

Behavioral Health ED Use During Covid: Trends and Analysis

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eocco
EASTERN OREGON
COORDINATED CARE
ORGANIZATION



Disclosures

- ▶ There are no disclosures.
- ▶ All data are sourced from GOBHI and the OHA.

Project Team

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Learning Objectives

- ▶ **Describe the changes caused by the pandemic in the EOCCO region's Emergency Department (ED) census generally, 2019 through August 2020.**
- ▶ **Describe the changes caused by the pandemic in the EOCCO region's ED usage by members with behavioral health disorders.**
- ▶ **Describe the changes caused by the pandemic in the EOCCO region's ED usage by members with substance use disorders.**
- ▶ **Understand possible causal effects for trends observed in these three data sets.**

Why We Are Doing This

- ▶ The CCO 2.0 contract requires the attainment of numerous clinical objectives that are aligned with CCO incentive measures.
- ▶ **Reduction in member visits to Emergency Departments is required of the CCO.**
- ▶ Reductions in actual time members with SPMI and SUDs spend in jails, hospitals and EDs is also required of EOCCO.
- ▶ CCO Contract Exhibit M Section 14 requires EOCCO to reduce member ED use generally and for those with behavioral health problems.

Why We Are Doing This

CCO Contract Exhibit M Section 14:

“Contractor Behavioral Health services must address the following key areas:

- ▶ Reduce visits to Emergency Departments.
- ▶ Reduce repeat visits to Emergency Departments.
- ▶ Reduce the length of time Members spend in Emergency Departments.
- ▶ Ensure Members are contacted and offered services to prevent utilization of Emergency Departments.
- ▶ Ensure Members with SPMI have appropriate connection to Community-based services after leaving an Emergency Department and will have a follow-up visit from Intensive Care Coordinator or other relevant Provider within three (3) days.”

Why We Are Doing This

CCO Contract Exhibit M Section 14 (continued):

“Contractor shall develop and implement an Individualized Management Plan for a Member who has two (2) or more visits to an Emergency Department within a six (6)-month period.”

Important Note: In this first year of the contract, we are limiting GOBHI Individual Management Plans to Members who have two or more visits in a six month period that are due to SUD and/or manifestations of major mental illness signs and symptoms. This is because many have medical comorbidities, dental issues and ordinary emergencies unrelated to behavioral health disorders.

What We Are Doing

- ▶ GOBHI assigned a set of daily tasks to its Care Management team who work together with MODA's Care Management team.
- ▶ Each morning the team examines a report from Collective Medical's Premanage product that details all EOCCO member ED visits for the prior 24 hour cycle.

What We Are Doing

- ▶ This report is first examined by Dr. Davidson with an eye toward picking out which members with SPMI and SUD went to the ED for reasons related to their mental state (not for example, because of a fever, orthopedic issue, etc.).
- ▶ Each of the visitors so identified are contacted within three days, or for repeat visitors, an Individual Management Plan (IMP) is created.

What We Are Doing

- ▶ We collect data on ED use for all members and for all who meet diagnosis criteria within our claims system for MI/SPMI and SUD. We collect claim information for both outpatient and inpatient services in our network, but only for behavioral health provider claims. We do not have access to medical claim information.
- ▶ For the SPMI cohort, we include all clients with a recorded diagnosis and age fitting the definitions within the OHA Disparity Measure for ED Utilization among members experiencing Mental Illness. This is, in turn, based on the HEDIS definition of SMI. You can find the technical specifications for that disparity measure here:
<https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2019-Disparity-Measures-ED-Utilization-Among-Members-Experiencing-Mental-Illness.pdf>

What We Are Doing

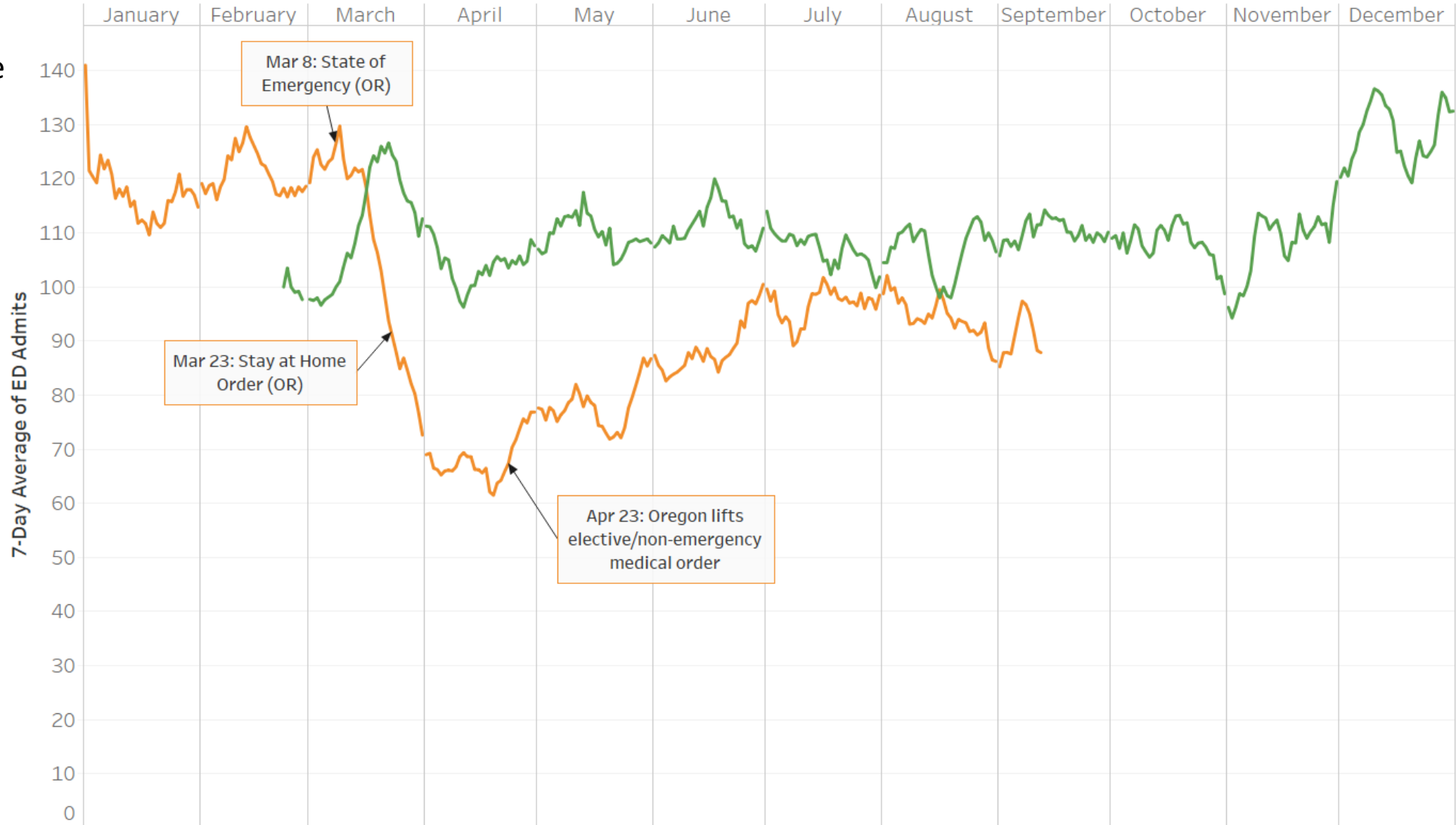
- ▶ For the SUD cohort, we include all clients with a diagnosis falling within the F10-F19 range of ICD codes, within the broad category of "Mental and behavioral disorders due to psychoactive substance use."
- ▶ For both cohorts, we consider a member part of the cohort for 1 year after the date of their last applicable diagnosis.

Then Covid happened...

Moving 7 Day Avg of ED Visits (All EOCCO)

Year of Admit Date

2019
2020



In March we wondered what would happen “post-Covid”

- ▶ What was happening to all the people who would have gone to the ED?
- ▶ Would there eventually be a “surge” in SPMI and SUD ED visits?
- ▶ Or was significant pre-Covid ED traffic in a sense unnecessary?

It turned out “post-Covid” didn’t happen.

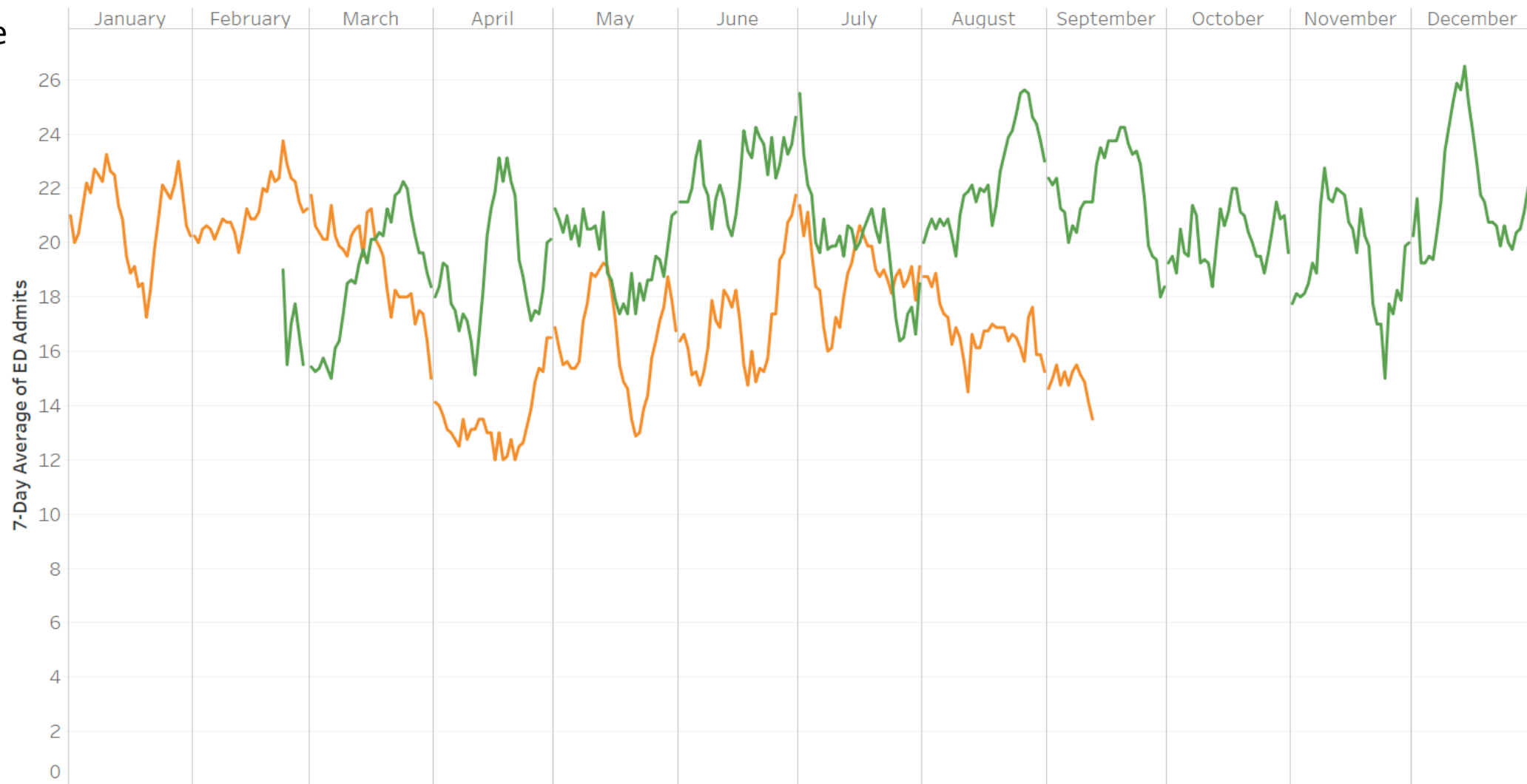
We have observed:

1. EOCCO ED traffic volumes have rebounded, but have **not returned to the 2019 baseline.**
2. Volumes have **dropped again, though not as steeply,** once Covid prevalence increased markedly in EOCCO region counties this summer.

Moving 7 Day Avg of ED Visits (SPMI)

Year of Admit Date

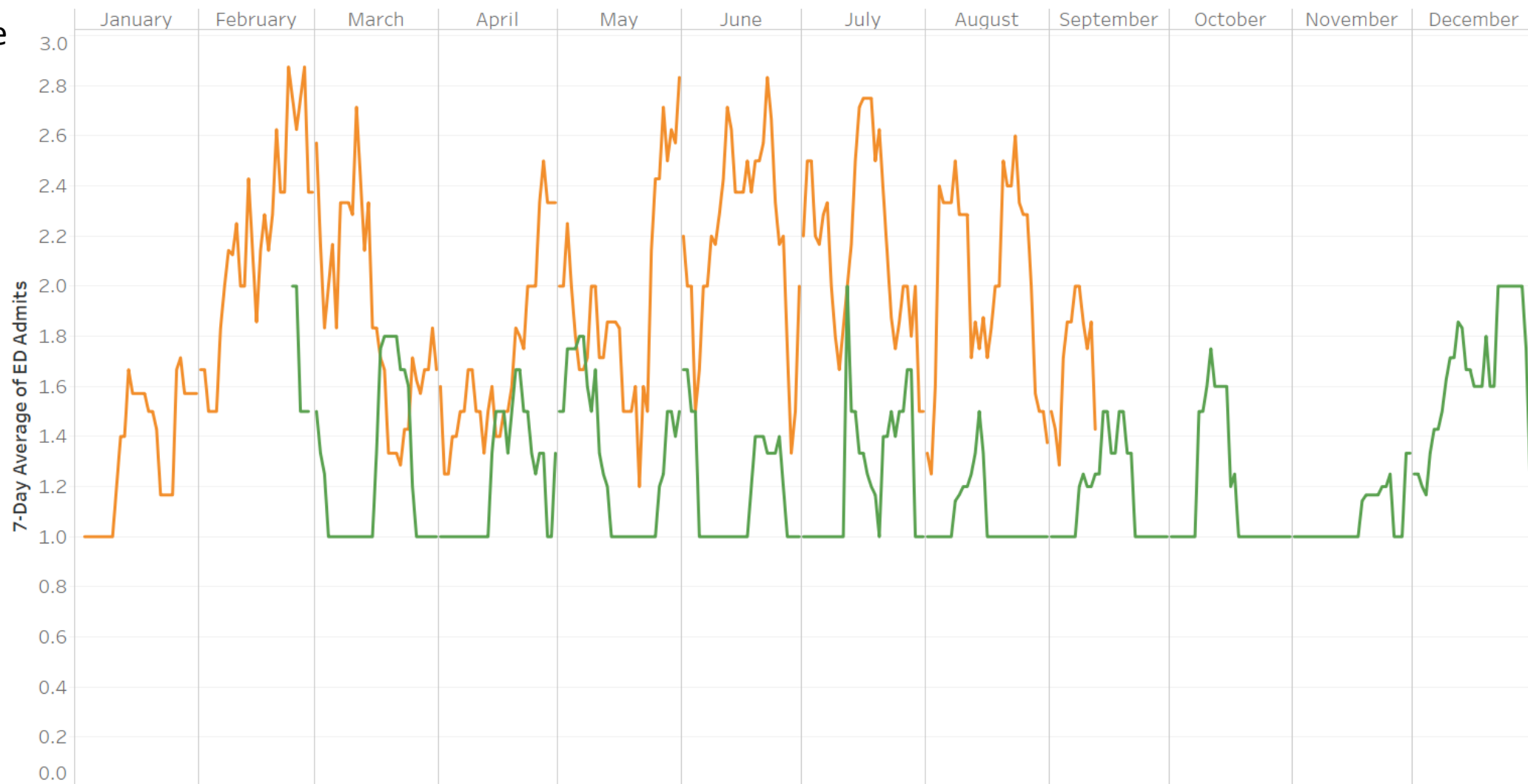
■ 2019
■ 2020



Moving 7 Day Avg of ED Visits (SUD)

Year of Admit Date

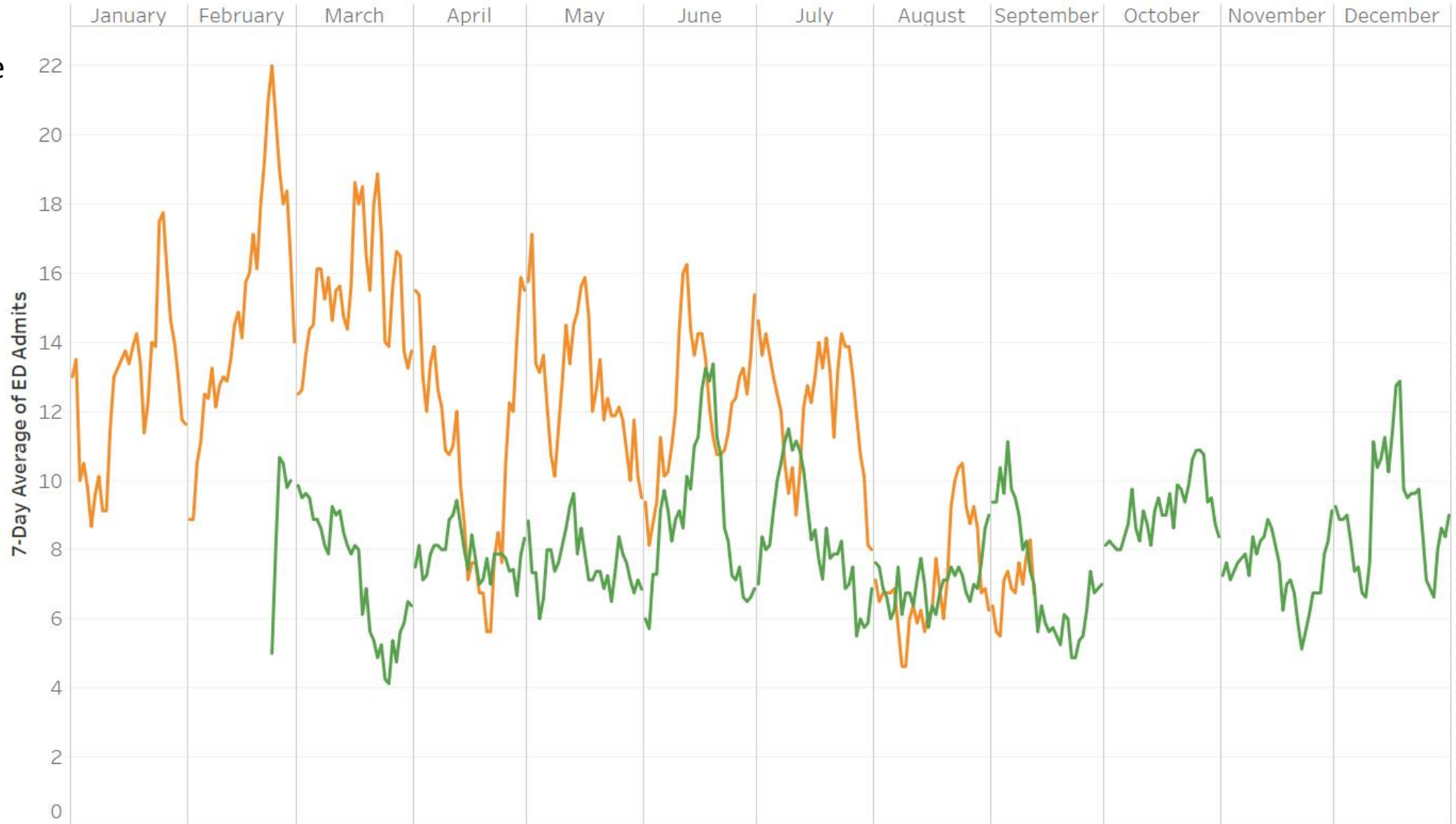
2019
2020



Moving 7 Day Avg of ED Visits (Combined CM Programs)

Year of Admit Date

2019
2020



Qualitative Observations

- ▶ Caveat: This presentation is a description of an ongoing event. No statistical validity, nor causation has been demonstrated. This is a presentation of certain observations.

For further study: There are more non-emergent presenting complaints than there were before Covid.

- ▶ EDs seem now to be serving more than the usual volume of primary care, scheduled routine follow up, ordinary dental and anxiety related complaints. This is of course, difficult to quantify.
 - ▶ Could this be the result of decreased member access to primary care clinics due to Covid?
 - ▶ Has a decrease in the incidence of actual emergencies occurred?

- ▶ Objective: **Understand possible causal effects for trends observed in these three data sets.**
- ▶ It is likely a 'fear of Covid' produced the initial drop in ED visits seen in the spring. The recrudescence of the disease this summer has not produced a drop in ED visit volume of similar magnitude.
- ▶ Even so, with the exception of the SUD cohort, ED visit volumes remain down compared to 2019.

- ▶ We do see variance between the general background of ED visitors and those in the SUD and SPMI cohorts.
- ▶ Again, variance cannot be considered significant because of the brief interval and enormous number of variables involved.

- ▶ We found no clear evidence of any effect on the ED visits of the SUD and SPMI populations with which we have been intervening according to the terms of the Exhibit M contract.
- ▶ This may be for one or a combination of several reasons including:
 1. Very brief capture interval
 2. Skew caused by very frequent ED visitors
 3. Interventions (3d follow up and IMP) prescribed by Exhibit M are ineffective, or at least insufficient to alter choices made by members relative to ED visit decisions.

- ▶ Objective: **Describe the changes caused by the pandemic in the EOCCO member ED census generally, 2019 through August, 2020.**
- ▶ A massive drop in all traffic, followed by an increase, though not to the 2019 baseline, even as Covid prevalence increased dramatically in July and August

- ▶ Objective: **Describe the changes caused by the pandemic in the EOCCO region's ED usage by members with behavioral health disorders.**
- ▶ Initially tracked the pattern of the general population, a marked reduction, then a slow increase, but not to the 2019 baseline.
- ▶ This cohort's ED use may have decreased more than the general population's ED usage during the summer.

- ▶ Objective: **Describe the changes caused by the pandemic in the EOCCO region's ED usage by members with substance use disorders.**
- ▶ Initially tracked the changes of the general population, the reduction after February.
- ▶ Has increased and remains well above the 2019 ED use baseline for the same cohort of individuals ever since the spring of this year.

Discussion & Conclusion