MIDD Briefing Paper

ES 12c High Utilizer Case Management
BP 83 Emergency Department Super Utilizer Care Team
BP 86 Peer Support Medical Integration Team

Existing MIDD Program/Strategy Review ☒ MIDD I Strategy Number 12c (Attach MIDD I pages)
New Concept ☒ 83 & 86 (Attach New Concept Form)
Type of category: Existing Program/Strategy EXPANSION

SUMMARY: Current MIDD Strategy 12c, the Emergency Department High Utilizer Case Management Program (HUP) at Harborview Medical Center, serves individuals who are frequently seen at Harborview's emergency department (ED) or psychiatric emergency service (PES). Program funding within the current contract covers 3.3 full time equivalent (FTE) staff [2.3 FTE clinicians and 1.0 FTE program support staff for Screening, Brief Intervention and Referral to Treartment (SBIRT) and HUP reporting, financial counseling, and benefits application assistance]. The program assistant, previously paid by county substance abuse and and mental health funding, is currently funded via MIDD supplantation, while the 2.3 FTE clinicians are supported by $200,000 per year in MIDD Strategy 12c funds. This paper encompasses expanded service provision available through the HUP, including the addition of a Super Utilizer Care Team and a Peer Support Medical Integration Team. The core team could also be expanded with the Existing Strategy service model if the services were to match the level of need.

Collaborators:

Name	**Department**
Brigitte Folz	Community Behavioral Health Center
Dan Floyd	King County MHCADSD

Subject Matter Experts and/or Stakeholders consulted for Briefing Paper preparation. List below.

Name	Role	Organization
Brenda Mayer	Chemical Dependency ITA Coordinator	MHCADSD
Topher Jerome	Supervisor of Peer Bridgers	Harborview Mental Health
Brigitte Folz	Director for Behavioral Health and Addictions Programs	Harborview Medical Center

The following questions are intended to develop and build on information provided in the New Concept Form or gather information about existing MIDD strategies/programs.

A. Description

1. **Please describe the New Concept or Existing MIDD Strategy/Program: Please be concise, clear, and specific. What is being provided to whom, under what circumstances? What are the New**

Concept Existing MIDD Strategy/Program goals? For New Concepts, does it relate to an existing MIDD strategy? If so, how?

Current MIDD Strategy 12c, the Emergency Department High Utilizer Case Management Program (HUP) at Harborview Medical Center, serves individuals who are frequently seen at Harborview's emergency department (ED) or psychiatric emergency service (PES). Program funding within the current contract covers 3.3 full time equivalent (FTE) staff [2.3 FTE clinicians and 1.0 FTE program support staff for Screening, Brief Intervention and Referral to Treartment (SBIRT) and HUP reporting, financial counseling, and benefits application assistance]. The program assistant, previously paid by county substance abuse and and mental health funding, is currently funded via MIDD supplantation, while the 2.3 FTE clinicians are supported by $200,000 per year in MIDD Strategy 12c funds. This paper encompasses expanded service provision available through the HUP, including the addition of a Super Utilizer Care Team and a Peer Support Medical Integration Team. The core team could also be expanded with the Existing Strategy service model if the services were to match the level of need.

The HUP program's goal is to connect individuals who have frequent crisis visits to the ED or PES to care providers and treatment systems in the community in order to decrease their need for emergency services. The most frequent service connections upon discharge are in mental health, substance abuse, and medical clinics. HUP staff coordinate with other social service provider agencies, as well as the High Utilizer Group network, facilitated by King County (which includes County members as well as other EDs and behavioral health and housing providers), to ensure appropriate referrals and linkages to services. The team uses Harborview Medical Center (HMC) primary care and aftercare clinics to provide urgent and long-term service connections to primary care. Harborview's mental health services provide mental health urgent care, while long-term case management comes from a variety of community mental health providers.[1]

Since its inception in 2008, the Existing Srategy 12c has been narrowly construed to focus on services for individuals seen at HMC.[2] However, if the program scope were expanded, similar hospital-based care management teams could also potentially benefit patients at other major medical centers in King County whose EDs have a critical mass of patients who have ongoing behavioral health and medical concerns. Other ED participants in King County's High Utilizer Group, such as Swedish, Virginia Mason, and the Veterans Administration, may be appropriate candidates for expansion.

Expanding the program to a multidisiciplinary team model, a Super Utilizer Care Team, would allow for the program to more effectively and more adequately respond to the specifically identified needs of these individuals in the community. Super Utilizers are identified as individuals who have presented to the Emergency Department at least eight times in a six month period. The Super Utilizer Care Team concept increases the capacity of the program to serve individuals with behavioral health needs, and reduce their reliance on EDs. This expansion would include a chemical dependency professional (CDP), a peer support specialist, and nursing staff, with psychiatric and medical consultation. With this expansion the program could be expected to serve 200 individuals per year in a clinically sound modality, doubling the current capacity.

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

[2] Mental Illness and Drug Dependency Action Plan FINAL – October 6, 2008, Expand Re-Entry Programs, 12c – Increase Capacity for Harborview's Psychiatric Emergency Services to Link Individuals to Community-Based Services Upon Discharge from the Emergency Room.

The top two admitting conditions for individuals served in the HUP are alcohol use disorder and substance intoxication (to the point of incapacitation). The addition of a CDP on the team allows for the ability to provide substance use disorder (SUD) assessments that could facilitate access to residential and outpatient SUD treatment . Also, having a peer provider as a member of the team allows for additional opportunities and approaches to more effectively engage with these individuals, especially given the fact that some individuals respond more positively and openly to providers with lived experience related to behavioral health needs. Peer providers could also increase the efficiency in which barriers to housing are removed through the provison of the time intensive services needed to access housing (i.e., obtaining legal identification, completing housing applications), transportation to appointments, and emotional support throughout the transition process. It would also provide the option for the peers to visit the client while they are in SUD treatment, and when they are discharged from treatment, to accompany them to their first recovery support groups or other support services.

Peer support services have become well recognized and established in community behavioral health treatment settings. Inclusion of a Peer Support Medical Integration Team in to the current HUP would expand the penetration of peer support services beyond community mental health and psychiatric inpatient settings. This would allow for services to be provided as part of a High Utilizer Team, or as a distinct program of its own, to outreach individuals who are medically fragile and have behavioral health disorders in order to ensure connection to health care services (including behavioral healthcare service). It is also possible for this concept to be wrapped into the existing Peer Bridger Program[3]. This service would occur in a broad range of community settings including individual homes, primary care, shelters and adult family homes, with the intention of reducing unnecessary utilization of the EDs and increasing linkage to appropriate community-based care**.**

Individuals with behavioral health disorders have a decreased life expectancy and poorer health outcomes than the general population.[4&5] These individuals are frequently alienated and estranged from traditional medical services and treatment providers. The Peer Support Medical Integration Team, utilizing certified peer counselors, would provide an important peer connection through the provision of outreach and engagement in the community. This peer lead approach would help ensure linkage to medical and behavioral healthcare services for persons with behavioral health disorders and extraordinary utilization of ED and medical resources. This team would target individuals who are being discharged from medical hospitals, EDs and in primary care who have a history of, or are at risk for, frequent ED and medical resource utilization. This peer support team could additionally take referrals from first responders (e.g., paramedics, law enforcement) to target individuals needing additional support to remain safe in the community.

2. **Please identify which of the MIDD II Framework's four Strategy Areas best fits this New Concept/Existing MIDD Strategy/Program area** (Select all that apply):

   ☒ **Crisis Diversion** ☒ **Prevention and Early Intervention**

   ☒ **Recovery and Re-entry** ☒ **System Improvements**

   Please describe the basis for the determination(s).

[3] http://www.seattletimes.com/opinion/the-rare-mental-health-fixers/. Accessed on 1/10/16.

[4] Bruce P. Dembling, Ph.D. Donna T. Chen, M.D., M.P.H. Louis Vachon, M.D. *Life Expectancy and Causes of Death in a Population Treated for Serious Mental Illnes;* PSYCHIATRIC SERVICES © August 1999 Vol. 50 No. 8 pp. 1036-1042.

[5] Caroline R. Richardson, M.D. Guy Faulkner, Ph.D. Judith McDevitt, Ph.D., F.N.P. Gary S. Skrinar, Ph.D. Dori S. Hutchinson, Sc.D. John D. Piette, Ph.D.; *Integrating Physical Activity Into Mental Health Services for Persons With Serious Mental Illnes*, PSYCHIATRIC SERVICES ♦ http://ps.psychiatryonline.org ♦ March 2005 Vol. 56 No. 3 pp. 324-331.

The programs are intended to assist people in the midst of crisis by delivering flexible and individualized service beginning in the ED or hospital inpatient unit. Their goal is to build on this 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.[6]

The current and expanded program concepts focus 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. Peer support specialists provide meaningful examples of recovery in action for individuals and ensure continued focus on recovery goals determined by the people they serve. Peer services in the community also can help prevent additional crises by linking individuals to appropriate community-based services, and intervening earlier when individuals are struggling to manage their healthcare and emotional needs. In addition, these programs represent system improvement by working to integrate behavioral health with all three disciplines of mental health, substance use, and primary healthcare.

B. Need; Emerging, Promising, Best, or Evidence Based Practices; Outcomes

1. **Please describe the Community Need, Problem, or Opportunity that the New Concept Existing MIDD Strategy/Program addresses: What unmet mental health/substance use related need for what group or what system/service enhancement will be addressed by this New Concept/Existing MIDD Strategy/Program? What service gap/unmet need will be created for whom if this New Concept Existing MIDD Strategy/Program is *not* implemented? Provide specific examples and supporting data if available.**

The existing Harborview HUP is designed to serve individuals that use the Harborview ED or psychiatric emergency service four or more times in three months.[7] Data from Washington's Emergency Department Information Exchange (EDIE) indicates 655 HMC patients have been seen in the Harborview ED four or more times over six months.[8] The Harborview ED saw a total of 4522 individuals in 2015, the majority of whom are not HMC patients, who were also seen at other EDs in King County for a total of four or more visits to an ED in the past six months. These 4522 individuals had a total of 20,926 visits to Harborview ED, and a combined 53,293 visits to all EDs in the EDIE system, over the past year. Of the individuals who reached the threshold of four or more visits in the past six months, the average number of visits at Harborview ED was 9.25, and 11.78 visits across all EDs in Washington State.

Due to the intensity of service as well as the complex needs of program individuals, caseloads are kept smaller, meaning the program only has the capacity to serve about 100 people per year (about 30 to 40 people at a time). As a result, the program has prioritized serving people with eight or more ED visits in six months who are most likely to benefit from the services offered by this specialized care team. HUP staff report that, as of December 2015, EDIE data show that 486 individuals seen by Harborview ED have eight or more visits in six months – up from an estimated 150 to 190 such patients in 2009-10. Of those patients who had four or more visits to an ED in the past six months, including at least one visit at HMC, 2522 had eight or more visits to all EDs in the past year according the EDIE system. Of those, 732

[6] MIDD II Framework Updated 8.27.15. Retrieved from: http://www.kingcounty.gov/~/media/health/MHSA/MIDD_ActionPlan/RenewalPlanningDocuments/150828_MIDD_II_Framework.ashx?la=en.
[7] Extracted from 2015 Harborview Medical Center Contract, Exhibit IV.
[8] Data provided by Harborview Medical Center, December 2015.

patients had eight or more visits to HMC alone in the past year.[9] It is clear from these numbers that there is a large proportion of individuals with high ED utilization who are not able to be served within the current HUP program; this data does not include individuals who may frequently use other EDs in King County at the rate of four or more times in a six month period, but have not utilized Harborview ED.

Recent trends in the Harborview HUP individual population reflect developments across the behavioral health system. Most notably, more patients have medical complications than in past years, and individuals' behavioral health needs are more elevated. In addition, there has been an increase in individuals with undocumented status, legal barriers to housing and shelter, and traumatic brain injuries.[10] These increases in complexity, and the corresponding increased service need per individual, may explain a recent slight downturn in the total number of individuals seen by the program, from 104 in MIDD Year 5 (2012-13) to 86 in MIDD Year 6 (2013-14). However, since inception, the program has consistently exceeded its minimum service target of 75 individuals per year.[11]

In recent years and especially during the second half of 2015, more of King County's psychiatric patients have been served in EDs, and more patients are served, and remain longer, in acute care settings. This is due, in part, to a statewide inpatient capacity shortage and worsening issues with access to Western State Hospital that have collateral effects throughout the behavioral health service system.[12] Major urban medical centers such as HMC often encounter the most frequent emergency system users. In this broader environment, effective hospital-based interventions such as HUP that intervene upon first contact to reduce overall emergency system utilization and connect or reconnect people to community-based care and supports represent an opportunity to stabilize and reduce costs for individuals served directly by the program. In addition, these interventions improve access to care for individuals with emergent healthcare needs whose access to such care is often constricted by inadequate capacity.

The individuals currently served in the HUP are having difficulty accessing residential SUD services at the moment when individuals are ready and willing to participate. Community resources for these individuals were significantly impacted by the closure of the Recovery Centers of King County, resulting in a significant number of individuals experiencing difficulty engaging in services, and less success in moving towards recovery. The current program staff have also noted that there are individuals who are less willing to engage in case management services with professionals, and are in need of the unique relationships that can be forged with peer providers. In particular, individuals who are transitioning from homelessness frequently need help understanding the importance of accessing community supports and attending to chronic health needs, but often lack the skills and belief that they can do so on their own. Healthcare outcomes have been poor for persons with mental health and/or SUDs. Proactive outreach and case management to transition individuals into appropriate and accessible outpatient medical and behavioral health interventions would positively impact these outcomes.

2. **Please describe how the New Concept/Existing MIDD Strategy/Program Addresses the Need outlined above.**

[9] Data provided by Harborview Medical Center, December 2015.
[10] ED/PES High Utilizer Case Management Annual Report, MIDD Strategy 12c, King Co. Contract 5656153 – Exhibit IV (December 2014), and phone interview with Brigitte Folz and Ann Allen, December 2, 2015.
[11] Enumeration of All Performance Measurements and Summary of Performance Outcomes, Jail and Hospital Diversion Strategies.
[12] Community Alternatives to Boarding Task Force Progress Reports 1 and 2, June 2015 and January 2016. Retrieved from http://www.kingcounty.gov/healthservices/MHSA.aspx

The existing Harborview HUP team's work with individuals includes such components as a harm reduction approach to substance abuse, motivational strategies to engage individuals in primary healthcare 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.[13] This approach is consistent with the evidence-based practices described in section B3 below. Housing set-asides, accessed through the High Utilizer Group and/or such initiatives as the County's client care coordination efforts, have been an important component in helping individuals achieve greater stability and reduce system use, although HUP staff report that expedited access to housing has become more difficult recently.[14]

Treatment on demand has been more effective in meeting the needs of this population than appointment-based intake assessments and screening/eligibility processes. Adding staff will allow for the increased assessment and case management services needed to assist individuals in accessing community-based services as quickly as possible.

The Peer Support Medical Integration Team will work with the HUP and other community agencies to target superutilizers, particularly patients with behavioral health challenges and medical risk. This team would utilize assertive outreach and engagement in the community, and work to remove barriers that prohibit effective linkage to medical, clinical behavioral health resources and housing. This team would also take referrals from the first responder agencies for vulnerable individuals who often utilize the 911 system as a way to care for their medical needs. As shown in the Peer Bridger Program, peers significantly improve successful connection to community supports with the people they serve. This success begins with their unique capacity to forge relationships and build trust with individuals who are often reluctant to engage with other professionals. Through this trusting relationship, peer staff work with people to problem solve barriers faced in accessing community supports, often using their own experience in working through similar challenges. Historically, individuals who have a low number of service days in the current HUP are generally poorly engaged in services. Adopting a model that includes peer support services, similar to the Peer Bridger Program, is intended to increase the ability to effectively engage more individuals and improve their primary and behavioral healthcare outcomes.

3. **What EVIDENCE exists that the approach of this New Concept/Existing MIDD Strategy/Program will successfully address the identified need? Please cite published research, reports, population feedback, etc. Why would this New Concept/Existing MIDD Strategy/Program be expected to work? If this is an existing MIDD I strategy, please provide evidence of the results from existing MIDD evaluation reports, including who has/has not benefited from this strategy.**

Ample evidence exists of the existing base program's effectiveness in reducing ED and medical admissions and associated costs. The program has achieved a 24 percent reduction in ED admissions between the year prior to service and the first year after, and a further 52 percent reduction in the second year after HUP, before the effect leveled off.[15] A four-year review of average ED usage by 281 program participants showed a reduction from 11.3 visits in the year prior to the HUP service down to

[13] ED/PES High Utilizer Case Management Annual Report, MIDD Strategy 12c, King County Contract 5656153 – Exhibit IV (December 2014).
[14] Phone interview with Brigitte Folz and Ann Allen, December 2, 2015.
[15] Seventh MIDD Annual Report, page 3.

just 4.5 visits in the third year after the service.[16] A review of 78 individuals who had psychiatric stays revealed that average days spent in community inpatient psychiatric hospitals dropped 65 percent after the HUP intervention, from 23 days to eight.[17]

HMC's own studies (2013) of total medical charges for program participants during the six months before and after receiving the HUP intervention during 2012 showed similar major reductions. Most notably, inpatient charges for this group dropped by 63 percent, from more than $1.5 million in the six months before the intervention to less than $700,000 afterward – and ED costs likewise dropped by 55 percent, from $1.1 million to just above $500,000.[18] These benefits continued in the 2014 program cohort. When comparing the six-month pre- and post periods, total medical charges fell by 46 percent, from $7.0 million before HUP to $3.7 million afterward. ED costs also were reduced by 59 percent from more than $1.6 million to less than $700,000, with the total number of ED visits dropping 61 percent.[19]

A recent 5-year utilization study by HMC concluded that the HUP is most effective in achieving stabilization outcomes when it keeps clients engaged with its services for at least 51 and less than 120 days.[20] In addition, most individuals – an estimated 86 percent as of 2013[21] – are homeless at the start of the HUP service, while about half are housed upon program exit.[22] The HUP has had no significant impact on jail utilization, reducing average jail days only slightly.[23]

The existing HUP is modeled after the successful ED case management approach at Zuckerberg San Francisco General Hospital and Trauma Center that has been replicated in at least eight other communities.[24] An initial study of the Zuckerberg model in 2000 examined the impact of case management on hospital service use, hospital costs, homelessness, substance abuse, and psychosocial problems in frequent users of its urban ED. It found reductions in the median number of ED visits, median ED costs, and median medical inpatient costs. Statistically significant outcomes included decreases in homelessness and alcohol/drug use, increased linkage to primary care, and Medicaid enrollment. Over $1.40 in hospital costs was saved for every dollar spent. Thus, the study concluded that case management was a cost-effective means of decreasing acute hospital service use and psychosocial problems among frequent ED users.[25] A follow-up study in 2008 confirmed these results, showing that case management was associated with statistically significant reductions in psychosocial problems common among frequent ED users, including homelessness, alcohol use, lack of health insurance and social security income, and financial need. Case management was associated with

[16] Ibid, Seventh MIDD Annual Report, page 44.
[17] Ibid, Seventh MIDD Annual Report, page 44.
[18] Community Collaboration and Intensive Case Management for Patients with High ED Utilization, Ann Allen LICSW, Brigitte Folz LICSW, Crig Jaffe MD.
[19] 2014 outcome study, provided by Harborview HUP.
[20] Data from Harborview High Utilizer Case Management Retrospective, provided December 2015.
[21] Community Collaboration and Intensive Case Management for Patients with High ED Utilization, Ann Allen LICSW, Brigitte Folz LICSW, Craig Jaffe MD.
[22] Ibid, Seventh MIDD Annual Report, page 44.
[23] Ibid, Seventh MIDD Annual Report, page 44.
[24] San Francisco General's emergency department case management model is also being replicated in Denver, Washington DC, Detroit, Camden, and Santa Clara, Alameda and Tulare Counties in California.
http://psych.ucsf.edu/research/programs/psychosocial
[25] Okin RL, Bocellari A, Azocar F, Shumway M, O'Brien K, Gelb A, Kohn M, Harding P, Wachsmuth C. The effects of clinical case management on hospital service use among ED frequent users. Am J Emerg Med 2000;18:603–608. Retrieved from http://www.sciencedirect.com/science/article/pii/S0735675700149447

statistically significant reductions in ED use and cost. Unlike results from Harborview's HUP, however, this trial found no difference in the use or cost of other hospital services.[26]

There is support for the addition of these models in an Expanded Strategy. A study evaluating the benefits of intensive, strengths-based case management in assisting indivdiuals with connections to treatment has shown success. The study found that "having received more case management time was independently predictive of treatment entry. In particular, participants who received 30 minutes or more of case management within seven days of the baseline visit were 33 percent more likely to enter treatment."[27] Similarly, a study on peer support models of care indicated that individuals who received consumer-driven services were more likely to to remain in the community, without instances of rehospitalization, than the comparison group.[28] These findings are promising in determining the effectiveness of peer support services in facilitating recovery for individuals with behavioral health disorders.

Additional evidence for the peer support model comes from a recent Peer Bridger Program outcomes report[29], where it was determined that, when compared against a similar comparison group, the Peer Bridger Program is resulting in significant reductions in hospitalizations and hospital days with the rate of change being greater for the participants than the comparison group. The data indicate that the rate of re-hospitalization for individuals in Peer Bridgers was ten percent within 30 day of discharge, compared to 14 percent for the comparison group, and the rate of re-hospitalization within 90 days of discharge was 15 percent for Peer Bridger participants, compared to 22 percent for the comparison group. Participants also become enrolled in outpatient mental health services and in Medicaid at a higher rate than the comparison group. Individuals served by the Peer Bridger Program had a 20 percent rate of involvement in outpatient services upon admission, which was slightly lower than the comparison group, and 65 percent rate of involvement in outpatient mental health services after 90 days, which was significantly higher than the comparison group. Similarly, rates of Medicaid enrollment were higher for the control group upon discharge from the hospital; however, within 90 days of discharge the rates for individual enrolled in Peer Bridgers was significantly higher than the comparison group. The analysis suggests that there is benefit in utilizing peer-lead programs to reduce hospital use and increase engagement in community-based mental health services.

4. **Please specify whether this New Concept/Existing MIDD Strategy/Program is a/an: Best Practice Please detail the basis for this determination. Please include a citation or reference supporting the selection of practice type.**

In addition to the strong evidence in support of the Zuckerberg San Francisco ED case management model that HUP uses (described in B3 above), the local program is also garnering recognition as a best practice within Washington. A January 2015 list of best practices for reducing ED visits, jointly published by the Washington State Hospital Association, the Washington State Medical Association, the Amercian

[26] Shumway M, Boccellari A, O'Brien K, Okin RL. Cost-effectiveness of clinical case management for ED frequent users: results of a randomized trial. Am J Emerg Med. 2008 Feb; 26(2):155-164. Retrieved from http://www.sciencedirect.com/science/article/pii/S0735675707003026

[27] Drug Alcohol Dependence. 2006 Jul 27;83(3):225-32. Epub 2005 Dec 20. *Facilitating entry into drug treatment among injection drug users referred from a needle exchange program: Results from a community-based behavioral intervention trial.* Strathdee SA[1], Ricketts EP, Huettner S, Cornelius L, Bishai D, Havens JR, Beilenson P, Rapp C, Lloyd JJ, Latkin CA

[28] Psychiatry Rehabilitation Journal. 2007 Winter;30(3):207-13. *Peer support for persons with co-occurring disorders and community tenure: a survival analysis.* Min SY[1], Whitecraft J, Rothbard AB, Salzer MS.

[29] Peer Bridger Program Participant and Comparison Group Outcome Analysis; Department of Community and Human Services, Mental Health, Chemical Abuse and Dependency Services Division; prepared by Debra Srebnik, PhD August 2015.

College of Emergency Physicians Washington Chapter, and the Washington State Health Care Authority, includes the strategy of intensive case management:

> "Identify Frequent Users of the Emergency Department and EMS – Frequent emergency department (ER) or EMS users are identified as those patients seen or transported to the ER five (5) times within the past 12 months. Hospitals should identify those frequent ER users upon arrival to the emergency department and develop and coordinate case management, including utilization of care plans. Plans, EMS, and mental health clinics will work with patients with five or more visits to identify and overcome core issue [sic] which is documented in statewide information system."[30]

In addition, the SAMHSA National Registry of Evidence Based Programs and Practices recognizes the model of Brief Strengths Based Case Management for Substance Abuse used in this program as a Best Practice.[31]

The HUP program won a Washington Award of Excellence in Healthcare Quality from consulting group Qualis in 2013,[32] and has presented posters at national conferences including University Health System Consortium (UHC) in 2014 and the National Behavioral Health Conference in 2015.

5. **What OUTCOMES would the County see as a result of investment in this New Concept/Existing MIDD Strategy/Program? Please be as specific as possible. What indicators and data sources could the County use to measure outcomes?**

The expected outcomes are:

- Reduced ED utilization,
- Reduced psychiatric hospitalizations,
- Decreased medical hospitalizations,
- Increased referrals and linkages to treatment,
- Increased access to health benefits/entitlements and primary care, and
- Reduced deaths due to behavioral health conditions and/or chronic homelessness.

As described above, based on both published research as well as outcomes from MIDD I, continuation of the base program can be expected to yield reductions in ED utilization, inpatient costs, and overall medical charges for frequent emergency system users, thereby contributing to the broad-based communitywide effort to improve acute care access. If HUP capacity at HMC is increased, a corresponding increase in impact on inpatient and ED expenditures can reasonably be expected.

The intent would be for the program to collect information on a wide array of client related data including demographics, referral sources, dispositions, and program length of stay/utilization. Data sources include: data reports from current Strategy 12c; internal data that MCHADSD collects on client demographics, referrals, linkages and treatment admissions; demographic and service data available through the Homeless Management Information System (HMIS) system; pre- and post admission and readmission data collected by the program or the referring provider; and data available through negotiated agreement with the state EDIE.

---

[30] http://www.wsha.org/wp-content/uploads/er-emergencies_ERisforEmergenciesSevenPractices.pdf. EMS = Emergency Medical Services.

[31] SAMHSA National Registry of Evidence Based Programs and Practices, *Brief Strengths Based Case Management for Substance Abuse*; Review date: June 2009, Reviewer: Richard Rapp, MSW, ACSW.

[32] http://www.qualishealth.org/about-us/newsroom/press-releases/2013-qualis-health-washington-quality-award-winners-announced

To capture systemwide effects, the establishment of data sharing agreements that cross multiple EDs would be preferred, as cost savings for the base Strategy 12c program are currently captured for HMC utilization only and do not address possible contact with other EDs or inpatient units. If the program were expanded to other facilities beyond HMC such as Virginia Mason, Swedish, the Veterans Adminstration, or others, adding these additional data sources would be especially important.

C. Populations, Geography, and Collaborations & Partnerships

1. **What Populations might directly benefit from this New Concept/Existing MIDD Strategy/Program:** (Select all that apply):

☐ **All children/youth 18 or under**	☒ **Racial-Ethnic minority (any)**
☐ **Children 0-5**	☐ **Black/African-American**
☐ **Children 6-12**	☐ **Hispanic/Latino**
☐ **Teens 13-18**	☐ **Asian/Pacific Islander**
☒ **Transition age youth 18-25**	☐ **First Nations/American Indian/Native American**
☒ **Adults**	☒ **Immigrant/Refugee**
☒ **Older Adults**	☒ **Veteran/US Military**
☒ **Families**	☒ **Homeless**
☐ **Anyone**	☒ **GLBT**
☐ **Offenders/Ex-offenders/Justice-involved**	☒ **Women**
☒ **Other – Please Specify:**	

Please include details about this population such as: individuals transitioning from psychiatric hospital to community; individuals judged incompetent by the court; children of drug users who are in foster care, etc.

As indicated above, the vast majority of program participants are homeless at the outset of the intervention. Along with homelessness, almost all HUP individuals' vulnerability arises from at least two of the following: chronic medical issues, SUDs, and serious mental illness. HUP 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 such as diabetes, high blood pressure, or a seizure disorder.[33]

2. **Location is an important factor in the availability and delivery of services. Please identify whether this New Concept/Existing MIDD Strategy/Program addresses a specific geographic need in the following area. Please provide additional that discusses the basis for the selection**: County-wide

The base program at HMC primarily serves people from the Seattle area, but as a major medical center it does serve individuals from elsewhere. If the program were replicated at other sites, its geographic reach could be broadened to hospitals across the greater King County region, and ensure access to individuals throughout the County.

3. **What types of COLLABORATIONS and/or PARTNERSHIPS may be necessary to implement this New Concept/Existing MIDD Strategy/Program, and with whom (other jurisdictions & cities, law enforcement, first responders, treatment providers, departments within King County, housing, employers, etc.)? Please be specific.**

[33] Phone interview with Brigitte Folz and Ann Allen, December 2, 2015.

Partnerships to implement this program include: King County hospitals, community-based treatment providers, housing and shelter programs, Washington State Department of Veterans Affairs, Washington State Department of Social and Health Services, primary care providers, transportation agencies, first responder agencies, respite programs, ongoing collaboration with other members of the County-convened High Utilizer Group, King County Department of Community and Human Services, Public Health–Seattle and King County, and Managed Care Organizations.

A key piece of system coordination needed to support the individuals served through the program surrounds access to withdrawal management (detoxification) services (which have been less accessible since the closure of Recovery Centers of King County in 2015). In addition, access to set-aside SUD residential treatment beds, harm reduction housing options, and housing and supports for medically fragile individuals would help with implementation of an integrated multidisciplinary approach.

D. Drivers, Barriers, Unintended Consequences, and Alternative Approaches

1. What FACTORS/DRIVERS, such as health care reform, changes in legislation, etc. might impact the need for or feasibility of this New Concept/Existing MIDD Strategy/Program? How?

The program directly relates to the state-legislated Behavioral Health Integration initiative by also offering SUD services within the program. Integration of primary and behavioral healthcare will be realized with the inclusion of a nurse or medical provider to offer outreach similar to the services available currently.

EDs may be specifically affected by the 2015 state legislature's Substitute House Bill 1721, which now allows for transportation to places other than emergency rooms for individuals in a behavioral health crisis.[34] Depending on how the bill is implemented, this might allow for diversion to other services before ED contact, thereby impacting utilization of the HUP program.

Continued efforts to address the severe shortage of emergency system resources – via the launch of new resources, community care settings, or procedural innovations – may impact the overall demand for these services over the long term.[35] However, as noted previously, current demand far outstrips the capacity of the current base program.

2. What potential BARRIERS, if any, might there be to implementation? How might these be overcome? Who would need to be involved in overcoming them?

Barriers to effective implementation may include limited access to withdrawal management services or housing resources, both of which have been more difficult to access recently according to program staff. Launch of expanded withdrawal management services for King County, and support for expedited access to housing for the population served by this program, would help to address this.

Additionally, expanded multidisiciplary staff require supervision capacity that is not currently available in the program as it stands today. However, there are programs within the Mental Health & Addiction Services at Harborview that provide outpatient SUD and peer support services, [36] and these programs may be utilized to assist with needed clinical supervision.

[34] http://lawfilesext.leg.wa.gov/biennium/2015-16/Pdf/Bills/Session%20Laws/House/1721-S.SL.pdf
[35] Community Alternatives to Boarding Task Force Progress Reports 1 and 2, June 2015 and January 2016. Retrieved from http://www.kingcounty.gov/healthservices/MHSA.aspx
[36] http://www.uwmedicine.org/locations/addictions-program-harborview.

3. **What potential UNINTENDED CONSEQUENCES might exist if this New Concept/Existing MIDD Strategy/Program is implemented? Please be specific---for whom might there be consequences?**

One consequence could be potential duplication of services if the individuals are receiving care through the behavioral health system in the community. The current HUP team, however, is vigilant in regards to this issue and works to respond to the needs of the individuals served through the program in a coordinated manner to ensure appropriate utilization of resources. If the program expansions are implemented that allow for the ability to serve more of HMC's frequent user population, or to serve other EDs, similar or greater outcomes as those identified in section B3 could be expected.

4. **What potential UNINTENDED CONSEQUENCES might there be if this New Concept/Existing MIDD Strategy/Program is *not* implemented? Please be specific---for whom might there be consequences?**

If the base program were terminated, patients in HMC's ED and PES could expect to receive less or different assistance with connecting to community resources and housing, and the demonstrated improved system use outcomes described in section B3 may not continue to be realized. If the program does not expand and continues to be funded at its current level, it will continue to assist individuals who struggle with addiction and medical comorbidity. It would lack the broader scope and the ability to impact a great number of individuals with more robust and integrated services.

At a system level, ED utilization at King County's largest and busiest medical center would likely increase. This would have collateral effects throughout the community hospital system, as other patients who need the unique care that HMC can provide would not be able to receive emergency access as easily.

5. **What ALTERNATIVE APPROACHES currently exist to address this need apart from this New Concept/Existing MIDD Strategy/Program? At a high level, how does this New Concept/Existing MIDD Strategy/Program compare to those other approaches in terms of cost, feasibility, etc. Could this New Concept/Existing MIDD Strategy/Program be merged with one or more of the alternatives? What are the pros/cons of merging?**

This briefing paper encompasses an existing program with a track record of success alongside two proposed enhancements that were received through the MIDD New Concept solicitation process. It also briefly explores potential expansion of the program to other EDs beyond HMC.

The expanded components of the program would be best merged with the existing high utilizer team. There are no other programs that are hospital based that currently address the needs of this population prior to admittance into a hospital bed. The intensity and immediacy of service availability have led to the positive outcomes that have been seen to date. This enhanced program could penetrate more broadly and robustly and link closely with initiatives in the first responder community. If this program does not continue, it is possible that services such as peer bridgers could help such individuals, although not as early in their crisis, as the peer bridger program in its current form intervenes once a person is admitted to a psychiatric unit and has funding/priority population restrictions (i.e., it is limited to patients who have no funding or who have Medicaid only). Also, the housing set-aside component of this program is unique and would not be as readily available to these individuals.

Enrollment in outpatient behavioral health services is another resource to help stabilize and support individuals in the community, and provide coordination of care to address unmet needs resulting in crises or behavioral problems, and subsequent law enforcement response. For individuals who are

enrolled in the King County Behavioral Health Organization (BHO), this also includes crisis response. The intent of crisis services is to respond to urgent and emergent mental health needs of persons in the community with the goal of stabilizing the individual and family in the least restrictive setting appropriate to their needs, considering individual strengths, resources, and choice.

The current crisis response system for individuals enrolled in the BHO does not require an outreach to the community to assess the individual's needs or determine what services and supports could be provided to assist the individual with remaining in the community. Additionally, many contracted providers subcontract their crisis response services to other agencies, which often include telephone access only to an individual, with limited outreach availability into the community to directly address a crisis need, and with little direct knowledge about the individual. Finally, enrollment in the BHO is limited to individuals eligible for publicly funded behavioral health services, and there are limited response options for other populations in need.

Programs such as this one, which serve individuals who frequently use scarce emergency resources, represent one aspect a broad range of interventions to reduce overall emergency system use, including EDs and local acute care settings such as inpatient psychiatric units and state hospitals. Some of these interventions already exist, while others have been identified through the work of groups such as the Governor and Executive's Community Alternatives to Boarding Task Force.[37] Programs that intervene farther upstream have the potential to impact system use as well, or prevent it completely, but interventions that begin in the ED often may also truncate emergency stays and reduce future utilization, especially for individuals with no previous service engagement or with multiple, comorbid chronic conditions.

E. Countywide Policies and Priorities

1. **How does this New Concept/Existing MIDD Strategy/Program FIT within the CONTINUUM of care, and within other county initiatives such as Behavioral Health Integration, Health and Human Services Transformation, Best Starts for Kids, All Home, the Youth Action Plan, and/or the Vets and Human Services Levy or any other County policy work?**

Healthcare reform and Behavioral Health Integration will play significant roles in the work of this program. The services provided through these programs are an initial step in the continuum of care, intended to provide early intervention, crisis stabilization, and case management services to promote access to ongoing services in the community. By providing individualized, flexible support to frequent ED users regardless of the particular primary driver of their crisis needs, the HUP program works to create connections for individuals between mental health, substance abuse, and primary care; this supports the broad aims of the state's physical and Behavioral Health Integration initiatives being launched under 2014's Second Substitute Senate Bill 6312, which aims to bring together mental health and behavioral health services under a single organizational and payment structure by April 2016, with physical and behavioral healthcare integration set to occur by January 2020.[38] These efforts in Washington State also reflect a broader national movement toward integrated care as a means to deliver improved outcomes for individuals.[39]

[37] A range of such alternatives is identified in the draft recommendations of the Community Alternatives to Boarding Task Force, published in its January 2016 progress report. Retrieved from http://www.kingcounty.gov/healthservices/MHSA.aspx.
[38] http://lawfilesext.leg.wa.gov/biennium/2013-14/Pdf/Bills/Session%20Laws/Senate/6312-S2.SL.pdf, http://www.kingcounty.gov/healthservices/MHSA/BehavioralHealthIntegration.aspx
[39] https://www.thenationalcouncil.org/consulting-best-practices/center-for-integrated-health-solution/, http://www.integration.samhsa.gov/

Without the benefits obtained through healthcare reform, many of these individuals would have been deemed ineligible for Medicaid or other health coverage based on exclusionary factors no longer in place. Without access to benefits, most of the more therapeutically appropriate services needed for stabilization would not be available to the population of focus– treatment, medications, housing – and the target population would continue to cycle through EDs and hospital settings.

The King County Health and Human Services Transformation Plan's work, focused on using an integrated cross-system approach to improve outcomes frequent users of the King County Jail, known as "Familiar Faces," may also relate to the work of the HUP team.[40] Although data do not show a high level of hospital utilization for the Familiar Faces, individuals who have been identified with behavioral health indicators and admitted into the jail four or more times in 12 month period, frequent jail bookings and more time spent behind bars likely suppress hospital use due to less community tenure and corresponding crisis system contact.[41] As Familiar Faces spend less time in jail as a result of innovations currently being considered, specialized crisis services in the community and at EDs such as HUP may be helpful in meeting their needs.

Linkage to other key King County initiatives, including All Home and the Community Alternatives to Boarding Task Force, are discussed elsewhere in this document.

2. **How is this New Concept/Existing MIDD Strategy/Program rooted in principles of recovery, resiliency, and/or trauma-informed care?**

Clinicians in this program use individual-centered goals as their guiding strategy from the beginning of engagement, through the change process, to service termination. They develop authentic relationships that reflect larger goals of finding purpose, remaining open minded, and reaching out to others. These approaches enable clinicians to know individuals' goals, see their concerns from their perspective including possible solutions, and provide the individualized help that they feel will make the difference in enabling individuals to avoid future emergency system use. Additionally, the use of certified peer support specialists, who have been specially trained in trauma-informed care, solidifies a recovery focused approach.

3. **How does this New Concept/Existing MIDD Strategy/Program enact and further the County's EQUITY and SOCIAL JUSTICE work?**

Individuals with behavioral health disorders engaging with first responders are often sent to costly resources such as EDs and jails due to the symptoms of their disorder(s), and these are often re-traumatizing to individuals, especially if they have previously experienced the loss of their rights and privileges due to detainments or involuntary hospitalizations. These programs are intended to provide alternative response options that reduce the over-reliance on the crisis systems to manage the needs of this population. These programs will work with the understanding that recovery can take time and often multiple engagement efforts are needed, by both first responders and service providers, to build relationships and impact behavior change to support the recovery process.

HUP's focus on promoting stability through housing also supports the goals of King County's All Home initiative, which aims to make homelessness rare, brief, and one-time by addressing crises quickly and

[40] http://www.kingcounty.gov/elected/executive/health-human-services-transformation/familiar-faces.aspx
[41] Analysis of 2013 Familiar Faces cohort by King County MHCADSD.

tailoring housing and supports to individual needs,[42] and addresses the state of emergency regarding homelessness declared by the City of Seattle and King County in November 2015.[43] All Home's individually tailored service designed to connect people to housing and services also relates to two determinants of equity identified by the King County Equity and Social Justice (ESJ) work: access to health and human services and affordable, safe, quality housing.[44]

F. Implementation Factors

1. **What types of RESOURCES will be needed to implement this New Concept/Existing MIDD Strategy/Program** (staff, physical space, training, UA kits, etc.)**?**

The base HUP program at HMC is currently operating. If capacity of approximately 100 individuals is to be maintained, a funding level consistent with MIDD I, along with increases to accommodate ongoing wage and benefit expenditures, will be necessary. The program assistant currently funded through MIDD supplantation is not included in this amount, as it may be a MIDD-ineligible service because a 1.0 FTE liaison service for frequent ED users was in place prior to the beginning of MIDD I.

If the base program model is maintained without any multidisciplinary enhancements, and simply expanded to include more staff, this could yield greater penetration among the very frequent utilizer population that the program targets. As indicated above, the program currently serves approximately 100 of the 486 individuals who have visited the Harborview ED at least eight times in the past six months, so the need far exceeds current staffing capacity.

To expand the program to a multidisciplinary model would require: 2.0 FTEs to include a CDP and a peer counselor. In addition, reimbusement would be needed for the third staff person to return to full capacity, adding 0.7 FTE, as well a the 0.1 FTE consultation from a psychiatrist and medical provider. An additional expansion would include a 0.5 FTE nurse provider to do outreach to assess medical concerns.

Expansion to other hospitals within King County would significantly add to the resource needs for this program. Staffing models would need to be developed in order to determine the level of response and staff needed to address the demand for services for this population.

2. **Estimated ANNUAL COST. $501,000-$1.5 million Provide unit or other specific costs if known.**

The current program, with 2.3 FTE, is funded through the Existing Strategy at $200,000 per year, although this does not include the 2015-2016 inflationary increase. Additional costs would be required to expand staff, provide flexible funding to support immediate individual needs, and procure additional office space including computer and phone capability. A combined total cost of $600,000 is estimated, assuming implementation to hospitals across King County. These costs estimates would potentially be more than offset by savings noted in the Harborview HUP studies (2013)[45] identified previously.

3. **Are there revenue sources other than MIDD that could or currently fund this work? Clarify response, citing revenue sources.**

[42] http://allhomekc.org/the-plan/#fndtn-brief-and-one-time
[43] http://www.seattletimes.com/seattle-news/politics/mayor-county-exec-declare-state-of-emergency-over-homelessness/
[44] http://www.kingcounty.gov/~/media/elected/executive/equity-social-justice/2015/The_Determinants_of_Equity_Report.ashx?la=en
[45] 2014 outcome study, provided by Harborview HUP.

The intensive outreach and engagement services that require travel, meeting time, and consultation are not funded by current payors. However, there may be sources of support available if such outreach programs become payable under a Section 1115 Medicaid waiver.[46] There may be the possibility of funding Medicaid reimbursable services through local funding for mental health outpatient services. This would need to be arranged through the BHO.

4. **TIME to implementation: Less than 6 months from award**

   a. **What are the factors in the time to implementation assessment?**

   The existing program could be maintained continuously, and capacity could be expanded through hiring additional case managers. Replication at other medical centers that have a critical mass of frequent ED users would require several more months for full implementation to begin.

   a. **What are the steps needed for implementation?**

   The base program is currently being implemented. The following steps are expected in order to implement the enhancement portions of this proposal:

   1. Expand the current contract exhibit;
   2. Create, and obtain approval for, job descriptions for expanded program personnel;
   3. Recruit and hire for positions; and
   4. Increase existing space of the program.

   b. **Does this need an RFP?**

   An Request for Proposals (RFP) would become necessary if the base program were replicated in other EDs.

G. Any OTHER INFORMATION that would assist reviewers with making recommendations about this New Concept/Existing MIDD Strategy/Program? (optional). Do you have suggestions regarding this New Concept/Existing MIDD Strategy/Program?

This program could link with the Crisis Diversion Facility (MIDD Strategy 10b) and the South County Crisis Center (MIDD BP 37, 51, 64, 66 South County Crisis Center Schoeld), should the program expand throughout King County, and provide a more intensive resource for first responders across South King County when engaging individuals who need more intensive medical/psychiatric supports in order to remain in the community and avoid hospitalizations. It could also link with the Crisis Intervention Team-Mental Health Partnership Project (MIDD ES 17a BP 4 Crisis Intervention Team-Mental Health Partnership Project Schoeld).

[46] https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/section-1115-demonstrations.html.

MIDD Implementation Plan FINAL – October 6, 2008

Strategy Title: Expand Re-entry Programs

Strategy No: 12c – Increase Capacity for Harborview's Psychiatric Emergency Services to Link Individuals to Community-Based Services upon Discharge from the Emergency Room

County Policy Goals Addressed:

- A reduction of the number of people with mental illness and chemical dependency using costly interventions like jail, emergency rooms and hospitals.

1. Program/Service Description

◊ *A. Problem or Need Addressed by the Strategy*

This strategy was proposed during the original development of the Mental Illness and Drug Dependency Action Plan (MIDD) as a way of addressing the needs of individuals who are repeatedly admitted to Harborview Medical Center's Psychiatric Emergency Services (PES) and to the Emergency Department (ED) as a whole, due to substance abuse and/or mental illness. In 2007, there were over 6000 admissions to PES and over 80,000 to the entire ED. In 2006, there were 332 individuals identified as the highest utilizers of ED services. Of these 332 people, 62% were homeless, 49% were diagnosed with a mental illness and 74% were diagnosed as substance dependent. In addition, over 70% of these 332 individuals had a significant medical illness that required treatment in the Emergency Department. Without referral and linkage to housing and services, many will continue to return frequently in the future. Increasing visits of high utilizers contributes to PES and ED crowding, thus increasing the number of individuals with mental illness and chemical dependency who are directed to other hospital emergency departments across King County.

◊ *B. Reason for Inclusion of the Strategy*

Hospital emergency departments are increasingly experiencing difficulty in placing individuals who are frequent users of emergency services due to mental illness, homelessness and chemical dependency. Emergency rooms are a very expensive resource, and individuals, and the public, would be better served if community service alternatives were provided to reduce the use of emergency services.

◊ *C. Service Components/Design*

The final service design has not been determined at this time. There are a number of programs targeting homeless individuals who are high utilizers of emergency medical services and jails that are being developed in the next year, and it is critical that these efforts be well-coordinated in order to reduce duplication of effort and to achieve the most efficient and effective results. The High Utilizer Referral System is a major effort underway to serve homeless individuals who are frequently involved with the criminal justice and hospital emergency systems. Funding is provided by the Veterans and Human Services Levy and the United Way Campaign to End Chronic Homelessness. The Service Improvement Plan being developed this year includes a redesign of the Emergency Services Patrol and Dutch Shisler Sobering Center, increased outreach and service engagement for individuals with chemical dependency and improved coordination among key stakeholders to identify high utilizers of criminal justice and emergency medical services in order to facilitate placement into dedicated supported housing. In addition,

strategy 1b in the MIDD targets this same population and includes providing outreach and engagement for individuals being discharged to shelters from hospitals and jails.
We propose delaying the final determination of design for this strategy in order to coordinate with these other strategies in order to create a well-coordinated and efficient system for responding to the needs of individuals who are high utilizers of emergency department services and jails.

◊ *D. Target Population*

Adults who are frequent users of the Harborview Medical Center ED.

◊ *E. Program Goal*

Provide increased coordination with other initiatives and providers to link individuals who are high utilizers of Harborview ED with ongoing community supports and housing

◊ *F. Outputs/Outcomes*

Outputs will be determined once a final model is developed.
Expected outcomes include increased linkage of individuals to needed community treatment and housing and reduced use of emergency medical services.

2. Funding Resources Needed and Spending Plan

To be determined. The budget identified in the MIDD is $200,000 per year to pay for two full-time professional staff and one program assistant.

3. Provider Resources Needed (number and specialty/type)

◊ *A. Number and type of Providers*

To be determined

◊ *B. Staff Resource Develop Plan and Timeline*

Still to be developed

Will depend on the model developed through the planning process

◊ *C. Partnership/Linkages*

Stakeholders include Harborview Medical Center, The Committee to End Homelessness, The Veterans and Human Services Levy Boards, United Way of King County, shelter providers, jails, and hospitals throughout King County, the King County Department of Community and Human Services, and Public Health –Seattle and King County.

4. Implementation/Timelines

◊ *A. Project Planning and Overall Implementation Timeline*

To be determined

◊ *B. Procurement of Providers*

To be determined

◊ *C. Contracting of Services*

To be determined

◊ *D. Services Start Date(s)*

To be determined

New Concept Submission Form

New Concept 83

Working Title of Concept: Peer Support Medical Integration Team

Name of Person Submitting Concept: Brigitte Folz
Organization(s), if any: Harborview Medical Center
Phone: 206-744-4052
Email: ebgf@uw.edu
Mailing Address: Harborview Box 359897 325 9th Ave. Seattle WA 98104

Please note that county staff may contact the person shown on this form if additional information or clarification is needed.

Please share whatever you know, to the best of your ability.
*Concepts must be submitted via email to MIDDconcept@kingcounty.gov by **October 31, 2015**.*

1. Describe the concept.
Please be specific, and describe new or expanded mental health or substance abuse-related services specifically.

This concept proposes the creation of a Peer Support Medical Integration Team.
Peer Support Services have become well recognized and established in community behavioral health treatment settings. This concept would expand the penetration of Peer Support Services beyond community mental health and psychiatric inpatient settings to provide services as part of a High Utilizer Team or as a distinct program, to outreach medically fragile and behaviorally challenged (by mental illness or substance use) individuals to ensure connection to health care services (including behavioral healthcare service). This service would occur in a broad range of community settings including individual homes, primary care, shelters and adult family homes.

2. What community need, problem, or opportunity does your concept address?
Please be specific, and describe how the need relates to mental health or substance abuse.

Persons with a substance use disorder or a serious mental illness have a decreased life expectancy and poorer health outcomes than the general population. These individuals are frequently alienated and estranged from traditional medical services and treatment providers. A certified peer counselor would provide an important peer connection by outreach and engagement in the community. A certified peer counselor would help ensure linkage to medical and behavioral healthcare services for persons with extraordinary utilization of ED and medical resources and target high risk individuals being discharged from medical hospitals, EDs and in primary care. This peer support team could additionally take referrals from the First Responder providers to target individuals needing additional support to remain safe in the community.

3. How would your concept address the need? Please be specific.

This concept would encourage the development of a team of peer support staff who would work with the High Utilizer Team and other community agencies to target superutilizers, particularly patients who are behaviorally challenged and have medical risk. Methods used would be assertive outreach and

engagement in the community and work to remove barriers that prohibit effective linkage to medical, clinical behavioral health resources and housing. This Peer Support team would also take referrals from the 911 - First Responder Providers for vulnerable individuals

4. Who would benefit? Please describe potential program participants.

The program participants would be medically high risk or vulnerable patients who have a concurrent mental illness or substance abuse.

5. What would be the results of successful implementation of program?
Include outcomes that could be measured and evaluated. Please indicate whether this data is currently collected in some fashion, and in what form.

Decreased medical admissions and ED visits and increased engagement with outpatient behavioral health services. ED visit data could be captured from the Emergency Department Information Exchange. Pre and post admission and readmission data would be collected by the program or the referring provider. If this team were resourced with nursing staff, improvements in health measures such as BP and other health outcomes could be readily captured.

6. Which of the MIDD II Framework's four strategy areas best fits your concept? (you may identify more than one)

☐ **Prevention and Early Intervention:** Keep people healthy by stopping problems before they start and preventing problems from escalating.

☐ **Crisis Diversion:** Assist people who are in crisis or at risk of crisis to get the help they need.

☒ **Recovery and Reentry:** Empower people to become healthy and safely reintegrate into community after crisis.

☒ **System Improvements:** Strengthen the behavioral health system to become more accessible and deliver on outcomes.

7. How does your concept fit within the MIDD II Objective – to improve health, social, and justice outcomes for people living with, or at risk of, mental illness and substance use disorders?

The primary focus would be to improve health outcomes of individuals living with mental illness and substance use disorder. We would plan to demonstrate improvement in health outcome by decreased ED visits and hospital readmissions.

8. What types of organizations and/or partnerships are necessary for this concept to be successful? Examples: first responders, mental health or substance abuse providers, courts, jails, schools, employers, etc.

First Responders, EDs, Inpatient units, respite programs, Jail, MH and SUD providers, housing resources, primary care clinics.

9. If you are able to provide estimate(s), how much funding per year do you think would be necessary to implement this concept, and how many people would be served?

Pilot/Small-Scale Implementation: $ 150,000 per year, serving 40 people per year
Partial Implementation: $ 300,000 per year, serving 80 people per year
Full Implementation: $ 600,000 per year, serving 160 people per year

---

New Concept 86

Working Title of Concept: Emergency Department Super Utilizer Care Team

Name of Person Submitting Concept: Ann Allen
Organization(s), if any: Harborview Medical Center
Phone: (206) 744-5838
Email: annall3@uw.edu
Mailing Address: HMC Box 35875 325 Ninth Ave Seattle, WA 98104

Please note that county staff may contact the person shown on this form if additional information or clarification is needed.

Please share whatever you know, to the best of your ability.
Concepts must be submitted via email to MIDDconcept@kingcounty.gov by ***October 31, 2015****.*

1. Describe the concept.
Please be specific, and describe new or expanded mental health or substance abuse-related services specifically.

The current High Utilizer Team would like to develop the concept of transitioning to a multidisciplinary team to include a chemical dependency professional, a peer support specialist and potential nursing and MD consultation. This would increase the team's ability to meet the needs of our clients in the community. A CDP would add the ability to provide chemical dependency assessments that would provide increased access to residential chemical dependency treatment. Also, with a peer provider as a member of our team we would have multiple approaches to engage clients with co-occurring disorders into services that include medical, mental health and substance use treatment. We could also increase the efficiency in reducing barriers to housing that take time intensive interventions such as gathering community identification and filling in applications with a peer providing support to clients that are already case managed by the program. With two added staff we believe we could serve 150 clients per year versus 100.

2. What community need, problem, or opportunity does your concept address?
Please be specific, and describe how the need relates to mental health or substance abuse.

The clients served in the High Utilizer Program of the Emergency Department, currently strategy 12c in MIDD, are having more difficulty accessing residential chemical dependency services when they are ready to for change. Our community services have been significantly impacted by the closure of Recovery Centers of King County , a previous primary partner. The clients remain in need of the services. Treatment had been effective in providing a significant decrease in emergency department visits in the past and even move a person toward readiness to connect with other providers and supports. In regard to the need for peer services, we have some clients who are less willing to engage in case management with professionals and are in need of the unique relationships that can be forged with peer providers. In particular, clients who are transitioning from homelessness, frequently have to build life skills in accessing community supports such as food banks, the bus system, and doing more independent scheduling including attending to chronic health needs as well as mental health and substance use concerns. Health care outcomes have been poor for persons with mental illness and substance use disorder. Proactive medical intervention would positively impact these outcomes.

3. How would your concept address the need? Please be specific.

The creation of a multidisciplinary team would enhance the ability of the team to provide integrated medical, and behavioral services. The partnership of peers lends itself to the clinical interventions helping clients to access and transition to housing. A chemical dependency specialist would be able to perform a formal an evaluation and refer a client to outpatient tor residential services when clinically appropriate. Furthermore we could increase the number of clients we serve. Currently we are contracted to serve people coming to the emergency department 4 or more times in a six month period. There are more than 1,000 patients using the emergency department more than 8 times in six months and we have 2.3 staff that are available to offer the intensive outreach approach that has been necessary to connect clients to ongoing support.

4. Who would benefit? Please describe potential program participants.

Our current clients are generally persons with co-occurring disorders and serious medical concerns. Those that are struggling with substance use, chronic medical conditions and homelessness would be most impacted by adding multidisciplinary providers to our team.

5. What would be the results of successful implementation of program?

Include outcomes that could be measured and evaluated. Please indicate whether this data is currently collected in some fashion, and in what form.

We could increase the number of client we serve. For the current clients we serve we have reduced their emergency department visits by about 60% which then decreases the charges for their services as well. We collect this data and forward it to the county yearly in our current reports. The summary of our outcome study from 2014.

ED High Utilization Summary
All "Pre" values are 6 months prior to CM Start, all "Post" values are 6 months after CM Stop

Average ED Visits Per Month

Cat	AVG
Pre	1.73
Post	0.68

Total Charges

Cat	Total
PreTotal	$5,357,763.87
PreED	$1,640,858.65
PostTotal	$3,108,902.50
PostED	$664,900.82

	Pre	Post	% Change
Total Charges	$6,998,622.52	$3,773,803.32	-46.08
Total Cost	$3,235,848.07	$2,087,873.78	-35.48
ED Visits	613	238	-61.17

With a higher number of clients served it would be expected that the pre-total charges and visits that we are reducing would increase, as would the cost saving savings from effective interventions.

6. Which of the MIDD II Framework's four strategy areas best fits your concept? (you may identify more than one)

☐ **Prevention and Early Intervention:** Keep people healthy by stopping problems before they start and preventing problems from escalating.

☒ **Crisis Diversion:** Assist people who are in crisis or at risk of crisis to get the help they need.

☒ **Recovery and Reentry:** Empower people to become healthy and safely reintegrate into community after crisis.

☒ **System Improvements:** Strengthen the behavioral health system to become more accessible and deliver on outcomes.

7. How does your concept fit within the MIDD II Objective – to improve health, social, and justice outcomes for people living with, or at risk of, mental illness and substance use disorders?

Data from the MHCADS report for MIDD oversight for 2014 indicate that the intervention has decreased jail days. "Significant three-year reductions in average days spent in community psychiatric hospitals for the 28 eligible cases were 85 percent, from 36 days to five. During the same timeframe, jail bookings were reduced by 66 percent and jail days dropped 49 percent for the 62 eligible cases with any jail utilization. We have not formally collected data on the other referrals or connection made to medical care but the increase of outpatient versus inpatient medical charges would indicate that clients access community based medical care at a higher rate leading to improved health.

8. What types of organizations and/or partnerships are necessary for this concept to be successful? Examples: first responders, mental health or substance abuse providers, courts, jails, schools, employers, etc.

Partnerships with different residential substance abuse providers need to be established, an increased number of supported housing options with medical / personal care available to clients with profound needs will need to move forward with partnerships of Home and Community Service and local housing

providers. Increased care planning with Seattle Fire department to share plans to divert patients when possible from emergency department visits where there is a plan to offer needed services in alternative venues will also be a priority. We also need to reestablish a priority of residential treatment availability for high utilizer with providers of substance use services, including medication assisted treatment being offered through primary care clinics.

9. If you are able to provide estimate(s), how much funding per year do you think would be necessary to implement this concept, and how many people would be served?

Pilot/Small-Scale Implementation:	**$ 150,000 per year, serving 50 people per year**
Partial Implementation:	**$ 300,000 per year, serving 100 people per year**
Full Implementation:	**$ 500,000 per year, serving 200 people per year**

Once you have completed whatever information you are able to provide about your concept, please send this form to *MIDDConcept@kingcounty.gov*, no later than 5:00 PM on October 31, 2015.

If at any time you have questions about the MIDD new concept process, please contact MIDD staff at *MIDDConcept@kingcounty.gov*.