Administration on Aging
Affordable Care Act Training
Partnership for Patients: The Community-Based Care Transition Program
April 20, 2011
3:00-4:30 pm Eastern

Coordinator: Welcome and thank you for standing by. At this time all participants are on listen only mode. During the question/answer session please press star 1 on your touchtone phone.

Today's conference is being recorded. If anyone has any objections you may disconnect at this time. And I'd like to go ahead and turn today's call over to Marisa Scala-Foley. Ma'am, you may begin.

Marisa Scala-Foley: Thank you so much, Julie. Good afternoon, everyone. Good morning to those of you on the West Coast and beyond. My name is Marisa Scala-Foley. I work in the office of Policy Analysis and Development of the Administration on Aging.

We thank you for joining us today for the next installment in our training series that focuses 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.

If you've been with us before you know these webinars are designed to provide the aging network with the tools that you need to participate in many

of the different programs and demonstrations authorized by the ACA including care transitions.

Last week Health and Human Services Secretary, Kathleen Sebelius, announced the Partnership for Patients, a new national public-private partnership with ambitious goals for improving patient safety.

The announcement of the partnership included what a lot of us I know have been waiting for within the aging network, certainly as evidenced by questions on previous webinars.

And that was the release of the solicitation for the Community-Based Care Transition Program mandated by Section 3026 of the Affordable Care Act through which HHS has committed $500 million to community-based organizations partnering with eligible hospitals to help people with Medicare to safely transition between settings of care.

Today's call will provide an overview of both the Partnership for Patients and the Community Based Care Transition Program, so before I turn things over to our wonderful panel of speakers, a couple of housekeeping announcements.

If you've been with us before on previous trainings you'll note today represents a bit of a departure for us. Today's training will be through the audio line only, no webinar, so that we can accommodate as many people as possible on this due to the high level of interest in this initiative.

However, we have posted the slides on the Health Reform page of the AoA Web site if you would like to access them and follow along with us as our speakers present.

If you go to www.aoa.gov, again that's www.aoa.gov, click on the Health Reform and the Aging Network button on the right side of your screen, that will bring you to our health reform page where you can scroll down to our list of webinars.

And you'll find a link to the slides for today's webinar as well as recordings, slides, and transcripts from our previous four webinars. So again, that's www.aoa.gov, click on the Health Reform and the Aging Network button, and scroll down to get access to the slides for today's webinar.

As Julie mentioned, all participants are on listen only mode. However, we do welcome your questions throughout the course of this training. There are two ways that you will be able to ask your questions.

The first is via email. In lieu of having a webinar and chat we are asking you to submit questions via email to affordablecareact@aoa.hhs.gov, again that's affordablecareact, and that's all one word, @aoa.hhs.gov.

And we know several of you have submitted questions in advance which we'll get to during the course of this presentation. But if you want to email your questions to us we'll sort through them and answer them as best we can when we take a break for questions at the end of the presentation.

In addition, as Julie mentioned, after our presenters wrap up we'll offer you a chance to ask your questions through the audio line as well. When that time comes Julie will give you instructions as to how to queue up to ask your question.

And if there are any questions we can't answer during the course of today's call you can email them to us and we'll follow up to make sure that those

questions get answered. There are going to be lots of email resources for you to ask your questions both about the Community Based Care Transition solicitation as well as about the broader Partnership for Patients.

Finally, as Julie mentioned, we are recording this call. We will post the - as we've done for all of our past webinars, we will post the recording, the slides and the transcript of this webinar, or of this call, on the Health Reform page on the AoA Web site as soon as possible, likely by the end of next week.

So with that our housekeeping announcements are done. We are thrilled to have with us today a wonderful panel of speakers from the Centers for Medicare and Medicaid Services, also known as CMS, to talk with us today.

I'm going to go in order that they'll be speaking so let me do those introductions. Joe McCannon is Senior Advisor to the Administrator of CMS and Group Director for Learning and Diffusion in the Innovation Center.

Prior to this he was Vice-President and Faculty on Dissemination and Large Scale Improvement at the Institute for Healthcare Improvement. He's a graduate of Harvard University, and was a Reuters and Merck fellow at Stanford University in 2003/2004.

After Joe, will be James Hester who's a Senior Advisor in the Innovation Center at CMS where he assists with the development of delivery system transformation and payment reform initiatives such as accountable care organizations and medical homes.

Prior to joining CMS he was Director of the Health Care Reform Commission for the Vermont State Legislature. He has his PhD in Urban Studies and his M.S. and B.S. degrees in Aeronautics and Astronautics, all from M.I.T.

Our final speaker today will be Juliana Tiongson who is a Social Science Research Analyst with the Center for Medicare and Medicaid Innovation at CMS. Juliana has 15 years experience working in the public health arena, predominately in the non-profit and public service sectors.

Prior to her work at CMS she served as a research associate in the Center for the Study of Traumatic Stress at the Uniformed Services University of the Health Sciences. We are thrilled to have them all with us today to talk with us about these important initiatives. And with that I will turn things over to you, Joe.

Joe McCannon: Well thanks very much, and thank you, everyone who's on the line here today for the opportunity to speak with you about the Partnership for Patients.

This is an initiative that was launched last week with great fanfare by the Secretary and with the involvement of stakeholders from across the healthcare industry, employers, health plans, providers, and of course patients and families.

And we think it represents a real turning point, I would hope a milestone in work to improve patient safety and really demonstrate that healthcare delivery system reform is possible. Many of you have been hearing for the last year about all of the components of the Affordable Care Act that relate to insurance reform and increasing access to care.

But there's a great deal in the Affordable Care Act that also focuses on improving the system itself, on making sure that the care that patients receive is reliable and effective, on making sure that the system provides a seamless care experience that has as few complications as possible.

And so, we think that this initiative hopefully draws attention to those components of the legislation and also really gives us an opportunity to amplify our efforts to improve the quality of care overall.

If we sort of think about the problem itself, I don't need to sort of belabor all of the details on the human and financial costs of unnecessary harm. But I can simply say that we know we have a system that's rife with harm and waste and complication.

We know that tens of thousands of people die each year unnecessarily in the healthcare system. We know that there are millions of patient injuries. Regardless of the measure you use there's consensus on the fact that millions of patients are harmed in the course of care each year.

This of course is not a function of negligence or any maliciousness on the part of providers, far from it. I think we have some of the most innovative and skilled and devoted providers in the world. It's simply a function of the fact that we have a very chaotic system, a very complex system with lots of inputs and demands and technologies.

And operating in that system are human beings who are subject to error and subject to mistakes and can simply become overwhelmed by all that complexity. So it's incumbent on us to provide a system that's safer and more reliable.

The good news is that if we look around the country there are pockets of success, tremendous success, where we can see organizations that have taken certain forms of infection and eliminated them for years at a time.

See other organizations where surgical complication is no longer a part of the care experience for the vast majority of patients, full states where pressure ulcers have been reduced by 60% or 70%.

There's no reason to believe, after the last decade of work, that we can't solve just about every adverse event that we encounter. There's no reason to believe that we can't do this work, as hard and painstaking as it is. What we have to do is we have to figure out how to do it at scale and bring it to the country.

And that really is the genesis of the Partnership for Patients. The Partnership, again launched by the Secretary last week, has two objectives to it. The first is to reduce harm caused to patients in hospitals. And the goal is that by the end of 2013 preventable hospital acquired conditions would decrease by 40% compared to 2010.

The impacts of this would be significant. We think about 1.8 million fewer injuries to patients and about 60,000 lives saved over the course of the next three years.

Equally though we know that the harm that's happening isn't just happening in hospitals. And we know that there are complications and confusions and frustrations with care transitions in a system that is not always seamless and is often quite fragmented.

The goal there is by the end of 2013 to reduce preventable complications during transitions with a specific goal of reducing hospital re-admissions by 20% by targeting preventable re-admissions. And here we think that would mean 1.6 million fewer patients without complications and very significant I think reduction in cost to the system.

The overall reduction in cost to the system we think, if we succeed in reducing harm and complications to the levels described here, is upwards of $35 million. The overall impact on Medicare over the next decade would be about $50 billion, that's just Medicare alone.

So we know that there's tremendous potential here to reduce cost in addition to the important work of reducing harm. The question then becomes if that's our response to the problem, if those are our objectives, how will change actually happen?

What will we actually do to make a difference? And we know that there's no silver bullet. If there was we would have solved this problem long ago.

The answers that we need to imply a number of incentives. We know that there are very significant payment incentives on the horizon, a good deal of payment at risk, and a good deal of payment opportunities, or payment increase opportunities, for those who successfully perform in these areas in 2013 and beyond.

We know too that we have to point to those examples of success and give people opportunities to really study alternatives, to study what works in the places that are thriving and having levels of performance that are significantly better.

And we know we need to offer really significant supports for actually making change and this I think is the heart of our conversation here today. We are offering as much as $1 billion in investment in meeting the goals of this initiative.

We certainly do all of this work in conjunction with the private sector and with a lot of excellent work that's already happening. But we want to start by making a contribution of our own to this work.

Up to $500 million of those funds will focus primarily on the in-patient setting and figuring out how we can reduce hospital acquired conditions. Doing so by creating local, either state system or association level improvement activities where learning environments and learning collaboratives can happen around the country.

Doing so by actually working closely with a group of advance participants, Vanguard Hospitals around the country who are willing to test even more ambitious work on all cause harm reduction that's been what's happened to this point.

By engaging patients and families and making sure that they have a stake in not only reminding providers of issues of quality and safety but actually having tools and resources to make their care experience that much safer, things like discharge plans and medication cards and things of that sort.

So about $500 million just thinking about the hospital setting in particular and how we can make the hospital experience and the discharge experience that much more reliable and that much more effective.

In addition though, we of course are introducing and haven't reduced the solicitation for the Community Care Transitions Program. And this of course represents a wonderful opportunity to get started in the work of improving transitions and to do so by engaging community-based organizations, but also all of the other stakeholders in care across the continuum from hospitals to outpatient settings to home care.

We know that this is a terrific opportunity and one that we're very, very excited about. So I think I will stop there recognizing that there are much more expert people than myself in Jim and Juliana who can both outline the Community Care Transitions work in more detail than me and provide very good answers to your questions.

But I, again, appreciate the opportunity. Encourage everyone who's with us to please sign the pledge to take part in the initiative. You can get there from the Partnership for Patients Web site. And I encourage you to begin to gage on this important work on care transitions after hearing from Jim and Juliana. So thanks so much.

Marisa Scala-Foley: Thank you, Joe. I think now we'd like to turn things over to Jim. For those of you who are following along in the slides, we are on Slide 11.

James Hester: Thanks, Marisa. Joe, you know, you did a great job of setting the context in terms of the overall campaign. I suspect that the folks on the line are really interested in getting into the meat of the, you know, the Care Transitions Program, the 3026 program that was announced.

But we feel it's important to sort of provide a broader context because while that's the cornerstone of the care transitions work it's just part of a larger strategy and a larger program. So I want to start off by just, you know, talking about the problem.

You know, I think you've recognized that this transition from one setting to another, as the slide says, is - offers high risks for communication failures, you know, process errors, and limited or unimplemented plans.

The people who are most vulnerable to these problems are the most vulnerable population, you know, individuals with multiple chronic conditions, frail

elders, and folks with, you know, at higher risk because the care's more complicated.

You know, I think the thing that's encouraging is in this area, as in the ones that Joe was talking about, we have clear evidence that we can do a better job and significantly reduce, you know, hospital admissions that are caused by flawed transitions.

I'll say here that, you know, that the re-admissions rate is just one indicator of the transition and we are interested in supporting and improving care transitions between all settings. And I'll be talking about some of the metrics and how we'd like to expand those metrics beyond just re-admissions later on.

So on the Slide 12 the, you know, one of the things we've learned from the work that's been going on to date that is in order to have an effective transition, you know, there's multiple elements that are required. You certainly need active engagement of the patient and the caregivers.

The care plans really need to be absolutely person-centered and being shared across those settings of care. And trying to improve the - and standardize the way that we communicate between the providers who are handing off the patient - receiving the patient, you know, is at both ends of the transition.

One item that's received a lot of attention is the whole issue of medication reconciliation and also the whole issue of educating patients when they return to their home.

When the setting is changed on how to, you know, use the medications effectively and some of the confusion that exists, particularly when they return to their homes and have the old medications and the new ones - and sitting in the medicine cabinet and not clear what to do.

An absolute mainstay of the program is the concept of the sending provider retaining the responsibility until there's a clear and affirmative confirmation of the transfer and that the clinician in the new setting has assumed the responsibility.

So again, you know, these are fairly basic. But you think - we know we can do, the question is how to put them in place in a fragmented care setting.

So the vision that we have, you know, for the effort is to create a care system in which each patient, but particularly those with more complex needs, has an effective care plan that, you know, deals with all of the care that they're dealing with, follows the patient from one setting of care to the other accurately.

It's truly patient centered in that it reflects the priorities of the patient and family. And in particular meets the needs of persons with serious, chronic conditions. So, you know, again we feel it's a very achievable vision.

The Slide 14, you know, re-admissions is one indicator as I said, you know, of the care transitions issue. You know, we know that a little over 20% of Medicare hospital patients are re-admitted within 30 days of discharge. Our goal, as Joe has pointed out, is to reduce over the next three years by 20% the number of re-admissions within 30 days of discharge.

However, we recognize that other indicators are needed of effective transitions and we're actively working on developing the framework for a broader set of measures and trying to implement those as - over time as part of the work of the campaign.

So the approach that we want to use is outlined on Slide 15 where his good evidence from the work that's been done in many pilot programs, you know, such as the (night) scope of work or the QIO where they had the 14 demonstrations that they sponsored.

We want to really build on the existing local coalitions of the hospitals, nursing homes, and other key stakeholders that have been created by these early efforts, support the work that they've been doing. But what's critical as you'll see is we really - we have a major task in encouraging the formation of new coalitions.

We simply don't have enough partnerships engaged in this work to get the job done. So that a central theme - a central part of the campaign is to stimulate the development of new coalitions, you know, very widely throughout the country. And then to provide those coalitions the support and services that they need in order to be effective.

Sometimes, that's data, and they have to - they need the data in order to do the root cause analysis and understand the problem. They need technical support in terms of how to approach this, you know, payment changes and payment mechanisms, so that the better care transitions are sustainable, you know, organizationally, is critical.

And along with consumer information, you know, training and the wide variety of other mechanisms that are required to, you know, help those coalitions, in fact, achieve that vision we were talking about earlier.

So the strategy that we've developed is on Side 16. One of the things that is absolutely obvious is that given the spread that's required, the number of organizations that we hope to be able to engage in this work, we have to have a broad-based public and private partnership.

The public sector has committed some significant resources to this, as Joe has pointed out, but even those resources are inadequate to the task given the scale that we need to achieve.

So we're already in conversations with a variety of organizations, who want to partner with us on the private sector. And that is - I mean building that partnership and then coordinating the work between the two sectors is an essential piece of our work, particularly, in the next year.

The approach that we want to use is we recognize that while a variety of partnerships and coalitions are in existence, the capabilities - the current capabilities and maturity vary widely.

And our approach has been to try to develop a portfolio of interventions, a portfolio of supporting programs to match the support to the needs of these organizations at the different stage of their journeys.

The analogy that we've been using is the three levels of walkers, joggers, and marathoners where the walkers are organizations and partnerships that don't have much of actual experience. But they're interested in starting and may have, you know, begun this work in a simple way working in one of two tasks and feel ready to move along.

The joggers are the folks who are more mature, have a proven track record. This is really the focal group for the Section 3026 Program that Juliana's going to get in to in a moment. And then finally the marathoners are the superstars of the effort. There are much fewer of them around.

These are mature coalitions and, you know, some examples are, you know, organizations that are ready or eligible to qualify as the ACO under the Shared Savings Program that was just announced.

So working with these three, you know, different levels of organization, the goal is to build a national network of a little over 2000 community-focused coalitions which partner hospitals and community resources to do this work. That's a massive job.

As I said, it's going to take the combined efforts of the public and private sector, but we believe that it is feasible over the three years - the next three years.

So to wrap up my piece on Page - Slide 17, how do you get started? Joe has mentioned the partnership for patients' pledge. We encourage you to sign that pledge, you know, whether you're a hospital, whether you're a community-based organization. Whatever status you are, sign that pledge as a starting point.

And then in terms of the care-transitions work, begin the process of creating that working relationship between the community of providers who care for the patients in your area. If you haven't - if you're a community-based organization, and you have not established in a partnership with the hospital or a hospital network in your area, we encourage you to do that.

Even if you're not, you know, immediately looking to qualify for 3026, for that program, we believe that partnership and developing that - those working relationships is a critical first step.

And in fact, we're trying to come up with a commitment statement which would be a symbolic first step along that journey. Stay tuned for more

information on that. You know, once you've got the partners identified then, you know, the steps of the work are spelled out and (able) in terms of the root cause analysis, implementing interventions, and getting experience.

I think the key thing is to actually put something in place and do it. There's nothing that builds the capability of the organization, builds the confidence of the partnership more than having a successful track record in actually having put an intervention in place and see some positive results.

So on that note, again, that's the overall care-transitions framework and the strategy we're trying to use in the program. I'll turn it over to Juliana so she can focus on the 3026 Program. Juliana?

Juliana Tiongson: Thank you Jim and Joe for giving such a comprehensive overview on the partnership (appropriations) and in particular, the vision around care transitions. I'm very excited to be here today to be able to talk in greater detail about the Community Based Care Transitions Program. And I'm hoping to leave ample time for questions.

So to start off just, you know, I'm going to go through an overview and try and address some questions that we got in advance as I go along here, but I also will leave ample time at the end.

So as you know, the Community Based Care Transitions Program that we also call CCTP is mandated by Section 3026 of the Affordable Care Act and provides funding to test models for improving care transitions to high-risk Medicare beneficiaries. As you learned just moments ago, this is part of the larger initiative of the partnership for patients.

The goals of the community-based care transitions program are to improve transitions of beneficiaries from the inpatient hospital setting to home or other

settings, improve quality of care, reduce readmissions for high-risk beneficiaries, and to document measurable savings to the Medicare program.

And now on Slide 22, eligible applicants are statutorily defined as acute-care hospitals with high re-admission rates in partnership with the community-based organization or community-based organizations that provide care-transition services.

It is important to note that there must always be a partnership between the acute-care hospital or hospitals and the community-based organization.

There has been some confusion around this. There always needs to be a partnership. And furthermore, the hospitals on the high re-admission hospital file are not the only eligible acute-care hospitals. All Subsection D acute-care hospitals are eligible, but there always has to be the partnership with the community-based organization.

And just wanted to reiterate, as Jim stated, we are looking for community-based organizations in this program that have a track record delivering care-transition interventions. There are some other initiatives in the partnership for patients targeted to groups that are just getting started in this arena.

So to go on to the definition of a community-based organization is defined as an organization that provides care-transition services across the continuum of care through arrangements with Subsection D hospitals whose governing bodies include sufficient representation of multiple health care stakeholders and consumers.

And because of this statutory requirement, a single provider is generally not going to provide as a CBO, rather, providers across the continuum of care

may need to come together to form an eligible CBO with an appropriate governing body.

And I would encourage people to visit our Frequently Asked Questions link on our CCTP Program Web page for additional guidance on this point.

Slide 24 key point, CBOs will use care-transition services to effectively manage transitions and report process and outcome measures on their results. And for some beneficiaries, this will involve intervening in multiple transitions across the continuum of care following the precipitating hospital discharge.

For example, a beneficiary could be discharged from the acute-care hospital, transitioned to a SNF, and then transitioned home. Applicants will not be compensated for services already required through the discharge planning process under the Social Security Act and stipulated in the CMS conditions of participation.

We need to see in the proposals that what is being proposed is being integrated with the discharge process that exists in the partner hospitals that is not duplicative of it but that is well integrated.

Okay, preferences on Slide 25. The preference will be given to proposals that include participation in a program administered by the AoA to provide concurrent care-transition interventions with multiple hospitals and practitioners. Or to CBOs that provide services to medically underserved populations, small communities, and rural areas.

So what does this mean exactly? What this means is that all other things equal we would give greater weight to those groups describing the solicitation as having preference or consideration.

Given the requirement set forth in the solicitation and the rolling application provision, we do not expect to get flooded with applications in the coming weeks. However, as we approach our budgetary constraints, you know, preference will become a more important issue.

Slide number 26, considerations. Applicants must address how they will align their Care Transition Program with Care Transition Initiatives sponsored by other payers in their respective communities and how they will work with accountable care organizations and medical homes that develop in their communities.

There have been some questions about working with other populations besides Medicare Fee-for-Service. We can - through this program 3026, we can only pay fees for Medicare Fee-for-Service and dually-eligible beneficiaries.

However, we would encourage working with other groups and you would just need to pursue negotiations with other payers say if you wanted to work with Medicare Advantage beneficiaries, for instance.

Okay, Slide number 27, additional considerations. Consideration will be given to hospitals whose 30-day re-admission rate on at least two of the three hospital compare measures, AMI, heart failure, pneumonia, falls in the fourth quartile for its state. You can find this data file posted on our program Web page, the CCTP Program Web page.

This file was derived from hospital compare data that covers 30-day re-admission rates for hospitalizations that occurred between July 2006 and June 2009, and is the most current data available on these outcome measures.

Okay, applicants are required to complete a root cause analysis payment methodology. So CBOs will be paid a per-eligible discharge rate. This rate will be paid no more frequently than every 180 days for the same beneficiary.

And the rate is determined by several factors including the proposed target population, the proposed interventions or intervention, the anticipated patient volume, and the expected reduction in re-admissions, which will be the cost savings.

We have provided an Excel budget worksheet on our CCTP Program Web page to aid organizations in calculating this sort of rate we're expecting to receive as well as the justification for the proposed rates. So that worksheet is available to assist organizations in developing that per-eligible discharge rate.

Performance measurements on Slide number 29. Awardees will need to demonstrate reduced 30-day all-cause re-admission rates over the first two years of program participation in order to be considered for continued participation over the remaining three years of the program.

Awardees will also be required to attend up to three face-to-face learning collaboratives each year in Baltimore. And these will be two-day meetings during which the top three to five performers of the previous quarter will present their models to the larger group for possible adoption.

In conclusion, the solicitation is now available on our program Web page. We are accepting applications on a rolling basis. And the program will run for five years with the possibility of expansion beyond 2015 if the Secretary and Chief Actuary of CMS determine that the program reduces Medicare expenditures while maintaining quality of care.

Lastly, please direct all your CCTP unanswered questions to our Care Transitions mailbox, and the address is there, caretransitions@cms.hhs.gov. We will also be updating our Frequently Asked Questions link sometime this week and, you know, we'll keep updating it as we get new questions and answers that need to be posted. Okay, thank you.

Marisa Scala-Foley: Okay, thank you so much Joe, Jim, and Juliana for a wonderful presentation looking at not only the partnership for patients but also a closer look at the CCTP solicitation. We've got lots of time for questions, so we're going to get to them. A number of you have emailed them in ahead of time, and we'll also open up the lines shortly.

Before we do that I did want to just go really quickly through the way we always sort of conclude our trainings, and that is to talk a little bit about resources. You've heard about some of them.

It - general resources on Care Transitions we have listed on Slide 31 include not only the Partnership for Patients Web site and the Community Based Care Transition Web site, but also AoA's own Care Transitions page that lists some of the activities or details some of the activities being done by our aging and disability resource centers.

We also have a listing for the Care Transitions Quality Improvement Organization's support center. You heard both Jim and Juliana reference the QIOs. They can be very valuable partners to you as you begin or continue your Care Transitions work in your community.

I've also listed a report in here that was done by the Long-Term Quality Alliance that looks at innovative communities working on Care Transition issues.

In addition, we've listed some resources from the Affordable Care Act, our health reform Web page, AoA's Health Reform Web page which is where you access these slides for today's webinar or you can access them if you haven't do so already.

As well as that is where all of our - you can find more information about the Partnership for Patients Initiative. You can also find all of the recordings, transcripts, and slides from our webinar series...

James Hester: Marisa?

Marisa Scala-Foley: Yes?

James Hester: This is Jim. I just wanted to highlight for the - that first resource on the Care Transitions slide on Page 30, the Partnership for Patients Web site. We are planning on having a Care Transitions piece on that which will include a road map for organizations who are interested in sort of the full range of programs that are available, you know, in addition to the 3026 program.

It's not up yet, but I want to encourage people to sort of look in to that particularly in about a week or so as another resource for them in trying to figure out what's available to help them move along the journey.

Marisa Scala-Foley: Great, thank you, Jim, for mentioning that. Let's see. As well in terms of Affordable Care Act, we've got a link to the Affordable Care Act text as well as related information if you'd like to go straight to the source on some of these initiatives that we've been talking about.

Our next training, we will continue our webinar series in May like we would a continued focus on care transitions. Please do watch your email for date, time, and registration information. So with that let's get to some of the questions

that have been submitted through our affordablecareact@aoa.hhs.gov email address.

A lot of these email questions are for Juliana related to the solicitation. We will try to work through them as best we can and then we will open the lines up so folks who weren't able to email questions can do so as well. Juliana sort of - and Jim you may want to chime in on this as well, we got a question earlier with regard to root cause analysis.

Folks really want to know - we did do a webinar on this actually back in February so I would invite people to take a look at that on our Web site. We had the folks from the QIO support center do one that talked a little bit more about root cause analysis but really briefly can you talk about that?

Is it simply medical chart review or is there more involved in root cause analysis in a given community?

Juliana Tiongson: Thank you Marisa. Yes, we tried to address this a bit in one of our questions posted on our program Web page as well. Medical chart review is one possible component.

There are other approaches as well such as focus groups with providers, focus groups with beneficiaries or patients, process reviews and analyses, data review of admission and discharge data, partnering hospitals. So, all of those would be potentially included in a root cause analysis.

Marisa Scala-Foley: Okay, there we go. Sorry my mute button wasn't coming off there. And a follow up question along those lines is, if a community-based organization partners with multiple hospitals should they be thinking about doing a root cause analysis for each hospital with which they are partnering?

Juliana Tiongson: Well in a given community, a lot of the same factors will likely be at play. But I would certainly think it would be important to conduct some sort of analysis at the hospital level for every hospital that was proposed as a partner.

James Hester: Marisa, I think that the QIOs and the 9th Scope of Work, particularly the (Collarta Foundation), have developed some useful tools for getting started on this. Where a starting point is simply to identify what are the transitions and who are the partners who are involved in the transitions.

Folks who, you know, use some of the data and have done an analysis of that have gotten some surprising results in terms of who's involved and where the volumes are.

So I think, you know, part of the answer is how many root causes analysis make sense relate to the question of what are the patterns. Is there one pattern between, you know, the network of hospitals or are they very different patterns, and if they're very different patterns they probably require different analyses.

Marisa Scala-Foley: Great, thank you both so much on that - for that information. And we have included - as I mentioned before, we have included a link to the QIO support center for the work that was done under the ninth scope of work on care transitions. They have some tremendous resources there.

In addition, as I mentioned, we've done a webinar as well. You can find that on - it's our care transitions making the programmatic case webinar which you can find on the health reform page of the AoA Web site

Juliana, we got a number of questions along this line related to sort of we know that there are a number of evidence based models that have been used for care transitions effort in communities around the country.

Are the expectations that applicants will use one of these models, is it permissible to use an adaptation of a model, or something entirely new on that front?

Juliana Tiongson: Yes, applicants are not required to use one of the models that were outlined in the solicitation put out there as examples of evidence-based care transition models. We certainly are willing to accept adaptations of models.

I would ask that applicants proposing to do so make it clear that that's what's being proposed. You know, it's a new model but they're using pieces of, you know, someone else's model, if that's what their plan is.

In other words, don't call it the Coleman Care Transitions model unless it is truly that and it's not just pieces of it. But we are open to the models in the solicitation, we are open to adaptations, and we're open to other proposals.

Now you would need to provide some sort of documentation, rational evidence data that what you're proposing, you know, we would have a reasonable expectation that it would serve the purpose of, you know, improving care transitions and reducing readmissions.

What is proposed does not need to have gone through a randomized control trial. I think that was another question that came in.

Marisa Scala-Foley: Great, thank you so much. Okay, let's keep moving through some of these questions. One has to do with sort of the issue of eligible applicants and partnerships with hospitals. When you refer to the establishment of formal relationships with hospitals, what do you mean by formal?

Is it a memorandum of understanding, and are there minimum requirements for validating a formal relationship with a hospital or community-based organization?

Juliana Tiongson: So we need to feel confident in someone's application and see evidence in that application that that hospital's leadership is indeed onboard with what is being proposed.

And this is why we are requiring letters of commitment from the CFO, CEO, and operations manager for discharges at every hospital that's proposed as a partner on the application. And that's clearly spelled out in the solicitation that we will need those letters of commitment from those hospital leaders for every hospital that is being proposed.

Marisa Scala-Foley: Okay, continuing along the line, we got several questions in that have to do with, you know, this issue of eligible applicants and the nature of the CBO and so forth, so let's walk through a few of those. Can a state or local government agency be considered a formal partner in an application or an applicant for that matter?

Juliana Tiongson: A partner, I would say yes. When we talk about eligible CBOs as applicants, we have to go back to the composition of the governing body of that community-based organization and back to the fact that there needs to be consumer representation and multiple health care stakeholder representation on that governing board for the CBO.

So I know that this has come up and it does pose an issue for some of the governmental area agencies on Aging and ADRCs.

It is also my understanding though that some of these have foundations and it's better 501C3 foundations who do have boards that meet the requirements set forth in our frequently asked questions link.

So I would encourage, you know, if in the case of a governmental, AAA, or ADRC, if such a foundation exists, that would be probably the best way to proceed, or to partner with an eligible entity in the community.

Marisa Scala-Foley: Okay, so we got a couple questions that are almost follow-ups to that that may be able to help deal with this sort of issue of governmental agencies applying for these grants, or excuse me, for applying - serving as applicants for the solicitation.

And one question was can a consortium apply with more than one community-based organization receiving funding for the implementation of a care transitions program at different hospital sites?

Juliana Tiongson: Okay, so the general model that we're looking for is a CBO working with multiple acute care hospitals in a geographically contiguous area representing a community. We would consider a consortium of multiple CBOs each working with different acute care hospitals if that model made sense given the geographic spread proposed in the application.

There would need to be one lead CBO that would coordinate the services and billing for all CBOs in the consortium, and interface with CMS and its contractors. For it to be clear for all awards CMS will only pay one CBO that will then be responsible for, you know, any sharing arrangements with any partners.

So in the case of a consortium, that lead CBO, this would result - this approach would result in a lot of additional work by the lead CBO who would

need to distribute the payments to all of the CBOs in the consortium. And there would have to be some clear advantage to this model over having separate applications over a large geographic area for it to be accepted.

Marisa Scala-Foley: So that would need to - you would need to see some sort of justification of that in an application that came in proposing such a model.

Juliana Tiongson: Exactly, because of the complexities that it introduces and the burden it, you know, potentially puts on. I mean we would really just need to look at that on a, you know, case by case basis and see if it made sense.

Marisa Scala-Foley: Okay, so, I'm just going to scroll through some of these questions. With regard to the scale of the proposal - and then we'll get into some of the more nitty-gritty about the applicants and the evaluation and so forth.

Are you proposing or promoting replication sort of on a larger scale with this grant? Or would it be possible for an applicant to propose sort of a smaller scale implementation with the thought of expanding a little more slowly over the course of the two years of the contract?

Juliana Tiongson: Yes, I just wanted to make this statement that this is really not a grant program. The only thing that's similar to a grant is that CBOs are not going to owe us money back at the end of the program.

But we intend to pay for care transition services as they are provided in the community. It's not like a lump sum grant. So I just wanted to just put that out there in case there was any confusion.

But as far as your question goes in terms of the scale, because of the finite resources available for the program and the rolling review and rolling awards of applications provision, we cannot guarantee later expansions.

We can't guarantee that later expansions will be possible because of the whole way that the budget is developed, that organizations will be submitting and culminating in and not to exceed amount for their participation in the program.

We are going to be using that to let us know basically when we can't make any more awards, when we've sort of hit the ceiling of our budget. So we cannot guarantee later expansions unfortunately

And in terms of scope I would just say that we are hoping for, again, for CBOs to be working with multiple acute care hospitals except for a case that is a rural area where there is - really only is one acute care hospital for a CBO to work with.

Where that's the case, then we would certainly, you know, look very closely at that. But otherwise we are hoping for multiple hospitals partnering with the eligible community-based organization.

Marisa Scala-Foley: Okay, great, a couple questions that we got in regarding to evaluation. First is, does the CCTP solicitation allow applicants to use funds to hire an independent evaluator to do a process or quality improvement evaluation or is all evaluation going to be handled by an evaluator contracted by CMS?

Juliana Tiongson: Yes, CMS will be doing the formal evaluation using an independent contractor. So we do not expect to see that worked into the budget of anybody's application.

Marisa Scala-Foley: Okay, great. And will that contracted evaluator be compiling HCP data, or is that something that would be expected of applicants who are chosen to participate?

Juliana Tiongson: Yes, actually not the evaluation contractor but we have two contractors. The implementation and monitoring contractor and the technical assistance contractor that will be facilitating the face-to-face meetings that I mentioned in my presentation and identifying the top three to five performers.

Applicants will be required to report on a couple of HCP measures that will be part of a larger instrument that would include care transition measures, HCP, and patient activation measures.

Marisa Scala-Foley: Okay, I'm going to do just a couple more questions from our list and then I'd like to open up the lines for questions so that folks that weren't able to email in their questions have an opportunity to ask them through the audio line. Just a couple more.

First, the posted budget template for the CCG applicants allows applicants to consider the cost - or hospitals to consider the cost of technical assistance programs such as BOOST, or Project RED, into their calculations of readmission cost savings. Can applicant's line item the cost of participation in those programs as part of their budget? Can they include that?

Juliana Tiongson: I'm not completely sure I understand the question, but if I am understanding it correctly, yes. I mean a broader systemic change, you know, more at the hospital level such as BOOST, that would be one intervention and then say, you know, it could look like this, this is why we say a blended rate, someone could come in saying they're going to do BOOST.

And they're also going to do some other intervention where, you know, they directly, you know, go to the patients' home and do (meds) conciliation or something like that. So those would be shown separately but then, you know, everything would be totaled up and divided to get the final rate.

Marisa Scala-Foley: Okay, great. Just two more questions and then we'll open up the lines. And one has to do with sort of incentives. And we've gotten a couple questions related to whether or not a CBO that was an applicant could provide - could incentivize, for example, physician participation by paying physicians for their care transition service such as follow up calls to patients after discharge and so forth.

Or whether a CBO might be able to contract and pay a hospital for any labor required to provide needed information that CMS might require. Is that permissible within an application?

Juliana Tiongson: So what we're looking to do is pay the per eligible discharge rate to the CBO. They can get into, you know, enter into any kind of sharing arrangements between partners that they wish, we're going to stay out of that piece.

Marisa Scala-Foley: Okay. And the final question that I'd like to pose before we open up the lines, and I know you talked about this Juliana, but I think folks definitely need some clarification because we've gotten - not only did we get advance questions about this but we've gotten another one since we started the webinar.

And this comes from a state that has no hospitals actually that fit the criteria in terms of being in the fourth quartile for high rate admission hospitals. Does an - will you consider applications that come from CBOs that are partnering with hospitals that aren't on that list?

Juliana Tiongson: Yes.

Marisa Scala-Foley: Okay, great. All right, I think we did get a couple more questions in but I'd like to open up the lines because people have been waiting very patiently for

this. Julie, could you please give our folks on the line instructions as to how they can queue up for questions?

Juliana Tiongson: Thank you. We will now begin the question and answer session. If you'd like to ask a question over the phone please press star one. Please un-mute your phone and record your name clearly when prompted. A name is required to introduce your question.

Again if you would like to ask a question over the phone, please press star one, to withdraw your question press star two. One moment, please, to see if we have any questions over the phone. I do have a couple questions. (Margaret Kerry), your line is open.

(Margaret Kerry): Yes, I have two questions and its regarding the CBO eligibility issue. And if you are a homecare organization that is owned but affiliated with the hospital system, would you be - and you qualify as a 501C3 as your home health agency meeting the criteria for the board membership, would you be eligible to apply as the CBO part of this healthcare system?

Juliana Tiongson: Okay, so the board has representation of multiple healthcare stakeholders in the community?

(Margaret Kerry): Right, we have some, we're going to enhance that going forward. But yes, it is affiliated visiting nurse association, homecare agency.

Juliana Tiongson: But it's not, I mean, I guess I'm a little unclear on - okay, so are you under the same umbrella with the hospital system?

(Margaret Kerry): We are owned but we are affiliated, we are not a hospital based system. We have a separate board of directors, if that's your question.

Juliana Tiongson: And you would be proposing to work with...

(Margaret Kerry): With two of the hospitals that meet the criteria in our healthcare system of being the fourth quartile.

Juliana Tiongson: It sounds like you would meet the eligibility based on what you are saying. It's hard to, you know, without actually seeing things on paper it's hard to say, you know.

(Margaret Kerry): So again, we are part of the healthcare system, but we have our separate board. We are a community-based visiting nurse association with some community membership, possibly expanding that. And a board that meets frequently.

And so I'm just asking if that could be the CBO as the organization applying with the hospitals, again, who meet those - the several hospitals who meet that criteria being partnered with?

Juliana Tiongson: Yes, I mean that sounds reasonable.

(Margaret Kerry): Okay. Thank you very much.

Marisa Scala-Foley: The next question comes from (Anne Proley), your line is open.

(Rosanna Stefanon): Hi, this is actually (Rosanna Stefanon) with (Anne Proley). The question is on, we're an (unintelligible) agency on aging, and I - our board is 51% consumers over the age of 60. But what I'm confused about or concerned about is, what is a healthcare stakeholder, and is that in addition to the consumers?

Juliana Tiongson: Yes, the healthcare stakeholders, that is in addition to the consumers. And that would be the healthcare providers that most beneficiaries in your community receive services from.

So all of those across the continuum of care are all the healthcare stakeholders, you know, SNF, (unintelligible) physicians, Hospice, Home Health. So I mean that's what we mean by - and also, you know, and social service providers as well.

(Rosanna Stefanon): So the - I just wanted the clarification because our conflict of interest is such that we do not want providers on our board. These are people that we have vendor contracts with, so they are part of the healthcare community, and they provide healthcare service. And if they're under contract with us, we prefer not to have them on the board.

So that's why I was - I'm concerned about that and I imagine that the (unintelligible) agencies that are doing case management or contracting for in-home services have a similar provision of conflict of interest.

Juliana Tiongson: That is a difficult situation because we - because of the statutory language that we are bound to follow there does need to be healthcare stakeholders on the governing body.

(Rosanna Stefanon): So is there a number that has to be reached, or?

Juliana Tiongson: No, we didn't set any numbers to that requirement. And if you go, again, you know, if you go to our Frequently Asked Questions link there's a question, you know, there's at least one that directly relates to this.

(Rosanna Stefanon): Okay, thank you.

Marisa Scala-Foley: Our next question comes from (Robert White), your line is open.

(Robert White): Yes, good afternoon. Can you clarify if an accepted CBO would be able to subcontract out the actual intervention work to another organization or provider within that community? An example might be, subcontract that work out to an agency that employed advanced practice nurses if they were using the care coach model as the intervention.

Juliana Tiongson: Yes, that would be acceptable. You know, we would just need to see who the subcontractors were, that they had the relevant experience, and that the eligible CBO that we would be paying, you know, met the requirements as an eligible CBO in terms of their governing body and so forth.

(Robert White): Thank you.

Marisa Scala-Foley: The next question comes from (Barbara Goloth), your line is open.

(Barbara Goloth): Thank you, I had two questions. One is, I'm interested in whether or not a federally qualified health center qualifies as a CBO.

Juliana Tiongson: What - I mean, does your governing structure meet the requirements set forth?

(Barbara Goloth): Yes.

Juliana Tiongson: And I guess, you know, then it's sort of - another thing that comes into play here is the proportion of Medicare beneficiaries. Medicare beneficiaries or Duels that you serve since that's, you know, really who this program is targeting and who we can pay for.

(Barbara Goloth): And is there a set percentage?

Juliana Tiongson: I mean we would need to see, you know, what your anticipated volume of, you know, beneficiaries to be served with your intervention was.

(Barbara Goloth): And my other question is, you talked about how CBOs would be paid. But if it is the hospital applicant, because the hospital - I understand a hospital can be an applicant if it's on the high readmission list, would they be paid in the same way?

Juliana Tiongson: Because the hospitals are required to partner with a community-based organization, you know, as stated on I think it's Page 7 of our solicitation, we only intend to pay community-based organizations.

(Barbara Goloth): Okay.

Juliana Tiongson: It is up to them to, you know, establish agreements, sharing arrangements, if they're so inclined to do so, with any partners including the partner acute care hospitals.

(Barbara Goloth): Okay, thank you.

Marisa Scala-Foley: The next question comes from (Christine Fitzpatrick), your line is open.

(Christine Fitzpatrick): Hi, I was - thank you. I was wondering if the - a CBO would have to be a Medicare enrolled provider? And I'm thinking in terms of adult day health care programs in New York State which 75% of the people in them are dual eligibles with multiple chronic conditions.

And I think they otherwise would meet the definition that you have established of a CBO. But they don't have - they're not a Medicare enrolled provider. They're not eligible, by that I mean for direct payment through Medicare.

Juliana Tiongson: Yes, that is not a requirement for participation in the community-based care transitions program.

(Christine Fitzpatrick): Okay, thank you.

Juliana Tiongson: Sure.

Marisa Scala-Foley: The next question comes from (Ruth Spink), your line is open.

(Ruth Spink): I just wanted to verify two things, where we can find for absolute certain what the hospital readmission rate is. I'm trying to look on the hospital compare web site but it's a little bit challenging. And I guess the other question is I have not heard any dollar figures. How do we have an idea what we may be looking at if we were able to get this grant?

Juliana Tiongson: Okay, there are - so the hospital re-admissions file is posted on our program Web page. Aside from that, if your hospital is not on there and you'd like to know the rate for those three conditions, you would look at the hospital - you would have to just go in to the hospital compare site.

And I guess, you know, if you're still having trouble send me an email and I could send you, you know, explicit directions.

Marisa Scala-Foley: Yes, Juliana, this is Marisa. We actually did a webinar on this back at the beginning of February. It was part of our care transitions building the programmatic case webinar. We provided some pretty specific instructions as to how to use hospital compare to get re-admission data for hospitals in a given community.

So I would invite the person who asked the question to look on the Health Reform and the Aging Network page on the AoA Web site. All of our

webinars are there, you can find the slides and it does present in pretty graphic detail as - in terms of how to go about getting that data.

If there are hospitals that aren't on - that you would like to partner with that are not on the re-admission list, the high readmission list that Juliana mentioned.

Juliana Tiongson: That's great. Thanks, Marisa, for mentioning that. To your other question about the dollar figures, I don't have an answer for that. It's really going to vary.

It's going to depend on, you know, how you're targeting your population, what your proposed interventions are. And then, you know, using the budget worksheet we provided or something similar to get it distilled down to a per-eligible discharge rate.

And to just, you know, keep in mind that this program is focused around the care transition, intervening upon an eligible beneficiary, as they're discharged from the acute care hospital.

It's not really going to support an ongoing care coordination, case management kind of structure. I mean we have done a lot of demonstrations looking at care coordination, disease management, you know, chronic care management with, you know, per member per month fees.

Where that's more of an ongoing thing, this is more of an intense intervention around the transition of care. So I'm just putting that out there that some of those things that are more ongoing care coordination are probably not going to fit with this program.

Marisa Scala-Foley: Were you done with your questions?

(Ruth Spink): Yes, thank you.

Juliana Tiongson: I have a few more questions. Are you ready to take those?

Marisa Scala-Foley: Yes, go ahead Julie.

Coordinator: The next question comes from (Carla Felv), your line is open.

(Carla Felv): Yes, we had a question regarding the CBO in that it says in the solicitation that preference is given to AoA grantees. If there were to be multiple responses to the solicitation in a geographic area, and somebody else was applying as a CBO, I mean how is that going to be handled?

Juliana Tiongson: So I, you know, I tried to speak to this in my presentation. And what the preferences and considerations do is give additional weight when all other things are equal.

So, you know, that is, you know, the applications will be reviewed by a technical expert panel. They will be scored. It's laid out pretty clearly what needs to be included under each section and what's going to be, you know, looked at in the scoring, you know.

(Carla Felv): So the weighted scores for AoA grantees in your rubric, is that what I'm hearing you say?

Juliana Tiongson: I'm sorry, can you repeat that?

(Carla Felv): So you're saying that the scoring rubric gives additional weighted score to AoA grantees over non-AoA grantees applying as the CBO.

Juliana Tiongson: Not exactly. I mean what I think I'm saying is if there were two applications that scored equally well overall and one was an AoA grantee, they would get preference.

(Carla Felv): Thank you.

Marisa Scala-Foley: The next question comes from (Amy Schneider), your line is open.

(Amy Schneider): You know, given the focus on (unintelligible) elders with this sort of program. What would you envision the role of the AAA to be, because I'm assuming that a majority of them wouldn't be able to apply given the fact that they don't function with a governing board. So how do you expect them to partner or be listed within the actual application?

Juliana Tiongson: You sort of faded out, can you speak and repeat (unintelligible) into the phone?

(Amy Schneider): Yes, we were curious about what the expected role of AAAs are in terms of the application given the fact that we're presuming from based on this call that a majority of them wouldn't be eligible to apply as CBOs given the fact that they don't function with a governing board.

So how do you envision them, you know, maintaining an active role given that a majority of consumers will be their consumers?

Juliana Tiongson: In the case of some of the governmental AAAs that might not have the board that meets the requirements, I would just recommend that they partner with - I mean because the social services is such an important component in care transitions that they try and partner with another entity in the community that could come in as the eligible CBO.

Perhaps a senior center or some other entity that you have a working relationship with established with already. You know, you could partner with them and they could come in as the CBO. And again, you know, they would have to - amongst yourselves, you would have to negotiate in terms of any shared payments.

(Amy Schneider): Okay.

Marisa Scala-Foley: Julie, are there any other questions?

Coordinator: Yes, I do have a couple more.

Marisa Scala-Foley: Okay.

Coordinator: (Joan Butler), your line is open. Hello, (Joan), please check your mute button.

(Joan Butler): Sorry. I'm the director of an AAA in an area that has hospitals that are not on a high re-admit list. And I'm wondering - I have two questions. One is, how would you view a proposal between a CBO, as myself, and one hospital where it's not high re-admit but where we feel we have a creative approach to care transitions and, you know, can always, you know, do better kind of thing.

Or, you know, I mean would that be viewed in a competitive way? I'm questioning like the - or does it need to be multiple - a proposal with multiple hospitals?

Juliana Tiongson: Well, you know, as I stated earlier, we are hoping for models that are a community-based organization partnering with multiple hospitals...

(Joan Butler): Okay.

Juliana Tiongson: ...unless you're located in a very rural area where that's just really not a possibility.

(Joan Butler): So if I were to go it with multiple hospitals so then you're looking - is it - so the CBO and the care transition approach, you're looking for some kind of consistency across the hospitals that would impact care transitions?

Juliana Tiongson: Yes, I mean I wouldn't think that you would be proposing a different intervention for each hospital.

(Joan Butler): Okay.

Juliana Tiongson: And if these hospitals and you were located in the community, I mean, again a lot of the same factors would be - likely be at play.

(Joan Butler): Right.

Juliana Tiongson: The contributing factor to, you know, avoidable readmissions.

(Joan Butler): Right. Okay.

James Hester: Juliana, this is Jim. You know, it might be worth your reiterating the point that, you know, the 3026 is designed for sort of those, you know, more mature, you know, organizations, relationships.

And that you, you know, you've been working with other efforts such as the QIO 10th Scope of Work which could - which I think it would be providing some opportunities for, well, the pairing organizations to qualify. Do you want to talk about that at all? Give it some...

Juliana Tiongson: Yes, that, you know, I was just thinking of trying to reiterate that point. That, yes, this - we are really looking to build upon existing programs with this

program by pairing this service fee with, you know, community-based care transition interventions. I mean there's the QIO work and the 9th Scope of Work.

And I know there's been several waves of grants from the administration on aging to organizations to AAAs and ABRCs a lot of them specifically around care transition interventions, providing care transitions.

So we are really looking at people that have, you know, partnerships that are fairly well established, they've been providing care transition services to the elderly population.

And, you know, they may have gotten - and they've received training in a lot of these transition interventions through the small grants that they received from AoA or through their work with the QIO program. And so we're looking to build upon those models where they could possibly expand by participating in this program.

As Jim stated, the QIO 10th Scope of Work is going to afford opportunities for organizations that are just trying to convene in their communities, of the multiple health care stakeholders, and just starting to look at this issue of care transitions.

James Hester: Yes, and another resource for people out there who are just getting started is the (Hersa) patient safety through pharmacy reconciliation program. It's a wonderful opportunity focusing on one specific area of medication reconciliation that is known to have a high impact.

And again, give you a chance to get started. So there's a portfolio of ways of programs to support getting started on this and moving along the path.

Marisa Scala-Foley: Juliana - and, Jim, this is Marisa. We got a question related to what we've just been talking about. And that comes from someone who's a CBO applicant talking about care transitions experience.

They mention that they're a home care agency which hasn't done care transitions per say but has implemented similar kinds of programs such as disease management and so forth which included patient education counseling and (telemonitoring). So it was similar to a care transitions type intervention.

Would that be considered to be experience in this realm or does it really - does it needs to be direct care transition intervention experience?

Juliana Tiongson: This is Juliana. I mean I think we'd really need to see the application and what was being proposed. And if it was based on (a root cause) analysis and, you know, if it made sense. But I mean generally speaking that type of experience doesn't directly equal care transition experience.

And often times in my experience those models are more, you know, ongoing, indefinite, almost sort of, you know, care coordination requiring a per member per month fee which is not what this program supports.

Marisa Scala-Foley: Okay. With that I think - Julie, how many questions do we have left in the queue?

Coordinator: I have one more.

Marisa Scala-Foley: Okay, well let's just take that one last question and then we're going to go because I want to be respectful of people's time.

Coordinator: Okay, no problem. (Kristen Pavley), your line is open.

(Kristen Pavley): Hi, can you hear me?

James Hester: Yes.

(Kristen Pavley): I'm wondering if a consortium applies and there's one - the lead applicant as you were talking about, does that lead applicant have to be geographically contiguous with all of the sites?

So what if we wanted to implement, let's say, a rural site, and urban site, suburban site, but the hospital and the community-based organization will always be contiguous, but that lead applicant might not necessarily be contiguous with all of the site, all implementing the same transitional care model?

Juliana Tiongson: Right, right. You know, again, this is one that, you know, we'd have to look at on a case by case basis.

(Kristen Pavley): Sure.

Juliana Tiongson: And, no, I mean obviously the consortium in that model I guess because of the geographic spread would not be able to be contiguous with all of the CBOs. That would be the whole reason for having multiple CBOs. But, you know, as I stated earlier there would have to be some advantage to this model...

(Kristen Pavley): Sure.

Juliana Tiongson: ...for us to really consider it.

(Kristen Pavley): I also had one additional question about the continuum of care and you talked about multiple transitions, for example, from hospital to SNF and then SNF to home. Are you looking for applications to focus on all of these different

transitions or would it be acceptable if you were focusing on one transition like from hospital to SNF or from hospital to home?

Juliana Tiongson: Well I mean this really needs to be a community - it has to be an approach that goes across the continuum of care...

(Kristen Pavley): Sure.

Juliana Tiongson: ...or you're likely not going to prevent all of the avoidable readmissions. So I would say that, you know, for once you initiate service for an eligible beneficiary that's being discharged from a partner hospital, that person needs to be, you know, intervened upon, you know, and this won't be for everyone.

But certainly some of the folks will be need to be intervened upon multiple times during multiple transitions.

(Kristen Pavley): Great, thank you.

Marisa Scala-Foley: All right, with that I think we're going to close - we've hit our time limit so I think we're going to close things out. Thank you so much to Joe, Jim, and Juliana for wonderful presentations and for talking through the solicitation and the partnership for patients. And we thank all of you as participants for wonderful questions.

We've gotten lots via the phone lines as well as via email. If you think of additional questions, we've included the resources to which you can ask those questions whether it's directly to the Partnership for Patients or to the CCTP Web site or to us here at AoA through the - our affordablecareact@aoa.hhs.gov email.

Those are all included in the slides which are posted on the health reform and the aging network page on the AoA Web site.

We do also - we want to hear from you so if you think of - if you have suggestions for future training topics or stories even about your own community's care transitions work, we do want to hear from you so please do email us at our Affordable Care Act email address.

We want these training webinars and calls to be as useful to you as possible so we very much welcome your suggestions. Thank you all for joining us today and we look forward to having you with us again on future trainings. Thank you.

Juliana Tiongson: Thank you.

Coordinator: Thank you so much for participating in today's conference call. You may disconnect your lines at this time. Thank you and have a great day.

END