Insights from the Follow-up After Hospitalization (FUH) Clinical Study: Addressing Disparities and Enhancing Care Continuity for HUSKY Health Members

To combat disparities in follow-up care for HUSKY Health members using behavioral health services, the Follow-up After Hospitalization (FUH) Clinical Study has been launched under the All-Administrative Service Organizations (ASOs) Health Equity Project. This collaborative effort involves Carelon Behavioral Health of Connecticut, Community Health Network of Connecticut, Inc., and the Connecticut Dental Health Partnership.The study addresses the critical issue of differences in follow-up care rates between Black and White individuals discharged from psychiatric hospitals. These discrepancies often lead to higher readmission rates, increased emergency visits, poor medication management, and deteriorating health outcomes.

Central to the FUH Clinical Study is a predictive model that identifies individuals at high risk of not engaging with outpatient care within seven days post-discharge. This model classifies members based on their demographics, socioeconomic status, and clinical history. Data from HUSKY Health members was analyzed using multivariate logistic regression to customize interventions aimed at improving access to aftercare.

For members identified at higher risk (designated as Tier 1 and 2), Intensive Care Managers (ICMs) are available to assist in facilitating connections to aftercare services. Additionally, Clinical Liaisons (CLs) support care connectivity post-discharge for those who decline ICM intervention, thus enhancing access to necessary treatment. Hospitals with higher rates of Tier 1 and 2 members receive tailored interventions, along with additional resources to address these challenges effectively. **(See figure 1 on page 7).**

A significant part of the strategy involves direct communication, education, and collaboration with hospital providers to ensure a seamless transition from inpatient to outpatient care. Connect-to-care meetings are being conducted with nine hospitals and 71 community providers to enhance cooperation and develop targeted interventions for hospitals with higher at-risk member rates**.** **(See figure 2 on page 7).**

The study emphasizes continuous monitoring of outcomes for Tier 1 and Tier 2 members to assess the effectiveness of these interventions. The ultimate goal is to expand predictive models across various levels of care, potentially offering scalable solutions that can positively impact the broader healthcare landscape.

Looking forward, the FUH Clinical Study aims to make significant strides in reducing disparities and improving care continuity for mental health patients, providing a framework for equitable healthcare outcomes for all community members. Ongoing data collection and evaluation of interventions are key components of this project, serving as a beacon of hope for achieving health equity.

For more information on how hospitals can connect members to ICM services, they are advised to reach out to their assigned Regional Network Manager or Clinical Care Manager or contact ctbhp@carelon.com.

Predictive Model at a Glance:

- ✓ Unit of analysis: HUSKY Health member's episode of care.
- ✓ Outcome variable: did or did not follow up.
- ✓ Independent variables: Gender, age, race, ethnicity, diagnosis, hospital of admission, Medicaid benefit, region, Behavioral Health Home (BHH) enrollment and Department of Children and Families (DCF) involvement.
- ✓ Model composed of four (4) tiers: 10% at greatest risk of not following up, 15% with elevated risk, 25% with moderate risk, and 50% with less than average risk.
- ✓ Increased risk factors in Tier 1 compared to overall sample include individuals identifying as Male, between ages 45-64, identifying as Black, members diagnosed with schizophrenia spectrum and other psychotic disorders, members experiencing homelessness or housing insecurity, and individuals residing in region 5.

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Figure 1 - Member Intervention with ICM/Peer Support Strategies

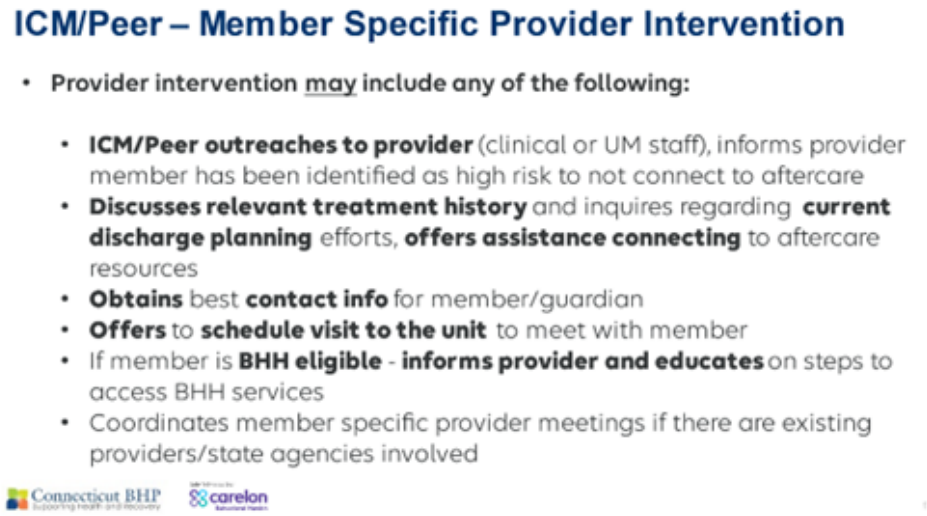

Figure 2- Provider Intervention details of members with higher risk of not connecting to care.

Visit our website at [After Care Follow Up (AFU) | CTBHP Providers] for more information on Provider Support and Intervention guidelines and resources.