UTILIZATION MANAGEMENT FOR ADULT MEMBERS

Executive Summary & Analysis by Level of Care

Calendar Year 2017: January-December 2017 - Submitted March 1, 2018

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This report was created by Beacon Health Options on behalf of the CT Behavioral Health Partnership. However the opinions, conclusions, and recommendations contained herein are solely those of Beacon Health Options, and may not represent those of DSS, DMHAS, and DCF.

UTILIZATION REPORT FOR ADULT MEMBERS

Calendar Year 2017: January-December 2017

Reports

General Overview

On at least a semiannual basis, the reports mutually agreed upon in Exhibit E of the CT BHP contract are submitted to the State for review. The shift to semiannual reports was designed to minimize noise created by quarter-to-quarter fluctuations that do not reflect a true trend in the data. The March deliverable serves as the annual report and covers four consecutive years of utilization data. The September deliverable covers 10 consecutive quarters with a focused analysis on the most recent two quarters, but may include the past four if there is information necessary to review that had not been analyzed previously.

This report focuses on the utilization management portion of these reports, evidenced in the 4A series, which reviews utilization statistics such as admissions per 1,000 members (Admits/1,000), days per 1,000 members (Days/1,000), and average length of stay (ALOS).

Within this interactive report, all utilization data is available via drop-down filters, but the narrative highlights the areas of interest related to certain utilization trends. In some cases, demographic breakouts are available to enhance the understanding of utilization. Additionally, the narrative identifies the underlying factors, which drive the trends and associated programmatic responses taken by Beacon Health Options to impact/mitigate or support the trend. Beacon also presents recommendations to address remaining challenges and reports progress related to these planned recommendations. The areas of focus for this deliverable are listed on the following page.

Methodology

The data contained in this report are based on authorization admissions and are refreshed for each subsequent set of updates during the year. Due to changes in eligibility, the results for each quarter or year may change from the previously reported values. The reports and analyses for all levels of care are affected by this change. Please note that utilization metrics may change with the refresh of the data. Therefore, the reader should be cautious when interpreting the latest quarter of data. The contractor will monitor the post-refresh changes closely. If warranted, methodology will be revisited.

The methodology for membership totals remains unchanged. For the Total Membership counts, each member is only counted once per quarter, even if he/she changes eligibility groups or experiences gaps in eligibility. For instance, if a member changes benefit groups within the quarter, that member is included in the totals for each benefit group, but only once for the total membership. This methodology is referred to in the graphs as “Unique Membership”. For the benefit groups, members are counted in each group in which they were eligible during the time period (quarter or year). This means that the individual benefit group membership counts cannot be added to obtain an overall total since members can shift between benefit groups.

The methodology for calculating age has changed, resulting in a slight shift in adult and youth membership totals. Previous to this report, counts for adults and youth were based on if a member met that age criteria during the time period. This meant that youth who were both 17 and 18 years old in a quarter were counted in both the adult and youth totals. In order to allow for the drill-down of demographic and age information, it was required that members be counted in only one group during a time period. Age group is now based on the age that a member was for the majority of the time period (quarter or year). Other demographics such as gender and race/ethnicity are based on the most recently updated eligibility. These demographics will update as needed as we want to report on the most accurate gender or race/ethnicity that a member identifies with.

Additionally, while unchanged from previous reporting periods, it is worth noting that the per 1,000 measures compare the utilization rates of the population to the population’s “member months”. This means that when viewing the Admits/1,000 of HUSKY D members the rate is based on the number of admissions within the HUSKY D population, not the entire adult population. This helps to analyze which populations are potentially more chronic, acute, or in need.

EXECUTIVE SUMMARY REPORT FOR ADULT MEMBERS

Calendar Year 2017: January-December 2017

The information in this report demonstrates that we continue, overall, to bend the utilization curve in Connecticut. Additionally, with our new Annual Rates Dashboard, which includes Per Member Per Month (PMPM) rates, we hope to offer insight into where Beacon is bending the cost curve by level of care in CY 2018. Please note that while the Provider Analysis and Reporting (PARs) program and assignment of clinicians by need has been effective to the above efforts, it will be important to pivot to more substantive outlier management techniques and value-based payment strategies to continue to improve clinical outcomes and programmatic efficiency.

Total Membership

In CY 2017, the Medicaid membership continues to be predominately adults without dual Medicaid/Medicare coverage. Adults comprise 61% of the total Medicaid membership. There was a slight (4.1%) increase in the adult members without duals, which is accounted for by the 4.6% increase in the Q4 '17, after being stable for several quarters. Whereas after increasing over the last five (5) years, the adult dual membership decreased in 2017 by 2.7%.

Membership Demographics

The Department of Social Services (DSS) made changes at the end of 2016 to the system where members entered their demographic information. The system, known as ImpaCT, allows members greater access and selection options for various demographics including race and ethnicity. This change has had an impact on race and ethnicity numbers for 2017 as it relates to prior years. Therefore, for this iteration of the Semiannual Utilization Report, demographics related to age and gender will be discussed if relevant for all years and race/ethnicity will be discussed for 2017 as a new baseline for future reports when applicable. More information on this system can be found here: http://portal.ct.gov/dss/Common-Elements/ImpaCT.

In CY 2017 and consistent with previous years, females (56%) comprise the majority of the adults without dual Medicaid population. Most (27%) of the adult Medicaid members are ages 25-34, which is consistent with previous years. With respect to race/ethnicity, 40% of the adult membership are White. In 2016, the percentage of adults that were White was 46.1% and although it appears that the reduction between 2016 and 2017 is due to changes in how this information is collected and greater numbers of "unknown" race/ethnicity, it is likely to impact subsequent analyses regarding proportionate access based on race/ethnicity.

Members ages 65 and older, without dual eligibility, saw the greatest increase (78%) in their membership between 2016 and 2017. There has been minimal change in the race/ethnicity for much of the adult membership but the Unknown category increased by 23% between 2016 and 2017. As mentioned above, Beacon believes this increase is due to the changes in DSS's ImpaCT system and how members can now identify their race/ethnicity perhaps more accurately.

Benefit Membership

Consistent with previous years, HUSKY D is the largest Medicaid benefit group followed by HUSKY A. HUSKY D members are predominantly White, males, ages 25-34, which has remained unchanged year over year. While on the other hand, the majority of the HUSKY A members are females with similar demographics – White and ages 25-34.

The HUSKY D membership continues to increase with a 9% change between CY '16 and CY '17. HUSKY C Single (LTC and ABD) increased as well, with LTC single having the most significant increase. The anomalies identified in the benefit package data specific to HUSKY A and D assignments in the last semi-annual submission in September 2017 were resolved by October 2017.

The re-classification may account for some of the increase observed in the HUSKY D population. The increase is seen during both Q3 and Q4 '17. While HUSKY A had an overall increase (3%) between CY '16 and '17, after increasing in Q1 '17, the membership trended down for the remainder of the year.

For HUSKY D members, the largest growth was in the 18-24-year-old age group, which experienced a 20% increase between CY '16 and CY '17. By contrast, the HUSKY A membership saw a more substantial increase in the 55-64-year-old age group by 36%.

Inpatient Psychiatric Hospital Utilization

In CY '17, the discharges from inpatient psychiatric hospitals tended to be HUSKY D members (6,282), followed by HUSKY A members (2,531). HUSKY D members have been consistently higher and this is the second year that HUSKY A had more discharges than HUSKY C. HUSKY A discharges increased by 31%, while the HUSKY C discharges decreased by 13%. Overall, the discharges are predominantly male and in the age group 25-34 years old. The number of discharges remained flat from CY '16 to CY '17, but has been trending down on a quarterly basis since Q2 '17.

The average length of stay (ALOS) increased by 0.4 days, from 8.5 days in CY '16 to 8.9 days in CY '17. After the ALOS decreased in Q2, it increased in both Q3 and Q4 to the highest quarterly ALOS to date (9.6). (See graph on next page)

The ALOS had been the same for men and women in CY '16; however, in CY '17, the men on average stayed longer with an ALOS of 9.1 days. The men's ALOS increased slightly (0.6%) more than the females' (0.2%) when comparing CY '16 to CY '17. The two oldest (55-64 and 65+) age groups historically stay the longest and account for the largest increase in Q3 and Q4 '17. The 18-24 year olds follow with an ALOS of 9.1 days in 2017, which increased in Q3 and then remained stable in Q4.

The average length of stay for in-state hospitals range from 5.4 days at Charlotte Hungerford Hospital to 16.4 days at Prospect Rockville Hospital. Other providers that had longer average lengths of stay were Yale New Haven Hospital (12.2), Prospect Waterbury (11.9), and Hospital of Central CT (11.3). The performance in CY '17 is consistent with CY '16.

Both the average acute days and the average overstay days have increased in CY '17. The total acute days for in- and out-of-state psychiatric hospitals was 7.8 days in CY '15 and increased to 8.6 days in CY '17. The total days awaiting a state bed increased from 26.9 days in CY '15 to 38.2 days in CY '17. Fewer state beds due to previous state budget cuts and longer lengths of stay appear to account for this increase. Additionally, the volume of outliers (those staying greater than 40 days) increased from 93 in CY '15 to 167 in CY '17. These outliers tend to be in the 25-34-year-old age group and diagnosed with schizophrenia.

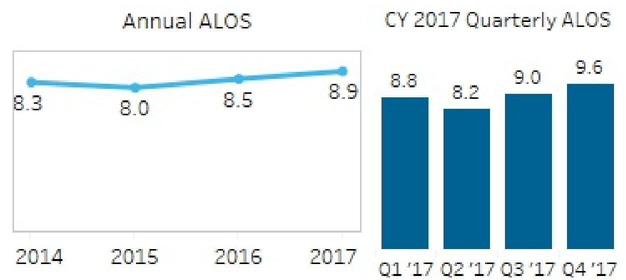
From the data shared in the Provider and Analysis Reporting (PAR) Program, the 7- and 30-day readmissions rates, for in- and out-of-state hospitals, continue to improve from year to year, with CY '17 being the lowest to date at 5% for 7-day and 16% for 30-day readmission rates. The vast majority of members who readmit return for inpatient psychiatric treatment and the members are predominately men (over 60%).

Recommendation 1: Continue Adult Inpatient PAR Program
In Q3 and Q4 2017, the Regional Network Managers (RNMs) continued to hold Provider Analysis and Reporting (PAR) meetings with the adult inpatient psychiatric hospitals. Clinical and Medical Affairs staff from Beacon joined the RNMs when applicable to participate in the PAR discussions. These conversations provided an opportunity to better understand the varied clinical philosophies and approaches of the treatment teams at different hospitals and to facilitate progress by sharing where individual hospitals stand in comparison to the statewide group.

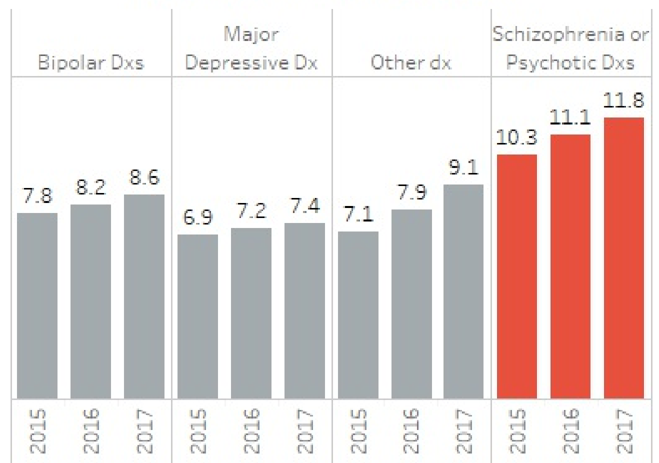
There continues to be notable variation across the network in regards to ALOS so in many instances PAR discussions focused on hospital specific performance including barriers and best practices for achieving and/or maintaining an efficient length of stay. Hospitals identified the following barriers influencing longer lengths of stay: physician turnover and/or use of locum tenens, access to residential rehab and intermediate beds, homelessness, probate hearings, geriatric population, ECT, and DDS involvement.

In 2018, Beacon will begin conducting an analysis of length of stay to identify case mix indicators affecting length of stay, with the goal of refining our PAR methodology to adjust for conditions that are more complex. Enhancing our case mix methodology will allow for even richer discussions as the data will either validate and/or challenge a provider's perception about factors influencing their performance.

Inpatient Psychiatric Facility (Excl. State) ALOS
Adults - Excluding Duals



Inpatient Psychiatric Facility (Excl. State) ALOS
by primary identified diagnosis group



The largest age group of discharges with schizophrenia or psychosis are 25-34 year olds.

	Schizophrenia or Psychotic Dxs		
Age Group	2015	2016	2017
18-24	574	585	565
25-34	861	845	883
35-44	516	497	475
45-54	511	480	450
55-64	252	260	310
65+	21	35	37
Grand Total	2,735	2,702	2,720

Discharges with a length of stay greater than 40 days also tend to be ages 25-34. In fact, 60% of the outliers in 2017 had a primary schizophrenia or psychotic diagnosis.

Age Group	2015	2016	2017
18-24	24	40	39
25-34	22	36	46
35-44	13	13	25
45-54	16	12	24
55-64	17	17	31
65+	1	3	2
Grand Total	93	121	167

Recommendation 2: Modify Inpatient Bypass Program
In 2018, as a part of our outlier management initiative, Beacon plans to begin work on revising the current Bypass Program and create new targets or metrics to address both member and facility outliers. At this time, we continue to measure Bypass status based on ALOS (<=8.2 days), 7-day readmission rates (<=6%) and discharge form completion rate (90% form completion in 2 business days).

Inpatient Detoxification – Hospital Utilization
In CY ’17, similar to inpatient psychiatric hospitals, the discharges from inpatient detoxification hospital-based were predominantly HUSKY D members (2,719) followed by HUSKY A members (443), but at a significantly lower volume. HUSKY A members being the second highest in terms of discharges is a change from previous years when it was typically HUSKY C. HUSKY A discharges increased by 52%, while the HUSKY C discharges decreased by 12%. Overall, the discharges are predominantly male and in the age group 45-54 years old. The number of discharges increased by 6% to a high of 3,448 in CY ’17.

The ALOS in CY ’17 was unchanged from previous years at 5.4 days. Men and women have a similar length of stay, and the 55-64 year olds stayed, on average, the longest at 5.8 days. Danbury Hospital had the longest average length of stay at 7 days followed by Yale New Haven Hospital (6.3), and Hartford Hospital (6.2).

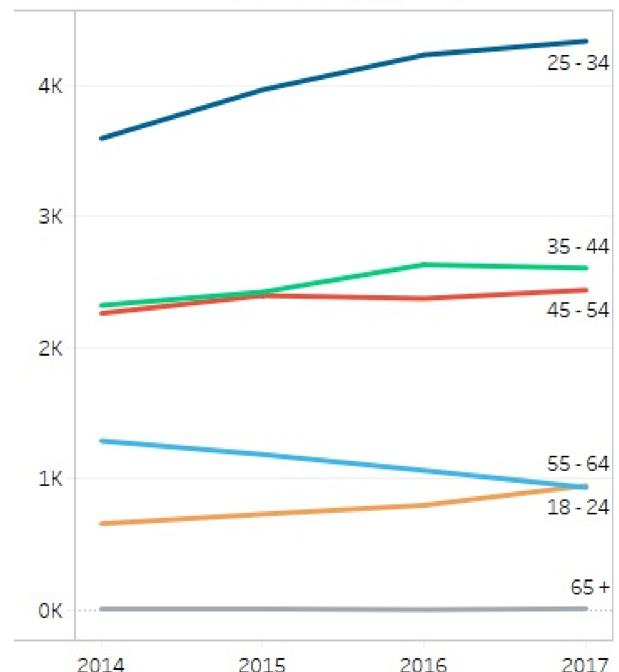
From the data shared in the Provider and Analysis Reporting (PAR) Program, the total readmissions rates for all providers increased for the 7-day rate (10%) and remained the same year-over-year for the 30-day readmission rate (28%). The vast majority of members who readmit return to detoxification treatment, opposed to inpatient psychiatric treatment, and the members who readmit were mostly men ages 45-54.

Recommendation 3: Continue Hospital-based Detoxification PAR Program with high volume facilities
In 2017, the Regional Network Managers continued to engage hospitals in reviewing their inpatient medical detox data. While many hospitals were agreeable to formal Inpatient Medical Detox PAR meetings, a few requested the data be sent to them electronically. A challenge for this level of care is that often members receive treatment on medical floors across the hospital, which can make identifying and engaging the appropriate hospital leadership difficult. In each PAR meeting that was held, demographics, ALOS, readmission rates, and connect to care rates were discussed but the variable that impacted the data most frequently was that discharge forms were not being put in, thereby skewing the data. This presented an opportunity for Beacon to explain the impact on the dashboard as well as to remind medical detox providers of the benefit of discharge calls that Beacon clinical staff make if they have discharge information accessible.

Moving forward, as mutually agreed upon with the state partners, Beacon will target the high volume facilities such as Yale and St. Francis, which account for approximately 40% of discharges statewide. Meetings with lower volume facilities will be held only if indicated. A continued focus of the discussions with hospital based detox providers will be on increasing utilization of Medication Assisted Treatment (MAT) for both Alcohol Use Disorder (AUD) and Opioid Use Disorder (OUD).

Recommendation 4: Continue to Provide Education to Providers
The Clinical Supervisors, Clinical Care Managers (CCMs), and Co-Management CCMs continue to provide case consultation and differential diagnosis support to all hospital-based detoxification providers in determining which Administrative Service Organization (ASO) is the correct ASO to authorize this level of care. In February 2018, Beacon is hosting a webinar and all inpatient and residential rehabilitations providers will be invited to learn how to enter the discharge form and set a Health Alert for the member’s appointment reminder, medication reminder, and filling a prescription reminder. The Clinical Liaisons continue to make multiple connect-to-care efforts to all the members for whom we have received a discharge form.

Inpatient Detoxification – Freestanding Utilization
Consistent with the other inpatient levels of care and across the years, freestanding inpatient detoxification discharges were far more frequently to be HUSKY D (9,335) than other benefit groups. HUSKY A was the next highest benefit group with 1,515 members discharging in CY ’17 and this was a slight increase (14%) from CY ‘16. The majority of the discharges were men ages 25-34-years-old with minimal change in the demographics or volume of discharges year over year.



The ALOS was stable over the last three (3) years at 4 days but increased in CY ’17 to 4.2 days . The increase in ALOS occurred in Q1 ’17 and then increased again in Q4 ’17 to 4.3 days. Men and women have the same ALOS. Aside from the few (12) discharges ages 65+ with an ALOS of 5.1 days, the next two age groups (45-54 and 55-64) had an ALOS of 4.4 days, which was only slightly longer than the other groups. Stonington Behavioral Health had the longest average length of stay at 4.8 days followed by MCCA (4.7) and Recovery Network of Programs (4.7).

From the data shared in the Provider and Analysis Reporting (PAR) Program, the total readmissions rates for all in-state freestanding detoxification providers increased for both the 7-day rate (3% in 2016 to 5% in 2017) and the 30-day readmission rate (16% in 2016 to 19% in 2017). The vast majority were males, ages 25-34 and readmitted to detoxification treatment.

Recommendation 5: Continue Provider Workgroup Meetings and PAR Program
In Q3 and Q4 ‘17, Beacon continued to meet with the freestanding detoxification facilities to engage in discussions about the PAR measures used in Inpatient Psychiatric and Inpatient Medical Detox dashboards, which include ALOS, readmissions, AMA (leaving Against Medical Advice) rates, discharge form completion, and connect-to-care rates. While the ALOS range is relatively small, the 7-day readmission rate and AMA rate vary across the network. With the newly added diagnostic breakdown by primary Substance Use Disorder (SUD), Beacon was able to highlight the need for a different treatment philosophy to better manage the high AMA rates correlated with an Opioid Use Disorder (OUD).

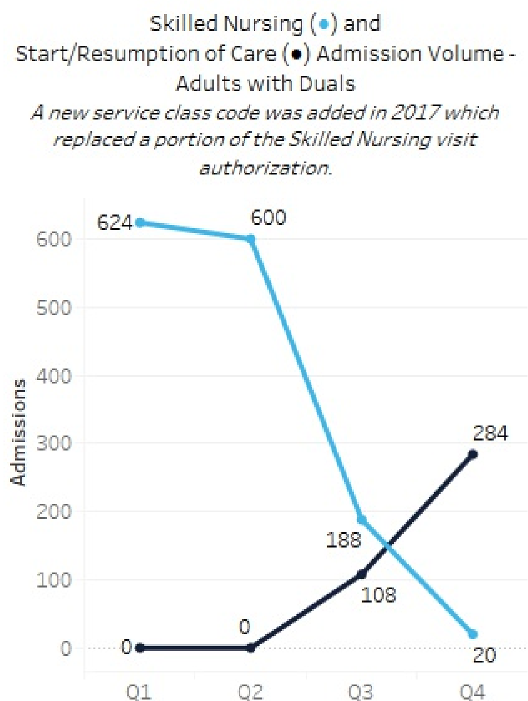
The focus of the most recent PAR cycle and statewide workgroup was engaging freestanding detox providers in a meaningful conversation about evidence-based practices for addiction treatment, such as induction onto Medication Assisted Treatment (MAT) for members with OUD. Having the data to support this conversation and to show the high AMA rates of members with a primary diagnosis of OUD when compared to those with a primary diagnosis of Alcohol Use Disorder, has strengthened provider interest in shifting treatment philosophies and even taking action to operationalize a new approach. While there is variability amongst the seven free-standings in terms of readiness to change practice, all received the same message that was well supported by individual data and all were open to next steps in addressing the raised concerns.

An additional area of focus during the most recent PAR cycle was on developing relationships with MAT providers in the community for a warm hand-off post withdrawal management on detox. The warm hand-off to Medication Assisted Treatment is not only a better member experience, but it is also a better connect to care practice that is likely to reduce relapse and readmissions. Again, while there is variability amongst freestanding providers depending on provider concentration in the region, their own continuum of care, and existing partnerships with community providers, all had a favorable response to the Beacon’s efforts to partner on joint next steps.

Development and implementation of Medication Assisted Treatment induction and warm hand-off, as well as other best practices to reduce AMA rates and readmissions and increase connect to care rates, will continue to be areas of focus during PAR meetings in 2018.

Home Health Utilization
In CY ’17, the start of authorizations (admissions) for Medication Administration is consistent with previous years for all members including duals. The HUSKY C (ABD/Other Dual) members’ admissions are consistently higher than other benefit groups, despite trending down slightly since CY ‘15. Also consistent with previous years, in CY ’17, 45-54 is the age group that most frequently has authorizations for Medication Administration.

The authorizations for Skilled Nursing continued to decrease in CY ’17. This was to be expected due to the addition of a new service class for Start of Care/Resumption of Care. Changes to the billing and authorization processes for home health services required a separation of services for a Start of Care/Resumption of care, 60-day recertification review and Skilled Nursing visits. Under the new guidelines, 60-day recertification reviews no longer require prior authorization and are billed with a new code exclusive to this service. This service was previously authorized as a Skilled Nursing Visit. Start of Care and Resumption of Care services were also previously billed as a Skilled Nursing visit, and now have a new code exclusive to these services. The use of a Skilled Nursing visit is now limited to a once weekly pre-pour of medications, in home wound care for members receiving behavioral health services or a full nursing assessment in the event of a change in condition. The utilization for the Start of Care/Resumption of Care has steadily increased since starting in Q2 ‘17. Since the Skilled Nursing/Start of Care/Resumption of Care are authorized in conjunction with Medication Administration, the trends by benefit and age group are the same for Medication Administration.



Home Health Prompting, Home Health Aide, Med Box and Med Tech requests for new authorizations continued to decrease in CY '17. Providers report the most significant barrier to increasing utilization of Home Health Aide prompting to be logistical barriers and insufficient staffing.

In order to provide the most up to date information, Home Health claims are presented as quarterly data during this submission. The annual data will be in the next submission on September 1, 2018. Progress continues to be made in decreasing the BID rate, as appropriate, and the QD rate increases. Despite the decrease in BID rates, the rate of utilization of emergency departments, observation beds and inpatient admissions remain stable across the measurement periods. The gap between Statewide Medication Administration volume and the volume for the high volume provider continues to decrease.

Recommendation 6: Continue Home Health Bypass Program
Beacon has continued the Bypass Program for home health agencies. The Bypass Program provides administrative relief for both Beacon and home health agencies while promoting practice change that will benefit members and improve the efficiency of Home Health services. The agencies on bypass are authorized for longer periods of time, thus decreasing the number of concurrent reviews required for an episode of care. The Bypass Program eligibility criteria includes achievement of a BID medication administration target rate.

In addition, Beacon has established a Bypass Plus Program last year which includes the achievement of a BID medication target rate and an emergency department (ED) utilization rate. The home health agencies provided positive feedback regarding this newly added measure during our last all home health agency statewide meeting. Beacon continues to review opportunities to enhance the Bypass parameters to further incentivize providers to decrease member reliance on homecare services.

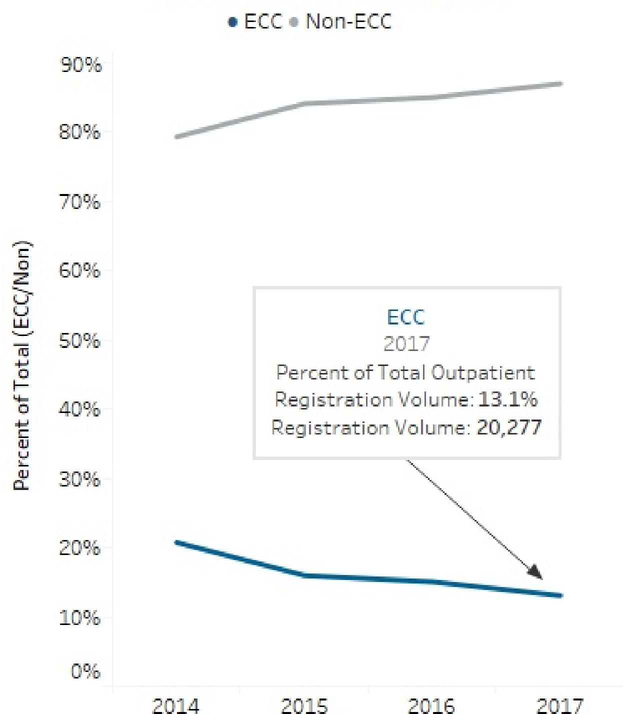
Beacon has continued to work with providers to achieve these goals. Beacon has continued to collaborate with providers regularly to review and monitor their status within the Bypass Program and discuss the tools to support the reduction of the BID rate. This year, home health agencies have increased their utilization of the Home Health Prompting service which has supported the reduction in the BID rate.

Lower Level of Care Utilization
Outpatient admissions continued to increase in CY '17. The rate of increase was slightly lower in CY '17 (8%) as compared to CY '16 (17%). Additionally, Intensive Outpatient (IOP) increased in CY '17 (6%) at a similar rate to previous years.

Enhance Care Clinics (ECCs)
The total non-ECC registration volume (inclusive of both adults and youth) continues to steadily increase year-over-year, while the total ECC volume remains relatively flat. This trend is consistent with the data specific to the adults as well – Non-ECC registrations continue to increase, while the ECC registration remains relatively flat.

The routine and emergent access standards have been consistently met for the last four (4) years. While the urgent access standard does not appear to have been met in CY '17 it is on account of Q4 '17, which is below the expected standard. It is anticipated that once this quarter is addressed with the providers and corrected for approved data entry errors the access standard will be met.

Recommendation 7: Assess ECC initiative
The ECC program has been operating unchanged for many years. Beacon recommends reviewing the ECC initiative regarding the choice and operationalization of ECC program metrics, a cost-benefit analysis, opportunities to incorporate value based payment methodologies, and opportunities to broaden the initiative so it applies to a greater percentage of members served in outpatient clinics.



Enhanced Care Clinics (ECC) Appendix Summary Pg 1: Quarters 3 & 4: June-December 2017

Summary includes analysis of both adults and youth

Provider Compliance for Q3 and Q4 2017

NOTE: Catholic Charities closed their New Britain Enhanced Care Clinic in Q4 '17. Therefore, there were 37 ECCs in Q3 '17 and 36 in Q4 '17.

Routine Access compliance with the 14-day standard for the ECCs fell into the following categories:
1. Met the access standard of 95% in **Q3**: 33
2. Met the access standard of 95% in **Q4**: 34
3. ECC falling below the 95% Routine Standard:
   - Child and Family Agency of SE CT – Essex: 85.71% in **Q3 '17**
   - Connecticut Renaissance Norwalk: 92.06% in **Q3 '17**
   - Hartford Hospital IOL: 90.00% in **Q3 '17**
   - Middlesex Hospital Child: 94.74% in **Q3 '17**
   - Family and Children's Aid: 92.50% in **Q4 '17**
   - Hartford Hospital IOL: 90.91% in **Q4 '17**

Urgent Access compliance with the 2-day standard for the ECCs fell into the following categories:
1. Met the access standard of 95% in **Q3**: 37
2. Met the access standard of 95% in **Q4**: 32
3. ECC falling below the 95% Urgent Standard:
   - Child and Family Agency of SE CT New London/Groton: 85.71% in **Q4 '17**
   - Child and Family Guidance Center Bridgeport: 75.0% in **Q4 '17**
   - Community Health Resources: 50.0% in **Q4 '17**
   - McCall Foundation: 50.0% in **Q4 '17**

Emergent Access compliance with the 2-hour standard for the ECCs fell into the following categories:
1. Met the access standard of 95% in **Q3**: 37
2. Met the access standard of 95% in **Q4**: 36

Interventions and Activities

Annualized Measure: Although the formal measurement period has been annualized, ECCs continue to receive data on a quarterly basis. This includes both quarterly and year to date totals for each access standard.

2017 Volume Exemptions: Will be addressed in the Q1 and Q2 '18 semi-annual report in order to allow enough time for the Q4 '17 data entry errors to be addressed.

Data Entry Errors: All agencies that did not meet the 95% access standard for the urgent or emergent measure in Q3 '17 were asked to review their data to verify whether those failures were data entry errors. In addition, any data entry errors that were unresolved at the time of the Q1 and Q2 '17 semi-annual report were resolved in Q3 and Q4 '17. Data entry errors for Q4 '17 will be addressed in the Q1 and Q2 '18 semiannual report.

The following agencies had data entry errors approved during Q3 and Q4 '17:
- BH Care Inc. Valley
- CT Renaissance Bridgeport
- Community Health Resources Manchester
- Mid Fairfield Child Guidance
- Middlesex Hospital Adults
- Family and Children's Aid

2017 Mystery Shopper Program: The following agencies were mystery shopped in Q3 and Q4 '17:
- Bridges: Passed
- Clifford Beers: Passed
- Mid Fairfield Child Guidance Clinic: Passed
- Connecticut Renaissance Norwalk: Failed
- Connecticut Renaissance Stamford: Failed
- Recovery Network of Programs. Passed; however, cited for quality of care concerns

Enhanced Care Clinics (ECC) Appendix Summary Pg 2: Quarters 1 & 2: January-June 2017

Connecticut Renaissance Norwalk and Connecticut Renaissance Stamford failed Mystery Shopper because three of the four calls place to the clinics exceeded the Mystery Shopper timeline of 24 hours for returning calls. Per PB 2007-44, same day screening is required on calls made to ECCs. There were also quality of care concerns to do with the lack of screening and triaging to assess risk as well as concerns to do with their answering service. Both clinics are currently on a Corrective Action Plan (CAP). Beacon will place follow up Mystery Shopper calls to the clinics in Q1 '18.

Agency on Probation in 2017: There are currently three agencies on probation because of the Mystery Shopper process.
● Child Guidance Clinic Bridgeport submitted a Corrective Action Plan that went through several versions of edits before final approval on November 17, 2017. A follow up Mystery Shopper call was placed in Q1 '18 and the clinic passed. A letter will be sent to Child Guidance Clinic Bridgeport shortly informing them of this update and that they are off probation.
● Connecticut Renaissance Norwalk and Connecticut Renaissance Stamford submitted Corrective Action Plans, which were reviewed at the ECC Operations meeting on January 18, 2018. The initial submissions were not approved as the Corrective Action Plans required further edits to properly address the cited issues. A call was held with Connecticut Renaissance on February 13, 2018 to review the updated Corrective Action Plans and to give feedback, which resulted in recommendations for further changes. The updated Corrective Action Plans for both locations were presented at the ECC Operations meeting on February 15, 2018 and were approved.

ECC Agency Activity in Q3 and Q4 '17: Five clinics received permanent ECC designation in Q3 '17 and Q4 '17:

Agency Name	Date of Permanent Designation
Connecticut Renaissance Norwalk	September 21, 2017
Connecticut Renaissance Stamford	September 21, 2017
Catholic Charities Waterbury	October 5, 2017
Catholic Charities Torrington	October 5, 2017
McCall Foundation	September 26, 2017

Catholic Charities Waterbury and Torrington: As a follow up to Catholic Charities receiving their permanent designation in Q4 '17, a letter was sent and follow up calls were done to understand how Catholic Charities was going to address the quality of care concerns cited in their adjustment of status letter. The quality of care concerns had to do with their processes for deferring psychiatric evaluations and for addressing highly scored mental health screenings that are part of their evaluation process.

Catholic Charities Waterbury and Torrington did not respond to initial outreach regarding this issue. A conference call was eventually held with the clinic on December 5, 2017. Based on the outcome of the call, Beacon and the State Partners have agreed to require both sites to submit four charts to ensure that the stated issues above have been addressed.

Catholic Charities NB/Bristol: This clinic closed on July 31, 2017, reportedly due to financial reasons.

Clifford Beers Clinic: There were multiple issues related to the clinic reporting non-ECC sites as ECC sites. There were several internal and external meetings with Clifford Beers in Q3 '17 to provide clarification about their active ECC sites.

Additionally, in Q4 '17 the clinic requested to temporarily stop admissions for monolingual Spanish speaking clients. The clinic reported an increase in monolingual clients and a shortage of Spanish speaking therapists. The request was reviewed at an ECC Operations meeting and the decision was made to have the clinic provide a monthly update on progress towards increasing capacity for monolingual clients. The monthly updates are reviewed in the ECC Operations meetings.

Connecticut Mental Health Affiliates (CMHA): This agency is planning to implement Open Access in their outpatient clinic, starting with a pilot beginning March 1, 2018. An extensive amount of time, including telephonic and in-person meetings, was spent in Q4 '17 providing technical assistance on the ECC requirements in the context of open access.

Q3 and Q4 '17 Meetings

ECC Operations: The standard monthly meetings were held throughout each quarter as well as many additional meetings in order to adequately address ad hoc ECC issues. Some of the issues addressed have been:

- Closing of Catholic Charities NB/Bristol on 7/31/17
- Clifford Beers – issues with ECC and non-ECC locations
- Edits to ECC Policy Transmittal language
- Data Entry Errors
- Mystery Shopper Calls
- Corrective Action Plans
- Quality of Care Concerns