RI Office of Management and Budget

Performance Report

RI Department of Behavioral Healthcare, Developmental Disabilities & Hospitals **October 30, 2013**

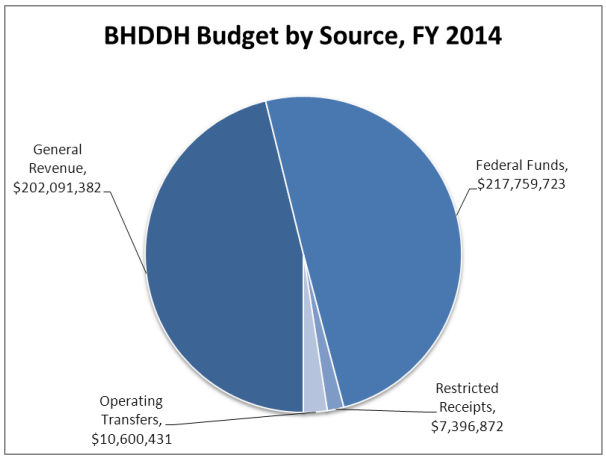
The mission of the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) is to administer and coordinate a comprehensive system of care for Rhode Island citizens with specific disabilities (i.e. mental illness, physical illness, developmental disability) and with substance use disorders or addiction; and to organize and administer a coordinated system of mental health promotion and substance abuse prevention. In FY 2014, it has 1,423.4 full-time equivalent (FTE) positions distributed among five main units: Central Management; Hospital Community and System Support; Services for the Developmentally Disabled; Behavioral Healthcare Services; and the Eleanor Slater Hospital.

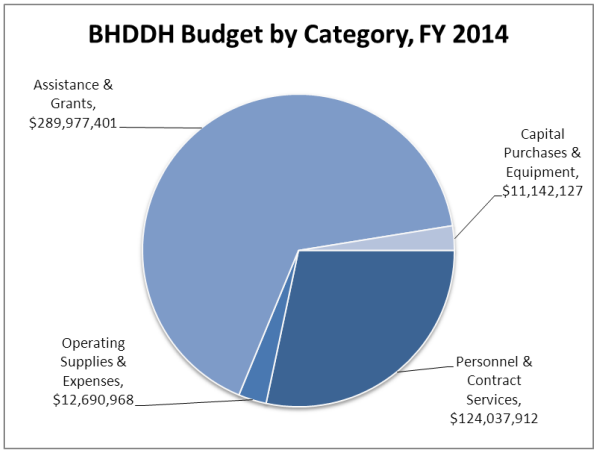
Behavioral Healthcare, Developmental Disabilities and Hospitals – FY 2014 Budget

The majority of BHDDH's funding in FY 2014 comes from federal funds (49.7 percent), followed by general revenue (46.2 percent), with restricted receipts and operating transfers accounting for 4.1 percent of revenue. BHDDH's largest category of expenditure is assistance and grants (66.2 percent) followed by personnel and contracted services (28.3 percent), with operating supplies and capital purchases representing 5.4 percent. The tables below illustrate the sources of funding for BHDDH and how funds are budgeted in FY 2014.[1]

BHDDH Expenditures by Source, FY 2014			
General Revenue	$	202,091,382	46.2%
Federal Funds	$	217,759,723	49.7%
Restricted Receipts	$	7,396,872	1.7%
Operating Transfers	$	10,600,431	2.4%
Total	**$**	**437,848,408**	**100.0%**

BHDDH Expenditures by Category, FY 2014			
Personnel & Contract Services	$	124,037,912	28.3%
Operating Supplies & Expenses	$	12,690,968	2.9%
Assistance & Grants	$	289,977,401	66.2%
Capital Purchases & Equipment	$	11,142,127	2.5%
Total	**$**	**437,848,408**	**100.0%**



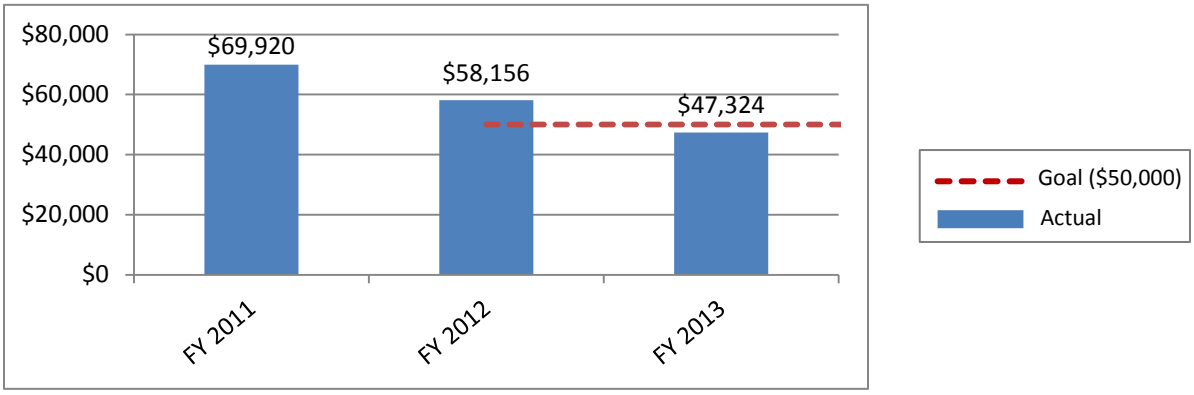


[1] Figures for BHDDH's expenditure sources and categories are from the FY 2014 budget, as enacted (2013 R.I. Pub. Laws , Ch. 144).

PER PERSON EXPENDITURE

BHDDH operates RI Community Living and Supports (RICLAS), the state-operated community provider of services to individuals with developmental disabilities. BHDDH also administers the privately operated System of Care. The agency works to provide clinically necessary supports to individuals in need while containing costs.

Figure A: Average Expenditure per Developmentally Disabled Individual



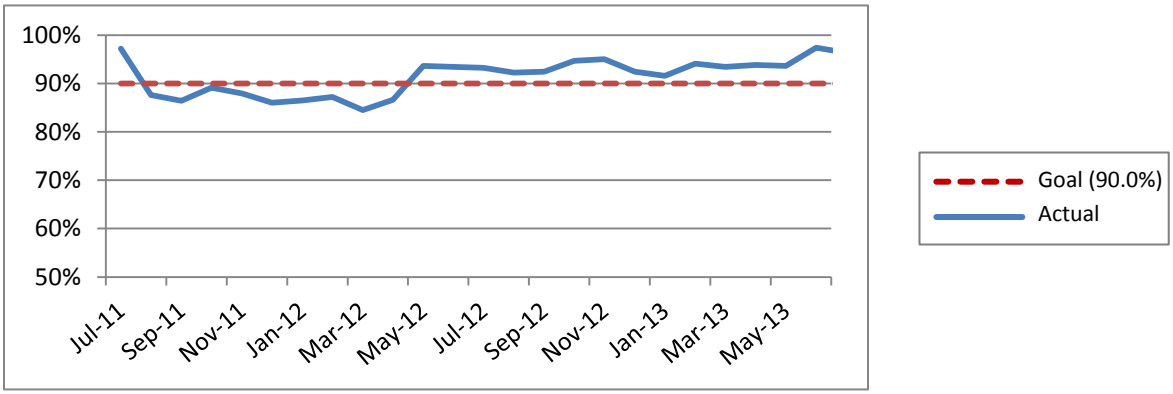
Key Points:

- The system has moved from an average annual cost of $69,920 per person in FY 2011 to $47,324 in FY 2013.
- The reduction can be attributed to moving appropriate clientele from residential care to community supports, shared living arrangements, and day activities. Also, funding constraints have led to reductions in reimbursement rates for some services.

NON-MEDICAID REVENUE

BHDDH administers services to those needing long-term care at Eleanor Slater Hospital (ESH) and Rhode Island Community Living and Supports (RICLAS). Although the population is primarily Medicaid-eligible, many individuals are both Medicaid and Medicare-eligible and/or have other potential funding sources for this care.

Figure B: Percent of ESH and RICLAS Clients with Non-Medicaid Revenue



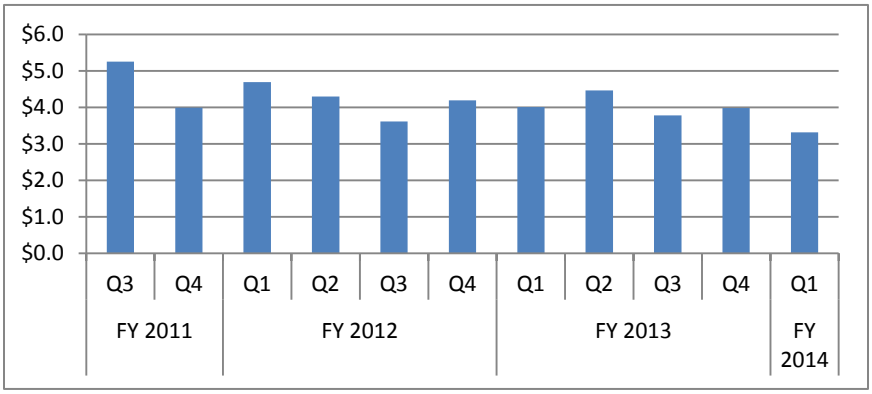
Key Points:

- By identifying other source of funding for services provided at ESH and RICLAS, BHDDH can reduce reliance on General Revenue funds.
- Since June 2012, the percent of clients with non-Medicaid revenue has risen 4.0 percentage points.
- BHDDH identified a total of $7.6 million in FY 2013, and projects $7.8 million in non-Medicaid revenue in FY 2014.

OVERTIME COSTS

RICLAS facilities and ESH provide 24/7 client and patient care. BHDDH employees may work additional hours over the regular schedule because of staff absences (e.g., illness, vacation, worker's compensation); longer-term position vacancies; and instances when clients' safety requires clinical staffing and/or one-to-one staffing.

Figure C: Amount of Overtime Dollars Spent (in Millions)



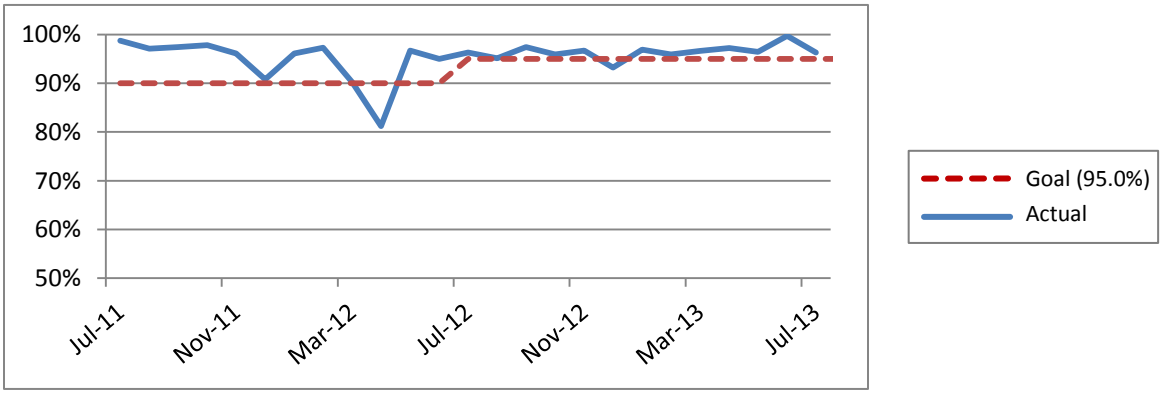
Key Points:

- Since January 2011, overtime pay has represented 20.1 percent of BHDDH's gross payroll (not including the cost of fringe benefits).
- The positions with the highest overtime costs have been Community Living Aides, Institutional Attendants, Certified Nursing Assistants, and Registered Nurses.
- OMB has approved the use of continuous recruitment to ensure high-turnover positions are filled promptly when they become vacant.

CLAIMS PROCESSED

As part of its efforts to provide services to individuals in long-term care, BHDDH seeks to ensure that such services are correctly billed and paid.

Figure D: Percent of Successfully Processed Claims for Services Provided by ESH or RICLAS



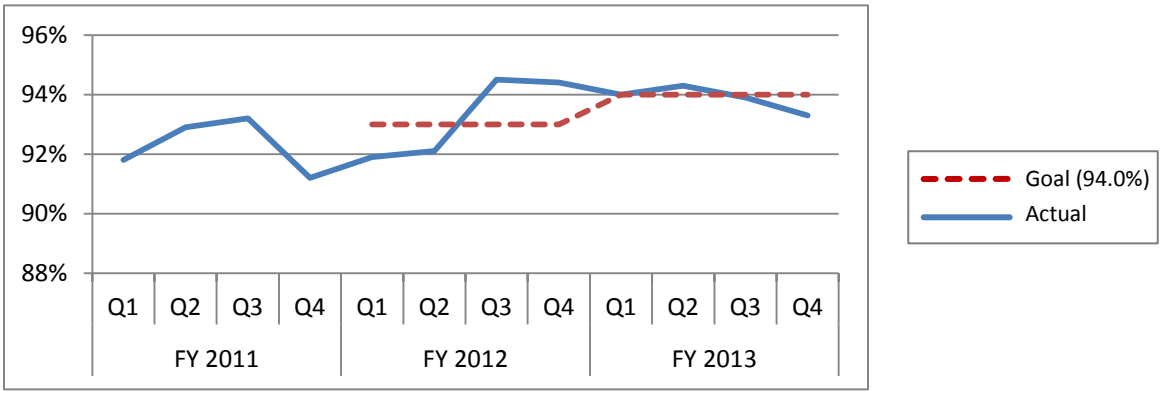
Key Points:

- This measure tracks BHDDH's efforts to reduce billing errors, including data entry errors relating to authorization numbers, authorized dates, or incorrect bill types.
- In an effort to improve performance, BHDDH has created a series of checklists and reports that will eliminate errors in the billing process.

COMMUNITY SUPPORT CARE PROVIDERS

People with a serious mental illness often have other significant health conditions. One focus of BHDDH's Health Homes initiative is to improve regular coordination of physical health care with behavioral health care for these individuals, to improve health outcomes.

Figure F: Percent of Seriously Mentally Ill Clients with Regular Healthcare Provider



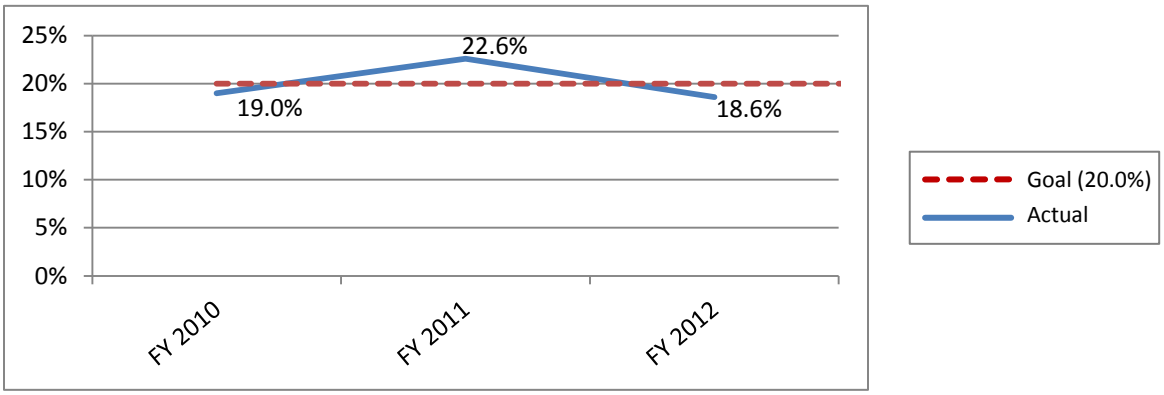
Key Points:

- This measure reflects the extent to which those with serious mental illness are connected with ongoing non-emergency physical healthcare. According to BHDDH, individuals with a regular healthcare provider can expect to have reduced emergency room usage, decreased inpatient hospitalizations, and longer life expectancies.
- This data is collected at clients' annual treatment plan review, and is reported on a rolling basis.

COMMUNITY INTEGRATED EMPLOYMENT

Employment of developmentally disabled individuals in a structured setting promotes integration into community settings so that this population not separated or isolated from the general public.

Figure F: Percent of Developmentally Disabled Clients Participating in Community Integrated Employment



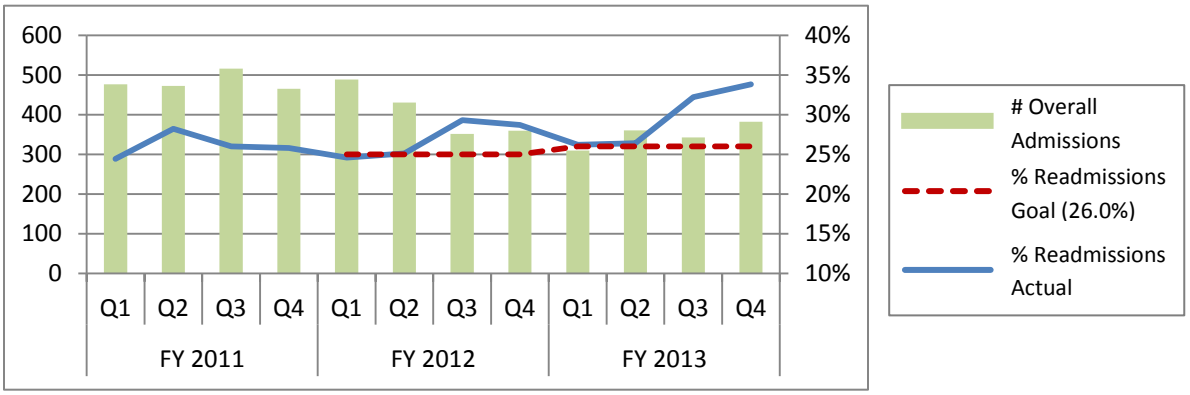
Key Points:

- This measure provides BHDDH with a benchmark for promoting and expanding employment programs, with the goal of providing independent living opportunities for developmentally disabled individuals.

DETOXIFICATION RE-ADMISSIONS

If clients do not access community-based services after inpatient detoxification, they may face an increased likelihood of readmission to costly inpatient care. Tracking readmission rates helps measure BHDDH's effectiveness in connecting uninsured patients with post-discharge treatment and recovery support services.

Figure G: Detoxification Admissions that are Re-Admissions within 90 Days of Discharge



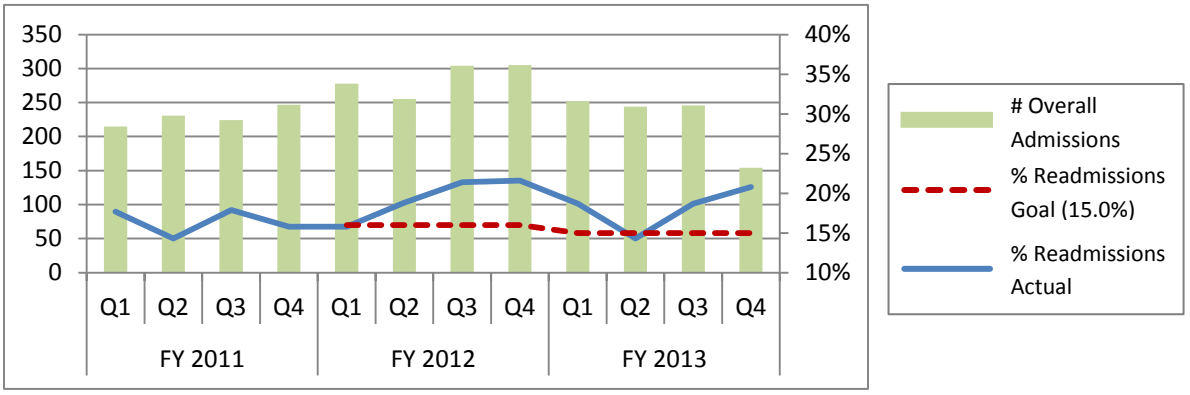
Key Points:

- BHDDH's goal is to direct clients towards alternative care services such as step-down and outpatient treatment.
- As admissions to inpatient care have declined, readmission rates have increased. BHDDH is currently reviewing patient data to determine how to reduce readmissions.

PSYCHIATRIC HOSPITALIZATION RE-ADMISSIONS

If clients do not access community-based services after psychiatric hospitalization, they may face an increased likelihood of readmission to costly inpatient care. Tracking readmission rates helps measure of the effectiveness of BHDDH's ability to connect uninsured patients with post-discharge treatment and support services.

Figure H: Psychiatric Admissions that are Re-Admissions within 90 Days of Discharge



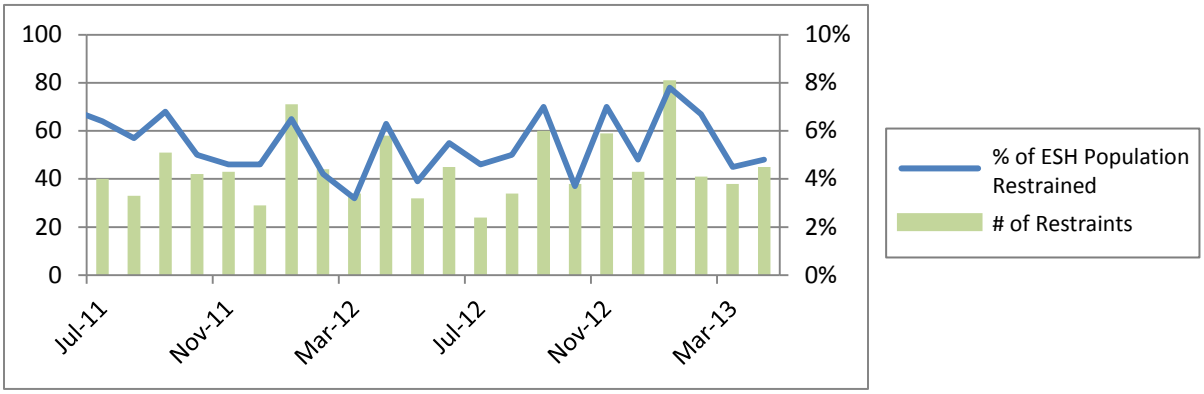
Key Points:

- During the past two fiscal years, total admissions have ranged from 50 and 100 each month, with approximately 10 to 20 of those being re-admissions.

PHYSICAL RESTRAINTS

At Eleanor Slater Hospital (ESH), patients that exhibit violent and/or assaultive behavior not adequately controlled by less restrictive means are placed in a time-limited acute psychiatric restraint until calm for the safety of patients and staff.

Figure I: Restraints Applied at ESH



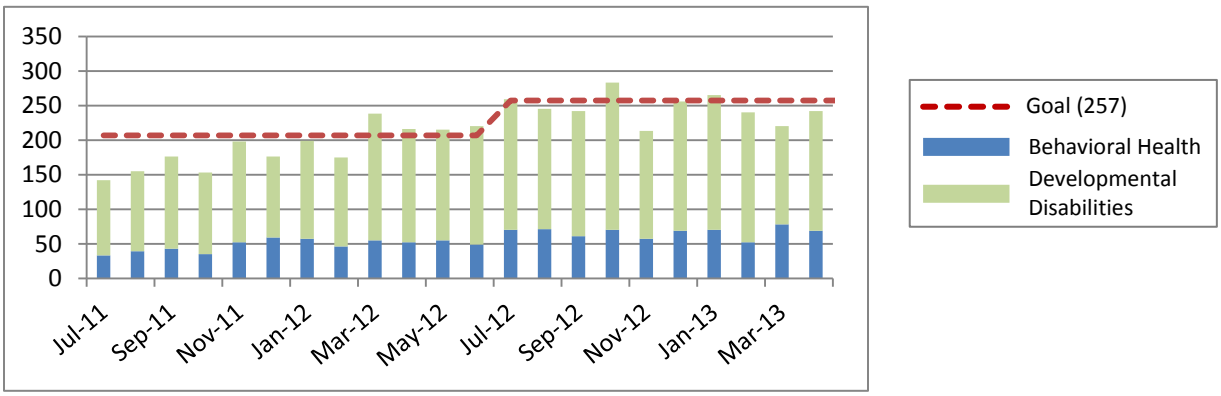
Key Points:

- The number of restraints applied does not equal number of patients restrained in a given month, as some individuals can require multiple restraints within the same month. On average, 5.2 percent of ESH patients require restraints in a given month.
- Restraint training is provided to all employees by the hospital staff educators through professionally developed courses. This training includes instruction on behavioral interventions including trigger identification and de-escalation techniques.

SERIOUS INCIDENTS

The Office of Quality Assurance (QA) implemented a data collection mechanism that tracks reports of alleged abuse, neglect, and mistreatment of individuals with behavioral health and/or developmental disability needs. QA is working to encourage the appropriate reporting of these serious incidents.

Figure J: Number of Serious Incidents Reported



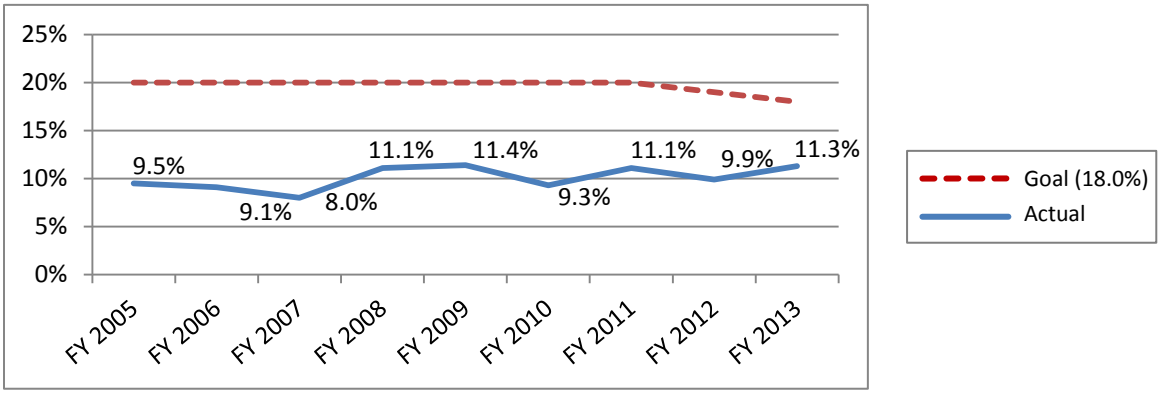
Key Points:

- The recent increase in target and actual number of reported incidents results from BHDDH's outreach to providers and health care professionals in an effort to have all serious incidents documented. Once BHDDH determines that all serious incidents are being reported, the target will be lowered.
- "Serious incidents" include assaults and abuse, patient mistreatment or neglect, and serious medical incidents requiring medical care, among other instances as defined by statute and regulation.

TOBACCO SALES TO MINORS

The Division of Behavioral Healthcare Services collaborates with police, municipal task forces, the Division of Taxation, youth groups, and tobacco vendors to reduce youth access to tobacco products.

Figure K: Percent of Surveyed Sites Selling Tobacco to Youth Under the Age of 18



Key Points:

- States must conduct an annual survey of a random sample of tobacco outlets statewide to determine retailer compliance with laws relating to the sale of tobacco products.
- Non-compliance (sale rates over 20.0 percent) carries penalties of the loss of up to 40.0 percent of the Federal Substance Abuse Prevention and Treatment Block Grant. For Rhode Island, this represents approximately $2.6 million.