UTILIZATION MANAGEMENT FOR YOUTH MEMBERS

Executive Summary & Analysis by Level of Care

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

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Connecticut BHP
Supporting Health and Recovery

A Beacon Health Options-CT Dashboard

UTILIZATION REPORT FOR YOUTH MEMBERS

Calendar Year 2017: January-December 2017

General Overview

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

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

Within this interactive report, all utilization data is available via drop-down filters, but the narrative highlights the areas of interest related to certain utilization trends. In some cases, demographic breakouts are available to enhance the understanding of utilization. Additionally, the narrative identifies the underlying factors 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. The contractor will monitor the post-refresh changes closely. If warranted, methodology will be revisited.

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

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

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

EXECUTIVE SUMMARY REPORT FOR YOUTH MEMBERS

Calendar Year 2017: January-December 2017

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

Membership

Connecticut Medicaid membership increased annually until 2016 when, due to changes in income levels for eligibility, membership dropped slightly from 2015 to 2016. However, in 2017, total membership increased by 0.9% to 969,486 members.
The total youth membership (without dually eligible members) ages 0-17 in 2017 was 354,820 – a 1.0% increase from the prior year. Youth membership has seen less overall growth from 2011 to 2017 (11.8%) compared to the adult population including dually eligible members (44.2%).

Benefit/DCF Membership

In 2017, anomalies in the eligibility file that Beacon received were identified and actions were taken to rectify the issue. Unfortunately, the data was not corrected until Q1 '18 and therefore analysis on membership and utilization related to DCF involvement status cannot be interpreted at this time.

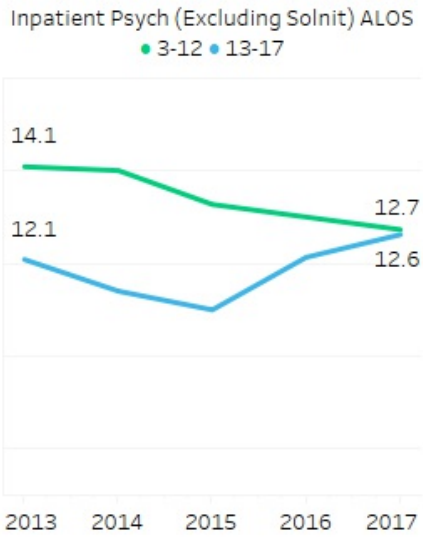
Additionally, the Department of Social Services (DSS) made changes at the end of 2016 to the system where members entered their demographic information. The system, known as ImpaCT, allows members greater access and selection options for various demographics including race and ethnicity. This change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

Inpatient Utilization (Excluding Solnit)

Medicaid youth utilize in-state, and a few select out-of-state, hospitals for inpatient psychiatric treatment. There are approximately 147 in-state pediatric acute psychiatric hospital beds across 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, a facility over the Connecticut border in New York State.

Discharge volume for in- and out-of-state inpatient psychiatric hospitalizations was relatively stable over the past four (4) years with an average of approximately 2,640 discharges. In 2017, volume reached a four-year high of 2,708 discharges, a 4.5% increase from 2016. The second quarter of 2017 had a particularly higher than average volume of discharges. However, much of the annual increase was due to increases in out-of-state psychiatric utilization and the Hospital for Special Care (combined they accounted for 88% of the total volume increase).

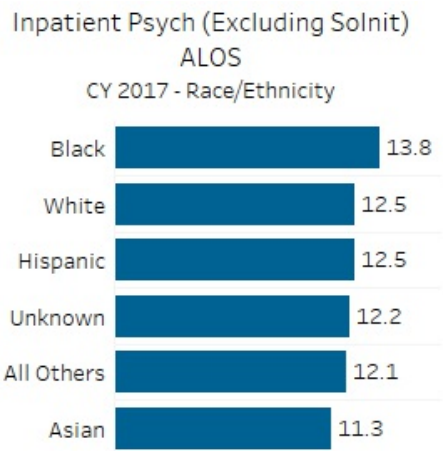
In the Q1 and Q2 '17 Semiannual Deliverable, Beacon reported that the volume increase had been more dramatic for the adolescents than the younger children. While adolescents continue to account for the majority of discharges, youth ages 0-12 increased in volume from CY 2016 to CY 2017, while adolescents decreased. In fact, younger children experienced a 19% (901 discharges) increase, resulting in a four-year high. The number of discharges accounted for by youth ages 4 to 6 increased by 44% from 2016 (43) to 2017 (62), and nine (9) unique youth had more than one inpatient stay in 2017.



Despite volume increasing, data from the youth Provider Analysis and Reporting (PAR) program indicated that youth 7-day and 30-day readmission rates have declined from 2016 to 2017; thus showing that the increased volume is likely a reflection of increased need and access, not readmissions. The 7-day readmission rate for in- and out-of-state hospitals decreased from 4.1% in 2016 to 2.6% in 2017.

The average length of stay (ALOS) for all inpatient psychiatric discharges increased slightly by 0.3 days from 12.4 to 12.7 days in 2017,a four-year high. The ALOS for adolescents continues to increase over the years while the ALOS for youth ages 0-12 has declined resulting in almost identical average lengths of stay in 2017. In line with historical trends, males continue to have a longer ALOS than females.

White (38%) and Hispanic (25%) youth were the largest two racial/ethnic groups using inpatient psychiatric services in 2017, followed by Black youth (17%). The ALOS for the Black youth population was the highest in 2017 of all the racial/ethnic groups at 13.8 days, over a day longer than the second highest ALOS, which 12.5 days for White youth.



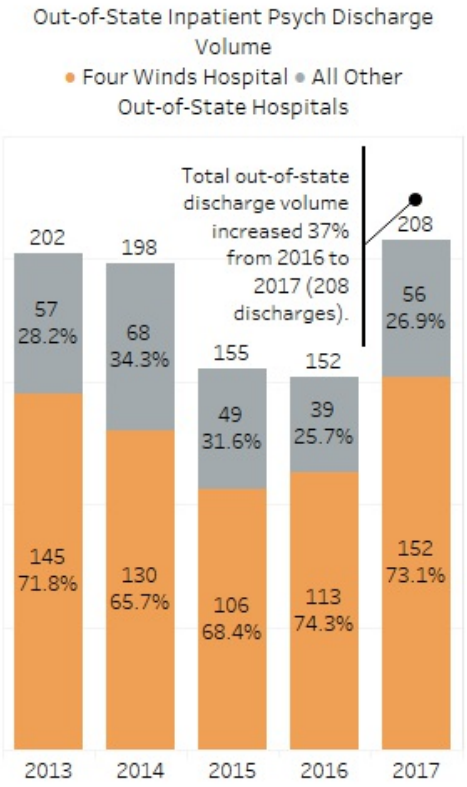
As aforementioned, most of the youth accessing inpatient psychiatric treatment receive that treatment in one of Connecticut's in-state acute facilities. There are seven (7) main pediatric hospitals that treat youth for psychiatric disorders; however, older youth may receive their treatment on an adult unit, which is also included in the in-state data. Over 60% of discharges occurred at the three largest in-state hospitals: Hartford Hospital, Natchaug Hospital, and Yale New Haven Hospital. One in-state specialty hospital also exists, the Hospital for Special Care, but is not considered a typical acute facility as their target length of stay is longer than the other pediatric hospitals due to the population they treat and the treatment approach/philosophy.

In-state acute inpatient discharges (excluding the Hospital for Special Care) remained stable over the past four (4) years around 2,438 average annual discharges. Prospect Waterbury Hospital closed its adolescent unit for periods during CY 2017, and despite the reduction in available in-state beds, overall statewide discharges remained stable. Many of the other in-state hospitals had increases in volume including Hartford Hospital and St. Francis, which both had the largest percent increase in discharge volume from 2016 to 2017 (14% and 12.5%, respectively).

In-state providers, excluding the Hospital for Special Care, had an ALOS of 11.7 days, which was relatively stable from 2016. The ALOS for only the pediatric PAR hospitals was 11.6 days in 2017, practically unchanged from 2016. The most notable change in ALOS was at Natchaug Hospital, the second largest pediatric hospital in the state, which had an ALOS of 11.5 days in 2016 increasing to 13.7 days in 2017. St. Francis Hospital, which had a large increase in volume, had a drastic decrease in ALOS going from 12.4 days in 2016 to 9.8 in 2017. Both Hartford Hospital's and Yale New Haven Hospital's ALOS remained stable between the two years (13.2 and 11.4, respectively in 2017).

Four Winds Hospital in New York State continues to account for the largest portion (73% in 2017) of discharge volume of all out-of-state hospitals. Four Winds experienced a 34.5% increase in volume from 2016 to 2017 (113 to 152 discharges). The ALOS at Four Winds had been stable, averaging 15.4 days, from 2014-2016, but in 2017, the ALOS increased to 17.8 days, a 25.5% increase.

As the Hospital for Special Care continues to treat more Medicaid youth, their volume has increased since 2016, reaching 68 discharges in 2017. Operating as a specialty psychiatric hospital for youth diagnosed with an autism spectrum disorder, their average length of stay is much longer than the other acute in-state hospitals. However, their ALOS decreased significantly from 58.1 days in 2016 to 30.9 days in 2017.



From 2016 to 2017, out-of-state discharge volume increased 37%, from 152 to 208. Out-of-state discharges accounted for 7.7% of all psychiatric youth discharges in 2017, nearly a two-percentage point increase from the prior two (2) years. Out-of-state ALOS has been on the decline over the past four (4) years reaching a low in 2017 of 18.3 days, a 9.4% decrease from 20.2 days in 2016.

Given the increase in out-of-state inpatient utilization, Beacon reviewed the ED Overstay Report, which monitors various factors of youth in the ED including challenges in discharging to the next treatment post ED discharge. Beacon's Intensive Care Managers (ICMs) reach out to Emergency Departments (EDs) across the state daily to identify youth who have been in the ED for over 8 hours waiting for an appropriate after-care service. Often, these youth are waiting for an inpatient psychiatric bed to be available and ICMs support the EDs in finding an appropriate facility that will accept these often psychiatrically complex youth.

In CY 2017, Beacon identified 1,295 ED admissions in which the youth was in the ED for over 8 hours, which was a 51% increase from CY 2016 of 856 ED stuck youth. Of those youth in CY 2017, the EDs recommended inpatient psychiatric treatment, or inpatient was the identified disposition plan on the ED overstay form, for 855 of them (66%), which was similar to the rate in CY 2016 (64%).

Inpatient psychiatric treatment was the completed discharge plan for 578 (68%) of these youth in CY 2017 (based on actual authorizations admitted the same or next day following their ED stay). This was a decrease from the 76% of youth that were recommended, and admitted to, inpatient in CY 2016. Despite an increase in ED overstay volume in CY 2017, there was a decrease in the percent that went inpatient after an initial recommendation of inpatient.

Of the 578 youth on overstay in the ED that were admitted inpatient post their ED stay, 21% were admitted to Hartford Hospital, 19% to St. Francis Hospital, 15% to Natchaug Hospital, and 11% to Four Winds Hospital. While 75% of these youth were admitted to in-state acute hospitals, 15% went out of state and 10% were subsequently admitted to a non-acute facility (Solnit or Hospital for Special Care). There was an increase in the percent of ED stuck youth that were admitted to an out-of-state facility from 7% in 2016 to 15% in 2017.

Recommendation 1: Continue to Monitor ED Overstay Cases Going Out of State
Beacon will continue to monitor the ED overstay cases and the use of out-of-state hospitals. Additionally, Beacon will closely monitor any populations more frequently waiting in the ED over 8 hours and require a psychiatric bed in a specialty hospital. Barriers to keeping the youth in state will be determined and strategies will be identified to work toward resolving.

Recommendation 2: Continue Pediatric Inpatient PAR Program
In CY 2017, the Regional Network Managers (RNMs) met with the pediatric inpatient hospitals in continued efforts to improve access to care and the quality of care for Medicaid youth. Measures reviewed include demographics, ALOS, discharge delay, readmission rates, and HEDIS ambulatory follow-up rates.

The pediatric inpatient PAR hospitals have made notable efforts to reduce readmission rates and ensure timely and appropriate connection to care post inpatient discharge. Hospitals such as the Institute of Living at Hartford Hospital and Natchaug Hospital have adopted the zero suicide framework and have implemented callbacks post inpatient discharge. Not only does this serve as a best practice under the zero suicide framework but this also supports improvements in connect to care rates by ensuring prescription medications are being filled and addressing any barriers to completing outpatient appointments. Additionally, a number of hospitals are implementing warm transfers from their inpatient unit to the next level of care, particularly within their continuum. Prospect Manchester Hospital, for example, has their clients attend the first PHP appointment on the day of inpatient discharge and the parent/guardian signs the youth out of the inpatient unit upon completion of the PHP session.

As noted above, Natchaug's ALOS increased from 2016 to 2017, while St. Francis' ALOS decreased. A next step from the Natchaug PAR meeting is to connect Natchaug leadership with St. Francis leadership so Natchaug learn from the strategies implemented by St. Francis to lower their length of stay. Both hospitals were very receptive to the suggestion for collaboration.

During the next PAR cycle, Regional Network Managers will explore the increase in younger youth admitted to inpatient, including top referral sources, reasons for admissions, and the hospital's treatment approach for youth ages six (6) and under.

Recommendation 3: Modify Youth Inpatient Bypass Program
Beacon has continued to offer a Youth Inpatient Bypass Program. In 2018, as a part of our outlier management initiative, 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).

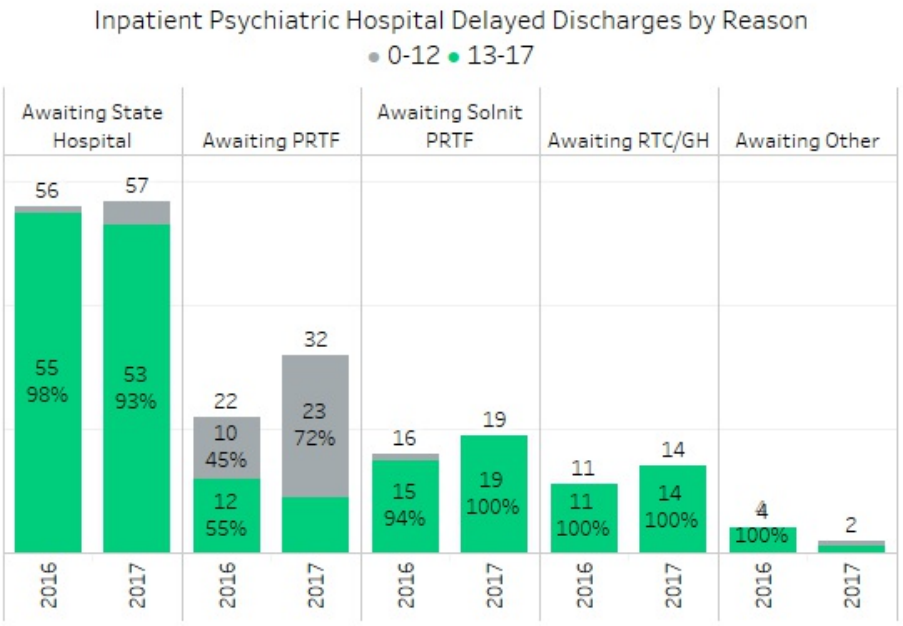
Inpatient Discharge Delay
While the majority of youth were able to discharge timely to services post inpatient treatment, there are cases when a youth ready for discharge may remain in the hospital waiting for a service to be available, which Beacon identifies as "discharge delay." Even though the percent of total discharges that are on delay tends to be low, waiting in the hospital can have a negative impact on both the individual waiting and on the entire system of care. Beacon works closely with hospitals and community providers to ensure youth can access community services as soon as they are clinically ready for them.

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 from 109 in 2016 to 124 discharges in 2017. While discharges are the number of youth who discharged from the hospital during the time period, cases are any youth who was in delay regardless of if they discharged in the time-period. Total delayed cases also increased from 118 in 2016 to 130 in 2017. While both volume of discharges and cases increased, the average days on delay decreased in 2017 to 22.8 days, a rate similar to 2015. Total delay days also decreased in 2017 to a total of 2,826 days, a 1.2% reduction.

The overall percent of days delayed for youth (cases) ages 0-17 in any psychiatric facility (excluding Solnit and the Hospital for Special Care) declined from 2016 to 2017 to 8.4%, a rate identical to 2015.

The main reasons for discharge delay for youth differ for the two age groups. Over 77% of the delayed discharges in 2017 were adolescents. Of the 96 delayed adolescent discharges, 53 (55%) were waiting for Solnit Inpatient and, of those, 36 (68%) were females. This means that over a third of adolescents on delay were females waiting for Solnit inpatient. The average wait for Solnit inpatient in 2017 was unchanged from 2016 at 27 days.

The second largest discharge delay reason from inpatient in 2017 was awaiting Solnit PRTF. Nineteen (19) youth, 10 males and nine (9) females, waited for this provider. The number of youth on delay waiting for Solnit PRTF has increased every year. The average days a youth waits for Solnit PRTF has been variable and recently decreased from 30 days in 2016 to 16 days in 2017.



Solnit Inpatient Utilization

The annual volume of discharges from Solnit inpatient declined from 2014 to 2016 and was stable from 2016 to 2017 at 120 discharges. The ALOS for Solnit inpatient increased in 2017 to a four-year high of 128.3 days – an 11% increase from 2016. Quarterly, both Q1 and Q4 '17 had the highest ALOS of the past 10 quarters, around 140 days. Historically, seasonality has not influenced Solnit inpatient's quarterly ALOS. This increase in ALOS from 2016 to 2017 was due to an increase in acute days. Total acute days for Solnit inpatient increased from 2016 (12,496 days) to 2017 (14,515 days), and the average acute days increased even more so from 297.5 to 362.9 days during the same time period—a 22% increase.

The majority of the discharges from Solnit inpatient are females (63% in 2017). Females generally have had a longer annual average length of stay than males; however, in 2017 the gap between the genders widened to approximately 47 days. This is the largest ALOS gap the genders have experienced in the past four (4) years. While males tend to be the majority of the court ordered population, there were only 11 identified court-ordered youth in total for CY 2017—all males, which had a ALOS of 52 days. With court-ordered youth excluded, the overall ALOS for 2017 increased to 136 days, but the gender gap remained—145.4 days for females and 114.4 days for males (98.7 with court-ordered males in the data).

Solnit Inpatient Discharge Delay

The number of delayed discharges at Solnit inpatient has ranged from 14 to 18 over the past four (4) years and the volume of delayed cases has ranged from 16 to 22. Both the volume of delayed discharges (14) and cases (19) has been stable from 2016 to 2017. Given the stability in discharge delay volume, the overall increase in ALOS at Solnit inpatient was a result of the increase in acute days, not delay days.

The average days in delay increased slightly to 63 days, but the total delay days decreased to 881 days. The quarterly data shows that the average days delayed increased in Q2, but had declined in Q3 and Q4. Additionally, quarterly discharges in 2017 declined from Q2 to Q4 while cases increased in Q4. This may mean that there is a higher than average number of youth currently waiting at Solnit on delay that have not yet discharged. The percent of days delayed at Solnit has been stable from 2016 to 2017 at 6.6%.

Of the 14 youth on delay in 2017, 64% (9 discharges) were waiting for a Residential Treatment Center (RTC) or Group Home placement. In fact, 50% of all delayed discharges were adolescent females waiting for RTC (3) or GH (4). The average days delayed for youth waiting for congregate care was 62 days, a decrease in time waiting from 2016. All other delay reasons had only one or two youth that was waiting for that level of care during the year so average delay days should be interpreted with caution.

Recommendation 4: Continue Collaboration with Solnit Inpatient

Beacon ICM's have continued collaborate with Solnit inpatient staff, utilization nurse, and administrators in supporting timely discharges to clinical care and services. Beacon ICM's continue to attend triage rounds and participate in discussions around in-coming youth's clinical presentations and treatment needs. The ICM has been actively engaged in assisting clinical teams with exploring appropriate discharge services and facilitating communication between the clinical team and discharge resources to promote timely discharge.

Solnit established their own discharge delay protocol this past year, taking a very collaborative approach in developing and identifying solutions that lead to better outcomes for families highlighting that the discharge planning process begins at referral, and emphasizing at various lengths of stay what the expectations are for who should be involved, including the Beacon ICM. The ICM additionally continued to be a part of the summer learning series for incoming psychiatric fellows, presenting on systems and levels of care in the State of CT to help orient staff to available services for youth and how to navigate engaging various systems of care.

Recommendation 5: Begin to Hold PAR Meetings with Solnit Inpatient
The Pediatric Inpatient PAR dashboard in Tableau contains data for Solnit inpatient; however, the dashboard is primarily used with the seven (7) in-state community providers. Beacon recommends holding a PAR meeting with Solnit inpatient leadership to share the PAR measures and discuss best practices, challenges, and potential strategies for improvement.

Psychiatric Residential Treatment Facility (PRTF) Utilization
There are three (3) Community PRTF providers in Connecticut with a licensed bed capacity of 47 (individual providers' capacity ranges from 14 to 17). The volume of Community PRTF discharges has been stable, only dropping by six (6) discharges from 2016 to 2017 to 87, which was slightly below the four-year average of 92. Utilization of Community PRTF continues to be mostly males (77%) in 2017 and White (40%).

The average length of stay has varied slightly over the past four (4) years averaging at 168 days. Compared to 2016, the ALOS in 2017 was up 14.6 days (9%) to 176.4 days, a four-year high, but similar to 2015 values. While the ALOS increased for all gender and most racial/ethnic groups, males have a longer length of stay than females, and Hispanics have the highest length of stay of all the racial/ethnic groups.

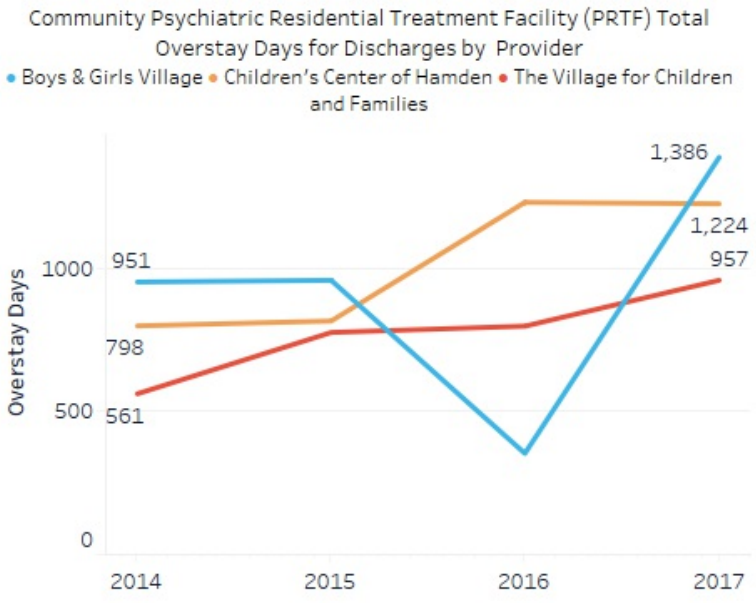
Two (2) of the three (3) PRTF providers had large increases in ALOS from 2016 to 2017. The Boys & Girls Village's ALOS increased 22% from 144.4 to 176.4 days. This increase at the Boys & Girls Village was largely due to a higher than average portion of youth staying over 300 days—14.3% of discharges in 2017 compared to the other providers which had 7.7% each. The Children's Center of Hamden had a 7.6% increase in ALOS from 173.9 to 187.2, the highest of all three (3) providers, but this was significantly impacted by one outlier discharge. The Village for Families & Children remained stable between the two (2) years at 165 days.

Recommendation 6: Continue to Share Data with the PRTFs on a Semiannual basis
As mutually agreed upon with the state partners, the PRTF PAR Program will sunset in 2018. Beacon held a provider workgroup meeting with DCF and the three community providers to review the new PRTF PAR profile in Tableau and to discuss the transition. As a follow up, the RNM, with agreement from the Community PRTFs, disseminated the PRTF providers' contact information so that the PRTFs can stay connected to one another in real time and discuss best practices, challenges and implementation of new interventions.

Moving forward, providers will receive their program specific data on a semi-annual basis. The Regional Network Managers will be available as a resource if there are questions or concerns with the data. Additionally, Beacon will hold a workgroup with the community PRTFs on an annual basis to review progress and to discuss any ongoing challenges.

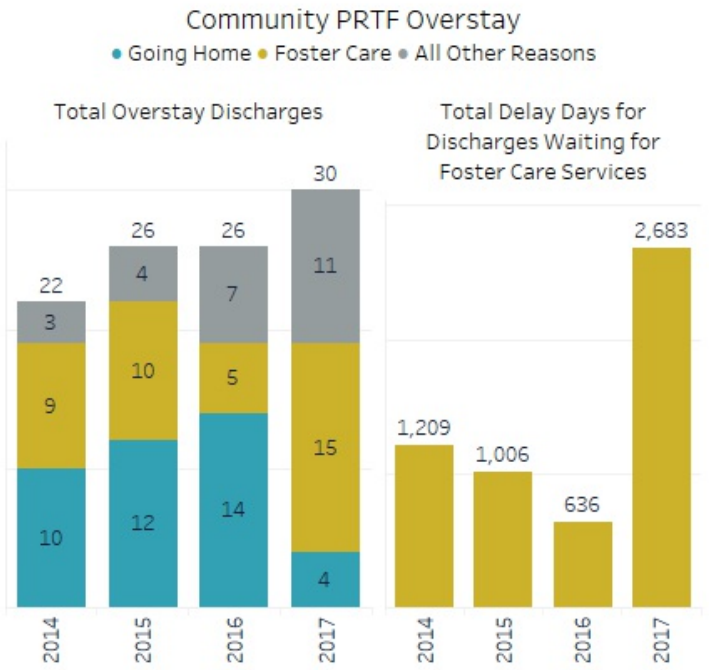
Psychiatric Residential Treatment Facility (PRTF) Overstay
Total discharges and total cases in overstay at Community PRTFs have increased every year since 2014. Total overstay values hit a 4-year high in 2017 of 30 discharges and 40 cases. Subsequently, the total overstay days for discharges also reached a 4-year high increasing over 1,000 days to 3,567 in 2017 after three years of stability. Quarters 1 and 2 of 2017 accounted for most of the annual increase for both the total discharges and total overstay days.

Fifteen of the 30 discharges in overstay were waiting for therapeutic foster care, and 13 were male. This was an increase from 2016, where only 19% were waiting for foster care and the majority (54%) were waiting to go home. Note that the data only captures the last reason a youth was in overstay, and therefore youth who were waiting to go home may have had another plan initially considered, but home was the final recommendation.



Youth who wait for foster care, on average, wait longer than most other youth on overstay. In 2017, youth waited an average of 179 days for therapeutic foster care. The range for total overstay days for these 15 youth was from 55 to 462. While "Awaiting GH" had the longest average delay, only one youth waited for this treatment service.

Additionally, due to the increase in the number of discharges in overstay waiting for foster care, the total overstay days for this group also drastically increased from 636 days in 2016 to 2,683 days in 2017.



Recommendation 7: Enhance Collaboration Between PRTF and Therapeutic Foster Care Agencies

DCF held its first PRTF and TFC statewide meeting in June of 2017 with a goal of improving collaboration and discharge planning for youth transitioning from PRTF to TFC. Objectives in this meeting included identification of current system barriers and improved process development. As a follow up to the workgroup, the PRTFs have been working on ensuring that the referral forms accurately reflect a youth's current symptoms. However, an ongoing challenge is that the longer the youth wait, they often start to decompensate, affecting their presentation of symptoms on the referral forms.

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, etc. 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.

Beacon recently presented the Community PRTF PAR data to the DCF state partners, Regional Clinical Leadership, and the TFC Project Lead, with an emphasis on average length of stay and overstay information by Therapeutic Foster Care. The group brainstormed additional strategies to try to address overstay awaiting TFC, such as timely notification to key DCF staff about youth on overstay awaiting foster care.

Recommendation 8: Enhance Marketing and Social Media Efforts to Increase Recruitment and Capacity in Therapeutic Foster Care

All three community PRTFs have expressed concern with the lack of therapeutic foster care families available for youth in overstay. In addition, they believe that the current written referrals do not lend themselves to seeing the full child and their strengths. The Village and Boys & Girls Village both offered creative strategies via technology to present youth to therapeutic foster care providers with a goal of viewing the full child and hearing his or her personal story.

The Community PRTFs are sending clinicians to the TFC referral meetings to represent the youth's voice and story. The PRTFs are also sending the child to represent himself/herself when it is both appropriate and feasible. 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 RAC meetings, the RNM will be supporting the RAC in the development of this event.

Recommendation 9: Value Based Purchasing Strategy for Therapeutic Foster Care

On-going meetings with Therapeutic Foster Care (TFC) at DCF to continue to discuss and to begin to construct a Value Based Purchasing strategy designed to increase access to TFC in the Southeast part of the state, while improving outcomes at the same time.

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 has 40 beds, while Solnit South has 24.

The volume of all Solnit PRTF discharges, at both the North and South campus combined, has been stable from 2016 to 2017 (111 and 107, respectively). The average length of stay, however, has declined from a four-year high in 2016 of 164.8 days to 151.0 days in 2017. This decrease was driven by Solnit South PRTF (females), which had a 30-day reduction from 149.1 days in 2016 to 118.7 in 2017. The last quarter in 2017 had a large impact on the overall annual ALOS decline at Solnit South. Quarter 4 had an ALOS of 89.9 days, the lowest in the past 10 quarters. The three (3) prior quarters were stable around 125 days. Solnit North has had a stable ALOS for the past three (3) years around 180 days, but also saw a large decrease in the ALOS for the fourth quarter of 2017 (124.3 days) to the lowest ALOS in the past 10 quarters.

Solnit PRTF Overstay

The volume of discharges in overstay at Solnit PRTF North and South combined had been increasing from 2014 to 2016 (from 13 to 31 discharges), but dramatically decreased in 2017 to 18. Almost 89% (16) of the discharges in overstay were from Solnit North PRTF (males). Only two females were on overstay at Solnit South in 2017—a marked decrease from the 11 overstay discharges in 2016. The total cases in overstay also decreased in 2017 to a four year low of 21. Due to fewer youth in overstay, the total overstay days for cases declined from 2,704 in 2016 to 1,640 days in 2017.

While youth at Solnit PRTF waited for a variety of reasons, nine out of 18 on overstay were waiting for congregate care (RTC or GH). Six males were waiting for Group Homes, and two males and one female waited for RTC. There was a decrease in youth on overstay waiting for therapeutic foster care from 2016 to 2017, but an increase in average days waiting for the three youth in this category.

As mentioned in the prior semiannual report, females at Solnit South PRTF do not appear to experience the same barriers in discharge as the males at Solnit North. Additionally, there has been a shift in the largest overstay reasons from 2016 to 2017 indicating perhaps a shift in need. The largest groups of youth in 2016 were waiting going home and therapeutic foster care. While there were fewer youth on overstay in 2017, they were largely waiting for RTCs and Group Homes. This shift may be in part due to foster homes availability and alternative discharge plans identified as well as proactive work to support families in taking youth home post treatment at the PRTF.

Recommendation 10: Over the next 6 months, the Solnit PRTF PAR program will focus on ALOS, overstay and transfers from PRTF to inpatient level of care

In 2017, Solnit implemented a new process in which discharge delay meetings are held at 60 and 90 days. Objectives in this meeting include the review of discharge plans, identification of barriers to discharge and improved collaboration and communication amongst the PRTF, family members, providers and stakeholders. The ICM supports these meetings on an as needed basis. Solnit North triage meetings also include a heavy focus on identified barriers, next steps and the owner of the next steps to track progress towards goals and reduce or eliminate barriers. In addition, Solnit PRTFs have focused on setting limits with all parties involved during the intake process to ensure appropriate cases enter PRTF.

The PRTF PAR data was integrated into Tableau with the ability to view data in a non-static way. This will allow for richer conversations at future PAR meetings and internal pre-planning meetings. The RNM will be holding the next Solnit PRTF PAR meeting soon and will discuss the target measures and additional interventions put in place.

Recommendation 11: Enhance collaboration between Solnit PRTF and Therapeutic Foster Care (TFC) agencies

As noted in Recommendation 7, DCF held its first PRTF and TFC statewide meeting in June of 2017 with a goal of improving collaboration and transition planning for youth transitioning from PRTF to TFC. Beacon will continue to collaborate with DCF, the PRTFs, and TFC providers to improve processes, promote improved collaboration, and enhance discharge planning for youth in PRTF. As noted above, the volume of youth awaiting therapeutic foster care decreased from 2016 to 2017. Solnit PRTFs have been working on including the TFC agencies in the planning meetings. Solnit PRTF clinicians are also presenting the youth in TFC referral meetings to capture the youth's voice and story when feasible and appropriate. It appears that there still may be an opportunity to ensure that all parties involved in the DCF area office are aware of status changes for youth awaiting TFC in real time. As a result, it may be appropriate to implement the same notification strategy referenced in recommendation #7 regarding real time notification to DCF for youth awaiting TFC.

Residential Treatment Center (RTC) and Group Homes

In-state RTC admissions have been variable over the years, but have been around 150 for the past two years. Out-of-state RTCs were infrequently utilized, as evidenced by only two (2) admissions in 2017. Both the in- and out-of-state ALOS decreased from 2016 to 2017. In-state ALOS was 243.4 days and out-of-state ALOS was 289.5 days in 2017 (down from 592.3 and 319.9 days in 2016, respectively).

Therapeutic Group Home (TGH) admissions had been declining from 2014-2016, but increased in 2017 from 103 to 115 admits. Discharges and ALOS has been declining. Almost all of the admissions to both RTCs and TGHs are adolescents.

Recommendation 12: Monitor RTC utilization for possible outlier management

Beacon continues to monitor RTC admissions and is working towards developing an outlier management that would allow Monthly Treatment Plan Progress Reviews (MTPPRs) to move from authorization to registration.

Autism Spectrum Disorder (ASD) Services

The majority of youth accessing ASD services are 3-12 years old and male. Diagnostic evaluations continue to have the largest volume of all ASD services, but the growth has leveled off from 2016 to 2017. Connecticut Children's Specialty Group at CCMC continues to be the largest provider of Diagnostic Evaluation services. While age and gender utilization trends have not changed, there was an increase in Hispanic youth accessing Diagnostic Evaluations in 2017. This may have been a result of now having two (2) Spanish-speaking Beacon care-coordinators on the ASD team as well as new Spanish-speaking providers offering this service.

The other services, including Service Delivery, have continued to grow as a result of more youth now accessing treatment services and more providers available. There were 42 unique providers authorized to provide Service Delivery in 2017, which was a 62% increase from the prior year. Collectively these providers authorized 422 treatment service episodes. Able Home Health Care, LLC was the largest provider of these services.

Recommendation 13: Collect data regarding authorization to first claim
ASD members receiving direct services continues to grow (from 278 total new authorizations in Q1 '17 to 422 total new authorizations in Q4 '17, making up 1,238 unique members receiving direct services). This increase can be attributed to the growth in the provider network, most specifically in providers who perform direct services. Q1 '17 there were 109 providers enrolled while in Q4 '17 there were 186 and 163 of those providers were able to perform direct services. Beacon plans to continue this provider network growth and further develop their adequacy by offering more Learning Collaborative opportunities.

Beacon looks to enhance the system of care for members and families impacted by autism spectrum, intellectual disability, or developmental disorders, in 2018 by implementing a new Intensive Response Team. The goals of this team are 1) to decrease emergency department and inpatient psychiatric hospitalization utilization and length of stay; (2) increase 'successful' referral and connection to appropriate levels of care; and (3) summarize best practices in providing high quality treatment and recommendations for quality improvement. The current ASD team will continue to work with members and will implement the strategies of the Wrap Model in supporting an identified cohort of ASD members who meet a severity rating of 1 (least impacted) within the Autism Diagnostic Evaluation process. The work of this team will focus on preventing these members from needing to access higher levels of care by connecting them with natural resources to support the work completed by in home ABA providers.

Lower Levels of Care
Outpatient admissions continue to increase over the years. As mentioned in prior semiannual reports, these counts only reflect initial authorization and does not inform how many sessions a youth attended or engaged in treatment, which could result in a subsequent admission to another provider. Beacon aims to integrate claims-based reporting specifically on the lower levels of care to enhance our understanding of the utilization of these services. Measures such as visits per 1,000 users and users per 1,000 members are expected.

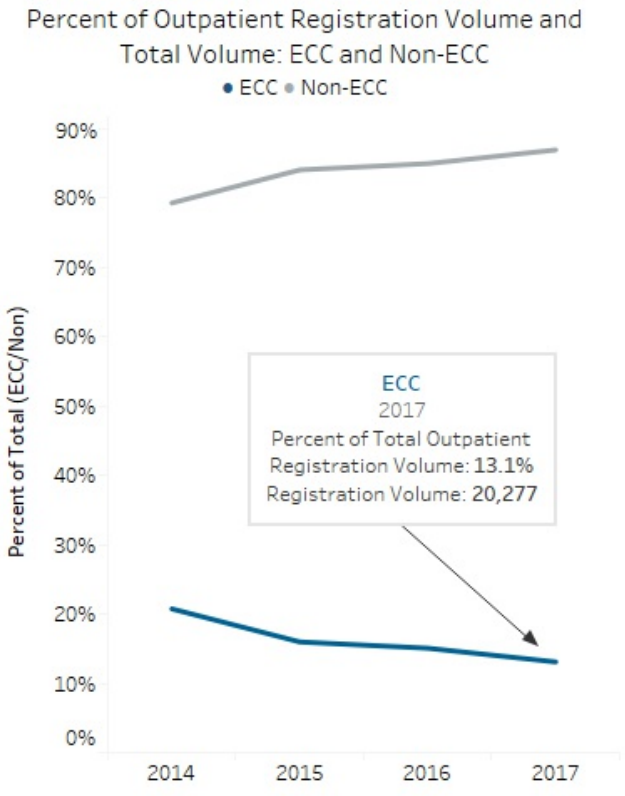
Partial Hospital Program (PHP) and Intensive Outpatient Program (IOP) admissions increased from 2016 to 2017, but resemble numbers from prior years. The volume increase was largely due to a drastic Q2 spike at Natchaug Hospital. The latter half of 2017 had admissions back to historical values. Admits/1,000 increased for Outpatient, but has been stable for all other lower levels of care. This is a positive trend in efforts to shift utilization to lower levels of care.

Enhanced Care Clinics (ECC)
The volume of non-ECC outpatient registrations, for youth and adults, continues to climb year after year. The percent of ECC volume out of all outpatient registrations was 13% in 2017, a decline from 15% in 2016. Since the volume of ECC registrations has been stable while non-ECC registrations climb, the percent of ECC registrations out of the total continues to decline each year.

For youth, non-ECC outpatient registrations increased 14.6% from 2016 to 2017 and ECC outpatient registrations increased 5%, to 9,659. ECC registrations accounted for 27% of all youth outpatient registrations in 2017. Youth have a greater portion of ECC to non-ECC registration than the adults do.

In CY 2017 the statewide child ECC rates continued to meet the access standards for routine (99.23% were offered within two weeks), urgent (96.8% were offered within two days), and emergent (99.2% were received within two hours).

Recommendation 14: Assess ECC initiative
The ECC program has been operating unchanged for many years. Beacon recommends reviewing the ECC initiative regarding the choice and operationalization of ECC program metrics, a cost-benefit analysis, opportunities to incorporate value based payment methodologies, and opportunities to broaden the initiative so it applies to a greater percentage of members served in outpatient clinics.



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

Summary includes analysis of both adults and youth

Provider Compliance for Q3 and Q4 2017

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

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

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

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

Interventions and Activities

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

<u>Q3 and Q4 '17 Meetings</u>

ECC Operations: The standard monthly meetings were held throughout each quarter as well as many additional meetings in order to adequately address ad hoc ECC issues. Some of the issues addressed have been:
- Closing of Catholic Charities NB/Bristol on 7/31/17
- Clifford Beers – issues with ECC and non-ECC locations
- Edits to ECC Policy Transmittal language
- Data Entry Errors
- Mystery Shopper Calls
- Corrective Action Plans
- Quality of Care Concerns