Overview of Presentation

1. Enhancements and Core Elements of Emergency Mobile Psychiatric Services (EMPS) in Connecticut
2. The EMPS Performance Improvement Center: Review of Quality Improvement Approach and Findings

Connecticut Context

- Child Health and Development Institute of Connecticut
- Connecticut Center for Effective Practice
- Department of Children and Families

Learning Objectives

1. Understand the process of re-designing and re-procuring a statewide mobile crisis service
2. Review key elements required to support provider performance and child and family outcomes
3. Understand role of the Performance Improvement Center for training coordination, data analysis and reporting, and CQI
4. Explore policy and practice implications and applications for similar initiatives in systems of care

EMPS Video: Incorporating Parent and Family Voice

Enhancements and Core Elements of Emergency Mobile Psychiatric Services (EMPS) in Connecticut

Bert Plant, Ph.D.
Tim Marshall, M.S.W.
Connecticut Department of Children and Families
What is Emergency Mobile Psychiatric Services (EMPS)?

- A system of mobile psychiatric care including:
  - 211 – A centralized call center
  - Six service providers covering every town in CT
  - A Performance Improvement Center that monitors and supports EMPS Service provision
- Who is eligible?
  - Any child/youth through the age of 18 (19 if still enrolled in school)
- How is it funded?
  - State grants and Medicaid Fee-for-Service

Re-Design and Re-Procurement

- Why - Problems with the service:
  - Mobility
  - Volume
  - Hours
  - Service model
  - Variability
  - Context – Growing ED volume and overstays
- Expert Consultation
  - CHDI/CCEP
- Community Forums
- Budget Request – With Key Model Components

Systems Coordination

- Facilitated improved Medicaid rates under Rehabilitation Option
- New Program & Services Data Collection and Reporting System (PSDCRS) implemented simultaneously with project
- Medicaid - Pay For Performance Incentives for improved collaboration with Emergency Departments
  - MOU’s
  - Data collection
  - Diversions from inpatient
- Linkage with MacArthur Foundation as a school-based JJ diversion pilot project
- Legislation to empower providers to issue emergency certificates

211 Triage Decision-Making

- 211 "screen outs" include calls for information and referral and calls that are appropriate for 911
- Calls that are "screened in" as EMPS Responses require triage into three categories:
  - Non-mobile response (telephone only)
  - Deferred mobile response (usually next day)
  - Mobile response (benchmark: under 45 minutes)
- 211 clinical triage facilitates standardized decision-making and expectation for a mobile response
- 211 collects and enters basic data and makes a "warm transfer" to the appropriate EMPS provider
- EMPS provider takes call, intervenes, and collects and enters episode data into the PSDCRS web-based system

EMPS Access

- A single statewide, centralized access point versus eleven separate 800 numbers
- 3-digit access far superior to 800#s
- 211 multi-service referral, information, and crisis line
Statewide Referral Sources

Top Five Referral Sources Statewide

- Self/Family: 34.5%
- School: 6.1%
- Other community provider: 23.3%
- Emergency Department: 13.0%
- DCF: 13.0%

Demographic Characteristics

Gender of Children Served

- Male: 53.1%
- Female: 46.9%

Age of Children Served

- <=5: 36.6%
- 6-8: 27.3%
- 9-12: 25.6%
- 13-15: 0.5%
- 16-18: 0.5%
- 19+: 0.5%

Race of Children Served (n=1515)

- American Indian: 0.2%
- Alaska Native: 0.1%
- Asian: 65.2%
- Black/African American: 20.7%
- Other (not in top 5): 1.1%

Ethnic Background of Children Served (n = 1515)

- Mexican, Mexican American, Chicano/a: 10.9%
- Puerto Rican: 0.2%
- Cuban: 62.5%
- South or Central American: 0.9%
- Other race: 0.0%

The EMPS Performance Improvement Center: Review of Quality Improvement Approach and Findings

Jeffrey J. Vanderploeg, Ph.D.
Jennifer A. Schroeder, Ph.D.

Child Health and Development Institute
Connecticut Center for Effective Practice

Two Primary Functions:

1. Standardized Training and Practice
2. Quality Improvement Analysis and Reporting

Core Training Modules
- Crisis Wraparound
- Crisis Assessment, Planning, and Intervention
- Suicide Risk Assessment
- Violence Risk Assessment
- Secondary trauma, burnout, and self-care
- Principles and Practices of System of Care
- Identification and Use of Natural Supports

Additional Training Modules
- Traumatic Stress and Trauma-Informed Care
- Orientation to CT Behavioral Health System
- Culturally and Linguistically Competent Care
- Working with Foster Families
- Parent Support and Behavior Management
- Parents who are or have been consumers of EMPS services will be paid as co-trainers for select modules

Training
Quality Improvement

- Our QI approach calls for shared responsibility for performance improvement as opposed to accountability.
- Data are extracted from PSDCRS each month and sent to the Performance Improvement Center for cleaning, analysis, and reporting.
- Data are reported at the levels of: a) statewide network, b) six regional contracts (primary contractors and their subcontractors), c) each of the 15 individual providers.
- Data are regularly reviewed with providers and used to inform practice.
  - Monthly, quarterly, and annual reports.
  - Network-wide meetings with data transparency.
  - Attempt to review performance close to real-time practice (i.e., monthly reports).
  - Uses performance benchmarks and performance relative to statewide averages and performance relative to other providers.
  - PSDCRS internal reporting mechanisms help providers monitor missing data and entry errors.
  - QI results are used to inform training modifications and identify electives.
  - Next QI phase will roll out provider-specific Performance Improvement Plans.

Primary Performance Improvement Indicators

Number of EMPS Episodes

- Number Served per 1,000 Children

- Number Served per 1,000 Children in Poverty

Mobility Percentage
**Response Time**

Percent Total Mobile Episodes with Response Time Under 45 Minutes by Service Area:
- Hartford: 60%
- Eastern: 62%
- Western: 48%
- New Haven: 36%
- Fairfield: 38%
- Central: 47%
- Statewide: 50%

**Response Time (by Provider)**

Percent Total Mobile Episodes with Response Time Under 45 Minutes by Provider:
- Hartford: 29%
- Eastern: 27%
- Western: 35%
- New Haven: 31%
- Fairfield: 25%
- Central: 28%
- Statewide: 28%

**Emergency Department Referrals**

ED Referrals as a Percentage of Total EMPS Referrals, by Service Area:
- Hartford: 29%
- Eastern: 29%
- Western: 35%
- New Haven: 20%
- Fairfield: 27%
- Central: 23%
- Statewide: 25%

**Clinical Outcomes**

Ohio Scales are administered to families that receive a mobile or deferred mobile response AND have an open episode of care lasting 5 or more days.

<table>
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<tr>
<th>Ohio Scales Score</th>
<th>Mean Intake</th>
<th>Mean Discharge</th>
<th>Average Intake</th>
<th>Average Discharge</th>
<th>Paired Intake</th>
<th>Paired Discharge</th>
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<td>Parent Functioning</td>
<td>93.1</td>
<td>43.44</td>
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<td>49.26</td>
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**Practice and Policy Implications**

- Do your homework
- It is much harder to rebuild than to build it right the first time. Great job of rebuilding
  - Trust, Money and Time
- Great use of data for Continuous Quality Improvement
- Think about some form of awards or rewards for top performers, to reinforce positive behavior
  - Paper awards
  - Plaques
  - Pay for Performance
- Number one service requested by families

**Questions, Comments and Discussion**