

Health Care Cabinet Inquiries:

What are the cost drivers in your program?

- HUSKY members who cycle repeatedly through the Emergency Department and who utilize inpatient care more than 3 times in a twelve month period.
- Those youth who remain beyond their treatment needs in congregate facilities.

How are you addressing through policies, initiatives, programs?

For children, almost 50% of the ED high utilizers are DCF involved which makes sense given the complexity of their histories and resulting behavioral health needs'. DCF involved includes those children who are residing at home with their families and not committed or placed by the Department. To help address the issue and provide better care for this cohort, DCF Regional staff are provided lists of youth who reach the frequent visitor status (6+ times within a 6 month period) generated by Beacon Health Options. This list is used to prompt additional case planning activities that identify and address the issues contributing to the youth's repeated return to the ED and to facilitate alternative treatment planning (Integrated Service System review, RRG consultation, etc.) In addition, Regional meetings between DCF Clinical staff, ED Directors, and community providers are convened by Beacon Regional Network Managers to address local systemic issues that impact ED volume. Efforts to ensure that ED staff know what diversionary services are available and whom to contact are underway (local resource directories, EMPS MOUs, DCF Rapid Response Teams). Beacon Intensive Care Managers are also attached to the various EDs to help identify Medicaid covered services that are available and to help connect to care post discharge from the ED.

Those Medicaid involved youth who are spending inordinately long periods of time on inpatient units or who return for inpatient treatment within a six month period receive additional attention within the Beacon ASO structure. All are assigned Intensive Care Managers and are reviewed weekly in Complex Case Rounds. DCF clinical staff are consulted if the child is DCF involved. Most often children who are experiencing long lengths of stay are on discharge delay due to the complexity of their behavioral health issues and/or the lack of immediate step down options. The purpose of the complex case review is to problem solve and to create alternative, individualized step down programs as alternatives to services that are not currently available. The Department of Developmental Services also participates in these reviews as this cohort often has concomitant ASD or intellectual challenges that contribute to the barriers to discharge. Access to specialty hospitals and additional DDS funded services are considered on an individual basis for those youth who are eligible.

Improved outcomes for youth and a decrease in costs have been the results of:

- the adoption of a standard practice model
- policy shifts in appropriate and timely utilization of congregate care tied specifically to treatment needs
- investment and increase in intensive in home and evidence based community based services to better support children at home and in their communities
- enhanced supports to schools through the dissemination of CBITS
- the implementation of ACCESS MH to support pediatric practitioners in better supporting the behavioral health needs of children in addition to their primary care needs

Documented Savings/Quality Improvement

- Quality improvement is evident in better care for individual youth and higher rates of connect to care.
- Since 2011 to date, a reduction in out of state congregate care placement from 363 to 8 youth and a reduction in the percentage of youth placed in residential placement from 30% to 11.7%

Long Term Strategies

- Drawing on the findings of the ACE's study was both a catalyst for and has further supported CT's investment in trauma focused evidence based practice models. The lifetime costs associated with child maltreatment are extraordinarily high due to associated health, behavioral health, educational impairments, increased involvement in criminal justice, child welfare and lost work opportunities (Florence, et al, Pediatrics, 2013). The evidence demonstrates that investments in trauma focused services can be recouped through reduced health care costs in as little as one year (Greer et al, Adm Policy Mental Health, 2013). Such models include; CFTSI, MATCH-ADTC, CBITS and broad dissemination of TF-CBT.
- DCF is working closely with other state agencies to assure that there is greater awareness of services across systems, equitable access and strong collaboration. For example, efforts are underway between DCF and DPH and their work on the State Level Care Coordination Collaborative, to more intentionally connect families to this service.
- In partnership with DSS, the DCF continues to identify ways to obtain additional Medicaid reimbursement for care management activities, i.e, Wrap Around, health navigators, Intensive Care Managers, etc to capitalize on best and most appropriate use of existing resources. Investment in enhanced screening i.e: Trauma Screening, Adolescent Screening Brief Intervention and Referral to Treatment (A-SBIRT) and early intervention strategies that are evidence based serve to decrease higher rates of complexity and acuity due to undetected and/or unmet needs.
- DCF established a Care Management Entity using high-fidelity wraparound based on the recommendations of the Children's Behavioral Health Plan. It is primarily designed for DCF involved youth though DCF has created capacity for those involved with the juvenile justice systems and those who have complex needs but are not known to DCF to demonstrate the effectiveness of this comprehensive approach.