2009 Annual Report to the

Behavioral Health Partnership Oversight Council

December 2010

ANNUAL REPORT
Calendar Year 2009

Contents

- Program Review
  - Call Volume
  - ICM Caseloads
  - Peer Caseloads
  - VO Performance Target Outcomes
  - Provider Performance Incentive Program Outcomes
- Enhance Care Clinics (ECC) Current Status
- Utilization
- Expenditures

Program Review

Customer Call Volume

- Revised workflow for responding to member and provider calls implemented in Q2 ‘10 resulted in revision of methodology for counting calls
- During Q4 ’09, 17,297 calls were received
  - 44% from members (7591)
  - 56% from providers (9706)

Peer Support and Intensive Case Management (ICM) Volume

- ICMs were involved with the care of 1,533 members during 2009, up from 1,439 in 2008
- Peers outreached to 1,424 Families and/or members during CY 2009, down from 1,539 in 2008
  - One factor in the decrease is loss of staff resources due to medical leave
  - Numbers do not reflect unduplicated members

ASO PERFORMANCE TARGETS

CY 09

Data Management Related to Authorization and Payment

- 259 authorization files were created: 100% were delivered within the Turn Around Time (TAT) standards (Standard 98%)
- 214,020 authorizations processed: 212 were errors, 99.53% were resolved within the TAT standards (Standard 98%)
- 100% of all auth files (510 files) were loaded within time frame (Standard 100%)
- Quarterly Provider File Accuracy Audits resulted in accuracy scores of >98% for all four (4) quarters (Standard 98%)
- Target Continued in CY 2010

Improving Quality of Care for DCF-Involved Youth in Foster Home Placement

- Five Area Offices Participated
  - Waterbury, Norwich, Hartford, New Britain and Manchester
- Eligibility Criteria:
  - Ages 4-18
  - 1st time foster care placement
  - Authorized for behavioral health treatment within past 18 months
  - CT BHP member covered by HUSKY A or B
- Improvement Activity
  - Assignment of an ICM
    - Assessment of Behavioral Health History
    - Outreach to DCF worker and current Behavioral Health Provider
  - Assignment of a Peer Specialist
    - Outreach to Foster Family
    - Coordination between DCF and ICM to identify needs

Improving Quality of Care for DCF-Involved Youth in Foster Home Placement *(Cont.)*

- 102 Referrals received and, of those, 37 were found eligible for the activity
  - Of those 37, 10 (27%) disrupted from their placement within 45 days
  - 16 (43.2%) of them received at least one new authorization for behavioral healthcare within 45 days of placement
  - 17 (45.9%) accepted Peer Services
  - All process elements of target met

Improving Quality of Care for DCF-Involved Youth in Foster Home Placement *(Cont.)*

Recommendations:

- Discontinue the project as a quality improvement activity given the small number of eligible participants
- Consider the continuation of service to this high risk population by including them in the CT BHP ICM program as “youth at risk”
- Consider expanding the population receiving the intervention to include:
  - Children placed initially in Star and Safe homes and then moved to foster care
  - Children with multiple disruptions from placement

Next Steps:

- DCF Social Workers to continue to utilize the CT BHP ICM program to better understand clinical needs of children disrupting from placements

Maintaining the Reduction of Discharge Delay for Children and Adolescents Receiving Inpatient Care

Target: No more than 7,492 discharge delay days across CY 2009 and acute average length of stay shall increase no more than 3%

Results:

5,043 (50.4% decrease from CY 2008) discharge delay days

4.95% decrease in acute average length of stay

Target Met and continued for CY 2010

DCF Residential Rightsizing Initiative

Practice Improvement

- 3 Residential Strategy Work Group Meetings held between April and August 2009
- 2 Literature Reviews were completed
  - Effectiveness of Residential Treatment
  - Average Length of Stay and Factors Effecting Length of Stay
- An Overview of Residential Financing Models
- Review of Financing Options in Child Welfare

DCF Residential Rightsizing Initiative *(Cont.)*

Congregate care transformation project plan Re: Developing residential services for special populations

- Residential Data Summary Analysis
  - Utilization, Demand and Capacity, by Diagnostic Tier
  - Admits and Discharges
  - Average Length of Stay
  - Discharge Delay
  - Registrations and Authorizations
  - Match and Admission Decisions
  - Outcomes
  - In-State Capacity Forecasting

DCF Residential Rightsizing Initiative *(Cont.)*

Reporting

- Utilization Analysis Quarterly Summary – Q3 ’09
  - Utilization Data Review
    - Demand and Capacity by Diagnostic Tier
    - Other Data of Interest
      - » Youth 0-12
      - » Average Length of Stay
      - » In-State and Out of State Admits
      - » Discharge Delay

All elements of the target completed and met

MOU Initiative between CT Hospitals and Emergency Mobile Psychiatric Services

- Part A: Executed MOUs between acute freestanding hospitals and their respective EMPS – 28 (93%) of the acute care hospitals executed MOU with their respective EMPS prior to 6/1/2009 – Target Met
- Part B: Evidence of a working relationship between EDs and EMPS based on 3 months of referral source data. Received data from 21 high volume hospitals and 4 low volume hospitals – Target Met

Evaluating Residential Treatment Center (RTC) Performance and Outcomes

- Performance Indicator Outcome Data
  - Seven (7) Indicators to Evaluate RTC Performance and Outcomes grouped into three (3) broad categories:
    - Post Placement
    - Experience in Placement
    - Provider Performance
- Universal Outcome Tool
  - TOP Outcome Tool was selected and made mandatory for all youth entering RTCs and therapeutic group homes commencing January 1, 2010

Evaluating Residential Treatment Center (RTC) Performance and Outcomes *(Cont.)*

- All elements of target met
- Continued and expanded in CY 2010

PROVIDER PERFORMANCE INITIATIVES

Pediatric Psychiatric Inpatient Hospital Performance Initiative SFY 2010

Goal I. Decreasing Length of Stay

- Baseline Period: CY 2008
- Target lengths of stay established for each of the four (4) Case Age Mix categories
  - DCF-Involved 0-12
  - DCF-Involved 13-18
  - Non-DCF 0-12
  - Non-DCF 13-18

Results: 6 of 8 hospitals reached or exceeded their Predicted Length of Stay during the Performance Period (CY 2009)

Pediatric Psychiatric Inpatient Hospital Performance Initiative SFY 2010 *(Cont.)*

Goal II. Family Engagement Initiative

Indicator 1. Creation of a Family Support Group

- Establish an ongoing Family Support Group by January 1, 2010
- Documentation that group was offered to family/guardian of eligible HUSKY members 95% of the time.

Results: 3 of 8 hospitals met the goal

Pediatric Psychiatric Inpatient Hospital Performance Initiative SFY 2010 *(Cont.)*

Indicator 2. Creation of an Individualized Communication Plan (ICP)

- Within 24 hours of admission, co-create a mutually agreed upon ICP with the member and their family that specifies frequency and content of contact between hospital staff and family during the child's stay

Results: 2 of 8 hospitals met the goal; 1 hospital partially met goal

Psychiatric Residential Treatment Facilities (PRTF) Performance Initiative SFY 2010

Goal: Decrease Average Length of Stay (ALOS):

- Lowering ALOS to target of ≤120 days OR
- Making significant progress towards achieving target length of stay

Performance Period: CY Q3 & Q4 ’09

Results: 1 of 4 PRTFs achieved ALOS of <120 days

2 more PRTFs made significant progress towards meeting target ALOS

Emergency Mobile Psychiatric Service Performance Initiative SFY 2010

Immediate Goal: Incent EMPS providers to develop relationships with EDs to improve the coordination of emergency psychiatric services as per MOUs established

Longer Term Goals:

- Reduce ED visits for HUSKY youth
- Divert unnecessary inpatient admissions
- Reduce ED overstays

Emergency Mobile Psychiatric Service Performance Initiative *(Cont.)*

Indicator 1. EMPS to conduct outreach and education of high volume ED referral sources and families

Results:

- 6 of 6 EMPS providers conducted outreach with high volume community providers/agencies/schools
- 6 of 6 EMPS providers supplied partner EDs with EMPS brochures for use as part of discharge materials for families

Emergency Mobile Psychiatric Service Performance Initiative *(Cont.)*

Indicator 2. Divert inpatient admissions and reduce ED overstays

Results:

- 2 of 6 EMPS providers conducted on-site evaluations, when requested by the ED, at least 10 times
- 6 of 6 EMPS providers supplied EDs with current lists of key aftercare services, supports and contact information

Hospital Emergency Department Performance Initiative SFY 2010

Immediate Goal: Incent EDs to develop relationships with EMPS providers to improve the coordination of emergency psychiatric services as per MOUs established

Longer Term Goals:

- Reduce ED visits for HUSKY youth
- Divert unnecessary inpatient stays
- Reduce ED overstays

Performance period: January 1, 2010 – March 31, 2010

Hospital Emergency Department Performance Initiative *(Cont.)*

Indicator 1. Collect and provide partner EMPS providers with de-identified Referral Source Data

Results:

- 21 of 25 eligible EDs submitted three (3) months of accurate referral source data; 3 more submitted partially accurate data

Hospital Emergency Department Performance Initiative *(Cont.)*

Indicator 2. Provide data that allows assessment of ED use of EMPS to divert inpatient admissions and reduce ED overstays

Results:

- 15 of 25 EDs submitted accurate data; 3 more submitted partially accurate data
- 7.7% of the youth in the ED were evaluated face to face by an EMPS team
- Another 3.3% had an EMPS telephonic consultation
- Of the 19 hospitals who treated more than 20 youth in their ED, thirteen (13) had EMPS involvement fewer than 5 times
- Two EDs treated more than 200 youth; both used EMPS fewer than 5 times

Extended Day Treatment Performance Initiative SFY 2010

Goal I. Family Engagement in Treatment

Indicator 1. Multi-Family Groups

- 50% of parents/caregivers who are invited to multi-family groups each month attend

Results: 13 of 22 EDTs reached the 50% goal

Extended Day Treatment Performance Initiative SFY 2010

Goal I. Family Engagement in Treatment

Indicator 2. Program Participation – goals for 2 or more of the following must be met

- 80% attendance by parent/caregiver at scheduled Initial Assessment Interviews
- 85% of admitted cases each month have a parent/caregiver attending Initial Treatment Plan session
- 75% of parents/caregivers participate in Treatment Plan Review 60 days after approval of Initial Treatment Plan and every 60 days thereafter
- 70% attendance by parent/caregiver at family therapy sessions

Extended Day Treatment Performance Initiative SFY 2010

Goal I. Family Engagement in Treatment

Indicator 2. Program Participation

Results: 22 out of 22 EDTs reached the goal of meeting 2 out of the 4 objectives

Extended Day Treatment Performance Initiative SFY 2010

Goal II. Quality of Care

Indicator 1. Project Joy Therapeutic Play Group Implementation

Delivery of 2 or more Project Joy Therapeutic Play Groups per month

Results: 14 of 22 EDTs met the goal

Extended Day Treatment Performance Initiative SFY 2010

Goal II. Quality of Care

Indicator 2. Risking Connection Training

- 90% of EDT staff hired between July 1, 2009 and October 31, 2009 successfully completes Risking Connections Training within 6 months of date of hire

Results:

- 3 of 22 ECCs met the goal
- 7 of 22 ECCs did not meet the goal
- 11 of 22 ECCs did not have new hires

Extended Day Treatment Performance Initiative SFY 2010

Goal III. Child and Family Outcomes

Indicator 1. Ohio Scales Implementation

- 85% of families/caregivers complete the Ohio Scales at Intake
- 50% of families/caregivers complete the Ohio Scales at Discharge

Results:

- 20 of 22 EDTs met the goal for Ohio Scales at Intake
- 17 of 22 EDTs met the goal for Ohio Scales at Discharge

Extended Day Treatment Performance Initiative SFY 2010

Goal III. Child and Family Outcomes

Indicator 2. Ohio Scales Treatment Outcomes

- 50% of cases show a 5-point increase in Functioning between Intake and Discharge, or;
- 50% of cases show a 5-point decrease in Problem Severity between Intake and Discharge

Extended Day Treatment Performance Initiative SFY 2010

Goal III. Child and Family Outcomes

Indicator 2. Ohio Scales Treatment Outcomes

**Only programs that met the goal for Ohio Scales Implementation are eligible to receive the Treatment Outcomes incentive*

Results: 21 of 22 EDTs met the goal

Enhanced Care Clinics

Current Status

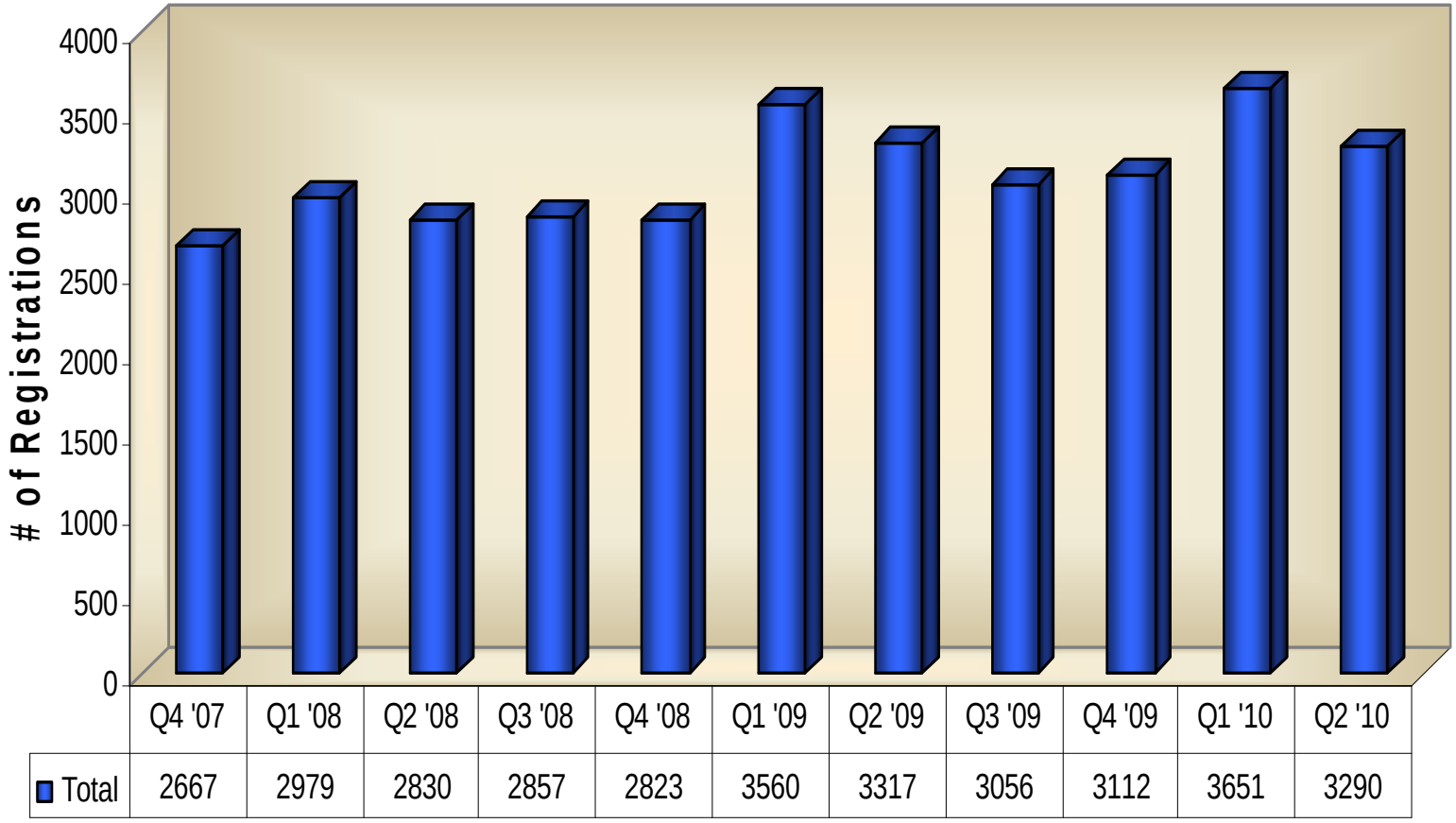
ECC Overview

- 35 Enhanced Care Clinics receive higher fees (approximate 25% higher than non-ECC clinics) in return for meeting the following requirements:
  - Timely Access
  - Collaboration with Primary Care
  - Proficiency in screening, assessment & treatment of co-occurring mental health and substance abuse disorders

ECC Access Requirement

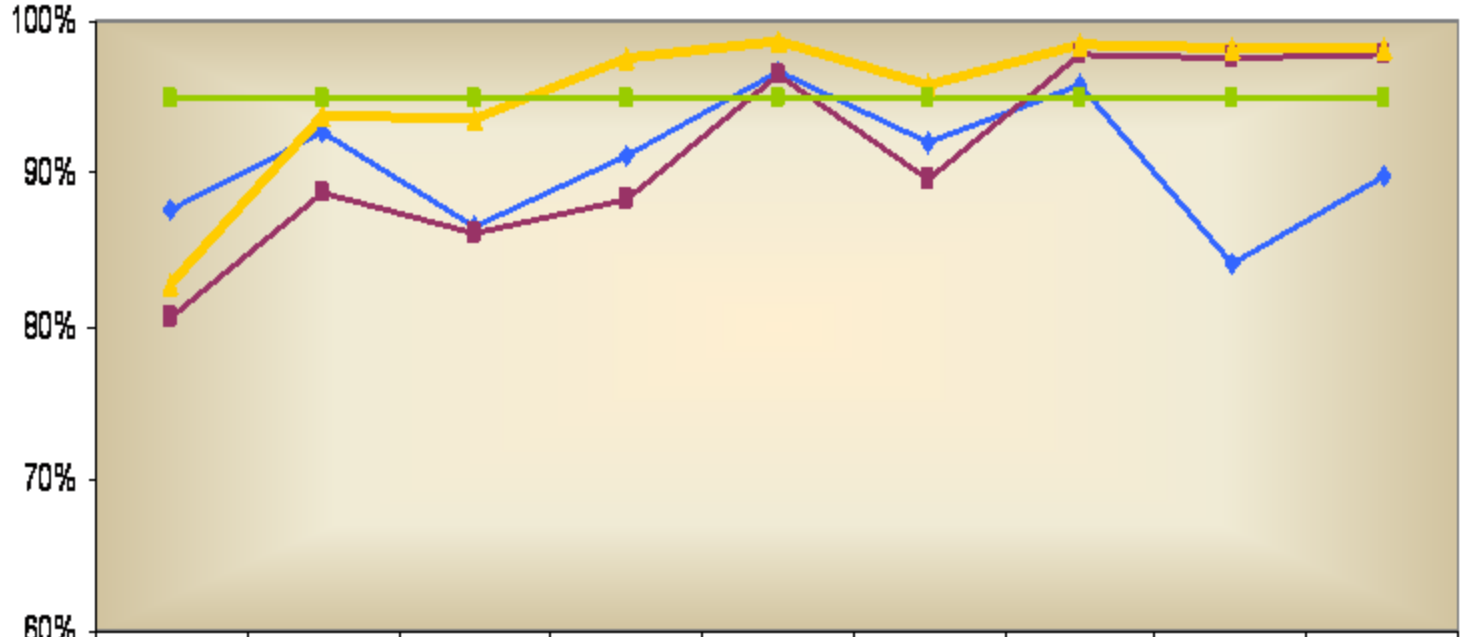
- Timely access to initial appointment is measured quarterly within the Calendar Year
- To date, only routine access is being counted towards compliance with timely access
- Numbers for urgent and emergent cases continue to be low

18E: ECC- Total Outpatient Registrations Volume



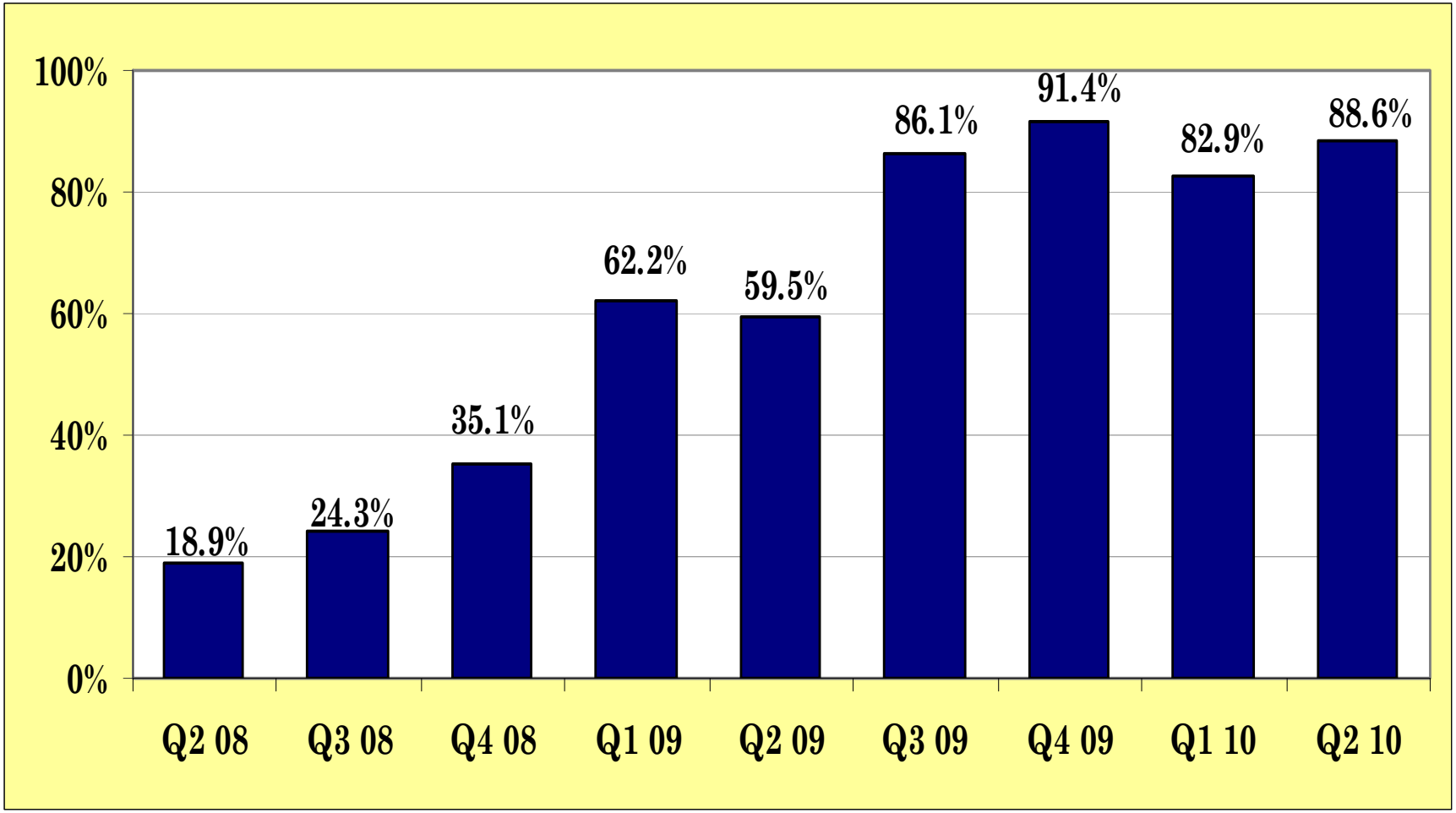
	Q4 '07	Q1 '08	Q2 '08	Q3 '08	Q4 '08	Q1 '09	Q2 '09	Q3 '09	Q4 '09	Q1 '10	Q2 '10
Total	2667	2979	2830	2857	2823	3560	3317	3056	3112	3651	3290

18E: ECC Access Measures

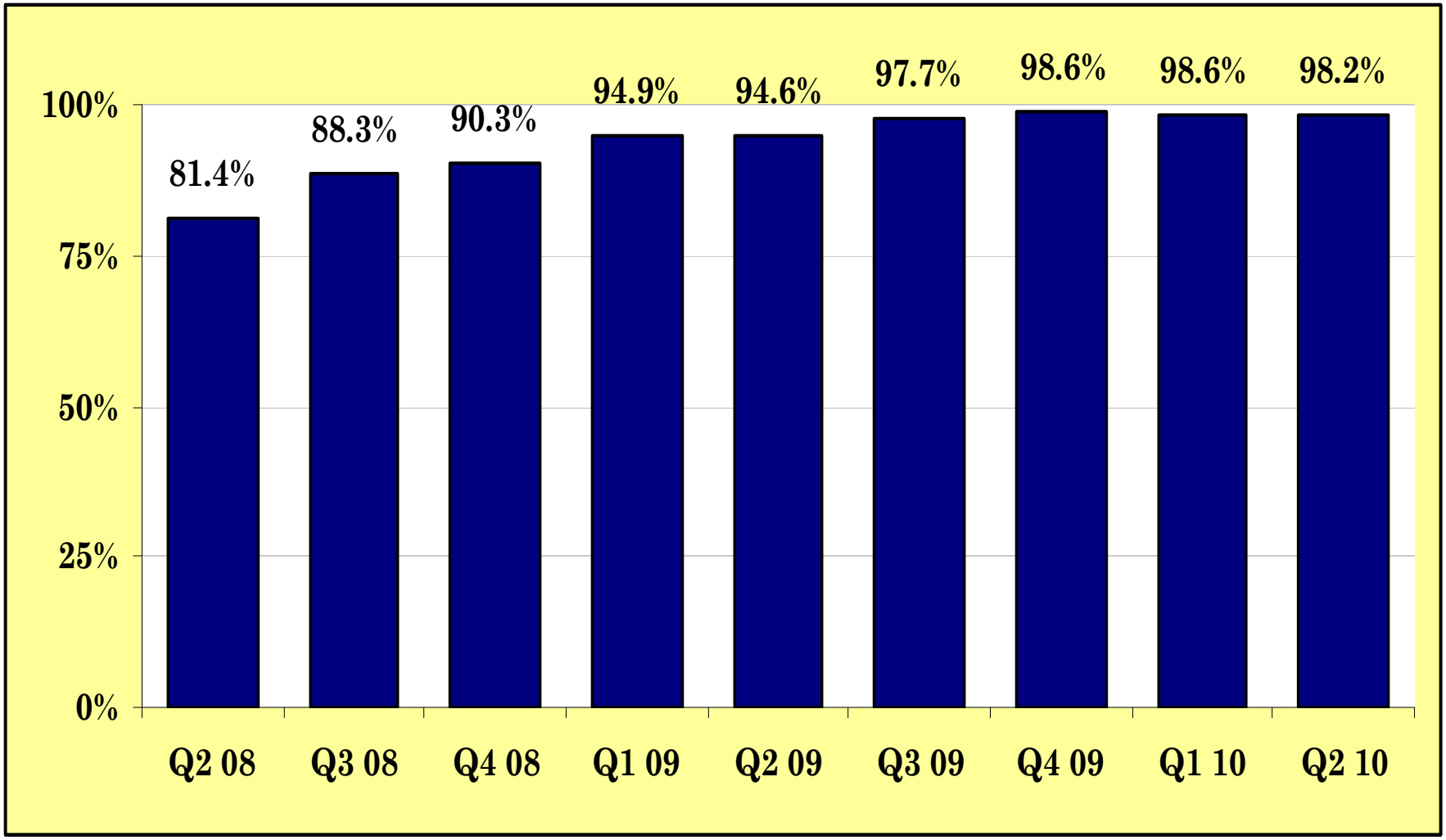


	CY '08	Q1 '09	Q2 '09	Q3 '09	Q4 '09	CY '09	Q1 '10	Q2 '10	'10 YTD
Emergent	87.63%	92.73%	86.54%	91.11%	96.61%	91.94%	95.71%	84.06%	89.93%
Urgent	80.55%	88.78%	85.99%	88.23%	96.39%	89.63%	97.73%	97.67%	97.70%
Routine	82.67%	93.85%	93.56%	97.49%	98.58%	95.76%	98.40%	98.23%	98.32%
Access Standard	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%

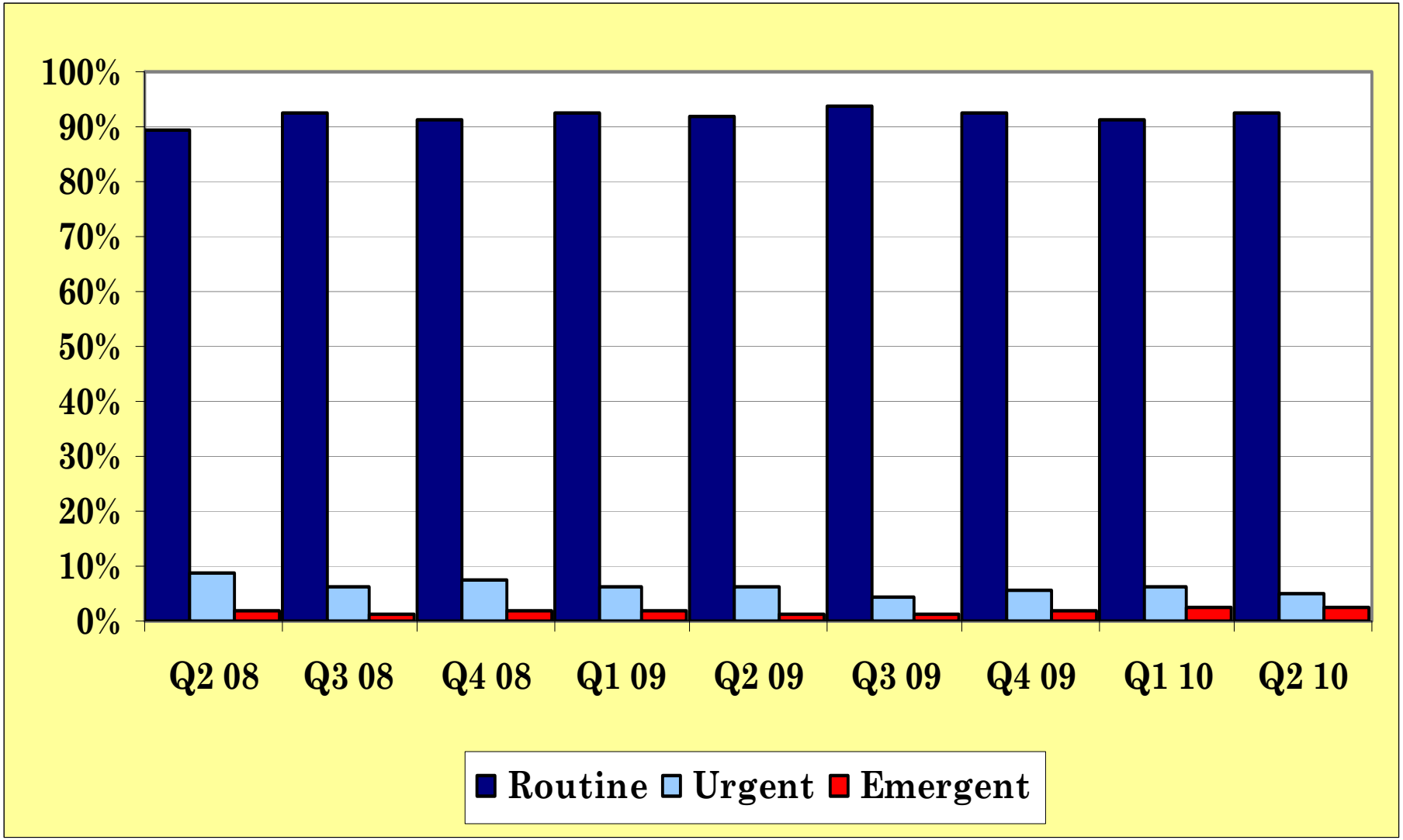
% of ECCs that Met the Routine Appointment Access Standard



% of Members Offered Routine Appointment within 2 Weeks



Types of Appointments Offered



Mystery Shopper

Mystery Shopper Program:

- ECCs are assessed on whether screening is done at time of first client contact and whether triage for level of urgency of need (emergent, urgent, routine) occurs.
- All 35 ECCs have been Mystery Shopped as of September 2010
- A total of 12 ECCs submitted Corrective Action Plans (CAP)
- All 12 passed Mystery Shopper on follow-up
- Issues that led to CAPs include:
  - messages left on voice mail and not returned
  - no screening for urgency of need

Mystery Shopper *(Cont.)*

- 4th Round of Mystery Shopper calls in CY 2010 highlighted the need to review the Mystery Shopper process
- The current audit tool is being reviewed and revisions will be shared with a council sub-committee
- The current method of oversight of the ECC initiative is also being retooled and the new process will be shared with a council sub-committee

ECC Primary Care Collaboration Requirement

- Goals:
  - To develop formal relationships between primary care practices and ECCs
  - To support mutual referral practices
  - To facilitate collaborative care and efficient exchange of information to support patient care
  - Each ECC must enter into MOU with its primary care partner and develop policies and procedures that implement such MOUs

ECC Primary Care Collaboration Requirement

- All ECCs have provided MOUs with their primary care partners
- Policies and Procedures that support those MOUs will be requested as well under the new ECC Oversight Model
- ECC clients who are deemed stable on their medication may be referred to their PCP partner for ongoing medication management.
- **E&M consultation codes were implemented to support a brief psychiatric consultation by the ECC when requested by the primary care provider who is managing medication .**
- **To date, few of these consultations have taken place.**

ECC Co-Occurring (Mental Health and Substance Abuse) Requirement

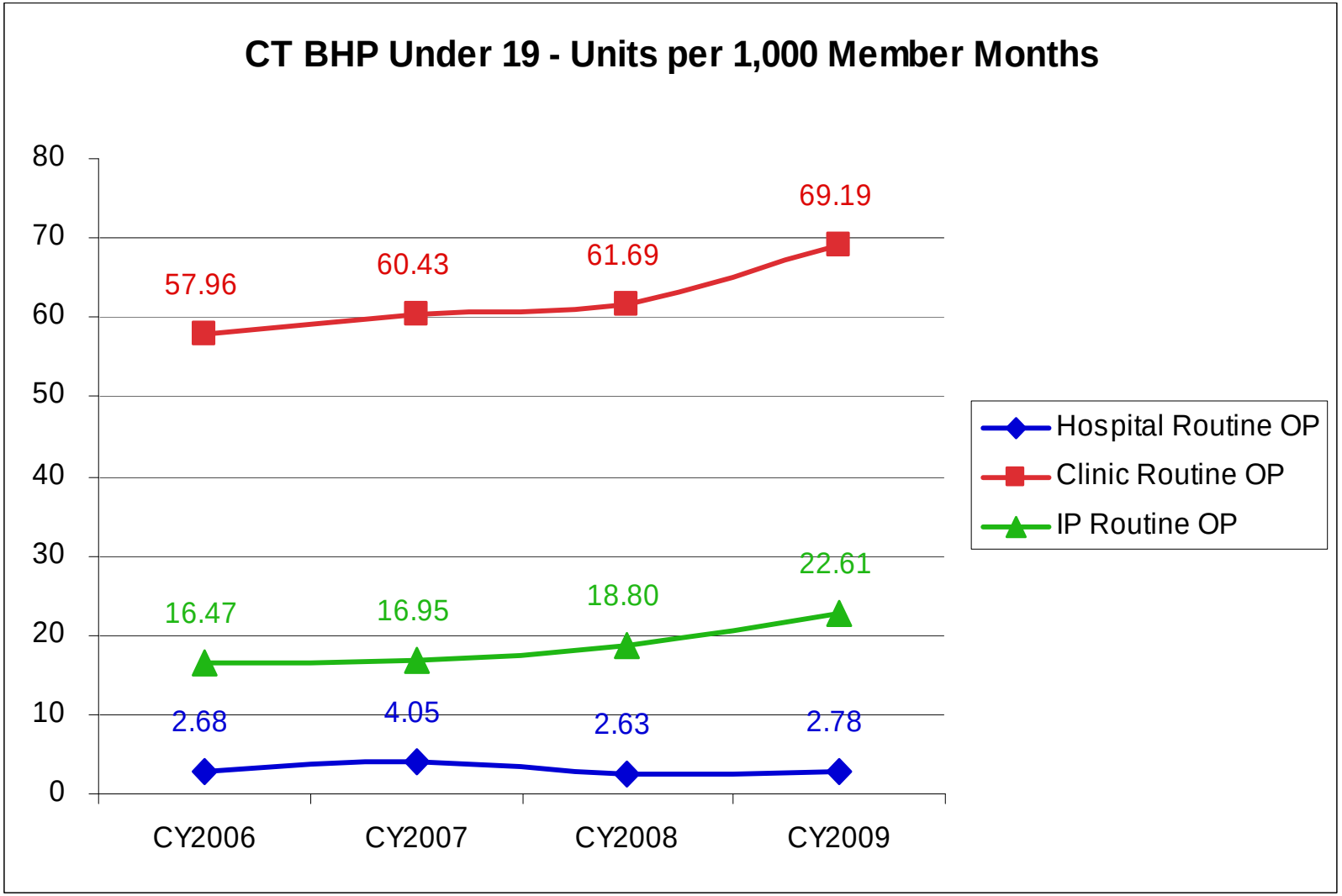
- Policy Transmittals outlining requirements for co-occurring screening, assessment and treatment were issued in April 2010
- ECCs will need to be in compliance by April 2011
- Workgroups met to collaboratively develop the oversight tools
- Oversight will begin once the new oversight model has been developed

Service Utilization – Paid Date of Service (DOS)

Units per 1,000 Members

CT BHP Under 19 DOS Utilization

Routine Outpatient

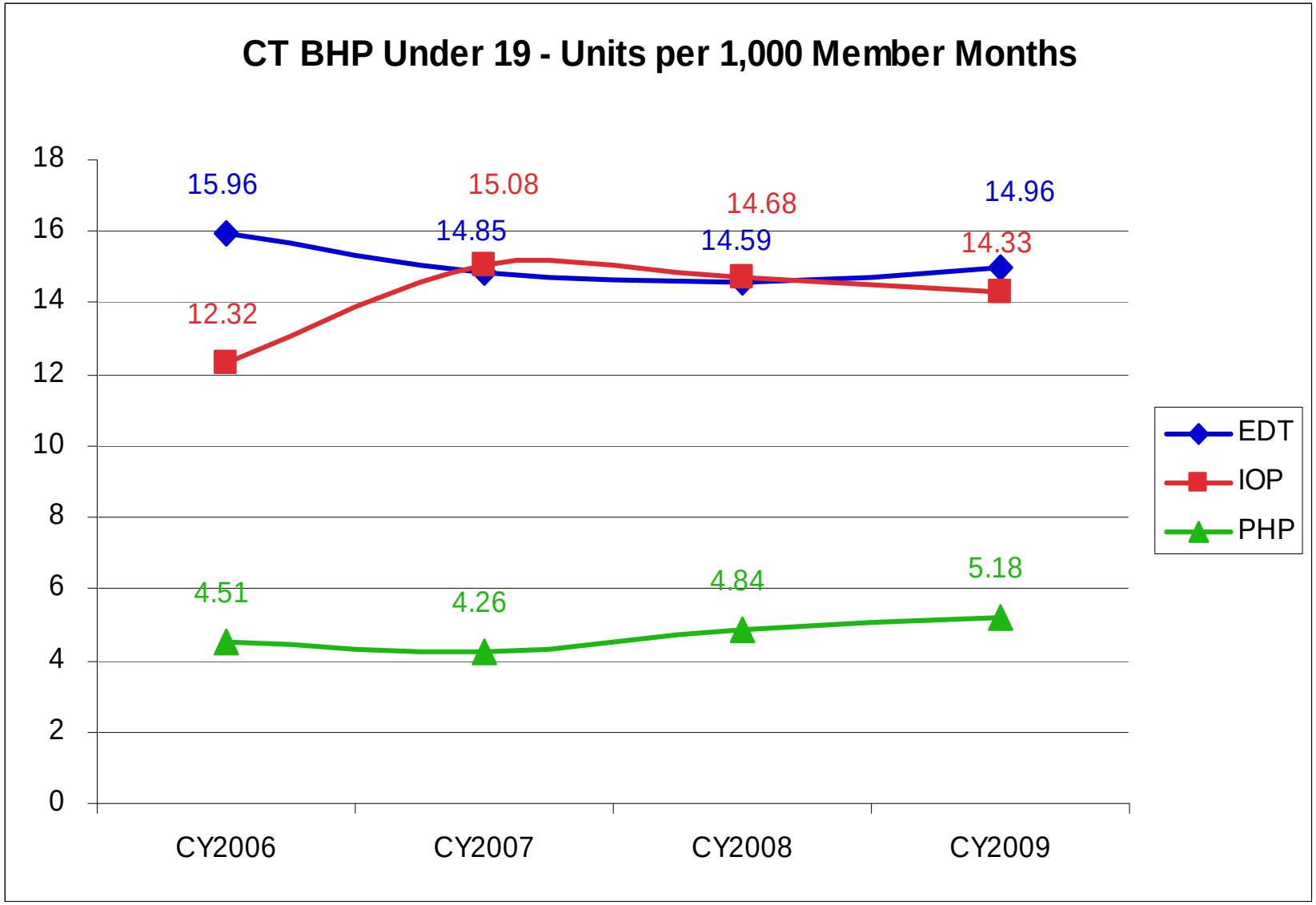


CT BHP Glossary of Terms

- Intermediate Care
  - Extended Day Treatment (EDT)
  - Intensive Outpatient (IOP)
  - Partial Hospitalization Program (PHP)
- Home-Based Care
  - Intensive In-home Child and Adolescent Psychiatric Services (IICAPS)
  - Multi-Systemic Therapy (MST)
  - Functional Family Therapy (FFT)
  - Multi-Dimensional Family Therapy (MDFT)
- Emergency Mobile Psychiatric Services (EMPS)
- Psychiatric Residential Treatment Facility (PRTF)
- Independent Practitioner (IP)

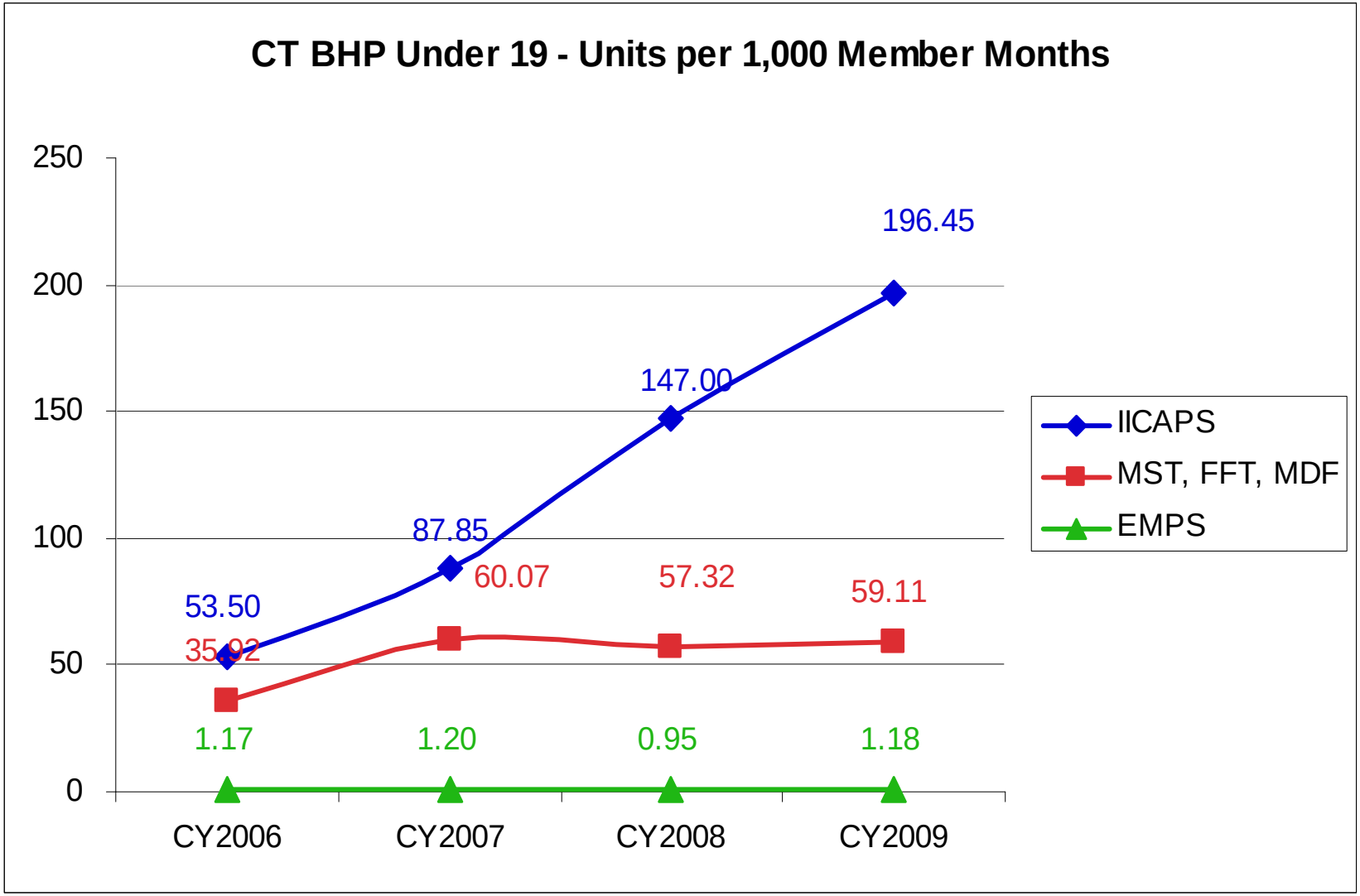
CT BHP Under 19 DOS Utilization

Intermediate Care



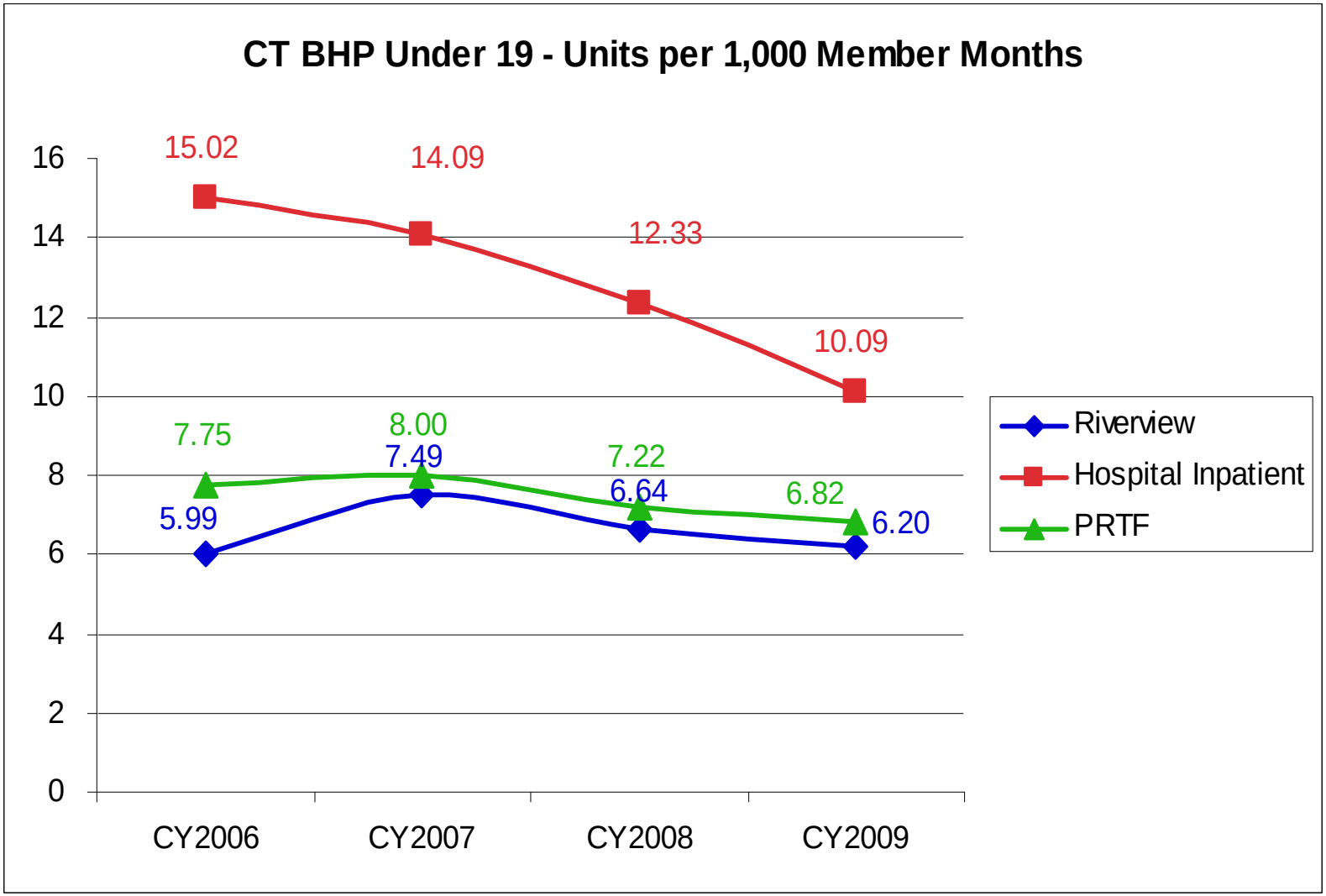
CT BHP Under 19 DOS Utilization

Home and Community Services



CT BHP Under 19 DOS Utilization

Inpatient Psychiatric

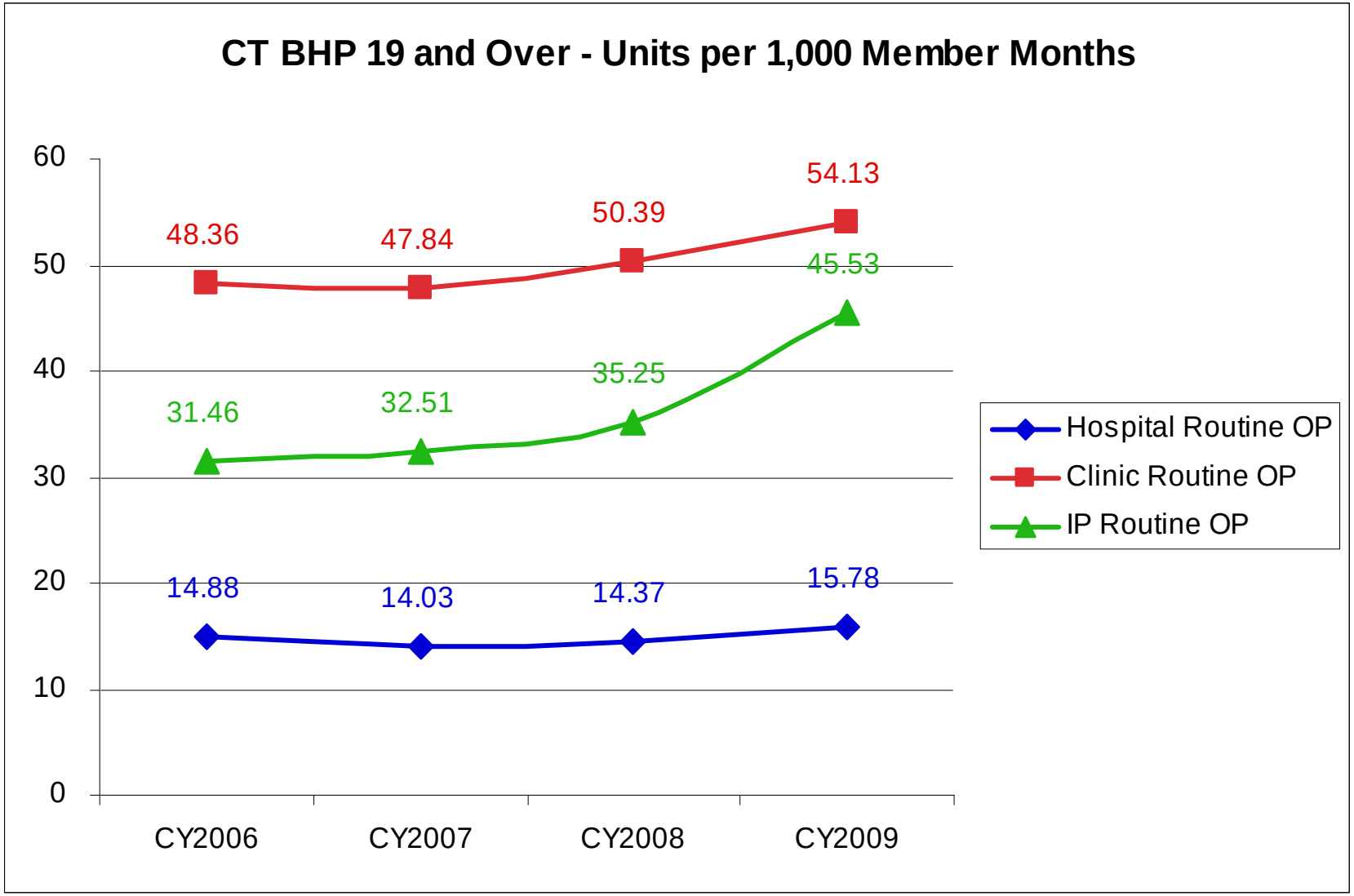


CT BHP Under 19 DOS Utilization
Summary – Units per 1,000 Members

- Routine Outpatient utilization continues to grow for freestanding clinics and independent practitioners but remains steady for hospital clinics
- Intermediate Care services have held steady since 2007
- IICAPS utilization has increased substantially in contrast to other home based programs and EMPS
- Hospital inpatient utilization has substantially decreased each year
- Riverview and PRTF utilization shows a slight decrease

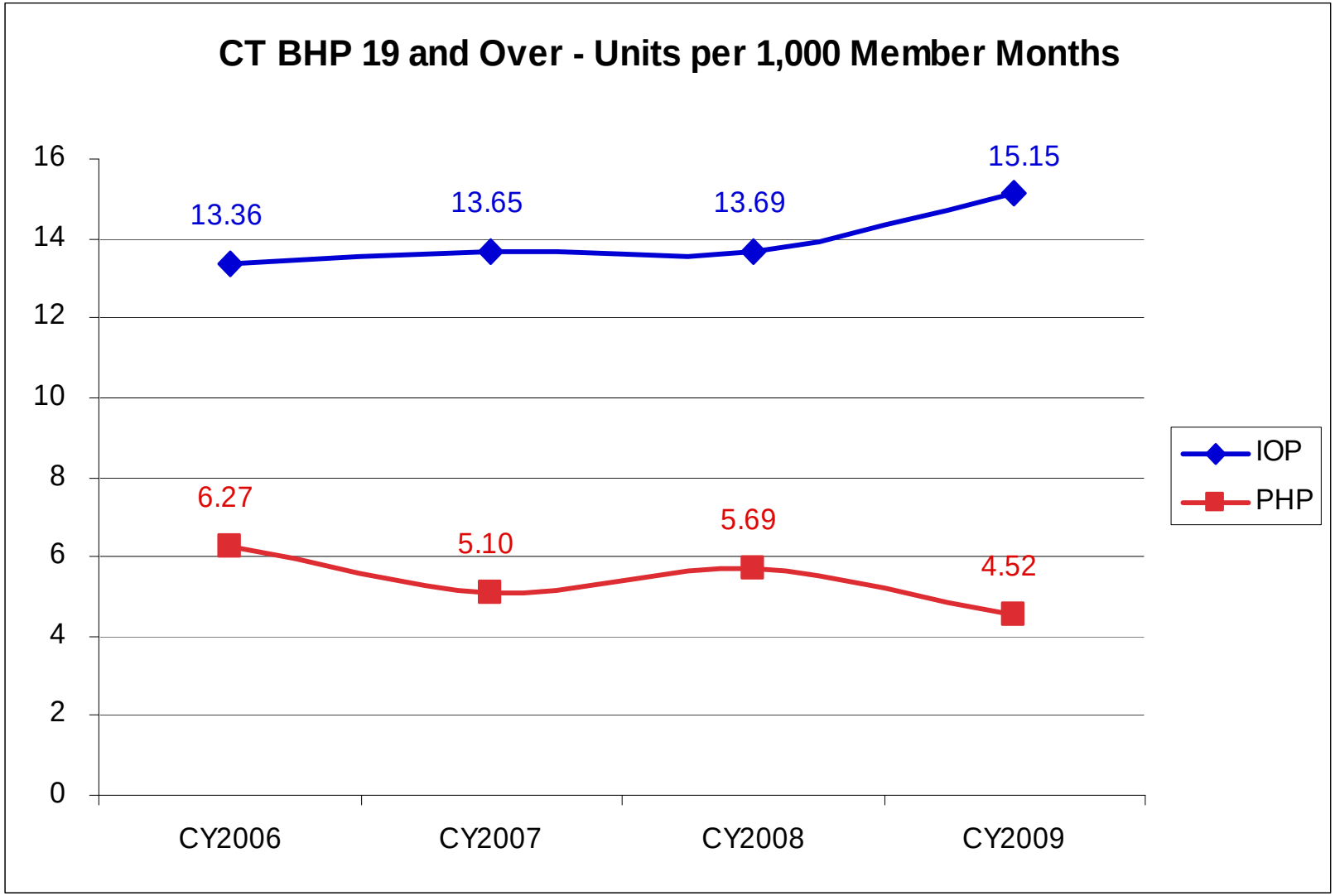
CT BHP 19 & Over DOS Utilization

Routine Outpatient



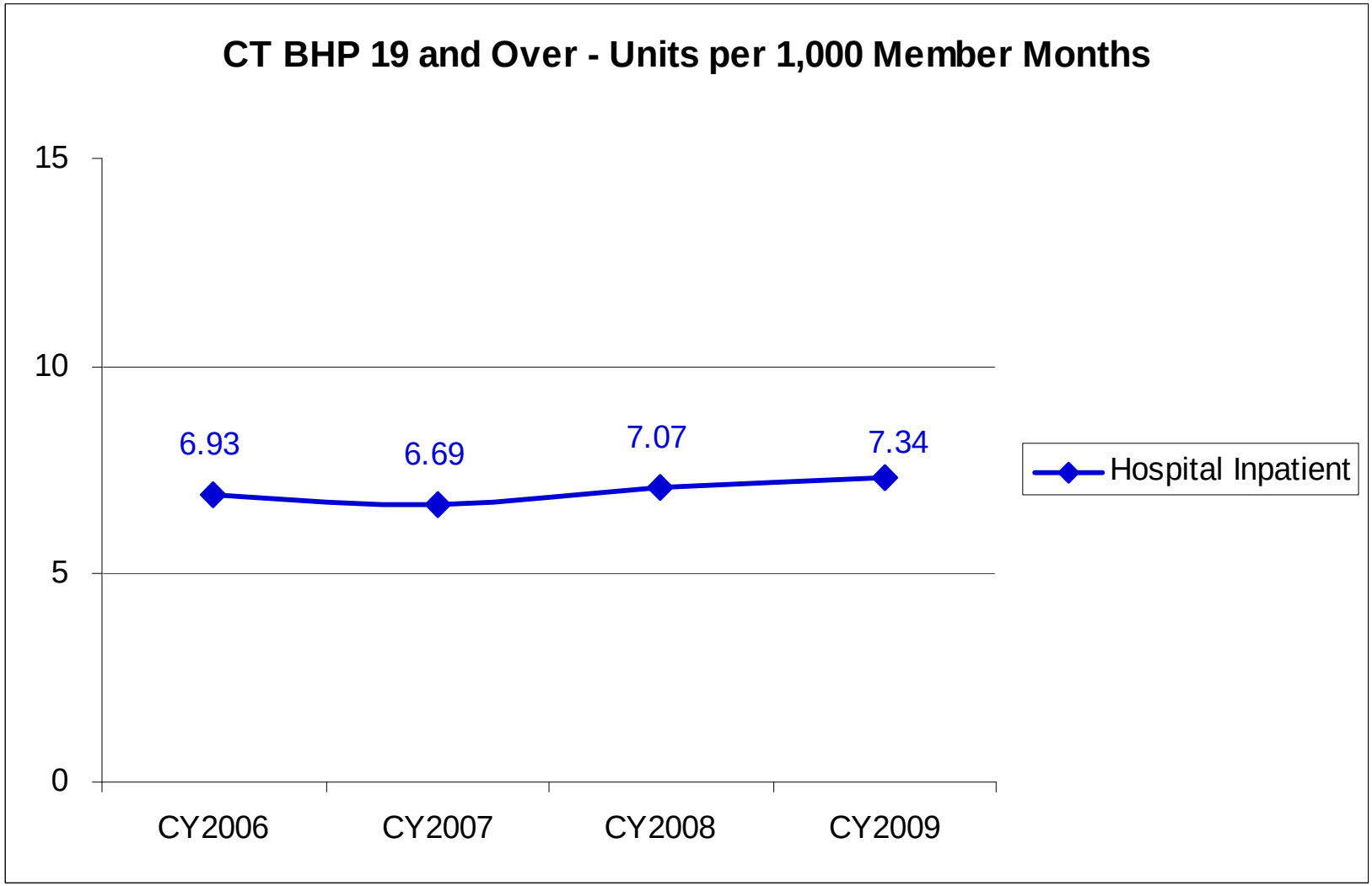
CT BHP 19 & Over DOS Utilization

Intermediate Care



CT BHP 19 & Over DOS Utilization

Inpatient Psychiatric



CT BHP 19 & Over DOS Utilization

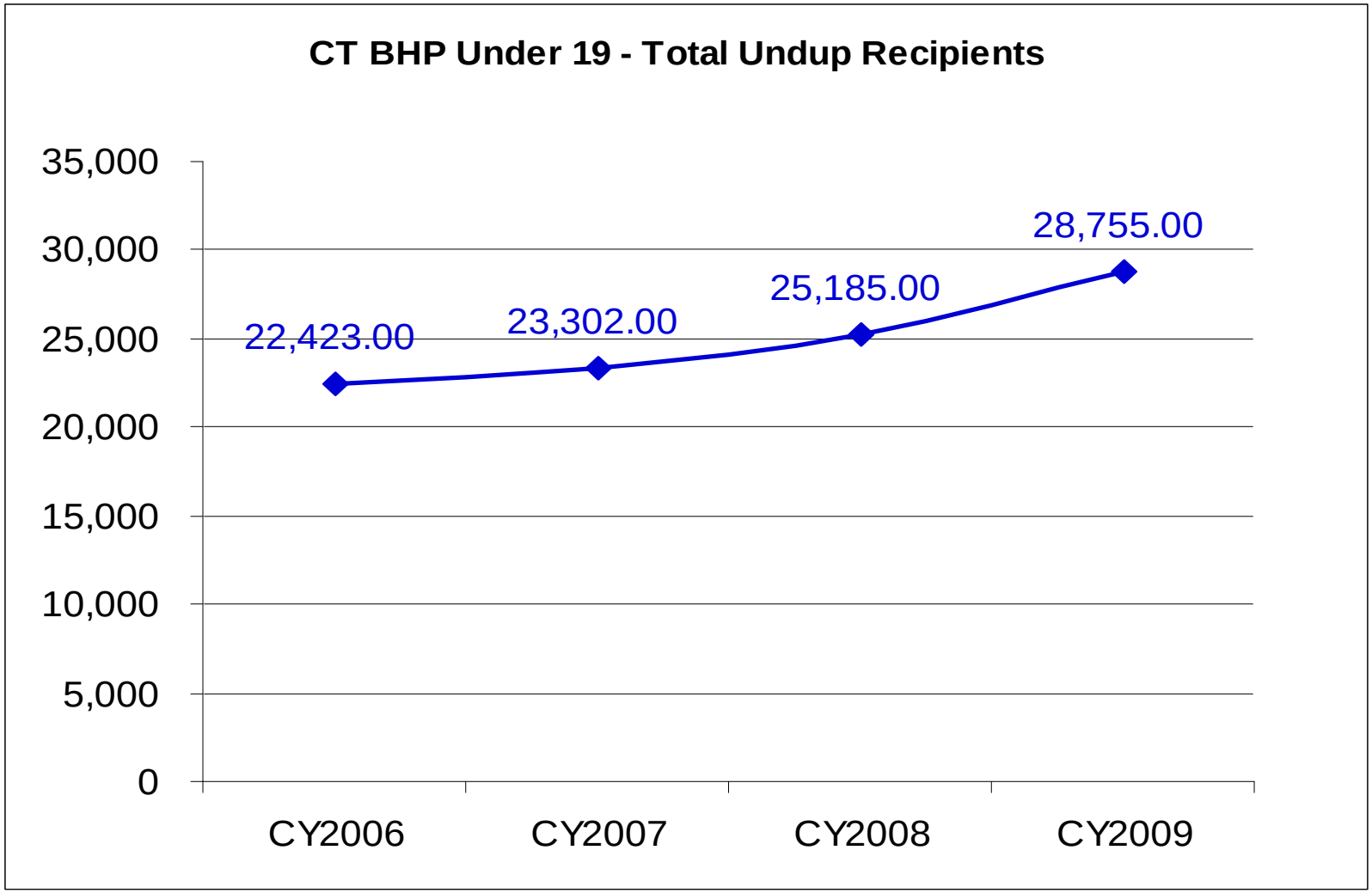
Summary – Units per 1,000 Members

- Routine Outpatient utilization continues to grow for freestanding mental health clinics and independent practitioners
- Adult use of independent practitioners is nearly double that for children
- IOP utilization shows a slight but steady increase while PHP shows a slight but steady decrease
- Hospital inpatient shows a slight increase

Total Unduplicated Recipients

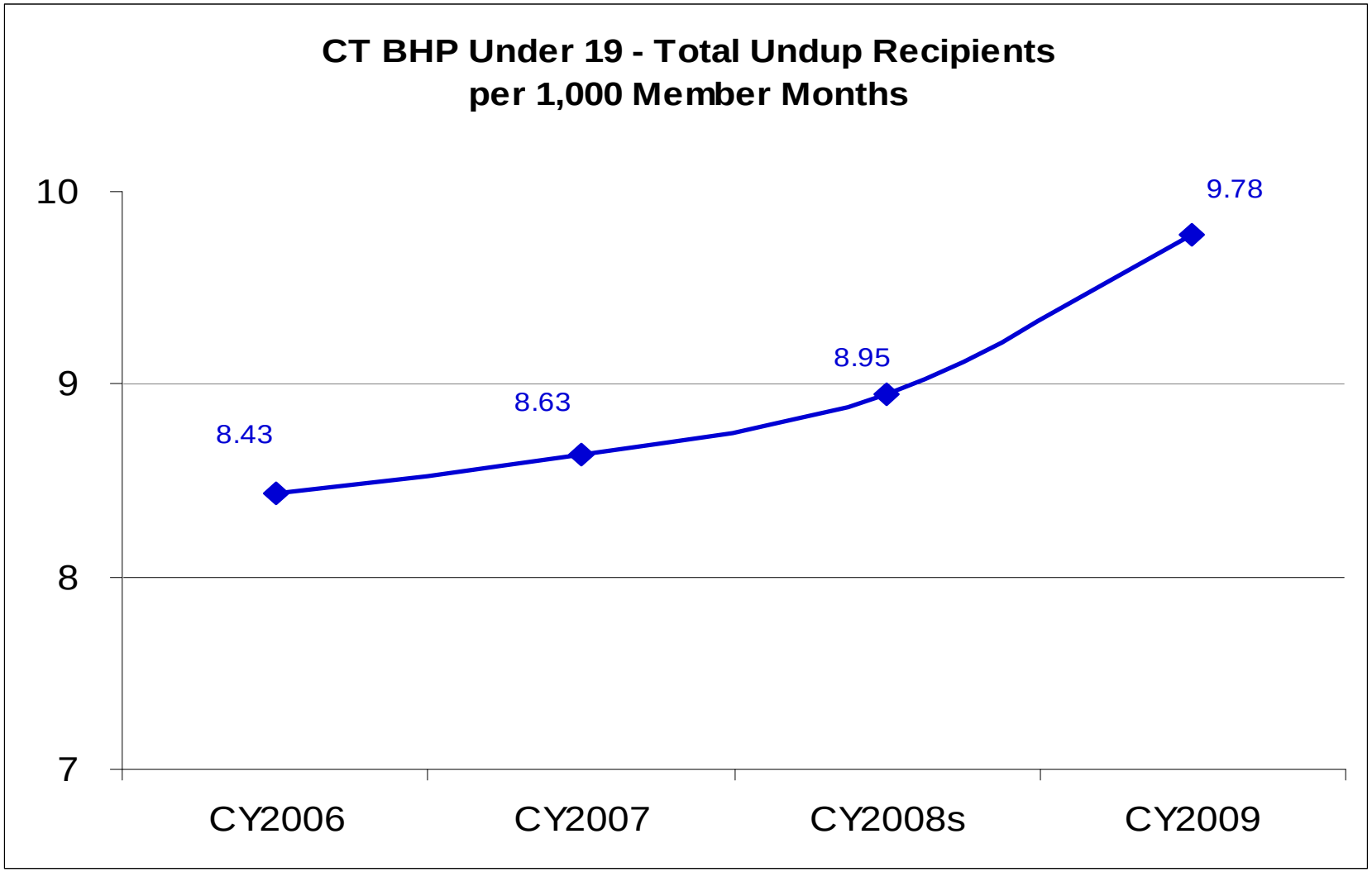
CT BHP Under 19 DOS Utilization

All CT BHP Services



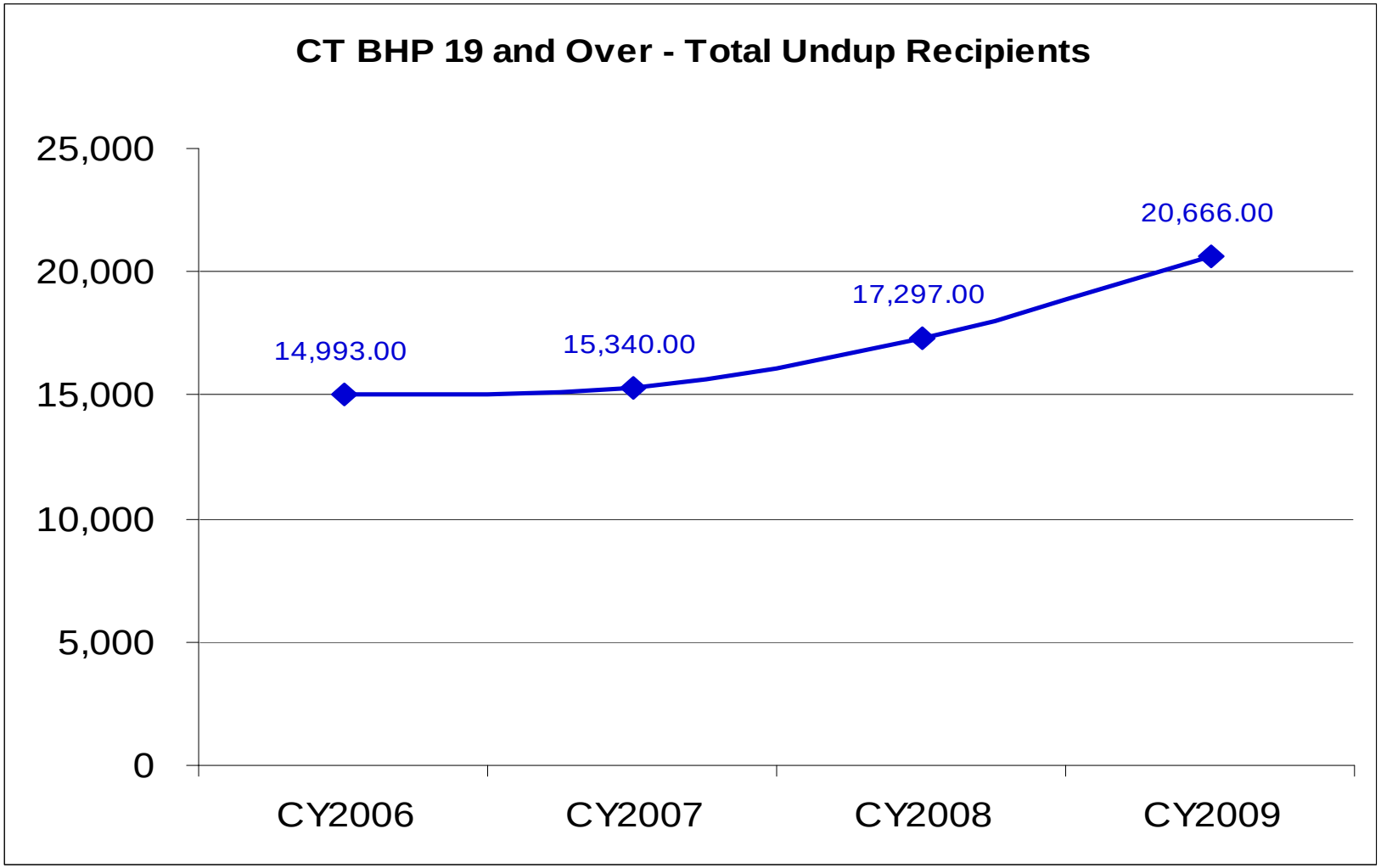
CT BHP Under 19 DOS Utilization

All CT BHP Services



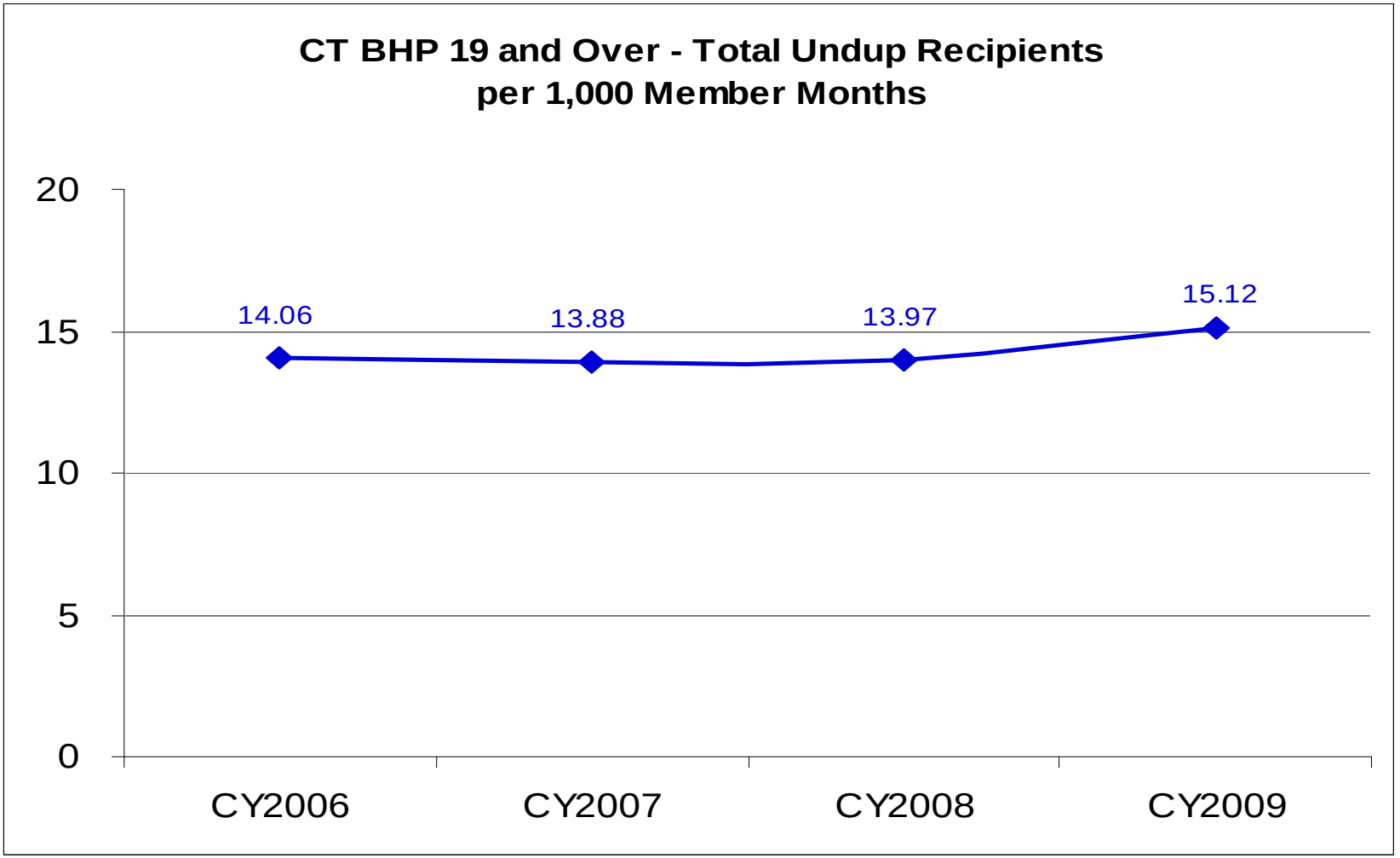
CT BHP 19 & Over DOS Utilization

All CT BHP Services



CT BHP 19 & Over DOS Utilization

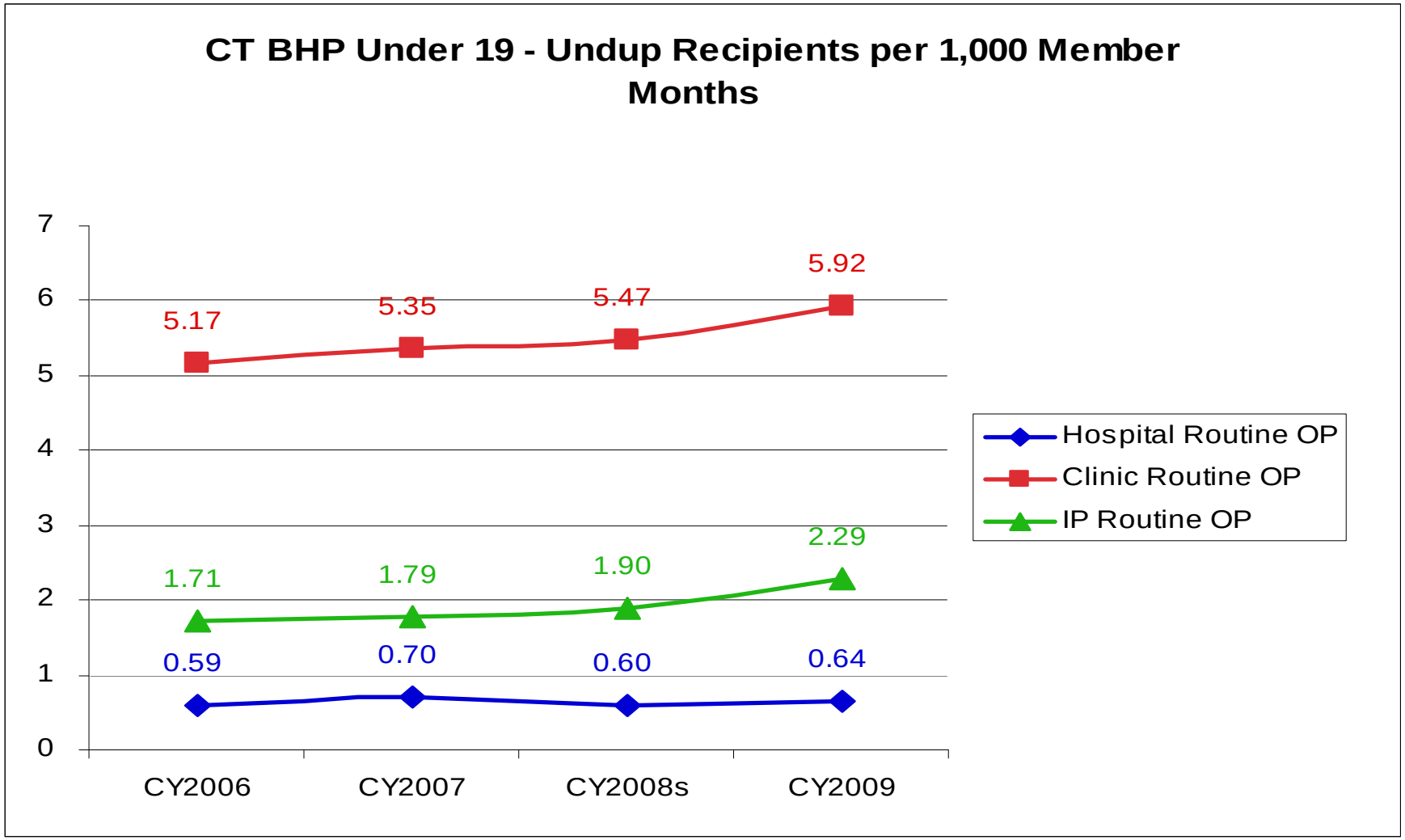
All CT BHP Services



Unduplicated Recipients per 1,000 Members

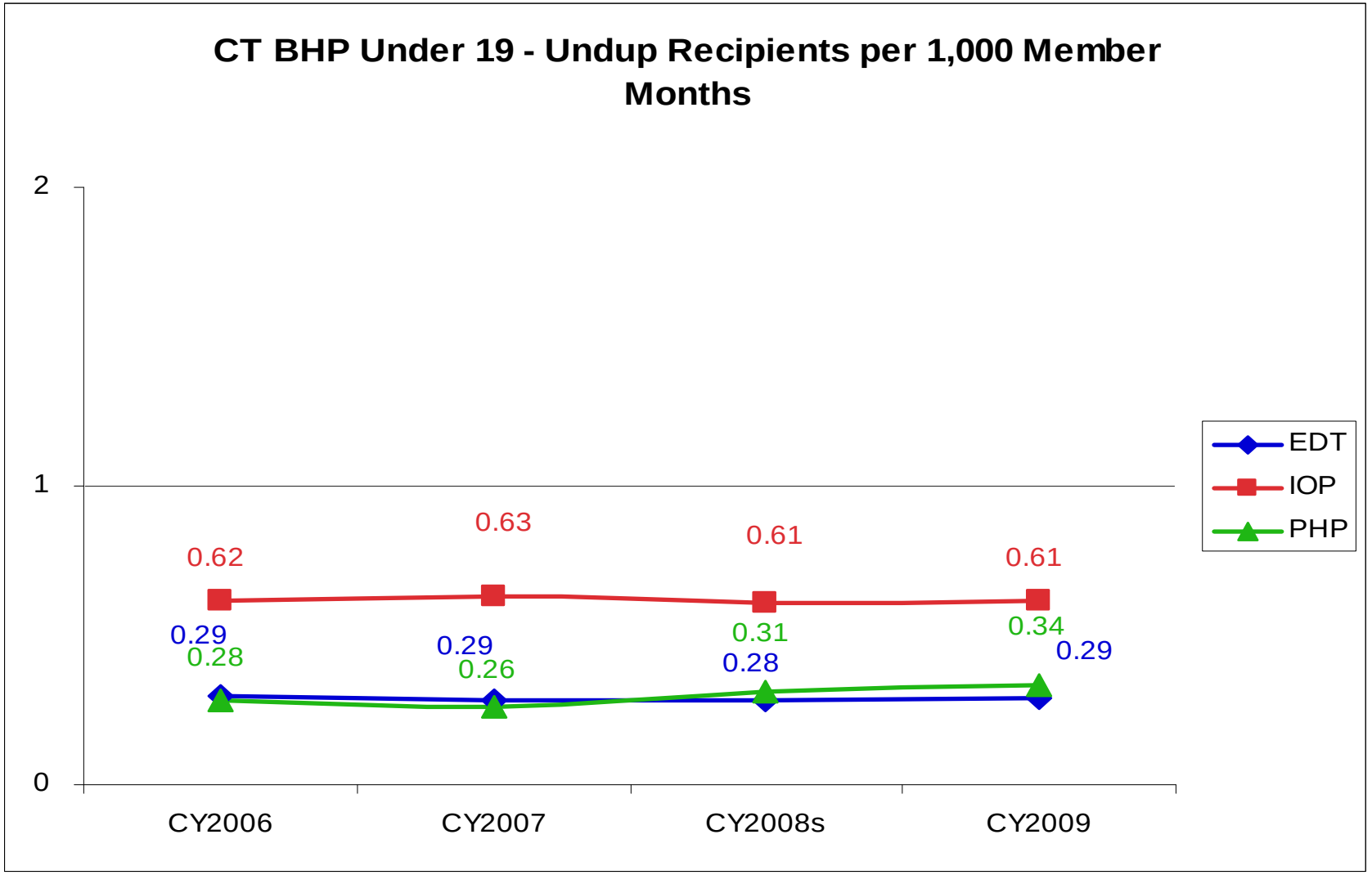
CT BHP Under 19 DOS Utilization

Routine Outpatient



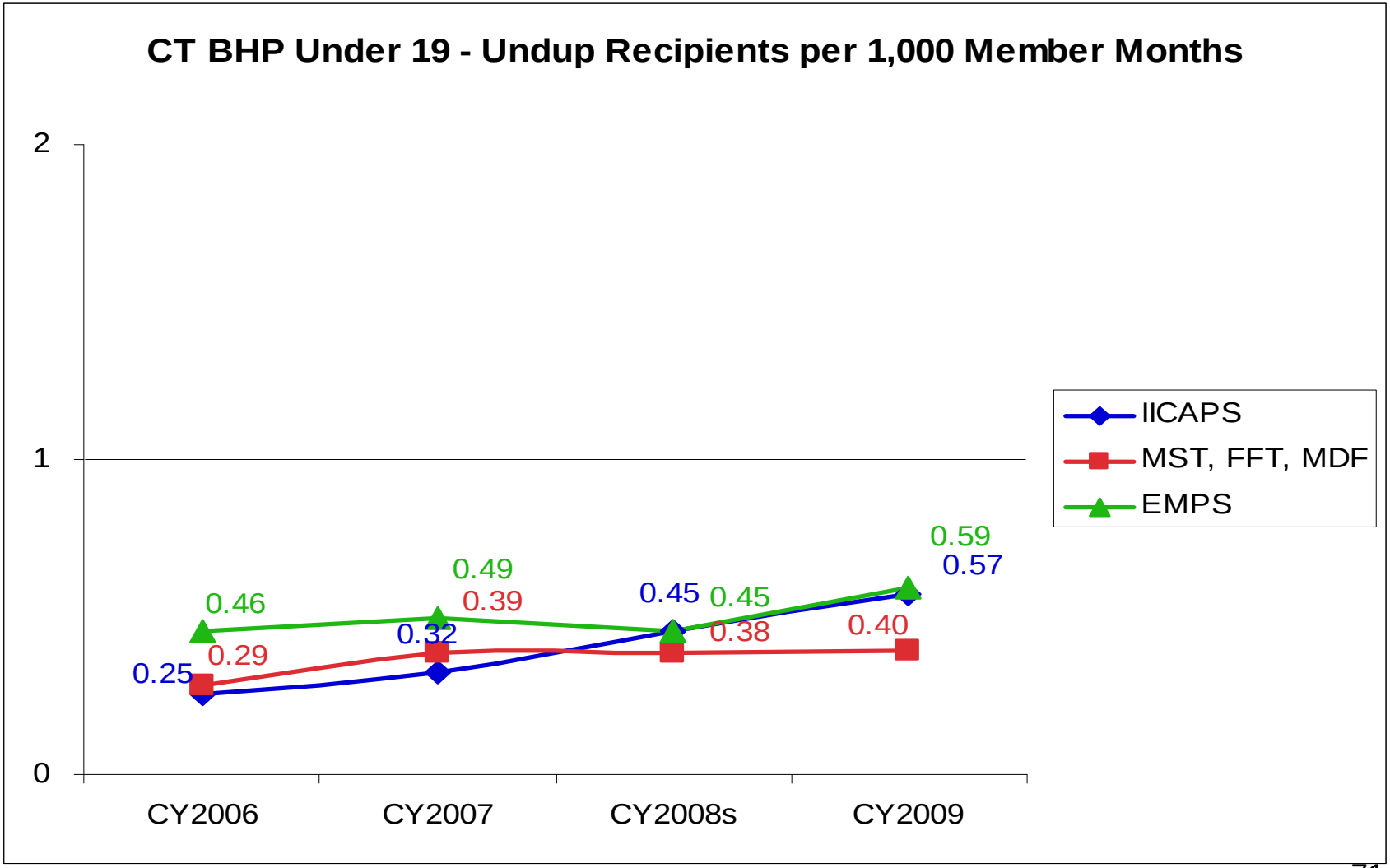
CT BHP Under 19 DOS Utilization

Intermediate Care



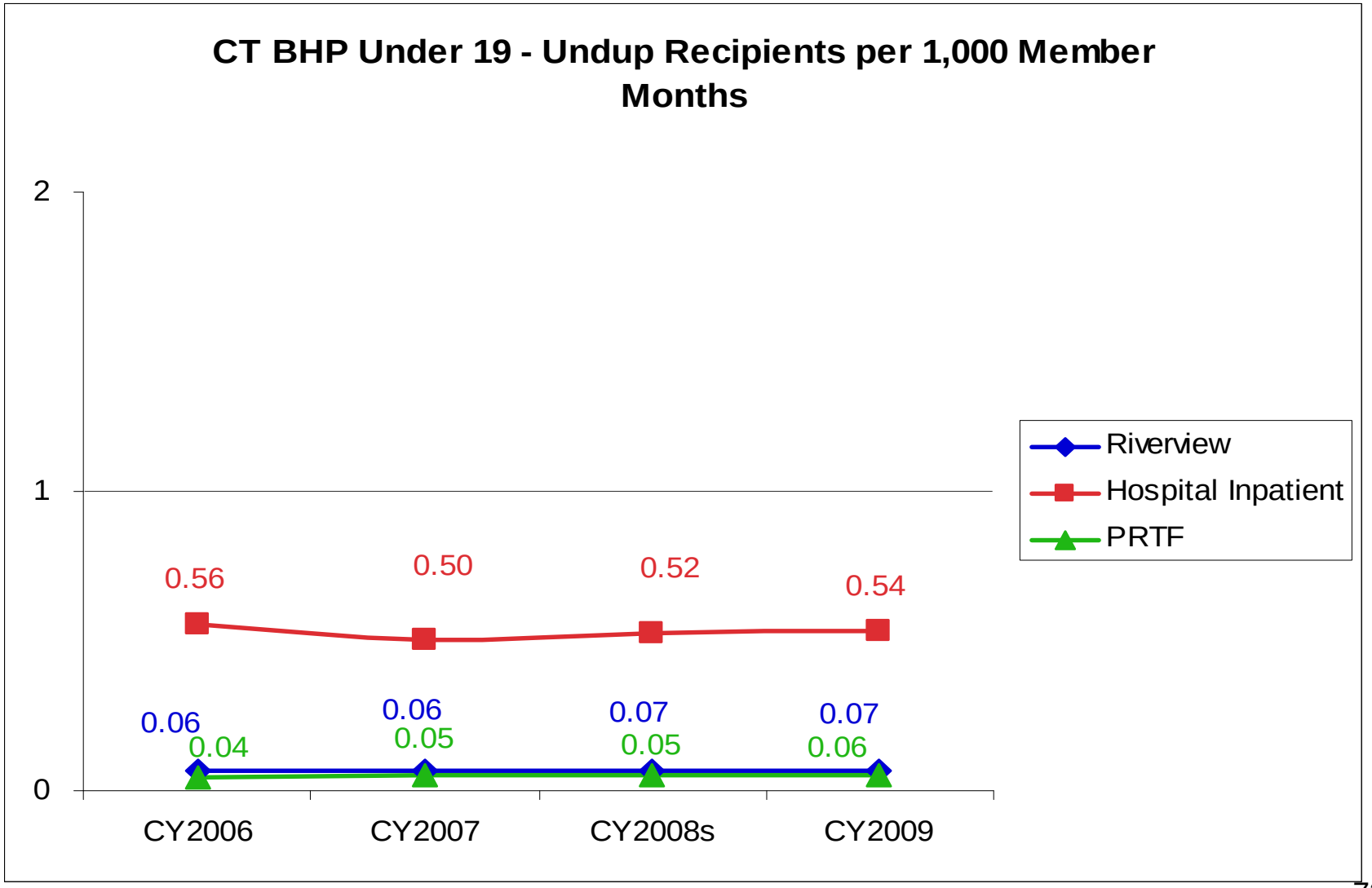
CT BHP Under 19 DOS Utilization

Home and Community Services



CT BHP Under 19 DOS Utilization

Inpatient Psychiatric



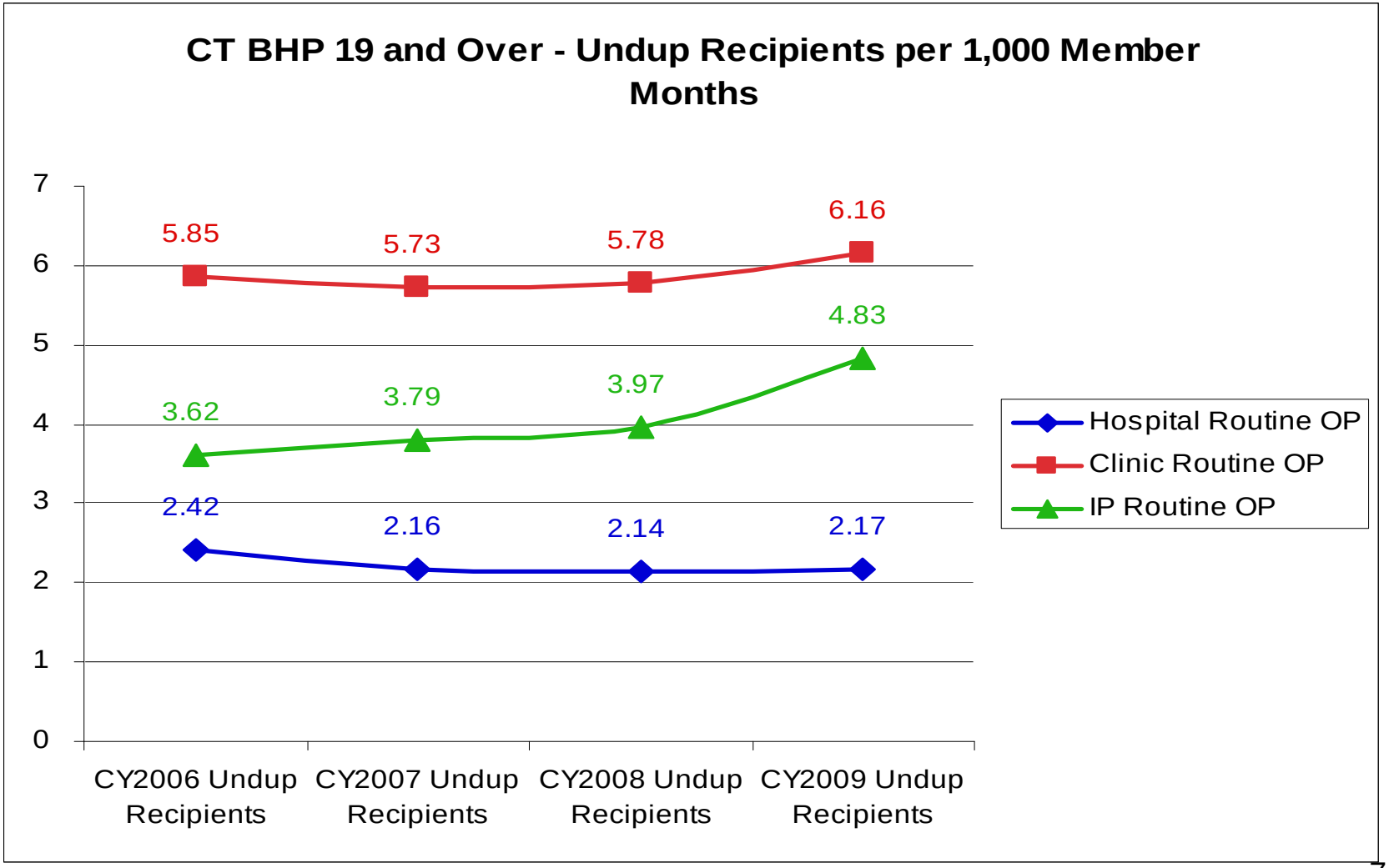
CT BHP Under 19 DOS Utilization

Summary– Undup Recipients per 1,000 Members

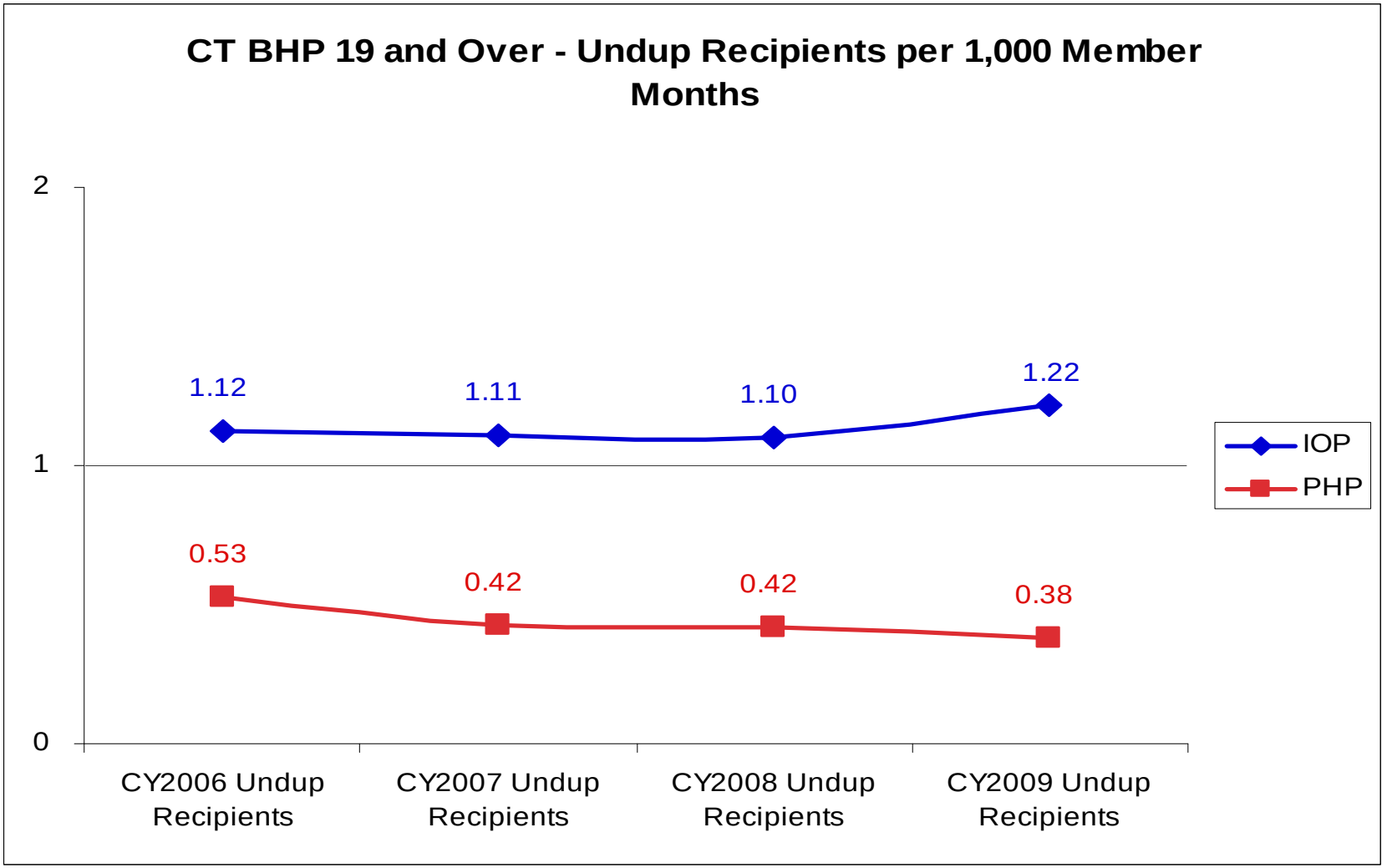
- Penetration rate (member access adjusted for enrollment) has increased for clinic and independent practitioner services
- Penetration rate has remained steady for intermediate care and inpatient services
- Penetration rate has increased for EMPS and home and community services, most significantly (127%) for IICAPS

CT BHP 19 & Over DOS Utilization

Routine Outpatient

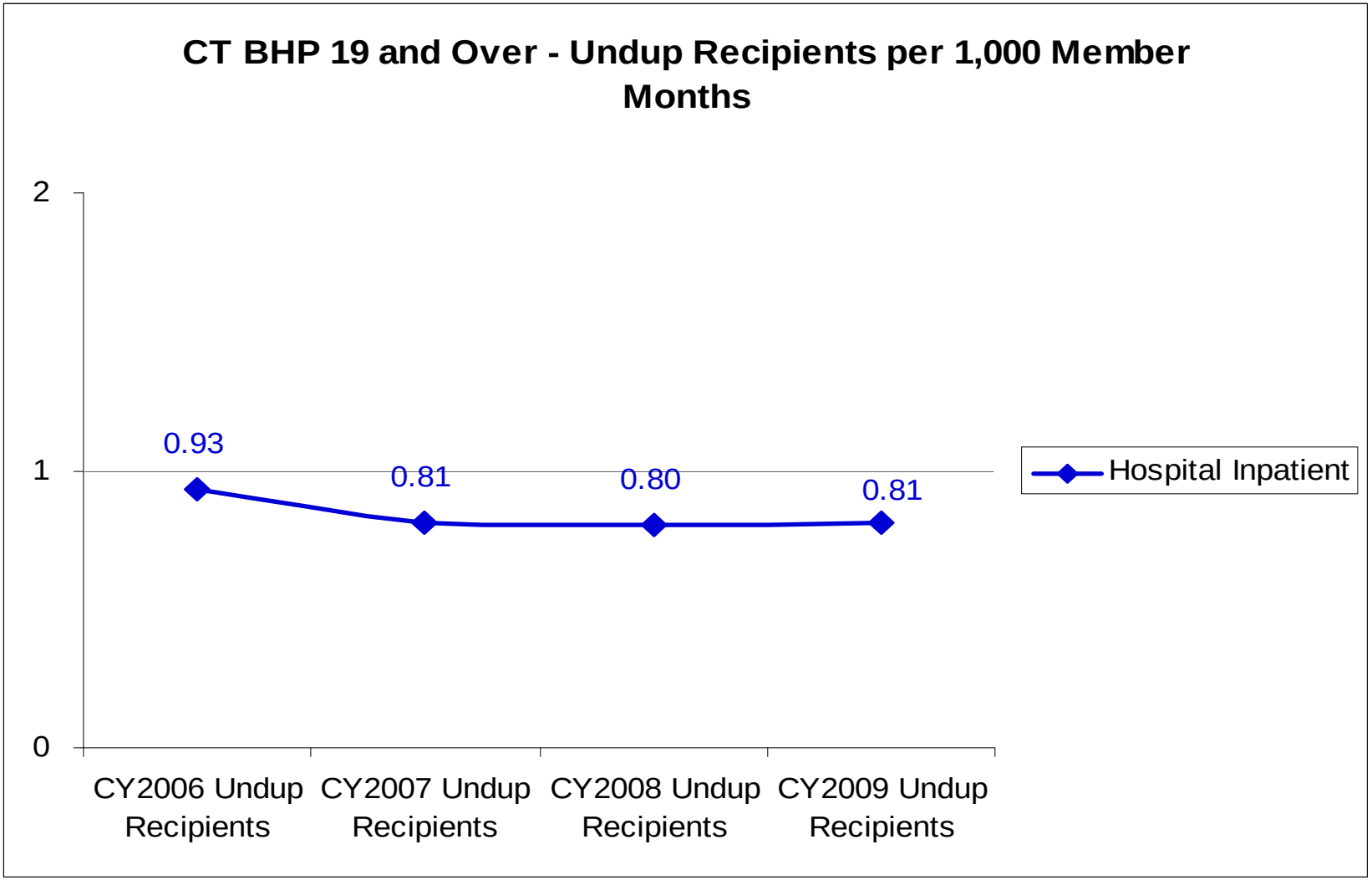


CT BHP 19 & Over DOS Utilization
Intermediate Care



CT BHP 19 & Over DOS Utilization

Inpatient Psychiatric



CT BHP 19 & Over DOS Utilization

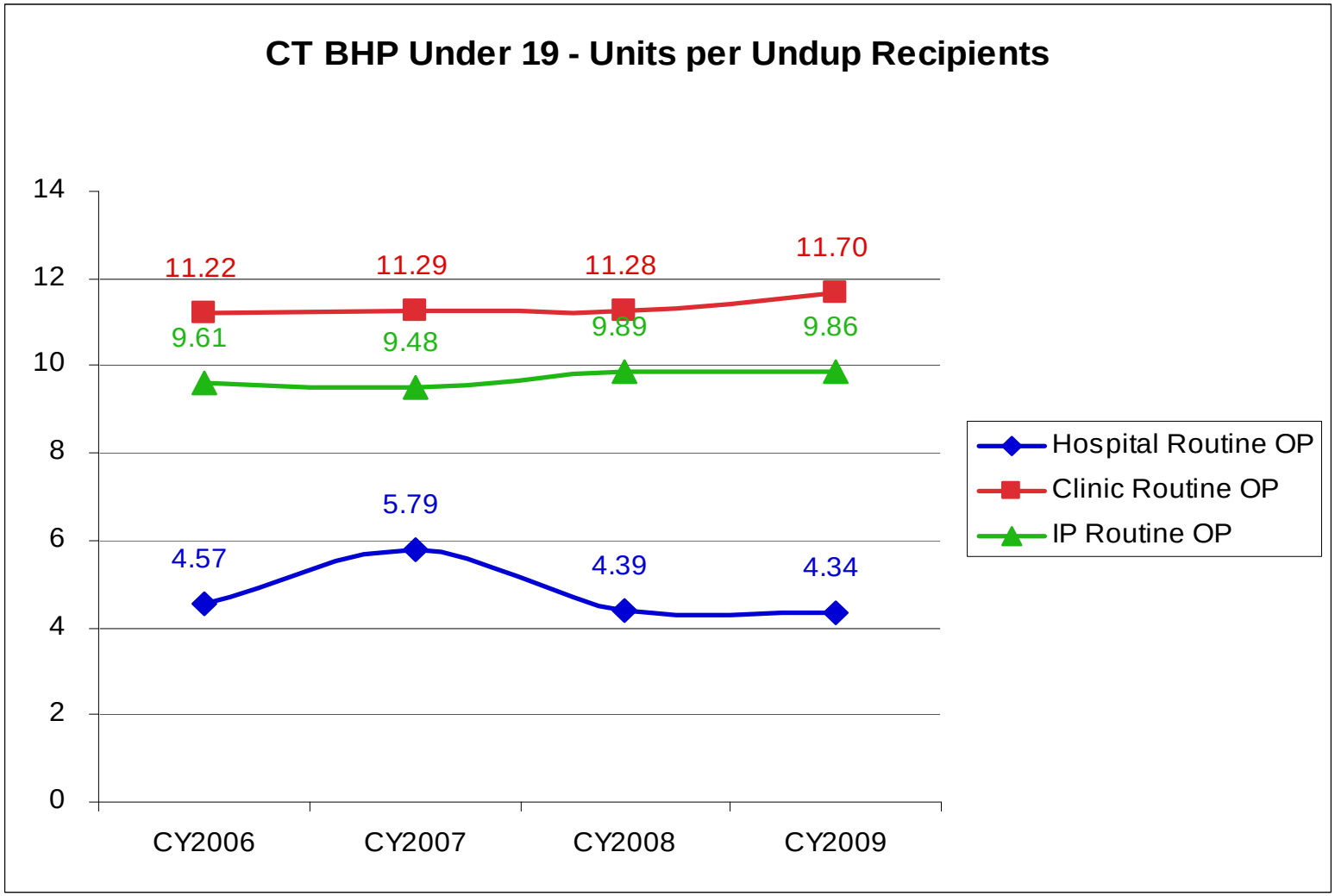
Summary– Undup Recipients per 1,000 Members

- Penetration rate (member access adjusted for enrollment) has increased for clinic and independent practitioner services, but decreased for hospital outpatient services
- Penetration rate has increased for IOP services and decreased for PHP services
- Penetration rate has declined for hospital inpatient services

Units per Recipient

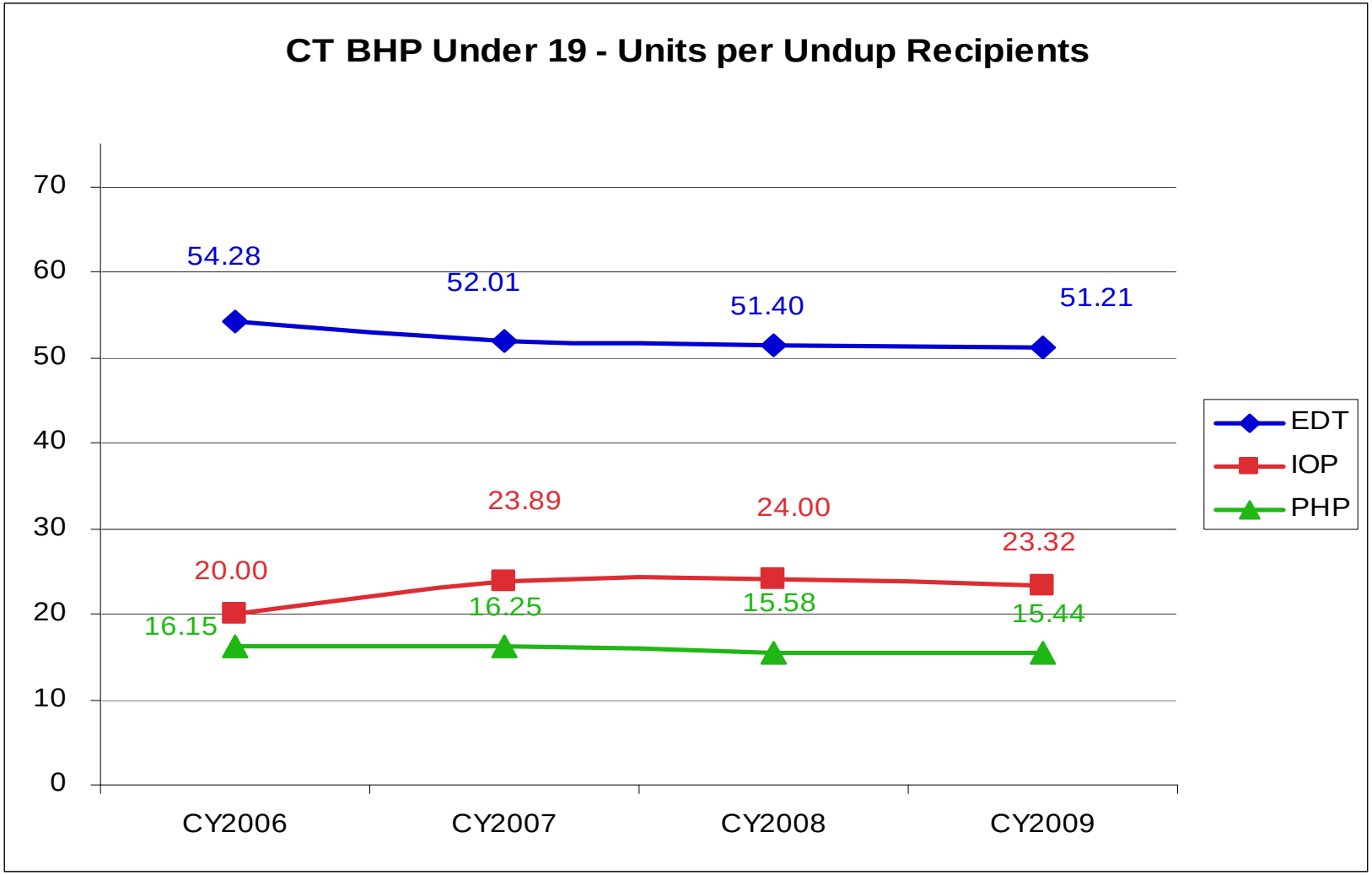
CT BHP Under 19 DOS Utilization

Routine Outpatient



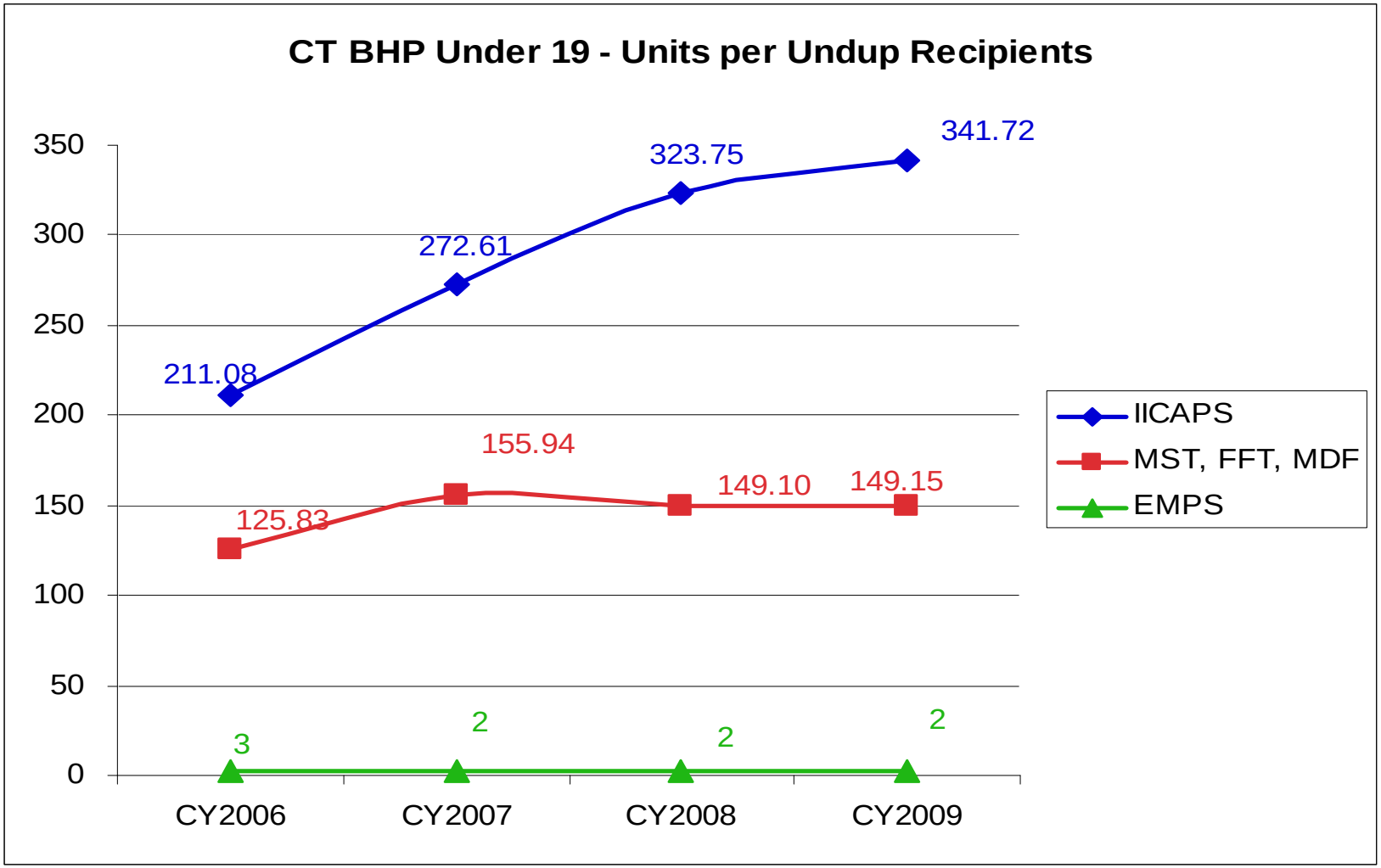
CT BHP Under 19 DOS Utilization

Intermediate Care



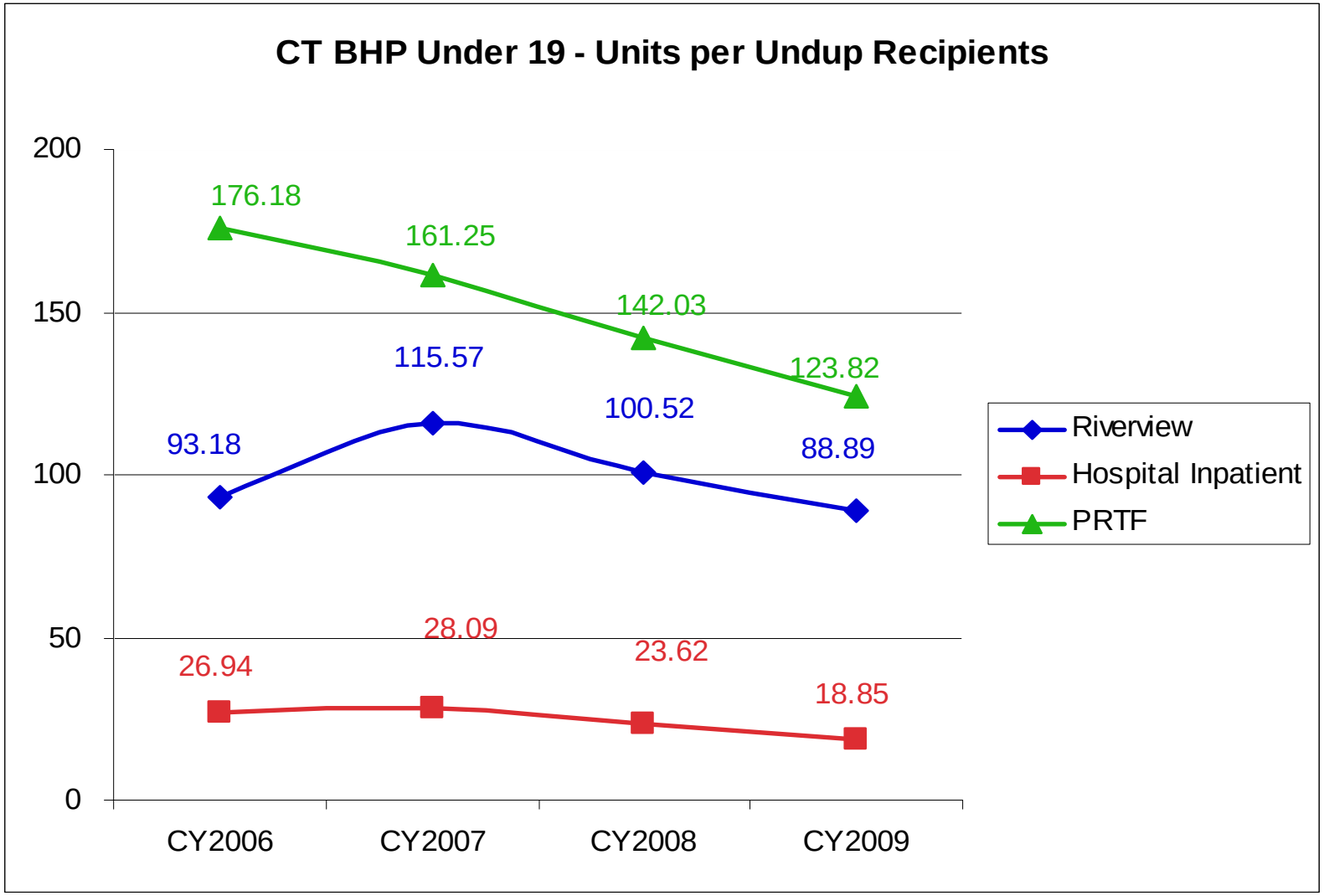
CT BHP Under 19 DOS Utilization

Home and Community Services



CT BHP Under 19 DOS Utilization

Inpatient Psychiatric

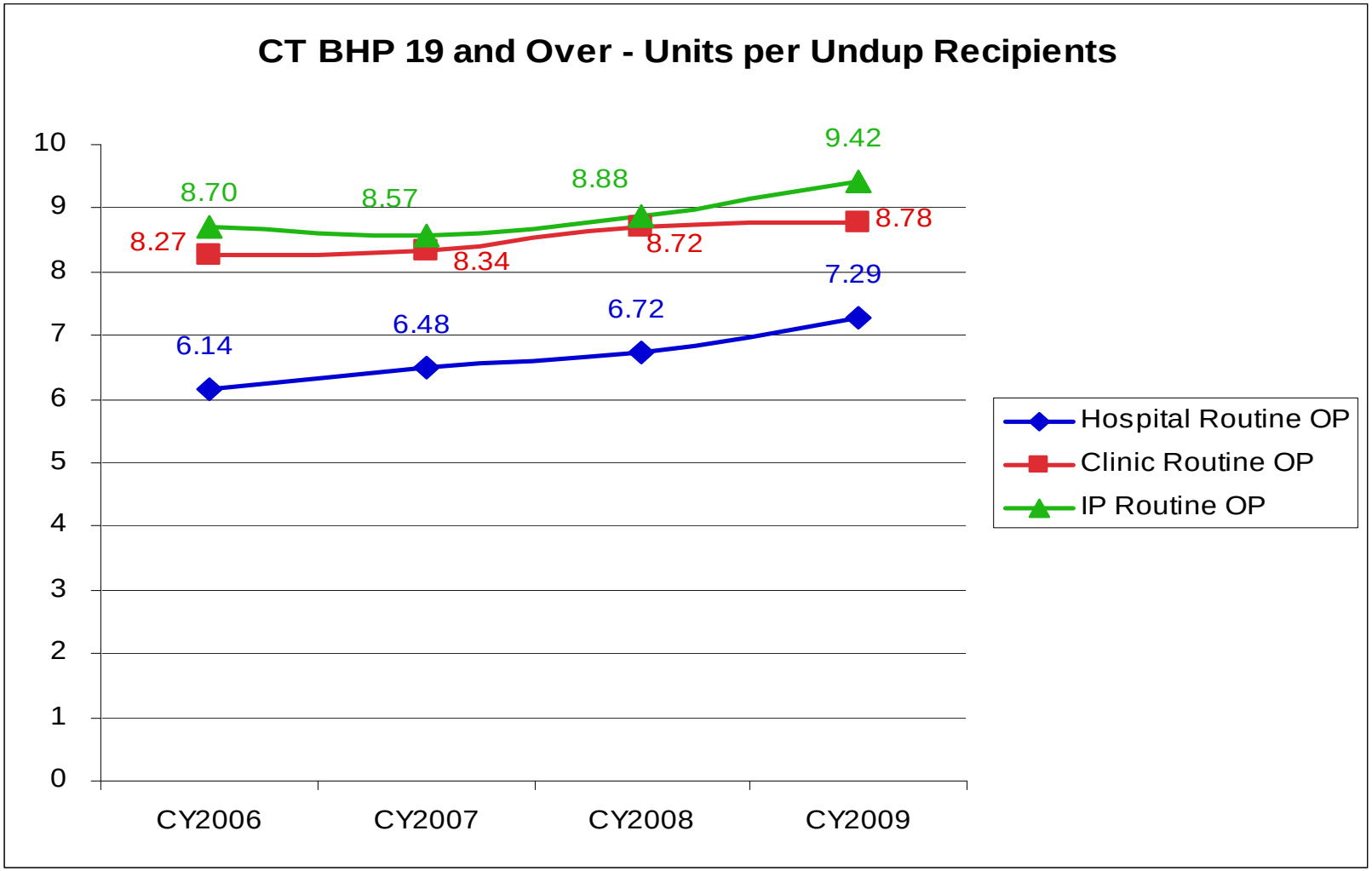


CT BHP Under 19 DOS Utilization

Summary – Units per Recipient

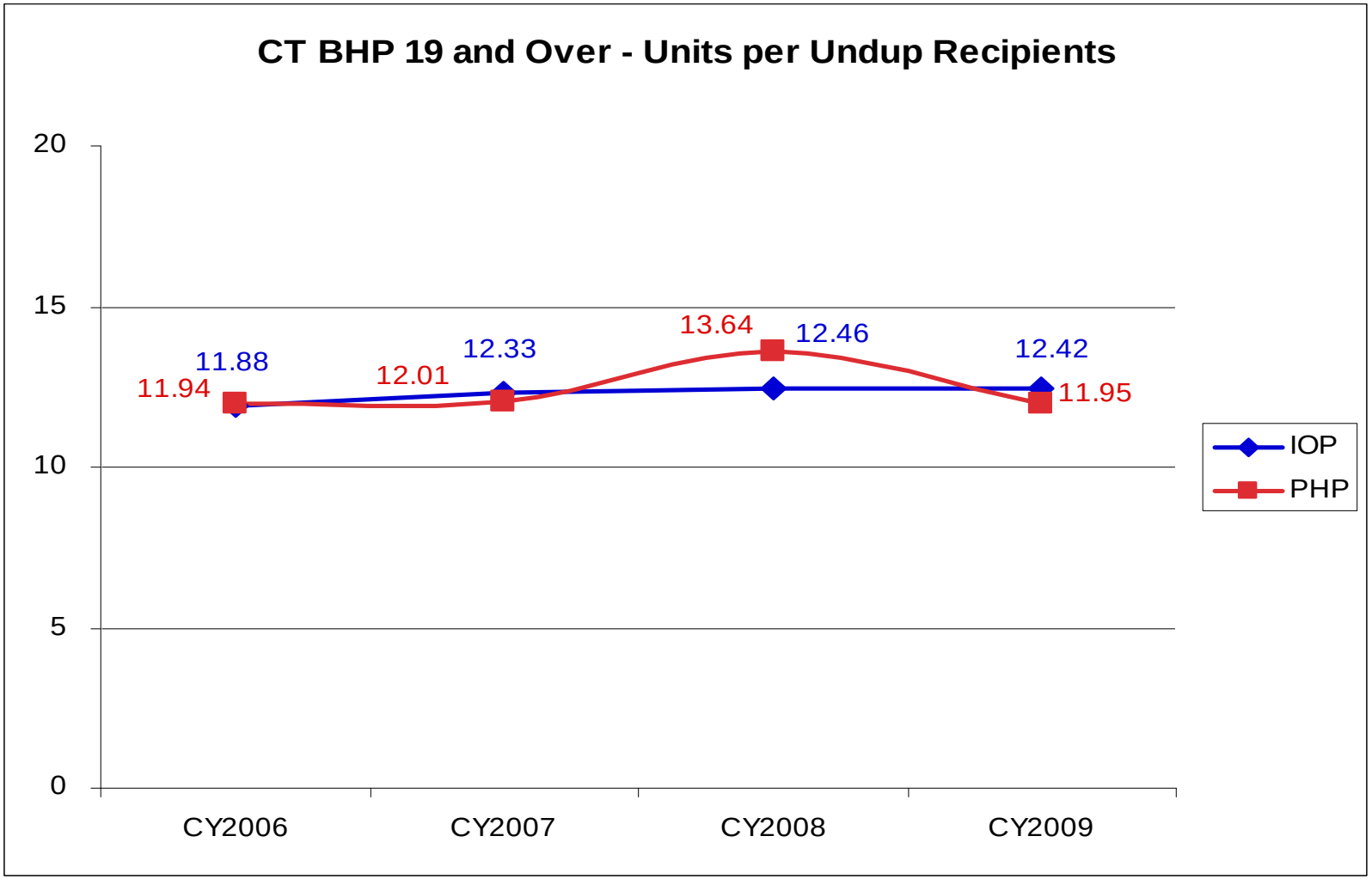
- Units per recipient for year has remained relatively steady each calendar year but has for routine outpatient and intermediate levels of care
- There has been an extraordinary increase (62%) in units per recipient for IICAPS
- Inpatient days per recipient have decreased in all settings, but most dramatically in private hospital inpatient

CT BHP 19 & Over DOS Utilization
Routine Outpatient



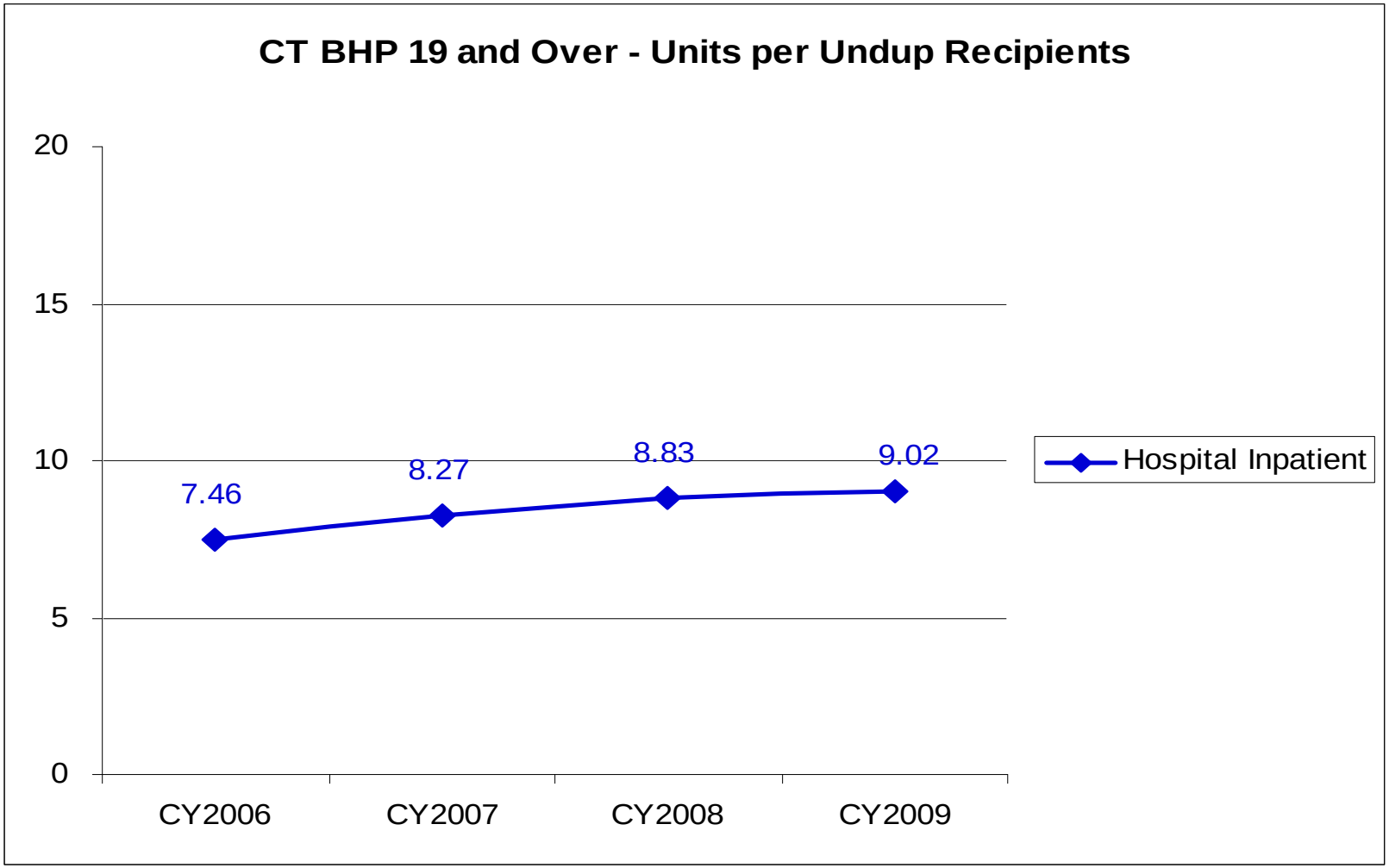
CT BHP 19 & Over DOS Utilization

Intermediate Care



CT BHP 19 & Over DOS Utilization

Inpatient Psychiatric

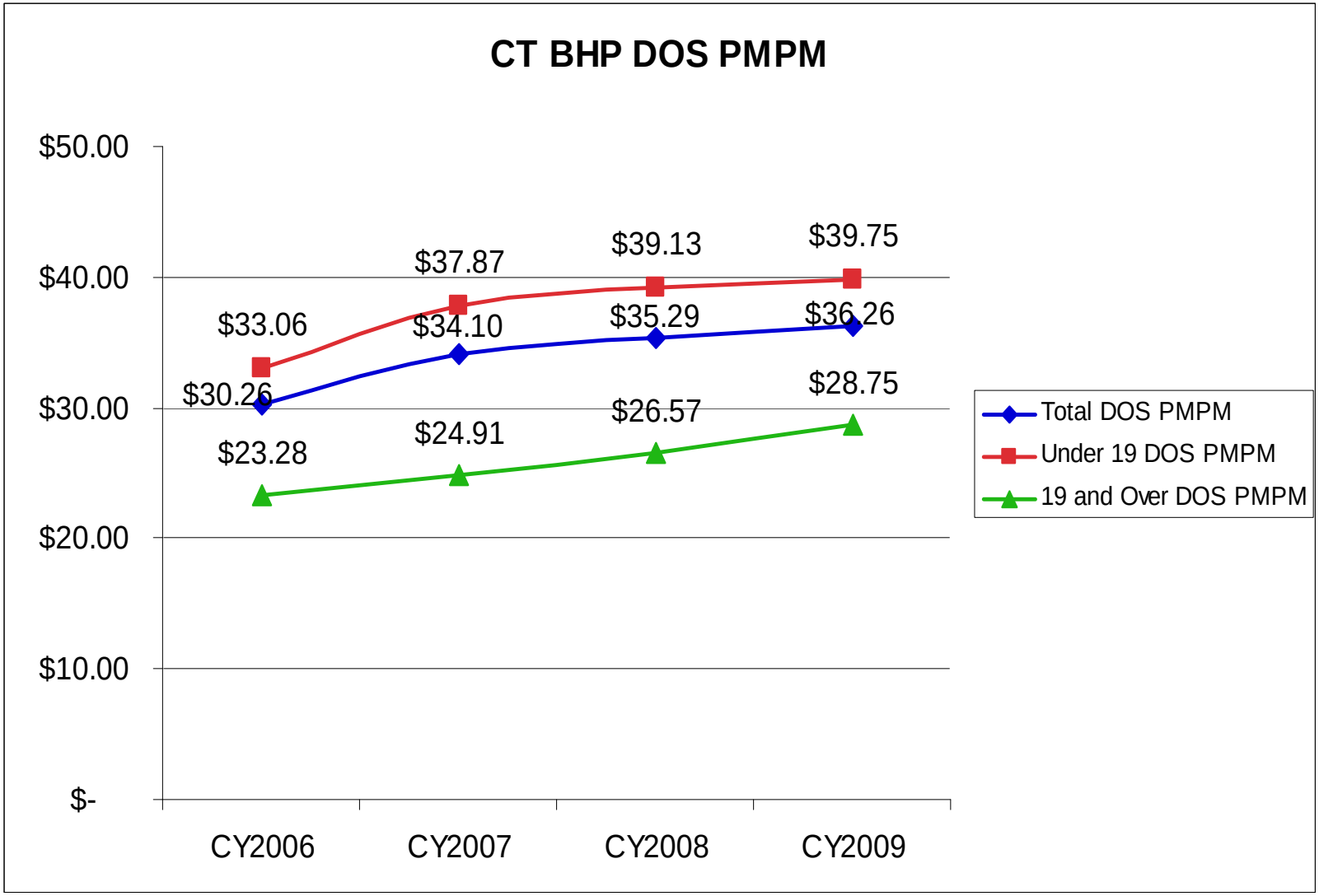


CT BHP 19 & Over DOS Utilization
Summary – Units per Undup Recipient

- Modest increase in units per recipient for all routine outpatient settings
- Little or no change in units per recipient in intermediate care settings
- Steady and significant increase (21%) in days per recipient in hospital inpatient settings

Date of Service (DOS) Expenditures

CT BHP DOS Per Member Per Month (PMPM)



CT BHP Under 19 DOS PMPM

Summary 2006 to 2009

- Hospital inpatient PMPM declined from $11 to $8 from 2006 to 2009
- Home and community service PMPM has increased from $2 to $7 from 2006 to 2009
- Intermediate care PMPM has increased from about $3.80 to nearly $4.50
- Routine outpatient PMPM has increased from about $4.50 to nearly $7.50

CT BHP 19 & Over DOS PMPM
Summary 2006 to 2009

- Hospital inpatient PMPM increased slightly from about $4.90 to nearly $5.50
- Intermediate care PMPM hovered around $3
- Routine outpatient PMPM increased from about $6 to about $8.25

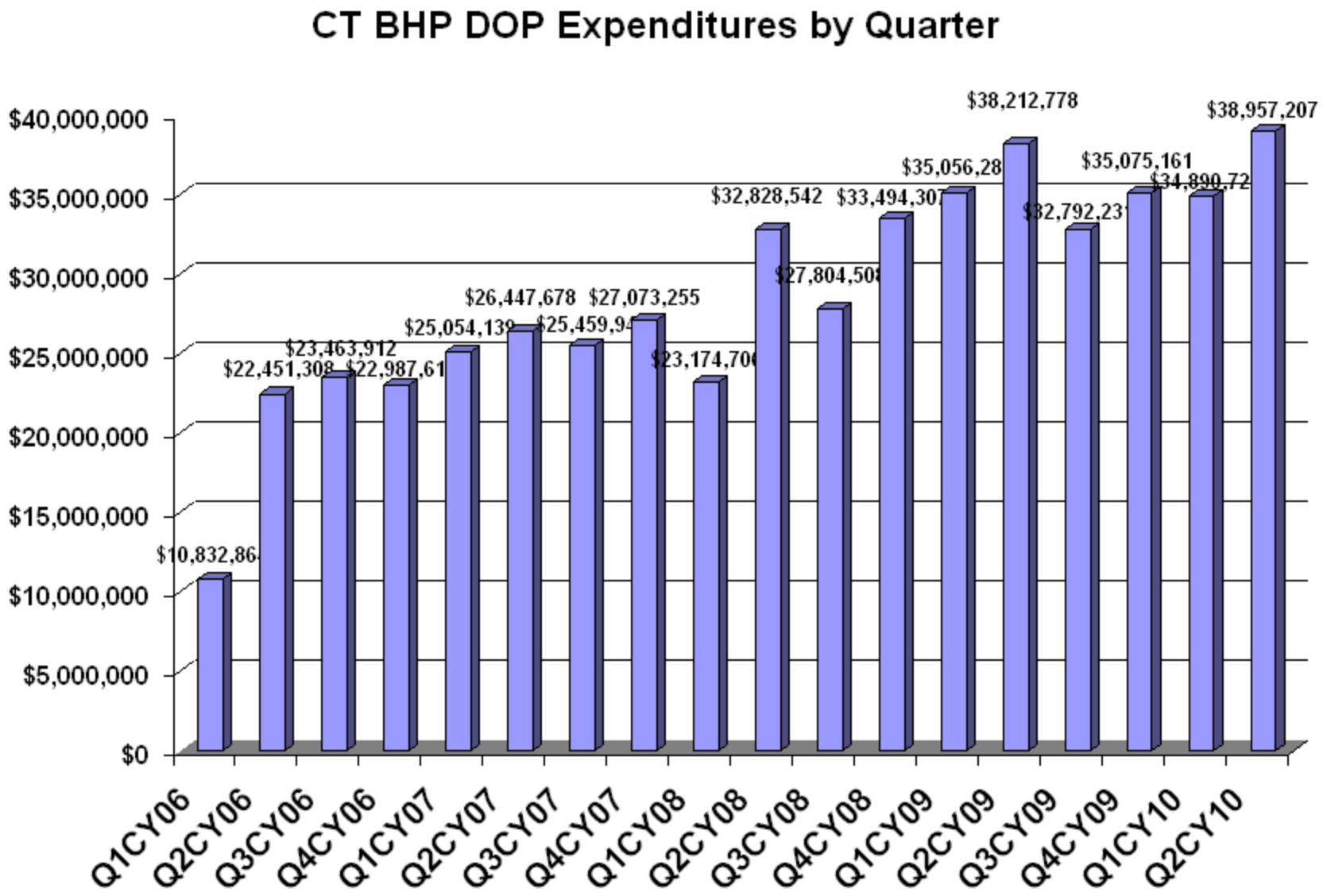
DSS Date of Payment (DOP) Expenditures

Annual CT BHP DOP Expenditures

by State Fiscal Year

	SFY06	SFY07	SFY08	SFY09	SFY10
HUSKY A	**$32,560,572**	**$94,563,848**	**$104,931,636**	**$130,578,440**	**$137,393,654**
HUSKY B	**$723,599**	**$3,389,493**	**$3,604,812**	**$3,989,433**	**$4,321,668**

Note: Does not include State Ops


CT BHP DOP Expenditures by Quarter
$40,000,000
$35,000,000
$30,000,000
$25,000,000
$20,000,000
$15,000,000
$10,000,000
$5,000,000
$0
$10,832,86
$22,451,308
$23,463,912
$22,987,61
$25,054,139
$26,447,678
$25,459,94
$27,073,255
$23,174,70
$32,828,542
$27,804,50
$33,494,307
$35,056,28
$38,212,778
$32,792,23
$35,075,161
$34,890,72
$38,957,207
Q1CY06
Q2CY06
Q3CY06
Q4CY06
Q1CY07
Q2CY07
Q3CY07
Q4CY07
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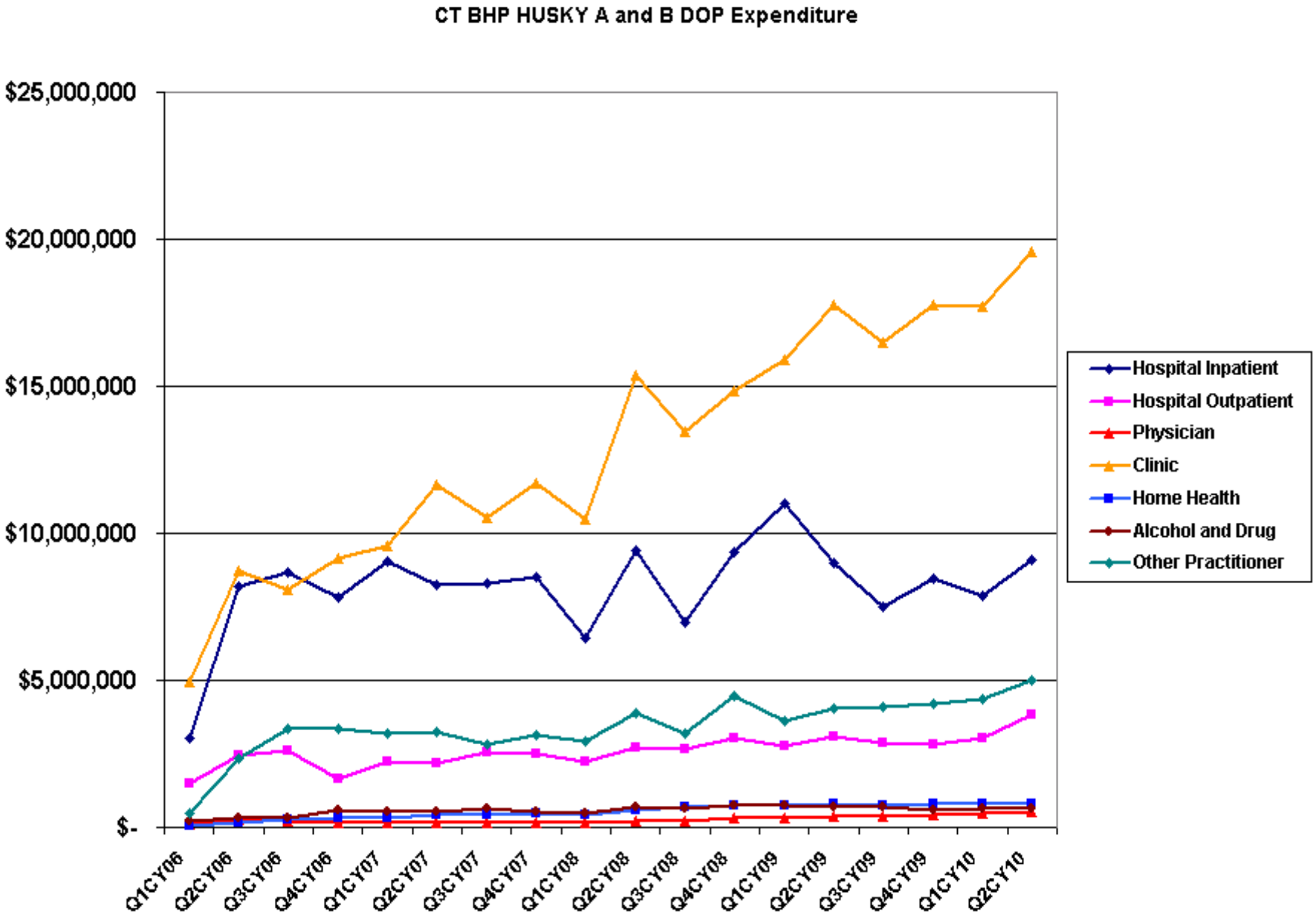
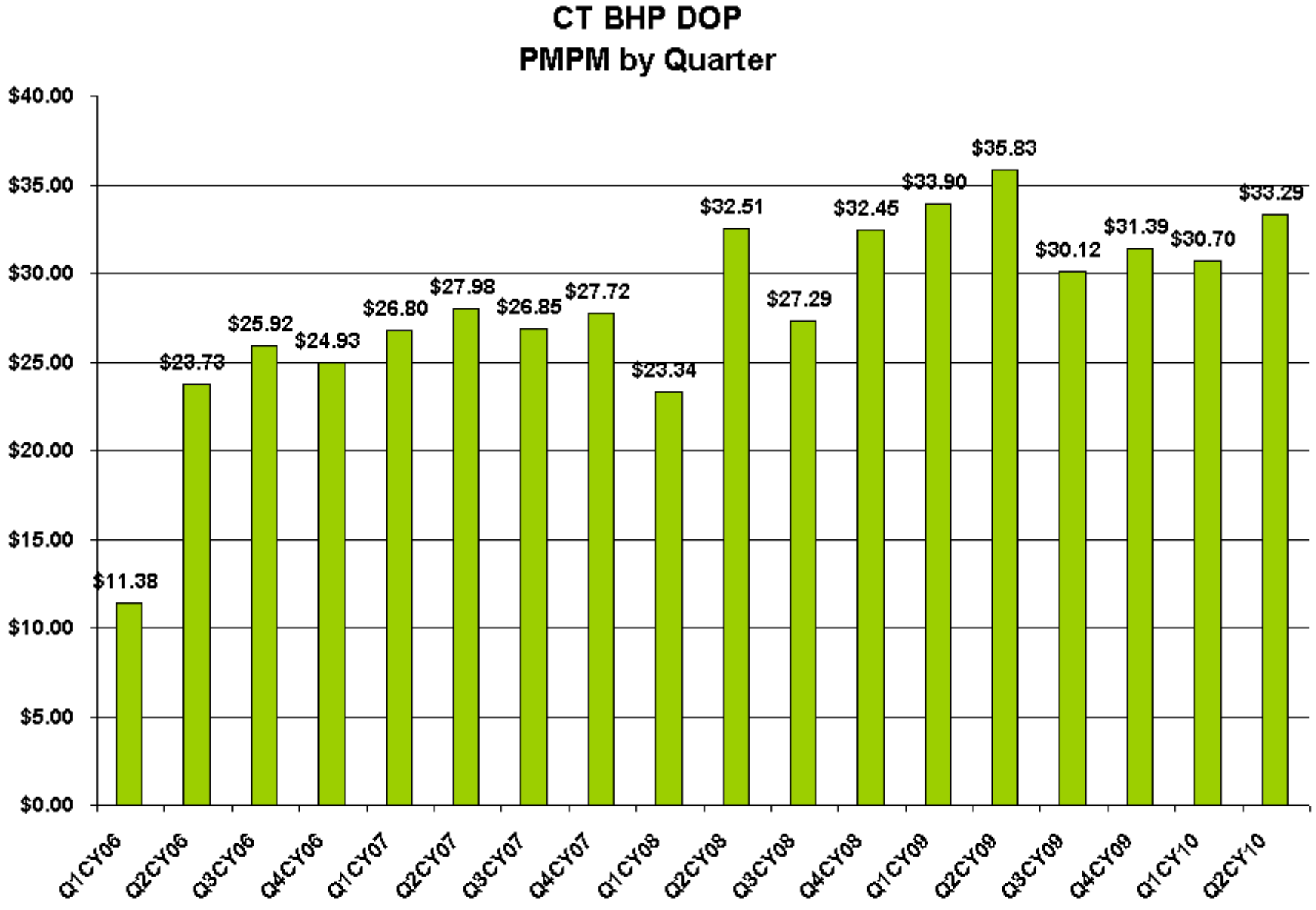
Q2CY09
Q3CY09
Q4CY09
Q1CY10
Q2CY10


CT BHP HUSKY A and B DOP Expenditure
$25,000,000
$20,000,000
$15,000,000
$10,000,000
$5,000,000
$-
Q1CY06
Q2CY06
Q3CY06
Q4CY06
Q1CY07
Q2CY07
Q3CY07
Q4CY07
Q1CY08
Q2CY08
Q3CY08
Q4CY08
Q1CY09
Q2CY09
Q3CY09
Q4CY09
Q1CY10
Q2CY10
Hospital Inpatient
Hospital Outpatient
Physician
Clinic
Home Health
Alcohol and Drug
Other Practitioner


CT BHP DOP
PMPM by Quarter
$40.00
$35.00
$30.00
$25.00
$20.00
$15.00
$10.00
$5.00
$0.00
$11.38
$23.73
$25.92
$24.93
$26.80
$27.98
$26.85
$27.72
$23.34
$32.51
$27.29
$32.45
$33.90
$35.83
$30.12
$31.39
$30.70
$33.29
Q1CY06
Q2CY06
Q3CY06
Q4CY06
Q1CY07
Q2CY07
Q3CY07
Q4CY07
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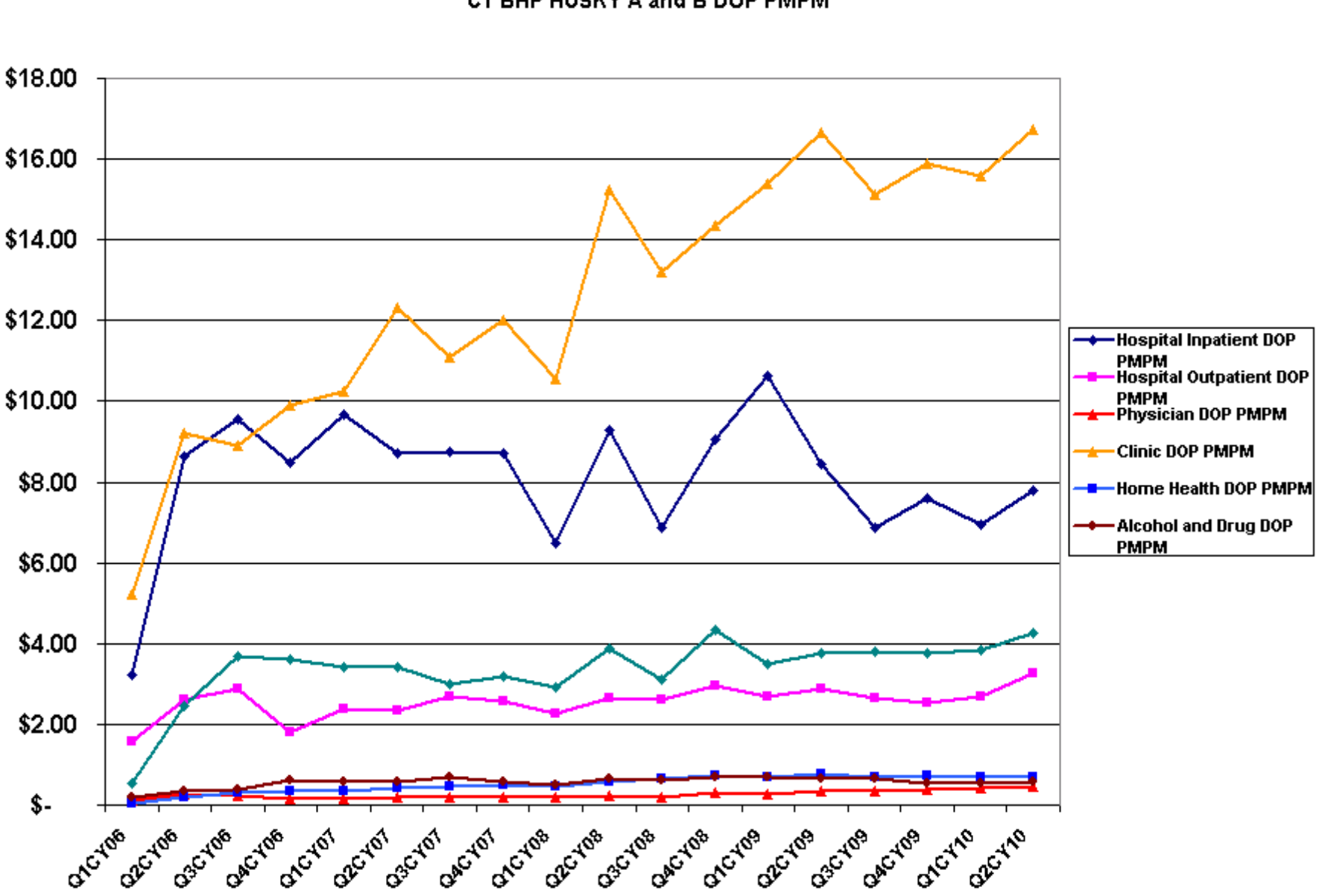
Q2CY09
Q3CY09
Q4CY09
Q1CY10
Q2CY10

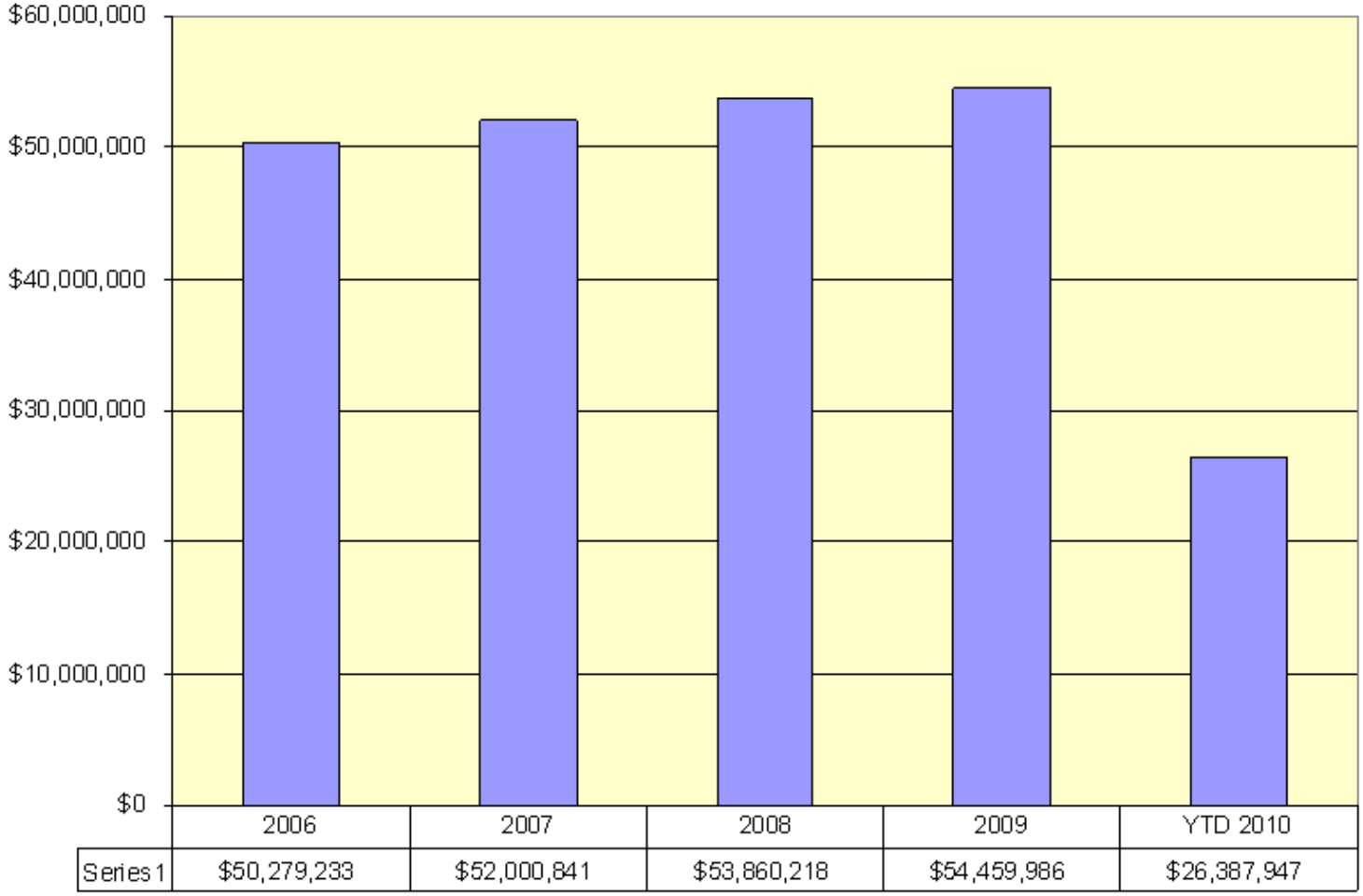

CT BHP HUSKY A and B DOP PMPM
$18.00
$16.00
$14.00
$12.00
$10.00
$8.00
$6.00
$4.00
$2.00
$-
Q1CY06
Q2CY06
Q3CY06
Q4CY06
Q1CY07
Q2CY07
Q3CY07
Q4CY07
Q1CY08
Q2CY08
Q3CY08
Q4CY08
Q1CY09
Q2CY09
Q3CY09
Q4CY09
Q1CY10
Q2CY10
Hospital Inpatient DOP PMPM
Hospital Outpatient DOP PMPM
Physician DOP PMPM
Clinic DOP PMPM
Home Health DOP PMPM
Alcohol and Drug DOP PMPM

DCF Expenditures through June 30, 2010

Community-Based Services

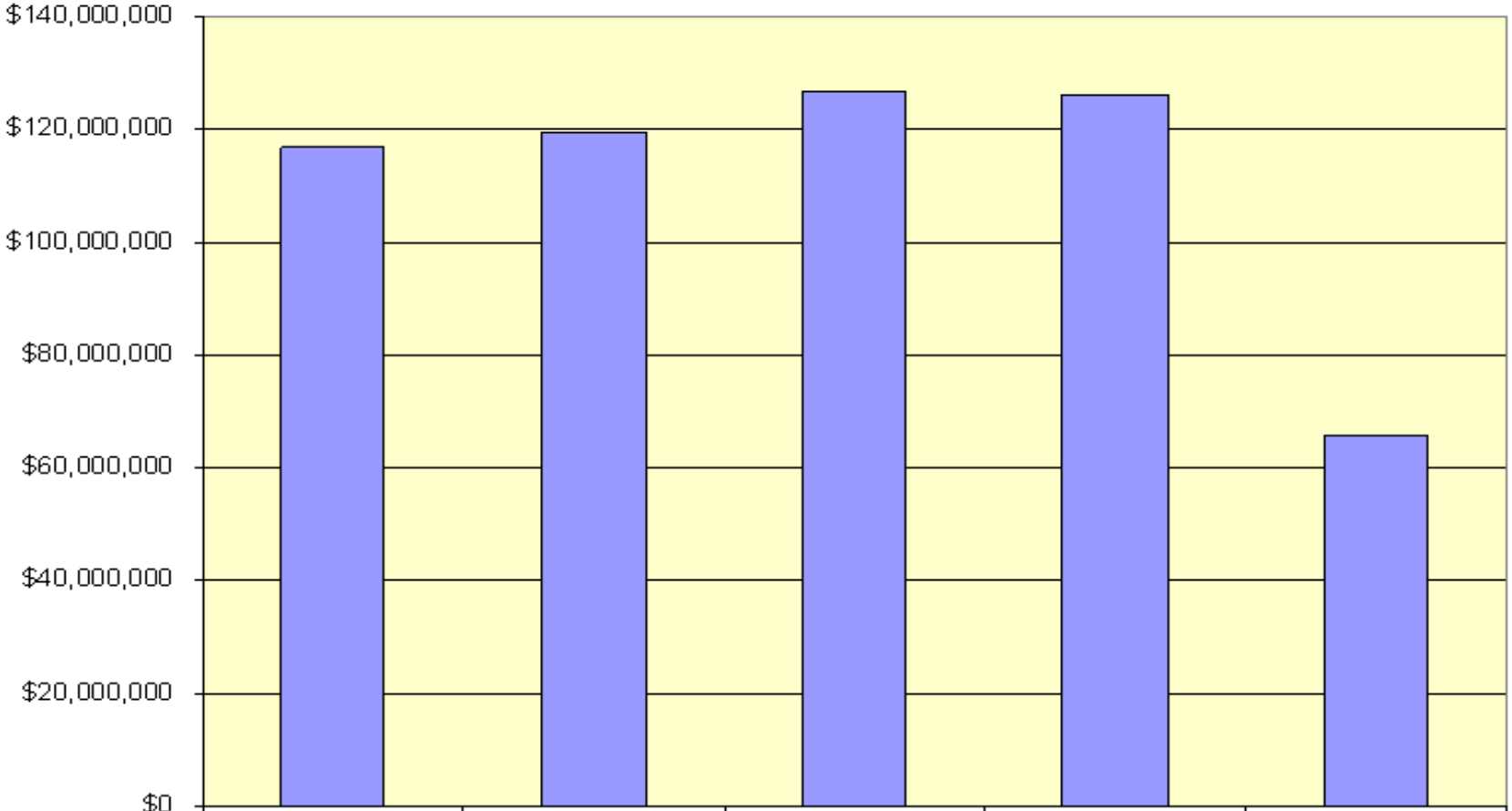
- Crisis Stabilization
- Care Coordination
- Emergency Mobile Psychiatric Services
- Extended Day Treatment
- Home-Based Services
- Child Guidance Clinics
- Outpatient Adolescent Substance Abuse

Annual Expenditures for Community-Based Services
Calendar Year thru June 30, 2010



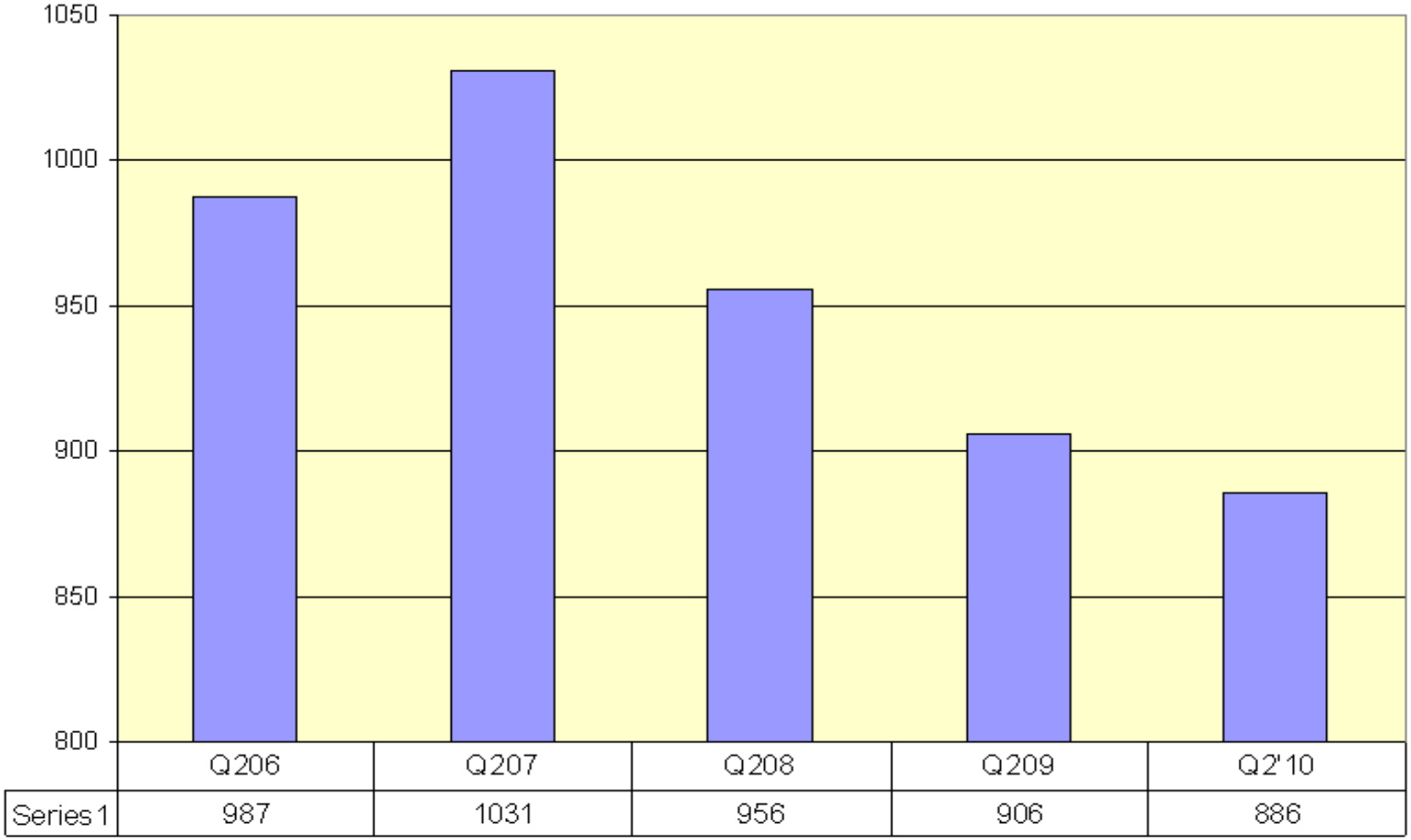
	2006	2007	2008	2009	YTD 2010
Series 1	$50,279,233	$52,000,841	$53,860,218	$54,459,986	$26,387,947

Combined Annual Expenditures - Residential and Therapeutic Group Home
Calendar Year thru June 30, 2010



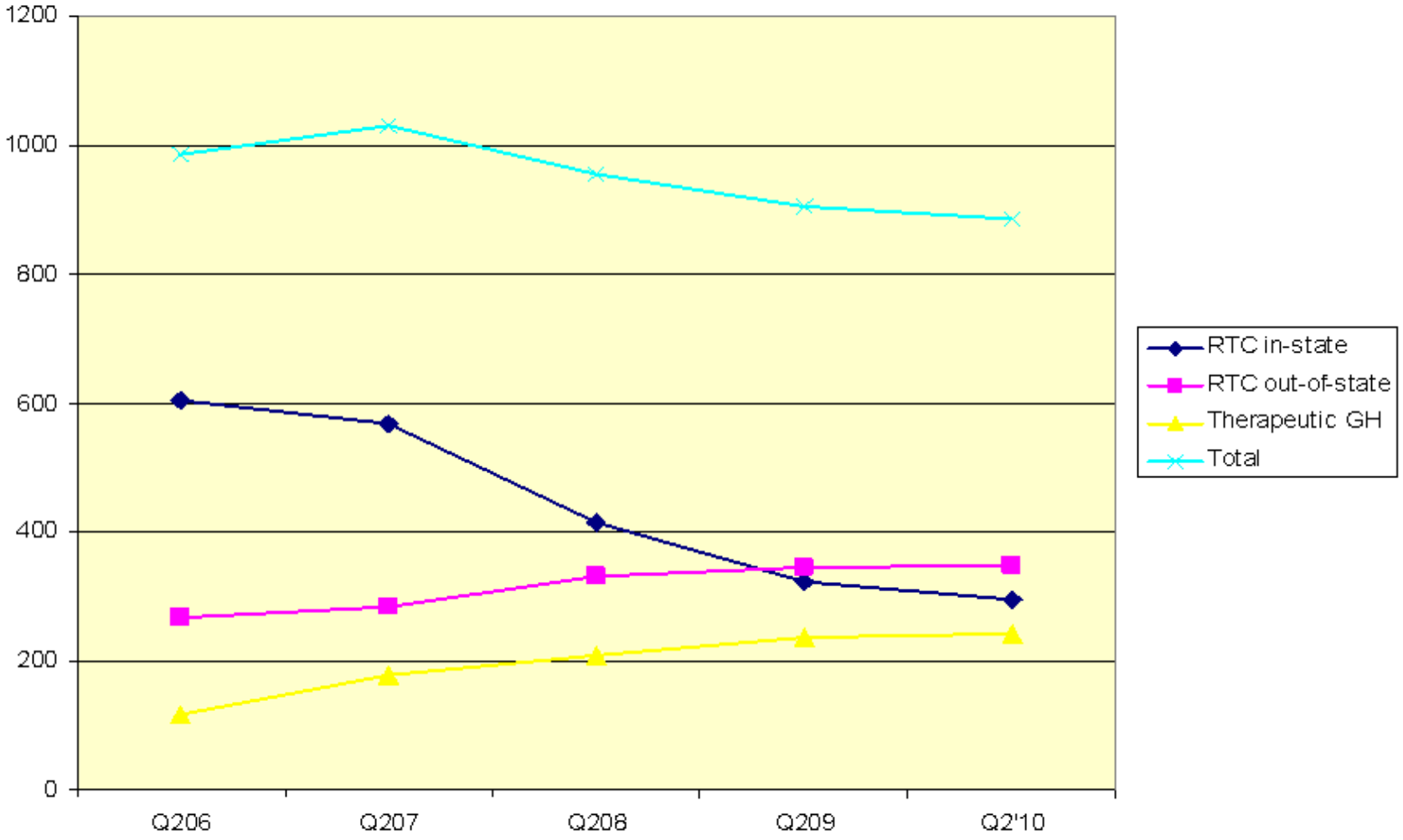
	2006	2007	2008	2009	YTD 2010
Series 1	$116,701,292	$119,421,513	$126,671,213	$126,295,135	$65,887,448

Number of Children in Residential and Therapeutic Group Home Placement
Point in time - last day of quarter of calendar year



	Q206	Q207	Q208	Q209	Q2'10
Series1	987	1031	956	906	886

Number of Children in Congregate Care: RTC & Therapeutic Group Home
Point in time - last day of quarter of calendar year



Lessons Learned

- Targeted attention to utilization and programmatic goals has continued to yield positive outcomes (i.e. reduced inpatient discharge delay, foster care disruption, decreased reliance on institutional care, increased use of community based care)
- PARS has proven to be effective vehicle to prompt system change and communicate positive change or areas for additional attention
- Transparency promotes trust, shared commitment, and creative problem solving
- Data has proven immensely valuable as a management tool

Opportunities for 2010

- Data should be made more readily available to inform and educate other constituents (i.e. consumers, DCF staff, legislators, etc.)
- Utilization management should be refined to decrease administrative burden to providers whose performance falls within acceptable standards of practice (i.e., bypass)
- Departments should continue to enhance outpatient care under ECC initiative through expansion to co-occurring capability and welcoming/engagement

Opportunities (cont.)

- Continued focus on ED utilization and diversion
- Continued focus on Residential system to better understand practice and enhance clinical outcomes