Helping Children & Youth Succeed

June 29, 2016

Welcome
Michael Williams

System Development
Tim Marshall

Statewide System Integration Efforts
Beresford Wilson
Susan Graham

Statewide System Integration Efforts

Committees and Work Groups

1. Family Engagement Action Teams and Workforce Development
2. Cultural and Linguistic Competency Development
3. Network of Care Analysis
4. Social Marketing and Communication
5. Data Integration Collaboration and Data Dashboards Development

Data Integration
Tyler Kleykamp

Data Dashboards
Michelle Riordan-Nold

Dr. Karen Andersson

Six Years of the Road Traveled: Where We Were & What We've Done

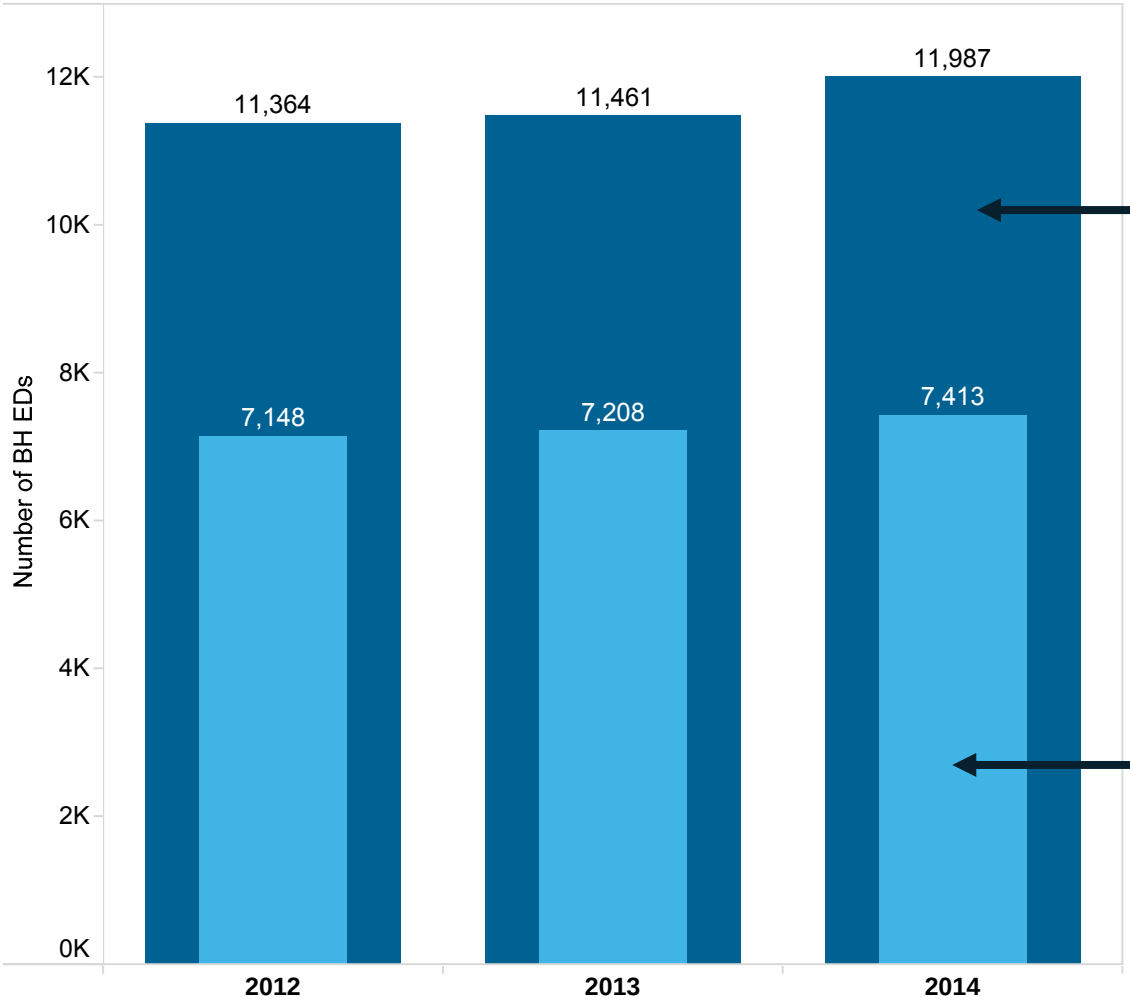
Knute Rotto

Key Points to Note

- Data is based on either Medicaid authorizations or claims and only includes youth ages 0-17 (unless otherwise specified) with Medicaid eligibility.
- “DCF Involvement” includes any youth under eighteen who is involved with the Department of Children and Families through any of its mandates. This includes youth committed to DCF through child welfare or juvenile justice, and those dually committed. It also includes youth for whom the Department has no legal authority, but for whom DCF provides assistance through its Voluntary Services, Family with Service Needs and In-Home Child Welfare programs.

Behavioral Health ED Volume

Total Number of BH ED Visits by Youth & Number of Unique Youth
Ages 3-17, Excluding Duals & D05
CY 2012-CY 2014



Behavioral Health (BH) ED utilization has been relatively steady, with a 5% increase from 2012 to 2014, which mirrors the 5% increase in youth Medicaid membership for the same time period.

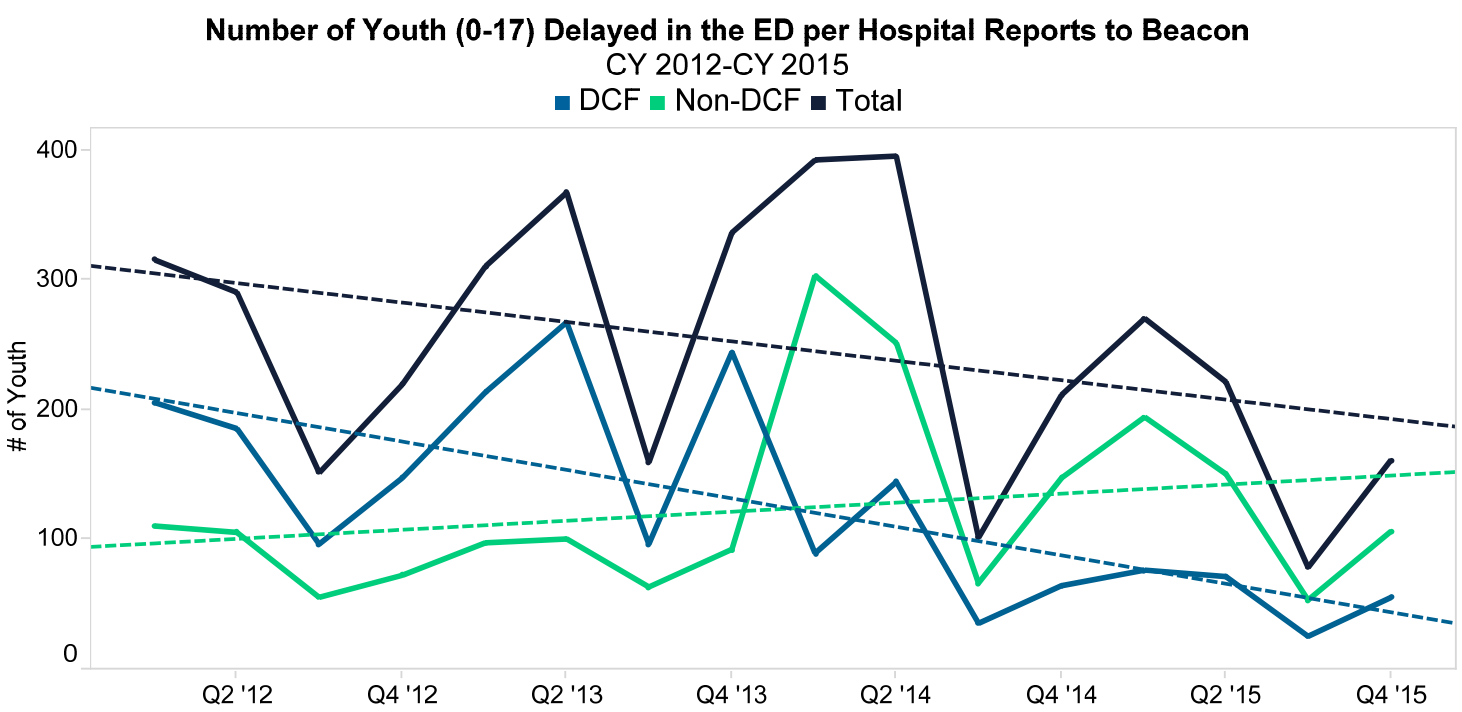
The number of unique youth accessing the ED for behavioral health needs has also been steady, with a 3.7% increase.

All data in this presentation is for Medicaid youth only.

Quarterly Volume of Youth Delayed in the ED

2012	2013	2014	2015
975 youth	1,172 youth	1,099 youth	730 youth

Number of Youth (0-17) Delayed in the ED per Hospital Reports to Beacon
CY 2012-CY 2015



Volume of youth delayed in the ED, while seasonal, has been declining. Trend lines show this to be most true for DCF involved youth.

All data in this presentation is for Medicaid youth only.

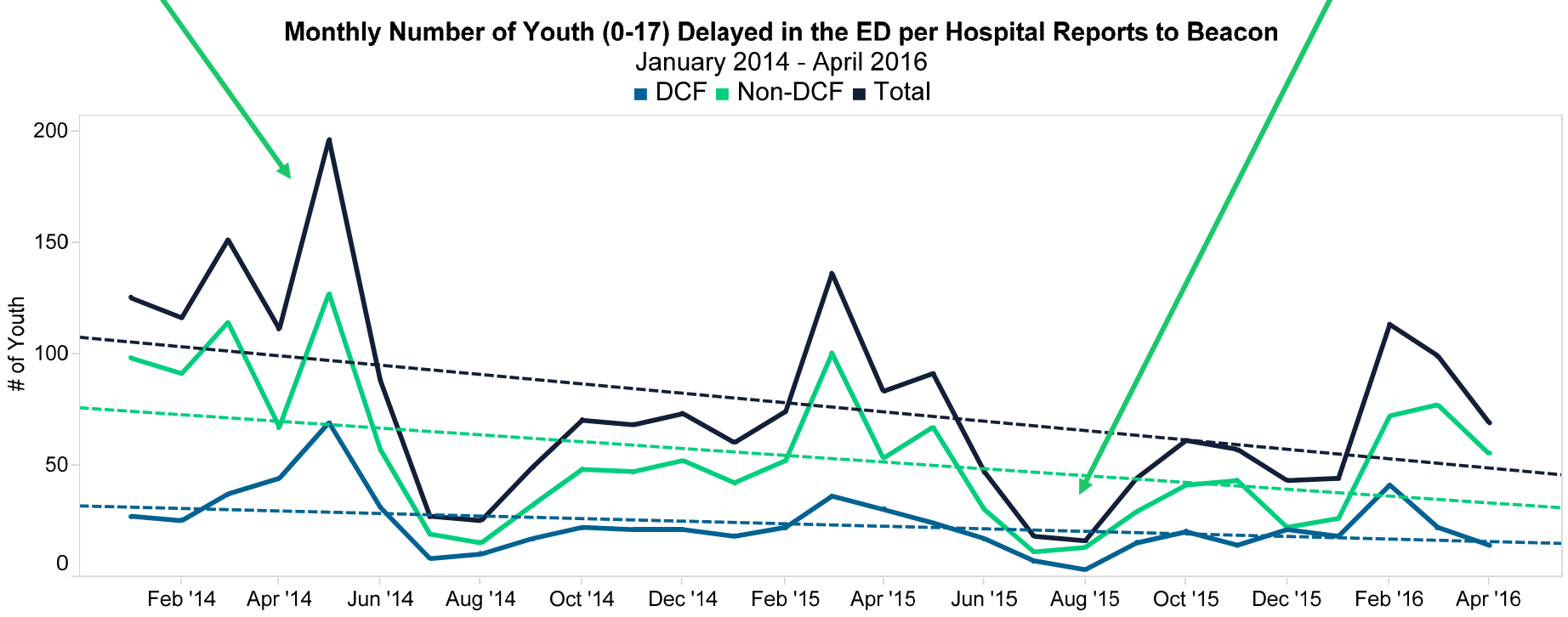
Seasonal Monthly Trends of ED Delays

Highs

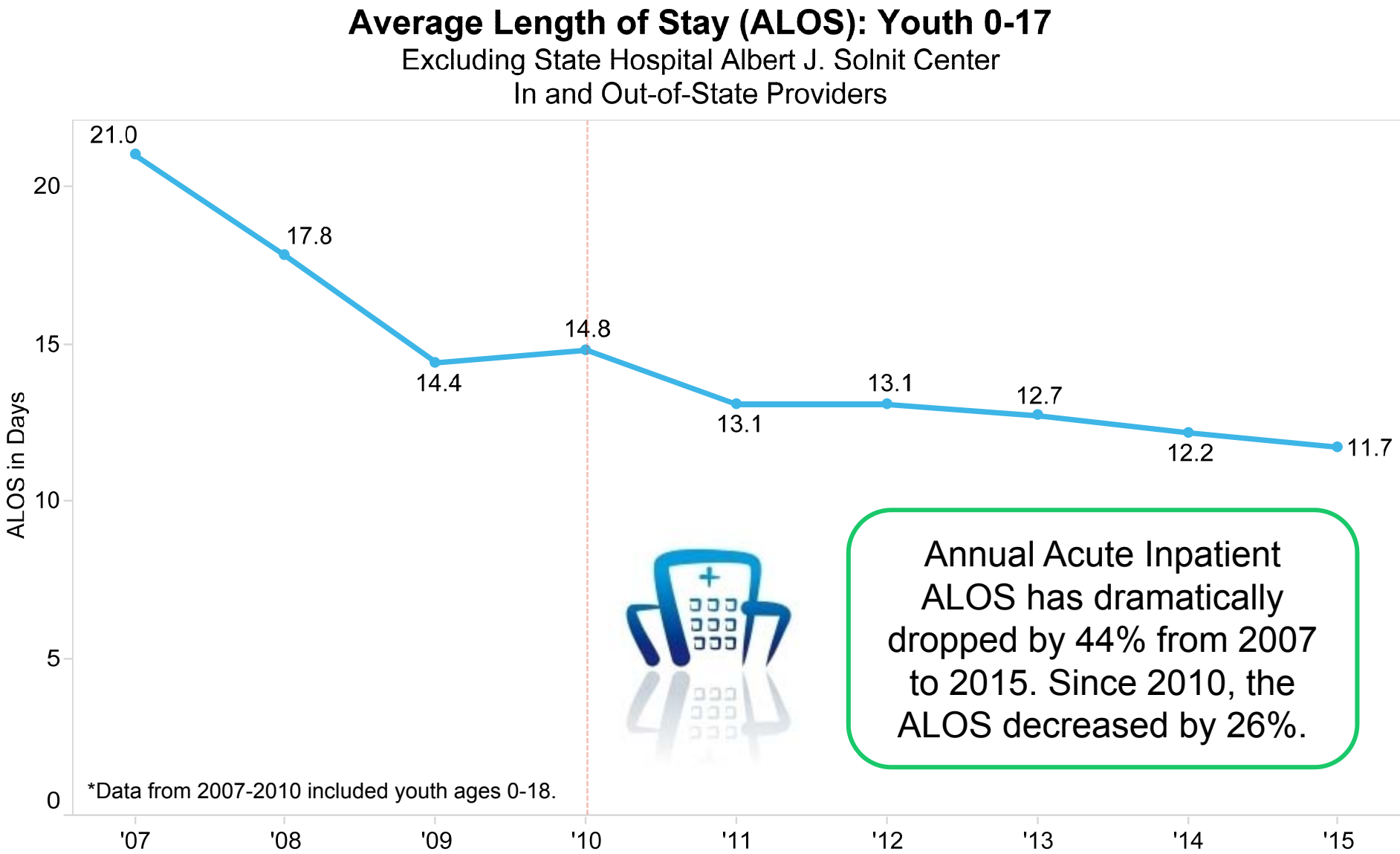
March & April

Lows

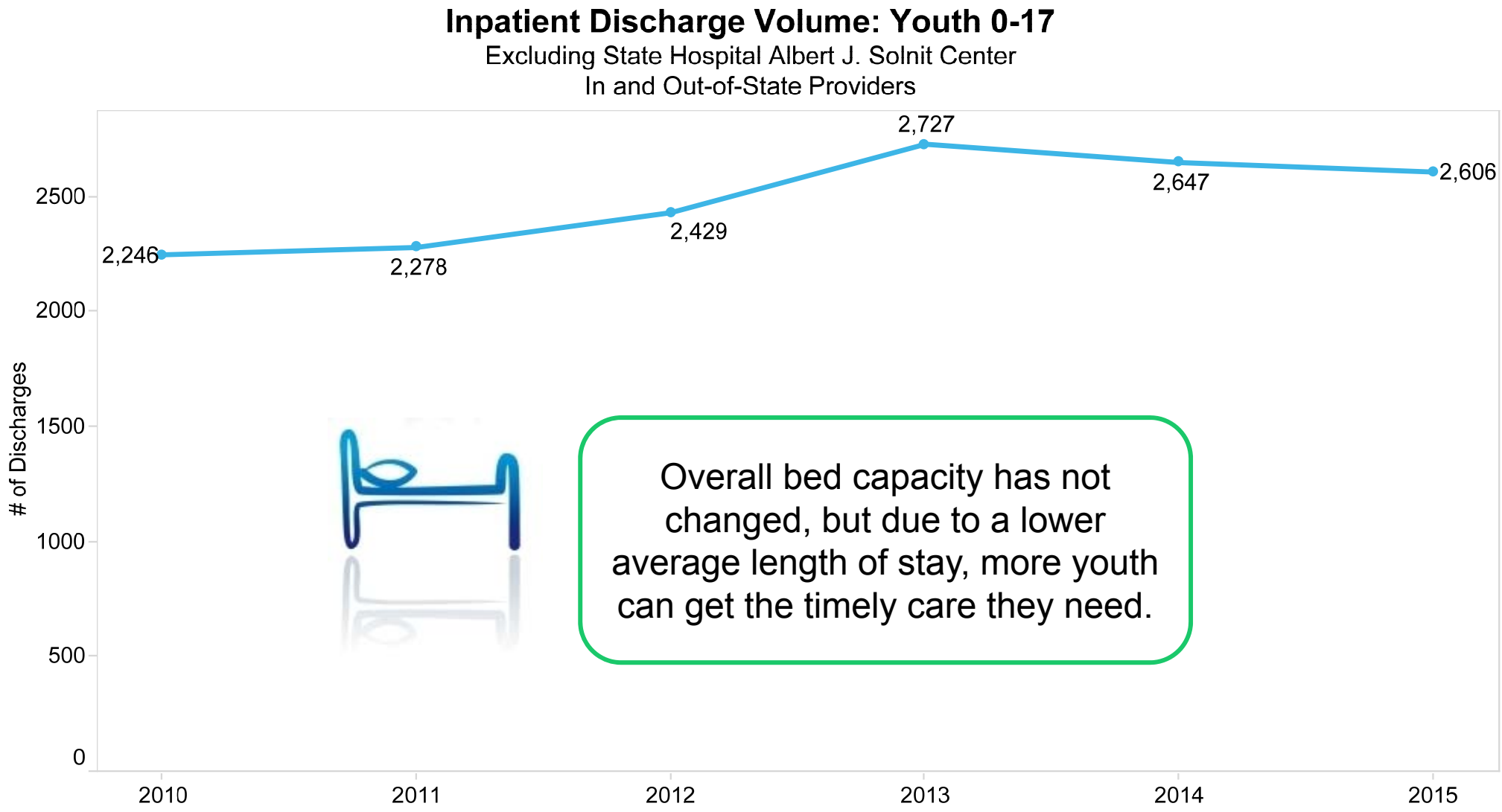
July & August



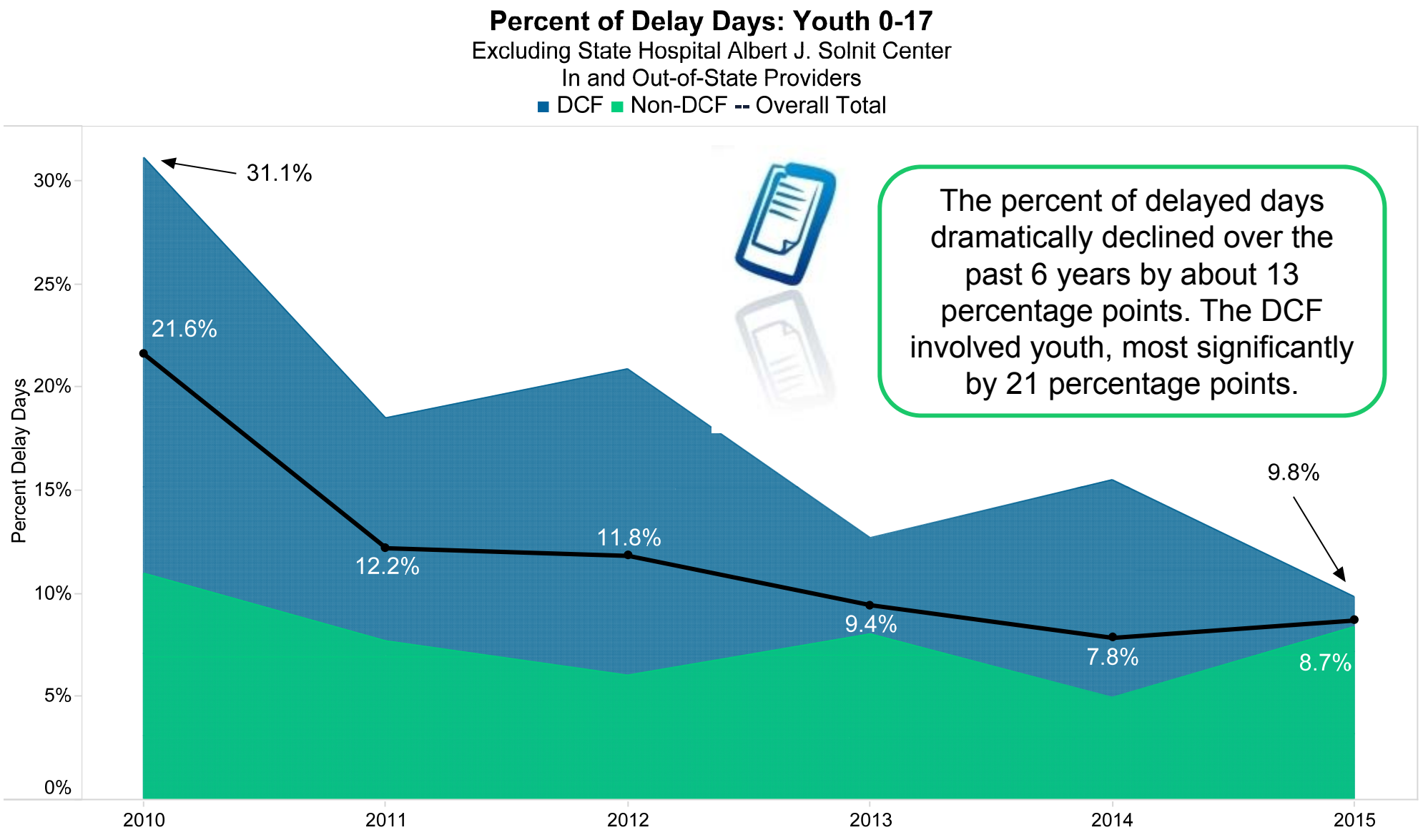
Acute Inpatient Average Length of Stay



Acute Inpatient Discharge Volume



Percent of Delayed Days



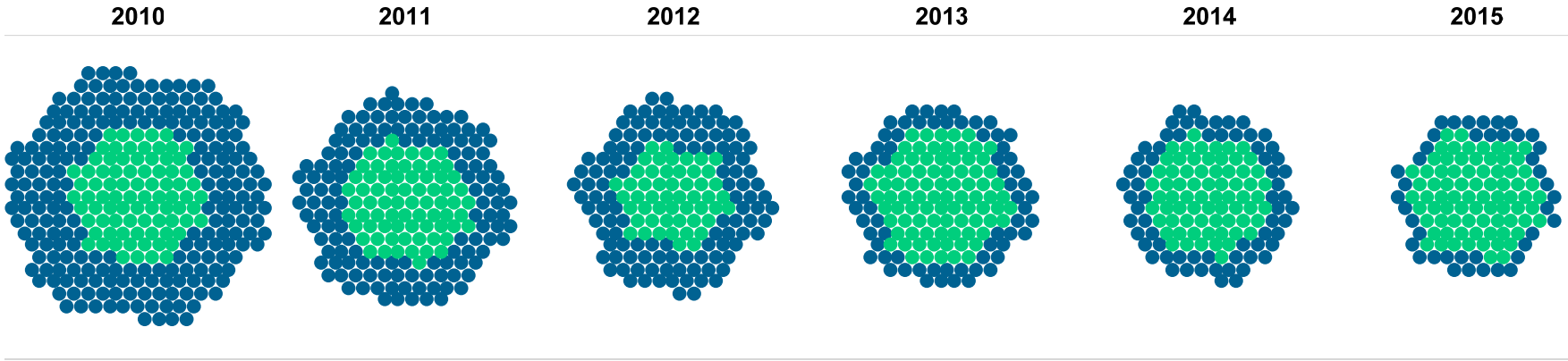
Volume of Youth on Discharge Delay

Volume of Youth on Discharge Delay from Acute Inpatient: Youth 0-17

Excluding State Hospital Albert J. Solnit Center

In and Out-of-State Providers

DCF Non-DCF



302 Youth on Delay

219 had DCF involvement

An 81% reduction!

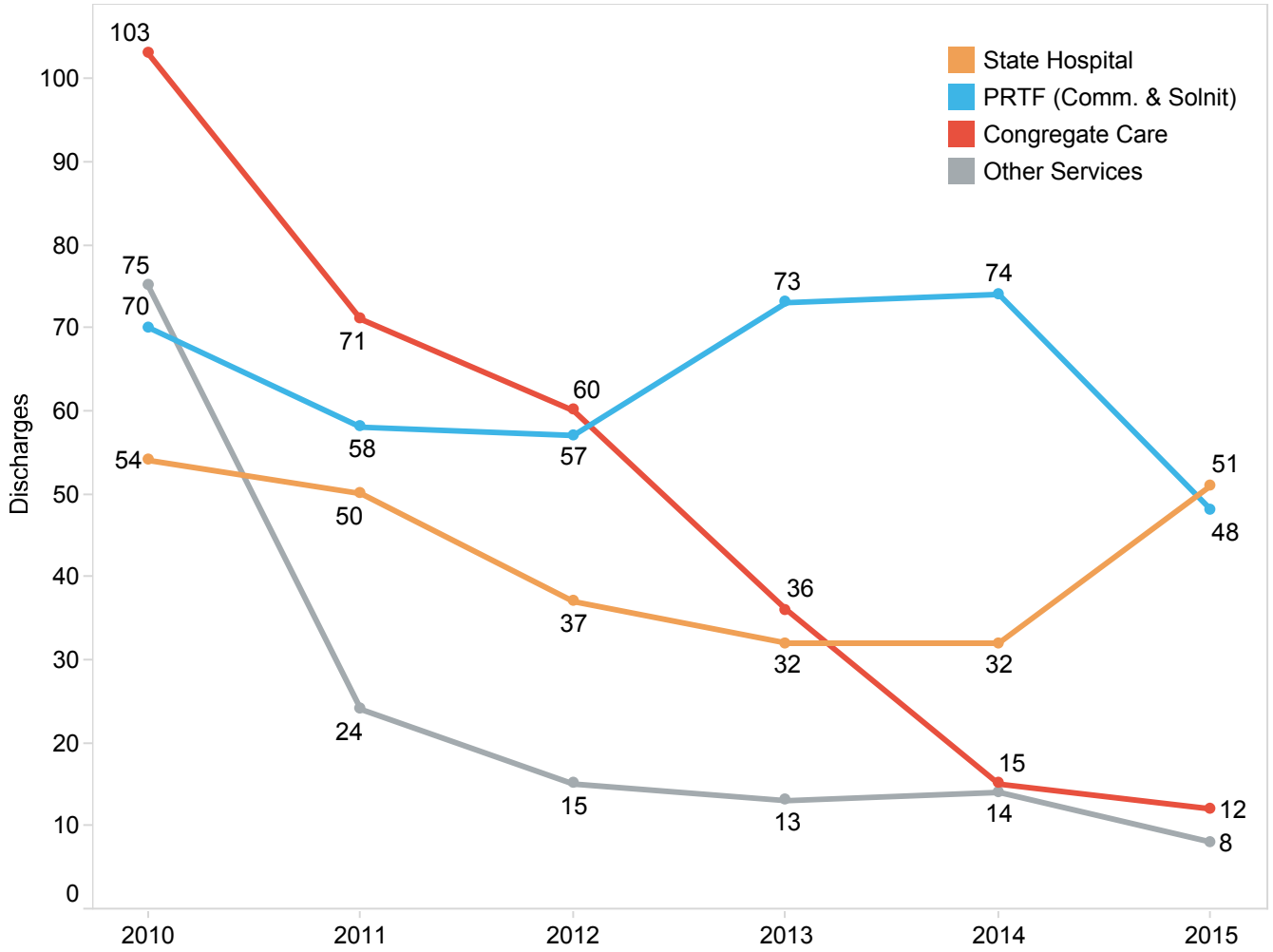
119 Youth on Delay

41 had DCF involvement

Acute Inpatient Discharge Delay Reasons

Volume of Youth on Discharge Delay from Acute Inpatient: Youth 0-17

Excluding State Hospital Albert J. Solnit Center
In and Out-of-State Providers



While overall volume of youth on delay has decreased over the past 6 years, youth waiting for congregate care has dramatically declined while waiting State Hospital and PRTF has increased more recently.

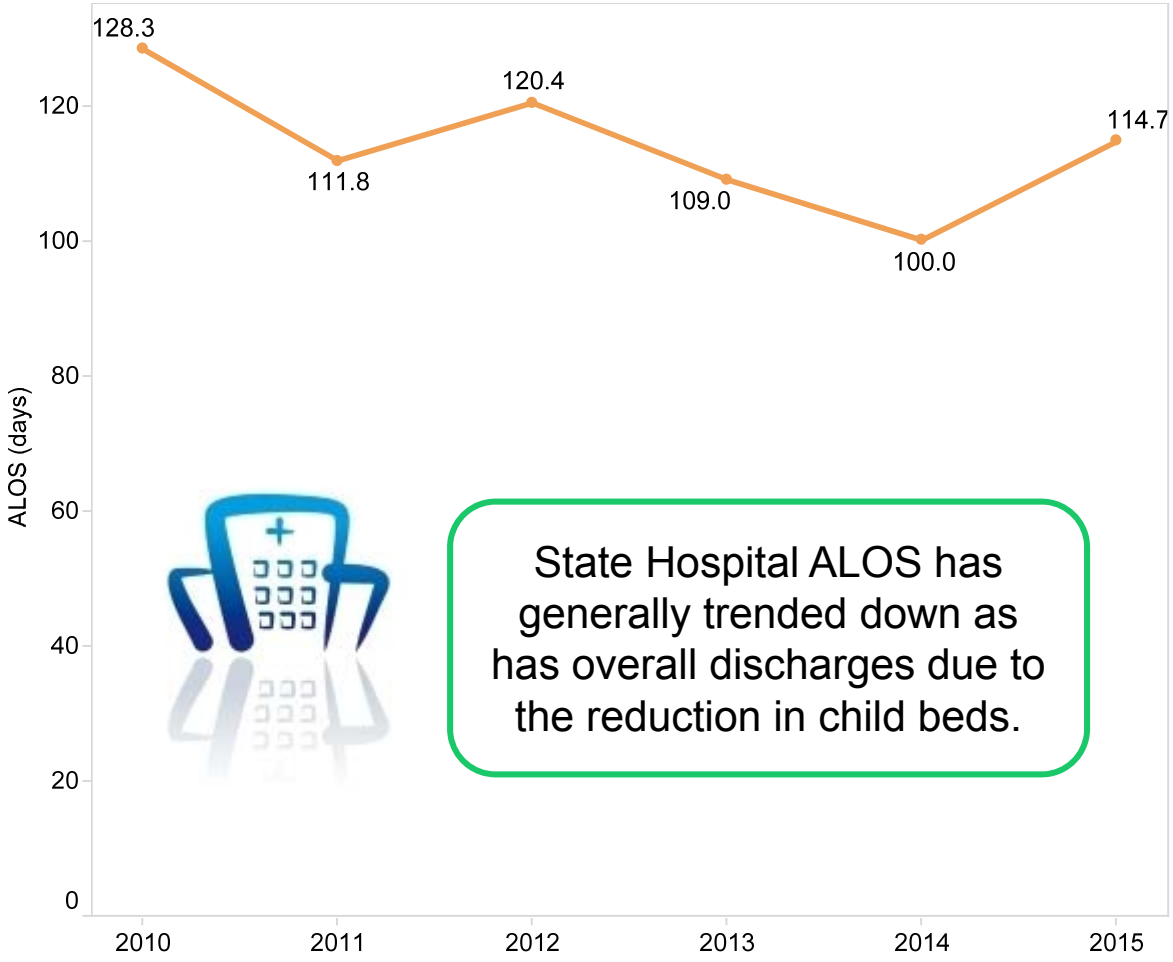
*Solnit North PRTF opened December 2013

State Hospital: Solnit Center

State Hospital Average Length of Stay (ALOS): Youth 0-17

Albert J. Solnit Center

Ages 0-17

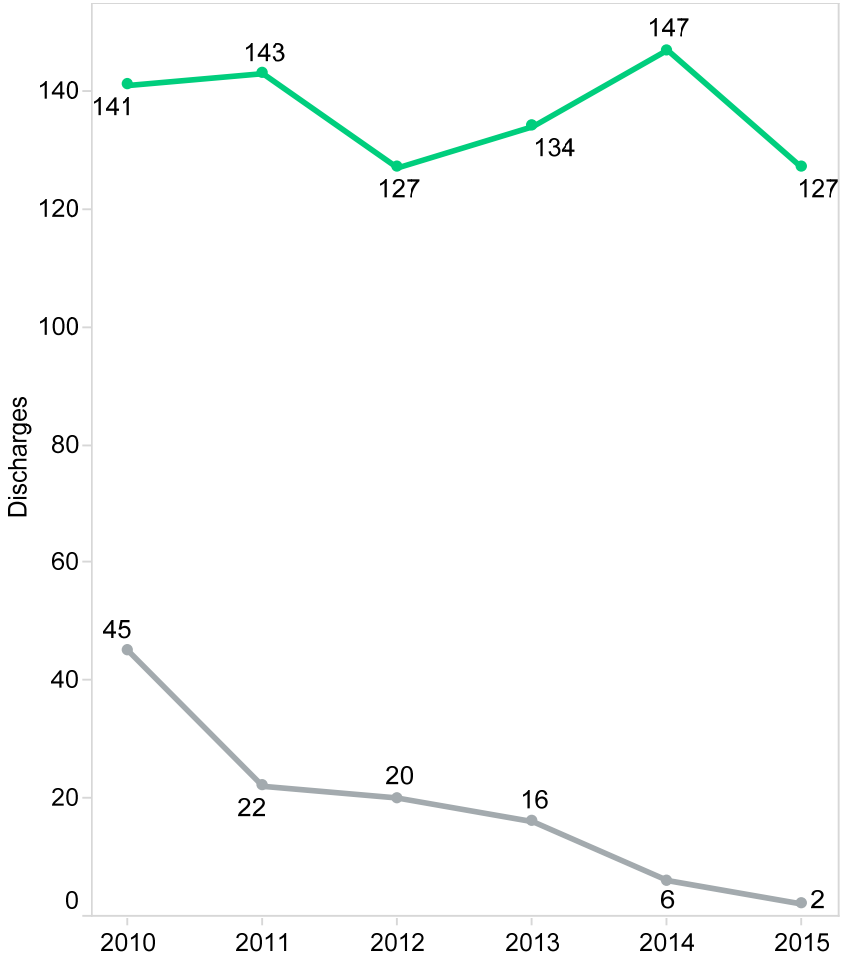


State Hospital ALOS has generally trended down as has overall discharges due to the reduction in child beds.

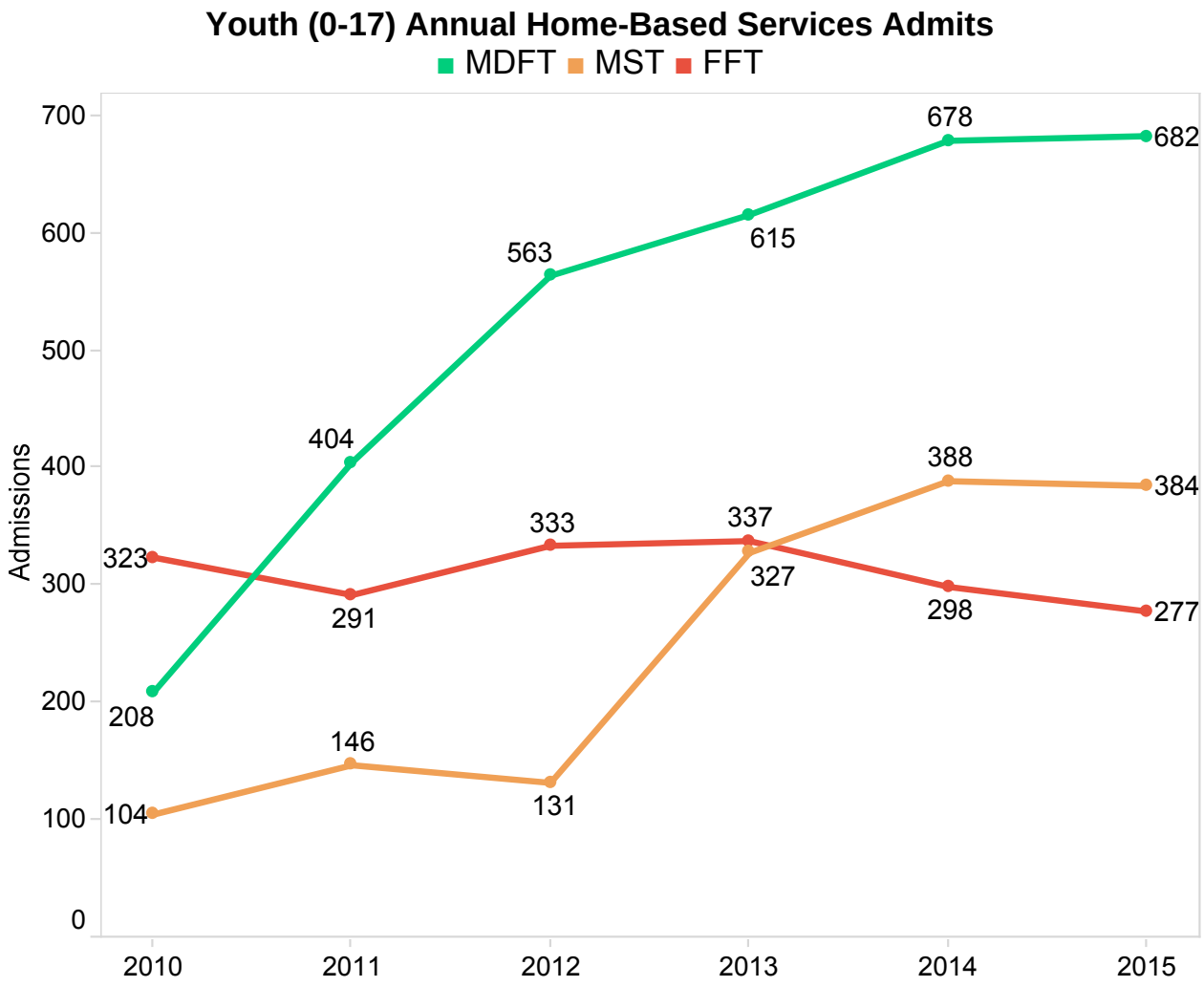
State Hospital Discharge Volume: Youth 0-17

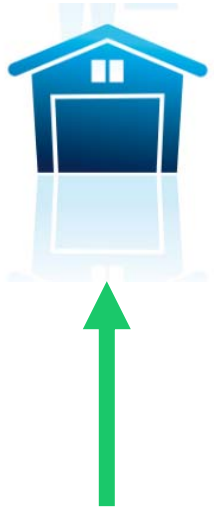
Albert J. Solnit Center

Ages 0-12 Ages 13-17



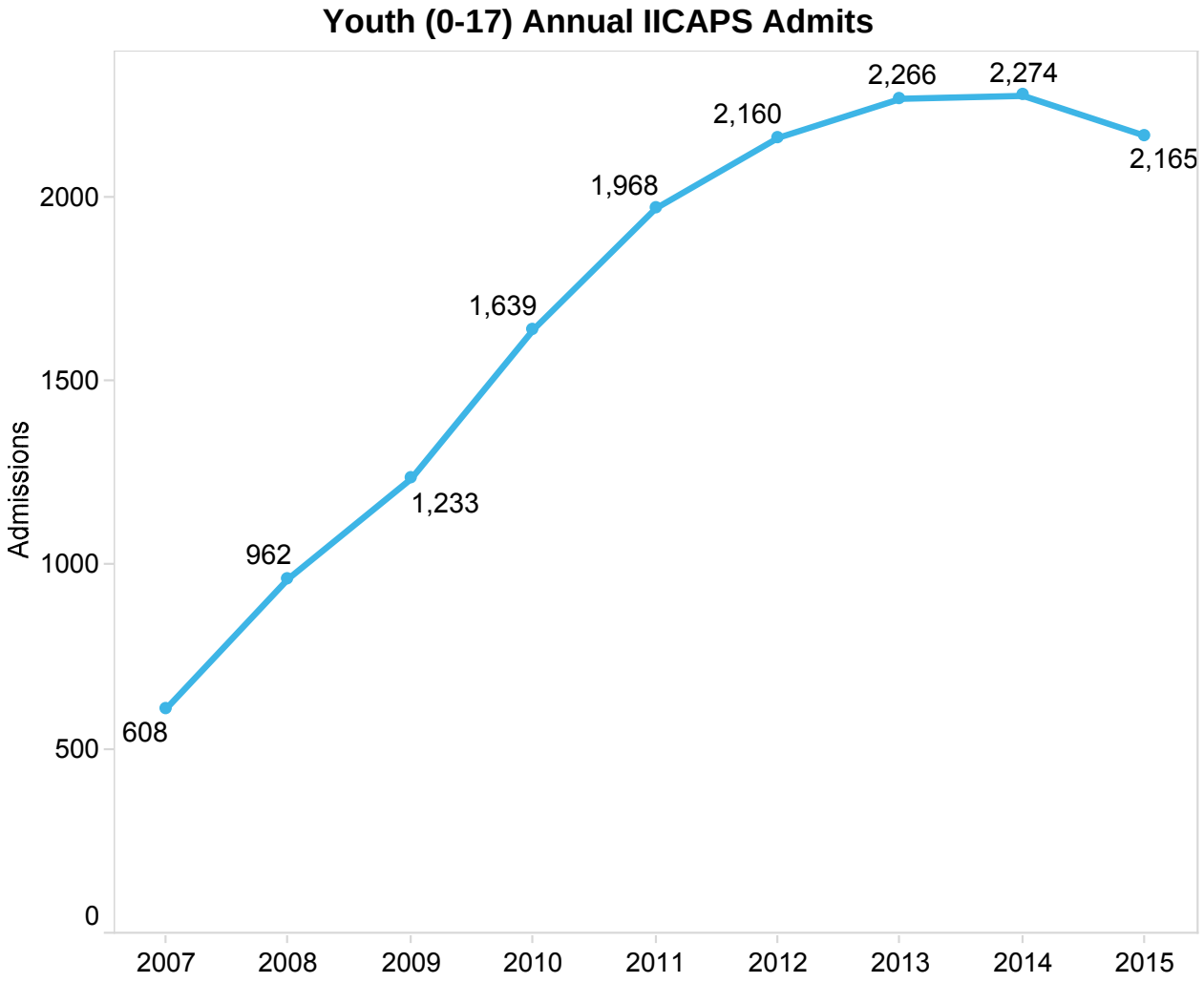
Home-Based Services Admits





MDFT and MST home-based services have seen a gradual increase in utilization and in availability. FFT has been consistent over the past 6 years.

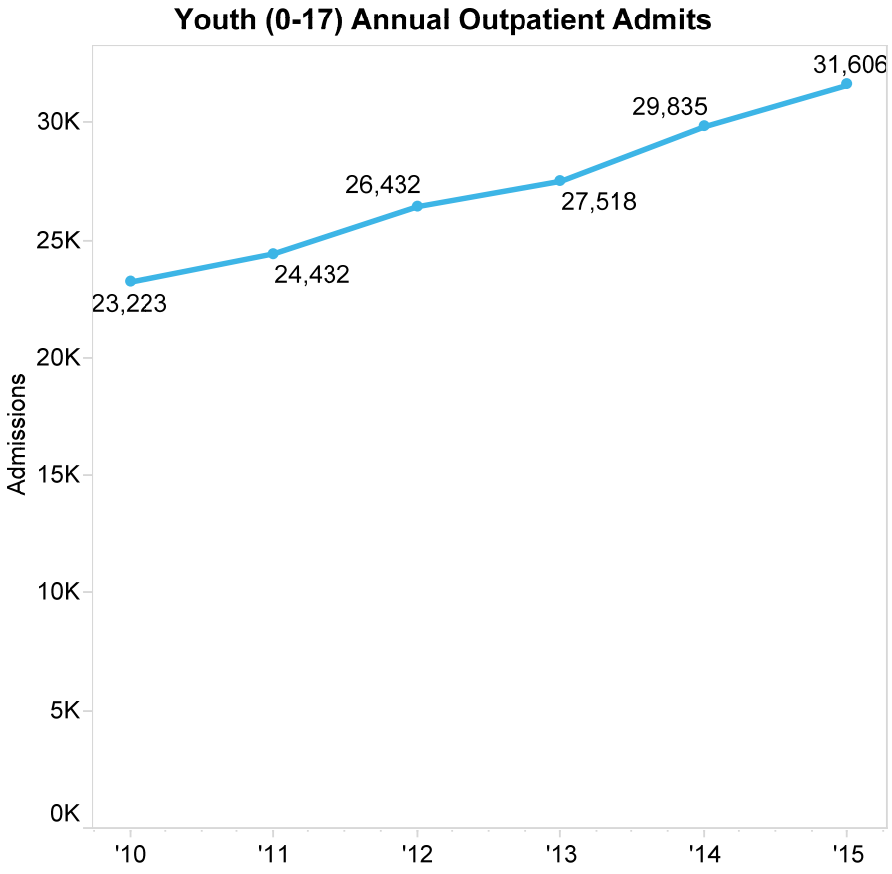
IICAPS Utilization

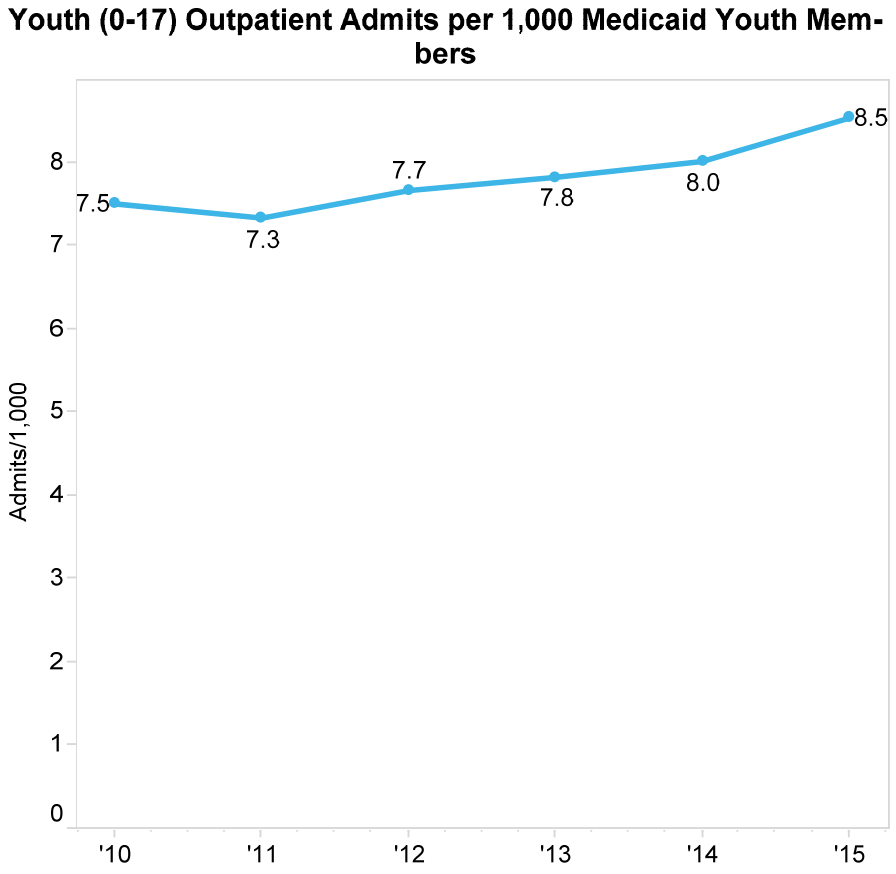


With a shifting to full Medicaid coverage and expansion of teams, more children have been able to access in-home services.

Outpatient Utilization Growth

Outpatient admissions have increased by almost 27% between 2010 and 2015. Admissions per 1,000 youth members has also increased suggesting more youth are accessing outpatient services.

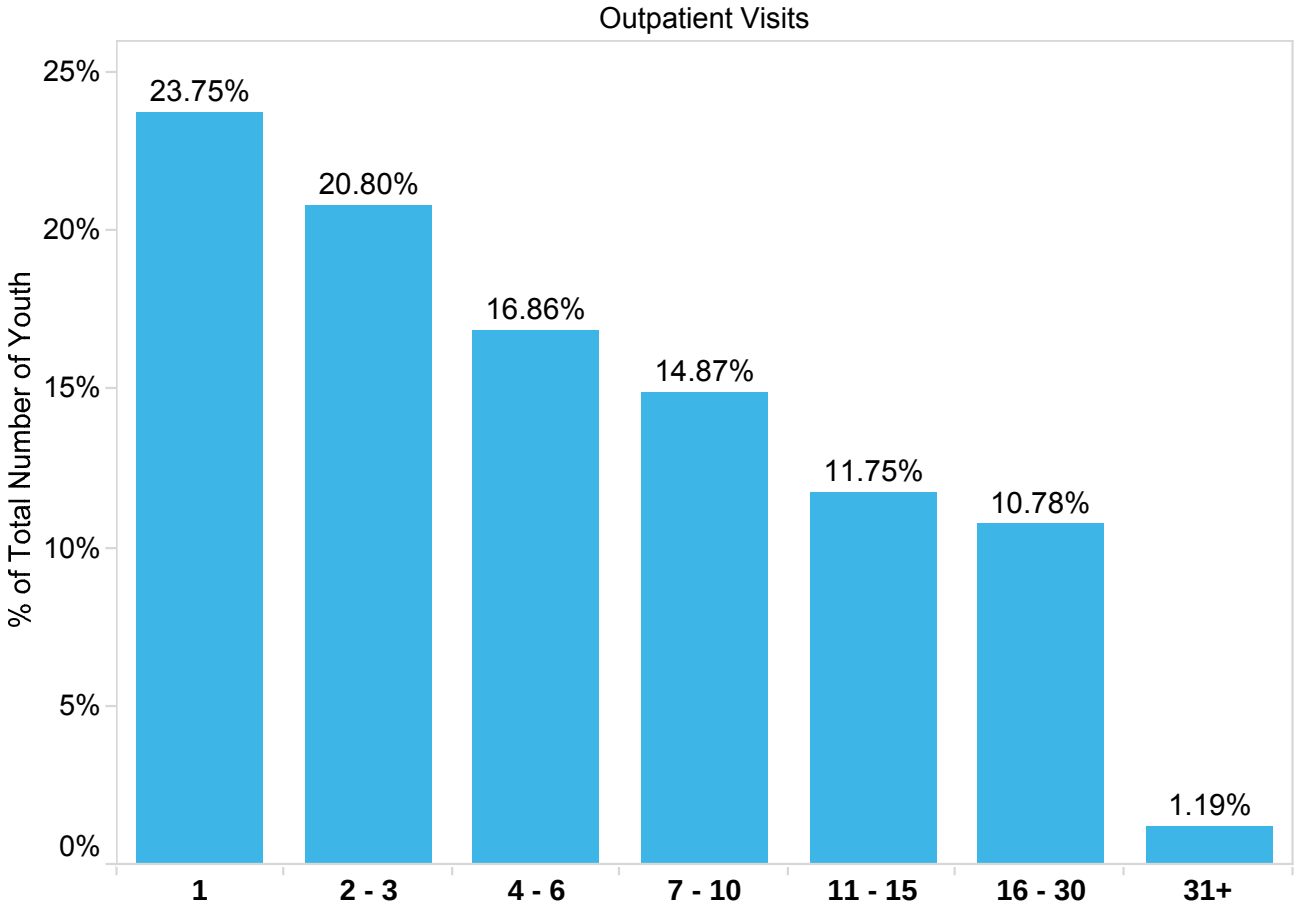




All data in this presentation is for Medicaid youth only.

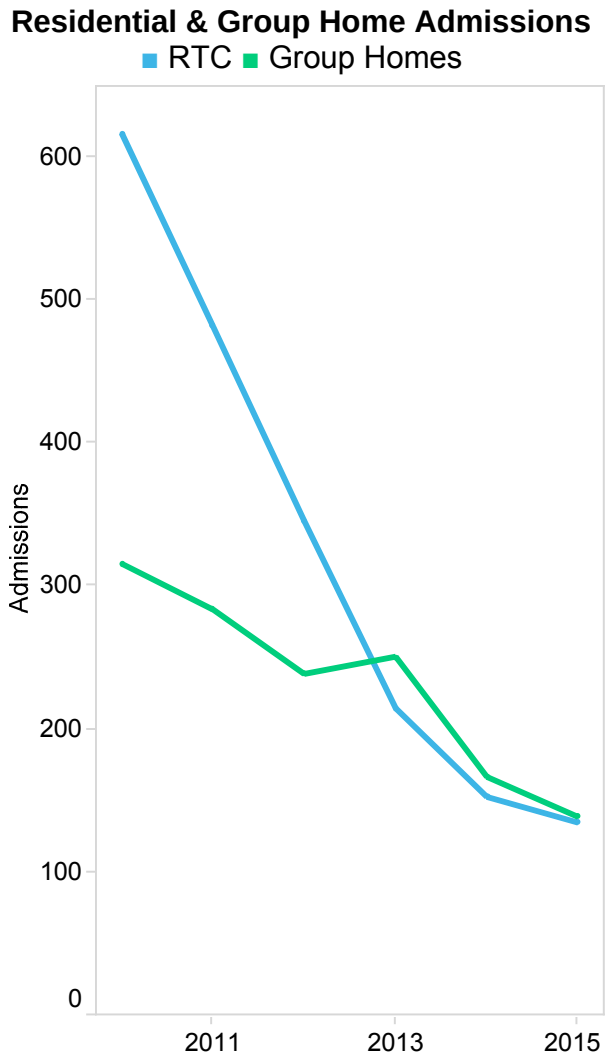
Frequency of Outpatient Use

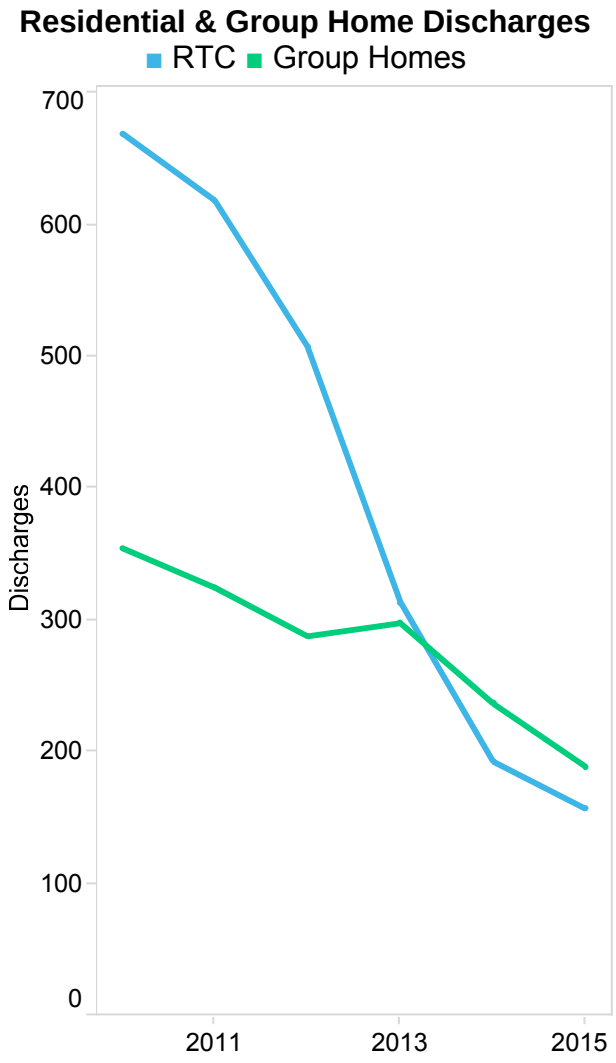
Frequency Distribution: Percent of Youth Medicaid Members by Number of Outpatient Visits in a 6-Month Time Period
CY 2011-2013

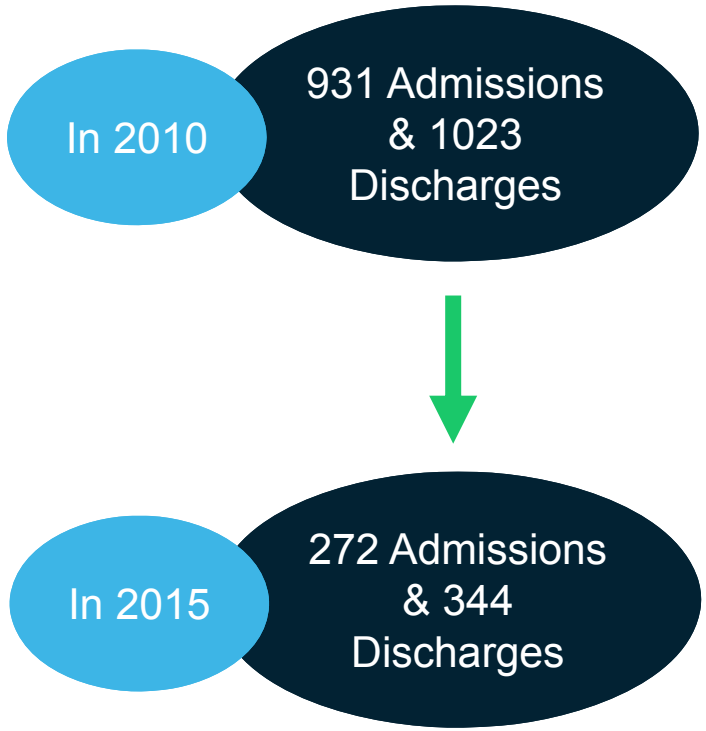


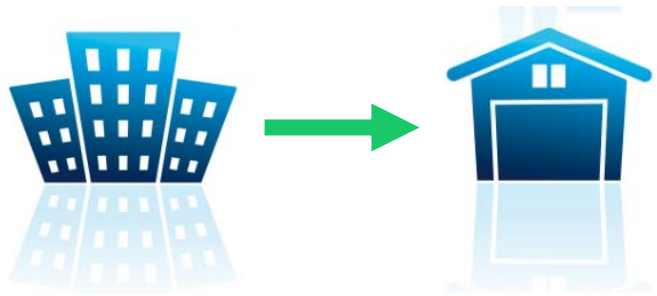
More than 55% of youth attended 4 or more outpatient visits showing increased engagement.

Residential Treatment Centers









Note: 2010-2011 included 18 year olds, 2012-2015 included 0-17.

Jeff Vanderploeg

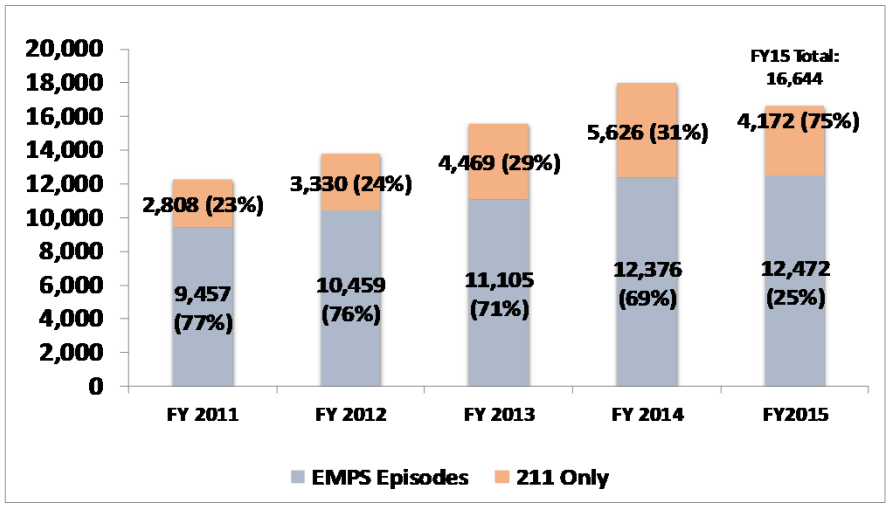
What do we want in a Children's Behavioral Health System?

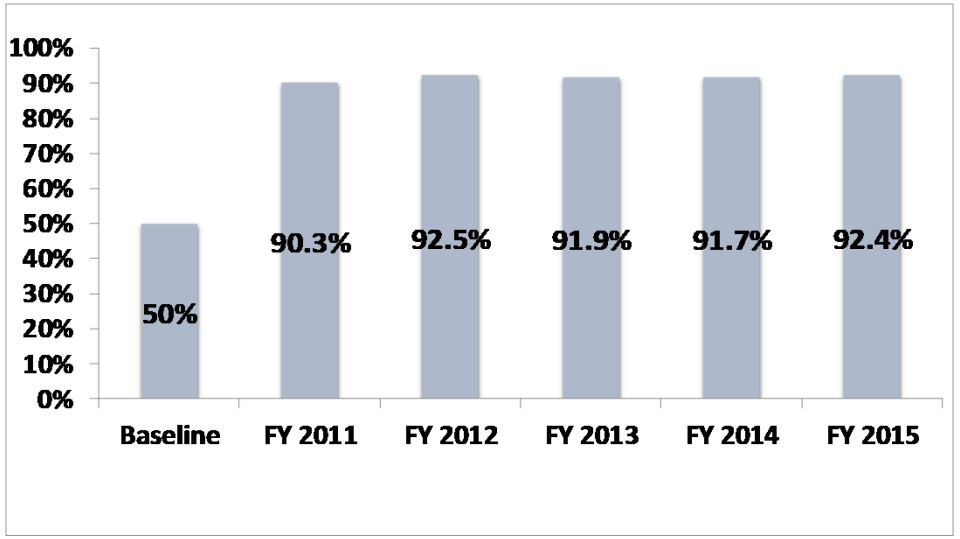
- Youth with behavioral health needs are identified early and have access to appropriate care; promote equity, reduce racial and ethnic disparities
- A full service array is available and youth and families are matched to the appropriate treatment based on their needs
- Providers are trained and supported to provide services backed by the best available science for effectiveness
- Service delivery is supported by robust data collection, reporting and quality improvement systems
- Children and families achieve the best possible outcomes and expenditures are held at reasonable levels
- A system development "blueprint" represented by the Children's Behavioral Health Plan (www.plan4children.org)

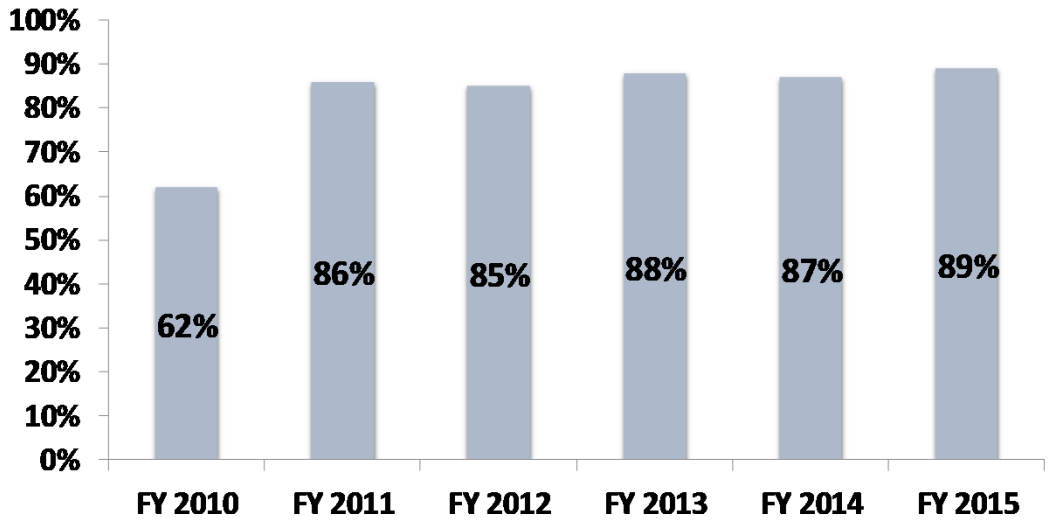
The Triple Aim +

The Triple Aim+

Access, Quality and Outcomes in EMPS







Access, Quality and Outcomes in EMPS

Statewide Ohio Scale Scores (based on paired intake and discharge scores)	N	Mean (intake)	Mean (discharge)	t-score	Sig.	% Clinically Meaningful Change
Parent Functioning Score	361	42.94	45.52	4.70	p < .001	13.0%
Worker Functioning Score	3133	43.44	45.38	14.96	p < .001	8.4%
Parent Problem Severity Score	340	28.66	23.04	-8.53	p < .001	19.1%
Worker Problem Severity Score	3113	28.51	25.56	-21.24	p < .001	10.4%

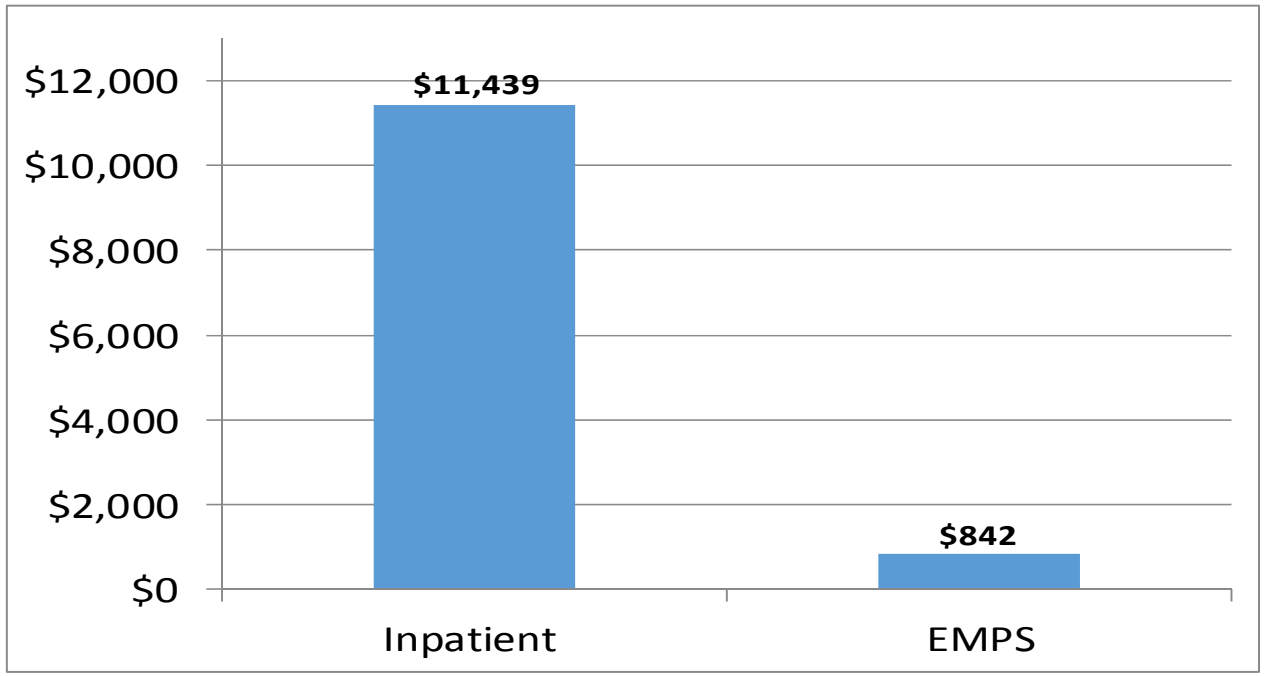
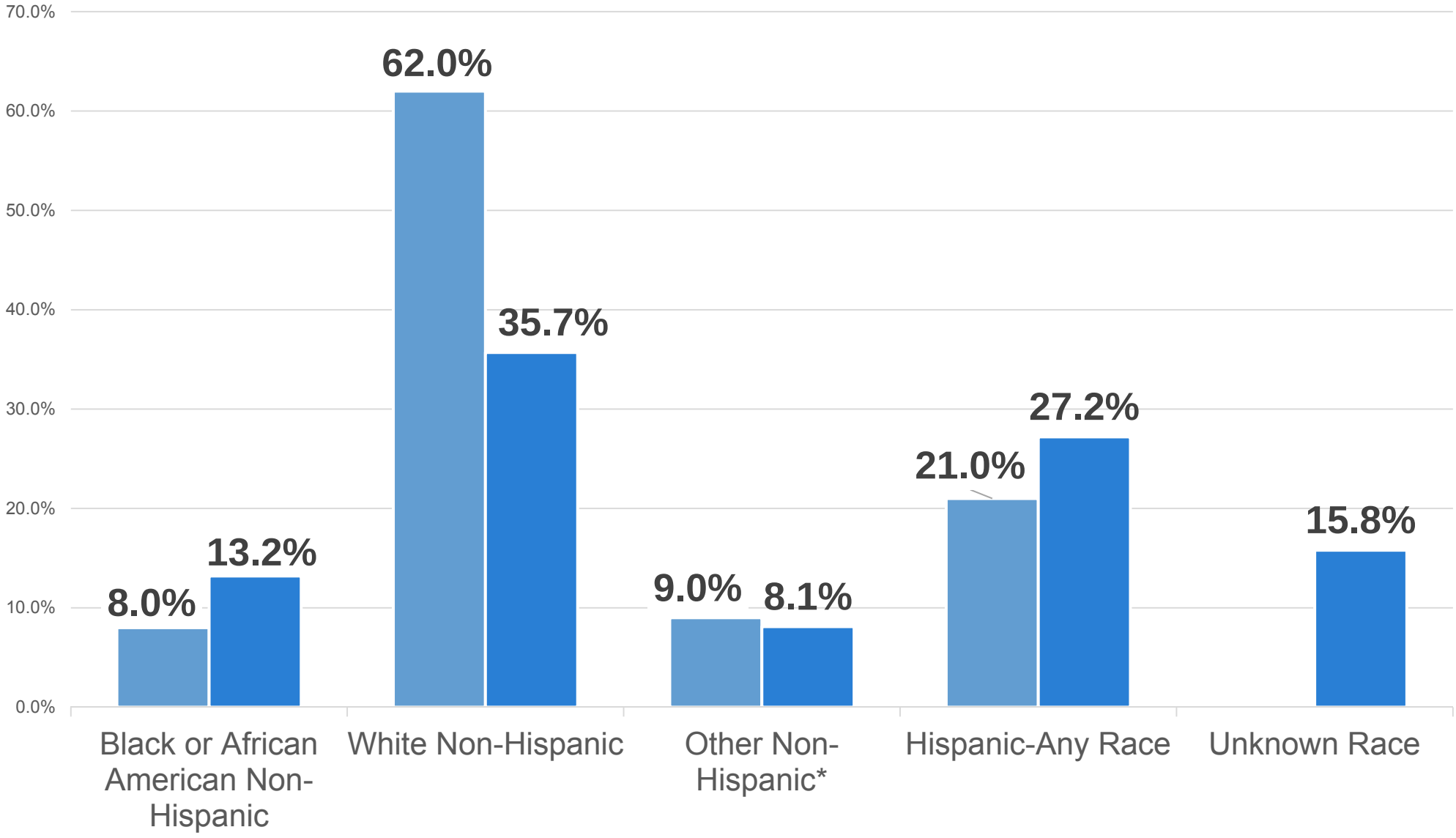


Figure 1: Connecticut Children Population and EMPS Unique Children Served, 2015

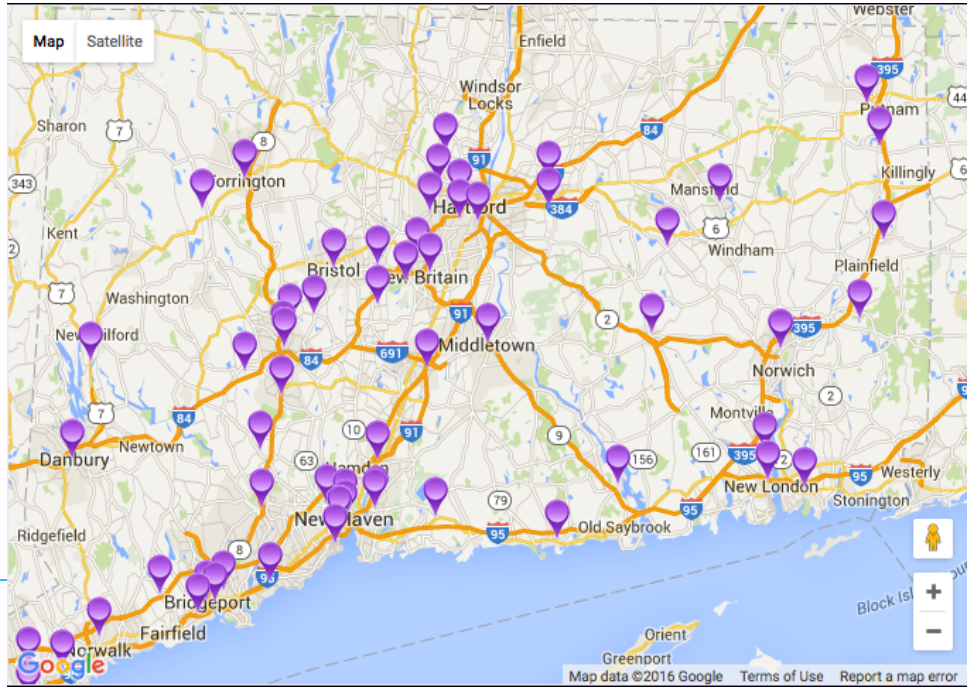


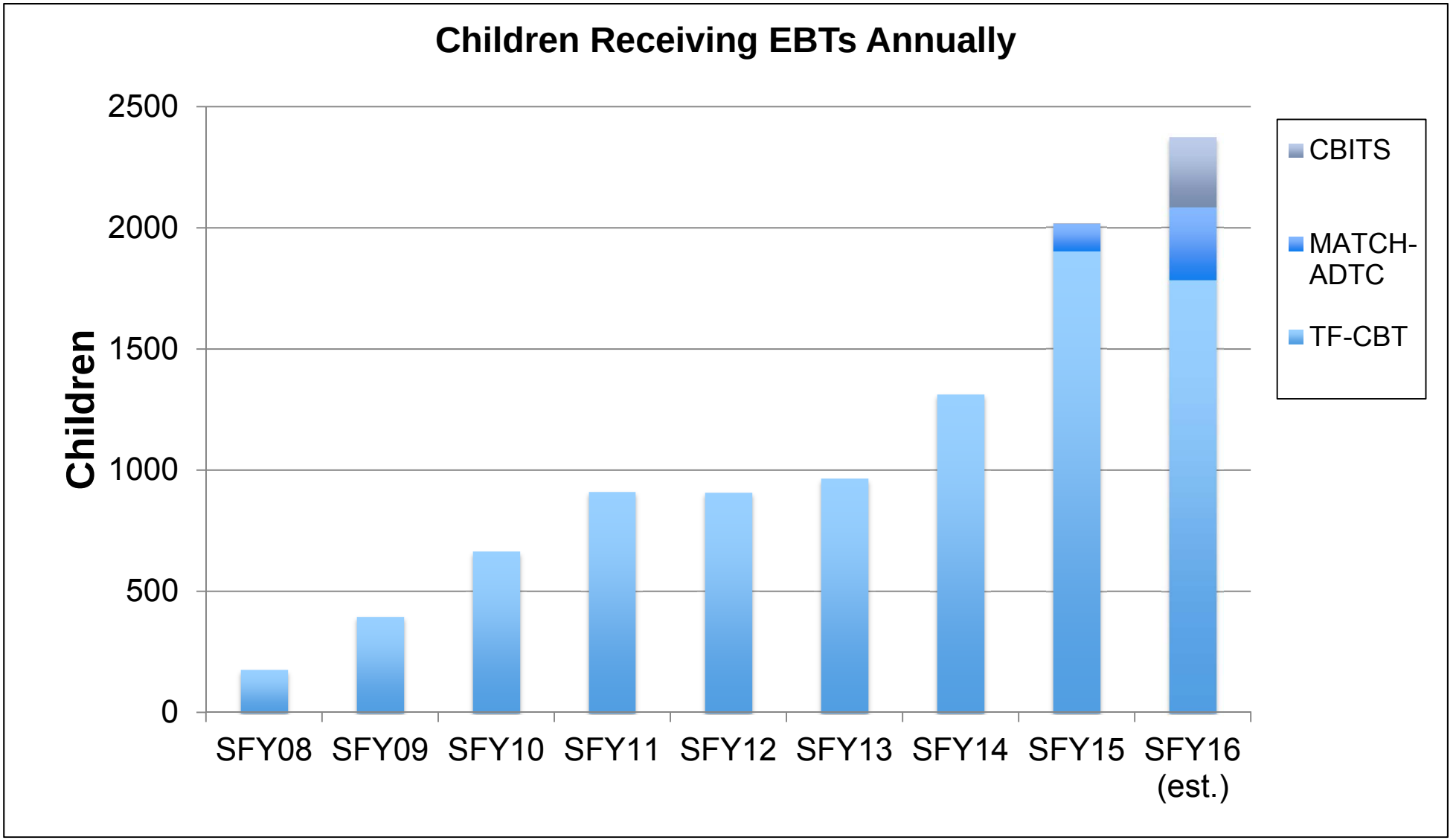
*Other-Non Hispanic category includes: Asian, Native American/Native Alaskan, Native Hawaiian/Pacific Islander and more than one race.

Evidence-Based Treatments (EBTs)

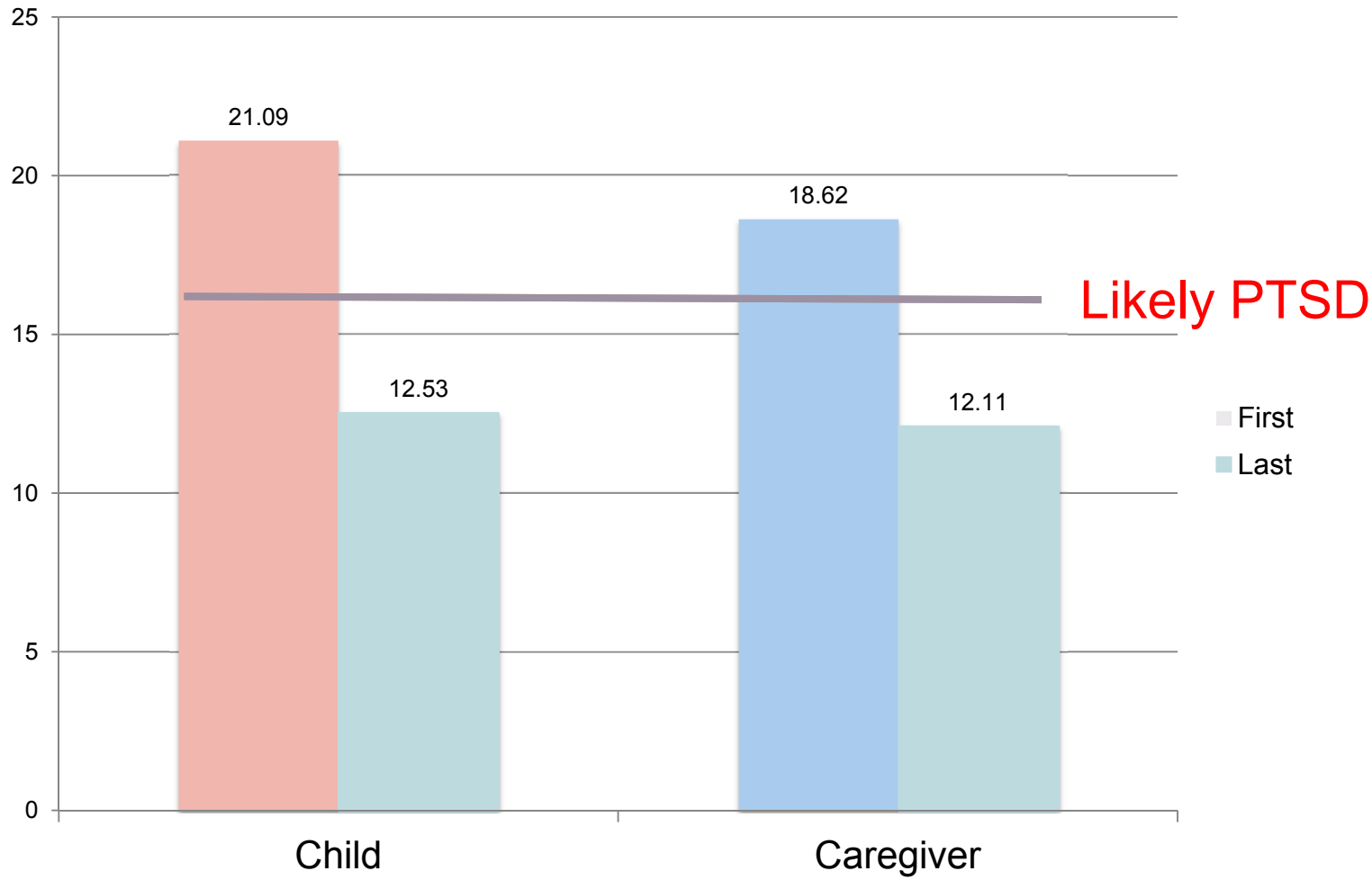
Practice Model	Appropriate for	Age Range	Format
Cognitive Behavioral Intervention for Trauma in Schools **(CBITS)**	Distress caused by violence, abuse, or other trauma	7-17	Group-based; School-based
Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, and/or Conduct Problems **(MATCH)**	Anxiety, depression, behavior problems, and/or trauma	6-15	Individual; clinic-based
Trauma-Focused Cognitive Behavioral Therapy **(TF-CBT)**	Distress caused by violence, abuse, sexual abuse, or other trauma	3-17	Individual (caregiver preferred); clinic-based

A searchable directory for EBTs:
www.kidsmentalhealthinfo.com




Children Receiving EBTs Annually
Children
2500
2000
1500
1000
500
0
SFY08
SFY09
SFY10
SFY11
SFY12
SFY13
SFY14
SFY15
SFY16 (est.)
CBITS
MATCH-ADTC
TF-CBT

PTSD Symptom Reduction in TF-CBT



N=745 N=664

Summary: Improving Children's Behavioral Health Care in Connecticut

- Service systems have been designed to promote access, quality, and outcomes
- Increased awareness of health equity and disparities, with implications for programming and data collection/reporting
- More kids are getting cutting-edge treatment than ever before; CT is a national leader in delivery of EBTs and trauma-informed systems and services
- Outcomes data demonstrate that **kids are getting better**
- We are delivering home, school, and community-based care that is effective and cost effective

Linda Dixon

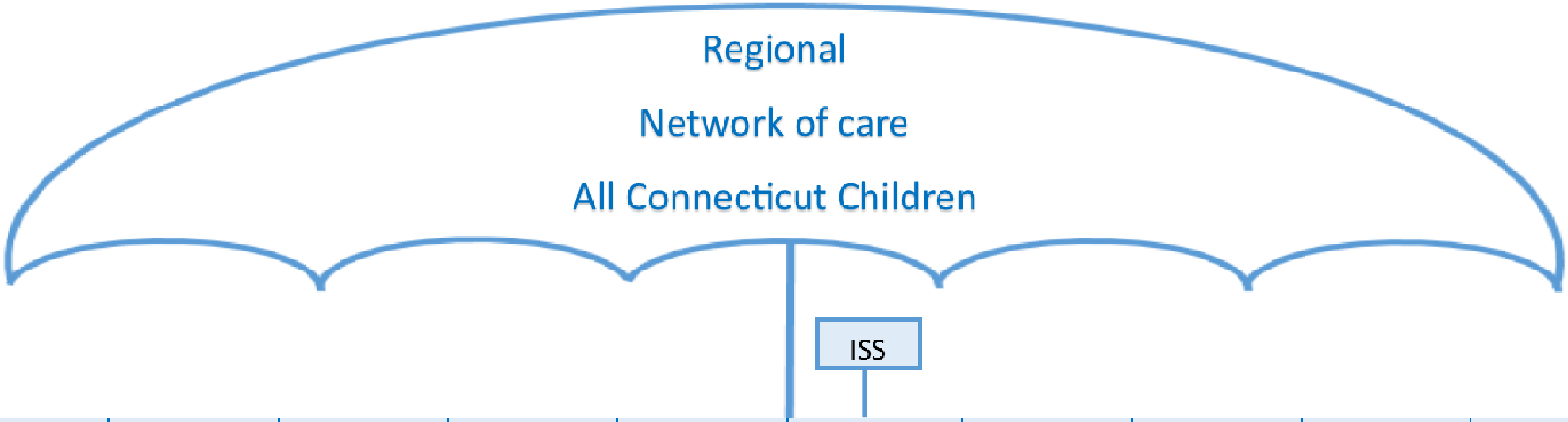
Enhancements over six years

- Growth in Kinship Placement - Since 2011, increase in relative/kin placement from 21.1% to 41.4%
- 88% of children/youth living in the community
- Workforce development in several areas including extreme recruitment, permanency preparation, family engagement, violence prevention, restorative justice, cultural humility
- Growth in specialized foster care resources (e.g., Family and Community Ties)
- Enhancements in foster parent training (e.g., using a model that includes a component in understanding trauma, adding online training components)
- Implementation of the Caregiver Support Team (statewide capacity of 676 families)
- Expanding availability of specialists who help locate and engage family resources for youth
- Improvements in our Risk/Needs Assessment process for youth involved in the juvenile justice system
- Addition of an online Virtual Academy that provides DCF involved youth with individualized academic tutoring, credit retrieval/recovery
- Addition of specialized supportive living environments for adolescents over age 17 in the juvenile justice system
- Increasing Survivor Care for youth involved in Domestic Minor Sex Trafficking
- Implementing a structured length of stay protocol for youth at CJTS
- Helping to prepare youth for adulthood by implementing a new life skills program for our adolescents (the same program used by our sister agency, DMHAS)

Kristina Stevens

Enhancements over six years

- Adoption of Strengthening Families Practice model and implementation of a child and family teaming continuum
- Growth in Community Resources including; EMPS, EBP availability, Crisis Stabilization/Crisis Respite
- DCF Culture change: Child and Family Teaming, ISS, Using what we have better, WrapCT, Trauma Informed Care
- Expansion of Emergency Mobile Psychiatric Services (EMPS) including the completion of 87 Memorandums of Agreement (MOA's) between Local Education Agencies (LEA's) and EMPS teams
- Expansion of Modular Approach to Therapy for Children (MATCH) to 17 clinics
- Implementation of Cognitive Behavioral Intervention for Trauma in Schools (CBITS) in 13 school districts including 90 school based clinicians
- Implementation of Adolescent Screening, Brief Intervention and Referral for Treatment (A-SBIRT)
- Establishment of Autism Spectrum Disorder (ASD) Unit at CT Behavioral Health Partnership
- Continued investment in Infant Mental Health training and implementation of Circle of Security Parenting
- Implementation of CT's first Care Management Entity
- Issuance of the CT Suicide Prevention Plan



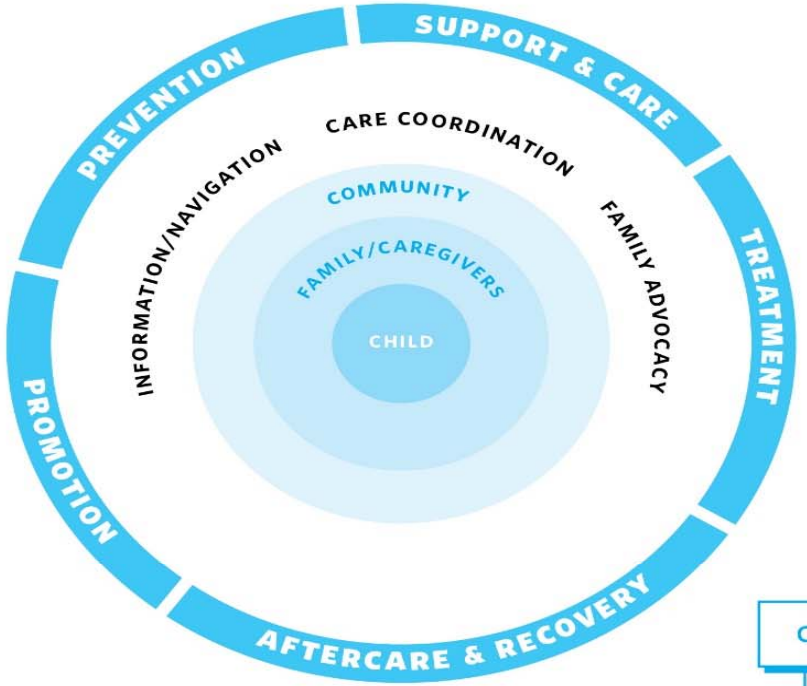
Early Childhood Community Collaborative	Medical Home Community Collaborative	System of Care Community Collaborative	Local Interagency Service Team (LIST)	Juvenile Review Board (JRBs)	Child Welfare Regional Advisory Council	Citizen's Review Panel	Prevention Council	Autism Support and Advocacy	Etc.
OEC Graustein Foundation	DPH	DCF	CSSD DCF	CSSD	DCF	DCF	DMHAS	Family & Caregivers	
Area of Focus									
Children with Educational Needs	Children with Medical Needs	Children with Behavioral Health Needs	Children with Juvenile Justice Needs	Children with Juvenile Justice Needs	Children with Child Welfare Needs	Children with Child Welfare Needs	Children at risk of Substance Use	Children with Autism Spectrum Disorders	

DCF CONNECTICUT

CT Children's Behavioral Health System of Care

SYSTEM INFRASTRUCTURE/ CARE MANAGEMENT ENTITY:

- No "Wrong Door"—Single Point Access
- Unconditional, Outcome-driven, individualized care
- Intensive Care Coordination and Child and Family Wraparound Team Meetings
- Single Plan of Care Development
- Peer to Peer/Family Advocacy Support
- Flexible Wraparound Funds
- Family/Parent/Caregiver/ Youth involvement
- Community involvement and oversight
- Utilization Management
- Continuous Quality Improvement
- Data/Outcome Reporting
- Local Systems/Network of Care, Infrastructure and Coordination
- Workforce Development
- Cultural and Linguistic Competency



Non-traditional / Non-clinical

Community/grassroots/ organic/faith-based programs
Afterschool programs

Diversion

Juv. court/school programs
Juv. review boards
Youth services and positive youth development

Therapeautic Intervention

Therapeutic child care
Therapeutic after school

Identification & Early Intervention

Universal screening
Home visiting
Behavioral healh consultation

Outpatient Treatment

Clinic-based
Evidence-based practices
Counseling
Substance-use treatment

School-based
School clinicians
Health Centers
Outposted-school clinicians

Social-Emotional Learning

Early Care/Head Start
Social-emotional learning models
School climate (e.g. PBIS)
After school

Family Strengthening

Parent skill building
Parent leadership training
Community programs

Intensive Outpatient

Intensive clinic-based
Partial hospitalization
Intensive outpatient
Extended-day treatment

Home-based
Intensive In-home services

Ongoing Supports

Community support
Supportive housing
12-Step Programs
Peer supports
Basic needs support
Recovery Supports

Crisis Intervention

Mobile Crisis
Crisis stabilization units
Intensive Behavioral Health Assessment Centers
ED (last resort)

Transitions

Life skills/Support
Transition support
Support & Care

Congregate care

Group Homes
Residential Treatment Centers

Inpatient

Psychiatric Residential Treatment Facilities
Inpatient units

Impressions
Mary Jo Meyers

Q & A