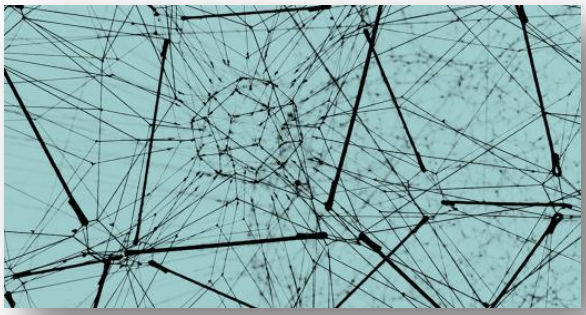


The Community-based Care Transitions Program: A Survey of Participating Sites

Summer 2019

Enacted as part of the Affordable Care Act (Sec. 3026), the groundbreaking Community-based Care Transitions Program (CCTP) was administered by the Centers for Medicare & Medicaid Services (CMS) as a five-year demonstration project under the Innovations Center.

The CCTP was the agency's first initiative to provide community-based organizations (CBOs) with funding to provide services to manage Medicare beneficiaries' transitions from hospital to home and to reimburse CBOs – mainly Area Agencies on Aging (AAAs) – for providing supports in the community to improve their quality of care. Starting in 2012, 101 community-based organizations across the country were funded to collaborate with hospitals and offer transitional care. CBOs were reimbursed for each beneficiary who was provided with transition services, based on an agreed-upon, all-inclusive rate per eligible discharge.

The principal metric that CMS used to evaluate the results was narrowly focused on the impact of the program on all-cause 30-day readmission rates among participating hospitals. For many CBOs and hospitals, the initial challenges of working across two very different systems – medical care institutions and providers that are trained to work in the home – were daunting. Nonetheless, 44 CBOs persevered, receiving continuing funding through 2017. Some CBOs provided comprehensive care transition services post-discharge in the beneficiary's home, such as assistance with obtaining personal care and with household tasks that many people returning from the hospital are not able to manage. However, the evaluation did not include a specific analysis of the impact of these interventions.

N3C
National Coalition on Care Coordination

CHaSCI
Center for Health and Social Care Integration

Impact of CCTP

CMS' goals for the CCTP included: achievement of a 20% reduction in the 30-day all-cause readmission rate across all partner hospitals compared with baseline; reduction in the 30-day all-cause readmission rate among the high-risk cohort served; and achievement of the target volumes for full enrollment. The final evaluation of CCTP, completed by Econometrica under CMS contract,[1] identified several achievements:

- CCTP participants had lower readmission rates and Medicare expenditures when active in the program, relative to comparable nonparticipants (matched comparisons). Specifically, Medicare Part A and Part B expenditures were $634 lower ($7,064 vs. $7,698; $p < 0.01$) for participants from the 101 sites than for the matched comparisons.

- High-achieving sites "successfully identified beneficiary needs, effectively linked participants with community-based services, and coordinated with post-acute care (PAC) providers. Specifically, successful sites responded to challenges with the provision of support services by identifying new service providers, sources of funding, and ways to connect participants with appropriate services in a timely manner."

- Successful sites were integrated with their hospital partners – with access to electronic health records, access to work space, and regular communication with hospital staff – allowing for streamlined data processes that could aid in program monitoring and quality improvement.

Yet the evaluation did not clearly credit many of these achievements to the work of CBOs participating in the CCTP, and did not identify a causal or longer-term impact of the demonstration, as argued by some advocates and members of the National Coalition on Care Coordination (N3C). Therefore, to learn more about outcomes of the CCTP, N3C surveyed participating sites to ask about their challenges, successes, and longer-term structural results that followed their participation in the demonstration.

Methods

The survey was developed by N3C members and was completed by a convenience sample of CCTP participants. The survey was disseminated to the National CCTP Coalition, which included CCTP sites that received continued funding from CMS and was convened by Aging & In-Home Services of Northeast Indiana, Inc. The survey was also disseminated broadly via the National Association of Area Agencies on Aging's Aging and Disability Business Institute to capture input from other CCTP participants. The authors reviewed all responses, edited examples for clarity and grammar, and conferred on themes. All respondents have had the opportunity to review this report.

Survey findings

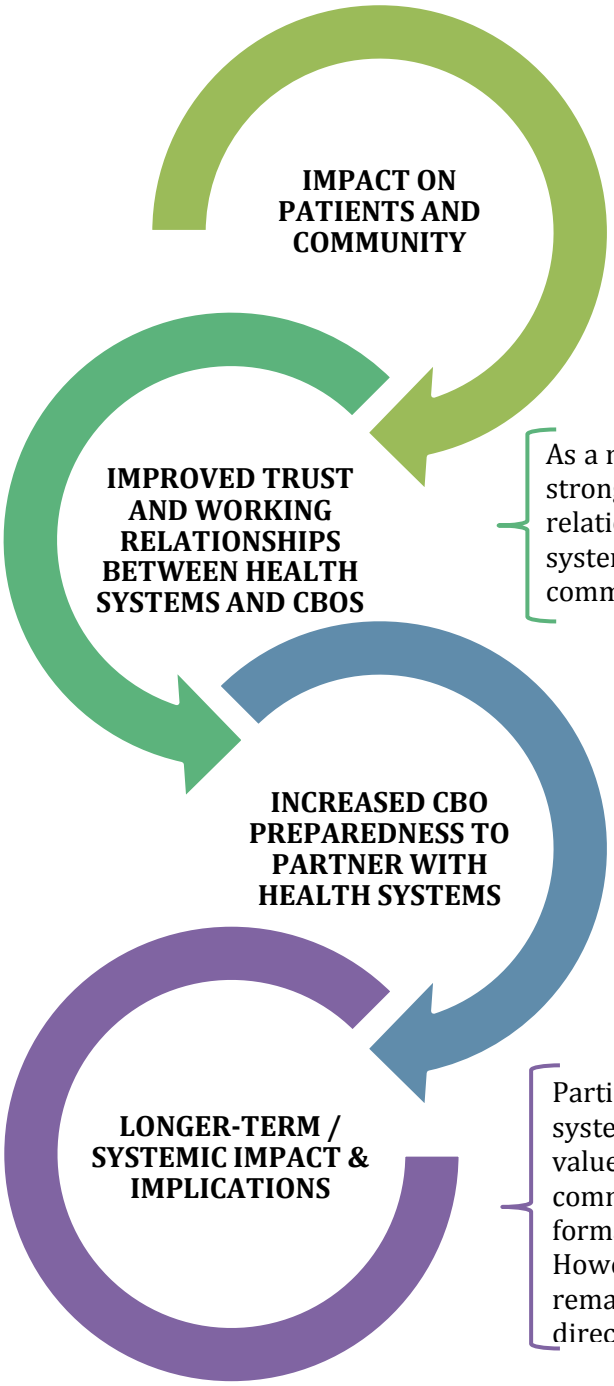
While CMS' formal evaluation may not have attributed significant lasting achievements to CBO-provided transitions interventions, qualitative data suggests that CCTP opened the door for CBOs to make key improvements to the way that health care and care transition services are coordinated and delivered. Notably, systems used by hospitals and CBOs to manage complex patients gradually became more efficient at communicating critical information about patients; relationships between medical and CBO staff improved; and referral processes solidified. Additionally, many CBO respondents reported an increase in trust and rapport-building between health systems and their partnering CBOs.

Though business protocol challenges remain and some momentum and cross-learning between CBOs and health systems was lost when the program ended, Area Agencies on Aging (AAAs) and CBOs have nevertheless continued to move forward in creating partnerships with health care organizations. Overall,

[1] *Final Evaluation Report: Evaluation of the Community-based Care Transitions Program. November 2017.* https://downloads.cms.gov/files/cmmi/cctp-final-eval-rpt.pdf

the CCTP served as a springboard for learning, and boosted the Aging Network's abilities to take on work that was more systemic. For example, CBOs developed better clinical protocols with health care providers and increased their field capacity, taking on new contracts as they worked to connect with health systems and engage with health insurance plans. One CBO respondent in this survey reported success in becoming an Accountable Health Community (a subsequent CMMI demonstration), and credits participation in CCTP with providing them with the necessary experience.

Four overarching themes were identified in the participant surveys:



The CCTP program has had a lasting impact in improving care for vulnerable Medicare beneficiaries. This is manifested in improved patient care experience, better connection to resources/services, and reductions in hospital readmissions.

As a result of participating in the CCTP, CBOs built strong relationships with health systems. These relationships were strengthened by the health systems' increased trust and improved communication with partner CBOs.

CBOs also expanded their capacity to partner with health systems, as well as their ability to plan and execute programs within a business model framework. CBOs became more business-oriented and learned how to market their programs so they can compete in the ever-changing health care landscape.

Participation in the CCTP resulted in long-term, systemic changes, such as increased recognition of the value of transitional care services in the medical community. It also led to longer-term contracts and formal partnerships between health systems and CBOs. However, despite these developments, challenges remain with sustaining programs that no longer have a direct revenue source.

Snapshots & highlights: Observations across CCTP sites

IMPACT ON PATIENTS AND COMMUNITY*

The CCTP program had a lasting impact on the patients and the community, including improved patient care experience, connection to resources/services, and reductions in hospital readmissions.

"Our organization…developed contracts and programs that are needed by the hospital…to improve the overall quality of health for the patients and the community."

"[We learned] many people are struggling with managing their care and accessing the resources… Addressing social determinants of health within overall patient management...does provide improved health outcomes."

"Hospitals and CBO both understand more about what each other does and how they can work together to improve things for our community."

"CCTP filled a huge gap between health care and community-based services."

"The CCTP allowed us to integrate our social needs focus with the health care environment…We also discovered a large number of people that could benefit from our community-based services but were not being reached through our traditional methods. By working with the healthcare community, we broadened our reach and impact."

"[Results showed] a reduction in unnecessary re-admissions which saved more than a million dollars to the hospitals collectively; better medication management; [and an] increased number of patients keeping their physician appointments....There were changes in the discharge processes at the hospital that were more efficient and patient friendly."

IMPROVED TRUST AND WORKING RELATIONSHIPS BETWEEN HEALTH SYSTEMS AND CBOS*

As a result of participating in the CCTP, CBOs built strong relationships with health systems. These relationships were strengthened by the health systems' increased trust and improved communication with partner CBOs.

"Our participation provided us with a great deal of insight into what challenges the area healthcare organizations were facing and allowed us to more fully realize the value and contributions a CBO was able to bring to the table."

"We now have a strong, ongoing relationship with both hospital systems' care management departments…. [They] are much better informed about our services as an AAA and routinely access our staff and services for patients."

"We had to build trust with hospitals through accountability, honesty, and transparency…. Over time… they came to recognize that our strength together was greater on behalf of the patient as compared to our individual strengths. We also learned a great deal from each other."

"We saw the importance of maintaining our relationships and communication with the hospital staff and hospital leadership."

INCREASED CBO PREPAREDNESS TO PARTNER WITH HEALTH SYSTEMS*

CBOs also expanded their capacity to partner with health systems, as well as their ability to plan and execute programs within a business model framework. CBOs became more business-oriented and learned how to market their programs so they can compete in the ever-changing health care landscape.

"We began to develop a business model."

"We…improved our ability to define our programmatic costs and Return on Investment (ROI), which assists us strategically as to what is important and what is sustainable in our practice. We continue to learn [through]…collaborations, and of course the strong relationships we built with other CCTP communities."

"Learning the language and culture of the medical community and how to successfully navigate that reality was another lesson learned."

"Our CCTP program highlighted for us the importance of our own required culture change to effectively work with health care…[including] enhancing our data management capabilities to demonstrate outcomes and understanding our own expertise related to addressing social determinants of health."

"The Area Agency on Aging needed to create a business plan to build capacity and develop an understanding of the more complex payment models. CCTP helped the agency to implement performance standards and quality improvement systems based on value and outcomes, rather than volume."

LONGER-TERM / SYSTEMIC IMPACT & IMPLICATIONS*

Participation in the CCTP resulted in long-term, systemic changes, such as increased recognition of the value of transitional care services in the medical community. It also led to longer-term contracts and formal partnerships between health systems and CBOs. However, despite these developments, challenges remain in sustaining programs without an ongoing source of revenue.

"*The value of post-discharge support…has led several health care organizations to make changes in their discharge processes… The CCTP led to increased awareness among hospital discharge personnel of how significant a role the individual's social needs can play in their eventual outcome."*

"Our experience and results from the CCTP project was invaluable…our program is so well-developed that we have been able to quickly start up with other payers and partners."

"By the end of the program, our CCTP staff was so incorporated into the hospital system that they were treated very much like members of the integrated hospital team."

"*The concept of transitional care has become more prominent, not only with hospitals but also in the community."*

"There has been some evolution in the medical community's perspective on the value of care transitions."

"CCTP demonstrated that relationships between medical and social providers are effective, and further, that local stakeholders can have a positive impact on hospital readmissions."

**Quotes are edited for clarity*

Appendix I: Survey Respondents

Organization	Brief description of CCTP project set-up	Dates of Participation
AgeOptions, with 6 Chicago area social care organizations and 6 hospitals	Our CCTP project consisted of 6 sites implementing the Bridge Model of transitional care: 5 Care Coordination Units, and Rush Health and Aging. Each worked in partnership with a local hospital. AgeOptions provided oversight.	April 2012 - March 2014
Aging & In-Home Services of Northeast Indiana, Inc.	CCTP was launched with Aging & In-Home Services of NE Indiana (AIHS), an AAA, as primary contractor and an initial subcontractor AAA in Eastern Indiana. Within the first operating year AIHS assumed full responsibility for program. AIHS staff were embedded in 11 hospitals with discharges to 33 counties. Our coverage area encompassed approximately 25% of Indiana's Medicare population.	2012 – Jan 2017
Appalachian Agency for Senior Citizens Cedar Bluff, VA	One CBO, 4 hospitals	Apr 2013 - Mar 2015
Atlanta Regional Commission	Enhanced CTI [care transitions intervention], including medically-based nutrition care and transportation to medical appointments, with 6 hospital partners (5 systems); 1 manager, 1 supervisor, 6 hospital-based coaches, 1 central scheduler deploying 13 field-based coaches to home visit.	Feb 2012 - Jan 2016
Chautauqua County Office for the Aging Mayville NY	1 mega CBO (P2 Collaborative), 7 CBOs (7 AAA) and 10 hospitals, Western NY	May 2012 - Mar 2014
County of San Diego Health and Human Services Agency, Aging & Independence Services (AIS)	The San Diego Care Transitions Partnership (SDCTP), was a partnership between Aging & Independence Services (AIS) and Palomar Health, Scripps Health, Sharp HealthCare and the University of California San Diego (UCSD) Health System (13 hospitals), and served over 50,000 clients with a variety of interventions.	January 2013 - January 2017
Delaware County Office of Services for the Aging (COSA) Eddystone, PA	1 CBO, 5 hospitals (using modified Naylor model)	Aug 2012 - Jul 2014
Denver Regional Council of Governments (DRCOG) CO	CBO (AAA), 7 hospitals	May 2013 - April 2015
Elder Services of the Merrimack Valley, Inc. Lawrence, MA	One CBO, 6 hospitals	Feb 2012 - Jul 2015
Hospice of the Bluegrass/ KY Appalachian Transition Services	One-community-based organization, 4 hospitals	Feb 2013 - Mar 2017
Lifespan of Greater Rochester, New York	Our collaborative project was done in conjunction with 2 hospital systems (5 hospitals), 2 home care agencies and Lifespan (a non-profit aging service provider).	2012 - 2017
Lower Rio Grande Valley Development Council AAoA301 Wesalco, TX	1 CBO and 11 hospital partners	Aug 2012 - Feb 2016

Organization	Brief description of CCTP project set-up	Dates of Participation
Missoula Aging Services Care Transitions Program Missoula, MT	One CBO and 2 hospitals in Missoula	Mar 2013 - Aug 2016
Partners in Care, San Fernando, CA	3 different sites: two sites with 1 CBO and 3 hospitals, and one with 1 CBO and 5 Hospitals	May 2013 - Jan 2017
Pierce County Human Services Tacoma, WA	Area Agency on Aging and 2 hospital networks comprising 6 hospitals	Mar 2012 - Jun 2014
Southern Alabama Regional Council on Aging	One CBO, 8 hospitals	Feb 2013 - Jan 2018
Southwestern PA Area Agency on Aging, Inc Charleroi, PA	The Western Pennsylvania CCTP community consisted of two AAAs, 6 acute care hospitals across 4 health care systems and a network of sub-acute care providers including skilled nursing facilities, home health agencies and personal care homes. The SW PA Area Agency on Aging acted in the capacity as the CBO for the project.	May 2012 - Feb 2017

Appendix II: All Survey Responses

Q1. What were your top lessons learned as a community-based organization (CBO) participating in the CCTP demonstration?

- **AgeOptions**
  All participating CBOs shared a similar challenge in garnering enough referrals from their partnering health care system. There were no embedded referral systems and no way for patients to be "flagged" as appropriate for participation in the program, and therefore the CBOs had to rely on direct provider referrals for participants. Issues such as high turnover rates at the partnering hospitals resulted in an overall lack of referrals. We learned that in order for this type of program to be sustained, there needs to be initial buy-in from healthcare providers to create an embedded referral system of patient registry that eliminates the need for education and participation from each specific provider within that healthcare system.

- **Aging & In-Home Services of Northeast Indiana, Inc.**
  Our CCTP program highlighted for us the importance of our own required culture change to effectively work with health care. These changes included structuring a 24/7 response capability, integrating medical professionals (i.e., nurses) into our own team, enhancing our data management capabilities to demonstrate outcomes and understanding our own expertise related to addressing social determinants of health.

- **Appalachian Agency for Senior Citizens**
  Developing a business model and offering care transitions as a fee for service program to the hospitals and Managed Care Organizations after the project ended with CMS.

- **Atlanta Regional Commission**
  1. Building deep non-traditional partnerships with health systems during a volatile environment moving to readmission penalties, volume to value-based, and the advent of shared savings ACO's.
  2. Staff recruitment, configuration, training, and productivity supporting quick deployment to meet the discharge needs of our hospital partners.
  3. Find ways to scale up, spread, yet still meet triple aims of contract.
  4. Keep eye on readmissions and ability to pivot program to meet changing demands and learning.

- **Chautauqua County Office for the Aging**
  The medical system (at the time) did not consider the social determinates of health in their discharge plans. Caregivers often felt left out of the discharge process, and there was no electronic connection between medical and social services, so a lack of communication about mutual clients and protocols that could improve health outcomes and prevent avoidable readmissions. Discharge instructions in the hospital setting are still focused on giving information and not making sure the client or their caregiver understand.

- **County of San Diego Health and Human Services Agency, Aging & Independence Services**
  1. Establishing an organizational structure that clearly delineates roles and responsibilities is essential for success of a large-scale partnership. The SDCTP was the largest program in the country and included 4 large health systems and a County (government-based) Area Agency on Aging (AAA). The SDCTP established a Steering Committee comprised of a Senior Executive from each partnering organization for oversight, and a Work Team comprised of "boots on the ground" leadership to manage the day-to-day operations of the program.
  2. Administering the program (quality management, data aggregation and reporting, and billing) required significant investment from the CBO. Administrative costs could not be included in the blended per patient rate paid by CMS.

3. It takes more time to ramp up and expand a program with a large footprint than you anticipate (The SDCTP targeted over 50,000 FFS Medicare beneficiaries).
4. Identifying and targeting the "right" patients was critical to achieving expected outcomes.
5. The metric that CMS used to calculate the reduction in readmissions did not accurately reflect our success, as it did not take into consideration the program's impact on the reduction in admissions.

- **Delaware County Office of Services for the Aging**
  We learned the cost of operating a CCTP, the role of unexpected costs, and the need to increase enrollment quickly at the start of the program – considering mandatory versus not mandatory enrollment at start-up.

- **Denver Regional Council of Governments**
  1. We underestimated the financial investment.
  2. We underestimated the number of staff we would need to reach our enrollment numbers.
  3. We overestimated our target population- once we ruled out managed Medicare enrollees and patients with language barriers, those living out of our region, people not returning home and going to a SNF, PAM 4's, and those who chose not to enroll, we were left with a minimal number of people that qualified. That number dropped off further due to difficulty locating participants after they left the hospital.
  4. We overestimated our hospital and stakeholder engagement and underestimated the amount of work necessary to maintain their commitment.
  5. The intervention worked well for the small cohort of people that we worked with -- our readmission rate was way below the target rate.

- **Elder Services of the Merrimack Valley, Inc.**
  We learned about bolstering staffing capacity to support high volume, building and maintaining relationships with hospital partners, developing a more "a la carte" intervention protocol based on patient need, the importance of having internal data analytics with a more robust reporting system, and increasing nursing oversight to support non-medical coaching staff.

- **Hospice of the Bluegrass/ KY Appalachian Transition Services**
  We found evidenced-based models of transitions (Naylor primarily) when used consistently in fact do prevent avoidable hospital readmissions and ED usage. Close partnerships with the hospitals is essential to success, this including full integration into the hospital case management, C-suite discussions, electronic records and medical staff work flow. We learned that success requires that not only our team, but the whole community, including clients, commit to the process. Providing regular reports with real-time data demonstrated to our partners how successful the program was.

- **Lifespan of Greater Rochester**
  People need reassurance about medical instructions. It is important to reinforce red flags to patients. Medication reconciliation was critical.

- **Lower Rio Grande Valley Development Council**
  We found that the LRGV Care Transition Intervention Program was very successful due to the buy-in and cooperation from all 11 hospital partners who saw the value of the program with reduced readmission across the board.

- **Missoula Aging Services Care Transitions Program**
  We realized that there was a learning curve in working with CMS. We learned there was great value in learning from the other teams-especially seasoned teams with track records and teams located in similar rural/frontier areas. We also learned that lowering readmit rates was just one area of measuring success and that our efficacy in tackling the social determinant needs of our clients was an invaluable component of the program that now seems to be acknowledged by all. Learning the language and culture of the medical community and how to successfully navigate that reality was another lesson learned.

- **Partners in Care**
  We found that to be successful, you must have a physician champion from the hospital side. It is necessary to make the referral process easy for the hospital to do, and it's important to try to get EMR access. Since CMS claims data are delayed, we learned how to work with the hospital to get internal data.

- **Pierce County Human Services Tacoma, WA**
  The introduction of new programs and ensuring adherence to program protocols within large hospital systems takes very strong leadership, constant oversight, and clear, consistent communication. While leadership buy-in is essential, there must also be buy-in from patient care staff and their supervisors in order to successfully identify participants for the program.

- **Southern Alabama Regional Council on Aging**
  Many people are struggling with managing their care and accessing the resources that may be available. Other people have poor outcomes due to issues that can be resolved or ameliorated by appropriate education, assistance identifying resources, behavior modification, and increased patient engagement. Addressing social determinants of health within the overall patient management and support process provides improved health outcomes and assists in assuring care is accessed at the most effective acuity level.

- **Southwestern PA Area Agency on Aging, Inc.**
  To be successful, the Area Agency on Aging needed to create a business plan that helped the agency to build capacity and develop an understanding of the more complex payment models. Additionally, CCTP helped the agency to implement performance standards, quality improvement / continuous quality improvement systems based on value and outcomes rather than volume.

Q2. As a CBO, were there initial challenges in establishing close working relationships with participating hospitals? If so, what were they and how did you work to try to address them?

- **AgeOptions**
  Three of the participating CBOs had not previously utilized the Bridge Model of transitional care, so there were challenges establishing partnerships with the hospital staff. Additionally, continual turnover at the hospitals and CBOs contributed to problems with program buy-in and sustainability.

- **Aging & In-Home Services of Northeast Indiana, Inc.**
  We initially were challenged with hospitals not fully understanding the role we could play by bridging care to the home. Discharge planners needed to become comfortable with us as their "partners" in coordinating care for complex patients. Agency and hospital leaders agreed to a monthly meeting to review data and discuss problem-solving options. The relationship built through these regular meetings led to the hospital providing office space and access to electronic medical records, which proved to be key to identifying appropriate referrals for the program. By the end of the program, our CCTP staff was so incorporated into the hospital system that they were treated very much like members of the integrated hospital team.

- **Appalachian Agency for Senior Citizens**
  Our organization had a professional relationship with the hospitals because of our PACE program, but there were still challenges. We speak the language of health care and understand how to collect the data, which was important and useful to the hospital. Based on our CCTP experience, we began to develop a business model.

- **Atlanta Regional Commission**
  Initially we had to build trust through accountability, honesty, and transparency. Hospitals were reluctant to hand off their patients while embracing population health strategies without formal hand-off and back protocols. Over time, they opened their EHR to all coaches on the OP side for documentation, allowed us to scour admissions for referrals, and came to recognize that our strength together benefitted patients more than our individual strength. We also learned a great deal from each other-about defining "our lane" while reaching back for support when appropriate within "their lane."

- **Chautauqua County Office for the Aging**
  Access to electronic medical records is vital to identify eligible clients. However, it was not until the last six months of the project that we finally got access. Hospitals needed better direct guidance form CMS. With regard to observation stays, we saw a significant increase in the use of observation stays by local hospitals after the start of CTTP. This skewed the data, so it was difficult for us to show that we were successfully avoiding readmissions.

- **County of San Diego Health and Human Services Agency, Aging & Independence Services**
  We did not experience challenges with establishing close working relationships with the four health systems in the partnership because all of the hospitals were at the table from the very beginning and were directly involved in developing the program design and application that was submitted to CMS.

- **Delaware County Office of Services for the Aging**
  We experienced challenges and also made progress with regard to access to records, staffing replacement needs, working with our local hospitals to resolve implementation issues.

- **Denver Regional Council of Governments**
  Our local QIO helped make the initial introductions and then we establish a solid commitment from to two individuals who became our hospital champions and formed the program implementation team.

- **Elder Services of the Merrimack Valley, Inc.**
  Challenges included integrating our staff into the hospital to ensure the appropriate patients were being identified for the program. Having a lead coach "housed" in each participating hospital provided consistency and produced a more integrated model.

- **Hospice of the Bluegrass/ KY Appalachian Transition Services**
  Because we did a pilot prior to the CCTP award, we already had close relationships and were integrated into their medical records, etc. Keeping the hospital engaged was a challenge, and working with long-time case management staff at one hospital was challenging. We did PDSAs repeatedly on engaging the hospital partners. Giving data in real-time, showing our results, and having CMS & contractors visit 2 times was instrumental in our success with the partner hospitals.

- **Lifespan of Greater Rochester**
  There were challenges in terms of figuring out work flow and who is doing what. For instance, if home care was necessary, we discussed whether to assign a "transition coach" too. We worked through the work flow problems.

- **Lower Rio Grande Valley Development Council**
  Due to the intense completion between the local hospitals, we enlisted our local QIO-Texas Medical Foundation to assist in coordinating and establishing the need to address the high readmission rate in our region through the QIO 9th Scope of Work.

- **Missoula Aging Services Care Transitions Program**
  Our initial challenges in working with the hospitals had to do with the medical community's cultural norms of going-it-alone/we have this covered. It was very difficult to establish any sense of the value of our services, experience, resource knowledge and position in the community in providing ongoing supports to the population receiving services at home. A significant challenge was our initial lack of EHR access at both hospitals. Our program did not experience any measurable success until our CEO advocated for EHR access – and we gained that access. As far as establishing good working relationships with both hospitals, we were sure to provide whatever the hospitals wanted from us in respect to communicating how we work with their patients. The hospitals knew of each client we worked with, and if they experienced a readmit during our intervention, we discussed the diagnosis or cause of that readmit. We also provided presentations to hospitalists and other hospital staff as requested.

- **Partners in Care**
  Our initial challenge was IT. We had three different sites and each had its uniqueness. However, it was not easy establishing relationships - what really worked was having daily to weekly meetings (preferably in person) and having a physician champion who can speak "hospital language."

- **Pierce County Human Services**
  We were fortunate to have hospital leadership (Chief Nursing Officers) strongly supporting the CCTP initiative, as well as strong support from the hospital's IT teams, care management and utilization review staff.

- **Southern Alabama Regional Council on Aging**
  We experienced different processes at each hospital, variation in hospital information systems, and differing discharge processes that required us to adapt our personnel's approach by facility, in effect forcing a customized program for each. In the end, this proved to be a positive because it let us develop as a large multi-hospital implementation program out of the CCTP project, while also retaining the benefits of a single hospital implementation because we were very adapted to each individual partner hospital's needs. We also learned the importance of maintaining our relationships and good communication with the hospital staff and hospital leadership, which led to ongoing changes and improvements in our program.

- **Southwestern PA Area Agency on Aging, Inc.**
  Initially hospitals were hesitant to share information with other hospitals in the region. However, as the contracting CBO we were able to overcome this challenge through our partnership with the QIO under the QIO 8th Scope of Work which helped to create a culture of collaboration prior to the CCTP demonstration project. Equally important, we established a CCTP Leadership Council which met monthly and facilitated the active engagement of all stakeholders in the project.

Q3. Describe some of the ongoing gains you achieved through participation in the CCTP project (e.g., greater knowledge about how to partner with health care organizations).

- **AgeOptions**
  One participating CBO continued contracting with hospitals for transitional care and expanded their work by partnering with Skilled Nursing Facilities. We continue participating in state-level programs that provide transitional care services, such as Money Follows the Person and Choices for Care. We are also members of the Coordinated Care Alliance where we've presented our services to managed care entities and gained contracts with local health systems.

- **Aging & In-Home Services of Northeast Indiana, Inc.**
  For us, CCTP can be credited with changing the trajectory of our agency. It provided the impetus for us to make all of the culture and operational changes that have allowed us to reposition as a partner with integrated care in our region. It also gave us the insight and tools to help with statewide and national contracts for care transitions and care coordination for complex patients. AIHS has an LLC that now holds contracts with private insurance companies and managed care organizations. We work with multiple patient populations within Commercial, Medicaid and Medicare arenas. We also have recently received additional care transition contracts with a major health system that was part of CCTP to re-initiate this work.

- **Appalachian Agency for Senior Citizens**
  Our organization has maintained a good partnership with the hospitals and we are now offering care transitions to one of the hospitals and have developed contracts and programs that are needed by the hospital to not only prevent re-admissions but also to improve the overall quality of health for the patients and community. We also have a private contract with a managed care organization and are also working with MCOs in a dual eligibles project.

- **Atlanta Regional Commission**
  Through this project we improved our ability to define our programmatic costs and ROI, which now assists us strategically as to what is important and what is sustainable in our practice. We continue to learn throughout multiple webinars, collaborations, and of course the strong relationships we built with other CCTP communities.

- **Chautauqua County Office for the Aging**
  Hospitals and CBO both understand more about what each other does, and how they can work together to improve things for the people of our community. Primary care practitioners saw the advantage of CCTP and began contracting with us after the CCTP initiative ended. Hospitals did not continue.

- **County of San Diego Health and Human Services Agency, Aging & Independence Services**
  The four health systems in the San Diego CCTP realized that they had more in common than they thought initially, and were able to achieve more by working together than they would have individually. The hospitals shared data and worked though challenges together. They benefited from and leveraged best practices and lessons learned across health systems. They also learned about programs and services that were available both from the partnering CBO as well as in the broader community that could address the social needs of their complex patients. Partnering CBOs established themselves as a knowledgeable and accomplished care transitions leaders in in the community and nationwide.

- **Delaware County Office of Services for the Aging**
  We experienced greater interaction with local hospitals and skilled nursing facilities.

- **Denver Regional Council of Governments**
  We gained greater knowledge and access to partner organizations which lead to an Accountable Health Community grant, an invitation to participate in the Linkage Lab as well as a Community Care Management pilot University of Colorado Health Care system (funded by the Colorado Health Care Association.)

- **Elder Services of the Merrimack Valley, Inc.**
  We negotiated contracts with two separate Senior Care Options plans to provide care transitions to their members. We have become a Long Term Services & Supports Community Partner under the new Accountable Care Organization initiative in the state of Massachusetts.

- **Hospice of the Bluegrass/ KY Appalachian Transition Services**
  Our experience and results from the CCTP project have been invaluable in obtaining other partners and payers. Our program is so well developed that we have been able to quickly start up with other payers and partners. The sustainability workgroups were fabulous and helped us understand the value proposition and return on investment for payers and partners. We expanded to MCOs, Medicare Advantage Plans and other hospital partners prior to the end of the demonstration.

- **Lifespan of Greater Rochester**
  We have used the CCTP to better integrate health care and community-based services.

- **Lower Rio Grande Valley Development Council**
  Our team was able to see and appreciate the intensely high-level activity that our hospital partners go through on a daily basis.

- **Missoula Aging Services Care Transitions Program**
  A significant "gain" for us was how to establish this type of unique support in a rural area without a lot of existing rural models to go by. Learning the language and culture of the medical community was important. It was also important to learn that the medical community was unwilling or unable to participate as a pay source for community services. This has led us to redirect our energies to pursue other potential pay sources (i.e. insurance companies; grants; clinics; State programs, etc.) in order to sustain the program. Another gain is that the hospitals and now clinics are willing to continue working with us. There has been some evolution in the medical community's perspective about the value of care transitions through the years (going on 5 1/2 years now). We think the reason for the change is 1) the obvious success we have had locally and 2) the uptick in the acknowledgement of the value of community programs. Currently, we are sustained through grant money from several sources and are pursuing other potential paying partners.

- **Partners in Care**
  We definitely learned how to partner with hospitals. We learned that being embedded in the hospital's medical records is the way to go; that way, it makes us as part of the team. We learned that case managers are not going to be inclined to refer unless we make it easy for them. One most important gains was to require minimum volume guarantees in future contracts.

- **Pierce County Human Services**
  We have a strong, ongoing relationship with both hospital systems care management departments. While we no longer support any type of care transitions program with these hospital systems, their care management teams are much better informed about our services as an

Area Agency on Aging and routinely access our staff and services for patients. We also maintained a collaborative relationship with one hospital system and have looked for ways to develop new partnerships that would draw on our strengths as the AAA.

- **Southern Alabama Regional Council on Aging**
  Our participation provided us with a great deal of insight into what challenges healthcare organizations in the area were facing and, allowed us to more fully realize the value and contributions a CBO can bring to the table. It also allowed us to integrate our social needs focus with the health care environment to provide a more comprehensive management of the population. We also discovered a large number of people that could benefit from our community-based services but were not being reached through our traditional methods. By working with the healthcare community, we broadened our reach and impact.

- **Southwestern PA Area Agency on Aging, Inc.**
  Through the success of CCTP, our agency was able to secure a contract with a large health care plan in the region. Currently, the agency is providing care coordination to members enrolled in the plan's Dual Eligible-Special Needs Plan.

Q4. Describe any of the downsides you experienced related to participating in CCTP.

- **AgeOptions**
  One of the challenges working with the health care systems/hospitals was that because CCTP services were originally offered at no cost to the partner hospitals, when the pilot ended and we tried to continue partnering with the hospitals in the form of creating contracts, the hospitals were reluctant to pay for a service they had been getting for free.

- **Aging & In-Home Services of Northeast Indiana, Inc.**
  It was difficult to achieve enrollment goals as initially submitted to CMS with AIHS as contractor and a subcontractor. In 2013, this meant that ramp-up costs exceeded initial planning. The subcontractor exercised the termination clause and AIHS was then able to train/monitor compliance to the intervention more effectively. We were able to dramatically shift referral levels as we increased staff skill set, and gained access to electronic medical records and could identify our own referrals.

- **Appalachian Agency for Senior Citizens**
  Not all of the hospitals continued to participate in care transitions work after the CCTP project.

- **Atlanta Regional Commission**
  We had a tough time reducing all-cause, all-condition readmission rates. We had approximately a 2% reduction but we were able to reduce the participant rate by 23%. Direct referrals from care coordination were difficult to sustain; hence our hospital-based coaches scoured admission lists. This was not efficient and did not support broader coordination with CBOs.

- **Chautauqua County Office for the Aging**
  We were very frustrated with the lack of communication from CMS to our hospital partners with specific guidance on how to best work with CBOs. The CMS measures included all high-risk clients regardless of whether they participated in CCTP or not. A better measure would have been comparing those who enrolled in the program against those who opted out rather than a 20% reduction in readmissions across the board. How can they expect us to have an effect on those not in the program?

- **County of San Diego Health and Human Services Agency, Aging & Independence Services**
  The CBO (County) costs to create a technology solution for data collection and billing was not reimbursed by CMS, nor were all of the CBO administration staff costs.

- **Delaware County Office of Services for the Aging**
  Our modified Naylor model was very costly due to the need to hire hiring nurses, although it is a proven successful model for CCTP.

- **Denver Regional Council of Governments**
  We achieved greater knowledge and access to partner organizations which led to us receiving a CMMI Accountable Health Communities (AHC) grant, an invitation to attend the SCAN Foundation's s Linkage Lab, and a Community Care Management pilot funded by the Colorado Health Foundation with UC Health.

- **Elder Services of the Merrimack Valley, Inc.**
  N/A

- **Hospice of the Bluegrass/ KY Appalachian Transition Services**
  The only downside is in our area, which is challenged with health-care disparities, poverty, low health literacy, lack of community resources/transportation, is that the fee for service Medicare beneficiaries now do not have access to the program unless a partner hospital includes them.

- **Lifespan of Greater Rochester**
  N/A

- **Lower Rio Grande Valley Development Council**
  It was difficult to achieve enrollment goals as initially submitted to CMS. In 2013, we made a dramatic change in how we assign hospitals to CBOs, and how we handle coaching staff. We made staffing changes that allowed us to go from a monthly average of 265 to almost 700+ within two months.

- **Missoula Aging Services Care Transitions Program**
  The overall downside of creating and maintaining this program is the lack of a sustained funding source to allow us to just do the work. We see the value of the program but it is disheartening to have to split your time and energy between operations and refining of the program and pursuing funding sources. We have also been frustrated by the lack of congressional willingness to continue to fund a proven Medicare cost savings program.

- **Partners in Care**
  As wonderful as the results were, most of the hospitals did not want to contract with us after CCTP ended. It seems like the CMS readmissions penalty was less onerous than paying us. However, SDOH and "net promoter" scores were not highly visible and hospitals, at that time, did not understand the benefits as much.

- **Pierce County Human Services**
  We did not continue because we found that the reimbursement rate received did not cover the extremely high investment of staff time given by all three systems to make this collaboration a success.

- **Southern Alabama Regional Council on Aging**
  We faced and overcame obstacles in the process, and the overall result was all positive. The only true downside was that the mandated sunset of the program meant that the assistance the partner hospitals had come to value had to be discontinued. We have also been contacted by individuals who participated in the program and were looking for similar help for themselves, family or friends. While we continue to assist them within the programs we still have, the loss of the CCTP program left a definite hole in the safety net for the community.

- **Southwestern PA Area Agency on Aging, Inc.**
  There were no downsides. The knowledge and expertise we gained in working with our hospital partners was the catalyst that facilitated our expansion into other health care providers and currently with an ACO.

Q5. How did you track and measure your own progress during the course of your work? What were key changes observed that are not documented in the final CCTP evaluation report that you believe are important (e.g., estimated savings, changes in ED visits, physician follow-up)?

- **AgeOptions**
  Initially, our sites were focused primarily on reducing readmissions for the individuals referred to us, not necessarily on the volume of participants. Quality improvement was challenging to implement along the way because we did not initially realize CMS was looking for a certain volume of participants in order to track include our metrics in their evaluation report. Each participating CBO site tracked their own data, needs, and interventions, and we did reduce overall readmissions for the patients we served through our six sites, but were ultimately not extended additional funding due to the size of our footprint in partner hospitals.

- **Aging & In-Home Services of Northeast Indiana, Inc.**
  Attributes we identified included: quality metrics were developed to review readmissions with hospital staff to implement rapid change and generate aggregate reports to quantify trends with specific populations; a national coalition of "high-performing" CCTP programs was created to identify and share lessons learned and information about sustainability strategies; improve communication with Primary Care Physicians post-hospitalization to inform of hospitalization, diagnoses, release, medication changes, etc.; and to increase patient engagement/ self-advocacy.

- **Appalachian Agency for Senior Citizens**
  We collected data which we shared with CMS and the hospitals which asked both patients and the hospital to participate in satisfaction surveys. We observed improved quality of health in our program such as reduction in unnecessary re-admissions which saved more than a million dollars to the hospitals collectively, better medication management, increased number of patients keeping their physician appointments post discharge and there were changes in the discharge processes at the hospital that were more efficient and patient friendly.

- **Atlanta Regional Commission**
  We managed and analyzed our data through Harmony. It is not ideal for large initiatives, but did enable us to provide comprehensive reporting for our partners. We were cited as high performers in readmission reduction reviews, including monthly root cause analysis with partners and moving the definition of unavoidable to avoidable.

- **Chautauqua County Office for the Aging**
  Individuals who enrolled in the program benefited greatly from learning about and increased access to community based long-term services and supports like home delivered meals, transportation and homecare beyond Medicare covered homecare. We also saw improvements in physician follow-up within 7-14 days following discharge, and better compliance with medication regimens.

- **County of San Diego Health and Human Services Agency, Aging & Independence Services**
  The San Diego CCTP built a shared IT platform that allowed the hospitals and the CBO to track patient/client enrollment, interventions provided, and automated billing to CMS. The individual health system data, the CBO data, and combined data across all partners were shared monthly at the SDCTP Work Team and Steering Committee meetings. CMS used the ratio of readmissions to hospital admissions or discharges as the outcome metric for the program. Because of the impact of the SDCTP on admission rates as well as readmission rates, this metric did not accurately capture improvement. Both the percent reduction in readmissions and the cost savings to Medicare

resulting from these reduced readmissions reported by CMS were inconsistent with the SDCTP's evaluation.

- **Delaware County Office of Services for the Aging**
  Our hospitals tracked readmissions, and CBOs provided monthly reports for meetings that reviewed progress.

- **Denver Regional Council of Governments**
  We measured our progress internally and estimated a cost savings in Medicare funds exceeding $6,000,000 in 23 months. At 11 percent, we showed our targeted high risk CCTP participants maintained an all-cause readmission rate that was 5 percent lower than our all-cause hospital baseline readmission rate, and 8 percent lower than the national average.

- **Elder Services of the Merrimack Valley, Inc.**
  We used the Access database as well as Care at Hand to track our progress. Increased collaboration across the care continuum with CBOs to ensure consistency of care. We increased the visibility of CBOs to the medical community -- showcasing value within the care team.

- **Hospice of the Bluegrass/ KY Appalachian Transition Services**
  Our program tracked and reported on every imaginable data element: Readmissions, the length of stay of the readmission, days home prior to readmission, MD follow-up, readmission root cause analysis, patient/family satisfaction, cost savings on readmission and cost avoidance, case mix index of readmitted and non-readmitted patients, first visit findings, behavioral outcomes, community referrals, clinical assessments (e.g., Realm-SF Health Literacy, KATZ ADL, Symptom Bother Scale, Geriatric Depression Scale, SPMSQ, GAD-7, etc.) Evidenced-based Risk Scores (Naylor) to stratify into the correct and most effective transition mode.

- **Lifespan of Greater Rochester**
  Individuals became more stable. It was an easy hand-off from a coach to other community-based services. It filled a huge gap between health care and community-based services.

- **Lower Rio Grande Valley Development Council**
  We embedded a data platform partner within our CCTP program, Loopback Analytics. They tracked all measurements and progress related to QI and evaluations. We saw that participants were non-compliant with their medication adherence and we initiated the MAP program. (Medication Adherence Program with Walgreens).

- **Missoula Aging Services Care Transitions Program**
  We calculated savings associated with reduced readmissions for enrollees in our program. We continue to measure the confidence of our clients in managing their health through a pre and post survey. We also tracked the amount and type of resource supports we have provided to our clients.

- **Partners in Care**
  We paid for a custom IT system which was the best investment we've made throughout the CCTP process. It helped us track not only coach productivity but also the referral volume from each hospital. We would send a daily email of all referrals received from each hospital in a group email so that they can all see who was sending more or not. The CCTP evaluation did not focus on the patient satisfaction piece of it (the net promoter score). Also, estimated savings would have been great to see.

- **Pierce County Human Services**
  We used our own reports, including those from the hospital systems, to track patients through the CCTP intervention. Key changes were seen in staff understanding of the challenges faced by patients post-discharge. By maintaining a communication loop back to the hospitals, care managers developed greater understanding of how patients frequently shared only partial truths about their post-discharge situations, levels of support, etc.

- **Southern Alabama Regional Council on Aging**
  We invested in IT systems that supported our work and facilitated process improvement and reporting. It's not clear that the improvements in coordination of care between the hospitals, providers, SNFs, and home health agencies were captured. We were able to resolve many medication errors, service order errors or delays, and patient communication issues that without our work would likely have had very significant negative impacts.

- **Southwestern PA Area Agency on Aging, Inc.**
  We utilized the Care Transitions Module from Mediware. Key performance results for the "target population" were: up to a 34% decrease in the hospital readmission rate for those beneficiaries who participated in CCTP, 20% increase in primary care provider visits within 7 days of discharge, 85% program enrollment or footprint, and 94% of clients received a comprehensive medication review and reconciliation,

Q6. What are some health/social service infrastructure improvements in your community that can be traced to the CCTP demonstration? Did CCTP spark any collaborative and interoperable IT improvements in the health and social service sectors in your community?

- **AgeOptions**
  One of the main challenges to our sites was the lack of access to the electronic health records (EHRs) of the partnering health systems. Since CCTP, participating sites still implementing Bridge have gained reading access to EHRs, aiding tremendously.

- **Aging & In-Home Services of Northeast Indiana, Inc.**
  During our pilot program, we identified an agency need for a more robust, state-of-the-art interoperable health IT platform. Software with two key attributes was acquired with these characteristics: 1) interoperability to connect existing state-mandated databases with electronic medical records, and 2) embedded social determinants of health to stratify clients by risk factors and recommend interventions to improve outcomes. We formed a partnership with a software-as-service firm and assisted in the customization of their product Population Health Logistics to meet CBO needs.

- **Appalachian Agency for Senior Citizens**
  The hospitals and demographic surveillance systems (DSS) became members of our No Wrong Door project and have begun to share data using our software, PeerPlace, which has improved the referral process. Clinch Valley Medical Center was awarded the Duke-Lifepoint Quality Affiliate Award and their participation in our organization's care transitions program was cited as key to their success.

- **Atlanta Regional Commission**
  Lessons learned in CCTP provided valuable insight and staffing to negotiate and contract within two programs listed below. CCTP was the learning lab for field-based workers. Our ADRC is now staffed with field-based counselors.
  We have a contract with Kaiser Permanente for a high-risk member group providing home visits, enhanced service intervention, identifying unmet need, and streamlined access to services that support people in the setting of their choice.
  We have a partnership with Atlanta Housing Authority to link residents in senior housing to appropriate services so that residents can gain a greater sense of well-being, maintain a greater quality of life, and reduce evictions and homelessness.

  The Behavioral Health Coach:
  1. Serves 11 Atlanta Housing Authority high rise buildings in metro-Atlanta.
  2. Serves as a resource with an expertise in behavioral health and access to services.
  3. Provides connection with behavioral health providers such as therapists, counselors and psychiatrists, and/or link you to appropriate medical, aging or disability services.
  4. Connects resident with primary care providers for evaluation and medical management, day programs, and in-home assistance as appropriate.
  5. Can serve as an advocate among service or housing providers when appropriate.

- **Chautauqua County Office for the Aging**
  We have a relationship and increased referrals from local primary care practices not just for care transitions but for evidenced -based health and wellness programs like CDSME, Tai Chi and Stepping On, powerful tools for care givers, as well as Medicare Insurance Counseling through SHIP, and other AAA programs. Our IT improved, allowing the AAA to become part of the local

Regional Health Information Organization so that primary care practitioner and an AAA can send secure referrals and updates on client status.

- **County of San Diego Health and Human Services Agency, Aging & Independence Services**
  Several of the partnering health systems have continued to provide both hospital-based and community-based interventions to address readmissions for high-risk patients, including patients that are in ACOs or other value-based care arrangements, and patients whose primary funding is through Medicaid. ALEX, an IT system that was built specifically to support the administration of the SDCTP and automate large-scale billing to CMS, was a shared space in which all of the hospitals and the CBO could share information including care transition interventions that were provided. ALEX also tracked readmissions over time across 4 health systems (13 hospitals) to prevent duplicative billing within 90 days post-intervention.

- **Delaware County Office of Services for the Aging**
  In Delaware County, we now have a collaborative (DC3) where hospitals, nursing homes, and Committee on Substance Abuse share best practices and communicate through Quality Insights of PA.

- **Denver Regional Council of Governments**
  N/A

- **Elder Services of the Merrimack Valley, Inc.**
  We have seen increased collaboration between community hospitals and CBOs. We are continuing discussions regarding how the Mass HIWAY will be utilized to efficiently and securely share mutual patient information.

- **Hospice of the Bluegrass/ KY Appalachian Transition Services**
  Start remote access to the hospital's electronic medical record has continued with hospital partners that allows us to screen for patients remotely. The community-based coalitions continue.

- **Lifespan of Greater Rochester**
  It did lead to other projects to integrate health and community-based services.

- **Lower Rio Grande Valley Development Council**
  There was definitely a huge impact between the post-acute care providers and the acute setting partners. Both saw the need to work together more cohesively towards reducing hospitalizations. Both saw the immediate need to access the CBO's resource database, and a referral system was developed and initiated to address the social determinants that contributed to readmissions in our region.

- **Missoula Aging Services Care Transitions Program**
  Through the evolution of this program we are realizing better communication between our program and the broader medical community. Though the hospitals and some clinics have created care transition positions, we do receive referrals from both for our transition services. This is an acknowledgement of the value of this service that the medical community cannot replicate successfully. We still maintain EHR access for both hospitals and several of the clinics we work with our utilizing the EHR systems too allowing us access to their patient information.

- **Partners in Care**
  The coaching model has become a big part of the communities we served. The concept of

transitional care has become more prominent, not only with hospitals but as well as in the community with physician groups, health systems, community providers etc.

- **Pierce County Human Services**
  While our hospital partners carried forward some care transition-based projects, we have not continued to provide care transition services specifically to the medical community.

- **Southern Alabama Regional Council on Aging**
  Our efforts helped identify the need of a post discharge clinic at one hospital and they are undertaking the development of another. Our work with another non-profit providing refurbished DME to the community has led to greater awareness and growth in it. The value of post discharge support, nutrition and feedback provided on discharge paperwork has led several organizations make changes in their discharge processes. The program led to increased awareness among discharge personnel of how significant a role the individual's social needs can play in their eventual outcome.

- **Southwestern PA Area Agency on Aging, Inc.**
  Unfortunately, the greatest challenge and one that continues to exist is the need to develop an interoperable data system which operates in real time. There continues to be hesitancy among health care providers to share information in an integrated fashion with AAAs even in a delegated model.

Q7. Have you participated in any other significant quality improvement or state/federally-funded demonstration projects? What is/was it?

- **AgeOptions**
  Yes, AgeOptions' six participating sites have since participated in various quality improvement initiatives, including partnering with providers on an Accountable Health Communities grant, partnering with Medicare and commercial Accountable Care Organizations, and various initiatives with Medicaid managed care organizations.

- **Aging & In-Home Services of Northeast Indiana, Inc.**
  AIHS was lead for our region for the statewide QAPI project in nursing homes as outlined in the Affordable Care Act. AIHS was an early champion NCQA LTSS accreditation and was the first AAA/community-based organization in the country to achieve this goal. We were one of five founding organizations advocating for Advance Care Planning (ACP) legislation in the state, and have supported those efforts from initial planning to today's statewide coalition "Honoring Choices Indiana" and have embedded ACP into our traditional AAA services, such as Case Management, as well as our managed care contracts. We provide leadership to the regional coalition that is part of the national CMS' Quality Improvement Organizations – Leadership for Community Care Transition Coalition. Indiana is one of seven states chosen for Administration on Community Living's No Wrong Door Business Case Development funding; we are one of only two pilot sites in Indiana.

- **Appalachian Agency for Senior Citizens**
  The Virginia AAA Cares Program works with the Commonwealth Coordinated Care program with the MCOs.

- **Atlanta Regional Commission**
  We are one of four leads in the World Economic Forum's Value-based Health Care Heart Failure initiative. The vision for the Atlanta Pilot is to create a continuously improving value-based healthcare system that positions Atlanta as a national leader in heart failure patient survival rate by 2022 through significant improvements in quality of life and reductions in the average cost per patient.

  This approach has the potential to transition the heart failure business model from an incentive-based approach to a value-based system. This will improve the outcome for heart failure patients dramatically.

  The goals of the pilot are to:
  - Break down silos to develop a systemic, collaborative system of data sharing among health providers
  - Move towards a value-based healthcare system
  - Utilize data and outcomes of heart failure patients to build a strong strategy for moving forward that works for all stakeholders
  - Work towards long term goals including improving life expectancy and lowering healthcare costs
  - What is the impact of this initiative?
  - The pilot can help employers, employees, residents, and healthcare providers on a local, national, and global scale
  - This could ultimately influence healthcare value and costs for billions of people with other serious health issues.

- **Chautauqua County Office for the Aging**
  We have an Accountable Care Organization called Associated Medical Partners (9 PCP practices) that continue to contract with us for care transitions. We were instrumental in them adopting the CDC falls toolkit as part of their strategies and continue to serve on the Board of Directors.

- **County of San Diego Health and Human Services Agency, Aging & Independence Services**
  Our CBO participated in the Coordinated Care Initiative (CCI). In July 2012, legislation was passed in California that established the CCI to transform the State's Medi-Cal (Medicaid) care delivery system. CCI integrated the administration of medical, behavioral, and long-term services and supports for older adults and persons with disabilities into a single organized delivery system. Also, beneficiaries may choose to join a "Cal MediConnect" health plan, which combines Medicare and Medi-Cal benefits.

- **Delaware County Office of Services for the Aging**
  Prior to the CCTP, we were involved in a 2-year grant program through the PA Department of Aging: a demonstration project using a Naylor model.

- **Denver Regional Council of Governments**
  See previous answer.

- **Elder Services of the Merrimack Valley, Inc.**
  We are participating in the CHART (Community Hospital Acceleration, Revitalization, & Transformation) Investment Program through the Health Policy Commission. Two area hospitals were awarded grant funding through this initiative and we became the hospital's community partner -- 2 year grant (October 2015-October 2017).

- **Hospice of the Bluegrass/ KY Appalachian Transition Services**
  Our program has been featured and is still involved with the QIO/QIN Scopes of Work.

- **Lifespan of Greater Rochester**
  N/A

- **Lower Rio Grande Valley Development Council**
  N/A

- **Missoula Aging Services Care Transitions Program**
  We are currently running a care transitions program funded through grant money. The Montana Healthcare Foundation is our main funder for this project. We currently serve on the Mountain Pacific Quality Health Foundation Resource Committee. This QIO organization pursued grant funding for a care transitions demonstration project with hospital participants in three Montana communities and a fourth participant that is a federally funded community clinic. Though we are not participating in this demonstration project as a funded participant, we were asked to participate as a committee member to share our experience as a historical CCTP care transitions program that is continuing to provide this service through our own grant pursuits with the intention of finding sustained funding through other pay sources.

- **Partners in Care**
  No.

- **Pierce County Human Services**
  We are participants in the Washington State Health Home Program, a Managed Fee-for-Service Demonstration model authorized under Section 2703 of the Patient Protection and Affordable Care Act of 2010. As a Care Coordination Organization (CCO), we began serving Medicaid beneficiaries identified as high-risk/high utilizers in 2015 through contracts with Medicaid Managed Care Organizations (MCO). We also contracted as a CCO serving dual-eligible beneficiaries through our local Health Home Lead entity, Optum. When Optum withdrew from the program in late 2018, we contracted with the Washington State Health Care Authority to take on the Health Home Lead entity role for dual-eligible beneficiaries and currently contract with three CCOs to provide care coordination services in Pierce County.

- **Southern Alabama Regional Council on Aging**
  No.

- **Southwestern PA Area Agency on Aging, Inc.**
  The CBO partnered with Quality Insights of Pennsylvania during its CMS 8th and 9th Scopes of Work which effectively demonstrated that relationships between medical and social providers are effective and further that local stakeholders can have a positive impact upon hospital re-admissions.

The National Coalition on Care Coordination (N3C) is a national membership coalition and platform to identify and advocate for policies and practices that advance coordinated and integrated care.

N3C is housed at the Center for Health and Social Care Integration (CHaSCI) at Rush University Medical Center.

www.chasci.org

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