

CMS 310, Project A, Task 7
LTSS Webinar
Supporting Elders Across Settings:
Care Transitions Opportunities and Tribal Organizations
March 28, 2012

Paula: Hello everyone and welcome. My name is Paula Rablo (*sp?*) with Kauffman and Associates. We do have people slowly joining in, so I will go ahead now and introduce Ms. Abigail Morgan and we'll begin. If you are on the line as a reminder, star six does mute your phone. We ask that you mute your phone during the presentation. Star six again will unmute it for question and answer sessions. As a reminder, this recording is... This is being recorded, so please keep that in mind as you are speaking. And I am happy to introduce Ms. Abigail Morgan with AoA to discuss care transitions and I'll turn the presentation over to her.

Abigail: Thank you very much. Can you hear me all right?

Paula: Yes. I believe everyone's on mute. Yes, you are coming along quite clearly.

Abigail: Great. Thanks. And again my name is Abigail Morgan and I'm with the Office of Policy Analysis and Development here at AoA. And so the past year and a half has been focusing a lot of my work here on the Affordable Care Act as it relates to the aging network and what the programs within the Affordable Care Act need for providers within AAA's, ADRC's and Title VI to be able to take advantage of some of the opportunities that came around two years ago. So I just want to start out and say thank you very much to Meg Greys and Cynthia LaCount for asking me to present on your new series for long-term services and support for Title VI and IHS and Indian health programs. I had a chance to review some of the materials from the past webinar and I think today's topic to support care transitions is just one more useful perspective and tool that can help integrate medical and non-medical long-term services and support in your programs and communities. So if you move to the next slide. What I'll try to do

is give kind of a high-level overview of some common themes related to care transitions and talk about one of the biggest funding opportunities. (*Background noise.*) I think if there's somebody who needs to hit star six for mute. They might be on hold for somebody. Paula, are you able to mute everybody?

Paula: Yes. Let me go ahead and check on that. As a reminder, if everyone could hit star six. We may have somebody which often happens that places on hold, but we'll go ahead and get everyone muted.

Abigail: Thanks. Great. But I'll also talk about one of the big funding opportunities to support care transitions and then if you hang around until the end, it varies - a number of technical assistance resources, free resources that are publicly available, people that are able to help you kind of walk through the elements to creating a care transitions program. If you turn to slide three, I think it's important to define what we're talking about in terms of care transitions and what we're talking about here really is a movement of patients between health care practitioners and settings as their conditions and care needs change during the course of a chronic or acute illness. So this could really occur between settings such as from a hospital or a skilled nursing facility to home or between levels of care, such as between a surgical unit and an intensive care unit within a hospital. So, those are just some examples. And when you look at slide four, care transitions or transitions in care settings for individuals or elders that are living with serious or complex care issues can often be prone to error; medication errors or poor communication or coordination between providers from an inpatient setting to a community-based setting can all have problems and have drawn some national attention to be able to develop efforts that improve the safety and effectiveness for individuals who might be transitioning between settings. Right now this is particularly important because about one in five Medicare beneficiaries that are

discharged from the hospital are being readmitted within 30 days. So this is really having significant high cost both financially for Medicare. For example, approximately 30...hospitalizations account for approximately 33%, of total Medicare expenditures, but at the same time it has high costs physically and emotionally for people with Medicare and their care givers. So really what these figures illustrate is why we can't continue to go about business the status quo. The exciting part though is CMS and health care systems have publicly recognized that really this is a community issue requiring a community-based response, or approach. Hospitals realize that they really cannot do this improvement work alone. Moving to slide five, if you look at the research, some studies have found that between 40 and 50% of readmissions are linked to social problems or the lack of access to community resources. A recent article in the Journal of Nutrition and Gerontology and Geriatrics found that one third of older adults discharged from hospitals were unable to shop or prepare meals at home. Another study found that individual's receiving attendant care or homemaking services or home delivered meals were at lower risk of hospitalization. So really, these findings highlight important opportunities for the aging network and Title VI grantees to collaborate with health care systems to reduce hospitalization. If you move to slide six... The next several slides actually highlight some of the basic themes or components present in many local care transitions programs or that are featured in several of the evidence-based care transitions models which I will talk about a little bit later in the presentation. These can often be discussed in new or unfamiliar terms. So when you go to slide seven, because care transitions programs bring together both medical providers and community-based social service providers, many local sites who are operating these programs have realized and that partners are often using different terms when talking about the same thing. For example, talking about what does it mean or what is a transferring provider versus a

receiving provider; what is patient activation and enhanced post discharge follow-up. It's been an important lesson for the partners to come to a common language. So in order to address these important human and community factors as well as medical factors in a care transitions program, it's good to understand how these factors coincide with existing Title VI and other community-based services and how hospital and other post-acute or medical care providers may discuss them. If you look at slide eight you can see in simple terms how care transitions being fall into the work of Title VI programs. So as we examine one by one, starting on slide nine, successful care transitions programs require a collaboration across provider settings such as hospitals, nursing homes, primary care providers, home health or community-based services as well as between disciplines which could include nurses, doctors, social workers, discharge planners, volunteers, pharmacists. Um, together partners have to develop a streamlined or a standard way to share important information about an elder or an individual to be able to coordinate their necessary services. This ensures that everyone along the way that is involved in a person's care after a discharge is appropriately informed and this of course includes family care givers. Through your area plans and local partnership in your caregiver programs you are able to identify what is the best path or tools to help share the important information and coordinate services across stakeholders. Next slide. In terms of follow-up after a hospitalization, hospital discharge plans provide standard information related to an individual's current hospitalization but they're often unable to provide context or additional information about what's needed once a person returns home. For example, if a person needs or has trouble accessing medications or transportation to primary care or follow-up appointments, there might be additional in home needs such as home modifications or dietary needs or nutrition restrictions. So all of these things are kind of outside of the discharge planners information. New wide successful care transitions

partnerships and programs feature a strong connection to community services, many of which Title VI programs are currently have experience providing. If you move to the next slide kind of wrapping up the themes here, in order to help reduce an individual or an elders risk for future readmission, it's important that they are empowered with information and resources to be able to best manage or take responsibility for their health. So this refers to the last theme of patient or client activation. This can include doing assessments that are person centered in providing education and counseling based on an individual's needs, but also really includes training or coaching an individual to take an active role in their health decisions such as calling doctors, asking questions, maintaining personal health information, et cetera. Next slide. So based on this review of care transitions themes you can see how a care transitions program can fit within your local work admissions. You're the experts on your program participants and their needs and you hold the institutional knowledge of existing community resources. At the same time on slide 13 it's important to approach a care transitions program as an opportunity to enhance your partnerships between all types of providers and really break the gap between medical and long-term services and support. The majority of people receiving services under the Older American's Acts are living with multiple chronic conditions and complex health issues and are really at high risk for multiple re-admissions or transitions in care settings. So regardless of how in tune care transitions may be with the services you're currently providing or your mission to serve individuals in your community, the aging network and Title VI programs have to think about how to change the way we're doing business to be able to provide a very robust timely care transitions program. This effort does require up front work to be able to develop additional infrastructure, training or skills and capacity. The good news is that there are a number of resources that are available to help start initiating these necessary changes and we'll go into

those details a little bit later on. If you go to slide 15, one avenue is to learn from existing best practices. For example, there are currently about 100 active care transitions sites or programs that are being operated within local AAA's or ADRC's. They've experienced a number of growing pains and lessons learned in developing their programs and this slide highlights some of their key takeaways. That includes engaging leadership at all levels within partner organizations such as hospitals, all the way from direct service staff to executive level staff. You may already have a number of ties to local and discharge planners or social workers but need to map out how to engage leadership in your hospital such as the CEO, the Director of Case Management, or the Chief Financial Officer. Additionally, cross training partners are participating in joint trainings such as site visits and providing opportunities to shadow staff at your partner organizations are all helpful strategies to get on the same terms and within that common language for supporting people as they transition across care settings. Written protocol or formalized partnerships such as memorandums of understanding or business associates agreements all helps to outline and understand roles and responsibilities of people that are involved and finally leveraging the strength and building existing infrastructure and expertise from your partner organizations. How can your partners experience and expertise help enhance your care transitions efforts? So these are just some high-level lessons learned. So now next slide, we're going to kind of talk about what is the big funding opportunity that's really related to care transitions. There's a number of them, but I'm going to start with the partnership locations in the community-based care transitions program.

Paula: Abigail, I'm going to... I'm sorry. This is Paula. I'm going to interrupt you. If we could just remind everyone to press star six to mute your phones. They are working on muting everyone, but in the meantime star six will allow Abigail to continue. Thank you.

Abigail: Okay. Great. Thank you. Okay. So moving on to slide 17. The first initiative that really heavily involves the work of the network is the partnership for patients which was launched last April. It's a public-private partnership to improve care in and coming from hospitals. It's driven by two main aims seen here. The bulk of our work at AoA and in partnership with CMS have been around the second aim in getting the aging network more engaged in supporting transitions from hospital to home. So moving to slide 18. In order to support that second aim of the partnership, CMS has issued a solicitation for communities to implement and test local models and partnerships that support transitions of care for Medicare fee-for-service beneficiaries. This is the community-based care transitions program also known as CCTP. Slide 19 outlines the goals of the program. CCTP supports the three-part aims adopted within CMS and it is part of healthcare reform, which is really to improve care, improve the health of individuals, while also lowering health care costs to quality improvement. The goals outlined here form an opportunity for organizations to take a community-based approach to building a brand-new Medicare benefit which is really quite unique. This new benefit that is designed by individual communities will be tested. If it is proven to be effective based on improving quality while also producing cost savings it will be expanded nationwide. It's a five-year program. So going on to slide 20. I do want to go through kind of how people can qualify for this funding opportunity and some pointers and lessons learned for those who are interested in applying. On slide 20 it talks about eligible applicants. The solicitation does require identification of a lead applicant under this funding proposal. It can be either a community-based organization that provides direct care transitions services or an acute care subsection C hospital that has a high re-admission rate and regardless of who the eligible applicant or lead applicant may be, there must be at all times a partnership between an acute care hospital and a

community-based organization, but when you go to slide 21, the true preference is for a model with one community-based organization or CBO working with multiple acute care hospitals in a community. (*Background noise.*) If we could have people hit star six to make sure that they're on mute, that would be great. So under this definition of a CBO they are talking about organizations that provide care transition services across the continuum of care and have a governing body. It could be a tribal governing body. It could be a Board of Directors whose stakeholders include a sufficient representation of health care stakeholders such as consumers of health care services. They have to be a legal entity so that they could be paid for services and they must be physically located in the community that they are proposing to serve. It's also important to note that critical access hospitals or specialty hospitals are excluded from being lead applicant's within this funding opportunity but could be part of a larger community collaborative or partnership to address care transitions or re-admissions within a community. And moving to slide 22. Entities that could be a CBO or examples include Area Agencies on Aging and Tribal Organizations, Federally Qualified Health Centers. It could be a coalition of community partners. The goal here really is to note that it's not to create new entities or organizations, but to work within existing organizations that have already been doing care transition services, or have experience serving individuals in that community. It's meant to be a community-based effort that should not originate from a closed linked health system and when we say that what we're talking about is for example it could not be a home health agency that is owned by the partnering hospital. That is considered a closed link system. It must be transparent and open in the community. Looking at slide 23 talks about a couple of preferences within this funding opportunity; something that we always like to note. That includes if the applicant has participation in a program administered or received funding from the Administration on Aging,

including Title VI and Area Agencies on Aging and also communities that provide services to medically underserved populations. There's also preference for a model in which if one CBO working with multiple hospitals and/or hospitals that are included have high re-admission rates; there is a list of high re-admission rates hospitals that is included in the resources section of this slidex. So you can access that list and see if hospital partners fall within that frame. CBO's should also have to address how they're going to work across post acute care settings when they are coordinating with different hospitals. This is important for a few reasons. If it's really a community-based effort to address re-admission there, both of the *** (22:29) of re-admission should show... You know, it might not be just one hospital that's driving up the re-admission rate in the community, it might be multiple hospitals or a hospital and a skilled nursing facility that's experiencing a number of re-admissions. So it's important to include the important partners and stakeholders in the community that all have to do with re-admissions and hospitalizations. So going on to slide 24, payment methodologies. Community-based organizations will be paid a per eligible discharge rate and that's determined by this list here. The rate does not support ongoing disease management or chronic care management such as a per member per month fee that you might see in a care coordination program. Payment will always go to the community-based organization partners so that could be the tribal organization, regardless of whether or not the CBO or the hospital partner is the lead applicant; payment is always funneled to the community-based partner. So that's important to note as well. And so starting on slide 25 we outlined some of the requirements for the funding proposal and in a nutshell, there is a pretty good formula for developing an application. To go through these a little bit starting on slide 26, this slide really should incorporate both the strategy and implementation plan. And so, I'm going to try and modify my slide because the strategy slide is

missing from the slidex and hopefully we can post that slide to the website afterwards. But in talking about strategies for this funding announcement we're talking about a description of a comprehensive community specific root cause analysis or RCA that's incorporating downstream providers. And when they say downstream providers that's including post acute care providers such as skilled nursing facilities, also includes transportation providers, meals providers, community-based service providers. The results of the root cause analysis should be used to drive the selection of the target population that you're proposing to serve in your application and the interventions or the plan that you will use to address re-admissions. There needs to be a clear process for identifying who is at high risk for re-admissions within Medicare fee-for-service and the intervention or implementation strategy about how they will be integrated into the discharge process. There are resources available to help complete a root cause analysis which I will get into at the end of this presentation, but the important thing to note is that a root cause analysis can take many forms. You can look at the local discharge rates of your hospital partners; you can do chart reviews of patients who were discharged and re-admitted and look at what was the cause of the re-admission; you can do interviews with patients and care givers and hospital staff and community staff to get a sense of what drove the re-admission; you can monitor processes in a hospital or during the discharge process and do further data analysis. In the end your root cause analysis should clearly address three things; what's causing the re-admissions or what are the drivers, who you should target to be most effective, and who are the partners that you need at the table to effectively do this work. So then when you talk about the implementation plan, while the root cause analysis addresses what needs to be done, the implementation plan walks the reviewer through the process and how you know it will work. So how will you identify people to go through the care transitions program; who is the staff that specifically will do that; what

processes need to be changed in the hospital and during discharge and during transferring information to help support the care transitions, how will an elder or a beneficiary experience the program; what is your intervention, is it an evidence-based model; do changes need to be made within the hospital or within the model; what and how...what staff are involved. So then if you go to slide 27, this outlines some of the care transitions models that are currently being implemented by sites within the aging network and that are being evaluated with their connection to their existing long-term services and supports programs. This is just a few of the models. There are many, many others. If you have questions about these models, feel free to ask at the end of this presentation and I can provide some more information about how these models differ and there's a number of resources on the AoA website that talks about these models. And again with these models there are many sites that are actively implementing these models. Sometimes they may make changes in order for the models to work appropriately in the community, but it is always important to start with the original *** (28:41) intervention that is outlined here. Many of these models require specific training and there are resources about that as well. So going on to slide 28. Okay. So the next two slides discuss the section for organizational structure and capabilities. Again, this section really must tie to the root cause analysis that you are going to need to do. If in your root cause analysis you identify other providers that have an impact on your community and re-admissions, what will their role be - this is the place to address that - do you have evidence of their support, how will you and your partners track your progress on the program; how will you know if you need to make adjustments or when you're making success. If you look at the capabilities slide on slide 29, it's important to make it easy for reviewers and to spell out exactly how your organization is eligible for this or supplemental materials to highlight the organizational structure and the role of members in the community. What are the letters of

support that you have been able to gather for this? There are several required letters of support between hospital partners and the community-based organizations, so it is important to spell all of those things out. We go to slide 30. Great. So this program is looking for communities that have made some previous effort and progress and are ready to kind of expand their care transitions efforts. Again, when I talked about the theme, in a lot of ways Title VI programs are already doing the community-based services that might support a care transitions and then hospital partners may have made some in-hospital changes to help enhance their discharge process. So if you have started putting these things together or started a pilot, what has been the result of these changes and these efforts or the partnership; how long has it been going on; who are the people that you've served under this; what have been any results that you have seen. It's good to present that to those kind of details in this section. Slide 31 talks about the budget guidance for this program. I think the first bullet is very important and I'll kind of address more fully, but I think the bottom line or take away for this is that this program is really paying for direct services for elders and is not paying for start up costs, training, or infrastructure. It is a Medicare... It's designed to be a Medicare benefit so therefore must have a direct impact to the Medicare beneficiary in order to be a justifiable cost. So in your budget, you'll need to address how you will coordinate with discharge planners not to duplicate their services and you need to be able to provide justification for the proposed number of people you're planning to serve as outlined in the budget worksheet. This will include how you get your cost rates, your calculations, and your estimated volume. Again, there are resources to help work to develop that budget worksheet. So the next slide 32 talks about some lessons learned of previous applicants. This is a rolling application process that has been ongoing since last April. There are currently review panels posted to the CMS webpage that's on the resources slide of this slidex. You

know, I think CMS understands that this is a complicated and involved application process. You know, it requires managing multiple partners and complicated targeting procedures and working to alter existing hospital systems and community systems. So there are some lessons learned for people and this slide outlines some of those challenges. Slide 33 talks about some of the common budget errors. In order to estimate what a cost savings for your program would be CMS puts out the figure of \$9,600 as a starting point for the cost of a re-admission, and often times CMS will see applications that are developing a *** (34:31) eligible discharge rate of just under \$9,600. So it's important to understand that Medicare only sees savings on preventive re-admission. Applicants shouldn't expect that 100% of people who are eligible for the program will enroll in the program. Not everybody wants this care transition service even though there is no cost to them. Similarly applicants shouldn't assume that all re-admissions will be prevented. So these are just some of the common budget errors that happen with the worksheets. Also building a budget like a grant program to include costs for training and evaluation for equipment or overhead, et cetera, are not allowable under this program. And so finally on slide 34, this is where you can find the solicitation for the program as well as the list of the high re-admission rate hospitals where you can direct some additional questions that's very specific to this solicitation. So that's one resource, but then starting on slide 35, I know I talked a lot about what are the technical assistance resources that are available under this program and so this kind of provides some of that for you. First on slide 36, this is coming soon to AoA care transitions resource page IHS that notification that this page is now live and you can access it from the URL at the bottom of this slide and what it is is it's a kind of a one place to go for all of the resources that CMS and AoA and their contractors have put together on care transitions including toolkits and webinars, information about the funding opportunities, basic information on the evidence-

based models and their background and then resources that have been developed by sites who are currently doing care transitions programs. So this is just one place where you can get all of that information and be directed to all of the appropriate websites. The next slide features the AoA care transitions toolkit and it has a number of chapters about just how to get started. This toolkit was posted about six months ago and it's specific to the aging network. We are beginning the first update to this toolkit to more specific for targeting special populations. We have made an offer to Cynthia and Meg to work together with them to identify resources that are specific to the needs of tribes. We certainly welcome your thoughts and your suggestions about what would be helpful for you for getting started so that we can consider that as we do this update. And then finally on slide 38 I know that Kim Irby from the Colorado Foundation for Medical Care, CFMC, spoke last week at your conference, and I think she might actually be on the webinar today as well and she talked about the work of the quality improvement organizations under the integrating care for populations and communities theme. So this is effectively the care transitions theme under the QIO's tent scope of work. This is just a list of some of those things that the QIO's are able to do for the communities that they are recruiting under the tent scope of work to be able to start the work of applying for a CCTP or start the work of developing a care transitions program in their community. They are able to help develop with the root cause analysis and in looking at the discharge rates, putting together a measurement strategy for your community. There are learning and action networks within the states that the state QIO's are developing. There's a number of webinar services. Additionally, on the website that's on the slide, if you go to 'contact us' section of that website, there is a list of QIO state leads who are focusing on this aim within care transitions. So you can see directly who to go to for more information here and then when we do post the slides I will work with Kauffman to make sure

that that direct link is included in the slide so that you don't have to search for it. But there's a lot of great information and great expertise that is available both with the National Coordinating Center in Colorado as well as the QIO's that are within your state. And then the last several slides has additional information and resources about care transitions and the partnership for patients as well as the QIO information and AoA's resources. This is just another list of places to go for more information. That being said, a lot of these resources occur on that new AoA care transitions resource page that just went live. It will be included in the final slides, but hopefully if you do have very specific information about the information presented here about the models, I am always open as well as people from my staff to answer specific questions if you don't think of anything now, but would like to talk after the webinar. That's always an option as well. And with that, that kind of concludes all of the notes I have for today and I'm happy to answer questions.

Paula: Just as a reminder you can hit star six to unmute your line for questions. *(Pause.)* I do see that Kim... I think you're still on the line. Kim, do you have anything to add from your perspective or from your presentation last week?

Kim: Hi. This is Kim Irby. I don't actually, but I do want to also reiterate that we at CFMC are also here to help if you have any questions, you can feel free to contact me as well.

(Pause.)

Abigail: If there aren't any other questions for today, I do want to reiterate we are looking for help and your suggestions and what would be helpful to you in updating the AoA toolkit so that the materials that are applicable to tribes and make sense and are useful to you. So if you are able to take a look at the AoA toolkit please let us know if there are other things that you need or if there's something that you feel we could address.

Paula: Thank you so much Abigail and also Kim. And as a reminder the slides will be available on...

Genoe: Are you there?

Paula: Hello. Do you have a question?

Genoe: Yes. This is Genoe Lanaldy (*sp?*) from the state of New Mexico. I have a question. When we're looking at a lot of our various pueblos, which are each individual sovereign nations, they might have a very small a number of their folks that go through, you know the hospital and so the number of folks we're talking about are minimal in total. How would you propose that they get involved where they're able to take advantage of...

Abigail: Well, there's a couple of things. First off, there are preferences for rural areas and medically under served areas. So there is a potential for an applicant to come in with kind of a small product volume. At the same time the way that the application is set up to have a lead applicant that could be a collaborative of tribal organizations, and other community providers. It could include say a Federally Qualified Health Center in there that might have other Medicare beneficiaries that are impacted by re-admissions that aren't served by just Title VI programs. So they could be the kind of lead collaborative...lead CBO in a collaborative that also includes a Title VI program as a partner that could include a special focus or a special targeting for elders that are going through the hospital as well as other Medicare beneficiaries that are experiencing re-admissions within the...that are also utilizing the community-based...the health center services. So I think it's important when you're looking at the community that you're trying to serve who are all the providers in that area? Are there other beneficiaries that are experiencing re-admissions that aren't elders, but could benefit from a collaborative care transitions program that targets all the populations?

Genoe: Um, good answer, but I think the optimum word is collaborative.

Abigail: Uh huh.

Genoe: And I think there's a possible... You know that should maybe say this.

Abigail: It really is. I mean... I'm sorry; go ahead.

Genoe: I'm not sure you...how familiar you are in working within the tribal infrastructures and again *** (46:16). I was just saying that that makes it difficult.

Abigail: Yeah and I don't want to minimize that struggle, because I think it's been a big struggle with just care transitions programs in general and I used to work for a Title VI survey and you know working on that survey it was a very unique experience in how it differed from the other surveys that *** (46:49) it and I think that the collaborative process for getting everybody on the same page and willing to work through issues, there is no way to minimize that. I do feel that is important to make an offer, because something else AoA is currently offering to grantees who are interested is community organizing skill sessions. CFMC, Kim's organization is currently hosting a free webinar series that provides some basic community organizing principles and what AoA is doing is taking those principles and setting up additional skill building sessions to allow grantees to apply those skills within their own projects and so if there is a specific partnership that you or others are really trying to improve or work on those skill sessions are open to you. We haven't started them yet and if you're interested I just ask that you send me an e-mail.

Genoe: Okay. How do we download the PowerPoint?

Paula: So the PowerPoint will be available probably at the beginning of next week on the long-term services and supports website. We'll go ahead and make sure that an announcement is e-

mailed out once it's available and you can just follow the link and you'll be able to download and access it.

Genoe: Thank you.

Paula: You're welcome.

Meg: This is Meg Greys from AoA and I just want to say thank you, Abby. I appreciate you taking the time to do this and sharing this information and certainly people can send their submissions on it if they have some if they think of them after this webinar and thank you. Great information.

Abigail: Thank you.

Paula: Great. Well, thank you everyone. And I know that we're winding down now. If you have any questions feel free to reach out through the website and as a reminder our next chat will be in a month on the Greenhouse Initiative and there was information regarding that on the website as well as in the e-mail that you were sent with a reminder on this chat. Thank you so much.

(End of webinar - 49:51.)