National Chronic Disease Self-Management Education Resource Center

Final Report: Process and Findings from the 2016 DSMT and HBAI Learning Collaboratives

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Executive Summary

The following report provides a detailed account of the process of and results from a year-long effort spearheaded by the National Council on Aging (NCOA), National Chronic Disease Self-Management Education (CDSME) Resource Center, funded by the Administration for Community Living, Administration on Aging. Between January 28 and December 2, 2016, NCOA conducted two learning collaborative communities, one focused on Diabetes Self-Management Training (DSMT) and the other on Health and Behavior Assessment and Intervention (HBAI) services. The primary purpose of the learning collaboratives was to achieve integrated, sustainable service systems for CDSME programs by supporting state and community-based organizations as they worked toward obtaining reimbursement for their programs via the DSMT and HBAI Medicare benefits. Eleven organizations, each from a different state, were selected to participate in the DSMT learning collaborative, while nine organizations, also from different states, participated in the HBAI learning collaborative. Three organizations participated in both.

Implementation of both learning collaboratives included the delivery of a variety of forms of technical assistance, namely monthly call/webinar sessions, one-one-one support, an in-person meeting, and exchanges via the online community for each cohort. During the monthly call/webinar sessions, participants were given new information and resources and were encouraged to participate in opportunities for peer-to-peer interaction to share challenges, learnings, and best practices. Learning collaborative participants were asked to complete homework assignments that were instrumental in helping them move forward. The conference call/webinar session in December 2016 officially brought the learning collaboratives to closure. During the final months, key informant interviews were conducted to elicit information about progress, challenges, and ongoing needs.

The project goal was that participating organizations would achieve or would make significant progress toward achieving all the necessary tasks to obtain Medicare reimbursement for their services. To support participants in working toward this goal, a framework of change approach was adopted with specific steps, or incremental stages of change, focused on appropriate clinical supervision, accreditation (DSMT only), processes for documenting and tracking services, and billing. To make the necessary changes, each learning collaborative participant developed an implementation plan that outlined who its partners would be, as well as how or where the DSMT or HBAI services would be delivered.

As a result of the learning collaborative experience, participating organizations underwent varying degrees of change and progress within the framework of change. At the end of the learning collaborative period, participants consistently agreed that they now had the knowledge, skills, and resources necessary to make their programs viable through Medicare reimbursement. Additionally, they made a number of other noteworthy developments, including the formation of partnerships and/or mentoring relationships, the development of a model policy for health care referrals, and standards and person-centered support materials for DSMT.

As they worked toward achieving Medicare reimbursement, participants encountered a number of challenges, such as internal and external organizational changes, as well as the large amount of time, effort, commitment, and resources that were necessary to carry out the tasks associated with Medicare reimbursement. Yet, on the whole, both the DSMT and HBAI learning collaborative participants agreed that the project was instrumental in developing business acumen and gaining a practical understanding of how to become viable providers of health and wellness programs. They concurred that their participation was a very positive experience and that they would do it again. Their feedback, as well as the evaluative result gleaned from the project overall, led to a number of recommendations for future iterations of the DSMT and HBAI learning collaboratives. Taken together, this information clearly shows the benefits of this form of technical assistance and strongly points to the utility of offering future learning collaboratives.

Final Report: Process and Findings from the 2016 DSMT and HBAI Learning Collaboratives

1. Introduction

The purpose of this report is to describe the process and findings from the initial community-integrated health care learning collaboratives offered by the National Council on Aging (NCOA) National Chronic Disease Self-Management Education (CDSME) Resource Center, in collaboration with the Administration for Community Living, Administration on Aging (ACL/AoA), to support integrated, sustainable service systems for expanding evidence-based CDSME programs. Two learning collaborative communities, one focused on Diabetes Self-Management Training (DSMT) and the other on Health and Behavior Assessment and Intervention (HBAI) services, were launched in January 2016 to support the network of CDSME partners in working toward reimbursement for their services through these two distinct Medicare benefits. The DSMT learning collaborative was also intended to prepare participants for getting their diabetes self-management programs accredited by the American Association of Diabetes Educators (AADE) or the American Diabetes Association (ADA), a requirement for Medicare reimbursement. Each learning collaborative was designed to create a rich learning environment in which participants would work together toward their specific aims, which were aligned with the project goal of achieving or making significant progress toward achieving specific tasks that are necessary to bill Medicare for DSMT and HBAI services.

2. Background, Evolution, and Leadership of the Learning Collaboratives

As a result of multiple funding opportunities from ACL/AoA, significant gains have been made toward developing diverse partnerships within states across the U.S. to expand CDSME programs and embed them within organizational operations. A number of organizations have developed sustainability and/or business plans to guide program efforts in their states toward continued growth and sustainability beyond grant funding. However, as they endeavor to implement their plans, they are faced with major challenges. These challenges stem, in part, from inadequate business skills or business acumen, as well as from a lack of understanding of health care regulations in a rapidly changing environment, including payment models and billing procedures. While Medicare reimbursement for CDSME programs is available through defined benefits when specific circumstances are met, community-based programs are not accessing these benefits. The DSMT benefit is far under-utilized, and when the learning collaboratives were formed, none of the organizations in the CDSME network offered the HBAI benefit, even though it provides an avenue for reimbursement of the Stanford Chronic Disease Self-Management Program.

In recognition of the need for additional support and technical assistance to help the CDSME network promote the value of their programs and take advantage of opportunities to be reimbursed or paid for their services, NCOA formed a Community-Integrated Health Care Leadership Team. The purpose of the Leadership Team is to provide leadership, guidance, subject matter expertise, and specialized technical assistance to support the network of partners with their efforts to integrate CDSME programs as valued and essential components of health care. Through this collaborative leadership model, the ultimate goal is to expand integrated, sustainable service systems for CDSME programs, making them accessible in communities everywhere throughout the U.S. to improve the health and quality of life of older adults and adults with disabilities. As shown in Table 2.1, the membership is comprised of key NCOA staff, the ACL/AoA project officer, subject matter experts, and leaders from exemplary community-based organizations (CBOs). Additionally, NCOA engaged a Project Evaluator for the learning collaboratives to monitor and provide feedback on performance, apply methods for quality improvement throughout the learning period, and work with the leadership team to document the process and the findings.

Table 2.1 Leadership for Community-Integrated Health Care Efforts

Community-Integrated Health Care Leadership Team, by Affiliation	
NCOA Staff (Internal)	
Senior Director National CDSME Resource Center	Provides leadership, supervision, and oversight for the Resource Center and the community-integrated health care initiatives.
Senior Program Manager National CDSME Resource Center	Responsible for planning and leading the community-integrated health care work of the Resource Center.
ACL/AoA	
Kristie Kulinski, MSW	Administration for Community Living/Administration on Aging
Subject Matter Experts and Community-Based Organization Leaders	
Mary Altpeter, PhD, MSW, MPA	University of North Carolina, Center for Health Promotion and Disease Prevention
Leigh Ann Eagle, BS	Maintaining Active Citizens (MAC Inc.), Living Well Center of Excellence
Neal Kaufman, MD	Canary Health
Sue Lachenmayr, MPH	MAC Inc., Living Well Center of Excellence
Lynnzy McIntosh, BA	Consortium for Older Adult Wellness
Timothy McNeill, RN, MPH	Independent Consultant
Robert Schreiber, MD	Hebrew Senior Life, Healthy Living Center of Excellence, Harvard Medical School
Sharon R. Williams	Williams Jaxon Consulting, LLC
Project Evaluator, 2016 Learning Collaboratives	
Katherine Leith, PhD, LMSW	College of Social Work, University of South Carolina

In December 2015, NCOA convened the Leadership Team for a full-day planning session to set the direction for the community-integrated health care work and afterward continued to engage the members in a planning process that led to the development of NCOA's Roadmap to Community-Integrated Health Care (CIHC). The Roadmap is a strategic framework, consisting of four broad components that are necessary to guide the network of partners toward the goal of community-integrated care: 1) leadership, 2) learning collaboratives, 3) an online multi-level CIHC Toolkit, and 4) public policy and advocacy.

The decision to conduct learning collaboratives as one of the Roadmap strategies was based on a number of factors. First, the Learning collaborative approach is recognized in relevant literature as an effective means for spreading, adopting, and adapting best practices across multiple settings and for creating organizational changes that promote the delivery of effective interventions and services. The model incorporates the widely accepted belief that knowledge can be created within a group where participants share experiences and work together to search for solutions or to create products of their learning. The learning collaborative approach has been shown to overcome challenges related to reducing the disparity between actual and best practices by convening groups of practitioners from different and often disparate organizations to foster learning about best practices,

create and share effective strategies for making improvements, and test and implement changes across organization.

Another factor that played into the decision to form learning collaboratives was the success that ACL was experiencing in conducting business acumen learning collaboratives via its Center for Integrated Programs, Office of Integrated Care Innovations. The enhanced support and technical assistance provided through the learning collaborative format was found to be effective in helping participants build business capacity to work effectively with integrated health care entities. Additionally, a number of evaluative indicators (e.g., the 2015 CDSME Integrated Services Delivery System Assessment Tool and the 2014 and 2015 CDSME Resource Center Needs Assessments) pointed to the need for the provision of more targeted technical assistance to support grantees, former grantees, and other state and CBOs in their efforts to develop integrated, sustainable service systems for CDSME programs.

3. Planning and Establishing the Structure of the DSMT and HBAI Learning Collaboratives

During the late fall and early winter of 2015, the Resource Center began planning and coordinating the specific tasks necessary for successful implementation of the learning collaboratives. Learning Collaborative Charters were developed to inform the network of the specific purpose, timeline, aims, and expectations, and support that would be provided from the Resource Center. The Charters are available on NCOA's website[1].

Purpose and timeline. As described in the Charters, the primary purpose of the learning collaboratives was to achieve integrated, sustainable service systems for CDSME programs by supporting states and CBOs as they work to obtain reimbursement for CDSME services provided under the Medicare DSMT and HBAI benefits. A timeline of ten months was established. The learning collaborative initiative launched on January 28, 2016, and concluded on December 2, 2016.

Goal and framework of change. The overarching goal of the learning collaboratives was that participating organizations would achieve or make significant progress toward achieving the necessary tasks to obtain Medicare reimbursement for their services. To support this goal, NCOA adopted a framework of change approach with specific steps or stages of change along a continuum of change. As described in the Community Toolbox, the online resource developed by the University of Kansas to build healthier communities and bring about social change[2], this approach provides a pathway of activities which are implemented to achieve intended outcomes. It involves communicating a description of the purpose and direction of an initiative, an outline of the initiative's goals and objectives, explanation of the initiative's scope and strategies to effect change, and adjustments in the course as needed to achieve the intended outcomes.

In applying the framework of change approach, NCOA administered individual readiness assessments for DSMT and HBAI to each organization to determine its degree of readiness to work toward the project goal. Recognizing the importance of effective partnerships to carry out the project, NCOA also asked each organization to identify partners and potential partners that could help achieve the desired outcomes. The following key steps or stages of change were identified as necessary for success: 1) appropriate clinical supervision and oversight, 2) changes focused on accreditation (DSMT only), 3) necessary processes in place for documenting and tracking services, and 4) a Medicare provider number or billing partner and billing processes.

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[1] See https://www.ncoa.org/center-for-healthy-aging/cdsme-resource-center/sharing-best-practices/community-integrated-health-care/learning-collaboratives/

[2] See http://ctb.ku.edu/en/4-developing-framework-or-model-change

Support provided to participants. As shown in Table 3.1, a variety of technical assistance approaches and communication strategies were established to support the participants throughout the implementation period.

Table 3.1 List of DSMT and HBAI Technical Assistance Approaches and Communication Strategies

Schedule	Strategy	*Description*
January 2015	Orientation	Welcome email, recommended readings, and "Crash Course"
Monthly	Conference calls/webinars	Interactive presentations on selected topics, with group discussion and peer-to-peer sharing to increase knowledge and understanding of the steps to achieve the learning collaborative goals.
Ongoing	An online community for each learning collaborative cohort	An online site to post webinars, recordings of calls, resources, and best practices; foster peer-to-peer interaction; and provide answers to questions between monthly conference calls.
Midpoint, endpoint, and as needed	One-on-one technical assistance	Time with Tim McNeill, independent consultant, for participants and their partners to ask questions specific to their unique concerns and to receive guidance for implementing their programs; one-on-one technical assistance was made available to all participants at mid-point and at the end of the learning collaborative period and upon request throughout the ten-month period.
May 2016	In-person meeting	An opportunity for participants to come together in person to share their progress and learn from one another.

Announcement and selection of participants. On December 3, 2015, NCOA sent an email to the network of CDSME partners to announce the learning collaborative project and to invite interested organizations to apply. The invitation included the learning collaborative Charters to inform organizations of the aims and expectations, as well as outline the support that NCOA would provide to learning collaborative participants. Interested organizations were asked to respond with a paragraph or two describing their level of readiness and any progress that they had made toward stated learning collaborative aims. They were also asked to designate a liaison to serve as a point of contact for participating on the monthly calls/webinars and to list local partners who could assist with the effort.

NCOA announced the selection of participants for both learning collaboratives on December 23, 2015. The DSMT learning collaborative originally consisted of eleven participants, but due to staff turnover resulting in loss of one of the designated liaisons, only ten organizations were able to complete the process. Nine organizations were selected to participate in the HBAI learning collaborative. As shown in Table 3.2, a variety of organizations from different states participated in one or the other learning collaborative. The Health Foundation of Florida, Maintaining Active Citizens (MAC Inc.) Living Well Center of Excellence in Maryland, and Michigan State University (MSU) participated in both learning collaboratives; different liaisons were assigned for DSMT and HBAI.

Table 3.2 DSMT and HBAI Participation, by Learning Collaborative Type and State

Type	Participating Organization		Designated Liaison
DSMT	CA	Partners in Care Foundation	Karol Matson
	CT	Department of Public Health	Cindy Kozak
	CO	The Center for African American Health*	Glenda Mitchell
	FL	Health Foundation of Florida	Carol Montoya
	MD	MAC Inc.	Leigh Ann Eagle
	MI	MSU	Laura Anderson
	NC	Centralina Area Agency on Aging	Linda Miller
	OR	Northwest Senior & Disability Services	Lavinia Goto
	PA	Philadelphia Corporation on Aging	Bea Winn
	TX	North Central Texas Area Agency on Aging	Doni Green
	WI	Wisconsin Institute for Healthy Aging	Betsy Abramson
HBAI	CO	Colorado Department of Human Services	Doreen Gonzales
	FL	Health Foundation of Florida	Martha Pelaez
	IL	AgeOptions	Robert Mapes
	MD	MAC Inc.	Sue Lachenmayr
	MI	MSU, Research Initiatives, College of Human Medicine, Office of Research	Joan Ilardo
	MS	Mississippi State Department of Health	Caroline Newkirk
	OR	Rogue Valley Council of Governments Area Agency on Aging	Lauren Champagne
	SD	South Dakota State University, Better Choices, Better Health Program	Vicky Palmreuter
	VA	Valley Program for Aging Services	Joyce Nussbaum

* Unable to complete the learning collaborative due to staff turnover

4. Implementing the DSMT and HBAI Learning Collaboratives

The implementation phase consisted of learning periods, followed by action periods during which participants implemented the framework of change toward the goal of integrated, reimbursable services. New information and resources were provided throughout the duration of the learning collaboratives, along with opportunities for peer-to-peer interaction to share challenges, learnings, and best practices. As participants learned new information and developed business acumen skills, they worked with their local partners to make incremental changes toward the intended outcomes.

NCOA's Senior Program Manager coordinated and facilitated the monthly conference call/webinar sessions and served as NCOA's point of contact to provide technical assistance, share new information, and respond to inquiries and questions between monthly calls. She also guided the development of new resources; posted webinars, resources, best practices and other information via the online communities; and ensured that learning collaborative activities were conducted accordingly, as outlined in the Charters, to support participants in achieving their goals.

Tim McNeill, a member of the leadership team, served as faculty and lead subject matter expert, working closely with NCOA's Senior Director and Senior Program Manager to plan the training content for the monthly call/webinar sessions and the in-person meeting and to develop new tools and resources for the learning collaborative participants. He presented the topic-specific trainings each month and served as a primary technical assistance resource to participants throughout the learning collaborative period.

To provide additional support, NCOA enlisted a registered dietitian from Elder Services of the Merrimack Valley (ESMV) to serve as a mentor to participants of the DSMT learning collaborative. She participated on the group monthly call/webinar sessions to provide a practical experience perspective. Also, during the project period, several organizations reached out to ESMV on an individual basis for real-world insight and guidance.

Monthly conference call/webinar sessions. Monthly conference call/webinar sessions were a key component of the learning periods. The 90-minute interactive sessions consisted of programmatic updates; sharing challenges, progress, and best practices; presentation of new information; group discussion; and problem solving. Polls, surveys, and round-robin sharing were used to enlist feedback from each group regarding its needs and recommendations for future topics.

As shown in Table 4.1, the monthly webinar topics were congruent between the two learning collaboratives because the mechanisms for successfully preparing an organization for Medicare reimbursement are fundamentally the same, regardless of which benefit is used for reimbursement. Content within the broader topic was then geared for the specific group, i.e., DSMT or HBAI, as needed.

Table 4.1 Monthly Conference Call/Webinar Session Topics

Month	Topic
January	Orientation
February	A Roadmap to Community Healthcare Integration
March	How to Build Partnerships: Landing the Contract
April	Ask the Expert Panel: The Ins and Outs of the Break-Even and Market Analyses
May	In-Person Meeting
June	Program Sustainability Models and Rate Changes for 2016
July	Understanding the Medical Loss Ratio, Healthcare Effectiveness Data and Information Set Measures, and Medicare Star Ratios
August	Medicare, Billing, and Other Topics
October	Billing, Referral Patterns, and Growing Your Programs
December	Learning Collaborative Closure and Next Steps

Homework assignments. As part of the ongoing effort to assist learning collaborative participants in moving toward Medicare reimbursement of their CDSME programs, participants were asked to complete a number of homework assignments designed to help them understand the basics of and take the necessary steps toward building strong business acumen skills. Initial homework involved participants assessing their readiness for seeking Medicare reimbursement and developing an organizational profile with a listing of partners and measurable aim statements of what participants intended to accomplish by the end of the learning collaborative period. Later homework was designed to help participants determine their position in the marketplace and to figure the costs

associated with providing the services, compared to the reimbursement rates. Table 4.2 shows a list and description of all homework, in chronological order.

Table 4.2 List of DSMT and HBAI Learning Collaborative Homework, by Due Date

Due Date	Homework	*Description*
January 2016	Organizational Profile with Aim Statements	A worksheet for each learning collaborative participant to provide a written overview of the lead organization, listing of key partners and potential partners; brief summary of progress; and identification of specific aim statements and action steps that would serve as their framework of change toward the learning collaborative goals; designed to provide participants and NCOA with clear, well-defined objectives desired by each organization.
February 2016	Readiness Assessment	Individual assessment tools for DSMT and HBAI with a detailed checklist of activities that are necessary to achieve accreditation for DSMT and reimbursement for DSMT and HBAI; designed to help participants determine their readiness, degree of progress, and next steps; important in helping NCOA identify and plan for the technical assistance needs to support participants.
April 2016	Market Analysis	Designed to help learning collaborative participants gather important data on potential customers and competition in the marketplace; the data assisted organizations in their business decision-making process and served as an effective strategy in reducing the risks associated with those decisions.
April/May 2016	Break-Even Analysis	Designed to help learning collaborative participants determine the minimum number of workshops that must be offered within a given time frame to cover the costs associated with offering the program; a rough gage of what learning collaborative participants need to "sell" monthly or annually to cover their cost of doing business.

Staying connected. As presented earlier in Table 3.1, NCOA used a number of strategies or approaches to keep participants engaged and connected throughout the learning collaborative process. In addition to the formal strategies, informal communications, such as emails and phone calls, were used on an as needed basis to exchange information or to seek clarification about issues that related to an individual DSMT learning collaborative or HBAI learning collaborative participant.

5. Concluding the DSMT and HBAI Learning Collaboratives

Two closing activities were offered to bring the learning collaboratives to a successful conclusion, a final conference call/webinar session for each cohort and in-depth key informant interviews with learning collaborative participants. Feedback from key informants was used to evaluate the project's activities and outcomes, determine the overall effectiveness of the project, and inform decisions about future learning collaboratives.

Final conference call/webinar session. A final 90-minute conference call/webinar session was held on December 2, 2016 for each cohort to officially bring the learning collaboratives to closure. The overall content was consistent for both groups, although there were some differences related to the specific benefit, i.e., DSMT or HABI. Each session began with organizations sharing their successes, insights, and inspirations gained as a result of the learning process. Topics covered

during the webinar presentation included Medicare updates and opportunities, review of strategies to compete in the marketplace, preliminary findings from the evaluation, and ongoing support that NCOA will make available to participants as they continue to work toward integrated, sustainable CDSME programs within their states.

Key informant interviews. Telephone interviews were conducted with each participating organization with a two-fold purpose: 1) to provide an opportunity for in-depth one-on-one technical assistance calls with Tim McNeill, faculty for the learning collaboratives; and 2) to gather qualitative evaluation data on the learning collaborative experience and results. Between October 17, 2016 and December 6, 2016, interviews were held with all ten organizations that completed the DSMT learning collaborative and all nine that completed HBAI. The learning collaborative liaison or designee who played a lead role throughout the process served as the primary respondent to a set of broad, open-ended questions designed to elicit common information across interviews. Some organizations invited other key staff and partners to participate in the calls. The calls were recorded, and notes were taken during the calls; later, the recordings were transcribed. As needed, follow-up contact was made with the key informants via email or phone to clarify information. The interview transcripts were used to develop this report and have been stored for future reference.

The interviews lasted 90 minutes, with the technical assistance and evaluation portion of the calls held back-to-back. In some instances, due to the need for more time for the technical assistance portion, a separate second call was scheduled for the evaluation component; two participants opted to provide some or all of the responses to the evaluation questions in writing after their technical assistance call was held.

The technical assistance portion of the calls provided an opportunity for participants to ask questions, discuss challenges, problem solve, and strategize their next steps with the assistance of Tim McNeill. A variety of implementation models were revealed through these discussions and are outlined later in this report. The questions in the evaluation component were designed to gather data about participating organizations' partnerships, progress, challenges, learnings, and ongoing needs. Questions were also asked about participants' perceptions regarding the collaborative – what went well and what could have been done better – and their recommendations regarding replication of HBAI and DSMT learning collaboratives in the future. Questions were identical for both groups, with the exception of a question about accreditation status that was added for DSMT informants. The calls provided rich, detailed information, which is summarized in the remainder of this report and has potential to be used in the development of new resources (e.g., tip sheets, frequently asked questions, and success stories/best practices) to assist others who wish to provide and receive reimbursement for DSMT and HBAI services. The almost identical nature of the questions resulted in overlap in responses and similar findings. For those questions, the responses are combined. However, where variances occurred, those findings are noted.

Key partnerships and implementation plans. Each learning collaborative participant developed an "implementation plan" that outlined who their key partners would be, as well as how and where the DSMT or HBAI services would be delivered. Broadly, partner roles that were described by learning collaborative participants fall into the five types or categories: 1) implementation, 2) leadership or advisory 3) billing, 4) clinical oversight, and 5) referral.

Implementation partners are those organizations that play a major role in delivering DSMT and/or HBAI services by conducting CDSME workshops in their designated geographic areas through their infrastructure of leaders and master trainers. Sometimes, implementation partners also have other important roles, such as becoming the accredited DSMT organization, serving as the Medicare provider to bill the services, or the required clinical supervision and oversight. The diversity of implementation plans and partners is shown in Table 5.1 and 5.2 for DSMT and HBAI respectively.

For the most part, leadership or advisory partners were already in place to provide a collaborative leadership approach for CDSME program delivery within each designated state or region. Typically state departments of aging, state departments of health, and academic institutions are involved, along with a variety of other partners unique to each state. These existing partnerships could be leveraged for HBAI services. To meet the American Association of Diabetes Educators (AADE) or American Diabetes Association (ADA) accreditation standards, each organization in the DSMT learning collaborative was required to form and convene a separate DSMT advisory council for their initiative.

Some learning collaborative participants decided to obtain their own Medicare tax identification number, while others wanted to develop partnerships with organizations that were already Medicare providers to serve as the billing partner. In many instances, existing partnerships were leveraged to carry out the billing function. Billing partners included CBOs and health care entities, as well as other internal organizational units. For example, Michigan State University Extension is collaborating with its HealthTeam medical practices, and Mississippi Department of Health is partnering with its diabetes initiative to carry out the billing function.

Similarly, a variety of approaches were identified to provide the necessary clinical supervision and oversight required for DSMT and HBAI reimbursement. These included providing the supervision internally, contracting with a clinician, or developing an agreement with another organization to serve as the clinical supervision partner.

To develop effective and financially sustainable programs for DSMT and HBAI services, learning collaborative participants also needed to identify referral partners or those partners that would serve as "referral pipelines" for their programs. Common referral partners included health care organizations, federal Quality Improvement Organization Programs (DSMT only), Area Agencies on Aging or Aging (AAAs), Aging and Disability Resource Centers (ADRCs), senior centers, and public health departments.

While all participating organizations had some referral partners at the start of the learning collaborative project, most were not receiving enough or the right kind of referrals, i.e., billable referrals, to cover the costs of providing their new DSMT or HBAI initiatives. Therefore, learning collaborative participants had to think critically about how they could build referrals to support their new services. In the early stages of the project period, participants were generally focused on addressing the more immediate issues related to implementing new services. However, toward the end of the project period, when other programmatic issues had been successfully addressed, participants were starting to realize that they needed to focus more attention on building referrals. To support those efforts, NCOA provided specific strategies for increasing referrals during the last two monthly call/webinar sessions, as well as during the one-on-one technical assistance calls that were held with learning collaborative participants at the conclusion of the project.

Table 5.1, DSMT Implementation Plans and Key Implementation Partners by State

State	Implementation Plan	Implementation Partners
CA	Partners in Care Foundation will serve as the accredited organization to coordinate the DSMT effort through its network hub, making DSMT available at multiple sites in conjunction with its network of implementation partners.	• AAAs • CBOs: senior housing sites, senior centers, and other sites • Health clinics
CT	The Department of Public Health will offer DSMT through a contractual relationship with a CBO to implement the program. Once the program is well established, DPH plans to expand it to four additional sites.	• CBOs: CT Community Care Inc. • AAAs: one as an expansion site • Public health districts: three as expansion sites
FL	FL Health Networks will serve as the network hub to implement DSMT through its network of partners, starting with one permanent site and then expanding to four other sites.	• ADRCs: Elder Options (initial site), four additional ADRCs (expansion sites)
MD	MAC Inc.'s Living Well Center of Excellence will serve as the accredited organization and the network hub to implement DSMT through its network of community-based and hospital partners.	• State Agencies: MD Department of Health and Mental Hygiene • AAAs • Health care entities: Peninsula Regional Medical Center
MI	MSU Extension plans to implement its DSMT program, as well as HBAI services, through its statewide network, in conjunction with its vast group of medical practices.	• State Agencies: Statewide network of MSU Extension educators, MSU HealthTeam medical practices
NC	Centralina AAA, which serves a nine-county region, intends to establish a foothold for its DSMT program in Gaston County and then expand to Mecklenburg and Union Counties in 2017.	• Aging service providers: Gaston, Mecklenburg, and Union counties
OR	Northwest Senior and Disability Services (NWSDS) AAA, which covers five counties, is working in collaboration with the state AAA association to implement DSMT. The association will become the accredited organization and the Medicare provider to serve as the network hub for DSMT services. NWSDS and a second AAA will operate as the two initial implementation sites, with potential for expansion to other sites later.	• Oregon Association of AAAs and Disabilities • AAAs: Multnomah AAA (one of two initial sites)

State	Implementation Plan	Implementation Partners
PA	Health Promotion Council, an affiliate of Public Health Management Corporation, is working in collaboration with the state aging and public health departments to develop a statewide network for DSMT by serving as a technical assistance center to support existing diabetes programs in becoming accredited and receiving reimbursement for their services. Health Promotion Council is also leveraging health care partnerships to grow and sustain DSMT throughout the state.	• State Agencies: PA Department of Aging, PA Department of Health • AAAs: Philadelphia Corporation for Aging (initial site)
TX	North Central TX AAA, which serves a 15-county region, is exploring the potential to become accredited to provide DSMT and working to identify a clinician that can provide oversight for the program.	• Aging service providers within AAA region
WI	After thoughtful planning and consideration, Wisconsin Institute for Healthy Aging (WIHA), which serves as the state network hub for CDSME programs, has decided not to pursue accreditation or Medicare reimbursement for DSMT; instead WIHA has opted to offer the Stanford Diabetes Self-Management Program (DSMP) without enhancements and is negotiating a contract with a health plan to pay for that service.	• State Agencies: WI Department of Aging and Elder Services, WI Department of Health Services • AAAs, aging service providers, and other CBOs

Table 5.2 HBAI Implementation Plans and Key Implementation Partners by State

State	Implementation Plan	Implementation Partners
CO	The Department of Aging plans to implement HBAI through one of the Area Health Education Center (AHEC) that covers 16 counties in the southeastern portion of the state.	• Southeastern Colorado AHEC
FL	FL Health Networks is exploring getting its Program to Encourage Active Lives for Seniors reimbursed by Medicare, in conjunction with its network of ADRC partners.	• ADRCs: network of partners that offer PEARLS
IL	After weighing the options, AgeOptions AAA has decided to focus on DSMT first and then explore how HBAI can be added as a service to help individuals with multiple medical conditions overcome the barriers to managing their health. AgeOptions is exploring contractual relationships with managed care organizations and other health entities to provide a menu of services, including DSMT and HBAI, within its region.	• Aging service providers: within the AAA region

State	Implementation Plan	Implementation Partners
MD	MAC Inc. intends to implement DSMT first and then explore the possibility of including HBAI in its wrap-around services, leveraging both Medicare and Medicaid funding. MAC is exploring offering HBAI services for patients who are being served by a hospital-sponsored Weight Loss Center.	• MD Department of Health and Mental Hygiene • AAAs • Health care entities: Peninsula Regional Medical Center
MI	MSU Extension plans to implement both HBAI and DSMT through its statewide network, in conjunction with its vast group of medical practices.	• State agencies: Statewide network of MSU Extension educators, MSU HealthTeam medical practices
MS	The Department of Health intends to rollout HBAI services through its public health districts as a complement to its diabetes initiative within the Office of Preventive Health.	• State agencies: MS Department of Health public health districts
OR	Rogue Valley Council of Governments AAA is working to find a health care entity that will help provide the necessary infrastructure to deliver the program.	• Aging service providers in the AAA region
SD	SD State University Extension (SDU) is laying the groundwork for an infrastructure that will support HBAI services, including development of draft model policies for health care referrals. SDU plans to explore partnerships with regional health hospitals and clinics.	Health care entities: exploring potential partnerships to provide the necessary infrastructure for HBAI
VA	The Department of Aging Services plans to offer HBAI services through its partnerships with AAAs, starting in two regions and later expanding to others. Referrals will be solicited from skilled nursing facilities and rehabilitation centers as patients are discharged back into the community.	AAAs: Jefferson Area Board for Aging (initial site), Valley Program for Aging Services (expansion site)

Progress and accomplishments. During the ten-month learning collaborative process, participants worked together to achieve or make significant progress toward achieving the stages of change necessary to receive Medicare reimbursement for DSMT or HBAI services. Additionally, the diabetes learning collaborative participants worked toward attaining national accreditation for their DSMT programs, a requirement for Medicare reimbursement. The learning collaborative process was not a straightforward path from point A to B; rather, it was involved, dynamic, and complex. A number of internal and external environmental factors, often outside of the control of participants, affected both the process and the outcomes. To some extent, the process was defined by the unique make-up of each participating organization, its delivery infrastructure model, and the political and health care environment within each state. Despite these differences, there were certain activities in the process that were common to all participants and were critical to achieving the desired outcomes, e.g., conducting the market analysis and the break-even analysis. The completion of these activities in and of themselves can be considered an accomplishment, as participants were learning and applying business acumen skills that would make their integrated care efforts more successful in the long run.

Certain stages of change within an overall framework of change were tracked throughout the process. These incremental changes focused on appropriate clinical supervision, accreditation (DSMT only), processes for documenting and tracking services, and billing. As in shown in Table 5.3 below, two of the ten states that completed the DSMT learning collaborative (CT, NC) made it to the final goal of having all the measures in place to bill Medicare. Additionally, they each submitted their first claims. Three other organizations were close to achieving the endpoint goal (FL, MD, PA); two of the three submitted their accreditation applications (MD, PA), and one had its DSMT test class underway (FL), with plans to submit the accreditation application in December. Five of the nine organizations that participated in the HBAI learning collaborative had achieved the appropriate clinical supervision and submitted or received their Medicare tax identification numbers. At the end of the project period, the Virginia Department of Aging was conducting its first HBAI workshop, which will be billed retroactively once its billing partner, the Jefferson Area Board for Aging, receives a Medicare tax identification number (the application has been submitted). Regardless of the stage of change, participants concurred that they had gained business acumen knowledge and skills and had the necessary resources to continue their progress. It will be important to continue tracking the progress of participants to highlight their successes and share their learnings.

Table 5.3. Framework of Change Progress, by State

Stage of Change	DSMT	HBAI
Clinical Supervision		
Clinician available or in place	CA, CT, NC, MD, PA, FL, MI,OR	FL, IL, MD, MI, MS, OR, VA
Exploring options		CO, SD
Solicited bids from clinicians and exploring financial feasibility	TX	
Accreditation		
Accredited	(CA, CT*) NC	
Application submitted	MD, PA	
Test class underway	FL	
Working on application	TX, MI, OR	

Stage of Change	DSMT	HBAI
Processes for documenting and tracking workshops		
Track workshop and identifiable participant data via a database	CA, CT, MD, OR, PA, WI	MD, CO, IL
Track workshop and identifiable participant data via spreadsheets	FL, NC, TX	FL, MS, SD, OR, VA
Exploring an integrated documentation and billing system linked with the EHR	MI	MI
Billing		
Submitted claims to Medicare	CT, NC	
Received or submitted application for Medicare Tax ID number	CA, MD, MI, NC	MD, MI, MS, VA
Developed an agreement with a partner to serve as the Medicare provider	FL (health care partner), OR (AAA association)	FL (health care partner)
Exploring options for billing DSMT/HBAI services	PA, TX	CO, IL**, OR, SD
* Accredited when project began ** Have a Medicare provider/billing partner for DSMT that could potentially be used for HBAI, but also weighing options of getting their own Medicare tax ID number		

In addition to the above stages of change, key informants described other notable activities and accomplishments associated with their efforts. While not a complete listing, some of these activities and accomplishments are highlighted below:

- **AgeOptions, IL –** is partnering with the Illinois Department of Human Services to broach and further explore the topic of contract development with Medicaid Managed Care Organizations for a menu of services, which may include HBAI.
- **Centralina AAA, NC** – is mentoring a neighboring AAA that has just begun its DSMT accreditation process.
- **Connecticut Department of Health** – is developing a set of "quality leaders plus missing pieces" standards; it will not only create specific standards for DSMT leaders but offer suggestions for adding necessary educational components to the Stanford program that the registered dietitian will offer to assure a high quality DSMT program.
- **Colorado Department of Human Services**, **Division of Aging and Adult Services** – is partnering with the State Medicaid Agency to evaluate the impact of its Stanford Chronic Disease Self-Management Program on health claims data; preliminary findings are positive, and the Division of Aging is optimistic that results from the study will help engender support for HBAI.
- **Florida Health Networks** – is developing standard practices for person-centered support materials that will be given to each DSMT participant.
- **MAC Inc. Living Well Center of Excellence, MD** – will offer the Diabetes Prevention Program (DPP), along with DSMT, which will strengthen its recognition as a provider of diabetes services; MAC, Inc. receives referrals on a daily basis from its hospital partners, including the Peninsula Regional Medical Center's Weight Loss Center, whose campus is co-located.

- **Michigan University Extension** – has just received a new Partners in Aging Strategies and Training (PAST) grant from the Michigan Endowment Fund to advance integrative services models and improve health outcomes for individuals with chronic health conditions. This initiative will reinforce the importance of CDSME, including the DSMT and HBAI services.
- **South Dakota State University** – is developing a model policy for health care referrals, which is in the final stage of internal review.

Challenges. When asked about their biggest challenges, by far, the most common response across both learning collaboratives was the time, effort, commitment, and resources that were involved in understanding and carrying out the tasks associated with Medicare reimbursement for DSMT and HBAI services. Key informants reported that initially, there was a "learning curve" to understand what was expected and to figure out how to implement DSMT and HBAI services within their respective organizations or partner networks. They had not realized in advance how much time and effort it would take, not only to learn about the specific Medicare business model, but also to put those learnings into practice. They came to realize that, while operating as a business was important and necessary for sustainability of their programs, it was also complex, time consuming, and "a lot of work." They found it challenging to balance their time between the learning collaborative project and other competing organizational priorities. As the project progressed, there was a "reality check" of what was and was not doable, which helped learning collaborative participants become clearer about what could be done and how to go about it.They were committed to doing the work and saw real value in it.

Several key informants also pointed to their own internal organizational instability, such as changes in leadership, staff turnover, funding shortages, and layoffs that set back their timelines. Further, they expressed disappointment that partners were not always able to fulfill their commitments for a variety of reasons, which delayed progress. Despite these setbacks, the learning collaborative participants maintained an optimistic outlook and understood the importance of taking the long view. There was a recognition that slow progression toward the final product (i.e., Medicare reimbursement) is a small price to pay if it ensures that the final product is well thought-out and well-received.

In addition to issues internal to their organizations, key informants across both learning collaboratives identified the rapidly changing health care sector as a significant challenge. They cited changes in leadership; new rules and regulations, such as MACRA, that were a higher priority; and new medical record systems as barriers to enlisting the support of health care entities for DSMT or HBAI services. Aware of the importance of timing, they tread lightly, making efforts to maintain and nurture relationships with the hope that in the long run, they would build strong, lasting partnerships.

Key informants mentioned two challenges unique to DSMT. First of all, they found that diabetes educators who work in hospitals with their own diabetes programs often perceive community-based providers as a threat, even though the hospitals serve only a small portion of individuals with diabetes. Given this perception, the learning collaborative participants were very cautious about promoting their programs because they did not want to damage relationships that had been established. While initially they were excited about the opportunity to change the way they were "doing business," as they faced the reality of what that meant, they found themselves oscillating between maintaining the status quo and evolving their business model. As stated by one participant, "Seeing ourselves as health care providers is a switch. It is difficult convincing internal and external customers that the programs are valuable, but the world is changing."

A related challenge expressed by several DSMT learning collaborative participants was that they were not receiving enough referrals or the right kind of referrals. This challenge was due, in

part, to their focus on hospitals and CBOs as primary referral sources, rather than seeking out other niches in the marketplace that offer potential for more of the right-kind of referrals. To address this challenge, NCOA provided training and technical assistance to help participants understand the importance of forging new referral partnerships. Information was provided to encourage partnerships with physician practices and federal Quality Improvement Organizations, as well as enrollment in Medicare Advantage plans.

Key learnings. When asked about key learnings, both groups strongly concurred that they developed business acumen and gained a practical understanding of what they need to do to "rebrand" themselves as viable providers of health and wellness programs that have value in the marketplace. They came to understand the importance of applying their newly developed skills to sustain their programs and felt that they could now "speak the language" of the health care to promote their services in a way that would be well received. They explained that they understand the specific Medicare benefits and the detailed requirements for billing. They elaborated that they understood the costs associated with offering the services, how to position themselves to compete in the marketplace, what is necessary to break even, what is entailed in documenting and billing for the services, and the importance of enrolling in Medicare Advantage plans. Regardless of their specific stage of incremental change, they pointed out that they understood the step-by-step process for reimbursement, had the tools available to continue to take steps forward, and felt confident in their ability to do so. They also learned that they "are not in this alone," and found it comforting have the support of others and helpful to share their experiences with one another.

Ongoing needs of learning collaborative cohorts. When asked what additional support they need beyond the project period, key informants unanimously agreed that they want to stay connected and be able to access the webinars, call recordings, and resources that are posted on the online communities. They would like a forum to exchange views and to share their progress, challenges, and learnings as they continue to work toward integrated, sustainable service systems for their programs. They would also like NCOA to post new resources and information that is relevant to DSMT and HBAI via the online communities. Informants also universally agreed that it would be very helpful to have access to one-on-one technical assistance from Tim McNeill on an as-needed basis to ask questions, overcome hurdles, and strategize next steps.

The majority of informants also liked the idea of having quarterly conference calls with their peers, although they had different ideas as to what those calls should entail. Suggestions included topic-specific calls, round-robin check-ins to share progress and new learnings, and group discussion among participants who are at a similar stage in their business acumen development, with ample opportunity for questions and answers.

Additionally, various themes, which point to the ongoing technical assistance needs of the learning collaborative participants, evolved from the technical assistance calls. Discussions centered on the following topics:

- billing logistics and required documentation,
- difficulties establishing a "referral pipeline,"
- uncertainty about how to secure buy-in from potential partners,
- concerns about competing with hospitals (DSMT),
- inquiries about the new MACRA rules,
- issues with covering costs/breaking even, and
- discussion about data management and billing systems.

Key informants perception of the experience. Across the two learning collaboratives, key informants shared very similar views about their organizations' participation and about the extent to which the effort was a valuable experience.

Overall experience. Key informants responses to the question, "How would you summarize your experience?" were consistently positive, with participants across both learning collaboratives agreeing that the project was extremely worthwhile and beneficial. They recognized the important contributions of the project toward helping them understand and put into practice business acumen concepts to develop integrated, sustainable programs. Regardless of the extent to which their specific aims were met, they agreed that they had gained and were applying new knowledge and skills to improve the results of their community-integrated health care efforts. Two participants reported that they found the experience to be stressful at first, but as the process evolved, they felt secure and confident in their ability, as well as very positive about the experience. One stated, "Now, it feels as though we can do it." Two participants who were more advanced in terms of their stage of "readiness" for the project commented that, while they benefitted from participation and learned new information, they might have gained more from the experience had they not be as advanced. Below are typical responses from key informants from both collaboratives:

- *"It has been transformative from a knowledge base and how all the pieces fit together. We wouldn't be where we are and ready to move forward in an informed way if we had not participated."* DSMT learning collaborative participant
- *"We probably wouldn't be where we are without it...NCOA provides a wonderful forum for the group to come together and learn from one another and utilize the tools and resources."* DSMT learning collaborative participant
- *"It's been a great opportunity – a wide spectrum of information and strategies for implementing the program in a variety of ways [...]. It was a nice blending of a variety of ways to be exposed to information and learn how to put this in place."* HBAI learning collaborative participant
- *"When you reach out and get questions answered, it is reassuring. It was a community. You feel as though you aren't in this alone. It has been a very positive experience. I don't know how someone could do it without you."* DSMT learning collaborative participant
- *"We are so grateful to have been part of this [...]. We are not where we want to be, but we have learned so much, and we have the resources we need. It has been great."* HBAI learning collaborative participant

What key informants found most helpful. By far, the single-most helpful aspect of the experience, according to all key informants across both learning collaboratives, were the one-on-one technical assistance sessions with Tim McNeill. His extensive experience as health care consultant was invaluable in reinforcing learnings from the group sessions, responding to questions, assisting with homework assignments, and helping participants learn how to overcome specific challenges or trouble spots that they faced as they went through the process.

Almost unanimously, the DSMT learning collaborative informants also found the monthly conference call/webinar sessions to be most helpful. They agreed that the topics were well chosen and liked the interactive nature of the sessions, which provided an opportunity to ask questions, engage in discussion, and share learnings. This opportunity was viewed as an integral part of keeping participants connected and invested, while building confidence in their ability to succeed. A majority of DSMT informants also noted that they liked having the webinars, resources, and other materials available via the online community so that they could go back to review them. The online community also provided participants with an opportunity to ask questions and interact between calls, although most of the online conversations were initiated by NCOA. Other responses for DSMT informants

included the in-person meeting, which was held in May 2016 for each cohort to connect with their peers and share their learnings. Several also commented that all learning collaborative components were helpful, with each having a "synergistic" effect.

The most common response from HBAI informants as to what was most helpful after the one-one-technical assistance of Tim McNeill, was the break-even analysis homework assignment. While both groups recognized the importance of the break-even analysis, it appeared to be of greater importance to HBAI participants. Six of the nine HBAI participants identified this as a significant learning and a turning point in the process for them. Likewise, while HBAI informants also mentioned the value of the monthly conference call/webinar sessions and the ability to access them via the online community, fewer rated this "most helpful," as compared to DSMT informants. Several HBAI informants also indicated that learning the language of business and gaining business acumen were most helpful. Both groups valued being in a community with peers, who were working toward the same goals.

What key informants said could have been done better. Key informants unreservedly addressed the specific aspects of the project that were challenging and difficult to grasp. While they understood that each organization had its unique identity that resulted in varying stages of "readiness" and lack of a common knowledge base, they noted that this diversity presented a challenge in terms of which topics should be covered, and how and when each piece of information should be presented. For example, there was a lack of agreement as to when homework assignments should be given. A few participants in each learning collaborative felt that the break even analysis homework should have been provided earlier. However, in the HBAI learning collaborative, a few participants also felt that some of the homework was premature. Several informants in both learning collaboratives indicated that they would have liked more support at the beginning of the process to better understand and prepare for the experience and to assist with the completion of their aim statements and other homework assignments. While participants in both learning collaboratives found the break-even analysis to be a valuable experience overall, some found some aspects to be challenging. They would have liked more support in completing the assignment or would have liked the exercise to be broken into smaller, more manageable pieces.

Respondents also indicated that they would have liked even more opportunity for interaction, exchange of ideas, and group problem solving. Suggestions to improve the process included quarterly "check ins" with participants sharing of their progress, smaller sub-groups similar in their stage of readiness working more closely together, and special sessions dedicated to group question and answer periods, with problem solving around specific topics. Similarly, while key informants highlighted the in-person meeting as a positive experience, they also noted that it could have been improved by offering more opportunity for group interaction and shared learning.

Recommendations for Future Replication. Almost unanimously, key informants agreed that they would participate in the project again and recommended that the DSMT and HBAI learning collaboratives be repeated for other organizations. Four DSMT informants suggested that future participants should be more similar in terms of their stage of readiness (i.e., organize learning collaboratives by level of experience, such as introductory and advanced). Because the teachings, tools, and assignments were similar for both groups, several key informants suggested combining the DSMT and HBAI learning collaboratives, with a broader focus on Medicare reimbursement and billing. Two HBAI informants suggested broadening the HBAI learning collaborative focus to include other CDSME programs, such as the Chronic Pain Management Program, as well as self-management support programs.

Several informants also suggested connecting participants to other successful organizations that might serve as role models or mentors. Pairing learning collaborative participants with mentors could be an effective strategy in fostering relationships to share knowledge and reduce trial and error for the mentee. The DSMT learning collaborative did have an experienced mentor available to

support the group, but the role could have been better defined with more support offered throughout the process. This suggestion was a challenge for HBAI, as there were no organizations that had successfully achieved Medicare reimbursement to serve as role models or mentors.

6. Conclusions and Recommendations for Future Learning Collaboratives

As one component of the "Roadmap to Community-Integrated Health Care, the DSMT and HBAI learning collaboratives were established to support the CDSME network in developing business acumen to achieve integrated, sustainable service systems for CDSME programs. The project aims or objectives stated that learning collaborative participants would achieve or make significant progress toward achieving certain stages of change that would lead to Medicare reimbursement. In weighing the progress, accomplishments, and positive feedback provided by key informants at the conclusion of the project, the learning collaboratives were found to be a highly useful and effective method of providing technical assistance. The process was dynamic and fluid with a number of internal and external challenges that frequently required learning collaborative participants to "rethink" and to modify their strategies, approaches, and timelines. On the whole, learning collaborative participants were successful in grasping business acumen concepts and putting them into practice, as was evident by measurable progress along stages of change within an overall framework of change. Also a measure of success, learning collaborative participants reported that they now had the necessary tools and resources to continue their progress after the official end of the project, and they expressed confidence in their ability to take the next steps to achieve their longer-range goals. They also conveyed a true sense of commitment in continuing the work that they had started, hope and optimism about the future, and gratitude for having had the opportunity to participate.

Based on the project findings, feedback from key informants, and insights from NCOA's Leadership Team and Project Evaluator, the following recommendations are proposed for future iterations of the DSMT and HBAI learning collaboratives:

1. Select participants according to their stage of readiness. Initially, the leadership team thought that selecting organizations with varying stages of readiness would establish a learning environment in which participants could help and learn from one another. While true to a certain extent, the "uneven playing field" created some frustration among members, especially at the beginning of the process. Those who had little or no business acumen experience felt uncertain, while those who were more advanced found some of the information repetitive. Conducting initial readiness assessments to group participants by level of business acumen skill and then using those groupings to determine webinar topics and timing of homework assignments may reduce participants' level of frustration and improve their experience.

2. While maintaining a focus on DSMT and HBAI, construct the learning collaboratives differently. Because the DSMT accreditation process is unique, complex, and labor intensive, it is recommended that a DSMT learning collaborative be offered for those who are in the early to intermediate stages of working to attain accreditation for their diabetes programs. A two-fold purpose is suggested: 1) to support organizations as they work to achieve accreditation for their diabetes self-management programs, and 2) to help them learn and apply business acumen associated with obtaining reimbursement to make DSMT a viable service. A second intermediate to advanced learning collaborative is recommended to focus on Medicare reimbursement for DSMT and HBAI services, while also providing information about the potential to incorporate these services into contracts with Medicaid managed care and commercial health plans. Potential learning collaborative participants would thereby have the option to select DSMT, HBAI, or both, as well as to determine what payment model works best for their specific circumstances.

3. Provide additional opportunities for mentorship. The worth and value of professional mentorship is well established. Greater group sharing and problem solving should be fostered in future learning collaboratives, and peers who have successfully completed the DSMT accreditation and reimbursement process or who have achieved reimbursement for HBAI should be encouraged to take an active role as mentors. Specific roles might include stimulating discussions via the online communities, taking a more active role during the monthly call/webinar sessions, being available to answer questions, assisting with homework assignments, and working with sub-groups to discuss common issues or work through challenges.

4. Provide more one-on-one technical assistance. In addition to the formally scheduled, one-on-one technical assistance sessions that were provided at mid-point and at the end of the learning collaborative, feedback suggests that a session should be scheduled with each participant at the beginning of the experience, as well. An initial formal technical assistance session is important to help learning collaborative members understand what is expected and to assist them in preparing their aim statements. Feedback also suggests that one-on-one technical assistance should be offered for homework assignments.

5. Use NCOA's Salesforce database as the online community platform. NCOA's Salesforce database would serve as an ideal platform for the online communities and also as a means to document participants' progress toward or achieving each stage of change defined in the project Charters. The first generation learning collaborative participants used the Crossroads online-communities site regularly to access webinars and resources, but for the most part, they did not use it to communicate with one another between the monthly group sessions. The Salesforce database offers unique and user-friendly features, which might encourage more interaction among members. Additionally, Salesforce can be used to document, track, and report progress, which would be helpful to learning collaborative participants, as well as to NCOA and the leadership team in managing the project more effectively and efficiently.