Connecticut Medicaid Youth Emergency Department Utilization Data Brief

Review of Medicaid Claims and Service Data from 2011-2012

This report was made possible through the collaborative effort of the Connecticut Behavioral Health Partnership. Multiple data sets and complex statistical analyses were used to provide a comprehensive summary of how youth, ages 3-17 with Medicaid, utilized Emergency Department (ED) services, with a specific focus on mental and behavioral health ED utilization.

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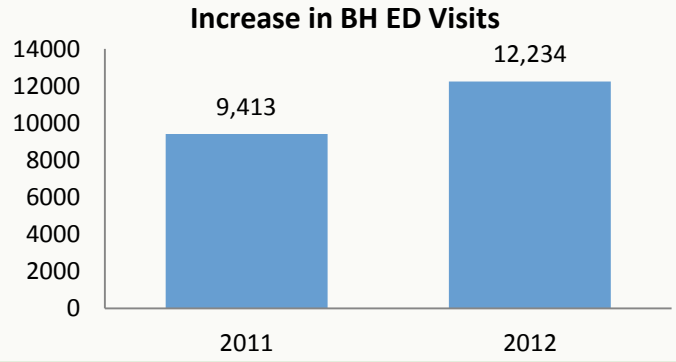
Youth ED Utilization

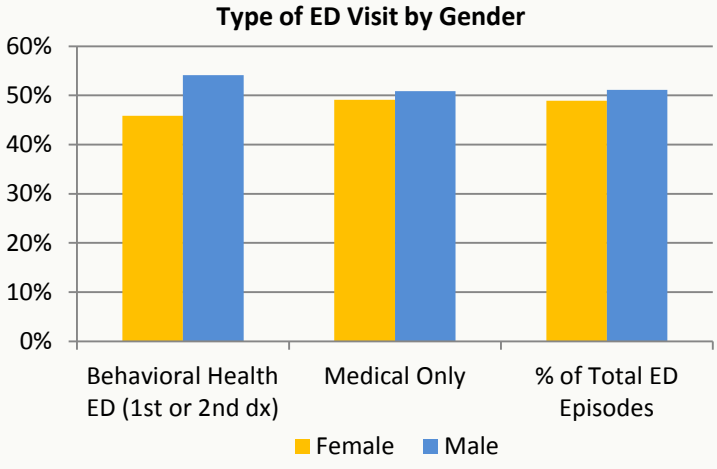
Over the two-year study period, 133,288 youth ages 3-17 had a total of 304,686 Medicaid ED claims. Only about 7% of those ED visits were for behavioral health (BH) needs (primary or secondary), as identified by the claim diagnosis.

Medical Only	Primary Behavioral Health	Medical with BH Secondary
		
93.08%	4.20%	2.73%

Behavioral Health ED Increase

While there were fewer BH ED visits than medical ones in total, Connecticut experienced a 30% increase in youth BH ED utilization from 2011 to 2012. This significant increase occurred despite comparable growth in the use of alternative services such as EMPS. The study did find, however, that most of the youth who were receiving community BH services did not utilize the ED. Only 18% of the BH cohort visited the ED for BH needs.





ED Use by Gender

While males and females utilized the ED for medical reasons at rates similar to their percent of the total visits, males were overrepresented in BH ED utilization. Additionally, the study found that when youth who were non-ED utilizers but received community BH services were compared to those who were ED-utilizers, males had a higher rate of utilization in both groups compared to their percent of the population. Therefore females underutilized BH services in general. However, female BH ED utilization increased among those who visited the ED 3 or more times.

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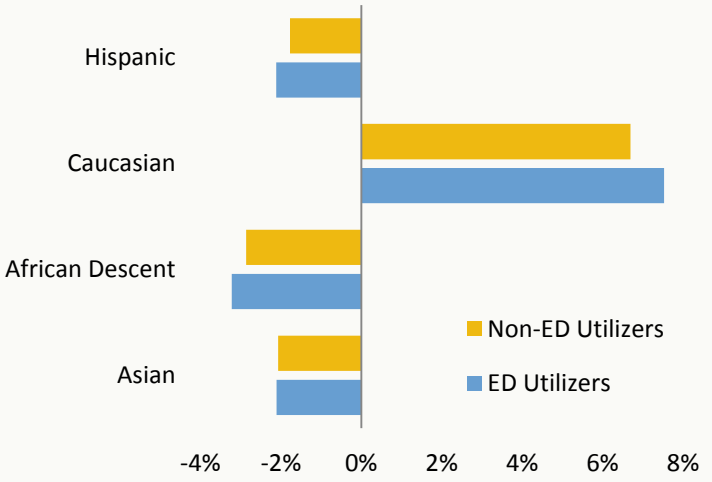
Racial and Ethnic Disparities

Almost 39% of the youth Medicaid population identified as Caucasian; however, they used BH services (both ED and non-ED utilizers) at rates 6-7% more than that. Youth who identified as Hispanic, African, or Asian utilized BH services at rates lower than their population rate. To better understand these racial and ethnic disparities it is recommended that CTBHP collaborate with other entities that are working on projects/initiatives focused on racial health disparities.

Behavioral Health Cohort: Race/Ethnicity Variance from % of Total Medicaid Population

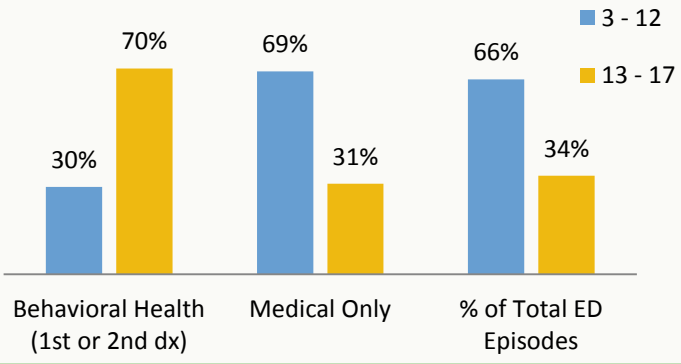


The "All Others" category was not graphed as they utilized services at rates similar to their population rate so there was no variance.

Age and ED Utilization

Similar to national research, older youth (ages 13-17) were more likely to go to the ED for BH reasons than younger children, whereas younger children (ages 3-12) accounted for the majority of medical ED visits.

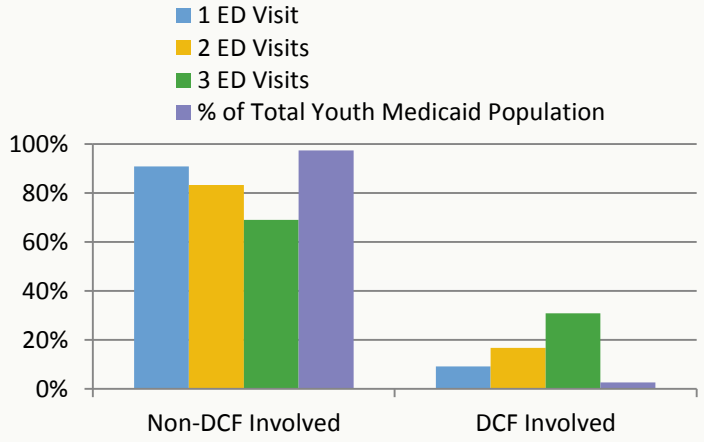
% of ED Visits



DCF Involvement

Out of the entire youth Medicaid population there were few DCF-involved youth (from 3-5% depending on methodology). However, despite low numbers, youth who had DCF involvement utilized the ED for BH needs at rates significantly higher than their population rate. Additionally, the study showed that DCF-involved youth were an ever larger percentage of those who went to the ED 3 or more times. An intensive service, such as high fidelity wrap around model, should be implemented to serve this group.

Impact of DCF Involvment on BH ED Frequency



Predictors of Youth ED Use

Youth diagnosed with Autism and Intellectual Disabilities were at a higher risk for multiple BH ED visits. Establishing stronger partnerships with DDS and mental health providers, as well as developing or expanding specialty community-based services for this population, is recommended.

Receiving outpatient services was a protective factor against BH ED utilization. While being treated in outpatient services may be a proxy for reduced symptom severity, it is recommended that the quality of outpatient services be enhanced to bolster this protective effect.

This data brief summarizes the key points of a more extensive report. If you are interested in further information on this topic or are interested in a presentation to your group, committee, or agency, please contact Dr. Bert Plant, Ph.D at Robert.Plant@valueoptions.com.