The ED-MI Incentive Measure, Tips for Success

Bonnie Thompson, RN, MBA, MSN

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Presenter Information

- Bonnie Thompson works for Greater Oregon Behavioral Health, Inc. Her past experience includes working as a Nurse Practitioner in the Emergency Department, Family Practice Clinic and as a the County Designated Mental Health Provider.

- She has no financial relationship with any of the software vendors mentioned in this presentation.

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Learning Objectives

- Describe one strategy for reducing emergency department utilization among individuals experiencing mental illness
- Understand the inter-related nature of care needed for individuals experiencing mental illness
- Understand how to utilize community care plans to improve communication and care coordination
- Learn about alternate deliver models to reduce ED utilization

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Health Future Enhancements

- Share data with other State PMPs
- Interface with the Emergency Department Information Exchange
- Education programs
- Health information exchange
- Outcome evaluation

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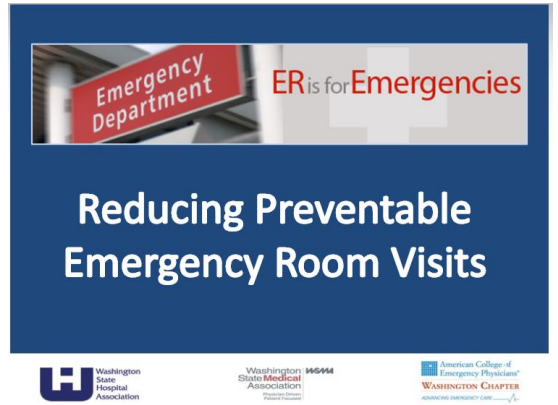
ALWAYS WORKING FOR A SAFER AND HEALTHIER WASHINGTON



National Priorities Partnership
Convened by the National Quality Forum

COMPACT ACTION BRIEF: A Roadmap For Increasing Value In Health Care

Reducing Emergency Department Overuse: A $38 Billion Opportunity

Opportunity

Emergency department overuse: $38 billion in wasteful health care spending

An increasing number of people are using hospital emergency departments (ED) for non-urgent care and for conditions that could have been treated in a primary care

Solutions

67 million, or more than half of the 120 million annual emergency visits, are potentially avoidable

Increasing access to primary care services can reduce emergency department overuse by up to 56 percent. A number of tested measures already exist, including offering

Drivers for Change

- Payment Reform for Providers
- Financial Incentives for Patients
- Improved Data on Emergency Department Utilization

Reducing the overuse of emergency department services requires policy actions that involve providers, payers, and patients.

Action Steps

OPCA Oregon Primary Care Association

ABOUT US | PROGRAMS & SERVICES

visits to the emergency room.

- Hotspotting Data Toolkit: Some organizations have created health care teams to better coordinate the care of "super-utilizers" - those who visit the emergency department for care much more often than the average.
- Health Integration Project: Emergency Room Diversion Project that explores some key strategies for reducing emergency department utilization
- EDIE/PreManage: Web-based tools that provide real time information to primary care clinics about their patients' emergency department utilization
- Opportunities, Solutions and Drivers for Change: A look at the financial impact of emergency department overuse and some potential strategies for addressing it
- Community Care Coordination Pathways: A quick start guide to developing a plan for care coordination and connecting with patients who are at risk of high utilization
- Connecting with your CCO: Many Coordinated Care Organizations are starting to send data regarding emergency department utilization to clinics. Contact your organization's CCO to see what data is available.

For additional information on this measure, refer to the links below:

- Coordinated Care Organization (CCO) Incentive Measure Definition (Outpatient and ED Utilization)
- Hospital Transformation Performance Program - PCP Notification in EDIE
- Core Performance Measure Definition (Avoidable ED Visits)

Resources and Tools for Reducing Emergency Department Utilization Rates:

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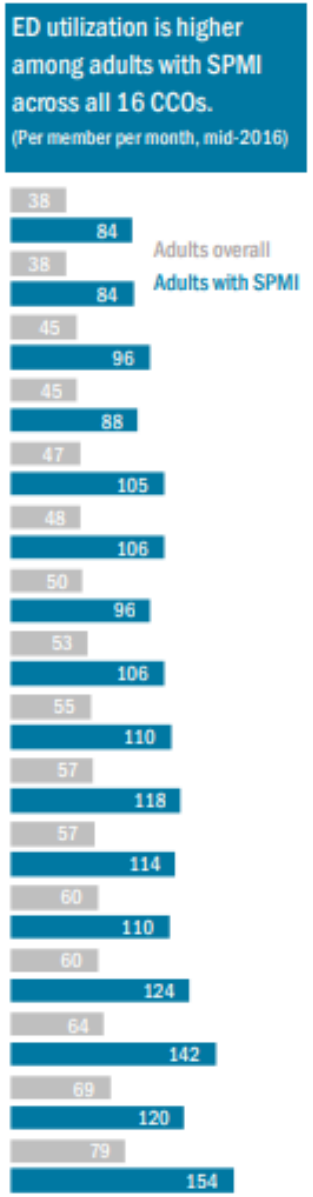

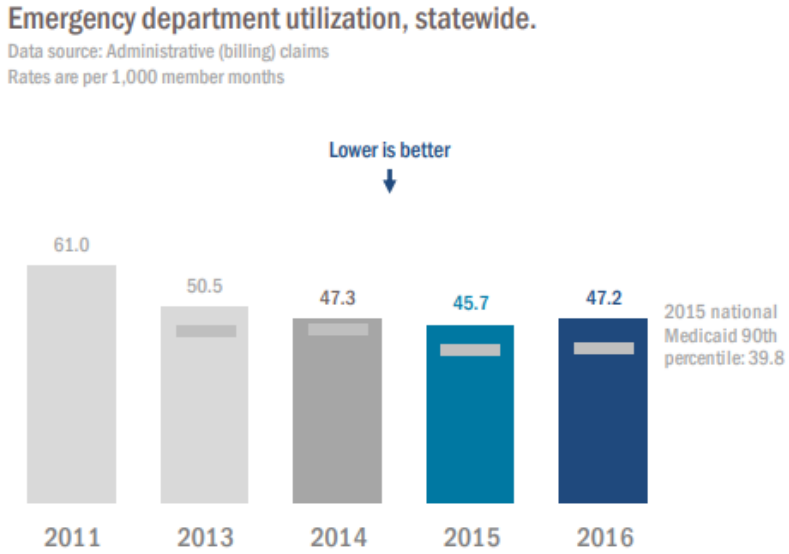

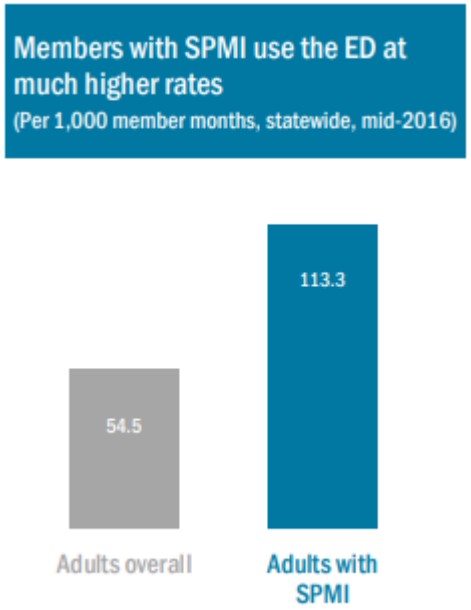

Perspective

Effect of Medicaid Coverage on ED Use — Further Evidence from Oregon's Experiment

Amy N. Finkelstein, Ph.D., Sarah L. Taubman, Ph.D., Heidi L. Allen, Ph.D., Bill J. Wright, Ph.D., and Katherine Baicker, Ph.D.

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Emergency Room Use Stays High In Oregon Medicaid Study

October 19, 2016 · 5:45 PM ET
Heard on All Things Considered

KRISTIAN FODEN-VENCIL

FROM OPB

October 20, 2016
N Engl J Med 2016; 375:1505-1507
DOI: 10.1056/NEJMp1609533

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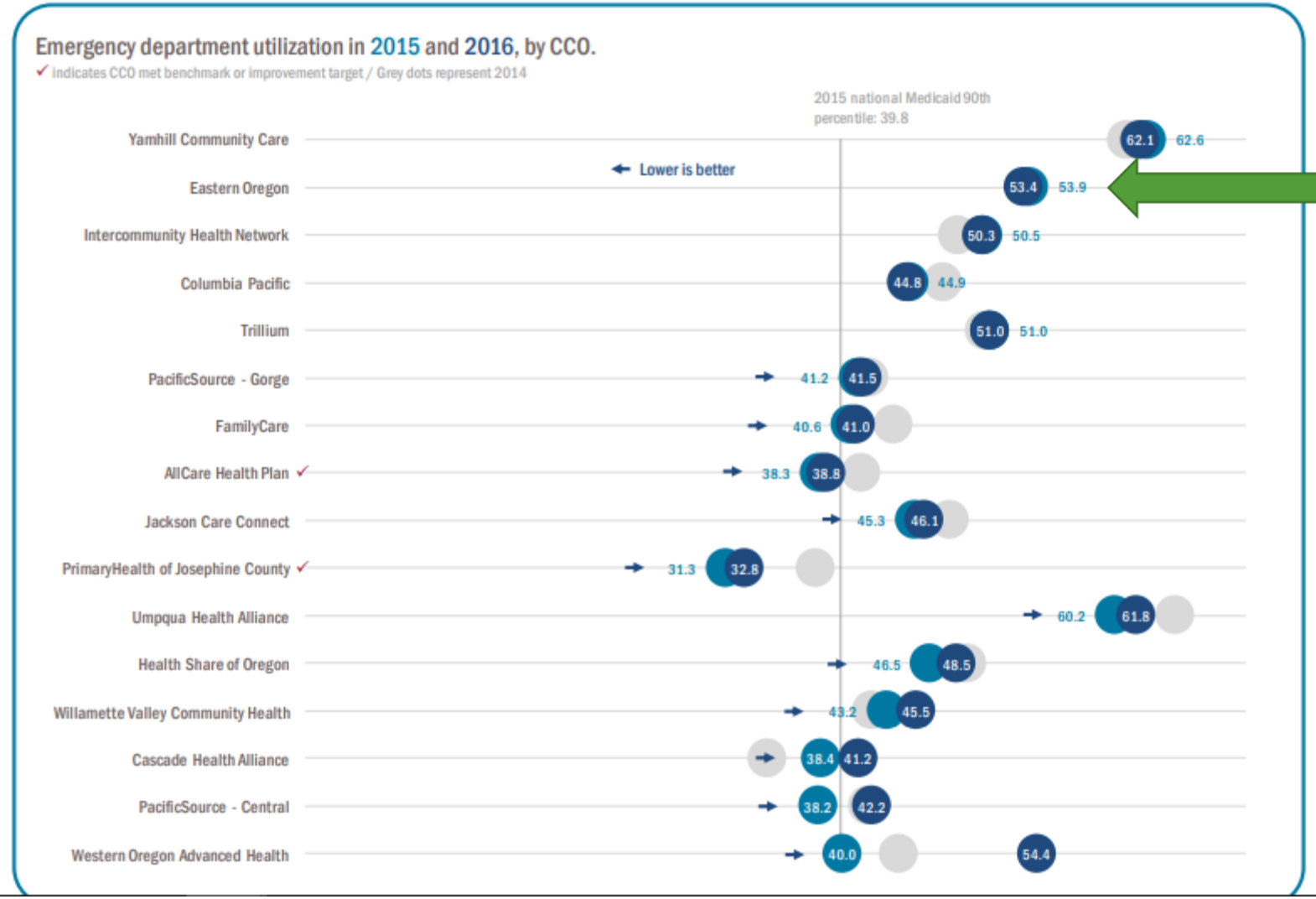
AMBULATORY CARE: EMERGENCY DEPARTMENT UTILIZATION



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Top Diagnoses by Region

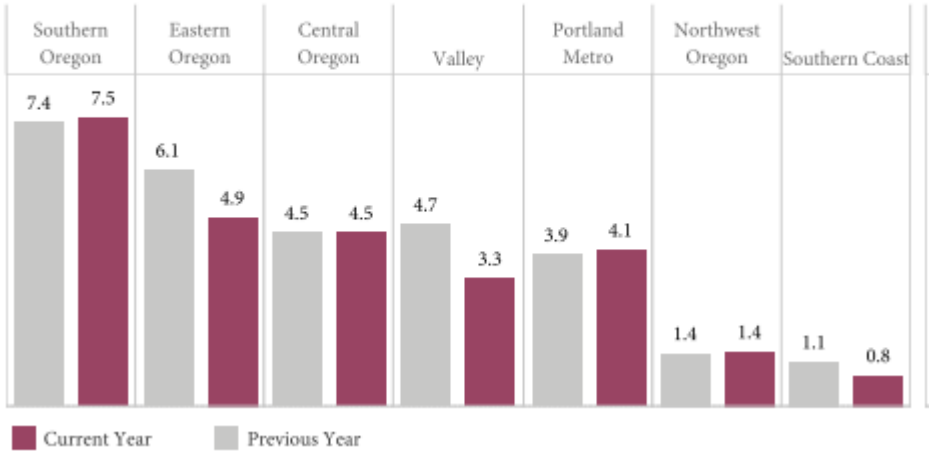
(High Utilizer Visits)

	Central Oregon	Eastern Oregon	Northwest Oregon	Portland Metro	Southern Coast	Southern Oregon	Valley
Chest pain, unspecified	638	231	521	2,796	409	661	2,178
Unspecified abdominal pain	651	304	457	2,435	680	692	2,102
Headache	433	240	570	2,683	412	542	1,823
Other chest pain	277	307	492	2,293	375	367	1,705
Nausea with vomiting, unspecified	381	223	532	2,034	379	458	1,471
Urinary tract infection, site not specified	362	240	342	1,341	551	452	1,951
Low back pain	325	224	406	1,680	424	289	1,525
Anxiety disorder, unspecified	242	201	385	1,900	344	300	1,400
Acute upper respiratory infection, unspecified	249	157	438	2,063	299	306	1,216
Migraine, unspecified, not intractable, without..	204	298	213	1,095	283	184	1,276

The top three diagnoses in each region are highlighted

Comorbidity & Mental Health by Region

(High Utilizer Visits /1000 Residents)



http://www.orhealthleadershipcouncil.org/wp-content/uploads/2018/07/Q4-2017-EDIE-Dashboards-002-1.pdf

http://www.orhealthleadershipcouncil.org/wp-content/uploads/2018/07/2017-EDIE-Annual-Report-002-1.pdf

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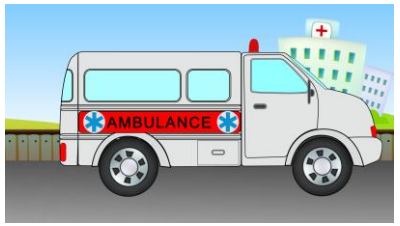
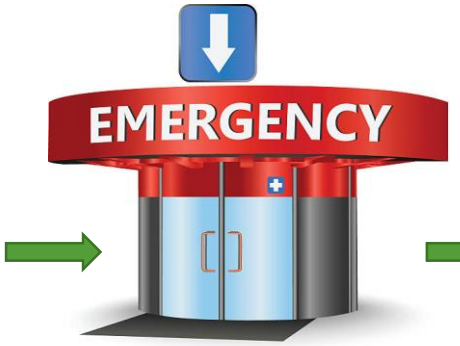
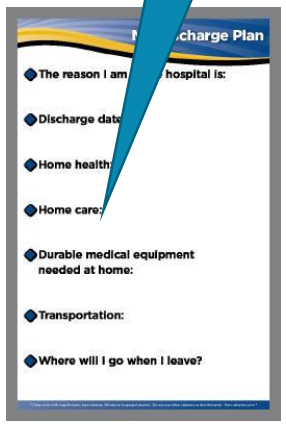
Creative Community Challenges

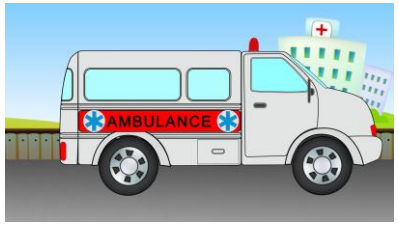




Visit with PCP in 4 days



2 Days to go…



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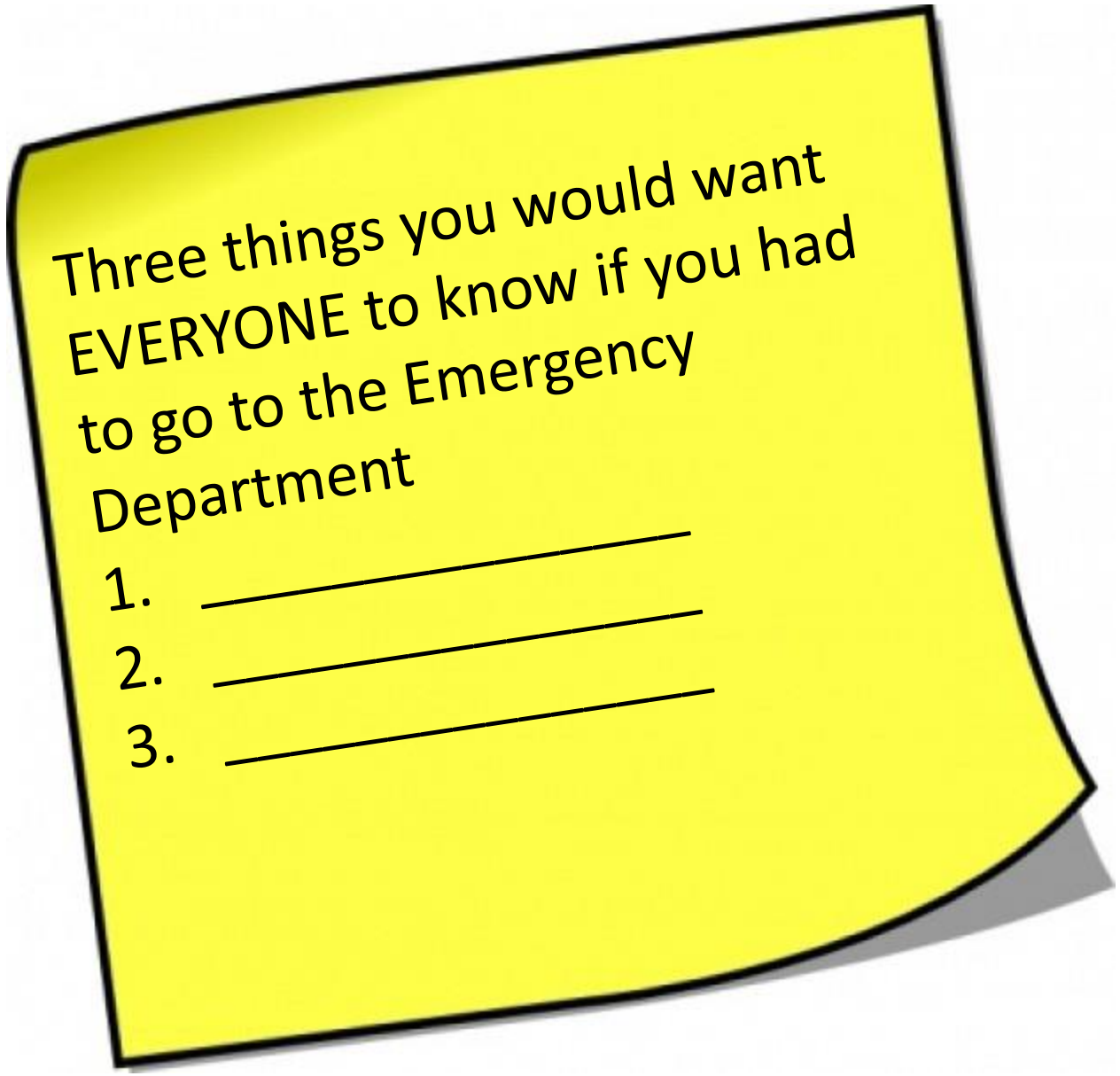
Community Communication


Three things you would want EVERYONE to know if you had to go to the Emergency Department
1. _____
2. _____
3. _____

This is EDIE

Every ED Instantly at Your Fingertips

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EDIE/PreManage
2018 Goals

Improve quality and cost markers associated with emergency department utilization

Goal #1: Promote/expand community collaboration and cross organizational care coordination

- Promote community collaboration and coordination in use of EDIE/PreManage tools to clarify roles, streamline workflows and improve communication for ED high utilizers and transitions of care
- Facilitate statewide user communities of practice (behavioral health, rural)
- Foster the establishment of aligned cross organizational processes for the creation of a single care recommendation to avoid duplication and conflicting information.

Goal #2: Enhance dissemination of information and resources to support improvement efforts

- Develop, analyze and distribute quarterly aggregated actionable data reports for key metrics associated with tracking ED utilization.
- Sustain and expand Online Learning Community as a central repository of resources and peer networking.
- Identify, recommend and communicate best practices and workflows

Goal #3: Leverage use of EDIE/PreManage technology tools to support key initiatives

- Implement EDIE/PDMP Integration to support efforts to reduce ED opioid prescribing
- Align efforts with other statewide and regional opioid prescribing reduction initiatives
- Convene, coordinate statewide and regional efforts to address ED utilization in members with mental illness diagnoses
- Convene, identify and communicate EDIE/PreManage workflows to improve communication and coordination for transitions of care
- Promote and align with organizational efforts to incorporate EDIE utilization data into other data systems to enhance patient and population management.

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PreManage EDIE 07/02/2016 11:56 PM

This patient has registered at the [redacted] **Hospital Emergency Department**. You are being notified because this patient has recommended Care Guidelines. For more information please login to EDIE and search for this patient by name.

Care Providers

Provider	Type	Phone	Fax	Service Dates
Lemeul Diggs, MD	Primary Care	(415) 555-1213	(206) 555-1212	Current
Vernon Ingram MD, PHD	Hematology/Oncology	(650) 231-3125	(206) 231-3126	Current
Jane Hendrick MD	Pain Management	(415) 782-2342	(206) 782-2343	Current

ED Care Guidelines from Burlington Pain Center

Last Updated: Wed Jan 20 12:35:40 PDT 2016

Care Recommendations: (These are guidelines and the provider should exercise clinical judgment when providing care):

Patient has Sickle Cell Disease and is on chronic opioid treatment.

Recommended Vaso-Occlusive Crisis plan:

--Oxygen and IV NS

--Ketorolac IV (IM ok) 30 mg q6h, limit to 4 doses

--Hydromorphone 8 mg IV; 4 mg IV q 30 min until pain is addressed.

--shift to PCA as possible

--Reassess patient every 30 minutes for pain and vital signs.

Additional Information:

1. No prior history of cardiac pathology, but consider Acute Chest Syndrome in addition to pain management; patient has NO antibiotic allergies.
2. Has received frequent imaging; prior scans can be seen at https://centralbayhealthinformationexchange.com, call (650) 555 2121 if unable to access.

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Care Histories

Medical

01/6/2016 Fremont Medical Center

- Sickle Cell Anemia, Pain Crisis

Imaging

1/6/2016 Fremont Medical Center

- CT Chest PE Protocol with no clinical findings

Security Events

Date	Location	Type	Specifics
12/20/2015	Wallace Mem Hosp	Verbal	• Patient needed chemical restraints

Security Events (18 Mo.)	Count
Verbal	1
Physical	0
Total	**1**

Recent Visit Summary

Visit Date	Location	Type	Diagnoses
06/29/2016	Fremont Medical Center	Inpatient	- Sickle Cell Disease, Vaso-occlusive Crisis
04/18/2016	Fremont Medical Center	Inpatient	- Sickle Cell Disease, Acute Chest Syndrome
03/20/2016	South Bay Hospital	Inpatient	- Vaso-occlusive Crisis

ED Visit Dates	Location	Type	Diagnoses
06/29/2016	Fremont Medical Center	Emergency	- Shortness of Breath
06/20/2016	Fremont Medical Center	Emergency	- Chest Pain
06/15/2015	Fremont Medical Center	Emergency	- Vaso-occlusive Crisis
05/28/2015	Fremont Medical Center	Emergency	- Shortness of Breath

E.D. Visit Count (1 Yr.)	Visits
Fremont Medical Center	25
South Bay Hospital	8
Wallace Memorial Hospital	1
Total Known Visits:	**34**

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Ford Medical Center

Care Recommendation:

Patient previously responded well to 8 puffs of albuterol. After one hour, had markedly improved retractions (still mild intercostal), good air movement in anterior and posterior lung fields, breathing in 20s with good oxygenation.

Counsel family on at home asthma management plan and return precautions; verbalize understanding.

These are guidelines and the provider should exercise clinical judgment when providing care.

Created by James Fallon on Sep 01, 2016

Social History

0 | 0 2016-09-01 Ford Medical Center James Fallon

- Homeless, stays near Liberty Park
- Does have casement/housing options through XYZ

Ford Medical Center

Care Recommendation:

Coordinate with patient's XYZ CM (contact information in Care Provider section). Assist patient to get reconnected with Dr. Smith, discuss housing resources and assess for additional substance abuse.

These are guidelines and the provider should exercise clinical judgment when providing care.

Created by James Fallon on Sep 01, 2016

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1. Include only information in Care Recommendations that is relevant in an ED setting.

A patient's Care Recommendations should provide information that is relevant to a patient's treatment in an ED setting, including care considerations, care coordination details, pain management information, suggested ED-based interventions, and any other information that is appropriate and applicable to the setting.

Below are a few patient examples to help demonstrate.

EXAMPLE PATIENT: Patient with a chronic condition that requires a specific treatment in the ED. **CARE RECOMMENDATIONS**: • Include treatment recommendations • Include medication recommendations	**EXAMPLE PATIENT:** Patient on a pain contract. **CARE RECOMMENDATIONS:** • Care coordination information for the patient • Brief details pertaining to the Pain Contract and note that it has been uploaded to EDIE web portal. • Other pain treatment recommendations for the ED	**EXAMPLE PATIENT:** Patient who has historically inappropriately over-utilized the ED, but who has responded well to interventions. **CARE RECOMMENDATIONS:** • Details for successful intervention methods • Care coordination information for the patient

Attributes of a GREAT Care Recommendation

M/BH Providers can write Care Recommendations that comply with applicable state and federal law and provide significant value to ED clinicians by doing one or more of the following:

1. Provide a Care Coordination Note with a simple statement that the patient has complex M/BH needs, is receiving treatment at your clinic, and provide contact information (24-hour "hotline" contacts are especially helpful) for a treating provider or case manager who can consult on providing optimal care for the patient when he or she presents at the ED.

2. Provide a description of the patient's baseline presentation. Some patients with serious psychiatric conditions may appear to be agitated, impaired or erratic even when their condition is well managed. ED providers benefit from having a simple summary of the patient's underlying condition and baseline presentation in many ways. For example, a brief description of diagnosis and baseline presentation may simplify the ED provider's efforts to identify the cause for the ED visit (i.e., in some cases it may relate to medical issues only and not to the underlying psychiatric issue).

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Attributes of a GREAT Care Recommendation

4. Where applicable, it can be helpful to ED providers for you to provide recommendations for things to avoid or tips to try in the ED to help provide reassurance to M/BH patients. Some M/BH patients may have specific concerns or fears

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3 For more explanation on how to comply with state and federal mental and behavioral health laws when working with EDIE and PreManage, see CMT Whitepaper "How EDIE & PreManage Work with Mental & Behavioral Health Laws." [Note to Draft: currently in development]. Please note that neither the guidance in this Toolkit nor the M/BH Whitepaper constitute legal advice and you should consult with your own legal counsel on the specifics of state and federal law applied to your clinical context.

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Feedback from the ED

- **"Simpler and clearer… Provide essential, brief background and clear, bulleted direction on what to do."**
- "More information on actual medical problems."
- "I want Useful information. Narcotics. Care Plans for chronic illness Radiology studies performed in the last year."
- "Add more care plans and real information."
- **"Some of them seem to use a lot of space to say very little and repeat the same info multiple times.** Condense."
- "Possibly limit number of characters in a care plan."
- "Many times **doctors have told me that information that I have told them about the patient is not in the guideline, but it is--it is just buried in random information."**

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Attributes of a GREAT Care Recommendation

One coordinated care plan!

If a care plan already exists please do one of the following:

- Connect with one another and coordinate information to author one care recommendation
- Much of the information can also be shared in the care history section as well

If there isn't one listed or no PCP assigned, by all means create a care plan if it is meaningful.

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42 CFR Part 2

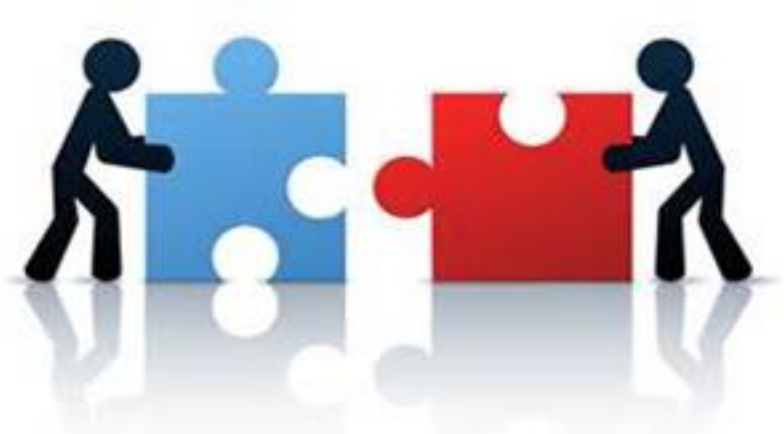
- PreManage allows the ability to provide selective MH/BH information—
  - **Do not** include information about services covered by Part 2: psychotherapy notes, etc.,

Cascading Efforts – What you can expect

Behavioral Health Care Plans in PreManage

- Each County Mental Health Provider (CMHP) will be entering 10 care plans per month for members with SPMI entered into PreManage

- Target: by the end of 2018 every EOCCO member with an SPMI diagnosis will have a care recommendation entered into EDIE



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Stand Up and then Sit Down If…

- You buy all of you music at a record store
- You buy all of your books at a bookstore
- You buy all of your clothes at a clothes store
- You do all of your banking at a bank
- You get all of your healthcare at an office or facility

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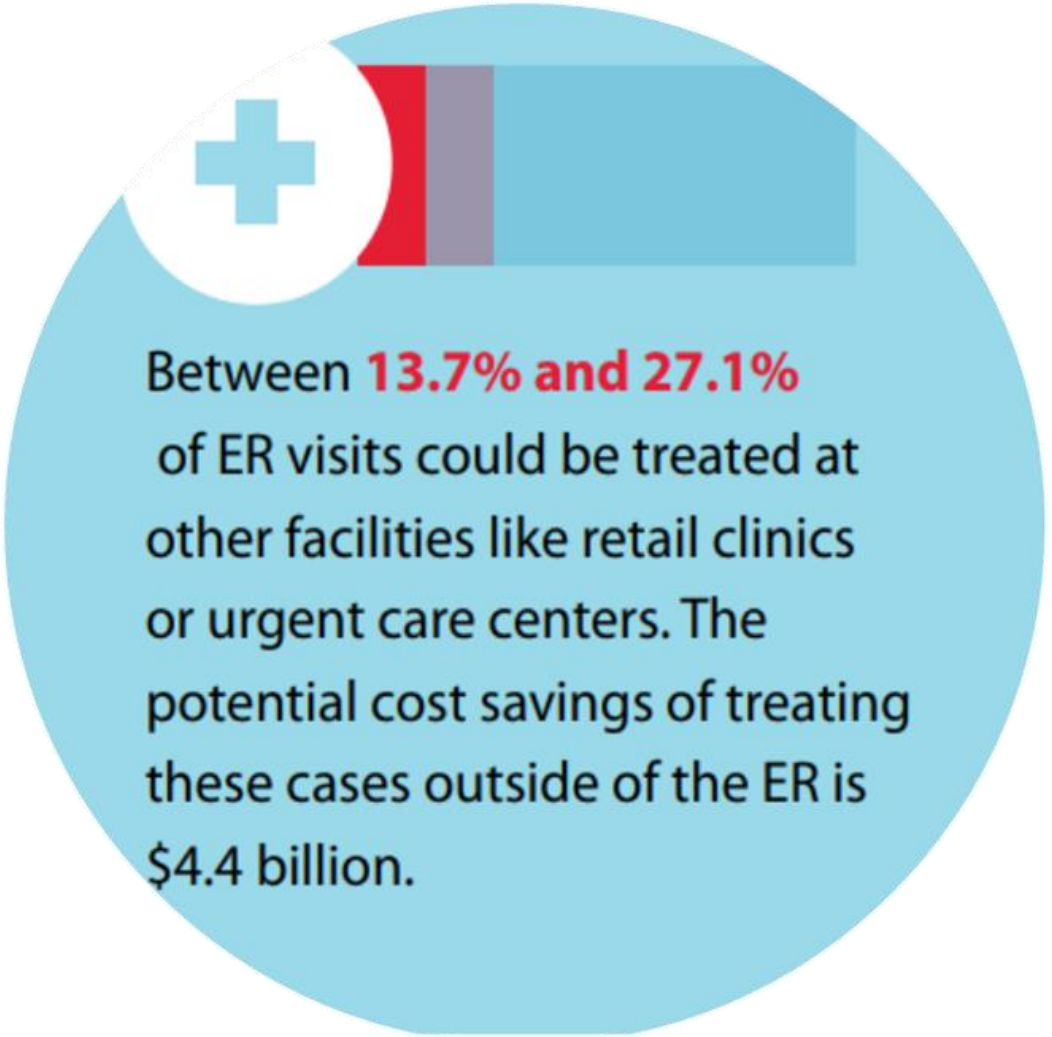
Direct to Patient Care



Weinick RM, Burns RM, Mehrotra A. How Many Emergency Department Visits Could be Managed at Urgent Care Centers and Retail Clinics? Health affairs (Project Hope). 2010;29(9):1630-1636. doi:10.1377/hlthaff.2009.0748.

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Most studies find that at least

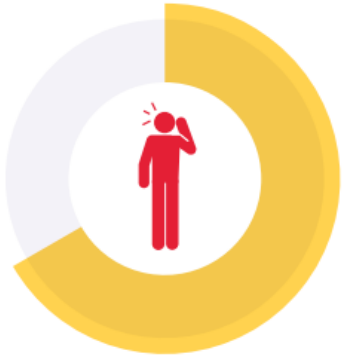
30% of emergency room visits are non-urgent

The 4% of America's doctors who work in emergency medicine provide:

11% of all outpatient visits

28% of all acute care visits

1/2 of all acute care visits by Medicaid and CHIP beneficiaries



2/3 of all acute care visits by the uninsured

Due to lack of access to other providers, uninsured adults ***are twice as likely to visit the ER*** *than those with private coverage.*

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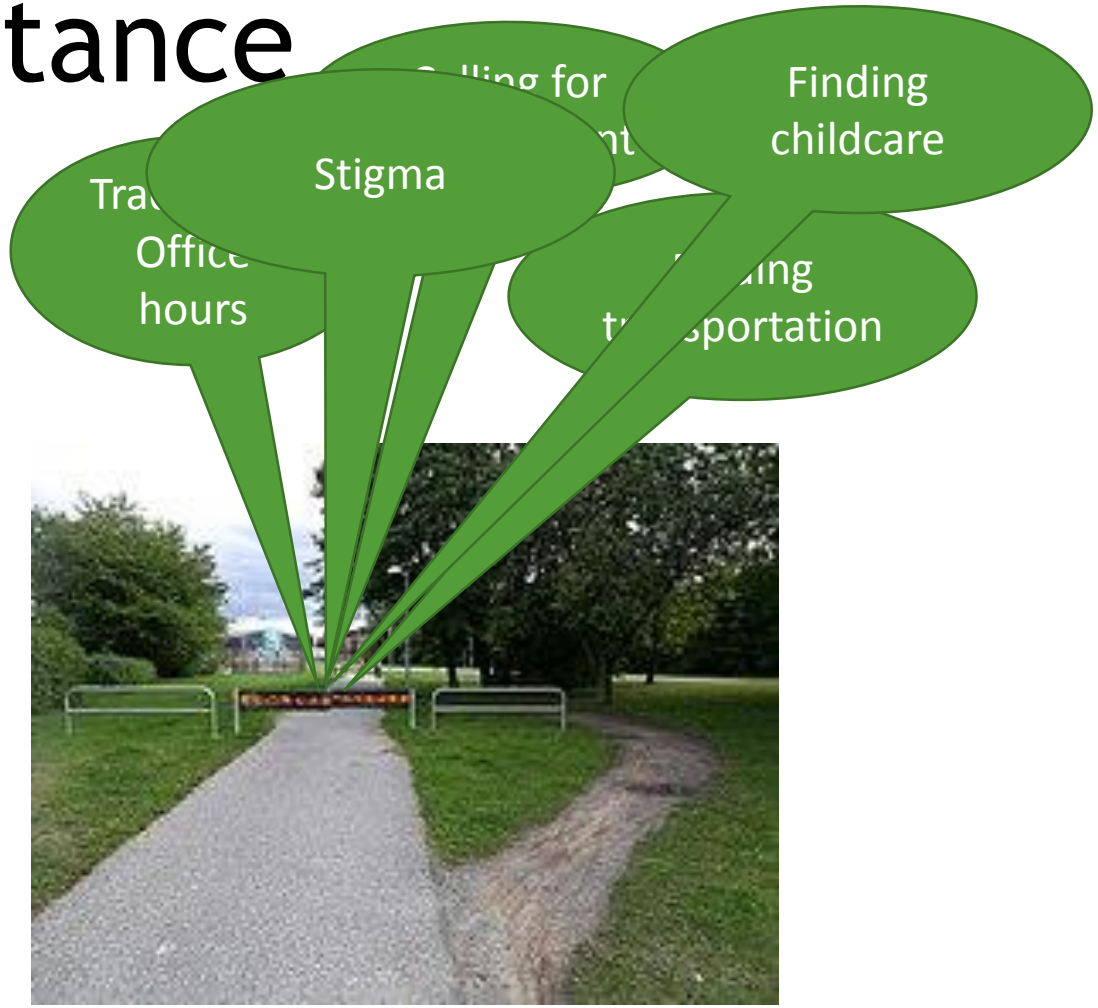
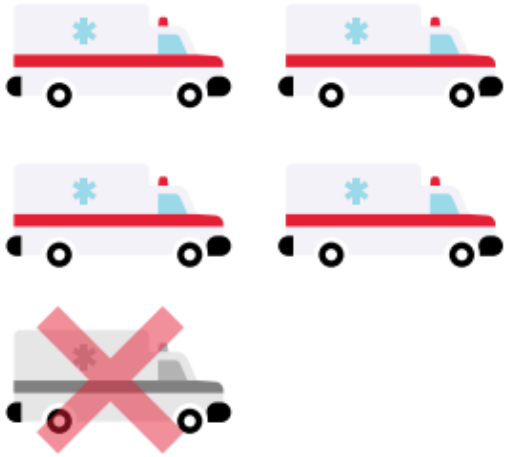
Path of least resistance



Telehealth can reduce overall costs
and keep people out of the hospital

The average estimated cost for a telehealth visit is **just $40 to $50.**

20% of ER visits require follow-up care for similar conditions, while **only 6% of telehealth visits do.**



A study of approximately 1,500 older adults found that telehealth was able to eliminate nearly **1 in 5 ER visits.**

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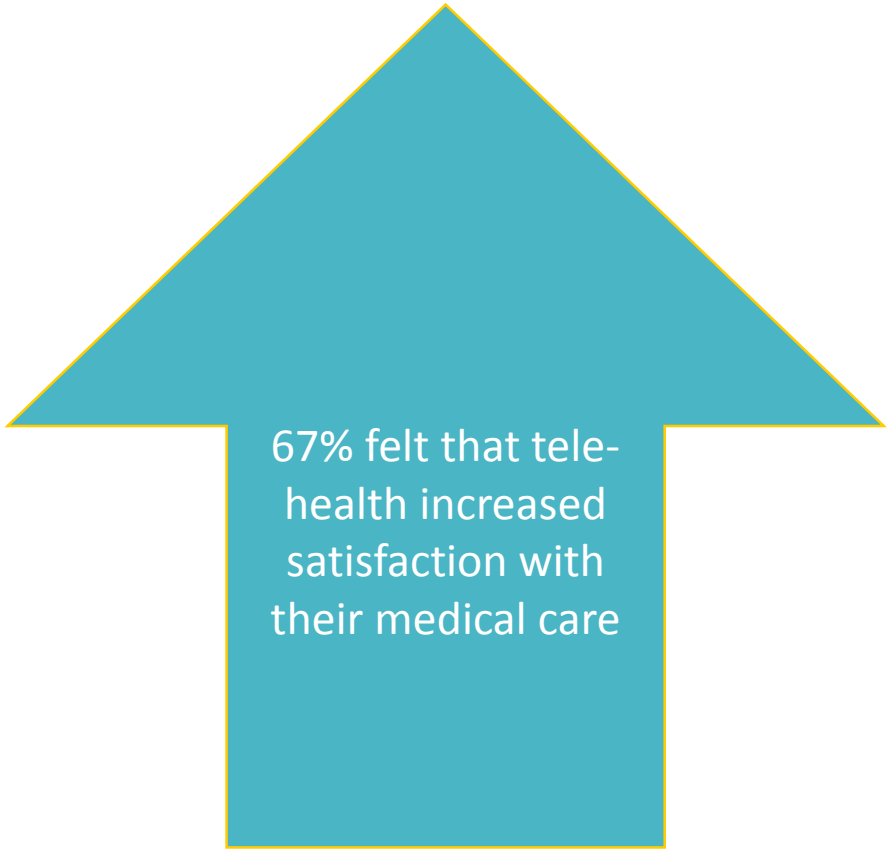
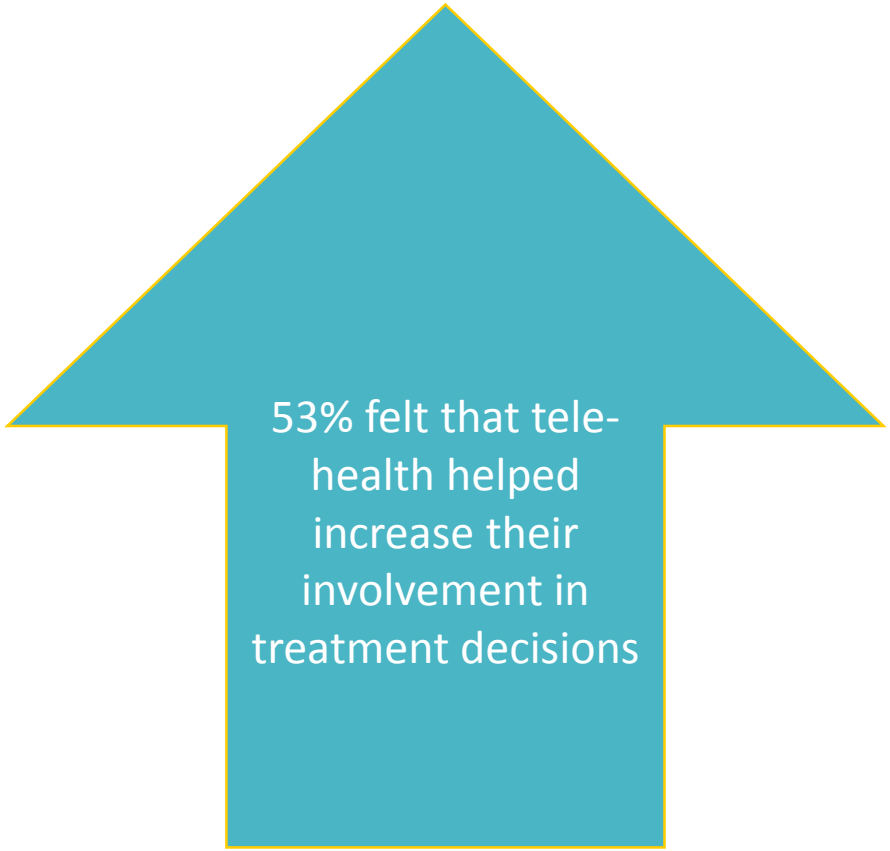
Patient Satisfaction and Engagement





https://www.softwareadvice.com/medical/industryview/telemedicine-report-2015/

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