2018-2019 MEDICARE REIMBURSEMENT LEARNING COLLABORATIVE FINAL REPORT

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1. BACKGROUND AND INTRODUCTION

NCOA's National Chronic Disease Self-Management Education (CDSME) Resource Center located in the Center for Healthy Aging is funded by the Administration for Community Living, Administration on Aging to support community-based organizations (CBOs) in implementing, bringing to scale, and sustaining evidence-based CDSME programs. In recognition of the need for additional support and technical assistance to help CBOs develop integrated, sustainable CDSME program networks, NCOA implemented a series of Medicare Reimbursement Learning Collaboratives.

The initial Medicare Reimbursement Learning Collaborative initiatives were launched in January 2016 and implemented over a 10-month period. Participants were grouped by which Medicare benefit they chose to implement, diabetes self-management training (DSMT) or health and behavior assessment and intervention (HBAI). Since then, NCOA has implemented two more year-long Medicare Reimbursement Learning Collaboratives (May 2017 through April 2018 and May 2018 through April 2019). Based on feedback from the 2016 cohorts, the 2017 and 2018 initiatives were constructed with a combined focus on both DSMT and HBAI. Moreover, chronic care management (CCM), a new Medicare benefit introduced in 2017, was added to the curriculum for the latter two initiatives. While participants learned about all three benefits (DSMT, HBAI, and CCM), they selected one benefit for their primary focus throughout the project period. The learning collaboratives also covered the process for achieving national accreditation for diabetes self-management education and support (DSMES) services, which is a requirement to receive Medicare reimbursement for the DSMT benefit.

The overarching goal or aim of the learning collaboratives was that participants "achieve or make significant progress toward achieving Medicare reimbursement for their CDSME programs and accreditation for their diabetes programs (for those who selected DSMT as their focus) by the end of the learning period."

The learning collaboratives were designed to provide a rich, dynamic and interactive learning environment for participants to work together toward Medicare reimbursement with intensive training and technical assistance from NCOA. The major types of technical assistance included an in-person kick-off meeting, monthly webinar learning sessions, one-on-one technical assistance calls, mentorship calls, and an online community. Regular homework assignments were given to provide opportunities for participants to apply the concepts learned to real-world practice settings. Participants were guided through a process that fostered ongoing feedback, peer-to-peer sharing, and accountability to support them in working toward the project goals.

The 2018-2019 Medicare Reimbursement Learning Collaborative

Ten organizations were selected to participate the 2018-2019 initiative, and eight completed the process. Two participants withdrew before the end of the learning period, one due to lack of organizational readiness and the other due to organizational restructuring and change in leadership. Participants were from different states, representing a variety of types of organizations, including area agencies on aging, health departments, a federally qualified health center, an integrated care network hub, and a social services agency. Five participants selected DSMT for their focus, and two focused on CCM. Table 1 below provides a list of organizations that participated by state and focus area. Participant profiles and information about the process can be found at the following link: https://www.ncoa.org/center-for-healthy-aging/cdsme-resource-center/sharing-best-practices/community-integrated-health-care/learning-collaboratives/2018-2019-mrlc/.

Table 1. Learning Collaborative Participants by State and Focus Area

Participant	State	Focus Area
Central District Health Department	NE	DSMT
Connecticut Community Care, Inc.	CT	
Council on Aging of Southwestern Ohio	OH	
New Mexico Department of Health	NM	
United Neighborhood Centers of Northeastern Pennsylvania	PA	
Big Sandy Health Care Center	KY	CCM
Community Council of Greater Dallas	TX	
Western New York Integrated Care Collaborative, Inc.	NY	

2. METHODOLOGY

Several methods were used to evaluate the learning collaborative. First, progress was measured by tracking the degree to which participants took incremental steps to move through stages of organizational change toward the overarching aim of achieving Medicare reimbursement. The stages of change framework revolved around five core programmatic elements: accreditation (applicable only to those who selected DSMT as their focus), implementation, clinical supervision, billing, and documentation and tracking. Participants documented monthly progress by completing a structured online form with a series of check boxes that defined specific steps that were necessary to move through each stage of change. The form also contained a field for participants to provide a brief narrative update each month.

Second, to evaluate participants' satisfaction with the learning collaborative experience, a brief online survey "How Are We Doing?" was administered to leads and co-leads three times during the project period (August 2018, December 2018, and April 2019). The survey included Likert-scale questions to assess participants' level of satisfaction with the different types of technical assistance provided during each four-month period (i.e., one-on-one technical assistance calls, mentor calls, monthly webinar learning sessions, and the online community). Participants were

also asked to what extent they were given ample opportunity to ask questions and how timely and satisfactory the responses were. Several questions were added to the final survey to gauge participants' overall satisfaction with the homework, peer-to-peer sharing, and the learning collaborative experience on the whole. The final survey also included a question to assess participants' confidence with their ability to continue working toward their goals once the learning collaborative ended.

The brief surveys also contained several open-ended questions to elicit information about participants' satisfaction with the learning collaborative. The first two surveys included questions about what they liked best and what suggestions they had to improve their experience. At the conclusion of the learning collaborative, these questions were incorporated into final interviews that were conducted with each participant.

A third evaluation method involved conducting individual telephone interviews with each learning collaborative lead and/or co-lead at the end of the project period. The purpose of the interviews was to gather in-depth, descriptive data about participants' perceptions of the learning collaborative. Questions were asked about their challenges, key learning experiences, what they liked best, what could have been improved, and what continued support they would like to receive from NCOA after the learning collaborative ended.

3. FINDINGS

Progress through the Stages of Organizational Change

Accreditation**.** This stage of change element applied only to participants who focused on DSMT, five of the eight participants (see Table 1, page 2). Progress toward accreditation was measured by tracking movement through four incremental steps: 1) developing a policy and procedure manual, 2) starting and completing a test class, 3) applying for accreditation, 4) achieving accreditation/recognition from the American Association of Diabetes Educators (AADE) or the American Diabetes Association (ADA).

One organization completed the accreditation process prior to starting the learning collaborative. Of the four remaining participants, one completed the policy and procedure manual; a second participant was nearly finished and expected to finalize it the first week of June. None of the four unaccredited organizations completed the test class; however, one scheduled the test class for the first week of June, and another was planning to offer the test class during the summer.

Two organizations were still developing their specific business model for DSMT. One of the two decided to work collaboratively with an existing health care system partner that already had an accredited program, rather than attain its own accreditation. Together, they were exploring different options for expanding the scope of the existing DSMT program. They were committed to working through the process together, had hired a consultant to help them, and were quite

optimistic about the future. The other organization that had not yet defined its business model underwent a major reorganization and a change in leadership that placed the accreditation process on hold temporarily. The project lead for this organization was prepared to present a detailed plan, including a market analysis and break-even analysis, to senior leaders to demonstrate the value of DSMT. Once the plan was presented and approved, the steps toward accreditation could be taken.

Implementation**.** To move through this stage of change, participants were expected to accomplish two related tasks: establish an implementation plan for their organization and develop the necessary partnerships to carry out the plan. An organization was considered to have an implementation plan in place once decisions were made about the following: 1) the focus for the effort (DSMT, HBAI, or CCM); 2) where the program will be implemented; 3) who the target audience will be; 4) leadership, staff (including a program coordinator or quality assurance coordinator for DSMT), and infrastructure to implement the program (leaders, trainers, etc.); and 5) whether or not the lead organization would or would not serve as the Medicare provider. To demonstrate that they had established partnerships, participants were expected to "develop partnerships to successfully implement the program and at least one key partnership to make referrals to the program on an ongoing basis."

Nearly all organizations (8 of 9) met 100% of the criteria for implementation. Participants were highly successful in developing innovative partnerships with health care organizations. Partner roles involved providing clinical supervision and oversight for program implementation and making referrals to Medicare Part B services. Several partnerships resulted in formalized, written contracts to pay participants for their services. Key health care partnerships are highlighted in Table 2 below.

Table 2. Key Partners and Activities by Learning Collaborative Participant

Participant	Key Partner(s)	Activities
Big Sandy Health Care	-Federally Qualified Health Center (FQHC) providers	Collaborating with multiple internal providers who have agreed to make referrals and provide supervision and oversight for billable CCM services delivered by community health workers. Plan to embed CCM in clinic practices and share the experience with other FQHCs in KY.
Central District Health Department	-A large family practice group -An urgent care facility	Leveraging partnerships to refer patients to DSMT classes.
Community Council	Hospital system with physician practices	Negotiating a contract for a hospital system to make referrals and provide oversight, supervision, and billing for CCM (contract being reviewed for approval and signature).

Participant	Key Partner(s)	Activities
Connecticut Community Care	-FQHC	Negotiating a contract with a health center to provide and bill for DSMT under the Sate Innovation Model federal grant (contract is being reviewed for formal approval and signature).
Council on Aging of Southwestern Ohio	-Veteran's Administration (VA) -Tri-Health -Medicare Advantage Plans	In the process of determining the appropriate business model to sustain these partnerships; exploring options to transition from DSMP to DSMT with clinical wrap-around structure and billing potential; investigating becoming a CHOICE provider with the VA for DSMT.
New Mexico Department of Health	-Presbyterian Health Services, Center for Community Health -Pecos Valley Medical Center -The State Pharmacy Association	Collaborating with Presbyterian Health Services, Center for Community Health, a statewide health care provider, Pecos Valley Medical Center, and the New Mexico Pharmacy Association to explore options for accreditation and reimbursement of DSMT.
United Neighborhood Centers of Northeastern Pennsylvania	-3 Managed Care Organizations (MCOs) -FQHC	Submitted applications to provide DSMT to 3 new MCOs that will begin rolling out services in January 2020; FQHC provides space for classes.
Western New York Integrated Care Collaborative	-Medicare Advantage plan -Medicaid plan -2 Managed Long Term Care (MLTC) health plans that serve dual eligibles	Negotiated and signed contracts with a large Medicare Advantage plan, a Medicaid plan, and 2 MLTC plans.

Clinical Supervision. Clinical supervision was measured by three incremental steps: 1) a clinician has been identified and is in agreement to provide the services, 2) the clinician has registered as a Medicare Part B provider (i.e., an online application for the NPI has been completed and the NPI issued), and 3) the clinician's national provider identifier (NPI) has been linked to the designated provider transaction access number (PTAN) of the Medicare Part B provider. By the end of the learning collaborative, most participants (6 of 8) had identified a clinician to supervise the Medicare services. More than half of the clinicians (5 of 8) had obtained an NPI, and half (4 of 8) had linked their number to the designated Medicare provider's PTAN.

Billing. Learning collaborative participants were asked to choose between two options for handling billing: 1) their organization could serve as the Medicare provider, or 2) they could develop an agreement with another organization that would serve as the Medicare provider. Organizations that decided to serve as the Medicare provider needed to apply for and receive a Medicare PTAN before they could submit claims to Medicare for the services provided. Organizations that chose to partner with a Medicare provider were expected to identify and

enter into a verbal agreement with a willing partner. Once a verbal agreement was obtained, the next step was to negotiate and sign a formal written agreement (i.e., contract) that defined the roles and responsibilities of each organization and specified the payment terms and rates.

As shown in Table 3 below, four organizations decided to serve as the Medicare provider themselves, and four chose to partner with a Medicare provider for the delivery of Part B services. One organization (Community Council) developed its own unique delivery model, which entailed offering CCM services initially under the auspices of another Medicare provider, while ultimately aiming to offer the services under its own Medicare provider number, consistent with its DSMT delivery model.

Table 3: Learning Collaborative Participants by Whether They Intend to Serve as a Medicare Provider or Partner with a Medicare Provider for the Delivery of Part B Services

Participant	Serve as Medicare Provider	Partner with Provider
Big Sandy Health Care	X	
Central District Health Department	X	
Community Council	(For DSMT)	X (Plans to partner with a provider for CCM initially and later serve as its own provider)
Connecticut Community Care		X
Council on Aging of Northwestern Ohio	X	
New Mexico Department of Health		X
United Neighborhood Centers of Northeastern Pennsylvania	X	
Western New York Integrated Care Collaborative		X

Three of the four organizations that decided to serve as the Medicare provider completed the Medicare enrollment process, i.e., applied for and received a Medicare PTAN (Big Sandy Health Care, Central Health District, and United Neighborhood Centers of Northeastern Pennsylvania). Similarly, three of the four organizations that decided to partner with a Medicare provider were successful in identifying a partner to bill the services (Community Council, Connecticut Community Care, and Western New York Integrated Care Collaborative). All three were able to formalize their agreements through written contracts. By the end of the learning collaborative, one organization (Western New York Integrated Care Collaborative) had signed multiple contracts, and the other two organizations were in the final review stage of contract negotiations.

Participants were also asked to report on whether they planned to handle the billing process in-house or outsource it. Half of the participants intended to handle the billing process in-house,

and the other half said they would outsource it. Organizations that chose to outsource billing were expected to work toward developing a formalized, written agreement that specified the billing roles, responsibilities, and fees. Of the four organizations that planned to outsource billing, one (Western New York Integrated Care Collaborative) had signed a formal agreement with a third party contractor by the end of the learning collaborative.

To demonstrate progress with billing, participants were also expected to establish a written billing process, submit claims to Medicare, and achieve reimbursement. Half of participants (4 of 8) completed a written billing process, which included establishing pre-billing procedures, defining how they would coordinate clinical and back-office functions, and creating a process for reconciling claims. None of the organizations had submitted claims to Medicare or achieved reimbursement by the end of the learning collaborative, which isn't surprising since these were the final steps in the process. The organization that made the most progress with billing (Big Sandy Health Care) was preparing to submit its first claims to Medicare and anticipated "dropping the codes" shortly after the learning collaborative ended.

Documentation and Tracking. Participants were asked to develop a process for clinical documentation and data tracking (e.g., workshop and billing data) to comply with Medicare requirements, including HIPAA. They reported on whether they would use a paper-based system, an electronic platform, or a combination of both approaches. By the end of the learning collaborative, all participants, except one, had developed a documentation and tracking process. Attuned to HIPAA requirements, participants developed specific processes for their organizations to provide HIPAA training and ensure compliance.

One participant (Big Sandy Health Care) planned to use its electronic health record to document and track data, and one (Central District Health Department) planned to use a paper-based process, while exploring options for an IT system. The other five participants (Community Council, Connecticut Community Care, Council on Aging of Southwestern Ohio, United Neighborhood Centers of Northeastern Pennsylvania, and Western New York Integrated Care Collaborative) planned to use a combined approach.

All five of the participants that planned to use a combined approach decided to use an electronic platform for clinical documentation and a paper-based processes for other functions. Three of the five (Community Council, Connecticut Community Care, and United Neighborhood Centers of Northeastern Pennsylvania) were customizing or adapting their existing electronic platforms. One organization (Council on Aging of Southwestern Ohio) implemented a new IT system that would be used for clinical documentation, and another (Western New York Integrated Care Collaborative) was in the process of negotiating a contract with an information technology system for clinical documentation.

Overall Progress. Participants were expected to make "significant progress" in moving through the stages of organizational change as a result of participating in the learning collaborative. The

degree of overall progress was measured by determining how many steps within the overall stages of change framework each organization actually took, as compared to the total number of steps that were necessary to achieve Medicare reimbursement. The total number of steps varied, depending on each participant's focus area and implementation model. A percentage was calculated for each organization, with 0% representing no movement through the stages of change and 100% indicating movement through all the stages.

On the whole, participants did meet the expectation of "significant progress," as evidenced by the percentage of movement through the stages of change. Three participants scored at the mid- to upper-80th percentile (85%, 88%, and 89% respectively); three scored at the upper-60th to the mid-70th percentile (67%, 74%, 75% respectively); and another scored 43%. The organization with the lowest score (5%) faced major challenges internally and with its partners. Even so, this participant was successful at strengthening an existing partnership with a health care system to explore implementation model options for Medicare Part B services. A joint meeting was scheduled to take place shortly after the learning collaborative ended to set priorities and establish a plan for moving the initiative forward. Regardless of their scores, participants unanimously agreed that they gained knowledge and skills necessary to develop sound business models, position their programs in the marketplace, and promote the value of their services to potential health care partners. Table 4 below shows the overall progress that participants made through the stages of change framework.

Table 4. Total Number and Percentage of Participants That Completed Each Step within the Stages of Change Framework

Stages of Change Element	Step-by-Step Process	Total Number and Percentage* of Participants That Completed Each Step
Accreditation	Policy and Procedure Manual in place	2 of 5 (40%)
	Test class started or scheduled	2 of 5 (40%)
	Test class completed	1 of 5 (20%)
	Application submitted to ADA/AADE	1 of 5 (20%)
	Accreditation Achieved	1 of 5 (20%)
Implementation	Implementation plan in place	7 of 8 (88%)
	Necessary partnerships established to successfully implement program and obtain referrals	7 of 8 (88%)
Clinical Supervision	Licensed clinician committed to provide supervision	6 of 8 (75%)
	Clinician registered as Medicare provider	6 of 8 (75%)
	Clinician's NPI linked to designated Medicare provider	5 of 8 (63%)
Billing	Lead organization plans to become Medicare provider to offer Medicare Part B services:	n= 4**
	Applied for Medicare PTAN	3 of 4 (75%)
	Received Medicare PTAN	3 of 4 (75%)

Stages of Change Element	Step-by-Step Process	Total Number and Percentage* of Participants That Completed Each Step
Billing (Continued)	Lead Organization does NOT plan to become Medicare provider:	n=4
	Medicare provider identified and in agreement to bill the services	4 of 4 (100%)
	Formal agreement signed with Medicare provider	2 of 4 (50%)
	Billing will be handled by CBO	n=4
	Billing will be outsourced to third party:	n=4
	If outsourced, contract signed with third party vendor	1 of 4 (25%)
	Billing process established	4 of 8 (50%)
	Submission of claim	0 of 8 (0%)
	Reimbursement achieved	0 of 8 (0%)
Documentation and Tracking	System established for documentation and tracking that is HIPAA compliant	7 of 8 (88%)

*Rounded to nearest percent

**Community Council was not included in the count because it plans to partner with a Medicare provider for implementation of CCM, even though the organization has a PTAN for the delivery of DSMT (see Billing, page 6 for more information).

Brief Online Survey Findings

Satisfaction with the Types of Technical Assistance. Findings from all three brief surveys indicated that learning collaborative participants who were surveyed (leads and co-leads) found the different types of technical assistance quite helpful. The specific findings for the perceived degree of helpfulness (i.e. very helpful, moderately helpful, somewhat helpful, or slightly helpful) for each type of technical assistance are summarized below:

- Kick-Off Meeting – Participants unanimously agreed that the kick-off meeting was helpful, with a majority (6 of 11) rating it very helpful.
- Monthly Learning Sessions – Participants reported a high degree of satisfaction with the monthly learning sessions across all three surveys. In the first survey, a clear majority of respondents (7 of 11) said they found the sessions very helpful. The level of satisfaction increased at mid-term and at the end of the learning collaborative, with nearly all respondents (9 of 10 and 8 of 9 respectively) rating the sessions very helpful.
- One-On-One Technical Assistance (TA) Calls – Similar to the results for the monthly learning sessions, the perceived level of helpfulness of the one-one-one TA calls increased slightly over time. A majority (7 of 10) of respondents rated the initial TA call very helpful, while nearly all rated the midterm and final TA calls very helpful (9 of 10 and 8 of 9 respectively).

- Mentor Calls – Across all three surveys, participants unanimously agreed that the mentor calls were helpful, and nearly all respondents rated them very helpful (10 of 11, initial survey; 6 of 6, midterm; and 7 of 9, final survey).
- Online Community – Overall, participants found the online community helpful. However, they did not rate it as helpful as the other types of technical assistance. Across all three surveys a clear majority of responses fell into the "very helpful" and "moderately helpful" categories. However, each time, a few respondents perceived this form of TA as only "slightly helpful." The midterm and final responses were more positive than the initial survey results. The less positive responses initially may be related to technical issues that were encountered with establishing the online platform, as well as the learning curve required to navigate the site. In general, the results suggest that participants may have placed more value on personalized types of technical assistance with live, real-time support.

Opportunity to Ask Questions. Across all three surveys, there was a high degree of consensus among participants with regard to being given ample opportunity to ask questions, having questions answered in a timely fashion, and having questions answered satisfactorily. With choices ranging from "all of the time" to "never on a five-point Likert Scale, nearly all respondents answered "all of the time" to all three of these questions.

Overall Satisfaction. Participants were asked to rate their overall level of satisfaction with the homework, peer-to-peer sharing, and the learning collaborative experience on the whole. The questions about participants' overall satisfaction with the homework and peer-to-peer sharing were added to the final survey to allow participants to reflect back on their experience over the twelve-month period. The question about overall satisfaction with the learning collaborative experience was included in all three surveys.

Consistent with other survey results, participants expressed a high degree of satisfaction with the homework, peer-to-peer sharing, and the learning collaborative experience itself. Across all three surveys, a large majority of participants rated their overall satisfaction with the learning collaborative as "very satisfied." The level of satisfaction increased slightly at midterm and remained higher at the end of the learning collaborative.

When given an opportunity to provide comments about their overall satisfaction with the learning collaborative, participants provided very positive feedback about their experience. They expressed appreciation for the expert technical assistance that was provided, as well as for the process that kept them engaged, held them accountable, and broke down complicated concepts into manageable parts. Below are typical comments from the final survey:

- *"This has been an amazing experience. It was extremely helpful. I loved the calls and homework assignments, as it kept me focused on the experience, which led to progress being made."*

- *"Our experience with the learning collaborative has been exceptional. The leaders and technical experts were so helpful. The monthly calls/homework assignments and webinars were well-organized and designed to address the key steps in the reimbursement process. We are so thankful to have been part of this learning collaborative and hope to continue to share the information we have gained and contribute in a meaningful way in the future. Thank you!"*
- *"(The technical assistance team) have extensive knowledge. This collaborative is a high value to CBOs. Thank you."*
- *"The information and guidance have been extraordinary! I can't believe how much content was covered. Thank you!"*

Self-Rated Confidence. To assess participants' self-rated confidence in their ability to continue working toward Medicare reimbursement after the learning collaborative ended, the following question was added to the final survey: "To what extent do you feel confident in your ability to continue to work toward Medicare reimbursement for the Part B benefit that you selected as your area of focus (DSMT or CCM)?" On a five-point Likert scale, the choices ranged from "completely confident" to "not confident at all." The results indicated that participants had gained a high level of confidence in their ability to continue working toward Medicare reimbursement: 3 respondents said they were completely confident, 4 were very confident, and 2 were moderately confident.

Telephone Interviews

From April 19 through April 30, 2019, telephone interviews were conducted with each designated learning collaborative lead and/or co-lead to learn more about their experience over the course of the learning collaborative. Participants were asked to share their challenges and key learning experiences, as well as what helped them most, what could have been improved, and what continued support they would like to receive from NCOA after the learning collaborative ended.

Major Challenges. When participants were asked what major challenges they faced, by far, the most common response was staffing. Participants were expected to form a team to work collaboratively toward specific goals that they agreed upon at the beginning of the initiative. However, changes in roles and responsibilities of key staff, attrition, shifting priorities, reorganizations, and other internal changes often resulted in one or two people bearing the brunt of the workload. Therefore, the timeline for completing specific tasks associated with achieving the learning collaborative goals often had to be adjusted, even though participants were committed to the process. Several participants also said that they had difficulty securing the buy-in of their senior leaders to fully support the Medicare initiative. They had to slow down the process to help their leaders understand more about Medicare Part B services, the

benefits of becoming a Part B provider, and the process of calculating the break-even point for financial sustainability.

Key Learning. When asked about their key learning experiences, participants expressed gratitude for the year-long process that helped them understand and apply Medicare Part B and business acumen concepts to develop their own business models. They related that the learning collaborative created new opportunities to expand and sustain their evidence-based programs. As one participant stated, “Learning about the whole process and working with (our partners) has made me think about . . . our appropriate role . . . and how we can work to overcome some of the barriers. It’s a whole new world – it was exciting to learn that these opportunities are available.”

There were also specific aspects of the learning collaborative that participants cited as key learning opportunities. Participants said they gained an in-depth understanding of the billing codes and the billing process and learned about how to calculate the break-even point to make financial projections. They pointed out that learning about how to conduct a market analysis helped them understand how to target their services to Medicare beneficiaries and which Medicare Advantage plans to approach. Furthermore, they noted that completing the value proposition homework taught them how to effectively market their services to health care entities. Participants focused on DSMT commented that they understood more about the role of the registered dietitian and benefited greatly from the sample policy and procedure manual for accreditation.

Overall Experience. Participants’ feedback about their overall experience was exceedingly positive and consistent with responses to the question on the brief online survey about their overall satisfaction. They valued the structure of the learning collaborative that guided them through a step-by-step process, encouraged them to ask questions, and supported interaction with their peers. They were struck by the learning curve when they first started and came to recognize the importance of the year-long process to understand and put into practice the knowledge and skills they were learning. Below are typical responses:

- *“I want to thank you for allowing us to be part of this. This has been completely out of my comfort zone and so important for our community and staff. I couldn’t say that something was most helpful because everything was tremendously helpful. The homework helped me to stay focused . . . and the monthly calls were helpful. It was nice to know I wasn’t alone, and there were others at the same place . . . it was reassuring.”*
- *“It was a huge learning curve and helpful to go step-by-step to learn the process. . . . We had a year to delve into the issues and think them through. . . .You don’t always realize all the details involved. . . . It was helpful to start thinking about the big picture. . . . It brought us to a point to make new relationships . . . and understand how our organization can grow.”*

- *“Excellent. . . . I’ve learned so much, and I’ve gone from a participant to the one in our board meetings who is informed and telling them how it is. It’s been excellent.”*
- *“Very supportive . . . I felt very supported throughout the learning collaborative. You were very responsive and went above and beyond in your responses.”*

What Was Most Helpful. Participants reported that the most helpful aspect of the learning collaborative was the homework. They valued the step-by-step guidance that was provided, appreciated the opportunity to review the homework of others via the online community, and found it helpful to discuss assignments with their peers during the monthly learning sessions. They pointed out that they liked the design of the assignments that built on the knowledge and skills taught in previous lessons. They concurred that the homework held them accountable and recognized it as an important process to help them work toward their goals.

Additionally, participants indicated that the different types of technical assistance were helpful, including the monthly webinars, one-one-one technical assistance calls, and the online community, which provided access to webinar recordings and other resources between sessions. Further, they appreciated having the ability to ask questions and learn from their peers throughout the process.

What Could Have Improved the Experience. When asked if there was anything that could have improved their experience, participants again were very complimentary about the process. The majority said they wouldn’t change anything. However, several participants expressed disappointment in their own efforts due to limited human resources. As one participant noted, “I wish I had more time to devote to it and a more solid team.” One participant would have liked more one-on-one and small-group calls focused on each specific benefit. She suggested that the monthly learning session calls be shifted to separate calls for DSMT and CCM once a quarter. Another participant suggested that the monthly agenda for the entire year be shared at the beginning of the initiative to give participants an overall view of the project upfront. Still another participant commented that the group didn’t seem to be quite as engaged toward the end of the learning collaborative. She wondered if some type of exercise could be added to encourage more participant interaction during the latter stage of the process.

Continued Support from NCOA. Participants were asked if they would like any assistance from NCOA to support their efforts once the learning collaborative ended. They unanimously agreed that they want continued support. Specifically, they would like to be able to continue to access the online community to review archived webinars and other resources, as well as to interact with their peers. As they move forward, they also want to be able to contact NCOA for technical assistance to answer their questions and to help them address challenges and overcome barriers. As one participant acknowledged, “Having support is huge. I’ve been in learning collaboratives where that didn’t happen; it’s over and you were left where you are. It is rare you end up completely finished. Having ongoing technical support is huge.”

Participants were also queried as to whether they would be interested in work groups to support them in continuing their efforts. All participants resoundingly expressed a desire to participate in work groups to help them continue moving forward.

4. CONCLUSIONS AND RECOMMENDATIONS

The progress, accomplishments, and positive feedback of participants, demonstrate that the Medicare Reimbursement Learning Collaborative was a valuable technical assistance approach to help participants work toward Medicare reimbursement. At the beginning of the learning collaborative, participants were unfamiliar with the concepts and the process. By the end of the project period, they had gained an in-depth understanding of the requirements for delivering Medicare Part B services and the stages of organizational change necessary to achieve Medicare reimbursement. On the whole, participants made significant progress toward the goal of Medicare reimbursement, as evidenced by the percentage of steps taken, as compared to the total number of steps, in the stages of change framework (accreditation, implementation, clinical supervision, billing, documentation and tracking).

Beyond progress through the stages of change, participants also developed critical business acumen skills to help them successfully implement and sustain their programs. They completed a series of homework assignments to gradually build these skills. For example, they were responsible for conducting a market analysis, developing a value proposition, and completing a break-even analysis, all critical to achieving their goals. Throughout the process, participants had opportunities to apply their learning experiences in real-world settings. They also worked with local partners to develop their own unique business models. The completion of all of these activities can be considered important accomplishments, as participants were learning and applying concepts that would ultimately make their integrated care efforts more successful.

At the end of the learning collaborative, participants expressed a high degree of confidence in their ability to continue working toward Medicare reimbursement. However, at the same time, they realized that they needed further support from NCOA. They also expressed a desire to continue to interact with and learn from their peers. Based on their feedback and insights from the technical assistance team, the following three recommendations are proposed:

- Provide continued access to the online learning community; use the online platform to post updates and to create opportunities for peer-to-peer learning.
- Provide ongoing technical assistance by email, and offer individual technical assistance calls as needed to answer participants' questions and help them address challenges.

- Consider forming work groups to support participants in their continued efforts to achieve Medicare reimbursement and to develop sound business practices for long-term sustainability of their programs.