Middlesex County Community Care Team: The Impact of Care Coordination Across Providers

Connecticut Coalition to End Homelessness 15th Annual Training Institute

May 18.2017

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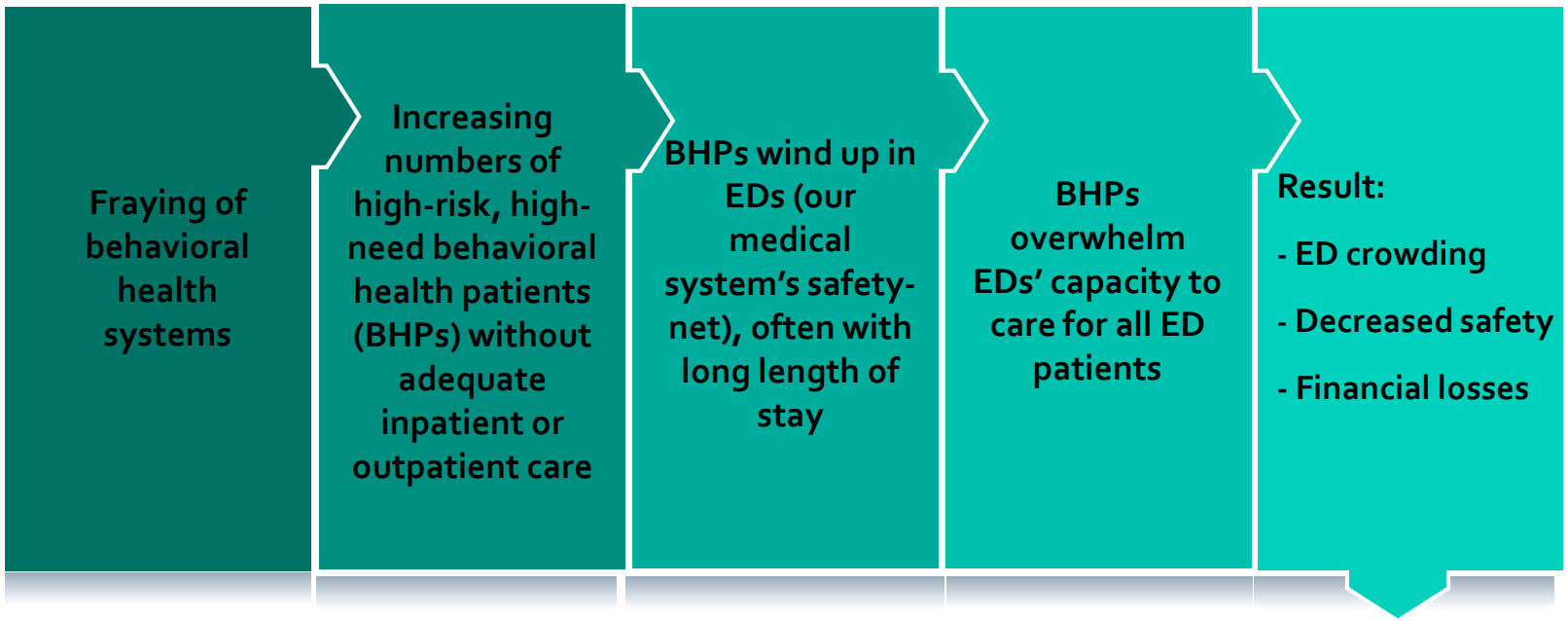
CHA Community Service Award

- https://vimeopro.com/cthosp/connecticut-hospital-association/video/68695816

A Community Collaboration

A National Crisis: Emergency Department Perspective



Needed: a different model of care

A Closer Look…The Major Challenge of BH Super Users

This population does not get better with the traditional model of episodic care delivery

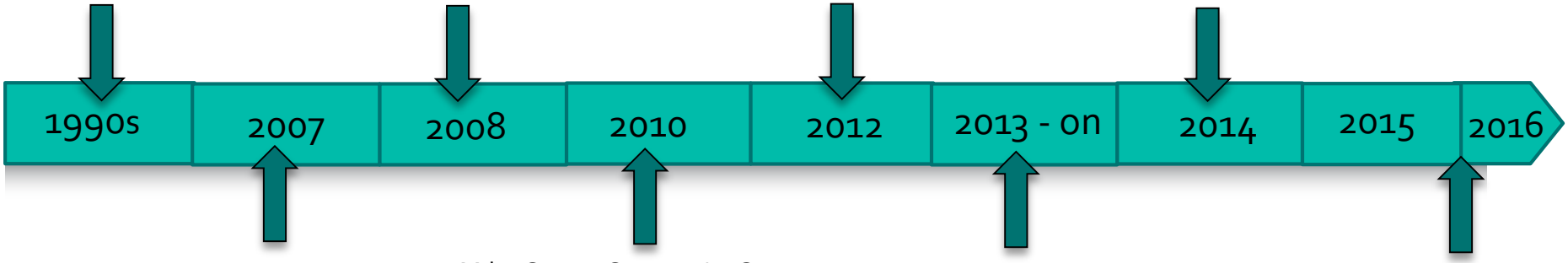
"Falling through the cracks"

Required: Care Coordination

Question Uncovered Along the Way:

How is the experience different for the homeless and those experiencing fragile housing?

Middlesex County CCT History



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

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

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

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*)

- 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

- 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)

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

2015:

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

2016:

- Mdsx County CCT is expanded to 14 agencies

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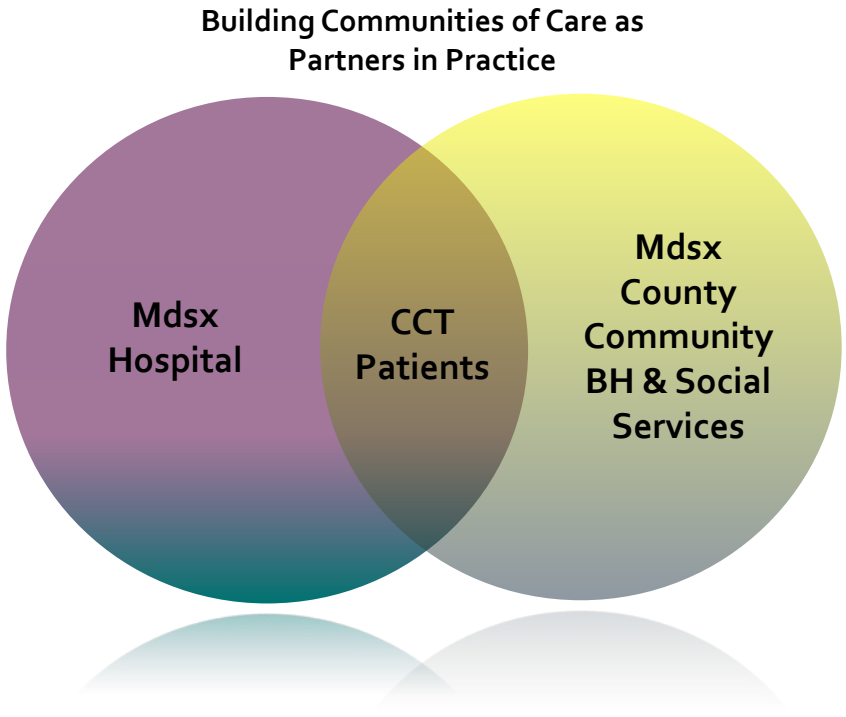
Middlesex County CCT Agency Members

- 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
- Chrysalis Center, Inc.
- Community Health Center
- Gilead Community Services, Inc.
- Advanced Behavioral Health
- Beacon Health Options, Connecticut
- Community Health Network

Case/care management agencies



Middlesex County CCT Guiding Principles

- **Objective**: To provide patient-centered care and improve outcomes by developing wrap-around services through multi-agency partnership and care planning
- **Core belief:** Community collaboration is necessary to improve health outcomes
- **Core understanding**: Psycho-social problems are community problems. No one entity alone can effectively improve outcomes for this population

Middlesex County CCT Program Development

- Weekly meetings (1st meeting: March 27, 2012); for 1 hour
  - In year 1, individual patient utilization ranged from 12-80+ ED visits in past 12 months
- Expansion of CCT Release of Information form (required for each patient)
- Developed process for patient selection
- Health Promotion Advocate (HPA) position; HPA is:
  - only added labor resource
    - Grant funded in 1st year by CHEFA (Connecticut Health and Educational Facilities Authority)
    - Continued/expanded by DMHAS Grant Conversion from year 2 - on
  - care coordination & case management
  - direct & indirect referrals to treatment
  - link between: patient – ED – CCT – community services
  - does "check in" calls for those in community who are stabilized or still struggling

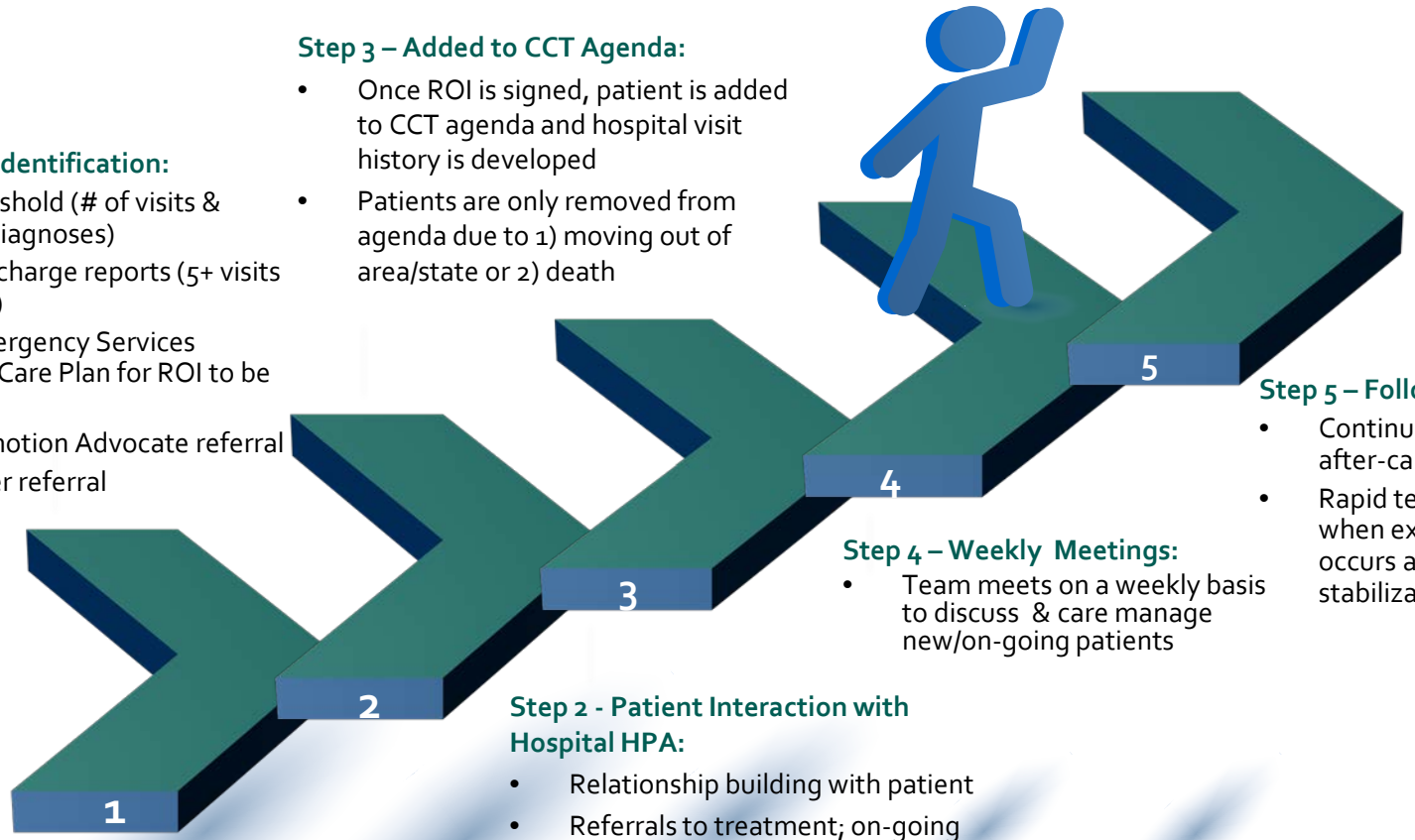
Middlesex County CCT Process

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

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Middlesex County CCT Weekly Meeting Format

Typical CCT meeting: discuss 10-20 patients per meeting; weekly tracking minutes

Element	Process
Research:	Team members research patient histories and psycho-social backgrounds (prior to meetings)
Review:	Team members share histories and review: 1) Outpatient and inpatient utilization 2) Access to care issues: what's currently being provided, where there are gaps 3) Housing status & options 4) Insurance status; available resources based on insurance 5) Arrests; legal issues
Brainstorm:	**Team brainstorms** re: best care management strategy
Care Plan:	Team members collaboratively develop customized care plans, with goals for: 1) Treatment and/or stabilization (PECs and adjudication, if necessary) 2) Stable housing 3) State insurance redetermination 4) Case management 5) Linkage to primary care, psychiatrists, specialists, outpatient services 6) Wrap-around services and supports for post-treatment 7) After-care planning
Ongoing:	Long-term follow-up: team members follow-up, review progress and revise care plan as needed; *once on CCT agenda, always on CCT agenda*

What We Track & Measure

Impact Metrics:

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

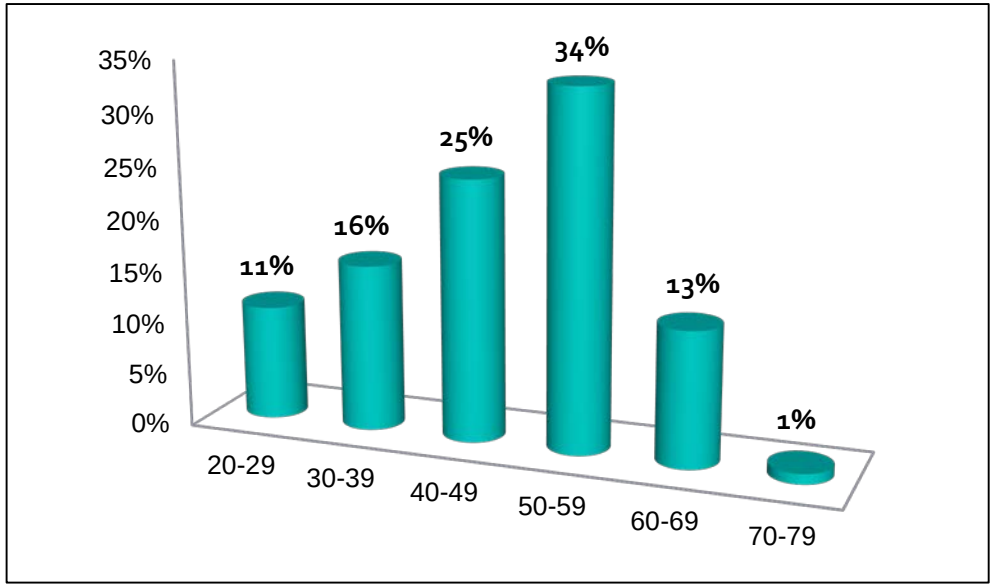
Demographics:

- # 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: **334**

What We Track & Measure

Age Distribution



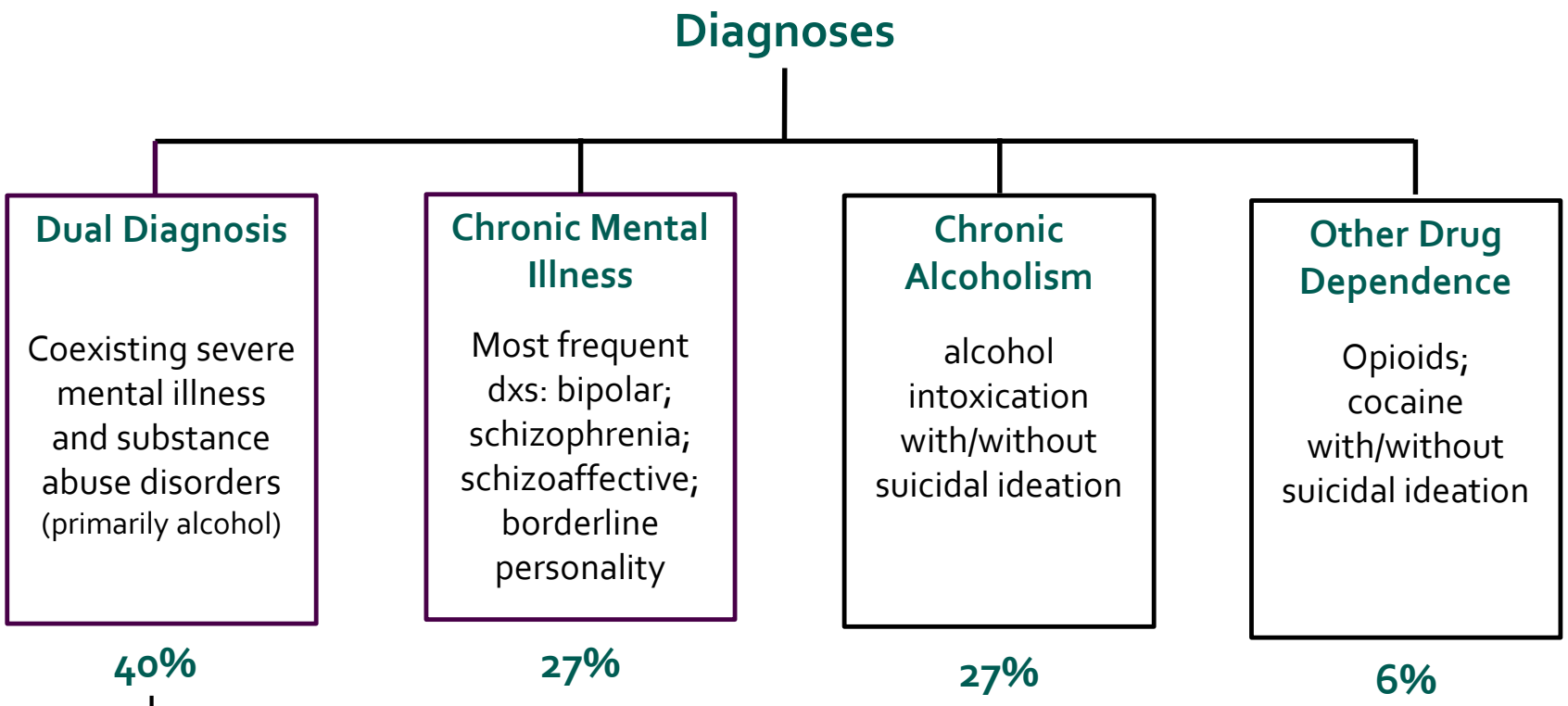
Gender:

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

Payer Status:

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

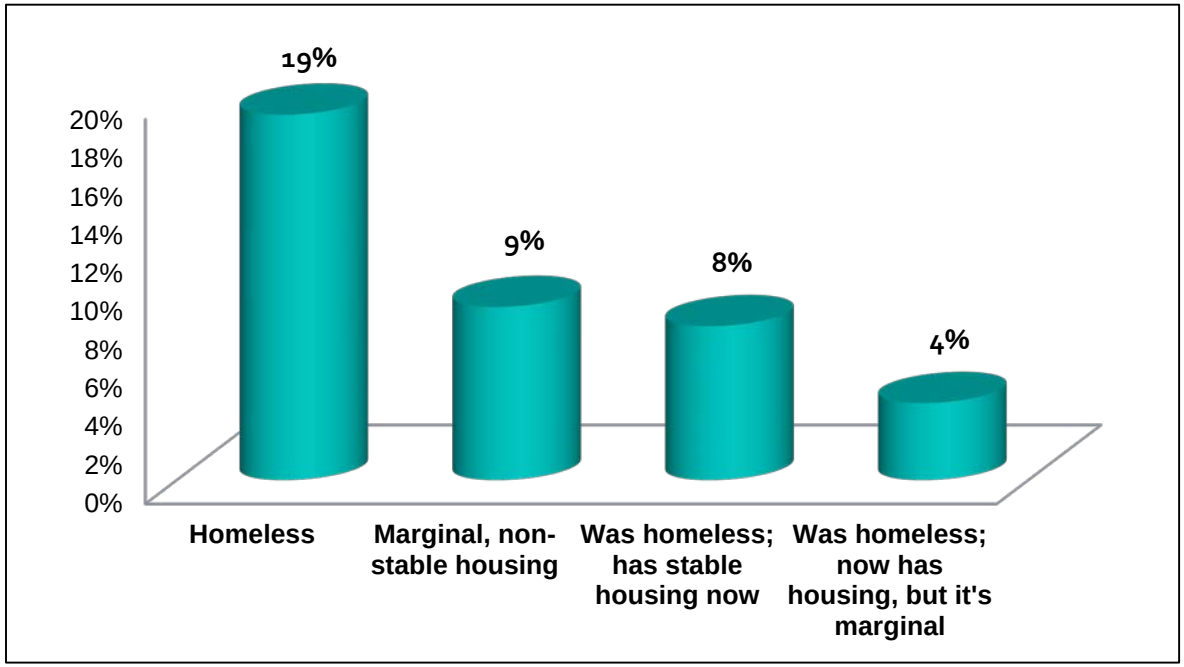
What We Track & Measure



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

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, Mercy Housing, The Connection, Columbus House, Chrysalis Center)

CCT Patients who are Chronically Homeless – Common Traits

Driving Forces

- Barriers to receiving healthcare
- Behavioral Health problems
- Disjointed care/lack of care coordination
- Poor primary care connections
- Lack of social network
- Noncompliance (with meds, follow-up/discharge instructions)
- Loneliness/hopelessness
- Use of ED as "home" → multiple ED & IP visits

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:

- Since 1992 200 Ed visits. Sometimes three times in one day. Forty visits in 2016 from February to July. Refused to use shelter system. During this five month period was admitted three times medically for complicated detox, in July was intubated for two weeks

CCT Intervention:

- In June of 2016 requested LMHA request a case conference with The Office of the Commissions (OOC). First meeting was held on July 11, 2016
- Action steps were identified at this meeting including was there an underlying serious and persistent mental health diagnosis? Was there a need for psych testing?
- Patient was started on Vivitrol, completed 45 day rehab at Merritt and agreed to referral to long-term referral. He had several court cases pending so the court liaison worked to have his long-term rehab ordered through CSSD to serve as a safety net that he would follow through.

Result:

- The patient was admitted to long term rehab. The local LMHA will monitor his progress via their liaison service.
- The patient will be referred back to LMHA once long term rehab is complete as he does have Major Depression Recurrent which has not been treated in twenty years due to ongoing substance abuse.

Why We Do What We Do…

"I was living on the street. I was unemployed. I had a suitcase…I really didn't have too much hope for anything…the help that I was given and the resources that were made available to me changed my whole outlook on life. If I didn't have this help, I'd still be on the streets, drinking, maybe dead by now. I can't say enough about the help I got…

"All the services are desperately needed by people in the community who have mental health issues and substance abuse issues or both…this changed me from a frequent flyer in the ED to a law-abiding, productive tax payer…

"I feel good about myself. There were people that believed in me when I didn't believe in myself that I owe my life to. I can't put into words how hopeless I felt. My whole life is turned around."

- CCT patient (dual diagnosis, alcohol substance use disorder is primary)

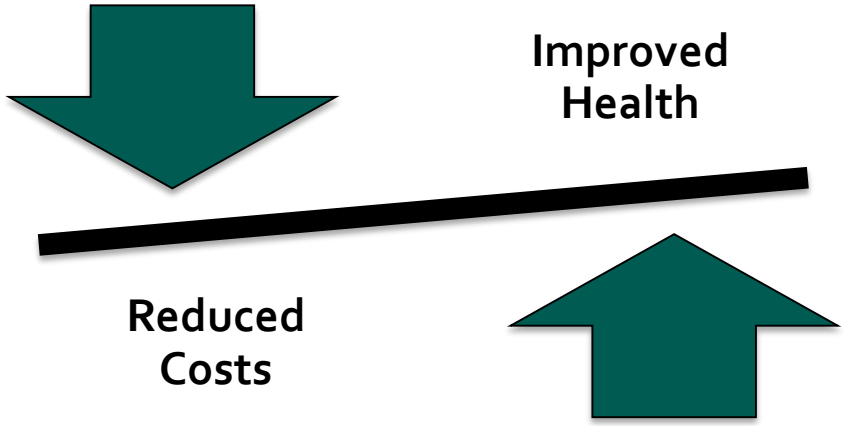
Visit & Cost Reductions

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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