CHA CONNECTICUT HOSPITAL ASSOCIATION

COMMUNITY CARE TEAMS

MARCH 31, 2015

What is a CCT?

A COMMUNITY CARE TEAM (CCT) is a regional multi-agency partnership of healthcare and community service providers who collaborate to improve health outcomes for vulnerable populations, including the chronically physically and mentally ill, homeless, or abusing substances.

Goals of a CCT

- **ACHIEVE** regional cooperation and efficiency
- **IMPROVE** healthcare outcomes
- **RELIEVE** pressure on healthcare and community service providers
- **REDUCE** Medicaid costs to the State.

Panelists

- **STEPHEN MERZ,** Vice President and Executive Director, Behavioral Health, Yale New Haven Hospital
- **TERRI DIPIETRO,** Director of Outpatient Behavioral Health, Middlesex Hospital
- **TAIT MICHAEL, MD,** Behavioral Health Services, Western Connecticut Health Network
- **KAREN EISENHAUER,** Director Of Behavioral Health, Bristol Hospital

Proof of Concept

CCT PILOT PROGRAMS:

- Middlesex Hospital intensive care coordination model
- Partnership for Strong Communities/Connecticut Hospital Association Opening Doors Hospital Work Group
- Department of Social Services/ValueOptions Connecticut Emergency Department Frequent Visitor Program

2014 Review

PROGRAM REVIEW & INVESTIGATIONS 2014 report on Hospital Emergency Department Use and Its Impact on the State Medicaid Budget, concluded that: "the more successful initiatives, especially for frequent users of the ED who have behavioral health or substance abuse disorders, are associated with ICM programs that: (i) have more face-to-face client interaction; (ii) involve EDs in the selection of clients, and in the development of a care plan; (iii) perform ongoing, and not episodic, monitoring of clients' stability and progress, including frequent meetings of providers involved in client care and services; and (iv) demonstrate a persistence in engaging the client and managing health and psycho-social needs."

Goals Revisited

- **ACHIEVE** regional cooperation and efficiency
- **IMPROVE** healthcare outcomes
- **RELIEVE** pressure on healthcare and community service providers
- **REDUCE** Medicaid costs to the State.

CHA CONNECTICUT HOSPITAL ASSOCIATION

Stephen Merz

A COMMUNITY CARE TEAM (CCT)

YALE-NEW HAVEN
PSYCHIATRIC HOSPITAL

MORE Commission Testimony

Recommendations on Mental Health &
Community Care Teams (CCT)

Stephen M. Merz, FACHE
Yale-New Haven Hospital
March 31, 2015

Outline

- Describe the CHA Mental Health Agenda / Recommendations
- Describe recommendation #3 – Community Care Teams
- Discuss YNHH's implementation of the CCT model and the need for ongoing state support.

YALE-NEW HAVEN PSYCHIATRIC HOSPITAL

CHA Subcommittee on Mental Health Priorities

- Subcommittee to develop policy and advocacy approach for mental health system in Connecticut
- Goal: Specific, actionable advocacy and policy guidance for spring legislative session

Subcommittee Membership

- 23 members representing 11 CHA member organizations
  - Eastern CT Health Network (ECHN)
  - Hartford Healthcare, including Connecticut Children's Medical Center
  - Lawrence & Memorial
  - Middlesex
  - Saint Francis
  - Saint Mary's
  - Saint Vincent's
  - Western Connecticut Health Network (Danbury and Norwalk)
  - Yale-New Haven Health (Bridgeport and Yale-New Haven)
  - PLUS VA Connecticut
- Include:
  - A hospital CFO
  - Members of the CHA Committee on Government (4)
  - Nine (9) appointees of the CT Behavioral Health Partnership Oversight Council
  - Strong ED representation (co-occurring mental health needs AND addictions)
  - Special emphasis on children and adolescents

Subcommittee Process

- Process:
  - Brainstormed concrete, actionable priorities and recommendations
  - Ranked based on the triple aim objectives of cost, quality and access
  - Using an ease/impact grid or “4-block” ranking system, identified 5 or 6 key recommendations that were “above the line” and significantly impacted cost, quality and access

Recommendations

1. Redesign the Medicaid Program for Behavioral Health Services:
   a. Establish shared savings
   b. Achieve equitable Medicaid reimbursement
   c. Expand the Behavioral Health Home model
2. Improve access to state resources by requiring transparent health outcomes and quality measures
3. Support Community Care Teams (CCTs) and related care coordination services

--NET SAVINGS--

Recommendations

4. Improve and determine short- and long-term bed needs
   a. Expand availability of Intermediate Stay Beds
   b. Increase number of beds for behavioral health patients
   c. Determine short- and long-term bed needs
5. Develop crisis stabilization and emergency services for children in consultation with hospitals
6. Reduce inappropriate opioid use

--INCREASE CAPACITY--

--IMPROVE EFFECTIVENESS OF SYSTEM--

Support Community Care Teams and Related Care Coordination Services

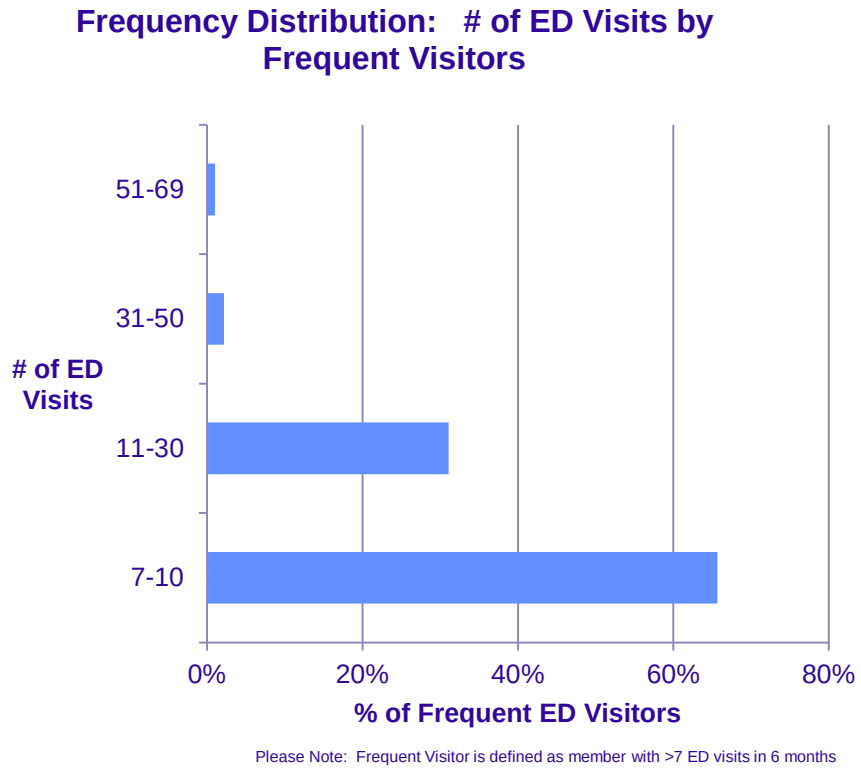
- Enhance patient screening
- Ensure timely release of information
- Establish patient-centered community care management plans
- Engage patients in housing and social wraparound support services.

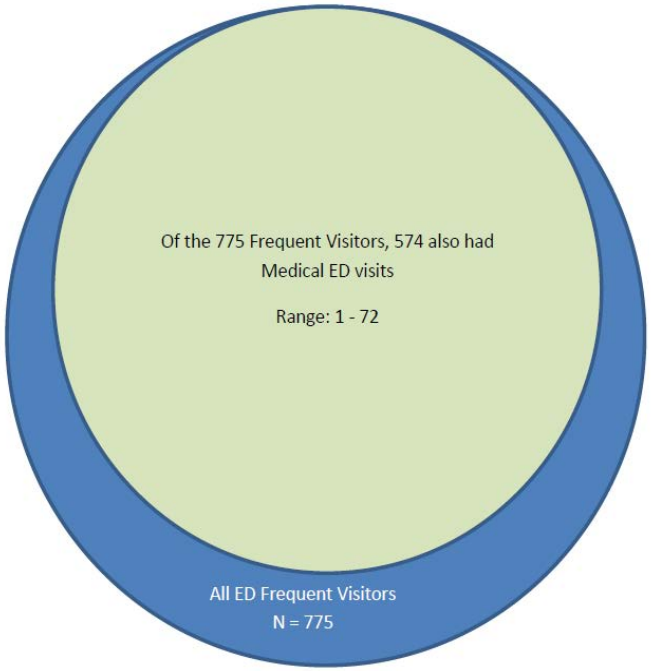
YALE-NEW HAVEN PSYCHIATRIC HOSPITAL

What is a Community Care Team?

- A CCT is a group of healthcare and community service providers who understand that community collaboration is necessary to improve health outcomes for vulnerable populations, including those who are chronically physically and/or mentally ill, homeless, or abusing substances.
- The goals are to improve care, increase community safety, and reduce costs by providing wraparound services through multi-agency partnership.
- Funding for CCT deployment was initially provided by the CT Department of Social Services under a pilot arrangement using ValueOptions, the state behavioral health ASO
- DSS / VO support for CCT ends June 30, 2015

Why a Community Care Team?





Preliminary Data from Bert Plant, PhD and Ann Phelan, MA, ValueOptions, 2014.

Who typically participates in a CCT?

- Lead Mental Health Agencies
- Federally-Qualified Health Centers
- Housing agencies, shelters, soup kitchens and other municipal agencies
- Home health care agencies
- Substance abuse treatment and psychiatric service providers
- First responders (police, fire)
- Hospitals / emergency departments

What does a CCT do?

- Identify patients with frequent emergency department use for substance abuse, alcohol or psychiatric service needs (7 or more visits in prior 6 months)
- Initiate a Release of Information (ROI), usually by the hospital in the Emergency Department
- Develop a community care plan around the patient and assign a Health Promotion Advocate (HPA)
  - » Connect to existing resources
  - » Communicate key information among providers
  - » Keep the patient connected!

What are the results?

- Improved health outcomes:
  - Sobriety
  - mental health stabilization
  - reduced homelessness
  - re-entry to the workforce
- Reduction in ED overcrowding, decreases in costs of care, and reduced losses for undercompensated and uncompensated care.
- Positive fiscal impact to Connecticut - typically more than half of these patients are Medicaid beneficiaries.

What do we need?

- Ongoing funding for CCT Health Promotion Advocates (HPAs) and Intensive Care Managers (ICMs) in Connecticut communities with Hospital Emergency Departments
- $1.8m in FY 16; $3.0m in FY 17
- Funding provides 1 HPA and 1 ICM in 24 Connecticut communities

Examples of CCT deployment

- Yale-New Haven Hospital
- Middlesex Hospital
- Norwalk Hospital

YNHH Provides Psychiatric Services

Across ages and settings of care

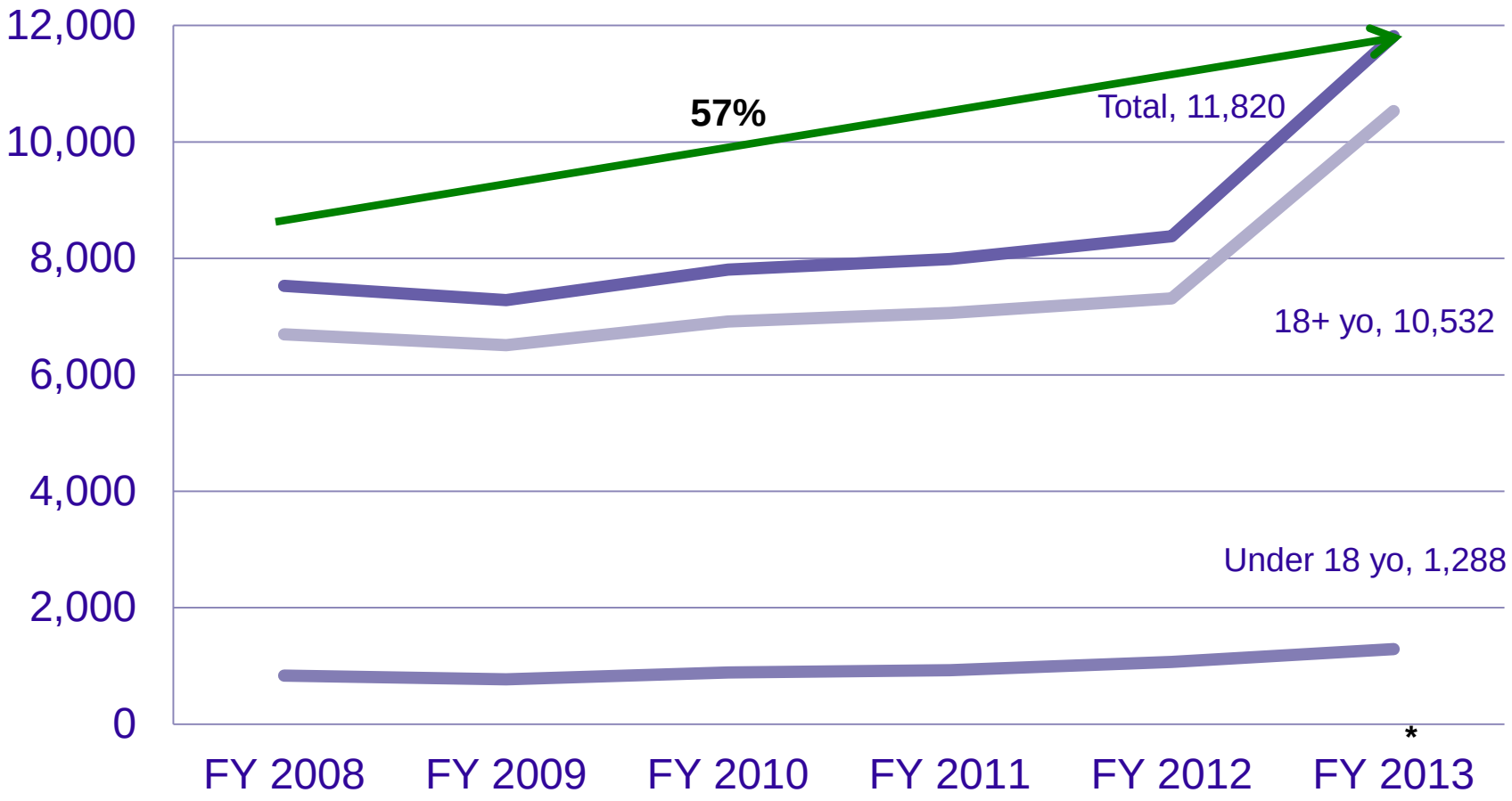
- Child/Adolescent
- Transitioning Youths
- Adults
- Geriatrics

Outpatient Community Support

Inpatient

Urgent/Emergency

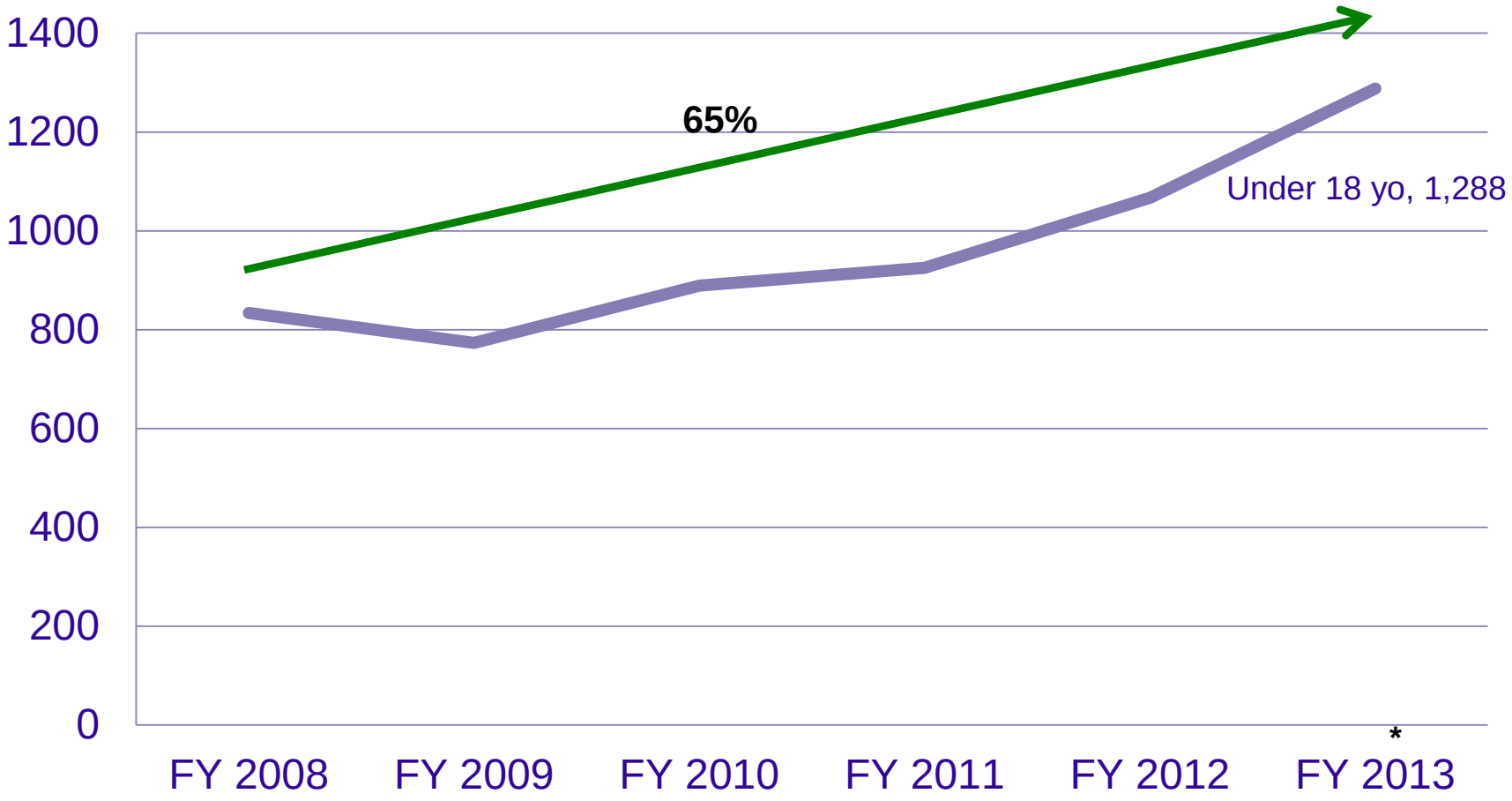
Emergency Psychiatric Visits Steadily Increasing



Source: CHIME
Definition: HCUP 650-663, 670 ; All Ages; Outpatient Emergency Patients with a Psychiatric Primary Diagnosis,
*Acquisition of Saint Raphael's Hospital

YALE-NEW HAVEN HOSPITAL

Steep Increases in Child/Adolescent Emergency Psychiatric Visits



Source: CHIME
Definition: HCUP 650-663, 670 ; Under 18 yo; Outpatient Emergency Patients with a Psychiatric Primary Diagnosis,
*Acquisition of Saint Raphael's Hospital

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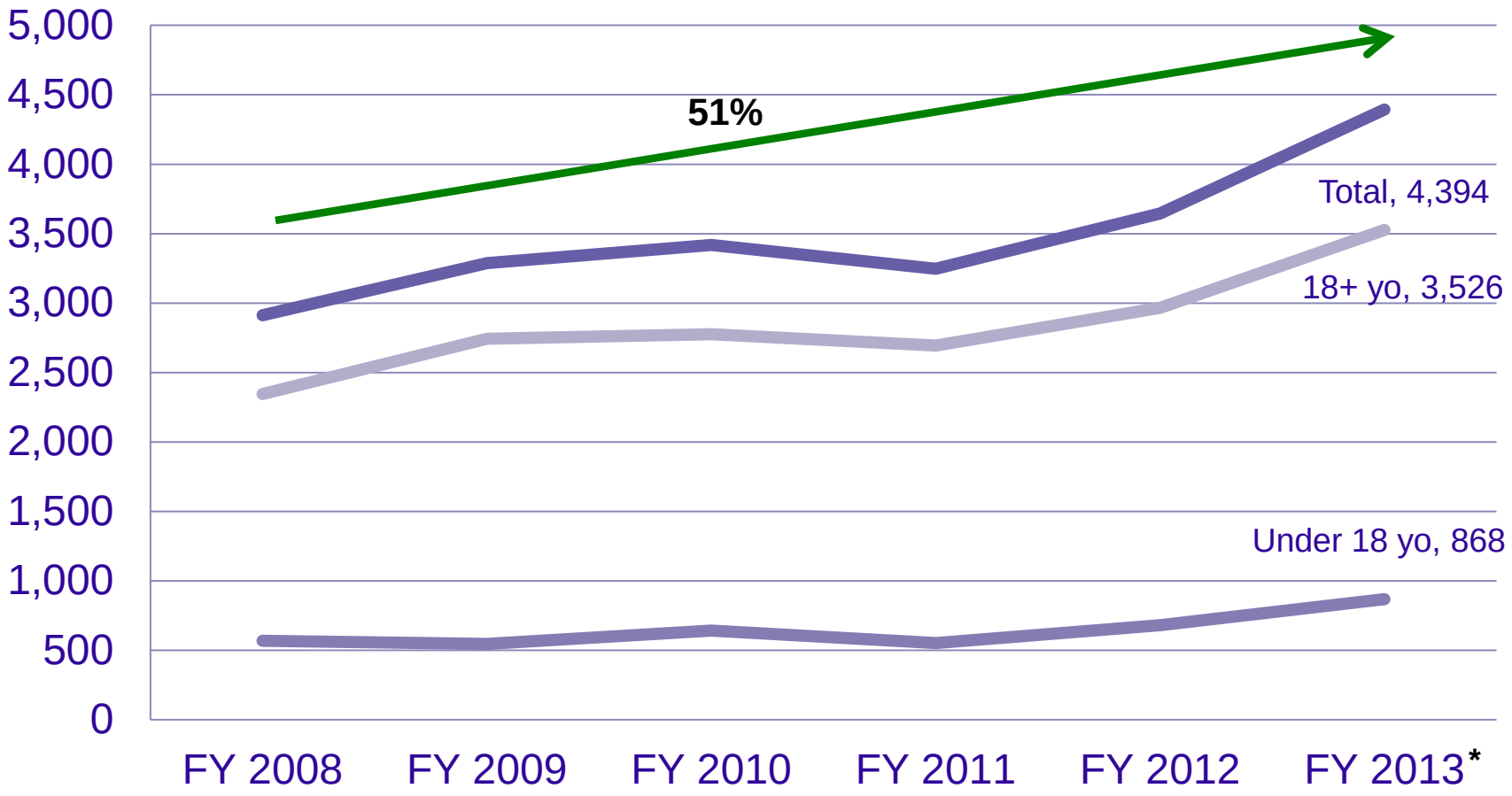
Admitted Patients through the ED Steadily Increasing



Source: CHIME
Definition: HCUP 650-663, 670 ; All Ages; Emergency Patients with a Psychiatric Primary Diagnosis that are amditted
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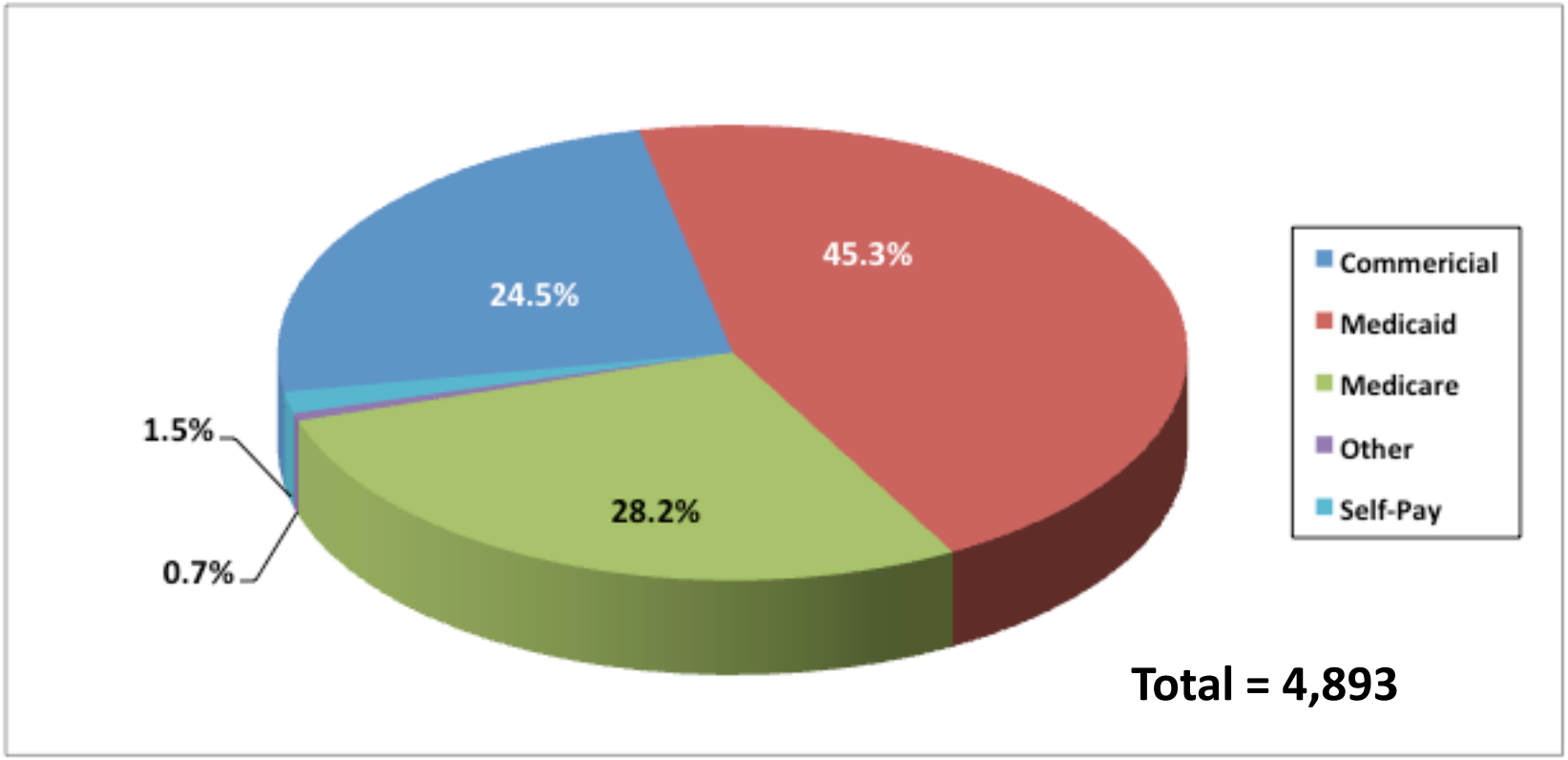
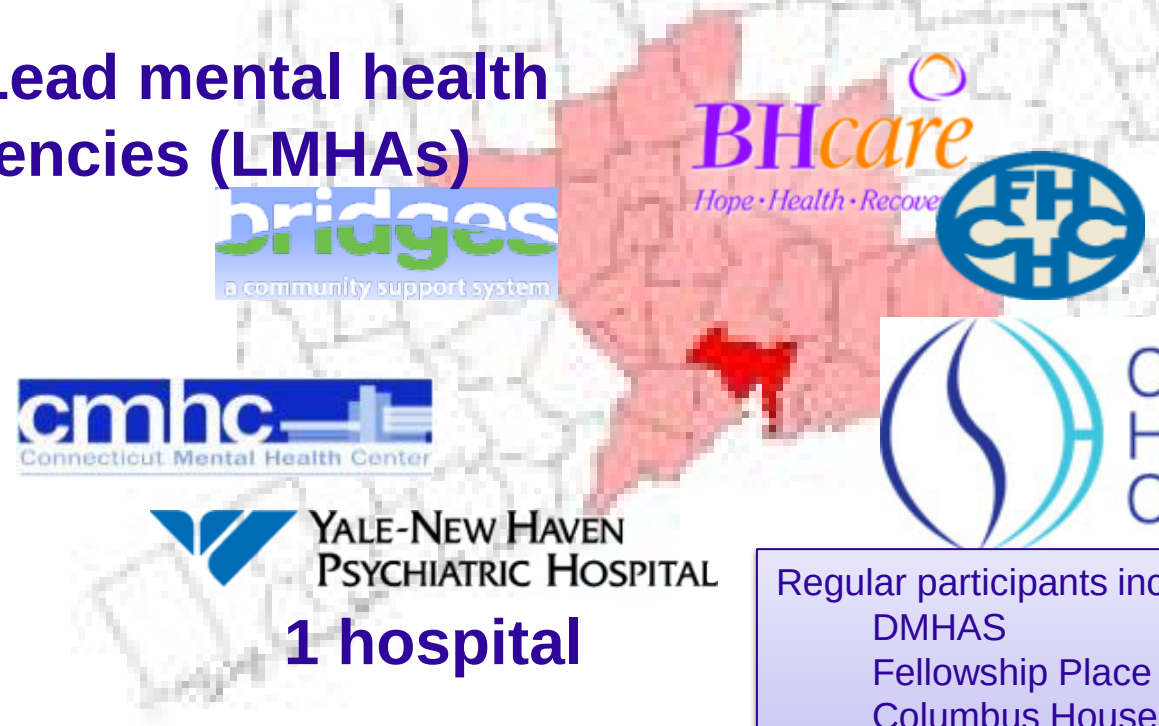
Yale New Haven Psychiatric Services Inpatient Payor Mix, FY2013



Source: CHIME
Definition: HCUP 650-663, 670; Primary Diagnosis, 18+ only
FY= Fiscal Year

Agencies in the New Haven Community Care Team



3 Lead mental health agencies (LMHAs)

bridges
a community support system

BHcare
Hope · Health · Recovery

cmhc
Connecticut Mental Health Center

2 FQHCs

Cornell Scott Hill Health Center

Yale-New Haven Psychiatric Hospital

1 hospital

Regular participants include:

- DMHAS
- Fellowship Place (mental health services provider)
- Columbus House (housing provider/shelter)
- Continuum of Care (mental Health services provider)
- South Central Visiting Nurse Organization
- ValueOptions and Connecticut Health Network
- Advanced Behavioral Health

YALE-NEW HAVEN HOSPITAL

New Haven CCT
July 2014 – December 2014

Typical Number of Frequent Visitors on List *(7+ ED visits in prior 6 months)*	270+
Frequent Visitors Identified in ED	88
Frequent Visitors signing ROI to opt in *(100% sign-in when seen by ICM)*	27
Frequent Visitors with an Outreach and Engagement Plan	27
Frequent Visitors remaining to opt in (once ICM is available)	61

Note: Originally 2 ICMs reduced to 1 in Nov. 2014; zero ICMs since Dec. 2014

New Patients Identified Each Month

(Reporting period = 8/1/14 – 1/31/15)

Patient	Total_BH ED Visits	Total Medical ED Visits	Total ED Visits (Medical and BH) All Hospitals	Yale BH ED Count	A ED	B ED	C ED	D ED
A	8	15	23	3	3	3	1	1
B	9	11	20	3	3	3	2	1
C	12	5	17	2	8	2	2	
D	7	6	13	7	7			
E	7	5	12	1	3	3	1	
F	11	0	11	11	11			
G	8	2	10	5	5	3		
H	9	1	10	7	7	2		
I	9	0	9	9	9			
J	7	2	9	6	6	1		
K	8	1	9	4	4	3	1	

Early Findings

- Too soon to draw any significant findings
- ValueOptions and DSS studying impact on ED visits and readmissions
- Other CCTs are more developed
- Positives:
  - Significant improvement in provider collaboration
  - 100% patient participation in ROI process
  - Identifying patients in the community
  - Flagging in medical record is key
  - Majority of plans have aimed at engagement and connecting to care resources in the community

YALE-NEW HAVEN HOSPITAL

Thank you

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Terri DiPietro

A COMMUNITY CARE TEAM (CCT)

Middlesex County Community Care Team: Care Management for Emergency Department ED Frequent Visitors

MORE Commission

March 31, 2015

Terri DiPietro, MBA, OTR/L, Director, Outpatient Behavioral Health, Middlesex Hospital

The Smarter Choice for Care
MIDDLESEX HOSPITAL

A Community Collaboration

A National Crisis: Emergency Department Perspective

Fraying of behavioral health systems

↓

Increasing numbers of behavioral health patients (BHPs) without adequate inpatient or outpatient care

↓

BHPs wind up in EDs (our medical system's safety-net), often with long length of stay

↓

BHPs overwhelm EDs' capacity to care for all ED patients

↙ ↓ ↘

ED crowding

Decreased safety

Financial losses

A Closer Look…The Major Challenge of BH Super Users

This population does not get better with the traditional model of episodic care delivery

"Falling through the cracks"

Required: Care Coordination

Question Uncovered Along the Way:

How is the experience different for the homeless and those experiencing fragile housing?

CCT History

- 1990s: Mental Illness Substance Abuse project through Rushford (grant funded by state); continuing care team for dual diagnosis; strong relationships were developed
- 2007: Middlesex County initiated the 10 Year Plan to End Homelessness; a component was the formation of a community care team → without a designated champion, the team was never formed
- 2008: Middlesex Hospital conducted a health assessment

- 2010: Community Care Team (CCT) was developed
  - Middlesex Hospital agreed to be the organizer
  - 4 core agencies: Middlesex Hospital, Gilead, Rushford, RVS
  - met on a monthly basis
  - barrier addressed: common Release of Information (ROI)
- 2012: CCT expanded to 9 agencies

CCT Agency Members

- Middlesex Hospital
- River Valley Services
- Connecticut Valley Hospital (Merritt Hall)
- Rushford Center, Inc.
- The Connection Inc
- St. Vincent DePaul Soup Kitchen
- Mercy Housing
- Columbus House
- Community Health Center
- Gilead Community Services, Inc.
- Advanced Behavioral Health
- Value Options, Connecticut
- Community Health Network

Case/care management agencies

CCT Guiding Principles

- **Objective**: To provide patient-centered care and improve outcomes by developing wrap-around services through multi-agency partnership and care planning
- **Core belief:** Community collaboration is necessary to improve health outcomes
- **Core understanding**: Psycho-social problems are community problems. No one entity alone can effectively improve outcomes for this population

CCT – Program Development

- **Weekly meetings (1st meeting: March 27, 2012); for 1 hour**
- **Expansion of CCT Release of Information form (required for each patient)**
- **Developed process for patient selection**
- **DMHAS Grant Conversion Created Health Promotion Advocate (HPA) positions**
  - **only added labor resource; grant funded**
  - **care coordination & case management**
  - **direct & indirect referrals to treatment**
  - **link between patient – ED – CCT – community services**
  - **does "check in" calls for those in community who are stabilized or still struggling**

CCT Process

Patient Identification:

- ED visit threshold criteria (# of visits & behavioral diagnoses)
- Daily ED discharge reports (5+ visits in 6 months)
- Chair of Emergency Services dictates ED Care Plan for ROI to be signed
- Health Promotion Advocate referral
- CCT member referral

- Once ROI is signed, patient is added to CCT agenda

- Team meets on a weekly basis

- In year 1, utilization ranged from 12-80+ ED visits in past 12 months

- # of patients who have received CCT care planning to-date: **199**

CCT – Weekly Meeting Format

Typical CCT meeting: discuss 20-30 patients per meeting; weekly tracking minutes

Research:	Team members research patient histories and psycho-social backgrounds (prior to meetings)
Review:	Team members share histories and review: 1) Outpatient and inpatient utilization 2) Access to care issues: what's currently being provided, where there are gaps 3) Housing status & options 4) Insurance status; available resources based on insurance 5) Arrests; arraignment reports
Brainstorm:	**Team brainstorms** re: best care management strategy
Care Plan:	Team members collaboratively develop customized care plans, with goals for: 1) Treatment and/or stabilization (PECs and adjudication, if necessary) 2) Stable housing 3) State insurance redetermination 4) Case management 5) Linkage to primary care, psychiatrists, specialists, outpatient services 6) Wrap-around services and supports for post-treatment 7) After-care planning
Ongoing:	Long-term follow-up: team members follow-up, review progress and revise care plan as needed; *once on CCT agenda, always on CCT agenda*

What We Track & Measure

Impact Metrics:

- # of visits (ED & inpatient) pre- and post- intervention (snapshot in time)
- Cost/losses

Demographics:

- # of patients who have received care planning
- Diagnosis category
- Gender and age distribution
- Insurance status
- Housing status

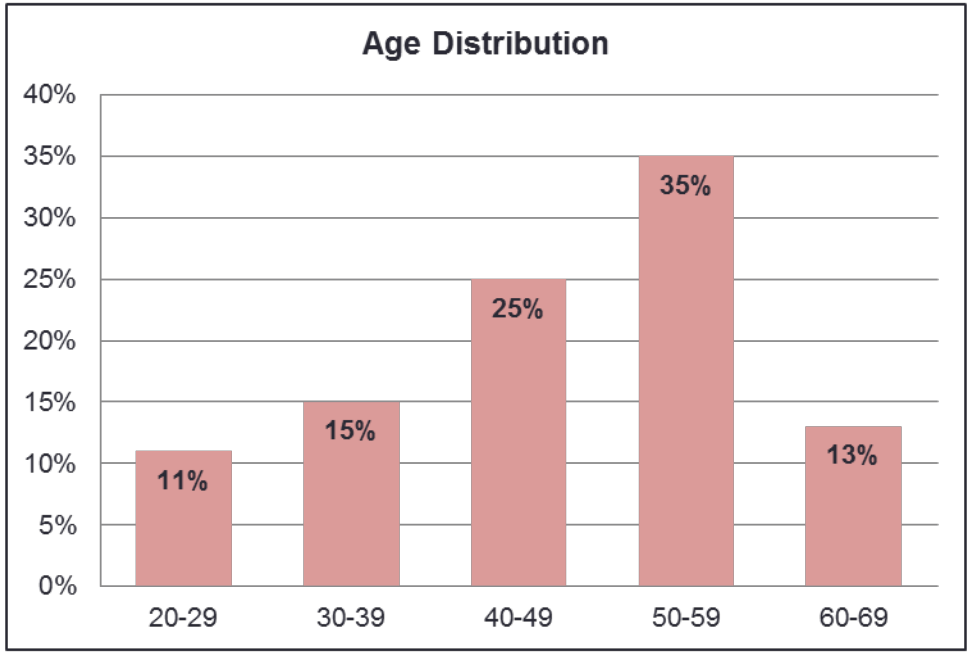
Community Care Team (CCT)

Complex high-risk and high-need ED "super user" patients with diagnoses of:

Dual Diagnosis	Chronic Mental Illness	Chronic Alcoholism	Other Drug Dependence
Coexisting severe mental illness and substance abuse disorders (primarily alcohol)	Most frequent dxs: bipolar; schizophrenia; schizoaffective; borderline personality	alcohol intoxication with/without suicidal ideation	Opioids; cocaine with/without suicidal ideation
43%	**29%**	**22%**	**6%**

- Dual: alcohol only → 45%
- Dual: other drugs → 28%
- Dual: alcohol & other drugs → 27%

What We Track & Measure



Gender:

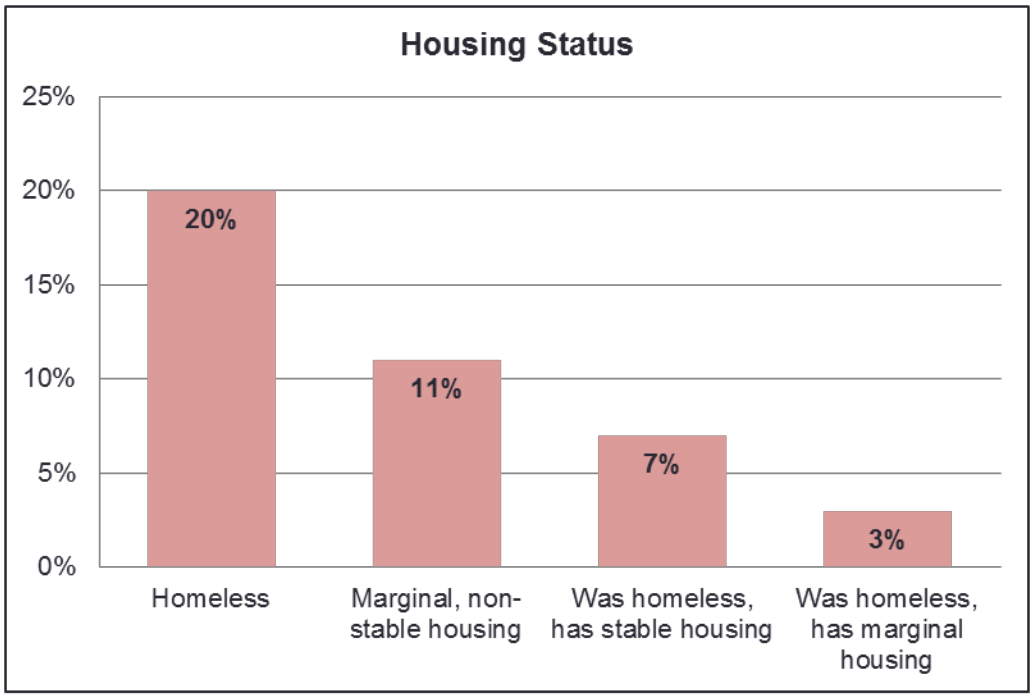
- Female – 37%
- Male – 63%

Payor Status:

- Medicaid – (50%)
- Medicare – (40%)
- Self-pay no insurance – (6%)
- Managed Care – (4%)

Analysis of total cohort of CCT patients to-date (150)

Housing is an Issue



Total = 41%

Analysis of total cohort of CCT patients to-date (150)

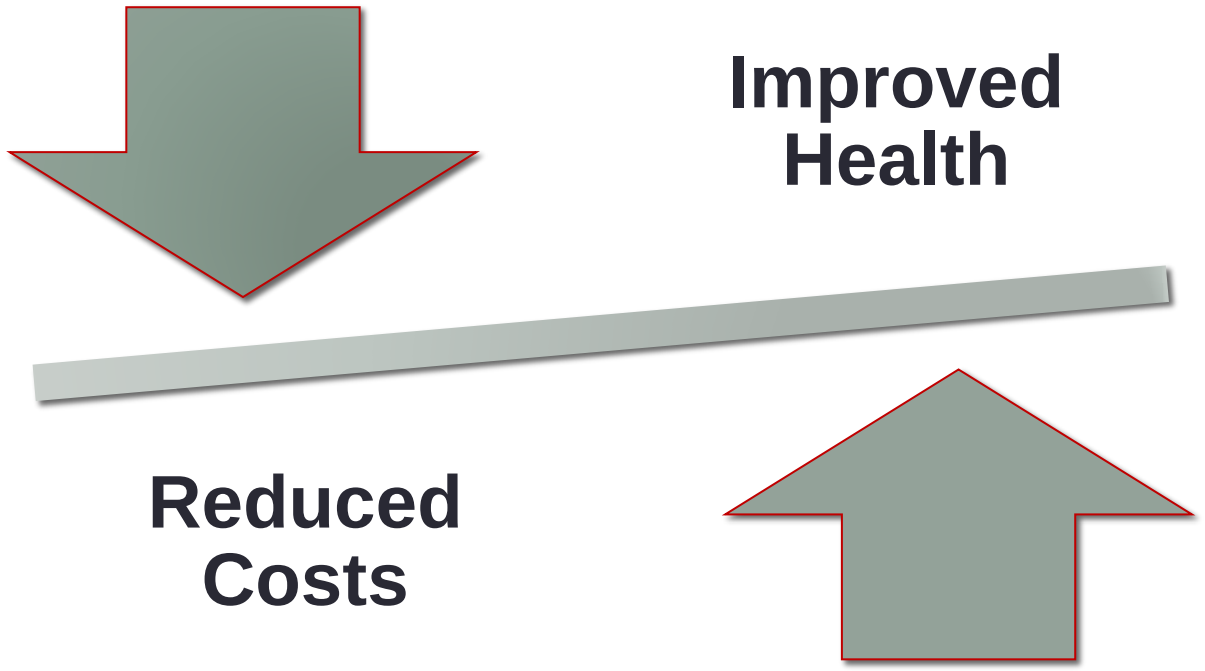
CCT Patients who are Chronically Homeless – Common Traits

- Behavioral Health problems
- Disjointed care/lack of care coordination
- Poor primary care connections
- Lack of social network
- Noncompliance (with meds, follow-up/discharge instructions)
- Loneliness/hopelessness
- Use of ED as “home” → multiple ED & IP visits

Chronic Mental Illness – A Case Study

- Background:
  - 84 ED & Inpatient visits in 12 months
  - Between 2007-2011: 365 ED visits
  - Complex psych (which exacerbates her medical illnesses)
  - Length of stay: days
  - Frequently in restraints
- History:
  - The Patient has a significant sexual trauma history. One of the only times she felt safe as a child was when she was in a hospital setting. During periods of stress, she gravitates to the ED as a safe place
- CCT Intervention:
  - The team has collaborated on strategies to help the Patient identify her needs as an adult and work on coping strategies. Her last few ED visits have been short in duration and each time she has demonstrated insight to her misuse of ED services
- Results:
  - Within 9 months of CCT intervention the Patient's ED & IP utilization has reduced from 52 visits pre-CCT intervention to 31 visits post-CCT (a reduction of 21 visits or 40%)

Building Communities of Care as Partners in Practice



Cost Reductions

Hospital Cost Avoidance

- 1142 reduction in visits x $1513.32 (average ED cost) = $1,728,205.99

Medicaid Claims Only

- 640 reduction in visits x $915.66 (average ED cost) = $ 586,022.40

Additional Benefits

Patient:

- Improved quality of life:
  - Sobriety
  - Mental health stabilization
  - Reduced homelessness
  - Re-entry to workforce
  - Re-connection with family
  - Achievement of feelings of self-worth and respect
- Linkages to:
  - Primary care physicians, psychiatrists, specialists, etc.
  - Supportive housing
  - Appropriate outpatient services

Collaborative:

- Improved patient care
- Improved agency-specific care plans
  Improved inter-agency communication and relationships

Society:

- Increase in safety to all
- Reduction in Medicaid & Medicare expense

What Have We Learned?

1) This target population does not get better with the traditional model of care delivery

2) Chronically ill behavioral health patients consume a disproportionate amount of medical resources

3) Behavioral health chronic diseases require care coordination and customized treatment plans

4) Individualized care plans must have the ability to be flexible and evolve

5) Many agency providers were unaware of frequency of ED visits → communication allows for agency-specific care plans (a major part of CCT's success)

Questions?

Thank You!

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CHA CONNECTICUT HOSPITAL ASSOCIATION

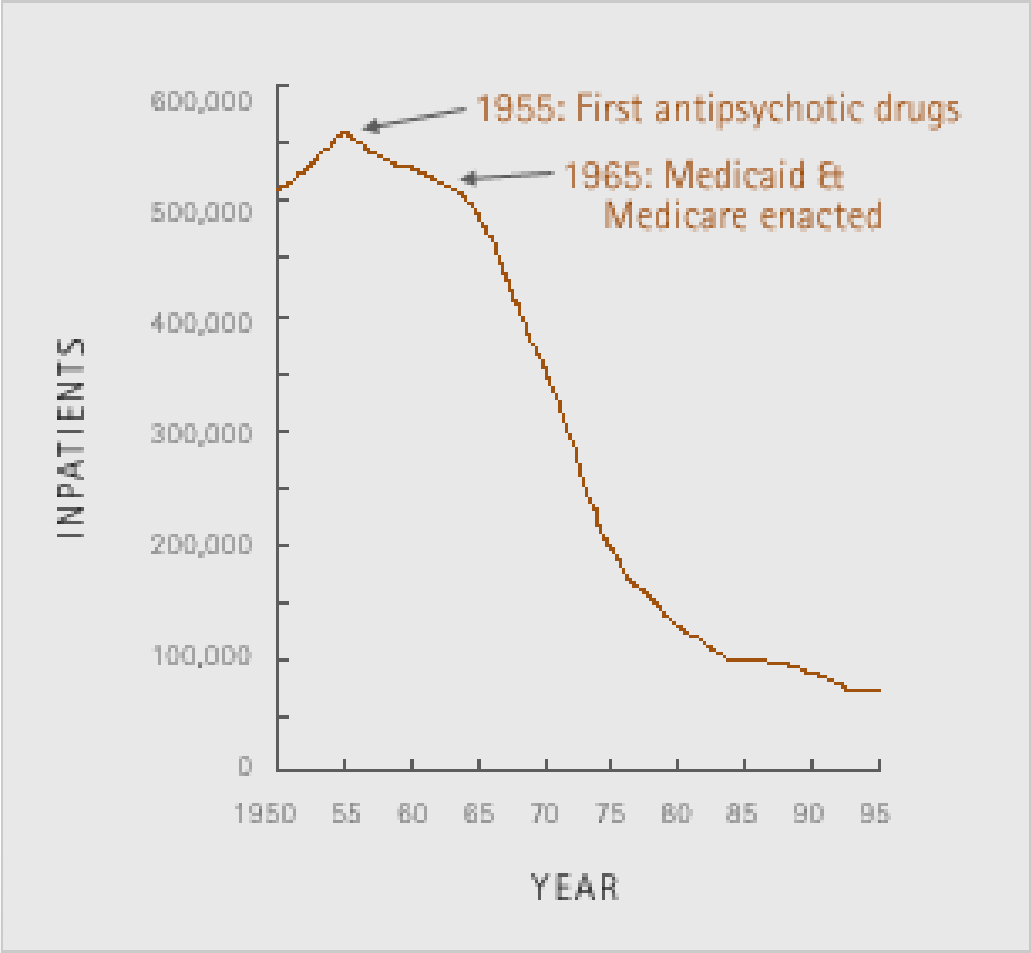
Tait Michael, MD

A COMMUNITY CARE TEAM (CCT)

MORE Commission Regional Entities Subcommittee

March 31, 2015

Deinstitutionalization



1955 – 558,000 in State Hospitals

- US pop – 164M

1995 – 71,000

- US pop – 260M

→ 92% effective discharge rate

Special Report PBS.org

Connecticut

Fairfield Hills 1931 – 1995 (4000 patients)

Norwich 1904 – 1996 (3000 patients)

1955 – **8668** in state hospitals

1994 – **958**

- Effective rate of discharge – 92%

CVH 1867 – 250 forensic beds

GBMHC: 62 beds

Conn MHC: 38 psych beds

Capitol Region MHC: 16 beds

- Total of ~ **500** beds

Results: 50% have done very poorly (“SPMI”) → 30% of homeless
20% of inmates

Treatment of Psychosis

Average length of time needed to treat:

- Hallucinations – 2 months
- Delusions – 4 months
- Restore Jared Loughner to competency – 1 year

Average time insurance will pay for acute inpatient stay

- 7 to 10 days

Need for structured outpatient programs

2012 Norwalk Community Health Needs Assessment

- Year-long study
- 200 community stakeholders
- Departments of Health from Norwalk, New Canaan, Darien, Wilton, Westport, Weston, Fairfield
- Of 20 public health concerns raised, 3 identified as critical: mental health, obesity, substance abuse

Greater Norwalk Community Care Team

Norwalk Community Stakeholders

Americares
Catholic Charities
CT BHP – Value Options
Mid Fairfield Child Guidance
Norwalk Community Health Ctr
Norwalk Hospital
Norwalk Shelter
Family and Children's Agency
Keystone Inc
Gillespie Center
Norwalk Department of Health
DMHAS, DSS
Norwalk Police Department
St. Vincent's, Homestead Program
Connecticut Renaissance
Homes with Hope
Liberation Programs
Connecticut Counseling Inc
Norwalk Housing Authority
Norwalk Board of Education
US Veterans Affairs
Day Street Clinic
Westport Department of Health Services

Norwalk Community Care Team

Started in February 2014

169 individuals reviewed

- 40% Female, 60% male
- Age Range: 20 to 86
- 35% homeless or fragile housing
- Payer Mix: 71% Medicaid
  9% Dually Eligible
  9% Commercial
  6% Medicare
  5% Uninsured

3500 ED visits in FY14

Outcomes

> 95% with treatment plans

VI-SPDAT completed on all but one

- 20+ housed (11 additional vouchers)

Virtually all eligible connected to insurance

50% linked to other specialty services

ED utilization for high-users reduced by 32%

→ Translates to decrease of 784 Medicaid visits

WCHN Utilization Data

Norwalk Campus: October 2013 to September 2014

- Top 40 patients = 1213 ED visits
- Top 100 patients = 2057 visits
- Alcohol, substance abuse = 66% of visits
- 35% either homeless or at risk
- Medicaid = payer for 60% of visits
- 18% have no primary care provider

Impact of Alcohol

- Top 20 in Network with alcohol diagnosis = 1262 visits
- Direct ED Cost = $ 925,800

Super-utilizer Summit 2013

- 5% of Medicaid patients drive 50% of cost
- 80% of high cost beneficiaries have 3+ illnesses
- 60% have 5+ chronic illnesses
- Uniform agreement that care coordination necessary to achieve results

Rand Corp:

- 4.4 B in routine, non-emergent ED care
- 40B in uncompensated hospital care

Hennepin County, MN

Created care coordination and shared savings model

- For costliest, care management reduced expenses by between 40 and 95%
- Projected annual cost of 3,500 rather than 130,000 for care delivered in the ED

Savings allowed investment in a sobering center

- Alcohol high users showed 80% reduction in ED visits

  - Center for Healthcare Strategies, Super-Utilizer Summit; October 2013
  - NYT: Healthcare Systems try to cut costs by aiding the poor and troubled, 3/22/15

CHA CONNECTICUT HOSPITAL ASSOCIATION

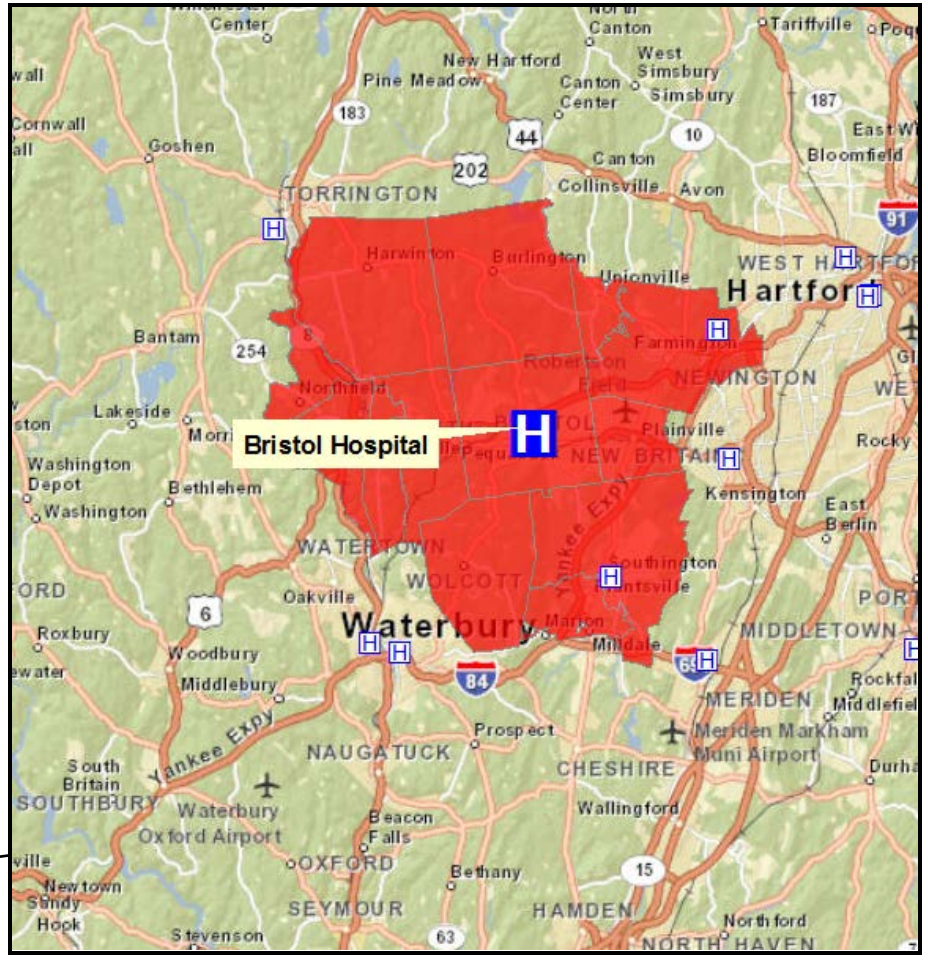
Karen Eisenhauer

A COMMUNITY CARE TEAM (CCT)

Bristol Hospital Community

Demographic and Socioeconomic Profile

Geography	▪ The Bristol Hospital service area covers 13 US Census zip code tabulation areas (ZCTAs)
Population	▪ Total: 198,880 ▪ Under 18 Years Old: 44,115 (22%) ▪ Above 65 Years Old: 30,572 (15%)
Demographic Characteristics	▪ Hispanic or Latino: 10,873 (5%) ▪ Non-Hispanic White: 175,775 (88%) ▪ Non-Hispanic Black: 4,118 (2%) ▪ Non-Hispanic Asian: 5,046 (3%) ▪ Non-Hispanic Other: 3,068 (2%)
Education	▪ Bachelor's Degree or Higher: 40,563 (29%)
Economic Measure	▪ Number of people in Poverty: 10,448 (5%)



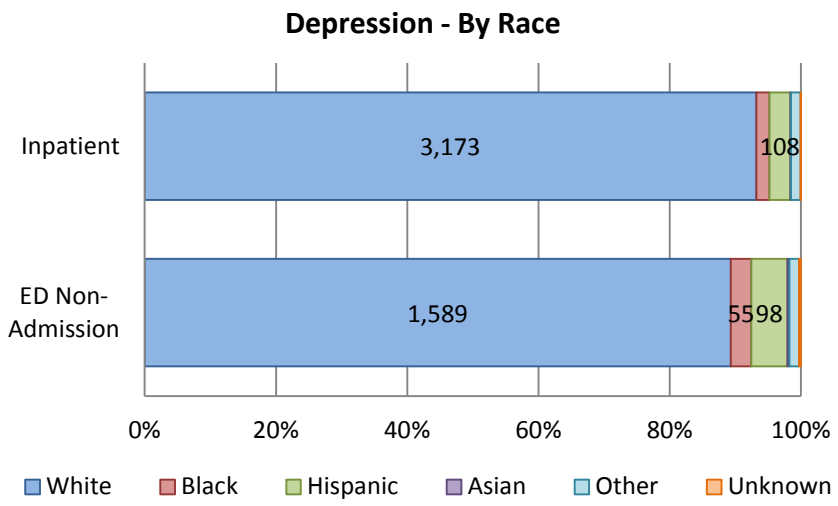
Community Health Needs Assessment

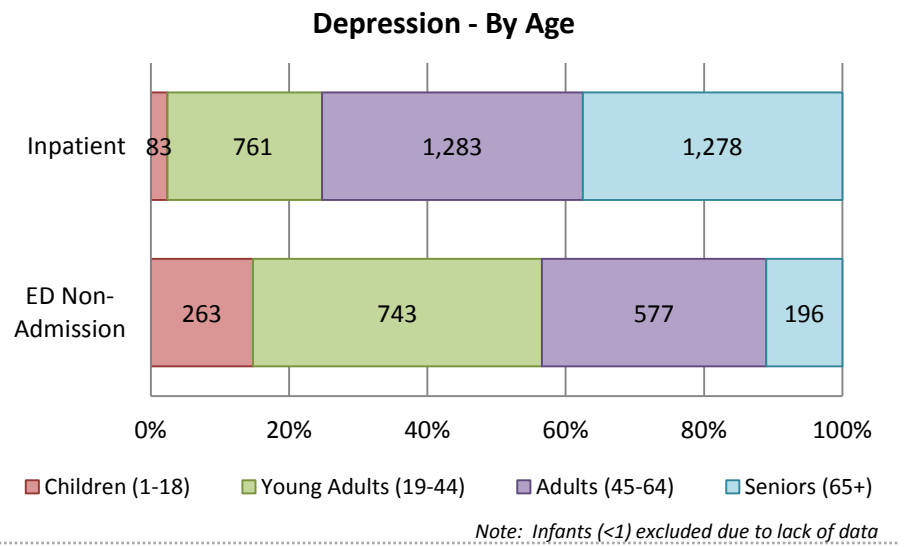
In September 2013, Bristol Hospital led a comprehensive Community Health Needs Assessment to evaluate the health needs of individuals living in and around Bristol. The purpose of the assessment was to gather information about local health needs and health behaviors.

Based on the feedback from community partners including health care providers, public health experts, health and human service agencies, and other community representatives, the following health priorities were identified:

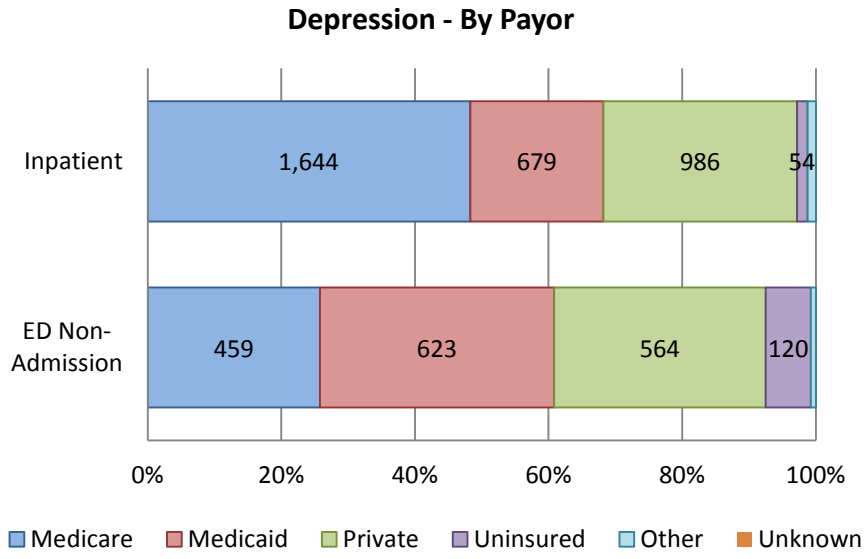
1. Mental Health & Substance/Alcohol Abuse
2. Access to Care
3. Senior Support
4. Overweight/Obesity

Mental Health





Note: Infants (<1) excluded due to lack of data

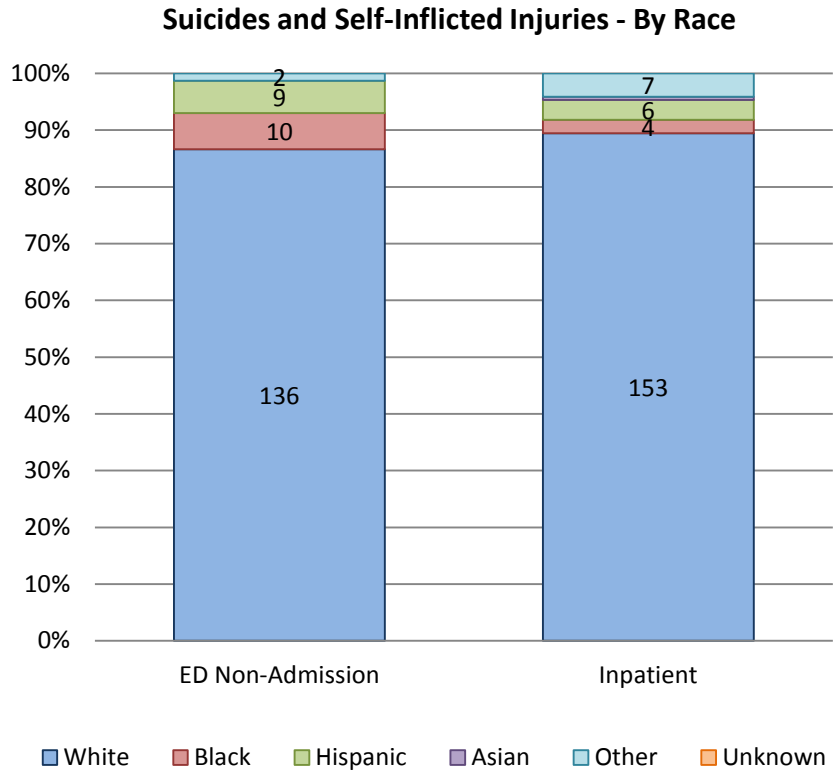


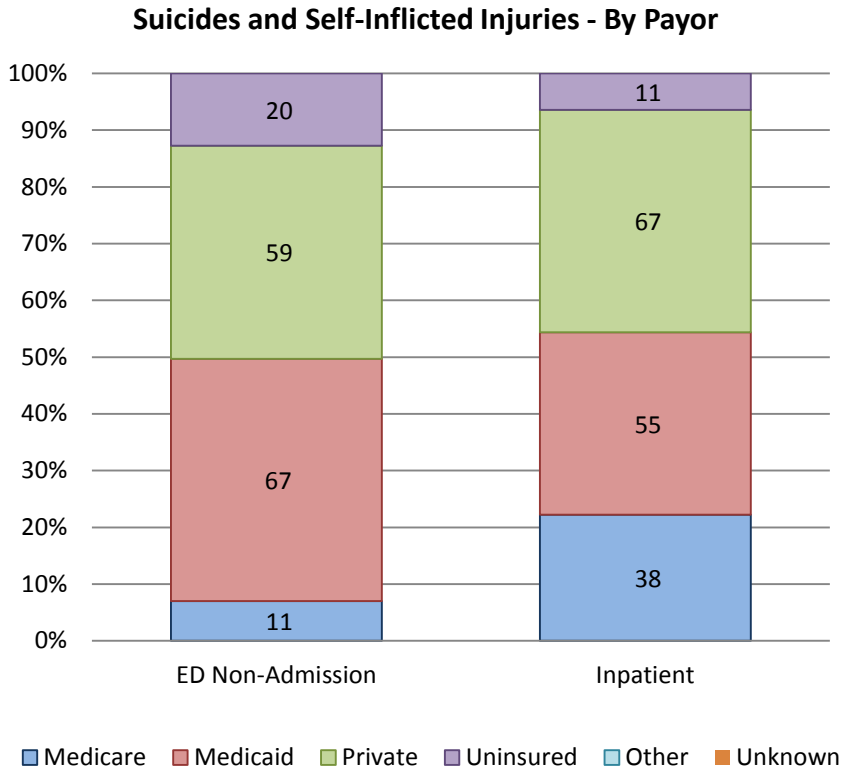
Key Insights

- Whites accounted for a disproportionately large number of Inpatient encounters for depression.
- Adults and Seniors had the largest number of Inpatient encounters for depression, while Young Adults had the most ED Non-Admission encounters for depression.
- Medicaid accounted for a disproportionately large number of ED Non-Admission encounters for depression, while Medicare covered nearly half of Inpatient depression encounters.

Data and Analysis Sources: FY 2012 ChimeData

Mental Health



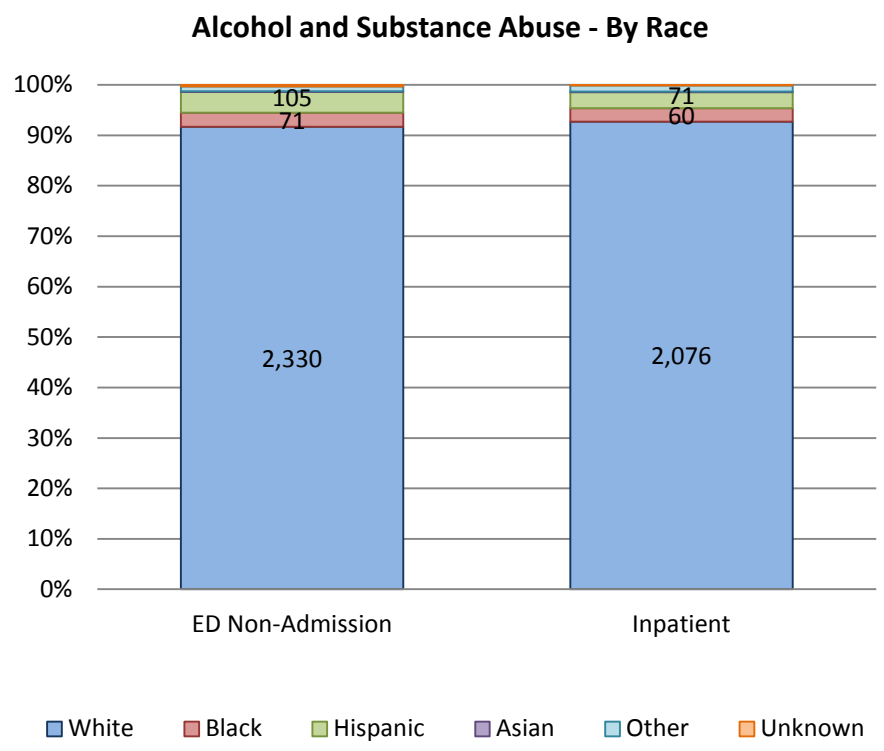


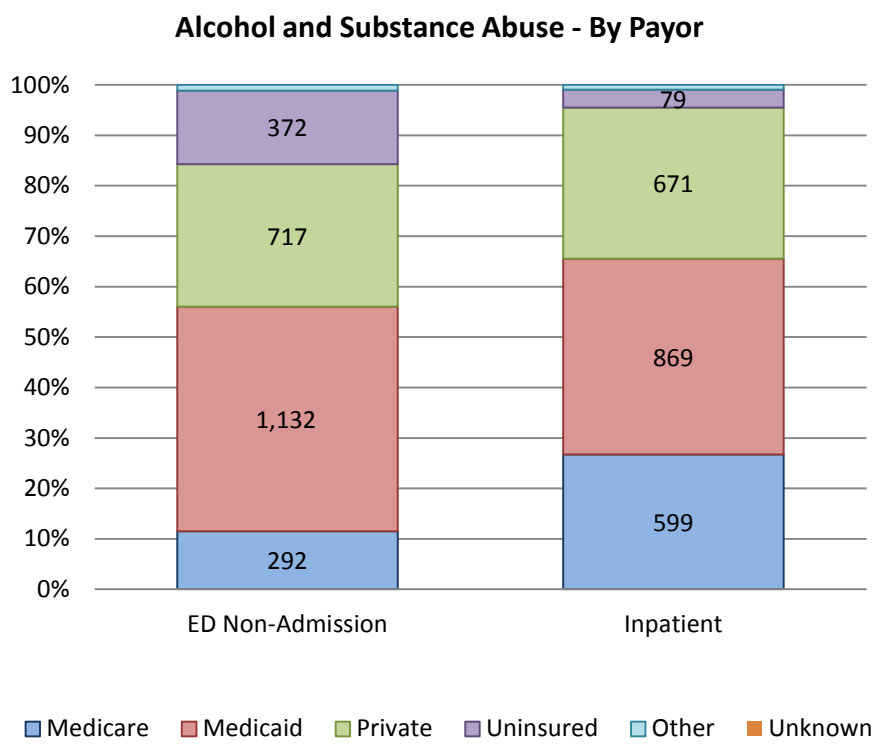
Key Insights

- Similar to the results for depression, Whites were proportionally over-represented among Inpatient encounters for suicides and self-inflicted injuries.
- Medicaid beneficiaries made up over 40% all ED Non-Admission encounters for suicides and self-inflicted injuries, while the Uninsured accounted for over 10% of the ED Non-Admission volume.

Data and Analysis Sources: FY 2012 ChimeData

Alcohol and Substance Abuse





Key Insights

- Whites accounted for a disproportionately large volume of ED Non-Admission encounters for alcohol and substance abuse.

- Medicaid had the most Inpatient and ED Non-Admission encounters for alcohol and substance abuse of any payor group. Meanwhile, over 15% of all ED Non-Admissions for alcohol and substance abuse were among Uninsured encounters.

Data and Analysis Sources: FY 2012 ChimeData

CHA CONNECTICUT HOSPITAL ASSOCIATION

Moving Forward

A COMMUNITY CARE TEAM (CCT)

From Pilot to Best Practice

INITIATIVES: These short-term initiatives have proven that Community Care Teams will achieve the four goals. We need your help to turn an innovative regional solution into a statewide best practice.

An Investment in CCTs

An appropriation of $1.8 million in FY 2016 and $3 million in FY 2017 will support grants to establish CCTs in 24 regions across the state.

Will fund a CCT manager and a healthcare promotion advocate to coordinate the medical, mental health, and social service needs of the patient.

CHA CONNECTICUT HOSPITAL ASSOCIATION

QUESTIONS?