2012
Quality Management
And
Utilization Management
Program Evaluation
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I. EXECUTIVE SUMMARY

In 2006, the Department of Children and Families (DCF), the Department of Social Services (DSS), in conjunction with a legislatively mandated Oversight Council, formed the Connecticut Behavioral Health Partnership (CT BHP) with ValueOptions serving as the Administrative Service Organization (ASO). The Partnership was described at that time as a redesign of the behavioral health service delivery system for low-income children and their parents. The program emphasized families as partners in care planning, serving to enhance cultural competency within the service system, and striving to improve the quality and availability of community-based services and supports. The Partnership was a reform initiative designed to help children and parents with serious behavioral challenges remain in their homes and communities, through the use of targeted, individualized clinical and support services. The ultimate goal under the initiative was to allow children and parents to function independently, restore or maintain family integrity, improve family functioning, achieve a better quality of life, and avoid unnecessary hospital and institutional care.

Towards the end of 2010, the Department of Mental Health and Addiction Services (DHMAS) decided to join the CT BHP, so an RFP was issued for an ASO vendor. ValueOptions bid on and was awarded the contract to be the ASO for the expanded CT BHP. The new contract went live on April 1, 2011 when more than 200,000 additional Medicaid members, primarily adults but also including a small number of youth, were added.

While the goals of the original CT BHP described above remained in place, ValueOptions, CT as the ASO is described in the new contract as being “the primary vehicle for organizing and integrating clinical management processes across the payer streams, supporting access to community-services, assuring the delivery of quality services and preventing unnecessary institutional care.” Additionally, ValueOptions is expected to enhance communication and collaboration within the behavioral health delivery system, assess network adequacy on an ongoing basis, improve the overall delivery system and provide integrated services supporting health and recovery by working with the Departments to recruit and retain both traditional and non-traditional providers.

Much of 2011 was focused on the integration of the new business into the existing service center. By the end of 2011, the new adult business was combined under one leadership structure within every department. The integration of the adult and child business lent itself to reassessment of processes and workflows and the identification of practices from both the adult and child business that would benefit both. This re-evaluation of processes had a positive impact on the entire service center and resulted in more consistency and efficiency.

While 2011 was a year of growth and integration of new business, 2012 was a year of increased focus on informatics. In the past year we have developed the ability to integrate external datasets, improved the depth of our analyses of data through the use of more advanced statistics, and moved towards the ability to measure outcomes. ValueOptions, CT worked closely with the Departments to study the use of Intensive Outpatient services and integrated data sets collected by DMHAS to enhance the study. We expanded our use of DSS claims data to develop claims-based measures of the frequency and duration of utilization of Home Health services and developed individual
provider profiles to assist these providers in their understanding of how they compare to their counterparts. We utilized claims data to analyze the service usage by members on the Autism spectrum. Our analysis contributed to recommendations from a committee of experts to the governor of CT. The enhanced focus on informatics has resulted in the re-evaluation of the staffing requirements of the QM and Reporting Departments and the hiring of staff with more advanced skills that allow us to conduct more robust analyses of our data.

At the same, the service center is making advances in the use of technology to adapt the utilization management process to make it more efficient. Through the use of web-technology, select providers are able to enter clinical information directly into the system and need only interact with clinical staff when risk indicators require more communication and planning or when stays are prolonged. These efficiencies are allowing clinical staff to have more time in the field with providers where they focus more on the treatment planning of members with greatest need. These efficiencies have also allowed clinical staff to work more closely with the Regional Network Managers (RNMs) as they identify network-wide themes that can be addressed by the Provider Analysis and Reporting programs.

There has also been significant expansion of the Peer Program with the hire of additional Peer Associates to work with the adult population. Pilot programs have been developed to improve the connection to follow-up care following inpatient stays and to decrease readmissions to higher levels of care.

The ValueOptions, CT Quality Management Program

The ValueOptions, CT Quality Management (QM) Program was initiated with the implementation of the original contract in 2006. The QM Program serves as the overarching structure to evaluate continuously the effectiveness of ValueOptions CT as the ASO for the BHP and to ensure that the clinical and support services offered within the CT BHP live up to their promise for the youth, families and adults served by the program. The QM Program identifies the key indicators that affect the operation and then monitors these indicators, analyzes the findings, identifies issues, trends and barriers, and then initiates actions to improve performance when necessary. The program also conducts studies in collaboration with the Departments to improve our understanding the impact of the services on the members we serve.

On at least an annual basis, the QM Program is evaluated. The annual QM Program Evaluation provides an opportunity to examine completed and ongoing quality activities and to identify new opportunities for the coming year. The QM Program evaluation assesses the overall effectiveness of the QM Program including the effectiveness of the committee structure, the adequacy of the resources devoted to it, practitioner and leadership involvement, the strengths and accomplishments of the program with special focus on patient safety and risk assessment, and performance related to clinical care and service. Progress toward the previous year’s project plan goals is also evaluated. A review of each of the goals is included within this evaluation along with a description of each goal and sub-goal, commentary regarding their completion status, and recommendations for whether to carry them over into the Quality Program for the following year. The results of this program evaluation, together with the additional goals
that reflect the strategic planning done collaboratively with DSS, DMHAS and DCF will be used to formulate the 2013 Project Plan.

After implementing the new business in 2011, 2012 was a year of developing a better understanding of who the new adult members are and how they are different from the adult members within the HUSKY A population. Utilization within the different benefit packages was reviewed in many different forums and statistical analyses were performed to gain a better understanding of what variables impacted length of stay and readmission rate. Providers and groups that served our new adult members were identified in 2011. Relationships with those entities were further developed in 2012.

**Membership:**

In 2012, the ages for youth and adult Medicaid membership were redefined to align with DMHAS and DSS’ definition of an adult. Youth were identified as members under the age of 18 and adults were identified as members 18 and over. The membership for youth has been relatively stable over the past year, rising only 1.8% from Calendar Year (CY) ’11 to CY ’12. Youth membership has increased annually over the past several calendar years, beginning in CY ’08. During 2012, there was a slight increase in membership of 1.10% from Q1 ’12 to Q4 ’12. DCF-involved youth accounted for approximately 3.0% of all youth members during the quarter (8,731 members) and 4.2% (13,947) of all covered youth for 2012. The remainder of the youth members were Non-DCF involved (291,252 members) and accounted for 99% (324,829) of total membership. There has been a gradual decline of 22.1% (11,214 to 8,731) in DCF membership over the past 6 quarters (Q2, 2011 to Q4, 2012), with a 6% (9,289 to 8,731) decline occurring just within the last quarter – Q4 ’12. The decline is also apparent from CY ’11 to CY ’12, with a 9% (15,321 to 13,927) decrease during that span.

Membership for the adult population has grown since Q2 ’11, when the new membership totals were first collected. This growth is most evident in the HUSKY D population where it appears that membership increased by somewhat more than 20% between Q2 ’11 and Q3 ’12.
Membership figures for CY ’12 for each of the eligibility categories are included in the following table. Please note: The numbers in the total membership cells of the table will not add when the figures for youth and adults are totaled nor will the rows by eligibility category. While the numbers in each of the cells are unduplicated counts, individual members may be duplicated in different cells. For example, a member may have belonged to more than one eligibility category during the year or they may have turned 18 during the year.

<table>
<thead>
<tr>
<th>Eligibility Category</th>
<th>Total Membership</th>
<th>Youth (&lt;18)</th>
<th>Adults (18+)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Single</td>
<td>505,777</td>
<td>314,046</td>
<td>202,667</td>
</tr>
<tr>
<td>Family Dual</td>
<td>6,105</td>
<td>8</td>
<td>6,098</td>
</tr>
<tr>
<td>HUSKY B</td>
<td>21,746</td>
<td>20,666</td>
<td>1,846</td>
</tr>
<tr>
<td>DCF Limited Benefit (D05)</td>
<td>412</td>
<td>412</td>
<td>0</td>
</tr>
<tr>
<td>Aged, Blind, Disabled (ABD) Single</td>
<td>40,219</td>
<td>522</td>
<td>39,705</td>
</tr>
<tr>
<td>ABD Dual</td>
<td>58,915</td>
<td>0</td>
<td>58,915</td>
</tr>
<tr>
<td>Long Term Care (LTC) Single</td>
<td>3,194</td>
<td>9</td>
<td>3,185</td>
</tr>
<tr>
<td>LTC Dual</td>
<td>22,434</td>
<td>0</td>
<td>22,434</td>
</tr>
<tr>
<td>Medicaid Low Income Adults (MLIA)</td>
<td>133,596</td>
<td>25</td>
<td>133,586</td>
</tr>
<tr>
<td>Charter Oak</td>
<td>9,254</td>
<td>0</td>
<td>9,254</td>
</tr>
<tr>
<td><strong>Total Membership</strong></td>
<td><strong>771,326</strong></td>
<td><strong>329,726</strong></td>
<td><strong>453,478</strong></td>
</tr>
</tbody>
</table>
Key accomplishments of ValueOptions, CT Quality Management Program in 2012 include:

- Challenges were identified with sharing PHI with providers in order to coordinate care for the adult members with substance abuse and solutions were identified that ensure that care coordination could continue.
- Documentation audit processes were refined further to become a collaborative QM/UM process and now not only assess performance but also allow for CCM development by providing feedback regarding the quality of the review.
- Continued trainings on complaints and grievances were provided, and led to improved identification of informal complaints.
- Continued trainings on adverse incidents were provided, leading to further refinement of the process following the identification of an incident and ensuring that high risk members connect to care following incidents.
- Quarterly/Annual analysis process evolved to be a collaborative process between QM and UM with greater discussion about the data prior to submission of the analysis and executive summaries.
- Further development of our claims knowledge occurred as several more projects involved pulling claims queries.
- Integration of external data sets with internal data was initiated with the IOP performance target.
- With support from DSS, the administrative appeal review process was strengthened. Reasons for overturning administrative denial were re-evaluated and updated to address current issues.
- Continued trainings were conducted on the denial and appeal process which allowed for an increase in not only denials but also provider appeals.
- New Provider, Analysis and Reporting (PARs) programs were established for therapeutic group homes, home health and adult inpatient providers.
- Provider, Analysis and Reporting (PARs) programs continued for child and adolescent Inpatient, PRTF, RTC, Emergency Departments and ECCs.
- Geo-Teams were expanded and co-led by Clinical Supervisors and RNMs.
- Completion of the Autism Spectrum Disorder Feasibility Study with multiple Departments, external subject matter experts and families participating.
- Audit tool was created and tested in order to assess the ECC providers compliance with the expectations communicated in the DSS Provider Bulletins. Audits at the providers’ sites began at the end of the year.
- Certificate of Need letters were sent to providers for non-emergent admissions to PRTF, Solnit and CVH.
Key accomplishments of the CT BHP Utilization Management Program in 2012 include:

- Integration of the clinical department - Moved away from an adult and child division to an integrated regional model which supports provider relationship development and increased knowledge of the resources within the regions.
- Increased interdepartmental collaboration with the regionally-based RNM team.
- Establishment of a strong working relationship with Community Health Network of Connecticut (CHN) and the evolution of the care coordination identification process.
- Increased collaboration with DCF which evolved into co-location of ICMs within the DCF regional offices to assist in care coordination and discharge planning for members in inpatient and residential care.
- Increase in ICM and Peer presence at clinical rounds within the community hospitals as well as Solnit in order to prevent discharge delay and coordination in discharge planning.
- Moving toward National perspective of ICM assignments and utilizing National platform while keeping the local perspective.
- Movement away from the face to face model for the adult ICMs except around ED diversion where a Peer was added to assist in the diversion efforts.
- Increase in calls to identify open beds at detoxes and inpatient psychiatric hospital so that the information can be shared with providers if needed.
- Began completing the Certificate of Need for non-emergent admissions to PRTF, Solnit and CVH.
- Established rounds for complex, high risk cases with MD to ensure that members are receiving the appropriate care.
- Re-assignment of the Residential Care Team with 2 CCMs becoming ICMs and being deployed to the DCF regional offices; 3 becoming RTC-RNMs and being actively involved in the RTC/TGH PARs profile development and cohort provider meetings.
- Child and adult ICMs assisting EDs as needed when volume was elevated or with participation in case conferences and discharge planning.
- Built relationships with CHN, Advanced Behavioral Health (ABH), Local Mental Health Authorities (LMHAs) and adult hospitals.
- Expanded work with National Alliance on Mental Illness (NAMI) and Connecticut Community for Addiction Recovery (CCAR) with inclusion at the joint ICM/Peer staff meeting.
A. Committee structure

The following QM committee structure is in place at the time of this evaluation:

VO-CT Quality Management Committee (QMC)

The QMC was established to provide oversight of the VO-CT QM program. The QMC is co-chaired by the Vice President (VP) and the Associate Vice President (AVP) of QM. The QMC reports to the ValueOptions Corporate Quality Council and is also guided by the Senior Management Quality Management Steering Committee (also known as CORE) which is attended by representatives of the Departments as well as ValueOptions, CT senior leadership.

The membership of the QMC includes representatives from all departments within the Service Center including the leadership of the service center. Included are:

- Chief Executive Officer
- Chief Operating Officer
- Medical Director or designee
- VP of Quality Management
- AVP of Quality Management and QM staff
- VP of Recovery and Clinical Operations
- VP of Health and Wellness
- VP of Provider and Customer Relations
- Clinical Director
- Director of Community Support
- Director of Customer Service
- Director of Human Resources
- Director of Finance
- Director of Provider Relations

The QMC met on a quarterly basis during 2012. The focus of the committee during 2012 was on continued review of performance on the operations indicators as well as the PARs program and clinical studies. Attention was paid to telephone access, turn-around times for UM decisions, new protocols for medical necessity denials and partial denials, and adverse incidents. The Safety and Risk Management program continued to receive the attention of the committee as processes for identifying and managing high risk members continued to be enhanced and expanded as a result of differences in the new population.

Safety and Risk Management Sub-Committee

The Safety and Risk Management Sub-Committee reports to the QMC and is co-chaired by the Medical Director and the AVP of Quality Management. In addition to the co-chairs, the membership of the committee included:

- VP of Quality Management (ad hoc)
- QM Coordinator
- VP of Recovery and Clinical Operations
- VP of Health and Wellness
In 2012, the sub-committee met weekly to review adverse incidents as well as quality of care and service issues identified by ValueOptions staff, members, providers, and, on request, the Departments. The focus of the sub-committee was on verifying that high risk members were connecting with care and ensuring that established tracking processes were working effectively. The sub-committee reviewed all issues identified during the previous week and followed up on the results of actions and/or investigations previously identified by the committee. The sub-committee periodically reviewed the trends of specific facilities or programs. Due to the large volume of adverse incidents reviewed in 2011, the committee reviewed the criteria necessitating an adverse incident and the decision was made to return to original criteria established by National VO. Upon review with the Medical Director and VP of UM it was determined that care managers were assessing risk appropriately and that the focus of the sub-committee would return to the members at the highest risk. While all adverse incidents are reviewed at the time of receipt by the AVP of QM, the sub-committee reviews the incidents that the committee identifies to ensure that high risk cases are being reviewed with Clinical Supervisors, Directors and Medical Directors.

Network Management Sub-Committee and Provider Analysis and Reporting (PARs) Workgroup

The Network Management Sub-Committee meets weekly and reports to the QMC. The sub-committee is chaired by the Director of PARs and VP of QM. Its members include:

Regional Network Managers
VP of QM
AVP of QM
QM Analysts
CEO (Ad Hoc)
Medical Directors (Ad Hoc)

The primary focus of this committee continues to be on the developing strategies to improve systems of care, with particular focus on addressing issues generated by the PARs and Performance Incentive programs. The complexity of the PARs program has necessitated the formation of several workgroups off of the Network Management Sub-Committee, including workgroups focusing specifically on the inpatient, ECC, RTC, and PRTF programs. The Network Management Sub-Committee then focuses on improving the consistency of strategies across the PARs program and the development of new indicators for the various programs.

This committee also provides oversight of the five (5) Geo-Teams. The Geo-Teams include ValueOptions staff, both clinical and administrative, who are involved with facilities and programs in specific geographic regions. These teams reviewed PARs data and the results of Performance Incentive programs for providers within specific geographic regions. The Geo-Teams members also provide their perspective on the findings, and develop strategies for improving the performance of the facilities and programs in the region.
During the implementation of the new business, the Geo-Teams did not meet as frequently as usual. By the end of 2011, as the Clinical Department moved towards the development of regionalized clinical teams, the Geo-Teams were reinvigorated and membership of the teams was expanded to include both adult and youth clinicians.

The PARs Workgroup was established late in 2007 as the vehicle to oversee the development and implementation of the PARs initiatives and to provide the opportunity for all departments to provide their input into the various programs. During 2011, the workgroup met weekly to assess profiles for each of the PARs programs, review data, hear feedback and recommendations from providers involved in the PARs programs, and to share the findings of the PARs programs with other departments. As new staff were included in the Workgroup and the histories of the various programs were reviewed, the work of the committee necessarily slowed. Additionally, with the implementation, existing programs had to be adjusted to include the new adult population. Additionally, with the implementation, existing programs had to be adjusted to include the new adult population. Existing indicators and methods of measurement had to be reassessed to consider the impact of the new populations.

The workgroup is currently chaired by the VP of QM. Included in its membership are:
Medical Director
VP of Recovery and Clinical Operations
Directors of UM
Director of IT/Reporting
Regional Network Managers
Quality Department Staff
Provider Relations
CEO (Ad Hoc)

**Utilization Management Sub-Committee**

The Utilization Management Sub-Committee meets weekly and reports to the QMC. The sub-committee is co-chaired by the VP of Recovery and Clinical Operations and the Medical Director. In addition to the co-chairs, the membership of the committee included:

VP of Recovery and Clinical Operations
Associate Medical Director - Adults
Associate Medical Director - Children
Chief Operating Officer
Director of Intensive Care Management and Peer Support Services
VP of Quality Management
QM Quality Analyst Staff

In 2012 the focus of the committee was to review the quarterly utilization and bypass data.
Consumer and Family Advisory Sub-Committee

The Consumer and Family Advisory Sub-Committee was established in 2006 and meets monthly. In 2012 the sub-committee was co-chaired by the Director of Community Support Services and a family member. The committee membership includes:

- Peer Support staff
- CEO
- Director of Customer Service
- Families of members
- Member advocates
- Consumers

In 2012, the sub-committee continued to advise the Service Center and QM program of member interests and needs related to behavioral health services and the system of care. Feedback and input from members was obtained regarding system-related barriers to accessing care, family engagement, transportation coordination, accuracy and efficiency of provider referrals, voluntary services programs, language barriers, mentoring services, supports for members and their families, and concerns regarding interactions with DCF. During 2012, the committee provided input regarding the wellness and recovery initiatives undertaken by ValueOptions and the revision of the CT BHP Member Handbook to incorporate the new adult business.

Assessment and Recommendations regarding QM Committee and Sub-Committee Effectiveness:

As the service center nearly doubled in size and folded new business into the existing business, the QM Committee and sub-committees played a key role in keeping staff apprised of performance on indicators that allowed us to assess the ongoing operation of the service center. Participation in the committees allowed new staff to understand better the key role of data in making decisions concerning operations. Existing staff were assisted to identify necessary changes in operations with the addition of populations with different clinical needs than those of the youth and families previously managed. Many of the committees met more frequently during 2012 and/or formed workgroups to address the needs of the operation to assure timely response to identified challenges/programmatic needs. The growing size of the committees presented a challenge as the service center grew from a staff that could be housed on a single floor to the need to house several departments on another floor. Assuring the participation of all committee members in the quality oversight structure was addressed in several meetings and a team of leadership staff attended a 3-day, off-site forum designed to assist them in providing leadership and improved communications to impact this change in our program and physical space.

While the QM committee structure experienced growing pains during 2012, the structure dependably provided forums for improving the communication around critical information and obtaining the input of all staff in decisions about how to proceed.
B. Adequacy of QM resources

The following chart is a summary of the positions currently included in the Quality Management Department, their credentials and the percentage of time devoted to quality management activities. Additional departmental staff are listed with the percentage of their time devoted to quality activities.

<table>
<thead>
<tr>
<th>Title</th>
<th>Credentials</th>
<th>Percent of time per week devoted to QM</th>
</tr>
</thead>
<tbody>
<tr>
<td>VP Quality Management</td>
<td>PhD</td>
<td>100%</td>
</tr>
<tr>
<td>Assistant VP QM</td>
<td>LCSW</td>
<td>100%</td>
</tr>
<tr>
<td>Director of PARs</td>
<td>1 Vacancy</td>
<td>100%</td>
</tr>
<tr>
<td>Regional Network Managers (8 FTEs)</td>
<td>Master's level</td>
<td>100%</td>
</tr>
<tr>
<td>Quality Manager</td>
<td>Master's level</td>
<td>100%</td>
</tr>
<tr>
<td>Quality Analyst (6 FTEs)</td>
<td>5 Master's level and 2 Bachelor's level with experience</td>
<td>100%</td>
</tr>
<tr>
<td>Consulting Statistician</td>
<td>PhD</td>
<td>20%</td>
</tr>
<tr>
<td>QM Coordinator-Complaints/Appeals (2 FTEs)</td>
<td>2 Bachelor's level</td>
<td>100%</td>
</tr>
<tr>
<td>Contract Monitor</td>
<td>1 Associate's level</td>
<td>100%</td>
</tr>
<tr>
<td>QM Specialists-Auditor (2 FTEs)</td>
<td>2 Master's level/Licensed clinicians</td>
<td>100%</td>
</tr>
<tr>
<td>Director of Compliance</td>
<td>Bachelor's level</td>
<td>100%</td>
</tr>
<tr>
<td>CEO / VP Service Center</td>
<td>MA</td>
<td>20%</td>
</tr>
<tr>
<td>Chief Operating Officer</td>
<td>PhD</td>
<td>30%</td>
</tr>
<tr>
<td>Medical Director (2 FTEs)</td>
<td>MD</td>
<td>40%</td>
</tr>
<tr>
<td>VP of Clinical Operations</td>
<td>MA</td>
<td>30%</td>
</tr>
<tr>
<td>Director of Utilization Management</td>
<td>Master's level</td>
<td>20%</td>
</tr>
<tr>
<td>VP of Health and Wellness</td>
<td>Master's level</td>
<td>20%</td>
</tr>
<tr>
<td>Director of Health and Wellness</td>
<td>Master's level</td>
<td>20%</td>
</tr>
<tr>
<td>Director of Community Support</td>
<td>RN</td>
<td>20%</td>
</tr>
<tr>
<td>VP Member and Provider Support</td>
<td>Master's level</td>
<td>20%</td>
</tr>
<tr>
<td>Director of Customer Service</td>
<td>N/A</td>
<td>20%</td>
</tr>
<tr>
<td>Director of Provider Relations</td>
<td>N/A</td>
<td>20%</td>
</tr>
</tbody>
</table>
In 2012, with the addition of new business activities, several positions were added to the QM Department. While several new staff were hired during the year, there is a steep learning curve associated with becoming familiar with our data sets. We promoted an internal subject matter expert to Quality Manager. This position was extremely helpful during the growth in the department as she was able to train new staff and be readily available to answer questions and provide direction. It also became increasingly clear with the growing complexity of the data sets and increased volume of reports and analyses required, that Quality Analyst staff need a strong educational background in math and statistics. As a result, the department has begun to hire applicants with an MBA or a BA in finance or accounting. This background lends itself to improved comfort with data. Finally, we hired a high level statistician, shared with national ValueOptions, to conduct more advanced analytics and provide direction and mentoring of the statisticians in the department.

C. Practitioner Involvement

One of the strengths of the CT BHP QM Program is the active involvement of network practitioners/providers in the program. Behavioral health practitioners representing different levels of care are integrally involved in the development and ongoing evaluation of the PARs program. They are instrumental in establishing measures and in setting goals for their performance. Providers are also involved in multiple QM Committees and Sub-Committees, including those that provide oversight of the Partnership at the highest level. Please see the 2013 CT BHP Program Description for details about those committees that involve providers.

D. Leadership involvement

Another significant strength of the QM program is the continuing involvement of service center leadership at the highest level. The CEO and members of the senior management team are all active participants in the day to day operations of the QM Program. Their active involvement provides a clear message to all CT BHP staff regarding the importance of the active involvement and support of the activities. Newly hired members of the leadership team were quickly introduced to the quality culture of the service center and to the central role that quality and data play in decision making.

The CEO brings her special expertise and experience in the development of the PARs and Performance Incentive programs. When possible, she participates in the PARs Workgroup and meets monthly with the Regional Network Management team to strategize and shape their projects. The Medical Directors also play an influential role in the Quality of Care Committee, the development of protocols for handling high risk cases and the PARs Programs. They are active members of the QMC and provide input to the design of Quality Improvement Activities, particularly those involving clinical activities. They help monitor utilization trends and contribute to the oversight of the appeals process.

E. Patient safety

There has been an increased focus within the service center over the past two years on patient safety and risk management. With the addition of the increase in adult business came a very large increase in the reports of adverse incidents. The committee that reviews these incidents has been expanded to include an additional Medical Director to
ensure review of every situation where a hospitalization occurred as the result of an adverse incident. Discharge planning for this population is also closely scrutinized. As a result, protocols for review of these cases have been enhanced to assure appropriate follow-up prior to and following discharge.
II. EVALUATION OF THE 2012 CT BHP QM PROJECT PLAN


Description of Activities and Findings that include trending and analysis of the measures to assess performance over time:

A-C. The 2011 QM Program Evaluation, the 2012 QM Program Description, and the 2012 QM Program Project Plan were submitted to the Departments on April 2, 2012 and then resubmitted on September 4, 2012 following discussion with the departments about the content of the QM project plan. Formal approval of the documents by the Departments was received on September 19, 2012.

Goal 2: Ensure timely response and resolution of member/provider complaints and grievances. (Contract Reference Exhibit E; 20 A-E)

Description of Activities and Findings including trending and analysis of the measures to access performance over time:

A-D. Total number of overall complaints and grievances and number of member (child and adult) complaints and provider complaints

<table>
<thead>
<tr>
<th>Year</th>
<th>Adult Member Complaints</th>
<th>Youth Member Complaints</th>
<th>Provider Complaints</th>
<th>Total Complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>CY '07</td>
<td>7</td>
<td>24</td>
<td>16</td>
<td>47</td>
</tr>
<tr>
<td>CY '08</td>
<td>16</td>
<td>12</td>
<td>16</td>
<td>44</td>
</tr>
<tr>
<td>CY '09</td>
<td>11</td>
<td>8</td>
<td>9</td>
<td>28</td>
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<tr>
<td>CY '10</td>
<td>14</td>
<td>20</td>
<td>6</td>
<td>40</td>
</tr>
<tr>
<td>CY '11</td>
<td>21</td>
<td>20</td>
<td>40</td>
<td>81</td>
</tr>
<tr>
<td>CY '12</td>
<td>53</td>
<td>14</td>
<td>36</td>
<td>103</td>
</tr>
</tbody>
</table>

In 2012, the Service Center received 103 complaints/grievances, an increase of 27.2% from CY ‘11. The adult member complaints more than doubled from CY ‘11 to CY ‘12 and represent 51.5% of the complaints/grievance received in 2012. (Note: Adult members were included in the partnership for only nine months in 2011, April through December.)

Complaints/grievances continue to be submitted more frequently by the adult members. The adult members and parents of child members primarily expressed dissatisfaction with accessing services timely and with clinical issues that they experienced with providers. Many members disagreed with providers’ assessment of the services needed, the treatment approach and the involvement of family members. Providers
were most frequently dissatisfied with being able to obtain authorization for members that were not eligible for services with specific licensure types. Trainings were conducted quarterly for all departments that interface with members, providers and our state clients to ensure that all staff were educated on what constitutes a complaint and how it is to be documented in the system. By the final quarter in 2012, it was agreed with the State partners to modify the complaint reports so that all formal complaint reasons would be included. Previously the reports included only specific reason codes based on decisions made at the inception of the contract. Staff are still given suggested reason codes but this modification should allow for more robust reporting.

**E. Average number of days to resolution**

![Annual Average Amount of Time to Resolve Complaints](image)

In CY ’12 the average time to resolve a complaint decreased by 17.1% from CY ’11 (18.45 days) to CY ’12 (15.30 days). There was a 26.5% decrease in the average time to resolve member complaints from CY ’11 (22.34 days) to CY ’12 (16.42 days). This decrease was driven by Adult and Child complaint resolution time decreasing 29.1% and 19.65% respectively, from CY ’11 to CY ’12. The average time to resolve Provider complaints remained relatively stable. Complaints continue to get addressed in a more timely manner as complaint resolution occurs in existing meetings that include the necessary staff from various departments.

**F. Percent of complaints resolved within 30 days**

In CY ’12 a total of 103 complaints were resolved and, of those, 101 were resolved within 30 days. Two (2) complaints were resolved within 31 to 45 days after a 15 day extension was approved by the complainant. Thus, 100% of the complaints were resolved within the required timeframe.

**G. Most frequent reasons for complaints**

**Adult Member Complaints:** In CY’12 there were 53 adult member complaints received; the reasons were:
• One (1) was classified as complaint regarding benefits.
• Two (2) were classified as transportation issues.
• Two (2) were classified as issues with the contractor’s performance
• Three (3) were related to provider network accuracy.
• Three (3) were classified as billing and financial issues.
• Ten (10) were classified as access to services issues.
• Thirty-two (32) were classified as issues related to clinical services from providers.

**Child Member Complaints:** In CY ’12, 14 child member complaints were received; the reasons were:

• One (1) was classified as billing and financial Issues.
• One (1) was classified as an issue with transportation.
• Three (3) were classified as issues with the contractor’s performance
• Nine (9) were classified as issues related to clinical services from providers.

**Provider Complaints:** In CY ‘12 there were 36 provider complaints received and the reasons were:

• One (1) complaint was classified as access to services issues.
• One (1) complaint was classified as transportation issues.
• Two (2) complaints were about benefits.
• Three (3) complaints were classified as issues with the contractor’s performance
• Three (3) complaints were classified as issues related to clinical services at the provider level.
• Nine (9) complaints were classified as billing and financial issues.
• Seventeen (17) complaints were classified as authorization issues.

The most frequent complaints from providers centered on the authorization process. In response, several internal process changes occurred to increase timely call backs to providers.

**Recommendations for continuing sub-Goal in 2013:**
This sub-goal continues to be applicable for 2013 and should be included in the 2013 Project Plan.

**Goal 3. Promote patient safety and minimize patient and organization risk from Adverse Incidents and Quality of Care and Service Issues (Contract Reference M.11)**

**Description of Activities and Findings including trending and analysis of the measures to access performance over time:**

**A. Quality of Care (QoC) Concerns**

1. **Number of QoC concerns identified; broken out by child and adult members**

   In CY 2012, there were 194 QoC issues identified and submitted to Quality Management for review. The volume in 2012 represents a 6% increase from 2011 when QM received
All of the incidents are reviewed in real time by the AVP or VP of Quality Management and follow up is completed in real time as necessary to ensure that members’ safety is maintained. In addition, the issues were reviewed either by the Safety Risk Management sub-committee or separately with the Medical Director and AVP of Quality Management due to the limitation of the committee’s time which was focused on the continued high volume of high risk events. Upon review of QofC submission, 114 of the concerns submitted were deemed to not be quality of care or service issues. The remaining 80 were found to quality of care or service concerns and further categorized. All concerns related to Enhanced Care Clinics (ECCs) and meeting access standards with given to Regional Network Managers and they addressed the concerns directly with the ECCs. Concerns related to RTC and Group Homes were shared with the Department of Children and Families to ensure that DCF Risk Management was aware of any concerns.

Of the 194 received QoC submissions in 2012, 76 (39.2%) involved youth (0-17) members, 101 (52.1%) involved adult (18+) members and 17 (8.8%) did not involve a specific member.
- Of the 80 deemed to be QoC issues in 2012, 40 involved youth members and 35 involved adult members.
- Of the 114 submitted QoC’s that were deemed “not a quality of care”, 36 involved youth members and 66 involved adult members.

2. The QoCs issues categorized following the Committee review of the concern.

In 2012, 86.3% of the QofC concerns were categorized as issues related to clinical practice which remains consistent with previous years.

<table>
<thead>
<tr>
<th>Quality of Care Categories</th>
<th>Volume</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to Care Related Issues; Concerns as to:</td>
<td>4</td>
</tr>
<tr>
<td>Clinical Practice-Related Issues; Concern as to:</td>
<td>69</td>
</tr>
<tr>
<td>CT BHP Other Monitored Events:</td>
<td>2</td>
</tr>
<tr>
<td>Not Categorized</td>
<td>3</td>
</tr>
<tr>
<td>Provider Inappropriate/Unprofessional Behavior; Accusation of:</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>80</td>
</tr>
</tbody>
</table>

Within the category of Clinical Practice Related Issues, the most frequently sub-categories were:

<table>
<thead>
<tr>
<th>Clinical Practice-Related Subcategories</th>
<th># of QoC</th>
<th>% of QoC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abandoned member</td>
<td>2</td>
<td>2.90%</td>
</tr>
<tr>
<td>Adequacy of assessment</td>
<td>4</td>
<td>5.80%</td>
</tr>
<tr>
<td>Concerns of providers lack of supervision</td>
<td>10</td>
<td>14.49%</td>
</tr>
<tr>
<td>Failure to attempt to involve family in treatment</td>
<td>2</td>
<td>2.90%</td>
</tr>
<tr>
<td>Failure to Coordinate Care</td>
<td>12</td>
<td>17.39%</td>
</tr>
<tr>
<td>Failure to follow practice guidelines</td>
<td>2</td>
<td>2.90%</td>
</tr>
<tr>
<td>Clinical Practice-Related Issues: Totals</td>
<td>69</td>
<td>100.00%</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-----</td>
<td>---------</td>
</tr>
<tr>
<td>Inadequate discharge Planning</td>
<td>11</td>
<td>15.94%</td>
</tr>
<tr>
<td>Medication error</td>
<td>8</td>
<td>11.59%</td>
</tr>
<tr>
<td>Pre-mature discharge</td>
<td>1</td>
<td>1.45%</td>
</tr>
<tr>
<td>Timeliness of assessment</td>
<td>6</td>
<td>8.70%</td>
</tr>
<tr>
<td>Timeliness of referral of medication consultation</td>
<td>1</td>
<td>1.45%</td>
</tr>
<tr>
<td>Medication error</td>
<td>8</td>
<td>11.59%</td>
</tr>
<tr>
<td>Pre-mature discharge</td>
<td>1</td>
<td>1.45%</td>
</tr>
<tr>
<td>Timeliness of assessment</td>
<td>6</td>
<td>8.70%</td>
</tr>
<tr>
<td>Timeliness of referral of medication consultation</td>
<td>1</td>
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</tr>
<tr>
<td>Inadequate discharge Planning</td>
<td>11</td>
<td>15.94%</td>
</tr>
<tr>
<td>Medication error</td>
<td>8</td>
<td>11.59%</td>
</tr>
<tr>
<td>Pre-mature discharge</td>
<td>1</td>
<td>1.45%</td>
</tr>
<tr>
<td>Timeliness of assessment</td>
<td>6</td>
<td>8.70%</td>
</tr>
<tr>
<td>Timeliness of referral of medication consultation</td>
<td>1</td>
<td>1.45%</td>
</tr>
</tbody>
</table>

3. Trend Quality of Care issue by provider

When sorted by Level of Care (LOC), the highest volume of quality of care issues were identified regarding inpatient (32.5%), RTC (13.8%) and outpatient (12.5%). The following quality of care issues were identified for specific providers:

Inpatient:

<table>
<thead>
<tr>
<th>Provider/Facility Name</th>
<th>Sub-Category/Reason</th>
<th># of QoC</th>
</tr>
</thead>
<tbody>
<tr>
<td>CVH</td>
<td>Inadequate discharge Planning</td>
<td>1</td>
</tr>
<tr>
<td>Danbury Hospital</td>
<td>Prescribed wrong, too much, too many, too little medication</td>
<td>1</td>
</tr>
<tr>
<td>Hartford Hospital</td>
<td>Adequacy of assessment</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Failure to Coordinate Care</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Failure to report required info to DCF (i.e. 136, Critical incident, abuse/neglect, med changes)</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Inadequate discharge Planning</td>
<td>2</td>
</tr>
<tr>
<td>Hospital of Central CT</td>
<td>Delay in treatment</td>
<td>1</td>
</tr>
<tr>
<td>Hospital of St. Raphael</td>
<td>Medication error</td>
<td>2</td>
</tr>
<tr>
<td>Manchester Memorial Hospital</td>
<td>Concerns of providers lack of supervision</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Failure to Coordinate Care</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Inadequate discharge Planning</td>
<td>1</td>
</tr>
<tr>
<td>Natchaug Hospital</td>
<td>Concerns of providers lack of supervision</td>
<td>1</td>
</tr>
<tr>
<td>Riverview</td>
<td>Medication error</td>
<td>2</td>
</tr>
<tr>
<td>St. Vincent's</td>
<td>Pre-mature discharge</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Medication issue</td>
<td>1</td>
</tr>
<tr>
<td>Waterbury Hospital</td>
<td>Delay in treatment</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Failure to attempt to involve family in treatment</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Failure to Coordinate Care</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Inadequate discharge Planning</td>
<td>2</td>
</tr>
<tr>
<td>Residential:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>Provider/Facility Name</td>
<td>Sub-Category/Reason</td>
<td># of QoC</td>
</tr>
<tr>
<td>Yale New Haven Hospital</td>
<td>Failure to attempt to involve family in treatment</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Failure to Coordinate Care</td>
<td>1</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td></td>
<td><strong>26</strong></td>
</tr>
<tr>
<td><strong>Residential:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider/Facility Name</td>
<td>Sub-Category/Reason</td>
<td># of QoC</td>
</tr>
<tr>
<td>Adelbrook (CHOC)</td>
<td>Inappropriate physical contact</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Concerns of providers lack of supervision</td>
<td>1</td>
</tr>
<tr>
<td>Klingberg Family Center</td>
<td>Concerns of providers lack of supervision</td>
<td>2</td>
</tr>
<tr>
<td>Mount St. John</td>
<td>Concerns of providers lack of supervision</td>
<td>1</td>
</tr>
<tr>
<td>Waterford Country School</td>
<td>Concerns of providers lack of supervision</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Failure to follow adequate search procedures.</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Timeliness of assessment</td>
<td>1</td>
</tr>
<tr>
<td>Wellspring Foundation</td>
<td>Failure to Coordinate Care</td>
<td>1</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td></td>
<td><strong>11</strong></td>
</tr>
<tr>
<td><strong>Outpatient:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider/Facility Name</td>
<td>Sub-Category/Reason</td>
<td># of QoC</td>
</tr>
<tr>
<td>Ashwini Sabnis</td>
<td>Failure to provide appropriate appointment access for member already in care</td>
<td>1</td>
</tr>
<tr>
<td>Dorian Parker, LADC</td>
<td>Inappropriate physical contact</td>
<td>1</td>
</tr>
<tr>
<td>Dr. Daniel Feldman</td>
<td>Medication issue</td>
<td>1</td>
</tr>
<tr>
<td>Greater Bridgeport Mental Health</td>
<td>Failure to follow practice guidelines</td>
<td>1</td>
</tr>
<tr>
<td>Jose Camacho-Pantoja</td>
<td>Failure to provide appropriate appointment access for member already in care</td>
<td>1</td>
</tr>
<tr>
<td>Kathleen Ennis, APRN</td>
<td>Abandoned member</td>
<td>1</td>
</tr>
<tr>
<td>Optimus Health Care</td>
<td>Failure to provide appropriate appointment access for member already in care</td>
<td>1</td>
</tr>
<tr>
<td>St. Francis Hospital</td>
<td>Medication issue</td>
<td>1</td>
</tr>
<tr>
<td>UCONN Health Center</td>
<td>Failure to monitor medication</td>
<td>1</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td></td>
<td><strong>10</strong></td>
</tr>
</tbody>
</table>
B. Adverse Incidents

1. Number of adverse incidents broken out by child and adult

<table>
<thead>
<tr>
<th>Total Adverse Incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td># of Adverse Incidents</td>
</tr>
<tr>
<td>CY '08</td>
</tr>
<tr>
<td>Adult (18+)</td>
</tr>
<tr>
<td>Youth (0-17)</td>
</tr>
</tbody>
</table>

In 2012, 989 adverse incidents were reported to QM for review. Incidents are typically self-reported by providers during authorization reviews conducted by care managers. Of those incidents, 275 (27.8%) met the ValueOptions Inc. national criteria for adverse incident and were given a risk severity rating. The remaining 714 were events that involved the member engaged in high risk behaviors but did not meet standards as an adverse incident (i.e. did not require urgent or emergent treatment following the incident and/or were not receiving services or not recently discharged from services managed by ValueOptions Inc.). The volume of adverse incidents meeting the VO National criteria increased by 9.6% from CY ’11 (251) to CY ’12 (275). Of the 275 incidents, 20.0% (55) involved youth and 80.0% (220) involved adults.

The 275 adverse incidents were categorized by severity rate based on both the client’s enrollment in treatment at the time of the event and the level of treatment they required after the event.

- One hundred sixty one (161) were Minimal risk.
- Ninety five (95) were categorized as Moderate risk.
- Fifteen (15) were categorized as Major risk.
  - Six (6) involved self-inflicted harm by an adult member, three (3) involved self-inflicted harm by a youth member
  - Two (2) involved alleged sexual behavior by a youth member with another patient or staff while in a behavioral health setting
  - One (1) involved medication or treatment error of a youth member
  - Three (3) involved the unanticipated death of adult members
- Four (4) incidents were categorized as Sentinel risk.
  - Two (2) involved alleged sexual behavior with other patients or staff within the behavioral health setting by a youth member and one (1) by an adult member
  - One (1) involved the unanticipated death of an adult member.
All incidents were reported to the departments or were determined to have already been reported to the departments by the facility or provider.

2. **Most frequent types of Adverse Incidents identified:**

<table>
<thead>
<tr>
<th>Adverse Incident Category</th>
<th>CY ’08</th>
<th>CY ’09</th>
<th>CY ’10</th>
<th>CY ’11</th>
<th>CY ’12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Property Damage</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Serious Adverse Reaction to Treatment</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Medication Errors</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Other Occurrences</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Unexpected Death</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Elopements</td>
<td>0</td>
<td>2</td>
<td>5</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Human Rights Violations</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Violent/Assaultive Behavior (non lethal)</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Injuries (Accidents): Urgent or Emergent</td>
<td>3</td>
<td>3</td>
<td>7</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Sexual Behavior</td>
<td>5</td>
<td>12</td>
<td>5</td>
<td>10</td>
<td>8</td>
</tr>
<tr>
<td>Self Inflicted Harm</td>
<td>7</td>
<td>5</td>
<td>169</td>
<td>226</td>
<td>251</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>19</strong></td>
<td><strong>29</strong></td>
<td><strong>192</strong></td>
<td><strong>251</strong></td>
<td><strong>275</strong></td>
</tr>
</tbody>
</table>

Consistent with CY 2011; in 2012 the most frequent type of reported adverse incidents involved self-inflicted harm (91.3%) which required urgent or emergent treatment.
- Of the 251 incidents involving self-inflicted harm nine (9) were deemed as Major risk involved either both youth (3) or adult (6) members. The remaining incidents were classified as minimal or moderate risk.

The next most frequent adverse incident reported involved sexual behavior (8) with other patient or staff while in a behavioral health setting.
- Three (3) were classified as Sentinel risk, two (2) were classified as Major Risk and three (3) were classified as Minimal risk.

All incidents were reported to the departments or were determined to have already been reported to the departments by the reporting facility or provider.

3. **Trending of Adverse Incidents by provider**

In 2012 there were 17 adverse incidents reported regarding members either recently (within two weeks of discharge) or currently in treatment at Yale New Haven Hospital, including their inpatient, outpatient, intensive outpatient, and methadone maintenance programs. All incidents involved self-inflicted harm; five (5) were classified as moderate risk and twelve (12) were classified as minimal risk.

There were 12 adverse incidents reported regarding members either recently (within two weeks of discharge) or currently in treatment at Community Health Resources, including their outpatient, intensive outpatient, group home and home based service programs. All incidents involved self-inflicted harm except for one (1) which involved sexual behavior; this was classified as a sentinel risk. The remaining incidents were categorized as follows: five (5) as moderate risk and six (6) as minimal risk.

There were 10 adverse incidents reported regarding members either recently (within two weeks of discharge) or currently in treatment at Waterbury Hospital, including their
inpatient, outpatient, intensive outpatient, and methadone maintenance programs. All incidents were classified as self-inflicted harm; one (1) was classified as major risk, three (3) as moderate risk and six (6) as minimal risk.

There were 9 adverse incidents reported regarding members either recently (within two weeks of discharge) or currently in treatment at Natchaug Hospital, including their inpatient, residential treatment center, partial hospitalization, intensive outpatient, and outpatient programs. All incidents were categorized as self-inflicted harm except one (1) that was categorized as an injury; this incident was classified as a minimal risk. The remaining incidents were classified as the following: four (4) as moderate risk and five (5) as minimal risk.

In 2012 there were four (4) sentinel incidents reported.

Three incidents involved sexual behavior from the following providers:
   1. Children’s Center of Hamden (Psychiatric Residential Treatment Facility)
   2. Community Health Resources (Group Home)
   3. Lakeview Neurorehab Center (Residential Treatment Center)

One incident involved an unanticipated death from the following provider:
   1. Stonington Behavioral Health (Inpatient Detoxification)

All incidents were reported to the departments or were determined to have already been reported to the departments by the reporting facility or provider.

Recommendations for continuing sub-Goal in 2013:
This sub-goal continues to be applicable for 2013 and should be included in the 2013 Project Plan.

Goal 4. Establish and maintain CT BHP-specific policies and procedures (P&Ps) in compliance with contractual obligations that govern all aspects of CT BHP operations (Contract Reference D.9 and P.2)

Description of Activities and Findings including trending and analysis of the measures to access performance over time:

A. All CT BHP-specific Clinical, Quality, Customer Service and Provider Relations Policy and Procedures (P&Ps) are reviewed and revised as necessary but no less than annually

CTBHP assumes National ValueOptions Policy and Procedures except in cases to meet contractual requirements. During 2012, Clinical, Customer Service, Provider Relations and Quality Management each reviewed their own department’s CT specific P&P’s. The Clinical, Customer Service and Provider Relations Departments reviews found that there were no revisions necessary. Clarification was made to procedural steps in Quality Management P&P, Q316 Adverse Incidents, Critical Incidents, Significant Events and Sentinel Events.

Recommendations for continuing sub-Goal in 2013:
This sub-goal continues to be applicable for 2013 and should be included in the 2013 Project Plan.
Goal 5. Establish and maintain training program that includes compliance with state regulatory requirements and HIPAA regulations (Contract Reference V.1 and V.3)

Description of Activities and Findings including trending and analysis of the measures to access performance over time:

A. Staff training on state regulatory requirements

Staff training on federal and state regulatory requirements is conducted with our new employees during new hire orientation and periodically throughout the year in departmental staff meetings. During 2012, the Compliance Department completed 27 face to face training sessions and sent 16 electronic training alerts to staff. In May 2012, the service center was involved in Corporate Compliance and Ethics Week. The staff participated in activities which highlighted the importance of compliance and ethics in the workplace.

B. Staff training on HIPAA privacy regulations

The CT service center staff completed the annual companywide 2012 HIPAA training. ValueOptions National Human Resources Department monitored the process to ensure full compliance with this requirement. Refresher trainings on basic information about PHI, what constitutes a HIPAA violation and how to report a HIPAA violation were conducted over the course of the year. There were 10 audits conducted of the service center staff to ensure compliance with the rules around protecting PHI.

The local and national compliance staff continues to monitor all violations closely. Each violation reported during 2012 was thoroughly investigated and placed into one of the categories listed below.

There were no privacy breaches and a total 83 policy and regulatory (privacy) violations in 2012. The 83 policy and regulatory (privacy) violations equate to .14% of the 59,274 authorizations issued during 2012.

Thirty Six (36) – Policy Violations:

Seventeen (17) - Instances of incorrect information being entered into a member’s record set; there was no disclosure of PHI
Ten (10) - Emails were either sent unencrypted to the intended party (Low risk as email went to intended party) or were sent encrypted to an unintended party (Low risk as email was encrypted) or sent internally with PHI in the subject line (Low risk as email was internal).
Six (6) – Authorizations were created for the wrong member by the Clinical Department or Central Night Service, an authorization letter was not generated.
Two (2) – Authorizations were created for the wrong provider by the Clinical Department or Central Night Service, an authorization letter was not generated.
One (1) – Fax was sent to the intended party (DCF) but inadvertently contained non-DCF member information (low risk as fax went to intended party)

Forty Seven (47) – Privacy (Regulatory) Violations:
Thirty Five (35) Authorizations were created for the wrong provider by Clinical Department or Central Night Service and an authorization letter was generated. Three (3) Authorizations were created for the wrong member by Clinical Department or Central Night Service and an authorization letter was generated. Three (3) - Emails were either sent encrypted to an unintended party (Low risk as email was sent encrypted and VO does not have a history of being hacked) Three (3) – Fax was sent to the intended provider and inadvertently contained member substance abuse information (low risk as fax went to a provider who is required to adhere to HIPAA requirements) Two (2) – Letter sent to an unintended provider (Low risk as mail was returned and the provider is required to adhere to HIPAA requirements.) One (1) - Discussion with intended provider regarding member substance abuse information (low risk as provider advised they had a Release of Information from member. Upon further discussion the provider advised they did not have a Release of Information on file)

C. Staff training on Denials and Appeals

Clinical staff trainings were conducted two times over the course of 2012 in order to review the medical necessity denial process. Workflows were reviewed and specific questions were answered. The providers’ rights to a doctor-to-doctor conversation (peer to peer review) prior to a determination of a denial was reiterated and further explained so that care managers could inform providers better of their rights prior to the appeal process. The partial denial process was also reviewed as well as appropriate documentation for when providers are in full agreement with modified requests.

D. Staff training on Complaints

Trainings with all departments that interface with members, providers and our state partners occurred two times over the course of 2012. Staff were reminded how to identify dissatisfaction and what clarifying questions needed to be asked in order to clearly understand the concern(s). The documentation process of a complaint was reviewed as well.

Recommendations for continuing sub-Goal in 2013:
This sub-goal continues to be applicable for 2013 and should be included in the 2013 project plan.

Goal 6. Ensure timely telephone access to CT BHP (Contract Reference Q.3 and Q.4)

Description of Activities and Findings including trending and analysis of the measures to access performance over time:
Volume of Calls

In 2012 the total annual call volume increased 12.2% from 116,258 (CY ’11) to 130,457 (CY ’12). Provider calls contributed most significantly to this increase, rising by 14.1% from CY ’11 (88,386) to CY ’12 (100,879). Member calls increased by 8.5% over the same time frame. Both increases are largely due to the call volume in CY ’12 reflecting a full year of the added adult business as opposed to CY ’11, which only reflects three quarters. Based on past years’ data, member calls continue to exhibit seasonality in that there is an increase in Q1 call volume that tapers off throughout the rest of the year. On the other hand, crisis calls decreased by 14.0% from CY ’11 (2,982) to CY ’12 (2,566) primarily due to providers becoming familiar with telephone menu changes that occurred last year (providers would historically utilize the phone menu inappropriately, selecting the crisis prompt).

A. Average speed to answer: Average number of seconds until call is answered by a live person

In 2012 the average speed of answer for provider calls increased one (1) second, while the average speed of answer for crisis calls decreased by one (1) second. The increase in time to answer provider calls can be attributed to the increase in provider call volume. The average speed of answer for member calls remained the same. The service center continued to be well within this performance standard in 2012.
B. Abandonment Rate: Percentage of calls not answered before caller hangs up

The call abandonment rate saw a 59.26% decrease from CY '11 (317) to CY '12 (137), and still remains well below the performance standard. This decrease may be attributed to the Customer Service staff becoming more seasoned, developing better competency and efficiency with the phone system.

C – D. Percentage of calls placed on hold and average length of time on hold for Clinical, Customer Service and Crisis Calls

In 2012 the percent of total calls placed on hold increased 1.2% from CY '11 (63.42%) to CY '12 (64.15%). While the volume of calls placed on hold for member and provider calls increased, the volume of crisis calls placed on hold decreased 60.5% from CY '11 (228) to CY '12 (90). The volume of calls placed on hold is related to the total volume of calls received.
The average hold time for provider calls decreased 35.0% from CY ’11 to CY ’12 after increasing 81.8% from CY ’10 to CY ’11. The average hold time for crisis calls decreased 17.3% from CY ’11 to CY ’12, while the average hold time for member calls increased 19.0% from CY ’11 to CY ’12. Although the average hold time for member calls increased, all average hold times continue to be well below the performance standard.

E. Average Length of Time on Call

The average handle time of all calls decreased by 17 seconds from CY ’11 to CY ’12, the lowest it has been since CY’10.

Note: All graphs only report as far back as CY ’10 due to anomalies in phone reporting prior to 2010.
Recommendations for continuing sub-Goal in 2013:
This sub-goal continues to be applicable for 2013 and should be included in the 2013 Project Plan.

Goal 7. Develop and implement Quality Improvement Activities (QIA) to address opportunities for improvement (Contract reference M.6)

Description of Activities and Findings that include trending and analysis of the measures to assess performance:

A. Child/Adult Study: Autism Spectrum Disorder (ASD) Feasibility Study
Description of Activities and Findings including trending and analysis of the measures to access performance over time:

In Q2 ’11, the Departments proposed an Autism Spectrum Disorder (ASD) Feasibility Study. In collaboration with the departments, it became clear that the project would not only address youth but would also include adults with the disorder. It was agreed that the ASD study would satisfy two of the contractually obligated clinical studies for the second year of the new contract. Please refer to Appendices A and B for the final documents on the Autism study that was submitted to the Departments.

Recommendations for continuing sub-Goal in 2013:
The autism study was completed as of the end of 2012 and will not continue in 2013.

B. Child/Adult Study: Intensive Case Management; Time in Community Pre and Post ICM and/or Peer Assignment

The Impact of the Intensive Case Management Program is a study designed to assess the impact of having an Intensive Case Manager (ICM) and/or a Peer Specialist (PS) involved in the care of a HUSKY member. The primary measure for this study is a comparison of the number and percentage of days spent in the community during the six (6) months prior to and post the assignment to an ICM and/or a Peer. Please see Appendices C and D for a summary of the analyses.

Recommendations for continuing sub-Goal in 2013:
This study was completed as of the end of 2012 and will not continue as a sub-goal in 2013.

C. Reducing discharge delays for youth receiving inpatient behavioral health treatment (Contract Reference: 2012 Performance Target 4)

The 2012 Performance Target related to discharge delay days was a maintenance measure. The goal for Performance Target 4 was to maintain discharge delay days at 14% or less of total inpatient days. In addition, acute average length of stay could increase no more than 3% in CY 2012 from the revised baseline of 12.05 days. The new baseline represents the midpoint between the longest Acute average length of stay that occurred during Q3 and Q4 of 2008 (12.92 days) and the shortest Acute average length of stay that occurred during 2011 (11.17 days). At the end of CY 2012 the total percent of discharge delay days for CY ’12 was 10.6% and the acute average length of stay for CY ’12 was 11.94 days, thereby meeting 100% of the established performance target.
In calendar year 2012, there was a slight decrease in the discharge delay rate compared to CY 2011, from 10.9% of all inpatient days delayed down to 10.6% for CY 2012. Both 2011 and 2012 reflect a considerable decrease from the rate of discharge delay shown in CY 2010 (19.4%). Strategies identified in 2011, with respect to special populations and the selective use of out of state hospitals when clinically necessary, were maintained in 2012. Another measure that was taken to decrease discharge delay in 2012 included VO Family Peer Specialists attending clinical rounds at inpatient units that have longer discharge delay rates to assist and support families with barriers to discharge. The hours that ICMs spent in the DCF Regional offices were increased and an additional ICM was assigned to support discharge planning and coordination of care at Solnit Center.

<table>
<thead>
<tr>
<th></th>
<th>CY'08</th>
<th>CY'09</th>
<th>CY'10</th>
<th>CY'11</th>
<th>Q1'12</th>
<th>Q2'12</th>
<th>Q3'12</th>
<th>Q4'12</th>
<th>CY'12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Days</td>
<td>28,895</td>
<td>29,094</td>
<td>28,552</td>
<td>29,135</td>
<td>8,102</td>
<td>8,156</td>
<td>7,008</td>
<td>7,719</td>
<td>30,985</td>
</tr>
<tr>
<td>Discharge Delay Days</td>
<td>9,959</td>
<td>5,133</td>
<td>6,854</td>
<td>3,555</td>
<td>985</td>
<td>1,232</td>
<td>697</td>
<td>763</td>
<td>3,677</td>
</tr>
<tr>
<td>Total Days</td>
<td>38,854</td>
<td>34,227</td>
<td>35,406</td>
<td>32,690</td>
<td>9,087</td>
<td>9,388</td>
<td>7,705</td>
<td>8,482</td>
<td>34,662</td>
</tr>
</tbody>
</table>

It is also important to note the very substantial decrease in overall use of inpatient days for CT youth from 2008 to 2011. However, there was a slight increase in inpatient days from CY’11 to CY’12, an increase of 5.2%. Please see the discussion under Goal 10 for more analysis of this topic.

**Recommendations for continuing sub-Goal in 2013:**
This sub-goal continues to be applicable for 2013 and should be included in the 2013 Project Plan.

**Goal 8. Monitor performance of Customer Service staff via audits of performance**
*(Contract Reference: F.13 and F.14)*
Description of Activities and Findings that include trending and analysis of the measures to assess performance:

A. Assess individual Customer Service staff (at least 5 cases per month) on performance in five (5) areas

During 2012, the ValueOptions NICE system was utilized to conduct auditing of the Customer Service staff. The Customer Service Supervisor conducted the audits. The audit average for the department was 97.8% for 2012. Customer Service staff received feedback regarding their individual performance during supervision and the Customer Service team received feedback regarding overall department performance during staff meetings.

B. Assess adequacy and accuracy of documentation of content of call.

The Customer Service Department conducts audits of the accuracy of the documentation that results from calls into the department. Audit results indicate that with the exception of misdirected calls (medical, dental or vision) Customer Service staff routinely document every call received. Based on results from the NICE system, the scores for documentation were above the goal of 90%. Actual results for 2012 were 98.6%. The audits identified opportunities for improvement in the quality of the documentation in member records regarding the content of the call. This finding was followed up in individual supervision, weekly staff meetings, and trainings.

The opportunity for improvement around professional etiquette and tone was also identified during the audit process. During 2012, 80% of the Customer Service Staff were new hires. All staff completed one-to-one professional etiquette and tone training. In addition to that training, all new staff completed the Comprehensive CT Call Center training, including system application, telephone etiquette and handling, resource development, and process & procedural work flows.

Recommendations for continuing sub-Goal in 2013:
This sub-goal continues to be applicable for 2013 and should be included in the 2013 Project Plan.

Goal 9. Review and approve the 2012 CT BHP Utilization Management (UM) Program Description (Contract Reference F.3)

Description of Activities and Findings that include trending and analysis of the measures to assess performance:

A. Annual development and review of the 2012 UM Program Description
The 2012 UM Program Description was submitted for approval on April 2, 2012. Two of the Appendices (F and J) were resubmitted on September 21, 2012 following discussions with the Departments. Formal approval of the documents by the Departments was received on August 20, 2012.

Recommendations for continuing sub-Goal in 2013:
This sub-goal continues to be applicable for 2013 and should be included in the 2013 Project Plan.
Goal 10. Monitor for under or over utilization of behavioral health services; identify barriers and opportunities

Activities and Findings that include trending and analysis of the measures to assess performance:

Utilization Management reports were reconfigured late in CY ‘11 and early in CY ‘12 to reflect the changes resulting from additional Medicaid populations, as well as a modification in age parameters for youth and adult membership. Beginning with Q2 ‘11, utilization management reports include aggregate utilization data for all eligibility categories including comparisons of utilization for multiple levels of care for the following adult populations: Family Single and Dual, ABD Single and Dual, Long Term Care Single and Dual, MLIA, Charter Oak, and HUSKY B. The former HUSKY population (CY ‘08 – Q1 ‘11), included only HUSKY A, HUSKY B, and DO5 members. Additionally, starting in Q1 ‘12, adult members were defined as being aged 18+ years (instead of the previous classification for adults as 19+ years).

It is important to note that the data for the following sections is refreshed for each subsequent set of quarterly reports during the year. Due to retrospective authorizations and changes in eligibility, the results for each quarter change from the previously-reported values. In most cases, the changes do not create significant changes in the reported conclusions, however, on some occasions there is sufficient variation that the analysis would change. One example is that of the adult membership in Q3 ‘12. When first reported, there appeared to be a decline in adult membership from Q2 ‘12 to Q3 ‘12. By Q4 ‘12, however, the data revealed that membership actually increased in Q3 ‘12, although the increase was slight. We expect a similar process to occur in Q4 ‘12. The reports and analyses for all LOC’s are affected by this change. As a result, any conclusions drawn from the data are subject to revision as the data is refreshed.

As a reference to the UM data presented in this section, membership data is pictured below.

Over the past year, youth membership has been relatively stable, rising by only 1.8% from CY ‘11 to CY ‘12. Annual increases in youth membership are a trend that has been consistent over the past several calendar years beginning in CY ’08.
From Q2 ’11 through Q3 ’12, there has been a gradual increase in overall membership, as well as in many of the eligibility groups with the exception of CTOAK, HUSKY B, HUSKY C (ABD Single), and HUSKY C (LTC Single). The largest eligibility groups, HUSKY A (Family Single) and HUSKY D (MLIA) both have shown increases from Q2 ’11 to Q3 ’12. It is too soon to analyze membership totals for Q4 ’12 because there has not been ample time to include all new members. We assume that total membership will increase once additional time has passed and we are able to look retrospectively at membership for Q4 ’12. The total adult membership for CY ’12 includes unique membership for the entire year, exceeding quarterly totals.

A. Inpatient Psychiatric Hospitalization

Adult Inpatient

As stated above, UM data for adult members is only available for all benefit groups beginning Q2 ’11. As two complete calendar years are not available for comparison, adult data is analyzed quarterly.
In Q4 '12, of graphed benefit groups, HUSKY C (ABD Single) had the highest number of days/1,000 at 56.31 which was a decrease from Q3 '12. Days/1,000 also decreased for HUSKY D and HUSKY A (Family Single) from Q3 '12 to Q4 '12. This is the lowest recorded days/1,000 for the HUSKY D membership. A seasonal trend may be emerging, since Q4 '12 and Q4 '11 have fewer days/1,000 when compared to other quarters. (Note: Q2 '11 cannot be included in the comparison because it was the first quarter measured, and the data did not include all inpatient days.)

Of the larger benefit groups, only HUSKY C (ABD dual) show an increase from Q3 '12 to Q4 '12 of inpatient days/1,000. Due to varied authorization procedures for members with both Medicare and Medicaid (dual eligible) benefits leaving dual data incomplete, analysis of any changes in this population is not suggested.

Overall, adult inpatient psychiatric days/1,000 decreased from Q3 '12 to Q4 '12 for all benefit groups. Generally days/1,000 has shown slight variance quarter to quarter during the calendar year, and no significant upward or downward trend.
During Q4 '12, HUSKY C (ABD Single) and HUSKY D (MLIA) continued to have the highest penetration rate of all benefit groups. In Q4 '12, the two benefit groups combined, account for about 74% of all adult admits to inpatient psychiatric hospitals.

The overall admits/1,000 rate was 1.91 for Q4 '12. Both admits/1,000 and the actual number of admits are the lowest reported numbers since reporting began in Q2 '11. It appears that the admits/1,000 rate has been dropping slightly from quarter to quarter, beginning in Q1 '12. Prior to Q4 '12, this may have been attributable to the steadily, though slightly, increasing adult population. However, as of the run date of the Q4 data, adult membership had not increased for Q4 '12 and as the grid above shows, the total number of admissions also decreased in Q4 '12.
The average length of stay for all benefit groups decreased from 8.63 days in Q3 ’12 to 8.32 days in Q4 ’12. There has been some slight variation from quarter to quarter, but generally the adult inpatient psychiatric ALOS has ranged from 8-8.5 days. The calendar year 2012 average was 8.30 days for all benefit groups.

Of the largest benefit groups, HUSKY C (ABD Dual and ABD Single) members consistently have had the longest recorded ALOS, while HUSKY D and HUSKY A (Family Single) consistently have had shorter length of stays.

In Q4 ’12 admits/1,000, days/1,000 and ALOS all decreased. It is our hope that this creates more fluidity within the inpatient system; beds are being utilized by those members who need to be treated in an acute setting and members are appropriately discharged to less restrictive settings when an acute setting is no longer necessary.
Youth Inpatient Psychiatric Hospitalization

From CY ‘11 to CY ‘12, the inpatient days/1,000 for all youth remained about the same, increasing only slightly.

The inpatient days/1,000 rates indicate similar quarterly trending for all youth (0-17) in both 2011 and 2012. Quarterly seasonal trends identified in previous years for youth inpatient days/1,000 continued to be evident in CY ‘12. As with previous years, days/1,000 is highest in quarters 1, 2 and 4 and lowest during the summer months (Q3). This pattern suggests seasonal variation that is possibly the result of referrals by school-based and other community sources that change during the summer months.

Since CY ‘08 there has been a steady decline in DCF inpatient days/1,000. Conversely, since CY ‘09, the non-DCF inpatient days/1,000 rate has increased. Both of these trends
continued in CY ‘12. In CY ‘12, DCF involved youth again accounted for less days/1,000 than non-DCF youth, a change in utilization that was first seen during CY ‘11.

Youth inpatient admits/1,000 in CY ‘12 remained nearly unchanged from CY ‘11.

Mirroring the trend of days/1,000, the DCF inpatient admits/1,000 rate has steadily decreased from CY ‘08 to CY ‘12 while the non-DCF admits/1,000 rate has steadily increased during that same time period. The non-DCF admits/1,000 rate continues to remain more than twice as high as that for DCF youth, continuing a pattern found in recent years.
When comparing CY ‘11 to CY ‘12, the inpatient average length of stay (ALOS) for all youth has remained unchanged. The inpatient ALOS rates indicate similar quarterly trending for all youth (0-17) in both 2011 and 2012. As with previous years, the third quarter rate was the highest during the year, while the other three quarters were relatively equivalent.

While the overall ALOS remained unchanged, the ALOS for DCF-involved youth increased in CY ‘12, as compared to CY ‘11. As DCF continues to implement Differential Response, the youth remaining in DCF services likely are in greater need of the higher levels of care, thereby possibly taking longer to resolve their presenting issues. By comparison, the non-DCF ALOS decreased for the second, consecutive year. It is expected that non-DCF youth will have lesser acuity, on average, than their DCF-involved counterparts, and therefore that their ALOS will be shorter.

When inpatient data for all youth is considered changes in all three measures, admits/1,000, days/1,000 and ALOS are relatively small when comparing CY ‘11 to CY
‘12. When the data is split into DCF and non-DCF identified youth more significant system changes are apparent. Since CY ‘08, DCF youth have required fewer admissions to this level of care and experienced an overall decreased length of stay. This has allowed for beds to become more available for non-DCF involved youth. With a limited amount of bed capacity system wide, these two groups of youth intrinsically affect each other's inpatient utilization.

**Solnit Center Inpatient**

Solnit Center inpatient data continues to be analyzed separate from community based inpatient psychiatric data because of its overall influence on inpatient trends. Solnit data was not refreshed to include two decimal places, thus CY ‘12 data is the first timeframe when these changes appear.

Inpatient days/1,000 for Solnit Center decreased 14.0% in CY ‘12 when compared to CY ‘11 (5.7 vs. 4.90). As displayed above, days/1,000 at Solnit Center has decreased every year since 2008. Because ALOS and admits to the level of care have different trends and because this data is so small compared to the overall youth population, this trend is most likely a function of steady membership increases. The more marked decline since CY ‘10 is likely a combination of this and decreases in total bed days, amplifying the decrease in days/1,000.

Below, admits/1,000 is not considered for the analysis of Solnit Center data because the overall number of admits is so small compared the youth population. Thus, any admission trends are washed out by the larger population. The below graph merely depicts the total number of admissions to the facility.
The number of HUSKY youth admitted to the Solnit Center has decreased by 15.0% (167 to 142) from CY ’11 to CY ’12, and by 23.2% (185 to 142) from CY ’10 to CY ’12. The CY ’12 decrease in admissions is a result of decreased capacity in inpatient beds due to the repurposing of beds in two units to the PRTF level of care.

The Solnit inpatient ALOS for all youth increased by 8.8% from CY ’11 to CY ’12 (111.4 days to 121.25 days). Since the noticeable decrease in ALOS from CY ’08 to CY ’09, average length of stay at Solnit Center has not had any noteworthy trends. The overall number of youth discharged during CY ’12 (n = 144) is lower than that of CY ’11 and is the fewest number of youth discharged during any of the reporting years.

**Solnit Inpatient; ALOS – Court Ordered vs. Non-Court Ordered**

The ALOS at Solnit is driven by the youth who are non-court ordered to that placement. Non-court ordered youth have a significantly longer ALOS than court-ordered youth, as seen below in the below table. The ALOS for non-court ordered vs. court ordered youth
was 171.7 days vs. 64.5 days, respectively, in CY ‘12. For CY ‘12, there were 144 total discharges, 76 for non-court ordered and 68 for court ordered youth.

There has been considerable variability in the ALOS for non-court ordered youth over the past five years. Results show alternating decreases and increases in the average value for each of the years since CY ’08. For court ordered youth, the pattern has been much more stable. Although there was a longer ALOS for court-ordered youth in CY ’11, the overall ALOS since CY ’09 has been consistently around 64 days, down 30% from its high point of 92 days in CY ’08.

For court ordered youth, there has been a 12.8% decrease in ALOS (74.0 days to 64.5 days) from CY ’11 to CY ’12. This decrease in ALOS may be a result of the expanded collaboration between State agencies, ValueOptions and Solnit Center. ValueOptions intensive care managers expanded their participation in Court Review team meetings with Solnit Center and CSSD to improve coordination of care and effectuate timely discharge planning.

<table>
<thead>
<tr>
<th>ALOS, days</th>
<th>Non-Court Ordered</th>
<th>Court Ordered</th>
</tr>
</thead>
<tbody>
<tr>
<td>CY 2008</td>
<td>244.4</td>
<td>92.0</td>
</tr>
<tr>
<td>CY 2009</td>
<td>157.7</td>
<td>63.9</td>
</tr>
<tr>
<td>CY 2010</td>
<td>206.7</td>
<td>64.1</td>
</tr>
<tr>
<td>CY 2011</td>
<td>157.9</td>
<td>74.0</td>
</tr>
<tr>
<td>CY 2012</td>
<td>171.7</td>
<td>64.5</td>
</tr>
</tbody>
</table>

The court ordered cases have shorter lengths of stay by design. This is due to the fact that court ordered cases are ordered for two purposes; 30 days, for an evaluation, and 60 days to determine restoration and competency. Both types of court ordered cases involve an evaluation and treatment for a defined period of time based on a judge’s order. Once the court order time period is complete, it is expected appropriate services to meet the clinical needs of the youth have been determined and the youth is discharged with those services, returning to detention or to another viable placement. There are some incidences where a youth may require continued inpatient treatment at Solnit beyond the initial 30 or 60 day court order and will remain at Solnit. Thus, the ALOS for Court ordered cases are routinely and overall lower than the non-court ordered cases.

Although we have seen a decrease in overall admits and days/1,000 for all youth, there has been an increased ALOS for all youth over the past year. The decreased bed capacity at Solnit Center has impacted the movement of youth throughout the delivery system. During CY ‘12, 22.2% of youth in discharge delay at community hospitals were awaiting placement at Solnit. Given its important role within the continuum of treatment resources for our most at risk youth, it is imperative that we continue to monitor Solnit Center utilization patterns closely. Current data reveal a trend of decreased admissions with an increase in the ALOS for all youth from CY ’11 to CY ’12 by 8.8% (111.4 to 121.25). In response to this trend, ValueOptions attends weekly discharge planning meetings and regularly scheduled admission and court review team meetings to support discharge planning and coordination of care among Solnit, community providers and
DCF. As community services become more creative and successful in supporting youth upon discharge from congregate care, we expect both ALOS and discharge delay to decrease.

**B-C. Inpatient Psych Days in Discharge Delay vs. Acute Length of Stay**

<table>
<thead>
<tr>
<th></th>
<th>CY’08</th>
<th>CY’09</th>
<th>CY’10</th>
<th>CY ‘11</th>
<th>CY ‘12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Days</td>
<td>28,895</td>
<td>29,094</td>
<td>28,552</td>
<td>29,135</td>
<td>30,995</td>
</tr>
<tr>
<td>Discharge Delay Days</td>
<td>9,959</td>
<td>5,133</td>
<td>6,854</td>
<td>3,555</td>
<td>3,667</td>
</tr>
<tr>
<td>Total Days</td>
<td>38,854</td>
<td>34,227</td>
<td>35,406</td>
<td>32,690</td>
<td>34,662</td>
</tr>
</tbody>
</table>

From CY ‘08 to CY ‘12, there has been an overall 63.2% decrease in the total number of discharge delay days (9,959 vs. 3,667 days). In CY ‘12 the rate of discharge delay (10.6%) remained consistent with CY ‘11 (10.9%), and remains substantially lower than the rate seen during CY ‘10 (19.4%). This measure continues to be a performance target for the Connecticut service center.

**Discharge Delay; Child Inpatient PAR**

![PAR: Total Number of Acute Days vs. Discharge Delay Days for Big 8 Youth (0-17)](image)

Similar to the trend reported for all youth, rates of discharge delay at the Big 8 Hospitals were consistent from CY ‘11 to CY ‘12. Over the past four years, however, there has been a 24.7% decrease in discharge delay days from 15.8% in CY ‘09 to 11.9% in CY ‘12. As can be seen by comparing the total acute and discharge delay numbers with the Big 8 Hospital totals above, in-state hospitals provided the majority of inpatient days in the HUSKY youth system (81.6% of all CY ‘12 inpatient days). Only a small number of youth obtain services out of state. As average length of stay has decreased, an
increased percent of all inpatient days are utilized at in-state facilities. In CY ‘09, only 69.1% of all inpatient days were at the Big 8 providers.

**Discharge Delay; Solnit Cases**

**Solnit IPF Percent of Days Delayed, Youth (0-18) HUSKY Members**

<table>
<thead>
<tr>
<th>CY ‘08</th>
<th>CY ‘09</th>
<th>CY ‘10</th>
<th>CY ‘11</th>
<th>CY ‘12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Youth</td>
<td>42.1%</td>
<td>21.7%</td>
<td>36.7%</td>
<td>17.0%</td>
</tr>
</tbody>
</table>

Solnit has experienced a similar decrease in discharge delay, although to a greater magnitude. After the significant increase of 69.1% from CY ‘09 to CY ‘10, the percent of discharge delay days has tapered, decreasing by 66.8% between CY ‘10 and CY ‘12.

**D. Inpatient Detox (IPD)**

**Adult IPD Hospital**
In 2011, HUSKY D and HUSKY C (ABD Single) had the highest days/1,000 in hospital-based detox programs, far exceeding the days/1,000 for other benefit groups. During CY '12, although HUSKY D and HUSKY C (ABD Single) continue to have the highest days/1,000, the difference between benefit groups has been noticeably reduced. Overall, there has been a great decrease in days/1,000 because fewer and fewer HUSKY D and HUSKY C (ABD Single) members are utilizing this level of care.

The previously reported decline in admissions to hospital-based detox continued throughout CY '12. This trend, we believe, is related to our continuous efforts to authorize hospital-based detox only for those members who require medical management during their detox. In the last year and a half, we have worked diligently to
educate providers about the distinction between detox levels of care 4.2 (hospital based detox) and 3.7 (free standing detox), and that we require evidence of medical risk factors to authorize a 4.2 detox level of care. It appears that our efforts, along with the cooperation from detox providers, have made a significant impact on the use of detox in a hospital setting. It will be important to work with CHN to evaluate the utilization of inpatient detox within the medical ASO to affirm a system change in the utilization of this level of care and to work collaboratively to continue to shape the system around this issue.

The average length of stay for all Medicaid members who received detox in a hospital setting was 4.58 days in Q4 ‘12 and 4.54 days for the calendar year. The ALOS in 2012 for hospital-based detox is about half a day longer than free standing detox programs. When members with co-morbidities present for detox, providers must evaluate, monitor and, at times, treat medical conditions; often lengthening the time it takes to ensure a safe detox. ALOS for detox in hospital-based programs has fluctuated, but this fluctuation has appeared more pronounced in the last year. Because there are so few admissions to this level of care, outlier cases will have a greater effect on the variance of the ALOS. Overall, however, the actual variance is not large. Less than a day separates the longest ALOS (Q2 ‘11 at 4.89 days) and the shortest ALOS (Q2 ‘12 at 3.98 days) during the seven quarters reported.
Adult IPD Free Standing

The days/1,000 at free standing detox facilities has remained relatively stable quarter to quarter, for each benefit group. HUSKY D members consistently have the highest days/1,000 each quarter, though there does appear to be an overall decreasing trend both among the HUSKY D eligibility group, as well as the system as a whole. When Q2 ‘11 is compared to Q4 ‘12, there has been a 19% decrease in days/1,000 for HUSKY D members and an overall 9.6% reduction in days/1,000 for all benefit groups. We will continue to monitor this measure for trending purposes.
Overall, admits/1,000 to free standing detox programs have continued to remain relatively stable. Each quarter, there are approximately 2,200 Medicaid members admitted to free standing detox programs. During CY ’12, HUSKY D consistently had the highest number of admits/1,000, utilizing detox at a higher rate than all other benefit groups combined. As with Q4 ’11, Q4 ’12 had the fewest admissions over the course of CY ’12 for HUSKY D members. Additionally, over the seven reported quarters there appears to be an overall decrease in admits/1,000 for HUSKY D. This trend is likely more an artifact of increases in HUSKY D membership, rather than changes in the number of member’s admitted from that eligibility group. HUSKY D membership has increased nearly 20% from Q2 ’11 (86,622) to Q4 ’12 (103,533).
The average length of stay at free standing detox programs for all benefit groups was 4.04 days in Q4 '12 and 4.07 days for the calendar year. Average length of stay at free standing detox programs remains consistent quarter to quarter.

E. Psychiatric Residential Treatment Facility (PRTF)

Because of the overall small number of youth accessing this level of care, admits/1,000 is not reported for PRTF. As with Solnit Center, the concern is that any trends in admission numbers would not be captured in an admits/1,000 measure because of the small number of utilizers relative to the overall population size.
The PRTF days/1,000 for all youth has steadily decreased since CY ‘08, continuing through the end of CY ‘12, representing a total decrease of 36.8% over the past five years. In the past year alone, the PRTF Days/1,000 decreased 23.7% (6.11 to 4.66). In CY ‘08, youth utilized over 27,000 PRTF bed days while in CY ‘12 that number decreased to just under 16,000 days. Bed days during calendar years 2009, 2010 and 2011 were fairly consistent and hovered around 20,000 bed days per year, yet during these years days/1,000 continued drop. Much like Solnit Center, this decreasing days/1,000 trend is due in part to increases in youth membership, but also decreases in the overall PRTF bed days utilized during the calendar year.

Similar to the decrease shown in days/1,000 for PRTF youth, there has also been a decrease in the ALOS for youth in PRTF. From CY ‘08 through CY ‘12, the ALOS has decreased from 276.2 days to 147.4 days (a decline of 46.6%). After a pronounced decrease in ALOS from CY ‘08 to CY ‘09, ALOS once again began declining in CY ‘10. Most recently, the ALOS for CY ‘11 to CY ‘12 decreased by 2.5%.
Overall, the data illustrate a decrease in both days/1,000 and ALOS in the PRTF level of care. The most recent reduction in days/1,000 and ALOS may be a result of the various initiatives implemented by DCF to decrease the reliance on congregate care and improve coordination of care to meet children’s clinical needs within the home and community-based programs. To further this goal, ValueOptions intensive care managers continue to partner with DCF and PRTF providers to coordinate appropriate discharge planning.

Residential Treatment Centers (RTC)

Residential admissions (in-state and out-of-state combined) have been trending downward over the past five years. RTC admits decreased 8.8% from CY ’11 to CY ’12 (486 vs. 443) and decreased 39.6% from CY ’08 to CY ’12 (734 vs. 443). These rates are in alignment with the DCF strategy to decrease utilization of congregate care and to return youth to treatment in the community.

<table>
<thead>
<tr>
<th>Year</th>
<th>In-State</th>
<th>Out-of-State</th>
</tr>
</thead>
<tbody>
<tr>
<td>CY ’08</td>
<td>69.9%</td>
<td>30.1%</td>
</tr>
<tr>
<td>CY ’09</td>
<td>62.5%</td>
<td>37.5%</td>
</tr>
<tr>
<td>CY ’10</td>
<td>57.5%</td>
<td>42.5%</td>
</tr>
<tr>
<td>CY ’11</td>
<td>76.3%</td>
<td>23.7%</td>
</tr>
<tr>
<td>CY ’12</td>
<td>92.3%</td>
<td>7.7%</td>
</tr>
</tbody>
</table>

The percent of out-of-state (OOS) admissions to RTCs has decreased for the second consecutive year. The reduction in OOS admission volume is likely attributed to swift efforts by DCF in implementing policy changes focused on treating fewer youth at out-of-state RTCs and treating youth closer to home.
In-state ALOS continued to decrease in CY ‘12, with a 9.4% reduction from CY ‘11. For OOS RTCs, ALOS increased 27.7% in CY ‘12 when compared to CY ‘11. OOS ALOS continues to be much higher than in-state ALOS (640.13 vs. 253.26 days). The longer lengths of stay seen at OOS facilities are likely a result of in-state RTCs not being equipped to handle the acuity of the population that is treated OOS.

As a result of Commissioner Katz’s clear policies related to use of congregate care, there has been a re-commitment of effort by DCF and CT BHP to utilize all possible treatment options before making referrals to congregate care. Therefore, fewer CT children are receiving treatment in congregate care settings (in-state and out-of-state). The children who are being referred to programs out-of-state have very complex needs which impact the out-of-state average length of stay.

F. Day Treatment Programs Partial Hospital Programs (PHP), Intensive Outpatient Programs (IOP) and EDT

PHP
Since CY '08, youth PHP admits/1,000 has shown little variation from year to year.

Adult PHP data reflect very little change across quarters for any benefit group. There were 970 adult admissions to PHP during Q4 '12, a slight decrease when compared to all other quarters in CY '12. This number is similar, however, to the number of admissions occurring during the fourth quarter of 2011.

<table>
<thead>
<tr>
<th>Benefit Group</th>
<th>Q3 '11</th>
<th>Q4 '11</th>
<th>Q1 '12</th>
<th>Q2 '12</th>
<th>Q3 '12</th>
<th>Q4 '12</th>
</tr>
</thead>
<tbody>
<tr>
<td>CTOAK</td>
<td>0.18</td>
<td>0.26</td>
<td>0.14</td>
<td>0.10</td>
<td>0.27</td>
<td>0.11</td>
</tr>
<tr>
<td>HUSKY A (Family Dual)</td>
<td>0.23</td>
<td>0.28</td>
<td>0.28</td>
<td>0.61</td>
<td>0.54</td>
<td>0.20</td>
</tr>
<tr>
<td>HUSKY A (Family Single)</td>
<td>0.37</td>
<td>0.36</td>
<td>0.43</td>
<td>0.35</td>
<td>0.38</td>
<td>0.34</td>
</tr>
<tr>
<td>HUSKY B</td>
<td>0.39</td>
<td>0.41</td>
<td>0.00</td>
<td>0.43</td>
<td>0.00</td>
<td>0.44</td>
</tr>
<tr>
<td>HUSKY C (ABD Dual)</td>
<td>0.17</td>
<td>0.26</td>
<td>0.22</td>
<td>0.26</td>
<td>0.22</td>
<td>0.15</td>
</tr>
<tr>
<td>HUSKY C (ABD Single)</td>
<td>1.42</td>
<td>1.43</td>
<td>1.61</td>
<td>1.68</td>
<td>1.58</td>
<td>1.28</td>
</tr>
<tr>
<td>HUSKY C (LTC Dual)</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>HUSKY C (LTC Single)</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>HUSKY D (MLIA)</td>
<td>2.72</td>
<td>2.40</td>
<td>2.67</td>
<td>2.51</td>
<td>2.47</td>
<td>2.29</td>
</tr>
<tr>
<td>All Benefit Groups</td>
<td>0.96</td>
<td>0.90</td>
<td>1.02</td>
<td>0.97</td>
<td>0.98</td>
<td>0.87</td>
</tr>
</tbody>
</table>

*Benefit groups with less than 100 admits were excluded from graphing.
Since CY '08, intensive outpatient (IOP) admits/1,000 has remained consistent for the youth population.

**IOP Admits/1,000; All Youth (0-17)**

CY '08-Q1 '11: HUSKY A, HUSKY B, D05  Q2 '11 - To Date : All Membership

<table>
<thead>
<tr>
<th>Year</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td># of Admits/1,000</td>
<td>1,781</td>
<td>1,915</td>
<td>2,101</td>
<td>2,077</td>
<td>1,998</td>
</tr>
</tbody>
</table>

Numbers above each bar represent the number of admissions for that time period.

---

**IOP Admits/1,000; Adults (18+)**

Q3 '11-To Date: All Membership

<table>
<thead>
<tr>
<th>Year</th>
<th>Q3 '11</th>
<th>Q4 '11</th>
<th>Q1 '12</th>
<th>Q2 '12</th>
<th>Q3 '12</th>
<th>Q4 '12</th>
</tr>
</thead>
<tbody>
<tr>
<td># of Admits/1,000</td>
<td>MLIA</td>
<td>HUSKY A (Family Dual)</td>
<td>HUSKY A (Family Single)</td>
<td>HUSKY B</td>
<td>HUSKY C (ABD Dual)</td>
<td>HUSKY C (ABD Single)</td>
</tr>
<tr>
<td>--------</td>
<td>-------</td>
<td>----------------------</td>
<td>--------------------</td>
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<td>-------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>CTOAK</td>
<td>0.71</td>
<td>0.56</td>
<td>0.66</td>
<td>0.55</td>
<td>0.69</td>
<td>0.33</td>
</tr>
<tr>
<td>HUSKY A (Family Dual)</td>
<td>1.52</td>
<td>0.99</td>
<td>1.61</td>
<td>1.56</td>
<td>1.96</td>
<td>1.54</td>
</tr>
<tr>
<td>HUSKY A (Family Single)</td>
<td>1.39</td>
<td>1.35</td>
<td>1.47</td>
<td>1.44</td>
<td>1.47</td>
<td>1.26</td>
</tr>
<tr>
<td>HUSKY B</td>
<td>1.96</td>
<td>1.22</td>
<td>1.26</td>
<td>1.29</td>
<td>1.77</td>
<td>1.32</td>
</tr>
<tr>
<td>HUSKY C (ABD Dual)</td>
<td>1.04</td>
<td>0.95</td>
<td>1.01</td>
<td>0.94</td>
<td>1.02</td>
<td>1.00</td>
</tr>
<tr>
<td>HUSKY C (ABD Single)</td>
<td>4.06</td>
<td>4.01</td>
<td>4.18</td>
<td>4.20</td>
<td>4.04</td>
<td>4.11</td>
</tr>
<tr>
<td>HUSKY C (LTC Dual)</td>
<td>0.00</td>
<td>0.02</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>HUSKY C (LTC Single)</td>
<td>0.19</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>HUSKY D (MLIA)</td>
<td>8.84</td>
<td>8.14</td>
<td>8.76</td>
<td>8.15</td>
<td>8.01</td>
<td>7.73</td>
</tr>
<tr>
<td>All Benefit Groups</td>
<td>3.24</td>
<td>3.04</td>
<td>3.33</td>
<td>3.19</td>
<td>3.22</td>
<td>3.06</td>
</tr>
</tbody>
</table>

*Benefit groups with less than 100 admits were excluded from graphing.
HUSKY D members continue to utilize IOP at the highest rate, followed by HUSKY C (ABD Single), HUSKY A (Family Single), and HUSKY C (ABD Dual). Admissions have remained relatively flat over the past year for all benefit groups combined, with little variation for any particular eligibility group.

**EDT**

Extended day treatment (EDT) admits/1,000 for youth remained consistent from CY ‘08 through CY ‘12.

**G. Home based Services (IICAPS, MDFT, MST, FFT Total) and Home Health**

Admits/1,000 for all home based services, as well as the volume of youth served has been gradually increasing since CY ‘08. From CY ‘08 to CY ‘12, there has been a 48.4% increase in admits/1,000 and an 86.4% increase in the volume of admissions.
Because IICAPS accounts for the largest majority of in-home services for youth, that level of care is analyzed separately below.

IICAPS admits/1,000 has increased year to year since CY ’08. However, the rate of increase is slowing. From CY ’11 to CY ’12, admits/1,000 increased by 5.1%. This is smaller than the rate of increase seen from CY ’09 to CY ’10 and also from CY ’10 to CY ’11 (with a 23.3% and a 11.3% increase, respectively).

H. Home Health

Home Health (SNV) Admits/1,000; Adults (18+)

* Benefit groups with less than 40 admits are excluded from graphing
** In Q2 and Q3 ’11, admits/1,000 included all existing auths transferred from DSS. For Q4 ’11 and forward, admits/1,000 includes new admissions to home health.
Given that admits/1,000 reflects only first-time authorizations and that the majority of home health utilizers are in treatment for an extended period of time, this indicator is not particularly useful in describing utilization management efforts with this level of care. It is likely that this indicator will have minor fluctuations in the future, barring a significant change in the number of home health providers or significant changes in practice patterns. As of Q4 '12, most members receiving home health services have existing authorizations with VO so any new authorizations will come from new members receiving the services for the first time or from members who change service providers.

A future source of increased admissions to home health services will be created by the elimination of the “standard benefit” in 2013. Historically, standard benefit-level services did not require either an initial or ongoing authorization. With the elimination of the standard benefit, these services now will require authorization, thereby increasing the admits/1,000, at least until current standard benefit members are registered. Once that registration has occurred, it is expected that admits/1,000 would decrease similar to the overall pattern seen since Q2 '11. At the last examination, it appeared that there were more members on standard benefit than were receiving services that required an authorization.

Because admits/1,000 is not particularly useful in describing utilization management efforts, a detailed, claims-based review of the frequencies of medication administration service utilization has been conducted. Medication administration services have been the focus of considerable utilization management activity, with the intention of ensuring that members receive only services that are medically necessary, and that they are moving toward recovery. The UM activities have been directed at reducing high-frequency services, when possible, and assisting in moving members toward greater autonomy. The following analysis is based on claims data for medication administration services. Because this analysis is claims-based and to allow for a claims lag, Q2 '12 is the most recent period for which data are available.

From Q1 '11 to Q2 '12, the number of members receiving home health services rose by 4.3% (4,617 to 4,815). During this same period, however, there has been a 15.4% decrease in the percentage of members receiving twice daily (B.I.D.) medication administration services (from 25.9% of members in Q1 '11 to 21.9% of members in Q2 '12). (A B.I.D. member is defined as “a member who received 10 or more medication administration services in a week for 10 or more weeks in a quarter”.) Once daily (Q.D.) medication administration visits increased by 16.3% during this same period (from 29.5% in Q1 '11 to 34.3% in Q2 '12). (A Q.D. member is defined as “any member who receives between five and seven medication administration services in a week, for 10 or
more weeks in a quarter"). This change was anticipated as providers responded to the
intensive work by clinical care managers and the utilization management strategies to
focus services on recovery principles.
For completeness, results for all service frequencies are shown in the table below.
Members in the “Between” category are those that do not meet the B.I.D. or Q.D. criteria
but whose average number of visits per week is greater than 7. Members in the “Lower”
category average 7 or less medication administration visits per week and do not meet
the Q.D. criteria.

<table>
<thead>
<tr>
<th></th>
<th>Members Served</th>
<th>% at BID</th>
<th>% Between</th>
<th>% at QD</th>
<th>% Lower</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 ‘11</td>
<td>4,617</td>
<td>25.9</td>
<td>10.1</td>
<td>29.5</td>
<td>34.4</td>
</tr>
<tr>
<td>Q2 ‘11</td>
<td>4,761</td>
<td>24.7</td>
<td>9.8</td>
<td>31.7</td>
<td>33.9</td>
</tr>
<tr>
<td>Q3 ‘11</td>
<td>4,754</td>
<td>23.3</td>
<td>10.1</td>
<td>30.9</td>
<td>35.7</td>
</tr>
<tr>
<td>Q4 ‘11</td>
<td>4,724</td>
<td>21.7</td>
<td>9.9</td>
<td>31.9</td>
<td>36.5</td>
</tr>
<tr>
<td>Q1 ‘12</td>
<td>4,833</td>
<td>21.2</td>
<td>10.3</td>
<td>33.0</td>
<td>35.4</td>
</tr>
<tr>
<td>Q2 ‘12</td>
<td>4,815</td>
<td>21.9</td>
<td>9.1</td>
<td>34.3</td>
<td>34.7</td>
</tr>
<tr>
<td>Change between Q1 ‘11 and Q2 ’12</td>
<td>4.29%</td>
<td>-15.44%</td>
<td>-9.90%</td>
<td>16.27%</td>
<td>0.87%</td>
</tr>
</tbody>
</table>

From Q1 ‘12 to Q2 ’12 there was a slight increase (0.7%) in the number of members
receiving twice daily (B.I.D.) medication administration. During that same time period
members receiving daily medication administration increased by 1.3%. There was a
decrease of members receiving between B.I.D. and daily medication administration by
1.2% and members receiving lower than daily by 0.3%. The slight increase in B.I.D.
medication administration utilization is reflective of increased utilization on the part of
approximately 11.7% (6 of 51) of the home health care providers. These identified
providers are receiving more intensive review and education by the clinical care
managers.

Future analyses are planned to determine any relationship between reduction in
Medication administration frequency, re-hospitalization rates, and connection to other
community services for members. To this end, we have initiated a peer pilot program
with our largest provider and have designated a Regional Network Manager to the home
health program to improve care coordination between home care agencies and other
levels of care.
I. Ambulatory Detox (AMD)

The actual number of admissions for ambulatory detoxification remains relatively small, but the admits/1,000 continue to rise for all benefit groups. In fact, actual admissions for all benefit groups have more than doubled from the inception of data collection. As expected, HUSKY D members have consistently had the greatest number of admissions, followed by HUSKY A (Family Single). This level of care has been underutilized for the population and the goal is to increase utilization by viewing ambulatory detox as an alternative to inpatient detox when clinically appropriate.

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**AMD Admits/1,000; Adults (18+)**

Q3 '11-To Date: All Membership

*Benefit groups with less than 20 admits are excluded from graphing.*

<table>
<thead>
<tr>
<th>Admits/1,000</th>
<th>Q3 '11</th>
<th>Q4 '11</th>
<th>Q1 '12</th>
<th>Q2 '12</th>
<th>Q3 '12</th>
<th>Q4 '12</th>
<th>Number of Admits</th>
<th>Q3 '11</th>
<th>Q4 '11</th>
<th>Q1 '12</th>
<th>Q2 '12</th>
<th>Q3 '12</th>
<th>Q4 '12</th>
</tr>
</thead>
<tbody>
<tr>
<td>CTOAK</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>HUSKY A (Family Dual)</td>
<td>0.15</td>
<td>0.07</td>
<td>0.28</td>
<td>0.00</td>
<td>0.27</td>
<td>0.13</td>
<td>HUSKY A (Family Dual)</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>-</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>HUSKY A (Family Single)</td>
<td>0.05</td>
<td>0.05</td>
<td>0.05</td>
<td>0.10</td>
<td>0.08</td>
<td>0.08</td>
<td>HUSKY A (Family Single)</td>
<td>24</td>
<td>23</td>
<td>26</td>
<td>47</td>
<td>41</td>
<td>39</td>
</tr>
<tr>
<td>HUSKY B</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
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<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>HUSKY B</td>
<td>0.01</td>
<td>0.03</td>
<td>0.04</td>
<td>0.03</td>
<td>0.01</td>
<td>0.07</td>
<td>HUSKY C (ABD Dual)</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>5</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>HUSKY C (ABD Single)</td>
<td>0.06</td>
<td>0.00</td>
<td>0.07</td>
<td>0.08</td>
<td>0.11</td>
<td>0.13</td>
<td>HUSKY C (ABD Single)</td>
<td>6</td>
<td>-</td>
<td>7</td>
<td>7</td>
<td>10</td>
<td>12</td>
</tr>
<tr>
<td>HUSKY C (LTC Dual)</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>HUSKY C (LTC Dual)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>HUSKY C (LTC Single)</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>HUSKY C (LTC Single)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>HUSKY D (MLIA)</td>
<td>0.26</td>
<td>0.24</td>
<td>0.30</td>
<td>0.40</td>
<td>0.42</td>
<td>0.49</td>
<td>HUSKY D (MLIA)</td>
<td>66</td>
<td>62</td>
<td>80</td>
<td>111</td>
<td>121</td>
<td>141</td>
</tr>
<tr>
<td>All Benefit Groups</td>
<td>0.11</td>
<td>0.15</td>
<td>0.16</td>
<td>0.18</td>
<td>-</td>
<td>-</td>
<td>All Benefit Groups</td>
<td>100</td>
<td>90</td>
<td>123</td>
<td>170</td>
<td>178</td>
<td>204</td>
</tr>
</tbody>
</table>

The actual number of admissions for ambulatory detoxification remains relatively small, but the admits/1,000 continue to rise for all benefit groups. In fact, actual admissions for all benefit groups have more than doubled from the inception of data collection. As expected, HUSKY D members have consistently had the greatest number of admissions, followed by HUSKY A (Family Single). This level of care has been underutilized for the population and the goal is to increase utilization by viewing ambulatory detox as an alternative to inpatient detox when clinically appropriate.
HUSKY D consistently has the greatest number of methadone maintenance admissions, followed by HUSKY C (ABD Single), and HUSKY A (Family Single). Admits/1,000 decreased from Q3 ‘12 to Q4 ‘12 for all graphed benefit groups, and in Q4 ‘12 admits/1,000 is lower than the rate recorded in previous quarters when all benefit groups are combined (0.89 admits/1,000). The overall trend shows a slight decrease in admits over time.
K. Outpatient (OTP/TST)

Outpatient admissions for youth increased 8.5% in CY ‘12 over CY ‘11 (27,087 vs. 24,959). Admits/1,000 for youth members to outpatient care has increased gradually since CY ‘08.

During each quarter of CY ‘12, approximately two-thirds of all youth registered for outpatient services received outpatient treatment at free-standing clinics. Treatment with independent practitioners accounted for the remaining one-third of all youth outpatient treatment. Few youth received outpatient treatment in the hospital setting (only between 4.0% - 5.0% during each quarter of CY ‘12).
Between 2011 and 2012, utilization data related to adult outpatient registration of service were unremarkable, revealing no significant changes.

Similar to the youth population, approximately two-thirds of all adults received outpatient treatment at free-standing clinics during each quarter of CY '12. However, a larger percentage of adults received outpatient services within the hospital setting (ranging from 13.3% - 14.7% of cases during each quarter of CY '12).

**Outpatient: ECC vs. Non-ECC**

The below graphs show outpatient registration information for both youth and adult populations combined and are used to measure enhanced care clinic (ECC) data. Enhanced care clinics are outpatient providers who receive an enhanced payment rate in exchange for meeting access standards related to the amount of time it takes for a member to be seen after an initial referral. For routine cases, members must be offered an appointment within two weeks of their first contact with the clinic. Urgent cases require two day access and emergent cases two hours.

Please note logic for the ECC/non-ECC reports differs from logic used above in the reporting of the levels of care. The ECC/non-ECC counts of outpatient registrations include only those registrations with a unique member and provider combination.
Duplicate registrations for the same member and provider are not included in these counts and in this way the number of registrations counted in this section are less than those used to calculate the outpatient admits/1,000.

Outpatient registrations for both ECC and non-ECC outpatient providers continue to increase year over year with the most noticeable increases occurring between CY '10 and CY '11 due to the increase in the adult population with the new contract. Non-ECC volume has been more than double that of ECC volume since CY '10. The ratio of total ECC outpatient registration volume in comparison to total non-ECC volume for CY '12 was approximately 1:2.5

With the exception of two hospital ECC’s, the remainder of enhanced care clinics are categorized as free-standing clinics (FSC). In the above graph, those free-standing ECC clinics are compared to non-ECC FSC’s.
Since the acquisition of the adult business in Q2 ’11, the total number of evaluations measured against the access standard remains fairly equally distributed between the ECC and non-ECC free-standing clinics (FSC). Prior to the new adult business, the volume of ECC evaluations had exceeded the volume of FSC evaluations by a greater margin.

L. Develop claims-based metrics for Goal 10 F-G if claims extract is available thru DSS.

The claims extract was not made available by DSS in 2012 so claims-based metrics have not been developed.

M. Ongoing evaluation of use of Data Warehouse meeting to provide oversight of claims-based reporting and to identify changes in DSS claims data.

The data warehouse meeting was not used in 2012 to provide oversight of the claims – based reporting as the claims file was not available. The meeting was used to support the development of the methodology for several of the performance targets and clinical studies.

Recommendations for continuing sub-Goal in 2013:
This sub-goal continues to be applicable for 2013 and should be included in the 2013 Project Plan.

Goal 11. Monitor timeliness of UM decisions; identify barriers and opportunities (Contract Reference F.6, T.2 and Exhibit E)

Description of Activities and Findings that include trending and analysis of the measures to assess performance:

Overall turn-around time (TAT) for higher levels of care, both with and without peer review, was met well within the performance standards. For initial reviews, 29,526 of 29,535 (99.97%) were completed with the target time. For concurrent authorizations, 33,911 of 33,924 (99.96%) decisions were rendered within standards.

For lower levels of care, the results were even stronger. Overall TAT for initial reviews, both with and without peer review, was met at 100% (2,727 of 2,727 decisions). Overall, TAT for concurrent authorizations were met at 99.97% (11,668 of 11,672 decisions).

A. Initial decisions re: authorization for acute levels of care (LOC) (Gen Hosp, Inpatient Psych, IP Detox, Resi Detox, PHP, IOP, Intermediate Duration Acute Psychiatric Care, Psychiatric Resi Treatment and Crisis Stab ); communication within 60 minutes:

In 2012, UM decisions not requiring a peer review met the TAT goal of 60 minutes for 29,326 of 29,333 (99.98%) of the decisions.

B. Initial decisions regarding authorization for non-acute levels of care within 1 business day:
In 2012, UM decisions not requiring a peer review met the TAT of 1 business day for 2,710 of 2,710 cases (100%).

C. Concurrent decision within 60 minutes of the date the authorization expires for acute LOC:

In 2012, UM decisions not requiring a peer review met the TAT goal of 60 minutes in 33,776 out of 33,789 (99.96%) cases.

D. Concurrent decisions re: authorizations for non-acute LOC within 2 business days of request:

In 2012, UM decisions not requiring a peer review met the TAT goal (2 Business days) for 11,634 of 11,636 decisions (99.98%).

E. For IP Psych, offer an appointment for peer to peer review within 60 minutes of completion of CM review

In 2012, for TAT decisions requiring a peer review within 120 minutes, all 77 decisions met the standard.

F. For IP Detox, offer an appointment for peer to peer review within 120 minutes of completion of CM review

Of the 116 decisions in 2012 that required a peer review within 180 minutes, 114 (98.28%) met the standard.

G. 98% of all authorization decisions result in a letter being available within 48 hours

In order to monitor this process, a quarterly audit is conducted of a sample of authorizations in ProviderConnect to assure that letters are available. The audit found that 100% of the authorizations audited resulted in an authorization letter being available within 48 hours of the authorization being created.

H. 98% of all batch extracts of authorization notifications created will be delivered to the vendor, who creates and mails letters, within 2 business days

Batch extracts of authorization notifications are only occurring when authorizations are created for out of state providers. The extract has been delivered to the vendor 99.97% of the time within 2 business days.
I. **Total number of Administrative Denials Issued**

The total number of administrative denials continues to increase since CY '08. The total number of administrative denials increased by 22.5% from CY '11 (2,513) to CY '12 (3,079). While the number of administrative denials issued for youth decreased by 21.1% from CY '11 (779) to CY '12 (615), the number of administrative denials issued for adults increased by 42.1% from CY '11 (1,734) to CY '12 (2,464). While there was a large increase in administrative denials issued for adults from CY '11 to CY '12, a true comparison between the two years cannot be made. In CY '11, the acquisition of the adult business occurred in Q2, which does not capture the full picture of the number of administrative denials for the full year as CY '12 does. Comparison from CY '12 to CY '13 will be more meaningful.

Overall, administratively denied requests for home health services accounted for the majority of all administrative denials, 29.1% (897 of 3,079). Of the 897 home health administrative denials, 82.1% (736 of 897) were service requests that should have been made of the medical ASO. Non-timely requests for outpatient services accounted for the second most administrative denials, 26.7% (821 of 3,079), while non-timely requests for intensive outpatient was third with 19.2% (590 of 3,079) of all administrative denials.

The majority of administrative denials of services for youth members were for non-timely requests for outpatient services, 44.6% (274 of 615). Similarly, administratively denied non-timely requests for intensive outpatient accounted for 15.1% (93 of 615).

Administratively denied non-timely requests for home health agency services accounted for 36.2% (892 of 2,464) of all administrative denials issued to providers for adult members. Administratively denied non-timely requests for outpatient accounted for 22.2% (547 of 2,464), while non-timely requests for intensive outpatient accounted for 20.2% (497 of 2,464).

The primary reason administrative denials were issued to providers in CY '12 was due to providers not following the appropriate concurrent review procedures; this accounted for 41.6% of all administrative denials (1,281 of 3,079), 50.6% of denials (311 of 615) issued to providers for youth members, and 39.4% of denials (970 of 2,464) issued to providers for adult members.
J. Medical Necessity Denials

The total number of medical necessity denials increased by 50.9% from CY ’11 (216) to CY ’12 (326). The number of medical necessity denials issued for adults increased by 82.3% from CY ’11 (164) to CY ’12 (299). The number of medical necessity denials issued for youth continues to decrease, most recently by 48.1% from CY ’11 (52) to CY ’12 (27). Since CY ’08 (131), the number of medical necessity denials issued for youth decreased by 79.4% to CY ’12 (27).

The majority of medical necessity denials for the youth population continue to be for requests for inpatient treatment; 74.1% (20 of 27). The most frequently denied level of care for the adult population in CY ’12 resulted from requests for inpatient detox stays, 37.5% (112 of 299).

K. Number and % of Notices of Action (NOAs) and denials issued within 3 business day of decision

In CY ’12, 3,079 administrative denial notifications were sent out and 3,077, 99.9%, were compliant with TAT standards. In CY ’12, 326 medical necessity denials notifications were issued and 100.0% were compliant with TAT standards.

There were 3,405 total denials, administrative and medical necessity, of which 3,403, 99.9%, were compliant with TAT standards.

Recommendations for continuing sub-Goal in 2013:
This sub-goal continues to be applicable for 2013 and should be included in the 2013 Project Plan.


Activities and Findings that include trending and analysis of the measures to assess performance:
A-O. Member Medical Necessity Appeals:

There were five (5) Expedited Level I member appeals for calendar year 2012, all of which were from adult members.
- Two (2) of the expedited appeals were overturned.
- All five (5) requests were resolved within the TAT standard.
- Of the five (5) Expedited Level I Member appeals, two (2) requested a Level II External Appeal-Administrative Hearing. The results of the External Appeal hearings were as follows:
  - One (1) member did not show to the hearing.
  - One (1) was withdrawn from the hearing.

There were three (3) Routine Level I member appeals for calendar year 2012, all of which were for adult members.
- None of the routine appeals were overturned.
- All three (3) requests were resolved within the TAT standard.
- All three (3) Routine Level I member appeals requested a Level II External Appeal-Administrative Hearing. The results of the External Appeal hearings were as follows:
  - Two of the members did not show for the hearing.
  - One was overturned from the hearing.

A total of eight (8) member appeals were received in 2012; all were processed and had determinations made within the required timeframe meeting the standard at 100%.

P. Provider Medical Necessity Appeals:

Provider Medical Necessity Appeals – Level I:

<table>
<thead>
<tr>
<th>Year</th>
<th>% of Appeals</th>
<th>Total Appeal Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>CY ’09</td>
<td>30</td>
<td>24.0%</td>
</tr>
<tr>
<td>CY ’10</td>
<td>18</td>
<td>15.7%</td>
</tr>
<tr>
<td>CY ’11</td>
<td>35</td>
<td>15.8%</td>
</tr>
<tr>
<td>CY ’12</td>
<td></td>
<td>44.8%</td>
</tr>
</tbody>
</table>

Q2 ’11 was the start of the new adult business
Q1 ’12 change in Youth category’s age from (0-18) to (0-17) and Adult category’s age from (19+) to (18+)
The total number of medical necessity appeals and the medical necessity appeal rate increased by over 100% from CY '11 to CY '12. In CY '11 there were 35 appeals with an appeal rate of 15.8%, while in CY '12 there were 146 appeals with an appeal rate of 44.8%. These findings result from an increase in denials of services and a commensurate increase in providers taking advantage of their right to appeal denial decisions. There has been improved verbal communication of the appeal process to providers who have received a denial at the time of denial. Often, providers are immediately transferred to the appeal department so that the process of appeal can be initiated. As a result, communication regarding the appeal process occurs at the time of the denial as well as in written communication to providers and members.

The increase in the rate of appeal was seen for both denials associated with treatment of adults and youth. The provider level 1 appeal rate for adults increased by 60.1% from CY ’11 (20.8%) to CY ’12 (33.3%), and for adults by over 100% from CY ’11 (14.3%) to CY ’12 (45.8%).

**Provider Medical Necessity Appeals – Level I Overturn Rates:**

<table>
<thead>
<tr>
<th>Year</th>
<th>Youth</th>
<th>Adult</th>
</tr>
</thead>
<tbody>
<tr>
<td>CY '09</td>
<td>19</td>
<td>34.4%</td>
</tr>
<tr>
<td>CY '10</td>
<td>16</td>
<td>5.9%</td>
</tr>
<tr>
<td>CY '11</td>
<td>11</td>
<td>14.3%</td>
</tr>
<tr>
<td>CY '12</td>
<td>24</td>
<td>45.8%</td>
</tr>
</tbody>
</table>

Q2 ’11 was the start of the new adult business
Q1 ’12 change in Youth category’s age from (0-18) to (0-17) and Adult category’s age from (19+) to (18+)
While there was an increase in the appeal rate, there was a decrease in the overturn rate for these appeals. The youth overturn rate decreased from 36.4% in CY '11 to 0% in CY '12. The adult overturn rate decreased by 26.1% from CY '11 (37.5%) to CY '12 (27.7%), even though the number of overturns increased from 9 in CY '11 to 38 in CY '12. This is due to the increase in the number of appeals from CY '11 (35) to CY '12 (146), rather than an actual increase in the number of overturns.

**Provider Medical Necessity Appeals – Level II:**

<table>
<thead>
<tr>
<th>23A: Number of Provider Appeals - Level II</th>
<th>CY '08</th>
<th>CY '09</th>
<th>CY '10</th>
<th>CY '11</th>
<th>CY '12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Youth</td>
<td>10</td>
<td>4</td>
<td>5</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Adult</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>7</td>
<td>32</td>
</tr>
<tr>
<td>Total</td>
<td>11</td>
<td>7</td>
<td>5</td>
<td>10</td>
<td>36</td>
</tr>
</tbody>
</table>

*Note: Q2 ’11 was the start of the new adult business  
Q1 ’12 change in Youth category’s age from (0-18) to (0-17) and Adult category’s age from (19+) to (18+)*

The number of Level II Provider Appeals for youth has been consistent since CY '09, while the number of Level II Provider Appeals for adults has increased since the acquisition of the adult business in Q2 ’11. This increase is more notable in CY '12 (36) compared to CY ’11 (7).

**Provider Medical Necessity Appeals – Level II Overturned Rates:**

<table>
<thead>
<tr>
<th>23A: Percent of Medical Necessity Appeals - Level II Overturned, Youth (0-17)</th>
<th>CY '08</th>
<th>CY '09</th>
<th>CY '10</th>
<th>CY '11</th>
<th>CY '12</th>
</tr>
</thead>
<tbody>
<tr>
<td># of Cases Overturned</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>% of Cases Overturned</td>
<td>10.0%</td>
<td>25.0%</td>
<td>40.0%</td>
<td>66.7%</td>
<td>0.00%</td>
</tr>
<tr>
<td>-----------------------</td>
<td>-------</td>
<td>-------</td>
<td>-------</td>
<td>-------</td>
<td>-------</td>
</tr>
</tbody>
</table>

**23A: Percent of Medical Necessity Appeals-Level II Overturned, Adults (18+)**

<table>
<thead>
<tr>
<th># of Cases Overturned</th>
<th>CY '08</th>
<th>CY '09</th>
<th>CY '10</th>
<th>CY '11</th>
<th>CY '12</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of Cases Overturned</td>
<td>9.1%</td>
<td>14.3%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>31.25%</td>
</tr>
</tbody>
</table>

*Note: Q2 ’11 was the start of the new adult business.
Q1 ’12 change in Youth category’s age from (0-18) to (0-17) and Adult category’s age from (19+) to (18+)*

After experiencing an increase in the overturn rate for Provider Appeals-Level II for youth members from CY ’08 to CY ’11, CY ’12 had no overturns for youth Provider Level II appeals. However, there were 10 Provider Level II appeals for adults that were overturned, resulting in a 31.25% overturn rate.

Notices of the determination for all Level I Medical Necessity Appeals were mailed within 2 business days of the determination 100% of the time. Notices of the determination for the all Level II Medical Necessity Appeals were sent out within 5 business days of receipt of information necessary to make a determination 100% of the time.

**Q-S. Administrative Appeals:**

**Number of Administrative Appeals:**

<table>
<thead>
<tr>
<th>Total Administrative Appeal Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>CY '09</td>
</tr>
<tr>
<td>285</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>% of Appeals</th>
</tr>
</thead>
<tbody>
<tr>
<td>CY '09</td>
</tr>
<tr>
<td>49.3%</td>
</tr>
</tbody>
</table>

*Q2 ’11 was the start of the new adult business.
Q1 ’12 change in Youth category’s age from (0-18) to (0-17) and Adult category’s age from (19+) to (18+)*

The overall administrative appeal rate in CY ’12 has been consistent with the previous two (2) calendar years. While the total number of administrative appeals has increased
over the same time frame, the rate has stayed the same due to the larger increase of administrative denials issued. From CY ’11 to CY ’12 the number of administrative denials increased by 9.9%, but the appeal rate decreased by 10.5%. This is due to the number of denials increasing at a larger rate, 2,513 in CY ’11 to 3,079 in CY ’12.

**Administrative Appeals - Overturned Rate:**

![Total Administrative Appeal Overturn Rate](chart)

Q2 ’11 was the start of the new adult business
Q1 ’12 change in Youth category’s age from (0-18) to (0-17) and Adult category’s age from (19+) to (18+)

After the overall administrative overturn rate increased in CY ’11 to 35.6%, CY ’12 decreased by 15.5%, down to 30.1%. The total number of administrative appeals that were overturned also decreased, by 6.9% from CY ’11 (290) to CY ’12 (270).

100% of the appeals had determinations made and notices sent out within 7 days of receipt of the appeal.

**Recommendations for continuing sub-Goal in 2013:**

This sub-goal continues to be applicable for 2013 and should be included in the 2013 Project Plan.

**Goal 13. Monitor consistency of application of UM Criteria (IRR) and adequacy of documentation. (Contract Reference F.13.2)**

**Activities and Findings that include trending and analysis of the measures to assess performance:**

**A. % compliance with clinical inter-rater reliability (IRR) audit**

Annually, the CT BHP service center participates in the company-wide IRR audit. This IRR audit consists of 20 clinical vignettes, each of which the clinicians must determine the appropriate level of care. For the past year, 100% of our clinical staff passed the IRR examination, with an average score of 93.3%. The average score remained consistent with last year.

To address and ensure the consistency and quality of clinical decisions, clinicians meet in rounds on a weekly basis to review high risk cases. These rounds, conducted by
CTBHP Medical Directors and Supervisors, provide case managers with immediate feedback regarding the accuracy of their use of the UM Criteria. The feedback obtained in rounds is supplemented by the frequent feedback from documentation audits. The audits provide an assessment of whether the documentation in the case supports medical necessity.

B. Assess adequacy and accuracy of clinical documentation

Following the challenges that were experienced with the audit process in 2011, 2012 brought positive adaptation to both the process as well as the scoring of the tool. By the end of Q1 ’12, the audit tool was modified to score both the thoroughness of documentation as well as the quality of the care management during the review. The process became a collaboration between the QM auditors and UM supervisors both reviewing the call and documentation jointly. This new process allowed for combined feedback to the care managers and also provided support from both departments in furthering the development of the care managers in their roles.

Continued training was provided to the clinical staff on specific standards in order to enhance the quality of care management skills. In addition, to ensure new hires receive adequate training a weekly audit using the collaborative process was implemented in the middle of Q2 ’12.

Results of the documentation audits were as follows:

<table>
<thead>
<tr>
<th></th>
<th>% Passed with 90% or better</th>
<th>Average Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q1</td>
<td>93.0%</td>
<td>95.7%</td>
</tr>
<tr>
<td>Q2</td>
<td>97.6%</td>
<td>97.2%</td>
</tr>
<tr>
<td>Q3</td>
<td>97.6%</td>
<td>97.5%</td>
</tr>
<tr>
<td>Q4</td>
<td>96.9%</td>
<td>96.1%</td>
</tr>
</tbody>
</table>

The joint audits will be continued in 2013. Audits will be conducted on a quarterly basis for clinical staff. Training opportunities will be highlighted based on results for specific standards within the audit tool.

Recommendations for continuing sub-Goal in 2013:
This sub-goal continues to be applicable for 2013 and should be included in the 2013 Project Plan.

Goal 14. Monitor continuity of care; identify barriers and opportunities (Contract Reference: I.1)

Description of Activities and Findings that include trending and analysis of the measures to assess performance:

A. Number of referrals of cases from MCOs

This indicator tracks the number and types of cases being co-managed by CT BHP and the medical ASO - CHN. Cases for co-management can be referred to CT BHP from
CHN or vice versa. There are six automatic referrals that have been in place since CY 2008 and continue to guide the referral process. High risk pregnancy due to depression and or substance abuse, post-partum depression, child/adolescent type II diabetes, sickle cell, eating disorders, and any medical detoxes make up the existing automatic referral list.

In 2012, there were 63 cases that were specifically referred to CT BHP for co-management from CHN. This is a large decrease from previous years but the referral process has changed since CHN became the medical ASO. With CHN’s contract including VO-ICM nurses, the majority of referrals are being made in-house. The VO-ICMs received 531 referrals from CHN staff. Much of the year was spent developing the relationship with CHN and clarifying the roles of the Intensive Care Managers that both CHN and VO have to support members. It was concluded that VO-ICM nurses at CHN would support the members with SPMI and Tier I medical conditions (asthma, COPD, CHF, CAD or diabetes), SPMI in combination with a Tier 2 or Tier 3 medical condition would be referred to a CHN ICM. Any member with SPMI or substance abuse and any medical condition may be co-managed at the request of either ASO.

B. Wellness Care Coordination Program implementation

The Wellness Care Coordination Program representing a partnership between ValueOptions and McKesson in which nurse care managers initiate care coordination activities with members who have co-morbid behavioral health and medical concerns.

Members continue to be selected for possible inclusion in the program based on the following criteria:

1. Members with a Behavioral Health or Substance Abuse diagnosis as a primary cost driver in claims data AND
2. Members with at least one “tier one” or “tier two” physical health condition AND
3. One or more Inpatient or ED psychiatric events in past 12 months
4. Gaps in treatment contribute to the overall risk rating
5. Overall risk ratings are 1 low, 2 medium, 3 High
6. Belong to a prioritized eligibility group
   o 70% HUSKY C
   o 20% HUSKY D
   o 5% HUSKY B & HUSKY A
   o 5% HUSKY A & Charter Oak

Tier one physical conditions include: Heart Failure, COPD, Diabetes, Asthma and Coronary Heart Disease

Tier two physical conditions include: Stroke, TIA, Chronic Kidney Disease, Cystic Fibrosis, Hepatitis B and C, Inflammatory Bowel Disease, Peripheral Vascular Disease, Sickle Cell, Migraine, Back Pain, High Cholesterol, Hypertension, Lupus, Rheumatoid Arthritis, Seizure disorder, Gastro-esophageal reflux disease, Multiple Sclerosis., and Peptic Ulcer Disease

By the end of 2012:
- 8,229 members had been identified since launch of the McKesson program.
  These members were referred to the McKesson program and proactive
enrollment calls were scheduled to provide those members with the opportunity to enroll in the care management programs.

- 801 members of the 8,229 members who were identified enrolled in the McKesson program
- 629 members had a completed assessment
- 404 members received at least one completed “monitoring” call (a counseling or educational call) which signifies that they are or were actively engaged in the McKesson care management programs at that time.
- 52.8 years is the average age of the 404 members who received at least one completed monitoring call
- 79.5% of members who received at least one completed monitoring call were Caucasian, 19.8% African American and 0.7% were Hispanic or Undefined
- 62.4% of members who received at least one completed monitoring call were female, 37.6% were male

As of 12/31/2012 the outcomes are as follows:

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Cohort</td>
<td>- 15.9% increase in members receiving flu vaccine</td>
</tr>
<tr>
<td></td>
<td>- 24.2% increase in members receiving pneumonia vaccine</td>
</tr>
<tr>
<td>Common Care</td>
<td>- 4.2% increase in those taking medications as prescribed</td>
</tr>
<tr>
<td></td>
<td>- 20.9% increase in members with blood pressure in normal range</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>- 25.0% increase in members prescribed beta blockers</td>
</tr>
<tr>
<td></td>
<td>- 30.0% increase in members prescribed ACE Inhibitors</td>
</tr>
<tr>
<td>Coronary Artery Disease</td>
<td>- 16.6% increase in those with daily ASA/antiplatelet therapy</td>
</tr>
<tr>
<td></td>
<td>- 101.4% increase in those with BP in target range</td>
</tr>
<tr>
<td></td>
<td>- 37.7% increase in those prescribed beta blockers</td>
</tr>
<tr>
<td>Diabetes</td>
<td>- 34.4% increase in those receiving an annual dilated eye exam</td>
</tr>
<tr>
<td></td>
<td>- 100.3% increase in those undergoing annual kidney function test</td>
</tr>
<tr>
<td></td>
<td>- 56.9% increase in those prescribed beta blockers</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease</td>
<td>- 16.5% increase in those recommended bronchodilator</td>
</tr>
<tr>
<td></td>
<td>- 6.2% increase in those with daily inhaled corticosteroid</td>
</tr>
<tr>
<td>Asthma</td>
<td>- 15.5% increase in those with written action plan</td>
</tr>
<tr>
<td></td>
<td>- 3.9% increase in those prescribed inhaled short-acting beta2-agonist (SABA)</td>
</tr>
<tr>
<td>Bipolar Disorder</td>
<td>- 6.3% increase in those receiving blood glucose test annually</td>
</tr>
<tr>
<td></td>
<td>- 50.0% increase in those receiving a thyroid function test biannually</td>
</tr>
<tr>
<td>Depression</td>
<td>- 22.0% increase in those with PHQ9 score within target range</td>
</tr>
<tr>
<td></td>
<td>- 31.2% increase in those prescribed an antidepressant or psychotherapy</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>- 18.2% increase in those receiving blood glucose test annually</td>
</tr>
<tr>
<td></td>
<td>- 5.9% increase in those prescribed an antipsychotic</td>
</tr>
</tbody>
</table>

**Recommendations for continuing sub-Goal in 2013:**
This sub-goal continues to be applicable for 2013 and should be included in the 2013 Project Plan.
Goal 15. Reduce Emergency Department (ED) Discharge Delays (Contract Reference: F.17)

Activities and Findings that include trending and analysis of the measures to assess performance:

A-B. Number and average length of time of youth are delayed in the ED

**Child ED Stuck CY '10 through CY '12**

<table>
<thead>
<tr>
<th>Child (0-17)</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>CY '10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total ED Stuck</td>
<td>164</td>
<td>208</td>
<td>115</td>
<td>184</td>
<td>671</td>
</tr>
<tr>
<td>ALOS</td>
<td>1.68</td>
<td>1.36</td>
<td>1.43</td>
<td>1.53</td>
<td>1.50</td>
</tr>
<tr>
<td>Q1</td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
<td>CY '11</td>
<td></td>
</tr>
<tr>
<td>Total ED Stuck</td>
<td>193</td>
<td>300</td>
<td>168</td>
<td>185</td>
<td>846</td>
</tr>
<tr>
<td>ALOS</td>
<td>1.34</td>
<td>1.72</td>
<td>1.25</td>
<td>1.48</td>
<td>1.49</td>
</tr>
<tr>
<td>Q1</td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
<td>CY '12</td>
<td></td>
</tr>
<tr>
<td>Total ED Stuck</td>
<td>315</td>
<td>290</td>
<td>151</td>
<td>219</td>
<td>975</td>
</tr>
<tr>
<td>ALOS</td>
<td>1.49</td>
<td>1.59</td>
<td>1.28</td>
<td>1.53</td>
<td>1.49</td>
</tr>
</tbody>
</table>

While there was an increase in the number of Children (0-17) that were delayed in the ED of 15.2% from CY ’11 to CY ’12 and 45.3% from CY ’10 to CY ’12, the ALOS of time delayed remained consistent year over year.

**Adult ED Stuck 04/01/2011 - 12/31/2012**

<table>
<thead>
<tr>
<th>Adult (18+)</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>CY '11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total ED Stuck</td>
<td>N/A</td>
<td>464</td>
<td>349</td>
<td>273</td>
<td>1,086</td>
</tr>
<tr>
<td>ALOS</td>
<td>N/A</td>
<td>1.30</td>
<td>1.74</td>
<td>1.78</td>
<td>1.56</td>
</tr>
<tr>
<td>Q1</td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
<td>CY '12</td>
<td></td>
</tr>
<tr>
<td>Total ED Stuck</td>
<td>371</td>
<td>325</td>
<td>253</td>
<td>191</td>
<td>1,140</td>
</tr>
<tr>
<td>ALOS</td>
<td>1.56</td>
<td>1.53</td>
<td>1.71</td>
<td>1.66</td>
<td>1.60</td>
</tr>
</tbody>
</table>

The number of Adults (18+) that were delayed in the ED decreased each quarter in CY ’12. There was a decrease of 12.4% from Q1 ’12 to Q2 ’12, a decrease of 22.2% from Q2 to Q3 and a decrease of 24.5% from Q3 ’12 to Q4 ’12. This decrease in the number of adults delayed in the ED calls into question the accuracy of the findings. Several of the EDs have been consistently non-compliant with sharing this information with ValueOptions staff while others only sporadically report adults delayed in the ED.
C. Frequency Distribution of ED Stuck Stay

<table>
<thead>
<tr>
<th>% of Members Stuck</th>
<th>0 Days</th>
<th>1 Days</th>
<th>2 Days</th>
<th>3+ Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010 LOS</td>
<td>6.42%</td>
<td>69.55%</td>
<td>12.69%</td>
<td>11.34%</td>
</tr>
<tr>
<td>2011 LOS</td>
<td>9.59%</td>
<td>65.11%</td>
<td>13.79%</td>
<td>11.51%</td>
</tr>
<tr>
<td>2012 LOS</td>
<td>7.76%</td>
<td>64.91%</td>
<td>15.11%</td>
<td>12.22%</td>
</tr>
</tbody>
</table>

In CY ’10, CY ’11 and CY ’12, Youth (0-17) were delayed in the ED between 1-2 days, approximately 80% of the time. This is consistent with the average length of time that youth are delayed in the ED (1.50 days).
Consistent with the youth population, adults (18+) were most frequently stuck in the ED 1-2 days with an ALOS of 1.60 days in CY ‘12.

**Recommendations for continuing sub-Goal in 2013:**
This sub-goal continues to be applicable for 2013 and should be included in the 2013 Project Plan.

**Goal 16. Measure network adequacy: support Departments in maintaining adequate Provider Network to ensure member access (Contract Reference O.4.1.4)**

A. Number of network providers by degree type
B. % of members with access to each provider type in each county within appropriate radius
C. Density ratios of providers to members

Geo-access reports for outpatient practitioners were available for review in 2012 and an analysis was conducted. Please see Appendix E. It was determined that because of current requirements on claims for outpatient services, geographic access analysis is being suspended.

**Recommendations for continuing sub-Goal in 2013:**
This sub-goal will be suspended for 2013 and will not be included in the 2013 Project Plan.

**Goal 17. Maintain the Provider Analysis and Reporting (PARs) Initiatives for Inpatient Child and Adolescent, Enhanced Care Clinics and Psychiatric**
Residential Treatment Facilities, and CT Emergency Department levels of care and Implement initiatives with, Residential Treatment Centers (RTC), and Emergency Mobil Psychiatric Services (EMPS) levels of care. (Contract Reference: M.12)

Activities and Findings that include trending and analysis of the measures to assess performance:

During 2012, ValueOptions CT continued to use the Provider Analysis and Reporting (PAR) programs as a strategy to reform the behavioral health system of care in CT with the goal of improving the quality and efficiency of the service system. Several performance improvement initiatives were planned but as a result of budget restrictions, funds were not available to pay the providers performance incentive payments. Despite this change, the initiatives were completed and providers continued to be invested in receiving feedback regarding their performance.

During 2012, the following PARs programs were in existence:
1. Child and Adolescent Inpatient Hospital
2. Psychiatric Residential Treatment Facilities (PRTFs)
3. Adult Inpatient Hospitals
4. Emergency Departments
5. Home Health
6. Youth Residential Treatment Centers and Therapeutic Group Homes
7. Enhanced Care Clinics (ECCs) for Youth and Adults

The following Performance Incentive Programs were initiated:
1. Child and Adolescent Inpatient Hospitals
2. PRTFs
3. Emergency Mobile Psychiatric Services (EMPS)

Each of these programs and initiatives are evaluated below.

CHILD AND ADOLESCENT INPATIENT HOSPITALIZATION PAR PROGRAM

The Inpatient Child and Adolescent PAR program initially focused on the need to address exceptionally long lengths of stay that resulted from the delays in discharge of children and adolescents being treated in inpatient psychiatric units. In 2007, the Child and Adolescent Inpatient PAR program was implemented as a method to address these long lengths of stay. The initial phase of the program included the development of a workgroup with the hospitals in CT that provided psychiatric inpatient treatment for children and adolescents. The participants shared information regarding the barriers encountered when discharging youth and worked towards developing strategies for addressing those barriers. The group agreed to work towards lowering the length of stay of youth in CT.

In 2008, the first performance initiative was conducted with the child and adolescent inpatient facilities, with the focus on decreasing lengths of stay. The goals set for each facility’s performance were “case mix adjusted” to take into consideration the longer lengths of stay of the DCF youth population. The Average Length of Stay (ALOS) of children and adolescents dropped over 2008 with the most significant decreases during the second half of 2008. The acute portion of the length of stay remained fairly stable.
while the discharge delay portion of the stay dropped considerably. A second performance initiative was conducted in SFY ’10 that resulted in continued decreases in length of stay and improved communication between the family and hospital staff during the inpatient stay.

During CY 2011, two performance initiatives with pediatric inpatient hospitals were conducted. The first focused on achieving and/or maintaining efficient lengths of stay and continued the family engagement portion implemented the previous year. The second performance initiative focused on stabilizing re-admission rates and enhancing discharge planning practices.

**Pediatric Inpatient Hospital Performance Initiative 2012**

The 2012 performance incentive program focused on reducing and/or maintaining efficient lengths of stay and re-admission rates, as well as the continued implementation of enhanced discharge planning.

**Goal 1: Achieve and/or maintain efficient lengths of stay.** For the CY 2012 initiative, workgroup participants agreed that the performance targets for each of the case mix categories would be based on CY 2010 authorization data. The performance period was Q3 and Q4 of CY 2012.

In order to earn the full 2 points for this indicator, each hospital was required to achieve an Adjusted Average Length of Stay that was better than or within 0.5 days of the hospital’s Predicted Length of Stay. The hospital was eligible to earn 1 point if the difference between the Predicted Length of Stay and the Adjusted Average Length of Stay was $\leq 1.5$ but $>0.5$ days.

**Outcome Goal 1:** Results of this performance goal revealed that seven of the eight inpatient hospitals earned the maximum 2 points for this goal and the remaining hospital earned 0 points. The results are displayed in the chart following the summary of goal 3.

**Goal 2: Reduce or maintain already satisfactory 7 and 30-day re-admission rates.** CT BHP has been reporting on state-wide and hospital-specific readmission rates semi-annually for the past several years. In reviewing readmission rates with each of the hospitals, we learned that readmission to an inpatient unit within 7 or 30 days of discharge from an inpatient psychiatric unit can be an important indicator of quality and efficiency of care. As a result, this indicator was added to the 2012 Performance Initiative.

The performance period for this measure was the entire CY 2012. In order to earn the maximum 1.0 point for this goal, each hospital had to achieve a 7-day readmission rate of $\leq 4\%$ (0.5 points) and a 30-day readmission rate of $\leq 14\%$ (0.5 points).

**Outcome Goal 2:** Results for this indicator showed that two of the eight hospitals earned the maximum 1.0 point, three hospitals earned 0.5 points, and three hospitals earned 0 points. The results are displayed in the chart following the summary of goal 3.

**Goal 3: Establish Wellness and Recovery Planning.** Hospitals are required to complete member-specific Discharge Wellness and Recovery Plans. Those plans are designed to assist families in caring for the youth when they return home, with particular focus on how the family can assist the youth during a crisis.
The performance period for this measure was Q3 and Q4 of 2012. To earn the entire 1.0 point for this indicator, each hospital was required to document that a wellness and recovery plan was created for 85% of members prior to discharge, and that the plan contained several required elements.

Outcome Goal 3: Two of the eight pediatric inpatient hospitals chose not to participate in this goal, citing other priorities related to pending hospital mergers. Of the six participating hospitals, three hospitals earned the maximum 1.0 point and three hospitals earned 0 points.

The chart below displays the results of the CY 2012 Performance Initiative for each of the pediatric psychiatric hospitals.

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Goal 1 Predicted LOS</th>
<th>Goal 1 Performance AALOS (4% Removed)</th>
<th>Goal 1 Points Earned (out of 2)</th>
<th>Goal 2 7 Day Readmission</th>
<th>Goal 2 30 Day Readmission</th>
<th>Goal 2 Points Earned (out of 1)</th>
<th>Goal 3 Wellness Plans</th>
<th>Goal 3 Points Earned (out of 1)</th>
<th>TOTAL Points Earned (out of 4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hartford Hospital</td>
<td>11.16</td>
<td>12.90</td>
<td>0</td>
<td>1.97%</td>
<td>12.50%</td>
<td>1</td>
<td>n/a</td>
<td>19/20= 95%</td>
<td>1</td>
</tr>
<tr>
<td>Hospital of St. Raphael</td>
<td>11.06</td>
<td>10.90</td>
<td>2</td>
<td>5.12%</td>
<td>16.38%</td>
<td>0</td>
<td>n/a</td>
<td>n/a</td>
<td>0</td>
</tr>
<tr>
<td>Manchester Hospital</td>
<td>9.65</td>
<td>6.10</td>
<td>2</td>
<td>1.67%</td>
<td>12.50%</td>
<td>1</td>
<td>4/19= 21%</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Natchaug Hospital</td>
<td>10.87</td>
<td>11.06</td>
<td>2</td>
<td>5.25%</td>
<td>16.67%</td>
<td>0</td>
<td>17/20= 85%</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>St. Francis Hospital</td>
<td>10.89</td>
<td>11.26</td>
<td>2</td>
<td>4.30%</td>
<td>12.54%</td>
<td>0.5</td>
<td>20/20= 100%</td>
<td>1</td>
<td>3.5</td>
</tr>
<tr>
<td>St. Vincent's Hospital</td>
<td>10.03</td>
<td>10.16</td>
<td>2</td>
<td>6.12%</td>
<td>16.55%</td>
<td>0</td>
<td>4/20= 20%</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Waterbury Hospital</td>
<td>10.27</td>
<td>8.35</td>
<td>2</td>
<td>3.92%</td>
<td>16.67%</td>
<td>0.5</td>
<td>n/a</td>
<td>0</td>
<td>2.5</td>
</tr>
<tr>
<td>Yale-New Haven Hospital</td>
<td>11.09</td>
<td>11.41</td>
<td>2</td>
<td>4.83%</td>
<td>13.04%</td>
<td>0.5</td>
<td>15/20= 75%</td>
<td>0</td>
<td>2.5</td>
</tr>
</tbody>
</table>

Throughout 2012 the pediatric inpatient provider workgroup met regularly. Workgroup discussions focused on strategies to enhance relationships with relevant DCF staff, identifying methods for maintaining efficient lengths of stay, stabilizing readmission rates, enhancing discharge planning practices, and improving rates of ambulatory follow-up.

Assuring that members discharged from the hospital have a follow-up appointment within a week is an industry standard measure of the quality and effectiveness of treatment. To increase the focus on ambulatory follow-up for youth in CT, CT BHP collaborated with the eight pediatric hospitals to roll out Regional “Connect-to-Care” meetings across the state. Hospitals and community stakeholders were invited to participate in these meetings in an effort to improve member transitions across the behavioral health continuum of care. The initial round of meetings included representation from the 8 hospitals, 69 community-based providers, several school systems, the Department of Children and Families, and ValueOptions.
The Regional Connect-to-Care meetings will continue during 2013 with a particular focus on ensuring timely and smooth transitions for youth following discharge from an inpatient facility. In addition, CT BHP will use claims data for CY 2011 to establish a baseline rate of ambulatory follow-up within seven days of discharge from an inpatient facility. This data will be shared with the pediatric inpatient hospitals and the Regional Connect-to-Care workgroups as it becomes available.

**ADULT PSYCHIATRIC INPATIENT PAR PROGRAM in 2012**

Given the success of the Pediatric Inpatient PAR program, the CT BHP implemented an Adult Psychiatric Inpatient Hospital PAR Program in CY 2012. Statewide workgroups were held with the adult inpatient facilities on April 25, 2012 and September 14, 2012. The discussion included a review of length of stay and readmission data with the intent to define collectively performance goals and related methodology. The April meeting focused on identifying potential case mix indicators. Data was also provided for Q4 CY ’11 regarding Average Length of Stay (ALOS) by eligibility group, age and geographic region as well as readmission data for Q3 & Q4 CY ’11.

The September meeting’s purpose was to share potential length of stay and readmission case-mix indicators and continue the collaborative development of an adult inpatient PAR program. Variables which may impact ALOS were explored including the use of 23-hour observation beds, access to state inpatient beds, and the inpatient facilities’ relationship with the Local Mental Health Authorities (LMHAs). Inpatient admission rates were also provided as there was high variability among providers. The discharge form completion rates were shared and the value of entering discharges properly was communicated, as well as the goal of meeting the 90% target for discharges entered via the web. The idea of holding adult regional meetings with various levels of care was suggested and well received.

A first round of hospital-specific adult inpatient PAR profiles containing Q3 ’12 data were delivered during the last quarter of 2012 via face to face meetings, conference calls, or emails to all inpatient psychiatric hospital facilities in CT. Several barriers to treatment and discharge planning were identified during this process, including such challenges as obtaining rehab beds especially for individuals with more severe co-occurring disorders, homelessness, connecting with outpatient level of care, especially for medication management, the delays associated with members needing Skilled Nursing Facilities (SNFs), legal matters and wait list for state beds. It was also determined during this time that there was variation in how hospitals were reporting and requesting authorizations for Medicaid/Medicare dual eligible individuals. This discrepancy had the potential to skew ALOS and was identified as a component to be reviewed in greater detail. Several of the adult PAR meetings were held in conjunction with ED PAR meetings during the same time frame. These joint PAR meetings led to interesting dialogue and in some cases improved communication within the facilities themselves.

The information shared and collected from both the workgroups and individual, hospital-specific first round of hospital-specific PAR meetings, clarified that advanced data analysis expertise was necessary to analyze future quality measures and potential case mix indicators. A smaller sub-committee of the Adult Inpatient Workgroup was organized with the sole purpose of discussing potential case mix indicators. One meeting was held on February 22, 2013 with hospital representatives, DMHAS
representatives and ValueOptions quality department staff. The meeting produced robust discussion regarding the previously identified barriers to discharging adults, but did not achieve the desired focus on data. Therefore, it was determined that this strategy was ineffective.

Based upon discussions in the first round of hospital-specific PAR meetings about ALOS outliers and barriers, the Q4 '12 PAR profiles for the adult psychiatric inpatient hospitals were enhanced to include:
- Frequency distribution of lengths of stay during hospitalization
- Average Length of stay by eligibility group

In CY 2012 The Adult Psychiatric Inpatient PAR Program identified variables that contribute to ALOS of >14 days. The following variables showed significant impact on length of stay (LOS):
- Age group vs. LOS for members ages 55-64
- Eligibility Group vs. LOS- ABD/Other Single
- Diagnosis vs. LOS- Schizophrenia & Other Psychotic Disorders

Members who had a combination of Schizophrenia, ABD Single eligibility and age of 55+ were found on average to have an ALOS 5.98 days longer than those without these variables. Next steps include:
- ALOS analysis- how to define what constitutes an “outlier”
- Possibility of utilizing Claims Data
- Further break down the mood disorder diagnosis category
- Add median, range & standard deviation to the analyses descriptions

A third Adult Psychiatric Inpatient Workgroup is scheduled for March 26, 2013. At a minimum the discussion will include:
- Implications of involuntary medication and other probate-related concerns
- Implementation of Adult Provider Regional Meetings

**EMERGENCY DEPARTMENT AND EMERGENCY MOBILE PSYCHIATRIC SERVICES PARS PROGRAM**

The Emergency Departments (EDs) and Emergency Mobile Psychiatric Services (EMPS) PARs program was initiated in 2009 as a collaborative effort between DCF, DSS, the Connecticut Hospital Association’s (CHA) committee on Patient Care Quality, and ValueOptions. The program was designed in an effort to improve the services provided to youth with a behavioral health crisis in an Emergency Department. In order to align incentives across all stakeholders, ValueOptions was assigned a performance target that supported the collaboration between the EDs and the EMPS providers. MOUs between EMPS providers and ED were established and EDs collected data regarding their use of EMPS.

**Please Note: After Year 1, the ED and EMPS PARs programs and performance initiatives were separated. The following section describes the ED PARs programs**
The CT BHP implemented a Provider Analysis and Reporting program (PAR) for CT Hospital EDs during 2010 and 2011. ValueOptions continued to shape and enhance this ED PAR program in 2012.

An internal ED workgroup was established to develop additional decision rules to augment those used in previous year’s PARs profiles. These rules were necessary due to the shift from using authorization data in prior years to using 2011 claims data. The change allowed a more accurate determination of whether members not admitted to the hospital from the ED received follow-up care in the community.

The findings in this year’s ED performance target cannot be compared to last year’s submission as a result of the shift from the use of authorization data to claims data. An additional reason for the non-comparability of previous ED follow-up rates is that only the HUSKY A and B populations were included in 2009 and 2010 ED PAR data, whereas the ED data for 2011 includes all Medicaid eligibility groups.

The recent analysis using the methodology previously approved by the Departments for the claims query and a combination of Medicaid claims data for ED visits and inpatient hospitalizations for dates of service in CY 2011. Data were broken out into six (6) month increments to establish the number of behavioral health visits to the ED by youth (ages 0 – <18) and adult (>18) members. Included visits were identified by a primary diagnosis code of 291 – 316. The behavioral health inpatient hospital admission rate and Average Length of Stay (ALOS) for youth and adults were then determined for each of the EDs. Finally, admissions were broken out between mental health and substance abuse, and within the substance abuse category by inpatient hospital detox vs. free standing residential detox.

For ED outcomes other than psychiatric inpatient admissions, Medicaid claims data were used for CY 2011 dates of service to establish the number and percentage of youth and adults with at least one behavioral health visit. Data again were separated into six (6) month increments. The following behavioral health levels of care were examined, with focus on admissions within 7 and 30 days of the ED visit:

- Routine and intermediate outpatient
- Free-standing residential detoxification (authorization data was used for determining return to residential treatment for youth, and claims data for return to adult residential treatment)
- Group home treatment (authorization data was used for determining return to group home for youth, and claims data for return to adult group home treatment)
- Residential treatment
- No known behavioral health service (as measured by the absence of a claim for a behavioral health service)
- Readmissions to the ED (Re-ED Visits)

Additionally, ED data were used to match EMPS evaluations as measured by the presence of a paid claim with procedure code S9485 on the same day and within 7 days as the ED visit.
Two ED PAR profiles were created for CY 2011; one for [Medicaid] youth and one for [Medicaid] adults. Each was broken out into 6 month increments containing the data identified above and included the following information for each ED:

1. Volume of members treated in the ED
2. Inpatient hospital admission rate
3. Follow up rates for routine and intermediate outpatient, congregate care, home-based and no known behavioral health services
4. Average Length of Stay (ALOS) for behavioral health inpatient admissions
5. Use of an EMPS evaluation on the same day and within 7 days as the ED visit
6. Repeat ED visits within 7 and 30 days of the initial ED visit

In addition to the two profiles noted above, hospital-specific ED PAR profiles were created for those hospitals with the ten highest ED volumes during Q3 and Q4 2011 and were submitted as a component of the deliverable. It was later determined that these additional profiles would not be utilized in the PAR cycles.

The adult and youth ED PAR profiles were shared individually with all 30 EDs via face to face meetings, conference call or email.

**Results:** Additional analyses were conducted on both the youth and adult ED data related to this performance target. This included further investigation of the relationship between:

1. Inpatient admission rates and ED volume
2. Inpatient admission rates and ED readmission rates
3. Inpatient admission rates and the average length of stay in inpatient psych and detox, and
4. ED follow up services and ED readmissions

The following significant relationships were found:

- ED’s with higher volumes also had significantly higher inpatient admission rates for youth
- Adults who had follow-up services within 7 or 30 days of an ED visit readmitted to the ED at a statistically lower rate than those who did not have follow-up services
- Youth who had follow-up services within 7 days readmitted to the ED within 30 days at a statistically higher rate than those who had no follow-up. However, this finding is related to the type of service that the member attended after leaving the ED. Members who attended outpatient and intermediate levels of care as follow up service readmitted to the ED at a statistically significant lower rate. Members who returned to congregate care as follow up service had the highest readmission rate (35.9%) to the ED. There was no association for youth between follow up services within 30 days and readmission to the ED within 30 days.

No significant relationship was found between:

- Adult ED volume and ED to hospital admission rate
- Adult ED to hospital admission rate and 7 or 30 day readmission rate to the ED
• Youth ED to hospital admission rates and 7 or 30 day readmission rate to the ED
• Adult inpatient admission rates from the ED and inpatient average length of stay
• Youth inpatient admission rates from the ED and inpatient length of stay

The following section describes the EMPS Performance Initiatives

In tandem with the 2010 ED Initiative, CT BHP began a Performance Initiative with the state-wide EMPS providers focused on reducing ED psychiatric visits, emergency department overstays, and diverting unnecessary inpatient stays for youth 18 years old and younger. As with the 2010 ED Performance Initiative, this incentive program was focused on the EMPS provider’s demonstrated ability to develop and maintain on-going working relationships with their respective EDs to coordinate hospital ED and emergency psychiatric services as outlined in the MOUs established in 2009.

Due to the success of the 2010 EMPS incentive program, a performance initiative was again completed the EMPS providers for CY 2011 to promote further reduction of unnecessary pediatric psychiatric ED visits, improve the rate of diversion of potentially unnecessary inpatient admissions, and to enhance the relationship between the ED staff and the EMPS teams. Statewide admits/1000 for HUSKY youth (age 0-18) to CT EDs between 7/1/11 and 12/31/11 from the number of admits/1000 of HUSKY youth (age 0-18) to CT EDs in the same time period during CY 2012 were reduced as a result of this initiative.

CY 2012 EMPS PERFORMANCE INITIATIVE

In 2012, an EMPS performance initiative was continued in order to further the enhancement of the collaborative relationships between EDs and EMPS that had been built over the previous years. This initiative required that EMPS vendors renew any MOUs that had lapsed, and to continue to educate EDs on benefits of the use of EMPS in diverting HUSKY youth from inpatient, reducing overstays in the ED, and in assisting ED staff with establishing appropriate follow-up care after discharge from the ED.

The following performance goals were established:

**Goal 1.** Review the MOUs that each of the EMPS providers have in place with the EDs in their region to assure that the MOU is still in effect

**Results:** 4 out of the 6 EMPS providers earned the full 0.5 points

**Goal 2.** Conducting at least two (2) face to face informational sessions with line staff in the EDs with which EMPS providers have active MOUs in order to establish and/or improve the working relationship between EMPS providers and ED staff and improve use of EMPS in the ED. Guidelines for the content of these educational sessions similar to those used for the CY 2011 initiative were used. The suggested content of the informational sessions with the EDs included, but were not limited to at least one of the following three topics:

1. Education of the ED line staff about the services EMPS providers can either provide themselves or in arranging, including the timeframe within which those services can be accessed;
2. Identification of the specific needs of each ED in terms of how EMPS providers can be of assistance to them, taking into consideration:
   a. the resources available in the ED to evaluate members with behavioral health issues and
   b. program/service providers either affiliated with the ED or with whom the ED has a referral relationship;
3. Identify and address the barriers of the ED using EMPS frequently and effectively
4. **AND always include**: A review of the ED's recent utilization of EMPS

**Results**: Of the 4 Providers eligible for Goals 2 and 3, all 4 earned the full 1.0 point

**Goal 3.** Work toward the objectives established in the MOUs between the Emergency Departments (ED) and EMPS providers to reduce Statewide admits/1,000 HUSKY youth (age 0-<18 ) to CT EDs between 7/1/12 and 12/31/12 from the number of admits/1,000 of HUSKY youth to CT EDs in the same time period during CY 2011. .

**Results**: All 4 Providers will be eligible for Goal 3 however the performance period data will not be calculated until after April 15th to allow for timely filing parameters.

**PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES (PRTF) PROGRAM**

The Psychiatric Residential Treatment Facility (PRTF) Program began in 2008 in response to the need for a more efficient referral process to PRTF level of care. A workgroup of the PRTF providers were established that resulted in the successful design and implementation of the “Universal PRTF Referral Form.” This workgroup then continued to address the long length of stay in PRTFs; in 2008, the average length of stay (ALOS) for PRTF level of care was over 300 days. The workgroup revised the UM Criteria to indicate a target length of stay of 90 to 120 days and designed a PAR data profile to inform the progress on this measure.

The PRTF PAR profile included the following indicators:

- demographics of children in PRTF care
- individual and comparative bi-annual ALOS
- program-specific frequency distribution of lengths of stay
- frequency of children that experience an inpatient stay during a PRTF episode of care
- prevalence of discharge delay
- reasons for discharge delay

**2012 PRTF Performance Initiatives**

Since 2009, annual performance incentive programs have enhanced the PRTF PAR programs in an effort to accelerate the attainment of shorter lengths of stay as well as to improve the quality of the PRTF programs. These incentive programs have been highly successful in achieving the goals of the CTBHP.

In CY 2012 the performance initiative methodology was adjusted to raise the bar for the length of stay measure and a goal to improve family engagement was maintained. Programs were scored on whether or not they achieved the 120 day target average length of stay and successfully co-constructed Individualized Communication Plans with the family or guardian within three (3) calendar days of admission.
Late in 2011, the decision was made to close one of the PRTFs. Of the remaining three (3) PRTF programs, one (1) PRTF program achieved the length of stay goal (105 days risk-adjusted ALOS) and 100% (3 out of 3) of the programs earned full credit on the Family Engagement goal, a significant improvement from performance during 2011.

<table>
<thead>
<tr>
<th>Provider</th>
<th>Goal 1 Actual LOS</th>
<th>Goal 1 AALOS (12% Removed)</th>
<th>Goal 1 Points Earned (out of 2)</th>
<th>Goal 3 Individualized Communication Plan</th>
<th>Goal 3 Points Earned (out of 2)</th>
<th>TOTAL Points Earned (out of 4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boys &amp; Girls Village</td>
<td>148.8</td>
<td>124.9</td>
<td>0.0</td>
<td>13/13 = 100%</td>
<td>2.0</td>
<td>2.0</td>
</tr>
<tr>
<td>Children’s Center of Hamden</td>
<td>189.8</td>
<td>156.3</td>
<td>0.0</td>
<td>15/15 = 100%</td>
<td>2.0</td>
<td>2.0</td>
</tr>
<tr>
<td>Village for Families &amp; Children</td>
<td>122.0</td>
<td>104.8</td>
<td>2.0</td>
<td>17/17 = 100%</td>
<td>2.0</td>
<td>4.0</td>
</tr>
</tbody>
</table>

**Home Health PARs Program**

A key goal for the CT BHP is to support the movement towards recovery for members receiving Home Health services. The objective of this goal is to decrease the intensity of Home Health services, especially medication administration services, for those members who can be more autonomous; this may also decrease the duration and frequency for which members receive Home Health services overall.

During late 2011, a workgroup comprised of Home Health agency representatives and CT BHP representatives from DSS, DMHAS, and ValueOptions was formed for the purpose of developing a PAR Program for the Home Health agencies. The workgroup met several times in late 2011 and continued to meet in 2012 to identify collectively measures that would allow for the assessment of, and/or promote, the successful movement towards independence in medication administration.

Taking into consideration feedback from the workgroup, CT BHP conducted multiple data analyses to develop the means of measuring the frequency and duration of medication administration services both in the aggregate and by individual Home Health agencies. After review and collaboration with the Departments, an alternative methodology was introduced for measuring medication administration frequency and duration. The new process would assist in identifying whether the agencies were making progress towards decreasing the frequency of medication administration visits. A Home Health profile was developed that includes the following indicators:

- Volume of behavioral health medication administration utilizers by each provider agency
- Patterns of use of different frequencies of medication administration by each provider agency
• Evidence of reduction in patterns of higher frequencies of use of medication administration services over time (i.e., % of members, aggregate and by provider, with twice per day (BID) services quarter to quarter and once per day (QD) services quarter to quarter)

• Rate of hospitalization

By April 2012, the decision was made to roll out the Home Health PAR Program. Due to the large number of Home Health agencies, it was determined that the PAR program would include providers that serve a minimum of 75 utilizers with primary behavioral health diagnosis per quarter. As of Q3 ’11, 15 Home Health agencies met this criteria. These 15 agencies provided services to 88% of all members receiving Medication Administration services in Q2 ‘12.

The Home Health PAR Workgroup met quarterly beginning in Q3 of CY 2012. The meetings included representatives from the 15 Home Health agencies, the Department of Mental Health and Addiction Services (DMHAS), the Department of Social Services (DSS), and ValueOptions. The workgroup focused on the following:

• Review of the Home Health PAR data
• Barriers to increasing client self-sufficiency and reducing service frequency
• Provider-driven initiatives and/or best practices to address identified barriers
• Challenges and opportunities to improve connect-to-care for members receiving Home Health services
• Strategies to improve communication with prescribers of medication administration services
• Identifying methods for enhancing recovery-oriented practices in the delivery of home health care services

Over the course of the Home Health PAR Program to date, the percentage of twice per day (BID) services has decreased from 26.1% in Q1 ’11 to 21.9% in Q2 ’12. At the same time, the percentage of once per day (QD) services increased from 30.1% in Q1 ‘11 to 34.5% in Q2 ’12. The graph below displays these changes.
In addition to the Home Health PAR workgroup, the Home Health Provider workgroup met bimonthly throughout 2012. The meetings included representatives from all of the Home Health agencies in CT, the Department of Mental Health and Addiction Services (DMHAS), the Department of Social Services (DSS), and ValueOptions. The workgroup focused on the following:

- Development of performance indicators and methodology
- Review of the draft Home Health profile
- Review of quarterly Home Health medication administration utilization data
- Resources for traditional and non-traditional services and supports that would allow members to utilize fewer medication administration visits as they became more self-sufficient
- Training on the clinical review criteria for prescribers of medication administration services
- Training on the Recovery Model and Skills Transfer
- Implementation of the CTBHP Peer Specialist Pilot Program
- Policy and procedure updates and clarifications (e.g. temporary member certification, required documentation for continued authorization requests, changes to authorization parameters, denial and appeals process)
- Access to psychiatry and outpatient services
- Implementation of the Supplemental Clinical Attachment tool for Home Health Care Authorization tool
- Training on the Evaluating Capacity for Self-Management tool
- Identifying best practices for Recovery-oriented practice

To assist Home Health providers with enhancing recovery-oriented practices, CT BHP developed and implemented a Recovery and Skills Transfer Training Program for the Home Health agencies. The training program focuses on the Home Health authorization process, integrating the recovery model and techniques for evaluating members’ current levels of functioning and engagement. Trainings are conducted on-site at the Home
Health agencies with the Home Health nurses. Between June-December 2012, CTBHP staff conducted 17 presentations and trained a total of 174 Home Health staff.

In addition to the work done with the Home Health agencies, CT BHP worked collaboratively with physicians and other DMHAS representatives to develop clinical review criteria for prescribers of medication administration services. The clinical review criteria tool is designed to assist in the clinically appropriate reduction of medication administration services. In addition, it can be used to clarify with Home Health providers the areas in which their efforts should be focused to assist in skills transfer and Recovery. In November 2012, CT BHP staff met with and trained the medication administration prescribers from two high volume prescriber agencies, Capitol Region Mental Health Center and the Western Connecticut Mental Health Network, regarding the clinical review criteria.

The Home Health PAR program will continue during CY 2013.

**ENHANCED CARE CLINIC (ECC) PAR PROGRAM**

The Enhanced Care Clinic (ECC) PAR program followed a unique progression when compared to other CT BHP PAR programs. In the case of the ECCs, providers received incentive payments prior to demonstrating that they could meet the expectations of their agreement for the following:

1. Centralized telephonic access to appointments
2. Timely access to care including:
   a. Routine appointments offered within 14 days 95% of the time
   b. Urgent appointments offered within 48 hours 95% of the time
   c. Emergency evaluations within 2 hours of arrival at the ECC 95% of the time
   d. Psychiatric evaluations within 2 weeks of evaluation when the need for psychiatric evaluation was identified
   e. Extended clinic hours
3. A signed Memorandum of Understanding (MOU) with PCPs or Pediatricians in their areas providing consultation and timely access to those providers so that they may in turn provide psychopharmacologic treatment to HUSKY members within their practices.

As the PAR program was implemented in 2008 and ECCs were held accountable for meeting access standards, more than a third of the ECCs were on CAPs. ValueOptions monitored the routine access standard for members of HUSKY A, HUSKY B and Charter Oak.

**2012 Annual Analysis**

At the close of 2012, there were 34 primary ECC clinics and 49 secondary sites, totaling 83 statewide locations. Several site changes were made throughout the year. Additional updates were made as a result of the request for all ECC providers to submit updated Attachment B forms in Q3 ’12.

The total ECC volume of members registering for treatment has increased by 12.9% from CY ’11 to CY ’12. Again, increases seen during CY ’11 and CY ’12 are related to
managing additional Medicaid eligibility groups effective 4/1/11. The graph below displays this change.

The number of routine evaluations conducted in CY ’12 (16,226) has increased by 20.2%, from CY ’11 (13,497). It is important to note that the increase in the number of routine evaluations during both CY ’11 and CY ’12 is attributed to the addition of all Medicaid eligibility groups to the original counts based only on the HUSKY A, HUSKY B and Charter Oak populations.

The percentage of evaluations meeting the routine access standard decreased slightly in CY ’11, but has since improved in CY ’12 to a rate that is similar to that seen prior to the decline. Since the inception of the ECC PAR Program, the percentage of routine appointments meeting the 14-day access standard of 95% has increased from 82.67% in CY ’08 to 98.47% in CY ’12 (a 19.1% increase).
The percent of members offered an Urgent appointment within the 2 day standard was on a consistent downward trend from Q1 '11 (89.2%) to Q2 '12 (79.7%). However, performance started to rebound in Q3 '12, with Q4 '12 increasing to 89.51%. Even with this improvement, CY '12 was slightly lower than CY '11 and remains below the 95% standard.

While the percent of members triaged by the ECC as needing an Emergent appointment and then seen within the 2-hour requirement decreased in CY '12 (97.38%) as compared to CY '11 (99.57%), it is still well above the 95% standard.
2012 ECC-related Activities

The ECC Operations Workgroup met once a month throughout 2012. The meetings include representatives from DCF, the Department of Mental Health & Addiction Services (DMHAS), and ValueOptions. The Workgroup focused on the following:

- Planned the 4th Annual Statewide ECC Meeting
- Finalized revision of the ECC Oversight tool
- Discussed provider specific challenges to meeting the ECC Access standards
- Monitored CAPs for ECCs out of compliance with access or Mystery Shopper program
- Continued developing methodology for moving the three access measures from a quarterly to an annual measurement

The ECC Interagency Workgroup met monthly throughout 2012 and included representatives from DSS, DCF, DMHAS, and ValueOptions. The Workgroup focused on the following:

- Finalized revision of the ECC Oversight tool
- RNMs worked with the providers to clarify and confirm that ECC providers are maintaining one phone number for the central point of access
- Reviewed lifespan comparison data as changes to the 18E report in 2012 allowed for further drill down of child and adult utilization data
- Discussed policy relevant to ECC status changes (adding, closing, moving ECC locations)
- Reviewed Attachment B updates
- Reviewed Policy Transmittals PB 2012-44 and PB 2012-56
- Continued developing methodology for moving the three access measures from a quarterly to an annual measurement

The ECC Provider Workgroup on Capacity and Access moved from a monthly to quarterly schedule throughout 2012 and continued to review and analyze the impact of capacity on provider compliance for the ECC access standards. Participation grew throughout the year to include representatives from all 34 ECCs as well as representatives from the Departments and the Connecticut Community Providers Association (CCPA). The Workgroup focused on the following:

- Reviewed current status of Oversight Committee
- Discussed frequently asked questions related to the upcoming oversight on-site surveys
- Reviewed current Oversight Survey Tool
- Reviewed decline in percent of members with access to urgent care within 2 days
- Reviewed current access procedures and agency triage process
- Reviewed the policy relevant to ECC status changes (adding, closing, moving ECC locations) and requested updated Attachment B forms

The 4th Annual Statewide ECC Meeting was held on February 28, 2012. Agenda and discussion included:

- Reviewed a power point presentation: “ECC Progress & Accomplishments”
- Reviewed ECC Oversight Tool
- Discussed upcoming Pediatric Inpatient Psychiatric Connect-to-Care Initiative

Additional activities:
- The GAIN Short Screen Training conducted by Melissa Sienna, DCF, was offered to all ECCs at ValueOptions on April 4, 2012.
- Conducted inter-rater reliability using the revised, abridged ECC Oversight Review Tool with sample charts provided by three volunteer ECCs (The Village, Clifford Beers, and BHCare Inc.)
- Connect-to-care meetings were conducted regionally in the Fall of 2012 with ECCs, each of the pediatric inpatient psychiatric units and other community providers treating children and adolescents.
- On-site surveys of all 34 ECCs utilizing the ECC Oversight tool and a team of representatives from DSS, DCF, DMHAS and ValueOptions began December 7, 2012. Nine sites were surveyed by the end of the year. Oversight surveys will continue throughout 2013; corrective action plans will be reviewed and follow-up surveys will be conducted.

The ECC PAR program will continue in CY 2013.

RESIDENTIAL TREATMENT CENTER (RTC) PAR PROGRAM

In late 2008, a workgroup made up of DCF and ValueOptions staff began working together to develop several reports, identified in collaboration with RTC providers, that would allow DCF to assess RTC performance. Several of the reports were based entirely or in part on CT BHP authorization data. In other instances, the CT BHP worked collaboratively with DCF staff to develop data collection tools for DCF’s ongoing use that would assist them to collect the data necessary for the reports by conducting chart and file audits. In 2010, a PARs profile for each of the in-state RTCs had been completed that included all 13 of the measures. In 2011, while the profiles were continued, some of the measures were deleted when, as a result of staffing changes within DCF, the measures that were dependent upon DCF staff were curtailed.

CY 2012 RTC PAR Program

During 2012, the RTC PARs program was included in a performance target that also included the development of a PARs program for Group Homes. The 2012 profiles for the RTC providers included the following performance indicators that are based on data collected by ValueOptions or on data supplied by DCF:

1. Average Length of Stay (ALOS) for planned discharges, ALOS for unplanned discharges, Acute Length of Stay, and Discharge Delay Length of Stay

2. Experience in Placement
   a. Average length of time to achieve readiness for planned discharge to a lower level of care, also referred to as the Average Acute Length of Stay
      i. This measure begins with the subset of youth discharged during the reporting period from the program to a CT BHP authorized lower level of care within 90 days and then measures the total days and average length of time for those youth to achieve readiness for discharge.
b. Number of inpatient hospitalization events during the program stay
   i. This measure begins with all youth discharged during the reporting period
      and then determines the number of hospitalizations and percentage of those
      youth who had an inpatient stay during their program stay.

c. Program Discharge Delay Days
   i. This measure begins with all youth discharged from the program during the
      reporting period and then determines the number and percentage of those
      youth who experienced discharge delay during their program stay.

d. Number of Suicide Attempts, AWOLS, Arrests, Restraints
   i. This measure, based on data received from DCF, displays graphically the
      number of suicide attempts, AWOLS, Police/EMS calls, Arrests and
      Restraints for youth during their program stay.

3. Program Post Placement Experience
   a. Lower Level of Care within 90 days
      i. This measure determines the number of discharges per quarter for each
         program and then determines the % of those cases with an authorization
         for a lower level of care within 90 days.
   b. Incidence of Hospitalizations Post Program Stay
      i. This measure takes the subset of youth discharged during the reporting
         period and authorized for a lower level of care post-discharge who were
         subsequently admitted to a higher level of care within 180 days of
         discharge.
   c. Number of Youth Experiencing First Hospitalization
      i. This measure begins with all youth discharged from the program and then
         measures how many of those youth were admitted within 180 days to a
         higher level of care.

On August 15, 2012, the workgroup for RTC convened and the profiles were reviewed.
Individuals from the Department of Children and Families, ValueOptions, CT, and 10 of
the Residential Treatment Centers attended.

The suggestions by the RTC workgroup included:
1. Refine the use of "Planned" vs. "Unplanned" discharges so that the category of
   "planned" reflects those discharges of youth who completed RTC treatment
2. ALOS data be broken out by specialty subgroups based on population served
   (e.g. psychiatric, juvenile justice, intellectual disability and problem sexual
   behavior, and substance abuse)
3. Break out hospitalization rate by the phase of treatment when the hospitalization
   occurred, the assumption being that newly admitted members and/or members
   close to discharge will have a higher rate of hospitalization than those in the
   middle of their RTC treatment
4. Risk management statewide comparison data be broken out by provider
   subgroups and by individual RTC programs
5. Risk management data for restraints be broken out by duration of restraint and
   by member age
6. For Post RTC Placement Experience measures that the data doesn’t capture services paid for via a different funding source (e.g. DCF flex funds, Therapeutic Foster Care)

7. For Percent of Youth Hospitalized within 180 Days Post RTC discharge that VO CT provide RTC providers with data detail on members who were hospitalized post-RTC placement

Over the next two months, many of the recommendations of the RTC providers were incorporated into the RTC profiles. Once those were reviewed and approved by the Departments, PARs meetings were held with RTC providers from each of the four (4) cohorts that had been established at the recommendation of the RTCs; those cohorts included primary psychiatric, juvenile justice, intellectual disability and problem sexual behavior, and substance abuse. The newly appointed Clinical RTC Regional Network Managers also had individual meetings with several of the RTC providers to review their profiles.

During this process, it became increasingly clear that for many of the RTCs the number of discharges during a quarterly reporting period, upon which many of the utilization indicators are based, is too small to result in meaningful data. In fact, there were multiple occasions when there were no discharges during a reporting period. As a result, it is recommended that the profile utilization-based data be reported semi-annually rather than quarterly in order to improve its usefulness. In order to provide the RTCs with utilization information on a quarterly basis, we will add frequency graphs that display the length of stay for the members that are currently in care in the RTC on a quarterly basis.

The RTC PARs program will be continued into 2013.

2012 THERAPEUTIC GROUP HOME PAR PROGRAM

As described above, the establishment of a PAR program for Therapeutic Group Homes (TGHs) was included in a 2012 performance target for ValueOptions, CT. Each of the indicators that had been included in the RTC PARs profiles and that are listed above in the RTC section were to be included in the TGH profile.

TGH profiles were generated for each of the TGHs by August 2012. On delivery of those profiles to DCF, the recommendation regarding moving to bi-annual reporting was made as there were many instances in the profiles of no discharges during a quarter. The rationale for this recommendation was that the small number of youth discharged from this service resulted in multiple graphs that display no data for the individual TGH and that our experience had been that the providers would lose interest if we shared those graphs. Instead we recommended that we focus on the graphs that compare each TGH to all others and the data from PREU and Risk Management. This recommendation was accepted.

In September 2012 the TGHs met to review and discuss the first version of the TGH profiles. During that meeting, ideas were generated and explored as to how the data could be collected differently going forward. The following recommendations were made by the TGHs:
1. Experience In Placement (Based on youth discharged from TGH in Q1 '12)
   a. Average Length of Stay Data
      i. ALOS data be broken out by specialty subgroups based on population served similar to those used by the RTCs (e.g. psychiatric, juvenile justice, intellectual disability and problem sexual behavior, and substance abuse)
      ii. Factor in the discharge plan which may account for long lengths of stay as the discharge plan is effectuated (e.g., therapeutic foster care)
      iii. Discharge delay data for TFC should be incorporated into the profile and alternative methods for capturing discharge delay were explored such as looking at case specific long lengths of stay.

2. Hospitalizations During TGH Stay Data
   a. Break out hospitalization rate by the phase of treatment when the hospitalization occurred based on the assumption that newly admitted members and/or members close to discharge will have a higher rate of hospitalization than those in the middle of their TGH treatment
   b. Change methodology to measure current members in care by quarter
   c. Capture the average number of ED visits during each reporting period and report this over time.

3. Risk Management Data
   a. Break out the data based on age with the assumption being that older youth are being arrested more frequently than the younger youth and that the younger youth are being restrained more frequently than then older youth
   b. Break out risk management data by the phase of treatment
   c. Clarify the reporting criteria for the various risk management indicators

4. Percent of Youth Authorized to a Lower Level of Care within 90 Days
   a. Include services paid for via a different funding sources (e.g. DCF flex funds, Therapeutic Foster Care)

5. Percent of Youth Hospitalized within 180 Days of Discharge from RTC to Lower Level of Care
   a. Include Discharge Location/Level of Care as an additional indicator

6. Percent of Youth Hospitalized within 180 Days Post RTC Discharge
   a. Collect outcome data post discharge at 30 days and as far out as a year

Over the next two months, recommendations of the TGH providers regarding breaking the profiles out into cohorts were incorporated into the profiles. Once those were reviewed and approved by the Departments, PARs meetings were held with TGH providers from each of the four (4) cohorts that had been established; those cohorts included primary psychiatric, juvenile justice, intellectual disability and problem sexual behavior, and substance abuse.
Barriers similar to those encountered in developing the RTC profiles were also faced during the development of the TGH profiles. The number of discharges from TGHs during a quarter is too small to result in meaningful data. There were many occasions when there were no discharges from a TGH during a reporting year. As a result, it is recommended that the profile utilization-based data be reported semi-annually rather than quarterly in order to improve its usefulness. In order to provide the TGHs with utilization information on a quarterly basis, we will add frequency graphs that display the length of stay for the members that are currently in care in the TGH on a quarterly basis. The TGH PARs program will be continued into 2013.

**Recommendations for continuing sub-Goal in 2013:**
This sub-goal continues to be applicable for 2013 and should be included in the 2013 Project Plan.

**Goal 18. Establish the CT BHP Pharmacy Reporting and Analysis Program**
(Contract Reference: I.7)

**Description of Activities and Findings that include trending and analysis of the measures to assess performance:**

During 2012, discussions were held the Departments regarding the usefulness of the existing pharmacy reporting package. The reports currently focus on aggregate trends regarding the use of psychotropic medication. While the reports produced in 2011 that displayed data through the end of 2010 included information regarding use of psychotropics by age groups, the reports did not result in any actionable findings. As a result of these discussions as well as on increased interest and concern of the Commissioners regarding the use of psychotropic medications by youth in CT, it was decided not to expand the pharmacy report beyond the HUSKY A and B population, to report pharmacy data through the end of 2011 using the existing reporting package, and to begin to develop pharmacy reports that will be more actionable.

The pharmacy reports for the HUSKY A and B populations were completed in October of 2012. The findings were submitted to the Departments as well as to the DCF Psychotropic Medication Advisory Committee (PMAC) and the Psychotropic Medication Workgroup. The highlights of the reports include the following:

**Rate of Use of Psychotropic Medications:**

1. Between 2008 and 2010, the number of behavioral health medication utilizers grew at a faster rate than the growth in membership.
2. From 2010 to 2011, the rate of behavioral health utilizer growth was smaller than the rate of membership growth.
3. For the first time since 2008, there was a slight decrease (0.6%) in the number of HUSKY A and B members utilizing behavioral health medications in the second half of 2011.
4. The percentage of HUSKY Adult members utilizing behavioral health medications (21-23%) continues to far exceed the percentage of HUSKY Youth utilizing behavioral health medications (7-8%).

100
5. For the first time since 2008, the percentage of adults utilizing medications decreased during the second half of 2011

**Gender Differences:**

6. Across the entire HUSKY A and B behavioral health utilizer population, females utilize more psychotropic meds than do males.

7. While females consistently make up approximately 58% of the HUSKY A and B population, they make up 63% of the utilizers of psychotropic medications.

8. However, when we look at gender differences of psychotropic medication use between youth and adults, we find that among HUSKY A and B youth, there were ~70% more male utilizers than female in Q3-4 2011.

9. On the other hand, in the HUSKY A adult population, 5 times as many females as males utilize BH medications.

10. Among HUSKY A and B youth, the penetration rate of use of psychotropic medication for males is 10% and for females is 6%.

11. Among HUSKY A and B adults, the penetration rate for males is 13.5% and for females is 21%.

**Differences in Use of Psychotropic Medication between DCF-Involved and Non-DCF-Involved Youth**

12. While the number of DCF involved HUSKY A and B youth utilizing psychotropic medications has remained stable, the number of non-DCF involved youth utilizing psychotropic medications has increased steadily over the past 4 years.

13. While 7% of Non-DCF Youth have utilized a psychotropic medication, 28% of DCF youth have utilized a psychotropic medication

**Utilization of Psychotropic Medications by Therapeutic Class**

**HUSKY A Adults:**

1. Of those adults utilizing behavioral health medications, about 65% are taking Antidepressants agents.

2. Utilization of Antipsychotic agents is trending downward (15.4% in Q1&2 2008 to 13.9% in Q3&4 2011).

3. Utilization of Antianxiety agents is trending upward (36.2% in Q1&2 2008 to 39.5% in Q3&4 2011).

4. Utilization of Stimulant medications is trending upward (4.7% in Q1&2 2008 to 7.6% in Q3&4 2011).

**HUSKY A & B Youth:**

1. The use of Antipsychotic agents is decreasing among youth, (30.5% in Q1&2 2008 to 24.8% in Q3&4 2011).

2. Stimulants are the most widely prescribed BH medication with a continuing upward trend (~59%).

3. Antidepressants are used by nearly 25% of all HUSKY A and B youth medication utilizers.

**Comparison of DCF and Non-DCF Involved Youth**
1. Over the past two years, Antipsychotic use by all youth members has decreased, and for DCF members it has decreased more dramatically (from 61% in Q1&2 2010 to 52% in Q3&4 2011)

2. DCF youth continue to have significantly higher rates of Antidepressant and Mood Stabilizer utilization than non-DCF youth

3. Non-DCF youth more commonly use Antianxiety agents and Stimulants than DCF youth

In October of 2012, DSS established a Psychotropic Medication Workgroup that includes representatives from DMHAS, DCF, and ValueOptions. The workgroup has focused on developing studies of the impact of psychotropic medications on metabolism in adults and on the use of more than one antipsychotic for more than 30 days in youth. DMHAS staff are responsible for the development of the former while ValueOptions is responsible for the development of the latter.

By the end of 2012, a template for the report had been developed and critiqued by members of the workgroup. The report will be produced monthly and include the names of all youth who filled prescriptions more than one antipsychotic during the month, the name of the drugs, the dosages, the age of the youth, the DCF status of the youth, the prescriber name, and the NPI number of the prescriber. It is anticipated that the report will be finalized by the end of Q1 ’13. Next steps include decisions regarding who will review the reports and make decisions regarding the need to intervene with the prescriber.

**Recommendations for continuing sub-Goal in 2013:**
This sub-goal is under evaluation by the Departments. It is anticipated that the content of future pharmacy reporting will be revised. Once these decisions are made, a revised goal for 2013 will be incorporated into the 2013 QM/UM Work Plan.
III. ONGOING QM/UM GOALS AND OBJECTIVES TO BE CARRIED FORWARD FROM THE EVALUATION YEAR

Goal 1. Review and approve the 2012 CT BHP Program Evaluation, 2013 CT BHP QM Program Description and 2013 CT BHP QM/UM Project Plan.

Goal 2. Ensure timely response and resolution of member/provider complaints and grievances.

Goal 3. Promote patient safety and minimize patient and organization risk from Adverse Incidents and Quality of Care and Service Issues.

Goal 4. Establish and maintain CT-BHP-specific policies and procedures (P&Ps) in compliance with contractual obligations that govern all aspects of CT BHP operations.

Goal 5. Establish and maintain a training program that includes compliance with state and regulatory requirements, HIPAA regulations and QM functions.

Goal 6. Ensure timely telephone access to CT BHP.

Goal 7. Develop and Implement Quality Improvement Activities and Initiatives to address opportunities for improvement.


Goal 9. Review and approve the 2013 CT BHP UM Program Description

Goal 10. Assure Utilization/Care Management Department compliance with established UM standards.

Goal 11. Monitor compliance with individual standards for compliance with ICM caseload expectations.

Goal 12. Monitor for under- or over-utilization of Behavioral Health Services; identify barriers and opportunities.

Goal 13. Monitor and update operational process to reduce inpatient discharge delay.

Goal 14. Ensure consistent application of activities to maintain and/or improve the rate of ambulatory follow up services after inpatient admissions.

Goal 15. Monitor timeliness of UM decisions; identify barriers and opportunities.

Goal 16. Monitor timeliness of appeal decisions; identify barriers and opportunities.

Goal 17. Monitor consistency of application of UM Criteria (IRR) and adequacy of documentation.
Goal 18. Monitor continuity of care; identify barriers and opportunities.

Goal 19. Reduce emergency department (ED) discharge delays.

Goal 20. Establish additional outlier management/bypass programs while monitoring standards of existing programs.

Goal 21. Maintain the Provider Analysis and Reporting Programs for pediatric inpatient hospitals, adult Inpatient hospitals, enhanced care clinics, emergency departments, home health providers, residential treatment facilities, therapeutic group homes and psychiatric residential treatment facilities (PRTF) levels of care.

Goal 22. Maintain the CT BHP Pharmacy Reporting and Analysis Program
The **ValueOptions Connecticut Service Center Quality Management Committee** has reviewed and approved the 2012 Quality Management/Utilization Management Program Evaluation, 2013 Quality Management Program Description, Utilization Management Program Description, and Work Plan:

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<tbody>
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<td>Name</td>
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<td>Laurie Vanderheide, PhD</td>
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<td>Name</td>
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<td>Rose Yu-Chin, MD</td>
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<td>Name</td>
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<td>Ann Phelan</td>
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<td>Lori Szczygiel, CEO</td>
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B. The **Company Quality Council (CQC)** has reviewed and approved the 2011 Quality Management Utilization Management Program Evaluation, 2012 QM Program Description, 2012 UM Program Description and 2012 QM/UM Work Plan:

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<td>Name</td>
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<tr>
<td>Deborah Hirschfelder, MSMA</td>
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<td>Vice President, Quality Management</td>
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<td>Janice Maurizio, LCSW-R ACSW</td>
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<td>Vice President, National Clinical Operations</td>
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<td>Sandy Potter, LCSW, MBA Vice President</td>
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V. APPENDICES

Appendix A: Report on Autism Feasibility Project
Appendix B: Autism Services in Connecticut
Appendix C: Impact of ICM Program Analysis for Adults
Appendix D: Impact of ICM Program Analysis for Children
Appendix E: GeoAccess Executive Summary