Transitional Care Work Group Meeting

Meeting Summary, March 27, 2018

Support and Backbone Staff: Christina Mitchell – *CHOICE*, Shannon Linkous – *CHOICE*, Megan Moore – *CHOICE*, Alexis Sullivan – *CHOICE*, Alexandra Toney – *CHOICE*
In Attendance: Christina Garcia – *Molina Healthcare*, Jennifer Luna – *SeaMar*, David Stipe – *Qualis Health*, Katie Cross, Linda Johnson – *Morton General Hospital*, Stephen Riehl – *HCA*, Carlos Martinez – *SeaMar*, Nancy Holman – *PSWIPA*, Mary Monohan – *Providence*, Marc Bollinger – *Great Rivers BHO*

I. Welcome, Introductions, and Non-Emergency Medical Transportation (NEMT) Presentation

Alexandra Toney welcomed the group and facilitated introductions. She reviewed the objectives for the meeting. Alex introduced Stephen Riehl, NEMT Program Lead for Washington HCA, who shared about non-emergency medical transportation. NEMT's mission is to provide access to necessary non-emergency medical services for all eligible Medicaid clients who have no other means of transportation. The presentation can be accessed here. Main points of the presentation included the following, listed below.

- Broker Transportation, Requirements, Area, and Responsibility
- Client Eligibility for Transportation
- Requesting Services (Scheduled vs. Urgent Calls & Hospital Discharges)
- Modes of Transportation
- Transportation Costs (Total Cost & Total Trips)
- Data Tracking Utilization System
- NEMT Utilization as of February 2018
    - Methadone Dosing – 47%
    - Specialty Care – 16%
- Broker Contract Information

Email any questions and/or concerns to the NEMT Program Lead, Stephen Riehl, at Stephen.riehl@hca.wa.gov or 360-725-1441. You can also reach out to the NEMT staff members, Tracy Graves (tracy.graves@hca.wa.gov, 360-725-9791), or James Walters (james.walters@hca.wa.gov, 360-725-1721).
Christina Mitchell determined this information would be helpful to present to the consumer advisory committee because they could benefit from the transportation provided. Stephen or one of his colleagues will either present to them in person or provide more information for the committee.

II. Transitional Care Logic Model

Alex briefly described the logic model layout to the group. The logic model can be accessed here.
She reviewed Domain 1 investments, and the group agreed that this region needs to establish protocols for everyone to follow for consistency. Communication is key, especially in transitional care. Then, she reviewed the group's proposed target populations, as well as the pay for performance metrics and how

money is earned while progress is measured. She asked the group how they would categorize high risk populations in their respective regions, to which the group answered that avoidable visits are noticed. These visits are considered too high if they are anywhere beyond three to five. Finally, she reviewed the core elements of implementation. Work group members shared that providers need to have the opportunity to work with patients rather than be limited to a timeframe within a visit. Some evidence-based strategies being used within the region's organizations are the following, listed below.

- Patient is discharged with a business card containing appointment information.
- Some practices are implementing Eric Colman's 4 pillars – The Colman Method – with up to 30 days to follow up with questionable patients.
- In one practice, the RN does high needs notes and a brief assessment for social determinants of health. Implementation of this practice reduced ED utilization by approximately 13%.
- Grays Harbor BHO is using a system that will embed social workers into a hospital setting, as well as a community-based transition specialist that will track follow-ups. This team will then follow the patient to take some pressure off the provider.
- Providence is using Mary Naylor's tool to follow up with patients.

III. Addressing Risk Screenings and Communication Among Practices

Alex asked the group two questions, numbered below. The responses follow in bullet format.

1. How are hospitals, Behavioral health agencies and community agencies currently doing risk screenings?
    - BHO does this at the time of intake, but no transitional planning takes place at that point; however, a lot of referrals are made. Transitional planning happens if it's an emergency visit. Screenings happen after hospitalization.
2. How are hospitals communicating with BH, DOH, and other community resources?
    - It is difficult to communicate effectivly when you can't pull the EDIE report to see what's going on with a patient. More open communication and access is definitely needed.
    - Information has to be helpful and meaningful if it's going to go into a system like EDIE. BH providers in general don't provide timely information to hospitals or medical providers.
    - Transitional care is much divided right now because people are not providing the outpatient service in the hospital.

IV. Next Steps & Closing

- Next work group on Tuesday, April 24, 2018
    - 6223 197th Way Southwest, Rochester, WA 98579
- Assessment survey extended until March 30th
- Submit any requested training or work group topics to Alexandra Toney – toneya@crhn.org.