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

American Hospital Association
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A Community Collaboration
A National Crisis: Emergency Department Perspective

Fraying of behavioral health systems

Increasing numbers of high-risk, high-need behavioral health patients (BHPs) without adequate inpatient or outpatient care

BHPs wind up in EDs (our medical system’s safety-net), often with long length of stay

BHPs overwhelm EDs’ capacity to care for all ED patients

Result:
- ED crowding
- Decreased safety
- Financial losses

Needed: a different model of care
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 & Investigations Committee Report (Hospital ED Use and Its Impact on the State Medicaid Budget)

1990s

2007

2008

2010

2012

2013 - on

2014

2015

- 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

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

- 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

The Smarter Choice for Care
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

Building Communities of Care as Partners in Practice

Mdsx Hospital

CCT Patients

Mdsx County Community BH & Social Services

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 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 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 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

The Smarter Choice for Care
MIDDLESEX HOSPITAL
Middlesex County CCT Weekly Meeting Format

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

<table>
<thead>
<tr>
<th>Element</th>
<th>Process</th>
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</thead>
<tbody>
<tr>
<td><strong>Research:</strong></td>
<td>Team members research patient histories and psycho-social backgrounds (prior to meetings)</td>
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</tbody>
</table>
| **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: 231
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’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

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:
• 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
“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 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

**Improved Health**

**Reduced Costs**

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