

Coordinating Care to Improve Population Health, Increase Consumer Satisfaction and Create Shared Savings

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St Charles Health System**

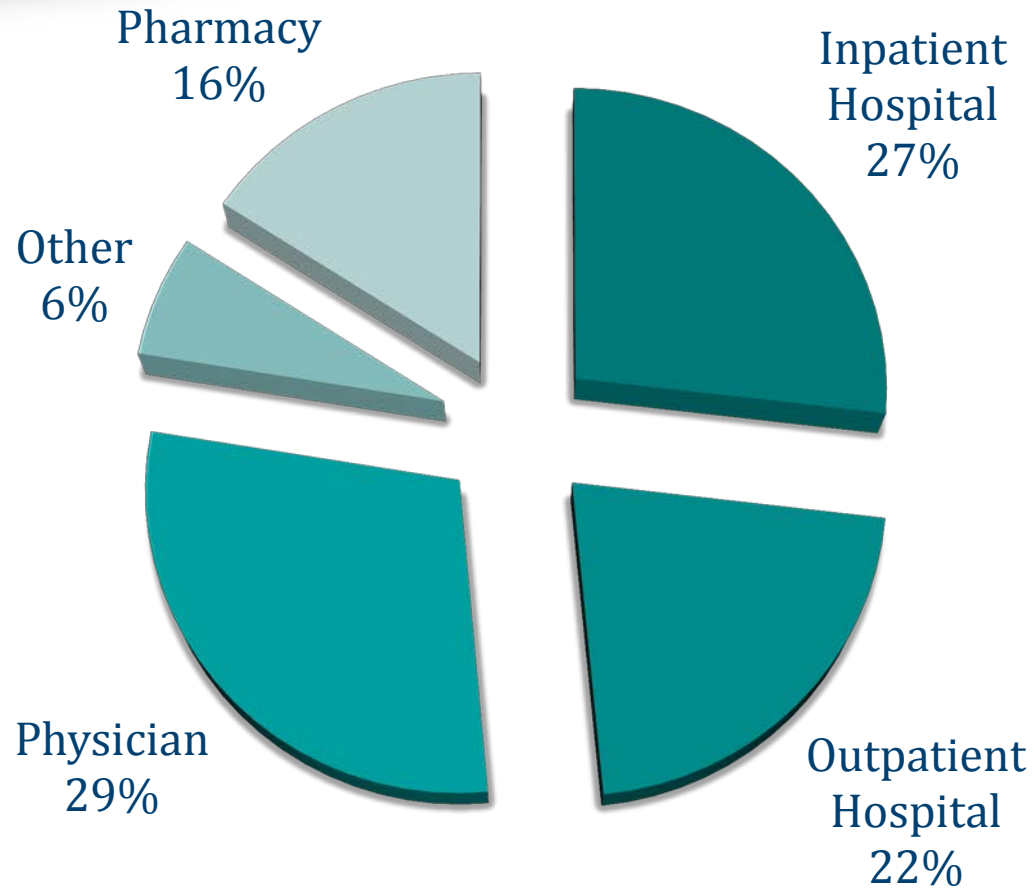
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Our work to date (examples)

- **2009 Budget Note**
- **State pilot**
 - **ED diversion, coordinated care**
- **Integration of physical and behavioral health**
 - **BHCs, FQHCs, BH specialty clinic**
- **Counties unified thru CO Health Board (county roles)**
 - **Public health, mental health, safety net**
- **SB 204 (2011) created CO Health Council**
 - **Integrated regional planning**

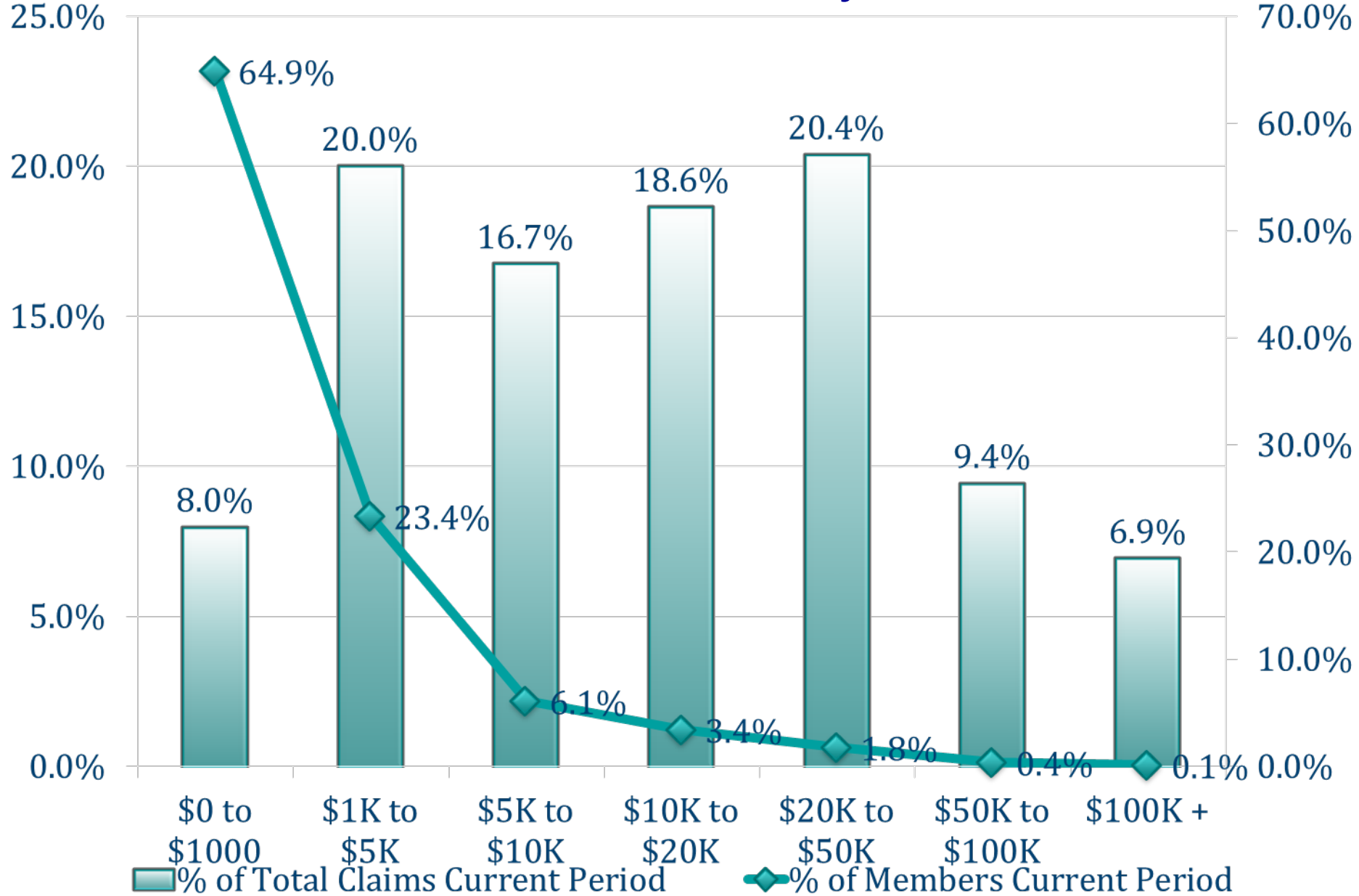
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Distribution of non-MH Claims Paid



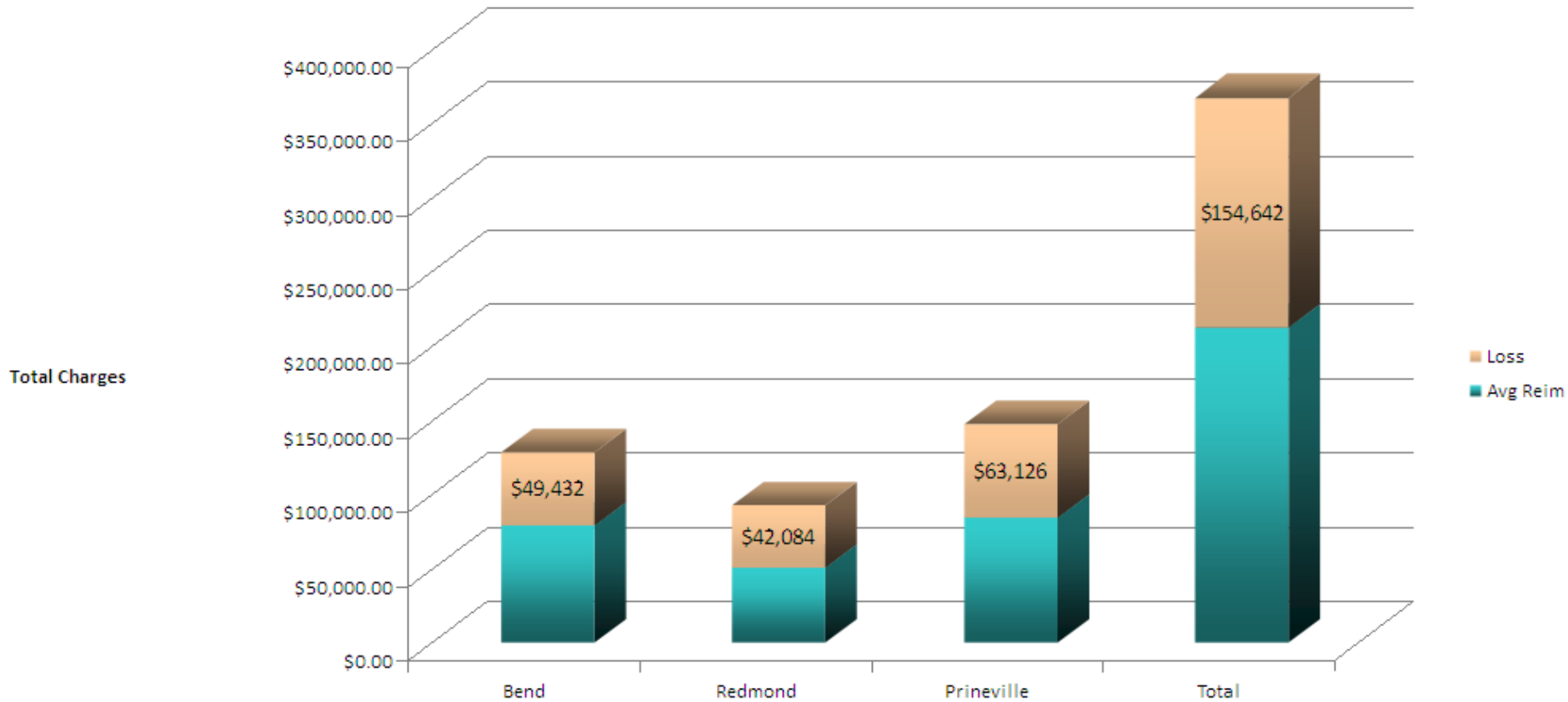
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Claims Distribution by Member



Total ER Charges 10/08 - 9/09

Top 5 Frequent ER Visitors



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Reduction of Non-Emergent ED Usage

- Project focused on reducing non-emergent use of the Emergency Department in regional Emergency Department's using Health Engagement Teams, Behavioral Health Consultants and Community Health Workers
 - 274 Patients in the first cohort; over 600 identified participants to date
- 144 of these are actively identified needing intervention
 - Patients removed from study due to
 - Death
 - Relocation (moved, jail, etc.)
 - Data issues from the original pull

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Who is this Population?

- Thirteen or more Emergency Department visits/year
- Diagnostic cluster one or more of the following:
 - Mental Health diagnosis
 - Chronic Pain
 - Addiction
- Initial assumptions:
 - Primarily Indigent: **WRONG**
 - Lack of Primary Care Home: **WRONG**
 - Primarily chronic mental health: **WRONG**

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Who They Really Were

- Primarily Medicaid Recipients
- Always enrolled in Primary Care Home
 - Did not know who PCP was
 - Kicked out of Primary Care Home due to missed appointments or other behavioral issues
- Rarely engaged with Mental Health services
- Complex Social Health issues
- Often clusters of familial or socially related individuals
- Eager to engage in care

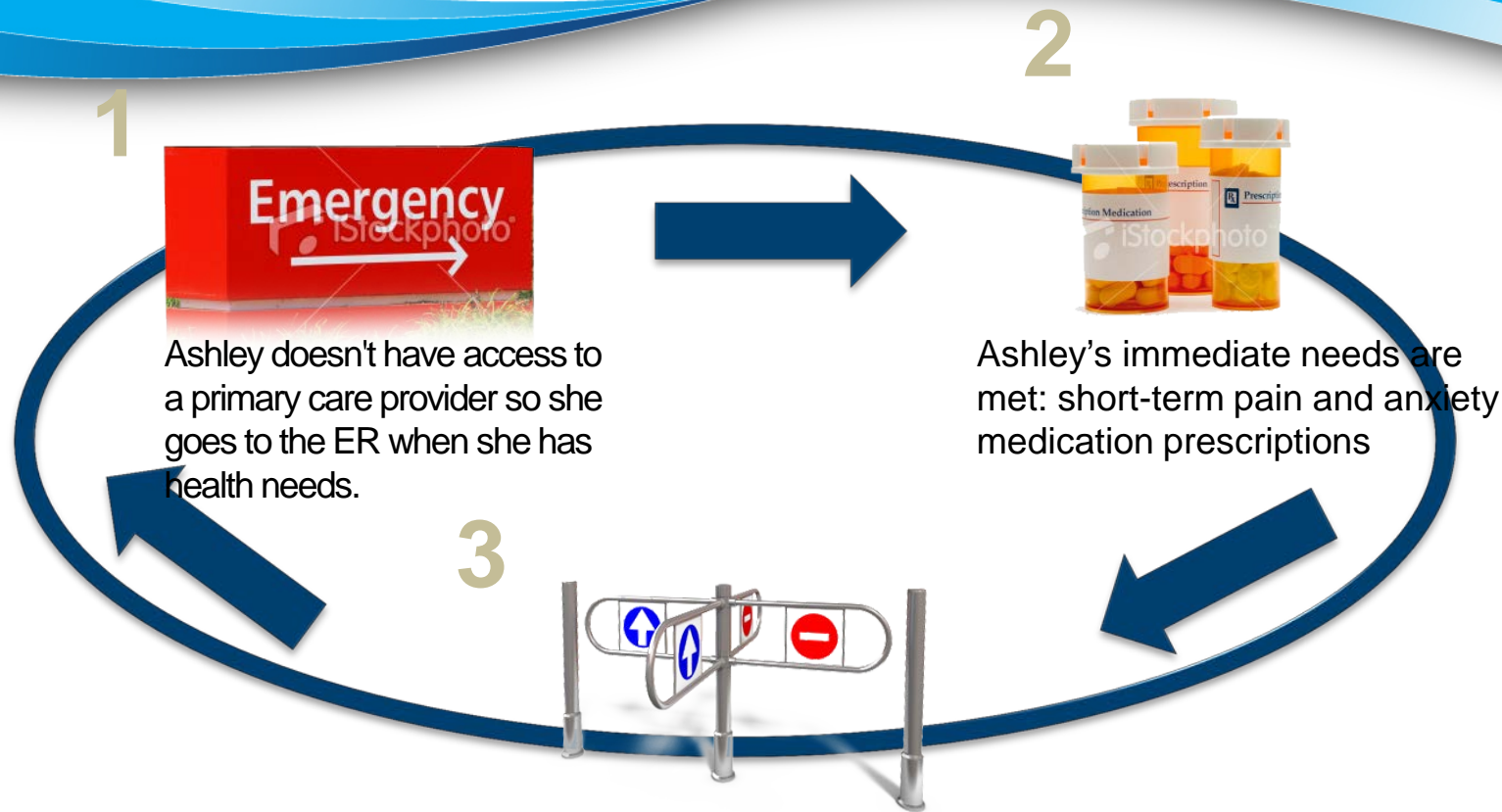
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Meet Ashley.

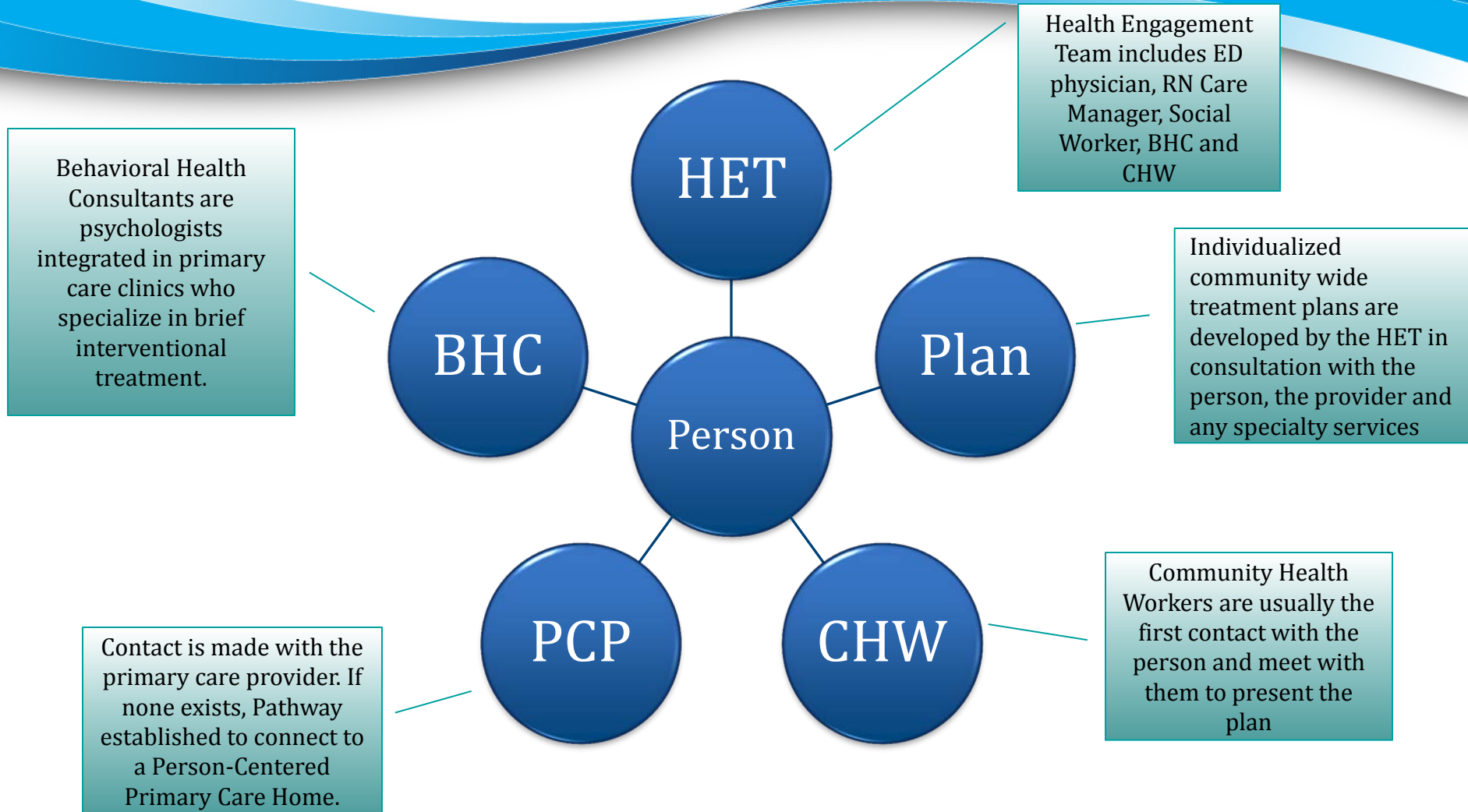
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Ashley attempts to negotiate the barriers of her primary care community.



She's referred to Community Mental Health for her anxiety disorder but she's not acute enough to qualify for county services

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- Primary Focus: the 90%
 - Social Disparities of Health
 - Poverty
 - Food Insufficiency
 - Transportation
 - Healthcare Navigators
 - Walk alongside the patient
 - Based in ER and in PCPCH
 - Voluntary Program
 - Under Supervision of RN Care Coordinator or Behavioral Health Consultant

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- Psychologists work with medical providers in shared system
 - Focus on behavioral interventions for medical conditions
- Always available for consultation and interventions with patients
 - Primarily unscheduled
 - Some targeted appointments
- One integrated treatment plan covers full spectrum of patient's needs
- Shared medical record

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- **Medically Unexplained Physical Symptoms**
 - Cyclical Vomiting
- **Plan of care attached to ED Record**
 - Interventions
 - Plan for Discharge
- **Behavioral Health Plan**
 - Plan for care from Community Mental Health
 - Children
 - Elders
- **Increased Provider satisfaction**

Decline to Participate

- Medication Seeking Behaviors
 - Regional Pain Contract
 - Pain School to obtain medication
- Chronic Mental Health Conditions
 - Alternative plan with Community Mental Health
- Illegal Behavior
 - Seeking drugs for others
- Generational
- ED as Primary Care
 - Urgent Care intervention

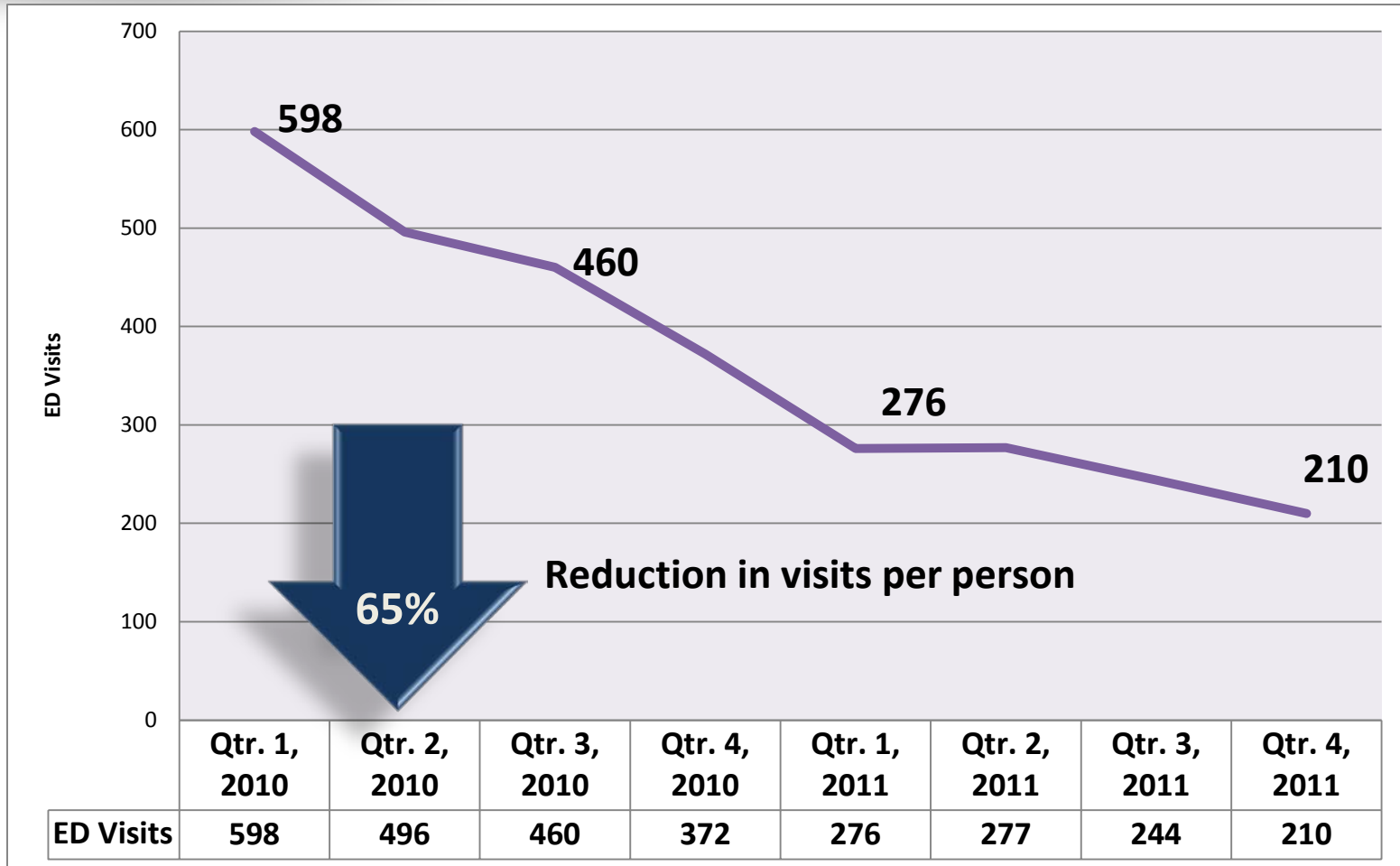
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Legislators like shiny, sparkly things....

....that finance real change

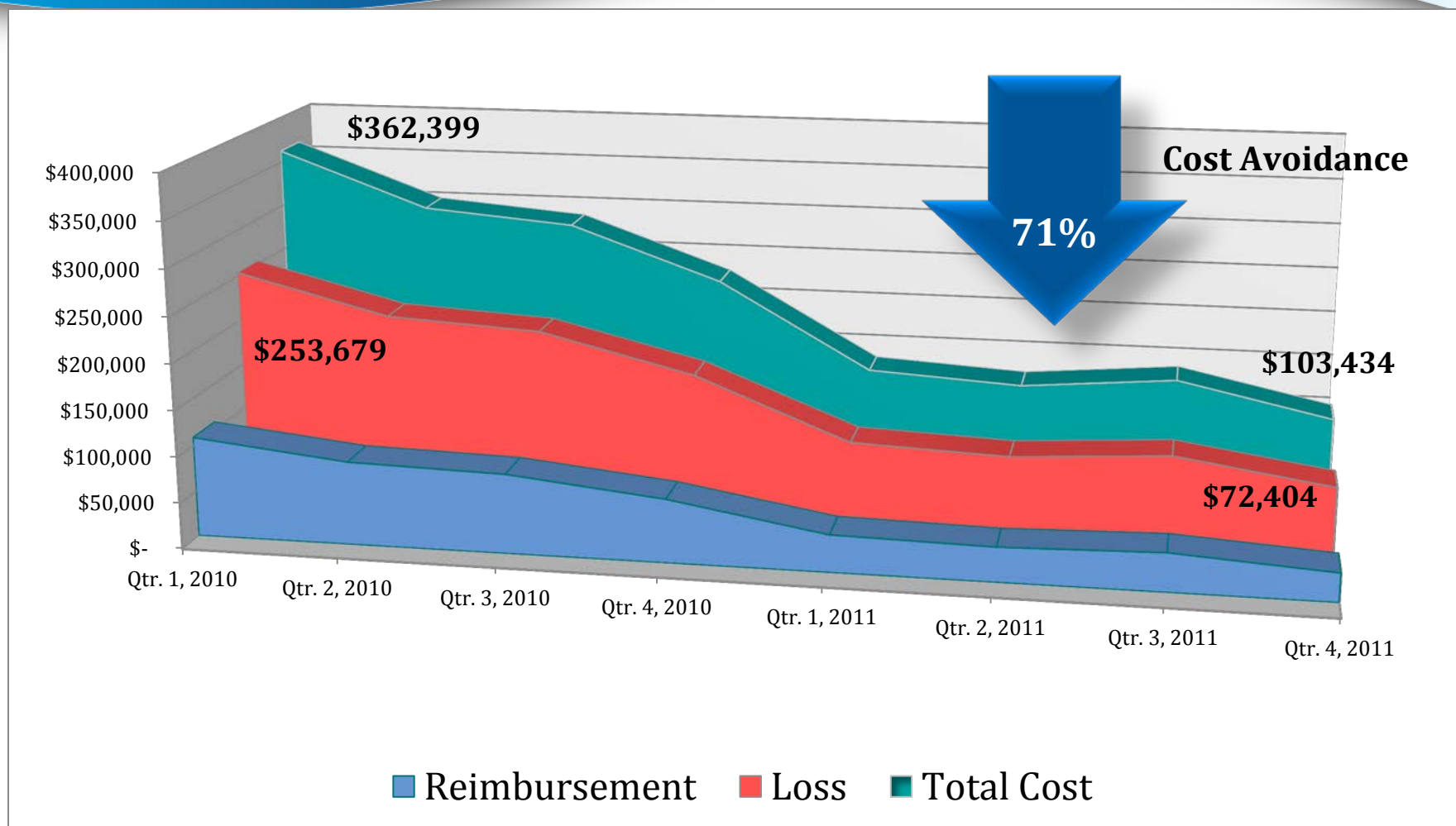
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Emergency Department Visits per Quarter 2010-2011



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Reduction in Emergency Department Costs (excluding ancillaries)



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100 people

\$200,00 investment

\$325,000 RETURN

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Central Oregon Health Council

www.cohealthcouncil.org

www.stcharleshealthcare.org

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