

23rd Annual Children's Mental Health Research and Policy Conference


From Model to Practice:
Connecticut Emergency Mobile Psychiatric Services

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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




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

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EMPS Video: Incorporating Parent and Family Voice

EMPS Informational Video



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

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

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

Re-Design and Re-Procurement

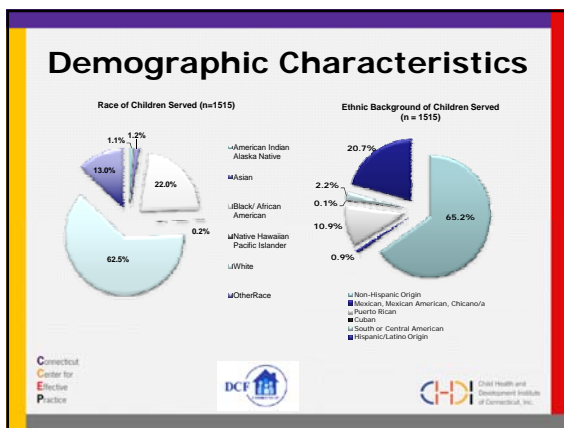
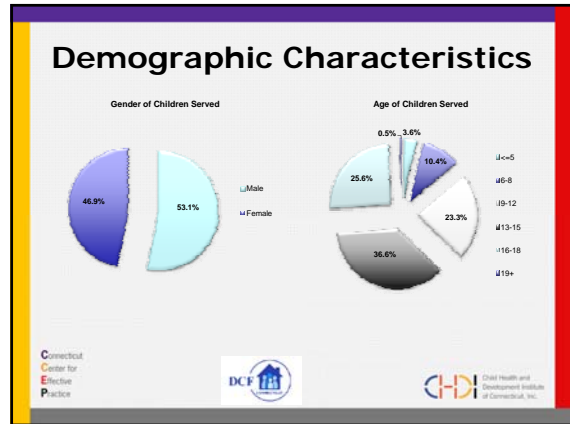
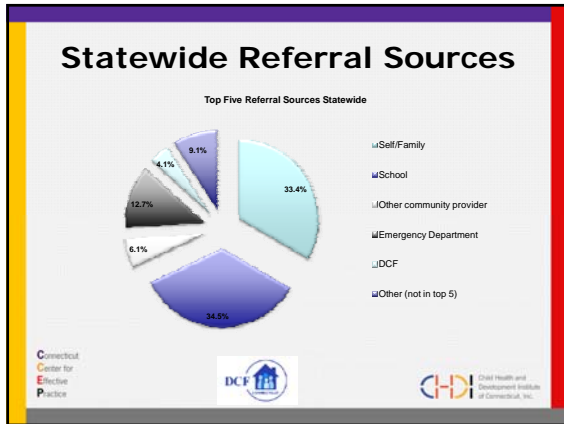
- Decision to Re-Procure
- Lobbying and Political Process
- Six Phase Procurement/Implementation
 1. Central Call Center
 2. Service Areas 1&2
 3. Service Areas 3&4
 4. Service Areas 5&6
 5. Performance Improvement Center
 6. Marketing

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



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

Jeffrey J. Vanderploeg, Ph.D.
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Child Health and Development Institute
Connecticut Center for Effective Practice

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The EMPS Performance Improvement Center

Two Primary Functions:

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

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Training

Core Training Modules

- Crisis Wraparound
- Crisis Assessment, Planning, and Intervention
- Suicide Risk Assessment
- Violence Risk Assessment

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
- Secondary trauma, burnout, and self-care
- Principles and Practices of System of Care
- Identification and Use of Natural Supports

> Parents who are or have been consumers of EMPS services will be paid as co-trainers for select modules




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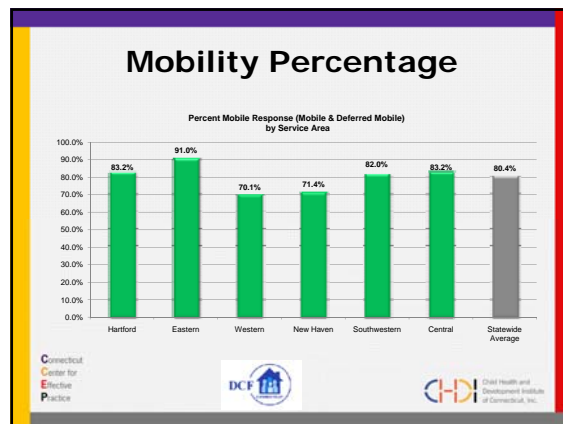
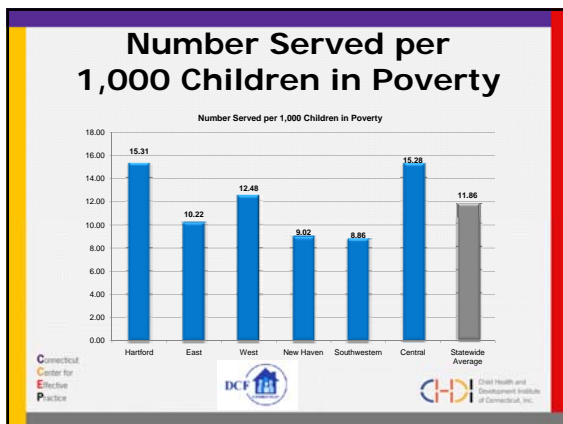
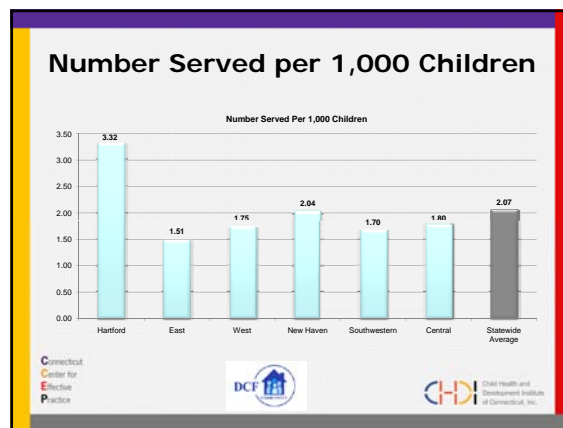
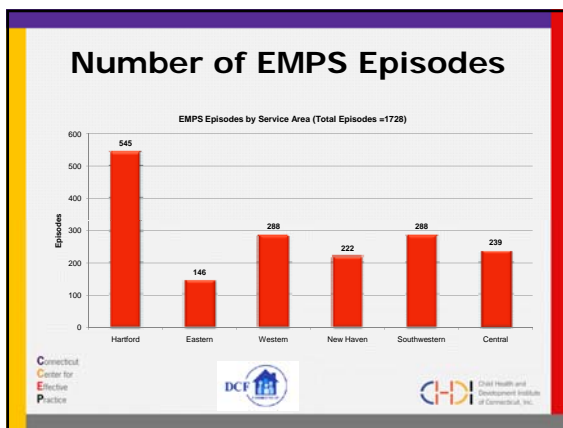
Quality Improvement

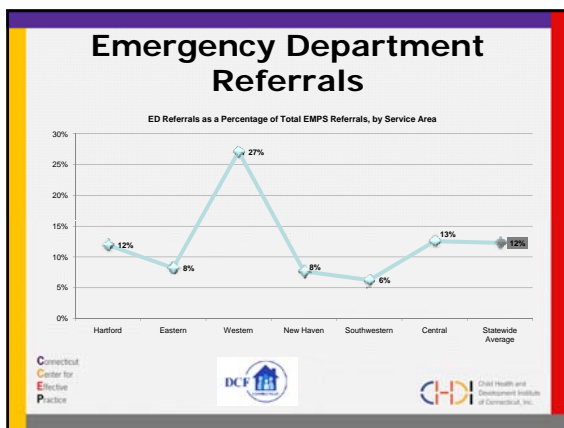
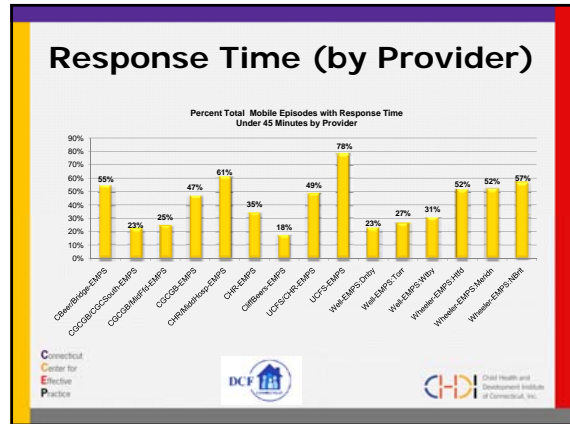
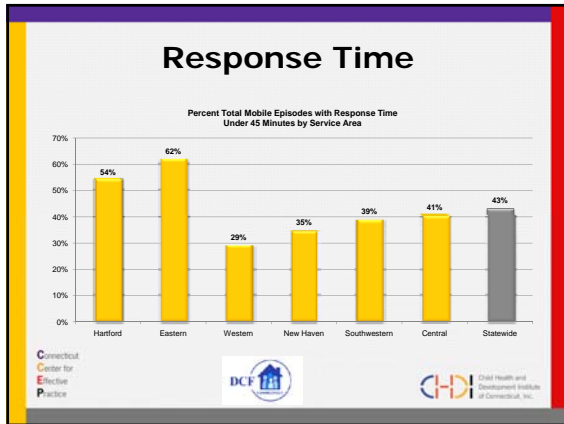
- Our QI approach calls for **shared responsibility for performance improvement** as opposed to accountability
- Data are extracted from PSDCRS each month and sent to the Performance Improvement Center for cleaning, analysis, and reporting
- Data are reported at the levels of: a) statewide network, b) **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 also are used to inform training modifications and identify electives
 - Next QI phase will roll out provider-specific Performance Improvement Plans

Primary Performance Improvement Indicators





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

Statewide Ohio Scales Scores	N All Intakes	Mean All Intakes	N All Discharges	Mean All Discharges	N Paired Intakes and Discharges	Mean Paired Intakes	Mean Paired Discharges	Mean Difference
Parent Functioning Score	331	42.44	108	49.20	187	44.53	46.0	1.67
Worker Functioning Score	1154	41.80	341	44.63	327	42.28	43.67	1.39 ***
Parent Problem Score	948	29.45	204	25.33	197	26.73	23.25	-3.48 ***
Worker Problem Score	1169	33.20	342	28.61	329	31.61	28.00	-3.59 ***



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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

Acknowledgements

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