

Executive Summary: Utilization Management for HUSKY Youth Members Quarter 4, 2012 (Annual Report)

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 and 10B series which reviews utilization statistics such as average length of stay (ALOS) and admissions per 1,000 members (Admits/1,000) and Discharge Delay. NOTE: A detailed description of the measures can be found at the end of this document.

In the selective review on the following pages we will be providing information regarding the Child/Adolescent Medicaid populations through various levels of care. This summary will outline the areas of interest in regards to utilization trends, as well as the possible causes for those results and efforts that have been identified to address them. This submission focuses on the 4A and 10B reports for the youth population, providing an in-depth analysis of the Q 2012 and annual data, compared to previous quarters. We also discuss some remaining challenges and potential lines of progress as recommendations This UM analysis focuses on the following areas:

- Youth Membership
- 4A2 Inpatient Hospital services Admits/1,000, Days/1,000 and Average Length of Stay (ALOS)
- 10B series which describes discharge delay (DD) during an inpatient facility stay
- 4A2 Solnit Center South Inpatient Admits/1,000, Days/1,000, ALOS as well as Court Ordered and Non Court Ordered data
- 4A2 PRTF services Admits/1,000, Days/1,000 and Average Length of Stay .

NOTE: A detailed description of the measures can be found at the end of this document.

Beginning in 2012, and as agreed in the CORE meetings the Executive Summary now focuses only on those LOC's in which the data warranted analysis and discussion. If the analysis for an LOC did not reveal results or trends that warranted discussion, then those results were removed from the body of the analysis document and placed in an Appendix at the end of the analysis document. For this quarter the following graphs can be found in the Appendix at the end of the main report.

- 4A_2: PHP Admits/1,000, All Youth (0-17);
- 4A_2: IOP Admits/1,000, All Youth (0-17);
- 4A_2;EDT Admits/1,000, All Youth (0-17);
- 4A_2: Home Based Services (IICAPS, FST, MST, FFT) Admits/1,000, All Youth (0-17);
- 4A_2; IICAPS Admits/1,000, All Youth (0-17);
- 4A_2;Outpatient (OTP/TST) Admits/1,000, All Youth (0-17)

The data in this report is primarily authorization-based. In some cases, additional data has been provided to enhance the understanding of the LOC or the utilization management efforts. One example is in the Inpatient Child PAR data that is included to further the understanding of the statistics included within the Child Inpatient data. The following PAR for the eight Child/Adolescent inpatient programs (Big 8) Utilization graphs are also placed in the Appendix:

- Inpatient Average Length of Stay (ALOS) for Big 8, All Youth (0-17);
- Inpatient Average Length of Stay for Big 8, Child (0-12);

- Inpatient Average Length of Stay for Big 8; Child (0-12) DCF vs. Non-DCF Members;
- Inpatient Average Length of Stay for Big 8, Adolescent (13-17);
- Inpatient Average Length of Stay for Big 8, Adolescent (13-17); DCF vs. Non DCF Members;
- Total Number of Acute Days vs. Discharge Delay Days for Big 8, All Youth (0-17).

The appendix additionally includes graphs for the 10B Discharge Delay data series, including:

- 10B4A, Inpatient (excluding Inpatient Solnit Center) Discharge Delay Reason Codes by Major Category;
- 10B4A, Inpatient (excluding Inpatient Solnit Center) Discharge Delay Reason Awaiting Placement;
- 10B4B, PRTF (excluding PRTF Solnit Center) Discharge Delay Reason Codes by Major Category;
- 10B4B Discharge Delay Reason Awaiting Placement;
- 10B4A, Inpatient Solnit Center Discharge Delay Reason Codes by Major Category;
- 10B4A, Inpatient Solnit Center Discharge Delay Reason Awaiting Placement.

Finally, the appendix includes: 18A: Routine Outpatient graphs including:

- 18A Location of Outpatient Treatment Youth (0-17);
- 18A OTP – Provider Obtained Consent to Contact Other Providers:
- Percent of Cases, Youth (0-17);
- 18A OTP – Provider Indicated Need for Medication Evaluation/Management Visits: Percent of Cases, Youth (0-17);
- 18A OTP- Provider Indicated Family/Significant Other is Involved Members Treatment/Recovery Plan: Percent of Cases, Youth (0-17)

Methodological Factors

The data for this report 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 differ 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 Quarter 3, 2012. When first reported, there appeared to be a decline in adult membership from Quarter 2 to Quarter 3. By the current quarter, however, the data revealed that membership actually increased during that span, although the increase was slight. The reports and analyses for all LOC's can be affected by this phenomenon. As a result, when the results are based on membership totals, these reports can identify only general trends, not specific changes between quarters. In those instances, the analyses will focus more on multi-quarter results than on changes within a single quarter.

Membership

Membership for All Youth (0-17) has been relatively stable over the past year, rising only 1.8% from CY '11 to CY '12. Annual increases in youth membership have occurred consistently over the past several calendar years, beginning in CY '08. During CY 2012, there was a slight increase in membership of 1.10% from Q1 '12 to Q4 '12. While there appeared to be a minimal decrease of less than 1% in youth membership from Q3 '12 to Q4 '12, it is expected that the actual youth membership will increase further when the data is refreshed in the next quarter. DCF 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 CY '12. The remainder of the members were Non-DCF involved (291,252 members) and accounted for 98% (291,252) of total membership in Q4 '12 and 99% (324,829) in CY '12. 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. The decline is also apparent from CY '11 to CY '12, with a 9% (15,321 to 13, 927) decrease during that span.

Please note: Membership numbers for DCF and Non-DCF youth will not add up to the total number of youth members. The total membership number for youth is an unduplicated count of all youth who were eligible for services at any time during the quarter. Since youth members can and do fall into both the DCF and non-DCF category during a quarter, there are members who are included in both the DCF and Non-DCF count during a quarter. Thus, the total unduplicated membership count will always be less than the sum of DCF and non-DCF youth during the quarter.

In reviewing the year to year change, and in hearing from providers during the past year about their perceptions regarding DCF-involved volume, we determined the need for a deeper analysis of DCF-involved members throughout the state. Therefore, we conducted a review of DCF membership totals broken into geographic regions associated with the DCF Area Offices. Results indicate some statewide trends, but also some changes specific to some regions, but not others.

The overall decline in DCF membership has occurred statewide, but the magnitude of the changes has differed among DCF regions. The table below shows changes in the number of DCF members by region for the past three years, 2010 to 2012.

Change in DCF-involved Members, by DCF Area Office, 2010-2012

Area Office	2010	2011	2012	Change in Membership,	Change in Membership,
				2010 vs 2012	2011 vs 2012
Bridgeport	1,056	1,497	1,355	28.3%	-9.5%
Danbury	247	331	295	19.4%	-10.9%
Hartford	1,899	2,221	2,064	8.7%	-7.1%
Manchester	1,021	1,303	1,044	2.3%	-19.9%
Meriden	575	740	625	8.7%	-15.5%
Middletown	404	513	438	8.4%	-14.6%
Milford	572	898	884	54.5%	-1.6%
New Britain	1,234	1,613	1,503	21.8%	-6.8%
New Haven	1,293	1,551	1,500	16.0%	-3.3%
Norwalk	223	291	295	32.3%	1.4%
Norwich	1,033	1,385	1,236	19.7%	-10.8%
Stamford	207	276	150	-27.5%	-45.7%
Torrington	405	594	558	37.8%	-6.1%
Waterbury	1,019	1,208	1,116	9.5%	-7.6%
Willimantic	660	899	891	35.0%	-0.9%
Total	11,848	15,320	13,954	17.8%	-8.9%

Results show that the number of DCF-involved members increased by 29.3% from 2010 to 2011, but then decreased by 8.9% from 2011 to 2012. Those changes resulted in an overall increase of 17.8% in the number of DCF-involved members from 2010 to 2012 (11,848 to 13,954). The changes did not occur evenly throughout the state, but were much higher in some regions, compared to others. The Stamford Area Office was the only one with a net decrease in DCF-involved members, falling from 207 to 150 members in the two-year span. That decline is even more significant when considering that the Stamford office had a 33% increase from 2010 to 2011 (207 to 276), but then fell by approximately 46% from 2011 to 2012 (276 to 150).

All other Area Offices had an increase in DCF-involved membership. The increases ranged from a low of 2.3% in Manchester to a high of 54.5% in the Milford office. Despite these differences in magnitude of the changes, there was very little change in how members were distributed throughout the state, overall. For example, although DCF-involved membership in Milford increased by 54.5% from 2010 to 2012, the percentage of statewide DCF-involved members in Milford increased only by 1.51%. In 2010, 4.83% of DCF-involved members were from Milford, and in 2012, that number rose only to 6.34%. These results indicate that the statewide changes in DCF-involved membership were relatively uniform across Area Offices.

Given the efforts made by DCF in the past two years to maintain community involvement for youth, we also decided to examine the length of time members were identified as “DCF-involved”. This examination was of particular interest, given the significant, unexpected increase in DCF-involved members from 2010 to 2011. The table below shows the length of DCF involvement, in months, for each Area Office from 2010 to 2012. Eligibility file data shows a decrease of 23.6% (9.38 to 7.17 months) in the length of time members were “DCF-involved” during that time span. The decreases were consistent across all Area Offices, and the data showed that there was a large decrease in involvement duration from 2010 to 2011 with a somewhat smaller decrease from 2011 to 2012.

Duration of DCF Involvement, in months, by Area Office			
Area Office	2010	2011	2012
Bridgeport	8.99	6.82	6.64
Danbury	9.34	7.16	6.89
Hartford	9.45	7.82	7.53
Manchester	9.13	7.34	6.71
Meriden	9.69	7.78	7.64
Middletown	9.35	7.30	7.24
Milford	9.66	6.96	6.84
New Britain	9.20	7.51	6.94
New Haven	9.59	8.02	7.55
Norwalk	9.24	6.84	6.96
Norwich	9.34	7.43	7.17
Stamford	9.92	6.62	6.55
Torrington	9.43	7.13	7.06
Waterbury	9.40	7.86	7.39
Willimantic	9.57	7.09	7.43
Total	9.38	7.44	7.17

One reason that the average duration has decreased is that there has been a corresponding increase in the number of members who are identified as DCF Involved for only one month. As shown in the table below, membership involved with DCF for only one month increase from 4.5% to 8.06% of all DCF-involved youth between 2010 and 2012.

	2010	2011	2012
Number of Unique Members	11,849	15,320	13,952
Avg Duration of DCF Involvement, months	9.38	7.44	7.17
Members Involved for Only 1 Month	534	811	1,124
Percent of Members Involved for Only 1 Month	4.51%	5.29%	8.06%

At this time, we are unable to explain the reason(s) for these changes. We anticipate that DCF's Differential Response Model may influence both the number of members who become DCF involved and the duration of that connection. That Model was not initiated until March of 2012, however, so it cannot account for the changes between 2010 and 2011.

INPATIENT LEVEL OF CARE

HUSKY Inpatient Admits/1,000- Youth (0-17)

Inpatient Admits/1,000 for all youth decreased throughout 2012, until increasing in the fourth quarter. A similar increase was noted from Q3 '11 to Q4 '11, indicating a probable seasonal trend. The rate of Inpatient Admits/1,000 in CY '12 remained nearly unchanged from CY '11.

While the overall rate of Inpatient Admits/1,000 for All Youth has remained nearly unchanged year to year, as expected, there has been a decrease in DCF Admits/1,000 and an increase in Non-DCF Admits/1,000. That trend is evident, both from Q3 '12 to Q4 '12 and from CY '11 to CY '12.

Overall, the DCF Inpatient Admits/1,000 rates have steadily decreased from CY '08 to CY '12 while the Non-DCF Admits/1,000 rates have steadily increased during that same time.

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.

HUSKY Inpatient Days/1,000 Youth (0-17)

The Inpatient Days/1,000 rates indicate similar quarterly trending for all youth (0-17) in both 2011 and 2012, with an increased rate from Q1 to Q2, decreasing in Q3 and increasing again in Q4. This pattern suggests seasonal variation, possibly the result of referrals by school-based and other community sources. For example, one explanation for the increase in this measure is that referrals typically increase in Q2 each year as schools anticipate the end of the school year and the need for stabilization for some youth.

During 2012, while the Inpatient Days/1,000 for all youth increased from Q3 '12 to Q4 '12, there has been a decline in the Inpatient Days/1,000 from Q4 '11 to Q4 '12. Year to year, the Inpatient Days/1,000 for all youth remained about the same, increasing only slightly from CY '11 to CY '12.

The DCF Inpatient Days/1,000 have decreased substantially from Q3 '12 to Q4 '12, and show a steady decline over the past year from CY '11 to CY '12.

The Non-DCF Inpatient Days/1,000 rate has increased from Q3 '12 to Q4 '12, but is on par with the rates during Q1 '12 and Q2 '12. The pattern is similar to the quarterly trending seen between Q3 '11 to Q4 '11, There also is an increase in the Non-DCF Inpatient Days/1,000 from CY '11 to CY '12.

The Inpatient Days/1,000 rate for DCF youth has been lower than the rate for Non-DCF youth since Q1 '11 and that trend continued in the most recent quarter as well as the calendar year.

HUSKY Inpatient Average Length of Stay (ALOS) Youth (0-17)

The Inpatient Average Length of Stay (ALOS) rates indicate similar quarterly trending for all youth (0-17) in both 2011 and 2012. In both years, the third quarter rate was the highest during the year, while the other three quarters were relatively equivalent. These results indicate the existence of a seasonal trend in ALOS with minimal change from quarter one to quarter two, higher lengths of stay in quarter three, and then a decrease in quarter four of each year. The overall Inpatient ALOS has remained nearly unchanged over the past year from CY '11 to CY '12.

While the overall ALOS remained unchanged, the ALOS for DCF-involved youth increased, compared to 2011. As DCF continues to implement Differential Response fully, 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.

Conclusions:

In general, the results for all three measures, Admits/1,000, Inpatient Days/1,000 and ALOS are relatively stable, despite some small fluctuations between quarters. Some of the results continue to reflect trends and the influence of seasonality. At present, the data indicates that over the past year:

- DCF membership has steadily declined, leading to a proportionate increase in Non-DCF members. Overall membership remains stable.
- The rate of Inpatient Admits/1,000 in CY '12 remained nearly unchanged from CY' 11.
- Inpatient Admits/1,000 decreased from Q2 to Q3 and increased from Q3 to Q4 of both 2011 and 2012, indicating a seasonal trend.
- Inpatient Admits/1,000 continues to remain lower for DCF-involved youth and higher for Non-DCF youth. We believe that reflects the broader service involvement and therefore more alternative services available for DCF-involved youth.

- The DCF Inpatient Admits/1,000 rate has been steadily declining from CY '08 to CY' 12 with a greater than 40% decrease since that time. Conversely, the Non-DCF Admits /1,000 has steadily increased during that same span.
- ALOS, Admits/1,000 and Days/1,000 likely are impacted by seasonality, as noted by the similar quarterly variations/trends each year. With DCF fully implementing Differential Response, the youth remaining in DCF services are in greater need for this high level of care, thereby possibly taking longer to resolve their presenting issues.
- The data continues to suggest that many of the interventions undertaken by DCF and ValueOptions in the past year have been effective. It appears that there is better utilization of community-based programs and crisis programs by all youth. This change is specifically seen in the DCF Inpatient Admits /1,000. The Admits/1,000 rate in CY' 12 was the lowest of any calendar year yet.

Internal ValueOptions Connect to Care process and interventions continue to assist members and families with follow up care when discharging from an inpatient stay and support care in the community. In addition, the VO Intensive Care Managers continue to support the State's Emergency Departments by calling daily to assist with coordination of care for any HUSKY youth. They assist with discharge planning to community services, if possible, to divert from unnecessary inpatient admissions.

We believe that these positive trends may reflect an early outcome of the Department of Children and Families initiating and broadening of the Strengthening Families Model to the community and providers, resulting in improved coordination of care and less youth disruption from the community. In addition, the decrease in admits and membership for DCF-involved youth may reflect the implementation of the Differential Response Model beginning in March of 2012. That Model is designed to provide earlier access to community programs and to prevent inpatient admission when possible. Greater utilization of those programs also means greater accessibility for members who truly need the inpatient services. An artifact of these initiatives is that there has been an increase in ALOS during acute inpatient stays; children identified as DCF-involved remain the youth in most need of acute-level services to resolve their presenting issues.

Discharge Delay (DD) ~ Inpatient

Discharge delay occurs when a youth is awaiting placement from the present level of care to an alternative program or level of care.

Inpatient Number of Days Delayed

The Inpatient Number of Days Delayed in Q4 '12 increased by 9.4% (from 697 to 763) over Q3 '12, which had the lowest days delayed in the past four years. With this increase however, the number of cases delayed in Q4 '12 (49) were the second lowest number of cases in the past four years. When comparing 2011 versus 2012, there was an 11% (856 to 763) decrease in the number of inpatient days delayed from Q4 '11 to Q4 '12.

The Inpatient Number of Days Delayed rates in 2011 and 2012 showed similar quarterly variations and trending, rising from Q1 to Q2, decreasing in Q3 and then increasing in Q4, which trends the same way that all acute inpatient stays demonstrate.

Based on our review of cases over the past years, we believe the seasonality relates to the school year. The fewest referrals to inpatient programs occur during the summer months when school is not in session. At times of higher demand, such as the end of the two semesters, referrals are higher and placement slots can be full, leading to longer waits for placements.

Inpatient Percent of Days Delayed

During CY 2012, only 178 cases entered discharge delay. That number is the lowest recorded in any calendar year, decreasing by 16% (211 to 178) from CY '11 and by 48% (341 to 178) from CY '08 to CY '12. In addition to the fewest delayed cases in any calendar year, 2012 also recorded the lowest percent of inpatient days delayed of any calendar year. Only 10.6% of inpatient days delayed, representing a 58% decrease in percent of days delayed from CY '08 to CY '12.

This measure appears to have achieved some stability. The percent of inpatient days delayed for all members in Q4 '12 was identical to that of Q3 '12 (9%). Those last two quarters of 2012 had the lowest percentages of this calendar year 2012, as well as any previous quarter recorded. When comparing 2011 to 2012, the inpatient percent of days delayed has decreased from Q4 '11 to Q4 '12 (9.7% to 9.0%) as well as from CY '11 to CY '12 (10.9% to 10.6%).

The quarterly trending between 2011 and 2012 follows the same pattern as the Number of Days Delayed, rising from Q1 to Q2, decreasing in Q3 and decreasing or stable in Q4. This suggests the influence of seasonality on the Inpatient percent of Days Delayed. See the explanation above.

Inpatient Average Days in Delay by Reason Code

The reasons and percentages identified for discharge delay in CY 2012 are shown in the table below:

Discharge Delay LOC	Number of Cases 2012	2012 Average days in Discharge delay	2012 % of Cases awaiting LOC
Awaiting State hospital	38	31.05	29.2%
Awaiting PRTF	59	17.66	29.2%
Awaiting RTC	33	22.64	12.5%

Awaiting Placement ~ State Hospital

In calendar year 2012, there were a total of 38 cases in discharge delay awaiting Solnit – State Hospital. The average Inpatient Days in Delay awaiting the State hospital for CY 2012 was 31.05 for those 38 cases. From CY 2011 to CY 2012, there has been a 25% decrease (51 to 38) in the number of cases on discharge delay awaiting State hospital, but a 50% increase (20.76 to 31.05) in the average days awaiting placement. This increase in the 2012 vs. 2011 average days delayed was driven by the lengthy delays in the first three quarters of 2012. For example, the average delay in Quarter 2 was over 36 days. However, some improvement occurred in the fourth quarter, with an average delay of only 19.57 days. In fact, the average days in discharge delay decreased by 24% (25.67 to 19.57) from Q3 '12 to Q4, '12. The average days in discharge delay awaiting State hospital has also decreased from Q4 '11 to Q4 '12 by 14.4% (22.88 to 19.57).

Awaiting Placement ~ PRTF.

The average inpatient days in delay awaiting PRTF has increased by 25% (14.17 to 17.66) from CY '11 to CY '12 with a similar number of cases delayed each year. On average, a member in discharge delay awaiting PRTF waited 3 days longer in calendar year 2012 than in 2011. From Q3 '12 to Q4 '12, there has been an 8% (11.80 to 12.79) increase in the Inpatient Average Days in Delay for members awaiting PRTF for a similar amount of cases.

The longer inpatient average days in delay awaiting a PRTF level of care is thought to reflect changes in the statewide availability of PRTF beds. The 12-and-under PRTF program at Klingberg Family Services closed this year, so overall capacity was decreased. While new PRTF

beds for adolescent girls were created at Solnit South, that implementation took time. The changing bed capacity created several “log jams” at points over the past year.

Awaiting Placement ~ Residential

The average number of days in discharge delay for those members awaiting placement to a Residential facility increased by 18% (15.27 to 18.0) from Q3 '12 to Q4 '12, even as the number of cases for that time period decreased by 45% (11 to 6).

The average inpatient days in delay awaiting RTC placement has remained the same from CY '11 to CY '12, with less than a 1% increase (22.51 to 22.64) in days delayed. The number of cases decreased by 33% (49 to 33) over the same time period. This may be a result of ValueOptions partnering with the Department of Children and Families on the various initiatives to decrease the reliance on Congregate Care.

Conclusion:

ValueOptions continues to collaborate with the Department of Children and Families and community providers to monitor and address discharge delay as one of the most significant shared utilization management goals within the system of care. These strategies include weekly discharge delay rounds with DCF and providers, Inpatient hospital facility rounds, and Regional DCF rounds for any member identified in or at risk for discharge delay. It is evident that these interventions have been effective. Additional collaborative interventions were implemented in this quarter, as well. Family Peer Specialists are attending clinical rounds at inpatient units that have longer discharge delay rates to assist and support families with any barriers that may impact a youth returning home. They also provide continued support in the community when the child discharges from inpatient.

ValueOptions and DCF continue to collaborate regarding Intensive Care Management provided to the PRTFs to support the community service continuum and coordination of care. To address some of the reductions in placement options identified last quarter (reduction in Solnit Center inpatient beds, limited access to Solnit PRTF and the closure of one of four community PRTFs), ValueOptions has increased hours for the Intensive Care Managers at the DCF Regional offices. This change has expanded the scope of clinical collaboration to identify and coordinate services needed for highly complex cases. In addition, to address the increased discharge delay days for youth awaiting Solnit Center, ValueOptions has assigned an additional Intensive Care Manager to that facility to support discharge planning and coordination of care..

In Q3, '12 VO identified Residential Network Managers, clinicians who specialize in Residential Network Management and utilization management techniques. These RNM's, formally assigned to the Residential Care Team, have begun collaborating with assigned DCF area offices and the Systems Managers at DCF to improve care coordination and program management processes that will ultimately assist DCF in managing the clinical needs of CT's youth.

Solnit Center Inpatient

Admissions

The number of HUSKY youth admitted to the Solnit Center has decreased by 15% (167 to 142) from CY '11 to CY '12, and by 23.2% (185 to 142) from CY' 10, to CY, '12. As noted in previous quarterly reports, the decrease in admissions is the result of decreased capacity in inpatient beds due to the repurposing of two units as a PRTF program for adolescent girls.

Days/1,000

There was a 3% decrease (4.83 to 4.69) in the Inpatient Days/1,000 for Solnit Center from Q3 '12 to the most recent quarter. This was the lowest Inpatient Days/1,000 in any quarter in any calendar year that we have measured. The decrease from Q4 '11 to Q4 '12 was 6.2% (5.7 to 4.9), and the rate for 2012 was 14% lower (5.7 vs. 4.90) than the rate recorded in 2011. This change may be a result of ValueOptions and DCF/Solnit partnering to coordinate care. In addition, the ValueOptions assignment of an Intensive Care Manager to Solnit South to assist

with discharge planning and coordination of care has facilitated movement between the Solnit facility and community providers.

ALOS

Although Admissions and Days/1,000 decreased, the Solnit Inpatient ALOS for all youth increased by 9% from CY '11 to CY '12 (111.4 to 121.25). This measure has had considerable variability over the past 8 quarters, but the general trend in 2012 was higher. The overall number of children discharged during this quarter (N=31) is also the smallest in 8 quarters. This number is consistent with the increased length of stay; although fewer children are admitted, they are staying longer than they did in 2011.

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. Those non-court ordered youth have a significantly longer ALOS than court-ordered youth, as seen in both the fourth quarter and annual results for 2012. Seventeen (17) of the 31 total discharges from Solnit during Q4 '12, were non-court ordered cases, while 14 were court ordered. The ALOS for non-court ordered vs. court ordered youth was 150.8 vs. 67.3 days. For CY '12, there were 144 total discharges, 76 for non-court ordered and 68 for court ordered youth. The annual ALOS was consistent with the results found in Q4, with non-court ordered youth staying much longer than court ordered youth. A comparison is shown, below:

ALOS, days

	Non-Court Ordered	Court Ordered
Q4 2012	150.8	67.3
CY 2012	171.7	64.5

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 2008. For court ordered youth, the pattern has been much more stable. Although there was a spike in the ALOS for court-ordered youth in 2011, the overall ALOS since 2008 has been consistently around 64 days, down 30% from its high point in 2008 of 92 days.

Although there has been an increase in ALOS this past quarter, there has been a 13% decrease (74.0 to 64.5) 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 as ValueOptions Intensive Case Managers expanded their participation in Court Review team meetings with Solnit Center and CSSD to improve coordination of care and effectuate timely discharge planning.

ALOS, days

	Non-Court Ordered	Court Ordered
CY 2008	244.4	92.0
CY 2009	157.7	63.9
CY 2010	206.7	64.1
CY 2011	157.9	74.0
CY 2012	171.7	64.5

The court ordered cases are of a shorter lengths of stay by design. This is due to the fact that court ordered cases are ordered for two purposes; thirty days, for an evaluation, and sixty 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 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 thirty or sixty 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.

Solnit Inpatient; Discharge Delay

During Q4 '12, the largest number of members in discharge delay status at Solnit Center were awaiting placement in the Group Home level of care (42.9%). By comparison, 28.6% of members in discharge delay were awaiting PRTF and another 28.6% were awaiting Foster Care placements or other services.

For CY' 12, the majority of members in discharge delay status at Solnit Center were awaiting GH (36.7%). An additional 26.7% were awaiting RTC, with the remainder of the delayed members awaiting PRTF (16.7%) and Foster Care or other placements (19.7%). In an effort to assist in the movement of children through the service continuum, ValueOptions has expanded the scope of the Intensive Case Management clinicians to participate within weekly admission, discharge and court review treatment meetings at the Solnit Center. Their focus is assisting with coordination of care and discharge planning.

Conclusion:

Although we have seen a decrease in overall Admits/1,000 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 calendar year 2012, 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 9% (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.

HUSKY PRTF

Admits/1,000,

Admissions to PRTF increased by 10.3% (29 to 32) from Q3, '12 to Q4, '12 and have increased by 33.3% (24 to 32) over the past year from Q4, '11 to Q4, '12. During the calendar year 2012, the PRTF admissions for all youth increased by 19% (27 to 32) between Q2 '12 and Q4' 12. This change is likely due to decreasing PRTF ALOS evident from year to year, allowing for an increased volume of admissions to the PRTF level of care.

Days/1,000

The PRTF Days/1,000 for all youth has steadily decreased since Q1, 2011, continuing through the present quarter. In that time, the PRTF Days/1,000 has declined by 33.3% (6.54 to 4.36) to the lowest rate in the past four years. In the past year (Q4, '11 to Q4, '12) the PRTF Days/1,000 has fallen by 24% (6.11 to 4.66). There has been a downward annual trend since 2008, decreasing by 37% (7.37 to 4.66) from CY ' 08 to CY '12, with the CY '12 rate of 4.66 the lowest of the calendar years.

ALOS

The decrease in Days/1000 is consistent with increases in ALOS for this level of care. In the past year (Q4, '11 to Q4, '12) the PRTF ALOS has decreased by 10.5% (162.9 to145.8). There also has been a 3% decline from CY '11 to CY ' 12 (151.2 to 147.4) continuing a gradual annual

decline in the PRTF ALOS for all youth since 2008. The ALOS for 2012 has decreased by 47% (276.2 to 147.4) since 2008, reaching its lowest value of any calendar year.

Conclusion:

Overall, the data indicates there has been a decrease in Days/1,000 and ALOS in the PRTF level of care while Admits/1,000 have increased. The decrease in the Days/1,000 and ALOS have led to greater availability of PRTF beds, and therefore the increase in admissions. The 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. ValueOptions Intensive Care managers also continue to partner with DCF and PRTF providers to coordinate discharge planning.

OVERALL CONCLUSIONS:

The quarterly and annual analyses reflect trending across the Inpatient level of care towards decreased and stable Days/1,000 Admissions and ALOS. The quarterly and annual analyses for Solnit Center follow that of the inpatient level of care, reflecting decreased Days/1000, and Admissions, but indicate a longer ALOS over the past year. The quarterly and annual analyses reflect trending across the PRTF level of care towards decreased Days/1000 and decreased ALOS with increased admissions seen throughout this year. Additional innovative community programming is still needed to assist in the movement of children through the entire health care delivery system at all levels of care for particularly the Non-DCF involved youth. The community-focused service delivery system is critical to our ability to manage the complex clinical needs of those children who previously would be referred out of state or to an in-state inpatient or congregate care setting, but who are now being served in local communities.

Collaboration between inpatient hospitals and community providers / agencies is imperative to achieve further integration of systems of care, ensure connect-to-care after discharge and to improve outcomes. Creative approaches are still needed to improve collaboration with physical health care providers for DCF-involved youth. Finding new collaborative opportunities with CHN will help the system transition to a more effective partnering of behavioral health and physical health entities. These needs are addressed in our recommendations below.

RECOMMENDATIONS:

It is crucial at this time to assess the needs in the entire youth/adolescent service delivery system, with particular focus on the changes occurring within the Solnit South and North Campuses, community based care, and prevention. That assessment will allow us to continue to impact positively the utilization trends and clinical outcomes of the youth of CT. In looking across the recent trends in utilization and population needs, several opportunities may be available to impact services in the near future.

1. Redefining the Bypass program parameters for the inpatient youth hospital programs: Inclusion/exclusion criteria should be re-evaluated and re-set to insure relief of administrative burden for the hospitals, as well as ValueOptions clinical staff. Similar to the twice-yearly benchmarking being done with adult hospitals, the inclusion/exclusion criteria should be reviewed at the second and fourth quarters, rather than waiting until the end of the year. Further, we recommend that hospitals on Bypass be allowed to access authorization via our web technology to improve administrative efficiency and allow hospitals to reallocate their resources to more creative community discharge planning efforts. As already established, hospitals would have to meet targets related to ALOS, readmission rates and completion of discharge notifications.

2. Continuing to develop and implement the role of the Intensive Care Managers, Family Peer Specialists and Residential Network Managers; The CT BHP Residential Network Managers' role and scope of activity will continue to be adapted to work most effectively with the System Managers at DCF. It is expected that they will use data to inform the Regional Offices of programmatic issues, and to discuss multi-prong management strategies to impact desired clinical and utilization goals. We propose the Residential Network Managers continue to focus on facility performance for in-state programs and identified out-of-state programs, as needed. Residential Network Manager's will assess progress accurately based on identified performance standards. As the Intensive Care Managers' role has expanded to include serving as clinical consultants to DCF Regional offices, we also recommend ongoing refinement of their scope and function and collaboration with the Central Office Congregate Care Unit at DCF. The Family Peer Specialists role and scope will also continue to be adapted to work most effectively with DCF, Intensive Care Managers and the DCF/FAVOR Family System Managers to promote families and communities as partners to support desired goals.

3. Collaboration with Solnit Center as units continue to change in scope – The changes to Solnit Center to further expand and develop PRTF units, as well as maintain the Inpatient units will support the efforts of DCF to increase the opportunities for adolescent girls on the South Campus and boys on the North Campus to benefit from a short focused clinical experience in the PRTF setting. In addition, the changes to Solnit will also allow the younger adolescents (13 and 14 year olds) awaiting RTC to be moved to a community based service with a shorter length of stay and a stronger programmatic focus on returning youth to community based services. This expanded access to services for youth, particularly older girls, 13-17 years is a clear need as this population has traditionally been involved at the residential or Group home level of care. It is hoped that the creation of these units at Solnit South and the conversion of the Solnit North units for older boys will round out PRTF services for Connecticut youth. These additional "repurposed" beds will provide greater flexibility in treatment options as the focus for care is centered on community based services for all CT youth.

4. Expand access to PRTF services for Adolescent females, particularly the older girls, 13 -17 years. There is a clear need for these girls who have traditionally been involved at the residential or Group Home level of care but who need additional support offered by a more structured level of care. It is hoped that the creation of these units at Solnit South and the conversion of the Solnit North units to PRTF for older boys will round out PRTF services for Connecticut youth.

5. Regional Meetings: Continue to facilitate scheduled meetings between hospitals and community services providers in their regions. Such meetings facilitate communication among providers while improving coordination of care that will result in improved ambulatory follow-up on discharge from the hospital.

6. Establishment of Intensive Community Based Acute Treatment (ICBAT) services: As part of the reorganization of Solnit South and North service array, this program has been identified as a viable option that is to be housed at the Solnit South Campus., With the inclusion of this service, the landscape of the delivery system will add a

viable and creative option to meet the need for community based programs designed for all youth. This level of care will also support DCF's efforts to develop the new program that is described in the recently released Community Bridges Program Part 1: Assessment and Rapid Treatment (ART) RFP. Aligning new and creative approaches to community based services will create opportunities for all youth to be treated in the most appropriate, least restrictive setting that will support individual recovery efforts.

7. Establishment of Community Support Programs (CSP) as utilized in other states would provide "hands on" paraprofessional support for families as youth transition from acute and congregate levels of care back to community. This alternative, home-based service, while not evidenced based, provides a fiscally prudent and effective peer model to support families during times of change.