CASE STUDY

Coordinating Care for Vulnerable and Complex Patient Populations

CBCS patients see, on average, a **50-60 percent reduction in ED visits**—in addition to breaking the addiction cycle.

"I experienced on a daily basis through my physician work the gap in healthcare that exists for complex care patients; I knew we could create methods to address these and felt a moral obligation to do so. With collaboration tools like Collective, I knew I had what it took to jump into that space and really start engaging to help these vulnerable patients get the care they need at a cost we can afford."

Enrique Enguidanos,
CEO and Founder of Community Based Care Solutions and Washington ED Physician

Community Based Care Solutions

Community Based Coordination Solutions (CBCS) works with at-risk entities—such as insurers, health systems, accountable care organizations, managed care organizations, and health foundations—to coordinate the care of patients with complex care needs. Many of their patients have comorbid conditions, including substance use disorder and mental illness and social determinants of health that require special care.

The Challenge: Controlling Costs While Caring for Patients with Unique Care Needs

For complex care patients, the care needed often exceeds what can be reasonably provided within the emergency department and/or hospital walls. Approximately 30% of these patients struggle with homelessness, 40% struggle with substance use disorder (SUD), and 50% have some behavioral health diagnoses. Many of these patients face more than one social determinant of health issue simultaneously, and some struggle all three of the above.

Without appropriate care, these conditions will go untreated, leading to a costly and unending cycle of ED utilization. CBCS works with at-risk entities to create better community care coordination patients within the top 2-3% of utilization, with a goal of reducing and preventing utilization by connecting these patients with the care they really need. As patients are connected to strong resources outside the ED, patient outcomes improve, leading to fewer unnecessary ED visits and readmissions and the associated reduction in cost.

"Vulnerable patients often turn to the ED when psychosocial crisis occur and they feel they have nowhere else to go; in such instances, they would be better served by a community-based team and care plan that's designed to meet their individual needs.

Hospitals, health systems, health plans, and other entities that are trying to care for the unique needs of these complex patients— but without the insight and support of a community care team their efforts are limited, and come at a high financial cost. This is when providers and payers need additional help to control costs and strengthen care for their patients."

The Solution: Working Proactively with Patients in Real-Time to Direct Care

Working as an ED physician, Enguidanos understood the urgency required when caring for these patients. When a patient presented at the ED with an opioid overdose, suicidal following a psychotic episode, or hungry and ready to be off the streets, the patient needed access to appropriate care connections in that moment—not days or weeks later.

CBCS implemented Collective Medical, a care collaboration platform designed to connect care teams across medical neighborhoods through real-time ADT-based patient notifications and care guidelines. With the platform, CBCS case managers receive real-time notifications when one of their patients present to the ED, allowing the case manager to meet the patient in the hospital and work with appropriate care team members to determine the next steps of care.

Along with meeting patients at the point of care, coordinating with others has been crucial in helping these vulnerable patients. Creating cohorts within the platform, case managers are able to bring ED physicians, primary care and specialty physicians, social workers, pharmacists, and key community members together to collaborate on patient guidelines and determine what can be done to best help each patient. Enguidanos explains:

An Advocate for Change

When "Beth" was referred to CBCS for case management, she was sleeping in her car. A wife, mother, and successful business owner, she lost everything—including her business—after her divorce. She turned to alcohol, and that turned into a substance use disorder.

A CBCS case manager met Beth in the hospital every time she presented, often with dangerous blood-alcohol levels, but Beth wanted nothing to do with any of the programs offered. Finally, on the tenth visit, she accepted help.

The case manager was able to put Beth up in a hotel for two days while they waited for an opening in the detox facility, then helped Beth get the clearances she needed to complete the nine-day detox and move to a rehabilitation facility.

Upon successful completion of both, Beth was released and continued to attend regular community meetings. Her case manager worked to get her into temporary, and eventually permanent, housing and employment, and Beth became proactively involved in her community meetings as a mentor for those patients currently struggling with SUD.

Beth eventually graduated from the program and went on to work with CBCS as a powerful advocate for change—approaching her patients with empathy and hope.

"As we bring both those who will provide the care and the entities that will pay for it to a table together, we're able to create plans for these patients that not only reduce unnecessary spending, but genuinely improve the care each patient is being given. As we focus on these individuals, rather than increasing cost and complexity, it actually simplifies care by ensuring each patient goes to the best resource for his or her needs the first time and receives a continuity of care across care teams."

Outcomes and Patient Stories:

By bringing the care community together to coordinate care for these patients, outcomes improve—both for individual patients, and for groups as a whole.

Patient Stories: "Ken"

When Vietnam War veteran, "Ken" was referred to CBCS for case management, he had over 200 visits within two years across hospitals. The case manager began receiving notifications whenever Jim was in the hospital and made a point to meet him at the ED or follow-up shortly thereafter. The increased follow-up led to a 50 percent reduction of readmissions within one year.

With each visit, the case manager noticed a trend—Ken was struggling with post-traumatic stress disorder (PTSD). When his PTSD became unmanageable, he would turn to the hospital, often presenting ten or more days in a row wanting to talk with someone. When the symptoms subsided, he could go up to two months without a hospital visit.

The case manager met with hospital care teams and local resources to determine a plan for Ken. It was decided that someone from a community support resource for veterans would call Ken twice a week to check in and talk with him. During these calls, a member of Ken's care team could gauge how he was feeling and watch for triggers or patterns that might suggest his PTSD was becoming unmanageable. If things started to get bad, the care team member would have the appropriate resource reach out to follow-up with Ken at home. With a care guideline in place to address his behavioral health needs, Ken's ED utilization decreased by 50%.

Organizational Outcomes: The Mat-Su Health Foundation

The Mat-Su Health Foundation—a non-profit organization set up to support the health of the people of Mat-Su, Alaska—was looking for a way to support its "High Utilizers of Mat-Su" (HUMS) program. Partnering with CBCS, it relied on improved communication through real-time notifications and collaborative care to track and help these patients, achieving a 61 percent reduction in ED visits and a 20 percent reduction in opioid use.

This ultimately saved Mat-Su several million in unnecessary care costs, and improved community satisfaction.

Overall Outcomes: Breaking the Cycle of Addiction and Utilization

Depending on the area, CBCS will partner with a number of different resources—including those outside the traditional care continuum. Law enforcement and correctional facilities, EMS services, housing authorities and food banks, chemical dependency services and more all come together with one platform, bringing unique insights that lead to a custom-tailored care plan for each patient.

CBCS patients with these collaborative care plans see, on average, a 50-60 percent reduction of ED visits—*while breaking the addiction cycle in the process.*

The organization continues to expand its collaborative efforts to improve care for these vulnerable patients, including addressing social determinants of health, behavioral health, and complex chronic medical diagnoses.