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Captioner standing by.

Ladies and gentlemen, welcome to the CCME AHRQ Medicaid webinar. Your host will begin.

Good afternoon, everyone. Thank you so much for taking an hour out of your day for joining us for your webinar 3 featuring Dr. Amy Boutwell. We are pleased to have AHRQ sponsoring, hosting the research work on the Medicaid readmission project here in the state of South Carolina. Today, Dr. Boutwell is going to be focused on reducing Medicaid readmissions, enhanced services to reduce the readmissions. And so on behalf of the University of South Carolina, CCME, your QIO in the state of South Carolina, we would like to thank all of our supporters and now turn this over to Dr. Boutwell.

Great. Thank you, Karen. Thanks to everyone for joining. This is webinar 3 of a three-part series on reducing Medicaid readmissions, specifically orienting you to the AHRQ guide to reducing Medicaid readmissions. We hope you've been able to listen into the prior two webinars. If not, we'll make sure you know where to find them. So for those of you who are new to the webinar series or who might have missed the last webinar, to quickly give an overview of the content we've covered, we'll just remind you that we started with webinar 1, talking about updating your readmission reduction strategy in 2015 by really taking command of your own data and knowing what your readmission patterns are locally. Of course for your Medicare population that you've probably been focused on and need to continue to focus on, of course, but really taking this opportunity in 2015 as your readmission work right then evolves as market changes in South Carolina seem to be coming and really look at your data again with fresh eyes to see what readmissions look like locally for you, for not only the Medicare population, but now also for the Medicaid or even the all-payer population at your hospital. So furthermore, when you do that work that we discussed in webinar 1 and the tools that we presented to you, it's really important to then disseminate that knowledge, insight from your root cause analysis to your staff at the hospital, your leadership, partners in the community. Use that data and those root cause insights to really be a powerful tool to update and galvanize support for readmission work in 2015. The second webinar covered really the concept of cross continuum team collaboration. And that's really where our partners who are hosts here, who have brought us together, especially the QIO, CCME, really have a lot of, a lot to offer. We encourage you to know what's going on in your hospital across all departments and service lines. There's so much going on in a busy hospital. It's easy to lose sight of the fact that there are many complimentary initiatives. And sometimes you just need somebody to write down what's going on and make sure that everybody is coordinating and aligning, even within the institution. Furthermore, of course, community agencies, primary care practices, maybe there are patient-centered medical homes, behavioral health providers, social service agencies, that all have something to contribute to help you in your hospital's quest to reduce the admissions, and so to know what's going on across the continuum as well. There's no better way than to get systematic and document what's going on within the hospital and across

the community. Today we're going to talk about taking that knowledge from the first two webinars and weaving it together into a portfolio of efforts. I think many of us who have been working on readmissions and for those of you who might be new to this work, there is no one strategy and what we do know and when we do see hospitals that have gotten themselves out of the penalty zone, if you will, or who have achieved their transformation goals with regard to reducing readmissions and improving cost-setting care, which is really what we're talking about, it always, always involves a multiplicity of aligned and complimentary strategies. So that's the topic for today. We're going to also talk about modeling the expected impact of a portfolio of efforts and, and the role that hospitals have and this is from demonstrable observations across the country, the roles that hospitals have and are taking in delivering the enhanced services that high risk patients need because they will otherwise go persistently unmet and thus the readmission cycle for the highest risk patient will always be there, if we don't fill the gaps with enhanced services. So I hope that coming out of this hour you'll come away with the following objectives. Understanding that hospital-wide readmission reduction requires a portfolio of efforts. That at the minimum include process improvement within the hospitals, improving the standard care for everybody across the board. Purposeful collaboration with existing partners across the continuum, and delivering enhanced services that are not otherwise available to the highest risk patients. I hope you'll understand that hospitals around the country are in fact providing enhanced services to the highest risk populations in order to reduce the admissions and that this -- that this can make sense from a mission perspective, from a penalty perspective, from a future market orientation perspective. There are many ways of looking at why hospitals do this. And hopefully you'll come away with three specific ways that other hospitals are delivering enhanced services that might be applicable to your work at your hospital. So as an orientation, just a reminder, my team and colleagues at JSI, with the support of funding from the agency for healthcare research and quality has done field work over the past several years to create this hospital guide to reducing Medicaid readmissions. It is freely available. The website is below graphic here on the slide, freely available for download from the AHRQ website and the hospital guide has really six chapters of content, if you will, the know your data, the inventory effort, developed portfolio of strategies, improve hospital-based standard care, collaborate with cross-setting providers, and provide enhanced services. And you can see I've indicated the parts of the guide that we'll be focused on today. There's, of course, much more detail and many more examples in the guide, should you be so interested. In addition, the hospital guide, in addition to the hospital guide narrative guide book content, as we did our field work, we encountered several common questions, several common barriers, and in the quest of the hospitals that we have worked with over the years. And every time we ran into a common question or barrier, we tried to turn, to come up with some specific advisement. And we turned that into a set of 13 tools. So these 13 tools are really an attempt to meet the questions, the common questions that hospitals just like yours may have as one tries to implement the advisement that we give in the guide. So today, the particular tools that we'll focus on is developing a portfolio of strategies and estimating the impact of your multifaceted strategy. So moving into the designing and data-driven portfolio of strategies, often times in 2015 we find that hospitals have some good, a lot of good work going on. I'm sure that's the case at your hospitals as well. It's hard to find a hospital in 2015 that hasn't tried to identify readmission risk, trying to teach facts, trying to make follow-up appointments within seven days of discharge, for example. A lot of really good work is going on. In addition to the hospital-based process improvement work, we also meet hospitals, increasingly the case, thanks in large part to the QIO program, who are working with their

partners across the continuum, maybe a small working group with SNF or the aging service agencies, or both, community coalition as the QIO calls them. And then sometimes you will find hospitals that have in fact redeployed, but say a critical nurse specialist or a social worker or someone that serves as a discharge advocate or a transitional care person of some role. And so I often am asked the question, well, we have a discharge advocate, but it doesn't seem to have been working. And the first observation I make is, well, how many people did you serve? And was it set up for success from the beginning? And so, and so here's a little -- this is actually more than a thought experiment. This is directly from several hospitals analysis I've done over the years. Imagine that you're a hospital with 5000 adult non-OB discharges. That's the denominator we talk about in this setting. 5000 adult non-OB discharges a year. Non-OB readmission rate of 18%. So 18% of 5000 is 900. For your hospital can expect to have 900 readmissions per year. Now, you decided to redeploy a cracker Jack of clinical nurse specialist to focus on heart failure and COPD patients. And she is going to find people who have a primary discharge diagnosis of heart failure and COPD because you're worried about those Medicare penalties, and so you're going to run a pilot. And so over let's say the pilot is six months. Over the six months, this clinical nurse specialist, who really is fantastic, sees and connects with 200 COPD patients. And you know that typically speaking or from your data or from the literature, you know that heart failure and COPD patients have readmission rate of about 25%. So among those 200 discharges for COPD, they have an expected readmission rate of 25%. So 25% of 200 gives you 50. So among those 200 discharges, we would expect if we did nothing different to have 50 readmissions. And the goal of this discharge advocate's job is consistent with the partnership for patients, we want to reduce those readmissions by 20% in that success. And so that's fine. That's a worthy goal for a pilot. So the question is, what is 20% of 50? We are reducing readmissions by 20%. We're not looking at 200 discharges she is going to serve. We're looking at the 50 expected readmissions. So 20% of 50 is 10. So you know what? The pilot goes, she loves the job and she's great at it. You know what? She absolutely hits that goal. She reduced readmissions for that tough, tough population, they have so many issues, end of life issues, medication issues, health literacy issues, engaged in care issues, but you know what she got the job done. And she deserves a gold star and, and all of the credit in the world. However, from a mathematics standpoint, we've got to take a step back and say what did that get us? A lot of people turn to me or turn to themselves and their team and say wait a second, we deployed heart failure or clinical nurse specialist, we don't see any change in our readmission rate. Well, you didn't set it up the right way. You didn't set it up in order to detect the signal. When you take a step back and you look at your readmissions for the hospital, you took 10 readmissions out of the system of 900. You're left with 890 still, and that's not even going to be a blip on your chart. You won't be able to see that as a 1% improvement. So as you all know, this isn't just about Medicare. We are encouraging you to think about Medicaid. I think the object lesson here in this model, and this is, again, from real calculations from several hospitals across the country that have run into this problem, is not that the discharge clinical nurse specialist didn't work. Please, please remember, it did work. The issue is it's not at scale and it's not near broad enough. We didn't set it up in order to detect the signal or improvement. So it worked for this population. It's not going to get the hospital where they need to go. This is germane to you and your hospitals that are facing Medicare penalties, not only in the penalty program, but for those of you who know what I'm talking about in the value-based purchasing program, which is a much bigger deal, and as well for whatever market changes I understand are about to come to bear for Medicaid and readmissions in South Carolina. So it's really time to think about going beyond pilots, going

beyond specific narrowly defined target populations, and think about the portfolio of work that your hospital needs to engage in rather urgently in order to achieve the performance standards that you need to achieve in order to avoid penalties or the performance standards that your hospital wants to achieve in order to achieve transformation and future success in the market. So what we observe in our field work is that hospitals have done that. There aren't that many. They are still notable examples who deserve a lot of credit, but when we do study hospitals that have made hospital-wide improvement on readmissions, they all came through the journey with their own flavor, with their own strategy, but to my analysis, I can -- the best I can tell, they boil down to at the minimum three common elements. One is improved standard transitional care for everybody, not just for heart failure, not just for COPD, not just for the penalty commission, for everybody. Everybody gets the same elevated, updated standard of care. If you look into the guide, we recommend really working off of the CMS discharge planning conditions of participation that were updated in May 2013. They incorporate best practice from the star initiatives, from red, from boost, Dr. Coleman, Dr. Jinx, notables in the field. Think updated surveyor guidance is a very nice compilation of raising the standard of care for all. The neat thing about looking at that CMS document is they reminded us way back in 2013 in this document, and again, the reference is in the guide and you can chat in if you want me to get you the reference directly or Karen Southard from the QIO can do that for you too, the neat thing that is pretty profound as we here in South Carolina think about Medicaid penalties coming down the pike, is that in document in 2013, two years ago, reminded hospitals across the nation that the CMS conditions of participation apply to Medicare, as well as to Medicaid, and that the guidance that you read is not only regulatory compliance guidance, but it's -- it was pressing it for your hospitals in terms of preparing yourselves to be ready for Medicaid penalties as well. So that is portfolio strategy number one. Improve the -- elevate the standard of transitional care for everybody. Strategy number 2 is purposeful collaboration with cross-setting partners. This is not networking. This is not, oh, we know -- this is what the QIO can help guide you to do, what you've heard other best practice hospitals doing, monthly meetings, sometimes even weekly coordinating calls, person-to-person, professional-to-professional collaboration, warm handoffs, feedback loops, open channels of communication around how good the handoff is, how well we're doing on a professional-to-professional basis, handing over the care of complicated patients to each other. And then finally what we'll talk about today is, again, hospitals that have achieved this level of performance across the country have recognized that sometimes the best transition out of the hospital, the best collaboration with the next setting of care will still not suffice for a group of highest risk patients. And they dig into their pockets and they problem solve. What are the persistent gaps that are going unfilled time and time again, such that these patients keep coming back to us. And really, that is, that is the, a real leadership distinction or a distinction -- it's not even a leadership distinction. It's a distinction of how serious your hospital is about getting out of the penalty zone, if you will, or about transforming for the future.So once you assess your own portfolio of strategies, you've hopefully from the last webinar, you've taken that hospital inventory and that cross continuum inventory and you're able to say, okay, we know what's going on in the hospital, we know which partners, especially Medicaid relevant partners, if you will, can help us, coproduce this readmission goal that we are aiming for. Then you can ask yourself, you can use your current state as a gap analysis and you can ask yourself, are you right now, without explanation, without any other caveat and ask yourself this kind of gap analysis set of questions. Are you targeting just Medicare patients? If so, are you addressing their needs? Are you getting it done? Are you addressing what they need? Are you targeting Medicaid

patients? If so, are you addressing what they need in order to reduce readmissions? Are you targeting behavioral health patients in particular? Very high connection between the Medicaid population and behavioral health issues, and the more we get into Medicare, it's also a big connection that drives Medicare readmissions as well. So something classically, historically, have categorically not addressed behavioral health at all. So ask yourself as you update and refresh your strategy and your gap analysis, are you attending to behavioral health patients? Are you specifically targeting high utilizers? If you're targeting high utilizers, are you ramped up to address that set of needs, which is rather unique. Are you addressing medication issues? Are you addressing chronic recurrent symptomatic presentations, IE, patients who might need palliative care? Do you have an issue with housing issues, if that's an issue in your community. And what gaps, what gaps still persist or exist for whatever other target populations you might have come to recognize are driving readmissions at your hospital?

So once you think about what you're doing for standard care for all, for collaborating across settings with providers and for delivering enhanced services, I'll bring you back to an example, again, there is a -- the tool we circulated in the prework has this type of an Excel document, this type of table as a live Excel document. You can plug in some numbers and play with the numbers, et cetera, and see. You can change the labels. Really, this is just a simple mathematical calculation to say through the strategies that you have in place right now or that you could have in place as you update your work, will they get you mathematically? Can they even get you to something like reducing readmissions by 20% overall? And so again, a simple example could be that, that you improve, you do something to improve the standard of care for everybody. Maybe that's a check list. Maybe that's -- you know, things like using a check list, adhering to the spirit of the CMS discharge planning, conditions of participation, et cetera. And it's spread out over all 5000 patients who come through your hospital and, again, if your hospital's bigger, this is all just proportional. Maybe you don't -- maybe improving standard care for all has a slightly smaller incremental impact. Let's say, for example, it has a 10% impact overall on readmission. The neat thing is, by disseminating even a lower impact intervention over the maximum number of patients that come through your facility, you can see mathematically that's actually your strongest strategy, because mathematically, you are giving your hospital the greatest opportunity to mathematically to reduce readmissions by that strategy, which can be counter intuitive to people until you play with the numbers here a little bit. So even a, quote, lower impact or more diffuse impact strategy like improving care for all, has a very powerful mathematical impact when you look at it in terms of the potential for readmissions avoided. And then number two, let's just say that you and your collaborating agencies start to do warm handoffs, start to run common patient lists and make sure the care plans are in place for, care plans are in place, feedback loops are in place, referral processes are worked out for timely access to follow-on care and that that set of collaborative cost setting efforts impacts about a third of your discharges overall. Those patients who you're focusing on have a higher than average rate of readmission. And if you do this well, you would aim to reduce readmissions through this collaborative type of work by 20%. And again, it gives you mathematically a lot of power there. You're serving fewer patients, but as we know, those patients by definition are at higher risk because they have ongoing skilled care needs, for example. And so again, just doing the math, 1650 times 20%, with a 30% readmission rate and then taking that down by 20% gives you 99 readmissions possibly avoided. And then we have the first example. The clinic goal specialist attending to a population of patients with specific diseases who need their ongoing issues met, who need

enhanced services post discharge, and that's the exact same pilot that I shared with you earlier and that has a place in the strategy. That's enhanced services. And you may have a couple of those different types of services in your own portfolio. But what you can see from this example is that then if you add up the impact of improving care across the board, purposeful patient-specific process, collaboration across settings, as well as enhanced services, now this hospital has a mathematical model for achieving a 20% overall reduction that before they had no, no way of knowing where or how the set of efforts they were undertaking would lead them to their ultimate game from a modeling standpoint.

So moving on from there to providing enhanced services, so that was really about modeling, about looking at the big picture of everything you're doing, making sure that your team is set up, that your hospital is set up for success. And if cannot model out what the pathway looks like to a 20% readmission rate for the hospital, then you're probably not going to achieve a 20% readmission reduction for the hospital. So you'll remember that I said even, even among all of the process improvements we make and the collaborative improvements we make, there appears to be a commonality across all successful hospitals that more needs to be done. Something extra is needed for a certain subset of patients. We interviewed a social worker in north Philadelphia, for those of you who don't know north Philadelphia, it's a tough neighborhood. Lots of social complexity and challenges of a variety of types. And this was a transitional care social worker implementing what's called the bridge model of transitional care. And as this social worker remarked, there's always going to be a group of folks that's going to need somebody to help them. That's never going to change. And really, that's, that's what we're referring to when we say deliver enhanced services to address those persistent gaps. We, we would be wise to recognize the insights of this social worker in north Philadelphia that there's always going to be a group of folks who need somebody to help them. So I just have to pause for a moment because you're all in South Carolina and I'm sitting here in Boston and I'm just going to tell you that it just started snowing. So sorry! Sorry to deviate, but I just cannot believe it. All right. Back to work. So deploying enhanced services. Enhanced services, what are we talking about? We're talking about services that go beyond the standard transitional care delivered to all patients at your hospital. This might, this might be accomplished lieu redeploying existing staff or reallocating existing resources, or investing new resources into new services. So to be clear, just like the clinical nurse specialist example, that was an example of let's just say redeploying existing staff. And so not all enhanced services take, if you will, new bright green dollars, new money for new, for new staff. Often times we see hospitals achieve deploying enhanced services by a reallocation of existing resources. And furthermore, we have the option in the hospital to reallocate or redeploy existing resources or as evidenced by the half a billion dollar demonstration project called the CMSCCCP program, sometimes hospitals are contracted to other agencies to provide those enhanced services, such as elder service agencies or social service agencies, or community health workers, et cetera. And so we're differentiating this from coordinating with existing services, because coordinating implies you -- implies that an agency in the community maybe like a faith-based organization or home health agency or someone who is already on point to deliver the services that they have to offer. And what we need to do when we're coordinating in that kind of second domain of collaboration across the continuum is we're making sure we're optimizing the resources that exist out in the community, or in the post acute setting. This topic is how are we going to deliver something more and different that doesn't exist in the community? So when we looked at the variety in the field around enhanced services, we started to see that some hospitals

are delivering enhanced services that could be described as very short-term enhanced services, extra services after discharge, or they could be longer term. So we -- along the bottom axis, you see short-term to long-term, and usually I mean one or two episodes over the immediate days post discharge or several points of contact over maybe the month or slightly more than that in terms of the time horizon. On the Y axis, you can see the resource intensity. And so again, enhanced services ranged from very minimal resource intensity, very minimal incremental costs, if you will, to much more intense. We'll give you some examples of that, more intense both in terms of human resource investment and/or infrastructure investment. And so, so you can see that these are all specific examples that we see, that we observed in the field of enhanced services that are being deployed right now by hospitals across the country in order to achieve their readmission reduction rate. Now I'll go through some of those examples with you. Interestingly, just last week in the "New York Times," I cited the date so you can look at this article, it was very interesting and timely for our work here together, but just about 10 days ago, there was an article, as you can see, healthcare systems try to cut costs by aiding the poor and troubled. And you know what? We know that readmissions, especially for the Medicaid population, but also for dual eligibles or your elders who have economic constraints, we know readmissions are driven to some extent, not exclusively, but to some extent by a lack of access to resources specifically financial wherewith all or the ability to successfully navigate the system or advocate for themselves. So-so there's a raging debate in the field, mostly around from advocacy organizations that say, well, hospitals shouldn't be possible for this. This article is, is food for thought around the hospitals, you know, a smattering of hospitals across the country that are highlighted in this article that I encourage you to read, that are saying, look, but bottom line, we're responsible for readmission. If we're going, or utilization. If you're going to make headway on this particular problem, that our payment is tied to -- that we have other performance expectations, then we've got to get in this business. And this is an article that is really interesting that shows you that, that the field is rapidly learning how to, in the words of the "New York Times" here, quote, aid the poor and the troubled in order to achieve the performance expectations that the market is expecting of us. Again, interestingly enough, just last month in March, a think tank called the center for healthcare strategies did a very quick preliminary inventory of providers across the nation who are delivering enhanced services to patients with a history of high utilization. And so, again, I just gave you a screen shot and the link is here, but it's really informative to look at this inventory. They even freely acknowledge this is a starting inventory, and some of the examples in my slide deck aren't even in here, so you know there are many, many other examples of providers that are deploying enhanced care teams, social services, in-home visits, you know, economic, housing support, et cetera, in order to get a handle on the utilization of people with social behavioral or financial complexities. Furthermore, another interesting signal in the field is coming from the Medicaid program in New York. We know that Medicaid programs across the country, including I believe yours, are getting serious about cost control and one of the obvious ways to address costs is by readmission prevention and it's really interesting to see the New York Medicaid program has an $8 billion payment program right now to transform Medicaid. And they have, you know, also I think it's a 30-page book of models of care that they believe will help providers transform Medicaid and save money through improving quality and of note, a few domains are relevant at models for us, in our thinking. The care coordination and transitional care programs, they talk about ambulatory ICUs, so those are one-stop-shopping, multidisciplinary, urgent access, where patients can go instead of going to the emergency room, where they can go repeatedly, not just one time, but repeatedly and be

stabilized. Maybe they are seen by several professionals sever days in a row, et cetera. Colocated primary care in the emergency room. Sometimes, and I know this is true in South Carolina, sometimes people come to the emergency room because it's convenient, it's after hours, it's 24/7, that's what they did as a child so now that's what they do as an adult. And so thinking creatively, again, meeting -- answering the need the way you find the root cause, you know, not the way we want it -- we might want it to be in a product design, but figuring out what is driving the utilization and how do we meet that need? In addition, they talk about what I had spoken about a few minutes ago, connecting setting. That in Medicaid, it's interesting to see that they are willing to pay for community-based health navigation services, for telemedicine, to increase access because we know that Medicaid patients have long wait times and maybe they can't get into the behavioral health or specialty services that they need in a timely manner. And then finally, the behavioral health focus through this program in New York, around community crisis stabilization so people don't have to always present to the ED if they are in crisis, and community-based withdrawal management for -- et cetera. So I share this not because you're in New York, but to paint a picture that as you start to understand what's going on with your incentives in Medicaid in South Carolina, there is a whole serious high stakes big money transformation of Medicaid in other states as well, and I don't think this is a flash in the pan. I think this is, this is an idea whose time has come. So figuring out how to embrace and address social, financial and behavioral health complexity I think is very much the next phase of readmission work. So hospital-provided enhanced services. An oldie, but goodie example at this point, getting increasingly dated. I like to start with this example from Mass General Hospital and their high cost demonstration program. Yes, it was a demonstration program, but what's relevant about this example, several relevant examples about what the Mass General team did, they specifically were charged with reducing the costs, the total cost of care for the highest cost Medicare patients in your hospital. Now, whenever we look at highest cost, you can equate that to, of course, medically complex, but socially complex, behavioral issues, cognitive issues, financial issues, you know, this population was complicated in every way that you could think of. And so in that way, it's applicable to our conversation when we think about the Medicaid population and the complexities that we immediately think about how to address for the Medicaid folks. So what they did was actually not a whole bunch of project red or boost or anything like that. They deployed, if you will, a high-risk, high intensity complex care team to these patients. You could think of them as the concierge case management S.W.A.T. team. And they used not the transition out of the hospital as their leverage point, but rather what I learned from them that I've subsequently seen in other successful programs is they used the front door of the hospital, the emergency room as their key point of influence. So when one of these patients, and you can draw the connection to either your high utilizing patients or your high risk Medicaid patients or any of your high risk patients. When any high risk patient hit triage in the emergency room, the complex care team was what we call hammer paged, right? Everybody got notified automatically and the expectation was that the clinicians would present down to the ED. The case manager, the social worker, the pharmacist, the discharging hospitalist, the specialist who was on campus, whoever -- whoever was able to respond, they had a little response protocol, would go to the ED and work with the emergency room doctor to assess whether or not an acute change in clinical status was really occurring, such as to warrant hospitalization, and if not, assure and collaborate with the ED doc that an admission did not seem to be in order and that the complex care team was in place in order to follow up in a timely, comprehensive manner with that patient. There's a very important insight that this team would share with you, which is

complex, you know, high utilizing or complex patients, they look bad on their best day. The baseline breathing, you know, might be 32 times a minute. Or their creatine is always hovering between -- et cetera. To an ED doc who doesn't know them, there's always a reason for admission, right? I thought the clever, insightful intervention that this team took in order to achieve, as you can see, very, very powerful ROI for every dollar spent on a complex care team, $2.65 were saved to the Medicare program. And Mass General definitely shared in a very substantial portion of shared savings as a result of this work. So was it an expensive program? Yes. But was the expense -- the expense was dwarfed by the magnitude of the savings that they were able to achieve even with a very high intensity, urgent, rapid response, high touch hype of a program.

Another example currently from St. Agnes hospital in Baltimore, Maryland, has a very challenged, economically challenged population. And they have a 15-member -- this hospital, not a massive size hospital. This hospital has a 15-member transitional care team. They have an ED-based team and an inpatient team, both of which do inpatient/outpatient outreach. The inpatient is two registered nurses -- working to avoid readmission. This is not just review and leveling. This is working with the staff to identify patients who do not really need to be admitted and putting good discharge plans in place because that's something that we can't really ask our ED docs to do. They are supporting the ED docs in creating the option to not admit a patient. The ED-based team is comprised of nurses and social worker Navigator, pharmacist, and educator. And this team floats on top of, of course, the regular staff, the floor nurses and the case managers. So everyone already has, all patients have standard care, four nurses, four care managers, this team floats on top of that and executes comprehensive care planning and follow-up, ensure bedside delivery of medication, establish the relationship with the high-risk patient in the inpatient setting, and sets the stage for telephonic follow-up. Then they follow them telephonically for at least 30 days and sometimes more depending on their judgment. The leader of the team at St. Agnes Hospital describes their work as flexible, proactive, that her team is distinguished by incredible interpersonal skills. They are persistent and very wholistic in their approach. So there is something special about the people who do this work. It's -- some people describe it as old-fashioned detective work. You know, et cetera, it's the spirit of doing this work is really problem-solving and persistent and patient is how the leader of this team describes their work.

Another example comes from a very small hospital in Massachusetts, Addison Gilbert Hospital in Gloucester. Where I live, and I don't know where you, it is ravaged by a crushing opiate crisis right now. And they have a high risk care team. Their high risk patients are behavioral, high-risk behavioral, including substance abuse disorder, behavioral issues, social issues, homelessness, as well as the issues of the frail, elderly and those in need of guided care. Their high-risk care team, as you can tell from the definition, is extremely comprehensive identification of patients at high risk. And the team is comprised of -- not just one, but there are multiple types, social work, pharmacist, and a layperson coordinator. They don't describe her as a community health worker, but you could substitute care Navigators, advocate, community health worker, and they call this person a coordinator. Over time, they added a pharm tech because they realized the work of the pharmacist is really to do that cognitive task of net optimization, making sure medications are affordable, explaining the meds, working with doctors to streamline regimens, et cetera. What they didn't want pharmacists to be caught up all day was chasing down medalists. Over time,

they added a pharm tech. Interestingly enough, and I see -- I see this increasingly, they added a nurse practitioner, because they realized that as this complex care team followed people after hospitalization, their biggest barrier was medication issues that needed prescriptions or not being able to get into any of their doctors within a couple days and certainly not within the same day. If these -- in these complex folks, they are not used to waiting, right? They will call 911. It's kind of what they have always done. And so in order -- this team realized that in order to stop that cycle of calling 911 and address the persistent gap in their community, that, that was access to urgent care, they added a nurse practitioner who does go do home visits and who does collaborate with PCPs and specialists on titrating medications and doing that level of clinical work. And then they would encourage me to emphasize that this program did not run on its own, that they had a dedicated program manager who was on the job of assessing, making sure that they were targeting patients, that they were serving patients, that she was the one who made the analysis and the request for additional resources to add these goal types to make the program successful. And the neat thing is they were pair blind, so they served people regardless of pay or type. And what I find so fascinating from this community hospital is you can see the breakdown of payer. There is, there is 8% straight Medicare fee for service, 8% straight Medicaid. And then of course there is the duals, there's Medicare eligible -- I'm sorry, Medicare Advantage. And then there's Medicare with additional private coverage, et cetera, and so it's really interesting to this pie graph really reminds us that complexity does not, does not follow payer-specific -- when we talk about complexity and these needs, really we would be doing a disservice if we only thought about one particular payer type or another. I was just speaking of community health workers and in Philadelphia, and in north Philadelphia at Temple university hospital, another economically challenged community, Temple university collaborated with two of their Medicaid managed care organizations to hire up, train, and deploy community health workers. Interestingly enough, I think our big grappling from Temple was their first choice was to go with community health workers, people of the community who know, who know the communities, know people in the community, who are great communicators and Navigators and really can help people on a very human, human level establish trust, engage them in care, help them navigate the delivery system, get to the follow-up they need, ask the questions they need, and I think it's very informative that a, even a tertiary academic medical center like Temple, when they thought what is the enhanced service that our patient population needs, they reached to the community health worker as, as one of their enhanced services. Local example at the medical university of South Carolina, we were so fortunate to do a visit last year. What we learned about that is something that many of you know is that the -- some of the highest readmission rates you're going to see in South Carolina are among patients who live with sickle cell disease. And so what we know about that illness is that fortunately there are better and better treatments, but the illness has historically been punctuated by recurrent pain crisis, sickle cell crisis. And there's an abundance of evidence that when folks in sickle cell crisis go to the emergency room and even get hospitalized that we are not doing the very best medicine for them. And there are really good leave-ins to carve out a specialty way of treating them in crisis. And there are examples across the country of sickle cell clinics, but what the MUSC did that I thought was so creative was they stood up a sickle cell outpatient clinic in their practice that's on-site at the hospital, such that, such that patients can be redirected from the emergency room to this clinic. The clinic is staffed up to provide the IV, medications, and the, the best practice protocols that people in crisis need, and most of the time they are able to address the crisis without needing to have the patient admitted to the inpatient setting. So again, it's an enhanced service. Certainly it took additional resources in the sense of it

was opening in this urgent clinic on-site, but an effective approach to a specific target population with specific needs. And I love this example because none of the best discharge planning or follow-up phone calls would have done the job for addressing readmissions for the sickle cell community. So this is exactly what we're talking about when we're talking about enhanced services, something different. A different approach was needed for these patients and I think particularly relevant food for thought for many hospitals in South Carolina.

Just a few other examples in the last couple of minutes. Okay. I was just looking at a comment in the chat box. One more example from Almeida county hospital in Oakland, they have an eight-member transitional care team. To be sure, I want to share this, because I know with the priorities you already have, and it also -- they started with the priorities you have and they grew into the priorities they learned their population have. So they have a heart failure nurse, COPD nurse, social worker and community workers. They specifically have learned in Oakland, California that they have to look for, acknowledge, address substance abuse disorder at every turn with this patient population. And also they target patients with HIV. And the community outreach worker that they call the CHOW, the community health outreach worker, makes the contact with -- he does the job of screening for patients in the inpatient setting, meeting with them. He specifically addressed not only the chronic medical issue, but all of the social issues, again, as I said, including housing, marginal housing, substance use, et cetera, and the community health outreach worker accompanies the port touches base with, follows up, very, very hands-on, very relationship-oriented role. It's through this relationship that folks who otherwise didn't engage kind of in systematic outpatient care are supported over time to go from relying on the hospital and the emergency room for their care to being comfortable with changing the focus of where they seek care through the outpatient setting. They really describe it as kind of an evolution based on a trusting relationship,that we will take care of you. We will make sure you get what you need. You don't always need to go to the ED. Here's another way. I think the example, again, really highlights that, that the quote that that social worker shared with us at the beginning of this section of the talk, which is there will always be some people who need help. And this team really embraces that and does a great job. In conclusion, another quote from a care transition program manager in our field work who said it's always been about social work fundamentals. Meeting the patient where they are, counseling, teaching, educating. To expect people who are already working and living in a deficit to be able to readily navigate these systems is just unrealistic. And so this is really complimentary to all of our teaching around self empowerment, patient engagement. This is not to negate any of those teachings. Certainly patient engagement, self management support, engagement of family caregivers, all of this still stands. All we're doing is adding to our understanding in this webinar that when and if those strategies are not appropriate or applicable to certain patients, that directly helping navigating, advocating and problem solving is in order. So in conclusion, what we observe about complex care teams is they are very often, almost always multidisciplinary in nature, as per the examples I gave you today. They address the full complement of medical social logistical needs. Basically they will all tell you that nothing is off the table. No need is out of their purview, that they feel accountable for addressing. They identify patients, high risk patients using a combination of clinical and nonclinical criteria, so this is not just about specific diseases. And moreover, they don't overmedicalize the approach. They take a whole person approach. They take a social approach. And they really start with the patient's priorities and needs. And so it's with that that we encourage you to think about deploying enhanced services. Now, we'll get to the last couple

slides here in our in-person learning session on April 29, where we'll talk about is it affordable and how do you thunk about that. So my apologies. We'll just go ahead and skip over those slides in the interest of coming up to time here, but I would like to encourage you to attend the learning session, where we'll pick this up, as well as hear from a great variety of examples of great work going on in South Carolina. It's April 29. If you're not registered, please do so. We're really looking forward to a great session on that day. So with that, thank you so much for attending and as always, we welcome your feedback on the webinars, on the guide, if you've read it or the tools if you've used them. We're trying to make them as helpful to you as possible. So we appreciate your feedback, however you can get it to us, via e-mail or otherwise. So with that, it looks like we've got a poll and we'll adjourn for today and look forward to seeing you at the end of the month.

Okay. Thank you, everyone, for attending the webinar. And if there are any questions or anything that we have? Katina, if you want to open up quickly for anyone who has a question?

Ladies and gentlemen, if you have any questions, please press the number one key. Again, if you have any questions at this time, please press the number one key.

Okay. Yes, just a reminder, this has been an excellent webinar series and positioned ourselves to have a wonderful in-person learning session. So please, if you haven't registered, please do so or reach out to us, Karen Southard or Heather Jones at the QIO. We can get you connected to the event registration. And we do have some excellent presenters from all over South Carolina, as well as MCO panel to really connect our payers to our providers and have a really robust conversation about this. So we're looking forward to this event in a couple of weeks. Operator, Katina, any questions?

There are no questions in queue at this time.

Okay. Well, I thank you, Dr. Boutwell. We hope you don't get too much snow there.

Can you believe it?

Well, pack your sun dresses because it's lovely here in South Carolina.

Will do.

We look forward to seeing you in a couple of weeks. weeks. Thank you, everyone. Have a great day.

Thank you.

Bye-bye.

Ladies and gentlemen, thank you for joining. You may all disconnect and have a wonderful day.
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[event concluded]