AIR
AIR CCTP 3.27 Webinar Audio File

OPERATOR: Good day ladies and gentlemen and welcome to the community based care transitions program's conference call. My name is Chenille and I'll be your operator for today. At this time all participants are in listen only mode. Later we will conduct a question and answer session. If at any time you require operator assistance, please press star followed by zero and we'll be happy to assist you. I will now like to turn the conference over to your host for today, Mr. Ray Thorn, CMM. Please proceed.

RAY THORN: Thank you, Chenille. Good afternoon everyone and thank you all for joining. This is Ray Thorn and I'm with the Stakeholder Engagement Group here at the CMS Innovation Center. We're really thrilled that you have joined us today for this exciting webinar on the community based care transitions program. So thanks again for joining us on this webinar for the community based care transitions program. We have a very packed agenda for you today and some great speakers and hope that we will be able to get to all of your questions.

Just a few housekeeping items just at the front, this webinar is being recorded and will be posted on the CMS Innovation Center website within a couple of days and the

Care and Transitions webpage. Also the slides and transcript will be posted on the CMS Innovation website as well within a couple of days. And that website is innovation.cms.gov. And if you go to the top header under what we're doing there will be a drop down bar that will have Partnership for Patients. Click on Partnership for Patients and that will address you to the Care and Transition's webpage from the Partnership for Patient's page.

In addition this call is for stakeholders only. This is not for press. If you are a member of the press, please contact the Centers for Medicare and Medicaid Services Media Relations Group. Lastly if you do have questions at any point and we're not able to answer them on this webinar conference call, you can always email us. Our email address is careandtransition@cms.hhs.gov.

So let me quickly review the agenda for you. First we're going to have an overview of the Community Based Care Transition Program its goals and objectives presented by Julia Tiongson, the program lead, and then we'll be joined by Ashley Ridlon who will discuss the Community Based Care Transition Program as part of the larger Sponsorship (ph.)

for Patients Program. And then we will have a special treat, we've invited six of the new 23 program partners who are part of the March 14th announcement to join us and share their experiences with you.

Joining us will be Luke Mattingly, the Chief Operations Officer at Carelink in Central Arkansas, Tony Lewis the Administrator at Cobble Hill Health Center in Brooklyn, New York, Steve Touzell, the Long Term Care Director at the Philadelphia Corporation for Aging, Leslie Grenfell, the Executive Director at the Southwestern Pennsylvania Area Agency on Aging. And then we will also have Ann Oasan, Executive Director at the UniNet Healthcare Network in Omaha, Nebraska, and then we'll round it up with Roger Suters who is the Community Services Director at the Elder Services of Berkshire County in Massachusetts.

And then we'll open it up for some questions and hopefully get to all of your questions and answering your questions on the phone and take a few questions from the chat function if time allows. Again if we don't get to your question today, we have an email address and that is caretransitions@cms.hhs.gov. And at this time we do have a question that we would like to push out through the webinar

function. And we would like to just gather some information for our own internal purposes just to get a sense of who is on today's webinar. So that question should be coming shortly and please answer it as appropriate on which category directly applies to you.

And so with that introduction I would like to turn it over to Juliana Tiongson with the CMS Innovation Center. Juliana.

JULIANA TIONGSON: Thank you, Ray. So the Community Based Care Transitions Program was created by Section 3026 of the Affordable Care Act and provides $500 million over five years to test models for improving care transitions specifically for high risk Medicare fee for service beneficiaries. We are currently accepting applications on a rolling basis and will continue to award applications as funding permits. It is important to note that we are currently a little over 50 percent capacity for this program. We have panel dates posted on our CCTP program webpage through the end of June. Two panel dates per month. And we will add additional panels as needed based on application flow.

So the program goals for the CCTP are to improve transition to beneficiaries from the in patient hospital setting to home or other care settings, improve the quality of care to the beneficiary, reduce readmission for high risk beneficiaries and document measurable savings to the Medicare program and hopefully expand the program beyond the initial five years. Next slide.

So now it's with great pleasure that we present the most recent site selected to participate in our program. These 23 sites add to the first seven that were announced last November, for a total of 30 sites currently in our program. So now I wanted to talk a little bit about who these CCTP participants are. They represent, there are two types of sites. One is a CBO led applicant and the other is a high readmission hospital led applicant. And so we have in this group of 23 we have 21 that are CBO led applications and 17 of those are AAAs, some are also ABRCs in that 17. And then we have two non-profit organizations that are not AAAs or ABRCs. And we also have a non-profit physician hospital organization and a community health center with short term and long term care facilities.

The two high readmission hospital led sites that we have in this round are the St. John Providence Health System in Warren, Michigan, partnering with the Adult Well Being Services, a service provider of the Detroit AAA and then we have the Al New Haven Hospital in partnership with the AAA of South Central Connecticut and the Hospital of St. Raphael. It is important to note that there must always be a partnership of an eligible community based organization when a high readmission hospital is the primary applicant.

So there's a variety of intervention models in this group of 23 including the Bridge Model, the Transitional Care Model, the Care Transitions Intervention Project, Project Boost, Project Red and other models. And we will be having some sites speak to their models later on this webinar. There is about an average of four hospital partners for this group of 23 sites selected. The largest partnership is with ten hospitals. And that's with the Western New York Regional Rural CCTP led by the T2 Collaborative of Western New York.

And in this batch we did have two rural sites selected the Tompkins County Rural Community based Care Transitions Program and the Berkshire County Massachusetts Community

based Care Transitions Program. Because these were rural they each only have one hospital partner. And that is really the only instance that we accept communities with one hospital partner when it's demonstrated in their applications that they are sufficient rural and there really are no other acute care hospitals to bring into the partnership.

And then we have a link where detailed information, very detailed information on all of the 30 sites that have been awarded in the program so far can be found at the Innovation website. And that's on slide six. Then I just wanted to share with you a map that shows geographically where the current participants are located. The blue circles are the first seven sites that were announced in November and then the red circles represent the most recent 23 sites.

So just to go over some eligibility points. Again eligible applicants for this program are statutorily defined as acute care hospitals with high readmission rates in partnership with an eligible community based organization and community based organizations that provide care transition services. There must always be a partnership

with at least one acute care hospital and one eligible CBO. And critical access hospitals and specialty hospitals are excluded as feeder hospitals, but could be part of the larger community coalition, just as other healthcare providers such as home health, SNF, hospice and palliative care should be part of the larger community collaboration.

It's important to note here that if an eligible CBO is the primary applicant none of its partner hospitals have to be on the high readmission hospital file that was posted. And conversely if we have an application from a high readmission hospital with an eligible CBO we are still looking for other acute care hospitals to be part of that partnership. Again unless it's a rural area, the partnership of two is just not competitive based on the applications that we're getting in. This program is all about community partnerships and we want to see as many medical and social service providers pulled into the partnership as possible.

So the definition of a community based organization is really there's three main points that have to be met. The governing body of the community based organization has to include sufficient representation of multiple healthcare

stakeholders including consumers. They must be a legal entity that can receive payment for the services from CMS. And they must be physically located in the community that they propose to serve. Again our preference is for a model with one CBO working with multiple acute care hospitals in a community and also bringing in downstream providers such as home health, SNF, and others. A self contained or closed health system does not qualify as a community based organization. Next slide.

Just a few key points. Applicants for this program are awarded two year agreements, with continued participation dependent on achieving reduction in 30 day all cause readmission rates. So that means all cause readmission rates for the fee for service population among the partner hospitals of the community. The CCTP does build on the care transitions pilots completed in 14 states through the ninth scope of work, QIO program.

And the tenth skip of work, QIO tenth scope of work includes tasks to build communities focused on care transitions and provides technical assistance to providers and CBOs interested in applying for the CCTP. So that's a

very important point. Assistance is available to communities and providers that are interested in applying.

And on the next slide we have the sort of assistance that the QIO can offer. So they can offer assistance with community coalition formation, community specific root cause analysis, which is the requirement as part of the application. Intervention selection and implementation, that ties back to the results of that community specific root cause analysis. And to otherwise assist with the application for the CCTP or other formal care transition programs. And we have a link there for how do you find your QIO if you don't already know them.

Next slide. Payment methodology. Okay, this is not a grant program. It was never designed to be one. The program targets organizations that have care transitions experience and are looking to build on that experience or expand current pilot programs or small care transitions programs that they have. So that is another piece with the eligible CBO to be able to demonstrate that you have care transitions experience.

CBOs are paid a per eligible discharge rate for the direct service cost of the provision of the care transition services to the eligible high risk beneficiaries. And CBOs cannot be paid for discharged planning services that are already required by the Social Security Act and stipulated in the CMS Conditions for Participation.

Another important point, last point that I'd like to mention on rates is that this program is not meant to support ongoing disease management or chronic care coordination, which generally require a per member per month fee. This is meant to be a more intensive intervention around a hospital admission and discharge. And so it is different than a traditional disease management chronic care coordination program.

And at this time I'm going to turn it over Ashley Ridlon who's going to speak about how this fits in with a broader initiative.

ASHLEY RIDLON: Thank you, Juliana. And we'll pause for just a moment to answer another polling question, if we can have the polling question come up. We want to know for the participants on today's webinar are you a part of a

community that is applying to the CCTP? So either yes, you've already applied and been selected, yes, you've applied and not been selected but you're planning to reapply or yes, you're planning to apply and we'd like to know when you'd like to apply, so we've got several timeframes there. And the final answer is no, if you're not planning to apply to the CCTP.

So I'll give you just a moment to answer that question and then thank you for your responses there. It's helpful to us as we're learning what to anticipate in terms of the application flow, and also so that we can do a better job in helping you successfully apply to the program.

So we'll go ahead and move to the next slide. As Juliana mentioned the Community Based Care Transitions Program was created by Section 3026 of the Affordable Care Act. It's also part of a broader initiative, the Partnership for Patients, which is a nation wide public/private partnership that will help improve the quality, safety and affordability of healthcare for all Americans. It has two aims. By the end of 2013 a 40 percent reduction in preventable hospital acquired conditions, which would

prevent 1.8 million injuries in the hospital and save 60,000 lives.

The second aim, which is especially relevant to this program, is a 20 percent reduction in preventable 30-day hospital readmissions. This 20 percent reduction means 1.6 million patients would recover without readmission to the hospital. And achieving these two aims has a potential to save up to $35 billion over the next three years. And the next slide, please.

So as we're thinking about both of these programs we're looking at the three part aim; better health, better healthcare and lower costs. And this is how we'll know we're successful. That means better health as measured by individual and population metrics, better healthcare in terms of improved experience of care measures, safety effectiveness, patient centeredness, timeliness, efficiency and equity, and lower cost of total care through improvement.

So with that we will turn it over to a select number of sites. Unfortunately we don't have time for all 23 of these newly awarded sites to give their summaries, but we

will allow some question and answer where other sites can chime in as well with highlights from their site. So we'll start with the North Philadelphia Safety Net Partnership and we'll turn it over to Steve Touzell, the Long Term Care Director for the Philadelphia Corporation on Aging.

So Mr. Touzell you have selected the bridge model, developed by the Illinois Transitional Care Consortium for you intervention. And you're coupling that with elements from Project Boost and Project Red given the experience that your hospitals have with these models. Can you tell us a little bit more about how the root cause analysis findings of your community in North Philadelphia led you to select this intervention strategy?

STEVE TOUZELL: Well, we really took a look at the population that lives in the north section of the city. And as you mentioned we're partnering with two safety net hospitals and both of them had community transition efforts in place at the time and were going to be adding to that the Bridge program. The population is highly impoverished; 24 percent of the population has incomes less than 100 percent of poverty and 54 percent have incomes less than 200 percent of poverty. Sixty three percent of the population is

minority and 22 percent have less than a high school education.

The population also has a disproportionate prevalence of health problems which exceed national averages. For example, among our target population of all cause Medicare fee for service admissions discharged to home 24.4 percent have cardiovascular disease, 35 percent have diabetes and 75 percent have high blood pressure. Moreover the older adult population in this part of the city has high rates of health and social risk factors including multiple IADL and ADL impairments and they face economic, systemic and other barriers to obtaining healthcare.

And our primary interest in the Bridge Model was based on the statistic that we found that demonstrated that social determinants such as these factors account for 40 to 50 percent of hospital readmissions. So taking a look at the socio economic variables of the population that we're serving and also our strength as an organization, and we are an Area Agency on Aging and our practice is rooted in social work message based on a strength based approach in working with older people and the various long term services and supports programs that we provide.

ASHLEY RIDLON: Thank you, Steve. So we'll now turn it over Tony Lewis, Administrator of Cobble Hill Health Center, which is the lead applicant in the Brooklyn Care Transitions Coalition. So Mr. Lewis as Juliana described of the 23 applicants selected in this round 17 of the lead applicants are area agencies on aging. So you are a different kind of CBO. Can you tell us a little bit about how Cobble Hill Health Center and speak to how you met the eligibility criteria for this program?

So, for example, how did you meet those criteria of the governing body with multiple stakeholders or your status as a legal entity located in the community you're serving and the partnerships that you develop in your community?

TONY LEWIS: Sure. Good afternoon, everyone. We've actually been around a long time, our organization. In fact, was first established in 1976. And at that time we were a nursing home and in fact still are a nursing home. But as the years progressed not only as the nursing home world changed we're now actually discharging over 500 patients back to the community through our short term rehabilitation, but we also recognize around about 1996 the emerging need for greater community based services.

And we wanted to, and it was a recognition by our Board of Directors at that time that we needed to adapt the organization and develop services which really was going to meet the needs of the population that essentially wanted to remain in their own homes for as long as possible. So to that end we established a whole series of community based services from adult daycare and in 2007 we also established the long term home health program, which is, I think it may be unique to New York in the form that it's taken, it's a Medicaid program, but essentially it provides long term services to keeping people in their own home through the provision of a whole range of services, such as home care, dental services, podiatry, transportation to clinics.

So it's a very comprehensive plan that's designed to meet the needs of people with long term care needs in the community. Though these experiences we began to establish a lot of networks with a lot of community based organizations and we could see that our role actually could extend much further to also providing services to senior centers funded through the Department for the Aging. We provide a lot of speakers to those organizations. We do blood pressure screenings and a whole host of different

kinds of activities designed again to provide education to seniors living in the community.

In addition to that, perhaps most importantly for us living in an ethnically diverse area we also needed to ensure that our services were culturally sensitive and were able to meet the needs of those emerging minority communities. And to that extent we've worked with a whole host of organizations, such as RAICES is the Spanish speaking Council for the Elderly or the Puerto Rican Family Institute.

And the reason I mention these is because it really indicates how we had moved from being a skilled nursing facility into a broad based community based organization with a whole host of services meeting the needs of the community. The specific criteria because we looked at do we meet those, because to be honest with you we hadn't often thought of ourselves where we saw ourselves as a community based organization, we hadn't looked at those definitions until we actually came to applying for this particular program.

And we certainly, we were able to meet the standard of being a 501c3 organization. We're certainly physically located in the community we're serving. We have very strong linkages with a range of hospitals in our area. And we've actually made this application with two of our neighboring hospitals. But also just as importantly we looked at the composition of our Board of Directors and that certainly met the criteria because our Board of Directors actually comprises of people who are healthcare consumers and also have stakeholders from the various healthcare entities with which we have relationships.

So based on this we saw ourselves as meeting that criteria. We also because we're financially, a fairly large organization had the ability both to do the billing and to be able to manage the funds because we would possibly have to disperse some of those funds to some of the entities with which we're working. So we've had a lot of experience, we're deeply rooted in our community and looking at the specific criteria we felt that we met that standard and I'm very happy to say that we were selected and actually do meet that criteria for a definition of a CBO.

ASHLEY RIDLON: Thank you very much. Now I'd like to turn to Ann Oasan, Executive Director of UniNet Healthcare Network in Omaha, Nebraska. Ms. Oasan, like the Brooklyn community you have a unique type of CBO leading your community in the CCTP. So can you tell us a little bit about UniNet Health Network and how it fits into this program as an eligible CBO?

ANN OASAN: Sure. UniNet is a clinically integrated PHO. We were formed in 1998, so we have been around several years. We currently represent 13 hospitals and over 1,400 different providers, physicians and midlevel providers. And for the last two years we've actually been doing a discharge transition program with one of our local managed care payers. So we felt that we were very well positioned to work with Medicare and the CCTP program.

We are not a wholly owned facility with hospitals. Our PHO is actually funded by all of the members of the PHO, the physicians, the hospitals, all pay into help fund that infrastructure. We are currently managing discharges for just five of our member hospitals, but not all of them at this time. We did have a Board who is made up of providers. And a couple of our providers were actually

community members and Medicare age. But we did expand that Board to add two additional community members.

And one of the most important things we did was actually partnering with Eastern Nebraska Office on Aging to expand our program, so we could offer home services to our members.

ASHLEY RIDLON: Wonderful. Thank you very much. And we do recognize even though we're talking about focusing mainly on the primary applicants to the program, which as Juliana described fall into these two categories of a CBO partnering with hospitals or a high readmission hospital partnering with CBOs. That there are other partners as well as hospitals and those lead CBOs, a number of different types of partners and we've seen all kinds. So thank you for sharing a little bit about some of those other partners.

So now we will turn to Carelink, the Central Arkansas Care Transitions Program, and Luke Mattingly who is Chief Operations Officer for Carelink. So Mr. Mattingly can you describe the demographics of the population that you'll be serving in Central Arkansas and why you chose to partner

with two community health centers, R Care and Jefferson Comprehensive Care Systems for this program?

LUKE MATTINGLY: In reference to all the northern friends that I've made as part of this process that's a nice offshoot. (AUDIO DIFFICULTY)

OPERATOR: This is the Operator, Chenille. Your line is braking up. Are you on a cell phone?

LUKE MATTINGLY: No I'm on a land line.

OPERATOR: Well, okay, you sound better now. (AUDIO DIFFICULTY CONTINUES)

LUKE MATTINGLY: (POOR AUDIO THROUGHOUT, INDICATED WITH "BREAK") I hear you guys fine. I'm sorry for the interruption. I'll continue here and if you need to cut me off, just tell me so. But the Central Arkansas Care Transitions Coalition in the most densely populated urban area. (BREAK) One of which is a high readmission watch list, federally qualified health centers. Our CBO Carelink serves (BREAK) and has 800 employees, provides a wide variety of services to home bound and older people active on the caregivers. (BREAK)

hospital is the University of Arkansas Medical Sciences, which is viewed as a world class healthcare and (BREAK).

It is the state's only academic medical center and that brings in a disproportionate risk of uninsured and medically undeserved patients. (BREAK) 615 bed private bed hospital founded in a (BREAK) provides specialty care in a variety of medical disciplines and a comprehensive and holistic manner. (BREAK) two community health centers in the partnership, R Care and Jefferson (BREAK), these partners were approached for primarily two reasons.

The root cause analysis at our hospital was a wider service area than Carelink typically serves, so partners were sought to cover that wider region. And our community health centers (BREAK) provide services to that segment of the population and provide (BREAK) particularly important in our rural areas. (BREAK) are the big three at both hospitals, heart failure (BREAK). The hospital added (BREAK) that they determined were at high risk for readmission.

(BREAK) elected the Coleman Model of Care Transitions Intervention. This model has coaches going in 30 days post

discharge (BREAK) four essential pillars, which are medication, self management, patient centered health record, PCP follow up (BREAK) of their disease. We added two additional services to that model. One is two non-emergency medical transportation round trips for follow up medical appointments and an in home follow up prevention assessment.

Many of patients in our (BREAK) for medical treatment but are discharged back into their rural communities where medical services are nowhere easily as accessed. (BREAK) like tele medicine are not practical when broadband internet service is not yet available. (BREAK) root cause analysis we discovered that nearly half of readmitting patients had not seen a (BREAK). Transportation to our bundle (ph.) particularly in rural areas was a key element in preventing readmissions. (BREAK) aging and community health centers provided the coalition with a very (BREAK) in overcoming obstacles to delivering service in our (BREAK) had this experience simply knowing that an address (BREAK). And yes those are real places.

Additionally the (BREAK) plug patients into community services that (BREAK) may have previously been unaware of

that will assist them in living better and healthier. (BREAK) patient services available for our coalition includes two dedicated geriatric (BREAK), specialized information and assistance for seniors, skilled and unskilled home healthcare, chronic (BREAK), meals on wheels, senior centers, primary care, dental care, pharmacy comps and fitness activities.

All these resources combined with our intervention will ensure our success at reducing readmissions in our urban and rural communities.

ASHLEY RIDLON: Thank you very much. I'm sorry to cut you a little bit short, but we wanted to go ahead and move on and also you're cutting out a little bit. I think we caught the bulk of the key points that you wanted to make, but for the participants on the call just a reminder that all of the details for each of the sites will be available on the CMMI website that was shown earlier in the slide deck. So thank you very much, Luke Mattingly. The community was Carelink in Central Arkansas and speaking to those additional partners the federally qualified health centers and the rural nature of that community and why they've

selected the interventions they've selected. So thank you very much.

Another participant we wanted to highlight today is the Western Pennsylvania Community Care Transitions Program. And we have Leslie Grenfell, the Executive Director of the Southwest Pennsylvania Area Agency on Aging here to tell us about it. So Ms. Grenfell can you tell us how you worked with your QIO in Pennsylvania and how you incorporated downstream providers explicitly into your application as part of CCTP?

LESLIE GRENFELL: Yes, absolutely. Good afternoon, everyone. Our Western Pennsylvania community gained valuable experience in providing transition services and piloting readmission reduction initiatives for working with Quality Insights of Pennsylvania, the quality improvement for Pennsylvania during the ninth scope of work. Encouraged by the progress made in the readmissions during our two year pilot the partners agreed to make application to CMS for the CCTP funding opportunity.

In doing so the Western Pennsylvania partners decided very early on to propose a unified community approach to the

application in order to achieve the care transition goals and welcomed once again the opportunity to collaborate with the QIO in the Integrated Care for Populations and Community initiatives under the tenth scope of work. So for those considering making application for the CCTP funding, the QIO proved to be a very valuable resource to us.

As Juliana noted earlier in the presentation on the slides the QIO provided us with technical assistance and guidance in three specific areas. The first is the root cause analysis which helped us to identify the community specific causes for poor transitions, and number two helped us also as a community to select the most appropriate intervention strategy. And then finally and equally important of course is they helped to facilitate the development and collaboration of downstream providers and other healthcare stakeholders in building the community network to address the various drivers of readmission.

As the QIO's experience in reaching out to providers of care such as hospitals, physicians and home care agency helped us to create a community focus, which in turn ensured that partnership developed a community wide

adoption of improved practices and strategies and care transitions. As the liaison between CMS and local providers in this specific geographic area the QIO has developed the relationships with a variety of healthcare providers and also has acquired the knowledge base and expertise of processes designed for continual quality improvement that clearly benefited our application.

During the development of the CCT application the QIO helped to facilitate and assisted with arranging meetings with hospital partners and also provided us with the ability to help develop the downstream provider collaborative network. The Western Pennsylvania Community Care Transition Coalition was created over several months of working with a number of hospitals and their downstream providers individually an in cluster groups and has now been successful in recruiting a total of 18 skilled nursing facilities and 15 home care and hospice agencies who are committed to working with us to support the seamless transition across care transition settings.

All of the 23 organizations signed a community charter at the kick off event that was scheduled in February and agreed to improve the experience of care and health of

patients in four counties in Western Pennsylvania by encouraging the development and implementation of a variety of care transition strategies in reducing preventable 30 day readmissions. And it's interesting that we received word of the approval of our application during that same week, the Monday of the week in which we had our kick off campaign where we had over I believe 105 individuals attended to support the community wide effort.

And in closing I would like to say that we believe that cross setting community based collaboration is critical to our success and truly essential if we are to have a long lasting and sustainable impact of reducing readmissions. I want to thank the QIO and the opportunity to participate today.

ASHLEY RIDLON: Thank you, Leslie. And finally we'll turn it over to Roger Suters, Community Services Director of Elder Services of Berkshire County in Massachusetts. So Mr. Suters for your intervention strategy your community is using the care transitions intervention also known sometimes as the Coleman Model and the Transitional Care Model developed by Mary Naylor and other supportive services as well. Can you tell us why these interventions

made the most sense for your community based on your root cause analysis?

ROGER SUTERS: Yes, thank you. Elder Services of Berkshire County in Massachusetts is one of the organizations as a CBO that's uniquely an aging services access point, as well as an area agency on aging. And we have partnered with Berkshire Health Systems, the major healthcare provider in this rural county, and together we are able to cover the entire population of the county which consists of 30 towns, two cities. We're distributed across 946 square miles, largely rural. And our colleagues at Berkshire Health Systems, Berkshire Medical Center cover about 80 percent of Medicare fee for service beneficiaries that are hospitalized in Berkshire County.

I'd like to ask Ed Perlak, Vice President of Berkshire Health Systems to talk about the root cause analysis that really defined our intervention model.

ED PERLAK: Thanks, Roger. Around 2009, 2010 the Health Systems worked on what they called a SAAR project that was sponsored by the IHI. SAAR stands for State Action on Avoidable Readmissions. Part of this process was

developing a cost continuum team, which in part actually focused on interviewing patients, families and providers about the experience of care and circumstances leading to unplanned readmissions. This gave us a pretty good understanding, actually a much deeper understanding of care transitions as a cross setting challenge.

That led to the multi faceted root cause analysis that the hospital, the VNA and elder services did on hospital readmissions in our area. And what we found was that there was a subgroup that was at significantly higher risk. And that subgroup included persons with a personal history of three times readmission within a year or those people with congestive heart failure. And this target population within itself had a 36 percent readmission rate. And 50 percent of those readmissions were within the first ten days. So that root cause analysis led us to the choice of the interventions that we were talking about as far as this particular project.

ROGER SUTERS: So the strategy for implementation is to identify those high risk patients on admission, so that's basically the triage nurse will screen for that criteria. Case management at the hospital will screen the participants on

admission for referral to either the Naylor or Coleman as they're called, and patients who are referred to Naylor will be directed one way which will involve the nursing practitioner providing an in hospital assessment prior to discharge and notifying the primary care physician on enrollment in the program, establishing a communication with the patient and case managers assisted execution of the home care plan upon discharge.

At which point the nurse practitioner will provide regular home visits, ongoing telephone support, seven days per week through 30 days post discharge and continuity of medical care between the hospital and the primary care physicians by accompanying the patients for the first follow up visits.

Beyond that patients referred to Coleman's Community Transition Intervention would be referred to Elder Services of Berkshire County and part of that intervention the transition coach will meet with the patient in the hospital, evaluate the need or urgent Elder Services bundle in conjunction with hospital case management and then that care transitions coach will establish a communications path

with the patient to provide all four sessions based on that transitions model.

In addition there will be a transition advocate available to assist with cross disciplinary enhanced discharge preparation from the hospital into the community. In the event that it's required as an Area Agency on Aging we were able to package an urgent support bundle where we can provide meals on wheels, for example, upon the day of discharge. We will put together a package, transportation for the consumer to medical appointments if needed, to pharmacies if needed, and all this for selected high risk patients starting on the day of discharge.

In addition we will be providing all referrals to an accelerated visit by the social worker. And beyond that we should also point out that Berkshire Medical Center has a highly recognized heart failure clinic and patients who had not previously been seen by the clinic will be referred to that asset or resource, if you will. That pretty much covers the seven steps or so of the intervention or implementation strategy.

ASHLEY RIDLON: Wonderful. Thank you very much. And thank you to our six sites who presented today. Again, congratulations to the 23 sites featured in this month's announcement of CCTP participants. So with that I will turn it back over Ray Thorn who will help us open up for questions.

RAY THORN: Great. Thank you, Ashley. And thank you Juliana. Before we open it up for questions I do want to send out a few reminders. We are on the last slide of the program and if you are looking for more detailed information on the partner sites they can found on the Innovation Center website with that link that's posted on the slide. So when we mentioned all the community based care transition sites that means all of them, the first seven sites that were announced in November and then the 23 sites that we just recently announced.

And then additional information on the Community Based Care Transitions Program is also on the Innovation Center website. The link is listed on the website, excuse me on the slide as well. So that's where you can find the application information and the solicitation and the fact sheet for the program. In addition if you do have any

questions that we are not able to get to today you can always email us at caretransitions@cms.hhs.gov.

And again if you're interested in learning more about all of our sites, including the six sites that spoke just a few minutes ago, you can click on the first link on the slide. And this slide will remain up throughout the question and answer session. So at this time I think we're ready. Operator, we're ready to open it up. And one last thing if you do have a question, we ask that you state your name and then your organization and location, so that we can keep track of who folks are. So with that, Operator, I turn it over to you.

OPERATOR: Thank you. Once again ladies and gentlemen that's star one for questions. After the tone, please record your first and your last name, your organization and your location. Again, those items must be collected in order for your question to be registered. Again, that's star one to ask a question. And please record your name, your organization and location. Please stand by.

RAY THORN: And Operator while we're standing by we do have some questions. Also I was going to mention that you can also

submit a question through the chat function as well. And we will be taking some questions through that feature as well. And in the meantime while we're waiting for people on the phone I think we did get a question from the chat box here and the first question is can a CEO apply on two separate applications working with two separate hospitals if the projects are targeting a different population? And Juliana.

JULIANA TIONGSON: Yes, thank you. So the answer to that question is no. We are not going to be awarding multiple applications to the same community based organizations.

RAY THORN: Great. Thank you, Juliana. Operator we have someone standing by?

OPERATOR: Yes, the first question comes from the line of...

DR. GONIAN: This is Dr. Gonian from Los Angeles with Primary Care Associates of California.

OPERATOR: Go ahead, please proceed with your question.

DR. GONIAN: Is there any particular reason that Southern California doesn't have any representation in this program? Or there has just not been applications? Because even

though it's not a rural area, there are areas of Los Angeles that are particularly served by one or two main hospitals.

JULIANA TIONGSON: Yes, hi, this is Juliana. In some ways the applicants selected are representative of the overall pool of applications that we've received. So although it appears like there is some density on the East Coast it's just based on application volume received to date. So who know what will happen in the future. But we award on a first come, first serve basis. When there's an application that is highly rated it gets awarded. So we're not holding out certain geographic areas. I hope that answers your question.

DR. GONIAN: So what you're stating is that there hasn't been too many applications from Southern California?

RAY THORN: Well, we don't want to get into the specifics of who has applied and who hasn't or who has applied, but you know we do have, the sites that are selected are representative of the applications that we've received so far to date. We are mindful of geographic diversity and representations

across the country and we welcome all sites from all areas of the country to submit an application.

DR. GONIAN: Okay. Thank you.

RAY THORN: Thank you. Operator do we have someone standing by?

OPERATOR: Yes, we do. Your next question comes from the line of Erin Fitzsimons, Angel E Cares. Please go ahead.

ERIN FITZSIMONS: Hi, can you hear me?

RAY THORN: Yes, we can. Please go ahead.

ERIN FITZSIMONS: You were saying early in the presentation that there was help available to identify the types of readmissions and the types of interventions for our particular geographic area. Could you explain that a little bit further?

JULIANA TIONGSON: Yes, this is Juliana. So one of the tasks with the quality improvement organizations for the tenth scope of work is to assist providers in communities that are interested in applying to the Care Transitions Program or other programs. And we have a slide that basically goes over the sort of assistance they can provide. And as you

may have heard when Leslie Grenfell from the Western Pennsylvania Care Transitions Coalition was speaking about how helpful their QIO Quality Insights of Pennsylvania was in terms of root cause analysis, community coalition building and so forth.

So I would encourage you to go to that link that's provided on the slide, figure out who the QIO is for your region and ask them for assistance.

ERIN FITZSIMONS: Okay, thank you.

RAY THORN: Leslie, this is Ray Thorn. I don't want to put you on the spot, but maybe you might have some additional insights that you might want to offer?

LESLIE GRENFELL: Well, thank you, Ray. I would just say that it's important to note that the QIO role is to help provide some technical assistance. I would say that it's not their responsibility of course to write and submit the application. So I would just like to reemphasize the fact that they are a resource. The hospitals completed the root cause analysis with a tool that was very useful provided by the QIO. And then upon each of the six hospitals completion of the root cause analysis information it did go

to the QIO and was aggregated and then sent back to the hospitals and then provided to us as the applicant.

So it was very helpful because of the expertise they have as I stated in my presentation. I hope that was helpful Ray.

RAY THORN: Great. Thank you, Leslie. And I will throw it out to the other five sites as well if they wish to... Again not to put anyone on the spot, but if they want to address the QIO aspects of the application, please feel free to do so.

TONY LEWIS: This is Tony Lewis of Cobble Hill Brooklyn. I just what to say that we used our QIO extensively. They were very helpful in both generating data that could lead us in the right direction and then critically evaluating the proposal as we developed it. And posing a lot of good questions for us and giving us some very good ideas how we might go about things. But it was a very interactive process and enormously helpful though in getting, clarifying our thinking and also getting us to the right questions so that we were really able to both do the root

cause analysis and set this in the context of what kind of program we were going to develop.

ASHLEY RIDLON: Thank you. And this is Ashley Ridlon. I would just add one more time the link for the specific Care Transitions point of contact at each of the 53 QIOs across the country, there's a QIO in every state and a few territories, those links, those contacts are available at www.cfmc, that's Colorado Foundation for Medical Care, cfmc.org/integratingcare. So it's cfmc.org/integratingcare. If you go to the contact us tab you will find where it says contact your QIO directly click here. There's a document there that has all of the QIOs and the specific emails and phone numbers of the care transition contact at that QIO.

RAY THORN: And that link is also on the Care Transitions, on the Innovation Center Care Transitions website. So if you didn't catch what Ashley was just saying, it's also directly on the Innovation Center website directly above the "how to apply" section of the webpage. So thank you Leslie and Tony for your comments and thank you Erin for that question.

At this time I would like to go to the chat box and take a question from the chat box that we received. And one of the questions that we've received are there special circumstances under which awards are given to applications that do not have a hospital from the high readmission's list. And Juliana.

JULIANA TIONGSON: Yes, so again if the primary applicant is an eligible community based organization none of their partners need to be on the high readmission hospital file that we posted on our CCTP program webpage. Again, our preference is for communities that have multiple acute care hospitals working with an eligible community based organization involved. And so the only instance where you have to have a high readmission hospital from our posted file is when they are coming in as the primary applicant.

RAY THORN: Great. Thank you, Juliana. And again we ask you if you want to submit a question, you can do it over the phone. The phone lines are open. Or you can do it through chat room. And I also encourage you, we do have our six partners on the line with us today, so I encourage you to, don't be shy in asking them questions in addition to asking

the CMS program staff. So Operator do we have the next person ready?

OPERATOR: Yes. Your next question comes on the line of Angela Halpin, Hope Hospital, Newport Beach, California.

ANGELA HALPIN: This is Angela. I was going to ask are all the participating hospitals, are you going to pull all the data into a databank so that we can publicly look at how well they're doing with the choice of program or design that they have used for their success?

JULIANA TIONGSON: This is Juliana at CMS. No, we're not going to be doing that.

ANGELA HALPIN: It will be up to them to disseminate?

JULIANA TIONGSON: Data will be provided for the participants through the contractor that's supporting this program. So the participants in the program will see their readmissions data for all the hospitals in their community and they'll be able to see as they're improving over time. The Partnership for Patients and the CCTP program I think will ultimately report final results publicly.

ANGELA HALPIN: Is that current?

JULIANA TIONGSON: Yes, there is going to be evaluation contractor that will be looking at the program in total across all the sites and there will be an evaluation report that will be publicly available. I'm not sure how soon that will happen. Maybe it's a five year program, so it would probably not be, that evaluation report typically doesn't come out until the program's run its full course.

ANGELA HALPIN: Thank you.

RAY THORN: Thank you, Angela. Operator do we have the next question?

OPERATOR: Yes, your next question comes from the line of Lisa Greenstein from the Visiting Nurse Service of New York.

LISA GREENSTEIN: Hi, I think my question was actually already answered. It was about a CBO applying with a hospital that was not on the high readmissions list. But is there anything that would make that application more competitive, obviously a partnership with multiple acute hospitals.

JULIANA TIONGSON: And bringing in other downstream providers, such as home health, SNF, hospice and palliative care and

social service providers in the community, home and community based service providers.

RAY THORN: Thank you Lisa for that question. Our next question, Operator?

OPERATOR: There are no further questions.

RAY THORN: Okay, then we will take some from the chat room here. Let's see, we did receive a question from Peter. Does all cause readmits include behavioral health?

JULIANA TIONGSON: This is Juliana. So if the admission is to an acute care hospital it does get included, all cause includes behavioral health. Basically just what it says, all cause could be elective procedures, it could be someone breaks a leg.

RAY THORN: Thank you, Juliana. Another question that we received from the chat room and this is from Carla. What definitely of rural is being used for community applications? Any guidance that you can provide for source sites to help us confirm our rural status would be appreciated.

JULIANA TIONGSON: So when claiming the rural preference in applications it's important to site a credible source that you have a designation, some sort of official designation is rural. It could be a HERSA designation is rural. It could be, it would be your census. There are a number of official rural designations that you can point to. But it is important to substantiate that claim if it's made in the application with either HERSA census or some other designation.

RAY THORN: Great. Thank you, Juliana. And another question that we received, and this question is directed to our six sites, if they could just briefly what care transition models are the speakers using for the demo? And if our partners can describe what models they're using that would be great.

STEVE TOUZELL: Hi, Ray. This is Steve. And I could start that off by talking little bit about the Bridge Model, which is a model that was developed by the Illinois Transitional Care Consortium. And it is to the best of our knowledge the only social work based model of community care transition. It emphasizes a strength based approach which focuses on the strength of the individual, including

personal talent, ability and resources. The model also encourages a use of motivational interviewing techniques to promote patient activation and engagement.

Moreover the Bridge Model makes use of an ecological approach to problem solving which is systems-oriented and person centered. Features of the model include intensive coordination across the continuum of care, integrating aging and disability resource center on AAA services, an emphasis on community resources including information referral and assistance and collateral support to participants, caregivers and others at the acute care setting.

It is an evidence based model. And it is demonstrated to be effective with a wide range of risk populations including medically underserved, minority communities and older adults. And specifically with regard to readmissions, the Bridge Model is demonstrated success I reducing readmissions at the 30 and 90 day intervals. And finally, the model also has demonstrated improvement in compliance with PCAP and follow-up care.

And all of those are the factors that we took into consideration in selecting that model for our target population in Philadelphia.

RAY THORN: Great. Thank you, Tony (It was Steve). Leslie?

LESLIE GRENFELL: Thank you, Ray. We, in the Western Pennsylvania community we are using Dr. Eric Coleman's Care Transitions Intervention. That was the model that we tested during the ninth scope of work. And not only found it to be successful but also was obviously the intervention strategy that best was identified during our robust route cause analysis. And again as I stated previously that was something in which the QIO did assist us with. Thank you.

RAY THORN: Thank you, Leslie. Roger.

ROGER SUTERS: Yes, we too have... It was about two years ago we had four or our social workers at our agency trained in the Coleman Model. So that was a nice fit as we partnered up with Berkshire Health Systems determining from their root cause analysis that that would be one of the models that could work well. In addition, on the hospital side as described earlier the Naylor Model is based on the use of the nurse practitioner and the assessment will be made

prior to discharge as to which gate if you will that the consumer would then pass through. So both models seem to fit the root cause analysis pretty well.

RAY THORN: Thank you, Roger. And to recap we've had, that was Roger Suters from the Elder Services of Berkshire County, before him was Leslie Grenfell from Southwestern Pennsylvania and then the first person who was speaking was Tony Lewis from Cobble Hill Health Center. I do want to give Luke Mattingly from Carelink and then also Steve Touzell and Ann Oasan from UniNet the opportunity to briefly describe their models.

STEVE TOUZELL: Actually, Ray, I was the first person. This is Steve. I was the first person that spoke on the Bridge Model.

RAY THORN: Oh, my apologies.

TONY LEWIS: So this is the real Tony Lewis.

RAY THORN: Go ahead Tony.

TONY LEWIS: Thank you. So we're also using, we used the PASS program. It's Post Acute Support Services, Support Systems, which is based on the Coleman Model. There were

some modifications that we've made in the light of some experiences that we've had. Most importantly we actually have a coach based in the hospitals. They're there full time, so actually see patients either just after admission or just prior to discharge. And then the patient is seen at home post discharge within 48 hours, maximum 78. And then there's a telephonic follow up on the 7, 14 and 30 post discharge.

The elements are similar to the Coleman Model with medication self management, the personal health record, physician follow ups and the signs and symptoms red flags and linking people to home and community based services. We also added an additional element, particularly for the population that we work with which is a seriously underserved population. And that's a nutritional management where we actually look at their nutritional status. We look at meal planning and diet. And for those who have difficulty getting access to nutritional food we provide meals at home to them.

So we've made some adaptations to this as we've gone along since we actually started doing this last year. We also have a comprehensive system. It's a software that was

developed that enables us to put all the information in and this is also transmitted to an accessible by the home care agency as well. It's a web based program. So what we've tried to do is really also help other agencies that are serving that patient to be able to access our information to get a better cross communication going on.

RAY THORN: Thank you, Tony. Ann.

ANN OASAN: Yes. This is Ann Oasan at UniNet. We use the Coleman Model. And I think I know everyone understands what that is.

RAY THORN: Great. Thank you, Ann. And Luke.

LUKE MATTINGLY: Well, if I'm not breaking up we also use the Coleman Model and with slight modifications for transportation and fall prevention.

RAY THORN: Great. Thank you, Luke. Operator, do we have someone waiting on the phone?

OPERATOR: No further questions.

RAY THORN: Great. Thank you. We do have another question from the chat box. It comes from Barbara. And her question is

will success of projects be judged on the readmission rates being identified, high risk target populations or by the readmission rate of all cause readmission?

JULIANA TIONGSON: This is Juliana. The goal here is to reduce the 30 day all cause readmission rate among the fee for service beneficiaries at your partner hospitals. So we are looking at the broader fee for service population. If you're targeting strategy is appropriate you should be able to drive down that 30 day readmission rate among all fee for service beneficiaries at your hospital.

RAY THORN: Great. Thank you, Juliana. And we did get a question about where this webinar will be posted. And again it is on the link under that last slide on the Innovation Center, Community based Care Transition web page on the Innovation Center website, that link on that last slide. And it will be posted, the slide, the audio and the transcript will be posted within about a week after today.

We do have another question that comes from the chat room and that question is are critical access, this comes from Jeff, are critical access hospitals able to participate in a group of acute care hospitals with a CBO?

JULIANA TIONGSON: Thank you. This is Juliana. So critical access hospitals are not eligible to be feeder hospitals for the program, meaning that an admission and subsequent discharge from a critical access hospital cannot be what initiates the care transition service or intervention. There must be an admission and discharge from an acute care partner hospital. Critical access hospitals can be part of the larger community collaboration just as SNFs, home health agencies, hospice and palliative care agencies, home and community based service providers and so on can and should be part of the larger community collaboration.

RAY THORN: Great. Thank you, Juliana. We do have some additional questions that we've received. And I think Ashley you want to take the question here.

ASHLEY RIDLON: Well, I'm not sure if ... I know some of the other 17 sites of the 23 that we have announced. Okay, so they're not on the line. But do we want to go back to the chat?

RAY THORN: Yes, we can do that.

ASHLEY RIDLON: Okay. So we've got a number of questions here in the queue.

RAY THORN: Let's see, we did get a question regarding ... we did get a question from Jean, is it possible to receive a sample copy of the rating sheet used by the review panel?

JULIANA TIONGSON: This is Juliana. We cannot share the rating sheet, but the rating sheet is directly derived from the solicitation that is available on the CCTP program web page. Specifically the last section of the solicitation breaks out the four parts and allocates the points to each of those parts. So it's implementation strategy is the first part. The second part is organizational structure and capabilities. The third part is previous experience. And the fourth part is budget. And so what is asked for in the solicitation and paying particular attention to those points in the scoring there, it's almost like having the score sheet in front of you.

RAY THORN: Thank you, Juliana. Another question that we received, can a community have more than one application with two competing hospitals?

JULIANA TIONGSON: I'm not exactly sure that I fully understand that question. Again, to reiterate if you mean can a community based organization have more than one application

in a community with competing hospitals, the answer is no. We are asking the hospitals to come together. We're asking all providers in a given community to come together and be part of one application. And we're seeing among the sites that have been awarded, we're seeing that that is possible, we have partnerships scaling across hospital systems, hospitals that have been competitors are coming together for this program. So it is possible.

RAY THORN: Great. Thank you, Juliana. And on that note we are almost out of time here and I'm just going to go ahead and wrap it up and I really want to first off thank our six partners who for joining us on the line today and for sharing their experiences for the application process and also their experiences in general. So thank you again to our six partners on the line, and congratulations. And also congratulations to all 23 sites that were announced a couple of weeks ago. So we're really excited to move this program forward and really get it up and running even further than the November announcement.

So again thank you all for joining us today. I hope this has been very helpful to you all. And if there are any questions that we were not able to answer today, please

feel free to email us at caretransitions@cms.hhs.gov. In addition, any additional information is posted on the Innovation Center website and that link is on that slide 17. So again thank you all very much. I hope this was a very insightful webinar. And everyone have a great day.

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