INTEGRATED CARE DC
A learning community for District of Columbia Medicaid providers

May 9, 2023

DC Integrated Behavioral Health Managed Care Readiness Breakout Session

Case for discussion:

Mr. Greene is a 55-year-old man who is a long-standing client in your practice. He only seems to come in when he is on his last dose of medication or has an urgent health issue. He has been diagnosed of schizophrenia, COPD, and alcoholism. He is a chronic smoker. He has unstable housing and was recently kicked out of his sister's home. He has difficult accessing transportation.

The team has tried to engage with him, including visiting him in the community, to help him keep regular appointments. The team has tried to connect him with social services and other supports.

Last month, after he missed another appointment and ran out of medications, he ended up in the emergency department (ED). EMS picked up Mr. Greene on the street after he was reported as confused, belligerent, stumbling, and speaking incoherently. He was admitted for 3 days for rehydration, treatment of pneumonia, (minor) head laceration, and to be restabilized on his regular medications. Looking back at his chart, he has had 5 ED visits leading to 4 inpatient admissions in the last 6 months.

- ### Follow-up after hospitalization for mental illness:

  The percentage of discharges for members ages 6 and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. Follow-up visits that occur on the same day as the inpatient discharge do not count.

- ### Follow-up after emergency department visit for mental illness:

  The percentage of ED visits for members ages 6 and older with a principal diagnosis of mental illness or intentional self-harm who had a follow-up visit for mental illness. Follow-up visits can occur the same day as the ED discharge.

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Discussion and Group Exercise:

What processes and functions are necessary to performing well on these two metrics? Specifically, how can your practice help with:

- Reducing unnecessary ED visits
- Connecting to patients after ED visits and hospitalizations
- Avoiding re-admissions after an inpatient stay?

How can Medicaid health plans partner to address these barriers and improve performance on these two metrics?

What if your practice had formal partnerships with other practices and providers to jointly share in these activities to improve these measures? How could these partnerships (clinically integrated network) help to address barriers and improve performance on these two metrics?