Administration on Aging
Affordable Care Act Webinar
Care Transitions: Building the Business Case
February 23, 2011
2:00-3:30 pm Eastern

Coordinator: Welcome and thank you for standing by. At this time, all participants will be in a listen-only mode.

During the question and answer session, please press star 1 on your touchtone phone and please record your name clearly when prompted. Your name will be required to introduce your question. When recording your name, please make sure that your phone is off mute.

Today's conference is being recorded. If you have any objections at this time, you may disconnect.

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

Marisa Scala Foley: Thank you so much (Rico).

Good afternoon everyone. Good morning to those of you who are on the West coast. We thank you for joining us today for our third in a series of webinars, focused on opportunities for the Aging Network, both state and local agencies within the Patient Protection and Affordable Care Act, also known as the Affordable Care Act, or the ACA.

Our webinar today, Care Transitions, Building the Business Case, continues our discussion of the important topic of care transitions. Clients or patients going from one care setting to another, whether it's from hospital to home, from hospital to skilled nursing facility, from skilled nursing facility to home and more.

As we've talked about on earlier webinars, reducing avoidable hospital readmissions is a major focus of many provisions within the Affordable Care Act. Most notably, 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.

Now I want to say up front, the solicitation for the Community-based Care Transitions Program has not yet been released. But these webinars are designed to provide the Aging Network with the tools that you need to help to develop Care Transitions Programs in your community.

While the last time we focused on the programmatic side of initiating care transitions work, today's webinar focuses on the business side of this work.

As you'll hear from AOA's own Bob Logan and Costas Miskis, care transitions work provides you with the opportunity not only to examine your current business practices, but also to create a business plan that can help you to position better not only for care transitions work, but also for future Affordable Care Act related opportunities at the state and local level, such as accountable care partnerships with accountable care organizations, Medicaid health homes, patient-centered medical homes, and more.

An important part of building this business foundation is knowing what it costs you -- your agencies -- to deliver you services. And you'll hear from Ken Wilson, from the Council on Aging of Southwestern Ohio about their agency's experience in doing just that, and how it relates to their current care transitions work.

So before I introduce our speakers, we have a couple of housekeeping announcements.

First of all, if you have not yet done so, please do include the link - or please do - please use the link included in your email 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 some questions when you have them through chat.

As you heard the operator mention, all of you are in listen-only mode right now. If you don't have access to the link that we emailed you, you can also go to www.webex.com -- and I'll repeat that -- www.webex.com. Click on the Attend a Meeting button at the top of the page, and then enter the meeting number, which is 663033785 -- and I'll repeat that. The meeting number is 663033785.

If you have any problems at all with getting into WebEx - and we know a couple of you did have some problems during the last webinar, because of technical issues that we have on the WebEx side, we do ask you to call. We have a special WebEx technical support number this time, and that is 1-866-569-3239 -- and I'll repeat that -- 1-866-569-3239.

As you heard (Rico) and me both mention, all of you are in listen-only mode right now; however, we do welcome your questions throughout the course of the webinar. There are two ways that you can answer your questions.

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

In addition, after all of our speakers wrap up, we'll offer you a chance to ask your questions through the audio line. When that time comes, as you heard (Rico) mention, he'll give you instructions as to how to queue up to ask your questions.

If there are any questions that we can't answer during the course of this 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 email them to us at affordablecareact@aoa.hhs.gov. And all of the email addresses that I'm mentioning will be included in the PowerPoint slides that are that the basis for this webinar.

We also want to hear your agency's care transition stories, and also invite you to send those into affordablecareact@aoa.hhs.gov.

A couple last things. First of all is, as (Rico) mentioned, we are recording this webinar. We will post the recording, slides and a transcript of this webinar on the AOA Web site, under our Health Reform link as soon as possible, likely by the end of next week.

The recording of last - if you're looking for the recording of our last webinar, that should be up, hopefully, by the end of this week on the AOA Web site. Just click on the Health Reform button on the front - on the Home Page.

Okay. Finally now, I'm going - I'm thrilled to introduce our terrific panel of speakers today. First up will be AOA's own Robert Logan and Costas Miskis, who will discuss the business of aging.

Bob Logan serves as the Deputy for Regional Operations within AOA. He's worked in aging for 37 years, including in the nursing home industry as a direct service provider, and as head of the Area Agency on Aging in Cincinnati, Ohio. He also served as the Deputy Director of Operations and Membership Services for N4A, before joining us here at AOA.

Costas Miskis has served as a Regional Administrator for Region IV of AOA, under the Department of Health and Human Services, since 2005. Before immediately joining - or immediately prior to joining HHS, Costas served as the General Counsel and Director of Legislative Affairs for the Florida Department of Elder Affairs. And before that, he was the Deputy General Counsel and Chief Medicaid Counselor for the Florida Agency for Healthcare Administration.

And finally, Ken Wilson. Ken is the Director of Program Operations for the Council on Aging of Southwestern Ohio, from Cincinnati - in Cincinnati, Ohio. He's been with the Council for nearly 16 years.

Actually, it looks like it's your anniversary this month Ken; 16 years at the Council on Aging of Southwestern Ohio.

He holds a Masters degree in Gerontological Studies from Miami University.

And we are thrilled to have all three of them today to talk with us about building the business case for care transitions. So with that, I am going to turn things over to Bob and Costas to talk about the business of aging.

Bob, I think we're on the right slide, so I'm going to turn things over to you.

Robert Logan: Okay, thanks Marisa.

Our session objectives today will be the examination of current - your current business practices, examination of new opportunities. In the case, a transition - Care Transition Program and the challenges there will be in creating a Care Transition Program. Next slide.

Now who will benefit from this webinar? In developing a Care Transition Program, it's something you cannot wait for new resources to do. You can't - you have to do this now with your existing resources; is something you need to figure out; do it with existing resources and make it work.

So anyone who has ever said that an idea will not work because you've tried it years before, you need to pay attention, because there's a lot of negativity when people change and we need to combat that.

Anyone who uses the rationale that the state, their Board, or the order American - Older Americans Act will permit them to move forward or try something innovative, anyone who has used the phrase it's not in our budget as well, has the rationale not to improve or change. Or anyone who wants to improve the operation of the organization, this webinar is for you.

If none of these bulleted remarks apply to you, then you're in a good position develop a Care Transition Program. Sometimes our biggest obstacles to change are ourselves, our members of our organization. And because of the newness of this program and the - it's different than what we're used to do, we have to be open minded.

Costas?

Costas Miskis: Thank you Bob. And thank you Marisa.

Sometimes one of the biggest challenges we need to overcome with new programs is breaking free from our habitual way of perceiving things. You know, as renowned psychologist Abraham Maslow said in 1966, "It is tempting if the only tool you have is a hammer to treat everything as if it was a nail."

This diagram that we have up now represents the network structure we are used to, as created by the Older Americans Act. And while this continues to be our core structure, some of the new opportunities, including community-based care transitions, will require all of us to think about our focus and our processes in new and innovative ways.

Hopefully our talk today will provide some food for thought about whether something or other - something other than the proverbial hammer might be the best approach to a particular circumstance. Let me emphasize that this is not an either/or situation.

This diagram continues to be our core structure. And as we avail ourselves of new opportunities, we can and should do so in a way that ensures the long-term viability of our core structure and core services.

That said, I think it's important to examine our underlying assumptions and processes, so that our ability to avail ourselves of the new opportunities is not limited by inapplicable assumptions.

The most striking aspect of this particular diagram is the very rigidly defined roles, the fixed relationships, the prescribed services, and to a certain extent the captive audiences. This system has worked very effectively and continues to work very effectively for the services addressed by it.

However, when we look at new opportunities, like community-based care transitions, we need to be very aware that the same rigidity and predetermination does not necessarily apply. Next slide.

In the Community-based Care Transitions Program, there are no reserved roles for particular organizations. There are some preferences. But there are no reserved roles. In a sense, it is a first come first served kind of situation. The only caveat to that is that CMS has exhibited every intention of making sure that they enlist the best possible organizations, not simply the first to apply.

A better way to put it might be first and best qualified is the first served. But the bottom line is that every role will have to be earned.

There is also no rigidly fixed structure. We needn't get into the details here. But my point is that we need to approach community-based care transitions with much more flexibility and creativity than we might under the Older Americans Act.

There are also no captive audiences, where we're not the only game in town. And neither our business partner clients nor our service recipient clients are stuck on a waiting list, waiting for us. Roles will be determined by who steps up with the best quality product.

Roles will be determined by the ability to develop and nurture business relationships. And a little later on, we'll discuss developing partnerships and nurturing business relationships.

Success will be determined ultimately by the ability to deliver services in a manner that meets the needs of all the stakeholders, including our business partner clients and our service recipient clients.

Finally, it will key to be flexible, adaptable, and continually improving. I mean, the great news is that the Aging Network has the best possible experience and expertise to make community-based care transitions a roaring success. We just need to show the world what the Aging Network is capable of in this context. Next slide.

We'll start with the fungible services. One of the most important things you can do is make sure your focus is on the services as a product, but you are producing for essentially an open market. These are fungible services. Services that could be provided by a myriad of different entities.

Again, these services don't have to be delivered or coordinated by an organization that has a particular historical designation. The service delivery structure is being created from scratch.

The Aging Network has, like I said earlier, has the most suitable experience and expertise to provide those services. But we should never allow ourselves to become complacent or act as if we have a lock on providing those services.

Your operating approach -- you should recognize that the purchaser of the services has choices about where the services are purchased from. And we need to make sure that we keep them believing in the Aging Network as the best possible source, which it absolutely is.

Now bundled services. While on the back end -- in other words operationally -- we have to differentiate between different lines of service.

On the front end -- in other words, to our market -- we must think of services in terms of bundles that provide a total package, a total solution. The purchaser isn't necessarily interested in the inner workings of your operation. What they're interested in is whether you can deliver a total package of services that they want to purchase.

An incomplete package of services would be a day late and a dollar short. We must be able to put together bundles of services that satisfy both the client and the business needs.

Robert Logan: Okay. Next slide Marisa.

Costas Miskis: Oh no. It's not next - hold on. We're still on the same one.

Robert Logan: Sorry.

Costas Miskis: Business partner process needs. Historically, the Aging Network's focus has been almost exclusively on the client, and perhaps also the care giving family.

In a program like care transitions, we need to make sure that we not only satisfy the client's needs, but also the operational needs of our business partners.

In care transitions, our business-partner client is the discharging hospital. For instance, right now a hospital can call a nursing home about a patient to be discharged. And the response they will get is -- just lest us know when you want to discharge the patient and we'll take care of the rest.

Notice there is no discussion about waiting lists, no discussion about being able to provide certain services but not others. And most importantly, the focus is on making the transition as smooth as possible for the hospital.

We must deliver that same ease of service and total package service that our competitors are offering our business partner. And as we design our processes, we must make sure that our business partner's processes are also given significant consideration.

The service-recipient client must be happy, and so must our business-partner client. We can't allow one without the other. It's all about those business relationships.

Now being responsive to demand, likewise it's important we design our service delivery processes in such a way that we can be responsive to demand. We've got to be - we have to be careful not to fall back on the grant-based mentality of the fixed amount of funding for a fixed number of clients and nothing changes until the next grant cycle.

We must plan for the eventuality that demand may increase beyond our initial expectations. We must build in a process for scaling the delivery of services to

the demand that develops. As I'll discuss in a moment, that increased demand will come with a proportional increase in funding, so we need to make sure our plans are not so rigid that we don't allow room for scaling up. Flexibility and responsiveness must be our motto all along, all through this.

Now cost plus pricing. Setting prices for our services is critically important, and it's really a balancing act to a certain extent. But the good news is that the pricing should be guided by the market value of those services.

Remember, you're providing a fungible service on an open market. You should price your services at a competitive market rate. And your goal should be to ensure that your costs are such that when you are paid the market value of those services you are left with a margin, not just covering your costs, but cost plus.

In the private sector, that might be called a profit. Many in Aging Network might call it a margin or a surplus that could be used to augment other programs you offer. This may be an unusual concept for some organizations in the Aging Network. And you may need to address some of these issues with your Board of Directors.

Remember that you may be a not-for-profit, but that doesn't necessarily mean you have to be a non-profit. It's just a matter of plowing profits, or margins, or surplus back into the organization to provide services.

Economies of scale. Scale will be critically important for the success of the organization. While serving two or three clients would be good and important work, serving so few would likely be operationally unsustainable. It does no one any good to operate a program in a way that is not sustainable in the long-term. It's critically important that you run the numbers to scale.

In other words, what do the numbers look like if you're serving 25, or 50, or 100, or 200 clients? Running the numbers also helps put your margins in perspective. You know, a margin that may look anemic on a single service starts to look very robust when it is multiplied by 50 or 100 per month.

It's that scale that will give you the resources to cover your expenses and create a surplus. It's also that scale which ultimately will make programs like care transitions outshine most grant programs that we're used to.

Finally, client needs. Nothing that I've discussed here should detract from meeting the service-recipient client's needs. The client's well being is our ultimate and most important goal. There's no question about that.

What I've discussed is intended to make sure that the program is sustainable, and that the client truly gets the benefit of the Aging Network's experience, expertise and commitment. The value of the Aging - the value that the Aging Network offers will only benefit people if we're engaged and we're competitive. It won't matter how good we are if we don't step up or if we aren't competitive.

I, for one, have every faith that the Aging Network cannot only adapt to these new programs, but can execute them more effectively and successfully than anyone else out there.

Bob, you want to take the next slide?

Robert Logan: Sure. Something I think it's important before you start developing a business plan is to ask yourself what direction would you take if you owned your own

business, you are running, or managing. You should ask yourself the following questions.

Would you be operating your - the - your current business with the same staff? Would you be headed in the same strategic direction? Is your strategic mission driven by data and community need, or by grants and funding sources? Would you be committing more of your time and energy to - into the business operation? And would you be more aggressive in developing funding sources?

I think at times we get stagnant in our approach to operating our business, or it's easy for us to operate it the way it was always operated. But these are times that are demand change. Next slide.

Do you know your care transition market place? Who are your potential customers? Does your current mission restrict you from serving the under 60 population? If so, do you need to change your mission statement?

Keep in mind the Older Americans Act does not prohibit you from serving the under 60 population if you use other resources.

Who is your current or future competition? Do you know who they are or who they - who your future competition may be? This is a very competitive service -- care transition -- and you'll have to deliver high quality, competitive service.

What must you do as an organization to prepare for a new opportunity? Creating a Care Transition Program is a major change for your organization. You'll have to change your current business practices or strategic direction. This cannot be done overnight. You'll need to commit the time, and manpower, and resources. Next slide.

How do you do that? Well first of all, you create a strategic vision to create a Care Transition Program. I would suggest you need to sit down and brainstorm with your Board or key staff and strategic partners, and brainstorm on the direction you want to go.

Depending on how far you are along in your initial meetings, you might decide what partners you need to include and discuss why. Your part - your possible partners would probably include hospitals and community-based organizations. Do research on Care Transition Programs and discuss areas of your expertise and weakness.

Possible partners could be brought in to help fill service gaps in your organization. Examine the way you are currently doing business. Decide what changes you're going to need to make, and then choose the partners you need.

One simple cultural change you can make immediately is change the name of your case managers or care managers to option counselors. Create a business plan and develop a roadmap for change. Next slide.

In order to create a business plan, you have to know where you want to go to do a care - to create a Care Transition Program. Some of the most - the biggest characteristics are it's fee for service. Understand your product and cost. You can't be open 35 or 40 hours a week. It's a 24/7 business.

In choosing your strategic partners, some partners might be open longer or 24/7. They could take on this role. This is something you have to decide.

You can't be afraid or ashamed to make a profit. Profits can fund other services in your organization. And you have to know what your costs are. Not

only do you have to be profitable, but you have to be competitive and make timely, strategic decisions.

The question you need to ask yourself is -- what does your organization need to do to model the above characteristics and develop strategies for a business plan? Next slide.

Doing a business plan will take time. This is developing an operational roadmap for your organization. Creating a business plan will change the way you are currently doing business. You might say -- I can't afford - we don't have the expertise to do this; we might not - we might - we can't afford to go through this process.

Well bringing in a consultant to help you do a business plan is advised if you need help. Also there are foundations or philanthropic businesses out there that would provide someone to help you with a business plan, or with the foundations to even help pay for a consultant.

Seek hospitals in community-based organizations as partners that will mutually benefit from your strategic vision. A number of triple As that have gotten into this business started out by putting hospital employees and leaders on their Boards to start the dialog. This has been very effective.

Do not be afraid to tackle insurmountable issues. Think out of the box. You are not alone. Utilize your partners. The partners that you choose should need you as much as you need them, and you should mutually benefit. Next slide.

Include your partners in the development of the business plan. Monitor your business plan and make adjustments. Develop a confident attitude and a willingness to change if roadblocks occur.

Remember, you never make a bad decision. You never put together a bad plan if you monitor it and you change as you go. There's no such thing as a plan that's written in stone. They're made to be changed and they need - they're made to be adjusted.

Costas?

Costas Miskis: Next slide.

If there's any illusion that the skills and the processes that you're going to develop for the Care Transitions Program are only applicable to the Care Transitions Program, I just wanted to have you take a look at this pie chart.

It gives you an idea of how much funding and resources there are out there that are seeking long-term care supports and services. And that a lot of the skills and processes you are going to be develop though care transitions are transferable to a lot of other payer sources.

For instance, the economic value of informal care is estimated at over $257 billion a year annually. So this may just be the tip of the iceberg, as far as some of these processes that you're developing, and you should keep that in mind as you go forward. Next slide.

As we've discussed on numerous occasions in the past, there will be many opportunities for the Aging Network and the Affordable Care Act. And as the Community-based Care Transitions Program will roll out shortly, so will other programs roll out in the coming months.

And as those programs are developed, you can fully expect your regional AOA office to provide information and guidance that you can use to participate in those opportunities. Your AOA regional office should be your key partner in navigating these programs as they come out. Thank you.

Marisa Scala Foley: Okay. Thank you so much Bob and Costas. I think before we turn things over to Ken, we've gotten a few questions in through chat. And lets take a couple of minutes to go through some of those.

The first question we got was from (Peggy) who asks - and I think this was part of what you were talking about before Costas; about sort of just because you're a not-for-profit doesn't mean you can't turn a profit.

And (Peggy) asks, "If you're a part of local government, can you actually ask market price since some of your operation is funded through taxes?"

Costas Miskis: Well, I mean, clearly, you will have to talk to your legal counsel and your governing body as to what you can and cannot do. But I would suggest that if you've designed this program correctly, you should be only using CMS funds to run this program.

Your processes and the way you deliver the services should be designed in such a way that the payment you're getting from CMS covers those costs. And you shouldn't be needing to use local tax money, for instance.

Marisa Scala Foley: Okay. Our next question comes from (Wendy) who asks, you know, "When we - when you talk about bundled services, how do you avoid - how can you make sure that that's person-centered? And how do you avoid sort of prescribing services that individuals are to receive, and then fitting them into that predetermined set of services?"

Costas Miskis: Well, I mean, it should always be client/client centered. The point is that when a client is being discharged from a hospital, his or her treating physicians will have determined that a certain set of services are necessary for this individual.

And my point was simply that it doesn't do the hospital any good if the hospital decides that this person needs three services, or say four services when they return to the community, if we say to them -- well we can provide two of them.

My point is that we need to provide that complete bundle that's based on what the client's needs are, rather than a partial bundle.

Robert Logan: And you do that through partnerships.

Costas Miskis: Absolutely.

Marisa Scala Foley: Okay. We got another question having to do with sort of how do you keep - how do you sort of match sort of staffing and your ability to provide services with demand? And here was the question and the statement.

"I see demand for services provided in - under care transitions having huge demand, but the ability of providers to provide the services being limited to the number of people available, the number of staff they have, and so forth.

You know, how can agencies deal with that challenge of sort of having staff, you know, existing staff available, and then - and meeting - and yet meeting growing demand for these services?"

Costas Miskis: Well, I mean, your staffing costs should be covered by the payment that you're receiving under the Care Transitions Program. And that's perhaps one area where your margin or surplus can come into play, where you build in a slight excess capacity, so that you can absorb excess capacity.

And as that buffer starts to dwindle down, have a process set up to hire additional individuals, and train them, and have them ready to go.

So, you know, unlike a grant program, where you're given X number of dollars for a position and that's what you get, with a sort of a fee-for-service type situation, like care transitions, you build in the costs into the way you're running the program. And use the money that you're receiving for each client or each patient to cover those expenses.

And as the demand increases, you're getting additional funds, because you have additional fees for each patient you're treating.

Marisa Scala Foley: And part of this too, I think, Costas and Bob get to the point that you were talking about before with regard to building partnerships, you know, as you work with your local hospitals or skilled nursing facilities, you know, to set up some of this care transitions work.

Hospitals have - I'm fairly confident have good data in terms of the number of, you know, sort of discharges that they have on a - in a given day or a given week. And part of the planning process can involve, you know, some forecasting in terms of what this demand might look like.

Costas Miskis: Absolutely.

Robert Logan: That's right. And you don't have to do this alone. If you need more capacity, that's where your partners can help.

Marisa Scala Foley: Okay. We got - let's see. Okay. Just - sorry. Give me a second. Going - searching through some of these questions. Okay.

A question from (Vidia) who asks, "If hospitals are on the hook for readmission costs, why would they contract it out with such a big risk?"

How should - can the aging - if, you know, if you're an administrator, you know, you would - you might think you might want to control it yourself. How do - how can the Aging Network set themselves apart from, you know, services that a hospital might be able to provide on their own?

Costas Miskis: Well, I mean, for one thing, the Aging Network has unparalleled expertise and experience in this area. And with an existing organization out there with an existing delivery structure, it doesn't make a lot of sense for the hospitals to necessarily recreate the wheel. It's not unusual for them to subcontract out different functions.

And so the Aging Network is really the best possible position to offer a pre-packaged, ready to go, experienced network that can satisfy their needs.

Now that said, the Community-based Care Transitions Programs will not be a - the one we're talking about that's going to be released shortly - will not be a payment from the hospital to you. It's a payment by CMS through a system that is parallel to the Medicare payment system.

So in this particular situation, it won't actually be the hospital looking to hire someone outside, even though it will be a partnership between the

community-based organization and the hospital. But the payment is actually coming from CMS.

Robert Logan: In some cases that are happening now, hospitals who are partners also provide office space for options counselors to be on site, so that helps.

Marisa Scala Foley: Okay. Let's see. Just trying to see - okay. I think we got one more question in from (Robert), who asks, "How can this proposal - or how can community-based care transitions fit in with the functions of existing home care agencies?"

Robert Logan: Well...

Costas Miskis: You want to take that one?

Robert Logan: Yes. It depends on what the need is. I think when you develop partners, you develop with - develop them with community-based organizations. You figure out what you can do. And you figure out their strengths.

And when you bundle service, it's a combination of your options counseling and community-based services, and it's a package, so you'll work in tandem, all be part - providing the bundled service together.

Marisa Scala Foley: All right. One more question. What do you - someone else asks -- what do you do when you can't get the kind of trained staff that you need, whether it's internally or from partners? How can deal with that issue?

Costas Miskis: I mean, I'm sure Bob can...

Marisa Scala Foley: Particularly in terms of paraprofessional shortages.

Costas Miskis: I'm sure Bob can address that, but I will. It's just that maybe you need more and different partners, including local technical colleges and the like.

Bob?

Robert Logan: I think Ken can address this as well, because I know they deal with this in the Cincinnati area. But one thing I've discovered working out in the field is because of resources are lacking, the pay isn't as competitive as it should be.

And one thing I've found in my tenure as a provider with limited resources and then creating resources is that when you had money to pay for service, the providers, the capability and the professionalism of the providers increased.

That might not be the case in rural areas, but it's something that you have to work on. And as business grows with the Care Transition Program, so will the number of providers increase.

Marisa Scala Foley: Okay. I think we've come to pretty much the end of our questions that have come in through chat. So Ken, why don't we turn things over to you?

Ken Wilson: Okay. Thank you. I've been at the Area Agency on Aging for 16 years. And care transitions is new for us too. We have a program that's up and running at one area hospital, and are scheduled to implement in a second hospital in the next few months.

I'm going to provide you with our experience in designing and creating a business plan, and implementing care transitions, because we see this as an investment in our future.

During our strategic planning process a couple of years ago, we saw the need to be more aggressive with nursing home diversion in order to increase our effectiveness of moving the needle and rebalancing long-term care.

Marisa Scala Foley: Hey Ken, I'm sorry. We're getting a couple of people who are saying that you're a little bit hard to hear, so can you speak up just a little bit?

Ken Wilson: Sure.

Marisa Scala Foley: Thanks.

Ken Wilson: Our focus has been on moving seniors out of nursing homes. And this is a challenging task, as seniors who have frequently lost their home when they're in a nursing home and they've become dependent on the total care provided at the nursing facility. It made sense to prevent them from going to the nursing home in the first place, or to make sure that those who do go there are there for a shorter period of time.

And since 60% of all longer-term nursing home stays start with an acute episode from a hospital, it makes sense to start with the source, the people that are leaving a hospital. We determined that it made sense to make a staff - to have a staff presence in hospitals and to help seniors who are in the midst of a major transition of care.

The problem has been that we do not have a source of funding, and still do not have a dedicated source for care transitions. But we determined that we couldn't wait until money became available, because if we didn't provide the program somebody else would step in and do it for us. So we started care transitions by reprioritizing and using existing sources of funding that we already had. Next slide.

We formed a new department that is dedicated to nursing home diversion and transition strategies. And we did this through a reorganization that resulted in eliminating departments and positions and creating new ones.

We determined that nursing home diversion was a key to our future success and we needed dedicated staff resources for that effort. I had considered tagging it onto our existing care management function, but ruled that out after reading that - reading research that said it was difficult to be a care manager, and to be a healthcare coach, a transition coach at the same time.

I also realized that it was unrealistic to expect a lot of care managers going in and out of hospitals, because hospitals want a few dedicated employees who are credentialed at their hospital.

While we are doing - while we were doing the reorganization, we began having meetings with key hospital staff around town. Our goal was to communicate our value to them, to be seen as a good community partner, and to identify mutual goals and interests, and to understand their priorities and interests. We explained to them all that we do and the value and services that we bring to the community.

We were surprised that most of the hospital executives had very limited knowledge of community-based, long-term services and support, and were also unaware of the unbiased nature of our Area Agency on Aging. Many of the hospitals admitted that they had very little knowledge of what was available outside of the hospital walls.

And discharge professionals confirmed that nursing homes were their preferred discharge plan, because nursing facilities were a known entity and

they were seen as safe, easy, and they had a comfort level with the services that they provide.

We created our goal and our vision, which is to make community-based, long-term care just as easy and safe for hospital discharges as it is to discharge a senior to a nursing home. We still have a long way to go in that regard, but that is our vision for the future.

We also met with area health plans and educated them on the same things -- our shared interests and the value that we bring to the table. Because we see health plans as a possible future of source of revenue for care transitions. Next slide please.

This sums up why better care transitions are so important. It has a significant cost to our healthcare system, and patient and family satisfaction.

When we talk to hospitals and health plans, we made sure that we distinguished ourselves from vendors that they're frequently hearing from. We told them, "We're not here to sell anything. We also aren't just doing care transitions. We are providing long-term care consultations. We're options counseling to make sure that the patient understands all of their options."

Care transitions saves money from Medicare. Nursing home diversion and long-term care consultations saves predominantly Medicaid dollars.

We also discussed with them the financial impact on Medicaid and Medicare with the nursing home care, our shared goals, and also our shared goals of reducing hospital - re-hospitalizations and improving customer service. Next slide please.

Our motto, which this has been our motto within our care management system, and continues to be our motto with care transitions, which resonated very well with the hospitals and health plans, is to make sure that older adults receive the right care in the - at the right time, in the right setting, and at the right cost. Next slide.

We adopted the care transitions model developed by Eric Coleman. We are integrating this model into our value-added benefits of long-term care services and supports expertise, which includes access to home and community-based care, not simply having the client make an appointment with their primary care physician, but also making sure that they have the transportation to get there. Next slide.

We implemented our model at an area hospital with a trauma center and a high-volume emergency room. We later learned that we chose the right hospital, because the Center for Medicare and Medicaid Services recently released a report that identified them as having the highest readmission rate in the state of Ohio. Next slide.

Our initial results are very impressive. As you can see, the 30-day readmission rate for those who went through the program was only - is only at 5%, compared to 20 - the 20%, which is the benchmark rate. We are working on several opportunities to have this program externally evaluated by a university to provide more credibility for in the future. Next slide.

We've been working on developing several partnerships, and here's an example of one of them. One of our greatest challenges has been identifying when there is an admission to an area hospital by one of our clients in our care management system.

A couple of years ago, we began using a client ID card, which is shown on the bottom of this slide, that goes into a plastic sleeve with their Medicare card. The idea was when they pulled this out at the hospital; it is supposed to trigger an alert to the hospital and family that they need to call us. This has helped in some cases but has not been sufficient, because when they're in the hospital, there's often confusion, and there's a lot going on, and people just forget to make those contacts.

At the local hospital, we have been manually matching their admission list with our client list to find matches. That has been very - a very cumbersome process. And now we are working with a local health information exchange organization, known as HIE, that collects electronic medical records on hospital patients in all but one hospital in our five-country region.

We will begin sending them daily electronic rosters of all clients we are providing services to and that we have a release of information on. They in turn will send us automated alerts when someone - when one of those clients goes into an emergency room, is admitted to an area hospital, or has been discharged. This will initiate the care transitions intervention.

We believe that this partnership with the health information exchange will have bigger opportunities down the road for us, including enhancing communications with primary care physicians, and maybe even providing an electronic health record for the family and client to access. Next slide.

We have also established a partnership with two area universities that have provided us with a lot of help for - helpful expertise. One university has a medical school that provides a lot of healthcare experience. The other has a gerontology focus and has a health economist on staff. These two partners have helped us with grant writing, and are working with us to secure resources

to conduct an evaluation. All of this work brings more credibility to our project. Next slide.

One disclaimer that I need to make is that I am not a CPA. I am a program operator, an administrator, and a gerontologist. But I am not an accountant. So I'm going to provide you with a framework for calculating your costs to make sure that you don't lose money, because that's not what we're interested in doing either. And hopefully this new program can bring additional resources, as was described earlier, into your organization that you can use to expand our missions.

We are still working on our cost models and find - and finding funding sources to pay for this intervention in the long run.

On this webinar we have used the term bundling, which can mean a couple of different things. And I just wanted to make sure this is clear. In the managed care world, bundling is sometimes used to mean bundling services together into a capitated reimbursement, or in a risk-based environment. That's not what we're talking about here.

What we're talking about is bundling all the services and costs that are associated with care transitions into a fee-for-service program, or a cost-per-unit contract, that would either be through CMS, or a health plan, and maybe in the future with a hospital. This can be difficult to do with a service that you don't have a lot of experience with, which is the case with all of us.

In this - since care transitions is brand new, we have been very careful not to publicly quote a price for our care transition service, because it is still too new for us to understand all the dynamics and the costs that are associated with it.

We know from past experience with provider organizations that we work with that quoting a price-per-unit that is less than your actual cost is a recipe for financial disaster. Some say we will make it up with volume. Well that only works in very few cases with some fixed costs. But most of our - most costs that are associated with the service are variable and will increase as the volume increases; therefore, you need to make sure that your margins are correct.

And the way we're approaching is - this is that there are two pieces of cost information that are very important to determine.

The first one is what is your cost of providing the service? This is the most important thing to calculate, because you don't want to put yourself in a situation where you're incurring costs and don't have the funding to pay for them. This component of cost can be changed over time through greater efficiency or productivity. But generally, it's there because it's the cost of what it costs you to do your business.

The second piece of information is determining what the market will pay. This one is a little more challenging; however, it's very possible that this will be defined for us very shortly. If CMS comes out with a cost-per-transition rate, that will become the going rate that funders will pay.

However, other possible payers in the future we are exploring include the health plans and the hospital. It's also conceivable that there could be a private pay market out there as well in the future.

In order to determine what the market will pay, market research is needed. And usually this can be obtained by having a consultant, or an organization

that does social enterprise work, or other group or an individual with expertise in starting up a new business.

They need to understand the benefits of the product, which is care transitions, to the customer -- the customer being the health plan or the hospital. And they would share the results and the benefits with the customer and determine what they would be willing to pay for that service.

Another option could be submitting a bid to a funder that has solicited to help for that - with that service.

In the end, you want your price to be somewhere above your actual cost and at or below what the market is willing to pay, and it needs to be competitive. Next slide.

So let's spend a few minutes talking about calculating your fully allocated cost. You have both direct and indirect cost. And indirect cost being overhead or administrative cost associated with your program. And there are many ways to calculate indirect costs that are acceptable.

For example, it could be based on the number of FTEs or compare it with the total workforce. So for example, if you have a workforce of 20 and you have 2 FTEs, 20% of your indirect cost could be charged to that program. So there are several ways that that can be calculated, and that's just one example.

Here are some lists of some costs that you need to think about when you're building your bundled rate for both indirect and your direct costs.

Number one is staff salaries and wages. You also have payroll taxes and benefits, professional and consultant fees.

In our case, we're going to be building in our costs with the health information exchange into this line item. We also have travel, postage, office supplies, telephone costs, legal expenses, maintenance, insurance. And this particular item has generated from interesting dialog at our agency, because we're moving more and more into a medical model, which may change our cost of insurance.

Occupancy and rent, which could be calculated by the floor space the - or the number of FTEs that are within this program in comparison to all of your programs.

Printing and publications. So this could be some of the care transitions literature, such as the health record, the medication reconciliation documents, as well as options counseling paperwork that you are leaving behind with the client and the family at the hospital.

Communication costs, minor equipment and depreciation.

Marisa Scala Foley: Ken do you want to show that worksheet?

Ken Wilson: Sure.

Marisa Scala Foley: Would you like me to do that?

Ken Wilson: Sure. We have a worksheet that's in an Excel document that we've used with our providers when they're bidding on a unit rate for their - purchase a service contract. And this is an Excel spreadsheet where they can fill in their direct expenses on Column 1 for each of those items that I mentioned, and their indirect expenses on Column 2, which adds up to their total cost in Column 3.

And then building in any revenue, which I think in this case -- unless you have some other revenue that's coming in -- hopefully it will be paid in full by the CMS contract.

And you'll also have to build in your units -- an estimate of how many units you'll be delivering -- which then is divided into your total program expenses, to come out with a bundled cost per unit.

If we can go back to the PowerPoint, next slide please.

So when we talk about units, that deserves a little bit of conversation as well, because it's important to understand and have an understanding of how billable units will be calculated. And a lot of this has not been defined yet.

For example, will it based on the number of clients that complete the 30-day intervention? If that's the case, we have found that some hospital visits do not result in an enrollment into care transitions. And we have other attrition throughout the 30-day process.

For example, some people have cognitive impairment. They end up enrolling into hospice. They're in the intensive care unit or they may decease before they're discharged from the hospital. However, your program has incurred cost on these clients but has not resulted in a billable unit. And it's important to understand to make sure that all of the costs associated with the - with this are included in the bundled rate.

Our intervention includes a hospital visit, a home visit, and multiple phone calls, and documentation time, all of which will be included in our costs.

Other unit definitions could be hours of service, or home visits, et cetera. And that's not going to change your cost necessarily. But it would change the number of units you count into the cost of your program. Next slide please.

In closing, care transitions represents a huge opportunity for the Aging Network and the Area Agencies on Aging in particular. And the window of opportunity, I believe, to develop the product to meet the need is small, because healthcare is changing and changing quickly.

And there are many other competitors out there who will step up if we don't. So we need to make sure that we step up and demonstrate our value and become the care transitions leader in our local community, so that somebody else will not step into that role.

Marisa Scala Foley: Okay. Thanks Ken. We've gotten several questions in, so let's try to take these one at a time. Let me just scroll back up.

First question came in from (Sherry) who asks, "Do the transition coaches interface or interact with care managers in your agency? And how has your care management process evolved in response to the - to this interaction and in general in the development of the Care Transitions Program?"

Ken Wilson: That's a great question. And the answer is yes there is an interaction. And that's something that we've been working through over the last few months, because care managers have a shifting role, because many of them see themselves as being responsible for the client, even when they're in the hospital.

However, it's not practical or nor is it feasible for the care manager to carry, you know, a caseload and be in and out of the hospital, and be responsive to

that. So we've had to do a lot of education with our care managers about care transitions and about what the roles are, and developing documentation procedures, and procedures for communication, because there is a handoff between the care transition specialist and a care manager that needs to occur.

And a lot of our basic communication has been occurring through email. And then the more specific client issues are documented in our care management software system.

Marisa Scala Foley: Okay. We got another question in from (Donna) who asks, you know, "Can you explain a little bit more about the kind of staff positions and programs that you eliminated in order to create the new position or new department to do care transitions?"

Ken Wilson: Well that's - to give a full answer, that's a very involved conversation. But in short, what we've done is we've dropped - we've removed a layer of management essentially, and we've created self-directed teams. So we don't have supervisors that are supervising groups of care managers. They're now working independently. And the managers are seeing a larger number of staff.

We've also reorganized some of our administrative functions that were no longer needed and shifted roles around the organization. All of this resulted in us being able to free up some resources to make an investment in care transitions.

It was not an easy project by any means. But it was a necessary one for us to be able to do new things with the same or less resources than what we had to do something. And it was a very disruptive process at first, but we've come through it, and we're starting to see the results of that effort.

Marisa Scala Foley: Okay. (Robert) asks, you know, "Have you been able to get the hospital to pay for his services - for the services that your agency provides?" And actually, a similar question in terms of what the funding sources are to pay for the care transitions work that you're doing right now.

Ken Wilson: Well no. We have not - we do not have anyone paying for care transitions by itself right now. We are hoping, you know, the - in the future to have either CMS, or hospitals, or health plans pay for the service.

However, right now what we're - the resources that we're using were resources that were used for administrative functions previously, or care management services. So we basically shifted - made them - made this a priority and were able to shift existing resources to pay for this.

We've also, as I've said in the presentation, have been very careful not to quote a price, so we haven't been actively, you know, pursuing a contract with hospitals yet, because we want to make sure that we have a solid understanding of what our costs are before we enter into an agreement with them. Because once your prices are out there, it's hard to come back later and say -- oh, we messed up; we need to increase it by 20%, because we're losing money.

Marisa Scala Foley: Okay. We've got another question. I'm just scrolling through. Let me - bear with me for one second.

Can you talk a little bit about the services - the care transition services that you provide? What, you know, what services does your AAA provide to local hospitals in doing the transition of care?

Ken Wilson: Well our care transition specialists goes into the hospital and meets with the patient and their family, and also talks with the physician and the nursing staff at the hospital, and helps with the discharge planning.

So we're working on make sure that the patient is discharged with home care services, and also to make sure that the patient and their family understands their healthcare conditions, and their medications, and their need to follow-up with their primary care physician.

But most of care transition actually occurs outside of the hospital setting, because once they're discharged home the same care transition specialist goes and visits them in their home, and makes sure that they follow through with their primary care appointment, and that they have an understanding of all of the red flags. And if they see one of the red flags, they know what to do.

And also to make sure that their medications are reconciled, so they're not going home and taking their medications that they picked up during the hospital visit on top of the medications they're already taking at home. So a lot of the care transitions is it's client-focused. And it's about making sure that the client takes responsibility for their own healthcare.

But we're also wrapping them with supports of in-home, community-based care at the same time.

So from a hospital perspective, you know, this is about better and more coordinated client-focused discharge planning. And the hospitals have been for the most part very, very receptive to this. And they see this as an enhancement in their discharge planning process.

This is better customer service. And it prepares them for healthcare reform, which down the road will have penalties if they have a high readmission rate for the same condition.

Marisa Scala Foley: Okay, great. We've got another question in from - hold on one second. Just got another one in.

We've got a question in from (Maria) who asks, "What tactics did you find most successful in engaging the hospital that you're currently partnering with?"

Ken Wilson: That's a great question. We - it was really important for the hospital to have a complete understanding of the Area Agency on Aging. We weren't going in just saying -- with our product of care transitions. What we were going in with all of things that we already do.

And we made sure that we distinguished ourselves from being a vendor, because hospitals hear all the time from hospice organizations and home care agencies that are there to sell their product. And we made it very clear to the hospitals that, you know, we're - we have some shared goals here, and this is why we are different from a home health agency that may be talking to you.

And it's also very important to - in our presentations and conversations with them, what's in it for them. So we identified, you know, what is the value added for them, because at the end of the day, they need to see care transitions as something that's going to benefit them. And I already described some of those things, like customer service, and reducing readmissions because of healthcare reform.

I think, you know, some of the hospitals in the past weren't - probably were not as interested in this, because in a fee-for-service system hospitals, you know, actually make money by readmissions. But that's going to be changing in the future. And we found that there's a recognition of that and an interest in doing something different.

Marisa Scala Foley: Okay. I'm going to take a couple more questions, and then we'll look to do - talk about resources and our next training. And then we'll open up the lines for questions.

So we got a question in from (Joseph) who asks, you know, either for you Ken, or for Bob, or Costas. Are you including - do you all - are you all one of the chronic disease self-management sites? And do you include - if you are, do you include that -- the CDSMP services -- in the bundle in your bundles, right, for the hospital that you're currently doing business with?

And I know you said you're not billing the hospital right now. But would you include something like that, I guess, in the unit rate that you would be calculating?

Ken Wilson: Well in our case, yes we do have a CDSMP program up and running. But we have not and are not planning on including that in the bundled rate as of yet.

I think, you know, there's more potential for that down the road, I think, with health plans potentially, because I think they're going to see some value with CDSMP.

Honestly, in our case, we're - CDSMP is still new. And we're - we do see care transitions as a - probably a very good feeder into CDS - the CDSMP program, and we're still in the early stages of developing that.

Marisa Scala Foley: Okay. Ken can you talk a little bit about the role of - if technology plays a role in the care transitions services that you're providing right now? And if so, how? Whether it's on, you know, in terms of technology that you may be providing to the clients whom you're working with or, you know, any kind of care management or software that your coaches might use in terms of the work that they're doing.

Ken Wilson: Yes. I - technology plays a big role in care transitions. And I - this is an evolving industry. It's something that we need to keep a handle on in terms of what technology is available, because what we know today will be totally different in what, you know, in 12 months from now, or 2 years from now. There will be things that we're not even imagining today.

But some of the ways that we're using technology is all of our case files are electronic and are available at the hospital. So when the care transition specialist is meeting with somebody that's already on one of our programs, that care transition specialist can pull up their file and find out, you know, who their provider is, who their care manager is, what their major (diagnosises) are right there from the hospital.

And they can document in the system that can be viewed and shared with the care manager, as well as appropriate providers that are also part of their care.

The other part of technology that is very new for us -- and I'm excited about the potential here -- is with the health information exchange. And in our case it's called HealthBridge.

But health information exchange is a universal term used around the country for technology systems that share electronic medical records across health

plans, and across hospital systems, in an attempt to have better communication with - about somebody who is going into a hospital, and about the fact that they went to the hospital, so that the primary care physician -- or in our case, the care transition specialist -- can be engaged in that patient's care as they move from setting to setting.

Without that technology, it's a very manual process of either relying on the hospital to make referrals to us, as they see a patient that needs care transitions, or for us to do some manual sorting and matching of lists, or to have the family have the wherewithal to call us and let us know that they're in the hospital, that can trigger the care transitions.

I think the other part of technology that's going to be a big part of our future is the technology once they go home. And there's some really interesting technology that's coming out onto the market that's becoming more and more affordable that I think is worth looking into.

We have not made an investment in this yet. But with the - with TeleHealth; that can help with monitoring, you know, the person's blood pressure and some other vitals with their primary care physician, as well as their care manager.

Marisa Scala Foley: Okay. I think what we'd like - we have gotten several more - I - well let me take one more question and then we will - I'll turn things over to (Rico) to open up the lines for questions. And we'll try to sort through some more of the chat questions, because they've been coming in fast and furious. I'm not sure we'll be able to answer all of them before 3:30, but we'll do our best.

So (Courtney) asks, “Even though the hospital isn’t paying for your services right now, do you think that the hospital that you’re working with will look to contract with you for some - or other hospitals for similar kinds of services?”

I guess the concern is that we don’t want to set up a system where hospitals expect AAAs to provide these services for free.

Ken Wilson: Well that’s a really good point. And we’ve made it clear that we have limited funding and limited resources at this point, laying the foundation for having the hospital pay for this in the future.

But the problem right now is that it’s a new program, so it’s not like we’ve had it up and running for several years, so we’re not in a position today to do that.

However, I think, you know, within six months - within the next six months we will have solid cost models in place and be able to approach, you know, a hospital or a health plan and contract with them on an ongoing basis for this service.

But your point is well taken. We need to make sure that - and be careful that we’re not communicating that this is a free service of the Area Agency on Aging, because it’s not free.

Marisa Scala Foley: Okay. Thanks Ken. Let’s really quickly talk about resources and our next training. And then we will let (Rico) open up the lines for questions. And I’ll try to sort through some more of the chat questions and see if we can consolidate some of them and pose those to Ken, Costas, and Bob before we sign off at 3:30.

So we've included a number of slides in here related to resources that could help you as you start to plan your care transitions work, or move forward with your care transitions work.

First one in here has to do with business planning. N4A, the National Association of Area Agencies on Aging, has developed what they call their Ready Center, their resource exchange for aging data and innovations, which includes a business academy, so you may be able to find some good resources there.

We've included links related to care transitions. Certainly, we've had lots of questions. All of you have asked some wonderful questions with regard to the Community Section 3026, the Community-based Care Transitions Program. As I mentioned before, we can provide very limited answers at this point about this, because the funding has not yet been released.

But we have included a link to the Web site where - about the Community-based Care Transitions Program, which includes frequently asked questions. So if you have specific questions with regard to the CCTP program, there is an email address to which you can send some of those questions.

We've also included links here to the Care Transitions Quality Improvement Organization Support Center. In 14 sites around the country, quality improvement organizations as part of the - their 9th scope of work. These are contractors with Medicare; were focused on care transitions. And there was a support center set up for these QIOs. Some of you may have - be partnering with the QIOs in your state on some of this work. We've set up a link there.

They are also doing a series of webinars related to the (ninth) scope of work and what they've been learning about with regard to care transitions. And those are - webinars are offered at pretty much every - two a month.

We've also included a link to our own Aging and Disability Resource Centers and their care transitions work. Here at AOA, we've got a section that looks at resources that look at data sources, including where you can find out data on hospitals in your area, particularly high readmission rate hospitals.

And finally as we always do, we've included information in here. Links to not only AOA's Health Reform Web Page, which is where you will find the - when we post them, the slides, transcript and recording of this webinar, as well as past webinars.

So our next training will be in March. We don't have a date yet. We will continue our focus on care transitions. And we encourage you to watch your email for the date, the topic, and the date, time and registration information.

And so with that, we will turn things over to (Rico) to talk - to open up the lines for questions.

(Rico) if you could tell - let people know how they can go about doing that.

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

Once again, star 1 on your touchtone phone. Please record your name clearly when prompted. And please make sure your phone is off mute when recording your name.

One moment as we wait for our first question.

Marisa Scala Foley: Ken while we're waiting for the first question to come in, maybe you can answer this other question that we got in. We've gotten a couple of questions about this; about whether - what are the certification or education requirements for your coaches or care transition specialists? Are they nurses, social workers, or both?

Ken Wilson: We have a combination of nurses and social workers. And our goal is to have a diverse mix of both of those backgrounds.

Marisa Scala Foley: Okay. (Rico) have we gotten any one in the queue?

Coordinator: We do have two questions. And our first question comes from a Ms. (Regina Thayers). Your line is open ma'am.

(Regina Thayers): Yes. This program sounds very much like the PACE Program, the program for the all-inclusive elderly, which is a medical program. It - are these - are you all providing medical services 24 hour/7? And if not, then the services that you're providing, how are you billing for those?

Ken Wilson: The services that we're providing are custodial, in home, long-term care services, so they're not medical services.

(Regina Thayers): Okay.

Ken Wilson: So we're, you know, we're providing services such as personal care, home making, meals on wheels, transportation, adult-based services, through our home and community-based Medicaid waiver, or through federal Older Americans Act funds, state and local government funds.

(Regina Thayers): Okay. That helps me a lot; being able to understand the difference between the two programs.

Ken Wilson: Sure.

(Regina Thayers): Thank you.

Ken Wilson: You're welcome.

Coordinator: And our next question comes from Mr. (Robert Truvarro). Your line is open sir.

(Robert Truvarro): Hi. This is (Robert Truvarro) in San Francisco. I'm wondering if anybody's done any research on the cost savings potential for hospitals, if we're going to get them to motivated to participate in some reimbursement back to community-based services? Anybody's doing that kind of research on the other side.

Marisa Scala Foley: You know, I can tell you what we did do. This is Marisa. And then I'll let - I'll turn things over to the other panelists if they want to add to this.

Our first webinar in this series focused on some of the different evidence-based care transitions models, including the care transitions intervention that Ken talked about, as well as other evidence-based models that some of AOA's own care transitions grantees are using.

Some of the researchers that developed these models have - including Eric Coleman, have calculated some of the savings - potential savings - well the accrued savings to hospitals as a result of the use of their particular models.

So you may try our - the webinar is posted on the AOA Web site. If you look on - if you click on the Health Reform button when you get to our Web Page, which is www.aoa.gov, the slides for the January 24 webinar do include links to the various researcher's Web sites where you can find some of that information.

Ken, Bob and Costas, I don't know if you want to add to that at all.

Ken Wilson: No. that sounds complete to me. Eric Coleman has some really good information out on his Care Transitions Web site that I would encourage you to look at.

(Robert Truvarro): Great. Thanks very much.

Coordinator: And our next question comes from Ms. (Marguerite Lentell). Your line is open ma'am.

(Marguerite Lentell): Hi. My question is you made note to a couple of times on the call that there may an announcement that CMS will pay for part of care transitions. Or did I misinterpret that?

Marisa Scala Foley: No. You did not misinterpret that. As we mentioned earlier in the call, a lot of what we're focusing on is care transitions. And these webinars that we've been doing through AOA and other resources we're looking to develop them, focus on Section 3026 of the Affordable Care Act, which directs the

Secretary of Health and Human Services to provide funding for care transitions interventions at the community level.

We've included a link to that program in the Resources section of the slides, as I mentioned just a few minutes ago. That funding announcement has not yet been released; although, we anticipate it will be out soon. We don't have an exact date yet.

That funding will be provided through the Centers for Medicare and Medicaid Services. But that's about as much as we can say at this point, until the funding announcement is released.

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

Marisa Scala Foley: Okay. We got a couple more. I think we're going to take just one more question, because we are just about out of time at this point. And that question is for Ken, and that comes from (Beth) who asks, "How do you avoid duplication of services with other, you know, sort of hospital liaisons?

Was that part of your process that you looked at when you were developing partnerships with the hospital that you're working with right now?"

Ken Wilson: No. Our experience is every hospital is different. And they have different levels of experience and process with discharge planning. And some of them do a very good job and others not so much. So we cater and modify our care transitions intervention according to what their existing procedures are at the hospital.

We're not there to replace what they do. We're there to enhance what they're already doing and providing value added to it.

The hospitals that we've been talking to and are working with, none of them are - have the component that we're doing and proposing, which is both seeing them in the hospital and then following up within 48 hours in their home. That distinguishes what we're doing from what they're already doing.

Marisa Scala Foley: Okay. With that we are at 3:30. In fact, we're just over 3:30, so I want to be respectful of people's time.

I do understand that there are several questions that we were not able to get through in chat and Q&A. We have recorded those questions. We have saved those questions. And we will work behind the scenes here at AOA to get the answers that you need from Ken, from Costas, and Bob -- our presenters today.

I do want to say thank you very much to Bob, Costas and Ken for being part of this session and presenting on their - for sharing with us their expertise in this area. And we thank you all for being on the - for being part of this webinar and for such stimulating questions.

If you have additional questions, or if you have suggestions for future webinar topics, we invite you to email us at affordablecareact@aoa.hhs.gov. We do want these webinars to be as useful to you as possible, so we very much welcome your suggestions.

In addition, please view - you can use the same email address -- affordablecareact@aoa.hhs.gov -- to email us your stories.

If you are engaging in care transitions work with a hospital, or skilled nursing facility, or another provider in your community, we are developing a tool kit

for the Aging Network having to do with care transitions. And we'd love to be able to do some - put some case studies in there, so we would welcome hearing about your story and may follow-up with you on that.

Other than that, we thank you for joining us. And we look forward to having you with us on future webinars. Thank you so much.

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

END