CONNECTICUT HOSPITAL ASSOCIATION

CHA MENTAL HEALTH RECOMMENDATIONS

SUPPORT COMMUNITY CARE TEAMS AND RELATED CARE COORDINATION SERVICES

The Connecticut Hospital Association (CHA) supports short- and long-term solutions to improve Connecticut's mental health system. These recommendations are intended to improve health outcomes, reduce unnecessary use of Emergency Department (ED) services, and ensure adequate funding for key safety net services.

Support Community Care Teams and Related Care Coordination Services. Fund community care efforts by hospitals to enhance patient screening, ensure timely release of information, establish patient-centered community case management plans, and engage patients in housing and social wraparound support services. Funding options may include grant support based on ED volumes, case rates for identified high-risk utilizers, and similar support for community care team clinicians, administrators, navigators, and/or intensive case managers.

One innovative solution that is proven to achieve improved health outcomes for high-frequency adult visitors to EDs, relief to behavioral healthcare providers, and potentially substantial and sustainable Medicaid savings to the state is known as a **Community Care Team (CCT)**. A CCT is a group of healthcare and community service providers who understand that community collaboration is necessary to improve health outcomes for vulnerable populations, including those who are chronically physically and/or mentally ill, homeless, or abusing substances. The goals are to improve care, increase community safety, and reduce costs by providing wraparound services through multi-agency partnership.

How A CCT Works

Across Connecticut, hospitals are teaming up with other community-based healthcare providers and providers of wraparound social services to establish a CCT or to engage in other related community care coordination initiatives. These regional multi-agency partnerships are often led by a community hospital, with active participation by local agencies, including mental health, substance abuse, federally qualified health centers (FQHCs), other medical

services, city social services, housing authorities, religious organizations, shelters, vocational programs, and law enforcement. A CCT may also include representatives of Community Health Network of Connecticut and ValueOptions Connecticut, the state's two Medicaid administrative services organizations.

The CCT meets either weekly or every other week, usually at the hospital, where members work collaboratively to identify patients based on the frequency of ED visits or referrals from other CCT members. These patients are complex, high risk, and high-need ED "super users" who are typically diagnosed with coexisting severe mental illness and substance abuse disorders, chronic mental illness, chronic alcoholism, or other drug dependence.

Once a candidate is identified, a patient-centered intensive case management (ICM) plan is developed. The hospital reviews the ICM plan with the patient and then offers admission to the CCT program. The patient is also asked to sign a Release of Information (ROI) to authorize the exchange of information among the participating agencies. Once the ROI is signed, the patient is admitted and begins working with a key member of the CCT known as the Navigator or Healthcare Promotion Advocate (Advocate).

The Advocate establishes a relationship with the patient by making direct and indirect referrals to treatment, by engaging the patient in housing and social wraparound support services, and by completing "check-in" calls for those in the community who are stabilized or still struggling. The Advocate achieves care coordination and engages in case management by establishing a personal connection between the patient and the CCT, ED, and other community service providers.

The Promise of CCTs

In those places where CCTs have already been established, the patients enrolled in these programs have experienced improved health outcomes including sobriety, mental health stabilization, reduced homelessness, and re-entry to the workforce, highlighted by fewer ED visits. Hospitals have experienced a reduction in ED overcrowding, decreases in costs of care, and reduced losses for undercompensated and uncompensated care. Most notably, there is a positive impact on the state's bottom line, since typically more than half of these patients are Medicaid beneficiaries.

Middlesex County CCT

Middlesex Hospital is a founding member of the Middlesex County Community Care Team. This group of more than 14 provider agencies meets for one hour each week at the hospital to address clinical concerns for frequent visitors to the ED, those with at least 10 visits in a six-month period. In a three-year period, the CCT has reviewed 192 ED patients, some with as many as 70 visits in a year.

Access: Patients range in age from 20 to 69, with females comprising 37% and males 63%. Payor status includes Medicaid 50%, Medicare 40% (each of whom is also enrolled in

Medicaid), Commercial Insurance 4%, and Self-Pay No Insurance 6%. 41% of the CCT caseload experiences homelessness or fragile housing.

Quality: Care plans have been created for all 192 enrolled patients. Each of these patients has been connected to at least one outpatient service: medical, mental health, substance abuse, and/or homeless services.

Loss Reduction: The CCT has helped reduce the frequent visitor population to the hospital's ED by over 50%. The dollars invested by DMHAS that fund the Advocate within the ED have led to significant savings in ED and inpatient costs, while engaging high-volume ED users in community care. It is believed that Medicaid costs for these patients have been reduced by as much as 67%.

Norwalk CCT

The Norwalk Community Care Team was established in February 2014 to target mental health and substance abuse, two of the three most urgent public health initiatives identified in the 2012 Norwalk Community Health Assessment. Since its inception, the Norwalk CCT has reviewed 169 individuals and created care plans for more than 95% of those providing consent.

Access: In 154 cases reviewed, patients range in age from 20 to 69, with females comprising 40% and males 60%. Payor status includes Medicaid 70%, Dually Eligible 9%, Medicare 7%, Commercial Insurance 9%, and Self-Pay No Insurance 4%. 35% of the CCT caseload experiences homelessness or fragile housing.

Quality: Most of these patients have been connected to at least one outpatient service: medical, mental health, substance abuse and/or homeless services. Those in need have been connected to inpatient mental health facilities, substance abuse treatment or rehabilitation centers. More than 90% of those eligible for insurance have been connected. The Vulnerability Index & Service Prioritization Decision Assistance Tool (VI-SPDAT) has been completed on all but one ED frequent visitors. Twenty individuals have been housed to date, and seven more patients have vouchers and are awaiting placement.

Loss Reduction: Utilization by ED frequent visitors has been decreased by 32% for this high-utilizer population. Since 70% of these patients are Medicaid clients, one may calculate a reduction of roughly 784 Medicaid visits for the year. The resulting reduction in Medicaid costs for these visits is substantial.

Community Care Initiatives in Other States

There are other successful hospital-based models involving community care in the United States. The Center for Health Care Strategies and the National Governors Association held a "Super-Utilizer Summit" in 2013[i]. Several points from this informative document stand out. In Medicaid, 5% drive 50% of the spending. 80% of the high-cost beneficiaries have three or more chronic conditions, and 60% have more than five. Most have an array of complex social

problems. Universally, these teams agreed that coordinated care involving diverse agencies is required to succeed.

The Rand Corporation has estimated that hospital emergency rooms perform up to $4.4 billion in routine, non-emergency care every year. Uncompensated care sought at hospitals by the uninsured is estimated to approach $40 billion annually. These costs are then passed onto taxpayers and consumers.

Hennepin County, Minnesota, invested in community care coordination and a Medicaid shared savings model. Their results were impressive. For the costliest 5% of patients, case management reduced costs by 40 to 95%. They were anticipating spending about $3,500 per enrollee as compared to $138,000 for treatment sought only in the ED. As a result of these savings, Hennepin County was able to invest in a sobering center where intoxicated individuals may be connected to community-based treatment services in a safe, cost-effective setting. ED costs for these individuals decreased by 80%.

The Potential for Statewide CCT Implementation

Across Connecticut, hospitals and other community healthcare and social service providers are demonstrating an unprecedented degree of dedication, cooperation, and commitment of time and resources to community care coordination.

As of March 9, 2015, CCTs have been organized in 14 regions of the state, with another five still in the planning stages, and still another five interested in moving forward some program of care coordination. Efforts to organize CCTs have been driven by hospitals and other care providers, and have been funded primarily through the generosity of these providers. These new initiatives are being organized with little or no state support.

The Middlesex County Community Care Team was funded with a grant from the Department of Mental Health and Addiction Services. Other CCTs have been formed at the expense of hospitals and other community providers pursuant to short-term initiatives such as the *ED Frequent Visitor Project*, sponsored by ValueOptions Connecticut under the auspices of the Department of Social Services, or the Connecticut Hospital Association/Partnership for Strong Communities *Opening Doors Hospital Work Group*, funded by a grant from the Connecticut Health Foundation. These short-term initiatives have worked well to demonstrate the potential value of CCTs, but communities require financial assistance to ensure statewide implementation of community care coordination through CCTs.

In its 2014 report on *Hospital Emergency Department Use and Its Impact on the State Medicaid Budget*, the Program Review Committee (PRC) concluded that "the more successful initiatives, especially for frequent users of the ED who have behavioral health or substance abuse disorders, are associated with ICM programs that: (i) have more face-to-face client interaction; (ii) involve EDs in the selection of clients, and in the development of a care plan; (iii) perform ongoing, and not episodic, monitoring of clients' stability and progress, including frequent meetings of providers involved in client care and services; and (iv) demonstrate a persistence in engaging the client and managing health and psycho-social needs." The CCTs being

established in Connecticut abide by the conclusions articulated by the PRC, and merit your consideration for financial support.

An Investment in CCTs

CHA has determined that an appropriation of $1.8 million in FY 2016 and $3 million in FY 2017 to the Department of Mental Health and Addiction Services will be sufficient to support grants to hospitals in 24 regions across the state to support the establishment and operation of CCTs and related care coordination services, specifically for administrators to manage the CCTs and for Advocates to coordinate the mental health and social service needs of each patient. Under this approach, hospitals and other community providers would continue to provide access to the clinicians, facilities, mental health treatment, and social services required by these patients.

Hospitals and community healthcare and social services providers need a relatively modest financial commitment from the state to turn an innovative community-based solution into a statewide best practice that will benefit patients, relieve pressure on providers, and achieve savings for the state. Based on the performance of the programs referenced above, an investment by the state in CCTs will result in a reduction in Medicaid costs that will be much greater than the cost of investing in CCTs.

[i] Robert Wood Johnson Foundation & Dianne Hasselman, Center for Healthcare Strategies; "Super-Utilizer Summit," October 2013.