RESULTS IN BRIEF
CHILDREN'S HEALTH COUNCIL

Emergency Care and Hospitalization of Children in HUSKY A: FFY 2002

September 2003

Like other children in Connecticut, children in HUSKY A (Medicaid managed care) are generally healthy. They need regular preventive care to maintain good health and access to primary care for acute, mainly ambulatory care-sensitive conditions like conjunctivitis, otitis media and upper respiratory conditions. However, national data show that publicly insured children are more likely than privately insured or uninsured children to be hospitalized or seek emergency care.[1] In addition to higher costs, hospital admissions and emergency visits may indicate a problem with access to primary care and other health care services that keep children healthy.

This report from the Children's Health Council describes emergency care and hospitalizations in HUSKY A in federal fiscal year 2002.[2]

Methods

Using HUSKY A enrollment and encounter data for the one-year period between October 1, 2001 and September 30, 2002, emergency visits and hospitalizations for continuously enrolled children under 21 (n=140,395) were identified.[3] The distribution of emergency visits and hospitalizations across diagnostic categories was determined. Average length of stay associated with diagnostic categories was determined.

Results

Emergency visits: Thirty-five percent of children made at least one emergency visit in the one year period, for a total of 86,650 visits (average: 1.8 visits per child with emergency care). Overall, the leading reasons for emergency visits were treatment of injuries (27%) and respiratory conditions (Figure 1). The leading reasons varied by age (Table 1) for some diagnostic groups.

Hospitalization: Just over 4% of children were hospitalized at least once for a total of 11,658 hospitalizations (average: 2.0 hospitalizations for each child who was admitted). Children with special health care needs were hospitalized at more than twice that rate (8.5%).[4] Average length of stay was 4.1 days (range: 2.7 for pregnancy and childbirth to 10.9 for perinatal conditions). Overall, the leading reasons for hospitalization were treatment of mental disorders (48%) and respiratory conditions (12%) (Figure 2). The leading reasons varied by age (Table 2) for some diagnostic groups.

Table 1. Emergency Visits

	<1	1-5	6-14	15-20
Injuries	7%	20%	**34%**	**31%**
Respiratory conditions	**39%**	**25%**	19%	16%
Nervous system	12%	19%	10%	4%
Ill-defined conditions	20%	16%	12%	14%
Infectious/parasitic	11%	10%	8%	4%
All other conditions	11%	10%	17%	31%

Leading reasons in each age group shown in bold.

Table 2. Hospitalization

	<1	1-5	6-14	15-20
Mental disorders	---	3%	**71%**	**47%**
Respiratory conditions	**40%**	**37%**	7%	2%
Pregnancy, childbirth	---	---	<1%	33%
Injuries	4%	12%	6%	5%
All other conditions	56%	48%	16%	13%

Leading reasons in each age group shown in bold.

Results are consistent with emergency care and hospitalization rates in HUSKY A in previous years.[5]

Discussion

Emergency care rates in HUSKY A are far higher than national rates.[1] Data from the 1998 Medical Expenditure Panel Survey show that just 15% of publicly insured children under 18 had any emergency department visits, compared with 35% of children in

HUSKY A. Hospitalization rates in HUSKY A are essentially the same as in national data (4.2%, compared to 4.1% of publicly insured children under 18).

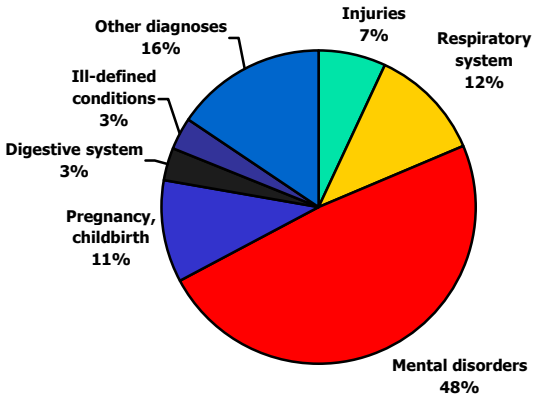
Conclusion

- **Emergency visit rate in HUSKY A is high, suggesting a problem with access to primary care.**

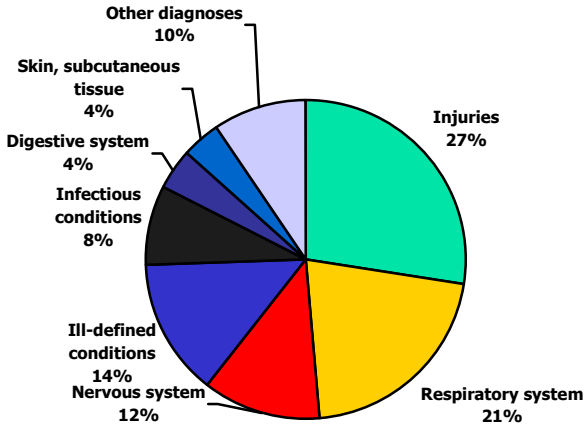
- **Families in HUSKY A would undoubtedly benefit from injury prevention initiatives and guidance from health plans and primary care providers.**

- **Efforts to improve the mental health care delivery system in Connecticut should continue, with an expanded provider network and investment into innovative community-based services that will help families and decrease the need for hospitalization.**

Hospitalizations for Children in HUSKY A



Emergency Department Visits for Children in HUSKY A: 2002



[1] Elixhauser A et al. Health care for children and youth in the United States: 2001 annual report on access, utilization, quality and expenditures. Ambulatory Pediatrics, 2002; 2(6): 419-437

[2] The Children's Health Council was created by the Connecticut General Assembly in 1995 and charged with evaluation of the impact of Medicaid managed care on children's health services under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. The Children's Health Council monitors children's health services with funds appropriated to the Connecticut Department of Social Services and with support from the Hartford Foundation for Public Giving. The Children's Health Council contracts with MAXIMUS, Inc. for data management and data analysis.

[3] Emergency care: CPT-4 codes (99281, 99282, 99283, 99284, 99285) and UB-92 revenue codes (450, 456, 459) with any diagnoses other than well-child (v20 series, v70, v70.0, v70.3-v70.9) or pregnancy and childbirth (ICD-9-CM codes 630-677). Hospitalizations: CPT-4 codes (99433) and UB-92 revenue codes (100, 219) with all diagnoses including conditions related to pregnancy and childbirth, perinatal conditions, and congenital anomalies (ICD-9-CM codes 630-676, 740-759, and 760-779).

[4] Children with special health care needs: Children in foster care or adoption assistance, children receiving SSI, children in Title V program.

[5] Data available upon request.