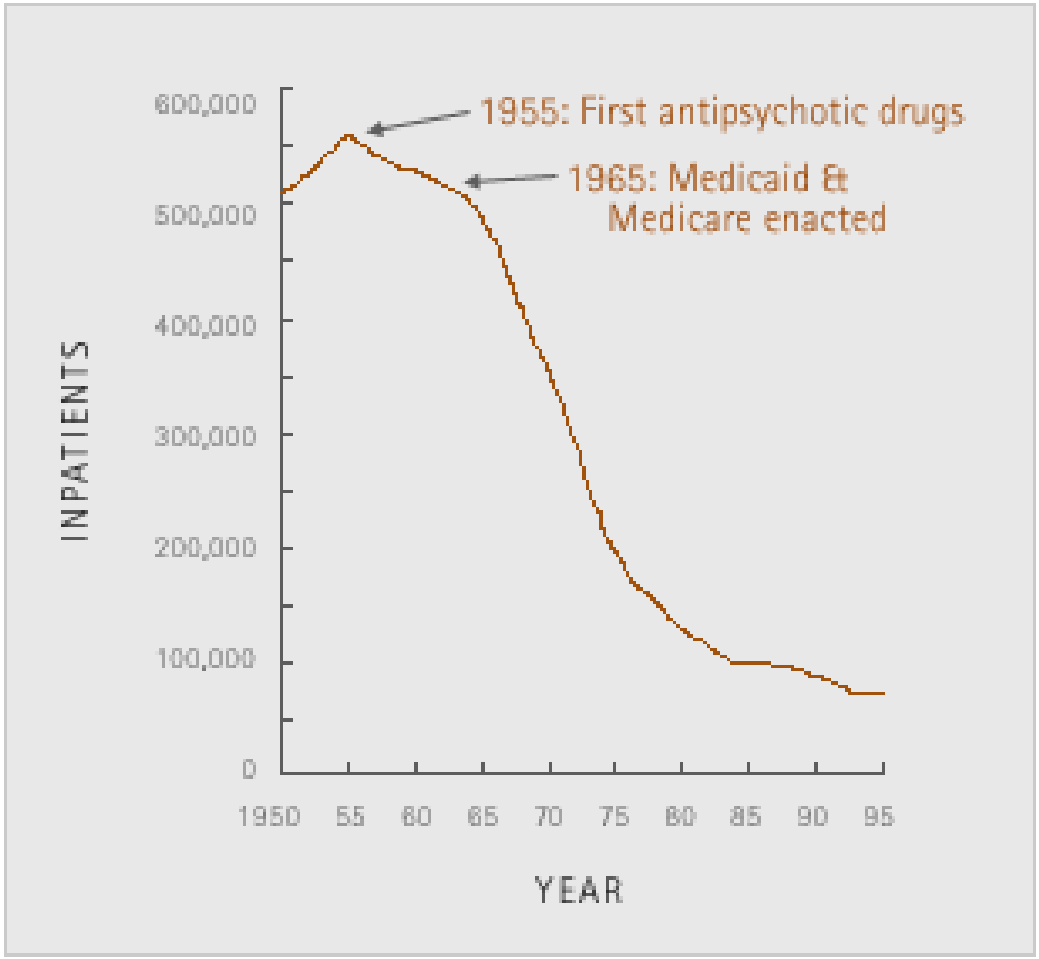
BEHAVIORAL HEALTH PARTNERSHIP OVERSIGHT COUNCIL

July 8, 2015

Deinstitutionalization



1955 – 558,000 in State Hospitals

- US pop – 164M

1995 – 71,000

- US pop – 260M

→ 92% effective discharge rate

Special Report PBS.org

Connecticut

Fairfield Hills 1931 – 1995

Norwich 1904 – 1996

1955 – **8668** in state hospitals

1994 – **958**

- Effective rate of discharge – 92%

Results: 50% have done very poorly ("SPMI") → 30% of homeless
20% of inmates

Treatment of Psychosis

Average length of time needed to treat:

- Hallucinations – 2 months
- Delusions – 4 months
- Restore Jared Loughner to competency – 1 year

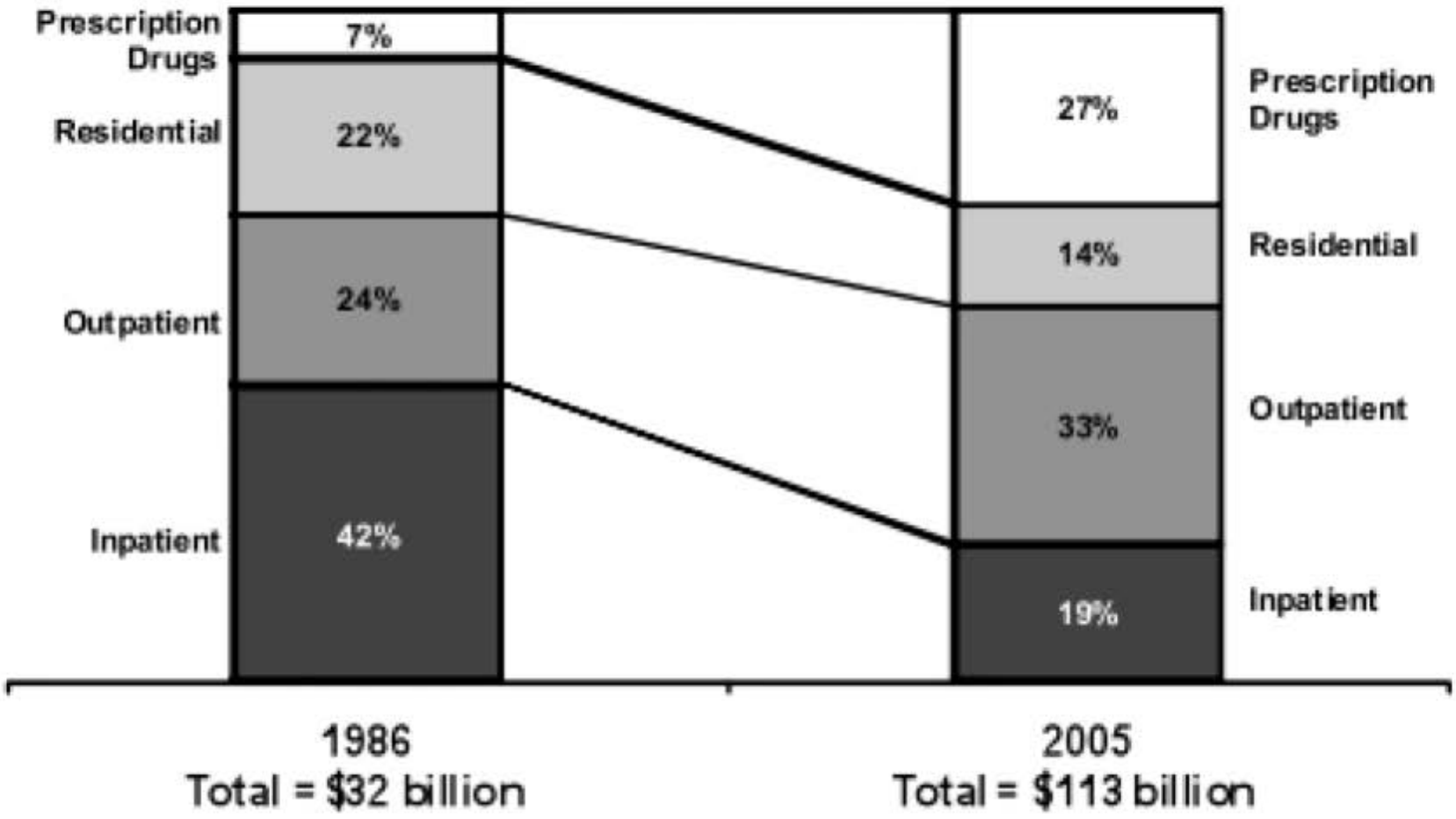
Average length of stay on acute inpatient psychiatric unit

7 to 10 days

→ Need for structured community programs

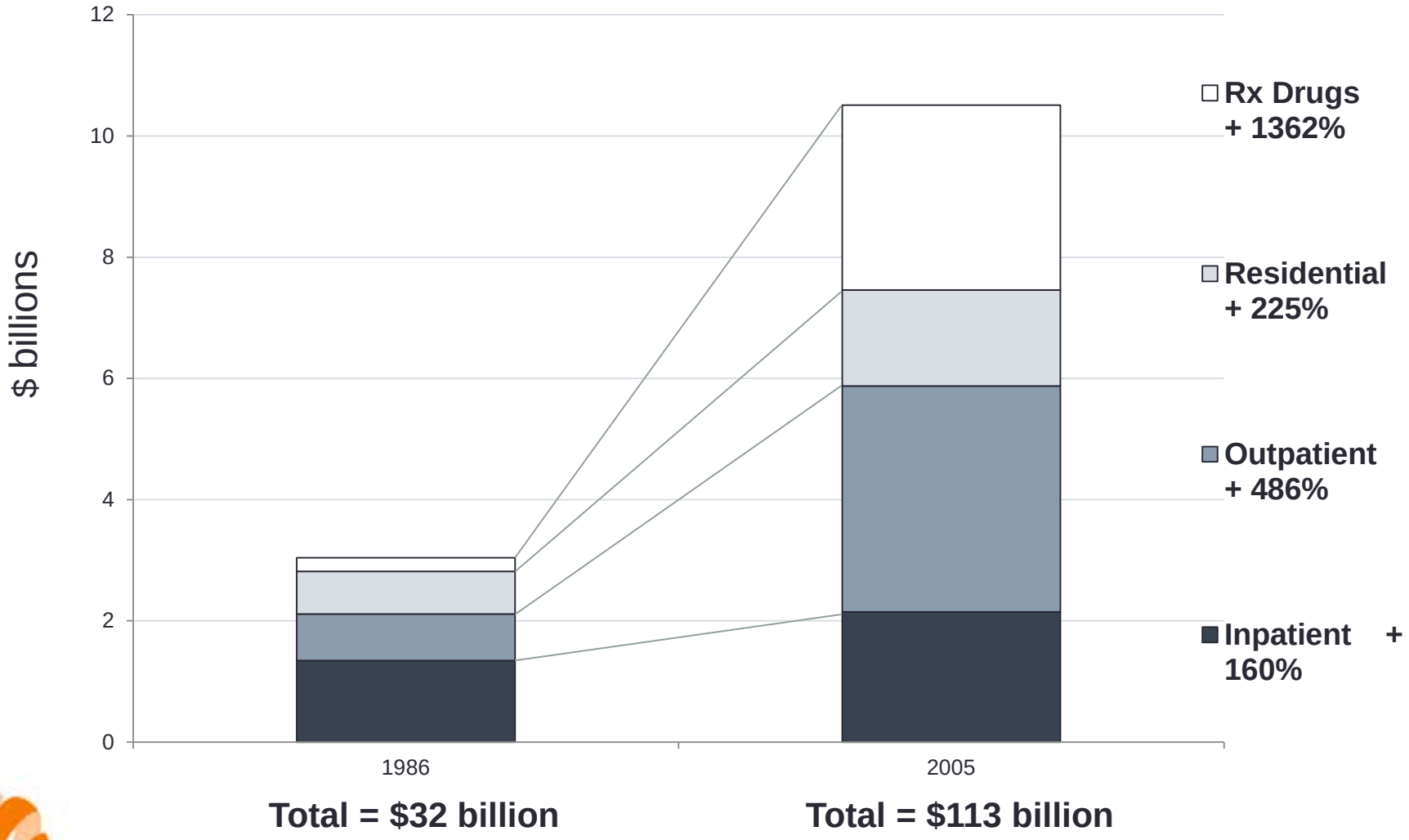
Figure D

Distribution of Mental Health Expenditures by Type of Service, 1986 & 2005



Note: Excludes spending on insurance administration. Data not adjusted for inflation.
Source: SAMHSA Spending Estimates Project, 2010.

Distribution of Mental Health Expenditures by Type of Service



Total = $32 billion

Total = $113 billion

Summary of the Current MH Situation

Fragmented system
- *Loss of long-term beds*
- *Lack of support for community services*
- *Lack of residential services*

+

Diagnosis inflation
- *Pharmaceutical marketing*
- *Payment incentives*
- *Defensive practice*

+

Misallocation of services
- *Overtreatment of some*
- *Inability of the seriously ill to connect with needed services*

+

Homelessness, substance abuse
- *"Revolving door" to ED, acute services*
- *Catchment, eligibility, coverage*
- *Lack of disposition options*

= *Poor Outcomes, Wasted Resources, Unsustainable Finances*

Volume vs Value Based Treatment

Volume based (Fee for Service):

- Providers paid for each visit, episode

Population based:

- Integration with Primary Care
- Minimize use of acute services, encourage outpatient services
- Align Incentives for doctors
- Partner with State Agencies
  - Substance abuse
  - Chronically and severely mentally ill
- Plan for High-users
  - Community Care Teams
  - Intensive Care Managers/Navigators

Super-utilizer Summit 2013

- 5% of Medicaid patients drive 50% of cost
- 80% of high cost beneficiaries have 3+ illnesses
- 60% have 5+ chronic illnesses
- Uniform agreement that care coordination necessary to achieve results

Rand Corp:

- 4.4 B in routine, non-emergent ED care
- 40B in uncompensated hospital care

WCHN Utilization Data

Norwalk Campus: October 2013 to September 2014

- Top 40 patients = 1213 ED visits
- Top 100 patients = 2057 visits
- Alcohol, substance abuse = 66% of visits
- 35% either homeless or at risk
- Medicaid = payer for 60% of visits
- 18% have no primary care provider

Impact of Alcohol

- Top 20 in Network with alcohol diagnosis = 1262 visits
- Direct ED Cost = $ 925,800

Community Care Team

- Community Care Teams (CCTs) are innovative programs developed to provide collaborative care for complicated patients through multiagency partnerships.
- Referred patients generally have medical, mental health, substance abuse and social problems requiring involvement of a wide range of community providers.
- Greater Norwalk implemented a CCT in February 2014 and Greater Danbury in January 2015

Community Stakeholders-Norwalk

Americares
Catholic Charities
CT BHP – Value Options
Mid Fairfield Child Guidance
Norwalk Community Health Ctr
Norwalk Hospital
Norwalk Shelter
Family and Children's Agency
Keystone Inc
Gillespie Center
Norwalk Department of Health
DMHAS, DSS

Norwalk Police Department
St. Vincent's, Homestead Program
Connecticut Renaissance
Homes with Hope
Liberation Programs
Connecticut Counseling Inc
Norwalk Housing Authority
Norwalk Board of Education
US Veterans Affairs
Day Street Clinic
Westport Department of Health Services

Norwalk Community Care Team

Started in February 2014

- 40% Female, 60% male
- Age Range: 20 to 86
- 35% homeless or fragile housing
- Payer Mix: 71% Medicaid
  15% Medicare or Dually Eligible
  9% Commercial
  5% Uninsured

3500 ED visits in FY14

Outcomes: Norwalk: >175 Care Plans, >40 housed, >25% decrease in ED visits, >40% reduction in IP days

Strengths and Barriers

Requirements:

- Active participation by key hospital departments and community providers
- Dedicated Navigator or HPA
- Outreach capability

Barriers

- Payer: Medicare, Husky C
- Access to alcohol/substance abuse treatment
- Patient motivation/engagement

Hennepin County, MN

Created care coordination and shared savings model

- For costliest, care management reduced expenses by between 40 and 95%
- Projected annual cost of 3,500 rather than 130,000 for care delivered in the ED

Savings allowed investment in a sobering center

- Alcohol high users showed 80% reduction in ED visits

  - Center for Healthcare Strategies, Super-Utilizer Summit; October 2013
  - NYT: Healthcare Systems try to cut costs by aiding the poor and troubled, 3/22/15