UTILIZATION MANAGEMENT FOR YOUTH MEMBERS

Executive Summary & Analysis by Level of Care

Quarters 1 & 2 2018: January-June 2018 - Submitted September 4, 2018

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Connecticut BHP
Supporting Health and Recovery

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UTILIZATION REPORT FOR YOUTH MEMBERS

Quarters 1 & 2 of 2018: January-June 2018

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 two most recent 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 that 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 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. Beacon 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 YOUTH MEMBERS

Quarters 1 & 2 of 2018: January-June 2018

Membership

Overall Connecticut Medicaid membership has not had a quarterly change in either direction by more than 2% in the past two-and-a-half years. Membership (including those dually eligible) was stable in the first two quarters of 2018 (873,499 and 869,402, respectively). Adult members continue to account for 62% of the total Medicaid membership including duals.

The total youth membership (without dually eligible members) ages 0-17 has been extremely stable ending at 326,083 in Q2 '18. In fact, youth membership has only increased by 2% since the same quarter two years ago (Q2 '16).

Benefit/DCF Membership

The youth Medicaid membership continues to be largely youth ages 3-12 (57%), followed by adolescents ages 13-17 (26%), and youth ages 0-2 (17%). This has been consistent throughout recent quarters. Gender has also been consistent at 51% male and 49% female members. There have been race/ethnic changes since DSS's implementation of a new application system in 2016. Since that time, Beacon has seen a dramatic increase in the number of members as Unknown, or uncategorized. There is not an option for Unknown in the eligibility system, so while the increase in the Unknown population could be due to members not selecting a race or ethnic category, Beacon plans to investigate any other possible contributing factors. Currently in Q2 '18, youth identified as Unknown were 32% of the youth population, followed by Hispanic and White youth at 25% each. Black youth have been consistent around 13%, followed by 3% Other Races, and 2% Asian youth.

As reported in the prior semiannual deliverable, anomalies in the eligibility file related to DCF status were identified in 2017 and fixed for 2018, so while comparisons cannot be made to 2017, DCF information can be reported out for Q1 and Q2 '18.

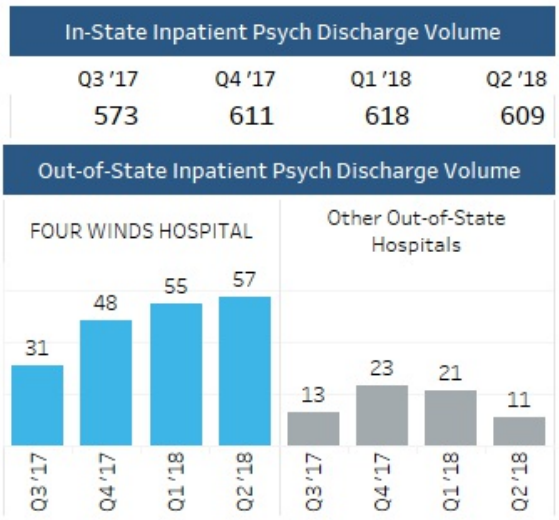
Non-DCF involved youth continue to make up 97% of the youth population in both Q1 and Q2 '18. The total membership of non-DCF involved youth has been relatively unchanged. Non-DCF youth followed a similar demographic pattern to the DCF population: slightly more 3-12 year olds (57%), similar percent of 13-17 year olds (26%), and slightly less 0-2 year olds at 17%. Males (51%) and females (49%) were also equally represented in the non-DCF population. As mentioned above, there has been an increase in youth characterized in DSS's eligibility system as "Unknown." For the non-DCF population, this has increased from 26% in Q4 '16 to 32% in Q2 '18. The portion of the non-DCF population identified as White has been decreasing and was 24% in Q2 '18. Black youth have had relatively consistent enrollment at 13% of the non-DCF population. Hispanic youth have also been consistently enrolled at 25%. Asian youth made up 2.5% of non-DCF membership and all other races made up 3.0% of the non-DCF population.

From Q1 to Q2 '18, the membership of DCF involved youth increased by 9.6% from 9,602 to 10,520, which was a similar volume to Q4 '16, prior to the DCF identification anomalies. DCF involved youth, in both quarters, were mostly 3-12 year olds (52%), followed by 13-17 year olds (27%), and 0-2 year olds (21%). Males and females were equally represented in both quarters. White youth are over-represented in the DCF-involved population at 30% (compared to 25% of the youth population) in Q2 '18 and youth identified as Unknown were slightly under-represented at 30% (compared with 32% of the youth population). Hispanic youth were slightly under-represented at 21%, and Black youth were slightly over-represented at 15% of the DCF-involved population. Asian youth were more significantly under-represented at only 0.4% of the DCF-involved youth.

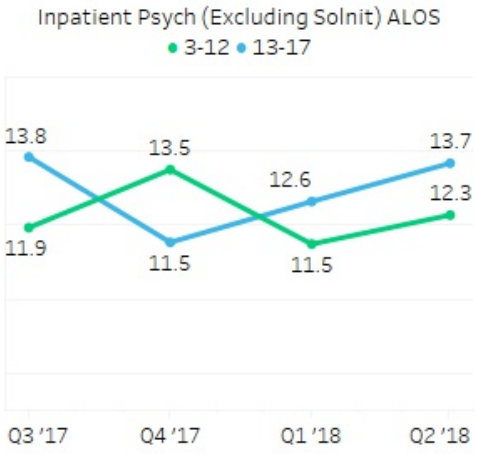
Inpatient Utilization (Excluding Solnit)

Medicaid youth utilize in-state, and a few select out-of-state, hospitals for inpatient psychiatric treatment. As of the start of 2018, there had been approximately 125 total in-state pediatric acute psychiatric hospital beds available between seven (7) hospitals (this excludes two non-acute hospitals: Albert J. Solnit Children's Center, also known as Solnit, and the Hospital for Special Care). Collectively, the in-state hospitals account for the vast majority of all discharges during any given year. The utilization of out-of-state inpatient psychiatric care is primarily at Four Winds Hospital, an in network facility over the Connecticut border in New York State.

Discharge volume for in-state and out-of-state inpatient psychiatric hospitals, excluding Solnit, has been stable the past three quarters near the 10-quarter average of 668. Discharge volume was 694 in Q1 '18 and decreased 2.4% to 677 in Q2 '18. There was a reduction in in-state psychiatric beds due to the closure of Prospect Waterbury's 6-bed adolescent unit on January, 25, 2018. Despite the reduction, overall access was not impacted, as there was a proportionate increase in volume of admissions to Four Winds Hospital.

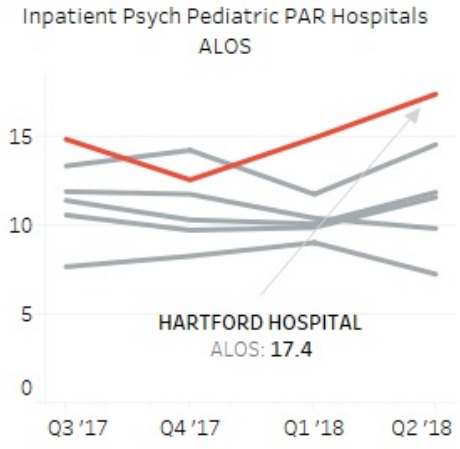


The average length of stay (ALOS) for all inpatient psychiatric discharges, excluding Solnit, was 12.6 days in CY 2017. ALOS remained stable from Q4 '17 to Q1 '18 at 12.3 days, but increased by 7.2%, to 13.2 days in Q2 '18. The increase in the total ALOS is attributed to an overall increase in delayed days, which went up 31% from Q1 to Q2 '18 (22.4 to 29.3 days). Acute ALOS had been trending down and only increased by 2.4% from Q1 to Q2 '18. The ALOS for adolescents increased the past two quarters up to 13.7 days in Q2 '18, which was over a day longer than youth ages 0-12 (12.3 days). The ALOS for DCF-involved youth also increased more dramatically than for non-DCF youth. The ALOS for DCF youth had been trending down recently and was 14.7 days in Q1 '18, but increased by 22.4% to 17.9 days in Q2 '18. This ALOS was 5.7 days longer than that of non-DCF youth in the same quarter.



For both in-state and out-of-state providers, as mentioned in prior deliverables, adolescents continue to account for the large majority of discharges; however, there continues to be a slight upward trend in the volume of younger youth ages 0-12 utilizing inpatient psychiatric treatment.

As aforementioned, most of the youth accessing inpatient psychiatric treatment receive that treatment in one of Connecticut's in-state acute facilities. Currently there are six (6) main pediatric hospitals that treat youth for psychiatric disorders; however, older youth may receive their treatment on an adult unit, which is also included in the in-state data. During Q1 and Q2 '18, over 66% of discharges occurred at the three largest in-state hospitals: Hartford Hospital, Natchaug Hospital, and Yale New Haven Hospital.



In-state acute inpatient discharges (excluding the Hospital for Special Care) remained stable over the past four (4) quarters (most recently 596 discharges in Q1 '18 and 592 discharges in Q2 '18). As mentioned above, Prospect Waterbury Hospital closed its adolescent unit, but overall in-state discharge volume was not impacted since other hospitals had subsequent increases in volume.

In-state providers, excluding the Hospital for Special Care, had an ALOS of 11.3 days in Q1 and 12.6 days in Q2 '18. The most notable change in ALOS was at Hartford Hospital, the third largest pediatric hospital in the state, which had an ALOS of 17.4 days in Q2 '18, almost five (5) days above the statewide average.

Only two (2) of the six (6) in-state pediatric hospitals had a decrease in ALOS from Q1 to Q2 '18 (Prospect Manchester and St. Vincent's Hospital). The Hospital for Special Care, due to being a specialty unit, has had variable discharge volume, but their ALOS has been decreasing.

The out-of-state discharge volume has been increasing over the past 10 quarters. In fact, volume reached a 10-quarter high in Q1 '18 of 76 discharges before decreasing slightly to 68 discharges in Q2 '18. The majority (78%) of out-of-state discharges in the first half of 2018 were from Four Winds Hospital. The ALOS at Four Winds has been exceptionally stable over the past four (4) quarters at around 16 days, which is much lower than prior years when their ALOS was around 20 days.

Recommendation 1: Continue to Monitor ED Overstay Cases Going Out of State
Beacon continues to monitor the ED overstay cases and the use of out-of-state hospitals. Beacon continues to outreach to the Pediatric EDs daily to identify youth in overstay and document rationale for why the youth is unable to access the recommended level of care. Beacon continues to monitor the data to identify any populations that tend to have more significant barriers to accessing care. In response to identifying ASD/IDD and DD as populations that experience longer overstays Beacon is developing an Intensive Response Team which will be discussed in more detail in Recommendation 15. Beacon is also involving peers and care coordinators while families are in the ED to help develop discharge plans that the family understands and helped to develop. Additionally, in conjunction with our state partners, we continue to explore opportunities to incent IP providers to accept more complex youth from the ED.

Recommendation 2: Continue Pediatric Inpatient PAR Program
The Regional Network Managers (RNMs) continue to hold PAR meetings with the pediatric inpatient hospitals to improve the quality of care and access to care for our Medicaid youth. Measures reviewed include demographics, ALOS, discharge delay, and readmission rates. In addition, a new measure of prescriptions filled within seven and fourteen days post inpatient discharge was recently added.

An ongoing focus of the PAR program is the increase in discharge delay in 2018. Beacon continues to promote active treatment of youth on an inpatient unit while on delay status, including an emphasis on family involvement and efforts to continue to stabilize the youth while awaiting the next recommended service. DCF has been invited to the recent PAR meetings as it relates to discharge delay concerns for DCF involved youth.

Additionally, the Regional Network Managers continue to work with the pediatric inpatient PAR hospitals to ensure that there is movement towards standardized substance use screening, triage, and referrals to treatment for youth with co-occurring mental health and substance use disorder (SUD). Best practices related to screening and referral to treatment was the focus of the Pediatric Inpatient workgroup held in April 2018.

Recommendation 3: Modify Youth Inpatient Bypass Program

Beacon has continued to offer a Youth Inpatient Bypass Program. In 2018, as a part of our ongoing evolution of our utilization management program, Beacon plans to revise 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 (<=12.0), 7-day readmission rates (<= 5%) and discharge form completion rate (90% form completion within 2 business days).

As part of the enhancements to the bypass program, Beacon is working towards further refinement of the case-mix adjusted length of stay measure in order to capture the clinical complexity of youth treated within inpatient facilities. In July 2018, Beacon held a workgroup with the state partners and several inpatient providers to brainstorm potential case mix indicators and methodology. A follow-up meeting will be held in the fall to collectively review data regarding the potential indicators and identify those with most impact.

Inpatient Discharge Delay

Youth on an inpatient unit that are unable to discharge to the next appropriate level of care are considered delayed. If a youth on discharge delay discharges in the quarter, they are classified as a "discharge," and any youth on delay during a quarter, regardless of if they discharged or not, is considered a "case." Beacon works closely with hospitals and community providers to ensure youth can access appropriate services as soon as they are clinically ready for them. Despite ongoing attention and collaboration with providers, there have been a number of system changes that have impacted the discharge delay measure in recent quarters.

As noted in the calendar year 2017 semiannual submission, the annual volume of all delayed discharges for youth ages 0-17 on acute inpatient psychiatric units, excluding Solnit and the Hospital for Special Care, increased by 14% from 109 discharges in 2016 to 124 discharges in 2017. During Q1 and Q2 of 2018, the volume of delayed discharges has continued to increase. In fact, there were 73 delayed discharges in Q1 and Q2 combined, which was greater than the 64 delayed discharges in Q1 and Q2 of 2017. The second quarter of 2018 hit a 10-quarter high with 40 delayed discharges.

Delayed cases have also continued to increase in Q1 and Q2 of 2018. The number of quarterly delayed inpatient cases was relatively flat the last three quarters in 2017, ending at 35 cases in Q4 '17, but increased to 41 cases in Q1 '18 and to 49 cases in Q2 '18, a 10-quarter high. Because there were 40 discharges, there are nine (9) cases that remain on discharge delay going into Q3 '18 (six waiting Solnit inpatient, one waiting for Solnit PRTF, one waiting for community PRTF, and one waiting for other services).

The average days a youth waited in the hospital for an alternate level of care has increased the past two quarters to 28.6 days in Q2 '18 with a total of 1,142 delayed days—the second highest total delay days over the past 10 quarters.

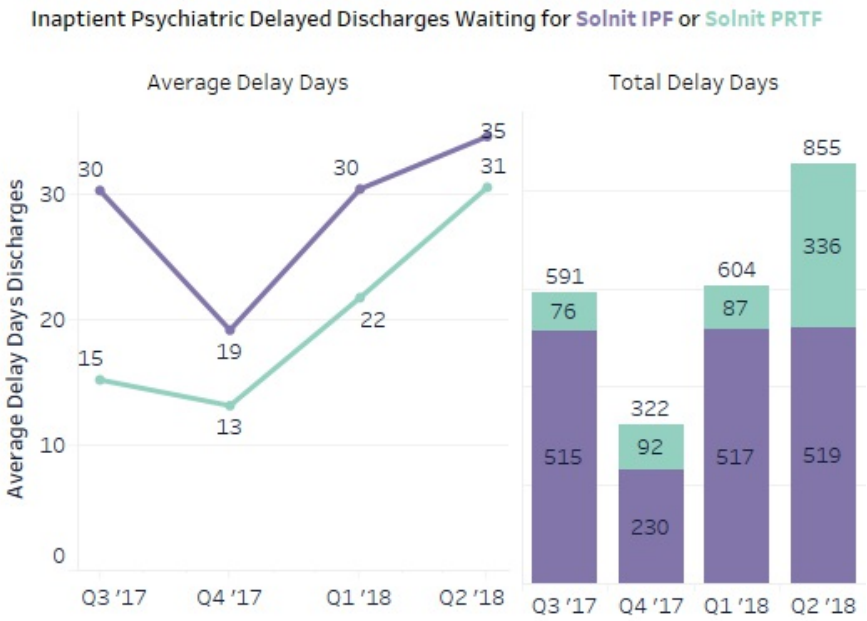
The overall percent of days delayed out of the total inpatient days for youth (cases) ages 0-17 in any psychiatric facility (excluding Solnit and the Hospital for Special Care) declined from 9.8% in 2016 to 8.4% in 2017, a rate almost identical to CY 2015. All four quarters in 2017 met the target of 10% or fewer days delayed. Both Q1 and Q2 of 2018 were above the target at 11.3% and 12.1%, respectively. In fact, in 2017, the percent of days delayed in Q1 was 9.3% with a reduction in Q2 to 6.7%. However, there was not a Q2 reduction in 2018, but instead an increase. Beacon anticipates that with many system changes, listed below, it is possible that the annual percent of discharge delay days will be higher than previous years due to longer wait times to access both Solnit IPF and PRTF. System phenomenon impacting discharge delay includes:

- A reduction in Solnit IPF unit capacity due to staffing resources and member acuity
- A reduction in unit capacity at Solnit North PRTF in March 2018 from 30-35 beds down to 29-30
- Boys & Girls Village PRTF holding on admissions beginning in early June 2018
- Boys & Girls Village PRTF announcing its closure in July of 2018 with all youth needing to discharge by October 2018
- Data showing that youth in PRTF and Solnit inpatient needing RTC or Therapeutic Foster Care experiencing more days in overstay is contributing to throughput issues

The programmatic factors above which impact discharge delay require significant action from the state and broader system to rectify, and meetings to brainstorm and identify needed system change and/or program development have initiated. These factors noted above are beyond the capacity of Beacon to singularly impact given our defined role and assigned responsibilities as the Administrative Service Organization in Connecticut. We remain engaged in problem solving and are assertively assigning resources to maximize the impact we can have (thought leadership, analytics and reporting, ICM/Peer program, corporate resources to brainstorm value based payment strategies and to share other experiences in other markets).

Similar to prior years and quarters, 75% (55 discharges) of the delayed discharges in Q1 and Q2 '18 combined were adolescents ages 13-17. Of the delayed adolescents, 58% (32 discharges) were waiting for Solnit Inpatient and 27% (15 discharges) were waiting for Solnit PRTF. For the first time, the number of male discharges waiting for Solnit Inpatient in Q2 '18 (9) as greater than the number of females waiting (6). The average wait for Solnit Inpatient was 30 days in Q1 and 35 days in Q2 '18. The average wait for Solnit during these two quarters was higher than the average wait during CY 2017, which was 27 days. The average wait for Solnit PRTF also has increased from 16 days in CY 2017 to 22 days in Q1 '18 and 31 days in Q2 '18.

All but one (94%) of the 18 delayed discharges for ages 0-12 were waiting for Community PRTF– 10 discharges were waiting in Q1 and seven (7) were waiting in Q2.



The quarterly total number of days youth spend waiting for PRTF has been on a steady increase. While the average days a youth waits for Community PRTF had decreased from 38 days in Q3 '17 to 12 days in Q1 '18, the average wait increased again to 22 days in Q2 '18. In summary, much of the increase in discharge delay metrics thus far in 2018 resemble values in 2016 more than they do the values from 2017.

Recommendation 4: Develop an intermediate/transitional unit as alternative to Solnit Inpatient
Over the past 18 months, there have been 86 discharges from an inpatient hospital (one of the seven inpatient facilities or Four Winds) on delay status awaiting Solnit inpatient. Those 86 youth waited a total of 2,446 days for the next level of care to be available, an average of 28 days per discharge. The impact of the delay is significant, most notably for the youth and family, as well for other youth who need inpatient treatment but may have to wait in an emergency department due to limited inpatient capacity. To assist with system throughput, Beacon is recommending the creation of an intermediate level of care as a concurrent resource to Solnit inpatient.

Recommendation 5: Increase PRTF capacity
There is ongoing need for increased capacity at the PRTF level of care, as evidenced by the discharge delay days awaiting PRTF. Beacon anticipates that discharge delay awaiting PRTF will only increase with the closing of the Boys & Girls Village PRTF and other situational factors at Solnit PRTF. Therefore, it is recommended that the CT BHP continue current efforts to expand the PRTF capacity for both youth and adolescents.

Solnit Inpatient Utilization
The quarterly discharge volume has been stable with 29 discharges in both Q1 and Q2 '18, which is exactly at the 10-quarter average. While the ALOS decreased from a 10-quarter high of 146 days in Q4 '17 to 136 days in Q2 '18, the ALOS is still higher than in previous years. In fact, the ALOS in 2016 was 115.6 days, which then increased to 129.1 days in 2017. Thus far for Q1 and Q2 '18, the ALOS was 140 days.

Historically, the majority of discharges were females (ranging from 53-73%). In Q2 '18, for the first time, there were more males discharged (55%). The ALOS continues to be higher for females by over 3 weeks. In the past two quarters the ALOS for males has increased while females have had a slight decline in the ALOS. Of the 58 discharges in Q1 and Q2 '18, only seven (7) were court-ordered (five males and two females; four Black, two White, and one Hispanic youth), and they had an ALOS of 61 days.

Excluding the court-ordered youth increases the Q1 and Q2 '18 combined ALOS to 151 days. Additionally, it brings the male and female ALOS closer together (males ALOS 142.6 days and females 156.9 days) for the two quarters combined. There was an increase in discharges for Black youth, although the overall numbers are small (11 in Q1 and 10 in Q2 '18). ALOS for Black youth decreased from Q1 to Q2 '18 to 103 days.

Solnit Inpatient Discharge Delay

The number of delayed discharges and cases at Solnit inpatient had been on an overall annual decline from CY 2016 to CY 2017. However, Q2 '18 had delay numbers that have not been seen since early 2016. There were only three (3) delayed discharges in Q1 '18, but there was a 133% increase in Q2 '18 to seven (7) delayed discharges and 10 cases.

At the current rate, CY 2018 has the potential to have the highest number of delayed youth over the past four (4) years. In CY 2016 there were 16 discharges and 19 cases delayed. This decreased slightly in CY 2017 to 14 discharges and 19 cases that were delayed. Thus far in 2018, there have been 10 delayed discharges and 13 delayed cases, which at half a year is approaching prior annual values.

All of the 10 youth (five males, five females) delayed in Q1 and Q2 '18 were waiting for congregate care--seven (7) for residential treatment (RTC) and three (3) for therapeutic group home. This has been the only delayed reason for the past four (4) quarters. Additionally, the average days a youth waits for an RTC or GH increased from 47 days in Q4 '17 to 89 days in Q1 '18, then decreased slightly in Q2 '18 to 79.6 days. Youths wait over two and a half months on average for placement in an RTC or GH. Also, the total delay days reached a 10-quarter high of 557 days in Q2 '18. Due to the increase in delay days and number of youth waiting, the average days in delay increased, but the acute ALOS did not. In fact, the acute ALOS hit a high in Q4 '17 of 140.5 days, but decreased in both Q1 and Q2 '18 (134.8 days and 117 days, respectively). Of note Solnit IP bed capacity has been 48 however as aforementioned due to staffing resources and acuity of the youth being served the capacity is temporarily being reduced by 8 beds to a capacity of 40 beginning in August 2018.

Recommendation 6: Continue Collaboration with Solnit Inpatient

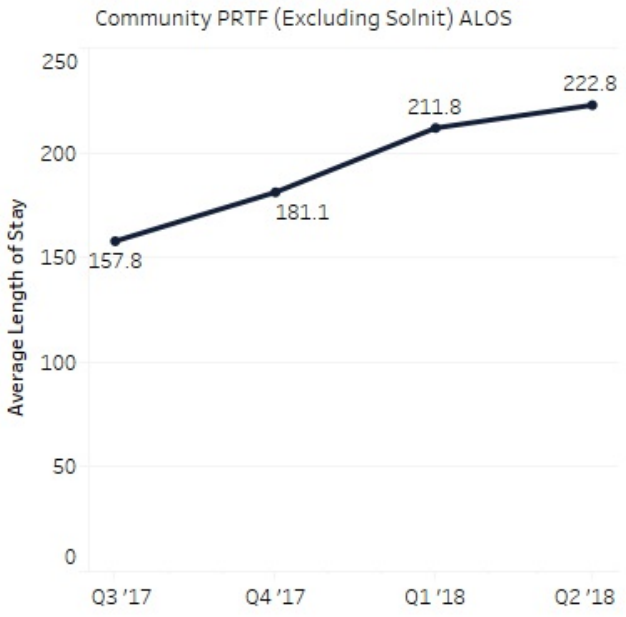
Beacon and Solnit continue to engage in a collaborative process around the clinical treatment and care of Medicaid Youth. The process of collaboration begins at time of initial referral and continues through to discharge. The Beacon ICM is present on site three days per week and participates in triage meetings, care planning, discharge delay/overstay rounds and attends Solnit's quarterly Utilization Review Committee. Solnit treatment teams have continued to reach out to Beacon's ICM regarding support/assistance needed as it relates to addressing barriers to discharge planning. Solnit has incorporated Beacon into the Summer Learning Series to inform new psychiatry fellows about the different programs available to Medicaid youth and families.

Recommendation 7: Begin to Hold PAR Meetings with Solnit Inpatient

As mutually agreed upon following the last semi-annual report, Beacon plans to hold PAR meetings with Solnit Inpatient. A tableau dashboard has been created specifically for Solnit Inpatient that includes data on discharges, length of stay, discharge delay, and readmission rates. A PAR meeting will be scheduled in the second half of 2018 to review the dashboard with Solnit.

Psychiatric Residential Treatment Facility (PRTF) Utilization

During Q1 and Q2 '18, there were three (3) Community PRTF providers in Connecticut with a licensed bed capacity of 47 (individual providers' capacity ranged from 14 to 17). The volume of Community PRTF discharges has been variable each quarter, typically spiking in the second quarter. Quarterly discharge volume dropped each quarter from Q2 '17 (28 discharges) through Q1 '18 (12 discharges), until it increased in Q2 '18 to 24 discharges. Utilization of Community PRTF over the past two quarters continues to be mostly males (67%).



The average length of stay (ALOS) has increased each of the past three quarters since a recent low in Q3 '17 of 157.8 days. Quarters 1 and 2 of 2018 had the two highest ALOS out of the past 10 quarters at 211.8 days and 222.8 days, respectively, increasing 17% from Q4 '17 to Q1 '18. There were seven (7) youth who discharged in the first two quarters of 2018 that had a length of stay greater than 300 days. In CY 2017, there were a total of nine (9) discharges that stayed over 300 days. More significantly, in CY 2017, 67% of youth discharged stayed between 0 and 180 days. Thus far in 2018, only 52% are discharging within 180 days, which means youth are staying longer on average, even if they do not hit the 300+ days category.

The Boys & Girls Village had a large increase in ALOS from 150.7 days in Q1 '18 to 282.3 days in Q2 '18. The Village for Children and Families and The Children's Center of Hamden both had a decrease in ALOS from Q1 to Q2 '18 after each hitting a 10-quarter high for ALOS in Q1 '18.

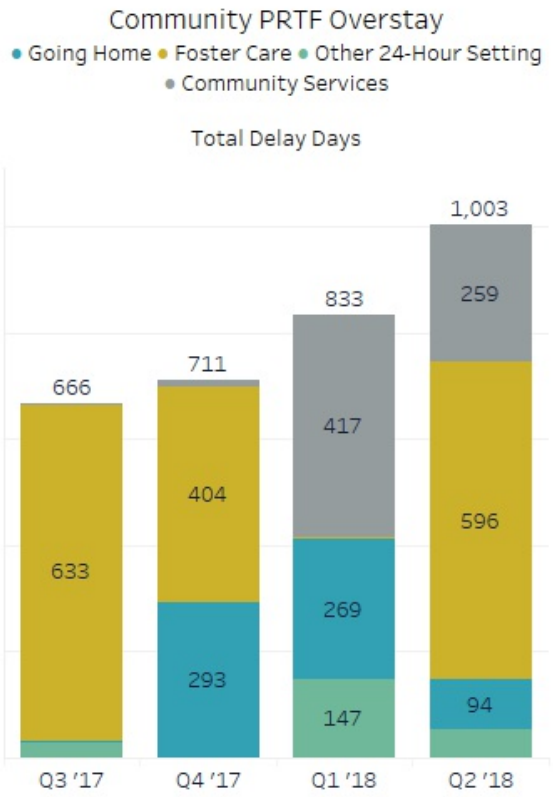
In Q2 '18, the Boys & Girls Village announced it would close its PRTF program and has since stopped admissions. Their plan is to discharge or transfer all children out of the PRTF by October 1, 2018. Undoubtedly, this will have an impact on both the Community PRTFs and the inpatient units where youth are often waiting for PRTF services to be available. Beacon is working with DSS and DCF to explore strategies for improving PRTF availability of care and expand capacity.

Recommendation 8: Continue to Share Data with the PRTFs on a Semiannual basis
As mutually agreed upon with the state partners, the PRTF PAR Program was discontinued. Beacon and DCF met with the Community PRTF providers in January 2018 for a workgroup meeting and will continue to meet with them annually to review the statewide annual data. In addition, the RNM will send the Community PRTFs their data and data details on a semi-annual basis.

Psychiatric Residential Treatment Facility (PRTF) Overstay
Total discharges in overstay at Community PRTF have been stable the past four (4) quarters: 12 discharges total in Q3 and Q4 '17 combined and 12 discharges again in Q1 and Q2 '18 combined. The total days in overstay for discharges has been incrementally increasing since the recent large drop in Q3 '17. In Q2 '18 there were 1,003 overstay days, which was the highest it's been since Q2 '17.

The total quarterly delayed cases has been declining. There were 12 cases on overstay in Q1 '18 and nine cases (9) in Q2 '18. Since there were seven (7) discharges in Q2 '18, this means there were two (2) youth in overstay in Q2 '18 that continued to be on overstay going into Q3.

While historically youth in Community PRTF on overstay were waiting for foster care, the trend has shifted. In fact, the reasons youth wait is highly varied with no one reason that stands out. Of the 12 discharges in overstay during the first half of 2018, two (2) were waiting for another 24-hour setting and two (2) were waiting for foster care. The remaining eight (8) were waiting for various community services.
Youth who wait for foster care, on average, wait longer than most other youth on overstay. While there were two (2) youth waiting for foster care thus far in 2018, the average wait was 298 days with 596 total overstay days. There was one (1) youth in Q1 '18 who waited 312 days for ABA services. It is worth noting that this information only captures the last reason for overstay and a youth may have had alternate planned treatment recommendations that the youth waited for prior to the final one that was reached at discharge.



Recommendation 9: Enhance Collaboration Between PRTF and Therapeutic Foster Care Agencies
DCF and Beacon continue to provide education to the PRTFs on appropriate next steps towards finding a foster care family, i.e. statewide recruitment, special recruitment, and for those agencies that also offer Therapeutic Foster Homes to work internally to identify viable families. In addition, DCF and the ICMs have collaborated to ensure that the PRTFs are identifying and including the right people in the provider meetings and family-teaming meetings. In addition to attending rounds at the PRTF facilities DCF and Beacon will reinstate PRTF weekly overstay and mid-stay rounds in September '18 that will include DCF Area Office Behavioral Health Program Directors, DCF Contract Managers and Beacon's Child Psychiatrist, ICMs, and Clinical Leadership. The goal will be to identify next steps and assign tasks to provide direction and clarity for the team and access to TFC closer to the time the youth is appropriate for discharge.

Recommendation 10: Enhance Marketing and Social Media Efforts to Increase Recruitment and Capacity in Therapeutic Foster Care
Currently, some regional systems have efforts underway that focus on foster care engagement and recruitment. For example, the Region 6 DCF Regional Advisory Board is planning to host an event focused on recruiting new foster care families and retaining current foster care families. Through the Regional Advisory Council (RAC) meetings, the Network of Care Manager and RNM will be supporting the RAC in the development of this event. The Region 2 South Central Network of Care (SCNC) is restoring its Foster Care workgroup and is currently exploring ways that the SCNC will support foster care as a priority area for the coming year.

Building off the success of the meeting that DCF held in 2017 with the PRTF and TFC agencies, next steps include connecting the PRTFs and foster care programs with their local regional network of care and/or coordinating presentations to share relevant data that can inform discussions about current system barriers and opportunities for collaboration. Building on previous recommendations Beacon will work to enhance collaborative relationships between various levels of care and TFC.

Recommendation 11: Develop a Value Based Purchasing Strategy for Therapeutic Foster Care
On-going meetings with Therapeutic Foster Care (TFC) leadership at DCF to continue to evolve initial discussions and to begin to construct a value based purchasing strategy designed to increase access to TFC, while improving outcomes at the same time.

Global Recommendation: Improve Connections with Regional Networks of Care in order to Improve Outcomes for Children and Families.
Since 2016, Beacon Network of Care Managers have been supporting the development of Regional Networks of Care in each DCF Region. The goal of each Network of Care is to increase collaboration among all child-serving systems in order to improve outcomes for children and families. In addition to providing information, resources and opportunities for collaboration, the regional Networks of Care can serve as a resource to address system needs such as those outlined in population-specific recommendations (i.e. ASD, foster care) and can provide opportunities to include community-based, non-traditional programs and families in systems-level discussions about current system challenges (i.e. system throughput, overstays). Each Regional Network of Care includes representation from their local community such as Community Collaboratives ("Systems of Care"), behavioral health providers, juvenile justice/LIST leads, schools, pediatric primary care, and family champions.

Solnit Psychiatric Residential Treatment Facility (PRTF) Utilization
Solnit PRTF is a state-run PRTF facility for adolescents ages 13-17 and has two locations in Connecticut—one that treats males (Solnit North) and one for females (Solnit South). Solnit North began the year with 30-35 beds and has since reduced to 29-30 beds, while Solnit South continued to have 24 beds throughout Q1 & Q2'18.

On average, Solnit PRTF has had 28 discharges each quarter. Discharge volume for the PRTFs increased by 22% in Q1 '18 to 28 discharges and again by 29% in Q2 '18 to 36 discharges. The recent spike in discharges was driven by Solnit North PRTF, which had 21 of the 36 discharges (58%) in Q2 '18. While admissions have been steady, Solnit North had to reduce their bed capacity due to unit acuity and needing to allocate more staff. Additionally, due to an incident at Solnit South's PRTF, admissions have recently slowed. Both of these factors may show a decrease in either admissions or discharges in Q3 '18.

The ALOS for both PRTFs has been on a general declining trend. The overall ALOS reached a high in Q2 '17 of 176.9 days, but has reduced to 131.5 days in Q2 '18. Solnit North PRTF (males) continues to have a slightly higher ALOS than the female unit at Solnit South.

Solnit PRTF Overstay
The volume of discharges in overstay at Solnit PRTF North and South combined has continued to be low. There were five (5) total youth in overstay that discharged in the first half of 2018, four (4) of which were from Solnit North. There were six (6) cases in overstay during the same time period, which means only one youth in overstay has not discharged.

Due to the continued decline in youth in overstay at Solnit's PRTFs, the total overstay days reached a 10-quarter low of 91 days in Q2 '18, which was for an overstay for one youth. The average days in overstay is variable each quarter due to the low numbers of youth waiting for the next level of care. Of the five (5) youth in overstay in the first half of 2018, three (3) were waiting for a therapeutic group home, one (1) was waiting for foster care, and one (1) was waiting to return home.

Recommendation 12: Over the next 6 months, the Solnit PRTF PAR program will focus on ALOS, overstay and transfers from PRTF to inpatient level of care
A PAR meeting was held with Solnit in the first half of 2018. This was the first PAR meeting utilizing the new Tableau PRTF dashboard. The focus of this meeting was on the reduction in average length of stay and overstay days for Q3 & Q4 2017, and transfers from Solnit PRTF to Solnit inpatient. The Solnit PRTFs discussed strategies they have implemented to target the length of stay, including discharge planning meetings and a more proactive approach to identifying potential barriers early into the PRTF stay. In addition, the PRTFs have been collaborating with the DCF area offices to ensure all parties are consistent with discharge planning and disposition.

The lower ALOS for Solnit PRTF South is partially driven by the transfers from PRTF level of care to Solnit inpatient. The percent of females transferred from Solnit PRTF to Solnit inpatient continues to rise. In the last PAR meeting, Solnit PRTF spoke to the acuity of these adolescent females, which is supported by the number of days spent in Solnit inpatient once transferred from Solnit PRTF. In Q3 & Q4 2017, there were nine transfers that accounted for 849 total inpatient days, an average of 94 inpatient days per transfer. Similarly, in Q1 & Q2 2018, there were 12 transfers, 10 of which were still inpatient as of the data run of this report in July 2018. Total days inpatient for these 12 youth already exceeded 1,400 and continues to grow until they all discharge. Beacon will be outreaching to Solnit PRTFs soon to schedule the next PAR meeting to review Q1 & Q2 2018 data.

Residential Treatment Center (RTC) and Group Homes
In-state RTC admissions have been variable over the past 10 quarters, ranging from 33 to 47 admissions per quarter. Most recently, there were 36 admissions to in-state RTC facilities in Q1 '18 and 37 admissions in Q2 '18. Out-of-state RTCs continue to be infrequently utilized – only five (5) out-of-state admissions occurred thus far in Q1 and Q2 of 2018 combined. Overall admissions to RTCs were flat (39 total admissions in each of the first two quarters of 2018).

The total (in and out-of-state) RTC ALOS was 229.7 days (for 45 discharges) in Q1 '18 and 275.3 days (for 43 discharges) in Q2 '18. The in-state ALOS has been relatively stable, with 233.8 days ALOS (for 44 discharges) in Q1 and 282.9 days (for 40 discharges) in Q2 '18. The majority of admissions are males and most are DCF involved.
Therapeutic Group Home (TGH) admissions increased from 101 in 2016 to 116 admissions in 2017, but again declined in the first two quarters of 2018 (16 admissions in Q1 and 19 admissions in Q2). The admissions thus far in 2018 are much lower than the same quarters in prior years, indicating that access has slowed down. The ALOS increased dramatically in Q1 '18 to 752.8 days and then decreased to 566.2 days in Q2 '18. Both quarters in 2018 were higher than any other quarter in the past two (2) years. The higher than normal ALOS was a result of three (3) discharges by youth ages 3-12 with exceptionally long lengths of stay, each over 1,500 days. Almost all of the admissions to both RTCs and TGHs are adolescents.

Recommendation 13: Monitor RTC utilization for possible outlier management
Beacon, in collaboration with DCF, was able to successfully transition the Monthly Treatment Plan Progress Reviews (MTPPRs) on May 1, 2018 from a manual authorization process to web based registration. By moving to a registration this allows DCF area offices immediate access to review MTPPRs in ClientConnect once submitted by an RTC. At this time, there is no indication for an outlier management program for RTC level of care.

Autism Spectrum Disorder (ASD) Services
The majority of youth accessing ASD services continue to be 3-12 years old and male for all service classes. Diagnostic evaluations and treatment plan and program book development are the two most frequently authorized services for ASD.

The ASD provider network continues to grow. From 2017 to 2018 thus far, there has been an increase in unique providers for every service class. As of Q2 '18, there were 44 unique providers offering Service Delivery. Connecticut Children's Specialty Group at CCMC continues to be the largest provider of Diagnostic Evaluation services. Able Home Care and A Piece of the Puzzle both had high volumes of Behavioral Assessments in Q1 and Q2 '18. Able Home Care provided the highest volume of Service Delivery authorizations in both Q1 and Q2 '18.

Recommendation 14: Collect data regarding authorization to first claim
ASD members receiving direct services continues to grow from 110 total new authorizations in Q1 '18 to 113 total new authorizations in Q2 '18, making up a total of 1,420 unique members connected to a provider in Q2 '18. This increase is explained by an overall growth in the provider network, for those providers who perform direct services. In Q1 '18 there were 155 providers enrolled and in Q2 '18 there were 175 (a total increase of 20), all of whom are able to perform direct services. While there has been a slight increase in agencies enrolling, most growth has been seen within agencies which now hire BCBAs, Licensed Clinicians and Behavior Technicians statewide to accommodate a greater area of need. In addition, by moving prior authorization requests to ProviderConnect, providers have reported having more time to do direct work versus administrative tasks during business hours. Autism Diagnostic Evaluation moved to web-based authorization requests in 2016. Following the success of this, Behavior Assessment, Treatment Plan Development and Program Book Development moved to web-based requested in January 2018. Beacon Health Options plans to move the remaining Service Delivery, Direct Observation and Direction and Group Treatment services to the same web-based authorization request process in September 2018.

Recommendation 15: Enhance supports to individuals in the Emergency Departments and Inpatient Settings: Beacon looks to enhance the system of care for members and families impacted by autism spectrum disorder, intellectual disability, and/or developmental disorders, in Q3 & Q4 '18 by implementing a new Intensive Response Team (IRT). The goals of this team are (1) to decrease frequency of emergency department visits and ED overstay; (2) to decrease inpatient psychiatric hospitalizations and length of stays in acute hospitals; and (3) increase 'successful' referral and connection to appropriate levels of care for this vulnerable population. In order to connect members to appropriate services in the home in a timely manner, Beacon plans to continue to grow the provider network. Beacon will also work to increase the quality of treatment provided to highly complex members by offering Learning Collaborative opportunities and CEU opportunities targeted at supporting these populations.

Lower Levels of Care

Quarterly outpatient admissions for youth follow a seasonal pattern, likely related to school and summer vacation. Admissions dip in the summer months of Q3 each year (July, August, September) and increase again in Q1 and Q2. Admissions hit a 10-quarter high in Q1 '18 (10,884 admissions), but decreased slightly in Q2 '18 as consistent with seasonal trends.

IICAPS admissions have been trending downward and reached a low of 498 admissions in Q1 '18. All other levels of care have been variable over the quarters; however, Partial Hospital Programs (PHP) and Intensive Outpatient Programs (IOP) have been trending upward while all other home-based programs (FFT, MDFT, MST) and Extended Day Treatment have been trending downward.

Enhanced Care Clinics (ECCs)

The total non-ECC registration volume (inclusive of both adults and youth) continues to steadily increase over time, while the total ECC volume has been on a slight decline. ECC volume has decreased by over a thousand registrations between Q1 '17 (5,698 registrations) and Q2 '18 (4,519 registrations). Quarter 2 of 2018 was a 10-quarter low for ECC registrations. Non-ECC registrations are now approximately 89% of all outpatient registrations. Youth ECC volume has been relatively stable, but often peaks in the first quarter of the year. Youth ECC volume was 2,450 in Q1 '18 and declined by 10.6% in Q2 '18 to 2,191 registrations.

The routine access standards have consistently been met each quarter for youth in ECCs, while there has been variability in the achievement of urgent and emergent access standards, fluctuating between meeting and slightly missing the 95% access standard. Both the urgent and emergent standard was not met in Q1 '18 (91.8% and 90.9%, respectively) and in Q2, the urgent measure was not met at 93.8%. This data does not factor in any updates to reported data entry errors, which are referenced in the ECC summary.

Recommendation 7: Assess ECC initiative

Over the past several months, there were many meetings held to discuss an ECC Redesign that addresses the operationalization of ECC program metrics, incorporation of value based payment methodologies, and opportunities to broaden the initiative. These meetings remain ongoing. Feedback to members of the Operations Subcommittee on the progress being made around these discussions is scheduled for Friday September 7, 2018.

Enhanced Care Clinics (ECC) Appendix Summary Pg 1: Quarters 1 & 2: January-June 2018

Summary includes analysis of both adults and youth

Provider Compliance for Q1 and Q2 2018

NOTE: There are 36 ECCs currently.

Routine Access compliance with the 14-day standard for the 36 ECCs fell into the following categories:
1. Met the access standard of 95% in **Q1 '18**: 33
2. Met the access standard of 95% in **Q2 '18**: 33
3. ECCs falling below the 95% Routine Standard:
   - Connecticut Renaissance Norwalk: 90.91% in **Q1 '18**
   - Family and Children's Aid: 90.40% in **Q1 '18**
   - Klingberg Family Comprehensive Services: 92.98% in **Q1 '18**; 68.63% in **Q2 '18**
   - Hartford Hospital IOL: 75% in **Q2 '18**
   - Middlesex Hospital ECC Adult: 93.75% in **Q2 '18**

Urgent Access compliance with the 2-day standard for the 36 ECCs fell into the following categories:
1. Met the access standard of 95% in **Q1**: 31
2. Met the access standard of 95% in **Q2**: 33
3. ECCs falling below the 95% Urgent Standard:
   - BH Care Inc. Valley: 0.00% in **Q1 '18**
   - Child and Family Agency of SE CT Essex: 66.67% in **Q1 '18**
   - Child and Family Guidance Center Bridgeport: 50.00% in **Q1 '18**
   - Community Health Resources: 75% in **Q1 '18**
   - Yale Child Study Center: 0.00% in **Q1 '18**
   - Charlotte Hungerford Adult: 75% in **Q2 '18**
   - CMHA (NW): 0.00% in **Q2 '18**
   - Yale Child Study Center: 77.78% in **Q2 '18**

Emergent Access compliance with the 2-hour standard for the 36 ECCs fell into the following categories:
1. Met the access standard of 95% in **Q1**: 35
2. Met the access standard of 95% in **Q2**: 36
3. ECCs falling below the 95% Emergent Standard:
   - Child and Family Guidance Center Bridgeport: 75% in **Q1 '18**
   - No ECC's fell below the 95% Emergent Standard in **Q2 '18**

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: No agency had a volume exemption applied in 2017.

Data Entry Errors: All agencies that did not meet the 95% access standard for the urgent or emergent measure in Q1 '18 were asked to review their data to verify whether those failures were data entry errors. Q2 '18 data entry errors are pending and will be addressed in the Q3 and Q4 '18 semi-annual report. Quarter 4 2017 data entry errors were all approved.

The following agencies had data entry errors approved for Q4 '17 and Q1 '18.

Q4 '17
- Child and Family Agency SE CT - Groton
- Child and Family Guidance Bridgeport
- Community Health Resources
- Mid Fairfield Child Guidance
- McCall Foundation

Q1 '18
- Child and Family Agency SE CT - Essex
- Child and Family Guidance Bridgeport
- Community Health Resources
- Yale Child Study

Enhanced Care Clinics (ECC) Appendix Summary Pg 2: Quarters 1 & 2: January-June 2018

2018 Mystery Shopper Program: The following agencies were mystery shopped in Q1 & Q2 '18:

- Catholic Charities – Torrington: Passed, however cited for quality of care concerns
- Community Health Resources – Enfield: Passed
- Central CT Child Guidance Clinic: Passed
- Charlotte Hungerford Center for Youth and Families: Passed
- Child and Family Agency of SE CT – Essex: Failed
- The Village for Children and Families: Passed, however cited for quality of care concerns

Follow up calls from Q4 '17 were also completed on Child and Family Guidance Bridgeport, Connecticut Renaissance Norwalk and Connecticut Renaissance Stamford. All three clinics passed allowing them to come off probation.

Child and Family Agency of SE CT – Essex failed Mystery Shopper in Q2 '18. The triage process was deemed insufficient because it was based on one question, which did not effectively tease out whether a call was routine, urgent, or emergent. In addition, given their limited open access hours, questions were raised around their ability to respond to urgent calls coming in on a Friday afternoon that may need to be responded to on the weekend. The clinic submitted a Corrective Action Plan, which was approved in July 2018.

Agencies on Probation in 2018: There are currently three agencies on probation. Child and Family Agency of SE CT – Essex is on probation as a result of failing Mystery Shopper in Q2 '18 as noted above. They will remain on probation until they pass a follow up call. The follow up call is scheduled to be completed in Q3 '18. Catholic Charities Norwich and Family and Children's Aid are on probation as a result of failing the 2017 Annual Measure. Both clinics submitted Corrective Action Plans which were approved at the ECC Operations meeting held on July 19, 2018.

ECC Agency Activity in Q1 & Q2 '18:
Hartford Hospital IOL ECC: Orientation of new interim supervisor upon the retirement of the former Director.
CMHA: Provision of support through meetings and consultation around their Open Access Pilot.
Clifford Beers Clinic: Meetings and consultations to address the agency's requests to approve seeing adult members in instances where clinics had now acquired adult licenses at ECC locations.

Q1 & Q2 '18 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 included:

- CMHA – Open Access Pilot
- Clifford Beers – Steps to address lack of enough Spanish speaking resources for client volume
- Clifford Beers – new request for approval of additional clinics with adult licenses
- ECC Redesign
- Edits to ECC Policy Transmittal Language
- Data Entry Errors and Challenges to How They Are Applied
- Mystery Shopper Calls
- Corrective Action Plans
- Issues with Attachment B's