



**THE CENTER  
FOR HEALTH CARE SERVICES**  
Mental Health & Substance Abuse Solutions

Where hope and healing begin.

# The Center for Health Care Services High Utilizer Program and Integrated Care Team

Changing the way we provide care so  
that our consumers  
can change their lives.

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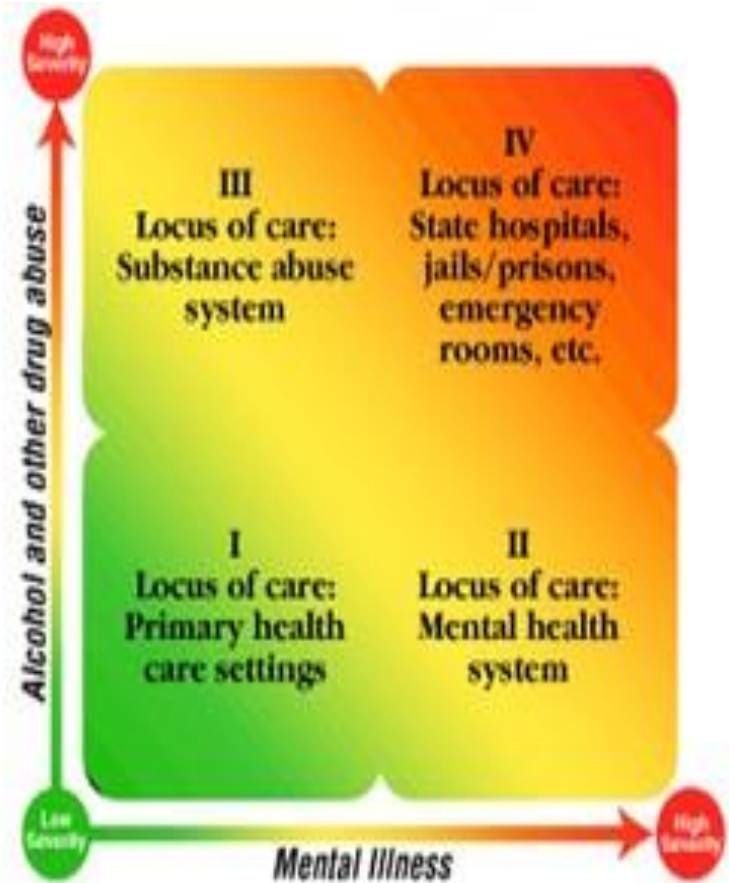
# WHO ARE WE

- *The High Utilizer Program is a supportive, comprehensive, and holistic approach to serving people on their road to recovery. The Integrated Care Program is a dedicated group of behavioral and primary care clinicians that work together to provide the finest integrated healthcare.*

# PROGRAM MODEL ASSUMPTIONS

## Development Assumptions

- HUs have complex conditions and needs: medical co-morbidities, psychiatric and/or substance abuse; psychosocial needs (i.e. homeless or unstable housing; eroded social support)
- HUs present to emergency department (ED) systems due to medical, psychiatric, and/or substance use conditions



# PROGRAM MODEL IMPLEMENTED

## Implementation Observations

- HUs present with co-morbid medical conditions with acute psychosocial needs
- The presentation in the EDs were driven more by their psychosocial needs than their co-morbidities
  - Safe place
  - Warm bed and food
  - Social interaction and support
  - Likely a system that was caring throughout their traumatic lives

# PROGRAM MODEL IMPLEMENTED

## Implementation Observations

- As expected – but on a larger scale - preponderance of Axis II Personality Disorders; especially Borderline Personality Disorder
  - “Manipulative to gain nurturance”-DSM IV-TR
  - Relations alternating between idealization to devaluation. In this case...the system.
  - Failure to successfully maintain or navigate boundaries
- Baseline definition was used for initial data set to identify potential targeted consumers. As the program evolved, we have adopted our referring partners’ definition of high utilization.

# Who are the High Utilizers

## Community/System Views

- Pejoratively perceived as “working the system” to meet their needs
- Clinically judged as “non-compliant” consumers
  - Inconsistent with adherence to pharmacological intervention
  - Difficult to engage in treatment both geographically and psychologically
  - Suspicious of the system
- The overuse of community resources leads to care fatigue by systems being utilized

# Who are the High Utilizers

## Our View

- HUs are individuals who undoubtedly have a history of trauma personally and systemically
- Often times with broken/no support system
- Difficulty maintaining appropriate boundaries
- Individuals who are survivors but not self-sufficient
  - Lack of confidence
  - Lack of experience
  - Lack of support
  - Lack of resources
- Business as usual has not worked for HUs. In need of consistent, intense, purposeful engagement.



# What's the Difference?

## Model

Standard Approach	Integrated Care for HUs
Assume Quadrant Model (Hi Med/Hi Psychiatric)	Complex Psychosocial Needs; Trauma history; Axis II/Personality Disorders
Providers and Care System in silos	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/ <i>in vivo</i>
Non-compliance/exclusion	Engagement/inclusion
System-driven/productivity goals	Person-centered/quality outcomes
Individual Professional Services	Groups; Peer Services
Re-traumatizing	Trauma-Informed



# What's the Difference?

## Services

- **Linkage to Center for Health Care Clinic-** Assistance in linking to CHCS clinic to connect with case management services
- **Psychiatric medication management-** Meeting with a prescriber to receive medications
- **Psychiatric nursing services-** Clinic based medication training and assistance services to educate client on medication use, symptoms diagnosis and effects
- **Linkage to primary care specialist-** In house primary care for qualifying benefits or linkage to outside providers and medical support systems
- **Supportive/supplemental case management services-** In addition to case manager obtained through CHCS clinic, ICT case manager will provide additional services as needed to include advocacy, psychosocial rehabilitative services, supported employment, and supported housing.
- **Substance Abuse/Addiction treatment-** Education on effects of substance abuse, coping skills to manage cravings, skills to reduce substance use, coordination of access into rehabilitation programs, access to in-house substance abuse groups, and substance abuse specific counseling.
- **Peer Support-** Certified peer specialist to support, engage, and assist in the recovery process through assisting in developing goals for recovery, learning and practicing new skills, helping monitor progress, assisting in treatment, modeling effective [coping techniques](#) and [self-help](#) strategies based on the peer support specialist's own recovery experience, and supporting in [advocating](#) for themselves to obtain effective services
- **Individual Counseling-** The program provides trauma informed evidence-based psychotherapy practices including Cognitive Behavioral Therapy, Cognitive Processing Therapy, Dialectical Behavior Therapy (DBT) and other individually-focused counseling.
- **Group Counseling-** The program provides a comprehensive array of behavioral health groups utilizing trauma-informed and evidence-based practices. These groups are designed to meet the individual clinical and social support needs of participants in a recovery-oriented environment built on peer support and reinforcement.
- **Wellness groups-** An array of groups to support physical health and living
- **Behavioral Psychologist Consults-** Behavioral psychologist provide intervention for physical health issues to include but not limited to weight loss, smoking cessation, chronic pain management, etc.

# Why does it work?

## High Utilizer Program

- Ability to meet the individual where they are physically and metaphorically.
- Ability to provide consistent, intensive engagement throughout their involvement in the program.
- Working organically and fluidly to adjust to the ever changing needs of the consumers.
- Ability to keep individuals indefinitely throughout recovery (\*continued support and communication after “graduation”)
- Ability to transport consumers
- Dynamic, dedicated, and gifted clinicians and peers!

# Why does it work?

## Community

- We are cultivating and growing relationships with all emergency systems within our community and own agency.
- Work quickly and collaboratively with our partners. We are willing to accommodate the emergency systems to meet needs of consumers.
- Within the clinic have a very open and supportive communication between team clinicians and clinic staff from front desk to providers.

# Why does it work?

## Integrated Care Clinic Collaboration at its finest

- Daily Huddle to include all involved parties
  - Psychiatrist
  - Nurse Practitioners
  - Nurses
  - Behavioral Psychologists
  - Case Management
  - Primary Care
  - Residents and Interns
- Discussion
  - Troubleshoot clinic flow issues
  - Evaluate previous day concerns, referrals, consumer needs
  - Present day schedule: discussion of referrals needed, non-medical internal services needed, consumer status
- Benefits
  - Risk Assessment and Risk Reduction
  - Person-centered/Trauma informed
  - Integrated Care



# Facility Accommodations

## Groups Rooms and Teaching Space

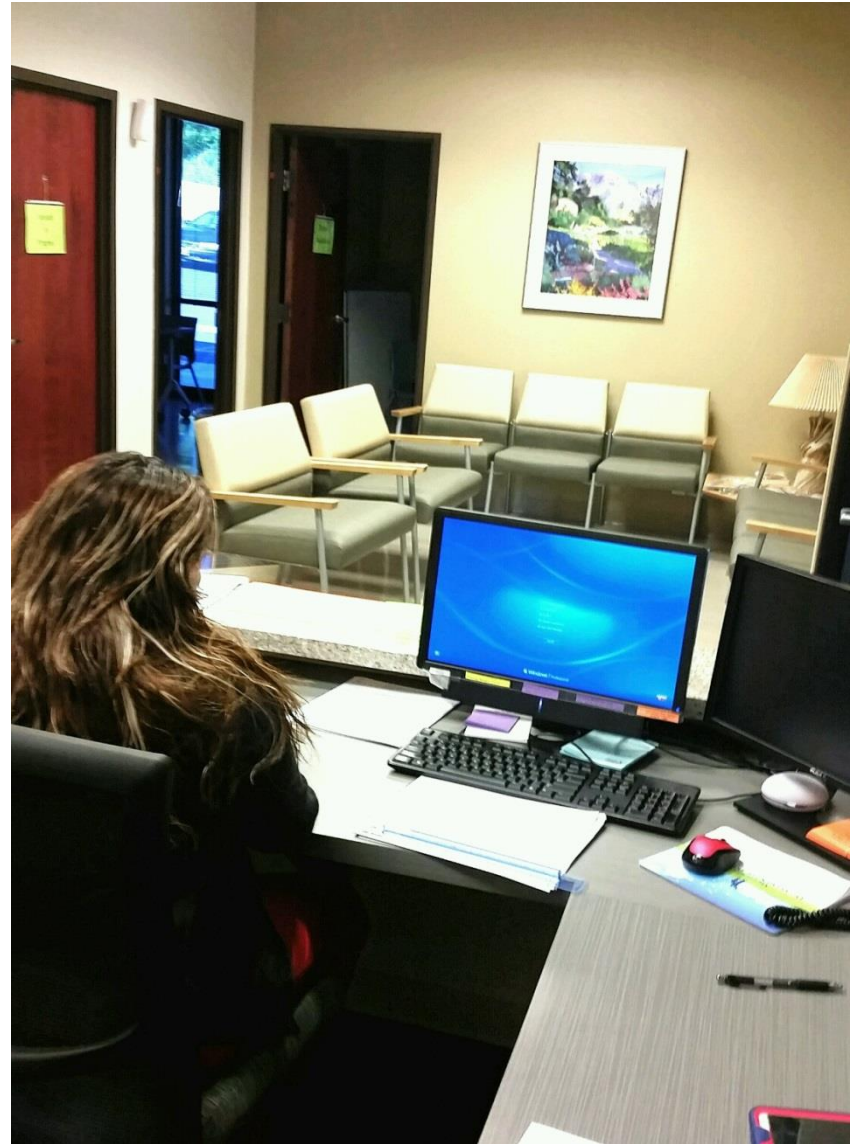


# Facility

## Accommodations

### Small Waiting Rooms

- Supports a productive and positive clinic flow
- Consumers aren't "lost" in the space
- Person-centered (ie, no glass, communication/conversation with friendly staff)
- Bright and inviting
- Our consumers deserve facilities that we deserve



# High Utilizer Program

## Numbers Talk: DSRP Year 3 Numbers

- **Program inception November 2012**
- **180 individuals served unduplicated since inception to 9/30/2014**
- **156 individuals served unduplicated 10/1/2013-9/30/2014**
- **Of the 156, 139 individuals received 3+ face-to-face encounters. Total number of encounters for the year: 3369.**
- **Population 58% male, predominantly Hispanic or Non-Hispanic/White**

### **ESTIMATED SAVINGS**

Group (154) total: 1782 visits pre-IC; 1067 post-IC

Group total visit decrease of 715 (40% reduction)

Estimated savings:  $715 \times \text{est } \$1200 = \$858\text{K}$  savings per year for one hospital system

Estimated savings for 5 Bexar County Hospital= \$4,290,000

10/27/2014: Of ~120 active consumers: 48 active consumers with no ED utilization for 90+days

# High Utilizer Program

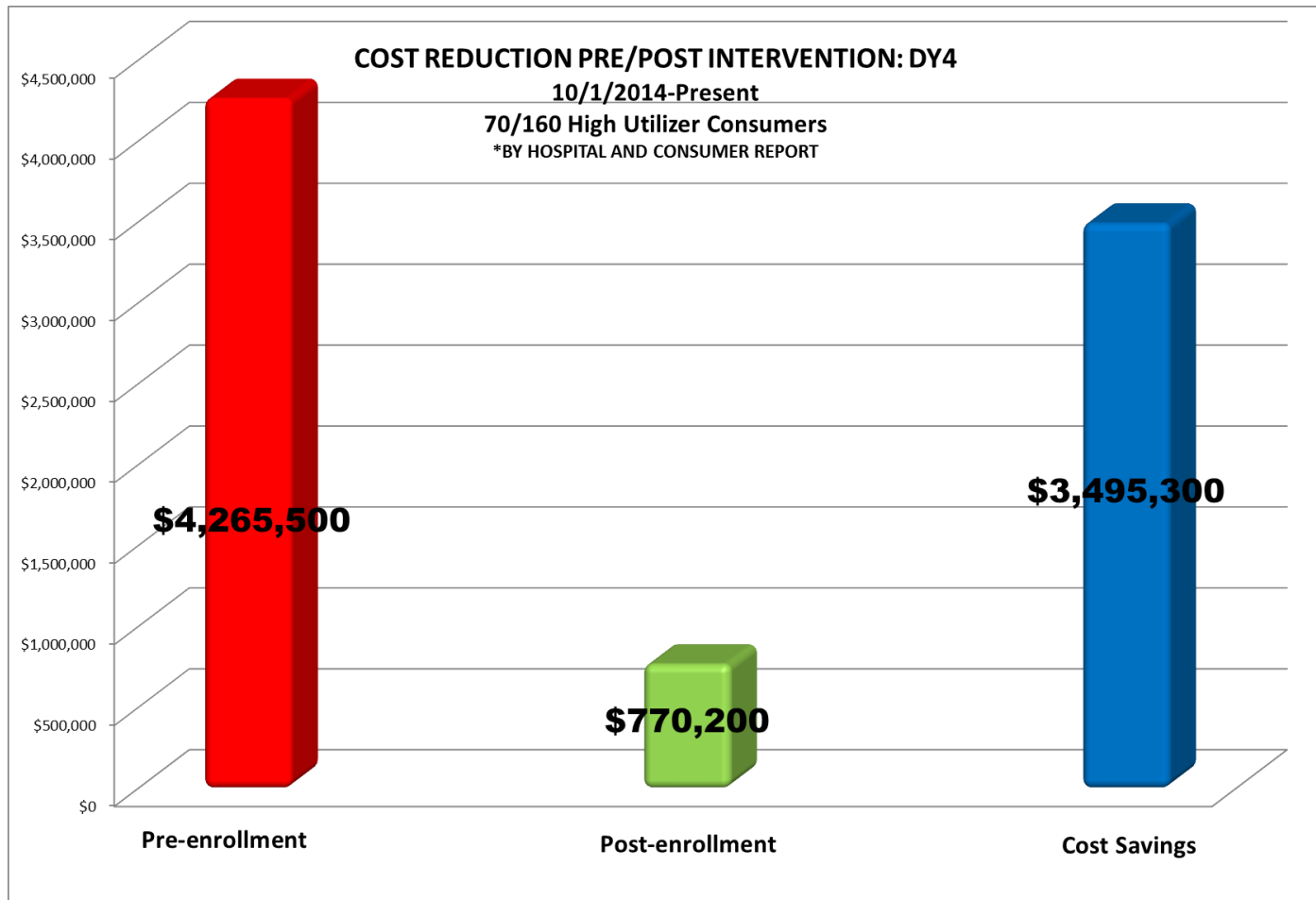
## Numbers Talk: case example

- KN: 127077 Originally enrolled in program in 10/2013
- Attempted engagement 10/23/13-2/15/2015.
- Each time agreeing to services, each time avoiding engagement
- Reportedly touching each emergency department (5) at least 3x/week at least two weeks out of the month.
- Finally in 2/15 consumer engaged and has not admitted to a hospital since.
- Savings from 2/15-6/15: \$144,000
- \*cost noted only includes the understated estimate of ER visits. Consumer also utilizes, MCOT, Crisis, Inpatient, and SASH.
- Now in housing, engaged in recovery and psychiatric services
- Since enrollment has received 589 contacts and 136.55 client hours



# High Utilizer Program

## Numbers Talk: DY4 qualitative snapshot



# Integrated Care Clinic

Where Passion and Innovation  
Integrate

