

## **Executive Summary: Utilization Management for HUSKY Youth 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 and 10B series which review 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.

The review on the following pages provides information regarding the Child/Adolescent Medicaid population's utilization of behavioral health services in various levels of care. This summary focuses on trends in utilization during Q4 '13 and particularly on those levels of care (LOC) with significant findings. Additionally, this summary provides possible explanations for the findings and descriptions of any utilization management strategies identified to address them. When appropriate, recommendations are made regarding remaining challenges with utilization patterns.

This Q4 '13 UM analysis focuses on the following areas:

- 4A\_2: Total Unique Membership Youth (0-17)
- 4A\_1: Membership Youth (0-17) DCF Members
- 4A\_1: Membership Youth (0-17) Non-DCF Members
- 4A\_2: Inpatient Admits/1,000; All Youth (0-17)
- 4A\_1/4A\_2: Inpatient Admits/1,000; DCF vs. Non-DCF Members
- 4A\_2: Inpatient Days/1,000; All Youth (0-17)
- 4A\_1/4A\_2: Inpatient Days/1,000; DCF vs. Non-DCF Members
- 4A\_2/4A\_2: Inpatient Average Length of Stay (ALOS); All Youth (0-17)
- 4A\_1/4A\_2: Inpatient Average Length of Stay, DCF vs. Non-DCF Members
- PAR: Inpatient Average Length of Stay (ALOS) and Discharges for In-State Pediatric Hospitals; All Youth (0-17)
- PAR: Inpatient Average Length of Stay (ALOS) for In-State Pediatric Hospitals; Child (0-12) and Adolescent (13-17), DCF vs. Non-DCF
- 10B\_7: Inpatient Number of Days Delayed
- 10B\_7: Inpatient Percent of Days Delayed, DCF vs. Non-DCF Members
- CTBH12087: Inpatient Average Days in Delay by Reason code(s)
- CTBH12087: Inpatient Solnit Center ALOS; All Youth, Court Ordered and Non Court Ordered data
- 4A\_2: Community PRTF Admissions; All Youth, Community PRTF Days/1,000 and PRTF Average Length of Stay, All Youth
- 10B7: Community PRTF Number of Days Delayed, Percent of Days Delayed, DCF vs. Non-DCF, Percent of Cases Delayed, DCF vs. Non-DCF
- 4A\_2: IICAPS Admits/1,000; All Youth (0-17)

Beginning in 2012, and as agreed upon in the CORE meetings, the Executive Summary now focuses on only those levels of care in which the data reveals findings or trends that warrant discussion. Those

findings that have remained flat or consistent over time are 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: Inpatient Solnit Center Admissions by Calendar Year; All Youth (0-17)
- 4A\_2: Inpatient Solnit Center Admissions by Quarters; All Youth (0-17)
- 4A\_2: Inpatient Solnit Center Days/1,000; by Calendar Year; All Youth (0-17)
- 4A\_2: Inpatient Solnit Center Days/1,000 by Quarters; All Youth (0-17)
- 4A\_2: Solnit Center PRTF Admission by Quarters; All Youth (0-17)
- 4A\_2: Solnit Center PRTF Days/1,000 by Quarters; All Youth (0-17)
- 4A\_2: PHP Admits/1,000 by Calendar Year; All Youth (0-17)
- 4A\_2: PHP Admits/1,000 by Quarters; All Youth (0-17)
- 4A\_2: IOP Admits/1,000 by Calendar Year; All Youth (0-17)
- 4A\_2: IOP Admits/1,000 by Quarters; All Youth (0-17)
- 4A\_2;EDT Admits/1,000 by Calendar Year; All Youth (0-17)
- 4A\_2;EDT Admits/1,000 by Quarters; All Youth (0-17)
- 4A\_2:Home Based Services (IICAPS, MDFT, MST,FFT) Admits/1,000 by Calendar Year; All Youth (0-17)
- 4A\_2:Home Based Services (IICAPS, MDFT, MST,FFT) Admits/1,000 by Quarters; All Youth (0-17)
- 4A\_2: Outpatient (OTP/TST) Admits/1,000 by Calendar Year; All Youth (0-17)
- 4A\_2: Outpatient (OTP/TST) Admits/1,000 by Quarters; All Youth (0-17)
- 4A\_1: Yearly Inpatient Admits/1,000; Youth (0-17)
- 4A\_1: Quarterly Inpatient Admits/1,000; Youth (0-17)
- 4A\_1: Yearly Inpatient Days/1,000; Youth (1-17)
- 4A\_1: Quarterly Inpatient Days/1,000; Youth (0-17)

In addition, the following sets of graphs will be found in the appendix each quarter:

#### The 10B: Discharge Delay Series

- 10B7: Inpatient Solnit Center Percent of Days Delayed by Quarters
- 10B7: Inpatient Solnit Center Percent of Days Delayed by Calendar Year
- 10B7: Inpatient Solnit Center Percent of Days Delayed DCF vs. Non-DCF
- 10B7: Inpatient Solnit Center Percent of Cases Delayed by Calendar Year
- 10B7: Inpatient Solnit Center Percent of Cases Delayed by Quarters
- 10B7: Inpatient Solnit Center Percent of Cases Delayed DCF vs. Non-DCF
- CTBH12112: Quarterly Inpatient Solnit Center Average Days in Delay by Reason Code
- 10B7: Solnit Center PRTF Percent of Days Delayed
- 10B7: Solnit Center PRTF Percent of Days Delayed DCF vs. Non-DCF Members
- 10B7: Solnit Center PRTF Percent of Cases Delayed DCF vs. Non-DCF Members
- 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: PRTF (excluding PRTF Solnit Center ) Discharge Delay Reason Awaiting Placement

- 10B4D: Group Home Delay; Reason Codes by Major Category
- 10B4D: Group Home Discharge Delay Awaiting Placement
- 10B4A: Inpatient Solnit Center Discharge Delay Reason Codes by Major Category
- 10B4A: Inpatient Solnit Center Discharge Delay Reason Awaiting Placement
- 10B4B: PRTF Solnit Center Discharge Delay Reason Awaiting Placement
- 10B4B: PRTF Solnit Center Discharge Delay Reason Codes by Major Category

#### The Provider Analysis and Reporting (PAR) Graphs

- PAR: Inpatient Average Length of Stay (ALOS) for In-State Pediatric Hospitals by Calendar Year; All Youth (0-17)
- PAR: Inpatient Average Length of Stay (ALOS) for In-State Pediatric Hospitals by Quarters; All Youth (0-17)
- PAR: Total Number of Acute Days vs. Discharge Delay Days for In-State Pediatric Hospitals by Calendar Year; All Youth (0-17)
- PAR: Total Number of Acute Days vs. Discharge Delay Days for In-State Pediatric Hospitals by Quarters; All Youth (0-17)
- PAR: Quarterly Solnit Center PRTF Average Length of Stay by Quarters; All Youth (0-17)

#### The 18A: Routine Outpatient graphs:

- 18A; Volume of Outpatient Registrations, Youth (0-17)
- 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 utilization data in the 4A and 10B series reports are exclusively based on authorizations entered into the ValueOptions Connect system. In some cases, additional data, primarily drawn from the Provider Analysis and Reporting program (PAR), are included to enhance the understanding of the drivers of the utilization trends. An example of this is the inclusion of the Inpatient Child PAR data that helps to further explain how changes in the average length of stay (ALOS) for child inpatient hospitalization during Q4' 13 are impacted by individual hospital performance.

The data for the utilization reports are refreshed in each subsequent set of Quarterly Reports. As a result of retrospective authorizations and changes in eligibility, the results for each quarter often differ from the previously-reported values. In most cases, the refreshed data does not result in significant differences in the previously reported conclusions. However, on some occasions there is sufficient variation that the previous analysis is no longer relevant. This phenomenon has been much more common for analyses of adult utilization, as retrospective membership variations have been significantly larger for adults than for

youth. For any analysis affected by these variations, we identify it in the narrative and describe the implications.

## **Membership**

Total youth membership has increased 20% from 2008 to 2013 with consistent annual increases over the past six calendar years, and a 0.8% increase over the last year (330,902 to 333,441). This quarter, however, membership for all youth (0-17) has remained stable, with a minimal decrease (0.4%) from Q3 '13 to Q4 '13. The total unique youth membership (0-17) for Q4 '13 was 302,500, with DCF youth accounting for approximately 2.62% (7,939) of all youth members and Non-DCF youth accounting for the remaining 97.8% (296,072). Over the past two years, there has been a 19% decline (15,321 to 12,427) in DCF youth membership, with an 11% decline (13,964 to 12,427) occurring over the last year. Conversely, Non-DCF membership increased 3.6% (317,977 to 329,348) over the past two years, with a 1% increase over the last year. There have been consistent annual increases in Non-DCF membership.

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.

## **INPATIENT LEVEL OF CARE**

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

#### **Annual:**

Inpatient Admits/1,000 for all youth (0-17) increased 10% (0.70 to 0.77) from calendar year 2012 to 2013. The Non-DCF Admits/1,000 accounted for the majority of this annual increase, increasing by 13.7% (0.51 to 0.58), compared to the DCF Admits/1,000 which did not change (0.19 to 0.19). The Non-DCF population comprised 75% of the total volume of admissions this year, compared to 25% of the DCF admissions. There has been a consistent annual increase in the Non-DCF Admits/1,000 since 2008. Over the same period, the DCF Admits/1,000 annual rates have steadily decreased. This suggests the increase in Total membership has contributed to the overall increased admissions, specifically the Non-DCF population. We see similar quarterly trending between the Non-DCF and the Total Admits/1,000. Non-DCF Admits/1,000 continues to be three times as high as that for DCF-Involved youth.

#### **Quarterly:**

The Total Admits/1,000 increased 14.2% (0.70 to 0.8) from Q3'13 to Q4'13. Both the Non-DCF and the DCF admits/1,000 increased from last quarter to this quarter. Non-DCF increased by 18% and the DCF increased 5.3%. We have seen increased Inpatient admissions from Q3 to Q4 for the past three years which continues to evident a seasonal trend. This result likely relates to the beginning of the school year when there are increased educational and social demands upon children. Expanding services that can identify and treat trauma, such as TF-CBT (Trauma-Focused Cognitive Behavioral Therapy) may help to meet this need, and therefore support decreased admissions to acute care.

We will continue to monitor inpatient admissions to identify any potential factors contributing to the trend of increased admissions.

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

### **Annual:**

There has been a 6.4% increase (9.12 to 9.70) in Inpatient Days/1,000 for all youth from calendar year 2012 to 2013. The Non-DCF Inpatient Days/1,000 account for most of this increase, increasing by 18.7% (5.67 to 6.73) from 2012 to 2013, while the DCF Inpatient Days/1,000 decreased over the last year by 13.6% (3.45 to 2.98). Beginning in 2009, we have seen the Non-DCF Days/1,000 increase annually accounting for the majority of the increased Days/1,000, while the DCF Inpatient Days/1,000 has decreased annually. Since 2011, the Non-DCF population has utilized more Inpatient Days/1,000 than the DCF population. There are more Non-DCF children being admitted, and therefore utilizing more Days/1,000. This could be related to the increased identification of children as Non-DCF with the implementation of Differential Response in 2011. With the resulting decrease in the DCF involved population, more children have been placed within family settings receiving services in their community. This increase in children in community based services may contribute to greater utilization of acute care services for crisis stabilization and the resulting increased total inpatient days. We will continue to monitor this trend over the next several months as well as access to other levels of care to determine if the system has adequate capacity for referrals throughout the entire continuum.

### **Quarterly:**

The Total Inpatient Days/1,000 have increased 5% (9.37 to 9.82) from Q3'13 to Q4'13. We have seen an increase in Inpatient Days/1,000 from Q3 to Q4 for the past 3 calendar years. For the last two years, this increase was primarily driven by the Non-DCF population.

The Non-DCF Inpatient Days/1,000 accounted for most of the annual change, increasing 13% (6.18 to 6.98) from last quarter, while the DCF Inpatient Days/1,000 decreased 11% (3.19 to 2.84) this quarter. During Q4 '13, Non-DCF (N=592) comprised 74% of the total cases (797), and DCF comprised 25% (N=205). There is similar quarterly trending noted between the Non-DCF Inpatient Days/1,000 and the Total Inpatient Days/1,000. This is likely related to the higher volume of the Non-DCF population admissions.

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

### **Annual:**

The Inpatient Average Length of Stay (ALOS) for all youth decreased 2.8% (13.07 to 12.71) from calendar year 2012 to 2013. This is the lowest ALOS recorded in the past six calendar years. The DCF ALOS decreased 13.9% (18.02 to 15.52), while the Non-DCF ALOS increased 5.8% (11.12 to 11.77). The DCF ALOS for Q4' 13 (15.52) was the lowest ALOS recorded over the past six calendar years. The Annual decrease in the DCF ALOS, was also noted in the PAR Inpatient ALOS for in-state pediatric hospitals in both the younger children (0-12) by 3.5 % (17.1 to 16.5) and the adolescents (13 -17) by 16% (17.4 to 14.6). Similarly, the increase in the Non-DCF Annual ALOS also occurred in both age groups. The younger children (ages 0-12) increased by 5 % (12.0 to 12.6), and the adolescents (ages 13- 17) increased 3 % (10.1 to 10.4). As expected, the DCF ALOS continues to be higher than the Non-DCF ALOS in all calendar years.

### **Quarterly:**

The Inpatient ALOS for all youth decreased 14.8% (14.25 to 12.14) from Q3'13 to Q4'13. Both the DCF and Non-DCF populations decreased this quarter. The DCF ALOS decreased by 17.6% (17.06 to 14.06) which was statically significant, while the Non-DCF ALOS decreased 12.7% (13.18 to 11.5). We have seen this seasonal trending from Q3 to Q4 for the last 3 calendar years in the DCF population.

The DCF ALOS (in-state pediatric hospitals) for the younger children (ages 0-12) decreased 19.1%

(18.3 to 14.8) this quarter, while the Non-DCF ALOS for this age group increased 8.5% (12.9 to 14.0). The ALOS for the DCF population (14.8) for Q4' 13 was the lowest recorded in a quarter for this population. The DCF ALOS for the younger children however, continues to remain higher than the Non-DCF involved children across all time periods.

We also saw a decrease in the DCF ALOS (in-state pediatric hospitals) rate for adolescents (ages 13 -17) by 22% (16.1 to 12.6) this quarter, while the Non-DCF rate remained unchanged (10.2). The DCF younger children ages 0-12 continue to have the longest length of stay, followed by the Non-DCF children 0-12, the DCF adolescents 13-17, and last, the Non-DCF adolescents 13-17 continue to have the shortest ALOS of the four groups. Across all time periods, the DCF involved youth have longer lengths of stay than Non-DCF involved youth.

We will continue to closely monitor the ALOS for the DCF children ages 0-12. We believe the longer length of stay for this age group reflects the lack of service alternatives for this population. As previously stated, we believe this finding reflects DCF's policy regarding limiting the use of congregate care with younger children and promoting community and family based intervention.

The ALOS of the seven (7) in-state hospitals is displayed below.

|                                         | Average Length of Stay (ALOS) |             |             |             |             |             |             |             |
|-----------------------------------------|-------------------------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|
|                                         | Q1 '12                        | Q2 '12      | Q3 '12      | Q4 '12      | Q1 '13      | Q2 '13      | Q3 '13      | Q4 '13      |
| <b>ALL In-State Pediatric Hospitals</b> | <b>12.7</b>                   | <b>12.8</b> | <b>13.4</b> | <b>11.8</b> | <b>12.0</b> | <b>12.0</b> | <b>12.7</b> | <b>11.8</b> |
| Waterbury Hospital                      | 5.9                           | 6.8         | 8.8         | 10.0        | 5.9         | 8.3         | 9.5         | 9.1         |
| Manchester Hospital                     | 7.6                           | 8.1         | 6.9         | 6.2         | 6.5         | 6.2         | 7.0         | 10.2        |
| St. Vincent's                           | 14.1                          | 15.4        | 11.3        | 11.7        | 9.9         | 11.5        | 13.1        | 8.7         |
| St. Francis                             | 12.9                          | 13.2        | 14.9        | 11.7        | 10.2        | 11.9        | 13.7        | 11.6        |
| Yale New Haven Hospital                 | 12.3                          | 12.8        | 12.9        | 12.1        | 12.5        | 12.1        | 12.1        | 13.1        |
| Natchaug Hospital                       | 14.3                          | 12.7        | 13.2        | 12.4        | 14.7        | 13.4        | 13.6        | 11.6        |
| Institute of Living                     | 13.9                          | 14.2        | 16.0        | 13.4        | 15.6        | 15.2        | 14.4        | 12.9        |

The ALOS for all In-State pediatric hospitals has decreased by 22% this quarter to 11.8 days. In addition, the number of discharges from Q3 '13 to Q4 '13 has increased by 16% (580 to 674). These metrics indicate increased movement through the inpatient level of care in Q4 '13. All the community hospitals, with the exception of Yale New Haven Hospital and Manchester Hospital experienced a decrease in ALOS when comparing Q3 '13 to Q4' 13.

**Conclusion:**

The Admits/1,000 and Inpatient Days/1,000 increased over the past year and most recent quarter, while the ALOS has decreased. This indicates increased movement though the inpatient level of care. These results signify that there are more youth being admitted to hospitals, but their lengths of stay are shorter allowing for an increased volume of admissions/days.

- The increase in Admits/1,000 and Inpatient Days/1,000 for all youth was largely due to the Non-DCF population. The Non-DCF Admits/1,000 and Days/1,000 increased during the past year, while DCF remained the same (Admits/1,000) or decreased (Inpatient Days/1,000).
- The decrease in the ALOS for all youth over the past year was largely due to the DCF population. The DCF ALOS decreased in both the younger children and adolescents from 2012 to 2013. The ALOS for Non-DCF youth increased in both age groups over the past year.
- However, while the DCF ALOS has decreased over the past year, the DCF population continues to have longer lengths of stay than the Non-DCF youth. The DCF youth ages 0-12 have the longest ALOS, as options for other levels of care are limited.
- The Q4'13 data indicates the same trending as the annual analysis; the total Admits/1,000 and Inpatient Days/1,000 have increased, but ALOS has decreased.
- There was an increase in both the DCF and Non-DCF Inpatient Admits/1,000 this quarter. However, DCF Inpatient Days/1,000 has decreased, while there was an increase in the Non-DCF inpatient days utilized.
- The ALOS for both DCF and Non-DCF has decreased this quarter (Q4' 13).

### **Discharge Delay (DD) ~ Inpatient**

Discharge delay occurs when a youth no longer meets inpatient medical necessity criteria and is awaiting placement to an alternative program or level of care.

### **Inpatient Number of Days Delayed**

**Annual:** Over the past year, however, the number of discharge delay days have increased by 4% (753 to 783).

**Quarterly:** The number of days delayed decreased by 17.0% (943 to 783) from Q3 '13 to Q4 '13. The number of cases in discharge delay has also decreased by 25% (57 to 43).

### **Inpatient Percent of Days Delayed**

#### **Annual**

The Annual Inpatient Percent of Days Delayed decreased from 2012 to 2013 (10.5% to 8.4%) with 9% fewer cases (177 to 161) in delay status this year. This was the lowest inpatient percent of days delayed (8.4%) recorded in any calendar year. The Non-DCF population comprised 55% of the total delayed cases and DCF the remaining 45%. Over the past year, the Non-DCF percent of days delayed increased (5.4% to 7.1%), and the DCF decreased (18.8% to 11.5%). Although the DCF percent of days delayed remains higher than that of Non-DCF, this is the lowest annual percent of days delayed recorded for the DCF population (11.5%). We will continue to monitor those factors which contribute to the discharge delay of the DCF population as that is the population that tends to drive this measure.

#### **Quarterly**

The Inpatient Percent of Days Delayed decreased (10.2% to 8.0%) from Q3'13 to Q4'13. The DCF inpatient percent of days delayed increased (12.0% to 12.4%), and the Non-DCF decreased (9.2% to 6.2%), indicating Non-DCF is the primary driver of this quarter's decrease. There were a total of 43 cases

in delayed status this quarter. DCF comprised 51% (N=22) of the total volume, and Non-DCF 49% (N=21), indicating an approximately equal distribution of delayed cases.

**Inpatient Average Days in Delay by Reason Code**

The reasons and percentages identified for Inpatient discharge delay in Q4 '13 are shown in the table below:

|                         | Q3 '13          |                                 |                         | Q4 '13          |                                 |                         |
|-------------------------|-----------------|---------------------------------|-------------------------|-----------------|---------------------------------|-------------------------|
|                         | Number of Cases | Average Days in Discharge Delay | % of Cases Awaiting LOC | Number of Cases | Average Days in Discharge Delay | % of Cases Awaiting LOC |
| Awaiting State Hospital | 9               | 18.9                            | 16.7%                   | 12              | 21.5                            | 28.6%                   |
| Awaiting PRTF           | 30              | 18.7                            | 55.6%                   | 20              | 20.3                            | 47.6%                   |
| Awaiting RTC            | 8               | 13.8                            | 14.8%                   | 4               | 12.8                            | 9.5%                    |
| Awaiting GH             | 3               | 29.3                            | 5.6%                    | 1               | 16.0                            | 2.4%                    |
| Awaiting Foster Care    | 1               | 1.0                             | 1.9%                    | 2               | 8.0                             | 4.8%                    |
| Awaiting Other          | 3               | 84.0                            | 5.6%                    | 3               | 2.7                             | 7.1%                    |

**Awaiting Placement ~ State Hospital**

In Q4 '13, 28.6% of youth who were delayed during their inpatient stay were awaiting placement for the State hospital. There were a total of 12 cases in discharge delay awaiting Solnit South – State Hospital. The average Inpatient Days in Delay awaiting the State hospital was 21.5 days for those 12 cases. From Q3 '13 to Q4 '13, there was a slight increase in the number of cases (9 to 12) on discharge delay awaiting Solnit inpatient, but a 13.8% increase (18.9 to 21.5) in the average days awaiting placement. Although we have seen an increase in this measure from last quarter to this quarter, the average days in delay has decreased from 2012 to 2013 by 27% (31.62 to 23.09). The number of youth awaiting placement has also decreased year to year by 8% (37 to 34).

**Awaiting Placement ~ PRTF**

Over the past four quarters, there has been an increased trend in the average days youth are awaiting PRTF. The past four consecutive quarters, the greatest percentages of youth in discharge delay (47.6%) were waiting for PRTF. The inpatient average days in delay awaiting PRTF increased by 8.3% (18.7 to 20.3) from Q3 '13 to Q4 '13. There are 33% (30 to 20) fewer cases on delay this quarter compared to last quarter, however, the average time in delay (20.3), is the longest recorded awaiting PRTF. We have seen a steady increase in the average days in delay awaiting this level of care. There has been a 7.2% (17.61 to 18.88) increase in the average inpatient days in delay awaiting PRTF level of care over the past year. The number of youth awaiting PRTF placement has also increased by 32.2% (59 to 78) from 2012 to 2013.

**Awaiting Placement ~ Residential**

In Q4 '13, 9.5% of youth in discharge delay during an inpatient stay were awaiting Residential level of care. The average number of days in delay for those members decreased by 7.3% (13.8 to 12.8) from Q3 '13 to Q4 '13, and the number of cases for that time period decreased by 50% (8 to 4). Over the past year, there has been a 39% (22.64 to 13.83) reduction in the average days awaiting Residential placement and 27.3% fewer youth (33 to 24) on delay waiting for this level of care.

**Awaiting Placement ~ Group Home, Foster Care, and Other**

Only six (6) additional cases were identified in Discharge Delay for this category of services during the past quarter, with one awaiting a Group Home, two awaiting Foster Care, and three awaiting "Other" services. The designation "Other" is used for non-Medicaid reimbursed services such as Clinical Day School, DMHAS, DCF or DDS supervised housing or services. In Q4 '13, Youth awaiting Group Homes waited, on average, 16 days. The two members awaiting Foster Care services waited an average of 8 days day in delay, while the three members awaiting other services were delayed an average of 2.7 days.



### **Conclusion:**

The inpatient percent of days delayed for this year was the lowest annual percent recorded. The percentage of DCF children in delay has continued to decrease over the past year, while the Non-DCF percentage has increased. The decrease in delay for the DCF population is the primary driver of the overall decrease seen this year and is the lowest recorded for this population. The overall number of children in discharge delay has also decreased over the past year by 9%. The Non-DCF population comprised 55% of the annual cases delayed, and DCF the remaining 45%.

The greatest percent of discharge delay for the year and the current quarter were those children awaiting PRTF level of care. This year we have seen consistent quarterly increases in the average days in delay for those children awaiting PRTF. The population awaiting community PRTF level of care are those children who are ages twelve and under. We have seen a 36% increase in the number of cases (59 to 80) in delay awaiting PRTF level of care this year, as well as an overall increase in PRTF referrals.

Subsequently, clinical service availability for children 12 years old and younger remains a particular concern. Due to State mandates, DCF and hospitals are no longer requesting residential or Solnit placement, but instead are more frequently seeking PRTF. While the discharge delay days and volume of children awaiting the State hospital and Residential placement has decreased over the past year, the volume and the time in discharge delay awaiting PRTF has increased.

ValueOptions continues to collaborate with inpatient providers and State agencies to address the barriers and the gaps in the service delivery system that contribute to discharge delay at various levels of care, including hospital emergency departments. The Rapid Response system utilized at CCMC to address high volume and delays in the emergency departments has continued. The goal is to support connection to the right clinical services in a timely manner and prevent unnecessary hospitalizations. The program also assists in building a diversion system that can then follow the youth post discharge from the ED within the community. It is the goal in the upcoming quarters to expand this model to other high volume emergency departments.

Intensive Care Managers have continued to work with DCF on site, including the inpatient units, as well as on site at Solnit Center inpatient unit. The Intensive Care Managers have implemented weekly triage meetings with the Solnit PRTF units (South and North), and the community PRTFs to discuss admissions, case management, discharge planning, and identifying those youth who may be at risk for discharge delay. The Family Peer Specialists have continued to work in collaboration with DCF and the FAVOR Family System Managers to build collaborative networks within their regions to support families. The Family Peers have an increased focus on connecting and supporting the member to care post discharge from an ED or an inpatient unit while supporting crisis planning and education to families. They have continued this process through case management and the Connect to Care process.

In addition, the Congregate Care Network Managers have continued to collaborate with assigned DCF area offices and the Systems Managers within the DCF Regions 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**

#### **ALOS** **Annual**

The annual Solnit Center Inpatient ALOS for all youth in 2013 decreased by 7% (120.39 to 111.71) from the previous year. The annual ALOS for the Court ordered population increased by 18% (65.3 to 76.9), and the ALOS for the Non-Court Ordered decreased by 32% (173.3 to 118.7), indicating the Non-Court ordered population was the primary driver of the decreased annual ALOS. There were 146 total discharges for 2013. The Non-Court ordered comprised 82% of the discharges and the Court ordered population, the remaining 17%. There was a 60% increase in the Non-Court ordered discharges from 2012 to 2013; conversely, we saw a 61% decrease in the Court ordered discharges.

### **Quarterly:**

The average length of stay for all youth increased by 47.7% (85.37 to 126.11) from Q3 '13 to Q4 '13. The ALOS for non-court ordered youth increased by 61.7% (84.6 to 136.8), and the ALOS for Non-Court ordered youth decreased by 55.2% (90.0 to 40.3), indicating the Non-court ordered population was the primary driver of the increased ALOS seen this quarter. There were 27 discharges during Q4' 13. The Non-Court ordered comprised the majority of those children discharged 89% (N=24), and only 3 Court ordered cases (11%) were discharged.

We have monitored a trend recently identified in which youth are discharged from inpatient units and emergency departments back to detention with a recommendation for a court ordered referral to Solnit. That procedure bypasses the established CT BHP referral process. In follow up to this from last quarter, ValueOptions met with the Emergency Department, CSSD and Detention. The goal of the meeting was to increase discussions with State Agencies and hospital providers regarding communication and discharge planning. As we have seen an increase in the volume of children in overstay in emergency departments this year, it will be important to continue to monitor the recidivism rates to an Emergency Department or an Inpatient unit when a child is discharged from Solnit South.

The ALOS and number of discharges for Non-Court Ordered youth and Court Ordered youth are found in the table below for each corresponding quarter:

| Quarter     | Non- Court Ordered   |              | Court Ordered        |             |
|-------------|----------------------|--------------|----------------------|-------------|
|             | Number of Discharges | ALOS         | Number of Discharges | ALOS        |
| Q1 '12      | 25                   | 150.5        | 12                   | 64.1        |
| Q2 '12      | 18                   | 212.2        | 25                   | 70.1        |
| Q3 '12      | 15                   | 191.5        | 18                   | 43.1        |
| Q4 '12      | 17                   | 149.4        | 17                   | 82.7        |
| <b>2012</b> | <b>75</b>            | <b>173.3</b> | <b>72</b>            | <b>65.3</b> |
| Q1 '13      | 29                   | 133.3        | 9                    | 71.3        |
| Q2 '13      | 37                   | 123.4        | 11                   | 87.0        |
| Q3 '13      | 30                   | 84.6         | 5                    | 90.0        |
| Q4' 13      | 24                   | 136.8        | 3                    | 40.3        |
| <b>2013</b> | <b>120</b>           | <b>118.7</b> | <b>28</b>            | <b>76.9</b> |

The decreases in the annual ALOS in the Non-Court Ordered population reflect the continued efforts of a dedicated team, including our Intensive Care Manager at the Solnit Center Campus. This intervention has improved the clinical collaboration between DCF, ValueOptions and Solnit Center. The ICM participates in weekly triage admission/discharge meetings, as well as case conferences, weekly utilization rounds and Court Review team meetings with staff from the Solnit Center and CSSD. The goal of these meetings is to improve coordination of care and effectuate timely discharge planning. As this approach to coordination has proven to be effective, we have expanded this coordination approach to the Solnit North PRTF campus which begun taking admissions for adolescent boys (13- 17) in December.

**Conclusion:**

The average length of stay for all youth at Solnit Center inpatient has decreased over the last year. The Non-Court Ordered population is responsible for this decline in ALOS; decreasing 32% from 2012 to 2013, compared to the Court ordered ALOS which increased. The number of discharges for this year remains relatively flat when comparing year over year numbers. The non-court ordered discharges rose significantly this year as the rate of court ordered discharges decreased.

VO has continued to support triage and coordination efforts with the State agencies and Solnit Center. We have built upon this successful framework as Solnit began admissions to Solnit North PRTF level of care for adolescent males. This unit has supported the successful transition of adolescent males from Solnit inpatient, creating greater capacity for those adolescents in the hospitals awaiting inpatient level of care at Solnit; In addition, VO has collaborated with Solnit North to support Emergency department diversion efforts for those members who meet PRTF level of care.

**Community Psychiatric Residential Treatment Facility; PRTF**

**PRTF Admissions; All Youth**

Admissions to PRTF decreased by 28% (29 to 21) from Q3 '13 to Q4 '13. We have seen a 34.4% (32 to 21) decrease from Q4'12 to Q4'13.

**Days/1,000**

There have been consistent annual decreases in PRTF Days/1,000 for all youth over the past six calendar years. Over the last calendar year, PRTF Days/1,000 have decreased by 3% ( 4.66 to 4.54), and from Q3 '13 to Q4 '13 by 1.5% ( 4.57 to 4.50).

**Average Length of Stay; ALOS**

The PRTF ALOS has increased and the number of discharges has decreased over the past year. There was a 1.7% (144.1 to 144.6) increase in PRTF ALOS, and 13.5% fewer discharges (111 to 96) from calendar year 2012 to 2013. The spike we saw in the ALOS in Q2'13 (178.8) contributed to the overall annual increase. Although we have seen a decline in the ALOS over the last two quarters ( 178.8 to 117.7) by 34%, the annual increase in ALOS indicates decreased throughput from the PRTF level of care. There continues to be decreased service capacity for this age group as DCF mandates limit the residential and Solnit inpatient levels of care for the 12 and under age group. These mandates continue to place strain on other levels of care, such as the community PRTF programs. With limited service capacity, referring providers and DCF workers are looking at PRTF as the only viable option for younger children for discharge options from inpatient level of care when home is not an option. With the loss of the inpatient beds at Solnit for this age group, the need for additional community based PRTF beds is clear.

**Discharge Delay**

**PRTF Number of Days Delayed**

The number of days delayed increased from Q3'13 to Q4'13 by 116.6% (277 to 600). There were only 11 cases in delayed status during this time.

**PRTF Percent of Days and Cases Delayed**

We have seen consistent annual increases in the Community PRTF percent of days delayed over the past two years. There has been a 26.4% increase in the percent of days delayed since 2011 and a 15.8% increase (9.5% to 11.0%) over the last year. This year, there was a significant increase in delay for both Non-DCF and DCF members. From 2012 to 2013, the DCF percent of cases delayed increased (14.9% to 30.7%) and the the Non-DCF increased ( 7.5% to 12.3%). There were more DCF members ( 30.7%) in delay compared to Non-DCF members (12.3%). Across all time periods, there were more DCF members in delay at PRTF level of care, than Non-DCF. In addition, there was also an increase in the percent of cases delayed for both DCF and Non-DCFmembers from Q3 '13 to Q4'13.

Of those youth on discharge delay this year the majority ( 84.2%) were awaiting Foster Care placement. In Q4'13, all the children (100.0%) on discharge delay were awaiting foster care placement. The loss of

treatment capacity for the younger children (12 and under), both within Congregate settings, and at Solnit South, has placed additional demand on the community-based PRTF services to manage the acuity of these children. It is imperative that community based services expand to meet the clinical complexities of the children awaiting these services.

**Conclusion:**

Over the past year, there have been decreased Admissions to PRTF level of care , fewer Days/1,000 and an increased ALOS and Discharge Delay. This continues to indicate a decreased throughput from this level of care. The most significant factor affecting the PRTF level of care continues to be the Discharge Delay for youth awaiting Foster care. With the majority of children in discharge delay awaiting a Foster care placement, it is necessary to increase capacity and develop additional services/placements for this age group. In addition, due to DCF mandates, the 12yr and under age group who would have been placed at Solnit inpatient, and/or Residential level of care are now being referred to the PRTF level of care. This adjustment to the availability of services has placed additional strain on the PRTF level of care as these children present with higher acuity and more complex issues. ValueOptions will continue to monitor this level of care. We have implemented weekly rounds with the community PRTF providers to support effective and timely triage of referrals, admissions, and discharges to this level of care. We have also initiated a streamlined internal process utilizing our Care Conect system to monitor the higher volume of PRTF referrals from date of referral to date of PRTF placement. This process will allow increased reporting capabilities to identify any contributing factors that may affect placement at the PRTF level of care. We will also continue to dialogue with our State partners on creative ways to increase service capacity for this age group.

**Intensive In-Home Child and Adolescent Psychiatric Services (IICAPS)**

There have been consistent annual increases in the Admits/1,000 for all youth to IICAP services over the past six calendar years with an 83% increase from 2008 to 2013 and an 8.5% increase in the last two years. While the Admits/1,000 for Q3'13 (0.63) and Q4'13 (0.60) have decreased, we have seen an 3.3% increase in the annual Admits/1,000 to IICAPs from 2012 (0.62) to 2013 (0.64). While the utilization of IICAPs services may be explained by the overall increase in membership, this service is also one of the only community based services available to meet the clinical needs of complex youth. As DCF mandates limit utilization of Residential for all age groups, and Solnit South for younger children, the need for increasing services in the community to meet the needs of complex children is clear.

**OVERALL CONCLUSIONS:**

The current analyses indicate Admits/1,000 and Inpatient Days/1,000 have increased over the past year and the most recent quarter, while the ALOS and Discharge Delay have decreased. This indicates increased movement though the inpatient level of care. These results signify that there are more youth admitted to hospitals, but their lengths of stay are shorter allowing for an increased volume of admissions/days.

The majority of children on discharge delay on inpatient units continue to be those children awaiting PRTF (47.6%) and Solnit (28.6%) levels of care. There continues to be an increase in the volume of PRTF referrals from the inpatient providers and longer periods of time awaiting placement at a PRTF level of care.

This reduction in resources/capacity for the 12 and under children continues to have an adverse impact on this age group. The time a child spends on discharge delay in the PRTF has increased in the last year. We have seen this in both the DCF and Non-DCF populations, but this is more evident in the DCF youth. The majority of youth on discharge delay in the PRTF are awaiting foster care placement. The delay in accessing foster care placements from PRTF continues to decrease the fluidity within the delivery system. This has the potential to impact movement of children from EDs to inpatient facilities.

The recent trends and mandates, suggest a need to build a community behavioral health care delivery system which is able to meet the needs of a more complex child/adolescent population. The utilization of IICAP services indicates annual increases in admissions over the past six years and a 3.3% increase over the last year. IICAP service capacity is stretched as this has become the primary community clinical treatment for complex youth. The increased PRTF, Foster Care and community services capacity will be necessary for moving younger children through the system. This expansion is particularly important for the 0-12 age group. The community-focused delivery system is critical to our ability to manage the complex clinical needs of those children who previously would be referred to Solnit South Campus, out of state or to a congregate care setting, but who are now being served and supported in local communities.

Collaboration between EDs, inpatient hospitals and community providers/agencies is imperative if we are to experience further integration of systems of care, ensure connect-to-care after discharge, and to improve outcomes. Creative approaches are still needed to improve collaboration among both physical and behavioral health providers. These needs are addressed in our recommendations below.

### **CHILD/ADOLESCENT RECOMMENDATIONS**

#### **UPDATES TO RECOMMENDATIONS FROM PREVIOUS QUARTER – This section documents activity since the previous quarterly report**

1. Establish a preventive model of behavioral health care and crisis intervention: During the past three months, ValueOptions has implemented this recommendation through the following activities:
  - a. ISS/MSS meetings: ValueOptions has collaborated with the State agencies, providers and the community on strategies to identify youth who are in need of behavioral health services, and to provide more effective crisis prevention services. Last quarter, a Pediatric Workgroup which included representatives from Inpatient Providers, Psychiatric Residential Treatment Providers and DCF was organized. The potential for utilizing the existing Integrated Service System/Managed Service System (ISS/MSS) meeting as a forum to implement a Community Care Team (CCT) model was discussed. This quarter, several Integrated Service System meetings, Region 1 (Bridgeport), Region 3 (Willimantic), Region 4 (Hartford), and Region 6 (New Britain/Meriden) have included standing agenda items to discuss local area Emergency Department activity, including ED stuck children, ED volume, best practices for crisis prevention, and coordination of care. The CTBHP Intensive Care Manager participates within these meetings providing clinical updates, and relevant data to support an action plan for those youth identified as high risk. Representatives from local area inpatient units have been invited to attend. ValueOptions has also collaborated with New Haven area providers to potentially implement a similar meeting format.
  - b. Intensive Care Managers on site at DCF offices: In all DCF area offices, ValueOptions Intensive Care Managers are on site to assist and support identification of those children who are at high risk for disruption or high utilization of emergency services. The Intensive Care Manager participates within preventative meetings with DCF such as: Early Warning Team Meetings, Team Decision Making (TDM), ARG meetings, Clinical rounding with all youth inpatient units, and member specific case conferences with efforts

to implement preventative coordination of care and discharge planning through wrap around treatment plans.

- c. Family Peer Specialists: ValueOptions Family Peer Specialists continue to provide families information, education, and referrals to preventative services such as Triple P (Positive Parenting Programs), Community Support for Families (CSF), Nurturing Families Network (NFN), Care Coordination, FAVOR advocacy, Enhanced Care Clinics and School based Services. They provide information on these types of preventative services through collaboration with Systems of Care, FAVOR Family System Managers, DCF and providing telephonic support through ValueOptions member referral line.
2. Continue Connect to Care meetings: During this quarter, ValueOptions has continued to organize and facilitate Regional Connect to Care meetings to explore best practices, gaps and barriers within the youth service delivery system. In the Hartford area, ValueOptions coordinated meetings in which The Institute of Living and Connecticut Children's Medical Center met with the Greater Hartford area community Enhanced Care Clinic providers to identify best practices surrounding referrals, discharges and coordination of care efforts. In the New Haven area, ValueOptions has worked to initiate a Connect to Care meeting between the local hospital Pediatric Inpatient units and the local area IICAP providers. In the Waterbury area, ValueOptions has met with the area inpatient providers and both Region Five (Waterbury) and Region Six (New Britain) DCF area offices. The goal of the meetings was to discuss best practices to care coordination and communication. Follow up meetings have been scheduled with the inpatient providers and DCF to maintain a regular forum of communication. ValueOptions has also continued to provide telephonic support to providers and members upon discharge from inpatient hospitalization to ensure timely connection to care. During this quarter, ValueOptions has continued to refine this process to promote efficiency to best serve our members and providers.
3. Continue to work collaboratively with EMPS agencies: ValueOptions has continued to work collaboratively with EMPS agencies. ValueOptions has met regularly this quarter with EMPS agencies in Hartford ( Wheeler Clinic), New Haven ( Clifford Beers) and Waterbury (Wellmore). ValueOptions has continued collaboration with Wheeler Clinic, DCF and the Connecticut Children's Medical Center Emergency Department in organizing and facilitating daily clinical rounds to discuss those children present in the Emergency Department. The clinical rounds focus on timely connection to care utilizing a multiagency model. Through this rounding process, CCMC has worked this quarter with Wheeler EMPS and DCF to begin allocation of an additional EMPS position dedicated to on-site evaluations at CCMC Emergency Department. Quarterly administrative meetings have continued between ValueOptions, DCF, EMPS and CCMC to discuss progress of this model. During this quarter, ValueOptions has also met several times with EMPS, DCF, and Yale New Haven Hospital administration and Emergency Department staff to implement a similar mode. Through these multiple meetings, Yale is working with Clifford Beers and DCF to implement an on-site EMPS position at the Yale Pediatric ED to support timely connection to care. This quarter, ValueOptions Intensive Care Managers have initiated daily telephonic dialogue with the Yale ED CIU to identify Medicaid members who require coordination of care while in the ED. We have worked with the Yale ED to begin the process of coordination of care for those members on the Medical boarding bed unit (CPP). Similarly, in the Waterbury area, the Region Five Intensive Care Manager has continued to meet and work closely this quarter with Wellmore EMPS agency in the coordination of care for those members at Saint Mary's and Waterbury hospitals. In addition, ValueOptions has also scheduled upcoming

meetings with UCFS and Middlesex EMPS in Region 3 to discuss the level and quality of interactions with various programs and entities in their local areas.

4. Continue to expand implementation and development of Rapid Response model: In response to the ongoing volume of children presenting to the Connecticut Children's Medical Center (CCMC) Emergency Department with behavioral health needs, VO has continued to work collaboratively with the DCF, DSS, CCMC, and Wheeler Clinic EMPS to implement a Rapid Response model for the CCMC ED this quarter. The team consists of clinical leadership from the CCMC Emergency Department, the Institute of Living (IOL), DCF, Wheeler EMPS and VO. This team has participated in daily rounds to discuss children present in the CCMC emergency department who need behavioral health services. The goal of the process is to discuss triage, assessment, recommendations, and possible diversion options, and to coordinate rapid access to treatment settings, interventions and disposition plans. In addition to daily rounds, the team members function as liaisons to escalate and communicate with leadership within their respective agencies and other, community resources, such as Solnit Center, Court Support Services Division (CSSD), and other providers. There have been ongoing meetings among agency participants to improve the referral process, and address the goal of expanding the existing EMPS support to CCMC's Emergency Department. As discussed above, ValueOptions has met several times this quarter with Yale New Haven Hospital, DCF and Clifford Beers EMPS agency to begin a similar model in the New Haven area. Clifford Beers EMPS, DCF and Yale New Haven hospital have discussed allocation of an on-site EMPS position as well within the Yale Pediatric ED.
5. Implement Intensive Community Treatment services: We continue to recommend building capacity within the service delivery system to implement intensive community treatment. There has not been any follow up to this item during Q4' 13 as this has been placed on hold with the State agencies.
6. Expand PRTF capacity and develop alternatives for the children 12 years and under to include crisis stabilization: VO has continued to discuss this recommendation with State agencies to develop increased capacity for the children 12 years and under. During inpatient workgroup meetings, PRTF providers have expressed their interest in expanding their capacity to provide crisis stabilization as well. During this quarter, ValueOptions has initiated weekly telephonic triage meetings with leadership from the three community PRTF facilities. We have also established weekly triage and rounding processes with the Solnit PRTF facilities. The purpose of the triage meeting is to manage the high volume of PRTF referrals effectively and collaboratively. ValueOptions also has refined internal processes this quarter to track the higher volume of PRTF/Solnit referrals efficiently. We have worked collaboratively with the Solnit North PRTF agency to initiate crisis stabilization for youth in the ED when appropriate, supporting coordination of care and authorization. In addition, ValueOptions and DCF representatives have met with PRTF providers to discuss programming, staffing, and treatment planning for a higher acuity population. To support the PRTFs treatment planning and discharge planning efforts, assigned ValueOptions Intensive Care Managers continue to meet weekly at each of the community and Solnit PRTF facilities

7. Establishment of Community Support Programs (CSP): There have not been any further developments on this recommendation this quarter. We continue to recommend community support programs. As utilized in other states, this service would provide “hands on” paraprofessional support for families as youth transition from acute and congregate levels of care back to the 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. We will continue to explore opportunities to work with providers to develop such programs.

### **New Recommendations**

Over the past year, the child/adolescent utilization trends have indicated an increase in the volume of children twelve years old and younger awaiting clinical placement and services. We have seen this in the increased discharge delay for youth who are inpatient awaiting PRTF level of care, as well as those children in community PRTFs awaiting Foster Care placement. The data also indicates a continued decreased volume of children/adolescents utilizing congregate care, out of state resources, and Solnit Center inpatient services. There is also an increased volume of children utilizing Emergency Departments for first time access to crisis stabilization. These trends which we have now seen over the past year, in addition to DCF mandates which limit the use of congregate care, out of state resources and Solnit center, indicate the increased need to build community based infrastructure which provides a high level of clinical treatment, and crisis stabilization. In response to this trending, we continue to recommend the development of a preventative model of integrated care which provides early identification of children in need of services with timely connection to crisis and behavioral health care. The following are opportunities which will promote this type of community based delivery system.

1. Establish a preventative model of behavioral health care and crisis intervention: There is a continued need to increase early intervention efforts to identify children and adolescents in need of behavioral health services and promote effective crisis prevention. Preventative interventions that target multiple domains, such as the family, child and the school have the potential to result in decreased use of Emergency Departments as primary access to services, decrease reliance on higher levels of care, and improve the quality of life for children, families and communities.

We continue to recommend expansion of the following strategies to promote a preventative model:

- Establish and/or expand existing ISS/MSS meetings within each of the DCF Regional areas with participation from local area community providers, including, inpatient providers, PRTF providers, school, outpatient providers, congregate care, and foster care providers to discuss high risk youth within the region. The goal of the meeting will be to develop a coordinated treatment and crisis plan with input from the family/caregiver.
- Continued State Agency collaboration with ValueOptions Intensive Care Managers on site at DCF, inpatient units, PRTF units and Emergency Departments to identify high risk youth or high utilization of services. The ICM will continue to utilize a wraparound philosophy to coordinate care and discharge plan which focus on crisis prevention and protective factors.
- Utilize the Family Peer Specialist role to inform and engage family members/caregivers, and local school personal within preventative programs and interventions which focus on strengthening parenting, building child resilience and crisis intervention.



2. Increase collaboration with CHN to establish preventative integrated care: Behavioral health and physical health are interwoven. Coordinating medical care and behavioral health care has the potential to decrease utilization of emergency services, increase member engagement within care, and provide better health outcomes. ValueOptions has continued daily, weekly and quarterly meetings with CHN staff to identify members who present with both medical and behavioral health needs. ValueOptions has continued to participate with CHN in the Hartford Medical Care Collaborative, as well as the Coalition to improve Birth outcomes. We also have identified specific VO clinicians in each of the geographic regions to collaborate with CHN staff in an effort to coordinate care. In addition, a Clinical Supervisor serves as the liaison to our Co-Management program. Some recommended strategies to expand collaborative efforts include: CHN participation within ISS/MSS and System of Care meetings, CHN participation within Regional Connect to Care meetings, and CT BHP ICM collaboration with CHN on-site at pediatric inpatient units.
3. Continue to work collaboratively with EMPS agencies to identify providers that refer to emergency departments at a high rate and provide crisis education to parents, schools, group homes and other community providers. To promote further crisis prevention with families and the community, it is also recommended that expansion of EMPS continues. In addition, it is recommended this expansion potentially includes allocation of an EMPS clinician on site in each of the high volume Emergency Departments.
4. Continue to expand implementation and development of Rapid Response model as described above. In collaboration with DCF and EMPS, we recommend the continued development and implementation of this model within high volume Emergency Departments to promote timely connection to care for children and adolescents.
5. Establish Behavioral Health Urgent Care Centers for Youth: Utilization trending within the last year has indicated increased emergency department utilization and an increased volume of children/youth stuck in emergency departments. Expansion of alternative crisis assessment and stabilization services within the community, such as Behavioral Health Urgent Care Centers, or expanded crisis assessment/ stabilization capacity within existing regional Enhanced Care Clinics, is recommended to meet this increasing need.
6. Expand PRTF capacity and develop alternatives for the children 12 years and under to include crisis stabilization: Utilization trending over the past year has indicated the need for increased capacity for youth 12yrs. and under. We continue to recommend the expansion of PRTF capacity to meet the needs of this age group. It is also recommended to include crisis stabilization within this expansion to promote diversion within PRTF facilities from unnecessary Emergency Department utilization, or the development of additional units similar to Hartford Hospital CARES unit in existing inpatient units.
7. Collaborate with DMHAS and DCF to support coordination of care for youth in transition: Youth transitioning from DCF to DMHAs present with complex clinical needs which may contribute to an increased risk for disruption. There are opportunities for ValueOptions to partner with DMHAs and DCF to support care coordination efforts during this period of transition. One potential way ValueOptions can support this effort is through the Intensive Care Managers' participation in Youth transition meetings while on site at the regional DCF area offices. The ICM would provide needed information such as clinical history, prior services and authorizations. In addition,

ValueOptions is able to provide relevant data reports pertinent to youth in transition to inform clinical treatment planning for this population.

8. Continue Connect to Care meetings: ValueOptions has organized Regional Connect to Care meetings focused on improving coordination of care between providers. The meetings have included Inpatient providers, Enhanced Care Clinics, EMPS agencies, Outpatient providers and DCF, and are a forum for providers to discuss best practices and barriers to connecting youth to appropriate clinical care. They build on existing programs to maximize available knowledge and resources. It is recommended that Connect to Care meetings continue to promote timely and coordinated planning for youth. It is also recommended that participants from CHN attend Regional Connect to Care meetings to promote an integrated service delivery system. ValueOptions supports members in connecting to care upon discharge from an inpatient hospitalization through the Connect to Care Process. Clinical Liaisons, Peer Specialist and Care Managers telephonically support members discharging from an inpatient level of care connect with services. It is recommended this process continue to assist members with timely follow up care after hospitalization.
  
9. Participation within Youth Behavioral Health Forums: There are many efforts across the state to improve behavioral health care for children. In collaborative effort with State agencies, DCF plans to hold forums across the State to gather input about the need for mental health services for youth from families, communities and providers. The forums will examine access to services, early identification of behavioral health issues, and crisis response and management. To support continued efforts to build infrastructure within the State to meet the behavioral health needs of children and adolescents, it is recommended ValueOptions participate within these forums.