## Goal
The Coordinating Care for High Users Implementation Team was charged to improve care for consumers who utilize public healthcare services at a high frequency due to limited care coordination and/or limited availability of treatment options.

### End Goals
- Reduce acute inpatient care
- Improve health outcomes
- Reduce hospital care and emergency department usage
- Develop new treatment options for most acute cases

## Findings
### Key Findings/Observations
- The total costs to the system for the region’s 291 highest utilizers in 2006 and 2007 were $14,901,438. For the same period, the total costs for the 27 pilot participants were $2,838,083.
- High representation of African American males in the high utilizer population (40 of the top 50 are African American, 31 of the top 50 are male)
- More high utilizers are in the correctional system than anticipated by providers (45 of the top 50 have a criminal history, 26 of the top 50 have active warrants)
- Most high utilizers had Medicaid or were Medicaid eligible (49 of the top 50 have Medicaid)
- Current reimbursement structure for outreach and engagement are not sufficient for the high utilizer population
- Consumers and provider staff consistently report respect and cultural competency are system deficiencies that should be addressed to effectively outreach and engage high utilizers
- A continuum of housing is a key factor for the stabilization of the high utilizer population (as captured by team input - see service and capacity needs document)
- High utilizer clients have a higher level of acuity than anticipated by the clinical team
- CMHC crisis beds in the region have a relatively low utilization rate per analysis of bed utilization reports (51% occupancy rate, 4th quarter FY ’08)
- Evidence-based programs have been beneficial in the treatment of high utilizers (18 of the 27 pilot participants are receiving Assertive Community Treatment (ACT) services).
- External supports (i.e. peers, family members, etc.) are needed to assist in the engagement of this population (clinical team analysis of top 50)
- After hour services are needed to effectively stabilize high utilizers (per Out. & Eng. group discussion)
- Consumers believe that all staff should have the same training and skill set in order for outreach and engagement services to be effective (Focus Group Feedback, January 2009)

## High Utilizer Team’s Recommendations to Address System Limitations
- Include High utilizers part of priority populations for administrative agents (Recommendation F3, approved by Steering Committee & Commission, December 2006)
- Explore options to address service area limitations (Recommendation F2, approved by Steering Committee & Commission, December 2006)
- Establish a case rate reimbursement stream for needed services (Recommendation C3, approved by Steering Committee & Commission, December 2006)
- Provide mentoring and/or best practices training for staff in outreach and engagement to spread excellence across the region (Recommendation E8, approved by Steering Committee & Commission, December 2006)
- Establish a Medicaid funded housing option to fund onsite housing support
- Add crisis stabilization capacity in region
- Change utilization criteria for crisis beds and/or increase the awareness to increase use of crisis beds in the region
- Explore options to increase the accessibility of crisis beds in the region
- Utilize the Access Tool to capture high utilizer data to assist in improving communication across systems (EDs, Corrections, CIT, Providers, Peer Run Orgs, and other orgs in the future) (Recommendation F3, approved by Steering Committee & Commission, December 2006)
- Utilize evidence-based practices to treat high utilizers and expand such services (Recommendation E1, approved by Steering Committee & Commission, December 2006)
- Increase family involvement in the provision of services (Recommendation E2, approved by Steering Committee & Commission, December 2006)
- Extend service delivery hours (Recommendation F5, approved by Steering Committee & Commission, December 2006)
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Mark Stansberry, Exec. Director  
Hopewell: Ericson Smith, VP Clinical Svcs  
Crider: Jennifer Lee, VP of Adult Services  
Comtre: Margo Pigg, Clinical Director |
|--------------|--------------------------------|--------------------------------------------------------------------------------|
|              | Alcohol and Drug Abuse        | Preferred: Kim Feaman, Program Director  
CLS: Cheryl Gardine, Exec. Director  
Queen of Peace: Lee Burnett, C-Star Supervisor |
|              | Affiliate Provider            | Places: Francie Broderick, Exec. Director  
Debbie Moorman  
Adapt: Cindy McDannold, Program Director  
Independence Cntr: Mary Alice Scherrer, Residential Svcs Director |
|              | Missouri Dept of Mental Health| Virginia Selleck, Clinical Director  
Larry Fletcher, Dir, Supported Community Living  
Liz Hagar-Mace, Housing Director  
Scott Giovanetti, CPS Chief of Adult Community Operations, East and Southeast Regions |
|              | Federally Qualified Health Center| Grace Hill: Tina White, Homeless Services Coord. |
|              | Inpatient/Emergency Departments| SSM: John Eiler, VP Behavioral Health Svcs  
MPC: Jim Mitchell, Licensed Clinical Social Worker  
Laurent Javois, Regional Executive Officer |
|              | Advocacy Organization         | NAMI: Wendy Dudek/Jackie Lukitsch, Exec. Dir |
|              | Additional Community Organizations and Stakeholders| St. Louis City: Bill Seidhoff, Dir. Human Services  
Valerie Russell, Executive Assistant  
St. Louis County: Doris King, MH Collaborative  
Corrections: Dr. Fred Rottnek, Chief of Medical Operation, Institute of Family Medicine, Bob Crecelius, Chief Parole and Probation Officer, City of St. Louis  
Law Enforcement: Barry Armfield, St. Louis Area Crisis Intervention Team Coord.  
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