UTILIZATION MANAGEMENT FOR YOUTH MEMBERS

Executive Summary & Analysis by Level of Care

Calendar Year 2018: January-December 2018 - Submitted March 1, 2019

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Supporting Health and Recovery

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For any inquiries, comments, or questions related to the use of Tableau, or the interactive features within this report, please contact Elizabeth McOsker at elizabeth.mcosker@beaconhealthoptions.com.

A Beacon Health Options-CT Dashboard

Reports Used:

UTILIZATION REPORT FOR YOUTH MEMBERS

Calendar Year 2018: January-December 2018

General Overview

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

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

Within this interactive report, all utilization data is available via drop-down filters, but the narrative highlights the areas of interest related to certain utilization trends. In some cases, demographic breakouts are available to enhance the understanding of utilization. Additionally, the narrative identifies the underlying factors that drive the trends and associated programmatic responses taken by Beacon Health Options to impact, mitigate or support the trend. Beacon also presents recommendations to address remaining challenges and reports progress related to these recommendations. The areas of focus for this deliverable are listed on the following page.

Methodology

The data contained in this report are based on authorization admissions and are refreshed for each subsequent set of updates during the year. Due to changes in eligibility, the results for each quarter or year may change from the previously reported values. The reports and analyses for all levels of care are affected by this change. Please note that utilization metrics may change with the refresh of the data. Therefore, the reader should be cautious when interpreting the latest quarter of data. Beacon will monitor the post-refresh changes closely. If warranted, methodology will be revisited.

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

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

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

EXECUTIVE SUMMARY FOR YOUTH MEMBERS

Calendar Year 2018: January-December 2018

Total Membership

Since the change in eligibility criteria implemented in 2015, Connecticut Medicaid membership including duals has remained stable with a yearly change of no more than 1.5%. All members, including dually eligible members, decreased slightly from 2017 (from 975,577 to 975,346). However, all members without duals had an almost 1% increase from 2017, which was offset by a 6% decrease in members with duals. Adult members, including duals, continue to comprise 63% of the total Medicaid membership. The total youth membership has remained stable. In 2018, the youth population increased 0.3% to 357,525. Only six (6) youth members were dually eligible at any point in 2018.

Please see the accompanying Tableau dashboards to view graphical representations of the data presented here, as well as to use filters to segment the data in different ways.

Benefit/DCF Membership

The majority of youth Medicaid members in Connecticut continue to be part of the HUSKY A Family Single benefit group (341,005 members in 2018). The second largest benefit group for youth is HUSKY B (26,961 members). The adult HUSKY A population declined in 2018, but youth membership remained stable, suggesting that single male and female adults lost or left HUSKY A, but adults with children were largely unaffected by the decreases. The youth Medicaid membership has remained stable by age group—mostly 3-12 year olds (55.4%), followed by 13-17 year olds (25.9%) and 0-2 year olds (18.7%). Gender demographics have also been stable over the past four years, with slightly more male (51.5%) than female (48.9%) youth members.

Now more than one third of the youth Medicaid population (35.2%) is categorized as Unknown race/ethnicity.

As noted in the CY 2017 and Q1/Q2 2018 deliverables, changes to the ImpaCT system used to manage member eligibility have led to a significant increase in members identifying race/ethnicity as "Unknown." The group identified as Unknown continues to rise, up a further 13% from 2017. Now more than one third of the youth Medicaid population (35.2%) is categorized as Unknown race/ethnicity. Beacon's investigations have suggested that this is a true unknown, as members are not required to choose a race/ethnicity when applying for Medicaid. There are concerns that having such a large unknown category will hinder efforts at tracking utilization and outcomes, indicative of health disparities, as we cannot know if the unknowns are evenly distributed among racial and ethnic groups or if certain groups are more likely to opt out of responding. Beacon understands that the state partners share our concerns and are discussing potential solutions.

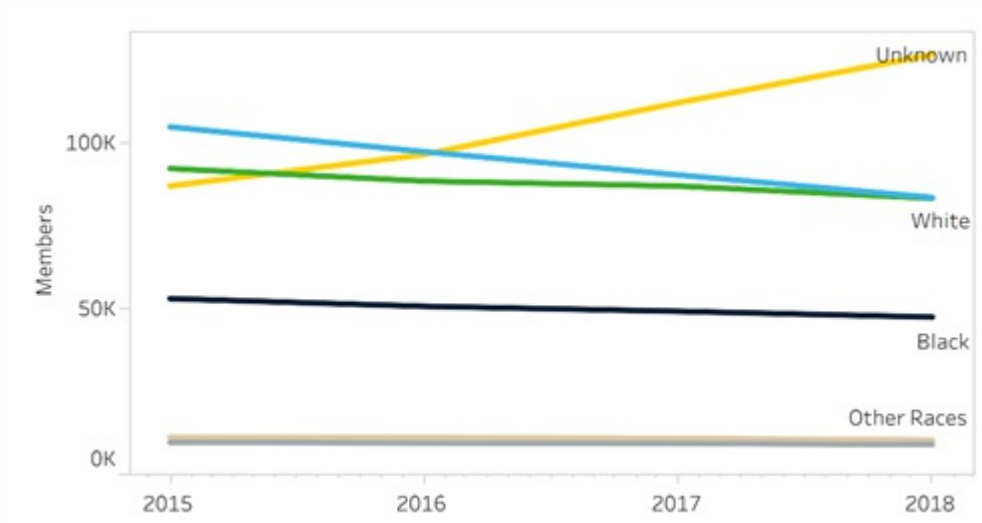

Figure 1: Youth Medicaid Membership by Race/Ethnicity, 2015-18

After Unknown, the next largest racial/ethnic groups are White (23.3% of youth members), Hispanic (23.2%), and Black (13.1%). Other races (2.8%) and Asian (2.4%) members continue to make up a small portion of the youth membership. All racial/ ethnic groups decreased in membership from 2017-18 with the exception of Unknown. While the large unknown population makes it difficult to compare the Medicaid population with Connecticut's overall population, Hispanic youth do appear to be overrepresented in the Medicaid population, at 16% of the total state population and at least 23% of the Medicaid youth population.[1]

"DCF-involvement" includes any youth who is involved with the Department of Children and Families through any of its mandates. This includes youth committed to DCF through child welfare or juvenile justice, and those dually committed. It also includes youth for whom the Department has no legal authority, but for whom DCF provides assistance through its Voluntary Services, Family with Service Needs and In-Home Child Welfare programs.

As reported in the two previous semi-annual deliverables, anomalies in the eligibility file related to DCF status were identified in 2017 and fixed as of January 1, 2018, so while comparisons cannot be made to 2017, DCF information can be reported for 2018. In 2018, 14,552 youth were identified as DCF-involved, about 2% higher than the number of youth identified in 2016. Approximately 2.4% of the youth Medicaid population is DCF-involved at any point in a given year.

[1] US Census Bureau (2018). "Quick Facts: Connecticut." Retrieved from census.gov/quickfacts/ct

In 2018, DCF-involved youth membership consisted of mainly 3-12 year olds with an even split between males and females. Unknown race/ethnicity had the highest membership, followed by White, Hispanic, and Black youth. Most DCF-involved youth were a part of In-Home Child Welfare, followed by Out-of-Home. Most DCF groups had similar gender, age, and racial/ethnic demographic breakdowns, with the exception of Juvenile Justice, which had 96 members in 2018, 99% of whom were 13-17 years old and 84% of whom were male. This breakdown is consistent with prior years. Given the recent contract changes and transfer of juvenile justice services from DCF to CSSD effective July 1, 2018, it is likely Beacon will see shifts in this DCF status in future semi-annuals. Beacon cannot be sure what the impact will be, but by the next semi-annual deliverable there should be a clearer indication if any changes in DCF status have occurred.

Inpatient Utilization (Excluding Solnit)

Medicaid youth utilize in-state and a few select out-of-state hospitals for inpatient psychiatric treatment. In 2018, there were approximately 120 total in-state pediatric acute psychiatric hospital beds available between six (6) hospitals (this excludes two non-acute hospitals: Albert J. Solnit Children's Center, also known as Solnit, and the Hospital for Special Care). Collectively, the in-state hospitals account for the vast majority of all discharges each year. Out-of-state inpatient utilization of psychiatric care takes place primarily at Four Winds Hospital, an in-network facility just over the Connecticut border in New York state.

Discharge volume for in-state inpatient psychiatric hospitals, excluding Solnit, has been fairly stable the past four years, decreasing by 3.3% to 2,422 discharges in 2018. The total in-state psychiatric bed capacity was reduced due to the closure of Prospect Waterbury's 6-bed adolescent unit on January 25, 2018. At the same time, there was a proportionate increase in volume of admissions to Four Winds Hospital, so the entire 3.3% decrease in utilization cannot be attributed to the reduction in in-state beds.

The average length of stay (ALOS) for all in-state inpatient psychiatric discharges, excluding Solnit, had a slight increase of 0.3 days to 12.5 days in 2018. The increase in the total ALOS is attributed to an overall increase in average delayed days, which increased from 22.6 days in 2017 to 28 days in 2018. (Analysis of the discharge delay data is reviewed later in this document). Although 13-17 year olds had more discharges (67.9%) than 3-12 year olds (32.1%), the ALOS for 3-12 year olds is higher (13.1 days) than for 13-17 year olds (12.2 days). Youth 3-12 years old have fewer post-discharge service options, and there was a reduction in PRTF capacity in 2018. These system realities are significant factors in the increased ALOS for youth.

Females had more discharges (53.8%) than males (46.2%), but males had almost a two-day longer ALOS (13.5 days vs. 11.7 days for females). This variance is expected, as 3-12 year olds have a longer ALOS and males comprised 59.4% of the inpatient discharges for 3-12 year-olds, but only 40% of the adolescent discharges in 2018. Adolescent males also had a two-day longer ALOS than females.

Most racial and ethnic groups had slight decreases in inpatient admissions in 2018. White youth continued to have the most discharges (33.2%), followed by the Unknown group (24.8%) and Hispanic youth (22.5%). Black youth had the highest ALOS of all racial and ethnic groups, up a day from 2017 to 13.7 days, while the other racial and ethnic groups had an ALOS between 9.8 (Asian) and 12.6 days (all other races/ethnicities).

In-state inpatient discharges for non-DCF-involved youth increased 4.3% from 2016[2] to a total of 1,998 in 2018, while discharges for DCF-involved youth decreased 19.2% from 2016 to 424 discharges in 2018.[3] Despite this shift, DCF-involved youth still have a disproportionate volume of inpatient stays, as they constitute around 2.4% of the youth population and had 17.5% of the youth inpatient discharges in 2018. DCF-involved youth also have a longer ALOS than non-DCF-involved youth. The ALOS for DCF-involved youth increased 2 days from 14.1 days in 2016 to 16.1 days in 2018, while the ALOS for non- DCF-involved youth increased only slightly from 11.3 days in 2016 to 11.7 days in 2018. The disproportionate use of inpatient services and longer lengths of stay for DCF-involved youth is an ongoing trend and a well-documented phenomenon.[4]

Most Connecticut youth Medicaid members access inpatient psychiatric treatment at one of Connecticut's in-state acute facilities. Currently there are six (6) main pediatric hospitals that treat youth for psychiatric disorders (PAR providers); however, older youth may receive their treatment on an adult unit, which is also included in the in-state data. In 2018, 70% of discharges from PAR providers occurred at the three largest in-state hospitals: Yale New Haven Hospital (790 discharges), Natchaug Hospital (525 discharges), and Hartford Hospital (314 discharges).

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[2] Due to aforementioned anomalies in DCF-status indicators for 2017, comparisons of 2018 with prior years must also exclude 2017 data.
[3] "DCF-involvement" includes any youth who is involved with the Department of Children and Families through any of its mandates. This includes youth committed to DCF through child welfare or juvenile justice, and those dually committed. It also includes youth for whom the Department has no legal authority, but for whom DCF provides assistance through its Voluntary Services, Family with Service Needs and In-Home Child Welfare programs.
[4] Connell et al (2019). "Caseworker assessment of child risk functioning and their relation to service use in the child welfare system." Children and Youth Services Review 99 : 81-86. doi 10/1016/j.childyouth.2019.01.027

	2015	2016	2017	2018
HARTFORD HOSPITAL	428	356	406	314
NATCHAUG HOSPITAL INC	439	476	465	525
PROSPECT MANCHESTERHOSP INC	113	123	138	133
ST FRANCIS HOSPITAL& MEDICAL CTR	272	289	325	260
ST VINCENTS MEDICALCENTER	326	339	279	302
YALE NEW HAVEN HOSPITAL	790	777	774	790
Provider Total	2,368	2,360	2,387	2,324

Figure 2: Inpatient Discharges from PAR Hospitals, 2015-18

In-state PAR providers had an ALOS of 12 days in 2018. Hartford Hospital was the only PAR provider with an ALOS higher than the statewide average; their ALOS increased 3.5 days to 16.6 days in 2018. Discharges were likewise down nearly 100 members (22.7%) at Hartford Hospital, likely a direct consequence of longer lengths of stay and reduced bed turnover. St. Francis Hospital also had a large drop in discharges (down 65, or 20%) and a two-day increase in ALOS from 9.8 to 11.9 days.

Hartford Hospital and St. Francis identified many factors influencing length of stay, including the increased wait for PRTF and Solnit Inpatient, increased acuity of youth, internal staffing changes, and limited discharge options for youth under 12 years old. Additionally, with the realignment of hospital systems, there have been increased efforts to centralize admissions across hospitals within a system. This appears to be impacting both St. Francis and the IOL, with both hospitals experiencing an increase in admissions for youth outside of the Hartford Region in CY 2018. It is possible that the change in population could be impacting ALOS since the hospital may be less familiar with resources outside the region. Beacon will continue to offer support in connecting to resources at both the member level (ICM) and provider level (RNM). The only PAR provider with a large decrease in ALOS from 2017 to 2018 was Natchaug Hospital, which dropped nearly two days from 13.6 to 11.9 days. Natchaug has been participating in a pay-for-performance initiative related to reducing ALOS, which may be an important factor in their reduction.

Out-of-state discharge volume has increased since 2016, including a 31.6% increase from 2017 to 2018. In 2018, there were 275 youth discharges from out-of-state inpatient psychiatric facilities. Nearly 80% of out-of-state discharges were from Four Winds Hospital, and the increase of discharges at Four Winds accounts for the entire increase in out-of-state discharges. Four Winds Hospital has made up for the loss of youth inpatient beds in Western Connecticut; this facility also acts as a safety valve when youth are unable to access inpatient beds in-state.

The ALOS at Four Winds (15.3 days) remains higher than the in-state PAR ALOS of 12 days, which may be partly explained by Four Winds accepting Connecticut youth who were "stuck" in other levels of care awaiting inpatient. Along with an increase in CT youth admitted to Four Winds, more focused UM time has been spent with the facility to assure that services are timely and clinically appropriate. As a result, Four Winds' ALOS for Connecticut youth decreased by 2.5 days from 2017 to 2018. Four Winds also has a 7-day readmission rate (1.9%) that is lower than the CT state average 7-day readmission rate of 2.7%.

Recommendation 1: Continue to Monitor ED Overstay and Subsequent Out of State Placement
Beacon continues to monitor youth in ED overstay status and the use of out-of-state hospitals. Beacon ICMs continue to outreach to Emergency Departments daily and involve Peers and/or Care Coordinators as indicated. Beacon met with Four Winds Hospital, the largest volume in-network but out-of-state provider, in Q3 '18. The meeting focused on ways Beacon could further support Four Winds in identifying creative ways to engage with parents or guardians to gain approval for medication changes when travel distance was a barrier to onsite family sessions. Beacon shared resources available through the ICM program and the CT BHP website to assist in identifying providers in the local communities in which the youth would return in order to support connections to care post discharge. Beacon provided the facility staff with updated contact information for the Child ICMs, ASD and DCF Area Office Program Directors. Four Winds provided information regarding the cottages on campus and admission protocols to support clinical and milieu needs. Four Winds reported a total of 150 child and adolescent IP beds and a willingness to continue to accept CT youth with ongoing support and collaboration from Beacon and DCF on clinically complex youth. Four Winds also shared that they experienced a turnover in their clinical staff that impacted completion of discharge forms and bed tracking. Four Winds committed to improving the frequency and timely submission of both forms and in fact, demonstrated improvement in Q4 '18.

Recommendation 2: Continue Pediatric Inpatient PAR Program
Regional Network Managers continued to hold PAR meetings with the child and adolescent hospitals during CY 2018 with a concentrated focus on Average Length of Stay (ALOS) and discharge delay. Embedded within these discussions was the identification of systemic barriers and the review of best practices to improve outcomes pertaining to these identified metrics.

There was a slight increase in the ALOS for PAR hospitals, from 11.6 days in 2017 to 12.0 days in 2018. The primary driver of the increase was youth on discharge delay. The ALOS for youth not on delay remained relatively stable from CY 2017 to CY 2018 (10 days to 10.1 days), while the ALOS for youth on discharge delay increased by 5.6 days from 46.2 days in CY 2017 to 51.8 days in CY 2018.

Given the systemic realities outlined in the discharge delay section below, PAR discussions included an increased emphasis on concurrent planning and referrals to community based services, when appropriate, as diversion from limited PRTF or state hospital resources. Additionally, Beacon continued to promote active treatment of youth on an inpatient unit while on delay status, including an emphasis on family involvement and efforts to continue to stabilize the youth while awaiting the next recommended service. Newly added PAR meetings at Four Winds appeared to contribute to favorable outcomes related to a reduction in ALOS. This is attributed to the improved communication and collaboration across behavioral health systems, particularly for regions 1 and 5. As a result, the increase in discharge volume has improved access.

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Regional Network Managers also continued to promote the adoption of standardized substance abuse screening for youth while on an inpatient stay. The emphasis has been on improving screening and processes, including promotion of the Assert Treatment Model (ATM) for youth with opioid use disorders.

Recommendation 3: Modify Youth Inpatient Bypass Program

Beacon continues to offer a Youth Inpatient Bypass Program and we continue to measure Bypass status based on ALOS (≤ 12.0), 7-day readmission rates (≤ 5%) and discharge form completion rate (90% form completion within 2 business days). In Q3 & Q4 '18 Beacon made significant progress towards an IPF PAR case-mix predictive model. Through multiple stakeholder input, Beacon utilized a number of different episode-level demographic, social determinant, utilization, expenditure, diagnosis, and severity variables with calendar year discharge dates 2016-2017 to predict total length of stay. Two final separate predictive models were developed for children (<18 years of age) and adults (18+ years of age). The predictive model used data from the PAR reports, authorizations, and claims to provide a comprehensive dataset. In operationalizing the variables of interest (i.e., predictors) new methodologies were created in order to fully capture possible predictors of length of stay. Beacon trained, validated, and tested the predictive models for both youth and adults. Several different predictive models were explored and assessed for possible inclusion, however, a backward elimination multiple linear regression was selected as the final predictive model with strong fit statistics.

Through multiple stakeholder inputs, Beacon utilized a number of different episode-level demographic, social determinant, utilization, expenditure, diagnosis, and severity variables with calendar year discharge dates 2016-2017 to predict total length of stay.

Results of the predictive model were presented to the State Partners during the November 29, 2018 Core Executive Meeting. Additional State Partner and Provider Workgroup meetings will be held in Q1 and Q2 of 2019 to review how the predictive model applies to Q1 to Q3 2018 IPF PAR discharges at the provider level. Furthermore, the impact of the new bypass metrics and point system will be reviewed with stakeholders in upcoming workgroup meetings. We look forward to implementing this enhancement in Q3 of 2019.

Significant Predictor	Categories
Age Category	• 0-12 • 13-17
DCF Involvement	• DCF-involved • Non-DCF-involved
Discharge Delay Reason	• Awaiting Group Home • Awaiting PRTF • Awaiting Residential Treatment Center • Awaiting Solnit PRTF • Awaiting State Hospital • Awaiting Other • None
Total Claims Cost for Primary Diagnosis in prior 12-months (CCS Categories)	• Anxiety Disorders • Conduct Disorders • Disorders from Infancy • Mood Disorders • Psychosis

Figure 3: Significant Predictor Variables for Pediatric IPF PAR Case-Mix Predictive Model

Inpatient Discharge Delay

Youth on an inpatient unit who are unable to discharge, despite being ready to discharge to the next appropriate level of care are considered delayed. If a youth on delay, discharges in the calendar year, they are classified as a "discharge," while any youth on delay during a year, regardless of whether they discharged, is considered a "case." [5] Beacon works closely with hospitals and community providers to ensure youth can access appropriate services as soon as they are clinically ready to do so. Despite ongoing attention and collaboration with providers, system changes have affected the discharge delay measure in recent years.

[5] Note: for the Discharge Delay section only, Beacon is reporting rates for 0-18 year olds instead of 0-17 year olds. Since Discharge Delay is a Performance Target, we wanted the methodology used in the Semi-Annual reports to match the methodology used in the Discharge Delay reports. Users can view rates and counts for 0-17 year olds only by unchecking the "18" box in the "Age Group" filter on Tableau.

The annual volume of all delayed discharges for youth ages 0-18 on acute inpatient psychiatric units, excluding Solnit and the Hospital for Special Care, decreased by 4% to 120 discharges in 2018. However, the Average Delayed Days increased by 5.4 days to 28 days. There were 3,363 delay days in 2018, which is the highest amount since at least 2015. Delayed cases also decreased by 2.3% to a total of 128 in 2018. At the end of 2018 there were more delayed cases than discharges, thus eight (8) cases remained on discharge delay at the start of 2019. Six (6) of those delayed cases were waiting for Solnit inpatient, one (1) was waiting for Community PRTF, and one (1) was waiting for a Residential Treatment Center/Group Home.

The overall percent of days delayed out of the total inpatient days for youth (cases) age 0-18 in any psychiatric facility (excluding Solnit and the Hospital for Special Care) increased from 7.3% in 2017 to 9.7% in 2018. In 2018, three of the four quarters did not meet the target of 9.5% or fewer days delayed. Q1, Q2, and Q3 were all above the target at 9.9%, 11.3%, and 9.9%, respectively. In Q4 '18, the target was met, with 7.8% of days delayed; however, for 2018 as a whole, the target was still not met. As anticipated in the previous semi-annual deliverable, the annual percent of discharge delay days was higher than previous years due to significant changes in system capacity. In Q1 '18 there was a clinical/administrative decision at Solnit North PRTF to reduce capacity by four beds due to the significant acuity on the unit. As a result, the four youth awaiting these beds remained on discharge delay status in a hospital setting until beds became available. Of these four beds, two came back on line in May. This created a magnification of discharge delay days at a time when we historically experience the highest rates of discharge delay across the system.

In the 2nd Quarter of 2018 we were informed that Boys and Girls Village would be slowing admissions to their PRTF in anticipation of program closure on 10/1/18. The decrease in admissions to Boys and Girls Village resulted in a total loss of 16 beds. Admissions to Solnit IPF decreased at this same time due to staffing and refurbishing issues. Over the course of the 2nd and 3rd Quarters of 2018, we lost access to 8-12 beds at the Solnit South PRTF due to refurbishing/staffing issues. In total, we lost 23.36% of our total PRTF capacity over this period of time. The bed capacity has increased slightly as The Village for Families and Children opened three additional beds in December 2018 with plans to increase another nine beds over the next six months. These efforts will provide 12 beds to replace those lost by the closing of Boys and Girls Village in October of 2018. The total loss of beds over time will be at four (4) for the PRTF level of care. Beacon, in collaboration with the state partners, continues to identify alternative programming, payment structures, and incentives to support the provider network to increase system capacity to support the clinical needs of our youth.

Similar to previous years, 70% (84 discharges) of the delayed discharges in 2018 were adolescents ages 13-17. Of the delayed adolescents, 57.1% (48 discharges) were waiting for Solnit Inpatient and 29.8% (25 discharges) were waiting for Solnit PRTF. In 2018, more female adolescents (56.3%) were awaiting Solnit Inpatient than males (43.8%). The average wait for Solnit Inpatient was 36.4 days, which increased almost 10 days from 2017 (26.7 days). All but five (84.8%) of the 33 delayed discharges for ages 0-12 were waiting for Community PRTF. Three were awaiting Solnit Inpatient and two were awaiting other services.

Of the delayed adolescents, 57.1% (48 discharges) were waiting for Solnit Inpatient and 29.8% (25 discharges) were waiting for Solnit PRTF.

The percentage of youth (0-17 years of age) awaiting both Solnit PRTF (21.4%) and Community PRTF (26.5%) increased in 2018. Additionally, the average wait for Solnit PRTF also increased, from 16 days in 2017 to 25 days in 2018. The average wait for Community PRTF increased, but not as dramatically as for Solnit PRTF, rising 4 days from 15 days in 2017 to 19 days in 2018.

Notably, the percent of youth awaiting a Residential Treatment Center/Group Home (RTC/GH) dropped from 11.3% in 2017 to 5.1% in 2018. The average delay days waiting for RTC/GH also dropped in the past year from 31 to 10 days. Possible explanations for the decrease in wait to access RTC/GHs include increased utilization of Short-Term Family Integrated Treatment programs (S-FITs) and the collaboration between Beacon staff and providers to refer youth to appropriate community-based services where they can be supported successfully in their communities.

Additionally, Beacon recommends the creation of an eight (8) bed PRTF program for females ages 10-14 with an evidence-based trauma treatment model that has a proven track-record of success with a 10-14 year old population in a congregate care setting.

Recommendation 4: Increase PRTF capacity

In 2018, Community PRTF capacity was reduced from 48 beds to 32 following the closing of Boys and Girls Village PRTF in October 2018. Beacon, in collaboration with DCF, met with The Village PRTF leadership to discuss opportunities for expansion. The Village reported an ability to increase bed capacity and have committed to adding an additional 12 beds over time. Currently The Village PRTF has added six (6) of the additional 12 beds and is currently at a census of 22 youth.

Additionally, Beacon recommends the creation of an eight (8) bed PRTF program for females ages 10-14 with an evidence-based trauma treatment model that has a proven track-record of success with a 10-14 year old population in a congregate care setting. The program should include a strong emphasis on family involvement throughout the episode of care.

Solnit Inpatient Utilization

In 2018, discharges from Solnit Inpatient remained steady at 118, while the ALOS increased almost two weeks to 142.7 days. Solnit reduced intakes in 2018, but beds are available for short-term stays, which may explain how the discharges remained steady despite a large increase in ALOS.

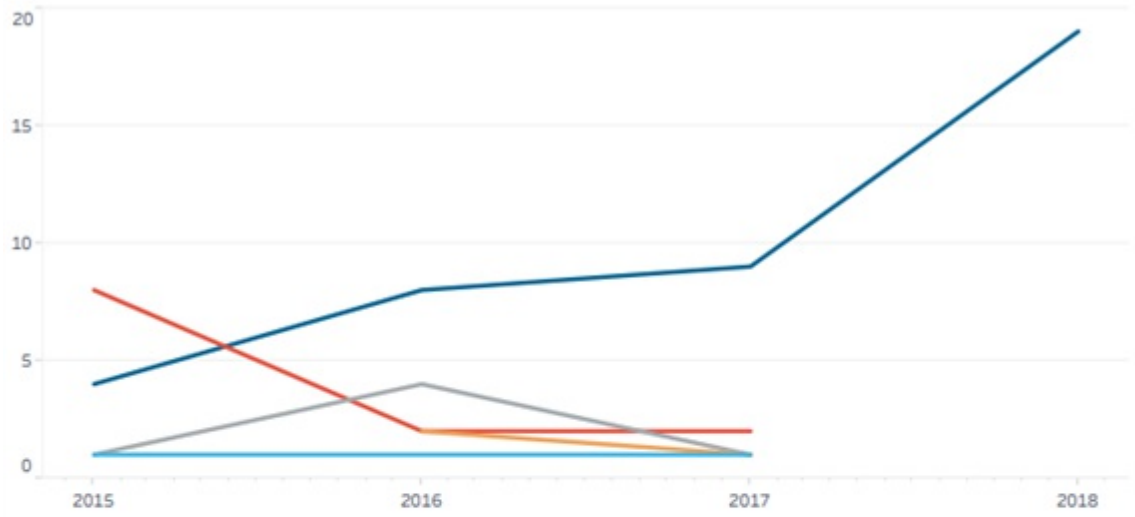
Males and females were more equally represented in discharges in 2018 than in previous years, due to a decrease in discharges for females and an equivalent increase for males. Females still had slightly more discharges (65 discharges/55.1%) than males (53 discharges/44.9%). Among racial and ethnic groups, youth identified as Black, Unknown, or Other Races had increased discharges in 2018, while White and Hispanic youth had decreased discharges. Unknown was the largest represented group (34 discharges/28.8%), followed by Black youth (30 discharges/25.4%). Black youth had the longest average stays in 2018, as ALOS rose 29% to 160.2 days. Discharges for white youth decreased 32% to 23 discharges (19.5% of the total), but the overall White youth population only decreased by 7.7% in 2018, so the decrease in White discharges cannot be explained by demographic changes alone.

Despite being 2.4% of the total youth population, DCF-involved youth had more discharges (60/50.8%) than non-DCF youth (58/49.2%) from Solnit Inpatient in 2018.[6] The ALOS for both DCF-involved and non-DCF-involved youth has increased from 2016 (the last year for which DCF data is interpretable), and both groups had an ALOS of 142.7 days in 2018.

Solnit Inpatient Discharge Delay

In the previous semi-annual deliverable, Beacon indicated concern that CY 2018 had the potential to have the highest number of delayed youth from Solnit Inpatient over the past four years. This concern was founded, as 2018 saw the highest four-year number of both delayed discharges and cases. In 2016, there were 16 discharges and 19 cases delayed. This decreased slightly in CY 2017 to 14 discharges and 19 cases that were delayed. In 2018, there were 19 discharges and 20 cases delayed.

All of the 19 youth (10 males and 9 females) on delay in 2018 were waiting for congregate care—16 for residential treatment (RTC) and three (3) for therapeutic group homes (GH). This has been the only delayed reason for the past six (6) quarters. The average days a youth waits for an RTC or GH increased from 61.7 days in 2017 to 68.2 days in 2018. Also, the total delay days reached a 4-year high of 1,296 days in 2018. However, the acute ALOS also increased about 10 days from approximately 122 days in 2017 to approximately 132 days in 2018.[7] Since the overall ALOS at Solnit Inpatient increased 13.6 days in 2018, and about 10 of those days were for acute stays, only about 3.5 days of the ALOS increase can be attributed to delays.



	2015	2016	2017	2018
Awaiting Other	8	2	2	
Awaiting PRTF	1	4	1	
Awaiting RTC/GH	4	8	9	19
Awaiting Solnit PRTF		2	1	
Awaiting State Hospital	1		1	
Total	14	16	14	19

Figure 4: Solnit IPF Discharge Delay Reasons, 2015-18

Recommendation 5: Begin to Hold PAR Meetings with Solnit Inpatient

During CY 2018, Beacon and the State Partners mutually agreed to begin holding PAR meetings with Solnit Inpatient. A tableau dashboard was created specifically for Solnit Inpatient that includes data on discharges, length of stay, discharge delay, and readmission rates. The draft PAR dashboard was reviewed with DSS and DCF in the September Child Operations meeting, and many of the suggestions from that meeting were incorporated into the final version of the dashboard.

[6] "DCF-involvement" includes any youth who is involved with the Department of Children and Families through any of its mandates. This includes youth committed to DCF through child welfare or juvenile justice, and those dually committed. It also includes youth for whom the Department has no legal authority, but for whom DCF provides assistance through its Voluntary Services, Family with Service Needs and In-Home Child Welfare programs.

[7] Note: this data comes from the IPF Pediatric PAR dashboard. The data feeding this dashboard is updated weekly, and data updates may impact prior quarters' numbers as well, so any numbers reported from the PAR dashboard in this deliverable may differ slightly from the numbers currently shown on the PAR dashboard.

The first PAR meeting was held with the Solnit leadership team in November 2018. The focus of the PAR meeting was introducing the PAR measures, including ALOS, discharge delay, and readmissions. The main challenge identified in terms of discharge delay was timely access to residential treatment, as 11 of the 14 youth on delay in Q1 through Q3 '18 were awaiting RTC. Additionally, much of the discussion focused on the coordination of care between Solnit Inpatient and Solnit PRTF, as the readmission data showed a high number of youth readmitting to the hospital from the PRTF. Moving forward, PAR meetings for Solnit will continue to be combined to include the PRTF and Hospital.

Moving forward, PAR meetings for Solnit will continue to be combined to include the PRTF and Hospital.

Psychiatric Residential Treatment Facility (PRTF) Utilization—Community and Solnit

At the beginning of 2018, there were three (3) Community PRTF providers in Connecticut with a licensed bed capacity of 48 (individual providers' capacity was 16 beds apiece). In October, the Boys & Girls Village closed their PRTF facility, transferring all remaining youth. The Village for Families and Children added six (6) of the planned 12 additional beds, which results in a total net loss of 10 Community PRTF beds in 2018. Solnit PRTF is a state-run PRTF facility for adolescents ages 13-17 and has two locations in Connecticut—one that treats males (Solnit North) and one for females (Solnit South). Due to member and milieu acuity, unit capacities on both campuses were temporarily reduced throughout calendar year 2018. In 2019 we anticipate continued reduction in census at Solnit South PRTF due to required building renovations.

There were 196 total discharges from all PRTF providers in 2018, a slight increase from 192 in 2017. Meanwhile, the ALOS rose seven (7) days to 171.5 days in 2018. Eighty-four (84) discharges (42.9%) came from the three Community PRTF providers, while 112 discharges (57.1%) came from Solnit PRTF. The ALOS for Community providers was longer, at 199 days, than for Solnit (150.8 days). There were 15 discharges (17.6%) from Community PRTF providers with long lengths of stay (ranging from 303 to 572 days, which may help explain the 12% increase in ALOS at Community providers.

Community providers serve mostly 3-12 year olds, who accounted for 39.8% of all PRTF discharges in 2018. Solnit PRTF serves mostly 13-17 year olds, who comprised 60.2% of PRTF discharges in 2018. More males (59.2%) than females (40.8%) discharged from PRTFs, although the gender gap did narrow in 2018. Male youth also have a longer ALOS (182.6 days) than females (155.4 days), even though the ALOS increased for females in 2018 while remaining flat for males.

Overall, White youth were the largest racial and ethnic group with 35.2% of the PRTF discharges in 2018. White members are disproportionally overrepresented in PRTF utilization, as White youth comprise 23% of the Medicaid youth population. The unknown race/ethnicity (24%), Hispanic (22%), and Black (16%) groups made up most of the remaining discharges. Black youth are disproportionally overrepresented in Community PRTF, where they comprise 23% of discharges but only 13% of the total Medicaid youth population. Black youth were slightly disproportionally underrepresented (10.7%) in Solnit PRTF, so it is worth noting that as the Black youth population that is currently 3-12 years old and utilizing community PRTF ages into adolescent services, Solnit PRTF may see an increase in cases among Black youths.

While representing 2.4% of the youth Medicaid population, DCF-involved youth accounted for 54.1% of all discharges from PRTF in 2018, and they had a longer ALOS (188.3 days) than non-DCF-involved youth (151.6 days).[8] While this disproportional overutilization is not surprising, the high level of need for PRTF services for DCF-involved youth is noteworthy.

Both the Childrens' Center of Hamden and the Village for Families & Children, the two Community PRTF providers that remained open throughout 2018, had both increased admissions and ALOS in 2018. The increase in admissions was likely caused by the need to transfer youth from the Boys & Girls Village facility before they closed in October. Nevertheless, Boys & Girls Village had 22 fewer admissions in 2018 than in 2017, and the other two Community providers only increased by 12 admissions combined, so there were still fewer youth admitted to Community PRTF in 2018 than in 2017.

Admissions at Solnit North PRTF (males) remained steady from 2017 to 2018, but admissions decreased by 11 (from 55 to 44) at Solnit South (females) over the same time period. Due to previously stated capacity changes, this decrease was expected.

Recommendation 6: Continue to Share Data with the PRTFs on a Semi-annual basis

As mutually agreed upon with the state partners, the PRTF PAR Program was discontinued in CY 2018. Beacon and DCF met with the Community PRTF providers in January 2018 for a workgroup meeting and will continue to meet with them yearly to review the statewide annual data. In addition, an RNM will send the Community PRTFs their data and data details on a semi-annual basis. The most recent data was sent to them electronically in September 2018. Beacon will coordinate the next Community PRTF annual meeting to take place this spring.

[8] "DCF-involvement" includes any youth who is involved with the Department of Children and Families through any of its mandates. This includes youth committed to DCF through child welfare or juvenile justice, and those dually committed. It also includes youth for whom the Department has no legal authority, but for whom DCF provides assistance through its Voluntary Services, Family with Service Needs and In-Home Child Welfare programs.

Psychiatric Residential Treatment Facility (PRTF) Overstay—Community and Solnit

Twenty-two (22) youth had delayed discharges from PRTF in 2018, which is a marked decrease from 49 youth in 2017. There was turnover in a key position at Beacon during the early part of 2018, so there is a possibility that this data is not perfectly accurate, although there was still certainly a significant drop in delays. The total cases dropped to 24 in 2018, so there were two (2) youth in overstay at the end of 2019 who continued on overstay in 2019. The total overstay days also dropped to 3,115 after reaching a four-year high of 5,484 days in 2017.

Twenty-two (22) youth had delayed discharges from PRTF in 2018, which is a marked decrease from 49 youth in 2017.

Of the 22 delayed discharges, most (22.7%) were awaiting foster care, followed by awaiting community services and awaiting RTC/GH (each at 18.2%). While the number of youth waiting for foster care declined sharply from 18 youth (36.7%) in 2017 to just 5 youth (22.7%) in 2018, youth still wait longest for foster care, on average. Youth awaiting foster care waited an average of 251.6 days in 2018, a pronounced increase from the 178.1 day average wait in 2017. It is worth noting that this information only captures the last reason for overstay and a youth may have had alternate planned treatment recommendations that the youth waited for prior to the final reason that was recorded at discharge.

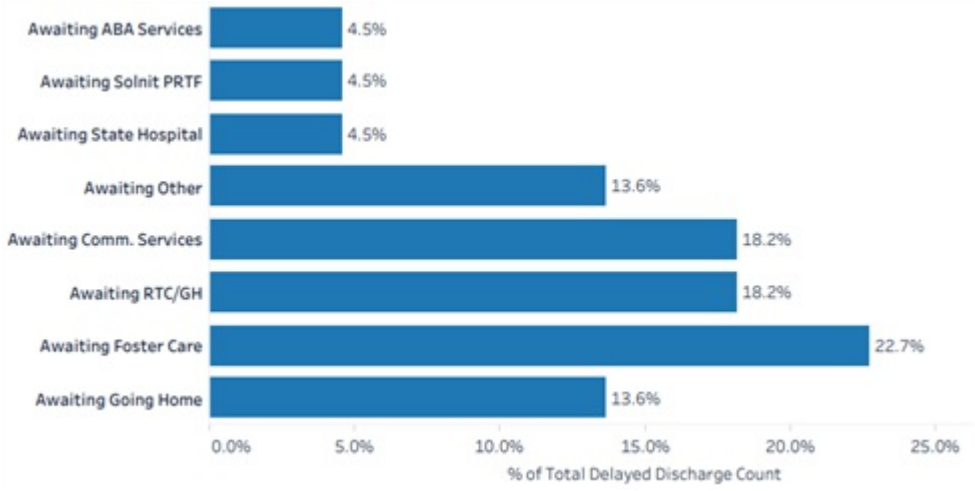


Figure 5: Solnit and Community PRTF Discharge Delay Reasons, 2018

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

In Q3 '18 PRTF overstay rounds were reinstated and have had consistent attendance from Beacon, DCF, and both Community and state PRTF Clinical staff. DCF and Beacon continue to collaborate with the PRTF providers to find appropriate foster care families. The focus of discussion has been identifying next steps and assigning tasks to provide direction and clarity for the team and access to therapeutic foster care (TFC) closer to the time the youth is ready for discharge. Since resumption of the rounds, we have seen many successful and timely discharges from this level of care and an overall reduction of youth needing to go into an overstay status.

Recommendation 8: Support Efforts to Increase Recruitment and Capacity in Therapeutic Foster Care

Currently, some regional systems have efforts underway that focus on foster care engagement and recruitment. The Region 2 South Central Network of Care (SCNC) continues to support the foster care workgroup and is currently exploring ways that the SCNC will support foster care as a priority area for the coming year. Ongoing efforts are also taking place in Region 5 at the Adoption/Foster Care/Kinship Care Collaborative and through active participation in other community initiatives. Building on previous recommendations, Beacon will work to enhance collaborative relationships between various levels of care and TFC.

Global Recommendation: Improve Connections with Regional Networks of Care in order to Improve Outcomes for Children and Families

Since 2016, Beacon Network of Care Managers have been supporting the development of Regional Networks of Care in each DCF Region via the Department of Children and Families, CONNECTs Grant. The goal of each Network of Care is to increase collaboration among all child-serving systems in order to improve outcomes for children and families. In addition to providing information, resources, and opportunities for collaboration, the Regional Networks of Care can serve as a resource to address system needs such as those outlined in population-specific recommendations (i.e. ASD, foster care), and can provide opportunities to include community-based, non-traditional programs along with families in systems-level discussions about current system challenges (i.e. system throughput, overstays). Each Regional Network of Care includes representation from the local community, such as Community Collaboratives ("Systems of Care"), behavioral health providers, juvenile justice/LIST leads, schools, pediatric primary care physicians, and family champions. The Network of Care Managers continue to explore opportunities to collaborate with other community initiatives that support network of care development through the lifespan.

Recommendation 9: Over the next 6 months, the Solnit PRTF PAR program will focus on ALOS, overstay and transfers from PRTF to inpatient level of care

A PAR meeting was held with Solnit PRTF in the first half of 2018. This was the first PAR meeting utilizing the new Tableau PRTF dashboard. The focus of this meeting is the reduction in average length of stay and overstay days, and the increase in transfers from Solnit PRTF to Solnit inpatient. The Solnit PRTFs discussed strategies they have implemented to target the length of stay, including discharge planning meetings and a more proactive approach to identifying potential barriers early into the PRTF stay. In addition, the PRTFs have been collaborating with the DCF area offices to ensure all parties are consistent with discharge planning and disposition.

In November 2018, Beacon held a joint PAR meeting with the Solnit PRTF programs and Solnit Inpatient. The reason for combining meetings was to analyze, collectively the data for the Solnit Continuum as a whole, as many of the youth are treated in both settings. In Q1 & Q2 2018, 40% of Solnit South PRTF discharges were directly transferred to Inpatient. Likewise, the newly developed Solnit Inpatient PAR data highlights an increase in readmissions to Solnit inpatient within 2 - 30 days post inpatient discharge. The majority of the Solnit Inpatient readmissions are from Solnit PRTF. A follow up from the PAR discussion is for Solnit to review the member level data on the youth who readmitted to the hospital from the PRTF in order to identify any trends and/or potential opportunities to enhance the transition from the hospital to PRTF. Beacon recommends continuing the combined hospital/PRTF PAR meetings moving forward.

Residential Treatment Center (RTC) and Group Homes

In-state Residential Treatment Center (RTC) admissions dropped to 120 in 2018, down from a high of 156 in 2016. ALOS increased nearly 30 days to 273 days in 2018. Out-of-state RTC admissions increased from three (3) in 2017 to seven (7) in 2018, but constituted only 5.5% of all RTC admissions.

Overall, the ALOS for 2018 was 537.9 days, an increase of more than 150 days from the average of 383.9 days in 2017.

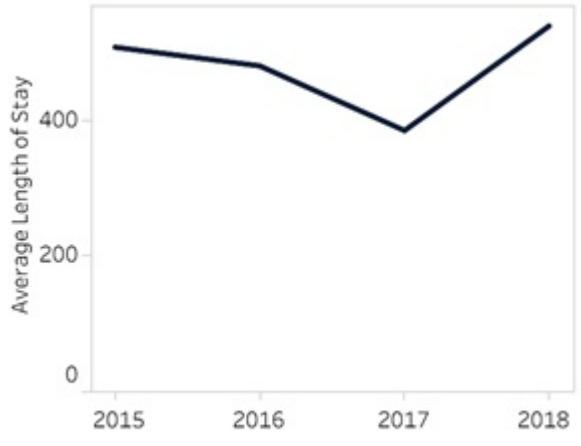


Figure 6: ALOS for TGH Stays, 2015-18

Most RTC admissions (98.4%) were 13-17 year-olds, male (79.9%), and DCF-involved (78.7%).[9] Unknown (33.9%) was the largest racial or ethnic group, followed by Hispanic youth (22.8%). White youth were underrepresented with 18.9% of RTC admissions and 23.2% of the total Medicaid youth population. Males (273.5 days), White youth (426.3 days), and DCF-involved youth (276.2 days) all had higher ALOS than other groups, with the exception of outlier groups with very few admissions.

Therapeutic Group Home (GH) admissions decreased significantly from 116 in 2017 to 65 in 2018. As noted in the previous semi-annual deliverable, the ALOS for Group Homes was higher in 2018 than in previous years, reaching a 10-quarter high of 661 days in Q4 '18. Overall, the ALOS for 2018 was 537.9 days, an increase of more than 150 days from the average of 383.9 days in 2017. The higher than normal ALOS was a result of three (3) discharges. All three of these youth had Intellectual Disabilities and significant co-morbid medical conditions.

Autism Spectrum Disorder (ASD) Services

Overall admissions for every type of ASD service have increased steadily since 2015. Treatment Plan/Program Book Development (26.7%) and Diagnostic Evaluation (26.4%) continue to be the most utilized services, followed by Behavioral Assessment (19.4%). Both Treatment Plan and Program Book Development can be authorized every 90 days as needed to make updates to goals, objectives, and teaching materials. This accounts for the higher utilization of these services over Service Delivery. All requests for concurrent authorization of Treatment Plan and Program Book Development are reviewed for medical necessity and require a clear justification for the needed updates to the plan of care.

Overall admissions for every type of ASD service have increased steadily since 2015.

Overall, most of the youth accessing ASD services continue to be 3-12 years old and male for all service classes. White youth had the highest utilization in all service classes except Diagnostic Evaluation, where Hispanic youth had the most admissions. There, Hispanic youth are disproportionally overrepresented (30.3% of utilizers), as they comprise 23.3% of the overall Medicaid youth population. However, in the other service categories, Hispanic youth are underrepresented. This may be due to several factors. Not all Autism Diagnostic Evaluations result in a diagnosis of Autism Spectrum Disorder; a diagnosis of Autism is required in order to access further ABA services. Furthermore, while an individual may meet the criteria for an autism diagnosis, the family may opt to not pursue in home ABA services, may be receiving services and supports from other state agencies or through their school system, or may feel that they are able to manage the symptoms of autism within their family unit and without additional formal services.

Additionally, there are providers who are bilingual and able to evaluate individuals who are Spanish speaking using standardized and valid tools. However, while the number of qualified providers continues to grow, there are still not enough bilingual Autism Service providers to meet the service needs of the Hispanic population. While there are sometimes behavior technicians who are bilingual, there is not the same diversity in qualified providers overseeing the service delivery. Along with continuing to grow the provider network, Beacon is committed to working with agencies to encourage the hiring of bilingual clinicians and behavior technicians in order to improve access to services.

[9] "DCF-involvement" includes any youth who is involved with the Department of Children and Families through any of its mandates. This includes youth committed to DCF through child welfare or juvenile justice, and those dually committed. It also includes youth for whom the Department has no legal authority, but for whom DCF provides assistance through its Voluntary Services, Family with Service Needs and In-Home Child Welfare programs.

The number of ASD providers increased in every service class from 2017-18. The greatest number of providers deliver Treatment Planning & Program Book Development (54), Behavioral Assessment (52), Service Delivery (49), and Direct Observation & Direction (48). Able Home Health Care was the largest provider again in 2018. A Piece of the Puzzle has grown to become the second largest provider, followed by Connecticut Children's Specialty Group, Family Strong CT, A Brand New Day, and South Bay Community Services Inc. Connecticut Children's Specialty Group at CCMC continues to be the largest provider of Diagnostic Evaluation services.

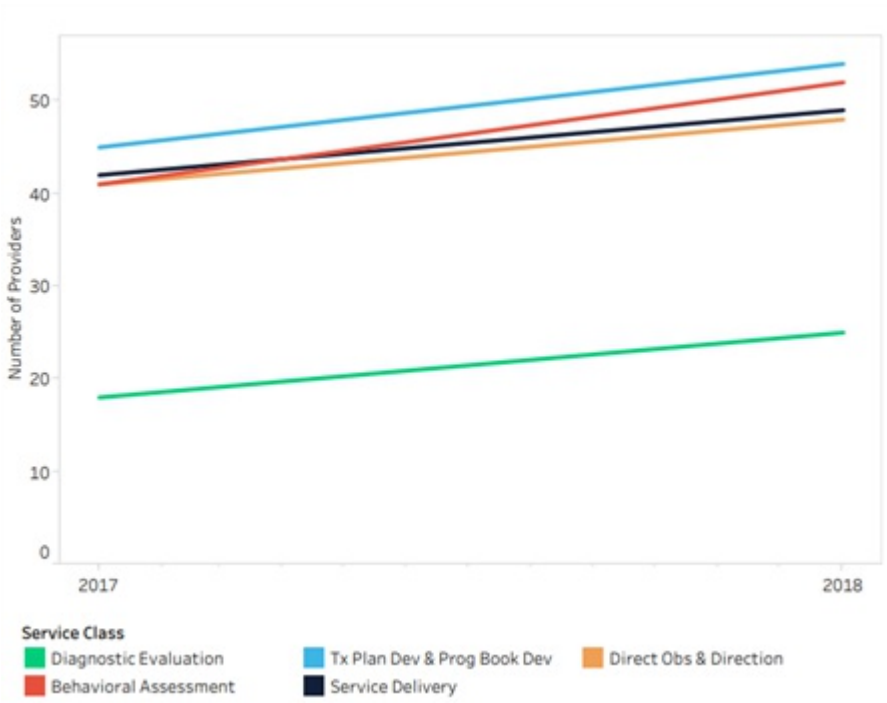


Figure 7: Number of ASD Providers by Service Class, 2017-18

Recommendation 10: Collect data regarding authorization to first claim

The number of ASD members receiving direct services continues to grow, increasing from 424 total new authorizations in 2017 to 573 total new authorizations in 2018, making up a total of 1,791 unique members connected to a provider for direct ABA service delivery in 2018 (as of 2/1/19). An additional 25 members were connected to Group Treatment services (ASG).[10] This increase is explained by an overall growth in the provider network for those providers who perform direct services. In 2017 there were 177 providers enrolled and by the end of 2018 there were 294 (a total increase of 117), all of whom are able to perform direct services. While there has been a slight increase in agencies enrolling, most growth has been seen within agencies that now hire Board Certified Behavior Analysts (BCBAs), Licensed Clinicians, and Behavior Technicians statewide to accommodate a greater area of need.

As the numbers of individuals accessing services grows, ASD will collect data to show the length of time members wait to start services once connected to a provider by measuring the date of first authorization to the date of first claim for services. This information will help us to understand the pressure on the capacity of the network to serve more members in a timely way. The longest wait times to start of services tend to occur when a member is connected to an ASD Peer Specialist/Care Coordinator. Our goal is to decrease this time and capture the results through ongoing data collection. Once a provider accepts a referral and requests an authorization, it appears in Service Care Connect that the member has been successfully connected to a provider. We know through reports from providers and member families that providers may accept referrals and request an authorization but then not start services for several months while they hire and train staff specific to the members' needs. With data, the ASD Team can reach out to individual providers to streamline a more efficient, effective, and ethical system of accepting and starting to work with a member upon acceptance of a referral. While we also understand there is an ongoing capacity issue across the state, our goal is to decrease wait times and support this through ongoing data collection.

In addition, after Beacon moved prior authorization requests to ProviderConnect, providers reported having more time to engage in services rather than administrative tasks during business hours. Autism Diagnostic Evaluation moved to web-based authorization requests in 2016. Following the success of this, Behavior Assessment, Treatment Plan Development and Program Book Development moved to web-based authorization requests in January 2018. Service Delivery, Direct Observation and Direction and Group Treatment services moved to the same web-based authorization request process in September 2018.

Recommendation 11: Enhance supports to individuals in the Emergency Departments and Inpatient Settings

As mentioned in the mid-year submission, Beacon looks to enhance the system of care for members and families impacted by ASD, intellectual disability, and/or developmental disorders, by implementing a new Intensive Response Team (IRT). These individuals are typically the highest utilizers of all levels of care throughout the state and require the support of care coordinators with specialized training and knowledge. The goals of this team are (1) to decrease frequency of emergency department visits and ED overstay; (2) to decrease inpatient psychiatric hospitalizations and length of stays in acute hospitals; and (3) increase "successful" referral and connection to appropriate levels of care. In order to connect members to appropriate services in the home in a timely manner, Beacon plans to continue to grow the provider network. Beacon will also work to increase the quality of treatment provided to highly complex members by offering Learning Collaborative opportunities and CEU opportunities targeted at supporting highly complex members and their families within the home setting. In addition to these plans for future support, the Beacon Health Options ASD leadership will participate in quarterly meetings with DDS Behavior Support Program (BSP) leadership to ensure smooth transition of services when individuals age out of State Plan services at 21 years of age.

[10] Note: this data comes from the ASD Monthly Review dashboard. The data feeding this dashboard is updated monthly, and data updates may impact prior months' numbers as well, so any numbers reported from the ASD Monthly dashboard in this deliverable may differ slightly from the numbers currently shown on the ASD Monthly dashboard.

Lower Levels of Care

Outpatient admissions for youth have continued to increase year over year, rising to 41,453 admits in 2018 (10.8 admits/1,000). Outpatient admissions continue to represent the vast majority (86%) of all admission to Lower Levels of Care.

Outpatient admissions for youth have continued to increase year over year, rising to 41,453 admits in 2018 (10.8 admits/1,000).

All other lower level of care service classes decreased slightly and admits/1,000 decreased or remained flat, suggesting true decreases in utilization, not just a reduction in population size.

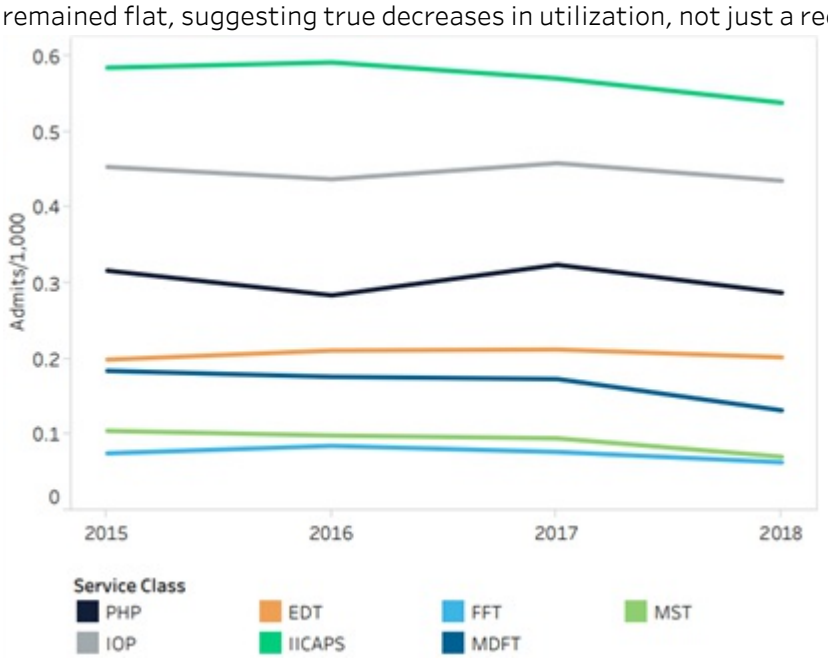


Figure 8: Admits/1,000 for Lower Levels of Care Excluding IOP, 2015-18

Intensive In-Home Child Adolescent Psych Services (IICAPS) was the second most utilized Lower Level of Care, with 2,064 admissions in 2018, followed by Intensive Outpatient (IOP) with 1,669 admissions, and Partial Hospitalization (PHP) with 1,102 admissions.

Multi-Dimensional Family Therapy (MDFT) admissions decreased by about 150 to a four-year low of 506 in 2018. MDFT referrals were on hold throughout the month of November due to a new contract start date of December 1, 2018. Beacon expects the capacity and utilization of MDFT services to return to previous levels in 2019.

Multi-Systemic Therapy (MST) admissions decreased by nearly 90 to 271 in 2018. Some MST services have been split off into a separate contract through CSSD, so it is likely that Beacon will see reduced utilization of MST services into the future, as we may not have access to CSSD utilization information.

Enhanced Care Clinics (ECCs)

The total non-ECC registration volume (inclusive of both adults and youth) continues to steadily increase over time, while the total ECC volume slightly declined. In each of the past four years, the share of outpatient registrations by non-ECCs has increased, so while the overall ECC volume has remained similar, a larger percent of outpatient registrations come from non-ECCs each year (from 84% of registrations in 2015 to 89% in 2018). In 2018, non-ECC registrations increased to 144,587. ECC volume decreased by more than 1,500 registrations to 18,668 registrations in 2018. Youth ECC volume decreased by 7.6% to 8,926 registrations in 2018.

In 2018, like in 2017, the 95% access standard was met for all three classes in ECCs. For youth in 2018, routine standards were met 99.0% of the time, urgent were met 98.4% of the time, and emergent were met 98.9% of the time. Across all outpatient evaluations, ECCs had higher rates of meeting the 95% access standard than non-ECC clinics.

Recommendation 12: Assess ECC initiative

Over the past year, there were many meetings held to discuss an ECC Redesign that addresses the operationalization of ECC program metrics, the incorporation of value based payment methodologies, and opportunities to broaden the initiative. These discussions remain ongoing. During the September Operations Subcommittee, an open invitation for feedback on ECC redesign was given to providers. While the subsequent Operations Subcommittee meetings have not generated any additional feedback, the CT BHP ECC team remains open to provider input.