Community Coordination of Care (C³) Initiative

Stakeholder Kickoff Meeting
Tuesday, April 10, 2018
9:00 – 11:00 a.m.
United Way of Greater Houston
Mission Statement

The purpose of the Network of Behavioral Health Providers is to provide a forum for the leadership of Houston’s mental health and substance use providers, both public and private, to communicate, coordinate, and collaborate to improve the community’s behavioral health system.
NBHP’s Goals

• Provide formal programming and training and informal networking for the greater Houston behavioral health community

• Advocate on behalf of the behavioral health provider community and the 100,000s of individuals they serve

• Be the “voice for behavioral health providers” in the community
## Members

| Association for the Advancement of Mexican Americans (AAMA) |
| Avenue 360 Health and Wellness |
| Baylor College of Medicine Teen Health Clinic |
| Behavioral Hospital of Bellaire |
| Career and Recovery Resources |
| Catholic Charities of the Diocese of Galveston-Houston |
| Cenikor Foundation |
| The Center for Success and Independence |
| The Council on Recovery |
| Covenant House Texas |
| DePelchin Children’s Center |
| EL Centro de Corazon |
| Family Houston |
| Fort Bend Regional Council on Substance Abuse |
| The Harris Center for Mental Health and IDD |
| Harris County Protective Services for Children and Adults |
| Harris County Psychiatric Center |
| Harris Health System |
| Healthcare for the Homeless-Houston |
| HGI Counseling Center |
| Hope and Healing Center and Institute |
| Houston Recovery Center |
| Interface-Samaritan Counseling Centers |
| IntraCare Behavioral Health |
| Jewish Family Service |
| The Jung Center |
| Kingwood Pines |
| Krist Samaritan Center |
| Legacy Community Health |
| Memorial Hermann Behavioral Health Services |
| The Menninger Clinic |
| Mental Health America of Greater Houston |
| The Montrose Center |
| NAMI of Greater Houston |
| Open Door Mission |
| The Salvation Army |
| Santa Maria Hostel, Inc. |
| SEARCH Homeless Services |
| SUN Behavioral Houston |
| Vecino Health Centers |
| Volunteers of America Texas, Inc. |
| West Oaks Hospital |
| The Women's Home |
•The Power and Value of Care Coordination
What, Why & How???
What: Care Coordination

• SAMHSA definition:

• Care coordination involves bringing together various providers and information systems to coordinate health services, patient needs, and information to help better achieve the goals of treatment and care.
Why: To improve client outcomes

• By better understanding client needs
• By knowing and being in communication with other providers serving our clients
How: Sharing

• Sharing information and data between providers serving our clients
Houston Recovery Center Client Analysis

Houston Recovery Center data from April 10, 2013 to report date

- 70% - 2 or less visits
- 30% - 3 or more

The 1,463 "high utilizer" clients admitted account for 35% of total clients served.
Untold Story

Houston Recovery Center
Service Usage Pattern

- One Client Profile
- Transported 80 times
- To 7 different Emergency Centers
- In 8 months – between January & August, 2013

Thanks to Cpt. Karen DuPont with HFD
Care Coordination Planning Team

Houston Recovery Center
Care Coordination Planning Team

- Created in September, 2013

- The team meets quarterly to discuss data sharing and care coordination of clients who are familiar to us.

- Many community partners are involved in the conversation and solution building to improve the quality of life and care delivery to these vulnerable clients who most commonly frequent our services.
What We’ve Learned

- Many of our clients are also clients of other service providers
- This is often unknown to the other providers
- No one was watching or tracking this behavior
- Care coordination is important for high utilizers who often do stabilize given time
A Vision Whose Time Has Come

CARE COORDINATION

ALICIA KOWALCHUK, DO, FASAM
OBJECTIVES

• Describe the social determinants of health and their impacts on the health of our communities through the lenses of trauma and substance use.
• Discuss the role care coordination plays in addressing social determinants to improve the health and well being of communities.
SOCIAL DETERMINANTS OF HEALTH

Healthy People 2020, www.healthypeople.gov
Mental Health in My Community

It's OK to talk about mental health.

Get help if you need it.

Help is available and effective.

If you know someone in need, help is available.

Nearly two-thirds of the 45 million U.S. adults over 18 years old with any mental illness went without treatment.

Almost 21.6 million persons over 12 years old in the U.S. needed treatment for a substance use problem.

Mental health issues result in an estimated $193 billion in lost earnings.

The cost of treatment for mental health issues is equivalent to the cost of cancer care.

Nearly 1 out of 4 community hospital stays involved a mental or substance use disorder.

$247 billion annual estimated cost of mental and emotional problems among young people.

1/2 of adult mental health problems begin before age 14.

3/4 of adult mental health problems begin before age 24.

Supportive and meaningful relationships help build resilience and well-being.

Suicide is the 3rd leading cause of death for youth ages 15-24.

Find more information at:
Click Here for Citations
COMORBIDITIES ARE COMMON

- 50% of people with SUD will have a mental health diagnosis
- 50% of people with a mental health diagnosis will have SUD
- Estimated 8 million Americans living with co-occurring disorders

- Having SUD or other mental illness increases risk of developing and decreases effective management of a host of chronic physical diseases
- Chronic physical illnesses can lead to and worsen SUD and impact other mental illnesses
TRAUMA IS COMMON

• ACE study showed nearly two thirds of study participants had at least one trauma and 1 in 5 had 3 or more
  • 'dose response': more trauma, more likely to have (and have multiple) health, mental health and SUD problems in adulthood in addition to poorer educational, employment and relationship outcomes
  • Largely middle-class, Caucasian adults with health insurance
• ACE traumas: childhood abuse (experienced/witnessed), neglect, deprivation, parent with SUD/mental illness, divorced parents
• Traumas not accounted for in ACE: any experienced as adult, micro-traumas, -isms trauma
THE OPIOID EPIDEMIC

- Overdose is THE leading cause of death for people under 50 in the US
- US overdose deaths in just 2016 (64K) exceeded:
  - total US casualties during the entire Vietnam War (58K)
  - AIDS-related deaths in 1995, worst year of AIDS crisis, (51K)
  - Peak year, 1991, of US homicides, (25K)
  - Suicides, rising for past 30 years (to 44K in 2015)
- For the first time in modern US history, life expectancy rates decreasing for younger generations, primarily driven by overdose deaths
EXPLORING CARE COORDINATION

Dora: 32 year old, bilingual Latina, admitted to Santa Maria Hostel’s WHO program
• 7 months pregnant, no prenatal care
• paraphernalia charge
• Daily IV heroin and MJ; cocaine or methamphetamine once or twice a week
• Homeless (stays alternatively at sister’s apartment or with friends)
• unemployed (last worked as club hostess)
IT TAKES A VILLAGE

- legal aid
- prenatal care
- SUD treatment, including OUD MAT
- housing services
- employment services
MORE ABOUT DORA

Grew up on the East End, father in and out of household, AUD, violent; mother worked as office cleaner in evenings and school cafeteria during day; 2 older brothers, one younger sister; oldest brother’s best friend moved in with family, helping with rent, and molested Dora (age 6) and younger sister (age 5) until incarcerated for drug dealing when Dora 9 years old.

Dora started MJ and ‘bars’ at 11; began cutting by age 14; first suicide attempt at 15 (alcohol and ‘bars’)

First pregnancy at age 16yo and dropped out of 10th grade, functionally illiterate, left home, using cocaine MJ and alcohol; CPS placed infant in foster and Dora lost parental rights, second suicide attempt post partum (swallowed a baggie of cocaine)

Four subsequent pregnancies (1 termination dealer/bf paid for, 1 miscarriage after dv incident with same bf, 1 child placed with Dora’s sister who is doing ok)
SOME VILLAGES ARE BIGGER...

- prenatal care
- SUD treatment, including OUD MAT
- legal aid
- housing services
- employment services
- mental health services
- literacy/GED/job training
- parenting skills
- transportation
BARRIERS TO CARE COORDINATION

- Cost, reimbursement, and ‘ownership’
- Lack of knowledge of other resources
- Limited resources across systems
- Privacy concerns
- Liability concerns
- Transportation
- Stigma and traumatizing care
- Lack of self-care
- ‘Wrong doors’

LACK of RELATIONSHIPS AND TRUST
FACILITATORS

• Co-location, integration
• Data sharing
• Interprofessional meetings and organizations
• Acceptance and trauma informed care
• Community engagement and support
• Robust self care encouraged within and across organizations
• ‘No wrong door’

BUILDING RELATIONSHIPS AND TRUST
THE CHOICE IS CLEAR

• Continue provision of uncoordinated services: continued same results
• Duplicate full spectrum of needed expertise, resources, and services within each service organization: resource and time intensive
✓ Coordinate existing resources and expertise to provide seamless service experience to our community
CHOOSING NOW

• If it’s broke, then fix it
• No resource ‘magic wand’
• Opportunity to lead
• Collaboration is regenerative
Our Mission is to improve healthcare quality and costs for the vulnerable in our community through data integration and care coordination.

Our Vision is to create a coordinated health safety net where all stakeholders share data to make better decisions.
PCIC’s origin

India street medicine
Houston street medicine
Health record for street medicine
Technology-driven care coordination addressing SDoH
who are complex patients?

$439,600 = Mr. J’s utilization in 1 year

- 76 Arrests $23K
- 44 visits to Houston Recovery Center $35K
- 6 bookings at County Jail $68.6K
- 95 visits to County Hospital $232K
- 65 EMS Transports $81K
We spend all our time and resources in clinical care. What about the remaining 80%? No connection of client needs to resources at the community level.
our solution
(for a Mr. J)

- Community database integrating medical and social data
  - Exposing overlaps in care
  - Opportunities for intervening

- Patient values based care plan shared with all agencies (medical and social)
  - Mapping out responsibilities across agencies with one plan

- Connect patient needs to resources in real-time
  - Meet in jail, connect to services, housing and medications

- Identifies barriers for system change
  - Continuity with meds, sobriety, treatment, primary care
community impact today

- 91 clients served
- $5.1M in cost avoidance
- 52% reduction in ER visits
- 16% improvement in quality of life measures
our partners
Continuum of care for Harris County’s most vulnerable patients

Care coordination *across* existing social and medical agencies
How it Works
Unified Care Continuum Platform

**Linking social and medical records**
*Community Data eXchange*
Discovery of how SDoH impacts your clients/patients through overlap analyses

**Connecting the right resource to right client at right time**
*Community Resource eXchange*
Provides real-time access to community resources that address health needs (social & medical)

**Client value-centered care coordination**
*Community Care Coordination*
Identifies clients’ goals and what’s important to them; one shared record used by all providers
why share data?

Better understanding of the client and their needs

Demonstrate impact

Cross agency accountability to the client

Make decisions with actionable data

Reduce duplication
thank you.
Houston Recovery Center
PCIC Dashboard

Suzanne Jarvis – Program Manager
Climents with high admissions rates into the sobering center:

1. How do we stabilize this population?
2. Which organization (s) are also seeing this population?
Houston Recovery Center: PCIC Dashboard

1,842 Clients

- Sobering Center frequent clients
- Program Clients
Houston Recovery Center: PCIC Dashboard

Analyzes client service use across these systems

- HPD
- JAIL
- EMS
- HHS
- HMIS

HRC
Houston Recovery Center: PCIC Dashboard

Shows who else is working with our clients & the services most used
Client Service Utilization:

<table>
<thead>
<tr>
<th>Service</th>
<th>HRC Clients</th>
<th>Percent of Population</th>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>EMS</td>
<td>1,210</td>
<td>66%</td>
<td>9,616 transports</td>
</tr>
<tr>
<td>Harris Health</td>
<td>1,155</td>
<td>62%</td>
<td>8,104 visits</td>
</tr>
<tr>
<td>System</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HPD*</td>
<td>388</td>
<td>21%</td>
<td>1,145 incidents</td>
</tr>
<tr>
<td>Jail*</td>
<td>274</td>
<td>15%</td>
<td>1,351 admissions</td>
</tr>
<tr>
<td>HMIS</td>
<td>588</td>
<td>32%</td>
<td>108,921 visits</td>
</tr>
</tbody>
</table>

* Partial data supplied so numbers are low
Houston Recovery Center: PCIC Dashboard

EMS transports:
Range:
1 transport – 427 transports
Hospital Destinations : 40+
Top Hospitals Identified
Houston Recovery Center: PCIC Dashboard

Total HHS Patients
1,155

Total HHS Visits
8,104

HHS Visits:
2013-09-19 to 2017-09-30

Harris Health System
8,104 ER and Hospital Admissions
Houston Recovery Center: PCIC Dashboard

The Harris Center
Search
Salvation Army
Temenos
Housing
HACS/Avenue 360

Organizations that provide services to these clients
Sharing data across organizations allows us to see who else is working with our client population.

With this information how do we begin to coordinate care?
C³ Initiative Overview & Goals

• One Year planning grant
• NBHP serves as neutral convener/coordinator

• Goals
  ➢ Create the blue print for a system-wide, person-centered continuum of care that integrates medical, behavioral health and social services
  ➢ Pilot a project focused on improving client outcomes and generating cost savings through coordination of care that addresses social determinants of health
C³ Initiative Key Elements

• Identification and participation of service providers that address medical, behavioral health, and nonmedical needs (social determinants of health) to develop continuum

• Development and/or modification of integrated, easily navigable, HIPAA compliant database

• Development and/or modification of integrated case management system that includes an identified lead case manager for each client and warm handoffs

• Identification of funding streams for sustainability
C³ Initiative Tentative Workplan

• Survey/interview workgroup members and community members at-large to determine current system barriers to care coordination and how to overcome them

• Research best practices to address current system barriers and review integrated continuum of care models across the country

• Come to consensus on a model for implementation

• Implement pilot project
C³ Initiative Tentative Timeline

- Kickoff (April 2018)
- Surveys, Interviews and Research (May-August 2018)
- Workgroup Meetings (May-August 2018)
- Analyze interviews and survey results (August-September 2018)
- Preliminary Results & Half Day Retreat (October 2018)
- Continued Workgroup Meetings & Model Development (November 2018-January 2019)
- Final Retreat and Model Finalization (February 2019)
- Issue Report (March 2019)
- Pilot Project Implementation begins (April 2019)
Initial Next Steps

• Complete Feedback Form

• Assign Committees and Schedule Workgroup Meetings (monthly)

• Complete and Distribute Survey
Questions?