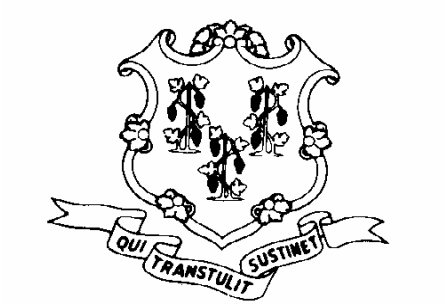
STATE OF CONNECTICUT



Report of the Region 5 Pediatric Inpatient Psychiatric Services Implementation Group

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Prepared for:

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Office of Health Care Access

I. Background

In January 2006, the *Report of the Committee to Examine Hospital Inpatient Behavioral Health Bed Capacity for Children* was issued. The report was prepared in response to Public Act 05-280, "An Act Concerning the Expenditures of the Department of Social Services." The report examined the challenges faced by the 31 acute care hospitals in Connecticut in providing inpatient behavioral health services to pediatric[1] patients, particularly in Mental Health Region 5 (Region 5). Currently, statewide only four of the hospitals have inpatient psychiatric units for children (ages 0 to 12) and six for adolescents (ages 13 to 17). Although not all hospitals have inpatient pediatric behavioral health services, hospitals attempt to accommodate these pediatric patients either in other units within the hospital or transfer them to other facilities for inpatient care.

The committee was to focus on the existing situation in Region 5 which has six acute care hospitals, Charlotte Hungerford, New Milford, Sharon, Danbury, St. Mary's and Waterbury, but only five beds for adolescent behavioral health patients at Waterbury Hospital and none at all for children in any of the hospitals (see Table 1). Also, there are no freestanding psychiatric hospitals in the region. According to the committee's report, in 2004, at least 200 the pediatric patients from the region had to access needed acute inpatient psychiatric care outside the region.

Table 1: CT acute care pediatric behavioral health beds, FY 2004

	# of Operational Beds					
Acute Care Hospitals	Age 0 - 12	Age 13 - 17	Swing beds[1]	Age 0 – 17	Location	Region
Hospital of Saint Raphael	10	5	5	20	New Haven	2
Yale New Haven Psychiatric Hospital	15	14	0	29	New Haven	2
St. Francis Medical Center[2]	12	8	0	20	Hartford	4
Hartford/Institute of Living/CT Children's	9	13	0	22	Hartford	4
Manchester Hospital[3]	0	10	0	10	Manchester	4
Waterbury Hospital	0	5	0	5	Waterbury	5
Sub-Total	46	55	5	106		
Psychiatric Hospitals						
Public						
Riverview Children & Youth[4]	-	-	85	85	Middletown	2
Sub-Total	0	0	85	85		
Free-standing						
Hall-Brooke Behavioral Health Services	-	-	20 - 34	20 – 34	Westport	1
Silver Hill Hospital	0	10	0	10	New Canaan	1
Natchaug Hospital	6	12	3	21	Mansfield	3
Stonington Institute	0	4	0	4	N. Stonington	3
Sub-Total	6	26	23 - 37	55 – 69		
Statewide	52	81	113 - 127	246 - 260		

Source: *Report of the Committee to Examine Hospital Inpatient Behavioral Health Bed Capacity for Children, Table 2, page 10.*

[1] Hospitals swing beds between the two age groups on as needed basis.

[2] Physical capacity is 23 beds.

[3] Survey was not administered to hospital.

[4] CT Department of Children and Families (DCF) provided the information; the facility has 12 additional sub-acute care beds.

[1] Under 18 years old.

In accordance with Public Act 05-280, the committee's report contains recommendations concerning the expansion of licensed hospital psychiatric inpatient bed capacity for children in Region 5. These recommendations are:

1. *Increase the number of acute care general hospital and/or psychiatric hospital beds and Psychiatric Residential Treatment Facility (PRTF) beds for children and adolescents in Region 5 based on the process outlined in Recommendation # 2.*

2. *The commissioner or designee of the Office of Health Care Access (OHCA) will convene an implementation group including the six general hospitals in Region 5, other behavioral health service providers to Region 5 residents under the age of 18, and representatives of state agencies for input on the appropriate number and location of beds. Execution of the group's proposal(s) will be subject to Certificate of Need (CON) authorization.*

To fulfill these recommendations, the Office of Health Care Access established an Implementation Group consisting of representatives of the six general hospitals in the region and of the Department of Children and Families (DCF), the Department of Social Services, Wellspring Foundation, the Child Guidance Clinic of Waterbury and the Northwest Center for Family Services and Mental Health (see Attachment 1).

The Implementation Group, which met three times during the summer and autumn, reviewed the most current pediatric inpatient behavioral health utilization data available to develop recommendations for the region. This report presents the recommendations about the appropriate number and locations of acute care, PRTF and emergency crisis stabilization beds needed in the region to facilitate patient access and transfer to appropriate levels of care and reflects the opinion of the majority of the group.

II. Implementation Group Recommendations and Rationale

Recommendation 1: Any Certificate of Need application for adding to behavioral health pediatric beds in Region 5 must include a plan for coordinating proposed additions with existing community-based services.

The overriding concern of the group is that an evaluation to establish the appropriate number of acute care beds should be system-based and not done in a vacuum. The behavioral health system includes emergency, acute and step down levels of care, all of which needed to be evaluated concurrently and any changes to be implemented should be coordinated with existing community-based services.

Recommendation 2: An additional 20 to 30 acute care general hospital and/or psychiatric hospital beds are required in Region 5. In order to provide developmentally appropriate care for children and adolescents, the additional beds should be allocated to two discrete units, one for children (up to 12 years old) and one for adolescents (13 – 18 years old).

According to the Committee's January 2006 report, there are 2.1 acute care pediatric behavioral health beds available per 10,000 residents under age 18 in Connecticut, but only 0.3 per 10,000 for the same age cohort in Region 5 (see Table 2). This demonstrates that Region 5 has substantially lower number of beds available for its pediatric population than the state in general. As a result, hospitals in the region admit children needing inpatient behavioral health services to general pediatric and adolescent units and adolescents to adult psychiatric and medical/surgical units; and the remaining are transferred or referred to hospitals located elsewhere in Connecticut or out-of-state. Currently, about one-half of the pediatric patients transferred out-of-state for behavioral health services are from Region 5. Area hospitals transferred one-third of pediatric patients from the region to other acute care providers in Connecticut for acute behavioral health treatment.

Table 2: Pediatric acute care behavioral health bed availability

Geographical Location	Regions	Acute Care Beds*	Share	Bed per 10,000 of child population
Southwest	1	44	25%	2.6
South Central	2	49	28%	2.6
Eastern	3	25	14%	2.6
North Central	4	52	30%	2.2
Northwest	5	5	3%	0.3
Statewide		175	100%	2.1

Source: *Report of the Committee to Examine Hospital Inpatient Behavioral Health Bed Capacity for Children, Table 3, page 11.*

* Includes beds in acute care psychiatric units and freestanding psychiatric hospitals.

Patients receiving behavioral health treatment benefit most when their families are involved. Hence, additional acute care beds should be located in the region to improve families' ability to participate in care. In the absence of a state adopted standard bed need methodology, the group applied the statewide standard of 2.1 beds per 10,000 to the pediatric population of Region 5, of 149,927 based on Census 2000, to determine the maximum number of beds the area needs. Based on this methodology, there should be up to 31 beds in total in the region, or about 26 new beds given that five already exist in Waterbury. According to the experts in the group, a 10 to 15-bed unit is the most efficient and clinically appropriate size for an acute care behavioral health unit. The treatment of children and adolescents in the same milieu is developmentally inappropriate and may be counter-therapeutic. Consequently, the group recommends establishing two discrete units in the region, with a combined capacity of 20 to 30 new acute beds.

Recommendation 3: Locate any additional acute care pediatric psychiatric units in one of the three major population centers in Region 5; Danbury, Torrington and Waterbury.

Region 5 is a geographically large and diverse area that consists of 43 cities and towns. Table 3 is an analysis of acute care hospital Region 5 pediatric behavioral health discharges by town of origin. The data indicate that the majority of discharges and their associated patient days are from three metropolitan areas, Waterbury (27% and 33%), Torrington (8% and 12%) and Danbury (11% and 7%). In order to enhance access to acute programs, the group recommends the location of any additional programs in one of the three metropolitan areas.

Table 3: Region 5 Average Annual Acute Care Pediatric Behavioral Health[1] Discharges and Days by Town of Origin: SFYs 2004 - 2006q1-q3

	Children Ages 0 - 12	Adolescents Ages 13 - 17	Ages 0 - 17
Town of Origin	Discharges = 86	Discharges = 234	Discharges = 320
Waterbury	35%	24%	27%
Danbury	16%	9%	11%
Naugatuck	6%	7%	7%
Torrington	11%	7%	8%
Cheshire	5%	6%	6%
All other towns in region[2]	27%	48%	42%
Total	100%	100%	100%
Town of Origin	Patient Days = 1,777	Patient Days = 2,053	Patient Days = 3,830
Waterbury	47%	21%	33%
Torrington	15%	9%	12%
Cheshire	6%	10%	8%
Naugatuck	4%	10%	7%
Danbury	9%	5%	7%
All other towns in region[2]	20%	46%	34%
Total	100%	100%	100%

Source: *CT Office of Health Care Access Acute Care Discharge Database*

[1]Acute care hospitals' behavioral health discharges assigned Diagnosis Related Group (DRG) 424 to 437 or 521 to 523.

[2]For this purpose, discharges and patient days for the other 37 towns in the region were not significant individually.

Recommendation 4: Establish fifteen to twenty five Psychiatric Residential Treatment Facility (PRTF) beds in Region 5. These beds should be located in proximity to existing beds or as part of the establishment of a new program or facility, which includes acute beds.

Psychiatric residential treatment facilities (PRTFs) provide inpatient psychiatric care to Medicaid-covered patients under 21 years old. PRFTs facilitate acute care hospitals' patient "throughput" to ease system gridlock and "boarding" in the EDs.

In SFY 2004, over one-half (or 167) of acute care inpatient transfers to another type of institution were Medicaid beneficiaries who might have been better served by a step down level of care at facilities such as a PRTF or community-based alternatives;[2] this is an average of 14 patients per month. According to data from the Connecticut Behavioral Health Partnership (CT BHP) at four points in time for each month between September and November of 2006, on average 9.1 patients from the region were placed in mostly non-area PRTFs (Table 4). The highest number of patients placed within a month during the period was 11.5.

Table 4: Region 5 PRTF average admissions from September to November 2006

Region 5 Hospitals	Average # in all PRTFs	Average # in Wellspring	Average # in Non-Area PRTFs
Danbury	0.7	0.1	0.7
Charlotte Hungerford	4.0	1.5	3.0
Waterbury	4.5	2.0	3.4
St Mary's	-	-	-
Total	**9.1**	**3.6**	**7.1**

Source: Department of Social Services Region 5 hospital and PRTF admits under the CT BHP between September and November 2006 taken at four points in time per month.

Within a month, an average of 1.5 patients awaited placement in a PRTF. The highest number of patients who awaited placement in the three-month period was 2.0.

In all, there was an average of 10.6 PRTF placements needed in the region during the three months. The highest number of placement needed within a month was 12.75. This means, between 50 and 60 percent of the region's acute care pediatric patients admitted during the period, required placement in a PRTF after acute care. The need for a PRTF level of care has increased with Wellspring's decision to discontinue its PRTF service in November 2006.

[2] *Report of the Committee to Examine Hospital Inpatient Behavioral Health Bed Capacity for Children*. Submitted to the Connecticut General Assembly. January 2006. Ibid.

Emergency Crisis Stabilization Beds

In evaluating the needs of the region, the group discussed the feasibility of establishing emergency crisis stabilization beds (ESC) as part of the continuum of care. ECS beds are used for managing demand spikes, extended patient observation and minimizing "boarding" or patients waiting in the ED for more than 23 hours before admission to an inpatient bed or discharged to the community. Based on the committee's report, in FY 2004, hospitals in Region 5 evaluated 660 children and adolescents with a behavioral health diagnosis in the ED before transferring them to inpatient acute care. As many as one-quarter of those patients, waited in the ED for over 23 hours before the inpatient admission (see Table 3); [3] that is, an average of 15 boarders per month.

Table 3: Number of pediatric behavioral health patients evaluated in Region 5 Emergency Departments and length of stay in hours prior to inpatient admission, FY 2004

	Ages 0 - 12		Ages 13 – 17		Ages 0 - 17	
	< 23 hours	> 23 hours	< 23 hours	> 23 hours	< 23 hours	> 23 hours
Charlotte Hungerford	56	6	149	32	205	38
Danbury	27	0	122	6	149	6
New Milford	2	0	8	0	10	0
Sharon	0	0	2	0	2	0
St. Mary's	0	56	0	74	0	130
Waterbury[1]	35	4	77	3	112	7
Total	**120**	**66**	**358**	**115**	**478**	**181**

Source: *Report of the Committee to Examine Hospital Inpatient Behavioral Health Bed Capacity for Children.* Submitted to the Connecticut General Assembly. January 2006. Table 6, page 15.
[1] One adolescent outlier spent 170 hours in ED.

Assuming an average stay of 48 hours in the ED for those boarders, then the average daily census is one. According to information provided by DSS, a hospital based ED affiliated crisis unit is only economically viable if it serves more than 800 to 1,000 pediatric patients per year with an average overnight census of three or more patients. Therefore, currently there is not sufficient need to sustain a hospital based crisis stabilization unit in the region. The additional acute care and PRTF beds will be enough to handle potential demand spikes and extended stays, thus eliminate boarding.

[3] Ibid.

Attachment 1

Region 5 Pediatric Inpatient Psychiatric Services Implementation Workgroup

The membership of the Region 5 Pediatric Inpatient Psychiatric Services Implementation Workgroup included the following persons:

1. Susan Cole, Director of Certification, Financial Analysis and Forecasting & Chair	Office of Health Care Access
2. Mark Schaefer, Ph.D., Director, Medical Policy and Behavioral Health, Medical Care Administration	Department of Social Services
3. Karen Andersson	Department of Children and Families
4. Peter Johnson, Ph.D.	Department of Children and Families
5. Dr. Charles Herrick, Medical Director, Inpatient Psychiatric Services	Danbury Hospital
6. Dr. Steven Singer, Chief of Psychiatry	Charlotte Hungerford Hospital
7. Thomas Narducci, LCSW	Charlotte Hungerford Hospital
8. Maureen Salerno, Director of Social Work	New Milford Hospital
9. Jena Brebbia, LCSW	Sharon Hospital
10. Dr. Peter Jacoby, Chairman of Emergency Services Department	St. Mary's Hospital
11. Doreen Elnitsky, Administrative Director, Behavioral Health	Waterbury Hospital
12. Tom Czarkosky, Manager, Child & Adolescent Behavioral Health Services	Waterbury Hospital
13. Gary Steck, Executive Director	Child Guidance Clinic of Waterbury
14. Herb Hall	Wellspring Foundation, Inc.
15. Donna Campbell	Northwest Center for Family Services and Mental Health

Staff to the Implementation Group

1. Olga Armah, Associate Research Analyst, Research and Evaluation	Office of Health Care Access
2. Steven Lazarus, Associate Health Care Analyst, Certification, Financial Analysis and Forecasting	Office of Health Care Access