MIDD 2 Initiative CD-05: High Utilizer Care Teams

How does the program advance the adopted MIDD policy goals?

This program primarily addresses the adopted MIDD policy goal of "divert individuals with behavioral health needs from costly interventions, such as jail, emergency rooms, and hospitals."

The initiative assists people in the midst of crisis by delivering flexible and individualized service beginning in the emergency department (ED) or hospital inpatient unit. This program builds on initial supportive contact to help people reintegrate safely into the community after an immediate crisis, and help them to acquire and engage with stabilizing resources such as housing and community-based care, thereby reducing future emergency system use.

The program focuses on reducing individuals' use of crisis services, including the emergency room, inpatient psychiatry, and inpatient medical care, and enhancing the capacity to link individuals to community services. The initiative serves people who are falling through the cracks of the existing service system, such as people who have no services in place but need intensive outreach to connect to care, or people with mental illness who also have chronic medical conditions.[64]

1. Program Description

◊ *A. Service Components/Design (Brief)*

This initiative will serve individuals who are frequently seen at the ED or psychiatric emergency service (PES) at Harborview Medical Center (HMC). This initiative will serve individuals that use the HMC ED or PES four or more times in three months.[65] Due to the intensity of service as well as the complex needs of program individuals, caseloads are kept smaller, so people with eight or more ED or PES visits in six months will be prioritized, because they are most likely to benefit from the services offered by this specialized care team. The program also provides support for clients' basic needs that reduce barriers to participating in the plan of care through a modest fund to address transportation, clothing, rent and similar expenses.

Data from Washington's Emergency Department Information Exchange (EDIE) will also be used to identify Harborview patients who may not meet the priority threshold based on HMC data alone, but have a high level of ED use at other King County hospitals.

Most participants are homeless at the outset of the intervention. Along with homelessness, almost all individuals' vulnerability arises from at least two of the following: chronic medical issues, substance use disorders and serious mental illness.[66]

[64] Harborview Medical Center, December 2015.
[65] Extracted from 2015 Harborview Medical Center Contract, Exhibit IV.
[66] Harborview Medical Center, December 2015.

Service components include a harm reduction approach to substance abuse, motivational strategies to engage individuals in primary health care for chronic conditions, active engagement of community supports, outreach during individuals' crises in the ED or during an inpatient admission, and continued engagement of individuals once they return to the community. Broadly, the team assists individuals to find stable housing, improves de-escalation skills to decrease behavioral barriers to care, and helps individuals with co-occurring disorders access needed behavioral health services and connections to primary care for their medical needs.[67]

The most frequent service connections upon discharge are in mental health, substance abuse and medical clinics. Staff will coordinate with King County; other EDs; and behavioral health, social service, and housing providers in order to ensure appropriate referrals and linkages to services. The team uses HMC primary care and aftercare clinics to provide urgent and long-term service connections to primary care. HMC's mental health services provide mental health urgent care, while long-term case management comes from a variety of community mental health providers.[68]

◊ *B. Goals*

This initiative's goal is to connect individuals who have frequent crisis visits to EDs or the PES to care providers and treatment systems in the community in order to decrease their need for emergency services.

◊ *C. Preliminary Performance Measures (based on MIDD 2 Framework)*[69]

1. *How much? Service Capacity Measures*

   The program has the capacity to serve approximately 100 unduplicated individuals annually.

2. *How well? Service Quality Measures*

   - Increased use of preventive (outpatient) services

3. *Is anyone better off? Individual Outcome Measures*

   - Reduced behavioral health risk factors
   - Reduced unnecessary hospital and emergency department use
   - Reduction of crisis events

[67] ED/PES High Utilizer Case Management Annual Report, MIDD I Strategy 12c, King County Contract 5656153 – Exhibit IV (December 2014).

[68] ED/PES High Utilizer Case Management Annual Report, MIDD I Strategy 12c, King County Contract 5656153 – Exhibit IV (December 2014).

[69] Throughout 2017, review and refinement of Results-Based Accountability (RBA) performance measures for MIDD 2 initiatives will be conducted whenever applicable, in consultation with providers. Updates to performance measures that may result from this collaborative process will be reported in the next MIDD Annual Report in August 2018.

◊ *D. Provided by: Contractor*

All services offered under this initiative will be contracted to Harborview Medical Center. The contractor will manage expenditures on clients' basic needs and seek reimbursement from the County up to allowed limits.

2. Spending Plan

Year	Activity	Amount
2017	High utilizer care team services, with support for basic needs to reduce barriers to care plan participation	$256,250
2017 Annual Expenditure		**$256,250**
2017	High utilizer care team services, with support for basic needs to reduce barriers to care plan participation	$262,913
2018 Annual Expenditure		**$262,913**
Biennial Expenditure		**$519,163**

3. Implementation Schedule

◊ *A. Procurement and Contracting of Services*

Harborview Medical Center continues to serve as the contractor for these services. No RFP is needed.

◊ *B. Services Start date (s)*

Services continued in January 2017.

4. Community Engagement Efforts

This initiative is continuing from MIDD 1 with an established program model and minimal expected change. No active community engagement is occurring at this time.