TRANSCRIPT OF AUDIO FILE:

2015-03-19 14.01 BRIDGING THE DIVIDE_ IMPROVING TRANSITIONS OF CARE TO REDUCE HOSPITAL READMISSIONS

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BEGIN TRANSCRIPT:

MODERATOR: … HRSA Center for Integrated Health Solutions webinar, Bridging the Inpatient/Outpatient Divide: Improving Transitions of Care to Reduce Hospital Readmissions. My name is Sarah Steverman, Consultant for the SAMHSA-HRSA Center for Integrated Health Solutions at the National Council for Behavioral Health, and your moderator for today's webinar.

As you may know, the SAMHSA-HRSA CIHS promotes the development of integrated primary and behavioral health services to better address the needs of individuals' mental health and substance abuse conditions, whether they're seeing a specialist in behavioral health or primary care provider setting.

In addition to national webinars designed to help providers integrate care, the Center is continually posting practical tools and resources to the CIHS website, providing direct phone consultation to providers and stakeholders, and directly working with SAMHSA primary and behavioral health care integration grantees and HRSA-funded health centers. Please check out the website for more information. [00:01:03]

Before I introduce your speakers for today's webinar, I do have a few housekeeping items. Today's webinar is being recorded, and all participants will be kept in listen-only mode. You can find the caller number for the webinar on the right-hand side of your screen. Questions may be submitted throughout the webinar by typing your question into the dialogue box to the right of your screen. I encourage you to submit your questions as you have them, and we'll answer as many of your questions as time allows.

If at any point during the webinar you experience technical difficulties, please call Citrix tech support at 888-259-8414. The webinar slides are currently posted online at www.integration.samhsa.gov under the webinar section.

Lastly, at the end of the webinar, please take a moment to provide your feedback by completing a short survey. We use that information to inform future events. [00:02:04]

On today's webinar you will be introduced to the issues related to avoidable hospital readmission and the care transition models that aim to improve outcomes and reduce those readmissions. We hope that you will be able to identify the components of transitions models and begin to figure out what might work for your health center and community. And lastly, this is a starting place. We hope you'll take the resources and information presented here to explore the issue further.

We're going to start off with a couple of poll questions. We'd like to get a sense of who we have participating in today's webinar. The first poll question, and you can indicate on your screen where you fall: How do you identify your role in primary care/behavioral health integration? Are you a primary care provider or administrator? Are you a behavioral health provider/administrator? Are you on the inpatient side, inpatient hospital or emergency department provider/administrator, policy maker, or do you sit in some other stakeholder group? Please vote now, and we'll see who's on the line. [00:03:15]

All right, we can close the poll and see what we - see what answers we have. All right, it looks like the majority are behavioral health providers or administrators, but we also have some other primary care and inpatient folks and then other stakeholders. Thank you.

And we have one more poll question for right now. For those of you who on the line are providers or administrators of clinical programs, are you a primary care organization, a mental health or addiction organization, part of an accountable care organization, or part of a hospital-based system? So for those first two, are you in a stand-alone primary care, a stand-alone mental health or addiction, part of an accountable care organization, or part of a hospital-based system, or, of course, other? [00:04:34]

All right. Most of you are a stand-alone mental health or addiction organization, although 13 percent of you are with a primary care organization, and 13 percent with a hospital-based system, and just a small number with an ACO. It's helpful for us, in going forward and figuring out who we can speak to and the resources that are most useful, so thank you. [00:05:16]

We are going to start off today with an example of a provider who is doing some really great work in Maryland. Jason Martin is a - has been working in the mental health field for the last 18 years. In the last four years, he has been with Family Services, Inc. in Gaithersburg, Maryland, in a variety of settings, and he's currently the Director of the Carelink Transitions and the OnTrack Maryland projects. Jason also works in a local emergency room at Shady Grove Medical Center, where he works for those in crisis, help them navigate the complicated mental health system.

And Jason is going to start out by discussing his program, his Transitions program, where he works in an integrated community setting, working with an inpatient provider to try to promote quality transitions and reduce hospital readmission.

So I'm going to turn it over to Jason and he's going to give us an overview of his program. [00:06:23]

JASON MARTIN: Well, good afternoon, everybody, thanks for having me, and thanks for giving me the opportunity to speak about our program here in Maryland, the Carelink Transitions program. It is a homegrown effort between our agency, Family Services, and a few local hospitals that reach out to us.

So I thought we'd start off today by talking a little bit about the community that we serve here at Carelink and the general community at Family Services. So if you go to the next slide, you can see that Family Services is located in Montgomery County and Prince George's Counties, Maryland. We have multiple sites, but our primary office is here in Gaithersburg, Maryland, which is a suburb of Washington, D.C. [00:07:07]

Our area is very diverse, it's a very culturally diverse area, and it's a very economically diverse area. We have a very large population of people from El Salvador and Ethiopia, Nigeria, Ghana, Vietnam, all over. And so the hospitals that we're working with also have a representation of that culture and the economic diversity that we have.

Carelink is part of a large social services agency that's part of the Sheppard Pratt Health System, which is primarily a mental health system. Family Services, in the last year, in 2014, served over 25,000 people in our community, and we have 400 staff operating 33 distinct programs; Carelink is one of those programs.

The Carelink program was started back in 2011, after being approached by Washington Adventist Hospital. Are we on the right slide? I'm sorry. [00:08:08]

MODERATOR: I'm not sure, Jason. Go ahead and keep - there we go.

JASON MARTIN: Okay, I'm sorry. I just wanted - I'll keep going. So Washington Adventist had a history of very high readmission rates, somewhere around 20 percent or so of their folks were readmitting somewhere in the state of Maryland, and they wanted to have a community partner come alongside with them and help to develop a solution to keep folks out of the hospital. The hospital's request was basically to connect client-to-community resources, implementing the discharge plan that was discussed and approved by the physicians and the staff there at the hospital, and to reduce or eliminate avoidable readmissions in the hospital, to the hospital. Carelink's solution was to create a 30-day intensive case management system service. [00:09:07]

So I said earlier that this was really a homegrown effort; it really was. It was started with one nurse and grew into having a program with nurses and benefits folks, which we'll talk about a little bit later.

But as we started the program we realized how vital it was to have an intensive - a very intensive 30-day case management program and that it wouldn't just focus on behavioral health clients, but that it would also have some medical clients as well, as well as the emergency department.

So we have folks that come in from the behavioral health side of things, but we also have folks from the physical health side of things, and then folks in the emergency room that are frequent

visitors that really don't need an emergency room kind of setting, that could be better served if they were linked really well with community providers. [00:10:00]

As an agency, we are experts in working with the behavioral health population. Family services started more than a hundred years ago, but it kind of morphed into having a very large component of behavioral health providers. So we have a psychiatric rehabilitation program, residential rehab, we have an outpatient mental health clinic; all of that together onsite at our complex here in Gaithersburg.

But we have a lot of experience in providing community-based case management through that, through our psychiatric rehabilitation program. We have staff that are very well versed in going into the community and meeting with people. We also have home visitors that are going to visit newborns in the home. We have staff that are visiting clients with a number of different difficulties in the community. So we have a lot of experience with that as an agency. So we had the ability to make home visits, and we also have the ability to connect people with community resources and providers. [00:11:07]

One of the great things that we had here a number of years ago was - or that just finished up actually - was a SAMHSA grant that allowed us to really integrate our behavioral health and primary care here onsite. Within our outpatient mental health clinic, we have an embedded primary care office right in the clinic, so if someone comes in for their checkup to see their psychiatrist, they can walk down the hall and get services from their primary health physician. If the therapist sees that, you know, maybe they're not doing well, they can walk them down the hall, get their blood pressure checked. They can go there to get blood draws if they have medication where they need to have blood draws regularly.

Also down the same hallway is a case management program for folks that live in the community so that they can get food resources and things of that sort, so it really is a one-stop shop. [00:12:01]

You know, with hospitals being pressured to discharge patients sooner, we have the ability to implement the discharge plan in the home and connect clients to resources and providers in the community, like ours throughout both Montgomery and Prince George's County.

When we first started Carelink back in 2011, it was very small with one nurse just providing the support. We worked with Washington Adventist Hospital to achieve their desired metrics, which was to reduce readmissions and to connect clients to community resources. Their goal was to have folks that kept coming back to the hospital for things that could be managed in the community. They wanted us to help them be connected with primary care, with behavioral health, and things of that sort in the community. It started initially with complicated behavioral health clients and then moved into clients of all diagnoses very quickly. [00:12:53]

Now, I'd also like to take a minute here to discuss the finances of how our program is paid, because it's kind of unique and it's something we'll talk about a little bit later as well as a challenge. But initially we started charging the hospital $650 a month that was paid by the hospital to provide the service for 30 days. [00:13:20]

Over time, the rate had to increase to where it is now at the $1200 a month. Now, that service is paid directly by the hospital. We're not involving - at this time, we're not involving insurance companies or any other payment source, it's coming straight from the hospital, and it's paid one time based on 30 days of service.

We do have the ability to go back to the hospital and say, hey, this person really needs more than 30 days, could we extend that further, and then we work out a plan to negotiate an extension for that client based on their circumstances. Sometimes it's just for a week or two if we're waiting for some benefits to be brought on, but most of the time it's for an extra 30 days that we can continue to provide some stability for them in the community. [00:14:10]

Now, how does it work? This is kind of the nitty-gritty of how our program works. So the hospital - the Washington Adventist or Shady Grove Adventist Hospital - will identify a high-risk patient that is likely to readmit. This may be somebody who has been admitted a number of times for something that may have been prevented with good community wraparound services. It could be someone that's just really complicated. Or it could be an individual that just has a - they're very high risk. They may have had surgery but they're homeless. They may have diabetes, but they also suffer from schizophrenia and they have a history of not taking both their diabetic medications and their medications for their schizophrenia.

And so the hospital then contacts us and says, hey, we have this referral for you, and we go to them and we do what's called a warm handoff, where our staff meet with a client while they're in the hospital to start establishing that rapport and helping them to get to know our program and make sure that they want our services and start the process of seeing what they really need. [00:15:16]

After that warm handoff, you know, if we need to, we'll continue to visit that person in the hospital, but normally that warm handoff occurs close to the discharge date. After discharge, within 24 or 48 hours, our risk care managers will go into the home or the community, wherever that person may be, and provide services, and our entitlements manager will also provide services, and we use the Coleman model for care transition.

So again, the warm handoff we already talked about. We build rapport and we have a verification of their address. We're also verifying a phone number if they have it. If they don't, we provide a phone to them and a brief needs assessment, so we're trying to figure out what kind of services does this person need. Do they need housing referral? Do they need a referral to primary care? Do they need a referral to a specialist, substance abuse issues, domestic violence, legal issues? Whatever the situation may be, we're trying to figure out initially kind of where are we going with this client and what will help this person stay out of the hospital and be successful. [00:16:17]

And we do a lot of collaboration with the social worker that's there in the hospital. We found that the warm handoff is very, very important. Without that warm handoff and that initial establishing of rapport, we often are not able to reach our clients after the fact. It's been very

difficult without the handoff and without sometimes getting them the telephone to be able to follow up with the folks in the community.

Our team consists of two licensed practical nurses, an entitlements coordinator, a clinical manager, a hospital liaison, and a data manager. Now, our staff is very diverse as well. Like I said, I mentioned earlier, the community that we're serving is very diverse and our staff is very diverse. Our staff speak English, Spanish, French, Swahili, and a number of other dialects, African dialects. And so because our community has a lot of folks from Africa, we are able to reach them and talk with them in a culturally sensitive and culturally appropriate kind of manner. [00:17:23]

So if we move on to the next slide, we'll talk a little bit about what the nurses do in those 30 days that they're working with their clients. So they will meet a client initially and complete a basic nursing assessment, where they're trying to gather as much information from the discharge summary from the hospital as well as the previous medications and other services that the patient have been utilizing.

We will assist a client with establishing a primary care physician, and if needed, a mental health provider in the community - psychiatrist, therapist, what-have-you - and we will provide transportation for those follow-up appointments. So sometimes we are picking up the client with our staff, picking them up, driving them to the appointment, sitting with them through the appointment, and then finishing up. [00:18:15]

After the fact, oftentimes we will involve a cab service, where the cab will pick up the client and meet us there at the doctor's office so that we can coordinate there. And from time to time the clients will go independently and then fill us in after the fact; that's normally for the follow-up appointments. Most of the time, our staff are present for those appointments. We are assisting with scheduling the appointments and finding the providers.

The other key piece that the nurse completes is that medication reconciliation. So many times we're finding that our clients, when they're coming out of the hospital, they have this discharge summary with all of the new medications, and they're prescribed 12 meds, and six of them they used to take and six of them are new, and the client is confused as to whether they should continue to take those six new medications, should they take the medications they were taking before. Oftentimes they'll just say, well, I'm confused, I'm not going to take any of them. [00:19:09]

And so our nurse goes into the home right after discharge and performs that medication reconciliation by looking at the discharge summary and looking at the previous meds and say, okay, here's what the discharge summary says you should be taking, this is what we'll take now. We'll schedule your next follow-up with your primary care, your psychiatrist, your specialist, and see if we need to make any changes after that. But oftentimes we're just there and following the discharge plan with the client and providing a lot of education and a lot of services around that.

We're also providing education, so many times in our community, folks, they feel bad, they go straight to the ER. And we're helping folks to understand that maybe we don't have to go to the emergency room all the time, maybe we can follow up with your primary care, maybe we can go to an urgent care center, something of that sort, instead of having to go to the ER. [00:20:02]

We're also teaching them some self-management and self-soothing and coping skills for folks when things are difficult, to when - maybe when the depression is getting worse. Instead of initially going straight to the emergency room, do you have a plan in place and some other folks that you can talk to, to help distract you from the situation? Or if you really are feeling unsafe, do you have some folks that you can talk to, to help you get to the emergency room if it's needed?

The last thing I'll talk about is the coordination of the community-based providers. So many of our clients come with multiple providers; they have primary care, they have psychiatry, they have cardiology, they have nephrology, they have neurology. They have all of these providers in place, and they get very confused and there's not a lot of communication, oftentimes, between those providers. And so our nurses act as that communication point and they're able to gather all of the information, make sure that every doctor knows what every other doctor has been prescribing and can help to alleviate the double-dosing of medications or, you know, too many prescriptions of what-have-you, and so they're able to assist with that. [00:21:05]

On the next slide we'll talk about our entitlements coordinator. This position is what really makes us unique, I believe, in providing services, and that we have someone that's dedicated solely to assist with making referrals and assisting people to get on to public benefits or to see what benefits they may be eligible for in the community.

Our entitlements coordinator will meet with the client within the first couple of days of discharge. It may not be the first day; it may be. But it often is day two, day three, day four, after being discharged from the hospital, and they complete a more detailed needs assessment of what the client's needs may be that's based off of the more brief needs assessment that was completed at the hospital.

They're looking to see if the client has insurance, if they have food, if they have things that keep them safe in their home, do they have issues with housing, what are their needs? And so they're able - our benefits coordinator is able to provide the referrals for those individuals, but they're also able to help them complete the applications and stand with them in line at the Social Security office, if need be, and help to calm them down and soothe them and use some coping skills as they're waiting in the three-hour-long line to get a copy of the Social Security card or what-have-you. [00:22:23]

This person is also trained in filling out our complicated forms for psychiatric rehabilitation services. Those forms are often meant for providers and not something that is very easy to comprehend as a layperson, and so she is able to complete those forms and get them signed by the right individuals and reviewed by the right individuals. And then because we have good community networks, we're able to get that referral in the hands of someone that's able to assist with completing that referral and calling first (ph) and take appointment if need be.

The last thing that often the benefits coordinator and myself assist with is getting the required documents. Everybody knows that in order to get these services, oftentimes they need to have ID, and a lot of our clients are coming without identification. And so what we do is we help them to get the necessary documents to get that photo ID, to get that state issued ID. So we may order birth certificates from the Internet and have them sent to us. We may help them to go get certified medical records from the hospital, helping to find something from their landlord that says that it's a copy of their lease or what-have-you or a copy of their electric bill. We're assisting them with that and getting them really set up to start the referral process. Oftentimes, because we are a 30-day process, we're not able to complete that process or see it through the whole way, but we're able to start it and pass it off, hopefully, to somebody else that then can follow up with the client. [00:23:57]

So that's our entitlement coordinator. Now, the next thing I want to talk a little bit about is our Pathways model. So back in October of 2014, Carelink partnered with Delmarva Foundation here in Maryland to try to expand Carelink and to see how we can utilize, best utilize, technology to assist us with assisting our clients, and so we adopted the Care Coordination System as our documentation system. [00:24:28]

Now, before that, we had our own system that we had in place that was initially paper/pencil; then we moved to an electronic record that we kept here in our office. But we moved to this Pathway model that's a Web-based - the CCS that's a Web-based model that we can utilize anywhere. Our staff can have tablets in the community and be working with a client right then and there and be filling out these assessments, which has been very helpful to us.

The CCS System helps us document the integration of care. It provides progress reports and outcome assessments on how we're doing, things that we have completed, things that we're not completing, and it allows us internally then to take that into where we need to go and where we need to grow. [00:25:13]

We use the pathways within that system. A Pathways model, in a quick snapshot, is basically we have - there's multiple entry points into our system and multiple entry points where folks need assistance, and there's a pathway that might be opened to assist that person from not having the service to having the service, and so there's steps within that pathway that need to be complete for that pathway to be seen as complete.

For example, if we have somebody that we're working with that's homeless, we may open up a housing pathway, and the first step to that is to get the required documents that you need to show your identity. The second step would be to fill a referral to the housing agency, the third step would be making the appointment to go with the housing agency, and the fourth step would be moving into your new place. [00:26:07]

And so in Ohio, where they use the system very frequently, at each of those steps, there is a tie-in with an insurance payment that then comes back to the agency. So as soon as step one is complete, then they get $20, and step two is complete then they get another $20, but when it's someone's house, maybe they get $250, and so there's - it's outcome-based. So as soon as

someone's house - you know, there's a benefit to the client, you know, that they have housing, but there's also a benefit through (ph) the agency in assisting them to get to that point.

The last thing that CCS does for us, which is really great, is it allows us to assign risk to individuals. So when we're completing all of our assessments - we have a needs assessment, we have a clinical assessment, we have the benefit assessment - we put all of those into the CCS system, and it calculates, based on those assessments, what kind of - how high of a risk this person may be to readmit to the hospital. [00:27:04]

So a lot of our clients, when they're coming right out of the hospital, they're assigned as high risk. That's not something that I go in and click a button and say, no, they're high risk. It's based off of all the data that we're putting in from all the other issues that's going on, and different items are weighted differently. So if someone is homeless, it's weighted maybe higher than if they have allergies to certain foods. And so all of the data that we're putting in is synthesized into getting this risk score, and then we can see where they are at the beginning of the service and where they are at the end of the 30 days or 60 days as needed, okay?

So the next few reports are reports that have come out of our CCS system, and it shows the types of clients that we have been working with in our program for the last three years. If you look here at this first slide, you can see that we're really working with a wide variety of clients. We have a - 33 percent are complex medical cases, 29 percent are behavioral health, but 39 percent right there in the middle are both. So there may be somebody with schizophrenia that has congestive heart failure and diabetes and they're homeless, and so this just shows you how complicated some of our cases are. [00:28:16]

If you want to go to the next screen, it splits it out, whether the referral came from our medical unit or whether it came from behavioral health. That number tends to fluctuate some, so right now we're getting a lot of behavioral health clients, not as many medical clients. But as the seasons change, we tend to get less behavioral health clients and more medical health clients, and so it really depends on the season and just the month and the time of day; there's really no rhyme or reason to that. But you can see that it's pretty close to being equal.

Now, here's the common - most common referrals from clients at - of clients that we serve. Many of our clients have diabetes, congestive heart failure. The third piece says ETOH, and what we're talking with there is not necessarily alcoholism, but there are complications from their alcohol use, so they may be coming in with hepatitis and things of that sort. [00:29:12]

This next slide, the behavioral health referrals, you can see the overwhelming majority of our clients coming from behavioral health, the behavioral health unit, have some sort of psychotic illness. So whether it's psychosis, NOS, schizophrenia, schizoaffective disorder, that accounts for over 50 percent of the referrals that we're getting, which makes sense if, you know, we're working with someone who has schizophrenia that had some thoughts about their medication may be poison, or they're hearing voices telling them that the medication is bad, that they shouldn't take it; you know, that's going to lead to complications for them to return to the hospital.

Last slide here is really our bragging point. It shows the number of folks that are not readmitting to the hospital. This is - you know, if you would look at this from the outside, you would say, oh, 82, 83 percent of our clients are not being readmitted, but these are folks that have already readmitted a number of times and they were considered very high risk to readmit. So we feel like we're doing a really good job here with that and keeping that number down. [00:30:14]

We're getting this data both from the client, but we're also using technology to go in through CRISP (ph), which is our area, data infrastructure kind of thing, that allows us to see if someone is readmitted to the hospital every month. We go in and check that data versus the data that we're collecting from our clients.

Moving forward, we really hope to be able to expand to other hospitals. We've recently been discussing expansion to another health system here in our area, and we're hoping to be able to do that soon.

We're also looking at changes in staffing, so as I stated earlier, we have LPNs working with us now. And the LPNs are great, but they're not necessarily working up to the level of their license when they're driving folks to doctors' appointments or assisting somebody with waiting in line at the MVA. And so we're hoping to be able to utilize our community health workers in the future, the near future, the very near future, to assist us with that while we can still maintain our model and still stay financially viable. [00:31:18]

We'll continue to use the nurses, but they'll be more in a consultative role. So the nurses would be available to complete that medication assessment, but then they will also be available for the complications that come up and things of that sort.

We also expect some changes in funding. We recognize that the hospitals that we're working with, both Washington Adventist and Shady Grove Adventist hospitals, that they will not be able to continue to provide the level of funding that they have been forever and ever. So we're looking to expand, to be able to contract with other insurance companies that might be interested in keeping some of their costs down by utilizing our service, working with the hospitals and working with other providers that might be interested in using us. [00:32:01]

That's all that I have to say today, so thank you very much for your time, and I guess we'll take some questions if there are any now.

MODERATOR: Thank you very much, Jason. If you'd like to ask a question, you can type that into the question box on the right-hand side of your screen. But we're going to take a few questions here, and then we will continue with the presentation; then we'll have a little bit more time at the end to ask questions about those, Jason's presentation and the next presentation that you will see.

So Jason, if you can just talk a little bit more about the process of referring individuals to your program. Who is it in the inpatient setting that identifies the client, and then how many clients do you generally have at one time? And then also, how do you measure success? So you had your

readmission rates; about 83 percent are not readmitted to an inpatient setting. How long do you track the folks after that (crosstalk)? [00:33:25]

JASON MARTIN: Got you. So the first question is how are they referred. So they're normally coming from the social workers there on the unit, so we have a very good relationship. We spend a lot of time there at the hospital doing those warm handoffs and the staff know us. And so the social work staff may approach their supervisor when they're teaming with their folks in the morning and say this client is homeless and has diabetes and is not maintaining things well and has been in the hospital six times over the last three months, we think he might be a good referral for Carelink, and the social work supervisor then says yes. At that point, then they contact us and send us the referral. It's also similar with the behavioral health unit; we go there, we meet with the director of social work there, and they will often refer folks directly to us. [00:34:15]

There's also - within Washington Adventist, there is a director of population health, and that person often refers folks that they're seeing coming into the emergency room multiple times for preventable issues and they may refer to us. So we really have - within the hospital we have three referral sources: The medical units, the behavioral health units, and then the director of population health. I forgot the second part of that question; I apologize.

MODERATOR: The second question: How many patients or clients do you generally have at one time who come in working?

JASON MARTIN: We can have up to 50 at a time, which would be getting 25 referrals a month, and working through the one month, and, you know, the previous month and so forth. We're averaging about 35 or so, so each nurse is covering between 16 and 20 clients a month and our -

MODERATOR: And then how (crosstalk) - oh, go ahead.

JASON MARTIN: The measuring success is really - you know, we look at our readmission rates. We also look at the pathway completion. So when we talked about earlier in the CCS, when a pathway is open, we can track how far people are on that pathway through their system and when we really look at the pathway completion as being a measure of success. So if we see continually that we're getting lots of medication reconciliation pathways completed, that's a success for us. [00:35:50]

But it's not necessarily that the pathway not being completed is a failure, it's just that look, we look at that and say, oh, you know, housing is a huge issue. What can we do then to try to work with our community leaders to get more housing available for these folks? And so it really gives us the ability - the system really gives us the ability to look at that and say, you know, this is our data, numbers don't lie, so how can we… We can take that data then to our politicians in the county and state level and higher level, if need be, and say look, you know, these folks need housing, it would help to reduce the costs of hospitals, hospitalizations and such, so…

MODERATOR: Great. And just one more question about financing. You're paid per client by the hospital. Are these generally individuals who have Medicaid, and at what point do they begin

to - do they (ph) get to bill insurance at some point once they've been actually released from the hospital for discharge from the hospital?

JASON MARTIN: We do not bill insurance at all. This service is paid 100 percent at this point by the hospital. We do have a number of folks that have Medicaid and Medicare. We have a number of folks that have no insurance. And then we do have folks that have private insurance. We have a lot of folks that are coming through with your Blue Cross/Blue Shield and United Healthcare type plans. And so - but at this point in time we're not set up to be able to bill the insurance company. That's something that we're looking forward to in the future to be able to sustain the program further.

MODERATOR: Okay, excellent. Well, we're going to stop here with questions. We will have plenty of time later. We have a couple of poll questions that we wanted to just ask in this interim.

Thank you, Jason, for your presentation and (inaudible at 00:37:50) a lot of questions. This whole question, for those of you who are in the community and in provider organizations or in inpatient settings, you have a care transition program. We're interested in knowing if any of you are actually already doing that but have a plan for care transition program that is operational. So you're going to put yes or no. If you aren't a community provider or an inpatient setting, then you can sit this poll out. [00:38:25]

All right, we can close that poll and we'll see the answers here in a second. All right, so about 50-50. A little more than half of you already have a care transition program of some sort, and 46 percent of you do not.

And then the next question is a question regarding the type of model you're using. If you're using a particular model, we'd like to know which one that is. And Dr. Pincus, who I'll be introducing in a moment, is going to be talking a little bit more about these models. Jason mentioned that they utilize the Coleman model, and Dr. Pincus is going to talk about that. And some of you had asked in the questions about - a little bit asking a little bit more about what that model is.

And so for - but we have one more poll before we introduce Dr. Pincus. There it is. So for those of you who have a care transition program, the 54 percent of you who said that you do, if you could just take a second to let us know which model you're using. If you're using a care transition intervention, the Coleman model, the transitional care model, the Naylor model, the RARE, the Reducing Avoidable Readmissions Effectively model, the re-engineered discharge, or some other model, or have some sort of system that is not necessarily a full-blown model. [00:40:01]

So you can just vote there now; then we can close it whenever you're ready, Rose. All right, so the vast, vast majority of you are using either some other model or perhaps have some sort of agreements that are not necessarily based on a model in the literature; that's good to know.

So now we're going to move onto some of the nuts and bolts part of the presentation after we had Jason discuss what they're doing in their (inaudible at 00:40:41) at Family Services. I'm

going to introduce now Dr. Harold Alan Pincus, who is - he has a lot of jobs as well as physician. He is a Professor and Vice Chair of the Department of Psychiatry and the Co-Director of the Irving Institute for Clinical and Translational Research at Columbia in New York. He's also Director of Quality and Outcomes Research at New York-Presbyterian Hospital. And he serves as a Senior Scientist at the RAND Corporation and he also is the National Director of the Atlantic Philanthropy Health and Aging Policy Fellowship. Dr. Pincus graduated from the University of Pennsylvania and received his medical degree from the Albert Einstein College of Medicine in New York. Following completion of a psychiatry residency at George Washington University Medical Center, Dr. Pincus was named a Robert Wood Johnson Foundation Clinical Scholar. And Dr. Pincus has done quite a bit of work regarding transitions of care, and so he's our expert today and we want to welcome him on the line today. Dr. Pincus? [00:41:51]

HAROLD PINCUS, MD: Thank you, Sarah. I'm delighted to be here. So I'm not sure how much I'm going to go into the nuts and bolts, because Jason really was presenting a lot about what happens sort of on the ground in the trenches as they've implemented their local transition program. [00:42:10]

I'm going to start out at a kind of 30,000-foot level, thinking about some of the policy issues, and then come down to maybe a 300-foot level to talk about some of the models and the different key elements of the models and how they're implemented.

So again, the problem we face, and this is not limited to behavioral health issues, is that we have far too many rehospitalizations, which often represent rework. So many hospitalizations are quite appropriate, but many represent simply rework or inadequate transitions.

You know, basically hospitals are incentivized to discharge early, they discharge early to a very fragmented inpatient/outpatient care system, and there is a lack of attention to transition planning. And so the obvious result is that we have high rates of potentially preventable readmissions, which is bad for consumers and also bad for costs. Next slide, please. [00:43:08]

So if you look - and I'm talking here about sort of overall readmission rates, not just for behavioral health - but basically a fifth of people get rehospitalized after 30 days, and about a third within 90 days. And if you look further from this sort of really important article from Steve Jencks, et al, that was published a couple years ago in the New England Journal, it brought up a great deal of attention to the whole issue of readmission rates. If you could advance the slides, please?

Basically, among the people who are readmitted within 30 days, half of them have no visit with an MD during that 30-day period, so there seems to be a real problem there. And if you look further on the next slide, you'll see that the number of - that there is a huge variation across the country in terms of the extent to which people actually wind up with an outpatient visit, in this case within 14 days of discharge, and the variation goes from about half of them not having a visit within 14 days to about a quarter of them not having an outpatient visit within 14 days. So when there's large amounts of variation, it means that there's something we can do about it. There's no obvious reason why there should be such extensive variation, and there ought to be ways to fix that.

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I mean so this problem, when one looks at this from the point of view of the behavioral health field, came up in the context of a major Institute of Medicine study that came out a number of years ago that had to do with crossing the quality chasm and identified significant problems in quality in the behavioral health field. Please advance the slide. [00:45:08]

And basically the point made about the quality chasm is that the problems that exist in quality don't represent a small gap between the quality that people should be getting and compared to what they are getting, but really represents a large chasm, and a number of issues were looked at. Next slide, please.

In particular, one of these you (ph) looked up was follow-up after hospitalization within seven days after discharge, and this is data that comes from the National Committee on Quality Assurance, which puts out the HEDIS measures. And what's disturbing is roughly, depending upon the payer, which also obviously relates to the kind of clients that are getting paid for, somewhere between two-fifths and - excuse me - three-fifths and half of all individuals who get discharged with a mental disorder from a hospital who have no visit within seven days, you know, when you think about how difficult it is to get somebody into a psychiatric hospital or psychiatric unit, people have to be pretty ill. And the thought that they're going from 24-hour care to essentially nothing for more than a week is a concern, so there's obviously some kind of problem there. [00:46:34]

And this is further identified when one looks at more recent data, and the other problem is that this is not improved over time despite the fact that this is regularly reported. As you can see, these rates are pretty flat.

The next slide shows how much of a problem readmissions are. And basically if you look among all Medicaid patients at the top ten with common readmissions, four out of ten are behavioral health-related readmissions. And so this is a problem for the health care system as a whole and it shows that we have a real problem with regards to behavioral health issues. [00:47:11]

The other problem that comes up again at a fairly high level, it's demonstrated on the next slide, is how much of a priority is focusing on behavioral health readmissions, and this is perhaps not the most scientific survey, but it was a survey of hospital administrators that participated in a hospital information network, and they were asked which conditions are being targeted by their reducing readmissions program, and as you can see, that behavioral health falls second from the bottom.

So not only is it a big problem in terms of the field not being able to improve things over a number of years and because of the impact it has on Medicaid, but also it seems to not being getting much of a priority.

So several years ago we did a review of this issue and looked at - and tried to look at what models exist out there with regard to improving transition care for people with mental health and substance abuse conditions and to what extent might models in other areas be adapted for use with individuals with behavioral health conditions. Next slide. [00:48:28]

And what we found is that, you know, for the most part, the most extensive efforts are on areas outside of behavioral health. Most of those are focused on individuals that have multiple chronic conditions, particularly focused on the elderly. There are a number of models that have been developed for particular illness groups, especially again for going back to chronic conditions like diabetes or cardiovascular disease.

Some states, like Minnesota, for example, which developed a RARE campaign, have developed their own specific quality initiatives, and individual hospitals in health care systems have done that in different ways, and in some cases have actually implemented specific policies that have been directed at reducing readmissions in terms of building in incentives, and this has been further augmented with regard to Medicare and Medicaid and health care reform, where hospitals are faced with potentially significant penalties for failing to reduce their readmission rates. Again, they have not been specifically directed at behavioral health conditions. But in fact, there is a component of the Affordable Care Act which includes mandating reporting or pay for reporting that is yet penalized if you don't report certain features of your inpatient care, and one of those elements is related to follow-up after hospitalization. And so that there are a number of different issues that have come up with regard to care transitions in health care reform. Next slide, please. [00:50:07]

And so various ways of dealing with some of these incentives that come from the public reporting, from the different quality measures and penalties that have been put in place, include developing inpatient and outpatient collaborative care teams, building up patients that are in medical homes, which require more coordination, having some broader overarching financial models that incorporate various elements of bundling, both inpatient/outpatient care, accountable care organizations, and other coordination mechanisms like medical homes and health offices (ph). Next slide.

So we did a systematic review, including a Web search, various snowballing techniques, speaking with experts in best practices, to identify those models that exist both in the literature that's published on the purity (ph) literature, as well as the gray literature, as well as looking at various forms of material that maybe have been developed for educational purposes, whether it's slides or technical assistance or other sort of implementation tools. [00:51:21]

We included intervention models for both general medicine and mental health, in part because there were so few that we identified specifically for mental health. And we also want to look at those where there was some kind of evidence of effectiveness through some kind of trial, formal clinical trial, or through some kind of less formal evaluation.

So what we identified in terms of the key kinds of issues that we - the key kinds of models that we found, by far and away the most commonly described, discussed, and published was the so-called Coleman model and the Naylor model, Eric's model being the Care Transition Intervention model, or CTI, and Mary's model being the Transitional Care model, TCM. [00:52:15]

But there are a number of other models that largely have adapted some of the same concepts. I mentioned the reducing avoidable readmissions effectively, which is a campaign that was developed in Minnesota; the BOOST model; the Transforming Care at the Bedside; the Re-engineered Discharge; different types of more comprehensive programs for people with multiple chronic conditions, especially focused on the elderly, such as the GRACE model or the Guided Care model; the Bridge model in Illinois. And then the Centers for Medicaid and Medicare Innovation Center actually - during this period of time actually put out a call and has, in process, a whole series of demonstrations that exist across multiple states for reducing readmissions. [00:53:09]

So the Care Transition model, which is the one that Jason really focused on, has four components. There is a patient-centered record. There is a pre-discharge checklist or tool for critical activities that enable patients to be empowered. There's also a pre-discharge patient session with a transition coach that occurs in the hospital setting. And then there's also the role of the transition coach in follow-up visits and calls to maintain the plan that was developed earlier.

And the overall intervention is based upon what Eric calls "Four Pillars," realizing… Number one is medication self-management; realizing that many of these patients are on multiple medications and often don't understand how they're supposed to take the medication and have often gotten a poor education in that regard. The use of a dynamic patient-centered record that is accessible to all the providers involved as well as to the patient and family; critically making sure that there's primary care and specialist follow-up; and again, incorporating the patient and the family in the knowledge of what the red flags are so that they can identify key elements of what might be going on in their lives that might be both symptoms as well as stresses and other kinds of issues that might be a sign that they may be getting into trouble. Next slide, please. [00:54:51]

The Transitional Care model from Mary Naylor is very similar in scope with regard to your Coleman model. It tends to focus more on chronically ill patients who have multiple chronic conditions, are older, and they're hospitalized for common medical and surgical conditions. And the key feature that distinguishes this is that it's a nurse-led program. The nurse serves as the health coach and links with multiple other disciplines and includes a kind of a longitudinal series of interventions that include screening, engaging the elder and the caregiver, managing symptoms that are of concern to the consumer, educating and promoting self-management with self-management tools, developing strong collaborations with other disciplines, other providers, making sure that continuity is maintained with the patient's home provider or primary care provider as well as specialists, coordinating information and care, and then maintaining the relationship with the nurse over the time of the transition. Next, please. [00:56:13]

All of the other models really include the same kind of major components that are in the CTI and the TCM. They recognize that health care delivery and support are generally the way it is when most people leave the hospital and they're faced with a series of silos and there's a lack of communication and collaboration, and so that's really the challenge that is addressed through these models.

There's a focus on the elderly and on chronically ill populations, particularly people with multiple chronic conditions. They utilize (ph) some kind of individual who serves as kind of a

health coach or transition manager and could be somebody specially trained to be a transition manager or an assigned nurse or social worker. They all include something that's under (ph) the hospital that develops a pre-discharge plan that engages the patient and their caregivers so that everything is understood what's supposed to happen after they leave the hospital, and that there are follow-up visits or calls with the patient and the coach to make sure that plan is in fact being implemented, and that, importantly, the patient and the family must take an active role and have some responsibility for the outcomes of their care. Next slide. [00:57:40]

So the one model that we found that actually was specific to behavioral health is something that actually is not specific to inpatient - to outpatient transitions but really is something that the ARC model - which is for Availability, Responsiveness, and Continuity - which is the model that has been conceptualized to apply across all transitions, you know, in the behavioral health sector, whether it's inpatient to outpatient, whether it's from criminal justice to outpatient, whether there's any other kind of transition that might occur, and it was particularly focused initially with the improvement of social and mental health services for children. [00:58:23]

But in a similar way, there is a transition coach, or what they term a change agent, and there are ten intervention components that are part of this model: Building personal relationships, developing a network, both a network of providers, but also a network that's specific to the patient, building a team of clinicians that can respond to multiple patient needs, having sufficient information through various assessments so that you know what's going on with the patient and you know what they're at risk for, providing continual feedback to how things are working, involving the patient and the family in participatory decision-making, realizing that conflicts are going to come up over time, and having conflict resolution skills, maintaining data so that you can understand whether you're continuously improving the system. And then as part of that also, adjusting individual provider's jobs and redesigning them over time and training in self-regulation for the individuals. [00:59:27]

They think of it in terms of four phases, starting with problem identification, and then based on that, setting specific directions for where things should be going, implementing the strategy, and stabilizing things over time, and working simultaneously at three levels, essentially walking, chewing gum, and juggling at the same time, focusing on the community level within the clinical organization and at the individual consumer level. Next slide.

So in thinking about the implementation of any kind of care transitions program, whatever model you use, you're going to have to grapple with several different issues. Number one is you need to consider what are the components that you need to put in place that constitute the model that you're going to do based upon the themes from existing intervention models? You know, are you going to pick and choose? Are you going to be comprehensive? [01:00:23]

Number two, to think about who is your target population and how you need to adapt the model for the specific clinical population that you have responsibility for addressing. Who are the players on your team? Which professionals, and also the extent to which you need to involve caregivers, and consumers are expected to play which roles? Next, please.

You also need to think about what transitions you're focusing on and which elements of the model need to be in place in which of those settings, and I think that's a key issue. [01:01:00]

For the most part, we've been talking about inpatient and outpatient, but there are multiple other transitions to think about. At the same time, as you're developing your model and your strategy, you're thinking about not only what and where things get done, but at which point in time do they need to get done, both for the purposes of where the intervention needs to anticipate being at each point, but also to think about where you need to collect data so that you can understand how things are progressing. [01:01:30]

I mean and once you've come up with the model and have a plan, you need to think very clearly about how you're going to implement it, what kind of technical assistance you're going to need, what kind of training is needed for who, for whom, what kind of infrastructure you need to have, what kind of measure in communication and health information technology capacities you need to have within your setting.

So in sticking (ph) through all of the different models and all the different programs we looked at, we came up with nine components: Prospective modeling, consumer and family engagement, transition planning, care pathways, information transfer/personal health records and health information technology more generally, transitioning coaches or agents or whatever you want to call them in your setting, provider engagement, quality metrics and feedback, and the concept of shared accountability. [01:02:25]

So when we talk about prospective modeling, really what we're talking about is you need to identify who is at greatest risk. I mean what you're assembling as a model, that actually takes considerable resources. If you spread it out too widely, it's going to get diluted, so you need to think about who is at greatest risk for bad outcomes and to focus on that population.

And ideally, you would have data that helps to inform your decision-making that is your own community or your own population-specific rather than relying on sort of generic, you know, U.S. population data. And in this case you really need to think about the site at which this element gets put into play as being before you even develop the program pre-hospital. [01:03:15]

Component two, next slide, please, is consumer and family engagement. And here, as everybody realizes, that you really can't be patient-centered, you can't be successful, unless you really engage consumers and families authentically and have them really assert what are their objectives and have them very directly involved in the treatment plan, and this occurs throughout all the phases of the transition program.

When we talk about transition planning, we're talking about having a formal plan that is - and collaboratively with the patient and their caregivers - establishing a client-specific plan for transition to the next point of care that's written out so that everybody understands it's accessible to everybody, and this is generally done in the hospital before the patient is discharged. [01:04:12]

Also, in many cases you're going to want to have specific care pathways that provide advice for guidance and describe what needs to be done when for specific types of patients that are based upon evidence-based practices. So these are specific clinical and procedural guidelines and instructions that help providers, what needs to be done when. It includes issues around assessment, medications, or psychosocial interventions or clinical management, self-care instructions, follow-up, et cetera. In general, there are national guidelines that can be utilized, but of course you need to be customized to your own local situation. These should be in place in a generic way, and they can be pulled out and tailored to the needs of specific individual patients. Next slide. [01:05:10]

In some ways this is something that - you know, as Jason talked about, his CCS system that they have. This is ensuring that there's information that's continually communicated among all the providers and with the patient and their caregivers so that everybody understands what's going on and what needs to be done when. And in many ways this has been expanded, as Jason described, so one can utilize all forms of health information technology and communication, including mobile phones, tablets, other sources of information, and have a way of exchanging the information so that people are all working at the same level with the same type of information.

All of the models have somebody who is accountable for making sure this all happens, so that is a clear expectation for an individual related to a specific patient who has clear roles and tasks laid out. They've been trained and assessed for competencies to carry out those roles and they have specific supervision in their job. Their training includes giving them various tools for planning, how to think about those red flags, strategies for engaging clients, and how to educate them as well as for caregivers. People can't come into this cold. They really have to have significant training and experience and supervision. [01:06:42]

You also need to get - engage providers. By necessity and simply by definition, if somebody is transitioning from one level of care to another level of care they're going to have multiple providers. If you're going to be targeting people that are at greatest risk, they're going to be people who are seeing multiple providers, that have multiple comorbidities. So you're going to have to engage providers at each level of care and make sure that they understand their role in implementing the plan for transition. They have to be part of the communication arrangements. There has to be a clear understanding about what are the handoff arrangements in a pre-specified way, having some kind of formalized agreements among the organizations involved so that they understand what their accountabilities and expectations are, and again, making the communication about what's going on with an individual patient available to all parties. Next. [01:07:45]

To make this work, you need to understand how it is working, so there needs to be some way of gathering metrics so that you can understand are we being successful, and make sure that people are in fact getting follow-ups post-hospitalization. Are we avoiding rehospitalization as Jason, you know, just demonstrated, to get other kinds of feedback on the process and outcomes of the care as well as perceptions of the consumer and the families, and then to use that information and feed it back to all the members of the team for quality improvement and also for accountability. [01:08:24]

And on the accountability side, more and more is being put out there as part of the expectations for what kinds of reporting is needed either for public reporting or for reporting as part of the contrast with managed care organizations or for reporting for which there's actually a penalty based upon performance. Next slide, please.

So among the measurement options that are being considered, that are actually being more than considered, they're actually being put in place, are things like all-cause readmission, or readmission for the same condition; for example, it's being done for congestive heart failure or for pneumonia or for heart attacks. Whether there's in fact a - and this requires chart reading - whether there's independent chart view (ph), whether there's in fact a discharge plan or transition plan, now, with specific transition elements, in fact, that's one of the HFPs measures for inpatient psychiatric care developed by the joint commission, and whether that care transition record is in fact transmitted to the outpatient or next level of care. Also looking at administrative data or claims data to see what is the performance of different hospitals or outpatient settings with regard to seven or 30-day outpatient follow-up. [01:09:52]

And then we're also looking at patient perceptions. There's a survey that's been developed and haven't (ph) yet been adapted or tested for behavioral health, but the CTM3 is something that actually is being built into some of the national quality measures, which looks at it on the next slide, which basically poses to the patients these three items, of whether the hospital staff took my preference and those of my family or caregiver into account in deciding what my health care needs would be when I left the hospital. When I left the hospital, I had a good understanding of the things I was responsible for in managing my health. And when I left the hospital, I clearly understood the purpose for taking each of my medications. And they have the options of strongly disagree, disagree, agree, strongly agree, don't know or don't remember. And this is actually being utilized in national Medicare accountability measures. Next slide. [01:10:49]

And finally there's the issue of really culture change for people across multiple providers and multiple organizations that are involved in the care of the patient, to get away from the fragmentation that currently exists, and have an understanding of shared accountability; that all providers share in expectations for quality and results across all the domains of patient outcomes. So if you have a patient who has schizophrenia and diabetes, you as a behavioral health provider have responsibility for both their schizophrenia outcomes as well as for their diabetes outcomes. [01:11:28]

And their primary care provider or diabetologist also has responsibility for both their diabetes outcomes as well as their schizophrenia outcomes. And accountability mechanisms are in place that may include, you know, financial mechanisms or public reporting that actually puts some skin in the game across all of the parties that are involved in the care of the patients. And also the consumers and families have an important share in terms of accountability and responsibility. [01:12:03]

So just going back, these are the models, these are the different elements that we identified. And hopefully, by learning and implementing these kinds of things effectively, we can move further and maybe move the needle in terms of better follow-up, less fragmentation, and reduced readmissions, and better outcomes both for patients as well as for the cost of the system, and

basically moving from this sort of shaky bridge across transitions to something a bit more stable in the next slide. Thank you.

MODERATOR: Thank you, Dr. Pincus, for that great overview. We are going to be taking questions in a minute, and I welcome you to type those in on the right-hand side of your screen. But first I wanted to just review a couple of resources that we have for you here. [01:13:11]

There's a health affairs brief on improving care transitions that you can access. Dr. Pincus mentioned the Minnesota RARE, the Reducing Avoidable Readmissions Effectively project. They have a lot of great resources on their website and on this exact topic that you can identify. There's another brief that might be of interest from the American Hospital Association as well as some resources at the National Transitions of Care Coalition.

And then lastly, there are a few specific resources on the CIHS website that we posted. There is an article by Dr. Pincus and some colleagues from the Journal of Clinical Psychiatry called measurement-based care in psychiatric practice: A policy framework for implementation that you can check out. [01:14:07]

And then there's also a couple transition protocols and policies that we obtained from other organizations that are doing this work that you can utilize. Check out a few other - other folks are doing, what other protocols, what protocols are coming into play, and see if that's something that you'd like to adopt for your own.

There is one article that we weren't able to get, it's not in the public domain, but if you have access to the library or a database, it's another article, a current opinion on psychiatry by Dr. Pincus and a couple of colleagues called care transition, interventions in mental health, and I will put that citation in the chat box in a moment for you if you can access that. It isn't in the public domain so we weren't able to link to it, but I commend it to you as a great resource on these exact issues. [01:15:07]

So we're going to move on to some questions here, and again, go ahead and ask whatever questions you might have. We have about 14 minutes, so we have time for a few questions. And we won't be able to get to everyone's questions, but we'll do our best to get to a few.

I want to go through, first to Jason, give Dr. Pincus a little breather, and I want to ask you about how you adapted - if you adapted in any way the Coleman model. Dr. Pincus discussed how these different models work for behavioral health and work for your own particular setting. And I'm just wondering if you have referrals for behavioral health as well as referrals on the medical side, if you utilize if there are any adaptations to the models that you did to meet the needs of the various clients, the two different types of clients for those obviously with (inaudible at 01:16:11) issues. [01:16:13]

JASON MARTIN: Sure. We had to spend a lot of time in engagement. We train our staff a lot in motivational interviewing to discuss with them the benefits of, you know, continuing to care for yourself after you leave the hospital, and that's something that we really have utilized a lot to, you know, point out some discrepancies in people's thinking and, you know, things of that sort.

So I think if we've modified anything, particularly on the behavioral health units where folks think that there's nothing going on, there's no problem, I don't need to take medication, what-have-you, we've really tried to use motivational interviewing to at least allow them to allow us to help them in something.

So the other thing we've done is said, well, do you need benefits? You need assistance with your food stamps? We can help you with that. And then while we talk about the food stamps, we're also talking about their symptoms. We're asking them if they've taken their medication, et cetera. So we have, you know, tweaked that a little bit, but I think we've held pretty true to the model. [01:17:20]

MODERATOR: Great, thank you. And to that point, I'm wondering if there is anything that Dr. Pincus or Jason - if you also have any information regarding training for these transition models. How do you get to the point where administrators and the frontline staff are confident to carry out these tasks and also obviously implement all of the moving parts, technology and metrics and that sort of thing? Is there a - I mean do you have examples of where training has worked and who's usually involved in that type of training? [01:18:13]

JASON MARTIN: Sure, I can answer for our program. I mentioned earlier the Care Coordination Systems. They provided a lot of training on what it is to be a community health worker and how community health workers can use their system. So when we first started the program, our community health worker that came to us from Delmarva went through their training, it's a 40-hour training that they do, and it's a standard - you know, it's a book form, and they're talking a lot about community resources and being safe and using basic concepts of motivational interviewing without necessarily using the phrase "motivational interviewing." They talk about trauma. They talk about all of those things, and, you know, things to look out for. It's a very basic concept, so we use that a lot. [01:19:00]

And plus the folks that we're hiring for this often have training, they're coming from a different field, and we're trying to utilize that. And then ourselves as a mental health professional coming in from the mental health side, but the nursing staff coming in from the nursing side, and kind of coming together as a team. We kind of consider us a mini - a sort of community treatment team without the peer support piece because that's what we're doing.

HAROLD PINCUS, MD: In terms of training, most of the models that I described, they have sort of websites and train materials and other kinds of materials, other resources that are available, but as I point out, very few of them had been adapted specifically for behavioral health.

What has been very effective in a number of places, and this has been done in some states or with certain subgroups, is developing essentially, you know, a quality improvement collaborative in this area. And I mentioned the RARE campaign that's in Minnesota. Originally that was primarily focused on, you know, med search readmissions. But then as a result of the interest across a number of different behavioral health providers and hospitals, they developed a separate spinoff group that's been doing a behavioral health quality improvement collaborative around reducing readmissions, and they've developed a number of, you know, different tools in that

regard. But I think there's something about having a collaborative where people share information, share lessons learned sort of on a local basis, that can be very effective. [01:20:42]

MODERATOR: Absolutely. Can we pivot a little bit to some of the financing issues with transition model? Jason mentioned that he is currently just billing or getting the finance from the inpatient, from the hospital system. Dr. Pincus, can you speak to any models or different examples of methods of billing insurance or how different health care systems or communities have dealt with the issue of billing for transition services? [01:21:31]

HAROLD PINCUS, MD: So a lot of the work that is being done here is based upon, you know, various incentives that are being put in place largely through health care reform, so for example, there is now a penalty for hospitals who have bigger numbers of readmissions. It can be as much as two percent of their Medicare PATs (ph), and so hospitals are incentivized to reduce readmissions. [01:22:00]

Now, they tend - most of these are focused not on behavioral health readmissions, but they are focused on an individual with chronic diseases who often, very often in fact, not, you know, a large proportion of whom, at highest risk, have some kind of behavioral health component or comorbidity, and so that incentive is built into the, you know, hospital payment models.

Then there are other payment models that are being put in place whether it's accountable care organizations or other kinds of hospital cost-bundling that may be bundled, both the hospitalization cost with post-hospitalization costs, and there are different models for this that are currently undergoing various sorts of demonstration projects by CMS, and they've built in very strong incentives to reduce readmissions.

Again, most of these are not focused on the behavioral health population per se, but when one looks at the people that are at greatest risk for readmissions, there is a very high prevalence of behavioral health conditions, including, and especially, substance abuse. [01:23:09]

MODERATOR: Great. Can either of you speak to whether or not these models have been tested with children? I think we've been speaking mostly about adult populations, both on the medical and the behavioral health side. But have either of you come across any model, for example, where these transition services have been applied to the pediatric population?

HAROLD PINCUS, MD: Yeah. The ARC model that I mentioned before was specifically developed for kids.

MODERATOR: Okay.

HAROLD PINCUS, MD: Yeah. And you know, they actually have a very detailed website and also have, you know, detailed training materials. [01:24:04]

MODERATOR: Excellent. All right, other questions, we have a lot here. I'm trying to figure out what would be best. Goodness. There is quite a bit of interest around the implementation of community health workers. What sort of credentialing do community health workers have, and

what specific roles do they play, or are you planning to have them play either in your model, Jason, and your program at Family Services or in any other model, if that's a role that they - if there's a place for community health workers in those, in those models? [01:25:05]

JASON MARTIN: So I'll say for our model here at Carelink that the hope is we can use the community health workers to do a lot of the tasks that are time-intensive and that are actually boots on the ground.

So our nurses would be involved in that, a patient reconciliation, but potentially the client would go out with the community health worker to the pharmacy to pick up the medication and would really be - most likely be identified staff person working with the client; that's who that would be the primary worker and that's what we're hoping to accomplish.

You know, as far as credentials and things of that sort, we're looking at folks that probably have a high school diploma or an associate's degree, and we're looking at hiring folks that may have been a CNA, nursing assistants that have a basic understanding of the medical field, or maybe a phlebotomist or something along those lines. But they also may have taken a class or two at their community college in psychology or they've taken abnormal psych and have an undergrad somewhere, so that's what we're looking for. Maybe they were a psychiatric technician on an inpatient unit. Those are the types of individuals that we're really seeking out for the positions. [01:26:24]

MODERATOR: Great. And when we're thinking about the transition process, obviously the medication management is a large part of it. How do you - what are some best practices with regard to involving either a psychiatrist or other physicians who deal with complex medical conditions within the team? Is that generally - is there a method of kind of transitioning or bridging the gap between the inpatient physicians and psychiatrists and the outpatient physicians and psychiatrists? [01:27:10]

JASON MARTIN: So for us, it really depends on the case. Oftentimes we're getting individuals that really have no identified provider, so in that regard we're assisting them with finding that initial provider and that isn't so much the case. But if there is an identified provider, once we have the discharge summary in place and we've done that initial reconciliation from the hospital discharge summary, we will make sure that the psychiatrist or the community provider, whomever that may be, gets a copy of that either by fax or we take it with us to the next appointment and let them know like what medications the client is actually taking.

HAROLD PINCUS, MD: I think your point earlier about the warm handoff is really critical; that really making sure it's a group, you know, and that you're - sending a fax that may or may not be picked up or may not necessarily make it into the purview of the provider, you know, it doesn't work as well as the warm handoff that actually provides direct information. Or, you know, increasingly, people are, you know, are having accessible, you know, sort of registries or ways of sharing data through various types of information exchanges, and that's where things are moving in different ways and creating a personal health record, you know, at least for those that have access to, you know, information technology. [01:28:43]

So that's, for example, part of the… And I know this, the high-tech act (ph), doesn't apply to behavioral health centers in terms of the incentives at least, you know, and most of you are from behavioral health centers. But in the meaningful use stage that's currently being implemented, there's an expectation that buyers will get patients and families to utilize a common health record that's available electronically so that information can be shared, you know, between the patient and the providers in a more transparent way so that they can - so that everybody is working off the same plan.

MODERATOR: Great. Thank you, Dr. Pincus, and thank you, Jason. We are at the end, we're at 1:30. And just want you - to let you know that a recording and transcription of the webinar is available on the Center for Integrated Health Solutions' website, so please check that out there.

Some of you, after the webinar, you will be asked to complete a short survey, and we really appreciate you offering your feedback on today's webinar so that we can inform the development of future CIHS webinars and technical assistance.

And I really just want to extend a thank you to our presenters, Jason Martin and Harold Pincus, for joining us on today's webinar. We really appreciate all of your expertise from on this topic. And thank you all for participating in our webinar, and please stay tuned for more events and more webinars in the near future. Thank you so much, and have a great afternoon. [01:30:20]

END TRANSCRIPT