

Draft High Risk Populations: Frequent Behavioral Health ED Visitors

Complex Care Committee
June 19, 2015

Acknowledgements



OVERVIEW

Data Sources and Methodology

Emergency Department (ED) Use for Behavioral Health (BH) Services

- High Utilizers (Top 10%)
- Frequent Visitors (Top 2%)
- Characteristics of Frequent Visitors
- Frequent Visitor High Volume EDs
- Interventions with Frequent Visitors
 - ICM/Peer Intervention
 - Community Care Teams
- Evaluating the Interventions
- Next Steps

THE BASICS

Medicaid Members

- **Separate Analyses for;**
- **Adults: 18+**
- **Youth 3-17**

Includes all adult Medicaid members in volume Information

Excludes members who are dually eligible for Medicaid and Medicare for measures involving connect to care and readmission rates

For adults, measures based on Medicaid claims and DMHAS service data from 2012 & 2013

Use of Descriptive Statistics



Definitions

Behavioral Health (BH) ED

Visits include:

- ED Visits with Primary and/or Secondary BH Diagnosis

BH ED High Utilizers

- Top 10% of BH ED Users
- Measured over a calendar year
- Adults : 4 or more BH ED visits
- Youth : 3 or more BH ED visits

BH ED Frequent Visitors

- Top 2% of BH ED Users
- Measured in 6 month intervals
- Adult: 7 or more visits
- Youth: 3 or more visits



Four Basic Questions

1. What are the patterns of frequent ED Use?
2. What are the characteristics of frequent visitors that are persistent vs. episodic in their pattern of use?
3. What are the characteristics of those that Opt-in to the ICM/Peer Intervention?
4. How do hospitals differ in their rates of the % visits accounted for by BH ED Frequent Visitors, and Connect to Care & Readmission Rates?



2013 Medicaid Adult BH ED Users

	# of Unique Adults	# of BH ED Visits
Top 10% Adult BH ED Visitors (4+ visits in 12 months)	5,345	39,222
Top 2% : Frequent Visitors (7+ visits in 6 months)	721	8,829



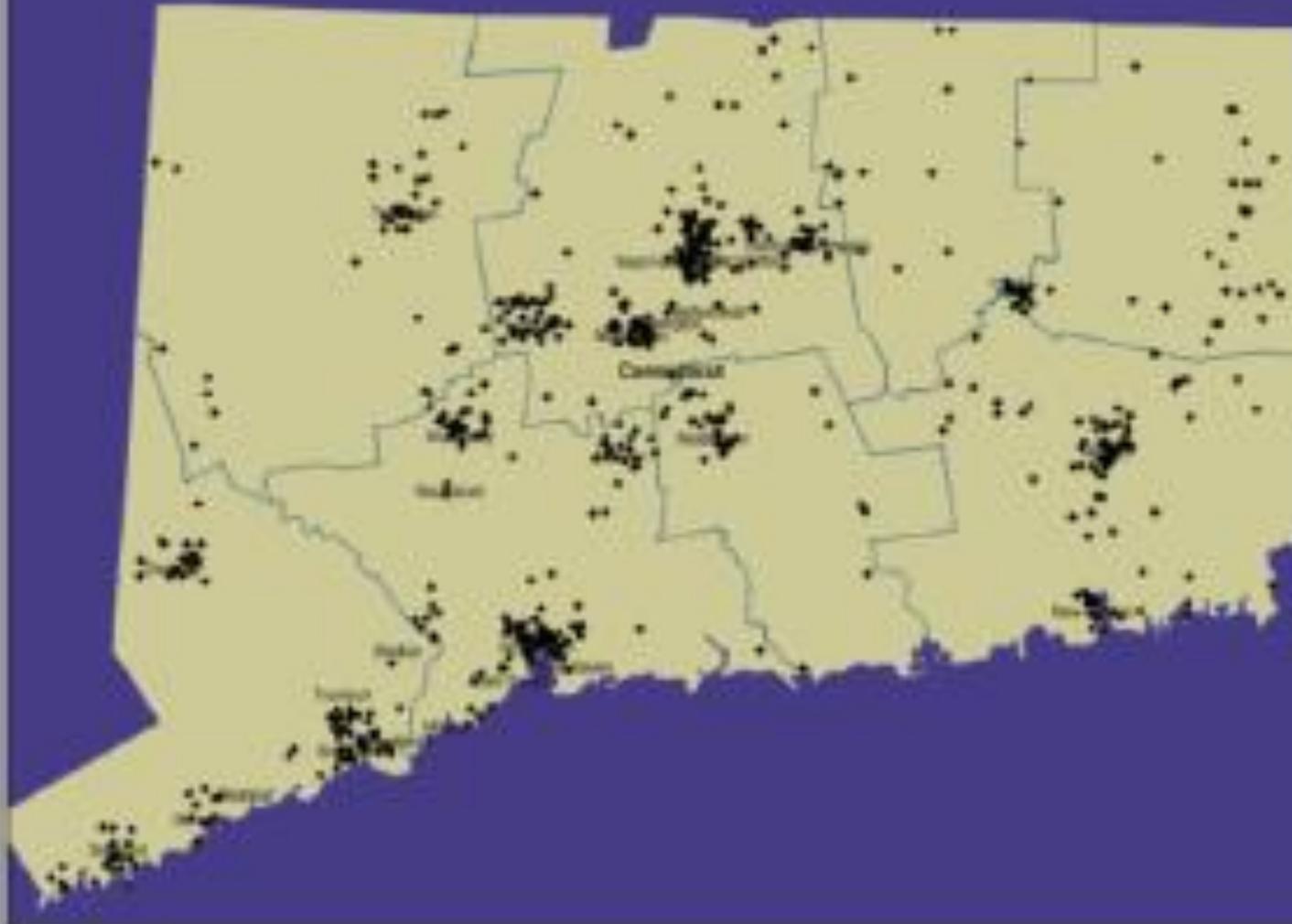
2013 ADULT FREQUENT VISITORS: DEMOGRAPHIC SUMMARY

	Adult BH ED Frequent Visitor (FV) Demographic Profile: Index Period BH ED FREQUENT VISITORS (top 2%)
Number of Adults	721
Range of # BH ED Visits	7-69
EDs Visited	31.2% visited 1 ED 14.4% visited 4 or more
Eligibility Category	Husky D (61.6%) Husky C (28.6%)
Gender	Male (62.1%)
Age	Average age: 41.1 years-old
Race/Ethnicity	Caucasian (71.2%) African-American (15.5%) Hispanic (12.5%)



GEO-MAP OF ADULT FREQUENT VISITORS

GEO-MAP of the Adult ED Frequent Visitors—Calendar Year 2013



2013 ADULT FREQUENT VISITORS: NUMBER OF ED FACILITIES VISITED

Number of ED Facilities	Prior 6-Months (January 1-June 30, 2013)		Index Period (July 1-December 31, 2013)		Following 6-Months (January 1-June 30, 2014)	
	#	%	#	%	#	%
0	68	10.5%	0	0.0%	90	13.5%
1	280	43.3%	225	31.2%	273	41.1%
2	183	28.3%	249	34.5%	175	26.3%
3	69	10.7%	143	19.8%	80	12.0%
4+	47	7.3%	104	14.4%	47	7.1%
Total	647	100.0%	721	100.0%	665	100.0%

Among Frequent BH ED Visitors during the index 6-month period, approximately one-third (34.2%) of adults visited three or more EDs.

2013 ADULT FREQUENT VISITORS: PERSISTENT VS. EPISODIC FREQUENT BH ED VISITORS

	# Adult Frequent Visitors	Denominator	% Adult Frequent Visitors
Index Cohort during Prior 6-months: Jan 2013 to Jun 2013	250	647	38.6%
Index 6-months: Jul 2013 to Dec 2013	721	721	100.0%
Index Cohort during Following 6-months: Jan 2014 to Jun 2014	242	665	36.4%

Most BH Frequent Visitors to the ED did not meet the threshold for frequent visiting in the six months prior to the index period, or in the six months following the index period.

The number in the “denominator” column indicates the number of FVs during the Index Period that had Medicaid eligibility during the 6 months pre and post the Index Period. Some were ineligible in the 6 months prior and some lost eligibility in the subsequent 6 months.

2013 ADULT EPISODIC VS. PERSISTENT FREQUENT VISITORS

Episodic Frequent Visitors (FVs)

The majority of adults (64%; 461/721) did not continue to meet the threshold for FVs in the 6-months after the target period.

Persistent FVs

36% (260/721) of adults continued to be FVs in the 6 months following the target period



NEWLY DEVELOPED HOSPITAL BH ED MEASURES

- **% of BH ED Visits accounted for by Frequent Visitors**
- **% of BH ED 7 & 30-Day Readmissions**
- **BH ED 7 & 30-Day Connection to Care Rates**



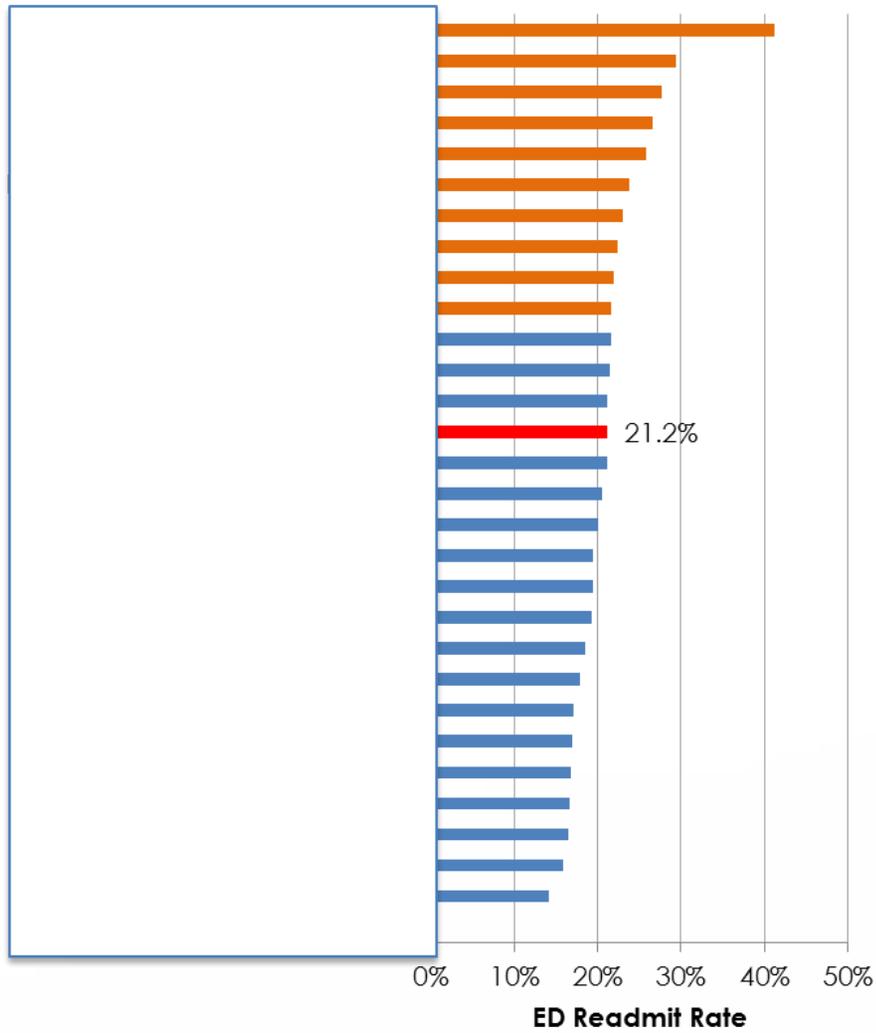
ADULT BH ED VISITS BY FREQUENT VISITORS

TOP TEN HOSPITALS: 7/13- 12/13

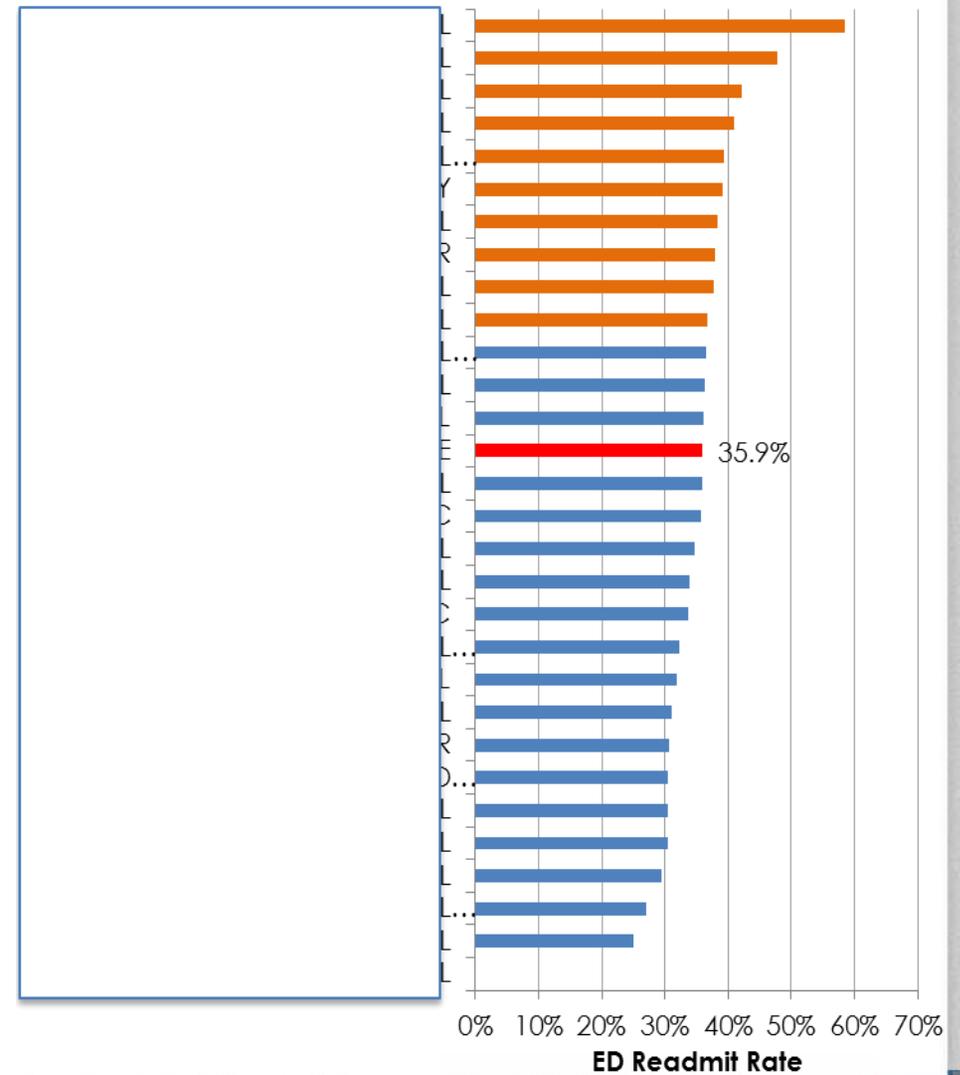
HOSPITAL NAME	TOTAL BH ED VISITS	BH ED VISITS BY FVS	% BH ED VISITS BY FVS	TOTAL BH ED VISITORS	# OF FVS	% OF VISITORS THAT ARE FVS
YALE NEW HAVEN HOSPITAL	6114	1217	19.91%	3539	147	4.15%
HARTFORD HOSPITAL	6211	930	14.97%	4087	180	4.40%
THE HOSPITAL OF CENTRAL CONNECTICUT	5022	799	15.91%	3076	124	4.03%
THE WILLIAM BACKUS HOSPITAL	7034	749	10.65%	4026	119	2.96%
ST FRANCIS HOSPITAL MEDICAL CENTER	5043	562	11.14%	3708	165	4.45%
BRISTOL HOSPITAL	3600	503	13.97%	2010	76	3.78%
ST MARYS HOSPITAL	3467	337	9.72%	2456	75	3.05%
LAWRENCE AND MEMORIAL HOSPITAL	3790	310	8.18%	2311	71	3.07%
WINDHAM COMM MEM HOSPITAL	2171	259	11.93%	1264	50	3.96%
THE CHARLOTTE HUNGERFORD HOSPITAL	2573	240	9.33%	1556	44	2.83%

7 & 30 DAY BH ED READMIT RATES: ALL ADULTS: Q3 & Q4 2013

**7 Day BH ED Readmit Rates
Adult: Q3 & Q4 2013**

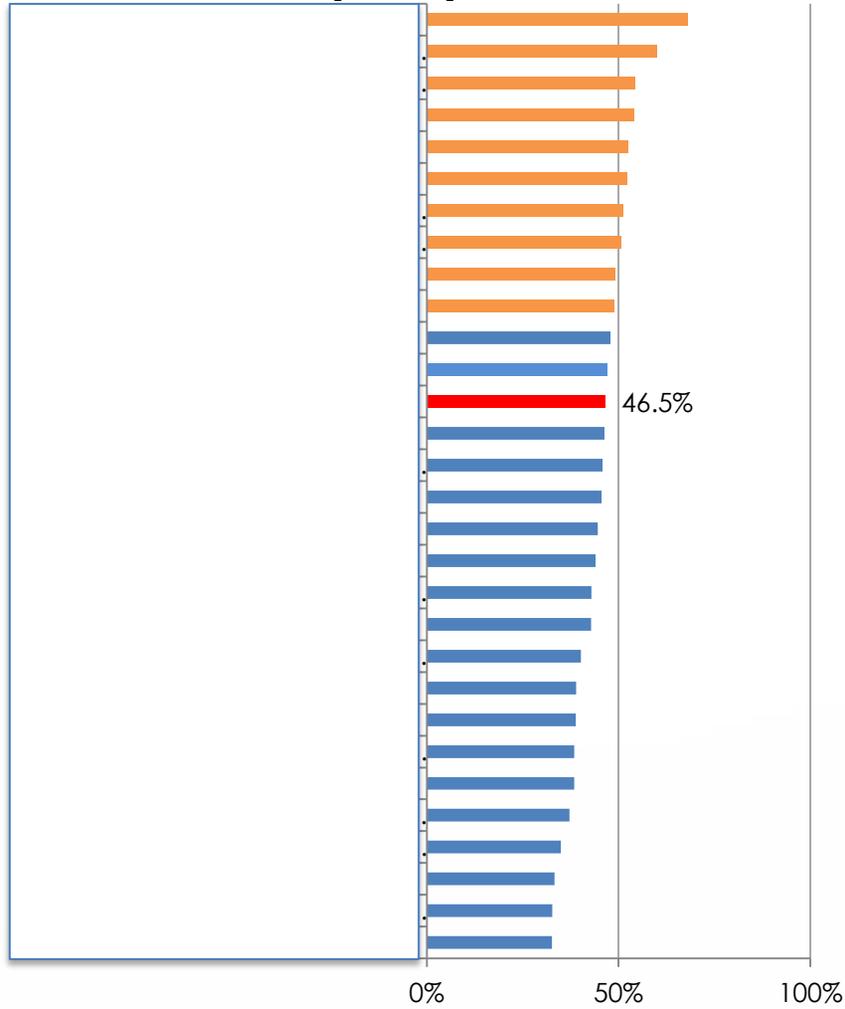


**30 Day ED Readmit Rates
Adult: Q3 & Q4 2013**

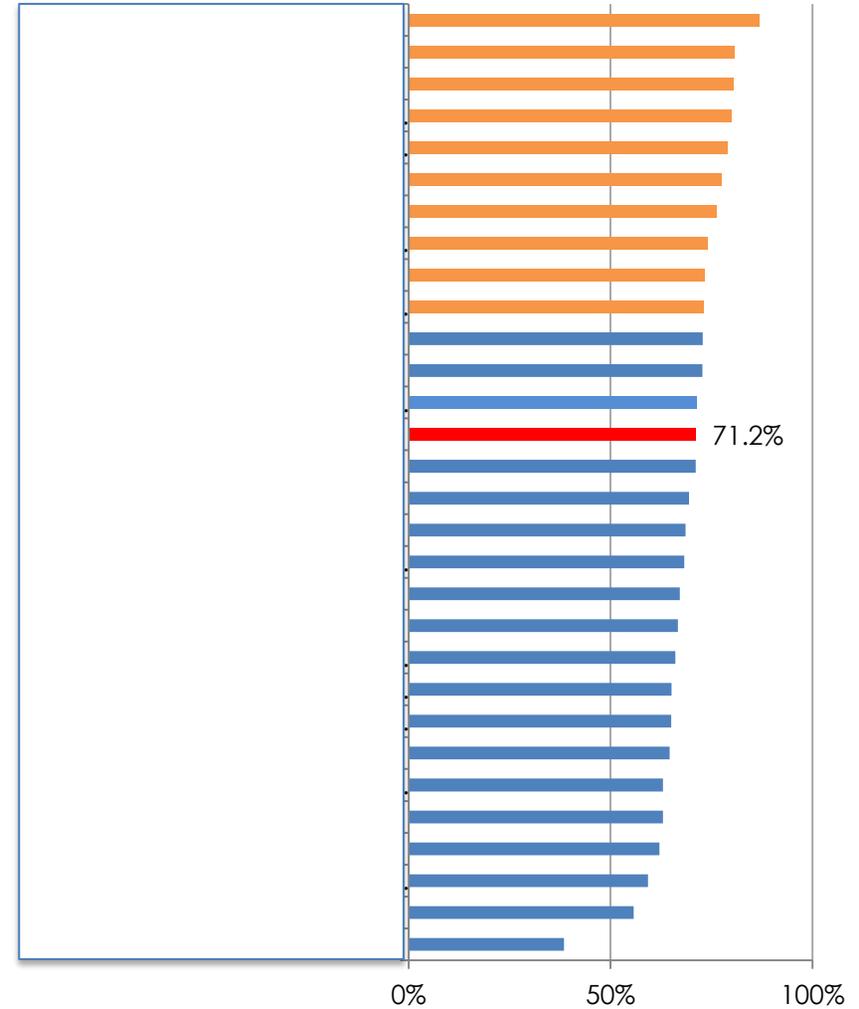


7 & 30 DAY BH ED READMIT RATES BY HOSPITAL ADULT BH ED FREQUENT VISITORS: Q3 & Q4 2013

**7 Day ED Readmit Rate
Adult BH ED Frequent Visitors
Q3 & Q4 2013**



**30 Day ED Readmit Rate
Adult BH ED Frequent Visitors
Q3 & Q4 2013**

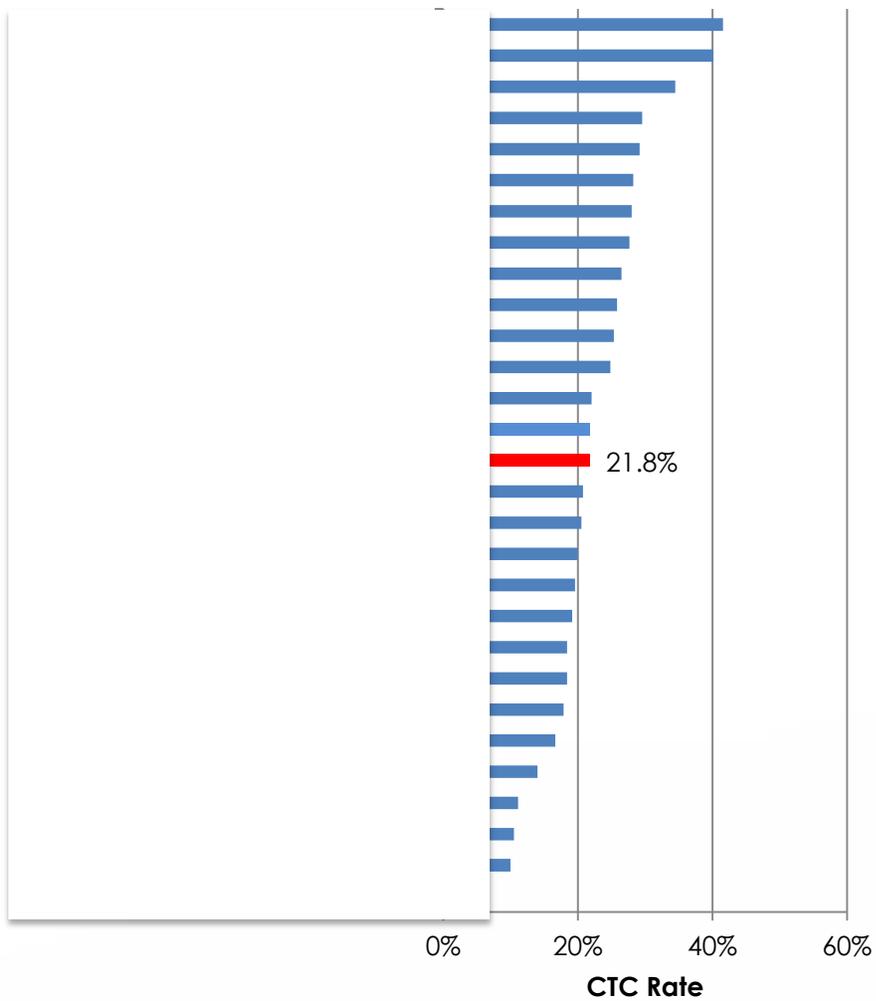


7 Day Readmit Rate

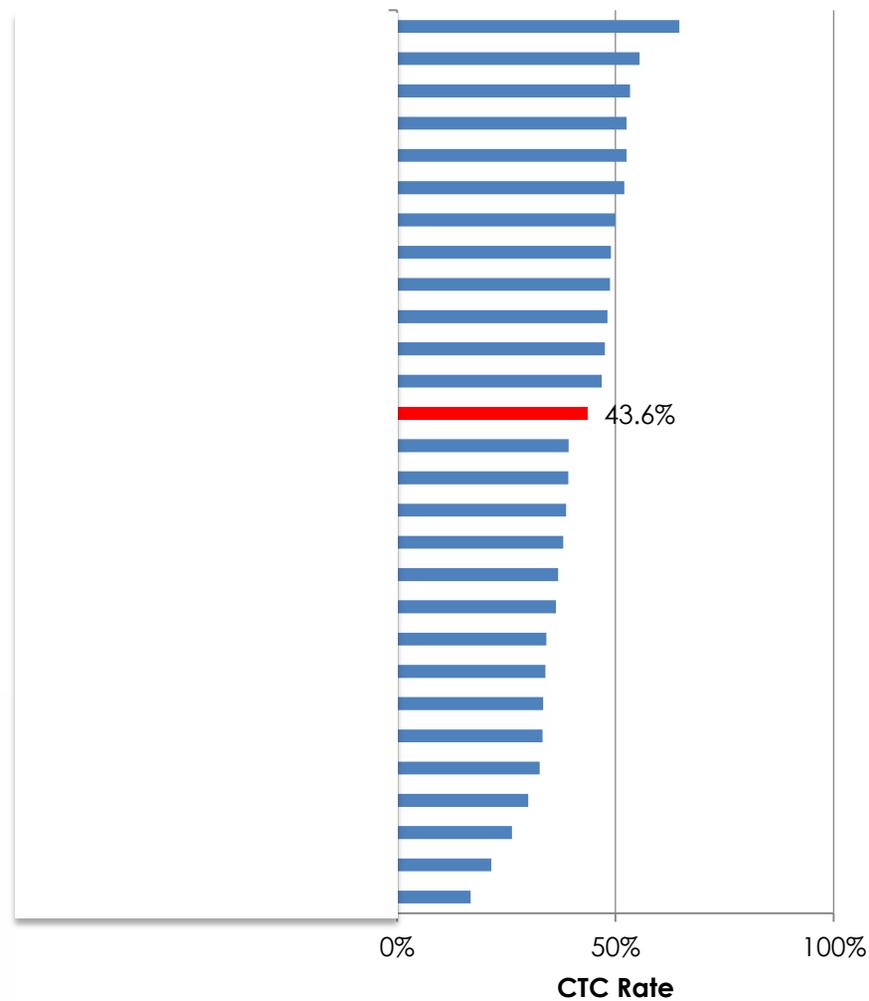
30 Day Readmit Rate

7 & 30 DAY BH ED CONNECT TO CARE RATES ADULT BH ED FREQUENT VISITORS: Q3 & Q4 2013

7 Day BH ED Connect to Care
Adult Frequent Visitors
Q3 & Q4 2013



30 Day BH ED Connect to Care
Adult Frequent Visitors
Q3 & Q4 2013



INTERVENTIONS

- **VALUEOPTIONS
INTENSIVE CASE
MANAGER/ PEER
INVOLVEMENT IN 5
HOSPITAL EDS WITH A
HIGH VOLUME OF ADULT
FREQUENT VISITORS**
- **COMMUNITY CARE TEAM
MODEL**



Intensive Care Manager/Peer Intervention

- High - touch
- in the home, hospital & community
- hybrid model combining aspects of care management, care coordination, peer support, and in-home care
- Distinctly different from office based or telephonic outreach/case management



INTENSIVE CASE MANAGER/ PEER INVOLVEMENT

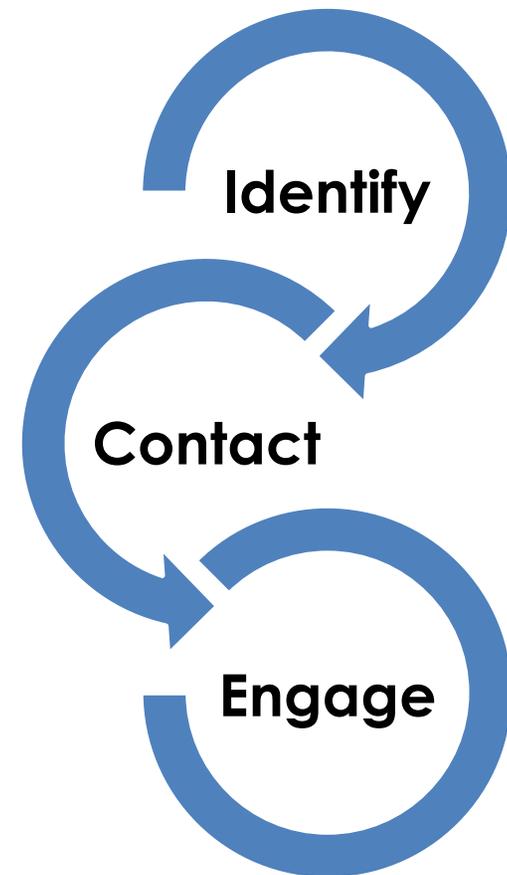
5 HIGH VOLUME FREQUENT VISITOR BH EDS IN 3 DMHAS REGIONS

Hospital	DMHAS Region
Bristol Hospital	Region 4
Hartford Hospital	Region 4
Saint Francis Hospital	Region 4
William Backus Hospital	Region 3
Yale New Haven Hospital	Region 2

- Also working with the Partnership for Stronger Communities and the two other hospitals (Middlesex & Norwalk) that are part of the Opening Doors Initiative

PEER/ICM NOTIFICATION PROCESS

- **List of frequent visitors is sent to each ED monthly**
 - **List contains previously and newly identified members**
 - **Active caseloads (Peer/ICM) are shared**
- **Hospital staff and/or Peer/ICM Team identify FV when member presents to the ED**
- **Peer/ICM team meet with member**
 - **Settings for initial meeting: ED, Obs, Hospital (medical or behavioral health unit), community**



PEER/ICM NOTIFICATION PROCESS

- **Initial meeting with member consists of the following:**
 - Introduction of the Initiative
 - Description of Peer and ICM roles
 - Member agreement to participate/"opt-in"
 - Completion of SF12 (functional assessment tool)
 - Explanation and signing ROIs
 - Development of a member-driven follow-up plan



PEER/ICM ACTIVITIES

- **Peer/ICM activities to assist members in connecting to community providers and supports:**
 - **Prepare and present cases at CCT meetings**
 - **Develop a person-centered WRAP(Wellness Recovery Action Plan)**
 - **Provide telephonic and in-person support using Motivational Interviewing techniques**



PEER/ICM ACTIVITIES (CONT'D)

- **Peer/ICM activities to assist members in connecting to community providers and supports:**
 - **Meet with providers/supports/member to develop short and long-term recovery plans**
 - **Complete ongoing functional assessments (SF12 and Acuity Assessment) to gauge progress**
 - **Contact collaterals to ensure aftercare plans are understood and followed**



PEER/ICM ROLES

ICM (Intensive Care Manager)

- **Licensed Behavioral Health Clinician**

- Research member-specific clinical history and outcomes
- Assess clinical needs based on history and member-driven follow-up plan
- Complete Acuity Assessment
- Coordinate care with identified providers and supports



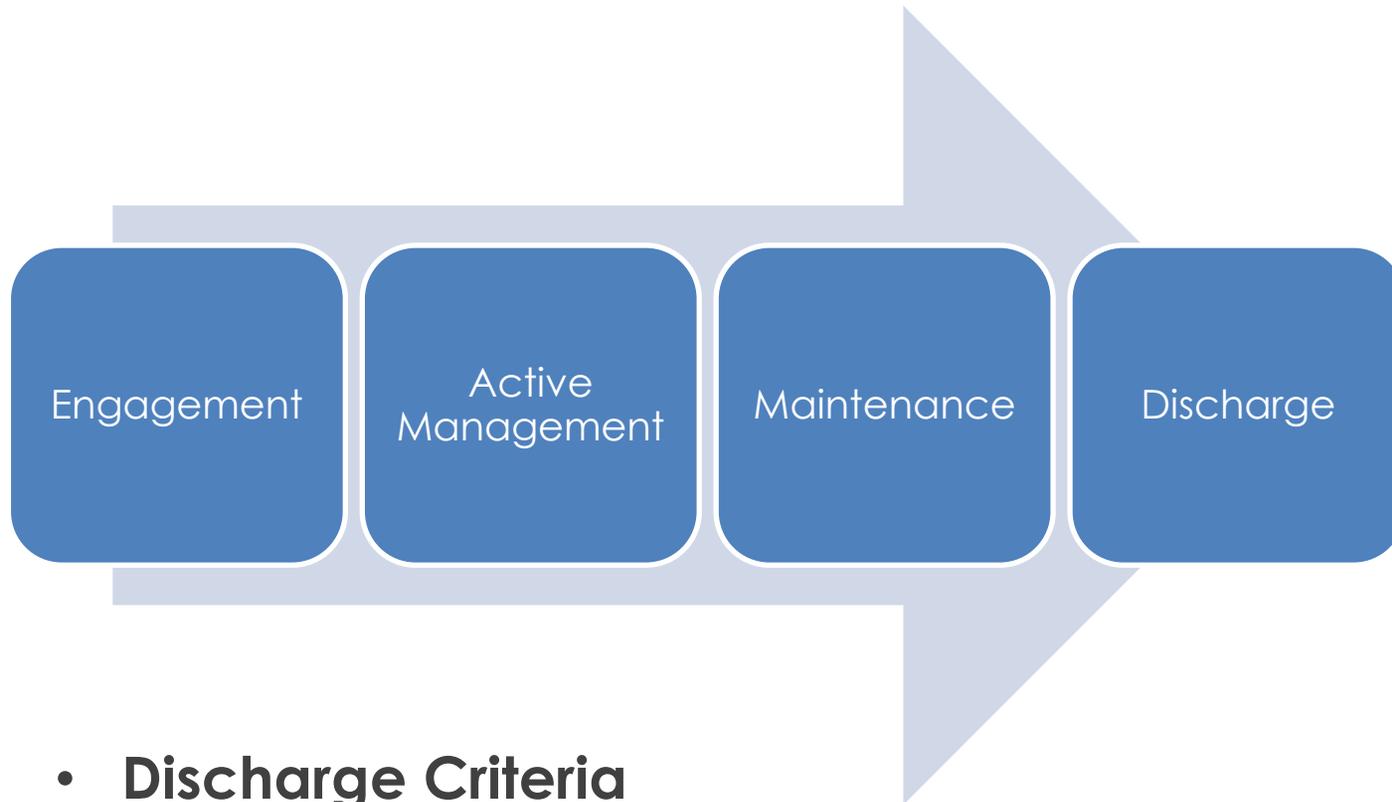
PEER/ICM ROLES

Peer Specialist

- An individual with lived experience in the area of MH and/or SA
- Provide telephonic and/or face to face support to member
- Complete SF12 monthly
- Encourage self-reliance and self-confidence using Motivational Interviewing (MI) techniques
- Coordinate with providers and recovery supports as needed



PEER/ICM PHASES OF CARE



- **Discharge Criteria**

- **Stability for approximately 1 month with proper support**
- **Lack of contact with member for at least 1 month**

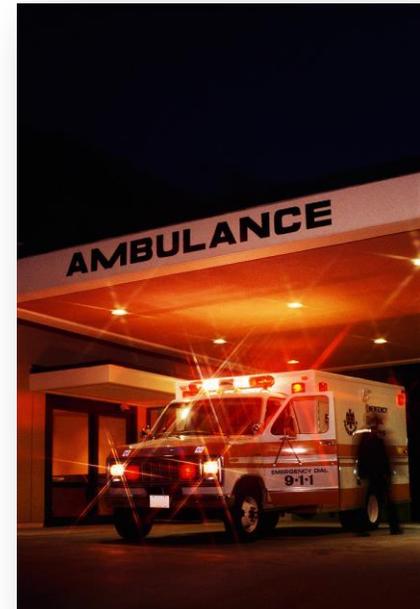
DEFINITIONS – IDENTIFIED & OPT-IN

IDENTIFIED

- Individuals who presented to the ED
- & were on the list of ED BH Frequent Visitors
- & who were referred by ED staff for the VO ICM/PEER Intervention

OPT-IN

- Of those referred for the VO ICM/PEER Intervention:
 - Those that chose to accept the ICM/PEER Intervention



Key Features of the OPT-IN Group

- More likely to be male and Caucasian
- High % with;
 - substance abuse diagnoses
 - comorbid medical conditions
 - Homeless status
- Average mental health composite score on the SF-12 is 1.5 to 2 standard deviations below the norm for those that opted in.
(N for the Opt-in group is 157)

white



Resolution: 1200x1024 px
Free Photoshop PSD file download
www.psdgraphics.com

Substance Abuse

Homeless

COMMUNITY CARE TEAMS (CCTs)

WHAT IS A CCT?

Community Care Team Model

Team of **local** community providers and agencies

Utilizes **Wraparound** approach to provide patient-centered care

Requires multi-agency **partnership** and care-planning

Traditional and **non-traditional** (non-authorized) supports and services



CCT MEMBERSHIP



The ideal CCT will include: active participation from provider and agency representatives who have the ability (authority) to make real-time decisions in order to address issues and break down barriers.

RELEASE OF INFORMATION

- CCTs utilize a “Release of Information” (ROI) that lists all the provider members of the CCT and has been signed by the frequent visitor so that the frequent visitor’s situation may be discussed openly.



CCTS MAY INCLUDE THESE TYPES OF PROVIDERS

- Hospitals (Psychiatry/BH & EDs)
- CSSD (Court Support Services Division)
- Outpatient providers
- Group homes
- LMHAs (DMHAS local mental health authorities)
- Shelters
- Soup kitchens
- Visiting nurse agencies
- Housing authorities
- Substance Use providers
- ABH (Advanced Behavioral Health)
- CHN (Community Health Network)
- FQHCs (Federally Qualified Health Centers)
- Municipal service agencies

NEW CCTs

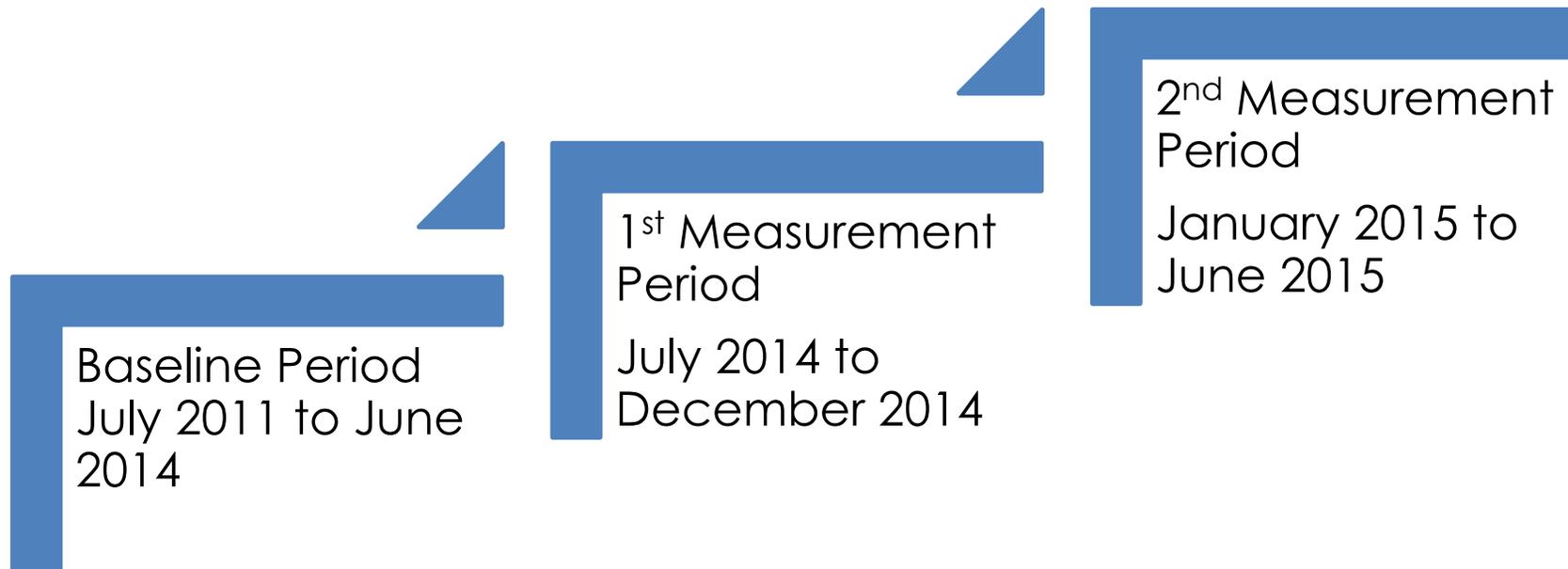
Hospital (s)	CCT Development
Backus Hospital	Enhanced existing case conference
Bristol Hospital	Established new CCT
Yale New Haven Hospital	Established new CCT
Hartford Hospital and Saint Francis Hospital	Established new <u>joint</u> CCT

FREQUENT VISITORS REVIEWED AT THE NEW CCTS

Hospital (s)	Members Reviewed
Backus Hospital	10 members*
Bristol Hospital	38 members
Yale New Haven Hospital	53 members
Hartford Hospital and Saint Francis Hospital	127 Case Presentations; 70 unique members

* These 10 members are those that are formal CCT reviews with ROIs in place. Many other members are reviewed but VO participation is limited if there is no ROI.

EVALUATION OF ICM/PEER AND CCT INTERVENTIONS



A 5-month delay in extracting data is required. 4 months due to claims lag, and an additional 1 month due to 30 day follow-out for CTC and Readmit rate computations. 1st Evaluation should be completed August of 2015. 2nd Evaluation should be completed January of 2016.

Next Steps

- **Further Study of Episodic and Persistent Frequent Visitors**
- **Use Intensive Care Management with frequent visitors**
- **Maintain/Establish Community Care Teams at larger volume hospitals**
- **Develop Predictive Algorithm**
- **Use new measures in a performance improvement program**
- **Complete Evaluation of Outcome of the ICM/Peer and CCT Intervention**
- **Child Applications – CCT for Youth and tracking DCF FVs**



