Administration on Aging
Affordable Care Act Webinar
Care Transitions: What Do These Programs Look Like? And How Can the Aging Network Play a Role?
January 24, 2011
2:00-3:30 pm Eastern

Operator: At this time, all participants are in a listen-only mode. Today's call will feature a question and answer period. At that time, if you'd like to queue up to ask a question, you can do so by pressing star then 1 on your phone.

Today's call is being recorded. If you have any objections you may disconnect at this time. I'd now like to turn the call over to Marisa Scala Foley. You may begin.

Marisa Scala Foley: Thank you so much (Tom). Good afternoon, good morning to those of you who are the West Coast. My name is Marisa Scala Foley and I work in the Office of Policy Analysis an Development at the Administration on Aging.

And we thank you for joining us for AoA's first in a series of webinars focused on opportunities for the Aging Network within the Patient Protection and Affordable Care Act also known as the Affordable Care Act or the ACA.

Today's webinar Care Transitions -- What do these programs look like and how can the Aging Network play a role is as the title indicates focused on the important topic of care transitions. Patients or clients going from one care setting to another. So from hospital to home, from hospital to skilled nursing facility. From skilled nursing facility to home and more.

Before I turn things over to our speakers for the substance of today's call and webinar, we have a couple of housekeeping announcements.

First of all if you have not yet done so, please use the link that we emailed you to get onto WebEx so that you can not only follow along with the slides as we go through them but also ask your questions when you have them through Chat and I'll come back to that in a minute.

If you don't have access to the link that we emailed you, you should also be able to go to www.webex.com, click on the Attend the Meeting button at the top of the page and enter the meeting number which is 665306726. So however you - you will likely only be able to do this if you have registered for this webinar.

If you have not registered for this webinar, WebEx may not let you in. If you have any problems and you are a registered participant and you have any problems with getting into WebEx, please do call WebEx's technical support at 1-866-229-3239. And I'll repeat that.

WebEx technical support can be reached at 1-866-229-3239. The second housekeeping announcement, as (Tom) mentioned, all of you are in listen-only mode. However we do welcome your questions throughout the course of this webinar.

There are two ways that you can ask your questions. First is I mentioned before, through the web using the Chat function in WebEx. You can enter your questions when you have them. We'll sort through them and answer them as best we can when we take breaks for questions after each speaker presents.

The second way that you can ask your questions is as (Tom) mentioned, we will offer you a chance to ask questions through the audio line. That will happen at the

end of this call. And when that time comes, (Tom) will again give everyone instructions as to how to queue up to ask your question.

And finally, our final housekeeping announcement has to do with follow up. As (Tom) mentioned we are recording this webinar. We will post the recording, the slides, a transcript of this webinar and on AoA website which is www.aoa.gov, www.aoa.gov by early February.

And we have a link to the AoA website in the resources section of these slides. Now we're pretty much set with housekeeping announcements. So I would like turn things over to Cindy Padilla, AoA's Principal Deputy Secretary on Aging who will provide a welcome from AoA's leadership. Go ahead Cindy.

Cindy Padilla: Great. Thank you Marisa and welcome everyone. Thank you all for joining us.

Assistant Secretary for Aging, Kathy Greenlee wishes she could have joined us today. And she sent her regards to all of you. And as the Principal Deputy Assistant Secretary for the Administration on Aging it's great and a great opportunity for me to be here with all of you today.

This is the first in a new series of webinars sponsored by AoA that focus on opportunities for the Aging Network within the Patient Protection and Affordable Care Act of 2010 also known as the Affordable Care Act or the ACA.

Today's webinar Care transitions what do these programs look like and how can the Aging Network play a role provides an introduction to the topic of care transitions of some of the evidence-based models currently in use around the country as you'll hear from AoA's own Caroline Ryan.

Before we begin, I do want to take a minute though to recognize the work of Mimi Toomey, Marisa Scala Foley and Abby Morgan, they've all been very, very busy putting this series together and we want to thank all of them. And thank you all very much for your efforts.

We also want to thank Sue Banning and Dave Buchanan also from AoA whose technical expertise have wired us in today. And of course we want to thank Caroline and Sandy Marwood, our two featured speakers.

Caroline Ryan is Aging Services Program Specialist in the Office of Program Innovation and Demonstration at the Administration on Aging. And was previously employed by the Aging Care Connections in Lagrange, Illinois where she implemented and evaluated a community-based service that supported older adults and their families as they transitioned home from a community hospital and four skilled nursing facilities.

In fact, in 2009, Caroline was elected as a Practice Change Fellow and designed a community-based program to support the transition home for observation patients and their families.

She received her undergraduate degree from Washington University in St. Louis and her Masters Degree and Certificate in Health Administration and Policy at the University of Chicago School of Social Service Administration.

Our next speaker, Sandy Marwood as most of you know, is the Chief Executive Officer of the National Association of Area Agencies on Aging or n4a. And has more than 30 years experience in the development and delivery of aging, health, human services, housing and transportation programs in counties and cities across the nation.

Prior to coming to n4a in January of 2002, Sandy served as the Deputy Director of County Services of the National Association of Counties where she took a lead role in research, training, conference planning, program development, technical assistance, and grants management.

Sandy holds both a Bachelors and Masters degree from the University of Virginia. And so when you look at their experience and what they bring to this webinar, you know that we know that the work happens at the local level. And our speakers are going to definitely talk to you all about that.

As I mentioned, Caroline and Sandy will outline for you many of the opportunities for our network not only in the implementation of America's new healthcare law but how we can use this law to support and strengthen the work we already do and have done for over 45 years as we serve older Americans and people with disabilities each and every day.

So why did we choose this topic? And why talk about transitions at all? Well we know that about 1 in 5 Medicare beneficiaries discharged from the hospital are readmitted within 30 days.

These unwanted readmissions have high costs both financially for Medicare as well as physically and emotionally for the people we serve who are Medicare beneficiaries and of course their families.

Improving care transitions when patients move from one care setting to another can help to reduce many of avoidable readmissions. Section 3026 of the Affordable Care Act authorizes the Secretary of Health and Human Services to establish a community-based care transitions program under which the Secretary will provide funding to eligible entities that furnish improved care transition services to high-risk Medicare beneficiaries.

So why is this important to the network? Well priority approved funding under the community-based care transition program will be given to program administered by AoA and those that provide services to medically underserved populations, small communities, and rural areas.

And as we said before and as most of you know, many area agencies on aging and other aging network providers are already engaged in care transitions work. As you'll hear from Sandy Marwood from n4a, the activities involved in care transitions, interventions are a good fit for work already being done by aging and disability services providers under funding from the Older Americans Act.

Care transitions also provide a wonderful opportunity to integrate other important work being done by the Aging Network including aging and disability resource centers, benefits outreach and enrollment, care giving and respite programs, chronic disease self-management and other health promotion disease prevention programs and many more.

Finally, the partnerships that you can build so your care transitions work with hospitals, physician practices, long-term care facilities and other organizations can also help position you better for future ACA related opportunities such as accountable care organizations, health homes, patient-centered medical homes, and more.

So again, thank you for joining us today. We look forward to the presentation. We look forward to your questions. And of course, we look forward to the continued dialogue as we all work to strengthen the Aging Network and of course support the people that we all serve.

So again, thank you all for joining us. And I'm going to give it back to you Marisa. Thank you.

Marisa Scala Foley: All right, thank you so much Cindy, for that wonderful welcome.

With that, I'd like to just quickly walk through the agenda. As we've just heard from Cindy Padilla from here at AoA. Next we will hear from Caroline Ryan who is also with the Administration on Aging who will present an overview of evidence-based care transitions model.

And then finally we'll turn things over to Sandy Marwood from the National Association of Area Agencies on Aging or n4a who will talk about care transitions and the Aging Network and the opportunities for the Network for care transitions work.

So Caroline, I will turn things over to you.

Caroline Ryan: Great thank you Marisa. So this portion of the presentation is going to provide information about the six evidence-based care transition models that are currently being implemented through the 2010 ADRC evidence-based care transition grants.

I will also share some information on where and now these models are being implemented by grantees.

But before I describe specifics of these models, let's begin with some common themes that are seen across the models. One of the common themes in the literature is the recognition that healthcare and community support are often delivered in service silos. And that lack sufficient communication and collaboration.

So a focus of these six models is looking at coordination across disciplines and silos of care. The six models also identify specific staff who are trained to support individuals to ensure smooth transition from hospital to home.

An important feature of that staff role is to empower patients and caregivers to take an active role in their own healthcare. The transitional care staff also perform an enhanced follow-up function

Staff may perform home visits and/or follow-up phone calls post discharge and address topics like medication management. Follow up with the primary care physician as well as some self-management skills training in connection to home and community-based services.

While selecting a care transition model often depends on the care transition setting and other contextual factors that are unique to individual transitional care partnerships, you will see these common themes throughout the discussion of the evidence-based models.

So now let's take a closer look at the six models. The following slide has the six transitional care models listed here. The first four target the transition from hospital to home well grace and guided care, our care coordination models within primary care settings that have transitional care elements.

So let's start with the care transition intervention. This model was developed by Dr. Eric Coleman and its based in the Division of Health Care Policy and Research at the University of Colorado Denver School of Medicine.

You will find with each of the models that we've included the website on the PowerPoint slides. I will be providing some general information during this

presentation. However the websites have content information as well as more detailed information about the model.

So the care transitions intervention is designed around four pillars. One of the pillars is medication management, ensuring that the patient understand the medications that they are taking or have been prescribed. And that they have a management system in place.

Another pillar is the patient-centered record. That a patient develops and maintains a personal health record that can be used to communicate with providers.

The third pillar is primary care physician and specialist follow up. Ensuring that the individual schedules a follow-up appointment with their primary care doctor or specialist and is also an active participant during that appointment.

The fourth and final pillar is knowledge of red flags. That an individual understands the signs of symptoms of their condition worsening and also knows how to respond to those signs.

So the care transition staff person in this model is called the transitions coach. And the coach's role is really to empower the individual to take an active role in their own care by modeling behavior to improve self-management as well as communication with providers.

Nurses, social workers and other professionals have been trained as transition coaches through the care transition intervention training that is offered in Colorado as well as onsite at organizations implementing this model.

The care transition intervention is a four-week intervention that includes the following components. So the transition coach first meets with the individual and their families at the hospital prior to discharge.

During that initial meeting, the coach introduces the idea of the program and provides the individual with a patient health record that includes a discharge preparation checklist. After the patient is discharged, within 24 to 72 hours, the transition coach will meet with the individual and the caregiver at home.

During that home visit, the coach engages the client in medication reconciliation. They review red flags and also talk about strategies for responding to any red flags that may come up. They also develop and practice communication strategies so that can effectively speak with their healthcare providers.

So for example, an example of how the coaching role may be different from other practices. Instead of calling the primary care physician to schedule a follow-up appointment on behalf of the individual, a coach may practice or role play with the person what that call will be like. And then the individual makes the call themselves.

So the concept is that the individual develops a skill set that can be applied to future interactions with their providers. After that home visit, the coach also performs three follow-up calls to reinforce some of the coaching that occurred during that visit.

And again, for more information about the model, please refer to the website for additional resources as well as contact information.

The next model I'll describe is called the transitional care model. This model was developed by Dr. Mary Naylor from the New Courtland Center for Transitions in Health at the University of Pennsylvania School of Nursing.

The transitional care model provides comprehensive hospital planning and post follow-up post discharge for chronically ill high-risk older adults. So the transitional care model focuses on these four components.

Patient and caregiver education to ensure the individual understands the information that is communicated to them. It also focuses on helping patients develop individualized care plans and self-management strategies.

There's also a component that looks at assessing existing medication management systems as well providing education related to medication reconciliation. And there's also an emphasis with this model that it's not intended to provide ongoing support.

It's designed as a short-term transitional care intervention to help the patient and caregiver develop strategies to manage their own care as well as prevent re-hospitalization. The care transition staff in this model are called transitional care nurses or advanced practice nurses.

And the University of Pennsylvania has developed a series of web-based training modules to prepare staff to become transitional care nurses. And the transitional care model support is usually provided anywhere from one to three months.

During those one to three months of the program, the following activities occur. After a referral is made to the program, the transitional care nurse meets with individuals at the hospital every day throughout the hospitalization.

The transitional care nurse also collaborates with the healthcare team to coordinate the discharge plan and follow up post discharge based on the patient's goals. Then within 24 hours of discharge, the transitional care nurse will perform a home visit to assess activities of daily living and instrumental activities of daily living.

They'll also talk about symptom and medication management during the visit. The transitional care nurse will also go with the individual or their caregiver to a follow-up physician appointment to ensure and help the patient and family achieve their health goals during the visit.

During the first month following hospitalization, the transitional care nurse also performs weekly home visits. And then semi weekly visits after the first month. On the weeks that a home visit doesn't occur, the transitional care nurse will also call the patient.

The nurse is on-call and available seven days per week throughout the time fame of the intervention.

The next model we'll talk about is the Bridge program. It was developed by the Illinois Transitional Care Consortium. The Bridge program is designed to connect medical and social support through linkage to home and community-based services, home health and primary care.

The care transitions staff in this model are social workers called bridge care coordinators. And the Illinois Transitional Care Consortium provides the training curriculum for staff preparing to assume the role of bridge care coordinator.

The bridge intervention provides support for 30 days following hospitalization. And then they're also mechanisms built in to transition individuals requiring more

long term support to existing care management services within the Aging Network.

The bridge care coordinators also occupy an office space on site at the hospital called an aging resource center. The aging resource center provides dedicated space on site at the hospital for older adults and caregivers to explore community resources, health information and care giving materials and develop community care plans prior to discharge.

So when a referral is made to this program, a bridge care coordinator will meet with individuals either in a hospital room or in the aging resource center to identify unmet needs as well as complete assessments for home and community-based services prior to discharge.

Within 48 hours of discharge from the hospital, the bridge care coordinator will make a follow-up phone call to address any emerging unmet needs. During this call, they will address access queue and scheduling a follow-up physician appointment as well as access to and understanding of medications.

The bridge care coordinator also provides the individual with a consumer-driven health record which can relay important health information to post discharge care providers. Additional phone calls and home visits may take place during this time to resolve indentified issues and ensure an ongoing connection to home and community-based services.

At the end of this intervention, the bridge care coordinator will contact the individual 30 days post discharge to track the progress, address any emerging needs, and provide connection to long-term support in the community if it is needed.

The next model, boost, was developed by the Society of Hospital Medicine and has a slightly different format then the other models I've described thus far. This intervention is designed to work with hospitals and hospital lists and has been implemented by itself or in conjunction with some of the other care transition models that I mentioned today.

Boost provides an intervention as well as an implementation guide to help interdisciplinary teams redesign the workflow at hospitals as well as plan, implement and evaluate care transition interventions.

They also offer technical assistance that includes training as well as a year of expert mentoring. And staff will facilitate communication across sites implementing Boost through a list serve, access to a community site as well as quarterly teleconferences and webinars.

Boost also has an online resource center which allows Boost sites to store and benchmark data against other sites as well as generate reports. The Boosted intervention focuses on four key areas -- standardized discharge processes.

And under this, they've developed a tool called the target. And it has four pieces. One of the risk stratification processes that addresses what they call the eight Ps which includes topics like problem medications, prior hospitalizations, patient support, poli-pharmacy and palliative care.

Then there's an intervention plan that is linked to that eight P risk score. They also use an universal checklist as well as a general assessment of preparedness to ensure that there is a standardized discharge process.

Another focus area is around patient and caregiver preparedness. And they've developed a path tool that addresses post discharge situations and ensuring that the

patient is prepared to meet those situations successfully as well as teach-back which assesses a patient's understanding of a concept or a topic.

The Boost intervention also focuses on tools that address medication safety as well as follow-up care.

The next model we will talk about is GRACE. Dr. Steven Counsell is the principal investigator for the Geriatric Resources for Assessment and Care of Elders model. And this program is based in the Indiana University Center for Aging Resource.

Now this model as I mentioned previously is designed as a primary care for low-income seniors and primary care physicians. But it has transitional care elements built in.

The GRACE support team is comprised of a nurse practitioner and a social worker that collaborate with a larger multidisciplinary team. Staff that are going to be part of this GRACE support team participate in a 12-session training program. And the model, as I mentioned before, is really designed to provide long-term support versus a time limited intervention.

The GRACE model also targets 12 geriatric conditions like dementia, depression, chronic pain to mention a few. And for each of those conditions, there are recommended protocols for evaluation and management which are then individualized for patients.

So upon enrollment in the program, the GRACE support team performs a home visit to conduct a comprehensive geriatric assessment. That GRACE support team then meets with a larger interdisciplinary team which includes a geriatrician, a pharmacist, a physical therapist, a mental health social worker, and a community-

based services liaison. And the interdisciplinary team develops an individualized care plan.

The GRACE support team also meets with the patient's primary care physician to discuss the plan. And they use an electronic health record to facilitate communication.

The GRACE support team also provides ongoing care management and coordination of care across sites. Which includes supporting transitions from hospital to home.

The last model we'll talk about today is guided care. And Dr. Chad Bolt has presented a lot of information on this program. The model is based out of Johns Hopkins University. And the care transition staff associated with this model are called guided care nurses.

To become a guided care nurse, staff complete training at Johns Hopkins that is a six-week, 40-hour web based course. They complete an exam and then they earn a certificate in guided care nursing.

Now the guided care nurse is also based in a primary care office and works with patients and their families. The nurse assesses patient needs. They monitor conditions. They educate and empower the patient and the family. And work with community-based agencies to ensure that the patient's healthcare goals are met.

The guided care model as I also mentioned previously is a long-term intervention based in a primary care setting that have transitional care components. So the guided care program also begins with an initial home visit with the patient and the primary caregiver.

The guided care nurse as I mentioned completes a comprehensive assessment and also asks the patient to identify their most important priorities for their health and quality of life.

This assessment information is then combined with evidence-based recommendations to create a care guide that lists the plans for managing the patient's chronic condition. This care guide is reviewed with the primary care physician, the patient and the caregiver.

And is also given out to other healthcare professionals that interact with the patient. The guided care nurse also makes monthly phone calls and uses motivational interviewing to encourage an active participation of the participant in their care.

They also make referrals to chronic disease self-management programs. When an individual is admitted to the hospital or short-term rehab, the guided care nurse will coordinate the efforts with the healthcare providers at that site, share the care guide and facilitate smooth transitions from hospital to home.

The guided care nurse also provides support to caregivers and facilitates the connection to home and community-based services.

So now that I've described these six care transition models, I'd like to share some information about how these models are being implemented through the 2010 ADRC evidence-based care transition grants.

Marisa Scala Foley: Hey Caroline, before we get to that, we've got actually a couple of questions that I think we might want to answer before we move onto to talking about the care transitions grants. If that's okay with you?

Caroline Ryan: Sure let's go ahead.

Marisa Scala Foley: Okay, great. We got a question from (Pam) who asks, with regard to the care trans, the Coleman model, the care transitions intervention, what are the qualifications for a care transitions coach?

Could a volunteer be trained to do this?

Caroline Ryan: With the care transitions intervention, nurses and social workers and other professionals have been trained. And volunteers have been trained as well.

One of the challenges with volunteers is to find someone who would have the time availability and be able to go through training to respond to the frequency of referrals that would come through a partnership with a hospital.

Marisa Scala Foley: Okay great. We got another question along similar lines from (William). And I think you answered the first part of his question. But he would like to know how the coaches in the care transitions intervention model are trained.

Caroline Ryan: There is a full day training that really provides education around the coaching role. Because it is very different from skilled care or care management. And talks about the four pillars and provides training on how to implement the intervention.

It is also offered on site at organizations that implement the program. More information about that can be found at the care transition intervention website.

Marisa Scala Foley: Okay great, that's all the questions we have so far.

Caroline Ryan: Okay, should I continue?

Marisa Scala Foley: Yes, please do.

Caroline Ryan: Okay so let's go back a little bit and we'll talk about the 2010 ADRC evidence-based care transition grants. ADRC actually stands for Aging and Disability Resource Center. It's a national effort to help create seamless access to long-term services and support.

Which is really designed to help individuals regardless of their age, income and disability. And states that were eligible to apply for the grant, they were required to have already had care transition activity occurring within the ADRC. And then they, with this grant, they build upon that activity.

So with the next slide, you'll see that there are - we've listed the 16 states that received these grants. And then on the following slide, we have some more specific information about how these models are being implemented.

Twelve out of the sixteen states are implementing the care transitions intervention. Illinois is implementing the Bridge program. Pennsylvania is implementing the transitional care model. We've used the abbreviations here.

Maryland is working with guided care. Indiana is with GRACE and then New Hampshire is actually implementing both CTI, care transitions intervention and the Boost model.

We've also provided some information about how long it took for hiring and training staff as well as the estimated number of patients to be served. For more information about these care transition activities, we have listed some information at the end of this PowerPoint presentation with links to be able to share some more information on these activities.

Are there any questions?

Marisa Scala Foley: Caroline, could you talk a little bit more about the piece of this chart that talks about the target population? You mentioned that there are 14 of 16 targeting measures in place. Could you elaborate a little bit more on that?

Caroline Ryan: Sure. So depending on the grantee, they've identified maybe specific diagnoses that they're targeting with this intervention. There may be an age range of individuals. It could be from zero to a hundred or focusing on older adult population. It just depends on the grantee.

So it's targeting different criteria for implanting these programs. As these programs, if you look into the different models, they do identify certain criteria or a risk assessment strategies to identify who might be most appropriate for these interventions.

One size does not fit all. And so, you know, it's really about targeting the intervention and who might benefit from the program.

Marisa Scala Foley: Great. We've gotten a couple more questions in. First from (Pearl) actually now we've gotten several questions in. So we'll take them one at a time.

First from (Pearl) who asks, are these grants, are they statewide grants or projects or are they localized?

Caroline Ryan: They're statewide grants. So we've listed the 16 states that received the grants and then are being implemented through ARDCs within the states.

Marisa Scala Foley: Okay. And we've gotten another question from (Scott) who asks, how do you ensure that these interventions, that they're handled in a person-centered manner where the person, the patient or the client is in charge of decision making rather than the coach, or the nurse, or whomever the professional or volunteer is who's assisting the patient or client?

Caroline Ryan: Great question. And what you'll find if you, you know, pursue some of the additional information about these models is that they are patient-centered and family-centered.

The coach is designed to empower the patient to assume an active role in their healthcare. And that theme echoes throughout a lot of the other models. That they're put in the center of care. That their wishes and their goals are highlighted and reinforced throughout the process.

They keep coming back to what is the patient's goal which may not be the same as the healthcare team's goal or the community-based support. So the focus is really on identifying, keying in on what the patient's goal is and trying to help facilitate that process of reaching the goal.

Marisa Scala Foley: Okay. Let's see. We've got another question in from (Nancy) who asks, are these models of transition in addition to Medicare's skilled care or are they replacing Medicare skilled care when the client goes home?

Caroline Ryan: It's not replacing Medicare skilled care. These models really look at enhancing that transition from hospital to home. And they work in conjunction with skilled care services.

So some folks may not actually receive skilled care, Medicare skilled care but may be eligible for a transition program. Otherwise, the models actually work quite

nicely hand-in-hand with skilled care. And often facilitate a lot of communication between a home health team as well as a transition team.

It's all about collaboration and communication across the different care sites and disciplines.

Marisa Scala Foley: Okay great, a couple more questions. We got a question from (Ann) who asks, with regard to this chart, are the 200 to 800 number of patients for all 16 states or for each state?

Caroline Ryan: It's for each state. That just gives you an estimate and an average. And it's a two-year process. So that would be 200 to 800 within two years.

Marisa Scala Foley: Okay great. Another question we got from (Barry). He asks, do any of the programs target populations that may be experiencing health disparities?

Caroline Ryan: Yes. The models do. Oftentimes it's targeting specific chronic conditions. But there are also interventions that are designed around - so the Bridge program specifically targets limited English speaking elderly, individuals who living in medically underserved communities.

And a lot of these other models are really trying to address and target individuals who may be at risk for re-hospitalization and could benefit from a supported care transition.

Marisa Scala Foley: Okay, a question from (Laura) who asks, I see that my state is not one of the grantees. What can they do to become part of this important initiative?

Caroline Ryan: Well beyond sort of the scope of these grantees, there's a larger network that is involved in implementing care transition activities. The ARDC network is

actively involved as well as Triple As and other organizations throughout the country.

So if you are interested, one option would be to visit the websites, the ADRC website which is linked. It's one of the slides at the very end of this presentation.

There's a lot of information about care transitions and AoA's role with care transitions on that website as well as a link to a care transitions workgroup and other information sharing opportunities.

Marisa Scala Foley: Great. Another question from (Pam) who asks, which of these interventions would be appropriate for a transitioning from skilled nursing facility to home or from a skilled nursing facility to assisted living rather than from hospital to home?

Caroline Ryan: Sure. And when I say hospital to home, I mean it broadly across the spectrum. So someone may transition from hospital to short-term rehab to home. Or directly from hospital to home.

And these six interventions really focus on the continuum of care. So looking at if someone is transitioning from the hospital to short-term rehab that connection is still there to have that next transition supported as they return home. Or if they transition to an assisted living, independent living scenario.

With GRACE and guided care because they're located in a primary care setting, they start sort of in the primary care office. And then if someone transitions to the hospital, they work with the discharge team to facilitate the transition to the next setting.

With these other models, I've seen them implemented out of skilled facilities as well as the hospital. So there is some flexibility in the site. It's really more about

the components, patient activation and collaboration, coordination, ensuring a smooth transition that are important with these models.

Marisa Scala Foley: Let's see, okay. A question from (Jean) who asks, do any of the models include patients with dementia? Is there any screening out of patients with certain illnesses such as dementia or perhaps other mental health issues before they're accepted into one of these programs?

Caroline Ryan: Some of the programs have targeted individuals who, you know, they may be more relevant for individuals who are able to activate in their own care. Or if they have a caregiver or someone that can assume that role on their behalf.

Other models, the Bridge program, guided care, and the GRACE model have opportunities for some more of the care coordination and support for folks who may not be able to activate and take a very large active role in their own care.

Marisa Scala Foley: Okay. Let's see, we've got a couple more questions then I think we'll turn things over to Sandy and we'll try to answer some questions at the end of this.

Let's see. We've got -- sorry, I've got scroll through. From (Dave), (Dave) asks, are any of these six models working in rural areas say under 50,000 people in population?

Caroline Ryan: The grantees are actually applying these models in rural areas. So yes, it is possible. And this really provides a framework. What I've talked about today is sort of the key components of the models.

And then what you'll find is that, you know, with our grantees as well as with others that they have looked at applying these models and maintaining model fidelity but applying them to different environments and settings.

Marisa Scala Foley: Okay. We got a couple of questions actually related to costs. And so let me see if I can sort of put them together.

We had a question with regard to the cost, sort of the average cost for patients across the models. And I think, Caroline, am I correct that each of the models sort of has their own costs estimates in terms of, you know, what it costs sort of to go from beginning to end in terms of the intervention?

Caroline Ryan: They do. And I would encourage anyone who's interested to link into the websites that we've provided because there will be more information about the cost.

Marisa Scala Foley: And can you talk a little bit about any evaluation that's being done of AoA's own EBCT grantees in terms of, you know, costs savings as a result of their care transition activities?

Caroline Ryan: Sure I mean I think that that's something that the grantees are aware of and are in the process of calculating at this point as well as evaluating the outcomes of implementing these models within an ADRC setting.

Marisa Scala Foley: Okay. Let's see. Hold on. We got a question from (Allen) who asks are any of these demonstrations being implemented with people being discharged from nursing homes under the money follows the person initiative?

Caroline Ryan: No they are not. This particular set of interventions with these grantees are really targeting the transition from the hospitals to short-term rehab to home. Right now there isn't a link in with these grantees with the money follows the person program.

Marisa Scala Foley: Okay. Hold on one second. We got a question, just a couple more quick questions, and then we will turn things over to Sandy. And we'll follow-up with everyone else afterwards.

A question from (Nancy) who asks what's the average number -- for the EBTC grantees -- what's the average number of sites within a state? And who, you know, who are some of these grantees who are implementing and evaluating programs and monitoring them for compliance?

Caroline Ryan: Sure. So the states received the grants. And we have on our slide the 16 states that are implementing the grants. And then in terms of I'm sorry, tell me the other part of the question again. Could you repeat it Marisa?

Marisa Scala Foley: Sure. I put them together. Let me go back. So the average number of sites within a state. Who are some of these grantees who are implementing and evaluating the program as well as monitoring them for compliance?

Caroline Ryan: Sure. So in terms of monitoring for compliance, I mean there is model fidelity. The grantees are working with the researchers around ensuring that, you know, there is model fidelity as it's being implemented at the site.

Typically we've seen with the grants I would say anywhere between two to four sites. The average is probably two or three sites that are implementing the program through this grant.

Did I answer all of the pieces of the question?

Marisa Scala Foley: Yes, I think you got everything. I think what we're going to do right now in the interest of time and we will have more time for questions. So I'll keep

watching and sort of queuing these up and we'll come back to as many. I'll try to answer some of them while Sandy's talking.

But I think Caroline, did you have anything else you wanted to mention as part of your presentation?

Caroline Ryan: I think that's it.

Marisa Scala Foley: Okay great. For those of you who have questions in the queue, don't worry we won't forget about you. I'm going to sort of walk through, you know, scroll through them and get them down. And we'll come back to some of these questions later on. And I'll try to answer some of them as best as I can while Sandy's talking.

But I think with that, we would like to turn things over to Sandy Marwood from n4a who will talk about care transitions and the Aging Network. Sandy, we'll turn things over to you.

Sandy Marwood: Greta Marisa, thank you so much. And again, I would like to focus in on what I believe are opportunities for the Aging Network in the care transition program.

And as Cindy Padilla said in her welcome, the issue and involvement of the Aging Network, triple As, ADRCs and care transitions it's not foreign to the Aging Network. There are many triple As and ADRCs who are already engaged either formally or informally in care transition programs.

But I'd like to start out by focusing in on why the Aging Network, I believe, is so critical to care transitions. And first I think we need to recognize the unique and trusted position that the Aging Network has in the community and have had for 40 years.

And that the Aging Network is a very credible resource and viewed as such by older adults and their caregivers. And especially in accessing that critical trusted position in a time of need or crisis which often occurs when someone is leaving a hospital and returning home.

I think another key point is the fact that the Aging Network has intellectual property. The Aging Network has programs and services that are in place and can be replicated and drawn upon to be able to meet that care transitional need.

Also there is no one at the local level, no one at the community level who knows the needs of older adults and caregivers like the Aging Network. And as such, in the work that the Aging Network has done for the past 40 years, you've done that work by contracting with the right service providers at the community level who you trust, who the Aging Network trusts to reach out and to serve the needs of older adults.

You know who the best service providers are. You know how to setup contracts to ensure that the needs of older adults are met. And that's very powerful. It's a power broker position when you're looking at being able to meet the multiple needs that an older adult would have as they leave the hospital and they need a myriad of services and supports to be able to stay home successfully.

And also again, you have service provisions skills on how to contract and to ensure that those needs are met. And also how to assure the quality and the outcomes that have resulted in a track record of success for the Aging Network.

But then I'd like to turn around and look at why care transitions is so critical to the Aging Network. Why it's critical to the core mission of what we do. And when

we look at our core mission of maximizing independence for at risk populations really there is nothing that speaks so clearly to the need of care transitions.

We're looking at trying to meet the needs for independence, for health and dignity for people as they leave hospital settings and return home. And to ensure that they return home successfully.

We are also looking at the need to engage the Aging Network in a changing long-term care landscape. And we have been doing that, building and enhancing our position for many, many years in this arena. And expanding the role the Aging Network plays in home and community-based services. And care transition is just another opportunity in that changing landscape.

Also as we look at care transitions, it can afford a new revenue stream for the Aging Network whether it be a revenue stream for private pay clients or for contracts with hospitals as they try to develop more robust care management programs, care transition programs.

As we're looking, we're also looking to about not just meeting the needs of new clients but also recognizing that we're looking at 1 in 5 older adults being readmitted to the hospitals within 30 days. Many of those clients, many of those patients are already our clients.

And many of them are involved in maybe one or two of our programs. But this puts them in a different context when they need care transitions to be able to provide services and supports that meet their needs at that point in time.

So when we're looking at care transitions themes and how they relate to the Older Americans Act and to the Aging Network of services and to the work that we do everyday, I think they fall into two or three buckets really.

The first is looking at interdisciplinary teams and service coordination. The second is looking at enhanced follow-up activities for that patient-client. And the third is patients and client activation, all themes that Caroline had already focused on as she walked through the six models.

But I'd like to look at those three themes in terms of the work of the Aging Network. First let's look at interdisciplinary teams and service coordination. And when we consider that theme, we need to look and focus on the Aging Network perspective on the coordination of services that are already happening out in triple As and ADRCs across the nation.

And the fact that we are looking and working hard to build seamless bridges between the medical community and the human services community. And looking at building that bridge between the acute world and our world of person-centered support services.

The coordination of services is key also workforce development and training. And also developing significant standards for training and workforce development.

Recognizing that as we move into building that bridge between the medical and human services world that we need to ensure that we have the workforce who are able to successfully build that bridge. And walk between both the medical world and the human services world.

Also we need to look at developing, refining, enhancing our planning processes to be able to ensure that we can successfully work in a care transition situation. And in saying that, we need to look at developing and enhancing our existing area plans and/or setting up and developing new strategic plans at the Aging Network level, at the triple A level.

That include a business development model as part of those. Recognizing that care transitions really puts us in an expanded business model. Also we need to look at creating new partnerships. To be able to ensure that we can do this interdisciplinary team and this expanded service coordination.

And there is no better system than the Aging Network to develop partnerships. Already at the triple A level, there are at least ten formal partnerships that have been formed at the community level to provide enhanced services to older adults.

We're looking at moving into care transitions gives us an opportunity to expand our partnership base. To include hospitals, physician practices and medical facilities.

But it also gives us opportunity to expand our coordination. And to be able to have more enhanced access to benefits and supports for older adults who as they leave that hospital setting will likely need more care and support for 30 days but oftentimes it exceeds that 30 day period to 60 and 90 days.

And helping then to be able to access the benefit program that they need to be able to maintain those supports.

The other bucket that I think that we need to look at from the Aging Network perspective around care transitions is looking at that enhanced follow up. And this is an arena where the Aging Network has exceeded and had the base of expertise again, since its inception.

Looking at enhanced care management or care coordination. And recognizing that we know how to develop, implement and monitor individualized service delivery plans. Providing in-home services and supports, home health, personal

care, homemaker services, friendly visiting or telephone reassurance or chore services.

Looking at nutrition and home delivered meals. Access to transportation and coordination of transportation. But also looking beyond into monitoring and assistive devices. Personal emergency response systems that are needed and necessary when you're looking at monitoring and assuring that a person can remain home safely during that 30 day period after a hospital stay or beyond.

And we've already heard from the six models how important medication management is. But that it's also an opportunity to be able to reach out and to do disease prevention and health promotion activities that the Aging Network is already engaged in through health risk assessments, chronic disease self-management programs, the myriad of evidence-based programs that are delivered at the community level as well as home injury prevention and screening.

The third bucket is really looking at patient and client activation. Recognizing that an older adult may be a patient in the hospital. But once they transition from the hospital to the home setting and they start activating supportive services, they become the client.

And in looking at that is to be able to provide a comprehensive patient-client assessment. And in that assessment to ensure that we include home assessments and caregiver assessment. Because when we're looking at trying to meet the needs of that individual to be able to stay home, to remain home successfully, the home setting is critical to that as well as the needs and support that the caregiver can provide.

So looking at that comprehensive assessment. But also recognizing that as we look at activating the patient that we need to ensure that we do it in a self-directed way. And look at as many of the models that Caroline had focused on.

Looking at coaching the client to be able to meet their own needs not just in this situation, this period of time after they've left the hospital but beyond. To ensure that they're more educated and self-activated patients for their health needs in the future.

In doing that, the Aging Network has moved so strongly into self-directed care. And this is just another opportunity for the Aging Network to expand in that arena. And then also looking at health and nutrition education which has long been part of the Aging Network service delivery system as well as benefits, access to benefits, and insurance counseling which we've done and done well.

In addition to that is also looking at supporting the caregiver. The important caregiver who is there and is the backbone of the long-term system, care system as we know it. But ensuring that they get supported in their needs. They get the appropriate counseling and training.

So when we look at those three buckets and we recognize that there is so much the Aging Network is also doing to intersect with care transitions. As we look at these opportunities both now and into the future, we need to really reflect on how as we move into this expanding arena and it's expanding with the opportunities that are outlined in the Affordable Care Act.

But there are some things that the Aging Network also needs to consider as we look at expanding our reach into this arena. And the first is capacity. Recognizing that if we really intentionally expand into care transitions, we need to expand the agency's business model.

And develop and sustain those new partnerships. And look at establishing fee for service billing systems. To be able to ensure that we can move in that arena successfully. Also from a human resources perspective, the need to expand and enhance our existing operations and perhaps our personnel.

Recognizing that from a care transition model there needs to be a quick turnaround and possibly even 24-7 service delivery. And recognizing that in many of our agencies that's not the model that we work on now. But if we move into care transitions, we would need to move into that direction.

Also looking from a partnership and provider relations is how to respond to broad scope of care transition service needs. And from a service provider's perspective that may mean changing or amending our existing contract with service providers.

And last is looking at culture change to expand your agency's position. It's really a new way of doing business. And that new way of doing business is one that really the Aging Network has been changing its model of operations for many, many years as we've repositioned ourselves in home and community-based services.

Care transitions which would be a way to further accelerate the change that we've already seen. So in looking at that, I think that from the National Association of Area Agencies on Aging perspective and 4A, we believe that the care transitions models provide a wonderful opportunity for the Aging Network to build on the work that we've done so successfully for so many years.

And to be able to expand our reach and our outreach to serve older adults at the community level. And in saying that to do that with an expansion an enhancement of the programs and services that the community has come to rely on the Aging Network to serve and deliver and to deliver well.

Marisa Scala Foley: All right, thank you so much Sandy. Let's see I'm trying to look through. We've gotten a bunch of questions. And I'm trying to look through and see if there are any questions specifically for you.

I think not at this time. So what I'm going to ask that we do right now is we're going through - So thank you so much for your presentation, Sandy.

The questions are continuing to come in. So we'll call on both you and Caroline as we get them.

What I'm going to do right now is talk a little bit about some of the resources that we've included in these slides for folks to be able to consult with later on. And then we'll go back to do some more questions. We'll answer a couple more questions that have come in through Chat.

And then we will open up the audio lines for questions. So let's just take a look at the resources section of these slides.

The first two slides on resources take a look at providing again the links to all of the different models that Caroline outlined in her portion of this webinar -- the care transition intervention or the Coleman model, the transitional care model also sometimes called the Naylor model, the Bridge program as well as Boost, Project Boost, GRACE and guided care.

Let me mention for those of you because we've gotten this question a number of times. For those of you who are trying to frantically scribble down and some of these URLs are a little bit complex. We will posting these slides on the AoA website by early February.

If you need these slides beforehand, please do, you can email us at affordablecareact and that's all one word, affordablecareact@aoa.hhs.gov. And that will be on the last slide that we look at in here.

So you can email us and we're happy to send these resources so that you're not trying to copy down complicated URLs right now.

So the first set of resources as I mentioned look at the models. We also have included in these slides some other resources related to care transitions. Several of the questions that have come in via Chat through WebEx have asked about, you know, future funding that exists.

One potential source of future funding that we anticipate coming out sometime this year. It will be from CMS in the form of the community-based care transitions program.

As Cindy mentioned earlier in her welcome, Section 3026 of the Affordable Care Act does authorize the Secretary of Health and Human Services to provide funding for programs that focus on community-based care transitions.

But we've been spending, you know, our time this afternoon talking about. That solicitation has not yet been released. But we have listed a link to the website. CMS did do a conference on looking at community-based care transitions in early December which I'm sure many of you participated in either in person or via the web.

You can find resources related to that conference at the community-based care transitions program on that website. And certainly as soon as that solicitation is released, we will make sure to get that word out to the Network as quickly as possible.

In addition, some other care transitions related resources, as Caroline mentioned, we have a website that focuses on AoA's aging and disability resource centers' efforts related to care transitions.

In addition, the quality improvement organizations that are funded by the Centers for Medicare and Medicaid Services had as part of their ninth scope of work, a sub national theme that looked at care transitions. There were I believe 14 states that were involved in some of that care transitions work for the QIOs.

We have included a link to their website as well. They also offer some training, some webinars focused on the results of that QIO effort. So I do encourage you -- we've sat in on some of them and they actually they're very good -- so we encourage you to participate in those as you can.

Also some resources related in general to the Affordable Care Act. AoA's own health perform webpage as well as we have a link to healthcare.gov which is the Department of Health and Human Services healthcare reform website. And we have a link to the text of the Affordable Act in here.

We do invite you to join us for our next training which will continue this theme of talking about care transitions. And we'll focus this next time on making the programmatic case for care transitions work in your community.

We have scheduled that webinar for Wednesday, February 9 from 2 to 3:30 Eastern time. And please do watch your email for additional registration information. That should be coming out fairly soon.

With that, I think I will turn things back to (Tom). (Tom), if you could tell people how they can queue to answer questions through the audio lines just so we can take some questions there.

And then we'll finish up with the few remaining questions that are available via Chat.

Operator: Thank you very much. At this time, if you'd like to ask question, you can do so by pressing star then 1 on your phone. You'll be prompted to record your name so that I may introduce your question.

Once again that is star then 1 if you'd like to ask a question. One moment please. At this time I show no questions coming in the queue.

Marisa Scala Foley: All right. So let's go back to our Chat questions and see what else we can answer.

Let's see. Hold on one second. We got a question in from (Jane) who asks and I believe this question is for Caroline. First, are there any collaborations? Do any of these models promote collaborations with human services departments for follow up for clients who may have been admitted following reports of elder abuse or specifically self-neglect?

Caroline, do you know if any of our EBCT grantees or any of the other models have worked in that area?

Caroline Ryan: You know they may already have that in place with their ADRC rollout. It really can vary from site to site.

Marisa Scala Foley: Okay. We got another question that asks are there any other measures with regard to - We got a question about outcome measures.

Are there any other measures besides re-hospitalization being used to evaluate some of these evidence-based care transitions models?

Caroline Ryan: Absolutely. And if you refer to the websites, they can give you some of the measures that they've looked at. The models have randomized control trials where they have outcomes and measures. So if you're looking for specifics, I would certainly encourage you to look at the websites and the resources that they provide.

In terms of the grantees, you know, certainly re-hospitalizations is one of the measures that will be considered. But, you know, access to home and community-based services and other measures are also important in this work.

Can I also Marisa, I just also wanted to mention, make one other comment. As we have our resources and listed information in the last couple of slides, is really the focus of today's presentation was on the six evidence-based care transitions that are being implemented by the grantees, you know, 2010 ADRC evidence-based care transitions grantees.

There are other care transition models that exist and are being implemented throughout the country. And so this just sort of gives, you know, highlights a few of the models that are being used. And, you know, I would encourage for others who are looking for more information to, you know, explore, you know, other models that are out there as well.

Marisa Scala Foley: Sandy, a question for you from (Kristen) who asks, you know, what can the Aging Network do now in order to become part of, to partner with and to

implement care transitions projects? And Caroline, you can chime in too on this one I think as well.

Sandy Marwood: Well great. I think that there are opportunities right now for the Aging Network to start knocking on the doors of hospitals and physician practices but primarily hospitals. To be able to ensure that they know all of the services and support that the Aging Network has.

Many area agencies on aging, or ADRCs have worked with the hospital discharge planners already. But I think that this provides an opportunity to have an introduction at even a higher level at the hospital when you look at the Affordable Care Act. And that down the line, hospitals will be penalized if they do not avoid preventable readmissions in that 30 day period.

I think a lot of hospital administrators are looking in a new way of that discharge planning role and the services and supports that patients are connected to as they go home. So I think that if you've already knocked on the doors, if you already have relationships, go back in and make sure that the hospitals really know about the broad extent of the triple A network and the services and support that you provide.

If you don't have that relationship, now is the time when your knock on the door, your call may be heard and responded to differently than it has been in the past. Partnership development I think is key and critical.

But I think the other part of it is looking internally at your own operations. And recognizing what you do and how it can fit into that care transitions mode and model one of the ones that Caroline had outlined previously.

And recognize that as you move more significantly into one of those models that there may be internal changes that you need to do to your business to be able to setup those models successfully in your community.

So partnership development, looking internally at how you would need to change your own business operations I think are two things that you can do right now.

Marisa Scala Foley: Caroline, did you have anything you wanted to add to what Sandy said?

Caroline Ryan: I agree with everything that Sandy said. And just in terms of thinking about partnerships that those relationships may be established but thinking about formalizing partnerships. In terms of memorandum of understanding or some type of formal agreement that really highlights, you know, what the roles are and defining that partnership or collaboration.

Marisa Scala Foley: Okay. Caroline, I think this next question in Chat is from you or is for you. It's from (Meghan) who asks, I thought I heard that some care transitions models were incorporating other evidence-based programs such as the chronic self-management program.

Can you specify again which models were encouraging such referrals to or implementation of other evidence-based programs?

Caroline Ryan: Some of the models are. But I think also within the grantees and as we look at care transitions, we're looking at the connection between care transition models and the evidence-based health programs.

CDSMP, falls prevention and they just seem like a natural fit to connect care transitions with that kind of work.

Marisa Scala Foley: Okay. Caroline we just got several questions. I'm going to try to combine them all into one question that has to do with sort of who pays these models?

Are these expenses that are being reimbursed by Medicare or, you know, who's paying for the nurse or the coach who can help patients or clients through these transitions?

Caroline Ryan: It's a great question. For our grantees, obviously the grant is compensating those efforts. In terms of a larger scale and implementation, you know, there could be grant funding or, you know, other opportunities for partnership then and funding to support the transitions staff and the implementation of these models.

Marisa Scala Foley: Okay great. I think those are all the questions that we have through, almost all the questions we have through Chat. (Tom), have we gotten any other questions in the queue through the audio line?

Operator: We do have one question that's come in the queue.

Marisa Scala Foley: Great.

Operator: The question is from (Miriam Rose). That line is now open.

(Miriam Rose): Hi. My question is whether any of these six models or any others that you know of actually start in the nursing home and without having a hospitalization be the first step. But really start initial contact in the nursing home?

Caroline Ryan: You know, I think probably the best resource for you is going to be the actual model websites. Because they can share - they share more information about how the model has been implemented in different settings.

And so perhaps that would provide the most detailed and accurate information in terms of the skilled nursing facility transition process.

(Miriam Rose): Okay thank you.

Marisa Scala Foley: Any more questions (Tom)?

Operator: At this time we've had no more questions come in the queue.

Marisa Scala Foley: Oh we've gotten a couple more in via Chat. First is from (Anna) who asks, are there any regulations or state guidelines that care facilities and hospitals have to follow with regard to care transitions? Or is it optional for them?

Caroline, do you want to take that one?

Caroline Ryan: Sure. I think, you know, a lot of the development around these models was the recognition that their formalized systems were not in place. And that these models try to build systems that can enhance that support from hospital to home.

And that was really the intention or where, you know, the design came from.

Marisa Scala Foley: We got a question in from (Denise) who asks, what background social worker, nursing is most prevalent for care transition personnel?

Caroline Ryan: You know, it really varies. It depends on the setting and personnel and the model.

Marisa Scala Foley: Okay Sandy we got a question in for you. We got a question from (Carla) who asks, are there members of the Aging Network who have made some of the

business models you spoke of who might be willing to mentor or provide webinars or conference sessions on how they successfully did this.

I'm going to just pipe in before I turn things over to you, Sandy, and mention that this will be a future topic for one of our webinars, probably our late February webinar. We will take a look at making the business case.

But Sandy maybe you want to talk about the Business Institute and how that might relate to some of this work?

Sandy Marwood: Sure I think that in recognizing that as I mentioned that this really is an opportunity for the Aging Network for triple As to move into a private pay model.

We have been looking and gathering information from a number of area agencies on aging across the country who have developed and are implementing care transition models and the business systems that they've put in place to do that successfully.

So we are gathering that information. We'll be happy to share it with AoA if Marisa, you're doing the webinar at the end of February. But then we will also be posting it on the n4a website, www.n4a.org if not up there now. But probably will be within the next two to three weeks.

Marisa Scala Foley: Great, thank you. Caroline, we got a question in from (Dave) who asks, do the hospitals have a funding source that they can tap into to pay for care transitions on their end?

Caroline Ryan: It's something worth exploring as these collaborations develop. But it would depend on the setting again.

Marisa Scala Foley: Okay great. I think let's see we are just about out of questions. For several of you who have asked with regard to the URLs of the six projects, if you email us at the email address that is shown on your screen right now, affordablecareac@aoa.hhs.gov, we can send you, you know, the slides or the URLs for the six projects. So that you can take a look at those.

We got one more question, another question from (Marlene) who asks, can we get data on re-hospitalization rates for specific hospitals in a community?

We are going to be exploring that on our next webinar and as part of building the programmatic case. But yes, that data is available through Hospital Compare on the CMS website. So you may want to take a look there.

And finally, we've got a question in from -- I apologize, let me scroll up -- from (Nancy) who asks a great segue for us to sort of closeout things for this webinar.

And she asks about AoA's plans to help build the Aging Network's infrastructure and development to be part of care transitions. And that is what, really what this webinar series is all about.

We're going to be spending the next webinars over the next several weeks. We have three webinars planned and we'll likely be adding a fourth we hope. All focused on care transitions and different elements of care transitions in order to help prepare the Aging Network for building the partnerships. Finding the data, building the business case for care transitions work in your community.

Please do stay tuned to your email for additional information about registering for some of these webinars. We also are planning a toolkit for the Aging Network that focuses on care transitions.

And that will include not only what you've been hearing on some of our webinars but also case studies and other information that can help you to build care transitions, help you to build care transitions efforts in your community.

And so we invite your suggestions, your comments for future webinar topics or for things that we can include in the toolkit. Please do email us and let us know what you think. And how we can help to better prepare you for undertaking care transitions work in your community.

I'll ask (Tom) one more time if we've gotten anymore questions into the queue for the audio line?

Operator: At this time, we have not received anymore questions.

Marisa Scala Foley: All right. So with that, I think we will close things out. We thank you so much for your participation in today's webinar and for the lively discussion through Chat as well as for your questions through the audio line.

We do invite you to contact us and let us know how we can assist you as you move forward with your care transitions work in your community. And we look forward to having you with us on future webinars.

Thank you so much.

Operator: That concludes today's conference. Thank you for your participation.

END