Connecticut Department of Social Services

Making a Difference

Testimony before the Human Services Committee and

the Select Committee on Children

December 18, 2008

Good morning Senator Harris, Representative Villano and members of the Human Services Committee. My name is Mark Schaefer. I am the Director of Medical Policy and Behavioral Health at the Connecticut Department of Social Services (DSS). My agency has collaborated with the Department of Children and Families (DCF) on behavioral health services for HUSKY children and families for more than 10 years. This collaboration was strengthened under legislation establishing Connecticut Community KidCare in 2001 and the Connecticut Behavioral Health Partnership in 2005, which fully realized the creation of an integrated system of public behavioral health services for HUSKY children and families.

I am here today to talk about the leadership role that the Department of Children and Families has played in this initiative. DCF can be credited with laying out the original vision for systems of care and community services that exist outside the walls of clinics and private offices. They have established an array of home-based services, more than five distinct models to date, along with a network of emergency mobile psychiatric services. They have also recognized the essential role of evidence based practice. This is reflected in the fact that 3 of the 5 home-based models are evidence based. Moreover, evidenced based practice will be an essential element of the new Enhanced Care Clinic standards. Evidence based practice in behavioral health is unquestionably the way of the future and DCF is helping to take us there.

DCF is the lead agency for clinical management under the Behavioral Health Partnership. They direct the ASO in its conduct of utilization management and quality management and play a major role in the administration of the Enhanced Care Clinic initiative. They have served as the lead in developing medical necessity guidelines under the statutorily established Clinical Management Committee and have done so with the active participation of providers and parents. DCF has focused the resources of the Partnership on some of the most intractable problems in child mental health in Connecticut including inpatient psychiatric discharge delays and boarding in hospital EDs.

In the past year alone, the number of inpatient delay days has dropped by more than 40% over the past four quarters. The average length of stay in hospital EDs has also dropped by more than 30% since 2007. Through the BHP, DCF is using performance dollars to reward reduced lengths of stay in hospitals. In the coming year, the departments will continue their work with community providers and the Connecticut Hospital Association to establish performance initiatives focused on reducing pediatric psychiatric ED admissions and increasing ED diversion to community services. DCF has recently undertaken other initiatives that focus on quality of care and length of stay in DCF and DSS funded residential facilities.

DCF continues to focus on the improvement of existing service models. Though controversial the reprocurement of the mobile psychiatric system will bring a number of needed enhancements to this essential service. DCF is undertaking similar initiatives in their extended day treatment and care coordination programs. They are working to incorporate the best and latest thinking in these enhancements. They are evaluating new approaches to care coordination in Bridgeport and Bristol/Farmington Collaboratives, which remains the central component in the delivery of wraparound services.

Access has improved. Waiting lists have been eliminated in most of the state's freestanding child psychiatric clinics. The great majority of children are able to get appointments within two weeks or sooner if they have urgent needs. Satisfaction with BHP customer service is at an all time high, with more than 92% of those surveyed feeling customer service addressed their needs for information, support, or referral assistance. Access to home-based services for children with serious psychiatric disorders has more than doubled since the inception of the BHP.

As all of you know, child welfare and juvenile justice involved children have exceptional needs. Nowhere is this more evident than the fact that child welfare involved children use more than 30 times as many hospital inpatient days per capita, when compared to non child welfare involved children. We have always suspected this, but could never measure it until DCF developed an indicator, which, combined with DSS eligibility data, allows us to understand the needs of various DCF populations, but also to monitor our progress in serving those populations. Related to this, DCF has introduced performance initiatives focused on foster care disruption. This initiative promises to take advantage of the interdependence of child welfare and behavioral health services and to focus resources early after placement, to those at greatest risk, in order to prevent or break the cycle of disruption that leads to lengthy or repeated stays in hospital and residential settings.

These achievements are possible because of DCF's leadership and their strong and capable behavioral health management team. I have worked with DCF now for three years, under an MOU and through a joint contract with ValueOptions, the administrative service organization for the BHP. It is a credit to the collaborative spirit that they bring, that we have never had a disagreement among senior managers that could not be resolved through discussion and debate. They bring mutual respect for our differing areas of expertise and authority. The inherent tension that arises from administering a multi-agency initiative is resolved in ways that leads to better policy and better administration—beyond what either agency could accomplish on its own. This is transformative leadership and transformative action, of exactly the kind called for in the President's New Freedom Commissioner on Mental Health and that is promoted through Connecticut's DMHAS lead transformation grant.

Thank you for this opportunity to testify. I would be happy to answer any questions you may have.

For additional information on this testimony or any other legislation concerning the Department of Social Services, contact Matthew Barrett at (860) 424-5012 or via email at matthew.barrett@ct.gov