Café Session 1

Project Handouts:

Reducing emergency department use with a focus on behavioral health

Introduction to 2018 CCO Equity Measure: ED Utilization Among Those with Severe, Persistent Mental Illness

Measure Overview:

The Metrics and Scoring Committee is responsible for selecting measures for the coordinated care organization (CCO) incentive metrics program. Since early 2016, the Committee has been exploring ways to use the CCO quality pool structure to incentivize CCOs to focus on equity. In January 2017 the Committee selected **emergency department (ED) utilization among members with severe and persistent mental illness (SPMI)** as its equity measure.

ED utilization has been a CCO incentive measure since the beginning of the program in 2013. For its first equity focused measure, the Committee chose to create a new version of this measure, focused specifically on members experiencing SPMI.

Why ED Utilization?

In selecting the metric most appropriate to serve as the program's equity measure, the Committee wanted a measure that would:

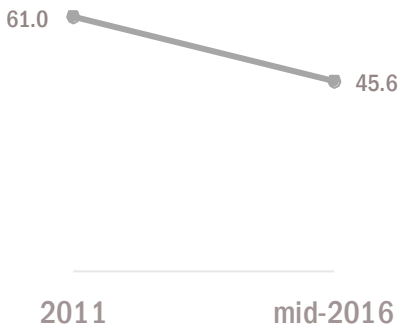
- Be transformative
- Be simple to explain/message and administer
- Not require additional data collection / add provider burden

Therefore, the Committee wanted to utilize an existing incentive metrics, and focus in improving performance for selected populations experiencing disparities.

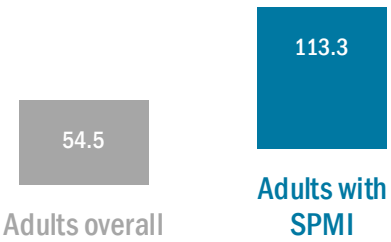
The CCOs were surveyed to understand the measures and populations each CCO found to be of most importance in terms of reducing disparities, and to have a better understanding of any data availability or reporting issues, such as small denominators for specific populations.

After reviewing CCO feedback and OHA's recommendations, the Committee chose ED utilization. While Oregon overall is doing well on ED utilization, certain populations are being left behind. In fitting with the Committee's goals, this measure is high impact, has a sufficiently large denominator for all CCOs, and shows large disparities across multiple populations (including race/ethnicity, gender, language, urban / rural, people with severe and persistent mental illness, etc.).

Overall, ED utilization has improved since CCOs were started...
(Per member per month, all ages, statewide)



...however, members with SPMI use the ED at much higher rates.
(Per member per month, statewide, mid-2016)

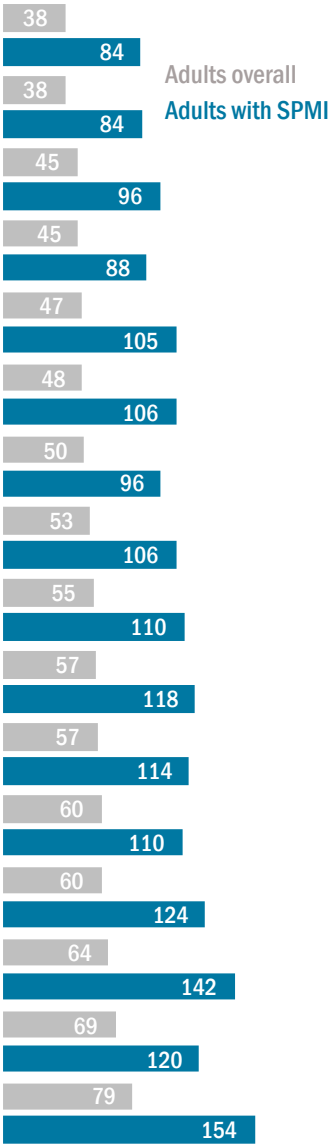


Introduction to 2018 CCO Equity Measure: ED Utilization Among Those with Severe, Persistent Mental Illness

Why SPMI?

The Committee was particularly interested in addressing disparities with regard to race and ethnicity. However, in reviewing the data provided by the CCO, there were numerous instances of small denominators, particularly when stratifying the various measures by race and ethnicity.

ED utilization is higher among adults with SPMI across all 16 CCOs.
(Per member per month, mid-2016)



The Committee therefore chose to focus on members experiencing SPMI. This provides additional focus on behavioral health integration and care coordination, and aligns well with the Oregon Performance Plan as part of Oregon's USDOJ agreement. While ED utilization has been declining in Oregon since 2011, Medicaid members with severe and persistent mental illness have much higher rates of ED utilization, and national data indicate that individuals with more severe mental health conditions are more likely to have multiple ED visits during a year.

CCOs already receive monthly dashboards with the ability to stratify measures for individuals with mental health diagnoses, and SPMI (as defined by Oregon's USDOJ agreement). ED utilization for individuals with SPMI has been publicly reported at the state level since January 2015.

Future Decisions:

While the Committee has chosen to include this new equity measure in the program beginning in 2018, there remain additional decisions yet to be made:

- Will this measure *replace* the existing emergency department utilization measure (for all adults)?
- Will this measure be incentivized *in addition* to the existing ED utilization measure?
- Will this measure be added solely as a challenge pool measure?

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2017 Innovation Café
Improving Key Health Metrics

Tri-County 911 Service Coordination Program (TC911)

About TC911

In April 2013, TC911 began serving Washington, Clackamas, and Multnomah county residents who use emergency medical services (EMS) frequently when other health and social services would more appropriately serve their needs.

TC911 aims to reduce unnecessary use of emergency medical services (EMS) by linking clients to the right care at the right place and time. Annually, TC911 serves roughly 450 unique people; most are Medicaid enrollees (~80%).

Client Profile

Compared to the average adult Medicaid member, TC911 clients have significantly more disease burden and higher utilization, averaging:

- **40 x** higher rates of ED and inpatient visits;
- **10 x** the outpatient mental health care visits per member per month;
- **3 x** the use of primary care; and
- **13 x** greater costs ($57,672 per member/year)[1]

	TC911 n=337	Typical Medicaid
Avg EMS calls per mo.	1.8	N/A
Avg ED visits per mo.	2.3	0.05
Avg inpatient visits per mo.	.33	0.008
Avg PCP visits per mo.	1.12	0.31
Avg total expenses per member/mo.	$4806	$360
Dual dx (1+ physical hlth & 1 MH)	64%	7%

Source: Providence Center for Outcomes Research and Education 2016

Lessons Learned

- Pre-hospital systems are a critical, untapped part of the health care system.
- A neutral, third party allows for successful bridging across systems and providers.
- Direct access to referrals and EMS Medical Directors helps facilitate regional EMS coordination and improve pre-hospital care.
- Intergovernmental agreements and/or contracts may be necessary to work across counties/systems.
- Early HIPAA conversations are essential.
- Staff access to the right information, at the right time improves clinical outcomes. E.g. real-time ED notifications, ambulance patient care reports.
- Clinical expertise, field-based work and flex funds are critical to client engagement and care management.
- Service demand quickly exceeded staff capacity.

Intervention Highlights

- Receive referrals from pre-hospital and emergency response systems.
- Act as a bridge between EMS and other health and social service systems.
- Staffed by seven licensed clinical social workers who are administratively employed by the Multnomah County Health Department's EMS Program.
- Use high intensity, high touch clinical interventions, such as provider consultation, multi-system care coordination and intensive case management. Interventions average 180 days.
- Work across counties and systems to facilitate communication, advocate for needed services, link to resources, and improve care coordination with and on behalf of the client.
- Partnerships with over 80 medical clinics, 10 hospitals and all area hospital systems, multiple payers, and hundreds of behavioral health, long term care, Aging, Disability and Veteran Services case managers, housing and EMS providers.

Impact and Outcomes

- Evaluation of impact on Medicaid members showed statistically significant declines in the rates of EMS responses (-40%), ED visits (-41%), and inpatient admissions (-24%) after clients engaged with the TC911 program.
- Overall costs went down significantly (-18%) from pre to post; reductions were largely driven by reduced ED costs (-45%).
- Overall program impact and calculated return for Medicaid payers when comparing pre- and post- TC911 engagement:

	TC911 - Medicaid Members Evaluated
#TC911	337
Cost savings	$887 PMPM reduction; $10,644 PMPY savings**
Utilization	Significant reductions** in EMS responses, ED visits, and non-OB admits
ROI	~$2.8M in annual savings (after deducting $787K investment by Medicaid payers to serve 340 enrollees

* Baseline intervention and control groups were different and the sample size was small.
**p<.05

Sources: Bailit Health, TC911 Payment Options Memo. September 2016. Providence Center for Outcomes Research and Education (CORE). September 2016.

Funding

- Grew from a 2012-2015 regional CMMI demonstration grant.
- FY17 budget is $1.1M; 75% are personnel-related costs.
- Expenses are based on 7 social workers and include flexible funds and a subcontract for Peer Wellness Services.
- Direct CCO contracts (Health Share of Oregon and FamilyCare Health) represent roughly 79% of the total budget, and allow service delivery to a specified number of Medicaid members.
- Additional revenue from county general funds allows the program to serve non-Medicaid enrolled clients who use EMS frequently.
- A business case has been presented to both CCOs for future funding to support this regional utility.

For more information, contact Alison Goldstein, TC911 Lead at alison.j.goldstein@multco.us
Check out our video https://vimeo.com/125402751

Reducing ER visits through Outreach

A look at the changes that Cascade Health Alliance has put into place to make an impact on meeting Behavioral Health needs while reducing ER expenses.

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Shelly Morton- Behavioral Health Care Coordinator 541-851-2091

Process:

- Activate mobile crisis team
- Daily review of ER report
- Notify PCP of any Behavioral Health issues and provide quick referral
- Contact members to follow up
- Weekly meeting with Behavioral Health provider to monitor ongoing contact and services

Challenges:

- Accurate and timely receipt of follow up info from BH provider
- Members not returning calls and not responding to attempts to re-engage them in services
- BH providers not actively providing post crisis outreach services to members
- PCPs not getting feedback from BH providers following a crisis or referral

Recommendations:

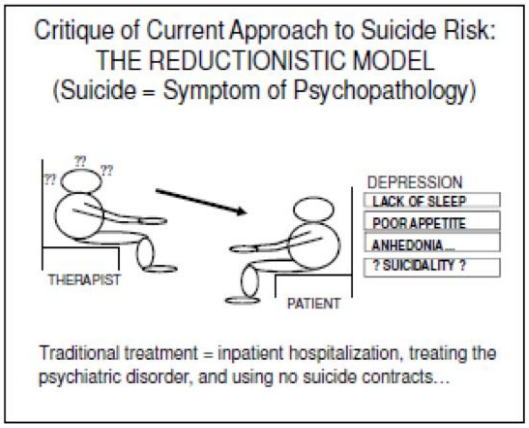
- Designate case assistant for follow up calls
- Refer high utilizers to BH case manager for ongoing check-ins and support
- Establish regularly scheduled meetings with providers to ensure members' needs are being met.
- Build a robust Mobile Crisis Team to ensure ability to provide timely services in member's homes when needed

Organizations- KBBH, LCS, SLMC, PCPs

Funding Source- State BH funding passed through from CHA to KBBH

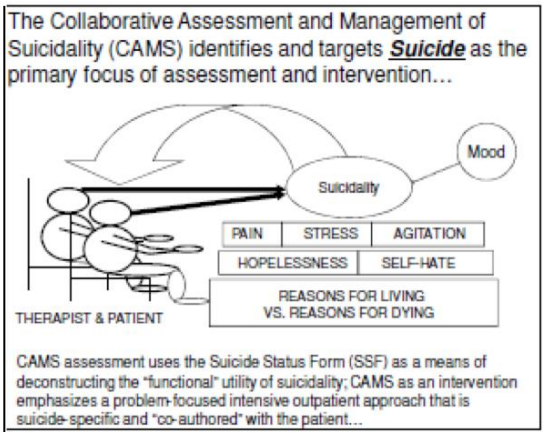
Implementing EBP Leads to Reduction in ED Visits for Suicidal Ideation

Collaborative Assessment and Management of Suicidality



SHIFT FOCUS FROM:

- Medical model to trauma informed care
- Professional authority to collaboration
- Immediate safety to chronic SI as coping strategy
- Shame to normalizing and insight
- Symptom management to skill building



Change community philosophy and approach (outpatient, hospital, behaviorists, law enforcement, crisis)

Familiarization resources

Book: *Managing Suicidal Risk: A Collaborative Approach, 2nd Edition; Jobes, David, Guilford Press*

3 hour training video: cams-care.com

On-line learning: empathosresources.com

Ensure access to new practice in all outpatient settings

Agency P&P to ensure orientation, training, identification of suicidal individuals

Skill building trainings for clinical leadership with consultation calls

Identify and refer in ED for Psychiatric Crisis Center intervention

Goal is to move work with suicidal ideation to crisis center rather than ED

CAMS plus case management support and referral to address drivers of suicidality

Monitor impacts

Sessions using SSF in outpatient+Psychiatric Crisis Center (PCC): Average 188/quarter 2016

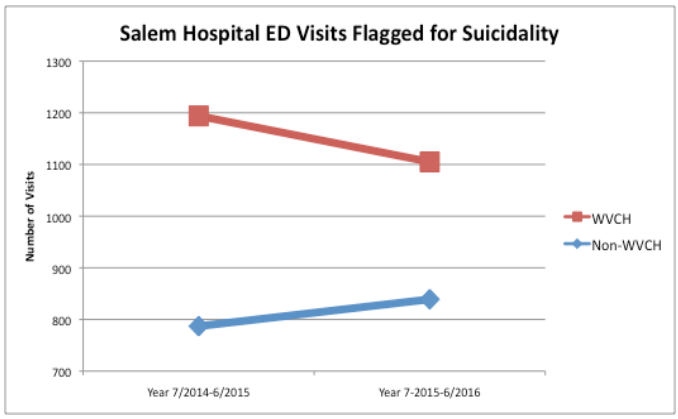
Interventions at PCC: Average 65 per quarter/2016

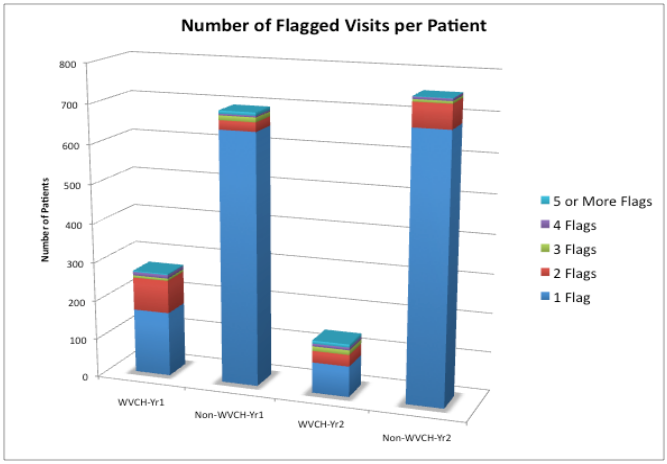
Half referred by ED, half seeking crisis support at PCC

9% no show rate for next day appts following ED referral

15% return to PCC in 6 months; 34% return since project began

Ave. 6 visits + 2 for case management





Funding: BCN training budget, licensed agency use of SSF, interventions reimbursed as individual tx

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Ann Marie Bandfield, MSW ambandfield@co.marion.or.us 503-566-2967

SAMPLE QUESTIONS FROM SUICIDE STATUS FORM (SSF)

———	1) RATE PSYCHOLOGICAL PAIN (*hurt, anguish, or misery in your mind, **not** stress, **not** physical pain*): **Low pain: 1 2 3 4 5 :High pain** What I find most painful is: _____
———	2) RATE STRESS (*your general feeling of being pressured or overwhelmed*): **Low stress: 1 2 3 4 5 :High stress** What I find most stressful is: _____
———	3) RATE AGITATION (*emotional urgency; feeling that you need to take action; **not** irritation; **not** annoyance*): **Low agitation: 1 2 3 4 5 :High agitation** I most need to take action when: _____
———	4) RATE HOPELESSNESS (*your expectation that things will not get better no matter what you do*): **Low hopelessness: 1 2 3 4 5 :High hopelessness** I am most hopeless about: _____
———	5) RATE SELF-HATE (*your general feeling of disliking yourself; having no self-esteem; having no self-respect*): **Low self-hate: 1 2 3 4 5 :High self-hate** What I hate most about myself is: _____
N/A	6) RATE OVERALL RISK OF SUICIDE: **Extremely low risk: (will not kill self) 1 2 3 4 5 :Extremely high risk (will kill self)**

1) How much is being suicidal related to thoughts and feelings about yourself? **Not at all: 1 2 3 4 5 : completely**
2) How much is being suicidal related to thoughts and feelings about others? **Not at all: 1 2 3 4 5 : completely**

Please list your reasons for wanting to live and your reasons for wanting to die. Then rank in order of importance 1 to 5.

Rank	REASONS FOR LIVING	Rank	REASONS FOR DYING

I wish to live to the following extent: Not at all: 0 1 2 3 4 5 6 7 8 : Very much
I wish to die to the following extent: Not at all: 0 1 2 3 4 5 6 7 8 : Very much

The one thing that would help me no longer feel suicidal would be: _____

Integrating Doulas to Enhance a New Mother's Confidence During Their Newborn's First Year of Life

Background

In 2011, the Oregon legislature passed House Bill 3311, which directed the Oregon Health Authority to explore options for including doulas in state medical assistance programs to reduce health disparities among women who face a disproportionately greater risk of poor birth outcomes. African American and African immigrant women are at the greatest risk.

Presenter Information

Maegan Pellatt, MSW
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Partner Organizations

Black Parent Initiative (BPI) was established in 2006 to help families achieve financial, educational, and spiritual success. BPI co-founders Johnell Bell and Charles McGee formed the organization based on a large body of research showing the importance of familial engagement and stability in educational success.

FamilyCare Health, a Coordinated Care Organization in the tri-county area, serves around 120,000 Oregon Health Plan members.

Funding Source

Funding was provided through a bundled APM capacity building grant given to BPI to get the doula workforce trained and certified. FCH will purchase the *"What To Do When Your Child Gets Sick"* books at $8.95 per book (around $600 total).

Situation

Non-Hispanic black infants are twice as likely to be seen in the Emergency Department (ED) as white and Hispanic infants.[1] They also face the most disparate birth outcomes, including premature birth, low birth weight, infant mortality, and more. Research shows that having a doula (a form of traditional health worker) present during pregnancy, childbirth, and postpartum periods of care can improve birth outcomes and infant health.

Project Description

This two-year project will explore how a Coordinated Care Organization (CCO) and a community-based organization (CBO) can improve birth outcomes and postpartum and infant health by offering doula services to African American and African immigrant women. Within the first year of this two-year project, Black Parent Initiative, (BPI), a culturally-specific CBO, will connect 50 pregnant members of FamilyCare Health (FCH), a CCO in the tri-county area, with community-based culturally-specific doula services.

In the program, called "Sacred Root Community":

- BPI will provide parent education classes, continuing education for doulas, and quarterly reports highlighting performance metrics in the contract. This aligns with the BPI initiative, *"Pre-birth through the first 1,000 days: Creating an environment that promotes healthy babies and parents."*
- BPI doulas will provide at least four prenatal and at least two postpartum visits. This includes accompanying each member to at least one prenatal visit with the treating provider, establishing PCP care for a newborn within 2 weeks of birth, and providing breastfeeding support.
- FCH will provide the book *"What To Do When Your Child Gets Sick."* Research shows that families who receive this book along with appropriate coaching and education by a traditional health worker can reduce low-acuity ED use by as much as 60%.
- FCH will track the birth outcomes and infant health for the duration of the program, including avoidable emergency room visits by these infants in their first year of life.

[1] Lee, Henry C. et al. "Emergency Department Visits in the Neonatal Period in the United States." Pediatric emergency care 30.5 (2014): 315–318. PMC. Web. 14 Apr. 2017.

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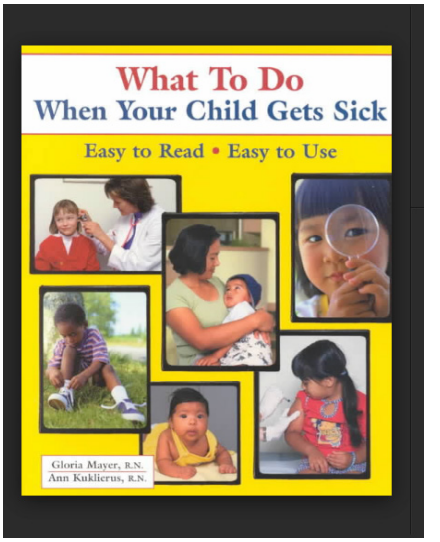
Project Objective
In addition to showing the effectiveness of doulas on mother and infant health, this program was designed to demonstrate how this model can be sustained through the use of an APM Medicaid reimbursable billing model.



Lessons Learned
Getting a CBO approved to bill Medicaid was a new and lengthy process.

Challenges
For a doula workforce to be reimbursed by Medicaid, a doula must be certified, registered through OHA, and enrolled wtih DMAP. There are very few certified doulas registered with OHA in the metro area, and even fewer who are culturally diverse. The first step in this project was to work with BPI to train and certify a culturally-specific doula workforce. Funding this type of work through Medicaid reimbursement on a fee-for-service schedule is not sustainable due to low reimbursement rates, which do not provide doulas an incentive to diversify their private-pay clientele.

SACRED ROOT COMMUNITY

DOULA PROGRAM

An Analytic Method for Exploration of Avoidable ED Utilization

FamilyCare Health

Background

Up to 27% of emergency department (ED) visits in the U.S. could be managed in physician offices, clinics, and urgent care centers. Moving these non-emergent visits to alternate medical centers could lead to a savings of $4.4 billion annually.[1]

According to a 2013 National Hospital Ambulatory Medical Care Survey on Emergency Department Visits:

- 130.4 million ED visits were made in 2013
- 12.2 million of these resulted in hospital admission (9.3%)
- 29.8% of patients were seen in fewer than 15 minutes

Presenter Information

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Organization

FamilyCare Health, a Coordinated Care Organization in the tri-county area, serves around 120,000 Oregon Health Plan members.

Project Description:
As part of FamilyCare Health's ongoing drive to improve member health and optimize available resources, we undertook an investigation of avoidable Emergency Department (ED) visits to identify clinical patterns which would inform intervention strategies.

Avoidable ED events were identified according to Medi-Cal diagnostic categories. These events were then grouped using K-means clustering, an unsupervised machine learning technique that "lets the data speak" by forming groups based on the characteristics of the data. Taking avoidable diagnoses as the clustering input variables, this yielded clinically similar groupings which we could then explore in greater detail. Within each cluster, we characterized member demographics, explored cost profiles, and checked for patterns of utilization in space and time.

Results:
After experimenting with how many clusters to form, we settled on a 6-cluster solution, which isolated visits into 6 diagnostically similar groups. To get a sense of the success of our clustering, we examined demographics both within and between clusters. As we expected, the individuals within a cluster were more similar to each other than to the members of other clusters. As further validation, we also compared our results to those of commercially insured health plan members as well as members of the Puget Sound Medicaid program in Washington State, and found that our clusters were similar in both composition and relative importance.

Examining the demographics of each cluster illuminated individual level factors potentially related to this utilization; patterns in the locations and days of visits helped to elucidate structural factors that may be driving various types of avoidable utilization. For example, a cluster consisting of upper respiratory infection and ear, nose, and throat infections emerged, which revealed that the majority of such visits were for young children. An unexpected result was the discovery that young women, primarily in the ACA rate group, were also responsible for this type of utilization, while men of equivalent age were not.

Lessons Learned:
This approach to the analysis of avoidable ED visits allows for the development of comprehensive—yet targeted—prevention programs that address both the individual and structural level components that motivate avoidable ED visits. Using unsupervised machine learning allows for a data-driven approach to segmentation of the membership involved.

Organizations Involved:
FamilyCare Health

Funding Source:
Internal FamilyCare initiative; no external funding required.

[1]Weinick RM, Burns RM, Mehrotra A. Many emergency department visits could be managed at urgent care centers and retail clinics. Health Affairs. 2010;29(9):1630–1636.

Café Session 2

Project Handouts:

Reducing emergency department use with a focus on behavioral health

REDUCING EMERGENCY DEPARTMENT UTILIZATION USING EDIE AND PREMANAGE

Background

In 2013, Oregon Health Leadership Council's (OHLC) Evidenced Based Best Practice Committee identified Emergency Department (ED) utilization as a priority area of focus. They became aware of work in the state of Washington aimed at reducing ED utilization employing the Emergency Department Information Exchange (EDIE) system provided by Collective Medical Technologies (CMT). Looking to leverage the successes of Washington, Oregon began its own efforts in partnership between the Oregon Health Authority (OHA), OHLC, Oregon Association of Hospitals and Health Systems (OAHHS) and CMT, to promote the statewide adoption of EDIE to reduce ED utilization, improve care coordination and improve care management. By July 2014, all hospitals in Oregon had adopted EDIE and began to receive ED notifications that included all ED visits and inpatient (IP) admissions for the past 12 months for high risk, high needs individuals.

In 2015, the EDIE Utility was formed to build off the initiative to bring the EDIE to all hospitals in Oregon, and expand EDIE to include inpatient and discharge information. Under the EDIE Utility model, funding partners agreed to commit to funding for three years (2015-2017) to allow for sufficient time to demonstrate the value of the utility. The EDIE Utility also provided a foundation for hospital event notifications to health plans, Coordinated Care Organizations (CCOs) serving Oregon's Medicaid population, local health information exchanges, and providers through a second service, PreManage, also offered by CMT. An EDIE Governance Board was established with representatives from all key stakeholder organizations to provide oversight to the administration of EDIE Utility contractual relationships among stakeholders, CMT, and management, including financial management and oversight/coordination of data analysis. The EDIE Governance Board is accountable for financial, operations, data use and communication policies and procedures among stakeholders.

The goals of the EDIE Utility include:

- Continue trend of decline in ED utilization by 1% from 1,254,692 visits in 2013 to 1,242,145 by end of 2015 (a reduction of 12,547 visits).
- Match State of Washington ED utilization rates per 1000 population (2011 data) by the end of 2016.
- Meet the Oregon Health System Transformation ED visit benchmark by the end of 2016 for the Oregon Health Plan patient population.

In 2016, the Oregon Health Authority (OHA) began supporting a statewide Medicaid subscription for PreManage. PreManage is a complementary product to EDIE that allows hospital event information (ED and Inpatient admissions and discharges) to be sent real time to health plans, coordinated care organizations (CCOs), health systems, provider groups, behavioral health teams and long-term care providers for specified member or patient populations.

ED physicians have reported significant value in receiving EDIE notifications, which in addition to providing information about utilization, may include providers and care managers involved in the management of the patient, relevant patient background and brief care recommendations. Oregon stakeholders continue to increase adoption of PreManage, with nearly all CCO's and commercial health plans, and over 200 primary care practices and community mental health organizations having adopted PreManage. Timely notifications improve communication and promote information sharing, with the goal of providing higher quality care to patients, identifying patients at risk for hospital readmission, reducing burdensome duplication of tests, and ultimately reducing reliance on costly EDs through better coordination of care.

EDIE/PreManage Use Cases

EDIE/PreManage Community Adoption

Central Oregon piloted a community adoption of EDIE/PreManage tools. Benefits cited by the pilot organizations included reduced duplication of efforts, better insight into who is involved with the patient, improved relationships/collaboration between health plan, hospitals and clinics, and ability to see the same information, discuss specific cases and assist each other.

Based on the success in Central Oregon, Jackson Care Connect CCO is sponsoring a similar initiative, including several organizations in Jackson County in early 2017. Other community collaboratives underway include Salem, Yamhill and Portland.

Behavioral Health

There are fifteen Assertive Community Treatment Teams (ACT) who receive notifications via a pager when one of their members is admitted to the Emergency Department or is hospitalized. The case managers reach out to the hospital and provide important information about the client and assist with identifying appropriate follow-up care. In some cases, the case manager will go to the hospital and support/assist the patient while they are there. Several community mental health organizations have implemented workflows to follow-up with clients after ED visits and MH hospitalizations. Health plans are also utilizing these tools to improve care, post discharge. The following is an example received from a health plan care manager regarding how they are utilizing the information they receive through PreManage to improve care transitions:

"As a behavioral health care coordinator, I focus on psychiatric related discharges for Medicare members. Through PreManage I receive e-mail notifications when members on my caseload are discharged. I immediately connect with the hospital care manager to inform them about the member and connections they have to community supports. We all work together to develop an OP plan for the member—it's a great example of care coordination and integration."

Reducing Opioid Prescribing

OHLC/OHA/OMA worked together to support the development of successful legislation that allows PDMP information to be incorporated into EDIE and other approved EHR Systems. Having the capability to view PDMP information in the ED provider's workflow will support a coordinated effort to reduce emergency department visits for chronic pain and request for opioid medication refills. Implementation of PDMP integration with EDIE notifications is anticipated at the end of 2ndQ 2017.

Challenges/Lessons Learned

While there has been much success in the adoption of EDIE and PreManage tools to facilitate improved care management and care coordination for high risk, high needs individuals, competing organizational priorities challenge the sustained focus on reducing ED utilization. Using these tools to enhance cross organizational care coordination and communication has proved to be very helpful, but working across systems to identify roles, responsibilities and workflows takes time and requires continued commitment by stakeholders.

Future Funding Source

The three-year EDIE Utility pilot concludes in 2017. There is an EDIE Utility evaluation underway to inform recommendations regarding future EDIE Utility structure, financing and program development. OHA leverages enhanced federal match (75/25) to fund the statewide Medicaid subscription for PreManage. Current subscription runs through July 31, 2018.

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allcare health™

allcare cco

Reducing Emergency Department Visits

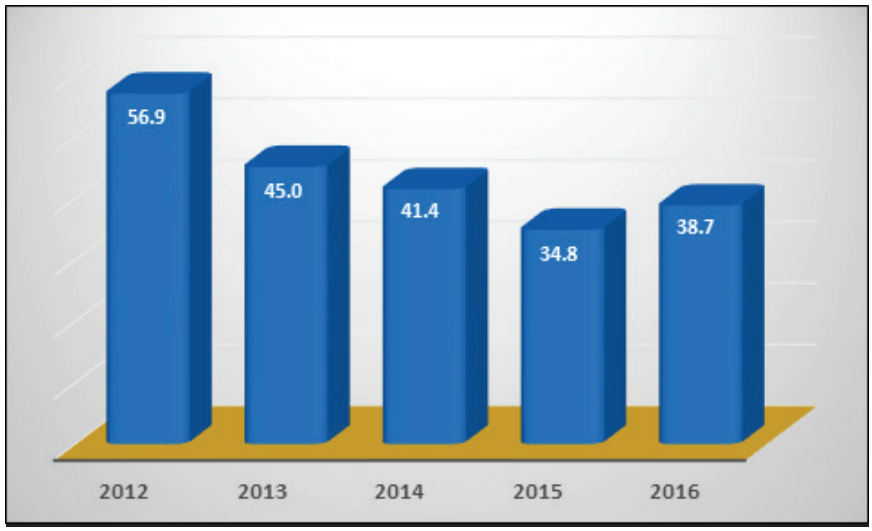
Initiative:

To reduce emergency department (ED) visits by partnering with both internal and external staff and providers.

Outcome:

AllCare CCO ED Utilization

Rate per 1,000



Financial Impact:

The cumulative savings over the 5 years period is over $2,000,000

Alternative Payment Models (APM)

Incentive measures included in:

- Primary Care APM
- Specialty Care APM
- Behavioral Health APM
- Hospital APM

Population Health Interventions

- Daily emergency department visit monitoring
- Calls to high utilizers
- Outreach to Primary Care Providers
- Focus on behavioral health populations

Challenges:

- Training patients to go to their Primary Care Provider.
- Training providers on how to improve access.

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Intensive Case Management for High Emergency Department Utilizers:

Transforming Care to Serve Non-traditional Members

Over 50% of overall health is determined by environmental and socio-economic factors. To serve non-traditional members (high ED utilizers) who have significant non-medical needs, health systems must abandon traditional models of care for a more fluid, customized model of wrap around care for these members. This approach requires developing multi-disciplinary health care teams that think outside of the box; engage directly with the member to understand their unique challenges; provide a compassionate plan of care, and connect the member with a support team (PCP, social worker, mental health case manager, peer support, specialists, county/state resources and family/care givers) that addresses their healthcare needs in a meaningful and effective way. Core teams must communicate the plan of care, partner with the member (opiates, one PCP, one point of contact), be consistent, follow-up, stay connected, and persevere. Engagement of the entire team and upper level Administration support are also requirements for a successful program.

Background:
KPNW's Emergency Department Utilization Intensive Case Management pilot started in September 2014 for a period one year and was aimed at reducing costly ED utilization at Kaiser Sunnyside Medical Center (KSMC).

This study began at Kaiser Sunnyside Medical Center (KSMC), and lessons learned have spread to Kaiser Westside Medical Center (KWMC). Table 1 shows a comparison of utilization by a traditional member versus a KP ED high utilizing member (non-traditional), illustrating the stark contrast in utilization of services in 2015. By crafting and implementing teams to address the needs of high ED utilizers and manage their support systems, KPNW has seen dramatic reductions in acute care utilization while providing comprehensive, holistic and sustainable patient care to these members.

The KP EDU Population:
KSMC identified approximately 1,000 high ED utilizing members who had utilized the ED three or more times in the previous six months; and a sub-group of 254 "Super Utilizers" who had utilized the ED six or more times in the same period. Some of these had been seeing upwards of 20 PCPs. Characteristics of this sub-group included the young (<45 years of age), those with behavioral and mental health issues, chronic pain, social challenges, lower incidence of medical issues, frequent no-shows and/or who sought out a high number of touches through high ED utilization.

The KP EDU Process:
To improve quality of patient care and reduce ED utilization by high utilizers, KSMC implemented an ED Intensive Case Management Core Team to support individual members and connect them with the resources they need to better manage their healthcare. Members are identified through high risk characteristics; data pull and referrals. Initially, the team Navigator reviews the member's chart for demographics, ED utilization history and problem list and bring the patient to the team to determine the best point of contact/care manager. The care manager engages the member to understand their needs, hear their voice, and identify family and support systems. Each member is assigned a main point of contact (MPOC) who has a comprehensive 10,000-foot view of the member and what their needs are. The teams co-manage the member's care with daily to weekly interventions with members that are crafted based on the member's needs; participation in interdisciplinary case conferences, development

of a patient-centered care plan, and ultimately stabilizing the member's care by addressing non-medical needs and integrating them into a Primary or Complex Care Medical Home.

Traditionally, the needs of member with high ED utilization have not been adequately addressed through access to costly and more frequent ED visits. This project was aimed at the highest utilizers (Super Utilizers) through implementation of an Intensive Care Management team comprised of an RN case manager, MSW, LCSW behaviorist, navigator and emergency department physicians to address the medical and non-medical needs of these members. This is a hard population to care for as high ED utilizers are very fragile, with a 6% mortality rate as compared to a national mortality rate of 1% for the same age group (<45). Implementation includes many things such as identifying drivers and removing barriers; addressing non-medical issues (behavioral health, mental health, housing, financial issues, alienation of traditional resources); outreaching to the member and finding resources for them. Care extends into the community for peer support, community case managers and other outside-KP resource engagement. By engaging compassionately with these members and staying connected, these teams have been successful in providing better quality of patient care as well as reducing unnecessary ED utilization.

Evaluation:

One year from the date the pilot program began at KSMC in September 2014, ER visits per 1000 were reduced by 55%, Admissions per 1000 were reduced by 38% and Days per 1000 were reduced by 30% (Table 2). A case-control study of the population showed that the impact of the KP EDU team was greater as the utilization of the member increased, showing a decrease of >13 visits for those members who accessed the ER over 20 times in 6 months as compare to a control population. Evidence of the effectiveness of the KP EDU intervention shows up in members who seek care in the ED 6 or more times in 6 months. KPNW estimates that prior to joining KP EDU, the average high utilizing ED member has ~9 ED visits in 6 months. KPNW is presently looking to expand enrollment by 350 members, which will save 1,418 visits or $1.2M assuming an average ED cost of $900 (based on a 45% reduction in ED visits).

Table 1: Comparison of Traditional Member vs KP EDU Member

2015	Traditional Member	Non-Traditional
Ed Visits:	0	49
UCC Visits:	0	63
Prescriptions:	0	50
Pills:	0	1864
Prescribers:	0	27
PCP changes:	1	20
Care Conferences	0	6
Encounters (avg/mo):	<1	43

Table 2: Outcome Measures

Outcome Measures	KP EDU
ER visits per 1000 (reduction)	-55%
Admits per 1000	-38%
Days per 1000	-30%

# of ED Visits 6 Months Prior to Index Date	All ED Visits	<= 5 ED Visits	>= 6 ED Visits	>= 10 ED Visits	>= 15 ED Visits	>= 20 ED Visits
	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)
KP EDU and UC Mean # of ED Reduction Gap	3.2	0.3	4.2	6.0	8.3	13.4
p-value	<0.0001	0.6354	<0.0001	<0.0001	<0.0001	<0.0001

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Title: The Medicaid Life Course Health Study

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Project Description: Study of "what has happened" in the lives of Medicaid enrollees with poor health outcomes that is different from those who do well in order to inform health policy & health system strategies.

Background: As part of a CMMI Challenge grant award (2012-15) an initial study interviewed 50 people with high utilization in a complex care program. The results showed a high prevalence of early family maltreatment/adverse childhood events (ACEs) as well as subsequent problems with school, substance use, interpersonal relationships, criminal behavior, homelessness, traumatic experiences and failing health. A Life Survey was created based on those interviews and sent to a representative sample of Health Share of Oregon members. A follow up study by CORE is now examining results from the 2400 complete surveys.

Key Findings To Date: High complexity members have high rates of adversity across the life span:

In Early Life:

- 51% have ≥ 4 ACES. 47% have physical or emotional abuse, neglect, or a parent/caregiver with substance abuse; 40% have sexual abuse; 38% have a parent/ caregiver with mental illness.
- A quarter also experience family homelessness, and 40% run away from home

In School:

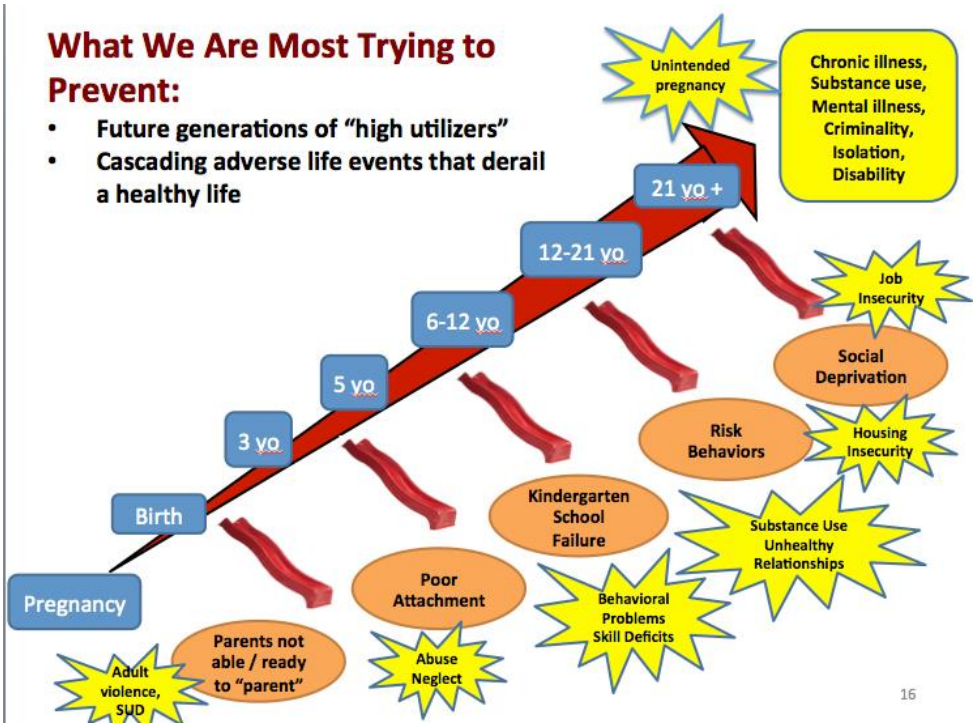
- 60% struggle with school; 40% drop out; 34% do not graduate high school or get a GED.
- 50% begin substance use before 18; 10% before 13

As Young Adults and Adults:

- A third struggle to find work
- 40% report physical violence from a loved one; 67%, verbal abuse
- 45% are homeless at some point
- Close to 50% report being arrested; 44% have been in jail

For those with ACEs ≥ 4, prevalences are even higher:

- Substance abuse in childhood is almost 5 times higher (48%)
- Childhood homelessness: 40%
- Physical violence from a loved one: 56%; verbal abuse from a loved one, 84%
- Homelessness ever: 70%
- Jail: 45%



Initial CCO Response: Connecting early life & subsequent adversity to "high utilization" led Health Share's Board of Directors to focus a prevention strategy on early childhood risk, initiating pilot initiatives to identify and support at risk children and their families: pregnant women with substance use, foster children, cultural communities with low developmental screening rates, developmental promotion, and partnerships with schools.

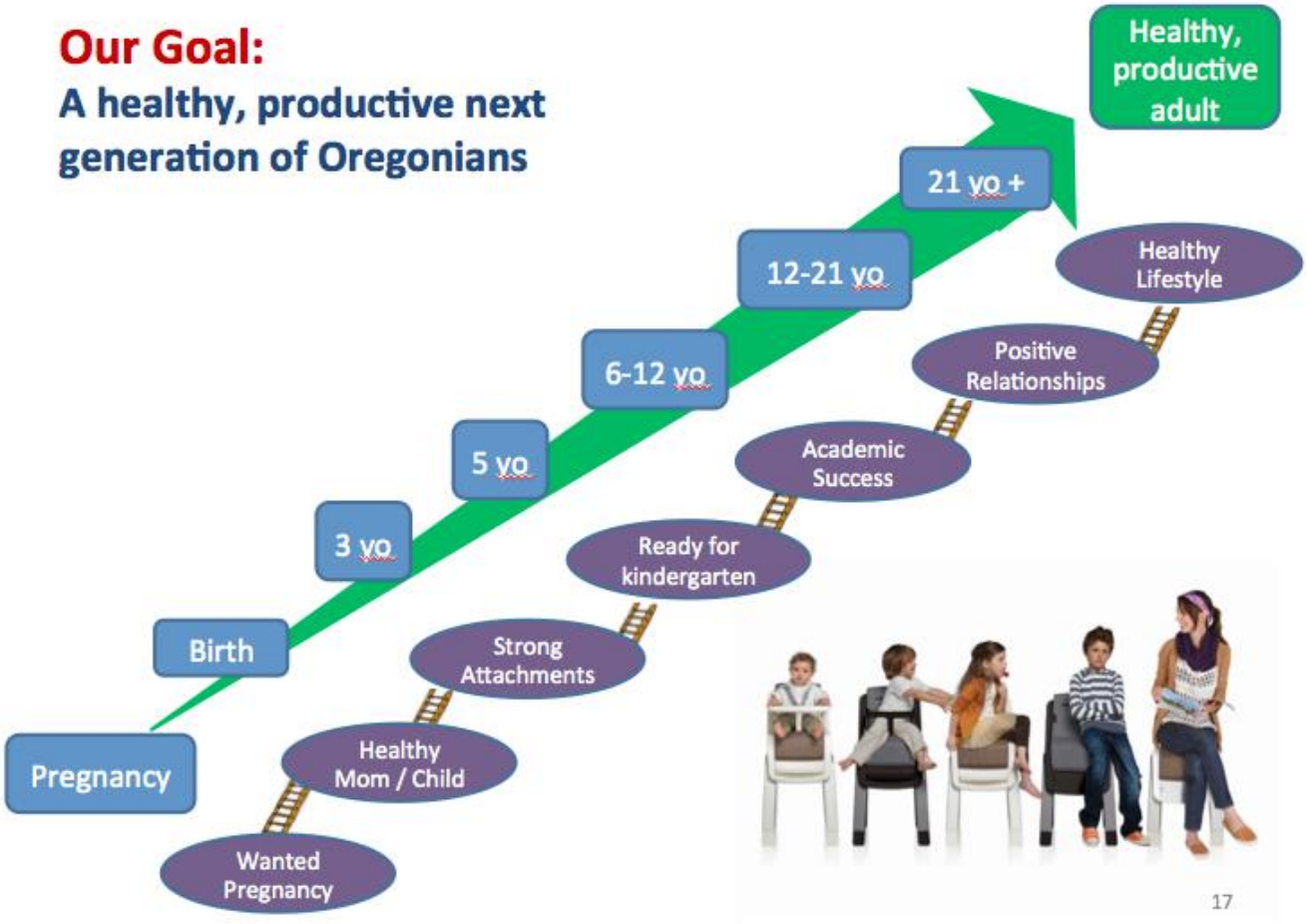
Further questions: The data strongly suggests that these events occur in "pathways"-- one adversity can lead to another. Our analysis will explore these connections, particularly as they help us understand critical partnerships and leverage points for health system strategy. How is it that our usual data sources do not tell the stories of what actually happens to people in their communities, and what resources are required to ensure health? What new ways of collecting data and what new questions should we be asking?

Challenges: "Health" must be addressed in families, communities, schools, and in criminal justice; traditional Medicaid funding silos are a barrier to systems' improvement. Working with the Early Learning Hubs, community based organizations, peer workers, culturally specific organizations, and schools are required to move upstream. Additionally, factoring in early life events, and social determinants of health require the need for primary care providers to think *differently* about their interactions and interventions with their patients and families. Pediatricians, obstetricians, and nurse midwives are beginning new work flows in their practices as they grapple with how to put this information into action.

Lessons Learned: Each community has its own story to tell. The lived experience of each community will be different from the next. What we've learned in the tri-county region will not necessarily translate to other regions; the resources and programs we identify as essential or helpful will not necessarily be the right ones in other places. Community- and culturally-specific exploration and planning are necessary.

Organizations involved: Health Share of Oregon and Providence's Center for Outcomes Research partnered for the study itself. Both regional CCOs & many Medicaid plans, providers, & CBOs involved in the initiatives.

Funding source: Robert Wood Johnson grant for the Life Course Study; incentive metrics funds for initiatives to explore moving health "upstream".



Lane County Child/Youth Emergency Department Diversion Pilot Program:

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- **Purpose:** The purpose of this project is to reduce boarding time for children and youth presenting to the Peace Health University District Emergency Department with serious mental health crisis, and to reduce readmission after discharge.

- **Description:** This project will utilize an ED diversion team created through partnerships and subcontracts with community based providers. This would consist of a Family Peer Support Specialist (QMHA level) and a Family Navigator (QMHA Level). The ED staff would have access and the ability to contact these providers in the event of a youth presenting to the ED in crisis. During high usage day/hours the Family Peer Support Specialist would respond to the ED within 4 hours. The initial engagement with the family, youth and peer support specialist, would lead to a next day appointment with the Family Navigator. This team works with the ED staff to provide care and support needed for presenting youth to return to the home.

- **Follow Up:** If presenting youth is not currently receiving services, case planning will include connections with the appropriate provider agency by the ED diversion team, to include Lane County Behavioral Health (LCBH), who will assist with the recovery plan and recommended referral sources.

- Crisis resolution and service engagement support will be offered for up to 45 days from initial contact at the ED. Funds will be used to support non-billable services, including family peer support and therapeutic services to youth/families that are uninsured or underinsured. Subcontractors will be expected to maximize billable services to leverage additional support resources.

- Funds will also be allocated for flexible support purposes, such as transportation, basic needs, or other barrier-removal purposes. These funds will be available to the ED Diversion Team staff, based on specific, established policies/procedures.

- **Challenges:** Lack of funding
- **Impact Outcomes:** Although the implementation of the project was delayed due to funding being denied, the project has created an increased communication and dialog between family partners and family Navigators in the community. A team of providers are now meeting together and addressing children in crisis and ways to problem solve and identify needed services

- **Lessons Learned:** Prior to developing and moving forward with the project, I would make sure that the funding was secured, and in place. This would minimize the usage of time and resources for a project that could not be fully implemented.

- **Partner Organizations and Departments:** Health and Human Services: Lane County Behavioral Health, Peace Health, Oregon Family Support Network, Trillium Health Plan (CCO)