Health Care Innovation Awards Round Two – Measuring for Success and Developing an Operational Plan

ANDREW RUSHTON: Thank you, operator. Good afternoon, everyone. This is Andrew Rushton from the CMS Innovation Center. I will be serving as the moderator for this fifth webinar in a series on the Health Care Innovation Awards, Round Two. Today's webinar will focus on measuring success and developing an operational plan.

Before we proceed, there are a few important housekeeping items to address. This webinar is being recorded, and the slides and transcript of the webinar will be posted to the Innovation Center's website within the next week. If you are a member of the press, this webinar is off the record, and if you have a question, please email press@cms.hhs.gov, or call 202-690-6145.

Furthermore, it should be noted that the comments made on this call are offered only for general informational and educational purposes. The Innovation Center's comments are not offered and do not constitute legal advice or legal opinion, and no statement made on this call will preclude the agency and/or its law enforcement partners from enforcing any and all applicable laws, rules, and regulations. Applicants are responsible for ensuring that their actions fully comply with applicable laws, rules, and regulations, and we encourage you to consult with your own legal counsel to ensure such compliance. Finally, to the extent that we may seek to gather facts and information from you during this call, we intend to gather your individual input. The Innovation Center is not seeking group advice.

The main purpose of today's webinar is to focus on success measurement and developing an operational plan. Additionally, subject matter experts will make themselves available to answer questions. I will provide a very brief overview now for our attendees of today's webinar.

After I conclude my remarks, Christy Meyer, Team Lead for Health Care Innovation Awards at the Innovation Center, will highlight goals of the second round of the Health Care Innovation Awards. Fran Griffin, Improvement Adviser at the Innovation Center, will provide an introduction to theory of change and driver diagrams. Following her will be Tim Day, Research Analyst at the Innovation Center, who will talk through performance measures. Mark Wynn, Senior Analyst at the Innovation Center, will discuss operational plans and the role of project officers. He will be followed by Christy Meyer, who will briefly review next steps, including upcoming webinars.

Immediately following these presentations, a question and answer session will conclude the entire webinar. During the question and answer session, questions will only be accepted through the box titled Submit Your Questions that is located on the lower left of the webinar portal appearing on your computer screen. Please note that no questions will be accepted by phone.

For all attendees of today's webinar, if any technical difficulty appears in viewing presenters' slides, you are encouraged to click the button for the webinar portal entitled Enlarge Slides to assist in viewing the slide presentation materials. Furthermore, at any time during today's webinar, if you believe the slide appearing on your screen is not the one being discussed, we encourage you to press the F5 button on your computer keyboard to refresh the webinar portal screen. This should ensure that you are viewing the most up to date slide that's being discussed.

If you have any questions that we were not able to answer on this webinar, you can always email us at innovationawards@cms.hhs.gov. Lastly, the Innovation Center will be doing further webinars on the Health Care Innovation Awards, Round Two. More information will be forthcoming on how to register for these webinars through the CMS Innovation Center website and listserv. And with that, I will now turn it over to my colleague, Christy Meyer. Christy?

CHRISTY MEYER: Thank you, Andrew. Good afternoon, and thank you everyone for joining us today in this fifth installment of our webinar series to discuss the latest steps we're taking to spur innovation in our health care system by supporting some of your most promising ideas from around the country for lowering costs and improving quality of care. The Health Care Innovation Awards Round Two reflect the mission of the CMS Innovation Center. The awards are designed as a partnership with innovators in the field to collaborate in testing new service, delivery, and payment models that hold promise for better care and lower costs for Medicare, Medicaid, and the Children's Health Insurance Program.

Today's webinar on performance measures and the operational plan will speak to the tactical execution required to partner with us in the Health Care Innovation Awards. Building on the first round, this second round of Health Care Innovation Awards will continue to partner with innovators to engage them to identify new payment models, test models in specific innovation categories, and develop a clear pathway to new Medicare, Medicaid, and CHIP payment models. Finally, the success of the Health Care Innovation Awards Round Two will be measured by delivering better care, lower costs, and improved health status.

As a reminder, a few key dates are fast approaching. Our application materials have been posted to our website and grants.gov. Please access them there. On June 28, this Friday at 3:00 PM Eastern time, the letters of intent are due. Thank you to everyone who has submitted letters already, but please try to submit letters prior to this due date to avoid any extraordinary traffic on our website. We fully recognize that the model design may change from the time you submit a letter of intent to the actual application. Applications will be due August 15 by 3:00

PM Eastern time, and we expect to announce awards in early 2014 with the three year cooperative agreement period starting April 1 in 2014.

Today's webinar agenda will begin with a focus on an introduction to performance measurement. Because this is a cooperative agreement, CMS will collaborate closely with awardees to optimize model performance. Awardees will be asked to develop performance improvement plans, and CMS will support them in making sure that they improve their model over time. Interim feedback on performance is very vital to optimizing performance on each model. The applicant's plan for self monitoring and continual improvement of performance is a very important component of the application for the Health Care Innovation Awards Round Two.

In order to create a strong performance measurement plan, your application should convey specific details on your intervention design. These include a detailed overview of your service delivery model and the expected targeted beneficiaries. Possible approaches on how you will introduce and promote your innovation into a new environment, into your organization, or the marketplace, should be discussed. Your application should also speak to how your intervention will relate directly to better health and lower costs. The nature of your intervention and how it will drive your aim is an important organizing principle of your operation plan and the application. I will now introduce my colleague, Fran Griffin, Improvement Adviser at the Innovation Center, to talk about techniques for communicating your theory of change.

FRAN GRIFFIN: Thanks, Christy. So a fundamental first step in the operational plan-- and those of you working in quality improvement and innovation will likely already be familiar with some aspects of this-- is mapping out the theory of change. All of you who may consider submitting for one of these innovation awards have some sort of theory about an intervention or set of interventions that you believe will effect better health, better care, and lower costs through improvement. So as you lay out how that will work and what you intend to do over the three years, should you receive an award, we would ask you for, then, a theory of change laying out the explicit hypotheses about what you will be working on and how you predict it will impact on those three key areas.

The first step of that is identifying an aim, or a goal statement, specifically noting what is it that you are seeking to improve, which will have already been articulated in your application, by how much, and by when. Having that quantifiable goal with a due date is really fundamental in order to ensure progress towards the goals over time.

And then once the "what" part has been established in the aim, then thinking about what are the strategies that you predict will be necessary to achieve that aim, and how will you know whether or not you are successfully implementing the strategy? So identifying all of the strategies, all of your predictions in this theory of change will be critical. And then thinking another level down, what will it take to implement each of the primary strategies? So this will be a key part of operational plans.

One visual for laying out a theory of change is called a driver diagram, and a driver diagram-- similar to a logic model, if you've used those, this will look very familiar, or a tree diagram-- is simply a visual representation of the theory of change. So in the example that's on the slide, you'll see that on the left, we start with the aim statement. In that box, we've contained the text of, what are you trying to accomplish, what will be improved, how much, by when, in a very concise way, and we'll show you some examples of that.

Then when we think about the strategies, we call them primary drivers. What are the general categories or high level processes that you predict in your change theory that will help you achieve that aim? And those are laid out in the next column of boxes. And then over on the right, we get into the details. What are the specific processes that need to be in place what are required to ensure these high level processes, or categories of processes, are occurring?

And so you can see on this one, it reads from right to left with the aim on the left. That's just how we happen to lay ours out at the Innovation Center, and if we could stay on the blank one for the moment, please. It's not necessarily the correct way to do it. You could also do them left to right, right to left. Some folks do them top to bottom. It really doesn't matter. What's really important here is to be showing the impact of working on key processes and how they align with larger processes to impact the overall aim. So that's really the key, not so much whether it reads from left to right. So there's several ways you can do this, and we will be making a document accessible to you that gets into this in more detail. Next slide, please.

So here's an example of a driver diagram that has been filled in. And if you look on the left, the aim for this particular example is, "Reduce preventable emergency department admissions by," and then it gets into the quantifiable part. So there's a placeholder in this one, x%. So if you're not sure of the goal when you write it the first time, at least putting the placeholder in there that you need to put a quantifiable goal. "For a certain number of frail elderly within Area Z," some specific area, a county, a zip code, a geographic region, "and reduce cost of care by a certain percentage by March, 2017."

So you'll see that it tells people what you're doing-- reducing emergency department admissions-- it has quantifiable goals, percentage of admissions, number of frail elderly impacted, where they are, cost of care, and a date, March, 2017. So somebody coming into the work would be able to quickly get a sense of what it's all about. And then as you look over to the right, three primary drivers, high level categories. We'll look at the first one, deploying community health care workers. And then if you go over further to the right, you can see there's specific examples of things that would have to be done in order to truly deploy community health care workers in a consistent and reliable way.

And the theory is that by doing these things, the person who conceived or the team conceived this driver diagram predicts that doing all of these well would have significant impact towards achieving the goals laid out in the aim. So we'll get into some more about how this ties into measurement as I turn it over to my colleague, Tim Day.

TIM DAY: Thanks, Fran. So I'd like to start with an overview of awardees' responsibilities in self monitoring, and how that relates to what CMS's role is. So awardees are responsible for self monitoring for continuous quality improvement. This is not a formal evaluation, and we'll discuss the distinction in the next slide.

As part of this self monitoring, awardees will be reporting to CMS on the progress and impact of their model, which entails providing data and reports to CMS as specified. It may also include providing patient identifiable information to support the independent evaluation, and will certainly include collecting patient identifiers to provide to the independent evaluator. CMS will consider requests for Medicare claimsdata on a case by case basis to support self monitoring.

CMS will also be hiring a contractor to conduct the independent evaluation, and will work with awardees to refine self monitoring metrics and strategies to report progress. And this last part really happens throughout the cooperative agreement period, so I want to emphasize at the start that what you develop initially in your self monitoring plan is just a starting point. CMS will continue to work with you throughout the agreement period.

So let's turn now to this important distinction of doing self monitoring versus evaluation. Whereas the awardees are responsible for self monitoring, CMS is responsible for the independent evaluation. So let's start with the goals. The goals of self monitoring, the primary goal is to provide close to real time data for continuous quality improvement. On the other hand, the goal for CMS's independent evaluation is to assess how the intervention is implemented and how it impacts beneficiaries to inform decisions to scale.

So these different goals then have influence on what methods are required. So whereas the awardees can use methods with simply a pre post type design, CMS is going to look for probably a more rigorous design, including concurrent controls. This also dictates what data is used. So whereas in self monitoring, we're primarily looking for data that's readily accessible to the awardees with some of their own primary data collection, CMS will be doing more significant primary data collection as well as secondary analyses, including claims.

So I want to reiterate that this measurement is really a partnership. As I said earlier, CMS is planning to work with awardees throughout the grant period to develop and refine their self monitoring plans, and CMS may, in fact, use this data as part of the independent evaluation. And we also see it as a two way street, whereas the awardees are providing data and insight to us, we also will look to ways to provide insight back to the awardees from the independent evaluation.

So let's dive into some of the details. There's two broad classes of measures referenced in the FOA and application, which as Christy said, can be found on our website, and I encourage you all to look at those if you haven't already. The first is programmatic and operational measures. These are things that are standard across all awardees. They're kind of the basic measures that we'll track over the course of the agreement period. Examples of this are counts of full time equivalents that the awardees hired, if that's part of their intervention, and participant counts.

The other broad class is called “Outcome Measures” in the FOA, and this is some standardized measures, along with some customized measures by the awardees. And here, I'd refer you to the list of recommended outcome measures, which is also on our website. Examples of these are things like hemoglobin A1C control, proportion of patients with a care plan, and so these are things that are really specific to your intervention. And we'll talk more about measures in the coming slides.

So a few best practices for your self monitoring plans. Really, the best plans are going to start with a driver diagram. I really can't emphasize enough how important what Fran talked about is. If you start with a really good driver diagram, it's going to make your self monitoring planning so much easier. It's really impossible to go the opposite way.

So another really important piece is to, where possible, use validated measures. So these are things like measures from NQF. And again, our list on the website has some of these recommended measures. Finally, a good measurement plan is going to cover three equally important areas that are referenced in the FOA application. These are health and care quality, total cost of care, and operational performance. So let's dive into those three categories.

The first category, health and care quality, is really primarily outcome and intermediate outcomes, and we can separate them into care quality and health to think through them a bit more. So care quality involves things like reducing inappropriate utilization, increasing recommended or evidence-based services, patient satisfaction, and patient access. These are just some of the domains here, and depending on your intervention, you might not have all of these domains. You might have other domains. And I'll also give some examples here. So for example, reducing inappropriate utilization, you have the rate of low acuity ED visits if that's part of your intervention.

On the other hand, there's measures of better health. So these are things like clinical outcomes, health behaviors, and health related quality of life. Pretty much all interventions are going to have some type of outcomes in better health. Again, they might not be these examples, such as hemoglobin A1C or the SF12 instrument, but you should have some impact on better health.

Moving to the next major category is total cost of care. This is another outcome measure, and when we talk about total cost of care, we're really talking about all of the medical expenditures for a given population. And generally, this is reported on a per beneficiary, per month basis, but there's other ways to think about cost as well. While you should always kind of keep the total cost of care picture in your mind, if your intervention is specifically targeting certain areas of the health care system-- for example, if you're trying to reduce inpatient admissions-- you might look specifically at a particular cost category such as inpatient expenditures. The other thing to say here is that cost is pretty hard to measure, even for CMS, but especially for awardees. And so here, we see areas where you can use proxy measures, such as measures of utilization, to get at total cost of care.

The final category, again, I think this is a really, really crucial category, the operational performance. These are your process and structure measures. And so here, you're not telling us what your program accomplished, but you're telling us how you went about accomplishing it. And so whereas the first two are connected to your aims and maybe your primary drivers, this is where you get into your primary drivers and your secondary drivers.

And so here, you're going to be reporting on the progress of implementing your intervention and the fidelity with which you've implemented it. And fidelity is simply how closely you followed your initial plan. So some examples are proportion of the recruited patients who agreed to participate. So if you're targeting a certain number of enrollment, it's pretty critical to know how close you are to meeting that goal. One important metric in recruitment is: of the number of people you're invited to join, how many people actually do? And so this could give you a leading indicator of: are you on track to reach your goals?

Another one is proportion of patients with assigned care managers. So in an intervention where every patient is supposed to have an assigned care manager, you want to track: are people really getting assigned care managers? Finally, another is the number of lay educators trained. So if you have a training component, it's important to track that as well. So these are just a couple illustrative examples, and clearly, you'll have your own for your own intervention.

So I wanted to take these nebulous concepts and apply it to an example here. This is a driver diagram laid out with a diabetes prevention intervention. This is really a stripped down, bare bones example to give you some sense and then link these to measures. So as Fran said, we'll start on the left with the aim and outcomes. It's to reduce the incidence of diabetes by 10% and reduce the cost of care by 5% within a given geographic region by March, 2017. So as you can see here, it's a very crisp, numerate aim. You know exactly what you're going for and the time by which you want to achieve it.

The primary drivers to do this are: to decrease the proportion of patients who are overweight and obese, and to improve the status of persons with diabetes. So this is telling you how you're going to go about achieving those aims and outcomes. The secondary drivers get into the nitty gritty of how you're driving those primary drivers. So in this case, we're educating and recruiting patients at risk for diabetes, providing classroom-based weight management classes, and recruiting and training diabetes educators.

So now, let's take that example of a program and link it to, again, a pared down measurement plan here. You'll see when you look at the application materials, if you haven't already, there are more categories than this that we'll want information on, but this is really the starting point of figuring out: which aim and driver are you looking to measure; how are you going to measure it; what's your data source; and how frequently are you going to measure it? So as I said, if you start out with a good driver diagram, these things are going to lay out pretty easily for you.

So you start with the first aim, which is to reduce incident cases of diabetes, and the measure for this is suggested exactly by what you're trying to do. So you want to measure the proportion

of patients who develop diabetes in the past 12 months. And so then you'll need to think about what kind of data sources you could get for this. You might look at medical records, charts. In this case, we propose proposing a survey of participants.

And then you'll also want to think about your frequency of measurement. We really encourage at least quarterly measurement where you can. Not all measures are able to do quarterly measurement, but that way, you get at least some rapid cycle sense of how your program's going.

The next one on the list is one of the primary drivers. This is: decrease the proportion of patients who are overweight and obese. And again, the driver itself suggest what measures you might use. So here, we're going to look at the proportion of patients who are obese and the proportion of patients who are overweight. We'll have that data, we propose, from the classes themselves, and we'll get that monthly.

Finally, on this slide, the other aim is to reduce total cost of care. Here, we propose using total Medicare A and B spending as that measure using claims. Again, I reiterate that this is not expected of all awardees. Claims are very difficult to work with, so you might use a proxy measure here instead.

Now let's look at some more of the process measures, rather than the outcomes. So one of the main secondary drivers here is to educate and recruit patients at risk for diabetes. And so here is where you might not find as many standard outcome measures. Our list of outcome measures on the website don't have process, and it's kind of by design because you're proposing an innovative program, you've got unique drivers, and so you're going to have to do some creative thinking on how you're going to measure these drivers.

So we'll just run through quickly the measures we're proposing to measure. This first driver is number of health fairs held in the past quarter. So this is, for example, if you were trying to recruit patients through health fairs. The number of people given blood tests who were pre-diabetic. So this is telling you of those people that you see, how many are actually in your target population? And then the proportion of pre-diabetic patients recruited for the program. So this gives you step by step. Each of these are crucial for getting your program off the ground, and if you can track all three of these, it'll give you the most nuanced sense of whether you're on target or not.

Second driver is recruit and train diabetes educators. So this is another key part of the program. If you don't have these folks on board, you're not going to be able to get your outcomes. So here, we have two measures: proportion of diabetes educators positions filled and proportion of diabetes educators trained. Finally, another important driver in our example here is providing classroom-based weight management classes. And here, we are looking at the proportion of participants completing the course, and the number of classes held in the past quarter.

So again, I can't emphasize enough how important these measures are to tell you at the earliest moment in the program how things are going. If there are things that aren't going so well, you can hopefully quickly fix them through quality improvement. And if things are going well, we'll be able to track that over time, and it'll be easier for us if we want to replicate your program to do so. So with that, I'm going to turn it over to Andrew.

ANDREW RUSHTON: Great. Thank you, Tim. Before moving on, we just want to remind our attendees that if they are having any issues with sound quality or viewing the most current slide, please press the F5 button on your computer keyboard. Again, that's the F5 button. That should refresh the webinar portal so that everyone is literally on the same page.

All right, moving along. We're going to now turn to Mark Wynn, Senior Analyst at the Innovation Center, who will discuss operational plans and the role of project offices. Mark?

MARK WYNN: Thanks, Andrew. Yes, I'd like to mention the importance and a number of facts regarding operational plan. We take the operational plan and implementation issues very seriously. We're well aware that even great designs need great implementations to succeed, and this is an important part of making sure that the project works well. As a matter of fact, Section Two of the application is on implementation. It's 25 points of the evaluation, and so the operational plan and related issues are an important part of what we're looking for in the application.

Now, the formal operational plan is part of the supplemental application materials. So this is required in the FOA and will be submitted as part of the application in the supplemental materials. Please do use the updated version that was posted on June 20. As Christy noted earlier, we did update that, and so we want you to make sure that you're using that latest version.

Now, the awarded applicants will be updating their operational plan at the beginning of their performance period. That is, the initial application will include a draft which will be further refined, developed, and so forth with the assistance of the CMS team, including a project officer, as the actual project gets rolling. It will also be updated on a quarterly basis for each next six month period, so this is a rolling process. We want the operational plans be modified with events and looking forward in more detail to the coming period.

The operational plan is going to be focused on implementation realities. We're looking for the applicant to show us that they can effectively launch the program's service delivery within a six month period if the project is awarded. We're looking for them to know the steps that they need to take and to rapidly implement so that we can get into the operational phase of the program and see how that project design actually works in the real world.

We're looking for the awardee or the applicant to show us how they are going to do prove their operational capacity and their project readiness, and we want them to define your path to implementation. This is going to be a mutual roadmap between the Innovation Center,

particularly the project officer, and the awardee, so this will be an issue of continuing conversation.

The sections of the operational plan include, A, Strategy Aims and Drivers, B, Project Setup Needs, Risks, and Key Personnel, C, The Implementation Milestones and Work Plan, and D, the Self Measurement Plan that Tim just went into. The effective operational plan strategy will include identification of the critical enablers and potential barriers to project success.

We're looking not only for you to tell you what you think should happen, but some sort of understanding of risks and mitigation strategies as well. Anyone can run a project with no problems at all, but in fact, almost all projects have significant problems that need mitigation. So a mature and well functioning operational plan will have that mitigation in place. We're looking for use of rapid cycle improvements to project operations and outcomes using a self monitoring process. And finally, we're going to be focused on milestone planning and execution.

Let's talk, then, about Section A, the Strategy Aims and Drivers. Fran just talked about doing a driver diagram and the importance of this. And certainly, she showed us the logical relationship between the goals and the activities that are required to implement a project. These goals are not self implementing. They require a sophisticated and thorough understanding of the steps that are taken to actually develop these goals and put them into operation. If you want more information about this, please look at the website which is cited on the slide, which gives additional information on defining and using aims and drivers.

In Section B, we'll be looking for the project setup needs, risks, and key personnel. Content will include, could you deliver your intervention or service today? If not, when will it be ready to be deployed to patients or recipients, and what is needed to have your service or intervention ready within the first six months of the award period?

And on the right hand columns of this chart, you see potential risks and mitigation strategies. We're looking for a mature and knowledgeable understanding of what those primary risks are and how you would deal with those risks if they occur. Of course, you can't know every risk, but certainly some understanding of what the primary and most likely risks are are very important here.

In Section C, we're going to be looking for implementation milestones and the work plan. This should relate, like all the parts of the operational plan, to the driver diagram. We're looking for you to show how you're going to actually put your project into operation. What are the specific steps to get that project moving?

At the project start, you will probably have a short term focus. That is, over the first six months, how are you going to get this into operation? And then a longer time period, another 10 steps or so, about the next two and a half years after the implementation period. So you might have

something like 20 or 25 steps and particular activities on this diagram. There would be more detail later on if you're actually awarded the project.

Section D will have measurement and self monitoring activities. This relates to what Tim Day just told us, an explanation of the measurement and monitoring, and we're looking for projects that will be using their self monitoring results to do rapid cycle improvement so that they can actually carry out the design that they have developed and proposed to CMS. We're looking for you to share your data collection capabilities and show us that you can share that with the independent evaluators. We're looking for you to have operational measures, such as patient counts, encounters, and so forth, as well as process and outcome measures, that would be used for self monitoring as you go forward.

Now, we have proposed a Section D4, which has a number of standard measures that should be used when they are relevant and specific related to your particular project. In some cases, however, you'll want to use other measures, some of which might come from standard measure lists, just not on our Section D4, such as NQF measures that are not there, or your own custom measures that you can develop and use when needed. For each of these measures, the operational plan asks you to tie that in, the aim, frequency, and data sources, so that we can see how this all flows together.

Let me propose a few operational plan hints about how to fill in the plan. First of all, you can add additional tables in similar formats if there's not enough space on the tables that are presented, keeping to similar margins and fonts of the template. By the way, some of the margins are a little bit in excess of what we've asked for. Don't worry about that. If they're a half inch instead of a full inch, we're not going to ding you for that, of course. Be mindful of the page length. There is a 50 page limit to the entire section on supplemental materials, including the operational plan.

I'd now like to briefly talk about project oversight, the role of the project officer, and the role of the grant specialist. As Christy mentioned before, these are cooperative agreements. This requires significant involvement from the CMS project officers, ongoing discussion, development of mitigation strategies, and so forth. This is not a process where we're just going to put some money in your bank account and go away for three years.

The project officer is going to be meeting regularly with the awardee, and especially frequently at the beginning of the process, to work on the approval process of the operational plan, the progress reporting andescalation of any issues. Project officers are going to be working with the awardees at least weekly, and possibly every few days during the initial period. We expect also the awardees to work with other CMS contractors as needed, such as the independent evaluation contractor, the monitoring contractor, active involvement with the learning process, active involvement in all aspects, and collaboration with our contractors, because we rely on these contractors to assist us in making sure that this project operates well.

Now, the project officer is the person who does a number of things, including working on a day to day basis, the design, the project implementation, and making a project continuation recommendation. The grant specialist, on the other hand, is a separate person who manages the formal business functions of the project, including budget, payment issues, formal agreements, contractual issues, and so forth. Both of these people have an important role in the operation of the project.

Project support will also be done through our learning and diffusion activities, which will be organized by the Innovation Center. Shared learning activities will be bringing the organizations together to learn from each other, especially affinity groups of similar organizations that have similar goals. They'll be expected to participate in collaboratives and action groups, to organize peer networks of innovators, to learn from each other, and provide assistance to each other as issues arise. We'll be actively measuring success as they go forward and sharing breakthrough ideas to accelerate the progress of each other's.

We're expecting all of our awardees to actively participate with all of these programs and to work with these learning and diffusion projects which will be increased starting this year. That's the end of the role of the project officer. Andrew?

ANDREW RUSHTON: Great. Thank you, Mark. Moving along, we next have Christy Meyer up, who will now go over next steps in the submission process and highlight upcoming webinars. Christy?

CHRISTY MEYER: Thanks, Andrew. As we move forward to the application process, just a reminder to submit your application electronically at grants.gov. In order to apply, you will need specific information, a Dun and Bradstreet Data Universal Number System, a DUNS number. On the website, you'll obtain that as listed, as well as you also must be registered in the system for award management. Please plan ahead to obtain these numbers prior to your submission.

Our next webinar will be focusing on payment models, which is a unique component of HCIA Round Two, and there'll be more information forthcoming on the timing and how to register through our Listserv and on our website, so look forward to that information upcoming. And we do hope to have all of our slides and transcripts posted shortly on our website.

Any additional information about the Innovation Awards can be found on our innovation website, specifically our HCIA Round Two website. That's the location where you can find of all the supplemental materials for the application as well as the user guide for driver diagrams and the CMS measures list. If you have any questions, please contact us at our Innovation Award hotline.

ANDREW RUSHTON: Thank you, Christy. We're now going to transition into the question and answer session of the webinar. Before we get to our first question, there are several important

bits of information to emphasize. We are unable to provide you or your organization with feedback regarding proposals or ideas during this procurement sensitive time period.

We're also unable to meet with any applicants during this time period. This is to ensure the integrity and equity of this competitive funding opportunity. If you meet with CMS Innovation Center staff during this time period, you may be deemed ineligible for funding in Health Care Innovation Awards, Round Two.

And with that, now we are ready to begin with our first question. And it reads, where does the number I receive with my LOI go on the application? Christy?

CHRISTY MEYER: Sure. Since the Letter of Intent deadline is Friday, we're going to front load a few questions on the LOI, make sure we cover those. The LOI number that you receive will go into two places on the application kit. One is on the Executive Overview Supplemental Form, as well as grants.gov will prompt you to put the LOI number in a specific location in the SF 424 when you walk through that process.

ANDREW RUSHTON: Great. Thank you, Christy. Moving along, another LOI question. How can I go back and print a copy of my LOI? Christy?

CHRISTY MEYER: After you complete a letter of intent, you click on the Submit and Print button at the bottom, and then you will get a page that shows your responses that gives you the option to print that out, and you will use your browser function to do that. If you navigate away from that page, unfortunately, you will not have the option to print that out in the future, so you can't go back to that and reprint it. So make sure you print that when that confirmation screen comes up. If for some reason you need to change information in the LOI, you can submit a new one or you can make modifications in your application.

ANDREW RUSHTON: Our next question in some ways closely ties into that one, Christy. It reads, I entered some information into LOI incorrectly. Is there a way I can change this or a way that CMS can change this for me?

CHRISTY MEYER: Unfortunately, we cannot make corrections to the LOI after submission. Once you've submitted it, it's not possible to edit or delete any of the information. If you want to make corrections to your Letter of Intent, you can submit a new Letter of Intent and then use that new number in your subsequent application. Please know that the LOI is non-binding, and that you're free to make changes between the LOI and the application so this question really may not be necessary. Really depends on the significance of what you'd like to change and if you would like to submit a new LOI.

ANDREW RUSHTON: OK, Christy, one more LOI in this first batch. The question reads, I'm having trouble entering some of the numbers into the Letter of Intent. Is there any assistance that could be provided for this?

CHRISTY MEYER: Sure. Just as a reminder, some of the numeric fields in the LOI, like Phone Number, only take numeric digits, so you cannot include any commas, dashes, spaces, other punctuation. Those fields just take numbers, and if it's not formatted in that way, it will blank out your value and you have to start over. One way to check this as well is to check your internet options on your browser and make sure that you're in Compatibility Mode. That may also help address the issue. But in general, any of the numeric fields, you'll just want to put in a numeric value.

ANDREW RUSHTON: OK, our next question, I'm going to take to my colleague, Fran Griffin. And the question reads, if we already use logic models in our organization, can we use that format instead of a driver diagram as shown in her presentation? Fran?

FRAN GRIFFIN: Thanks, and the answer is absolutely yes. The visual layout that we showed today is just one example. It's not meant to be a prescriptive layout that must be followed. What we would be looking for if you use a logic model, though, is we would still look for a clear aim, so we would want to see a clear statement of what you're trying to accomplish with quantifiable goals and a date. And we would also look for how the items in your logic model align towards impacting that aim, and we'd look to make sure that the logic model includes references to health, to care, and to cost, all three areas. But absolutely, yes, if you're already using logic models, stick with what you know and are already using.

ANDREW RUSHTON: OK, great. Thank you, Fran. And one more question for Fran. Should projects focus on just one specific aim, or can your program target multiple aims?

FRAN GRIFFIN: Sure, great question, and I think several people asked about this. Yes, you can have more than one aim. I would add a note of caution here, though, that you don't want too many. And generally, I would say try to not go over three in your aims, the main reason being that the aim statement is the overarching statement of what the project is all about and what the project hopes to achieve.

Now within that, we have seen examples in other work where people include in their aim, as in the one example we showed, a reference to health care, and cost with quantifiable goals for all three in the same aim statement, or three aim statements that are all related to each other. I wouldn't recommend going much beyond three because a big, long list of aims can then make it more difficult for the team working on the initiative to stay focused and clear on what the purpose is.

Now, that's not to say that the aim is the only goal that one should set in this kind of work. As Tim was mentioning, there should be measures that align to the primary drivers, and in some cases even the secondary drivers, and each of those may have goals, too, and probably should. So in addition to the aim statement, further in, there'll be sub-aims or sub-goals as well. So to recap, the answer is yes, you can have more than one aim statement. Just remember that this should be high level overarching, and so it's best to not go much beyond three. Depends on the scope of your project, though, as well.

ANDREW RUSHTON: Great. Thank you, Fran. Our next question, can innovation grant applications be submitted that target Medicare Advantage beneficiaries? Going to hand this to my colleague, Sheila Hanley. Sheila?

SHEILA HANLEY: Yes. Proposals can focus on Medicare Advantage beneficiaries, although CMS will be looking for an ROI to CMS.

ANDREW RUSHTON: OK, our next question. If CMS is giving preference to models that reduce costs within six months, how will applicants be considered if their prevention models have longer ROIs, potentially even beyond the three year award period? Sheila, you want to take this one?

SHEILA HANLEY: Sure. We recognize that prevention and wellness models may take longer to generate ROIs and that other innovation categories may be able to generate ROIs sooner. We are looking for a balanced portfolio of projects and encourage the submission of prevention proposals.

ANDREW RUSHTON: Great. Sheila, another one for you. This one reads, must the new payment system be in place from inception of the three year performance period? If not, by what period of time?

SHEILA HANLEY: Applicants must submit the design of a payment model as part of their application. Applicants do have the option to submit, as part of the application, a detailed and fully developed payment model, as well as a list of payers interested in testing the new payment model and the service delivery model. However, there is no assumption that a payment model would be operationalized within the performance period.

ANDREW RUSHTON: Great. Moving along to our next question, do applications have to have partners in the LOI application? Christy?

CHRISTY MEYER: No. We understand that at the time of doing the Letter of Intent, you may not have all your partners specified, so it is not a requirement to have them all listed in your Letter of Intent. However, we are looking for partners to be mentioned in the application.

ANDREW RUSHTON: OK, our next question, to clarify a statement from last week's Total Cost of Care webinar regarding proposals demonstrating an ROI in three years. I'm going to toss this over to Sheila. Sheila, you want to clarify this one?

SHEILA HANLEY: Sure. CMS will require applicants to complete Budget Form SF424A and a financial plan demonstrating their ability to achieve both total cost of care savings and a strong ROI over the three year performance period for the award. We are interested to see whether the proposals have a reasonable expectation to generate net programmatic savings over the three year award period and a positive ROI on a projected annualized basis after the term of the award is finished. There are no minimum thresholds for a required ROI. Proposals will be

evaluated in light of credible, favorable performance shown by the proposed model and in the context of criteria specified in the Funding Opportunity Announcement.

ANDREW RUSHTON: Next question. Will CMS accept Letters of Intent after this Friday, June 20, 2013? Christy?

CHRISTY MEYER: Thanks, Andrew. The deadline for this Friday for the Letter of Intent is firm, and we will not be taking letters past that date. The deadline is 3:00 PM Eastern time on Friday.

ANDREW RUSHTON: OK, thank you for that important confirmation. The next question I'm going to toss to Sheila, and it reads, if we submitted a proposal in Round One and received scores, is Round Two automatically considered a revision or re-submission, and will you entertain those proposals addressing the Round One reviewer comments, or would any submission now be considered a new submission since the RFP focus has changed somewhat? Sheila?

SHEILA HANLEY: So any submission would be considered a new application and will be reviewed and scored based upon the specific criteria and authorizing official considerations that are outlined in the Round Two Funding Opportunity announcement.

ANDREW RUSHTON: Next question. Will proposals that benefit prevention or wellness and prevent chronic disease in a pre-Medicare beneficiary population be eligible, or is funding limited to proposals that impact current enrollees in Medicare, Medicaid, or CHIP? Sheila, you want to take this?

SHEILA HANLEY: Proposals may indirectly benefit patients other than those covered by current Medicare, Medicaid, and CHIP, however, CMS funds must directly target and benefit Medicare, Medicaid, and CHIP beneficiaries. CMS cannot allow expenditures that do not directly benefit Medicare, Medicaid, or CHIP beneficiaries.

ANDREW RUSHTON: Since the allotted time for the webinar is winding down, the following will serve as the last question for the webinar, and Sheila, it's one last one for you. The question reads, if we are submitting an application to fund implementation of a service delivery model that has been previously implemented by other organizations with funding from Innovation Center or other HHS agencies, does that disqualify us from applying or receiving an award? Sheila?

SHEILA HANLEY: Sure. So the answer is no. Submitting an application to fund implementation of a service delivery model that has been previously implemented by other organizations does not disqualify you from applying or receiving an award. However, please be mindful of the authorizing official considerations that will be used in the final selection of awards. These include consideration of the range of service delivery and payment models proposed and the fit with the current CMS portfolio, as well as the extent to which a proposal is not duplicative of other CMS or HHS activities. So it will be important in your application to make your best case

as to why your proposal is innovative and will be successful in lowering costs, improving quality, and meeting other scoring criteria.

ANDREW RUSHTON: Great. That concludes the question and answer section of the webinar. We ask that attendees please fill out the Participant Survey, accessible via the link that should appear now through the webinar portal screen. We value participant feedback throughout the webinar series. Now Christy Meyer has a few closing comments. Christy?

CHRISTY MEYER: Thank you. We just want to thank everyone for your engagement in this webinar series and all the important work that you do every day to make care better and more affordable. In the last few years, we've seen very large strides when it comes to keeping health care spending in check, and much of that is due to the innovations in the field that have helped us to make care delivery smarter and more efficient.

Thanks again for joining us this afternoon. We look forward to receiving your Letters of Intent this Friday. Please plan ahead for your submission. And we look forward to having you join us on our next webinar. Andrew?

ANDREW RUSHTON: Thank you, Christy. Just a friendly reminder to follow up. We will be hosting additional webinars relating to specific aspects of the Health Care Innovation Awards Round Two application process. We encourage all potential applicants to sign up for the Innovation Center Listserv on our website and stay abreast of the latest webinar dates. Thank you all for attending this afternoon, and have a good day. Goodbye.