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Please stand by for realtime captions.

Ladies and gentlemen, thank you for holding. Your call will begin momentarily. Please continue to hold. Thank you.

[music]

Ladies and gentlemen. Welcome to the the CME identifying and collaborating with Medicaid partners. Your host will begin.

Thank you. [Indiscernible] with the Carolina center and I would like to thank the volunteers for senior smart and professor at the College of social work at the University of South Carolina for partnering with us to sponsor this event on behalf of other supporters at Blue Cross Blue Shield of South Carolina and the hospital association, and the front the Cephalon and thank you for joining the webinar in assisting in identifying Medicaid reimbursements. I would like to turn the webinar over to our present or Dr. Amy Boutwell.

Great. Thank you and welcome everyone. We are so good that she glad you're joining us today. Today is a second and a three-part series in reducing Medicaid readmissions but the topic of identifying and collaborating with Medicaid relevant partners across the continuum.

The agenda for today is to cover the following points of information. We will discuss using your own hospitals readmission data analysis. To inform and better informed the composition of your cross continuum came. We will talk about forming a cross continuum team with community coalition. We will also focus on who are the relic -- Medicaid relevant community partners we should be seeking and reaching out to in our communities. We well reference some of the tools from the guide for Medicaid readmission that you have seen and pre-work packets. Tools, four, five, 12, and 13 in particular.

The objectives for today's webinar are the following. Hopefully at the end of the webinar you will be able to describe why a offsetting team comprised only of postacute providers may not be well matched to addressed -- address the Medicaid readmissions. You will be able to describe how your readmission team can identify Medicaid relevant partners and providers and your communities. And, you'll understand the value of identifying and optimizing the clinical and social services that currently exist and recognize to do so to really optimize and leverage the resources that do exist in your community require relationship development and effort.

As a reminder, in orientation, this work is grounded in the content in the RRC hospital guide to reducing Medicaid readmission. The link to the guide which is available on the AHRQ website is down at the bottom of the slide. You will be reminded that this guide is newly published in the past six months and this is a dissemination and this effort is to disseminate and get your feedback and thought around what is going to help you as your senses evolves and his or her market

changes and really understand and get a handle on strategies to effectively address readmissions overall and specifically extend and include in that work the needs of the Medicaid individual in particular.

This is the toolbox that 13 tools were developed in the course of our fieldwork. As a referenced, the bolded tools are the tools will be discussing today. We will discuss one through three on the prior webinar.

Using data to form cross continuum partnerships. This is a very informative data analysis we did with one of our ~work hospitals. It was a year ago or so. When we looked at the proportion of Medicare patients that were discharged to home versus two postacute care settings, we see something typical for your organization as well. With a slight majority of patients of Medicare beneficiaries discharged to home, that was a substantial proportion in this case, 38%, of Medicare beneficiaries discharged into postacute care. One thing I learned in the initiative and I know we emphasize and community coalition work with the QIO, is a great opportunity, a great starting opportunity support and build cross continuum teams or community coalitions is for hospitals to reach out to and engage with skilled nursing facilities, the home health care agency and the hospices and we know there are numerous organizations for any given hospital. It is a great way to start building a cross continuum teams.

However, in this new phase as we expand our view to understand how to build this cross continuum teams that will be in a way that will be high leverage and relevant for Medicaid patients as well, you can clearly see from the data that the vast preponderance of Medicaid patients are discharged to home without homecare services. Only a very small minority are Medicaid patients overall from your hospital are discharged into postacute care. This tells us that we can use our data to say and identify where our patients are being discharged to and what does that mean for the post hospital needs and the post hospital partner that we should engage with.

Furthermore, you will remember from the first webinar, we spent a lot of time looking at and you will remember that the top reasons and the top diagnoses that led to admissions in the Medicare population and the Medicaid population had some similarities but they also had very important differences. You can see here from this brief published last year, the top 10 diagnoses that went to Medicaid readmissions for adults were behavioral health, you can see for out of the 10 were behavioral health related. This reminds us also that if as we think about the agency and the providers, the resources that we need to link patients with, it's not always clinical follow-up. It is not always postacute care type services. In fact, this reminds us we need to be thinking that behavioral health and the recovery support may be the community health worker type support in the community because to do any otherwise, if we were only focusing on clinical follow-up, we would really be just completely ignoring the data and what is straight in front of our eyes, to confirm our work.

You will also remember we talked a lot about interviewing patients and listening to why they say they came back to the hospital. Similarly, this is not just an exercise or a research paper waiting to be written, but rather we need to make sure we take those insights and we use them to inform these services, what are the issues that people think of them back to the hospital setting, and who are the agencies and the support services and providers in the community that could mitigate

those needs. You will remember from this very groundbreaking interview study of bounce backs to the emergency room, really people did, the majority had a primary care doctor. That says we need to ensure that people have a primary care doctor and we need to assure that they have follow-up, but, in this case, and I would encourage you to repeat this in your organization, in this case the majority of the people she interviewed had a PCP. A strategy that says we will make sure everybody leaving this hospital has a PCP and has an appointment, that is not what their problem was. That is not what drove them back to the ED interesting enough. What we need to do is remember to use the information and the insight that our patients to less because they are right. They are the ones who decided to come back or they were the ones who called 911 and were brought back, or they were the ones that there providers told them to come back to the emergency room. If we do not listen and account for what they are telling us, which is they could not get care fast enough, it's not easy enough, they were filled full or uncertain -- fearful or uncertain that anyone knew what was going on, they needed assurance or advisement and that is what got them back to the emergency room. We need to use that to figure out how can we fill those gaps and what partners for providers in the community could have been involved to address those issues.

Coming-out of all of this, I find it is helpful to take one additional step that I am not sure we discussed last time quite fully. Which is, when she ran your numbers and interviewed her patients, we need to synthesize and summarize a one-page, it does not have to be extensive, a one-page snapshot of the insight that you gained from doing your readmission analysis. You need to post it and circulate it and use it with your internal readmission team. Use this as you reach out and start to engage and coordinate with community providers so that community-based providers know what you're cope problem is. What is the problem you're trying to solve? If you summarize it in a one-page snapshot like this, maybe you want to model this, we also have told number three in the guidebook that is a little longer and narrative and a little more detailed, but if you summarize this that we had 10,000 discharges and 1000 admissions, 600 were Medicare, 250 were Medicaid and 85% were some type of payer which means we are responsible for those outcomes. Discharge disposition is half of them going to postacute care, that is our cost continuum team for Medicare group but only 8% of Medicaid patients were discharged to postacute care. We have to find the community services that will be catching and following up with those patients. Don't forget to include in this one-page summary snapshot the insights on the patient interviews. What those things are, what patients told you, what they often times here they were rest are confused or uncertain. They could not get something. They could not get medication. They could not get transportation. Maybe they were instructed to return by their home health nurse or by their PCP. They did not have a discharge summary. Maybe for some patients, maybe they feel comfortable here and maybe they feel like they know the hospital staff and know they can trust them. Whatever those issues are we have to put them on the table and use it to and warm who we reach out and coordinate with.

The next step before we reach out to the community and say what can the community do for us, it's a good opportunity to take a moment, the field is changing so quickly Collier organizations are changing quickly, the research is changing quickly, and you probably would not be surprised even if you had a readmission team in the quality or the case management are the nursing department, you probably would not be surprised if you uncover something across your hospital that is called readmissions needed. That is where this hospital inventory tool is meant to do. It's

meant to prompt your thinking and brainstorming in a pretty systematic look across the departments and service lines of your organization. You want to make sure you are considering what if anything is going on in the emergency room. Are there case managers there? Have we dabbled with employing social workers? Are their regular huddles with the team? What is going on in the emergency room? Similarly, on the inpatient board, of course this is the bread and butter of nursing and case management, what is going on with hospital medicine? What is going on with specialties, increasingly we have cardiologist with heart failure, pulmonologist because of COPD, and even procedural list and surgeons because of ortho, hip, and knee.

It is a good time to look about and say what new stakeholders either are doing something or are thinking about doing something different or can be engaged in reduction across the organization.

Another place to look is IT. Increasingly, there are modules, care management modules, maybe medication reconciliation tools, maybe notifications and [Indiscernible] and 30 debris admits that are happening in the IT team, that is coming across the teams work list. I will say from my own hospital, one day I showed up and there was a new super helpful medication database, medication prescription database I could access to help me with medication reconciliation work. No one wrote a memo or made an announcement, it was just there. Another day, a month later, I showed up and I looked at the ED triage board and there were green arrows next to a bunch of people's name and I hovered over and it was a 30 day return flag. Again no memo it was just there. These tools might crop up in your organization and unless we bring it to the attention of the clinician, they will go underutilized and certainly not leverage the way they were intended to. It's a great opportunity to take this tool or the concept of it and survey what is going on with regard to readmission reduction across your organization.

At that point, it is also high value to look outside your four walls and try to assess who is doing what to provide services that will reduce the admissions or improve care in your community. Over our years of fieldwork and insights from our QIO program and their community coalition from the start initiative and their cross continuum team etc., we put together a list. It is not complete, it's just meant to be a starting point for prompting reminders to have you think about your agency on aging or the county health department. Whether or not there is a volunteer base for the outreach faith-based community for outreach workers or visitors, etc. This tool is meant to be delegated to someone on your team or maybe a couple of people on your team to take a link and reach out. Wigle does splitting your social workers know about your community. As our hospitals are changing our the time so are the resources in the community and it is a good idea to refresh and at date, especially because transitional care readmissions is something the community infrastructure is increasingly aware of. It feels like they can brain does bring solutions to bear. One thing we have learned a very quickly and are fieldwork is often times in the hospital we go with what we know and you either get referred to post acute care or home health care or you get a follow-up with your PCP and sometimes we do not leverage the full tapestry of what is available in the community.

Once you do this kind of inventory, it can serve two purposes. As many of these tools can, you will see what does exist, what you do now know about, who is doing what that you can leverage and partner and align with, and where the gaps are. You can use it as a gap analysis as well. You can ask yourself some of these checkbox questions in terms of have you made any formal

partnerships with any of these agencies? Is there an MOU or a stable referral relationship that has been established? Is all of this in formal and ad hoc in nature? Do you feel like if you are really honest with yourself, are you optimizing these resources? Do we have an easy pathway to getting our patients connected in a warm reliable handoff to some of the services? That is a great opportunity for improvement in most communities across the country.

Here is an example of a health system in Baltimore, busy, complex, under resourced, overcomplicated, type of a health system. They did conduct an internal hospital inventory as well as their community inventory. From that, you can see the diversity and a snapshot of the diversity of efforts that this particular hospital has going on within and across the continuum of care. They have their recovery coaches that are located in the emergency room. Their outcomes management which is their quality department involved and engaged, the social work department is engaged. May have a behavioral health program that is theirs they align with. They have clinics committed to providing postdischarge follow-up within seven to 10 days not only for their affiliated patients for their known patients but for any patient who needs timely post discharge. Their IT department has placed flags in the charts in the administrative record for ACO patients and they use their health information exchange for what is called ADT notifications that providers get notified if their patients are admission to the ED or to the hospital or discharged from the hospital. That is a tapestry of work going on within the hospital and then you can see they have laid out who they are working with and what kind of agencies they are working with in the community or not even working with but are aware of doing complementary work. I will not read that out to you but as you can see, it includes postacute care and that is definitely a high leverage opportunity. Don't get me wrong, but you can it see it expands beyond the traditional Medicare cross continuum team on the area of aging and the postacute providers and it expands to include the University transitional housing providers, homeless outreach, the coordinating center as a large social services entity and the help enterprise zone is a large grant funded community outreach program. It's a very nice tapestry that again, Baltimore city under resourced, complicated but you can see where we are looking for who is doing what. We often find that they are actually have resources to know about and there are things to bring to bear into our work that we might not have been fully leveraging.

Another example of a very rich community cross continuum team is from another hospital I happen to know in Maryland. You can see, I will not read this outlined by land, but whereas blurt the visual impact which look at who they integrate with. Who they are talking to pick this is not referral partners, these are dashed Heather Kirby the vice president at Frederick Memorial has what she calls the cross continuum team spirit you can call it coalition meetings, every man. Anyone who wants to come to this, any other agency is welcome. It is an open door policy. You come and discuss transition. You discuss services you deliver and services to coordinate hospital patients with your services. She and many cross continuum and community coalition teams like this have a come one, come all we want to learn about what you do and figure out how to better connect our patient needs with the services you deliver and it's a great way to optimize the resources that exist even if it is true that you might work in a resource constrained environments, this is a relatively new part of Central Maryland and she too would say we are pretty isolated and we do not have a lot here. Not having a lot is different from figuring out what you do have and making it work.

Forming a cross continuum team, the benefit is to expand your awareness of available resources. You can understand and better detail the scope and specifics of what is offered by agencies. I will speak for myself, I have gone through an amazing multi-year educational process of unpacking what behavioral health services are. What community services are. It is a heterogeneous, very broad term, these are terms that in adequately characterize the richness and variety and flexibility and sources of services and supports that can meet patients needs. In the hospital environment, we know what we know. If it is one thing that leaders across cross continuum teams have taught us is it's really important to bring community providers and agencies to the table so they can describe in better detail what it is they do and how we can work with them. Usually in the hospital filled call we are telling them, we either send people to them unilaterally or we tell them what we want and this is creating a different dynamic where we learn what they do and we figure out together how to make the pathways alignment more reliable and more high value for patient care.

Also, facilitate multiple agencies and multidisciplinary service coronation. What I mean by that is some hospitals say we meet with our [Indiscernible] for example and when we talk about maybe they have a private meeting every month or every quarter to give feedback on volume and maybe readmissions. May be difficult transfers or things like that. That is not the theme -- same as cross continuum team to get together to talk about processes and practices that can have benefits on a number of transitions from hospital to postacute care or from hospital to clinics for example. We can get a lot more leverage and a lot more alignment if we have these conversations in a group setting and get numerous providers on the same page for process improvement efforts together.

Similarly, the best teams that I see who are really leveraging cross continuum work for impact use this time to discuss shared care plans for their shared patients. This is like care lounge, this is care coordination and alignment for people to really make sure adult protective services or the community behavioral health agency or the primary care entity or hospital-based outreach team or what ever has an opportunity for multi agency care plan coordination. That is a very robust opportunity as well.

Finally, I would be [Indiscernible] if I did not mention that one thing that I observed as well as people tell me, is one of the important outcomes of regular cross continuum team meetings. It increases a [Indiscernible] and a shared sense of commitment to patient care and to patients who particular, that people say, materially change the way we talk to each other, the way we think about handoffs, the way we think about referrals or transitions, it elevates the shared mutual responsibility that senders and receivers have an accountability to each other because we are on a team together. We know things go wrong on both sides of the aisle, if you will, but if everyone is working to include then there is the shared sense to have collegiality that it could sound touchy/Philly but at the same time people fight it as a particular value added and a particular outcome of their investment in this kind of work.

If you have not done this, if you have not done that -- started down this path, we have heard your concerns. We heard concerns from the field saying who do we call? What do we do? What is an agenda? Why are we getting together? I do not think I can call a meeting without my boss approving it. All of these barriers that came up that we heard of, we tried to create some tools

and guidance in this resource to make it simple and easy. This is an approachable thing. It's something that you can rest assured is not bash if you will, does not need executive approval of a specific manner. In the sand that your care management department Collier integrated care, your readmission team, they have a need to coordinate and align with the services. You have a need to understand what agencies provide certain services and who has availability and how do you leverage that. What you are doing is, you are not picking an area that works. You are not identifying preferred providers in this setting. It is a come one come all coalition of the willing to share and help us leverage the work that you do in the community with the needs of our patients in the hospital. An approach that way, it's a very low profile and organic undertaking at the beginning.

If you're just getting started, my observation and recommendation are two number one. If you're just getting heart -- started, by all means set a schedule. Hold regularly scheduled monthly meetings. It's been privy to a lot of false starts where we said we will have one meeting and we will work hard and get this big indication less than a fancy agenda and Colin Lynch and you have it and then it never happens again. Start small and build that meet regularly. That is where the string comes and that is where the shared ideas come into play. Start with the coalition of the willing. It does not need to be a perfect imitation this. It is not meant to signal anything more than the beginning of starting to do better coordination of care in the community. You can stay open and invite. I would encourage you to invite new partners and agency as you learn about them. And inevitably, someone you invite says we should really invite the DME person or the pharmacist that does home visits or whatever it is. You will learn on who is doing what that you did not know about and in that way you will expand your cross continuum team inventory as to who is doing what and you expand the membership of this cross continuum team. At least allow get this a three to four months to gel. You will have people coming on board. Some people will not make meetings and so you need to remember with any good group dynamic process and relationship building process, there is going to be aperia it of time where you need to establish stability relationships before you get down to brass tacks and change the world for a better place. Do not get impatient to quickly. There is another observation that has needs from watching a couple of false starts, if you will.

But, with that said, you need an agenda. This is much more than coffee talk. This is business. This is penalty avoidance. There is a lock on the line. You can start with some common agenda that you can really way a solid foundation by even starting from eating one which is readmission data. Talk readmission patients to respect you don't have to give names of people, but the stories are informative.

Indeed, you should ask providers and community agencies and community providers to share their experience of receiving a patient from your hospital and what was in place. What was missing? What did the patients a? What was the expense of the service provider when they were trying to pick up the pieces after the patient left the hospital? Again, your referral agency may not come forth in the first couple of meetings with what they consider to be to Frank of a critique of your hospital because of course they want to be referral partners to you but as the leader of the team you need to create a safe base and want to do this a couple of times, people will realize this is in the spirit of learning and constructive feed back and identifying shared opportunities for improvement in the sharing of the openness will quickly evolve as it always does.

You can talk about handoffs communication including a very popular topic cross continuum team members which is when you receive a client or a patient from our facility, what information do you see to consistently miss. What is consistently problematic? How can we make your life as a receiving provider better and easier with the way we do things on our end? That is a very lively and rich topic for sure discussion at these kind of meetings.

If you have a team already it's fine -- hard to find a team in 2015 that has not have a couple of skilled nursing facilities are their own home health agency. It's a modest place to start but if that is where you are call you have a team already. You have a foundation to build on. Identify your gaps. We started the webinar with using your data to identify gaps. Now that you are expanding your focus from what might have started at a very Medicare eccentric focus to now a more inclusive focus, you might want to build out the number of SNF's and the number of home health agencies. Are there ACO's or medical homes or qualified health centers are clinics you need to bring on board? Definitely the behavioral health clinic are always left out of the party and our fieldwork suggest with they would like to be invited. Social service agencies, homeless provider outreach services, Medicaid managed care plans which are increasing in your market. Identify the gaps in membership and build on your foundation and expand it.

At some point, you may find once you are underway and you have relationships and you have a robust committee, you may want to dive into subgroups for transition specific work. For example, handoffs to SNF's. Or handoffs to behavioral health providers. Working out referral processes to minimize wait time or delays for an accuracy with community social service agencies. There may be some specific work that you do but I encourage you to not do it individually as one hospital and one entity but rather in a small group setting because if you are trying to work out the process with behavioral health providers then why not do it with the three or four that are in your area and you will get greater leverage for it.

Next, as the group of olives and this is something we the as groups evolve, consider moving into a requirements that everyone brings data. Everyone has patients, and on some label, it may not be easy or perfect, but on some level, you should be able to more or less figure out your client and your patients returning to the hospital and how often. It may be imperfect, it may be town heart does tally marks on a piece of paper. Rather, when you plan the community care team together around data, it reminds people implicitly that the reason why you're talking is because you are trying to avoid readmissions. By asking people to bring that return to the hospital type of data, we are reminding our conversation that what we're not trying to do is change America. Sometimes it feels that way. We start getting out of the horizon and numerous numerous issues of poverty and literacy and disparity and medical issues, but when you bring it right back to readmission rates, it reminds us of where our tree work is and where our focus point is for these conversations. I have found that is a very compelling management tool that leaders across teams use very well.

Finally, if you have a high functioning cross continuum team already, it's very robust, your representatives are a good spectrum of providers and agencies across the community, this is the leading edge of what I see in the field. You can consider taking those relationships from the informal to the more structured. What we see among pioneering CEOs and underpayment entity,

and even some community coalitions is to clarify the practitioners but what will we do consistently every time. What will you do consistently every time. How will we measure that together and how will we hold each other accountable. We are really coproducing an outcome caught a readmission. Eberly depends on me, it partly depends on you, and it partly depends on other factors. Let's quantify that and get it reliable unsystematic so we together can make the improvement that we are capable of optimizing.

What we see also in the field is leveraging those relationships and maybe a subcomponent of those relationships into more formal business agreements around preferred providers or actually contracting for services, co-locating services or collaborating on actual clinical comanagement to individual care plans and multi agency [Indiscernible]. All of this is really happening already. We do not have to look too far and wide to see real hospitals doing this kind of work even in what they would describe as busy and complex resource constrained Enterprises.

Let's take the last part of the webinar today and I will give you some examples of Medicaid relevant partners. My research for this webinar, I get a little searching from the information that your social worker and case managers know this. If your core team does not know this, if the orientation, if this kind of information of the services that exist and how you access it and literally who the coordinators are, if that is going only within a small number of staff people in your organization and you could probably say this is not leveraged and it's not being optimized to the greatest extent, in South Carolina, there is a map of all of your community health centers. I'm sure they are busy. I am sure they have [Indiscernible]. You can click on it and I did a search for community health centers who provided care management for care coordination in the greater Columbia region. They came up with seven results. They give me a location and a phone number and hours. It was handy. Again, maybe you all know this but I was impressed but I have not seen this kind of resource in many states. It is easy to use. In fact, when I was on that tool and I gave you the link there, you could search for cared management coordination call you could search for substance use, behavioral health, child and adolescent health issues, there was a menu you could search for based on the need you are trying to address and provide for.I would Say Starting Place, #1 is make sure you know, especially, the community health centers that have care management and behavioral care coordination resources in your region.

Again, similarly recognizing there is no community in America that would tell me they have enough behavioral health resources. We will stipulate the behavioral health resources is under resourced across the board. It is a honest those chronic problem. What we want to do here is we know the resources that do exist when we literally not only know there is a clinic but we have a relationship with the director of that clinic and we have discussed with her what kind every Perl capacity they have. What kind of patients can we refer to them? What kind of timely follow-up could there be? Are there other resources besides office visits? Maybe there is care coordination or. Outreach, maybe navigation support. Not only know there is a clinic downtown, but they have a wait list. Figure out what exactly and how to work with that clinic in order to get people seem. A great example I will give an anecdote from Massachusetts, it was in central Massachusetts, a somewhat rural community absolutely in the grips of a tragic overdose. Unfortunately all the time, very common. They were having a major crisis with wait times and length of stay. They figured out we does this people are not sick enough to be admitted so we send them with a list of detox centers and clinics and basically waved goodbye and say it's your

job to figure out and call someone on this list if you are motivated. They decided, that is an outdated and ineffective modality of care. We need to do more to link people to behavioral health in that community. They literally googled the name of the director at the community health center in their region. The community mental health Center. They knew there was a mental health center but they did know the woman's name or who ran it. They called a meeting and within 10 weeks they figured out not only what kind of referral capacity that the clinic had but they learned what was in fact a peer navigator program at the community health center and they stowed her to co-locate the navigators in the emergency room and followed up and stayed with the patients after an ED behavioral health visit to ensure they needed the connections back into the care etc. If we do not ask, we do not know and we'll does we will send up assuming. Here is a map from the South Carolina Department of mental health will regard to the mental health clinic. Again, I clicked through this. You might notice that I was impressed with how clear and straightforward the website was. With regard to clicking on any of those regions and finding out the contact name. You are not just calling the center, you can call April and I hope I am not embarrassing anyone out there. This is better does very clear and accessible information. I felt like it was really worth pointing out to you if you have not been on this website for a while.

Clicking through on the website, the Department of mental health, they have a section on clinical health care coordination for you can read the information. I am sure it's not nearly enough but it's something. They particularly highlight the Comprehensive Care assessment which tends to person needs, they have patient settings, and increase the accessibility of services in the community and I thought this was at least painting a picture at the bottom that during the first six months of operation, 19 care coordinators served 2300 clients and provided over 8000 care coordination services. That is not nothing. That is a very good resource to know about and who knows, maybe through a combination of your incentives and aligning with the resources, the skill set exist, perhaps this is an opportunity to grow over time, especially if your incentive start relying with what they deliver.

I thought this was interesting again, they make it very clear and transparent to identify in each of the community mental health centers who are the care coordinators and phone numbers. Get to know what is out there prick your clinics, your mental health centers, among the care coordination resources, etc.

Another emerging area as I understand for South Carolina, the market is changing with regard to Medicaid managed care. Medicaid managed care are working with the national Association to understand from their perspective how would they like hospitals and staff to enact with them. We have a shared interest in this particular case, reducing Medicaid readmissions. Leveraging available resources, it's really interesting that our fieldwork revealed a few instances where there was a managed care worker on the job and maybe there hospital was not really coordinating with that transitional care worker that was deployed from the plan. Again, there was not a of continuum team, there was not a thought but the hospital in the NCO were on the same team. We know how that is. There have been throughout -- you only have to have one utilization review conversation before you realize sometimes it feels like you are not on the same team but at the same time, managed care organizations are in the business of care management, disease management, complex integrated care management and coordination of services but they are in a position to the employee wraparound services to meet social and solicit goal housing and

financial needs. Reaching out and establishing, again, a clear pathway of contact. Villager hospital should contact who at a care plan, working out that pathway so it's easy the next time who is a high utilizer and you want to pick up the phone and say are you on the job or do we need to be on the job. That is the kind of the direction that we want to go with cross and in this case cross sector event care coordination.

We learned from a great care coordination group in North Alabama how they used this updated inventory. They literally created a community resource guide. North Alabama community care has fantastic outcomes for their Medicaid population with numerous chronic conditions including substance use and behavioral healthcare. They are managing a population that has the needs you are worried about. North Alabama community care, their team maintains literally a board ask, if you will, a community resource guide. The way they described if they use it all the time but they need to do know their current and they are calling Mary at that address and they are using the email and address to make it easy. If you want to make it easy for your team, don't keep -- I am sure your social work staff probably have in their collective consciousness, but maybe the challenge for 2015 is getting it out so others across the organization can similarly leverage the resources and the connection to services.

With that offset, in summary, we know readmission rates for Medicaid adults are high. Including they are high in South Carolina, they are probably higher to hospitals. There are important similarities and differences among Medicare and Medicaid readmission patterns but by no means are we talking about two separate issues. There are issues that are more predominant in the Medicare population and there are issues that are more prevalent in the Medicaid population and what we're trying to do is expand our understanding and our approach to addressing the comprehensive set of transitional care issues so we are reducing readmissions more effectively across the board. We recommend identify who is doing what across her hospital and across your community. Develop collaborations with community providers that specifically in this instance serve Medicaid patients to optimize what is available even if you believe and even if it's quite sure, I am sure, but there is not enough available at the very least inventory and coordinate with what is there. Finally, with everything that is coming in changing in the market in South Carolina and the rest of the country, this is -- we are hoping this advisement will empower you to have a hospital specific or community specific understanding of the patterns, the dynamics, the partnerships, the rates, the causes, the red missions for your organization and in your community and that approaching readmission reduction with a strategic approach that we are trying to share with you in the side through these webinars will prepare you to address whatever penalties in the Medicare or Medicaid or other markets may come your way and that we are hoping to provide you with some thoughts and insights that will set you up for readmission reduction overall as opposed to trying to sub optimize and chase and get out of any individual penalty programs in the penalty zone because penalty rules, they will come and go and they will change. They will be retrospectively applied and the smarter strategy is to attend a strategic approach to reducing the admission and a very robust fashion and of course, track and in sure that your not missing anything with regard to the current penalty rules. If there's anything we learned about penalties if they will change and they probably apply to years past are ready. Etc. as they do in Medicare, so attend to a robust approach which will serve you the best in the years to come.

As a reminder, we have one more webinar in this three-part webinar series on April 8. We will talk about providing enhanced services to reduce readmissions. We look forward to getting together at the end of April in Columbia for an in person learning Center and that will Off our readmission and Medicaid readmission Sprint together and we are so appreciative of your attendance and participation. We value your feedback on this material. On the guide and the webinars, our emails are here, our phone numbers are here. We really hope you will provide us with feedback, good, bad, ugly and whether this is helpful to you. With that, I will think we will wrap up today and look forward to seeing you in another two weeks on April 8. Thank you so much.

Ladies and gentlemen, this completes our conference call. You may now disconnect. Have a wonderful day.

[Event concluded]