



# STATE OF CONNECTICUT

## DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES

*A HEALTHCARE SERVICE AGENCY*

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GOVERNOR

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COMMISSIONER

### **Testimony by Thomas A. Kirk, Jr., Ph.D., Commissioner Department of Mental Health and Addiction Services Before the Public Health Committee March 3, 2008**

Good morning, Sen. Handley, Rep. Sayers, and distinguished members of the Public Health Committee. I am Dr. Thomas A. Kirk, Jr., Commissioner of the Department of Mental Health and Addiction Services. I am here today to speak on **H.B. 5038, An Act Implementing the Recommendations of the Hospital Task Force.**

I was a participant on the Governor's Hospital Strategic Task Force, very ably co-lead by Secretary Genuario and Commissioner Vogel, and composed of a well informed group of colleagues from the Executive and Legislative branches, as well as from different sectors of the hospital community. We spent long hours meeting as an overall group and in one of three subcommittees. Further, we searched for and considered ideas drawn from reviews of the most respected professional literature and – at least for me – from conversations with my counterparts in other northeast states. Finally, the format included an open forum or public testimony.

I found the process and final report to be among the most stimulating and productive that I have experienced in recent years in public service. The bill before you today is a sample of the depth, breadth and specificity of our recommendations, and I am very pleased that Governor Rell accepted so many of them, including some proposed new funding.

My primary focus was participating in the System Wide Utilization and Planning Subcommittee, not only because of the pressures placed on community hospitals due to the service demand resulting from persons with psychiatric and/or substance use disorders presenting for care at emergency rooms (ERs), but also because of the extraordinary stress experienced by such patients and their families as they wait for extended hours, and sometimes several days, in the ER for follow-up care and placement.

Let's consider a few of the key recommendations included in H.B. 5038 to deal with that part of the equation.

- Section 2 would require DMHAS, DCF and DSS to look at areas of the state where emergency rooms are experiencing high utilization of their services by persons with psychiatric and/or

substance use issues and make recommendations to address those needs. Within DMHAS we have data indicative of these high demand areas and, in addition to identifying the costs we are expending and the effectiveness of various interventions already in place in these areas, we preliminarily explored the use of geomapping tools to sharpen our approach. The latter would be of potential benefit to another requirement of H.B. 5038, i.e., to collaborate with DSS in determining what community services are available, and what is still needed, in order to reduce the use of emergency rooms by persons with behavioral health needs who are served by DMHAS.

- Section 3 directs DMHAS to work with the Departments of Children and Families and Social Services, in consultation with the Office of Health Care Access and representatives of the health care industry, to identify effective and feasible models of care for psychiatric emergency assessment or crisis response centers. The language gives us the flexibility to look at different models that are being used across the country and decide what type of model and which region of the state would benefit from such a program. Then, no later than January 1, 2009, DMHAS would implement a pilot center using the most effective model identified. We learned of different potential models from discussions with colleagues in Massachusetts, Delaware, New Jersey, Pennsylvania and other states. The budget contains \$500,000 (annualized to \$1 million) for DMHAS to implement this.
- Another essential component of the bill (Section 4) would allow DOC, DMHAS and DSS to plan for expedited eligibility for SAGA program benefits for persons leaving our prison system who are in need of behavioral health care, linking them to an appropriate provider for services. This is so critical and would facilitate a direct link to the highly successful DMHAS General Assistance Behavioral Health Program and to DSS' SAGA physical health care services.
- Section 6 would have us work together with the Office of Health Care Access, not only to determine the unmet needs of the people we serve, but also to gauge the workforce requirements— i.e., as a result of the nursing shortage and the increased demand for health care services, staffing has not kept pace.
- Lastly, Section 8 would combine our required 5-year plan for substance use disorders with a multi-year plan for persons with psychiatric disabilities. This would facilitate our efforts to determine new trends across our service system (such as where certain age groups are showing up for treatment), highlight our successes, and identify gaps and new service needs. The DMHAS plan would also be incorporated by the Department of Public Health into the overall state health plan.

In closing, I would note that the Task Force worked long and hard to come up with these recommendations. We are prepared to do the work necessary to ease the burden on emergency rooms, and we ask your support of H.B. 5038 and the budget options that accompany it in order to provide good health care to the people we serve.

Thank you for the opportunity to speak on H.B. 5038. I would be happy to answer any questions you may have at this time.