CASE STUDY

Navigating Coordination of Care for Behavioral Health Patients

Navos **increased follow-up rates 15 percent** by coordinating care for behavioral patients between providers.

"We take an integrated care approach. Even someone with a physical ailment like diabetes may experience a condition like depression when learning to adapt to a new diet and way of life. But the healthcare system can be so fragmented that we don't see those connections. Our goal is to make sure everyone gets the care they need, that everyone has a primary care physician, and that we connect providers with the resources they need to treat the whole person."

Jennifer Neumann,
LICSW and Clinical Systems Analyst, Navos

Navos Mental Health Solutions

Navos Mental Health Solutions specializes in serving patients with moderate to severe mental health illnesses and substance use disorders. With outpatient, community, inpatient, involuntary hospital, residential, crisis, and afterhours triage services, the organization provides a broad continuum of care to better help these patients. Careful coordination of care between these care settings is key to ensuring each patient gets the appropriate care for the best outcomes.

The Challenge: Coordinating Behavioral Health Between Providers

Navos works to provide patients struggling with behavioral health conditions and substance use disorders with appropriate, comprehensive care—including mental, physical, and behavioral health care. Tracking these patients proved difficult, as many of the patients transitioned regularly between hospital visits and specialized behavioral care. The staff at Navos began to look for a better way to ensure these patients were getting the care they needed. Jennifer Neumann, LICSW and Clinical Systems Analyst at Navos, explained:

"We weren't able to tell when our patients were in the hospital and when they were discharged. We might get a call from the hospital, or we might not. Often, it was not. This made it difficult to know who we should be following up with and when."

But the challenges of caring for these patients went beyond just knowing where a patient was. Navos providers at clinics, hospitals, triage services, and community organizations were lacking needed insight into key patient histories—including medical records, lab values, medications, and possible SUDs. To better facilitate transitions of these behavioral health patients

between hospitals and other facilities, Navos began using Collective Medical to track patients and coordinate care.

The Solution: An Integrated Approach to Care

With Collective's care collaboration platform, case managers and social workers at Navos could pull regular reports to find and identify their patients at highest risk and work collaboratively with clinical supervisors, medical directors, pharmacists, psych nurses, and members of the King County Public Health department to determine the best plans of care for each patient. These care plans were then housed in the platform, giving each member of the patient's care team the information they need to best help these patients. Neumann explains:

"A lot of the people we serve are people that do not have much engagement with us. If we weren't able to see their care histories and utilization patterns, they would continue to fly under the radar, and we wouldn't know how often they were using the ED or that they were having management issues with physical or mental health, or substance use disorder. With the platform, vulnerable patients pop up on our radar, so we're able to take him or her back to our briefings and determine the best plan of action for them—whether that means supporting them through an outpatient program or with additional resources."

Being able to identify and address patterns of ED utilization and the factors contributing to them, staff at Navos were able to help find solutions to current problems—and predict potential issues in the future.

Collaboration between both the physical and mental health providers helped ensure a clearer understanding of each patient. For example, a medical professional looking at physical symptoms can coordinate with a behavioral health specialist to see if any of the symptoms presenting are physical manifestations of a mental health condition like anxiety. Similarly, when patients are transitioned to

Giving Back—The Peer Bridger Program

For patients struggling with behavioral health diagnoses or SUD, the most helpful resources are the empathetic resources. Knowing that, Navos implemented the Peer Bridger program to help patients transition from inpatient psychiatric care to home.

Each peer is a trained and certified Peer Support Counselor—with their own experiences working through recovery from mental, behavioral, or SUD conditions. The peer works with the patient during hospital stay, then continues as a partner and mentor to them through the recovery process post-discharge.

Because peers have struggled with many of the same challenges as the participants in the program, they help show those in recovery that it is possible to overcome current difficulties and transition smoothly back into the community. But support goes beyond overcoming addictions or behavioral health disorders. Peers also work with participants to help secure housing, employment, and additional outpatient support and treatment.

By coordinating care beyond traditional provider-provider relationships, the Peers program has been able to increase enrollment in outpatient services, shorten length of stay, reduce the number of hospital episodes, increase Medicaid enrollment, and reduce rehospitalization.

outpatient or inpatient psychiatric care, those providers know and can see that tests have already been run to rule out physical conditions that could have been responsible for what the patient is feeling. Neumann continues:

"With a more complete view of these patients, we have the visual data needed to see where these patients are going and understand their patterns of ED utilization. We can even identify patterns that help us identify social determinants of health. We can see patterns of ED utilization that show someone presenting could just be hungry and without food, or feeling unsafe at home, and engage with the patient to see what else we can do to help our patients address the root of the problem."

By recognizing the likelihood of hospital readmissions, ED utilization, and other concerns, case managers can work proactively with patients to try and prevent unnecessary utilization and get patients the care needed—at an acuity level appropriate to the condition.

Clinical Outcomes

Using a combination of regularly pulled reports and real-time email notifications for patients with high-risk, Navos improved communication for more streamlined coordination. Their preliminary results include:

A 15 percent increase in follow-up rates within 7 days of hospital discharge, from 37 percent to 52 percent

Ability to predict readmissions of patients with 92 percent accuracy, and adjust care accordingly

Patients are now twice as likely to receive appropriate follow-up care within 30 days

Navos continues to build out programs to support individuals facing behavioral health conditions—including programs for children, teens, those with chronic conditions, and patients visiting the ED for the first time—through increased connection and care.

About Collective Medical

Collective Medical provides the nation's largest and most effective network for care collaboration. Our risk-adjusted event notification and care collaboration platform spans across all points of care—including hospitals, payers, behavioral and physical ambulatory, and post-acute settings.

The Collective platform uses the network to identify at-risk, complex patients and share actionable, real-time information with diverse care teams, leading to better care decisions.

TAKE CONTROL

collectivemedical.com/behavioral-health

collectivemedical®