Frisbie Memorial Hospital Community Care Team

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FACTS ABOUT FREQUENT EMERGENCY DEPARTMENT UTILIZATION

- 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 *(AHRQ Statistical Brief# 174, 2011).*
- Overuse of the ED is responsible for $38 billion in unnecessary spending every year *(New England Healthcare Institute March 2010: A matter of Urgency; Reducing Emergency Department Overuse)*
- 1 out of every 8 visits to the ED in the U.S. is mental health and/or substance use *related (AHRQ Statistical Brief #92, 2007)*
- Frequent visitors to the ED account for a ~ ¼ of all ED visits *(Lacalle and Rabin , 2014; Frequent Users of Emergency Departments; The Myths, the Data, and the Policy Implications)*

Community Care Team (CCT)

- Is a group of individuals representing healthcare providers (medical and behavioral health) in hospital and ambulatory settings, as well as social service and community support agencies, who align and combine resources to address community members at the highest risk for frequent utilization of Emergency Department services.

- The Community Care Team does not create clinical care plans, but rather “connects the dots” in coordinating the complex network of psychosocial supports and resources that many of these patients require but cannot access on their own.

- We are replicating efforts of Middlesex Hospital in Connecticut

Vision

The vision for the Strafford County Community Care Team (SC-CCT) is to improve identification of our highest risk individuals and coordinate services, including delivery of medical, behavioral health, and non-medical services, addressing complex medical and psychosocial needs.

Target

- Our target for this initiative are patients who have had 12 or more visits to the ED within a period of 12 or less months, and/or patients who are homeless or living in unsafe environments.

Program Goals

- The threshold for referral to the CCT is determined (i.e. number of Emergency Department visits and/or number of hospitalizations/re-hospitalizations).

- The records of patients meeting the threshold for CCT referral are "flagged" so that the next time the patient is encountered, they can be asked to sign the Release of Information.

- The patient signs the Release, allowing their case to be presented at the next regularly scheduled CCT meeting.

- When the ROI needs to be reauthorized, any CCT member can reintroduce the release because often it's someone other than the hospital who is working closely with the person.

Snapshot of Frisbie Data

High ED Utilizer Data Quick Facts

46 unique patients accounted for 584 ED encounters at FMH from 1/1/2015-12/31/2015 (does not include ED encounters at WDH)

Avg. 12.6 ED visits in 12 month period; Range 27-> 4 visits

Behavioral/substance Dx: Bipolar Disorder, PTSD, Anxiety, Depression, ETOH, Opioid Abuse

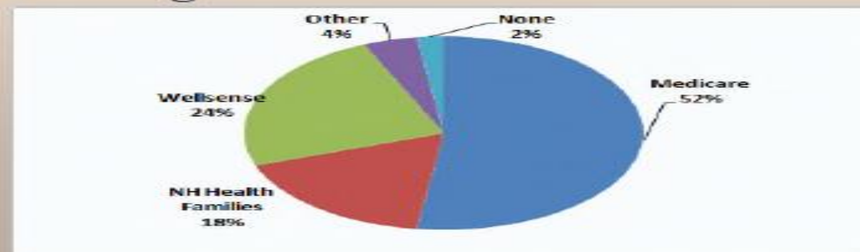
Most common medical conditions: HTN, COPD, Migraine, Asthma, Chronic Pain, CA

Average age: 41; 54% Male

Marital Status

- Single 74%
- Married 15%
- Divorced/Widowed 11%

Coverage



Hospital or Healthcare Provider Role

- Community health workers within CCT members/affiliates execute care plans by pulling recommendations based on knowledge of the patients needs.
- They are the “glue” that connects the pieces of the care plan in a way that best serves the client.
- Services that may be covered include case management, medication management and others such as transportation, housing, food, financial, and fuel assistance as well as outreach.

Partners

STRAFFORD COMMUNITY CARE TEAM

Families First
support for families...health care for all

Rochester Housing Authority

Homeless Center for Strafford County
Safety • Support Self-Sufficiency

U.S. Department of Veterans Affairs

MY FRIENDS PLACE

Community Action Partnership of Strafford County
1965 – 2015
50 Years of Community Action!

Frisbie Memorial Hospit
It's about People. Technology. Trust.

Southeastern New Hampshire Alcohol & Drug Abuse Services

Beacon
Psychcare
Beacon

Goodwin Community Health

Cornerstone VNA
Home • Health • Hospice
Trusted Care since 1913

New Hampshire Healthy Families

ServiceLink
Aging & Disability Resource Center

TIMELINE

Planning Call 6/26/15

11/1/2015 Approval of Strafford County CCT ROI

12/15/15 Meeting to plan training & referral/eval

1/26/2016- Meeting with FMH - providers- how to use ROI/ refer

- June 2015
  - Community Team at Workshop 6/15/2015
- July 2015
- August 10, 2015
  - 1st Meeting of Strafford County
- September 2015
  - 9/20/15 2nd Meeting of Strafford County CCT
- October 2015
- November 2015
  - 11/17 15 3rd Meeting of SCCCT
- December 2015
- Jan 2016 and beyond

Planning Call 7/28/15

11/17/2015 1st "test" Case Conference

2/1/2016- CCT Monthly meetings to begin w/case conf.

Challenges and Constraints

Issues/Obstacles	Strategy
Many patients are uninsured/underinsured and NH state funded resources are few and scarce	Engage with Medicaid programs; use CCT to see flexibility in programs on team;
Resources/staff for data analysis are limited; Limited ability to see utilization outside of each individual organization	Limited data analysis; measure impact at the individual pt level as evidenced by decreased utilization from prior indiv. Baseline; Use ROI to allow access/sharing of data across organizations
Organizations do not have shared systems for data/management of communication	Limited by financial constraints (no defined budget)as well as HIPPA; use ROI to share information within CCT; use tools on hand
Providers unaware of CCT and how to coordinate practice within team	Provide in person training and outreach
Patients may lack motivation to participate-participation is voluntary	Use each encounter as opportunity to engage patients; patients are not obligated & no fee to participate CCT

Process

- Identify and assess high risk patients based on behavioral and substance abuse issues as well as housing instability or homelessness for care planning.
- Develop clinical care plans (providers/CHW/CM), obtain consent/ROI, present care planning to CCT and achieve active participation of at least 6 clients by July 2016 - 1 year from start of initiative.
- Address fragmented care, gaps in care, exacerbations and/or complications of chronic disease and impaired social, economic and material resources within CCT with multi-agency collaboration.
- Co-manage to incorporate supportive services to address substance abuse (if applicable) or underlying behavioral health needs.

Measurements

- Reduce frequent visitor overall utilization of the ED for patients participating in the program by at least 10% within first 18 months
- Reduce readmission rates for patients who have more than 3 admissions in a 12 month period by at least 10% within first 18 months
- Improve connections to care following ED visit with follow up appointments with primary care provider within 3 days for at least 80% of CCT supported clients discharged from the ED/discharged from the hospital

Case Studies