Welcome!

**Reducing Emergency Department use among the 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 4!

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

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 successful community-based strategies to address the mental illness population.

Keys to Success in Managing CCO Disparity Population

Systems Improvement Virtual Learning Collaborative- What CCOs Can Do

March 4, 2019

Susan Kirchoff, Oregon Health Leadership Council

Learning Objectives

- Review key takeaways from previous sessions
  - Utilizing PreManage and CCO Disparity Cohort
  - Leveraging data to identify areas of focus
  - Engaging and supporting provider network to accelerate improvement
  - Utilizing cross-organizational collaboration to address physical, behavioral and social needs
- Learn about key components for successful community collaboration to enhance cross organizational care coordination and communication
- Shared understanding of successes/challenges in addressing this population

Question

Is your organization currently using the CCO Disparity cohort in PreManage?

____ Yes

____ No

Are your provider network partners using the CCO Disparity cohort?

____ Yes, most of the practices we partner with use the cohort

____ Yes, some of the practices we partner with use the cohort

____ No

____ Don't know

PreManage CCO Disparity Cohort

- Early identification of ED utilization among population
- Can see care team members, care guidelines
- Can see reasons for ED visit—physical health and behavioral health
- Can use information to segment the population by criteria of interest (e.g. engaged in primary care and behavioral health)

Leveraging Data

What data are you using to determine how to address the population? Choose all that apply

___ Chronic conditions

___ Mental health diagnoses

___ Substance use disorder diagnoses

___ Number of ED visits

___ Engagement with primary care

___ Engagement with behavioral health

Leveraging Data

Which provider networks have you shared data with?
Choose all that apply

____ Behavioral Health

____ Physical Health

____ Other providers

____ Have not shared information outside of CCO

Leveraging Data

- Other considerations
  - Look at those not going to the ED—what is working?
  - ED visits related to pain
  - Homelessness
  - Avoidable ED visits—patterns related to access?
- Caution against endless data analysis—there is no single solution to reducing ED utilization
- Start working with providers to surface successful approaches to engaging and caring for folks with mental illness

Engaging Provider Network

- Share data analysis with providers to inform the work
- Decide together best areas of focus—don't "tell" the providers what to do
- Incentives are helpful for provider engagement, but consider ways the CCO can provide support (e.g. technical assistance)
- Create opportunities to connect providers and foster partnerships—particularly between primary care and behavioral health
- Start small and build momentum

Cross Organizational Care Coordination

Does your organization sponsor or participate in cross organizational care coordination activities to address this population?

_____ Yes

_____ No

Cross Organizational Care Coordination

Benefits:

- Shared identification of members most needing support
- Addresses physical, behavioral and social needs together
- Ensures access to services and care needed
- Reduces duplication
- Leverages resources to better serve the population
- Provides support for clinicians and others dealing with a challenging population

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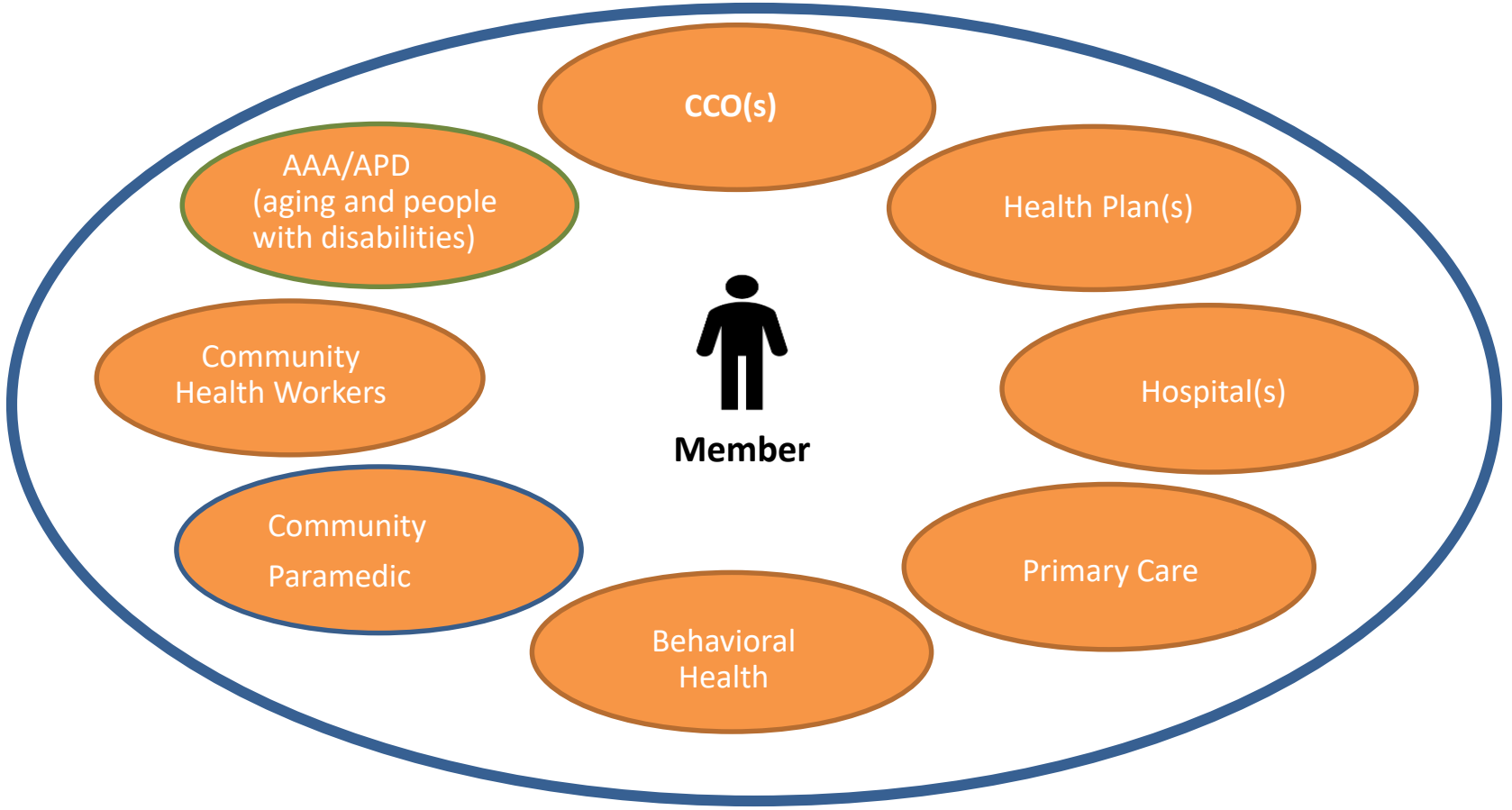
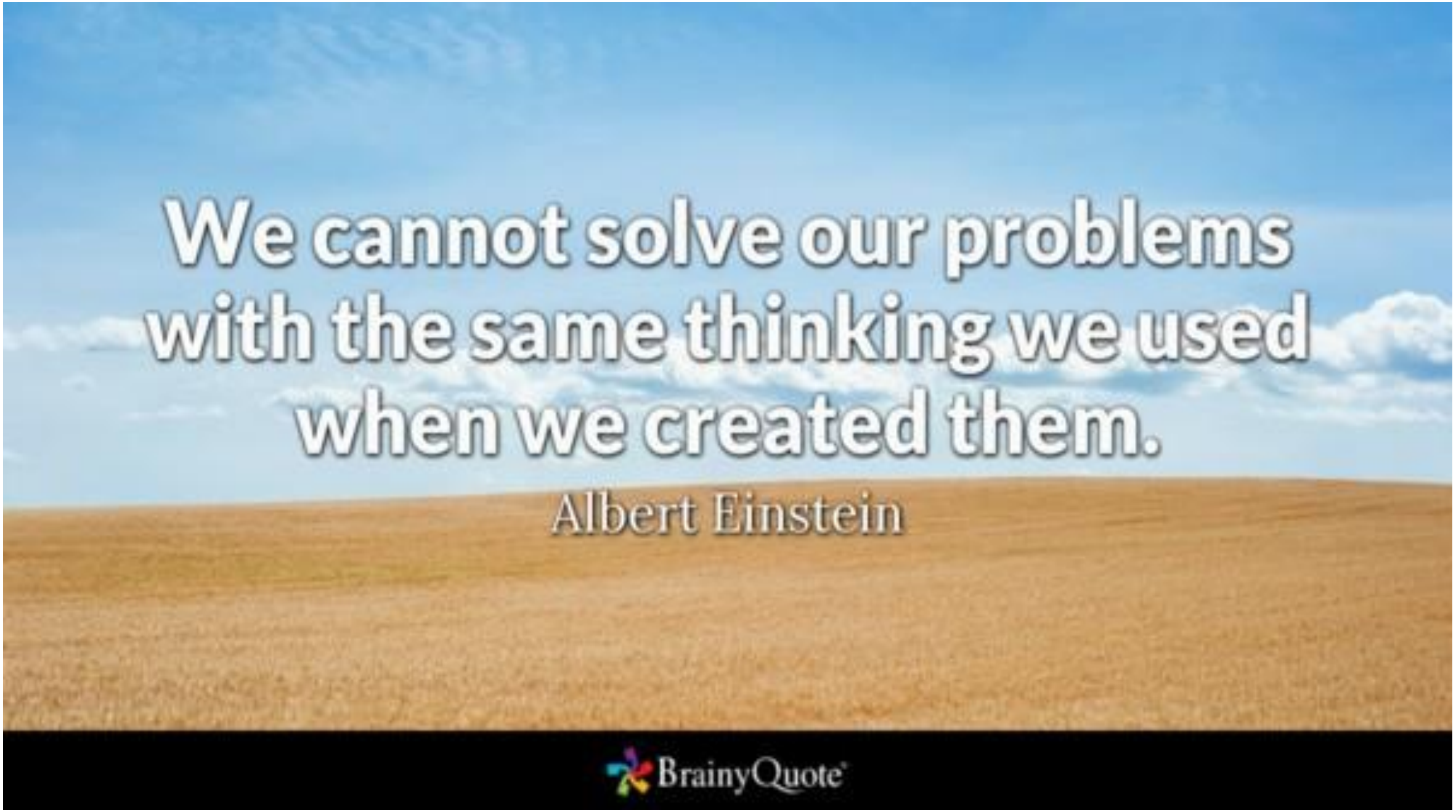
Community Collaboration

Working with all community systems to build a model of care for high needs, high utilizing members




We cannot solve our problems with the same thinking we used when we created them.
Albert Einstein
BrainyQuote

Community Collaboration

Opportunities:

- Organizations want to work together—despite sometimes competitive interests
- Develop a shared understanding of organizational environments and workflows
- Leverage resources by identifying shared workflows, roles and responsibilities
- Develop repeatable processes across organizations
- Build relationships which makes the work easier overall

Community Collaboration

Challenges:

- Organizations may have varying resources
- Takes time to build trust among organizations
- Lots of competing priorities can hamper sustained focus
- Some organizations are attached to their own workflows and struggle with adopting shared workflows

Community Collaboration

Getting Started:

- Solicit interest of key partners, including commercial health plans (e.g. Med Advantage)
- Sustained organizational leadership commitment required
- Convene those who are interested and get started—others may come along as momentum builds
- Consider leveraging or expanding existing related work
- Share data and agree together on population of focus (e.g. patients with MI and >___ ED visits in 12 months)

Community Collaboration

Process:

- Map current state to understand each organization's existing workflows
    - Before, during, after ED visits
- Identify together best opportunities for developing shared workflows
- Break down the work into manageable chunks, but avoid "silo" thinking
- Optimize the use of Collective tools to support cross organizational care coordination and communication (e.g. care guidelines)
- Document and test shared agreements, roles and responsibilities and continue to refine and expand

Q & A
and Comments

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Open Discussion

What strategies have you put in place to address the CCO ED disparity metric population that you think have been successful?

What challenges are you experiencing and what assistance might you need regarding PreManage or the disparity metric in general?

Type your name in the chat box and we will unmute you

Upcoming Events—See Link to Flyer Below

Mar 5th 1-2pm Webinar #1: Getting Started with PreManage: Clinic Staffing & Workflows
Register at: https://register.gotowebinar.com/register/1681236138558726401

April 12: Primary Care Collaborative at Oregon Medical Association
Limited to 50 attendees
Register at: https://www.eventbrite.com/e/primary-care-learning-collaborative-tickets-56428389833

May 14, 1-2pm Webinar #2: Designing an ED Strategy
Register at: https://attendee.gotowebinar.com/register/7013299085760806401

Sep 20: Primary Care Collaborative outside Portland metro area—location TBD

Behavioral Health and Payer Collaboratives—dates TBD

Full link to calendar of events with updates to dates as confirmed:
https://ohlc.egnyte.com/dl/9MTvCn0jol/

HIT COMMONS
Accelerating Health Information Technology

2019 Technical Assistance Webinars and Collaboratives
to support the use of the Collective Platform
(formerly known as EDIE/PreManage)

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Thank you!

Please complete the post-session evaluation.

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

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