



Continuum Case Conferencing for an Improved Behavioral Health System

COMMUNICATION BRIEF
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This report was prepared by Bright Research Group (BRG) on behalf of Alameda County Care Connect. AC Care Connect is committed to strengthening systems of care that work together to deliver consumer-centered care and to supporting high-need individuals (the people of Alameda County who face highly complex physical, behavioral, and social challenges) to achieve optimal independence and health.

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INTRODUCTION

Frequent utilization of emergency mental health and crisis-response services is a symptom of deeper challenges within the care system as well as unmet social needs. On the system side, these challenges can include access barriers, poor care coordination among community-level providers, stigma around substance abuse, and a lack of trauma-informed interventions. State and federal policies add additional layers of complexity—the result of intentional and unintentional regulatory and funding decisions. Consumers must do their best to navigate within the context of poverty, the toxic effects of chronic stress, exposure to trauma, and a dearth of social and economic supports. In order to proactively avert crisis and decrease the overutilization of high-cost emergency care, public mental health systems need to make community-level mental health and treatment services more accessible and responsive to the social determinants of health affecting those they serve.



In 2015, Alameda County launched Care Connect—a California Whole Person Care Pilot—to support Medi-Cal-eligible consumers with complex physical health, mental health, and housing needs in getting care and services that improve their overall health and reduce unnecessary crisis-system utilization. Care Connect leaders understood that encouraging and enabling providers from different systems (physical health, mental health, and housing) to work together to help consumers achieve optimal health was going to be foundational to this effort. With this in mind, Care Connect initiated the Psychiatric Emergency Services (PES) Frequent Utilizers Pilot to closely examine the longitudinal-care experience of some of the crisis system’s most frequent utilizers.

PSYCHIATRIC EMERGENCY SERVICES (PES) FREQUENT UTILIZERS PILOT

The Psychiatric Emergency Services (PES) Frequent Utilizers Pilot brought a unique array of mental health and social-service providers together, along with consumer and family advocates, housing specialists, and administrative leaders from various county agencies. This diverse group met monthly using a case-conference format. Initially, the pilot program focused on the 49 consumers in Alameda County who had appeared at John George Psychiatric Emergency Services department at least 10 times during the previous six months. It was eventually expanded to focus on a dynamic list of the top 700+ utilizers during the previous 12 months.

The case-conference goals were twofold: 1) to understand and develop empathy for the consumer’s experience across the care continuum by including representatives from a wide variety of organizations and disciplines; and 2) to illuminate system gaps to inform a more nuanced, human-centered response to crisis care. Using the lessons learned from the PES Frequent Utilizers Pilot, this brief describes how to plan and execute a mental health system case conference using a care “continuum” approach.

A CONTINUUM APPROACH TO CASE CONFERENCING



Traditional case conferencing brings together providers from multiple disciplines, usually from within the same organization, to coordinate care and planning for an individual. It is commonly used within medical-care settings in an effort to streamline care and discharge planning. The “continuum” approach to case conferencing differs in that it focuses equally on the individual (“consumer”) and the system, and does so from unique perspectives. It brings together not only multiple disciplines but also representatives from multiple organizations (representing various hierarchies within the system) that play a role in serving consumers.

The continuum perspective highlights the consumer’s experience with navigating the system, revealing gaps that previously were evident only to those who fell through them. It draws care and service providers out of their silos, fosters a sense of empathy for provider peers, and creates a shared responsibility for the consumer’s experience. Finally, it creates greater system accountability for the gaps and informs policies and resource decisions to help close them.

FOCUS OF CASE CONFERENCING

Having different providers of the consumer’s care experience in the same room at the same time results in improved collaborative problem solving and helps reveal system gaps that can be documented and addressed. Each case conference in the PES Frequent Utilizers Pilot focuses on the following:



Consumer Needs/Wants: What are the immediate and longer-term “needs and wants” of consumers who are frequent utilizers of psychiatric emergency services? What are the “needs and wants” of their family members/caregivers? What unmet needs or wants are contributing to crisis encounters?



Consumer Behaviors: What behavioral, medical, and social factors are contributing to psychiatric-emergency utilization behaviors? What are the reasons why consumers are seeking emergency services, and how are they arriving at emergency departments (voluntary vs. nonvoluntary)? What else can we learn about utilization behaviors, and what are the options for how the system could help change those behaviors?



System Behaviors: What system behaviors, protocols, workflows, or structures are contributing to or perpetuating the frequent utilization behavior of these consumers? Where barriers and gaps are present within the system’s purview, what are the options for strengthening the system of care, removing barriers, and closing gaps? Where barriers exist outside the system’s immediate control, how can it advocate for necessary state and federal policies?

ATTENDEES

Including a representative group of attendees is an essential component of continuum case conferencing. The attendees should represent the various disciplines and organizations consumers are likely to encounter in the course of receiving care in both crisis and non-crisis situations. Having both perspectives present makes it easier to envision alternate care scenarios. It is always helpful to invite individuals who have direct experience serving the consumer whose case will be discussed. Over time, it may become clear that discussions would benefit from additional perspectives. The PES Frequent Utilizers Pilot case conference broadened its initial list of invitees and continually seeks input on who else should be at the table. To start, consider representation from the following systems:



Community medical, behavioral health, housing, and social service partners

- Case-management agencies (FSPs)—case managers and outreach workers
- Outpatient clinics—social workers and behavioral health providers
- Crisis residential organizations—case managers and outreach workers
- Substance-abuse-disorder providers



Consumer and family advocates

- Consumer and family advisory councils—peer professionals and family advocates
- Mental Health Association—program director



Psychiatric Emergency System

- Physicians, nurses, and social workers



County Health Care Services Agency

- Cross-system outreach manager
- Behavioral health department—deputy medical director and critical care manager
- Crisis team—crisis-response staff
- Emergency medical services (EMS)—service coordinators



County justice system

- County jail—health-services staff
- Law enforcement—community outreach officer

ADVANCED PREPARATION

Case-conference preparation includes three key steps: identifying, preparing, and contextualizing the case. Plan to present and discuss no more than two cases in a one-and-a-half to two-hour period.

1. **Identify and prepare the case(s)**—Select a case from the utilization pool (frequent, very frequent, etc.) that attendees want to focus on. Prepare brief descriptions drawn from available records. Consider including the following:

- Consumer demographics
- Family or social relationships
- Housing status
- Assigned community-based social service/ outreach teams
- Primary care
- Insurance and financial status
- Justice-system involvement
- Physical health diagnoses, care, and treatment
- Mental health diagnoses, care, and treatment (including whether voluntary or involuntary)
- Primary care and mental-health system utilization, patterns, and cost history



2. **Contextualize the case(s)**—Incorporate qualitative details from notes and describe any utilization patterns. Attendees who have served or interacted with the consumer can add additional details to round out the picture during the case conference.

- Note any discrepancies between the chief complaint reported in the medical record and the observed or stated reason for seeking emergency psychiatric care
- Describe consumer-identified priorities for care, discharge, and post-crisis support
- Describe if/how the discharge options aligned with consumer preferences
- Identify consumer assets, e.g., spiritual beliefs, aspirations
- Identify gaps between crisis-care episodes, and describe what was happening for the consumer during the gaps with regard to housing status; access to and receipt of prescribed medications; family and community supports; trauma; and system, program, or eligibility changes

This multidimensional contextualized framework gives attendees a well-rounded sense of the consumer’s capacity and assets as well as their health and treatment burdens. Over time, common themes and recurring challenges will emerge across cases. These shared experiences among frequent utilizers point to system gaps. For example, all cases conferenced during the PES Frequent Utilizers Pilot involved a co-occurring substance-use disorder and extensive trauma history, revealing a greater need for disposition resources—both residential and outpatient.

LESSONS LEARNED

INCREASED UNDERSTANDING OF THE CONSUMER EXPERIENCE IN THE SYSTEM OF CARE

The data tell a powerful story about the financial and human toll of repeated crisis encounters and highlight the fact that having access to primary-care and case-management services is not a panacea for reducing emergency-department utilization. While each consumer's experience is unique, these cases from the PES Frequent Utilizers Pilot continuum case conferences share commonalities indicative of frequent-utilizer consumer experiences and provide insight into the system with regard to factors that drive utilization. Key learnings include:

**Consumers voluntarily seek care at emergency rooms (psychiatric and medical) despite connection with other outpatient services**

Despite the fact that consumers are technically connected to case managers and primary-care clinics, emergency utilization persists. Consumers may lack the health-literacy skills needed to navigate the care system and proactively access resources. Or perhaps the resources offered by the system are not what consumers need or want. Many consumers had a large number of voluntary emergency-department visits (medical and psychiatric) with few to zero inpatient admissions, raising the question of whether emergency utilization may be the result of other (non-emergent) drivers. Consumers are motivated to seek care at emergency rooms for a variety of reasons. When there's a need for care or services, the reliable path of least resistance is the emergency department, as it is open seven days a week and 24 hours a day. Of consumers who frequently utilized PES during the pilot period, over 90 percent of PES utilization took place outside of outpatient-clinic business hours. Consumers who've experienced a history of trauma or have experienced rejection due to substance use or erratic behavior can reliably receive care from familiar staff in an emergency setting. Chronically homeless consumers with untreated or unmanaged mental health conditions often present voluntarily in search of basic needs, such as shelter and food.



The system of care does not have a standard practice of hearing from consumers and documenting their preferences in an actionable way

Psychiatric-emergency-department consumers were often discharged to the community only to cycle back to the emergency department. The continuum case conferences revealed that the existing workflow within the behavioral crisis system does not include asking consumers about what is most important to them, their wants and needs, or the nonbehavioral health needs that may lead people to repeatedly seek care at emergency departments. Consumer advocates reported that consumers do want to be “in the loop” regarding their discharge planning, help drive the process, and have a say. Consumers often see medications as a temporary or surface-level fix and want to pursue long-term healing. While some providers may solicit consumer needs, wants, and preferences informally, it is not standard practice to do so. When this information is captured, it is documented in the notes section of the electronic-health-record system and cannot be easily queried. Similarly, the chief complaint documented in the record may not reflect the real reason why the consumer presented in the emergency department, because no medical code exists for seeking kindness, shelter, and food. As a result, many providers remain unaware of the consumer’s self-identified needs, personal goals, or spiritual beliefs—information that could be used to support motivation and inform linkage to community or services.



Follow-up care needs to be better coordinated, and consumers need to be better supported after a mental health crisis

Advocates working with newly discharged consumers noted that the burden of managing follow-up/outpatient care is often placed on freshly discharged consumers who didn’t have a say in crafting the plan. Case managers were often unaware that consumers in their caseload were in the emergency department. When case managers were notified by the emergency department, they were not able to show up in person, or they arrived after the consumer was discharged. Large case loads preclude case managers from having the capacity to provide intensive navigation support for frequent utilizers. As a result, consumers are responsible for coordinating linkage, including transportation, between the crisis system and outpatient, community-based care—a difficult task for those who are in a disorganized mental, emotional, or financial state. Medications or symptoms can prevent consumers from developing skills and retaining knowledge to effectively manage their post-discharge follow-up care, while lengthy community-clinic intake processes can overwhelm someone recovering from a mental health crisis. Lastly, there is a need for additional disposition options—both residential and outpatient—to treat commonly co-occurring disorders, such as mental health, substance-use, and trauma. In their absence, repeat emergency-services utilization will persist.

EXAMPLES OF HOW CONSUMER EXPERIENCE INFORMS SYSTEM IMPROVEMENTS

The process of continuum case conferencing during the PES Frequent Utilizers Pilot illuminated the challenges, gaps, and limits of the current system of care. These learnings have been used to inform other Care Connect pilots and innovations.

Identified System Gaps:

Emergency Care Remains the Path of Least Resistance: The system needs to be redesigned so that emergency care is no longer the most convenient option when someone needs care. With a vast array of outpatient service providers and programs to navigate, as well as a trend toward team-based care, consumers are increasingly being asked to interact with a large number of often unfamiliar providers while trying to manage multiple complex conditions under the weight of challenging social determinants.

Stronger Partnerships with Law Enforcement Are Needed to Support Diversion: Improved partnership with law enforcement is needed to explore whether individuals who are not in need of emergency psychiatric evaluation can be transported directly to an outpatient clinic.

Transitions to Adult Services Need to be Better Supported: Transitional-age youth experience little support or education about the transition to adult services. Without skills to navigate adult systems of care, vulnerable young adults easily fall through the cracks.

Lack of Long-Term Psychiatric Care: For individuals with severe mental illness, there remains a desperate need for long-term psychiatric residential care facilities. Community conservatorship has been proven to be very effective. The only challenge is that it requires a consumer to volunteer to be conserved and to be housed in a licensed facility. This requirement is a conservator program policy.

Changes Implemented to Address Gaps:

Updated Discharge Protocols: As a result of discussions about continuum case conferencing, social workers now are focused on ensuring that consumers are discharged to a care location that can take walk-ins or to the care of a case manager. This increases the likelihood that consumers will have post-discharge follow-up support.

Telephonic and In-person Follow-up after Psychiatric-Emergency-Room Visits: Continuum case conferencing led to a recommendation that the county consider implementing post-discharge outreach within 24–48 hours after a psychiatric-emergency encounter to assist consumers with stabilization and to support them in getting connected to resources. Newly developed programs include the following:



- The Crisis Connect program—This partnership between Alameda County Care Connect and Alameda County Behavioral Health Care Services offers a telephonic follow-up after all psychiatric-emergency encounters to assess for crisis and connect consumers to resources, with a focus on developing a person-centered plan for meeting follow-up needs.
- Friendly Faces program—This Alameda County Behavioral Health Care Services program offers in-person follow-up in the model of Crisis Connect for individuals who do not have telephone access.

Community-Based Assessments and Disposition Planning: Alameda County has a high number of 5150 writing agencies, which results in consumers being held on involuntary psychiatric-emergency encounters before they have been evaluated by a qualified mental health provider. As a result of discussions during continuum case conferencing, a variety of mobile crisis team programs were developed to offer community-based crisis intervention, assessment, medical clearance, and disposition options. Mobile crisis teams aim to stabilize consumers in the field, and assess their risk to offer the best possible path to receive care and reduce incidents of unnecessary emergency department visits.

IMPACT ON THE PROVIDER EXPERIENCE

The process of coming together as a group to focus on a shared case made a positive impression on attendees of continuum case conferences. The attendees report feeling increased empathy for consumers. Having a sense of what's been tried by others and what has worked (or not) also better prepares attendees to counsel or support the consumer. The providers also report a sense of camaraderie outside of their immediate care silo, stating that they “don't feel alone” in working on these problems and that it makes them feel “hopeful” to know that others are working to change the system. They also appreciate having different viewpoints and information at the table. One describes the process of looking at consumers from different perspectives as “a puzzle that's becoming more complete.” Continuum case conferencing offers a more whole-person perspective. For example, emergency-department personnel get to hear from social-service providers about what consumers are like when they are stable (not in crisis), including what consumers want for themselves in the long term.

BRINGING A HUMAN PERSPECTIVE TO THE SYSTEM EXPERIENCE

The prevailing perception prior to continuum case conferencing was that access to preventative care and social services/supports is the way to prevent crisis episodes. While this is generally true, continuum case conferencing revealed that it isn't as simple as just offering more resources. There's a very human driver of crisis-care-seeking behavior. Individuals who repeatedly seek care at the psychiatric-emergency department were found to often be seeking easily accessible care in a setting that is familiar, consistent, and nurturing (food, a place to sit, a safe spot in which to sleep). The system must create an equivalent care and service experience in settings designed to better meet consumers' immediate and long-term needs. Continuum case conferencing with a diverse array of providers, leaders, and advocates has proven to be an effective first step toward this aim and can help establish future strategy and policy agendas.

APPENDIX: CASE-CONFERENCE FORMAT AND SAMPLE AGENDA

1. BRIEF INTRODUCTIONS

PURPOSE: Informs attendees of the breadth of disciplines and organizations at the table.

VALUE: Much care coordination occurs by phone or via electronic communication. Attendees of the PES Frequent Utilizers Pilot continuum case conference were enthusiastic upon meeting frequent collaborators face-to-face for the first time.

2. UPDATE THE STATUS OF THE PREVIOUS CASE

PURPOSE: Opportunity to share what interventions have since been tried and the consumer's response to these new approaches.

VALUE: Revisiting the previous case after attendees have had time to reflect on the information and/or recontact the consumer leads to refined recommendations and more nuanced plans for subsequent outreach.

3. UPDATE THE STATUS OF PREVIOUSLY RAISED SYSTEM ISSUES

PURPOSE: Opportunity for system and organization leaders to share updates on progress to address system issues.

VALUE: Attendees of the PES Frequent Utilizers Pilot continuum case conference deeply appreciated knowing that issues they raise are heard and acted on. This fosters a more collaborative problem-solving approach whereby both front-line providers and organization leaders are working collaboratively on issues important to all. It also promotes continuity, so what's been discussed before can inform future cases.

4. PRESENT THE NEW CASE

PURPOSE: Provide a concise yet comprehensive picture of one consumer's history, including all known care, treatment, and utilization during the previous 6- or 12-month period. Note any patterns, including care-intense (or care-free) episodes.

VALUE: Gives attendees a longitudinal view of the consumer's mental, physical, and emotional experience—one that spans clinic walls and program boundaries. It also offers a glimpse of the totality of care offered, sought, and received. Utilization patterns may also become evident. For attendees of the PES Frequent Utilizers Pilot continuum case conference, this was often the first time they learned about barriers that a consumer was facing or a consumer's involvement with other county systems/programs.

5. DISCUSS AND CONCEPTUALIZE THE CASE

PURPOSE: Informed by the information presented as well as insights gleaned from encounters with the consumer from the various perspectives shared in the room, attendees develop a biopsychosocial conceptualization and share any personal details (habits, likes, dislikes, spiritual preferences, etc.) to inform subsequent problem-solving discussions.

VALUE: This is an opportunity to augment the “system” perspective (medical record / utilization data) with a more “human” perspective (anecdotes from interactions with the consumer) to create a fuller, more nuanced picture of the consumer’s experiences, needs, and wants—both in the near and long term.

6. IDEATE A NEW CONSUMER EXPERIENCE

PURPOSE: Imagine what could be done differently to better serve the consumer. Attendees of the PES Frequent Utilizers Pilot continuum case conference routinely considered the following intervention opportunities:

- Law enforcement
- Mobile crisis response team (MCRT)
- Emergency medical service (EMS)
- Medical emergency
- Psychiatric emergency services
- Psychiatric inpatient treatment
- Service-provider outreach
- Outpatient follow-up care
- Family and caregivers
- Peers and advocacy groups
- Alcohol and other drug programs

VALUE: With information about the consumer’s experience navigating the continuum, attendees are invited to problem-solve beyond their narrow service area.

7. IDENTIFY SYSTEM GAPS AND OPPORTUNITIES

PURPOSE: Building on the previous exercise, this is an opportunity for creativity and “outside the box” thinking.

- What does the consumer experience reveal about our system of care?
- What gaps exist?

- What might be some creative ways to work with the consumer?
- What are some of the things you've found useful when working with consumers with a similar history or in other counties?
- How is our system of care working for the consumer?
- How could we do better?
- What would be possible if there were no limits on your time?

VALUE: Over time, themes may emerge related to system-level or policy needs.

8. SOLICIT FEEDBACK TO IMPROVE THE NEXT CASE CONFERENCE

PURPOSE: Invite attendees to reflect on the meeting and communicate what went well and what could be done differently moving forward.

VALUE: Offers a means of continually improving the experience and serves as a retention strategy, ensuring that the continuum case conference adapts to the needs of the group.

9. GATHER/PREPARE ARTIFACTS

PURPOSE: Capture contacts, resources, and learnings for reference later, making the case-conference findings actionable for attendees and sharable for colleagues. Before adjourning, make sure to collect the following:

- Contact information for attendees of the case conference and the organizations represented
- A list of resources mentioned during the case conference
- Any system learnings or ideas raised during the case conference

VALUE: Developing a living document or tool kit that memorializes names, organizations, resources, and action items (both raised and addressed) gives attendees actionable information for use in between case conferences—information that can also be shared with colleagues. It also serves as a record of the group's progress and a road map for future policy discussions.