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 2!

Maggie McDonnell, ORPRN
Susan Kirchoff, OHLC
Liz Whitworth, OHLC
Emily Root, Health Share of Oregon
Beth Sommers, CareOregon

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 hear how Health Share of Oregon and CareOregon collaborated to share data on the ED MI population with both community mental health and primary care teams.

Health Share of Oregon & CareOregon

Systems Improvement Virtual Learning Collaborative- What CCOs Can Do

Beth Sommers, MPH | Clinical Innovation Manager, CareOregon

Emily Root, LPC CADC1 | Quality Improvement Coordinator, Health Share

Chandra Elser, MPH | Quality Improvement Analyst, Health Share

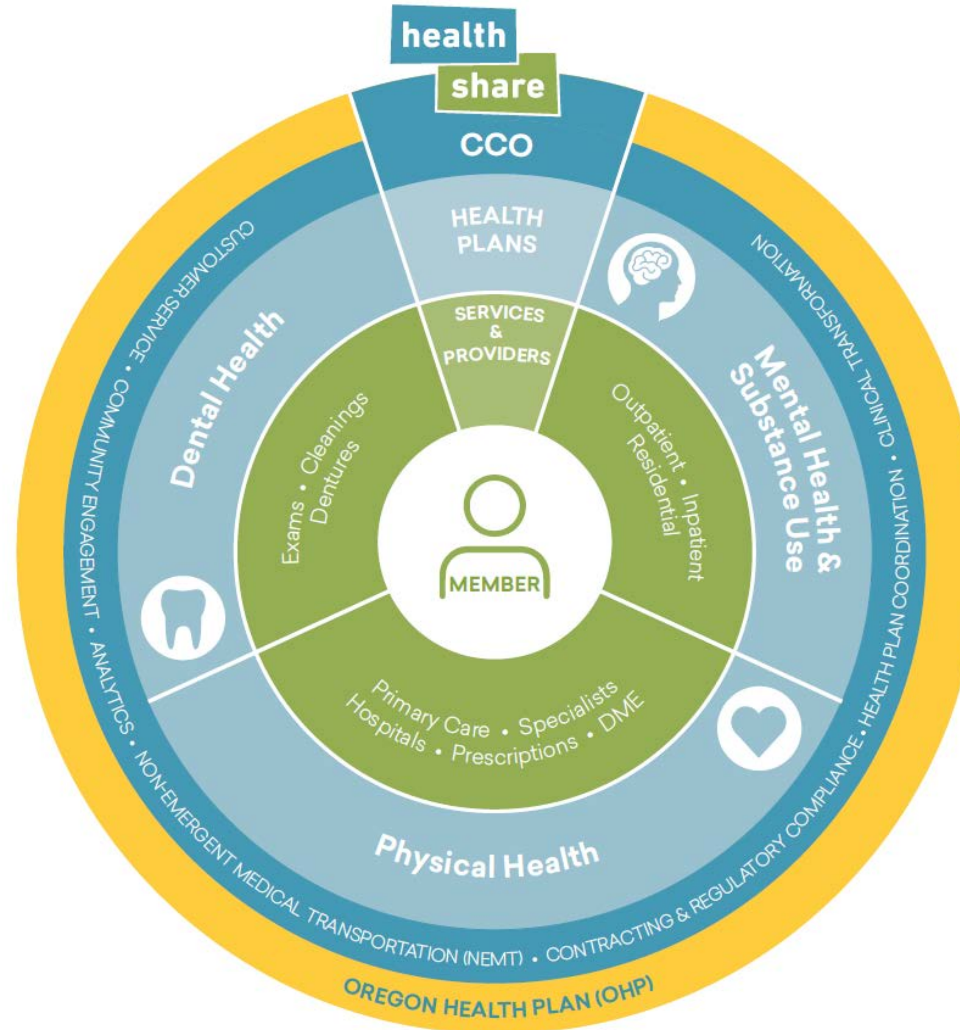
February 4, 2019

Background

Health Share of Oregon

Background:

- ~320,000 members residing in Multnomah, Clackamas and Washington Counties
- Health Share partners with each of our health plans to achieve our CCO incentive measures
- CareOregon is our largest Physical Health Plan Partner, with ~197,000 assigned members



Physical Health Plans

CareOregon
Kaiser Permanente
Providence Health & Services
Tuality Healthcare

Dental Health Plans

Advantage Dental Services
CareOregon Dental
Kaiser Permanente
ODS Community Dental
Willamette Dental Group

Mental Health & Substance Use Plans

Clackamas County
Multnomah County
Washington County

Background

ED utilization has been considered a physical health measure, with efforts underway but siloed in that space

The ED Utilization measure has been challenging for Health Share to meet, particularly for CareOregon

The ED MI measure created an opportunity to intentionally engage our behavioral health plans and our specialty behavioral health providers/community mental health agencies

CareOregon developed clinic capacity grants and a learning collaborative to drive performance improvement and better care around both ED measures

Timeline

Health Share timeline- Behavioral Health Focus

Summer 2017 - Spring 2018

- Data exploration focused on MI population
- Engage Behavioral Health Plans/Providers in ED reduction dialogue
- Develop recommendations for next steps
- Identify where data could help inform next steps

CareOregon timeline- Primary Care Focus

Summer 2017 - Spring 2018

- Develop ED Grant proposal, targeting PCP clinics who did not meet the 2016 ED utilization benchmark
- Develop a Learning Collaborative series for grantees
- Award grants, engage clinics
- Kick-off Learning Collaborative, session 1

CareOregon/Health Share: Integration Focus

May - Aug 2018

Synergy: connections developed between CareOregon's Primary Care driven efforts and Health Share's behavioral health focused efforts.

Led to planning Care Oregon Learning Collaborative session 3 in partnership with Health Share data support

Learning Collaborative session with BH providers

Sept 2018

Data Analysis

Where do we start?

As the holder of all the data, Health Share's first step was to understand the population.

With over 40,000 members making up the denominator cohort, we had many questions to answer

Initial stakeholders: our County Behavioral Health Plans, who saw this new measure as an area for focus as the "Follow Up After Hospitalization for Mental Illness" measure was ending

Question

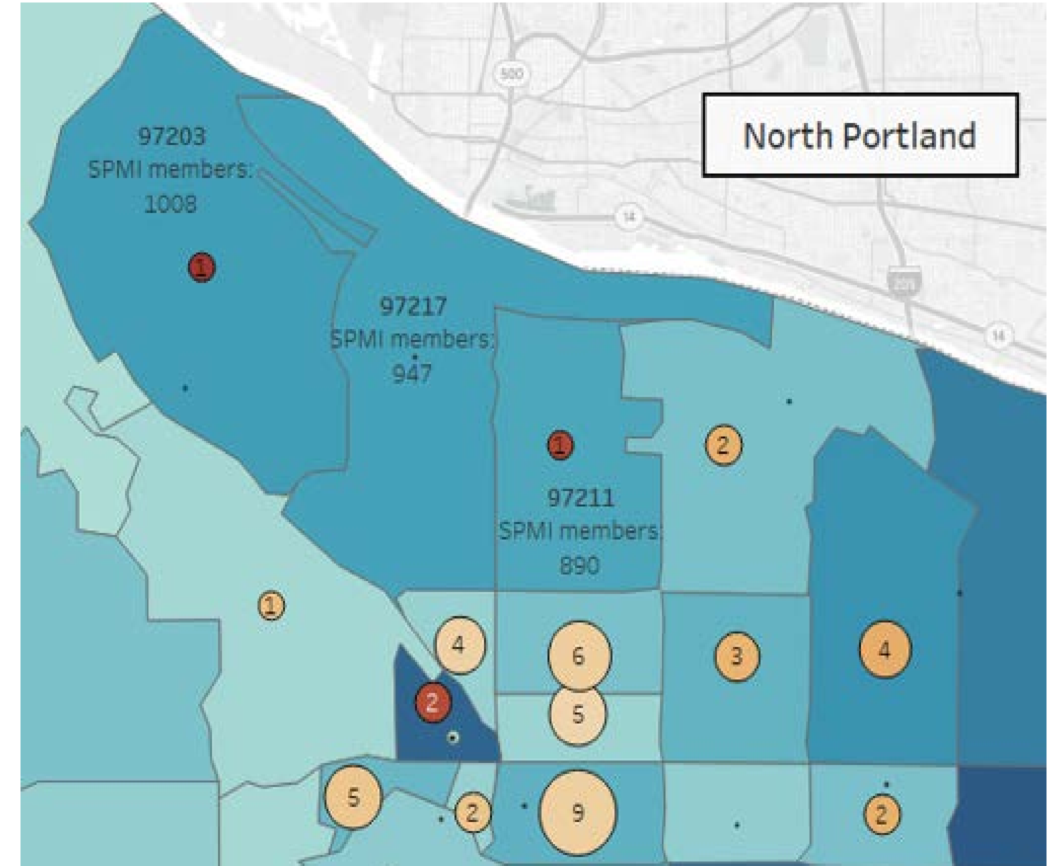
Start with the basics… what could be learned about this new population of focus?

Using OHA's Monthly Metrics Dashboard, began to explore demographic statistics for this new population:

- City + Zip code
- Race/ethnicity
- Language
- Gender
- Age
- Chronic condition flag
- Mental health diagnosis
- ED visit count

☑ **What we found:**

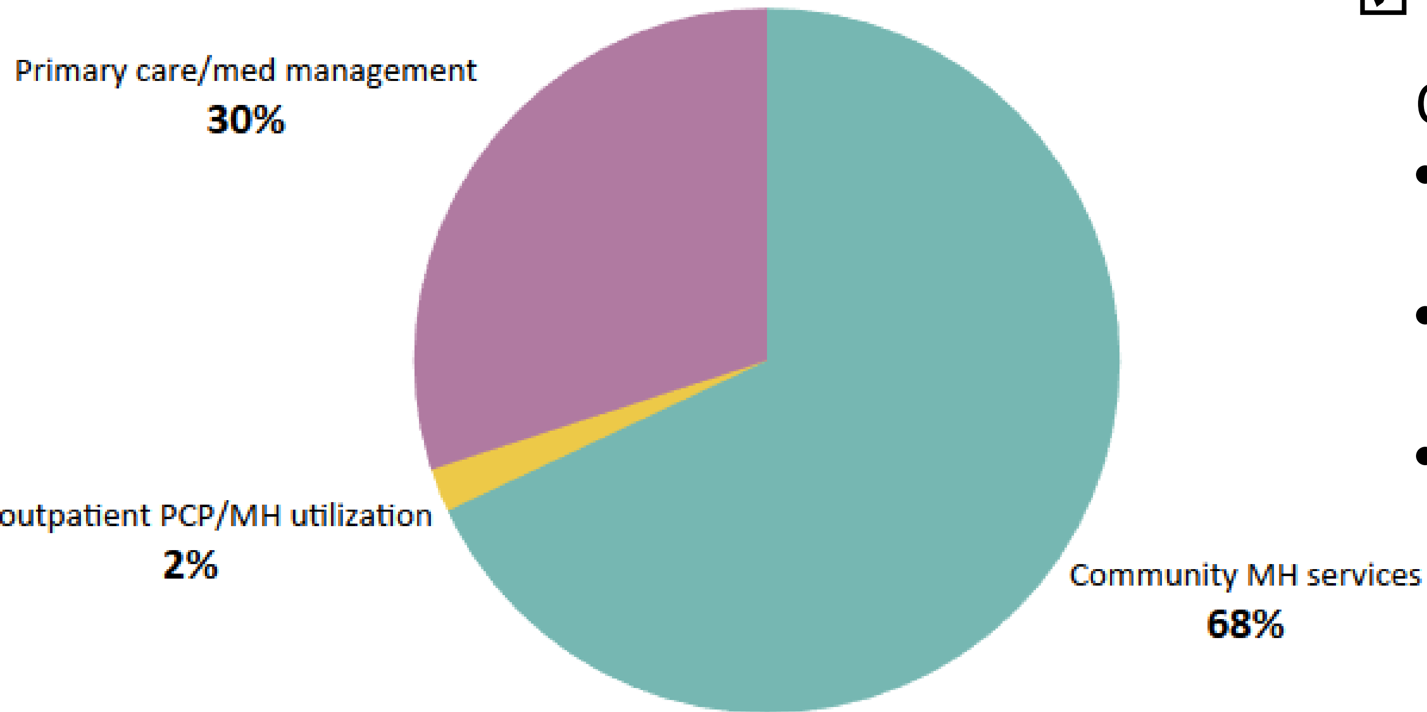
- **22% of adult Health Share members have a qualifying mental health condition**
- **ED utilization for this cohort 3x higher than for adults without MI**
- **Demographic profile and geographic distribution similar to overall adult population**



Example: geographic distribution exploration

Question

How are members in this cohort engaging within our system?



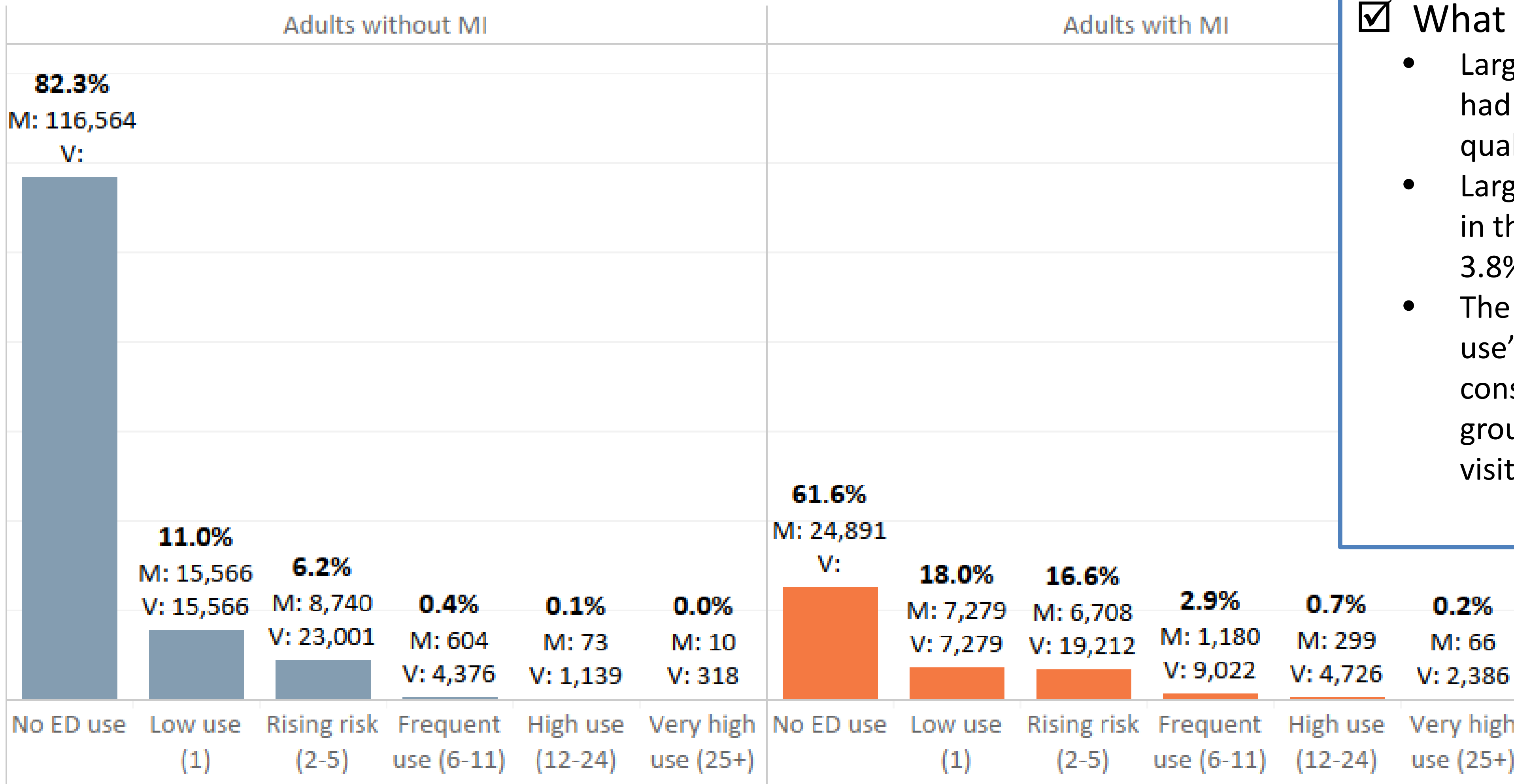
☑ What we found:

Our providers know these members

- Many have been engaged with our specialty mental health services
- The rest are connected to primary care
- Only 2% had not had any outpatient engagement

Question

What is the distribution of ED use within this population?



☑ What we found:

- Larger portion of population had at least one metric qualifying visit (28% vs 18%)
- Larger portion of population in the 6+ visit category (.5% vs 3.8%)
- The high end of the "very high use" category varies considerably between the two groups (45 vs. 137 qualifying visit count)

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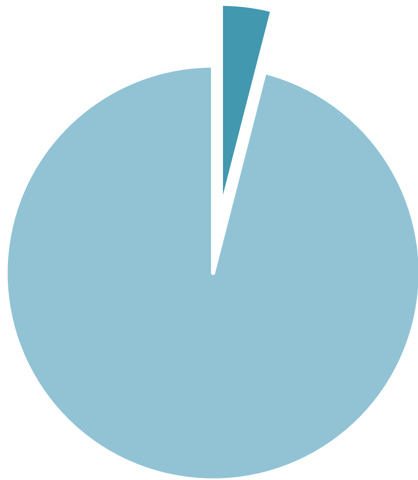
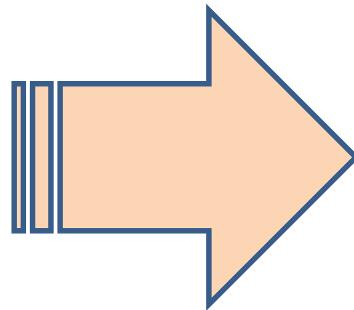
Question: Where is the richest opportunity and biggest disparity?

Population of focus:

Members who use the ED at the highest rates (6+ visits) represent 3% of the MI cohort but account for 33% of the ED visits generated by this population

3% of the Population





33% of the ED Visits

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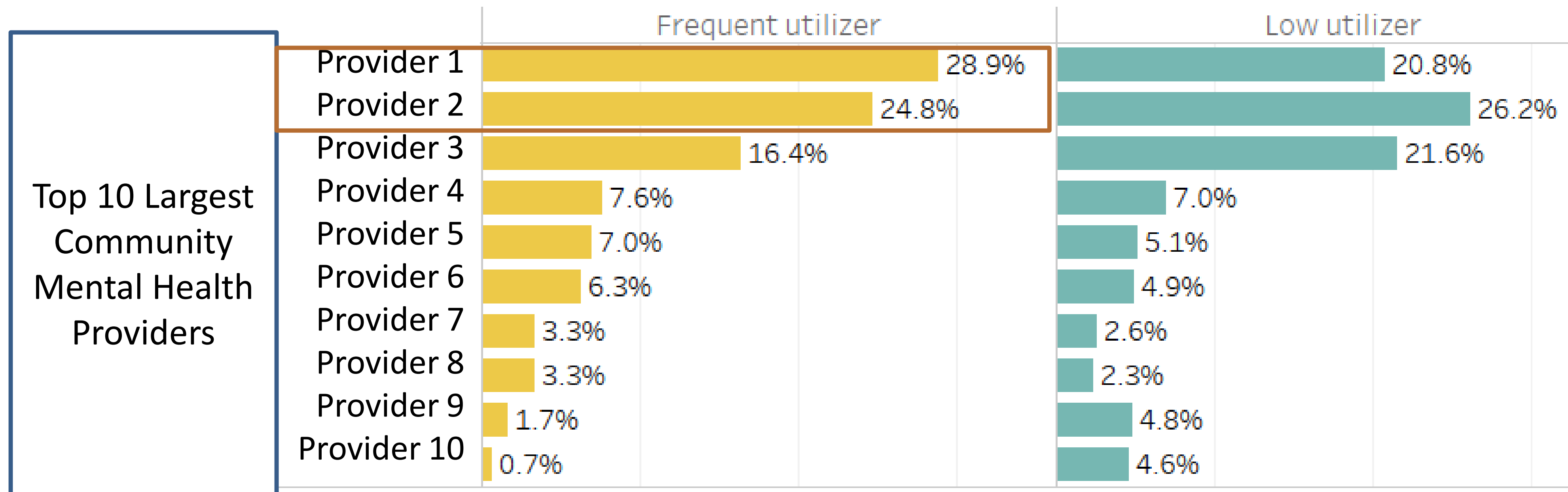
Question

Which Mental Health providers are working with this population?

☑ What we found:

- Most of our Community Mental Health providers had a mix of clients with both low and high ED visit rates.
- 54% of our members with highest ED rates were being served by just 2 of our providers- we learned which 2 providers to start engaging in conversation!



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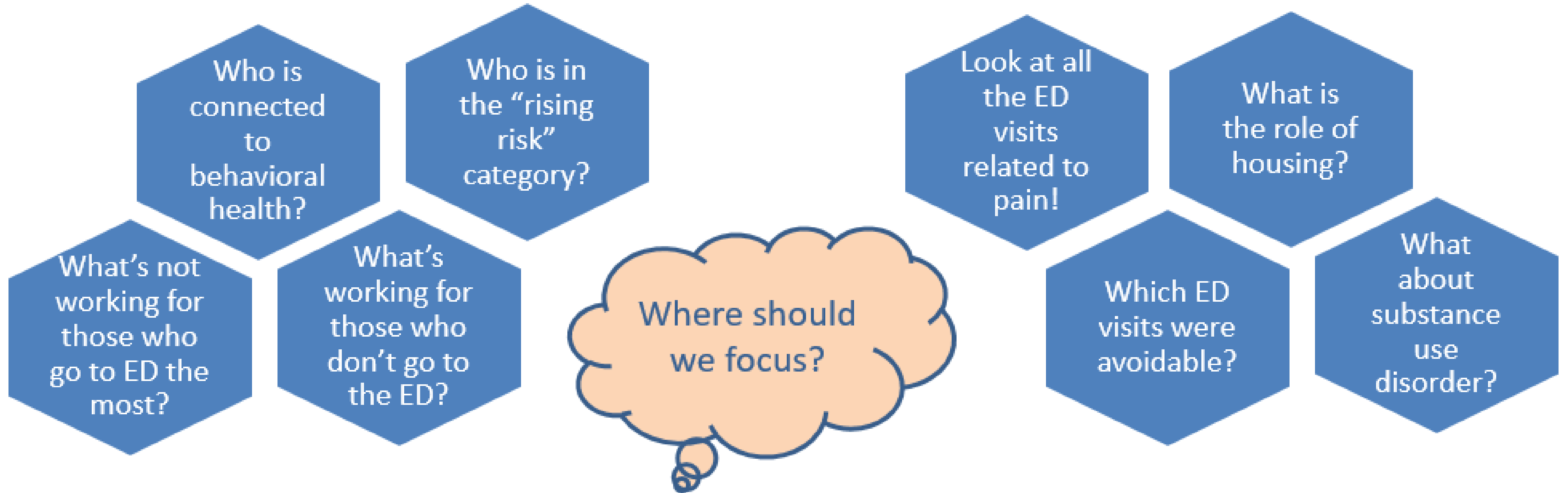
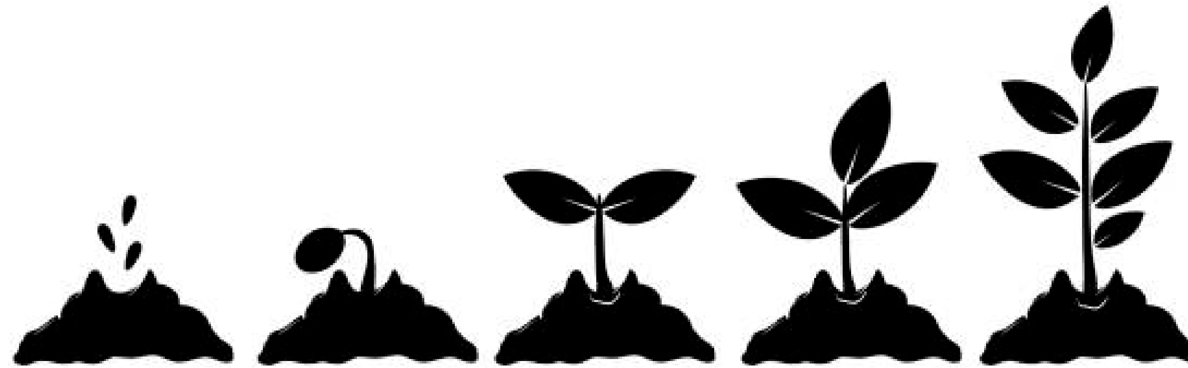
With all these avenues to explore… analysis paralysis set in!



We hoped the data would point us towards a clear solution…
but each query presented a new potential area to focus and more data to mine

Reflection

For us…



There would never be a single solution to reducing ED visits

An effective strategy would require multiple strategic efforts from within various parts of the system

Our Behavioral Health plans agreed that this was “their measure” but were eager to thought partner with others who are close to the work: specifically BH providers

Our Behavioral Health plans were aware of the great work CareOregon was doing in engaging their primary care providers in their ED grant.

Q & A

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CareOregon/Health Share: Integration Focus

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CareOregon/Health Share: Integration Focus
Where our work all came together

The ED MI Workgroup met in May 2018. Attendees included Health Share, our Behavioral Health Plans, leadership from our two largest BH providers, and representatives from CareOregon

Question

How is this population distributed across mental health and primary care provider systems?

"Quilt" view allowed plans and clinics to identify "hot spots" and areas of effectiveness

CareOregon ED Grant Primary Care Clinics (columns) × Specialty Behavioral health clinics (rows)

Specialty Behavioral health clinics	1	2	3	4	5	6	7	8	9	10	PCP Total
1	1,647.2 M: 21	1,050.8 M: 20	842.3 M: 17	500.0 M: 1	1,318.1 M: 9	1,823.7 M: 3	583.3 M: 1	1,100.0 M: 1	762.7 M: 2	500.0 M: 1	1,196.2 M: 76
2	1,067.5 M: 40	665.4 M: 22	1,006.5 M: 7	1,111.1 M: 4		888.9 M: 1	777.8 M: 3	625.0 M: 2	804.6 M: 3	500.0 M: 1	912.6 M: 83
3	921.9 M: 22	1,187.6 M: 20	773.3 M: 15	1,416.7 M: 1	848.3 M: 7	1,611.1 M: 3	916.7 M: 4	500.0 M: 2			976.2 M: 74
4	1,156.2 M: 16	875.0 M: 4		1,065.6 M: 29			722.2 M: 3	849.3 M: 4			1,042.1 M: 56
5	720.0 M: 16	1,091.5 M: 18	742.8 M: 13	775.9 M: 2	583.3 M: 2	2,909.1 M: 1	869.6 M: 1		583.3 M: 1	583.3 M: 1	883.5 M: 55
6	956.5 M: 1	946.2 M: 15	1,250.0 M: 2			692.5 M: 14		654.2 M: 1	958.3 M: 2		843.4 M: 35
7	1,124.6 M: 12	690.2 M: 11	944.4 M: 3	708.3 M: 2	708.3 M: 2		750.0 M: 1	500.0 M: 1		593.2 M: 1	867.2 M: 33
8	1,092.2 M: 5	654.0 M: 4	1,174.4 M: 5		898.5 M: 14			840.3 M: 1			944.0 M: 29
9	666.7 M: 1	616.7 M: 2	1,719.4 M: 9		828.0 M: 3	916.7 M: 1	807.2 M: 2		583.3 M: 1		1,192.1 M: 19
10	500.0 M: 1	699.3 M: 6	1,013.2 M: 2		1,208.3 M: 2	966.3 M: 6	500.0 M: 1				853.4 M: 18
BH Provider Total	1,100.0 M: 135	916.1 M: 122	968.2 M: 73	1,029.3 M: 39	970.7 M: 39	1,043.2 M: 29	777.5 M: 16	723.0 M: 12	780.1 M: 9	543.9 M: 4	981.4 M: 478

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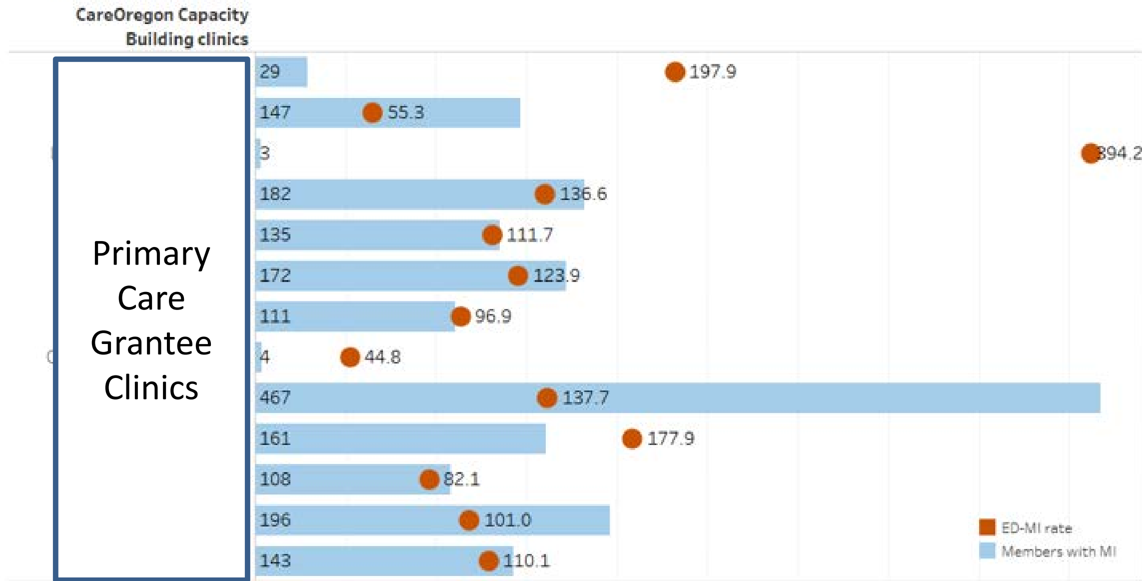
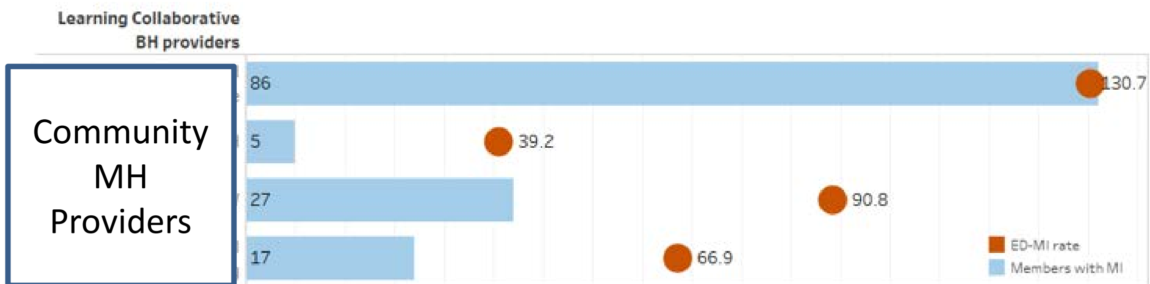
Learning Session #3

Collaborating with Community Behavioral Health

- Surfacing successful approaches to engaging and caring for individuals with mental health conditions
- Health Share overview of data analysis of shared members that meet the disparity metric
- Clinic-level dive into data analysis
- Activities to surface partnership opportunities for shared members leveraging PreManage

Health Share Data





ED utilization by shared population & MH diagnosis

Example Clinic

Learning Collaborative BH providers	Bipolar disorders	Depressive disorders	Schizophrenia spectrum & other psychotic disorders	Stress reaction and adjustment disorders	BH provider total
Community MH Providers	85.0 M: 13 V: 6	110.7 M: 34 V: 20	42.7 M: 17 V: 4	254.7 M: 22 V: 31	130.7 M: 86 V: 61
		M: 2 V:		59.2 M: 3 V: 1	39.2 M: 5 V: 1
	80.6 M: 5 V: 2	22.6 M: 9 V: 1	175.6 M: 9 V: 9	43.9 M: 4 V: 1	90.8 M: 27 V: 13
	104.4 M: 5 V: 3	36.4 M: 5 V: 1	M: 1 V:	72.5 M: 6 V: 2	66.9 M: 17 V: 6
Total by most frequent MH diagnosis	88.6 M: 23 V: 11	84.3 M: 50 V: 22	86.2 M: 27 V: 13	185.2 M: 35 V: 35	111.7 M: 135 V: 81

In addition to MI diagnoses, many members in this cohort experience other chronic illnesses that can drive more frequent ED use. Below is the prevalence of 5 key conditions among this population with the impact on ED utilization:

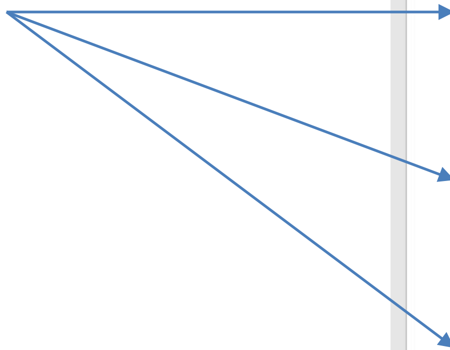
Condition	Members with condition		Members without condition	
	Number of members	ED utilization rate	Number of members	ED utilization rate
Asthma	**10**	**278.3**	**125**	**97.4**
Chronic pain	**23**	**221.0**	**112**	**88.6**
Diabetes	**10**	**302.5**	**125**	**94.7**
Hypertension	21	190.4	114	96.8
PTSD	59	162.6	76	70.2

Learning Session #3

Data & PreManage

Primary Care and Specialty Behavioral Health asked to consider their disparity metric population and data and complete this Roles and Responsibilities sheet.

All participants identified a role for a partner organization in at least one of these tasks:



Roles and Responsibilities Before an ED Visit - Disparity Metric management for mutually engaged members

Tasks	What PreManage-related actions will help address this task for your population of focus? *(see flipside for example actions)*	Who at your organization is supporting (or who can support) this task for your population of focus?	Please note which tasks you think a partner organization (SBH or PCP) may play a role, and how.	Notes
Monitor ED Utilization				
Identify patient engagement status in care.				
Share relevant objective patient background information with other community providers				
Generate and share relevant patient care recommendations with EDs and hospitals.				
Contact other care team members to coordinate care as needed.				

Learning Session #3

Create Opportunities to Connect Providers

Patient Scenario

A 59-year-old white woman presenting with worsened insomnia, cough/COPD exasperation. Per chart review her diagnoses include obesity, COPD, diabetes, hypertension, RA, gastritis and depression. She reports multiple self-harm attempts, the last one 5 years ago. She is currently prescribed the following medications: Cymbalta, Gabapentin, and Humira. Her hx is
choice are amphetamine and opiate pain medication. She w
after a routine UDS showed amphetamine in urine. Additio
amphetamine use for more than year. She is not currently
She is not currently prescribed mental health medications.
health medication.

There is considerable family chaos. Her main support is her
which she is really sorry but doesn't know how to fix it. Her
toe amputation, has not yet been discharged from the hosp
rural property and she recently wrecked her car, making tra
childhood trauma and abuse makes trusting others (family,

Patient Background Information/Care History

The Patient Background Section is for **objective information related to the patient'**

There are 6 subsections or 'tabs' that allow you to organize the type of information you'd

Recommended Content Per Subsection	Ex
Medical/Surgical: Include medical diagnoses; previous surgeries that are relevant for the ED to know; any Rx allergies or other alerts.	Patient has a history of kidney stones
Infection/Chronic: Diagnoses related to infections/chronic illness; hospital acquired infections	Pt has MRSA Pt has chronic back pain
Substance abuse/overdose: Diagnoses related to substance abuse or overdose risks; current drug use based on tox screening; previous overdose info; overdose risks associated with current or previous prescriptions	Alcohol Dependence; patient with hi prior detox episodes. Patient is not c treatment plan.
Behavioral: Diagnoses related to patient's behavioral health; the patient's baseline presentation; advisories or alerts that might be critical for ED to know	Pt often presents with various pain c having been assaulted and requestin
Social: Social/community services available to the patient – including relevant contact information; patient's living conditions; patient's primary care givers; any cultural/linguistic background that might be helpful.	Patient has transportation through T Pt should be strongly encouraged to pt get access to housing and treatm
Radiation: Patient's radiation history, number of x-rays and CT scans in a given timeframe, any additional radiation exposure that would be helpful to be aware of. Any objective findings that have come from these scans.	Has received multiple negative imaging studies for abdominal pain

Creating a Care Recommendation

Intended to deliver brief, critical information to ED providers at the point of care relevant to patient's treatment in the ED. Information should be in succinct, bullet point format with no more than 5-6 bullet points. There are different subsections that allow you to organize the type of information you'd like to include:

1. **Care Recommendation:** (A recommendation for how a condition should be treated or has been successfully treated in the past)

Recommended Content	Example
Goals for patient care	PCP recommends hospice, but family is hesitant
Specific treatment protocols/recommendations	Low dose haloperidol effective for acute agitation
Outpatient care patient is currently receiving so ED can redirect patient back to appropriate care	Pt requires paracentesis weekly for cirrhosis, f/u with Dr. Jones every Wednesday
Baseline presentation	At baseline patient lists to the left, has shuffling gait, poor short- term memory

2. **Care Coordination:** (An explanation of the coordinated efforts in regard to this patient's care)

Recommended Content	Example
Engagement in primary care	Patient has not seen PCP in over 1 yr despite repeated outreach. Please attempt to schedule if patient presents to ED
Availability of Care Team member to intercept ED visit	ACT team available to attend ED visit, please call phone# in Care Team Box as soon as patient presents to ED

3. **Pain Management:** (A recommendation for how the patient's pain should be managed, including pain contracts, etc.)

Recommended Content	Example
Presence of a pain contract	Note who the prescriber is and a brief description- Patient has a pain contract with PCP, Dr Jones, receives 10mg Norco bid for chronic back pain. Patient has agreed not to receive pain medications from any other source unless a new acute issue, or will be in violation of pain contract

4. **Helpful ED-Based Interventions to Try:** (A list of helpful interventions that have been successful in prior ED visits)

Recommended Content	Example
Tips/strategies for engaging with the patient	Patient calmer when mother present, music helps alleviate anxiety
Successful interventions to redirect ED over-utilization	Set clear limits, patient will be inappropriate or aggressive, will use manipulation maneuver to get what she wants. Limit comfort measures

Which subsection or subsections would you complete for this patient? Please fill in applicable sections on the back of this sheet.

Primary Care and Specialty Behavioral Health asked to complete a Next Steps Worksheet.

Goal: ID partner to move forward in collaboration with.

Next Steps Worksheet for (clinic name): ____________________

1. Based on my data, this organization makes the most sense to start working with on our shared members: (check one)

☐ Cascadia Behavioral Heal

☐ Clackamas County Menta

☐ LifeWorks NW

☐ Western Psychological

2. As a possible next step in organization, my organizatio

☐ Open to doing case confe organization for our shared r

☐ Open to working on stan specialty behavioral health o collectively in the future).

Additionally, please i capacity: (check one

☐ We are willing to specialty behavioral

OR

Next Steps Worksheet for (Org. name): ____________________

1. Based on my data, this organization makes the most sense to start working with on our shared members: (check one)

☐ Central City Concern	☐ OHSU Richmond
☐ Clackamas County Health Dept.	☐ OHSU Peds & Adolescent Health
☐ Legacy Randall Children's Clinic	☐ Oregon City Medical
☐ Multnomah County Health Dept.	☐ Outside In
☐ Neighborhood Health Center	☐ Rose City Urgent Care & Family Practice

2. As a possible next step in working with the above indicated primary care organization, my organization is: (check all that apply)

☐ Open to doing case conferences in conjunction with the above indicated primary care organization for our shared members (or a subset that we will define collectively in the future).

☐ Open to working on standardized care recommendations in conjunction with the above indicated primary care organization for our shared members (or a subset that we will define collectively in the future).

Additionally, please indicate which of the following best describes your organization's current capacity: (check one)

☐ We are willing to take responsibility for entering care recommendations, with input from our primary care partner.

OR

Follow-Up

Based on their data, the below organization(s) indicated it makes the most sense to start working with you on your shared members:	As a possible next step in working with you, the below organization(s) indicated they are open to:	The below organization(s) indicated their capacity for entering care recommendations:	The point person for coordination of next steps & Contact Information
Community MH Provider	• Doing case conferences in conjunction with the indicated primary care organization for our shared members (or a subset that we will define collectively in the future). • Working on standardized care recommendations in conjunction with the indicated primary care organization for our shared members (or a subset that we will define collectively in the future).	We are willing to take responsibility for entering care recommendations, with input from our primary care partner.	MH Provider staff
Community MH Provider	• Doing case conferences in conjunction with the indicated primary care organization for our shared members (or a subset that we will define collectively in the future). • Working on standardized care recommendations in conjunction with the indicated primary care organization for our shared members (or a subset that we will define collectively in the future).	It depends. We would benefit from further conversation with our primary care partner to decide who is best positioned to take point for entering care recommendations.	MH Provider staff

Each participating organization received a follow up email indicating:

- Which organizations identified them as a potential partner for collaboration
- What level of collaboration they are interested in
- What resources they can bring to the collaboration
- Contact information

- Each organization also received member-level lists from Health Share as follow-up to this email.

Current State

Care Conferences occurring in several counties with multiple partners

Specific partnerships fostered among multiple PCPs and Specialty Behavioral Health Providers

Data set not complete, but looks quite promising

Implementation: Feb 2018 – Jan 2019

				Performance Tracking		
Clini	To Target	Target	Baseline	Aug-18	Sep-18	Oct-18
site 1		59.7	62.1	62.2	62.2	61.9
site 2		62.9	65.5	64.5	64.7	63.3
site 3		65.3	68.0	66.9	66.7	64.7
site 4		46.1	48.1	50.4	50.0	51.4
site 5		41.8	43.6	44.9	44.2	43.9
site 6		68.0	70.9	68.1	67.7	66.7
site 7		161.4	168.2	161.7	161.0	163.0
site 8		87.7	91.4	84.0	84.0	82.8
site 9		54.8	57.1	52.2	51.1	50.7

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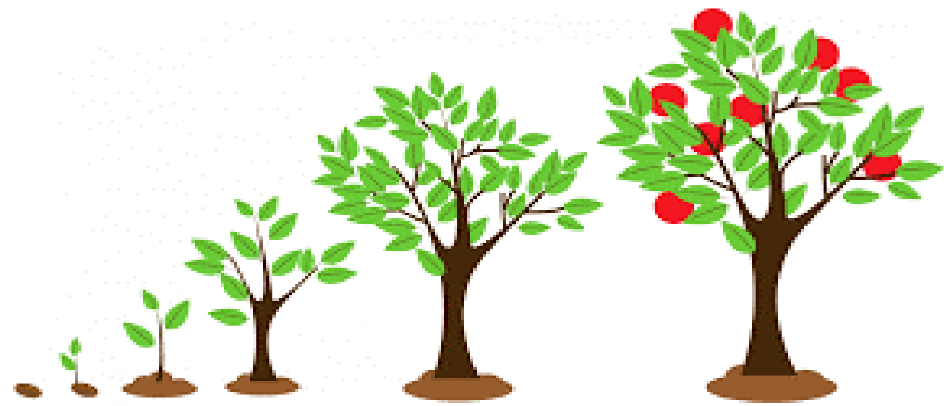
What We Learned

Beware of analysis paralysis!

- There are numerous ways to slice and dice this data- it is easy to become overwhelmed.
- Once you narrow in on either a population of interest or a particular intervention strategy, you can easily shift out of the paralysis.
- Use the data you have—we always want to know more, but some of the key elements we discovered in our analysis are flags available to all CCOs in the monthly delivery of data from OHA

Plant seeds where there is fertile ground



- This work takes resources. Where within your system are there resources to help in this work? Who is already focused on/interested in this topic?
- Target your data analysis on where you have internal/external resources to do the heavy lifting. Lean into that space, and provide the data to help inform their work.
- Start small and build momentum

The CareOregon Capacity Building Grants and Learning Collaborative was one great example!

Create opportunities to connect providers

- SET THE TABLE: bring providers together to share their experience caring for shared members—both sides have a lot to learn from one another! Co-Design to truly ensure partnership, engagement, and learning.

- GET THE CONVERSATION GOING: Present shared data, discuss PreManage workflows, bring in speakers with lived experience, etc. Build Community, build alignment in approach.

- GET RESULTS: Encourage whole person care, create referral pathways between primary care/behavioral health, develop care conferences, etc.

Center the conversation on patient experience

- Keep the member/patient experience in the center of the conversation
- Use a trauma informed approach- strive to understand "what is happening here" and not "what is wrong with these 'high utilizers'"
- Approach this work with compassion and curiosity: How is stigma a barrier to seeking care? How has our model of care worked or not worked for our most vulnerable members?

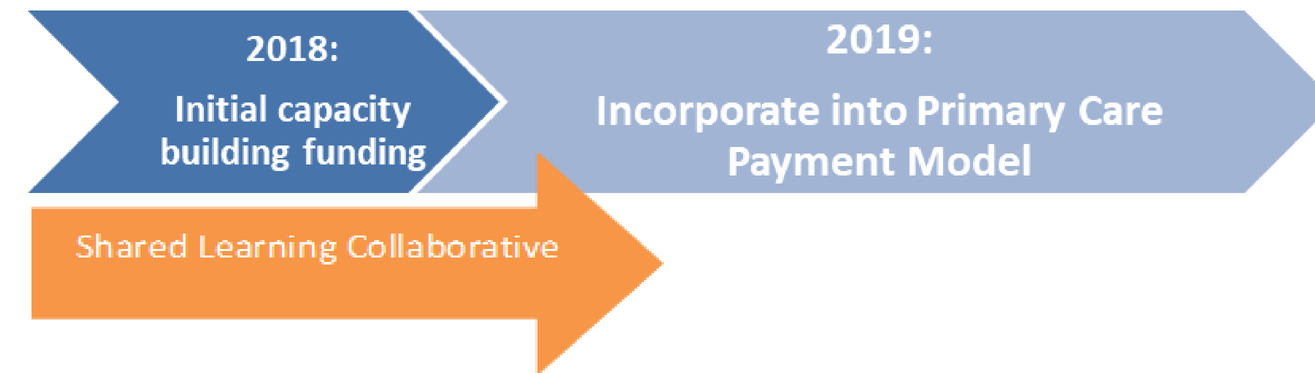
What's Next – Health Share

Intersection of diabetes + ED visits

Intersection of substance use disorder + ED visits

What's Next - CareOregon

- Final Learning Session, June, 2019: Storyboards
- 2019 Alternative Payment Model – inclusion of cost of care metric



- Continued PreManage use: developed cost of care cohorts to support clinic work; community case conferences, and high-risk huddles
- Future goal: Risk sharing and total cost of care framing and focusing work

Q & A

Presenter Contact Information

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ORPRN Oregon Rural Practice-Based Research Network

OHSU

Thank you!

Please complete the post-session evaluation.

Next session is on **Monday, February 25 from 1:00-2:00 p.m.**

- The session theme will be Clinic Workflows and will feature a presentation from Columbia Pacific CCO.

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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