Administration on Aging
Affordable Care Act Webinar
Care Transitions: Making the Programmatic Case
February 9, 2011
2:00-3:30 pm Eastern

Coordinator: Welcome and thank you for standing by. At this time all parties are in a listen-only mode until the question-and-answer session at the end of today's conference. At that time you may press star 1 on your touch-tone phone to ask a question.

I would also like to inform all parties that this call is being recorded. If you do have any objections, please disconnect at this time. I would now like to turn today's call over to Ms. Marisa Scala-Foley. Ma'am, you may begin.

Marisa Scala-Foley: Thank you, (Jacquelyn). Good afternoon, good morning to you, our friends on the West Coast. Thank you so much for joining us for AoA's second in a series of webinars that are focused on opportunities for the aging network both state and local agencies with the Patient Protection and Affordable Care Act also known as the Affordable Care Act or the ACA.

Today's webinar is called Care Transitions, Building the Programmatic Case and it continues our focus on the very important topic of care transitions. Patients or clients going from one care setting to another so from hospital to home, from hospital to skilled nursing facility, from skilled nursing facility to home and more.

If you were able to join us for our last webinar on January 24th, you'll know that reducing avoidable hospital readmissions is a key goal of many of the provisions of the Affordable Care Act.

Improving these care transitions can help to reduce these avoidable readmissions thereby providing better care and promoting better health for your clients at a lower cost.

Section 3026 of the Affordable Care Act authorizes the Secretary of Health and Human Services to establish a community-based care transitions program under which the Secretary will provide funding to eligible entities in particular AoA grantees that furnish improved care transition services to high-risk Medicare beneficiaries.

The solicitation for the community-based care transitions program is not out yet but this opening group of webinars that AoA is offering seeks to provide the aging network with the tools that you need to help to develop care transitions work in your area.

Today's webinar focuses on some of the programmatic elements that you need to think about when developing a care transitions initiative such as root cause analysis, partnership building and the use of data to target your partnerships and provide a rationale for your work.

We also think that care transitions work can provide a wonderful opportunity to integrate other important work being done by the aging network, things such as aging and disability resource centers.

As you'll hear about from Cathie Berger, one of our speakers; benefits outreach and enrollment, caregiving and respite programs, chronic disease

self-management and other health promotion or disease prevention programs, money follows the person, systems change work and more.

In addition, the partnerships that you build through care transitions work with hospitals, physician practices, long-term care facilities, state Medicaid agencies and other organizations can help to position you better for future Affordable Care Act-related opportunities at the state and local levels such as accountable care organizations, health homes, patient-centered medical homes and more.

So before I introduce our speakers, we have a couple of housekeeping announcements. First of all if you have not yet done so, please use the link included in your e-mail confirmation to get onto WebEx so that you can not only follow along with the slides as we go through them but also so that you can ask questions when you have them through chat.

If you don't have access to the link that we e-mailed you, please go to www.webex - W-E-B-E-X - dot com, click on the "attend a meeting" button at the top of the page and then enter the meeting number which is 660124537.

When prompted, enter this password which is AoA webinar. If you have any problems with getting into WebEx, please call WebEx technical support at 1-866-229-3239. Again that's 1-866-229-3239 for WebEx technical support.

As (Jacquelyn) mentioned, all participants are in listen-only mode; however, we do welcome your questions throughout the course of this webinar and there are two ways that you can ask your questions.

First through the Web using the chat function in WebEx, you can enter your questions. We'll sort through them and answer them as best we can when we take breaks for questions after each speaker presents.

The second way that you can ask your questions is that after all the speakers wrap-up, we'll offer you a change to ask your questions through the audio line. When that time comes, (Jacquelyn) will give you instructions as to how to queue-up to ask your questions.

If there are any questions we can't answer during the course of the webinar, we will follow-up to make sure that we get your questions answered and if you think of any questions after the webinar, you can also e-mail them to us at affordablecareact@aoa.hhs.gov.

All of the e-mail addresses are included in the PowerPoint slides that are the basis for this webinar and as I'll talk about at the end of this webinar, we really want to hear your agency's care transitions stories so we also invite you to send those in as well to affordablecareact@aoa.hhs.gov.

Just in terms of follow-up as (Jacquelyn) mentioned, we are recording this webinar. We will post the recording, the slides from this webinar, a transcript and any questions that we can't answer during the course of the webinar on the AoA Website which is www.aoa.gov as soon as possible, definitely before the end of February.

So now that we've gotten through all of our housekeeping announcements, I want to turn things over to our speakers and let me just give them a brief introduction. We're thrilled to have with us today a terrific panel of speakers who can talk about building the programmatic case for your care transitions work.

First up will be Dr. Jane Brock and Alicia Goroski from the Colorado Foundation for Medical Care who will talk about root cause analysis under the care transitions theme which is a three-year project funded by the Centers for Medicare and Medicaid Services or CMS which aims to improve the quality of care transitions and to reduce 30-day readmissions among Medicare beneficiaries residing in the 14 communities addressed under this theme.

Dr. Jane Brock is the Chief Medical Officer for the Colorado Foundation for Medical Care which is the Medicare quality improvement organization for the State of Colorado. She spent 25 years in clinical practice in urgent care and occupational medicine and she is the Chief Medical Officer for the care transitions QIO support contractor.

Her colleague Alicia Goroski is the Care Transitions Project Director at the Colorado Foundation for Medical Care. Alicia received her Master's in Public Health from the Rollins School of Public Health at Emory University in 1997 and has worked in public health and quality improvement for 12 years.

She now directs the care transitions activities at the Colorado Foundation for Medical Care including the care transitions QIO support contract that you'll hear about today, the local care transitions project in Northwest Denver in a geographic variations special study.

Cathie Berger who will follow Dr. Brock and Alicia is the Director of the Area Agency on Aging at the Atlanta Regional Commission. She is responsible for planning and administering the delivery of aging services provided through public and private funding in the 10-county Atlanta region.

She provides leadership for the development of systems for the aging services network including the age-wise connection that serves as the Atlanta aging and disability resource center, a statewide aging resource database that serves as a national model and a comprehensive care management system.

Our final speaker today will be Abigail Morgan. Abby is a Social Science Analyst with the Office of Policy Analysis and Development here at the Administration on Aging and in her work she focuses on technical assistance and partnership opportunities available to the network within the Affordable Care Act.

She has a Master's in Social Service and a Master's in Law and Social Policy from Bryn Mawr College so with that, I will stop talking and we'll turn things over to Dr. Brock and Alicia to begin our presentation. Thank you so much.

Alicia Goroski: Thank you, Marisa. This is Alicia Goroski and I'm actually going to start and go through the first few slides and then Dr. Brock is going to finish this up so the care transitions theme and I'm actually on Slide - we're on Slide 3, 3 to 4 - that's great, okay.

The care transitions theme is a CMS-funded subnational project that is part of the QIO Ninth Statement of Work. QIOs responded to a request for proposals in which they identified a community that they wished to work in in their proposal and CMS selected 14 communities in 14 different states that are working on this.

This project - there were five steps to this project - the first is to define your community then the QIOs identified service patterns using root cause analysis and data sources that are associated with readmission then the QIOs recruited and convened providers and partners in the community.

This was very different - this theme was different - than much of the past QIO work in that many, many of the QIOs reached out to non-traditional partners in the community and in many of the communities AAAs, ADRCs were part of the community in the care transitions theme.

The goal of this project was to reduce 30-day rehospitalizations for Medicare fee-for-service beneficiaries who reside in the community. Each community was defined based on a list, a set of Zip Codes, mostly continuous Zip Codes.

So again, the QIOs in the community were charged with reducing readmissions and improving care transition for those Medicare beneficiaries who lived there and the QIOs in the communities used evidence-based interventions and tools to accomplish this.

Next Slide 5, so the title of this slide is CMS Claims Data but it really could just be and other data source. The QIOs are very fortunate. We have access to CMS claims data so that was very, very useful in setting-up this project to determine where the readmissions were happening.

And again we found that it was very different from community to community. In some communities, 40 to 50% of the readmissions were coming back from nursing homes, skilled nursing facilities.

In other communities the majority of readmissions were coming from home so those patients who were discharged home without home health services were accounting for most of the readmissions in that community.

So the CMS claims data were very useful to kind of see what that starting point was. They were also ideal as a recruitment tool so QIOs were able to

take data to the providers as they were recruiting them. It also helped each community set a common target and speak in a common language.

So again the goal of the project was to reduce readmissions for the community so we were able to go out and, you know, be talking the same language to all the providers in that one of the measures was readmissions per 1000 fee-for-service Medicare beneficiaries who live here so, you know, everybody was able to kind of have that common vision.

Other types of data and we're going to talk in greater detail about root cause analysis and medical record reviews, almost all - well, every QIO - used those and also the use of single stories was extremely motivational in this theme.

And often times so this is actually something that you could get from CMS claims data. The QIOs do have a program that analyzes Medicare claims data and kind of tells the longitudinal story of what happened to a patient.

But in almost all of the studies, the QIOs found that when you bring providers together, everyone has a story to tell whether it is a patient that they were part of their care or a family member.

And those stories are extremely motivational for bringing people to the table and getting agreements to work on this effort so one of the other things that we did not use, however, we have just recently I credit Jane Brock with this is we think moving forward single-day prevalence studies would be a fantastic data source to use for this project.

So an example of this is and there used in Europe a lot more than they are here but so an example would be you could have each of your hospitals count the number of readmissions that come through their doors one day so pick a day.

Let's say April 15th and you're going to have all your hospitals count the number of readmissions and then publicize that. As of April 15th, 2011, these hospitals had 52 readmissions. Then do it again in six months and, you know, so you could also do this with nursing homes.

Have your nursing homes or your home health agencies count the number of readmissions so we think that would be a very powerful tool and it doesn't rely on CMS claims data. It just relies on a simple people counting.

So moving on to Slide 6, this is a graphical representation of a tool that a few of the communities found very, very useful in recruiting providers and really getting the providers that shared the most transitions to partner-up together so what this is actually a portion of the care transitions communities and I know you cannot read things. That's fine.

The graphical display in the upper left-hand corner actually shows all of the transitions, all of the transitions among providers for this subset of the community. The middle diagram figure is based on those providers who share 10 or more transitions so and you can see that some of the color - the lines - are red.

Those indicate transitions with a lot of readmissions so a lot of back-and-forth between those providers and then the figure down at the lower right-hand corner with fewer spokes kind of reaching out is showing providers who share 30 or more transitions.

So you can see how useful this would be if you have a community meeting of your providers to show this and of course this is de-identified but in theory each hospital would know who they were and Hospital A could then say wow,

who is (sniff) CC? We really, really need to be working with that nursing home and figure out what's going on here.

So again, this is just one of the tools that some of the QIOs found very, very useful in this work. All right.

Jane Brock: Okay, so I'm going to talk. This is Jane Brock. I'm going to talk a little bit about how we did root cause analyses so it was actually kind of a core component of our projects that we based interventions - actual interventions - that were delivered to patients on local root cause analysis.

So you know, the peer review literature is a great place to start but there's nothing like the power of saying this is how it really goes right here so we did root cause analyses based really on two-and-a-half specific methods.

One was very helpful was going into hospitals and reviewing medical records of readmission cases so QIOs are allowed to review readmissions records so we could go in and just pull all the readmissions as well as the previous discharge documentation and start to look at what we thought were common, you know, possible common issues that could be targeted by an intervention.

So we looked at the first hospitalization discharge, services provided in-between and then the readmission record. Oh, next slide, sorry. I was trying to advance it.

So there are now a number of readmission review tools that are available. This is one, this is just sort of a sample of what we developed here at CFMC for our Denver project and the things that we wanted to capture in the readmission records and the discharge records.

So we were looking for things like presence of certain types of comorbidities, quality of documentation on the discharge summary, indications of what kind of teaching was given to patients, that sort of thing.

And we were very interested in whether or not the admitting personnel understood that it was a readmission and the degree to which they proposed some kind of different care plan based on knowledge that it was a readmission so this was really fascinating.

We learned a lot just from doing this and the feedback to the hospitals was pretty valued because, you know, reviewing records is time-intensive and so this was a service that our participants valued.

I want to say there is a wonderful tool that IHI developed. It's on the IHI Website, Institute for Healthcare Improvement and it is under the transitions home toolkits and it's a review tool that can be done by interviewing readmitted patients while they are in the hospital.

And I would say that in my mind that's the gold standard is to find out what people think about their readmission because in the end, you know, there are so many patient level factors that lead to readmission, you're never going to capture that from a record review. You'll capture it better from talking to people.

My belief is that this could be done - this kind of data could be captured - after discharge so for staff that is not going to be working within hospitals, I think that seeing the patient at home after readmission, you could definitely use some of these interview tool ideas to try to capture, you know, commonalities in people who have experienced recent readmission so next slide.

So in addition to the medical record review, we did a lot of process assessment so first of all we wanted to assess our original idea was we were going to do a lot of mapping of hospital discharge processes and we did do that.

But every time you tried to assess a hospital discharge process, you end-up having to learn a lot about the admission process as well so within hospitals we did a lot of process - admission and discharge process - assessment as well as admission processes to different, you know, to the receiver site.

So you know, one of the most problematic transfers that have been studied a fair amount through the QIO program is hospital discharge through skilled nursing facility admissions because, you know, often that's a 20-minute experience for the patients and yet the amount of paperwork and activity being generated by the medical service providers is extraordinary.

And it's complicated and that's often where a lot of things get lost so we did a lot of direct observation that's fairly time-consuming. Increasingly we are tailoring this method to primarily focus on interviews of process owners so meaning discharge planners, case-and-care managers and, you know, admissions coordinators at other facilities. Next slide.

So this is an example of some value stream mapping that we have done with providers. These tools are available through packages that are often labeled with the term "lean." They're really all based on Toyota production system models where you try to map all of the inputs into a process today.

What you don't want to find is what we have as an example in the current state map where you have so much complexity, you almost can't follow this process so process simplification is often a goal in and of itself.

Certainly visible portrayal of decision points and an understanding of the frailty of those decision points is another key thing that you look for in process assessments. Next slide.

So here's some examples of what we found. This is - actually some of you do process assessment and no doubt there are people on the phone who are real experts at process assessment - you know, you sort of have to decide how detailed you want to go into this.

So this is an example of a hospital discharge process that we observed that doesn't contain every step. It contains the main steps but the things to notice is not only is it fairly complicated but it has a couple of what you call nested loops.

So decisions where you go around in a circle and it basically say go back to start so these are processes like when a field nursing bed falls through or when transport doesn't come in time and some other receiving setting no longer can receive so then the hospital has to hold onto the patient for another, you know, another night. Next slide.

So this is a skilled nursing facility admission process and what we found the most fascinating was that there's a couple of loops in this that you can see and some of those loops are analogous loops to the loops the hospital goes through.

So when we tried to get people across different settings to come together to develop process, it's very useful to show them, you know, there's a lot of chaos happening on one side of this transfer that is just being mirrored again

on the other side and, you know, the goal here being to develop a mutual, more-efficient process so next slide so...

Alicia Goroski: Yeah, hi, this is Alicia again. Sorry, we're jumping back and forth a bit here so the next kind of tool or activity that the QIOs was group discussion so many of the QIOs had focus groups. That included beneficiaries; some were beneficiary focus groups. Others were provider focus groups so they may have, you know, done a cross-setting provider focus group.

They may have done a focus group just of primary care physicians in their community but both of these were tools to gather information about what would be useful so one great example of a beneficiary focus group, one of the QIOs did a focus group of heart failure patients.

And out of this they actually developed a tool - a phenomenal tool, a heart failure passport tool - that is now used through the community to help heart failure patients better manage their care so that's just one example.

The other are appreciative inquiry-style interviews which are very much interviews that focus on the positive and they focus on one step of this is dreaming so one of the things that the interviewee is asked is imagine a perfect system and how would that look and it's just a fascinating process for the answers you get and some of the things are actionable.

So, you know, it's just a great way to keep things positive as opposed to focusing on well, the reason this doesn't work is because across the street that nursing home never does anything right.

So again it just really keeps the focus positive and allows people who are actually touching these transitions to give great feedback as to how they would envision a better system. All right, and next slide.

Jane Brock: Yeah, the next one after that. We kind of covered that one so we wanted to say a few words about a community engagement so when you start to look at really a complex issue like hospital readmissions, it's very clear that you really need to convene a large number of parties to meaningfully affect this.

So certainly there are things that hospitals can do within their walls that are certainly helpful. I mean I would not discourage anybody from trying to straighten out their own internal process around discharge and admission processes as well as standardized communication but some of the issues there are very problematic.

And in the end we - all the QIOs - came to the conclusion that this really needs to be done as a community engagement project both to engage patients and to engage a wide variety of medical services and non-medical services providers so if you review the medical literature on how we do handing over medical responsibility, the answer is, you know, we're dismal at this so far.

So on this slide I just have aggregated some numbers from the medical literature so certainly there's a number of initiatives that are focusing on more timely production of communication materials by hospitals and specifically by hospitalists in order to get that information to primary care physicians.

We know that primary care physicians, there is a published comprehensive survey of primary care physicians; they - less than 20% of them - get discharge information concurrently with the discharge.

About 33% say that they're unaware of admissions at the time of discharge, much less the discharge so we know that communication to home health agencies is probably far lower than that.

Communication within our project to skilled nursing facilities sometimes can be fairly well automated clinical discharge information but skilled nursing facilities typically do not get functional assessment information which is often what they need.

In the best-case scenario in the medical literature was an electronic system that sent out discharge information to physician e-mails - e-mail inboxes - 86% had that information within 48 hours.

Well, you know, I'm sure that those of you in the aging network know this very well. There's a huge proportion of Medicare beneficiaries that are already readmitted within 48 hours and certainly within 72 hours.

So a lot of the process issues around straightening-out transfer of medical responsibility are going to be very, very helpful but in the end are probably not going to solve the problem entirely until we start to do really home-based outreach to patients so next slide.

So when we talk about - I always point out - that if you're a primary care physician, you can be "it" without ever being tagged. In fact, it happens all the time. You accept medical responsibility without knowing that you've accepted medical responsibility.

But no matter how dismal the communication between medical service providers are in terms of handing over responsibility, the person that's really it has been it the whole time, always will be it is the poor, elderly person who's

being discharge with a lot of information, a lot of plans to schedule follow-up, that sort of thing.

But really is it from the moment they roll out of the hospital door and so we need to be much, much more thoughtful about how we can be directly supporting self-management capacity. Next slide.

So in terms interventions including interventions that support self-management capacity, we published the table of interventions and the evidence behind them in the Remington Report about a year ago and it's an eight-page table where we went over kind of each element and the evidence supporting elements of patient support as well as transfer standardization.

And so I would encourage any or all of you to review that table just to briefly scan it and look for the components that your agency is already providing or would like to provide and think about how you can scale up those types of services within the opportunity brought by 3026 dollars. Next slide.

So the way QIOs went about organizing a community effort really involved - this makes it look simple, like there's four ways to think about it - in reality, most QIOs use some combination of all of these approaches.

So in the upper left-hand corner we often organize partners that share a lot of patients like on the social network analysis map so typically that would be a hospital with a very large receiver of their patients so this hospital and this home health agency, you know, they have 40 transfers a month.

We're going to start with this pair so in the communities, it's useful to think about pairs that need support. In the lower left-hand corner, a lot of

communities went right to what we call clusters which is the hospital and all of their receiving partners.

Let me just say we think, you know, just as a general word of advice that we think it's easier to match a lot of partners with a hospital in that what you really want is standardization of service packages and understanding of responsibility.

So, you know, all the home health agencies that receive patients from a hospital have an inherent interest in trying to standardize the way they receive that information as does the hospital. They need, you know, one obvious way to do things.

In the upper right-hand corner there were some communities that came together the best when all the hospitals started their process work together, all the home health agencies started theirs together and once they got standardization then they integrated.

And then we think there's a lot of benefit to trying to from the outset form a large multi-setting steering committee and certainly a multi-setting includes non-medical service providers, community-based organizations.

Because as I said before, medical service providers I don't think can manage this whole thing by themselves because so much of what brings people back to the hospital is not medical. Next slide.

So we always try to make a Top 10 list of what a motivated, you know, whoever could do so, so where we think a motivated community could start is first of all there has been tremendous benefit to somebody just identifying the

community, putting it on a map so say we're going to - our goal - is to reduce readmissions for people who live in these Zip Codes as pictures on this map.

Certainly we think QIOs have a lot to offer, especially having been through this project in terms of, you know, being capable of reviewing medical records and, you know, a lot of process assessment type of expertise.

Certainly we think that informal social networking has a huge role in how people get along and whether or not they work together so I think intentional promotion of oh, I don't know, a monthly care transitions breakfast meeting or, you know, cocktail party or knitting circle or whatever you think will work we think is probably a useful thing to think about.

Everybody needs a forum for routine information exchange and discussion of how it's going. You know, so often there is no mechanism for senders particularly and let me just say hospitals are not the only senders.

You know, people send to the hospital as well but often the sender gets no feedback about how it went so what you hear out in the community is oh, that hospital never sends me what we need.

Well you know, if that's the reigning opinion, that's a really difficult situation for the hospital to learn from. What they really need is a case-by-case review of that was really great, I got everything I needed versus here are the things I was missing when I got, you know, Mrs. Smith.

We think that hospice and (pay you) to care providers and properly incorporating them into the trajectory of care providers is exceedingly important and particularly for Medicare beneficiaries and then we think that

creating sort of community-wide maps of how transfers and transitions are going has been very motivating in our community.

So for more information, these are where you can go for more information about all of this so now I'm seeing questions. Shall I answer these questions?

Marisa Scala-Foley: Let's go ahead and I - let me - feed you the questions one at a time. First question that we have - first of all thank you for that presentation - so let's take a few minutes. We've gotten a few questions in that have to do with the content that you were providing.

The first one comes from (Gina) who asks what about those individuals who may have been discharged from one hospital but go to another hospital for the same condition as their readmission? How would you recommend going about locating that data?

Jane Brock: Yes, so this is where what we think - we've just been asked this question so many times - that it's great for us to have Medicare data so we can see all readmissions but most providers cannot and this actually was the reason I started thinking about these single-day prevalence surveys.

So if every hospital were on a single day and I don't know, if I was starting a project I would do this maybe once a month. On the first day of every month, I want everybody to count-up how many readmissions they have and what the readmission source was.

You know, was it a readmission from our hospital or another hospital? Name that hospital and get together and share that information so if everybody captures that, you could sort of construct your own social network analysis map of how readmissions among hospitals are gathered.

So yes, we realized that something like 24% of all readmissions are readmissions to a different hospital and I think that within an engaged community network, that's the way to start attacking that problem.

Marisa Scala-Foley: Okay, so the next question came from (Martha) who wanted to know do you look at readmissions within a certain timeframe?

Jane Brock: Yes, good question. I'm sorry. We should have included. Medicare is defining readmission as a 30-day readmission and certainly there are limitations to that measure and I think so however the final rule states is obviously how you have to use the 3026 dollars.

But within driving community improvements, I think there's usefulness to looking at very short readmission timeframes like, you know, what's your five-day readmission rate and there's usefulness to looking at readmission behavior in a community in general over a six-month period.

So that's probably beyond the scope of this discussion but it's worth having that discussion in your community.

Marisa Scala-Foley: And the next question comes from (Vicki) who asks do the tools that you were talking about check patients in observation status to see whether they were previously admitted and could really be a readmission or check new admissions to see whether they were previously in an observation status?

Their fear is that observation status will be used to avoid classifying someone as a readmission.

Jane Brock: That's an excellent question, yes, so we did not in this scope of work so we're in the last six months of a three-year project but going forward we will, yes. Those are excellent issues and they are absolutely true and we are worried about them. No, we don't have a tool for it yet.

Marisa Scala-Foley: Okay. The next question comes from (Melissa) who says home-based outreach or handing over medical responsibility as you called it in the slides, she refers to this as engaging, you know, the care team and wants to know if there are any tools that you know of that are available to patients and their caregivers or their families that can work toward that issue?

Jane Brock: Yes, so the tool that was the most widely used was the intervention that was the most widely used in the care transitions theme was the care transitions intervention which is a coaching intervention that coaches patients and family to increase capacity for self-management.

So that was the intervention that was widely used and you can find that information on the Website. That is www.caretransitions.org. That's Dr. Coleman's intervention. It's just we were asked to talk about root cause analysis and process of - anyway - but the intervention we used was largely coaching.

Now there are tools as well that you can use within the hospital that are pretty good we think for starting out real patient activation and really one of the best that the QIOs really liked was CMS' tool, the CMS discharge checklist.

So CMS has developed a checklist that goes directly to patients and families so from CMS to you the Medicare beneficiary and it is a list of thing they recommend that patients know before they leave the hospital.

It's available on the cms.gov Website. If anybody has trouble finding that, you can e-mail us and we'll - oh it's also on our Website - the link is on our Website so the cfmc.org Website.

Marisa Scala-Foley: Okay. The next question - bear with me for a second - comes from (Ishi) which I apologize if I'm mispronouncing your name (Ishi). The question is what software or application would you recommend for producing a social network map? Do you have one that you've used?

Jane Brock: You know, we don't. we subcontracted with Dr. Bill Mahoney who is a primary developer of the social network analysis method so he is working with the QIO in Washington - Washington the State - and he was the one that helped us produce these social network analysis maps and I don't remember the name of the software he used.

Marisa Scala-Foley: Okay. We can try to get that from you afterwards and provide that in the slides when we post them next week.

Jane Brock: Okay.

Marisa Scala-Foley: The next question that we have comes from - we're just going to take a couple more questions and we'll try to come back because we have two other presenters and I want to make sure Cathie and Abby both get their time - comes from (Ishi) who asks are preliminary results of the QIO care transitions program available at this point?

Alicia Goroski: Hi, this is Alicia and yes, they are so the preliminary results are very, very promising. We actually - as we also - one other aspect that we again did not talk about, we had the 14 communities. We also identified 52 comparison

communities so we matched the 14 communities to other communities that were similar in size and, you know, that type of information.

And so we've used those as exactly that, a comparison or, you know, what happened in other communities and the 14 communities have reduced readmissions per thousand by about 5% and again the range, I think the top performer is about 18% improvement on readmissions per thousand.

The other interesting thing that we've found is readmission reduction work is linked to reductions in admissions so we're also monitoring reductions in hospitalizations overall and again, there was a decrease and the decrease for our 14 communities was greater than the comparison communities.

Again if you're more interested in that, I would refer you to our Website. Jane and I did a - we have a - care transitions learning session forum. We did a learning session I believe it was December 10th - 16th - and we do have there's a PowerPoint as well as a recorded presentation with the preliminary results.

Marisa Scala-Foley: Great, thank you so much and for those of you who have questions that we haven't answered, we'll try to come back to those at the end of this but I do want to next turn things over to Cathie Berger who's with the Area Agency on Aging at the Atlanta Regional Commission in Atlanta, Georgia who will be talking about the Atlanta care transition initiative. Cathie, go ahead.

Cathie Berger: Thank you and let me begin by saying thank you for the opportunity to share with you how we in Atlanta are working towards developing a regional approach to addressing care transitions and then secondly want to share with you how the Atlanta AAA and the aging network supporting the goals of care

transitions and doing that by really beginning to make adaptations to our current service system.

For your information that Atlanta region is 10 counties and we have about 450,000 older adults and we are one of 12 area agencies on aging in the State of Georgia. Next slide.

Key to the care transitions work in Atlanta has been the - sorry, I'm just wanting to make sure that we're on the right slide, yes - and I want to go back if you don't mind go back to the previous slide. I'm sorry about that.

Key to the care transitions work in Atlanta has been the care transitions workgroup that was formed about a year ago under the leadership of Piedmont Hospital and this partnership includes major hospitals, the Georgia Hospital Association, home health agencies, home care providers, our QIO, our Quality Improvement Organization – the Georgia Medical Care Foundation, the Area Agency on Aging and other key aging service providers.

And we have been getting together for the purpose of bringing together everybody who really has a stake in care transitions for the purpose of sharing best practices, educating ourselves, professionals and consumers and to promote a common understanding of care transitions for the purpose of establishing a regional approach.

This workgroup I have to tell you has become the driving force sponsoring work sessions, training programs. We've had Eric Coleman here in the Atlanta region, some other key experts and also the workgroup does sponsor quarterly network meetings that really have provided for a lot of discussion and motivation for many of us to move forward.

It certainly has been one of the key factors that made the Atlanta Area Agency on Aging and the aging network move forward and the next slide will how you some of the goals if you could go to the next one that we shared, the shared goal of of course obtaining safe transitions and preventing the trauma of readmission, making sure that as an aging network we are supporting care transitions with the right services at the right time.

It is also, I have to say, our firm belief that care transitions does provide us a tremendous opportunity to bridge the gap that still exists between the acute care and the long-term care systems and to address that divide that we have between the delivery of medical care and community support services. We see this opportunity.

We feel we have to move on it right now and then finally we share the concern over the large number of Medicare recipients. We know it's 20% who are rehospitalized within 30 days of their initial hospitalization and the urgency - we share that urgency - to reduce the staggering cost of readmissions that could be avoided with proper attention and support.

In the next slide you see our Atlanta care transitions framework. We developed this with input and guidance from the workgroup and it really shows how the community-based system supports transition work before and after hospitalization.

It also shows the key care transition activities as defined in the pillars of the Coleman model and those include in the next slide the approach of and the method of medication self-management. Of course the knowledge of warning signs and sometimes the follow-up methods to physician or other medical appointments and the use of the personal health record.

And then we have been putting much attention on the whole issue of clear communication with a patient and caregiver using Coleman's teach-back method to ensure understanding of the transition plan and of the whole process. Next slide is really where we want to talk to you about the aging network.

And in Atlanta the aging network, the ARC, the Atlanta Regional Commission aging network really includes the Area Agency on Aging and 20 aging services contract agencies providing a wide range of older Americans at state and locally-funded community-bases services and also our Visiting Nurse Health System that we contract with to provide the Medicaid waiver care coordination.

As care transition partners, the aging network has begun by integrating the Coleman approaches of care transition in our daily work beginning when older adults of the families first call for information or resources, when providing assistance in managing their care, in the delivery of services and ensuring that clients and their families know what to expect when they go into the hospital when they are discharged.

Beginning in the next slide with our first approach, in our information services that we provide as an aging and development resource connection, we are incorporating care transition protocols into the information counseling services we offer.

We handle over 70,000 calls per year with older adults and their caregivers seeking information about long-term care service options and many of the individuals that call us are either in the hospital or been recently hospitalized for an acute healthcare need or they are caregivers calling on behalf of such individuals.

So what we've done by using care transitions protocols and training staff, we are asking the right questions that are focusing on their transition from hospital to home. We also in that interview in our options counseling interview are looking what are the support options available and at all times of course empowering consumers to make their own choices.

We provide educational materials either via sending it by e-mail or mailing it and we are making sure, reminding them about the importance of their follow-up visit with a physician and at the same time we are really tracking those calls to find out what is happening to the individual once they get home.

In the next slide you will see some of the protocols that we have put together - actually the list of questions - and just looking at Number 5, we ask the individual do you know what the warning signs or red flags are for your condition and then we do a little bit of probing.

Tell me what you were told to watch for and report. We do this on so many of those items that come to us through the Coleman model to make sure that we are coaching the individual along and really making them aware of what their responsibility is and how they can possibly make a difference in making a successful transition home.

In Slide 30, the next one, we really go beyond the information counseling service. The Atlanta AAA supports through contracts with local country aging programs and community organizations care management services to more than 7000 frail older adults and persons with disabilities.

Visiting Nurse Health System, the agency I mentioned before provides care management to approximately 2700 of those individuals through our

community care service program that the Georgia Medicaid waiver program and has led the way by incorporating care transitions into their care management responsibilities.

Care managers are making sure that the individuals transitioning home and their caregivers understand their transition plans and instructions. They make sure that they know what medications to take and when to take them, what red flags to watch for and find out if they are following-up with a medical appointment and if they have a personal health record.

In the next slide you will - let me also say that it's very important that the care manager also makes sure that the home and community-based care plan - that community care plan - that they are helping the client with that it works seamlessly with the transition plan, that it supports the transition plan.

And they also make sure that all the information that has to be shared with the client, with the individual, with the other providers is passed on in a timely manner and then they are tracking hospitalizations. In this slide you can see how the care transition protocols have been incorporated into the various functions, the administration, the nursing and social work functions.

In the next slide just a few of the results that we were able to pull from Visiting Nurse Health System showing really what a frail population group we are serving. Out of the 2600 - nearly 700 - people, 31% were hospitalized, 26% of the population was hospitalized more than one time and several of them many more times during the year.

And then if we look at that 30-day mark, 22% of their population went back and were readmitted to the hospital. We're very much aware of these numbers and are looking how the care management process and the service system that

is available through the Medicaid waiver program can support and help make that transition safe and prevent the readmission.

Thirdly I would like to talk to you about the service delivery system that as a AAA we support through the Older Americans Act, the state and local funding and I think you're all aware of the home-delivered meals, the in-home services, the respite care services, transportation and adult daycare services that we do provide through our system.

We have for instance 44 senior centers that are available to older adults and we provide over a million meals to older adults in the region and then we have the second system which is the Medicaid waiver program providing the range of services listed on that slide.

However, what we have discovered and we can go to the next slide is the fact that our service system is challenged by long waiting lists - I think we all know that - and also by the intake processes that often focus on ensuring that the person in greatest need gets the service. Unfortunately, the unintended consequence is in many instance a cumbersome process that often delays access to services.

So in order to respond to the immediate needs of persons transitioning from hospital to home, we are supporting and will be replicating a pilot project implemented by one of our county aging programs in DeKalb County or DeKalb County Office of Senior Affairs that includes a care transition support package available within 24 to 48 hours after discharge.

And that package consists of one or any combination of the following services: the home-delivered meals, in-home support services, transportation and care management for 30 days.

That project has been implemented for several months and the initial pilot was over three months and was with five hospitals and they discovered that the average cost was $500 and for the people - the 54 people who came through the system - 16% were readmitted.

Now we are thinking - and not thinking - we are in the process of replicating this program in four additional counties. In the next slide what we show is for the 54 clients, what are the services that were provided that they chose out of the packet and you can see the cost for those services.

The dilemma we have is how do we provide this service at a reasonable rate at an affordable rate to the service system and also meet the immediate needs providing the family, the older adult and the service system time to put into place the needed services that may be required after this period.

As I said, we are expanding the pilot. We are working in four additional counties with hospitals. We are refining the tracking and care management procedures and we are beginning to look at how do we establish cost-sharing processes and how can we make this packet available on a fee-for-service basis.

Currently we are funding the packet through public funding using some federal, state and local funding to do that. Slide 36, the next one is our last effort that we have underway right now and it is our approach in which we want to get to people before they are admitted to the hospital or emergency room.

With the help of Piedmont Hospital in our care transitions workgroup, we've developed a special consumer education program and it's called How to Navigate the Healthcare System.

You can see what's included - some of the major topics included - in this educational program and we are implementing it through our Retired Senior Volunteer Program. Last year we trained 40 volunteers, gave 77 presentations and with the pre and post testing we know that we are being successful in transmitting critical information.

We do think it is critical for us to get to individuals before hospitalization, to empower the patient, the person who is going to face many serious decisions and has to know what happens when they get out of the hospital, to ask the right questions and to be prepared for that process.

So in summary, we think that our established community-based infrastructure and the models we are designing and implementing position us well to partner with hospitals throughout the Atlanta region and to achieve our mutual goals of safe transitions from hospital to home, bridging the gap between the medical and social service systems and ultimately reducing healthcare costs. Thank you.

Marisa Scala-Foley: Thank you so much, Cathie. We have a couple - we'll take just a couple - of minutes just to take a couple of questions that came in. The first one came in from (Thomas) who asks if adult protective services were also included in your working group.

Cathie Berger: They are coming. We have two individuals that are attending the workgroup and we would certainly see them as a very important part of what we are trying to achieve in a regional approach.

Marisa Scala-Foley: Another question comes in from (Anne) who asks how is the how to navigate the healthcare system program being financed?

Cathie Berger: We are doing that through the Retired Senior Volunteer Program. We were able to develop the program with the assistance of the workgroup and the Piedmont Hospital and we are taking it out through the Retired Senior Volunteer Program, the RSVP program that is funded through the National Community Service Corporation.

Marisa Scala-Foley: We got a question in from (Dan) who asks the 70,000 calls that you mentioned on an earlier slide, are they all related to discharge or is that INA calls overall?

Cathie Berger: No, it's I & A calls overall. We are just starting to pull out the calls as they come in that are related to discharge.

Marisa Scala-Foley: Okay, and another question from (Nora) who asks if the Atlanta care transition workgroup also works with private geriatric care managers, for-profit home care agencies, pharmacies and family caregiver groups?

Cathie Berger: Yes, they are all participating in the workgroup. The workgroup continues to grow and all those entities have been and individuals are part, the pharmacy group, I just remembered the last session they were very much a part of the discussion.

Marisa Scala-Foley: You know, and we got a couple of questions related to sort of electronic health records and so forth so let me ask those and these can either be for Cathie or for Jane and Alicia so whoever feels like they want to answer, go right ahead.

The question from (Melissa) was she was curious as to why Dr. Coleman's approach is all paper-based and if there's any connection between these programs and electronic health records at the hospitals. I don't know which of you wants to take a crack at that question.

Cathie Berger: I'll let the other two go first because I'm not sure.

Alicia Goroski: Thanks, Cathie, this is Alicia so the care transitions intervention is built around a coach, a care transitions coach which is a person who is not a health services provider. The coach's job is to activate the patient.

The coach is there to empower the patient, not, you know, to be a medical services provider so it's a little more than paper-based. The model includes five interactions between the coach and the patient.

The coach typically meets the patient while they're still in the hospital prior to discharge then the coach goes to the patient's home to do a home visit within 72 hours of discharge, preferably within 48.

At that point they go over the - there's a personal health record - they talk about red flags associated with the patient's symptoms or disease. They also talk with the patient about the importance of follow-up care and so then the coach follows the patient.

They have three more phone calls over the course of four weeks so it is very much a patient-focused intervention and no, there are no cases that I know of where it actually interacts with electronic medical records.

So I do know that some of the regional health information exchange, you know, work, the rec, the regional extension work and some of the beacon communities are trying to incorporate some care transitions work with electronic medical records and some of our communities had a little bit - worked on that a little bit - but in general it was not highly utilized.

Marisa Scala-Foley: Okay, I think I'd like to get to - we did get a couple of more questions - but I'd like to give Abby a change to go and do her presentation and then we'll come back and we'll not only open up the audio lines but we'll come back around to the remaining chat questions so Abby, why don't you go ahead?

Abigail Morgan: Thanks, Marisa. I want to start off my presentation by initially saying that we're going to take a little bit of a step back and look at data sources to initially target your efforts for new care transition work.

There are a number of data sources that are publicly available to help examine needs and resources in local communities. As we've heard throughout the presentation in many respects this care transition initiative will require data from and information beyond what your organization might collect from current providers or individual service recipients.

So to begin with what we know based on the legislative language, there are some key definitions under Section 3026. The provision references the need for partnerships between a hospital and a Community-Based Organization or CBO.

For our purposes, the legislation defines those entities as one, a Subsection D hospital identified by the Secretary of HHS as having a high readmission rate, by Subsection D that includes hospitals within one of the 50 states or D.C. that

is not considered primarily to be a psychiatric hospital, rehabilitation or children's hospital or a hospital primarily providing extending stays.

The legislation also defines high readmission rates under Section 3025, the hospital readmission reduction program. It's a fairly complicated definition with mathematical formulas that I'm not going to try and tackle here.

But then at the other end of a spectrum for community-based organizations, they're defined as appropriate CBOs that provide care transition services across a continuum of care through arrangements with partnering hospitals and whose governing structure includes representation of multiple healthcare stakeholders including consumers.

So for this presentation, I'm going to focus most of my time on data sources that will help community-based organizations to begin to identify and target local hospitals.

Looking at Slide 40, in addition to examining what your community populations look like, your partnerships, community service providers access to networks where there may be some gaps in resources, it will be important to understand what your potential or current local hospital partners look like.

When looking at hospitals as community partners, it's helpful to understand their structure, what services they provide, what the data about the hospitals show. Earlier this afternoon we heard some great information about the QIOs, the quality improvement organizations and the access they have to claims data and the role QIOs can pay as valuable partners in care transition work.

An additional easy first place to also start can be the Medicare hospital compare Website. We've been encouraging beneficiaries to use this public

user-friendly Website for a few years now as a place to compare and learn more about services and quality within hospitals.

As shown on Slide 41, the landing page of hospital compare, there are a few links to note. Across the top there are two tabs for consumers and professionals.

For those who are a little less familiar with hospital compare, the consumer tab does contain some great tutorials but the professional tab provides some additional information about the resources related to the data used in hospital compare performance and quality measures. Finally at the bottom right-hand corner, there's a link to download the comprehensive database.

Moving to Slide 42, as you can see medicare.gov provides a public database warehouse that is available for download. From here you can select a specific database, check your computer system information that will allow you to examine the data and learn when the databases were last updated.

On Slide 43 looking at local hospitals, their structures and readmissions, we will use the hospital compare CSV or comma-separated values flat files revised format so it's the third download option from that page.

Or if you prefer, you can also download the database using Microsoft Access which is the first option on that page. Once selecting your database preference, the compressed or zipped files should download automatically and troubleshooting instructions are available from the Website.

Slide 44 shows a screenshot of the zipped file. There's a ton of information here that just is begging to be looked at but I do want to draw attention to five specific files. The PDF document provides a detailed overview of each Excel

file and the fields you will find in each workbook as well as information about the performance measures and the reporting periods.

The hospital CSV file lists all local general hospital information including contact information, provisions of certain services, hospital type and ownership structure and finally for today, highlighting the outcome of care measure files.

These three workbooks list separately the national, state and local rates for a 30-day mortality and readmissions rates. At the local level, you can easily sort according to state, city or county and that will allow you to target or narrow your search.

So skipping forward to Slide 46, I do want to make a note about readmission rates. According to MedPac, seven diagnoses make up approximately 30% of spending on readmissions. At the top of those high-risk conditions are heart attacks, heart failure and pneumonia.

The readmission measures listed in the hospital compare database are risk-adjusted, all cause, 30-day rates for individuals discharged to a non-acute care setting so back to the community, home, personal care home, assistive living, nursing home that's not a skilled rehab with one of these three principal diagnoses.

For each condition, the risk-adjusted rate can be used to compare standards across hospitals and the formula calculations have been endorsed by the National Quality Forum. NQF is a non-profit membership organization including a wide variety of healthcare stakeholders.

They undergo a consensus development process for endorsing standardizes measures that is an open, transparent process with public comment and strict evaluation criteria.

So in summary, taking a look at this information is really just one step in identifying and targeting potential partners. We've heard a lot of information today about the multiple facets for strengthening or building a community approach to successful care transitions.

I do know that there are a number of hospitals that registered for the webinar today. In the resources section, I've included some additional Website information for hospitals that are looking to identify their local AAA, aging service provider or state-level office on aging.

The elder care locator is a public service sponsored by AoA that can provide detailed information about service providers, contact information, etcetera. Finally there's also a link in the resources section of an updated list of hospitals with higher readmission rates from the care transitions demo page of the CMS Website.

As we continue to move forward, I do encourage folks to check back to the AoA Website often. In addition to today's webinar materials, we will continue to add and update resources as they become available including toolkits, federal funding announcements, etcetera, and I think that's all I have for today.

Marisa Scala-Foley: Great, thank you so much, Abby. A couple of people did ask the question about whether or not the data that you mentioned - the hospital compare data and so forth and the readmission data - include the territories.

Abigail Morgan: I'm trying to...

Marisa Scala-Foley: I believe the readmission data did. I'm not sure about hospital compare.

Abigail Morgan: I do. I think I remember seeing Puerto Rico on there but beyond that I would have to get back to people after looking at it.

Marisa Scala-Foley: Okay, great. I think that was all the questions we had for you. I think let's take a couple of questions that came in for Cathie on chat and then we'll open up the lines for questions. Cathie, the first question came from (Lisa) who asks if the Atlanta hospitals are funding any part of the transitional support packages that you offer?

Cathie Berger: No, they are not. We are funding this on a very much demonstration basis to prove the value of that and also for us to really get the attention of the hospitals, to have something to walk into the door with so that they can see how serious we are.

I'm talking again about that divide that we have between the hospitals, the medical community and the community-based system so it's our way of saying here is our services then. We are willing to make the changes and once we have demonstrated it, we will continue to look at, you know, how can we market it to either the insurance community or the provider community.

Marisa Scala-Foley: Okay, and I believe also answered (Kate)'s question as well who was asking about how the coaching gets funded. (Jackie) asks what is the care-manager-to-client ratio in the waiver programs that you work with?

Cathie Berger: I would have to verify the client - the patient to - we have nursing staff and social staff in the Medicaid waiver program. I have that information in my office and I can certainly get back to you on that. I can provide you with that.

Marisa Scala-Foley: Great. We'll make sure to get that back to you.

Cathie Berger: I know that we have 11 RNs and 31 social workers and our current caseload is 2200 so we can work out the ratio for you on that.

Marisa Scala-Foley: Okay, great, so the question from (Anne) who asks how are your care managers notified of hospitalization or what is the referral process?

Cathie Berger: Our referral process is that the call will come into the ADRC. We are working out the referral process right now and they will make the call and we will put into place the packet.

Marisa Scala-Foley: Okay. Just look, scrolling to make sure. Abby, we got a question with regard to the data on hospital compare and (Catherine) asks is there any data on CMS hospital compare that indicates the numbers of discharged patients that may be going to nursing homes for long-term care?

Abigail Morgan: I don't believe that the data that's available on hospital compare actually notes where the patient is being discharged to. I do know that that is some information that I believe the QIOs have and is within the claims data but not available within the download database.

Marisa Scala-Foley: Alicia or Jane, do you want to add to that?

Jane Brock: That is correct. QIOs - that is in the claims data - but yeah, I'm not aware of it being on hospital compare either.

Marisa Scala-Foley: Okay, great, thank you. We got a question in from (Robert) and then we'll go ahead and open up the lines for questions so (Robert) asks - I think it's for Cathie - when you said that they make the call to the ADRC, is that the client or the hospital that makes the call to the ADRC?

Cathie Berger: The hospital but the client can also, the caregiver can also. We will take calls from everyone. As long as the person has been hospitalized, we will follow-up and put into place if appropriate the packet, the support packet and that's how they've done it in the pilot project.

Marisa Scala-Foley: Great, thank you and one last chat question from (Joanna) for Jane and Alicia. (Joanna) wants to know if the study - if your - the QIO scope of work showed a higher rate of readmission among patients for whom English was a second language. I don't know if you have that level of data.

Jane Brock: You know, we have not analyzed it at that level so and, you know, each community has analyzed things differently. I believe one of our communities has looked at that and it's a community that's about 80% Spanish-speaking and develops Spanish-speaking materials and did quite well, performed really well in the theme but nationally, I mean, over the 14 projects, we did not look at that.

Marisa Scala-Foley: Okay. All right. (Jacquelyn), I think we'd like to open-up the lines for any questions that others might have, if you could go ahead and instruct people as to how to go about queuing-up?

Coordinator: All right, great, so if you would like to ask a question, it is star 1 and record your name when prompted. Again that's star 1, unmute your line and record

your name when prompted. It'll take a few moments for those to actually come through.

Marisa Scala-Foley: All right, let's go through. While we're doing that, let's go ahead - I'm waiting for the questions to come through - let's go ahead and take a couple.

We did include some resources, slides in here related to not only care transitions including the Website for the QIO support center that Jane and Alicia talked about as well as a link to CMS' page about the community-based care transitions program and AoA's Aging and Disability Resource Centers and care transitions work that's going on.

We included a page on data sources that Abby talked about as well as some resources in general related to the Affordable Care Act including AoA's own healthcare reform page which is where the slides, the transcript of this webinar and the reporting will be posted in the coming weeks, hopefully be the end of next week but certainly before the end of February.

And finally before I let Jane see if there is anybody in the queue, our next training whereas this training focused on making the business case for care transitions in your community - or making the programmatic case, excuse me - for care transitions in your community, our next webinar will focus on making business case for care transitions work.

That webinar will be on Wednesday, February 23rd, also from 2:00 to 3:30 as this webinar has been and please watch your e-mail for registration instructions. It'll come in the form of a special AoA e-news. So with that, (Jacquelyn), do we have anybody in the queue?

Coordinator: We do have one question from (Marjorie Gamm). Your line is open, ma'am.

(Marjorie Gamm): Thank you. What are some of the ways that people have measured the success of care transitions other than just the readmission rates? Has anyone done more sophisticated types of analysis?

Jane Brock: So this is Jane. You know, we had several QIOs measure part of this as a contract requirement. We had to directly measure whether or not patient activation was improving and so, you know, that's the feature of coaching that leads to reduced readmissions.

So we had a number of the communities use the patient activation measure and if folks on the phone are not familiar with the patient activation measure, I would encourage you to look at it.

We think it's potentially quite a useful tool for understanding where people are with regard to self-management capacity and whether or not that is improving through these interventions. Is that the kind of measure you mean?

So aside from a utilization measure which is a proxy measure for whatever it is we really want to see, what we want to know is are we improving self-management capacity among the people we're serving.

(Marjorie Gamm): Thank you.

Coordinator: Thank you and again as a reminder, it's star 1 and record your name if you do have a question. I have no questions from the phone line so far but again, it is star 1 and record your name if you have a final question.

Marisa Scala-Foley: While we're waiting, we'll give it one more minute to see if anybody else queues-up but as I mentioned before, we do want to hear from you. We ask

that if you have questions or comments or suggestions for future webinar topics, also if you have stories about your agency's care transitions work, we would love to hear about them.

So please send them to affordablecareact@aoa.hhs.gov. As we've gotten lots of questions about getting access to the slides, we will post the slides, a recording of the webinar and a transcript of the webinar on the AoA Website on our healthcare reform page.

You'll see a button about that on the AoA homepage which is at aoa.gov. We will post those in the coming weeks, hopefully again by the end of next week. (Jacquelyn), anybody else?

Coordinator: I still have no questions from the phone line.

Marisa Scala-Foley: All right, with that then we will close things out. First of all we thank our presenters for a wonderful, stimulating presentation on making the programmatic case for care transitions work and we thank you all for joining us and for your wonderful questions on this topic. We look forward to having you with us on future webinars. Thank you so much.

Coordinator: Thank you for participating in today's conference. You may disconnect at this time.

END