PRESENTATION

Aging and People with Disabilities

PreManage Uses for Diversion/Transition: Basics & Collaborative Care Coordination



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AGING & PEOPLE WITH DISABILITIES

Overview- What is PreManage?

- Pilot through the OHA Office of Health Information Technology
- Web-based software
- Real-time information
- Emergency and inpatient
- Individual & population-level view of visits
- Reports customizable by cohort, diagnosis, location, etc.
- Care guidelines
- Care Community: Used by hospitals, CCOs, other health providers, PCPs, behavioral health providers, care coordinators and others

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APD/AAA Opportunity

- Earlier access to critical information for service needs, plans and monitoring
- Data available for individual and population based interventions
- Customizable tool to meet business needs
- Tools for cross collaborative care coordination

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APD/AAA Pre-Manage History

Mid-2016	• Pilot planning
2017	• Six month pilot • 4 APD, 2 AAA (Field)
Late 17- 2018	• Training • Expansion to all APD & AAAs (Field)
Late 2018-2019	• Learning Collaboratives: Regional, Rural, Leaders, SNF pilot • Expanded enrollment file: Eligibility only, non Medicaid? • Central Office Adoption: risk monitoring, critical incident reviews, prevention • Care Coordination

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PreManage Brief Demonstration

- Census
- Cohorts
- Reports
- Groups
- Individual look ups

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Discussion: Diversion/Transition PreManage Use

- How are you/your office using it?
- How does it help you in your work?
- If you are not using it, what are the barriers?

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Primary Use Cases- Medicaid LTSS

Services & Planning

- Current:
- Discharge planning
- Diversion/Transition
- Service plan adjustments after medical events
- Identify need for re-assessment
- Protective Services
- Other:
- In Development/Future:
- Identification & intervention of individuals at high risk
- Collaborative Care Coordination
- Risk monitoring & critical incident work
- Prevention Planning- individual & trend identification

Cohorts:
-Location- local office, district, hospital
-Death

Discussion:
What changes would you recommend?

- Other cohorts
- Changes to reports
- Other ?

Collaborative Care Coordination

- Care Guidelines
- Learning and care collaboratives
  - Regional
  - Rural
  - Skilled nursing facility

- Central Oregon Care Collaborative Guest:
  - Keshia Bigler, MPH, Emergency Department Improvement Coordinator, PacificSource

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Regional Care Collaborative Contacts

- Central Oregon: Keshia Bigler, PacificSource Keshia.Bigler@pacificsource.com
- Eastern Oregon: Sarah Patterson, EOCCO sarah.patterson@modahealth.com
- Eugene: Annette Bruer, Trillium/Health Net Annette.L.Bruer@healthnet.com
- Portland Tri County: Susan Kirchoff, OHLC susan@orhealthleadershipcouncil.org
- Salem: Lisa Parks, Options Counseling lisa.parks@options.org
- Southern Oregon: Meg Wills, Jackson CareConnect willsm@careoregon.org
- Yamhill: Dr. Bhavesh Rajani brajani@yamhillcco.org

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Challenges & Next Steps

Challenges:

- HIPAA questions
- Enrollment file- data included, timing
- Standardization/Policy/Training needs
- Role & Participation in collaborative care coordination
- Occasional IT issues

Next Steps:

- Adding populations and data (APD/AAA staff) to enrollment file
- Building/joining internal and external learning communities and care collaboratives
- Determining APD role & data in care teams, care guidelines, Insights & other sections of PreManage
- APD Central Office use as tool for planning & monitoring

Contact: Naomi Sacks Naomi.E.Sacks@state.or.us
Phone: 503-385-7168