The Connecticut Behavioral Health Partnership

2008 Quality Management Program Evaluation

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I. EXECUTIVE SUMMARY

The Department of Children and Families (DCF), the Department of Social Services (DSS), in conjunction with a legislatively mandated Oversight Council, have formed the Connecticut Behavioral Health Partnership (CT BHP) with ValueOptions serving as the Administrative Service Organization (ASO). The Partnership was initiated January 1, 2006 and serves as a redesign of the behavioral health service delivery system for low-income parents and children. The program emphasizes families as partners in care planning, serves to enhance cultural competency within the service system, and strives to improve the quality and availability of community-based services and supports. The Partnership is a reform initiative designed to help children and parents with serious behavioral challenges remain in their homes and communities, through the use of targeted, individualized clinical and support services. The ultimate goal under the initiative is to allow children and parents to function independently, restore or maintain family integrity, improve family functioning, achieve a better quality of life, and to avoid unnecessary hospital and institutional care.

The (CT BHP) Quality Management (QM) Program was initiated with the implementation of the contract. The QM Program serves as the overarching structure to continuously evaluate the effectiveness of the ASO so as to ensure that the clinical and support services offered within the CT BHP live up to their promise for the youth and families served by the program. The QM Program identifies the key indicators that affect the operation and then monitors these indicators, analyzes the findings, identifies issues, trends and barriers, and then initiates actions to improve performance when necessary.

At the beginning of 2006, a Quality Management Program Description and project plan was developed for the CT BHP QM program based on contractual requirements as well as the standards established by ValueOptions. That program was evaluated during the first quarter of 2007 and a project plan established that took into consideration contract obligations as well as the findings of the evaluation.

On at least an annual basis, the QM Program is evaluated. The CT BHP annual QM Program Evaluation provides an opportunity to examine completed and ongoing quality activities. The QM Program evaluation serves to assess the overall effectiveness of the QM Program including the effectiveness of the committee structure, the adequacy of the resources devoted to it, practitioner and leadership involvement, the strengths and accomplishments of the program with special focus on patient safety, and performance in quality of clinical care and service. Progress toward meeting the goals included on the previous year's project plan is also evaluated. A review of each of the goals is included within this evaluation along with a description of each goal and sub-goal, commentary regarding their completion status, and recommendations for whether to carry them over into the Quality Program for 2008. The results of this program evaluation together with the additional goals that reflect the strategic planning done collaboratively with DSS and DCF, will be used to formulate the 2008 Project Plan.

Key accomplishments of the CT BHP QM Program in 2008 include:

- Increased the reporting of Quality of Care issues by CT BHP staff by more than 500% necessitating weekly meetings of the Quality of Care Committee and a revised protocol for the investigation and handling of the issues identified.
- Improved the coordination and communication of trend information that results from the CT BHP identified Quality of Care issues with the DCF Quality Management Department.
- Revised the administration of the Member Satisfaction Survey to improve its validity so that members are surveyed within a month of receiving services
- Met all Member and Provider Telephone Access standards
- Finalized a retrospective data analysis comparing the behavioral health utilization patterns of children and adolescents who disrupt out of foster care placement with those who do not disrupt
- Implemented a quality improvement activity with two DCF Area Offices to identify children newly placed in foster care with a history of behavioral health issues to improve the timeliness of services and potentially decrease disruption
- Completed a literature review regarding the characteristics of foster parents that may be related to disruption patterns
- Implemented a quality improvement activity that addresses improved identification of members with post partum depression and connection to behavioral health services when necessary
- Implemented the Provider Analysis and Reporting programs for child and adolescent inpatient, PRTF, and ECCs
- Implemented two Pay for Performance initiatives including one for child and adolescent inpatient and one for PRTFs

Key accomplishments of the CT BHP Utilization Management Program in 2008 include:

- Achieved a highly significant reduction in the percentage of days in discharge delay of children and adolescents in inpatient care
    - Far surpassed the goal of achieving a 12% reduction in discharge delay: decreased discharge delay by 39% with no increase in acute average length of stay or readmissions.
- Achieved an improvement in the rate of ambulatory follow-up within 30 days from 64.6% in 2006 to a preliminary result of 85.8% in 2008
- Implemented an Adult Inpatient By-Pass program
- Implemented major improvements in the utilization management of RTCs
    - On-site reviews in state and bordering out of state facilities
    - Refined the medical necessity decision-making process for RTC placements
    - Tied authorizations to claims payment
    - Developed and implemented a large reporting package that supports DCF and CT BHP clinical and administrative decision making
- Achieved a service center pass rate for the IRR audit of 96.4% with an average score of 90.36%
- Decreased the average number of days that youth are delayed in EDs from 2.5 to 1.9 days

II. EVALUATION OF OVERALL EFFECTIVENESS OF THE CT BHP QM PROGRAM

A. Committee structure

The following QM committee structure is in place at the time of this evaluation.

CT BHP Quality Management Committee (QMC)

The QMC was established to provide oversight of the QM program. The QMC is co-chaired by the Medical Director and the Vice President (VP) of QM. The QMC reports both to the Senior Management Quality Management Steering Committee (SMQMSC) which is chaired by the Service Center VP/CEO, and to the ValueOptions Corporate Quality Council.

During 2008, the membership of the QMC was comprised of representatives from all key departments within the Service Center. These include:
CEO
Quality
Medical Affairs
Clinical/Case Management including representation from the Intensive Case Management area
Provider Analysis and Reporting
IT/Reporting
Customer Service
Human Resources
Finance

The QMC meets on a monthly basis. The committee reviews indicators included in the QM Project Plan with particular focus on those indicators where there is a trend either away from or towards the goal, as well as the status of the quality improvement activities in progress. Increasingly, the committee spends time on the current status of each of the activities identifying barriers and actions that can be taken to move the activity forward. Recommendations from all departments are obtained at that time.

During 2008, the number of quality improvement activities in progress necessitated the formation of workgroups that focus on particular activities. Decisions regarding actions that need to be taken regarding the activities need to be made more frequently than monthly. The QMC frequently acted as a committee that reviewed those decisions and updated the rest of the committee as to actions that had been taken in the last month.

Quality of Care (QoC) Sub-Committee

The QoC Sub-Committee reports to the QMC and is co-chaired by the Medical Director and the VP of QM. The committee was initiated in 2007 in order to establish a venue for the review of quality of care and service issues identified by CT BHP staff, members, and providers, and the Departments, As the volume of QoC issues identified increased during 2008, the committee began to meet weekly. The sub-committee reviewed all issues identified in the previous week and followed up on the results of actions and/or investigations previously identified by the committee. The sub-committee periodically reviewed the trends of specific facilities or programs and oversaw the action plans established for specific providers initiated by the committee or the PARs program. Additionally, the sub-committee identified new categories of QoC issues when necessary.

In addition to the co-chairs, the membership of the committee included:
CEO *(ad hoc)*

QM Staff
Director of UM

The protocols and P&Ps associated with this committee assure timely, appropriate communication and collaboration with DCF's Quality Bureau. On a monthly basis, trended information regarding QoC issues identified by the service center are shared with the DCF Bureau Chief for Quality Improvement.

Network Management Sub-Committee

Formerly called the System Management Sub-Committee, the Network Management Sub-Committee reports to the QMC. This committee resumed meetings during 2008 under the new title. The primary focus of this committee during 2008 has been on establishing strategies for addressing the issues generated by the PARs program. The complexity of the PARs program has necessitated the formation of several workgroups off of the Network Management Sub-Committee including workgroups focusing specifically on the inpatient, ECC, and PRTF programs. The Network Management Sub-Committee then focuses on improving the consistency of strategies across the PARs program as well as across the Geo-Teams. The sub-committee is currently co-chaired by the CEO and the VP of QM and its members include:

Regional Network Managers
Provider Relations staff
Clinical staff (*ad hoc*)

Provider Analysis and Reporting (PARs) Workgroup

The PARs Workgroup was established late in 2007 as the vehicle to oversee the development and implementation of the PARs initiatives. The workgroup meets weekly and develops, implements and oversees the program-specific methods for delivering performance information on appropriate quality indicators to providers in the network. As the complexity of the PARs program grew during 2008, several initiative-specific workgroups were added. The PARs Workgroup continues to meet weekly with the following specific goals.

- It provides the forum for senior management to review and provide input into the details of the initiatives,
- It provides the forum for the Regional Network staff to learn about the details of all of the PARs programs and offer input; and
- It is the setting in which the IT/Reporting Department works with Network Management and QM staff to make decisions regarding measurement of indicators.

The workgroup is currently chaired by the VP of QM. Included in its membership are:
CEO
Medical Affairs
Director of UM
Director of IT/Reporting
Regional Network Managers
Quality Department Staff
Provider Relations

Utilization Management Sub-Committee

The Utilization Management (UM) Sub-Committee was formally established 2006. It is chaired by the VP of Recovery and Clinical Operations. The committee meets monthly and primarily

focuses on review of utilization data and the oversight of the UM and ICM Program. The members of the committee include:
Medical Director
UM Director
Director of Intensive Care Management and Peer Support Services
QM Staff

Consumer and Family Advisory Sub-Committee

The Consumer and Family Advisory Sub-Committee was established in 2006 and meets at least quarterly. It is chaired by the Director of Intensive Care Management and Peer Support Services and includes members, families of members, member advocates and CT BHP peer support staff. The Sub-committee provides the forum for the service center QM program to receive input from members and families. Within the last year, the committee has provided input into the revision of the DCF Foster Care Handbook and the means of measuring the family friendliness of the Enhanced Care Clinics.

CT BHP Primary Care Physician Advisory Sub-Committee

The Physician Advisory Sub-Committee was established in 2006 and meets bi-monthly. The group is comprised of physicians from both behavioral health and primary care and is chaired by the CT BHP Medical Director. During 2008, the Physician Advisory Sub-Committee focused on the education of both behavioral and non-behavioral healthcare providers on the availability of services from the ECCs. The group reviewed the training materials to be used to educate pediatric practices regarding the Memorandum of Understanding (MOU) that was established between ECCs and pediatricians early in 2008. Later in the year, the sub-committee worked on the means of measuring pediatrician satisfaction with the consulting process established via the MOUs.

Assessment and Recommendations regarding QM Committee and Sub-Committee Effectiveness:

As the complexity of the QM activities undertaken by the service center grew, the QM Committee structure underwent change in order to assure timely oversight of the activities as well as to provide forums for senior management input and the education of line staff about the activities. As a result, multiple workgroups off of the committees and sub-committees were established. With the growth in the number of workgroups, there was frustration expressed regarding the amount of time spent in meetings. A goal for 2009 involves the continuing reassessment of the benefits of workgroups *vs.* the need to limit the amount of time spent in meetings.

D. Adequacy of resources

The following chart is a summary of the positions currently included in the Quality Management Department, their credentials and the percentage of time devoted to quality improvement activities. Additionally, extra-departmental staff are listed with the percentage of their time devoted to quality activities.

Title	Credentials	Percent of time per week devoted to QM
VP Quality Management	PhD	100%
Director of QM	LCSW	100%
Director of PARs	Vacant	
Regional Network Managers (6 FTEs)	Bachelors with experience and MA level	80%
Quality Monitoring Coordinator	LPC	100%
Quality Analyst	Bachelors of Science	100%
Appeals Coordinator II	Bachelors of Arts	100%
Complaint & Grievance Coordinator I	High School Degree	100%
CEO/ VP Service Center	Masters	20%
Medical Director	MD	40%
VP of Recovery and Clinical Operations	MA	30%
Director of Customer and Provider Relations	N/A	20%
Director of Utilization Management	LPC	20%
Director of Community Support	LCSW	20%

E. Practitioner Involvement

One of the strengths of the CT BHP QM Program is the active involvement of network practitioners in the program. Behavioral health practitioners representing different levels of care are increasingly involved via the PARs program. They are instrumental in establishing goals for their specific programs across the entire network. Providers are also involved in multiple QM Committees and Sub-Committees, including those that provide oversight of the Partnership at the highest level. Please see the 2009 CT BHP Program Description for details about those committees that involve providers.

F. Leadership involvement

Another significant strength of the QM program is the leadership involvement. The CEO and members of the senior management team are all active participants in the day to day operations

of the QM Program. This active involvement provides a clear message to all CT BHP staff regarding the importance of their involvement in and support of the activities. The message regarding the importance of quality improvement comes directly from the top of the organization and permeates the entire service center approach to care and service. The Service Center Chief Executive Officer, the VP of Recovery and Clinical Services and the Medical Director all participate actively in the committees, sub-committees and workgroups.

The Medical Director plays an influential role in the Quality of Care Committee and the PARs Program. He is an active member of the QMC and provides input to the design of Quality Improvement Activities, particularly those involving clinical activities. He is a senior management sponsor of two of the Regional Geo Teams and plays a significant role in the PARs program. He helps monitor utilization trends and contributes to the oversight of the appeals process.

G. Patient Safety

As the clinical management programs and line staff have matured, they are increasing adept at identifying clinical quality issues during their telephonic and on-site reviews. As a result, the number of issues identified grew significantly during 2008. As the identification of quality issues increased, the QoC Committee had to adapt to the increase in volume and enhance their protocols to ensure timely review of the issues and improved communication of issues to DCF when indicated. Coordination of investigation and partnership with DCF in addressing issues with particular facilities and programs has been improving during 2008 and continued improvement will be a goal for 2009.

III. EVALUATION OF THE 2008 CT BHP QM PROJECT PLAN

Goal 1: Review and approve the 2007 CT BHP Program Evaluation, 2008 QM Program Description and 2008 CT BHP QM Project Plan. (Contract reference: L3.1, L4 and L4.2.5)

Activities and Findings that include trending and analysis of the measures to assess performance:

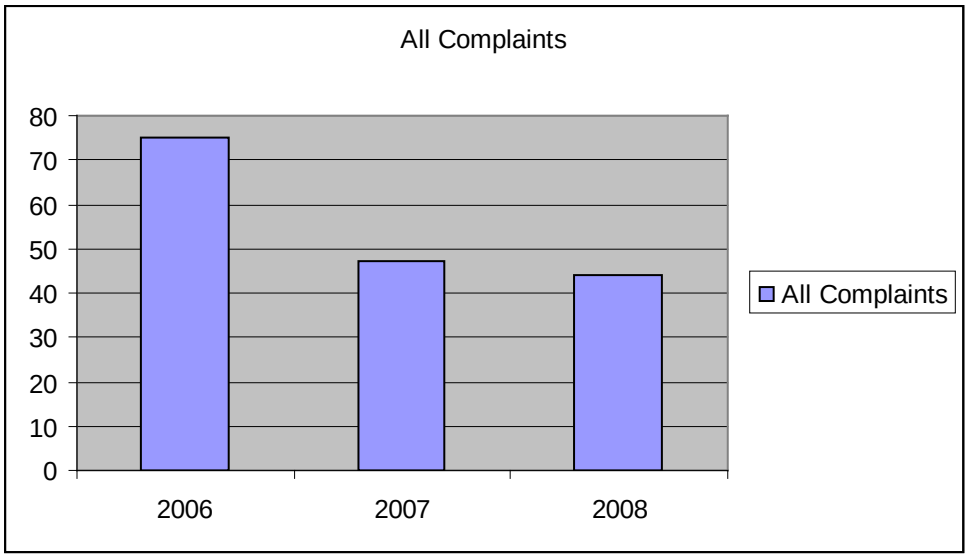
The 2007 QM Program Evaluation, the 2008 QM Program Description, and the 2008 QM Program Project Plan were submitted to the Departments on March 28, 2008. Minor revisions of the Program Evaluation were requested by the Departments on May 16, 2008, made and re-submitted to the Departments on May 23, 2008. Formal approval of the documents by the Departments was received on July 7, 2008.

Recommendations for continuing sub-Goal in 2009:
This sub-goal should be continued in 2009.

Goal 2: Ensure timely response and resolution of member/provider complaints and grievances. (Contract Reference Exhibit E; 20A-E)

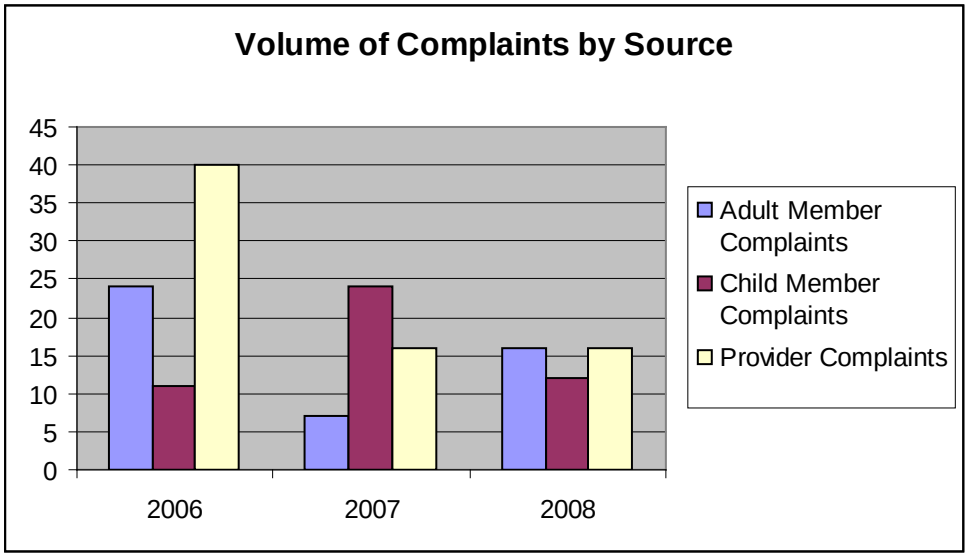
Description of Activities and Findings including trending and analysis of measures over time:

A. Total number of complaints and grievances broken out by member (child and adult) and provider complaints.



There were a total of forty-four (44) complaints and grievances received in 2008. This represents a slight decrease in volume from 2007 when 47 complaints were received. The high volume of complaints received in 2006 is accounted for by the volume of complaints received from providers when the web registration process was implemented at the end of 2006. At the

time, provider's requests of CT BHP to reconsider the decision to block their ability to register members for treatment more than 21 days after the visit were categorized as "complaints". Early in 2007, it was decided to handle these situations as administrative appeals (since these requests typically resulted from a denied claim), so that the volume of "complaints" appears to have decreased significantly.

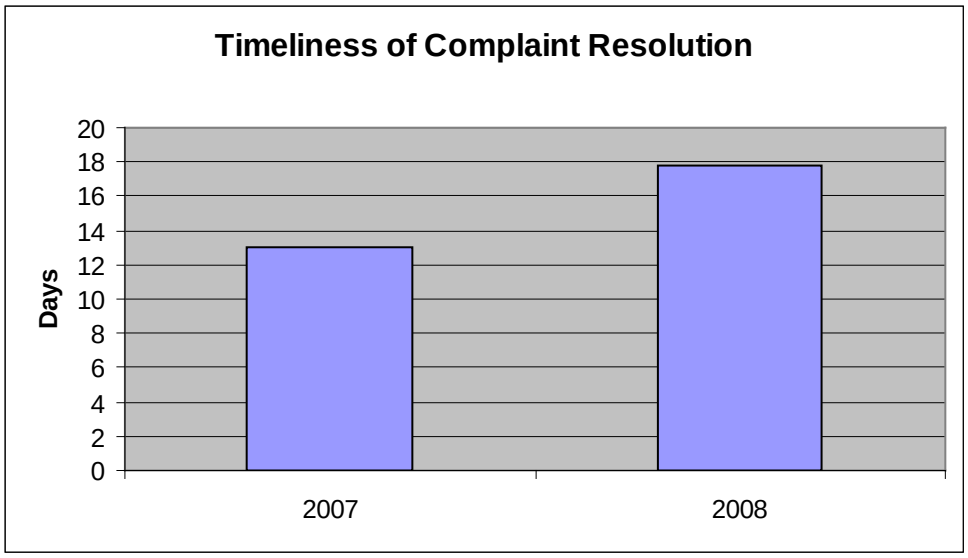


Of the 44 complaints received during 2008, 16 concerned adult members, 12 concerned child members, and 16 were complaints received from providers. The volume of complaints concerning adult members more than doubled while the volume of complaints regarding child members decreased. With regard to the complaints regarding child members, this decrease primarily results from the decrease in parental/guardian complaints regarding inpatient treatment concerns. The majority of member (adult and child) complaints filed were in reference to quality of care/quality of service rendered by providers treating them. The Quality of Care Committee reviewed all of the complaints that concerned provider quality of care.

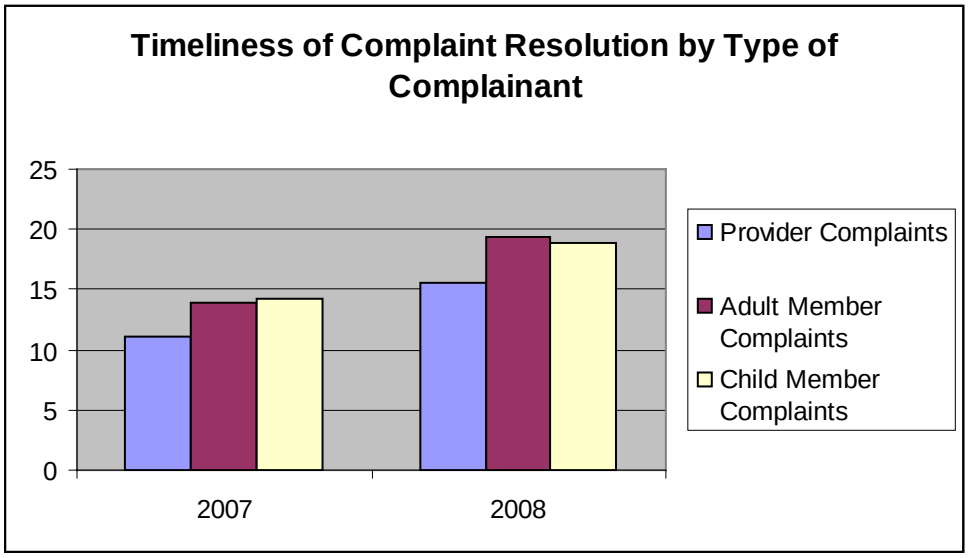
Additionally, a decision was reached early in 2008 to use the Quality of Care identification form as the means to document those issues, primarily identified by clinical and peer support staff rather than as "informal complaints". This decision resulted from review of issues identified when the member or their family either did not want to file a formal complaint, or when the member did not perceive the issue to be a complaint at all. Clinical and peer support staff were aware of potential quality of care issues during conversations with provider staff and/or members and their families; providers and members or their families either disagreed or were unaware of the implications of the information they were sharing. Rather than respond to these situations by categorizing this information as a "complaint", they are now categorized as quality of care issues. See the assessment of Quality of Care issues under Goal 4 for additional information.

The majority of complaints received from providers were in reference to claims and the WEB Registration process. Many of these complaints were referred to the rapid response team for investigation.

B. Average number of days to resolution



The average time of complaint resolution during 2008 was 17.72 days; this represents a 36% increase from 2007 in the number of days to resolve complaints. The average number of days to resolve complaints was 13.03 days in 2007. The turnaround time is still well within the 30 day standard.



The average number of days to resolve complaints is primarily accounted for by the increase in the amount of time to resolve member complaints as opposed to provider complaints. Many of the member complaints are reviewed by the Quality of Care Committee. This committee began meeting weekly (as opposed to every other week during 2007) in order to assure that all issues were reviewed timely.

C. Percent of complaints resolved within 30 days

100% of the complaints and grievances resolved during both 2007 and 2008 were resolved within 30 days.

D. Most frequent reasons for complaints

Of the 16 adult member complaints resolved in 2008, the following reasons described the complaints regarding the adult member: 5 requests by members to change providers due to dissatisfaction with the care provided, 3 regarding quality of care concerning provider treatment practice issues, 3 complaints that the member was treated unfairly by the provider, 2 complaints regarding the quality of service by a provider, 1 complaint regarding claims payment, 1 complaint regarding the provider's failure to coordinate their care related to pharmacy, and 1 regarding the provider not accepting new patients.

Of the 12 child complaints resolved in 2008, the following reasons described the complaints lodged on behalf of a child member: 4 complaints regarding claims not paid for their providers, 3 quality of care concerning provider treatment practice issues, 1 complaint regarding the inadequacy of benefits, 1 complaint regarding the provider's failure to coordinate care concerning pharmacy, 1 contractor complaint regarding transportation, 1 complaint regarding a referral appointment timeliness issue with an ECC, and 1 quality of provider service complaint.

Of the 16 provider complaints resolved in 2008, the following reason codes described the complaints received from the provider: 9 complaints regarding claims payment, 3 complaints regarding WEB Registration, 1 complaint concerning their authorization status, 1 disagreement with the treatment plan proposed by CT BHP staff, 1 quality of service of another provider, and 1 complaint concerning ValueOptions' staff lack of courtesy.

Recommendations for continuing sub-Goal in 2009:
This sub-goal will be applicable for 2009 and should be included in the 2009 Project Plan.

Please note: Goal 3 concerning the analysis of appeals data has been moved to follow the analysis of denial data in Goal 13.

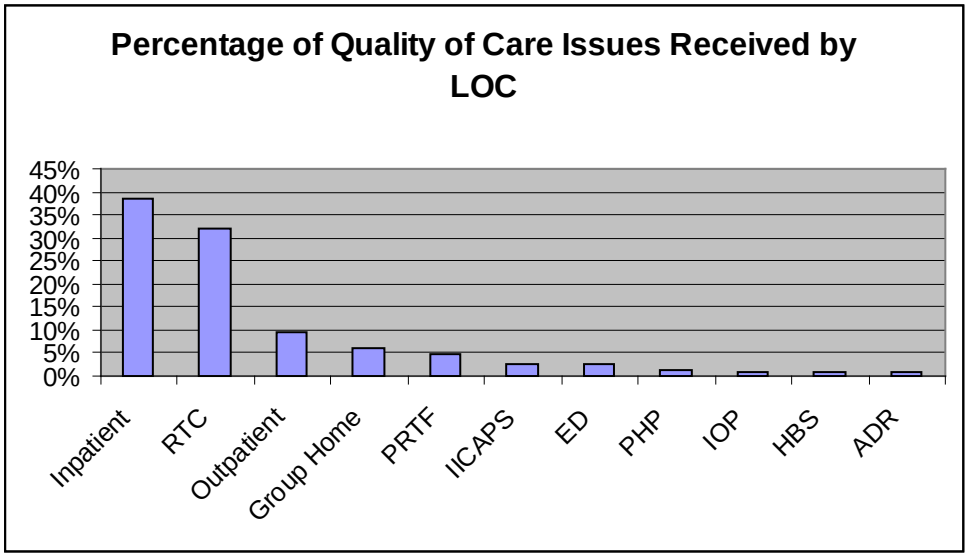
Goal 4. Promote patient safety and minimize patient and organization risk from Adverse Incidents and Quality of Care and Service Issues (Contract Reference L.10.1)

Activities and Findings that include trending and analysis of the measures to assess performance:

A. Quality of Care (QoC)

1. Number of QoC issues identified; broken out by child and adult

CT BHP began tracking QoC issues in February 2007. A total of 36 issues were identified during the remainder of 2007. During 2008, 203 Quality of Care issues were received and reviewed by the QoC Committee. Of those, 186 (91.6%) concerned the quality of the treatment of youth and the remainder, 17 (8.4%) concerned adults. The following chart displays the percentage of QoC issues by Level of Care (LOC):



The levels of care with the most quality of care issues associated were, by far, the inpatient and RTC level of care.

2. Most frequent types of QoC issues identified;

The most frequently occurring types of QoC issues across all levels of care were alleged:

- Failure to follow standard practice (27)
- Concern regarding provider lack of supervision (22)
- Difficulty accessing appointment with an ECC (16)
- Treatment setting not safe (14)
- Failure to coordinate care (12)
- Inadequate discharge planning (11)
- Delay in treatment (9)
- Failure to attempt to involve family (7)
- Psychotropic medication issues (7)
- Adequacy of assessment (6)

- Abandoned member (5)
- Treatment inconsistent with LOC (5)
- Sexual relationship with member (5; all reported to DCF by the program and investigated by DCF)

When sorted by LOC, trends in quality of care issues identified by LOC are:
Inpatient:
- Treatment setting not safe
- Inadequate discharge planning
- Failure to follow standard practice
- Failure to coordinate care

RTC:
- Failure to follow standard practice (i.e., lack of clinical oversight of medication, infrequent therapy sessions)
- Accusations of sexual relationship with member
- Treatment setting not safe (i.e., members attacked by other members)
- Failure to attempt to involve family in treatment

Outpatient:
- Difficulty accessing appointment with an ECC

3. Trend Quality of Care issue by provider

Two inpatient facilities account for the largest percentage of identified quality of care issues; both have quality improvement plans in place to address those issues. Both facilities had more than 20 issues identified during 2008, although not all were substantiated.

Four RTCs had 10 or more quality of care issues identified. Those quality of care issues are shared with the DCF Bureau Chief on at least a monthly basis.

B. Adverse Incidents

1. Number of adverse incidents broken out by child and adult

A total of 19 adverse incidents were documented during 2008. Of these, 13 (68.4%) involved youth and 6 (31.6%) involved adults.

2. Most frequent types of Adverse Incidents identified

The most frequent type (7) of the reported adverse incidents involved self-inflicted harm (36.8%). Of these, the largest percentage were of minimal or moderate risk. All were reported to the departments or were determined to have already been reported to the departments by the facility or provider.

The second most frequent type of incident during 2008 involved members accusing provider staff of sexual abuse (19.2%). In all of these incidents, the reports had already been submitted to DCF via the hotline.

There was 1 report of an unanticipated death during 2008. The case did not involve any investigation by CT BHP as the case was not managed by us at any time.

3. Trend Adverse Incidents by provider

There were no trends in terms of facilities or providers being associated with adverse incidents.

Recommendations for continuing sub-Goal in 2009:
With revisions, this sub-goal will be applicable for 2009 and should be included in the 2009 Project Plan.

Goal 5. Establish and maintain CT BHP-specific policies and procedures (P&Ps) in compliance with contractual obligations that govern all aspects of CT BHP operations. (Contract Reference E.3.1 and L.9)

Activities and Findings:

A. All CT BHP-specific Clinical, Quality, Customer Service and Provider Relations P&Ps are reviewed and revised as necessary but no less than annually.

During 2007, major process revisions were made regarding the service center-specific P&Ps. Those were:

- A revision of the list of P&Ps maintained by the QM Department to include only those that are service center specific;
- Review dates and revision dates were maintained on this master list.
- Training of all department leads responsible for writing P&Ps was conducted that included the review of guidelines for format and content.
- Centralized and shared electronic files for P&Ps, including an archiving system, were implemented.
- "Red-lined versions" of P&Ps, to make it easier to determine where changes have been made, were recommended.

These processes were implemented by the end of the first quarter of 2008, when a complete file of all CT BHP P&Ps were submitted to the Departments. During 2008, the CT BHP contract manager assured that all contractually required P&Ps were reviewed by the responsible departments at least annually.

B. All CT BHP-specific P&Ps related to contract requirements with substantive changes are submitted to the Departments for review and approval prior to implementation.

There were no CT BHP P&Ps that required revision with substantive changes during 2008.

Recommendations for continuing sub-Goal in 2009:
This sub-goal will be applicable for 2009 and should be included in the 2009 Project Plan. .

Goal 6. Establish and maintain training program that includes compliance with state regulatory requirements and HIPAA regulations (Contract Reference V.1 and V.3)

Activities and Findings:

A. Staff training on state regulatory requirements

Staff training on state regulatory requirements is completed during orientation and then via periodic review in departmental staff meetings. As a result of the audit completed in Q3 08 and the finding that notifications had not been sent out for several denials (See Goal 9 for details), a careful review of the requirements was completed and workflows were revised. Re-training of the entire clinical and QM staff was conducted.

B. Staff training on HIPAA privacy regulations

During the first half of 2008, there were three incidents of HIPAA breaches, all of which were reported to the Departments. Two of the incidents involved the same pharmacy report, which included PHI, being forwarded to individuals who should not have had access to this information. In all three instances, immediate actions were taken to retrieve the information with moderate success. However, a corrective action plan to address the overarching issues that led to these breaches and the actions taken to assure that similar types of breaches not occur in the future, was put into place on June 12, 2008.

The first issue that was identified had to do with sharing template reports generated by national ValueOptions or other ValueOptions service centers with the Departments or with members of committees on which CT BHP staff participate. On investigation, it was determined that there are five CT BHP ValueOptions senior staff members who, on a fairly regular basis, obtain reports from either national ValueOptions or from other service centers to use in the development of new reports or products for CT BHP. While the experience of national ValueOptions and/or other ValueOptions service centers is critical to the CT ValueOptions Service Center as a means for obtaining state of the art products to share with the Departments, there is risk associated with sharing these reports and/or documents as some may contain PHI.

The following actions were taken to prevent any future breaches:

1. Informed and educated the ValueOptions employee who had forwarded the reporting package and notified his supervisor (the Vice President of Data Management) of the occurrence, the need for a revised process for assuring that template reports not contain PHI, and the need for a revised template package. The file was deleted both from the national ValueOptions file as well as from all CT BHP files. The Pharmacy Report template file was replaced with sample reports that contained no identifying information.

2. Notified the National Director of Compliance for ValueOptions of this occurrence and discussed actions that should be taken by ValueOptions to prevent similar incidents from occurring in the future.

3. Established a local protocol for handling sample or template reports generated by national or service center ValueOptions offices received by CT ValueOptions. This revised protocol included the following actions to be taken before the reports are used:

- Review by the QM Department of any reports or documents received from national ValueOptions or any ValueOptions Service Center for PHI or other inappropriate information before further dissemination;
- Review of any reports by the QM Department before dissemination to any organization or person outside of the CT BHP service center;
- If the document contains PHI, either it will be redacted using pdf writer software or, if received from national ValueOptions and forwarded as a template file, it will be returned and a request made for a redacted edition.
- If the report is needed urgently for some reason, it will be redacted manually and saved in one of the limited access files on the shared drive that indicates it is a report that can not be shared with anyone external to ValueOptions.

The second issue identified concerned the need to continuously retrain CT BHP staff regarding HIPAA regulations. Retraining of the entire staff was conducted within a week of the occurrence. Training material was distributed. A postcard size set of instructions for encryption of e-mails was distributed to every staff person and all were requested to hang these at their desks as a reminder. Company-wide training, that included CT BHP staff, was conducted during the last week of May 2008. Every CDT BHP staff member completed and passed the on-line training module during that time.

In order to continually remind staff regarding the need to follow HIPAA regulations, periodic HIPAA reminders are mailed to all staff in the service center. These tips address topics such as the need to lock computers when staff walk away from their desk and HIPAA issues that can arise when faxing and e-mailing.

There have been no further breaches reported during 2008.

Recommendations for continuing sub-Goal in 2009:
This sub-goal will be applicable for 2009 and should be included in the 2009 Project Plan.

Goal 7. Measure and assess Member and Provider Satisfaction (Contract Reference L.5)

Activities and Findings:
Based on a review of the findings of the 2007 Member Satisfaction Survey on July 18, 2008, the Quality, Access and Safety Committee suggested that a workgroup be formed to make recommendations to the larger committee regarding changes to the Member Satisfaction survey that would improve its usefulness. There were two specific concerns about the survey:

- The length of the survey, and
- Concern that the members or parents/guardians responding to the survey may not be rating their satisfaction with the level of care of interest.

The second concern had to do with the fact that the survey was conducted once per year and that members surveyed had frequently used more than one level of care during that year. As a result, there was no way of ensuring that the member was actually rating their satisfaction with the specific level of care of interest.

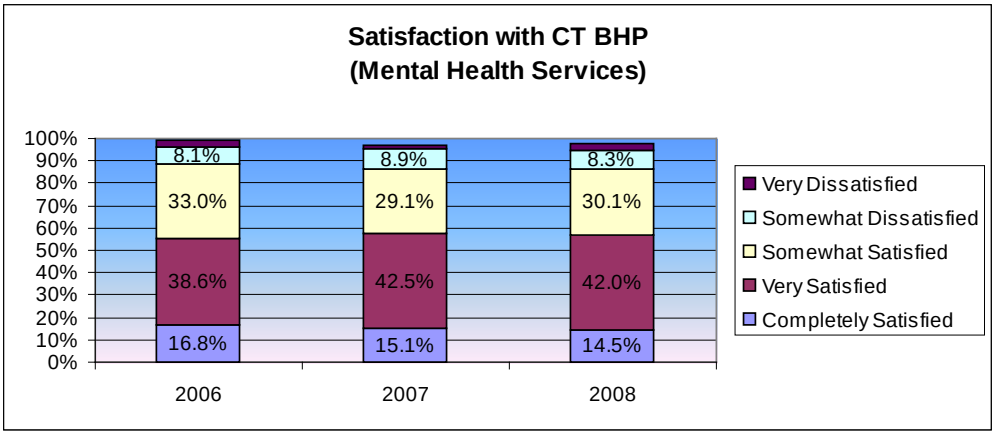
The workgroup met on August 15, 2008 and made the following recommendations to the Quality Access and Safety Committee:

- Shorten the survey tool by removing the eight questions regarding satisfaction with telephone access to CT BHP. The sample size of members responding to these questions had been consistently very small and the annual Mercer Survey of member satisfaction with telephone access made this aspect of the survey redundant.
- Move from an annual survey process that involved sampling members who had received treatment within the last year to a more real time, year round surveying process where members are surveyed within a month of receipt of the services.

The recommendations were adopted and implemented for the 2008 Member Satisfaction survey

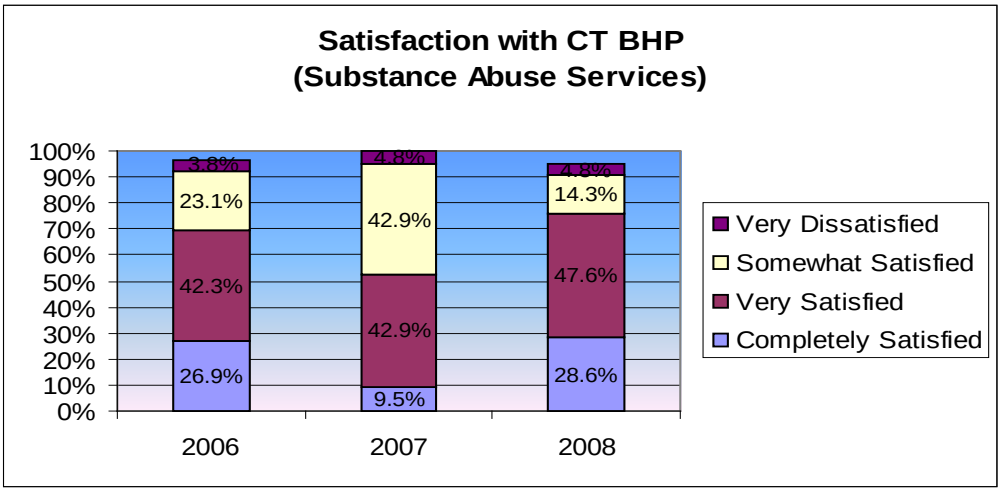
A. Member Satisfaction:
1. Overall member satisfaction with services provided by CT BHP
2. Overall member satisfaction with counselor
3. Member satisfaction with Customer Service
4. Member satisfaction with member materials
5. Member satisfaction with Peer Specialists
6. Member satisfaction with complaint resolution process
7. Member satisfaction with availability of providers
8. Member satisfaction with access to care
9. Member satisfaction with UM process

Overall Satisfaction:



Overall, how satisfied are you with the mental health services your child has received in the last year?

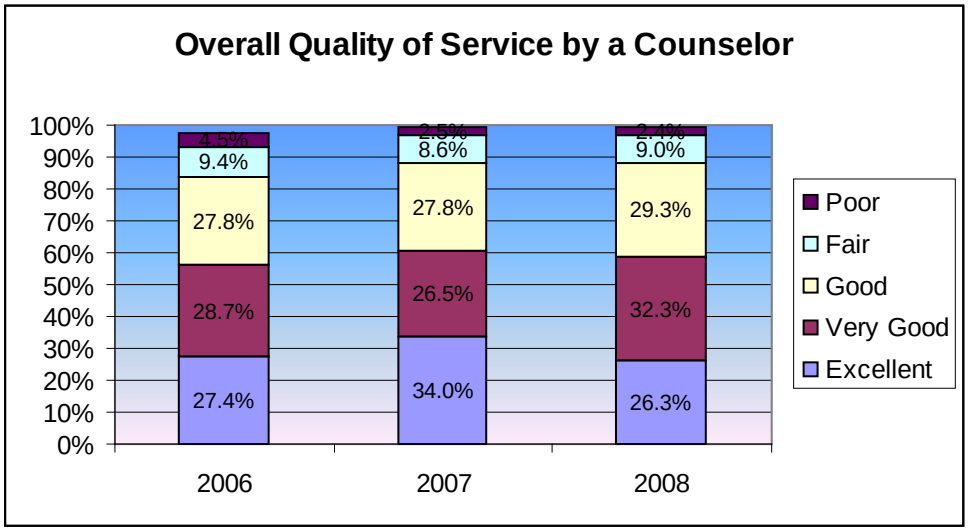
Members treated for mental health issues were somewhat to completely satisfied slightly more than 86% of the time in both 2007 and 2008. In 2006 this rate was 88.4%. Child members (or the parents or guardians responding for them) were more likely than adult members to say they were somewhat to completely satisfied; 89.4% and 75.6% respectively.



Overall, how satisfied are you with the substance abuse services your child has received in the last year? (This question was asked of only adult members who received treatment.)

In 2008, members treated for substance abuse issues reported that they were completely or very satisfied more often than during 2006 or 2007; just over 45% more than in 2007. However, the number of members responding to this question is small (N= 21 in 2008, and 21 in 2007) and the findings should be viewed with caution.

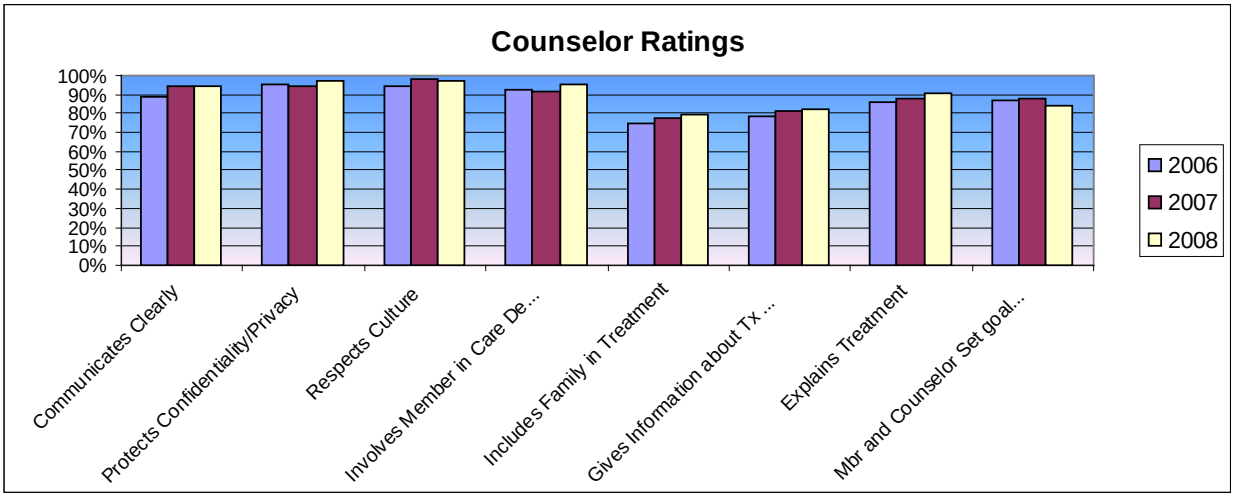
Overall Satisfaction with Counselor:



Overall, how would you rate the quality of service your child has received from the counselor?

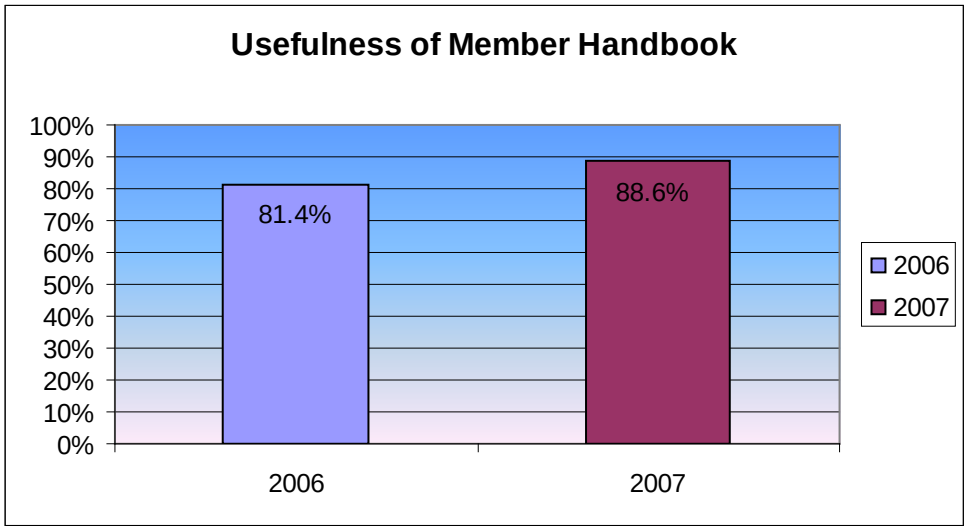
In 2008, overall ratings of counselors remain similar to those of 2007. Child members were more likely than adult members to rate the Quality of Service by their clinician as good, very good or excellent. When the categories of good, very good and excellent are combined, there is no change in the overall level of satisfaction with a counselor from 2007 to 2008.

In the 2008 survey, 167 of the 214 members surveyed reported that they had seen a counselor in the last year. The following chart represents member satisfaction with various aspects of the care they received from the counselor.



Does the counselor say things in words your child understands? . . . protect your child's privacy? . . .understand and respect your child's culture, religion and values? . . . involve you in decisions about your child's care? . . . include your family in treatment services? . . . give you information about treatment options? . . . explain what treatment your child would be getting? . . .Did you and the counselor set goals for the treatment services?

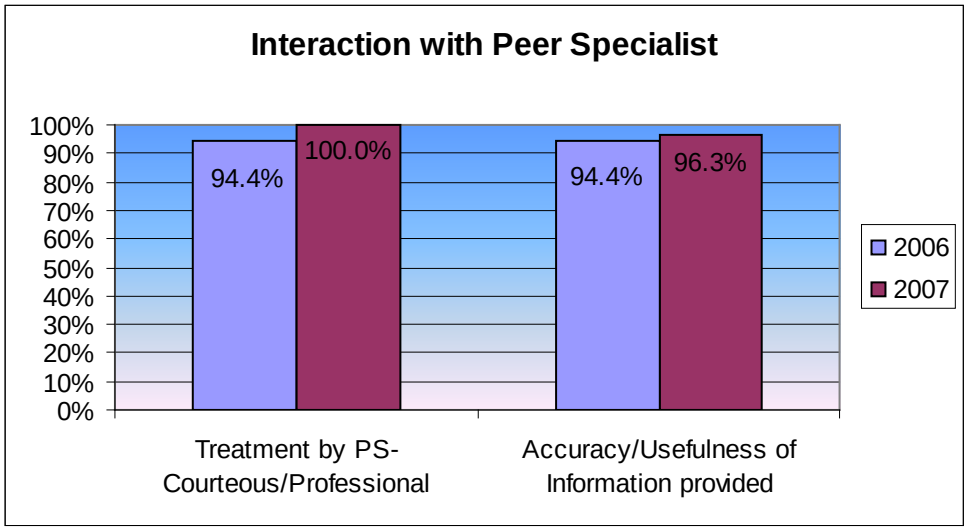
Member Satisfaction with Member Materials:



How satisfied were you with the usefulness of the Member Handbook?

2008 data is not available for comparison for this measure. The data for this particular measure is not provided by the ValueOptions survey. It is drawn from the findings of the Mercer Member Survey. Members were more satisfied with the usefulness of the Member Handbook in 2007 when compared to 2006.

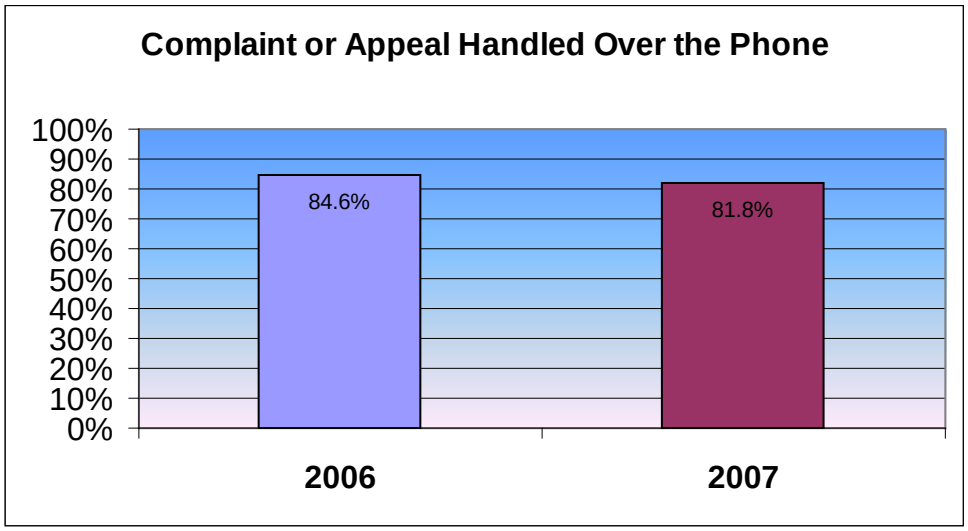
Member Satisfaction with Peer Specialists:



How satisfied were you with how courteously and professionally you were treated by the peer specialist?
How satisfied were you with the accuracy and usefulness of the information you were given by the peer specialist?

Again, since this information is drawn from the Mercer Survey, 2008 data is not available for comparison. Members were more satisfied with their interactions with the Peer Specialists in 2007 than in 2006.

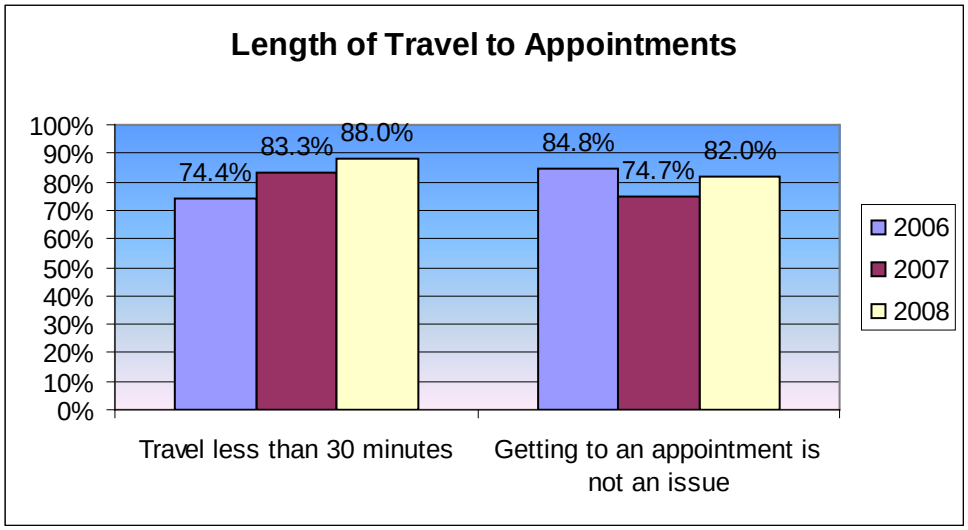
Member Satisfaction with Complaint resolution process:



How satisfied were you with how the complaint or appeal was handled over the phone?

2008 data is not available for comparison. Members were less satisfied with the telephonic handling of complaints and appeals in 2007 when compared with 2006. This percentage represents a small sample of just 11 members in 2007. While this is not a statistically significant drop in satisfaction this metric will need to be monitored to ensure a trend does not develop. This metric continues to be below the 90% goal.

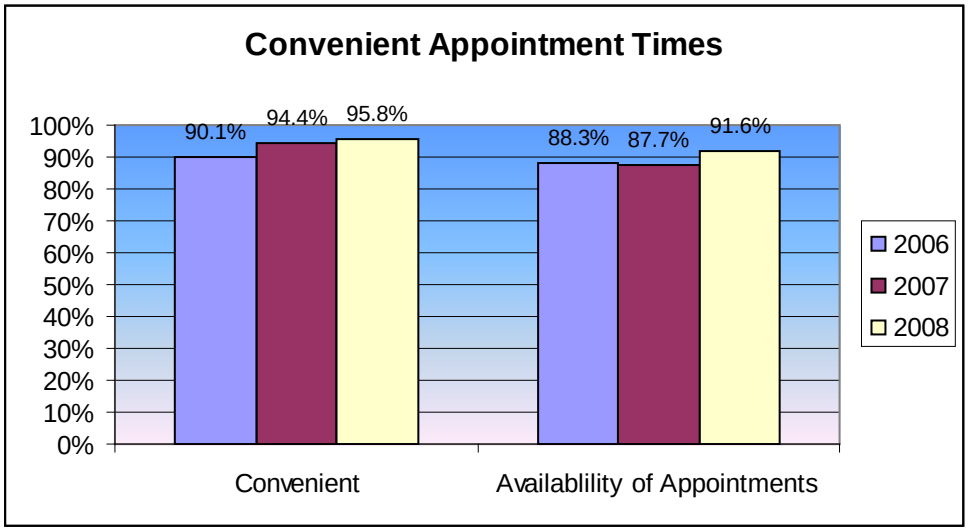
Member Satisfaction with Availability of Providers:



To get to the counselor, do you travel 30 minutes or less or more than 30 minutes?
Is getting to the appointments a problem for you or not a problem?

Of those members who reported that they had seen a counselor, they rated their satisfaction with availability of providers higher in 2008 than in 2007.

Member Satisfaction with Access to Care:



Does the counselor offer convenient appointment times?
Are you able to get appointments as often as you would like?

Convenience of appointment times has risen the past two years since baseline in 2006. With regard to availability of appointments, more child than adult members reported the ability to get appointments as often as desired, 93% and 88.7% respectively. With regard to travel to appointments, most members who reported difficulty getting to an appointment cited lack of transportation and difficulty using the provided transportation. When informed of the availability of transportation through the HUSKY program, 44.3% of members reported they were not aware of a transportation service.

Member Satisfaction with UM Process:

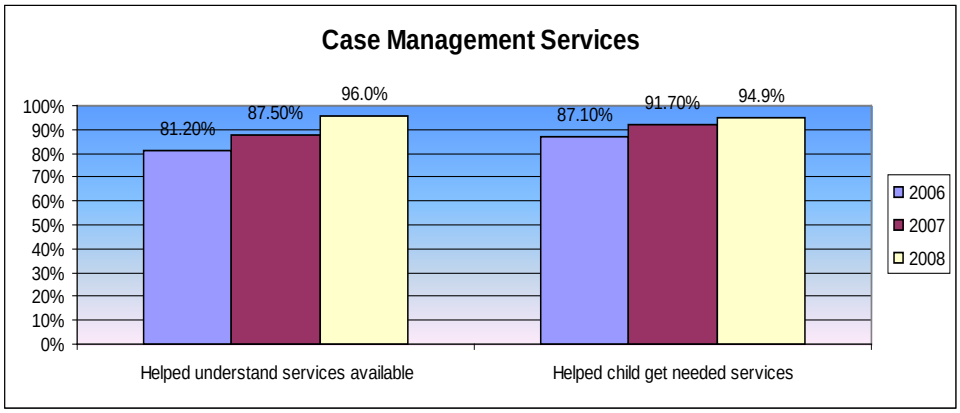
Members rarely have experience with the utilization management process at CT BHP. Nearly all of the time, providers obtain authorization for services while members only receive referrals from CT BHP. We do know from the Mercer Survey that members are very satisfied with the customer service they receive when they contact CT BHP and that there have been no complaints regarding telephonic access to CT BHP.

One of the only aspects of the UM process that members might be aware of is Case Management. However, it is not clear if members understand the term “case management”, or if they do, understand that we are referring to a case manager at CT BHP. One of the initial recommendations of the sub-committee was that these questions be deleted from the survey. This recommendation was not supported by the workgroup.

Overall, satisfaction with CT BHP case management has increased over the three years of the survey. (See chart immediately below.) 32% of members surveyed who reported seeing a counselor also reported having been assigned a case manager. However, in practice, it would be a rare instance when a member in outpatient care would have a CT BHP case manager assigned.

It is recommended that this measure be deleted from this goal in 2009.

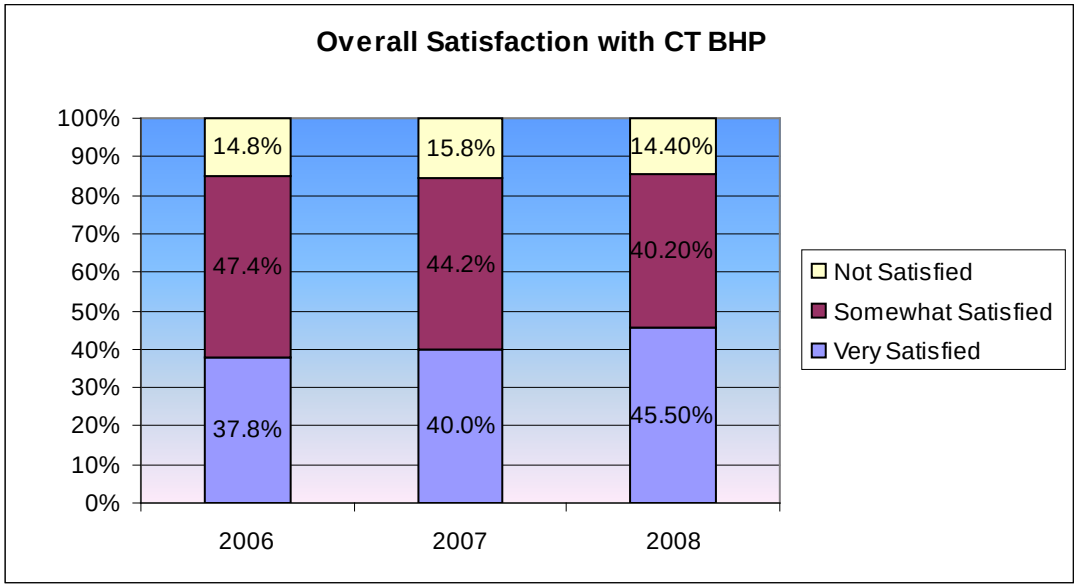
Satisfaction with CT BHP Case Management:



Has the case manager helped you understand which services are available to you?
Has the case manager helped you get the services your child needs?

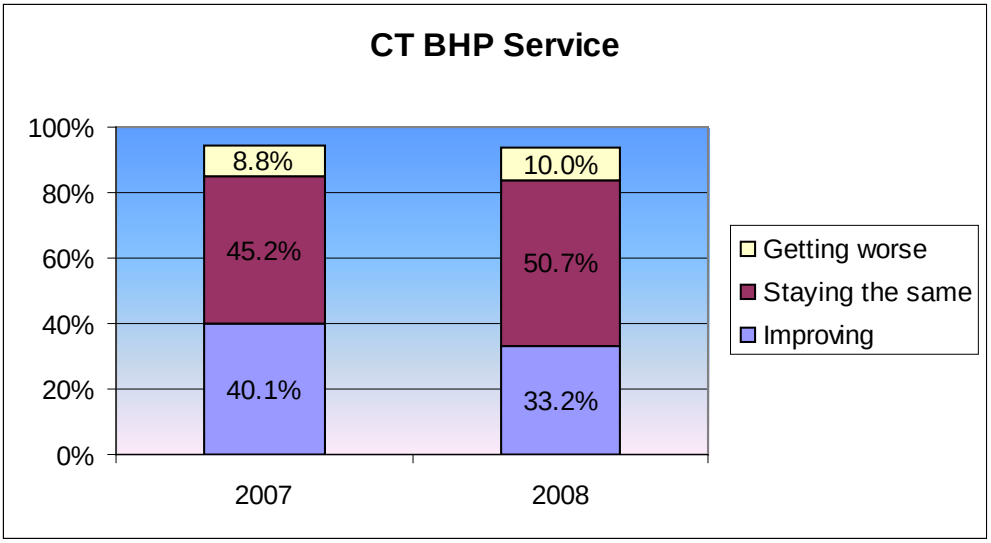
C. Provider Satisfaction

Overall Satisfaction:



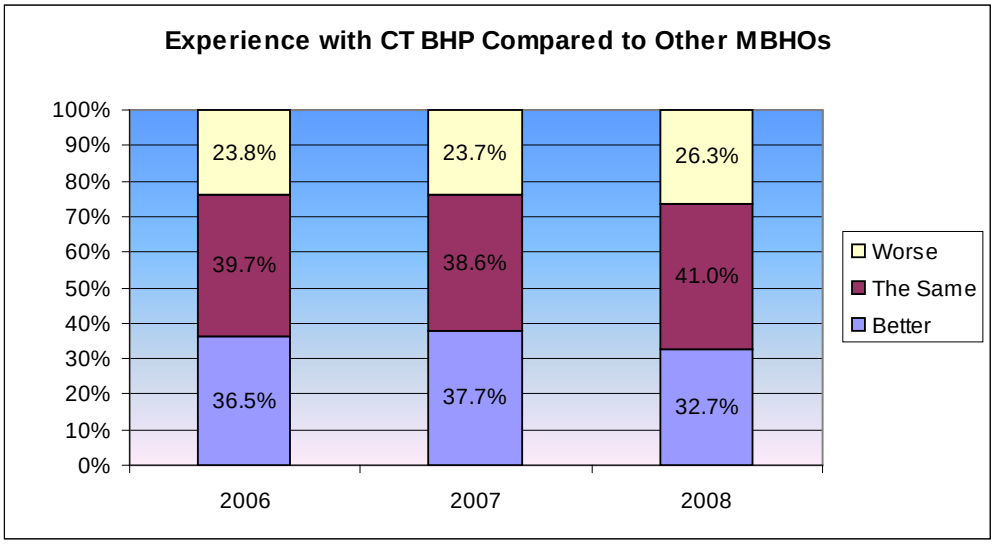
Overall, how satisfied are you with the services of CT BHP?

Overall, provider satisfaction with CT BHP increased slightly in 2008. Providers are at least somewhat satisfied with the services of CT BHP about 86% of the time. This percentage represents the highest overall provider satisfaction since inception in 2006. 80% of those providers who were not satisfied with the CT BHP reported that the authorization process was not simple, efficient and of low administrative burden.



Overall, Is Connecticut BHP's service improving, staying the same, or getting worse?

This question was added in 2007. Overall, Providers feel that CT BHP service is at least staying the same 83.9% of the time, a decrease from 2007. Individual practitioners felt service was getting worse more than two times as much as Facility providers, 13.5% and 6% respectively.

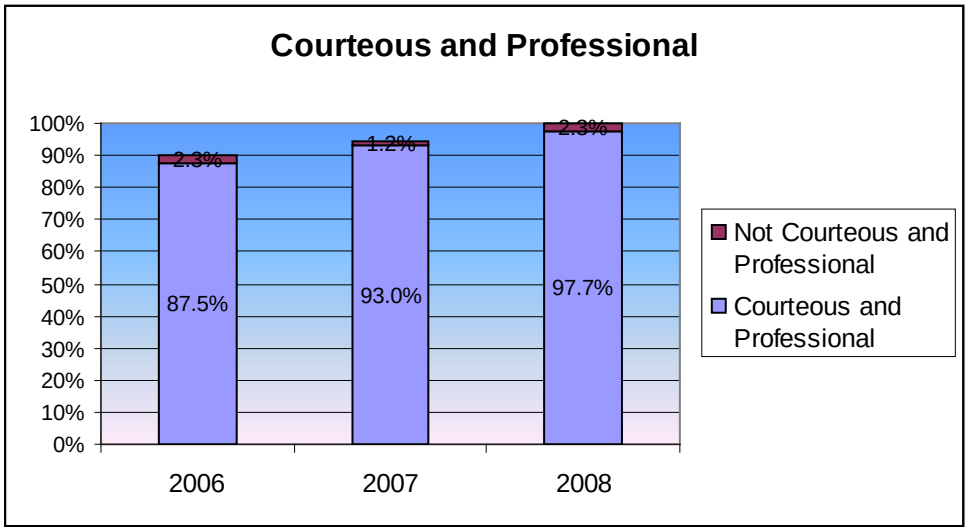


Compared to other managed behavioral healthcare organizations, has your experience with the Connecticut BHP been better, the same, or worse?

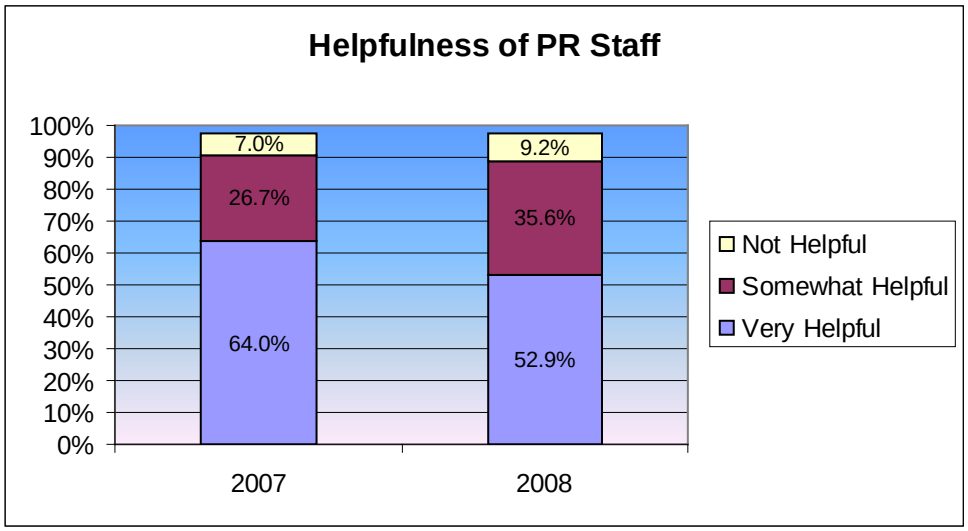
When compared to other Managed Behavioral Healthcare Organizations (MBHOs), providers experience with CT BHP is better or the same just over 73% of the time. This is a decrease from the two previous survey years. Once again individual providers rated CT BHP worse than facility providers. Individual practitioners reported that CT BHP, when compared to other MBHO's was better 22.5% of the time and worse 26.3% of the time whereas Facilities rated CT BHP better 44.7% of the time and worse 13.8% of the time.

Provider Relations:

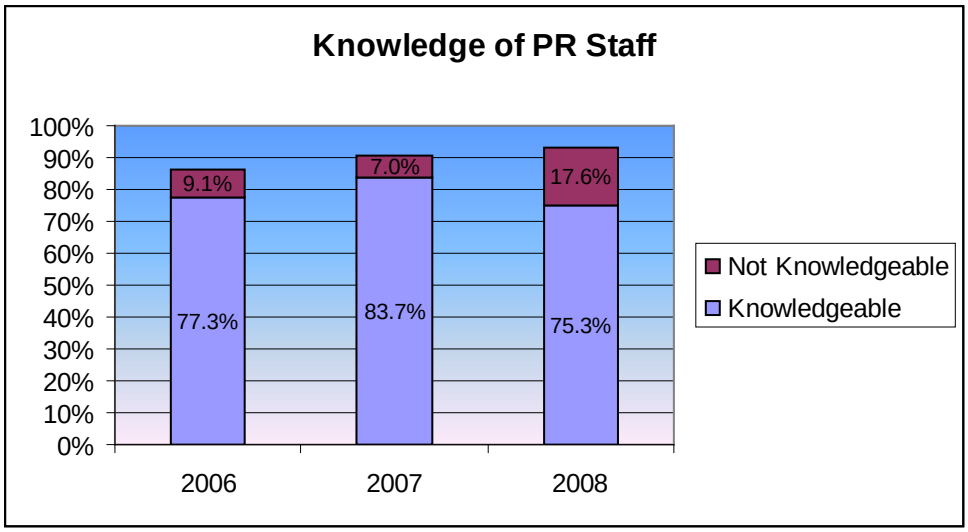
The following measures represent a subsample of providers (87 of the 213 providers surveyed) who reported that they spoke with Provider Relations staff in the last 6 months.



Was the provider relations specialist courteous and professional?



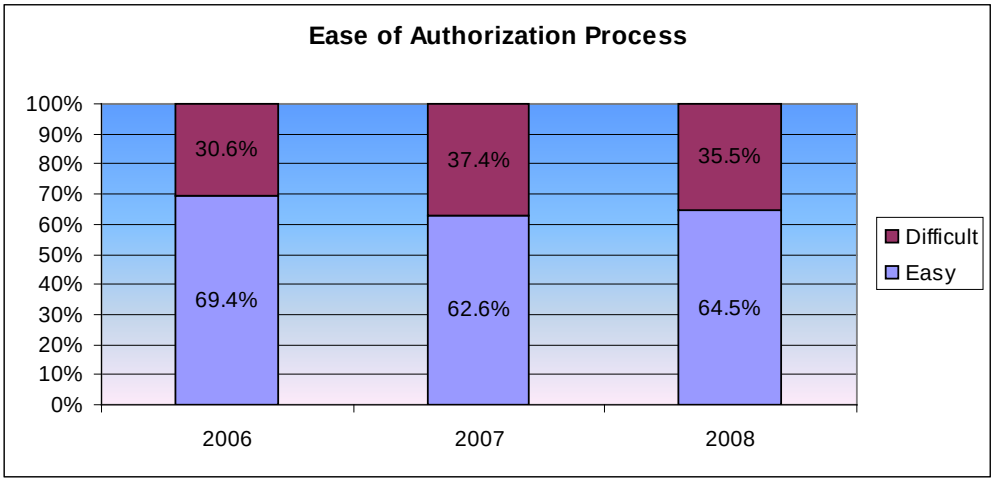
Was the provider relations specialist very helpful, somewhat helpful or not helpful?



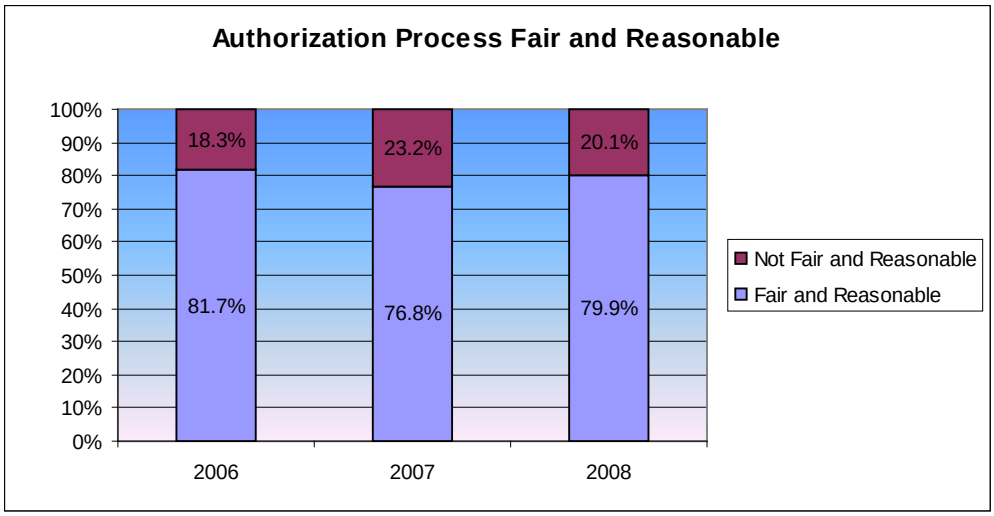
Was the provider relations specialist knowledgeable?

Since 2006, providers have consistently reported high rates of satisfaction with the courteousness and professionalism of the CT BHP provider relations staff (97.7% in 2008, well exceeding the 90% goal). Satisfaction with both provider relations knowledge and helpfulness has decreased since 2007. Providers reported that they find provider relations staff at least somewhat helpful 88.5% of the time in 2008, a 5% decrease from 2007. Overall, providers find provider relations staff not knowledgeable 17.6% of the time, an increase from 7% the previous year. This finding may be partially accounted for by the claims issues that resulted from the EDS upgrade in systems during 2008.

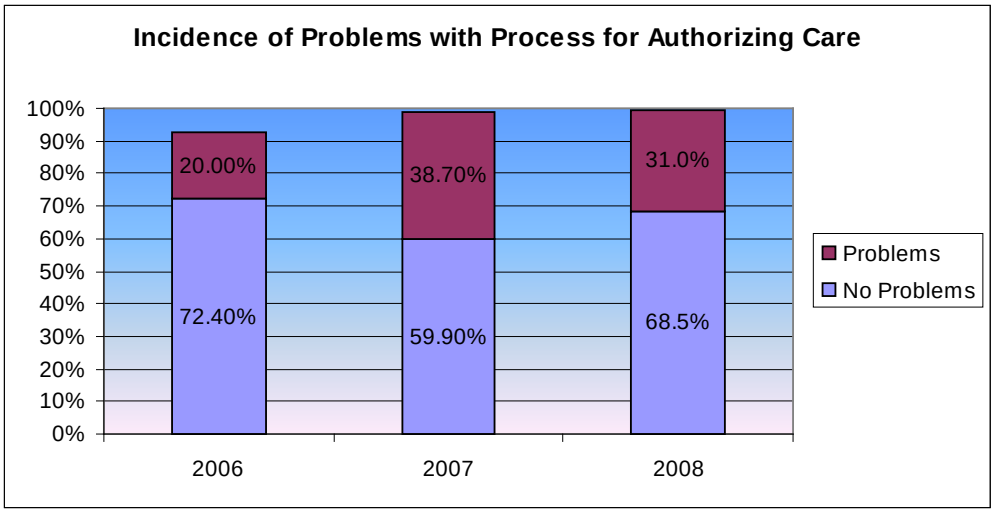
Clinical Management/Authorization Process:



Did you find the authorization process easy of difficult?



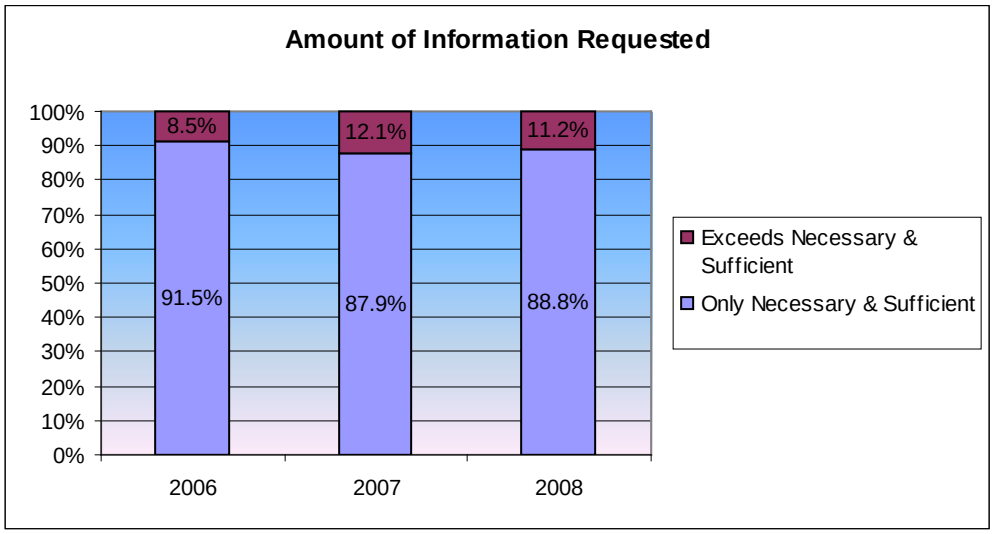
Do you find the authorization process fair and reasonable?



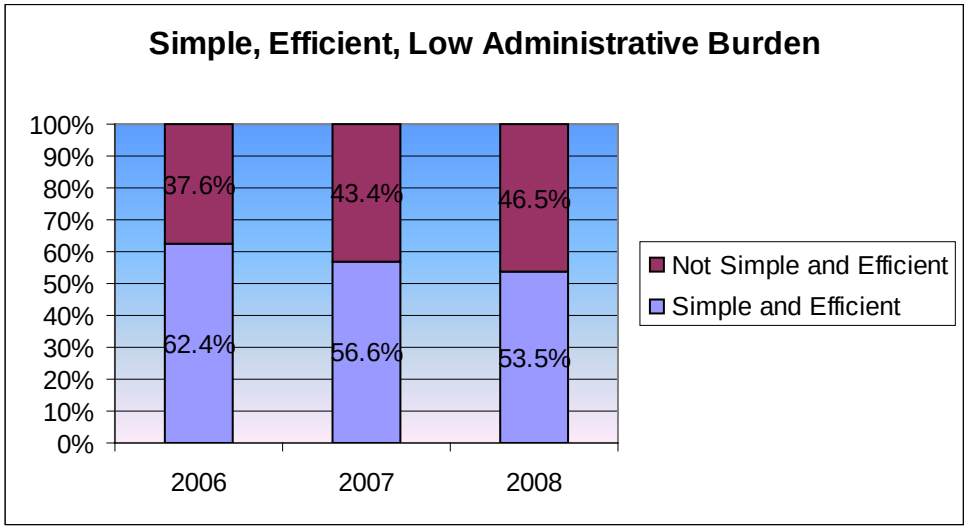
Overall, are you (or your staff) having any problems with the process for authorizing care?

Providers were slightly more satisfied with the authorization process during 2008 than during 2007. There was an increase in satisfaction with the ease of authorization, the fairness of the process, and a decrease in the report of problems authorizing care. The bulk of provider comments (documented during the survey by FactFinders) concerned the difficulty with the website, computer registration and frequent system updates adding to their confusion. Facilities most often suggested that they would like to authorize higher levels of care on-line through web-registration and streamline the authorization process as much as possible.

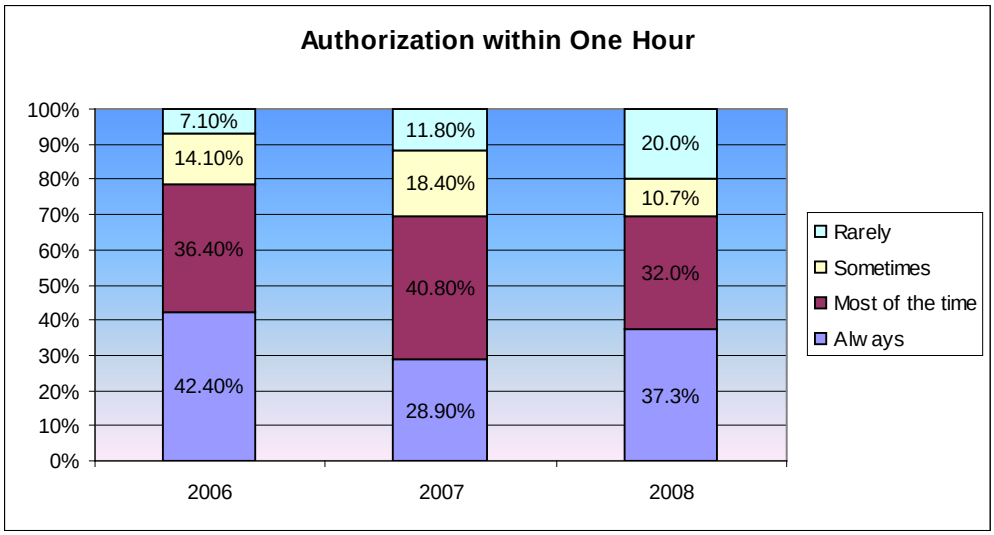
Clinical Practice and Protocols:



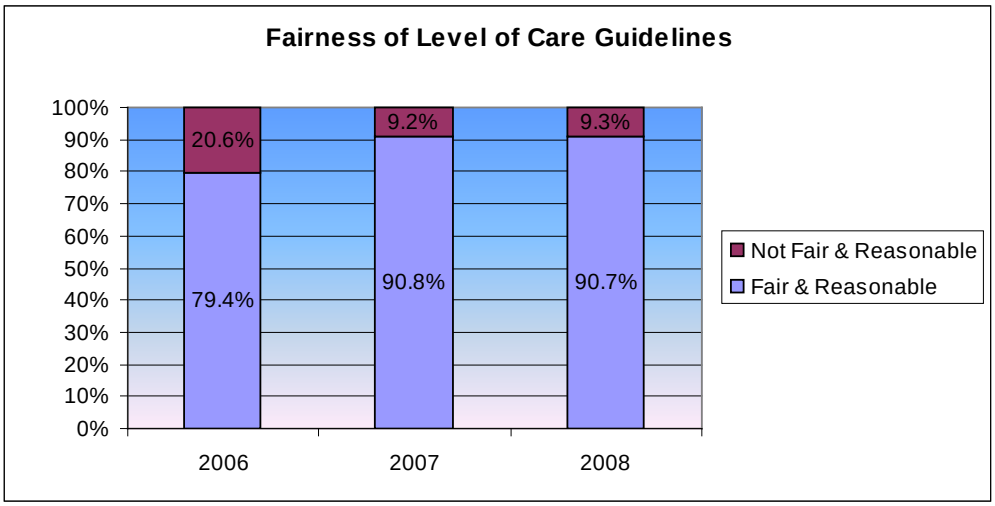
Do the staff request only the information that is necessary and sufficient?



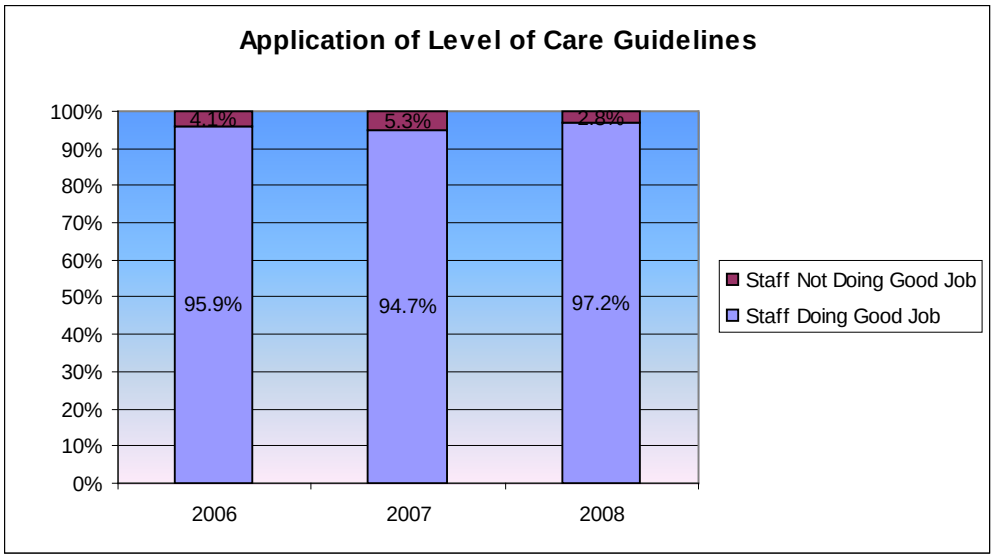
Do you find the process (authorization) simple, efficient, and of low administrative burden?



How often do staff authorize care within 1 hour of receiving all necessary information?



Do you think the state's level of care guidelines are fair and reasonable?

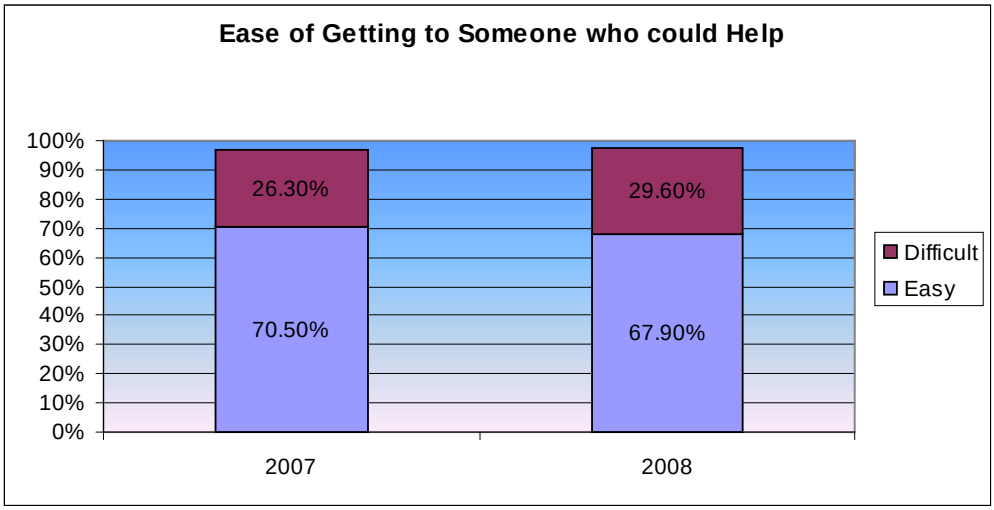


Do you think the CT BHP clinicians are doing a good job applying the guidelines?

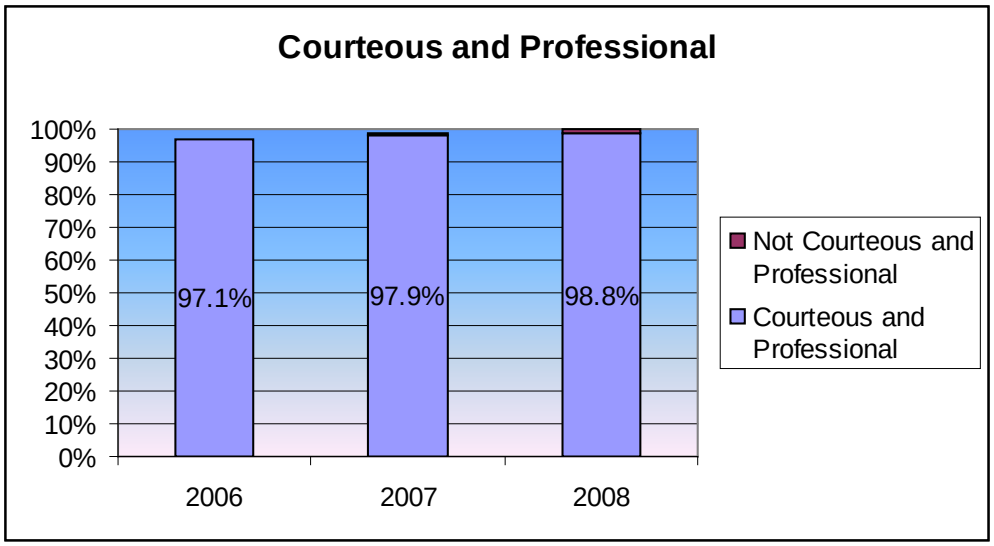
Providers report that CT BHP has slightly improved in 2008 in the amount of information requested for an authorization. There is an increase in performance with regard to CT BHP applying the guidelines in a reasonable and fair manner. Providers reported that the state's level of care criteria are fair and reasonable.

There is a decrease in providers who report that the authorization system is simple and efficient. This is a downward trend since 2006 that in 2008 seems to be driven by Individual providers, 55.1% of whom report that the system is not simple and efficient. There is also a downward trend in providers who report authorization decisions are completed within one hour. Providers answered "rarely" to this question 20% of the time in 2008, an increase from 11.8% in 2007 and just over 7% in 2006.

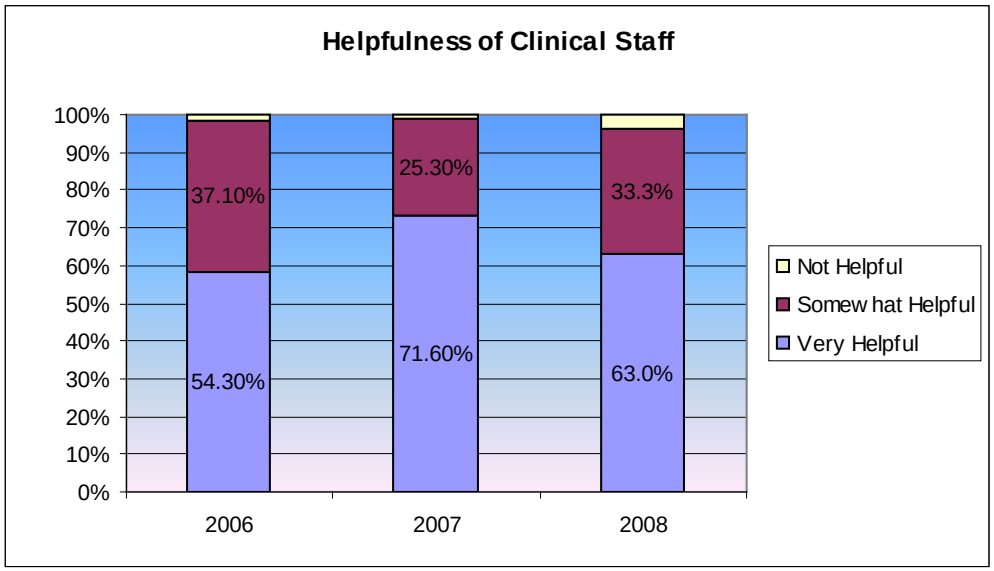
The following measures represent a sub-sample of those providers who reported that they called a CT BHP clinician during 2008 (87 of 212):



When you call, is it difficult to reach someone who can help?



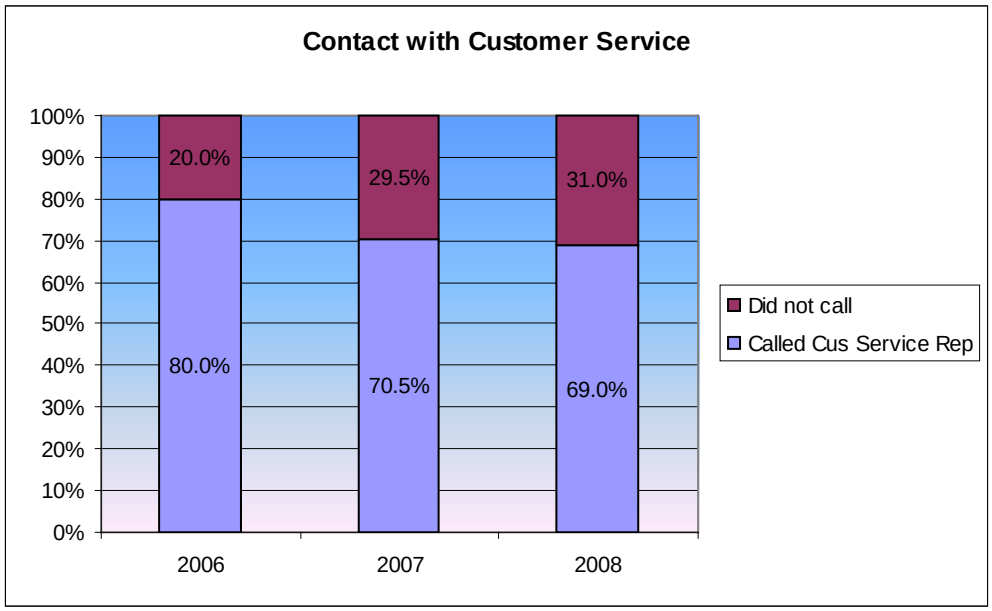
Are the clinicians courteous and professional?



When you call, are the clinicians very helpful, somewhat, or not helpful?

Providers report that CT BHP clinicians are more difficult to reach than in 2007, are very courteous and professional, however, less helpful than in 2007.

Customer Service:
The following measures represent a sub-sample of those providers who called a customer service representative (147 of 213):



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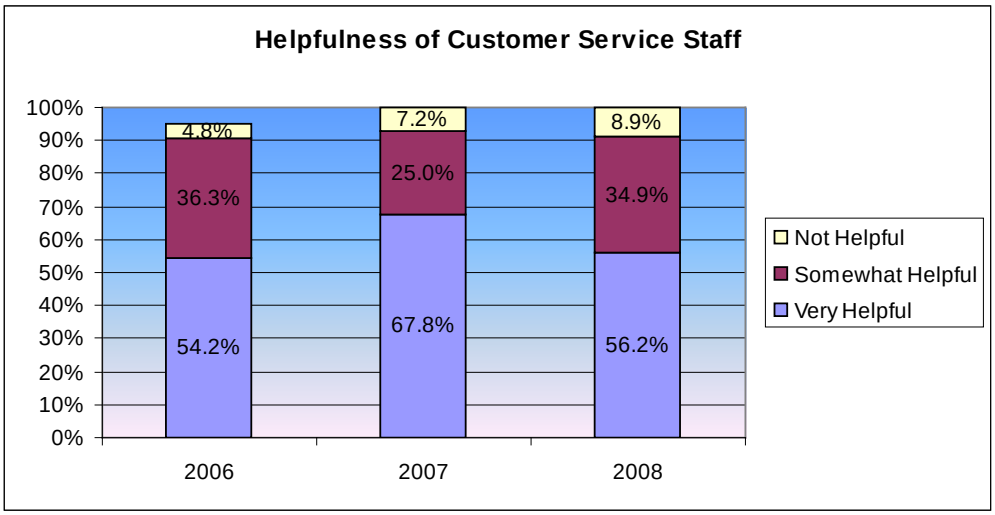
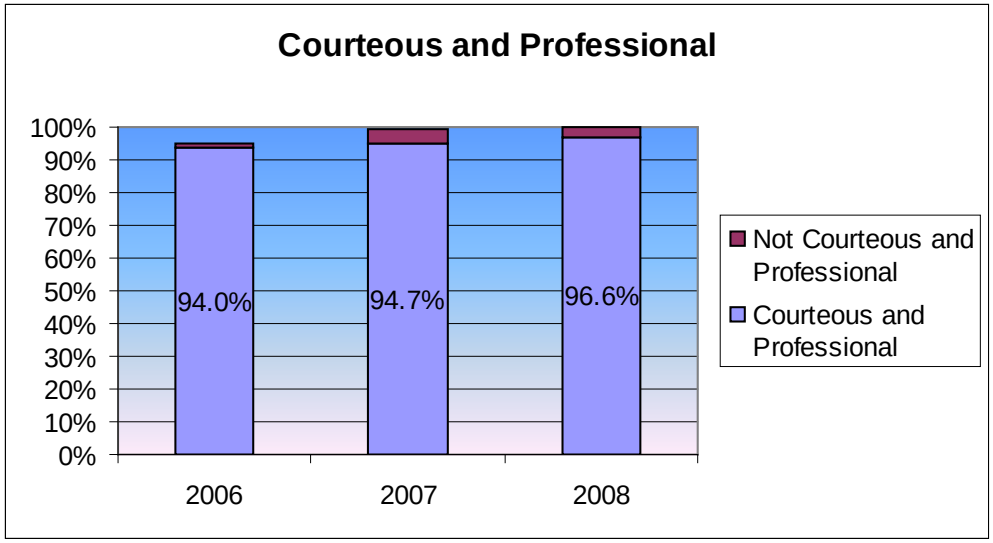
Have you called a customer service rep for a general question, or verification of member eligibility?



When you call, are the customer service representatives very helpful, somewhat helpful, or not helpful?

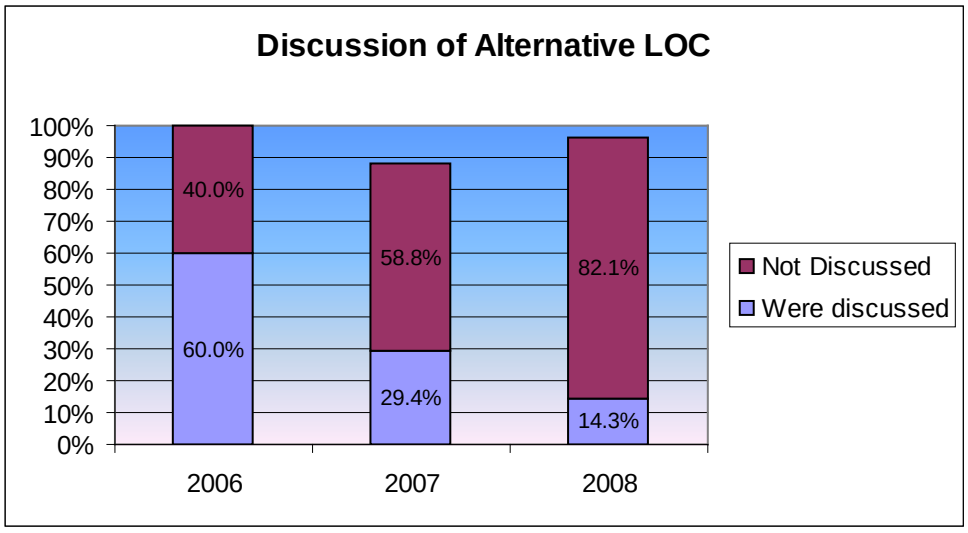


Are the customer service representatives courteous and professional?

Overall, Providers are very satisfied with the interactions they are having with Customer Service staff. In 2008, they rated Customer Service Representatives as slightly less helpful but more courteous and professional.

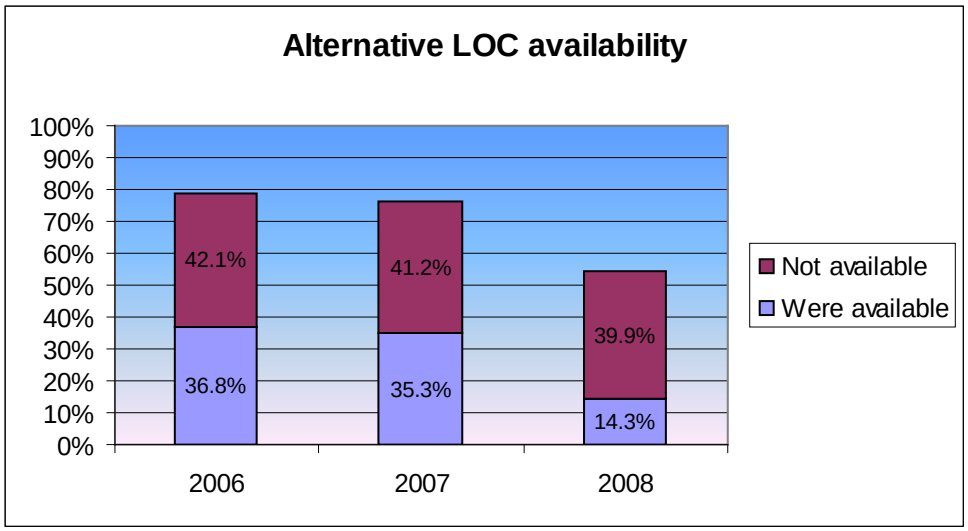
Clinical Denials/Appeals Process:

The following measures represent a sub-sample of those providers who received a denial (n=28):

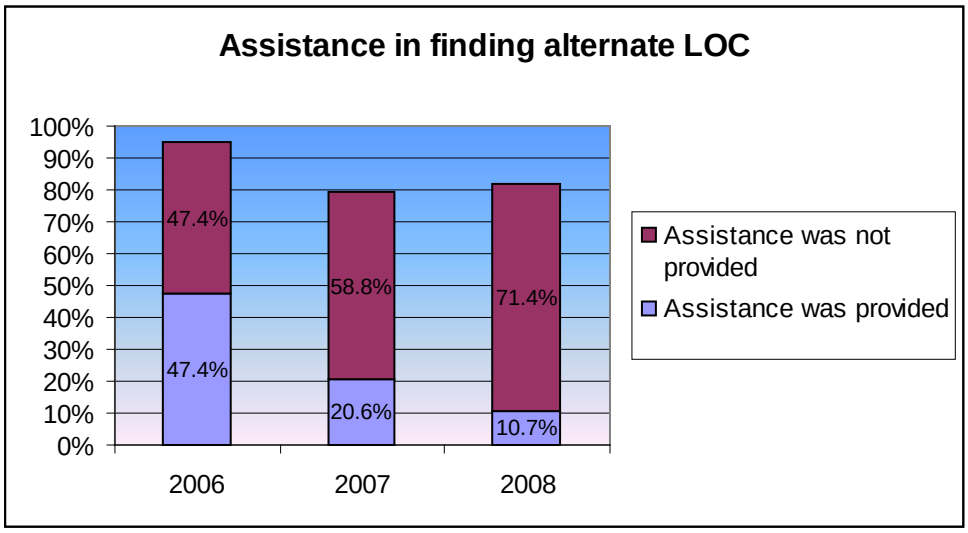


Were alternative levels of care discussed?

Overall, providers are reporting a decreasing trend in discussion of alternative levels of care during a conversation with a Peer Advisor about a denial decision. What is not clear from this question is whether or not providers are reporting this in relation to an administrative denial or medical necessity denial. Alternative levels of care would not be discussed during an administrative denial and as indicated in Goal 3, Administrative denials are a far greater volume of denials than are medical necessity denials.

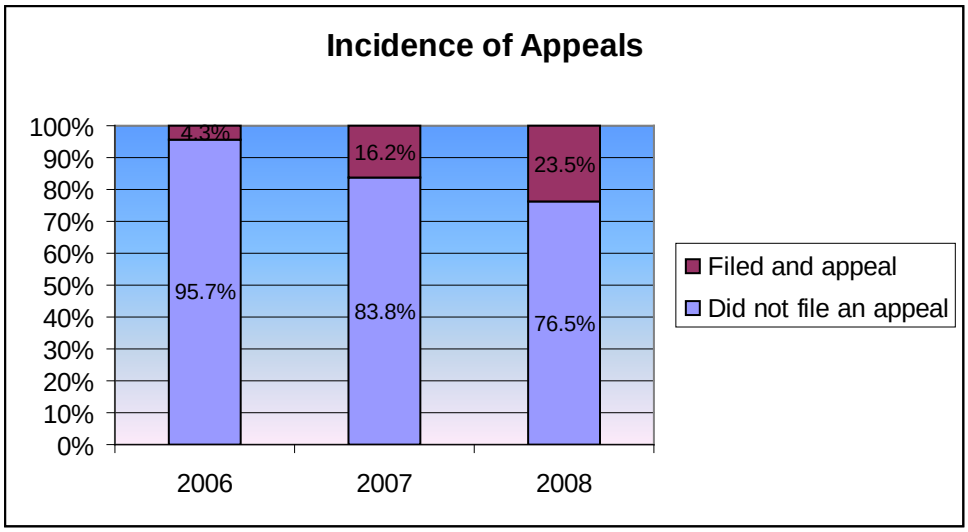


Were alternative levels of care available?



Were you assisted in finding an alternative level of care?

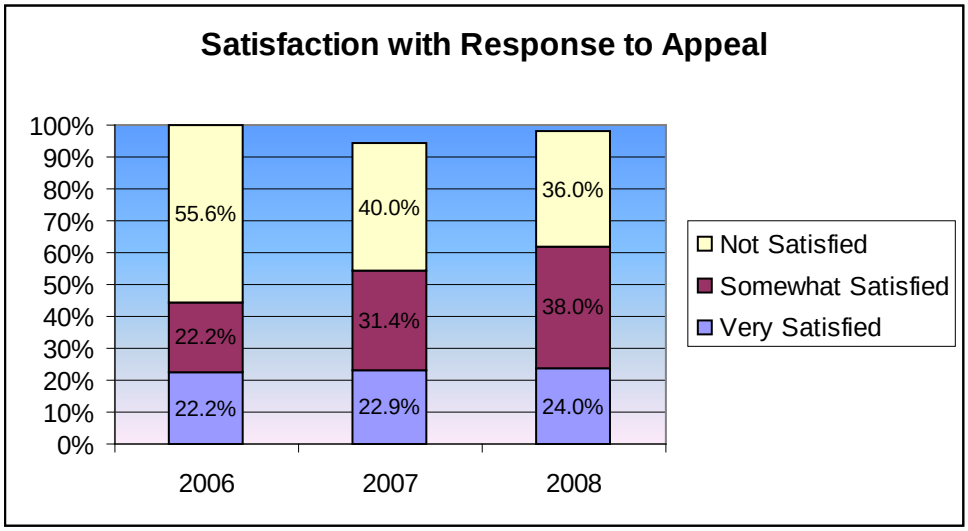
Overall providers who received a denial report a decreasing amount of availability of alternative levels of care and less assistance by the CT BHP staff in finding an alternative level of care. Both measures would be expected to be low given the first measure where 82.1% of providers given a denial reported no discussion of alternative levels of care.



. . . Providers can appeal a CT BHP decision regarding the level of care authorized or appeal a decision to deny payment of a claim for services already delivered. In the last 6 months, have you filed any appeals?

Providers report an increasing number of appeals filed. However, this measure is a measure of both appeals to the CT BHP for denial of authorization and denials of payment of claims by EDS. While the number of providers who reported receiving a denial for authorization was only 28, 50 providers reported filing an appeal. For a true representation of the percentage of providers filing appeals to the CT BHP, refer to Goal 3.

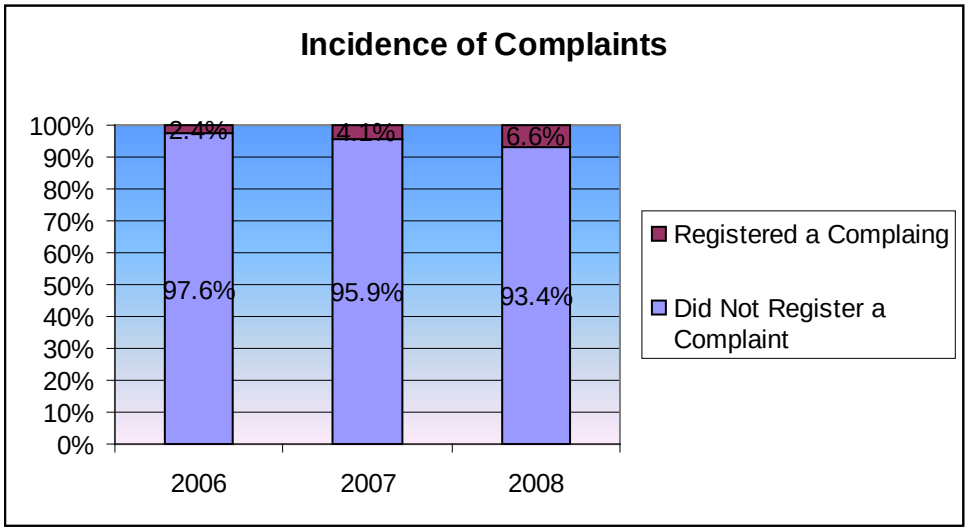
The following questions utilize the same cohort of providers so answers reflect providers experiences with both the CT BHP appeals department and EDS. The following measures represent a sub-sample of those providers who filed an appeal (n=50):



Are you very satisfied, somewhat or not satisfied with the Partnership's response to appeal.

Providers are increasingly satisfied with appeal responses. Providers are at least somewhat satisfied with an appeals response 62% of the time in 2008; this is an increase from 54.3% in 2007 and 44.4% in 2007.

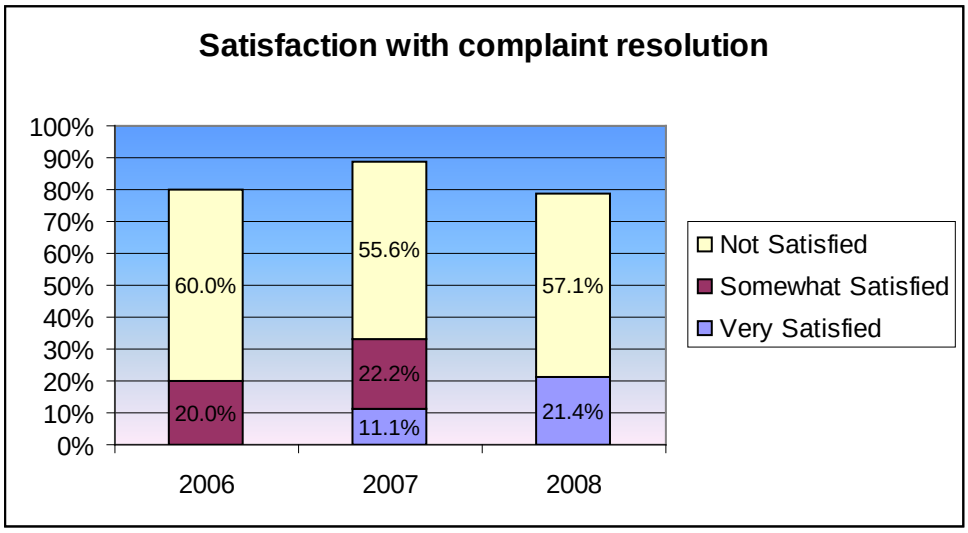
Complaint Resolution Process:



In the last 6 months, have you registered a formal complaint with the partnership?

A total of 14 providers (6.6%) surveyed reported registering a complaint to the CT BHP. This is an increase from both 2007 (4.1%, n=9) and 2006 (2.4%, n=5). However, the overall incidence of complaints remains low.

The following measure represents a subsample of those providers who filed a complaint (n=14):



Are you very satisfied, somewhat, or not satisfied with the Partnership's response to your complaint.

Overall, providers remain unsatisfied with CT BHP's response to complaints. Only 21.4% of providers reported satisfaction with the complaint response, well below the 90% favorable rating goal. Provider comments documented during the survey suggest that providers dissatisfaction is primarily related to complaints regarding claims payment and EDS.

Actions taken to improve, as appropriate:
The results of the Provider Satisfaction Survey will be reviewed with the staff of the Provider Relations Department. Any opportunities for improvement will be identified and added to the 2009 Project Plan as appropriate.

Recommendations for continuing sub-Goal in 2009:
Goals that relate to the actual findings of this survey will be identified and added to the 2007 Project Plan.

1. Provider satisfaction with provider relations
2. Provider satisfaction with clinical management
3. Provider satisfaction with authorization confirmation process
4. Provider satisfaction with clinical denials/appeals process
5. Provider satisfaction with complaint resolution process

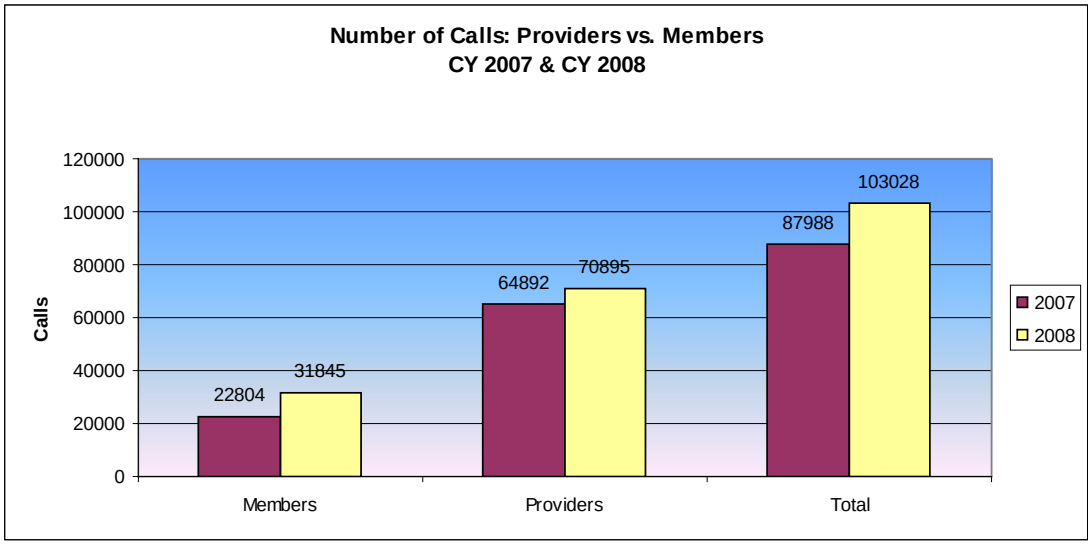
Recommendations for continuing sub-Goal in 2009:
This sub-goal will be applicable for 2009 and should be included in the 2009 Project Plan.

Goal 8. Ensure timely telephone access to CT BHP

Activities and Findings that include trending and analysis of the measures to assess performance:

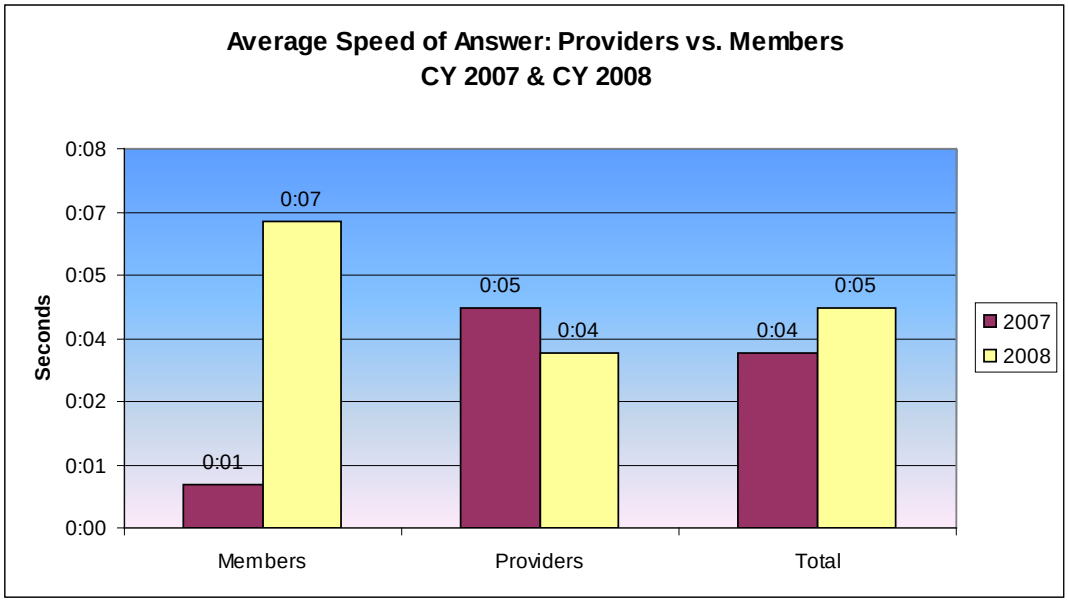
Member and Provider Telephone Access

1. Volume of Calls



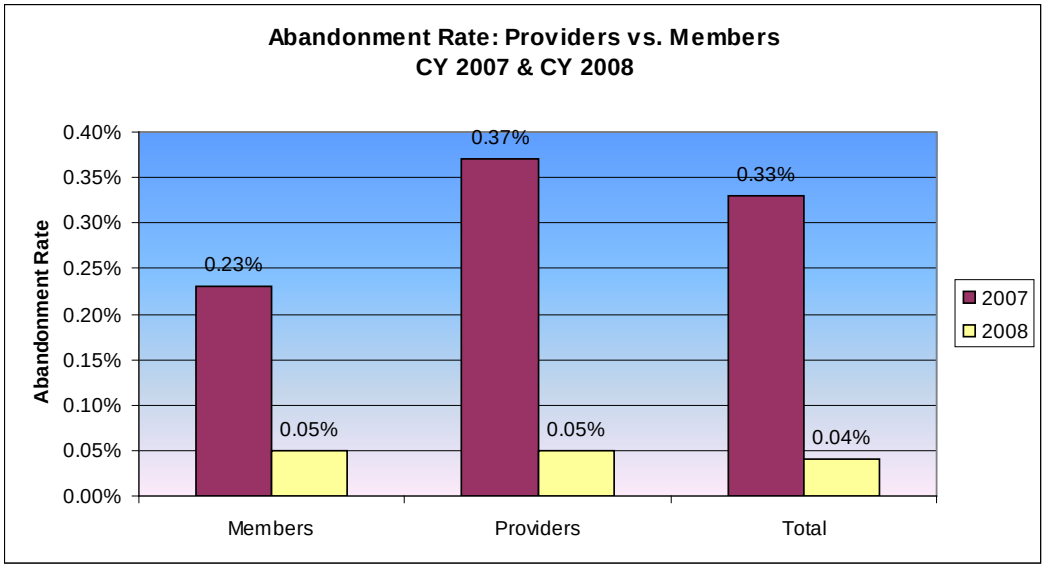
The service center received between two to three times as many calls from providers as from members in both calendar years reported. The range of call volume from members was between 22,804 in 2007 to 31,845 in 2008. The range in call volume from providers was between 64,892 in 2007 to 70,895 in 2008. The total volume of calls increased from 87,988 in 2007 to 103,028 in 2008.

2. Average speed to answer: Average number of seconds until call is answered by a live person



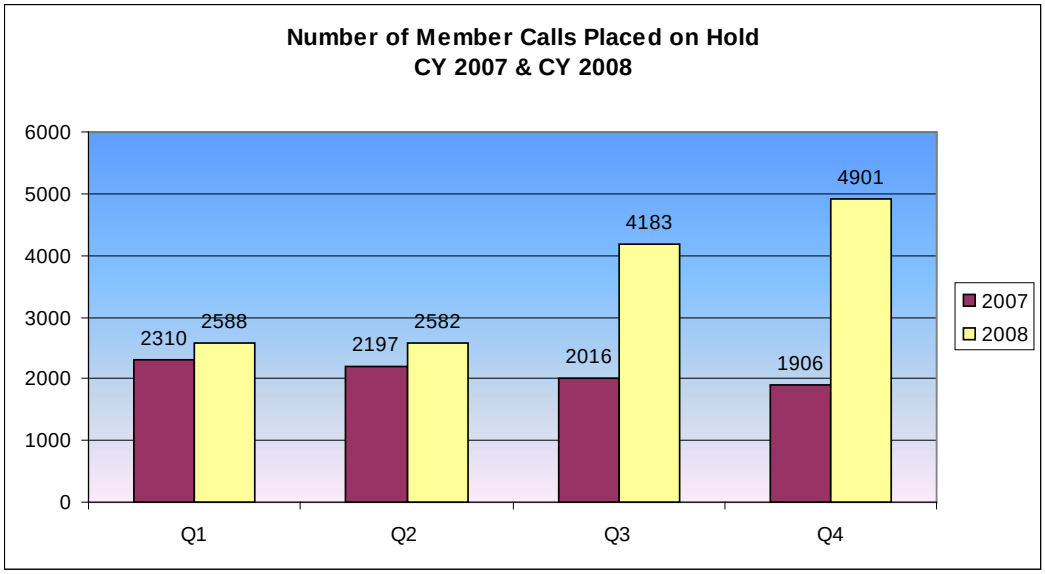
The standard for the Average Speed of Answer is ≤30 seconds for both member and provider calls. The service center was well within this standard for both provider and member calls in 2007 and 2008.

3. Abandonment Rate: % of calls not answered before caller hangs up

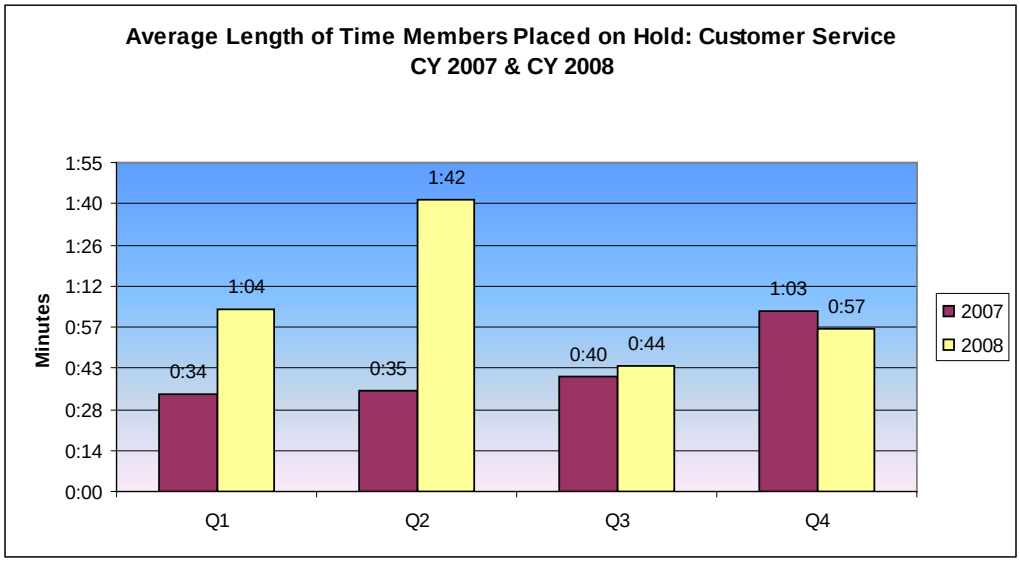


The standard for Call Abandonment Rate is ≤5% for both member and provider calls. The service center was well within this standard for both provider and member calls in 2007 and 2008. Overall, the service center decreased the Abandonment Rate by more than 85% in 2008.

4. Number of calls placed on hold and average length of time on hold for Customer Service

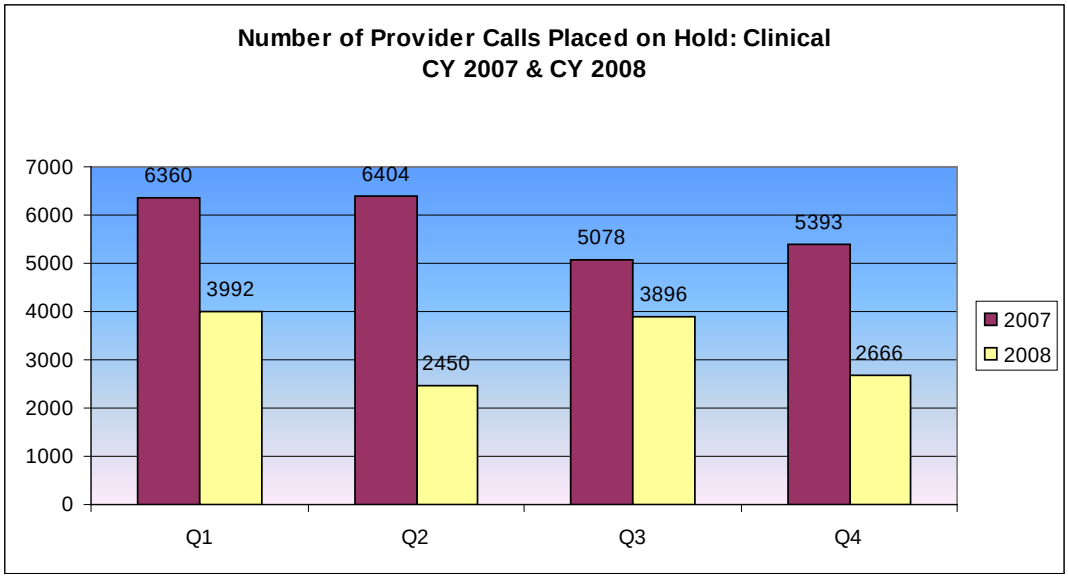


The range in the number of calls placed on hold by Customer Service in 2008 was from 4,901 in Q4 to 2,588 in Q2. The percentage of all Customer Service calls being placed on hold increased from 36.8% in 2007 to 48.6% in 2008.

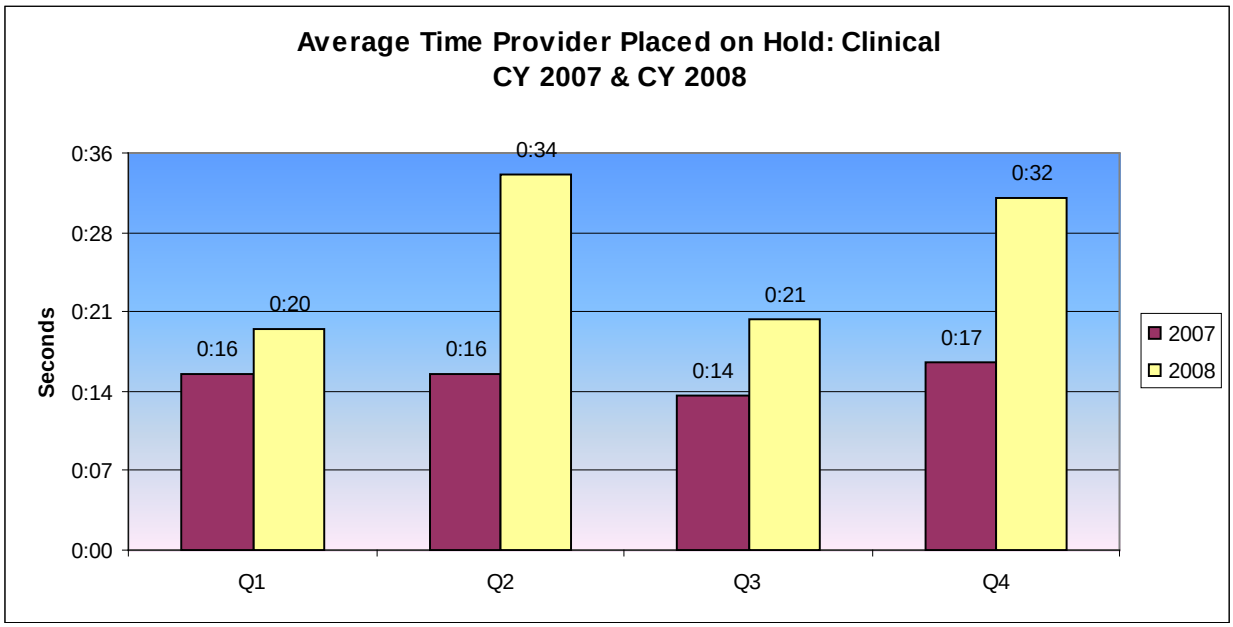


The average length of time on hold was well within the standard of ≤3 minutes in both 2007 and 2008 for Customer Service. The total average length of time on hold increased from 0:43 in 2007 to 1:07 in 2008.

5. Number of calls placed on hold and average length of time on hold for Clinical Services



The range in the number of calls placed on hold in 2008 by Clinical Services was from 2,450 in Q2 to 3,992 in Q1. The percentage of all Clinical calls being placed on hold decreased from 35.8% in 2007 to 19.8% in 2008. This decrease in calls placed on hold may be attributed to a lower rate of clinical staff turnover in 2008 and thus an increase in experience of clinical staff.



The average length of time on hold was well within the standard of ≤5 minutes for the Clinical Department. The total average length of time on hold increased from 0:16 in 2007 to 0:27 in 2008.

Recommendations for continuing sub-Goal in 2009:
This sub-goal will be applicable for 2009 and should be included in the 2009 Project Plan.

Goal 9. Develop and implement Quality Improvement Activities (QIA) to address opportunities for improvement

9A. Child Study: Retrospective data analysis of utilization patterns of children and adolescents who disrupt out of foster care placement (Contract reference L.6; Performance Target 4)

Activities and Findings that include trending and analysis of the measures to assess performance:
Please refer to Attachments A and B for the data analysis and a summary (previously submitted) of the findings of this quality improvement activity.

Recommendations for continuing sub-Goal in 2009:
For 2009, this goal will address the analysis of data concerning foster parents and any correlation between characteristics of foster parents and disruption rates. This sub-goal will be applicable for 2009 and should be included in the 2008 Project Plan.

9B. Adult Study: MCO Co-Management Quality Improvement Activity on Improving the Identification of Post-Partum Depression and Connecting Members to Treatment

Activities and Findings that include trending and analysis of the measures to assess performance:

In 2007 a Quality Improvement Activity (QIA) was identified that involved postpartum depression. Numerous activities ensued during 2007 and into 2008 to evaluate the feasibility of a medical co-management QIA for postpartum depression. At the conclusion of 2007 the QM Department was left with some recommendations by the QM Committee. Those recommendations included:

- Meet with each of the MCOs to determine:
    - Their mechanisms for identifying pregnant members
    - Their ability to identify delivery date
    - Whether they currently use any post-partum depression screening tools
    - Whether they currently mail information packets to newly post-partum mothers
- Depending on the MCO responses, identify whether screening tools will need to be adopted, brochures developed that could be used to improve identification of post partum depression and educate new mothers about symptoms and treatment.
- Enhance the consistency of the interventions used by CT BHP when members are identified.
- Measure the rate of connection to behavioral health services of those mothers identified as needing treatment.

Early in 2008 a re-procurement of the MCO's was initiated that changed the scope of the MCO co-management QIA. Only one MCO, CHN was chosen to continue as a Medicaid MCO, while the other three began transitioning members to different MCOs, unmanaged Medicaid (Title 19) and CHN. As a result CHN became the largest of the current Medicaid MCO's with around 211,000 members of a possible 350,000 members. Because the other Medicaid MCO's were in transition, CT BHP began collaborating with CHN to pilot the project. Already in a collaborative relationship that had begun between CT BHP and CHN in 2006, CHN was receptive to the post partum depression QIA proposed by the QM department. CHN shared that they do several mailings to members throughout their pregnancy including one four weeks after delivery. All mailings are based on claims. In an effort to minimize the duplication of effort, an arrangement was made between CHN and CT BHP that allowed CT BHP to add materials about post-partum depression to the mailings four weeks post delivery.

After the decision to continue the project with CHN, workgroups were formed to begin to develop the many aspects of the project. The Edinburgh Scale was chosen as the screening tool for the project based on past use by Value Options, it's availability of a Spanish language translation and a recommendation from Yale University.

The CT BHP, at the request of DSS, met in consultation with Yale University, who was conducting its own grant funded initiative with CT medical providers to improve treatment of postpartum depression. Once again, to avoid duplication of effort, CT-BHP staff met with Yale and Department of Public Health (DPH) staff to discuss the proposed project plan, as well as possible opportunities to coordinate efforts. The collaboration had several significant outcomes related to the project.

- It identified potential liability in positive Edinburgh scales that are mailed to CT BHP but where we are unable to contact the member in response. The resolution to this included:
  - The inclusion of a release of information on every Edinburgh scale so that the CT BHP could contact the member's medical provider in the event the member could not be contacted or for emergency purposes.
  - All members completing an Edinburgh, regardless of score, would receive a phone call from CT BHP staff offering Peer Support Services at a minimum.
  - The development of an urgent/emergent response protocol.
- Yale, as part of their grant had several postpartum depression provider trainings funded and offered one for behavioral health providers. CT BHP coordinated this training with them and it was held at the CT BHP in October, 2008.

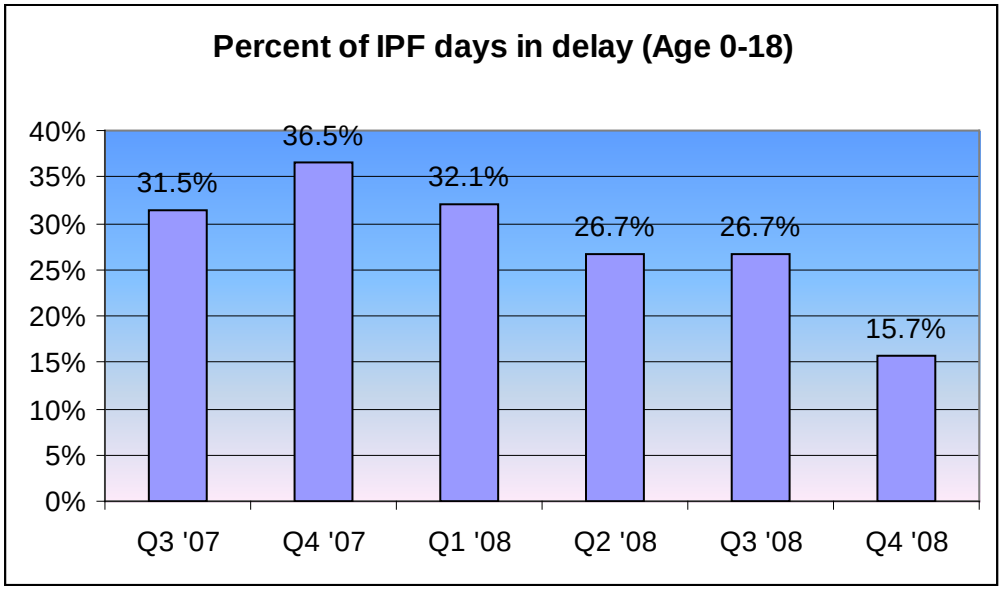
A postpartum informational tip sheet was developed as the final piece of the mailing packet. CT BHP also obtained a business reply postage permit from the US postal service in order for members to return the Edinburgh scale with postage pre-paid.

This tip sheet, Edinburgh scale, both in English and Spanish and the return envelope became the CT BHP post partum packet and in conjunction with the CHN materials is mailed to members four weeks post delivery. The first packets were mailed in February 2009.

Recommendations for continuing sub-goal in 2009:
This sub-goal will be continued in 2009 and should be included in the 2009 Project Plan.

9C. Reducing discharge delays for youth receiving inpatient behavioral health treatment (Contract reference 2007 Performance Target 6)

Activities and Findings that include trending and analysis of the measures to assess performance:



The percent of inpatient psychiatric days spent by youth in discharge delay has decreased significantly over 2008. Two full years of data is not depicted as the inter-rater reliability in determining discharge delay was not firmly established until Q3 '07. The above graph illustrates the percent of days in each quarter that were discharge delayed, and is not based on discharged cases. A performance target to decrease discharge delay days in Q3 and Q4 '08 from the baseline of Q3 and Q4 '07 by 12% was successfully met in 2008.

Per Performance Target #6, discharge delay days shall average no more than 3,070 discharge delay days across the 3rd and 4th quarters of CY2008 and acute average length of stay shall increase by no more than 3% across the same time period.

While the goal of meeting the established target of 3,070 discharge delay days would have been a significant accomplishment, the final performance was considerably better. A decrease in discharge delay days of 39% with no increase in acute average length of stay was the final result.

The marked decrease in discharge delay days in Q3 and Q4 is attributed to the focused efforts of the CT BHP utilization management team supported by the DCF Central Office and Area Office staff who worked with facilities to facilitate discharge plans. The success is also attributed to the Provider Analysis and Reporting program that successfully implemented a Pay for Performance Initiative that aligned hospital length of stay goals with the CT BHP Performance Target.
The following summarizes the key initiatives that we believe had a significant impact on the impressive decrease in discharge delay days:

- Increased micro/macro focus on discharge delay at case level and provider level, i.e. weekly Discharge Delay rounds to review each case; heightened intensity of utilization management approaches; heightened front-end diversion measures instituted for identified cohorts
- Increased Area Office BHPD response upon contact by CT BHP clinical staff if DCF action was needed to expedite a discharge delay case
- PARS impact: Provider's increased focus on improving length of stay

Recommendations for continuing sub-Goal in 2009:
This sub-goal will be applicable for 2009 and should be included in the 2009 Project Plan.

9D. Participate in Center for Health Care Studies (CHCS) project to improve the rate of connection with behavioral health services of children identified during the administration of the Multidisciplinary Exam (MDE) as needing services.

Activities and Findings that include trending and analysis of the measures to assess performance:

This project was implemented in 2006 after CT BHP received a grant from the CHCS for technical support to conduct a quality improvement activity. The QIA was designed to improve the rate of the connection of children identified during the administration of an MDE as needing behavioral health treatment with those services. Since that time, CT BHP has worked in collaboration with DCF central office and two Area Offices, all of whom continue to participate in the project. Data is collected on a quarterly basis and submitted to the CHCS for review and discussion on a pre-set time table. Although data is collected for numerous variables, the project is defined by two overall aim measures:

1. To increase by 25%, the percentage of children who are identified as needing Behavioral Health treatment on the MultiDisciplinary Exam (MDE) who receive behavioral health treatment within 60 days. .
2. To reduce by 10% the time to appointments after MDE recommendation for Behavioral Health treatment.

The first table below represents data for the projects first overall aim measure. The findings represent the aggregate of the two participating area office's (Waterbury and Bridgeport) data with regard to the percentage of children identified as having behavioral healthcare needs as a result of the MDE who had an appointment within 60 days. There was significant improvement in Q4 '07. At the time those data were collected, it was hoped that this finding was related to the improved access to care that resulted from the implementation of the Enhanced Care Clinic (ECCs) standards that require access to routine appointments in 14 days. There were ECCs in both regions where the QIA was taking place. However, the last two re-measures (Q1 '08 and Q2 '08) have shown a decrease in performance. Additionally, there are differences between the two area offices in terms of performance on this measure. One area office (Bridgeport) appears to be much more successful in connecting children to care, having twice as many children seen within 60 days when compared to the other area office.

Measure Period	# of children with Apt within 60 days	# of children identified as having BH needs	Rate or results
Q1&2 '07 Baseline	13	47	**27.66%**
Q3 '07	6	24	**25.00%**
Q4 '07	12	13	**92.31%**
Q1 '08	6	15	**40.00%**
Q2 '08	13	25	**52.00%**

The following table represents data for the second overall aim measure of the project. Once again, this data is aggregated for the two area office's data. The same area office that improved its rate of connecting children to behavioral healthcare treatment has also decreased the

amount of time until their foster children receive care by nearly 10 days more than the other area office.

Measure Period	Total # of days to apt.	Total # of children who had an apt	Rate or results in Average Days to Apt
Q1& Q2 '07	248	11	**22.5**
Q3 '07	164	6	**27.3**
Q4 '07	249	12	**20.8**
Q1 '08	201	6	**33.5**
Q2 '08	321	13	**24.7**

In early 2008, a meeting was scheduled with the two participating area offices to provide feedback with regard to their performance. Both area offices agreed to develop interventions to improve their rate of connection to treatment. However, in mid-2008, the focus of DCF efforts changed partially as a result of litigation and partially as a result of a proposed restructuring of the organization. Support for the project by the area offices has diminished. Additional interventions will need to be developed in 2009 to obtain the goals discussed above. Support from the DCF Area Offices will need to be renewed.

Despite lack of progress with the DCF local area offices, a significant outcome from the sharing of the baseline data with DCF central office staff did occur. At the request of the Bureau Chief, at the Bureau of Child Welfare services, a workgroup was formed and tasked to review the current MDE format and procedures and make recommendations for their improvement. The workgroup consisted of both CT BHP and DCF staff and met throughout 2008.

Key recommendations of the workgroup included:

- Revision of the MDE tool and
- Standardization of the administration of the exam,
- Recommendations regarding who should accompany the child to the MDE, how results should be disseminated and oversight of the process.

The recommendations have not yet been formalized.

Recommendations for continuing sub-Goal in 2009:
This sub-goal will be applicable for 2009 and should be included in the 2009 Project Plan.

9E. Improving the rate of ambulatory follow-up within 7 and 30 days. (Contract Reference 2007 Exhibit A; Performance Target 5)

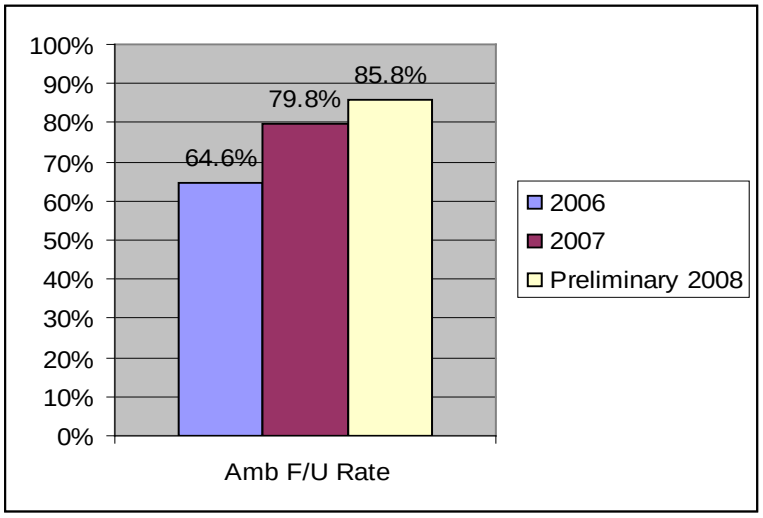
Activities:

During 2008, this measure was dropped as a quality improvement activity although it continues to be an indicator. Since it is claims based, data regarding performance is unavailable for long periods of time so that ongoing assessment of interventions and performance.

Nonetheless, activities to improve the rate of ambulatory follow-up within 7 and 30 days have continued throughout the year. The following interventions to improve the ambulatory follow-up rate were done during 2008:

1. Every member who is admitted to the hospital receives a brochure that describes the importance of follow-up care.
2. The 2007 focus on the early development of discharge plans was strengthened in 2008 with the addition of in-depth training on focal treatment planning (FTP). Training on FTP was done either at each inpatient facility treating youth, or conducted locally so that multiple institutions had access to the training. The FTP process incorporates the discharge plan from the beginning of a treatment cycle. The program builds the treatment plan around the issues that will enable the member to be discharged to the level of care where they are expected to go next.
3. Clinical and Peer Support staff submit Quality of Care forms whenever a facility fails to do adequate discharge planning. This enables us to identify trends within facilities. To date, poor discharge planning has been never been the only quality issue identified for a specific facility. It is typically coupled with other quality issues including delay in treatment, failure to involve family in treatment, and failure to follow standard practice.
4. Another intervention to improve the rate of early follow-up care after discharge from the hospital centered around work towards enhancing the relationships between inpatient units and local programs or organizations that the inpatient units should be coordinating discharge plans with. The Regional Network Managers in partnership with the clinical staff have increasingly been brokering meetings between inpatient unit staff and ECCs and PRTFs that are meant to establish relationships between providers that will subsequently facilitate transition to outpatient care when members are discharged. This activity was based on the finding that inpatient staff were sometimes unaware of community resources that could support their discharge planning activities.

Findings that include trending and analysis of the measures to assess performance:



Preliminary findings for 2008 regarding performance on ambulatory follow-up within 30 days for members discharged from an inpatient stay with a mental health diagnosis indicate that the rate is improving over the past three years.

In comparing the ambulatory f/u rate to NCQA's published benchmarks there are two items to be aware of. In 2006, NCQA dropped the Ambulatory Follow-up within 30 days measure in favor of 7 day follow-up. The last published benchmarks for 30 day follow-up are from 2006.

In comparing our results with those benchmark data, the CT BHP performance rates for 2007 and 2008 place us above the 50th percentile.

Recommendations for continuing sub-Goal in 2009:
The departments should consider moving to measurement of ambulatory follow-up rate within 7 days. This sub-goal will be applicable for 2009 and should be included in the 2009 Project Plan.

Goal 10. Monitor performance of Customer Service staff via audits of performance

Activities and Findings that include trending and analysis of the measures to assess performance:
A. Assess individual Customer Service staff (at least 5 cases per month) on performance in 5 areas
During 2008, auditing of Customer Service Staff was based on the ValueOptions NICE system. The audits were conducted by the Team Lead and Director of the Customer Service Department. The 2008 audit average for the department was 94.4%. Customer Service Staff received individual supervision every other week where audit performance was reviewed. Overall department performance was also reviewed in weekly staff meetings, as needed.

Recommendations for continuing sub-Goal in 2009:
This sub-goal will be applicable for 2009 and should be included in the 2009 Project Plan.

B. Assess adequacy and accuracy of documentation of content of call.

The Customer Service Department continues to make accurate documentation a priority. Audits performed reveal that Customer Service staff consistently document every call they receive with the exception of misdirected calls (medical, dental or vision inquiries). In 2008 Customer Service staff scored an average of 92.70% for Documentation based on the NICE system audit process. Despite staffing changes in the department that included two (2) new CSR's joining the department during 2008 as a result of turnover, Customer Service continued to offer a comprehensive training schedule to both Customer Service staff and Service Center staff which aided in meeting the 90% goal.

Recommendations for continuing sub-Goal in 2009:
This sub-goal will be applicable for 2009 and should be included in the 2009 Project Plan.

Goal 11. Review and approve the 2007 CT BHP UM Program Description

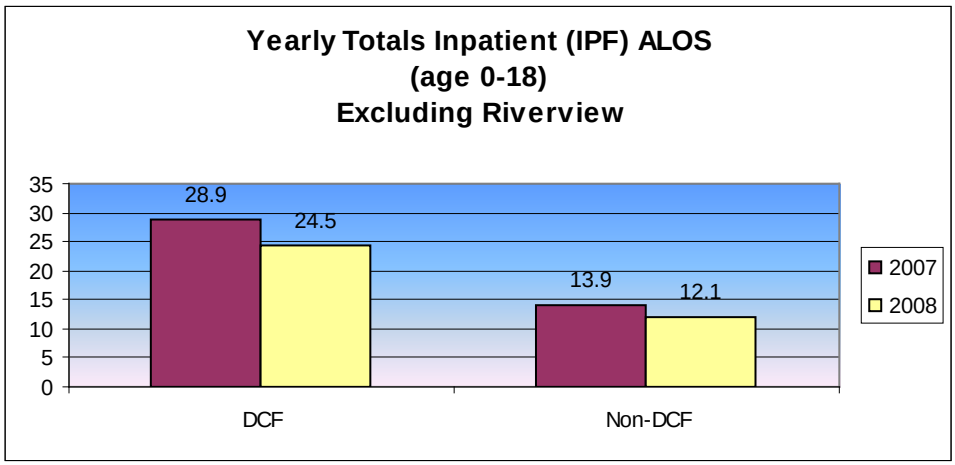
Activities and Findings that include trending and analysis of the measures to assess performance:
A. Annual development and review of the 2009 UM Program Description
The 2009 UM Program Description was submitted to the Departments on November 3, 2008 and was subsequently approved by the Departments.

Recommendations for continuing sub-Goal in 2009:
This sub-goal will be applicable for 2009 and should be included in the 2009 Project Plan.

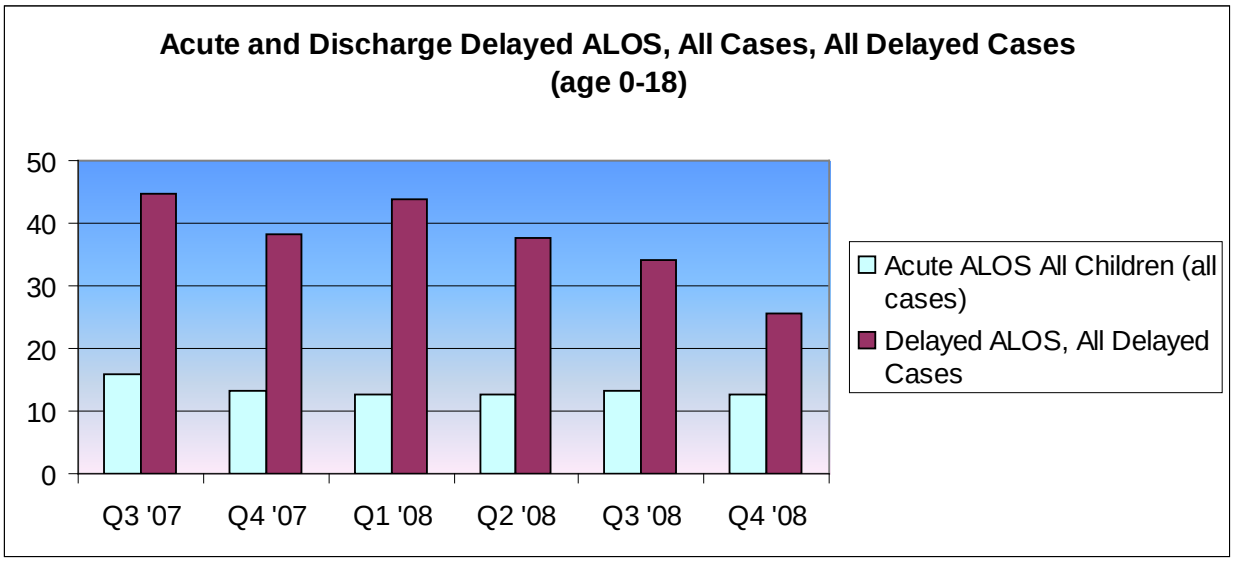
Goal 12. Monitor for under or over utilization of behavioral health services; identify barriers and opportunities

Activities and Findings that include trending and analysis of the measures to assess performance:
A. Inpatient Psych # of Admits, ALOS & Days/1000 & Admits/1000, Excluding Riverview and Riverview only

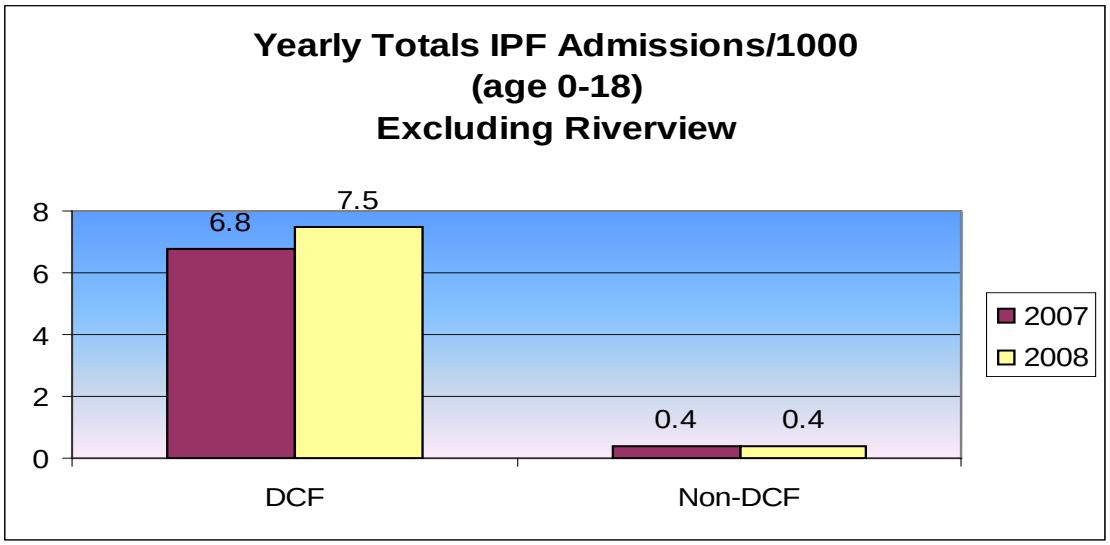
Children Inpatient



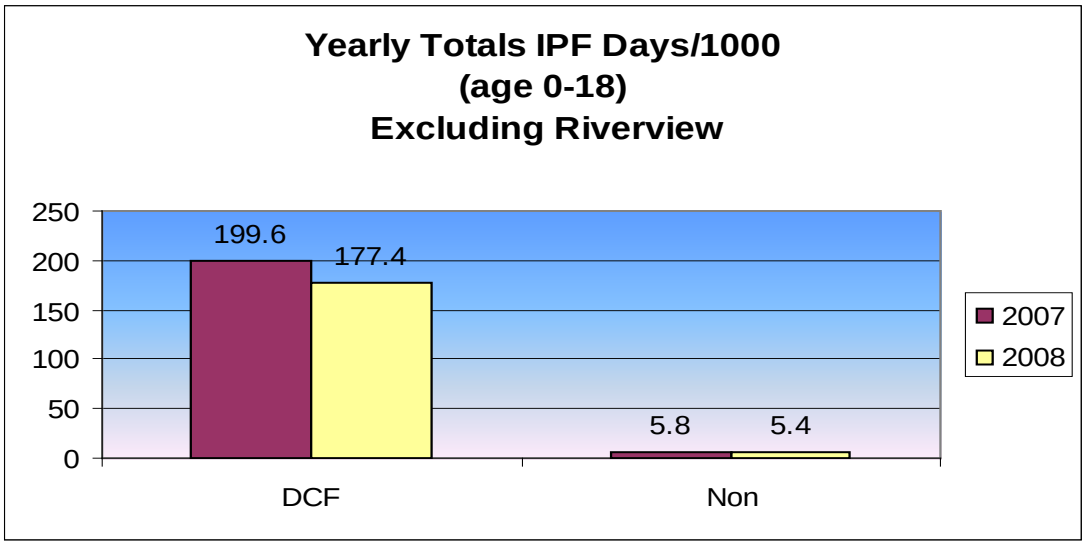
Average Length Of Stay (ALOS) is defined as total Length Of Stay (LOS) including acute and discharge delay days. The above graph depicts the average length of stay for youth (children and adolescents) in the inpatient level of care for calendar years 2007 and 2008 by DCF and Non-DCF, excluding Riverview. The ALOS for DCF children continues to be more than two times greater than that of Non-DCF children for both calendar years 2007 and 2008. ALOS for both DCF and Non-DCF children has decreased in 2008.



A further breakdown of youth ALOS shows that Acute lengths of stay have remained consistent across quarters since Q4 '07 while there has been a downward trend in Discharge Delay LOS.

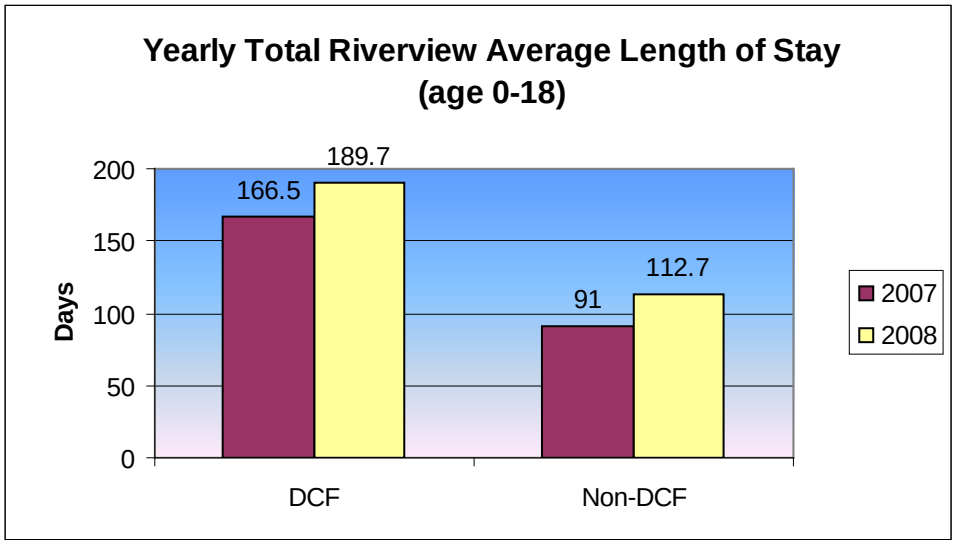


DCF children continue to have more admissions per 1000 than non-DCF children, yearly totals of 7.5 and 0.4 respectively. Non-DCF admissions per thousand remained the same in 2008 as in 2007. DCF admissions per 1000 rose from 6.8 in 2007 to 7.5 in 2008. As ALOS decreases as a result in the decrease in discharge delay, more children in need of services are able to access those services.

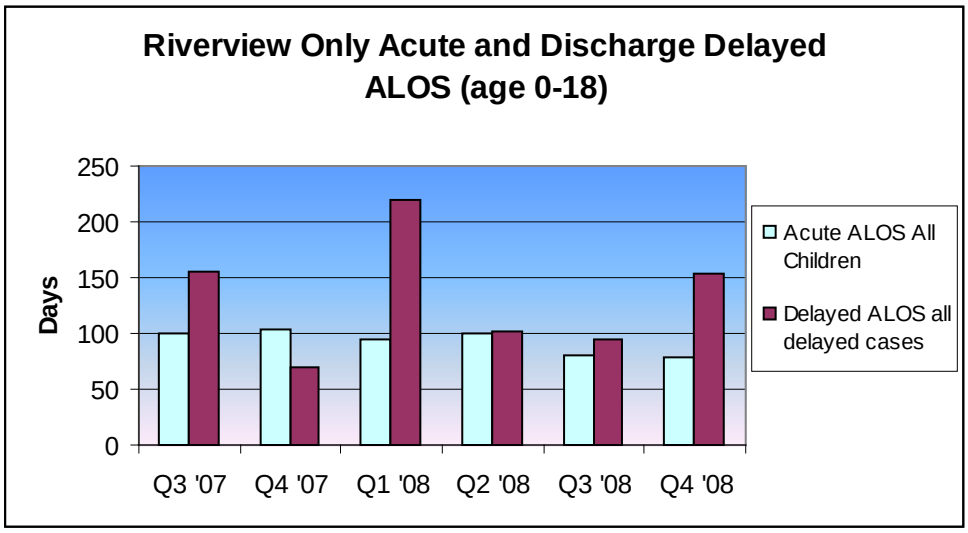


Child Inpatient Days/1000 have decreased throughout 2008 despite increases in Admissions/1000.

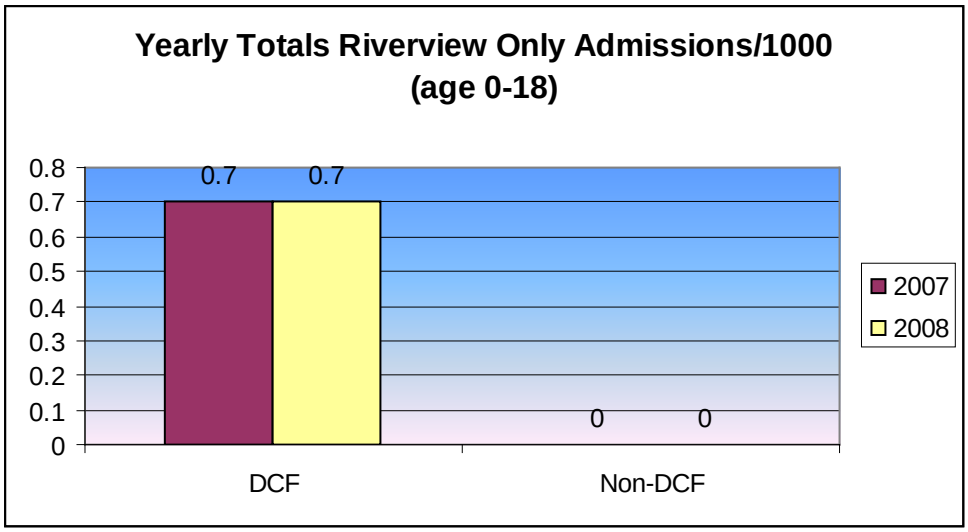
Riverview only



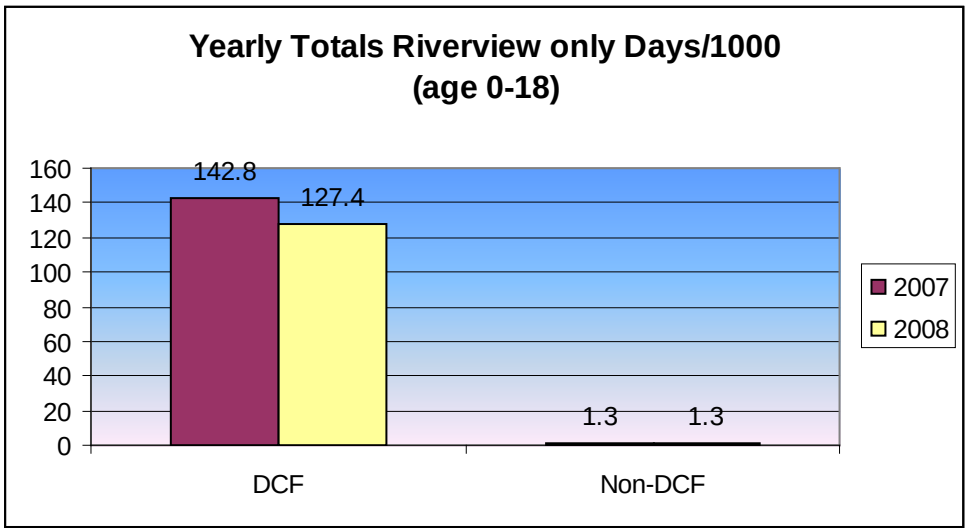
The ALOS for Riverview hospital has increased from 2007 to 2008 for both DCF and Non-DCF child members.



A further breakdown of Riverview Hospital ALOS shows that acute ALOS has decreased slightly in Q3 and 4 '08 while Q4 discharge delay ALOS has increased. The utilization management of this facility has been tightened over 2008 with additional clinical resources and focused rounds added. Two full years of data is not illustrated as the authorization data did not represent the entire length of stay for several quarters as a result of the long length of stay in this facility.

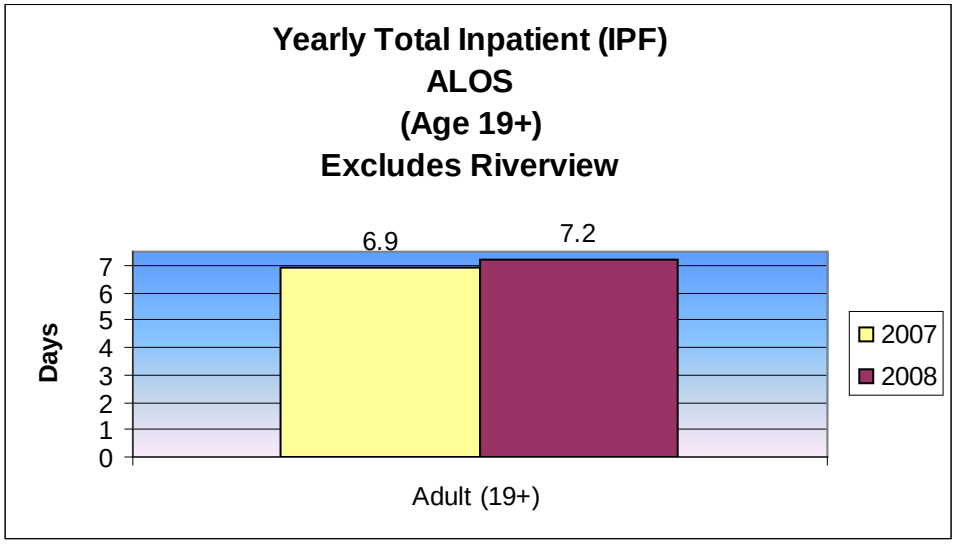


Riverview Hospital admissions/1000 remain constant across 2007 and 2008 for both DCF and Non-DCF children, although variation during both years from quarter to quarter is wide (0.6 to 0.9). The total number of children admitted to Riverview Hospital in 2008 was less than in 2007, 122 and 136 respectively.

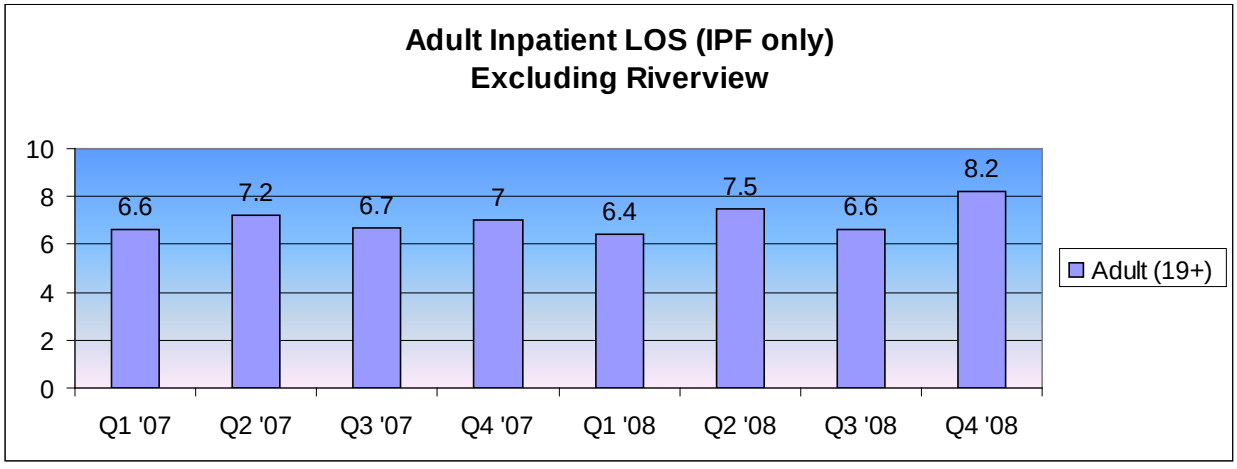


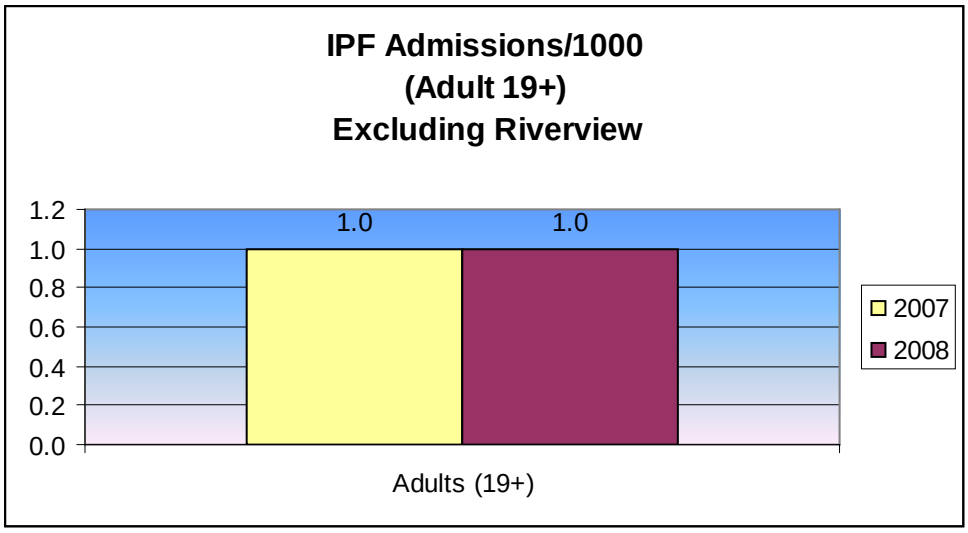
Riverview Hospital days/1000 has decreased in 2008 for DCF children but remains the same for Non-DCF children.

Adults Inpatient

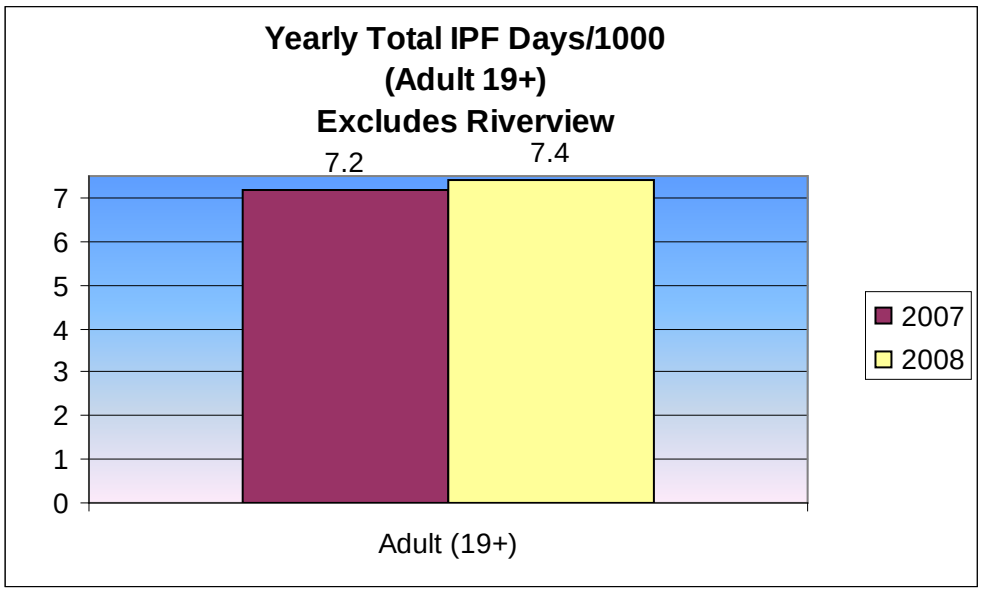


Adult inpatient ALOS has risen in 2008 with Q4 '08 having the longest ALOS in the last two years. In September of 2008 a by-pass program was begun with adult in-patient units. The increase in ALOS in Q4 '08 may be related to the implementation of the by-pass program. Changes in the utilization patterns of adult inpatient units included in the by-pass programs will be re-evaluated shortly. The original plan had been to evaluate individual hospital utilization patterns bi-annually, but this has been revised as a result of this finding.





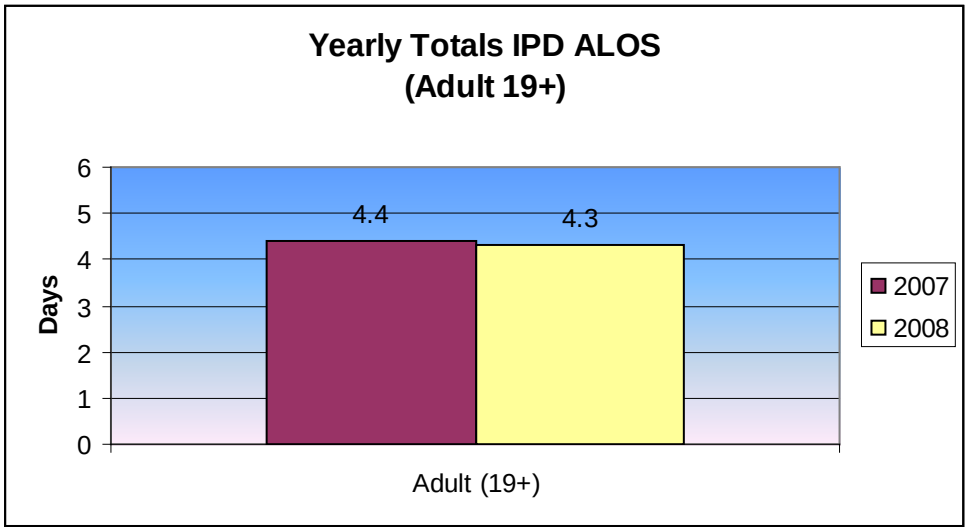
Adult admissions/1000 remain consistent across calendar years 2007 and 2008.



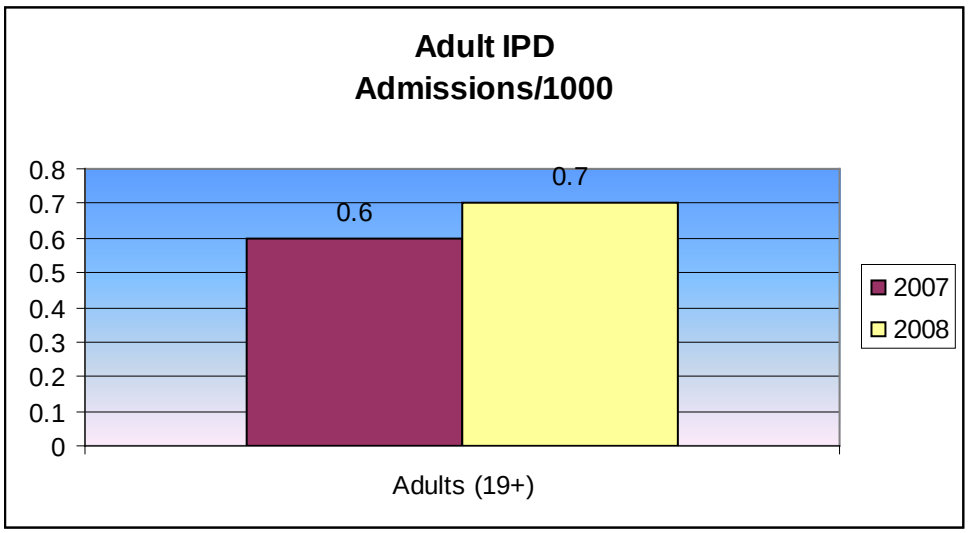
Adult IPF days/1000 have increased in 2008.

B. Inpatient IPD ALOS, Admits /1000 & Days/1000

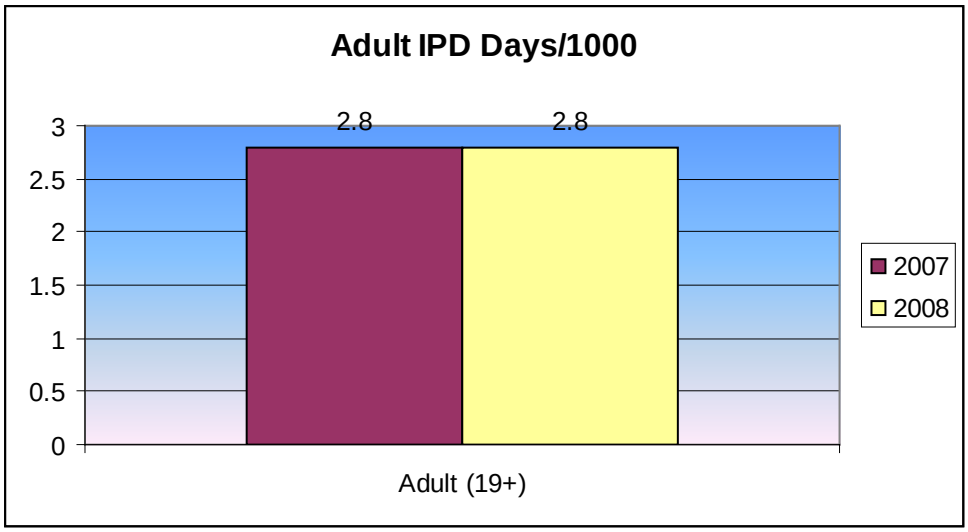
Adults



The ALOS of adults in inpatient detox has remained stable from 2007 to 2008.



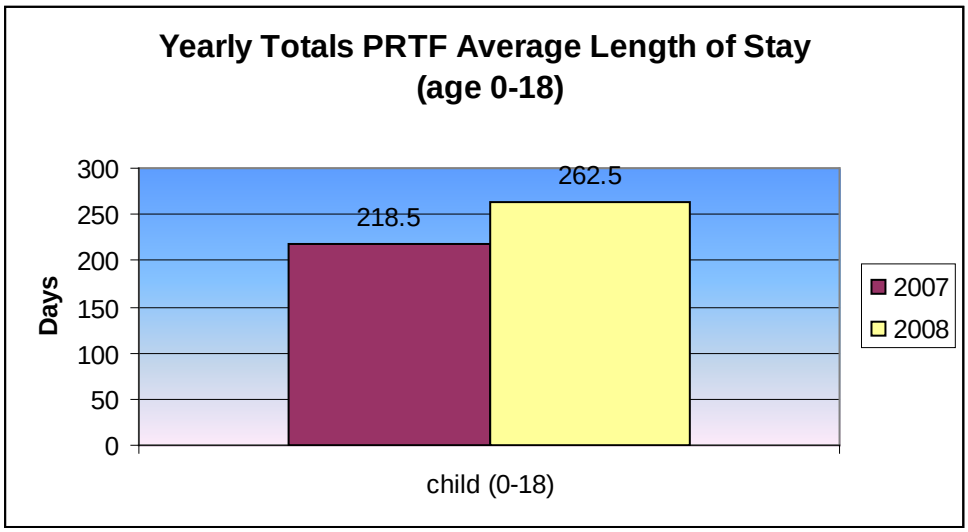
Adult Inpatient detox admissions/1000 has increased in 2008 to 0.7 from 0.6 in 2007.



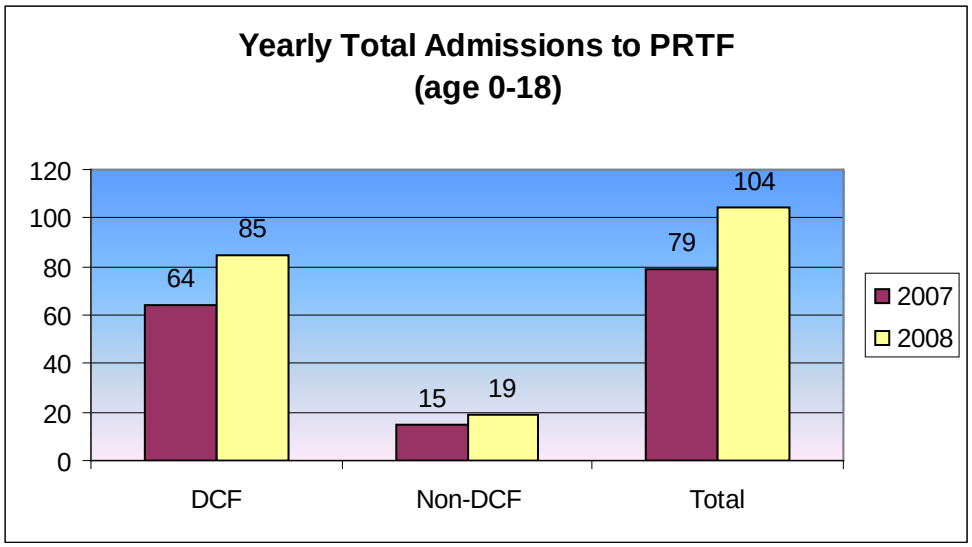
Adult Inpatient detox days/1000 has remained the same across calendar years 2007 and 2008.

C. PRTF ALOS, Days/1000 & Admissions

Children

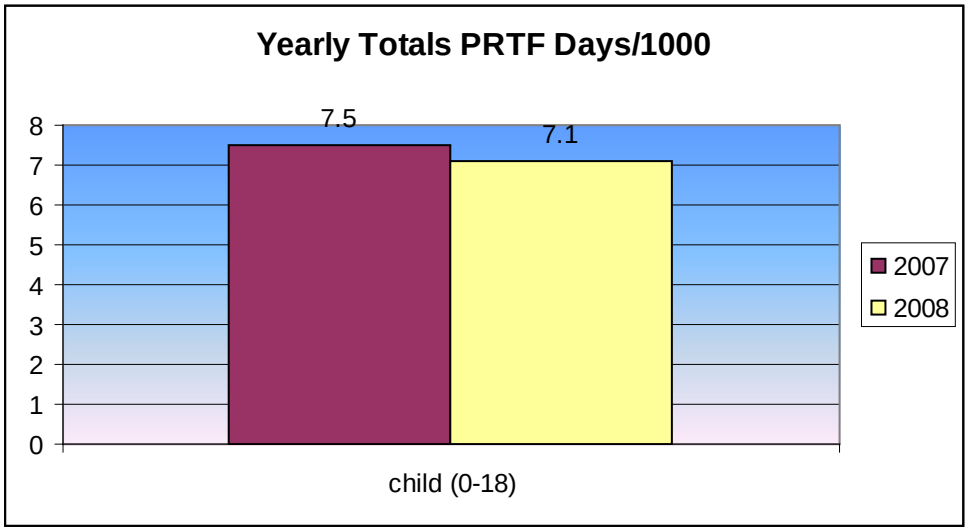


PRTF ALOS has increased in 2008. This measure will be discussed further in Goal 18, Provider Analysis and Reporting.



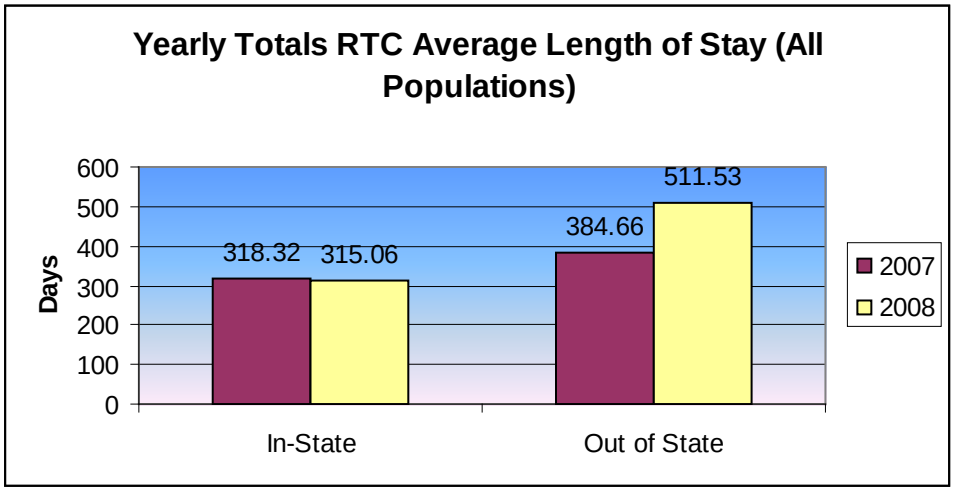
The annual number of admissions to PRTF increased from 2007 to 2008 for both DCF and Non-DCF populations. Because of the relatively small number of annual admissions to PRTF, the admissions per 1000 for non-DCF members is a small decimal. As a result, this measure is not included.

The increase in admissions to PRTF may be accounted for by the work of the Utilization Management team with the PRTFs during the first half of 2008. A workgroup that included representatives from the four (4) PRTFs in CT was established that revised the PRTF level of care guidelines and focused on strategies to shorten lengths of stay. During the second half of 2008, a Provider Analysis and Reporting (PARs) program for this level of care was implemented. A performance incentive initiative that will be described in more detail in Goal 18, was also begun.

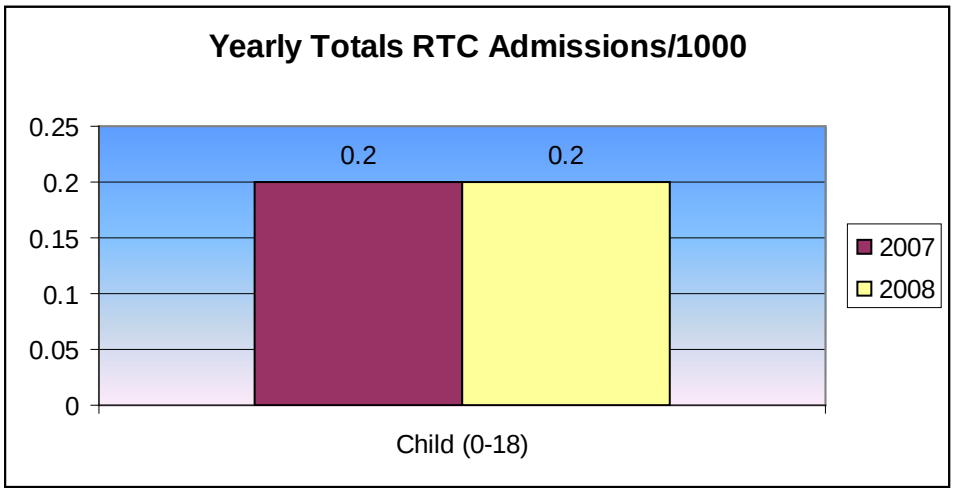


PRTF Days/1000 have decreased in 2008 from 2007.

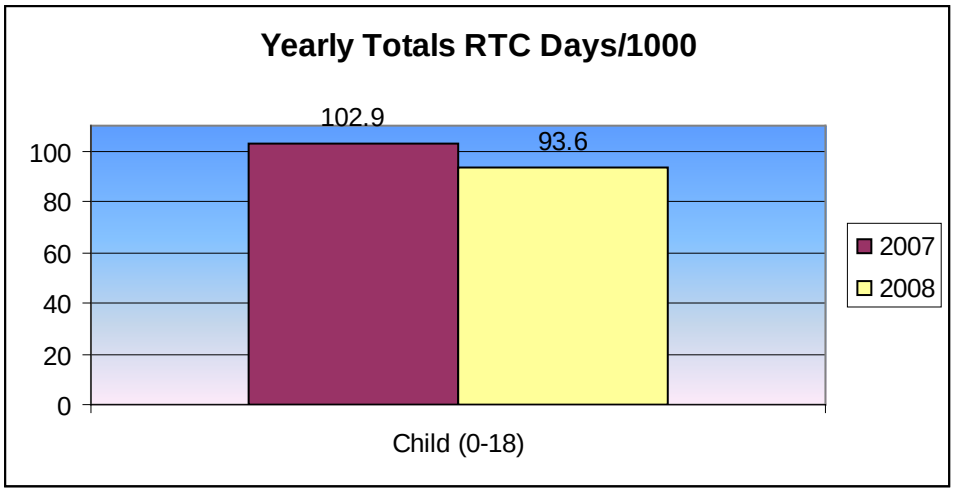
D. RTCs



During 2008, reports were developed that allowed utilization data for RTC to be reported in far more detail. Currently, RTC ALOS is calculated separately for in and out of state (OOS) residential facilities. In-State RTC ALOS has remained steady for 2007 and 2008 while OOS RTC ALOS, already longer than in-state, increased by more than 100 days in 2008. While relatively the same number of children were discharged from in-state RTC facilities in 2007 and 2008, discharges from out of state RTC facilities increased from 168 in 2007 to 202 in 2008. In early/mid 2008, CT BHP worked with DCF to identify youth in OOS facilities who did not have an authorization and also to assertively manage those cases in OOS facilities with long lengths of stay to effectuate a discharge plan. In '08, there were 42 more OOS discharges than during the previous year and many of these youth discharged had been in the OOS facilities for long periods of time. Since all of the days within a stay, even those from previous reporting years, are included in the ALOS calculation, the increase in ALOS for OOS RTCs in 2008 is skewed by the large number of discharges of cases with extremely long lengths of stay.



Only DCF involved children are eligible for residential care. Residential Admissions/1000 remains the same from 2007 to 2008. However, any true changes or trends are masked by the membership in the overall child population because of the relatively small DCF child population who have access to this level of care.



Only DCF involved children are eligible for residential care. Days per 1000 members remained the same in quarters 1 and 2, but quarters 3 and 4 show a decrease in 2008 when compared to 2007. Overall RTC days/1000 decreased in 2008 when compared to 2007.

Overview of Improvements made in the Utilization Management of RTCs

In 2008, significant and positive operational changes were achieved through the collaborative efforts of DCF, CT BHP management staff, Residential Care Team (RCT) staff, and the residential/group home providers.

Changes in the Structure of RCT Clinical Functions to Improve Efficiency and Utilization Management

RCT staffing was increased in 2008, from five (5) clinicians in 2007 to eight (8) clinicians. New positions were added by decreasing the number of Regional Network Managers (RNMs) and creating two Clinical Case Manager positions; no new dollars were spent. This was primarily in response to the need for increased clinical depth in the department to intensify the overall utilization management for the collective caseload of approximately 700-800 youth in care at an RTC (in-state and OOS) during any given month and approximately 400+ youth in group homes (1.5 &1/PASS & GH2). Responsibilities of clinicians were also realigned to better support consistency in clinician assignment for concurrent reviews within the same facilities (i.e. designated clinician for out of state, therapeutic group homes, high volume and low volume facilities).

There were 721 initial RTC authorizations conducted in 2008 and 297 group home initial authorizations (total 1,018 initial authorizations). Approximately 3,700 RTC concurrent reviews were conducted (the majority of concurrent reviews are conducted every three months/per youth and more frequently during the time period leading up to discharge). Additionally, there were approximately 800 group home concurrent reviews conducted. Beginning in late August/early September, the RTC clinicians began the process of conducting all concurrent reviews on-site at in-state and bordering out of state facilities. Clinicians meet with the clinical staff at the facility to complete continued stay reviews and participate in case conferences and discharge planning meetings. Finally, focal treatment planning trainings began in late 2008 at some of the residential facilities (provided by CT BHP psychiatrist) and these trainings will continue for the remainder of the RTCs into 2009.

The RCT team also began utilizing a new report identifying youth in an RTC/GH who are in discharge delay, including the discharge delay reason, and factors affecting discharge delay. This provides a quick management tool for the clinicians and management staff to utilize during on-site reviews and meetings.

DCF in partnership with CT BHP implemented a system-wide restructuring of the current CT BHP congregate care placement request, match and admit process. This new process was preceded by months of planning by DCF in conjunction with the Area Offices, the facilities and with CT BHP. It applies to all youth with a nexus to DCF's Bureau of Child Welfare, Bureau of Juvenile Services, The Court Support Services Division (CSSD), and Public Defenders operating through the Juvenile Court System. The process was promulgated thru an Alert/Bulletin to all providers and became effective December 15th 2008. Included in the new process was the move to have CT BHP RCT clinicians make level of care decisions for all congregate care placement requests. Previously, DCF had completed the Child and Adolescent Needs and Strengths assessment tool (CANS) as well as the supplemental clinical packet submitted by the referral source. At present, the CANS and clinical packet are reviewed by members of the CT BHP RTC clinical team who use this information as the basis for making the level of care decision. In 2008, the RCT CCMs reviewed 1,298 CANS and Registrations. Approximately 70% of these documents were for the residential level of care while the remainder were for Group Homes placements.

Improvements in RTC/GH Data, Reporting, and Analysis

During 2008, an analysis of RTC Utilization and Capacity was completed as the first phase of an overall RTC rightsizing project. This project will continue into CY'09. CT BHP will provide a series of reports related to all aspects of the RTC/GH referral, match and admission process. Further, CT BHP will work with DCF to design and produce reports that summarize and track key management and utilization processes.

During 2008, the following production reports were developed and submitted to the Department on a regular basis. While some of the reports are used for management purposes, others are used to inform the match and admission process in the bi-weekly RTC rounds.

- RTC/GH Monthly/YTD Dashboard & monthly Highlight summary w/supplemental reports
- Youth Awaiting OOH Placement-Matched and Unmatched and Unmatched Only
- Expired CANS report
- YTD Provider Accept/Deny/No Decision Yet report
- Admits to Residential & GH Services: InState, OOS and OOS Only
- D/C Delay: IPF & Awaiting RTC/GH
- RTC/GH Referral List
- Pre-Rounds report
- Rounds report
- In State RTC Vacancy and Projected Vacancy Report (on-line version also)
- RTC/GH Weekly auths
- RTC Auth to Claims Report

In addition, internal reports and queries are used by CT BHP to monitor utilization activities and improve performance. There were a total of 22 reports and queries run monthly in 2008 related to residential and group home management. This represents a significant increase in reporting from 2007.

The *RTC Auth to Claims report* was produced in 2008 to support a significant change to the payment process for RTCs. In February 2008, RTC authorizations were required for an RTC to receive reimbursement from the Department. Previously, providers were paid on a monthly basis and authorizations were not tied to payment. This new procedure was preceded by a joint meeting with DCF management staff, Child Welfare Accounting (CWA) and CT BHP management staff. A practice period was given to the RTC providers for five (5) months (March to July) as the providers were not accustomed to receiving Denial Notice Letters for any denied days. During this period, any denial letters were stamped with "Practice Only" and the RCT staff reminded the facility of the need to conduct reviews in a timely manner. Training was offered to all providers specific to any practice denials that were generated. August 1st, current authorizations and denials began to be linked directly with claims for payment purposes to RTCs. This report receives a quality check weekly and then is submitted to CWA for their use in reconciling payments to RTCs.

In October 2008 the *RTC Vacancy report* was posted on-line at the www.ctbhp.com website. This report was posted in response to the residential providers request to view their vacancy information to ensure accuracy; as this information is used in pre-rounds and rounds. This information is taken directly from the provider's faxed weekly census and bed vacancy form. In late 2008 discussions and planning began between DCF and CT BHP regarding the elimination of the paper faxed census forms to be replaced by the web-based bed-tracking system similar to the one implemented for inpatient and PRTF in 2007. This web-based version will be a more efficient way to manage vacancies and is expected to foster more timely matches. The elimination of 3-4 pages faxed weekly to CT BHP should be a welcome change for the providers. This project will fully commence in 2009.

Dashboard, Rounds and Expired CANS reports rely partly on information from the CANS. The CANS tool has been in use since 2007 and is completed for each youth referred for congregate care. To improve efficiencies and to begin a database with CANS information, this 16 page tool was converted to a web-based custom form that is now completed by the referral source on-line and reviewed by RCT staff on-line. Starting July 1, 2008, DCF Area Offices began training for the use of the web-based CANS. November 24, 2008 was the formal deadline for the cessation of faxed CANS. CT BHP RCT staff, Provider Relations and IT staff provided clinical, technical and IT support on-site at each Area Office that requested assistance following their training. In late 2008, a new report based on CANS information was under discussion that would capture member clinical profiles and allow comparison to the profiles of facilities being considered for referral. This report may commence in 2009.

With the introduction of the DCF restructuring process in 2008, planning for a new report began to be entitled *Response Time Pending Admission.* This new report will measure the response times between making a level of care decision, making a final match, making an accept/do not accept decision, setting up the pre-admission appointment and the admission date. Required time frames for each of these decisions have been established for DCF, CT BHP and the facilities. The first draft of the report was reviewed in 2008 and is expected to go into production in 2009. The report will provide the data to measure the performance of each party. For example, at any given month in '08, an average of 235 youth were awaiting placement in an RTC or group home; meaning they were in the process of waiting for a match or for the actual placement/admission to the RTC or group home. With the restructured process and increased monitoring of response times to be conducted in 2009, it

is expected the number of youth awaiting placement will decrease somewhat, barring any significant decrease of in-state beds in 2009.

RTC Outcome reports were first drafted in 2008 by a DCF and CT BHP work-group. These reports are due to be finalized in 2009 and will measure the outcomes of youth receiving residential care by various indicators such as number of youth receiving lower level of care within 60 days post RTC discharge, number of youth hospitalized within 60/90/120 days post RTC discharge, etc. This series of reports will become the basis for the Provider Analysis and Reporting (PARs) program for RTCs that is expected to be implemented in 2009.

Analysis of RTC Utilization and Capacity was completed November 2008 as part of a longer term project to improve and right-size the Out of Home (OOH) service delivery system. The Department, many stakeholders including residential providers, family members and interested legislators were involved. Using CT BHP data, the analysis covered the time period from July 2007 to June 2008 (12 mos) and broke out referral and admission data based on a tiered structure of five (5) diagnostic categories:

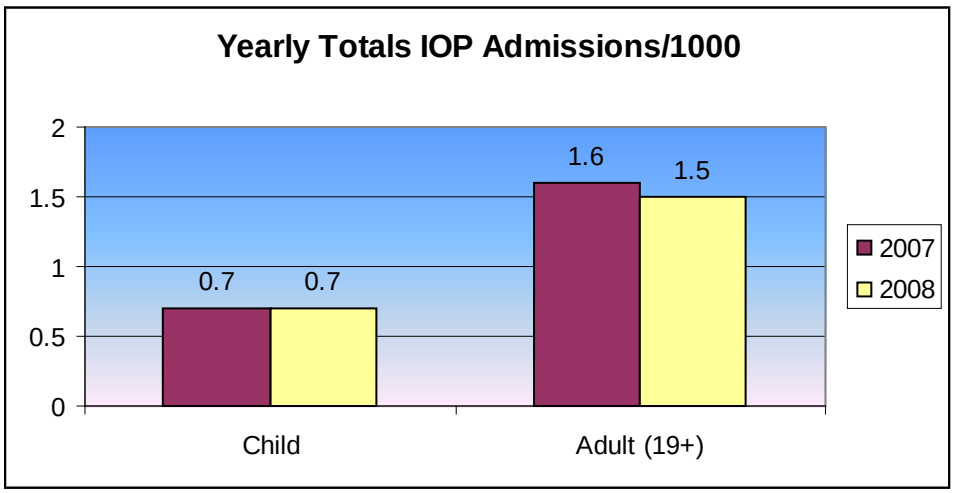
- Fire setters/Sexually Assaultive youth,
- Mentally Retarded /Pervasive Developmental Disorder,
- Juvenile Justice (JJ)/Aggressive/Explosive youth,
- Primary presentation of Substance Abuse,
- Primary presentation of Psychiatric disorders.

Diagnostic profiles, Length of Stay, RTC Vacancy rates vs. licensed beds, Maximum and minimum capacity, and forecasting of bed needs were included in this first phase of analysis. During this time period, 24% of RTC admissions were admitted out of state. The Department is seeking to appropriately size, fund and configure the in-state residential treatment system to decrease the number of children going out of state for RTC treatment. Decreasing in-state ALOS will also be a primary focus moving into 2009/2010. It is believed that OOS RTCs run a longer ALOS due to the highly specialized programs they administer for certain difficult populations. In 2008, discussions between the Department and CT BHP began regarding the timing of tying authorizations to claims in 2009 for OOS RTCs. Implementing this process should contribute to decreasing any unnecessary days in OOS RTCs.

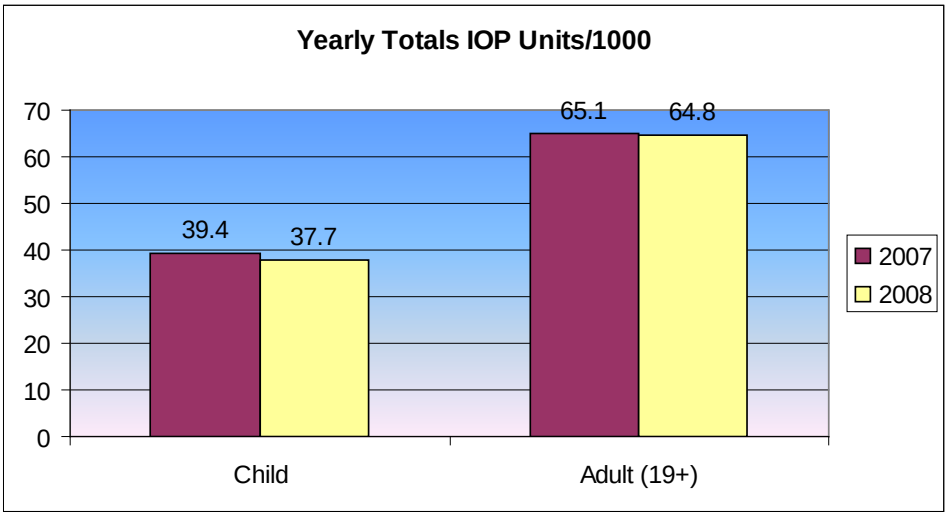
D. Day Treatment Programs (Intensive Outpatient Programs (IOP), Partial Hospital Programs (PHP), EDT, Total) Admissions/1000 & Units/1000

ALOS is not reported for these levels of care. Authorizations are established for set periods of time, as articulated in the level of care guidelines, and do not necessarily coincide with the actual length of time the member spends in the treatment setting as evidenced when authorization-based ALOS is compared to claims based information.

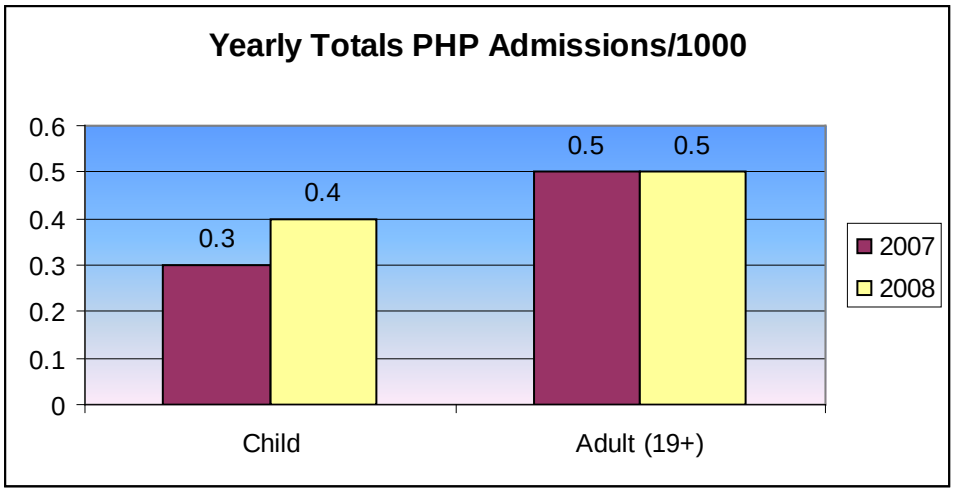
Adult and Child



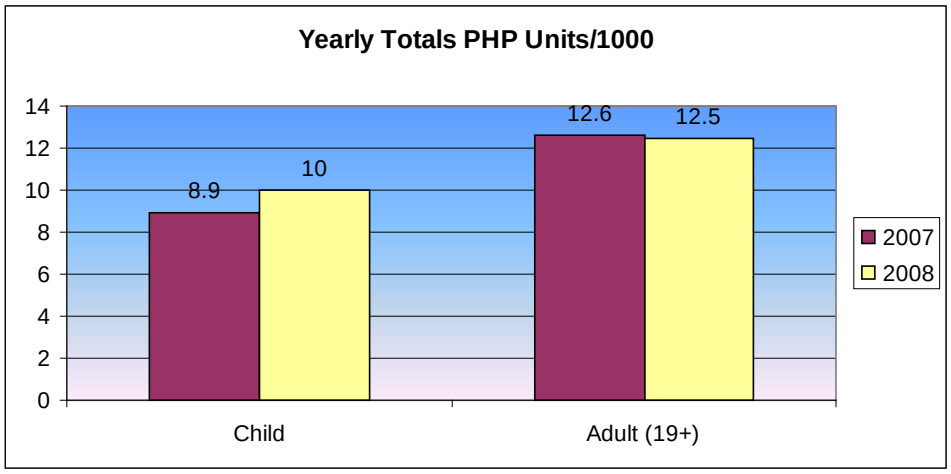
Adult IOP admissions/1000 members exceed child admissions/1000 by more than 100%. Both IOP admissions/1000 rates remain steady across calendar years 2007 and 2008. The actual number of child admissions decreased slightly in 2008 while the number of adult admissions increased in 2008, from 1,791 in 2007 to 1,882 in 2008.



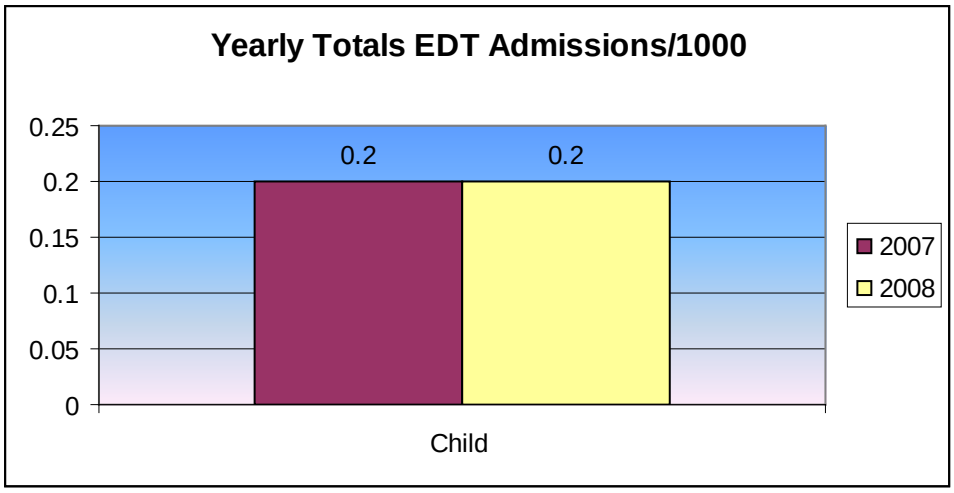
Adult IOP days/1000 continue to be more than one and a half times as many as child IOP Days/1000.



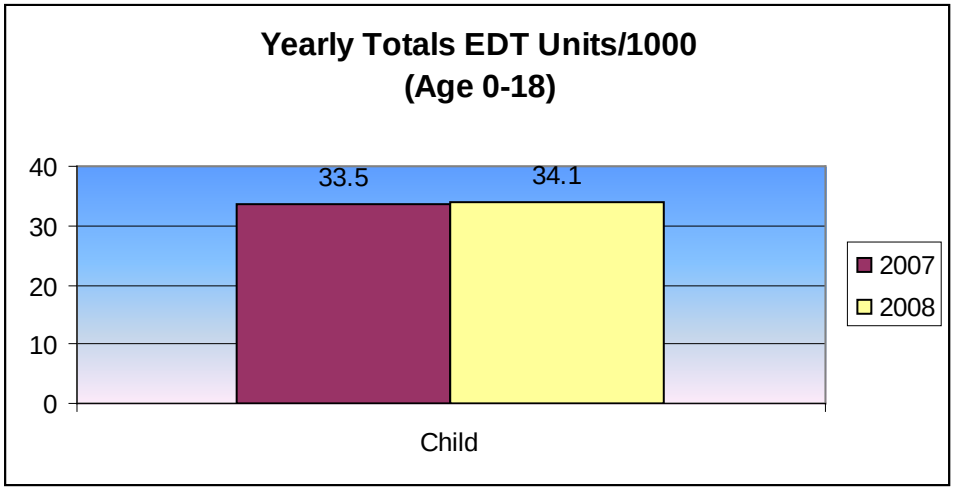
Both Child and Adult PHP admissions/1000 have increased in 2008. The total number of child admissions rose from 884 in 2007 to 1,042 in 2008, while adult admissions rose from 588 to 604 in 2008. Higher rates of admission to intermediate levels of care is to be expected as the length of stay in inpatient decreases.



Adult PHP days/1000 has remained nearly the same in 2008 as in 2007 while child PHP days/1000 have increased from 8.9 in 2007 to 10.0 in 2008.



EDT is not a level of care available to adult members. Child admissions/1000 to EDT remain consistent across the past two years. The actual number of admissions increased somewhat (<4%); there were 639 admissions to EDT in 2008 and 617 in 2007.

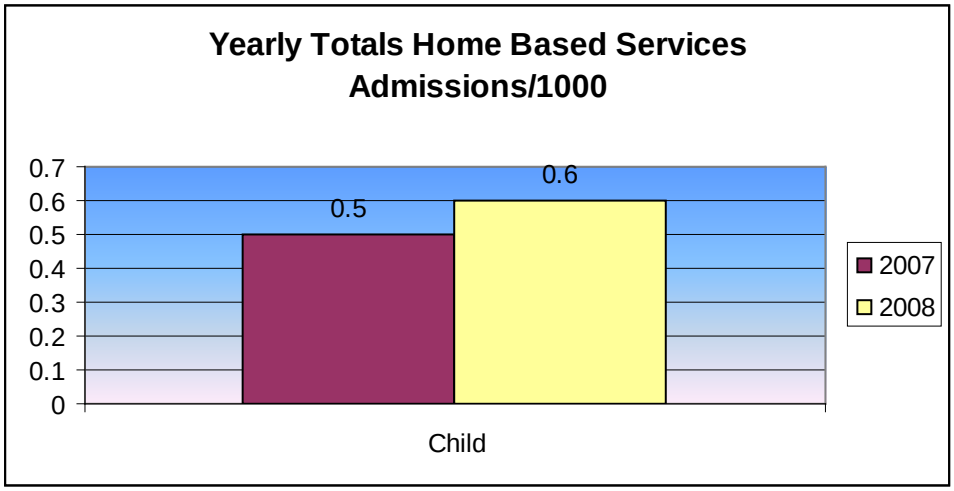


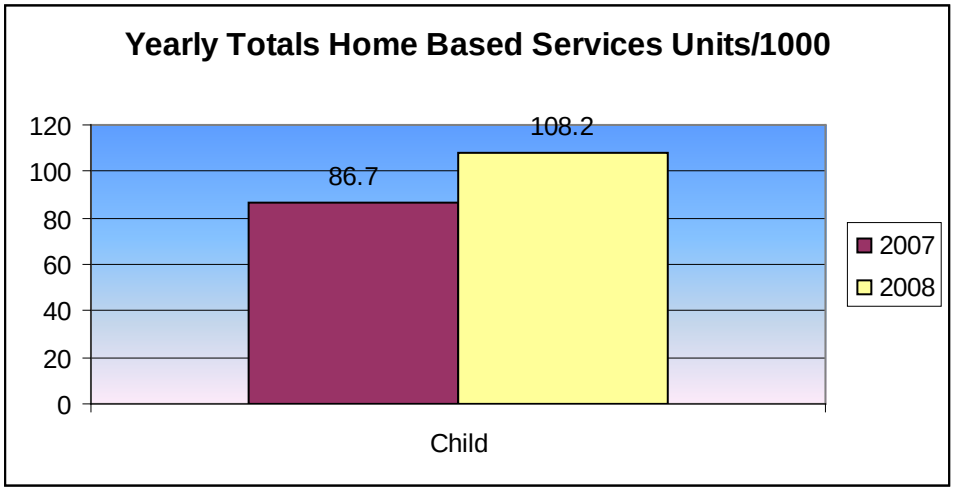
Child EDT units/1000 increased slightly in 2008 to 34.1 from 33.5 days/1000 in 2007.

E. Home Based Services (FST, HBS, MST, MDF, FFT, Total) Admissions/1000 and Units/1000

ALOS is not reported for these levels of care as it reflects average length of time a member spends in these levels of care, not average number of units used per episode of care.

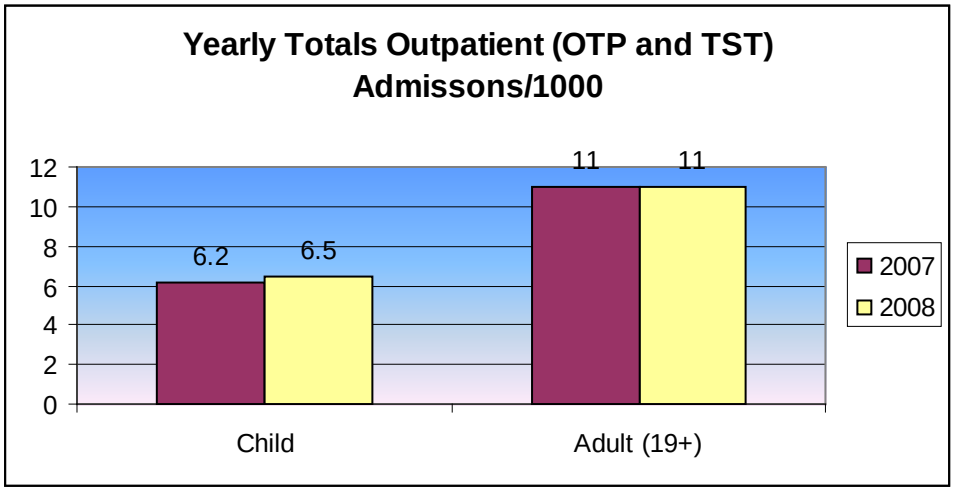
Children





The use of home based services has increased for both DCF and Non-DCF children over the past two years. Both admissions/1000 and units/1000 increased in 2008; increased use of IICAPs accounts for the majority of the increase in use of Home Based Services.

F. Outpatient (OTP/TST) Admissions/1000
Adult and Child



Outpatient units/1000 should not be calculated based on authorization data; 26 units/year is given for all new authorizations and does not accurately reflect units used. Outpatient admissions/1000 increased in 2008 for child members but remained the same for adult members.

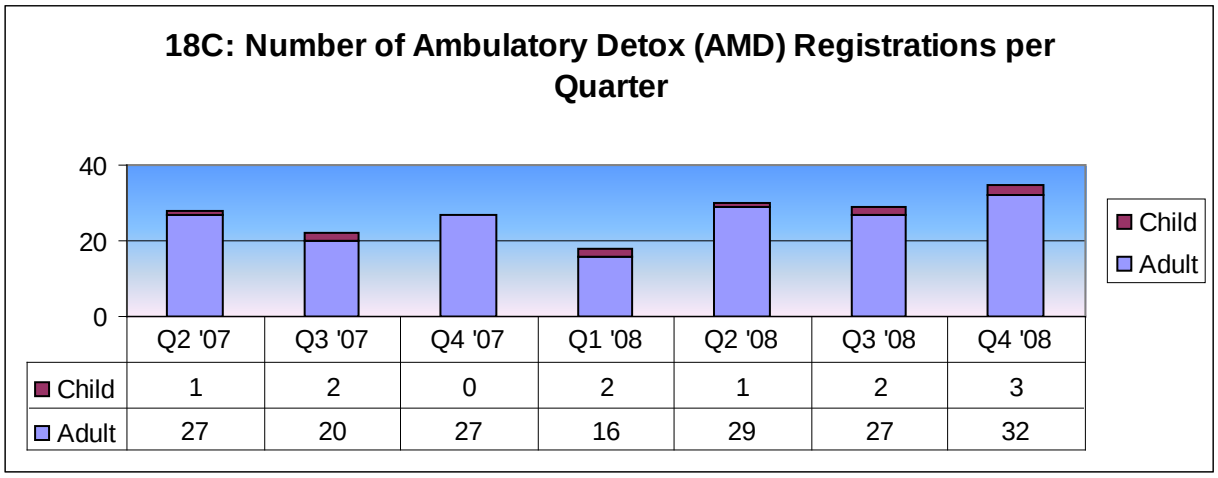
The total number of outpatient evaluations completed in 2008 was 30,208. Total volume has decreased 4.8% from Q1 '08 to Q4 '08. It is difficult to know if this is a seasonal difference or changing utilization patterns as CY 2008 represents the first full four quarters that this report has been available. Further volume analysis should be done at the completion of CY 2009 to assess any changes in utilization.

Volume has increased significantly (7.8%) from Q3 '08 to Q4 '08; however, the number of evaluations triaged as Urgent and Emergent has decreased 11.7% from Q1 '08 to Q4 '08. It is difficult to assess the significance of these changes without comparison data as these trends may be seasonally related as well. Providers attribute the drop in urgent and emergent cases to the improved access to routine appointments. They report that as waiting lists disappear and new members are seen much more quickly, treatment is provided before the case becomes an emergency.

Throughout CY 2008 the percentage of new members with timely access to Routine appointments (14 calendar days) has increased from 76.71% in Q1 '08 to 84.02% in Q4 '08. It is difficult to determine if improved performance by ECCs is solely responsible for this trend; currently, all outpatient providers are included in this report. Once the ECCs are separated out from all other outpatient providers in 2009 it will be possible to determine if there is an upward trend among non ECC providers as well or if it was ECC providers pulling up these rates.

G. Ambulatory Detox (AMD) and Methadone Maintenance (MET)
As with Outpatient care, units/1000 is not calculated because of the standard registration award of 26 units/year and low authorization to claims ratio on outpatient care.

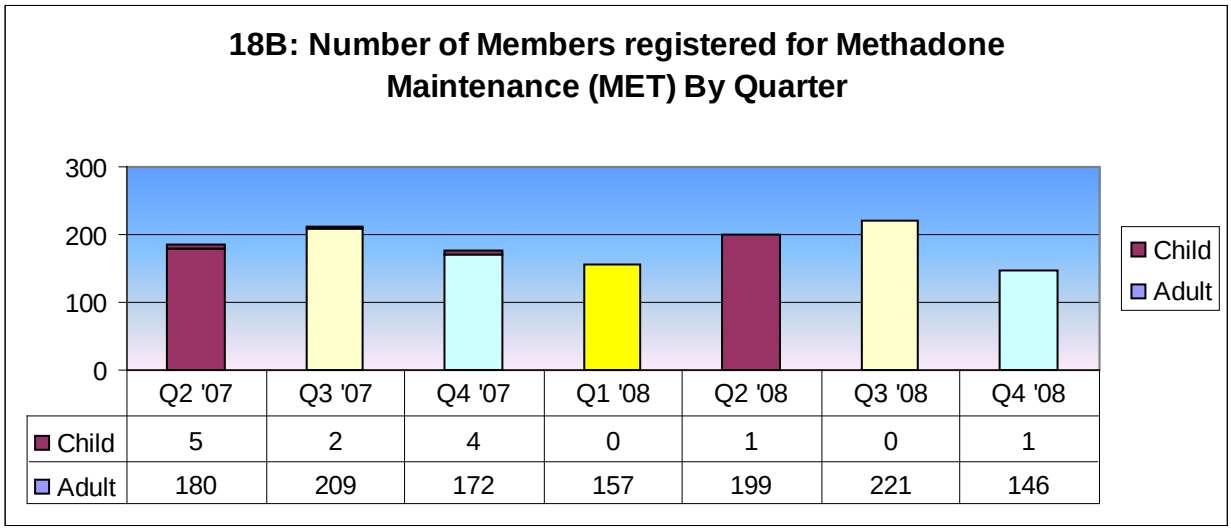
Ambulatory Detox:



	Q2 '07	Q3 '07	Q4 '07	Q1 '08	Q2 '08	Q3 '08	Q4 '08
Child	1	2	0	2	1	2	3
Adult	27	20	27	16	29	27	32

The number of ambulatory detox registrations per quarter has increased by almost 30% from Quarter 4 '07 (n=27) to Quarter 4 '08 (n=35). At the same time the overall CT BHP membership has increased 5.9% from CY 2007 to 2008, perhaps partially explaining the increase.

Methadone Maintenance:



	Q2 '07	Q3 '07	Q4 '07	Q1 '08	Q2 '08	Q3 '08	Q4 '08
Child	5	2	4	0	1	0	1
Adult	180	209	172	157	199	221	146

Consistent across all four (4) quarters in 2008, nearly all members who received methadone maintenance are adults. The range of number of admissions to methadone maintenance programs fluctuates from quarter to quarter and ranges from 146 adult members to 221 adult members.

Recommendations for continuing sub-Goal in 2009:
This sub-goal will be applicable for 2009 and should be included in the 2009 Project Plan. As will be described in Goal 18, Provider Analysis and Reporting (PARs) programs will begin for the PRTF and RTC level of care and will be continued for both Inpatient and Enhanced Care Clinics through 2009. PARs programs, coupled with continued tighter, more focused care

management strategies are expected to result in changing trends in UM data. It is recommended that a separate sub-Goal regarding the RTC UM program and rightsizing project be included in the 2009 Project Plan.

Goal 13. Monitor timeliness of UM decisions; identify barriers and opportunities (Contract reference E.12.2)

Activities and Findings that include trending and analysis of the measures to assess performance:

A. Initial Authorizations

1. Initial decisions re authorization for acute levels of care; communication within 60 minutes:
   UM decisions not requiring a peer review (60 minutes) met the Turn Around Time (TAT) goal for all four quarters of 2008 at a rate of 99.43%.

   Overall, TAT with and without peer review for initial authorizations for higher levels of care for 2008 was 99.48% or 10,144 of 10,197 decisions.

2. Initial decisions regarding authorization for non-acute levels of care with 1 business day:
   The average completion time for those decisions not meeting the 1 Business Day TAT goal was 10.2 days. A scrub report was developed to help identify cases where TAT goal was not met because of user error. The cases that are not in compliance are primarily due to eligibility issues with children in residential placements out of state.

   Overall, timely TAT with and without peer review for initial decisions regarding lower levels of care was 99.84% or 3,731 of 3,737 decisions.

B. Concurrent Authorizations

1. Concurrent decision within 60 minutes of the date the authorization expires for acute LOC:
   UM decisions not requiring a peer review (60 minutes) met the TAT goal for all four quarters of 2008 with an annual rate of 96.91%. Decisions in these TAT categories met the 95% standard.

   UM decisions not requiring a peer review (2 business days) met the TAT goal for all four quarters of 2008 with an annual rate of 97.43%. Decisions in these TAT categories met the 95% standard.

   UM decisions requiring a peer review (1 business day) met the TAT goal for all four quarters of 2008 with an annual rate of 100%. Decisions in these TAT categories met the 95% standard.

   Overall, TAT with and without peer review for concurrent authorizations for higher levels of care for 2008 was 96.94% or 11,717 out of 12,088 decisions.

2. Concurrent decisions re authorizations for non-acute LOC within 2 business days of request:
   Concurrent UM decisions not requiring a peer review (2 Business days) met the TAT goal for all four quarters of 2008 with an annual rate of 99.43%. Decisions in these TAT categories met the 95% standard.

   Concurrent UM decisions requiring a peer review (2 business days) met the TAT goal for all four quarters of 2008 with an annual rate of 97.5%. Decisions in these TAT categories met the 95% standard.

   Overall, TAT with and without peer review for concurrent authorizations for lower levels of care for 2008 was 99.47% or 8055 out of 8098 decisions.

C. Peer Review requirements:
   1. For inpatient psych, offer an appointment for peer to peer review within 60 minutes of completion of CM review (120 minutes total)
      In 2008, 88 of 89 or 98.9% of inpatient psychiatric decisions that went to a peer to peer were made within the 120 minute timeframe.

   2. For inpatient detox, offer appointment for peer to peer review within 120 minutes of completion of CM review (180 minutes total)
      In 2008, 4 of 4 or 100% of all inpatient detox precertification decisions that went to a peer to peer review were made within the 180 minute timeframe.

   3. For lower levels of care, offer appointment for peer to peer review within 1 business day of request for authorization unless provider unavailable
      During 2008, all peer to peer decisions with a 1 business day turn around time met that standard (100% or 15 of 15).

   4. For lower levels of care, offer appointment for peer to peer review within 2 business day of request for authorization unless provider unavailable
      During 2008, 98.2% or 56 of 57 peer decisions with a 2 business day turn around time met the standard.

D. Written Notice
   1. 98% of all authorization decisions result in an appropriate letter

   2. 98% of all batch extracts of authorization notifications created will be delivered to the vendor, who creates and mails letters, within 2 business days

   There were a total of 261 authorization files created. All 261 (100%) of the authorization files were delivered to the vendor within the TAT standards.

E. Denials

1. Total number of administrative denials issued

The advent of more on-site review in several levels of care coupled with a more mature case management department resulted in an increase in the number of administrative denials. A total of 518 administrative denials were issued during 2008, an increase of 28.5% from 2007 when 403 administrative denials were issued.

The inpatient psychiatric level of care incurred the biggest increase in administrative denials from 2007 when there were 26 administrative denials to 2008 when there were 137 administrative denials. IICAPS (48.9% increase from 43 to 64) and FFT (113% increase from 8 to 17) also had large increases in the rate of administrative denials. With the closer oversight of the RTC level of care, there was a significant increase of administrative denials from 2 during 2007 to 31 during 2008.

2. Number and % of NOAs and denials issued within 1 business day of decision
(100% of denials were issued within 1 business day of the decision.)

There has been an increase in the number of medical necessity denials issued in 2008 by our physician advisors. During 2007, a total of 48 denials were issued. During 2008, a total of 162 denials were issued. Of those 162 denials, 130 were denials of requests for care of children and 32 were for requests for care of adults. This increase in the number of denials is a result of a more seasoned/mature medical affairs department.

Most of the denials were issued for ongoing (concurrent) inpatient psychiatric care. The second most frequently denied level of care was for RTC, again primarily for ongoing care. Care at Riverview Hospital was also denied 21 times; denials for care at Riverview tended to be for admission to that facility rather than for ongoing care.

With regard to the percentage of denial notices being issued within 1 business day, 95.1% were issued timely. During an internal audit conducted during Q3 08 of medical necessity denials done since the beginning of 2008, a discrepancy was found between the number of Medical Necessity denials done in the system and the number of denial notifications sent. Up to that time, the number of denials reported in quarterly reports was based on the number of notifications mailed rather than on a system-based report. The audit revealed that a total of eight medical necessity denial notifications were not sent in 2008; seven (7) of those were not mailed during Q1 and Q2 08 and one was not mailed in Q3 08. In all cases the facility or program had been notified verbally that there had been a denial.

In order to prevent further failures to send denial notification letters, a corrective action plan was written and implemented. The process for making sure that written notification follows the verbal notification was immediately revised. All notifications are now based on the denial being entered into the system rather than on the receipt of a paper form that was used previously. Denials appear in the system in real time and thus provide the most timely notification of the coordinator that a denial has occurred. The most stringent measure taken was to conduct a daily reconciliation of denials between the clinical and quality departments.

Following the implementation of this new process, 100%of notifications were sent out timely for the remainder of the year.

Recommendations for continuing sub-Goal in 2009:
This sub-goal will be applicable for 2009 and should be included in the 2009 Project Plan.

Goal 3. Monitor timeliness of appeal decisions; identify barriers and opportunities. (Contract Reference Exhibit E; 23A-B)

Description of Activities and Findings including trending and analysis of measures over time:

A. Member Medical Necessity Appeals
1. Number of Expedited Appeals
   There were 3 expedited member appeals received during 2008.
2. Percent of Expedited Appeals completed and appeal decision issued within 3 business days of receipt of appeal from DSS or members
   All 3 appeals were resolved within the standard.
3. Number and percent of Expedited Appeals overturned
   None of the decisions were overturned on appeal resulting in a 0% overturn rate.
4. Number of routine appeals
   There were 7 member appeals received in calendar year 2008.
5. Percent of routine appeals resolved no later than 30 days of filing or the date of the fair hearing
   100% of the appeals were resolved within the standard.
6. Number and percent of routine appeals overturned
   Three of the seven denial decisions were overturned on appeal, resulting in a 42.9% overturn rate.
6. Total number and percentage of Member Appeals determined within the required timeframes
   A total of 10 member appeals were received; all were processed and had determinations made within the required timeframe. Of those 10 member appeals, 3 resulted in an overturn of the denial decision resulting in a 30% overturn rate of member appeals.

B. Provider Medical Necessity Appeals
1. Number Level I Medical Necessity Appeals
   There were 30 Level I appeals for calendar year 2008; 25 were appeals of medical necessity denials of care for children and 5 were of care for adults.
2. Percent of Level I Medical Necessity Appeals with Peer to Peer review within 1 business day
   100% of the Level I appeals with peer to peer review were completed within 1 business day.

3. Number and percent Level I Medical Necessity Appeals overturned
   Of the 25 child appeals, 10 were overturned resulting in a 40% overturn rate. Of the 5 adult appeals 1 was overturned resulting in a 20% overturn rate. Overall overturn rate at the first level of appeal was 36.67%.

4. Of the 162 medical necessity denials done during 2008, 40 appeals (member or provider) were received; this results in an overall appeal rate of 24.7%. This rate is rather low. This opportunity for improvement will be referred to the QM Committee for review.

5. Percent of Level I Medical Necessity Appeals with determination and notification within 1 hour of completion of Peer to Peer review
   100% of the Level I appeals had a determination and notification within 1 hour of completion of peer to peer review.

6. Percent of Level I Medical Necessity Appeals with notice mailed within 2 business days of determination
   100% of Level I appeals had a notice mailed within 2 business days of the determination.

7. Number of Level II Medical Necessity Appeals
   There were 11 Level II appeals for calendar year 2008; 10 were appeals of medical necessity denials for care for children and 1 concerned care for an adult.

8. Percent of Level II Medical Necessity Appeals with determination and notice of determination within 5 business days of receipt of information necessary to make decision.
   100% of Level II appeals were resolved within the timeframe.

9. Number and percent of Level II Medical Necessity Appeals overturned.
   Of the 10 child appeals, 1 (10%) was overturned. The one adult Level II appeal was upheld resulting in a 0% overturn rate. The overall overturn rate for Level II Provider Appeals is 9.1%.

   Of the total of 162 denial decisions, a total of 15 were overturned either on a Member Medical Necessity Appeal or a Provider Level I or II appeal. The overall overturn of medical necessity denials was 9.3%.

C. Administrative Appeals

1. Number of Administrative Appeals
   There were a total of 248 administrative appeals in 2008, an increase of 27.8% from 2007 when there were a total of 194 administrative appeals.

2. Percent of Administrative Appeals with determination and notice within 7 business days of receipt of appeal
   100% of the administrative appeals had determinations and notices mailed within 7 business days.

3. Number and percent of Administrative Appeals overturned
   Of the 248 administrative appeals received, 53 (21.4%) resulted in an overturn of the administrative denial decision. During 2007, of the 194 appeals resolved, 51 (26.3%) resulted in an overturn of the administrative denial decision.

4. Most frequent reasons for Administrative Appeals
   - 123 (49.6%) were based on the denials for registrations/prior authorization procedures not followed within the required timeframe, and

- 120 (48.4%) resulted from denials for concurrent review procedures not followed within required timeframe.

Recommendations for continuing sub-Goal in 2009:
This sub-goal will be applicable for 2009 and should be included in the 2009 Project Plan.

Goal 14. Monitor consistency of application of UM Criteria (IRR) and adequacy of documentation. (Contract Reference E.122.1)

Activities and Findings that include trending and analysis of the measures to assess performance:

A. % compliance with clinical inter-rater reliability (IRR) audit

On an annual basis, the CT BHP service center participates in the company-wide IRR audit. This IRR audit typically consists of 20-25 clinical vignettes for each of which the clinicians must determine the appropriate level of care. The audit process was enhanced for CT BHP this year via the addition of several clinical vignettes that were specific for levels of care that are authorized solely by CT BHP.

For the second year in a row, the service center performed extremely well. For the company-wide IRR, 96.4% of our staff passed; the average score was 90.36%. For the CT specific IRR, 100% of our staff scored above the corporate standard of 75%. For the CT specific audit questions, 91.96% of CT clinicians chose the best answer for the vignette. While the corporate standard for this audit is 75%, the CT BHP contract states that clinicians must meet a 90% standard. With the CT specific questions only numbering 8, clinicians would need to complete all 8 questions correctly for the score to remain above 90%. A total of 16 of 28 or 57% of staff achieved that and scored 100% on the CT specific IRR audit. Another 6 of the 28 answered only one question incorrectly. The remaining six answered two questions incorrectly.

To continuously address and ensure the IRR of clinical decisions, clinicians meet in rounds on a weekly basis to discuss both new and on-going cases. These rounds supply case managers with immediate feedback regarding their decisions. This feedback, accompanied by the frequent feedback from audits is partially responsible for the resulting improvement of IRR in 2008. During 2008, the rounds described above were expanded to include more levels of care and therefore to address IRR with a broader range and higher percentage of cases.

B. Assess adequacy and accuracy of clinical documentation
The audit process that was implemented in August 2007 in preparation for the Mercer audit of the clinical documentation of CT BHP staff, continued through Q2 ’08. The process required that both new-hire and seasoned clinicians falling below the 90% IRR standard (set by the CT BHP contract) be audited weekly until their four week average was above the standard. Once above the 90% standard, clinicians moved to monthly audits. If during any of those audits a clinician fell below the standard they returned to the weekly auditing schedule. Finally, any clinician not meeting the 90% standard on the audit is mandated to attend a weekly documentation training session.

At the conclusion of Q2 ’08 it was determined that clinical staff no longer required a monthly audit and that auditing should return to a quarterly schedule. Weekly audits continued for those

clinical staff who did not pass their quarterly audit as well as for new hires in their first 90 days of employment. In addition, the audit form used to bring documentation up to Mercer standards was shortened to include only key requirements for documentation. This change was closely scrutinized by QM staff. Old audits on the long form were transferred onto the short form to assess feasibility and accuracy. The short form was found to be more difficult to pass since it eliminated measures that seasoned clinicians rarely missed and thus focused more on essential documentation elements for a case. The short form was implemented in Q3 '08 for all seasoned staff. A team of experienced auditors continues to complete the clinical audits. This team participates in a monthly IRR meeting as well to ensure that all auditors score the documentation consistently.

By quarter the service center audit average for all CCM and ICM staff, including new hires and clinicians being re-audited are as follows:

Q1: 90.7%
Q2: 90.1%
Q3: 88.4%
Q4: 89.9%

As expected, the audit average went down in Q3 '08 with the implementation of a more difficult, shorter audit form and the increased auditing of new hires, with four new hires in that quarter alone. (In previous quarters new hires were only audited four times and if that average was above 90% they went on to be audited at the same frequency as that of seasoned clinical staff.)

Overall, CCM and ICM audit averages remain fairly consistent across quarters. Documentation to support the assessment of medical necessity has improved in 2008 when compared to 2007. In 2007, documentation for the assessment of medical necessity was present in 81.12% of precertification cases audited, while in 2008, that same documentation is present 94.63% of the time. In 2007, documentation for the assessment of medical necessity was present 84.09% of the time in concurrent reviews, while in 2008 that same documentation is present 87.63% of the time. Opportunities for improvement have been found in the area of correct citation of the level of care criteria that corresponds to their documentation. In precertification cases, 67.8% of the cases cited LOC guidelines codes that had documentation to support the use of the codes. The percentage in concurrent reviews is 58.7%. Continued training is being conducted to improve performance in these areas.

Recommendations for continuing sub-Goal in 2009:
This sub-goal will be applicable for 2009 and should be included in the 2009 Project Plan.

Goal 15. Monitor continuity of care; identify barriers and opportunities

Activities and Findings that include trending and analysis of the measures to assess performance:

A. During 2008 a form was added to the AIS system to automate and improve the reporting of cases being coordinated with the MCOs. Clinicians now choose medical and mental health diagnoses from drop-down boxes, making data more easily reportable and accurate. Prior to October 1, 2008, cases were manually logged and trended via an excel spreadsheet; the process is now web based. Data from 2007 was more difficult to trend and less quantifiable. A

monthly and yearly report will be developed during 2009 to further enhance reporting on coordination of care activities.

B. There were a total of 298 MCO co-management cases in 2008 while in 2007 there were a total of 505 medically co-managed cases. The drop in co-managed cases can be attributed to the re-procurement of the MCO's as discussed in Goal 9B.

In 2008, just over 36% of the medically co-managed cases were referred from CT BHP to the 3 MCO's active during the year. Adults age 19 to 62 made up 70% of all medically co-managed cases. In both 2007 and 2008 the most frequently occurring psychiatric diagnosis for members being medically co-managed is Mood Disorder, including Depressive disorders and Bipolar disorders. The most frequently occurring medical diagnoses in 2008 are Pregnancy and Post Partum Depression, as well as, Asthma. As discussed in goal 9B, the Post Partum Depression QIA continues to be highly relevant to our adult population and will continue into 2009.

Recommendations for continuing sub-Goal in 2009:
This sub-goal will be applicable for 2009 and should be included in the 2009 Project Plan.

Goal 16. Reduce Emergency Department (ED) Discharge Delays

Activities:

Late in 2007, a web-based form was developed in order to more accurately and easily report ED data. Prior to that, data was compiled manually from an excel spreadsheet. During 2008, the first system run reports were developed and produced for the reporting of ED data. In addition, drop down boxes were added to the already existing web-based form to make the fields more reportable. The data from this enhanced form will be used for additional reporting and individual ED analysis in 2009.

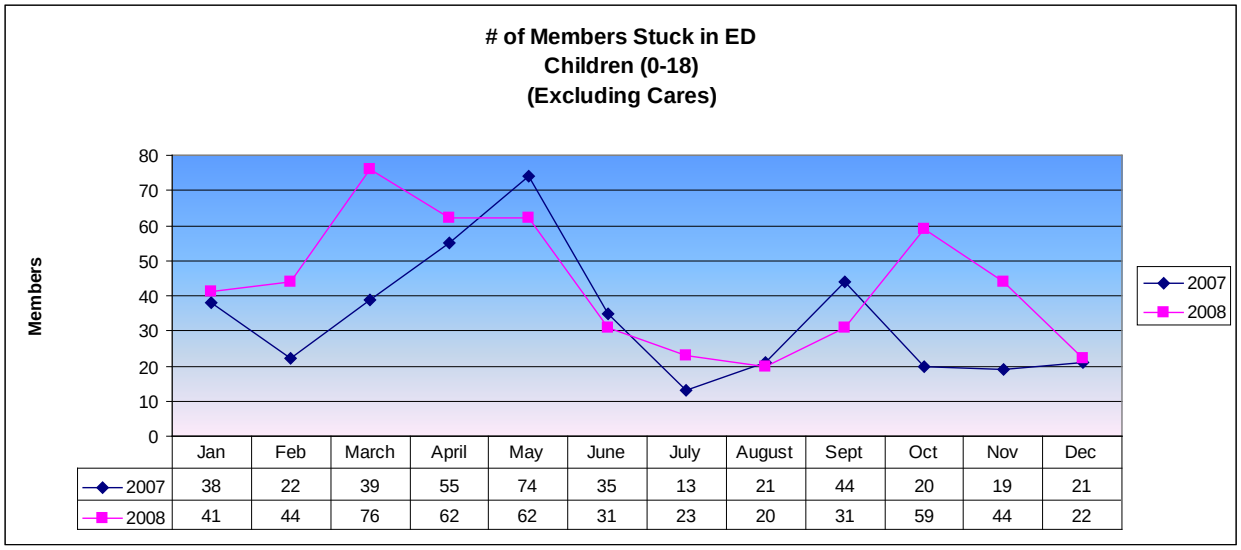
2008 also saw the first full year of the use of the CARES unit. The CARES unit, run by The Institute of Living/Hartford Hospital is a 3 day crisis stabilization/diversionary unit for members presenting to the ED or EMPS for behavioral health issues. The goal of the CARES unit is both to increase diversion from inpatient care (from the ED) and to decrease the length of time members spend in the Emergency Department awaiting the next level of care (i.e., decrease "stuck" length of time in the ED). As CT Children's Medical Center, CCMC, ED is one of the busiest in the state for children. The advent of the CARES unit is seen as one explanation for the decreased length of time children are "stuck" in the ED in 2008. Additionally, in 2008, CT BHP continued an on-call clinician program to provide after hours support to EDs and the CARES unit that consisted of case management and system-wide collaboration/coordination of care. In 2008 the CARES unit admitted 420 members.

Findings that include trending and analysis of the measures to assess performance:

While the number of children "stuck" in EDs increased from 401 in 2007 to 515 during 2008, the average length of delay in the ED for "stuck" children decreased from 2.5 days in 2007 to 1.9 days in 2008. The below graphs capture the seasonality trends of ED volume and bed availability.

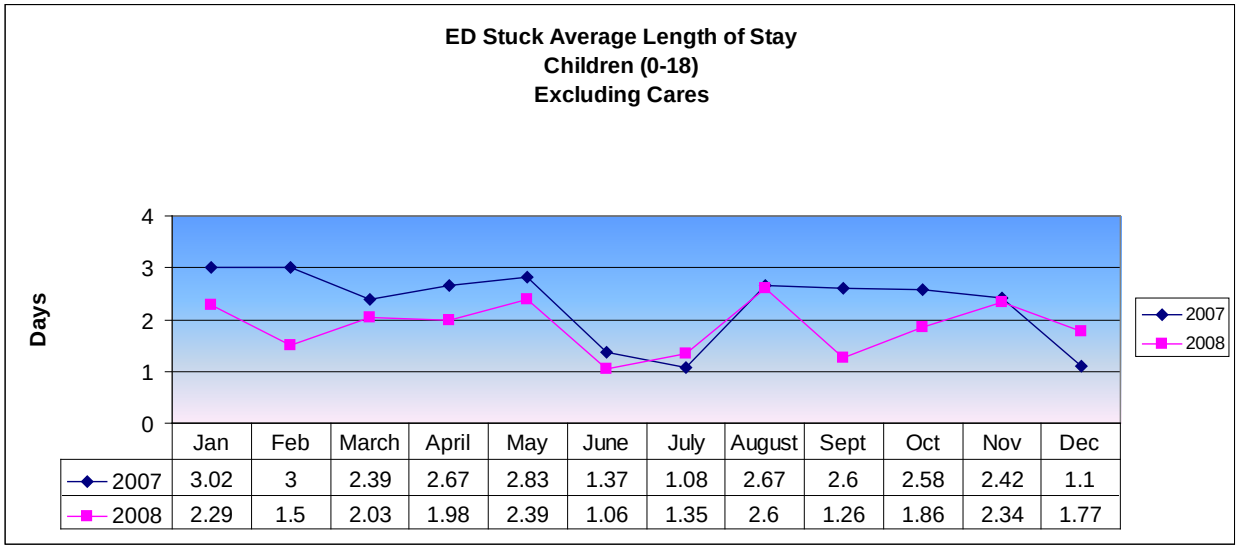
A. Number of Members Stuck in the Emergency Department by Month

The number reported is not a true count of visits to the ED. Rather, this count only includes those child members who have received medical clearance and remain in the ED awaiting a discharge plan for more than 8 hours. A CT BHP staff member contacts the EDs every day to speak with staff there who provide information regarding the identification and situation of children delayed in their ED.



	Jan	Feb	March	April	May	June	July	August	Sept	Oct	Nov	Dec
2007	38	22	39	55	74	35	13	21	44	20	19	21
2008	41	44	76	62	62	31	23	20	31	59	44	22

B. Average Length of Stay in Emergency Department by Month



	Jan	Feb	March	April	May	June	July	August	Sept	Oct	Nov	Dec
2007	3.02	3	2.39	2.67	2.83	1.37	1.08	2.67	2.6	2.58	2.42	1.1
2008	2.29	1.5	2.03	1.98	2.39	1.06	1.35	2.6	1.26	1.86	2.34	1.77

Recommendations for continuing sub-Goal in 2009:

Emergency Department length of stay should continue to be collected and analyzed in 2009. Additionally, the CT BHP is participating in a performance target with the CT ED's and EMPS providers during 2009 and next level of care after ED visit will become a statistic increasingly analyzed during this initiative. This sub-goal will be applicable for 2009 and should be included in the 2009 Project Plan.

Goal 17. Measure network adequacy; support Departments in maintaining adequate Provider Network to ensure member access (Contract Reference N.5.1.4)

Activities and Findings that include trending and analysis of the measures to assess performance:

A. Number of network providers by degree type
B. % of members with access to each provider type in each county within appropriate radius
C. Density ratios of providers to members

This goal has been suspended since 2007 when it was discovered that counts of network providers were significantly inflated as a result of outdated information in the data uploaded into the ProviderConnect system. Assessment of these indicators will resume when the data are corrected and more accurate assessment becomes available.

Recommendations for continuing sub-Goal in 2009:
This sub-goal will be applicable for 2009 and should be included in the 2009 Project Plan.

Goal 18. Implement the Provider Analysis and Reporting (PARs) Initiative for Inpatient Child and Adolescent, Inpatient Adult, Enhanced Care Clinic, and PRTF Levels of Care.

Activities and Findings that include trending and analysis of the measures to assess performance:

A new goal for 2008 involved the implementation of the CT BHP PARs program. The PARs program currently encompasses two types of activities.

1. The initial phase of a PARs program includes a level of care specific program (i.e., child and adolescent inpatient, PRTF, etc.) that works with the CT BHP to establish monitors to assess performance in relationship to other providers supplying the same or similar services. The ultimate goal is to improve provider performance. This aspect of the PARs program includes at least quarterly meetings with all participating providers to deliver feedback in the form of data, work with them to analyze their performance, and when necessary to establish corrective actions when their performance does not meet established goals.

2. A second aspect of the PARs program is the introduction of incentives to expedite system change. This aspect of the PARs program entails the establishment of goals with financial incentives attached. The goals are established in collaboration with providers as are the means of measuring performance. This incentive, or “Pay for Performance” program is utilized pending available funds through the CT Department of Social Services.

Child and Adolescent Inpatient PARs Program
The Inpatient Child and Adolescent PARs program was conceived during 2007. Initially the program focused on the need to address the exceptionally long lengths of stay of inpatient units treating children and adolescents. Certain populations within the CT BHP membership are made up of youth that have more complex treatment issues. These issues cause them to be more difficult to treat and/or arrange discharge plans for, and, as a consequence, cause them to have longer lengths of stay and delayed discharges.

In mid-November 2007 all eight hospitals that treat children and adolescents in CT were invited to participate with CT BHP on a Discharge Delay initiative. During December of 2007, meetings were held with each of the eight hospitals where collaborative discussions around discharge delay took place. The inpatient hospital staff from each of the hospitals offered feedback on how they currently address discharge delay issues. They also offered information addressing barriers to discharging children and adolescents to lower, more appropriate levels of care.

Based on information gathered at these meetings, the recommendation was made to work together to lower the number of discharge delayed children and adolescents within Connecticut. The hospitals agreed to meet quarterly with CT BHP staff to review the following information regarding their individual performance as well as their performance in relation to the other hospitals.

The following data were shared with each of the hospitals on a quarterly basis:

- Comparison of length of stay data for all eight facilities,
- Hospital specific Average Length of Stay (ALOS) broken out by length of stay for DCF and non-DCF 0-12 year olds and DCF and non-DCF 13-18 year olds
- Percentage of days each quarter that members spent in discharge delay
- Percentage of readmissions within 7 and 30 days.

Over the remainder of 2008, CT BHP staff met with each of the eight facilities to provide this information to each of the hospitals.

Child and Adolescent Performance Incentive Program 2008-2009

In January of 2008, a workgroup made up of representatives from three of the hospitals, the Departments, and ValueOptions staff was established. Initially the group reviewed utilization data concerning length of stay and discharge delays within their own facilities. As the project moved forward, representatives from more of the hospitals joined the workgroup. Together, based on utilization data and their clinical experience, they worked to clarify the issues involved in the long lengths of stay and identify actions they, with support and cooperation from the Departments and CT BHP clinical staff, could take to shorten the time in discharge delay and the total length of stay.

The workgroup determined that, in order to control for the acknowledged difficulty of treating certain sub-populations of the CT BHP membership, the goals set for each facility's performance would be "case mix adjusted" to take into consideration the proportion of those more difficult and/or complex cases that each of the facility typically treats. Data analysis has clearly shown that:

- DCF children age 0 to 12 have longer lengths of stay than do non-DCF children.
- DCF adolescents have longer lengths of stay than do non-DCF adolescents, but not as long as DCF children aged 0-12

Predicted lengths of stay for each of the hospitals were individually set based on their "baseline performance" during Q3 and Q4 of '07. Statewide targeted lengths of stay were set for each of the four groupings of sub-populations (DCF 0-12, non-DCF 0-12, DCF 13-18 and non-DCF 13-18) after the 6% longest length of stay within each of the categories for each of the hospitals were removed. This action served to "ratchet down" the statewide goals for each of the four categories. At the same time, hospitals had the 4% longest lengths of stay within each of the categories removed from the calculation of their "adjusted average length of stay".

Hospitals could meet their goal and receive their incentive payment in two ways:

- By meeting their case-mix adjusted ALOS goal or
- By making significant progress towards meeting their goal. This means of achieving the incentive payment was established for those hospitals with significantly longer lengths of stay than the others in the program.

Please see Attachment C for the detailed description of the program including the agreed upon methodology that supported it.

During the quarterly meetings with each of the hospitals described above, specific feedback was given to each of the hospitals regarding their actual performance with each of the categories. For instance, the hospital was provided with data regarding how their length of stay and days in discharge delay for DCF 0-12 year olds compared to other hospitals during the same time period. Frank conversations occurred that assisted the hospitals to identify differences in their treatment protocols, relationships with the departments and community providers in terms of working through discharge delays and how these differences might be impeding their performance. CT BHP clinical staff and DCF representatives simultaneously attended on-site rounds to work with each hospital to facilitate discharge planning.

In Q3 08, the Connecticut Behavioral Health Partnership (CT BHP) gained sign off from the Behavioral Health Partnership Oversight Council to proceed with the performance initiative program with the inpatient facilities treating children in CT.

Remeasurement of performance during Q3 and Q4 '08 found that 7 of the 8 hospitals had either met their goals or made significant movement towards meeting their goals. Only one hospital had a longer length of stay during the remeasurement period than they did during the baseline measurement period. As described in the findings in Goal 12, the ALOS of children and adolescents dropped over 2008 with the most significant decreases during the second half of 2008. The acute portion of the length of stay remained fairly stable while the discharge delay portion of the stay dropped considerably.

The incentive program is expected to be carried through CY2009. The recommendation is retain outcome measure 1 (meeting or exceeding the predicted length of stay) and to delete the second method of achieving the incentive payment (significant progress towards meeting the predicted length of stay). Instead, it is recommended that outcome measure 2 be based on improved family involvement in treatment and discharge planning.

Psychiatric Residential Treatment Facilities (PRTF) PARs Program

The PRTF PARs Program was initiated during 2008 by the Clinical Department and supported by the Quality Department. Early in the year, CT BHP Clinical staff began meeting and working with the four PRTF programs to revise the UM Criteria that served as the basis for authorizing care in their programs. PRTFs had originally been designed to serve as step down "sub-acute" programs for children 12 or under who no longer needed hospitalization but who were not yet ready to return to the community for services. Over time, delays in discharging youth from these programs grew as community services required by children leaving PRTFs became harder to access. As the meetings of the workgroup progressed, there was increasing focus on the changes that needed to occur to enable the PRTFs to move the children back to the community faster.

As the group worked on the revision of the UM Criteria, work also proceeded on the revision of the referral form used by the PRTFs to gain access to their programs. Initially, each of the four programs had their own referral form. This served as a barrier to the inpatient facilities in gaining access to PRTF care because they had to submit multiple applications to the PRTFs. Some of the forms were excessive in length. The PRTFs worked together with CT BHP staff to develop a "Universal Referral Form" so that application to all four of the programs could be done simultaneously by the hospitals.

PRTF Incentive Program

In late 2008, the Connecticut Behavioral Health Partnership (CT BHP) gained sign off from the Behavioral Health Partnership Oversight Council to initiate a performance initiative program with the PRTF's across the state. This initiative was crafted with two key goals; to improve process and quality while aligning the program's length of stay to anticipated performance levels. While the PRTFs are aware that the ultimate goal is to shorten the ALOS of the children under their care, there was the realization that they would need to make significant programmatic changes to enable them to achieve the goal of shorter lengths of stay. As a result, it was determined that the first step would be to attach incentives to their implementation of programmatic changes.

Two significant changes were made:

1. The first step in this process was to implement the Universal Referral Form across all four of the PRTF programs. CT BHP supported this implementation by facilitating meetings between the PRTFs and the hospitals to conduct training on the use of the new forms.
2. The second step in the process involved training on Focal Treatment Planning (FTP) with each of the PRTFs. As described above, the FTP process incorporates the discharge plan from the beginning of a treatment cycle. The process builds the treatment plan around the identified treatment issues that need to be addressed that will enable the member to be discharged to the level of care or living situation where they are expected to go after discharge. Once this is determined, the remainder of the treatment stay focuses on interventions designed to move the member towards those behaviors that will enable them to move out of the PRTF.

The CT BHP, in collaboration with the four PRTF providers in Connecticut, agreed that the incentive would be based on their implementation of these improvements and that their achievement of the goals would be based on the results of an audit of the PRTF providers, to be conducted in April 2009. The measures in the audit are based on the programmatic changes that the PRTFs should be implementing that promote the goals of improved efficiency and family engagement. Their implementation should assist in moving the PRTFs towards the goal of facilitating flow through the system thereby shortening their current lengths of stay. The audit will serve as the basis for determining whether the PRTF is eligible for a performance incentive payment. The implementation timeframe for these process measures is January through March 2009. The audit will be of cases admitted during that timeframe (if the sample is large enough) or of cases treated during that timeframe not scheduled for discharge before April 1, 2009.

Please see Attachment D for a summary of the elements that will be included in the 2009 PRTF Audit and a description of the methodology.

Enhanced Care Clinic (ECCs) PARs Program

The ECC PARs program has not followed the typical progression of the other two programs. In 2006, the Departments asked Child and Adult Outpatient Clinics to respond to a RFP whereby they applied for ECC status. This status would allow them to be paid 25% more than their current reimbursement rate for treating HUSKY members. In order to qualify for ECC status, there were multiple requirements that they had to meet:

1. Centralized telephonic access to appointments,
2. Timely access to care including
    a. Routine appointments offered within 14 days 95% of the time
    b. Urgent appointments offered within 48 hours 95% of the time
    c. Emergent evaluations within 2 hours of arrival at the ECC 95% of the time
    d. Psychiatric evaluations within 2 weeks of evaluation that identified the need for psychiatric evaluation
    e. Extended clinic hours
3. Improved family engagement
4. Sign a Memorandum of Understanding (MOU) with PCPs or Pediatricians in their areas to provide consultation and timely access to those providers so that they, in turn, are able to provide psychopharmocologic treatment to HUSKY members within their practices.

During the first application process, 28 ECCs were accepted and officially became ECCs as of 4/13/07. A second round of applications resulted in 9 additional ECCs as of 3/4/08.

The web application used by outpatient providers to register outpatient care was revised by CT BHP to enable CT BHP to measure compliance with the timely access requirements. Reports based on web registrations were developed during 2008; first in the aggregate, and then for each individual ECC.

Together with the Departments, the ECC data was analyzed and opportunities for improvement among the ECCs were identified. CT BHP began to work with the Departments to provide each of the ECCs with a consistent process to give the ECCs timely feedback regarding their compliance with appointment access standards. Statewide ECC meetings were initiated to provide a forum for consistent feedback to ECCs regarding their performance and the Departments expectations. The first of these statewide meetings occurred in April 2008.
As a result of those statewide meetings and the issues that were raised by the ECCs:

1. FAQs were developed and distributed to the ECCs
2. An ongoing workgroup of interested ECC representatives was initiated to work on identified issues and barriers to meeting the ECC requirements.

The ECC Workgroup began meeting in June of 2008. The workgroup identified web registration problems, lack of understanding and confusion about the ECC requirements, high member no-show rates that were preventing them from meeting their access standards, and difficulties hiring enough Spanish-speaking therapists to treat the volume of members.

During 2008, CT BHP Regional Network Managers (RNMs) increasingly were charged with providing the day to day support of the ECCs in their regions to assist them to meet their contractual requirements and improve the overall quality of the care they provide. Processes were put into place whereby the individual ECC quarterly reports that describe their performance on access standards were delivered to individual ECCs by the RNMs. Supported by key staff in DCF, the RNMs discuss performance with the ECCs, assist them to identify

programmatic changes they need to make to meet the standards, and then serve as a resource to making those changes.
RNMs played an active role in assisting the ECCs to meet the deadline of September 1 for obtaining signed MOUs with PCPs and Pediatricians. Additionally, in Q3 '08, the original 28 ECCs were held to their contractually agreed upon performance for access to routine appointments for the first time. ECCs not meeting the standards were placed on probation and asked to submit corrective action plans (CAPs). RNMs have worked with DCF staff to support the ECCs in the development and implementation of their CAPs. The original ECCs must come into compliance with routine access by Q2 '09 in order to maintain their ECC status. Newer ECCs will be held to the standards for the Q1 09 performance measurement period.

Finally, a Mystery Shopper program, contractually agreed upon by ValueOptions, was implemented during Q4 '08. Currently, the program entails calls to the ECCs by CT BHP staff to obtain a routine appointment. During the first cycle of these calls completed during Q4, 3 of the 5 ECCs contacted failed to either meet the requirements of providing adequate triage of the caller to enable them to assess the clinical urgency of the situation, or put the caller into voicemail and failed to return the call in 24 hours. Those ECCs were placed on probation and have submitted CAPs.

Despite the number of ECCs on CAPs, there has been remarkable progress in improvement of access to outpatient treatment. In the Q3 '08, just over 85% of members presenting for routine outpatient treatment were offered appointments within 14 days; this represents a 20% increase from Q1 '07. During Q4 '08, almost 88% of members were offered an appointment within 14 days.

At the present time, 13 ECCs are on probationary status for failing to meet access standards and 3 are on probation for failure to meet contractual obligations as a result of the Mystery Shopper Program.

Recommendations for continuing sub-Goal in 2009:
This sub-goal will be applicable for 2009 and should be included in the 2009 Project Plan.

IV. ONGOING QM/UM GOALS AND OBJECTIVES TO BE CARRIED FORWARD FROM THE EVALUATION YEAR

Goal 1: Review and approve the 2008 CT BHP Program Evaluation, 2009 CT BHP QM Program Description and 2009 CT BHP QM Project Plan.

Goal 2. Ensure timely response and resolution of member/provider complaints and grievances.

Goal 3. Promote patient safety and minimize patient and organization risk from Critical Incidents/ Significant Events.

Goal 4. Establish and maintain CT-BHP-specific policies and procedures (P&Ps) in compliance with contractual obligations that govern all aspects of CT BHP operations.

Goal 5. Establish and maintain a training program that includes compliance with state and regulatory requirements and HIPAA regulations.

Goal 6. Measure and assess Member and Provider Satisfaction.

Goal 7. Ensure timely telephone access to CT BHP.

Goal 8. Develop and Implement Quality Improvement Activities and Initiatives to address opportunities for improvement.

Goal 9. Monitor performance of Customer Service staff via audits of performance.

Goal 10. Review and approve the 2008 CT BHP UM Program Description.

Goal 11. Monitor for Under or Over Utilization of Behavioral Health Services; identify barriers and opportunities.

Goal 12. Monitor timeliness of UM decisions; identify barriers and opportunities.

Goal 13. Monitor timeliness of Appeal decisions; identify barriers and opportunities.

Goal 14. Monitor consistency of application of UM Criteria (IRR) and adequacy of documentation.

Goal 15. Measure network adequacy; support client in maintaining adequate provider network to ensure member access to care.

Goal 16. Reduce Emergency Department (ED) Discharge Delays

Goal 17. Measure network adequacy; support Departments in maintaining adequate Provider Network to ensure member access (Contract Reference N.5.1.4)

Goal 18. Maintain the Provider Analysis and Reporting (PARs) Initiative for Inpatient Child and Adolescent, Enhanced Care Clinic, and PRTF Levels of Care and Implement program for EDs and RTCs

Goal 19. Establish the CT BHP Pharmacy Reporting and Analysis Program

V. SIGNATURE PAGE

A. Connecticut Service Center Quality Management Committee has reviewed and approved the 2008 Quality Management Program Evaluation and the 2009 Quality Management Program Description and Project Plan

1. Program approval Date

Lori Szczygiel, MA, CEO

2. Program approval Date

Steven Kant, MD, Medical Director

3. Program approval Date

Laurie Van der Heide, PhD, VP QM

B. The Company Quality Council has reviewed and approved the 2008 Quality Management Program Evaluation and the 2009 Quality Management Program Descriptions and Project Plan

1. Program approval Date

Deborah Hirschfelder, MSMA
Vice President, Quality Management Health Plan & Employer Solutions Divisions, Co-Chair Company Quality Council

2. Program approval Date

Donald Christensen, Ph.D., MBA
Chief Clinical Officer, Co-Chair Company Quality Council