Second Round of Site Selections for the Community-based Care Transitions Program
March 2012

On March 14, 2012 CMS announced 23 sites selected to participate in the Community-Based Care Transitions Program (CCTP). Together with the first seven participants selected for the program, the CCTP now includes more than 126 acute care hospitals partnering with community-based organizations (CBOs) across 30 sites to provide care transitions services for an estimated 223,172 Medicare beneficiaries residing in 19 states.

The CCTP is a five-year program created by the Affordable Care Act. Participants sign two-year program agreements with CMS, with the option to renew each year for the remainder of the program, based on their success. As of the date of this announcement, CMS continues to accept applications and approve participants on a rolling basis as long as funds remain available.

For more information, visit http://go.cms.gov/caretransitions. Communities that wish to apply to the program are encouraged to contact their state's Quality Improvement Organization (QIO) and can find a care transitions point-of-contact at http://www.cfmc.org/integratingcare under "Contact Us."

ARKANSAS

CareLink, the Central Arkansas Area Agency on Aging (AAA), will partner with the University of Arkansas for Medical Sciences Academic Medical Center, a high readmission hospital, St. Vincent Hospital, and two Federally Qualified Health Centers, Jefferson Comprehensive Care System and ARcare. They will provide services for Medicare beneficiaries across five Central Arkansas counties including medically underserved populations and both urban and rural areas.

ARIZONA

The **Carondelet Chronic Care Navigation Program** will work to improve care transitions among high-readmission populations throughout southern Arizona. Carondelet St. Joseph's Hospital will lead the effort, partnering with two additional Carondelet Health Network providers, Carondelet St. Mary's and the Carondelet Heart & Vascular Institute, in cooperation with the Pima Council on Aging and the University of Arizona's Center on Aging.

CALIFORNIA

Advanced Care Transitions (ACT) is a partnership between California's Marin County Health & Human Service Agency, Division of Aging and Adult Services, and two hospitals:

Marin General Hospital and Novato Community Hospital. It will provide transitional care services to significantly reduce hospital readmissions among Medicare beneficiaries. ACT will reach at-risk populations along both the County's north-south urban corridor and rural west.

CONNECTICUT

The Greater New Haven Coalition for Safe Transitions, Yale-New Haven Hospital, a high readmission hospital, in partnership with the AAA of South Central Connecticut and the Hospital of Saint Raphael in New Haven, will provide care transition services to a diverse population in the New Haven metropolitan area some of which has been designated as medically-underserved by the Health Resources and Services Administration (HRSA).

ILLINOIS

AgeOptions, the AAA and Aging and Disability Resource Center in Cook County, Illinois, will partner with the Chicago, suburban Cook County, and southern Illinois Bridge Coordinating Agencies to provide care transition services at six hospitals. The Bridge Coordinating Agencies include Aging Care Connections, Kenneth Young Center, North Shore Senior Center, PLOWS Council on Aging, Rush University Older Adult Program, and Solutions for Care. The hospital network includes Adventist LaGrange Memorial Hospital, St. Alexius Medical Center, Advocate Lutheran General, Palos Hospital, Rush University Medical Center, and MacNeal Hospital.

MASSACHUSETTS

Elder Services of Berkshire County, a Massachusetts-designated Aging Services Access Point (ASAP) and federally-designated AAA in rural western Massachusetts, will partner with Berkshire Medical Center and the Berkshire Visiting Nurse Association to improve care transition services for Medicare beneficiaries. The program will rely on collaboration among the clinical and administrative leaders and build upon efforts underway to improve care intervention across the community in Berkshire County.

Elder Services of Worcester, a Massachusetts-designated Aging Services Access Point (ASAP) and federally-designated AAA, will partner with Bay Path Elder Services. They will provide care transitions services in partnership with seven hospitals extending from rural western Massachusetts counties to the MetroWest region between Boston and Worcester. Hospitals from both UMass Memorial and Vanguard systems include: MetroWest Medical Center; St. Vincent Hospital; UMass Memorial Medical Center; Wing Memorial Hospital; Marlborough Hospital; Clinton Hospital, and HealthAlliance Hospital.

MICHIGAN

The Michigan Area Agency on Aging 1-B, in partnership with southeast Michigan hospitals William Beaumont-Troy, Henry Ford Health System Macomb, Henry Ford Health System Macomb-Warren Campus and Pontiac Osteopathic Hospital; nursing homes; skilled home care agencies, and hospice agencies will target Medicare fee-for-service beneficiaries in the designated medically underserved areas in Oakland and Macomb counties, Michigan. This coverage area includes a diverse range of populations in the greater Detroit area, ranging from urban to sparsely populated northern communities.

St. John Providence Health System, located in Warren, Michigan, will partner with Adult Well Being Services to deliver care intervention to Medicare beneficiaries in Detroit (Wayne County), and Macomb and Southern Oakland Counties. The hospital partnership includes St. John Hospital and Medical Center, Providence Hospital and Medical Center, and St. John Macomb-Oakland Hospital. The care transition services will serve beneficiaries who predominantly reside in an urban area.

The Senior Alliance, Area Agency on Aging 1-C, located in Wayne, Michigan, will provide care transitions services across 34 communities in southern and western Wayne County. The Senior Alliance will partner with six hospitals that include Garden City Hospital, St. Mary Mercy Hospital, Oakwood Hospital and Medical Center, Oakwood Annapolis Hospital, Oakwood Heritage Hospital, and Oakwood Southshore Medical Center.

NEBRASKA

UniNet Healthcare Network, a clinically integrated Physician Hospital Organization located in Omaha, Nebraska, will partner with five acute care hospitals in Omaha: Alegent Health Bergan Mercy Medical Center, Alegent Health Immanuel Medical Center (a high readmission hospital), Alegent Health Lakeside Hospital, Alegent Health Midlands Hospital, Alegent Health Mercy Hospital in Iowa, and the Eastern Nebraska Office on Aging to provide care transition services to Medicare beneficiaries.

NEW YORK

Lifespan of Greater Rochester Inc. will partner with four acute care hospitals; Rochester General, Unity, Strong Memorial, and Highland Hospitals; two home health agencies; two additional CBOs; and the Finger Lakes Health Systems Agency to provide care transition services to high-risk Medicare beneficiaries across four counties in Western New York State.

Brooklyn Care Transition Coalition in New York will provide transition services and assistance to Medicare fee-for-service beneficiaries across 26 zip codes throughout northern and central areas of Brooklyn. The Cobble Hill Health Center will serve as the lead CBO, partnering with The Brooklyn Hospital Center, the Interfaith Medical Center, and Independent Living Systems, Inc.

P^2 Collaborative of Western New York, Inc. will serve as the regional coordinating body for 10 community hospitals across seven rural counties in western New York: Brooks Memorial Hospital (Chautauqua); Jones Memorial Hospital (Allegany); Olean General Hospital (Cattaraugus); Orleans Community Health (Orleans); TLC Health Network Lake Shore Health Care Center (Chautauqua); United Memorial Medical Center (Genesee); Westfield Memorial Hospital (Chautauqua); WCA Hospital (Chautauqua), and Wyoming Community Hospital (Wyoming County). Each participating hospital will collaborate with a local CBO to build upon and expand existing care transition services for Medicare beneficiaries.

The **Tompkins County Office for the Aging** will act as the lead CBO for the Tomkins County Rural Community-based Care Transition Program (TCRCCTP). Serving the Finger Lakes region of rural Central New York, the TCRCCTP will work with Cayuga Medical Center, the County's sole hospital and multiple local host agencies to improve the quality of care and reduce avoidable hospitalizations among Medicare beneficiaries.

OHIO

Ohio AAA Region 8 will partner with Ohio AAA Region 6, Ohio AAA Region 7, Adena Regional Medical Center, Southern Ohio Medical Center, Marietta Memorial Hospital, Fairfield Medical Center, and Holzer Medical Center to provide care transitions services to beneficiaries residing in a 27-county area spanning rural southern and central Ohio.

PENNSYLVANIA

Delaware County Office of Services for the Aging, located in Media, Pennsylvania, will provide care transition services to Delaware County. The program will build off the current experience of the Delaware County Office of Services for the Aging in providing evidence-based care transition services. Five hospitals across Delaware County will participate in the program which includes Crozer Chester Medical Center, Delaware County Memorial Hospital, Riddle Memorial Hospital, Moses Taylor Hospital, and Springfield Hospital.

North Philadelphia Safety Net Partnership, a partnership between the Philadelphia Corporation for Aging, the Einstein Medical Center and Temple University Hospital, will

provide care transitions services to Medicare beneficiaries across 12 zip codes in Northern Philadelphia, many of which have been designated as medically underserved areas.

The Western Pennsylvania Community Care Transition Program builds upon the experience of its partners' participation in the Quality Insights of Pennsylvania's 9th Scope of Work pilot projects. The Southwestern Pennsylvania AAA, in partnership with the Westmoreland County AAA will serve as the lead CBOs, and are joined by six acute care hospitals across four health systems and a network of sub-acute care providers, including skilled nursing facilities, home health agencies, and personal care homes. Participating hospitals include Monongahela Valley Hospital, The Washington Hospital, Canonsburg General Hospital – part of the West Penn Allegheny Health System, Excela Health Westmoreland Hospital, Excela Health-Latrobe Hospital, and Excela Health-Frick Hospital.

TEXAS

Aging and Disability Resource Center, located in El Paso, Texas will partner with surrounding hospitals Providence Memorial Hospital, Sierra Providence Hospital, Sierra Providence East Medical Center, Del Sol Medical Center, and Las Palmas Medical Center, and downstream providers and social service agencies to deliver culturally and linguistically driven community-based care transition services for an ethnically diverse population.

The Care Connection Aging and Disability Resource Center (Care Connection) CBO has partnered with local hospitals CHRISTUS St. Catherine and Memorial Hermann Katy, skilled nursing facilities, and CBOs immediately west of Houston, Texas. Serving the city of Katy, Texas, the initiative will also include portions of Harris, Fort Bend, Austin, and Walker counties. Established in 1977, Care Connection is a within the Harris County AAA program providing federally-funded social services for individuals aged 60 years and older.

WASHINGTON

Pierce County Community Connections' Aging and Disability Resources, Pierce county's AAA, located in the South Puget Sound region of Washington State, will partner with the Franciscan Health System, MultiCare Health System, the Pacific Lutheran University School of Nursing, and the Comprehensive Gerontologic Education Partnership to implement a care transitions program while providing a strong model of community collaboration that addresses the unique needs of Medicare beneficiaries in Pierce County.

Southeast Washington Aging and Long Term Care, an AAA located in Yakima, Washington, will partner with four hospitals in Yakima, Benton, and Franklin counties that will serve a rural and economically-challenged southeastern part of the state. The hospital

partnership includes Kennewick General Hospital, Yakima Valley Memorial Hospital, Yakima Regional Medical and Cardiac Center, and Toppenish Community Hospital. The program will build upon the extensive experience of successful community partnerships and collaborations to promote an integrated approach to care transition services for Medicare beneficiaries.