Community Care Team

Integrated Care Delivery for Vulnerable Populations : Universal Consent Form

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HEALTH CARE

Objectives

- Design care delivery system to meet the triple ain
- To find successful strategies to create community care teams to better meet the needs of high risk individuals in our community
- Share successful examples of our journey to care coordination across our community

Transitional Care Program

- Redeployed hospital based nurses to become transitional care nurses partnered with primary car provider offices
- Navigating high risk, high cost patients (medicatior management, symptom management and educatic
- 10 other programs 8implemented since onset of program
- Partnered with 1224 patients from across service area

Appreciation for Middlesex Hospital

- 57% reduction in Inpatient and ED visits
- Improved quality of life for patients
- Linkages (healthcare services, housing, support)
- Collaboration (hospital, community agencies, relationship building)

Community Care Team

- Objective: To develop patient centered care and improve outcomes by developing wrap-around services through multi-agency partnerships and care planning.

Guiding Principles

- Core Belief: Community collaboration is necessary to improve outcomes and meet the needs of the patients.
- Core Understanding: Psycho-social problems are community problems. No one entity alone can effectively improve outcomes for this population.

It takes a village . . .

BROC COMMUNITY ACTION
In Southwestern Vermont

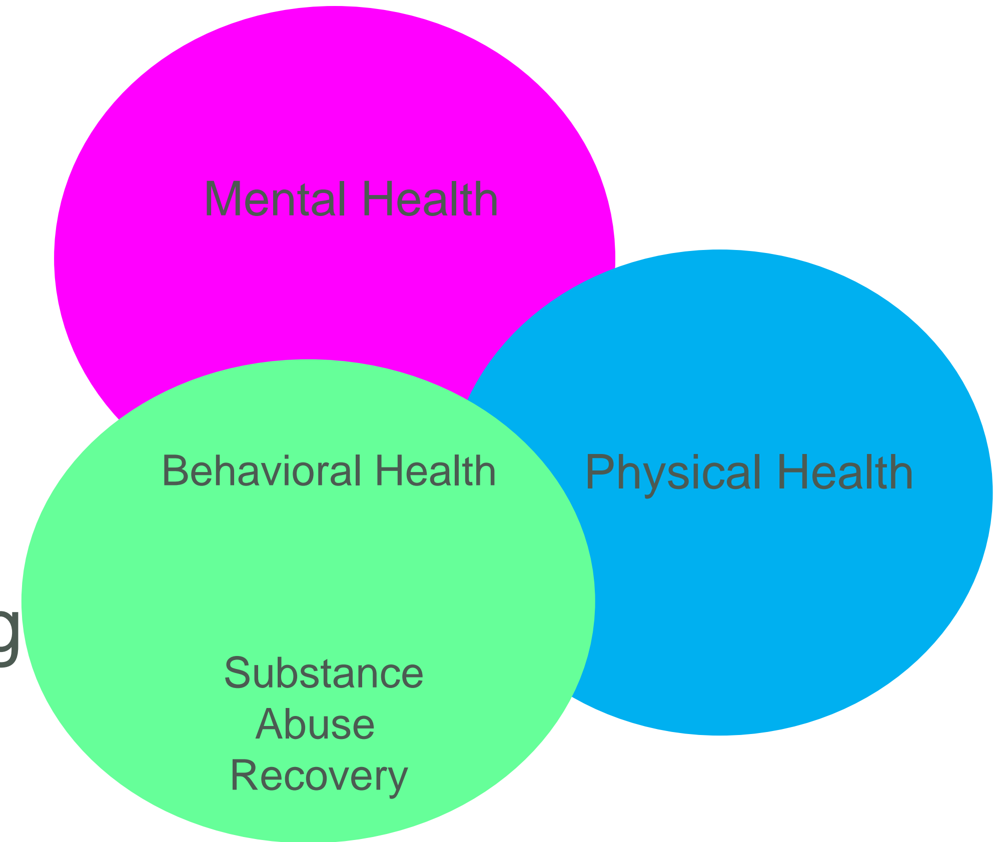
Patient Mix

- Dual Diagnosis
  - Co-existing severe mental illness and substance abu
    disorders
- Chronic Mental Illness
  - Bi-polar, schizophrenia, schizoaffective, borderline
- Chronic alcoholism
  - Alcohol intoxication with/without suicidal ideation
- Other Drug Dependence
  - Opioids; cocaine with/without suicidal ideation

Photo reference: https://namica.org/resources/mental-illness/types-mental-illness/

Common themes

- Behavioral health problems
- Disjointed care/lack of care coordination
- Poor primary care connections
- Housing issues
- Lack of social network
- Non-compliance (meds, follow-up, discharge instructions)
- Loneliness/hopelessness
- Use of ED as “home”



Our Major Collective Challenge

- This population does not get better with t
  traditional model of episodic care delivery
- They tend to “fall through the cracks”
- Lack of interagency Care Coordination
- Consume disproportionate share of resources
- Individualized care plans must be flexible and evolve

Health Promotion Advocate

- One year grant-funded position (VHCIP)
- 40 hour: 10am-6pm position (ED=home base)
- Care coordination and case management
- Direct and indirect referrals
- Works closely with ED providers and nurses
- Resource to connect with community agencies

Community Care Team / Health Promotion Advocate

- Navigate the healthcare system
- Explore choices for care
- Resolve problems you are experiencing (food, shelter, safety)
- Discuss financial assistance options
- Coordinate care and coordinate special needs

https://stories.marquette.edu/navigating-the-health-care-system-2871d425366e

Meeting format

- Research patient histories/background prior meeting
- Review present status and share updates with team
- Brainstorm best care management strategy
- Develop care plan (treatment, housing, insurance, case management, economic status, wrap around plan)

Release of Information

- Sample document from Middlesex hospital used as a guide
- Review by hospital attorney
- Lists agencies represented/included
- No police/probation officer
- Patient must provide consent prior to being discussed at meeting

Legal and Safety Officer Review

- Compliance officer
- Patient confidentiality
- Information on screen, no printed docume
- Strict adherence for participation to list on consent
- Consents required by any patients discussed

Other Safe Guards

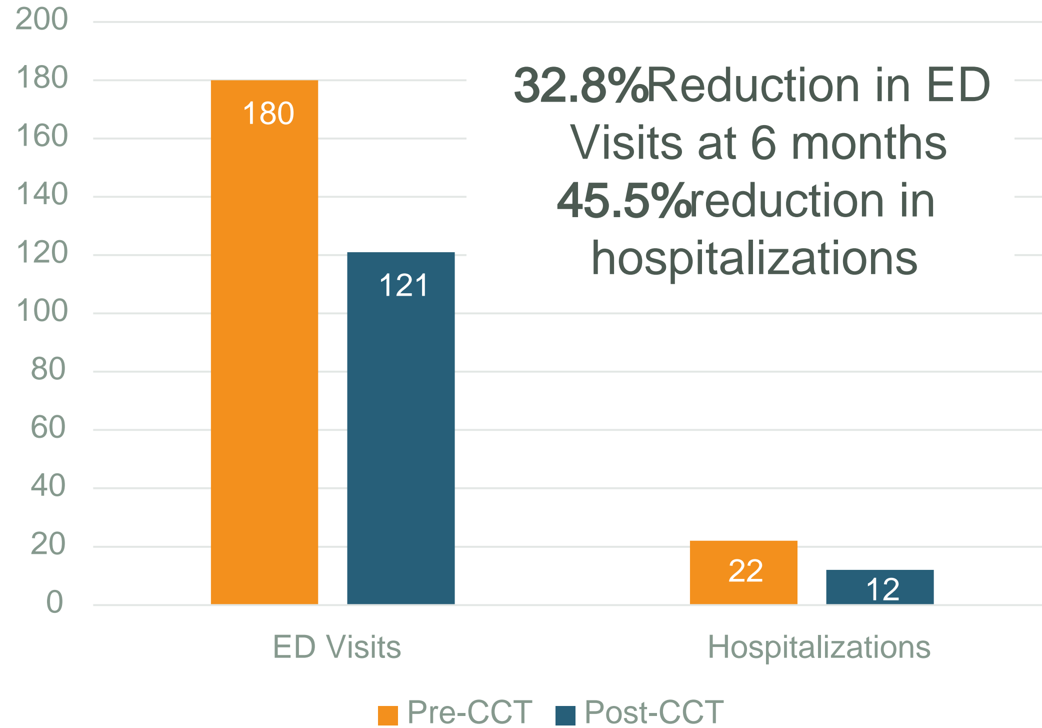
- HIPAA and confidentiality re-education of all team members
- Agencies call to find out patients to be discuss
- Consent forms kept on file, update consent on an annual basis
- New team members from agencies (training/conse prior to participating)

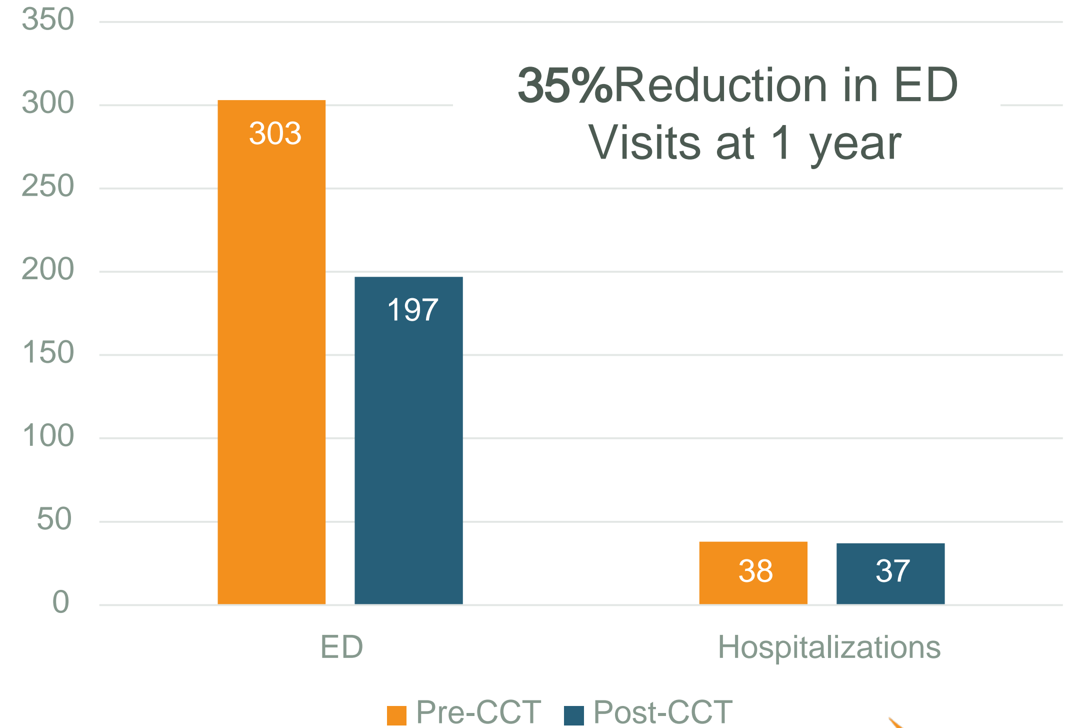
Challenges

- Engaging everyone to participate
- Discouraging "monopolizers"
- Finding the right person for HPA role
- Support and buy-in from ED team
- Sharing information broadly
- Educating care team to refer cases

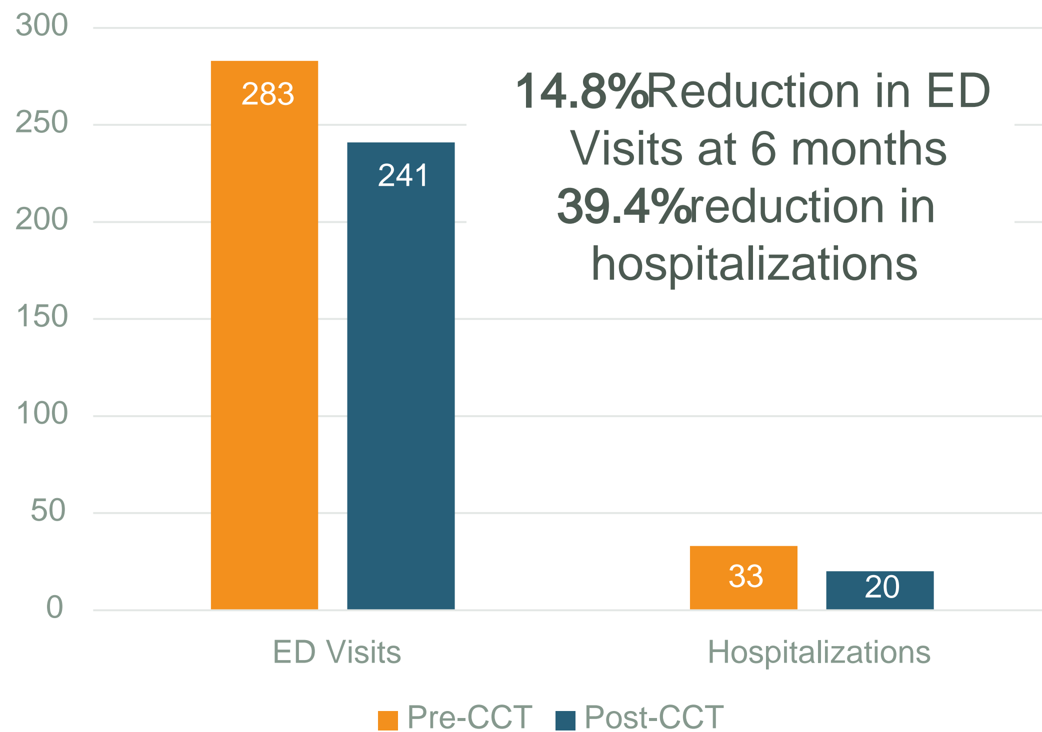
Reduced emergency department visits by 44%

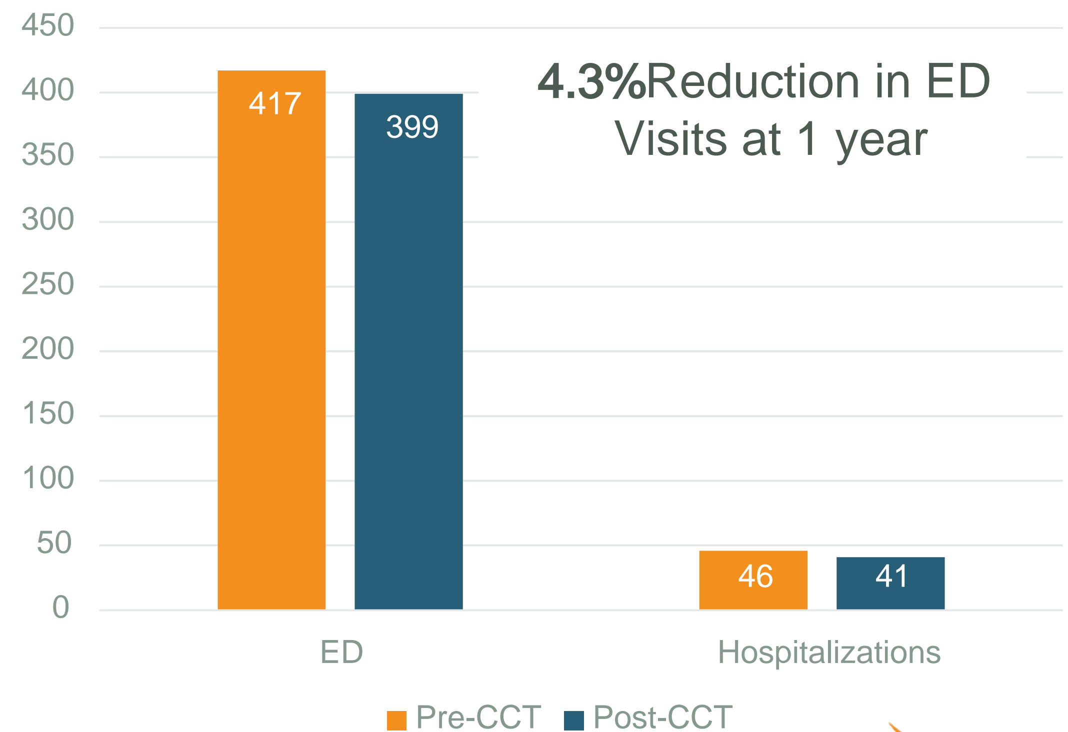
2017 Data





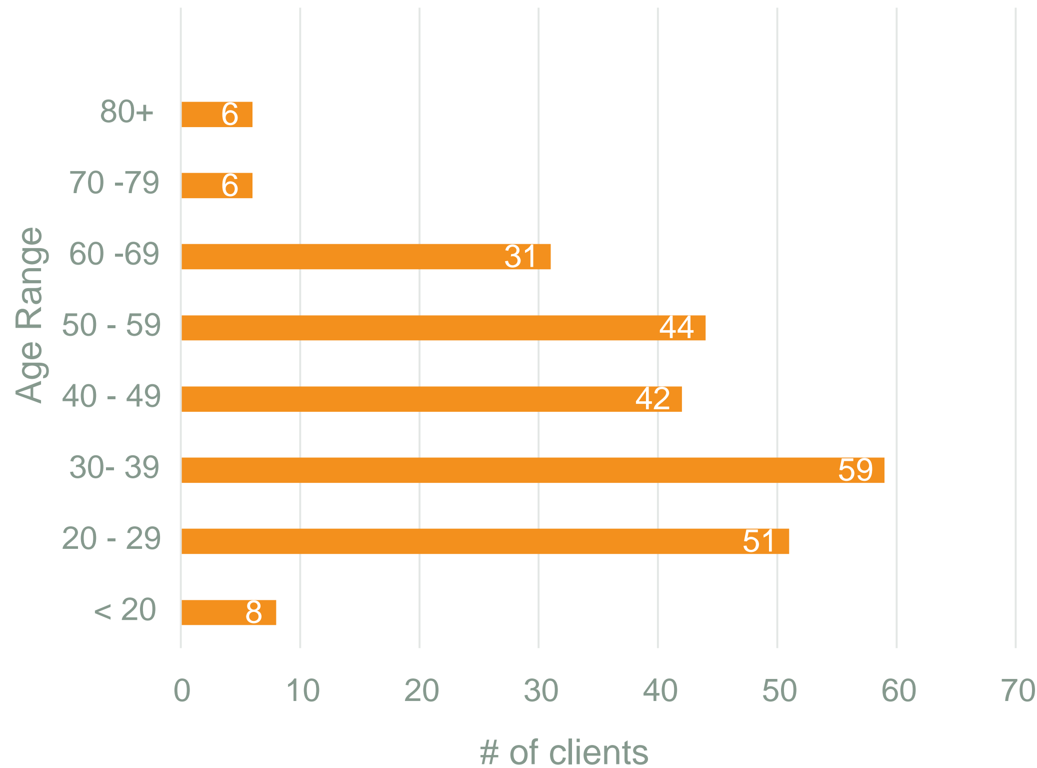
2018 Data

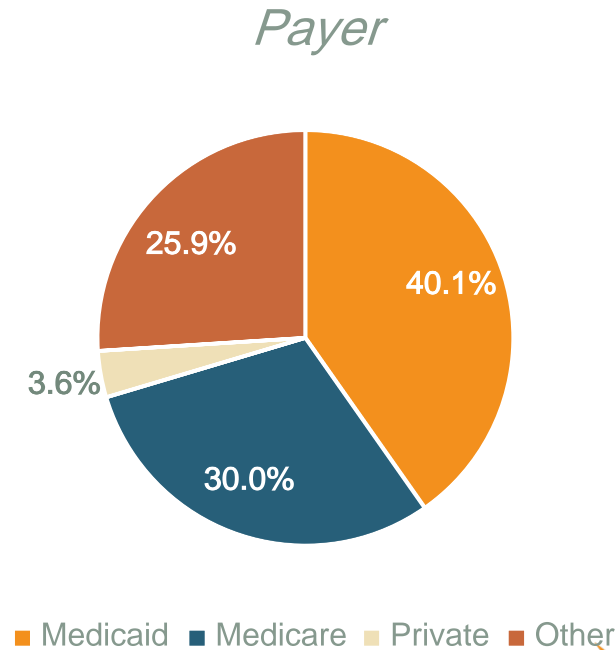




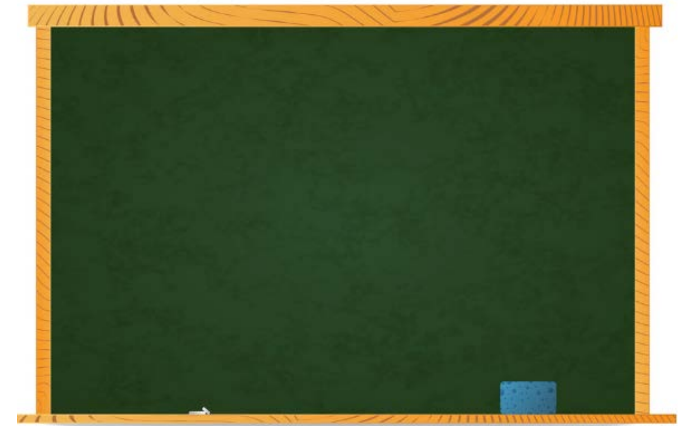
CCT Clients at a Glance

- **247** clients served from 2015-present
- **56.7%** female; **43.3%** male
- **94.7%** of clients live in Vermont





Lessons Learned



- Leave egos at the door
- Procced with patience…takes time to navigate and negotiate
- Engage partners early in the process
- Build on existing structures and maximize use
- Shared decision-making = critical to success
- Meet patients where they are without judgement
- Focus on the needs and wants of the individual, not the disease

https://www.vectorstock.com/royalty-free-vector/empty-green-school-chalkboard-in-wooden-frame-with-vector-18658419

5 Steps to Address Social Comorbidities

1. Health systems commit to real clinical integration of social needs
2. Develop a workforce that is truly focused on addressing social needs
3. Give the workforce the information they need to do their jobs well
4. Commit to follow-up
5. Collect and analyze data

Photo reference: https://kimfoard.com/purpose/want-success-steps/

Pediatric Community Care Team

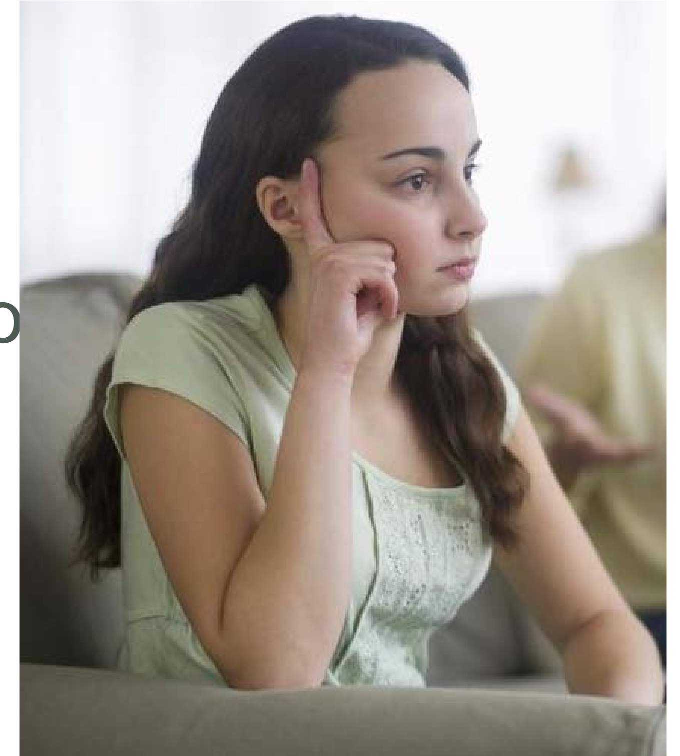
- Social worker (20 hrs.) in Pediatric practice
- Monthly meeting with community partners, schools, counselors to crea integrated care plans for high risk children/families
- Conception– 6 years old
- 7-19 years old
- Care plans created in Care Navigator

YSBIRT

- Youth, Screening, Brief Intervention, Referral to Treatment (Based on SBIRT program used in ED)
- Grant funded program
- Pilot project in one pediatric office and Express Care
- Screening for 12-24 years old
- Counselors/Screeners are part of PCCT
- Meet with individuals immediately
- Connecting with community and schools

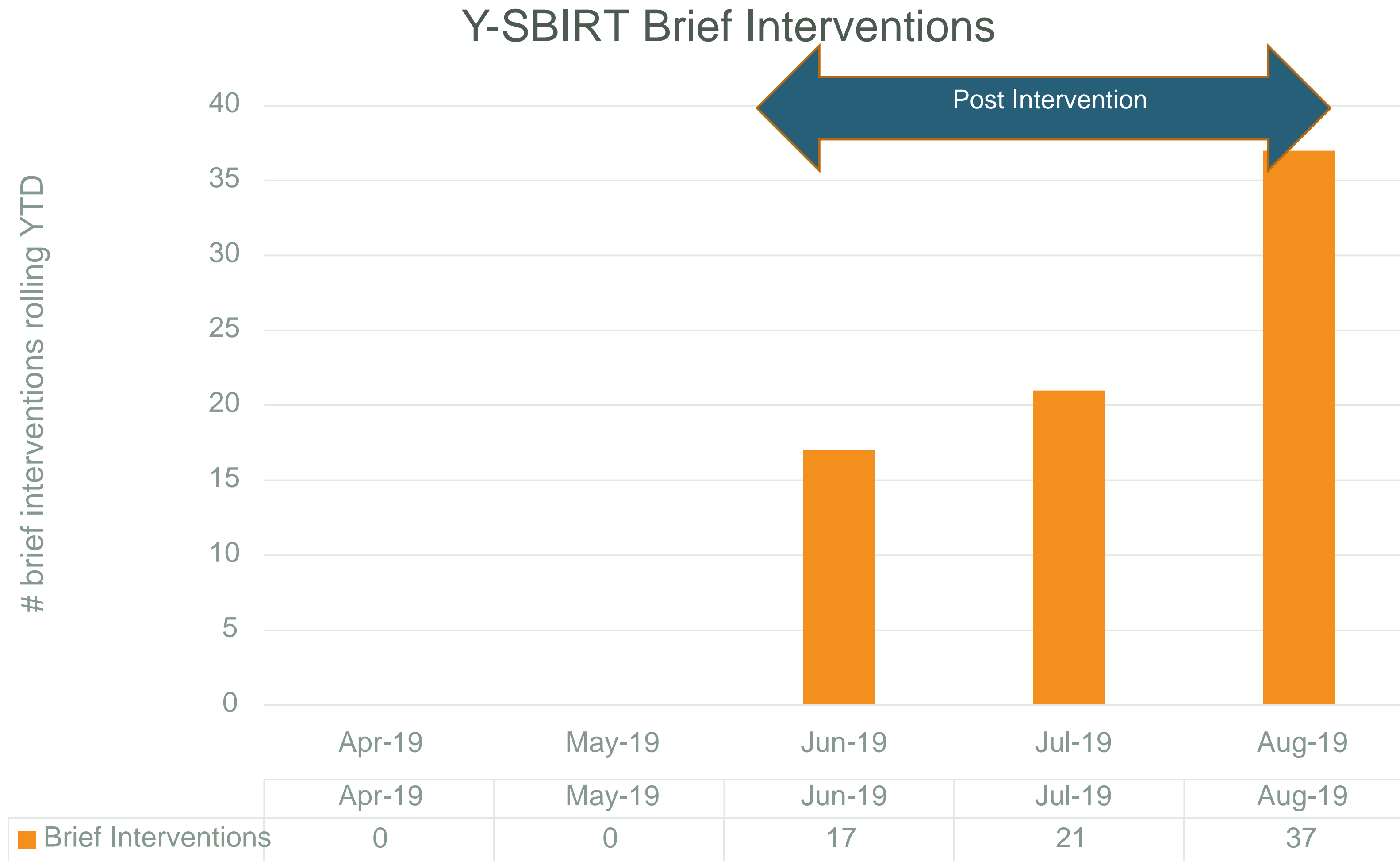
YSBIRT-May 2019 to September 2019 results

- 277 individuals screened
- High rate of depression/anxiety
- 15% suicidal thinking (some to ED for evaluatio
- Few homicidal thoughts
- Providers appreciative of support in office



https://www.verywellfamily.com/teach-teens-anger-management-skills-2609114

YSBIRT- Brief Interventions



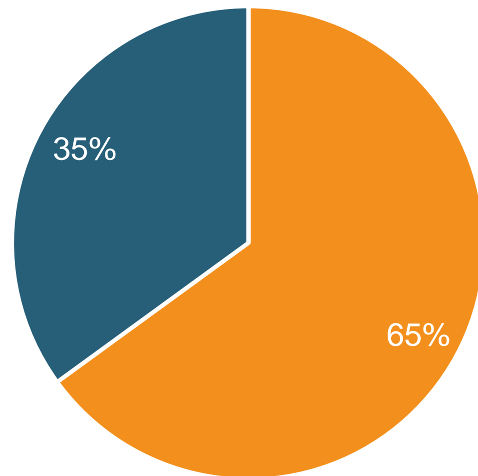
	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Brief Interventions	0	0	17	21	37

YSBIRT Data 5/15/19–9/6/19

Youth 12–17

Any Alcohol or Other Drug (AOD) Risk

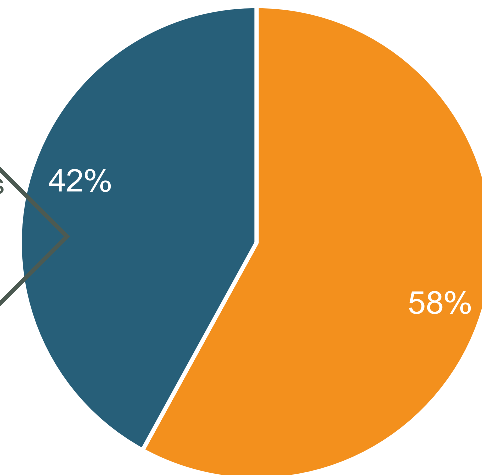
Of the *35% (58)* of patients who screened yes:
- *48%* received brief intervention
- *1.7%* received brief treatment
- *1.7%* received referral to treatment



18–24 years old

Any Alcohol or Other Drug (AOD) Risk

Of the *42% (27)* of patients who screened yes:
- *70%* received brief intervention



AOD: includes tobacco

Psychiatric Urgent Care for Kids

What we knew at the time:

- 4th Q 2018, 294 children seen in the ED
- Average LOS 20 hours, up to 31 days
- 82% of the children seen are sent home
- Numbers were increasing as well as the intensity of behaviors.
- Many of the children go to the ED directly from local schools

Psychiatric Urgent Care for Kids

- Almost 8 year old girl
- Since beginning of school banging head, dysregulated, not able to attend or participate, increasing over the first 10 days of school
- FES to Urgent Care
- Parent engaged
- Psychiatric consult with PCP and resulted in an immediate medication change
- Full intake for services completed by parent
- Follow up next day with onsite school observation and check in with staff
- She was able to attend and participate in group.

Psychiatric Urgent Care for Kids

- Expected Outcomes
- Next Steps

SBINS Screening in the ED and Express Care

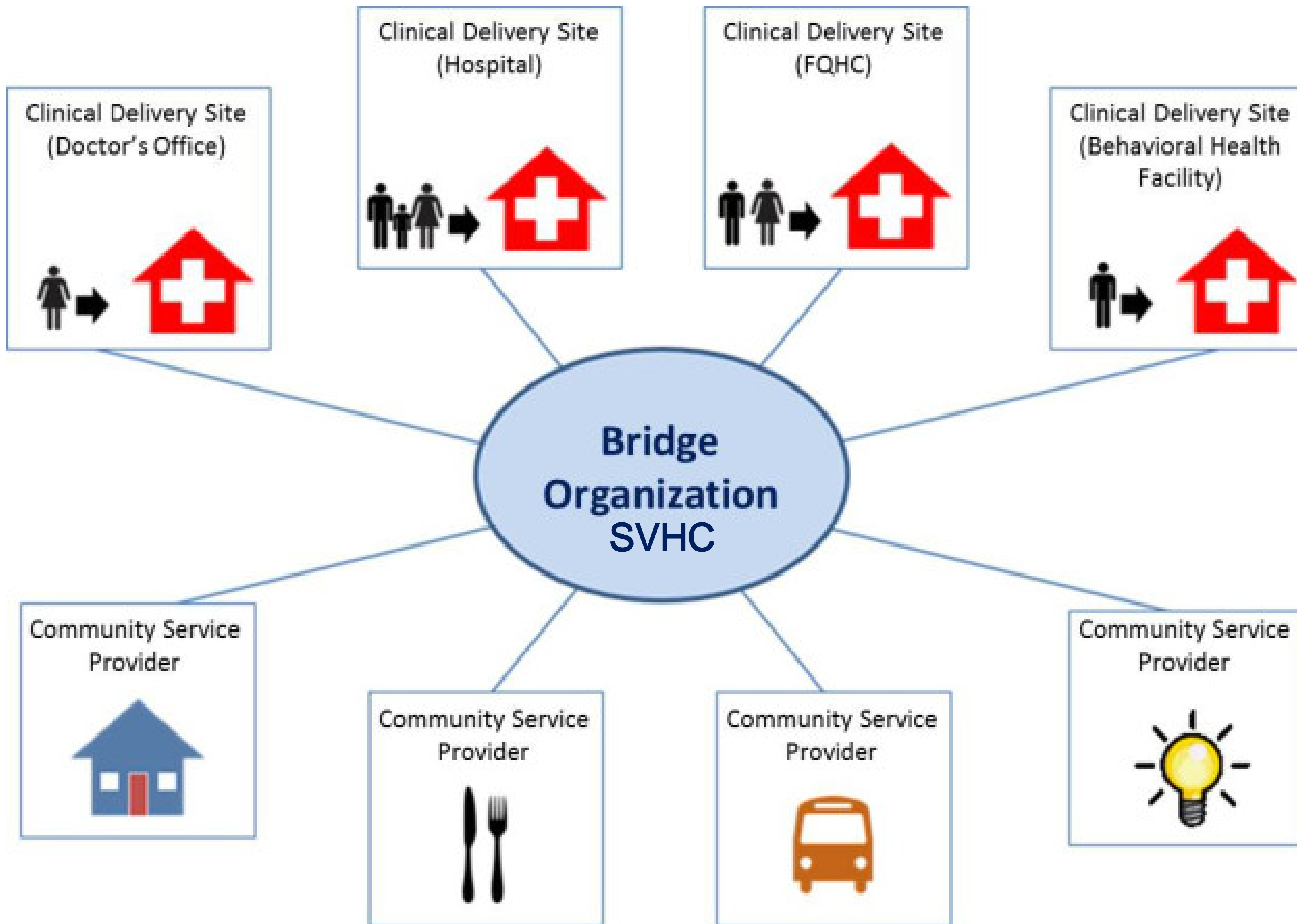
Definition : The Screening, Brief Intervention, Brief Treatment and Navigation to Services (SBINS) model ensures that Vermonters have timely access to care for mental health and substance use disorders and health-related social needs.

Goal: To produce a positive impact on well-being, the SBINS model is comprised of

5 core components

- Systematic Screening
- Same-visit brief interventions
- Brief treatment and navigation services
- Formalized referral relationships
- Continuous quality improvement

Photo reference: https://www.mhanational.org/b4stage4-get-screened



https://blog.cms.gov/2016/01/11/can-helping-patients-social-needs-also-be-good-for-their-health/

QUESTIONS?

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