Transitions of Care: Successes and Discoveries

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Today's Agenda

Challenges and Goals – 8:05 am

Top Causes of Readmissions – 8:15 am

Discharge Readiness: Pitfalls – 8:45 am

Medication Reconciliation – 9:15 am

Break 9:45

Care Management – 10:00 am

Discharge Coordination – 10:15 am

SNF – 10:45 am

PreManage – 11:00 am

Share Something – 11:20

Q&A Panel – 11:35

Learning Objectives

- Top reasons for hospital readmissions, and how to avoid them
- How pharmacy can be an effective resource across care environments
- Leveraging systems to provide stronger discharge insight and follow-up appointment coordination

Overview:
Challenges and Goals

Jane Duck, RN, BSN – High Risk Populations Program Manager, CareOregon

Mariah Alford, PharmD, BCPS – Pharmacy Clinical Supervisor, CareOregon

Outline

- Common readmissions by diagnoses
- Root cause analysis – what really went wrong?
- Member stories
- Hospital to SNF transitions

Common Causes of 30-day readmission (Medicare):

By diagnosis:

- Heart Failure
- Septicemia
- Pneumonia
- COPD

Source: Weighted national estimates from a readmissions analysis file derived from the Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP), State Inpatient Databases (SID), 2011. https://www.hcup-us.ahrq.gov/reports/statbriefs/sb172-Conditions-Readmissions-Payer.pdf

Common Causes of 30-day readmission (Medicaid):

By diagnosis:

- Mood disorder
- Schizophrenia
- Diabetes
- Complication of pregnancy
- Alcohol-related disorders

Source: Weighted national estimates from a readmissions analysis file derived from the Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP), State Inpatient Databases (SID), 2011. https://www.hcup-us.ahrq.gov/reports/statbriefs/sb172-Conditions-Readmissions-Payer.pdf

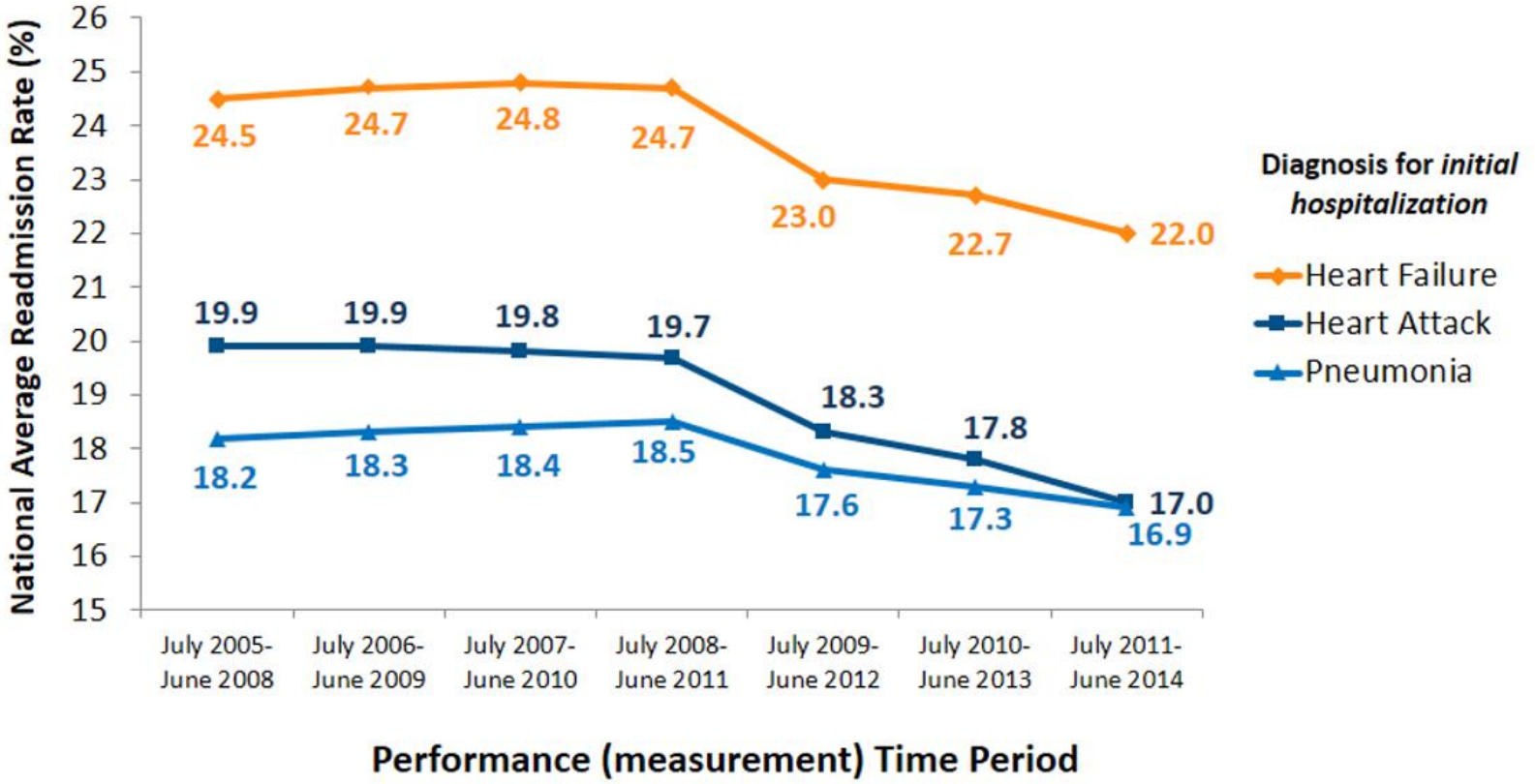
Common Causes of 30-day readmission (Commercial Insurance):

By diagnosis:

- Chemotherapy/radiotherapy
- Mood disorders
- Complications of surgical procedures
- Complications of device/implant/graft
- Septicemia

Source: Weighted national estimates from a readmissions analysis file derived from the Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP), State Inpatient Databases (SID), 2011. https://www.hcup-us.ahrq.gov/reports/statbriefs/sb172-Conditions-Readmissions-Payer.pdf

National Medicare Readmission Rates Started to Fall in 2012



Notes: National readmission rates include unplanned hospitalizations for any cause within 30 days of discharge from an initial hospitalization for either heart failure, heart attack, or pneumonia. Readmission rates are risk-adjusted for certain patient characteristics, such as age and other medical conditions.
Source: Kaiser Family Foundation analysis of CMS Hospital Compare data files.

THE HENRY J. KAISER FAMILY FOUNDATION

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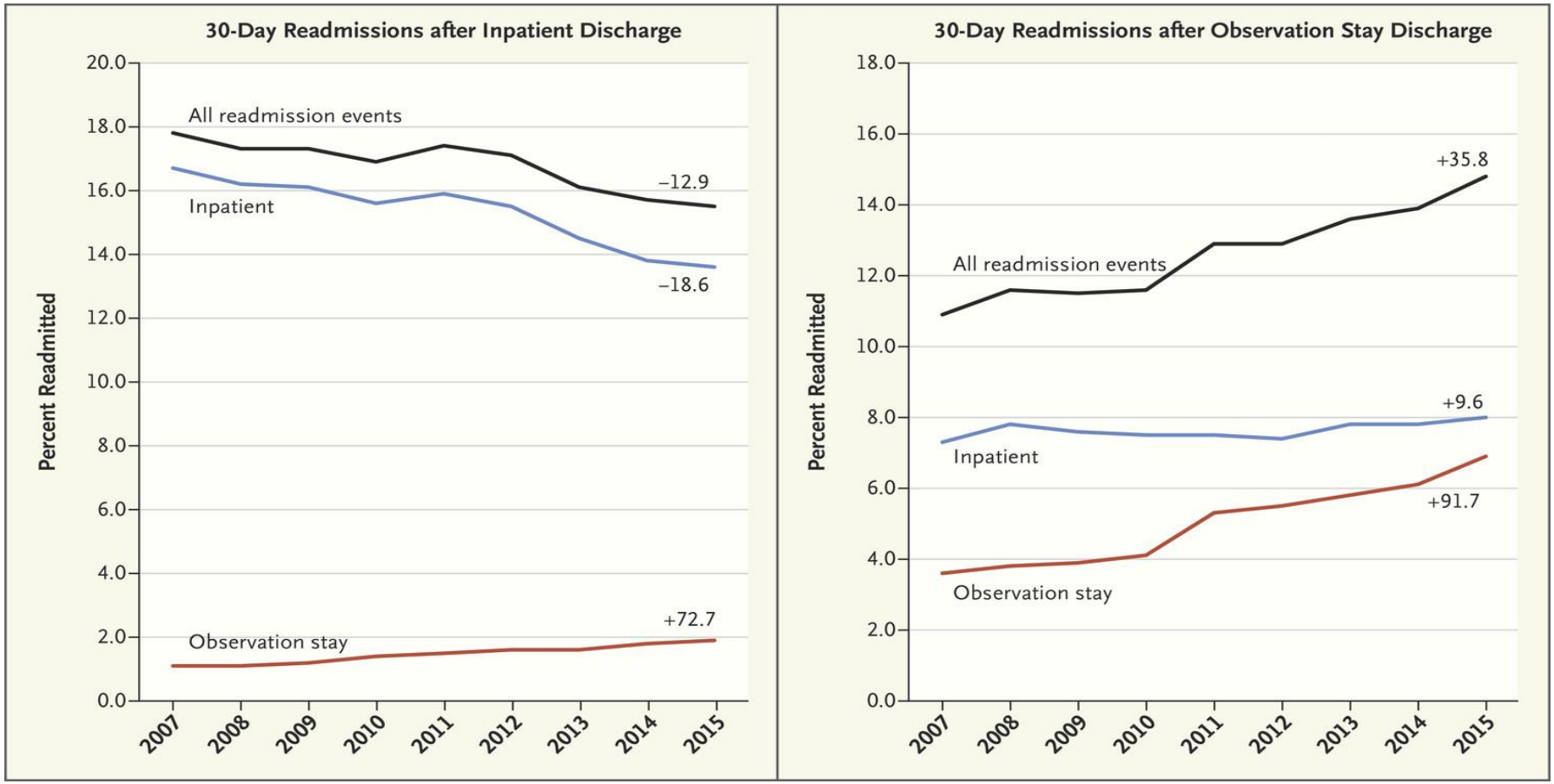
Rate of 30-Day Readmissions after Inpatient Hospitalizations and Observation Stays.



AK Sabbatini, B Wright. N Engl J Med 2018;378:2062-2065.

Pharmacists help reduce hospital readmissions at Einstein Medical Center Philadelphia

The Philadelphia Inquirer (5/30, Brubaker) reports that Einstein Medical Center Philadelphia has added three pharmacists to its staff who are "tasked with getting involved early with inpatients in a bid to reduce the chance that patients will end up back in the hospital 30 days after they are discharged." Research published this month which assessed pharmacist intervention at Einstein "found that it cut the readmission rate by more than half for traditional Medicare patients to 9.8 percent compared to 20.4 percent for a group that did not receive the interventions."

Discharge Readiness: Pitfalls and Best Practices

Jane Duck, RN, BSN – High Risk Populations Program Manager, CareOregon

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Hospital Guide to Reducing Medicaid Readmissions

Toolbox

AHRQ
Agency for Healthcare Research and Quality
Advancing Excellence in Health Care • www.ahrq.gov

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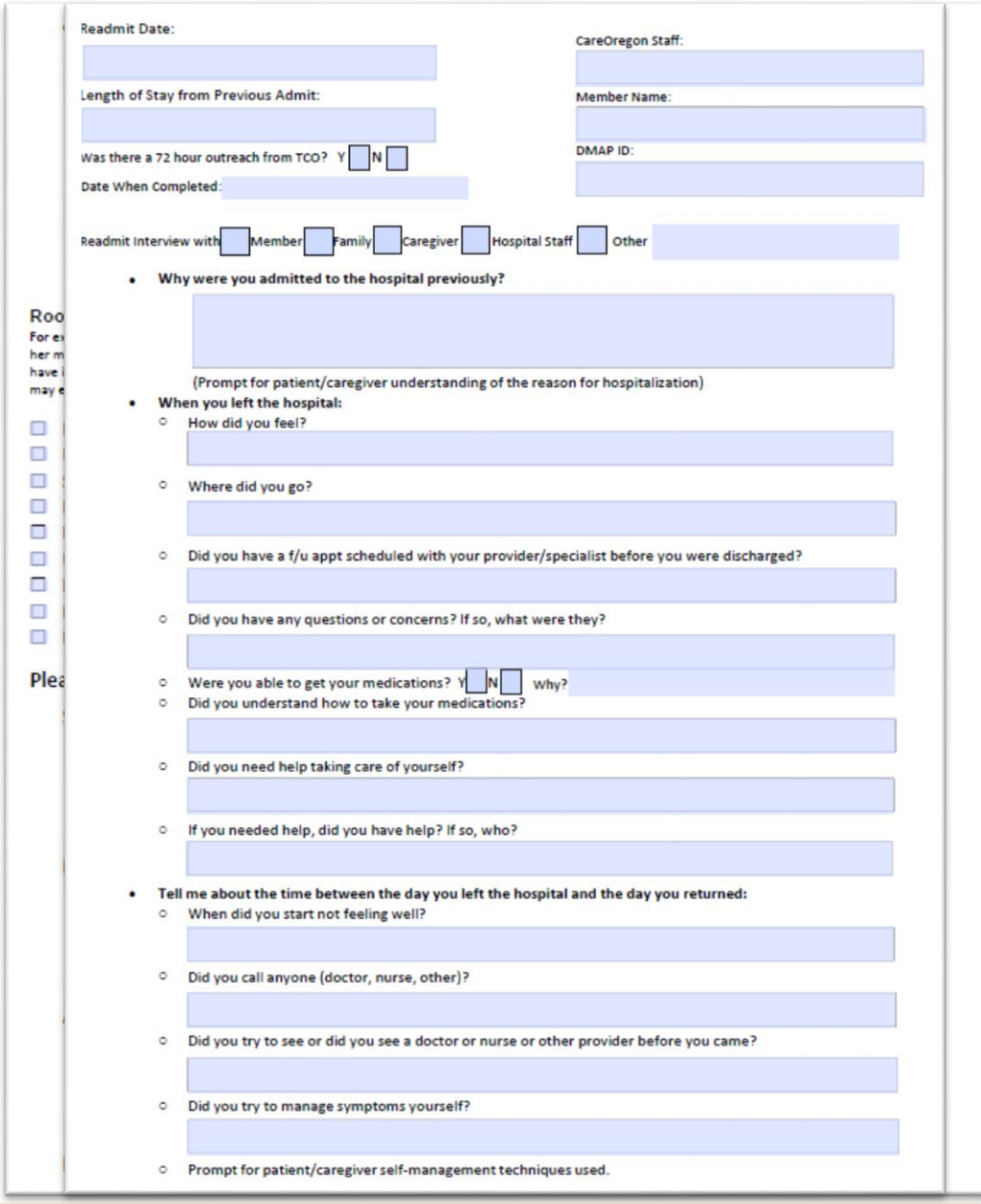
ROOT CAUSE ANALYSIS (RCA)

Readmission Interview Tool (RIT)



Readmit Date:

CareOregon Staff:

Length of Stay from Previous Admit:

Member Name:

Was there a 72 hour outreach from TCO? Y ☐ N ☐

DMAP ID:

Date When Completed:

Readmit Interview with ☐ Member ☐ Family ☐ Caregiver ☐ Hospital Staff ☐ Other

- **Why were you admitted to the hospital previously?**

  (Prompt for patient/caregiver understanding of the reason for hospitalization)

- **When you left the hospital:**
  - How did you feel?
  - Where did you go?
  - Did you have a f/u appt scheduled with your provider/specialist before you were discharged?
  - Did you have any questions or concerns? If so, what were they?
  - Were you able to get your medications? Y ☐ N ☐ Why?
  - Did you understand how to take your medications?
  - Did you need help taking care of yourself?
  - If you needed help, did you have help? If so, who?

- **Tell me about the time between the day you left the hospital and the day you returned:**
  - When did you start not feeling well?
  - Did you call anyone (doctor, nurse, other)?
  - Did you try to see or did you see a doctor or nurse or other provider before you came?
  - Did you try to manage symptoms yourself?
  - Prompt for patient/caregiver self-management techniques used.

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Readmit Date: 11/08/2017

CareOregon Staff RN

Member Name: Mr. V

- **Tell me about the time between the day you left the hospital and the day you returned:**
  - When did you start not feeling well?

    Day of discharge (Saturday 11/4). Pacemaker equipment malfunctioned. Weak, N/V, fever, confusion.
  - Did you call anyone (doctor, nurse, other)?

    Called cardiac surgeon who could not help with equipment. Called equipment company. Called cardiologist office Monday.
  - Did you try to see or did you see a doctor or nurse or other provider before you came?

    Saw cardiology Monday and PCP Wednesday as scheduled. Sent to ED from PCP office.
  - Did you try to manage symptoms yourself?

    Family advocated for help with equipment, fed mbr foods he liked, discussed different methods for pain control.
  - Prompt for patient/caregiver self-management techniques used.
- **In our efforts to provide the best possible care to you and others like you, can you think of anything that we—or anyone—could have done to help you after you left the hospital the first time so that you might not have needed to return so soon?**

  Family feels that mbr was still discharged too early with too many issues unresolved and no identified supports for equipment malfunction. Never got pacemaker monitoring equipment to work, pacemaker and monitor did not communicate. This time would like to DC to SNF so there is time for ADS screening etc. and more medical supervision.

Vital Sign Instability on Discharge Associated With Increased Risk of 30-Day Mortality and Readmission

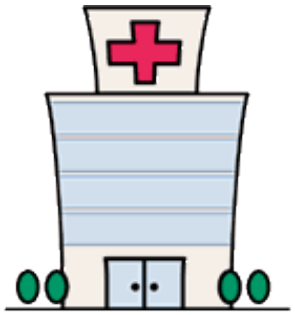
Criteria for abnormal value for a particular vital sign within 24 yours of discharge:

- Temperature ≥37.8 °C
- Heart rate >100 beats per minute
- Respiratory rate >24 breaths per minute
- Systolic blood pressure ≤90 mmHg
- Oxygen saturation <90%

VITAL SIGNS

- 18.7 % of hospitalized patients had at least one instability on discharge
- Having any instability was associated with significantly increased risk of 30-day mortality and readmission
- The greater the number of instabilities, the greater the risk of mortality and readmission

Hospital Readmission From Post-Acute Care Facilities



- ~23% of patients were readmitted at least once within 30 days.
- ~ Half of readmissions occurred within 2 weeks of discharge.
- Patients readmitted were 2x as likely to die within 30d of hospital discharge; 4x as likely to die within 100 days of discharge.
- Patients who experienced readmission were less likely to return to the community.

JAMDA March 1, 2016, Vol 17, Issue 3, Pages 249–255

Medication Reconciliation: Establishing a Continuum of Care between Health Plan and Hospital Pharmacists

Mai Tran, PharmD, BCACP, BCGP – CareOregon

Anthony Neises, PharmD, – Legacy Health

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Bedside Medication Delivery Pilot

- **Less than half** of patients discharged from the hospital fill their prescriptions on the day of discharge, and **nearly 25% fail to fill their prescriptions at all**. Medication non-adherence drives unnecessary health care utilization and costs
- A discharge medication bedside delivery program is currently being piloted with LEMC Apothecary within Emanuel hospital
- The CareOregon cohort in this workflow is given the option of being part of this pilot program

Goals:

- To ensure patients have necessary medications in-hand prior to discharge
- To reduce 30-day readmission rates of selected cohort

Admission

Inclusion Criteria
- Admitted to LEMC
- Diagnosis of:

1) Heart Failure
2) COPD
3) Myocardial Infarction
4) Atrial Fibrillation
5) DM with A1c >8.5%

Inpatient Pharmacist runs reports identifying high risk patients

CareOregon pharmacist reviews claims and clinic notes, then hands off assessment to IP pharmacist which is then placed in inpatient chart note

Inpatient Pharmacist runs reports identifying high risk patients

IP and CO pharmacists collaborate to resolve any identified barriers to medication adherence

IP pharmacist reviews discharge orders, provides patient education, and hands off discharge assessment3to CO pharmacist

CO pharmacist engages appropriate outpatient teams, including PCP clinic, for follow-up care and recommendations

Discharge

Data Analysis

n = 192	Interventional Group		Control Group	
Medicare	71 (37%)			
Medicaid	121 (63%)			
Readmission Rate	47 (25%)		58 (30%)	
	Medicare 17 (36%)	Medicaid 30 (64%)	Medicare 17 (30%)	Medicaid 41 (70%)
IP Cost Saving (average Medicaid IP visit = $9,000)	11 (5%) $99,000			
Discharged Medication List Accuracy (retrospective within 90 days)	Weekday (n = 30) 28 (94%)		Weekend (n = 26) 20 (77%)	
Sub-group analysis: - Enrollment in Palliative Care after intervention: 27 (14%) - Deceased: 14 (7%) - Severe Persistent Mental Illness (SPMI): 87% - Documented substance abuse: 45% - Documented homelessness or unstable housing: 30%				

Findings

- Improved collaboration as a result of line of communication established between IP and CO pharmacist
- Continuity of care between the outpatient and inpatient teams improved with transparency of chart note documentation
- This workflow has improved accuracy of discharge medication lists and one-year rolling readmission rates
- Palliative care is necessary with the patient populations included in this workflow, although palliative resources do not match the current demand for those services

Challenges

- Difficulty engaging clinic pharmacists in workflow due to lack of resources
- High proportion of non-impactable patients due to social or behavioral factors

Next Steps

- Obtain resources for IP transition of care pharmacist weekend coverage
- Continue expansion of meds to bed service
- Streamline workflow to accommodate time stressors
- Enlist data analysis support for ongoing study


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Br
eak

Successes and Challenges in Care Management

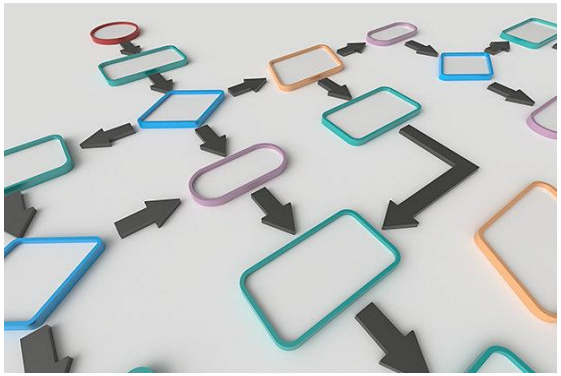
Nate Semm, CSWA, –
Legacy Health
Elizabeth Decker, RN Case Manager –
Legacy Health

True or False

Care Managers/Hospital Discharge Coordinators send people home from the hospital as fast as they can and exist only to stress families and other providers out.

False!

Process of Discharge

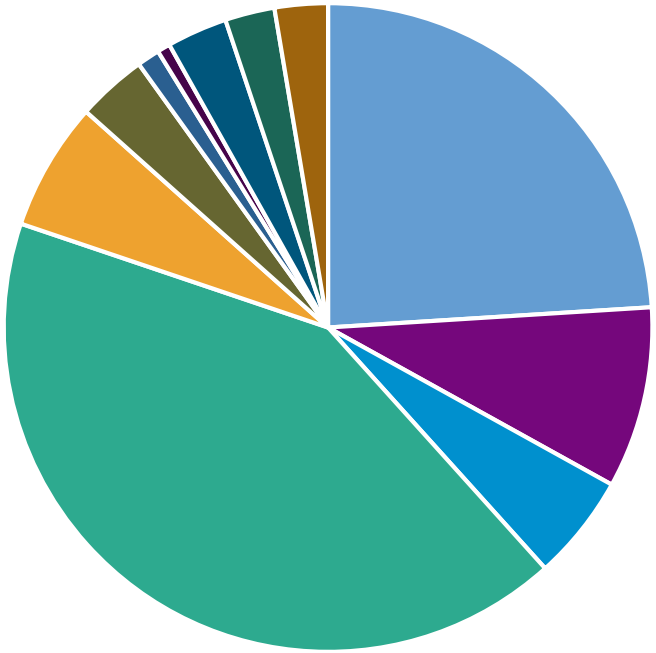


- Assessment by social worker and/or nurse cm
- Assessment is supposed to be strengths-based, and trauma and culturally informed
- Meet with IDT and discuss discharge planning
- Try to include family, personal choice and community supports if possible
- Average length of stay is between 4 and 6 days, depending on the hospital
- Not supposed to keep the individual longer than medically necessary
- Approximately 5,300 D/Cs per month across the Legacy system
- Care Management deals will about 53% of those

Transitions

- **Target: Enhance handoffs and transitions of care**
- **Results: Coordinated over 10,000 placements YTD FY 18**

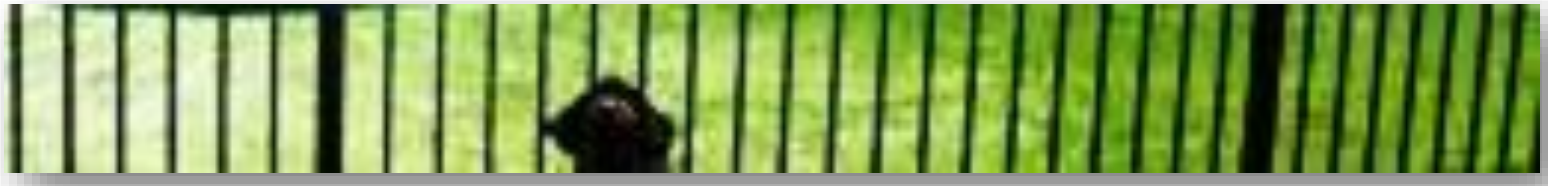
Discharge Placements



Community Partners

- Recuperative Care Program
- DePaul Residential Treatment
- Skilled Nursing Facilities (Marquis)
- Aging and Disability Services
- CCS Pool at Legacy
- Mobile Health
- Home Health

Barriers



- Houselessness
- Alcohol and Drug Use
- Not enough Beds!
- Processes
- Complex Care issues
- Transportation
- Psychiatric Diagnosis
- Lack of family/community supports
- Level of Care placement issues
- Time
- Mental health needs coupled with physical health needs
- Getting SNF Auth

Some Things Are Shockingly Not Barriers To Discharge

- Gunshot/stab wounds
- Client questionable decision making
- Houselessness
- High Risk for readmission
- Not ideal discharge plan

Story of David

David was in his 50s and had come to the ICU for acute alcohol induced pancreatitis. He was intubated for 5 days and finally woke up and started to recover. His family and friends wanted him to do inpatient treatment and then come home and do AA afterwards.

After sitting with David and talking to him about the causation of his drinking, I discovered that he was drinking to hide the pain of his ex-wife leaving him because he did not want children and he was very introverted. He and I came up with a plan for him to engage in grief counseling in a 1 on 1 setting as well as meeting with a CADC twice weekly. We talked about the stages of change and the process he was going to experience and had some of his friends present so they could know his truth. He called me 2 weeks ago and let me know he is 63 days sober and going strong.

The High-Risk Huddle

Carlo De Gregorio, Health Assistant –
Pioneers Care Team – Central City Concern

Beginnings

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HOMES HEALTH JOBS

- Huddles began using PreManage to look at all ED visits and hospital admits over the course of a week.
- List compiled – team meets to discuss each case – develop plan to outreach patients chosen by provider and CTM.
- Outreach process begins. Goal to reduce hospital readmissions & ED visits.
- Admits not that long – ED visits sometimes no more than a few hours.
- By the time we get to outreach, patients no longer in the system. Unstable population – difficult to contact. Many lack phone or address.

What Changed? PreManage

- Track high-risk patients; high utilizers
- Provides graphical data –see history; where a recent event may have occurred based on changes in ED utilization
- Coordinate care; provide insights among healthcare & service providers

The Roster

- Then:
  - Provider (DNP), Care Team Manager, Pharmacist, Nursing Director(sometimes), Health Assistant, CHIPS Worker
- Now:
  - Provider (PHNP), CTM, CHIPS, HA, SUDs (sometimes)

Process

- Compile list for the day

Receive PreManage email alert when patient is admitted

Run census to catch mental health ED visits – if pt is on Pioneer's panel & not engaged with MH services elsewhere, may get added to list

Research individual cases in EPIC & determine if patient is appropriate for High-Risk Huddle based on previous level of engagement & hospital utilization

Start a Phone Note (TRANSITION OF CARE PLAN)

Add pt to spreadsheet (redundancy – need to catch data and track by having software find TOCP documents in Centricity)

- Begin contacting hospitals to coordinate care
  - Speak to Nurse Case Manager or Social Worker directly
  - Leave message via voicemail or with bedside nurse

High-Risk Huddle – Short Term:

Determine immediate patient needs after discharge

- Are they being discharged directly back into the community or do they need somewhere to land before they are more stable and ready to care for themselves...or can they care for themselves? SNF? ALF? HH? RCP? Mainly determined by NCM & providers at the hospital – sometimes our input can be helpful
- Follow up with PCP, MHP
- Depending on the individual case, we may immediately initiate referral to specialty mental health, Summit, etc.
- Get CareOregon CHIPS worker involved

High-Risk Huddle – Long Term:

- What are the primary drivers that landed them here in the first place? SUDS, homelessness, MHD, lack of engagement…develop plan to get patients engaged/re-engaged in their healthcare…
- What services and support can we offer once the patients are willing to buy-in?
- Main goal: ask where this patient fits in the system, based on needs and help get them there
  - Identify barriers
    - How do we reduce barriers to engagement in care?

Learnings

Having PMHNP vs a NP as the provider on the team

- Many patients admitted for medical reasons (while they may be medically complex) are straightforward as far as outreach & follow-up is concerned.
- Many of the patients w/highest utilization rates have MH and/or SUDS drivers. Patients w/unmet need for a higher level of care
  - Patients that go to EDs then discharged with plan to follow-up with primary care when their main needs are MH and SUDS related.
  - Ask if patient is appropriate for primary care…
    - MH vs SUDS driven...
    - Inpatient vs outpatient…
    - What is appropriate acute care team?
  - Direct patients to those higher level of care services – CATC, Lifeworks, Cascadia, OTRC, CODA…

Learnings (cont.)

Having different team members in the huddle provides a unique lens

- CTM:
  - Relationships, medical, practical
- PMNHP
  - behavioral and SUDs
- CHIPS
  - Expertise and familiarity with outside resources through CareOregon or the team

Learnings (cont.)

- Knowing ahead of time (especially with MH patients) allows the team to be more responsive & proactive
  - We know what's going on, what they've been through & where they've been **before** they even get to the clinic
- We now know which our "Loyal Patrons" of the EDs
  - More eyes on them
  - Getting to know what makes them tick and have a finger on the pulse

Despite all the hard work, best efforts, collaboration and coordination:

- There are still gaps in communication w/ hospital teams
  - Even when we recommend something and outreach **ACTIVELY** (OTRC intakes), patients still get discharged without anything being done
- Patients refuse resources offered:
  - to engage in health care, groups, counseling/SUDs counseling
- Patients still don't show for follow-up appointments

Questions?

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HOMES HEALTH JOBS

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SNF 101

Meryl Manley, RN, PCCN –
Post Acute Care Manager – Prestige Care

Basic Information

Talking about an “average” SNF is really hard to do because each one is quite different. But here is some generalized information:

- Roughly 140 SNF’s in Oregon
- Size: Approximately 60-70 beds (small SNF 40, larger SNF > 100)

Staffing

- CNA ratios are set by the State.
  - In Oregon it is 7:1 on day shift, 11:1 on eves, and 18:1 on Noc.
- Nurses do not have a regulatory ratio, unfortunately, so the only requirement is to have 8hrs of RN coverage/24 hour period.

Sample nurse staffing from SNF with census of 75

- Day shift: 4 “charge nurses” (SNF calls the bedside care/floor nurses *Charge Nurses*)
- Evening shift: 3 charge nurses
- Night shift: 2 charge nurses

So……. A SNF nurse (either an RN or LPN) can be responsible for 18:1 on days, 25:1 on eves, and 38:1 on Nocs. Without the support of RT, IV team, in-house lab, etc.

Who else is in the building M-F?

- 1 DNS (Director or Nursing)
- 4 RCMs (Resident Care Managers)
- The Administrator and all department heads – Business Office, Dining Services Manager, Social Work, Medical Records, Activities Director, Admissions Director, Maintenance, Housekeeping/Laundry, Rehab Director, Receptionist.

- Therapy can be provided 7 days/week and the number of PT/OT/ST is determined by the case load in the building. How many patients are getting therapy 5-6 days/week compared to 3-4, etc.

MD and LIP coverage

(Can vary greatly)

- Using the same example of a census of 75 patients, a Medical Director (“Facility MD”) might be following about 75% of those patients (about 55 patients).
- Most buildings have their doc in at least one day/week, who spends 4 to 8 hours in the building. Others have physicians two or three days a week, and more are getting daily coverage by a NP/PA.
- A typical rounds list for the Medical Director can be from 12 to 20 patients. So not every patient is seen each time the MD is in the building.
- Once the initial visit has occurred for new patients, they may be put on the rounds list to be seen due to referral by the nursing staff, by patient or family request, or by the MD’s request as a follow-up. New patients are seen again within 30 days of the initial visit. Patients in SNFs must be seen by a physician at least every 60 days by regulation.

Regulatory Considerations

- **RESIDENT RIGHTS:** A SNF patient has the "right" to refuse meds/treatments, leave the facility, or otherwise decline care
  - Once a patient has completed their course at the SNF, it is required that we have a safe discharge planned, and, *the patient and their family determine what is considered safe*
- **SNFs are HIGHLY regulated (2nd only to the nuclear energy industry) and require orders for EVERYTHING (OTCs, orthotic use, etc.)**
  - "IJ" survey tags – Immediate Jeopardy tags carry hefty fines (from $3,000 to $10,000 per day) and can put a facility into "stop placement"
    - Smoking paraphernalia in resident room
    - Physical altercations between residents
    - Threat of psychological harm considered as serious as physical harm
    - Falls and elopement risk
    - Meds at the bedside (including cough drops, nose spray, eye drops)

Common Pitfalls

- Follow-up appointments
  - AVS is sent with patient, but the SNF receives no ORDERS
  - Patient is told at the appointment they are ok to discharge home, without confirming the plan with SNF
  - Because SNF care is still considered “inpatient” there can only be one attending physician. Problematic with PCP visits while patient is being followed by facility MD.
- Medications
  - Clinic MD sends prescriptions to the pharmacy instead of SNF
  - Failure to re-initiate home regimen. Who’s steering the ship?
- Insurance and Authorizations
  - DME, Medications, eligibility for services

Opportunities for Collaboration

- **Hospital DC to SNF**
  - SNF Admit/Stay
    - Planning for SNF DC
      - Avoiding hospital readmit
        - » Mental Health, SUD, and MAT

Ultimate Goal: Get everyone playing the same game….

With the same set of rules!

  - Hospital, CCO/ Health plans, Post Acute, Primary Care, Long Term/ADS, community supports, specialists, family/care givers, pharmacy
  - Pilot: CareOregon/Prestige/OHSU to establish workflows and best practices for communicating and working together.

PreManage for Post-Acute Care

Elizabeth Whitworth, MPH –
PreManage Project Manager – CareOregon

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Quick Survey

By show of hands,

- How many of you know what EDIE is?
- How many of you use EDIE?
- How many of you know what PreManage is?
- How many of you use PreManage?

What are EDIE and PreManage?

- **What:** Software products via EMR or Web platforms provide ED & IP hospital event data plus limited clinical information
- **Who**: Developed by CMT—Collective Medical Technologies, Salt Lake City, UT
- **How:** 2 products working in tandem across the care continuum:
  - **EDIE**—Emergency Department Information Exchange
    - Connects hospitals to hospitals via a centralized database of ADT feeds
    - Users are ED docs and other ED providers
  - **PreManage**—Companion product to EDIE
    - Provides access to the EDIE database to CCOs, health plans, clinics, SNFs based on active enrollment or treatment populations
    - Users are care coordinators, case managers, analytics teams and others
- **Why:** For ED & IP utilization management & care coordination around patient transitions of care—with options to focus on high risk patients

Collective Medical Technologies

POST-ACUTE CARE

WWW.COLLECTIVEMEDICALTECH.COM

We Cover…

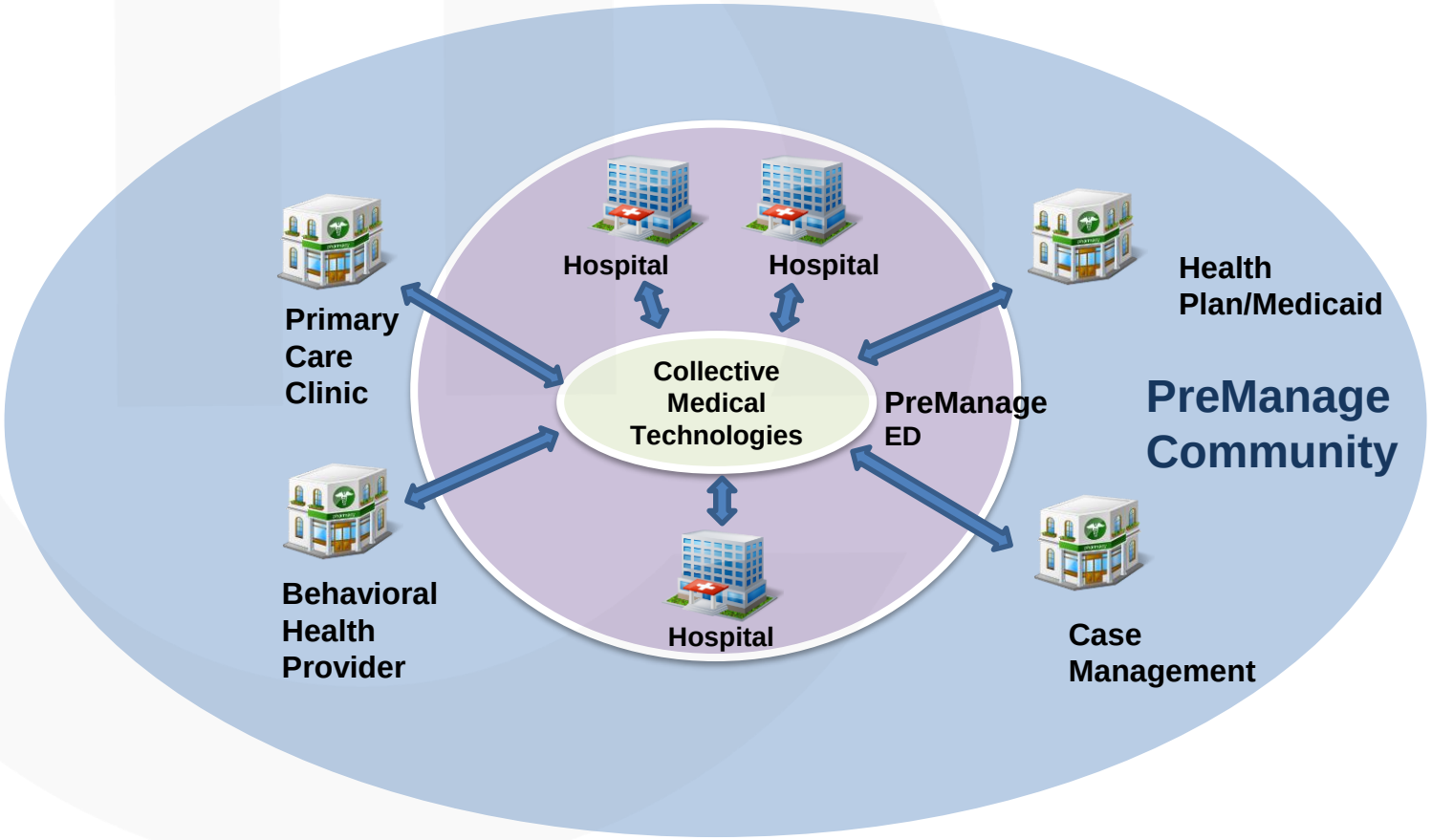
- 25,000,000+ Lives

- 200+ Hospitals (100% in OR and WA)

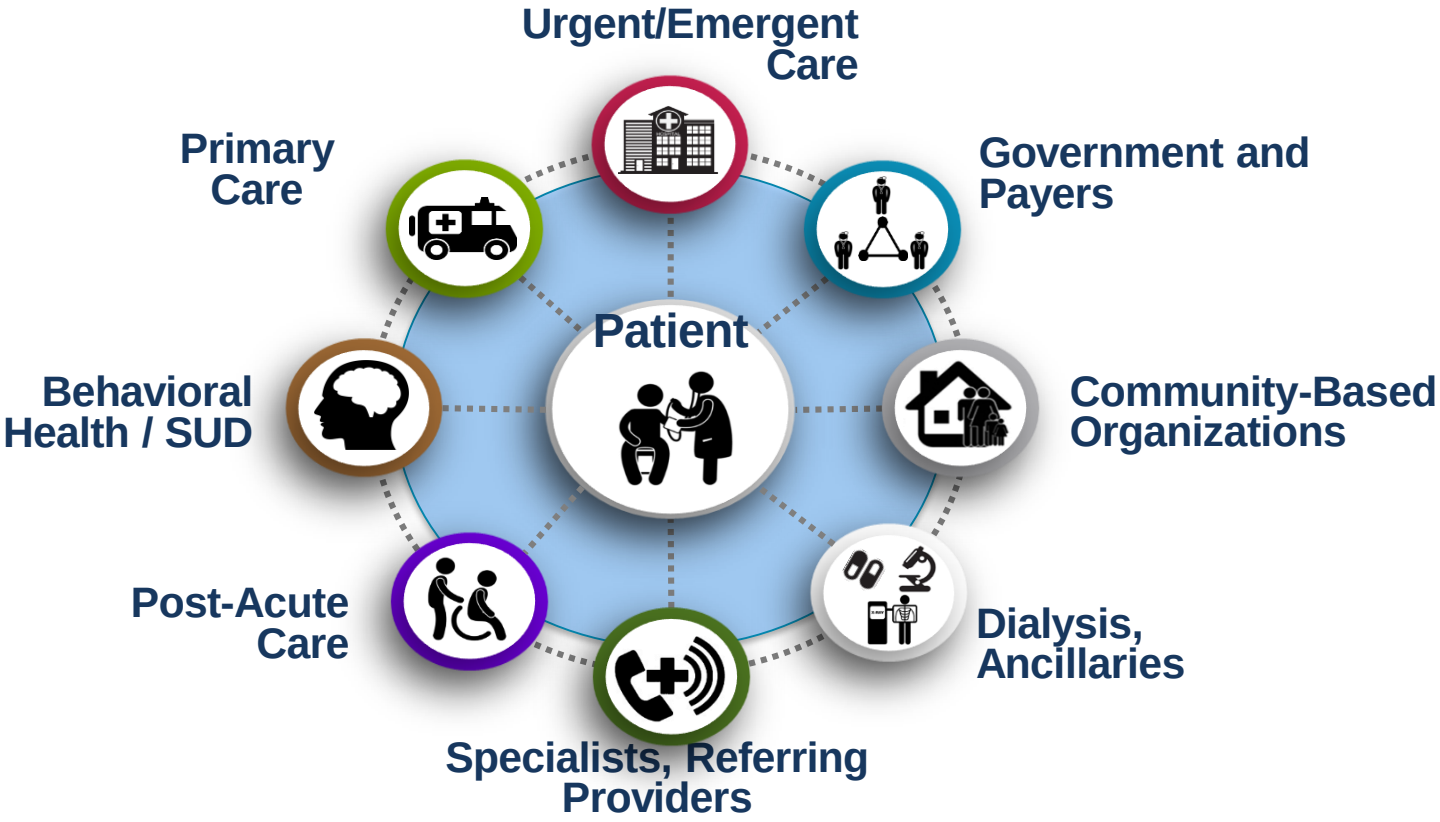
- 1,400 Clinics and Other Providers

- 30+ Health plans, ACOs, Health homes

CMT Network



Collaborative Coordinated Care in Real-Time



By connecting providers through real-time admission and discharge notifications, we strive to help providers transform the way care is delivered.

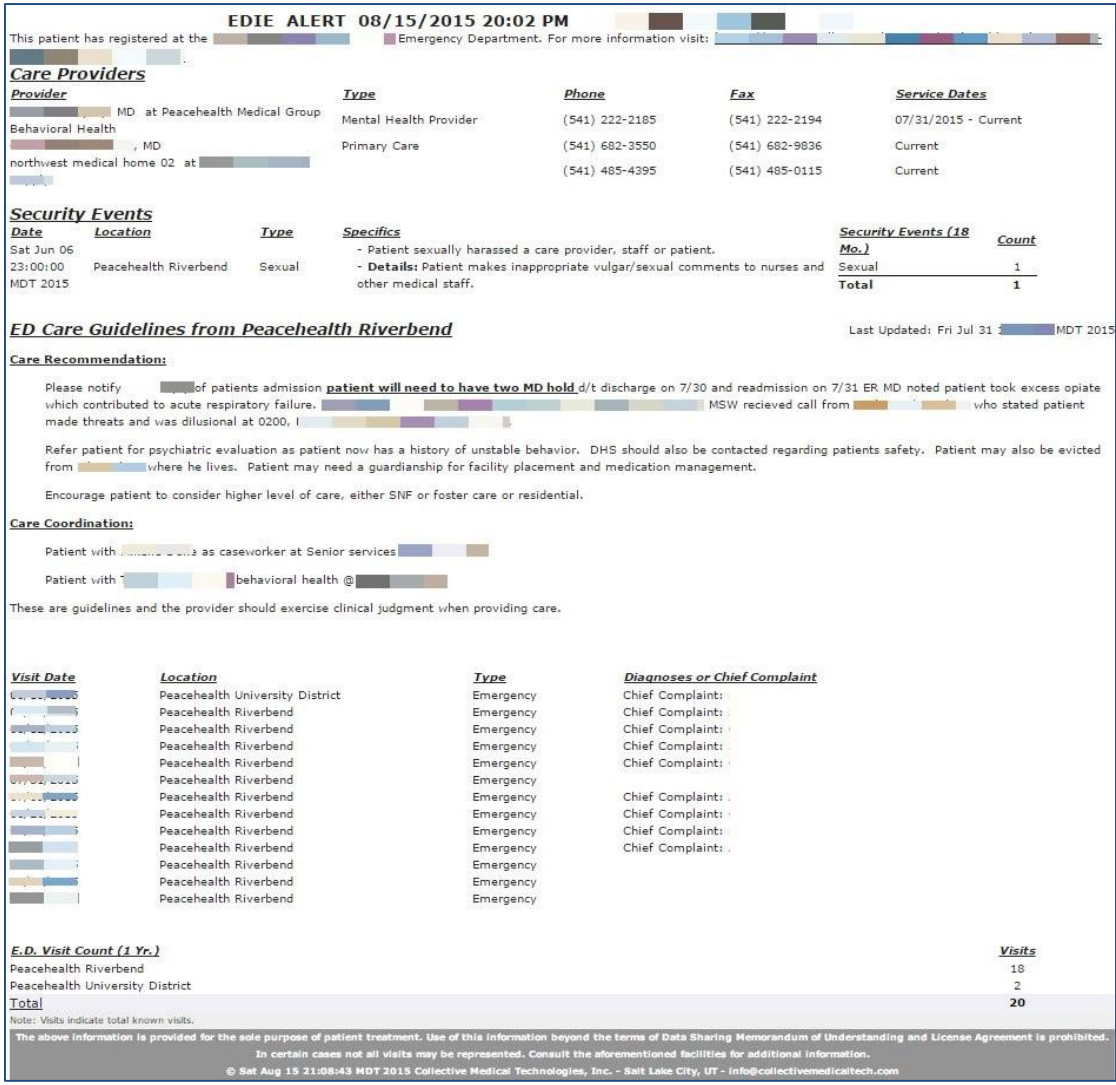
EDIE/PreManage in Oregon

- **2014** EDIE launched as a collaborative effort of OHLC, OHA, OAHHS and CMT
- **By end of 2015**, all 60 Oregon community hospitals had implemented EDIE
  - VA and State Psych hospitals in process
- **Mid 2015,** CCOs, health plans began adopting PreManage
- **2016-2017** PreManage adoption spreads to PCP & BH clinics
  - Unity hospital goes live in EDIE Jan 2017
- **2018** Work continues to extend EDIE/PreManage network and coordinate care across organizations.
  - Over 500 entities now Live or Onboarding w/ PreManage
  - SNF onboarding w/ PreManage begins

What is an "EDIE"?

An EDIE is a notification about a patient that can be delivered in different ways

- Email/Text Message
  - Link to the web application
- Fax/Print Notification (shown at right)
- Integrated into EMRs



EDIE ALERT 08/15/2015 20:02 PM

This patient has registered at the [redacted] Emergency Department. For more information visit: [redacted]

Care Providers

Provider	Type	Phone	Fax	Service Dates
[redacted] MD at Peacehealth Medical Group Behavioral Health	Mental Health Provider	(541) 222-2185	(541) 222-2194	07/31/2015 - Current
[redacted], MD northwest medical home 02 at [redacted]	Primary Care	(541) 682-3550	(541) 682-9836	Current
		(541) 485-4395	(541) 485-0115	Current

Security Events

Date	Location	Type	Specifics
Sat Jun 06 23:00:00 MDT 2015	Peacehealth Riverbend	Sexual	- Patient sexually harassed a care provider, staff or patient. - **Details:** Patient makes inappropriate vulgar/sexual comments to nurses and other medical staff.

Security Events (18 Mo.)	Count
Sexual	1
Total	**1**

ED Care Guidelines from Peacehealth Riverbend

Last Updated: Fri Jul 31 [redacted] MDT 2015

Care Recommendation:

Please notify [redacted] of patients admission **patient will need to have two MD hold** d/t discharge on 7/30 and readmission on 7/31 ER MD noted patient took excess opiate which contributed to acute respiratory failure. [redacted] MSW recieved call from [redacted] who stated patient made threats and was dilusional at 0200, [redacted]

Refer patient for psychiatric evaluation as patient now has a history of unstable behavior. DHS should also be contacted regarding patients safety. Patient may also be evicted from [redacted] where he lives. Patient may need a guardianship for facility placement and medication management.

Encourage patient to consider higher level of care, either SNF or foster care or residential.

Care Coordination:

Patient with [redacted] as caseworker at Senior services [redacted]

Patient with [redacted] behavioral health @ [redacted]

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

Visit Date	Location	Type	Diagnoses or Chief Complaint
[redacted]	Peacehealth University District	Emergency	Chief Complaint:
[redacted]	Peacehealth Riverbend	Emergency	Chief Complaint:
[redacted]	Peacehealth Riverbend	Emergency	Chief Complaint:
[redacted]	Peacehealth Riverbend	Emergency	Chief Complaint:
[redacted]	Peacehealth Riverbend	Emergency	Chief Complaint:
[redacted]	Peacehealth Riverbend	Emergency	
[redacted]	Peacehealth Riverbend	Emergency	Chief Complaint:
[redacted]	Peacehealth Riverbend	Emergency	Chief Complaint:
[redacted]	Peacehealth Riverbend	Emergency	Chief Complaint:
[redacted]	Peacehealth Riverbend	Emergency	Chief Complaint:
[redacted]	Peacehealth Riverbend	Emergency	
[redacted]	Peacehealth Riverbend	Emergency	
[redacted]	Peacehealth Riverbend	Emergency	

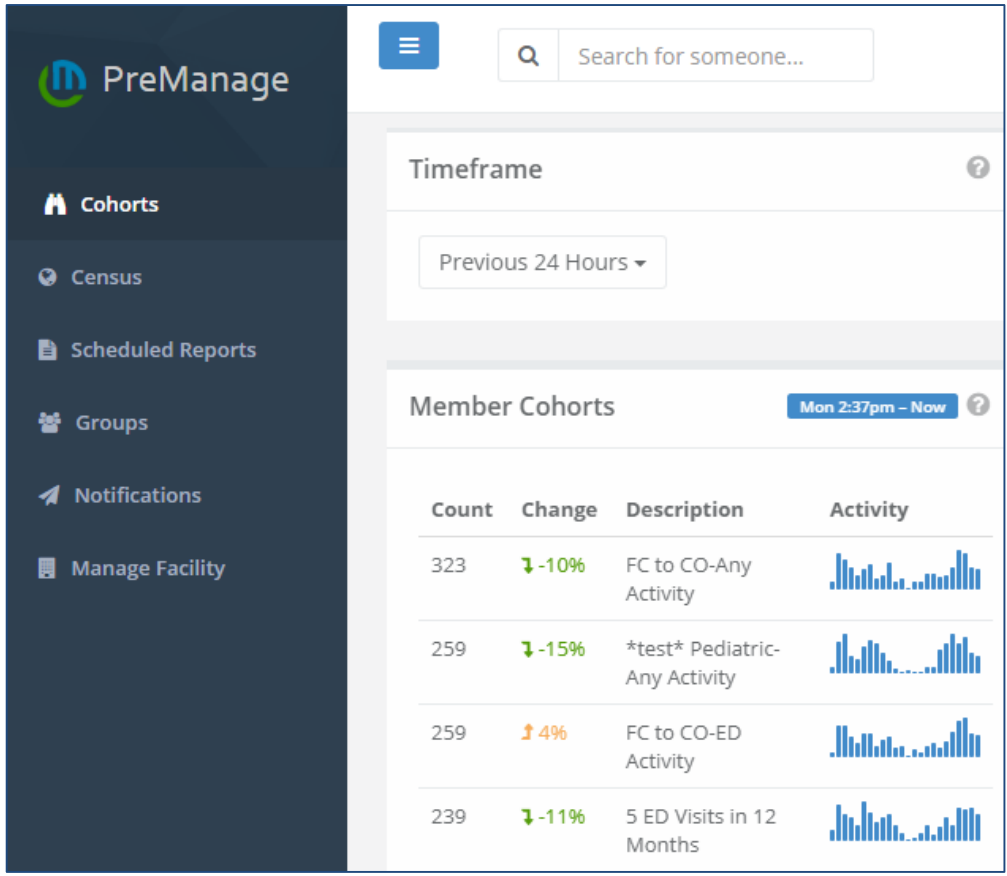
E.D. Visit Count (1 Yr.)	Visits
Peacehealth Riverbend	18
Peacehealth University District	2
Total	**20**

Note: Visits indicate total known visits.

What is PreManage?

PreManage delivers EDIE information about enrolled patients in different ways

- **Cohort** lists based on criteria
- **Census** data (ED & IP)
- **Scheduled Reports**
- **Groups** (aka ‘flags’)
- **Notifications**
- **Patient Background**
- **Care Recommendations**



PreManage Email Notifications (aka Alerts)

PreManage Notification 5 visits or more in 12 months

From: notify@ediecareplan.com

PreManage™

Sat Apr 18 10:03:00 MDT 2015

Information regarding a patient meeting Notification Criteria is available on PreManage.

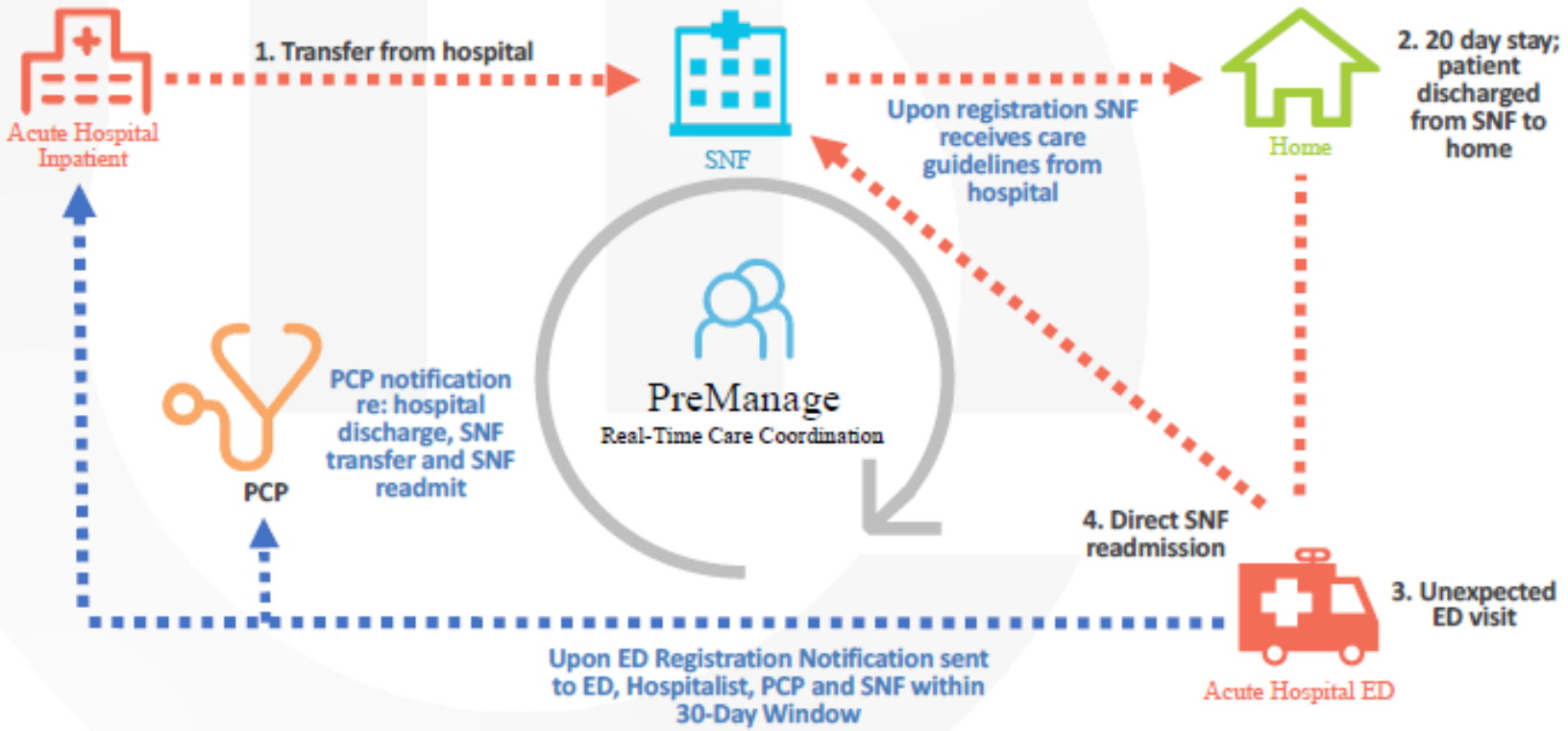
To view the patient's encounter information, please visit:

https://secure.ediecareplan.com/notify/3cc23897-1cf0-4331-9236-f169b0

PreManage for SNF

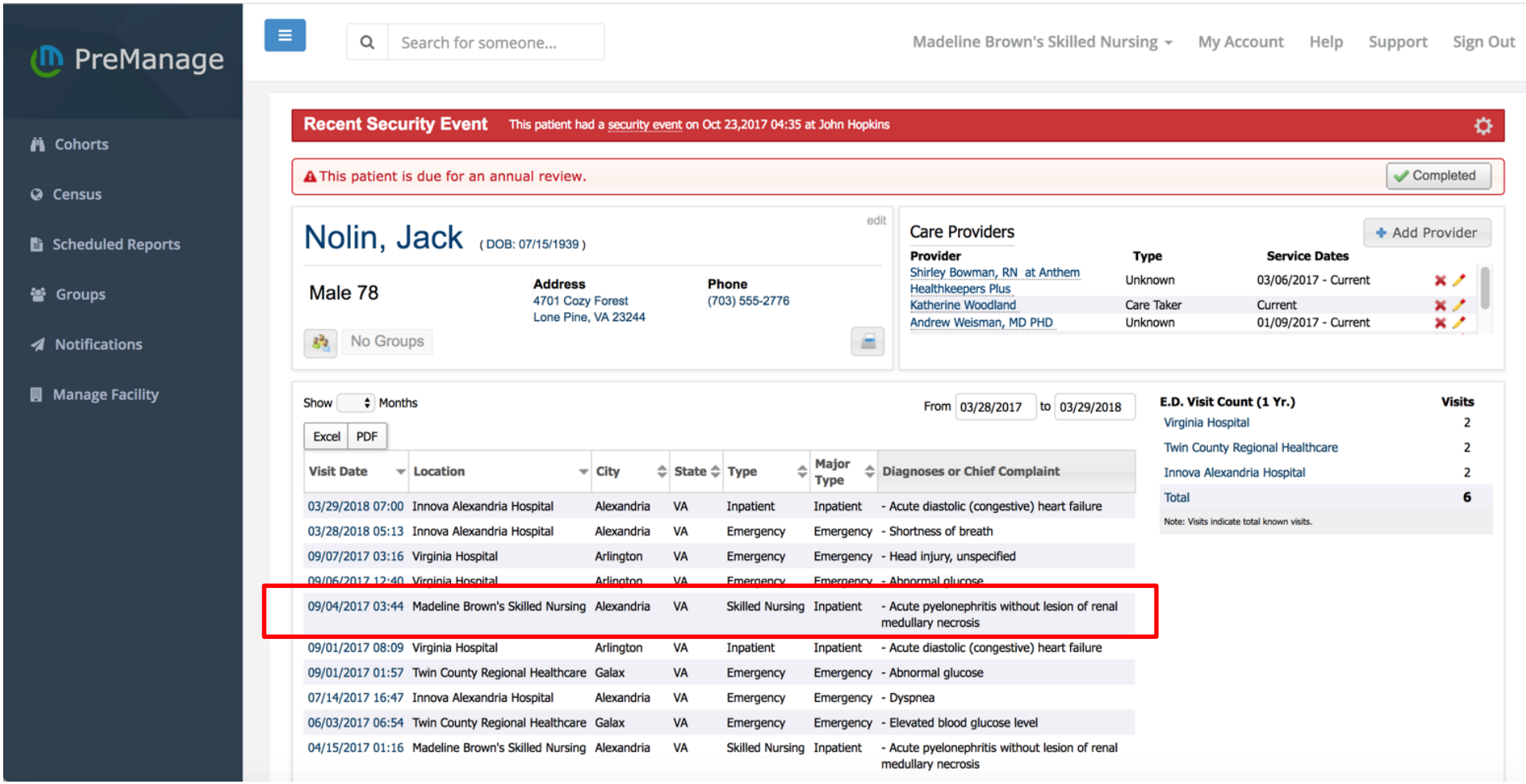
- EDIE/PreManage now expanding to SNF partners
- CMT is in active onboarding with:
  - Marquis (5 PreManage pilot sites in Portland metro area close to Live)
  - Prestige Care (all WA and OR sites in IT planning stages now)
- Prestige, CareOregon, OHSU and others are working on a pilot project to develop shared workflows utilizing PreManage

Patient Scenario: Risk of 30-Day Readmission



CollectiveMedical

SNF Data in Patient Utilization History



CareOregon

MEDS Ed

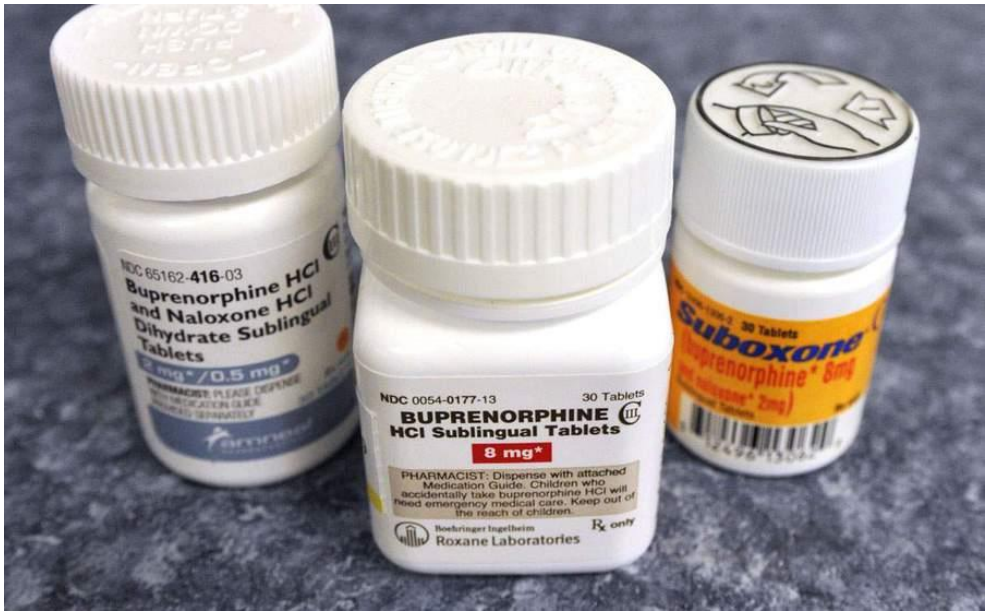
Thank you!

Share Something
Need Something

Question Time

Next Session:

Substance Use Disorder



October 12, 2018

Thank you!