State of Connecticut

GENERAL ASSEMBLY

Medical Assistance Program Oversight Council

Developmental Disabilities Work Group

ED Workgroup Meeting Presentation; April 4, 2018

Medical Assistance Program Oversight Council (MAPOC) Overview

The Council on Medical Assistance Program Oversight, referred to as the Medical Assistance Program Oversight Council (MAPOC), was established in 1994 under CGS 17b-28.

* The statute charges the Council with monitoring and advising the Department of Social Services (DSS) on all matters within the HUSKY Health Program (Medicaid).
* The Council consists of legislators, consumers, advocates, health care providers, administrative service organization representatives and state agency/commission staff as defined in statute.

https://www.cga.ct.gov/med

Medical Assistance Program Oversight Council (MAPOC) Overview

In 2016 the Legislature passed Public Act No. 16-142:

AN ACT CONCERNING RECOMMENDATIONS FOR SERVICES PROVIDED TO CHILDREN AND YOUNG ADULTS WITH DEVELOPMENTAL DISABILITIES.

* The Legislation created a standing subcommittee of MAPOC to study and make recommendations to the Council on children and adults who have complex health care needs.
* The group is required to report on the "efficacy of support systems for children and young adults [in CT], not older than twenty-one years of age, with developmental disabilities, with or without co-occurring mental health conditions."

https://www.cga.ct.gov/2016/ACT/pa/pdf/2016PA-00142-R00HB-05587-PA.pdf

Developmental Disabilities Work Group Overview

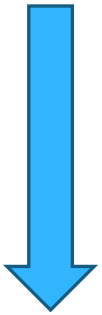
Guidelines for membership are outlined in Statute, and discretion is given to the Chairs of MAPOC; currently, Senator Terry Gerratana and Representative Cathy Abercrombie.

* Current Membership:
  * Chairs: Rep. Abercrombie and Rep. Johnson
  * Bill Halsey (DSS), Sarah Eagan (OCA) and representation from: OHA, OCA, Beacon, CCSN, Oak Hill, Vista Life Innovations, JumpStart Therapy, Benhaven, Harc and Generations.

Developmental Disabilities Work Group Overview

The first meeting was on September 23rd,2016.

* The Group discussed a vision statement and work plan; Members decided to look at a reverse continuum of care:



* Young Adults (18-21) transitioning out of the educational system.
* Pre- Adolescents and Adolescents in the educational system.
* Birth to Three

Developmental Disabilities Work Group Overview

During the first phase, the work group received information and presentations from:

* The Department of Social Services (DSS),
* The Department of Developmental Services (DDS),
* The Department of Children and Families (DCF),
* The Department of Education (SDE),
* and the Office of Early Childhood (OEC).

And also from service providers such as:

Beacon Health Options, Wheeler Clinic, Clifford Beers Clinic, The Center for Children with Special Needs, The CT Medical Home Initiative for Children and Youth with Special Health Care Needs, the Child Health and Development Institute, and the City of Meriden Public Schools.

Developmental Disabilities Work Group Overview

The Group submitted its first report in July of 2017

https://www.cga.ct.gov/med/council/qtr/2017QTR_Report%20of%20the%20Developmental%20Disabilities%20Work%20Group;%20July%202017%20-%20Final.pdf

Members decided to focus the second phase of work on:

* children and families at the point of a child's first/second contact with the ED for behavioral health crisis, and discussion of recommendations for effective and coordinated response.
* children who present with highly complex care and safety needs, which may often result in lengthy or repeated ED stays as well as prolonged or repeated inpatient admissions.

Developmental Disabilities Work Group Overview

During the second phase, the work group received information and presentations from:

* The Connecticut Children's' Medical Center (CCMC),
* Yale New Haven Children's Hospital,
* Beacon Health Options,
* The Center for Children with Special Needs,
* And several other providers including The Children's Center of Hamden, Adelbrook, and Clifford Beers.

Yale Data

Yale - New Haven Hospital
Developmental Disability Statistics
January 1, 2016 - August 14, 2017

Yale New Haven Hospital Definition:

I. Intellectual Disabilities: ICD-10 Code Range F70 - F79

II. Pervasive and specific developmental disorders: ICD-10 Code Range F80 - F89

III. Behavioral and emotional disorders with onset usually occurring in childhood and adolescence: ICD-10 Code Range F90 - F95

Developmental Disability Population - Admit Dx

Dx Code	Dx Description	Visits	%
R45.851	Suicidal ideations	728	23%
R45.1	Restlessness and agitation	238	7%
F91.9	Conduct disorder, unspecified	167	5%
Z00.8	Encounter for other general examination	155	5%
F32.9	Major depressive disorder, single episode, unspecified	149	5%
F91.1	Conduct disorder, childhood-onset type	136	4%
F39	Unspecified mood (affective) disorder	133	4%
Z04.6	Encounter for general psychiatric examination, requested by authority	84	3%
F29	Unspec psychosis not due to a substance or known physiological condition	80	3%
F60.89	Other specific personality disorders	73	2%
R45.89	Other symptoms and signs involving emotional state	71	2%
F91.3	Oppositional defiant disorder	63	2%
R46.89	Other symptoms and signs involving appearance and behavior	59	2%
F84.0	Autistic disorder	55	2%
R41.82	Altered mental status, unspecified	52	2%
F41.9	Anxiety disorder, unspecified	47	1%
F99	Mental disorder, not otherwise specified	47	1%
R45.850	Homicidal ideations	45	1%
F31.9	Bipolar disorder, unspecified	37	1%
	All Other	780	24%
	Total	**3,199**	

LOS in ED

Visits	ED LOS Min.	ALOS Min.
14,835	4,027,274	271.47

Average Time in ED = 4 hours 31 min.

Payer Mix

Row Labels	Visits	Payer Mix
Medicaid	10,388	70.0%
Medicare	2	0.0%
Anthem	1,492	10.1%
Commercial*	224	1.5%
Managed Care**	2,116	14.3%
Self-pay	169	1.1%
(blank)	444	3.0%
Grand Total	14,835	

* Commercial = Harvard Pilgram, Great West Health, Golden Rule, etc.
** Managed Care = Aetna, Cigna, United, Oxford, CT Care, YHP

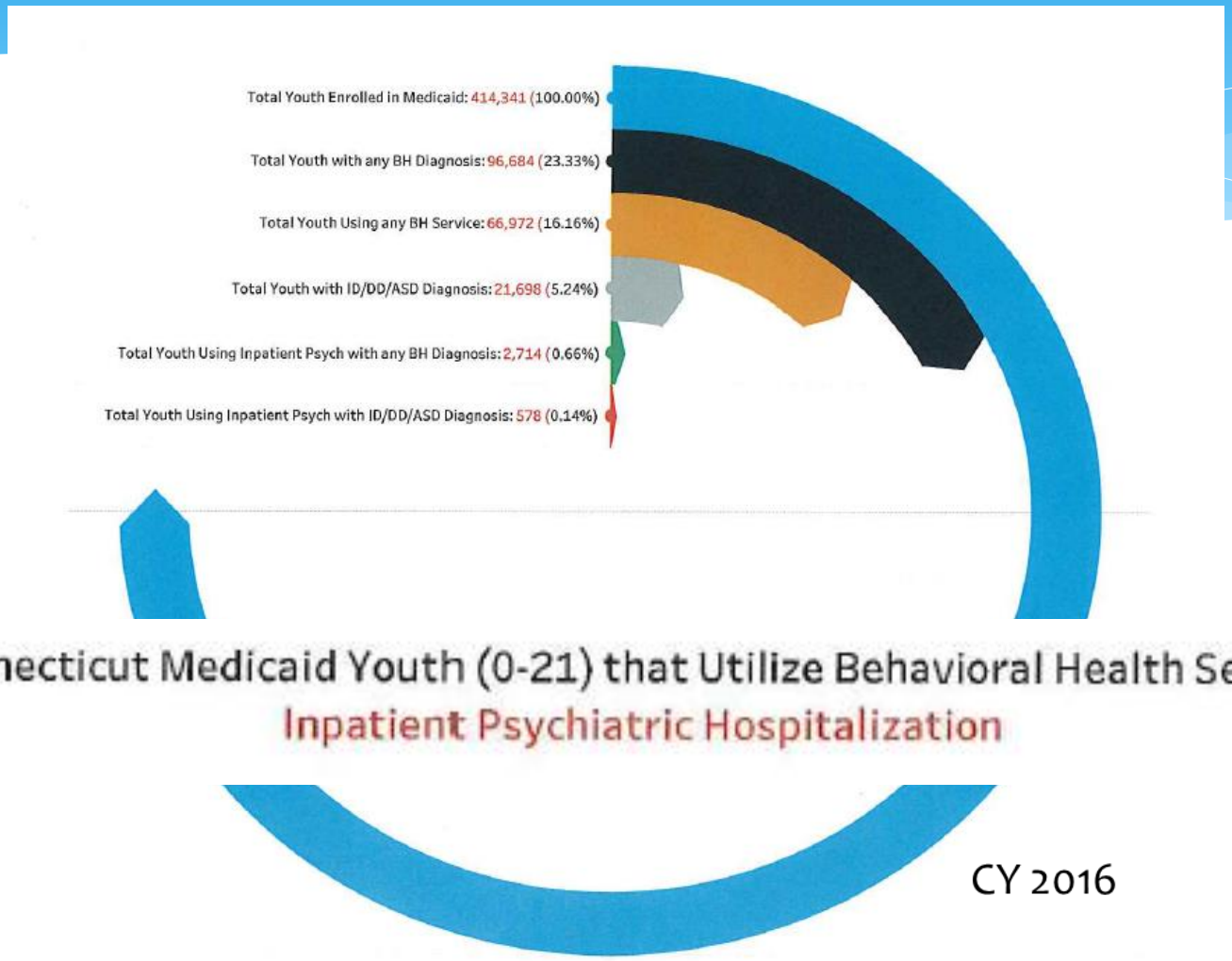
CCMC Data

ICD-10, F80-89		2015	2016	2017*
Total ED Patients Seen		328	310	114
Gender	Male	280	254	83
	Female	48	56	31
Age	Range	2-20	2-23	2-21
	Mean	11.9	12.6	12.4
	SD	3.8	3.6	4.0
	2-5	26	21	8
	6-10	80	56	23
	11-15	155	162	49
	16-20	67	69	33
	>20	0	2	1
LOS (Hours)	Range	0.22-412.63	0.23-592.40	0.70-608.23
	Mean	16.68	20.04	31.63
	SD	36.79	46.91	74.18

*YTD - 23 MAY 2017

Based on data provided by CCMC and Yale New Haven, it seemed apparent that children with developmental disabilities spend a longer time in the ED compared to their peers without developmental disabilities.

Beacon Data

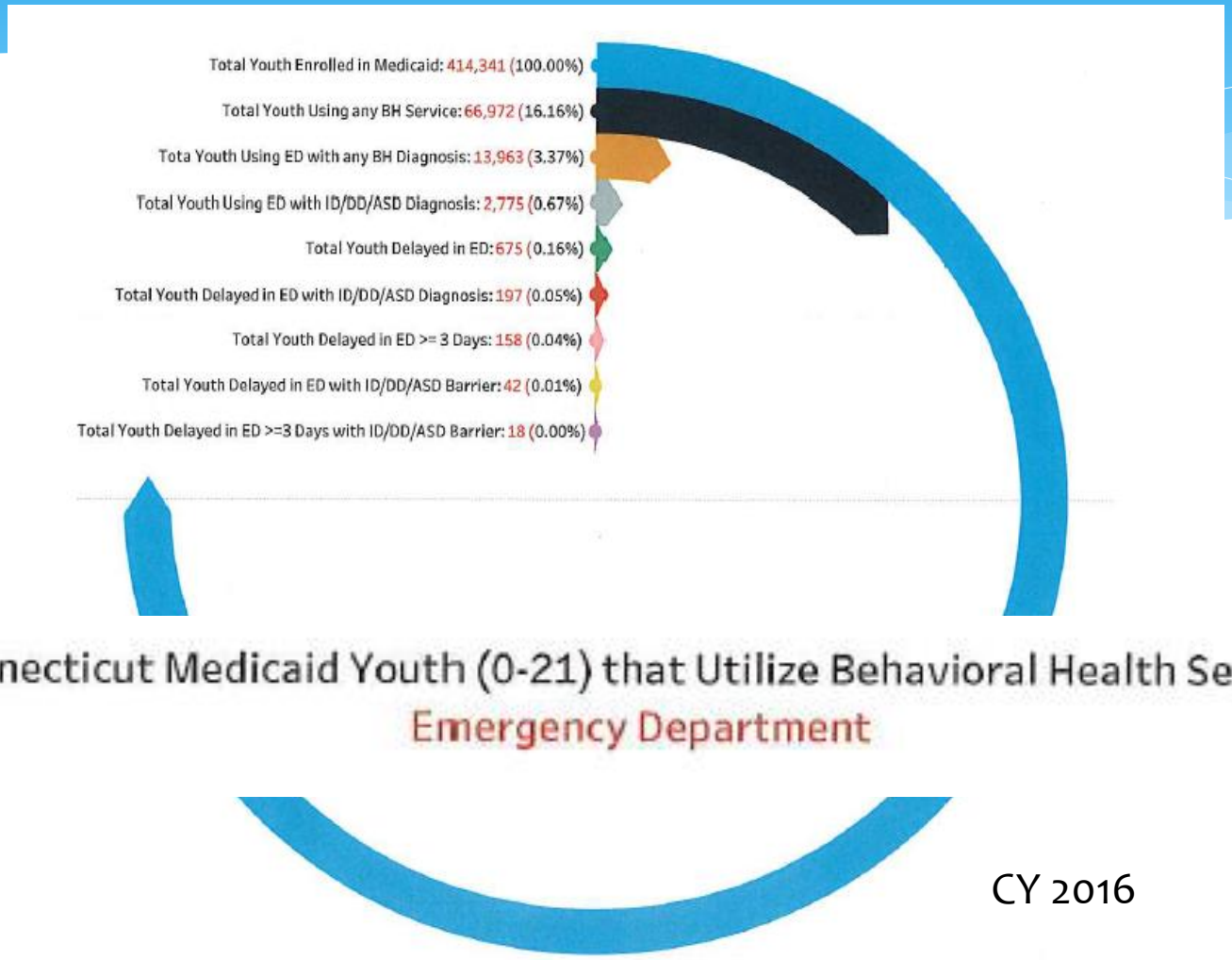


Connecticut Medicaid Youth (0-21) that Utilize Behavioral Health Services:

Inpatient Psychiatric Hospitalization

CY 2016

Beacon Data



CY 2016

Beacon Data

* In Calendar Year (CY) 2016, there were 578 Medicaid-enrolled children and youth aged 0 - 21 with an I/DD/ASD diagnosis that were admitted to an inpatient psychiatric hospital. This represents 0.14% of all Medicaid enrolled youth for CY 2016.
* Also, in CY 2016, there were 42 Medicaid-enrolled children and youth aged 0 – 21 with an I/DD/ASD diagnosis that were delayed in an emergency department with a reported barrier to discharge related to their diagnosis. This represents 0.01% of all Medicaid enrolled youth for CY 2016.
* Also, in CY 2016, there were a total of 365 in-state and out-of-state acute inpatient hospitalization (excludes Connecticut State-run hospitals) episodes in where there was an I/DD/ASD diagnosis on the claim for youth aged 0 - 21. These 365 episodes accounted for a total of about $6.6 million.

BRISC

Reducing Emergency Room Admissions for Children and Youth with Autism Spectrum Disorder

The BRISC model uses locally-based, nationally-recognized experts to assist community-based mental health treatment providers with serving children with developmental disabilities.

* Intended to divert children or adolescents with ASD from EDs to community based Psychiatric Residential Treatment Facilities (PRTFs)
* Partnership among private and state agencies in the state (PRTF, CCSN, DSS, DDS, and DCF)
* Create sustainable teams within community based organizations (PRTFs, home service organizations) to meet the needs of high-risk children with ASD and their families
* Focus on reducing the likelihood of recidivism

https://www.cga.ct.gov/med/committees/med6/2017/1117/20171117ATTACH_BRISC%20%20Summary%20Presentation;%20November%202017%20FINAL.pdf

BRISC

Reducing Emergency Room Admissions for Children and Youth with Autism Spectrum Disorder

Project Outcomes

* Successful support of 8 children and their families
* Families of each child were able to access:
  * Care coordination
  * Training on behavior intervention for their child
  * Well-trained, in home team
* For each child:
  * Substantial reductions in their unsafe behaviors
  * Return home and into community settings with newly developed coping skills
* Interagency collaboration
  * Progress made with each child/family required extensive facilitation by BRISC team to support collaboration across a variety of people and agencies, including ongoing guidance for children and families when challenges re-emerged post-PRTF discharge

https://www.cga.ct.gov/med/committees/med6/2017/1117/20171117ATTACH_BRISC%20%20Summary%20Presentation;%20November%202017%20FINAL.pdf

BRISC

Reducing Emergency Room Admissions for Children and Youth with Autism Spectrum Disorder

Project Outcomes Cont'd.

Aggregate Data: Key Project Indicators		
	Baseline	Post-Treatment
Patient Reduction in Target Behavior	-----	78.6% Average Decrease (Range 39.0% – 100%)
Patient Replacement Skill Acquisition	4%	76%
Staff Didactic Training Skill Acquisition	71%	91%
Parent Behavior Support Plan Implementation	68%	92%
Parent Acquisition of Positive Parenting Skills	57%	89%

https://www.cga.ct.gov/med/committees/med6/2017/1117/20171117ATTACH_BRISC%20%20Summary%20Presentation;%20November%202017%20FINAL.pdf

Key Recommendations

Care Coordination and Intensive Care Management

* Pilot an intensive care coordination service for children with I/DD/ASD who present to the emergency department with acute behavioral health treatment needs to support discharge and connection with appropriate community-based supports. This pilot must have an evaluation component that analyzes healthcare outcome measures for the child and family and cost effectiveness of the service.

Key Recommendations

Capacity Building

* Scale-up capacity-building technical assistance programs, such as the BRISC framework as part of Connecticut's workforce development strategies to serve children with I/DD/ASD.
* Develop a specialty Psychiatric Residential Treatment Facility (PRTF) that has capacity to serve children with psychiatric conditions and moderate to severe intellectual disabilities.

Key Recommendations

Agency Coordination

* The state should establish a lead agency or executive level leadership cabinet that can coordinate strategic investment and planning for children with complex developmental disabilities and their families. The cabinet can examine and address inefficiencies and waste in service delivery, identify and respond to children in crisis, and problem-solve regarding persistent service gaps for children.
  * State agencies should develop regional systems of care.
  * DSS, DDS, DPH and DCF should coordinate to remedy the current lack of access to critically needed mental health services that will serve children with developmental disabilities/intellectual disabilities.

Key Recommendations

Quality of Services

* Develop a core measure set to evaluate healthcare outcomes and quality of life. Healthcare utilization and outcomes measures should include access to routine preventive services such as primary care and dental care in addition to measures that track utilization of acute services.

Key Recommendations

Respite

* Expand access to respite services for families to ensure children with complex I/DD/ASD can remain in their homes and avoid the need for more acute services. If respite services are expanded, evaluate the impact respite has on reducing emergency or institutional care for children.

Key Recommendations

Financial Innovation

* Improve the cost effectiveness of state voluntary services through a systematic approach to third-party payer reimbursement (Example: OHA reimbursement work for DCF).
* The OHS should work with state health care policy makers to examine cost-effectiveness and outcomes achieved by providers who are or could provide "whole family" services where a child has complex I/DD (Example: Clifford Beers' new model of service delivery for children with ASD and their families).

Key Recommendations

Financial Innovation Cont'd.

* Examine other states' strategies for financing effective service delivery for children with complex I/DD/ASD and their families that increases individual functioning and reduces reliance on institutional care.
* Develop reimbursement strategies for (a) specialty extended day treatment for children with I/DD/ASD and (b) maximize capacity of Federally Qualified Health Centers (FQHC) to provide in-home services to children with I/DD and their families.

Thank you!

All meeting materials and information is available on the MAPOC website at: https://www.cga.ct.gov/med,Committees → Developmental Disabilities

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