Behavioral Health Super-Utilizers Program in Bexar County

The Center for Health Care Services
San Antonio

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Presentation Outline

- Program Overview – What is the Model?
- What have we learned?
- Keys to replicating the model
- What is needed to make it sustainable?

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Program Model

ASSUMPTIONS in MODEL DEVELOPMENT

- Super Utilizers (SUs)
  - have complex conditions and needs: medical co-morbidities, psychiatric and/or substance abuse; psychosocial needs (i.e. homeless or unstable housing; eroded social support), i.e. Quadrant IV
  - Attempt to get their needs met at EDs, and/or through inpatient hospitalization; OR, end up cycling through justice system rather than more "appropriate" sites for care

Program Model

- ASSUMPTIONS IN MODEL DEVELOPMENT
  - Helping professionals/systems are limited by resources, program constraints, or culture as to what they can offer in response to presentation of SUs
  - SUs have learned to "work the system" – (perceived in a pejorative way by helping systems) – to get their needs met at the same time that they have developed mistrust of the system and alienated the helping system
  - SUs create compassion fatigue and subsequent negative/ineffective response from helping professionals

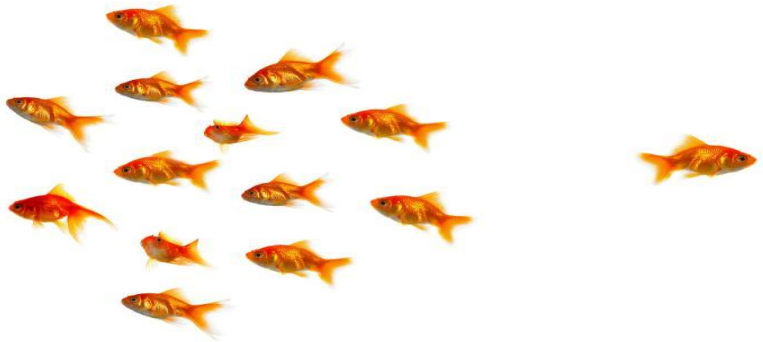
Program Model

- Clinical staffing
  - Clinical Director: PhD, LMFT, LPC
  - Clinical Practitioners: 1 LPC, 8 LPC-I
  - Substance Abuse: 1 LCDC
  - Peer Support: 1 Certified Peer Specialist

- Average caseload: 10-13 active, 15-20 total

- Est. FY2014 cost: $1,825,849

How does our model differ from standard approaches to Super Utilizers?



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Standard Approach	Integrated Care for Sus
Assume Quadrant Model (Hi Med/Hi Psychiatric)	Complex Psychosocial Needs; Trauma history; Axis II/Personality Disorders
Silo'd Providers and Care System	Integrated; Multidisciplinary; Community Coordinated
Focus on Pathology	Strengths-Based/Recovery Model
Driven by contract requirements/revenue	Driven by needs of the person served
Setting-determined/limited	Person-centered/*in vivo*
Non-compliance/exclusion	Engagement/inclusion
System-driven/productivity goals	Person-centered/quality outcomes
Individual Professional Services	Groups; Peer Services
Re-traumatizing	Trauma-Informed

What have we learned?

EMERGENCY ROOM PRESENTATION NOT CORRELATED WITH MEDICAL NEED or SEVERITY OF MEDICAL CONDITION

Social support

A bed

A safe place

What have we learned?

- Working Hypothesis
  - ER Presentation by SUs not correlated with access, medical condition--- including severity of behavioral health--- or culture

Population Served

- 176 unduplicated people served inception to date
- 39 undup people in program at least 3 months with at least 3 face-to-face contacts
- Still a pretty new program: median # of months in care = 5.9

Overview of Methods

- Ongoing enrollment creates challenges – hospital data is out of date as soon as you get it

- Must annualize jail and hospital encounters to compare pre- and post-intervention "apples"
  - "Lookup period" of equal length before and after date of first face-to-face ICT contact
  - Examine changes at
    - person level – change in use, median reduction
    - pop level – change in total use by group

Early Results: Methodist ER

- 54 (31%) of SU clients found in MHS ER data *in lookup period*
  - Pre-IC MHS ER visits: range 0-86.9 (median 4.7)
  - Post-IC MHS ER visits: range 0-21.8 (median 2.3)

- 54% of SU clients w reduced MHS ER utilization
  - higher super-utilizers: 74%; lower super-utilizers: 33%

- Group (54) total: 594 visits pre-IC; 354 post-IC
  - Group total visit decrease of 240 (40% reduction)
  - Estimated savings: 240 x est $1200 = **$288K savings per year for one hospital system**

Early Results: Methodist Inpatient

- 23 (13%) of SU clients found in MHS inpatient data *in lookup period*
  - Pre-IC MHS ann'd inpt visits: range 0-10.0 (median 2.0)
  - Post-IC MHS ann'd inpt visits: range 0-11.0 (median 2.0)
- 43% of clients had reduced MHS annual'd inpt visits
  - 39% showed increased annualized inpatient visits
- Group (23) total: 72 visits pre-IC; 69 post-IC
  - Est'd savings not yet calculated – depends on length of stay

Early Results: Bexar Co. Jail

- 25 (14%) of SU clients had incarceration *in the "lookup period"*

- Group total pre-IC annualized bookings: 31.7
- Post-IC annualized bookings: 18.9 (-12.8)

- 60% of clients had fewer annualized bookings after first face-to-face; median change = -1.1

- Incarceration *days* actually went up
  - Outlier: one client 0 days pre-IC, 384 days post-IC

Multi-system Contacts

- By definition, all have had recent hospital encounter or incarceration
- Half (n=84) have had a recent ER visit at a MHS hospital; doesn't include other systems
  - Half of those with ER visit had neither a recent MHS inpatient stay or incarceration
- 14% were incarcerated recently
  - Just over half had recent MHS ER visit

Cautions

- Without community-wide hospital dataset for single time period, impossible to be sure of changes in ER/inpatient utilization
- IC performance improvement muddies the "how much intervention does it take?" waters
- Hard to control for effect of just having moved to San Antonio
- Person-matching isn't perfect – possibility of false positive or false negative

Other questions to explore

- Cross-hospital utilization patterns
- Effects of policies/procedures like hospital going on diversion, police decisions
- "Dose-response" relationship between integrated care services and outcomes
- Clinical/demographic profile of people with especially good or poor results
- Are there early warning indicators?

Program Model – Replication

Critical to the Model:

- Strengths-based, recovery-oriented culture and approach
- Engagement and development of trust
- Meet the person where s/he is both in terms of needs and trust level
- Unified community response

Sustainability

- Many key features of the program that get results are not currently billable at all, or are not billable at the utilization rates required to get desired outcomes
- These include:
  - Engagement and outreach
  - Peer support services
  - Attending medical and other appointments to ensure linkage and continuity of care
  - Engaging and/or providing interventions in hospital settings or IMDs

Sustainability

- Start up and sustenance funding apart from service revenue at current billable rates is necessary to start up and run the program as conceptualized in this model.
- Carve outs with specialty rates or specialty contracts with capitated rates and/or other shared risk models needed to support delivery of full spectrum of services proven to be effective

Questions?