Inpatient Care for Children, Adolescents and Young Adults: Is the Safety Net at Risk?

Governor's Sandy Hook Advisory Commission

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Goals for Discussion with Sandy Hook Commission

- ✓ Background on the scope of behavioral health services provided by Hartford HealthCare and recent Bipartisan Task Force Initiatives.
- ✓ Access to, and capacity of, inpatient child and adolescent services in Connecticut – how has this changed over past 5-6 years?
- ✓ Connecticut Behavioral Health Partnership – demonstrated change in service delivery efficiency and outcomes for children and adolescents. Rebalancing the system of care – has it worked?
- ✓ Why is there an access problem in 2013? What are the threats and opportunities to ensure that the safety net for children and adolescents is secure?
- ✓ How are these changes reflected in access for adult inpatient services, particularly young adults?
- ✓ Recommendations for consideration by the Commission.

Hartford HealthCare Behavioral Health Network

Hartford HealthCare Behavioral Health Network includes:

- Hartford Hospital/Institute of Living – Hartford, Chesire
- Natchaug Hospital – Mansfield, Windham, Killingly, Norwich, Groton, Old Saybrook, Enfield and Vernon
- Rushford – Meriden, Middletown, Durham, Portland and Glastonbury
- Hospital of Central Connecticut – New Britain
- Midstate Medical Center - Meriden
- Backus Hospital (Pending regulatory approval) - Norwich

Scope of Services:

- Inpatient Services for Children, Adolescents and Adults - 241 Beds
- Residential Treatment for adolescents and adults
- Partial Hospital and Intensive Outpatient programs for children, adolescents, young adults, adults, and older adults.
- Extended Day Treatment programs
- Wide range of outpatient programs for all age groups and needs.
- Specialized substance abuse programs
- Intensive In-home Psychiatric Services
- Prevention programs, including Mental Health First Aid

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Mental Health Initiatives Recommended by the Bipartisan Task Force

We support the initiatives that have been recommended by the Bipartisan Task Force, and included in the Appropriations Bill currently under consideration:

- ✓ **Mental Health First Aid**. This internationally accepted program informs and engages first responders, teachers and parents. Hartford HealthCare is partnering with the Department of Mental Health & Addictions Services to train 30 instructors later this month, 15 who will be imbedded in our network.
- ✓ **Expanded Care for Young Adults**. The mobile ACT teams provide an evidenced-based approach to community care, and we have long endorsed expansion of this program. Case management and coordination for those involved in the probate system will be helpful in reducing crime and use of hospitals.
- ✓ The appropriations measure also includes increased **intensive in home care for children**. We see first hand the benefits of this program in supporting families to assist with sustaining time in the community, and effecting good discharge plans from our hospitals.
- ✓ The **ACCESS-MH program** will fund regional teams of child psychiatric resources to support pediatricians who provide much of the treatment for children with behavioral issues.
- ✓ Increases monitoring and accountability of managed care entities to provide real **parity in mental health and substance abuse care**, key to real access.

Access to Child and Adolescent Inpatient Care

As result of media reports of many children held in emergency departments for several days waiting for inpatient care, especially in Waterbury and Hartford, the General Assembly required the CT Office of Health Care Access in 2005 to:

> *"examine whether inpatient bed capacity for children in CT is sufficient and what steps, if any, are necessary to expand such capacity".*

It also required OHCA to:

> *"make specific recommendations concerning the expansion of …hospital psychiatric inpatient bed capacity for children in region five" (Northwestern CT, including Danbury, Waterbury and Torrington)*

OHCA issued its report in January 2006 and found that:

1. *About 10% of inpatient admissions were referred to out-of state units*
2. *A major problem in access was delays in discharging to lower levels of care*
3. *Only five beds were available to region 5, resulting in the majority of referrals outside of region or out-of-state in this region*
4. *There was an average of 2.1 acute care beds/10,000 children statewide, but 0.3/10,000 for Region Five.*

Access to Child and Adolescent Inpatient Care

OHCA recommended the following:

1. Increase the number of acute care psychiatric beds for children and adolescents in Region Five
2. OHCA convene an implementation group of general hospital and mental health providers in Region Five to determine appropriate number and location of beds.
3. State should support development of emergency stabilization beds in areas where emergency departments are holding children and adolescents with behavioral health crises.
4. DCF and DSS should address a mechanism for discharging child and adolescents to the appropriate level of care.
5. Implementation of the CT Behavioral Health Partnership in 2006 should impact the provision and access to child and adolescent behavioral health care....this should be evaluated after the first year of operation.

Region	2005 Beds	2012 Beds
1 – Southwest	34	17
2 – New Haven	49	48
3 – Eastern	25	24
4 – Hartford	52	43
5 - Northwestern	5	5
Total	**175**	**147**

CT Behavioral Health Partnership

The CT Behavioral Health Partnership is a jointly operated program with the Departments of Social Services, Children and Families and Mental Health and Addictions Services operational since 2006.

The Partnership has contracted with a specialty managed behavioral health organization on an administrative services only (non-risk) basis to manage the care for over 600,000 children, adolescents and adults covered under all Medicaid programs. Discharge delays and ED wait times included in authorizing legislation.

There is an Oversight Council, comprised of appointees of legislative leaders of both parties, and the Governor. The Council has a representative cross section of providers (community and hospital based), advocates, and clients and family members, designees of state agency commissioners and legislators.

In addition nearly 100 other volunteers, providers and consumer representatives participate in the various active committees of the Council – Quality and Access, Care Coordination, and Operations.

Key Results of the Behavioral Health Partnership

Inpatient Services:

- ✓ Intensive Case Managers and Family Peer Specialists have focused on assisting families navigate the system, and address key discharge issues.
- ✓ Child Inpatient providers collaborated with state agencies and developed a pay for performance program focused on discharge delays, length of stay, family engagement and crisis planning at discharge to reduce readmissions.
- ✓ Child Inpatient providers developed a provider profiling system, available real time, to track our performance on key efficiency and outcome indicators.
- ✓ Quarterly meetings with DCF and other providers to improve care coordination.

Residential Services

- ✓ Focused engagement of families and improved discharge planning reducing LOS 45% and creating more realized capacity with available beds.
- ✓ Implementation of 53 therapeutic group homes with over 250 beds.

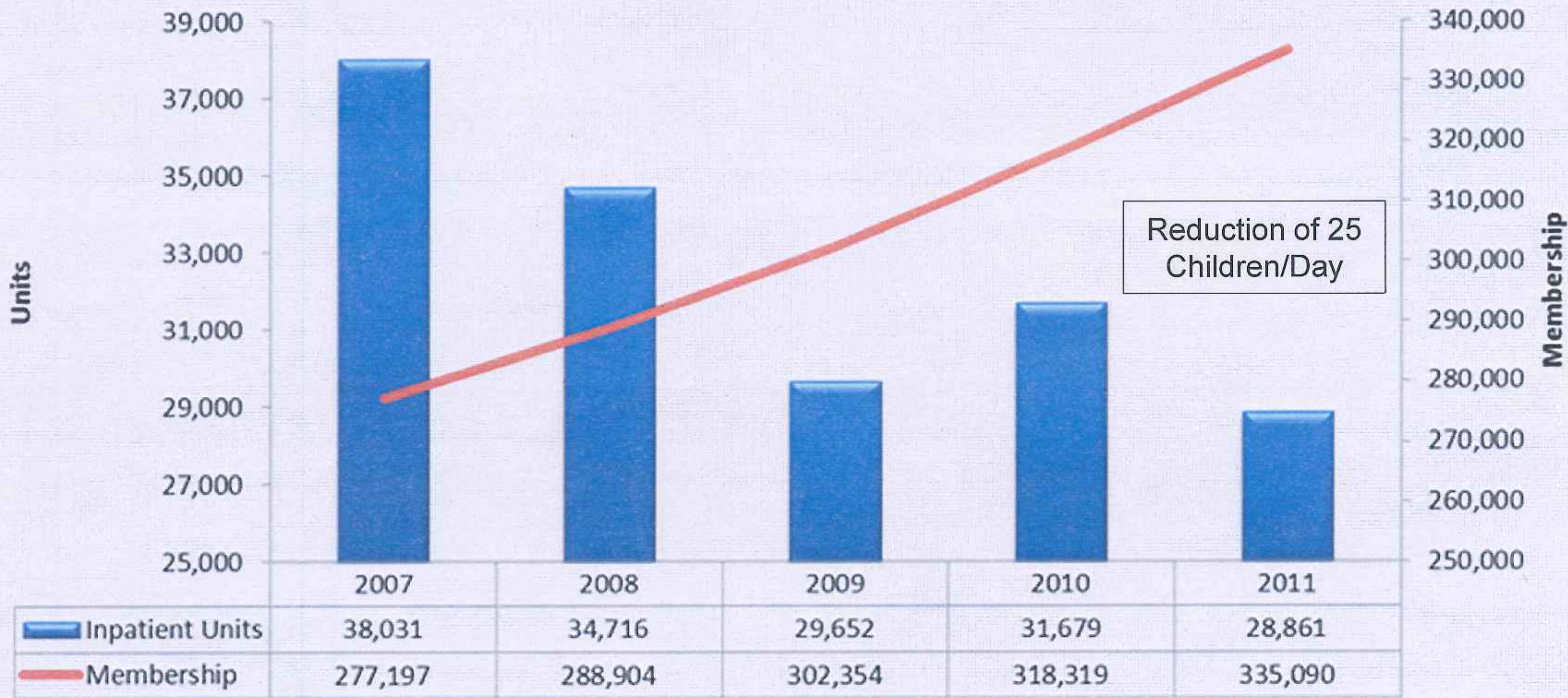
Outpatient Services

- ✓ Established improved reimbursement for those outpatient clinics that met specific access standards (2-2-2), these Enhanced Care Clinics improved timely consumer access (95%), and discharge planning from inpatient care.

Intensive In-home Psychiatric Services

- ✓ Yale Child Study Center developed program expanded state-wide & increased funding from $4 million to $22 million and serving over 2,600 in 2011.

Child and Adolescent Inpatient Trends



	2007	2008	2009	2010	2011
Inpatient Units	38,031	34,716	29,652	31,679	28,861
Membership	277,197	288,904	302,354	318,319	335,090

Since 2007, there has been a 20.9% increase in membership for Youth (0-18 years), with a 24.2% decrease in Inpatient days used for youth

Child and Adolescent Inpatient Trends

Youth (0-18) Hospital Inpatient Units Used and Unduplicated Individuals

	2007	2008	2009	2010	2011
Inpatient Units	38,031	34,716	29,652	31,679	28,861
Undup. Indiv.	1,354	1,470	1,573	1,633	1,658

Since 2007, there has been a 22.5% increase in unduplicated individuals for Youth (0-18 years), with a 24.1% decrease in Inpatient days used for youth

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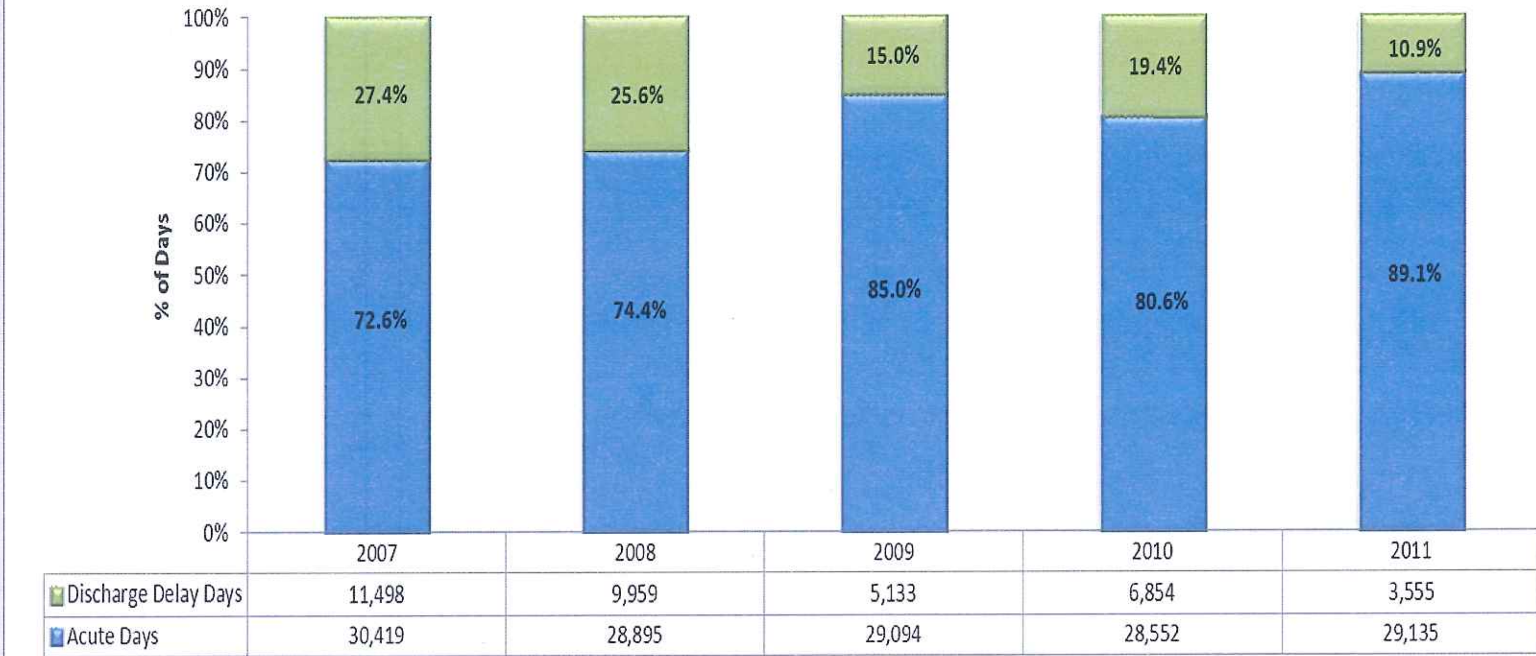
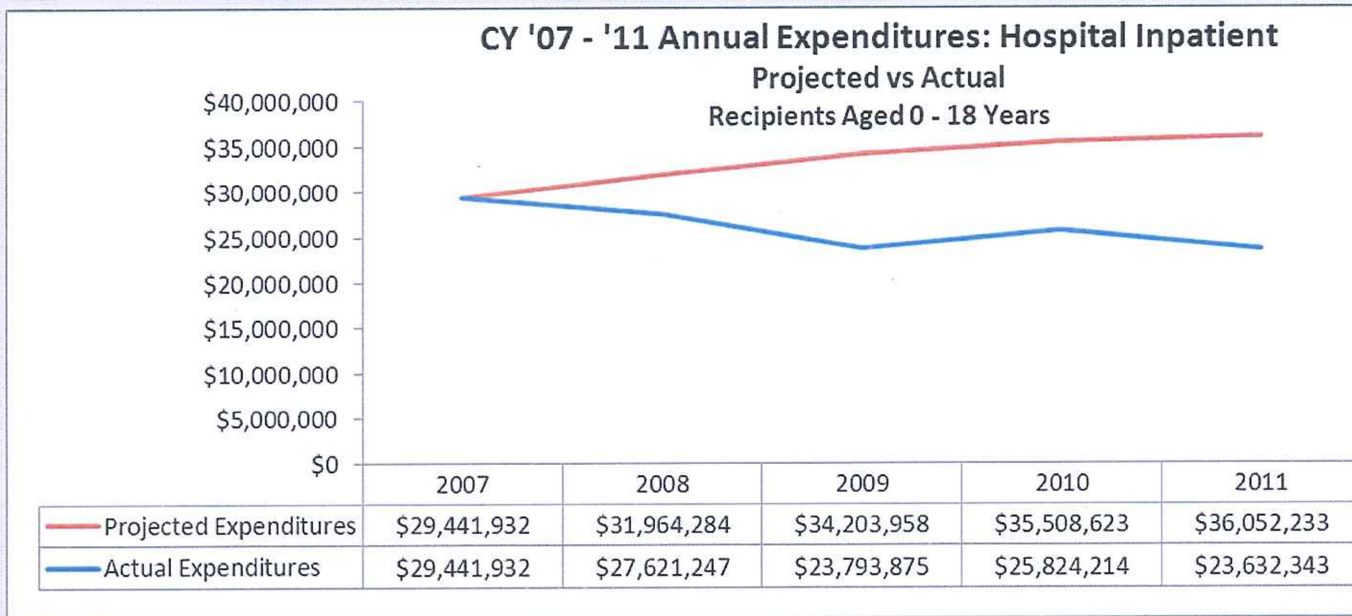
Impact of BHP in Reducing Discharge Delay Days



	2007	2008	2009	2010	2011
Discharge Delay Days	11,498	9,959	5,133	6,854	3,555
Acute Days	30,419	28,895	29,094	28,552	29,135

Reduction in Discharge Delay Days represents more than 22 children per day.

More than bending the Cost Curve!



	2007	2008	2009	2010	2011
Projected Expenditures	$29,441,932	$31,964,284	$34,203,958	$35,508,623	$36,052,233
Actual Expenditures	$29,441,932	$27,621,247	$23,793,875	$25,824,214	$23,632,343

Hospital Inpatient

	2007	2008	2009	2010	2011
Undup. Individuals	1,354	1,470	1,573	1,633	1,658
Units	38,031	34,716	29,652	31,679	28,861
Expenditures	$29,441,932	$27,621,247	$23,793,875	$25,824,214	$23,632,343
Cost per Individual	$21,744	$18,790	$15,126	$15,814	$14,254

Despite a 22.5% increase in the number of individuals receiving Inpatient care, the results also show a 24.2% decrease in inpatient days and a 34.5% decrease in Cost per Individual receiving care.

Were there improved outcomes?

- ✓ No increase in 30 day re-admissions, rate reduced from 13.9% to 12.6%. Family engagement increased.
- ✓ Access was improved, more children were admitted. ED delays in 2007 were 2.45 days, reduced to 1.5 in 2011. This may be increasing as Dr. Namerow reports, and we get 2012 and 2013 data reviewed by the Quality and Access Committee of the Council.
- ✓ Outpatient care provided timely, 95% of children referred to Enhanced Care clinics seen within 2 weeks, increased access by 50%.
- ✓ Increased access to private providers by 100%.
- ✓ Reductions in congregate care (from 1416 to 1021) is significant, but there are concerns about access when needed. This trend has continued, and out-of-state placements have also been reduced significantly.

Changes in Child & Adolescent Bed Capacity

Child & Adolescent	2005	2011	Change	%
Hartford Hospital - Institute of Living	22	24	2	9.1%
Natchaug Hospital	21	24	3	14.3%
St. Francis Medical Center	20	14	-6	-30.0%
St. Vincents (includes Hall Brook)	34	17	-17	-50.0%
Yale New Haven	29	28	-1	-3.4%
Yale - St. Raphael Campus	20	20	0	0.0%
Subtotal Child & Adolescent	146	127	-19	-13.0%
Adolescent Only				
Manchester	10	5	-5	-50.0%
Waterbury	5	5	0	0.0%
Silver Hill [1]	10	10	0	0.0%
Stonington Institute [2]	4	0	-4	-100.0%
Subtotal Adolescent Only	29	20	-9	-31.0%
TOTAL Child and Adolescent Inpatient	**175**	**147**	**-28**	**-16.0%**

Notes

1. Silver Hill is not a CT Medicaid Provider
2. Stonington Institute operated sub-acute program, subsequently closed.

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Challenges to preserving inpatient capacity – threats to the safety net

- ✓ With the effectiveness of reducing inpatient utilization and discharge delays, reimbursement and **bed capacity has been reduced.**
- ✓ On any given day, about 80 children and adolescents with Medicaid are in a hospital bed. This is **67% of all children in a psychiatric bed**.
- ✓ The reimbursement provided for these services is substantially below costs and has been **frozen** for six years. Hospitals lose between $300 and $500 per day depending on the hospital cost structure.
- ✓ Estimated losses for these services in excess of ($11.5) million state-wide for the 7 hospitals providing this care.
- ✓ OHCA was unable to increase capacity in Region 5, reimbursement key.
- ✓ Staffed capacity has been reduced and increased wait times in the ED, much like during 2006 and 2007 before these changes in utilization.
- ✓ Child inpatient programs cut $934,000 with the elimination of the pay for performance program in the FY 13 Deficit Mitigation Plan.

Factors that will likely increase inpatient hospital demand – how will this be met?

Reduced capacity at Solnit Center (Riverview Hospital):

- ✓ In 2005, total beds at Riverview were 85.
- ✓ Hospital utilization in 2011 was 45. Reorganization designed to reduce out-of-state residential placements, will likely further reduce hospital capacity.
- ✓ DCF has proposed eliminating admissions of children 12 and under in 2013. Data shows the following:
  1. 20 discharges of young children in 2012, with average LOS of 186 days.
  2. The 20 discharges represent a small % of total children admitted to the five community hospital programs (796), but more significant % of the bed capacity.
  3. We estimate about 48 of the community hospital beds are used for children, and the longer stay Solnit Center patients would use about 10 of these beds.
  4. In some cases these children are referred to Solnit because of intensive staffing needs and this will increase costs of care in the community.
- ✓ Increased Medicaid enrollment in January 2014 may increase demand for inpatient care, as un-insured patients have improved access to healthcare under the Affordable Care Act.

Similar issues regarding access for young adults?

- ✓ The Behavioral Health Partnership began managing the young adults on Medicaid in April 2010. Trending data is not as complete, and ED wait times not regularly reported to the Oversight Council.
- ✓ According to OHCA there are a total of 677 general hospital inpatient psychiatric beds, of which 606 were staffed in 2011.
- ✓ Total average census in 2011 was 520 or 86% occupancy of the staffed beds.
- ✓ In June 2010, the Department of Mental Health & Addictions closed Cedar Ridge Hospital in Newington, with a net reduction of about 50 beds. 17-bed Young Adult unit relocated to CVH.
- ✓ OHCA placed a condition on that certificate of need for the closure of these beds that the State contract with three community hospitals for acute care beds with intermediate LOS of 45-60 days, given that general hospitals are reimbursed per discharge under Medicaid.
- ✓ To date St. Vincent's has implemented this program, and no other hospital has been contracted in response to the RFP issued in 2010.
- ✓ Uneven distribution of community support for young adults.

Recommendations for Sandy Hook Commission

- ✓ We do not recommend building new beds, since there are existing beds not staffed. Only with improved reimbursement will this change.
- ✓ We strongly urge the Commission to advocate an increase in reimbursement for child and adolescent inpatient care, consistent with recent legislative action for general hospitals with high Medicaid, low reimbursement rates, given 67% of these services are used by Medicaid eligible children. Also re-instate pay for performance program.
- ✓ If DCF privatizes inpatient care for children, have targeted funding for high-need care, consistent with DSS recommendation in 2008 for a "hospital access initiative" to serve these high need children that was not funded.
- ✓ Determine feasibility of establishing a second CARES unit in southern CT to provide crisis stabilization services, using existing bed capacity.
- ✓ DMHAS re-issue RFP for additional acute care capacity for intermediate stays (45-60 days) and link with initiatives to better manage the dually Medicare/Medicaid enrollee.

Questions and Discussion