Administration on Aging
Affordable Care Act Training
Defining Communities: Partnerships between QIOs and the Aging Network
September 27, 2011
2:00 - 3:30 pm Eastern

Coordinator: Thank you for standing by. All participants will be in a listen-only mode until the question-and-answer session.

If you ask a question at that time, please press star 1. Today's conference is being recorded. If you have any objections, you may disconnect at this time. I would now like to turn the call over to Marisa Scala-Foley. You may begin.

Marisa Scala-Foley: Thank you, Daniella. Good afternoon everyone. Thank you for joining us today.

As Daniella mentioned, my name is Marisa Scala-Foley. I work in the office of Policy Analysis and Development at the Administration on Aging.

Thank you so much for joining us for this month's webinar which is our latest in a series of webinars that are 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.

Thank you for staying with us. We had a few technical difficulties, but we hopefully have gotten them resolved and we will forward with what we're looking to be a terrific webinar today.

As you know if you've been with us on past webinars, our focus for much of this year has been on the topic of care transitions. Patients or clients going from care setting to another whether that's from hospital to home, from hospital to skilled nursing facility, and more. And these webinars are designed to provide the Aging Network with the tools that you need to help to develop care transitions work in your area.

We know that many of you have submitted or in the process of working on your applications for the Centers for Medicare & Medicaid Services community-based care transition program also known as the CCTP which was authorized by Section 3026 of the Affordable Care Act.

A very important part of these applications is the development of root cause analysis basically identifying the underlying functions leading to poor outcomes in this case readmissions to hospitals and using that root cause analysis to select an intervention or a model that is appropriate for your community for care transitions to select a target population and to drive your budget.

Quality Improvement Organizations also known as QIOs can be invaluable resources and partners in this process. And part of their latest contract what's called the 10th Scope of Work focuses on this work.

In today's webinar we will hear more about the QIO 10th Scope of Work and how it relates to care transitions as well as lessons learned from the care transitions sub national theme that was included in the 9th Scope of Work.

And finally we'll take a closer look at a care transition partnership in action between a QIO and an area Agency on Aging.

For those of you who were with us last month when we got interrupted by the earthquake, you'll get to hear the content that we never got to hear in August. So if you were with us last month, we thank you for joining us again and we're hoping for no natural disasters this time to interrupt things.

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

First of all if you have not yet done so, please use the link that was included in your email confirmation or one of your reminders to get onto WebEx so that you can not only follow along with the slides as we go through them but also ask your questions when you have them through the chat function.

If you don't have access to the link that we emailed you, you can also go to www.webex.com, click on the attend a meeting button at the top of the page, and then enter the meeting number which is 661172599. Again, you can go to www.webex.com, click on the attend a meeting button, and enter 661172599 which ought to get you into the webinar.

And if you have any problems with getting into WebEx, please do call WebEx technical support at 1-866-569-3239. Again that's 1-866-569-3239.

As Daniella mentioned, all participants are in listen-only however we welcome your questions throughout the course of this webinar as always. There are two ways that you can ask your questions.

First through the web using the chat function in WebEx. Enter your questions, we'll sort through them and answer them as best we can when we take breaks for questions after each team presents.

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

And if you think of any questions after the webinar or if you have any questions you'd like us to follow up on, you can email them to us at affordablecareact@aoa.hhs.gov. Again that's affordablecareact@aoa.hhs.gov.

As Daniella mentioned, we are also recording this webinar. We'll post the recording, slides, and transcript of the course of this webinar on the AoA Web site as soon as possible likely by the end of next week.

So with that, we've had enough housekeeping. Let's get to our wonderful panelist speakers we have joining us today.

The first speaker will be Traci Archibald. Traci is with the Office of Clinical Standards and Quality, Quality Measurement, and the Health Assessment Group in the Division of Chronic and Post Acute Care with the Centers for Medicare & Medicaid Services. Traci will kick things off.

Then we will move to Naomi Hauser. Naomi is the Director of the Care Transitions Project with Quality Insights of Pennsylvania.

After Naomi will be Tim Landrin who is the Director of Home and Community-Based Long Term Care Division in the Southwestern Pennsylvania Area Agency on Aging.

And finally will be Ray DeCoeur who is the Administrator of the Westmoreland County Area Agency on Aging and both of these area Agencies on Aging are in Pennsylvania.

So with that, I will turn things over to Traci to get started.

Traci Archibald: Thanks, Marisa. We can advance to the next slide. Thanks for having me on this webinar.

I wanted to talk to you specifically about the Quality Improvement Organization's technical assistance in the QIO Scope of Work related of recruiting and convening communities that will work to reduce hospital readmissions. And the name for this work in the Scope of Work is the Integrated Care for Populations and Communities Aim.

I want to talk to you a bit about the importance of the community recruitment engagement and collaboration of the community to reduce hospital readmissions.

And then as Marisa said earlier to talk a few minutes about some national care transitions theme in the 9th Scope of Work where we work intensively in 14 communities.

So the goals of the Integrated Care for Populations and Communities Aim is to improve the quality of care for Medicare beneficiaries as they move from one provider setting to another as well as to reduce 30-day hospital readmissions by 20% over three years.

And as many of you know that goal is in alignment with the Partnership for Patients goal to reduce 30-day hospital readmissions over three years by 20%.

So one of the main roles of the QIOs have in providing technical assistance is to help identify potential communities. And the way the QIOs are defining communities is by the Medicare beneficiaries that live in a contiguous set of zip codes.

So we're looking from the community perspective to see if we can improve the care for the beneficiaries that live in specified zip codes rather than solely looking at improvement based on hospital providers' readmission rates only.

So this allows us to -- if beneficiaries goes from one community, they go on vacation, or snowbirds -- we can still account for the readmissions that occur outside of their community.

The QIOs technical assistance kind of goes into four different categories: the community coalition formation, helping perform the community specific group cause analysis, identifying ways for intervention selection and implementation, and assisting with the application for a formal care transition to programs such as ACA 3026 as Marisa mentioned earlier.

So in terms of community coalition building and support, QIOs have some experience in the 9th Scope of Work and are using that experience in terms of providing their communities with education on various models for convening the community and interacting within a community.

They have something called social network analysis which I'll go over in a bit more detail. They can help with strategic planning and developing in signing a coalition charter.

So in order to help build a community, we've identified in the 9th Scope of Work four main ways that communities came together to tackle the problem of improving care transitions. And you'll hear later from one of those communities and how they designed their model of community engagement.

So the first is multi-representative Steering Committee where leaders came together from all different types of providers as well as community stakeholders consumers to work on the issues that they identified were problematic in their community typically based on a particular topic.

So there may have been a subcommittee that works on identifying ways to transfer information across care settings in a more streamlined manner or other types of topics and then bringing that back to the overall steering Committee.

The second model that was used in many of the communities was aggregating providers vertically in clusters and then merging. So typical referral patterns that are occurring; hospitals, specific nursing homes, and home health agencies, and physicians would come together to work together to figure out how to improve the care across those settings that they commonly referred patients to and then merging those across the community.

The third is aggregating providers by setting and then vertically integrating. So the home health agencies work together to come up with strategies to improve care for their beneficiaries and then integrated that with the processes that the hospital and nursing homes were working on.

And finally the least used model was individual improvement projects with an information and data broker where each of the different provider types kind of

worked on their own improvement projects and then used the QIO to help communicate their efforts.

So this is just a slide that visually depicts the four different models.

So another key form of technical assistance that the QIOs can provide is something that was developed in the 9th Scope of Work by Qualis, the QIO in Washington. And what it is is a map that visually depicts the number of transitions that are shared between providers in the community. So if you can go to the next slide.

So this is the visual depiction of the social network analysis. The thickness of the lines show the number of transitions that are experienced. So the thicker the line, the more transitions that are shared between the two providers that are connected. And the red is the thing that you want to avoid which is where patients are being readmitted back to the hospital.

So this is a tool that can be used both to identify partnerships where there are more transitions occurring and then have those two providers working together closely to figure out how to fix that problem as well as to show improvement over time by doing the analysis at two different time periods and showing the change. If you see fewer red lines, then there's improvement. Next slide.

So the QIOs can also have learned about developing a strategic plan and one of the important things about that is including a broad range of community leaders. So provider groups, the community-based organizations, which are required to submit an application for the ACA 3026 working of course with Area Agencies on Aging and ADRCs, working with regional health

initiatives, state and local governments, other advocacy and service organization and other payers.

So during the 9th Scope of Work we learned a lot about why patients are readmitted to the hospital and identified three main drivers of four transitions.

The first was for information transfer between providers.

The second was decreased patient or family activation. And what I mean by that is that patients or families are not fully capable or actively participating in their healthcare.

And then the third is the lack of a standard of known process for sharing patients among providers. So there may not be a uniform transfer forum that's used for communication or there may not be an effective protocol for managing heart failure patients that come to the hospital.

So one of the strengths of the QIOs is working and being able to provide data to the providers that they're assisting in the communities that they're assisting.

So QIOs can help with the development of a community specific group cause analysis which is one of the pieces that is needed for the application for Section 3026.

And the kinds of things that they can do data analysis for are the proportions of transitions table which is what was visually depicted in the social network analysis that I showed you earlier, community coalition readmission rates, admission rates.

So looking at it from the perspective of the community: provider specific admission rates and readmission rates, emergency department rates, observation stays, mortality rates, post-acute care setting, specific rates, and disease specific readmission rates. So those are just some of the analyses that could potentially be run by the QIO.

They also have experienced and are very skilled at helping with process mapping, helping identify ways to do chart reviews, and incorporating patient and stakeholder feedback.

So the next piece of technical assistance is helping with the intervention selection process and the implementation plan. As part of 3026 application, communities are required to use the root cause analysis to determine which interventions will best fit addressing those root causes of poor care transitions in the community.

And so selecting from the evidence-based interventions that exist right now kind of is an important thing in terms of the strategy for the community in terms of tackling and implementing interventions.

So the selection of the interventions is going to be based on a lot of different things including the programs and resources that exist within the community already - the other funding resources. Looking at the costs associated with intervention implementation as well as how big or small the project is going to be - where the focus is.

Also a really important thing to consider is the sustainability of the model that’s being implemented and what the community desires to have implemented.

So the CMS has published the table of interventions in the Remington Report from January of 2010. And there is a list of all the evidence-based interventions from that time as well as the drivers that are targeted by those specific interventions. And those interventions are also on the National Coordinating Center this project's Web site which I will show you at the end of this presentation.

So QIOs are going to be advising and providing assistance to communities as well related to measurement of the intervention. So they're skilled and able to help assist developing ways to incorporate a series of process and outcome measurements where the providers and CBOs will need to be collecting the data, but the QIOs can help facilitate what kinds of measures might measure the impact of the interventions that are implemented which is useful for showing progress over time as well as important for the application to Section 3026.

And then they can also tie those process and outcome measures through Medicare claims-based outcome measures for the intervention.

They're also going to be looking at providing some time series graphs to show the progress of an intervention over time so that you can see whether the interventions are being implemented in a way that is improving care for the beneficiaries on a more regular basis than what you could do with just looking at claims data.

So as I've kind of integrated throughout this presentation, the QIOs are ready and able to assist communities with applying for the participation into a formal care transitions program such as Section 3026 to do the data analysis and trending reports, the intervention selection, and rational and cost estimates, and some of the other application requirements.

And for those communities that either do not meet the requirements for a formal care transitions program or apply and are not accepted, the QIOs will be continuing to support those communities through a statewide learning and action network where communities can come together to share best practices and learn from each other in order to improve care transition.

They'll also still be able to provide the quarterly readmission metrics as well as communities can participate in twice monthly care transitions learning sessions on various topics related to care transitions and will still be able to use the QIO develop tools and resources that are on the Web sites. Next slide.

So some of the overarching lessons that were learned in the 9th Scope of Work three-year project was the importance of community collaboration, providers talking, and visiting each other.

We had hospital representatives visiting nursing homes that were across the street that had never done that before and never set foot in the nursing home. And sharing stories about experiences with helping patients be able to manage their transition better. So that was an important lesson learned - tailoring the solution to fit community priorities, really making it community specific.

Not every evidence-based intervention is going to work in every community and the goal is really to integrate some of these interventions and see the processes that are unique to each community. Of course making sure to include patients and families incorporating them when they're sick and healthy.

So some of the communities incorporated targeting senior centers to do education while the beneficiaries were healthy so that they would know how

to better manage their care if they did end up in the hospital or in a healthcare setting.

And finally public outreach activities using storytelling to support the data on readmissions. Next slide.

So the results of the 9th Scope of Work in 14 communities were that hospital readmissions work also reduces admissions. So that was something that we noticed early on in the project and that some of these interventions not only impact the 30 days after discharge, but impact the experiences patients are having as they move way beyond that 30-day mark.

So we were looking at population-based measures and our results show the readmissions went down as well as the admissions and the preliminary cost savings as a result of that are very promising.

And here's just a summary slide of preliminary results using relative improvement. We compared the 14 care transitions communities to 52 peer communities and as you can see the 14 are in the yellow bar. There was a significantly higher improvement of the 14 care transitions relative to their baseline than the 52 comparison communities.

And just a summary of the common winning themes had cohesive communities that were evidenced, you know, midway through the project. There was definitely providers that were really willing to work on this project and had some champions that were willing to engage. That they also included strategic partners in the community outside of the traditional provider partners.

That there was cross-setting work. It wasn't just hospital work. It crossed all post-acute care settings as well.

Using coaching as an intervention. I haven't mentioned it a lot here, but I think it may get mentioned later. Coaching patients to be more activated and to participate actively in their healthcare and know how to manage their care once they leave the hospital was an important intervention that almost all of the 14 used. And then strong community leadership from physician champions and others.

And now I'll turn it back to Marisa...

Marisa Scala-Foley: Hi.

Traci Archibald: ...or if there are any questions.

Marisa Scala-Foley: Yes. We've gotten several questions so let's go through them one at a time.

The first question came from (Miriam) who asked, "Are all of the QIOs able to provide technical assistance at this point on care transitions and other topics related to the 10th scope or just those in the 14 areas that participated in the 9th Scope of Work sub national theme on care transitions?"

Traci Archibald: So beginning August 1 of this year, we're about two months in. All of the QIOs are able to provide technical assistance related to care transitions. So its gone national since August 1 and the QIOs have come up to speed very quickly and are able and eager to provide that assistance now.

Marisa Scala-Foley: Great. The next question comes from (Kimberly) who asked, "Will QIOs be able to continue to provide technical and/or data assistance to communities that may get funded under the committee-based care transition program?"

Traci Archibald: So not direct one-to-one technical assistance because there is a technical assistance contractor that is already funded for the community-based care transitions program. So we want to avoid duplication of those efforts.

But QIOs will still be able to include those communities that are accepted into broader, you know, webinars and other things that are relative to the state improvement.

Marisa Scala-Foley: Okay. We got a question in from (Sherry) who asks, "How can the QIOs help when it comes to convening providers in communities looking to apply for CCTP?"

Traci Archibald: So I think that the QIOs have a history of building relationships with a lot of the providers within their state. Many of them have been QIOs for a long time and so they have the experience with the recruiting providers to work on specific targeted issues in their system.

And I think we are also providing a lot of technical assistance to the QIOs to help facilitate community convening in the most efficient way as well. So we're continuing to support the QIOs in those efforts, but they will be able to help and recruit and convene those providers to form a community.

I mean, it's going to depend a lot on the community's motivation. But I think that the QIOs are skilled and ready to help identify the best ways to approach those providers if any of the community-based organizations are having troubles with that.

Marisa Scala-Foley: Great. I think we'll take two more questions. We've gotten one from (Wendy) who asked, "Are the QIOs using a specific model in terms of supporting care transitions?"

Traci Archibald: Of the specific models that I talked about today, the QIOs are not necessarily using any one specific model for that. It's really dependent on the community itself.

And I think you'll hear more from Naomi and others later in this presentation about how they've determined the best way to approach what model would be best for their community. But again, it's really specific to how individual communities are setup and what their priorities are.

Marisa Scala-Foley: All right. And the last question and we've got this question in a couple of different forms from different people, people on the webinar would like to how can they identify the QIO for their area. Is there a list that they can access on a Web site?

Traci Archibald: Yes. I believe it should be up on our National Coordinating Center's Web site shortly if it's not already - the contacts for each of the leads on care transitions and the time scope of work. And it should also be posted on the Partnership for Patients Web site as well.

Marisa Scala-Foley: And we've got the...

Traci Archibald: So if it's not there right now, it should be very shortly.

Marisa Scala-Foley: And we've got the links to both of those included in the resources section of these...

Traci Archibald: Yes.

Marisa Scala-Foley: ...slides which we'll get to later on. Yes. All right. With that, I think we will - I want to make sure that we give our other speakers ample time to talk because they have some terrific lessons to share.

The next speaker who will go will be Naomi Hauser. Naomi is the Director of the CMS Care Transitions Project for Pennsylvania and she is the Director of Healthcare Quality for Quality Insights of Pennsylvania which is the QIO in Pennsylvania from 2005 until now. So with that, I will turn things over to Naomi.

Naomi Hauser: Thank you very much Marisa and thank you Traci for covering so much of that important information. Could we have the next slide please, Marisa?

I will be talking about -- in the 9th Scope of Work, Pennsylvania was one of the 14 states that was part of the pileup project -- and we'll be talking about some of the lessons we learned in the community that we work with in Southwestern Pennsylvania.

And of course just as a bit of a review -- the slides of readmissions -- the slides of the opportunity is about 1 in 5 Medicare patients is re-hospitalized within 30 days of discharge. These are national statistics.

More than 85% of these re-hospitalizations are unplanned and the majority of Medicare beneficiaries who are hospitalized have been hospitalized before in the last year. Next slide, please.

To show all of you who are not familiar with Pennsylvania, this is the State of Pennsylvania and the Orange area is the Southwest Pennsylvania community that was identified to work in the 9th Scope of Work.

And that community was chosen because it had a higher than average readmission rate - higher than state average. It was located in Western Pennsylvania in the community surrounding Southern Pittsburgh of the metropolitan area. And the community spans most of Westmoreland County and small portions of Allegheny, Washington, and Fayette Counties.

The important part as Traci had said was developing partnerships and developing coalitions. Developing a community, developing relationships, and partnerships was really a very critical first step.

And very early on in the project one of the interventions that the root cause analysis showed that was needed in the community was to develop a care transition - a coaching transition intervention. And so the question was who would we partner with and where would we go to find the resources for that.

So one of the developing partners early on was approaching the Triple-As and the hospitals together to ask them how they saw that this could actually happen.

It was also critical that we engage leadership from all of the providers very early on. And the QIO set the culture for collaboration by making sure that there was transparency be equaling the playing field and making sure that the conversations were in a non-blaming way.

And developing partnerships, you may ask why did we pick the Triple-A has being a resource for having care transition coaches. Well one of the reasons

was that you can grow admission of the Triple-A and the project for the 9th Scope of Work all fit very nicely together. They had a shared vision.

The model that we were going to develop was sustainable and even after the QIO or after the 9th Scope of Work the model would be sustainable and in fact it is. And leadership and staff commitment was definitely there.

And doing a home visit was part of the care transition coach program and Triple-As are already very skilled at doing home visits. This would not have to be a skill and a competence level that would have to be developed and observing for additional services needed in the community. This was a perfect resource that was available in the community and would be very easy to transition over to. Next slide.

The referral process was certainly something that had to be worked out between the hospitals and the Triple-As. Although they had a relationship and had been working together, you know, throughout the community this was a different type of partnership they were going to have.

They had to work together to develop a workflow process that would work not only for the hospital staff and for the Triple-A staff, but also be seamless for the patients that were going to be included in this process.

And then there was a selection criteria and a risk assessment that had to be developed because obviously there were not enough resources to be able to coach every patient who was going to be transitioned from the hospital into the community.

So there were some other criteria identified was we certainly were going to reach out for Medicare Fee-For-Service, Medicare beneficiaries. We chose

that alert and oriented would be important or at least that they would have a caregiver that would be able to learn the essence of what we were teaching.

And diagnoses that we focused on were significant to that community and you would have to look at your community if in fact that was true and that was congestive heart failure, for chronic pulmonary obstructive disease, and AMI.

We found as we went forward that there was some other areas that we included, but this was how we begin and within the Care Transitions Interventions zip codes that we had identified for the community. Next slide.

The challenges were of course as always were the resources. There was really no funding mechanism for having the Triple-A do this and we had invited several Triple-A's approach, several Triple-As to do this, and only two of them actually saw the vision to be able to do this without any funding.

They did this budget neutral. They used their existing staffing and they used the staff that was already in place which of course had to be trained to be coaches, but at least were willing and able to do this. And the leadership was always behind this effort.

And 8% of the discharged patients were in fact coached and the challenge was that our Medicare Fee-For-Service was one of our criteria, our Medicare Fee-For-Service population in that particular community was decreasing.

So therefore even when we had enough resources at times, we did not have the number of Medicare Fee-For-Service patients that we needed to approach. That was a few of the challenges. Go ahead.

Some of the outcomes. We had very, very positive outcomes once the coaching was put into place between June 2009 and May 2011. Nine hundred and fifty or 65% of the patients accepted coaching. Eleven percent were overall - (decreasely) overall readmission rates and 497 completed the 30-day program. The coaching program goes over a period of 30 days and so 497 actually completed that 30-day program.

And the very important part is 74% of the patients demonstrated they became more activated or as Traci said more involved in their care. And we actually measured that by applying a questionnaire in the beginning of the coaching process and then reapplying that questionnaire 30 days after. And 74% of the patients did demonstrate an increase in activation scores. Next, please.

Some more patient outcomes were what we wanted to measure -- we knew this was better for patients because they were more activated, we knew this was better for patients because they were not going back to the hospital as much -- but we wanted to know did this do something for the relationship between the Triple-A and the hospitals.

So we developed a questionnaire and the questionnaire was addressed to the Triple-A staff that were identified as coaches and to the hospital staff that were involved in this process for the referral system, etcetera. And some of the questions that were asked we got a 96% response that staff said that they understood that the purpose of - oh, I'm sorry. I just stepped ahead for this.

This is for coach patients. Forgive me. This is for coach patients. When we asked the questions after we got done after the 30 days of was this helpful for you and to show the patient activation, 96% of the patients stated that they understood the purpose of their medications.

Ninety-six percent stated they understand the red flags of their condition or red flags that identified worsening of their condition, and 97% were more comfortable talking to their physician.

And 88% stated that they continued to use and update their personal health record which is a record that the patients keep for themselves and take from provider to provider.

And 96% stated that they had not been re-hospitalized since the last call from their coach. Next slide, please.

So the success was for the 9th Scope of Work was definitely in the relationship building that occurred across the community in the workflow and referral process that was developed by the providers in the community certainly with the help of the QIO and that there was a decrease refusal rate.

We found out in the very beginning when we first started approaching patients that there was anywhere from a 70% to 80% refusal rate. And we did get that down to a 45% refusal rate which was nationally considered very good.

Also, there was an expansion of community services that we could measure, and increase in patient activation, and lower readmission rate as we saw in our outcomes. Next.

The lessons we learned were engaging all levels of leadership for support was very important in developing a workflow process collaboratively so that everybody had skin in the game and everybody really was part of the process being developed, train and involve staff and leadership together.

Dr. Coleman actually came to the community and did training to the leadership, to the staff of not only the hospitals, the Triple-As as well as the QIO, and to have consistent Triple-A coaches on site three to five days a week.

There were several models that were tried, but having a consistent coach being the same person instead of having several part-time people having the same coach going into the hospital lent to more consistency for the program collecting data weekly and documenting the progress which was essential to know if the program was a success, ongoing monitoring and support to define success, and complete post-coach follow-up calls. Next slide, please.

Obtaining funding resources early and now we have the CCTP funding which is available for communities that decide to apply for that. So there will be resources for this kind of program (in) bringing all players to the table and leveling the playing field, support face-to-face and open communication between partners without blame, discussing opportunities and barriers openly is very, very important when that kind of communication happens in the community, robust facilitation from the QIO to even the playing field, and assist in data management, and complete post-coach follow-up calls. Next slide.

So the QIO story is the benefit of collaboration and lessons learned. The QIO role was critical to bring the community together. There was question about that and enhance relations with the hospital staff administration support, value on site hospital visitations, the value of the Triple-A involvement, and patient empowerment.

Some of the barriers were again just the resources and now the next steps are an intense Scope of Work. Next.

I'm going to turn the presentation over to Tim Landrin from Southwestern Triple-A. Tim, do you want to take it.

Tim Landrin: Okay. Well thank you, Naomi. This is Tim Landrin from the Southwestern Pennsylvania Area Agency on Aging.

Now this first slide talks about just a review of the points that I will cover. My focus will be on the specific collaboration and the relationship between our two Triple-As -- the Southwestern Pennsylvania Area Agency on Aging and also the Westmoreland County Area Agency on Aging -- our relationship with our respective hospitals.

The next speaker, Ray DeCoeur will talk more about the care transitions model. If we can go to the next slide, please.

Here you see the Triple-A mission. As Naomi said before, our involvement in this project was completely consistent with our mission to serve the older population. You see the mission statement there. This is a standard mission statement for most Area Agency on Aging. I'm sure there are variations.

But what we do in the community is provide many, many services as those of you who are involved with Area Agency on Aging know. Here in Pennsylvania we have the various senior centers.

As far as preventive care we have senior centers, volunteer opportunities, preventative health classes, nutrition services both home delivered meals, congregate meals. Transportation especially in Pennsylvania especially in our area it's a very rural area so transportation is very important.

Other home and community-based services such as the Medicaid Waiver program, adult day services along with caregiver assistance, and various other supportive services for folks to help them remain in their home and community. If we could go to the next slide.

This is the depiction of our coaching partnerships. As we have said, there are two Area Agencies on Aging. Westmoreland County Area Agency on Aging worked with the Excela Hospital specifically one. There are three Excela Hospitals in Westmoreland County. Primarily the Westmoreland County worked with the Excela Westmoreland Hospital. The other two are in Latrobe and in Mt. Pleasant is called Frick Hospital.

The Southwestern Pennsylvania Area Agency on Aging worked with one community hospital - Monongahela Valley Hospital. So those were the folks we worked with. Next slide.

This is a, you know, Naomi had mentioned and this is where we talk about our improved relationship with the hospital. As we work with the hospital staff, our relationships improved in a number of areas and you will see in the next slide the results of the questionnaire as we move forward. And so if we could go to the next slide, please. That would give us a, you know...

There you see the relationship success - a summary of that. You're looking at, you know, you see that the hospital staff believe that they have more contact with the Triple-A than before the project began. They know more about the services that the Triple-A can provide to the patients. That was a great help.

They feel more confident about understanding the services the patient needs upon transition back into the communities and with that relationship with our staff. And they are more satisfied with their contact with the Triple-A staff.

We always had that communication however, you know, this improved it. Our communication improved greatly.

From the Triple-A standpoint as far as our staff is concerned, we felt more satisfied with our hospital contacts. We became a part of the team in the hospital. It was felt that referrals from the hospital were more appropriate because of the understanding of the programs.

Triple-A felt that the confidence to patients needs are met, more confident that the hospital staff understands the services that the Triple-A provides to patients, and have more content and interaction with the hospital staff about the referrals and services in the community.

So just to summarize, you know. There was improved communication between the hospital and the Triple-A especially with the social service staff at the hospital.

The hospital staff know more and understand more about the services that the Triple-A provides even though we've been in the community for quite a while and provide a number of different services and have relationships with those hospital staff. It really improved quite a bit I believe.

And also the Triple-A staff felt that the referrals from the hospital became more appropriate. Thus, the services that have been provided to the staff more services have been provided to the patients who transition back into the community and you see that relationship.

A couple of those things I just wanted to talk about there really are no slides for, but just the effect on our services - on the Triple-A services. This experience has provided us with the opportunity to provide the necessary

home and community-based services to the patients who were coached as they transitioned back to the home.

Now not all patients that were transitioned that we coached needed any additional home community-based services. However, those who did where we were able to provide those services or at least attempt to provide those services if they were eligible for various services and also assist in reducing re-hospitalizations because they were getting services in the community and we were able to provide those services and act as a preventative measure in keeping folks from re-entering the hospital.

Some of the lessons we learned and some of these were mentioned and I just wanted to support that. Some of the lessons we learned as we worked through this coaching transition, it is very imperative that there be a strong support from both the Triple-A and hospital administrative leaders. That was key from the very beginning. Not only the leaders going to the training, but also being involved in the development of the whole program.

Development of the workflow process needs to be done collaboratively. Everybody has to have a say so in that and it's very, very detailed. Pay attention to the details of the process. Do not assume anything.

In talking about just the fact that an Area Agency on Aging staff member going into the hospital, do they need an identification badge? What else do they need? Where did they go? These types of things, very detailed so paying attention to that was very important for us. There were numerous meetings both face-to-face and by conference call as far as that is concerned.

As developed this workflow process, we also learned to respect each other's policies and limitations and to be open to suggestions. Those of you who work

with hospitals know that sometimes it's a different culture and they had to respect ours, we respected theirs, and it was a very open and honest conversation that we had with them throughout the whole process.

The other thing as far as selecting our staff - who did the coaching, who performed the coaching. We had three care managers and one registered nurse who were coaches who were trained as coaches. And so we looked for people who had knowledge of medical conditions that would be involved in this program, looked for flexibility -- make sure that folks could be available at times and be flexible -- organizational skills, and certainly having a positive attitude toward the whole idea of coaching and the process that would take place. So those were things that we looked at from that point of view.

Challenges, a couple of challenges we found at least in the hospital that we worked with in Southwestern Triple-A. The involvement of the nursing staff on the floors of the hospital, they need to buy into the concept. That was a bit of a challenge for a while, but I think we moved past that and we did very well after that.

The other challenge we saw was the referral for coaching from the hospital need to be made as soon as possible so that the coach can visit the patient before they leave the hospital.

Many times whenever we received a referral, the patient had already gone home so we didn't -- and Ray will talk about the model that was being used where in the care transition intervention model there is supposed to be a visit to the hospital -- and many times, or a few times, quite a few times that hospital visit couldn't be made because the person had already left the hospital and was at home. So that's just something else, you know, to work with the hospital on and we did that and that did improve as time goes on.

Our next steps, we are in the process of recruiting other hospitals to apply for the 3026 funding. We want to make sure that all the hospitals begin with the same consistent knowledge base and information.

The hospital that we work with - Monongahela Valley Hospital obviously has that. But the other two hospitals we want to make sure that they are, you know, so that we have a same level playing field as we go along.

And then the other next step we were looking at is enhancing the coaching experience by including services provided by our agency to the patients who are coached and now are now living in their home. And again just making sure that the services that we provide in the community -- all those various home and community-based services -- are available if those folks need them.

So that's where we are at this point. Thank you.

Marisa Scala-Foley: All right. Now I think we'd like to turn things over to Ray DuCoeur who's the Administrator of the Westmoreland County Area Agency on Aging who will talk about their part of the story in their partnership with Quality Insights. Ray? Ray, you need to take yourself off mute if you're on mute.

Ray DuCoeur: (Hello).

Marisa Scala-Foley: Ray, are you there?

Ray DuCoeur: Yes, I am.

Marisa Scala-Foley: Okay, great.

Ray DuCoeur: Okay. I'll start again here. I want to thank you Marisa and Tim and Naomi, and I want to wish a good afternoon to everyone on the line here.

I'm going to briefly address the coaching component itself and share a couple of highlights. Next slide.

We utilized the Dr. Eric Coleman model for coaching. In simple terms, the Coleman model is composed of four pillars. Those pillars are first, medication management; second, the personal health record; third, follow up with the primary care physician and/or specialist; and fourth, knowledge of red flags or warning signs and/or symptoms and how to respond to those. These are all important and proven to be effective in reducing unnecessary readmissions.

The use of a transition coach is one among several interventions and among other models for example Dr. (Mary Knailer)'s model and project (rata), etcetera. These are models that can be used to reduce readmissions.

The transition coach is a trained professional who helps patients become more empowered with their own healthcare. Next slide.

The primary role of the care transition coach is to empower the patient or caregiver to assert a more active role during care transitions and develop lasting self-management skills.

This coaching intervention is comprised of two visits; one in the hospital prior to discharge and one home visit preferably within 48 hours of discharge.

These are followed by three follow-up phone calls at days intervals of 2, 7, and 14 days and are completed within one month.

Strengthened patient activation is a primary goal to coaching intervention. Some examples of this strengthened activation are under medication management.

For each medication the patient understands the purpose, when and how to take, and possible side effects.

Under red flags, the patient demonstrates an understanding of red flags or warning signs that condition may be worsening.

Under medical care follow up, the patient can schedule and follow through on appointments.

And under personal health record, the patient agrees to bring personal health record to every health encounter.

Improvements in these areas are proven to reduce readmission rates within the 30-day timeframe and beyond. Next.

A couple of the challenges include the effort to shift the way of approaching healthcare towards self-empowerment and activation. And secondly, the more pragmatic logistical challenge of scheduling the initial home visits.

We have learned that there is a great benefit in having coaches that have both strong people skills and a commitment to an individual's empowerment as the philosophy. Next.

The successes have been both statistical and anecdotal. First, readmission rates within 30 days have been cut in half for coached individuals.

Secondly, for several persons their reasons for not visiting the physician such as the cost of transportation or not purchasing medications such as medication cost and utility cost were eliminated via linking them with various programs such as Shared Ride which is a transportation program in Pennsylvania, PACE which is a pharmaceutical program in Pennsylvania, or LIHEAP which helps with the heating bills. As a result, physicians were visited and medications were taken and readmissions were avoided. Next slide.

Lessons learned. Many lessons were learned. For success as has been mentioned several times, the congruent mission between the Triple-A Quality Insights organization and hospital which is a necessity, leadership, staff buy in, committed collaboration, and the availability of a dedicated coach are essential. Out of this collaboration already good relations between partners became better.

Working with Quality Insights, Pennsylvania in partnership with Excela Health in our county has been very beneficial to us and more importantly to the people we serve who are experiencing lower readmission rates along with that we think an overall higher quality of life.

And at this point, I want to thank you for your attention and we'll be open for questions I assume.

Marisa Scala-Foley: Yes, we will. Thank you so much to Ray, Tim, and Naomi. Several of you have asked some questions. We're just going to take a couple of minutes to go through the resources section of the slides and then we will answer some of the questions that have come in through chat as well as open up the audio line for anyone who wants to ask a question that way.

First, we've included a couple of resources specifically related to QIOs and care transitions. You heard both Traci and Naomi talk about the resource center for the (ICPCA) and we've listed the Web site here. It's at cmsc.org/caretransitions.

We've also included the Web site for the Partnership for Patients which you heard Traci refer to it in care transitions and reducing hospital readmission is an integral part of the Partnership for Patients.

We've also included some general resources on care transitions. We've a link to the CCTP Web site - the Community Based Care Transition Program or the Section 3026 Web site.

We've also listed AoA resources related to care transitions. Our healthcare reform page which is where we store the slides, recordings, and transcripts from all of our webinars and all of those from this webinar will be posted there later this week.

We've also done a toolkit specifically for the Aging Network which focuses on preparing your organization to work on care transitions.

And we've also included some resources to the work that our aging and disability resource centers are doing on care transitions.

And finally a link to the report that the Long Term Quality Alliance has done on innovative communities also related to care transitions.

A few general resources on the Affordable Care Act including a link to the text a link to the Department of Health and Human Services health care reform Web site.

Our next training, our October training will focus on a critical part of care transitions which you've actually heard Ray discuss in the context of the Coleman model which has to do with medication management. We'll talk about some tools and resources that are being implemented around the country in this vital area.

And so with that why don't we go ahead and take a few of the questions - actually before we do that Daniella if you could let people know how they can queue up to ask audio questions and while they're queuing up we'll take a couple of the questions that have come in under chat.

Coordinator: Thank you. To ask a question, please press star 1. You will prompted to record your name. It is required to introduce your question. You may withdraw your question by pressing star 2. Once again to ask a question, press star 1.

Marisa Scala-Foley: All right. So let's take a couple of the questions that have come in through chat while we're waiting for people to queue up.

First question for Naomi, "Naomi, you had talked about," this question came in from Nancy, "and you had discussed that under the course of the work that you had did under the 9th Scope you reduced readmissions to 11%. Can you talk about sort of what the baseline was? What was your starting point from which you reduced readmissions to 11%?"

Naomi Hauser: Sure. Our baseline was at 19% when we started and by the end of a project it was 11% for the coached patients. And that was up to June 2009, but we continued through July and our absolute final readmission rate for coached patients was at 8%. So that was reduced from 19%.

Our general community reduction rate was at 12% and it was at 8% for the coached patients. So the coached patients had a lower readmission rate than any of the community patients altogether that were not coached.

Marisa Scala-Foley: Okay, great. Thank you, Naomi. The next actually series of questions has to do with the relationships with the Triple-As had with the hospitals. And actually the first one isn't necessarily about the relationship, but just about the size of the hospitals that you all worked with Tim and Ray. So Tim why don't you go ahead and start and talk a little about Monongahela Valley Hospital.

Tim Landrin: Yes. This is Landrin. Monongahela Valley Hospital is a small community-based hospital. It has a bed capacity of around 200 patients so a relatively small community-based hospital.

Marisa Scala-Foley: And how about you, Ray?

Ray DuCoeur: Yes. Well, Westmoreland Hospital and I don't have exact figures on that but it's a larger hospital but still not an urban center per se. I don't know the actual bed capacity of the hospital.

Marisa Scala-Foley: Okay. If the person who - (Cheryl), if you could email us afterwards, we can try to get that information to you on the hospital that Westmoreland worked with.

So the next question was from Pat and she wanted to know if you could talk a little bit about how you went about establishing the referral process that you all used with the hospitals and how you overcame any barriers in terms of accessing patient data.

Naomi, that latter one may be for you. Ray and Tim, maybe you can start and talk a little bit about the referral system.

Ray DuCoeur: Yes, this is Ray. There was a lot of discussion involved with that in deciding how to go about it. We did want to do it as simply a possible and we started out with actually just a faxing of the name -- maybe not even the name -- actually the hospital ID number of the person prior to, you know, our coming to visit.

We decided to pretty much minimize the amount of initial information that was passed along and decided that we would more in the process of the coaching in relationships pick that information up.

Marisa Scala-Foley: Tim, anything you wanted to add?

Tim Landrin: Yes. I was just going to say that we also began with a fax from the hospital with some basic information; room number, the patient's ID number, things of that nature, and also the admission date, and things of that nature.

But also as we changed the model a little bit where we had a coach going to the hospital at least one day a week because at the start the coach would go right to the central service department and get the list of patients who would be potentially available or eligible for coaching. So that seemed to work in a much better way. So that's one of the kind of the tweaks that we had and that seemed to be a good lesson learned.

Ray DuCoeur: I'd add too that the medical information upfront when there was concerns about how much of that could or should be shared and as we got to learn more about the Coleman model, we learned that that was less important at that point

and it was more learning largely what the individual believed that they were to be taking and then match that up with what was prescribed.

Marisa Scala-Foley: Okay.

Tim Landrin: I agree. We had the same situation, yes.

Marisa Scala-Foley: Okay, great. Naomi, did you want to talk a little bit about sort of the barriers that you all overcame or how you overcame barriers related to accessing patient data because I know that's one of the strengths of the QIO in terms of brokering some of these relationships.

Naomi Hauser: Yes. And I'd also like to say as far as the referral process, etcetera, what Ray and Tim were talking about. It was a very dynamic process that changed over time and, you know, it was a collaborative. Again it was dynamic, it was collaborative because it really had to be a process worked out between the hospital and the Triple-As.

And as far as the - I'm sorry. What was the last part of that that you had asked?

Marisa Scala-Foley: Overcoming barriers in terms of accessing patient data.

Naomi Hauser: Okay. Well first of all we had a confidentiality agreement that was signed by all the providers that as a QIO of course we can provide information at a patient level to the individual providers.

It was a matter of actually being able to share that information that once we had a data sharing agreement or we had a confidentiality agreement it was not

a problem and the confidentiality agreement was between the Triple-A and the hospital.

There was a concern in the very beginning that that would be problem, but because the Triple-A really was not actually in the chart -- they were not actually going in the chart -- they were not actually seeing patient-level information.

Marisa Scala-Foley: Okay, great. Along similar lines in terms of working with the hospitals, (Sharon) asked a question about, you know, the point of working on care transitions is to reduce readmission to hospitals. When you started approaching hospitals or working together did you have any issues? Did you have to sort of sell them on this issue of reducing readmissions because that, you know, certainly affects the bottom line in hospitals in (terms needed).

Ray DuCoeur: This is Ray. That was my first question when they first met us. I asked are you interested in this occurring - that we become involved with you to accomplish that. And the initial answer from day one was yes. So we took that to be the green light. And it did appear to be the case.

Naomi Hauser: And I also would like to add, I do think that when hospitals really understood the way in which readmissions were going to be handled moving forward and that payment was going to be tied to readmissions, etcetera, they really were very open to what kind of assistance can we get and yes we are willing to work on interventions to do this.

Marisa Scala-Foley: Okay. So a question from (Margaret) - and we'll take a couple of more questions through chat and then I do want to get the audio line in case we have people waiting there.

A question from (Margaret) and this is for the Triple-As, what funding did you use to support this program? Because I think from what I understand you weren't funded necessarily under the 9th Scope of Work.

Tim Landrin: This is Tim. I can tell you our experience. Yes, there was no funding through the 9th Scope of Work for us. We basically in Pennsylvania we have some (block) grant funding through - we're lucky here in Pennsylvania we have a lottery program that benefits the older population. So we used some of that funding plus what we call some local program income that we were able to use to help that.

We had full-time staff doing this so they still had caseloads and that type of thing. So we just worked around that and had them use part of their time. We also had limited the number of referrals that we would receive from the hospital.

Ray DuCoeur: Yes. We did the same as Tim. One thing about the program, as we became involved with it as it started out very, very small and it certainly grew and it certainly showed how effective it was even at the low numbers we initially saw. But we utilized the same type funding as Tim.

Marisa Scala-Foley: Okay. We're going to take one more question from the list in chat right now and then we'll open up the audio lines and then if we have any time left we'll go back to other chat questions that have come in.

And this question came from (Wendy) who asked, are either of the Triple-As also considering using the Stanford Chronic Disease Self-Management Program with patients whom they're serving through their care transitions work?

Tim Landrin: This is Tim. A very interesting question because we just had - well let me go back to the beginning. We have two registered nurses who are part of a program in Pennsylvania we call Prime Time Health which we provide preventative health classes. We have two nurses who have completed the full training in the Stanford Chronic Disease Self-Management Program.

And the interesting thing, the reason I was chuckling is because there's was a program today where we had a class involved and those folks just kind of walked past my office as I began the webinar. So yes, we have been involved in that.

Ray DuCoeur: Yes, we're looking at that as well.

Marisa Scala-Foley: Okay, great. Daniella, do we have anyone on the audio lines who'd like to ask a question?

Coordinator: We have a question from (Kailey McDivey). Your line is open.

(Kailey McDivey): Actually this might have already been addressed now I see on chat. But I was just wondering if there was any correlation between the day of the week of discharge from a hospital and the readmission rate? And how was this addressed when you put your coaching availability into place?

Naomi Hauser: Would you like me to answer that?

Tim Landrin: Certainly.

Naomi Hauser: (Unintelligible).

Ray DuCoeur: Yes, I'm thinking about that one. That's a real good question and certainly was an issue.

Tim Landrin: I know, both of those.

Naomi Hauser: We did kind of look at that, you know. At the very beginning we did a lot of analysis and obviously with the limited resources that the Triple-As had we couldn't have a coach in the hospital every day. So we kind of have looked at what day of the week -- if they were there once a week -- what day would work best and we picked I think arbitrarily it was a Wednesday because that would catch as many patients as we possibly could that were in-house in the hospital and catch them before they were discharged on Friday.

And, you know, if they came in on Monday this was a tough day for the hospitals. So it was worked between the hospital burden, and between the Triple-A and between catching as many patients as we could. And I believe Ray it was Wednesday was the day that the coach was in there every week, right?

Ray DuCoeur: Right. Yes, it was Wednesday.

Naomi Hauser: And Tim was there a particular day for your coaches? I don't think there was every a particular day?

Tim Landrin: No, there was a particular. We also went on a Wednesday afternoon. The coach would be there at 1:00 on Wednesday afternoon...

Naomi Hauser: Okay.

Tim Landrin: ...to discuss it. So that seemed to be the best day for the reasons that you had given Naomi, yes.

Naomi Hauser: Okay.

Ray DuCoeur: Well when we received the Friday referrals, it would certainly be more difficulties in terms of trying to setup the home visit within 48 hours. So we were definitely running into that problem. And I think it would be kind of interesting to see, you know, if there was maybe a higher rate readmission by having to do with when the discharge occurred.

Tim Landrin: I think the other thing that we need to make clear is that even though we had a coach going in on that day on Wednesday, we were still receiving referrals throughout the week through that fax mechanism. So there were still faxes coming in with referrals to our agencies and we would respond immediately to get up to the hospital to see that patient so.

Ray DuCoeur: I would also add that we also tried to in terms of our hospital visits get in as early as possible. So we weren't' looking towards just getting in right under the time of the discharge, but to get in as early as possible in the process for that initial hospital visit.

Marisa Scala-Foley: Okay, great. Daniella, any other questions on the audio line?

Coordinator: No further questions.

Marisa Scala-Foley: Okay. We'll take the last couple of chat questions and then I think we will close things out.

Ray and Tim, we got this question actually from a couple of different people along the lines of what we were talking about before related to funding. A couple of people asked, you know, have either of you or your agencies approached hospitals about paying for this service? And what are you looking to for sustainability?

Ray DuCoeur: You want to take that first Tim or...

Tim Landrin: That has been approached with the local hospital. I think as we move forward now and in working with hospitals in the Section 3026 funding opportunity that's part of the process, yes.

Quite honestly we would need funding in order to continue the coaching as we are doing it now so. So talking to the hospital administration that has been discussed. There has been no decision on their part yet. However, they are obviously going to be involved with us as we move forward in trying to get that funding through 3026.

Ray DuCoeur: Yes like Tim, the 3026 is where we're, you know, that's where we're heading and if there's no success in that we'll certainly be talking to the hospital.

Tim Landrin: The hospital I know that we worked with were very appreciative and very supportive of our coaching as we moved forward. They saw it as a very positive aspect of the whole process and encouraged us to continue that as we moved forward so that's we are obviously moving forward then.

Ray DuCoeur: Same here. And I think that they're looking at it like we are in terms of well how are we going to continue this and how can we expand upon this. And it's more or less whatever it'll take to do that.

Marisa Scala-Foley: Great. Okay. We got a question from (Kathy) and I know you all talked - and Naomi in some of the successes you talked about you talked about reducing the patient refusal rate. Can you talk a little bit about tips for gaining patient buy in to participate in a care transition program?

Naomi Hauser: Well that was really a challenge because as I said in the beginning, it was a very high refusal rate. And out of the 14 states when we would discuss that that was prevalent throughout all the 14 states.

It was not a mandatory program for patients to accept coaching. It was a voluntary process. It really came down to the point of how could we improve on this and the coaches were really very, very critical in helping us to identify because we just for the first time out of the gate we would give the patients for instance a lot of information and paperwork.

And we really found we were almost overwhelming them trying to give them so much information while they were having an inpatient stay. And we found out that simplifying it, just really introducing it, the coach going in and introducing themselves to the patient and this is where I think Ray or Tim said that, you know, it was very important to pick the right person to be a coach. A people person. Someone who can actually sell this. Someone who can tell the patient the benefits of having a coach.

And we found that the refusal went down when the coach became more competent and more consistent in their approach. We even developed some scripts for the coaches. This was again a very dynamic process that only improved as it went along. But it really was much more effective when the coach became more competent at offering the coaching, the reasons for it, etcetera.

Ray DuCoeur: Yes. I think the refusal point at this point is even much less than that. And part of the key seem to be our coach just indicating that they were from the Area Agency on Aging and that often opened the door for them.

Marisa Scala-Foley: Okay, terrific. And the last question comes from (Wendy) and it's a great way to end this webinar. And she asks if we wanted to partner with QIOs on delivering content, or educate, or working with hospitals in our state how would we go about doing this? And I think Naomi or Traci. I think either one of you can answer this one.

Traci Archibald: Well, I think you can just reach out to the contact person for the QIO in your state to begin that partnership. I think the QIOs are very eager to hear from interested Triple-As and other community stakeholders. So you can look at the Web sites we've listed in the resource section and find the QIO lead on care transitions from your states and reach out to them.

Marisa Scala-Foley: Terrific. Okay. With that, I want to thank our speakers for wonderful presentations today and thank you to our audience for such stimulating questions.

If you think of any additional questions or if you have suggestions for future webinar topics or even stories about your own community (unintelligible) care transitions work, we'd really like to hear from you. So please do email us at affordablecareact@aoa.hhs.gov.

We want these webinars to be as useful to you as possible so we very much welcome your suggestions.

We thank you for joining us today and we look forward to having you with us on future webinars. Thanks everyone.

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

Ray DuCoeur: Thank you.

Naomi Hauser: Thank you.

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