CalAIM Population Health Management (PHM) All-Comer Webinar: Emerging Practices on the Implementation of Transitional Care Services

January 19, 2023

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VISUAL	SPEAKER – TIME	AUDIO
Slide 1	Palav Babaria – 00:01:00	Thank you so much, Carmella. I know it's a mouthful. Hi, everyone. Thank you for joining us for our first webinar of 2023, I believe, and this is one of the most critical topics, I think, in our population health management strategy. So excited to dig in. We can go to the next slide.
Slide 2	Palav Babaria – 00:01:21	So here's our agenda for today. We are just going to be walking through our transitional care policy as a refresher for those of you who may not have looked at it yet this year, sharing some new guidance that's been released around our California Data Exchange framework, which has relevance to transitional care services, and then really digging in on emerging best practices from the field, and then turning it over to our panel of in the field experts so that we can really help scale these best practices across the state. We can go to the next slide.
Slide 3	Palav Babaria – 00:01:54	So a reminder that we now finally have next steps on the Medicaid unwinding process. So hopefully, all of you have been tracking, but the public health emergency federal determination and Medicaid continuous coverage unwinding and redetermination have been uncoupled. So we, in the state of California, will be beginning redeterminations starting on April 1st in 2023. So that means for all of those members who have not had their redeterminations for eligibility done for the last few years of the public health emergency, we will be trying to reach most of them to see if they still qualify for Medi-Cal, keep them on Medi-Cal if they do, and/or help support them into transitioning to other coverage options through our exchanges.

VISUAL	SPEAKER – TIME	AUDIO
Slides 3-4	Palav Babaria – 00:02:44	The biggest part of this is we know people have moved, people have new addresses, people have new phone numbers, and so we need all of our members to be aware of this effort. So if you work with Medi-Cal members or communities in any capacity, please follow these links and sign up to become a coverage ambassador to get this word out. We definitely do not want people who otherwise qualify for Medi-Cal falling off of our roles just because we cannot reach them. And go to the next slide.
Slide 4	Palav Babaria – 00:03:14	We can keep going. This just shows that we are now in phase ... preparing for phase two when redeterminations are going to start. We can go to the next slide. So this is a walkthrough. As everyone is aware, we launched our Population Health Management program on January 1st, just a few short weeks ago. And we can go to the next slide. One critical component of the program is transitional care services. So that little box on the right is what we're going to be focusing on today. We can go to the next slide.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 5	Palav Babaria – 00:03:47	A few things. I think any of us who have ever interacted with patients, or had family members or loved ones who've gone through transitions of care, any time you have some sort of transition, whether that is being admitted to the hospital, being discharged, landing in a skilled nursing facility, this is something I've been going through with my own father-in-law over the last week, it is incredibly stressful and is one of the most risky times in terms of health outcomes for our members. And so, really getting this policy right and getting the implementation right on the ground is critical to ensuring the health and wellbeing for each and every member in Medi-Cal. So we've defined care transitions as when a member transfers from one setting or level of care to another. So this is a broad definition. It includes discharges from hospitals, institutions, other acute care facilities, skilled nursing facilities or discharges from those places to home or a community-based settings.
Slide 6	Palav Babaria – 00:04:43	Our goals are obviously to get members to the least restrictive level of care that meets their needs and their preferences, to make sure that members receive all of the needed support and coordination to have a safe and secure transition. You can look at the literature. It is riddled with adverse outcomes from medication errors and other things that are entirely preventable with the appropriate support and coordination post discharge. And then, we also want to make sure that members continue to have all the needed support and connections that they can be successful in whichever their new environment is. And go to the next slide.

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VISUAL	SPEAKER – TIME	AUDIO
Slides 6-8	Palav Babaria – 00:05:21	So there's a long list of requirements. You can read all about this in our lovely Population Health Management Policy Guide. The main takeaway from here is there are some key responsibilities which need to stay with managed care plans. So we expect all of our Medi-Cal managed care plans to know when a member is admitted discharge or transferred. This sounds so simple, but as we'll hear about today, it is easier said than done. We need managed care plans to process all prior authorizations in a timely manner so that doesn't hold up these critical transitions. And we need MCPs to assign or notify care managers of the above activities.
Slide 6-8	Palav Babaria – 00:05:57	There's a lot of other activities that we think go into making these discharges and transfers safer, including risk assessments, information sharing with a discharge planning document that is shared with all of the people who need to know, including the patient, the primary care provider, other providers, having appropriate follow-up outpatient appointments so that there is someone to catch that member and help address their needs from a medical or home health perspective. Do the medication reconciliation, etc.
Slide 6-8	Palav Babaria – 00:06:26	And then really making sure that we are taking advantage of these opportunities to make sure we're screening for eligibility for enhanced care management, complex care management, and community supports. Because as we know all too well, often members are stuck in the cycle of being transferred from facility to facility, and we need to intervene at those points. And so, those last few buckets you'll see are functions that may be delegated to the provider level or can be kept at the plan level. Go to the next slide.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 9	Palav Babaria – 00:06:58	So we have new policy guidance that we really issued late last year based off of feedback from the field and many of you who are on this call today. And so we've decided to take a phased approach to transitional care requirements just to acknowledge where all of our healthcare delivery system is today and how much work there is to be done to really make sure that we can scale transitional services. So as of a few weeks ago, 1-1-23, we are requiring all of our managed care plans to ensure that transitional care services, that entire list of services we just went over on the previous page, are completed for all high risk members. And you can look in the policy guide to see who is high risk, but we're really trying to get at those members that we're most worried about falling through the cracks because of social or medical situations.
Slides 9-10	Palav Babaria – 00:07:49	We also expect all managed care plans to implement timely prior authorizations, and to know when members are admitted, discharged or transferred for all members. So there should be no delays in prior [inaudible 00:08:01], and they should know, even if they're not providing transitional care services yet, when all members are admitted, discharged, or transferred. And then, we also are having all managed care plans work on executing a ramp up plan so that by January 1, 2024, the full suite of transitional care services can be provided to each and every single Medi-Cal member enrolled in that plan who has a transition of care, not just the high risk members. Go to the next slide.

VISUAL	SPEAKER – TIME	AUDIO
Slides 10-11	Palav Babaria – 00:08:34	So we won't lift up. We can go one more. As hopefully many of you are tracking, we have a California Health and Human Services Agency led effort around a statewide data exchange framework. And this was established by AB 133, and it requires that CalHHS set up a data exchange framework by July 1, 2022, which has happened, and that a broad spectrum of healthcare organizations, including health plans, are required to execute the framework by January 31st. And then there's a phased approach for some other organizations in data exchange by January 31st, 2024. And so the health plans that are required to sign the data exchange framework include all of our healthcare service plans, disability insurers providing any hospital medical surgical coverage, including those that are regulated by DMHC, and then all Medi-Cal MCPs that have a signed comprehensive risk contract with DHCS. We can go to the next slide.
Slide 12	Palav Babaria – 00:09:44	So the one piece of this that we did want to lift up is just very recently a draft set of policies and procedures was released by agency for public comment. And there are some provisions in those draft policies and procedures that are really relevant to the transitional care conversation that we are having today. So the current draft requirements include provisions that all participant hospitals send electronic notifications of admission, discharge, and transfer, known as ADT feeds, to at least one qualified health information organization. So this is to support that level of data exchange across the state, and it would require that qualified health information organization to then share ADT events with all of the other qualified health information organizations across the state. It would also require that qualified health information organizations accept requests of electronic notification of ADT events from participants and then communicate them in acceptable formats.

VISUAL	SPEAKER – TIME	AUDIO
Slide 12	Palav Babaria – 00:10:46	So as you'll hear about later today, ADT feeds are one of the ways in which our plans are really meeting those requirements to know when members are being admitted, discharged, and transferred in real time. There are barriers to getting that data statewide, and some of these draft technical requirements support getting that data statewide. So we wanted to lift that up, and it is up for public comment. So hopefully those of you who are interested after this webinar, we absolutely encourage you to submit public comments to our Health and Human Services Agency partners to inform this policy because it affects all of us.
Slide 13	Palav Babaria – 00:11:24	We can go to the next slide. I am going to turn it over to Dr. Shaw Natsui, who is our Medical Director for Population Health Management. And I think I covered everything I was supposed to, but, Shaw, absolutely welcome you and others of the team to fill in any gaps that I may have left.
Slides 13-14	Shaw Natsui – 00:11:42	Thank you, Palav. I think you covered everything, and we'll obviously keep an eye to the chat if there are any follow-up questions or things that we can bring back. But I can certainly take it over from here. So, good afternoon-
Slides 13-14	Palav Babaria – 00:11:56	Oh yeah. And I almost forgot to say we have an open chat, so please leverage it and use it. We want all of your feedback and questions.
Slides 13-15	Shaw Natsui – 00:12:03	Perfect. So good afternoon, everybody. As Palav said, my name is Shaw Natsui. I'm the Medical Director for Population Health Management here at DHCS, and I have the pleasure of facilitating today's panel. I guess I'll introduce the topic by saying, as Palav described, [inaudible 00:12:21] transitions, we know, are incredibly complicated and stressful in a high risk period. And compounding all of that really is how transitions are so ... the needs associated with them are so variable across different patients and populations such that there certainly is no single cookie cutter approach to meeting those varied needs.

VISUAL	SPEAKER – TIME	AUDIO
Slides 13-15	Shaw Natsui – 00:12:42	And so we are very excited to have our esteemed panelists join us today to share their practices around transitional care services. Following their initial presentations, we will then have an opportunity for a discussion with the panelists about some of the challenges that they have seen and have experienced on the ground and implemented, and providing TCS for their various patient populations. And so we want to really learn about how they are ensuring that everyone, especially those who are high risk, are supported during these time periods.
Slides 13-15	Shaw Natsui – 00:13:16	And so without further ado, introducing our speakers. So first we have Katherine Barresi, Senior Director, Health Services from Partnership Health Plan. Next, we have Nicole Gore, who is the Care Coordination Program manager, Santa Rosa Community Health. Next, representing Providence Santa Rosa Memorial Hospital are Alaina Zertuche, who is the Manager of Care Management, Sarah Behr, Supervisor of Social Work, and Wilfredo Bernardo, who's the Director of Care Management. And then, finally, we have Dr. Khush Grewal, who is the Medical Director at Community Health Center Network, or CHCN. And so, I guess at this point, I will turn it over to Katherine first, who will tell us more about Partnership Health Plan.
Slide 16	Katherine Barresi – 00:14:09	Great. Thanks so much to DHCS [inaudible 00:14:12] for giving Partnership the opportunity to talk about this. I will say when [inaudible 00:14:15] first got wind and took off, when we saw the TCS services under the PHM strategy, I got really excited because I think that this has been pockets within our network where we've done this really, really well, and happy to continue to build upon that.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 16	Katherine Barresi – 00:14:32	What I will share just with the group here today is that when we talk about high risk members, there's multiple different approaches here at the health plan that we take to make sure that we are providing TCS services in a way that makes sense for the community. If you think about this in a medical model, and you'll see here on your slide, we do primary level interventions, secondary and tertiary.
Slide 16	Katherine Barresi – 00:14:55	So the primary interventions, think of this as your status quo stuff that you're doing every day behind the scenes that impact high risk members in TCS services. So that may look like having language in your contracts, maybe folding in readmissions or better outcomes in your quality improvement programs. We have that here at Partnership for both primary care and for our hospitals. Secondary level interventions with regards to TCS are where we really dig a little bit deeper. We look at data and information sharing. We leverage activities that are already happening in our communities, whether they be promotors, or at the health centers, or even at the hospitals with some of their community foundation work.
Slide 16	Katherine Barresi – 00:15:40	And then, while we're doing that, we look at a higher level, a more detailed level to see pockets within our community where there are gaps, both from a health equity lens, but also in a real-time, member specific way, and work with those hospitals and those care settings, whether they're long-term care settings, skilled facilities, or hospitals, to talk about how we can better serve our mutual clients and align our resources and goals. So that in some areas within Partnership Network, we have actually embedded health plan staff to act as transitional care managers in partnering there with hospitals. We also facilitate extended length of stay meetings with our utilization management department and the case managers at many of the hospitals in and around our network. And we do that weekly to talk about how we can support moving members out of an acute setting into the next setting, and where we can support them in this process. Next slide.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 17	Katherine Barresi – 00:16:44	What I will quickly add is that this work doesn't come without earnest effort. It is solely built on partnerships, cross-sector partnerships. As you know, in a hospital setting, there's many different providers that are interfacing with a member in that moment, and then there's many different portfolio providers in the outpatient setting. And all of those people have to be communicating. So these are just some of the best practices from a health plan that I hope you guys think about when you think about TCS services and what you're doing today. Those extended length of stay meetings, they are amazing. You get a lot of real insights as to why that patient is experiencing problems in moving along.
Slide 17	Katherine Barresi – 00:17:27	Having local meetings, I can't stress this enough, going out to the hospitals, talking with the case managers, meeting with them, with the clinics. Sometimes the health plan is a facilitator of those meetings. Sometimes we're just a convener in connecting folks. But, really understanding what works locally, and meeting the moment and the communities where that is.
Slide 17	Katherine Barresi – 00:17:48	Data sharing, as Dr. Babaria explained at the top of this, we use an ADT feed to do all of this work for real-time notification across all of our counties and even outside of our network. We use Collective Medical, which is a real-time ED notification that we have now leveraged different functions of that system for our hospital, and provider, and ECM providers that are really emerging as a great best practice for high risk members.
Slide 17	Katherine Barresi – 00:18:16	And then lastly, to do this work and to form partnerships is to really align the priorities. So when you're speaking with hospitals and skilled facilities, understanding what their drivers are around readmissions and quality care, and pointing out where that is similar with the TCS services that are offered now with Medi-Cal. So I'm happy to pass the baton to our next panelists to talk about some of their activities.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 17	Sarah Behr – 00:18:45	Hi, everyone. I'm Sarah, Social Work Supervisor here at Providence. So, wanted to tell you a little bit about our department here at the hospital. Transitional care is what we do here. Our department aims to improve the quality inefficiency of healthcare delivery in the hospital setting. So it differs from transitional hospital care that you might think of doctors and nurses providing that traditional care. And we focus more on care coordination, and disease management, and patient education to achieve better patient outcomes.
Slide 17	Sarah Behr – 00:19:16	And so, in our department, we have case managers and social workers who see every patient and help to coordinate their hospital care and their discharge. So anytime they're leaving to a different level of care, we're looking at that. So the key components are transition management, disease management and prevention, and patient education and self-management support. We can go over to the next slide.
Slide 18	Sarah Behr – 00:19:43	And so, I wanted to talk about some benefits of a hospital care management program, just as we've been talking about this whole time. So the first is just improved patient outcomes. Our aim is to reduce a patient's length of stay here. That's always good for a patient not to spend too much time in the hospital, and to prevent their readmissions by linking them to what community supports they need so that they're sustained there in the community and aren't coming back to the emergency room or the hospital for care.
Slide 18	Sarah Behr – 00:20:11	Our social workers and our case managers, our social workers are in the middle here with our case managers, too, in this little graphic that you see. But we help enhance the communication and the coordination between the healthcare providers. We sometimes refer to ourselves as the hub of the wheel. We're taking all of the recommendations from all of the providers and consultants here in the hospital, and ensuring that the patient has the adequate services and follow-up care that everyone is recommending.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 18	Sarah Behr – 00:20:39	And then, the other benefit is just increased efficiency and cost savings. Along with patients not wanting to be here in the hospital a long time, their insurance companies and all those, they don't want their patients being in a high level of care for that long, either. And of course, all this comes with a lot of partnerships, as we're going to be discussing in this webinar, with health plans and other community providers. So I'll turn it over to ... I think Nicole is next.
Slide 19	Nicole Gore – 00:21:11	We can go to the next slide, please. Awesome. Hi, everyone. My name's Nicole. I am the Care Coordination Program Manager here at Santa Rosa Community Health. And so, as Sarah mentioned, we have quite a bit of partnerships within our county regarding TCS services. So just to give you a brief overview of what services we provide in our department, we have several different grant funded programs, many that do provide TCS. Some of the ones that I have highlighted here are the largest.

VISUAL	SPEAKER – TIME	AUDIO
Slide 19	Nicole Gore – 00:21:42	So we have our enhanced care management program. We are an ECM provider. We have our ED Diversion program that provides services, direct linkages services from our partners at Providence to our PCP providers here at Santa Rosa. We have our LICN program, which is the Local Indigent Care Needs program that provides TCS services for our patients that are being discharged from three of our local hospitals. And then we have our Homeless Care Transitions program that provides services, but much very similar to our ECM program, specifically targeting individuals experiencing homelessness that are high utilizers. Next slide, please. So I think just to create more of a framework, I think it was important to talk about how we measure success. Measuring TCS, it can be complicated. And so, these are some of our metrics that we track. We track re-hospitalization admission rates. We track successful PCP linkages, specifically with our ED Diversion program. We have a care coordinator that is embedded at Santa Rosa Memorial Hospital, we will provide those linkages for patients that are identified for PCP appointments. And we also focus on the timeframe of those appointments and when they occur. So this is a project that we're continuously working on, making sure that those folks are connected to a primary care provider within at least 10 days, is our metric. We also focus on "successfully housed and sheltered," so individuals that are experiencing homelessness, we try to ensure that prior to discharge from a hospital, that they have either access to transitional housing or to a shelter. We certainly don't want individuals being released from hospital, returning back to encampments, or back to unhoused situations.
Slide 20	Nicole Gore – 00:24:03	And then we also look at patient health outcomes. Some of our grant-funded programs regularly track BPs and PHQ9 depression scores. We also have a pretty multi-disciplinary approach to some of our programs.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 20	Nicole Gore – 00:24:19	We have RN case managers that will also assist patients with medication adherence and treatment adherence, to ensure we're lowering the chances of re-hospitalization.
Slide 20	Nicole Gore – 00:24:31	And then we also look at patient outreach and engagement. And this is probably the most important component, and making sure that we have our care coordinators ensure patients are not only going to those initial PCP visits, but also have follow-up appointments scheduled, making sure that they're addressing any barriers to care, whether that's transportation or just childcare, you name it.
Slide 20	Nicole Gore – 00:24:54	We also provide patient resource navigation. We utilize a prepared screening tool, which is a tool that our staff used with specific questions geared towards identifying any needs that a patient may need to be addressed. There may be a barrier to getting into care.
Slide 20	Nicole Gore – 00:25:14	And so with all of that, we really focus on closing the loop, so ensuring that not only are these referrals made, that there is a recall. We'll go back in making sure that those patients were adequately referred, that they made it to those resources, that they made it to that appointment, and troubleshooting in cases where maybe there was a barrier at that time.
Slide 21	Nicole Gore – 00:25:41	The next slide. So Santa Rosa Memorial Health, through Providence and Santa Rosa Community Health, we've had a pretty long standing partnership, and a lot of it was just born out of recognizing and addressing community needs within Santa Rosa.
Slide 21	Nicole Gore – 00:25:58	And then also just identifying within our own internal organizations what kind of quality improvement initiatives and projects that we're noticing. And one of the things that we definitely did notice was some gaps in services regarding patients that were being released from hospitalization, and then getting over to our organization for care, and specifically with access.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 21	Nicole Gore – 00:26:23	And so we've worked together very closely. Providence has developed several funded projects. Two of the projects that are funded, that I had mentioned, are the ED Diversion program and the Homeless Care Transitions program, which really works closely on identifying our patients, and making sure that they're connected to care.
Slides 21-22	Nicole Gore – 00:26:42	And then we also collaborate in several other projects that I mentioned that are not funded necessarily by Providence, but by our similar initiative, as the ECM, and then as well as our Local Indigent Care Program. Okay. Next slide. And so what are some of our current collaborative strategies? We really pride ourselves in making sure that we stay in communication. We have weekly leadership meetings where we address challenges and barriers experienced by staff. We'll review and improve individual workflows for our programs.
Slide 22	Nicole Gore – 00:27:19	Things are changing within the community and within our own organization, so we're just cognizant of that, and making changes when appropriate, to make sure that things are running efficiently. Case conferencing, also another major component of our meetings. We may have specific scenarios that just crop up that we're not really sure how to address, and working together as a team to come up with the best solutions for those particular patients.
Slide 22	Nicole Gore – 00:27:47	And also data sharing. Like I had mentioned, Providence has funded a couple of our programs, and part of making sure that we're making the impact that we're striving for is tracking data on a monthly basis, reviewing productivity, reviewing these metrics, to make sure that we're making a difference.
Slide 22	Nicole Gore – 00:28:08	Ultimately, it's what the goal is, making sure that the program that we're running is working the way that it should.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 22	Nicole Gore – 00:28:15	And then consistent communication, just checking in, looking at each other, looking at our individual organizations and what are the needs, expectations, setting realistic expectations and working with one another on trying to make improvements wherever we can.
Slide 22	Nicole Gore – 00:28:35	And then of course, internal updates. We're both rather large organizations and things change, and making sure that we're in the know, internally as well in a community-based as well. All right. And I think that is all for us. I'll just go ahead and hand it over to the next panelist.
Slide 22	Shaw Natsui – 00:28:57	Great. Thank you. Dr. Grewal.
Slide 23	Khush Grewal – 00:29:01	Hey everyone. I'm Khush Grewal. I'm a medical director at Community Health Center Network. We're an MSO in Alameda County. Thanks for having us. We're super excited to share about our Care Transition Nursing Program.
Slide 23	Khush Grewal – 00:29:16	So a little bit of a background. CHCN, we represent eight federally-qualified health centers in Alameda County. Our health centers are very unique. They evolved to serve the local communities that they're in, so they have somewhat varied patient populations.
Slide 23	Khush Grewal – 00:29:37	Some of our health centers have a high number of unhoused patients, so they specifically try to address problems that may affect that population.
Slide 23	Khush Grewal – 00:29:47	Others have high numbers of patients for whom English isn't their first language, and so they try to serve those, the specific needs. But the general underlying theme is our patients have complex medical, behavioral, social needs, and it puts them at high risk for utilizing the ED and hospital more than we would like, more than they would like.
Slide 24	Khush Grewal – 00:30:12	And the CTRN Program is evolving to address that, and reduce our rates of hospital admission and ED visits. Can we go to the next slide?

VISUAL	SPEAKER – TIME	AUDIO
Slide 24	Khush Grewal – 00:30:26	So just a high-level overview of what the CTRN Program is. It was started about four years ago, and it was started as a collaboration between four of our health centers and Sutter Health, specifically Alta Bates Medical Center in Oakland. And they were seeing high rates of admission and readmission from our CHCN health centers. And so they reached out to form a collaboration to problem-solve why this was happening. Our funding for the first two years was from Sutter, but we've been expanding to all eight of our health centers, and to other hospitals, and now we get more of our funding from Alameda Alliance as well as Anthem.
Slide 24	Khush Grewal – 00:31:17	So definitely we've been scaling up over the last four years. The CTRNs are at each of the health centers, and they're nurse-led teams. So we have one RN, along with one care coordinator functioning as a team, to help our patients transition.
Slide 24	Khush Grewal – 00:31:37	Some of the health centers have higher rates of hospital discharges, so that they're staffed appropriately. They may have two or three RNs, as opposed to just one. And a couple of the health centers have also hired nurse practitioners or physicians to serve as the CTRN, so that they would have a visit with the patient who's transitioning and do the transitions of care work, but also they're part of the CTRN program.
Slide 24	Khush Grewal – 00:32:09	So there's a few variations, but generally the idea is it's a nurse-led team. What they provided to the patient upon discharge, the basic stuff, making sure that medications are reconciled, patients know how to take them, patients have the medications, that they've gotten them from their pharmacies. A relatively high number of our patients are uninsured, so we do sometimes have difficulty making sure they get the medications they need. So the CTRN staff are trained on how to make this happen, whether it's through funding through the health centers, or other grant programs.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 24	Khush Grewal – 00:32:51	The other part of the care transition is making sure that the patients have a follow-up appointment with a primary care doctor or a primary care provider, and that's for everyone who's experiencing a care transition.
Slide 24	Khush Grewal – 00:33:05	And then specialists as well, our CTRN staff inform the patients of which specialists they need to follow up with, and then also help them make those appointments, because that can be difficult as well.
Slide 24	Khush Grewal – 00:33:20	And then they also provide support with social determinants of health. Our care transitions nurses are aware of the requirements for enrolling in ECM or complex case management, and they know to make referrals. We're also working on creating more contacts between them, as well as behavioral health specialists at the health center, so that patients who need behavioral healthcare also get the appropriate referrals.
Slide 24	Khush Grewal – 00:33:53	Some of our health centers also have street health teams, so we've made introductions between the CTRNs and the Street Health team, so they know who to speak to when making a referral for a patient who needs support finding housing, or if they do live in an encampment, making sure that someone is going out and following up with them to help them with medications and follow-ups.
Slide 24	Khush Grewal – 00:34:18	And then the last part is engagement and collaboration with the hospitals and health plans. Obviously our funding is coming from the hospitals and health plans, so we try to engage them as much as possible at the hospitals.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 24	Khush Grewal – 00:34:35	More practically, the case management hospitals need to know how to get ahold of our CTRN so that they can convey discharge plans. And so we make sure that those communications are open, that everyone knows that there's a telephone number to get ahold of someone at the health center. You don't have to wait for 30 minutes or whatever in a phone tree trying to get ahold of someone. There is direct communication. We're working on setting up communication through the EHR. Sometimes it's more difficult, but I think that's our next strategy, to make communications more effective.
Slide 24	Khush Grewal – 00:35:14	And then obviously providing data back to the health plans and the hospitals, showing that we are achieving our goals of reducing readmissions and improving patient care. So those are the basics. Could we do the next slide, please?
Slide 25	Khush Grewal – 00:35:32	So we are working on a workflow, and this is a work in progress, because new things keep getting added, and I think the new TCS requirements are definitely a big addition. So we looked at it as three, now four levels. So the hospital level, CHCN, and at the FQHCs, and then also the health plans, they will be more involved now, and they have been, but we're going to make some changes.
Slide 25	Khush Grewal – 00:36:03	Basically the workflow is, a patient gets admitted, we get daily ADT reports from the health plans regarding this. And then we also get updates through Care Everywhere, which is a feature in Epic, the EHR that's shared by all of our health centers, as well as most of the hospitals in Alameda County.
Slide 25	Khush Grewal – 00:36:22	So we have two ways of knowing when a patient is admitted, and that's done thoughtfully, to make sure that we don't miss anyone. And all of that gets compiled into a Tableau dashboard that we share with the CTRN staff at each of the health centers. This provides them with a working list of who is going to need to be outreached to, and also it gives them basics such as what the diagnosis was, where they were hospitalized, and how long they were hospitalized for.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 25	Khush Grewal – 00:36:55	The CTRN then takes that, and makes sure that the patient has a PCP that they're assigned to, and if not, then to work on getting them assigned to a PCP. And then also scheduling follow-up appointments.
Slide 25	Khush Grewal – 00:37:10	Back to the hospital level, we also provide lists of who the single point of contact is at the health center, to the hospitals. So when a case manager is looking to discharge someone, and it's a complicated discharge, like let's say a patient needs a CT scan within a week of discharge, they know that they can call someone at the health center and make sure that that arrangement is in process, before the hospital discharge happens, because with prior authorizations, scheduling, getting orders, those can often get delayed. So this is a way of making sure that all of that planning starts before the patient discharge happens.
Slide 25	Khush Grewal – 00:37:52	When the patient is eventually discharged, the CTRN has a visit with them. They make the referrals that we spoke about earlier, they do medication reconciliation, and then they handle specialist follow up. And we do track how many patients had an appointment made, how many followed up, how many canceled, and how many were no-shows.
Slide 25	Khush Grewal – 00:38:16	The no-shows are available in the Tableau dashboard so that there is a workflow to try to get them back engaged in care, even if it's not within 14 days or a month, but eventually those patients should be seen. And the new additions that we're making specifically for the new TCS requirements, for the pre-discharge risk assessment, the utilization management nurses at CHCN will be doing those assessments on all the high-risk patients, basically the lists provided to us by the health plan. So they will be involved in doing this, and then the utilization management nurses will then convey those risk assessments to the CTRNs as well, so they kind of know what to look out for when they're speaking with the patient, and making sure that the risks are addressed.

VISUAL	SPEAKER – TIME	AUDIO
Slide 25	Khush Grewal – 00:39:10	And then the post-discharge follow-up we feel like is a pretty natural workflow for our CTRNs. They're doing most of this already, so we feel pretty prepared for that.
Slides 25-26	Khush Grewal – 00:39:21	Another addition that I think the health plans or Alameda Alliance specifically will be doing, is looking at high utilizers overall for that plan. Not necessarily folks who are in the hospital right now, but who have gone to the hospital a lot, and on the side will work on them or make sure that appropriate referrals to ECM and complex case management have been made, whether they need community support referrals, and that that's still a work in progress, but it's something else we're thinking about. And then the last slide, please. We just wanted to share our outcomes for the last couple of years. We feel that they demonstrate success. Our rates of admission kind of go up and down, and I think that is a little seasonal, as in wintertime we expect more admissions, but our overall rate of readmissions has gone down. I think a lot of this tracks along with the expansion of the CTRN program. So for 2021, we only had four health centers, and now in 2022 we've expanded to all eight, and then we're seeing an appropriate decrease in readmissions.
Slide 26	Khush Grewal – 00:40:46	I think our data also gives us a lot of insight into the important parts of care transitions. So previously, when Sutter was the only one funding us, we were seeing decreased rates of readmission to Sutter facilities specifically.
Slide 26	Khush Grewal – 00:41:02	Now that we've expanded our outreach to the Alameda Health System hospitals, we're also seeing reduced rates of readmission of them as well. So having a partnership between the hospital and the health center is essential, because as a one-sided effort, it really doesn't work very well. And then also the health plan, as the health plans become more involved and then we learn more about their resources and offer those to our CTRNs and our patients, I think it's been shown to be really effective.

VISUAL	SPEAKER – TIME	AUDIO
Slide 26	Khush Grewal – 00:41:38	So yes, there's multiple ways of looking at our data, but overall it just shows that the more that we talk and collaborate, the more successful we are.
Slide 26	Khush Grewal – 00:41:52	Thanks.
Slide 26	Shaw Natsui – 00:41:54	Great. Thank you, Dr. Grewal, and to all of our panelists, a ton of great information, a lot of pearls and takeaways. I think it's definitely so much expansive work, and to try to give an overview of this, really thankful for your presentations.
Slide 27	Shaw Natsui – 00:42:13	I think to me, it demonstrates a lot about how a lot of great things are certainly possible in this complex area, but they certainly require, as Catherine mentioned, a lot of work, a lot of thoughtfulness around building relationships and good, or I suppose removing barriers to communication, whether that's between partners or between patients with members, and who they need to be in touch with, and investing and aligning resources to targeted strategies and challenges to try to bridge the gaps that folks are identifying. And so I want to take this time to now dive deeper. And so if we can go to the next slide, please.
Slide 27	Shaw Natsui – 00:42:58	So for the panel discussion, for the panelists you just heard from, we wanted to give an opportunity to expand a little bit more focus on these four discussion topics.
Slide 28	Shaw Natsui – 00:43:08	And so first is about identifying the individuals who would receive these transitional care services.
Slide 28	Shaw Natsui – 00:43:16	Next, we want to talk about the process of assigning a care manager and again, how to build that critical relationship between the care manager and the member.
Slide 28	Shaw Natsui – 00:43:26	Third is talking about the coordination between health plans, facilities, whether that's hospitals, SNFS, and so on, outpatient or continuity providers as well as care managers.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 28	Shaw Natsui – 00:43:39	And then finally wrapping up and focusing a little bit on evaluation and improvement, which is a big topic in itself. And so certainly lots to cover. So I want to really jump right in, but I think a lot of things we've heard so far, I think will get weaved into some of this discussion, too. So whether that's being intentional, again, around data and technology, or again, I love the references weaved in around ECM and CCM since really this is all meant as a continuum of care for the members. And so we will basically turn it back over to the panelists.
Slide 28	Shaw Natsui – 00:44:23	So for our first discussion topic, we're going to speak about, again, how to identify those individuals. So I'll turn to Katherine first, and so to Katherine, as Dr. Babaria mentioned at the top of the call, starting January, new MCPs must ensure that transitional care services are completed for all high risk members. So that includes assigning a care manager, or a single point of contact, who makes sure those responsibilities are completed. And so my question to you, Katherine, first, is, now what processes does Partnership Health Plan use to identify those who are high risk?
Slide 28	Katherine Barresi – 00:45:02	Great, thanks. So as you guys are pretty familiar with in the populational strategy, DHCS has already outlined who high-risk members are, right? Those are the folks that qualify for either enhanced care management or complex case management services. If you are an NCQA-accredited plan, you likely also have transitional care management services pulled into your umbrella of care management, and or UR services as part of that accreditation process.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 28	Katherine Barresi – 00:45:28	So how we go about identifying these members, it's a multi-modality approach. To be frank, what does that mean? It means through ECM, it's no wrong door. So it could be one of our ECM-contracted providers now out in the community, grabbing a patient, a high utilizer upon discharge, before they leave the hospital. Here at the health plan, if it is somebody who is likely qualifying for complex case management, it's identified usually, typically through one of those ADT feeds that we get. So our utilization management nurse says in real time "Oh, Katherine's showing up to Dignity & Mercy, and she meets our program criteria." And she's sending that referral real time to the care manager who's reaching out to the case manager while the person's inpatient and having those conversations and introducing themselves to say, "Yes, I know I'm calling from your health insurance company, but do you want help? Do you need help when you go home? Do you know where you're supposed to go to the doctors afterwards? I can see here that you're there for, let's say, diabetes care or your kidneys," or whatever's going on, and starting to open and invite that conversation and create some scaffolding. So believe it or not, I will also share that it's not uncommon, this may shock some of you who are not in the direct patient care world anymore, patients actually call from the hospital beds.

VISUAL	SPEAKER – TIME	AUDIO
Slide 28	Katherine Barresi – 00:46:48	It's happened a handful of times. Sometimes around situations we can improve on and sometimes we can't. IE, "I'm not leaving the hospital and you can't make me." Those things have come through and I'm just going to be real about that. So when I say our high-risk folks, it's how we identify them can be through analytics and we have to be careful about those analytics that we don't have unintended biases and that they're vetted and they're true and they're looked at annually, but also through untraditional channels such as the new benefits and services and under CalAIM, CS providers, ECM providers, and even members themselves. So multiple different ways for identifying.
Slide 28	Shaw Natsui – 00:47:29	Great, thanks so much. And you referenced that the ADT feeds as a main crux of getting the data timely. Is there anything else you can share about data sharing agreements or any insights for plans and others, again, who are already actively working in this space, but anything more related to the transitions that you want to share?
Slide 28	Katherine Barresi – 00:47:54	Yeah, I think with regards to the ADT feeds, especially if you are looking to get traditional sources of information such as information on the acute side into the outpatient world, creating that buy-in about not having another system to document in is huge and being real about how it's set up and how it's used. And then even in some cases, I'm again being super honest, incentivizing it. So partnership took on the cost administratively to pay for our collective medical licensing fees for our providers and then built in use, them using the system in our hospital QIP program.

VISUAL	SPEAKER – TIME	AUDIO
Slide 28	Katherine Barresi – 00:48:35	We require it of our ECM providers. So again, it's the stick and carrot approach because ADTs are only as good as the people who actually use them. We want people looking at these systems and communicating with them because it's the best way and the most timeliest way to reach the members. So figuring out if there's barriers or challenges, maybe it's on the hospital system or the SNF system side or their IT sophistication. Where can we lean into that a little bit? And even just the user end, what are the challenges? And understanding what's preventing them from buy-in.
Slide 28	Amy Salerno – 00:49:10	And Katherine, just something from the chat, when your care managers are reaching out to patients and helping them with this, do you notify the hospital team as well or how do you coordinate with them?
Slide 28	Katherine Barresi – 00:49:26	Yeah, so it's a two-prong approach. And so if it's identified for complex case management, the complex case management nurse and/or social worker is working directly with the hospital discharging case manager. And in the authorization piece, it's our utilization management team who's documenting all of this in the auth process. So it's not just the medical necessity about the number of days and what level of care, it's also this backend coordination piece. And here at the health plan, our case management team and our utilization management team work on the same platform so they can see that activity synergistically real time.
Slide 28	Shaw Natsui – 00:50:06	Great. Thank you, Katherine. Dr. Grewal, I wanted to turn to you next. From the CHCN perspective, as a provider who has implemented a transitional care program, how do you and your clinic partners identify those patients who qualify for transitional care services? How do you do it in a timely manner? Are there specific criteria that you use? And you spoke a little obviously to the nurse transition program, but wanted to get your additional thoughts there.

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Slide 28	Khush Grewal – 00:50:38	Yeah, so at this point, up until this point, the program, so we have received an ADTP dimension from the health plan, and then we also get the updates through the EHR. But basically we try to see every patient who has gone to the emergency room or the hospital and follow up. There's not really a select group of patients, specifically those who are ECM eligible or in complex case management. So the goal is to see everyone, but unfortunately I think it also makes it very difficult because the system gets impacted. We don't have enough providers to be able to see all of them. So for the last couple of months we've been talking about implementing risk scores into our Tableau dashboard so we can prioritize patients who are at higher risk for readmission. We've identified a few different ways of doing it.
Slide 28	Khush Grewal – 00:51:40	The Alameda Alliance for Health has started using ACG risk scores, and so sending us over lists of patients who have a high risk score and have been in the hospital and we can try to prioritize those patients. We also get a little bit of feedback from the hospitals. Sutter Health uses the LACE risk score, which looks at 50 different risk factors that predict the rate of readmission. And so the case managers from Sutter will sometimes send us lists of patients who score high based on that. And then the Alameda Health System hospitals do something similar. They're changing the risk score right now, but they do send us emails about patients who score high on their own internal risk scores to have them followed up sooner rather than later.
Slide 28	Khush Grewal – 00:52:31	I think what is going to be most successful for us is having a single centralized score that we put into the Tableau dashboard that all of our CTRN staff have access to, and so that they can prioritize based on that rather than trying to coordinate these multiple data streams. And so that's our next goal, is to figure out what would be best for us and then use that and use it with all of our CTRN staff.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 28	Shaw Natsui – 00:53:03	Great. Again, I thought that's super helpful. As we know, many of these entities, the plan side or the hospital side are using different versions of risk stratification and obviously something that I think a lot of the folks on the call know, the state is also working on more as part of population health management generally as well. But to take the variation or the variety of outputs that are coming your way and trying to integrate that, I think it's really helpful to hear how you're working with those different pieces of information. But ultimately, in some ways it's a good problem to have, that at least you're having that communication come in and that's established, right? Because otherwise the opposite would be that you'd be more in a silo, and so thanks for that example. Keeping an eye on the clock too, I want to move to our second discussion topic, which is about assigning a care manager and building that relationship between the care manager and the member.
Slide 28	Shaw Natsui – 00:54:07	And so I wanted to ask, just of our panelists, just to start, can you tell us a little bit more about what your transitional care model looks like? And as a primer, for example, do you meet the individual in person? Do you use telephonic encounters? Do you have community health workers as part of that engagement? How do you overcome challenges like transportation to follow-up appointments or medication reconciliation and many other potential examples? And so I think I will turn it over first to some of the other panelists that I haven't called on yet. So maybe we'll start with the Providence team.
Slide 28	Sarah Behr – 00:54:55	Muted, sorry. Yeah. Can you hear me now?
Slide 28	Shaw Natsui – 00:55:00	Yes.

VISUAL	SPEAKER – TIME	AUDIO
Slide 28	Sarah Behr – 00:55:01	Great. So our transitional care services starts with an initial assessment of each patient as they come in. Just like any traditional inpatient case management initial assessment, it begins with finding out where the patient is from and what their criteria are. Medically, obviously, we are going to wait until they're ready to go home and then we will implement the said services surrounding the patient's needs. As an example, if a patient does need assistance going home with a home living situation, we always will have home health set up for the patient. And we do collaborate well, not only with the home health agencies, we do have a home health agency actually on staff here, so it happens quickly for them. But we also have the care network within the Sonoma County that provides outpatient utilization for the high utilizers of the ED as well as outpatient case managers and social workers.
Slide 28	Sarah Behr – 00:56:05	When it comes to transportation services, we provide transportation services through what's called a We Care Fund, which is through the hospital as well. So a really big part of transitional care services is getting patients to and from their appointments and getting them from the hospital to home. And so we do offer that for our patients. A really big connector too is through Care Network or even the We Care Fund, we can also offer MedRec, reconciliation as well to help patients with their new medications going home.
Slide 28	Sarah Behr – 00:56:41	There are many different avenues that a patient can take coming from the hospital, but these are just the specifics for us. So medications, transportation, and then the outpatient networks that assist with the care from the hospital. So I hope that answered your question in regards to the transitional care services and what it looks like coming from the hospital. It begins here, but it also continues. We have a readmission coordinator, nursing supervisor also who looks at our high utilizers in the ED and looks at our readmissions and then evaluates for possible care that we can give through the community and through the hospital.

VISUAL	SPEAKER – TIME	AUDIO
Slide 28	Shaw Natsui – 00:57:25	Great. Thank you. Nicole, can I turn it over to you next to talk a little bit about your transitional care model?
Slide 28	Nicole Gore – 00:57:35	Yeah, sure. So our TCS model, it's very similar. We become aware of a patient that's referred to us either internally or through our hospital partners or community based organizations. And we do our initial outreach. It's a mix, sometimes we do more of a telephone encounter or we'll do an in-person assessment of that patient. And then just initially with that first visit, we conduct what's called a prepared screening where we'll review any potential barriers to care that a patient may have or just any intrinsic needs that we need to be addressing such as transportation or insurance status, behavioral health, and then just building a care plan surrounding the results of that assessment. Our programs really consist of teams that make up just a very ... We believe very much in having a multidisciplinary approach when it comes to building our teams.
Slide 28	Nicole Gore – 00:58:39	And so we have care coordinators, we have CHWs, social workers or registered nurses, care managers who will provide wraparound services for those patients and identify and address those needs as they come. And then we also utilize tools as well to our disposal, specifically with our ECM program, we developed an acuity tool, which helps stratify caseloads and that way we're able to really identify those individuals that are a little bit more critical and that require a little bit more support. And then also other tools that are really useful for re-hospitalization such as Collective Medical. We're a big proponent of that. It's been really helpful and it's just an internal flagging system to let us know if patients are being re-hospitalized and allowing staff to regroup and provide more crisis stabilization for those patients. And then another really important aspect of our model is just the ongoing collaboration with our hospitals, local CBOs and community stakeholders, especially with the county.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 28	Nicole Gore – 00:59:48	Oftentimes we'll get referred patients that just might not be at appropriate level of care. So just having those linkages with our stakeholders makes facilitating those referrals a lot more smooth. And then also just staying informed on available resources. Resources are constantly changing, funding as it becomes available. It's constantly changing, so it's good to stay involved within the community. I know in Sonoma County we have a community resource meeting that we have, shelters and local CBOs where we just check in and just discuss just gaps in care and any changes with community resources. So I think that gives you just a general sense of what our model looks like.
Slide 28	Shaw Natsui – 01:00:38	Definitely. Yeah, definitely comprehensive and makes sense. Katherine, is there anything you want to add from the partnership side and in how you work with these groups too?
Slide 28	Nicole Gore – 01:00:50	Yeah, I will just say in some instances, we're contracting directly with these groups for these services, whether it be through a capitated agreement or even a benefit like Enhanced Care Management. Sometimes we're funding them via grants outside of Medi-Cal. And other times, like I said, sometimes the health plan, we're just the conveners and we're helping to bring groups together who might not be aware, but also stepping in when asked and where needed. So for instance, if there's areas of our network where they've got huge staffing shortages and they don't have these rich resources, how can we as the health plan support that community until that infrastructure is there?
Slide 28	Shaw Natsui – 01:01:34	That's great. Thank you. And Dr. Grewal, anything else you want to add about your traditional care model that you may not have covered?
Slide 28	Khush Grewal – 01:01:45	I think that the process slide pretty much covers at all.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 28	Shaw Natsui – 01:01:49	Yeah. Yep. Sounds good. Great, thank you. So now that we've given again a little bit deeper into what your model looks like, how about that relationship again itself? Keep referring to how important this relationship is between the care manager and the member and how challenging it is, especially given that we are focusing delivery first on the highest risk members. And by nature of their high risk, they often may have complicated medical conditions, social economic conditions, different things that make everything from communication to access to trust, and all these important things more difficult or more of a challenge to be thoughtful about. So wanted to hear your perspectives around how each of your organizations build these relationships. What are some of the challenges and what are the things you have done to overcome those challenges? And so maybe I'll go reverse order again. Dr. Grewal, maybe I could start with you.
Slide 28	Khush Grewal – 01:02:58	Yeah. So I think one of the most important things is we do emphasize communication between the various stakeholders. So we have three sets of big meetings that happen every couple of months. One is a meeting between the CTRN's quality staff at each of the health centers and then CHCN. And we review workflows at the health centers. Do you have enough providers? Do you have enough people who are available to help the patients come and transition into care? Is the quality data good enough? Are we tracking it appropriately? Are we seeing your outcomes as well as we should? And then also those meetings serve as a clinical discussion forum for the CTRNs to discuss difficult cases and brainstorm ways to handle them. Another meeting that we have is between the CTRNs and the hospital partners, because I think a lot of the conflicts is often like, "Okay, well we discharged the patient and they needed to get a paracentesis every two weeks, but that's not happening and now they're coming to the ED."

VISUAL	SPEAKER – TIME	AUDIO
Slide 28	Khush Grewal – 01:04:13	And then the CTRNs may say that there's just not enough radiology access to have that happen. And so I think we were really not having those sort of discussions, and it ended up being a lot of finger pointing about what was driving readmissions. And I think having these meetings every couple of months to discuss these sticking points has been really helpful as well. And then the third meeting is between CHCN health plans and the hospital partners to talk about how we can serve as a better backbone organization. What information can we provide to the health centers, what resources can we give them to better communicate with the health plans and the hospital partners? And that's where a lot of our ideas about how to communicate better, whether to use EHR, whether to use external teams groups to talk amongst each other.
Slide 28	Khush Grewal – 01:05:05	Does everyone have everyone else's phone numbers? I think for a while, Alameda Health System was having difficulty scheduling patients at CHCN clinics because they just didn't have a single point of contact, which I think was a real missed opportunity because the case managers don't have the time to sit on the phone for an hour to schedule an appointment, and so we were able to help with that. So I think having those check-ins every couple of months has been really useful. I think checking in with the CTRNs is also really important because we learn about things that we don't think about. Recently we started a pilot project around cell phones. We found out that some of our patients aren't being able to get care transitions because they don't have a phone to know that they have an appointment or do telehealth visits, which isn't the first thing we think about, right?

VISUAL	SPEAKER – TIME	AUDIO
Slide 28	Khush Grewal – 01:05:56	Because 98% of the US population has a cell phone, but high utilizers of the ED are more likely to not have one. And the CTRNs brought that to our attention, and we thought that, "All right, well we have some money to try to fund this program where we give the patients the cell phones and see if we can reengage them better with care." So I think just that, the communication part of it. It's a lot of meetings and I think sometimes people get overwhelmed by meetings, but so far, the cadence that we have seems to be working well and we've been getting good feedback.
Slide 28	Shaw Natsui – 01:06:30	Great. Thank you. I'll turn it over to Katherine. Any thoughts on the relationship building?
Slide 28	Katherine Barresi – 01:06:37	Yeah, couple of different thoughts related to this just quickly. Obviously, what Dr. Grewal shared about the relationships with stakeholders involved in this work for workflows and patient referrals and understanding barriers. But to really underscore the point that if you, the health plan, are going to be embedding staff, that you've got the right staff in place that know how to have these conversations with patients in a real setting and know how to work in a power dynamic shared there in the hospital environment with clinicians there at the bedside and with the teams for their buy-in as well. And what I mean by that, is it is odd. Imagine if you and I were in a hospital bed and somebody walked up to you and said, "Hi, I'm from your health insurance company." The first thing in your mind you would say, "How did you know I'm here?"

VISUAL	SPEAKER – TIME	AUDIO
Slide 28	Katherine Barresi – 01:07:26	Or depending on your background, "I can't pay," or, "I don't understand you." So it's really, really important that you think about this from their lens and what's going on in their world and how we're going to show up in it, not to meet our TCS needs, but to meet their needs. And also, just a really key, important fact is that anybody who's doing this work, especially with the acute inpatient world where there's no time, no money, no resources, and you've just got to go, go, go, you really have to deliver on the things that you say you're going to do. Otherwise, you and that team are going to be faced with more readmissions around things that you didn't solve for, so seeing them as true partners and leveraging their expertise is key.
Slide 28	Shaw Natsui – 01:08:11	Definitely. Thanks, Katherine. Nicole from Santa Rosa Community Health, any thoughts?
Slide 28	Nicole Gore – 01:08:12	Yeah, definitely. I a hundred percent agree with what Katherine was saying, I was just going to piggyback off that idea. I think staffing is essential. All of our care coordination staff are trained in motivational interviewing, trauma informed care. I think operating through that lens is crucial in establishing successful relationships with our members or our patients. In addition to that, also just realizing the value of utilizing CHWs or other frontline care workers and specifically maybe even looking into hiring on staff that have that lived experience component, how valuable that is, and just establishing trust.
Slide 28	**[01:09:04]**	**PART 3 OF 4 ENDS**
Slide 28	Nicole Gore – 01:09:03	... how valuable that is in just establishing trust because you're hiring a staff member that's most likely it's been through it and understands and can meet that patient on their level and it's so critical in creating those linkages.
Slide 28	Shaw Natsui – 01:09:17	Yeah, this is super important. Great point. Thank you. From the Providence team, any other thoughts you want to add?

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 28	Sarah Behr – 01:09:25	Yeah, I just wanted to tell you how we go about it. Here in the hospital when someone's admitted, they're automatically assigned to a case manager or social worker just depending on their unit, and they're not spending too much time here usually. Though they're matched to someone who's going to know a lot about whatever condition they're coming in with, they're not going to know a lot about that person. Rapid engagement is really what our clinicians are really skilled at and just meeting the patient where they are and finding out what they can help most with in that moment to develop that relationship and then go on with a bigger assessment and go from there.
Slide 28	Shaw Natsui – 01:10:08	Great. Go ahead, Palav.
Slide 28	Palav Babaria – 01:10:10	I was just going to say, from the chat, there was a question related to behavioral health and so any one of the panelists that wants to chime in, I think there's a question about specific strategies for coordinating with behavioral health plans when follow-up from mental health or substance use disorder treatment is needed. Specifically, how do you navigate privacy concerns with 42 CFR Part 2 and is there any kind of live data exchange in place already? I think there's clear guidance in the policy guide around things like what should happen, but I think making that happen is a whole other world and I know that there's sometimes challenges and building up relationships and having that coordination happen between systems of care and just wondering if anyone could comment on that.

VISUAL	SPEAKER – TIME	AUDIO
Slide 28	Katherine Barresi – 01:11:19	This is Katherine. I'll jump in from like a 3,000 level view, right? I think this is also part of the exciting work under CalAIM, so the specialty mental health plans right now, just as the physical health side and the managed care side, have new initiatives that we are launching and growing deep roots here in California with. These specialty mental health plans are as well. They have new mandates around no wrong door and different criteria for their specialty mental health plan services and new mandates where they're going to be required to follow up when one of their existing clients were recently admitted, even if it wasn't related to a specialty mental health qualifying condition.
Slide 28	Katherine Barresi – 01:11:55	They're asking these same questions about like, "Oh, we're going to need to know when they were in the hospital." So we're starting those conversations about data exchange. We get it today here at the health plan in various forms. It's very rudimentary. A lot of it is claims data, a lot of it is not accurate or timely. Our ECM providers who are doing transitional care management services when a client qualifies for both ECM and is inpatient, part of the release of information includes sharing information, protected information that would be covered under CFR 42 and their willingness to opt in or opt out of sharing that information, so still very manual today in those places, but emerging.
Slide 28	Shaw Natsui – 01:12:42	Great. Thanks, Katherine. Again, in interest of time, I'm going to move on the next discussion area as well, focusing on coordination between the health plan and the facilities and providers and care managers. Katherine, I'm going to look to you for this first one, focusing a little bit more on contracting. The plan [inaudible 01:13:10] start with TCS requirements for their high-risk members through their own staff or through contracted entities, whether that's ACOs or hospitals, provider groups. What do you do on the partnership side to provide TCS, including whether it's contracted or capitated or other models of care?

VISUAL	SPEAKER – TIME	AUDIO
Slide 28	Katherine Barresi – 01:13:33	There's no quick math scenario where if you have this, this, then you're get a pass to do TCS. It really is organization provider specific, always with the goal of how close are we to meeting the need, how close are we into closing gaps and improving quality and improving, honestly, health equity. So when we're talking with organizations about contracting for this work, it's "Tell me what you're doing today." Right? I can't tell you how many small community-based hospitals, very rural hospitals, say, "Well, we have this person who does this thing." Immediately my mind starts churning. I'm like, "That sounds a lot like transitional care management." How are they doing that today, and do you want to get paid for those services?
Slide 28	Katherine Barresi – 01:14:17	Then in areas where there just is nothing, again, looking strategically here to the plan to kind of fill in those gaps until we can move people along and elevate communities and providers in this space. If it were at all possible, I will tell you there are telephonic models that address patients moving across settings. Many commercial health plans have them. Many boutique health plans have them, especially for certain types of benefits. There are proven evidence-based models out there that work. Coleman capable candlelight, a handful of them. But what I have found in my experience is particularly with the Medicaid population, particularly with the high risk Medicaid population, you can't beat in person and you really can't beat meeting them wherever they're at.
Slide 28	Shaw Natsui – 01:15:06	Thank you. Maybe I'll turn to Nicole and the Providence team. From your perspectives, having worked with each other extensively and with partnership as well, how do you ensure that those services are happening and what about that partnership has worked well, and anything else around data sharing that maybe if we haven't covered yet? I would love to hear your thoughts.

VISUAL	SPEAKER – TIME	AUDIO
Slide 28	Sarah Behr – 01:15:34	Yeah, so as Nicole kind of mentioned in one of her slides, we, me and Nicole actually and a few of the other leaders, we meet on a weekly basis and it's been really helpful. We kind of look back on the last week and identify any barriers that came up to getting a patient the care they needed and we work out any issues with our workflows that might not have been working out. It's just a really good way for us to work out the kinks and make sure that our process is smooth and that the patients we're referring are getting all of the services that they need. We've had some challenges. Nicole and I are both newish in our roles and we have a lot of staff members underneath us that are also newish in their roles. We've been doing a lot of in-services and trainings and education and so it's definitely an ongoing process, but I feel like we have already just in the last few months made a lot of changes that have made that access easier. I'll let Nicole talk a little bit about the data sharing arrangements.
Slide 28	Nicole Gore – 01:16:35	Yeah. I had mentioned in our presentation that Providence does and has funded several of our grant programs, identifying and providing services for Santa Rosa Community Health patients and specifically with Connecting to Care. A lot of our data sharing arrangements on a monthly basis, we'll do a report just really accurately tracking our productivity, and then just the overall program success. it really helps, gives us more of an informed view of what's working, what's not, as we're reviewing these workflows and making changes, and as well as just identifying if there's any gaps in care or any areas just for improvement in general for patient care.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 28	Nicole Gore – 01:17:22	As far as some challenges that we've had regarding data sharing, we are operating on different electronic health record systems, which has been an interesting endeavor on trying to navigate when it comes to data sharing. I'm hopeful though as we're right now in the transition to a new EHR system that's more in line with what the hospitals have currently, that will kind of resolve itself. But that I think probably has been the most challenging aspect, so a lot of our data reporting is done manually and we're looking towards kind of streamlining that in the future.
Slide 28	Shaw Natsui – 01:18:01	Thank you. I know there was a couple of questions in the chat too, but Dr. Grewal, wanted to give you a floor also about anything, insights you could share around your partnerships with the hospitals and health systems on this topic.
Slide 28	Khush Grewal – 01:18:20	I mean, I think Nicole spoke to this, but having different EHRs can be pretty difficult if we don't have a discharge summary to look at. It can be difficult to figure out how to transition a patient. I think gradually and thankfully, we're sort of all coming towards Epic. I think with time, hopefully the majority of the hospitals in Alameda County will be able to be on Epic and I think that makes things a lot easier. I think the other issues that we're facing, I think provider access is a big one because our CTRNs are having difficulty getting patients in to see primary care appointments. I think that can kind of, if a case manager is sending someone out with the intention that they're going to be seeing a primary care doctor and we can't do that, then that's kind of a sticking point, which it's a difficult problem to solve. But yeah, I think those are a couple of the big challenges we're having. Yeah.

VISUAL	SPEAKER – TIME	AUDIO
Slide 28	Shaw Natsui – 01:19:26	Great. Thank you so much. I know there's been, again, a couple of questions in the chat. One of the ones I think highlights one of the challenges around transitional care is again identifying when those transitions happen. I see there's a question around the ECM side, the ECM provider doesn't know if an individual, whether a child or an adult is in crisis, residential setting or other transition of their care setting, how can they be expected to fulfill TCS and receive those services? So definitely acknowledge this is a big challenge, hence a lot of the focus on trying to get all the ducks in a row as much as possible around the data integration and communication. But wanted to open this up to any of the panelists, if you have any thoughts around how to navigate some of these tough moments or tough challenges.
Slide 28	Katherine Barresi – 01:20:33	This is Katherine. What I'll say in terms from that example that Patty highlighted with regards to ECM, this is why we're using ECM providers and contracting with ECM providers who have experience serving this population of focus, not just from a trauma informed perspective, but from a systems perspective. I would imagine that if there is an individual who qualifies for ECM that has been placed in a crisis residential service setting, whether they be a foster youth being placed in that setting or whether they be an adult with qualifying SMI conditions, it's likely going to be the county specialty mental health plan who did that placement and likely the county specialty mental health plan who is their ECM provider who would have access to that data already. Today, that's how we're approaching it, but we know within CalAIM, the data sharing is going to be huge. We're starting the early warm start to that and learning best practices along the way.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 28	Shaw Natsui – 01:21:32	Great, thank you. Want to come back to some of these other threads, but I just want to make sure we leave enough time for our final discussion topic also, since it's a big one and we sort of acknowledge that it will just be on a very high level, but to talk about evaluation and improvement of this TCS work. So wanted to open this up again to all of our panelists, really, how do you measure success for transitional care, and how are you thinking about improving your models of care? I know some of your presentations touched on this as well. I know Dr. Grewal, you had your outcomes presentation as well. But maybe I'll start with you, anything further you could share with us around again how to measure success and how to go about improving?
Slide 28	Khush Grewal – 01:22:21	Yeah, I mean, I think that the readmission rates are one outcome. I think PCP re-engagement is another important one, because I think even if we don't save the next readmission, I think that the fact that the patient reengages with the PCP will hopefully improve their health overall. I think another measure of successes is how well we're able to integrate with other community partners. I think kind of speaking to the behavioral health questions earlier, we've identified that as a problem as well. We have a lot of difficulty getting transparency into behavioral health admissions and so our CTRNs are not able to do as good a job with helping those patients transition to the outpatient setting. So we've recently applied for funding and kind of a partnership with Alameda County Behavioral Health so we can use some of their resources.

VISUAL	SPEAKER – TIME	AUDIO
Slide 28	Khush Grewal – 01:23:18	I think they have a lot more insight into what patients are in the hospital and when they get discharged and what they need and what resources are available. I think identifying the appropriate community partners and making sure that we have linkages with them is going to be really important. I think also looking at just overall quality metrics for our health centers, I think patients who have well-controlled A1C and blood pressures tend to go to the hospital less. I think just looking at our overall care for the patients, hopefully as we see quality indicators rise, we'll see a decrease in readmissions as well.
Slide 28	Shaw Natsui – 01:23:58	Great. Thank you so much. Want to turn it over to the Providence team and Wilfredo, if I missed calling on you earlier, I apologize, but anything that I may have missed? Then also if your team wants to speak again around measurement and improvement, that's be great.
Slide 28	Wilfredo Bernardo – 01:24:15	Thank you, sir. I just wanted to add too, that, timely, we do have a weekly meeting with partnership team and we kind of help identify possible barriers, how we can best move the patient to the next level of care and how can the patient be supported. So we do have the scan team or what we call the PMF team. We discuss these complex cases that we have in-house. So I just wanted to share that that's one thing that is also working for Providence Santa Rosa. As far as the question, "How do you measure success for transitional care?" I totally agree, it's the readmission rates. We do have a population health coordinator embedded within care management, so it's just kind of working closely with the work surrounding the readmission. Part of the work that she's been monitoring is one avenue would be the readmission recent trends and help identify what are possibly the top three reason why they're coming back to the hospital.

VISUAL	SPEAKER – TIME	AUDIO
Slide 28	Wilfredo Bernardo – 01:25:31	Patient care experience would be an avenue for measurement too, because the patient care experience covers the discharge information survey questions as well as the care transitions. I agree with the reports received for the percentage of follow-up appointments made, so we do have several support or resources that it's available for Santa Rosa. We do have the SRCH working with us with follow-up appointments as well as our resource coordinators that yet again are embedded within care management and also our case managers are also involved in ensuring, obtaining a follow-up care appointment, especially for high risk readmissions patients. The utilization of some of the features that's already available in Epic, we do have a readmission symbol that makes it easier for our care team to identify patients that are with high risk scores and it entails the reason why they are categorized to be a high risk patient, so they are being closely watched. Our goal is to see how efficient we are with our 24 to 48 hour readmission assessment, because that's the critical time that we get to implement those measures. We haven't truly worked on utilizing the collaborative medical, which is the EDIE, so my experience from prior organization, this is a helpful avenue to work with outside agency to make sure that these vulnerable patients get the appropriate attention that they truly need.
Slide 28	Shaw Natsui – 01:27:47	Thank you. Thanks, Wilfredo. I know we're coming up on time for the panel. I know we didn't get to close off with everyone on that last one, but if there's anything burning, please, please just kind of jump in real quick. But in respect of folks' time, since we are at the hour, wanted to thank all of our panelists. Again, really helpful insights. We will follow up on any of the chat questions. Please email us in any questions that you may have for either DHCS or the panelists and we will make sure to come back to those.

CalAIM Population Health Management (PHM) All-Comer Webinar: Emerging Practices on the Implementation of Transitional Care Services

January 19, 2023

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slides 29-33	Shaw Natsui – 01:28:27	We can put on the look ahead screen, I guess, this slide really briefly, but looking at this quarter as well as the rest of 2023, as you know, as PHM program launched this year, we have additional focus coming up in particular around monitoring, which everyone will hear a little bit more about, but as well as updates to the PNA and the PHM strategy. So more to come, busy and exciting year. Oh yes, thank you. Want to remind folks of the upcoming PHM Advisory Group meeting where we will talk about PHM monitoring. That'll be on Wednesday, February 8th, so please join, and thank you again, everyone, for participating or joining today.
Slide 33 **End of Presentation**	Shaw Natsui – 01:29:23	Thank you.