CENTERS FOR MEDICARE & MEDICAID SERVICES

Moderator: Mandy Cohen
November 29, 2011
1:00 p.m. ET

Operator: Good afternoon my name is (Joan) and I will be your conference operator today. At this time I like to welcome everyone to the Community Based Transition Care Program.

All lines have been placed on mute to prevent any background noise.

After the speakers remarks there'll be a question and answer session. If you like to ask a question during this time, simply press Star then the Number 1 on your telephone keypad. If you like to withdraw your question, press the pound key.

I would now like to hand today's call to Ms. Mandy Cohen, ma'am you may begin you conference.

Mandy Cohen: Thank you operator and good afternoon and thank you all for joining.

This is Mandy Cohen; I'm the Director of stakeholder engagement for the innovation center at the Center for Medicare and Medicaid Services.

And so again thanks for joining us on this call for the community care transitions program. We have a pack agenda for you today and some great speakers and hope that we get to all your questions.

Just a few housekeeping items just at the front so you know that this call is being recorded and will be posted on the Care Transition's website within a couple of days. This call is for stakeholders only, this is not for press. If you

do have – if you are a member of the press, please contact the Medicare and Medicaid Services Medial Relations Group.

And then lastly if you do have questions at any point and we're not able to answer them on this call, you can always email; our email address at caretransitions@cms.hhs.gov.

And so let me quickly review the agenda for you. First we're going to have an overview of the partnership rotation among which the Community Based Care Transition is a part, presented by both Dennis Wagner and Dr. Paul McGann and we'll be joined by folks the work closely with Community Based Care Transitions Program Juliana Tiongson and as well as Ashley Ridlon.

And then we have a special treat we've invited all of the original awardees, this first round of awardees for the Community of Care Transitions Program to join us, to share their experiences with you.

And then we'll open up for some questions and hopefully get to all of you and answer your question on the phones. Again if we don't get to your question, we have an email address caretranstions@cms.hhs.gov.

And so with that introduction, I will just like to turn it over to Dennis Wagner who is on the co-director of the Partnership for Patients.

Dennis Wagner: Thank you, Dr. Cohen. I'm absolutely delighted to be here today with my co-director, Dr. Paul McGann. We're going to do kind of tag team presentation here over the course of the next seven minutes or so.

I also want to acknowledge that we're particularly happy at this stage of the game to be online with seven community based partnerships, who will be given – receiving payments for the Care Transition services. We're delighted with that because; one, they were accepted and enrolled into this program and that's great.

And secondly; we want more of these successful, collaborative partnerships to be approve for the Community Based Care Transitions Program that's really

our point with this call. We want to do as much as we can to give the stakeholders that are on this call insight into what makes for an affective application, what are the kinds of things that are being approved today, so we can have more successful applicants to this program.

Our secretary, our administrator, our principal deputy administrator wants lots of action and lots of learning and lots of results from this program and from your works. So we are thrilled that there are – I understand that there are already more than 500 people enrolled into this call, we think that's fantastic.

And I wanted to be just crystal clear that the purpose of this is really to enable ion every possible way can those of you who are joining us to be successful applicants as we go forward. And of course to answer your questions and be as helpful as we can be on that regard.

So with that I want to turn this over to my co-director in the Partnership for Patients, a fine leader, Dr. Paul McGann.

Paul McGann: Thanks very much Dennis.

Ad as you know Dennis with the last two years here at CMS, we have just have one of most privileged episodes of both of our (inaudible) in working with Administrator Don Berwick for the Centers for Medicare and Medicaid Services, really (exerted) I think leadership like that they never seen before in healthcare in this country.

And he and his principal deputy administrator Marilyn Tavenner have stated consistently before to the agency, what he calls the three paradigms and really that's what the partnership is all about.

The Partnership for Patients is out first attempt to operationalize the three paradigms -- better care, better care for – better health for the population, and lower cost through improvement – lower cost through improvement. We've only learned in the last 10 years or so that better care can actually be less expensive, not more expensive and there's not better illustration at the Community Based Care Transitions.

In the Partnership for Patients we have two main quantitative goals. A 40 percent reduction in hospital acquired conditions over three years, and a 20 percent reduction in 30 day readmissions over the next three years.

If we're successful in that second goal which the Community Based Care Transitions is the biggest support network, we will help 1.6 million patients recover without complications over the next three years. And in the process of meeting both these goals, we'll save the American taxpayer over $35 billion.

Now what is the Community Based Care Transitions Program and how does it form such a big part of the Partnership for Patients?

Well, the technical direction of it, for those of you who haven't followed the origin of it, is in the Affordable Care Act Section 3026. In this part of the legislation put $500 million out to test models for improving care transitions or high risk Medicare beneficiaries. The money is available for the next five years with the potentially actually to renew and extent it to five additional years if this first five years proves successful.

And so I think we're going to dive right now into a brief description of the goals of this and also the unprecedented opportunity that are forged for every single one of you on the call. And we would want an ideal situation for all of you to send an application and be and be approve, Dennis.

Dennis Wagner: Yes, thank you Paul.

So the key goals of this program are really couldn't be more clear. They come right from stat sheets. The three goals are to improve care transitions and therefore they improve care that occurs from patients moving from in patient hospital settings to home settings or home health or other care settings, that's the first thing.

The second is to reduce readmissions for these high risk beneficiaries. We want the quality of their life to be better; we don't want them to be re-admitted back to hospitals.

And because of the reduce readmissions that takes us to the third aim of this program which to document measurable savings to the Medicare program.

So this is really an unprecedented opportunity, one way to think about it is it's an unprecedented opportunity for community based organizations, together with their partnering acute care hospitals to actually define and then price a new cost effective care transition service for Medicare patients and their communities, that's really what's going on here.

The applicants to this program have the opportunity to actually define and price a new cost effective care transitions benefit that's tailored to the unique needs and circumstances of their community. I'm not aware of a single other effort like this in the history of the Medicare, but it's really is quiet extraordinary.

But I do want to cut our underscore, cost effective. This is not a grant, it's not a contract, this is an opportunity to price a payment benefit and to receive that payment benefit as Medicare patients are served through this program but its got to add up, that is to say that the cost of that benefit when applied to the patients who received it, have to generate more savings than they do in cost. So that's really key to successful application.

Paul McGann: Yes, you're so right Dennis in the 40 years history of Medicare was never been anything like this, even remotely thought of.

So this is a unique opportunity to sit down, analyze your community, think about what's right for patients and their families, and come up with a way to deliver them Medicare benefit (that's using) our top down (inaudible) what you do but what you think in your community.

Now it's linked to cost effectiveness so you have to do what we tried to do for 40 years here at CMS and that pay attention to that. But we're actually putting the control in your hands. You're the people who are delivering the care and you know what will work. We don't want to turn this thing into a revenue generating ability, we want this to actually work for patients and be good.

Now, we're not going to get into all the details, there have been other programs on that before but I just want to finish up with just a touching the surface of what the rules and regulations are behind this because it isn't a totally simple program that something that you didn't have to pay attention to legal structuring and stature. And we're going to get more into the details of that but I think it's going help you to have the actual first partnerships that have this award, talk about their experiences because you'll learn more from them than you would from me.

But just at a very high level, who can be our community based organizations? I'm just going to give you some examples. Community based organization can be area agencies on aging; Aging and Disability Resource Center, ADRC, Friendly qualified health centers, our QIOs, and QIO partners, and any coalition representing a collaboration of community and healthcare providers as long as a legal entity is formed.

We have to have a legal entity because as for a Medicare benefit by moral we have to have a taxpayer ID number, so that the payment for the service can be made. These are not contracts, they're provider agreements.

The governing body has to have multiple healthcare stakeholder representation including consumers and there has to be partnership with one or more sub section be acute care hospitals and that community based organization has to be physically located in the community of proposal to serve.

So to summarize, we're going to hear on the rest this hour on the most practical manifestation of this. So, we've been able to put forward so far in our education program around on the Community Based Care Transitions Program, we're going to hear from seven partnerships who are going to receive payment for care transition services, who have been successful in their application of CMS and we're gong to hear what made them successful.

We want to encourage all of you to listen and ask questions and to be successful yourselves. We ideally like every entity on this call to be successful in their application for this brand new and very unique opportunity.

And finally, our administrator wants to see lots of actions and learning in I this arena going forward and that will be done in partnership and under the structure with Dennis and myself and our entire CMS team, we're working to put the Partnership for Patients in place together not only the support in the community that's care transition program but a lot of other exciting supports that are going be announce by the secretary in the next few weeks.

So at this point, we turn it over to …

Dennis Wagner: Dr. Cohen.

Paul McGann): … Dr. Cohen. Thank you.

Mandy Cohen: Thank you Paul and Dennis.

And so, I'm going to turn it over now to Juliana Tiongson to give additional details about the – about the program; Juliana.

Juliana Tiongson: Thank you Mandy.

Just wanted to emphasize the community aspect of the program, that this program does build off of what was done in the – with the quality improvement organization in the (landscape) of our care transition sub national theme.

And we're looking for community – true community approaches here. With these many medical and (inaudible) service provides, downstream provider pulled into the partnership as possible in a community. And so just want to emphasize they we are also looking for multiple hospital partnerships and you'll see it from the southern sites that were selected that they all have multiple hospital partner engaged in the program.

So, also want to (stress that this is a rolling process, we are accepting applications now, you know as applications come in they get (inaudible) in, out in a queue, and get put before the first available panel.

We have panels convening all the time, we do sometimes post with new dates on our web page and cutoff dates just to give people an idea of the time it

takes between getting the application in and having it look at. But just wanting to stress, you know when someone is ready to get an application in to not wait for any posted review dates or cutoff, so just go ahead and get it in.

So today we are going to focus on the key attributes of a successful application and have invited the first seven sites selected for a participation in the CPCP to aid us in this endeavor.

And so it's my great pleasure to introduce the seven sites that were initially selected for participation in the program which are the Atlanta Based Care Transition Program, the Akron/Canton Area Agency on Aging in Akron – Canton Ohio, the Southwest Ohio Care Transition Collaborative; serving the Cincinnati metropolitan area and surrounding counties in Kentucky, Indiana, and Ohio, and the Southern Maine Agency on Aging/Aging and Disability Resource Center, the Area Agency on Aging Region One in Maricopa County, Arizona, the Elder Services of the Merrimack Valley, serving the Merrimack Valley in Massachusetts and 10 bordering cities in Southern New Hampshire, and the Council for Jewish Elderly (inaudible) CJE SeniorLife in Chicago, Illinois.

I'm going to now turn it over to Ashley Ridlon who's going to facilitate and moderate question and answer session.

Ashley Ridlon: Great, thank you Juliana and thank you for the seven participants who joined us today. Congratulations.

This is program as Dr. McGann and as Dennis Wagner mentioned earlier is very different than a lot of programs that we've seen before. So we know that you're pioneers here and just appreciate your being here to share with us the experience and kind of what it feels like to apply to the program and to apply successfully, so thank you for being here.

We wanted to turn to each participant and ask very specific questions of different areas of the application in kind of what that experience was like for you. So we'll begin with the Southern Maine Area on Agents – the Southern Maine Area Agency on Aging.

And this question is about the root cause analysis process, we asked the applicant conduct the root cause analysis of the readmission drivers in their community, so this was not a literature review, we really do as Juliana mentioned earlier want you to look very specifically at the needs of your community.

And so we like to ask Lawrence Gross to begin, kind of a 3 to 5 minute presentation on what's that root cause analysis process was like in their community in Maine and what their findings were. So I'll turn it over to Lawrence Gross.

Lawrence Gross: Thank you very much.

Well, our root cause analysis is covering a five county catch (win) areas, so it's not a community as (inaudible). We worked with our partner; MaineHealth which is a hospital health system and five of their community hospitals members. And we partnered with MaineHealth's Center for Quality and Safety which corrected a lot of data from the individual hospitals and then roll up into a regional analysis for us.

Another sources that we use for our data included PEPPER reports, HCAP reports, care transition measures, we had data that was available to us through a state organization called the Maine Health Data Organization. We also reviewed process measures from our care transition bundle, we have bundle of services in the system looking to improve the transition from hospital to community.

And we also conducted retrospective review of random – of randomly selected member of patient records looking at information related to their admission and discharges. We held a focus group with 26 providers to kind of get their feedback on what they saw to be some of the challenges we waited to transitions. And also we conducted a small number of interviews with patients.

The result of all of that indicated that really there ways a pattern of readmissions and point to opportunities for community based intervention that will support a safe transition. For example the biggest causes that we found in

our root cause analysis were problem medications; were more than 93 percent of the people involved indication that was some kind of a challenge in their transition.

The other area that's (calling) pharmacy – the (calling) pharmacy is described by us as more than five routine medications. Over 100 percent of the patients that we reviewed had multiple medications.

The other indicator was a principal – was a principal diagnosis more than 70 percent of the people that we looked at had problems with some of the principal diagnosis on the – in the (project boost AP) screening tool which would be things like cancer, stroke, COPD, or chronic heart failure.

We did look at some information out of the – what they called (Star Reports) and we found that even in the hospitals that were practicing some of the care transition techniques only 50 percent of patients that had a scheduled follow-up visit after discharge and of those who did have schedule visits only 43 percent did not keep their appointments, 30 percent didn't understand their medications, 30 percent left the hospital unprepared to meet their healthcare and healthcare health management responsibilities.

So, as a result of all those review we focused in the care transitions initiative because we felt that would be that best way to address these issues and our project goal is to expand the care transitions intervention across all five hospitals and do that in depth with the ADRC providing a critical linkage back to some of the community supports that many family members indicated were challenging for them for example getting transportation back to a medical appointments and some things like that.

That's it.

Ashley Ridlon: Great, great, thank you very much.

So, we'll move on from there and we'll also ask that you as you have questions; we'll have time at the end of the call to do Q&A.

And I also just wanted to mention we just got have a word that the first five summaries of each of these participant's programs are now up on our website. I know the other two will be coming but we wanted to, you know, kind of rather than go through each individual detail of the program on the call today, make those summaries available to you and so those are up and available now.

So now, we'll turn to Cathie Berger of the Atlanta Regional Commission and ask a little bit about establishing the partnerships in the community. The Atlanta community is working with six hospitals; they are working with the QIO and with aging services organizations. And again that really speaks to that community effort and really rallying around the patients in that community.

And also may turn to Dr. McGann and to Dennis Wagner to speak about the value of partnerships. I know this is a huge focus on the Partnership for Patients and looking to leveraging the commitments of our partners.

So, we'll start with Cathie Berger and then turn over to Dennis on call for their reactions.

Cathie Berger: Thank you very much for this opportunity.

And let me begin by telling you that they would really simply focus that we believe contributed and facilitated our partnership with our hospitals. And I think the most important one was that at about two years ago under the leadership of one of our hospital (statement) hospital and we started in Atlanta Care Transition Workgroup in Atlanta. And for two years have really on a monthly basis focus attention on the issue surrounding care transition so we really have a good ground, worked in the whole area that I think did help us to start talking about this two – our particular hospitals.

The second I think contributing factor was that as the area agency on aging we started a pilot program, a very small pilot program to prepare us for the submission to CMS and with that we worked with three hospitals and put into place a coaching model along with the support of service our program. And again it gave us background and it gave us a sense of what we have to do to apply, to become a provider for CMS.

And then I think the third factor was that we did have a long standing relationship with our QIO, the Georgia Medical Care Foundation and that when we turn to them for assistance it was a very easy process for us.

We have really three sets of community partners and of course the first one would be our six hospitals and we chose those very carefully and with much consideration and involving everybody in the decision. After six, two hospitals would – on the list for the high – the high readmission rate that CMS put out. So we had two hospitals falling in those categories and they were selected with the help of our QIO. And then we have four hospitals that for some and how already involved in doing care transitions internally. Out of those four, three were working with us in our pilot project and the fourth one was working with the QIO in the scope of – nine scope of work.

And then I have to say that the six hospitals served a ten county area and they – two of those hospitals are all really serving large diverse patient populations and these are all pretty big hospitals and, you know, serving a very diverse through both individuals.

Our second partner was the QIO which I mentioned and I really encourage Triple A and every other provider who is looking at the enrollment to be in close contact with the QIO because I believe we got tremendous support. They helped us when we did not know the hospitals and their hospital staff, they were the ones that would arranging the meetings for that and even accompanied us on our first meetings.

Then, the other help that we received from that was – were the group called (Fenalysis) for us to understanding and to help us – help us see what we needed to get from the hospitals and work with the hospitals. And then the third item they delivered to us was the readmission data, the information we received was critical in completing our application.

Our third set of partners would our community based organizations. We would be using the Coleman model but also have added a support of package where we for 30 days provide a home delivered meals and, you know, support and transportation services and for that we have turned to our traditional aging

services network, we already have contractors and providing these services and we were able to expand those contracts to include the package in our offering under these program.

I will just say that to anybody; going out there, it's good to (board) on existing relationships we certainly did do this when we did not know the (inaudible) we point to the QIO and also to note that we did not start with the hospital or CEOs.

We started with people we knew who was social service staff, the quality improvement staff, anybody we knew in the hospital setting and said, "We want to come and talk with you," and from there they were the ones once convinced about the program that could take you up the ladder and then by the time we would ask for firm that is a commitment those came from the CEOs was full support from the hospital.

So, that's basically our process and what we have done so that to answer questions taken.

Ashley Ridlon: Great, thank you, Cathie. And I'll just turn this for maybe a 60 second reaction as, if you can Dennis or Paul?

Dr. Paul McGann: Thanks, Ashley. I just have to compliment Cathie on the description area, back a few years till my 25 years in clinical practice as an internist and geriatrician at the front line. And nearly remembering those years and I think anyone has practiced with the poor orderly in the modern hospital system in America knows that the systems that evolved in this country over the last 30 or 40 years really aren't friendly to these relationships that Cathy talked about. They aren't friendly to patients, they break everything down into silos, and reward procedure driven specialties, and do not reward the people in the community or the doctors who try to make connections and create (nets) and showing the gaps and make patient care whole again.

And it's so frustrating in clinical practice I know of because I went through it that these gaps keep opening up and every time they try to fill them the system and the reimbursement system in particular pushes you away from that.

And so these relationships and in reaching out in these partnerships and linking things together are really the key to healing the healthcare system. And I think a lot of people will talk to Dennis and me how about how complicated the new healthcare law is and community-based care transitions and how can anybody understand it.

And it is true there's a lot of technical detail to get through but in the end it comes down to one simple fact and the simple fact is the existing healthcare system makes it hard to do the right thing for patients and they view programs are working they aren't there yet but they're working to make it easy to do the right and the care transitions program and especially these first instances are provider redeemer rewards.

I'm just starting to hear now the healing of the American Health Care System and people who know how to do the right thing and then trying to do it for years but have been prohibited by the restraints of the system their program like this and other programs that were creating or starting to make it easy to do the right thing.

And I think as long as you believe that and as long as you're acting a leadership way on that, I think you'll eventually get your application together and you'll eventually to get the help you need and it will become easier and easier as we get into the swing of things.

The other thing I wanted to, just briefly mention to Cathy talked about was this linkage to the work we've been doing the last 5 or 6 years in the QIO program. And I'll ask Dennis to make that link because it's no longer a restricted to just 14 site as it was in (Night's) scope award. We now have these resources available all around the country quite deliberately and by design in this current (10) scope award.

Dennis would have to say a minute about that.

Dennis Wagner: Yes, I'm very grateful to our guest speaker here from Atlanta for bringing up the collaboration that their partnership have with the QIO program because as Paul said we now have as part of the QIO contract that exists through all 50 states and three territories. We have built into that contract that the quality

improvement organizations are available to assist communities in the work of submitting application through this Section 3026 program.

So, if you're interested and you've not yet reached out to the QIO, please do so. It's a tremendous resource and I'm delighted to hear about the partnership that occurred there with the QIO and the Atlanta community, great going.

Ashley Ridlon: Great, thank you, Dennis and Paul and thank you again, Cathie.

So, we'll turn now to Rosanne DiStefano who will describe a little bit for us about the Elder Services of the Merrimack Valley. This is a participant that will be covering 33 towns in the Merrimack Valley and Massachusetts in Southern New Hampshire.

And we wanted to know a little about kind of how you how you – how you, you know, conducted your communities to specific root cause analysis and then used that to a very specifically choose an intervention strategy that targets the root causes that you found in your community. And this is one of the key points that we are looking for in applications was that then again it's based on your community needs.

So we'd ask Rosanne to speak to that.

Rosanne DiStefano: All right. Can you hear me OK?

Ashley Ridlon: We can hear you.

Rosanne DiStefano: OK, good. Yes, we – this I found – I found this part of the application to actually be the most fun because it was really an opportunity to put the – to match the interventions that we had won over the years as a community based organization. We intuitively knew a lot about what works and doesn't work for older people and to put that together for the first time we have root causes that we were able to identify.

Similar to – similar to what has been said before in terms of the process of the root cause analysis. There was a certainly look at the literature, they will certainly look at research that had been done but I found the most telling and

the most fruitful piece of that cause analysis was really through the focus groups. And talking with people at all levels of the continuum from skill nursing facilities, assisted living, certainly housing, board members, patients, our hospitals discharge planners, everybody along the continuum and each one asking them what they believe happens and why.

And some of the hospitals that we worked with had done some work internally that we were able to use their data in terms of looking specifically at root cause. Some of them did that specifically only for some diagnosis, so we had to take a much broader approach and say, "OK, what would be the root cause for all kinds of readmission."

So, our root cause analysis piece, you know, was the first step certainly and we were able to kind of foster if you will the root causes that we found into about seven different categories.

We saw perhaps the most obvious was inadequate care coordination and that's just what it sounds like. All the times that, you know, they're just isn't that kind of care coordination that really drove down to the home level that hospitals often don't see, don't know really what is going on at home.

The second thing was – that the second category was health systems failures. And that really is where – it's not just about just what the hospitals didn't do, it's about what we all didn't do and where things (down) apart. And looking at the failure, health systems failure, it largely, largely comes down to human, the human error part of poor communication.

There is just so many different examples where the expectation of discharge was different, people didn't understand the next level of care and what was going to be available at that point, the communication to the skilled nursing facility or the certified home health agency was not adequate.

The third category was poor patient and caregiver understanding and this was very, very large. They're sort of a big part of the readmission rate and certainly it became even more so when in the moment that we have a very diverse population, a lot of Cambodians and Hispanic and a variety of different other groups where language also becomes a barrier. But this was

actually not so much of the language but just not understanding what the next steps were and what they needed to watch out for.

The next category was behavioral risk and really that was another one that was – and not really a surprise but it was a surprise I think in the sense of how many people fell it into that category because so many of readmissions were due to anxiety and that maybe with a formal and to health diagnosis or without one.

But what we found is that there is just people new to healthcare system – overuse the healthcare system because that kind of behavioral risk. We look at not only the caregiver and that the caregiver as well as the patients themselves.

So, that was Number 4 and Number 5 was environmental risk and this is where I think the community based organization has an advantage of actually being in the home and knowing, you know, first hand what person is going to go home to. The number of environmental risk can (you) think from safety issues and, you know, what the home – how the home is designed and that's – those kinds of things.

Next was clinical risk and obviously this is the most – I think we expected this we're looking at the (inaudible) pharmacy issues, (comforts) chronic conditions, and then finally cultural barriers. And then – and this is what I spoke to earlier and it's not only the language but the culture that would often times form a barrier for people to get that kind of care that they should be getting.

We looked at our interventions and then matching interventions with these root causes was the interesting part and certainly by our experience with the Coleman model certainly proved that the Coleman model was – it has to be the basis, the Number 1 intervention that we wanted to choose.

We chose to enhance the Coleman model so that we could actually add pieces such as home safety checks, follow-up with PCT and some other pieces that we felt were so critical and with so much a part of the new process. But then,

we also took a look at a lighter touch (inaudible) transitional (up here), where the person answers skill nursing facility and then went home.

Some of the other interventions were being able to have a rapid responder available when the person gets home. And not in all cases was services going to be available to the individual when they arrive at home. Sometimes it's a new patient for certified agency and that they had to do an assessment process and sometimes the person may not be eligible for services that quite honestly be discharge plan that may have thought would have been eligible.

So, we look at and being able to pay for immediate home based services for that first week of services and that day of discharge.

Ashley Ridlon: Excuse me, Rosanne?

Rosanne DiStefano: Yes.

Ashley Ridlon: This is Ashley Ridlon, I'm sorry to interrupt but I just wanted to be mindful of the time and make sure that all of the callers have a little time to describe their programs and then we can reserve maybe the rest of that serves to Q&A if others have questions about the interventions, would that be OK?

Rosanne DiStefano: Sure, I'll just list them. The next one was interpretation, another intervention was mental health, the next one was patient self management, the next is once on basic necessities, then nutritional coaching, enhanced (tone) health, and then the vast array of community based services that was in existence that we would pull upon.

Ashley Ridlon: OK. Great, thank you. Thanks and it's very exciting to hear you describe just what fun that was to, you know, to really look at your community and see what those root causes were and how to – how to address them and, you know, we do – we do encourage multiple models but the really the key here is making sure that those models address your community needs. And there looks like you done – well a wonderful job there.

So, I wanted to turn next to Gary Cook of the Akron/Canton Area Agency on Aging. And Gary Cook, are you on the line?

OK, we weren't – we weren't sure if we had Gary. If he joins us we can have him – have him give his – toward the end.

So, we'll go ahead and move to Sharon Fusco of the Southwest Ohio Council on Aging.

So, we wanted to ask you a little about how do you chose to target the high risk that Medicare fee-for-service beneficiaries in your population, so how it – sort of looking at your community and your community needs and the readmissions patterns in your community needs workouts review and then – and then ultimately how are you targeting the beneficiaries in your community.

Sharon Fusco: Thank you, Ashley.

When we started this process in order to sort of get to our target population, we relied pretty heavily on a lot of data analysis of the admissions and readmissions were occurring in the facilities that were partnering with us. We have five hospitals in our partnership.

And so we really started by pulling data to see, you know, how many clients are being admitted and readmitted, what they're diagnosis were, both their primary and their secondary and giving a feel for how did those come together in terms of, you know, what were the commonality, what were the top diagnosis that were happening with these patients when they were being admitted and being readmitted.

And we also used the same kind of data from the pilot studies that we had here, you know, what did the patients that where in our pilot, you know, what were the conditions that they had, going in and being, you know, when they were admitted and what were their primary and secondary diagnosis, how many of them had multiple chronic conditions and so forth.

So we looked at it, we really did a lot of data analysis around the patients to really understand what was happening then, the questions that we were trying to answer with that was, you know who was being admitted and readmitted,

what were their diagnosis, what patient – where were the patients coming from, where they coming, you know, from the home, where they coming from nursing facilities, where they coming from other setting so that we would understand how to, you know, what interventions we should be looking at from the standpoint of where they are coming from.

Also trying to get a little deeper into the root cause of their admission and or readmission and then whether that – the other thing we wanted to know was whether or not the intervention we were looking at was actually effective and that's where the data analysis helped us with our pilot once they came in, you know, and we targeted patients and looked at those that were – that seem to be readmitted looking at our pilot data saying that, "Is this intervention going to work for people with those diagnosis?

Because in our pilot we had quite a range of admitting diagnosis once the data from the hospital shows that heart failure, chronic heart disease and pneumonia were the top for us as well as multiple chronic conditions, it was then going back to our pilot data saying, "Did the pilot show that we were effective with the care transitions intervention and reducing readmissions of among people with those diagnosis?"

So it allowed us to sort of check and balance between what we were seeing happening in the community and whether or not the intervention we were looking at was going to work.

We also looked at national data then once we had sort of define target market, we then look to national data to see what was happening nationally and we were looking at were the data aligned and if not why – where was the misalignment because if our community was pretty far off from what was happening nationally we wanted to understand why that was so that we can understand if we needed the different types of intervention or if we needed to broaden our definition in a certain way and to make – so that we could make sure that the intervention ultimately be selected in a way that we designed it would work.

So, I'm not sure what else to add to that but that's how – that's how we use data to come up with our target population and use it to support the intervention that we selected.

Ashley Ridlon: Wonderful, thank you for that.

So, we'll move next to Area Agency on Aging, Region One which is in Maricopa County Arizona and I hear a little a bit about your previous experience so we do ask applicants in their applications to describe their previous experience in improving care transitions so all of these participants on the call have a very valuable previous experience to the table and to the program.

And so we'd like to ask Mary Lynn Kasunic to describe your previous experience.

Mary Lynn Kasunic: OK, thank you, Ashley.

We – in October of 2010 about a little over a year ago, we did too many pilot projects. One was Dan – Banner Del E. Webb Medical Center in the Sun Cities area and with Care First, the Medicare, a very special needs plan that serves (dolly) enrolled Medicare and Medicaid beneficiaries in Maricopa County.

And we followed in our pilot project, the traditional home and four pillars model. And we identified some strengths and weaknesses and so I'm just going to share with you quickly three lessons that we learned.

One was that we realized that we needed more than the traditional two visits and so we proposed that we would do a visit prior to discharge, one within 24 hours after discharge and then on second home visit within a week to 10 days. Because what we found was that after discharge, the clients, the patients are still very overwhelmed, you know, in the hospital we've kind of done the introductions so what's going to be happening during the transitions and that's very valuable and in those – that first visit we go over the four pillars of the Coleman model but we're asking them to, you know, be looking at all of those different issues.

And the Medicare beneficiaries feel overwhelmed, they have either a new diagnose or is there a worsening of their condition. We've asked – going to do a follow-up appointment with their PCP and their specialists and to pick up their prescriptions and, you know, taking their new meds and so forth.

So, we proposed then between that first home visit, the second home visit, there would be telephone coaching and telephone reassurance but then there would be that other follow-up visits to make sure that their right on track.

The second issue that we found is the lack of transportation and our pilot are all over a 100 individuals, 46 percent of them lived alone and had no (rely), limited or no reliable transportation to do follow-up appointments or to go to the pharmacy to pick up their medications.

So, we're proposing two options to deal with that. One is that we have partners with Sunwest Pharmacy that offered to provide prescription delivery to any of those CMS program participants that don't have family and no other way to pick up their prescriptions.

And also we're going to be developing a consumer directed transportation option to help individuals find either friends or neighbors that can help take them to their appointments. In our pilot program, we use some AmeriCorps members and that really made a big difference, and so we think that that's going to be the one of most successful issues about the transition from hospital to home.

And then finally our pilot program, what we found that many of the individuals live alone as I said and that they didn't have a strong support system, they were socially isolated which led to depression or lack of desire to care for themselves, they might be depressed about the worsening of their condition or new diagnosis and they didn't want to take their meds, go see the doctor, and so forth.

So, we proposed to conduct a depression screening and then to refer the individuals to our area agencies, the licensed behavioral health agency and so we will provide in-home counseling, or refer them or facilitate access to

Medicare outpatient or inpatient behavioral health services and we feel that this is also going to be another valuable component.

And I'd like to just say in closing of course while we are in the home as other people – as speakers have pointed out, we'll be doing home safety checks and linking them to other homely community based services that our area agency provider network, you know, currently does.

Ashley Ridlon: Wonderful, thank you.

And last but certainly not least we have CJE SeniorLife to talk a little a bit about how to – how to show us, how you'd met the eligibility requirements and the structure in your partnership and to other than just sort of describing that you – that you meet the eligibility requirements really putting some justification behind that.

So, we'll turn to Heather O'Donnell to describe how CJE SeniorLife has done that successfully.

Heather O'Donnell: Thanks, Ashley.

Our CJE SeniorLife has a long standing elder quick care organization we've been in Chicago in the Illinois suburbs for over 40 years. And we have a number of programs where we have actually focused on reducing re-hospitalizations and we sort of walked through some of those programs in detail in the application.

We have a skilled nursing facility that has short term rehabilitations so to sort of demonstrate our previous experience in reducing re-hospitalizations; we walked through our advanced practice nurse model in reducing re-hospitalizations there.

We also talked about our home healthcare agency that we are Medicare certified home and healthcare agency and how we reduced re-hospitalizations in that area and we also provide a whole host of home and community based services in our community.

And so we really walked through how we had been in our community and how we – had been community focused in patient centers over the existence of our organization.

In addition, we really focused on the hospitals in our community that have high readmission rates and the free hospital (consider) measures and all of our hospitals would be subject to Medicare financial penalties if they're not able to bring down the 30 day readmissions that we really walked through that piece.

We've focused our model on hospitals that are doing an enhanced hospital discharge planning program either a project (food) or project thread. We really felt like this would be strong signal for the – an indicator that the hospitals are committed to and improving the quality of care across the (inaudible) of continuum. And we are doing the Coleman model which really takes those enhanced discharge planning programs to the next level.

Another thing that I think stood out in our application is that one of the – one of the big focuses in our community or one of the big needs in our community is skilled nursing facility of readmission. So in doing the Coleman model, we're not just going to be following people that are – that are going from a hospital back home but also people that are moving from the hospital into short term rehabilitation and or long term cares.

So we sort of outline how we would have a strong connection with the skilled nursing facility of (Ann's Home Health Care Agencies).

Another thing that we did is that we are going to be working very closely with the care coordination units and each of our hospitals that connect patients plus hospitalization to a critical support services once they return back home for short period of time.

Personal care, home delivered meal, transportation, I think all that in really shows that the support service are really critical in making sure of people stay out of the hospital after they've been hospitalized.

And we are also working very closely with our local QIO on tracking readmission to the hospital where they – where admitted initially and then other hospitals where they readmitted in our community.

And also following patients by the skilled nursing facility at (Ann's Home Health Care Agencies) where they receive care post hospitalization. So we really focus on a number of different aspects in our community.

Ashley: Wonderful, thank you Heather.

And I'll turn now to Ray Thorn who will move us into the next portion of the call which is our Q&A portion.

Ray Thorn: Thank you Ashley. Hi everyone. This Ray Thorn and I'm with the stakeholder engagement group in the CMS Innovation Center.

We are now ready to turn over to – go into the Q&A session and operator, we are ready to open the lines for Q&A.

We ask that callers are when they ask their question to state their name and their organization that they're affiliated with and keep their question brief as possible so that we can get to as many questions as possible on the time remaining.

So operator, I'll turn it over to you.

Operator: Thank you sir. At this time I would like to remind everyone, in order to ask a question please press Star then the Number 1 on your telephone keypad. If you would like to withdraw your question, press the pound key. Your first question …

Ray Thorn: Operator?.

Operator: … yes sir?

Ray Thorn: Operator as we're waiting for people to line up, we do have some questions that actually we'd like to ask.

Ashley Ridlon: Great, thank you, Ray. So and so as Ray mention we'll get people a second to queue for questions but I did want to highlight a couple of things that are frequently asked question as if Juliana Tiongson who's our program lead here for the care transitions program to kind of try chime in on these.

And one of them is as we were just hearing from Heather O'Donnell about structure and eligibility of the applicants, what are some of the things that the people need in sort of focus more on versus less?

I know, you know, we need to make sure that people have partnership in place and that that is reflected in the application. So, how is that sort of differ from other kinds of letters of support and where should people focus their effort there?

Juliana Tiongson: Thank you. Yes, we need to see formal partnership established with the critical partners proposed in an application such as all the partner hospitals, downstream providers that are – that are being involved in the collaborative and the community based organization.

So letters of support from the CEO, the CFO, and the head of discharge planning at each partner hospital are required and a minimum and we also like to see things like (MLU) between partners wherever possible.

Other letters of support from congressional staff and other that aren't really going to be a service provider in the partnership. They've really don't provide competitive edge to applicants. We've really need to see this letters from the key partners.

The other thing that I would mention is that to this requirement of our community based organizations have multiple healthcare stakeholders including consumers on its board. Often isn't flush out in enough detail in people's application so that we can make the determination that there are consumer representative and multiple healthcare stakeholders on the board to really laying out who the board members are and what there respective roles are is extremely important.

Gary Cook: Excuse me for a second. This is Gary Cook from Akron, Canton. We have been on the line but we were having technical difficulties being heard, so I just want to let you know that we're here.

Ashley Ridlon: OK, thank you. OK and thank you, Juliana. Well, I think we can turn to you Gary if you can – if you can give us and in just the couple of minutes, we want to know a little bit your previous experience and I know we've heard from others about theirs but if we could kind of and, you know, make sure to keep it short so that we can have as much time as possible for Q&A.

Gary Cook: Sure. We've had a long term strategic initiative of trying to integrate medical in the long term care and, you know, as a result to that as far back with 1998, we have had area agency on aging long term care nurses literally physically located in our area hospitals, in eight of our area hospitals that original purpose of that was for transitions but primarily transitions into our Medicaid long term care waiver programs and to divert individuals from permanent nursing home placement.

As we move on into the future, we begin to see the advantages are obviously of integrating medical in long term care and in later on in 2009, we developed to the hospital pilot with two hospitals to actually do care transitions much like we're doing now.

Of course the problem with that point was sustainability but we have – but we used that as a basis to sort of learn our craft if you will and to also document the very real – the very real reduction in readmissions that would stop.

Since that time we've under taken a contract with the Medicare advantage plan to do transition coaching for them under contract for the once again for Medicare advantage people.

Beyond that downstream, we've done – we've done several projects over the past several years but I think one of the once that has the most lasting effect and in terms of enhancing the transitions and ultimate outcomes of transitions are interdisciplinary teams with in cooperation with the hospitals and the area agency in aging we have an interdisciplinary team that meets on a regular basis from (inaudible) nutrition, a pharmacist, an area agency and agent case

manager, a long term care consultant or assessor, and on that (inaudible) basis in nutritionist, hospice, adult day services, and a CNS which we have on staff.

What these people do is take those hard to serve individuals and those difficult cases and then try to come up with once again interdisciplinary solutions to once again keep them from returning to the hospital, from having excessive ED visits from permanent nursing home placement, etcetera.

We have several other demonstration projects in the past where we work cooperatively with the medical care system. A couple of which is been featured in a new book that was out the "Comprehensive Care Coordination for Chronically Ill – Ill Adults" which was just publish by Cheryl Schraeder and Paul Shelton this year. In which it talks about two integrated models under best practices that we use. The stage project which is the (Zuma) area agency geriatric evaluation program and the page project which is a program for all inclusive care for the elderly (inaudible) essentially are interdisciplinary team.

So once again we have long history of working cooperatively with the medical community and of course the problem become sustainability and we really – we're really are grateful for the opportunity through the Affordable Care Act in this – in this contract to take a look at making some of this more sustainable.

Ray Thorn: Thank you, Gary and we're glad that you were able to join us and over come the technical difficulties.

Gary: I've actually do – I've actually been listening to the whole thing, trying to speak up and you couldn't hear me so I apologize.

Ray Thorn: No worries.

As this time we're ready to dive into questions for CMS staff or the selected sites and if there are any budget questions, please direct them to Juliana Tiongson.

So operator, do we have anyone waiting to ask a question?

Operator: Yes, sir. Your first question comes from (Hallie). Please state your full name and your organization.

(Hallie Stayley): My name is (Hallie Stayley) with SSM Health Care.

Ray Thorn: Go ahead (Hallie).

(Hallie Stayley): My question was how many of you coordinated across healthcare system and of those, how many healthcare systems did you coordinate across?

Gary Cook: This is Gary Cook from Akron. We coordinated 10 hospitals across four healthcare systems.

(Hallie Stayley): Right.

Gary Cook: Four major systems.

Sharon Fusco: This is Sharon Fusco from Cincinnati and we coordinated five hospitals across three systems. Atlanta, Georgia, we did six hospitals across five systems.

Heather O'Donnell: Heather O'Donnell. We did three hospitals, two systems.

Rosanne DiStefano: This is Roseanne that we had five hospitals with three different systems.

Mary Lynn Kasunic: In Phoenix, we have four hospitals, three systems, and then other partners.

Female: So do you hear your voice Mary Lynn?

Ray Thorn: Great, thank you (Hallie) and thank you everyone, operator the next question.

Operator: The next question comes from (Pamela). Please state your full name and the organization. Your line is open.

Pamela Clifford: This is (Pamela Clifford) from Hennepin County Medical Center in Minneapolis.

I have two questions actually. Most of you have been focusing on the elderly patients as we're doing our root cross analysis. We are finding that over 50

percent of our patients are under the age of 61 and many of them have end stage renal disease as opposed to the cardiac or respiratory diagnosis.

I'm interested if there is anyone out – if it's in your root cause analysis, any of you of the seven systems of efforts found that and how you addressed it?

And then my second question is I just need clarification, in every one of them is it actually a transition coach from the area agency on aging sort of doing that function. Is it from the area agency on aging that the transition coaches are coming from?

Heather O'Donnell: This is Heather O'Donnell from CJE SeniorLife, we are – we are not a Triple A and we're doing the Coleman model using a transitional care nurse. But we will be working closely with the care coordination units that setup the home and community base services in the (inaudible).

Pamela Clifford: OK, thank you.

Mary Lynn Kasunic: And in Phoenix, Arizona, they will be the area agency that is hiring and supervising the care transition coaches. And also has senior to your chair advocates that will be assisting them.

Rosanne DiStefano: This is Rosanne DiStefano. The coaches will be from the area agency on aging from our agency and in terms of the first question, we are an ADSD, we are comfortable working with people that are under the age of 60 and have worked collaboratively with the (inaudible) at living center and hope to find, you know, be able to use that partnership with the under 61 population.

Lawrence Gross: This is Larry Gross at Southern Maine. We are including people under 65 in our – in our project whether Medicare eligible and as far as who's doing the coaching – we're partnering with the physician hospital organization and betting one of our community resource specialist on to the team. The coaching is being done by the PHO and our person is participating as a team member.

Cathie Berger: Atlanta, Georgia and we will have the coaches work from the area agency on aging.

Gary Cook: This is Gary Cook in Akron. We also will have the coaches working from their agency on aging and we are on AVRC as well and can help the other population.

Sharon Fusco: This is Sharon (inaudible) Cincinnati. Our coaches will also be from our organization area agency on aging. We are AVRC can provide the same type of support and we also are picking up individuals with multiple chronic conditions so those with renal diseases with fall into that category.

Pamela Clifford: Great, thank you very much.

Ray Thorn: And thank you (Pamela). Operator, next question.

Operator: The next question comes from (Deborah). Please state your full name and organization. Your line is open.

(Deborah Cattles): Thank you, this is (Deborah Cattles) from (inaudible) California and you gave us two areas the focused on structure and partnership.

I'm wondering if there are additional areas have focused that you've seen some gaps in the application and if you can also tell us, you know, what's the number of applications are in the queue, give us some ideal of what (wait time) is before we would come up in the queue and if you can share with us a percentage that were declined or told to go back and work some more and resubmit.

Juliana Tiongson: Hi this is Juliana Tiongson. I'm trying to remember all these questions.

We can't – we can't give out numbers of applications received, the numbers reject.

We are accepting applications on – growing ongoing basis and, you know, estimate that, I mean generally from the time we get and application in there's about approximately three weeks before it would get it issued to – could be 3 to 4 weeks before we get it to a panel for review.

And then there's generally (inaudible) of weeks after that review before a notification would occur.

(Deborah Cattles): (Inaudible) repeat.

Juliana Tiongson: Some months we have, you know, four panels. Some months we have two. It's just really depends on application (flow).

What – let me (inaudible) so the areas we really did try and highlight here are, you know, making sure that the applicant has previous experience in care transition services. This program is really meant to come in and provide a sustainable funding stream for an organization that has some experience, providing this kind of services and by being a part of this program that you continue and even expand these services.

So just to be clear that it's really isn't for people that are just getting started. In terms of experience, it doesn't have to be, you know, it could just be having completed with small pilot but we do need to see some evidence of experience.

The other critically important thing is the root cause analysis that is a community specifically causes analysis and that applicant isn't just sighting national study. And then that root cause analysis then directs the targeting of the beneficiaries and the selection of the intervention.

So there has to be that tie back from the intervention selection back to the results of the root cause analysis. You know, structure is an important thing.

Again we have a strong preference for multiple hospitals in a community partnering with a community based organization and pulling in downstream provider as well. Because we're getting that as you can see with seven selected sites, really the only application that are considered with the partnership of just one hospital and one community based organization are those that are in a very rural area where the literally are no other acute care hospital to bring into the partners.

I think that that there is are – the key point in just making sure that you're clear on who's a boarded of your community based organization if they are the applicants that they may does requirements of multiple stakeholders, healthcare stakeholders, and consumer representative.

Ray Thorn: Thank you (Deborah). Operator?

Operator: Thank you. Your next question comes from the line of (Ruth). Please state your first and last name as well as the organization and your line is now open.

(Ruth Ratcliffe): This is (Ruth Ratcliffe) with the Aging and In Home Services that Lawrence Gross, when he spoke he said he did as root cause analysis utilizing some – looking at readmission drivers utilizing the PEPPER Report and the HCAP. I don't know what those are, could you tell me? Or where they get them from?

Lawrence Gross: PEPPER Reports are a report that goes to the hospitals from CMS and the HCAP are a patient satisfaction of reports that are done by the hospitals.

(Ruth Ratcliffe): All right, thank you.

Ray Thorn: Thank you, (Ruth). Operator.

Operator: Your next question comes from the line of (Emily). Please state your first and last name as well as your organization. Your line is now open.

(Emily Turn): (Emily Turn) Greater (inaudible) services.

My question is if we are submitting an application on behalf of our AVSC and our partners in that group and lead agency is a legal entity, is that sufficient or the AVSC require a legal – to be legal entity?

Female: So the CBR that community based is it a community based organization that the coronary applicant do – they must be legal entity that can receive payments. They must be the one that have the governing board with multiple healthcare stakeholders including consumers.

But being – if it's an area agency on aging a governmentally based – once we have a frequently asked question on this topic, there is in a case of a

governmentally based Triple A, there is the provision that in terms of the multiple healthcare stakeholders and consumers.

That requirement would determine to be met by virtue of the governing board being elected official. Therefore there's elected officials inherently represents the consumers and multiple healthcare stakeholders in the community states they serve.

One other important other piece that the community based organization must be physically located in the community that it proposed to serve.

(Emily Turn): Thank you.

Ray Thorn: Thank you (Emily). Operator.

Operator: Your next question comes from the line of (Katie). Please state your full name and your organization. Your line is open.

And (Katie) if your line is on mute, please unmute your lines.

(Katie): Hello, can you hear us? (Inaudible).

Female: (Inaudible).

(Katie): Hello.

Ray Thorn: Hi you're on the line.

(Katie): OK, I'm sorry. We did not think we have mute button. Sorry for that. This is (Katie) via internet from Saint Mary Mercy in Livonia, Michigan.

And if some of you had already touched on the topic but specific to the target population, we were interested in learning more about your focus diagnosis. And it sounds like most of you were really focused in on those three major diagnosis of CHS, AMI and Pneumonia but we were wondering if that was an inclusive list or if you would expand further than that?

Rosanne DiStefano: This is Rosanne DiStefano. Now we expanded far beyond the three major diagnosis and we really based it on what we were finding in a root cause analysis.

(Katie): OK.

Lawrence Gross: This is Larry Gross in Southern Maine. We also did not make that in exclusive list. We really use it the diagnosis that were represented in the – in the Coleman model.

Heather O'Donnell: This is Heather O'Donnell. We focused on the three diagnoses in addition to any other chronic medical conditions. We're really focusing in on the need of the patient.

Sharon Fusco: This is Sharon from Cincinnati. We focused on the three diagnoses. We added multiple chronic because the data showed that a number, you know, high number of our individual didn't have one of the three as an admitting but they all – they had multiple chronic conditions.

We also added mental (pulse) and modified and intervention for individuals we have mental health issues because we found that they were not able to participate in the Coleman intervention and but yet that is a significant number of them that came up in our pilot.

And so we partnered with our mental health board to help them find the medical home that could help them after they will release from or discharge from the hospital.

Gary Cook: This is Gary Cook in Akron. We focused on the three primarily because of the commonality of data and the difficulty in tracking readmissions on the broader based diagnosis when the readmission were sort of secondary and tertiary causes to (inaudible) to keep the data clean.

Cathie Berger: Atlanta Georgia and we are focusing on the three diagnoses.

Mary Lynn Kasunic: And same thing in Phoenix. The three diagnoses and also maybe individuals with the – a path of history or repeat admissions.

Sharon Fusco: This is Sharon from Cincinnati again. I would also add one other reason why we limited ourselves to a certain degree was also because of what the volumes were showing and wanting to make sure that we could sufficiently staff the hospitals with the transitioning coaches and not try and take on more than we really could handle.

Ray Thorn: Thank you (Katie) and thank you everyone. Operator we have time for one more question.

Operator: OK for you final question today comes from the line of (Elizabeth). Please state your first and last name as organization. Your line is now open.

(Elizabeth Jones): Hi, this is (Elizabeth Jones) from the Healthcare Providers in Oregon.

And I was hoping that you could (supply) a little more information about the examples of the community based collaborations, I was struggling to understand the different coalitions were small (inaudible) of primary care practice that (health calls) and that we've been tracking hospital ER visits and readmissions and we have care coordination.

But we're trying to figure out these all seem to be very large scale with multiple hospitals and just trying to figure out what is meant by the coalition?

Juliana Tiongson: This is Juliana. So the idea is to have a community approach here. So a primary, I think you've said that you very (inaudible) but I think it's that your small primary care office. And basically the idea is to bring in as many medical and social service providers in your community that touch same pool of beneficiaries into the partnership as possible.

We understand that it and you can bring in everyone but just one is be a good representation of the providers in the community. And then just to qualify to the eligible and (inaudible) it goes back to the points of being a legal entity that can receive payments from CMS. Having experience in a provision of care transition services being physically located in the community you propose to serve, and having a governing body with multiple stake – multiple healthcare stakeholders including consumers.

Sometimes new entities need to be formed because they don't currently exist in every community or in every state. And I would encourage you to reach out to your QIO in your region because as of August 1st it's part this town (inaudible) (scale if it work). The QIOs are tasked with assisting interest to these applicants for this program convening communities – convening this kind of collaborative partnerships assisting with root cause analysis and so forth.

So is this like to encourage everyone to reach to their local QIO. I've also heard that a lot of people have been reaching out to these seven sites asking for technical assistance and clearly they can't provide technical assistance and they're going to be focused on implementing their programs for this project. But the QIOs are tasked with this and they are available to help.

One other thing, I just wanted to touch on that is I'm sure it's people waiting in the queue that didn't get to ask their question about budget. I just wanted to stress that this is not a grant program. I know that what said in the early portion of the call but really is not a grant program and that's a common problem I see with application were the budgets includes a lot of indirect cost, infrastructure cost, equipments, space, training cost, you know, all kinds of ancillary positions around the position, around the (FTE) that would actually be providing a care of transition service to an eligible beneficiary.

So this one is to stress to everyone to keep in mind that we're testing a new service for a high risk, not a care fee for service beneficiaries and as such we can really only pay for the service that is being provided to the beneficiary. So the (inaudible) structure cost, I mean if this average to become a permanent benefit care transition services, we certainly cannot cover peoples infrastructure cost.

And the ways and just to mention again, this is meant to build on previous experience. It's not for organizations that are just getting started. From, you know, that's why we were not paying for training and for particular program.

Ray Thorn: Great, thank you Juliana and thank you (Elizabeth) for your question. At this time we're going to wrap up today's call and I will turn it over (Dr. Paul McGann) and Dennis Wagner for any closing comments that they might have.

Paul McGann: All right, do you think we are like 60 seconds or how much time do we have?

Ray Thorn: 60 seconds.

Paul McGann: OK. Well, we won't actually do it but we'll call you if we have another one of these calls but we will do. We'd like to start shifting and we taught today's calls was great and we love the interaction between the community that wants to join these seven. And to seven people that have put so much hard work into it and we thank them for appearing on this call.

Dennis and I both just think it was spectacular and what we want to do is give you preview next time. We think this was very helpful but of course we don't have a feedback from you.

And so when we design this program next time in addition to you asking us questions and you asking the seven questions, we're going to ask you questions. And we're going to ask things like "What did you hear in today's call that was most powerful and helpful to you and what more would you hear that would help you to be successful in the future."

So even though we don' have time to actually do that right now because of the interest (inaudible). I did want to say that we're very interested in your feedback and we're very interested in sort of interacting with you more so that we can maximize the success of the audience on the call. Dennis do you want to bring (inaudible) in here?

Dennis Wagner: Yes, thank you Dr. McGann and I would just like to close the call by asking a question. We won't have an opportunity to collect the answers today but I'd like you to develop your answer to this question and that question is "What action I'm going to take (inaudible) what I heard on this call today? What action am I going to take as a result to what I heard on this call today?"

And I hope for a lot of you that action will be the team up with others in the community to advance applications to the 3026 program because we want a lot more and we want really good ones and we want to get this ball rolling just as fast as we can to improve care, improve transitions of care, reduce (inaudible) readmissions and save the nation billions of dollars. And we've got that potential all of us as part of its growing and emerging community practice.

So thank you and thanks especially to our seven guests. We're delighted that you're in the program and we're delighted that you are already teaming with each other and with the emerging community or practice to spread what works and what's successful for you. Thank you.

Ray Thorn: Right. Thank you Dr. McGann and Dennis.

If you – do you have any comments or if you did have the question and were unable to ask your question, please to email the care transition email box at caretransitions@cms.hhs.gov.

I want to thank everyone for joining today's call. I especially also want to thank the seven sites for sharing their invaluable insights.

summaries of those seven selected site are posted online at http://go.cms.gov/caretransitions and there were also be a transcript in a recording of today's call will be posted on the website.

In addition, applications are still being accepted and there are being accepted on a rolling basis.

So again thank you everyone for joining and operator that concludes our portion of the call.

Operator: As of that concludes today's conference call, you may now disconnect.

END