# Administration on Aging
# Affordable Care Act Webinar
# *Care Transitions in Action: From Hospital to Home in Two Communities*
March 30, 2011
2:00-3:30 pm Eastern

Coordinator: Welcome and thank you for standing by. At this time all participants are in a listen-only mode. During the question and answer session, please press star-1 on your touchtone phone and please record your name clearly when prompted.

Your name will be required to introduce your question. When you are recording your name, please make sure your phone is off mute. Today's conference is being recorded, if you have any objections at this time you may disconnect.

And now I would like to the meeting over to your host, Ms. Marisa Scala-Foley. Ms. Scala-Foley, you may begin ma'am. Thank you.

Marisa Scala-Foley: Thank you, Rico. Good afternoon everyone, good morning to those of you who are in the West Coast, or in Hawaii or Guam as believe we have some participants from there.

Thank you so much for joining us for AOA's fourth in a series of webinars that are focused on opportunities for the Aging Network, both state and local agencies within the Patient Protection and Affordable Care Act also known as the Affordable Care Act or the ACA.

Given the emphasis on reducing hospital admissions within ACA, our webinar today which is titled Care Transitions in Action: From Hospital to Home in Two Communities continues our focus on the important topic of care transition, patients or clients going from one care setting to another so for example from hospital to

home, from hospital to skilled nursing facility, from skilled nursing facility to home and more.

Our webinars are designed to provide the Aging Network with the tools that you need to help develop care transition efforts in your area. We developed today's webinar in response to some post-webinar requests from some of you asking us to take a detailed look at some communities that are presently engaged in care transitions work.

And more specifically at the partnerships that have developed between the Aging Network and health care providers such as hospitals and skilled nursing facilities. So today you're going to hear from two such communities, Chicago and Akron, which are pioneers in this work.

So before I turn things over to our speakers, just a couple of housekeeping announcements, first of all, if you have not yet done so, please use the link that was included in your email confirmation to get onto WebEx so that you can follow along with the slides as we go through them. But also ask your questions when you have them through the chat function in WebEx.

That will be -- for most of the webinar -- that will be the only way that you can submit your questions. If you don’t have access to the link that we emailed you, you can also go to www.webex.com.

Click on the Attend a Meeting button at the top right-hand corner of the page. And then enter our meeting number which is 663084836. And I'll repeat that, the meeting number is 663084836.

If you have any problems with getting into WebEx, please contact WebEx's technical support at 1-866-569-3239 again that's 1-866-569-3239. As Rico

mentioned everyone is in listen-only mode. However we do welcome your questions throughout the course of the webinar.

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

In addition, after each team wraps up or after both teams wrap up, we'll offer you the chance to ask your questions through the audio line. When that time comes, Rico will give you instructions as to how to queue up to ask your questions through the audio line.

If there are any questions that we can't answer during the course of this webinar, we'll follow up to make sure your questions get answered and we'll email you those answers.

If you think of any questions after the course of the webinar, you can also email them to us at AffordableCareAct@aoa.hhs.gov and all of these email addresses are included in the PowerPoint slides that are the basis for this webinar. Those slides will be posted on the AoA website probably within the next week.

And finally, as Rico mentioned. we are recording this webinar. As I just mentioned, we'll post the recording, the slides, and a transcript of this webinar on AOA website likely within a week or so.

Okay so enough with the housekeeping announcements. Let's go ahead and introduce our panel. We are thrilled to have with us a terrific panel of speakers. The first team that will be up is the team from Chicago.

I'm going to just introduce them and give their titles and then I'll turn things over to them. First we have Robyn Golden, who is the Director of Older Adult Programs at Rush University Medical Center in Chicago, Illinois.

We have Robert Mapes, the Manager of Community and Agency Relations at Age Options, the Area Agency on Aging for suburban Cook County in Oak Park, Illinois. We have Ilana Shure, Program Manager of the Aging Resource Center, a transitional care program created by Aging Care Connections based on site at Adventist La Grange Memorial Hospital in La Grange, Illinois.

And finally we have Louise Starmann who is the Director of Social Service with Aging Care Connections as well.

So I'll turn things over to the team from Chicago.

Robert Mapes: We also have Walter Rosenberg from Rush University Medical Center as well.

Marisa Scala-Foley: Oh, I apologize Walter; I did not mean to skip over you in my list.

Walter Rosenberg: That's okay.

Robert Mapes: Great well this is Rob Mapes from Age Options. Marisa, if you could advance the next slide please. Thank you.

Today we're going to give an overview of the Aging Network in Illinois. We'll introduce you to the Illinois Transitional Care Consortium. Inform you about our efforts in the ADRC Care Transition Grants. Explain the Bridge model, how we build relationships with hospitals. How we made the business case and touch on the policy developments that affect care transitions. Next one please, great.

The Aging Network in Illinois is a little bit different than some other states. The Illinois Department on Aging was the first-cabinet level Department of Aging in the nation. Age Option is one of 13 area agencies in Illinois.

In the state, AAAs fund, plan, coordinate and advocate for services for older adults in the planning and service areas. Case coordination units also known as CCUs were setup by the Illinois Department and the aging AAAs to provide nursing prescreening, in-home assessments, care planning and other services such as caregiver support, elder abuse, and other abuse and neglect interventions.

The next slide please. The Illinois Transitional Care Consortium was formed to more effectively address the needs of older adults transitioning from the hospital to the community by linking hospital-based services with the Aging Network to intensive care coordination. Next slide please.

The ITCC is a unique collaboration of three sectors working to improve care transitions. Its members include community-based organizations, including Aging Care Connections which will be on this presentation, hospitals including Rush University Medical Center which is also part of this presentation and research, evaluation and policy partners. The next slide please.

ITCC has an advisory board with representatives from multiple sectors in the agencies including a funder, advisor to the governor, and leaders in the medical and aging networks. Next slide please.

Last year we were fortunate enough to receive an ADRC Care Transition grant. This grant is allowing us to expand the implementation of the Bridge model to people with disability under the age of 60 and includes a hospital with high Latino population.

With this grant, we are working with three hospitals and their care coordination partners including MacNeal Hospital whose CCU partner, Solutions for Care, and Adventist La Grange Memorial Hospital whose CCU partner is Aging Care Connections, and Rush University Medical Center whose CCU partner is Central West Case Management. Next slide please.

As I mentioned before, Age Options doest not directly connect hospital patients with community-based services. But we strive to support and promote improved care transitions in our area. This program was developed by our partners in this grant.

We believe in partnership programming and we'll do whatever we can to have strong and dependable services in our area. Age Options is virtual ADRC with Progress Center for Independent Living. Other agencies such as our care coordination units are an important part of our ARDC network.

For this grant, we provided specialized training to the Bridge coordinators so they could understand the disability system and connect younger people with disabilities to resources that will help them follow through with the discharge plan.

We are also working to ensure home and community-based services supported by the Older Americans Act and other funds support the efforts to improve care transitions in our area. And we have developed a plan to connect care transition clients with a Chronic Disease Self-Management Program also known as CDSMP.

Progress Center, our disability partner also has trained younger people to lead the CDSMP workshops so that are care transition clients regardless of age have the opportunity to attend these workshops with their peers.

Age Options has also worked in coordination with ITCC to prepare our area for thee upcoming CMS grants. We have informed our funded agencies about the Bridge model and the upcoming grants. We have also worked with our CCUs, our case coordination units in our area to reach out to hospitals and explain the important role that Aging Network plays in reducing readmission rates.

The next slide please.

Walter Rosenberg: All right, thank you, Rob this is Walter. I'm going to take a little time to go over the Bridge models specifics. So the Bridge model is a social worker based model with Masters level social workers called Bridge care coordinators providing the actual services.

The model works with interdisciplinary teams with focus on the hospital-to-home transition specifically. The model is patient focused and community specific. And at the heart of the model is the partnership between the community, the community and the hospital which is symbolized by the Aging Resource Center that Ilana will discuss a little bit later in the presentation.

It was very important for us to have the model be flexible enough so that it has urban-suburban and rural applicability as well. Next slide please.

So here we'll walk through the model step-by-step. Once the patient is admitted into the hospital, they are then referred to the program through one of several different means. So for example, you can have a risk screen integrated into a hospital electronic medical record which generates automatic referrals, daily referrals.

Also direct referrals can be made either by discharge planners in the unit or by a family member of the patient themselves self-referring into the program. Finally

after getting those referrals, the Bridge care coordinators complete the first days of the intervention by conducting a thorough discharge assessment and setting up services before discharge.

The information for the assessment comes from several different means including a face-to-face interaction with the patient or family members, participation in interdisciplinary rounds in the hospital and also reviewing the electronic medical record. Next slide please.

The second phase of our model is entirely telephonic and it begins two days after the patient was discharged with a follow-up assessment. Now this assessment is a key component of the intervention because as we have seen time and time again, the situation on the ground is almost always different from what was planned for from the hospital.

And this doesn't correlate with the type of medical care that they have received or the quality of discharge planning. It's unfortunately the reality that you can't plan for all the eventualities that a person faces when they come home. Once the secondary assessment takes place, the Bridge coordinators intervene and identify needs.

This phase of the intervention ends when all the identified needs have been addressed or resolved or one more transfer has been made to relevant community services. And then there's a component at 30 days when a Bridge care coordinator follows-up with the individual for evaluation purposes and to reconnect them into the Aging Network.

Now at the two-day period, I should mention that the typical length of the intervention takes place over the course of approximately five and a half days with approximately five and a half calls taking place. And at this point we address

issues such as the discharge plan of care confusion or medication regimen confusion.

We look at psychosocial issues facing caregivers and the patients themselves. We ensure that a patient follows up with community physicians and address other issues that come up. Next slide please.

It was very important to us as we were putting this model together not to duplicate any of the existing services. And so on the inpatient side we don't, so to speak, step on the discharge planners toes but work in partnership with them.

And on the community side it means that the same service setup and provision takes place as has been taking place with the Medicaid waiver programs. The same assessments are taking place but the Bridge models wraps around those existing services and makes them more robust. Next slide please.

A few words about Bridge care coordinators. So the post-discharge environment according to our model seems fairly neat like the graphic on the left with an older adults surrounded home health community services, community physicians, the pharmacy, hospital caregiver and other silos of care at the post-discharge level.

But the reality of course is a little more like the graphic on the right, a Kandinsky which shows a chaotic, confused environment. And so it's really important for somebody to have a birds-eye view of this playing field and help the older adult navigate this landscape. Next slide please. Thank you.

So we don't just intervene on psycho-social issues but the psych-social issues that we do address include social isolation, depression, difficulty coping with change, financial stressors, language barriers, health literacy barriers which is an important one.

And finally the older generation taught to be good patients. We have seen over and over again that older adults want to appear like they're doing the right thing for their doctors and for their nurses. And so a lot of times they sort of tell them what they want to hear.

We have found in our experience that social workers seem to get more information out of people so to speak. People tend to be more comfortable with us. I'm not sure why that is but that seems to be the case a lot of times.

And that really helps with our decision - to understand our decision why we went with social workers for this transitional care model. At the heart of our social work education is the so-called systems theory which looks beyond the physical body of the person, beyond the actual age, sex, health of the individual.

And moves into the systems that fold around the person including their interests, their families, their friends, their local communities resource landscape, their neighborhood, and of course policy implications on the local, state and federal levels. We use the biopsychosocial framework to intervene.

And we certainly focus on the psychosocial determinants of health and these have shown to be at the heart of 40% to 50% of readmissions. But that's not to say that social workers can only prevent or work to prevent those 40% to 50%.

Many medical issues such as medication regimen confusion, follow-up with physicians, et cetera are also issues that can be addressed by social workers who connect the necessary silos of care to make sure the right information transfer takes place. Next slide please.

The evidence base for the model comes from a randomized control trial that took place at Rush University Medical Center where 720 individuals and it took place from June 2009 to March 2010. Next slide please.

In an interest of time, I'll just go into quickly go over outcomes and we have shown an impact at 30, 60, 90, 120 and 180 days with readmissions. We've increased access to formal services, decreased the time between discharge and start of services.

We've increased follow up with physicians in the community is this is not just scheduling and appointment but actually attending them. And also we've increased understanding of medications and individuals' responsibilities for managing their own health.

Finally while we didn't set out to study this, we were pleasantly surprised to see that we've also made an impact, statistically significant impact on mortality. We were so surprised by this that we came up with a proxy control group and studied these for an additional six months with the results holding up.

So we're pretty pleased with that particular result and with all of them all together. And at this point, I'm going to hand it over to Ilana who will talk about Aging Resource Center.

Ilana Shure: Thank you. I'll be discussing the Aging Resource Center and explain its significance and its role in the Bridge model. The Aging Resource Center or ARC breaks between the silos of care and fosters communication between the community and the hospital.

It's the communities' on-site location in the hospital. So the role of the ARC, the ARC symbolizes a hospital-community collaboration and it provides greater

ability to interface with the community. It really creates continuity for the patient across the healthcare silos.

Bridge care coordinators meet with the patient in the hospital as Walter explained and follow up with them after discharge. They're going through the process with the patient by being actually onsite at the hospital.

The ARC creates the opportunity for the person to be able to have the community at the table with the rest of the interdisciplinary team so that they can also assist in planning for discharge. It's additional perspective to the interdisciplinary team. Next slide please.

Bridge care coordinators at the ARC are experts on the community. They know what's available and have relationships with the community-based agencies. If you look at this chart, you can see many of the common referrals that are made through the Aging Resource Center to community-based services on behalf of the patient.

While the most common referrals are made to some of the traditional services such as home delivered meals, case management and home care services, as you take a look you'll really see the range of services that the community provides. Having the Aging Resource Center onsite at the hospital, you have the opportunity to really connect people to those other services that can really assist in stabilizing somebody back into the community. Next slide please.

This slide covers more details as compared to the previous slide in highlighting what the community offers. You can look at some of the specifics such as caregiver support, benefits, housing. Under these categories there are a lot more specific services offered.

And at the ARC we have rich resources explaining the multitude of services that the community can provide and assist with the discharge to be as successful as possible. Thank you.

I'm going to turn it over to Louise Starmann.

Louise Starmann: Okay, my piece of the presentation is really about how we established the ARC and really looking at how to develop the partnerships that appear to be more and more at the forefront of where health care reform is going.

And we began back in 2008 really doing some primary work. We worked a lot with Rush University Medical Center and kind of picked their brains in terms of the direction that we're going.

Actually establishing an ARC is a difficult process in the sense that it involves bringing a community-based organization into an acute care setting. This is the community side. Rush's experiences is a mirror image in the sense that they're trying to work and build partnerships with community-based organizations.

But in our particular model and in our ARC we actually as a community-based organization went inside the hospital and established our partnership with the acute hospital personnel from the top down. This is a really new concept for both organizations.

And I want to encourage those who are thinking of beginning the process of talking with either a community-based or the hospital to realize that the startup time is really easily six to nine months in terms of really getting the partnership up and going and off the ground.

When you're looking to outreach the hospital system, I would encourage you to work from your strengths. Many of the hospitals are familiar with community-based agencies as referral sources for their discharge planners. Most of us have some sort of a role in the Federal OBRA requirements for nursing home screenings.

And for those of us in Illinois, many of us are actually onsite at the hospitals on a daily basis. And so I would work with those individuals in your hospital system that already know the work that you're doing. And I would begin to contact those individuals at the hospital who are already supportive of the work that you do and dialogue with them around what you plan to do with the future partnership.

How we worked it is many of the members in ITCC have been spending the last year in starting out making these contacts and we have worked with a social service director. We have worked with an executive director of external relations, the head of gerontology department, physicians.

Each hospital system has a different sort of hierarchy. And so I think it's important that you begin to work with the people who know you best and let them inform you as far as where the decision makers are in your particular hospital setting.

I would keep your eye on who the decision maker is in the hospital during the time that you're networking with all the others in the hospital system who maybe know you a little bit better than the CEO. But keep your eye on the fact that you ultimately need to get to the CEO.

So and when you're thinking about a partnership, I think the whole concept of partnership is one that there is a little step back and looking at who you'd like to be your partner. I think you have to evaluate what you're looking for in a potential partner.

There are issues that you may want to think about in terms of what their value systems look like. What their reputation for quality is. Sometimes you need to look at size. Is this an institution that will be easy to partner with? Or is it a very, very large institution that will take more time to partner with.

Institutions are known for their openness to change and some institutions are not as open to change. And so I think that's an important question to ask yourself when you're deciding who to choose as your partner. Then you need to make ask.

And we would encourage those, some of this we've learned from our own mistakes, but I would encourage you to think before you ask about what you're asking for. What specifically do you want your partner to contribute?

In our case it started out with some space. It started out with technology and it grew to data sharing agreements, referrals, protocols, and so forth. I would also encourage you to think about getting something even if it's just a memorandum of understanding or an MOU at a minimum.

We found over the course of the few years we've been doing this that staff and leadership change in these institutions. And so having a working agreement at the outset even if it's something as informal as an MOU really will help keep your project on the right track and it will sustain itself through personnel changes. Next slide please.

Ultimately though, I think that in order to have an enduring partnership of the type that I think is called for in healthcare reform, I would really encourage you to think about establishing a legal agreement.

The legal agreement should broadly define the service provisions, exactly what you're asking to do in the hospital system, who the recipient of the services are and the duties of each partner in the relationship including defining the purpose of the program, really clear-cut responsibilities of both parties and the individual responsibilities.

Looking, spelling out in legalese the financial liabilities, confidentiality and data sharing and whether or not it needs to be set out in the beginning what termination might look like and what would be cause for termination. We found that hospitals adapt to this very well probably better than community-based organizations.

Most hospitals have legal teams and they have working partnerships with multiple vendors. For us it was a little alien to us that we would have a legal partnership with another entity. But we have found that it's served us well over the past year and a half once it was established. Next slide please.

Marisa Scala-Foley: This is Marisa. I just want to let you all know you've got about five more minutes of presenting and we'll need to take some Q&A.

Louise Starmann: Okay. I think I'm going to skip over this last slide then because I know Robyn has a lot to cover and I guess maybe the main thing is that we want to - we start out as a guest in these hospital systems. But I think we want to become, the goal is to become an integral part of the hospital team. So thanks very much, Robyn.

Robyn Golden: Thank you very much. Let's go the next slide, thank you Louise. So I think we've talked about our partnerships and it's really broad. We really wanted to cover urban, suburban and rural so we truly have something that could be replicated in other states across various settings. You have a glimmer of that. Next slide.

So part of what -- to reinforce what Louise said -- part of how you get that hospital to the table or the community-based agency to the table is truly building the business case both in terms of the clinical and the economic outcomes or drivers.

And, you know, what we found is that there's a different language used in various settings and we try to work hard, particularly on our national advisory group, to try to come to some common language so we all can be around the table, the virtual table, speaking the same language.

And we know there's a lot around quality and cost outcomes right now in terms of reducing readmissions, emergency department, outpatient follow up. And it's important to talk that language but also talk about the clinical outcomes as well.

I think the biggest piece of why we created Bridge was so that Aging Network would not be an unfunded mandate as all of this unfolds with the Affordable Care Act. It would be too easy for hospitals to just say, oh, the aging and the disability network will take care of this. And it would be automatic without the notion of their being some cost sharing resource sharing down the road.

So again, the next slide, Marisa, in talking about the business case we have to make the case to the hospital or to the community-based provider which Rush had to do that we could bring something to the partnership. That it could be a win-win to reduce the sense of any threat there might be on the other end.

And, you know, everybody's talking about this, you know, the private insurers, the public payers. And, you know, part of what we need to do too is get the consumer voice out there and saying consumers want this kind of transitional care, care coordination from a psychosocial social model perspective, not just medical.

Because when we have the consumers, particularly the future boomers asking for that, you know, we all assume it's going to happen. So again, what's critical and next slide please is making sure we influence and interpret policy both to our partners as well as to the larger world. That's why we're so excited were part of this larger endeavor nationally.

And when you look at what's happening in terms of all of the reforms as part of Affordable Care Act whether that can community-based care transitions, 30 day readmissions, reducing them, bundling payments, accountable care and medical home which we don't have time to go into today, you'll really see that we can play critical roles both the hospital and the community.

And that bridging of them is what's truly going to be critical to make all of that happen and to make us as equal partners and ultimately be there for the patients, and families, and clients and families that we so much want to serve. And make sure that they're not falling through the proverbial crack.

So we thank the Administration on Aging -- if we can skip to the next slide -- as well as our many supporters that we're so excited to be part of this larger endeavor of the ADRC grants and care transitions. And we also thank the Bridge model, thanks not only AOA but some of our other funders along the way and particularly the Weinberg Foundation that really has supported ITCC is its fullest way.

So we thank you. We turn it back over to you and we look forward after our colleagues from Ohio to some questions.

Marisa Scala-Foley: Terrific, thank you all so much in Chicago. We have gotten several questions. So let's go ahead and get started. The first one came in via Chat from (Cheryl) who asks, who designed the electronic transmission system between the hospital and your Bridge care coordinators.

Robert Mapes: I think there was maybe a little miscommunication. So there is not an electronic transmission system. But most hospitals are now using electronic medical records. And one way to generate referrals to the program is to have a risk screen which we have developed and which is part of the evidence-based approach is to have a risk screen integrated into that electronic medical record that would generate daily referrals.

This is just one way to ensure that people that need the service actually get it consistently.

Marisa Scala-Foley: Next we got a question from (Steve) who asks, when you began your program, how did you develop your relationship with or market the program to hospitals?

Louise Starmann: This is Louise from Aging Care Connections, what we did basically is pretty much what I outlined in my presentation. We really went to the folks that we already knew at the hospital and began talking to them about how this would serve their patients well.

The case is already being made for many of us now with readmission rates being such an integral part of hospitals' future planning. And I think that's really your best approach. As Robyn said, I think we have to be able to present a business approach that it is a win-win from a patient perspective and also from a business perspective.

But we personally, our program started with the people that we knew. And they sort of launched us. We had a champion at our hospital that kind of pushed us forward.

Marisa Scala-Foley: Great, thank you. Okay next a question from Suzanne who asks, could you explain why you selected a social work model for the Bridge program rather than nurses or a combination of social workers and nurses?

Robyn Golden: Sure, it's Robyn. We had really done a fair amount of research nationally to see what was going on and there was a lot going on around nurse transitional care models through some of our great colleagues and partners. And we in looking at our own pilot here at Rush, we knew that a lot of the reason people were returning to the hospital had to do social determinative health or psychosocial and environmental factors.

And we decided as a result to task the social worker approach that would be able to look at things from biopsychosocial perspective as we do. And in no way say that we can do it better. But that we can do it too, the transitional care piece. So that's really why we selected social workers.

Walter kind of mentioned that as well. And it's nothing about not working with nurses. All of us are working with nurses particularly our home health colleagues.

Walter Rosenberg: And it's also just to briefly mention during the interdisciplinary rounds for example; pre-discharge, social workers are constantly communicating with the nurses involved in the patient care.

And then post-discharge, as questions come up, social workers in our model are serving as the connector for that information transfer from let's say the home health nurse to the patient or the nurse back in the hospital to the patient. Just as a centralized sort of source of information.

Marisa Scala-Foley: Oka,y great. We got a couple of questions related to this next one which had to do with what's your funding source. Who's paying for the Bridge transition

program? You mentioned some grants I know earlier, Robyn, but if you could talk briefly about that that would be great.

Robyn Golden: Sure. Well this is the trick of the trade and part of what we have talked about from the beginning is sustainability options beyond grants. So we're constantly hoping to be part of the care transitions, the different sections of the Affordable Care Act that are coming out both in terms of I believe Section 3026, the Community Care Transitions grant we're looking forward to on a more federal level grant wise beyond AOA.

But I think we're also just trying to prove the business case to the hospital. And hopefully the hospitals will be able, someday, to put as one of our advisors tells us, skin in the game in terms of helping to support the care coordinators role. But we have a potpourri of potential options in funding this down the road. But none of them are absolutely solid.

And that's why we need to keep showing the evidence and working the policy angles and need all of your help to do that.

Marisa Scala-Foley: Great. A question from (Eileen). She says, you know, she sees that your clearly having - you're making an impact via the results that you shared. Can you talk a little bit about, you know, once home that your contact is via the telephone as opposed to in-person. How do you feel you can get a - how can you get a real picture without being there because home environment can make a real impact for some of the clients that you're dealing with.

Robert Mapes: Sure, that's a great question. That's something that we get asked a lot. And as I mentioned in one of the slide, it was important for us to try and not duplicate some of the existing services that are already in place.

So for instance, many people, a sizeable chunk of the people that we see have home health for example who do make home visits who we communicate with to make our information a little bit more comprehensive.

And in some respects, our approach is less expensive because of this lack of the actual home visit. And targets different issues than the nurses from let's say the Coleman or the Naylor model target when they do their home visits.

And so we're kind of looking at different, at some different issues. And so...

Robyn Golden: That's why the partnership is with home and community-based agencies too...

Robert Mapes: That's true.

Robyn Golden: ...so there will be that constant back and forth as well. And they will be in the home. And then we don't need to duplicate those efforts. It's a stronger economic model we feel in this era of limited resources.

Marisa Scala-Foley: Great. We got a question -- I think we'll take a couple more questions and then we'll turn things over to the folks in Akron. I know there are a number of you who have questions. We will follow up with the team in Chicago to make sure that we can get your questions answered afterwards if we don't get a chance to answer them right now.

So we had a question from (Patrick) who asked who are the members of your interdisciplinary team?

Robert Mapes: So the interdisciplinary team is comprised of at Rush, the hospitalist, a discharge planner, the nurse on staff. We know also have a pharmacists that's on the team and our social work Bridge care coordinators as well.

Marisa Scala-Foley: Okay great. One second just trying to - Can you talk a little bit how you're maybe partnering with home care agencies.

Robyn Golden: Yes, Louise and Ilana, do you want to say something about that or...

Louise Starmann: Sure. From the community perspective, we're, you know, again we have, our organization is a community based organization inside the hospital. And we work with the home care providers both in the hospital prior to discharge. Most of them at least in our particular hospital have an onsite presence as well.

And so we work with them prior to discharge and then all community-based organizations are frequent collaborators with home health teams. And so we very definitely work with them pre and post discharge.

Robyn Golden: And we have MOUs with home health agencies because we were finding at Rush when people went home that there were a lot of problems with the home health following through. And it wasn't always the home health problem in doing that but it had to do with our communication with them, a variety of systematic issues.

And we have developed very solid expectations of home health and really have narrowed down our home health relationships to about five or six agencies that meet those expectations. And things are much smoother as a result.

Louise Starmann: Interestingly enough, I just want to add one more caveat is that many of the referrals that we've been getting in the last few months have come from the home health provider who's on site at our hospital. So they are also very eager to team up.

Marisa Scala-Foley: Great, and I think we'll take one more question and again, we will follow up. We are recording all the questions that are in Chat and in the Q&A. And we will make sure to follow up and get these to the team so that they can hopefully answer any questions that weren't able to answer today.

But I think a great way to leave things off is we've gotten lots of questions about your results. And if you can talk a little bit about what the reductions in hospital readmissions have been like since you implemented the program.

Walter Rosenberg: Sure. So we have seen and we've also seen recently that we're not alone in this, a really large challenge with getting accurate data. So specifically that means that we need to have access to CMS data to find the right groups that actually are matching the populations that we're addressing.

And this, as was recently mentioned at in AOA grantee conference this seems to be an issue really across the country. So I really hope that when 3026 comes out they have thought about this data issue and have some answers for us.

So our numbers come from Rush specific readmissions. And this is something that, you know, we're certainly happy to see. But it's really unclear if hospitals would be dinged for readmission to hospitals, different hospitals than the hospital of origin and I think they will.

And so at this point we actually have ordered, have paid for and ordered CMS data. And are waiting for that CMS data to come in to confirm our internal Rush results. And as soon as that happens, we will make that public as well.

Ilana Shure: And we're seeing a trend as well as Adventist La Grange Memorial Hospital of reduction in readmission rates. But again, we're waiting from some data to really compare it to and better understand the process.

Overall across sites, we can also share a little bit of our data in terms of the demographics and who were really working with. We're really working with frail, older adults, typically over the age of 75 with social needs identified as well.

And while our demographics indicate a much older adult with significant needs, we are able to help them stabilize in the community. We are seeing that. And we're seeing typically the population we're working with is satisfied with services and able to use services we connect them to remain in the community.

Marisa Scala-Foley: Okay we have, like I mentioned, we have gotten a number of questions in and we will make sure that we have them all recorded. And we'll work with the teams to get the answers to questions for those of you that weren't able to get your questions answered during this Q&A session.

But I do want to make sure that we have time for our next great team. First of all, thank you to our team from Chicago for a terrific kickoff presentation.

Now we're going to turn to the team from Akron and the team to talk about their care transitions work. The team from Akron include on today's call includes Dr. Kyle Allen who is the Medical Director of Post Acute and Senior Services, Program Director of the Geriatric Medicine Fellowship Program and Chief of the Division of Geriatric Medicine at Summa Health System in Akron, Ohio.

Carolyn Holder, who is the Manager of Transitional Care with Summa Health System, Akron City Hospital in Akron, Ohio and Joseph Ruby, who is the President and CEO of Area Agency on Aging 10B in Uniontown, Ohio.

So with that, I will turn things over to Carolyn.

Carolyn Holder: And I think Joe Ruby is going to be getting us started on this presentation.

Joseph Ruby: Marisa, could we go to slide Number 41 please?

Marisa Scala-Foley: Sure. Okay, there we go, I think we're set.

Joseph Ruby: And I'll say that the introduction ironically I was in transit getting here and that's why Carolyn was going to jump in first. I'm in the midst of a hospital transition with my father.

So let me say, the Area Agency in the Akron-Kent area has been doing nursing facility transition since 1987 as part of Medicaid Waiver program and in an acute care setting since 1998.

But before we get into some of those details, I thought It would be useful to kind of walk you through how we got there. And if you'll go to Slide 42 please, excuse me, yes. Well I have a different number on mine but we're on the same ride.

So how did we get there and this has kind of been our mantra we call it IDEA, identifying key stakeholders, developing relationships, exploring common interests and aligning efforts to achieve mutually desired outcomes.

Next slide please.

Marisa Scala-Foley: Sure Joe. Could you get a little bit closer to the speaker on your speaker phone?

Joseph Ruby: Okay, maybe I just need to talk louder.

Marisa Scala-Foley: There you go.

Joseph Ruby: Sorry, is that better?

Marisa Scala-Foley: That works.

Joseph Ruby: Okay. So we've kind of delineated the usual suspect of stakeholders. And what we noticed about 20 years ago is that we really were under represented in terms of our stakeholders on our board of directors. And felt like moving forward, particularly kind of getting into this transitional care stuff, we really needed to bring on some key leaders in both the hospital and the physician communities.

And we felt like that was really an important thing to integrate medical and long-term care and subsequently a lot of people think that. And that's probably why we have things like the Affordable Care Act. But we really worked hard I guess in terms of bringing on leadership to our board.

And that's really if you'll go to the next slide how we got to the dialogue that we needed to get to with some of these key players. And that's really how we got the entre if you will into the organizations like the hospitals.

And we used our board members then to as a vehicle to build engagement and to commitment to our mission and vision so that they understood what we did and how that could relate to what hospitals do and what doctors do on a day-to-day. And hopefully making that governance more of a meaningful relationship. Next slide please.

So historically the area agencies in Ohio and their role is Medicaid Waiver, we're there to provoke consumer choice in long-term care and to be considered a cost containment trying to allow people the option of going into a lower cost settings when it was more desirable and more appropriate.

And reducing permanent nursing facility placement as well as increasing length of stay in home and community-based programs like our waivers. Next slide please.

So the paradigm shift really came with the new Medicare initiatives aimed at reducing utilization particularly as it relates to hospital admissions. And that's really what I think aligns hospital activities with what we do.

Also the idea of reducing the length of stay and reducing emergency room visits, all issues that relate permanent nursing home placement which from our perspective which, you know, is kind of our prime directive if you will to steal a little bit from Star Trek. Next slide please.

I guess against that, the backdrop of our initial onset into hospital transition programs I guess it's worth saying in 1998, we went into the hospital with the idea of achieving outcomes related to the Medicaid Waiver program. And in fact had we gone into hospitals and say our role is going to try reduce readmissions and reduce admissions, I think we probably wouldn't have been welcome.

Again, with the change in Medicare, I think we now have an alignment. And so we worked on developing our hospital transition programs with that in mind. So one of the things we think that we need to do moving forward is developing a provider incentive payment plan through the AAA to achieve desired Medicare outcomes similar to an ACO model where if we have sort of a pay for performance system.

If we reduce readmissions for example, our PASSPORT providers, our Medicaid waiver providers would similarly be incentivized financially and to the contrary penalized if we don't achieve those goals so again, trying to ensure that our alignment is similar to that of the hospitals.

We felt like it's key to integrate planning with Medicare Advantage plans. And we feel again our efforts were very much aligned with efforts of health plans and have been for a long time. And why we work with health plans for a long time in that regard because they always had an interest in reducing readmissions as a payer.

And so we found building on that alignment was something advantageous as well. Another thing that we found is that if you work with physician practices, in our case particularly those that serve a lot of Medicaid members, it's a good way to get people into our system before maybe they even need the hospital let alone long-term care at a nursing facility. Next slide please.

So building on our Summa area agency on aging, geriatric evaluation, aka SAAGE hospital programs success -- and Dr. Allen's going to talk a bunch about that so I won't get into a bunch of that -- we were able to place nurses in Akron City Hospital back in 1998.

Subsequently, we were able to capitalize on our success there and moving our nurses again through our Medicaid Waiver program to seven other acute facilities and a specialty select hospital in our region. And actually there's 11 acute care facilities and two specialty hospitals so you can see we cover most of them now.

And we also a couple of years ago at the suggestion of one of our board member docs, put one of our Medicaid Waiver nurses in the Cleveland Clinic Wooster campus which again, fits our bill of having a large Medicaid patient population. In fact they see 800 Medicaid patients every day.

So again, we looked at our nurse consultants in the hospital to work with the patient care coordinators, the discharge planners and physicians to create that Bridge if you will to home and of course working with the patient and the family.

And we also were able to use that as an opportunity to enroll folks into our waiver programs, both PASSPORT and our assisted living Medicare Waiver program. And that's been very effective. And in fact, one in five of our members, we first saw in a hospital setting. And within six months they became members.

So it's been a very good way to sort of build our membership and our visibility in the community as well. Next slide please.

So we then looked at how to build even further on the Affordable Care Act as a driving force again with the idea of aligning what we do to help reduce readmissions. And so we put together a health coaching program in an affordable collaboration actually a contractual relationship among three entities, one independent living system in Florida who had sort of the health coaching system.

And we brought two hospital partners, partners where we had already placed our nurse assessors, our nurse consultants in those hospitals. So these weren't people that were new to those hospitals. And the purpose was very specific at reducing these avoidable readmissions.

I should say in our pilot that we reduced readmissions in both those facilities to under 2% from over 20%. So those pilots were quite successful. So again, building on our hospital-based assessor program, our Medicaid nurses in the hospital we provided this evidence-based health coaching program. Next slide please.

So in the nursing setting, as I said, we've been doing care transitions in that setting since 1987. And really the key driving force over the years has been when they've been enrollment limitations in the Medicaid waiver. In fact, we subsequently then build on that to get a grant from the Administration on Aging to better integrate

care management for common members of our Medicaid waiver program PASSPORT and Summa's Medicare Advantage plans.

And this grant allowed us to identify and address barriers to successful integration with managed care organizations. The outcomes of the grant including developing a high risk screening tool, care management protocols specifically aimed at high risk factors that we identified in this grant period.

And we developed a geriatrician led interdisciplinary team that we still use today. And it's been quite effective in terms of working with very difficult cases with very complex problems both in the sense of chronic diseases and in the sense of some of the social problems that were alluded to by our colleagues a little bit earlier. Next slide please.

So building on that care management integration, we developed this path to transition team which consists of three medical social workers and we started that in 2007. And we worked with the health plans NIFS what were in there provider panels to really expedite the transition of older adults back into the home and community-based settings.

And also of course it was a way for us to be able to get people enrolled into both our Medicaid waiver program, PASSPORT, and our assisted living waiver program. And subsequently we sent that information to all the nursing facilities in our region.

And we're going to try to branch out now with other managed care organizations, again aligning our efforts with those managed care organization are trying to accomplish. Okay next slide.

So we began meeting with staff at these targeted facilities, again part of the Summa care panel to discuss our agency being an extension if you will of their discharge planning team. Those nursing homes, their interests were aligned too.

They have a pretty robust post-acute skilled Medicare business through the health plan so they were anxious to work with us to get those folks transitioned back into home and community-based settings and continue serving new health plan members.

And then we followed these individuals, identified in our preadmission review process as being 60 plus and Medicaid eligible. And then the Path team spent time in the nursing facilities talking with the residents who want to get back home regardless of their age and again, trying to determine their eligibility for the programs that we offered PASSPORT and assisted living. Next slide please.

And you can see from our little bar graph have significantly increased enrollments from the NIFS to our PASSPORT and assisted living programs through these activities. In fact you can see that we pretty much doubled our annual enrollment through the NIFS setting. And the next slide.

So kind of our next step working with Summa Care and Summa Physicians, Inc. which is a geriatric medicine and the Area Agency on Aging to expand our health coaching partnerships through serving members of the health plan that go into hospitals. And then we will work with Summa Physicians Inc. who are training our staff to work with the health plan members and do this coaching.

And again get people back in the community and hopefully avoid those unnecessary avoidable readmissions. We're certifying additional staff on Dr. Kulveen's evidence-based model for evaluating the impact on discharge to permanent nursing facility placement of course as one of our outcome priorities,

hospital admissions, and readmissions again, aligning with the ACO that Summa is developing and the emergency department business as well.

And finally, we're going to continue developing our relationships with those nursing facilities and our other partners. If you go to the next slide I believe I'll be turning this over to Dr. Allen. Doc?

Dr. Kyle Allen: Thanks, Joe, and good afternoon everyone. Next slide please. I'm going to touch on a lot of things that Joe talked on but probably drill down and give you some of the operational nuts and bolts.

If I was to frame this in a large aspect, we are kind of the beta site for the AAA for a lot of these programs and then through Joe's leadership and his staff have been able to replicate this to non-Summa hospitals in the region. So it's kind of a whole regional impact through this partnership.

And I just would say that I've been involved with the AAA since I was a fellow in geriatric medicine. I think Joe was quite surprised when I showed up. We were at a combined meeting. I think at the time of that meeting we were looking at how to work together for research grants.

But I just looked at him and said, hey, can I join your board? So I actually said in full disclosure, I sit as the Chief Medical Officer for the Area Agency on Aging Board. But I think that's important because as a geriatrician, I kind and I have one foot in the hospital and one foot in long-term care and kind of one foot in the community, that's three feet. But to be able to boundary span and if there was some degrees of success, if I would list them on the table for this it would be that Joe and I are kind of bilingual or multilingual.

We could communicate together and trust each other and have mutual kind of aligned vision. Next slide please. That's the name of the project. That's what we give it. We don't really know what the acronym means anymore. It's changed many times. But that's what we continue to refer.

And we really did start - I came to Summa in 1994. Met Joe. Said can I join your board. And then we just started working from there. Next slide.

The SAAGE project, like I said is a 15 year partnership and many, many people involved. The common goal was to improve the health, well being, and functional status of our frail, older adults. We wanted like the Area Agency on Aging to prevent premature institutionalizations.

We had identified major gaps in the continuum of care for each partner in communication. We searched for and defined mutual benefits. And it wasn't all done upfront. We kind of did this as we went along.

We kind of have always addressed each other's threats and concerns and conflicts openly. We built trust. Like I said, this has grown to other multiple regional systems. And it's based upon communication, communication, and vision, vision, vision. Next slide please.

You can kind of see the goals there. And we wanted to integrate this across a hospital-based geriatric program and the Aging Network to gain those improvements. And it really is between - What started out just with the geriatric services but now it's more system wide and I'll share with that in a minute. Next slide.

That's the Area Agency on Aging. Its mission. The things it provides specifically the PASSPORT homecare Medicaid Waiver program in Ohio. But they've

provided a lot of other services. They know the Aging Network. They know it better than our hospital staff. And that's where we really found a lot of benefit to helping with these folks. Next slide.

Summa, large integrated delivery system Northeast Ohio, I think it's one of the largest in Ohio. We have six hospitals, Level 1 trauma center. Probably about 68,000 discharges a year, a major teaching program, two fellowships, one in geriatrics, one in palliative care and we have integrated programs across the continuum of care. Next slide please.

Keep going with the button please, yes thank you. And so that's kind of what our institute looks like and those are kind of the four pillars of the institute, the bottom one being our major clinical programs across in-patient, out-patient and post acute side.

We have a research office which I'll touch on at the end that also involves the Area Agency on Aging, robust education programs and these community partnerships on the right-hand side is where this sits. We also additionally have a network of nursing homes of about 37 that we formalized into what's called a care coordination network that's focused around improving handoffs and transitions of care and quality. Next slide.

A lot of this really theoretically, we know that if we're going to improve chronic illness care, we really need to work on self-management and kind of redesign. And we really needed to have the community partnerships. And so we kind of, in fact you could move that self-management support and kind of stretch it between the health systems side and the community side which is really what we're doing.

And we know that will improve the clinical and functional outcomes for this vulnerable population, next slide.

These, Joe touched on a little bit. I'm going to go through them. How did we first begin? We got together in a room and it was kind of like hi, what's your name, what's your major. And we just started dating from there.

We soon found out that - I mean this was as simply as just getting people's names on a telephone roster and how to contact them and what their fax number is. We then developed fax communication forms so that we actually got feedback from each other across those geriatric clinical sites.

We then, as this was the beta test of what Joe talked about, we saw a real need although I would say it was stealth, I wouldn't tell the hospital I was focused on reducing readmissions but that's what I was doing. Because we saw these vulnerable populations being admitted to our acute care for elders unit and they would get skilled care but their social determinants and other things wouldn't be met. And so enough they would be right back in the hospital.

So we wanted to expedite that referral to community-based long-term care services. We could identify the need proactively at the time of hospitalization. So we said, can we put - I said, Joe, can we put an RN assessor into our team?

We worked through all the other issues. It worked wonderfully. Then we expanded it to both hospitals, City and St. Thomas. And now it's gone more regional, next slide.

Joe talked about the grant that we worked on that helped bring about integration between the health plan and the Area Agency on Aging. We used kind of an appreciative inquiry technique to build these relationships. I think those case managers on both entities, from the health plan - But I guess I should talk about our health plan as part of our system.

It has about 25,000 Medicare Advantage lives, about 130 commercial lives. It's a health system-owned insurance company. It's for profit but it essentially acts like a not-for-profit. So we put the kind of any savings and that type of thing back into programs and development.

But this is where we were kind of building the relationships between the care management division of the health plan and the Area Agency on Aging. We then still saw that we needed more. Joe actually had lunch with me.

I don't know if he'll remember and he said hey, you know, can you bring some more of that Ace team and culture that you've kind of developed. And can we work to get more of that down here at the Agency? I said sure we can.

So with Carolyn's help and assistance, we went down. We did some educational series. And we put a geriatrician which then also expanded to include a pharmacist. And so the case managers were able to bring these high-risk cases.

And I say we end up concentrating a lot on medication issues I think is where one of the major quality improvement issues are. Out of that team meeting, we actually send academically detailed reports back to the primary care physician to kind of address best practice, if you will, of glaring things that we see as far as management of geriatric syndromes or pharmacology issues. And the case manager then follows up with that.

We then, the next thing is we kind of work with our (telesystem) where we have what's called the extended care information network. And now we've kind of got the Area Agency on Aging linked to that.

So if there happens to be a patient that went to a nursing home out of our system but the RN assessor didn't have time or didn't get them, the Agency still knows that they got placed in a nursing home. And then with the Paths program, they can follow up. Next slide.

Joe already talked to you about using the same kind of technique and putting a case manager in a prime care office. That's the Wooster Clinic that he talked about. And then through this partnership, we actually wanted to study a little bit about what we were doing about the integration. So we're just finished up spending 537 subject randomized control trial.

That's a care transitions intervention with a focus on coaching for self-management that integrates the geriatric side with the Area Agency on Aging side. And so we hope to have results here in the next 60 days or so.

We learned from that trial that we also wanted to see if we could advance or move upstream if you will geriatric and palliative care principles. Because a lot of times when we enroll patients in the add life trial, we didn't feel like we were doing much - we didn't have enough time or because of the acute illness and that type of thing, we couldn't get things stabilized.

So now we're actually doing this piece trial where we're picking up subjects at the time that they accept PASSPORT and they're enrolling. And we're teaching the case managers at the AAA how to coach not only in self-management for their symptoms but also self-management of defining their advanced directives and then having those meaningful discussions with their physicians. That's kind of nutshell of what those two trials are about.

The reason I put them up there is that we've leveraged the partnership into extramurally funded research as well. And I think it's helped both entities. Next slide.

So I'm not going to go into that, next slide, I already talked about it. Next slide. Piece trial, I spoke about it, next slide. You can kind of see the purpose. Next slide.

And then lastly, this is kind of the Venn diagram that we think and then the last thing that we've been doing here Joe touched on it. We're going to leverage the RN assessor program and the work that they've done in care transitions to actually be apart of our accountable care organizational strategy.

And under our leadership which is called, we call it Bridge to Home Transitions Coach model, we will be using the Area Agency on Aging coaches are part of our coaching team for reducing readmissions. So next slide.

These are big problems. We need policy fixes which we don't have. We're hoping our research will help in that policy debate. Just, to me, all health care is local. So just coming together and working on it is helpful. And we really think the whole is more the sum of the parts so. And effective collaboration is a team sport between or more organizations.

I'm going to finish there so we have time.

Marisa Scala-Foley: Okay all right, thank you so much. Let me just go through a couple of the slides that we always conclude with. And then we'll do some Q&A from the chat function in WebEx and then we'll open the lines for questions.

So just a couple of slides we have having to do with resources both on care transitions. You've heard people make mention of the community-based care transitions program that will be issued by CMS soon.

We've got a link to that website as well as to a number of other websites including AOA's own ADRC and Care Transitions page, the Quality Improvement organization in care transitions, their support center as well as a report that was recently issued by the Long-Term Quality Alliance.

We've also got some resources as well on the Affordable Care Act both to the legislation and the tax as well as to AOA's own health reform webpage which is where all of our webinar recordings, transcripts and slides are stored.

So we'll continue our trainings in April. We don't have a date yet because we are still working out a topic although we'll likely continue this focus on care transition. So please do watch your email for the date, time and registration information.

So with that, I believe we will start with some of the questions that have come up through chat and the Q&A on WebEx. And then we'll open up the audio lines.

So we got a question ion, Joe, this first question's for you from (Judy). We also got this from someone else. Can you talk a little bit about the PASSPORT program in terms of is your PASSPORT program open as opposed to you having a waiting list?

Joseph Ruby: Yes, the program is open now. And in fact we passed over this summer legislation that provides virtual open enrollment for this wavier, not all waivers, not all disability waivers but for anyone with imminent risk of permanent nursing home placement.

Without getting in details, there's four criteria. But that covers virtually 100% of the folks we enroll.

Marisa Scala-Foley: A question from (Peggy) who asks, are your transition efforts primarily focused on the Medicaid population or duals or Medicare fee for service?

Joseph Ruby: Well 85% of our members are duals. And in fact 92% of our members have one or more of those five chronic diseases. Doc, I think wants to add to that.

Dr. Kyle Allen: And this Risk to Home program that I spoke of, it will be initially focused at our Medicare Advantage population. But we're just in the pilot stage to become an ACO in 2012. So we'll expand beyond that hopefully in 2012 and come up with criteria and those kind of things.

Marisa Scala-Foley: Great. Pam asks can you talk a little bit about how some of these programs are funded and by whom?

Joseph Ruby: Well the Medicaid waiver is really the basis for the AAA's participation and kind of virtually everything except for the health coaching. The pilots were funded by the two hospitals that were involved.

And moving forward with the health coaching related to the health plan members, the health plan will be paying for the coaching through SPY, Summa Physicians, Inc. We'll then contract with the AAA.

Dr. Kyle Allen: And I think the other programs I spoke of, they're really just supported by the geriatric by Summa Health System whether it's an in-kind contribution. The Area Agency on Aging does pay for the time of the geriatrician to attend an interdisciplinary team. We found some other Title III monies to help pay for the pharmacist in that team.

The rest of it is kind of in-kind contribution. Of course, the Area Agency on Aging pays for the RN assessors in the hospital as well as into the nursing home.

And I wanted to mention something about the nursing home that I forgot, through that care coordination network and because we have the geriatrics program, has three specialized geriatric rehab units.

It was kind of similar to the AC and we took the RN assessor integrated them into those facilities, into that interdisciplinary team. And that's really, really helpful to get the nursing homes to buy in to having a AAA RN assessor in their facility.

Marisa Scala-Foley: Great. Can you talk a little bit, (Patrick) asks if you could repeat who the members of the Path interdisciplinary team were.

Joseph Ruby: There are three medical social workers, was that the question?

Marisa Scala-Foley: Yes. He asked about the Path interdisciplinary team.

Dr. Kyle Allen: Oh and for the CMET team if he's asking about that, there's a geriatrician, there's a pharmacist. There's the case managers. There is a clinical coordinator, a director from the Area Agency on Aging who kind of huddles the team together. Sometimes there's a hospice person there, it just depends. I'm not sure who else they bring.

Joseph Ruby: Well yes, and just for clarification, Path is the folks that go into the nursing home to transition folks out. And the CMET program, is the interdisciplinary team. So hopefully, if it was Patrick, I guess that was the name, hopefully that answered his question.

Dr. Kyle Allen: So sometimes those Path patients that are leaving the facility will get discussed in that CMET team as a way to kind of make sure there's a comprehensive care plan for that transition.

Marisa Scala-Foley: Great. We got actually a couple of questions for both teams which is a great way to sort of finish off the chat portion of this before we open the lines for questions. And Megan asks, what role do direct care workers, specifically home health aides play in either of the programs in Akron or in the program in Chicago that may go beyond their traditional scope of practice?

I don't know who wants to answer first.

Joseph Ruby: Well this is Joe and I guess what I said quickly in my presentation is, you know, the whole idea of the ACO, Accountable Care Organization is to incentivize providers both hospital and physicians to reduce readmissions. So there's a financial incentive to do that.

I think our key to success and to align what we do with what the hospitals and the docs are trying to accomplish would be to do a similar kind of a payment structure. That is to say, we would have specific benchmarks that where if our home health agencies hit those benchmarks they get essentially a bonus.

Marisa Scala-Foley: Okay. Rico, why don't we go ahead and open up with audio lines? If you could instruct people as to how they can ask their questions that way, that would be great.

Coordinator: Thank you. And at this time if you would like to ask an audio question over the phone, please press star-1 on your touchtone phone. Please record your name clearly when prompted. When recording your name, please make sure your phone is off mute.

Once again star-1 on your touchtone phone and please record your name clearly when prompted. And when you're recording your name, please make sure your phone is off mute. One moment as we wait for our first question.

Marisa Scala-Foley: Okay so while we wait for that to queue up, maybe we can just ask one more question. And let's see, I apologize as I scroll up here.

Both of your programs touched on the referral process. But could you talk a little about when the best time is to start the referral process. Is it upon admission, midway through the hospitalization or just prior to discharge?

What do you think works well both from a hospital perspective as well as from the ADRC or the care coordinators' perspective.

Ilana Shure: This is Ilana from ITCC. And the best time is as soon as possible. As soon as we can get the referral, we really can start meeting with the patient, scheduling a time with the family, working with the interdisciplinary team.

Starting to keep track of the electronic medical records to really get as much information as possible and take as much time as we can to really setup services. So that when the person goes home, they're stable and they have services that they'll need in place already. So as soon as we can get the referral is better for our model.

Carolyn Holder: This is Carolyn Holder from Summa and I have to agree with that, the sooner the better. And very often those referrals are made very close to the admission for the patient. And we do have the assessors on site so we can really easily get them involved right up front.

Marisa Scala-Foley: Okay Rico, do we have any questions on the audio line?

Coordinator: And we do at this time. Would you like to take them?

Marisa Scala-Foley: Yes, please.

Coordinator: Our first question comes from Ms. Roma Davies, your line is open ma'am.

(Roma Davies): Hi thank you. I'm wondering if both programs would provide their risk assessment tools.

Walter Rosenberg: If you would like to get Chicago's teams I guess the Bridge's model risk assessment tool, you can contact me, I'm Walter Rosenberg and my information is listed under our contact. And I'll be glad to share, thank you.

(Roma Davies): Thank you.

Marisa Scala-Foley: Yes and if either team wants to share them with us here at AOA, we can also handle some of the distribution on that as well.

Joseph Ruby: And the same with -- this is Joe Ruby -- if you all are interested in our assessment tools, you have our email contact. Just contact us; we'll make sure we get them to you.

Marisa Scala-Foley: Okay Rico, are there other questions?

Coordinator: Yes and we have one more. It comes from Mr. David Murphy your line is open.

(David Murphy): Yes thank you. I'd like to know about the client consent established through this extensive referral system. Are there multiple consent forms or a single consent form?

Joseph Ruby: I suspect that's more than one right?

Carolyn Holder: Well I can speak from the hospital side, there's a consent form that we use on the hospital side.

Joseph Ruby: And we would have a consent form and the health plan would have a consent form. So the answer to your question is multiple I think.

Ilana Shure: For the Chicago team -- this is Ilana -- and well the services we provide are for everybody. So it's just an oral, they can just verbalize their consent if they want services.

To be part of the study and for evaluation purposes, however, there's one consent form and we review that with the patient or with the patient and their family prior to continuing the study, the project.

Dr. Kyle Allen: And this is Dr. Allen. Because those are , you know, those are formal research trials, we have formal informed consent, all the different forms and HIPAA forms all that is supplied before anyone's enrolled so following IRB standards.

Marisa Scala-Foley: Any other questions, Rico?

Coordinator: And at this time we have no other questions in the queue.

Marisa Scala-Foley: Okay we got one more question in via chat and then I think we'll close things out because we're at the end of our time together. And that question came from Peggy. I believe this question is for you, Joe.

You mentioned three medical social workers who are part of the Path program. Who employs those medical social workers?

Joseph Ruby: Area Agency on Aging.

Marisa Scala-Foley: Okay. Great, okay we are at just after 3:30 and I want to be conscious of everyone's time. First I want to thank you so much to our speakers both from Chicago and from Akron for wonderful presentations.

You stimulated a lot of questions which we will be following up with you about if we weren't able to answer them during the course of this session.

And thank you all to our audience for the wonderful questions you asked and for your attention during this webinar. If you think of any additional questions, if you have suggestions for future webinar topics or if you have stories about your own community care transitions work, we really want to hear from you here at AOA.

So please do email us at AffordableCareAct@aoa.hhs.gov. We do want these webinars to be as useful to you as possible so we welcome your suggestions. We thank all of you for joining us today and we look forward to having you with us on future webinars. Thank you very much.

Coordinator: Thank you. And at this time your call has concluded. You may disconnect at this time. Once again, your call has concluded, you may disconnect at this time. Thank you and have a great day.

END