over 7,300 new beds in order to meet this threshold of 50 beds per 100,000 populations.

Table 1: New England State Operated/Funded Beds

	State Operated/ Funded Beds	State Operated/ Funded Beds + DOC Beds	CIV15 Census	Per-Capita Rates (beds/100,000)	
				State Op/Fund Beds	State Op/Fund Beds + DOC Beds
Connecticut	611	611	3,583,582	17	17
Maine	156	180	1,328,185	11.7	13.6
Massachusetts	696	1,005	6,789,446	10.3	14.8
New Hampshire	198	238	1,328,991	14.9	17.9
Rhode Island[1]	140	140	1,052,056	13.3	13.3
Vermont	84	84	625,462	13.4	13.4
New England:	1,885	2,258	14,707,722	12.8	15.4

[1] Rhode Island figures taken from FY14 URS tables.

Overview of Connecticut's Inpatient Services

Inpatient psychiatric services in Connecticut are provided through 4 state hospitals, psychiatric units in 23 general hospitals across the state, and in 3 free-standing specialty hospitals which the Office of Health Care Access (OHCA) labels as "Hospitals for Mentally Ill Persons". The total inpatient psychiatric bed capacity in Connecticut is 1,570 with approximately 162 of those beds focused on children. DMHAS manages state-operated psychiatric beds; it also purchases additional bed capacity at several private hospitals across the state. These private beds fill a need for intermediate level psychiatric treatment, while the state-operated beds are more typically focused on patients requiring longer lengths of stay. The role of the state hospital has been to provide services to persons that are inappropriate for other private inpatient options. This may have to do with behavioral considerations, lack of viable insurance payments, or individuals that are likely to require long lengths of stay that are not typically accommodated in the community. Another primary role for Connecticut's state hospitals is to serve forensic patients who are typically committed to DMHAS through court processes. Others patients that are admitted to DMHAS are civil patients that are either voluntarily or involuntarily admitted.

Data collected from OHCA shows the private hospitals in Connecticut generally serve individuals with private or public insurance that require acute stays that are of a duration of less than 10 days. DMHAS' community hospitals located in New Haven, Hartford, and Bridgeport may have provided more acute treatment in the past but recent data shows that the average length of stay at these hospitals continues to climb. These hospitals previously provided intermediate lengths of stay (0-180) days or longer, but data show that the average length of stay for all patients served within these facilities each year is now closer to 300 or more days. While some of the patients seen in acute care hospitals may have connections to the DMHAS community system, many do not and may have insurance coverage that limits community services that may be available to them. For example, many private insurance carriers will not pay for residential care or services like assertive community treatment (ACT) which may limit the discharge options available to private hospitals. Patients served within the DMHAS inpatient system are typically linked back to DMHAS' system of care and can access a range of community services funded by DMHAS. The state-operated and private psychiatric inpatient system will be examined in greater detail below.

State-Operated Inpatient Services

The state-operated inpatient services are provided at 4 facilities; Connecticut Valley Hospital (CVH) in Middletown, Greater Bridgeport Community Mental Health Center (GBCMHC) in Bridgeport, Capitol Region Mental Health Center (CRMHC) in Hartford and Connecticut Mental Health Center (CMHC) in New Haven. CVH has the largest capacity while the 3 other facilities are located in state-operated community mental health centers. These community hospitals have much smaller capacities and have historically admitted patients that would require shorter lengths of stay. They do not provide specialized services to distinct populations. The exception is the Co-Occurring Unit at Greater Bridgeport and a range of specialized inpatient services clustered at CVH. CVH has specialized units for the Geriatric, Persons with Acquired and Traumatic Brain Injuries (ABI/TBI), Young Adults and General Psychiatry. The distinct specialization of these units may limit bed availability because an individual may be discharged from one of these specialized units while an individual on the wait list may not meet criteria for that type of unit.

All forensic inpatient services are provided through the Forensic Division at CVH which has a bed capacity of 232 patients. The Forensic Division provides services to individuals who fall into the following categories:

- Psychiatric Security Review Board (PSRB) commitment
- Criminal court order for restoration of competency to stand trial

- Civil commitment (involuntary or voluntary)
- Transfers from the Department of Correction (during period of incarceration or at end of sentence)

Connecticut, like most of the country, underwent a period where hospitals were closed or consolidated. Most of this activity had ended by 1996 when Norwich Hospital was closed. Fairfield Hills Hospital was closed in 1995. Since those closures, bed capacities have changed very little in Connecticut. The one exception involved Cedar Ridge Hospital (CRH) which was closed in July 2010. At the time the decision was made to close CRH, the facility was serving approximately 100 psychiatric patients. In order to accommodate the existing need, new beds were consolidated at CVH and Greater Bridgeport; additionally, DMHAS purchased approximately 8 intermediate level beds at St. Vincent's Hospital in Bridgeport. At the time of that closure, there was a net loss of approximately 18 beds but DMHAS also developed new intensive residential programs in order to transition other patients out of the hospital.

While overall bed capacity may not have significantly decreased, many states have been impacted by an increased demand for forensic services. In those situations, beds that had been typically reserved for civil patients have been taken over by increased demand for forensic beds. The following graphs show how bed capacities have shifted over an almost 20 year period, and examine the extent to which Connecticut's beds have been impacted by forensic needs. Some beds are excluded from these graphs even though they are located at CVH and CMHC. They are excluded because they are classified as residential programs. Both facilities have programs that do not meet criteria for inpatient care but are used to transition or step-down patients who can be maintained in a less restrictive setting. These beds are shown in tables that examine residential beds in Connecticut.

State-Operated and Funded Bed Capacity

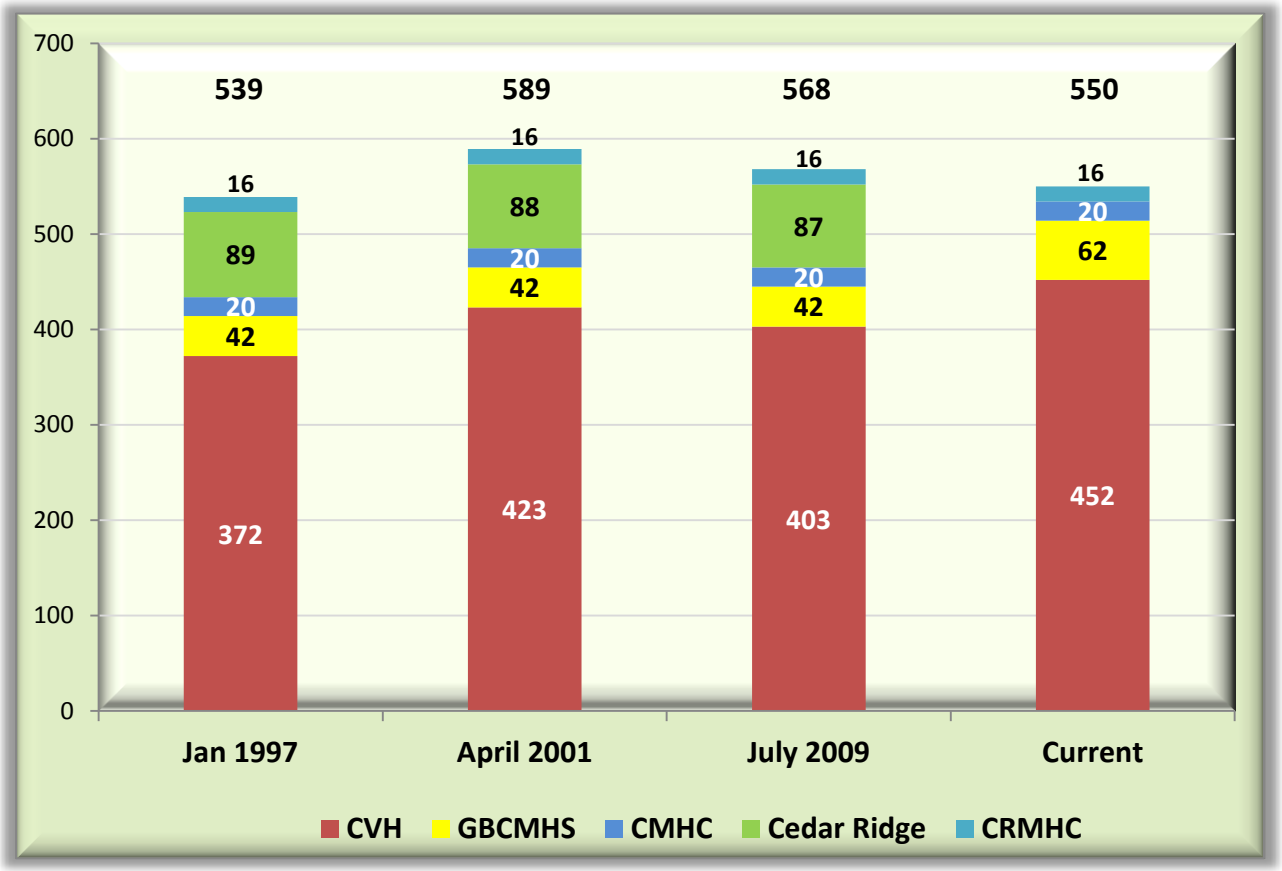

Figure 1: State Operated Inpatient Beds By Facility, 1997-2016

Figure 1 shows that the number of Connecticut state hospital inpatient beds has remained relatively constant over the past 20 years, with a net gain of 11 beds since 1997. Several of the data points selected for the Figure were used because they showed capacities just before Cedar Ridge Hospital (CRH) closed which occurred in July 2009 or just after several large state-operated psychiatric hospitals closed. Fairfield Hills and Norwich Hospitals closed in 1995 and 1996 respectively. It is important to understand that DMHAS has only included beds that meet inpatient criteria in this analysis. Certain facilities have historically had a small number of beds that were classified as residential programs. Those beds are not counted as inpatient beds. As an example, Cedar Ridge Hospital had 16 residential beds at their facility when it was closed in July 2010. After that closure, some beds were redistributed to other facilities.

An addiction treatment unit at Greater Bridgeport Community Mental Health Center became a 22 bed co-occurring unit. The current bed capacity shows that, since the closure of Cedar Ridge Hospital, beds have been increased at CVH (+49) and Greater Bridgeport Community Mental Health Center (GBCMHC) (+20). There was a slight decrease (-18) in beds following the CRH closure, which was finalized in the summer of 2010.

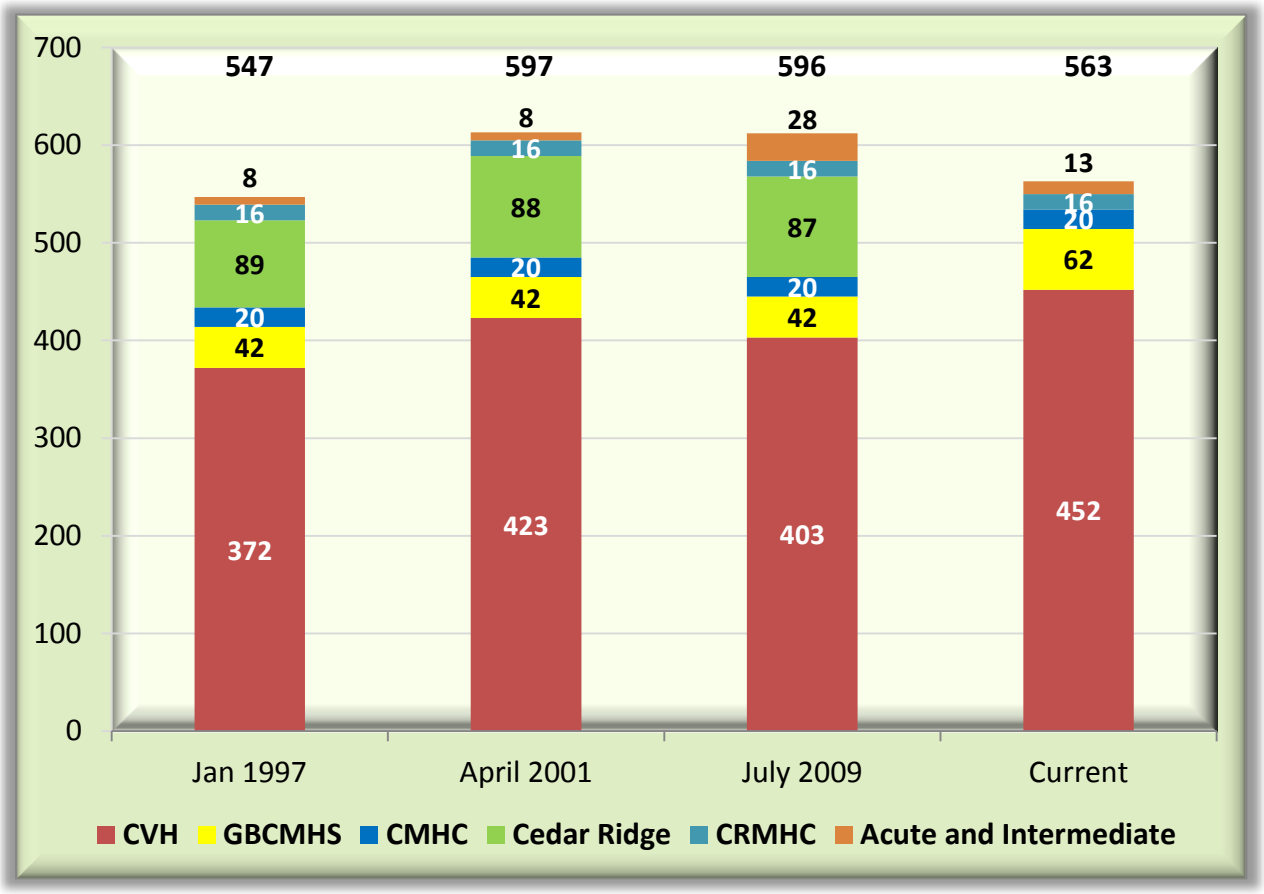

Figure 2: Acute & Intermediate Beds Including Private

Figure 2 displays state-operated acute and intermediate care beds and includes the bed capacity that DMHAS has purchased at private community hospitals. DMHAS has provided funding to hospitals across the state for acute psychiatric beds. This practice began around 2009 as way to support the hospitals that were serving State Administered General Assistance (SAGA) clients. Typically, the amount of funding per hospital has been sufficient to pay for about two beds at each location. Almost all of the acute care funding was withdrawn in July 2016 because the (SAGA) clients had become Medicaid clients under the ACA expansion. However, DMHAS continues to provide funding for intermediate care beds at Natchaug Hospital and St. Vincent's in Bridgeport. The intermediate psychiatric beds at St. Vincent's were developed after Cedar Ridge Hospital was closed.

Overall, the *capacity* of beds today has increased slightly when compared to 1997. However, there has been a slight reduction in bed *capacity* since 2009, the year when Cedar Ridge Hospital closed. The major factor for the decrease was that DMHAS withdrew the acute care funding early in FY 17. While the funding was withdrawn these beds remain at private hospitals.

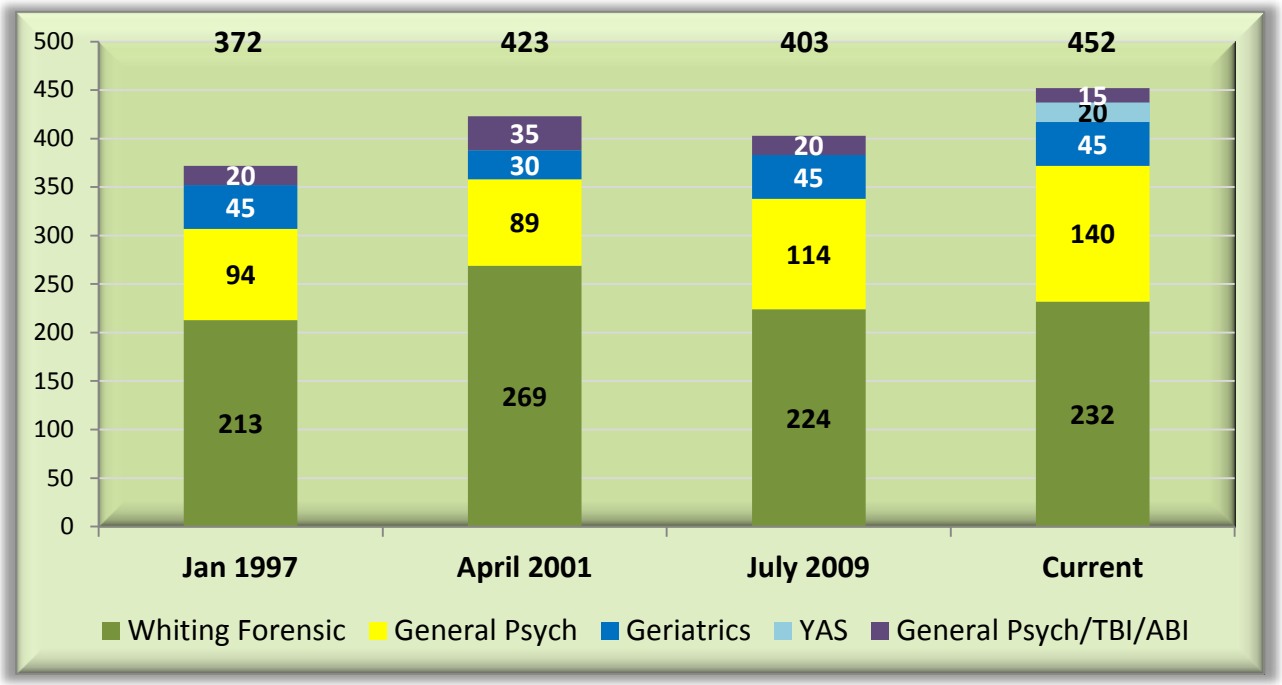

Figure 3: Total CVH Beds

Figure 3 displays bed allocation at DMHAS' largest psychiatric facility, Connecticut Valley Hospital (CVH). CVH bed capacity has increased, largely as a result of the CRH closure. The figure shows the way beds are currently configured at the facility; beds and bed availability are largely governed by allocations reserved for specific populations. CVH has certain beds focused on the general psychiatric population (no real restrictions); specific populations include young adults, forensics, geriatrics, and the acquired/traumatic brain injury population. Patient flow into CVH is influenced by the characteristics of people who are currently being discharged from CVH. Psychiatric bed availability may be restricted based on who has been discharged recently.

Additionally, Figure 4 below shows that, unlike other states, Connecticut has not seen the number of general psychiatric beds significantly eroded by increased demand for forensic beds. Over the almost 20-year period, General Psychiatric beds expanded by 8 and the Forensic Beds grew by 19 beds.

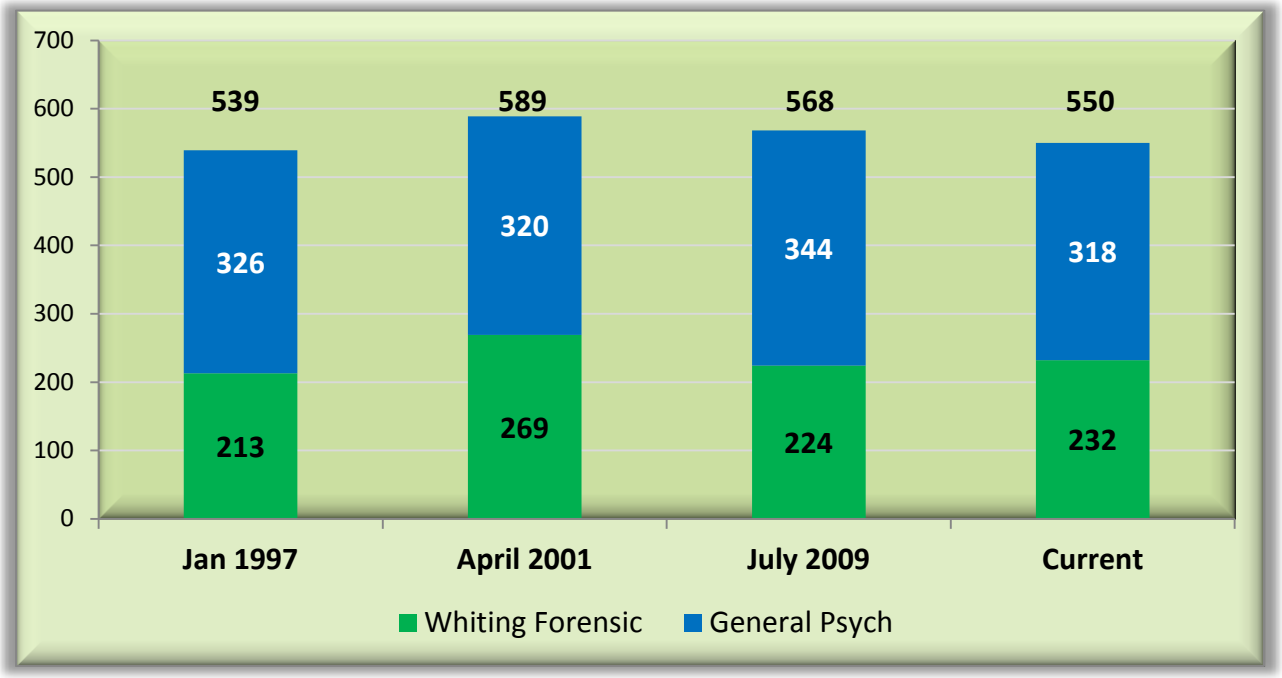

Figure 4: State Operated Beds: Forensic and General Psychiatric

Figure 4 above shows the ratio of general psychiatric beds to forensic beds over the past 20 years. Contrary to some trends seen in other states, Connecticut has not seen a conversion of beds from general psychiatric to forensic. The percentage of forensic beds compared to the total state-operated beds in the four time periods used above has remained relatively consistent. The percentage of total beds that are forensic = 40% in 1997, 46% in 2001, 40% in 2009, and 42% in 2016. While there has been a slight increase over the past 7 years, this increase has not significantly reduced DMHAS' capacity to serve the general psychiatric population.

State-Operated Inpatient Utilization and Admission and Discharge Data

This section describes our analysis of bed utilization and flow of patients into and out of state-operated or contracted intermediate beds. Bed availability is tied to flow within the system as evidenced by admission and discharge data.

Table 2: Bed Capacity and Utilization for Mental Health Inpatient Programs in SFY16

MH Inpatient	Bed Capacity	State Avg. Utilization
Acute Psychiatric	318	96%
Acute Psychiatric – Intermediate Contracted	11	84%
Transitional Residential CVH and CMHC	20	100%
Forensic MH Acute Psychiatric	232	97%

Table 2 above shows that, in general, these beds are being well utilized. For purposes of this analysis, Acute Psychiatric includes 16 beds at CRMHC that technically are classified as sub-acute, 220 beds at CVH, 20 at CMHC, and 62 at SWCMHS. The one exception is that the 8 intermediate beds are generally at about 85% of

capacity, meaning patients are somehow on waiting lists while some bed capacity exists. This intermediate capacity was created within recent years to accommodate discharges from Cedar Ridge Hospital. The utilization rate for these beds in the first quarter of FY 17 has improved to 90% utilization. All other hospital transitional beds are almost fully utilized.

Table 3: Number of Mental Health Inpatient Admissions by FY

Facility	Program Type	LOC Mode	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Capitol Region Mental Health Center	MH	Non-Certified Subacute	37	28	24	25	30	20
Connecticut Mental Health Center	MH	Acute Psychiatric	91	78	74	51	58	47
Connecticut Valley Hospital	Forensic MH	Acute Psychiatric	246	234	247	260	260	262
Connecticut Valley Hospital	MH	Acute Psychiatric	111	122	129	137	135	131
Southwest Connecticut Mental Health System	MH	Acute Psychiatric	108	101	80	100	94	94
Totals			593	563	554	573	577	554

Table 3 above shows the movement into the system over a five-year period. “Admissions” at CVH reflect “true admissions,” meaning that clients were admitted from the community rather than being transferred/admitted from other CVH services. Over the past five fiscal years, only CVH (acute psychiatric) has experienced an increase in admissions per year. All other DMHAS facilities showed reduced admissions during that period of time. Overall, there were 39 fewer admissions in FY16 compared to FY11; however, increasingly more patients are being admitted to CVH’s Acute Psychiatric beds. This reduction in admissions in other state hospitals may be one factor that contributes to the longer time that patients wait for a DMHAS bed.

Table 4: Number of Mental Health Inpatient Discharges by FY

Facility	Program Type	LOC Mode	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Capitol Region Mental Health Center	MH	Non-Certified Subacute	37	27	25	24	30	20
Connecticut Mental Health Center	MH	Acute Psychiatric	88	78	75	53	55	47
Connecticut Valley Hospital	Forensic MH	Acute Psychiatric	251	226	228	249	257	260
Connecticut Valley Hospital	MH	Acute Psychiatric	122	120	148	147	142	139
Southwest Connecticut Mental Health System	MH	Acute Psychiatric	104	99	80	101	82	95
Totals			602	561	556	574	566	561

Table 4 shows the total number of discharges by DMHAS facility over the past five years. In general, the data shows that as a bed becomes available, a new patient is admitted. However, total discharges have decreased over the past five years meaning that people are not leaving as quickly. There were 41 fewer discharges in FY16 compared to FY11, a 7% reduction in discharges during that period. Over the past five fiscal years; only CVH (acute psychiatric) is showing increases in discharges. These data may point to fewer community discharge

options (no turnover in residential beds or fewer housing options,) or patients preparing for discharge have more complicated presentations requiring special placements that are unavailable or experiencing low turnover rates.

Private Inpatient Services

Connecticut has a network of 23 general hospitals throughout the state that provide inpatient psychiatric services to children and adults. There are also three free-standing psychiatric hospitals in the state. Most hospitals serve adults and only a small number of hospitals provide inpatient psychiatric services to children. The total bed capacity for private and specialty hospitals is 959 beds. The Office of Health Care Access (OHCA) receives audited information that is submitted annually by the general hospitals, but does not receive the same information from the specialty hospitals that provide inpatient psychiatric care. In FY 15, only 6 hospitals provided inpatient psychiatric services to children and adolescents based on data accessed from the Connecticut Office of Health Care Access. One of these hospitals provided fewer than 15 bed days to individuals under the age of 18 in data obtained from OHCA. In FY 15, Connecticut's general hospitals had over 26,400 psychiatric discharges and provided 230,106 bed days to individuals seeking psychiatric treatment. The data is shown below in Table 5. This data does not discharges from the free-standing specialty psychiatric hospitals.

The OHCA data for discharges in 2015 show that 199,203 bed days were provided to adults and the remainder, 30,903, were provided to children and adolescents under age 18. Hartford Hospital provided 37,810 bed days while Yale New Haven (YNH) provided 46,490 inpatient psychiatric days. The two hospitals accounted for approximately 37% of all inpatient psychiatric days provided in private hospitals. These two hospitals accounted for about 65% of the days provided to children and adolescents under the age of 18. YNH and Hartford Hospital provided just over 20,000 bed days to children and youth.

Private Inpatient Patient Days and Bed Capacity

Table 5: Acute Care General Hospital Psychiatric Patient Days, Discharges and Beds, FFY 2015[2]

General Hospital	Patient Days Ages 0-17	Patient Days Ages 18+	Patient Days Total	Disch. Ages 0-17	Disch. Ages 18+	Total Disch.	Staffed[3] Beds, Ages 0-17	Staffed Beds, Ages 18+	Staffed Beds Total	Avail. Beds Total
Backus	0	4,874	4,874	0	636	636	0	18	18	20
Bridgeport	0	10,326	10,326	0	997	997	0	29	29	39
Bristol	0	4,598	4,598	0	908	908	0	14	14	16
Charlotte Hungerford	8	3,140	3,148	1	590	591	1	9	10	17
Conn. Children's	0	0	0	0	0	0	0	0	0	0
Danbury[4]	0	5,954	5,954	0	641	641	0	18	18	23
Day Kimball	0	3,748	3,748	0	565	565	0	12	12	15
Greenwich	0	0	0	0	0	0	0	0	0	0
Griffin	0	4,413	4,413	0	557	557	0	13	13	16
Hartford	9,344	28,466	37,810	1,124	3,249	4,373	26	85	111	121
Hospital of Central CT	0	7,694	7,694	0	791	791	0	22	22	24
John Dempsey	0	5,469	5,469	0	848	848	0	20	20	25
Johnson	0	4,144	4,144	0	624	624	0	17	17	20
Lawrence & Memorial	0	5,343	5,343	0	631	631	0	18	18	18
Manchester	1,426	9,321	10,747	182	1,130	1,312	5	26	31	36
MidState	0	1,471	1,471	0	121	121	0	6	6	6
Middlesex	0	6,120	6,120	0	835	835	0	17	17	20
Milford	0	0	0	0	0	0	0	0	0	0
Norwalk	0	2,777	2,777	0	462	462	0	10	10	20

[2] Source: DPH OHCA Hospital Reporting System (HRS), Report 400 for Federal Fiscal Year 2015
[3] Hospitals are licensed for a specific number of beds, but have fewer beds physically set up and "available" for use and may operate or staff fewer beds than available.
[4] New Milford Hospital became a Danbury Hospital campus on October 1, 2014.

General Hospital	Patient Days Ages 0-17	Patient Days Ages 18+	Patient Days Total	Disch. Ages 0-17	Disch. Ages 18+	Total Disch.	Staffed[3] Beds, Ages 0-17	Staffed Beds, Ages 18+	Staffed Beds Total	Avail. Beds Total
New Milford[3]	0	0	0	0	0	0	0	0	0	0
Rockville	0	0	0	0	0	0	0	0	0	0
Saint Francis	4,160	10,578	14,738	387	1,574	1,961	23	60	83	83
Saint Mary's	0	4,139	4,139	0	654	654	0	12	12	12
Saint Raphael[5]			0			0			0	0
Saint Vincent	3,949	23,996	27,945	485	2,277	2,762	17	75	92	92
Sharon	0	3,646	3,646	0	317	317	0	12	12	12
Stamford	0	5,465	5,465	0	552	552	0	15	15	20
Waterbury	1,205	7,842	9,047	128	643	771	4	23	27	30
Windham	0	0	0	0	0	0	0	0	0	0
Yale-New Haven	10,811	35,679	46,490	1,132	3,372	4,504	36	98	134	136
Statewide	30,903	199,203	230,106	3,439	22,974	26,413	112	629	741	821

[5] In September 2012, Yale-New Haven Hospital acquired the assets of Saint Raphael and became a single hospital with two main campuses.

Table 5 above shows each hospital and their staffed or licensed bed capacity. This report addresses "staffed bed" capacity. General hospitals have a higher number of beds that are available but may not staff them. The Connecticut Office of Health Care Access (OHCA) 2015 data shows that the general hospitals have 741 staffed inpatient psychiatric beds, with 112 of these beds allocated to children and adolescents under the age of 18. The total number of staffed beds in 2011 was 705 so staffed beds have actually increased by approximately 5% over the past 5 years. OHCA has more recent data for the three specialty hospitals. As of July 2016, the three specialty hospitals have an additional capacity of 218 beds. These are believed to be adult beds. When general hospital inpatient beds are combined with the free-standing capacity, the total number of private beds is 959.

Private Hospital Utilization Rates

The utilization rate for private hospital beds can be computed by looking at the total staffed bed days for children and adults (741 x 365 = 270,465) and the total bed days provided (230,106). This data is summarized in Table 6 below. This produces an overall utilization rate of 85% meaning that on average over 110 beds are available in the private system on any given day. The utilization rate for children and adolescents was approximately 76% while the rate for adults was approximately 87%. While many of the hospitals are operating at 90% or greater capacity, some are below that threshold.

The OHCA data from Table 5, which was shown earlier, can also be manipulated to determine an average length of stay (ALOS) by examining the total number of discharges and total bed days provided. The ALOS for all private hospital patients was approximately 8.7 days. The ALOS for adults was the same, approximately 8.7 days, while the rate for children and adolescents under the age of 18 was about 9 days. The data confirms that private hospitals generally are seeing individuals with acute psychiatric issues. These are most likely individuals that can be quickly stabilized and re-integrated into the community. The data seem to suggest that no additional acute care beds are needed because there is significant excess capacity on any given day based on the utilization data.

Table 6: Acute Care General Hospital Psychiatric Patient Days, Beds, and Utilization Rates, FFY 2015[6]

	Patients 0-17			Patients 18+		
General Hospital	Patient Days	Staffed Beds	Utilization Rates	Patient Days	Staffed[3] Beds	Utilization Rates
Backus				4,874	18	74%
Bridgeport				10,326	29	98%
Bristol				4,598	14	90%
Charlotte Hungerford	8	1	2%	3,140	9	96%
Conn. Children's						
Danbury[4]				5,954	18	91%
Day Kimball				3,748	12	86%
Greenwich						
Griffin				4,413	13	93%
Hartford	9,344	26	98%	28,466	85	92%
Hospital of Central CT				7,694	22	96%
John Dempsey				5,469	20	75%

[6] *Source: DPH OHCA Hospital Reporting System (HRS), Report 400 for Federal Fiscal Year 2015*

	Patients 0-17			Patients 18+		
Johnson				4,144	17	67%
Lawrence & Memorial				5,343	18	81%
General Hospital	**Patient Days**	**Staffed Beds**	**Utilization Rates**	**Patient Days**	**Staffed[3] Beds**	**Utilization Rates**
Milford						
Manchester	1,426	5	78%	9,321	26	98%
MidState				1,471	6	67%
Middlesex				6,120	17	99%
Norwalk				2,777	10	76%
New Milford[4]						
Rockville						
Saint Francis	4,160	23	50%	10,578	60	48%
Saint Mary's				4,139	12	94%
Saint Raphael[5]						
Saint Vincent	3,949	17	64%	23,996	75	88%
Sharon				3,646	12	83%
Stamford				5,465	15	100%
Waterbury	1,205	4	83%	7,842	23	93%
Windham						
Yale-New Haven[5]	10,811	36	82%	35,679	98	100%
Statewide	30,903	112	76%	199,203	629	87%

The general hospitals typically provide acute inpatient care, with average lengths of stay that are 10 days or less. Private hospitals are challenged by psychiatric patients with histories of violence and aggression or by those patients that are seriously mentally ill and have serious medical co-morbidities. These individuals are often referred to the state-operated inpatient system and placed on a wait list for admission to a state bed. These individuals often have limited options for follow-up care.

Private Hospital Charges by Payor Type

A closer examination of inpatient services in Connecticut shows that inpatient services delivered by general hospitals in Connecticut are financed through a combination of sources including Medicare, Medicaid, Commercial Insurance and Self-Pay. In FY 15, Medicare and Medicaid were responsible for over $747 million in charges (78% of all charges) while private insurance accounted for $199 million, approximately 21% of all charges. Another $17.8 million in charges were attributed to individuals that were uninsured, about 2% of total charges for this level of care. The breakdown of these charges over 5 years can be seen in Table 7 below. Charges do not necessarily equate to revenue, but the information cited below is helpful in understanding the primary funders of the care they provide.

Table 7: Mental Disorders Inpatient Discharges by Primary Payor, FY 2011-2015[7]

FY	Description	Medicare	Medicaid	Commercial	Uninsured	Self-Pay
2011	Total Charge	$235,133,204	$306,385,809	$159,026,916	$23,160,704	$22,510,505
	Maximum Charge	$887,027	$1,045,035	$571,319	$212,224	$212,224
	Average Charge	$28,429	$22,775	$19,556	$17,871	$18,257
	Minimum Charge	$974	$1,057	$1,076	$1,304	$1,304
	Total Discharges	8281	13456	8132	1298	1233
	Total Length of Stay	82518	103658	53960	7934	7600
	Average Length of Stay	10	7.7	6.6	6.1	6.2
2012	Total Charge	$245,673,003	$338,515,538	$182,070,316	$25,984,290	$25,410,955
	Maximum Charge	$989,984	$852,296	$660,862	$252,096	$252,096
	Average Charge	$29,475	$24,591	$21,387	$20,888	$21,176
	Minimum Charge	$34	$7	$971	$1,247	$1,247
	Total Discharges	8348	13767	8513	1244	1200
	Total Length of Stay	80588	103129	58735	8291	8082
	Average Length of Stay	9.7	7.5	6.9	6.7	6.7
2013	Total Charge	$275,667,071	$376,916,248	$205,516,515	$26,656,974	$25,239,070
	Maximum Charge	$1,043,957	$545,247	$888,022	$333,278	$333,278
	Average Charge	$32,635	$26,998	$23,696	$21,743	$22,062
	Minimum Charge	$888	$1,455	$1,600	$2,041	$2,284
	Total Discharges	8458	13963	8675	1235	1144
	Total Length of Stay	83166	107377	62506	8289	7655
	Average Length of Stay	9.8	7.7	7.2	6.7	6.7
2014	Total Charge	$301,379,550	$418,221,347	$197,588,836	$24,777,986	$23,153,848
	Maximum Charge	$1,405,089	$884,011	$665,261	$321,260	$321,260
	Average Charge	$35,315	$28,121	$25,522	$23,398	$23,919
	Minimum Charge					$1,846
	Total Discharges	8534	14872	7742	1059	968
	Total Length of Stay	85357	113581	55547	7140	6565
	Average Length of Stay	10	7.6	7.2	6.7	6.8
2015	Total Charge	$309,654,667	$437,905,793	$199,133,998	$17,756,467	$16,060,743
	Maximum Charge	$1,052,085	$1,040,669	$1,885,390	$383,721	$383,721
	Average Charge	$36,546	$28,078	$26,309	$24,028	$24,371
	Minimum Charge			$1,935		$2,047
	Total Discharges	8473	15596	7569	739	659
	Total Length of Stay	84914	116473	53617	4623	4077
	Average Length of Stay	10	7.5	7.1	6.3	6.2

[7] *Source: Connecticut Department of Public Health Office of Health Care Access inpatient discharge database system*

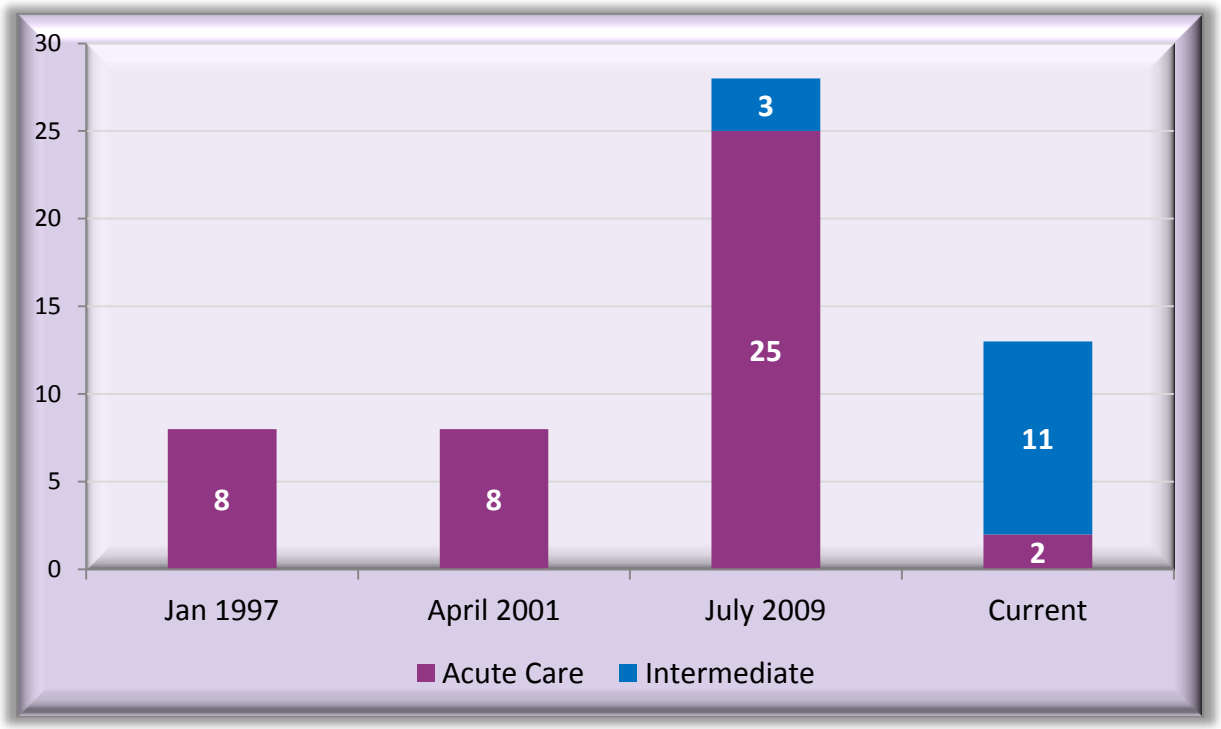

Figure 5: DMHAS Contracted Private Acute & Intermediate Beds

Figure 5 displays information about private psychiatric service beds that have been purchased by DMHAS in an effort to relieve pressure on state-operated beds. This graph does not reflect overall private bed capacity, but shows DMHAS contracted beds. There has been a slight increase since 2011, primarily due to the purchase of intermediate level of care beds at St. Vincent's Hospital following the closure of Cedar Ridge Hospital.

DMHAS Wait List Data

Currently, Connecticut does not maintain a system-wide real time bed vacancy or wait list. Some private hospitals have begun to track bed availability within hospital systems that have affiliated or are within a hospital network of care. However, there is a lack of centralized data that shows who is waiting for a bed, their insurance, presenting problems, and a determination that shows they meet medical necessity criteria. The utilization data cited above shows that unutilized capacity exists within the system. While many of the individuals waiting for admission may not be suitable for private hospital admissions, some may be but there is no mechanism that can match referrals with bed vacancies on a real time basis. A system like this might reduce the demand for state-operated beds.

DMHAS, however, does maintain a wait list for those patients who are being referred by private hospitals for a state bed. Private hospitals refer clients to DMHAS (state operated facilities) where they are placed on a waiting list for a bed. Wait list data collected by DMHAS includes the referring hospital, date of the referral, the state-operated facility a patient is referred to, and the disposition (final outcome) of the referral along with the date of the disposition. Dispositions may include acute care beds, crisis or respite, home or community, or state-operated inpatient admissions. This allows DMHAS to track and prioritize referrals and it provides information about how long a referral may wait for a state bed. It is important to point out that a client placed on the wait list is typically receiving inpatient psychiatric treatment, but is being referred to DMHAS because the hospital

believes the patient will require a much longer stay than typically provided in the general hospitals. Almost 75% of the individuals who are on a wait list are receiving treatment on an inpatient psychiatric unit.

While the wait list is an important tool, it has limitations. Currently there is no standard practice for managing wait list data. For example, an individual's placement may be back-dated from when they were placed on the wait list, skewing the data. At times they may request that somebody remain on the wait list even though they have already received a community disposition and do not need a state bed. In these instances, the individual may be left on the list in the event the client decompensates and needs a state bed. Wait list data is influenced by variations in how the data is managed.

The following table show a range of information related to DMHAS' wait list data compiled over the past five fiscal years. While it has limitations, it does provide useful information related to the wait list.

Table 8: State Hospital Wait Time Data

SFY	# Clients to State Facility (Disposition)	Wait List Total	% of Total to State Facility	Average Days on Wait List for State Facility Bed
FY 2012	270	641	42%	18
FY 2013	261	615	42%	23
FY 2014	261	607	43%	28
FY 2015	214	451	44%	27
FY 2016	215	480	45%	26

The Wait List Total includes clients whose disposition was acute care contract beds, crisis respite beds, home community, intermediate care contract beds, nursing home, private hospital, state sub-acute, and other. FY 15 data is incomplete as a result of a change to a new information system.

Table 8 displays the total number of clients that have been placed on the wait list each year, the percentage accepted into state hospital beds, and average wait time for beds. The numbers listed in this table represent duplicated client counts (a client may have been on the list more than one time in a fiscal year; each time a client is placed on the list, it is treated as a separate event). Client numbers were relatively stable in FY 12-14, with 260-270 admissions to state psychiatric service beds; additionally, the ratio of clients admitted to state beds has remained constant over this time (42-43%.) A significant shift was noted in FY 15 and 16 when fewer patients were admitted to state beds and there was a much lower number of patients who were placed on the wait list. Closer examination of the data shows that each DMHAS inpatient facility saw fewer patients placed on their respective wait lists. Discussions with state facilities and private hospitals have been unable to shed any light on why this occurred.

The figures show that the average wait time for a state bed has increased substantially since FY 2012; four years ago, the average wait was 18 days. The mean wait time in FY 16 was 26 days – an increase of over a week. The following graphs present more detailed information from Table 5.

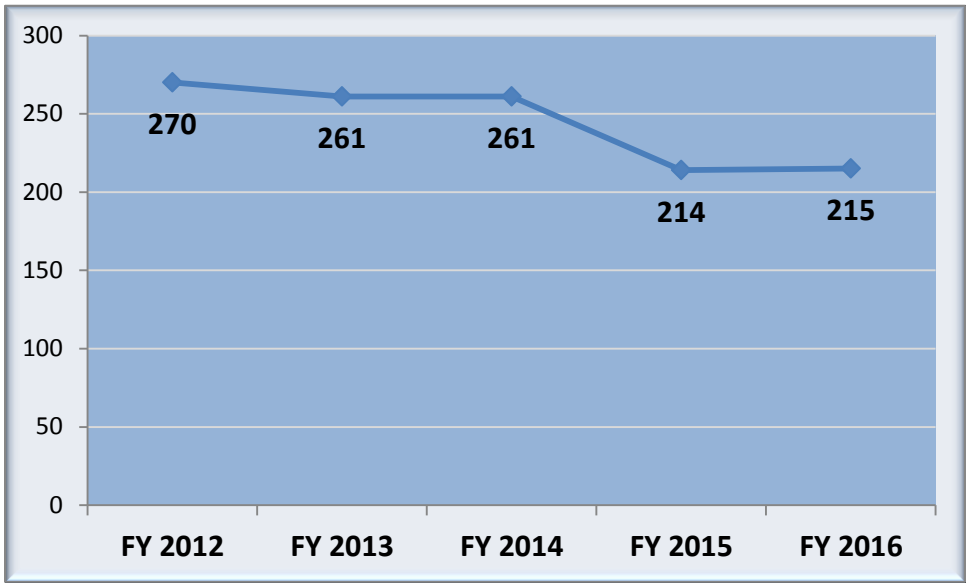

Figure 6: # of Wait List Clients with State Facility Disposition

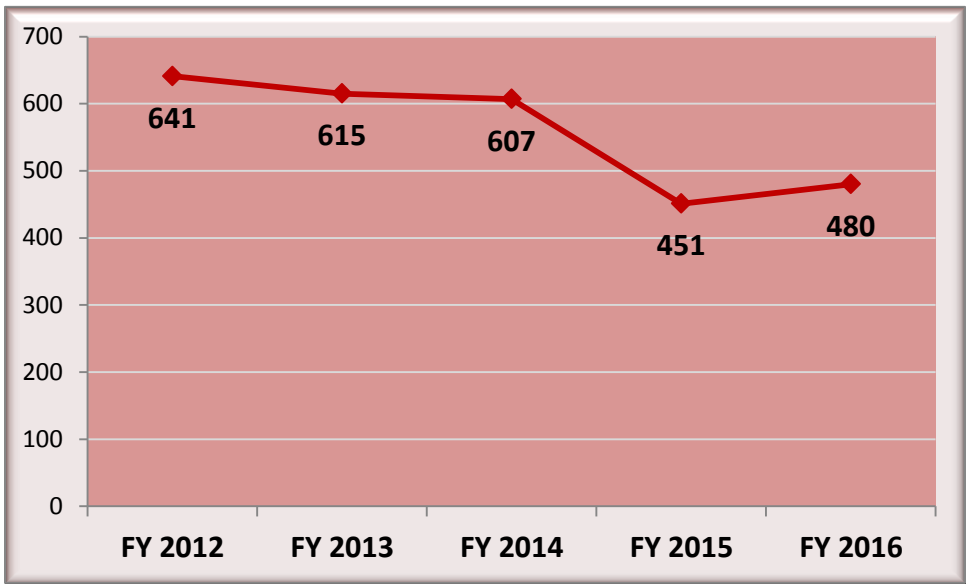

Figure 7: Total Number of Clients on Wait List

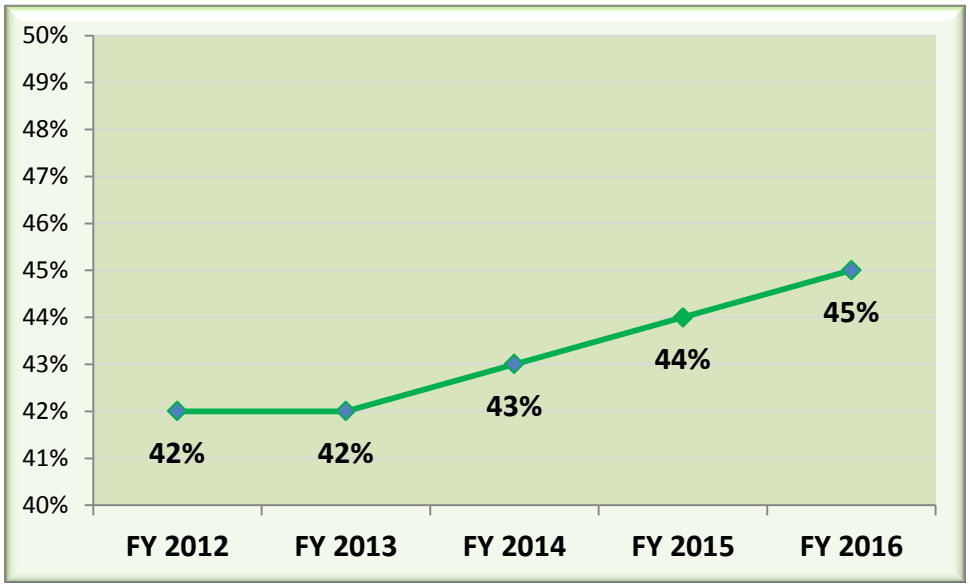

Figure 8: % of List with State Facility Disposition

Figure 8 above shows the percentage of clients who are on the wait list each year that are admitted to a state-operated bed. The data shows that each year about 42 to 45% of the patients on the wait list are admitted to a DMHAS bed. There has been little fluctuation in the percentage over the past 5 years.

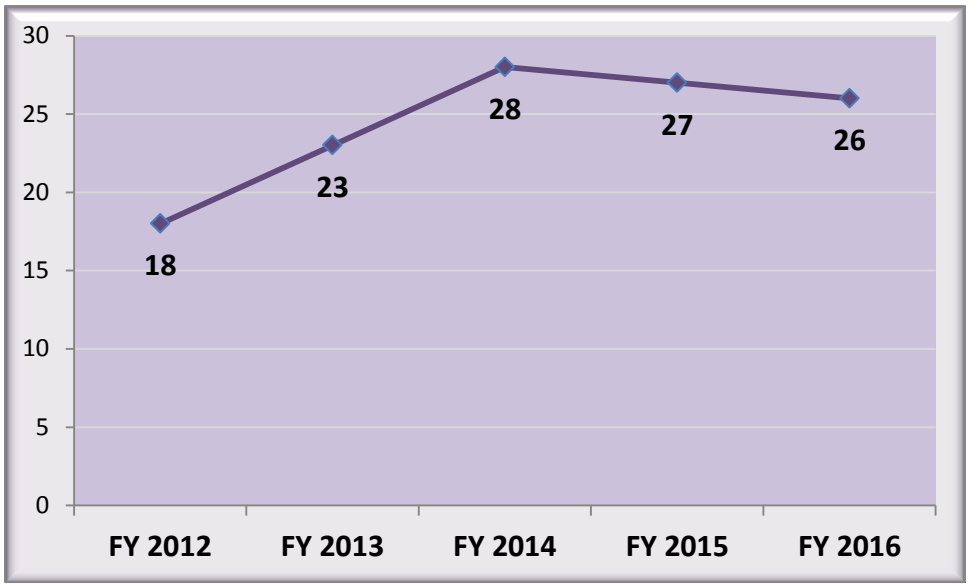

Figure 9: Average Days on Wait List

Figure 9 shows length of time a referral waits to get in a state bed. This data does show that the wait time has increased significantly over the past 5 years. It has risen from an average of 18 in FY 12 to the current mean of 26 days. It has reduced slightly over the past 3 years but is now 8 days longer than in FY 12.

Discharge Length of Stay for Wait List Clients

This section looks at how long people stayed in state psychiatric service beds after being admitted from the wait list; this statistic is commonly referred to as "length of stay" (LOS)

Treatment in an intermediate level program, which is generally less expensive and restrictive for patients, is often more appropriate than hospitalization in a long-term state facility In reviewing four years of wait list data in Table 9 below, findings show that 27 to 44% of people admitted to state facility beds could have been eligible for intermediate community treatment (stays of up to 90 days in duration,) had beds been available. These patients may have been referred to DMHAS beds because of reimbursement issues or lack of intermediate capacities within the state.

Table 9: Length of Stay in State Facility Beds

	LOS in State Facility Bed After Admission from the Wait List				Grand Total % (# Clients)
SFY	1 to 90 Days	91 to 180 Days	180 to 365 Days	> than 365 Days	
CY 2012	44%	22%	17%	17%	100% (255)
CY 2013	37%	18%	30%	16%	100% (250)
CY 2014	30%	25%	24%	21%	100% (267)
CY 2015	27%	27%	35%	11%	100% (214)

Over the four year period examined, approximately 1/3 of the people who were admitted to state facility beds from the Wait List received treatment for 1-90 days.

This analysis looked at calendar year data. In the most recent calendar year examined (CY15), findings show that a larger proportion of patients were staying in state facilities for longer periods of time. The increased number of people with increased lengths of stay has undoubtedly impacted the flow of clients from the wait list into facilities, which in turn lengthens the amount of time that people typically remain waiting for psychiatric beds.

Community Services

A strong community system is essential in order to create movement out of state hospitals, to divert consumers from the inpatient system, and to provide the necessary supports so individuals can recover in the community. DMHAS has adhered to a value that to the extent possible, consumers should have a right to live and flourish within the community. This value grew out of early efforts to deinstitutionalize patients within the state hospital system. The development of the community mental health system began in the mid-1980's when the Connecticut Department of Mental Health implemented the Local Mental Health Authority (LMHA) system. LMHA's were designated across the state and became the providers and managers of mental health services within designated catchment areas. The formation of the LMHA system became the starting point for the development of the community mental health system in the state.

The early efforts have evolved into a comprehensive system with a broad spectrum of services available across the state. If state hospitals are to be used as a last resort, sufficient resources must exist within the community to

assist persons with mental illness to live independently in the community. Connecticut provides a broad array of mental health services and recovery supports. This service array includes the following: diversionary services like mobile crisis, jail diversion and community intervention teams; a continuum of residential supports including group homes, intensive mental health residential programs, supervised apartments, and a range of housing supports designed to assist consumers to find and remain in stable housing, high intensity outpatient case management services like assertive community treatment, community support programs, medication management, and recovery support services that include employment, social rehabilitation, and housing programs. For purposes of this report each service area will be discussed in greater detail below. Recovery support services will be included under the Outpatient heading.

The grant funded services that are administered under DMHAS are generally non-reimbursable services with a few exceptions. The broader community mental health system includes those services that are part of DSS' Medicaid benefit, which includes inpatient, partial hospitalization and intensive outpatient, outpatient therapy services and medication management, and those services covered under various Medicaid waivers including group homes and in-home supports.

Outpatient and High Intensity Case Management Services

Outpatient services are those services provided in the community separate from residential and diversionary services. These include high intensity case management services like assertive community treatment (ACT) and community support programs (CSP), housing and employment services, and services designed to promote social interaction and rehabilitation. Table 10 below shows these unique levels of care (LOC), the number of unduplicated individuals served in FY 16 and the program capacity for each of these LOC's. Figure 10 is a map that shows where the ACT and CSP programs are concentrated.

Table 10: Outpatient and High Intensity Case Management Services, FY16

		Total
Forensic MH	Case Management	138
	Crisis Services	38
	Forensics Community-based	4,922
	Outpatient	295
Mental Health	Assertive Community Treatment (ACT)	1,254
	Case Management	8,155
	Community Support	5,514
	Consultation	254
	Crisis Services	7,447
	Education Support	232
	Employment Services	3,932
	Forensics Community-based	39
	Housing Services	475
	Intake	3,319
	Intensive Outpatient (IOP)	519
	Outpatient	38,071
	Prevention	477
	Social Rehabilitation	6,786
Total MH		58,387

Figure 10 below shows the distribution of Assertive Community Teams (ACT) and Community Support Programs (CSP). ACT is typically reserved for the highest-need community clients. These intensive supports are designed to provide intensive in-home services in order to maintain people in the community. Several years ago DMHAS received increased funding from the legislature to create additional ACT teams to fill gaps in the service system. DMHAS evaluated provider service data and made a determination regarding where these services should be expanded. Currently, DMHAS funds or operates 19 ACT teams across the state. They are largely concentrated in the most highly populated areas of the state. Based on service analyses that were conducted several years ago, DMHAS believes that the current ACT programs are sufficient to meet client demand. DMHAS served over 1,200 clients in ACT last fiscal year.

CSP is another in-home support that is less intensive than ACT, but still provides high intensity case management and rehabilitation services to clients. DMHAS funds or operates 39 CSP teams across the state. CSP typically serves clients with rehabilitation needs of high intensity, but a lower intensity than what is provided by ACT. The distribution of these programs are more widespread than ACT programs and annually they serve over 5,500 clients. DMHAS also served another 8,100 clients in lower level case management programs last year. Based on service utilization data, DMHAS has decided to convert many of these programs to CSP this fiscal year in an effort to standardize our case management models.

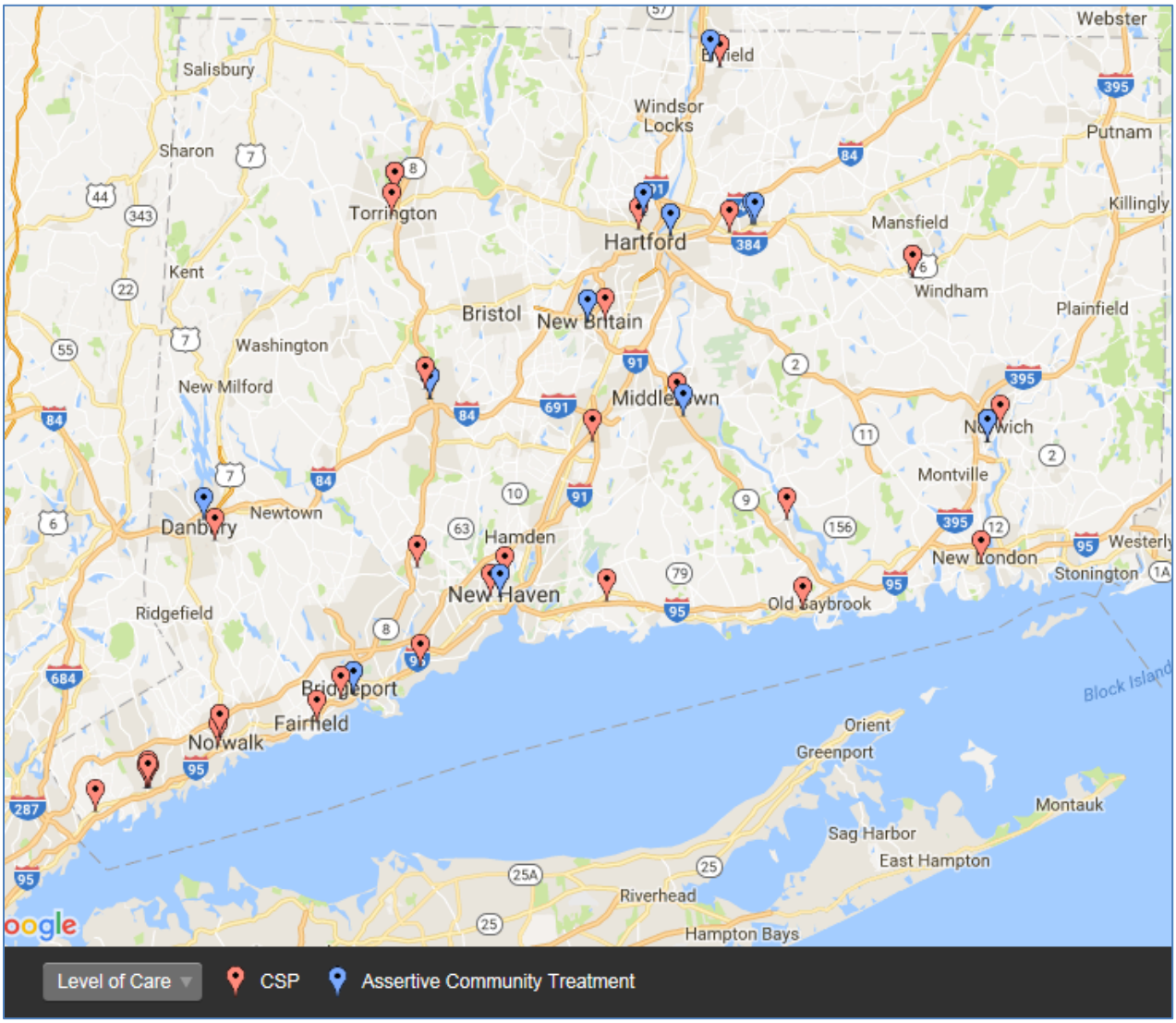

Figure 10: Locations of ACT/CSP Programs

Residential Services

Residential services are arguably the most essential community service to maintain consumers within the community prior to or following an inpatient stay. This level of care serves as a resource for community clients that may deteriorate and need additional structure and it serves as the most needed discharge service. Therefore these services continually experience pressure to meet community needs as well as those of community and state-operated psychiatric hospitals. In order to be effective, residential service options must encompass a continuum of residential options ranging from least restrictive to most restrictive. When discussing bed capacity for psychiatric services, it is important to be cognizant of the spectrum of available residential treatment options. Patients have the right to treatment in the least restrictive setting that is appropriate to their needs, and as a provider of services, DMHAS is charged with placing them accordingly. DMHAS' residential options include the following types of residential services:

Group home - The group home is a rehabilitative level of care that provides services to people whose mental illness is serious and/or disabling enough to warrant 24 hour, 7 days per week supervision in a supportive residential setting. The goal of group home treatment is to provide a structured, stable living environment where people can receive assistance with life skills, including self-care. Group homes serve up to 6 people in a home and clients must be able to participate in at least 10 hours of service per week in order to be able to bill Medicaid for these services. This treatment requirement poses some problems in that some DMHAS clients, due to the severity of their illness, are unable to actively participate to that extent.

Intensive Mental Health Residential - Intensive mental health residential treatment is similar to inpatient treatment in structure and intensity; however, the setting is in a less medicalized, more home-like environment. Clients live in a congregate setting. The clients served in these programs typically cannot meet the treatment requirements of a group home and these residential programs are an innovative step-down from inpatient care.

Supervised Apartments - Supervised apartments provide on-site staff support and services 24 hours a day to residents living in congregate apartments. Providers that operate these programs typically rent an apartment in the building and have staffing available 24/7 to provide support to consumers. The goal of this level of care is to assist people in developing skills towards fully independent living.

Transitional Residential – DMHAS has several variations of transitional residential programs. DMHAS operates two programs that are located on hospital grounds. These serve as alternative placements for individuals that no longer meet medical necessity requirements for inpatient care but still require highly structured living environments. They serve to move consumers along the continuum to greater independence. DMHAS also operates several community transitional residential programs that provide high intensity support in a community setting.

Table 11: Bed Capacity and Utilization for Mental Health Residential Programs in FY16

MH Residential	Bed Capacity	State Avg. Utilization
Group Home	172	98%
Intensive Residential	100	89%
Supervised Apartments	659	91%
Transitional Housing	51	93%

Table 11 shows that these services are typically well utilized. One exception is Intensive Residential where beds may be vacant because a client has deteriorated and requires short-term inpatient stays. These are often consumers with complex clinical needs that have been very hard to place in the community. The beds are held open so a new placement does not have to be developed when the patient is ready to be discharged from their inpatient stay. Discharge specialists familiar with the needs of patients ready for discharge indicate that this is a highly desirable level of care that is difficult to access. This is often used with high complexity, difficult to discharge patients and may be a LOC that needs to be expanded.

Tables 12, 13, and 14 below show the flow through these residential programs and the number of clients that are served each year. Access to inpatient beds is closely linked to flow out of high intensity residential services. There are several remarkable findings in this data. Group homes have a turnover rate of less than 50%, which means that fewer than half of the beds are freed up for new admissions each year. Similarly, supervised apartments turn over at a slightly higher rate, about 52%. While there is clearly movement within these levels of care, movement in and out of these programs are slow. Many people who require these high intensity services may be likely to need these supports for long periods of time. For some, this may mean indefinitely. Supervised apartments have a unique problem inherent in the model. Consumers hold the leases to their apartments and even when they become more independent they are not likely to move out of these beds. They may no longer require the high intensity services of the program, but they are holding a slot/apartment that could be used for other clients. Since these apartments are typically contained within an apartment complex, the owner/landlord may restrict the number of apartment units that he or she will set aside for our clients. This limits the ability to make more apartments available at that site.

Any bottlenecks in these most highly structured residential LOC's place pressure on community and hospital needs. This may be an area that could benefit from increased oversight and management in order to more effectively use these valuable levels of care.

Table 12: Number of Mental Health Residential Admissions by FY

Level of Care	2011	2012	2013	2014	2015	2016
Group Home	115	95	93	91	87	82
Supervised Apartments	297	342	361	300	305	344
MH Intensive Res. Rehabilitation	100	111	105	86	109	96
Transitional	175	189	180	169	164	155

Table 13: Number of Mental Health Residential Discharges by FY

Level of Care	2011	2012	2013	2014	2015	2016
Group Home	108	106	104	82	83	80
Supervised Apartments	280	321	329	292	286	323
MH Intensive Res. Rehabilitation	89	109	96	98	107	94
Transitional	170	192	180	162	165	158

Table 14: Number of Mental Health Residential Unduplicated Clients by FY

Level of Care	2011	2012	2013	2014	2015	2016
Group Home	268	262	251	237	246	243
Supervised Apartments	775	843	852	853	859	902
MH Intensive Res. Rehabilitation	162	178	176	170	180	177
Transitional	198	212	204	203	208	203

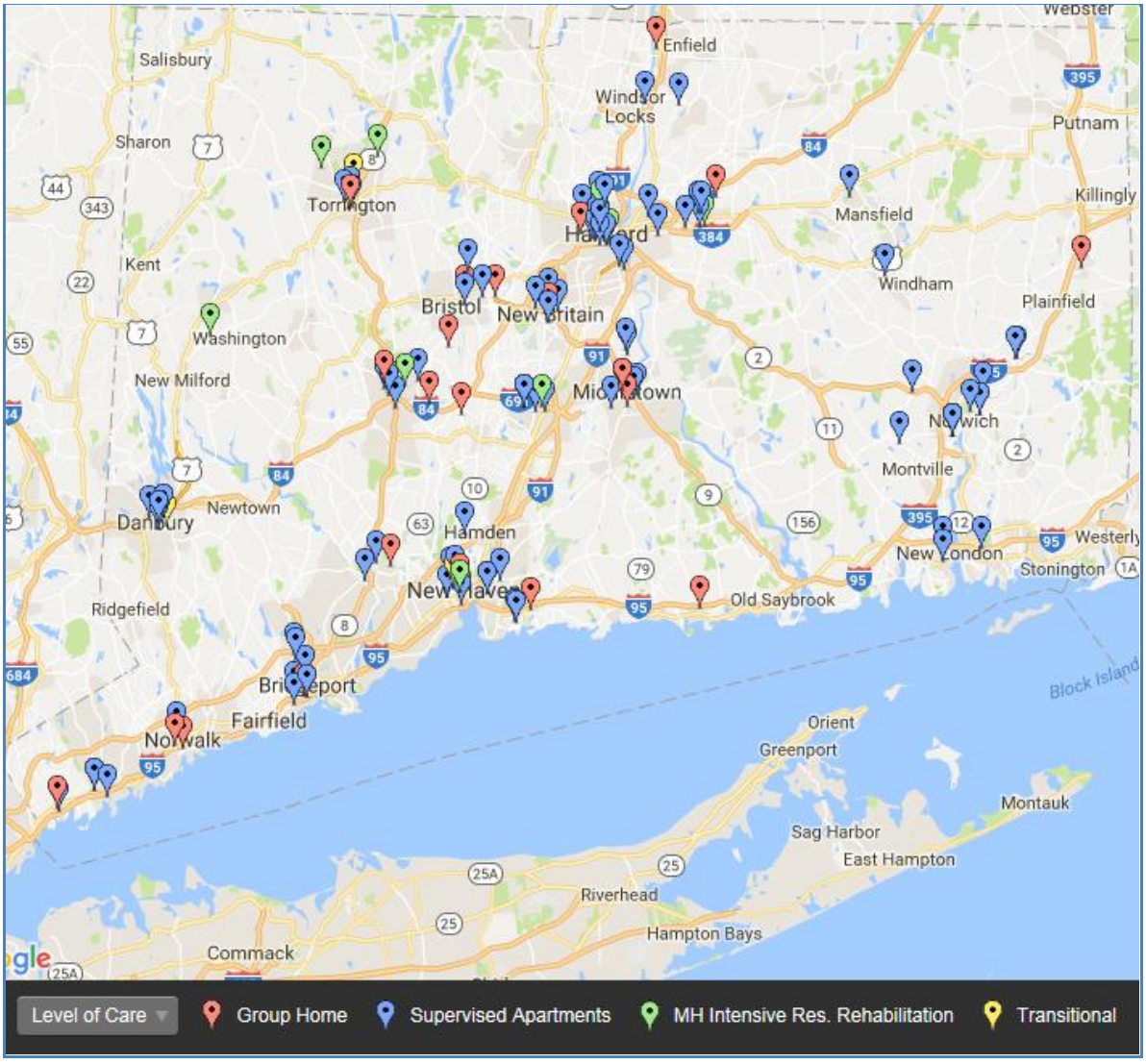

Figure 11: Locations of Residential Programs

One hundred and forty residential programs are plotted above in Figure 11. They are largely clustered in urban areas.

Diversionary Services

Diversionary services are important components of the service continuum because these are a range of services designed to divert individuals from hospitalization or criminal justice involvement. Diversionary services typically include mobile crisis services, community respite, jail diversion, and may also include community intervention teams who work alongside local law enforcement to de-escalate and manage clients who come to the attention of police. DMHAS funds or operates 27 mobile crisis teams, 19 Jail Diversion programs, and 12 respite bed programs which have a capacity of 88 beds. The table below shows the distribution of mobile crisis and respite programs and highlights the reach of these programs.

Respite beds are a critical diversionary service, providing a structured short-term residential resource to clients whose condition may be deteriorating. These programs are staffed 24/7 and typically have capacities of 6 beds or less. They are often located in such a way that they can tap into psychiatric supports in order to help stabilize these clients. When respite is working well, clients are able to stabilize and return back to their original living situation. They are diverted from an inpatient stay.

Data for FY 16 shows that respite beds are underutilized with just over 10% of the beds vacant over the course of the year. This means that, on average, close to 10 beds are available to be used to divert consumers from inpatient beds. Currently these beds are not managed centrally and are typically under the control of the LMHA. Vacant beds could be used more effectively if there was a more regional approach to their management.

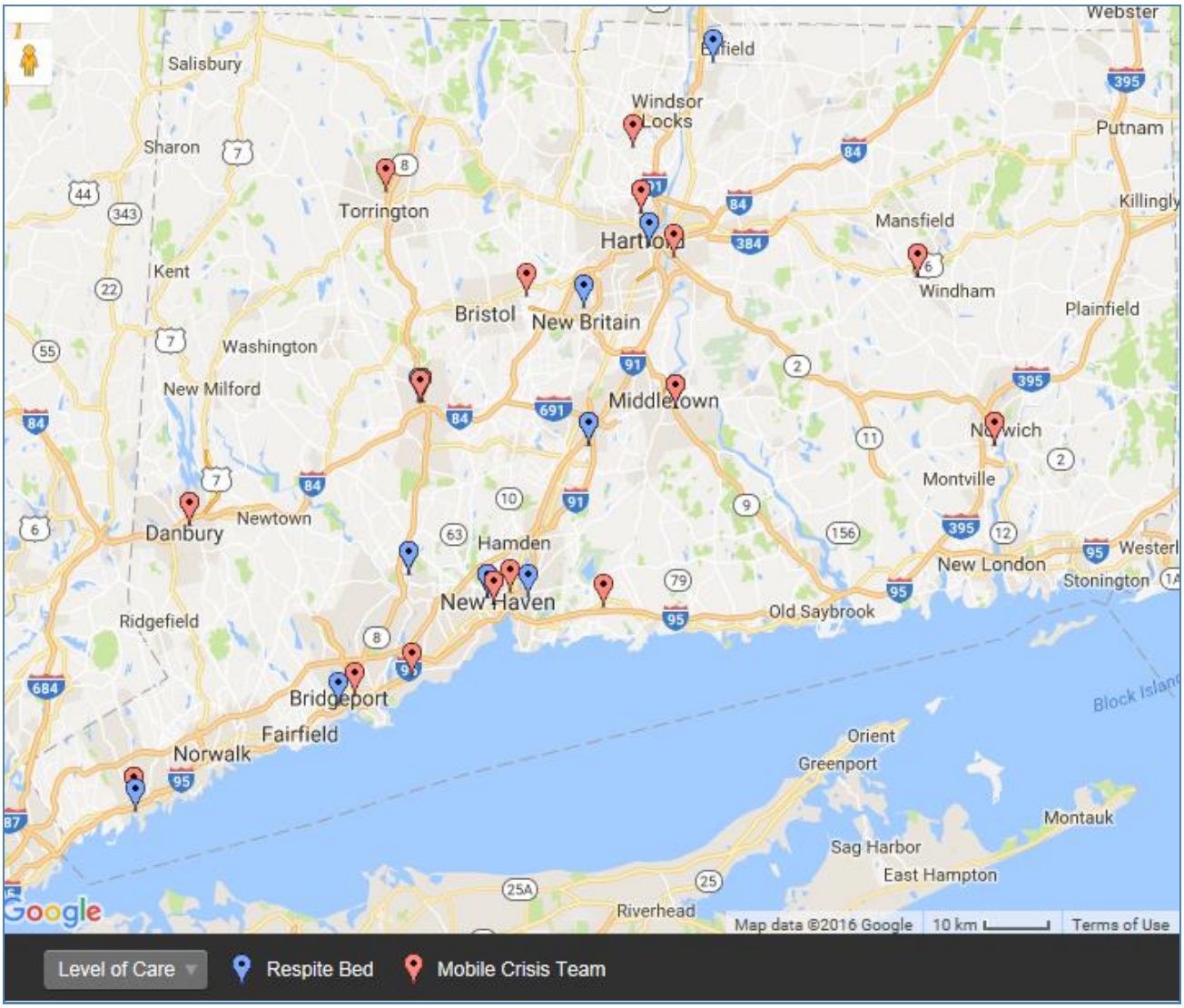

Figure 12: Locations of Respite and Mobile Crisis Programs

DMHAS funds or operates 44 crisis/respite programs, which are largely concentrated west of the Connecticut River and in urban areas.

Table 15: Client Counts in FY16 for Respite Programs

Region	Provider	Program Name	Admitted	Discharged	Unduplicated Clients
Region 1			**170**	**170**	**163**
	Continuum of Care	Bridgeport Crisis Respite	164	164	154
	Inspirica Inc.	Gilead Jail Div Respite	6	6	9
Region 2			**745**	**750**	**598**
	Continuum of Care	ASIST Respite	6	5	6
	Continuum of Care	Crisis/Respite Program	200	200	186
	Continuum of Care	Jail Diversion Respite	7	7	7
	River Valley Services	RVS/RESPITE	113	114	90
	Rushford Center	Crisis/Respite Program	135	139	110
	Yale-New Haven Hospital	Respite Bed Program	284	285	244
Region 4			**161**	**156**	**158**
	Community Health Resources	Respite - Enfield	84	82	72
	Community Mental Health Affiliates	Crisis Services/ Respite Bed Program	26	25	29
	Mercy Housing and Shelter Corporation	Community Respite	25	25	30
	Mercy Housing and Shelter Corporation				
		Crisis Respite	26	24	28
Region 5			**40**	**40**	**46**
	Western Connecticut Mental Health Network	Waterbury Respite/Transitional Housing	38	38	44
Totals			**1,127**	**1,128**	**969**

In FY16, 969 clients were served in Crisis and Respite programs. There were roughly equal numbers of admissions and discharges (1,127 & 1,128 respectively).

Respite beds can be used in two ways: as a step down from inpatient hospital care or as a means of diversion where clients can move from the community to respite as an alternative to an inpatient hospital level of care. DMHAS staff analyzed this data and concluded that diversion is the most frequent use of DMHAS respite beds.

Discretionary Discharge Data

Each year, DMHAS is appropriated funding to set up specialized living arrangements for some of the clients who are discharged and who require this assistance. This funding allows DMHAS to allocate specialized funds for patients that may be encountering significant discharge barriers. However, these funds must be continually replenished. Individuals that use these specialized funds may require additional supervision or programming throughout the time they receive treatment from DMHAS. This means that if somebody received $100,000 dollars last year to support their community placement, they will need the same amount of funding next year. This means that individuals who are being discharged that have similar needs will require new funds in order to stimulate their return to the community.. Withdrawal of these funds means that discharges will be slowed or reduced.

Discussion and Findings for Inpatient Services

Overview

Section 356 of Public Act 15-5 of the June Special Session mandated DMHAS to evaluate the adequacy of the state's mental health system. The mandate targeted specific areas for the review including inpatient, diversionary, and community services. While the impetus for this legislation seems to be related to difficulties associated with accessing state-operated inpatient beds, there is a complex interplay between inpatient bed capacity and the comprehensiveness of the community resources needed to divert and re-integrate individuals back into the community. The solution for a lack of access to inpatient beds cannot simply be an equation of creating more beds. Access to beds is critically dependent on adequate community mental health systems that are capable of managing diversions or discharges. The important findings from the report will be summarized and discussed below.

CT Per Capita State-Operated Bed Capacity is Among the Best in the Nation

Comparisons of bed capacity have examined how one state may compare to other states within that region of the country. This was recently done in Colorado as part of a study similar to ours (footnote Colorado study). Per capita bed rates were established based on the number of publicly funded psychiatric beds and the total population of the state. Connecticut's per capita bed rate for publicly funded inpatient beds is 17 beds per 100,000 population and exceeds all of the New England states and much of the nation. The New England average per capita rate is 15.0 beds per 100,000 population. Connecticut's per capita rate is the sixth best in the country, according to a report by the Treatment Advocacy Center.

State-Operated Bed Capacity Has Remained Constant for Almost 20 Years

Unlike what is being reported for most of the country, Connecticut's state-operated bed capacity has not changed significantly over the past 20 years. Connecticut's bed capacity in 1997 was 539 and today it is 550. Unlike other states, there have been no large scale closures during that period. Cedar Ridge Hospital, a 93 bed facility was closed in 2011 resulting in a net loss of approximately 20 beds, but most inpatient beds were consolidated at Connecticut Valley Hospital and Greater Bridgeport. DMHAS expanded intensive residential options in the community as a means of discharging more clients to the community. Intermediate beds were expanded (8) at that time to reduce the demand on the state's inpatient system.

State-Operated Inpatient Beds are Utilized Well but Bed Turnover Has Slowed at Certain Hospitals over the Past 5 Years

These inpatient beds are used well, with utilization rates of 96%. DMHAS carefully manages these beds through weekly utilization management meetings and when a bed becomes available, it is quickly filled. However, only a certain number of beds "turn over" in a year. In Forensic units this may occur quickly if somebody is restored to competency and discharged to face trial. Over the past 5 years, DMHAS has seen turnover rates decrease at their smaller community hospitals, while CVH has slightly increased the number of discharges.

This phenomenon is evident in Connecticut now. Inpatient discharges and admissions have decreased over the past 5 years. This is not due to changes in capacity, but likely reflects the specialized needs of many of the individuals who are now in the state's inpatient system. Capacity is created by discharges. There were 39 fewer discharges in FY 16 when compared to FY 11. During the same period, the average length of stay for all patients served in each fiscal year has increased significantly at the smaller hospitals while it has decreased at CVH.

Forensic Patients Are Impacting Bed Availability

Connecticut has not seen significant erosion of beds allocated for civil patients by increased demand for forensic beds based on bed capacities that are allocated to forensics versus general psychiatric or civil patients. Forensic beds currently comprise approximately 50% of all inpatient adult psychiatric beds in the state but this has been largely unchanged over the past 20 years. One function of the forensic services at CVH is to determine competency and whether a patient is restorable, often in the CVH Forensics Division. When a patient is unable to be restored, they become civil patients that then do compete for general psychiatric beds at the hospital. DMHAS has successfully used community forensic services to conduct community evaluations that at one time may have only occurred within CVH. However, it is known that a certain percentage of the community evaluations do lead to inpatient hospitalization. In FY 16, DMHAS reportedly conducted a record number of community evaluations, but increases in these evaluations can create additional demand for state-operated forensic services.

Many forensic patients create challenges for discharge and community reintegration. Some of these patients have been found "Not Guilty by Reason Of Insanity" (NGRI) and may be under the supervision of the state's Psychiatric Security Review Board (PSRB). Others may have been committed to an inpatient hospital after completing a prison sentence with the Department of Correction. Individuals under the jurisdiction of the PSRB must have their discharge plans reviewed and approved by the PSRB and their community transitions often proceed far more slowly than other discharges. The discharge plans for PSRB clients are public and at times subject to strong community opposition that slows the discharge process. These individuals and those that come to DMHAS end-of-sentence encounter significant discharge barriers because of past criminal behavior involving violence or sexual offenses.

Wait Times for State Beds are Increasing While Private Hospitals Have Excess Acute Bed Capacity

The state has maintained a wait list for a number of years, tracking referrals from community hospitals where patients may be in a hospital emergency department or on an inpatient psychiatric unit. Wait list data over the past 5 years shows that the average wait time for a state bed has increased from 17 days in FY 12 to approximately 26 days in FY 16. Annually, fewer individuals are being admitted to state beds from the Waiting List, about 55 in fewer in FY16 when compared to FY 12. While the wait time has remained constant in FY 15 and 16, there are still wait times of almost 4 weeks if an individual is in a community hospital and requires extended care. It is important to point out that most patients placed on the wait list are receiving actual treatment often on a hospital's inpatient psychiatric unit.

The state-operated wait list has some limitations because data is not collected in a uniform manner. Referrals to the wait list may be back dated and DMHAS may be asked to keep referrals on the wait list even though individuals may have already been returned to the community or had some other disposition. Modifications should be made to the maintenance of the list in order to track referrals in a more consistent manner.

The wait time has increased at a time when private general hospitals have excess capacity. Acute bed capacity and utilization were examined to determine if excess capacity exists within the state. Private general hospitals annually submit data to OHCA regarding psychiatric patients they serve in their inpatient units. The information contains a range of data elements. These include psychiatric bed days provided to children and adults, staffed bed days, and total number of discharges. The data can be manipulated to create utilization rates and average lengths of stay for these hospitals and the private system as a whole. The most recent data (FFY 15) data shows that there are 741 staffed beds available and the overall system utilization rate is 85%. The rate is 76% for children and 87% for adults. This means that on any given day over 110 beds are available in private hospitals, approximately 26 for children and 80 for adults. These beds are available while patients are waiting for state beds. This is not to say that all patients on the state wait list could be served in these beds but some may be appropriate for these vacant beds if state staff were able to readily identify bed vacancies.

Comparisons between FFY 11 and FFY 15 data submitted to OHCA show that staffed acute care bed capacity has risen. There were 705 staffed beds in FFY 11 and there are currently 741 staffed beds, an increase of approximately 5%. These numbers do not reflect the additional bed capacity of the free-standing specialty hospitals. These hospitals have an additional 218 beds to meet psychiatric inpatient needs.

No Mechanism Exists to Track Real Time Bed Availability in Private Hospitals

There is currently no statewide system for tracking real time bed availability. This means that some vacant beds may be unutilized because inpatient providers are unaware of where vacancies exist in the state. Certain private hospital systems are now employing wait lists within their affiliated hospitals, but there is no wait list that tracks and manages bed availability within the entire state. Hospitals may fear greater transparency due to concerns about accepting challenging patients who often have limited discharge options that prolong hospital stays and ultimately cause reimbursement issues for the hospital. A real time bed availability system would not eliminate the need for state-operated beds. Many of the individuals placed on DMHAS' Wait List may be inappropriate for vacant private hospital beds due to histories of violence or serious co-morbid medical conditions. However, it is believed that some referrals to the wait list could be managed in private hospital beds.

State and Private Hospitals are Increasingly Dealing with More Complex Patients

Both state-operated and private hospitals deal with patients that have increasingly complex behaviors. These groups of patients may present challenges at the time of admission or at discharge. Some of these individuals may be served in Whiting, DMHAS' Forensic Hospital, and be under the jurisdiction of the Psychiatric Security Review Board (PSRB). Some of these patients may have histories of violence or may pose dangers to themselves or others. Other patients are transferred to DMHAS after completing prison sentences. Often, these individuals encounter discharge barriers that may relate to risk factors and community safety. They may require specialized discharge placements with increased supervision. These individuals may have longer lengths of stay because their discharge planning moves much more slowly than that of other patients. Over time it is believed that this cohort of patients grows very slowly and may slow the flow into and out of a hospital.

The utilization data for private hospitals shows that they typically discharge patients within 10 days, so patients that are perceived to require long stays may not be admitted to a private hospital. When one looks at who gets placed on the DMHAS waiting list, common characteristics seem to be patients with a history of violence or serious medical co-morbid conditions. Some of the more complex patients may be "boarded" in the ED to avoid placing them on an inpatient unit. The lack of these discharge options may mean the hospital faces payment issues if at some point the individual no longer meets medical necessity criteria. Discussions with private hospital behavioral health leadership have touched on the need for more highly structured intensive residential placement where patients like these could be managed and treated in a setting that was less restrictive than an inpatient unit. It was felt that these programs could be a temporary "safe holding" environment or a longer-term treatment environment.

Development of Intermediate Bed Capacity Could Relieve Pressure on State Inpatient Beds

Inpatient bed capacity can only be expanded through state general funds, payment for Medicaid or Medicare services, or private insurance. There are no other ways to create new beds. The wait list data has also demonstrated a potential need related to intermediate level of care beds. Wait list data was analyzed over a period of 5 years in order to examine the lengths of stay for individuals who were admitted to state beds off of the wait list. Interestingly, approximately 30% of the individuals admitted off of the list had lengths of stay at a state hospital of less than 90 days. This means that approximately 70 individuals annually could be diverted from state beds if additional intermediate care capacity existed at the community level. If each of these individuals required a 90 day length of stay, this would mean that the system needed an additional 6,300 bed days.

Currently, DMHAS has 11 private intermediate beds in Bridgeport and Mansfield. Creating new intermediate care beds in Hartford, New Haven, and Waterbury would ensure statewide access to this important level of care and would deflect patients from state-run inpatient services. Private hospital providers may be interested in offering this service based on level of reimbursement. Recent Medicaid changes could make this more attractive to private hospitals. However, it may be necessary to provide some type of grant or subsidy to cover the cost of the patients who may be admitted to these programs and at some point in treatment no longer meet Medicaid or private insurance medical necessity criteria. This expansion of intermediate care beds would only be advantageous to the state if providers had limited ability to decline referrals and they had the capacity to serve patients with complex needs.

Discussion and Findings for Community Services

Overview

A comprehensive community mental health network is essential if individuals are to be diverted from inpatient hospitalization or successfully re-integrated into the community following discharge from an inpatient stay. A report by TAC indicated that states with well-developed diversionary services like mobile crisis, jail diversion, and respite beds were better able to manage fewer inpatient beds. The report also stressed the importance of having intensive community supports like assertive community treatment (ACT) and community support programs (CSP) and a range of residential options such as group homes and supervised apartments.

Connecticut is a National Leader in the Use of Diversionary Services

Connecticut has a rich array of diversionary services. Across the state, there are 27 mobile crisis programs, 19 jail diversion programs, 7 Community Intervention Teams, and 12 respite programs with 88 beds available for short-term respite. The programs have been in operation for a number of years and recently have been expanded to focus on specialty groups like veterans and women. These programs are broadly distributed across the state. One area, respite, can be more effectively utilized. Respite beds are managed through the Local Mental Health Authorities (LMHA's) and they are used to provide short-term residential support to clients that may be deteriorating and may need hospitalization if they are not stabilized.

Because respite programs are tied to the LMHA's and not looked upon as regional resources, a small number of vacancies in respite may occur on a regular basis. Respite utilization for FY 16 was approximately 80%, so beds are available and may be more effectively managed as a regional resource available to all providers in a given region.. While not all patients who are referred to the waiting list are appropriate for respite, some patients who are waiting could be diverted if the respite beds were more centrally managed.

Intensive Community Services are Strategically Positioned throughout the State

DMHAS has a comprehensive array of high-intensity community services across the state. These services are generally categorized as Assertive Community Teams (ACT) or Community Support Programs (CSP). CSP is provided by 28 agencies across in the state in 39 distinct programs. These programs have the capacity to serve over 4,500 clients annually. ACT services are offered at 10 LMHA's or affiliated providers in 19 distinct programs. The development of the ACT teams was based on an analysis of clients that met or exceeded ACT standards for service intensity. It is believed that ACT is positioned where needed in the state. These ACT programs have the capacity to serve almost 1,000 clients per month.

Connecticut Has a Comprehensive Spectrum of Residential Services but Movement Out of These Beds May be Insufficient to Accommodate Demand for Residential Beds

Most people that are being discharged from inpatient hospitalization need highly structured residential placements. A substantial portion of patients discharged to the community will require these intensive supports throughout their time in the community. Unlike some clients who continue their recovery and step-down to less restrictive residential services, some people do not follow that trajectory and will always require intensive supports. This creates bottlenecks as other patients require similar resources that are unavailable.

Connecticut has a number of options available including group homes, intensive residential, supervised apartments, and intensive case management programs that support clients who may be living in scattered-site apartments throughout the community. DMHAS has close to 900 residential beds but the capacity does not meet the need for discharge resources. Movement out of these programs is insufficient to accommodate demand for these beds.

Connecticut took advantage of a Medicaid Group Home Waiver which has allowed the state to receive federal matching for these services. There is a limitation associated with the Group Home Waiver in that group home residents must be able to participate in 10 hours of treatment services per week. There are clients who are unable to participate to that extent due to the severity of their disability. Providers are forced to be more selective regarding admission to these programs so group homes as structured under the waiver may not meet the needs of some of the patients with complex psychiatric histories.

In FY 15, 641 individuals were discharged from these residential levels of care. Group homes, which have a total capacity of 172 beds, only had 83 discharges in FY 15. While these beds are typically being fully utilized, the turnover is insufficient and many of these individuals will require intensive supports over a number of years. Placements in supervised apartments also face challenges because clients typically hold their own leases and do not "leave" the program. They remain in the apartment, but do not create new capacity by moving down to a less restrictive level of care.

Mental Health Intensive residential beds are an exception in that they are not being fully utilized. There are 100 beds in this level of care and utilization for FY 15 was just over 80%. However, many of these programs are "holding" placements as clients may decompensate and require inpatient stays to stabilize their conditions. Beds may remain open for weeks while providers protect a client's placement. This resource needs to be more carefully examined to see if certain beds could be used as respite resources, especially if providers have some sense of how long the bed may be vacant.

Residential Services are Well Utilized with Few Exceptions

Most high intensity residential services are generally at full capacity and the movement through these levels of care has generally remained constant. However, these levels of care have low turnover rates and are the most frequently needed services for hospital discharges. Annual discharges from these LOC's have remained constant over the past 5 years (about 650 per year), but additional flow is likely necessary to keep up with the demand in hospital settings for step-down options like these services.

Mental health intensive residential programs are one exception and have beds available over the course of the year. This needs to be examined more carefully to see if beds are being held open for periods of time when a client requires brief hospitalization. These vacancies should be more carefully evaluated in order to see if these beds could be used for short-term diversions similar to how respite beds are used.

Specialized Discharge Funds Are Necessary to Create Community Discharge Options

Individuals that are hospitalized within the state system need a broad continuum of community supports in order to transition and re-integrate into the community. Some simply can benefit from services that exist and are available in the community like group homes, ACT teams, or other residential supports. However, as the system begins to serve more patients with serious discharge barriers, these individuals require specialized supports that may be developed for them or, if possible, a small grouping of patients with similar needs. These discharge options require specialized discretionary discharge funds. These funds allow providers to tailor supports to the unique needs of the client. This might include enhanced supervision (1-1), structural modifications, and specialized medical assistance.

These discharge funds have been consistently allocated to DMHAS' budget in an effort to stimulate discharges.

Capacity at 60 West Nursing Home

DMHAS collaboratively developed 60 West Nursing Home with the Department of Correction in 2013 and has slowly been building capacity as it worked to get Medicaid and Medicare certification. The facility currently has bed availability (20+) that could be used for persons that are currently in one of our state hospitals, meet nursing home criteria, and who could be served in a less restrictive setting. The facility recently received their Medicare certification and may now be in a position to accelerate referrals. However, the facility must carefully screen admissions so they do not become classified as an Institution for Mental Diseases (IMD), which would negatively impact the facility's ability to bill for nursing home services.

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Recommendations

Data Collection and Tracking of Real Time Bed Availability

- Create a "real time" bed availability system that can be accessible to interested stakeholders. There is currently no way to identify where beds exist across the state and whether any of those beds could be filled by individuals waiting on the state hospital wait list. Without a real time bed availability system, it is extremely difficult to ascertain the systems' inpatient needs. The Administrative Service Organization (ASO), Beacon, may be able to develop and maintain such a system, as they currently authorize inpatient placement and could likely re-tool their system to collect this data. Certain hospital systems are now doing this with their affiliated hospitals, but this needs to be expanded to the entire state. Creating this new system would likely require additional funding.

- Create and disseminate standards for the state-operated wait list. Standards would be established for when clients are placed on the list, date used for that placement, and clear criteria for removal from the wait list. As part of the standardization current data elements will be reviewed and state staff will clarify whether any additional data elements need to be collected.

Improve Management of Existing Resources

- Regionalize adult respite beds and manage them through a centralized tracking system, similar to the Wait List that is maintained by DMHAS to manage inpatient referrals. DMHAS would need to coordinate with respite providers to communicate new operational standards and processes for filling respite vacancies.

- Expand DMHAS' utilization management office to better coordinate access to state-operated inpatient and contracted intermediate care beds, nursing homes, respite, and intensive residential supports. The office should be capable of utilizing data from multiple sources to determine respite, residential, and inpatient bed availability. This would allow that office to better track bed availability that may be the due to "holding" beds in intensive mental health residential programs where beds are left vacant for a period of time when a patient is re-hospitalized, but the patient will need the bed upon discharge.

- Enhance discharge planning capacities at state-operated community inpatient facilities. Connecticut Valley Hospital has benefited from increased emphasis in this area by hospital leadership. This is reflected by a consistent number of discharges over the past 5 years. This change was effected on multiple levels that involved hospital leadership, line staff, and increased involvement and responsibility of community providers. The same type of approach should be replicated at other community hospitals which have seen a trend of reduced discharges over the past 5 years. This type of enhancement might require funding for additional staff that would be instrumental for discharge planning.

- Currently, CRMHC has 16 beds that are not currently certified as an inpatient facility. DMHAS should consider moving these beds to CVH which is a certified inpatient facility. This would provide several advantages. This would allow DMHAS to bill for eligible patients and would create greater efficiencies from a staffing perspective, offering patients greater resources that could assist in clinical care and discharge planning. The move to CVH might permit more challenging patients to be admitted which is more limited at CRMHC. DMHAS might also be eligible for a small amount of DSH payments if this move were to occur.

- Systematically review all state-operated patients to determine if they meet nursing home care criteria and could be transitioned to 60 West Nursing Facility. The facility has slowly moved toward full

capacity as it worked to obtain Medicare and Medicaid certification. Now that this has been finalized, DMHAS should accelerate referrals to the facility. The same review should be applied to the state hospital wait list to determine if there are patients who have been referred to DMHAS by private hospitals who meet nursing home criteria and could be diverted from state-operated inpatient stays.

- Maintain the use of Community Care Teams (CCT's). The CCT's have been effective in managing patients who frequently use emergency department resources. These teams serve to link clients to appropriate community resources and reduce unnecessary utilization of emergency department or inpatient resources.

Explore the Development of New Resources Should Funding Becomes Available

- Explore whether private hospitals would be interested in developing a small number of adult intermediate care beds. If feasible, it would be advisable to try to develop these additional beds in those metropolitan areas that do not currently have this capacity such as the Hartford, Waterbury, and New Haven areas. Since DSS has changed the manner in which private hospitals are reimbursed for inpatient services (per diem rate), it is believed that this expansion could be paid for through Medicaid reimbursement. Based on data hospitals provide to OHCA, hospitals have excess capacity which could be tapped for the development of these beds. It might be necessary for the state to identify supplemental funds that could be used by these hospital systems in the event that patients need additional care and no longer meet medical necessity or are uninsured. A contractual arrangement like that which exists currently for intermediate beds could serve as a model.

- Relieve the gridlock in state inpatient facilities by increasing the availability of high intensity residential programs. These programs would accommodate individuals currently in state hospitals who could be placed in community settings with the appropriate level of treatment, supervision, and support.

- Maintain annual increases to the Discretionary Discharge Funds allocated to DMHAS. These funds are essential for the development of options for those patients that cannot be discharged to existing community resources. These funds have been instrumental in the past for increasing discharges from the state-operated system. If the funds are not enhanced each year it makes it increasingly difficult to discharge patients who require greater support than what is typically offered in our existing services.

The Department of Children and Families (DCF) Psychiatric Services Study Report

Introduction

On October 1, 2014, the Department of Children and Families submitted the Children's Behavioral Health Plan in fulfillment of the requirements of Public Act (PA) 13-178, one part of the Connecticut General Assembly's response to the tragedy in Newtown in December 2012. The legislation called for the development of a "comprehensive implementation plan, across agency and policy areas, for meeting the mental, emotional and behavioral health needs of all children in the state, and preventing or reducing the long-term negative impact of mental, emotional and behavioral health issues on children." Although the plan was developed under the guidance of DCF, the product represents the extensive public input and discussion over an 8 month period and aspires to be owned by the diverse set of organizations and individuals who had a part in its design.

The plan noted that there are approximately 783,000 children under age 18 currently in Connecticut, constituting 23% of the state's population. Epidemiological studies using large representative samples suggest that as many as 20% of that population, or approximately 156,000 of Connecticut's children, may have behavioral health symptoms that would benefit from treatment. Researchers have found that between 37 and 39 percent of youth in the three studies had received one or more behavioral health diagnoses between ages 9 and 16. Half of all lifetime diagnosable mental illness begins by age 14. Despite the prevalence of behavioral health conditions, an estimated 75-80% of children in Connecticut with behavioral health needs do not receive treatment. The 2014 report acknowledged the tremendous strides the State of Connecticut has made in building a more responsive service system while acknowledging the need for continued improvements and advancements. In addition to the extensive input gathering, the process examined milestones in the development of the children's behavioral health services and systems from 1980 through 2014. Based on the feedback, the plan put forth a theory of change to drive the work moving forward and identified seven thematic areas which are:

A. System Organization, Financing and Accountability
B. Health Promotion, Prevention and Early Identification
C. Access to a Comprehensive Array of Services and Supports
D. Pediatric Primary Care and Behavioral Health Care Integration
E. Disparities in Access to Culturally Appropriate Care
F. Family and Youth Engagement
G. Workforce

The Plan and recommendations set forth within has served as the "blueprint" guiding the Department's work and that of its partners and has the benefit of the Children's Behavioral Health Plan Implementation Advisory Board codified in Public Act 15-27. Since its original submission, two progress reports have been submitted, one in 2015 and the most recent on September 15, 2016, both of which can be found at www.plan4children.org

The below illustration, contained within the original report, serves as a visual of an improved service array and highlights primary system infrastructure functions.

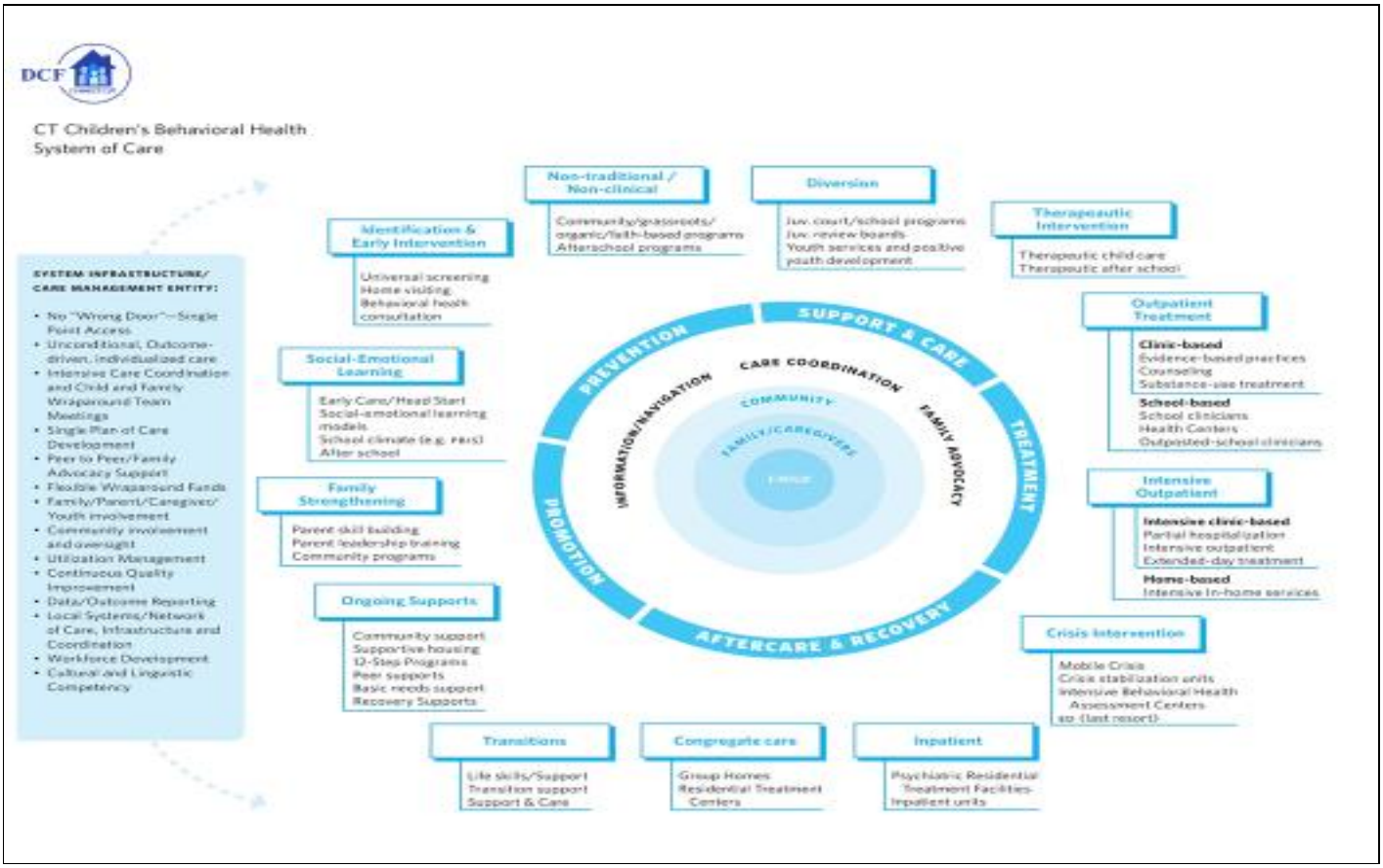

Figure 13: CT Children's Behavioral Health System of Care

In the last six year period DCF has made a concerted effort through numerous activities to reduce the number of children who:

- were stuck in hospital emergency departments (EDs)
- were in need of out-of-home residential placement
- had high numbers of inpatient and congregate care stays
- had high lengths of stay in inpatient hospitals and congregate care settings
- were slow to be discharged

Expanding and enhancing the community based service array has been a primary strategy to achieve these outcomes. The continued building of the children's behavioral health system is grounded in the following tenets:

- Children/youth with behavioral health needs are identified early and have access to appropriate care;
- The service system promotes equity and reduces racial and ethnic disparities;
- There is a full service array that is available and children/youth and families are matched to the appropriate treatment based on their needs not on what is available;
- Providers are trained and supported to provide services backed by the best available science for effectiveness
- Services are supported by robust data collection, reporting and quality improvement systems
- Children/youth and families achieve the best possible outcomes and expenditures are held at reasonable levels

The 2016 Progress Update outlines the multiple activities underway among seven state Departments and their partners, where collaboration and coordinated planning are advancing the service system. Findings to date include:

- Service systems being designed to promote access, quality, and outcomes, for example, eliminating exclusionary contract criteria that previously served as a barrier
- An increased awareness of health equity and disparities, with implications for programming and data collection/reporting
- More children and youth are getting evidence-based treatment (EBT) than ever before
- CT is a national leader in the delivery of EBTs and trauma-informed systems and services
- Outcomes data demonstrate that children and youth are getting better
- CT is delivering home, school, and community-based care that is both clinically and cost effective

The following charts are included to demonstrate the trends over the years in response to systemic changes.

Emergency Department and Inpatient Services for Children

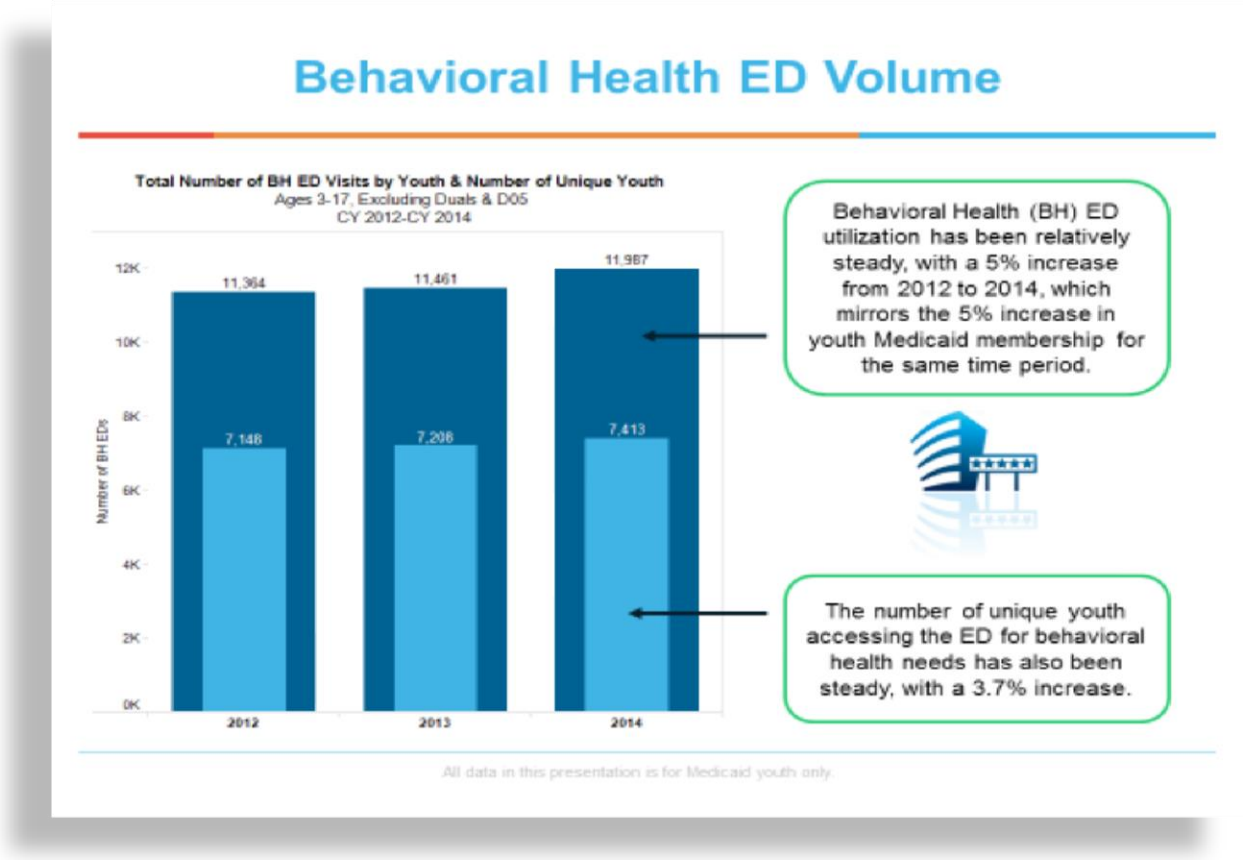

Figure 14: DCF – Behavioral Health ED Volume

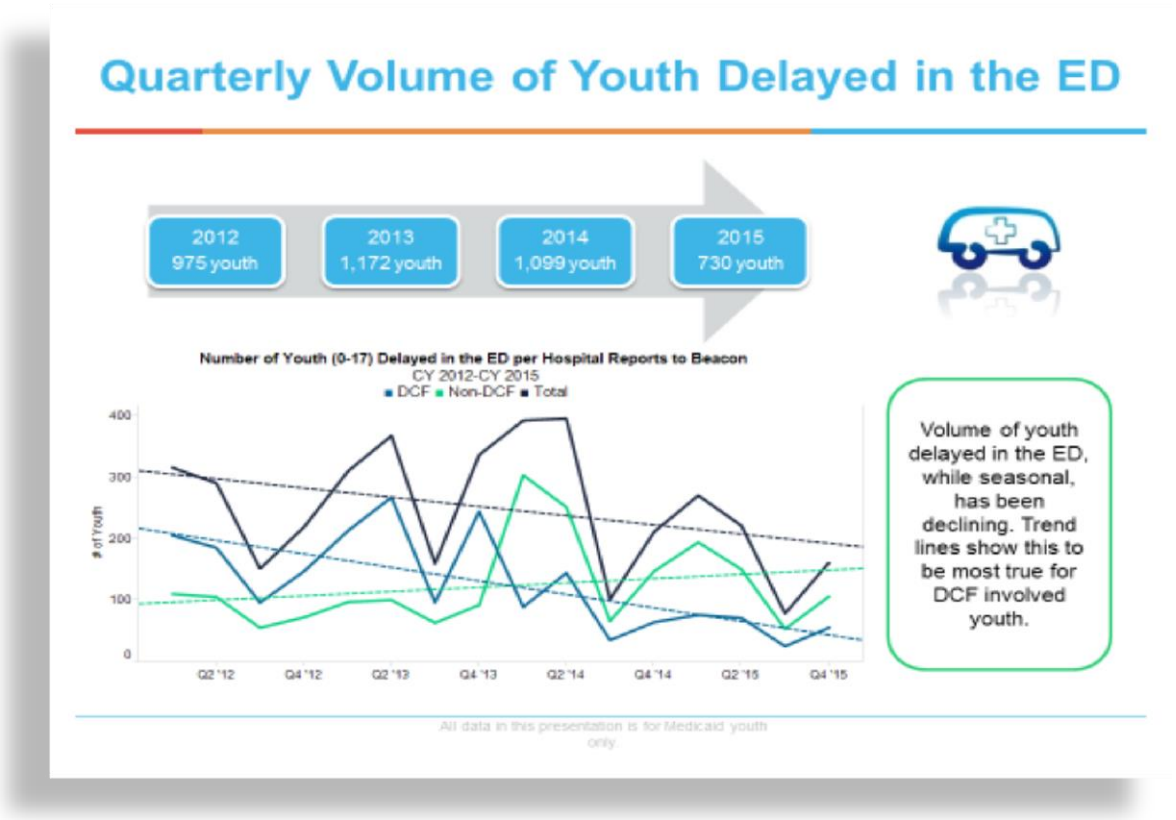

Figure 15: DCF - Quarterly Volume of Youth Delayed in the ED

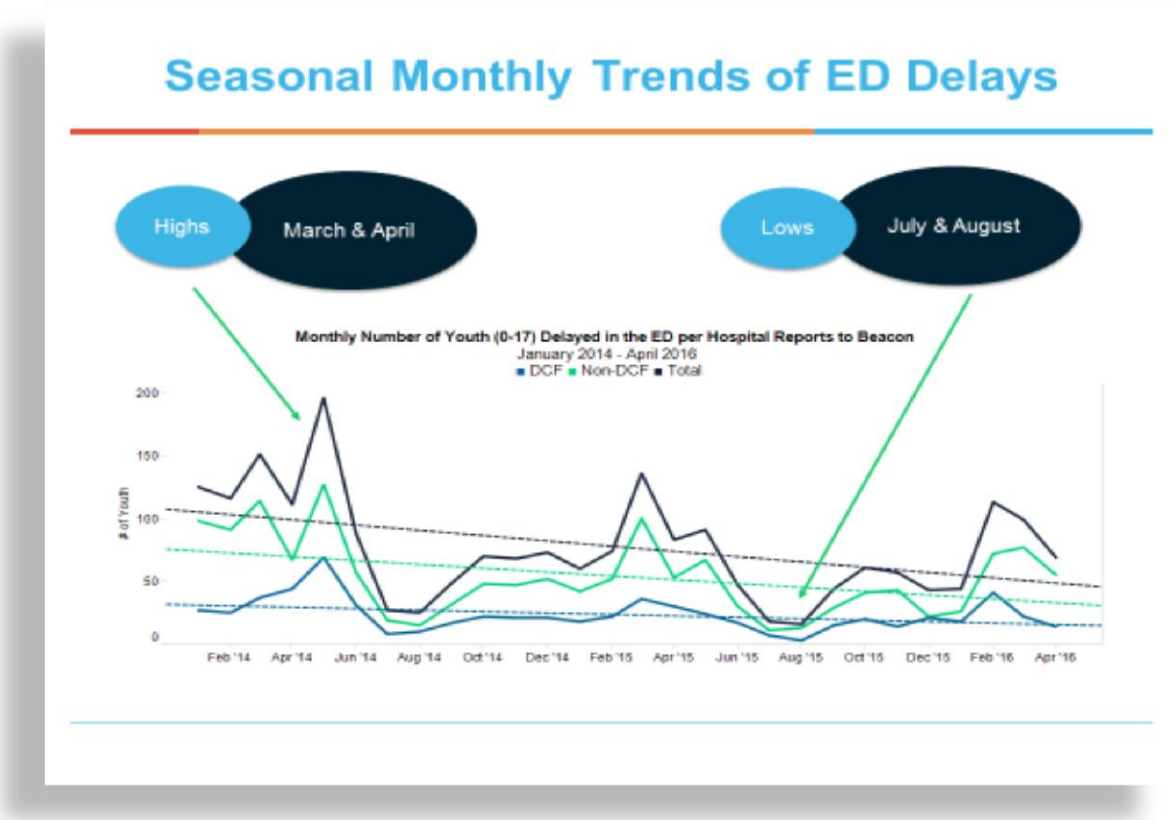

Figure 16: DCF - Seasonal Monthly Trends of ED Delays

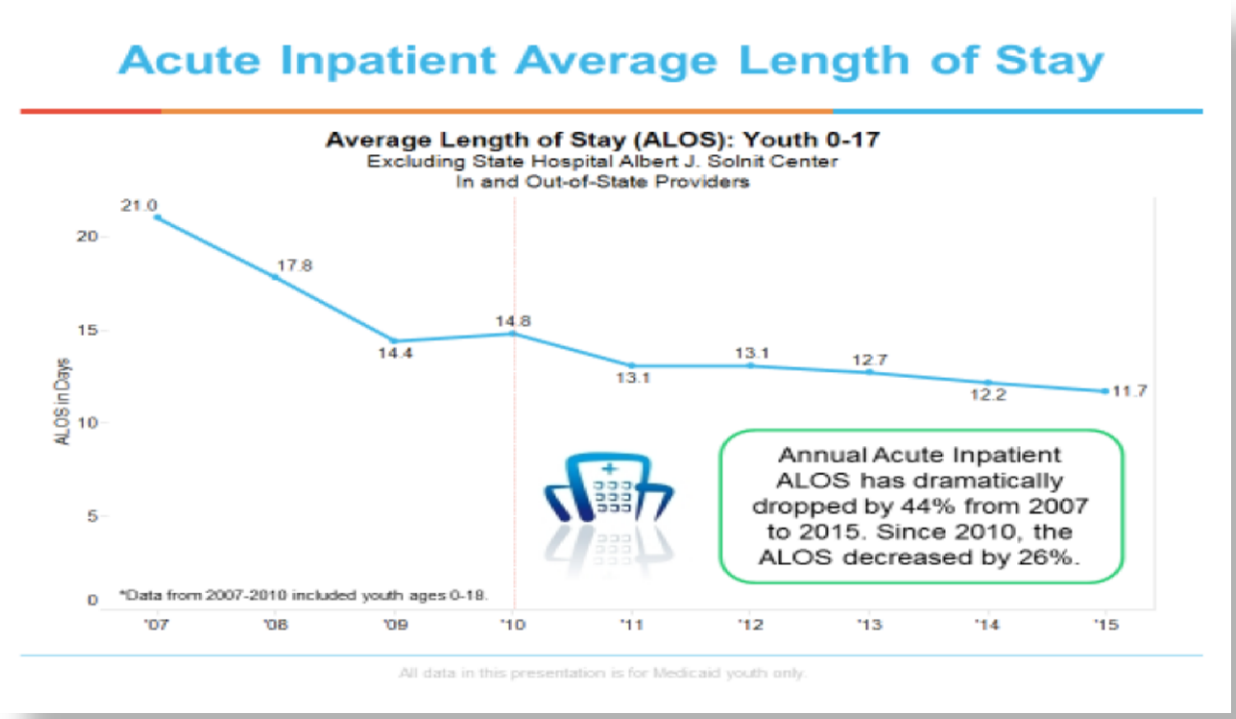

Figure 17: DCF - Acute Inpatient Average Length of Stay

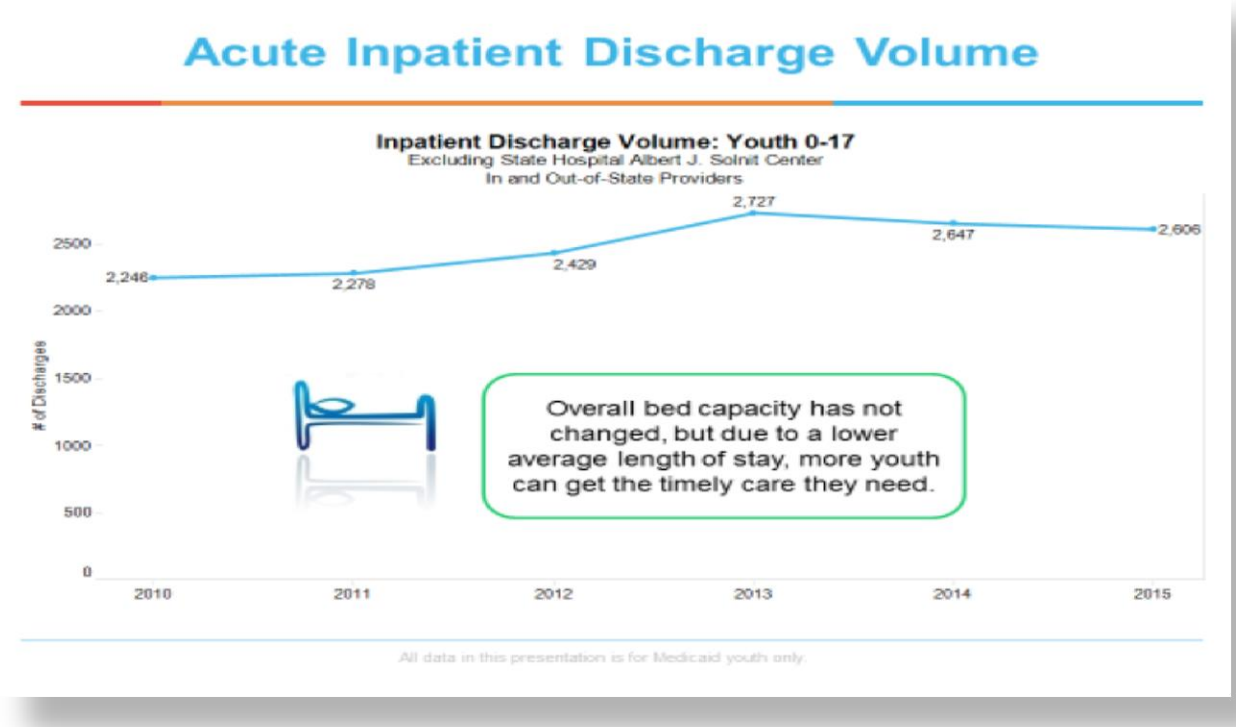

Figure 18: DCF - Acute Inpatient Discharge Volume

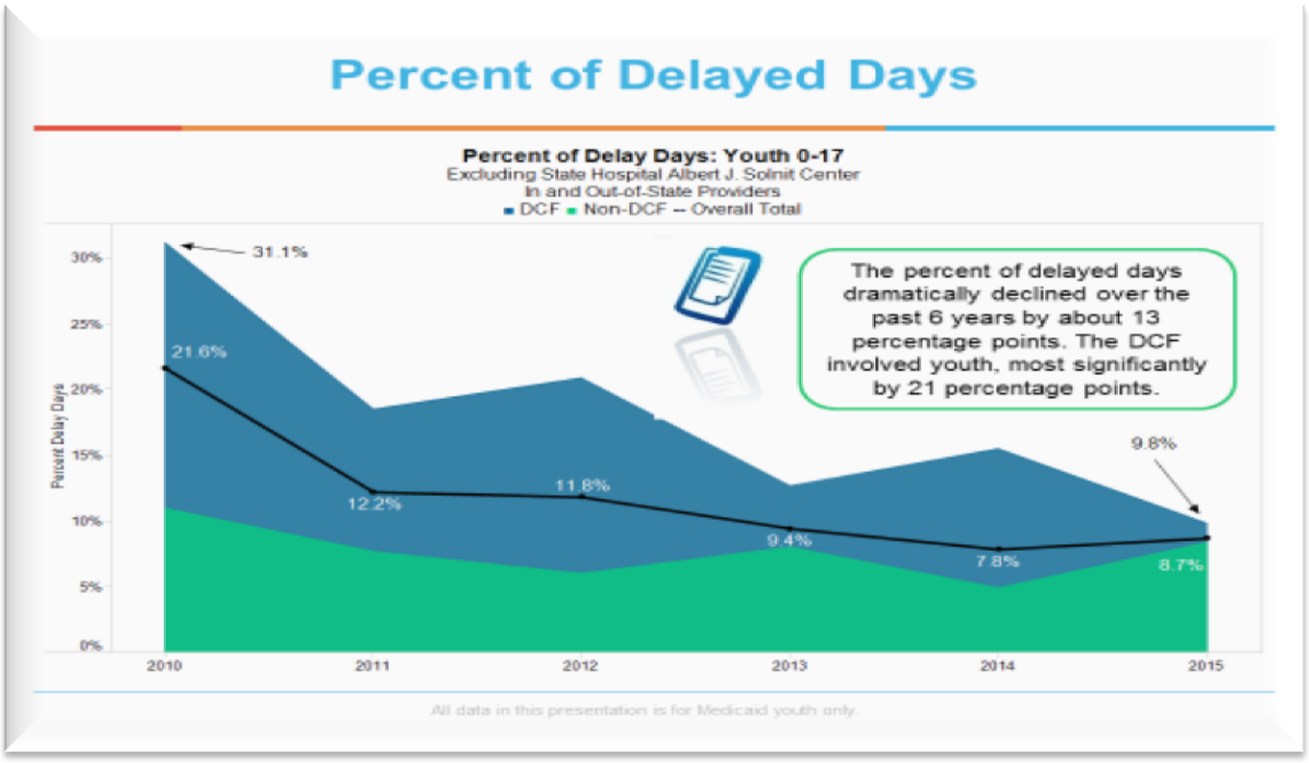

Figure 19: DCF - Percent of Delayed Days

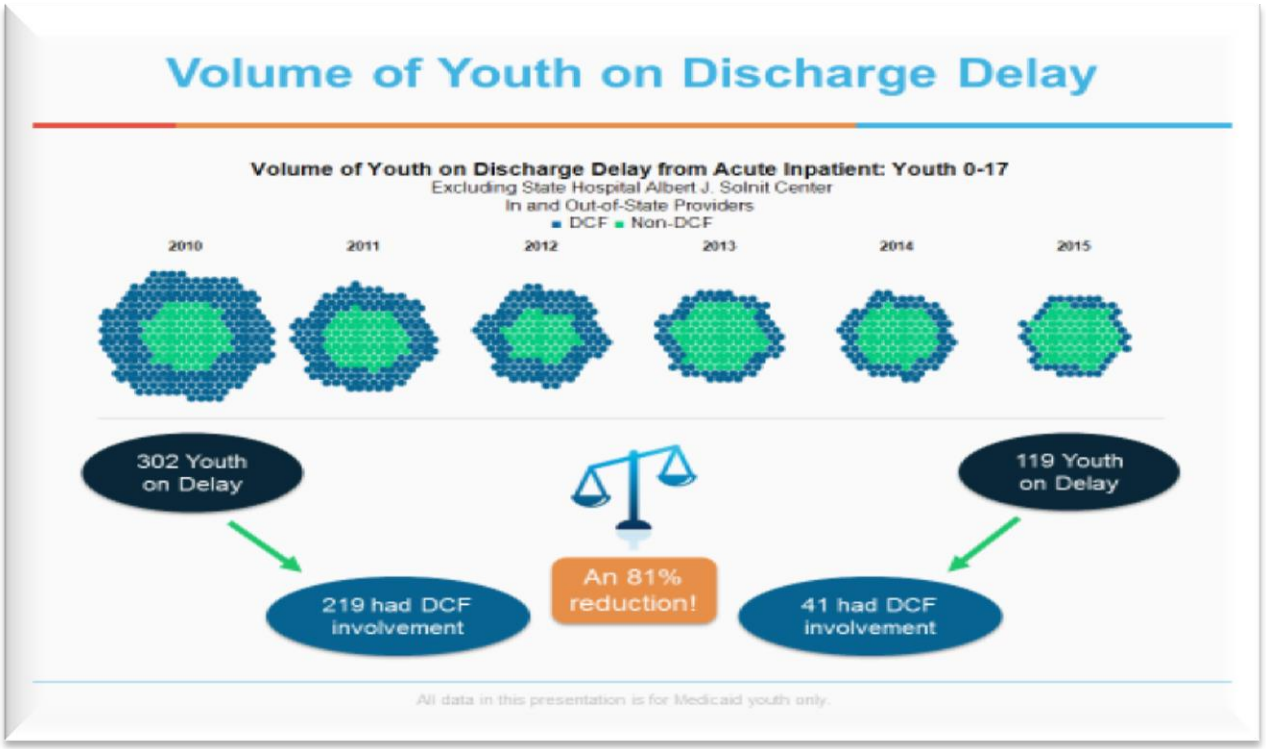

Figure 20: DCF - Volume of Youth on Discharge Delay

DCF State Operated Inpatient Services for Children

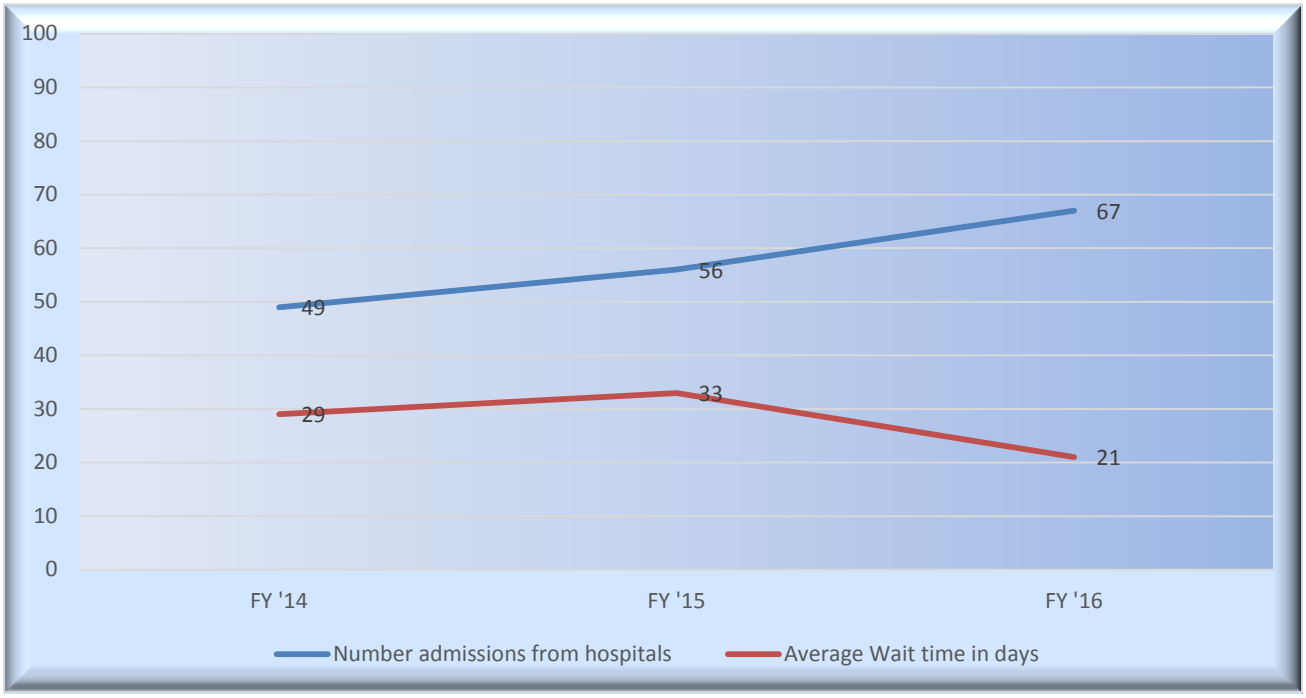

Figure 21: Wait time for admission into Solnit Hospital from private community hospitals FY '14 - FY '16

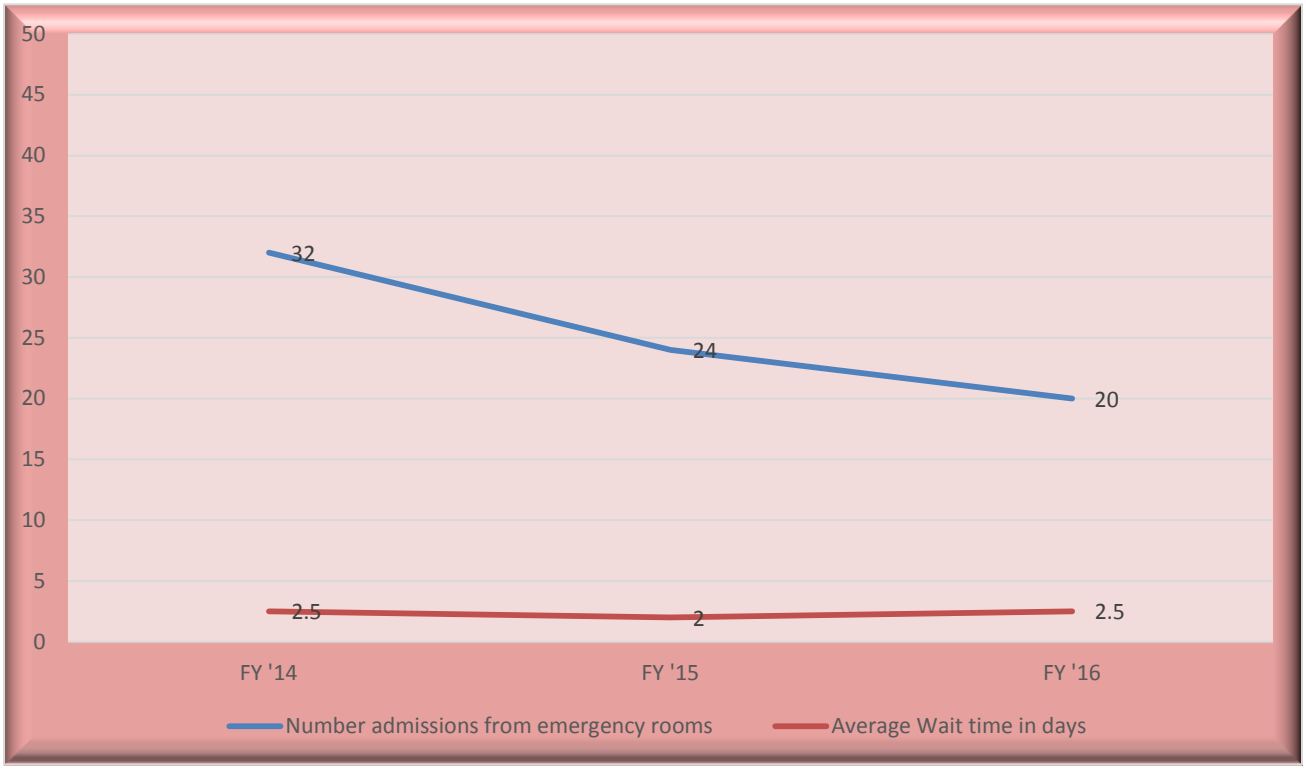

Figure 22: Wait time for admission to Solnit Hospital from emergency rooms FY' 14 - FY '16

Bed Capacity and Utilization for Solnit

Table 16: Solnit South Hospital Bed Capacity and Utilization, FY14-16

Solnit South Hospital		
	Bed Capacity	Utilization
FY14	50	84.18%
FY15	50	82.25%*
FY16	50	86.57%*

*Utilization rates lower than anticipated, secondary to RN vacancies and the need to meet CMS hospital standards

Table 17: Solnit South PRTF Bed Capacity and Utilization, FY14-16

Solnit South PRTF		
	Bed Capacity	Utilization
FY14	24	78.70%
FY15	24	77.94%
FY16	24	90.74%

Table 18: 2011 Pediatric Psychiatric Inpatient Bed Capacity

2011 Pediatric Psychiatric Inpatient Bed Capacity				
Hospital	Child Beds	Adolescent Beds	Swing Beds	Total
Hospital of St Raphael's	20 (combined child & adol)			20
IOL	8	14		22
Manchester Hospital	0	6		6
Natchaug Hospital	6	18	3	27
St Francis Hospital	8	8		16
St Vincent's Hospital	16 (combined child & adol)			16
Waterbury Hospital	0	6		6
Yale New Haven Hospital	15	15		30
Statewide				**143**

Table 19: 2016 Pediatric Psychiatric Inpatient Bed Capacity

2016 Pediatric Psychiatric Inpatient Bed Capacity				
Hospital	**Child Beds**	**Adolescent Beds**	**Swing Beds**	**Total**
Hospital of St Raphael's	N/A			0
IOL	9	14		23
Manchester Hospital	0	6		6
Natchaug Hospital	24 (combined child and adol)			24
St Francis Hospital	6	6		12
St Vincent's Hospital	16 (combined child & adol)			16
Waterbury Hospital	0	6		6
Yale New Haven Hospital	16	23		39
Statewide				**126**

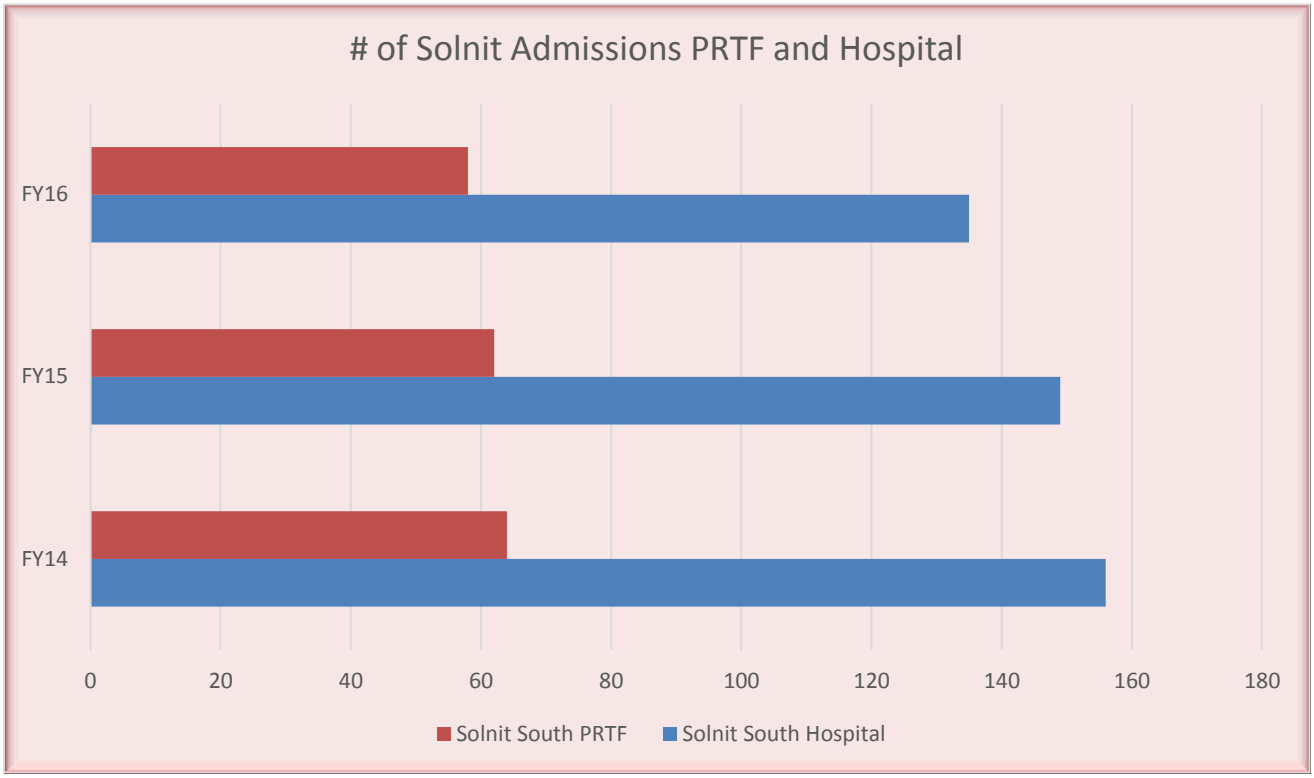

Figure 23: Number of Solnit Admissions, PRTF and Hospital

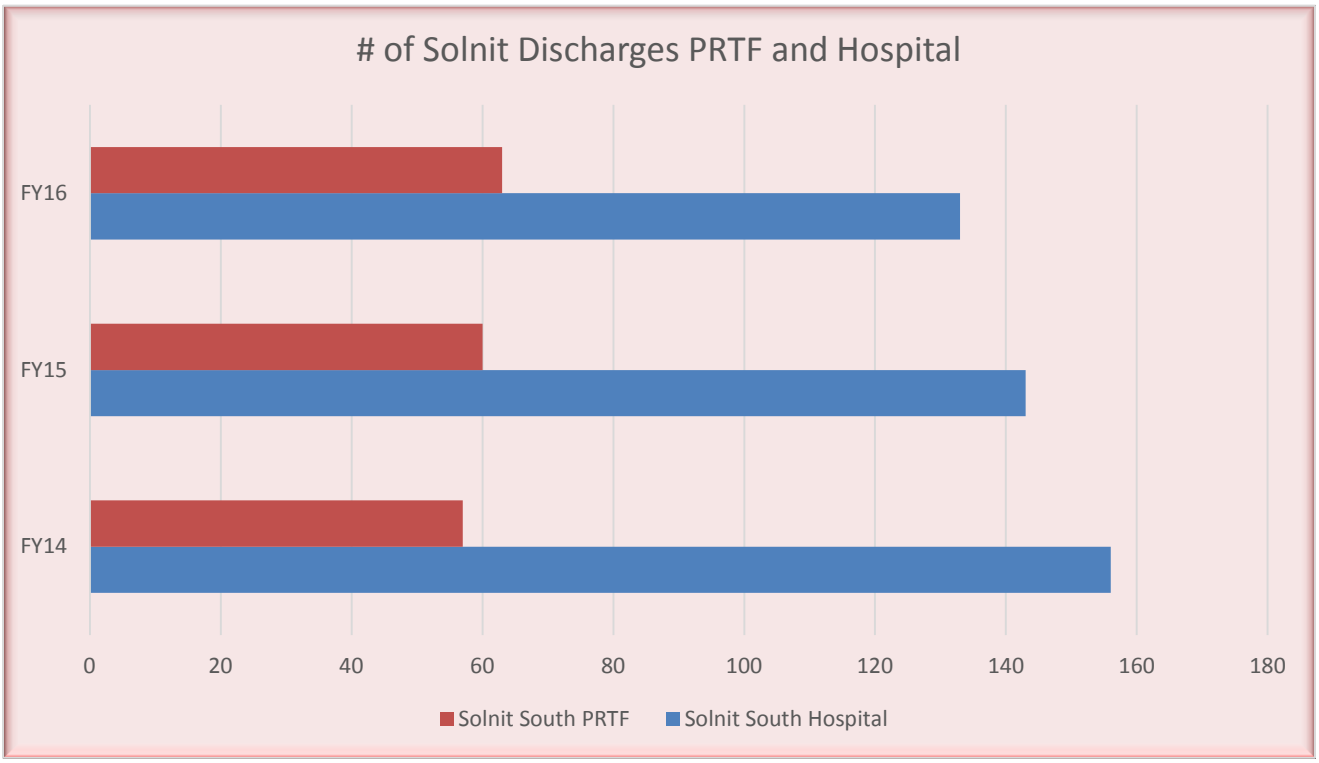

Figure 24: # of Solnit Discharges, PRTF and Hospital

Community-Based and Diversionary Services for Children and Families

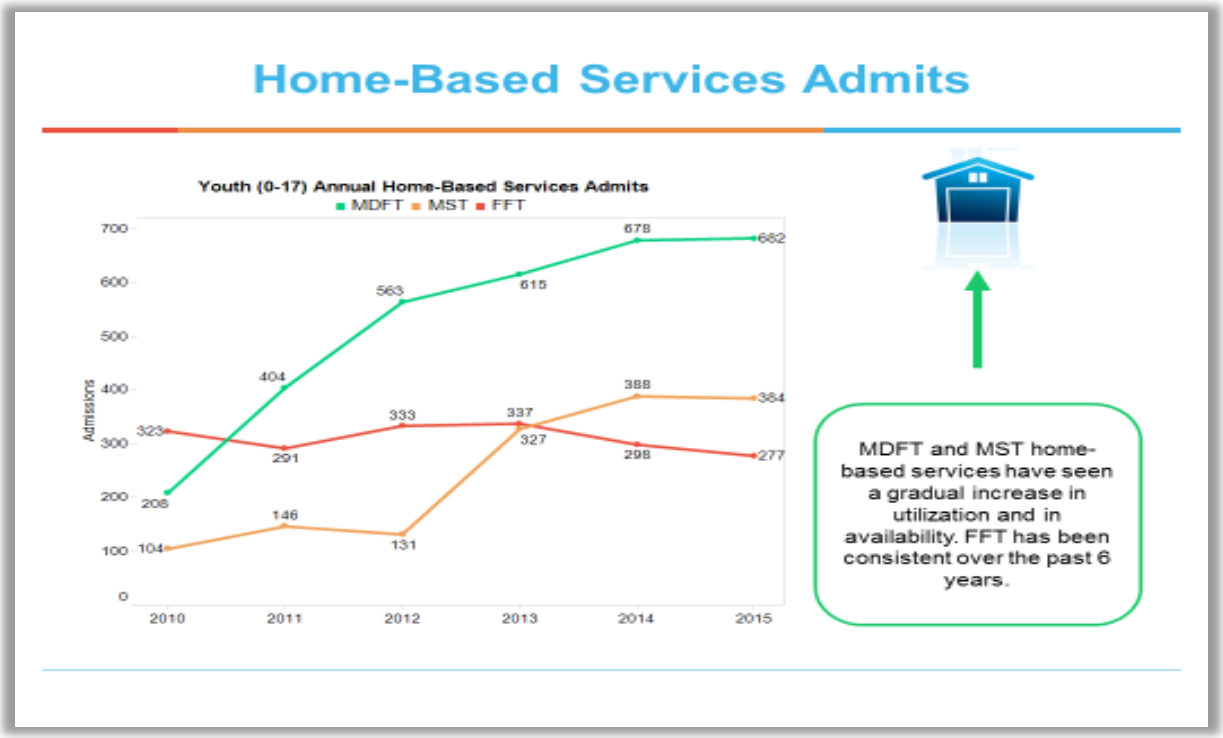

Figure 25: DCF - Home-Based Services Admits

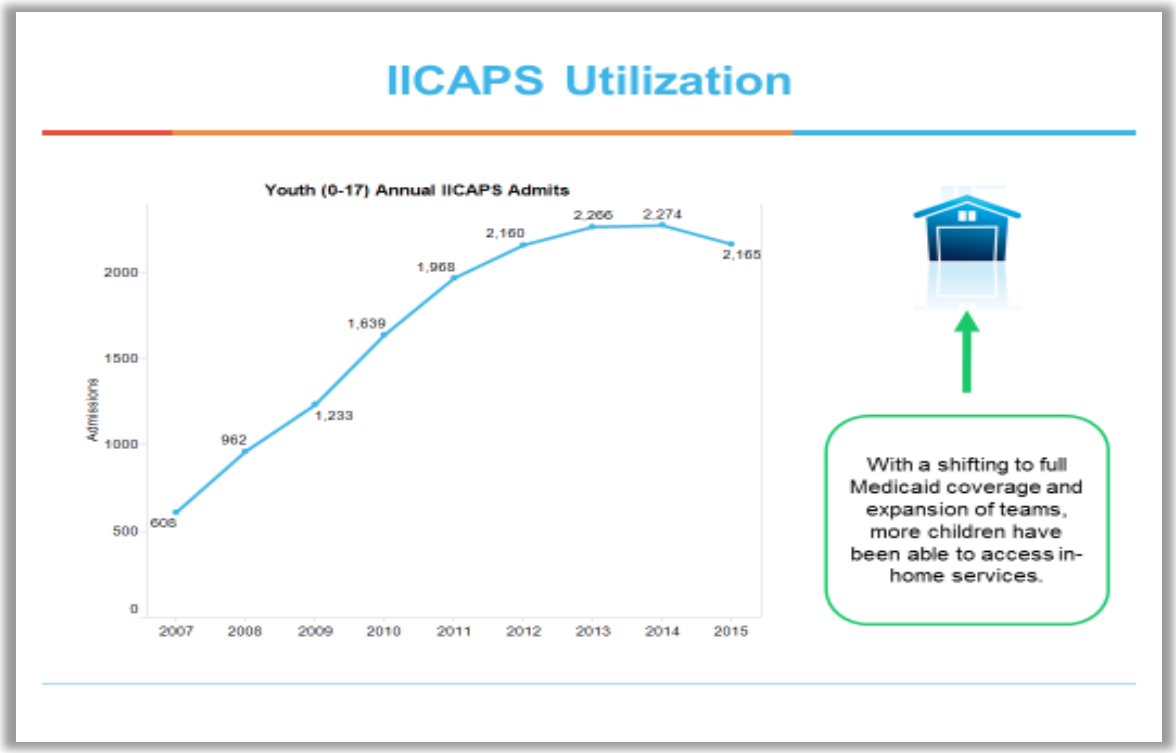

Figure 26: DCF - IICAPS Utilization

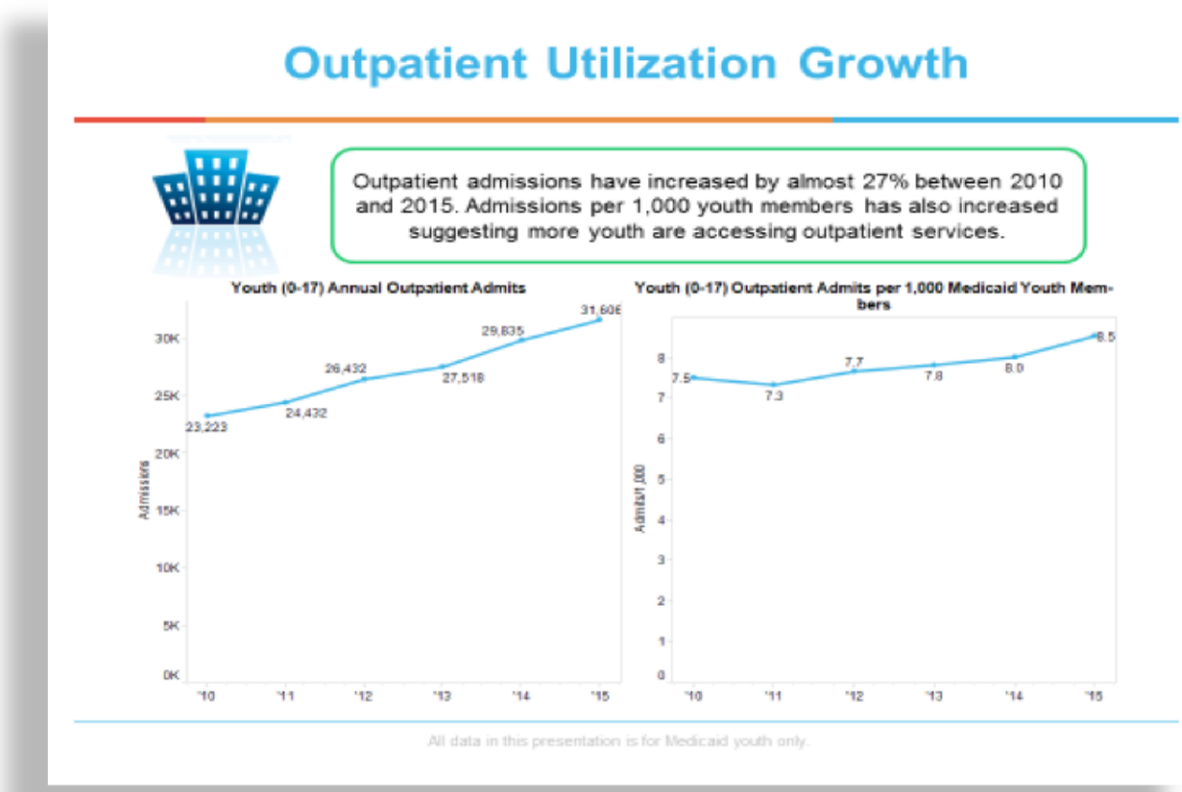

Figure 27: DCF - Outpatient Utilization Growth

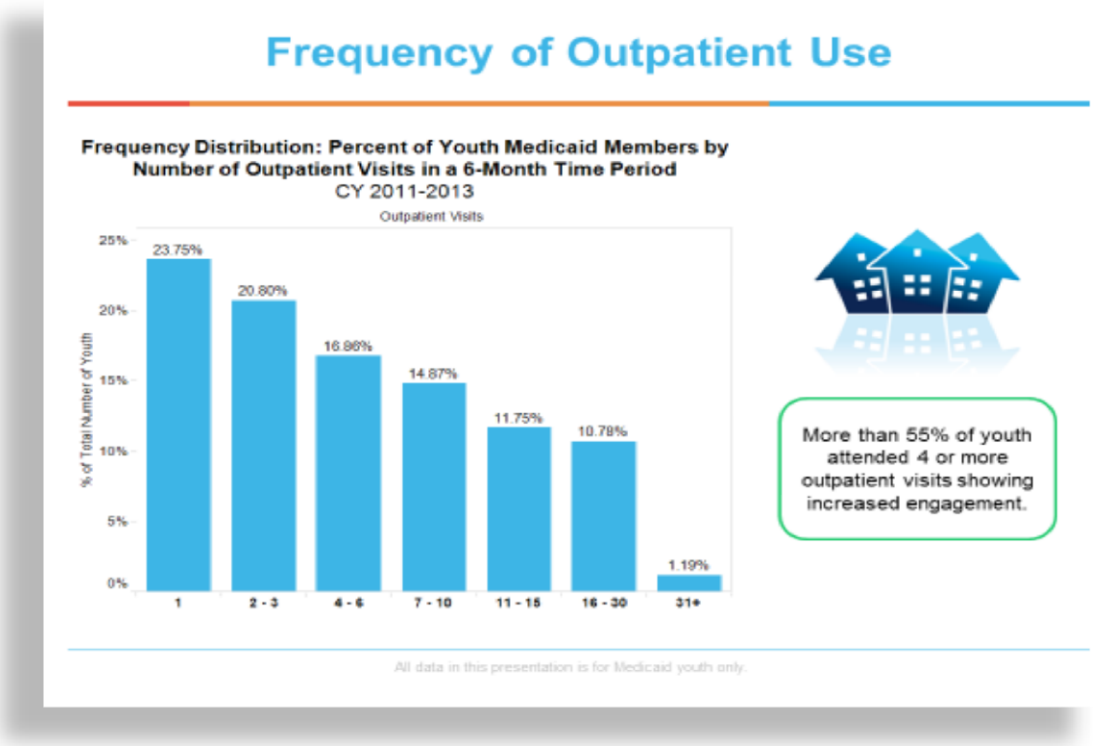

Figure 28: DCF - Frequency of Outpatient Use

Increase in EMPS-Mobile Crisis Intervention Services for Children

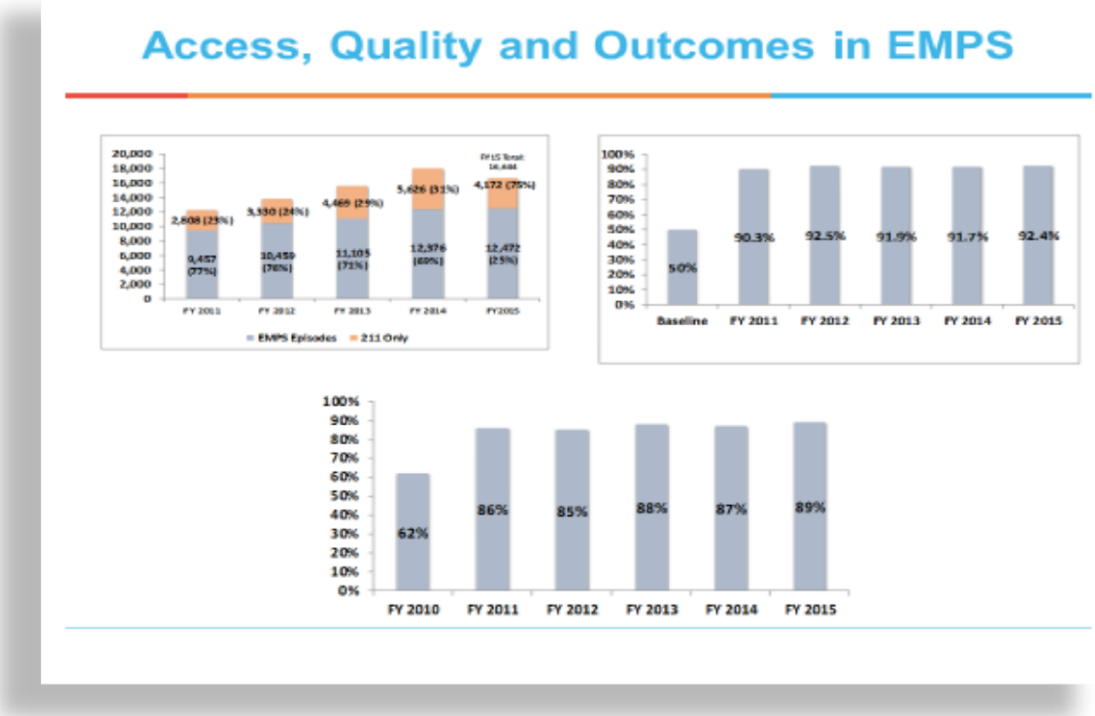

Figure 29: DCF - Access, Quality, and Outcomes in EMPS

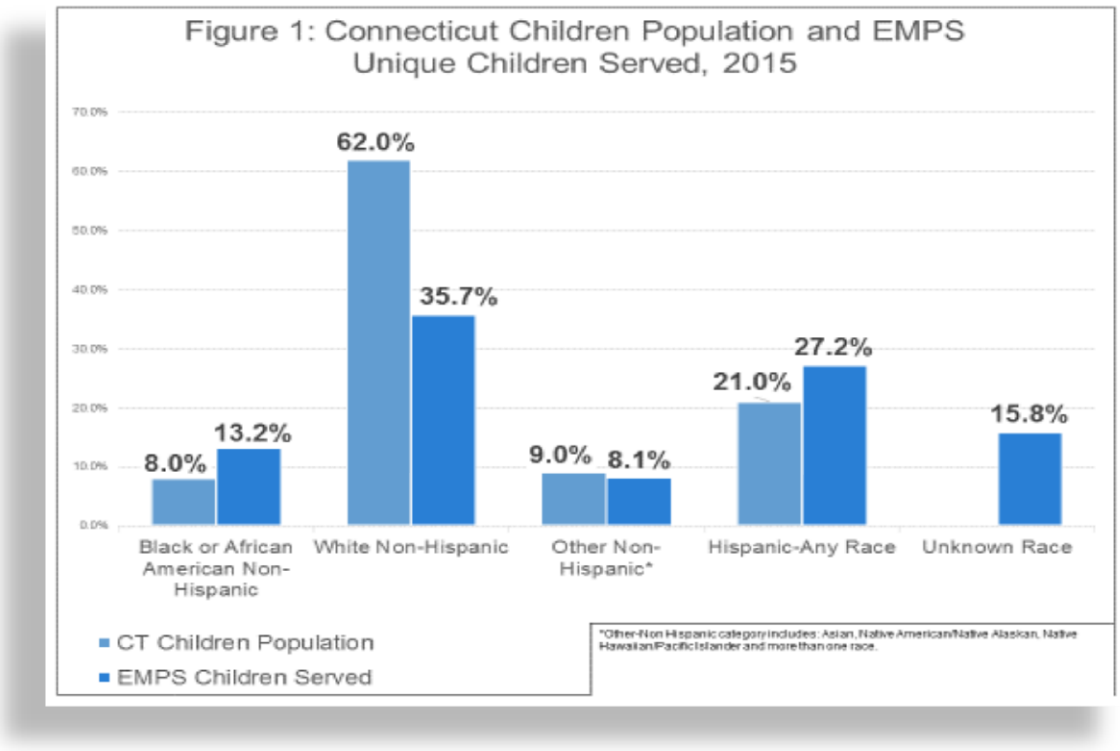

Figure 30: Connecticut Children Population and EMPS Unique Children Served, 2015

Increase in Evidence Based Programs

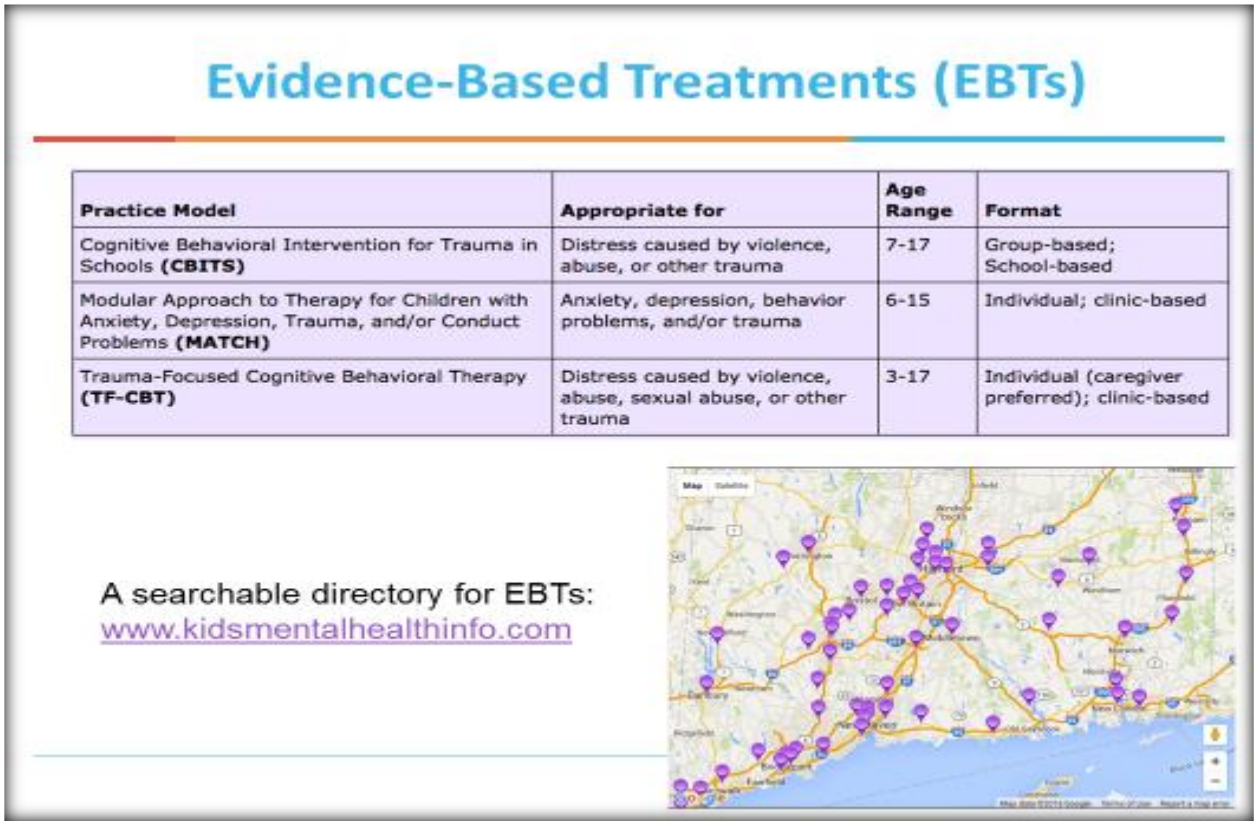

Figure 31: DCF - Evidence-Based Treatments

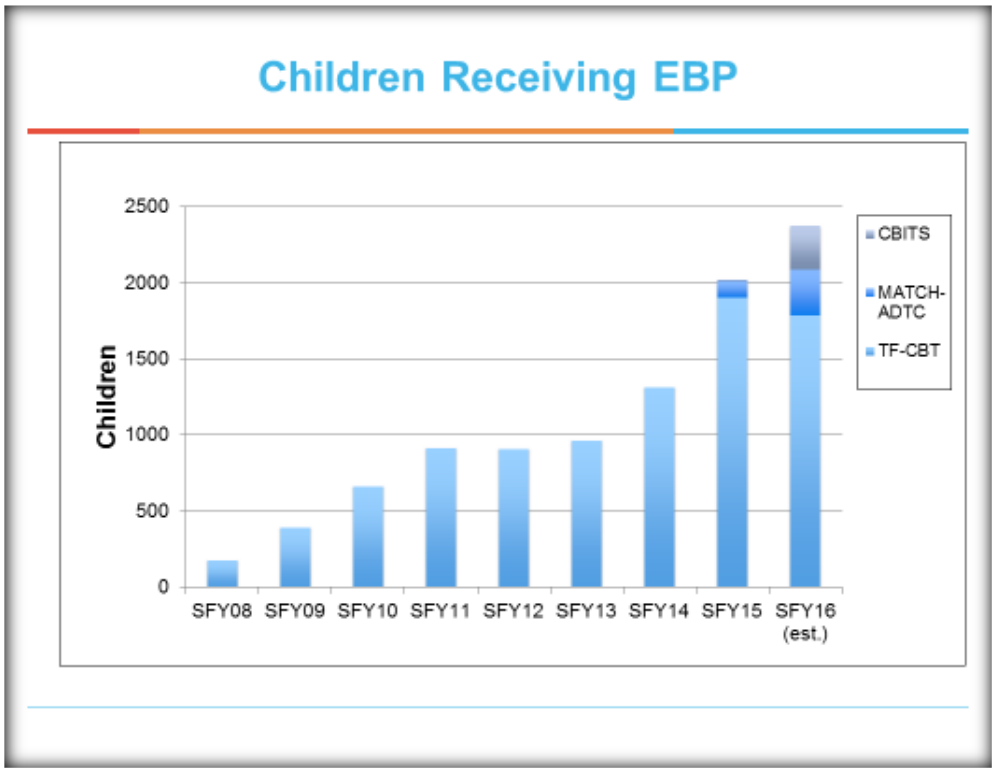

Figure 32: DCF - Children Receiving EBP

DCF Recommendations

Connecticut has seen significant progress over the last six years, responding to the feedback from families and continuing to enhance community based services and supports. Children generally do much better receiving treatment in their homes, community and schools, rather than being removed and placed in restrictive settings. When a child is in need of a higher level of care, it should be comprehensive, intensive and of short duration in order to minimize the unintended consequences of being removed from their home, community and school. Further support to schools and pediatricians, increased use of screening and capacity for crisis support are some ways in which the service system is responding earlier and supporting the whole family.

The Department set forth a comprehensive set of recommendations and strategies in the 2014 Children's Behavioral Plan and has outlined progress towards achieving those goals in the two subsequent reports. DCF convened the Children's Behavioral Health Implementation Advisory Board, implemented CT's first Care Management Entity, coordinated financial mapping efforts with other activities and state agencies and implemented services to better support the integration between behavioral health and schools and pediatricians.

The three reports also highlight the investment of multiple state agencies to advance the goals of the Children's Behavioral Health Plan. The 2016 submission includes a summary table that builds on the original grid included in the Plan's October 2014 report. This modified table is meant to serve as a snapshot reflecting the multiple activities underway by various stakeholders and includes progress updates on the intended measures as well as partners connected to each of the activities that support the fulfillment of the goals set forth. It is the Department's intention, in partnership with multiple stakeholders both public and private and in response to Public Acts 13-178 and 15-27, to continue to advance the goals outlined in the 2014 plan.

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