Executive Summary: Utilization Management for Adult Members
Quarter 4, 2013

General Overview

On at least a quarterly basis, the reports mutually agreed upon in Exhibit E of the CT BHP contract are submitted to the state for review. This Executive Summary focuses on the utilization management portion of these reports, evidenced in the 4A series which reviews utilization statistics such as average length of stay (ALOS) and admissions per 1,000 members (Admits/1,000). NOTE: A detailed description of the measures can be found at the end of this document.

As stated in previous submissions, results were graphed only for benefit groups that had a sufficient volume of members receiving services in each level of care (LOC). To provide better clarity when viewing the graphs, we have highlighted the benefit groups that appear on the related graph. The Executive Summary focuses only on those LOC's in which the data warranted analysis and discussion as evidenced by significant changes and trends or in cases when changes and trends are unclear and additional data is needed. If the analysis for a LOC did not reveal results or trends that warranted discussion, then those results were removed from the body of this Executive Summary and placed in an Appendix at the end. As a result, this Summary outlines/highlights the areas of interest related to certain utilization trends, as well as the underlying factors which drive the trend and associated programmatic responses taken by VO to impact/mitigate or support the trend. We also present recommendations to address remaining challenges and report progress related to these planned recommendations. The areas of focus for this quarter are:

- Membership
- Inpatient Facilities
    - Admits/1,000
    - Days/1,000
    - Average Length of Stay (ALOS)
- Detox Program: Free standing detox programs
    - Admits/1,000
    - Days/1,000
    - ALOS
- Home Health Services
    - Admits/1,000
    - Medication Administration frequency
- Partial Hospital Program
    - Admits/1,000
    - Admits/1,000 by Diagnoses
    - Admits/1,000 by Mental Health Diagnosis
    - Admits/1,000 by Substance Abuse Diagnosis

This quarter, the following utilization data points have been placed in the Appendix and are not discussed:

- Mental Health Group Home: Admits/1,000; Days/1000; ALOS
- Detox Program: Hospital-based detox programs: Admits/1,000; Days/1000; ALOS
- Ambulatory Detox: Admits/1,000

- Methadone Maintenance: Admits/1,000
- Intensive Outpatient: Admits/1,000
- Outpatient: Admits/1,000
- All adult graphs for 18A-C

Methodological Factors

The data contained in this report are primarily authorization-based and are 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 shifts in the reported conclusions. However, for some membership-based measures there is sufficient variation that the trends or our analysis would change. The reports and analyses for all LOC's are affected by this change. As a result, most conclusions drawn from the data for this submission are for Quarter 3, '13. Only ALOS will include conclusions for Quarter 4, '13, because ALOS is not affected by the refresh. To ensure that only refreshed data is the focus of the graphs, data from the most recent quarter that has not been analyzed has been shaded in gray.

As explained in previous summaries, the methodology for membership totals remains unchanged. Each member is only counted once per quarter, even if he/she changes eligibility groups or experiences gaps in eligibility. This methodology is referred to in the graphs as "Unique Membership."

Membership

Total Adult (18+) Membership

During Q1, 2013, in collaboration with the state departments, the decision was made to remove dually eligible members from all utilization data included in the quarterly reports, with the exception of the home health and mental health group home measures. As of Q2 '13, this was executed in all of the Exhibit E Reports. The decision was based on the finding of inconsistencies in the authorization of services for these populations among the providers. While a small minority of providers requested authorization for the entire stay of a dual eligible member's treatment, others gained authorization only when Medicare lifetime maximums were approached and still others never sought authorization at all. As a result of these inconsistencies, utilization measures for dually eligible members were inaccurate and potentially skewed aggregate "All Benefit" measures.

For this Quarterly Summary, indicators were only reported without the duals. However, we will continue to present a total membership table that includes the dually eligible and a membership table that excludes the dually eligible, for comparison purposes.

The total adult membership (including duals) has consistently grown from one quarter to the next. Although membership increased from Q2 '13 to Q3 '13, this increase was small (less than 400). It is unclear at this time why membership growth from Q2 '13 to Q3 '13 was minimal. There was a 0.1% increase in total adult membership from Q2 '13 to Q3 '13 and a 2.7% increase in total adult membership from Q3 '12 to Q3 '13. This growth is most evident in the HUSKY D and HUSKY A (family Single) populations where it appears that membership increased this year (Q3 '12 to Q3 '13) by 7.7% and 2.7% for those benefit groups, respectively. We anticipate this trend will continue for HUSKY A and HUSKY D with the implementation of the Affordable Care Act (ACA).

Inpatient Level of Care

Inpatient Admits/1,000

The overall Admits/1,000 rate was 2.40 for Q3, '13. Admits for All Benefits have increased slightly over the past two quarters, from Q1 '13 to Q2 '13 and again from Q2 '13 to Q3 '13. This quarter, admissions for HUSKY A (Family Single) and HUSKY C (ABD Single) increased, while admissions for the HUSKY D (MLIA) population decreased. The changes to Admits/1,000 from Q2 '13 to Q3 '13 were minimal. There were no statistically significant differences when comparing Q2 '13 to Q3 '13 for the All Benefit Groups and there were no statistically significant differences for any of the graphed benefit groups.

When comparing Admits/1,000 in Q3 '13 to a year ago, statistically significant decreases were found for All Benefit Groups and HUSKY D (MLIA). The actual number of members utilizing this level of care has remained stable over time. If membership continues to grow, and the number of members utilizing IPF remains the same, Admission rates will continue to drop.

Consistent with past quarters, HUSKY C (ABD Single) has the highest admission rate at 6.26 Admits/1,000, followed by HUSKY D (MLIA) at 3.95 and HUSKY A (Family Single) at 0.77.

Inpatient Days/1,000

Overall, Days/1,000 increased slightly from 19.01 in Q2 '13 to 19.26 in Q3 '13 for All Benefit Groups. Of the graphed benefit groups, HUSKY C (ABD Single) and HUSKY A (Family Single) Days/1,000 increased from Q2 '13 to Q3 '13. Days/1,000 slightly decreased by 0.5% from Q2 '13 to Q3 '13 for HUSKY D (MLIA).

HUSKY D (MLIA) Days/1,000 decreased from Q3 '12 to this quarter, contributing to an overall reduction in Days/1,000 from Q3 '12 to Q3 '13.

HUSKY C (ABD Single) members continue to have the highest number of Days/1,000 at 57.29, followed by HUSKY D (MLIA) and HUSKY A (Family Single). This quarter's HUSKY C (ABD Single) Days/1,000 remains almost twice as high as the HUSKY D rate (30.48). The variance from quarter to quarter for All Benefit Groups ranges from the all-time high of 21.93 in Q1 '12 to the all-time low of 19.01 in Q2 '13 .

Average Length of Stay (ALOS)

The Average Length of Stay changes from Q3 '13 to Q4 '13 and from Q4 '12 to Q4 '13 for All Benefit Groups were not significant. The ALOS for all adult Medicaid members with Duals removed was 7.95 days in Q3 '13 and 8.18 days in Q4 '13, an increase of 2.9%.

The table below lists each of the three benefit groups graphed and the All Benefits Group, the ALOS for Q1 '13, Q2 '13, Q3 '13, Q4 '13 and the percentage change from Q3 '13 to Q4 '13.

ALOS (in days) by Selected Benefit Group

	Q1 2013	Q2 2013	Q3 2013	Q4 2013	% Change (from Q3 '13 to Q4 '13)
HUSKY A (Family Single)	7.37	6.66	6.82	6.78	-0.6%

HUSKY C (ABD Single)	11.29	9.65	8.98	9.51	5.9%
HUSKY D (MLIA)	8.37	7.67	7.69	7.91	2.9%
All Benefits (Duals removed)	9.00	8.07	7.95	8.18	2.9%

HUSKY C (ABD Single) members continue to have the longest length of stay, followed by HUSKY D (MLIA) and HUSKY A (Family Single). We continue to understand that HUSKY C (ABD Single) members will have longer lengths of stays related to their complex needs. We also expect that HUSKY C (ABD Single) members will continue to utilize inpatient care at a higher rate than HUSKY D (MLIA) and HUSKY A (Family Single) members. We will continue to support providers in their efforts to reduce ALOS, particularly when working with HUSKY C (ABD Single) members as these members tend to have complex needs requiring a longer treatment episode.

Conclusions – Inpatient Psychiatric Level of Care:

Overall, inpatient admissions decreased this quarter (from Q2 ’13), and decreased even more significantly from 1 year ago (Q3 ’12). Days spent on inpatient psychiatric units increased this quarter (from Q2 ’13), but decreased when comparing year over year (Q3 ’12). Analysis for Q4 ’13 Admits/1,000 and Q4 ’13 Days/1,000 is pending next quarter’s refresh. Unlike the “per 1,000” measures, ALOS analysis included Q4 ‘13. The ALOS has ranged from the lowest of 7.77 in Q3 ’11 to the highest of 9.00 in Q1 ’13. The ALOS fluctuations have had no identifiable pattern or explanation, with the exception of Q1 ’13 We believe that the Q1 ‘13 ALOS was affected by providers taking extra caution when working with at risk members post the Newtown shooting tragedy, contributing to longer lengths of stays on inpatient units. The ALOS increased slightly from Q3 ’13 to Q4 ’13 and from a year ago. The ALOS for all Medicaid members (Duals removed) in Q4 ’13 was 8.18 days.

The on-line concurrent review process for Adult bypass programs was introduced in Q1 ’13. Providers and VO staff have adjusted well to the changes to the concurrent review process. Most concurrents completed via the web are reviewed by VO care managers and care is authorized quickly. Through discussions at PAR meetings and discussions with VO staff, clinical dialogue continues to occur for members with complex needs (ICM Cases) and on the infrequent occasions when questions related to current treatment planning and/or discharge planning arise. Providers continue to report enjoying the ability to submit web-based reviews at their convenience. The non-bypass programs are looking forward to the bypass re-evaluation process. The new methodology and measures will be finalized and shared with providers, once the analytical predictors are finalized from the Inpatient analysis that is being concluded now. Many non-bypass providers have reported in PAR meetings that they continue to work diligently to reduce ALOS and readmission rates. Non-bypass providers report enthusiasm for the opportunity to create efficiencies for staff by receiving an initial authorization of 5 days and by submitting concurrent reviews via Connect, VO’s web-based portal.

As stated last quarter, an additional tool that soon will be utilized by providers to monitor, analyze, and respond to ALOS and readmission rates is the adult inpatient dashboard. Providers will be given their passwords to the Connect system at the next round of inpatient PAR meetings, scheduled for February and March of 2014. Once providers gain access to VO’s web-based portal, providers will be able to view real-time (up to the most recent calendar month) hospital-specific and state-wide data measures. Member details also will be available to each participating provider. We believe that this innovation will help providers, state partners, and VO to identify changes in utilization more proactively and to

understand what may be impacting the change. It is believed that earlier identification of an issue will allow for more timely practice change if needed. We look forward to rolling out the adult dashboard and believe that the inpatient providers will benefit greatly from having real-time data.

Inpatient Detox – Free Standing

Admits/1,000

There were over 2,300 admissions to free standing detox programs in Q3 '13. This is the highest number of individual admissions recorded since Q3 '11. HUSKY D (MLIA) members continue to use IPD more frequently than any other membership group and account for 82% of the total admissions to this level of care in Q3 '13.

Admits/1,000 were decreasing over time for HUSKY D (MLIA) until Q3 '13, when a significant increase of 7.6% from the previous quarter was recorded. There were no additional statistically significant changes from Q2 '13 to Q3 '13. Admits/1,000 have remained relatively stable over time, ranging from the lowest of 2.31 in Q4 '12 to the highest of 2.55 in Q3 '11 for All Benefit Groups. There were no statistically significant changes from Q3 '12 to Q3 '13.

Days/1,000

There was a small increase in Days/1,000 this quarter (from Q2 '13). Consistent with past quarters, HUSKY D (MLIA) had the highest Days/1,000 when compared to other benefit groups. HUSKY D (MLIA) Days/1,000 increased by 7% from Q2 '13 to Q3 '13, driving the increase in Days/1,000 for All Benefit Groups. For HUSKY C (ABD Single) and HUSKY A (Family Single) members, Days/1,000 decreased slightly from Q2 '13 to Q3 '13. Although Days/1,000 vary for each benefit group from quarter to quarter, overall, Days/1,000 for All Benefit Groups appears to be trending down over time. Days/1,000 have been reduced by 1.8% from last year (Q3 '12 to Q3 '13).

Average Length of Stay

The average length of stay in free standing programs has been close to 4 days since we began gathering length of stay information for the adult population in 2011. Q3 '13 is without exception. Members receive medication by protocol and complications are unusual. The ALOS for Q3 '13 was 3.85 days and for Q4 was 3.95 days. Free standing detox ALOS, like per 1,000 measures, is most influenced by HUSKY D (MLIA) ALOS because detox is utilized most by those members. The free standing detox ALOS for HUSKY D (MLIA) in Q3 '13 was 3.85 days and in Q4 '13 was 3.95 days.

Conclusions – Detoxification Free Standing

The HUSKY D (MLIA) population consistently utilizes substance abuse treatment services at a higher rate than other HUSKY members. We continue to focus on HUSKY D utilization when providing analysis and recommending interventions. The table below shows the types of substance-related services authorized by VO for HUSKY D and the rates of Admission in the four, most recently measurable quarters.

Admits/1,000 for HUSKY D

	Q4 2012	Q1 2013	Q2 2013	Q3 2013
Hospital based detox*	0.18	0.14	0.18	0.19
Free standing detox	5.87	5.69	5.78	6.22
Ambulatory detox*	0.48	0.47	0.36	0.31

Methadone Maintenance*	2.54	2.35	2.75	2.66

***see appendix for related graphs**

As stated last quarter, HUSKY D members continue to utilize free standing programs far more than other detox options and far greater than other HUSKY members. We believe that members are receiving services in the right level of care, based on admission criteria, however, we would like to begin to use ambulatory detox as a safe alternative to inpatient programs. Currently, there is little incentive for members and providers to utilize ambulatory detox, rather than inpatient detox. As VO and our State Partners develop a substance abuse work plan, we will study capacity and work with providers to create appealing and evidence based treatment options for detox in outpatient settings.

We will continue to make ICM and Peer referrals for members with patterns of high inpatient detox utilization. We will continue to collaborate with providers, ABH, CCAR and identified natural supports to offer effective and creative treatment options. We will continue to support the OATP initiative, educating providers and diverting members to OATP facilities when appropriate. Lastly, we will continue our effort to individualize treatment options within a protocol driven delivery system. We would like to have a greater impact on the utilization of substance abuse services by Medicaid members. We believe that finding alternatives to inpatient detox (for opiate withdrawal, specifically) and offering new and improved medication assisted therapies (MAT) will reduce utilization and ultimately support better our members who are in pursuit of a healthier life.

Partial Hospital Programs:

Admits/1,000

Approximately 1,000 Medicaid members utilize PHP each quarter. The Partial Hospital Program Admits/1,000 graph has been included in the analysis section of this quarter's report because for the first time, in addition to providing a graph for PHP Admits/1,000 by benefit group, we provided admission statistics based on diagnostic category.

Although a slight downward trend appears visible for PHP Admits/1,000, Admits have remained relatively stable over time and decreases from one quarter to the next have not been significant. Consistent across quarters, HUSKY D (MLIA) members utilize PHP at the highest rate, followed by HUSKY C (ABD Single) and HUSKY A (Family Single).

This quarter three graphs have been added to the PHP Exhibit E reports. The first additional graph is PHP Admits/1,000 by Members' diagnosis. When all PHP admissions are broken out by diagnosis, members with substance abuse disorders or substance abuse and mental health disorders make up 85.3% of all members utilizing this level of care. Only 14.9% of adult members who started PHP in Q3 '13 did not have any type of substance abuse disorder.

The second and third additional graphs show each diagnostic category (MH, or SA and SA with MH) and the related utilization based on benefit group. For members with a MH only diagnosis, HUSKY D (MLIA) and HUSKY C (ABD Single) utilized PHP at the highest rate, followed by HUSKY A (Family Single), but the total number of admissions in each was very small. For the members with a SA diagnosis or a SA

and MH diagnosis, HUSKY D (MLIA) utilized PHP at the highest rate, more than double the HUSKY C (ABD Single) population.

Conclusions – PHP Levels of Care:

PHP continues to be utilized for members when a lower level of care is needed post discharge from a hospital setting. PHP also is utilized when a higher level of care is needed because outpatient and intensive outpatient services have been unsuccessful. In general, PHP continues to be utilized by members with HUSKY D (MLIA) most frequently. When looking at diagnostic categories (for PHP Admits/1,000), there are very few (14.7%) Medicaid members entering PHP with only a MH diagnosis. The majority of members entering PHP programs have at least one substance abuse diagnosis. This leads us to believe that PHP providers for adults in CT need to have experience assessing and treating members with substance abuse disorders. We have shared this information with clinical staff at VO so that they are reminded of the importance of asking about SA or at risk behaviors when conducting reviews with PHP providers. We will continue to track and trend PHP Admits/1,000, but will no longer create graphs specific to diagnostic categories.

Home Health Services

Admits/1,000

An admission is recorded for a first-time authorization for services by a provider to a specific member. There is an overall increasing trend from Q3 ’12 to Q3 ’13: All benefit groups increased by 3.8% (from 0.53 to 0.55 per 1,000) and HUSKY C (ABD Single) increased by 20.0% (from1.85 to 2.22 per 1,000). Comparing Q2,’13 to Q3 ’13, there is a slight decrease in admissions. Admits/1,000 for all benefit groups decreased by 9.8% from Q2 ’13 to Q3 ’13 (from 0.61 to 0.55 per 1,000), while HUSKY C (ABD Single) decreased by 1.3% (from 2.25 to 2.22 per 1,000). None of these changes were statistically significant.

Home Health authorization guidelines included a 60 day automatic authorization for new Med Admin services that are at a frequency level of daily or less often during this period. This resulted in the automatic approval of services that did not meet medical necessity or level of care guidelines upon concurrent review, and might not have been approved if the initial authorization request had been reviewed. The last day that initial authorizations will be automatically approved is 2/16/14. A preliminary analysis of the impact of this change will be reported when Q1 ’14 data becomes available.

Five of the 15 PAR providers have continued to show a consistent increase in the number of utilizers over the past four quarters, while five have had a consistent decrease in the number of utilizers over the past three quarters. We have continued the detailed, claims-based review of the frequencies of MedAdmin service utilization since Q1, 2011. Q1, 2011 is retained for analysis purposes, as it is the quarter prior to implementation of home health service authorization reviews by CT BHP. We compare this data to the most recent twelve month period of data available. The following data reflects claims analysis from Q3, 2012 through Q2, 2013, the most recent period for which claims data is available.

The number of overall members receiving Home Health services increased by 7.2% from Q1, 2011 to Q2, 2013, (from 4,617 to 4,951). During this same period, there has been a decrease in the percentage of members receiving twice daily (B.I.D.) medication administration services (from 25.9% of members in Q1, 2011 to 19.9% of members in Q2, 2013). Results for Q.D. and B.I.D. service frequencies are shown in the table below:

	Overall Members Served	% at B.I.D.	% at Q.D.
Q1, 2011	4,617	25.9	29.5
Q3, 2012	4,232	23.5	37.0
Q4, 2012	4,792	21.2	32.6
Q1, 2013	4,886	20.2	37.7
Q2, 2013	4,951	19.9	34.0

From Q1, 2013 to Q2, 2013 there was a slight decrease in percent of members receiving twice daily (B.I.D.) MedAdmin (from 20.2% to 19.9%). During this same period, the total overall number of active utilizers increased slightly by 1.3% (from 4,886 to 4,951).

Nine of the fifteen PAR providers had an increase in Q.D. MedAdmin in Q2, 2013 as compared to Q1, 2012. Five of the providers have lower than average utilization rates for both B.I.D. and Q.D., while four others are above the statewide average for both B.I.D. and Q.D. The PAR providers account for approximately 88% of the members receiving medication administration services. These results may indicate the extent to which providers are integrating skills transfer and recovery efforts, and also identify providers who may require additional attention and training. This information is shared with the providers during individual PAR meetings.

Provider Training:
One training program was conducted at New England Home Care which included staff from several branches and approximately 30 nurses and several supervisors in attendance.

As of 12/31/13, trainings were conducted at ten of the PAR 15 providers. Of the providers who had on site staff training:

- Four providers had a decrease in visit frequency from Q2 ’12 to Q2 ‘13
- Four providers maintained B.I.D. and Q.D. frequencies at levels below the state average

Of the five remaining PAR providers:

- One provider has training scheduled for January 2014
- One provider has a B.I.D. rate under 10% and Q.D. rate under the statewide average
- The remaining three providers will be offered on site staff training

Regional Network Manager (RNM)/Individual Provider PAR visits
Four additional PAR meetings were conducted with individual home health providers in December. Meetings have been conducted with ten of the fifteen PAR providers since September 2013. CT BHP clinical staff continues to partner with the RNM on these visits. Provider identified challenges in these recent meetings included: a) routinely referring members discharged from the hospital at a B.I.D. frequency, b) discharging members with no medication and no scheduled follow up appointment, and c) community providers sending members to the ED. Providers also identified internal challenges in training some of their nurses in recovery coaching and skills transfer.

Improvement opportunities continue to be pursued both internally and externally regarding the identified challenges. These steps include ongoing involvement of home health providers in Connect to Care meetings with hospital providers, as well as increased coordination of care between inpatient and home health authorization departments at CT BHP. Trainings continue to be offered to providers, both for supervisors and for direct care staff. The home health team reviews provider-specific challenges at weekly meetings to develop more effective shaping and teaching strategies.

ED/Inpatient Utilization

Claims for ED and inpatient admissions, both psychiatric and medical, were evaluated for members who had two or more medication administration visits in at least one month of the quarter during Q1, '11-Q1, '13. Updated information will be available for the Q1 '14 quarterly report.

Peer Pilot:

Of the five active members in the Peer Pilot, all had a decrease in MedAdmin frequency since enrollment in the Pilot. Since October, one member had services increased to her original frequency of twice a week, and one appears to be receiving services under Medicare, as there are no authorizations or Medicaid claims after September 2013. In addition, four of the participants have identified personal goals related to increased self-direction and expanded social connections and have made measurable progress towards meeting their goals. The fifth member participated in the pilot for less than a month, too little time to have measured success in personal goals.)

Member	Date enrolled	Jan. 2013 MedAdmin	Oct. 2013 MedAdmin	Dec 2013 Med Admin	% change	Member goal	Goal update
32 yo female	2/20/13	7x/wk.	3x/wk	n/a		Social activity	n/a, dropped out of pilot, rehospitalized
51 yo female	2/20/13	3x/wk.	Every two wks	Every two wks per claims	-83%	Job interview	Engaged with CT Works, went on job interview, applied for volunteer work
75 yo female	2/12/13	2x/wk.	1x/wk	2x/wk per claims	- no change	Social activity	Attending senior activities and groups at CMHA, agreed to CCAR referral
65 yo male	1/10/13	4x/wk.	3x/wk	3x/wk per NEHC (no claims)	-25%	Get organized, complete Medicaid redetermination	Attending group therapy and church, saving money, applied for subsidized housing
36 yo female	7/30/13	3x/wk	1x/wk	1x/wk	-66%	Improved mgmt. of household	Found new housing

Conclusions – Home Health

Current data indicates that changes are continuing in the practice patterns for MedAdmin services with the members. These changes are the result, we believe, of concerted efforts to partner and collaborate with provider agencies, and training related to Recovery principles and values. We believe there is additional room for bending the curve in both the numbers of members receiving services and the intensity of those services, while ensuring that members are receiving the optimum benefit from the services they receive.

Ongoing analyses are planned to determine any relationship between reduction in MedAdmin frequency, re-hospitalization rates, and connection to other community services for members. The Peer Pilot program at New England Home Care has been concluded and analysis is in progress, looking at service utilization before and during the Pilot as well as both member and provider perception of care. Lessons learned will be examined prior to initiating a program at a second agency.

Levels of Care Included in the Appendix

Mental Health Group Homes

Admits/1,000
See Appendix

Days/1,000
See Appendix

ALOS
See Appendix

Conclusions – Mental Health Group Homes:

This level of care did not warrant analysis in the current quarter. There were 20 admissions in Q3 '13. Of those 20 members, 75% were HUSKY C and 25% were HUSKY D. Group Home data and graphs include HUSKY C (ABD Dual) because members with HUSKY C (ABD Dual) are expected to continue to utilize this level of care, and unlike inpatient care, authorizations for MHG are routinely requested by treating providers. As stated in previous submissions, authorization data will only provide an accurate measure of ALOS when overall LOS is greater than the time period for which VO has been authorizing care.

We look forward to working more closely with DMHAS and group home providers in an effort to identify members who would benefit from a less restrictive setting. Once identified, we will support members in their transitions to lower levels of care.

Detoxification- Hospital-based

Admits/1,000
See Appendix

Days/1,000

See Appendix

ALOS
See Appendix

Hospital-based Detoxification Conclusions

This level of care did not warrant analysis in the current quarter. Hospital-based detox admissions continue to be very low. There were 73 Medicaid members who received detox in a hospital setting in Q3 '13. The ALOS for hospital-based detox has varied from one quarter to the next which seems normal, considering the small number of admissions.

As stated last quarter, when a member presents at an Emergency Department and is admitted with substance related symptoms, CHN is frequently called for an authorization. When detoxification is the primary reason for the admission, VO will soon be expected to authorize care and CHN will no longer authorize. When VO begins authorizing care for all members who receive hospital-based detox, a more thorough analysis will be completed. At that time, we will have a clearer picture of the members who utilize this level of care and how we can better support members in their recovery.

Ambulatory Detox

Admits/1,000
See Appendix

Ambulatory Detox Conclusions

This level of care did not warrant analysis in the current quarter. There are usually between 100-200 members who begin Ambulatory Detox each quarter. We will continue to work with our state partners to develop a substance abuse work plan for 2014. As part of the work plan, we would like to include a capacity study. When we have confirmed that providers have the ability to manage larger volumes, we will utilize ambulatory detox as a diversion from inpatient detox.

Methadone Maintenance

Admits/1,000
See Appendix

Methadone Maintenance Conclusions

This level of care did not warrant analysis in the current quarter. HUSKY D (MLIA) continues to utilize this level of care at the highest rate. There were 1170 Medicaid members who started methadone maintenance in Q3 '13. 71% of members utilizing this level of care were HUSKY D (MLIA). We continue to support DMHAS in the OATP initiative and would like admissions to MET increase in 2014. We will continue to help providers identify members who are "OATP eligible" and ensure that ICM referrals to ABH or VO are being made, in support of methadone as an evidence based medication assisted therapy.

Intensive Outpatient

Admits/1,000
See Appendix

Intensive Outpatient Conclusions

This level of Care did not warrant analysis in the current quarter. IOP Admits/1,000 have been stable over time. HUSKY D (MLIA) members have consistently utilized IOP at the highest rate, followed by HUSKY C (ABD Single) and HUSKY A (Family Single).

Outpatient Services

Admits/1,000
See Appendix

Outpatient Conclusions

This level of care did not warrant analysis in the current quarter. Admits/1,000 have been relatively stable over time with the exception of Q1 '13. There was a significant increase in Admits/1,000 in Q1 '13 when CPT codes changed and providers working with HUSKY C (LTC Single) in long-term care facilities were required to authorize outpatient services. Although, Q4 '13 has not yet been analyzed, it appears that a similar change in authorization and billing practices has caused a dramatic spike in HUSKY C (LTC Single) admissions.

RECOMMENDATIONS

UPDATES TO RECOMMENDATONS FROM PREVIOUS QUARTER – This section documents activity since the previous quarterly report

Global Recommendation

1. Support Regions in the Development of Community Care Team (CCT) Meetings – CCT and CCT-like models were presented at the the Inpatient workgroup meeting scheduled for February 11, 2014. This workgroup meeting was originally scheduled for December 10, 2013, but due to inclement weather was rescheduled. The outcome of the February 11th meeting and subsequent activities will be outlined in the next quarterly report.

Inpatient Level of Care

1. Increase Diversion Efforts – ICMs place calls to Emergency Departments Daily. Several hospitals welcome our inquiries and are receptive/thankful to have us aid in diversion efforts. We continue to work closely with hospitals that are open to our interventions on a member specific level. In 2014, we expect to have an increased presence in EDs. Several hospitals have created or are in the process of developing ED/OBs specific rounds and triage processes for members with behavioral health needs. ICMs and peers have been invited to participate in ED/OBs rounds and continue to aid the EDs in member specific diversions. In addition, those activities help to increase our understanding of specific barriers to assessment and discharge experienced by each ED. This recommendation will be subsumed by the 2014 ED diversion Performance Target

which describes in detail the ICM work that will be conducted in collaboration with high volume EDs across the state.

2. Improve Regional Communication and Expectations Related to Discharge Planning - The following themes were identified by providers in the 2013 Connect to Care meetings: Lack of outpatient prescribers, few residential rehab options, poor care coordination/communication among providers and limited shelter care beds for members who are homeless. Based upon these common themes, RNMs presented the following recommendations to the state: Develop an incentive program to encourage/reward communication between providers, and create a centralized data platform that will offer real time service availability. RNMs continue to hold regional/hospital meetings to follow up on specific plans that were developed in larger Connect to Care meetings. RNM's also will continue to partner with providers to address system issues as they arise.

3. St. Francis Pilot – The St. Francis Pilot has been completed. We are currently gathering pilot data to aggregate and analyze. A final analysis and summary of the St Francis Pilot will be submitted to state partners in March, 2014.

4. Review and update the Adult Inpatient Bypass Program – As described last quarter, this recommendation is on hold, pending the development of the new risk assessment methodology. We expect to initiate the new program in 2014. Hospitals currently on bypass will remain on bypass until then and will continue to submit concurrent reviews via VO's web-based portal.

5. Adult PAR Program – We informed providers that, beginning in 2014, the adult on-line dashboard will be available. This technology will allow individual providers to monitor PAR measures in real-time. RNMs will combine Q3 and Q4, 2013 data for the next round of PAR meetings which will take place in February and March.

6. Improve Communications with Skilled Nursing Facilities – Throughout the year we have tried to find ways to address communication needs between SNFs and inpatient facilities. We determined that there was value in looking more closely at individuals who have SNF involvement and inpatient hospitalizations, specifically Medicaid members age 55+ who were admitted to an inpatient psychiatric unit in Q1 or Q2 2013. 68 members were admitted to an inpatient psychiatric unit during that timeframe, the majority of those to Bridgeport Hospital (46), followed by Hartford Hospital (10). Most members coming from a SNF at admission returned to the same SNF with seemingly few challenges. During the last round of PAR visits, hospitals did not identify a need for further relationship building with local SNFs and reported that SNFs are generally accepting members back after an inpatient stay. Based on the data reviewed, input from the hospitals, and meetings with several large SNF agencies, relationships and communications with SNFs are moving in a positive direction. ICMs will continue to focus on coordinating care between Inpatient programs and SNFs to ensure that barriers or delays to discharge are minimal. Should new/repeat challenges arise both Clinical and RNM departments can work with the facilities to address the issues, with special attention to those facilities taking the greater number of SNF members. At this time we believe that this recommendation has been met, and that new challenges be addressed on an ongoing basis as necessary.

Inpatient Detox

1. Focus on discharge planning – Clinicians begin speaking with providers about potential discharge plans when a member is admitted for an inpatient detox. When barriers to discharge arise and/or the same discharge plan is tried repeatedly without a positive outcome, an Intensive Care Manager is assigned. We work collaboratively and creatively with providers to develop individualized discharge plans. ICMs are currently on-site at several Free Standing programs to aid in treatment and discharge planning. During Q4, 2013 several meetings with Free Standing programs were held by RNMs and ICMs to address specific challenges faced by the providers. We will continue to meet with providers, as necessary, to better understand the challenges members in need of substance abuse services face and the system of care designed to treat Medicaid members. We held one Connect-to-Care meeting with substance abuse providers and the RNM is following up to address barriers that have been identified.

2. Coordinate more effectively with ABH –We have continued to partner with ABH to educate providers, including state-run programs, on the two distinct ICM programs. We also agreed to hold a monthly strategy meeting between ABH and VO for the purpose of identifying likely program candidates for (re)education and to identify additional provider level interventions to ensure that transitions in the substance abuse continuum are smooth and timely. Our first meeting is scheduled for March 5th.

3. Increase Diversion Efforts – Clinical staff at VO undergo ongoing training on outpatient services that could serve as alternatives to inpatient care for opiate detox. We have diverted many members successfully from inpatient care when medical necessity criteria are not met. We have not yet begun to divert members regularly from inpatient detox to ambulatory detox, although that initiative is under consideration. In 2014, VO will work with state partners to develop and implement a Quality Improvement Initiative for Substance Abuse Services. The Quality Improvement Initiative includes, but is not limited to, understanding capacity in levels of care that may be used for diversion and alternatives to Methadone services, such as Vivitrol and Suboxone. This recommendation and associated efforts will be subsumed by the SA Quality Improvement Initiative and its associated efforts.

Partial Hospital and IOP

1. Analyze PHP Admits based on Specialty - This quarter PHP Admits/1,000 were broken down into two diagnostic categories. The first diagnostic category was for members with a Substance abuse diagnosis. These members may have more than one SA diagnosis and may have a behavioral health diagnosis. The second diagnostic category is for members with only one or more psychiatric diagnoses (no SA dx). We believed that by looking at this data, we would gain a better understanding of the needs of our members. Although a member's treatment needs are not solely based on diagnosis, we now know that, at the PHP level of care, the majority of members have a diagnosis related to Substance Abuse/Dependence. This leads us to believe that all Intermediate Care programs that treat Adults (with Medicaid) should employ clinical staff who can properly assess and treat members with substance abuse disorders.

Home Health

1. Continue planned focus on claims data analysis, including review of any changes in the relationship between hospitalization rates and changes in visit frequency for members receiving MedAdmin services. The quarterly PAR meeting was held on November 15, 2013. The enhanced PAR reports included cohort tracking for members receiving both Q.D. and B.I.D.

services from Q3 ’12 through Q1 ’13, as well as ED and hospitalization rates. Member specific data on ED and hospital utilization was given to the providers. Nine of the PAR 15 providers have had individual PAR visits, which included home health clinical staff as well as the RNM. Both providers and VO staff have reported improved understanding of intensity of service data as a result of these meetings, with providers identifying their own areas for improvement regarding skills transfer.

2. Continue and expand provider based recovery and skills transfer training for home health nurses
   Three training programs at two provider sites were conducted during the 4th quarter of 2013, reaching a total of 52 home health staff. One of these trainings was a supervisor session, which focused on coaching interventions for staff who have not yet embraced the Recovery model successfully in their interactions with their members. Basic motivational interviewing techniques with specific examples for home health have been incorporated into the latest training module that was presented at these trainings.

   Four non-PAR providers have been identified as having significant increases in behavioral health medication administration services in 2013. One of these providers attended the December webinar.

   The first expanded webinar, Strategies for Successful Completion of Home Health Documentation and Authorization Requests, was offered on 12/6/13. There were ten participants from six different provider agencies. We received immediate and unsolicited positive feedback from one of the providers. Post webinar surveys were sent to all attendees; there was one respondent, who rated the program overall as “good.”

   Due to claims lag, analysis of utilization rates has not yet occurred. Participation in provider training, individual PAR meetings and webinar trainings is being tracked and utilization analysis will begin once 3rd quarter 2013 claims data is available.

3. Continuation and expansion of peer pilot project.
   The Peer Pilot officially concluded on 12/31/13. Data from both ValueOptions and New England Home Care is being compiled and expansion of the Peer Pilot will be addressed after the findings are presented to the State partners in Q 1, 2014.

4. Ongoing collaboration with prescribers and provider agencies
   The home health Clinical Care Managers have continued to work telephonically with providers and prescribers in identifying opportunities to advance recovery and skills transfer for individual members. Final approval of the Level of Care Guidelines did not occur during this quarter. It is anticipated in the 1st quarter of 2014.

RECOMMENDATIONS FOR Q4, 2013

Global Recommendations

1. Support Regions in the Development of Community Care Team (CCT) Meetings - Adult inpatient providers were invited to a quarterly workgroup meeting on December 10, 2013. Due to inclement weather the workgroup meeting was rescheduled for February 11, 2014. This workgroup is usually held to discuss PAR, identifying more accurate ways to collect and analyze data based on shared practices and barriers. However, the February 11th meeting was dedicated to presentations on the Community Care Team model (CCT) and CCT-like models being used by communities across the state to reduce ED and inpatient utilization, while supporting members with mental illness in community-based programs. Following the presentations, each RNM will host a regional break-out session to discuss further interest in implementing region/hospital specific CCT or CCT-like meetings. Based on conversations at Connect to Care and PAR meetings, we believe that providers are excited about the opportunity to begin planning their own CCT meetings. RNMs will support each region/hospital in the planning and development phase and ICMs will participate in follow-up meetings.

2. Develop an ICM team specific to Co-management with CHN - We recommend developing a co-management Clinical (ICM) team to support planning for members with psychiatric and ongoing medical needs. Each team member will have knowledge of behavioral health and physical health, understanding that neither is mutually exclusive. In addition to working with behavioral health providers and medical providers, this team will work extensively and collaboratively with medical ASO (CHN) staff to ensure members receive quality care and individualized treatment planning with a goal of safe transitions to community providers.

3. Care Coordination for DDS Clients - RNMs have reported that hospitals have difficulty coordinating care for DDS clients. We recommend that RNMs reach out to DDS regional offices to initiate and develop relationships that may facilitate DDS involvement in discharge planning and care coordination.

Inpatient Level of Care

1. Complete the analysis of the St. Francis Pilot – We will complete a final St. Francis Pilot summary report in early 2014, after the St. Francis Pilot is finished and data for the entire year is collected.

2. Review and update the Adult Inpatient Bypass Program – We expect the new risk assessment methodology to be clarified early in 2014. We will initiate the new program soon afterward, after consultation and planning with the Departments. Hospitals currently on bypass will remain on bypass until then and will continue to submit concurrent reviews via VO's web-based portal.

3. Continue Adult PAR Program – RNMs will combine Q3 2013 and Q4 2013 data for the next round of PAR meetings which will be held in February and March of 2014.

Inpatient Detox

1. Continue to focus on discharge planning – We recommend continuing to conduct Connect to Care regional meetings focused on substance abuse services to identify gaps in service at the regional level. Once gaps/barriers have been identified VO will work with regional providers, ABH, DMHAS to develop solutions.

2. Continue to Coordinate with ABH – We will continue to meet with DMHAS and ABH on a monthly basis to review OATP outcomes and develop strategies to improve outcomes. We recently invited ABH to join us for a monthly strategy meeting and ABH agreed. The purpose of the strategy meeting is to identify likely program candidates for (re)education (on VO's and ABH's ICM programs) and to identify additional provider level interventions to ensure that transitions in the substance abuse continuum are smooth and timely. System issues that are identified through this process will either be addressed directly by ABH and VO ICM clinical team or will be escalated to VO Regional Network Managers and/or VO Clinical Managers.

Home Health Recommendations –

1. Develop proposal for home health bypass program and present to State partners. The proposed by pass program would incentivize providers by offering longer authorizations to those who successfully decrease the frequency of med admin visits.

2. Continue planned focus on claims data analysis, including review of any changes in the relationship between hospitalization rates and changes in visit frequency for members receiving MedAdmin services. Continue cohort tracking of members receiving B.I.D. MedAdmin services to refine our knowledge and understanding of utilization patterns. Add OBS beds to inpatient and ED tracking. Engage providers in exploration of the variances in frequency reduction rates and hospitalization/OBS and ED rates through group and individual PAR meetings.

3. Continue and expand provider based recovery and skills transfer training for home health nurses to enhance nursing skills related to motivational interviewing and member centered, goal focused care plans.
    a. Training that incorporates motivational interviewing techniques specifically tailored for work with the behavioral health population and in the context of a home health care nursing visit will continue to be offered to providers throughout the year.
    b. Non-PAR providers who have shown consistent growth in the number of utilizers will be specifically targeted for training.
    c. Training will be offered to home health supervisors/managers to enhance their effectiveness in communicating about recovery and skills transfer with the direct care nurses.
    d. Expanded webinars will be offered on a monthly basis by the home health clinical team to reinforce skills transfer techniques and provide additional provider training to a larger audience.

    Service reduction rates of providers who have training will continue to be evaluated. Offer providers targeted trainings based on PAR data and reviewer findings.

4. Peer Pilot project analysis and expansion. Complete the New England Home Care Peer Pilot analysis and present to the State Partners. Incorporate recommendations into plan for a second Pilot program.

5. Ongoing collaboration with prescribers and provider agencies for determining appropriate frequencies for medication administration services. Training on the new Level of Care Guidelines will be provided by the RNMs and home health clinical team once approved.