Transitional Care Work Group Meeting

Meeting Summary, 05/29/2018

Support and Backbone Staff: Megan Moore – *CHOICE*, Shannon Linkous – *CHOICE*, Alexandra Toney – *CHOICE*
In Attendance: Christina Garcia – *Molina Healthcare*, David Stipe – *Qualis*, Rene' Hilderbrand – *CHOICE*, Jennifer Luna – *SeaMar CHC*, Carlos Rodriguez – *Molina Healthcare*, Mary Zozaya-Monohon – *Providence*, Nancy Holman – *Physicians of Southwest Washington*, Mattie Osborn – *Amerigroup*, Angela Niday – *Cowlitz Family Health Center*, Renee Smith – *Summit Pacific*

I. Welcome and Introductions

Alex welcomed and thanked the group for being part of the meeting. She facilitated introductions and reviewed agenda items, which included program updates, assessment data, summary of toolkit and project area, and discussion.

II. Program Updates, State Capacity Assessment, and Discussion

Alex reviewed program updates, listed below.

1. Provider participatory payments were released; one per EIN in the amount of $3,753 on May 18th
2. RFP was released May 30th, and will close on July 16th with instructions
    a. Send questions to rfp@cpaawa.org. Answers will be posted on our website weekly.
    b. Virtual Town Hall meeting through Zoom on June 8 from 1-2pm to answer questions, as well.
3. Letter Of Intent due on 6/14 that states which project you'll be applying to and which strategies you plan to implement.
4. Will select partners by 8/15
    a. Process: CPAA will work with a third party for scoring RFPs and rating partners. There will be a ratio range of Behavioral Health providers, Community Based Organizations, and Primary Care providers selected. There will also be a specific pool of partners that CPAA will select that may score low, but will be integral to the process.
5. CPAA Implementation Plan will be completed in October.

Alex reviewed the feedback from the state assessment results. The assessment was open for one month and received 53 unique responses. A breakdown of the data can be accessed here. Please let Alex know if there is any specific data from the assessment you want broken down and she will present it at work group in June, or send it to you individually.

After learning about assessment results, a discussion about barriers to feedback and following up in individual practices; barriers coordinating transitional care; transitional care elements used or adopted within individual practices; teach back methods used in individual practices; and

documentation methods for risk factors/well-defined intervention programs within practices generated the following feedback, listed below.

- Access to acute care hospital or access to any health information exchange is limited.
- From the health plan standpoint, the biggest barrier is being able to find the patient at all. Community connectors can be assigned to find people in person, but it's hard to make actual connections without jumping through hoops for a low success rate. It's great when the people are found, but highly unsuccessful in the large scope.
- Hospital communication is lacking, i.e. staff doesn't fill out paperwork when patients have been discharged, so follow-up doesn't happen within 48 hours and then the connection is lost.
- Skilled nursing facilities and rehab centers are hard to track transitions in.
- Barrier: go to hospital to locate a patient and get told they aren't there when the provider knows they are.
- Use of a transitional management team who will follow up with complex patients and set up appointment in 7-14 days.
- Most organizations would like to implement some type of evidence-based process, but they are too costly.
- Motivational interviewing is a big "teach back" method used.
- Teach back isn't always the most effective method because it doesn't create a positive environment for the patient; however, would be a great transition to hand these teach back methods to Primary Care Providers so they can educate patients.
- Training provided for staff both in-person and telephonically, but in-person vs. telephone are very different processes and often produce different results.
- Health homes: involves 3 follow ups with the first two being telephonic and the third one in-person, hopefully in the home.
- Big time commitment and takes away from other programs.
- It can take a long time to track down a patient.
- If the resources are available, intervention programs are very doable.
- For example, tobacco intervention, because resources are already available.
- Everything is a barrier with coordination of transitional care, especially concerning social determinants of health and access issues.
- Housing – as the elderly run out of funds and you get them on Medicaid, family homes are starting to price themselves out of the market.

III. Evidence-based practices and MTP Toolkit

Alex pulled information from the toolkit to discuss evidence-based approaches. Some approaches under this model include the following:

- Interventions to Reduce Acute Care Transfers
- Transitional Care Model (TCM)
- The Care Transitions Intervention (CTI)
- Care Transitions Interventions in Mental Health

However, keep in mind, there will be an "other" option where providers can explain what they're going to do to address transitional care. This is for organizations, community-based organizations providing housing who might not use one of the listed evidence-based approaches. Keep in mind, the "other" approaches have to be approved by HCA and should still be evidence-based. Alex will provide a timeline back to the group on how long HCA will take to accept "other" interventions.

IV. Next Steps & Closing

- Next meeting will be June 26, 2018 from 10:45am – 12:15pm at Fairfield Marriott in Rochester
  - **Call In:** +1 408 740 3766
  - **Meeting ID:** 771 298 620
- Town hall meeting info: https://zoom.us/j/847516252
- Email for FAQs: rfp@cpaawa.org.
- General consensus among the group to combine Chronic Disease and Transitional Care Work Groups for future meetings so there is one meeting. They will still meet monthly for discussion.