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

General Overview

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

Beginning in 2012, two changes were made from previous submissions. First, results were graphed only for benefit groups that had a sufficiently large number of members receiving services in each level of care (LOC). This change made the graphs much easier to read and focused the discussion on benefit groups that warranted greater attention. In addition, to provide better visual clarity when viewing the graphs, we have highlighted the benefit groups that appear on the related graph. Second, the Executive Summary now focuses only on those LOC's in which the data warranted analysis and discussion. If the analysis for an LOC did not reveal results or trends that warranted discussion, then those results were removed from the body of the analysis document and placed in an Appendix at the end of the analysis document. The summary now outlines the areas of interest in regards to utilization trends as well as the causes and efforts that have been identified as pertinent to that review. We also present recommendations about some remaining challenges and potential areas for progress. The areas of focus for this quarter are:

- Membership
- Inpatient Facilities: Admits/1,000; Days/1,000; Average Length of Stay (ALOS)
- Detox Programs:
- Hospital-based and Free-standing detox programs
    - Admits/1,000
    - Days/1,000
    - ALOS
- Ambulatory Detox and Methadone Maintenance
    - Admits/1,000
- Home Health Services
    - Admits/1,000
    - Medication Administration frequency

This quarter, the following results have been placed in the Appendix and are not discussed:

- Mental Health Group Home: Admits/1,000; Days/1000; ALOS
- Partial Hospital Programs: Admits/1,000
- Intensive Outpatient Programs: Admits/1,000
- Outpatient: Admits/1,000
- All adult graphs for 18A-C

Methodological Factors

The data in this report is primarily authorization-based. In some cases, additional data has been provided to enhance the understanding of the LOC or the utilization management efforts. One example is in Home Health where the traditional "Admits/1,000" analysis has limited value due to a relatively stable number of referrals for that LOC.

The data for this report is refreshed for each subsequent set of Quarterly Reports during the year. Due to retrospective authorizations and changes in eligibility, the results for each quarter change from the

previously-reported values. In most cases, the changes do not create significant changes in the reported conclusions, however, on some occasions there is sufficient variation that the analysis would change. One example is that of the adult membership in Quarter 3, 2012. When first reported, there appeared to be a decline in adult membership from Quarter 2 to Quarter 3. By the fourth quarter, however, the data revealed that membership actually increased in Quarter 3, although the increase was slight. We expect a similar process to occur in Quarter 4. The reports and analyses for all LOC's are affected by this change. As a result, any conclusions drawn from the data are subject to revision as the data is refreshed. Our analyses therefore will focus more on multi-quarter results than on changes within a single quarter.

Membership

Total Adult (18+) Membership

In general, Membership for the Adult Medicaid Population has grown since Q2, 2011, when the membership totals were first collected. This growth is most evident in the HUSKY D population where it appears that membership increased by somewhat more than 20% between Q2 '11 and Q3 '12. An initial examination of current membership data suggests that membership dropped slightly from Q3 to Q4, 2012. However, as described above, it is likely that the membership value will change when the data is refreshed for the next Quarter. Any analysis related to membership will require sufficient lag to guarantee that the membership count is accurate.

As explained last quarter, the new methodology for membership totals still applies. Each member is only counted once per quarter, even if he/she changes eligibility groups or has gaps in eligibility. This methodology is referred to in the graphs as "Unique Membership." This methodology has been applied to all quarters retrospectively, so the integrity of the data has been maintained.

Inpatient Level of Care

Inpatient Admits/1,000

The overall Admits/1,000 rate was 1.91 for Q4, '12 and 2.15 for CY '12. It appears that the Admits/1,000 rate has been dropping slightly from quarter to quarter, beginning in Q1 '12. HUSKY C (ABD Single) and HUSKY D (MLIA) have consistently had the highest penetration rate of all benefit groups and Q4 '12 is no exception. Frequently, when Admits/1,000 decrease, Days/1,000 and ALOS increase, but this was not the case in Q4 2012. In fact, overall, Days/1,000 and ALOS decreased in that quarter. It is our hope that this creates more fluidity within the inpatient system; beds are being utilized by those members who need to be treated in an acute setting and members are appropriately discharged to less restrictive settings when an acute setting is no longer necessary.

Inpatient Days/1,000

Overall, Days/1,000 decreased from last quarter for All Benefit Groups. The Calendar Year Days/1,000 was 17.99. Generally Days/1,000 has shown slight variance quarter to quarter in the Calendar Year, and no significant upward or downward trend.

HUSKY C (ABD Single) members, as expected, continue to have the highest number of Days/1,000 at 56.31. This is lower than Q3, 2012 (61.65), but remains twice the level of Days/1,000 for the HUSKY D membership. Due to the complexity of their presentations, ABD Single members often need additional time to stabilize on an inpatient unit and may have more barriers to discharge planning. The ICM and Peer programs at Yale New Haven Hospital and the Pilot program at St. Francis Hospital are examples of

efforts to impact on connect to care and community follow up. ICMs and Peers exhibit ongoing dedication to the collaborative and creative planning that occurs with providers, state agencies, and members.

HUSKY D Days/1,000 also decreased from Q3 '12 (35.12) to Q4 '12 (28.52). This is the lowest recorded Days/1,000 for the HUSKY D membership. A seasonal trend may be emerging, since Q4, 2012 and Q4, 2011 have fewer Days/1,000 when compared to other quarters. (Note: Q2 '11 cannot be included in the comparison because it was the first quarter measured, and the data did not include all inpatient days.)

Days/1,000 for HUSKY C (ABD Dual) and HUSKY A (Family Single) remain low at 9.75 and 5.25 in Q4, 2012, respectively. Both benefit groups have had stable Days/1,000 since data collection began.

Average Length of Stay (ALOS)

The Average Length of Stay for All Benefit Groups decreased from 8.63 in Q3, 2012 to 8.32 in Q4, 2012. There has been some slight variation from quarter to quarter, but generally the ALOS has ranged from 8-8.5 days. The Calendar Year average was 8.30 days for All Benefit Groups.

HUSKY C (ABD Dual and ABD Single) members consistently have had the longest recorded ALOS, while HUSKY D and HUSKY A (Family Single) consistently have had shorter length of stays. This difference between the benefit groups is understandable considering the different needs among these populations. As stated above, HUSKY C members may need more time to stabilize in an acute setting and have additional resource needs at time of discharge, both contributing to a longer length of stay.

The table below lists each of the four benefit groups with the highest number of members utilizing inpatient care and the ALOS for Q3, 2012 and Q4, 2012, the percentage change from Q3, 2012 to Q4, 2012, and the CY, 2012 ALOS.

ALOS (in days) by Selected Benefit Group

	Q3 2012	Q4 2012	% Change	CY 2012
MLIA	8.28	7.78	-6.03%	7.87
Family Single	7.47	7.16	-4.14%	7.10
ABD Single	9.40	9.25	-1.60%	9.29
ABD Dual	9.23	9.43	+2.17%	9.07

Conclusions – Inpatient Psychiatric Level of Care:

We began gathering data on the Adult population at the onset of the expanded contract in Q2 2011, so 2012 is the first year that we are able to calculate a Calendar Year ALOS. The ALOS for All Benefit Groups for Calendar Year 2012 is 8.30 days. The individual quarterly data has changed slightly over time. Admits/1,000 have been relatively stable, with dips in Q4, 2011 and Q4, 2012. Inpatient Days/1,000 peaked for this year in Q1, 2012 and have been decreasing slightly since. The ALOS (when removing Q2 2011) ranges from 7.90 days in Q3, 2011 to 8.63 in Q3, 2012, hovering around 8 days for the past year and a half.

ValueOptions implemented a number of strategies in 2012 to further enhance relationships with inpatient providers and to support their efforts to provide quality care to our members. Early in the year we introduced the Adult Inpatient Bypass program which provided administrative relief to many inpatient providers. We also hosted PAR meetings with the providers in April and September, and have created individualized PAR profiles that were brought to each facility for review and discussion. We have had the opportunity to organize ongoing, on-site rounds for complex adult members at Yale New Haven Hospital in cooperation with the LMHA; CMHC and have begun a pilot program in conjunction with St Francis Hospital that is providing new opportunities to impact discharge planning and connect to care for our members

Throughout 2012, we have spent much time continuing to build strong collaborations with providers. We plan to continue these efforts in 2013. We hope to replicate at other facilities the on-site rounds being conducted at Yale New Haven Hospital. We will continue holding the successful regional meetings we operated in 2012, inviting providers from across the continuum of care within the regions, including SNFs, Respite and Residential Rehab facilities. These meetings address ways to improve coordination of care. Finally, we are moving to have inpatient providers complete concurrent reviews on-line through our web based portal. It is expected that web-based concurrent reviews will decrease the time providers spend communicating clinical information telephonically, therefore allowing for more time to treat members and work with us to plan for discharge and return to the community for our most at-risk members.

Inpatient Detox – Hospital-based and Free Standing

Admits/1,000

The previously reported decline in admissions to hospital-based detox continued into the fourth quarter. A total of 79 Medicaid members received detox in hospital-based settings this quarter which is lower than Q3, 2012 admissions of 98. This trend, we believe, is related to our continuous efforts to authorize hospital-based detox only for those members who require medical management. In the last year and a half, we have worked diligently to educate providers about the distinction between 4.2 and 3.7 levels of care, and that we require evidence of medical risk factors to authorize this level of care. It appears that our efforts, along with the cooperation from detox providers, have made a significant impact on the decreased use of detox in a hospital setting. It is possible that some hospitals are having these services authorized through CHN, the Medical ASO. At this time, we are unable to determine the volume of such possible authorizations, but we have begun discussions with CHN to explore ways to insure that members are receiving the proper treatment, and that the authorizations are being managed in a way that most effectively insures appropriate connections to follow up care.

Overall, Admits/1,000 to Free Standing detox programs have continued to remain relatively stable since the initial quarter this data was collected. Each quarter, there are approximately 2,200 Medicaid members admitted to Free Standing detox programs. Consistent with previous quarters, HUSKY D had the highest number of Admits/1,000 in Q4 2012, utilizing detox at a higher rate than all other benefit groups combined. There was, however, a slight decrease in Admits/1,000 for HUSKY D, preserving the slight declining trend that began in Q3 ‘11.

Days/1,000

In 2011, HUSKY D and HUSKY C (ABD Single) had the highest Days/1,000 in Hospital-based Detox programs, far exceeding the Days/1,000 for other benefit groups. At this time, although HUSKY D and HUSKY C (ABD Single) continue to have the highest Days/1,000, the difference between benefit groups

has been noticeably reduced. Overall, there has been a gradual decrease in Days/1,000 because fewer and fewer HUSKY D and HUSKY C (ABD Single) members are utilizing this level of care and length of stay has remained the same.

The Days/1,000 at Free Standing Facilities has remained relatively stable quarter to quarter, for each benefit group. Similar to past quarters, HUSKY D had the highest Days/1,000 in Q4, 2012 and for the Calendar Year. While HUSKY D members represent the highest number of Days/1,000 of any eligibility group in Q4; there was a decrease in Days/1,000 in Q4 2012 when compared to Q3 2012. We will continue to monitor this measure for trending purposes.

Average Length of Stay

The average length of stay for all Medicaid members who received detox in a hospital setting was 4.58 in Q4, 2012 and 4.54 for the Calendar Year. The ALOS in 2012 for Hospital-based detox is about half a day longer than Free Standing detox programs. When members with co-morbidities present for detox, providers must evaluate, monitor and, at times, treat medical conditions. often lengthening the time it takes to ensure a safe detox. ALOS for detox in hospital-based programs has fluctuated, but this fluctuation has appeared more pronounced in the last year. Hospital detox programs have very few admissions and the actual variance overall is not large. The longest length of stay was reported in Q2, 2011 at 4.89 and the shortest length of stay was reported in Q2, 2012 at 3.98.

At Free Standing detox programs, the average length of stay for All Benefit Groups was 4.04 days in Q4, 2012 and 4.07 days for the Calendar Year. The ALOS for the quarter and CY, 2012 are impacted by the ALOS for HUSKY D because this membership group continues to utilize Free Standing detox at a much higher rate than other membership groups. Protocol based detox continues to drive this ALOS. Efforts by clinical staff to challenge providers on the use of protocols will continue and we hope to that our encouragement of utilizing a more individualized approach will lead to system change.

Ambulatory Detox

Admits/1,000

As noted last quarter, the actual numbers of admissions remains relatively small, but the Admits/1,000 continue to rise for All Benefit Groups. In fact, actual admissions for All Benefit Groups and HUSKY D have more than doubled from the inception of data collection to the most recent quarter. As expected, HUSKY D members have consistently had the greatest number of admissions, followed by HUSKY A (Family Single). We are hopeful that members will begin to utilize community based detox more often. We will continue to work with providers and members to recognize the advantages of community based programs, especially when members do not seem to be making significant gains, despite multiple detox admissions.

Methadone Maintenance

Admits/1,000

Admits/1,000 have decreased from Q3, 2012 to Q4, 2012 for all graphed benefit groups, and now is slightly lower than the rate recorded in previous quarters. HUSKY D consistently has had the greatest number of admits, followed by HUSKY C (ABD Single), and HUSKY A (Family Single). In Q3 ’12, there was an increase in overall Admits/1,000 from Q2 ‘12. We were hoping to see this trend continue, but it did not. We consistently identify members as OATP and review this initiative with providers when OATP criteria is met, but it seems that these efforts to re-energize this initiative have not produced the desired

results. We would have preferred to see an increase in Methadone Maintenance Admits/1,000 and instead the overall trend shows a slight decrease in admits over time. The two challenges identified with the OATP protocol/methadone induction are that members are reporting more often that they prefer suboxone (rather than methadone) and that Releases of Information are not always signed by members to allow us to share substance abuse information with providers and ABH. While challenges persist with the utilization of this level of care, we are committed to working with our state partners and ABH to improve this process and additionally improve the rate of engagement in OATP.

Conclusions – Detoxification and Methadone Maintenance:

Substance abuse services authorized by ValueOptions are utilized most frequently by members with HUSKY D. In 2012, we continue to recognize that All Benefit Group totals are driven by the HUSKY D totals, which leads us to focus on this population when providing analysis. The table below shows the types of detox-related services authorized by VO for HUSKY D and the corresponding rates of Admission in Q3 2012 and Q4, 2012, and Calendar Year 2012.

Admits/1,000 for HUSKY D

	Q3 2012	Q4 2012	CY 2012
Hospital- based detox	.24	.17	.26
Free- standing detox	6.23	5.88	6.22
Ambulatory detox	.42	.49	.41
Methadone Maintenance	2.86	2.49	2.65

In 2012, HUSKY D members utilized Free Standing programs far above other detox options and far more often than other Medicaid members. The hospital-based detox programs are reserved for members with actual or potential medical complications. We believe that our level of care determinations, in partnership with providers' commitment to treating members in the most appropriate level of care, have resulted in fewer hospital-based detox authorizations over time. It is important to note, however, that the number of admissions to hospital detox in 2012 remains small, so the reduction in admissions from quarter to quarter and overall is exaggerated.

In 2013 we will continue to devote our efforts to producing systemic changes that will lead to growth in Ambulatory detox admissions. Although the trend line for Ambulatory Admits/1,000 is positive (increasing over time), the actual numbers are still too small to suggest that systemic change has occurred. We will continue to work with providers at all detox programs to evaluate members' need for detox and authorize the most appropriate setting for the detox. In 2013, we plan to pay additional attention to those members who are not benefitting from multiple detoxes. We continue to collaborate with ABH as the managers of the HUSKY D Residential Rehab services for coordination and discharge planning. In addition, we continue to collaborate with ABH to insure invigorate the Opiate Agonist Treatment Program (OATP) for members addicted to opiates. We will problem solve with members, providers, state agencies and CCAR to ensure that members have their best opportunity to respond to recovery resources in the community.

Home Health Services

Admits/1,000

An admission is recorded for a first-time authorization for services by a provider to a specific member. Home Health Skilled Nursing Admits/1,000 decreased by 16% this quarter, representing 93 fewer initial authorizations than last quarter (491 vs. 584). This total is also lower than the 505 admissions in the 2nd quarter. It is consistent across all high-utilizing payer groups, with the exception of Husky A Single, which was essentially unchanged. It is likely that this indicator will have minor fluctuations in the future, barring a significant change in the number of home health providers or significant changes in practice patterns. Most members receiving home health services have existing authorizations with VO so any new authorizations will come from new members receiving the services for the first time or from members who change service providers.

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

Given that Admits/1,000 reflects only first-time authorizations, the indicator is not particularly useful in describing utilization management efforts with this level of care. For that reason, we have performed a detailed, claims-based review of the frequencies of MedAdmin service utilization since Q2 '11. MedAdmin services have been the focus of considerable utilization management activity, with the intention of insuring that members receive only services that are medically necessary, and that they are moving toward Recovery. The UM activities have been directed at reducing high-frequency services, when possible, and assisting in moving members toward greater autonomy. (Because this analysis is claims-based, Q2, 2012 is the most recent period for which data is available.)

From Q1, 2011 to Q2, 2012, the number of members receiving Home Health services rose by 4.29% (4,617 - 4,815). During this same period, however, there has been a 15.4% decrease in the percentage of members receiving twice daily (B.I.D.) medication administration services (from 25.9% of members in Q1, 2011 to 21.9% of members in Q2, 2012). Once daily (Q.D.) MedAdmin visits increased by 16.3% during this same period (from 29.5% in Q1, 2011 to 34.3% in Q2, 2012). This change was anticipated as providers responded to the intensive work by clinical care managers and the utilization management strategies to focus services on Recovery principles. Results for all service frequencies are shown in the table below:

	Members Served	% at BID	% Between	% at QD	% Lower
Q1, 2011	4,617	25.9	10.1	29.5	34.4
Q2, 2012	4,815	21.9	9.1	34.3	34.7
Change	4.29%	-15.44%	-9.90%	16.27%	0.87%

From Q1, 2012 to Q2, 2012 there was a slight increase of 0.7% of members receiving twice daily (B.I.D.) MedAdmin and slight increase of 1.3% of members receiving Daily MedAdmin. There was a decrease of members receiving Between B.I.D. and daily MedAdmin by 1.2% and members receiving Lower than daily by 0.3%. The slight increase in B.I.D. MedAdmin utilization is reflective of increased utilization on the part of approximately 11.7% (6 of 51) of the home health care providers. These identified providers are receiving more intensive review and education by the clinical care managers. On-site trainings are being provided to train home health staff on the recovery model, evaluating capacity for self-management, and skills transfer. In addition, a supplemental clinical attachment was developed for medication administration authorizations, providing guidelines for documenting member level of impairments, interventions, and results of skills transfer assessment.

Conclusions – Home Health

Current data indicates that changes are occurring in the practice patterns for MedAdmin services with the members. These changes are the result, we believe, of concerted efforts to partner and collaborate with provider agencies, and the successful introduction of Recovery principles and values. We believe there is room for bending the curve while ensuring that members are receiving the optimum benefit from the service.

Future analyses are planned to determine any relationship between reduction in MedAdmin frequency, re-hospitalization rates, and connection to other community services for members. To this end, we have initiated a Peer Pilot program with our largest provider and have designated a Regional Network Manger to the Home Health program to improve care coordination between home care agencies and other levels of care.

Partial Hospital Programs:

Admits/1,000
See Appendix

Conclusions – Partial Hospital:

Results for PHP did not warrant separate analysis this quarter. There were 970 admissions to PHP this quarter, a slight decrease from last quarter. When reviewing year over year, Admits/1,000 and Days/1,000 are relatively flat across this level of care. We continue to utilize PHP as a step down from inpatient and a step up when lower levels of care have been ineffective. We continue to anticipate that as our diversion efforts intensify, that PHP admissions will rise.
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Intensive Outpatient

Admits/1,000
See Appendix

Conclusions – Intensive Outpatient:

Intensive Outpatient was moved to the Appendix this quarter, as recommended in the previous report. HUSKY D members continue to utilize IOP at the highest rate, followed by HUSKY C (ABD Single),

HUSKY A (Family Single), and HUSKY C (ABD Dual). Admissions have remained relatively flat over the past year for All Benefit Groups, with little variation for any eligibility group. A more thorough analysis of this level of care has been completed by the Quality department related to 2012 Performance Target 2 findings.

Outpatient Services:

Admits/1,000
See Appendix

Conclusions – Outpatient Levels of Care:

This level of care did not warrant analysis in this quarter. Utilization data between 2011 and 2012 were unremarkable, revealing no significant changes in utilization. As a result the graphs have been placed in the Appendix. In the future, we hope to review claims data to understand better how many sessions members are attending, and which provider/clinic is actually providing the outpatient care when there are multiple authorizations on file. Claims data will be an aid in developing creative strategies to better manage this level of care.

Mental Health Group Homes

Admits/1,000
See Appendix

Days/1,000
See Appendix

ALOS
See Appendix

Conclusions – Mental Health Group Homes:

This level of Care did not warrant analysis in the current quarter. There were only 22 admissions to Mental Health Group Homes in Q4, 2012, with an overall Admits/1,000 rate of .02. That rate has been consistent for the past three quarters. There is a finite number of beds to utilize and often there are few openings because the ALOS tends to be extended. As stated last quarter, authorization data will only provide an accurate measure of ALOS when overall LOS is greater than the time period for which CT BHP has been authorizing care. This has not yet occurred, evidenced by the consistent increase in ALOS. We will continue to collaborate with providers and DMHAS to ensure that Medicaid members are receiving supportive and effective treatment in this level of care.

RECOMMENDATIONS:

Inpatient Recommendations and Upcoming Planned Strategies --

1. Increase Diversion Efforts - We have consistently worked with Emergency Departments to ensure that members are diverted from higher levels of care when we believe a member would not

benefit from an inpatient admission. In the upcoming year we expect to intensify our diversion efforts. We will have to work creatively and collaboratively with each Emergency Department to develop specific diversion strategies together. Some suggested strategies include: additional on-site interventions with members by ICMs and Community Peers, producing and utilizing an alternative LOC (23 Hour Obs, PHP) vacancy report, and coordination with ABH for HUSKY D members. In addition, we currently are developing proposals for two possible interventions regarding high volume utilizers of ED services. First, we have held an initial consultation with one hospital ED about the possibility of initiating a pilot project involving peer services to connect in the ED with high-volume users. Second, we have held an initial discussion with one hospital that reports it has reduced utilization by approximately 40% by developing community treatment planning and providing wrap-around care coordination.

2. Improve Regional Communication and Expectations Related to Discharge Planning - Regional "Connect to Care" meetings have been held across the state in an effort to bring inpatient and community providers together to identify gaps in the continuum of care and develop plans to address those gaps. In 2013, we will hold additional regional meetings, specific to adult services, to aid providers in planning seamless, consistent transitions from higher levels of care to community based programs. Many inpatient providers have already highlighted a lack of outpatient prescribers, possibly leading to members not receiving symptom alleviating medication, and potentially leading to psychiatric de-compensation. Once this problem is understood better, we can begin working with providers to plan more effectively for these transitions, most likely enlisting the help of local ECCs and/or inviting additional APRNs to join the Medicaid network.

3. St Francis Pilot - The St Francis Pilot, went live in January, 2013. This initiative is a joint endeavor including staff form St Francis and VO; A VO ICM and Peer are working on-site at St Francis to meet with members and staff, working collaboratively and creatively to provide realistic and clinically appropriate discharge options. Medicaid members who are stable enough to attend a discharge planning group are identified by St Francis staff. During the group, ICM, Peer services and CT BHP's overall role in the care of the members is described. To date, Members have seemed receptive and eager to talk about discharge options in the community. The Peer, in particular, has supported members in the community to ensure a safe and smooth transition to aftercare services. Data collection has begun and we will monitor the progress over the next few quarters in order to provide confirmation that this intervention has been effective .

4. Review and update the Adult Inpatient Bypass program - Re-determination for participation in the Bypass program occurred in August 2012. Continued participation will be assessed biannually going forward. The indicators for bypass status include 30 day readmission rates, ALOS, and the percentage of discharges communicated to the CTBHP. Bypass criteria was not changed in August, but redefining the Bypass program parameters will again be considered in February, 2013. Inclusion/exclusion criteria will be re-evaluated in terms of their ability to provide relief of the administrative burden of frequent reviews for the hospitals, as well as for ValueOptions clinical staff. Further, we are planning to have the Bypass hospitals utilize our web-based technology and enter concurrent authorization requests directly on the web. This change will allow providers to enter their requests at their convenience, thereby improving administrative efficiency, allowing hospitals to reallocate their resources to more creative discharge planning.

5. Adult PAR program - All Adult Q3, 2012 PAR meetings have been completed. Regional Network Managers have successfully met with each inpatient program to deliver individual PAR profiles. An Adult Subcommittee has also been formed and the first meeting will be held on 2/22/13; participants include several adult inpatient administrators, state partners and RNMs. The goal of this subcommittee meeting is to review the PAR profiles and offer input before the next round of PAR reports are delivered in March.

6. Improve Communications with Skilled Nursing Facilities. When the Adult Average Length of Stay is analyzed, we often look more closely at factors that we believe influence the LOS. One factor we look at is the age of the member when admitted to a hospital. We have found that the 55+ population has a longer stay than the stay recorded for younger adults. We believe that the longer length of stay is explained by two contributing factors: members experiencing complex co-morbidities often take longer time to stabilize and lengthy processes related to making referrals for SNFs, including times when SNFs will not allow members to return and a new referral is needed. Skilled Nursing Facilities are not authorized by VO, yet they are relied on to provide treatment and housing for Medicaid members across the state. An initial step in the training process took place on 1/16/13 when Leading Age Connecticut presented information to VO staff regarding admission and discharge regulations for SNFs. Understanding these regulations has helped prepare us to have informed clinical discussions with inpatient providers and Skilled Nursing Facilities. In the next year, we will take the following steps to ensure that SNFs become more formally integrated into the continuum: invite SNFs to participate with other regional providers to identify gaps in services, ask SNF providers to attend an informative meeting at CT BHP at which time the ICM and Peer programs will be explained and program services will be offered. We look forward to the opportunity to work collaboratively with SNFs; to better understand their challenges as well as successes when treating Medicaid members with mental illness.

7. Remove Q2, 2011 data from graphs and analysis - The inpatient ALOS in Q3, 2011 was anomalous. This was the first quarter that we collected data, and the ALOS in this quarter is confounded by the limited timeframe for which ALOS was measured (max ALOS of 90 days) because the admission and the discharge had to occur within the quarter. As a result, the Q2 '11 ALOS is not comparable to that calculated for other quarters.

Inpatient Detox Recommendations and upcoming planned Strategies --

1. Focus on discharge planning - As stated above in the inpatient recommendations, there have been several regional meetings to identify connect to care barriers and plan for better transitions from higher levels of care to community based programs. In addition to working with State partners, ABH, and CCAR to help providers plan for members' discharge, we believe it would be beneficial to hold similar regional meetings to better understand gaps in the Substance Abuse continuum and what is needed to address the identified gaps. There are multiple step-down options for members, both traditional and non-traditional; it is critical that we promote the use of the resources available to members so that transitioning to a community based program is seamless.

2. Utilize readmission report to coordinate better with ABH - A report has recently been developed at the state's request that identifies OATP eligible members and tracks readmissions to detox (post-OATP eligibility). For the members who have multiple readmissions post OATP, we will make ICM and Peer referrals as appropriate, as well as ensure that HUSKY D members are being followed and supported by ABH ICMs. ABH has agreed to add their authorization information and ICM identification to this report which will provide a more comprehensive authorization and ICM "story." This report is a good example of the efforts VO and ABH make in collaboration to serve our members effectively.

3. Increase Diversion Efforts - As stated above, we will utilize a new readmission report to assign high risk cases to ICM/Peer Support Services and to improve coordination with ABH. In 2013, we also expect that members who are at the highest risk for readmission will be identified so we can offer support and community based treatment options. If a member does re-present for inpatient detox following multiple inpatient detoxes, we can begin to offer safe and appropriate alternatives (e.g., ambulatory detox). In the upcoming year, we will work closely with detox providers, DMHAS, and housing programs to ensure that the system can adjust to the proposed changes.

4. Organize Suboxone Referral List. As suboxone is becoming a more acceptable treatment for members who are opioid dependent, efforts are underway to identify who in the CMAP network is currently providing suboxone and supplemental treatment, and which individual providers and clinics would like to provide suboxone and supplemental treatment in 2013. . It is unnecessary for members to travel to a program for daily dosing, making this treatment less disturbing to daily life and reportedly less stigmatizing for members. In the upcoming months, we will provide and maintain a comprehensive list of providers who prescribe suboxone and the outpatient programs supporting and treating members on suboxone.

Partial Hospital and IOP Recommendations --

1. Track and trend PHP utilization to determine areas for future discussion. This is a continuation of a recommendation from last quarter. We may be able to use this measure in the future as a basis for how we determine if diversions from inpatient units are occurring.

2. Continue the process of evaluation and study of the IOP service level as agreed upon with our state partners in order to gain a better understanding of the efficacy and potential impact that this level of care adds to the delivery system.

Home Health Recommendations --

1. Continue planned focus on claims data, including review of any relationship between hospitalization rates and changes in visit frequency for members receiving MedAdmin services.

2. Continuation of pilot project with New England Home Care, embedding a VO Community Peer with a NEHC nursing team to enhance connection to community resources. The purpose is to reduce member reliance on nursing care and MedAdmin services. Development of outcome measurement reporting protocols has begun as an integral component of the project.

3. Continue and expand provider based recovery and skills transfer training for home health nurses to enhance nursing skills related to motivational interviewing and member centered, goal focused care plans. The training program currently in place is directly related to the home health authorization process, integrating the recovery model and techniques for evaluating members' current level of functioning and engagement. Future programs will identify step-by-step procedures to provide and measure success with skills transfer, including the use of incremental behavior change. In addition, training will incorporate motivational interviewing techniques specifically tailored for work with the behavioral health population and in the context of a home health care nursing visit.

4. Ongoing collaboration with prescribers and provider agencies for determining appropriate frequencies for medication administration services. Level of care guidelines are being reviewed to determine that they match the intentions of the Partnership.

   A Regional Network Manager (RNM) has been dedicated to the home health program as part of the UM activities with this level of care. The RNM serves as a resource to the providers regarding authorization questions and level of care/medical necessity needs. The RNM provides outreach to the home health provider agencies to improve care coordination between home care agencies and other levels of care as part of the overall strategy to identify and address gaps and barriers in the service system.