# State Health Improvement Process: Supporting Local Health Improvement Coalitions (LHICs) to Fuel Local Action and Improve Community Health

CECIL COUNTY LHIC
PRESENTATION TO MCHRC
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## Goals of Cecil LHIC Proposal Community Case Manager Program Pilot

- Reduce hospital readmissions for certain chronic conditions
- Increase access to mental/behavioral health treatment services
- Decrease rate of emergency department visits related to behavioral health conditions

## Goals of Cecil LHIC Proposal
## Mobile Crisis Response

- Increase access to mental health treatment services
- Increase the number of mental health providers in Cecil County
- Decrease rate of emergency department visits related to behavioral health conditions

## How Will Grant Funds be Used?
## Community Case Manager Program Pilot

- Hire 1 FTE nurse case manager (CM) to augment 1 FTE nurse case manager funded by Union Hospital
- Fringe for 1 FTE nurse CM
- Laptop, VPN token and cell phone for nurse CM
- Travel for nurse CM
- Training for nurse CM

## How Will Grant Funds be Used?
## Mobile Crisis Response

- Increase hours that contractor spends in Cecil County to improve response times and increase ability to respond
- With funds from Cecil County Government and MCHRC, hours *in Cecil County* will increase to 15 hours per day, 7 days per week, 52 weeks per year

## Sustainability Plan
## Community Case Manager Program Pilot

- If significant reductions in readmissions occur in FY14, then Union Hospital will fund two case mangers in FY 15 and beyond
- Incentives from the ACA may encourage physicians to incorporate case management into their practices

## Sustainability Plan
## Mobile Crisis Response

- Should expansion of response hours decrease the rate of emergency department visits for behavioral health conditions in FY14, then the Health Department will request an additional $100,000 from the County for FY2015

## Evaluation Plan
## Community Case Manager Program Pilot

- 95% of first/second visits with readmitted patients made within two days of discharge, with 75% of those contacts a home visit
- 75% of patients referred will complete the Community Case Management Program pilot
- 5% reduction of inappropriate hospital readmissions within a 30 day post-discharge window for Community Case Management Program pilot patients
- 75% of enrolled patient readmissions will be determined as appropriate per " red flag" guidelines

## Evaluation Plan
## Community Case Management Program Pilot

- Each enrolled patient will access at least two community and/or provider resources (clinic, primary care, home health, etc) that contribute to the successful accomplishment of the patient's health care plan and goals
- 75% of enrolled patients will be able to establish a personal health record
- 75% of patients/ family who complete the program would recommend the program to others

## Evaluation Plan
## Mobile Crisis Response

- Double the number of individuals served in Cecil County annually from 45 to 90 via mobile dispatches
- Decrease response time to the site of crisis from an average of 70 minutes to an average of 35 minutes
- Increase utilization by local law enforcement agencies
- Increase utilization by the public school system

## Evaluation Plan
## Mobile Crisis Response

- Reduce emergency department admissions for primary behavioral health reasons
- Increase the number of individuals who were connected to an outpatient care provider via mobile team or crisis line and show rate for outpatient appointments
- Increase the number of mobile dispatches resulting in diversion from emergency department services

## Thank You for This Opportunity

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