Improving Transitions of Care

Avoidable readmissions place a physical and emotional burden on patients and families, cost Medicare an estimated $12 billion annually, and soon will create a financial liability for hospitals that accept Medicare reimbursement—while interventions for improving care transitions are both known and effective. The 14 communities nationwide that participated in a recent Quality Improvement Organization (QIO) Program initiative, for example, reduced admissions per 1,000 beneficiaries by 5.6%, compared to a 3.4% reduction in 52 peer communities.

As a result, health care providers and patient advocates across the country are focusing increased attention on improving transitions of care for every patient. The QIO Program is an ally in this effort. All hospitals and other provider settings should be encouraged to take advantage of QIO assistance from August 2011 through July 2014 to build a multi-stakeholder coalition, identify the root causes of readmissions, select an intervention, and put it into action.

A Major Force for Improvement

QIOs in every state and territory, united in a network administered by the Centers for Medicare & Medicaid Services (CMS), have the flexibility to respond to local needs. At the same time, they offer providers the opportunity to contribute to broader health quality goals, such as those set by the U.S. Department of Health & Human Services’ National Quality Strategy.

Current QIO Program initiatives are aligned with other major health quality improvement programs and can help providers improve the quality of care for Medicare beneficiaries who transition among care settings. In addition, by working with their local QIO, community care transitions coalitions may qualify for federal funding to continue their efforts.

New Ways to Work Together

The latest in improvement science, including new models for accelerating and spreading change, has shaped the QIO Program’s approach. This means providers have more and different ways to be a part of QIO initiatives. QIOs are functioning differently, too. Rather than limiting their role to technical assistance, they are convening statewide learning and action networks (LANs) that recognize everyone has knowledge that can contribute to better care. By participating in a LAN, health care providers can harness the power of a 24/7 community for addressing common challenges, connect with a peer facility for mentoring, and be the first to know about improvement breakthroughs—and how they can replicate them in their own facility or practice.

Bold Goals for Better Care

Within 30 days of discharge, 17.6 percent of Medicare beneficiaries are re-hospitalized, and up to 76 percent of these readmissions may be preventable. Of beneficiaries who are readmitted within 30 days, 64 percent receive no post-acute care between discharge and readmission.

Quality Improvement Organization Program

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Communities that join the QIO Program’s initiative to integrate care for populations and communities will contribute to a three-year, 20% national reduction in readmissions within 30 days of hospital discharge. Participants can expect to benefit from membership in a local care transitions coalition comprised of hospitals, nursing homes, home health agencies, dialysis centers, hospices and palliative care facilities, senior advocates like area agencies on aging, and other local stakeholders. QIOs in every state and territory will convene these coalitions and provide technical support as they implement a comprehensive, fully integrated approach to reducing avoidable readmissions. Other benefits of participation include:

**Evidence-Based Interventions.** Each community will select one or more interventions from a set of multidimensional programs for improving care transitions whose effectiveness has been documented in the scientific and medical literature. These include the: Care Transitions Intervention℠ (Eric Coleman), Transitional Care Model (Mary Naylor), Better Outcomes for Older Adults through Safe Transitions or “BOOST” (Society of Hospital Medicine), Best Practices Intervention Package for Transitional Care Coordination (Home Health Quality Improvement Initiative), Interventions to Reduce Acute Care Transfers or “INTERACT” (Florida Atlantic University), STate Action on Avoidable Rehospitalizations or “STAAR” (Institute for Healthcare Improvement), Re-engineered Discharge or “Project RED” (Boston University), Geriatric Resources for Assessment and Care of Elders or “GRACE Team Care Model” (Indiana University), and the Bridge Model of Transitional Care (Illinois Transitional Care Consortium).

**Support for Sustainability.** To rapidly increase capacity for improving care transitions, QIOs are focusing their work on communities with high readmission rates that are not already supported by federal funding (such as the Administration on Aging’s Aging and Disability Resource Center program and CMS’ Community Based Care Transitions demonstration). QIOs will assist participating communities to build the structure and experience they need to qualify for funding through Section 3026 of the Affordable Care Act.
**Area Agency on Aging**
An Area Agency on Aging (AAA) is a public or private non-profit agency, designated by the state to address the needs and concerns of all older persons at the regional and local levels. “Area Agency on Aging” is a generic term—specific names of local AAAs may vary. AAAs are primarily responsible for a geographic area, also known as a PSA, that is either a city, a single county or a multi-county district. AAAs may be categorized as: county, city, regional planning council or council of governments, or private, non-profit.

AAAs coordinate and offer services that help older adults remain in their homes - if that is their preference - aided by services such as Meals-on-Wheels, homemaker assistance and whatever else it may take to make independent living a viable option. By making a range of options available, AAAs make it possible for older individuals to choose the services and living arrangement that suit them best.

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**Aging and Disability Resource Center**
The Aging and Disability Resource Center (ADRC) initiative, a collaborative effort of the U.S. Administration on Aging and the Centers for Medicare and Medicaid Services, is designed to streamline access to long-term care. Launched in 2003, the ADRC program supports State efforts to develop “one-stop shop” centers in local communities that help older adults and individuals with disabilities make informed decisions about their service and support options and serve as the single point of entry to the long-term care system.

ADRC programs provide information and assistance to individuals needing either public or private resources, professionals seeking assistance on behalf of their clients, and individuals planning for their future long-term care needs. ADRC programs also serve as the entry point to publicly administered long term supports including those funded under Medicaid, the Older Americans Act and state revenue programs.

ADRCs target services to the elderly and at least one additional population of people with disabilities (i.e., individuals with physical disabilities, serious mental illness, and/or mental retardation/developmental disabilities). ADRCs are working towards the goal of serving all individuals with long-term care needs regardless of their age or disability.

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1 Source: [http://www.eldercare.gov/ELDERCARE.NET/Public/About/Aging_Network/Index.aspx](http://www.eldercare.gov/ELDERCARE.NET/Public/About/Aging_Network/Index.aspx)
In April 2011, the Center for Medicare and Medicaid Services (CMS) announced funding opportunities for acute-care hospitals with high readmission rates that partner with community based organizations (CBOs) or CBOs that provide care transition services to improve a patient’s transition from a hospital to another setting, such as a long-term care facility or the patient’s home. Created by Section 3026 of the Affordable Care Act, the Community-Based Care Transition Program (CCTP) provides funding to test models for improving care transitions for high risk Medicare patients by using services to manage patients’ transitions effectively. Participants will use process and outcome measures to report on their results.

**Background**
Care transitions occur when a patient moves from one health care provider or setting to another. When people living with serious and complex illnesses move from the hospital to home or a nursing home, they may be at risk for readmission back to the hospital if they develop a complication. These complications are often preventable. Nearly one in five Medicare patients discharged from the hospital—approximately 2.6 million seniors—is readmitted within 30 days, at a cost of over $26 billion every year.

CCTP supports the three-part aim of making health care safer, more reliable, and less costly for all Americans. This initiative is part of the Partnership for Patients, a public public-private partnership charged with reducing hospital-acquired conditions by 40 percent and hospital readmissions by 20 percent by 2013. The Department of Health and Human Services plans to invest up to $1 billion in Affordable Care Act funds in the Partnership to reduce millions of preventable injuries and complications.

**Who can participate?**
CMS invites CBOs, or acute care hospitals that partner with CBOs, to submit an application describing the proposed care transition intervention(s) and people with Medicare who are at high risk of readmission in their communities.

CBOs must provide care transition services across the continuum of care and have a formal organizational and governance structure, including formal relationships with hospitals, other providers, and consumer representatives. Preference will be given to Administration on Aging (AoA) grantees who partner with multiple hospitals and practitioners to provide care transition interventions or entities that provide services to medically-underserved populations, small communities and rural areas.
What will participation require?
CBOs will be required to provide care transition services across the continuum of care, which may include at least one of the following:

- Care transition services that begin no later than 24 hours prior to discharge;
- Timely and culturally and linguistically competent post-discharge education to patients so they understand potential additional health problems or a deteriorating condition;
- Timely interactions between patients and post-acute and outpatient providers;
- Patient-centered self-management support and information specific to the beneficiary’s condition; and,
- A comprehensive medication review and management, including—if appropriate—counseling and self-management support).

Applicants must explain how they will align their care transition programs with care transition initiatives by other payers in their communities, including Medicaid, Medicare Advantage, and private payers.

All awardees must agree to and sign terms and conditions governing their participation in the program prior to initiating their programs.

How long will CMS accept applications?
CMS will accept applicants and enroll participants on a rolling basis as funding permits. The program will run for 5 years. Participants will be awarded two-year agreements that may be extended annually through the duration of the program based on performance.

What does the application require?
Interested parties must submit a written proposal that addresses all of the evaluation selection criteria described in the solicitation on the CCTP web page at: [http://go.cms.gov/caretransitions](http://go.cms.gov/caretransitions).

As part of the proposal, applicants must:

- Identify community-specific root causes of readmissions, define the target population, and strategies for identifying high risk patients;
- Specify care transition interventions and services that will address readmissions, including strategies for improving provider communications and improving patient activation;
- Describe how care transition strategies will incorporate culturally appropriate, beneficiary-centric, effective care transition approaches to reach ethnically diverse beneficiaries, and how other community and social supports will be incorporated to enhance beneficiaries’ post-hospitalization outcomes;
- Provide an implementation plan with milestones;
- Provide a clear budget proposal, including a per eligible discharge rate reflecting direct costs for care transition services; and,
- Describe prior experience with managing care transition services and reducing readmissions.
**What is the total funding allocation and how will participants be paid?**

CMS was appropriated $500 million in total funding for the CCTP for 2011 through 2015.

CCTP differs from a grant program in that it does not pay for administrative overhead and infrastructure costs. CBOs will be paid an all-inclusive rate per eligible discharge, determined based on the cost of care transition services provided at the patient level and systemic changes at the hospital level; however, the CBO will only be paid once per eligible discharge in a 180-day period of time for any given beneficiary.

**How will CMS evaluate a CBO’s performance?**

CMS will evaluate and track CBO’s targeted performance thresholds on quality and utilization measures such as focusing on 30-day all cause readmission rates, and will also monitor 90- and 180-day readmission rates, mortality rates, observation services, and emergency department visits to ensure that the program preserves or enhance the quality of care for Medicare beneficiaries while sustaining efforts to provide care transition interventions across different settings and result in greater program efficiency. Each CBO will be required to fully cooperate with the evaluation contractor and implementation and monitoring contractor. A CMS project officer will be assigned to all CBOs, and that project officer will serve as liaison to program and evaluation contractor staff. In addition, the project officer will provide technical consultation regarding program procedures and monitor CBO activities.

**What resources and technical assistance will CMS provide?**

Applicants are invited to contact Medicare Quality Improvement Organizations (QIOs) as they prepare their proposals. The QIOs’ mission includes assisting communities in improving care transitions, whether they are new to this work or they have experience in improving care transitions and wish to apply to the CCTP.

QIOs’ technical assistance capabilities include:

- Community-level readmissions data and trend analysis;
- Assistance with conducting a community-specific root cause analysis and in selecting the appropriate interventions;
- Helping recruit community partners, and,
- Other technical assistance on the CCTP application.

A roster of care transitions contacts for each of the country’s 53 QIOs is available on the CCTP webpage (see the bottom of this factsheet for the web address). Additionally, a template for developing the CCTP budget is on the CCTP webpage.

CMS encourages all applicants to seek assistance from their State’s QIO and learn more about how to improve care transitions through a comprehensive community effort at the QIO Integrating Care for Populations and Communities National Coordinating Center (NCC) at: [http://www.cfmc.org/integratingcare/](http://www.cfmc.org/integratingcare/).

For more information about the Community Based Care Transitions Program, visit [http://go.cms.gov/caretransitions](http://go.cms.gov/caretransitions).

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State Action on Avoidable Rehospitalizations (STAAR)

In May 2009 the Institute for Healthcare Improvement (IHI) launched the STAAR initiative — a groundbreaking, four year, multi-state, multi-stakeholder approach to dramatically improve the delivery of effective care at a regional scale funded by the Commonwealth Fund (CMWF.) The STAAR initiative aims to reduce rehospitalizations by working across organizational boundaries and by engaging payers, stakeholders at the state, regional and national level, patients and families, and caregivers at multiple care sites and clinical interfaces. IHI is currently partnering with three STAAR states (Massachusetts, Michigan and Washington)* to provide strategic guidance, support and technical assistance to hospitals and cross-continuum teams to improve transitions in care and reduce avoidable rehospitalizations. How-to Guides as well as other resources to assist hospitals, skilled nursing facilities, office practices and home health care agencies in improving transitions in care are available for free download on the IHI website at: http://www.ihi.org/offerings/Initiatives/STAAR/Pages/default.aspx

*Although not funded through the CMWF grant, Ohio also participated in a STAAR Collaborative from September 2012 through July 2011.