



**TESTIMONY OF
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SUBMITTED TO THE
PUBLIC HEALTH COMMITTEE
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SB 1089, An Act Concerning Mental Health Services.

Middlesex Hospital appreciates the opportunity to submit testimony concerning **SB 1089, An Act Concerning Mental Health Services**. Middlesex Hospital supports the bill, as it addresses improvements to the mental healthcare system in Connecticut. What we need is a strong policy and a modest investment in a plan to provide care to these patients in need.

Middlesex Hospital plays a critical role in providing all types of medical services to Connecticut residents, including mental and behavioral health services. We serve more than 14,000 inpatients and 123,000 outpatients each year, and this includes 3700 adults and 800 children we treat for behavioral health-related conditions.

Middlesex Hospital has a 20 bed inpatient unit that routinely runs at capacity. There are 8 designated beds in our Emergency Department (ED) Emergency Crisis Area (ECA). Last year, Middlesex Hospital's Emergency Department provided 2256 Crisis Evaluations, treated 940 patients for alcohol intoxication and 120 patients for drug use/abuse.

Middlesex Hospital's Center For Behavioral Health Psychiatric Day Treatment Service provides Partial Hospital Program (PHP) and Intensive Outpatient Program (IOP) services. There are 3 specialty tracks within the IOP Services: Dual Diagnosis, General Psychiatric Adult, and Geriatric Programs. The Adult Outpatient Clinic provides psychotherapy and psychopharmacology services. Our Child Clinic also provides psychotherapy and psychopharmacology services. In addition to the traditional inpatient and outpatient services, Middlesex also has community based services which

include: Maternal Child Health Services (MCH), Emergency Mobile Psychiatric Services (EMPS) Intensive In-Home Child and Adolescent Services (IICAPS), and Women, Infant and Children (WIC) services. I have been working with the Middlesex County Community Care Team since February of 2012. We are a group over 14 provider agencies that meet for an hour each week at Middlesex Hospital to address clinical concerns for frequent visitors to the Emergency Department. Our process is straightforward: we identify the barriers that a patient is experiencing which lead to the patient's perceived need to present to the emergency room. Using a care coordination model we develop a care plan to connect the patient to the appropriate services within the community and then monitor that plan until the patient is established in their recovery.

There are many stories of success that I can share but I would like to highlight two. The first is Jane. Jane was first referred to the CCT through the St Vincent DePaul Soup Kitchen in 2013. She was experiencing chronic homelessness and had significant behavioral health issues and borderline intellectual functioning. During the calendar year 2012, Jane had 30 ED visits; in 2013 the team developed a care plan that included admission to the Intensive Outpatient Program at Middlesex Hospital with aftercare at the Adult Outpatient Clinic. In 2013 Jane's visits were reduced to 11. In 2014, she had two visits, both for medical conditions. She was diagnosed with Flu A on one visit. This is an important story, as despite being very ill with the flu, Jane called her outpatient behavioral health providers, explained that she would be missing her appointment and why. Later that same year, there was a problem with her medical cab. She called the program to explain why she would be missing her appointment and shared that she had already called and complained to the medical transportation and explained that she needed her therapy to stay out of the hospital. I mention these details because prior to being followed by the CCT; several of the visits to the ED were due to lack of follow up with outpatient care providers. So for Jane, the combination of a coordinated care plan (and that she was one of the fortunate patients that the CCT was working with that had qualified for and obtained supportive housing) made all the difference.

The second case is Liz. While Liz's story does not have as positive an outcome as Jane's it is an important story to tell. Liz had experienced chronic homelessness, severe and persistent mental illness and addiction to crack cocaine. She had many visits to the Middlesex Hospital Emergency Department, CCU and medical units. Liz was fortunate that she was able to obtain supportive housing in 2014. However a tragic but

important lesson was learned by the CCT as we work with Liz. Not all individuals manage the transition from chronic homelessness to supportive housing with the same results. For Liz, her enduring addiction issues lead to arrests and ongoing admissions. She was incarcerated in the fall of 2014 and was released from jail within the last month. She is still housed; however her years of substance use and life on the streets have left her with a deteriorating health course. She currently requires a walker to ambulate, her Chronic Obstructive Pulmonary Disease has further limited her ability to ambulate and she has a number of cardiac concerns. Through all of this the CCT has monitored her progress and remains involved. So when she was recently hospitalized and required specific medical follow-up the hospital was able to notify both the housing care manager and her treatment team at the local mental health agency and clinical

needs are being managed. Without the CCT release of information and the collaboration of multiple providers she would likely not have followed up on these appointments. As of today she has not been back in the ED and the housing case manager is assisting her with following up with community based medical providers.

Much of the infrastructure of our community care team was already in place. The 14 involved providers were all doing their very best for their patients within their own silos. With a grant from DMHAS and a commitment from Middlesex Hospital's ED and Behavioral Health Leadership the CCT has helped to reduce the frequent visitor population to our ED by over 50%. Our team has been keeping data and we believe the dollars invested by DMHAS that fund our health promotion advocate within the ED have led to significant savings in ED and inpatient costs while engaging high volume ED users in community care environments.

In a three year period we have reviewed 199 ED patients, many of whom are the ED's most complex patients experiencing psycho-social issues. Within this cohort, patients can have 10 visits in a 6 month period and as many as 70 visits in a year. The lessons learned have been many. We have witnessed a dramatic reduction in visits and costs once a CCT plan is in place. The crucial elements have been communication, collaboration and the ability to follow a patient from the ED to the community and monitor their progress. At times that monitoring can be formal by an ACT team or another clinical provider, or it may be the soup kitchen staff providing the bridge that allows the patient to get to a medical provider.

There are now several Community Care Teams up and running at CT hospitals. This model offers an opportunity to establish patients in a community based recovery plan, while decreasing high cost services such as Emergency Department and inpatient admissions. I urge you to support developing CCT models at all CT hospitals.

The behavioral health needs of our community are many - a patient experiencing a mental health crisis could spend days, or even weeks, in our Emergency Department waiting for a bed in an appropriate facility, or waiting to be transitioned to the right outpatient setting, simply because there are not enough resources available to meet the constant need. Extended stays in the ED can be stressful and exacerbate a patient's condition rather than improve it. This problem is particularly acute for children and adolescents, for whom the need for services greatly outstrips the number of available beds and trained specialists.

In 2014, the Connecticut Hospital Association convened a Subcommittee on Mental Health comprising hospital behavioral health directors, emergency medicine physicians, chief executives, chief financial officers, and government affairs experts charged with developing recommendations to improve health outcomes, relieve the burden on EDs, and improve the adequacy of funding for key mental health safety net services. Several of these steps are set forth in Sections 14 through 22 of SB 1089.

Specifically, Sections 14 through 22 call for the development of a Medicaid shared savings model, expansion of Behavioral Health Homes, and the establishment of a grant program to provide funds to organizations that provide acute care and emergency behavioral health services. They would call for the adoption of measures to more effectively disclose and disseminate information regarding the admission criteria, admission process, and program capacity of state-funded and supported facilities and programs that offer mental health or substance abuse services. Additionally, they would call for the establishment and implementation of evidence-based quality measures. Finally, they would increase the number of Intermediate Care (ICC) beds, establish a framework to study, assess, and accommodate the current utilization of and need for hospital beds for acute psychiatric care, and raise Medicaid reimbursement rates for behavioral health services to levels comparable to Medicare.

Middlesex Hospital encourages the Committee to support SB 1089.

Thank you for your consideration of our position.

