Connecticut BHP
Supporting Health and Recovery

Administered by carelon Behavioral Health

Follow-up after Hospitalization (FUH) Project

DEI Subcommittee

September 2024

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Key Contributors

- CT BHP Staff from several different departments
  - Quality Management
  - Regional Network Management
  - Medical Affairs
  - Clinical
    - Peers
- Member Focus Groups (Consumer and Family Advisory Council and Other HUSKY Health members)
- Provider Interviews (Providers & Community Based Health Center)

Chapter

01

Background and Context

Background and Context

Overarching Goals of the All ASO Health Equity Project for BH

- Address Disparities in Care that impact particular subgroups among HUSKY Health Members
- Focus on members with behavioral health (BH) diagnosis or who have used BH services
- Initial Focus on disparities in Access to Care
- Initial Focus on groups defined by their self-identified racial and/or ethnic identity
- Documentation of the disparity and level of care where it could be focused
- Development of an intervention to address the documented disparity

Follow-up after Hospitalization (FUH) as a Key Access Point of Behavioral Health Care

- Healthcare Effectiveness Data and Information Set (HEDIS®)measure.
- This measure looks at continuity of care for mental health, which is critical for health and well-being of the patients.
- FUH rates are calculated as the percentage of discharges for adults who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and had a follow-up visit with a mental health provider within 7 days after discharge and within 30 days after discharge.
- **Higher rates are better for this measure.**
- National Quality Forum has identified FUH as one of the disparities sensitive measures to improve equitable access to care in their ‘A Road map for Promoting Health Equity and Eliminating Disparities: The Four I’s for Health Equity’.

Chapter

02

Follow-Up Concerns Identified

Follow-up Concerns Identified

- Data Findings
  - 7 and 30 day Follow-up Rates
    - Individuals identifying as Black have a lower rate of following up after a psychiatric hospitalization than White individuals
    - This disparity contributes to an increased likelihood of readmission, ED visits, lack of continued medication management, and deterioration in their general health condition
- Literature Review Findings
  - Post hospital discharge follow-up visits are associated with
    - Lower rates of readmission
    - Lower general medical comorbidities
    - Increased subsequent acute care use
    - Reduced risk of 30-day readmissions
  - Decreased likelihood of follow-up visits are associated with
    - Non-Hispanic or non-Latino black race and/or ethnicity
    - Fee-for-service insurance
    - Having no comorbidities
    - Discharge from a medical or surgical unit
    - Suicide attempt
  - Reasons for increased probability of a follow-up visit
    - Higher severity of illness
    - Prior visits to providers

Chapter

03

Possible Solutions to Support Follow - Up

Common themes across both focus group and provider interviews

- Education of both Provider and Member
- Tangible Support for Care Navigation
- Cultural Competency of Providers
- Collaboration
- Care Planning
- Social Drivers of Health

Provider Interviews

What is **most effective or helpful in connecting** all people to care after a hospitalization, including for people who identify as Black?

Provider Education

Cultural knowledge and community understanding of the patient and population that they serve.

Liaison/Transition Navigator

Need a care coordinator within the system mainly for hand holding for the marginalized population prior to/at the time of discharge.

Provider to Provider Communication

A phone call or text between providers and a standard referral improves access and enables member.

"Hard" Hand Offs

Physically taking a patient to their next step in the healthcare process; drive them in and around the area they will receive the next service.

People who identify as Black often report relying not only on biological family, but neighbors, friends and others to manage children and support each other.
"It takes a village is something integral in the Black community"

Provider Interviews

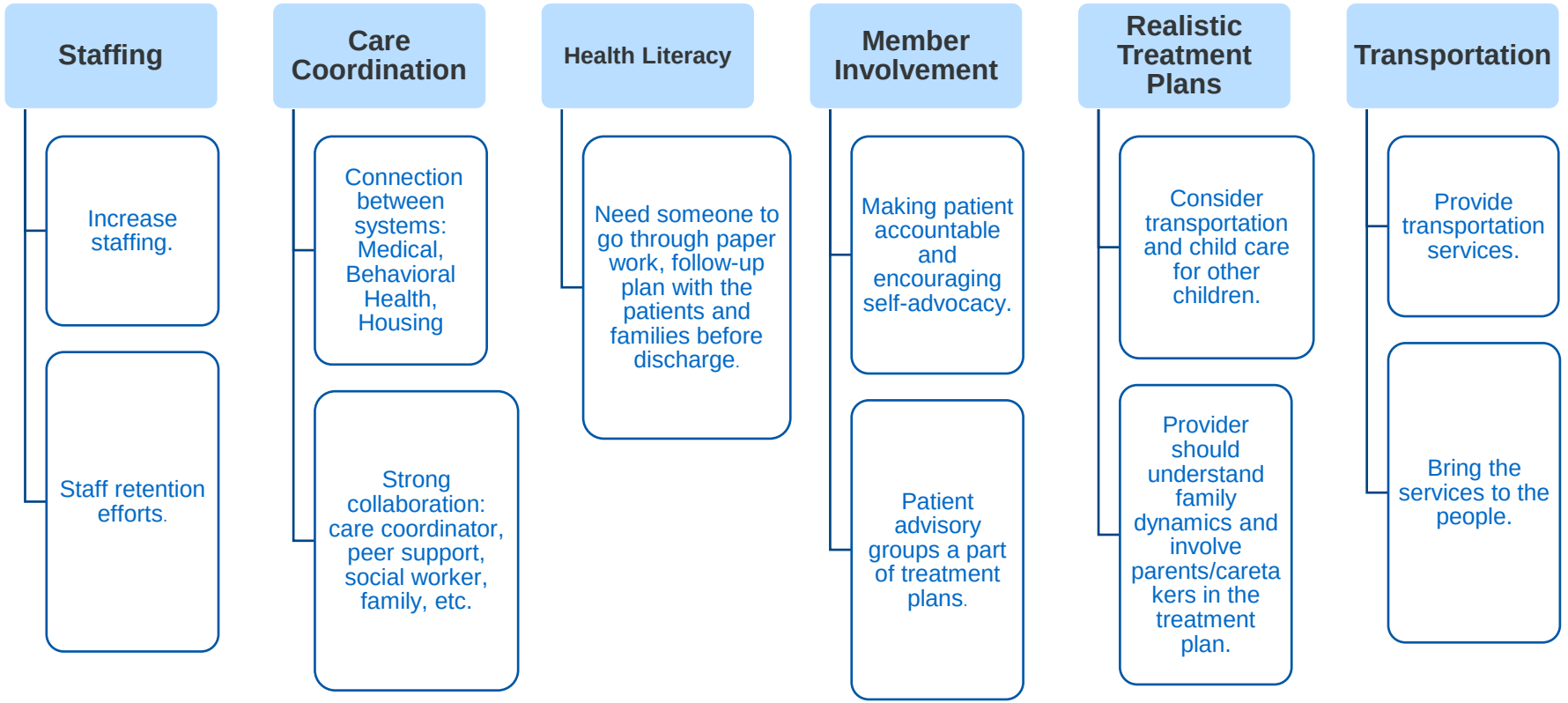
Describe the **practices, system issues, or other factors that you see as the biggest barriers** to timely access to care following hospitalization in general, and particularly for people who identify as Black.

Social Drivers of Health	Implicit Bias and Lack of Cultural Competencies	Staffing Issues	Lack of Member and Situation Specific Care Plans	Language, Fear and Stigma
Financial difficulties, transportation, housing instability.	Stereotypes of individuals who identify as black as more aggressive, forceful or potentially violent are seen as reasons that some services may not be compatible	Provider burnout and staff shortages negatively impact availability of appointments and extend hold times for members.	Members feel lost during the process.	Systems are not family friendly or culturally responsive. There is institutional racism.

"The Black community has **distrust, history of oppression**, and seeks care when conditions are worse."

Provider Interviews

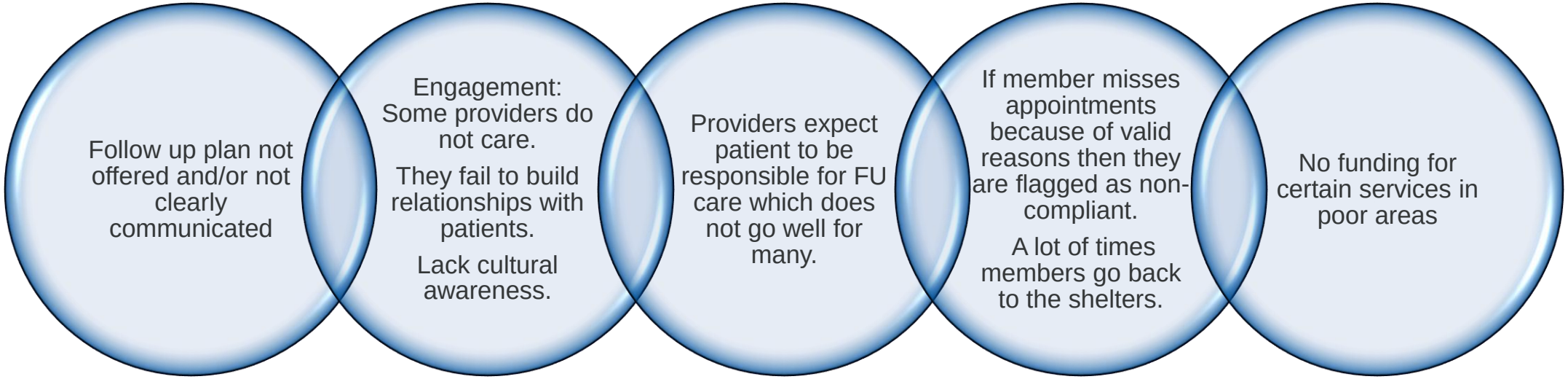
Describe the **top 3-5 services, practices, or other changes that would most improve timely connection to ongoing care** following hospitalization in general, and particularly for people who identify as Black.



"When dealing with members who have been disenfranchised and are struggling to survive you need to have **people who are willing to truly walk with them** through the process."

Focus Group Findings

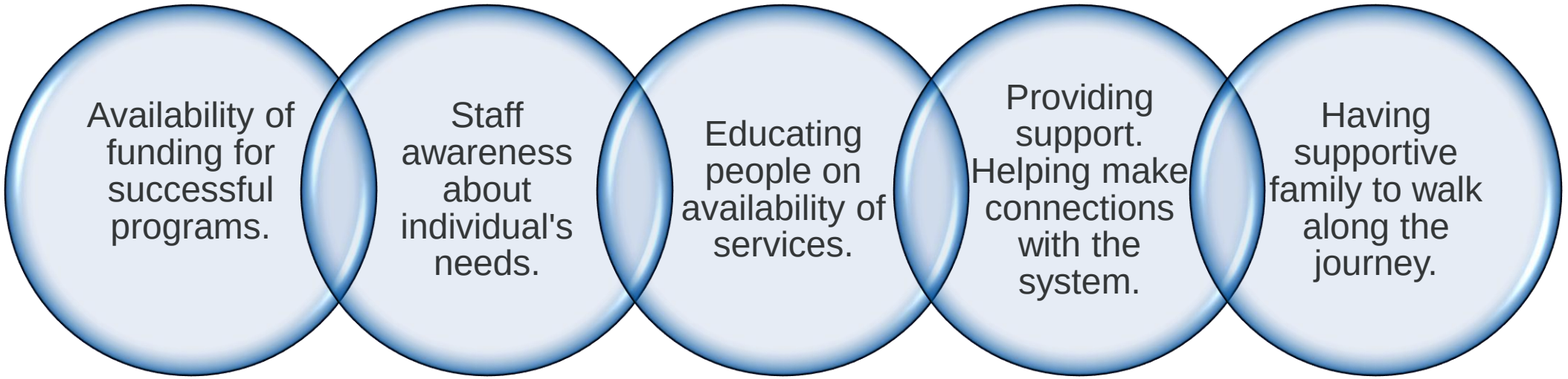
What were your experiences or the experiences you witnessed as a caregiver or family member in seeking follow-up mental health or substance use disorder treatment after an in-patient **hospitalization?**



"Sometimes members fail to participate in Follow-Up because of **distrust**."

Focus Group Findings

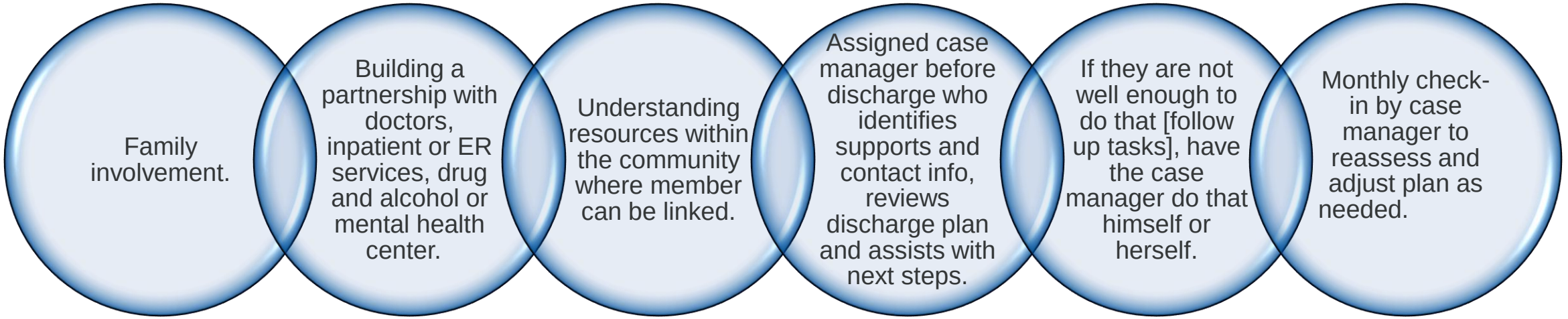
What **helped you or your family member be able to access follow-up mental health or substance use disorder treatment** after an in-patient hospitalization?



One member acknowledged **Carelon's Peer staff** and their outstanding work

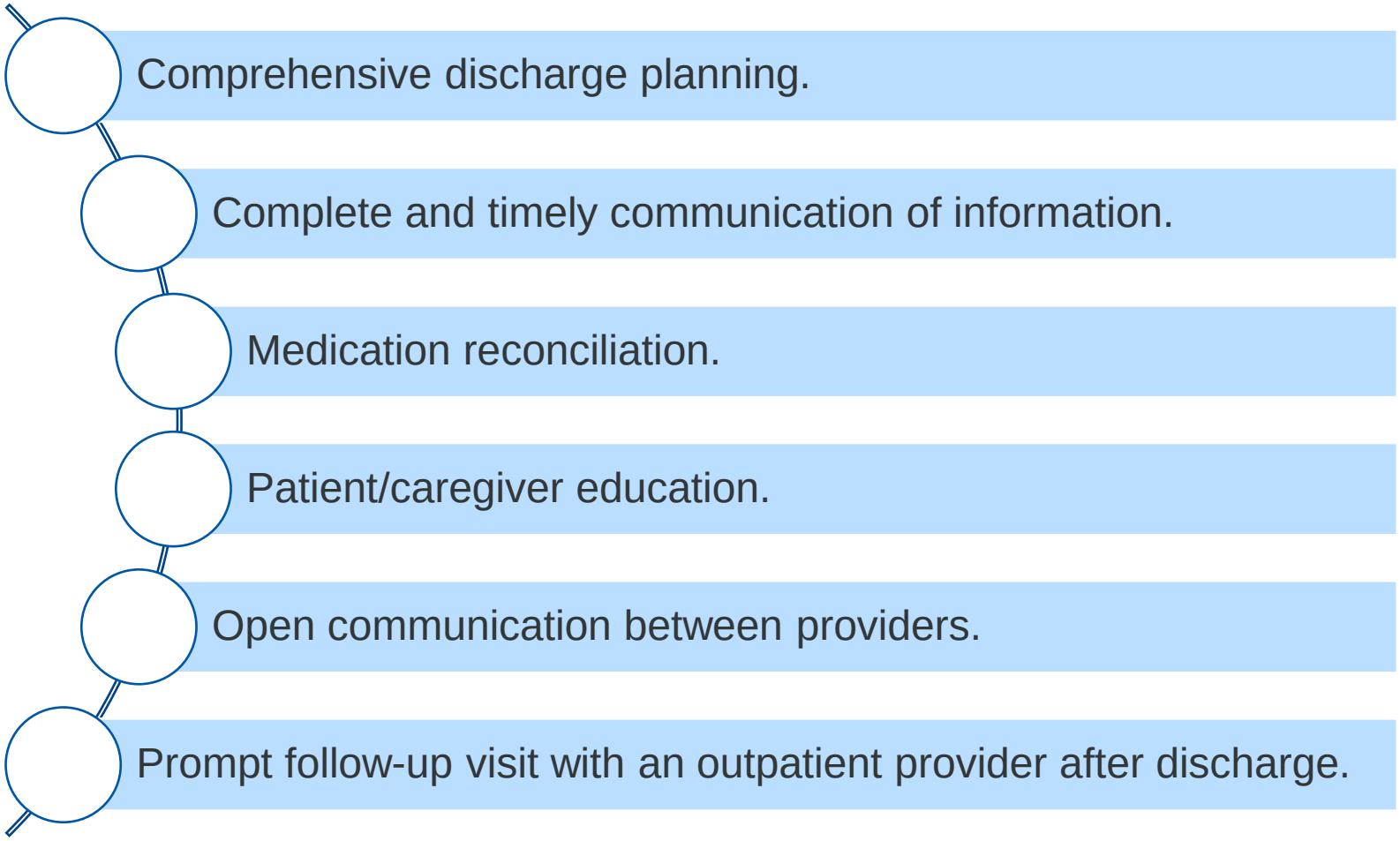
Focus Group Findings

What would **make you or family member feel more comfortable accessing follow-up mental health or substance use treatment** after hospitalization?



Keep repeating that until the person is **stable and healthy and thriving.**

Best Practices – Care Transition Process



Chapter

04

Predictive Model

Risk factors of not connecting to care

	Compared to	More likely to follow up	Less likely to follow up
Gender	Male	Female	
Age	25-34	Under 18	Over 35
Race	White		Black members and members for whom race is not known
Benefit Group	MLIA	Family Single	
Diagnosis	Depression		Neurodevelopmental disorders, unspecified mood disorders, schizophrenia
BHH Enrolled	Not Enrolled in BHH	Enrolled in BHH	
DCF Involvement	Not Involved in DCF		Involved in DCF
Housing Status	Housed		Unhoused

Conclusions

- **A predictive model was built** to identify patients at **high risk of not connecting to care** following discharge from inpatient psychiatric hospitalization.
- **Four risk tiers** were constructed.
- **Patients in the highest-risk tier (Tier 1) were 4.6 times more likely not to connect to care** compared to patients in the lowest-risk tier.
- Patients in Tier 2 were **2.2 times more likely** not to connect to care.

Chapter

05

Member Intervention

Triage and Connect

- Started in May 2024 to identification of members daily
- Communication to Inpatient providers as to who is at high risk of not connecting and offer Intensive Care Management Services (ICM)
- Referrals to ICM are made when member accepts services.
- If services are not accepted, Care Manager supports hospital in discharge planning
- Follow up call are made after discharge to all member who are at high risk of not connect

ICM – Member Intervention

- Member intervention **may** include any of the following:
  - **Introduces self** and explains **purpose of contact**, quick rapport building
  - **Discusses treatment history** including any barriers to connecting to services in the past, **assesses for motivation to connect** to treatment using motivational interviewing approach
  - **Supports member in addressing any social drivers of health** that may impact access to aftercare
  - **Ensures** member is fully **aware of aftercare appts** (where, when, why, how – including transportation)
  - Does member have any **family/friends** who are willing to support member in attending aftercare appts? **If yes and member agrees**, **obtain ROI** to communicate with the support person
  - **Follow-up** with member **post discharge to ensure connection to care**

ICM– Provider Intervention

- Provider intervention **<u>may</u>** include any of the following:

    - **ICM outreaches to provider** (clinical or UM staff), informs provider member has been identified as high risk to not connect to aftercare
    - **Discusses relevant treatment history** and inquires regarding **current discharge planning** efforts, **offers assistance connecting** to aftercare resources
    - **Obtains** best **contact info** for member/guardian
    - **Offers** to **schedule visit to the unit** to meet with member
    - If member is **BHH eligible** - **informs provider and educates** on steps to access BHH services
    - **Coordinates member specific provider meetings** if there are existing providers/state agencies involved

Chapter

06

Provider Intervention

Provider Intervention

- Updated Website to include information about Aftercare Follow Up
- Workgroup with Inpatient Provider
- Integration in Provider Analysis and Reporting meetings with providers
- Connect to Care meeting with Inpatient providers and other providers from various levels of care
- Community Care Team and Community Programs (Assertive Community Treatment, Community Support Program and Behavioral Health Homes)

Chapter

07

Questions and Discussion

Thank You

Contact Us

877-552-8247

www.carelon.com | www.ctbhp.com

CTBHP@carelon.com