Administration on Aging

Affordable Care Act Training

Transitions and Long-Term Care:

Reducing Preventable Hospital Readmissions among Nursing Facility Residents

March 27, 2012

2:00 - 3:30 pm Eastern

Coordinator: Thank you for standing by and welcome to today's conference. At this time all participants are in a listen-only mode. After the presentation we'll conduct a question-and-answer session. To ask your question, you may press star 1 on your touch-tone phone.

Today's conference call is being recorded. If you have any objections, you may disconnect. I will now introduce your conference host, Miss Marisa Scala-Foley. Ma'am, you may begin.

Marisa Scala-Foley: Thank you, Catherine. Good afternoon, everyone. Good morning to those of you on the West Coast and in Hawaii. My name is Marisa Scala-Foley. I work in the Office of Policy Analysis and Development here at the Administration on Aging in Washington, D.C.

We thank you for joining us for our Webinar this month, our latest 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 series if you've been with us before you'll know is designed to provide the Aging Network with the tools that you need in order to develop care transitions work in your area or to participate in other ACA-related efforts such as Accountable Care Organizations, health homes and other similar kinds of initiatives.

Most of our series over the course of the past year plus now has focused on the topic of care transitions, patients or clients going from one care setting to another, from hospital to home, from hospital to skilled nursing facility, from skilled nursing facility to home and more.

Today we will continue that focus looking specifically at care transitions and long-term supports and services. Today we'll be talking about transitions between hospitals and skilled nursing facilities.

First, you'll hear an overview of INTERACT II. INTERACT stands for Interventions to Reduce Acute Care Transfers which is a quality improvement program designed to improve the identification, evaluation and communication about changes in resident status.

And second, you'll hear about an exciting new initiative announced earlier this month by the CMS Innovation Center and the Medicare-Medicaid Coordination Office and this initiative will test a series of interventions to improve the health of and healthcare for nursing facility residents and reduce the frequency of preventable hospital admissions and readmissions.

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

If you don't have access to the link we e-mailed you, you can also go to www.webex.com, click on the attend-a-meeting button at the top of the page and enter our meeting number which is 668507106. Again that WebEx meeting number is 668507106 and if you're prompted for a passcode it is AoA Webinar and that's all one word.

If you have any problems getting into WebEx, please contact WebEx technical support at 1-866-569-3239. Again that number for WebEx technical support is 1-866-569-3239.

As Catherine mentioned, all our participants are in listen-only at this time; however, we do welcome your questions throughout the course of the Webinar. There are two ways that you'll be able to ask your questions. First as I mentioned earlier is through the chat function in WebEx.

You can enter your questions there and we will sort through them and answer them as best we can when we take breaks for questions after each presenter. In addition after both of our presenters today wrap up, we will offer you a chance to ask your questions through the audio line.

When that time comes, Catherine will give you instructions as to how to queue-up to ask your questions and if you think of any questions after the Webinar or have any questions you'd like us to follow-up on, you can e-mail

them to us at affordablecareact@aoa.hhs.gov. Again that's affordablecareact@aoa.hhs.gov.

Finally as Catherine mentioned we are recording this Webinar. We will post the recording, PDF of the slides and a transcript of this Webinar on the AoA Website hopefully by late next week. Okay, so with that I think we're done with housekeeping. I wanted to introduce the two terrific speakers we have with us today and I'm going to introduce them sort of in the order that they will be presenting.

Our first presenter will be Dr. Joseph Ouslander. He is the Professor and Senior Associate Dean for Geriatric Programs at the Charles E. Schmidt College of Medicine at Florida Atlantic University and Professor at the Christine E. Lynn College of Nursing also at Florida Atlantic University in Boca Raton, Florida.

Dr. Ouslander is an internationally-recognized geriatrician. He is a graduate of Johns Hopkins University and the Case Western Reserve School of Medicine and he is currently serving as a Health Policy and Aging Fellow supported by a grant from Atlantic Philanthropies.

And our second presenter, I'll give you more of his bio when he presents, will be Tim Engelhardt who is the Director of Demonstrations, Models and Analytics for the CMS Medicare-Medicaid Coordination Office but with that I will turn things over to Joe.

Dr. Joseph Ouslander: Thanks, Marisa and welcome everybody. Thanks for joining the call. I think we're going to talk about something that - some programs - that are very interesting and exciting and from my viewpoint a golden opportunity for the fields of geriatrics and long-term care to contribute to meeting our triple aim

of improving care and improving health in this population, preventing complications and morbidity and at the same time reducing costs.

So I'm going to talk about the INTERACT program that Marisa mentioned before, just give you an overview. It is one of the types of interventions that might be applicable for folks who are interested in applying for the initiative that Tim is going to talk about.

This slide shows a list of names of people. I always say that geriatrics is a team sport and it really requires an interdisciplinary team to design programs that really improve care in a way that's safe and effective. Next one.

So Marisa mentioned that the INTERACT program is an acronym for Interventions to Reduce Acute Care Transfers and it is evolving into an overall quality improvement program that's designed to improve the care of nursing home residents with acute changes in condition.

It's not a tool or just a set of tools but we're really making it, you know, a full quality improvement program that facilities can implement and again the primary purpose is to improve the management of acute changes in condition and as a byproduct of that when hospital transfers can be safely and effectively prevented, this program will help. Next one.

So the INTERACT program includes evidence and expert recommended clinical practice tools and strategies to implement them and related educational resources. The basic program and the tools are available free at the Website that's listed here, interact2.net. Next one.

The way that I view the INTERACT is it's one of a set of evidence or one of a set of care transition interventions that has some evidence that it's effective

and you can see there are many others and several of these have been talked about on these Webinars previously.

And I feel that INTERACT is complementary to these other care transition interventions and in fact we've talked about combining INTERACT with discharge planning interventions such as BOOST or Project RED and the transitional care model. Next one.

So I do want to acknowledge that the INTERACT program has evolved from what was originally a contract from CMS to the Georgia Medical Care Foundation, the quality improvement organization for Georgia.

And it's been revised over time and further developed by several people who are acknowledged here and some of the tools are copyrighted to the university I work for, Florida Atlantic University but again they're free to use and available publicly so just some background perspective. I guess this is why you're all on this Webinar.

We know that emergency room visits and observation stays and hospital inpatient stays and readmissions as nursing home residents are common. They result in complications and they're expensive. The next one so this is a slide that shows some data that were published by Vince Moore for rehospitalizations of nursing home residents in the year 2006.

And like most other things, there's a lot of variability between states but on average close to one in four people who are admitted to a skilled nursing facility are readmitted to a hospital within 30 days and these readmissions cost over $4 billion. Next one and all people that are geriatric healthcare providers know that the hospital is a very bad place for frail older nursing home residents to be.

There are a number of complications that can occur in the hospitalization including just the distress and discomfort for the resident and the family of the hospitalization and a variety of complications that range from acute confusion or delirium to falls and injuries and hospital-acquired infections and others so these risks of hospitalization are substantial and need to be weighed against the benefits of hospitalization in any given resident. Next one.

We also know from a number of different studies that some of these hospital transfers and emergency room visits, observation stay, hospital stays and readmissions are avoidable or preventable or unnecessary and I'd like to spend just a couple of minutes talking about those concepts. Next one.

We as part of our contract with CMS in Georgia we did a very detailed review of 200 hospitalizations from 20 nursing homes in Georgia and we got the records and we asked an expert panel to do a systematic review of the records and then at the end of that systematic review ask the question was this hospitalization avoidable and you can see on this slide that two-thirds of the hospitalizations were rated by this panel as potentially avoidable.

And the reasons they were rated potentially avoidable and the interventions the panel thought would have been helpful are in detail in the publication that's listed there. Next one.

I was also involved a project that was a CMS contract again where we looked at all hospitalizations of duly-eligible Medicare and Medicaid beneficiaries for the Year 2005 which is the most recent year for which all the data were available and this full report is available on the CMS Website.

There's a link to it in the RFP that Tim is going to talk about. I'll just mention a couple of things. What we did was we worked with some expert nurses and we defined a number of DRG diagnoses that we felt could at least sometimes be managed outside of a hospital setting.

These were not only transfer from nursing homes. These were transfers from home-based and community service programs as well but most of them were from nursing homes and Marisa, this is one build.

So you can see that of close to a million hospitalizations - close to 400,000 of them - are about 40% were considered potentially avoidable by the definition we used and that the cost of those potentially avoidable hospitalizations in 2005 dollars was $3.1 billion and that again report is publicly available. Next one.

The other thing that has just become available is a white paper that I worked on during my health and aging policy fellowship that is a very detailed review of how potentially preventable hospitalizations have been defined.

And I have to give a lot of credit to Katie Maslow who's the first author of this report who did a very, very detailed literature review in this area and let me just be clear and simple that there are no great definitions or valid definitions of what's potentially preventable in the long-term care population. Next one.

So from a kind of a health policy standpoint - a big picture standpoint - the way that unnecessary or preventable or avoidable hospitalizations have been defined and been using certain diagnoses, ambulatory care census, diagnoses we used in the report on dual eligibles.

And you can use other methods such as a structured medical record review by experts but that's very labor-intensive and expensive and it's not practical on the large scale. It is useful for internal quality improvement review purposes. Next one.

And one of the reasons that it's really difficult to define what's an avoidable or unnecessary hospitalization is because there are so many different factors that influence the decision to hospitalize an individual nursing home resident and they're pictured in this figure.

I'm not going to go through this but suffice it to say that this is a very person-centered decision and what's good for one nursing home resident may not be appropriate or good for another nursing home resident in a different nursing home with different resources so it makes defining what is a preventable hospitalization challenging. Next one.

So we have - there are different ways - to define these preventable events and I'll just walk through this figure very briefly and then Tim might want to address how what his thinking is about how these hospitalizations would be defined in the initiative he's going to be discussed.

But this slide builds a - Marisa go ahead - so first one way is just to continuously measure all unplanned hospital admissions of all residents and next you can - a subgroup of those - are readmissions within 30 days and as you all know, that's a major focus of care transition interventions. Next one.

Then there's admissions to the hospital that are not readmissions then the next two - the next one - so then there are readmissions or admissions for these diagnoses, some of which are listed there that might be considered preventable

and I think that's the way they're being defined in the nursing home value-based purchasing demo in this initiative also.

Then next there's also emergency department evaluations without hospital admission which are costly and traumatic and are not often measured in the statistics that we have nationally.

And then finally I feel strongly that admissions to observation status should be counted for a number of different reasons and as many of you know the number of people being admitted at least initially to observation status is increasing and so I think even though they may be coded as outpatient events, they should be considered as a potential preventable event.

You all know that there are going to be changes in Medicare financing that are a part of the Affordable Care Act and there are going to be pay-for-performance initiatives both positive reinforcement, negative reinforcement and bundling of payments and the formation of accountable care organizations that are going to force providers to work together to improve care and reduce these unnecessary hospitalizations.

And I think this is what creates a great opportunity for geriatrics and nursing home care providers. Next. The one other background issue I'll address is that another opportunity in this area is the Affordable Care Act also mandates that each nursing home will have a quality assurance and performance improvement program, QAPI.

The regulation for this new law and related survey or guidance are going to be written over the next year but the INTERACT program and other initiatives that you might implement in a nursing home, if they're implemented as a

quality improvement program would be an example of something that would allow facilities to meet this requirement for a QAPI program. Next.

So just to summarize where we see the INTERACT program, one of the goals here that we're all working towards is a safe reduction of unnecessary transfers which will improve quality, decrease morbidity and decrease costs. Next.

In order to do that, facilities need the infrastructure in place to take care of sicker people and incentives and I think that is what the initiative that Tim is going to describe is going to provide, the look at different innovative ways to provide the infrastructure and those incentives and the next one.

But in order to assure that this is done with quality, we need quality improvement programs and tools. The next one and that's where the INTERACT program comes in so INTERACT is a quality improvement program that's designed as we move towards trying to reduce these unnecessary transfers safely is designed to help providers do this in a safe and effective manner. Next one.

So we think that INTERACT program can help reduce unnecessary transfers by three different strategies. The first one is by identifying acute changes in condition early and preventing them from becoming severe enough to require a hospitalization. An example of that might be dehydration.

Second is that we know that the population we're talking about is going to have acute conditions. Some of them can be safely managed in the nursing home without transfer - not all but some - and third we all know that we're taking care of a very frail people, some of whom are at the end of life.

And that hospitalization may be futile care for them and the risks of hospitalization may outweigh the benefits and a (palative) care plan may be better so another strategy is to improve advanced care planning. Next.

And again I want to emphasize that the goal of the INTERACT program is to improve care and not to prevent all hospital transfers. That may in fact have unintended consequences and some of the INTERACT tools actually can precipitate more rapid transfer of residents who do require hospital care. Next.

Just want to go over a little bit of the evidence that the INTERACT program can be effective. I mentioned that this was originally developed in a contract supported by CMS and then it was revised based on staff from several nursing homes and national experts in a project that was supported by the Commonwealth Fund. Next.

So on the Website you will find different types of tools that are meant to be used in clinical practice. These are not meant to be put into a notebook somewhere. They're actually meant to be visible and usable in the facility and they include communication tools, decision support tools, advanced care planning tools and quality improvement tools.

I think the next slide shows an overview of how we conceptualize how these tools can be used in a quality improvement initiative that would I think help meet the goals of the initiative that Tim is going to be talking about.

So at the top - I want to go over that one a little bit - so at the top when someone is admitted to a facility or someone is readmitted after a hospitalization, it's important to address advanced care planning and some of the tools we have on the Website are really educational tools about how to do better advanced care planning.

As you go down the flow diagram, often front-line staff recognize a change in a resident's condition and there's a tool for that which is an early warning or stop and watch tool that helps nursing assistants communicate changes they observe in a systematic way to their supervising registered nurses.

Some of the facilities that we've worked with have actually trained housekeepers and dietary staff and even families to use this tool to recognize - to be proactive - and recognize when a change has occurred.

When that change has occurred, there are decision support tools for registered nurses that include care pass for common conditions that cause transfers and what we call acute change in condition file cards which are based on the American Medical Directors Association guidance for when to notify physicians.

So these are really decision support tools for nurses and then probably the most popular tool is the S-bar communication form and progress note which really helps nurses in the facilities structure their assessment and their communication with the medical provider.

And many residents do need to be transferred and an important of this program is communicating well with the hospital. There's a transfer checklist which we recommend being put on the front of the envelope where all the documents go to the hospital and a recommended elements of a transfer form that has been vetted by emergency room physicians and nurses.

And then as I mentioned - as I've been emphasizing - INTERACT is really a quality improvement program so there are quality improvement tools that I will show in a little more detail at the end of my remarks.

So just next one, what we did in a collaborative, we started with 30 nursing homes. The way that we implemented this and this for those of you who are thinking of putting in a proposal for this initiative, this is one kind of strategy you might think about incorporating.

We did on-site training for part of a day and the focus of that training was a facility-based champion - usually a nurse but not always a nurse - who was responsible for implementing the program and doing follow-up education.

We also did collaborative phone calls with a very experienced nurse practitioner that were facilitated and those calls were used to talk about implementation challenges and successes.

And then we had the facilities complete a certain number of quality improvement tools which is really a root cause analysis. I'll show you a little bit more about that and this is the way we implemented INTERACT in this project.

The next slide shows the results of the project and what we had - we started with 30 facilities - 25 finished the project and we had complete data on those facilities and in those facilities without going over the details of how the data were calculated, there was a 17% reduction in all-cause hospitalizations.

This was short stay and long stay and the next one, we felt by various measures that 17 of these facilities were engaged in the project and in the facilities we felt were really doing more to implement the project, there was a 24% reduction.

We rated the facilities engaged without knowing the hospitalization rates and in the facilities that were not engaged, you can see there was only a 6% reduction so we're not sure exactly what worked and what the most effective way to implement a program like this is but we know something happened in the facilities that were actively engaged. Next one.

So what does this mean, what does this all mean? Well, in a typical 100-bed nursing home, the reduction that we saw in hospitalizations would result in about two fewer hospitalizations per month.

And if you put a DRG payment - a Medicare Part A DRG payment - of $5000 on each of those hospitalizations, you get a $125,000 savings. Now that's probably a conservative DRG payment.

In our report on the duals in 2005, the average hospital payment for avoidable hospitalization was about $7500. This does not include any emergency room visits that were saved as well.

And based on data we collected from the nursing homes, we felt when we took into account all costs we felt that the intervention costs about $8000 per facility so there is a considerable amount of money left on the table there in potential savings as from a national perspective.

And those dollars we think can be used to help support the infrastructure that's necessary in facilities to achieve the goals we've been talking about and I think that's what the initiative Tim is going to be talking about is designed to do. Next one.

So I just want to address one of the most frequently-asked questions about the INTERACT program and that is how do you get started and many of you may

already be doing this but you can't do a quality improvement program unless you have an outcome and you're tracking the outcome and you may want to track certain process measures.

So one of the INTERACT tools is an acute care transfer log that enables you to track when transfers occurred and you would be able to calculate various different outcomes - the ones that I outlined - by using a tracking tool or a transfer log like this one. Next one.

And the second thing is is that you can't do a quality improvement project without looking at what you're doing and learning from what you're doing so the INTERACT quality improvement tool is a retrospective analysis of transfers and it walks through what happened, what was done in the facility to manage the acute change if anything and what happened around the transfer. Next one.

So the current tool has five sections and the next slide shows the key to quality improvement. Next one, Marisa, so the tool asks where there opportunities for improvement here so this is really like a kind of almost like a mini root cause analysis and if what learning can be developed, what can be derived from this transfer and what should we do about it?

So in order to at least get started doing projects like this, you have to have an outcome, you have to track it. You can track process measures as well and do some type of root cause analysis to learn from. Next one, I think that's my last slide so I don't know if there are any questions at this point or...

Marisa Scala-Foley: Thank you so much, Dr. Ouslander. We have gotten a few questions in through chat so let's go ahead and take those. The first question came from Carol who asks in the study that you did of 20 nursing facilities with two-

thirds where you identified two-thirds of the readmissions as being possibly preventable.

She wonders if there were any trends that were identified by facility? Were there certain diagnoses that were more likely to be associated with readmissions or days of the week, you know, staffing levels and so forth?

Dr. Joseph Ouslander: Yes, good question so with regard to the first part of that question, in that project as well as the report that I quoted on the duals about 70 to 80% of transfers are due to one of like eight conditions and they're in those reports.

And they're also if you look at the slide carefully where I looked at different options for measuring outcome measures, those kind of diagnoses are there and I think that they're also the diagnoses that are going to be tracked in an initiative Tim is going to describe.

So there are things like respiratory infection, urinary tract infection, acute changes in mental status, fever, sepsis, congestive heart failure so the point is the vast majority of transfers as well as transfers that are rated as potentially avoidable are from a relative small number of conditions.

To your second point we don't have data on that level - that level of data - on when these transfers occurred, what time, what day. That is exactly what the transfer log should be useful for, to look at that, you may have certain shifts, certain days.

We know this is common at night and on weekends where you can look at your own trends within your facility and see where you may need to address so those are both really good questions to target programs like this to get the biggest bang for the buck.

Marisa Scala-Foley: Okay, great. Our next question comes from Kristen who asks, you know, as you may know the quality improvement organizations or QIOs are involved working with communities right now to reduce preventable readmissions and to submit applications for the community-based care transitions program.

How have QIOs been involved with the implementation of INTERACT and are you working with any of them now in the work that they're doing under their current scope of work?

Dr. Joseph Ouslander: Yes, that's a good question. As I mentioned the INTERACT program actually developed from a CMS contract with the Georgia Medical Care Foundation and we've worked with the Colorado QIO which is a support center for care transitions. We've done Webinars.

We've done Webinars for individual QIOs and the other thing I'll mention is that we are about to get another grant support from the Commonwealth Fund to train trainers, to train INTERACT trainers and we would like to hold what we're going to call an INTERACT institute and we would invite staff from QIOs to join that institute so that they can help train facilities and staff to implement INTERACT in a fuller way than they may be doing now.

Marisa Scala-Foley: All right, our next question comes from Shaniqua who asks if there - given the structure of INTERACT - have you had any discussion about sort of the minimum number of staff needed, you know, whether it's doctors, nurses, social workers in nursing homes in order to have the program be successful and cost-effective?

Dr. Joseph Ouslander: Yes, well the answer to that question is about a 45-minute talk so I think I'll just try and respond briefly. I mentioned that geriatrics is a team sport so this has to be a quality improvement initiative that has a team effort.

We recommend and it has to have leadership support so that when people have to - when staff - have to take off time to do any education or do the additional work that's necessary to provide this improved care, leadership has to support that. The initiative that Tim is going to describe will provide some assistance in that.

We recommend that a facility champion be identified and also based on our experience a co-champion because we all know of the issues about turnover and changes in jobs in long-term care settings s

So a champion or a co-champion should be appointed and we don't know for sure but we would say that, you know, it's probably a four to eight-hour-a-week job between the two of those people and then the other important part of this which we haven't been real successful at is getting the medical directors and primary care physicians involved.

And that's again going to be hopefully part of this new Commonwealth initiative to get more buy-in on the part of medical directors and physicians because ultimately they give the orders to transfer people to the hospital.

Marisa Scala-Foley: Okay, just a couple more questions and then we'll turn things over to Tim. The first one comes from Becky who asks could the training that was provided to nursing facility staff on INTERACT be done by computer-based modules and if those have not been developed yet, are you working on those?

Dr. Joseph Ouslander: The answer to both those questions is yes. We had grant support from the Retirement Research Foundation and we pilot-tested what turned out to be a multi-session - it was about 12 sessions - that was on an online curriculum that was supplemented by teleconference calls.

So we've developed that and have it and we do have plans to upgrade it to a better online curriculum that's more interactive using state-of-the-art technology and we're working on that.

Marisa Scala-Foley: Okay, I think the last question that we're doing to take right now comes from Amy who asks - first of all she says thank you for your comments about the utility of linking improvement efforts across settings - she'd like to know what some of the top strategies INTERACT nursing homes have used to partner with hospitals in order to reduce hospitalizations.

Dr. Joseph Ouslander: That's a great question and I think they're some of the same strategies that are used just in general care transitions programs and the first one I recommend is person-to-person contact. I think that leadership from the nursing home should be visiting the hospital and know the people in the emergency room.

And the emergency room and hospital providers - the key hospital providers that refer - people should know the nursing home. They should visit the nursing home and we have a tool on the INTERACT Website that's called a nursing home capabilities list so that hospitals that are referring to a number of nursing homes know what the capabilities of the nursing homes are.

And I mentioned the checklist and transfer tool. All these things can be done on a local basis but I don't - I think there's no substitute - for actually meeting people in-person and getting to know each other and having some mutual

respect and the tools will help but I think that personal involvement is really critical to success.

Marisa Scala-Foley: Okay, with that we did get a couple more questions but I want to give Tim time to talk about the initiative that his office has put out in partnership with the CMS Innovation Center so thank you so much Dr. Ouslander. We'll come back to you.

For those of you whose questions were not answered, we'll come back to them after Tim is done presenting and we'll try to wrap all of those up in our next Q&A session.

So with that I would like to introduce Tim Engelhardt who is with the CMS Medicare-Medicaid Coordination Office where he directs demonstrations, models and analytics. The office was created in the Affordable Care Act to improve systems for individuals dually-eligible for Medicaid and Medicare.

Prior to joining CMS, Tim was a Consultant with the Lewin Group where he supported a variety of health and long-term care initiatives for federal, state and local government agencies.

And he also previously served as the Deputy Director for Long-Term Care Financing at the Maryland Department of Health and Mental Hygiene which is Maryland's state Medicaid agency so with that Tim I will turn things over to you.

Tim Engelhardt: Thank you, Marisa. This is Tim Engelhardt from CMS and I'm especially happy to be on this because it's a continuation of work that CMS and AoA have done together really dating back a long time now and we're focusing on care transitions.

We're focusing here on institutional population but really CMS and AoA have been working together on numerous initiatives with the objective of maximizing independence for older adults and people with disabilities and much of that work is focused on maximizing independence in the community and our commitment to that is strong and longstanding and continuing.

But as long as we've got a million-plus individuals who are living in nursing facilities and experiencing less-than-ideal outcomes, then we've got an imperative too to try to maximize their independence and to improve their outcomes ultimately and that's what this initiative that I'm going to talk about here a little bit touches on.

Dr. Ouslander said it so well but I'll only spend a few seconds on these first couple of slides but nursing facility residents are hospitalized with great frequency and a significant percentage of those hospitalizations appear to be preventable from some of the bigger studies that we have actually helped to sponsor and that Dr. Ouslander was involved in.

We think that somewhere on the order of I don't know 45% of hospitals admissions among long-stay nursing facility residents are for things that could have been avoided and that's both dangerous for individuals involved and it's wasteful from a financial perspective. In fact it's billions of dollars each year that we're spending on those avoidable hospitalizations.

We have significant evidence that this is a problem and perhaps we could quibble about what percent of hospitalizations are really preventable or avoidable and at the end of the day it probably doesn't matter all that much because what they represent is probably the upper bound of what is movable through an intervention.

But we in addition to knowing that's a problem, we feel like we have good evidence that the problem is addressable. Dr. Ouslander said it well. He said we don't always know exactly what about particular interventions has worked exactly the best and it's important as he articulated to recognize that the problem of avoidable hospitalizations has many different causes.

Some of them have to do with primary care delivery. Some of them have to do with poor nursing facility quality care. Some of them have to do with family preferences or communication patterns or financing incentives and others and so it's important to kind of recognize that going into anything that we do to try to address the problem.

We have past interventions that we know have worked, we know have been well-analyzed and INTERACT is one of those but others dating back a decade or more including some of the foundational ever-care demonstrations that became institutional special needs plans ultimately and then other targeted interventions including one in New York State that we cite here on the slide.

So recognizing both the nature of the problem but also its impactability based on other kind of demonstration opportunities, we at CMS - both my office Medicare-Medicaid Coordination Office but also the CMS Center for Innovation - we've announced a couple weeks ago a new opportunity to address this particular challenge.

And it's a new funding opportunity and I'll submit with some of the objectives that you might see here on the slide. It's reducing the frequency of avoidable hospital admissions and readmissions. It's improving resident health outcomes. It's improving the process for those people who are hospitalized, improving the process of transitioning between settings.

And ultimately reducing overall healthcare expenditures and hitting kind of the objectives from the CMS perspective of better health, better care and at lower cost and we think this is a great opportunity to do it.

We released a funding opportunity two weeks ago and you can find it. We have links to it here and we're inviting organizations to bid in response to it and we'll select organizations through a competitive process and Marisa I'm on the current slide that you're on, thank you.

We're not necessarily prescribing a very specific intervention. It doesn't have to be INTERACT. It doesn't have to be a nurse practitioner-based, it doesn't have to be any of these things. Instead we just put some general parameters around it and you can see some of them here.

You can read them in greater detail in the funding opportunity announcement but we talk here about having staff who will have some physical presence within a nursing facility and partnering with the actual nursing facility staff who are involved in the day-to-day services for nursing facility residents.

Working in great cooperation with the existing providers including in the hospital or in the nursing facility and without, facilitating those care transitions, improving communication patterns with other providers and coordinating and improving the management and the monitoring of prescription drugs including psychotropics which as many of know has been another major point of focus for CMS in recent years.

If you move to the next slide you'll see that the interventions we're seeking will all kind of share certain characteristics in addition to those base

requirements we just talked about including demonstrating that there is a strong evidence base for the types of activities that are being prepared.

We don't expect that everyone comes with a package of interventions that is exactly replicating something that has been done in a prior study but we'll want to see that the package of interventions is built on the evidence base that we have in place and in some cases may expand upon kind of models that have already been tested in the past.

We're looking for interventions that are replicable and sustainable in not just the places where we start them but in other places as well, looking for those that supplement instead of replacing existing care from nursing sort of (reds) so this isn't an intervention about simply paying someone to provide that which is already provided in a nursing facility.

And then and importantly here this is intervention in which nursing facility residents would participate without any need to enroll in a health plan or change providers or anything like that.

I'll talk more about the interventions in a second but the target population for it is not necessarily any person who happens to be in a nursing facility but we're primarily targeting people who are in fee-for-service.

That is not capitated managed care, people who are in fee-for-service arrangements for their Medicare services and who are long-stay beneficiaries in nursing facilities.

As many of you probably know, somewhere on the order of half of all people who are admitted to a nursing facility are gone within 30 days. We're not necessarily seeking to overlay a new intervention for those people for whom

the nursing facility is indeed serving as a brief stay in a post-acute kind of course of treatment.

Instead we're focusing on those people who are longer-stay residents and they are typically almost all people who are eligible for both Medicare and Medicaid or dual-eligibles as we often refer to them as and the applicants in this intervention will ask them to kind of describe how they're going to identify that target population and any other sort of changes to.

I want to talk a little bit about who is eligible to apply but I'm not going to be very specific and in fact we don't plan to kind of adjudicate who is exactly eligible until we receive real applications and instead we'll put some parameters around that.

Let me start with who's not eligible to apply for this announcement and that's at the bottom of this slide. It's nursing facilities or nursing facility-controlled organizations are not eligible to apply.

So in other words in this intervention, we're offering funding to organizations other than nursing facilities themselves but organizations who will partner with nursing facilities to implement new interventions and those eligible organizations really can take a variety of forms and you can see a few of them there. They could be standalone care management firms.

They could physician practices. They could be health plans although this is not a capitated kind of managed care arrangement and they could be other kind of public organizations that could be ADRCs or area agencies on aging or university systems or (sills) or others as we list out here.

We're not necessarily prescribing whether or not those entities have to be not-for-profit or for-profit organizations. Both would be eligible to apply but again not nursing facilities themselves.

In addition to kind of careful consideration of who might be eligible, there are contextual factors that we need to think about too and these are articulated in the funding announcement. I won't belabor them here but importantly we're seeking to support new things and we're seeking to be able to evaluate how well those things work.

And as such we need to be somewhat careful about the surrounding context. We're not necessarily seeking to fund demonstrations where we've got other demonstrations kind of concurrently happening.

We won't necessarily want to do this if we have a large number of nursing facility residents who are concurrently in a bundled payment demonstration or an accountable care organization or some of the other kind of major demonstration programs that we're offering here through CMS concurrently.

We touched on this before although we're not paying the nursing facilities to be involved in this particular intervention, they are critical partners and so first and foremost nursing facilities they're not required to participate and that we're seeking those applicants to come to us with a number of nursing facilities who are voluntarily willing to participate in this particular initiative.

So the arrangement is between CMS and an organization that we'll be calling the Enhanced Care and Coordination Provider but that organization will have partnering nursing facilities associated with it and those nursing facilities need to be identified at the point of applying for this new opportunity.

We'll be seeking applications that have letters of intent from those nursing facilities and a minimum of at least 15 - hopefully more - that's a minimum of 15 nursing facilities who will partner with the applicant.

We'll want them to be within the boundaries of the same state although there are options for applicants to cross state lines, some of the things we articulate in the funding opportunity announcement.

We'll give preference for applications that come from locations where we know there are high Medicare costs, there are high hospital readmission rates and where we know that there are significant problems associated with preventable admissions.

I didn't include it on the slide but we actually have some analysis of how those preventable hospital admission rates vary by state including from the nursing facility setting and I'll point out that states like Louisiana and Kentucky and New Jersey and Arkansas and Mississippi kind of head the list with states of really high rates of avoidable hospitalizations among nursing facility residents.

Partnering with willing sort of willing and interested nursing facilities will be - I want to be clear - it might be a challenge and it's going to have to be a challenge in finding the right mix of partners here and I don't want to short-change that.

Anybody interested in applying for this, I think one of the very early steps should be getting your mind around what the model might be but also building that collaboration with nursing facilities who you think you can bring in with you.

In addition to the nursing facility partnerships, states are kind of critical partners in achieving our objectives and their roles are two-fold. One is that Medicaid payment - which is driven by state policy choices - Medicaid payment is well it's a huge source of revenue for nursing facilities but more importantly in this context we know that Medicaid payment policies they actually correlate with hospitalization rates in important and different ways.

And as such we'll want the state Medicaid agencies to be partners here and the same on the survey and certification side, states have a big role in regulating the industry and we want to make sure that we're only doing this in states where both the Medicaid agency and the survey and cert agency are onboard.

And so as such we're requiring that applicants show us a letter of support from both the state Medicaid director and the survey and cert director. States can choose to support numerous applications from within their state.

They can also choose to opposite which is to support none of them and so in addition to reaching out to nursing facilities, there's this other challenge of making sure that the state policy-makers are onboard with the demonstration happening within their state.

And then the state will kind of build beyond that into some data sharing and other things. We're not seeking to make this a state-run demonstration or to add new burdens to our state partners but at the same time we'll be looking to them to contribute in a couple of important ways and we'll be executing a Memorandum of Understanding with each of the states before we go forward.

We're making available about $128 million to support this intervention. We estimate based on our own projections we estimate that we do this in approximately maybe seven different sites around the country but that's an

approximate number and we'll award a number based on the quality of the proposals that we receive.

We're also estimating that this would touch we were guessing maybe in the order of about 150 nursing facilities but again that's not a prescriptive number. That's based on our own estimates about the typical costs and what it might be.

And to the extent that we can make a bigger and broader impact within the budget that we have here, we'll want to do that so we put this up here for a frame of reference for potential applicants but not in any way to dissuade larger numbers or broader interests in the overall initiative.

We'll evaluate the outcomes of this with an outside evaluator and you can see here some of the evaluation metrics, hospitalization rates, readmission rates and others and the parameter for how we operationalize that.

We'll get more specific as we get closer to ultimately rolling this out but a big part of this will be assessing not just beneficiary experience but also the experience on Medicare costs and Medicaid costs as well. Our next steps are that for anybody interested in applying we are requiring - I want to be really clear - that we're requiring a notice of intent to apply that's due by April 30th.

That letter is completely non-binding but if anybody's interested in applying, we urge you to send in that letter by April 30th and you can see some parameters about what should be in that letter in the funding opportunity announcement. Full applications will be due in the middle of June with awards anticipated for later this summer and late August is our target date.

The initiative would kind of begin relatively immediately but it would start with a readiness review process where we would be kind of assessing the readiness of each applicant that we select to go forward before we really push go and start the actual intervention and we expect this to be a four-year demonstration opportunity once we get it off the ground.

I think just kind of reflecting on the folks who I think are on this particular telephone call, I want to urge you to think about this demonstration in different capabilities.

I think there might be some in the aging and disability networks out there who should think about this as an opportunity to apply for something and make a difference in the lives of a lot of people that we all kind of jointly care about here.

But to the extent that you might be thinking about this and not think it's an opportunity for your organization to apply, I hope too that you'll take advantage of your roles in the community as kind of a conduit of information on this because we're relying on some of you to help get the word out about this initiative, to help, you know, generate interest and enthusiasm among nursing facility partners too.

Even though they can't apply, it'd be important to spread the word, to spread it through the ombudsman networks and to spread it with any organizations that you think might be great candidates to apply in something like this. I hope you'll actively share information with them and hook them up with the funding announcement and some of the information in this Webinar today.

The next slide simply gives you - a couple of slides - gives you some resources for additional information. You can see a Website here where you

can find the actual funding announcement and a place where you can submit questions.

We also intend to have a couple more Webinar opportunities including one I think a week from today on Tuesday, April 3rd in the 2:00 time slot and more information will be available through different channels and we'll try to advertise that too so many more opportunities to learn more about this but I will stop there Marisa and see if you have any questions or if others do.

Marisa Scala-Foley: Okay, thank you so much, Tim. Really quickly before we take our next sort of break before we go into our final Q&A period, I just wanted to quickly go through a couple of resource slides that we have put together on both care transitions and the Affordable Care Act.

Please don't try to frantically scribble all of these down. The slides will be posted on the AoA Website on our health reform page which is accessible through our homepage which is www.aoa.gov. We will post the recording, slides and transcript within the next week or so.

If you need the slides before then, please feel free to e-mail us at affordablecareact@aoa.hhs.gov so you can get not only the resources on the two slides that I just showed but also resources on the connection to the INTERACT Website that Dr. Ouslander talked about as well as to the initiative that Tim has just been describing.

Our next training we will have one in late April. We will continue our focus on transitions and long-term supports and services likely looking at sort of the relationship between care transitions and core services, Older Americans Act services and other services that are provided by the Aging and Disability Networks.

So that is what we are looking at for April but please do watch your e-mail in early to mid-April for registration information so with that I think we'd like to take our final break.

We have had several questions come in through chat but I think before we get to those, I will let (Catherine) give people direction as to how they can queue-up on the audio line if they haven't already entered their questions in via chat.

Coordinator: If you would like to ask your question, please unmute your phone and press star 1. Only record your first and last name. To withdraw your question, you may press star 2. One moment for the first question.

Marisa Scala-Foley: Okay, so we got a question - let me start taking a couple of questions - from chat while we're waiting for people to queue-up. Tim, we got a question from Tony who asks about sort of the relationship between this initiative and Medicare managed care.

He works with a facility that has a significant proportion of their census that are dual-eligibles but about 25 to 30% of them are enrolled in Medicare advantage plans for their physician coverage. Would they be eligible to participate in the initiative?

Tim Engelhardt: That's a great question. We actually among the parameters we place on the participating kind of partnering nursing facilities we put a couple of parameters on that and one is that those nursing facilities should have Medicare managed care penetration rates of 25% or less.

Where we felt like there was a really large fraction of people who were in a Medicare advantage plan or an institutional snip or some other product, we

felt like it was impeding our ability to kind of implement a really broad almost facility-wide intervention.

And so we're looking for nursing facilities that are under that 25% threshold that target kind of population of people even in one of those facilities would be those who are receiving their Medicare services through fee-for-service channels but we did kind of put a factor on related to the penetration rate within the facility itself.

We also put on a size requirement for the partnering nursing facilities an average of 100 residents per facility. That's an average across the 15 or more facilities as opposed to each single facility needing to meet that individual threshold requirement.

Marisa Scala-Foley: Okay, great. We got another questions from a couple of different people who ask getting at the relationship between this initiative and Section 3026, the community-based care transitions program and a couple of people asked if they are involved in a CCTP program - if they are one of the awardees or partnering with an awardee - would they be eligible to apply for this funding opportunity?

Tim Engelhardt: Yes, I'll try to answer that question really carefully because there's a distinction between who's eligible to apply and where we would be most enthusiastic about an intervention and those easily mix so we don't have any requirement that says if you're a community-based care transition program awardee you are not eligible to apply for this.

However, we wouldn't want to implement the intervention in a place where we had other kind of things going on to a significant extent and so the applicant might be eligible to apply.

They're not excluded by virtue of their participation in the community-based care transitions program; however, we'd be looking to make sure that the intervention funded through this particular opportunity was one that was discretely measurable and was not duplicative of kind of other interventions that CMS is sponsoring.

So in other words if that community-based care transition program is focusing on a lot of nursing facility residents - supporting a lot - then that probably diminishes the value that the review panel would see that we were getting out of that application.

But if it was an entity where the community-based care transition program was focusing on a different target population or in a different geographic area or in different ways, then the review panel is probably going to be much more likely to look on that favorably.

Marisa Scala-Foley: Okay, let's see. Well, let's first, Catherine, have we gotten any questions in through the audio line?

Coordinator: We have one question by the phone. Mary Beth Personney, your line is open.

(Mary Beth Personney): Yes. My question is, are assisted living providers that serve dual-eligible participants able to participate in this initiative?

Tim Engelhardt: I'd encourage anybody who wants to think about applying to really carefully look at the eligibility criteria that we put in the funding opportunity announcement. Again there would be we do not have an explicit prohibition on an assisted living provider being involved in this should they meet the other kinds of requirements and expectations that we have on the demo.

But I encourage everybody to think about that in addition to the contextual factors about where and how to sponsor a new demonstration.

Mary Beth Personney:Thank you.

Marisa Scala-Foley: Okay, any other questions that have come in through the audio lines, Catherine?

Coordinator: We have no questions at this time.

Marisa Scala-Foley: Okay, a couple of questions that we've gotten in. I'm just trying to - bear with me while I scroll up through this, through our chat function - another question from Amy who asks, you know, based on some published work documenting the relationship between Medicaid bedhold policies and hospitalizations.

Tim, does your team envision that state Medicaid agencies that partner on successful application might consider policy changes or waivers to those policies?

Tim Engelhardt: Amy, great one. We've got some - I alluded to a relationship between Medicaid payment policies and how that affects hospitalizations even though the hospitalizations are covered by the Medicare program - and in fact one manifestation of that is that some states pay what is called a bedhold day.

So in other words when someone is hospitalized, the Medicaid agency still makes a payment to the nursing facility essentially to kind of hold the bed essentially.

To some extent many of those policies were created at a point in time when nursing facility occupancy rates were way higher than they are today but those payments still, you know, may serve policy purposes in certain states.

Anyway, when a state makes a bedhold payment, people in that state are actually kind of have significantly higher odds of being hospitalized and we can read into that what we wish and to the extent that those states are really interested in kind of changing some of their other types of payment policies to support the goals of this intervention, we'd be really, really excited to talk to them about that.

Marisa Scala-Foley: Okay, we got another question in from Kristen. Bear with me while I scroll up. That was actually for Dr. Ouslander. She asks with regard to INTERACT, how can AAAs play a role in INTERACT program given their involvement in care transitions in other settings?

Dr. Joseph Ouslander: That's a great question. I agree with what Tim said before that this initiative offers a great opportunity for some of the AAAand just off the top of my head I could think of two or three different ways a AAA might assist.

One is in being the facilitator or convener of relationships between hospitals and long-term care facilities, I think AAAs could serve as a good knowledgeable neutral party.

AAAs may also have people working in them who could serve as a technical resource to implement whatever program is designed whether it be INTERACT or some blend of INTERACT and other programs for the intervention and other AAAs may have other healthcare providers who could contribute to these initiatives.

So for some of the triple-As I could envision a really great opportunity and an important role.

Marisa Scala-Foley: Okay, and actually the next question we got from Becky is for both of you who asks are either of you aware of any interventions related to behavioral health that have been successful in impacting preventable hospitalizations either in nursing facilities or in other settings?

Dr. Joseph Ouslander: That's a great question so certainly some of the preventable hospitalizations that we're talking about relate to behavioral health and with respect to the INTERACT program it doesn't specifically address those issues except there is a care path and some other guidance in the changing condition file cards related to acute changes in mental status.

I know but I do think it's an important issue where when there are changes in behavior that could be a manifestation of a medical condition or a new onset or exacerbation of a neuropsychological disorder that intervening on that successfully prevent unnecessary transfers.

There is a group and I can't remember the name now in New England that provides behavioral health supportive services to a lot of long-term care facilities very successfully and I'm sure you can find the name of that group.

And you may or may not know that CMS and advancing excellence campaign are announcing a major initiative in this regard on Thursday in I think it's a video conference or Webcast but I think this is a really important issue to address.

It also relates to part of this initiative in terms of polypharmacy because as Tim was saying that there's just a lot of polypharmacy and inappropriate medication use in this population so I think it's an important issue to address.

Tim Engelhardt: My only contribution is to concur wholeheartedly. In fact one of the things we included in the funding opportunity announcement is basically inviting people to please think about behavioral health-related interventions and pharmacy's a big part of it and there are other aspects of it too because we encourage everybody to think about relationships to the PASARR process - Preadmission and Resident Review process - as well in contemplating how they put these plans together.

Because we view the opportunity for improvement here to be enormous especially when we're thinking about behavioral health treatment within the nursing facility context.

Marisa Scala-Foley: Okay, Tim we got a similar question during the one we had before about people who are CCTP awardees and their eligibility to apply. Similarly if a healthcare system who plans to participate in a Medicare accountable care organization, would such an organization be eligible to apply?

Tim Engelhardt: Yes, and I'd say it similarly in other scenarios which is we don't have a requirement per se that would say you cannot apply if you are an ACO or if you're planning to be an ACO or a CCTP site or involved in a bundled payment demonstration or a medical home demonstration and I could go on and on.

However, applicants are going to need to make a very compelling case to the reviewers that the intervention that they're proposing here is not duplicative in

its funding or even in its kind of incentive structure in its evaluation of other types of demonstrations that are going on concurrently.

And so everybody's going to have to think carefully about how that plays out in the individual setting but we have the blessing and a challenge related to the fact that we have numerous kind of demonstrations happening or coming live concurrently and in many cases we don't even know where they are or the shape that they'll take quite yet as we go and that'll be one of the fun challenges of putting together a cohesive proposal.

Marisa Scala-Foley: Okay, Catherine, have we gotten any more questions, anyone else queued-up on the audio line to ask a question?

Coordinator: We have no further questions at this time so as a reminder, you may press star 1 on your touch-tone phone.

Marisa Scala-Foley: Okay, I think we got one more question in for Tim and that comes from Miriam, who asks do you have - will you - is it possible to fund more than one project in a state or are you looking to only fund one project per state?

Tim Engelhardt: No, it's very possible that we would fund more than one in one state of course, you know, not in mutually-exclusive facilities I think but no, we're not restricting it to one per state.

Marisa Scala-Foley: Okay, and anyone else, Catherine, who may have hit star 1 in the interim?

Coordinator: Yes, we actually have two questions in queue. Peggy Haynes, your line is open.

Peggy Haynes: Thank you. I'm calling from Maine and it's a rural state and in the solicitation it talks about having each nursing facility have an average of 100 residents per facility or is it possible to over the 15 facilities participating have an average of 100, we cover actually our two largest urban areas in Maine and would not be able to bring together 15 facilities of more than 100 beds.

Tim Engelhardt: Yes, it's an average across the 15 as opposed to each of the 15 needing to meet that threshold so it certainly could include some facilities that are smaller and some that are bigger.

Peggy Haynes: Great, thank you.

Tim Engelhardt: Sure.

Coordinator: The next question is coming from Frazier Bunton. Your line is open.

Frazier Bunton: Thank you. Tim, a question for you. If a group has more - has two nursing home groups of 15 homes or more - in two different states that are not contiguous, would you recommend that just pick a state and apply for one grant in that state or potentially do two demonstrations across two separate states?

Tim Engelhardt: Well, we actually we put in kind of something like confusing provision in our funding opportunity announcement saying that you actually could apply with groups of facilities in multiple states but you basically had to meet all the requirements in each individual state.

Frazier Bunton: In each state.

Tim Engelhardt: So, you know, if you have a group of facilities in Arkansas and another one in Alabama, you need to have your letter of support from each of the respective state Medicaid directors and each of them have to meet each of the criteria.

I wouldn't dissuade anybody from applying with groups in multiple states and that's in part because kind of those some of those contextual factors might play in as well and we'll give additional weight to proposals from sites with high admission rates and so I wouldn't discourage anybody from applying with groups from multiple states.

And whether you do that mechanically as one application with two sets of attachments or multiple applications, I think we're okay in either Scott Craig.

Frazier Bunton: Okay, great. Thank you.

Marisa Scala-Foley: Anyone else, Catherine?

Coordinator: Yes, actually we do have another question coming from Christine. Your line is open.

Christine: Hi. My question has to specifically with INTERACT. We talk a lot about it in the nursing home environment and I am curious if you can comment on its use in assisted-living facilities.

Dr. Joseph Ouslander: Yes, hi, this is Joe Ouslander. It's a great question. The answer is yes. Many people have asked about that and many I think assisted-living providers are starting to use INTERACT or parts of it. When you look at INTERACT it's just good geriatric care made hopefully more user-friendly.

The one caveat about that is again the purpose of INTERACT is to improve the management of acute changes in condition and that certainly is applicable to the assisted-living setting.

However, when you get to trying to manage acute changes in condition, we don't want providers who are not well-prepared in terms of infrastructure needed to do that, to manage separate patients, to attempt to do that without good skilled staff and the other resources that are necessary, access to laboratory testing, access to pharmacy services, etcetera.

So I think the principles of INTERACT are certainly applicable and can help improve care and assisted living but executing, preventing, prevent unnecessary transfers may be more challenging.

Christine: Great, that's very helpful. Thank you.

Coordinator: We have no further questions at this time.

Marisa Scala-Foley: Okay, thank you, Catherine. We've got another question - a couple more questions - in via chat then we'll try to close things out. The first one comes or I think both of these are for Tim.

And the first one comes from Maureen who asks with regard to the target population that you talked about, while we understand the primary target population is fee-for-service long-stay dual enrollees, can individuals who go to a facility as sort of a Medicare post acute stay but who are at risk - who are sort of pre-duals - who are at risk to transitioning to Medicaid long-term care coverage also be included as part of the target population?

Tim Engelhardt: Recognizing that there's this group of people who are, yes, pre-duals is a great term who are and it's been done in fact many cases we kind of know who's a dual before they're officially dual because they have applied for Medicaid eligibility and sometimes it takes as I say it's a couple of months to process that and make the decision and then supply it retroactively.

But in any case we allow in the responses to FOA we allow bidders to describe to us any ways in which they might propose to reach out to other non-dual populations be they Medicare-only or Medicaid-only if they can make a proposal to us that they think that the potential benefits and potential savings are comparable to those that we would get from focusing on dual-eligibles in the population.

So the opportunity exists that the target population remains long-stay, Medicare-Medicaid enrollees but applicants can propose ways in which they would identify additional populations where there's comparable benefits available.

Marisa Scala-Foley: Okay, and I think the last question that we'll take comes from Amy who asks - and Tim this one is also for you - she asks, you know, understanding that there are several possible models, one of the requirements in the RFP states that the model include a person on-site.

Does the person have to be literally on-site full-time or could it be someone who's sort of available to be on-site when contacted?

Tim Engelhardt: Well, we expect that the model will include some on-site presence but we were not prescriptive about the number of hours on-site or who that staff actually had to be. We just want to make sure that it's not a completely

telephone intervention. We want to make sure that we're adding at least some physical presence to some extent.

Marisa Scala-Foley: Right. Any last questions on the audio line, Catherine?

Coordinator: At this time we still have no further questions.

Marisa Scala-Foley: All right, with that then we will close things out. I just want to thank both Joe and Tim for wonderful thought-provoking presentations and thank you very much to you our audience today for such stimulating questions.

If you think of any questions, you know, an hour from now or two days from now of if you have any suggestions for future Webinar topics, we invite you to e-mail 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.

And again thank you to our speakers and thank you all for joining us today. We look forward to having you with us on future Webinars. Thanks again.

Tim Engelhardt: Thank you, Marisa.

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