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**Testimony to Legislative Program Review and Investigations Committee
September 26, 2013**

My name is Dr. Michael Saxe. For the past 28 years, I have practiced Emergency Medicine at Middlesex Hospital in Middletown. For the past 19 years, I have served as the Chair of the Department of Emergency Medicine. I'd like to discuss the case management work being done by the Community Care Team at my hospital, and its effect on Emergency Department visits of Medicaid patients.

Because of my hospital's location in Middletown and its proximity to Connecticut Valley Hospital, my ED sees a disproportionate number of patients with serious chronic behavioral health problems. This includes chronic mental illness, chronic substance abuse, or a combination of the two. Over 90% of these patients have Medicaid, and about 25% also have Medicare. Management of this patient population, due to the complexity and number of the patients, is the greatest challenge that my ED deals with on a daily basis. During this past month of August, our ED had nine behavioral health patients in an ED bed during an average hour of the month, with a maximum of 24 BHP's at one time. This causes major safety and risk challenges to our patients and staff members, and compromises our ability to provide excellent care to other patients.

Many of these BHP's are very frequent visitors to our ED, known as "frequent flyers". In fact, if without intensive case management, some of these patients arrive at our ED dozens of times per year, up to 84 visits per year in one very complex patient's case.

About 18 months ago, because of this issue, I joined the Middlesex Community Care Team. This interdisciplinary team has about a dozen members, and includes staff members from our hospital's Emergency and Psychiatry departments, plus representatives from about ten local behavioral health agencies. The team now meets weekly. We discuss the most flagrant behavioral health "frequent flyers"; brainstorm how to get these patients into appropriate inpatient or outpatient treatment programs, and then work together to implement our plans. The team basically performs intensive case management for these high utilizing patients. So far, the team has engaged about 120 patients.

We track their number of ED visits, inpatient admissions, hospital costs, and dollars paid for their care, both before our team's engagement and in the six and twelve months after our initial engagement. We are seeing an average of 60% to 70% decreases in the number of ED visits, inpatient admissions, and dollars spent by payors. Most of the dollars spent, and now saved, have been Medicaid. This intensive case management is resulting in dramatic improvements in the health of these patients, ED operations and safety, and Medicaid expenditures.

I recommend that you direct resources into case management of the high utilizers in the Medicaid population. By doing so, the patients' care will be better coordinated, their health care will be more effective, and the dollars spent by Medicaid can be dramatically reduced.

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

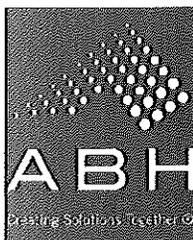
September 2013

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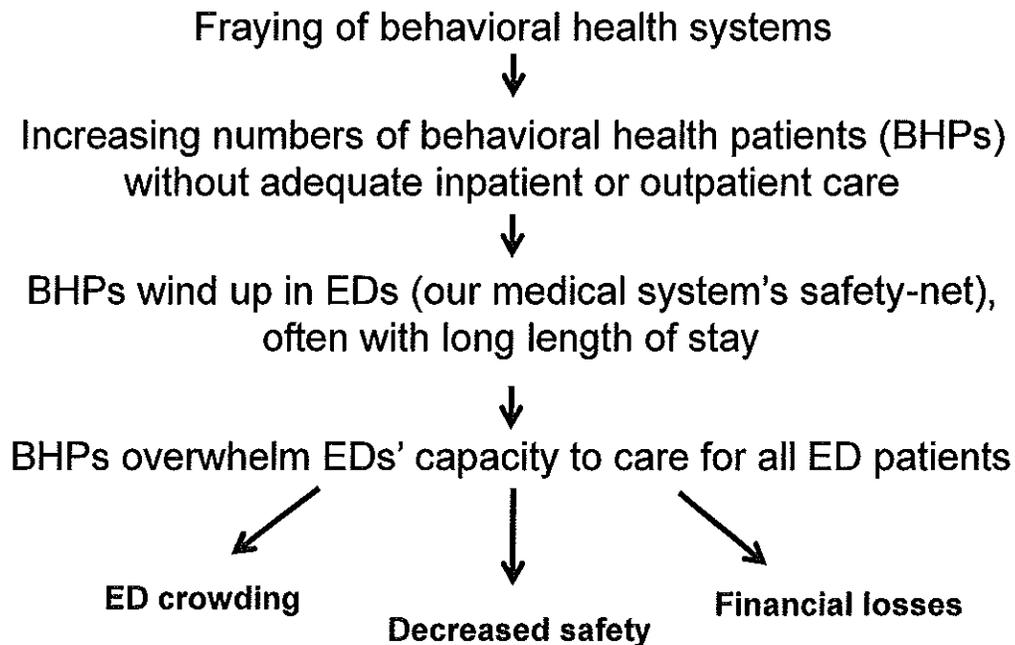
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A Community Collaboration



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A National Crisis



Middlesex County Perspective

- Middlesex Hospital 2008 health assessment results:
 - ED visit rate for alcohol diagnoses (in Middletown) 2x state average
 - hospital admission rate for Serious Mental Illness (in Middletown) 5x state average
 - need for improved access and coordination

- Middlesex County 2013 Community Health Needs Assessment: mental illness and substance abuse (primarily alcohol) continue to be a problem

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

CCT History

- 1990s: Mental Illness Substance Abuse project through Rushford (grant funded by state); 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
- 2010: Community Care Team (CCT) was developed
 - Middlesex 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: CCT expanded to 9 agencies

CCT Agency Members

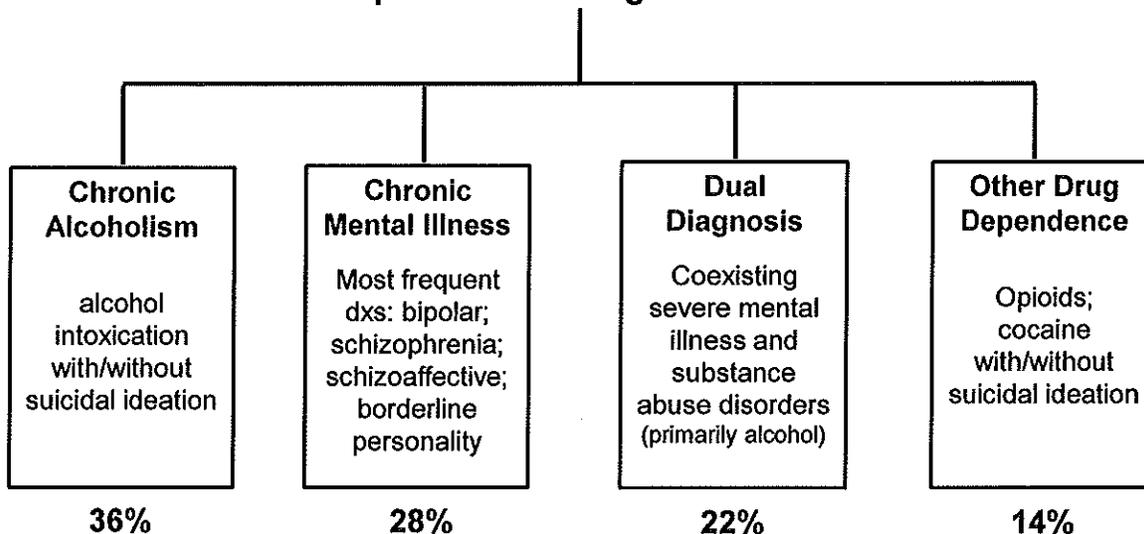
- Middlesex Hospital (*Emergency Department, Behavioral Health, Community Benefit; with assistance from Crisis, Information Systems, medical Social Work as needed*)
 - River Valley Services
 - Connecticut Valley Hospital (Merritt Hall)
 - Rushford Center, Inc.
 - St. Vincent DePaul Soup Kitchen
 - Community Health Center
 - Gilead Community Services, Inc.
 - Advanced Behavioral Health
 - Value Options, Connecticut
 - Community Health Network (Value Options)
- } Case/care management agencies

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

Community Care Team (CCT)

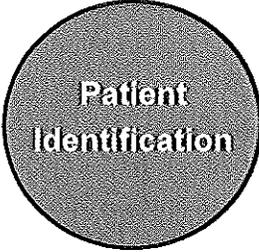
Complex high-risk and high-need ED "super user" patients with diagnoses of:



CCT – Program Development

- Weekly meetings (1st meeting: March 27, 2012); for 1 hour
- Expansion of CCT Release of Information form (required for each patient)
- Developed process for patient selection
- Created Health Promotion Advocate (HPA) position
 - only added labor resource; grant funded
 - 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

CCT Patient Selection



**Patient
Identification**

- ED visit threshold criteria (# of visits & behavioral diagnoses)
- Daily ED discharge reports (5+ visits in 6 months)
- Chair of Emergency Services reviews medical records to determine if CCT-appropriate & dictates ED Care Plan for ROI to be signed
- CCT member referral

Once ROI is signed, patient is added to CCT agenda

- In year 1, utilization ranged from 12-80+ ED visits in past 12 months
- # of patients who have received CCT care planning to-date: 117

CCT – Weekly Meeting Format

Typical CCT meeting: discuss 20-30 patients per meeting; weekly tracking minutes

Research:	Team members research patient histories and psycho-social backgrounds (prior to meetings)
Review:	Team members share histories and review: <ol style="list-style-type: none"> 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; arraignment reports
Brainstorm:	Team brainstorms re: best care management strategy
Care Plan:	Team members collaboratively develop customized care plans, with goals for: <ol style="list-style-type: none"> 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; <i>once on CCT agenda, always on CCT agenda</i>

CCT Patients – Common Traits

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

Chronic Mental Illness (28% of CCT patients)

- May live independently or in a group home or homeless
- Multiple ED visits/year for exacerbations of illness or suicidal ideation
- Sometimes violent in ED (may require restraints)
- ED Length of Stay can be multiple days → difficult placement to in-patient or CVH
- Multiple inpatient psych admissions in past

Chronic Mental Illness – A Case Study

- **Background:**
 - 84 ED & Inpatient visits in 12 months
 - Between 2007-2011: 365 ED visits
 - Complex psych (which exacerbates her medical illnesses)
 - Length of stay: days
 - Frequently in restraints
- **History:**
 - The Patient has a significant sexual trauma history. One of the only times she felt safe as a child was when she was in a hospital setting. During periods of stress, she gravitates to the ED as a safe place
- **CCT Intervention:**
 - The team has collaborated on strategies to help the Patient identify her needs as an adult and work on coping strategies. Her last few ED visits have been short in duration and each time she has demonstrated insight to her misuse of ED services
- **Results:**
 - Within 9 months of CCT intervention the Patient's ED & IP utilization has reduced from 52 visits pre-CCT intervention to 31 visits post-CCT (a reduction of 21 visits or 40%)

Acute & Chronic Alcohol Abuse (36% of CCT patients)

- Multiple visits to ED for alcohol intoxication; usually brought in by ambulance
- Physician Emergency Certificate multiple times in the past (to detox units), but hasn't been effective and patient continues to cycle
- While in the ED, sometimes combative where staff or patient have been injured
- Unstable housing, homeless or in and out of shelters
- In and out of jail for minor offenses

Chronic Alcohol Abuse – A Case Study

- **Background:**
 - Started coming to Middlesex Hospital ED for alcohol intoxication in 2011
 - 2011: 16 ED visits, 1 inpatient visit
 - 2012 (Jan – April): 12 ED visits, 3 inpatient visits
 - 2013 (to-date): 0 ED or IP visits
- **History:**
 - The Patient has a history of chronic alcoholism, was homeless, was on probation (restraining order) and is well-known to St. Vincent de Paul. The Patient was repeatedly brought to the ED for public intoxication and has a history of alcohol withdrawal seizures
- **CCT Intervention:**
 - A care plan was developed in April 2012 and included a 5-day PEC. The patient was willing to go to treatment at Merritt Hall, followed by long-term treatment at Trinity Glen. During this time, the Patient remained on the CCT agenda for after-care planning. St. Vincent de Paul, ABH and the Mdsx Hospital HPA kept in constant contact with the Patient through the Trinity Glenn stay
 - While at Trinity Glen the patient completed a supportive housing application. ABH was able to get the stay extended by several months until housing became available
 - The Patient moved into supportive housing in March 2013 with St. Vincent de Paul and ABH case management services. The Patient volunteered at the St. Vincent de Paul Soup Kitchen
 - In April 2013, the Patient experienced relapses and was quickly added back to the top of the CCT agenda. St. Vincent de Paul and ABH immediately intervened and connected the Patient to care
- **The Result:**
 - The Patient is now enrolled in Mdsx Hospital's Partial Hospital Program; is engaged in Focus on Recovery where the Patient is receiving resume help and computer skill training. The Patient is looking for a job
 - Last ED visit was 4.21.12

Focus on Homelessness in Mdsx County

- **Resources:**
 - St. Vincent de Paul
 - 10 Year Plan to End Homelessness
 - Homeless Outreach Team
- Homeless – approx. 26% of CCT patients
- Importance of supportive housing for CCT population
- Importance of homeless champions → connection to treatment, supportive housing, community support, primary care

Outcomes (Mdsx Hospital data)

Patient ID	Date 1st engaged by CCT	X months PRIOR			X months POST			Differential @ X mo.			# of Months pre/post CCT
		Total (ED + IP)	# ED Visits	# Inpt visits	Total (ED + IP)	# ED visits	# Inpt visits	Total (ED + IP)	# ED visits	# Inpt visits	
2	3.27.12	30	26	4	18	16	2	-12	-10	-2	11 months
11	3.27.12	81	81	0	42	42	0	-39	-39	0	11 months
10	3.27.12	26	26	0	18	18	0	-8	-8	0	11 months
12	3.27.12	40	39	1	0	0	0	-40	-39	-1	11 months
3	4.17.12	18	17	1	3	3	0	-15	-14	-1	10 months
5	4.17.12	24	24	0	14	13	1	-10	-11	1	10 months
6	4.17.12	26	23	3	1	1	0	-25	-22	-3	10 months
4	4.17.12	17	16	1	8	8	0	-9	-8	-1	10 months
7	4.24.12	17	16	1	5	5	0	-12	-11	-1	10 months
8	5.1.12	9	9	0	22	21	1	13	12	1	9 months
13	5.8.12	5	5	0	0	0	0	-5	-5	0	9 months
14	5.8.12	18	15	3	2	1	1	-16	-14	-2	9 months
15	5.13.12	52	49	3	31	29	2	-21	-20	-1	9 months
16	5.22.12	15	15	0	9	9	0	-6	-6	0	9 months
18	5.22.12	19	15	4	0	0	0	-19	-15	-4	9 months
19	5.22.12	9	9	0	3	3	0	-6	-6	0	9 months
17	5.22.12	20	20	0	16	16	0	-4	-4	0	9 months
21	6.5.12	13	10	3	0	0	0	-13	-10	-3	9 months
20	6.5.12	36	34	2	34	33	1	-2	-1	-1	9 months
27	6.19.12	9	9	0	0	0	0	-9	-9	0	9 months
22	6.19.12	17	15	2	0	0	0	-17	-15	-2	9 months

31 more patients.....not shown here due to lack of space

Totals:	924	849	75	446	415	31	-478	-434	-44
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- Of the 52 patients who have received CCT intervention for 6+ months:



- 52% reduction in combined ED and IP visits (924 visit pre-; 478 visits post-)

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

Gender:

- Female – 42%
- Male – 58%

Payor Status:

- Medicaid – 26 patients (50%)
- Medicare – 21 patients (40%)
- Self-pay no insurance – 3 patients (6%)
- Managed Care – 2 patients (4%)

Age distribution:

range	# of patients
60-69	5 (10%)
50-59	20 (38%)
40-49	16 (31%)
30-39	7 (13%)
20-29	4 (8%)

Outcomes – Financial (Mdsx Hospital data)

52 CCT patients (6-11 months intervention)	pre-CCT intervention	post-CCT intervention	Difference
Total Mdsx Hospital Costs	\$1,458,887	\$407,910	\$1,050,977
Total Mdsx Hospital Collections	\$714,591	\$148,704	\$565,887
Total loss	-\$744,296	-\$259,206	-\$485,090

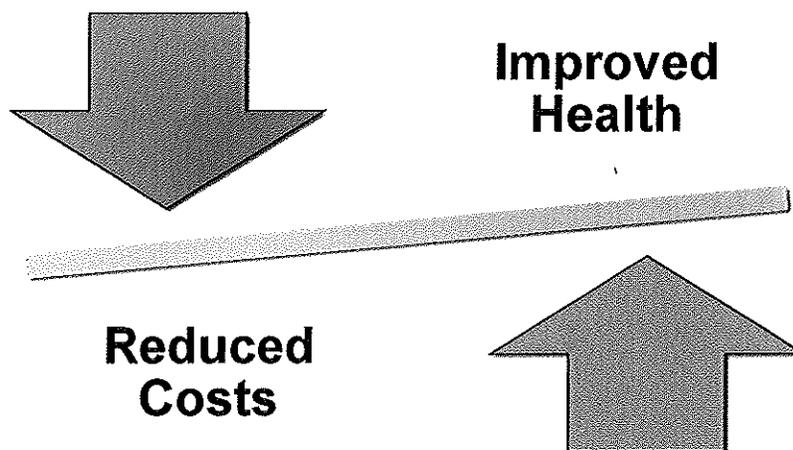
Average CCT Patient	pre-CCT intervention	post-CCT intervention	Difference
Total Mdsx Hospital Costs	\$28,055	\$7,844	\$20,211
Total Mdsx Hospital Collections	\$13,742	\$2,860	\$10,882
Average loss per patient	-\$14,313	-\$4,984	-\$9,329

- Decrease in losses = \$485,090 (65%↓)
- Decrease in costs = \$1,050,977 (72%↓)
- Decrease in average loss per patient = \$9,329 (65%↓)

Analysis of 52 patients who have received CCT intervention for 6+ months

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Building Communities of Care as Partners in Practice



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

Society:

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

Hospital:

- Improved patient care
- Reduction in ED violence and risk
- Reduction in employee injuries
- Reduction in ED crowding
- Increase in staff satisfaction which causes
→ reduction in staff turn-over
- Improved bottom line

Collaborative:

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

CT Hospital Association Community Service Award

- video

What Have We Learned?

- 1) This target population does not get better with the traditional model of care delivery
- 2) Chronically ill behavioral health patients consume a disproportionate amount of medical resources
- 3) Behavioral health chronic diseases require care coordination and customized treatment plans
- 4) Individualized care plans must have the ability to be flexible and evolve
- 5) Many agency providers were unaware of frequency of ED visits → communication allows for agency-specific care plans (a major part of CCT's success)

Next Steps

- Focus on “at-risk” patients to prevent migration to “super user”
- Focus on homelessness and housing vouchers
- Dissemination: sharing best practice process and results
- Creation of medical Frequent Admission Inpatient Reduction (FAIR) inpatient super user committee
- Expansion of Health Promotion Advocate role (via grants)

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