2011
Quality Management
And
Utilization Management
Program Evaluation

The Connecticut
Behavioral Health Partnership
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I. EXECUTIVE SUMMARY

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

Towards the end of 2010, the Department of Mental Health and Addiction Services (DHMAS) decided to join the CT BHP and issued an RFP for an ASO vendor. ValueOptions bid on and was awarded the contract to be the ASO for the expanded CT BHP. The new contract went live on April 1, 2011 when more than 200,000 additional Medicaid members, primarily adults but also including a small number of youth, were added. This brings the total membership included under the CT BHP to more than 600,000 members.

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

The RFP submitted by ValueOptions also included a new partnership with McKesson Health Systems, whereby a pilot project involving 300 members with both behavioral health and medical issues would receive health and wellness coaching by two nurses employed by McKesson who are located onsite in the CT ValueOptions office. The introduction of health informatics and health risk assessment into the program is an exciting addition with the hoped for outcome being improved health for our most at risk members. This project was implemented in September of 2011.

Still another significant event that occurred during 2011 was that DSS decided to move from three Managed Care Organizations (MCOs) managing the physical healthcare of their Medicaid population to a single ASO model similar to the model in place with ValueOptions. ValueOptions partnered with the MCO that ultimately won the bid for this contract; CT Health Networks (CHN). While this contract did not increase membership, it did result in increased responsibility for ValueOptions regarding the coordination of the care provided to CT Medicaid members. The new contract, that will go live in 2012, involves embedding ValueOptions Clinical Care Managers in the CHN office and
leveraging the McKesson technology to again identify the most at risk members to ultimately impact health outcomes.

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

On at least an annual basis, the QM Program is evaluated. The annual QM Program Evaluation provides an opportunity to examine completed and ongoing quality activities and to identify new opportunities for the coming year. The QM Program evaluation serves to assess the overall effectiveness of the QM Program including the effectiveness of the committee structure, the adequacy of the resources devoted to it, practitioner and leadership involvement, the strengths and accomplishments of the program with special focus on patient safety and risk assessment, and performance related to clinical care and service. Progress toward meeting the goals included on the previous year’s project plan is also evaluated. A review of each of the goals is included within this evaluation along with a description of each goal and sub-goal, commentary regarding their completion status, and recommendations for whether to carry them over into the Quality Program for the following year. The results of this program evaluation together with the additional goals that reflect the strategic planning done collaboratively with DSS, DMHAS and DCF, will be used to formulate the 2012 Project Plan.

The implementation of the new contracts during 2011 resulted in significant revamping of the Quality and Utilization Management programs. The Quality Program was expanded to include both the old and new membership under one department while the Utilization Management program was divided into Adult and Youth programs. New and/or refined QM and UM Committees were established. The number of staff employed by the Service Center nearly doubled and detailed training programs were designed and implemented to train both new staff as well as existing staff on the new business. Because the new business resulted in the addition of significantly more adult membership, a good deal of attention was paid to developing a better understanding of the clinical issues associated with the adult Medicaid population. While ValueOptions CT had previously managed the behavioral health care of the families of the youth involved in the HUSKY A and B programs, the needs associated with the new population are different. New reports were created and data was pulled to begin looking at the utilization patterns of the new populations.

The growth in membership coupled with the large number of new staff and tight timeframe in which the new program was implemented resulted in a year of significant change and hard work. Despite this, the service center had an extremely successful year in terms of continuing to meet performance standards and targets.

Membership:

The original contract included approximately 335,000 members, 2/3rds of which were youth under the age of 19. The membership managed under the original contract
included youth and their families covered under HUSKY A, HUSKY B, and D05 (DCF Limited Benefit) eligibility categories. This membership continued to increase year over year; 5.3% between CY '10 (318,319) and CY '11 (335,090). An increase of 28.4% in the DCF-involved youth membership (a sub-population of the HUSKY A, HUSKY B, and D05 (DCF Limited Benefit)) accounted for much of this overall increase in the youth population. After being at an overall low in 2010 (12,405), the DCF-involved population increased to an overall high in 2011 (15,931). The youth membership for Non-DCF members continued to increase slightly year over year with this past year seeing only a 6.6% increase between CY '10 (308,603) and CY '11 (328,879).

The former HUSKY adult (19+) membership who were included in the HUSKY A population as parents and guardians of the youth membership also increased but at a slower rate than was seen in previous years. Between CY '10 (164,226) and CY '11 (180,264) there was 9.8% increase in membership. The young adult membership identified as DCF-involved increased by 17.7% (between CY '10 (1,457) to CY '11 (1,715), returning to figures seen in CY '09 (1,724). The Non-DCF adult membership continued to increase at the same rate as previous years; 10.0% between CY '10 (162,968) and CY '11 (179,303).

The Charter Oak membership, decreased by 30.9% between CY '10 (20,283) and CY '11 (14,008).

With the new contract in Q2 '11, new membership was added to the population managed by ValueOptions CT. The new membership figures for CY '11 cover Q2-Q4 '11:

<table>
<thead>
<tr>
<th>Eligibility Category</th>
<th>Total Membership</th>
<th>Youth (&lt;18)</th>
<th>Adults (18+)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Dual</td>
<td>5,526</td>
<td>9</td>
<td>5,517</td>
</tr>
<tr>
<td>Aged, Blind, Disabled (ABD) Single</td>
<td>38,714</td>
<td>1,139</td>
<td>37,575</td>
</tr>
<tr>
<td>ABD Dual</td>
<td>55,259</td>
<td>4</td>
<td>55,255</td>
</tr>
<tr>
<td>Long Term Care (LTC) Single</td>
<td>2,830</td>
<td>15</td>
<td>2,815</td>
</tr>
<tr>
<td>LTC Dual</td>
<td>21,132</td>
<td>0</td>
<td>21,132</td>
</tr>
<tr>
<td>Medicaid Low Income Adults (MLIA)</td>
<td>108,817</td>
<td>659</td>
<td>108,158</td>
</tr>
</tbody>
</table>
Key accomplishments of CT BHP Quality Management Program in 2011 include:

- Trainings for all the new staff around all the QM functions – Complaints, grievances, quality of care, adverse incidents, denials, appeals and auditing
- Refresher trainings for all staff on HIPAA and impressionable disclosures which resulted in a more vigorous identification process.
- Documentation audit was strengthened and additional staff training was conducted
- Quarterly/Annual analysis moved to a highlights process whereby only highlights are being noted in the report analyses
- In collaboration with DSS, revised the medical necessity denial reason codes to improve the reporting of trends
- Extensive analysis was conducted on the Denial and Appeal process and modifications were made to reports to accurately reflect current practice.
- Continued Provider, Analysis and Reporting (PARs) programs for child and adolescent Inpatient, PRTF, RTC, Emergency Departments and ECCs
- Successfully closed the quality improvement activity conducted with DCF for the Center for Healthcare Strategies on Improving Access to Behavioral Health Services among newly placed Foster Children
  - Working with DCF Area Office staff we improved by nearly 60% the percentage of children in the target population who received behavioral health services within 60 days. We were also able to decrease the average time to an appointment for behavioral health services following Multidisciplinary Exam identification of need from 22.5 days to 6.5 days (a 71% improvement).
- Initiated the Autism Spectrum Disorder Feasibility Study with multiple Departments participating

Key accomplishments of the CT BHP Utilization Management Program in 2011 include:

- Hired and trained 80 new employees
- Successful “Go-Live” for authorization of services for new adult business on April 1, 2011
- Implemented the Wellness Program in coordination with McKesson
- Continued weekly calls between ICM staff and the BHPD’s from DCF to facilitate planning and problem solving on cases of concern to either group. A significant improvement in cooperation and communication has resulted from these meetings.
- Increased the number of inpatient and residential facilities with whom we do On-site reviews that are focused on initial care planning, case conferencing and discharge planning to better focus attention and resources on these areas.
- Developed and implemented the plan to move the clinical department into Regional Teams to improve and enhance the relationships with providers and increase our ability to improve the quality of care.
• Decreased Discharge Delay of youths during inpatient stays from 19.37% (CY '10) to 10.87% (CY '11).
• ICM clinicians continue onsite assistance in DCF Regional offices, to assist the BHPD and ARG staff in coordinating activities for discharge delay cases.
• Bypass programs for Adult and Child Inpatient, and IICPs were continued
• Outreach on a consistent basis is occurring with high volume hospitals in order to facilitate early resolution to any issues that may prevent timely discharge.
• Participation with DCF and other stakeholders in the discussions regarding decreasing the number of youth in congregate care settings.
II. EVALUATION OF OVERALL EFFECTIVENESS OF THE CT BHP QM PROGRAM

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

**CT BHP Quality Management Committee (QMC)**
The QMC was established to provide oversight of the CT QM program. The QMC is co-chaired by the Medical Director and the Vice President (VP) of QM. The QMC reports both to the Senior Management Quality Management Steering Committee (SMQMSC) which is chaired by the Service Center VP/CEO, and to the ValueOptions Corporate Quality Council.

During 2011, the membership of the QMC was expanded with the addition of the new contract. The membership includes representatives from all departments within the Service Center including the leadership of the service center. Included are:
- CEO
- Medical Director of Adult Division
- Medical Director of Child Division
- AVP of Quality Management and QM staff
- VP of Adult Clinical Management
- VP of Youth Clinical Management
- Director of Provider Analysis and Reporting
- VP of Provider and Customer Relations
- Director of Customer Service
- Director of Human Resources
- Director of Finance

The QMC met on a quarterly basis during 2011. The focus of the committee during 2011 was often on the implementation of the new business and in particular on performance on the operations indicators. Attention was paid to telephone access, turnaround times for UM decisions, new protocols for medical necessity denials and partial denials, and adverse incidents. The Safety and Risk Management program continued to receive the attention of the committee as processes for identifying and managing high risk members continued to be enhanced.

**Safety and Risk Management Sub-Committee**
The Safety and Risk Management Sub-Committee formerly known as the Quality of Care Sub-Committee reports to the QMC and is co-chaired by the Medical Director for Adult UM Program and the AVP of Quality Management. In addition to the co-chairs, the membership of the committee included:
- VP of Quality Management (ad hoc)
- QM Coordinator
- VP of Adult Clinical Operations
- Care Manager
- Regional Network Manager

In 2011, the Sub-Committee met weekly to review adverse incidents as well as quality of care and service issues identified by CT BHP staff, members, providers, and, on request, the Departments. The sub-committee reviewed all issues identified...
during the previous week and followed up on the results of actions and/or investigations previously identified by the committee. The sub-committee periodically reviewed the trends of specific facilities or programs. Additionally, the sub-committee identified new categories of QoC issues when necessary.

During 2011, the focus of the committee continued to be on the review of the adverse incidents identified during the clinical review of cases. The committee noted a substantial increase in volume of reported adverse incidents related to the new adult business as well as the training conducted with all clinical staff. The committee identified trends and opportunities for the improvement of internal processes. During 2011, the committee continued to ensure that high risk cases are being reviewed with Clinical Supervisors, Directors and Medical Directors and that appropriate follow-up care is being arranged that takes into consideration the severity of the high risk events associated with the member. In addition, the committee is tracking to see that processes are in place to verify that high risk members are connecting to care following high risk events.

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

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

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

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

This committee also provides oversight of the five (5) Geo-Teams. The Geo-Teams include CT BHP staff, both clinical and administrative, who are involved with facilities and programs in specific geographic regions. These teams reviewed PARs data and Performance Incentive programs in specific geographic regions, provide their perspective on the findings, and develop strategies for improving the performance of the facilities and programs in the region. During the implementation of the new business, the Geo-Teams did not meet as frequently. By the end of 2011, as the Clinical Department moved towards the development of regionalized clinical teams, the Geo-Teams were reinvigorated as membership of the teams were expanded to include both adult and youth clinicians. This resulted in significantly higher functioning Geo-Teams.
The PARs Workgroup was established late in 2007 as the vehicle to oversee the development and implementation of the PARs initiatives and to provide the opportunity for all departments to provide their input into the various programs. During 2011, the workgroup met weekly to assess profiles for each of the PARs programs, review data, hear feedback and recommendations from providers involved in the PARs programs, and to share the findings of the PARs programs with other departments.

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

**Utilization Management Sub-Committee**

In preparation for the implementation of the new business, the Utilization Management (UM) Sub-Committee was revised at the beginning of 2011. Initially, the committee was chaired by the Adult and Youth UM Directors and the AVP of Quality Management. However, the chairmanship of the committee was revised again in the fall of 2011 as it became clear that input from more senior ValueOptions staff more experienced in analyzing utilization data would be helpful. As more data concerning the new adult population became available, additional members were added to develop and review new reports and to develop strategies for addressing changes in utilization patterns. By the end of 2011, the Utilization Management Committee was meeting weekly and co-chaired by the VP of Child and Family Clinical Operations and the Medical Director for the Adult division. The members of the committee include:
- VP of Child and Family Clinical Operations
- Medical Director for Adult Medical Affairs
- Medical Director for Child Medical Affairs
- Director of Intensive Care Management and Peer Support Services
- VP of Quality Management
- QM Staff

**Consumer and Family Advisory Sub-Committee**

The Consumer and Family Advisory Sub-Committee was established in 2006 and meets monthly. It is chaired by the CT BHP Peer Team Lead and a Family Member and includes members, families of members, member advocates and CT BHP peer support and administrative staff. The Sub-committee advises the Service Center and QM program of member interests and needs related to behavioral health services and the system of care. Feedback and input from members regarding system disconnects, family engagement, transportation coordination, accuracy and efficiency of provider referrals, voluntary services program, language barriers, mentoring services and supports for members and their families and interactions with DCF.
During 2011, the committee provided input regarding the wellness and recovery initiatives undertaken by the CT BHP and the revision of the CT BHP Member Handbook to incorporate the new adult business.

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

As the service center nearly doubled in size and folded new business into the existing business, the QM Committee and sub-committees played a key role in keeping staff apprised of performance on indicators that allowed us to assess the ongoing operation of the service center. Participation in the committees allowed new staff to better understand the key role of data in making decisions concerning operations and existing staff to identify necessary changes in operations with the addition of populations with clinical needs that are different from those of the youth and families previously managed. Many of the committees met more frequently during 2011 and/or formed workgroups to address the needs of the operation to assure timely response to identified challenges/programmatic needs. The growing size of the committees presented a challenge as the service center grew from a staff that could be housed on a single floor to the need to house several departments on another floor. Obtaining the participation of all committee members in the meetings was addressed in several meetings and a team of leadership staff attended a 3 day off-site forum designed to assist them in providing leadership and improved communications to impact this change in our program and physical space.

While the QM committee structure experienced growing pains during 2011, the structure dependably provided consistent forums for improving the communication around critical information and obtaining the input of all staff in decisions about how to proceed.
Adequacy of QM resources
The following chart is a summary of the positions currently included in the Quality Management Department, their credentials and the percentage of time devoted to quality management activities. Additionally, extra-departmental staff are listed with the percentage of their time devoted to quality activities.

<table>
<thead>
<tr>
<th>Title</th>
<th>Credentials</th>
<th>Percent of time per week devoted to QM</th>
</tr>
</thead>
<tbody>
<tr>
<td>VP Quality Management</td>
<td>PhD</td>
<td>100%</td>
</tr>
<tr>
<td>Assistant VP QM</td>
<td>LCSW</td>
<td>100%</td>
</tr>
<tr>
<td>Director of PARs</td>
<td>LMFT</td>
<td>100%</td>
</tr>
<tr>
<td>Regional Network Managers (7 FTEs)</td>
<td>Bachelors with experience and MA level</td>
<td>100%</td>
</tr>
<tr>
<td>Network Coordinator</td>
<td>Bachelors</td>
<td>100%</td>
</tr>
<tr>
<td>Quality Analyst (4 FTEs; +1 vacancy)</td>
<td>2 MBA, 1 MA and 1 Bachelors of Art</td>
<td>100%</td>
</tr>
<tr>
<td>Consulting Statisticist</td>
<td>PhD</td>
<td>20%</td>
</tr>
<tr>
<td>QM Coordinator-Complaints/Appeals (3 FTEs)</td>
<td>High School Diploma and 2 with Bachelors of Arts</td>
<td>100%</td>
</tr>
<tr>
<td>Contract Monitor</td>
<td>High School Diploma</td>
<td>100%</td>
</tr>
<tr>
<td>Director of Compliance</td>
<td>Bachelors of Arts</td>
<td>100%</td>
</tr>
<tr>
<td>QM Specialist II-Auditor (2 FTEs)</td>
<td>1 vacancy and 1 MSW</td>
<td>100%</td>
</tr>
<tr>
<td>CEO / VP Service Center</td>
<td>MA</td>
<td>20%</td>
</tr>
<tr>
<td>Medical Director (2 FTEs)</td>
<td>MD</td>
<td>40%</td>
</tr>
<tr>
<td>VP of Child and Family Clinical Operations</td>
<td>MA</td>
<td>30%</td>
</tr>
<tr>
<td>VP of Adult Clinical Operations</td>
<td>PhD</td>
<td>30%</td>
</tr>
<tr>
<td>VP of Provider Relations</td>
<td>MSW</td>
<td>20%</td>
</tr>
<tr>
<td>Director of Customer and Provider Relations</td>
<td>N/A</td>
<td>20%</td>
</tr>
<tr>
<td>Director of Utilization Management</td>
<td>RN</td>
<td>20%</td>
</tr>
<tr>
<td>Director of Community Support</td>
<td>MA</td>
<td>20%</td>
</tr>
</tbody>
</table>

During 2011, with the addition of new business, several positions were added to the QM Department. While several new staff were hired during the year, the learning curve as new staff become familiar with our data sets is steep. The requirements of the contract are such that the reports and computations must be accurate every time. One of the existing Quality Analysts was promoted to Team Lead. This position was extremely helpful during the growth in the department as she was able to train new staff and be readily available to answer questions and provide direction. It also became increasingly clear with the growing complexity of the data sets and increased volume of reports and analyses required, that Quality Analyst staff need a strong educational background in math and statistics. As a result, the department is attempting to hire applicants with an
MBA or a BA in finance or accounting. This background lends itself to improved comfort with data.
Currently, the biggest need of the department is the need for a statistician who is capable of dealing with large complex data sets and advanced statistics. As we worked with the analysis of pharmacy and home health data during 2011, we hired a consultant to work with us on the analysis. While this was very helpful, it highlighted our on-going need at the service center. As a result, we outreached to national ValueOptions to inquire as to their interest in sharing a full time position. This was successfully negotiated, and we are currently searching for this new resource.

D. Practitioner Involvement
One of the strengths of the CT BHP QM Program is the active involvement of network practitioners in the program. Behavioral health practitioners representing different levels of care are integrally involved via the PARs program. They are instrumental in establishing measures and in setting goals for their performance. Providers are also involved in multiple QM Committees and Sub-Committees, including those that provide oversight of the Partnership at the highest level. Please see the 2012 CT BHP Program Description for details about those committees that involve providers.

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

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

F. Patient Safety
The strong focus of the service center that began during 2010 and continued into 2011 has been on patient safety and risk management. With the new business came a very large increase in the reports of adverse incidents, the extent of which was unanticipated. The committee that reviews these incidents was expanded to include an additional Medical Director to ensure clinically appropriate review of every case during the hospitalization that frequently occurs as a result of the incident as well as in the discharge planning for this population. As a result, protocols for review of these cases have been enhanced as has the follow-up on the cases both prior to and following discharge.
III. EVALUATION OF THE 2011 CT BHP QM PROJECT PLAN


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

A-C. The 2010 QM Program Evaluation, the 2011 QM Program Description, and the 2011 QM Program Project Plan were submitted to the Departments on April 15, 2011. Formal approval of the documents by the Departments was received on July 20, 2011.

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

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

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

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

In 2011, the Service Center received 81 complaints/grievances, more than double the number from CY ’10. The Provider complaints more than doubled from CY ’10 to CY ’11 and represent 50% of the complaints/grievance received in 2011.

The increase in complaints/grievances in CY 2011 is related to the additional members and providers added during the year as well as to provider dissatisfaction with process changes over the course of the year (e.g., IOP moved to a registration based process, clinical reviews took longer to complete while new staff gained expertise in using the computer system, and utilization reviews moved to a region based approach). In addition, all new hires were trained on the complaint process with particular emphasis on ensuring that complaints are being documented routinely and correctly by using the specific codes for categorizing the complaint types when entering complaints into the system. Throughout 2011, refresher trainings for the staff were conducted quarterly ensuring that the complaints received are being documented appropriately. Complaints
that are not documented correctly are returned to the submitter to make corrections, again to reinforce correct documentation.

E. Average number of days to resolution

<table>
<thead>
<tr>
<th></th>
<th>CY '07</th>
<th>CY '08</th>
<th>CY '09</th>
<th>CY '10</th>
<th>CY '11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average # of Days</td>
<td>13.03</td>
<td>17.84</td>
<td>16.28</td>
<td>20.03</td>
<td>18.45</td>
</tr>
</tbody>
</table>

In CY ’11 the total time to resolve a complaint decreased by 7.9% from CY ’10 (20.03 days) to CY ’11 (18.45 days). In CY ’11 the overall reduction in time to resolve complaints was driven by a 53% decrease in the total time to resolve a provider complaint from CY ’10 (29.07) to CY ’11 (13.8). The average time to resolve Adult and Youth member complaints remained relatively stable even with the addition of the new business. Complaints continue to get addressed more timely by bringing the complaint resolution process to existing meetings that include the necessary staff from various departments.

F. Percent of complaints resolved within 30 days

In CY ’11 a total of 79 complaints were resolved and, of those, 74 were resolved within 30 days. Four (4) complaints were resolved within 31 to 45 days after a 15 day extension was requested of the complainant. One (1) complaint was resolved within 31 to 45 days without requesting an extension. Although this complaint was officially closed just outside of the TAT Standard of 30 days, the work to resolve the complaint was completed within the 30 days. Thus, 98.7% of the complaints resolved were within the required timeframe.

G. Most frequent reasons for complaints

**Adult Member Complaints:** In CY’11 there were 22 adult member complaints received; the reasons were:

- Thirteen (13) were classified as Quality of Care–Provider Treatment Practice Issue
- Five (5) were classified as Complaint regarding benefits
- Two (2) were classified as Member treated unfairly
- One (1) Provider not accepting new patients
- One (1) Member Request Change: Disagrees with TX Plan
Child Member Complaints: In CY ’11, 20 child member complaints were received; the reasons were:

- Twelve (12) were categorized as Quality of Care–Provider Treatment Practice Issue
- Three (3) Member treated unfairly
- Two (2) were classified as Dissatisfied with complaint determination
- One (1) Member Requested Provider Change: Member Treated Unfairly
- One (1) Member Request Provider Change- Inconvenient Location
- One (1) Complaint and Grievance Referral Appointment Issue

Provider Complaints: In CY ’11 there were 41 provider complaints received and the reasons were:

- 21 were complaints regarding the authorization process
- 10 were complaints regarding the Web Registration process
- Three (3) were complaints regarding benefits
- Three (3) Contractor Complaints
- One (1) Complaint regarding claims
- One (1) Complaint & Grievance – Phone Prompts
- One (1) Access to Care Issue: No In Provider with Specialty
- One (1) VO staff lack courtesy

In 2011 we reviewed and established several interventions in order to address the concerns of our members and providers. The most frequent complaints from providers centered on the authorization process, several internal process changes occurred to better manage timely call backs to providers in order to complete reviews. Another frequent complaint by providers was regarding the web registration process; these concerns were addressed with several provider alerts which provided clarification of the web based process for requesting care authorization.

For both youth and adult members, the most frequent complaint received centered on the quality of the care they receive. In order to address this, we implemented a new policy in which a Peer is most often assigned to the case to ensure that the member is able to advocate for their needs and ensure that the member is connected to another provider if warranted.

Recommendations for continuing sub-Goal in 2012:
This sub-goal continues to be applicable for 2012 and should be included in the 2012 Project Plan.

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

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

A. Quality of Care (QoC)

1. Number of QoC issues identified; broken out by child and adult
In 2011, there were 183 QoC’s received, which represents a 19.4% decrease from the 227 received in CY 2010. During 2011, 34 of the incidents received were confirmed as QoC’s after being reviewed and categorized by the Safety and Risk Management Sub-Committee. After being reviewed by the Sub-Committee, 22 of the submitted QoC’s were deemed “not quality of care” issues. The remaining 127 QoC issues which were received in 2011 have not been categorized by the Sub-Committee. The Sub-Committee was unable to review all of the Qocs that were submitted due to the focus of the Sub-Committee’s time being devoted to the reviewing of the Adverse Incidents which increased greatly following the addition of the adult population in Q2 ’11 – see section B. Adverse Incidents below for more details. All QoC submissions are reviewed by the AVP of QM and concerns were followed up in real time. With all concerns related to Enhanced Care Clinics (ECCs) meeting access standards, Regional Network Managers were assigned and concerns were addressed directly with QM staff of the ECCs. Concerns related to RTC and Group Homes were shared with the Department of Children and Families to ensure that DCF Risk Management was aware of any concerns.

Of the 183 received QoC submissions in 2011, 121 (66.1%) involved youth members and 62 (33.9%) involved adult members.
- Of the 34 confirmed QoC issues in 2011, 25 involved youth members and 9 involved adult members.
- Of the 127 QoC issues not categorized by the QOC Committee, 78 involved youth members and 49 involved adult members.
- Of the 22 submitted QoC’s that were deemed “not a quality of care”, 18 involved youth members and four (4) involved adult members.

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

Consistent with 2010; in 2011 the category with the highest volume continues to be issues related to clinical practice, however there was a 14.2% decrease from CY ‘10 (85.7%) to CY ‘11 (73.5%).

Within the category of Clinical Practice Related Issues, the most frequently types of QoC issues across all levels of care reported were:

<table>
<thead>
<tr>
<th>Clinical Practice:Sub-category</th>
<th># of QOC</th>
<th>% of QOC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delay in treatment</td>
<td>1</td>
<td>4.00%</td>
</tr>
<tr>
<td>Effectiveness of treatment</td>
<td>1</td>
<td>4.00%</td>
</tr>
<tr>
<td>Failure to attempt to involve family in treatment</td>
<td>1</td>
<td>4.00%</td>
</tr>
<tr>
<td>Failure to coordinate care</td>
<td>1</td>
<td>4.00%</td>
</tr>
<tr>
<td>Inaccurate UR information impeding discharge planning</td>
<td>1</td>
<td>4.00%</td>
</tr>
<tr>
<td>Timeliness of assessment</td>
<td>1</td>
<td>4.00%</td>
</tr>
<tr>
<td>Failure to appropriately refer (Tx outside field of compliance)</td>
<td>2</td>
<td>8.00%</td>
</tr>
<tr>
<td>Failure to follow standard practice</td>
<td>2</td>
<td>8.00%</td>
</tr>
<tr>
<td>Inadequate discharge planning</td>
<td>2</td>
<td>8.00%</td>
</tr>
<tr>
<td>Adequacy of assessment</td>
<td>3</td>
<td>12.00%</td>
</tr>
<tr>
<td>Incomplete information for effective UR process</td>
<td>10</td>
<td>40.00%</td>
</tr>
<tr>
<td>Clinical Practice Related Totals</td>
<td>25</td>
<td>100.00%</td>
</tr>
</tbody>
</table>
When sorted by Level of Care (LOC), the highest volume of quality of care issues were identified regarding inpatient facilities and RTC. The following quality of care issues were identified for specific providers:

**Inpatient**

<table>
<thead>
<tr>
<th>Provider/Facility Name</th>
<th>Sub-category/Reason</th>
<th># of QOC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day Kimball Hospital</td>
<td>Incomplete information for effective UR process</td>
<td>1</td>
</tr>
<tr>
<td>Hartford Hospital</td>
<td>Failure to attempt to involve family in treatment</td>
<td>1</td>
</tr>
<tr>
<td>St. Francis Hospital</td>
<td>Incomplete information for effective UR process</td>
<td>1</td>
</tr>
<tr>
<td>Stamford Hospital</td>
<td>Incomplete information for effective UR process</td>
<td>1</td>
</tr>
<tr>
<td>Westwood Pembroke</td>
<td>Failure to report required info to DCF (i.e. 136, Critical incident, abuse/neglect, med changes)</td>
<td>1</td>
</tr>
<tr>
<td>Natchaug</td>
<td>Inaccurate UR information impeding discharge planning</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Incomplete information for effective UR process</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Inadequate discharge planning</td>
<td>1</td>
</tr>
<tr>
<td>Natchaug Total</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>10</td>
</tr>
</tbody>
</table>

**Residential Treatment Center**

<table>
<thead>
<tr>
<th>Provider/Facility Name</th>
<th>Sub-category/Reason</th>
<th># of QOC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bennington</td>
<td>Effectiveness of treatment</td>
<td>1</td>
</tr>
<tr>
<td>Devereux, MA</td>
<td>Failure to follow DCF protocol</td>
<td>1</td>
</tr>
<tr>
<td>Glen Mills</td>
<td>Failure to follow standard practice</td>
<td>1</td>
</tr>
<tr>
<td>Spurwink</td>
<td>Aggressive behavior, Threats of aggressive behavior</td>
<td>1</td>
</tr>
<tr>
<td>Wellspring</td>
<td>Peer to Peer sexual relationship</td>
<td></td>
</tr>
<tr>
<td>Children's Center of Hamden</td>
<td>Adequacy of assessment</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Failure to appropriately refer (Tx outside field of compliance)</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Failure to report required info to DCF (i.e. 136, Critical incident, abuse/neglect, med changes)</td>
<td>2</td>
</tr>
<tr>
<td>Total CCOH</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>10</td>
</tr>
</tbody>
</table>

3. Trend Quality of Care issue by provider (Categorized & Un-categorized)

In 2011 the following providers had the highest volume of QOC’s received. The totals below include the confirmed QoC’s (34) and those QoC’s (127) which are not categorized by the QOC Committee.

- St. Vincent’s Hospital had the highest volume (13) of QoC’s reported in CY ’11; all thirteen (13) were regarding the IPF LOC.
- Children CT of Hamden received the second highest volume (11) of QoC’s; with six (6) in regards to their PRTF and five (5) in regards to their RTC.
  - Four (4) of the RTC QoC’s have been reviewed and categorized by the QOC Committee and are included in the RTC table above.
- Natchaug Hospital received the next highest volume (9) of QoC’s; and all were in relation to the IPF LOC.
  - Five (5) of the QoC’s have been reviewed and categorized by the QOC Committee and are included in the IPF table above.
B. Adverse Incidents

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

In 2011, 832 adverse incidents were reported for review. Of those incidents, 251 (30.2%) met the ValueOptions Inc. National criteria for Adverse Incident and were given a risk severity rating. The remaining 581 were events where the member engaged in high risk behaviors but did not require urgent or emergent treatment following the incident and/or was not receiving services or not recently discharged from services managed by ValueOptions Inc. The volume of adverse incidents meeting the VO National criteria increased by 30.1% from CY ’10 (193) to CY ’11 (251). The substantial increase was due to two main factors, the first of which was the addition of the new adult population starting in the second quarter of CY 2011. Secondly, continued Service Center trainings and attention was placed on monitoring risk events. Due to CTBHP’s frequent contact with the hospitals, hospital staff quickly learned what information CT BHP was requesting and consequently provided more reliable information. Of the 251 incidents, 36.7% (92) involved youth and 63.3% (159) involved adults.

The 251 adverse incidents were categorized by severity rate based on both the client's enrollment in treatment at the time of the event and the level of treatment they required after the event.

- One hundred twelve (112) were Minimal risk.
- One hundred thirteen (113) were categorized as Moderate risk.
- Twenty (20) were categorized as Major risk.
  - Twelve (12) involved self-inflicted harm by an adult member, four (4) involved self-inflicted harm by a youth member
  - Three (3) involved alleged sexual behavior by a youth member with another patient or staff while in a behavioral health setting
  - One (1) involved the elopement of a youth member
- Six (6) incidents were categorized as Sentinel risk. These involved youth (13 -17) engaged in sexual behavior with other patients or staff within the behavioral health setting – RTC or Group Homes.

All incidents were reported to the departments or were determined to have already been reported to the departments by the facility or provider.
2. Most frequent types of Adverse Incidents identified:

<table>
<thead>
<tr>
<th>Adverse Incident Category</th>
<th>CY '08</th>
<th>CY '09</th>
<th>CY '10</th>
<th>CY '11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Property Damage</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Serious Adverse Reaction to Treatment</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Medication Errors</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other Occurrences</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Unexpected Death</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Elopements</td>
<td>0</td>
<td>2</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Human Rights Violations</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Violent/Assaultive Behavior (non lethal)</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Injuries (Accidents): Urgent or Emergent</td>
<td>3</td>
<td>3</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Sexual Behavior</td>
<td>5</td>
<td>12</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>Self Inflicted Harm</td>
<td>7</td>
<td>5</td>
<td>169</td>
<td>226</td>
</tr>
<tr>
<td>Adverse Incidents</td>
<td>19</td>
<td>29</td>
<td>193</td>
<td>251</td>
</tr>
</tbody>
</table>

Consistent with CY 2010; in 2011 the most frequent type of reported adverse incidents involved self-inflicted harm (90%) which required urgent or emergent treatment.
- Of the 226 incidents involving self-inflicted harm Sixteen (16) were deemed as Major risk and involved both youth (4) and adult (12) members. The remaining incidents were classified as minimal or moderate risk.

The next most frequent adverse incident reported involved sexual behavior (10) with other patient or staff while in a behavioral health setting.
- Six (6) were classified as Sentinel risk and three (3) were classified as Major risk.

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

3. Trending of Adverse Incidents by provider

In 2011 there were 14 adverse incidents reported regarding members either recently (within two weeks of discharge) or currently in treatment at Hartford Hospital, including their inpatient, partial hospital, and intensive outpatient programs. One (1) of the incidents involved an accidental injury and thirteen (13) were classified as self-inflicted harm. Of these incidents eight (8) classified as minimal risk, four (4) as moderate risk and two (2) as major risk.

There were eight (8) incidents reported for members treated at Community Health Resources (CHR) in 2011. They all involved self-inflicted harm; six (6) were classified as moderate risk and four (4) as minimal risk.

Yale New Haven Hospital had eight (8) adverse incidents reported in 2011 concerning members either recently (within two weeks of discharge) or currently in treatment at Yale New Haven Hospital or a program affiliated with Yale. All of the incidents involved self-inflicted harm; three (3) were classified as moderate risk, three (3) as major risk and two (2) as minimal risk.
In 2011 there were six (6) sentinel incidents reported. These incidents all involved sexual behavior and were from the following facilities;

(2) Children’s Home of Cromwell  
(1) Bennington School Inc  
(1) CT Institute for the Blind-Oak Hill,  
(1) Germaine Lawrence Inc  
(1) and Klingberg Family CTR Inc.

**Recommendations for continuing sub-Goal in 2012:**  
This sub-goal continues to be applicable for 2012 and should be included in the 2012 Project Plan.

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

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

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

During 2011, Clinical, Customer Service, Provider Relations and Quality Management each reviewed their own department’s CT-specific P&P’s. The Clinical and Provider Relations Departments reviews found that there were no necessary revisions. Revisions were made to the following Customer Service and Quality Management P&Ps:

- **Customer Service P&P:**  
  CS002 Inquiry/Call Documentation;  
- **Quality Management P&P’s:**  
  QM303 Medical Necessity Denials – Notice of Action,  
  QM 305 Provider Appeals,  
  QM308 Administrative Denials,  
  QM309 Member Appeals.

All revised P&Ps were submitted to the Departments for review and were subsequently approved.

**Recommendations for continuing sub-Goal in 2012:**  
This sub-goal continues to be applicable for 2012 and should be included in the 2012 Project Plan.

**Goal 5. Establish and maintain training program that includes compliance with state regulatory requirements and HIPAA regulations (Contract Reference V.1 and V.3)**

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

**A. Staff training on state regulatory requirements**
Staff training on state regulatory requirements is completed during orientation and then via periodic review in departmental staff meetings. This training has been conducted with 100% of new employees during orientation and existing staff were highly encouraged to attend as well. The QM and Compliance Department provided periodic updates on state and federal regulatory requirements during the year. With the hiring of a permanent Compliance position areas of additional opportunity will be identified and a more robust program will be developed.

B. Staff training on HIPAA privacy regulations

The annual service center wide HIPAA training was conducted as usual during 2011. All service center staff completed the training. Human Resources monitor to ensure full compliance with this requirement. Refresher trainings on basic information about PHI, what constitutes a HIPAA breach and how to report a HIPAA breach were conducted over the course of the year. In addition, quarterly audits were conducted of the service center staff to ensure compliance with the rules around protecting PHI. In 2011, there were twenty eight (28) incidents reported of PHI being exchanged with an unintended party. In each instance an assessment was conducted with the assistance of National ValueOptions as to the level of risk to the member and whether or not it was a violation or a breach. Following the assessment, three (3) of the twenty eight (28) events were deemed not to be a violation and PHI was not in fact exchanged with an unintended party. The remaining twenty five (25) instances fell into the following categories:

Privacy Violations (24):
- Seventeen involved sending an authorization letter to an incorrect provider.
- Seven involved clinical information being added for one member under another member’s record in the CareConnect system.

The determination that these incidents were privacy violations was based on the finding that the material was shared with covered entities who are bound by the same Privacy Rules as ValueOptions so that the risk to the member is low. In all cases, immediate actions were taken to retrieve the information or ensure that the information was destroyed if retrieval was not possible.

Policy Violations (1):
- One involved an unencrypted e-mail sent to DSS and HP that contained a spreadsheet with PHI

The determination was that that this incident was a policy violations was based on the finding that ValueOptions policy was not followed. In all cases, immediate actions were taken to retrieve the information or to ensure that the information was destroyed if retrieval was not possible.

The AVP of QM attended the Clinical staff meeting and reviewed the regulations with the entire semi-annually during 2011. In addition, periodic privacy reminders were e-mailed to all staff in the service center that included topics such as the need to lock computers when staff walks away from their desk and reviews of HIPAA issues that can arise when faxing and e-mailing. Privacy audits were conducted quarterly and feedback was
provided to the various departments with respect to how staff was complying with the privacy regulations.

Recommendations for continuing sub-Goal in 2012:
This sub-goal continues to be applicable for 2012 and should be included in the 2012 Project Plan.

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

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

Volume of Calls

In 2011 the total annual call volume increased 65.1% from 70,410 (CY ‘10) to 116,258 (CY ‘11). With the addition of the adult business beginning in Q2 ‘11, Provider calls were the most significant contributor to this increase, increasing by over 100% from CY ‘10 (38,031) to CY ‘11 (88,386). Crisis calls also increased by over 100% from CY ‘10 (311) to CY ‘11 (2,982) primarily due to the telephone menu changes. On the other hand, Member calls decreased by 22.4% over the same time frame. In order to better understand the decrease in member calls, the number of “hits” to the website for provider/facility searches was pulled. It was determined that there was a 16% increase in the number of “hits” to the website during the same time period (CY ‘10(14,953) to CY ‘11 (17,351)). One explanation for the decrease in member calls may be related to the increase in use of the website to obtain referrals.
A. Average speed to answer: Average number of seconds until call is answered by a live person

In 2011 the average speed of answer for Member and Provider calls decreased two (2) seconds each while the Crisis calls average speed of answer increased by two (2) seconds. This increase in average speed of answer for Crisis calls can be directly linked to the increase in crisis call volume. The service center remained well within this performance standard in 2011.

B. Abandonment Rate: Percentage of calls not answered before caller hangs up

The Call Abandonment Rate increased substantially from CY ’10 to CY ’11 however, the abandoned call rate remains well below the standard. The number of abandoned calls spiked in the first two (2) quarters of CY ’11, when new staff members began taking calls in the Service Center. The call abandonment rate decreased 80.7% from Q2 ’11 (171) to Q3 ’11 (33). As the Customer Service staff continue to develop better competency and efficiency with the phone system this rate should continue to decrease.
C – D. Percentage of calls placed on hold and average length of time on hold for Clinical, Customer Service and Crisis Calls

In 2011 the percent of total calls placed on hold increased 18% from CY ‘10 (53.73%) to CY ‘11 (63.42%). While the volume of calls placed on hold for Crisis and Provider calls substantially increased, the volume of member calls placed on hold decreased 32% from CY ‘10 (16,314) to CY ‘11 (11,105). The volume of calls placed on hold is related with the total volume of calls received.

In 2011 the average hold time for all calls received at the service center increased, however the Provider and Member average hold time remained well within their respective performance standards. The annual average hold time for Crisis calls more than doubled from CY ‘10 to CY ‘11 though it needs to be noted that the the average hold time for Crisis calls decreased during Q3 ‘11 and Q4 ‘11. The increase in average hold time is due to the upsurge in “Non-Crisis” calls coming through the Crisis queue and crisis call protocols then not being followed consistently on all calls during the early part of the implementation of the new business.
E. Average Length of Time on Call

The average handle time of all calls increased slightly from CY ’10 to CY ’11.

**Recommendations for continuing sub-Goal in 2012:**
This sub-goal continues to be applicable for 2012 and should be included in the 2012 Project Plan.

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

7A. Child Study: Autism Spectrum Disorder (ASD) Feasibility Study (Contract reference M.6)

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

In Q2 ’11, the Departments proposed an Autism Spectrum Disorder (ASD) Feasibility Study. In collaboration with the departments, it became clear that the project would not only address youth but would also include adults with the disorder. It was agreed that the ASD study would satisfy two of the two contractually obligated clinical studies for the first year of the new contract. Please refer to Appendix A of the summary of the progress made on this project by the end of 2011.

**Recommendations for continuing sub-Goal in 2012:**
This sub-goal continues to be applicable for 2012 and should be included in the 2012 Project Plan.

7B. Adult Study: Clinical Study Adult I (Contract Reference: M.6)

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

Please see 7A above for description of the Autism Spectrum Disorder (ASD) Feasibility Study which satisfies the obligation for one adult clinical study during the first year of the new contract.

**Recommendations for continuing sub-Goal in 2012:**
This sub-goal continues to be applicable for 2012 and should be included in the 2012 Project Plan.
Reducing discharge delays for youth receiving inpatient behavioral health treatment (Contract Reference: 2011 Performance Target 5)

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

The 2011 Performance Target related to discharge delay days was a maintenance measure. The goal for Performance Target 5 was to maintain discharge delay days at 20% or less of total inpatient days. In addition, acute average length of stay could increase no more than 3% in CY 2011 from the baseline established during Q3 and Q4 of CY 2008 of 12.92 days. At the end of CY 2011 the total percent of discharge delay days for CY ’11 was 10.87% and the acute average length of stay for CY ’11 was 11.17 days, thereby meeting 100% of the established performance target.

In calendar year 2011, there was a dramatic reversal of the high discharge delay rate during CY 2010; from 19.4% of all inpatient days delayed down to 10.9% for CY 2011. The increase discharge delay during 2010 was analyzed and the results led to the implementation of a number of internal utilization management strategies that have been maintained over the course of 2011. The measures taken include the enhancement of our collaborative activities with our DCF partners in the Area Offices as well as closer management of out of state inpatient facilities. The analysis showed that a significant amount of the growth in discharge delay during 2011 was driven by the delays in out of state facilities. The delays occurred especially with special populations who are hospitalized out of state but also for routine admissions. As a result of these efforts, discharge delay has gone from 6,854 total days delayed in CY ’10 to 3,555 for CY’11.
<table>
<thead>
<tr>
<th></th>
<th>CY’08</th>
<th>CY’09</th>
<th>CY’10</th>
<th>Q1’11</th>
<th>Q2 ‘11</th>
<th>Q3 ‘11</th>
<th>Q4 ‘11</th>
<th>CY ‘11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Days</td>
<td>28895</td>
<td>29094</td>
<td>28552</td>
<td>6646</td>
<td>7916</td>
<td>6629</td>
<td>7944</td>
<td>29135</td>
</tr>
<tr>
<td>Discharge Delay Days</td>
<td>9959</td>
<td>5133</td>
<td>6854</td>
<td>756</td>
<td>1115</td>
<td>828</td>
<td>856</td>
<td>3555</td>
</tr>
<tr>
<td>Total Days</td>
<td>38854</td>
<td>34227</td>
<td>35406</td>
<td>7402</td>
<td>9031</td>
<td>7457</td>
<td>8800</td>
<td>32690</td>
</tr>
</tbody>
</table>

It is important to note that there has been no addition to in-state capacity at either the acute, subacute or alternative LOC that would otherwise account for the reduction in DD. At the same time, this experience has highlighted the fragility of the service delivery system in that any number of variables affecting the system can derail previous success in the area of discharge delay trends. Continued focus on out of state admissions and more proactive approaches to the service needs of special populations in state has resulted in at least short term stability in discharge delay.

It is also important to note the very substantial decrease in overall use of inpatient days for CT youth from 2008 to 2011. With the exception of 2010, there have been decreases in use of inpatient days annually. Between 2008 and 2011, 15.8% fewer inpatient days were used despite the increase in the membership. Please see the discussion under Goal 10 for more analysis of this topic.

**Recommendations for continuing sub-Goal in 2012:**
This sub-goal continues to be applicable for 2012 and should be included in the 2012 Project Plan.

**Goal 8. Monitor performance of Customer Service staff via audits of performance**
*(Contract Reference: F.13 and F.14)*

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

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

During 2011, the ValueOptions NICE system was utilized to conduct auditing of the Customer Service staff. The Director of Customer Service and the Customer Service Supervisor conducted the audits. The audit average for the department was 95.7% for 2011. Customer Service staff received feedback regarding their individual performance during supervision and the Customer Service team received feedback regarding overall department performance during staff meetings.

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

The Customer Service Department conducts audits of the accuracy of the documentation that results from calls into the department. Audit results indicate that with the exception of misdirected calls (medical, dental or vision) Customer Service staff
routinely document every call received. Based on results from the NICE system, the scores for documentation were above the goal of 90%. Actual results for 2011 were 95.7%. The audits identified opportunities for improvement in the quality of the documentation in member records regarding the content of the call. This finding was followed up in individual supervision, weekly staff meetings, and trainings.

The opportunity for improvement around professional etiquette and tone was also identified during the audit process. The new Contract brought an increase in membership resulting in a higher call volume and over 40% growth in the Customer Service team. All staff completed one to one professional etiquette and tone training. In addition to that training, all new staff completed the Comprehensive CT Call Center training, including system application, telephone etiquette and handling, resource development, and process & procedural work flows.

Additionally, the audit process revealed inconsistent documentation of complaints voiced by members and providers as an area needing improvement. Education was provided to the Customer Service staff through refresher training and team meetings. As a result of the training, the number of documented complaints more than doubled between CY ’10 and CY ‘11.

**Recommendations for continuing sub-Goal in 2012:**
This sub-goal continues to be applicable for 2012 and should be included in the 2012 Project Plan.

**Goal 9. Review and approve the 2011 CT BHP Utilization Management (UM) Program Description (Contract Reference F.3)**

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

**A. Annual development and review of the 2011 UM Program Description**
The 2011 UM Program Description has been updated to address the entire book of business and was submitted for final approval on May 24, 2011. Formal approval of the documents by the Departments was received on June 22, 2011.

Please note that in collaboration with the departments it has been determined that the annual submission of the UM Program Description will now coincide with the submission of the QM Program Description on March 31, annually.

**Recommendations for continuing sub-Goal in 2012:**
This sub-goal continues to be applicable for 2012 and should be included in the 2012 Project Plan.

**Goal 10. Monitor for under or over utilization of behavioral health services; identify barriers and opportunities**

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

In order to be able to report on trends over time for the former HUSKY population, two sets of Utilization Management reports were developed by the end of 2011. The first set
includes the former HUSKY youth and adult population only while the second set reports on the new population of adults and includes the former HUSKY adult population. Please keep in mind that these reports still define adults as 19+. Beginning in Q1 ’12, these reports will define adults as 18+.

**Former HUSKY Population:** The former HUSKY population included HUSKY A, HUSKY B, and D05 members. In the current system of eligibility categorization, that began with Q2 ’11, the former HUSKY population reports include Family Single, HUSKY B, and D05 for Quarters 2, 3, and 4 ’11. This will be the last time that we report on the former HUSKY population.

**Adult Analyses:** The second set of Utilization Management reports includes aggregate utilization data for adults across all eligibility categories that include adults and breaks out the utilization measures for each category back to Q2 ’11. Included in these reports are comparisons of utilization for multiple levels of care for the following populations: Family Single and Dual, ABD Single and Dual, Long Term Care Single and Dual, Charter Oak, and HUSKY B.

A. **Inpatient Psych # of Admits, ALOS, Days/1000, & Admits/1000, Excluding Riverview and Riverview only**

### Children Inpatient

#### Inpatient Days/1000 All HUSKY Youth (0-18)

<table>
<thead>
<tr>
<th>Year</th>
<th>Days/1000</th>
</tr>
</thead>
<tbody>
<tr>
<td>CY ’07</td>
<td>15.5</td>
</tr>
<tr>
<td>CY ’08</td>
<td>13.4</td>
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<tr>
<td>CY ’09</td>
<td>11.2</td>
</tr>
<tr>
<td>CY ’10</td>
<td>10.9</td>
</tr>
<tr>
<td>CY ’11</td>
<td>9.4</td>
</tr>
</tbody>
</table>

Excluding Riverview

- CY ’07-Q1 ’11: HUSKY A, HUSKY B, D05
- Q2-Q4 ’11: Family Single, HUSKY B, D05

#### Inpatient Days/1000 HUSKY Youth (0-18)

<table>
<thead>
<tr>
<th>Year</th>
<th>Days/1000</th>
</tr>
</thead>
<tbody>
<tr>
<td>CY ’07</td>
<td>10</td>
</tr>
<tr>
<td>CY ’08</td>
<td>8.3</td>
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<tr>
<td>CY ’09</td>
<td>6.1</td>
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<tr>
<td>CY ’10</td>
<td>5.6</td>
</tr>
<tr>
<td>CY ’11</td>
<td>4.0</td>
</tr>
</tbody>
</table>

DCF vs. Non-DCF Members

- CY ’07-Q1 ’11: HUSKY A, HUSKY B, D05
- Q2-Q4 ’11: Family Single, HUSKY B, D05

<table>
<thead>
<tr>
<th>Year</th>
<th>DCF</th>
<th>Non-DCF</th>
</tr>
</thead>
<tbody>
<tr>
<td>CY ’07</td>
<td>10</td>
<td>5.5</td>
</tr>
<tr>
<td>CY ’08</td>
<td>8.3</td>
<td>5.1</td>
</tr>
<tr>
<td>CY ’09</td>
<td>6.1</td>
<td>5.1</td>
</tr>
<tr>
<td>CY ’10</td>
<td>5.6</td>
<td>5.3</td>
</tr>
<tr>
<td>CY ’11</td>
<td>4.0</td>
<td>5.4</td>
</tr>
</tbody>
</table>
The data reflective of the HUSKY Youth Inpatient Days/1000 demonstrates a steady and consistent decrease in the use of inpatient days, most notably for those youth who are DCF involved. The reduction in days by DCF involved youth is particularly impressive given the challenge that this group often presents to the system of care. These youth often present with the more complex problems due to the co-occurrence of severe psychosocial stressors, often limited familial resources and significant dispositional issues. The greatest gains for this cohort were made in the earlier years, though the trend continues downward.

Specific details for data from CY ’07 forward are presented in the following paragraph. Overall, Youth Inpatient Days/1000 has greatly decreased from CY ’07. Year over year Inpatient Days/1000 has reduced by 13.5% from CY ’07 to CY ’08, by 16.4% from CY ’08 to CY ’09, by 2.7% from CY ’09 to CY ’10 and by 13.8% from CY ’10 to CY ’11, for a total change of 39.4% from CY ’07 to CY ’11.

The decrease in the Days/1000 for the DCF-Involved population accounts for bulk of the change. DCF involved youth Inpatient Days/1000 decreased 60.0% from CY ’07 to CY ’11; more specifically, by 17.0% from CY ’07 to CY ’08, by 26.5% from CY ’08 to CY ’09, by 8.2% from CY ’09 to CY ’10 and by 28.6% from CY ’10 to CY ’11. DCF involved youth Inpatient Days/1000 is consistent with the overall youth inpatient Days/1000 trend. The Non-DCF involved youth Inpatient Days/1000 has stayed fairly stable since CY ’07.
As the membership of HUSKY has increased, so have the number of inpatient admissions since 2007. As average length of stay has decreased, more beds become available thus providing improved access for more members. At the same time, several initiatives have promoted increased use of multiple lower levels of care for HUSKY members. Since many factors influence need and bed capacity, no causal conclusions can be made. However, the trend, both long and short term, shows lessening demand for the inpatient level of care.

Year over year youth inpatient admissions have increased by 12.2% from CY ’07 to CY ’08, by 5.7% from CY ’08 to CY ’09, by 3.1% from CY ’09 to CY ’10 and by 2.9% from CY ’10 to CY ’11. Even with the increase in number of Inpatient admissions from CY ’10 to CY ’11, Admissions/1000 decreased from 0.8 to 0.7, respectively. This is due to Youth membership growing at a faster rate than Youth Inpatient admissions.

With the decrease in Days/1000 and increase of youth inpatient admissions, Average Length of Stay (ALOS) has continued to decrease, with the exception of a slight increase of 2.8% from CY ’09 to CY ’10. This slight increase was primarily accounted for by the increase in Discharge Delay (DD) days during the first three (3) quarters of 2010. The trend of high DD was reversed starting with Q4 CY ’10 and continuing throughout CY ’11; resulting in a decrease in overall ALOS once again. The role of DD in ALOS is underscored by the finding that, as with Days/1000, the biggest contributor to the
decrease in youth inpatient ALOS was the decrease in DD by the DCF involved population.

Year over year youth inpatient ALOS has decreased overall 40.0% from CY '07 to CY '11; and more specifically, by 15.2% from CY '07 to CY '08, by 19.1% from CY '08 to CY '09 and by 14.9% from CY '10 to CY '11.

Over the past five years, DCF involved youth inpatient ALOS decreased by 44.3%, with a 15.2% decrease from CY '07 to CY '08, a 25.3% decrease from CY '08 to CY '09 and a 22.6% decrease from CY '10 to CY '11.

**Riverview only**

Since 2007, Riverview Days/1000 has continued to decrease. Year over Year Days/1000 decreased by 13.1% from CY '07 to CY '08, by 2.7% from CY '08 to CY '09, by 4.2% from CY '09 to CY '10 and by 16.2% from CY '10 to CY '11.

After an increase in Riverview Admissions from CY '08 to CY '09, admissions decreased from CY '10 to CY '11. However, admissions still remain above CY '07 and CY '08 levels.
With the decrease in Riverview Days/1000 and increase in Admissions, ALOS has continued to decrease. During CY ’11, Riverview’s ALOS was the lowest to date. Initially this finding is perplexing in that the numbers of HUSKY children admitted to Riverview has remained flat. However, there are two issues at play. The first is that the percentage of admissions to Riverview that are court ordered has increased for the past two years. Court-ordered admissions have significantly lower lengths of stay than do medically necessary admissions. Until 2009, approximately half of Riverview admissions were consistently court ordered. The percentage has gradually been increasing over the past two years so that in 2011, more than 56% of the admissions were court ordered. Additionally, there have been a number of internal systems changes at Riverview affecting and ultimately reducing bed capacity. The concern going forward is that if the ALOS and DD at Riverview go back to CY ’10 levels, this decrease in capacity will impact the system’s ability to provide an alternative disposition for youth who require this intensive level of care. This could result in a ripple effect throughout the delivery system as this unique resource can act, at times, as a pressure valve for the system.

**Former HUSKY Adults Inpatient**

After Inpatient Days/1000 increased from CY ’07 to CY ’09, it has steadily decreased over the past two years. There was a 6.7% decrease from CY ’09 to CY ’10 and a 5.7% decrease from CY ’10 to CY ’11.
Inpatient Admits/1000 has steadily decreased over the past two years, even though there have been more Inpatient Admissions in CY '10 and CY '11 than in CY '07 – CY '09. This is due to the large increase in the Adult membership. Adult Inpatient Admissions increased by 24.5% from CY '07 to CY '11, while Adult membership increased by 52.2% over the same time frame. The dramatic increase in Adult membership has resulted in a decrease in the Admits/1000.
Average Length of Stay required a more intensive review of the data to understand the spike in length of stay that occurred during Q4 ’11; ALOS moved from a fairly consistent range of 6.9 – 8.2 from CY ’07 to CY ’10 and then spiked to 8.8 in CY ’11. Closer scrutiny revealed that the ALOS for the HUSKY Adult population for the Q4 ’11 was impacted by four (4) discharges from Connecticut Valley Hospital. While this population has been included in previous reporting, we have never experienced the impact on ALOS that 4 discharges in one quarter with significantly long lengths of stay (>365 days) could produce. As presented in the second graph, removal of these four discharges and a recalculation of the data resulted in an ALOS of 7.3 days for CY ’11, which is consistent with prior years.

### Adult Inpatient

![Inpatient Days/1000 Adult (19+)](image)

#### Days/1000

<table>
<thead>
<tr>
<th>Benefit Group</th>
<th>Q2 ’11</th>
<th>Q3 ’11</th>
<th>Q4 ’11</th>
<th>Q2-Q4 ’11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Single (BHK013)</td>
<td>4.76</td>
<td>6.05</td>
<td>6.09</td>
<td>5.63</td>
</tr>
<tr>
<td>Family Dual (BHK014)</td>
<td>4.87</td>
<td>4.42</td>
<td>6.02</td>
<td>5.13</td>
</tr>
<tr>
<td>ABD Single (BHK015)</td>
<td>52.5</td>
<td>3</td>
<td>57.04</td>
<td>9</td>
</tr>
<tr>
<td>ABD Single (BHK016)</td>
<td>9.17</td>
<td>11.64</td>
<td>10.5</td>
<td>10.4</td>
</tr>
<tr>
<td>LTC Single (BHK010)</td>
<td>32.0</td>
<td>7</td>
<td>68.49</td>
<td>9</td>
</tr>
<tr>
<td>LTC Single (BHK011)</td>
<td>1.20</td>
<td>4.52</td>
<td>4.98</td>
<td>3.52</td>
</tr>
<tr>
<td>MLIA (BHK009)</td>
<td>29.8</td>
<td>0</td>
<td>33.74</td>
<td>6</td>
</tr>
<tr>
<td>CTOAK (BHK006)</td>
<td>5.07</td>
<td>3.74</td>
<td>4.35</td>
<td>4.40</td>
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</tbody>
</table>

#### Cases

<table>
<thead>
<tr>
<th>Benefit Group</th>
<th>Q2 ’11</th>
<th>Q3 ’11</th>
<th>Q4 ’11</th>
<th>Q2-Q4 ’11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Single (BHK013)</td>
<td>367</td>
<td>415</td>
<td>384</td>
<td>1117</td>
</tr>
<tr>
<td>Family Dual (BHK014)</td>
<td>13</td>
<td>13</td>
<td>17</td>
<td>42</td>
</tr>
<tr>
<td>ABD Single (BHK015)</td>
<td>614</td>
<td>626</td>
<td>621</td>
<td>1762</td>
</tr>
<tr>
<td>ABD Single (BHK016)</td>
<td>182</td>
<td>212</td>
<td>169</td>
<td>530</td>
</tr>
<tr>
<td>LTC Single (BHK010)</td>
<td>16</td>
<td>14</td>
<td>11</td>
<td>36</td>
</tr>
<tr>
<td>LTC Single (BHK011)</td>
<td>10</td>
<td>23</td>
<td>17</td>
<td>45</td>
</tr>
<tr>
<td>MLIA (BHK009)</td>
<td>1056</td>
<td>1207</td>
<td>1120</td>
<td>3200</td>
</tr>
<tr>
<td>CTOAK (BHK006)</td>
<td>22</td>
<td>15</td>
<td>15</td>
<td>51</td>
</tr>
</tbody>
</table>

Results on Inpatient Days/1000 were consistent with expectations for the benefit groups. ABD Single members typically have the most complex clinical presentations and so frequently require longer inpatient stays for stabilization and disposition. Therefore, it could be expected that they would have the greatest number of inpatient days per 1000
members, and in this analysis, they did. That rate was consistent across the three quarters. This indicator was also stable across quarters for MLIA members, although their rate was only 60% as high as for the ABD Singles.

Members in the LTC Single group appear to have a higher Days/1000 indicator in Q3 due to extended length of stay. These members reside in the structured environment of long term care facilities, but in some cases those facilities refuse to re-admit the members following an inpatient psychiatric hospitalization. In those cases, the members may wait for an extended period while alternative placements are sought. One additional question relates to possible seasonality. The highest rates of inpatient days for LTC Single members did occur in the second and third quarters, times when staffing patterns in nursing facilities can be lower. This measure will be tracked in the future to determine if other factors play a role.

Finally, the rate for ABD Dual members was the lowest of the benefit groups with high utilization. It is unclear why their rate was lower than that for ABD Single, and that question also will be explored in the going forward.
Admits/1000 rates were fairly stable across benefit groups throughout the three quarters reviewed, though small decreases were seen in three of the four groups with the highest admission numbers. The ABD Single rate fell by 7.4%, ABD Dual fell by 14.7% and the rate for MLIA members fell by 6.9%. The Family Single group remained stable between Quarter 2 and Quarter 4, and while there was an 8.5% increase in Quarter 3, the rate in Quarter 4 returned to the baseline level from Quarter 2. The results are thought to reflect ongoing efforts to manage inpatient utilization and seek alternative services, and this process will be reviewed in future analyses.
The highest ALOS was found in the LTC Single (17.46 days) and LTC Dual (12.59 days) benefit groups. As described above, this result may reflect members who are stuck without options for discharge if the referring facility refuses to re-admit the member. For all other benefit groups, the ALOS fell between 5 and 9 days, with the next longest ALOS for ABD members, both Single and Dual. Their ALOS was, on average, approximately 1.4 days longer than that of the MLIA group.

Of note, the ALOS for all benefit groups increased across the three quarters, despite efforts to manage utilization for this level of care (LOC). Several focused interventions were initiated during the 3rd and 4th Quarters. The Adult Bypass Program was expanded to include all of the hospital treating adult members. Under that program, hospitals can bypass the first concurrent review and receive an initial authorization for 5 days, provided they meet certain performance standards. Future analyses will track the effect of this program, as well as ongoing efforts to manage this LOC. A second intervention was started in the latter part of 2011, which was the initiation of physician to physician telephone consultations for any adult member whose inpatient LOS reached 10 days beginning in Q4 ‘11. That program has continued.
B-C. Inpatient Psych Days in Discharge Delay vs. Acute Length of Stay

<table>
<thead>
<tr>
<th></th>
<th>CY’08</th>
<th>CY’09</th>
<th>CY’10</th>
<th>CY’11</th>
</tr>
</thead>
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<tr>
<td>Acute Days</td>
<td>28895</td>
<td>29094</td>
<td>28552</td>
<td>29135</td>
</tr>
<tr>
<td>Discharge Delay</td>
<td>9959</td>
<td>5133</td>
<td>6854</td>
<td>3555</td>
</tr>
<tr>
<td>Total Days</td>
<td>38854</td>
<td>34227</td>
<td>35406</td>
<td>32690</td>
</tr>
</tbody>
</table>

Between CY ’08 and CY ’11, there was a 64.3% overall decrease in the total number of discharge delays. Specifically, in calendar year 2011, there was a dramatic reversal of the high discharge delay rate of 19.4% in CY ’10 down to 10.9% for CY ’11. The increase in 2010 was analyzed and the results led to the implementation of a number of internal utilization management strategies that have been maintained over the course of the year. The measures include, to a large degree, collaborative activities with our DCF partners in the Area Offices. As a result of all of these efforts, discharge delay has gone from 6,854 total days delayed in CY ’10 to 3,555 for CY’11.

Discharge Delay; Child Inpatient PAR

Following all Youth, the Big 8 Hospitals had a similar decrease in discharge delay days from 17.8% in CY ’10 to 11.3% in CY ’11 for a total of a 63.9% decrease over the past four years.
Discharge Delay; Riverview Cases

Riverview has experienced similar trends in discharge delay. After the significant increase of 69.1% from CY ’09 to CY ’10, the percent of discharge delay days decreased by 53.7% from CY ’10 to CY ’11.

D. Inpatient Detox ALOS, Admits/1000 & Days/1000

Former HUSKY Adults

Inpatient Detox Days/1000 has steadily decreased since CY ’07.
The number of Inpatient Detox admissions has increased since CY '09. However, since adult membership has increased at a faster rate, the Admits/1000 has been decreasing steadily over the past two years.

**Adult IPD Hospital**

<table>
<thead>
<tr>
<th>Days/1000</th>
<th>Q2 '11</th>
<th>Q3 '11</th>
<th>Q4 '11</th>
<th>Q2-Q4 '11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Single (BHK013)</td>
<td>0.28</td>
<td>0.29</td>
<td>0.26</td>
<td>0.27</td>
</tr>
<tr>
<td>Family Dual (BHK014)</td>
<td>0.00</td>
<td>0.30</td>
<td>0.00</td>
<td>0.10</td>
</tr>
<tr>
<td>ABD Single (BHK015)</td>
<td>2.32</td>
<td>1.86</td>
<td>1.96</td>
<td>2.05</td>
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<tr>
<td>ABD Dual (BHK016)</td>
<td>0.16</td>
<td>0.20</td>
<td>0.11</td>
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<tr>
<td>LTC Single (BHK010)</td>
<td>0.00</td>
<td>0.78</td>
<td>0.00</td>
<td>0.25</td>
</tr>
<tr>
<td>LTC Dual (BHK011)</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>MLIA (BHK009)</td>
<td>3.88</td>
<td>3.83</td>
<td>2.87</td>
<td>3.52</td>
</tr>
<tr>
<td>CTOAK (BHK006)</td>
<td>0.68</td>
<td>1.00</td>
<td>0.21</td>
<td>0.66</td>
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</table>

<table>
<thead>
<tr>
<th>Cases</th>
<th>Q2 '11</th>
<th>Q3 '11</th>
<th>Q4 '11</th>
<th>Q2-Q4 '11</th>
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<tr>
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<td>27</td>
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<td>26</td>
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</tr>
<tr>
<td>Family Dual (BHK014)</td>
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<td>17</td>
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<td>0</td>
<td>1</td>
</tr>
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<tr>
<td>MLIA (BHK009)</td>
<td>184</td>
<td>191</td>
<td>148</td>
<td>502</td>
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<tr>
<td>CTOAK (BHK006)</td>
<td>5</td>
<td>6</td>
<td>1</td>
<td>11</td>
</tr>
</tbody>
</table>
As with Admits/1000, results for the past three quarters show an overall decrease in the number of Hospital Days per 1000 members. The MLIA and ABD Single benefit groups recorded the highest average number of inpatient days, suggesting that they also had the most complicated clinical presentations, warranting longer hospital stays. No other benefit groups reached even one day per 1000 members. All benefit groups also experienced an overall reduction in days, except for Family Single which was essentially unchanged from Quarter 2 to Quarter 4. These decreases may reflect the reduction in admissions to this level of care as a result of the intensive efforts to manage the utilization since the program’s inception.

Results for the three quarters show relatively stable rates of IPD Hospital admissions per 1000 members, although there was a downward trend for the benefit groups with the highest rates. For the MLIA and ABD Single groups, the results showed a decrease of over 25% from Quarter 2 to Quarter 4. Other groups had low rates of admission and/or very small numbers of admissions. For the year preceding the current contract, detox admissions had not been managed in any way. The reductions in the Admits/1000
among the highest-utilizing groups may represent the increasing attention devoted to managing utilization in these hospital-based programs. Specifically, efforts were devoted to reducing unnecessary admits overall and to diverting admissions to Level III.7 detox programs when the member did not require Level IV medical management.

The ALOS for this LOC was essentially unchanged across the three quarters reviewed here. This result likely relates to providers use of pre-determined protocols for detox, which is difficult to address via utilization management. Current authorization parameters call for an initial authorization for 3-4 days, followed by an additional 1-3 days for concurrent review. It appears that the majority of members complete their IPD episode within 4-5 days, which is within the initial or first concurrent review period. Utilization management efforts for the coming year may focus on addressing the initial treatment plan and emphasizing individualized treatment, rather than pre-designed protocols. In addition, intensive efforts to address discharge planning are warranted, including the process for routine referrals to non-traditional services and supports as part of the plan.
Results for Days/1000 are consistent with the reduction in Admits/1000 described in next section. MLIA members averaged 8.4% fewer days/1000 in Quarter 4 than in Quarter 2, while the ABD Single group averaged 24.1% fewer days. While the Days/1000 increased for both Family Dual and Charter Oak groups, only 21 and 24 members, respectively, were admitted from those benefit groups. Results on this measure again reflect the efforts to manage utilization of this level of care by reducing the number of inappropriate admissions and working with providers to divert members to more appropriate services.
The significant majority of members who receive inpatient detox do so in Level III.7, freestanding programs. These results show that the Admits/1000 are 2 to 25 times higher for freestanding programs than in hospitals, depending on the benefit group. For the two groups with highest utilization, MLIA and ABD Single, the rates are 10 and 7 times higher in freestanding programs than in hospitals, respectively. From Quarter 2 to Quarter 4, there was an overall decline in the rate of admission for the two highest utilizing benefit groups, and essentially no change for the other groups. The decreases for high-volume groups included 12.7% for MLIA and 23.9% for ABD Single. These results reflect the intensive utilization management efforts devoted to this level of care during 2011.

While there was an overall increase in the Admits/1000 for Charter Oak, that change reflects only 24 admissions for the entire span. We will watch this group to determine if the trend continues.
ALOS in freestanding detox programs was consistent across all benefit groups, and as with hospital-based programs, may reflect utilization of pre-determined treatment protocols by providers. The focus for 2012 will be on working with providers to individualize their treatment of each member, rather than relying on pre-determined rules. In addition, intensive efforts to address discharge planning are warranted, including the process for routine referrals to non-traditional services and supports as part of the plan.

<table>
<thead>
<tr>
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<th>Q2 '11</th>
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<th>Q4 '11</th>
<th>Q2-Q4 '11</th>
<th>Q2 '11</th>
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E. Psychiatric Residential Treatment Facility (PRTF) ALOS, Days/1000 & Admissions

The Average Length of Stay (ALOS) for the PRTF providers has continued to decline since 2008, with the single exception of the slight increase of less than one (1) day from 2009 to 2010. The ALOS has decreased by 125 days from 2008 to 2011, which allowed a 35.4% increase in the number of members accessing care. As the length of stay decreases, the number of members gaining access to PRTFs increases. The significant decrease in length of stay is due in part to shared initiatives in the Provider Analysis and Reporting department as well as in the clinical department where the focus on a single coordinated referral process, on site reviews, as well as DCF and ICM monitoring have resulted in improved length of stay. The Provider Analysis and Reporting department initiatives will be discussed in detail in Goal 17.

Since 2008, PRTF Days/1000 continues to decrease while the number of discharges continues to increase. This trend demonstrates the PRTF’s improvement in managing
length of stay, which has allowed PRTFs to increase the number of members that can access care. Again, the shared focus among the providers, DCF, and ValueOptions has resulted in improved management of length of stay.

**Residential Treatment Centers (RTC)**

Overall, Residential admissions (in-state and out of state combined) have been trending downward over the past three years. RTC admits have decreased by 21.5% from CY’10 to CY’11 and have decreased 33.8% from CY’08 to CY’11. This finding is in alignment with the DCF strategy to decrease utilization of congregate care and to return youth to treatment in the community. The decrease in overall admission volume that began in late 2008 and continued into 2011 is also partly the effect of gradual closures of in-state RTC facilities.

Out-of-State (OOS) admissions to RTCs during CY’11 have decreased 56.3% from CY ’10 after steady increases in volume from CY’08 to CY’10. In-State RTC admissions increased 4.2% during CY ’11 after incremental decreases between CY ’08 and CY ‘10.
The reduction in OOS admission volume and the simultaneous increase of in-state admissions is likely attributed to swift efforts by DCF in implementing policy changes focused on treating fewer youth at out-of-state RTCs and treating youth closer to home.

Aggregate RTC ALOS (in-state and OOS) continues to be monitored by the Residential Care Team at CT BHP. Additionally, RTC ALOS is one of several measures reported in the quarterly RTC analyses submitted to DCF. From CY’10 to CY’11, aggregate RTC ALOS increased 3.0%, while the volume of discharged youth decreased 4.7%. Overall, from CY’08 to CY’11, aggregate ALOS has remained flat year over year; with a 1.0% decrease when CY’08 (367.63 days) is compared to CY’11 (363.56 days).

For OOS RTCs, ALOS increased 9.8% in CY’11 (as compared to CY’10). The increased ALOS was accompanied by an 11.5% decrease in discharged youth. OOS ALOS continues to be much higher than in-state ALOS; 79.2% higher in 2011 when compared to in-state ALOS (501.12 vs. 279.60 days). The longer lengths of stay seen at OOS
facilities is likely a result of in-state RTCs not being equipped to handle the acuity of the population that is treated OOS.

Additional analysis of ALOS reveals that the diagnostic categories of fire starters, sexually reactive, and Mental Retardation/Pervasive Development Disorder have the longest lengths of stay; diagnostic/population categories that include Conduct Disorder, Juvenile Justice involved and Substance Abuse have the shortest lengths of stay.

The percentage of delayed days (days beyond clinically necessary) has decreased year over year for in-state RTCs (from CY’08), whereas the percentage of delayed days for OOS RTCs has fluctuated year over year. From CY’10 to CY’11, delayed days have decreased by 35.5% for in-state RTCs and have decreased by 64.9% for OOS RTCs.
The volume of acute days (clinically necessary days) has increased for both in-state and OOS RTCs from CY’10 to CY’11, by 2.2% and 3.5% respectively.

There were a total of 48 RTC cases in delay status during CY’11. Over the past three years, the percentage of cases in delay status has decreased, both in and out of state. From CY’10 to CY’11, the percentage of cases in delay status has decreased by 10.9% for in-state and by 67.5% for out-of-state RTCs. This measure correlates with the number of cases in delay status which has also reduced by 10.8% for in-state and 71.2% for out of state RTC’s (from CY’10 to CY’11). A hypothesis regarding this finding has to do with the implementation of the MTTPR form early in 2010. The MTTPR form serves multiple purposes for both VO and DCF but focuses on providing specific information on the past thirty (30) days. Taken in isolation, these reviews support continued stay but are used additionally to inform the progress of a member towards completing treatment goals. Consistency in the review process with completing it on the part of the providers and interpreting by the VO clinicians may be a factor of the continued stay review and may be influencing the case management staff.
From CY’10 to CY’11, the delayed ALOS of delayed cases has decreased by 27.7% for in-state RTCs (218.19 vs. 157.70 days) and has increased by 21.5% for OOS RTCs (204.37 vs. 248.33 days). The ALOS in delay for in-state RTCs for CY’11 is on par with rates prior to CY’10. It is not unusual to see a member completing treatment goals necessary for movement to a less restrictive level of care, but a component of their stay is incomplete and doesn’t allow movement to a different level of care. An example of this type of delay are children who complete schooling in several months, but for whom it would be unwise to disrupt the school setting to move them to another service. Efforts continue in working with DCF area office staff in coordinating these types of cases.

F. Day Treatment Programs Partial Hospital Programs (PHP), Intensive Outpatient Programs (IOP) and EDT Admissions/1000 & Units/1000

PHP
Although there was no change in Husky youth Admits/1000 there was an overall downward trend in the year over year comparison of Admits/1000 for HUSKY adults. At present, it would appear that the adult PHP programs are less relied upon for follow up after hospitalization and those that do utilize PHP have significantly decreased average lengths of stay.

The PHP Level of Care (LOC) is used for two primary purposes: As a step-down to assist with community re-entry after inpatient services and as an intensive intervention that might help prevent an inpatient admission. In both cases, it is designed for individuals who need a highly structured, supportive and intensive service level due to
severity and/or acuity of symptoms. The data for 2011 reflect very little change across quarters for any service group. The greatest changes occurred in benefit groups with low levels of utilization. For the three groups with the highest utilization (MLIA, ABD Single and Family Single), only Family Single showed an increase in Admits/1000, but the rate remained low, between 0.29 and 0.34 admits per 1000 members.

Given the intensive nature of these services, this LOC is commonly utilized by ABD members with complex needs. The level of utilization by MLIA members was surprising, however, especially since the rate of Admits/1000 was almost double that of members in the ABD benefit group. Results across the three quarters show a slight decrease in utilization for MLIA members, and future utilization management efforts will continue to be devoted to ensuring that less intensive LOC and alternative, traditional and non-traditional services and supports are considered when appropriate.

**IOP**

Since CY '07, Intensive Outpatient (IOP) Admits/1000 has remained consistent for both the Husky adult and youth populations. However, the volume of admissions has been steadily increasing year over year since CY '07.
Results for this indicator are inflated for Quarter 2 due to the initial registration of members for the April 1 start date. As a result, Quarter 3 and Quarter 4 results more accurately reflect utilization in this level of care. Across those two quarters, utilization remained relatively stable, but results did show a downward trend across all coverage groups. As with other service levels, the MLIA group had the highest utilization, in this case more than double the next highest group, ABD Single. From Quarter 3 to Quarter 4, there was a 7.5% decrease in Admits/1000 for members in the MLIA benefit group. That represents nearly 200 fewer admissions in Quarter 4 than in Quarter 3. In addition, a review of IOP services by provider was initiated during Quarter 4 and will be continuing in 2012. Ongoing efforts to understand this service level and address utilization will continue, as well. Those efforts will include evaluation of the alternative supports and services that might substitute for IOP and as a community resource when discharging from IOP.
Extended Day Treatment (EDT) Admits/1000 has remained consistent since CY ’07 with gradual increases in the total volume of youth utilizing services.

G. Home based Services (FST, HBS, MST, MDF, FFT, Total) Admissions/1000 and Units/1000

Admits/1000 for Home Based Services remained consistent between CY ’10 and CY ’11 after seeing gradual increases since CY ’07. However, there was a 119.1% increase in the volume of admits in the past five years, with a 14% increase from CY ’10 (2573) to CY ’11 (2930).
IICAPS utilization has been managed through a Bypass program throughout 2011. Admits have flattened over CY '11 as the robust growth in IICAPS teams has slowed over the past year.

Home Health

Results of this analysis confirm the expected findings that the ABD population accounts for the significant majority of admissions to Home Health services. In addition, Family Dual members had the third highest rate of Admits/1000. Dual eligible members and those in the ABD benefit groups typically are identified as having the longest-term and
most complex levels of need. As a result, it is understandable that they would have the
greatest need for home-based support services while in the community. Current results
show the number and rate of new admissions across the three quarters. It is thought
that the significant decrease in Admits/1000 during the fourth quarter occurred because
most members were registered with us during the second and third quarters. By Quarter
4, more of the authorization volume was focused on concurrent reviews rather than new
admissions.

H. Ambulatory Detox (AMD)

The number of ambulatory detoxification registrations for adult members has declined
over the past two calendar years, a 7.8% decrease from CY’09 to CY’10 and a 17.9%
decrease from CY’10 to CY’11. In fact, CY’11 is reporting the lowest number of
ambulatory detox registrations since CY’08 with a total of 87. Youth registration volume
has consistently remained low since CY’08, with a total of 5 youth registrations during
CY ’11.

<table>
<thead>
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<th>Number of Ambulatory Detox (AMD) Registrations</th>
</tr>
</thead>
<tbody>
<tr>
<td>CY ’08</td>
</tr>
<tr>
<td>Youth</td>
</tr>
<tr>
<td>Adult</td>
</tr>
</tbody>
</table>
I. Methadone Maintenance (MET)

Over the past two calendar years, there is a downward trend in the annual number of adult members registering for methadone maintenance. Year over year, the volume of adult registrations decreased by 11.0% from CY’09 to CY’10 and decreased by 31.4% from CY’10 to CY’11. The annual number of youth registering for methadone maintenance has remained low since CY’08 (10 or fewer registrations each year).

<table>
<thead>
<tr>
<th></th>
<th>CY ’08</th>
<th>CY ’09</th>
<th>CY ’10</th>
<th>CY ’11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult</td>
<td>723</td>
<td>995</td>
<td>886</td>
<td>608</td>
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<td>Youth</td>
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<td>7</td>
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</tbody>
</table>

J. Outpatient (OTP/TST) Admissions/1000

After Outpatient Registrations increased in CY ‘09 and CY ‘10, CY ‘11 saw a slight decrease. This suggests that Outpatient Registrations are leveling out.

<table>
<thead>
<tr>
<th></th>
<th>CY ’08</th>
<th>CY ’09</th>
<th>CY ’10</th>
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<tr>
<td>Total Youth Volume</td>
<td>19675</td>
<td>21653</td>
<td>23006</td>
<td>22038</td>
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</table>
No significant trends to analyze.

Consistent with youth Outpatient Registrations, Adult Outpatient registrations increased in CY ’09 and CY ’10 but decreased slightly in CY ’11 suggesting that the backlog of need for Outpatient behavioral healthcare that resulted from poor access to services has been addressed.
No significant trends to analyze.

The total number of Non-ECC Outpatient Registration volume has increased by 18.2% from CY ’09 (24,217) to CY ’11 (28,614) while the total number of ECC registrations has remained stable.
From CY ’09 through CY ‘11, the volume of ECC evaluations has consistently exceeded the volume of FSC evaluations (by 33.5%, 38.5%, and 60.7%, respectively).

**Recommendations for continuing sub-Goal in 2012:**
This sub-goal continues to be applicable for 2012 and should be included in the 2012 Project Plan.

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

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

Overall turn-around time (TAT) for initial reviews with and without peer review for higher levels of care for 2011 was 99.79% or 13,724 of 13,753. Overall TAT with and without peer review for concurrent authorizations for higher levels of care for 2011 was 99.71% or 16,367 of 16,415 decisions.

Overall TAT for initial reviews with and without peer review for lower levels of care for 2011 was 99.98% or 4,064 of 4,065 decisions. Overall, TAT for concurrent authorizations with and without peer review for lower levels of care for 2011 was 99.73% or 10,928 of 10,958 decisions.

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

In 2011, UM decisions not requiring a peer review met the TAT goal of 60 minutes for 13,605 of 13,632 (99.80%) of the decisions.

**B. Initial decisions regarding authorization for non-acute levels of care within 1 business day:**
In 2011, UM decisions not requiring a peer review met the TAT of 1 business day for 4,060 of 4,061 cases (99.98%).

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

In 2011, UM decisions not requiring a peer review met the TAT goal of 60 minutes 15,993 out of 16,039 (99.71%) cases.

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

In 2011, UM decisions not requiring a peer review met the TAT goal (2 Business days) for 10,926 of 10,956 decisions (99.73%).

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

In 2011, TAT decisions requiring a peer review within 120 minutes, all 66 decisions met the standard.

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

Of the 47 decisions in 2011 that required a peer review within 180 minutes, 46 (97.87%) met the standard.

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

Starting on November 15, 2010, Providers no longer receive paper authorization letters unless they specifically ask for a paper copy to be mailed to them. All providers are able to view and print authorization letters in ProviderConnect within 48 hours of receiving the authorization.

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

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

Batch extracts of authorization notifications are only occurring when authorizations are created for out of state providers. They are no longer occurring for all authorizations due to the authorization notifications being made available via ProviderConnect. The extract has been delivered to the vendor 100% of the time within 2 business days.
I. Total number of Administrative Denials Issued

The total number of Administrative Denials continues to increase since CY ’08. The total number of Administrative denials increased by 78.1% from CY ’10 (1411) to CY ’11 (2513). While the number of Administrative denials issued for Youth decreased by 15.1% from CY ’10 (918) to CY ’11 (779), the number of Administrative denials issued for Adults increased by over 100% from CY ’10 (493) to CY ’11 (1734) with the addition of more adult business beginning in Q2 of CY 2011. The large increase in administrative denials associated with the adult providers should not be surprising. Many of the providers of services for adults had not been accustomed to timely pre-authorization protocols. Although training was held with the provider community prior to the implementation of the new protocols, many of the providers had not appropriately staffed their organizations to meet the guidelines.

Intensive Outpatient accounted for 32.9% (828 of 2513) of all administrative denials issued. Outpatient accounted for 33.0% (257 of 779) of the administrative denials issued to providers for youth and Intensive Outpatient accounted for 39.7% (689 of 1734) of the administrative denials issued to providers for adults.

The primary reason administrative denials were issued in CY ’11 was due to providers not following the appropriate registration or prior authorization procedures (1120). The second reason administrative denials were issued in CY ’11 was due to providers not following the appropriate concurrent review procedures (1106).

In addition, in April 2011 Out of State RTCs were added to the Authorization to Claims process and began receiving administrative denials.
J. Medical Necessity Denials

The total number of Medical Necessity Denials increased by 89.4% from CY ’10 (114) to CY ’11 (216). This significant increase is due to the new Adult population. The number of Medical Necessity denials issued for Adults increased by well over 100% from CY ’10 (34) to CY ’11 (164). The number of Medical Necessity denials issued for Youth continues to decrease. Since CY ’08 (131), the number of Medical Necessity denials issued for Youth decreased by 60.3% to CY ’11 (52).

Consistent with previous years, Inpatient Hospitals accounted for 80.8% (42 of 52) of the Medical Necessity denials issued for Youth in CY ’11. Inpatient Detox accounted for 48.1% (79 of 164) of the Medical Necessity denials issued for Adults in CY ’11.

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

Out of the 2513 Administrative denials issued in CY ’11, 37 did not meet the TAT standard of having a letter issued within 3 business days. This represents 98.5% (2476 of 2513) of letters being issued within 3 business days. Out of the 216 medical necessity denials issued in CY ’11, 6 did not meet the TAT standard of having a letter issued within 3 business days. This represents 97.2% (210 of 216) of letters being sent out within 3 business days.

Total TAT for CY ’11 was 98.4% (2686 of 2729) of letters being issued within 3 business days.

The TAT decreased from 100% in CY ’10 to 98.4% in CY ’11 primarily due to the addition of the new adult business and the decision made during Q2 ’11 to begin reviewing requests for individuals without eligibility at the time of admission. These individuals are referred to as TEMP member. A process was implemented in Q2 whereby the notice to the member and provider of a denial was not mailed at the time of the denial; instead it was mailed at the time that the member obtained eligibility. That process involved the daily checking of eligibility updates to determine whether the member had gained eligibility within the previous 24 hours and then sending out the
denial notice within 3 business days. At the beginning of Q3, updated lists of Temp members who had gained eligibility were obtained on a weekly basis. This process was changed to daily review during the early part of Q4 when it was determined that TAT for mailing denial letters within 3 days of gaining eligibility was being missed. The process was changed in the middle of the Q4 whereby “non-official” notices of denials are sent out at the time of the denial decision. Currently it is left to the provider to monitor the gaining of eligibility of the member and to initiate a retrospective review at the time the member obtains eligibility if they wish to have CT BHP reconsider the denial issued at the time of the admission.

An additional item that will be addressed going forward will be re-training of staff who issue denials around better educating providers as to their appeal rights at the time of the denial being issued.

**Recommendations for continuing sub-Goal in 2012:**
This sub-goal continues to be applicable for 2012 and should be included in the 2012 Project Plan.


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

**A-O. Member Medical Necessity Appeals:**

There were 5 Expedited Level I member appeals for calendar year 2011; 4 of the expedited appeals were from adult members and 1 was for a youth member.
- None of the expedited appeals were overturned.
- Of the 5 Expedited Level I Member appeals, 4 requested a Level II External Appeal-Administrative Hearing. The results of all the Administrative hearings was dismissal due to the member not appearing at the hearing so that the denial was upheld.

There were 3 Routine Level I member appeals for calendar year 2011; 2 were for adult members and 1 was for a youth member.
- One Level I Appeal for an adult member was overturned, resulting in an overturn rate of 33.3%.
- Of the 3 Routine Level I member appeals, 2 requested a Level II External Appeal-Administrative Hearing. The result of the one adult External Appeal was dismissal of the case due to the member not appearing at the hearing. The result of the child External Appeal was that the denial was upheld.

A total of eight (8) member appeals were received in 2011; all were processed and had determinations made within the required timeframe meeting the standard at 100%.
P. Provider Medical Necessity Appeals:

Provider Medical Necessity Appeals – Level I:

The total number of Provider Level 1 Appeals for Medical Necessity increased by 94.4% from CY ’10 (18) to CY ’11 (35). However, the percentage of denials that result in an appeal stayed consistent from CY ’10 (15.7%) to CY ’11 (15.8%). This is due to the significant increase of denials that resulted from the new adult business.
Provider Medical Necessity Appeals – Level I Overturn Rates:

After the downward trend from CY ’08 (41.7%) to CY ’10 (18.8%), for the percent of Provider Level 1 Appeals for Medical Necessity (Youth) that were overturned, CY ’11 increased to 36.36% (4 of 11). The percent of Provider Adult Medical Necessity Level 1 Appeals for Medical Necessity (Adult) that were overturned reached the highest rate to date, 37.5% (9 of 24).

Provider Medical Necessity Appeals – Level II:

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<tr>
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<td>Youth</td>
<td>10</td>
<td>4</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Adult</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td>11</td>
<td>7</td>
<td>5</td>
<td>10</td>
</tr>
</tbody>
</table>
After the number of Level II Provider Appeals decreased in CY ’09 and CY ’10, CY ’11 saw an increase of 100% from CY ’10. The increase was solely due to the increase in the number of Adult Level II Provider Appeals, from 0 in CY ’10 to 7 in CY ’11.

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

<table>
<thead>
<tr>
<th>23A: Percent of Medical Necessity Appeals-Level II Overturned, Youth (0-18)</th>
<th>CY '08</th>
<th>CY '09</th>
<th>CY ‘10</th>
<th>CY ’11</th>
</tr>
</thead>
<tbody>
<tr>
<td># of Cases Overturned</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>% of Cases Overturned</td>
<td>10.0%</td>
<td>25.0%</td>
<td>40.0%</td>
<td>66.7%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>23A: Percent of Medical Necessity Appeals-Level II Overturned, Adults (19+)</th>
<th>CY '08</th>
<th>CY '09</th>
<th>CY ‘10</th>
<th>CY ’11</th>
</tr>
</thead>
<tbody>
<tr>
<td># of Cases Overturned</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>% of Cases Overturned</td>
<td>9.1%</td>
<td>14.3%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

While the overturn rate for Provider Appeals-Level II for youth members has increased over the last four years, the number of Level II Provider Appeals in general is so small, that this finding may be spurious.

Notices of the determination for all Level I Medical Necessity Appeals were mailed within 2 business days of the determination 100% of the time. Notices of the determination for the Level II Medical Necessity Appeals were sent out within 5 business days of receipt of information necessary to make a determination 90% (9 of 10) of the time.
Q-S. Administrative Appeals:

Number of Administrative Appeals:

While the total number of Administrative Appeals increased by 81.5% from CY ’10 (449) to CY ’11 (815), the total Administrative Appeal Rate only increased by 1.9%. This was due to the large increase in total number of Administrative Denials. This is most evident in the Adult Administrative Appeals. From CY ’10 (156) to CY ’11 (478) there was an increase of over 100% in the number of Adult Administrative Appeals, but a decrease of 12.9% in Adult Administrative Appeal Rate.
Administrative Appeals - Overturned Rate – Youth:

Of the 815 appeals, 327 were for youth cases.
- 116 (34.4%) of the appeals were overturned for youth cases – an increase of over 100% from CY ’10.
- 325 (96.44%) of the appeals were resolved within the 7 day turnaround time.

Administrative Appeals - Overturned Rate – Adults:

Of the 815 appeals, 478 were for adult cases.
- 174 (36.4%) of the appeals were overturned for adult cases – an increase of over 100% from CY ’10.
- 475 (99.37%) of the appeals were resolved within the 7 day turnaround time.

The significant increase in percentage of administrative appeals that were overturned was due to three major factors, described below, that began in Q2 ’11. The percentage of youth administrative appeals that were overturned increased by over 100% from Q1 ’11 (8.33%) to Q2 ’11 (51.65%), and the percentage of adult administrative appeals that
were overturned increased by over 100% from Q1 ’11 (10.34%) to Q2 ’11 (62.37%). After the increase in the overturn rate in Q2 ’11, the overturn rate steadily decreased in Q3 and Q4. In Q4 ’11 the overturn rate was 30.00% for youth and 27.40% for adults.

The three major factors that contributed to the large increase in the overturn rate were eligibility of both members and providers, and problems with the start date entered by the providers.

The member eligibility issue was related to the new business as of April 1st, 2011. Administrative denials were entered in the system for members who were ineligible and then overturned on appeal when the members became eligible. This process was stopped when the TEMP member process described above was implemented. The issue with provider eligibility was that many providers were due to renew their contracts at the beginning of the year; it was an unfortunate coincidence that this happened at the same time that the system was also dealing with member ineligibility.

98.16% (800 of 815) of the appeals had determinations made and notices sent out within 7 days of receipt of the appeal.

**Recommendations for continuing sub-Goal in 2012:**
This sub-goal continues to be applicable for 2012 and should be included in the 2012 Project Plan.

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

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

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

On an annual basis, the CT BHP service center participates in the company-wide IRR audit. This IRR audit typically consists of 20 clinical vignettes, for each of which the clinicians must determine the appropriate level of care. For the company-wide IRR, 96.08% of our staff passed, with an average score of 93.63%. Although this year we did not have a 100% of the staff passing, the average score has increased over last year when it was 90.53%.

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

**B. Assess adequacy and accuracy of clinical documentation**

Audits conducted in the later part of Q1 ’11 were administered using the documentation audit tool that had been created in 2010. The result of the Q1 audits were that 87.0% passed with a 90% or better and the average score was 94.7%. Following this audit, and in preparation for the addition of the new adult business, the audit tool was reviewed
and the decision made that revisions were needed not only due to the new business but also due to the migration to the new MIS system – CareConnect at the end of 2010. Also at this time, a decision was made to begin auditing using our NICE recording system in conjunction with the documentation in order to better support our new staff and ensure that opportunities for improvement of our internal processes were appropriately identified. In addition, the audit process moved from being conducted by a combination of Clinical Team Leads and Quality Management staff to being conducted solely by the Quality Management staff as a result of the addition of staff dedicated to audits within the QM department.

A new audit tool was created in April, which incorporated evaluation of the voice recordings as well as the documentation. The new audit monitored timeliness of completion and consistency with the UM criteria but also assessed the quality of the staff’s care management skills. Trainings around expectations were conducted for all staff in May and the Q2 audit was administered in June. The results of the Q2 audits demonstrated that while timeliness of completion of reviews and consistency with the application of the UM criteria were being done appropriately, opportunities for improvement were identified around the quality of the reviews.

Representatives from the Clinical, Quality Management and Medical Affairs worked together to develop clinical training that focused on delineating clinical questions that need to be asked during a review that would elicit the necessary clinical information but also contribute to shaping the care administered. Results of this audit were used to fine tune the training and supervision/coaching provided to the staff that needed it. Following additional training, another audit was conducted in January 2012 with continued improvement.

In order to more clearly report the results of audits, the audit tool’s scoring will be modified in 2012 to account separately for documentation and quality of care management.

**Recommendations for continuing sub-Goal in 2012:**
This sub-goal continues to be applicable for 2012 and should be included in the 2012 Project Plan.

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

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

**A. Number of referrals of cases from MCOs**

This monitor tracks the number and types of cases being co-managed by CT BHP and the three MCOs managing the medical benefits of CT BHP HUSKY members. Cases for co-management are referred either by the MCO to CT BHP or CT BHP to MCO. There are six automatic referrals that have been in place since CY 2008 and continue to guide the referral process. High risk pregnancy due to depression and or substance abuse, post partum depression, child/adolescent type II diabetes, sickle cell, eating disorders, and any medical detoxes make up the existing automatic referral list.
There were 236 MCO co-managed cases in 2011 which is consistent with previous years.

The MCO referrals in 2011 followed the same patterns from previous years with the majority of the referrals coming from CHN.

**B. Wellness Care Coordination Program implementation**

On 9/1/11, the Wellness Care Coordination Program was launched on September 11, 2011. The program represents a partnership between McKesson and ValueOptions with ValueOptions CT serving as the pilot site.

Members are selected for possible inclusion in the program based on the following criteria:

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

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

Tier two physical conditions include: Stroke, TIA, Chronic Kidney Disease, Cystic Fibrosis, Hepatitis B and C, Inflammatory Bowel Disease, Peripheral Vascular Disease, Sickle Cell, Migraine, Back Pain, High Cholesterol, Hypertension, Lupus, Rheumatoid Arthritis, Seizure d/o, Gastroesophageal reflux disease, M.S., and Peptic Ulcer Disease

By the end of 2011:
- 287 members had been enrolled (300 Maximum)
  - 227 (79%) Actively Engaged (member who has agreed to participate in the program; receives proactive outbound calls on a schedule that varies by severity level)
  - 60 (21%) Passive Participants (member participating in “on demand” services; no proactive outbound calls are scheduled, though members may call in and access nurse services. These are members who have been actively enrolled at one time but are no longer reachable or only wish to receive mailings)
- 24 of the 287 (8.4%) members have a primary, secondary or tertiary Substance Abuse condition (22 have active enrollment)
- 54.7 years is the average age of all enrolled members
- 75% of all enrolled members are Caucasian, 24% African American and 1% Asian
- 64% of all enrolled members are female

Communications are sent to a member and their provider at various points during the program. These communications may be used to summarize information reviewed on a call with our nurses, provide member health status updates to providers, or to engage a member as significant program milestones are achieved.

As of 12/31/11:
- 211 post-assessment letters have been mailed to enrollees
- 58 post-assessment letters have been mailed to providers

Outcomes
- An Average Length of Stay in this program model is approximately 6 months
- Outcomes are assessed at program “graduation” (including if member withdraws him/herself from the program)
- First run of outcome data by McKesson is expected in March/April 2012, however, these numbers are expected to be extremely low as enrollment has been gradually ramping up over the months
- Outcome data will be more meaningful once the graduation “N” is more significant
- VO will run authorization and claims based outcome reports in the future to look at utilization patterns pre- and post- program involvement
Recommendations for continuing sub-Goal in 2012:
This sub-goal continues to be applicable for 2012 and should be included in the 2012 Project Plan. The goal should be enhanced to include sub-goals that monitor and assess the Wellness Care Coordination Programs with both McKesson and CHN.

Goal 15. Reduce Emergency Department (ED) Discharge Delays (Contract Reference: F.17)

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

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

<table>
<thead>
<tr>
<th>Child ED Stuck CY '10 and CY '11</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Child (0-17)</strong></td>
</tr>
<tr>
<td>Q1</td>
</tr>
<tr>
<td>Total ED Stuck</td>
</tr>
<tr>
<td>ALOS</td>
</tr>
<tr>
<td>Q1</td>
</tr>
<tr>
<td>Total ED Stuck</td>
</tr>
<tr>
<td>ALOS</td>
</tr>
</tbody>
</table>

While there was an increase in the number of Children (0-17) that were delayed in the ED of 26.1% from CY ’10 to CY ’11, the ALOS of time delayed remained consistent year over year.

<table>
<thead>
<tr>
<th>Adult ED Stuck 04/01/2011 - 12/31/2011</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adult (18+)</strong></td>
</tr>
<tr>
<td>Weekday</td>
</tr>
<tr>
<td>Total ED Stuck</td>
</tr>
<tr>
<td>ALOS</td>
</tr>
</tbody>
</table>

The number of Adults (18+) that were delayed in the ED decreased each quarter in CY ’11. There was a decrease of 24.8% from Q2 to Q3 and a decrease of 21.8% from Q3 to Q4. While the number of members delayed in the ED decreased, the ALOS in the ED increased each quarter. There was an increase of 33.8% from Q2 to Q3 and an increase of 2.3% from Q3 to Q4.
C. Frequency Distribution of ED Stuck Stay

For CY '10 and CY '11, Youth (0-<18) that were delayed in the ED were most frequently delayed for 1 day. The next most frequent length of delay was 2 days. This is consistent with the length of time that youth are delayed in the ED (1.50 days).

Consistent with the youth population, adults (18+) were most frequently stuck in the ED for 1 day.

**Recommendations for continuing sub-Goal in 2012:**
This sub-goal continues to be applicable for 2012 and should be included in the 2012 Project Plan.
Goal 16. Measure network adequacy: support Departments in maintaining adequate Provider Network to ensure member access (Contract Reference O.4.1.4)

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

This goal was suspended under the previous contract 2007 when it was discovered that many network providers listed as credentialed with the state network were not accepting Medicaid referrals. This resulted in an inflated percentage of members with access to a network provider within a reasonable distance from their home.

During 2011, the decision was made to re-evaluate the suspension of the measure and attempt to develop an alternative method for identifying the providers in the CMAP network who are accepting referrals. During Q3 ’11, a query of claims data from 2010 was run to identify providers who were actively treating at least four (4) Medicaid members. This list of providers will serve as the basis for identifying the percentage of members who are within a reasonable distance from a provider who treats Medicaid members.

It is anticipated that the geo-access report for outpatient practitioners will be available for review by the end of April 2012.

Recommendations for continuing sub-Goal in 2012:
This sub-goal continues to be applicable for 2012 and should be included in the 2012 Project Plan.

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

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

The Provider Analysis and Reporting (PAR) program continues to be a vital strategy used to improve the quality and value of the CT behavioral health service system.

The PAR program and performance Initiatives typically entail two phases of development.

1. The initial phase of the PAR program involves the establishment of a workgroup that includes provider representatives from level of care-specific programs (i.e., child and adolescent inpatient, PRTF, etc.). The workgroup then collaborates with CT BHP to agree upon measures that allow for the assessment of key aspects of their performance in relationship to other providers supplying the same or similar services. Once determined, these measures serve as the basis for the development of “profiles” of the performance across the entire level of care as well as for each individual provider.
The providers then continue to meet with CT BHP on at least a quarterly basis. Some of these meetings are with individual providers and some include multiple providers. During these meetings, providers are given data regarding their performance, and a collaborative review/analysis of the findings is conducted. Variation between programs and the identification of variables that may be responsible for those differences occurs. This is the time when providers learn from each other with regard to best practices. Most importantly, goals for improving performance are agreed upon by all participants.

2. The second phase of the PAR program entails the attachment of financial incentives to the accomplishment of goals in an effort to motivate progress and expedite change. The first Performance Initiative was implemented in CT in 2008 and it continues to productively supplement the PAR program. The Performance Initiative programs continuation are dependent upon available funds through the CT Department of Social Services.

NOTE: Following the completion of the State Fiscal Year (SFY) 2011 Performance Initiatives, DSS learned that the Centers for Medicaid and Medicare Services (CMS) had determined that Performance Initiative methodology would need to be submitted for their approval prior to commencement of the performance initiative. As a result of these changes, Performance Initiatives that had been intended for SFY2012 were placed on hold with the intention that they would be conducted in CY 2012.

CHILD AND ADOLESCENT INPATIENT HOSPITALIZATION PAR PROGRAM

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

In 2008, the first Performance Initiative was conducted with the child and adolescent inpatient facilities, with the focus on decreasing lengths of stay. The goals set for each facility’s performance were “case mix adjusted” to take into consideration the longer lengths of stay of the DCF youth population. Hospitals could meet their goal and receive their incentive payment in two ways:

- By meeting their case-mix Adjusted Average Length of stay (AALOS) goal
- By making significant progress towards meeting their goal.

Re-measurement of performance during Q3 and Q4 '08 found that 7 of the 8 hospitals had either met their goals or made significant movement towards meeting their goals. The Average Length of Stay (ALOS) of children and adolescents dropped over 2008 with the most significant decreases during the second half of 2008. The acute portion of the
length of stay remained fairly stable while the discharge delay portion of the stay dropped considerably. This finding accentuates the fact that this initiative targets the decrease in time that youth are in delay in the hospital as opposed to the medically necessary days when they are in the acute phase of their illness. At the same time, seven (7) and thirty (30) day readmission rates dropped from 2007 to 2008.

**Child and Adolescent Inpatient Hospitalization Performance Initiative 2009-2010**

A second performance initiative was conducted in SFY ’10 that included two goals; one to continue to decrease length of stay and another to improve family engagement. Six of the eight hospitals successfully met their length of stay targets and four of the eight obtained at least partial success in achieving the family engagement goal. The family engagement portion of this initiative involved both the creation of an ongoing Family Support Group at each of the facilities as well as the development of an Individualized Communication Plan for each member admitted to the hospital.

In August of 2010, CT BHP rolled out a Pediatric Inpatient Web-based Dashboard. This web-based report not only allows the RNM team to review the pediatric inpatient hospital provider’s data during the quarterly meetings but also allows the providers to monitor their own facility’s utilization for HUSKY youth as well as to view other in-state pediatric inpatient facility data. A wide variety of data points including graphs on length of stay, discharge delay, aggregate demographic information regarding members treated, DCF area offices associated with members treated, case mix, and re-admission rates are able to be viewed. The Dashboard data refreshes each business day, allowing providers to view their utilization in real time. Data can be viewed in monthly, quarterly, and yearly increments.

**Pediatric Inpatient Hospital Performance Initiatives 2010-2011; Program I**

During SFY 2011, two performance initiatives with pediatric inpatient hospitals were conducted. The first focused on achieving and/or maintaining efficient lengths of stay and continued the family engagement portion implemented the previous year. Six (6) of the eight (8) inpatient hospitals earned the maximum points for the length of stay measure seven (7) of the eight (8) inpatient hospitals earned the maximum points for the family engagement portion of the initiative. During 2011, the family engagement portion of the initiative involved the establishment of an individualized communication plan with each family of a youth admitted to the hospital.

The second performance initiative that focused on stabilizing re-admission rates and enhancing discharge planning practices. The six in-state pediatric psychiatric hospitals that treated more than 200 members during 2009 were eligible to receive a temporary retroactive rate increase during the period of July 1, 2010 to December 31, 2010 for:

1. Maintaining a staffing ratio of one (1) professional staff member associated with discharge planning to six (6) patients (including HUSKY and non-HUSKY members; i.e., the average daily census),
2. Having at least two inpatient staff members directly involved in discharge planning attend two half day training sessions on Wraparound Discharge Crisis planning and
3. Obtaining a score of >85% on an audit of their documentation of a Wraparound crisis plan co-constructed with the family/guardian of pediatric HUSKY members for use upon discharge from their inpatient stay.
All six of the participating pediatric inpatient hospitals earned the maximum points for attending the Wraparound Discharge Crisis Planning training and four (4) of the six (6) participating hospitals earned the maximum points for documentation of having established the Wraparound crisis plan.

**Proposed Pediatric Inpatient Hospital Performance Initiatives CY 2012;**

The 2012 Pediatric Inpatient Performance Initiative will be enhanced to include the following goals:

1) A goal to continue to shape and maintain already efficient lengths of stay. During workgroup meetings with inpatient facilities in 2011, participants agreed the baseline period used for calculating the target length of stay for CY 2012 will be based on CY 2010 authorization data (in the two previous Initiatives, CY 2008 authorization data was used). Taking into consideration the new targets, the decision was made to expand the corridors for hospitals to be able to earn maximum points based on meeting their Predicted Length of Stay by 0.5 days.

2) In order to increase the focus on pediatric readmission rates, a goal based on achieving and/or maintaining efficient 7 and 30 day re-admission rates will be included. Because the number of readmissions is relatively low for some of the 8 in-state hospitals treating youth in CT, the target readmission rates for CY 2012 will be based on state-wide performance during the last two calendar years (2010 & 2011).

3) Assuring that members discharged from the hospital have a follow-up appointment within a week is an industry standard measure of the quality and effectiveness of treatment. The measure was developed by the National Committee for Quality Assurance (NCQA) and was the first behavioral Healthcare Effectiveness Data and Information Set (HEDIS) measure. In CY 2012, a target ambulatory follow-up within 7 days of discharge rate will be set for the CY 2013 performance period. Targets for this measure will be based on claims data for quarters 1 & 2 of 2012 and the performance period for this goal is expected to be quarters 1 & 2 of 2013.

**ADULT PSYCHIATRIC INPATIENT PAR PROGRAM in 2012**

Given the success of the Pediatric Inpatient PAR program, CT BHP will roll-out an Adult Psychiatric Inpatient Hospital PAR Program in CY 2012. A PAR workgroup with the adult inpatient facilities is scheduled for April 2012. Agenda discussion will include a review of length of stay and readmission data with the intent to collectively define performance goals and the methodology used to measure the goals.

In addition, CT BHP will be using claims data for CY 2010 and the first two quarters of CY 2011 to determine ambulatory follow-up rates within 7 days of discharge from an inpatient facility (to accommodate the 365-day claim registration lag for outpatient services). This data will be shared with 23 adult instate facilities as it becomes available. Assuring that members discharged from the hospital have a follow-up appointment within a week is an industry standard measure of the quality and effectiveness of treatment.
PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES (PRTF) PROGRAM

The PRTF Program was initiated during 2008 when a “Universal Referral Form” that facilitates the process for hospitals to refer to all PRTFs using the same form was developed. By the end of 2008, a decision was made to develop a PAR program for the PRTFs and an ongoing workgroup of PRTF providers was established. As a group, the PRTFs agreed to a revision of the UM Criteria that included a target length of stay for a PRTF of 90 to 120 days; the actual ALOS at the time was over 300 days.

Working collaboratively with the PRTFs, a PRTF profile was developed that includes the following indicators:

- Demographics of the members treated by the facility
- Bi-Annual average length of stay; PRTF specific vs. aggregate PRTF providers
- PRTF-specific average length of stay frequency distribution in terms of the number of members they treated within specific timeframes
- Average length of stay comparison of all four PRTFs
- Number of inpatient admissions that occurred during a PRTF stay
- Percent of cases in discharge delay status
- Discharge delay reasons

During late 2008, a performance initiative was developed to address PRTF programmatic changes that would be necessary to position the programs to achieve a shorter length of stay. The four (4) goals of the 2008-2009 initiative were:

1. Implementation of Universal Referral Form
2. Establishment of Focal Treatment Planning (FTP) meetings
3. Documentation of the individualized FTP and Discharge Plan
4. Documentation of weekly engagement activities with key entities involved in the FTP and Discharge Plan.

All of the PRTFs successfully gained some portion of the incentive payment.

2009 PRTF Performance Initiative:

In 2009, the PRTFs agreed to set a goal for the 2009 Performance Initiative of a target average length of stay of 120 days. Three (3) of the four (4) participating PRTFs achieved some portion of the performance awards.

PRTF Performance Initiative 2010-2011

In collaboration with the four in-state PRTF programs, a SFY 2011 Performance Initiative was implemented with a focus on achieving a target length of stay of 120 days and improving family engagement. Three of the four participating PRTFs earned partial points for the length of stay goal and none of the four PRTFs earned credit for the co-construction of the Individualized Communication Plans.

The PRTF PAR program and PRTF Performance Initiatives continue to have a positive impact on increased access to services and the continued achievement of increasingly more efficient lengths of stay. Year over year, the volume of members served during the calendar year continues to steadily increase, up by 11.7% from CY ’10 (120) to CY ’11
and up by 35.4% from CY ’08 (99) to CY ’11 (134) as the lower length of stay makes this level of care available to more members.

ENHANCED CARE CLINIC (ECCS) PARS PROGRAM

The Enhanced Care Clinic (ECC) PAR program did not follow the typical progression of the other CT BHP PAR programs. ECCs received increased reimbursement late in 2006 based on their agreement to meet the following expectations:

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

During the first application process, 28 ECCs were accepted and officially became ECCs as of 4/13/07. A second round of applications was conducted in 2007; in CY 2011, 35 ECCs were involved in this initiative.

In March of 2008 a workgroup composed of ECC representatives as well as CT BHP representatives from DCF, DSS and ValueOptions was formed to develop strategies to further assist the provider community in achieving compliance with the standards of the ECC Agreement. During 2008, the workgroup identified web registration problems, lack of understanding and confusion about the ECC requirements, higher member no-show rates that were preventing them from meeting their access standards, and difficulties hiring enough Spanish-speaking therapists to treat the volume of members. During the remainder of 2008 and into 2009, ValueOptions Regional Network Managers (RNMs) played a key role in assisting the ECCs in addressing their individual challenges in these areas.

A Mystery Shopper program was implemented during Q4 ’08. The program entails calls to the ECCs by ValueOptions staff to obtain a routine appointment. Several cycles of this program have been completed. ECCs that failed to either meet the requirements of providing adequate triage of the caller to enable them to assess the clinical urgency of the situation, or put the caller into voicemail and fail to return the call within 24 hours are placed on probation and asked to submit Corrective Action Plans (CAPs)

As the PAR program was implemented in 2008 and ECCs were held accountable for meeting access standards, more than a third of the ECCs were on CAPs. At the same time, there was remarkable progress in improvement in access to outpatient treatment. During Q4 ’08, almost 88% of members were offered a routine appointment within 14 days. This represented an almost 25% improvement in timely access from the same
quarter of the previous year when there were anecdotal reports of, at times, a six month waiting list for routine appointments.

2011 ECC Activities

- Per the Department of Social Services Policy Transmittal 2009-03, effective July 1, 2008, non-general hospital based ECCs were accountable to meet the Access Standards for the entire Medicaid population plus members of Charter Oak. At that time, ValueOptions monitored the Routine Access standard for members of HUSKY A, HUSKY B and Charter Oak only. Effective April 1, 2011, ValueOptions began managing behavioral health care for the entire Medicaid population plus members of Charter Oak, while continuing to monitor the Routine Access standard for members of HUSKY A, HUSKY B and Charter Oak only. Effective January 1, 2012, ValueOptions will begin monitoring the Routine Access standard for the entire Medicaid population plus members of Charter Oak.

- The ECC Operations Workgroup met twice a month throughout 2011. The meetings include representatives from the Department of Children and Families (DCF), the Department of Mental Health & Addiction Services (DMHAS), and ValueOptions. The Workgroup focused on the following:
  - Development of the ECC Oversight Tool and PILOT project
  - ECC training needs to support the protocol for using the standardized mental health and substance abuse screening tool (GAIN-SS) for adolescents ages 12 – 17, as well as for linkage to appropriate services
  - ECC focus group to support Primary Care/Coordination
  - Implementation and monitoring of Corrective Action Plans (CAP) for non-compliant ECCs
  - Provider-specific challenges to meeting the ECC Access standards
  - ECC and non-ECC clinic mergers
  - Planning for the 4th Annual Statewide ECC Meeting
  - An analysis of ECC providers Mystery Shopped between 2010 and 2011 (a total of 60 calls) was conducted to explore the necessity of calling each provider three times per cycle. The analysis revealed that noncompliance issues were invariably captured within the first two calls, obviating the need for a third call. A recommendation to reduce the protocol from three calls to two calls was presented and approved at the ECC Provider Workgroup on Capacity and Access, the Operations/PAG Subcommittee of the CT Behavioral Health Oversight Council, and the CT Behavioral Health Oversight Council. This change will take effect Q1 2012.

- The ECC Interagency Workgroup met monthly throughout 2011, including representatives from the Department of Children and Families (DCF), the Department of Mental Health & Addiction Services (DMHAS), and ValueOptions (VO). The Workgroup focused on the following:
  - Development of the ECC Oversight Tool and PILOT project
  - ECC training needs to support the protocol for using the standardized mental health and substance abuse screening tool (GAIN-SS) for adolescents ages 12 – 17, as well as for linkage to appropriate services
  - Policy relevant to ECC status changes (adding, closing, moving ECC locations)
- Measurement requirements for adult non-HUSKY Medicaid members
- ECC FAQ document updates
- DCF licensing and regulations for outpatient child clinics
- Outpatient Learning Community (OLC) Initiative – Family Engagement and Data/Quality Improvement workgroups
- Barriers with access to psychiatric services

### The ECC Provider Workgroup on Capacity and Access

The ECC Provider Workgroup on Capacity and Access met monthly throughout 2011 to review and analyze the impact of capacity on provider compliance for the ECC access standards. Participation grew throughout the year to include representatives from 18 ECCs as well as representatives from the Departments and the Connecticut Community Providers Association (CCPA). The Workgroup focused on the following:

- Review of HUSKY and Charter Oak provider volume data
- Provider-driven initiatives to address identified challenges (need for bilingual/bi-cultural services, meeting the demands of walk-ins, seasonality/peak demand, staffing issues)
- “No-show” policies and procedures
- Updates on the ECC Co-Occurring Requirements (GAIN-SS, legal status issues and confidentiality)
- Access to psychiatry and the fiscal impact of sustaining psychiatric resources in the outpatient clinic environment
- Discussion to move the Volume Exemption Access measure from current quarter over last year’s quarter, to an annual measurement

A Draft ECC Oversight Review Tool was piloted with three of the ECCs that volunteered to participate: Harbor Health, Yale and Catholic Charities-Norwich. Each ECC participated in an exit-conference with representatives from DMHAS, DCF, and VO and received a written summary of the findings.

A Provider Forum on Changes in Medicare conducted by staff from ValueOptions and the Departments was offered to all ECCs and outpatient providers at the Cromwell Marriott on February 28, 2011.

GAIN Short Screen Training conducted by Melissa Sienna, DCF, was offered to all ECCs at ValueOptions, CT on May 11, 2011, and will be offered again in early 2012.

Audits of all 35 ECCs utilizing the ECC Oversight tool and a team of representatives from DCF, DMHAS and ValueOptions will take place over the course of 2012.

### 2011 ECC Performance

- In CY 2011, a total of 12 ECCs were Mystery Shopped. Of the 12 ECCs, two did not pass the initial round of calls and were required to implement Corrective Action Plans (CAPs): Intercommunity did not screen/triage within 24 hours; and Bristol Hospital did not screen properly. Once the plans had been in place for a sufficient amount of time, the two facilities were re-tested and passed without incident.
- There were no changes to the capacity of the ECC network in CY 2011.

- **Corrective Action Plans**: Three ECCs experienced probationary status requiring a Corrective Action Plan (CAP) for one or more quarters during 2011 due to their inability to meet the routine access standard of 95%:
  - Q1 ‘11: CMHA-NW and Clifford Beers Child Guidance Clinic;
  - Q2 ‘11: Clifford Beers Child Guidance Clinic;
  - Q4 ‘11: Catholic Charities (NB/Bristol).

- CMHA-NW came off probationary status in Q2 ’11 and Clifford Beers, came off in Q3 ’11.

- **Volume Exemptions**: Six ECCs received a Volume Exemption during 2011:
  - Q1 ’11: Mid-Fairfield Child Guidance Clinic;
  - Q2 ’11: The Connection, Inc. and Middlesex Hospital;
  - Q3 ’11: Southern CT Child Guidance, Hartford Hospital/IOL, Catholic Charities (NB/Bristol) and The Connection;
  - Q4 ’11: The Connection.

- **Grace Status**: Birmingham Group was the only ECC to receive Grace Status (Routine Access percent falling between 90%- 95%). This occurred in Q2 11.

The CTBHP RNMs worked closely with ECCs that were noncompliant with access standards to identify any obstacles, and to monitor progress on their Corrective Action Plans. In addition, the RNMs met with their assigned ECCs at least quarterly to review data detail that might reveal trends requiring proactive intervention.

The number of Routine evaluations conducted in CY ’11 (9836) increased by 1.6%, from CY ’10 (9681). Since inception of the ECC PAR Program in CY ’08, the percentage of Routine appointments meeting the 14-day access standard of 95% has increased from 82.7% in CY ’08 to 97.6% in CY ’11. Please note: the percentage of evaluations meeting the Routine access standard decreased slightly in 2011, from 98.4% in CY ’10 to 97.6% in CY ’11. The graph below displays these changes.

![Percent of Routine Appointments Offered Within 2 Weeks](chart)

Adding in all Medicaid Eligibility Categories to the HUSKY A, HUSKY B and Charter Oak population (managed prior to 4/1/11) did not have a significant impact on the percent of Routine Appointments Offered within 2 Weeks (97.6% for CY ’11 shown above). When
adding in the new Membership, the percent of Routine Appointments offered within 2
weeks ranged between 96.6% and 98.5% for the last three quarters of 2011 (see Graph
below).

The total ECC volume of HUSKY A, HUSKY B and Charter Oak members registering for
treatment increased between CY ’08 and CY ’11 by 17.36%, and has remained relatively
stable since 2009. The graph below displays this change.

When comparing the total ECC volume of the HUSKY A, HUSKY B and Charter Oak
category to that of the entire New Membership (All Medicaid Eligibility Categories and
Charter Oak) during the last three quarters of 2011, a 54.7% increase is revealed in the
Total ECC Volume over the HUSKY A, B and Charter Oak population. The graph below
displays this difference.
Activities Going Forward

- The ECC 4th Annual Statewide Meeting is scheduled for February 28, 2012
- The ECC Operations Workgroup, the ECC Interagency Workgroup, and the ECC Provider Workgroup on Capacity & Access will continue to meet throughout 2012 to monitor and ensure compliance with ECC access standards and statutory regulations.
- Finalize methodology for administering ECC Oversight Tool audits
- Conduct ECC Oversight audits throughout 2012 by a team composed of representatives from DCF, DMHAS and VO
- Periodically analyze Oversight Tool audits to identify any trends in performance, as well as any gaps and barriers in delivery of service
- Breakout current combined 18D &18E report into two reports: Adult (ages 18+) and Child/Adolescent (ages 0 through 17)
- Establish a workgroup to review 18A report and to identify opportunities for enhancement (such as breaking out the report by ECCs).
- Continue to utilize the Mystery Shopper program to ensure effective triaging and screening
- RNMs to continue meeting with assigned ECCs as needed and at least quarterly to continue to monitor ECC policy requirements and to identify trends requiring support/intervention

The ECC PAR program will continue in CY 2012.
EMERGENCY DEPARTMENT AND EMERGENCY MOBILE PSYCHIATRIC SERVICES PARS INITIATIVE

As a result of a collaborative effort between DCF, DSS, the Connecticut Hospital Association’s (CHA) committee on Patient Care Quality, and ValueOptions, a performance initiative was developed during 2009 to advance Emergency Departments (EDs) and Emergency Mobile Psychiatric Services (EMPS) coordinated efforts in serving youth with a behavioral health crisis in an Emergency Department. In order to align incentives across all stakeholders, DSS and DCF negotiated a performance target for ValueOptions in CY 2009 that supported the following initiatives:

1. The development of a signed Memorandum of Understanding (MOU) between each of the EDs and the EMPS providers in their region by June 1, 2009. Twenty-eight (28) of the thirty (30) EDs in CT signed MOUs with their respective EMPS provider by that date.

2. During the latter half of 2009, the EDs collected data that was shared with the EMPS providers to assist them in improving their support of the EDs. Over the 1,440 youth presenting to the EDs, 11.0% (159) were reported to have some type of EMPS involvement. Of those, 7.7% of the youth in the ED were evaluated face to face by an EMPS team and another 3.3% had an EMPS telephonic consultation. However, one hospital accounted for the 65 of the EMPS on-site evaluations as their EMPS team staff their ED per a specific, pre-existing contractual arrangement. When this outlier was removed from the analysis, the rate of EMPS on-site evaluations of ED cases dropped to 3.3%.

SFY 2010 Hospital Emergency Department Performance Initiative

In SFY 2010 a performance initiative with hospital emergency departments focused on diverting inpatient stays and further reducing ED overstays. A total of 25 CT Emergency Departments participated in this initiative. Of the 25 participating EDs, 13 EDs earned maximum points, 11 earned partial points, and 1 ED earned 0 points. The results of the SFY 2010 ED performance initiative were disappointing. The EDs did not embrace the concept of using the EMPS providers to assist their ED staff in evaluating members for possible diversion from an inpatient stay nor did they use them to improve the discharge planning of those members being discharged from the EDs. EDs verbalized their skepticism regarding the clinical abilities of the EMPS staff and seemingly did not benefit from the EMPS staff knowledge regarding community services that might benefit members leaving the ED.

As a result of the assessment of the value of the ED Performance Initiative, it was determined that no ED performance initiative would be undertaken with the EDs during 2010. Instead, it was decided that we should step back and attempt to develop a more collaborative relationship with the EDs by implementing a PAR program. It was hoped that by establishing a workgroup with representatives of EDs in collaboratively developing performance measures with them, that we might get more buy-in for future performance initiatives.

During the remainder of 2010 and into 2011, a series of meetings with the EDs occurred and an ED profile was developed in collaboration with the ED representatives. The ED PAR profile that was developed that incorporated the following measures:
1. ED volume of HUSKY youth members treated in the ED broken out by four, six month periods and then rolled up by CY 2008 and 2009;
2. Based on authorization data, inpatient admission rates by ED, broken out by four, six month periods and then rolled up by CY 2008 and 2009;
3. A count, aggregated per quarter (Q4 ’09 through Q4 ’10) of the number of times that EMPS came on site at each of the EDs for assistance with HUSKY youth cases;
4. Demographic information regarding cases that present to each of the EDs;
5. Each ED’s volume of HUSKY youth members treated in the ED, sorted by low, medium and high volume for CY 2009;
6. Q3-4 of 2009 HUSKY youth inpatient admission rates, categorized by suburban, urban and rural locality of the ED in order to determine whether there is a relationship between admission rate and location of the ED;
7. Comparison of 2009 HUSKY youth inpatient admission rates for hospitals with and without a child/adolescent inpatient psychiatric unit;
8. Percentage of HUSKY youth inpatient admissions for 2009 to their own facility vs. another facility and
9. HUSKY youth inpatient admission rates for training hospitals vs. non training hospitals.

CY 2011 Emergency Department PAR Program

In CY 2011 the ED PAR program made the following advancements:

- Following consultation with DSS, a re-evaluation of the methodology for computing the measures of the number of visits to the emergency department and percentage of admits to inpatient from the emergency department was conducted along with decision rules for calculating these measures.

Using the rules, VO queried Medicaid claims data for dates of services in CY 2009 and 2010 was broken out into six (6) month increments, to establish the number of behavioral health visits (as identified with a primary diagnosis of 291-316) to the emergency department by CT BHP HUSKY youth (ages 0-<18) and adults (>18) and ED use was matched with authorization data to establish the following metrics separately for CT BHP HUSKY youth and adults:

- Behavioral health inpatient hospital admission rate (as measured by an authorized inpatient services within 2 days of the ED stay)

For members who were not admitted to the hospital from the ED:

- Behavioral health routine outpatient level of care rate (as measured by a registered routine outpatient service within 7 days of the ED stay)
- Behavioral health intermediate outpatient level of care rate (as measured by an authorized/registered service within 7 days of the ED stay)
- No known behavioral health service (as measured by the absence of an authorized behavioral health service within 7 days of the ED stay)

Additionally, the ED data was used to match on-site EMPS evaluations (as measured by the presence of paid claim with procedure code S9485 on the same day as the ED stay) for CT BHP youth (ages 0-<18).
As an opportunity to obtain feedback on the draft PAR ED profiles from the ED providers and the Departments, and to solicit any additional measures an ED Workgroup was held in June 2011. The workgroup was attended by seven (7) hospital staff representatives, a representative from the Department of Children and Families (DCF), one from the Department of Mental Health and Addiction Services (DMHAS), and six (6) representatives from the Contractor.

A group discussion followed review of the draft PAR ED Profiles, leading to the following suggestions for potential future measures:

- For all services following the ED stay; ambulatory follow up rate in 7, 14, and 30 day time frames
- ED re-admissions 7, 14, 21 and 30 days out for both youth and adult populations
- Capture EMPS use on the same day as the ED stay and 7 days out
- Re-admits to the EDs for those with EMPS vs. those without
- Draft PAR ED profiles (separate profiles for youth and adults) were submitted to the Departments. The profiles included:
  - Each ED’s volume of Medicaid members treated in the ED.
  - Each ED’s inpatient hospital admission rate, congregate care rate, routine outpatient rate, intermediate outpatient care rate, and no known behavioral health service rate.
  - Each ED’s use of on-site EMPS evaluation of Medicaid youth treated in the ED. On-site for EMPS was defined by on-site at any location, not just in the Emergency Department. This decision was made following the discovery that a significant percentage of EMPS claims do not specify the location of the EMPS service. As a result, any EMPS visit that occurred on the same day as the ED visit was included in this measure.
  - Use of EMPS within 7 days of an ED stay.

- Following further review of the method for calculating the percent of “diversion” levels of care it was agreed the method for calculating the percent for “diversion” levels of care should be calculated so the rate measures equaled 100% of the number of behavioral health ED visits (separately for HUSKY youth and HUSKY adults).
- A second ED workgroup meeting was held in September 2011. Agenda included a PowerPoint presentation of a review of the methodology used for computing the measures along with a review of a revised ED PAR profile (Separately for Youth and Adult)
- By the close of October 2011, the CT BHP Regional Network Managers and PAR team completed the first cycle of the ED PAR program by sharing the profiles with all 30 individual EDs via either face-to-face meetings (12 total), conference calls (13 total), or email distribution (5 total).

An ED PAR program is planned to continue in CY 2012.

**2010 EMPS Performance Initiative**

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

**Indicator I, part 1:** Reports detailing outreaches the EMPS vendors made to community providers, organizations, agencies, school, and/or families designed to increase their use of EMPS rather than send members to the ED;

**Indicator I, part 2:** A report documenting the education to families of members brought to the partner EDs during the performance period;

**Indicator II, part 1:** Evidence of on-site evaluations of members who present in partner EDs to assist them to divert unnecessary inpatient stays and reduce ED overstays; and,

**Indicator II, part 2:** Documentation of having provided a list of key aftercare services and contact information in their respective EDs at least once during the performance period.

Of the 6 participating vendors, all 6 providers earned full credit for indicator I, part 1 and part 2, with only 2 vendors earning credit for Indicator II, part 1 and all 6 providers earning credit for Indicator II, part 2. Although the results displayed the EMPS provider’s efforts towards further educating the EDs and community providers on the use of EMPS services, the outcome of their performance on this incentive program revealed minimal evidence of on-site evaluations for HUSKY members that presented to CT EDs during this performance period.

Taking into consideration the results revealed from this incentive program, a pay for performance initiative was developed in collaboration with the EMPS providers for SFY 2011 to further promote reduction of unnecessary pediatric psychiatric emergency department visits and advance appropriate diversion of potential inpatient admissions.

**SFY 2011 EMPS Performance Initiative**

In collaboration with the CT EMPS providers, the CT BHP commenced a performance initiative for SFY 2011 consistent with the objectives established in the MOUs that were developed between the Emergency Departments and EMPS providers in 2009. The following performance goals were established:

**Goal 1:** Conduct at least three (3) face to face informational sessions with Emergency Department line staff to establish and/or improve the working relationship between EMPS providers and ED staff such that EDs increase their use of EMPS in the ED. It was recommended the suggested content of the informational sessions with the EDs include but not be limited to at least one of the following three topics:

1. Education of the ED line staff about the services EMPS providers can either provide themselves or can assist the ED in arranging services, including the timeframe within which those services can be accessed;
2. Identify the specific needs of each ED in terms of how EMPS providers can be assistance to them, taking into consideration:
   a. The resources available in the ED to evaluate members with behavioral health issues and
b. Program/service providers either affiliate with the ED or with whom the ED has a referral relationship;

3. Identify and address and barriers of the ED using EMPS frequently and effectively

**AND always include**

4. A review of the ED’s recent utilization of EMPS

**Goal 2:** Reduce Statewide admits/1000 HUSKY youth (age 0-18) to CT EDs between 11/1/10 and 2/28/11 from the number of admits/1000 of HUSKY youth (age 0-18) to CT EDs during the baseline period of 11/1/09-2/28/10.

**Outcome Goal 1:** 5 of the 6 participating EMPS providers earned full points for goal 1.

**Outcome Goal 2:** All 6 providers earned points for goal 2.

An EMPS Performance Initiative is expected for CY 2012.

**RESIDENTIAL TREATMENT CENTER (RTC) PAR PROGRAM**

In late 2008, a workgroup made up of DCF and ValueOptions staff began working together to develop several reports, identified in collaboration with RTC providers, that would allow DCF to assess RTC performance. Several of the reports were based entirely or in part on CT BHP authorization data. In other instances, the CT BHP worked collaboratively with DCF staff to develop data collection tools for DCF’s ongoing use that would assist them to collect the data necessary for the reports by conducting chart and file audits. Completed by the end of 2009, these reports became the basis for the RTC PARs program. The reports were:

- **Outcome Measure 1: RTC Post Placement Experience**
  This report looks at the number of discharges per quarter and then determines the % of those cases with an authorization (or documentation in a DCF database) for another level of care within 90 days.

- **Outcome Measure 2: Incidence of Hospitalizations**
  This report takes the subset of youth in Outcome 1 report who were authorized for a lower level of care post-discharge who were subsequently admitted to a higher level of care within 180 days of discharge.

- **Outcome Measure 3: Number of Youth Experiencing First Hospitalization**
  This report begins with all youth discharged from RTC and then measures how many of those youth were admitted within 180 days 1) to a higher level of care or 2) to another RTC.

- **Outcome Measure 4: Readiness for Discharge to Lower Level of Care**
  This report takes the subset of youth identified in Outcome 1 who were authorized for a lower level of care post-RTC discharge, and then measures the total days and average length of time for those youth to achieve readiness for discharge. Discharge delay days are not included in the measure of days to achieve readiness.

- **Outcome Measure 5: Number of Hospitalizations During RTC Stay**
  This report begins with all youth discharged during the reporting period and then determines the number and percent of those youth who had an inpatient stay during their RTC stay.
• **Outcome Measure 6: RTC Discharge Delay Days**
  This report begins with all youth discharged from an RTC during the reporting period and then determines the number and percent of those youth who experienced discharge delay during their RTC stay.

• **Outcome Measure 7: Number of Referrals/Matches Accepted to RTC Program**
  This report displays the number of RTC match and admit decisions and then reported reasons for decline of a match or admission.

• **Outcome Measure 8: Number/Percentage of Children Arrested within 90 days post RTC-discharge**
  This report displays graphically the number and percent of youth arrested within 90 days of discharge from an RTC.

• **Outcome Measure 9: Number/Percentage of children who Maintain Placement Stability 90 days post RTC-discharge**
  This report displays graphically the number and percent of youth who maintained placement stability within the first 90 days of discharge from an RTC.

• **Outcome Measure 10: Number of Suicide Attempts, AWOLS, Arrests, Restraints**
  This report displays graphically the number of suicide attempts, AWOLS, Police/EMS calls, Arrests and Restraints for youth during their RTC stay.

• **Outcome Measure 11: Average Number of Hours per Child per Week in Group Therapy**
  This report displays graphically the average number of hours per child per week in an approved evidence-based therapy group for youth in RTC during the audit period.

• **Outcome Measure 12: Average Number of Hours per Child per Week in Individual Psychotherapy**
  This report displays graphically the average number of hours per child per week in regularly scheduled, planned individual psychotherapy of youth in RTC during the audit period.

• **Outcome Measure 13: Average Number of Hours per Child per Week of Family Treatment**
  This report displays graphically the average number of hours per child per week of family treatment for youth in RTC during the audit period.

In Q1 2010, the CT BHP compiled the RTC outcome reports, UM data, DCF chart/file audit data and corresponding graphs in preparation for distribution of the suite of reports to RTC Providers. Each provider received their own data in a binder that included a description of each of the reports and a User Manual to assist them in reviewing and understanding reports.

Upon completion of the RTC Provider Specific binders DCF and CT BHP staff visited each residential treatment center in CT and reviewed their provider specific outcome reports, laying the foundation for the RTC PAR program. The provider specific binders were completed again in December 2010 and distributed to each of the RTC providers.

**CY 2011 RTC PAR Program**

During the summer of 2010, CT BHP and DCF, in collaboration with RTC provider representatives, began the development of Performance Incentive methodology and
measures for in-state RTC providers. Three goals were established for SFY 2011. The goals included: 1.) “Decreasing the Average Length of Stay (ALOS) in RTCs” 2.) “Increasing the Hours of Behavioral Health Treatment of Children in RTC” and 3.) “Percentage of children who maintained placement stability during the 180 days after discharge from the RTC”.

Goal 1 Length of Stay: The baseline performance period for goal one were Q1-3 ’10. The Performance Evaluation period for goal one is Q1-3 ‘11

For goal 1 providers were categorized as primarily treating one of four diagnostic categories/populations of adolescents. The four populations are:
1. Conduct/Disorder/Explosive Disorder/Disruptive Disorder/and JJ
2. Substance Abuse
3. Psychiatric
4. Special Programs (includes youth with Mental Retardation and Pervasive Developmental Disorder as well as fire setters and sexually reactive youth)

For the Conduct and Substance Abuse groups the Target Length of Stay (TLOS) is 180 days for the 2011 Performance Evaluation Period. The TLOS for Psychiatric and Special programs is 250 days for the same Performance Evaluation Period.

Goal one included a calculation for Adjusted Average Length of Stay (AALOS). For the purposes of this performance initiative, cases with lengths of stay more or less than one standard deviation from the ALOS for the category were removed. This adjustment is made for both baseline and performance periods. Points towards receiving the performance incentive are awarded based on the percentage of members discharged from the RTC during the performance period who attain the length of stay in the defined cohort.

Goal 2, Hours of Treatment: This goal was developed after the initial audit reported in the first round of the PAR RTC program revealed that, on average, less than 3 hours of treatment per week per child were occurring for most RTCs. This number combined individual, evidence based group treatment and family treatment. For this performance incentive the third type of treatment, family treatment, was revised to include “bridge-transition” activities including; Family therapy, life skills training programs, mentoring, volunteer/community service, home visits when accompanied by staff and community based vocational training.

The baseline performance period for goal two is Q1-3 ’10. The Performance Evaluation period for goal two is Q1-3 ’11. Data for the baseline and performance measures are collected quarterly by DCF staff using the data collection tools developed by the CT BHP. Inter-rater reliability trainings are conducted on a quarterly basis to ensure accuracy and standardization across auditors.

A minimum of ten cases are audited for each RTC on a quarterly basis. A two week period during the quarter is chosen for each RTC is audited for the same time period. During the performance period of 6 hour per week per child target average number of treatment hours was set. The targets were set based on the consensus of the RTC provider group. Points will be given based on the percentage of children with greater than 5.5 hours of treatment per week during the audit period.
Goal 3, Placement Stability: Performance on goal 3 is based on the findings of an audit of LINK, the DCF database that documents the location of children involved with DCF and the reasons for anticipated and unanticipated moves from placements. Children who no longer have DCF involvement and who therefore cannot be assessed for stability post placement will be deleted from this measure.

The baseline measurement period for this measure was Q3-4 '09. The Performance evaluation period for this measure is Q3-4 '10. Points will be awarded based on each facility’s percentage of youth discharged from all RTCs during the Performance Evaluation period who maintained post placement stability.

A post evaluation period, results notification, and appeal period are built into the timeframes of this initiative. Performance awards to RTCs are expected to be paid out during Q1 '12, depending on the availability of funds.

April of 2011, an RTC provider meeting was held to review the data from Q4 2010. At the provider meeting all in state RTC providers received their provider specific suite of RTC Outcome Reports which included UM data, DCF child/file audit data and corresponding graphs. At this meeting, it was announced that due to changes that were occurring and would be happening in the coming months within DCF, the RTC Performance Incentive Program would not be moving forward.

Results of the 2011 RTC Performance Initiative:
In April of 2011, an RTC provider meeting was held to review the data from Q4 2010. At the provider meeting all in state RTC providers received their provider specific suite of RTC Outcome Reports which included UM data, DCF child/file audit data and corresponding graphs. At this meeting, it was announced that as a result of changes within DCF, the RTC Performance Incentive Program would not be moving forward.

Outcome measures that are based on data collected solely by ValueOptions continues to be reported to DCF on a quarterly basis.

Recommendations for continuing sub-Goal in 2012:
This sub-goal continues to be applicable for 2012 and should be included in the 2012 Project Plan.

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

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

In order to satisfy a semi-annual contractual obligation between ValueOptions and the Departments, a third cycle of reports containing an analysis of HUSKY Pharmacy Data based on dates of service between January 1, 2001 and December 31, 2010 was submitted to the Departments on February 15, 2012. The submission included six (6) reports for each of the six (6) month incremental timeframes and included a narrative analysis of the reports that utilized graphs and/or charts to further display the findings in the reports. Previous cycles of pharmacy reporting had included data from February 1, 2008 to December 31, 2009.
CHARACTERISTICS OF HUSKY BEHAVIORAL HEALTH MEDICATION UTILIZERS

These data are based on reports of all pharmacy claims with a date of service occurring between the date ranges of the report spans. The reports provide aggregate demographic data regarding the prescribing of behavioral health medications broken out by gender and age and, in some instances, DCF/Non-DCF Involvement status.

Although HUSKY membership has risen 21% between Q1 2008 and Q4 2010, there has been much steeper increase of nearly 40% in the total number of HUSKY BH medication utilizers from Q1 & Q2 ’08 to Q3 & Q4 ’10.
HUSKY youth membership has been consistently higher than HUSKY adult membership since Q1 '08. However, adult members are being added at a greater rate than youth members as evidenced by increases of 16% and 33% for youth and adults respectively from Q1 2008 to Q4 2010. Between Q1 and Q2 of 2008 and Q3 and Q4 of 2010, adult utilizers of behavioral health medications increased 52%, while youth utilizers increased by 25%.

**RATE OF USE OF BEHAVIORAL HEALTH MEDICATIONS BY HUSKY POPULATION**

In Q3-4 '10, a total of 23,284 HUSKY youth utilized some type of behavioral health medication. During that same time period, total HUSKY youth membership was approximately 286,501;

- During the second half of 2010, approximately 8.1% of HUSKY youth utilized some type of behavioral health medication
- This is an increase from previous reporting periods; 6.9% in Q1-2 '08 (first reporting cycle) and 7.7% in Q3-4 '09

In Q3-4 '10, a total of 31,541 HUSKY adults utilized some type of behavioral health medication. During that same time period, total HUSKY adult membership was approximately 141,886;
- During the second half of 2101, approximately 22.2% of HUSKY adults utilized some type of behavioral health medication.
- This is also an increase from previous reporting periods; 17.9% in Q1-2 '08 and 19.5% in Q3-4 '09.

![Number of HUSKY Utilizers of Behavioral Health Meds by Gender](chart1.png)

![Number of HUSKY Youth (0-18) Behavioral Health Meds Utilizers by Gender](chart2.png)
Across the entire age-span of HUSKY population, more females utilize behavioral health (BH) medications than do males. This observance is being driven by much higher numbers of female adult HUSKY utilizers. Although there are 71% more male youth utilizers than female youth utilizers, the pattern among adults is reversed. The HUSKY adult population has approximately 5 times more female utilizers than male utilizers.
AGE AND THE UTILIZATION OF BH MEDICATIONS

In the DCF involved HUSKY youth population taking a BH med, increased age strongly correlates with the percentage of behavioral health med utilizers. DCF Involved adolescents account for 35.5% of the DCF-Involved population but for 59.1% of the behavioral health medication utilizers. DCF-Involved youth ages 7-12 account for 25.7% of the population but for 32.0% of the behavioral health medication utilizers. The percent of behavioral health medication utilizers as a percent of all such BH med utilizers peaks between ages 7 and 12 among Non-DCF involved HUSKY youth. The same phenomena is observed when comparing to the population of non DCF youth. Non-DCF involved 7-12 year olds account for 29.9% of the Non-DCF involved youth population but for ~44% of the Non-DCF involved behavioral health medication utilizers.
BEHAVIORAL HEALTH (BH) MEDICATION USE BY THERAPEUTIC CLASS

This report is based on all pharmacy claims with a date of service occurring between the date ranges of the report. This report provides a description of the percentage of utilizers of the different therapeutic classes. Behavioral health medications are broken out by the following therapeutic classes:

- Antianxiety Agents
- Antidepressants
- Antiparkinsonian Agents (Meds used to counteract side effects of antipsychotics)
- Antipsychotic/Antimanic Agents
- Hypnotics
- Mood Stabilizers
  - Lithium (a mood stabilizer) is broken out
- Stimulants

The following charts display the percentage of HUSKY utilizers using medications within each of the therapeutic classes.

The following charts display the percentage of HUSKY utilizers using medications within each of the therapeutic classes.

### Adults (19+)

% of Total Adult Utilizers on BH Meds within Each Therapeutic Class

<table>
<thead>
<tr>
<th>Therapeutic Class</th>
<th>Q1&amp;2 '08</th>
<th>Q3&amp;4 '08</th>
<th>Q1&amp;2 '09</th>
<th>Q3&amp;4 '09</th>
<th>Q1&amp;2 '10</th>
<th>Q3&amp;4 '10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antianxiety Agents</td>
<td>36.20%</td>
<td>37.33%</td>
<td>37.09%</td>
<td>37.44%</td>
<td>37.48%</td>
<td>38.51%</td>
</tr>
<tr>
<td>Antidepressants</td>
<td>65.36%</td>
<td>65.56%</td>
<td>65.83%</td>
<td>65.56%</td>
<td>64.08%</td>
<td>63.91%</td>
</tr>
<tr>
<td>Antiparkinsonian Agents</td>
<td>2.22%</td>
<td>2.22%</td>
<td>2.42%</td>
<td>2.23%</td>
<td>2.11%</td>
<td>2.14%</td>
</tr>
<tr>
<td>Antipsychotic/ Antimanic Agents</td>
<td>15.40%</td>
<td>14.82%</td>
<td>15.59%</td>
<td>15.65%</td>
<td>16.03%</td>
<td>15.15%</td>
</tr>
<tr>
<td>Hypnotics</td>
<td>14.91%</td>
<td>16.00%</td>
<td>15.96%</td>
<td>15.72%</td>
<td>14.46%</td>
<td>14.44%</td>
</tr>
<tr>
<td>Lithium</td>
<td>1.35%</td>
<td>1.32%</td>
<td>1.26%</td>
<td>1.33%</td>
<td>1.40%</td>
<td>1.39%</td>
</tr>
<tr>
<td>Mood Stabilizers</td>
<td>28.79%</td>
<td>29.24%</td>
<td>29.51%</td>
<td>29.83%</td>
<td>28.76%</td>
<td>29.34%</td>
</tr>
<tr>
<td>Stimulants</td>
<td>4.65%</td>
<td>5.03%</td>
<td>5.47%</td>
<td>5.64%</td>
<td>6.63%</td>
<td>6.95%</td>
</tr>
</tbody>
</table>

For HUSKY adults, there is a great deal of consistency in terms of the percentage of members utilizing each of the therapeutic classes across multiple time periods. Reflecting national trends, use of stimulants continues to rise over time. Antidepressants are the therapeutic agents most widely used by adults.
Youth (0-18)
% of Total Youth Utilizers on BH Meds within Each Therapeutic Class

<table>
<thead>
<tr>
<th>Therapeutic Class</th>
<th>Q1&amp;2 '08</th>
<th>Q3&amp;4 '08</th>
<th>Q1&amp;2 '09</th>
<th>Q3&amp;4 '09</th>
<th>Q1&amp;2 '10</th>
<th>Q3&amp;4 '10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antianxiety Agents</td>
<td>17.87%</td>
<td>20.08%</td>
<td>19.06%</td>
<td>18.43%</td>
<td>16.44%</td>
<td>15.20%</td>
</tr>
<tr>
<td>Antidepressants</td>
<td>22.80%</td>
<td>22.64%</td>
<td>23.72%</td>
<td>23.92%</td>
<td>24.88%</td>
<td>24.69%</td>
</tr>
<tr>
<td>Antiparkinsonian Agents</td>
<td>1.23%</td>
<td>1.03%</td>
<td>1.25%</td>
<td>1.17%</td>
<td>1.39%</td>
<td>1.33%</td>
</tr>
<tr>
<td>Antipsychotic/ Antimanic Agents</td>
<td>30.46%</td>
<td>29.51%</td>
<td>28.83%</td>
<td>28.62%</td>
<td>27.90%</td>
<td>27.30%</td>
</tr>
<tr>
<td>Hypnotics</td>
<td>2.53%</td>
<td>2.76%</td>
<td>2.70%</td>
<td>2.41%</td>
<td>2.40%</td>
<td>1.67%</td>
</tr>
<tr>
<td>Lithium</td>
<td>2.46%</td>
<td>2.29%</td>
<td>2.10%</td>
<td>1.99%</td>
<td>1.92%</td>
<td>1.78%</td>
</tr>
<tr>
<td>Mood Stabilizers</td>
<td>14.60%</td>
<td>14.08%</td>
<td>13.75%</td>
<td>13.69%</td>
<td>13.53%</td>
<td>13.88%</td>
</tr>
<tr>
<td>Stimulants</td>
<td>52.46%</td>
<td>51.34%</td>
<td>52.22%</td>
<td>52.78%</td>
<td>54.93%</td>
<td>57.08%</td>
</tr>
</tbody>
</table>

Stimulants are the most widely prescribed BH medications for HUSKY youth, with use continuing to trend upward. Antipsychotic utilization among youth continues to exceed adult use. Antidepressants are also widely used among all HUSKY participants.

COMPARISON OF UTILIZATION BETWEEN DCF INVOLVED AND NON-DCF INVOLVED HUSKY MEMBERS

DCF Utilizers
% of DCF Utilizers on BH Meds within Each Therapeutic Class

<table>
<thead>
<tr>
<th>Therapeutic Class</th>
<th>Q1&amp;2 '10</th>
<th>Q3&amp;4 '10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antianxiety Agents</td>
<td>8.64%</td>
<td>7.65%</td>
</tr>
<tr>
<td>Antidepressants</td>
<td>38.75%</td>
<td>39.37%</td>
</tr>
<tr>
<td>Antiparkinsonian Agents</td>
<td>3.96%</td>
<td>4.16%</td>
</tr>
<tr>
<td>Antipsychotic/ Antimanic Agents</td>
<td>61.00%</td>
<td>59.01%</td>
</tr>
<tr>
<td>Hypnotics</td>
<td>1.73%</td>
<td>1.41%</td>
</tr>
<tr>
<td>Lithium</td>
<td>6.67%</td>
<td>5.98%</td>
</tr>
<tr>
<td>Mood Stabilizers</td>
<td>20.25%</td>
<td>20.68%</td>
</tr>
<tr>
<td>Stimulants</td>
<td>49.15%</td>
<td>50.35%</td>
</tr>
</tbody>
</table>

NON-DCF Utilizers
% of Non-DCF Utilizers on BH Meds within Each Therapeutic Class

<table>
<thead>
<tr>
<th>Therapeutic Class</th>
<th>Q1&amp;2 '10</th>
<th>Q3&amp;4 '10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antianxiety Agents</td>
<td>17.04%</td>
<td>15.77%</td>
</tr>
<tr>
<td>Antidepressants</td>
<td>22.62%</td>
<td>22.12%</td>
</tr>
<tr>
<td>Antiparkinsonian Agents</td>
<td>0.98%</td>
<td>0.76%</td>
</tr>
<tr>
<td>Antipsychotic/ Antimanic Agents</td>
<td>23.25%</td>
<td>22.72%</td>
</tr>
<tr>
<td>Hypnotics</td>
<td>2.43%</td>
<td>1.67%</td>
</tr>
<tr>
<td>Lithium</td>
<td>1.18%</td>
<td>1.00%</td>
</tr>
<tr>
<td>Mood Stabilizers</td>
<td>12.58%</td>
<td>12.80%</td>
</tr>
<tr>
<td>Stimulants</td>
<td>56.16%</td>
<td>58.65%</td>
</tr>
</tbody>
</table>
DCF Involved HUSKY BH medication utilizers were nearly three times more likely to be dispensed antipsychotic agents. The DCF group also has significantly higher rates of antidepressant and mood stabilizer use. Non-DCF involved utilizers more commonly used antianxiety agents than DCF involved utilizers

**COMPARISON OF UTILIZATION BY AGE AMONG DCF INVOLVED HUSKY YOUTH MEMBERS**

**DCF Utilizers**

**AGE 0 – 3** (N = 49 and 67 utilizers respectively during the reporting periods)

*Please note the small “N” for this age group*

<table>
<thead>
<tr>
<th>Therapeutic Class</th>
<th>Q1&amp;2 ’10</th>
<th>Q3&amp;4 ’10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antianxiety Agents</td>
<td>55.10%</td>
<td>52.24%</td>
</tr>
<tr>
<td>Antidepressants</td>
<td>0.00%</td>
<td>1.49%</td>
</tr>
<tr>
<td>Antiparkinsonian Agents</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>Antipsychotic/ Antimanic Agents</td>
<td>12.24%</td>
<td>5.97%</td>
</tr>
<tr>
<td>Hypnotics</td>
<td>16.33%</td>
<td>20.90%</td>
</tr>
<tr>
<td>Lithium</td>
<td>0.00%</td>
<td>1.49%</td>
</tr>
<tr>
<td>Mood Stabilizers</td>
<td>24.49%</td>
<td>26.87%</td>
</tr>
<tr>
<td>Stimulants</td>
<td>2.04%</td>
<td>4.48%</td>
</tr>
</tbody>
</table>

**DCF Utilizers**

**AGE 4 – 6** (N = 198 and 197 utilizers respectively during the reporting periods)

% of DCF Utilizers on BH Meds within Each Therapeutic Class

<table>
<thead>
<tr>
<th>Therapeutic Class</th>
<th>Q1&amp;2 ’10</th>
<th>Q3&amp;4 ’10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antianxiety Agents</td>
<td>16.67%</td>
<td>6.09%</td>
</tr>
<tr>
<td>Antidepressants</td>
<td>7.07%</td>
<td>8.63%</td>
</tr>
<tr>
<td>Antiparkinsonian Agents</td>
<td>0.00%</td>
<td>0.51%</td>
</tr>
<tr>
<td>Antipsychotic/ Antimanic Agents</td>
<td>45.96%</td>
<td>42.13%</td>
</tr>
<tr>
<td>Hypnotics</td>
<td>2.53%</td>
<td>2.03%</td>
</tr>
<tr>
<td>Lithium</td>
<td>0.51%</td>
<td>0.51%</td>
</tr>
<tr>
<td>Mood Stabilizers</td>
<td>11.11%</td>
<td>11.68%</td>
</tr>
<tr>
<td>Stimulants</td>
<td>63.64%</td>
<td>73.60%</td>
</tr>
</tbody>
</table>
DCF Utilizers-
AGE 7 – 12 (N = 959 and 953 utilizers respectively during the reporting periods)

% of DCF Utilizers on BH Meds within Each Therapeutic Class

<table>
<thead>
<tr>
<th>Therapeutic Class</th>
<th>Q1&amp;2 '10</th>
<th>Q3&amp;4 '10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antianxiety Agents</td>
<td>5.94%</td>
<td>5.25%</td>
</tr>
<tr>
<td>Antidepressants</td>
<td>30.55%</td>
<td>29.70%</td>
</tr>
<tr>
<td>Antiparkinsonian Agents</td>
<td>2.50%</td>
<td>2.83%</td>
</tr>
<tr>
<td>Antipsychotic/ Antimanic Agents</td>
<td>58.81%</td>
<td>57.50%</td>
</tr>
<tr>
<td>Hypnotics</td>
<td>0.52%</td>
<td>0.73%</td>
</tr>
<tr>
<td>Lithium</td>
<td>5.11%</td>
<td>4.72%</td>
</tr>
<tr>
<td>Mood Stabilizers</td>
<td>13.76%</td>
<td>14.38%</td>
</tr>
<tr>
<td>Stimulants</td>
<td>63.61%</td>
<td>66.95%</td>
</tr>
</tbody>
</table>

DCF Utilizers-
AGE 13 – 18 (N = 1746 and 1762 utilizers respectively during the reporting periods)

% of DCF Utilizers on BH Meds within Each Therapeutic Class

<table>
<thead>
<tr>
<th>Therapeutic Class</th>
<th>Q1&amp;2 '10</th>
<th>Q3&amp;4 '10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antianxiety Agents</td>
<td>7.90%</td>
<td>7.43%</td>
</tr>
<tr>
<td>Antidepressants</td>
<td>47.94%</td>
<td>49.49%</td>
</tr>
<tr>
<td>Antiparkinsonian Agents</td>
<td>5.44%</td>
<td>5.45%</td>
</tr>
<tr>
<td>Antipsychotic/ Antimanic Agents</td>
<td>65.29%</td>
<td>64.07%</td>
</tr>
<tr>
<td>Hypnotics</td>
<td>1.89%</td>
<td>0.96%</td>
</tr>
<tr>
<td>Lithium</td>
<td>8.42%</td>
<td>7.43%</td>
</tr>
<tr>
<td>Mood Stabilizers</td>
<td>24.74%</td>
<td>24.86%</td>
</tr>
<tr>
<td>Stimulants</td>
<td>40.89%</td>
<td>40.58%</td>
</tr>
</tbody>
</table>

Younger DCF involved HUSKY youth members were much more likely to be prescribed antianxiety medications than older members. It should be noted that medications in this category includes Hydroxyzine (Atarax) which is used for anxiety and to treat the symptoms of alcohol withdrawal. It is also used to relieve the itching caused by allergies and to control the nausea and vomiting caused by various conditions, including motion sickness. The inclusion of this medication inflates both the number of members on behavioral health medication as well as the percentage on antianxiety medications; only 4% of are prescribed Benzodiazepines. After age 4, approximately half of all utilizers were dispensed antipsychotic medication. Use of stimulant medication in this group peaked in the 4-12 year old age groups. Antidepressant use spiked among DCF involved HUSKY youth after age 6.

Recommendations for continuing sub-Goal in 2012:
This sub-goal is under evaluation by the Departments. It is anticipated that the content of future pharmacy reporting will be revised. Once these decisions are made, a revised goal for 2012 will be incorporated into the 2012 QM Workplan.
IV. ONGOING QM/UM GOALS AND OBJECTIVES TO BE CARRIED FORWARD FROM THE EVALUATION YEAR

Goal 1: Review and approve the 2011 CT BHP Program Evaluation, 2012 CT BHP QM Program Description and 2012 CT BHP QM Project Plan.

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

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

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

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

Goal 6. Ensure timely telephone access to CT BHP.

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


Goal 9. Review and approve the 2012 CT BHP UM Program Description

Goal 10. Monitor for Under or Over Utilization of Behavioral Health Services; identify barriers and opportunities.

Goal 11. Monitor timeliness of UM decisions; identify barriers and opportunities.

Goal 12. Monitor timeliness of Appeal decisions; identify barriers and opportunities.

Goal 13. Monitor consistency of application of UM Criteria (IRR) and adequacy of documentation.

Goal 14. Monitor continuity of care; identify barriers and opportunities.

Goal 15. Reduce Emergency Department (ED) Discharge Delays

Goal 16. Maintain network adequacy; support Departments in maintaining adequate Provider Network to ensure member access

Goal 17. Maintain the Provider Analysis and Reporting Initiatives for Inpatient Child and Adolescent, Enhanced Care Clinics and Psychiatric Residential Treatment Facilities (PRTF) levels of Care and Implement initiatives with CT
Emergency Departments, Home Health Care, and Emergency Mobile Psychiatric Services (EMPS) levels of care.

Goal 18. Maintain the CT BHP Pharmacy Reporting and Analysis Program
V. Signature page
ValueOptions Connecticut Service Center Quality Management
Quality Management/Utilization Management

The ValueOptions Connecticut Service Center Quality Management Committee has reviewed and approved the 2011 Quality Management/Utilization Management Program Evaluation, 2012 Quality Management Program Description, Utilization Management Program Description, and Work Plan:

<table>
<thead>
<tr>
<th>Program Approval:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td></td>
</tr>
<tr>
<td>Laurie Vanderheide, PhD</td>
<td></td>
</tr>
<tr>
<td>Date:</td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td></td>
</tr>
<tr>
<td>Steven Kant, MD</td>
<td></td>
</tr>
<tr>
<td>Date:</td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td></td>
</tr>
<tr>
<td>Ann Phelan</td>
<td></td>
</tr>
<tr>
<td>Date:</td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td></td>
</tr>
<tr>
<td>Lori Szczygiel, CEO</td>
<td></td>
</tr>
</tbody>
</table>

B. The Company Quality Council (CQC) has reviewed and approved the 2011 Quality Management Utilization Management Program Evaluation, 2012 QM Program Description, 2012 UM Program Description and 2012 QM/UM Work Plan:

<table>
<thead>
<tr>
<th>Program Approval:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td></td>
</tr>
<tr>
<td>Deborah Hirschfelder, MSMA</td>
<td></td>
</tr>
<tr>
<td>Date:</td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td></td>
</tr>
<tr>
<td>Janice Maurizio, LCSW-R ACSW</td>
<td></td>
</tr>
<tr>
<td>Date:</td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td></td>
</tr>
<tr>
<td>Sandy Potter, LCSW, MBA</td>
<td></td>
</tr>
<tr>
<td>Date:</td>
<td></td>
</tr>
</tbody>
</table>
VI. APPENDICES

Appendix A: Summary of Autism Spectrum Disorder Feasibility Study