UTILIZATION MANAGEMENT FOR ADULT MEMBERS

Executive Summary & Analysis by Level of Care

Quarters 1 & 2: January-June 2016 - Submitted September 1, 2016

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UTILIZATION REPORT FOR ADULT MEMBERS

Quarters 1 & 2: January-June 2016

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. This report covers 10 consecutive quarters with a focused analysis on the most recent two quarters. 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. However, as agreed, this semiannual report will continue to include quarterly level detail rather than a simple roll-up of six month periods. This achieves the balance of making sure that significant and meaningful quarterly fluctuations are not missed while maintaining a focus on more persistent trends. The format is displayed in Tableau, a more interactive data visualization product.

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 is 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 quarter are listed on the following page.

Select for List of Reports Used

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 may change from the previously reported values. The reports and analyses for all levels of care are affected by this change. Therefore, the graphical presentations of the data use a vertical line to designate a particular quarter as the most recent quarter that includes the refreshed data. 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.

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Table of Contents
Select Bookmark Icon to View "Areas of Focus"
And Go Directly to Selected Page

Areas of Focus

Membership & Demographics

Inpatient Facilities
Admits/1,000
Days/1,000
Average Length of Stay

Inpatient Detoxification: Hospital-Based
Admits/1,000
Days/1,000
Average Length of Stay

Inpatient Detoxification: Freestanding
Admits/1,000
Days/1,000
Average Length of Stay

Home Health Services
Admits/1,000
Medication Administration Frequency
Utilization Rates

Outpatient Enhanced Care Clinics (ECC)
Registration Volume
Access Standards

For this report, the following utilization data points have been placed in the Appendix and are not discussed:

Mental Health Group Home
Admits/1,000, Days/1,000 & Average Length of Stay

Partial Hospitalization Program
Admits/1,000

Intensive Outpatient
Admits/1,000

Ambulatory Detox
Admits/1,000

Methadone Maintenance
Admits/1,000

Outpatient Services
Admits/1,000

Inpatient Psychiatric Facility

Summary

Overview: After increasing for the last 4 quarters, the Admits/1,000 rate for the All Benefits Duals Removed group decreased for the first time since Q1 '15 in Q1 '16. This is being driven by the HUSKY D (MLIA) benefit group which is the largest benefit group and also has the most admissions of all benefit groups. The 25-34 age group had the largest volume of admissions and discharges of all the age groups. Days/1,000 generally follows the Admits/1,000 trend. The ALOS has remained around 8 days for the last 10 quarters, although from Q4 '15 to Q1 '16 there was a slight increase in ALOS to 8.46 days.

Conclusions

As the overall membership has decreased and there was a slight reduction in total number of inpatient psychiatric beds with a slight increase in ALOS this could account for the decrease in Admits/1,000 as there are less beds and members are staying longer.

Recommendations

1. Continue the Adult Inpatient Bypass Program – Determination of Bypass Program parameters will be conducted annually, and quarterly monitoring will be conducted to bring in facilities that have met the targets. Those providers who earned Bypass status but subsequently fail to meet the targets will be allowed two additional quarters to make adjustments and meet targets before Bypass status is lost.

Update – Quarterly updates of the Bypass status continue to be reviewed and analyzed internally to inform UM strategy. In collaboration with the Regional Network Managers (RNMs), the providers are updated monthly and quarterly on their performance as it relates to the Bypass targets and what actions are needed to maintain or earn Bypass status. In Q1 '16 the only status change was that one non-Bypass provider met all three targets and earned bypass status however in Q2 '16 one provider came off of Bypass due to an increased ALOS. Since the last update, there have been ongoing discussion and training provided to the inpatient facilities and as of Q2 '16 all adult Inpatient Psychiatric hospitals met the target of entering 90% of all discharge forms within two business days with the statewide average being 98.94%. The Adult Inpatient Bypass Program will continue and targets will be re-evaluated to determine if changes in the behavioral health service system have impacted inpatient hospital data statewide.

2. *Continue Adult PAR Program* – Regional Network Managers will continue to assess gaps, barriers, and best practices amongst the psychiatric hospitals. The Adult Inpatient Workgroup presentations/discussions will begin to include performance indicators broken out by provider and by geographical region. For hospitals whose data has been stable over the long term, it may not be necessary to meet individually, but data will be reviewed and shared electronically. RNMs will target these hospitals for best practices. For hospitals whose data has been inconsistent or where trends are noted that require action, communication will be regular and meetings will occur at a minimum of biannually.

Update – The RNMs and Clinical Supervisors will continue to identify and promote the sharing of best practices across the state. The sharing of best practices was the high-point of the Adult Inpatient Psychiatric Workgroup held in June 2016. Dubbed, "*Hospital Highlights",* Charlotte Hungerford was highlighted for maintaining a low ALOS over five consecutive quarters, which they attribute to the collective efforts of Psychiatry and Emergency Medicine working closely together.

The RNMs worked closely with inpatient psychiatric hospitals in identifying regional and systemic gaps in access to care post-discharge, as well as assessing any possible link to readmissions. During the past 6 months, RNMs initiated and facilitated provider meetings to enhance care coordination and provide technical assistance. Hospitals further reported wide-ranging initiatives that could potentially enhance service delivery and connection to care including: developing protocols for increased collaboration with Primary Care Physicians post discharge, implementation of Community Care Teams, establishing practices and partnerships with Psychiatry and Emergency Medicine, implementing Medication Assisted Treatment (MAT) services, and restructuring units by age and diagnosis cohorts.

Inpatient Detoxification: Hospital-Based

Summary

Overview: Admits/1,000 for the All Benefits Duals Removed group continue to increase slightly over the last three quarters as Admissions continue to increase for the first half of 2016. Admits/1,000 increased slightly over the last two quarters while days/1,000 increased in Q1 '16 and Q2 '16 after decreasing in Q4 '15. Despite relative stability in the Admits/1000 for All Members Duals Removed group, the HUSKY D (MLIA) and HUSKY C (ABD Single) groups have demonstrated opposite patterns of utilization. HUSKY D (MLIA) is trending upward over the last four quarters, while HUSKY C (ABD Single) has been declining, although spiking in Q1 '16, then declining in Q2 '16. The 45-54 age group has had the highest volume of admissions and discharges to this level of care of all the age groups.

Conclusions

Beacon Health Options (Beacon) continues to work with inpatient hospital detoxification providers to obtain authorizations for members with co-occurring medical needs when the admission is primarily related to detox. Through Beacon's efforts, it may be that the data is now more reflective of the true volume of medical admissions for detox services. The age group is to be expected as total years of use has led to more significant health issues requiring medical management

Recommendations

1. Train Hospital-Based Detoxification providers to complete discharges in ProviderConnect – Providers will learn how to submit discharges and learn about Beacon's connect-to-care process. Expectations to enter discharges via the web will support continued efforts to improve discharge planning.

Update – This recommendation was successfully completed in 2016. The Clinical and Provider Relations Departments collaborated to host three webinars focused on training the hospital-based detoxification staff how to complete discharge reviews in ProviderConnect. Beacon staff stressed the importance of entering discharge reviews for Medicaid members especially for the following purposes: 1) continuity of care – providing all clinical information from admission through discharge; 2) connecting to aftercare – providing all efforts to connect the member to an aftercare appointment 3) Beacon's involvement in the aftercare follow-up process 4) the Beacon Health Options' Health Alert – using this tool to send telephonic or email reminders to members to attend their scheduled aftercare behavioral health and medical appointments. The webinars were held on 3/22/16, 3/24/16, and 6/29/16. All inpatient providers were invited to attend. Providers reported that the trainings were helpful and discussed internally amongst their staff how they would complete the discharge reviews. One provider asked if they had the ability to print the discharge review so that they could make it a part of their medical record. Beacon is working to add this enhancement to ProviderConnect.

2. Increase communication and collaboration with Hospital-Based Detoxification providers – RNMs and clinical supervisors will continue to schedule and attend meetings with the hospital-based inpatient detoxification providers. Initial meetings will be used to clarify processes and protocols related to detox authorizations and aftercare planning. Subsequent meetings will offer the opportunity to promote real-time UM process communication, review ALOS and readmission data, devise innovative strategies to resolve barriers to discharge, identify gaps in services and expedite connect-to-care initiatives. Meeting attendees will include Beacon RNM and clinical manager, inpatient detoxification hospital-based administration, direct treatment providers, discharge planners, and utilization review personnel (specific to each hospital). Meetings will be offered at least twice a year for ongoing data review and collaboration with all hospitals.

Update – During the 6-month review period, the Clinical Supervisors and RNMs have continued to meet with hospital detox providers statewide to present data specific to their facility. The meetings focused on encouraging providers to enter requests for authorization into ProviderConnect and the importance of timely aftercare planning. An area for clarification is when to seek authorization from Beacon versus the Medical ASO. Additional meetings have been scheduled for the early fall to visit with at least two other providers who report ongoing confusion. These meetings will offer the opportunity to promote real-time utilization management process communication, review ALOS and readmission data, devise innovative strategies to resolve barriers to discharge, identify gaps in services, and expedite connect-to-care initiatives. Going forward, to the extent that there are identified regional variations in behavioral health resources, community relationships, and connections to care, RNMs will focus on constructing regional network development strategies/ interventions that will shape and support provider performance.

Inpatient Detoxification: Freestanding

Summary

Overview: The 25-34 age group has had the highest volume of admissions and discharges to this level of care of all the age groups. Admits/1,000, Days/1,000, and ALOS have remained relatively level over the last 2 years.

Conclusions

These results found are to be expected with a protocol driven service as there was no increase in the bed capacity within this level of care. The age group is also to be expected as total years of use has had less of an impact on overall physical health as compared to an older group with additional years of substance use which leads to more significant health issues requiring medical management.

Recommendations

1. Continue to Coordinate with Advanced Behavioral Health (ABH) – Beacon will continue to meet monthly with DMHAS and ABH to review Opioid Agonist Treatment Protocol (OATP) outcomes and develop strategies to improve outcomes. Beacon holds a bimonthly ICM strategy meeting with ABH regional managers and Beacon CCMs to ensure that transitions within the substance abuse continuum are smooth and timely for our shared members. The overarching purpose of this strategy meeting is to improve outcomes for our shared members through coordination, communication, and intervention.

Update – Beacon continues to meet with ABH and DMHAS to strategize about program changes, referrals and system barriers. These meetings have been reduced from bimonthly to quarterly due to scheduling conflicts and an increased overall collaboration in CCT meeting, monthly Opioid Treatment Program (OTP) meetings and biweekly Substance Abuse Workgroup meetings where Beacon, ABH and DMHAS are represented. As these meetings will continue the recommendation would be to end this goal and replace it with a goal focused on Beacon's next steps with the freestanding detox providers as a result of the joint audit of this level of care with DMHAS. The new recommendation is stated below.

New: *Collaborate with freestanding detox providers to develop OTP/MAT materials. Beacon will hold meetings with the seven freestanding providers to develop a curriculum for their staff to educate members on the multiple pathways to recovery. This would include resources available in the local community. Beacon will present the CTBHP MAT website and other materials available to support the providers on this project.*

Home Health Services

Summary

Recommendations

1. Continue planned focus on claims data analysis – Beacon will continue to provide analysis of the relationship between reduction in medication administration frequency, re-hospitalization rates, and connection to other community services for members to ensure that further reductions in medication administration frequency are not causing an increase in utilization of those other services. We will continue cohort tracking of members receiving BID medication administration service to refine our knowledge and understanding of utilization patterns. We will continue to engage providers in exploration of the variances in frequency reduction rates and hospitalization/OBS and ED rates through semiannual group and individual meetings with the 13 high-volume providers.

Update – Beacon has established a Bypass Program for home health agencies. The benefits of a bypass program are that it provides administrative relief for both CTBHP and home health agencies while promoting practice change that will benefit members and improve the efficiency of Home Health services. The Bypass eligibility criteria includes achievement of a BID medication administration target rate. Those agencies who are on Bypass have been authorized for longer periods of time, thus decreasing the number of concurrent reviews required for an episode of care. Beacon has continued to work with those providers not meeting the Bypass standards to achieve this goal.

Beacon has continued to meet with providers regularly to review and monitor their status within the Bypass Program. Most recently, Beacon met with 17 of the 22 eligible agencies to not only discuss the Bypass Program, but also review tools previously provided to help support the reduction of the BID rate such as Nurse Delegation, the use of electronic medication boxes and the effect of the continued implementation of the recovery model to help affect agency culture. In addition, providers were reminded of the latest tool – the Prompting Code.

2. Increased collaboration with CHN. To promote the efficient and appropriate use of Home Health services, it is necessary for the respective Administrative Service Organizations to collaborate on State initiatives and goals.

Update – Beacon has continued to meet with leadership from CHN to discuss home health authorizations, level of care guidelines and cases to develop parallel efficiencies in operational process, communication and criteria for Home Health services.

Continued on next page.

Home Health Services

Summary, continued

Recommendations, continued

3. Discuss and review home health agency data and reviewer findings, with a focus on providers whose frequency of visits has increased or remains above the statewide average.

Update – Beacon continues to meet weekly with the Medical Director, quality and clinical departments to discuss support for those providers whose frequency of visits has increased or remains above the statewide average. The Medical Director has continued to attend high-volume provider meetings and provide education to prescribers, as well as home health agencies on this process.

In February 2016, the Department of Social Services (DSS), DMHAS, the Department of Public Health (DPH), Beacon, and CHN held a statewide Home Health meeting with the goal of familiarizing providers with the aggregate utilization and expenditure trends, services covered by Medicaid that help support medication administration reductions, the methodology to track future utilization and cost trends and an encouragement to providers to attend small group sessions that would be held at Beacon in collaboration with CHN to afford providers an opportunity to review their individual agency level data on utilization and cost trends as well as the opportunity for peer to peer sharing and learning from those who had already made great strides in medication administration decreases to those agencies who were still struggling.

4. Work with the DSS to implement home health aide medication prompting. Utilization of certified home health aides to perform medication prompting for a cohort of Medicaid members has the potential to be an efficient process to reduce overdependence on skilled nursing for the sole purpose of Medication Administration.

Update – The use of Home Health Aide Prompting Medication Administration has been implemented in Q3 ’15. The purpose of the Home Health Aide Prompting is to reduce the dependence on skilled nursing medication administration utilization. Beacon has continued to meet with the Department of Social Services and Community Health Network ASO to monitor these operations. In addition, Beacon has continued to offer Medication Adminiatration Training (MAT) to home health agencies and residential care homes. The goal of the MAT program is to train certified home health aides in medication parameters to develop a knowledgeable and safe workforce that compliments and supports the skills of Registered Professional Nurses. To further promote MAT training to HHAs, Beacon has expanded MAT training to offer onsite training to home health and RCH agencies. Beacon will continue to provide MAT training and monitor the volume of Home Health aide prompting services.

Methadone Maintenance

Recommendations

Recommendations

Note: The data for Methadone Maintenance can be found in the Lower Level of Care Utilization graphs on the previous page via the drop down filter, along with the other lower levels of care.

1. Identify members receiving Methadone Maintenance who can benefit from services closer to their residence. Logisticare is sending transportation requests for members with complex needs and who are traveling more than 15 miles for Methadone Maintenance to Beacon's clinical staff for clinical review and recommendations. Staff will proactively outreach to providers to assist in transferring members to the closest methadone provider so that treatment is not interrupted. When transferring to a closer clinic is not feasible, alternative modes of transportation are explored and/or providers are asked if take home doses can be considered.

Update – Beacon continues to receive referrals from Logisticare when members are traveling greater than 15 miles via livery to methadone maintenance treatment to address any barriers in receiving services within their local community. Beacon met with several methadone clinics for ongoing collaboration and to understand continued challenges the clinics and our Medicaid members face when there is a need for a change in Provider or transportation method. The clinics visited since last update were Liberations Program both Stamford and Bridgeport locations, and CT Counseling in Danbury. Additionally Beacon attended two methadone round table meetings held by DMHAS which included presentations on the Prescription Monitoring Program, Medical Marijuana and Pregnancy Program Services while in Methadone Maintenance. Ongoing group discussion have included disaster plans, initial findings from DMHAS visits and areas for improvement for making and accepting referrals from freestanding detox providers to methadone clinics. Beacon created a reference sheet indicating providers' hours for open access, physician availability on site, appointments (scheduled versus walk-in), if the site offers guest dosing and other MAT services provided at the clinic. This document was reviewed by the methadone providers at the DMHAS roundtable to ensure accuracy with the goal of sharing this resource with the freestanding providers to help improve the referral process.

Outpatient Enhanced Care Clinics

Compliance, Interventions, & Activities

Compliance

Provider Compliance for Q1 '16

Routine Access compliance with the 14 day standard for the 30 ECCs fell into the following categories:
1. Met the access standard of 95%: 28
2. ECC falling below the 95% Routine Standard: Catholic Charities (Norwich): 89.32% (volume 103); Hartford Hospital (IOL): 90.91% (volume 10)

Urgent Access compliance with the 2 day standard for the ECCs fell into the following categories:
1. Number of ECCs that reported Urgent volume: 20
2. Met the access standard of 2 days: 18
3. ECC falling below the 95% Urgent Standard: Charlotte Hungerford (Adult): 50% (volume 2); Clifford Beers: 33.33% (volume 3)

Emergent Access compliance with the 2 hour standard for the ECCs fell into the following categories:
1. Number of ECCs that reported Emergent volume: 7
2. Met the access standard of 2 hours: 5
3. ECC falling below the 95% Emergent Standard: United Services: 91.67% (volume 11); The Village for Families and Children: 0.00% (volume 1)

As a result of Catholic Charities – Norwich's performance in Q3 '15 (routine) and Q4 '15 (urgent), they are on probation through the end of Q3 '16. They submitted a Corrective Action Plan on April 14 which was accepted on April 21, 2016. Charlotte Hungerford and the Village for Families and Children reported that the appointments where they did not meet the measure were data entry errors. This is still under evaluation. Clifford Beers reported having to put aside plans to hire new staff to help absorb the volume of clients they see as an indirect impact from budget cuts at the agency. This may explain their failure to meet the urgent measure with one client. However, in spite of this issue, they met every measure in Q2 '16.

Provider Compliance for Q2 '16

Routine Access compliance with the 14 day standard for the 30 ECCs fell into the following categories:
1. Met the access standard of 95%: 30

Urgent Access compliance with the 2 day standard for the ECCs fell into the following categories:
1. Number of ECCs that reported Urgent volume: 17
2. Met the access standard of 2 days: 16
3. ECC falling below the 95% Urgent Standard: Community Health Resources: 33.33% (volume of 3)

The Regional Network Manager is in discussion with CHR to better understand why they missed the Urgent measure.

Emergent Access compliance with the 2 hour standard for the ECCs fell into the following categories:
1. Number of ECCs that reported Emergent volume: 6
2. Met the access standard of 2 hours: 6

Continued on the next page.

Outpatient Enhanced Care Clinics

Compliance, Interventions, & Activities

Compliance, continued

Annual Measure Status – Agencies Not Meeting Measure:
Routine: Catholic Charities Norwich – 94.09%
Urgent: Charlotte Hungerford (Adult) – 85.71%; Clifford Beers – 33.33%; Community Health Resources – 33.33%
Emergent: The Village for Families and Children – 50%

Although two agencies (Hartford Hospital and United Services) did not meet a measure in Q1 '16, by the end of Q2 '16, their numbers had improved to meet the annual measure as of the end of Q2 '16. Hartford Hospital's routine percentage moved from 90.91% to 96.15%, and United Services' emergent percentage moved from 91.67% to 96.87%.

Interventions and Activities

Interventions to address ECC performance on Access Standards: ECC Mystery Shopper Calls for Q1 16 and Q2 '16:

Quarter 1: Middlesex Adult Clinic, Southern CT Child Guidance, and Child and Family Agency of SE CT-Groton
Every agency listed passed the two mystery shopper calls to each agency successfully. This means that they both successfully triaged calls and responded in the appropriate time frame.

Follow-Up Calls: Family and Children's Aid – Follow Up from Q4 '15
In Q4 '15, Family and Children's Aid did not return the Mystery Shopper calls made to them; however, the agency reported not being able to find a record of the calls. A decision was made to repeat the calls in Q1 '16. Family and Children's Aid passed both those calls.

Quarter 2: Hartford Hospital IOL; CHR Manchester; CMHA
Every agency listed passed the two mystery shopper calls to each agency successfully. This means that they both successfully triaged calls and successfully offered appointments to clients in the expected time frame. Of note though is CHR Manchester whose process through calling their centralized Assessment Center number is able to have clinicians answer the calls and do appropriate triaging of a call along with the offer of an appointment in less than 4 minutes. It is a smooth and seamless process that only involves the member potentially talking to one person.

In doing the calls to Hartford Hospital IOL, although the calls were successful, it was noted that the clinic's process takes two calls to get a screening and an additional call to generate an appointment to the member. A decision was made to have a meeting with the clinic and discuss their current workflow for triaging calls as well as discuss any possible improvements to the process that would eliminate the number of calls to an appointment and also examine the possibility of the screening happening in a more timely manner in order to clearly identify members in crisis from the first call to the clinic. The meeting is set up for Wednesday August 17, 2016. The Hartford Hospital IOL calls also helped us identify the need to update the language in PB 2007-44 on Access Requirements to be more specific and clear. The process of updating the language in PB 2007-44 will include getting provider feedback. This will be done at a provider meeting in September. The date is yet to be determined.

CMHA passed two mystery shopper calls without incident.

Continued on the next page.

Outpatient Enhanced Care Clinics

Compliance, Interventions, & Activities, continued

Interventions and Activities, continued

ECC Operations:
The meeting met regularly and discussions were around the issues discussed above.

ECC Provider Workgroup on Capacity and Access:
This provider workgroup did not meet for Q1 '16 and Q2 '16. However, because there is the need to explore updating PB 2007-44, there is a projected provider meeting that will happen in Q3 '16 in order to gather provider feedback.

Orientation for New ECC locations: June 28th, 2016

The new ECC clinics are:
1. Recovery Network of Programs - Bridgeport
2. Catholic Charities – Waterbury, Torrington
3. McCall – Torrington
4. CT Renaissance – Norwalk, Bridgeport, Stamford

*Although Wellmore was approved to go forward with an adult ECC location, after further consideration, the agency decided to withdraw their application as an adult location.

The ECC Orientation for the new adult locations covered: Access requirements, referrals, triaging urgent, emergent, and routine appointments, follow-ups, transportation, extended hours and after-hours coverage, documentation, collaboration with Primary Care Practices, measurement of ECC compliance, measurement of timely access and web registration. All new ECC locations will attend a follow-up meeting on October 11th at 1:30 PM at CTBHP. The purpose of the follow up meeting will be to prepare them for the on-site survey that will take place at each location immediately following their first 6 months as well as review a chart, make recommendations and identify opportunities for improvement.

Continued on the next page.

Outpatient Enhanced Care Clinics

Compliance, Interventions, & Activities, continued

Interventions and Activities, continued

Interventions:

Meeting with Community Mental Health Affiliates (CMHA):
During the course of Q2 '16, a complaint was received by CTBHP regarding the timely access of services at CMHA. In response to this complaint, a record review was done at CMHA on May 20t, 2016. While record review was inconclusive, as a result of the process of responding to this complaint, a decision was made to:
a) Review what percentage of members by agency request a later appointment even though they have been offered an appointment within the required timeframe
b) To begin doing Spanish speaking mystery shopper calls.

Spanish Speaking ECC Mystery Shopper Calls:
Spanish speaking ECC mystery shopper calls will be made in Q3 '16. The following steps though have taken place in Q2 '16:
a) The identification of three CTBHP Spanish speaking staff members who have agreed to make the mystery shopper calls
b) An initial orientation of those 3 staff members to the ECC's.
One step remains before the calls will be done, which is role-playing. This will take place in Q3 '16 before the calls are made.

Percentage of Members Requesting Later Appointment Even Though They Have Been Offered Appointment Within Required Time Frame:

Although the 18E reports traditionally capture these numbers, they had never been quantified into percentages and reviewed by agency across the board. A review was done of the percentages by agency for all of 2015 and Q1 '16. Three agencies stood out as having percentages that gradually increased all 5 quarters: CMHA, Child and Family Agency of SE CT (Groton) and Clifford Beers. Their percentages for those quarters are listed below:

ECC	Q1 '15	Q2 '15	Q3 '15	Q4 '15	Q1 '16	Q2 '16
CMHA	48.31%	54.55%	43.09%	65.52%	79.35%	69.23%
Child and Family Agency of SE CT (Groton)	45.12%	46.67%	46.48%	45.68%	65.52%	48.00%
Clifford Beers	31.68%	50.31%	43.06%	57.98%	72.39%	26.67%

We will continue to have conversations about next steps to do with this data. In Q3 '16 and Q4 '16, the RNMs will share this information with providers as a basis for gaining a better understanding of what the information means based on agency practice. That information will then be used to determine if there are some next steps needed.

Global Recommendations

Updates

1. Support Regions in the development of Community Care Team (CCT) Meetings – RNMs will continue to support each region/hospital in the planning, development and continuation of established CCTs. ICMs will participate in follow-up meetings and continue to facilitate the CCTs while working with the hospital and community providers to identify additional staffing resources.

Update – The RNMs have been actively involved in supporting the ongoing development of the five CCT meetings for the hospitals identified from the previous Performance Target (PT), as well as engaging and initiating discussions with the remaining hospitals. Over the past 6 months, the RNMs focused on community provider engagement and development, as well as hospital engagement for the five CCT PT hospitals. One important RNM approach consists of recognizing and outreaching to integral community providers who have not consistently participated and/or at the request of participating CCT community providers be invited to present/participate. In regards to hospital engagement, RNMs are working on re-establishing "check-in" meetings with the hospitals to discuss and review processes, and the effectiveness of the PT intervention, as well as to address any concerns hospital staff may have. In some instances, these will be newly formed meetings.

2. Increase coordination with CHN – Clinical managers/administrators from CHN and Beacon meet biweekly to review protocols and procedures related to authorizations and shared cases. As we move towards an integrated health model we will further develop communication plans and member specific interventions that reflect our shared efforts to provide quality care and support for Medicaid members.

Update – Clinical management from Beacon Health Options and CHN continue to meet on a monthly basis to further clarify inpatient referrals for co-management with the hopes of refining the referral criteria to have a more focused and impactful outreach with facilities to support our Medicaid members. The weekly complex member collaborative meeting continues in addition to the monthly community based co management meeting to provide member updates and offer feedback and suggestions for next steps. As previously stated Beacon is partnering with the medical ASO in scheduling meetings with hospital detox providers to further clarify authorization procedures and which ASO should be contacted based on case presentation. These efforts will continue through the next 2 quarters.

3. *Develop a comprehensive in-state continuum of care for members with Eating Disorders* – There are two intermediate care providers in-state and several outpatient providers that serve this population. Inpatient care that specifically focuses on both the medical and psychiatric effects/symptoms of the eating disorder are only available out of state. Continuity and coordination of care can be challenging when there are limited providers overall and providers treating members in one level of care are unfamiliar with providers treating members in lower/higher levels of care. Members with eating disorders need access to a variety of services within Connecticut to ensure that care is comprehensive and well-coordinated.

Update – Rockville General Hospital in Vernon opened a 20-bed inpatient program on August 8th 2016. Walden Behavioral Health also opened a second location for eating disorder treatment in Guilford for PHP and IOP levels of care in July 2016. The state now has a continuum of care for members with eating disorders and this recommendation is completed.

Recommendations continue on the next page.

Global Recommendations

Continued

4. Establish an ASO Behavioral Health Systems Committee (ABH/DMHAS) whereby systems of care (e.g. residential rehab) that fall outside the scope of Beacon's existing provider network of care work together to identify, problem solve, and address systemic barriers. Several Connect to Care meetings have been held in the New Haven area to discuss coordination amongst inpatient providers (IPD and IPF) and statewide residential rehabilitation programs. The following recommendations for improved access were identified:

a. Examine residential rehabilitation level of care capacity to adequately serve three distinct populations identified 1) SA, 2) Co-occurring, 3) Co-morbid
b. Examine utilization of DMHAS Recovery Houses (e.g. step-up versus step-down)
c. Examine the potential of developing a standardized referral form and centralized access

Update – Beacon continues to meet with ABH and DMHAS on a monthly basis to discuss substance use treatment programs and DMHAS' Strategic Plan regarding Opioid Treatment Protocol. Beacon is currently making updates to the current OATP report to reflect the expansion of OATP to outpatient and provide a summary table to better understand Medicaid members' frequency of connecting to methadone maintenance. Additionally, Beacon holds a bimonthly Substance Use Workgroup which includes participants from all three state agencies, DMHAS, DSS and DCF with a goal to increase access to Medication Assisted Treatment for adolescents and adults in Connecticut.

In addition to the state agency participation, Beacon also included representatives from ABH and CHN to identify, problem solve, and address systemic barriers. Moving forward, the group will discuss the ability to develop a standardized referral form for residential rehab level of care. Beacon would like to explore any opportunities within the residential rehab provider network to treat more medically and psychiatrically complex members which the inpatient medical detoxification providers have stated are more difficult to refer and access this level of care.

5. Develop a comprehensive Medication Assisted Treatment continuum of care.

a. Identify current MAT providers and develop an inclusive document that identifies which medicated assisted treatment is available through specific providers/facilities.
b. Identify current openings/capacity for new Medicaid referrals into these programs. Develop a provider resource list to encourage HLOC providers to begin MAT with members knowing which programs can provide ongoing MAT in the community.

Update – Beacon created a Medication Assisted Treatment (MAT) webpage which has provider and member resources available. Beacon also developed an interactive map that lists all known Medicaid MAT providers which will soon be available on the MAT webpage. Beacon has held two provider focus groups and several community forums in an effort to understand barriers that are preventing providers from offering MAT services and from the feedback developing a strategic plan to grow the network.