CONNECTICUT HOSPITAL ASSOCIATION

TESTIMONY OF
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CONNECTICUT HOSPITAL ASSOCIATION
BEFORE THE
OFFICE OF THE HEALTHCARE ADVOCATE

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My name is Carl Schiessl. I am the Director of Regulatory Advocacy at the Connecticut Hospital Association (CHA). I am here testifying concerning **Mental Health and Substance Use: Access to Prevention, Treatment and Coverage.**

My testimony today will focus on the utilization of hospital inpatient units and emergency departments by Connecticut residents seeking treatment for mental health and substance use disorders, offering a broad, statewide snapshot of the services being provided by acute care hospitals to patients in need of treatment for mental health and substance use disorders, through patient discharge data. I will also provide you with an overview of hospital utilization and behavioral health in FY 2012, as well as information on the trends we are experiencing in acute care hospitals, by age and by payor mix, over a five-year period, spanning FY 2008 through FY 2012.

While CHA's comments are intended to offer a high-level view of the present state of affairs relating to acute care hospitals and access to behavioral health services in Connecticut, you will also hear testimony that will provide a closer look at what's actually taking place at some of our hospitals. I am joined today by Dr. Sabina Lim, Executive Director of the Yale-New Haven Psychiatric Hospital, who will describe the efforts being made at her hospital to apply principles of patient and family-centered care for the benefit of those individuals who require psychiatric services.

We are grateful to the Office of the Healthcare Advocate for the opportunity to testify today, since our emergency departments remain one of the major entry points into the mental health and substance use disorders treatment system in Connecticut.

Connecticut hospitals offer behavioral health services in a variety of settings. Some provide these services as a department within a hospital, or through a separate institution or division within a hospital system, and maintain a distinct identity for those services, due to the size and complexity of the behavioral health treatment and research services provided. Other hospitals operate dedicated behavioral health units within their emergency departments.

In Connecticut, during FY 2012, every Connecticut hospital treated both adults and children with behavioral health-related conditions. While this is not necessarily indicative that there are dedicated inpatient mental health or substance use treatment programs at all or most of these hospitals, it indicates that all Connecticut hospitals are providing at least short-term inpatient services for individuals with a behavioral health diagnosis.

Today, we submit the following observations about the volume of care provided by Connecticut's acute care hospitals, derived from CHA's ChimeData database, using discharges from inpatient care, and non-admissions following treatment in hospital emergency departments.

Overview of Hospital Utilization and Behavioral Health, FY 2012

- In FY 2012, there were more than 380,000 inpatient discharges in Connecticut. Treatment for behavioral health was the principal reason for the stay for more than 9% (34,000) of these discharges (See Table 1). In addition, another 152,000 inpatient discharges had behavioral health as a secondary diagnosis.
- Meanwhile, in the ED setting, there were nearly 1.4 million ED non-admissions in Connecticut in FY 2012. Behavioral health was the principal diagnosis for more than 6% (82,000) of these encounters. In addition, another 154,000 ED non-admissions had behavioral health as a secondary diagnosis.

Table 1. Proportion of Behavioral Health Encounters within All Encounters, FY 2012*

Account Type	Total Visits	Behavioral Health Encounters (Principal Diagnosis Only)	% of Total	Behavioral Health Encounters (Principal + Secondary Diagnoses)	% of Total
Inpatient Discharges	380,447	34,055	9%	185,870	49%
ED Non-Admissions	1,424,273	82,328	6%	236,199	17%

****Source ChimeData database, FY 2012 annualized figure***

Trends in Hospital Utilization and Behavioral Health by Age, FY 2008 – FY 2012

- From 2008 through 2012, inpatient behavioral health discharges increased by 13% with the largest increases occurring among children ages 0-12 (+25%) and adolescents 13-20 (+26%) (See Table 2).
- Over that same time, ED non-admissions involving behavioral health increased by 40% with the largest increases occurring among children ages 0-12 (+48%).

Table 2. Trends in Behavioral Health Encounters Over Time by Age

Behavioral Health Encounters (Principal and Secondary)		FY 2008	FY 2012*	% Change
Inpatient Discharges	Pediatrics (0-12)	1,305	1,629	24.8%
	Adolescent (13-20)	5,180	6,548	26.4%
	Adult (21-64)	86,178	96,455	11.9%
	Seniors (65-Older)	71,176	81,239	14.1%
	Total	163,839	185,870	13.4%
ED Non-Admissions	Pediatrics (0-12)	3,112	4,602	47.9%
	Adolescent (13-20)	18,902	24,686	30.6%
	Adult (21-64)	127,313	179,541	41.0%
	Seniors (65-Older)	19,147	27,371	42.9%
	Total	168,474	236,199	40.2%

**Source ChimeData database, FY 2012 annualized figure*

Trends in Hospital Utilization and Behavioral Health by Payor, FY 2008 – FY 2012

- From 2008 through 2012, inpatient discharges with behavioral health diagnoses increased by 35% among Medicaid patients (See Table 3).
- Over that same time, Medicaid ED non-admissions with behavioral health diagnoses increased by 71%.

Table 3. Trends in Behavioral Health Encounters Over Time by Payor, FY 2008 vs. FY 2012

Behavioral Health Encounters (Principal and Secondary)		FY2008	FY 2012	% Change
Inpatient Discharges	Medicare	84,854	96,801	14%
	Medicaid	30,138	40,580	35%
	Private	43,233	43,698	1%
	Uninsured	4,852	3,713	-23%
	Other Fed Programs (e.g. TRICARE)	762	1,079	42%
	Total	163,839	185,870	13%
ED Non-Admissions	Medicare	34,794	49,568	42%
	Medicaid	58,853	100,788	71%
	Private	48,554	56,268	16%
	Uninsured	24,701	27,786	12%
	Other Fed Programs (e.g. TRICARE)	1,572	1,790	14%
	Total	168,474	236,199	40%

**Source ChimeData database, FY 2012 annualized figure*

Payor Mix of Hospital Utilization for Behavioral Health, FY 2012

- In 2012, Medicaid represents 43% of the ED non-admissions for behavioral health (See Table 4).

Table 4. Payor Mix of Behavioral Health Encounters, FY 2012

Behavioral Health Encounters (Principal and Secondary)		FY 2012	% of Total
Inpatient Discharges	Medicare	96,801	52%
	Medicaid	40,580	22%
	Private	43,698	24%
	Uninsured	3,713	2%
	Other Fed Programs (e.g. TRICARE)	1,079	1%
	Total	185,870	100%
ED Non-Admissions	Medicare	49,568	21%
	Medicaid	100,788	43%
	Private	56,268	24%
	Uninsured	27,786	12%
	Other Fed Programs (e.g. TRICARE)	1,790	1%
	Total	236,199	100%

**Source ChimeData database, FY 2012 annualized figure*

The barriers to access to prevention, treatment and coverage may be best addressed through an ongoing and robust dialogue that starts with consideration of the healthcare needs of the people of Connecticut, as demonstrated through trends in utilization.

By sharing both historical and current information on what is happening on the front lines of care, at critical access points such as inpatient units and emergency departments, we will all be better able to understand the trends impacting access to care, and make sound decisions about how best to achieve our common goal of providing the best quality services for all patients and families experiencing mental illness and substance use disorders.

Thank you again for the opportunity to testify on this important issue.