Good morning and welcome to our care transitions webinar session today. It's 11:00 so I think we are ready to get started. At this time I would like to turn it over to Kathy to officially begin the webinar. Kathy?

Kathy, if you are ready, we are ready to begin.

Good morning everyone. This is Kathy from the Rhode Island QIN-QIO. Thanks for joining us. Our webinar is called, Butler Hospital – Bridging the Divide: An Inpatient Psychiatric Hospital’s Approach to Improving Transitions of Care. We are going to speak to the inpatient psychiatric hospitals approach to improving transitions of care. Before we get started a quick review of some housekeeping items. The call will be recorded for training purposes. We will make the recorded session available within a few business days after the webinar on our website the phone lines will be on mute for the duration of the presentation. We are going to take questions at the end and I will provide you with some instructions on how to ask questions at that time. Although the lines will be muted we want you to actively participate. You will have an opportunity to weigh in via chat.

My colleague Gail is our Vermont transition lead and she will be monitoring and responding to chat during the session. We would love to hear more about your efforts and how we could support you moving forward. Just a word about our objectives for today. Providers across the continuum are exploring opportunities to enhance care transitions. Although much has been done a significant opportunity still exist for patients with behavioral health who are most vulnerable. Today we will hope you will learn how Butler Hospital and inpatient psychiatric facility is helping. During the virtual learning session it's very important for us to connect with each other. Please use our chat feature you will see at the top right-hand corner. Let us know how you are improving transitions of care for your patience. Use the tool throughout the presentation to know your questions, share insights and provide feedback you can type in your comments or your questions. If you remember to choose all participants in the drop-down we will be monitoring comments.

I would like to introduce today's speakers. We are very glad to have four colleagues of the hospital joining us today. Diane Ferreira, RN, MHAis the director of care management management and social services. She is a graduate of Rhode Island College and has over 27 years of psychiatric nursing experience in both inpatient and the home care setting. She also has 20 years of experience in utilization management
and care management. She is newly appointed as the co-chair of the Butler Hospital transition care committee.

Dr. Anna Fulton is chief of Internal Medicine, Butler Hospital and Chief of Geriatrics, Care New England Health Systems. After graduating from George Washington University school of medicine Dr. Fulton completed a residency in internal medicine followed by chief residency at geriatric fellowship at Brown University. She currently holds associate professorship in medicine and psychiatry and human behavior. A major focus of her clinical academic work is on improving transitions of care for persons of cognitive impairment or chronic mental illness. She establishes and co chairs the transition care committee, which you will hear about today.

Dr. Lisa Shea is the medical director of Butler Hospital. She sits on the board of a national Association of psychiatric healthcare systems and is a member of the quality committee. Dr. Shea is a member of the National Quality Forum’s Behavioral Health Steering Committee. She is a distinguished fellow of the American psychiatric Association as well as the appointment of clinical associate professor in the Department of psychiatry and human behavior at the Alpert school of medicine

Finally Carolyn Walsh is a Clinical Social Worker at Butler Hospital. She is an active member of their cultural diversity utilization review and transitions of care committee. A significant part of Carolyn's goal is focused on helping to safely transition patients back into the community. Ms. Walsh earned her Masters in social work from Boston College.

At this time I would like to turn it over to Dr. Anna Fulton.

Great. Thank you Kathy. We are very excited to be here with everyone today. To share our work and to hear about how you all are tackling this topic. Briefly, just for some housekeeping items. You have seen our disclosures. Myself and Dr. Shea had a couple of disclosures none of which are related to what we are discussing today. We are going to spend some time today talking about the evidence-based around transitions of care in particularly the behavioral health population. We will share some of the lessons learned from our experience here at Butler Hospital and hopefully leave with some strategies that might help you. We will start with a quick review of the landscape of evidence. Next slide.

The background briefly is just to talk about the reasons why we focus on transitional care. Which I think many of you are very familiar with. We know that good transitions of care can help reduce adverse events. It can improve patient satisfaction
and even reduce healthcare costs. For our chamber really spent a great deal of time focusing on the population of older adults with cognitive impairment. And in adults with psychiatric illness. Or substance abuse. If you look at this slide here, it refers to a landmark paper that really started the strong evidence-based for transitions of care work. This article was published in the new England journal back in 2009. What was interesting as you will see on the next slide is that even in this early work they began to see that for Medicare rehospitalization you can see -one slide back please. That psychosis was the fourth most common reason for Medicare readmission. This trend is notable in the Medicare population but is even more prominent when you look at Medicaid or dual eligible population.

Here you see this is a systematic review. This is one of the very first articles published around transition interventions looking at dental health populations. These authors found that there really wasn't a great deal of evidence that highlighted what was successful intervention for behavioral health population. They started one of the many trends to really identify specific interventions for this group. On the next slide you'll see another systematic review.

Published in 2013. This one looked at 15 different studies which looked at interventions specifically in the behavioral health population. They were able to find seven of those studies is having a significantly positive impact on readmission rates. They highlighted what some of those effective interventions components are. Will talk more about some of these specific interventions. The three that are underlined are things that we have incorporated into some of our pilot programs. We will talk in more detail soon.

In May 2015 AHRQ published a lengthy break around this topic and they really brought it to the forefront as needing more attention and not just an application of successful interventions in the acute care population but a targeted effort around specific interventions for this population. You can see they highlighted the scope of the issue. This slide shows you the top 10 most common reasons for readmission at 30 days in the Medicaid population. You can see that the top one, two, five and 10 reasons are all specifically related to behavioral health diagnosis. And not medical reasons for readmission.

They highlighted the evidence well in this brief. It's worth taking a look at. They noted that unlike the acute care medical populations coming in for congestive heart failure, pneumonia readmission rates in this population did not correspond well to length of stay. Really, they recommended that we needed to focus more on measures of well-being and daily functioning. She predicts discharge readiness as well as to predict risk of readmission. They also highlighted that the only successful intervention
in the community is the assertive community treatment program which again we will spend time talking about in more details when we show you what we have done.

Here we will spend a few moments telling you about our transitions committee and its history information. On the next slide you'll see that this really began for me personally in 2006 as a geriatric fellow this became something that I really developed an interest in with my care dementia patients. When I joined the Butler Hospital team in 2008 working on their geriatric psychiatry unit this led to collaboration between myself and a geriatric psychiatry and social work colleagues on that unit. We formed an internal working group and began to collaborate with advisors. We were looking to how we can shape the work internally as well as across the state. We had several people joined the health center advisor community coalition for both Providence and Kent counties in Rhode Island and whispered our own community work by forming our own transitions of care committee back in 2012 because we realized that we had a unique population which really needed our own committee work to form some successful interventions.

On the next slide you will see the composition. We really focused on developing a multidisciplinary group that represented all the departments internally at Butler Hospital. We had psychiatry, geriatrics, quality, occupational therapy, social work and care management as well as our quality colleagues and it does performance of permit colleagues. We began to focus internally and began to expand over time over the first year or so to include colleagues throughout our healthcare system which is care New England health system. Then we added some payers because we realized that to really make effective change and to be innovative we needed some of the payers at the table. We've also brought in state agencies and Medicaid this is what forms our regular monthly transitions committee group.

On the next slide you will see a slide that I know nobody can really read but I wanted to show you the breadth of the membership. This is now our community outreach group which meets on a quarterly basis. In 2015 we expanded to include all agencies, community mental health centers and some providers that other health systems and hospitals so that we all come together and really have a statewide perspective on what the issues are for this very high risk population. We modeled after the health center advisor's community transitions coalition and we now have over 40 participants that represent approximately 20 different organizations and groups. We meet quarterly to talk about this important issue

Here I just listed some of the projects we have completed since we started in 2012. I will not spend a lot of time here because we have a lot to share. I wanted to focus on a couple of the important ones. We spent a great deal of time particularly in our first
The second item is an example of a successful intervention. The geriatric unit at Butler Hospital had a one-page form that they xeroxed implode every time they had a transfer geriatric patient to an emergency room. This became known as the nurse to nurse communication form. When we did some ER staffing outreach meetings the ER staff told us they really loved that form because it had really helpful information. They kept saying why don't you send that with every patient. We realized the nurses had highlight this themselves. We ended up making this a streamlined part of our packet so I went with all of our patients. That was one of our first successes. We did a lot of work to understand our own hospital system, our own patient population to really know where we focused we did a lot of data deep dive to understand our patients. We asked them themselves what their challenges were and we tried to revise our psychosocial assessment to make sure we captured the right information at admission to make sure we knew what this patient's particular challenges were going to be. I already mentioned a lot of the collaboration of our members on the committee. We've done in-depth research projects to understand what works and doesn't work with their population. Two of the ones I will mention briefly was a patient survey project where we used Eric Pohlman's questions in his care transitions measure on our patient population to understand what their challenges were and how they felt at previous discharge. We also did the Navigator project. Those projects have informed some of the pilots that we have to tell you about later today in our slides.

The community outreach really was key and how we change the scope of our work. We used the coalition model that health center advisers had used. To grow our committee and to take it to the next level. Those collaborations have been very successful. And have led to some changes in how we communicate. One example of a successful intervention was the discharge summary project that actually happened naturally. At the very first quarterly outreach meeting one of the community mental health centers told was that they felt they never had discharge summaries at the time of follow-up for any patients coming out of Butler Hospital. Our medical records lead contact that community mental health centers began a quality improvement project. Every time a patient showed up for follow-up if the provider did not have a discharge summary at hand they would call our medical records lead directly and she would find out what happened. We ended up finding that the providers were looking for a faxed discharge summary when in reality we were sending them electronically right into the medical record she was able to solve the issue and we have never had complaints again. It also led to a wonderful development our next quarterly outreach meeting where other community mental health centers requested electronic access and we are
now sending into their medical records as well. We've also spent time with their legal representative at both their state level and our local level to talk about communication issues. Something that often came up was worries about HEPA and 42 CFR and any of our own internal social workers and care managers weren't sure when they could communicate and outside community mental health centers weren't sure when they could communicate with us. For instance could they tell us that our patient did not keep their follow-up appointment upon discharge. Those keen indications that our transition committee level have helped us improve communication in real-time on patients that are sitting in a hospital or sitting in their follow-up areas.

We wanted to talk to you a little bit about our readmission rates just so you can understand some of the work we have done in some of the challenges. As you look at the next slide this is an overview of our 30 day readmission rates since fiscal year 2010 through 2011. The committee started in 2012. We are happy to see a downward trend since then. Just for those of you who are not familiar with our system, our two graphs there and the first as a blue one represents the Butler Hospital unit the red bars represent our can't unit. That unit is on the campus and it's just like every other unit in the hospital. However it's licensed to Kent Hospital in Warwick which is our acute-care facility. The reason for this is secondary to the IMD or Institute for mental health disease organization exclusion in Medicaid. It just requires a different license. The only difference in the patient care population is that they tend to be more medically and psychiatrically complex. They tend to have a higher readmission rate as you can see here on the red bars. We are pleased with the overall downward trend over time for both of those units.

On the next slide you will see some deeper dive into our data, 2014 to 2015. Our rates for the whole hospital were about 16% which we are happy has been a gradual downtrend as you can see. The Kent Hospital unit last year at 27 -- 20 0.7%. Slight decrease. When we look at diagnoses, our top reasons for readmission by diagnosis tend to be consistent with literature otherwise. Substance abuse disorders, bipolar disorders, depressive disorders and the schizophrenia group had the highest and most common reasons for behavioral health readmission.

On the next slide you'll see where we are to date. We're pleased that Butler Hospital units are around 13.9%. Our Kent Hospital unit is now down to 19.4%. One of the challenges that we have been facing since we started this work is the lack of benchmarking or really a clear evidence based on what a good readmission rate is in this population. These are as you know chronic relapsing and remitting diseases and it's very hard to know what was a preventable readmission. We're still working on this and we are still learning more. We are now part of a quality network that gives you blinded data for lots of different measures but they did give us a readmission rate of
what they described as a close local similar organization. That organization was around 10%. So that the number we are shooting for.

I'm going to stop here and headed over to my colleague to tell you a little bit more about our specific work.

Thank you. We've taken a number of steps to understand and work towards reducing unnecessary readmission. We placed data entry fields in our psychosocial assessment of our electronic health record with categories for reason for readmission beginning in FY 15. We are piloting a rounding template with a social service clinician used in morning rounds. At the same time in January we also instituted complex care rounds where an interdisciplinary team needs to review cases with frequent readmission and transition barriers. The group that meets is the attending psychiatrist, social service clinician on the case, the nurse manager of the unit, the CMO, CNL, Carolyn Walsh and myself and various other disciplines as needed. In these rounds the cases reviewed and recommendations are made in the cases followed closely. Our committee had been meeting monthly and now meets twice a month and we review a dashboard that looks at readmission. Also in our committee we get updates on the complex care round cases. We are looking at embedding a readmission assessment scoring tool as well as a screening tool for two programs that we will be talking about later in the psychosocial assessment. We had shifted some social service clinician hours to the weekend to address transition issues. The morning round template, the social service clinician helps to facilitate morning rounds I using this template. In particular we are focusing on whether this is a readmission within 30 days and what we need to do differently to improve patient outcomes and reduce the likelihood of another readmission. We are focused on reducing barriers working with the patient's primary support system and improving transition plans.

This is the draft of the readmission assessment scoring tool. Adapted with permission from Cambridge health alliance. We also used this adapted tool in a pure navigated highlight that Dr. Fulton mentioned earlier. Our plans to embed this in the psychosocial assessment which would produce the score which would assist us in determining whether a patient was more likely to readmit within 30 days. Based on a score of 14 or higher, the patient would be considered a high risk for readmission and we are currently working on an algorithm based on the patient's payer source community provider availability and eligible programs to get patients into transition services within 24 to 48 hours post discharge.

This is the data from the psychosocial assessment on readmission factors. Responses are based on the patient's perspective. As you can see the top categories for requiring readmission relate to worsening or exaggeration systems relapse and an inability to
remain obtains sobriety and nonadherence to medication and follow-up care.

In FY 16 this is October through May October through May 2016 data. The same five categories mentioned FY 15 continue to trend in the same way. We are looking at the data to make improvements on how we work with patients. Now Carolyn Walsh will talk to you about the health pack program.

Thank you. In 2013 our health system care New England and Blue Cross Blue Shield of Rhode Island came together to form a strategic partnership with a commitment to create a more effective healthcare delivery system and to advance the triple aim of improving the patient's experience of care, improving the health of the population, and reducing healthcare costs. The behavioral health was the first initiative to be rolled out and it started as a two-year pilot which was named health pack. Common interest were to improve behavioral health treatment available to members to recognize the gaps in outpatient care, to redesign traditional commercial health insurance benefits, to be more assured of coverage across the continuum, to share the risks and also to take a long view by measuring outcomes in terms of quality of life rather than per episode.

So health pack was the first health home program for Blue Cross Blue Shield of Rhode Island commercially insured adults, and Medicare advantage adults. The clinical approach is based on the assertiveness community treatment model which is really integrated behavioral health services which includes counseling, psychiatry, care coordination, medication management, connections to primary care and wellness programs as well as vocational support and case management. The team was developed to offer these continuum of behavioral health services to patients who required more than traditional outpatient there are and medication management. These wraparound services were just historically available to the Medicaid population as most traditional commercial benefits did not reimburse for case management care recovery and other costs associated with the high coordination of care. Health pack is a bundled monthly payment so there was innovation also on the financial side. Health pack received a set monthly fee for each patient enrolled. In addition, the patient pays one co-pay per month not to exceed $40. So we looked at concern if the patient received many outpatient services during the month what would their co-pay be. We did not want that to be a barrier to them receiving the wraparound services that we felt were required to help maintain their health.

As I mentioned the model care was based on act. It's very team-based treatment multidisciplinary, flexible and available 24/7. The coordination of care is very high. For example, we have been funded through the partnership to have a dedicated social worker at Butler. Who handles all readmissions. She coordinates care between the
health pack team and the inpatient team. That also includes telephone conference two times a week with the program manager of health pack to review both the clinical needs and medical necessity for any health pack patients who have been readmitted to the hospital. Some of their outcome measures are based on DLA 20 score. Which looks at 20 areas of functioning. Areas such as health, housing, safety, managing time, coping, problem-solving, hygiene, nutrition, relationships, so there has been an overall 80 -- 80% improvement in patient functioning from when they entered the program.

We have seen some reduction in the overall behavioral health costs spend. We have seen some increase in spending on the medical side which we are attributing to a higher coordination of care getting people in to see their primary care physicians and addressing their physical health. The results are trending very positively with a slight decrease in the average length of stay for people who are in the program. A lowering of readmission rates compared to patients that are not in the program. And we are looking forward to continuing to get data on the program so we can continue with making innovative improvements.

Now I will ask Diane to take over and talk about our ACO.

Thank you Carolyn. The care New England integrity community network LLC. The integral behavioral health home team is located on Butler Hospital grounds and the program began mid-February of this year. It is run by the Providence center which is local community mental health center which is part of care New England. Prescribing is done by Butler Hospital staff and the health home team works with the ACO patient in the Medicare savings program. The program provides services much like health pack with complete wraparound services as you see listed on the slide.

We receive a daily list indicating which of our inpatient partial hospital and outpatient patients are eligible for the health home team. The social service clinician does the screening the program and makes the referral to the liaison. The handoff is then seamless and the health home team needs of the patient while the patient is still with us in services. The referral number four active patients is now 53 patients and we have eight referrals pending. Now Dr. Fulton is going to speak with you about the Integra chronic care management team which is an arm of the ACO.

Thanks. This Integra chronic care management team is a program focused on high risk patients most of whom have advanced illness. The team includes news care managers, social workers, nurse practitioners and resource specialist who really act as an extension of the primary care office to augment the care provided by their primary care doctor and his and her staff. The nurse practitioner visits because they have prescribing power allow us to avoid hospitalization in readmission by bringing care
into the home. They have done things such as bringing Lasix dosage for congestive heart failure exacerbation or prescribed antibiotics after hours for patients who have basic infections that can be treated in the home. The team has twice weekly interdisciplinary case conferences. Where we review active patients and all new patients. We run them by either a primary care physician or a geriatrician humans the meeting. We focus on addressing issues such as polypharmacy, symptom management or advance care planning. Our goal for these patients is to really understrength their goals of care and to provide care this focus on that. Here I wanted to spend time sharing a patient story with you that we consider as a prime example of success of these two programs.

This patient is a 65-year-old male with a complex medical and behavioral health history. CAD chronic hepatitis C, cirrhosis, congestive heart failure, chronic extra obstructive pulmonary disease and had a chronic history of pain and depression secondary to chronic pain. He had a history of opioid abuse and a list of substance abuse. At the time of his enrollment into these two teen programs he had had eight episodes of care at Butler Hospital. And several other medical admissions in the two years prior to his presentation. During his last admission at Butler Hospital he will -- he was referred and enrolled about the Integra health home team and the Integra chronic care management team. The two teams coordinated well together and met at the interdisciplinary case conference to discuss care for both sides. He received both behavioral health and medical support. With nurse care managers social workers and an assigned nurse practitioner. As you can see on the next slide he was discharged last in March 2016. Since then has not had any further either emergency room or Butler Hospital patient assessment service episodes. He continues to meet with the social worker in the home. Has an assigned nurse care manager and a nurse practitioner who can jump in when acute issues arise. Secondary to the resources provided by the ACO we were able to get him transportation which has been a major barrier for him to reach his primary care doctor as well. Some substance abuse support. He has had multiple visits to his PCP and provider regularly.

Here I will hand over to Dr. Lisa Shea to talk to you about how quality measures really help us drive air changes.

Thank you. Patient stories are very helpful as they let us know we are on the right track but as you have heard from my colleagues the key to progress and moving forward is using data to drive innovation and to ensure we are producing the intended outcomes for the patient population under our care. Beginning in fiscal year 14 as mandated in the affordable care act CMS has obligated publicly reported measures for inpatient psychiatric facilities. New measures have been added each year with the most recent focusing on successful transitions of care. The transition record measure
requires 21 essential elements of information to be transmitted to the next provider within 24 hours of discharge. The 30 day readmission measure looks at all readmissions weather for a physical or behavioral health issue. We also have contracts with our commercial payers that focus on transitions of care in a paper performance construct including the two measures already referenced as well as ensuring patients get to follow-up following an inpatient admission.

Internally, we have process measures on our quality dashboard that we feel are also essential elements of ensuring a smooth transition including encouraging and insisting our patients with enrolling in the Rhode Island health information exchange; this is a population that is historically been underrepresented. We also link their patients with the primary care provider to ensure that their total health needs are addressed. CMS is already developing new measures. Possible areas that will be addressed also focus on associated with seamless transitions of care including medication reconciliation and examining claim data to see if patients fill a prescription for the medication following discharge. But ultimately we do need to focus on outcomes such as quality of life. We also anticipate that there will be moved toward a value-based purchasing in behavioral health consistent with a triple aim of providing high-quality care in a cost-effective manner. With all of the progress being made there are challenges that still need to be addressed. There is a subset of patients with complex psychiatric and developmental needs who wind up with prolonged inpatient hospitalizations due to lack of community resources such as group homes and transitional programs. We also face shortages of providers who are able to provide medication assisted therapies for individuals struggling with substance abuse disorders as well as those who treat specialized populations namely geriatric and child and adolescent.

Needless barriers exist when it comes for patients the discharge from hospital to obtain needed medication without a prior authorization. For example, individuals stabilized on Suboxone experience several day delay of being able to get this medication once their discharge with significantly increases the probability of relapse. It is also very difficult for many of our patients to be able to make it to their follow-up appointments due to a statewide lack of public transportation. Additionally there are plans in her state to begin to charge disabled individuals to ride the bus. We also need to focus on assisting our colleagues and primary care to be better able to recognize and refer individuals for treatment. We know that providers are reluctant to screen and find problems that they are not able to address or know who to contact for help our next action item include adding patient and family members to our transitions of care committee as their voices essential as we continue our work and we will continue to work on coordinating home-based services, behavioral health services and primary care to provide seamless treatment.
In summary, we have learned that it is essential to involve and collaborate with community partners. Communication with the ongoing particularly around access. We must be data-driven and continuously strive to improve.

Here are some references that might be of use to you. Thank you so much for your attention. We really look forward to your questions. Please feel free to reach out to any of us using the contact information provided on this slide.

Thanks to all of our speakers today. It looks like we have a good 20 minutes for questions. Nancy, can your remind us how to ask questions and Gail will start with reading some of the questions in chat.

If anyone has a question they would like to ask over the phone, please press pound six to unmute your line and ask your question.

This is Gail your moderator for chat. We do have some questions. The first one, she would like you to say more about what was added to the psychosocial assessment and what specific questions did you find target the patient's challenges upon discharge.

Specifically on the psychosocial assessment we added a drop-down menu around the types of things that we know usually can cause a patient to readmit like do they have transportation? Was that an issue? Did they take their meds post discharge? Did they get their meds filled? Was their relapse involved did they keep their follow-up appointment? We also have an other category for narrative. That data is collected and put together. That is the patient's perspective on why they feel they needed to come back to the hospital.

Thank you. Our next question is from Mary Catherine, is your readmission data based on internal data or external and is in it include remission from other healthcare providers in your area?

What we did show you is in internal data. That is a very excellent question. With our partnership with Blue Cross we are able to get all cause readmission data from them and our most recent numbers is about 13% for that population which we attribute to the success of the health pack program. We also are able to get data from our Medicare patients once a year through the pepper report in terms of and all cause readmission.

Thank you. Our next question, what are your thoughts on using atypical long- to further reduce your 30 day readmission rate?
That is also something that has been shown to reduce readmission rates. We do know that patients have the ability to have wraparound services including nursing, this makes it a lot easier for people to be on long-term injectable medications where before patients with private insurance, this would serve as a barrier because there was really not an easy way for them to be able to get that injection.

This is Carolyn. I wanted to agree with what Dr. Shea said. In the past, and less the patient was going to a community mental health center, they would not be able to continue an injectable or medication because traditionally outpatient providers aren't equipped to do that. I wanted to stress that with the health pack program when it was being developed the Providence center became part of our care New England health system. They run the health pack program through their subsidiary continuum and they are able to continue injectables, they are able to continue medication. It's been very helpful.

Thank you. That's great information to know. Another question, they would like to know questions about the size and volume of your facilities, how many beds and the number of discharges per year. Also will your ACO qualify

This is Lisa. We have about 180 patient beds. We usually run full. We do have a regular ACO and we are now applying to be a next generation ACO. We also have a robust partial hospitalization program which has about 80 patients a day.

Thank you. I'm scrolling down to see what else we have. There's a question about this webinar being recorded. That will also be available on our website. Kelly, correct me if I'm incorrect. We have a question here from Ray, do you find that you have less readmit patients attend a PHP program?

Yes. Someone we do. There was a study that generally showed that. Partial hospitalization does tend to help reduce the readmission slightly. I don't know offhand by how much.

This is Carolyn. One of the areas where we are looking to develop with our referral sources in the community is also used partial hospital level of care as a step up program from outpatient. In addition to it being a step down. But I think we have some work to do there. In having community providers refer to the partial as an option instead of hospitalization. If at all possible.

This is Diane. The other thing that I would note is that from some of that data that we looked at around relapse and reasons why patients readmit, we started and ambulatory detox program back in October because we saw that as a need. Not everybody needs
to come in patient for withdrawal management. We have seen some real success with that. And we've also worked with the Recovery system through the Providence center. Whenever there is a patient coming through the ED on substances or are looking for detox. So we have a very tight network to get our patients into services.

Thank you. Clifford also has a question concerning the dual eligible population. How difficult is it to find nonpublic community providers and how have you engage the providers? I would also like to take a moment to remind people that they can call in. Nancy will remind people how they can do that. Thank you.

Just a quick reminder if you would like to -- after this question if you would like to ask another question its #6.

This is Diane. In regards to the dual eligible patient, because the Providence mental health center which is one of the major mental health centers in the state is partnered with us and is in fact part of care New England we have a very close collaboration. Getting services for dual eligible is really a sinless process. In addition a lot of the dual eligible are accountable care organization. We can enroll them in the ACO health home team which again all of those treatment model which I believe Anna referred to earlier in the slides around some work done by AHRQ that indicates act teams make a significant difference with keeping people out of the hospital.

Thank you. I do not see any more questions in chat. If you care to call in, please do so.

Once again, to ask a question just hit #6 on your telephone keypad.

I do have a question for the panel. What are some of the lessons learned on communicating the different types of programs to the providers and doctors so they can keep track?

Anna, do you want to take a shot at that one.

Sure. That has been something that we are continuing to work on. We now have several different pilots and the referring physician and providers have to know from which bucket the patient belongs to. We have done a lot of outreach to primary care physicians. We have done outreach to our inpatient psychiatrist to try to educate them on who could be eligible for certain programs. We are also working with our information systems colleagues on finding ways to identify patients through our electronic medical records and through our physician order entry system so that when people are in the charts, they can see on the banners at the top of the chart who is an
Integra ACO patient or who might be eligible for certain Blue Cross programs. I think we are trying to hit it from multiple angles. The other thing that has been super helpful is something that Carolyn and Diana have been working on which is making sure that our colleagues in social work and care management know all the different pilots and all the different programs and they have put together flowcharts to guide people in that discharge process onto what programs someone might be eligible for. That has been very helpful as well.

Are there also challenges migrating with outside agents—are there opposing of organizations, have you had to navigate that at all?

This is Anna. I think those issues are always something that we tread carefully with. I think what has been really helpful at least in the state of Rhode Island and I'm sure other states have noticed the same is that there is always enough patience to go around, so to speak. There's always enough business and I think especially with the changes in healthcare with value-based purchasing and the accountable care movement everyone is realizing they need to collaborate because we are always going to be taking care of each other's patients in certain settings and sharing information helps everyone in the end. I think the health center advisers community coalition being around in the last few years has also gotten everyone out of the competing health system mindset and put everyone more in the comfort level and getting into the habit of getting around the same table and thinking collectively around what we can do to improve the care for our patients across the state. I think you guys really helped set the trend whenever you started this coalition and that has continued which has been really helpful.

We do have about six minutes left. We are scheduled and tell 12 o'clock. If you would like to ask a question, jump in. Chat is still open. Gail, have you had any other activity?

No. Not in chat. I'm sure one of the questions would be would you be willing to share your template?

There were quite a few that were mentioned but in the beginning I think there was mention of when you're looking at risk of readmission.

Yes. That template is in the slide deck. That's the readmission assessment recording tool.

Rose Murray asks can you share the blue form and I think you just answer that question.
We can find a way to get that. No problem.

Once again if anyone has any questions over the phone it's #6. We have a couple minutes left if you want to ask something over the telephone.

If there are no more questions, I have put our last slide which gives the information on our safe transition in each of our states. These feel free to contact them to find out further information and also about the work that we do. We would love to hear from you always about your best practices. Feel free to contact any one of us. We thank you so much for joining us today. One last call for questions otherwise we will sign off and thank you again to our Butler colleagues for sharing so willingly and beautifully. Thank you.

One last thing before we hang up, when you close out of the webinar the evaluation will automatically pop up on your computer. If you could please feel that out we would greatly appreciate your feedback. It's very important. If you do not have time today or you are currently sharing a computer with someone else, we will be sending you an email tomorrow morning with the link to the evaluation. That email will also contain the direct link to the event page on our website. This web page has the PowerPoint presentation from today's session as Gail mentioned. Also within the next couple business days the recording from today's session as well as the transcript will be added to this webpage is well. And available for you to download and share with your colleagues. Lastly, please save the date for our next webinar session which will take place on September 22. Details will be shared with you in late August. We thank you again for attending today and we hope you all have a great day.

[ Event concluded ]