

GREATER NORWALK COMMUNITY CARE TEAM COLLABORATIVE

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Norwalk Community Care Team Navigator

Objectives

- Understand the forces driving the need for collaborative care for vulnerable populations and the role of these partnerships in successful population health models.
- Understand the structure, function and challenges of successful collaboration among community hospitals, homeless shelters, community health providers and other key stakeholders in caring for vulnerable residents.
- Understand the guidelines for successful implementation of a Community Care Team or similar collaborative care model.

A BRIEF HISTORY OF COMMUNITY MENTAL HEALTH

Community Mental Health - History

1800s – Many mentally ill imprisoned

1825 – Rev. Louis Dwight – Boston Prison Discipline Society

1833 – MA Legislature → first “State Lunatic Asylum”

1841 – Dorothea Dix

- Efforts led to opening 30 more state psychiatric hospitals

1880 – 75 Public Psychiatric Hospitals

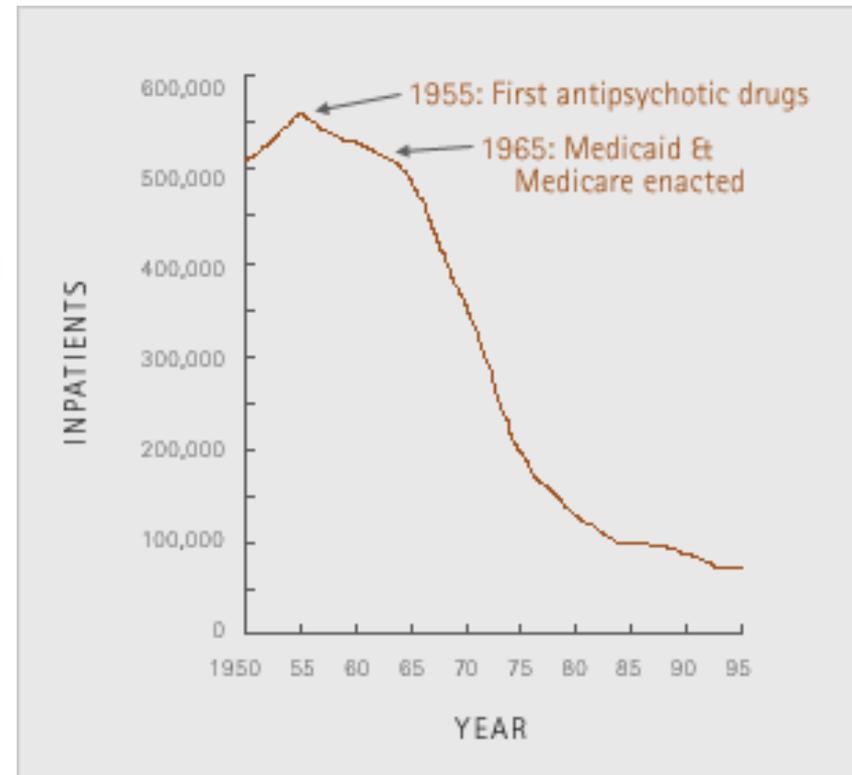
1880 – Complete census of “Insane Persons”

- 91,000 total
- 41,000 living at home
- 41,000 in hospitals
- 9000 in alms houses
- 400 in jails (0.4%)



Deinstitutionalization

- 1963 JFK: “Reliance on the cold mercy of custodial isolation will be supplanted by the open warmth of the community concern and capability...”
- \$2.7 B funded 789 CMHCs over 17 years
- 75% patients discharged from state hospitals over 30 years
- Only 4-7% of these actually treated by the CMHC



Results of Deinstitutionalization

American Journal of Psychiatry, 2005

15% of mentally ill were homeless at least once in 1 yr. period

NIMH, 2009

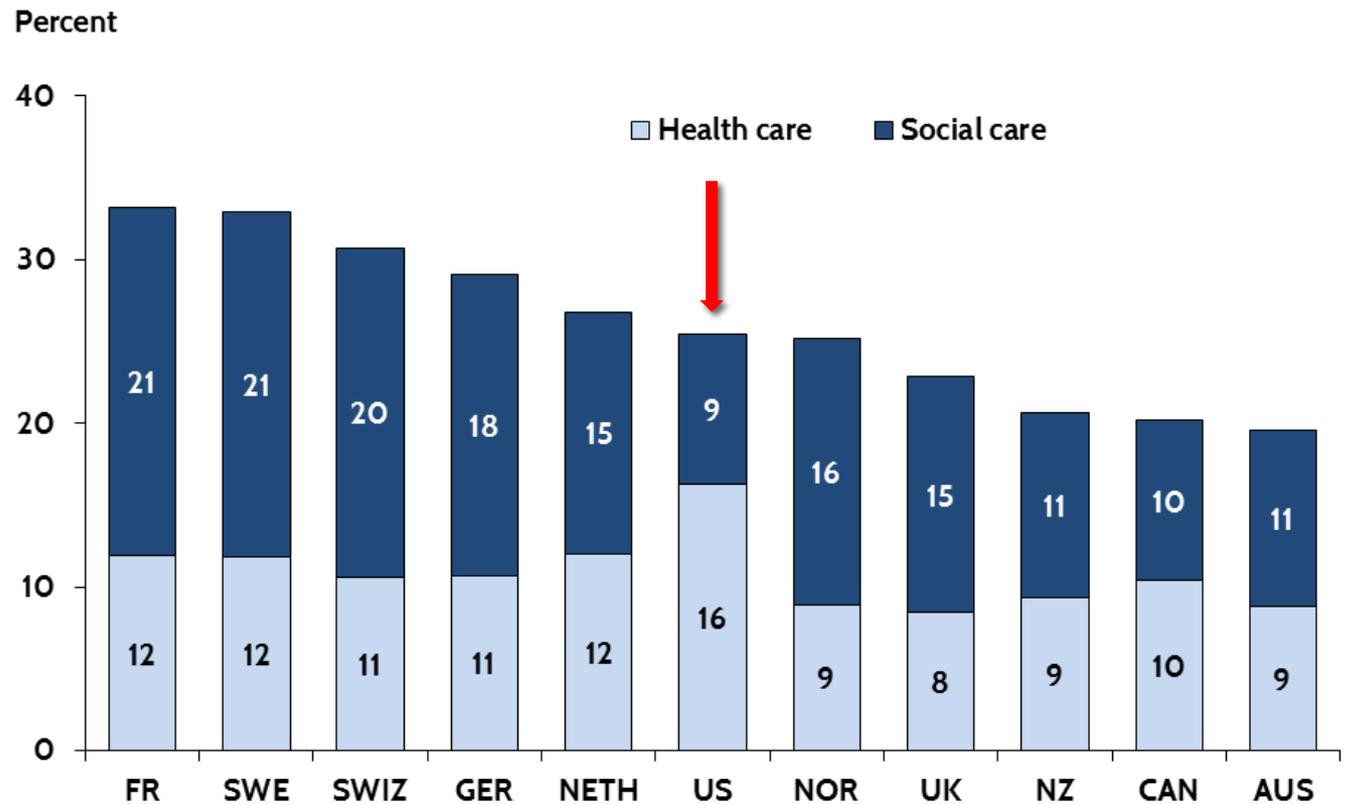
- 25% of street homeless have a serious mental illness
- American Academy of Psychiatry and the Law, 2007
 - More mentally ill in prisons than in state hospitals



Spending on Healthcare and Social Services

Exhibit 8. Health and Social Care Spending as a Percentage of GDP

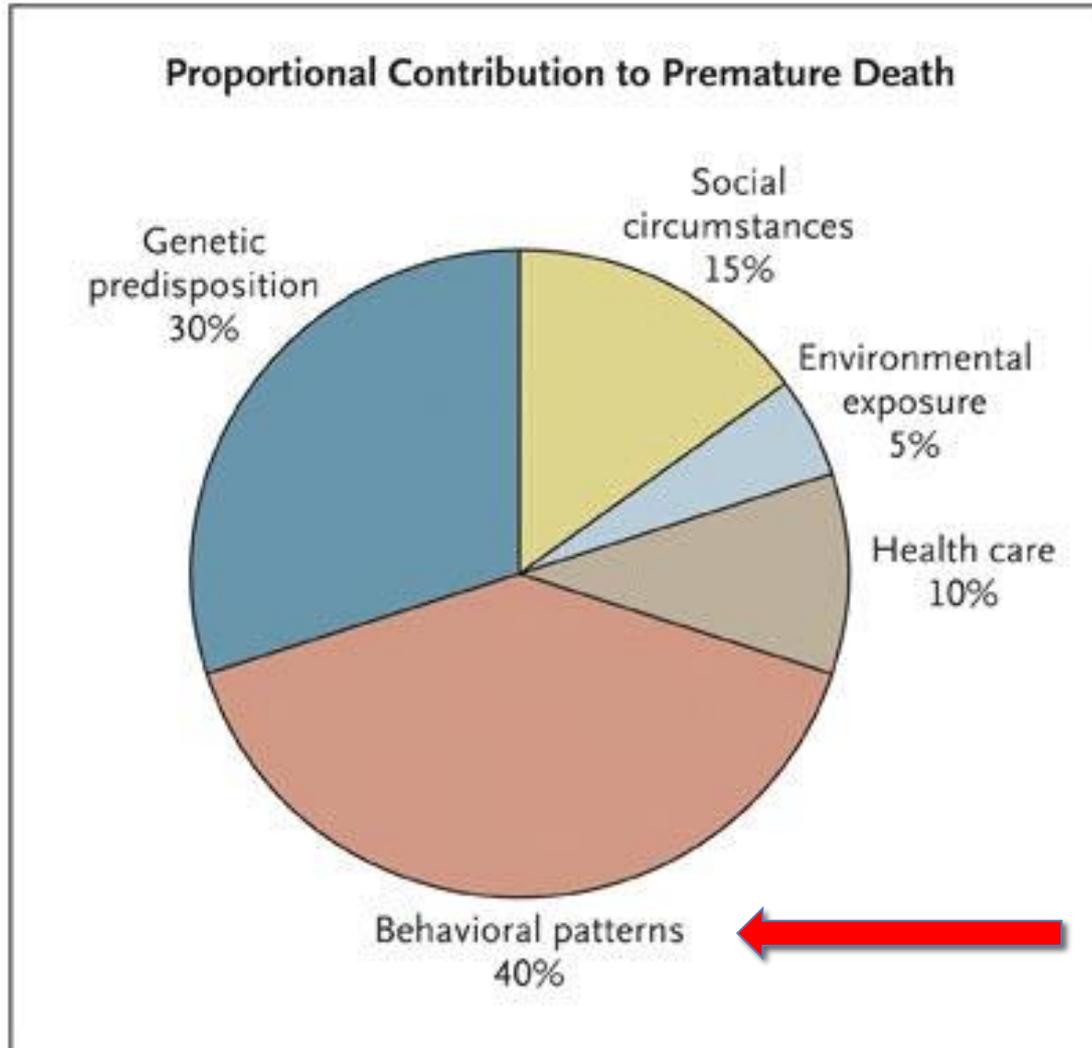
The only high income country spending more on health care than social services: housing assistance, disability benefits, employment programs, food security.
Commonwealth Fund, 2013



Notes: GDP refers to gross domestic product.

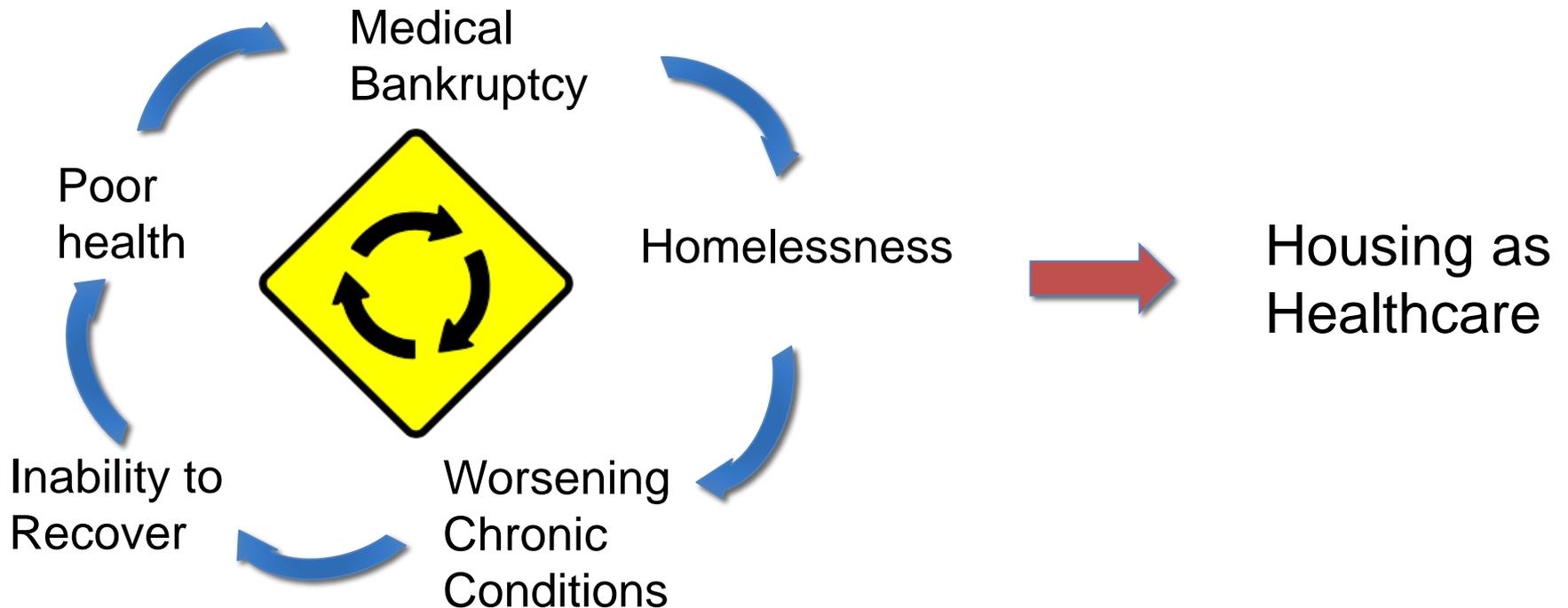
Source: E. H. Bradley and L. A. Taylor, *The American Health Care Paradox: Why Spending More Is Getting Us Less*, Public Affairs, 2013.

Drivers of Health Status



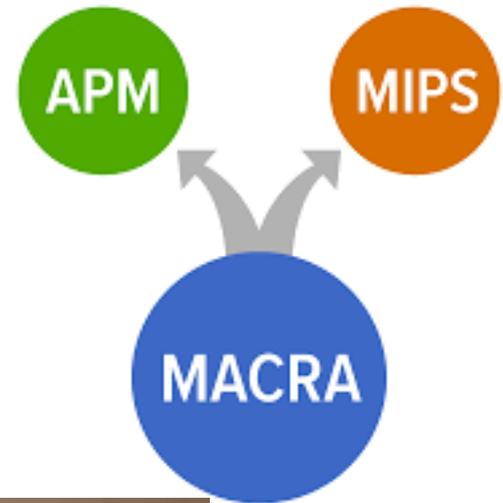
Schroeder, S.A.,
*"We can do better –
Improving the Health of
the American People,*
NEJM. 2007.

Impact of Homelessness on Health



- National Healthcare for the Homeless Fact Sheet Jan10, 2011
- Himmelstein, D.U.,(2009). Medical bankruptcy in the United States, 2007: Results of a national study. The American Journal of Medicine, p. 1-6.

Transition to Value-based Care?



BACKGROUND

CRAIG GLOVER, MBA

NORWALK COMMUNITY HEALTH CENTER

Fragmented Care

- Many organizations caring for same patient without coordination
- No single point of entry for help
- Duplication of services / Resource drain
- Not meeting community needs/ Gaps in service
- Frequent emergency room visits for primary care issues
- Competition between providers

Fragmented Care Cont'd

- Patients move frequently between communities
- Some patients unwilling to access any resources
- Lack of knowledge among providers about other resources
- Lack of data sharing among providers

Norwalk Community Health Center

- Federally qualified / community health center
- Opened in 1999
- Approximately 14,000 unique patients
- Approximately 53,000 annual visits
- Services
 - Adult medicine | Women's Health | Pediatrics | Behavioral Health | Dental
- Payer Mix
 - 60% Medicaid | 30% Uninsured | 6% Medicare | 4% Comm.
 - Approximately 18% of patients considered homeless

Norwalk Community Health Center Mobile Medical Unit

- Integrated medical and behavioral health team
- Staff
 - FP APRN | LCSW | Medical Assistant | Eligibility/Registration | Patient Navigator | Dental Hygienist
- Visits community partners on a regular schedule
- Provides comprehensive medical visits
- Weekly time dedicated to patient review with full team
- Provides about 1,000 visits per year

Norwalk Community Health Center Mobile Medical Unit



COMMUNITY CARE TEAM DEVELOPMENT, IMPLEMENTATION AND SUSTAINABILITY

K. Tait Michael, MD
Western Connecticut Health Network

Community Care Team

A Population Health Strategy: When all else fails, do what is right.

Objective: Provide patient-centered care and improve outcomes by developing wrap-around services through care planning and multi-agency partnership

Core understanding: Community collaboration is necessary to improve health outcomes for high-risk populations

Phase I - Development

- Hospital leadership buy-in
 - Review highest ED and inpatient visitors
 - Calculate potential cost savings
- Convene CCT Strategic Planning Meeting
 - Identify stakeholders – (cast a wide net)
 - Send invitation letter
 - Develop the imperative
- First meeting – convene shortly after
 - Review and pass charter
 - Review and distribute ROI
- Hire Navigator or Health Promotion Advocate
- Identify target population



ED Utilization – Norwalk Hospital

40 patients, one year:

1376 ED visits

765 EMS rides

- Seven of the top ten had primary diagnosis of Alcohol Use Disorder accounting for 476 visits
- Alcohol, substance abuse = 66% of total visits
- 35% either homeless or at risk
- Medicaid = payer for 50% of patients, 60% visits
- 43% followed at local community health clinic
- 18% had no primary care provider



Stakeholders

- Community Hospital, representatives from:
 - Emergency Department, Psychiatry, Population Health
- Mental health clinics (state run and private)
- Substance abuse treatment centers
- Medical clinics/FQHCs
- Local shelters and soup kitchens
- Faith-based organizations
- Local Health Department
- Department of Human Services
- Department of Housing
- Police Department
- EMS



Invitation

October 1, 2014

Dear All,

As you are all undoubtedly aware, the delivery of mental health services in the state of Connecticut and throughout the country is in a state of crisis. We are seeing growing numbers of individuals suffering from mental health and substance abuse disorders and at the same time the resources available to treat these disorders are shrinking. There are increasing numbers of chronically mentally ill people who are incarcerated or who find themselves homeless. In many states there are more mentally ill people incarcerated than in long-term psychiatric treatment. A 2010 Substance Abuse and Mental Health Service Agency (SAMHSA) survey reported that, 26% of the homeless population was severely mentally ill and 35% were abusing or addicted to substances. The shift of housing the mentally ill or individuals suffering from substance abuse issues to our prison system is largely due to the national closure of state psychiatric hospitals and residential treatment centers. In addition, we are seeing overcrowding of our homeless shelters, mental health clinics, and emergency rooms and increasing pressures on our community social service agencies, law enforcement, community health centers, and emergency medical services to do more with less as we collectively try to care for these vulnerable populations.

As psychiatric inpatient resources continue to contract, we must maximize the efficiency and effectiveness of our outpatient programs and supports. We are writing to you, the providers of community services to the mentally ill, chronically medically ill and substance abusing populations, to request your active participation in the development of the Danbury Community Care Team (CCT).

Community Care Teams are population based models that seek to improve quality and access to care, improve the health of a population and reduce excessive cost by identifying those at greatest risk for poor outcomes. CCTs have been implemented with success in other Connecticut Communities. On September 18th, the Danbury Housing Partnership in collaboration with the City of Danbury presented the *Strategic Plan to End Chronic Homelessness*. One of the recommendations was to develop a local CCT to improve health outcomes and effective use of health services for individuals who are homeless, or who are at risk for homelessness.

To date we have had volunteers willing to assist in guiding the development of the CCT: Rowena Bergmans, VP of Clinical Integration & Population Management, Western Connecticut Health Network (WCHN); Sandy Cole, MSW, LCSW, VP of Catholic Charities; Judith Simon, JD, Director of Housing and Economic Development, CIFC; Katherine Michael, MD, WCHN; Anna Maloney, Greater Danbury Community Health Center, CIFC and Michele Conderino, MSW, Director of Homeless Services, Catholic Charities.

Participation by community agencies is critical to the success of the CCT. A successful Danbury CCT will not only benefit the populations we serve but also the community agencies participating in the collaborative by increasing efficiencies in how we deliver medical, mental health and housing services.

We are seeking your support and asking that you attend the first meeting of the Danbury Community Care Team. It will be held on Wednesday, December 10, 2014 from 10:00am – 12:00pm at Danbury Hospital in the South Building, 4 South Classroom. Please RSVP to DrKTMichael@gmail.com.

Sincerely,



Charles Herrick, MD
Chairman, Behavioral Health Danbury




Rowena Bergmans
VP, Clinical Integration & Population Health

Katherine Michael, MD
Physician Consultant



Strategic Planning Meeting – Agenda

- Allow at least 90 minutes
- Review history and identify current need
- Describe CCT structure
- Introduce stakeholders and gauge interest in participation
- Review plan for CCT Operation including
 - Charter
 - ROI
 - Target Population
 - Goals
 - Meeting frequency
- Collect current contact information
- Set a date for the first meeting

Phase II – Implementation

First Meeting

- Review and pass Charter
- Distribute Release of Information
- Review Target population
- Begin discussing patients
 - Presentation
 - Needs assessment
 - Care Plans
- Documentation
- Review next steps

CCT Operation

1. Identify target population
 - Homeless or Emergency Department frequent visitor
2. Obtain consent for release of information
3. Research the individual's history and identify needs:
 - Mental health, medical, substance, housing, legal, insurance
4. Present to the team and develop plan for meeting needs:
 - Treatment, housing, insurance, social support, linkage to medical and mental health treatment
5. Implement Plan: community outreach or in engagement in ED
6. Track outcomes: housing, linkage to care, acute care utilization

Release of Information

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

Name of Patient: _____ **DOB:** _____

I hereby authorize the Western Connecticut Health Network (WCHN)/Danbury Community Care Team and any of the Community Care Team's Members listed on the attached page to disclose to, or receive from, any other Community Care Team Member the following confidential medical information:

My entire medical record

The following limited health information:

Other: _____

In addition to the above, **I hereby specifically authorize** the Community Care Team to disclose the following information:

Psychiatric (not psychotherapy notes)

Patient Initial: _____

Alcohol and/or drug abuse

Patient Initial: _____

HIV/AIDS

Patient Initial: _____

Purpose of Disclosure

The medical information disclosed shall be disclosed for the purpose of coordinating clinical treatment planning among the Community Care Team.

Release of Information – cont.

Authorization Duration and Revocation

I understand that I may revoke this Authorization at any time by providing written notice to WCHN. I understand that I may not be able to revoke this Authorization with respect to information for which the Community Care Team or a Community Care Team Member has already taking action in reliance on the Authorization.

This Authorization's Effective Date is: _____, If not previously revoked, this Authorization expires one (1) year from the Authorization's Effective Date.

Authorization Terms

I understand that no provider of services will condition treatment, payment, enrollment or eligibility for benefits based on my signing this Authorization. I acknowledge that I am signing this Authorization freely, and no one has coerced or pressured me to sign this Authorization.

I understand that the medical information disclosed under this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal or state law.

I understand that if the medical information disclosed under this Authorization is **confidential HIV/AIDS related information** or alcohol or drug abuse related information, **Federal and state law prohibits the recipient from re-disclosing such information** without the specific written consent of the discloser. I understand that a general authorization for the release of medical or other information is not sufficient to permit the disclosure of HIV/AIDS or alcohol or drug abuse related information.

I have been provided a copy of this Authorization.

Patient Signature

Date

Parent or Guardian Signature* (if applicable)

Date

*Authority to Sign on behalf of Patient (supporting documentation may be required)

Needs Assessment

History:

- Reason for presentations
- Medical, psychiatric, substance use, social history

Gaps in services:

- Acute treatment, housing, insurance, linkage to primary care or specialty services, wrap-around social services

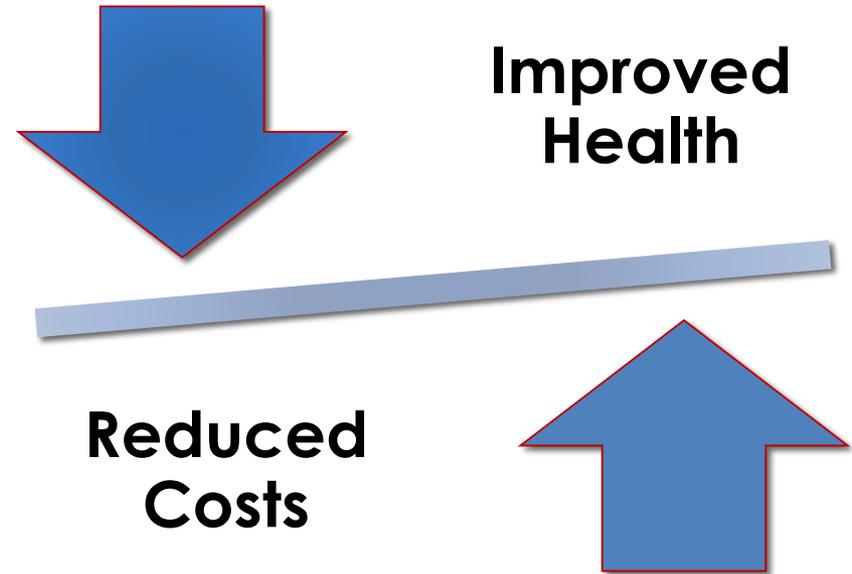
• Specific Recommendations:

- Medications to use or to avoid
- Contacts to notify: primary care, case manager etc.
- Treatment to initiate: detox, psychiatric, commitment etc.

Outcomes

Statistics we follow:

- Insurance status
- Housing status
- ED visits
- Inpatient Admissions
- Arrests, legal issues
- Cost data
- Connection to Community Services



Phase III - Sustainability

- Dedicated Navigator is essential
- Maintain community enthusiasm
 - Benefits of collaboration
- Follow and report outcomes
- Gain traction and expand
 - High Risk Navigator
 - Peer Recovery Specialist
 - Hot-spotter Team



Norwalk CCT Retrospective Review

Original Population (30 patients)

Service	Baseline	Year 1	Year 2	Change over 2 years
ED	1120	623 (-44%)	584 (-6%)	-48%
Inpatient days	450	375 (-17%)	281 (-25%)	-38%

Tier Two Population (115 patients)

Year	AMV Q1	AMV Q2	AMV Q3	AMV Q4	Annual
2015	1.25	1.19	1.41	1.24	1.273
2016	0.895	0.935	0.985	0.888	0.925
Change	-0.30	-0.27	-0.23	-0.30	-0.27

AMV = Average Monthly ED Visit

OUTCOMES

JEANNETTE ARCHER-SIMONS
NORWALK OPEN DOOR SHELTER

Activities

- Coordinated assessment
- Weekly meetings to discuss most challenging cases.
- Coordinated management of medical/treatment visits.
- Collective effort to monitor and achieve medication management goals.
- Provide workshops on health issues (smoking cessation, diabetes)
- Deliver assessment required for supportive housing applications.

Activities

- Provides access to healthcare in low income/multi-lingual neighborhood to individuals receiving food and other social services but not sheltered.
- Prevents homelessness.
- Adding respite beds to prevent homelessness.
- Leadership works collectively to advocate for additional mental health/addiction support in the homeless/poverty system.
- Collective impact discussions to change system challenges.

Impact

- Health/Mental health:
 - Identify issues and services needed.
 - Case managers partner to monitor health management.
 - Improved behaviors within shelter.
 - Reduced aggression.
 - Increased willingness to consider a program.
 - Sheltered children miss fewer days of school.
- Housing:
 - Stabilized clients for housing appointments.
 - Increased housing placement.

Impact

- Tools and information
 - Case managers have a partner in managing behavioral health and health issues.
 - Collaborative solutions are developed because of the ongoing conversations.
 - Slippages are documented and managed before they are out of control.
- Community
 - Law enforcement makes fewer calls/sees the results in reduced street challenges.
 - Client are not “raving” on street corners. Business owners see improved community.
 - Leaders recognize the community partnership as a process to solve a problem.

Outcomes

- Reduced length of stay in shelter by half.
- Lower incident of aggressive/inappropriate behaviors.
- Staff are better trained and supported in their work to achieve housing goals.
- Managed core health issues – clients feel better.
- Families begin managing healthcare with their children.
- Shelter is viewed as a center for meaningful, problem solving services.

Outcomes

- Housed clients:
 - Are more stable. Less likely to return to homelessness.
 - Addiction management begins and there is more willingness to consider detox programs.
 - Co-occurring mental health support results in stable behaviors that affect the success of addiction programs.
 - Some clients become employed.
 - Builds community for the client – gain independence to manage their own well being.

Future Outcome

- Job training program
 - Health access on site.
 - Healthier low income and homeless community participate in job training.
 - Fewer missed days of work because of health services for adults and children.
- Respite Beds

CASE EXAMPLES

STACI PEETE, LCSW

WESTERN CONNECTICUT HEALTH NETWORK

Client RR

Before CCT

- Untreated Paranoid Schizophrenia
- Not connected to service providers
- Homeless, living in a park
- 16 ED visits and 4 inpatient stays in the preceding year

After CCT

- Connected to outpatient psychiatry
- Taking medications
- Connected to primary care, drop-in center and shelter
- Obtained Housing, October 2015
- 0 ED visits or inpatient stays

Client OA

Before CCT

- Became homeless
- Declining physical health
- Active substance abuse
- Legal problems
- 22 ED visits and 22 inpatient days

After CCT

- Completed detox and inpatient program
- Improved physical health
- Transferred probation to Florida
- Moved to Florida with family
- No ED visits or inpatient stays

Questions?

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