

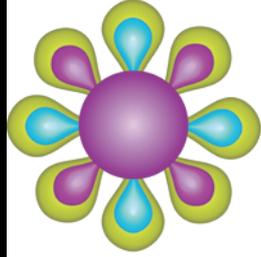
# Care Navigation: Creating a Bridge from Inpatient to Outpatient Treatment

*A Collaborative Effort*

*St. Rita's Medical Center*

*Coleman Behavioral Health*

*Mental Health & Recovery Services Board of  
Allen, Auglaize and Hardin Counties*



Mental Health &  
Recovery Services  
Board of  
Allen, Auglaize and  
Hardin Counties  
[www.wecarepeople.org](http://www.wecarepeople.org)



ST. RITA'S  
MEDICAL CENTER



COLEMAN™  
*Behavioral Health*

**nav-i-geyt** (verb) to walk or find  
one's way on, in, or across.

# The Partners – St. Rita's Medical Center

- **St. Rita's Medical Center** is dedicated to continuing the healing ministry of Jesus Christ. For 93 years, St. Rita's has been steadfast in its mission of caring for the poor, the elderly and the vulnerable members of the community and to improving the health of the many communities we serve.
- We have a total of 36 inpatient psychiatric beds, 18 of those are dedicated to serving the adult population.
- St. Rita's is committed to providing quality care to the behavioral services patient. In 2012, we provided **nearly \$1,000,000** in charity care to this population.
- **Patient Treatment Intervention Team** (PTIT) was also developed to serve the needs of the behavioral services patient that needed more structure and community services.

# The Partners – Mental Health & Recovery Services Board

- **The Mental Health & Recovery Services Board** serves Allen, Auglaize and Hardin Counties (approximately 182,000 people). The Board contracts with eight agencies and many other organizations to provide mental health and substance abuse prevention and treatment services.
- In 2005, the Board worked with SRMC and the adult treatment provider to establish a 24 hour crisis center and in 2007, the Board established an 8 bed crisis stabilization unit (CSU). In November 2012, the CSU expanded to 16 beds. The Board funds these services and the position of the Care Navigator.

# The Partners – Coleman Behavioral Health

- **Coleman Behavioral Health** serves adults in Allen, Auglaize and Hardin. The Board contracts with Coleman as the primary provider of adult services. Coleman manages all crisis, crisis stabilization, and hospitalization services on behalf of the Board.
- The agency serves as the **liaison** for inpatient hospitalization with St. Rita's and other public and private psychiatric hospitals.
- The agency manages the crisis center and the crisis stabilization unit, and employs the Care Navigator.

# *What was the problem?*

## ◎ Patient dropout:

- Motivating patients to follow up with outpatient mental health treatment has been a challenge for inpatient providers. The show rate for patients who were discharged from SRMC's inpatient services *prior* to instituting a Care Navigator program was less than **25%**.
- Missing appointments for therapy and medications led to the patient decompensating and potentially, another inpatient admission.

# *What was the problem?*

## ◎ **Continuity of Care:**

- Short-term inpatient stays made it difficult to conduct appropriate discharge planning.
- Physician prescribing practices varied widely and patients could often not access certain medications in the public system.
- Patients were uncertain about continuing care in the community.
- Limited ability to respond to rapid discharge or need for step-down stabilization services.

# What does a Care Navigator Do?

- Attends daily 8am clinical case staffings
- Attends physician rounds as requested
- Communicates with agency regarding ADM/DC
- Coordinates CSU step-down cases
- Coordinates medications and monitoring
- Works with family members on discharge care plan
- Coordinates follow up appointments
- Ensures access to housing, CPST, and other needed services

**Meets with client one on one to build trust and rapport.**

# Care Navigation

## *Special Services/Special Skills*

- Not just traditional “case management”.
- Specialized set of medical services modeled after patient-centered medical home principles.
- Highly collaborative and multisystem.
- Requires a highly skilled, independent provider to serve as “navigator”.
- Building rapport with patients and among systems a “**top priority**”.

## FY13 Nurse Care Navigator Statistics

Month	Total Admits Served	Open CPS Clients	Show rate for Follow up appt.	New referrals	Show Rate for Follow up DA	CSU referral
July	57	37	31/37=84%	20	12/20=63%	
August	42	26	23/26=88%	16	13/16=81%	
September	38	23	18/23=84%	15	10/15=67%	
<b>1st Qtr totals</b>	137	86	72/86=84%	51	35/51=67%	
October	55	35	27/35=81%	20	11/20=55%	0
November	56	33	26/33=84%	23	15/23=65%	1
December	43	24	20/24=87%	19	11/19=58%	4
<b>2nd Qtr totals</b>	154	92	73/92=79%	62	37/62=60%	5
January	55	35	30/35=86%	18	10/18=56%	3
February	52	30	25/30=83%	20	15/20=75%	4
March	48	32	25/32=78%	14	14/14=100%	4
<b>3rd Qtr totals</b>	155	97	80/97=83%	52	39/52=75%	11
April	40	23	22/23=96%	17		1
May	39	22	19/21=90%	17	14/17=82%	3
June	45	22	16/21=76%	25	18/24=75%	1
<b>4th Qtr totals</b>	124	67	57/65=88%	59	46/59=78%	5
<b>FY13 TOTAL</b>	570	342	303/342=86%	224	157/224=70%	21,no 1 qtr #

# “The Fit” of the Navigator

(From SRMC’s perspective)

- Embedding a Coleman treatment provider in the inpatient care staff has enabled patients to put a “face” to the outpatient treatment facility.
- That **human contact** and the Care Navigator’s ability to explain what services are provided for that patient post-discharge has made a positive difference in the show rates and for the patients and for their all-around **quality of life**.

# "The Value" of the Navigator

(From Board's perspective)

- Multisystem, collaborative approaches based on "medical home" models increase the **availability**, **appropriateness**, and **quality** of care.
- No one system has the answer – everyone brings resources to create a **value chain** for the consumer and effective deployment of resources.
- Funding approaches must be flexible and focused on outcomes.

# Contacts

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