DATABOOK

Acute Care Hospital Behavioral Health Trends in Connecticut

State Fiscal Years (SFYs) 2004-2007

November 2008

Acute Care Behavioral Health Trends, 2004-2007

Introduction

Access to behavioral health (BH) care services in Connecticut has been an ongoing concern for state government and providers of care. This data book presents an analysis of emergency department (ED) and hospital inpatient utilization over time to highlight changes or trends that have occurred within the system.

Connecticut citizens experience delays in accessing the services they need for several reasons; delays can be attributed mostly to gaps in service among the different levels of care. There has been much focus on these system gaps and progress has been made to reduce delays in access. However, patients may wait in emergency departments for days while hospitals try to locate an available inpatient bed, a community resource or until a safe discharge can be accomplished if discharge to home is not an option.

Although hospital emergency departments are the safety net for behavioral health patients, they may not be the most appropriate site for delivery of care of such services. Because the ED is often the place that police, school systems and family members think of first for behavioral health services, improvements in access to community programs and alternative models of care need to be developed to alleviate emergency department utilization. This data book includes a section on emergency department utilization for two separate age groups, as typically the providers and state agencies consider access issues by either under age 18 or age 18 and over.

Over time, treatment patterns for patients with behavioral health needs have shifted somewhat away from providing care in traditional institutional settings towards less restrictive care settings in the community. It is hoped that this shift in focus from the acute care treatment setting to a more community based system of care may help alleviate hospital emergency department overcrowding, reduce unnecessary admissions and long lengths of stay in hospitals and ultimately lead to better outcomes for patients and their families.

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State of Connecticut's Behavioral Health Agencies

In 2006, the Connecticut Department of Social Services (DSS) and the Department of Children and Families (DCF) formed the Connecticut Behavioral Health Partnership (CT BHP) to plan and implement an integrated pubic behavioral health services system for children and families enrolled in the state's Medicaid program (HUSKY A), SCHIP program (HUISKY B), and for other children with complex behavioral health needs. CT BHP's primary goal is to provide enhanced access to and coordination of a more complete and effective system of community-based behavioral health services and supports.

The Connecticut Department of Mental Health and Addiction Services (DMHAS) promotes and administers comprehensive, recovery-oriented mental health and substance abuse treatment and prevention services to adults throughout Connecticut. DMHAS operates on the belief that most people with mental illnesses and/or substance use disorders can and should be treated in community settings, and that inpatient treatment should be used only when absolutely necessary to meet the best interests of the patient. Effective care requires that services such as residential, supportive, rehabilitative and crisis intervention programs are available within their local communities. DMHAS is responsible for providing a wide range of services to adults in each of the five mental health service regions in Connecticut.

Structure of the Behavioral Health Trends Databook

For the purposes of this publication, all data are presented by state fiscal year (SFY) which runs from July 1 to June 30. Previous hospitalization refers to a prior hospitalization at the same hospital. Unless otherwise noted, all inpatient data are from the Office of Health Care Access Acute Care Hospital Inpatient Discharge Database and all emergency department data are from the Connecticut Hospital Association's CHIME Emergency Department (ED) database. All ED data and analyses exclude Sharon Hospital, as this facility does not report to the Connecticut Hospital Association.

The *Acute Care Hospital Behavioral Health Trends Databook* is intended as a reference document providing extensive, though not exhaustive, information. It is organized to allow the reader to quickly find relevant information. The first section presents a contextual background and summary of findings. The second section focuses on Emergency Department utilization by BH patients under age 18, followed by a section on ED utilization by BH patients age 18 and over. The third section examines BH patient discharges for children under age 13. The next section covers BH discharges for adolescents ages 13 to 17. That is followed by a section discussing adult behavioral health discharges for patients ages 18 and over.

Summary of Observations

Even as the system adjusts to a more coordinated community-based orientation, many patients still require hospital based services. This databook provides a thorough review of the emergency department and inpatient utilization data available to the Office of Health Care Access. Some of the trends from the data are detailed on the following pages.

Behavioral Health Emergency Department Utilization

- Emergency department visits for behavioral health-related primary diagnoses grew by 5% from 2004 to 2007 for all age groups; most of the growth occurred in 2006. The utilization rate (number of visits per 1,000 population) for 2007 remained at the 2006 level as a result of a 1% population decline.

- Although time of day plays a critical role in a patient's decision as to whether or not to go to the emergency department, in 2007 more than 40% of patients visited the ED for behavioral health services between 9:00 a.m. and 5:00 p.m.

- While no patients were "self-referred" to the ED in 2004, by 2007 approximately 13% of adults and 15% of children and adolescents fell into this category.

- In 2007, Medicaid covered the largest share (48%) of ED BH patient visits under age 18, followed by private insurance (46%), uninsured (5%) and Medicare (1%). Charges associated with these visits totaled over $39 million, with Medicaid responsible for 61% or $24 million of the total. Uninsured behavioral health patients under age 18 accounted for approximately $832,000 in charges.

- Medicaid also covered the largest share (38%) of adult ED BH patient visits in 2007, followed by Medicare and private insurance (both at 23%) and uninsured (17%). This was largely unchanged from 2004. Charges totaled approximately $394 million; 36% (or more than $142 million) of the total charges were Medicaid; while uninsured charges were 9% of the total, or over $34 million.

Behavioral Health Hospital Inpatient Utilization

Children (under age 13)

- Overall, statewide discharges for behavioral health patients under age 13 declined between 2004 and 2007; with the largest decline (-16%) occurring between 2006 and 2007 (-142 discharges). The number of children readmitted to the same facility for the same behavioral health diagnosis within a year decreased from 86 discharges in 2006 to 79 discharges in 2007 as did the number of first-time admissions, which dropped from 685 to 564.

- The total share of behavioral health inpatient charges for children was 10% of all charges for this age group; with Medicaid accounting for three-quarters of the $26 million in total behavioral health charges for children under age 13.

- In the four years reviewed, the statewide average length of stay for children dropped from 20.9 days in 2004 to 19.3 days in 2007.

Adolescents (ages 13-17)

- The number of adolescents discharged from inpatient behavioral health services declined by 7% from 2004 to 2007; however, the utilization rate per 1,000 adolescent population increased from 6.2 to 6.7 due to a 17% decline in population.

- The number of adolescents readmitted within a year to the same facility for the same behavioral health diagnosis increased from 129 discharges (9%) in 2004 to 163 (12%) in 2007.

- Insurance coverage for adolescent inpatient behavioral health patients shifted from 2004 to 2007, with Medicaid growing from 42% to 54% and private coverage dropping from 57% to 45%.

- The number of adolescent behavioral health patients transferred to another inpatient facility declined by 40% over the four years, from 236 transfers in 2004 to 140 transfers in 2007.

- Statewide average length of stay for adolescent behavioral health patients increased from 10.2 days in 2004 to 11.5 days in 2007.

Adults (age 18 and over)

- Both the adult population and the number of adults discharged from acute care inpatient behavioral health services increased by 3% over the four-year period; utilization per 1,000 adult population remained at 9.3.

- Medicaid paid for 36% of adult behavioral health discharges in both 2004 and 2007. Over that same time period, privately-covered adult behavioral health discharges dropped from 28% to 26% and uninsured discharges grew from 4% to 6% of total adult behavioral health discharges.

- The charges associated with uninsured adult behavioral health inpatient discharges totaled $21 million, or 5% of all behavioral health inpatient charges ($385 million).

- The average adult behavioral health inpatient length of stay dropped from 8.3 days in 2004 to 7.8 days in 2007. The average length of stay declined in all discharge categories except transfers to psychiatric hospitals and remained unchanged for Medicaid-covered adults.

BH ED utilization by patients under age 18

BH ED visits increased for children and adolescents

Table 1: ED visits for a BH- related primary diagnosis, < age 18, SFY 2004–2007

	ED Visits[1]	% Change in Visits	Population	% Change in Population	Utilization per 1,000
SFY04	8,312		852,985	-4%	9.7
SFY05	8,318	0%	839,723	-2%	9.9
SFY06	8,867	7%	832,474	-1%	10.7
SFY07	8,743	-1%	820,339	-1%	10.7
2004/2007	- -	5%	- -	-4%	9%

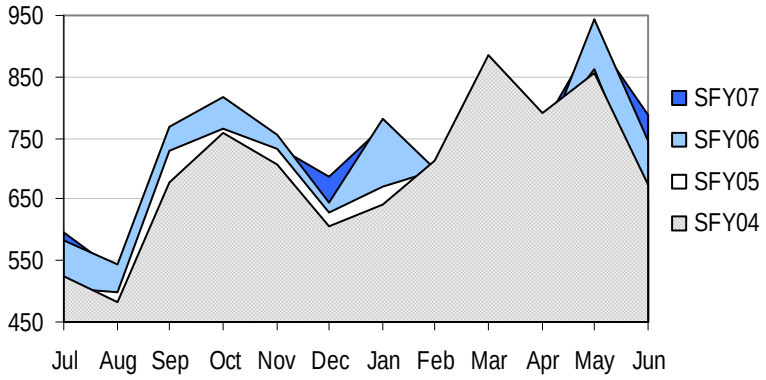
Source: *Connecticut Hospital Association CHIME ED database. U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2003-2007.*

[1] Emergency department discharges assigned an ICD- 9-CM primary diagnosis code in the range 290-319.

The number of visits made by children and adolescents in the state to emergency departments for a BH primary diagnosis increased by 5% from 8,312 in 2004 to 8,743 in 2007. The growth in visits and a declining population raised the utilization rate from 9.7 to 10.7 per 1,000 population.

BH ED visits peaked in January, March, May and October

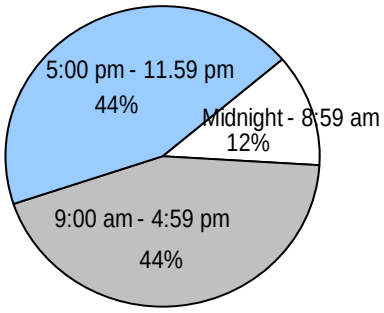
Figure 1: Number of BH ED visits per month, < age 18, SFYs 2004-2007



Each year, the number of BH visits peaked in October, March and May. In the last two years, they peaked in January as well.

Almost three in five BH ED visits occurred after office hours

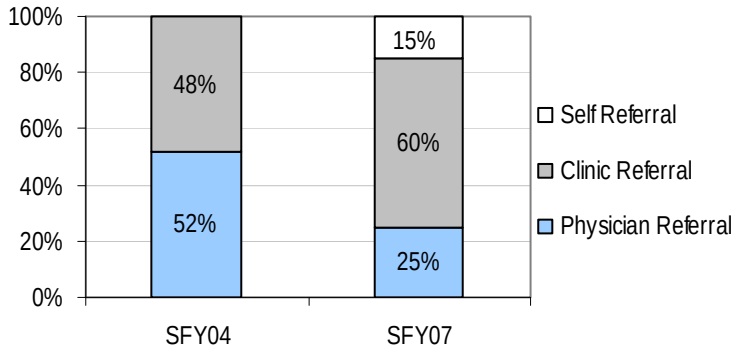
Figure 2: Admission times for BH ED visits, < age 18, SFY 2007



Almost three in five BH ED admissions occurred after physician and community services office hours. Most after-hours BH ED admissions occurred between 5:00 p.m. and midnight at an average rate of 1.5 per hour statewide. The average BH ED admission rate per hour dropped to 1.3 during office hours and to 0.3 from midnight to 8:00 a.m.

Three quarters of BH ED visits were clinic- or self-referrals

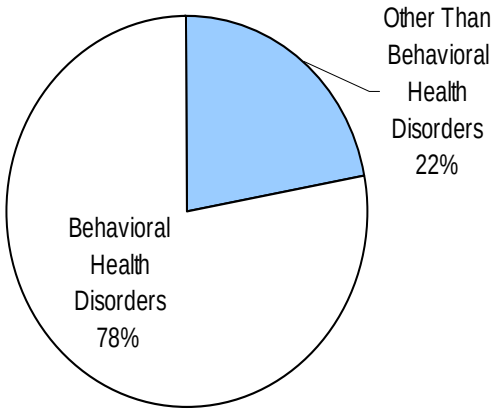
Figure 3: Point of origin for BH ED visits, < age 18, SFYs 2004 and 2007



There were fewer physician BH ED referrals in 2007 than in 2004. While there were no self-referrals in 2004, they comprised 15% of admissions in 2007. Clinic referrals also increased by 12 percentage points to 60% in 2007.

One in five children and adolescent BH ED patients presented with non-BH disorder

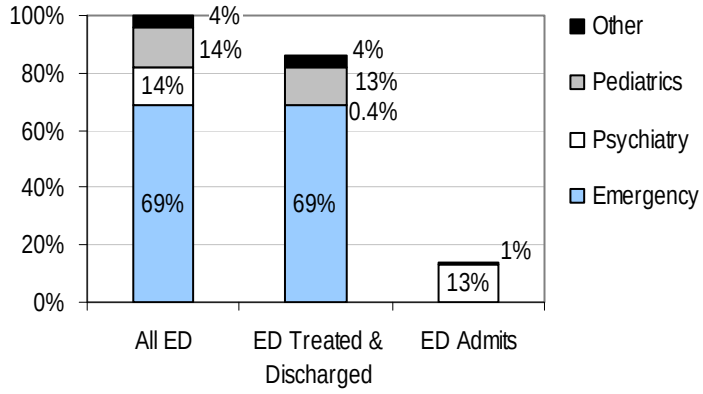
Figure 4: Admitting diagnoses, BH ED patients under age 18, SFY 2007



Approximately 22% of children and adolescents treated in the ED for a BH diagnosis initially presented with a non-BH disorder.

ED physicians attended to largest portion of children and adolescent BH ED patients

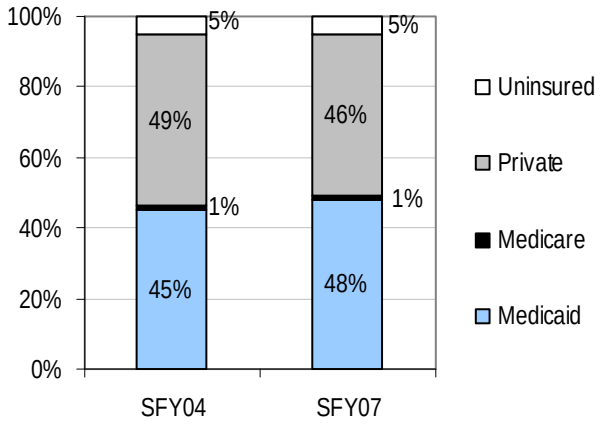
Figure 5: BH ED patients under age 18 attending physician specialty, SFYs 2004-2007



Pediatric and adolescent BH patients in the ED were treated by either an emergency room physician (69%), pediatrician (14%) or psychiatrist (14%).[1] Those patients admitted to an inpatient bed were nearly always treated by a psychiatrist.

Medicaid-covered BH ED patients' utilization increased

Figure 6: Primary payers for BH ED visits under age 18, SFYs 2004 and 2007



Medicaid-covered patients' share of visits increased from 45% in 2004 to 48% in 2007. Private insurance-covered visits dropped from 49% to 46%. Uninsured visits accounted for only 5% of visits in both 2004 and 2007.

Medicaid patients accounted for over 60% of BH ED charges

Table 2: Primary payer's share of total BH ED charges, under age 18, SFY 2007

Primary Payer	2007 Total BH Charges[1]	% of Total	% for Treated & Discharged	% of Payer's 2007 Total ED Charges[1]	2007 Charge Per Discharge
Medicare	$245,131	1%	33%	4%	$3,103
Medicaid	$24,118,644	61%	18%	12%	$5,751
Private	$14,427,618	36%	32%	6%	$3,585
Uninsured	$832,090	2%	71%	4%	$1,866
Total	$39,623,483	100%	24%	9%	$4,532

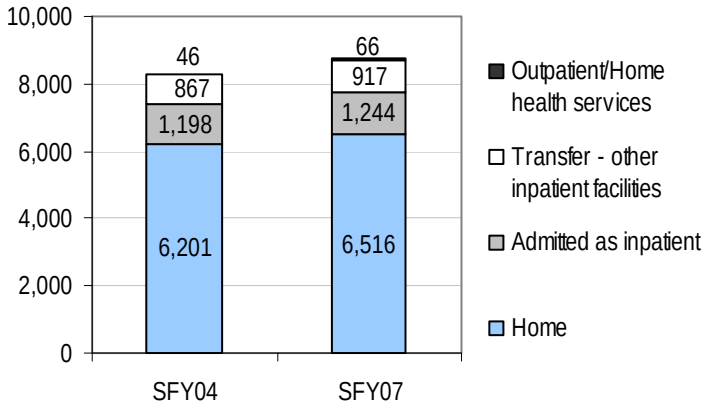
Source: *CT Office of Health Care Access Acute Care Discharge Database. U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2003-2007.*

[1] Includes inpatient charges for the treated and admitted.

Medicaid patients accounted for roughly 60% of the $39.6 million in total BH charges. Treated and discharged patients accounted for about one-quarter of total ED charges. BH related charges were almost 10% of total ED charges.

Number of BH ED patients discharged to "home" growing

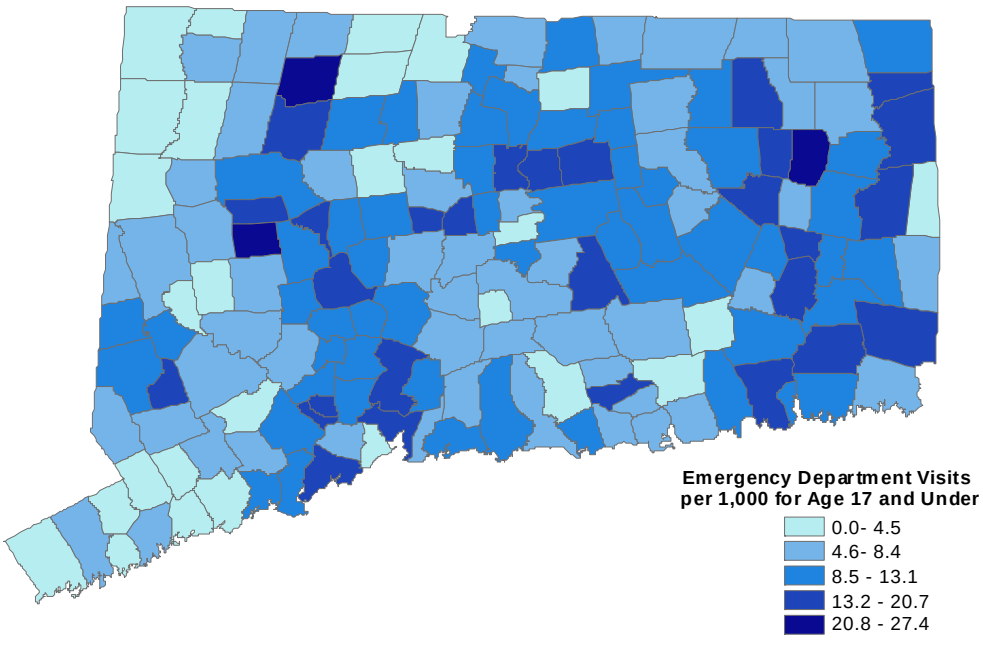
Figure 7: BH discharge destination, under age 18, SFYs 2004 and 2007



While the proportion remained at 75% in 2004 and 2007, the actual number of children and adolescents discharged to "home" increased from 6,201 to 6,516. The number admitted or transferred to inpatient services grew by just under 100 from 2004 to 2,161 in 2007.

BH ED utilization by children and adolescents in several towns exceeded statewide average

Map 1: BH ED visits per 1,000 under age 18 population, SFY 2007



In 2007, Winchester, at 27.4 per 1,000 and Bethlehem at 26.7 per 1,000 of under age 18 population had the highest BH ED utilization rates. Sterling and Barkhamsted, both at 1.1 per 1,000 population, had the lowest. The statewide BH ED utilization rate for this age cohort was 10.4 per 1,000. (See Appendix 2 for more detail.)

BH ED utilization by adults age 18 and over

Adult BH ED visits rose

Table 3: ED visits for a BH-related primary diagnosis, age 18 and over, SFYs 2004-2007

	ED Visits[1]	% Change in Visits	Population	% Change in Population	Utilization per 1,000
SFY04	69,859		2,568,350	3%	27.2
SFY05	69,576	0%	2,652,450	3%	26.2
SFY06	72,975	5%	2,654,201	0%	27.5
SFY07	73,601	1%	2,641,934	0%	27.9
2004/2007	- -	5%	- -	3%	2%

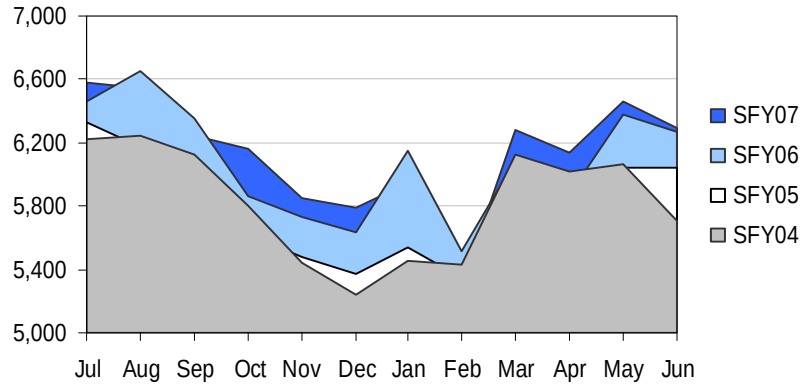
Source: *Connecticut Hospital Association CHIME ED database. U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2003-2007.*

[1] Emergency department discharges assigned an ICD-9-CM primary diagnosis code in the range 290-319.

Compared to a 3% population growth, adult ED visits for behavioral health care grew by 5% over the last four years, increasing utilization from 27.2 to 27.9 per 1,000 of the adult population.

Adult BH ED visits peaked four times a year

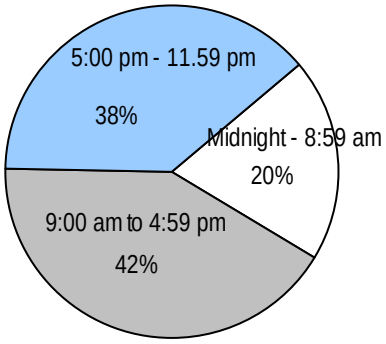
Figure 8: Number of BH ED visits per month, age 18 and over, SFYs 2004-2007



Adult BH ED visits peaked in January, March, May and August.

Three in five of adult BH ED visits occur after hours

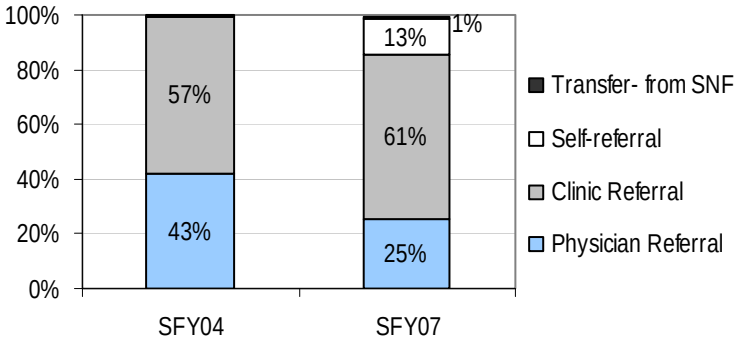
Figure 9: Admission times for BH ED visits, age 18 and over, SFY 2007



Nearly 60% of adult BH ED visits occurred after hours when most physician and community services offices are closed. Most after-hours admissions occurred between 5:00 p.m. and midnight. In 2007, the statewide average BH ED admission rate per hour was 10.9 during office hours and 4.3 from midnight to 8:00 a.m.

The majority of adult BH ED visits were clinic-referred

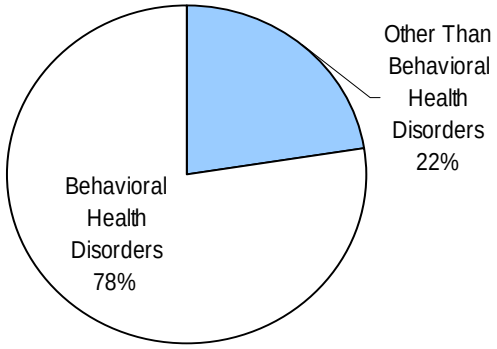
Figure 10: Point of origin for BH ED visits, age 18 and over, SFYs 2004 and 2007



There were fewer physician BH ED referrals in 2007 than in 2004. However, during the same period, self-referrals increased from zero to 13%. Clinic referrals also increased four percentage points to 61% in 2007.

One in five adult BH ED patients presented with non-BH disorder

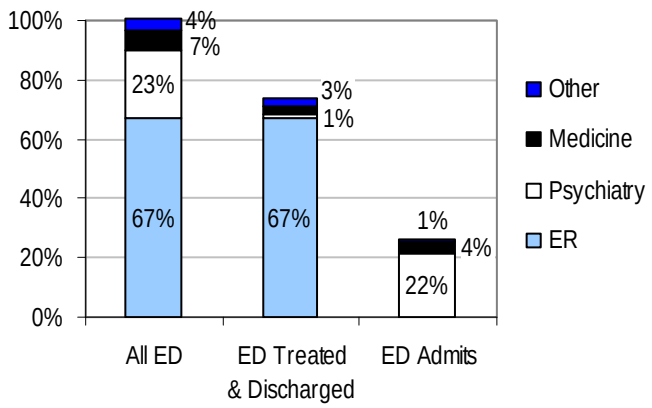
Figure 11: Admitting diagnoses, BH ED patients age 18 and over, SFY 2007



Approximately 22% of adults treated in the ED for a BH diagnosis initially presented with a non-BH disorder.

ED physicians treated two-thirds of adult BH ED patients

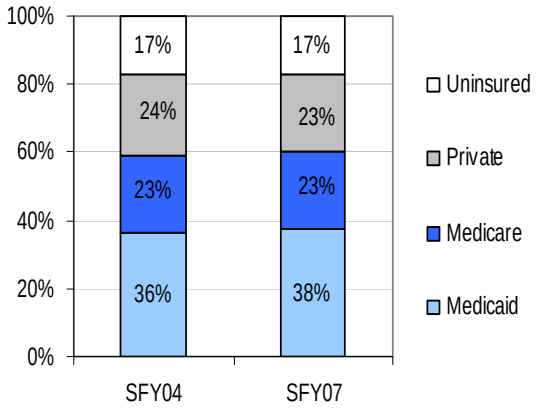
Figure 12: BH ED patients age 18 and over attending physician specialty, SFYs 2004-2007



Either an emergency room physician (67%) or a psychiatrist (23%) tended to majority of adult BH ED admissions, whereas 95% of adults treated and admitted to an inpatient bed in the same hospital had a psychiatrist as an attending physician.

Three in five adult BH ED visits publicly covered, one in five uninsured

Figure 13: Primary payers for ED BH visits, age 18 and over, SFYs 2004 and 2007



A significant share (60%) of ED visits by adults with a behavioral health-related primary diagnosis were covered by a public payer, Medicaid (38%) or Medicare (22%). Patients without insurance comprised almost one in five visits.

Public payers were responsible for significant portion of BH ED charges

Table 4: Primary payer's share of total BH ED charges, age 18 and over, SFY 2007

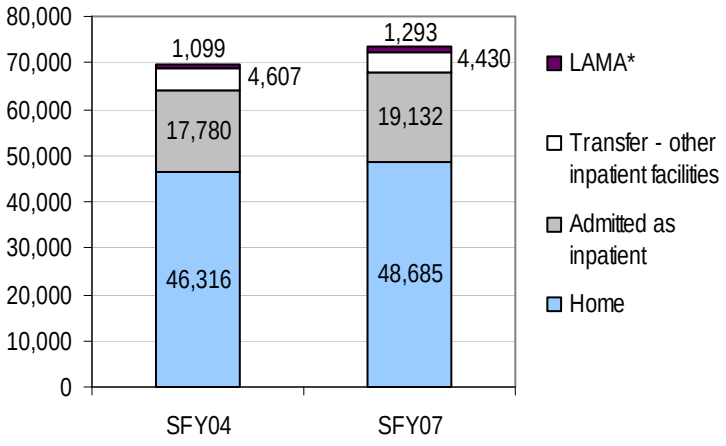
Primary Payer	2007 Total BH Charges[1]	% of Total	% for Treated & Discharged	% of Payer's 2007 Total ED Charges[1]	2007 Charge per discharge
Medicare	$134,704,778	34%	12%	4%	$8,022
Medicaid	$142,845,694	36%	19%	15%	$5,173
Private	$81,846,254	21%	22%	5%	$4,905
Uninsured	$34,810,087	9%	47%	10%	$2,783
Total	$394,206,812	100%	20%	6%	$5,356

Source: *CT Office of Health Care Access Acute Care Discharge Database. U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2003 - 2007.*

Public payers were responsible for a significant portion of the $394 million in total BH charges in 2007: Medicare (34%) and Medicaid (36%). Patients treated in the ED and discharged accounted for one-fifth of the total charges.

Increasing number of adult BH ED visits discharged to "home"

Figure 14: BH discharge destination, age 18 and under, SFYs 2004 and 2007



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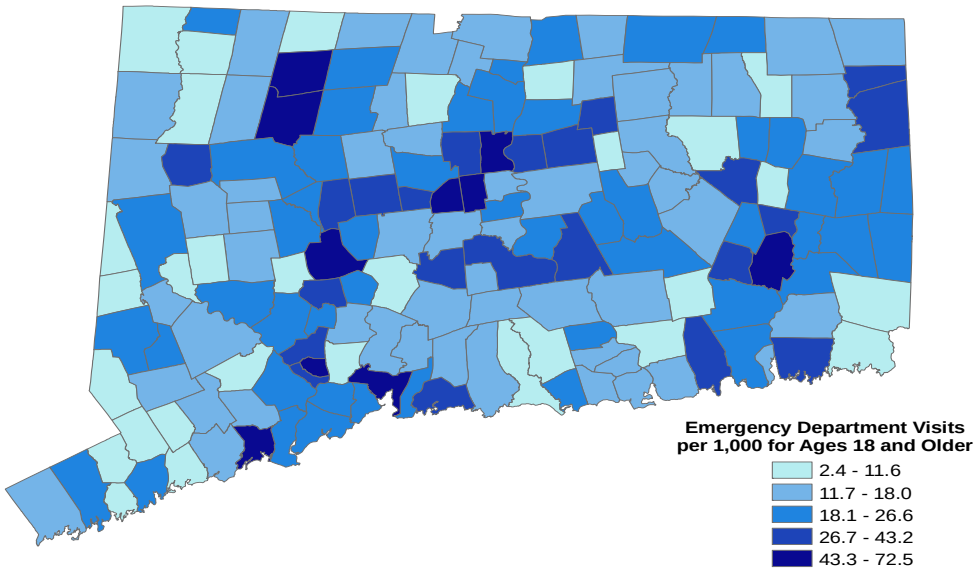
Approximately 66% of BH ED visits were discharged to home in both 2004 and 2007. While the proportion was the same in both years, the actual number of adults discharged to home increased from 46,316 in 2004 to 48,685 in 2007. The number of patients admitted or transferred to inpatient care grew by 1,175 from 2004 to 2007. Approximately 25% of patients were treated and admitted to inpatient care at the same hospital.

Highest BH ED utilization by adults more likely to occur in large cities

Map 2: BH ED visits per 1,000 age 18 and over population, SFY 2007



In 2007, Hartford (72.5 per 1,000) and Norwich (66.3 per 1,000) had the highest adult BH ED utilization rates. Lyme (2.5 per 1,000) and New Canaan (4.0 per 1,000) had the lowest. The statewide ED utilization rate was 28.7 per 1,000 of the adult population. (See Appendix 2 for more detail.)

BH inpatient discharges, children under age 13

Fewer children admitted to inpatient behavioral health care

Table 5: Acute care behavioral health utilization and bed availability, under age 13, SFYs 2004-2007

	Discharges[1]	% Change in Discharges	Population	% Change in Population	Utilization per 1,000	Beds[2] Available per 100,000
SFY04	802		580,004	-8%	1.4	7.9
SFY05	876	9%	583,715	1%	1.5	7.9
SFY06	881	1%	582,670	0%	1.5	7.9
SFY07	739	-16%	586,305	1%	1.3	7.8
2004/2007	- -	-8%	- -	1%	-10%	-1%

Source: *CT Office of Health Care Access Acute Care Discharge Database. U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement , 2003-2007.*

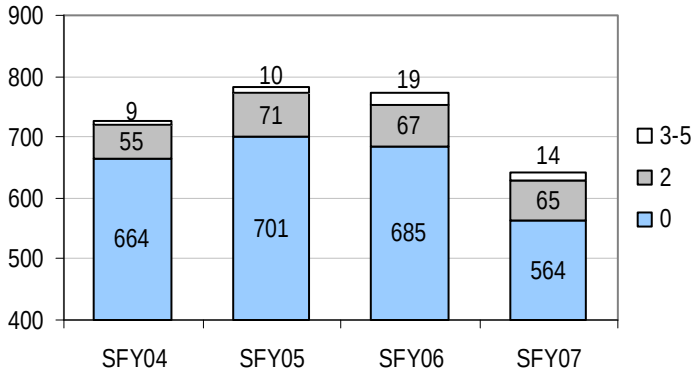
[1] Acute care discharges assigned a Diagnosis Related Group (DRG) code in the ranges 424-437 and 521-523.

[2] Assumes 46 beds over the five-year period. See Appendix 1 for details for 2007.

The number of children admitted to acute care inpatient behavioral health services declined by 8% between 2004 to 2007. Utilization per 1,000 of that population dropped slightly from 1.4 to 1.3 despite a 1% increase in Connecticut residents in that age group. The 16% reduction in discharges in 2007 may be attributable to activities of the CT BHP.

Number of children already known to the system increasing

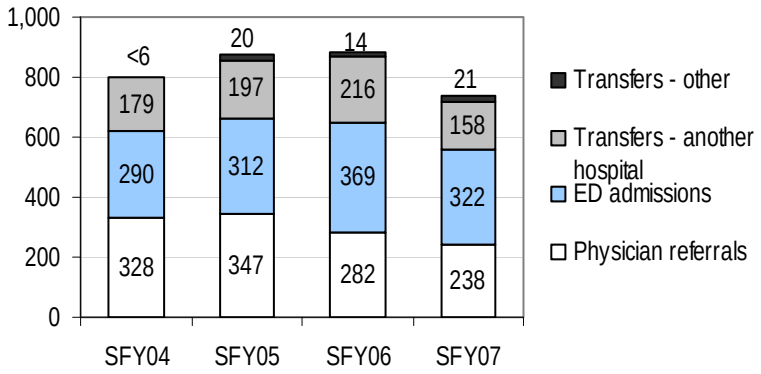
Figure 15: Number readmitted and frequency of readmissions for same BH diagnosis, under age 13, SFYs 2004-2007



The number of children readmitted to the same facility for the same behavioral health diagnosis within a year increased from 64 (9%) in 2004 to 79 (12%) in 2007. Readmissions were 2.1 and 0.7 times more likely to occur in 2007 than in 2004 within 30 days and six months of discharge, respectively. Most of the children were admitted only once into inpatient care within the year. First-time admissions declined by almost 100 from 664 to 564 over the same period.

More children access inpatient BH care through EDs

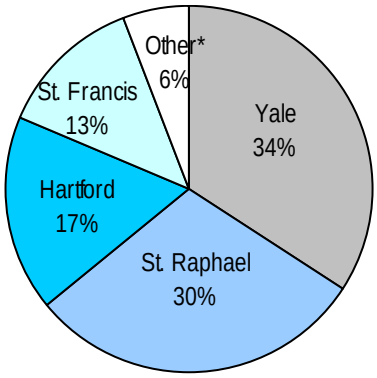
Figure 16: Source of BH admission, under age 13, SFYs 2004 and 2007



Children were more likely to access inpatient BH care through the emergency department (ED). Children that accessed inpatient care through the ED grew from 469 or 58% in 2004 to 480 or 65% in SFY 2007, when "ED admits" and "transfers from another hospital" are combined. Acute care hospitals without available and/or dedicated BH beds may transfer children to another hospital with available and appropriate beds.

Most children received BH care in a pediatric psychiatric unit

Figure 17: Treating hospitals, under age 13, SFY 2007

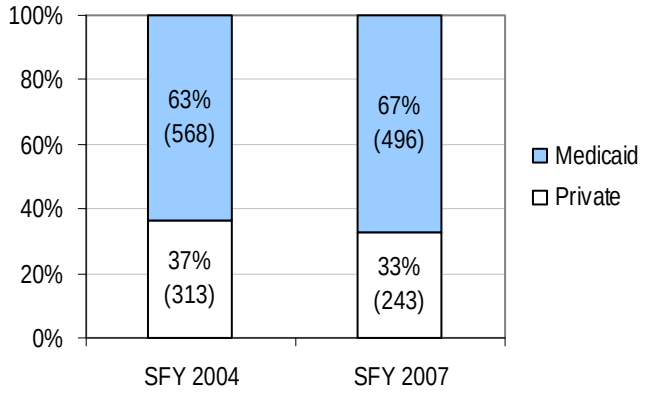


*Includes Danbury (2%), Manchester (1%), CCMC (1%), Waterbury (1%) and Stamford (1%)

In 2007, nine in ten behavioral health-related discharges received inpatient care at the four acute care hospitals that have dedicated psychiatric beds for children. The hospitals were Yale New Haven Hospital (34%), Hospital of Saint Raphael (30%), Hartford Hospital (17%) and St. Francis Hospital and Medical Center (13%). Also, seven in ten children of children receiving BH care did so in a psychiatric unit.

Children twice more likely to have Medicaid coverage

Figure 18: BH primary payers, under age 13, SFYs 2004 and 2007



Medicaid covered two-thirds of children that received acute care inpatient BH services. The number of Medicaid-covered children dropped from 509 in 2004 to 496 in 2007, a decline of approximately 4%.

Medicaid accounted for three-quarters of BH total charges

Table 6: Primary payer's share of children's total BH inpatient charges, under age 13, SFY 2007

Primary Payer	2007 Total BH Charges	% of Total	Change Between 2004 & 2007	Share of 2007 Total Inpatient	2007 Charge Per Discharge
Medicaid	$19,762,672	75%	14%	15%	$39,844
Private	$6,433,432	25%	15%	5%	$26,475
Total	$26,196,104	100%	14%	10%	$35,448

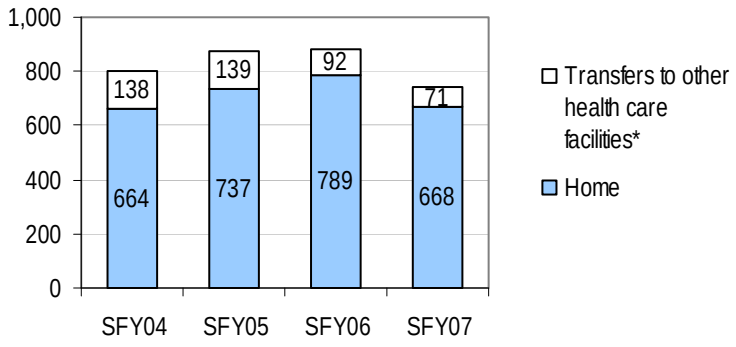
Source: *CT Office of Health Care Access Acute Care Discharge Database. U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2003-2007.*

[1] Total Inpatient charges exclude charges associated with newborns and births.

Medicaid accounted for three-quarters of total charges of $26.1 million for children receiving inpatient BH services in 2007. Between 2004 and 2007, total Medicaid and private insurance charges grew at almost similar rates.

Fewer BH children discharged to care other than "home"

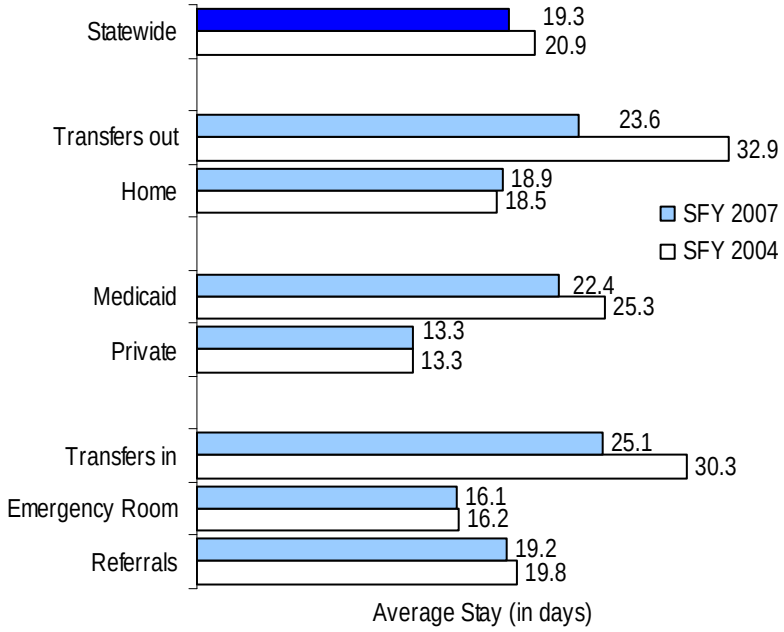
Figure 19: BH Discharge destination, under age 13, SFYs 2004-2007



The number of transfers to another inpatient facility (e.g., acute care, residential, etc.) for care subsequent to acute care dropped by one-half -- from 138 to 71.

Stays declined for BH transfers and Medicaid patients

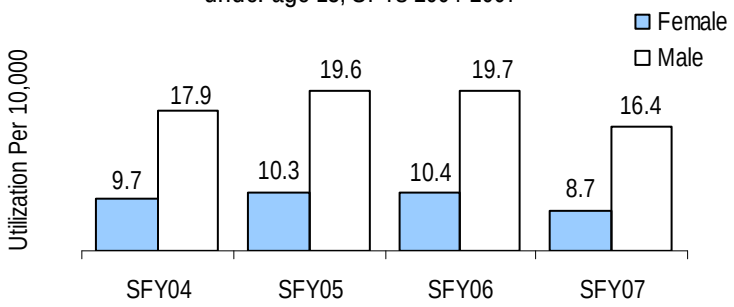
Figure 20: Average BH stay by admission source, insurance coverage and discharge disposition, under age 13, SFYs 2004 and 2007 (in days)



In four years, statewide average stays dropped by 1.6 days to 19.3 days in 2007. Between 2004 and 2007, the average inpatient stay declined for: (1) patients transferred in from other facilities (from 30.3 days in 2004 to 25.1 days in 2007); (2) patients transferred out to another facility (from 32.9 to 23.6 days); and (3) patients with Medicaid coverage from 25.3 to 22.4 days.

Boys twice as likely to be hospitalized for acute BH care

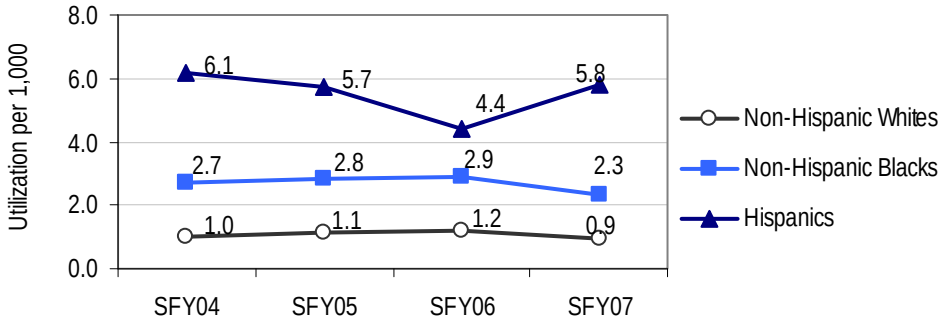
Figure 21: Inpatient utilization by gender, under age 13, SFYs 2004-2007



Boys under age 13 were twice as likely as girls of the same age to be admitted to acute behavioral health care. In 2007, the utilization rate for boys was 16.4 per 10,000 compared to 8.7 per 10,000 for girls. Both genders showed a similar rate of decline in utilization over the four years.

Hispanic children have highest BH utilization rate

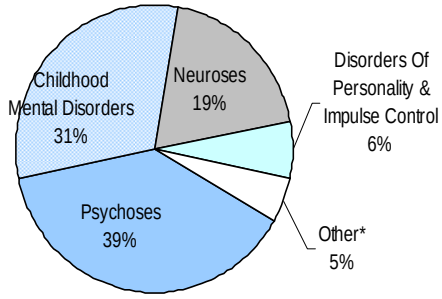
Figure 22: BH Utilization per 1,000 by race and ethnicity, under age 13, SFYs 2004-2007



Hispanic children had 6.3 times Non-Hispanic white children's utilization rate. Non-Hispanic black children had 2.5 times Non-Hispanic white children's utilization rate.

Most children admitted for BH care treated for psychosis or childhood mental disease

Figure 23: Primary reasons for inpatient admission, under age 13, SFY 2007



*All other behavioral health diagnoses

.

Adolescent BH inpatient discharges, ages 13 to 17

Adolescent BH discharges declined, but utilization rate rose

Table 7: Acute care hospital BH utilization and bed availability, ages 13 to 17, SFYs 2004-2007

	Discharges[1]	% Change in Discharges	Population	% Change in Population	Utilization per 1,000	Beds[2] Available per 100,000
SFY04	1,690		272,981	9%	6.2	22.0
SFY05	1,524	-10%	256,008	-6%	6.0	23.4
SFY06	1,523	0%	249,804	-2%	6.1	24.0
SFY07	1,566	3%	234,034	-6%	6.7	25.6
2004/2007	- -	-7%	- -	-17%	7%	14%

Source: *CT Office of Health Care Access Acute Care Discharge Database. U.S. Census Bureau, Current*

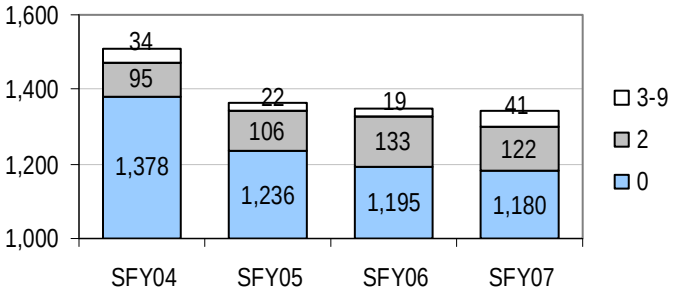
[1] Acute care discharges assigned a Diagnosis Related Group (DRG) code in the ranges 424-437 and 521-523.

[2] Assumes 60 beds over the five-year period. See Appendix 1 for details for 2007.

The number of adolescents discharged from acute care inpatient behavioral health hospitalization declined by 7% over the four-year period from 2004 to 2007. However, the utilization rate per 1,000 of the state's adolescent population increased from 6.2 to 6.7 due to a 17% decline in population. The decline in population increased bed availability by 14% from 22.0 to 25.6 per 100,000.

Number of adolescents already known to the system increased

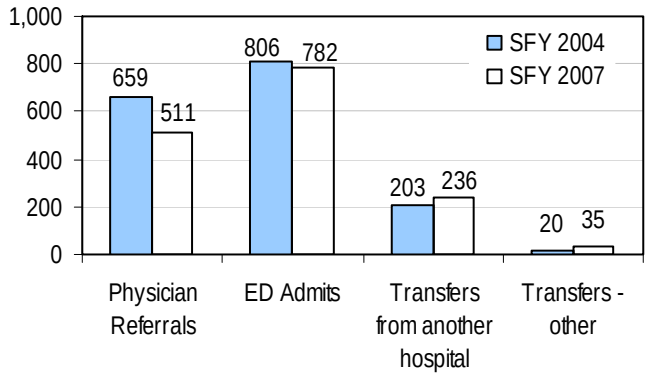
Figure 24: Number of adolescents readmitted and frequency of readmissions for same BH diagnosis, ages 13 to 17, SFYs 2000-2007



The number of adolescents readmitted to the same facility for the same behavioral health diagnosis within a year increased from 129 (9%) in 2004 to 163 (12%) in 2007. Readmissions were 2.2 and 1.4 times more likely to occur in 2007 than in 2004 within 30 days and six months of discharge, respectively. Most adolescents were admitted to inpatient care only once within the year. First time admits declined by 198 from 1,378 to 1,180 over the four-year period.

Adolescent inpatient BH admissions through the ED unchanged

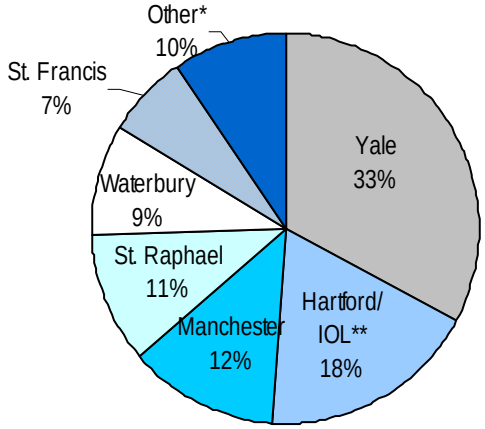
Figure 25: Source of BH admission for adolescents, ages 13 to 17, SFYs 2004 and 2007



The number of adolescents admitted to inpatient BH care through an ED remained almost the same (less than 1% change between the two years), from 1,009 in 2004 to 1,018 in 2007 when "ED admits" and "transfers from another hospital" were both taken into account. Acute care hospitals without available and/or dedicated BH beds may transfer adolescents to another hospital with available and appropriate beds. Physician referrals to inpatient BH care declined.

Most adolescents received BH care in a hospital psychiatric unit

Figure 26: BH treating hospitals, ages 13 to 17, SFY 2007

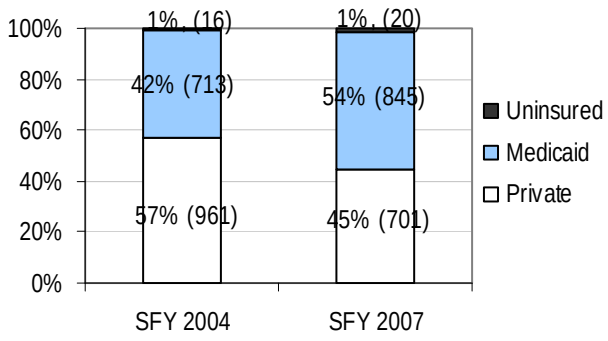


* Twenty-one other acute care hospitals
**Institute of Living

In 2007, nine in ten adolescents with a behavioral health-related diagnosis received their inpatient care at the six hospitals with dedicated adolescent psychiatric beds. The hospitals were Yale New Haven Hospital (33%), Hartford Hospital/IOL (18%), Manchester Hospital (12%), Hospital of Saint Raphael (11%), Waterbury Hospital (9%) and St. Francis Hospital and Medical Center (7%). The number of adolescents that received care in a non-psychiatric unit increased from 228 in 2004 to 353 in 2007.

Inpatient BH utilization by Medicaid-covered adolescents increased

Figure 27: BH primary payers, ages 13 to 17, SFYs 2004 and 2007



Medicaid-covered adolescent inpatient BH discharges increased by almost 20% from 713 in 2004 to 845 in 2007.

Medicaid's share of total inpatient BH charges largest

Table 8: Primary payer's share of total adolescent BH charges, ages 13 to 17, SFY 2007

Primary Payer	2007 Total Charges	% of Total	Change Between 2004 & 2007	Share of 2007 Total Inpatient Charges[1]	2007 Charge per discharge
Medicaid	$13,295,613	52%	39%	43%	$15,734
Private	$12,310,754	48%	-7%	16%	$17,562
Uninsured	$132,455	1%	51%	10%	$6,623
Total	$25,738,822	100%	23%	27%	$16,436

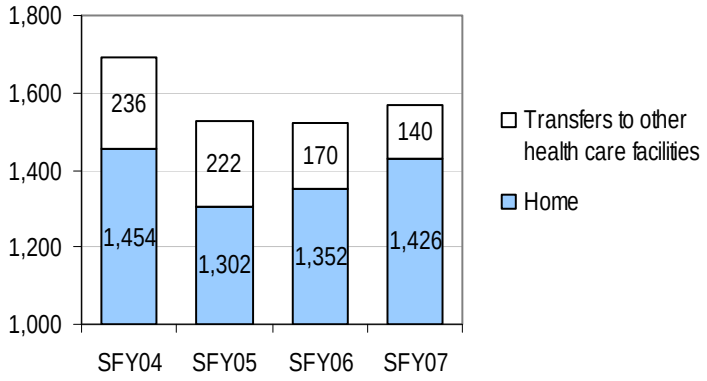
Source: *CT Office of Health Care Access Acute Care Discharge Database. U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement , 2003 - 2007.*

[1] Total Inpatient charges exclude charges associated with newborns and births.

Medicaid represented over one-half of $25.7 million in total charges in 2007. Medicaid and uninsured charges grew the most between the two years, 39% and 51%, respectively.

Number of BH adolescents discharged to inpatient care declined

Figure 28: BH discharge destination, ages 13 to 17, SFYs 2004-2007

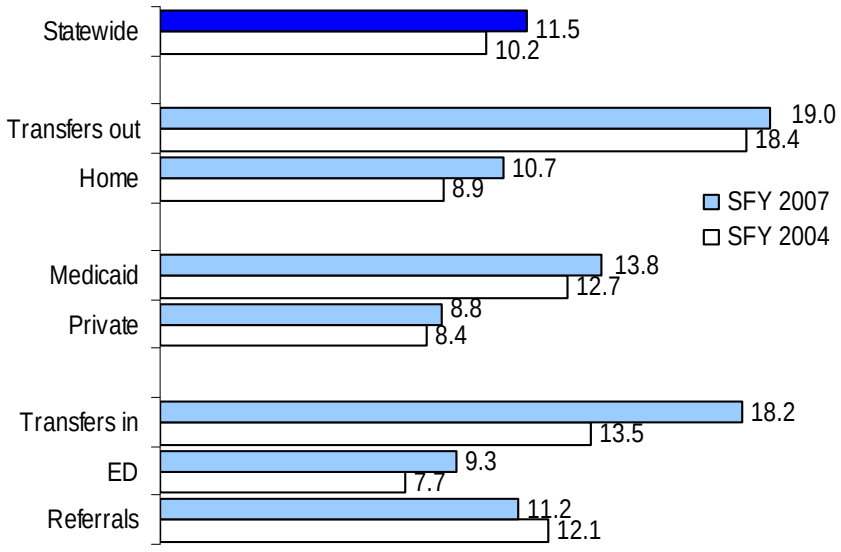


**Note: a small number of patients left against medical advice*

The number of transfers to another inpatient facility dropped by over 40% in four years, from 236 transfers in 2004 to 140 transfers in 2007.

Average stays lengthened for adolescent patients

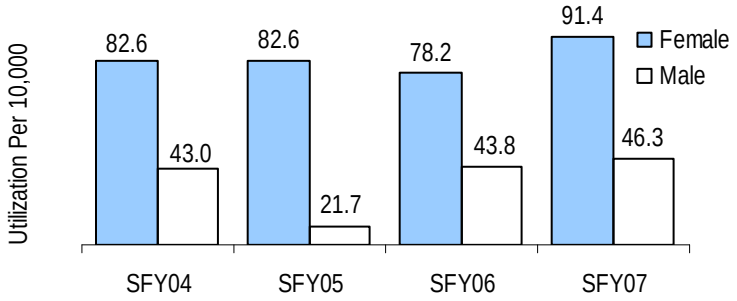
Figure 29: Average BH stay by admission source, insurance coverage and discharge disposition, ages 13 to 17, SFYs 2004 and 2007 (in days)



Statewide average stays for adolescents increased by 1.3 days in 2004 to 11.5 days in 2007. Average inpatient stays rose for all but physician-referred adolescents, whose average stay shortened by almost one day to 11.2 days. The largest increase in average stay was approximately five days for patients transferred from other health care facilities.

Female BH adolescents had higher utilization rate

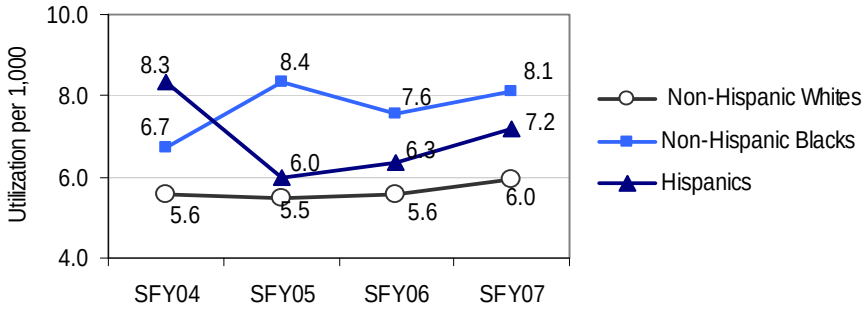
Fig 30: Inpatient BH Utilization by gender, ages 13 to 17, FYs 2004-2007



Adolescent females were twice as likely as adolescent males to be admitted to acute behavioral health care. In SFY 2007, the utilization rate for females ages 13 to 17 was 91.4 per 10,000 compared to 46.3 per 10,000 for males in the same age group.

Non-Hispanic black BH adolescents more likely to be hospitalized

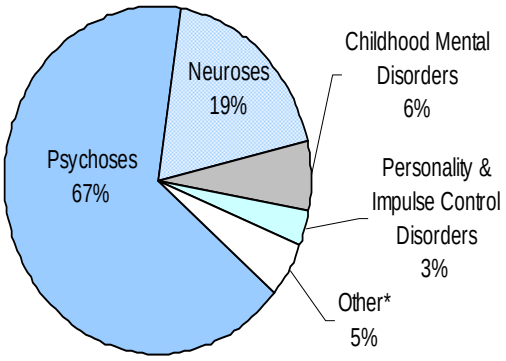
Figure 31: BH Utilization per 1,000 by race and ethnicity, ages 13 to 17, SFYs 2004-2007



Non-Hispanic black adolescents experienced the highest utilization rate at 8.1 per 1,000 compared to Non-Hispanic whites at 6.0 and Hispanics at 7.2 in 2007. Utilization rose for all three racial/ethnic categories in 2007.

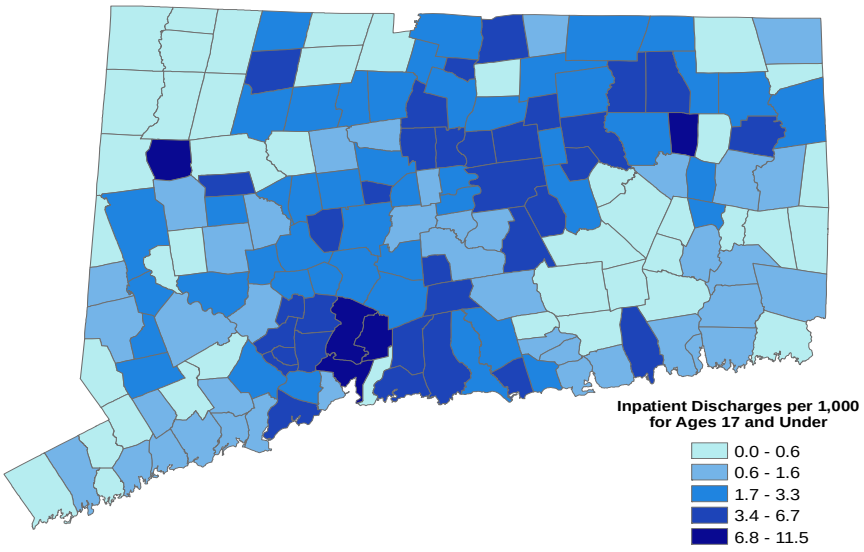
Most BH adolescents treated for psychoses or neuroses

Figure 32: Primary reasons for inpatient BH admission, ages 13 to 17, SFY 2007



High BH inpatient utilization towns are near hospitals with psychiatric beds

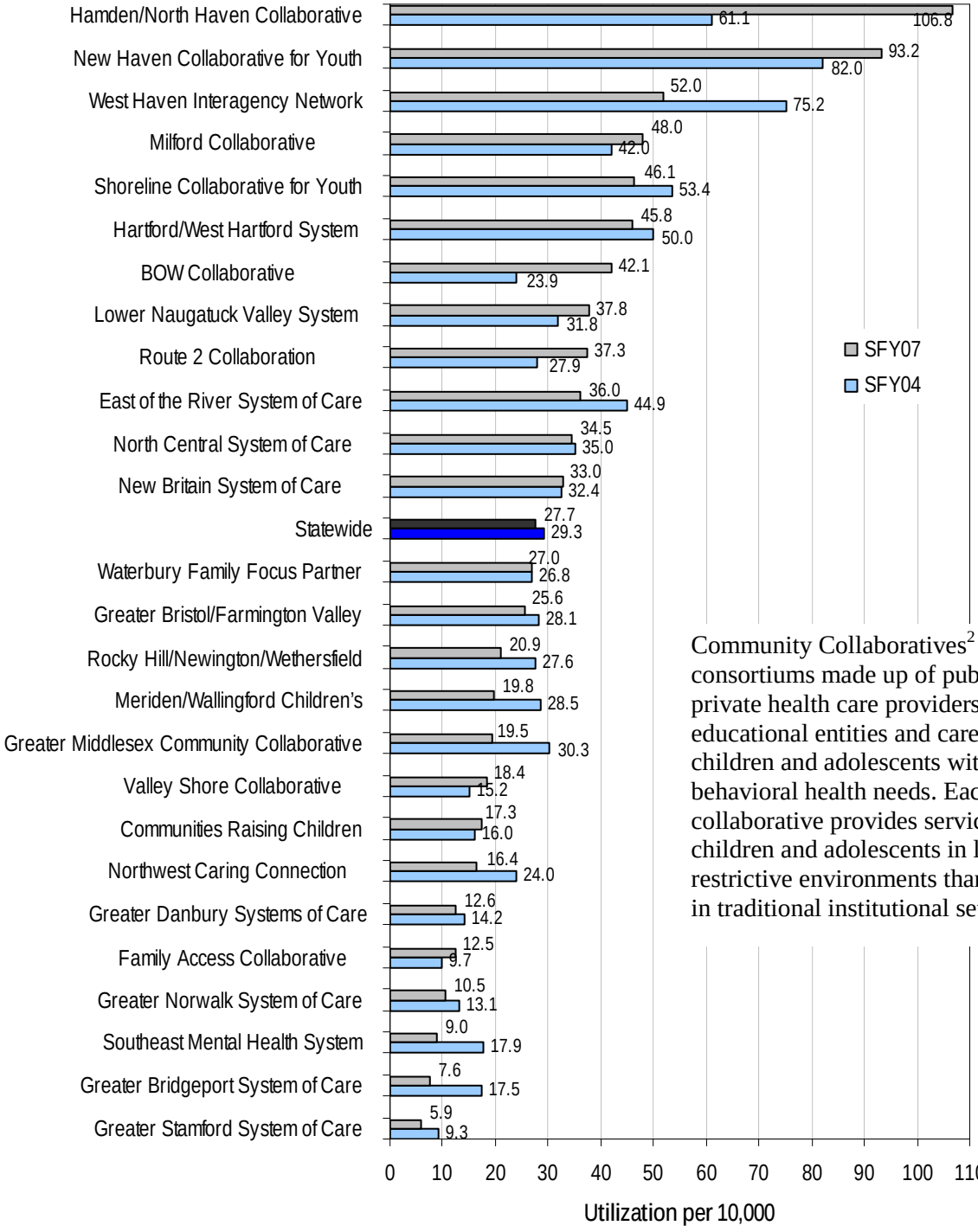
Map 3: Inpatient BH utilization per 1,000 of residents under age 18, SFY 2007



In 2007, most inpatient BH services high-utilization towns were in close proximity to the hospitals that provide inpatient BH services to children and adolescents. For example, in the New Haven area where Yale-New Haven Hospital and the Hospital of St. Raphael have psychiatric beds for children and adolescents, the surrounding towns had higher utilization rates than the statewide rate: Hamden had 11.5 per 1,000 and New Haven 9.3 per 1,000. Twenty-eight towns had no utilization and both Greenwich and Colchester had the lowest utilization rate, at 0.2 per 1,000 population. The statewide inpatient services utilization rate for this age group was 2.7 per 1,000 of the population. (See Appendix 2 for more detail.)

Most community collaboratives experienced declines in BH inpatient utilization

Figure 33: Inpatient BH utilization rates for residents under age 18 by community collaborative, SFYs 2004 and 2007



Community Collaboratives[2] are local consortiums made up of public and private health care providers, educational entities and caregivers of children and adolescents with severe behavioral health needs. Each collaborative provides services to children and adolescents in less restrictive environments than provided in traditional institutional settings.

Between 2004 and 2007, inpatient utilization for residents under age 18 declined for 16 of the 26 community collaboratives. In both years, utilization was highest for residents under age 18 in the Hamden/ North Haven Collaborative and New Haven Collaborative for Youth.

Adult BH inpatient discharges, age 18 and over

Adult BH discharges increase, utilization rate unchanged

Table 9: Acute care hospital BH utilization and bed availability, age 18 and over, SFYs 2004-2007

	Discharges[1]	% Change in Discharges	Population	% Change in Population	Utilization per 1,000	Beds[2] Available per 100,000
SFY04	23,969		2,568,350	3%	9.3	23.0
SFY05	23,797	-1%	2,652,450	3%	9.0	22.3
SFY06	23,677	-1%	2,654,201	0%	8.9	22.3
SFY07	24,629	4%	2,641,934	0%	9.3	22.4
2004/2007	- -	3%	- -	3%	0%	-3%

Source: *CT Office of Health Care Access Acute Care Discharge Database. U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2003-2007.*

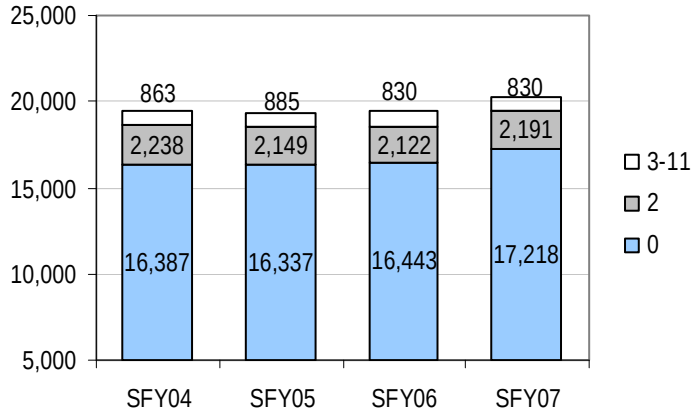
[1] Acute care discharges assigned a Diagnosis Related Group (DRG) code in the ranges 424-437 and 521-523.

[2] Assumes 592 beds over the five-year period. See Appendix 1 for details for 2007.

The number of adults discharged from acute care inpatient behavioral health services increased by 3% over the four-year period. However, utilization per 1,000 of the state's adult population remained at 9.3 per 1,000 and bed availability declined slightly, from 23.0 to 22.4 per 100,000 of the population. This may be due to the fact that, according to US Census estimates, Connecticut's adult population grew 3% from 2,568,350 to 2,641,934.

Increasing adult BH discharges driven by first time admits

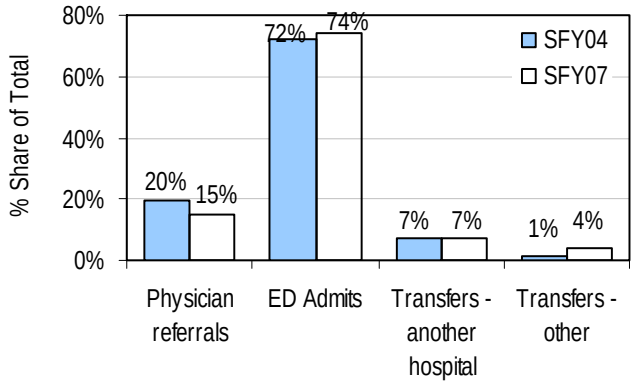
Figure 34: Number of adults readmitted and frequency of re-admissions for same BH diagnosis, age 18 and over, SFYs 2004-2007



Most adults were admitted for the first time within the year. The number increased from 16,387 in 2004 to 17,218 in 2007. Readmissions dropped from 3,101 in 2004 to 3,021 in 2007. Readmissions to the same hospital for the same diagnosis within 30 days of discharges were 1.3 times more likely in 2007 than in 2004. There was no difference in the rate of readmission within six months of discharge.

Most adults continued to access BH inpatient care through the ED

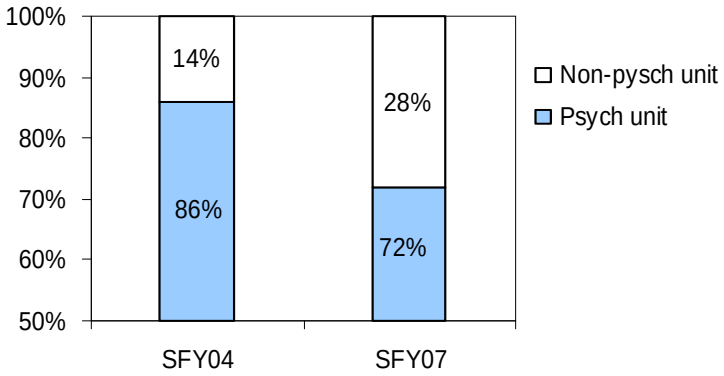
Figure 35: Source of BH admission, age 18 and over, SFYs 2004 and 2007



Three in four adults accessed inpatient BH care through the ED; increasing to four in five when "ED admits" and "transfers from another hospital" are combined. Acute care hospitals may admit some behavioral health patients to non-psychiatric beds.

Most adults received inpatient BH care in a psychiatric unit

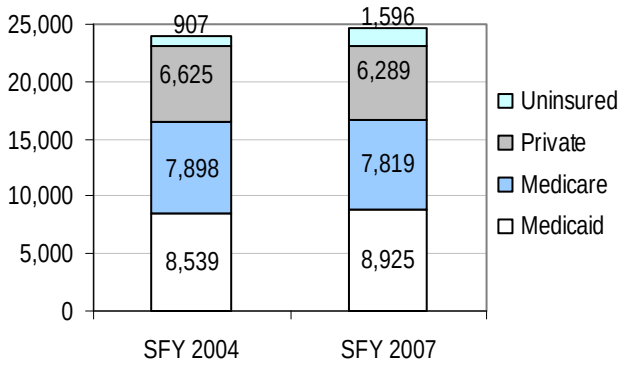
Figure 36: Treating hospital unit, age 18 and over, SFYs 2004 and 2007



In 2004, almost nine in ten adults received care in a psychiatric unit. Most (25) of the hospitals in the state have beds in a unit dedicated for adult behavioral health care. In the last four years however, the share of adults that received care in a non-psychiatric unit doubled from 14% in 2004 to 28% in 2007.

Uninsured and Medicaid adults drove increase in BH utilization

Figure 37:BH discharges by primary payers, age 18 and over, SFYs 2004 and 2007



The number of BH Medicaid-covered adults increased from 8,539 in 2004 to 8,925 in 2007, and for those without insurance, BH utilization increased from 907 (4%) to 1,596 (6%).

Public payers responsible for almost three quarters of BH total charges

Table 10: Primary payer's share of total BH charges, age 18 and over, SFY 2007

Primary Payer	2007 Total Charges	% of Total	Change Between 2004 & 2007	Share of 2007 Total Inpatient Charges[1]	2007 Charge per discharge
Medicare	$150,276,299	39%	13%	3%	$19,219
Medicaid	$134,900,671	35%	31%	15%	$15,115
Private	$78,977,391	21%	14%	3%	$12,558
Uninsured	$20,907,602	5%	131%	10%	$13,100
Total	$385,061,963	100%	23%	5%	$15,634

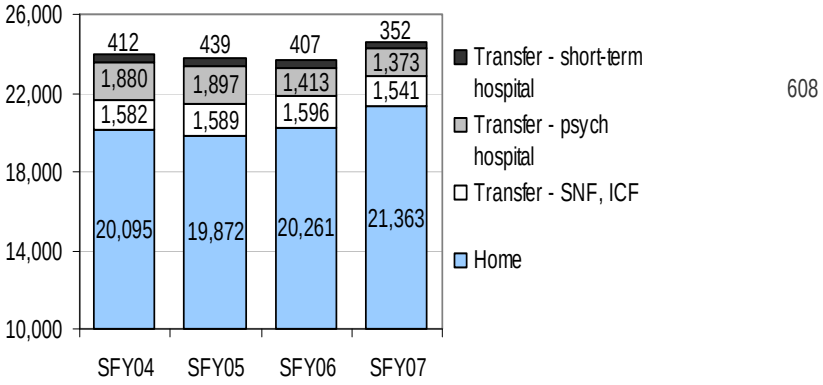
Source: *CT Office of Health Care Access Acute Care Discharge Database. U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2003-2007.*

[1] Total Inpatient charges exclude charges associated with newborns and births.

Public payers were responsible for almost three-quarters of the $385 million in total BH charges: Medicare (39%) and Medicaid (35%). Medicaid and uninsured charges grew the most, up 31% and 131%, respectively.

More BH adults discharged to "home," fewer to inpatient care

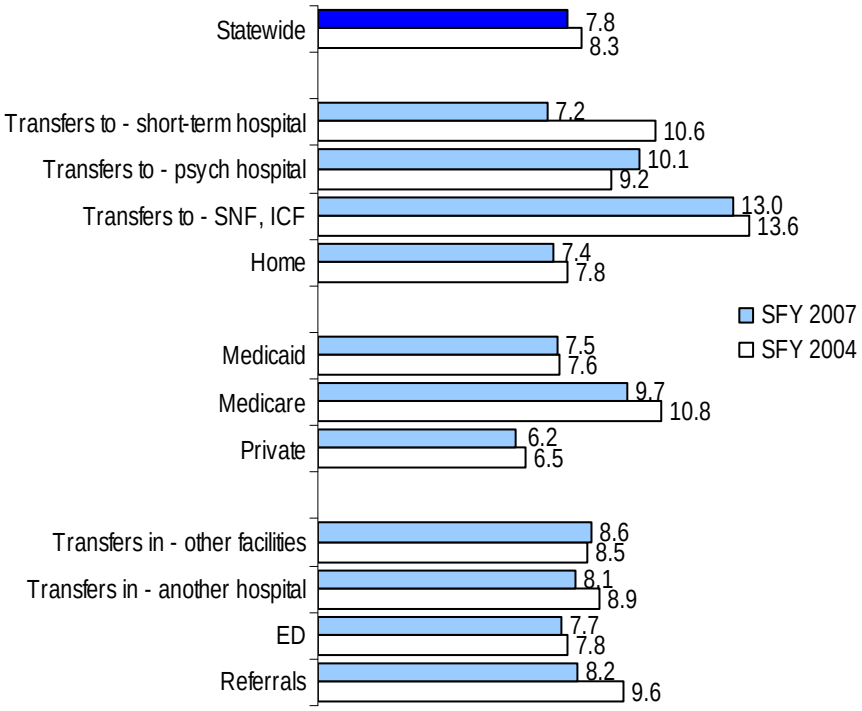
Figure 38: BH discharge destination, age 18 and over, SFYs 2004-2007



The number of adults discharged to home after acute care has risen in the last four years from 20,095 (or 84%) in 2004 to 21,393 (or 87%) in 2007. Transfers to inpatient care dropped by 608 to 3,266 in 2007.

Most BH adults' average stays shorter

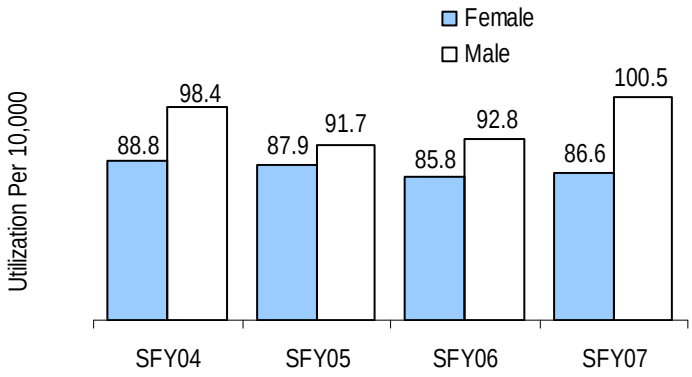
Figure 39: Average BH stay by admission source, insurance coverage and discharge disposition, age 18 and over, SFYs 2004 and 2007 (in days)



The average BH adult stay dropped from 8.3 days in 2004 to 7.8 days in 2007. Average stays declined for all but transfers to psychiatric hospitals and remained almost unchanged for Medicaid-covered adults. Privately insured adults experienced the shortest average stay, 6.2 days versus statewide the average of 7.8 days in 2007. BH adult stays dropped most (1.1 days) for those with Medicare coverage. Physician-referred adults experienced the most shortened average stay (1.7 days).

Adult males have slightly higher inpatient BH utilization

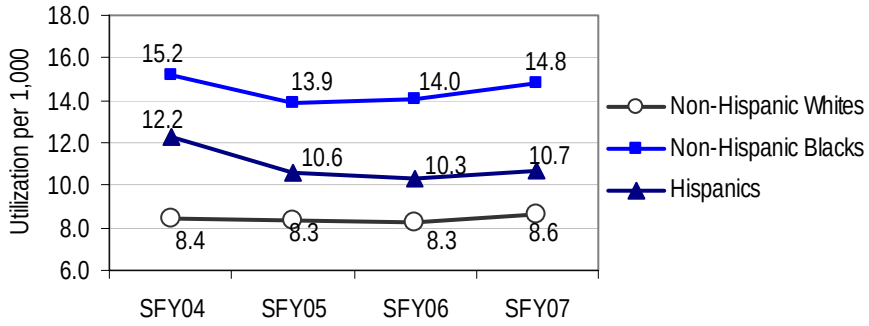
Figure 40: BH utilization by gender, age 18 and over, FYs 2004-2007



Adult males required inpatient acute care behavioral health services slightly more often than women of the same age.

Black adults more likely to be hospitalized for BH

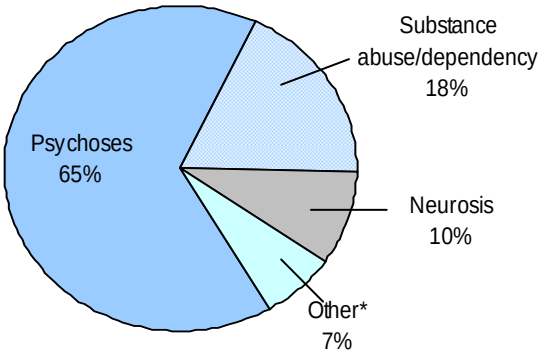
Figure 41: BH utilization rate by race and ethnicity, age 18 and over, SFYs 2004-2007



Minority adults were more likely to utilize acute care behavioral health than Non-Hispanic white adults. In 2007, Non-Hispanic blacks and Hispanics were 1.7 and 1.2 more likely to utilize BH services, respectively.

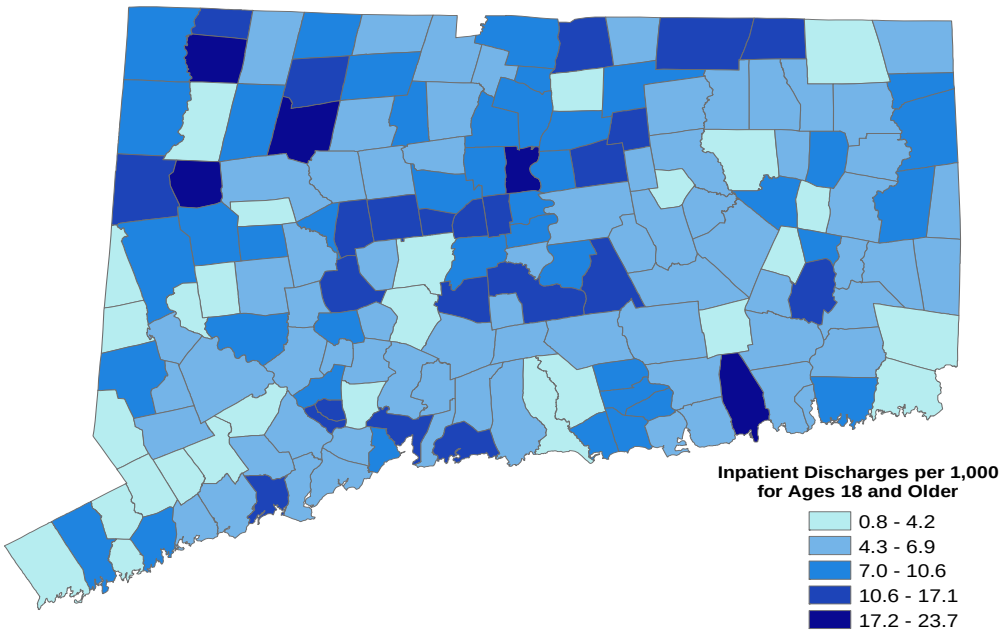
Most BH adults treated for psychosis, substance abuse or dependence

Figure 42: Primary reasons for inpatient BH admission, age 18 and over, SFY 2007



BH utilization for almost all towns below the statewide rate

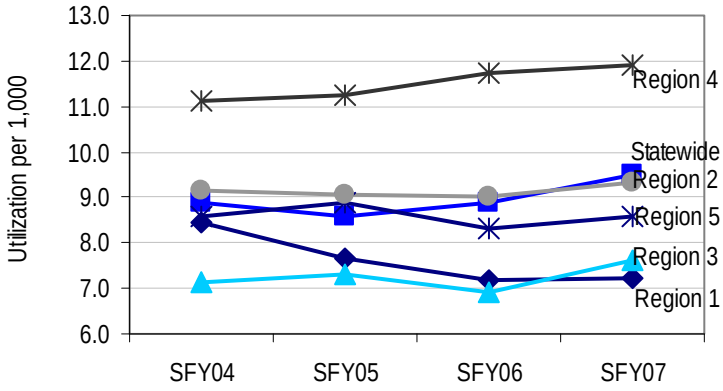
Map 4: Inpatient BH utilization per 1,000 of residents ages 18 and over, SFY 2007



While high utilization towns were concentrated in the northwestern and north central parts of the state, only three towns exceed the statewide utilization rate: Warren (23.7 per 1,000), Hartford (23.5 per 1,000) and Canaan (23.0 per 1,000). Cornwall and Scotland had the lowest utilization rates per 1,000 population, at 0.9. The statewide inpatient services utilization rate for this age group was 22.4 visits per 1,000 of the adult population. (See Appendix 2 for more detail.)

Adult BH utilization increased in all regions in the last year

Figure 43: Adult BH utilization per 1,000 by region, SFYs 2004-2007



Department of Mental Health and Addiction Services (DMHAS) mental health programs are organized within five geographical regions across the state. Each geographic region contains centers designated for mobile crisis response, community based mental health case management and other services. Adult utilization per 1,000 of residents increased in 2007 in all five DHMAS regions.[3] Adult residents in Region 4 were more likely to require inpatient BH care than in other DMHAS regions. Residents in Region 3 were least likely to utilize inpatient BH care.

Endnotes

[1]An overwhelming majority (98%) of children and adolescents treated by pediatricians in the ED were discharged from Connecticut Children's Medical Center or Yale New-Haven Hospital's Children's Hospital, the state's two pediatric acute care hospitals.
[2]For further information see the Connecticut Department of Children and Families website at http://www.ct.gov/dcf/cwp/view.asp?a=2558&q=314352
[3]For further information see the Connecticut Department of Mental Health and Addiction Services website at http://www.ct.gov/dmhas/cwp/view.asp?a=2902&Q=335196&dmhasNav=

APPENDIX 1: Acute Care Psychiatric Beds in Connecticut, 2007

Acute Care Hospitals	Licensed	Staffed Beds for Ages				
		0 - 12	13 - 17	0 - 17[1]	18+	All
Bridgeport	19				15	15
Bristol	16				14	14
Charlotte Hungerford	17				17	17
Danbury	23		1		19	20
Day Kimball	15				14	14
Essent-Sharon	12				12	12
Greenwich[2]	6				6	6
Griffin	16				10	10
Hartford /Institute of Living	150	11	17		111	139
Hospital of Central Connecticut	24				28	28
John Dempsey	34				34	34
Johnson Memorial	20				17	17
Lawrence and Memorial	24				18	18
Manchester Memorial	36		5		20	25
Middlesex Memorial	28				18	18
Midstate Medical Center	6				10	10
Norwalk	26				18	18
St. Francis	87	17	8		65	90
St. Mary's	22				10	10
St. Raphael	45	12	8		23	43
St. Vincent's Medical	16				16	16
Stamford	25				20	20
Waterbury	30		5		25	30
William W. Backus	20				18	18
Yale-New Haven/Psychiatric Institute[3]	87	15	15		33	63
Sub-total	804	55	59	0	591	705
Psychiatric Hospitals						
State-run Facilities						
DHMAS (For 18 years or older)[4]						
Southwest CT Mental Health Network	62				42	42
CT Mental Health Center	70				20	20
Capitol Region Mental Health Center	16				16	16
Cedarcrest Regional	104				87	87
Sub-total	252	0	0	0	165	165
Free-standing Facilities[5]						
Masonic Healthcare[6]	15				15	15
Hall-Brooke Behavioral Health Services	86	12	24		46	82
Natchaug Hospital, Inc.	60	6	15	3	33	57
Silver Hill	129		7		44	51
Stonington Institute[7]	73		4		63	67
Sub-total	363	18	50	3	201	272
Statewide	1,419	73	109	3	957	1,142

Source: CT Office of Health Care Access Hospital Reporting System Report 400; Hospitals' responses to CT Office of Health Care Access Psychiatry Hospital Survey administered in April 2008; Department of Mental Health and Addiction Services 2008 response to OHCA Requests; New England Hospital Directory, July 2008 Vol. 16. No.64; CT Department of Public Health.

[1] Hospitals swings these beds between children and adolescents on as needed basis.

[2] Beds are dedicated to alcohol and drug treatment.

[3] Number of beds form Yale New Haven Psychiatric Hospital website: http://www.ynhh.com/ynhph/adolescent.html#inpatient

[4] Licensed beds obtained from various online sources and comprise of acute, subacute and forensic beds for some hospitals. DHMAS may have limited programs for 16 and 17 year-olds.

[5] Hospitals' responses to CT Office of Health Care Access 2008 Psychiatric Hospital Survey.

[6] Facility's website.

[7] May 24, 2006 Certificate of Need (CON) Application Docket Number 06-30679-CON pages 118 and 119.

APPENDIX 2: Acute Care Hospital Behavioral Health Services Utilization per 1,000 of Connecticut Residents

Town	DCF Community Collaborative	DHMAS Regions	Inpatient Discharges per 1,000			ED Visits per 1,000		
			< Age 18	Ages 18+	All Ages	< Age 18	Ages 18+	All Ages
Andover	Route 2 Collaboration	4	6.0	1.4	2.6	9.7	12.2	11.5
Ansonia	Lower Naugatuck Valley System of Care	2	4.2	13.1	10.9	15.6	47.3	39.6
Ashford	Communities Raising Children (North East System of Care)	3	5.7	4.9	5.1	13.3	12.5	12.7
Avon	Greater Bristol/Farmington Valley System of Care	4	1.0	6.0	4.7	4.4	12.1	10.0
Barkhamsted	Northwest Caring Connection	5	0.0	10.3	7.7	1.1	21.4	16.3
Beacon Falls	Waterbury Family Focus Partnership	5	3.8	5.4	5.0	9.8	19.9	17.3
Berlin	Greater Bristol/Farmington Valley System of Care	4	1.6	7.1	5.7	5.8	18.0	15.0
Bethany	BOW Collaborative	2	4.4	4.6	4.6	10.2	12.8	12.1
Bethel	Greater Danbury Systems of Care	5	3.0	6.1	5.3	15.6	26.2	23.3
Bethlehem	Northwest Caring Connection	5	2.3	7.4	6.1	26.7	17.2	19.6
Bloomfield	North Central System of Care	4	4.8	10.3	9.1	12.9	23.4	21.1
Bolton	East of the River System of Care	4	2.3	6.2	5.2	11.5	10.5	10.8
Bozrah	Southeast Mental Health System of Care	3	0.0	6.1	4.7	7.2	31.0	25.5
Branford	Shoreline Collaborative for Youth	2	4.7	11.8	10.3	10.5	28.1	24.5
Bridgeport	Greater Bridgeport System of Care	1	0.7	11.6	8.5	9.1	46.9	36.1
Bridgewater	Greater Danbury Systems of Care	5	0.0	1.4	1.1	2.5	6.3	5.5
Bristol	Greater Bristol/Farmington Valley System of Care	4	3.2	16.7	13.6	12.9	43.2	36.2
Brookfield	Greater Danbury Systems of Care	5	1.9	5.1	4.2	8.9	14.5	13.0
Brooklyn	Communities Raising Children (North East System of Care)	3	4.1	4.9	4.7	12.4	15.9	15.1
Burlington	Greater Bristol/Farmington Valley System of Care	4	0.9	6.0	4.5	3.9	13.4	10.7
Canaan	Northwest Caring Connection	5	0.0	23.0	17.6	7.8	9.7	9.3
Canterbury	Communities Raising Children (North East System of Care)	3	0.8	5.7	4.5	12.4	20.9	18.8
Canton	Greater Bristol/Farmington Valley System of Care	4	1.8	8.8	7.0	9.8	16.1	14.5
Chaplin	Communities Raising Children (North East System of Care)	3	9.0	6.5	7.1	14.4	20.0	18.7
Cheshire	Waterbury Family Focus Partnership	5	2.8	3.8	3.5	10.4	11.0	10.9
Chester	Valley Shore Collaborative	2	0.0	10.3	8.0	6.0	18.6	15.8
Clinton	Valley Shore Collaborative	2	4.6	8.1	7.2	9.7	20.3	17.6
Colchester	Southeast Mental Health System of Care	3	0.2	5.9	4.2	11.1	20.5	17.7
Colebrook	Northwest Caring Connection	5	2.8	8.1	6.8	5.5	10.8	9.5
Columbia	Communities Raising Children (North East System of Care)	3	0.0	4.6	3.4	6.1	14.2	12.1
Cornwall	Northwest Caring Connection	5	0.0	0.9	0.7	0.0	6.5	4.9
Coventry	Communities Raising Children (North East System of Care)	3	3.5	6.8	5.9	7.7	15.9	13.6
Cromwell	Greater Middlesex Community Collaborative	2	1.1	5.8	4.8	9.4	14.8	13.6
Danbury	Greater Danbury Systems of Care	5	1.2	8.0	6.5	10.0	26.2	22.7
Darien	Greater Stamford System of Care Collaborative	1	0.0	3.8	2.6	3.0	8.1	6.4
Deep River	Valley Shore Collaborative	2	0.9	7.4	5.9	15.2	14.0	14.3
Derby	Lower Naugatuck Valley System of Care	2	4.5	12.4	10.7	13.4	38.1	32.8
Durham	Greater Middlesex Community Collaborative	2	4.7	6.6	6.0	6.8	13.2	11.3
East Granby	North Central System of Care	4	2.4	6.8	5.7	5.6	11.1	9.7
East Haddam	Family Access Collaborative	2	2.4	4.7	4.1	11.3	12.4	12.1
East Hampton	Family Access Collaborative	2	0.4	6.2	4.9	5.3	14.7	12.7
East Hartford	Route 2 Collaboration	4	3.9	12.2	10.2	13.6	34.6	29.5
East Haven	Shoreline Collaborative for Youth	2	6.7	10.6	9.8	14.1	33.6	29.3
East Lyme	Southeast Mental Health System of Care	3	0.5	4.7	3.8	8.3	18.4	16.2
East Windsor	North Central System of Care	4	3.7	18.7	15.4	11.9	38.9	32.9
Eastford	Communities Raising Children (North East System of Care)	3	0.0	3.4	2.5	7.0	15.1	13.0
Easton	Greater Bridgeport System of Care	1	0.5	3.9	2.9	3.8	7.9	6.7
Ellington	East of the River System of Care	4	2.8	8.1	6.7	8.9	17.3	15.2
Enfield	North Central System of Care	4	3.8	11.7	9.9	10.4	24.3	21.1

APPENDIX 2: Acute Care Hospital Behavioral Health Services Utilization per 1,000 of Connecticut Residents

			Inpatient Discharges per 1,000			ED Visits per 1,000		
Town	DCF Community Collaborative	DHMAS Regions	< Age 18	Ages 18+	All Ages	< Age 18	Ages 18+	All Ages
Essex	Valley Shore Collaborative	2	0.7	7.1	5.7	4.9	14.8	12.6
Fairfield	Greater Bridgeport System of Care	1	0.7	5.9	4.7	4.3	14.9	12.4
Farmington	Greater Bristol/Farmington Valley System of Care	4	3.1	8.6	7.3	7.6	19.0	16.2
Franklin	Southeast Mental Health System of Care	3	0.0	3.6	2.7	9.0	20.1	17.4
Glastonbury	Route 2 Collaboration	4	3.6	4.8	4.5	8.8	12.6	11.5
Goshen	Northwest Caring Connection	5	0.0	10.1	7.8	4.9	17.8	14.8
Granby	North Central System of Care	4	0.0	5.3	3.9	2.8	16.0	12.4
Greenwich	Greater Stamford System of Care Collaborative	1	0.2	3.9	2.9	4.5	12.8	10.7
Griswold	Southeast Mental Health System of Care	3	0.0	6.4	4.7	10.6	25.7	21.9
Groton	Southeast Mental Health System of Care	3	1.4	8.3	6.6	11.6	29.9	25.3
Guilford	Shoreline Collaborative for Youth and Valley Shore Collaborative	2	4.8	5.1	5.0	9.9	14.1	13.0
Haddam	Greater Middlesex Community Collaborative/ Valley Shore Collaborative	2	1.1	5.2	4.2	5.1	14.1	11.9
Hamden	Hamden/North Haven Collaborative for Youth	2	11.5	6.4	7.5	20.7	16.4	17.3
Hampton	Communities Raising Children (North East System of Care)	3	0.0	8.4	6.3	26.4	25.3	25.6
Hartford	Hartford/West Hartford System of Care	4	5.3	23.5	18.0	15.5	72.5	55.3
Hartland	Northwest Caring Connection	5	0.0	6.2	4.5	1.8	14.4	10.9
Harwinton	Northwest Caring Connection	5	0.0	6.3	4.7	6.0	19.2	15.9
Hebron	Route 2 Collaboration	4	2.7	6.8	5.6	13.2	18.9	17.2
Higganum	Greater Middlesex Community Collaborative							
Kent	Northwest Caring Connection	5	0.0	16.8	12.9	0.0	12.2	9.4
Killingly	Communities Raising Children (North East System of Care)	3	1.9	9.7	7.7	14.7	30.3	26.3
Killingworth	Greater Middlesex Community Collaborative and Valley Shore Collaborative	2	1.8	1.1	1.3	4.3	8.4	7.3
Lebanon	Southeast Mental Health System of Care	3	0.5	4.6	3.5	11.9	16.7	15.3
Ledyard	Southeast Mental Health System of Care	3	1.7	5.0	4.1	19.0	17.4	17.8
Lisbon	Southeast Mental Health System of Care	3	0.0	6.6	4.9	10.8	26.7	22.6
Litchfield	Northwest Caring Connection	5	0.5	6.6	5.1	11.5	18.6	16.8
Lyme	Valley Shore Collaborative	2	0.0	5.6	4.5	2.4	2.5	2.5
Madison	Shoreline Collaborative for Youth and Valley Shore Collaborative	2	2.2	4.2	3.6	7.1	11.4	10.2
Manchester	East of the River System of Care	4	5.1	14.9	12.7	16.1	40.8	35.1
Mansfield	Communities Raising Children (North East System of Care)	3	2.2	2.6	2.6	10.2	8.7	8.9
Marlborough	Route 2 Collaboration	4	3.8	6.3	5.6	11.5	20.5	18.0
Meriden	Meriden/Wallingford Children's Behavioral Health Collaborative	2	2.1	11.4	9.0	6.9	32.0	25.5
Middlebury	Waterbury Family Focus Partnership	5	1.9	4.7	4.0	10.1	10.9	10.7
Middlefield	Greater Middlesex Community Collaborative	2	4.8	5.4	5.2	2.9	12.3	10.0
Middletown,	Greater Middlesex Community Collaborative	2	1.5	15.1	12.1	7.6	37.0	30.6
Milford	Milford Collaborative	2	4.8	5.9	5.7	14.3	25.0	22.6
Monroe	Greater Bridgeport System of Care	1	0.5	3.5	2.6	2.9	9.9	7.8
Montville	Southeast Mental Health System of Care	3	0.5	6.4	5.0	11.4	24.2	21.1
Morris	Northwest Caring Connection	5	5.3	3.5	3.9	19.5	13.8	15.2
Naugatuck	Waterbury Family Focus Partnership	5	2.2	8.3	6.7	10.3	29.2	24.1
New Britain	New Britain System of Care	4	3.3	16.6	13.3	16.9	58.7	48.6
New Canaan	Greater Stamford System of Care Collaborative	1	0.3	2.6	1.9	2.5	4.0	3.6
New Fairfield	Greater Danbury Systems of Care	5	0.7	3.2	2.4	8.8	10.7	10.1
New Hartford	Northwest Caring Connection	5	2.4	6.3	5.3	12.8	21.4	19.1
New Haven	New Haven Collaborative for Youth	2	9.3	17.1	15.1	17.7	61.0	50.0

APPENDIX 2: Acute Care Hospital Behavioral Health Services Utilization per 1,000 of Connecticut Residents

			Inpatient Discharges per 1,000			ED Visits per 1,000		
Town	DCF Community Collaborative	DHMAS Regions	< Age 18	Ages 18+	All Ages	< Age 18	Ages 18+	All Ages
New London	Southeast Mental Health System of Care	3	1.0	13.9	10.9	11.1	59.3	48.3
New Milford	Greater Danbury Systems of Care	5	1.2	5.2	4.1	9.7	17.8	15.6
Newington	Rocky Hill/Newington/Wethersfield System of Care	4	2.0	7.4	6.3	7.8	19.0	16.7
Newtown	Greater Danbury Systems of Care	5	0.7	4.4	3.3	7.8	12.6	11.2
Norfolk	Northwest Caring Connection	5	0.0	6.3	4.8	5.1	13.4	11.4
North Branford	Shoreline Collaborative for Youth	2	3.9	5.1	4.8	5.3	13.7	11.6
North Canaan	Northwest Caring Connection	5	0.0	16.0	12.2	1.3	20.6	16.1
North Haven	Hamden/North Haven Collaborative for Youth	2	8.8	6.4	6.9	12.1	17.9	16.6
North	Southeast Mental Health System of Care	3	1.6	3.2	2.8	17.5	11.0	12.6
Norwalk	Greater Norwalk System of Care "CARE Team"	1	1.4	9.7	7.8	5.5	23.5	19.5
Norwich	Southeast Mental Health System of Care	3	1.3	14.9	11.6	16.2	66.3	54.2
Old Lyme	Valley Shore Collaborative	2	0.9	5.0	4.0	8.4	14.8	13.2
Old Saybrook	Valley Shore Collaborative	2	1.3	4.8	4.1	8.0	17.0	15.0
Orange	BOW Collaborative	2	3.4	4.7	4.4	5.8	21.5	17.7
Oxford	Waterbury Family Focus Partnership	5	1.1	6.3	4.9	5.6	21.5	17.2
Plainfield	Communities Raising Children (North East System of Care)	3	1.3	9.5	7.3	15.2	26.2	23.3
Plainville	Greater Bristol/Farmington Valley System of Care	4	4.6	11.9	10.3	15.8	31.3	28.0
Plymouth	Greater Bristol/Farmington Valley System of Care	4	2.3	14.5	11.3	11.3	30.6	25.6
Plymouth	Northwest Caring Connection							
Pomfret	Communities Raising Children (North East System of Care)	3	2.0	5.4	4.5	6.9	17.2	14.5
Portland	Family Access Collaborative	2	1.3	8.3	6.5	8.1	19.8	16.8
Preston	Southeast Mental Health System of Care	3	1.0	5.8	4.7	9.5	18.4	16.4
Prospect	Waterbury Family Focus Partnership	5	2.8	4.9	4.4	9.2	19.1	16.7
Putnam	Communities Raising Children (North East System of Care)	3	0.5	8.6	6.7	14.1	30.1	26.3
Redding	Greater Danbury Systems of Care	5	2.5	5.5	4.6	7.1	13.0	11.2
Ridgefield	Greater Danbury Systems of Care	5	0.6	3.9	2.9	6.6	9.2	8.4
Rocky Hill	Rocky Hill/Newington/Wethersfield System of Care	4	2.3	7.7	6.6	3.7	21.8	18.3
Roxbury	Northwest Caring Connection	5	0.0	2.4	1.9	4.1	6.7	6.1
Salem	Southeast Mental Health System of Care	3	0.0	3.7	2.6	3.5	10.3	8.3
Salisbury	Northwest Caring Connection	5	0.0	7.5	5.8	2.2	9.7	8.0
Scotland	Communities Raising Children (North East System of Care)	3	2.3	0.9	1.3	6.8	5.4	5.8
Seymour	Lower Naugatuck Valley System of Care	2	4.6	8.0	7.2	10.6	28.0	23.9
Sharon	Northwest Caring Connection	5	0.0	9.4	7.4	0.0	12.4	9.8
Shelton	Lower Naugatuck Valley System of Care	2	3.0	6.7	5.8	11.7	19.9	18.0
Sherman	Greater Danbury Systems of Care	5	0.0	1.8	1.3	4.9	10.0	8.6
Simsbury	Greater Bristol/Farmington Valley System of Care	4	2.9	4.6	4.1	5.0	10.1	8.6
Somers	North Central System of Care	4	1.4	6.4	5.4	6.9	14.2	12.7
South Windsor	East of the River System of Care	4	2.1	8.4	6.7	6.1	19.6	15.9
Southbury	Waterbury Family Focus Partnership	5	2.1	3.8	3.4	5.4	12.3	10.8
Southington	Greater Bristol/Farmington Valley System of Care	4	2.0	9.1	7.4	10.5	23.8	20.6
Sprague	Southeast Mental Health System of Care	3	2.6	9.1	7.4	15.5	30.9	26.9
Stafford	North Central System of Care	4	2.3	15.7	12.3	7.6	26.4	21.6
Stamford	Greater Stamford System of Care Collaborative	1	1.0	7.7	6.2	5.6	23.2	19.4
Sterling	Communities Raising Children (North East System of Care)	3	0.0	5.4	3.9	1.1	19.3	14.2
Stonington	Southeast Mental Health System of Care	3	0.3	2.5	2.0	5.7	11.3	10.1
Storrs	Communities Raising Children (North East System of Care)	Coded as part of Mansfield						
Stratford	Greater Bridgeport System of Care	1	1.3	5.5	4.5	10.6	19.5	17.4
Suffield	North Central System of Care	4	3.0	7.7	6.6	6.0	13.3	11.7
Terryville	Greater Bristol/Farmington Valley System of Care	Coded as part of Plymouth						

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			Inpatient Discharges per 1,000			ED Visits per 1,000		
Town	DCF Community Collaborative	DHMAS Regions	< Age 18	Ages 18+	All Ages	< Age 18	Ages 18+	All Ages
Thomaston	Northwest Caring Connection	5	3.2	7.3	6.3	14.7	23.4	21.2
Thompson	Communities Raising Children (North East System of Care)	3	0.9	5.1	4.1	9.0	17.0	15.0
Tolland	East of the River System of Care	4	1.9	5.6	4.6	5.6	13.7	11.4
Torrington	Northwest Caring Connection	5	1.8	19.6	15.5	15.9	58.0	48.3
Trumbull	Greater Bridgeport System of Care	1	0.8	4.8	3.8	6.5	13.4	11.6
Union	Communities Raising Children (North East System of Care)	3	2.3	15.1	12.4	7.7	21.5	18.5
Vernon	East of the River System of Care	4	4.0	12.5	10.6	10.8	31.5	26.9
Voluntown	Southeast Mental Health System of Care	3	0.0	4.3	3.2	6.0	22.1	17.8
Wallingford	Meriden/Wallingford Children's Behavioral Health Collaborative	2	1.8	5.4	4.5	5.2	14.3	12.1
Warren	Northwest Caring Connection	5	7.0	23.7	19.9	7.0	37.1	30.3
Washington	Northwest Caring Connection	5	1.1	7.7	6.1	6.8	16.2	13.9
Waterbury	Waterbury Family Focus Partnership	5	3.2	14.0	11.1	18.8	56.6	46.6
Waterford	Southeast Mental Health System of Care	3	1.2	5.1	4.3	16.2	18.8	18.2
Watertown	Waterbury Family Focus Partnership	5	1.5	5.7	4.7	11.7	22.9	20.1
West Hartford	Hartford/West Hartford System of Care	4	2.6	7.4	6.4	8.0	16.0	14.3
West Haven	West Haven Interagency Network for Children (WHINC)	2	5.2	10.6	9.3	11.0	34.1	28.8
Westbrook	Valley Shore Collaborative	2	0.7	7.1	5.7	3.7	19.5	16.1
Weston	Greater Norwalk System of Care "CARE Team"	1	0.9	3.4	2.6	4.5	6.0	5.5
Westport	Greater Norwalk System of Care "CARE Team"	1	0.8	4.5	3.5	3.8	11.7	9.5
Wethersfield	Rocky Hill/Newington/Wethersfield System of Care	4	2.1	7.0	6.1	6.4	17.0	14.8
Willington	Communities Raising Children (North East System of Care)	3	4.0	5.5	5.2	8.8	18.0	16.1
Wilton	Greater Norwalk System of Care "CARE Team"	1	0.4	2.7	2.0	2.5	6.7	5.4
Winchester	Northwest Caring Connection	5	4.8	15.4	12.9	27.4	51.1	45.6
Windham	Communities Raising Children (North East System of Care)	3	1.1	8.9	7.1	15.8	40.5	34.8
Windsor	North Central System of Care	4	2.6	7.9	6.6	10.5	21.3	18.6
Windsor Locks	North Central System of Care	4	4.6	7.8	7.1	8.4	19.1	16.6
Wolcott	Waterbury Family Focus Partnership	5	3.5	6.9	6.0	11.4	20.4	18.1
Woodbridge	BOW Collaborative	2	5.2	2.8	3.5	10.0	8.6	9.0
Woodbury	Northwest Caring Connection	5	0.9	5.2	4.1	5.0	16.5	13.7
Woodstock	Communities Raising Children (North East System of Care)	3	0.5	3.6	2.8	7.9	12.8	11.5

Sources: *CT Office of Health Care Access Acute Care Discharge Database, Connecticut Hospital Association CHIME ED database, and U.S. Census Bureau, Census 2000.*

STATE OF CONNECTICUT

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