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Supporting Health and Recovery

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Behavioral Health

Treatment, Utilization, and Best Practices for Adult HUSKY Health Members with Serious Mental Illness

September 9, 2025

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Agenda

1	Overview
2	Emergency Department Utilization & Connect-to-Care
3	Best Practices

Chapter

01

Overview

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Serious Mental Illness

According to SAMHSA, Serious Mental Illness (SMI) is defined by *"having (within the past year) a diagnosable mental, behavioral, or emotional disorder that substantially interferes with a person's life and ability to function.* ***SMIs include conditions like schizophrenia and other psychotic disorders, bipolar disorder, and major depressive disorder."*** [1]

Individuals with SMI have a higher risk of developing Metabolic Syndrome (three or more diagnoses of: obesity, hyperlipidemia, hyperglycemia, and insulin resistance), which increases the risk of cardiovascular disease, stroke, and diabetes. As a result, many individuals with SMI experience a shorter life span, approximately 20 years on average.[2]

1. Serious Mental Illness and Serious Emotional Disturbances | SAMHSA
2. Noam, K., Bory, C., Flanagan, E., Wigglesworth, J., & Plant, R. (2025). Predictors of Metabolic Syndrome (MetS) and the benefits of using the MetS diagnosis for people with serious and persistent mental illness. Journal of Psychiatric Research, 187, 108-115.

Data Overview

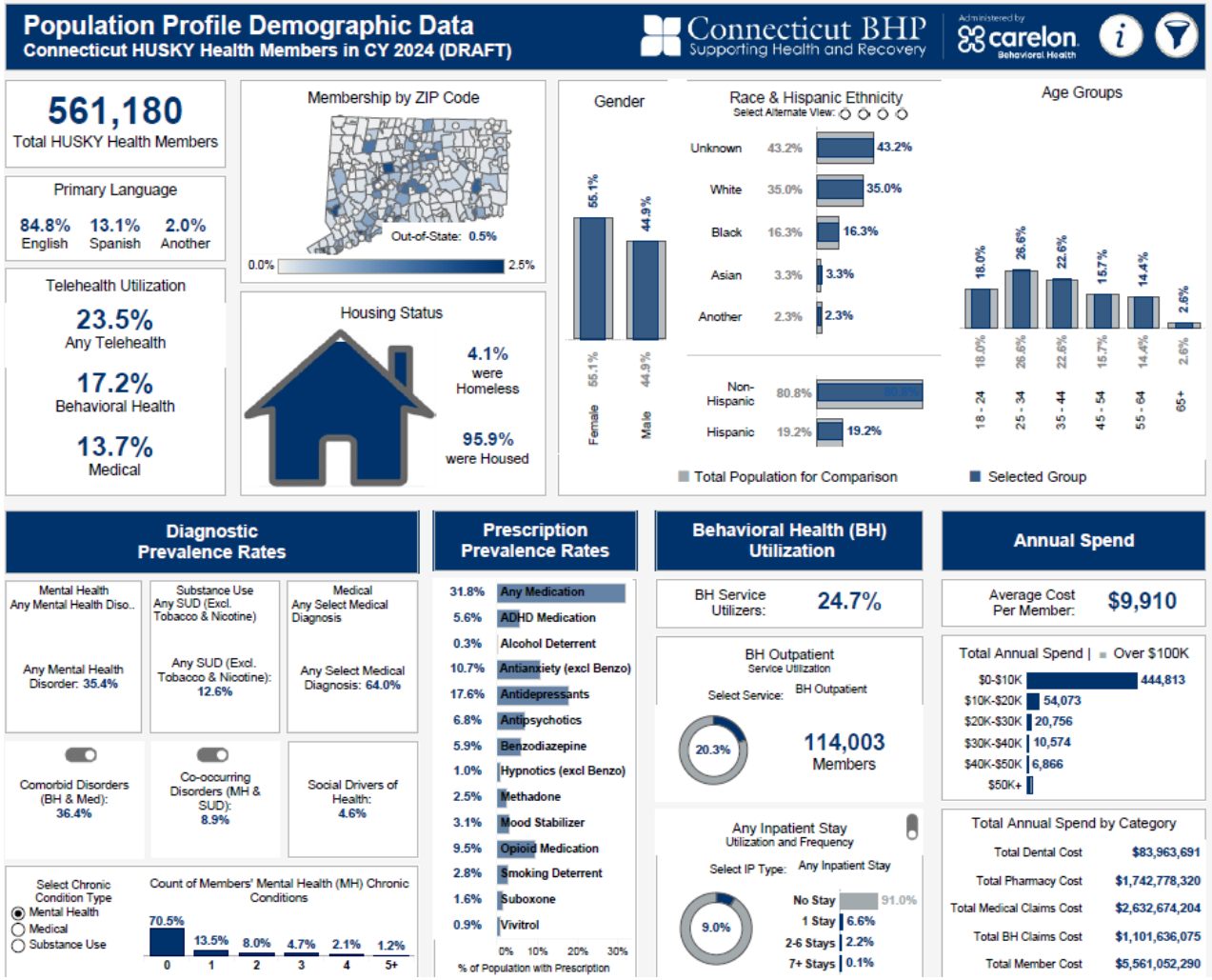
Today's meeting will focus on treatment utilization and best practices for HUSKY Health adults with an SMI who utilized the emergency department (ED) in calendar year (CY) 2024.

We will utilize **Demographics & Connect-to-Care (C2C) data** for HUSKY Health adults with:

- a primary mental health diagnosis
- schizophrenia spectrum & other psychotic disorders

Overall Adult HUSKY Health Population Profile – CY 2024

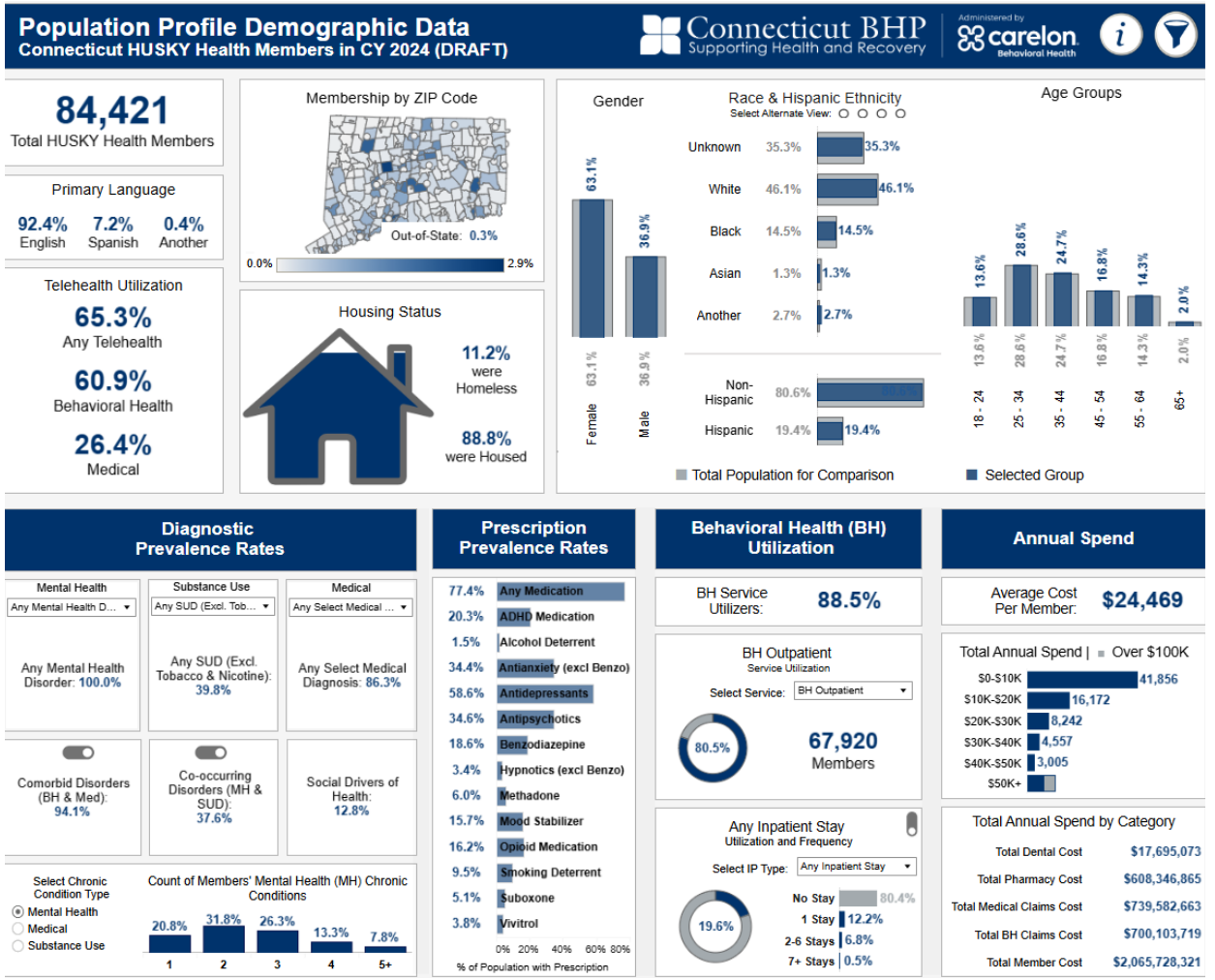
- total adult HUSKY Health population: 561,180 members
- 31.2% utilized the ED. (*n* = 175,356)
- 24.7% utilized a BH service. (*n* = 138,814)
- 20.3% had an outpatient BH service. (*n* = 114,003)
- 9.0% had one or more inpatient admissions. (*n* = 50,287)
- diagnostic prevalence:
  - any mental health disorder: 35.4% (*n* = 198,787)
  - co-occurring disorders (MH & SUD): 8.9% (*n* = 50,175)



***Please note, the 2024 population profile remains in DRAFT.**

HUSKY Health Members with an SMI – CY 2024

- 15% of HUSKY Health adult members had an SMI in CY 2024. (*n* = 84,421)
- 52.2% utilized the ED. (*n* = 44,060)
- 88.5% utilized a BH service. (*n* = 74,751)
- 80.5% had an outpatient BH service. (*n* = 67,920)
- 19.6% had one or more inpatient admissions. (*n* = 16,519)
- 39.8% had a substance use disorder (SUD). (*n* = 33,603)



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Chapter

02

Emergency Department Utilization: Connect-to-Care

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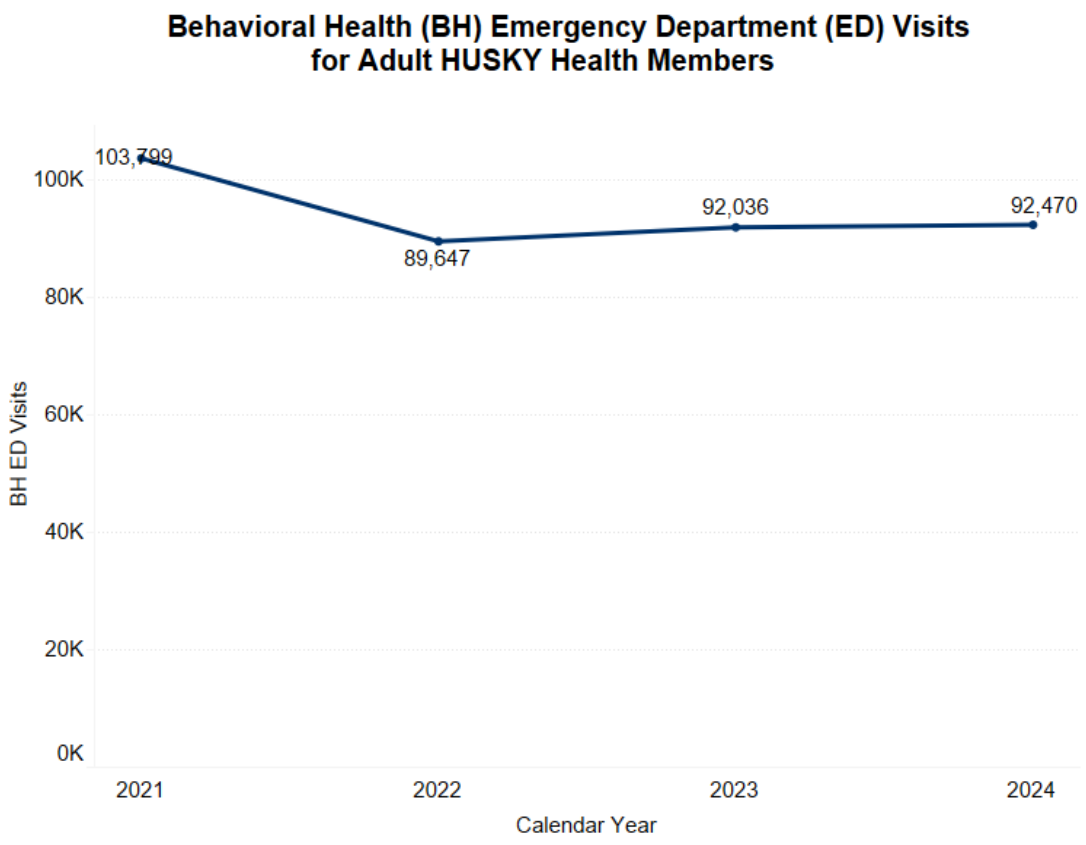
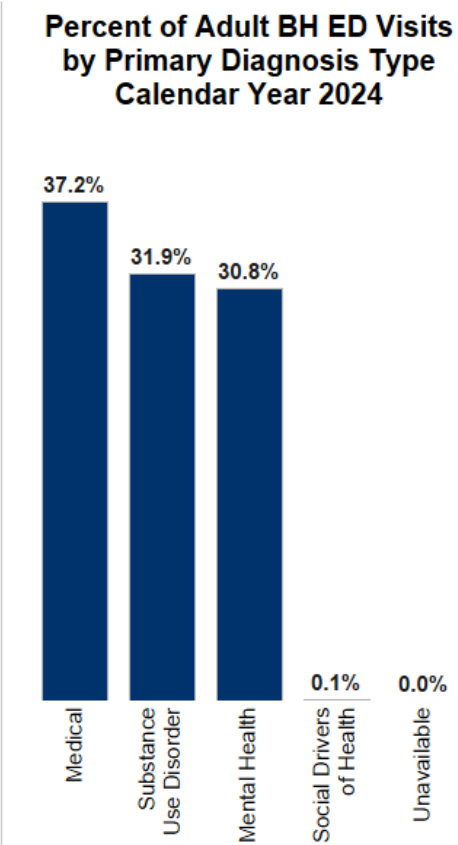
Adult BH Emergency Department (ED) Utilization

- The volume of BH ED visits among adult members remained consistent with 92,036 visits in 2023 and 92,470 visits in 2024, even though the adult membership decreased by 4.7%.
- The majority of adult BH ED visits had a primary medical diagnosis (37.2%, *n* = 34,411) followed by SUD (31.9%, *n* = 29,477) and mental health (30.8%, *n* = 28,449).

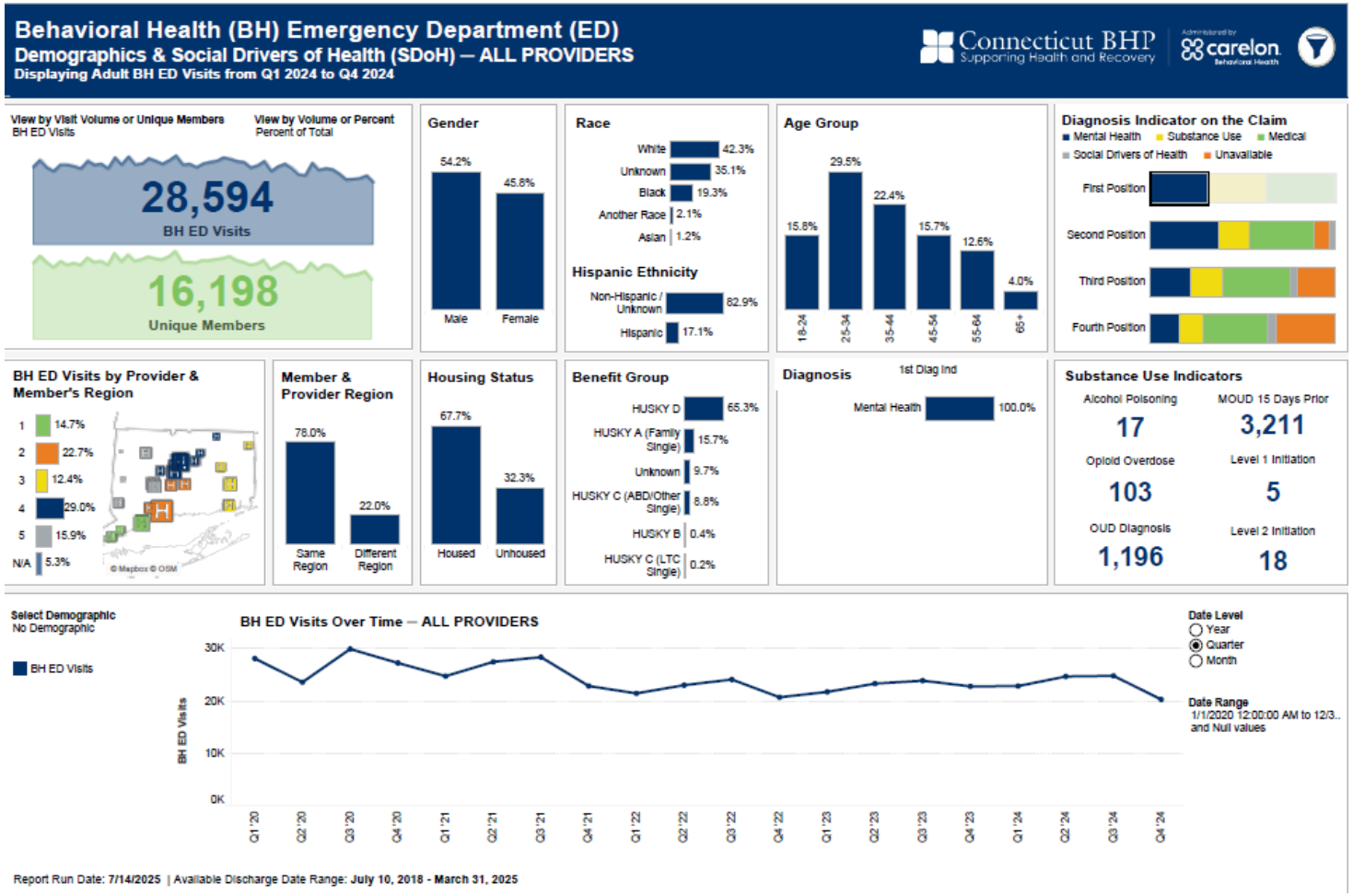




BH ED visits are defined as having a BH diagnosis on any of the first four positions on the claim.

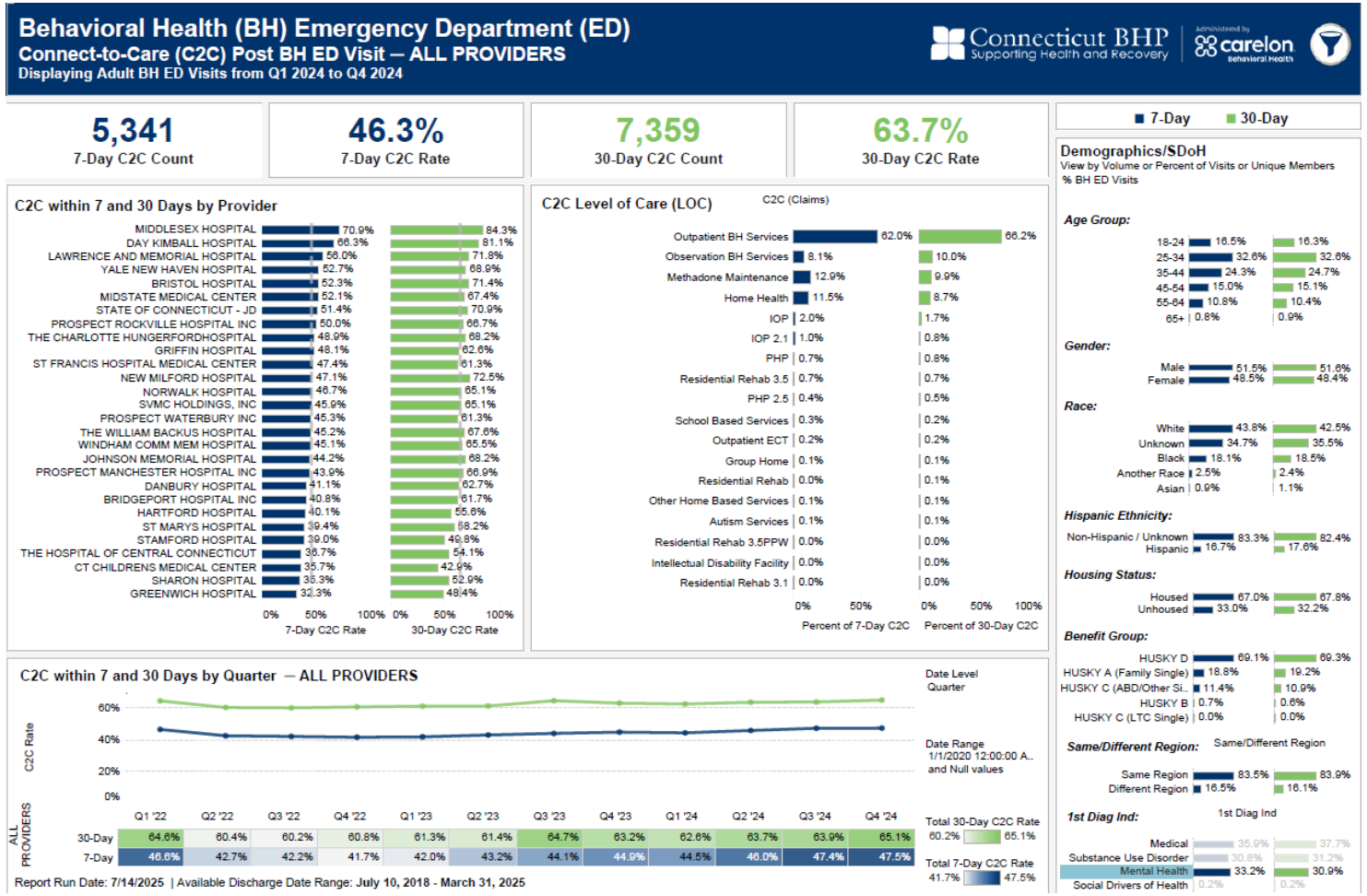
Primary Mental Health Diagnosis – CY 2024

- 16,198 unique members with a primary MH diagnosis utilized the ED, accounting for a total of 28,594 BH ED visits.
- Of all the BH ED visits:
  - 54.2% (*n* = 15,512) were male.
  - 51.9% (*n* = 14,859) were members between 25 and 44 years old.
  - 32.3% (*n* = 9,255) of members experienced homelessness at least one time during CY 2024.



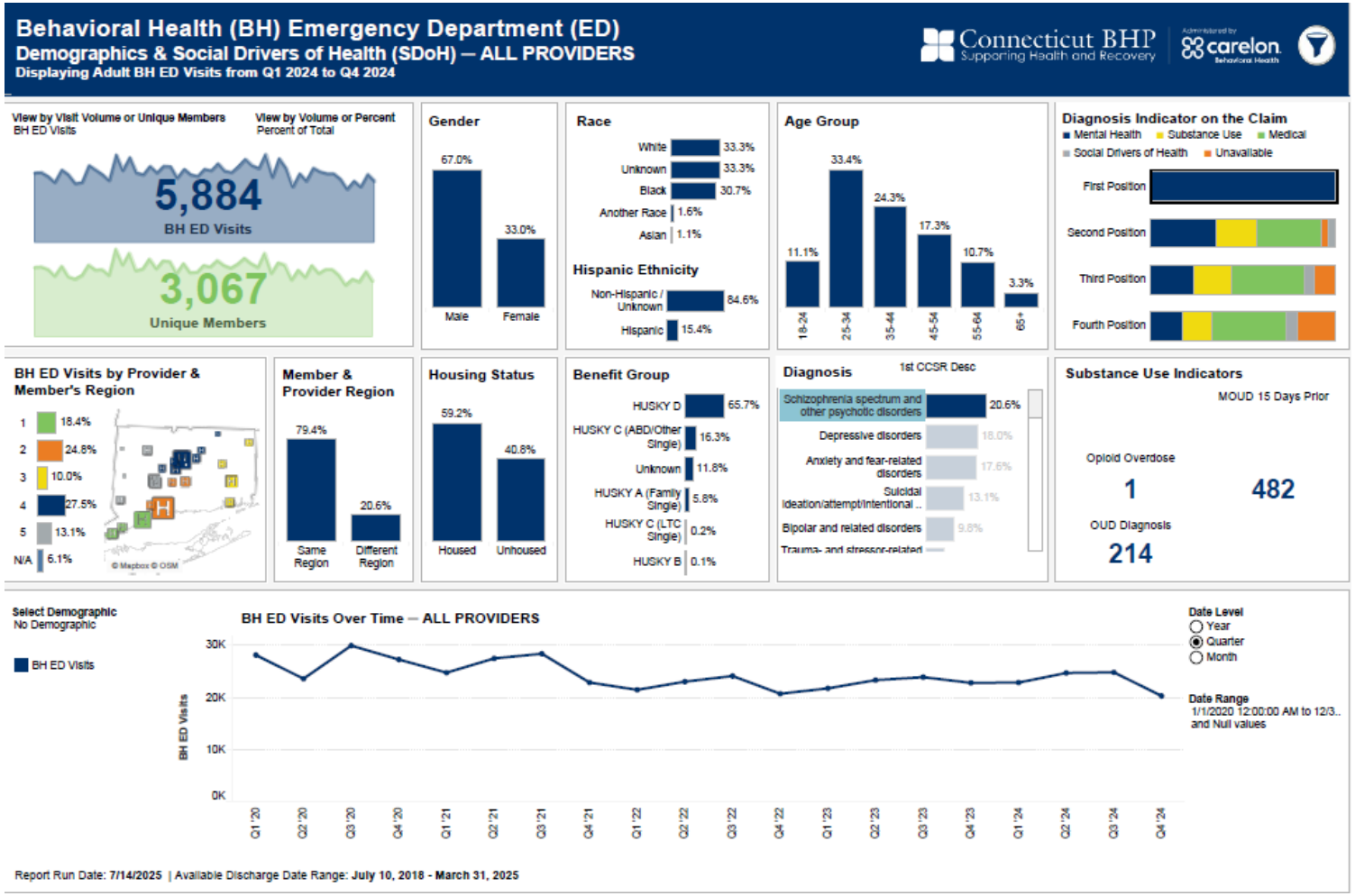
Primary Mental Health Diagnosis C2C – CY 2024

- 46.3% with a primary MH diagnosis connected to care within 7 days and 63.7% within 30 days.
- The majority connected to outpatient BH services within 30 days of discharge:
  - 66.2% connected to outpatient services. (*n* = 4,871)
  - 8.7% connected to home health. (*n* = 628)
  - 9.9% connected to methadone maintenance. (*n* = 718)
  - 0.8% connected to residential rehab. (*n* = 59)



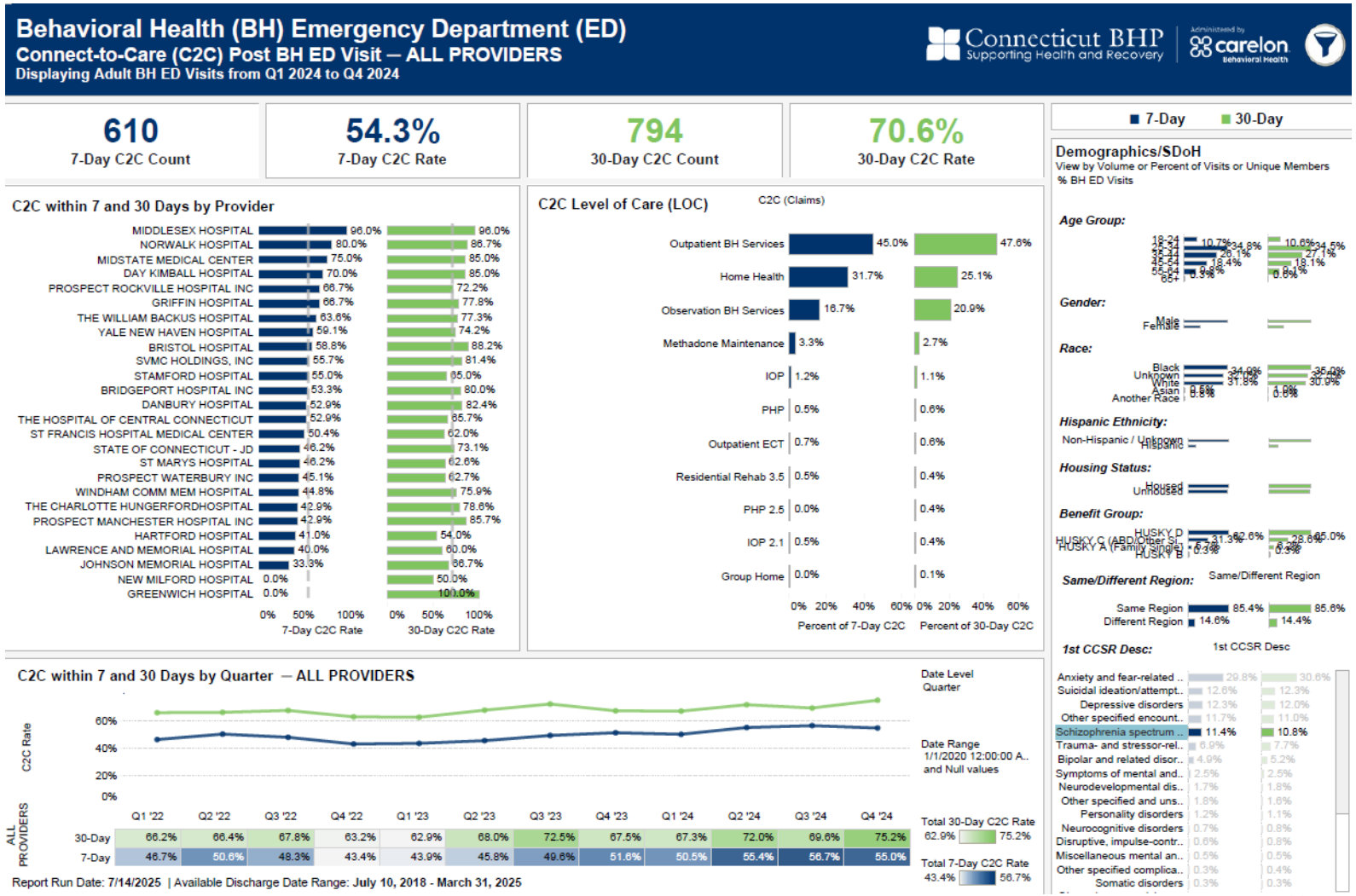
Schizophrenia Spectrum & other Psychotic Disorders – CY 2024

- 3,067 unique members with a primary diagnosis of schizophrenia or other psychotic disorders utilized the ED, accounting for a total of 5,884 BH ED visits.
- Of all the BH ED visits:
  - 67.0% (*n* = 3,946) were male.
  - 57.7% (*n* = 3,395) were members between 25 and 44 years old.
  - 40.8% (*n* = 2,400) of members experienced homelessness at least one time during CY 2024.



Schizophrenia Spectrum & other Psychotic Disorders – CY 2024

- 54.3% connected to care within 7 days and 70.6% within 30 days.
- The majority connected to outpatient BH services within 30 days of discharge:
  - 47.6% connected to outpatient BH services. (*n* = 378)
  - 25.1% connected to home health. (*n* = 197)
  - 2.7% connected to methadone maintenance. (*n* = 21)
  - 0.4% connected to a 3.5 residential rehab. (*n* = 3)



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Chapter

03

Best Practices

Connecticut Community Care Teams (CCTs)

- CT Community Care Teams (CCTs) are multidisciplinary groups of healthcare and social service professionals that collaborate to provide comprehensive, coordinated care to individuals, particularly those with complex health and social needs. These teams aim to improve health outcomes, reduce emergency department visits and hospital readmissions, and enhance the quality of life for patients through holistic care approaches.
- Since inception of the CCT model in 2013, Carelon BH CT's regional network managers, intensive care managers, and peer specialists continue to support 18 CCTs across the state. CCTs were modeled after programs at Middlesex Health and Norwalk Hospitals.
- Key partnerships:
  - CCTs typically include a mix of healthcare providers such as doctors, nurses, social workers, mental health specialists, and on occasion, nutritionists, or physical therapists.
  - CT partners include the Connecticut Behavioral Health Partnership (CT BHP), Connecticut Community for Addiction Recovery (CCAR), and the Connecticut Hospital Association (CHA).

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Behavioral Health Homes

Jeannie Wigglesworth
Director of BHH & Special Projects

Behavioral Health Homes for Individuals with SMI

- The Connecticut Behavioral Health Home (BHH) program is a collaborative partnership between DMHAS, DSS, and DCF that supports HUSKY Health Members with at least one SMI and with an annual Medicaid spend of at least $10,000.
- Connecticut's BHH model focuses on prevention and recovery from a person- and family-centered perspective. By taking a holistic approach, the model can generate better patient experiences as well as improved health outcomes.
- The BHH core services include:
  - care coordination
  - comprehensive care management
  - wide-ranging transitional care
  - patient and family support
  - referral to community support services

Behavioral Health Home Interventions

Implementing Whole Person-Centered Care

- Implement an assessment tool that incorporates both medical and behavioral health questions.
- Assist BHH enrollees in developing goals related to medical health and provide support for medical preventative care.

Using Integrated Data

- Utilize CONNIE to obtain real-time information on enrollees who are in the emergency room or inpatient settings to ensure comprehensive discharge planning is completed.
- Combine data from various sources, including claims, DMHAS, and CHN data, into comprehensive Tableau dashboards. This allows providers to identify both the mental health and medical needs of enrollees.

Provide Ongoing Education to Enrollees and Staff

- Providers regularly conduct psycho-educational groups focused on whole-person care, which are informed by data and best practices.
- Maintain a primary care consultant on staff to educate behavioral health workers on the medical issues most commonly affecting members.
- Establish a health literacy committee aimed at enhancing the clarity and readability of BHH's member-facing materials.

Collaborate with Medical Providers

- Collaborate with CHN to facilitate the sharing of data that will inform providers and help improve outcomes for enrollees.
- Partner with medical providers to develop educational materials on the medical conditions correlated with the SMI population, such as preventative care for diabetes, obesity, hypertension, hyperlipidemia, and more.
- When possible, staff accompany enrollees to appointments to provide advocacy and assist in interpreting discharge paperwork.

Behavioral Health Home Outcomes

Increased Preventative and Follow-up Care

- The rate of BHH enrollees with adequately controlled blood pressure increased from 39.6% in 2016 to 58.9% in 2022.
- The rates of depression screenings for BHH enrollees increased from 24.9% in 2016 to 68.2% in 2022.
- CT BHH has consistently outperformed the CT Medicaid population, as well as national and regional HEDIS Medicaid FUH 7- and 30-day follow-up rates for the past five years.
- In 2019, a CT BHH research study using propensity score matching on the BHH enrolled and BHH eligible populations revealed that BHH enrollees were more likely to receive mammograms and A1c screenings compared to those who were eligible but not enrolled.

Reduced Utilization of Higher Levels of Care

- CT BHH has demonstrated a reduction in emergency room visit rates for BHH enrollees, decreasing from 203.7 visits per 1,000 enrollee months in 2016 to 165.5 in 2022.
- CT BHH has shown a reduction in inpatient stay rates for BHH enrollees, from 63.2 admissions per 1,000 enrollee months in 2016 to 32.3 in 2022.

High Rates of Enrollee Satisfaction with BHH Services

- Annual satisfaction surveys conducted by DMHAS indicate a continually high level of overall satisfaction among enrollees with the CT BHH program, maintaining 90% or greater every year.

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DMHAS Housing and Homeless Services Programs

Robert Haswell, LCSW
Section Chief, Managed Services (DMHAS)

DMHAS Housing and Homeless Services Programs

Department of Housing and Urban Development (HUD) 2022 Special Notice of Funding Opportunity (SNOFO) –

- Primary focus outreach to persons experiencing unsheltered homelessness
- Activities include street outreach and permanent supportive housing subsidies and supportive services

Projects for Assistance in Transition from Homelessness (PATH) – SAMHSA

- Serves persons with Serious Mental Illness (SMI) or who are dually diagnosed with SMI and a co-occurring substance use disorder that are experiencing homelessness or at risk of becoming homeless
- Primary focus - outreach to persons experiencing unsheltered homelessness

Unsheltered Homeless Street Outreach

- Includes state funding that focuses on unsheltered, street outreach efforts to engage and house people experiencing homelessness

Transit Homeless Outreach Program (T-HOP)

- Collaboration between DMHAS and Department of Transportation (DOT) and Department of Emergency Services and Public Protection (DESPP)
- Outreach to train stations, FastTrack locations, encampments on DOT/State of CT property,
- Activities conducted during non-traditional hours including weekends, evenings, and early morning, outreach staff are supported by CT State Troopers and transit security

DMHAS Housing and Homeless Services Programs

Permanent Supportive Housing

An evidence-based model offering persons affordable housing along with wrap around services to decrease the time a person experiences homelessness.

Case managers use various engagement strategies to offer participants, who are experiencing homelessness and are diagnosed with a mental health and/or substance use disorder, services they may need or want

Department of Housing & Urban Development - Rental Assistance –

Rental assistance subsidies to persons meeting HUD's eligibility criteria – (persons experiencing long term-homelessness with a qualifying disabling condition - mental health, substance use, and/or HIV+), DMHAS houses approximately 2300 individuals and families annually

Homeless to Housing (H2H) –

Continuum of services and supports **provided by same case manager** from the point of unsheltered homelessness up to and including being stably housed by addressing their individualized needs

Pre-tenancy - H2H staff conducts outreach and engagement to persons residing out of doors and in places not meant for human habitation to assist them in locating permanent housing , Post-tenancy - case manager will continue to provide housing support/ tenancy sustaining services

DMHAS Housing and Homeless Services Programs

COMING SOON

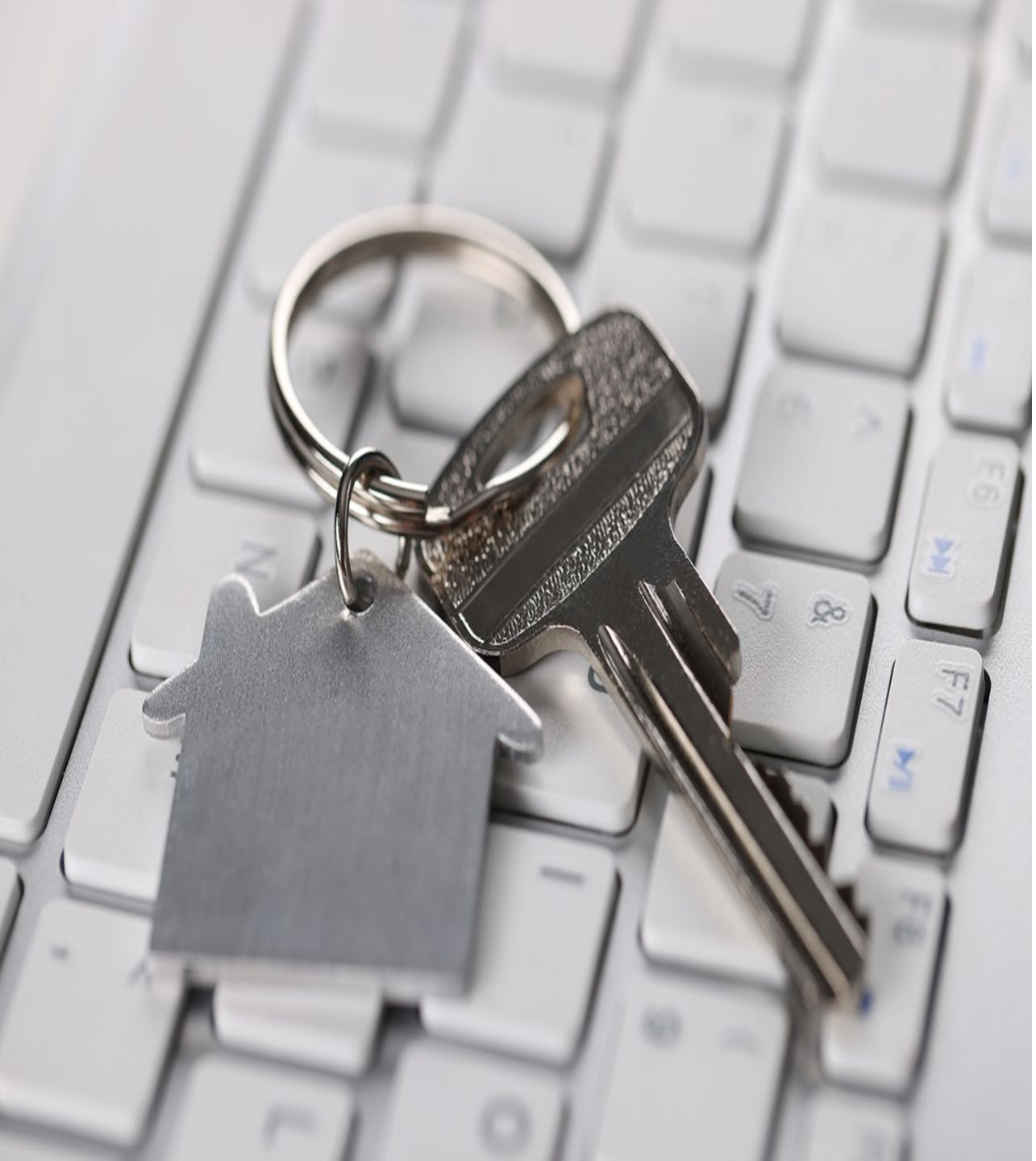
Housing Empowering Recovery from Opioids (HERO)

Initiative funded by the Opioid Settlement Advisory Council (OSAC) that aims to bridge the gap between housing instability and recovery by supporting individuals who are experiencing or at risk of homelessness and are living with an opioid use disorder

Through the HERO program, eligible households across Connecticut will be connected with housing subsidies, tenant support funds and comprehensive case management services.

The program is designed to support individuals who are:

- Homeless, chronically homeless, or unstably housed (including those who do not meet traditional HUD criteria (staying with a friend, recurrent admissions to ED and other SUD programs AND;
  - Living with an opioid use disorder
  - Seeking recovery with support for housing, employment, and behavioral/medical care



Housing and Homeless Services Resources

- 211 Connecticut
- 2-1-1, then #3, 1 for Housing and Homeless Services Unit
- Connecticut Department of Mental Health and Addiction Services
- DMHAS Housing
- Stabilization Services | ABH®
- Housing and Homeless Services

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Journey Home: Compassionate Connections to Housing

Matt Morgan
Executive Director (Journey Home)

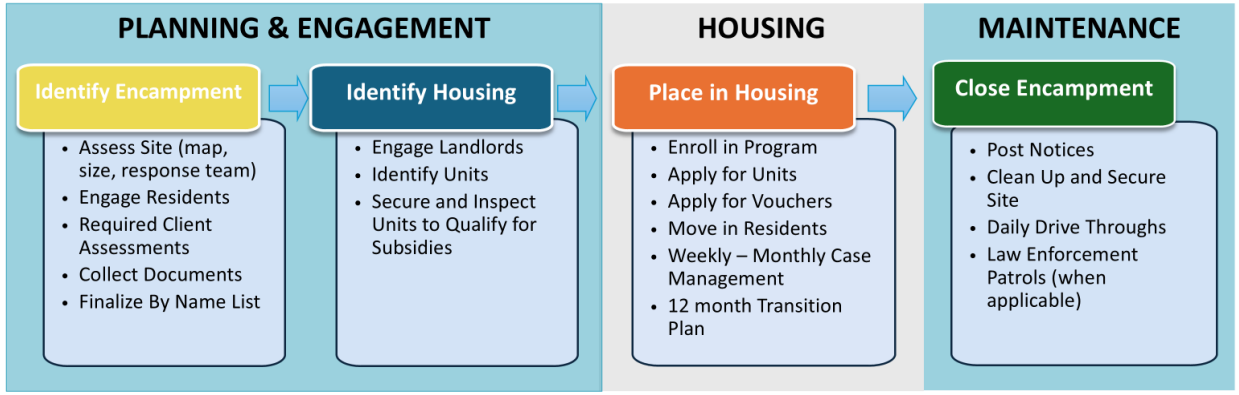
Compassionate Connections to Housing

- Journey Home believes the most powerful way to ensure a home for all is collectively- by working together with service providers, elected officials, business and local communities to end homelessness in the Capital region of Connecticut. We build partnerships, advance innovative solutions, and achieve enduring, systemic change.

- One of these innovative solutions is a new approach to responding to unsheltered homelessness. We streamline the path to housing with services for people living outside, rather than costly, temporary measures. When you have a real offer of housing- more people say yes.

New Model for Encampment Response

Typically **3-4 week cycle** per encampment area – size and housing availability will dictate timeline



Compassionate Connections to Housing Interventions

WHAT'S DIFFERENT ABOUT THIS APPROACH?

- Targets Encampments
- Faster
- Low Barrier
- More Supportive
- Maintains Public Health & Safety After Response
- Collaboration With Property Owners
- Housing Stabilization focus to prevent future episodes of homelessness

KEYS TO SUCCESS

Intensive Focus on a Single Location

Focus on a single location and group of people intensely for an extended period with a single objective of rehousing.

Bringing the Rehousing Services to the Site

Bringing all staff, procedures, and paperwork into the field resulted in higher rates of completion and faster processing time.

Landlord Engagement Team

The landlord engagement team model offers an opportunity to engage and broker access to larger portfolios of units.

Legal Notices

Legal notices were provided to residents 7 days, 3 days, and 24 hours prior to closure and were effective in notifying both residents and visitors of the site. Residents referenced the notice in conversations about details and timelines.

Closure Maintenance

New partnerships with the City departments required for closure maintenance were established during this process. Both newly established and existing partnerships will allow for faster communication and alignment.

Compassionate Connections to Housing Outcomes

- **8** municipalities with encampments
- **3** housing authorities
- **5** funders
- **9** street outreach and service agencies
- **70** people from encampments engaged
- **54** people housed
- **1** returned to homelessness
- **55** days-median time to be housed

Thank You

Contact Us

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