Goal 18. Monitor the Provider Analysis and Reporting (PAR) Initiative for Pediatric Inpatient Child and Adolescent, Enhanced Care Clinic, and Psychiatric Residential Treatment Facility (PRTF) Levels of Care.

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

The Provider Analysis and Reporting Initiative continues to be a vital tool utilized by the CT BHP to impact the CT system of care and encourage and support the use and development of best practices standards for the CT behavioral healthcare delivery system.

As we become more experienced in administering the PARs and Pay for Performance initiatives, we find that the more successful programs typically entail two phases.

1. The initial phase of the PAR program involves the establishment of a workgroup that includes provider representatives from level of care specific programs (i.e., child and adolescent inpatient, PRTF, etc.). The workgroup then collaborates with the CT BHP to agree upon measures that allow the assessment of key aspects of their performance in relationship to other providers supplying the same or similar services and develop a "profile".
The providers then continue to meet with CT BHP on at least a quarterly basis. Some of these meetings are with individual providers and some include multiple providers. During these meetings, providers are given data regarding their own performance, and collaborative analysis of the findings are conducted. Variation between programs and the identification of variables that may be responsible for those differences occurs. This is the time when providers learn from each other with regard to best practices. Most importantly, goals for improving performance are agreed upon by all participants.

2. The second phase of the PARs program entails the attachment of financial incentives to the accomplishment of goals in an effort to motivate progress and expedite change. The first Pay for Performance (P4P) initiative was implemented in CT in 2008 and it continues to productively supplement the PAR program. These initiatives are utilized pending available funds through the CT Department of Social Services.

CHILD AND ADOLESCENT INPATIENT HOSPITALIZATION PAR 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 that resulted from the delays in discharge of children and adolescents being treated in inpatient psychiatric units. We found that certain populations within the CT BHP membership are made up of youth that have more complex treatment issues and that these issues resulted in their being more difficult to treat. Their stays often involved long delays when the facilities were faced with not only developing adequate treatment discharge plans but also with finding longer-term living arrangements for the youth.

In 2007, the Child and Adolescent Inpatient PAR program was implemented as a method to address these long lengths of stay. The initial phase of the program included the development of a workgroup with the eight hospitals in CT that provide inpatient

treatment for children and adolescents. The participants shared information regarding the barriers encountered when discharging youth and worked towards developing strategies for addressing those barriers. The group agreed to work towards lowering the length of stay of youth in CT.

In 2008, the first P4P initiative was conducted with the child and adolescent inpatient facilities, with the focus on decreasing lengths of stay. The workgroup had 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 had clearly shown that:

- DCF children age 0 to 12 have longer lengths of stay than do non-DCF children and
- 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.

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. The Average Length of Stay (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. This finding accentuates the fact that this initiative targets the decrease in time that youth are in delay in the hospital as opposed to the medically necessary days when they are in the acute phase of their illness. At the same time, seven (7) and thirty (30) day readmission rates dropped from 2007 to 2008.

Child and Adolescent Inpatient Hospitalization Pay for Performance (P4P) Initiative 2009- 2010

Using data obtained from the Pediatric Inpatient PAR program during 2008 as well as the final performance results from the 2008 P4P initiative, the 2009-10 Child and Adolescent P4P Initiative was initiated in CT in 2009. The focus of this year's initiative was on further decreasing pediatric psychiatric inpatient hospital lengths of stay as well as on improving family involvement in their children's treatment.

Goal I, Length of Stay: The baseline period for the first goal of the 2009 initiative was Q1 through Q4 of calendar year 2008. The performance period for Goal I was Q1 through Q4 of '09. Case mix categories used in 2008 were continued in 2009. The component which allowed hospitals to earn points for movement toward the targeted length of stay in the 2008 Initiative was eliminated for the 2009 initiative.

In order for the hospital to earn points for the accomplishment of the goal in '09, they needed to either meet or exceed the target length of stay. Length of stay data from the baseline period was used as the basis for establishing target lengths of stay for each of the four case mix categories. These target lengths of stay were used to establish a predicted length of stay for each participating hospital based on their case mix during the baseline period. Each hospital was expected to achieve an adjusted length of stay that was better than or equal to it's predicted length of stay.

Outcome: Measurement of performance showed that 6 of the 8 inpatient hospitals achieved this goal, with only 2 hospitals having longer lengths of stay than their target. The below chart captures the performance results.

Provider Name PUT IN THE NAMES OF THE HOSPITALS	**Predicted LOS**	**Performance AALOS (4% Removed)**	**Goal 1 *Points Earned* (out of 2)**
Hartford A	14.15	11.84	2
Hospital B	**13.98**	**15.74**	**0**
Hospital C	12.23	5.6	2
Hospital D	13.54	10.82	2
Hospital E	13.39	13.09	2
Hospital F	**12.14**	**13.44**	**0**
Hospital G	11.92	5.62	2
Hospital H	13.25	10.85	2

Calculations for length of stay, predicted and adjusted average were completed by ValueOptions using inpatient authorization data from ValueOptions' AIS system.

Goal II, Family Engagement: During workgroup meetings with inpatient facilities in late 2008 and early 2009 it was agreed that a second goal to address the improvement of family engagement in the inpatient treatment of youth, a crucial aspect of care, should be added to the P4P initiative. Family members of youth who had recently experienced inpatient treatment in CT were included in the ongoing workgroup and assisted in the development of this goal. Ultimately, the eight (8) inpatient hospitals agreed to an initiative that included both the creation of an ongoing Family Support Group at each of the facilities as well as the development of an Individualized Communication Plan for each member admitted to the hospital. The performance measurement time period is the first quarter of 2010.

More specifically, with regard to the establishment of a family support group, each hospital first engaged in an evaluation process whereby they collected feedback from families and staff regarding the most convenient time of day, transportation constraints, and content and format of the group. Each hospital then developed a proposal regarding the format, structure and method of documenting participation in their Family Support Group which was submitted to CT BHP for review. Hospitals agreed to begin the groups by January 1, 2010.

For the Individualized Communication Plan, each hospital agreed to create a mutually agreed upon communication plan with the family of each youth admitted within 24 hours of admission. Each plan must include: frequency and preferred time of contact (i.e., in the evening), content of contact (i.e., critical incidents, medication changes, discharge updates), and specify who will initiate the call and include all necessary contact information.

Performance on Goal II will be reviewed during April 2010.

Please see attachment A for the detailed description of the methodology.

As the P4P initiative for 2009-10 unfolded, the PARs program for pediatric inpatient hospitals continued. Quarterly meetings with the inpatient providers were held to review and analyze the individual provider's profile data. These meetings are conducted by the Regional Network Management team and attended by additional CT BHP staff as necessary. The following data points are reviewed at each meeting:

- Demographics of the members treated by the facility with particular focus on DCF Area Offices involved. This enables the facility to identify which DCF Area Offices are most important for them to establish relationships with and which systems of care they need to be most familiar with to improve their discharge planning abilities.
- Case Mix by DCF and non-DCF 0-12 year olds and 13-18 year olds
- Hospital Specific vs. aggregate hospital average length of stay
- Comparison of average length of stay (ALOS) data for all eight facilities,
- Hospital specific: average length of stay frequency distribution in terms of the numbers of members they treated within specific timeframes
- Hospital specific average length of stay (ALOS) by quarter, broken down by case mix
- Percentage of days each quarter that members spent in discharge delay
- Discharge delay reasons by quarter
- Hospital specific vs. aggregate percentage of readmissions within 7 and 30 days

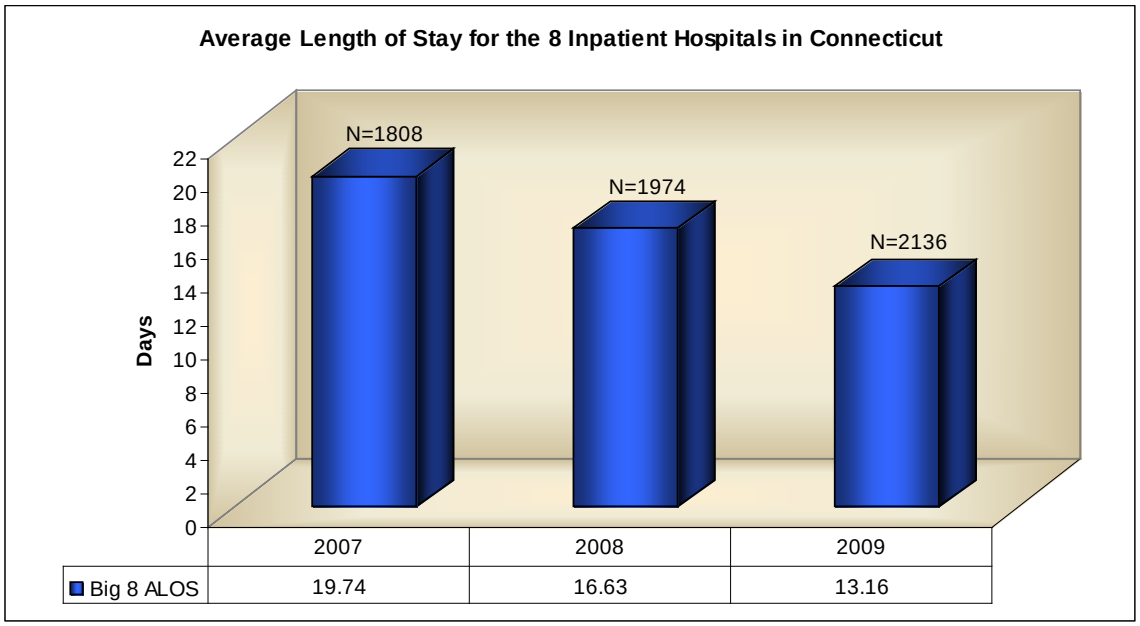
During these meetings, facilities have identified the following factors as having contributed to their ability to decrease their average length of stay:

- Having a clinical coordinator that is thoroughly involved with each case
- Pro-active, assertive discharge planning
- Utilization of a roster at rounds that keeps staff aware of the length of stay of each youth
- Active, collaborative, communication with DCF
- Familiarity with state wide referral resources for step down treatment

Barriers that continue to contribute to discharge delays are:

- DCF- involved youth with complex placement issues
- Gaps in the service delivery system for community based services

Impact of the PARs Program and P4P Initiative:
While the volume of children experiencing an inpatient stay continues to rise (2,136 in '09 compared to 1,974 in '08), the average length of stay days continues to decline (16.63 days in '08 to 13.16 days in '09). The graph below reflects the progress made in reducing the average length of stay by the eight inpatient hospitals in Connecticut.



PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES (PRTF) PAR PROGRAM

The PRTF PAR Program was initiated during 2008 by the Clinical Department and supported by the Quality Department. In 2008, CT BHP Clinical staff worked closely with the four PRTF programs in CT to revise their utilization criteria as well as to develop a method to facilitate the process for hospitals to gain access to their services. This was accomplished by collaboratively developing a "Universal Referral Form" that was subsequently adopted by all four PRTFs.

By the end of 2008, a decision was made to develop a PARs program for the PRTFs. An ongoing workgroup of PRTF providers was established and continues to be conducted by the PRTF Network Management team. Currently, the PRTF Provider profile includes:

- Demographics of the members treated by the facility
- Bi- Annual average length of stay; PRTF specific vs. aggregate PRTF providers
- PRTF-specific average length of stay frequency distribution in terms of the numbers of members they treated within specific timeframes
- Average length of stay comparison of all four PRTFs
- Number of Inpatient Admissions that occurred during a PRTF stay
- Percent of cases in discharge delay status

- Discharge delay reasons

PRTF Pay for Performance (P4P) Initiatives; 2008 and 2009

2008 P4P Initiative:
Subsequent to the implementation of the revisions of the PRTF Level of Care Criteria in 2008, the target length of stay for a PRTF was set at 90 to 120 days. 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 increasingly long as the placements and 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.

During late 2008, a P4P initiative to address PRTF programmatic changes they would need to make in order to equip themselves to achieve a shorter length of stay. The method of Focal Treatment Planning (FTP) was introduced through training provided by CT BHP. The FTP 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 and/or living situation where they are expected to go after discharge. Once the discharge plan is determined, the treatment during the stay focuses on interventions designed to address those behaviors that will enable the child to be treated/live in the more permanent setting.

More specifically, it was agreed that:
1. The measures included in the audit would be based on the programmatic changes that the PRTFs needed to implement to achieve the goals of improved efficiency, in terms of length of stay, and, in addition, to evidence family engagement.
2. The audit would serve as the basis for determining the portion of the total incentive payment the PRTF was eligible for.
3. The implementation timeframe for these process measures was January through March 2009 (Q1 '09) and the audit would be based on five (5) cases admitted during that timeframe, or, if the number of admissions did not reach five cases, of additional cases admitted just prior to January 1, 2009.

The four (4) indicators included in the audit were:
1. Implementation of Universal Referral Form
2. Focal Treatment Planning (FTP) meeting:
    a. FTP meeting held within 2 weeks of admission
    b. Documentation of PRTF inviting necessary participants AND documentation of the actual participants
3. Documentation of FTP and Discharge Plan elements AND key stakeholder agreement with the plans
4. Documentation of weekly engagement activities with key entities involved in FTP and Discharge Plan

Audit Process:

In early April 2009, a report was run to identify the admissions that had occurred between January 1, 2009 and March 31, 2009 to any of the four PRTFs. It was determined that there were a total of 28 admissions across the four PRTFs.

A random sample of 5 cases were selected from each facility. As previously agreed, if the PRTF did not admit 5 cases within the first quarter of '09, cases admitted prior to 1/1/09 would be used to supplement the audit sample size. Each PRTF was contacted to schedule the audit and to notify them regarding the five cases that would be audited.

Establishing Inter-rater Reliability of the ValueOptions Audit Team members

The audit team was comprised of four CT BHP staff, all licensed behavioral health clinicians. In order to establish inter-rater reliability of the audit team members, a request was made that each of the PRTFs submit a hard copy of a specified case (previously selected for the audit) during the week immediately prior to the audit. Each of the auditors and one of the medical directors (an expert in FTP) reviewed and scored each of those four cases using the audit tool. The audit team then met with the medical director and reviewed the audits; consensus was reached on how to score each of the items on the 4 cases. On-site audits were conducted of the four remaining cases at all four PRTFs during the week of 4/20-24/09. At least three (3) auditors were on-site at each PRTF.

Findings:

The total points possible for the five (5) cases is 220. The four (4) PRTFs scored between 150 and 186 points. All were eligible for a portion of the incentive payment. PRTF-specific results were shared with each PRTF. Additionally, the following overarching findings were shared with the PRTFs in the workgroup setting:

1. None of the programs demonstrated a mature FTP process. Further training on FTP accompanied by clinical vignettes and Focal Treatment Plans based on those vignettes was indicated for both PRTF and CT BHP Clinical Care Management staff to enable them to more effectively coach and mentor the PRTFs.
    a. Program staff dominated the FTP meeting; families/guardians typically played a minor role.
    b. Natural supports and family advocates were almost never identified or involved in FTP meetings, PRTF treatment or in discharge plans.
    c. All of the programs needed support in getting DCF to participate in the FTP meetings consistently when the member is DCF-involved.
    d. All of the programs needed support in getting the referral source (primarily the inpatient units) to participate in the FTP meeting.
2. There was a split between the programs; two of the programs appeared to have a low threshold for the management of acting out members and consistently used the ED and inpatient hospitalization to deal with acting out behaviors (small N may impact this finding). These usually brief hospital stays in the middle of PRTF treatment result in what appear, data-wise, to be shorter stays but that in reality are unplanned discharges. This issue needed to be discussed with the PRTFs in order to determine how to accurately measure each PRTF's length of stay.

3. It is critical to note that while the audit tool distinguished between those PRTFs who began to integrate FTP process and language into their programs and those with weaker attempts at this, the scores should not be used as measures of the quality of the clinical programs administered in the PRTFs. While the intent of the initiative was to assist the PRTFs to improve the PRTF programs so that they could shorten their length of stay, some of the PRTFs focused more on the documentation aspects of this initiative than on the improvement in focused clinical treatment that would allow the member to move to the next level of care; the actual intent of the initiative. For example, one of the PRTFs sent out form letters to all of the appropriate potential participants in the FTP planning meeting. While this technique earned high scores on inviting participants, the form letter did not result in high rates of actual attendance of necessary participants. Another PRTF telephoned potential participants, discussed the case, and obtained more clinically significant input from them, but did not score well on actual participation in the meetings.

Recommendations:

1. Hold the Focal Treatment Planning earlier in stay. The goal to have the FTP meeting within two weeks was meant to be the outside date for having the meeting, not the recommended timeframe. It may well improve the participation of the hospitals if the FTP meeting is closer to the actual inpatient stay.
2. As we move to measuring average length of stay of PRTFs, strongly recommend that we adopt tracking of "unplanned" discharges as such and then break out these stays from planned discharges when calculating average length of stay.
3. Provide additional training of all PRTFs on FTP process with new support training material that has been developed.
4. Share "best practice" tools accumulated during the audits with all PRTFs.

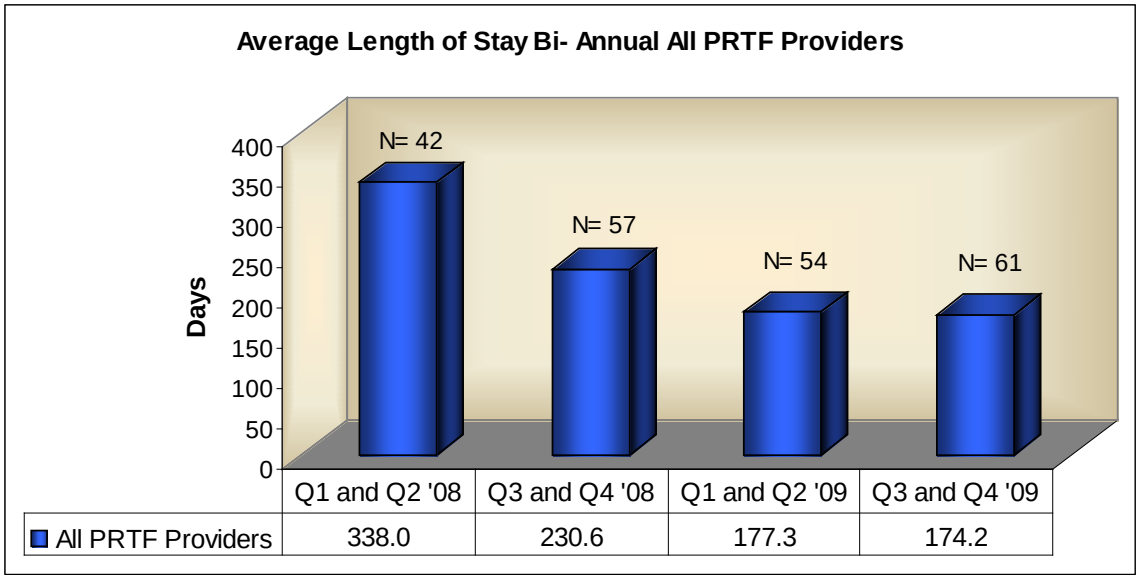
2009 PRTF P4P Initiative:

Since the CT BHP had been successful in improving access to community services and DCF was willing to work on improving access to placements, the PRTFs were willing to set a goal for the 2009 P4P initiative of a target length of stay of 120 days.

The baseline period for this initiative was the length of stay during Q3 and Q4 of calendar year 2008. The performance period was Q3 and Q4 of calendar year 2009. Taking into consideration outlier cases with excessively long lengths of stay the performance period measurement of length of stay was adjusted by eliminating 6% of the longest length of stay cases for each PRTF. In order to address the issue of inpatient hospitalizations that occur during the PRTF stay, the PRTFs agreed that inpatient hospitalization days would be rolled into the length of stay of the PRTF IF the youth returned to the PRTF following the inpatient stay. This served to nullify the impact that short stays in the PRTF sandwiched around inpatient stays would have on length of stay calculations. At the same time, the workgroup discussed at length the pros and cons of using inpatient stays as a means of addressing acuity during a PRTF stay.

Each PRTF had the potential to be awarded a full or partial share of the performance fund by achieving the target adjusted average length of stay or by making significant movement towards the targeted length of stay. Length of stay for the initiative was based upon discharges from each PRTF during the performance period. All calculations

for length of stay were completed by ValueOptions using PRTF authorization data from ValueOptions' AIS system. Measurement of performance revealed that three of the four participating PRTFs achieved performance awards, ranging from the maximum of 4 points to 3 and 2 points respectively. The data shows that while the volume of members that experienced a PRTF stay increased from 57 during the baseline measurement period to 61 in Q3 through Q4 '09, the average length of stay days decreased by 24.4 % (230.6 to 174.2). This compares to 42 members and an average length of stay days of 338.0, just prior to the performance initiative; reflecting a 48.4 % decrease in the average length of stay days and an improvement in access to PRTF programs. The below graph captures this dramatic improvement.



In addition to the bi annual PAR meetings that were held with individual PRTF providers, the CT BHP Network Management team conducted frequent workgroup meetings during 2009. The workgroups were utilized as a forum to problem solve and strategize methods to mitigate the barriers identified in shortening the length of stay. As the workgroups progressed, the influx of solution focused methods increased. The following is a review of some of the problem solving strategies that were generated:

- Increase collaboration efforts with DCF behavioral health program directors and DCF area resource clinicians
- When congregate care is potentially indicated; proactively arrange for the Central Office Case Conference that is required before application to those programs can be initiated.
- Develop a tracking method to monitor length of stay
- Assign a clinical coordinator to intently oversee each case
- Ensure that all line clinical staff have an authentic understanding of the spirit of the initiative
- Consistently utilize focal treatment planning methods

Pending available funds, another incentive program is expected to be implemented for 2010-11. The recommendation is to modify the methodology to exclude lengths of stay shorter than 45 days for discharges resulting from AMAs and AWOLs and to continue to exclude PRTF stays that result in inpatient admissions without return to the PRTF

program. In collaboration with the PRTFs, work is currently underway to develop goals for the next P4P initiative that will include increased focus on family engagement and placement stability following discharge.

ENHANCED CARE CLINIC (ECCS) PARS PROGRAM

The ECC PARs program did not follow the typical progression of the other CT BHP PARs programs. As described in detail in the 2008 Program Evaluation, ECCs received increased reimbursement (if accepted, they were paid 25% more than their current reimbursement rate for treating HUSKY members) late in 2006 and then were assessed in terms of their performance on meeting the expectations in their agreement. Those expectations included:

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 psychopharmacologic 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 was conducted in 2007; 35 ECC are currently registered.

In March of 2008 a workgroup composed of ECC representatives as well as CT BHP representatives from DCF, DSS and ValueOptions was formed to develop strategies to further assist the provider community in achieving compliance with the standards of the ECC Agreement. During 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 the remainder of 2008 and into 2009, ValueOptions Regional Network Managers (RNMs) played a key role in assisting the ECCs in addressing their individual problems in these areas.

Additionally, a Mystery Shopper program, contractually agreed upon by ValueOptions, was implemented during Q4 ’08. Currently, the program entails calls to the ECCs by ValueOptions staff to obtain a routine appointment. During the first cycle of these calls completed during Q4 ‘08, 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 submitted Corrective Action Plans (CAPs).

Despite the number of ECCs on CAPs, by the end of 2008, there had been remarkable progress in improvement of access to outpatient treatment. During Q4 '08, almost 88% of members were offered a routine appointment within 14 days. This represented an almost 25% improvement in timely access from the same quarter of the previous year when there were reports of, at times, a six month waiting list for routine appointments.

At the end of 2008, 13 ECCs were on probationary status for failing to meet access standards and 3 were on probation for failure to meet contractual obligations as a result of the Mystery Shopper Program.

2009 Activities

During 2009, CT BHP continued to work with the ECCs to address issues they had raised as barriers to their ability to meet the requirements of their agreements.

1. CT BHP made modifications to the on-line Web Registration form to allow providers to differentiate new members to their practice from members who may be stepping down from a higher level of care within their agency or who were existing members switching to HUSKY coverage from alternative coverage. The following revisions were incorporated into the web registration screens in January of 2009:
   - As a result of data entry errors regarding the entering of an offered appointment date that precedes the actual screen date, in September 2009, the web registration was modified so that providers were no longer able to enter an "offered" date that precedes the "screen" date entered. In addition, pop-up boxes were activated when an offered date is greater than the access standard, per evaluation type.
   - In an effort to provide more "real-time" feedback to ECC providers, CT BHP began providing monthly reports of ECC adherence to access standards. All ECC providers below the 95% access standard receive these reports.
   - Assertive outreach to providers who continually struggled with data entry issues was provided by the RNMs. Individual meetings were conducted to assist in training line staff in data entry to the Web Registration screens and ECC requirements were reviewed in detail with administrative staff.

2. A Frequently Asked Questions document regarding ECC registration procedures was developed to address registration data entry issues impacting compliance with ECC access standards was circulated to the ECCs.

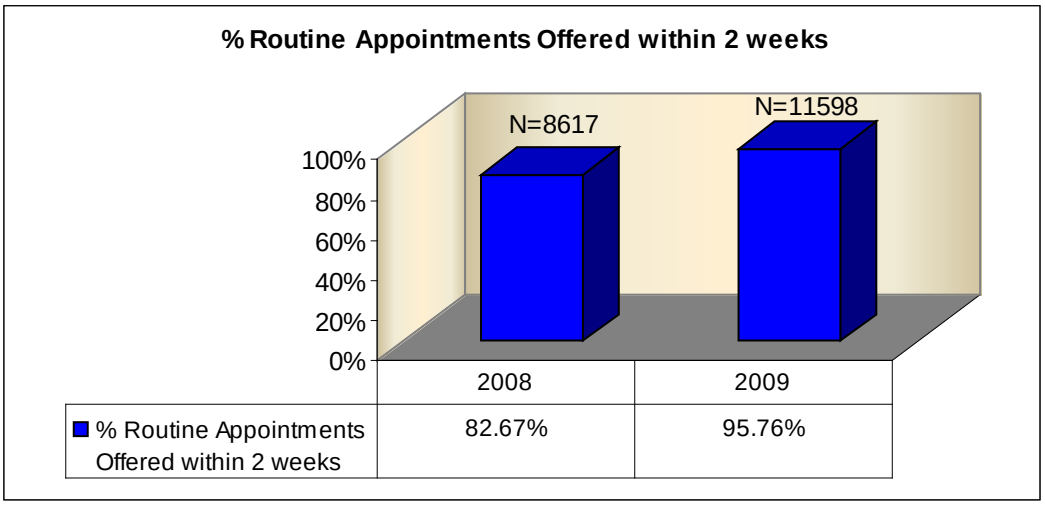
3. The RNMs provided assistance to the ECC providers in the task of fulfilling their contractual requirement of developing a 2nd set of MOUs with a Pediatric and Adult Primary Care Providers. To date, 100% of the 35 ECCs have completed a second MOU with a PCP. This intervention included continued collaboration with the Child Health and Development Institute (CHDI) regarding the integration of Behavioral Health with Pediatric Primary Care Initiative.

4. The Mystery Shopper was continued as a key quality assurance component. To date, 20 ECCs have been Mystery Shopped. The ECCs were assessed based on timeliness of response, use of a triage process and whether an appointment was offered within the 14 days required by the Access standard. Facilities that did not meet the Mystery Shopper criteria submitted a CAP and were then re-evaluated following a

probationary period. All of the ECCs from earlier cycles subsequently passed their re-evaluation. Cycle III, which began in November, 2010 resulted in 3 ECCs being placed on a CAP. All 3 have submitted CAPs which are currently under review.

ECC Performance:

- Access to routine appointments continues to improve. During 2009, 95.76% of members requesting a routine appointment are offered one within 14 days. This represents an improvement of more than 15% from the year end average for 2008.



- The number of HUSKY members served by ECC outpatient providers continues to rise. During 2009, a total of 13,045 members were evaluated by ECCs, an increase of 13.5% from 2008 when 11,489 members were evaluated. The bulk of this increase in evaluations occurred for routine evaluations that went from 10,424 in 2008 to 12,111 in 2009, an increase of 16%.
- Of the 36 providers that had ECC status during CY2009, 13 ECCs experienced probationary status at some point during the year. However, of the ECCs on probationary status during 2009, most occurred during Q1 and Q2 '09; by the end of Q4 '09 there were no ECCs on a CAP for failure to meet routine access standards. It should be noted however that three (3) ECCs were exempted from meeting the access standards as a result of their volume increasing more than 20% from the same quarter last year.

EMERGENCY DEPARTMENT AND EMERGENCY MOBILE PSYCHIATRIC SERVICES PARS INITIATIVE

As a result of a collaborative effort between DCF, DSS, the Connecticut Hospital Association's (CHA) Committee on Patient Care Quality, and ValueOptions, a P4P initiative was developed during 2009 to advance Emergency Departments (EDs) and Emergency Mobile Psychiatric Services (EMPS) coordinated efforts in serving youth with a behavioral health crisis in an Emergency Department. In order to align incentives across all stakeholders, ValueOptions as well had performance targets that supported the initiatives described below.

In 2009, the CT BHP RNMs were charged with the responsibility of promoting improved working relationships between the EDs of Connecticut hospitals treating HUSKY youth and their respective EMPS vendors. The focus of this phase of the initiative was the development of a signed Memorandum of Understanding (MOU) between both parties by June 1, 2009. During the months of March, April and May of 2009, the RNMs conducted numerous meetings with EDs in their regions and the associated EMPS vendors to help facilitate the process of developing an MOU that would address the roles and responsibilities of each ED and EMPS vendor related to the evaluation, consultation, diversion, and timely discharge and aftercare for members presenting at an emergency department. EDs were to agree to request EMPS consultation of members presenting to their ED to allow EMPS to assess for their potential for diversion from inpatient hospitalization and/or to assist the ED in developing a follow-up plan for members leaving the ED and returning to the community. EMPS vendors were to use referral source information provided by the ED to target providers and agencies in the area for education regarding EMPS services that would result in a decrease in the use of EDs.

By June 1, 2009, twenty-eight (28) of the thirty (30) EDs in CT had signed MOUs with their respective EMPS vendors. The EDs and EMPS vendors that successfully signed MOUs received incentive rewards for their participation in this aspect of the P4P initiative.

During the latter half of 2009, subsequent to the successful signing of the MOUs, the RNMs continued to work closely with the EDs to assist them in realizing the intention of the MOU. They did this by fostering an "active" working relationship between the EDs and EMPS vendors. The RNMs maintained regular contact with their respective EDs and EMPS vendors, scheduling monthly face-to-face or telephonic meetings. A large part of this aspect of the initiative involved the collection of data from the EDs and then sharing this information with the EMPS vendor. The following data was collected by the EDs and then shared with the RNM:

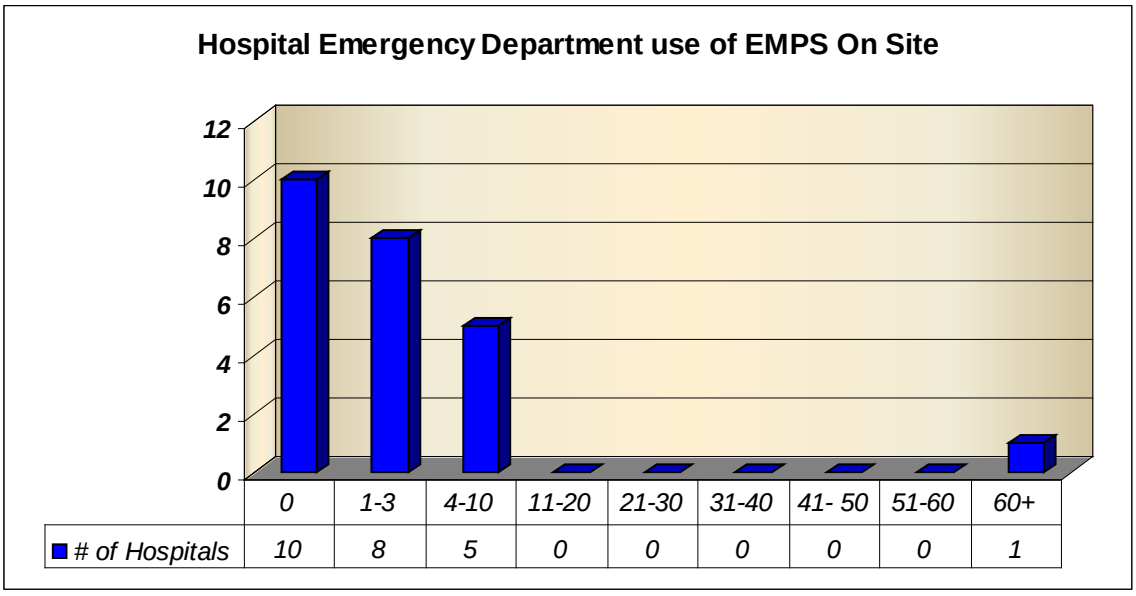
- Data regarding all youth that presented at the ED for behavioral health issues
- Referral source data regarding the providers or agencies referring youth to the ED for evaluation. As noted above, this information was valuable to the EMPS vendors in their attempts to identify providers in the community so that they could be educated regarding the value of using EMPS as opposed to the ED.
- Data regarding whether the ED requested the EMPS vendor to come on site to conduct an evaluation of the youth regarding the need for hospitalization or for aftercare needs
- Data regarding whether the ED conducted a telephonic consultation with EMPS regarding connection with follow-up services upon discharge from the ED

The productive relationships between the RNMs and their respective ED and EMPS staff contacts resulted in the successful collection of three months of data from a total of twenty-four (24) hospitals. The following represents the aggregation of the findings across all of the participating EDs: ,

Of the 1,440 youth presenting to the EDs, 11.0% (159) were reported to have some type of EMPS involvement. Of those:

- 111 (69.8%) were on-site EMPS evaluations and
- 48 (30.2%) were telephonic consultations with EMPS.

In other words, 7.7% of the youth in the ED were evaluated face to face by an EMPS team and another 3.3% had an EMPS telephonic consultation. However, one hospital, accounted for 65 of the EMPS on-site evaluations as their EMPS vendor is housed across the hall from their ED. They reported that every youth who visited their ED had an on-site EMPS evaluation. If this outlier is removed from the analysis, the rate of EMPS on-site evaluation of ED cases drops significantly. Without this ED, a total of 94 cases had EMPS involvement; 3.3% of youth in the ED had an on-site evaluation by an EMPS team and another 3.3% had an EMPS telephonic consultation. The below graph captures the EDs use of EMPS on site during the performance period.



Of the 1,440 youth reported during the three-month period, the following ED dispositions were reported:

- 36% inpatient admissions
- 29% outpatient
- 9% In-home services/Partial Hospitalization Program/Intensive Outpatient Program/EDT
- 6% CARES
- 6% Unknown or None
- 5% Other
- 5% EMPS
- 4% returned to RTC or Group Home

During 2010, ValueOptions intends to implement a PARs program with the EDs to continue to work towards improving the rate of their use of EMPS in their EDs. The goal is to decrease the rate of inappropriate inpatient hospitalization by EDs while improving the appropriateness of the follow-up treatment that youth receive following an ED visit.

- **Recommendations for continuing sub-Goal in 2010:**
  This sub-goal will be applicable for 2010 and should be included in the 2010 Project Plan.