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

Operations Committee
November 2015
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 November/December 2015
Background

- Increasing use of the Emergency Department (ED) is a national and international concern.
- In Connecticut, a few CCTs showed promise in their ability to impact outcomes for both the individual and the hospital.
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
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
Identified Pilot Hospitals

Bristol Hospital

Hartford Hospital

Saint Francis Hospital and Medical Center

Backus Hospital

Yale-New Haven Hospital

Connecticut BHP
Supporting Health and Recovery
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
Other Hospitals with CCTs
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

Connecticut BHP
Supporting Health and Recovery
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
  - Liaison 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

- Medical & Behavioral Health leadership

- ABH
- CHNCT
- VO

- Shelters & Soup Kitchens
- Housing Authorities

Hospital

BH & Social Services Programs

Care/Case Management Agencies

Individual

Housing Programs
Critical CCT Components cont’d
Release of Information (ROI)

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

**What Criteria?**
- Leadership
- Logistics, referrals, ROIs, mtg management.
- EHR & Technology

**How Identified?**
- Execution of Care Plan
- Feedback and Evaluation
- Track Metrics/Outcomes
## CCT Implementation Challenges & Solutions

<table>
<thead>
<tr>
<th>Challenge</th>
<th>Solution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personnel and resources to manage the CCT</td>
<td>Use anticipated cost offsets to fund resources, seek external funds</td>
</tr>
<tr>
<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>
</tr>
<tr>
<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>
</tr>
<tr>
<td>Hospital and system culture around recovery</td>
<td>Model Recovery Orientation, Engage CCAR, Offer Training</td>
</tr>
<tr>
<td>Obtaining approval and consistent use of the ROI</td>
<td>Start Early, use examples from successful projects, connect lawyers to lawyers</td>
</tr>
<tr>
<td>EHR limitations or restrictions</td>
<td>Address HIPAA and compliance concerns, point to successful projects</td>
</tr>
<tr>
<td>Lack of communication/training around protocol</td>
<td>Integrate Training into Implementation Protocol, Plan for turnover/changes</td>
</tr>
</tbody>
</table>
# Barriers to Care Coordination for Members

<table>
<thead>
<tr>
<th>Challenge</th>
<th>Solution</th>
</tr>
</thead>
<tbody>
<tr>
<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>
</tr>
<tr>
<td>Medical complexities prohibit access to services</td>
<td>coordination with CHN, engage primary care in CCT</td>
</tr>
<tr>
<td>Member choice/readiness</td>
<td>Be patient, respect choices, use MI Techniques</td>
</tr>
<tr>
<td>Transportation</td>
<td>Know available resources, purchase vouchers/tokens, seek creative solutions</td>
</tr>
</tbody>
</table>
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

Samantha.Forbes@valueoptions.com
Questions?
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/


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

15. Mental Health and Chronic Diseases, October (2012), CDC National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. 
   [Link](http://www.cdc.gov/nationalhealthyworksite/docs/Issue-Brief-No-2-Mental-Health-and-Chronic-Disease.pdf) last visited 10/12/2015


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