Community Care Teams: An Approach to Better Meeting the Needs of Frequent Visitors to the ED

Complex Care Committee
Acknowledgements
Overview

- Definition of a CCT
- Brief Summary of Emergency Department utilization
- CT BHP Frequent Visitor Program
  - Goals
  - Strategy
- Community Care Teams (CCT)
  - What is a CCT?
  - Critical Components
  - Stages of CCT Development
- CCT Webinars Planned for October/November 2015
CCT Defined

- A team of hospital staff, behavioral health, health, and social service agencies
- Focused on improving outcomes, care experience, and reducing unnecessary Healthcare expenditures
- For a target population of individuals with behavioral health and/or substance abuse diagnoses
- That are Frequent Visitors to the Emergency Department
Key Topics

- Overview of Frequent Visitors in CT
- CT BHP Intervention Summary
- Critical components of a CCT
- Challenges and Solutions for CCT model replication
Background

- Increasing use of the Emergency Department (ED) is a national and international concern.
- In Connecticut, CCTs are showing promise in their ability to impact outcomes for both the individual and the hospital.
Over the past decade, the increase in ED utilization has outpaced the growth of the general population, despite a national decline in the number of ED facilities.  

Overuse of the ED is responsible for $38 billion in unnecessary spending every year. 

1 out of every 8 visits to the ED in the U.S. is mental health and/or substance use related. 

Such BH visits are 2.5 times more likely to result in an inpatient admission. 

Frequent visitors to the ED account for about ¼ of all ED visits.
Utilization of the ED for Behavioral Health in CT

Top 10% of High Utilizers in CT (4+ visits in 12 months) accounted for 39,222 visits in 2013.  

Frequent BH Visitors (7+ visits in 6 months) account for 16% of BH ED visits statewide (n = 721)

Individual hospital Frequent Visitor averages ranged from 6% to 33% of their total BH ED visits.

1 in 5 BH ED visitors are homeless compared to 1 in 20 of the general adult Medicaid population.

Above data is for Medicaid Adults 18+ only
Characteristics of Frequent Visitors in CT

- Higher rates of housing instability and homelessness
- High rates of substance use disorders, particularly alcohol
- High rate of medical comorbidities
- Most often are already connected with the BH service system

Above data is for Medicaid Adults 18+ only
17% of American adults have comorbid mental health and medical conditions. Patients with complex medical and behavioral health needs have a disproportionate impact on ED services.\textsuperscript{10, 11}

In 2013, HUSKY Health frequent users accounted for approximately 1.7% of the members with an ED visit but 11.1% of the medical visits to the ED.\textsuperscript{12}

Nearly 20% of ED visits in 2013 for Frequent ED Utilizers had a secondary behavioral health or alcohol related diagnosis.\textsuperscript{13}

In 2013, of the 4,525 ED High Utilizers 76.7% resided in Fairfield, Hartford or New Haven county.\textsuperscript{14}
Individuals participating in the FV program have below average scores on the SF-12 Physical Health Scale (VO Frequent Visitor data N=301).

Most frequent medical comorbidities among FVs are Asthma, Chronic Obstructive Pulmonary Disease, & Diabetes (VO FV Data).

Substance Abuse Population has additional medical comorbidities of Hepatitis C, HIV, Liver Disease (National Data).

Homeless Population at elevated risk for Tuberculosis, hypertension, asthma, diabetes, HIV/AIDS and medical hospitalization (Nat. Data).

Above data is for Medicaid Adults 18+ only.
The CT BHP
ED Frequent Visitor Program
ED Frequent Visitor Intervention Goals

- Reduce BH Frequent Visitor overall utilization of the ED
- Reduce BH ED Readmission Rates
- Improve connections to care following BH ED visit
Additional Objectives

Identify and engage members with high ED utilization and multiple co-morbid conditions, including those with chronic medical and behavioral health or substance abuse conditions to:

- Refer to CHNCT Intensive Care Management to address fragmented care, exacerbations and/or complications of chronic disease and impaired social, economic and material resources.

- Co-manage with CHNCT to incorporate behavioral and medical supportive services.
Identified Hospitals

- Bristol Hospital
- Hartford Hospital
- Saint Francis Hospital and Medical Center
- Backus Hospital
- Yale-New Haven Hospital

Connecticut BHP
Supporting Health and Recovery
Other Hospitals with CCTs
CT BHP Frequent Visitor Program Overview

Target Population
- Top 2% of BH ED Visitors
- 7+ BH ED Visits in 6 months
- BH diagnosis as primary or secondary on claim
- Medicaid Member

Identify Frequent Visitor

Intensive Care Manager/Peer

Community Care Team

Medical and Behavioral Health ASOs partner to co-manage members with chronic conditions
The Community Care Team Approach to Frequent Visitors to the ED
Acknowledgement
Why a Community Care Team?

- Patient-centered care
- Improved health outcomes
- Community collaboration is required to improve health outcomes
- Potential for cost savings to the community
Community Care Teams (CCTs) Strategy

- Multi-agency involvement
- Utilizes a care coordination teaming approach
  - Develop individualized care plans that identify and address basic needs
- Communicate plan with individual to increase likelihood of success

Pro Tip!
Employ a peer professional to connect with member
Critical CCT Components: Consistent Commitment

- Commitment across multiple hospital departments, key agencies and support networks
  - Training of staff to recognize care plans
  - Dedicated staff to attend CCT, enter/update care plans
  - IT Modifications
  - Agencies that “step up” to assist

- “Navigator” person
  - Meeting facilitation and prep
  - Maintain ROIs
  - Liaise between CCT, ED and patient
Critical Components cont’d: CCT Membership

Most CCTs are held at hospital sites

- Outpatient MH/SA
- LMHA
- FQHC
- VNA
- CSSD
- Municipal Agencies

A typical CCT meeting has 10-20 participants

Hospital
- Medical & Behavioral Health leadership

BH & Social Services Programs
- Outpatient MH/SA
- LMHA
- FQHC
- VNA
- CSSD
- Municipal Agencies

Individual

Care/Case Management Agencies
- ABH
- CHNCT
- BHO

Housing Programs
- Shelters & Soup Kitchens
- Housing Authorities
Role of CHN in CCT Process

- Identify Frequent Visitors through real time notification and/or clinical indicators
- Make referrals to the CCT and regularly attend CCT meetings
- Provide key Medical History/Background
- Work with Beacon, ABH, and CCT in coordinating care and facilitating access to service
CCTs utilize a ROI that lists all provider members of the CCT

The member signs the CCT ROI

ROIs make the work of the CCT possible

Pro Tip! For CCT member list, more is better!
Stages of CCT Development

1. Define the population & Goal
2. Survey the landscape
3. Identify CCT resources
4. Implementation

Who?
What Criteria?
How Identified?

Existing Processes
Build new vs. Expand
What’s working?

Leadership
Logistics, referrals, ROIs, mtg management.
EHR & Technology

Execution of Care Plan
Feedback and Evaluation
Track Metrics/Outcomes
## CCT Implementation Challenges & Solutions

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<tr>
<th>Challenge</th>
<th>Solution</th>
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<tr>
<td>Personnel and resources to manage the CCT</td>
<td>Use anticipated cost offsets to fund resources, seek external funds</td>
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<td>Recruiting and maintaining essential community providers</td>
<td>Carefully select participant based on their contact w/members, make sure meetings are productive, follow-up</td>
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<td>Inconsistent commitment to the process by select hospital leadership</td>
<td>Seek buy-in from all parties early on, be persistent and sell based on how it can benefit the ED and the hospital</td>
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<td>Hospital and system culture around recovery</td>
<td>Model Recovery Orientation, Engage CCAR, Offer Training</td>
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<td>Obtaining approval and consistent use of the ROI</td>
<td>Start Early, use examples from successful projects, connect lawyers to lawyers</td>
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<td>EHR limitations or restrictions</td>
<td>Address HIPAA and compliance concerns, point to successful projects</td>
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<td>Lack of communication/training around protocol</td>
<td>Integrate Training into Implementation Protocol, Plan for turnover/changes</td>
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## Barriers to Care Coordination for Members

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<td>Lack of housing – no safe place to go while connecting to care</td>
<td>Housing Agencies/Shelters at the Table, outreach into the community</td>
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<td>Medical complexities prohibit access to services</td>
<td>coordination with CHN, engage primary care in CCT</td>
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<td>Member choice/readiness</td>
<td>Be patient, respect choices, use MI Techniques</td>
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<tr>
<td>Transportation</td>
<td>Know available resources, purchase vouchers/tokens, seek creative solutions</td>
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In addition to the CCTs associated with the CTBHP ED Frequent Visitor program, CHNCT actively participates in the following CCTs:

Norwalk Hospital
Waterbury Hospital
Middlesex Hospital
Stamford Hospital
New Haven Care Coordination Collaborative
Clinical Summary:

- 53 year old white male Husky C member
- Homeless
- Registered Sex Offender
- Severe ETOH Abuse
- Diabetes, Acute Pancreatitis, Cognitive Impairment
- Schizoaffective
- Traumatic Brain Injury
- 20 Inpatient Detoxes and 20 ED visits in 6 months
CTBHP Case Study
CTBHP ICM/Peer Interventions

- Member Identified after visit to the ED
- Member voluntarily agreed to ICM/Peer Program
- Member agreed to sign CCT ROI
- Collected Opt-in Information regarding SF-12, ICM Acuity Assessment
- Developed a Wellness Recovery Action Plan (WRAP)
- Utilized Motivational Interviewing over multiple visits/phone calls to engage member
- Utilized a Harm reduction approach
- Agreements that reporting to appointments sober would be necessary to secure housing
- Supported goal to achieve own housing despite restrictions associated with the Sex Offender Registry
- Close multi-agency collaboration across housing, medical, behavioral health, etc.
- ICM/peer interventions included:
  - Face to face visits with member
  - Check-in phone calls
  - Care Coordination
  - Care Planning
CTBHP Case Study Outcomes

- Member engaged in SA treatment
- Member reported to treatment sessions sober
- Member cut down drinking over 45 day period
- Member attended primary care appointments
- Member obtained housing
- Member picked up medications daily
- Member achieved sobriety within 60 days of opting in to the program
- Member is working, cooking his own meals, keeps a garden
- Member has been sober over 5.5 months!
CHNCT Case Study

Clinical Summary:

- 53 year old member with history of ETOH abuse, diabetes, hypertension
- 110 ED visits in 2014 to one local hospital
- Member homeless; known to local shelter

Barriers to Care:

- ETOH abuse
- Homeless
- No cell phone
- No medical follow up except ED visits
CHNCT Case Study
CHNCT ICM Interventions

- Member discussed at local hospital CCT
- Employee from the Residential rehabilitation treatment program attends local CCT meetings
- Member agreeable to treatment for ETOH abuse
- Member was admitted and kept in residential detox program until housing was arranged
- Housing First was able to assist with obtaining an apartment
- Local shelter assisted with food, furniture and household goods
- Member was referred to CHNCT ICM for coordination of care and services
- Member was discharged from residential rehabilitation treatment program but relapsed in 2 days and was allowed to return to residential program for continued treatment
- ICM interventions included:
  - Face to face visit with member
  - Ongoing counseling regarding diabetes and medications
  - Arrange for glucometer and diabetic supplies
  - Assist with obtaining a free cell phone
CHNCT Case Study
Outcomes

- Member completed residential treatment program
- Member was discharged to his own apartment
- Member attended an IOP program on discharge
- Member had a part time job at Good Will upon discharge from residential program
- Member attended follow up MD appointments at local Community Health Care Center
- Member is being followed by CHNCT Care Coordinator for continued medical follow up and diabetic testing
- Member has been in housing for 6 months
- Member has not had any ED visits since January 2015
VO CCT WEBINARS – 2015

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Adult CCTs
- November 17, 2015: 2-3:30pm
- November 19, 2015: 11-12:30pm
- December 1, 2015: 11-12:30pm
- December 4, 2015: 11-12:30 pm

YOUTH CCTs
- December 15, 2015 11-12:30
Your Questions Answered!
For More Information about CT CCTs…

- Norwalk Hospital Community Relations Weblog Video interview on the Greater Norwalk Community Care Team with Dr. Kathryn Michael retrieved from http://norwalkhospital.org/about-us/community-relations/


Thank you
Citations


5. LaCalle & Rabin. (2014). “Frequent Users of Emergency Departments: The Myths, the Data, and the Policy Implications.” From the Department of Emergency Medicine, Mount Sinai School of Medicine, New York, NY.
6. High Risk Populations: Frequent Behavioral Health ED Visitors” June 10 Complex Care Committee Presentation – based on 2013 data

7. Adult Frequent Behavioral Health ED Visitors & Hospital Specific Measures” July 2015 CHA Presentation

8. Adult Frequent Behavioral Health ED Visitors & Hospital Specific Measures” July 2015 CHA Presentation


12. Reduction of Inappropriate Emergency Department Utilization, June 19 Complex Care Committee Presentation – based on 2013 data
13. PA 14-62 2013 ED Summary Report submitted March 2015 to the CT Department of Social Services

14. Reduction of Inappropriate Emergency Department Utilization, June 19 Complex Care Committee Presentation – based on 2013 data


17. Institute for Healthcare Improvement Triple Aim for Populations retrieved from: http://www.ihi.org/Topics/TripleAim/Pages/Overview.aspx