

CRITICAL TIME INTERVENTION (CTI) PILOT REDUCES HOSPITALIZATION RATES FOR HIGH UTILIZING PATIENTS

By Luci de Haan



When Victor P.* first met with Daiana Mendez, a case manager at Mosaic Mental Health in the Bronx, he was homeless and in a state of mental decompensation.

“I didn’t know what I needed anymore,” he says. “I needed someone to advocate for me because I didn’t know how to say it.”

Today, Victor’s mental health has stabilized and he is following his medication regimen. He has both a primary care and a mental health provider whom he sees regularly. He has a place to live and wants to go to school to be a patient navigator. “I learned I can be an asset to my community,” he says. “I could be stronger and better.”

Patients who use the majority of healthcare services and costs make up a small fraction of the patient population. Like Victor, they often have complex health conditions that are compounded by such circumstances as financial and housing instability, and the absence of family or social structures.

Last year, Bronx Partners for Healthy Communities (BPHC), the DSRIP Performing Provider System led by SBH Health System, began a pilot program to provide intensive care coordination services to patients with serious mental illness (SMI) and unstable housing situations. The project applies “Critical Time Intervention (CTI),” a time-limited, evidence-based model started in New York City in the mid-1980s to provide people who are homeless and living with mental illness with sustainable healthcare and community support systems.

The goal is to help patients achieve long-term health improvements, become integrated back into the community, and reduce their stays in the hospital and other acute care settings. To date, the first cohort of 80 patients realized a 55 percent reduction in the number of days spent in a hospital setting in the six months following the start of CTI. This is according to utilization data obtained by the Bronx RHIO from the Statewide Health Information Network for New York (SHIN-NY). “Our initial goal was to reduce hospital utilization by 25 percent so we are very excited by these promising results,” said Irene Kaufmann, BPHC executive director.

BPHC has partnered with four community-based organizations (CBOs) on the CTI pilot: Coordinated Behavioral Care, Mosaic

Mental Health, SCO Family of Services, and Visiting Nurse Service of New York.

Patients eligible for CTI have a diagnosis of SMI and a history of repeated hospital stays and precarious housing or homelessness. Referrals come from SBH and other hospitals, shelters, Health Homes, psychiatric inpatient units and CBOs. CTI is divided into three phases that begin with intensive support by the case manager who works closely with the patient to identify goal areas that may include medical and behavioral health treatment, medication adherence, employment, housing, money management, and/or family intervention.

Case managers like Daiana Mendez play a key role among an extensive network of providers including physicians, hospitals, specialists, therapists, housing services, food programs, job training and more. Their smaller caseloads allow them to accompany patients to their PCP or behavioral health providers and help put family and community support structures in place. It can be challenging to engage in the care of many patients. Case managers will meet with patients in all kinds of settings where they live or spend time in their communities.

“No two cases are the same,” says Mendez. “We meet people at a critical point in their lives and are able to give them the time and support to connect them to the care and services they need.”

As the patient becomes connected to care and support, case managers focus on strengthening those links and empowering the patient to be more self-sufficient and adherent to his or her medical and behavioral health treatment plan. Gradually, the patient is transferred to a Health Home with a strong support system in place.

“We are proud of our partner organizations’ relentless work and commitment to helping patients improve their health outcomes and transition to the community,” says Kaufmann.

BPHC leads the hospital’s DSRIP program, the state’s five-year Medicaid transformation initiative to create a community-based provider network that is coordinated, patient-focused and improves health outcomes.

**The name has been changed to protect patient privacy.*