

## Middlesex Community Care Tem Model

Description: Initiative started to reduce ED admissions. A number of care providers came together in 2011 to try to address this. Members include: Middlesex Hospital, River Valley Services, Rushford, Gilead Community Services, St. Vincent DePaul Middletown, Value Options ICM, ABH Case Management, Merritt Hall Admissions Director, CHC Director of Behavioral Health for Middlesex County, Middlesex Hospital's ED Chairman, Director of ED Nursing, Middlesex Hospital Health Promotion Advocate, and Manager of Community Benefit. The team develops a holistic plan, including housing, for frequent visitors to the hospital.

### Interview Summary:

- Currently tracking 200 people identified over the past 3 years for intervention
- All patients belong to an FQHC (CHC)
- Within CHC patients are often seen by primary care and behavioral health specialist – if patient reaches behavioral health threshold will be seen actively for behavioral health
- Hospital tracks frequent ED users – once threshold is hit all providers of care for that individual are contacted and a care plan is developed.
- Work with various providers in the community to try to address needs of the patients:
  - Core diversion services – focus on getting patients in danger of incarceration into treatment instead
  - Work with shelters to visit patients in shelter while trying to get stable housing
  - Work with housing providers to help fill in health care portion of application, which they historically had a difficult time accessing – allows for housing application to be processed
  - Soup kitchen – identify patients who need services and will walk them down to FQHC
  - Merritt Hall partners to work with patients with substance abuse challenges – supports keeping patients out of jail, work with judge through probate process
- Program has shown positive results thus far:
  - Reduction in the use of the ED
  - Increased connectivity to community based services
  - Improved staff morale – feel like they can make a difference and there is process to do so
- Program currently has a care coordinator who helps to connect patient to services as well as a health promotion advocate in ED who connects patient with outside providers and services needed once discharged
- Starting to work with patients who are admitted to the hospital in addition to identifying patients in the ED.
- Biggest challenge with program is sharing of information, but also cautions that lack of information technology should not be barrier to moving forward with this type of program. In part this takes breaking down walls between hospitals and providers.
- While ED data is used to target patients – information on frequent users is shared with multiple providers (clinical and non-clinical) in community so patient can be targeted when interacted with in different settings or actively sought out by FQHC.