



Better Health | Better Care | Better Cost

PreManage Use Ideas

April 19, 2016



What is EDIE?

- EDIE
 - Acronym for “Emergency Department Information Exchange” (EDIE)
 - Collects real-time ED, inpatient, and outpatient events throughout Oregon hospitals
 - All Oregon Hospitals
 - Used for the purpose of sharing data between hospitals
 - Allows emergency department clinicians to identify patients who frequently visit the emergency room or patients with complex care needs so these patients can be directed to the right setting of care.
 - A community-derived “care guideline” allows all providers to see the same instructions for the member.
- We are not a hospital so we do not use EDIE, but..

So...what is PreManage?

- PreManage is a version of EDIE designed for health plans and providers
 - Leverages the same data collected in the statewide EDIE Utility and shares it in real time with those responsible for managing and coordinating patient care
 - Users are care coordinators such as our Case Management department
 - Delivered in a web-based environment
- Allows the health plan to see Emergency Department, inpatient/transfer, and discharge activity of our members based on our defined criteria.
 - Based on pre-defined criteria established by the entity and delivered in the workflow of the caregiver or case manager
 - Notification options include email messaging, secure fax, printed reports, text, or direct interface to systems
- What data is in the record?
 - List of Care Providers
 - ED Visit Count
 - Problem List / Diagnoses / Chief Complaint
 - Medical/Surgical, Infection/Chronic Care, Substance Abuse/Overdose, Behavioral History
 - Care Recommendations and more..

Clinical and Claims Integration

Timeframe Previous 24h

10/12 3:34 PM | 10/14 3:34 PM | Now

Event Type

Admit Discharge

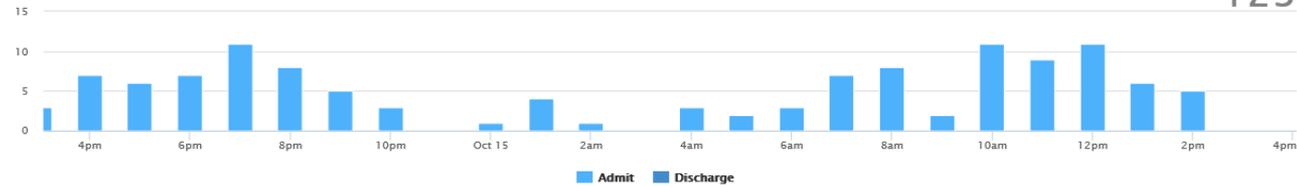
Encounter Class

Emergency Inpatient

Summary October 14, 3:34 PM — October 15, 3:34 PM

Previous 24h

123



Facilities (20) Previous 24h

- Blue Mountain Hospital District (1)
- Grays Harbor Community Hospital (1)
- Legacy Emanuel (1)
- Mckenzie Willamette Regional Medical Center (1)
- Mid-Columbia Medical Center (14)
- Oregon Health and Science University (2)
- Peacehealth Riverbend (3)
- Pioneer Memorial Hospital-Prineville (9)
- Providence Hood River Memorial Hospital (4)
- Providence Seaside Hospital (1)
- Providence St Vincent Medical Center (1)
- Providence St. Mary Medical Center (1)
- Salem Hospital (1)
- Samaritan Lebanon Community Hospital (1)
- Sky Lakes Medical Center (1)
- St. Charles - Madras (5)
- St. Charles Medical Center - Bend (54)
- St. Charles Medical Center - Redmond (20)
- Trios Southridge Hospital (1)
- Willamette Valley Medical Center (1)

Member Cohorts

Previous 30 Days

September 15 - October 14

Count	Change	Description	Activity
685	↑ 6%	Inpatient Readmission	
587	↓ -3%	5 Inpatient Visits in 12 Months	
529	↑ 1%	3 Visits In 60 Days	
392	↓ -13%	*Test* Behavioral Health (Diagnosis Codes)	
197	N/A	Has Care Guidelines	
59	↓ -3%	3 Facilities In 90 Days	
58	↑ 41%	Diabetes	
57	↓ -10%	Addiction "Abuse"	
54	↑ 29%	Asthma	
43	↑ 2%	Behavioral Health "Depression"	

*CCO Only – Gorge/Central Oregon

- Cohorts
- Census
- Scheduled Reports
- Referrals & Groups
- Notifications

Timeframe ?

Previous 3 Hours ▾

Member Cohorts 8:15am - Now ?

Count	Change	Description	Activity
19	↓ -5%	Inpatient Readmission	
16	↓ -11%	5 Inpatient Visits in 12 Months	
5	↑ 25%	Has Care Guidelines	
1	0%	3 Visits In 60 Days	
1	N/A	*Test* Behavioral Health (Diagnosis Codes)	
1	N/A	3 Facilities In 90 Days	

Previous 1 Next

Has Care Guidelines 8:15am - Now ?

Excel PDF

ID	Name	Gender	Age	Admit Time	Location
[Redacted]	[Redacted]	Female	39	Dec 24, 2015 10:09AM	St. Charles Medical Center - Bend
[Redacted]	[Redacted]	Female	44	Dec 24, 2015 08:49AM	St. Charles Medical Center - Bend
[Redacted]	[Redacted]	Female	50	Dec 24, 2015 02:14AM	Pioneer Memorial Hospital-Prineville
[Redacted]	[Redacted]	Female	42	Dec 23, 2015 12:44PM	St. Charles Medical Center - Bend
[Redacted]	[Redacted]	Female	22	Dec 23, 2015 05:50AM	St. Charles Medical Center - Bend

Showing 1 to 5 of 5 entries

Previous Next

PreManage Medicaid-Medicare Cohorts:

- **Inpatient Readmission within 30 days**
- **Dental ED & IP visits**
- **Pregnancy ED visits**
- **3 ED Visits in 60 days**
- **5 Inpatient Visits in 12 Months**
- **Has Care Guidelines**
- **6 ED Visits in 6 Months (Central Oregon)**
- **6 ED Visits in 6 Months with Care Guidelines (Central Oregon)**
- **6 ED Visits in 6 Months (Gorge)**
- **Behavior Health “Suicidal”**
- **Addiction “Abuse, ETOH, Poison”**
- **Addiction Intoxication**

Case Management (CM) was born out of UM/UR. The Team started with RNs and Member Support Specialists, then integrated Behavioral Health Specialists and Pharmacy consultations, and added Dental consultations as needed.

Traditional Health Plan CM:

- **Transitions of Care, Any Type of Inpatient Stay Monitoring, Disease Management**

Added With Growth of Population and Greater Health Plan Access:

- **Barriers in Social Determinants of Health**
- **Collaboration with Non-traditional Points of Access**
- **Lapses of Care (Poor or no PCP engagement)**
- **Co-Morbid, Uncontrolled and Complex Conditions**
- **Population Health**

Integrated Care Management Meeting Team members



Creating a shared plan of care

- The primary purpose of ICM meetings:
 - Enrich care through provider collaboration
 - Promote engagement with Primary Care Providers
 - Facilitate a common perspective and approach
- Providers and Community Partners involved in care are invited to attend in person or at least telephonically
- Development of plans promoting positive engagement with a focus on outcomes: increase provider engagement, lower risk, improve overall patient experience and health
- Core internal team will go out to provider's office and hold ICM when it is most convenient for the provider
- Most meetings are approx. 20 minutes long (per patient/member)

6 month pre/post ICM

Results from 82 members served:

- Claims reduced
- ER Visits reduced
- IP visits reduced
- BH visits increased
- PCP visits increased

Improvement Vision

“PreManage allows for real-time notification of healthcare resource use notification to health plans, medical groups and hospitals for those members/patients to whom they provide care.”

“Ideally, EDIE and PreManage tools can become community wide resources for all care givers to provide more personal, efficient and coordinated care.”

PreManage – Central Oregon Community Use Pilot

- What are the PreManage use roles of Primary Care Provider Care Homes?
- What are the PreManage use roles of the hospital Emergency Department?
- What are the PreManage use roles of the CCO Case Management team?

Central Oregon PreManage Pilot

Scoping Our Pilot – Focus Areas

- High ED Utilizers
 - 6 visits in 6 months per PreManage notifications
 - Focus on Medicaid populations
- Hospital / Clinics / Health Plan
 - St Charles Medical Center ED department
 - Prineville and Mosaic Clinics
 - PacificSource Medicaid Care Mgmt team
- Care Coordination Alignment
 - Simplify ED Follow-up activities and improve care

Improvement Objectives

1. Test the adoption of PreManage with goals of:
 - Increasing use of care recommendations
 - Defining/improving care management processes
 - Reducing overall ED utilization
2. Develop clear roles and a more coordinated approach across organizations to:
 - Reduce duplication in workflows
 - Improve Care coordination
 - Learn from others using PreManage

Central Oregon PreManage Pilot Outcome - Target Roles

1. “6 in 6” Notifications to Clinics

- Hospital sends fax to Clinics as needed for performance metric compliance (no email, but fax to Clinic electronic queue)
- Clinics receive 6 in 6 notifications directly from PreManage

2. PreManage Care Recommendations

- Care Recommendations provided by PCPs
- Target of 5 sentences
- Hospital informs PCP Care Recommendation
- Made visible to ED doctors via ED printouts
- Select Patient History data may also be entered

Central Oregon PreManage Pilot Outcome - Target Roles

3. Ensuring Care Alignment and Stratification of roles

- Level 1: Primary Care Provider Care Homes(PCPCH-enhanced clinic models) to orchestrate ED follow-up care
- Level 2: Hospital ED to use current “Health Engagement Team (HET)” to align Hospital and PCP interventions for PCPs without enhanced staffing, and when PCPCH is challenged in engaging patients
- Level 3: PacificSource to use Integrated Care Management meetings (ICMs) with providers and community partners triggered for 6 in 6’s, only as elevated by PCP and Hospital HET.