Middlesex County Community Care Team: Care Management for Emergency Department Super Users

Behavioral Health Partnership

Oversight Council

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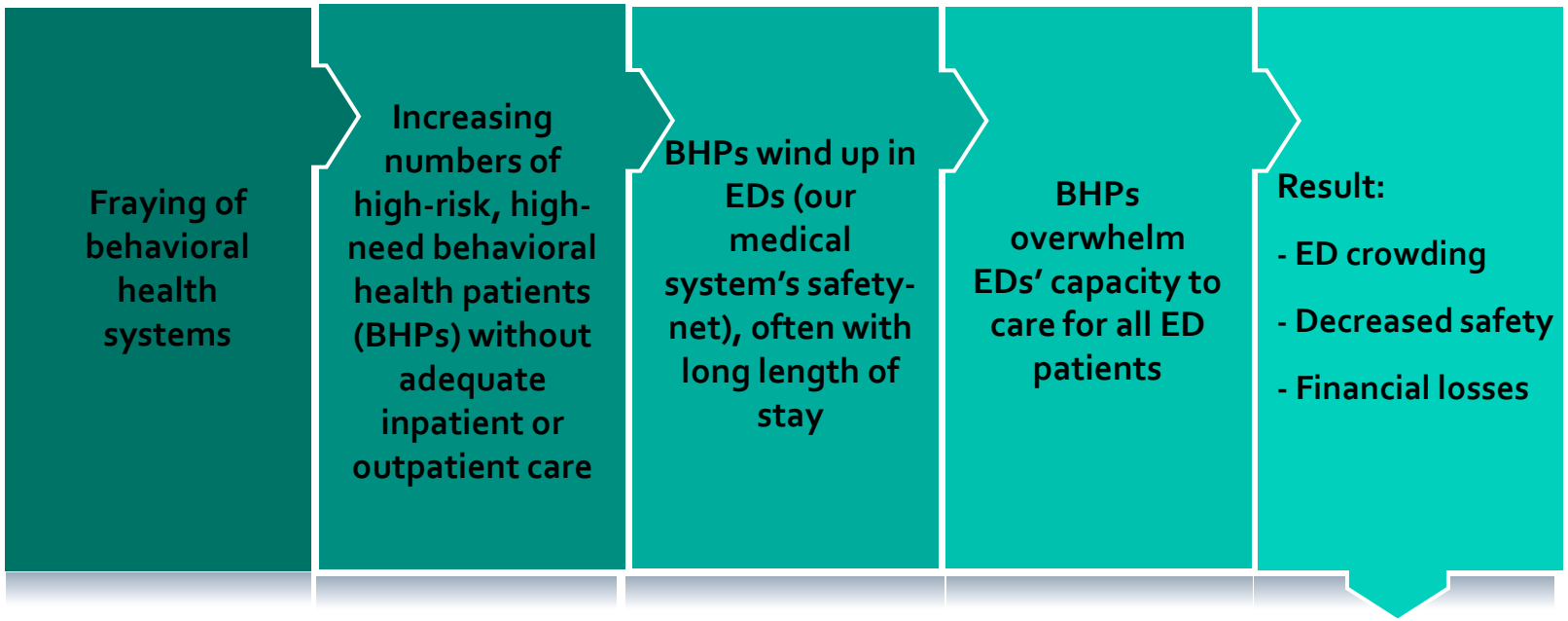
A Community Collaboration

A National Crisis: Emergency Department Perspective



Needed: a different model of care

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Middlesex County CCT History

1990s

- Mental Illness Substance Abuse project through Rushford (grant funded by state) → a continuing care team for dual diagnosis
- Strong relationships were developed

2007

- Middlesex County initiated the 10 Year Plan to End Homelessness; a component was the formation of a **community care team**
- Without a designated champion, the team was never formed

2008

- Middlesex Hospital conducted a health assessment
- Hospital priority area: access and coordination of care for mental health and substance abuse population

2010

- Mdsx County Community Care Team (CCT) was developed; Mdsx Hospital agreed to be the organizer
- 4 core agencies: Middlesex Hospital, Gilead, Rushford, RVS
- Met on a monthly basis
- Barrier addressed: common Release of Information (ROI)

2012

- Mdsx County CCT is formalized
- Expanded to 9 agencies
- Weekly meetings
- Health Promotion Advocate is added to Mdsx Hospital ED (through CHEFA grant)

2013 - on

- Dissemination efforts re: Mdsx County model for the CCT
- DMHAS grant continues the funding for HPA

2014

- Mdsx County model for the CCT was identified as best practice in January 2014 CT Legislative Program Review & Investigatoins Committee Report (*Hospital ED Use and Its Impact on the State Medicaid Budget*)

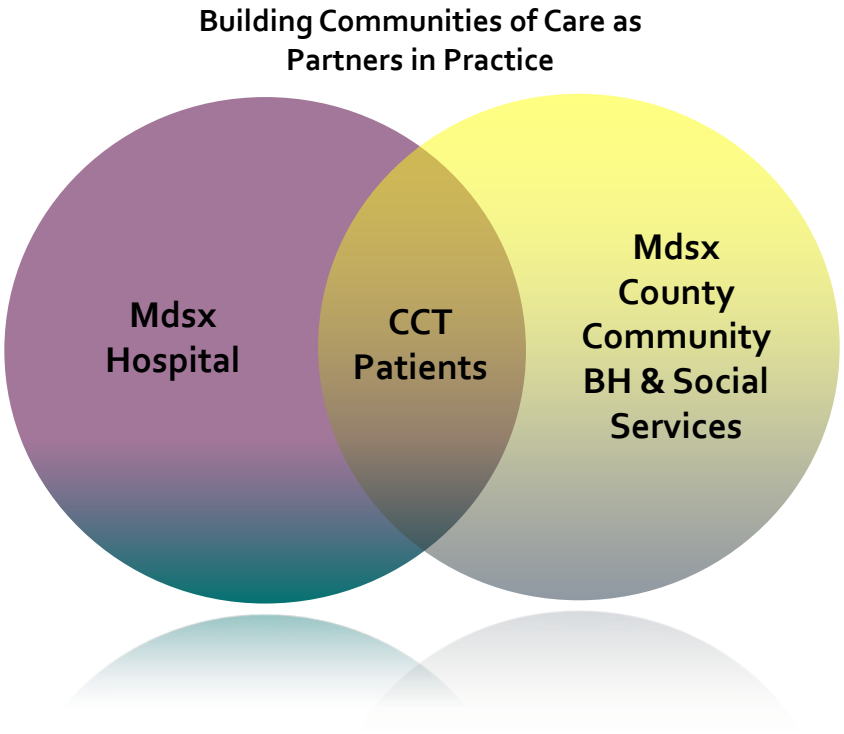
2015

- Mdsx County CCT is expanded to 13 agencies
- Mdsx Hospital outpatient case manager is added to the team

Middlesex County CCT Agency Members

- Middlesex Hospital
- River Valley Services
- Connecticut Valley Hospital (Merritt Hall)
- Rushford Center, Inc.
- The Connection, Inc.
- St. Vincent de Paul Soup Kitchen
- Mercy Housing
- Columbus House
- Community Health Center
- Gilead Community Services, Inc.
- Advanced Behavioral Health
- Value Options, Connecticut
- Community Health Network

Case/care management agencies



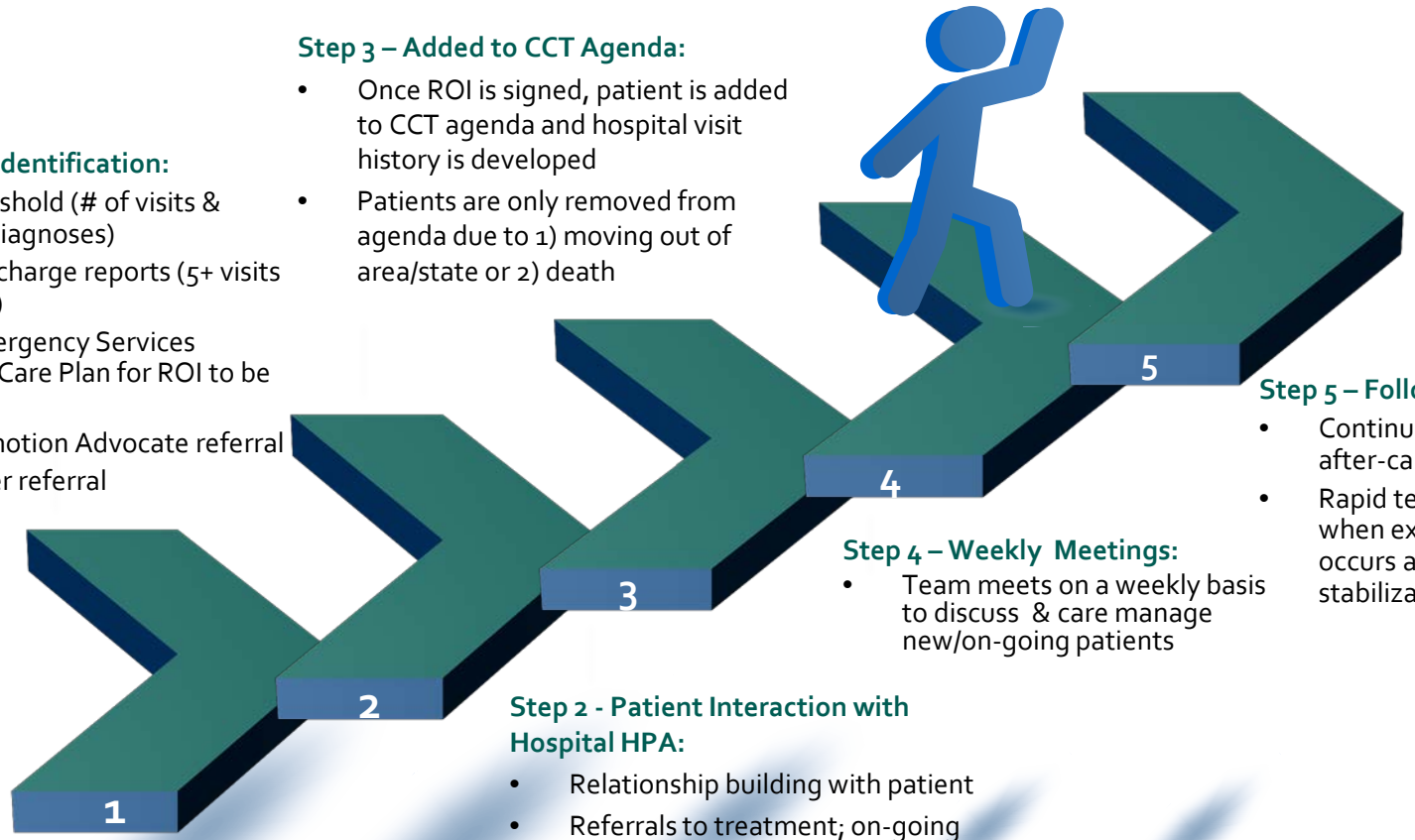
Middlesex County CCT Process

Step 1 - Patient Identification:

- ED visit threshold (# of visits & behavioral diagnoses)
- Daily ED discharge reports (5+ visits in 6 months)
- Chair of Emergency Services dictates ED Care Plan for ROI to be signed
- Health Promotion Advocate referral
- CCT member referral

Step 3 – Added to CCT Agenda:

- Once ROI is signed, patient is added to CCT agenda and hospital visit history is developed
- Patients are only removed from agenda due to 1) moving out of area/state or 2) death



Step 2 - Patient Interaction with Hospital HPA:

- Relationship building with patient
- Referrals to treatment; on-going follow-up
- Assists with completion of Universal Housing Applications

Step 4 – Weekly Meetings:

- Team meets on a weekly basis to discuss & care manage new/on-going patients

Step 5 – Follow-Up:

- Continued follow-up on after-care plans
- Rapid team intervention when exacerbation of illness occurs after a period of stabilization

What We Track & Measure

Impact Metrics:

- # of visits (ED & inpatient) pre- and post- intervention (snapshot in time)
- Cost/losses

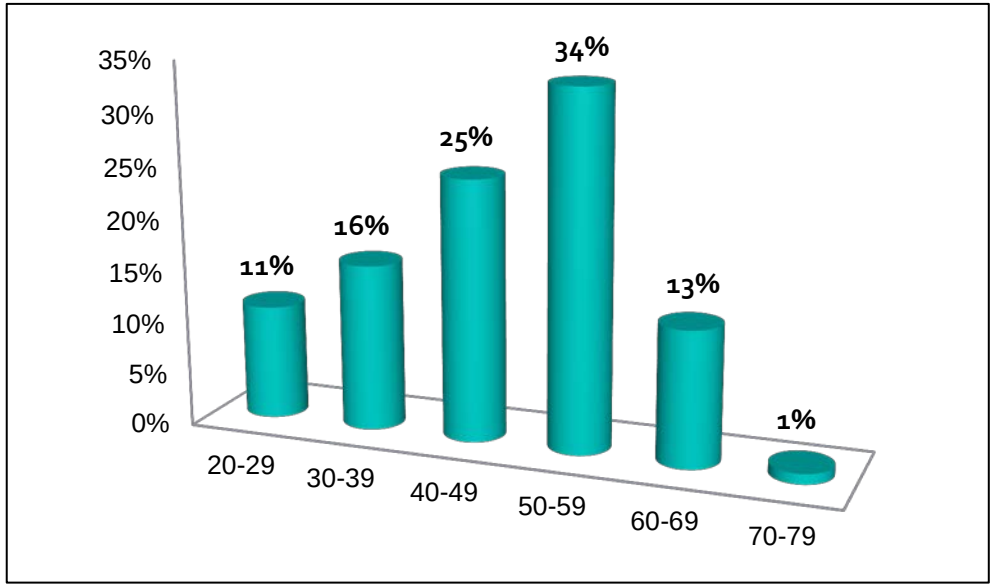
Demographics:

- # of patients who have received care planning
- Diagnosis category
- Gender and age distribution
- Insurance status
- Housing status

# of patients who have received CCT care planning to-date: **208**

What We Track & Measure

Age Distribution



Gender:

- Male – 64%
- Female – 35%
- Transgender – 1%

Payer Status:

- Medicaid – 54%
- Medicare – 40%
- Managed Care – 4%
- Self-pay no insurance – 2%

What We Track & Measure

Diagnoses

Dual Diagnosis

Coexisting severe mental illness and substance abuse disorders (primarily alcohol)

40%

- Dual: alcohol only → 47%
- Dual: other drugs → 23%
- Dual: alcohol & other drugs → 30%

Chronic Mental Illness

Most frequent dxs: bipolar; schizophrenia; schizoaffective; borderline personality

27%

Chronic Alcoholism

alcohol intoxication with/without suicidal ideation

27%

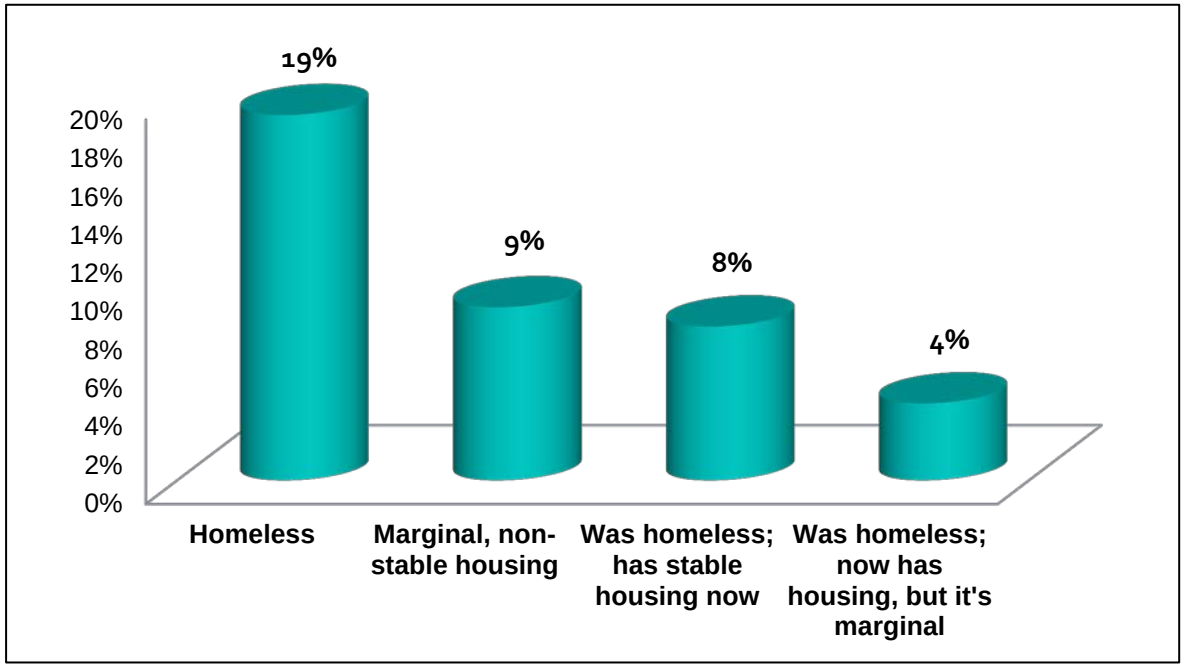
Other Drug Dependence

Opioids; cocaine with/without suicidal ideation

6%

In addition to behavioral health dxs, CCT patients oftentimes experience significant and complex medical conditions

What We Track & Measure

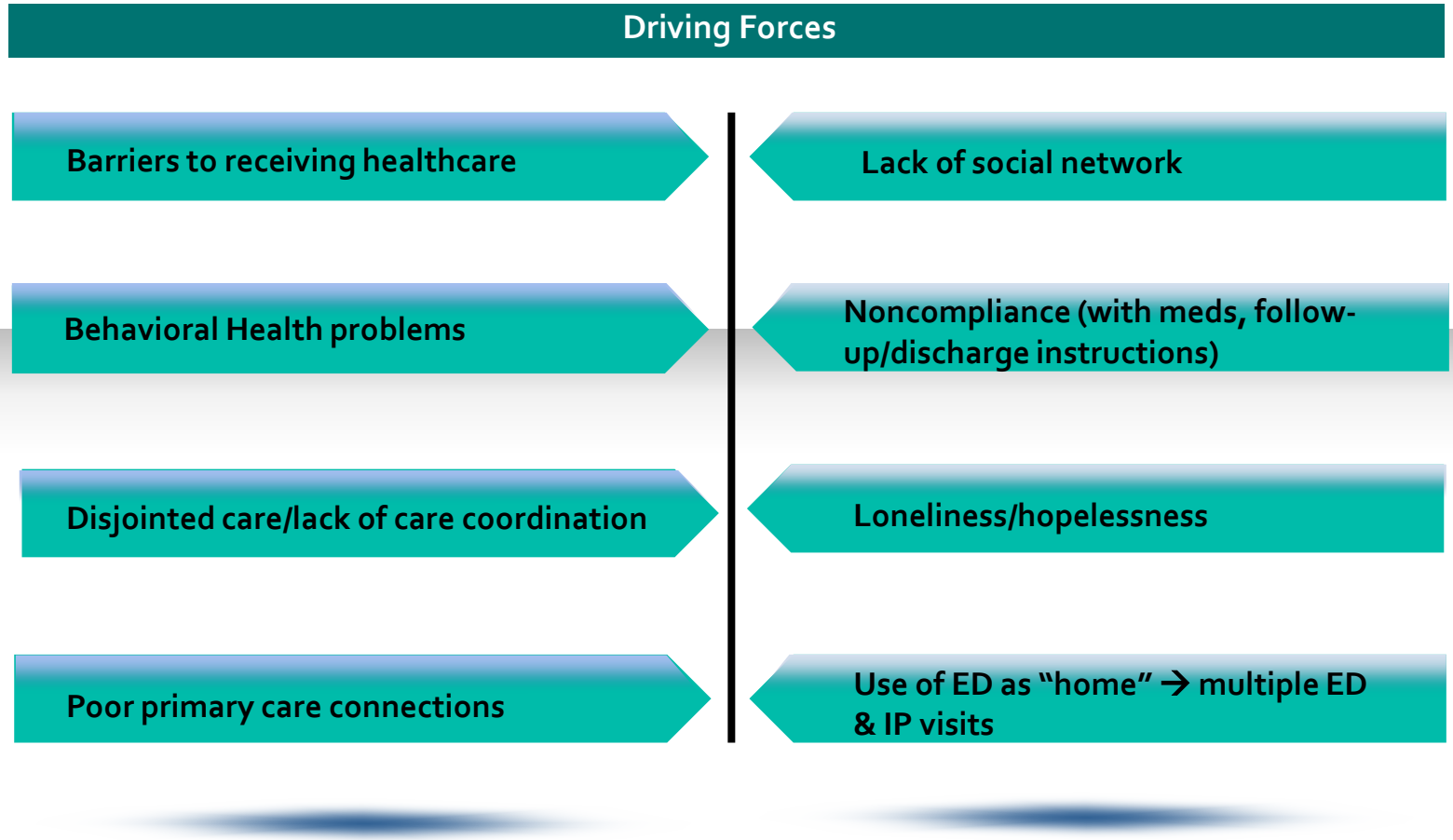


Total = 40%

What we've learned about housing status:

- Housing is an issue
- Stable housing is linked to better health outcomes, improved quality of life and reduced ED utilization
- It is critical to involve community partners who work with the homeless/marginally housed (St. Vincent de Paul)

CCT Patients who are Chronically Homeless – Common Traits



Alcohol Abuse: Supportive Housing – A Case Study

Background:

- As of 2008, patient had total of 245 ED visits at Mdsx Hospital for alcohol intoxication. At times with 2-3 visits in one day

CCT Intervention:

- In 2008 the Middlesex Hospital ED called meeting about patient → DMHAS central office was contacted and a case conference of all area providers including the hospital was held
- A care plan was developed that allowed the patient to enter a long-term rehab program ***of patient's choice*** and patient was housed with supportive case management upon discharge

Result:

- In 2009 (treatment with supportive housing): 7 ED visits, which were primarily medical as patient was diagnosed with stomach cancer
- In 2012, patient had an alcohol exacerbation and had 8 ED visits in 6 days. CCT rapidly developed a care plan that included placing patient in detox on a physician's emergency certificate. Patient had been in the ED 3 times since then for issues related to COPD
- Patient has since passed away from cancer

Mental Health: Supportive Housing – A Case Study

Background:

- in 2012, patient had 28 ED visits in 7 months at Mdsx Hospital for psychiatric issues and a possible seizure condition. The patient had a history of not keeping behavioral health appointments which resulted in discharge from outpatient BH services. Patient was living at a homeless shelter

CCT Intervention:

- In October 2012, patient was added to the CCT case load. A significant trauma history was discussed as well as barriers to care, one of which was lack of stable and supportive housing
- Scoring high on the Vulnerability Index, the patient was granted supportive housing as of December 1, 2012, with case management services through St. Vincent de Paul (SVD)
- A care plan was developed to get the patient back into BH day treatment by working with the SVD case manager, and to have continual communication with the case manager any time the patient missed an appointment
- The patient achieved emotional stability, successfully graduated from day treatment and entered adult outpatient care services

Result:

- Since connecting to supportive housing and on-going communication between the case manager and behavioral health treaters, the patient's ED visits reduced to: 11 in 2013; 7 in 2014 and 1 to-date in 2015 (the 1st 6 months of 2015)
- The patient continues to progress in her recovery
- A highlight includes the patient calling her behavioral health providers to inform them that she would need to miss an appointment due to illness

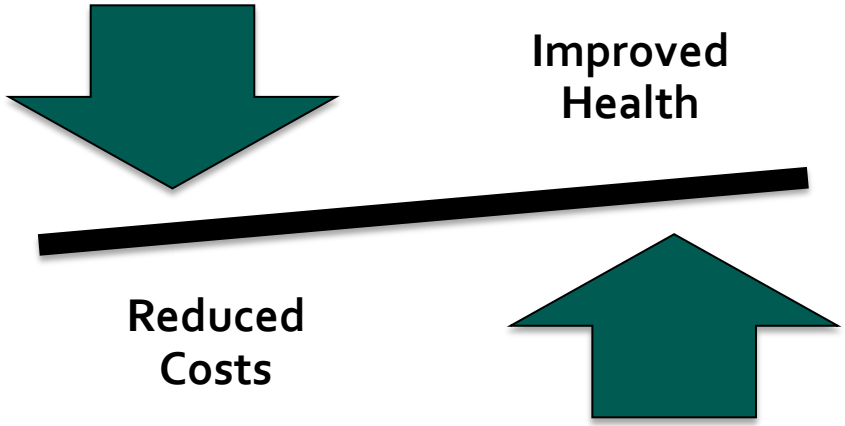
Visit & Cost Reductions

Hospital Cost Avoidance – All Claims:

- 1,142 reduction in visits x $1513.32 (average ED cost) = $1,728,211.40

Medicaid Claims Only - Cost Savings:

- 640 reduction in visits x $915.66 (average ED cost) = $586,022.40



- *Visit & cost data is based on CCT patients care managed for 6+ months*
- *Total cost is aggregate of direct and indirect costs*

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Additional Benefits

Patient – Improved Quality of Life

- Sobriety
- Mental health stabilization
- Reduced homelessness
- Re-entry to workforce
- Re-connection with family
- Achievement of feelings of self-worth and respect

Patient – Linkages to Care/Support

- Primary care physicians, psychiatrists, specialists, etc.
- Supportive housing
- Appropriate outpatient services

Mdsx County CCT Collaborative

- Improved patient care
- Improved agency-specific care plans
- Improved inter-agency communication and relationships

Society

- Increase in safety to all
- Reduction in Medicaid & Medicare expense

What Have We Learned?

1) The CCT target population does not get better with the traditional model of care delivery

2) Behavioral health chronic diseases require care coordination and customized treatment plans

3) Individualized care plans must have the ability to be flexible and evolve

4) Many agency providers were unaware of frequency of ED visits → communication allows for agency-specific care plans (a major part of CCT's success)

5) We have an effective system in place to identify those CCT patients who would have better health outcomes when provided supportive housing

6) The integration of the housing and medical communities is critical for addressing the social and medical needs of a shared population

Next Steps

- Continued focus on after-care planning
- Continued focus on homelessness and housing vouchers
- Enhancing how housing status is captured @ registration at Mdsx Hospital
- Continued dissemination about CCT model → and, how it impacts homelessness/marginal housing

Questions?
Thank You!

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