Welcome!

Reducing Emergency Department among MI Population Learning Series-
Systems Improvement- What CCOs Can Do-
Virtual Learning Collaborative

The session will start shortly!

Best Practices:

- Please keep your mic muted if you are not talking
- Please rename your connection in Zoom with your full name and organization
- We want these sessions to be interactive! Please participate in the polls, ask your questions and provide your input

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Systems Improvement-
What CCOs Can Do

Welcome to Session 3!

Maggie McDonnell, ORPRN
Susan Kirchoff, OHLC
Liz Whitworth, OHLC

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Participation Best Practices

- Please type your questions and comments into the chat box
- Please stay on mute unless you intentionally want to ask a question or make a comment
- Please rename your connection in Zoom with your full name and organization you work for
- All sessions will be recorded and shared on the OHA website
- **Please actively participate in the sessions! We want to hear from you**

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Systems Improvement- What CCOs Can Do

The goal of today's session is to learn about Columbia Pacific CCO's emergency department reduction strategy, including a focus on the disparity metric. The High Risk Huddle team will share how it is organized and operates, as well as how huddle structures can support other priorities.

ColPac CCO High Risk Huddles: A Tool to Support ED Reduction

Systems Improvement Virtual Learning Collaborative- What CCOs Can Do

February 25, 2019

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Jessica Dizon, CareOregon

Miriam Parker, Columbia Community Mental Health

Marika Shimkus, CareOregon

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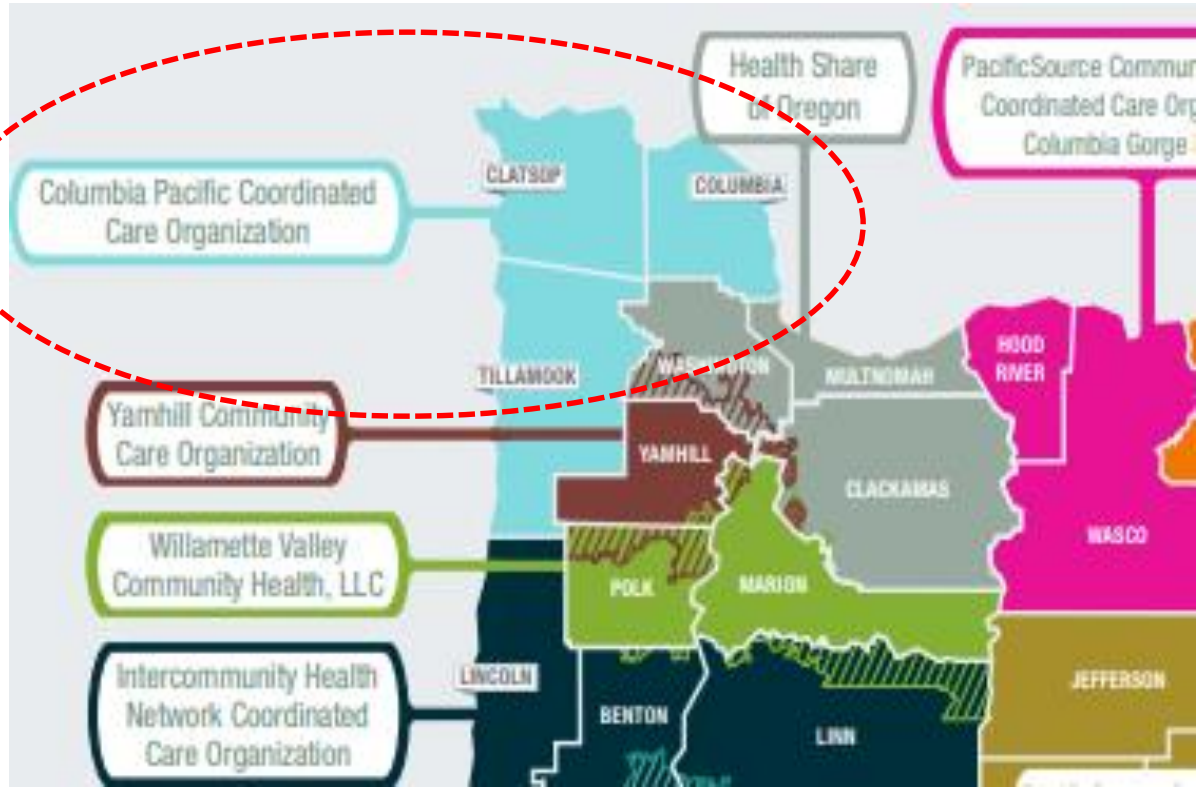
Learning Objectives

- Learn about ColPac CCO ED reduction strategy including a focus on the disparity metric
- Learn how the High Risk Huddle team is organized and operates
- Learn how the huddle structure can support other focused population health initiatives

Background

Columbia Pacific CCO is a non-profit, wholly-owned LLC of Care Oregon

- Operates in three counties: Clatsop, Columbia, Tillamook
- Serves ~23,700 Medicaid members
  - ~9,200 Columbia Co
  - ~8,400 Clatsop Co
  - ~5,800 Tillamook Co



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High Risk Huddle Introductions

Kathy Belwood: High Risk Triage Coordinator; organizes and facilitates the county huddles and case conferences

Marika Shimkus: Health Resilience Specialist; community-based behavioral health support

Jessica Dizon: Ambulatory Care Clinical Coordinator, telephonic pharmacist support

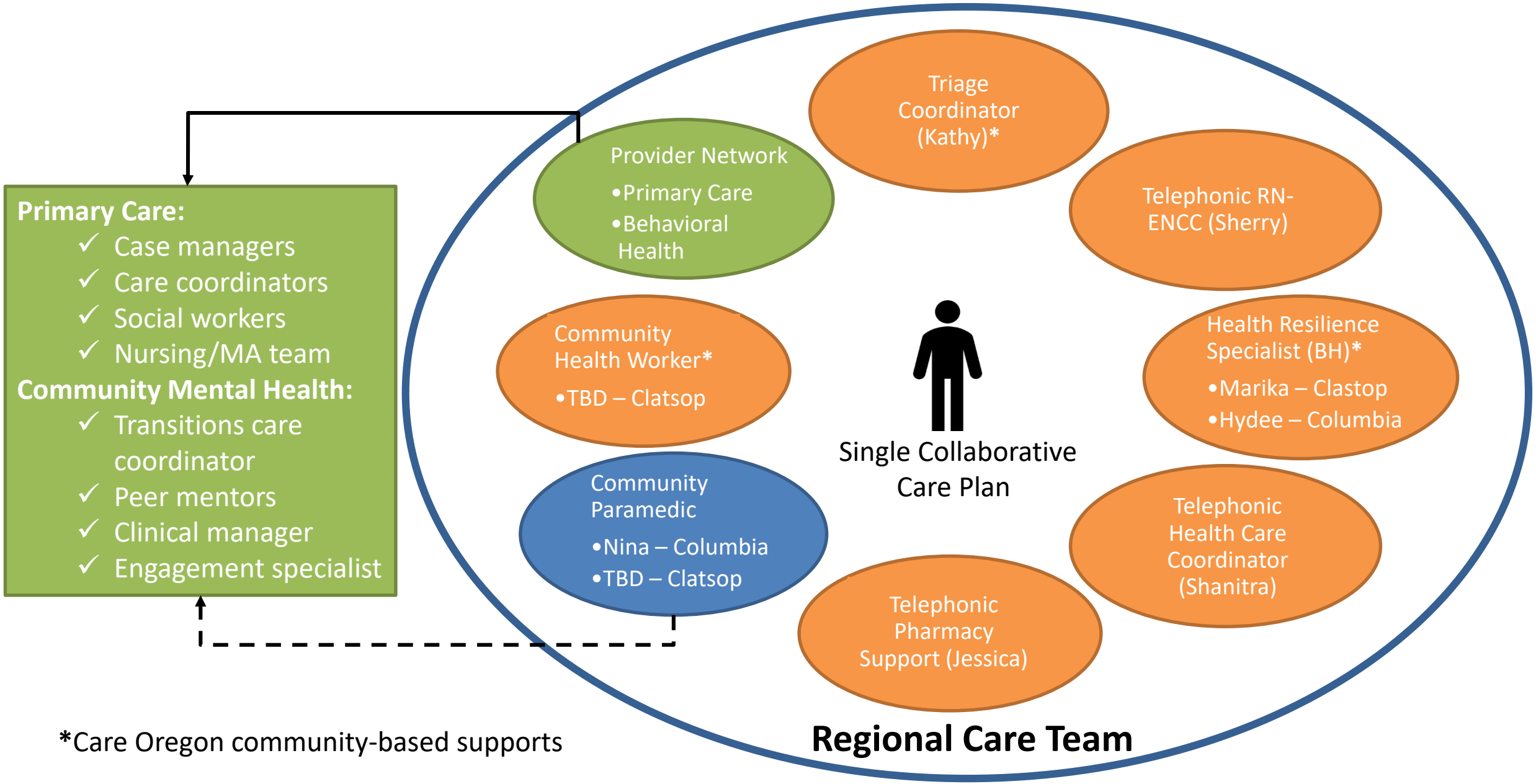
Miriam Parker: Transitions of Care Manager, community mental health provider (Columbia Community Mental Health)

Other huddle participants:

- Primary care clinicians
- Community mental health providers and peers
- Community paramedics

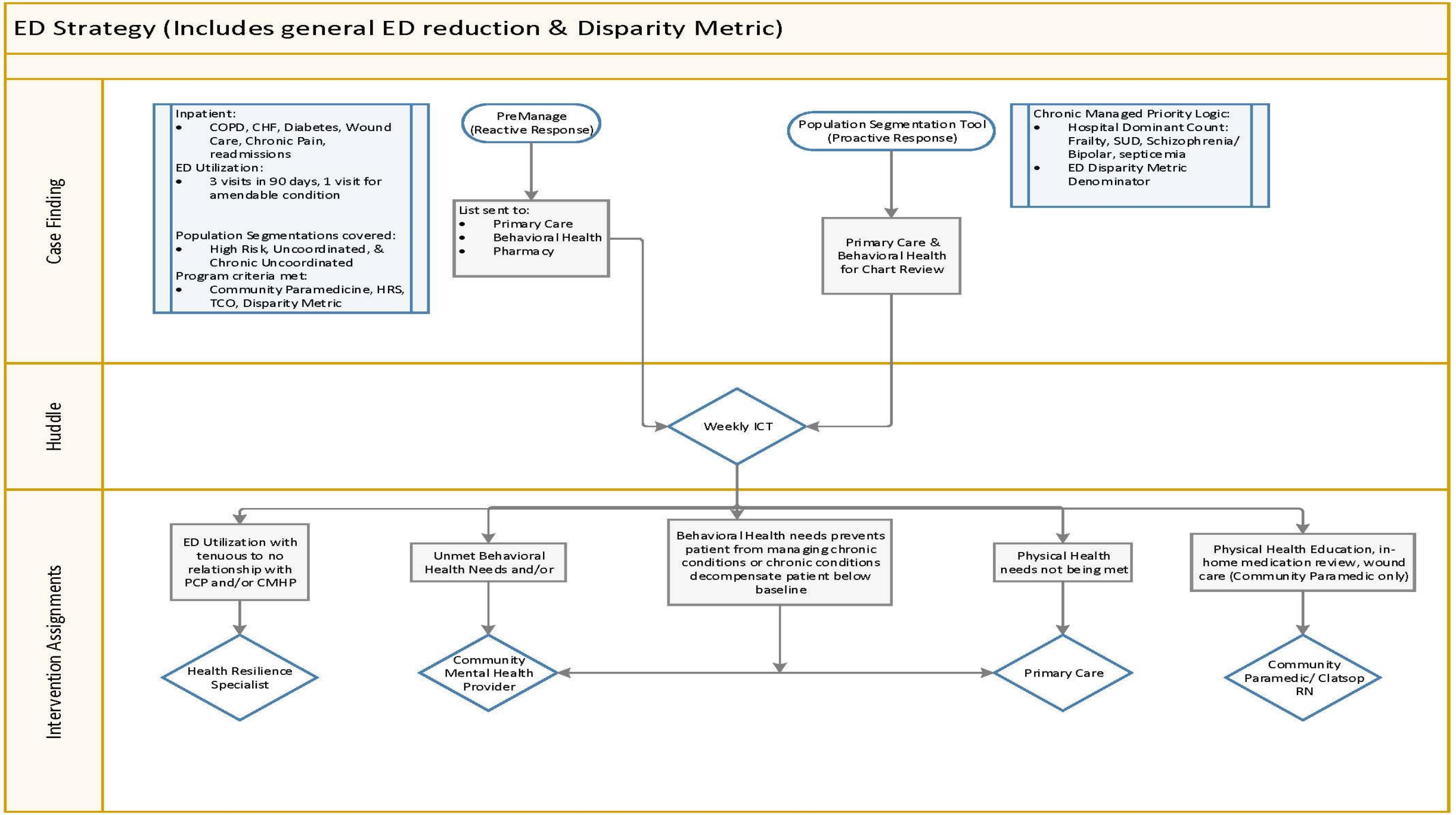
Goals of the Regional Care Team Huddle

- Proactive outreach to members needing more support
- Preventative approach to member care – thinking more upstream
- Ensure access to services and care that most appropriately address member needs and gaps in care
- Address physical and behavioral health needs collaboratively, and social needs



*Care Oregon community-based supports

ED Strategy (Includes general ED reduction & Disparity Metric)



HIGH RISK HUDDLE TEAM **Region 1** ☐ **Region 2** ☐

Huddle Date: mm/dd/yyyy

[All but "Next Steps" filled in prior to Huddle Date by Huddle Triage Coordinator using PreManage and other available systems]

Name	
DMAP/MRN	
DOB & Age	
Primary Care	
Current referral to Pharmacy?	
Current referral to BH/MH/SUD?	
Drivers of Utilization	
Needs/Concerns	
Current PreManage Care Recommendation	

NEXT STEPS

Action Items	Person Responsible

[To prepare for Huddle, Huddle Triage Coordinator adds here a current snapshot of recent ED & IP utilization and other relevant medical and behavioral diagnoses and complications.]

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Running the Weekly Huddle

1. Triage Coordinator sends via secure email prepared huddle sheets a week before the huddles
2. At huddle start time, participants dial into phone line
3. All huddle participants have computers up and running for data questions and note taking
4. Triage coordinator starts the huddle with patient #1
5. Huddle discussion occurs
6. Next steps determined and documented in huddle sheet
7. Team moves on to patient #2

Huddle time per patient: ~15 mins Each huddle hour covers 4-5 patients.

Huddle Demonstration

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Regional Care Team
Huddle Date: 11/30/18

CLATSOP [ ] **COLUMBIA** [X]

Name	Minnie Mouse
DMAP	XXXXXXX
DOB	02/12/1990 (Age: 26)
Primary Care	OHSU Scappoose- No Utilization
Referral to Pharmacy	Yes – is Mbr on any PH/MH Meds? Consistent fills?
Referral to BH/MH/SUD	**Yes** – DX: SI and attempts (overdose), Bipolar, Anxiety DO, Psychotic DO, Substance Abuse (stimulants), lack of expected development in childhood
Drivers of Utilization	SUDS, MH, Pregnancy, New dx of MS during 9/15/18 IP stay
Needs/Concerns	New to CPCCO 10/21/18 Is Mbr connected to PCP? OB/GYN? BH/MH? Living situation? Support needed?
PreManage Care Recommendation	7/01/18 Kaiser: Minnie is vulnerable when on the streets and **may need assistance accessing resources** beyond just hearing about them. Examples: Calling and reserving shelter space, assisting with transportation or obtaining a community detox bed would be helpful interventions that help with recidivism to the ED. If Minnie is having delusional thinking (poisoning, paranoia etc) it is helpful to give her some time to stabilize in the ED and reach a state closer to baseline so that aftercare and D/C plans have a chance to stick. We see that D/C before she is near baseline leads to her returning, as she is sometimes less capable of connecting to community resources than she presents.

NEXT STEPS

Action Items	Person Responsible

Legacy Emanuel	16
Legacy Good Samaritan	3
Providence Milwaukie Hospital	4
Providence St. Vincent Medical Center	1
Oregon Health and Science University	2
Providence Portland Medical Center	1
PeaceHealth St. John Medical Center	1
Total	**28**

2 IP Stays in last 12 months:

12 day IP stay 9/15/18, PeaceHealth, UTI, Psychotic DO

5 day IP stay 3/12/18, Providence ST V, Psychosis not due to substance and Stimulant use.

Adm: 9/15/2018, D/C:
HPI: 27 yo female CHIEF COMPLAINT: Suicidal, confused, psychotic.
presented to the hospital describing thoughts of self-harm and suicidality. She was found to be psychotic and demonstrated fear of drinking water and being poisoned with anthrax.
At the time of my evaluation, she was noted to be pacing naked back and forth in the Emergency Department, yelling and screaming inappropriately. UDS found no substances.

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Regional Care Team Huddle Date:	CLATSOP	X	COLUMBIA	

Name	Harry Potter
DMAP	ZZZZZZZZ
DOB	02/25/1961 (Age: 55)
Primary Care	Coastal Family Health – very little utilization, 3 visits this year
Referral to Pharmacy	Yes – Are medications correct for Dx? Are fills consistent?
Referral to BH/MH/SUD	Yes – Stimulant Dependence
Drivers of Utilization	COPD, Emphysema, CHF, Kidney Failure, Severe protein-calorie malnutrition, Primary Hypertension, Acute Hep C,
Needs/Concerns	All ED visits due to SOB/CHF. Connected to Pulmonologist? Cardiologist? Food Insecurity? Homeless
PreManage Care Recommendation	No current Recommendations in PreManage.

NEXT STEPS

Action Items	Person Responsible

Providence Seaside Hospital	39
Providence St. Vincent Medical Center	2
Columbia Memorial Hospital	5
Mid-Columbia Medical Center	1
Total	47

8 IP Stays in last 10 months due to COPD, CHF

11/08/2018 19:12	Columbia Memorial Hospital	Astoria	OR	Emergency	Emergency	Chief Complaint: DIFF BREATHING
11/08/2018 08:34	Providence Seaside Hospital	SEASIDE	OR	Emergency	Emergency	Chronic obstructive pulmonary disease, unspecified
11/06/2018 01:12	Providence Seaside Hospital	SEASIDE	OR	Emergency	Emergency	Chronic obstructive pulmonary disease, unspecified
11/03/2018 21:43	Providence Seaside Hospital	SEASIDE	OR	Emergency	Emergency	Chronic obstructive pulmonary disease with (acute) exacerbation
11/02/2018 15:32	Providence Seaside Hospital	SEASIDE	OR	Emergency	Emergency	Chest PainPrecordial pain
10/29/2018 04:12	Providence Seaside Hospital	SEASIDE	OR	Emergency	Emergency	Chronic obstructive pulmonary disease with (acute) exacerbation
10/22/2018 22:59	Providence Seaside Hospital	SEASIDE	OR	Emergency	Emergency	Heart failure, unspecified Chronic obstructive pulmonary disease

What We Learned

- Consistent attendance is key to success—community mental health providers and primary care clinicians
- Huddles that occur in person are more effective/higher level of engagement vs. telephonic
- Having the “right people”
  - Makes a difference when the person can directly connect people to the appropriate programs or resources.
  - Clinical expertise to identify if a person is an appropriate referral (physical and behavioral)
- Continued learning is inherent
  - Reduces silos between physical health and behavioral health
  - Increased interdisciplinary collaboration leads to understanding the scope, needs, and limitations of the other partners

Q & A
and Comments

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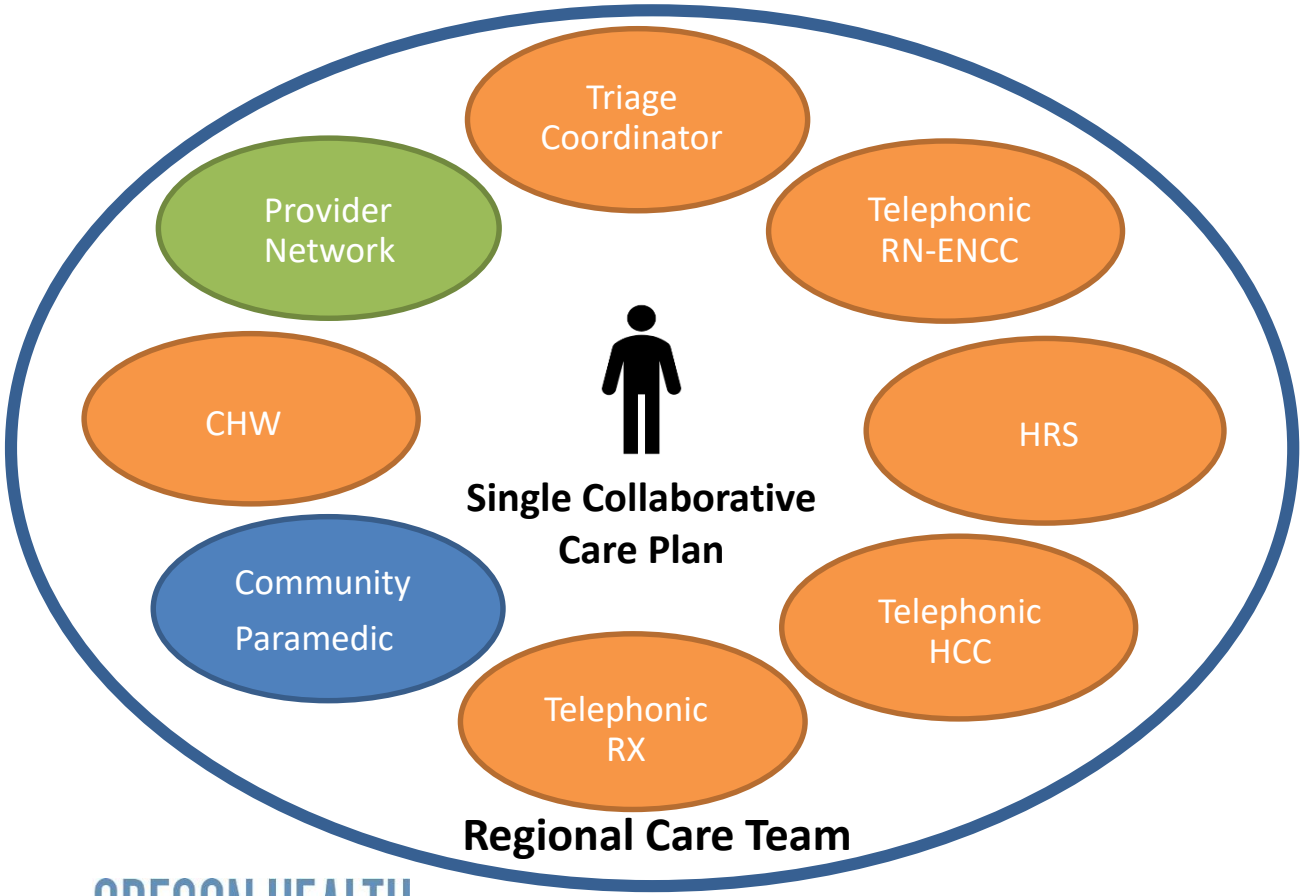
What's Next

Care Oregon has adopted the regional care team model and shifted the way care coordination is delivered at an enterprise level

- Health Resiliency Program
- Transitions of Care
- Exceptional Needs Care Coordination
- Housing
  Food
  RX

Siloed Programs



What's Next for CPCCO?

Alignment with our CCO population health strategy major areas of focus:

- Rising Risk members – specific focus on uncoordinated population
  - Average 5+ ED visits, less likely to engage with primary care clinician (PCP), 30-40% have a substance use disorder (SUD) diagnosis
  - Goal: multidisciplinary care team work with member on getting connected to SUD treatment and/or PCP, and appropriate community resources
- SUDs – specific focus on opioid use disorder (OUD)
  - ~28% with an OUD diagnosis are not engaged in treatment
  - Goal: multidisciplinary care team work with member to engage in treatment services as appropriate
- Palliative Care
  - Goal: triage referrals to community-based palliative care program, focus on engaging providers to refer earlier to prevent unnecessary hospital visits

Presenter Contact Information

Keshia Bigler, CareOregon biglerk@careoregon.org
Keshia contact for questions across Huddle team

Kathy Belwood, CareOregon
Jessica Dizon, CareOregon
Miriam Parker, Columbia Community Mental Health
Marika Shimkus, CareOregon

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Thank you!

Please complete the post-session evaluation.

Next session is on **Monday, March 4 from 1:00-2:00 p.m.**

- We will discuss approaches to community collaboration and participants will have an opportunity to share their efforts to address the emergency department disparity metric population.

Susan Kirchoff, OHLC, susan@orhealthleadershipcouncil.org

Liz Whitworth, OHLC & CareOregon, liz@orhealthleadershipcouncil.org

For more information on ED MI metrics support, visit www.TransformationCenter.org

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