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

November 17, 2015
Acknowledgements
Overview

- Summary of Emergency Department utilization
- CT BHP Frequent Visitor Program
  - Goals
  - Strategy
- Community Care Teams (CCTs)
  - What is a CCT?
  - Critical Components
  - Stages of CCT Development
  - Challenges and Solutions
- Suggested reference materials plus link to Guidebook
What You Will Learn from this Webinar

- How a CCT could reduce frequent visitor ED readmissions
- Critical components of a successful CCT
- Recommendations for establishing a CCT that are rooted in experience
What You Need to Know

- Increasing use of the Emergency Department (ED) is a national and international concern
- Frequent visitors often present with co-morbid diagnoses
- 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 visits are 2.5 times more likely to result in an inpatient admission. 

Spending for Medicaid members with 1 of 5 leading chronic conditions is doubled or tripled when accompanied by a mental illness or drug/alcohol use.
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 is homeless compared to 1 in 20 of the general adult Medicaid population.

Above data is for Medicaid Adults 18+ only
Frequent Visitors & BH ED Readmission Rates

<table>
<thead>
<tr>
<th>7 Day BH Readmission Rates</th>
<th>All Adults</th>
<th>Frequent Visitors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statewide</td>
<td>21%</td>
<td>47%</td>
</tr>
<tr>
<td>Lowest Hospital Average</td>
<td>14%</td>
<td>33%</td>
</tr>
<tr>
<td>Highest Hospital Average</td>
<td>41%</td>
<td>68%</td>
</tr>
</tbody>
</table>

Above data is for Medicaid Adults 18+ only
The CT BHP ED Frequent Visitor Program
Identified Hospitals

- Bristol Hospital
- Hartford Hospital
- Saint Francis Hospital and Medical Center
- Backus Hospital
- Yale-New Haven Hospital
ED Frequent Visitor Intervention Goals

- Reduce Frequent Visitor overall utilization of the ED
- Reduce preventable BH ED Readmissions
- Improve connections to care following ED visits
CT BHP Frequent Visitor Program Process Overview

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

Survey the Landscape & Identify Resources
- Meet with hospitals & community stakeholders
- Program goals & expectations
- Establish referral process and communication strategy
- Assess landscape for CCT

Implementation
- Monthly frequent visitor reports via secure email
- ED identification & notification to CT BHP if a FV has presented
- Development of Community Care Teams (CCT) & Release of Information (ROI)
The Community Care Team Approach to Frequent Visitors to the ED
Acknowledgement
What is a CCT?

A community-based model of integrated care consisting of multiple agencies who ensure timely connection to treatment and/or other community resources for a geographic region’s most complex individuals.
The Middlesex CCT Model

- **2010**
  - Development began with 4 core agencies
  - Monthly meetings
  - Establish Release of Information (ROI)

- **2012**
  - Weekly meetings
  - Expanded list of providers on the ROI
  - Funded Health Promotion Advocate

- **Since 2012**
  - 212 patients reviewed
  - 640 fewer ED Visits for Medicaid = $586K
  - 1,142 fewer ED visits for all claims = $1.7M

See sample ROI and tracking sheet on Pages10 -12 of Guidebook!
Why a Community Care Team?

**Three Dimensions of Value**

- Reduced burnout for professionals
- Shared savings for all involved
- Increased productivity
- Continue the push for an integrated system of care
Community Care Teams (CCTs) Strategy

- Multi-agency involvement
- Utilizes a care coordination teaming approach
  - Develop individualized care plans that identify and address basic needs
- Identify key person to share and continue to develop plan with the individual

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
  - IT Modifications to EHR
  - Dedicated staff to participate in CCT, enter/update care plans
  - Agencies that “step up” to assist

- “Navigator” duties
  - Meeting facilitation and prep
  - Maintain ROIs
  - Liaise between CCT, ED and individual to coordinate care

For a more complete list of Navigator responsibilities see page 13 of Guidebook!
Critical Components cont’d: CCT Membership

Hospital

- Medical & Behavioral Health leadership

Individual

BH & Social Services Programs

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

Care/Case Management Agencies

- ABH
- BHO
- CHN

Housing Programs

- Shelters & Soup Kitchens
- Housing Authorities
- Homeless outreach teams

Pro Tip!
CCT members must have authority to make real-time decisions
Critical CCT Components cont’d

Release of Information (ROI)

- ROIs make the work of the CCT possible

- Offered by CCT provider member & signed by the individual

- The ROI lists **all** provider members of the CCT

Pro Tip!
For CCT member list, more is better!
“Henry” is a 55 y.o. male who is diagnosed with Alcohol Disorder Severe, PTSD, Major Depressive Disorder and Bipolar NOS. In addition he suffers from COPD, Hypertension, Hepatitis C & GI bleeding due to ETOH use. He has been homeless for almost a year with multiple ED visits and inpatient stays for psych and medical detox. He was living at a shelter but was discharged due to missing curfew and drinking. He is most concerned with housing so he can properly take care of his amputated leg and treating his depression which he sees is the root cause of his alcohol use.
Sample Care Plan

Name of CCT
Date of CCT Meeting ________________

<table>
<thead>
<tr>
<th>Name/DOB of Individual</th>
<th>Referral Source/Date</th>
<th>Discussion (Needs/Goals/Desires)</th>
<th>Plan/Recommendation/Outcome</th>
<th>Responsible Persons</th>
<th>Target Date</th>
</tr>
</thead>
</table>
| Henry 1/1/1987          | ABC Hospital ED 10/1/2015 | Henry is residing in temporary housing, attending AA & IOP. Amputated leg is infected due to being homeless & not being able to care for wound properly. He is worried he will not get permanent housing as he’s failed to qualify in the past. IOP clinician reports he has been compliant and that he would like to obtain part time work | • VNA Service to provide medical education  
• Referral to housing support specialist to explore housing options  
• Vocational program recognized Henry’s name and told Case Mgr to have him call the intake worker | Bill from VNA will outreach to Henry to schedule a visit  
• John at temp housing to refer to internal housing specialist.  
• Jane Smith, Case Mgr to give Henry contact info for Vocational program. | 7/12/15 |
Stages of CCT Development

1. Define the population & Goal
2. Survey the landscape
3. Identify CCT resources
4. Implementation
Stages of CCT Development
Define the Population and Goal

Who do you want to impact?
- What criteria will you use to identify them?
- Where/how will they be identified?

What will you do?
- What are the stated goals/outcomes(?)
- How will you measure?
Stages of CCT Development
Survey the Landscape

What are existing efforts to coordinate care?

- Building new vs. expanding current efforts
- Assessing what works & what does not

Identify key players or stakeholders/resources

- Establish or strengthen relationships
- Reach out beyond service providers such as local municipalities
Considerations for Enhancing an Existing Meeting

Consider enhancement if:

- The existing meeting’s purpose aligns or can be aligned
- There is an overlap between the target populations
- The existing table has key stakeholders in attendance

Modifications to existing meeting

- Meeting proceedings
  - Duration, frequency, referral process, meeting location
- Membership
- HIPAA & 42 CFR Part II compliance
Stages of CCT Development
Identify Necessary Resources

Leadership
- Who is (are) your champion(s)?
- Who will train/communicate?

Logistics
- How will you receive referrals?
- Keep track of ROIs?
- Who will manage the CCT meeting?
- What is the meeting time/place/frequency/duration?

Technology
- What system modifications will be required?
- Time required to implement?
Stages of CCT Development
Implementation of CCT

**Execute care plan**
- CCT Member Commitment - providers responsible for active role in care plan
- Hospital Commitment - staff training & communication
- Review care plan weekly & revise as needed

**Evaluate**
- Monitor/revise flow periodically
- Expand ROI periodically
- Is the individual’s voice reflected in the care plan?

**Track outcomes**
- Establish parameters according to goal
- What and how much did you do?
## 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 base on their contact w/members, make sure meetings are productive, follow-up</td>
</tr>
<tr>
<td>Lack of buy-in to the process from medical and BH leadership</td>
<td>Seek buy-in from all parties early on, be persistent and sell based on how it can benefit the ED/Individual</td>
</tr>
<tr>
<td>Hospital 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, CFR 42 Part II 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 Individuals

<table>
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<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>Consider medical respite services, coordination with CHN,</td>
</tr>
<tr>
<td>Member choice/readiness</td>
<td>Be patient, respect choices, meet them where they are using MI Techniques</td>
</tr>
<tr>
<td>Transportation</td>
<td>Know available resources, purchase vouchers/tokens, seek creative solutions</td>
</tr>
</tbody>
</table>
Today's Guest Panel

Bristol Hospital
Diane Bernier, Operations Manager, Inpatient Behavioral Health

Hartford Hospital
Lori Johnson, Director of IOL Assessment Center and Utilization Management
David Pepper, MD, Psychiatry Director, Emergency Psychiatric Services

Saint Francis Hospital
Robin Nichols, Manager of Crisis Service
Your Questions Answered!

Please find the CCT Guidebook at
http://www.ctbhp.com/providers/prv-trn.html
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


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


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