Partnership for Patients: The Community-based Care Transitions Program

Agenda

- Introduction/housekeeping
- The Partnership for Patients
- The Community-Based Care Transition Program
- Resources
- Questions

Presenters

- Joe McCannon, Senior Advisor to the Administrator and Group Director, Learning and Diffusion, Innovation Center, Centers for Medicare & Medicaid Services
- James Hester, Senior Advisor, Center for Medicare & Medicaid Innovation, CMS
- Juliana Tiongson, Social Science Research Analyst, Center for Medicare & Medicaid Innovation, CMS

The Human and Financial Cost of Unnecessary Harm

- On any given day, 1 out of every 20 patients in American hospitals is affected by a hospital-acquired infection
- Among chronically ill adults, 22 percent report a “serious error” in their care
- One out of seven Medicare beneficiaries is harmed in the course of their care, costing the federal government over $4.4 billion each year
- Despite pockets of success -- we still see massive variation in the quality of care, and no major change in the rates of harm and preventable readmissions over the past decade

We can do much better – and we must.

Partnership for Patients: Better Care, Lower Costs

Secretary Sebelius has launched a new nationwide public-private partnership to tackle all forms of harm to patients. Our goals are:

1. *Reduce harm caused to patients in hospitals*. By the end of 2013, preventable hospital-acquired conditions would decrease by 40% compared to 2010.
   - Achieving this goal would mean approximately 1.8 million fewer injuries to patients with more than 60,000 lives saved over the next three years.
2. *Improve care transitions.* By the end of 2013, preventable complications during a transition from one care setting to another would be decreased such that all hospital readmissions would be reduced by 20% compared to 2010.
   - Achieving this goal would mean more than 1.6 million patients would recover from illness without suffering a preventable complication requiring re-hospitalization within 30 days of discharge.

Potential to save up to $35 billion over 3 years

How Will Change Actually Happen?

- There is no “silver bullet”
- We must apply many incentives
- We must show successful alternatives
- We must offer intensive supports
  - Help providers with the painstaking work of improvement

Getting Started

- Build on tremendous private sector enthusiasm
  - Hundreds of hospitals, clinicians, employers, insurers, consumer groups and community organizations have already signed up!
- NEW supports through the CMS Innovation Center. Up to $500 million investment for:
  - National-level content for anyone and everyone
  - Supports for every facility to take part in cooperative learning
  - Vanguard Group for ambitious organizations to tackle all-cause harm
  - Patient, family and professional engagement
  - Improved measurement and data collection, without adding burdens to hospitals
- We will work with communities to improve transitions between care settings:
  - CMS is now accepting applications to participate in the Community-Based Care Transitions Program
  - $500 million available for community-based organizations

Care Transitions: The Problem

- Transition from one source of care to another is a moment with high risk for communications failures, procedural errors, and unimplemented plan.
- People with chronic conditions, organ system failure, and frailty are at highest risk because their care is more complicated and they are less resilient when failures occur.
- Strong evidence shows that we can significantly reduce hospital readmissions caused by flawed transitions.

Safe, Effective Transitions Require:

- Patient and caregiver involvement
- Person-centered care plans that are shared across settings of care
- Standardized and accurate communication and information exchange between the transferring and the receiving provider
- Medication reconciliation and safe medication practices
- The sending provider maintaining responsibility for the care of the patient until the receiving clinician/location confirms the transfer and assumes responsibility.

Vision

- A care system in which each patient with complex needs has a care plan that
  - Guides all care
  - Moves with the patient across settings of care and time.
  - Reflects the priorities of patient and family, and
  - Meets the needs of persons living with serious chronic conditions

Care Transitions: Readmissions

- Hospital readmission is one important indicator of possible flaws in one major type of transition.
- 20% of Medicare hospital patients are readmitted within 30 days of discharge
- Partnership for Patients Goal: Within three years, reduce by 20% the number of preventable readmissions that occur within 30 days of discharge
- Other indicators are needed and under development.

Care Transitions: The Approach

- Build on evidence from research and pilots.
- Support existing local coalitions of hospitals, nursing homes, physicians, home health, consumer groups, and other stakeholders.
- Encourage formation of new coalitions where needed.
- Provide data, technical support, payment mechanisms, financial support, enhanced surveys, consumer information, training, and other mechanisms to help coalitions move providers toward seamless transitions.

Care Transitions: Strategy

- Create a broad based public/private partnership
- Tailor support to where providers are in their quality journey - match support to needs:
  - 'Walkers': little track record, but interested in starting e.g. using QIO or AoA programs
  - 'Joggers": proven track record, eligible for S 3026
  - 'Marathoners': established, mature coalitions eligible for S 3022 ACO support
- Build a national network of 2600 community focused care transition coalitions which partner hospitals with community resources

Quality Improvement Organizations

- **In 2008, QIOs launched community-based Care Transitions projects in 14 areas to pioneer new ways to bring communities and care teams together to reduce readmissions for Medicare beneficiaries.**
- **Resources including a comprehensive toolkit and information on care transitions learning sessions can be found at www.cfmc.org/caretransitions**
- **Based on that success, many QIOs will continue in their next contract cycle (beginning 8/1/11) to give focused technical assistance to support communities nationwide in strengthening care transitions.**

Administration on Aging

- In 2011, AoA sponsored a series of webinars and conference calls related to care transitions,
- Recordings, slides, and transcripts from all 5 webinars are archived on the AoA web site. www.aoa.gov,
- The direct link is http://www.aoa.gov/Aging_Statistics/Health_care_reform.aspx

Getting Started

1. Sign the Partnership for Patients Pledge
2. Care Transitions: Start fostering working relationships with the community of providers who care for patients in your area
   - Recruit and convene relevant partners,
   - Conduct a root cause analysis of the causes of readmissions or adverse events surrounding hospital discharge;
   - Implement interventions to address these causes;
   - Measure results and create a sustainable approach to maintain gains.

The Community–based Care Transitions Program (CCTP)

- The CCTP, mandated by section 3026 of the Affordable Care Act, provides funding to test models for improving care transitions for high risk Medicare beneficiaries.
- Part of Partnership for Patients
  - http://www.healthcare.gov/center/programs/partnership/join/index.html
  - http://partnershippledge.healthcare.gov/

Program Goals

- Improve transitions of beneficiaries from the inpatient hospital setting to home or other care settings
- Improve quality of care
- Reduce readmissions for high risk beneficiaries
- Document measureable savings to the Medicare program

Eligible Applicants

- Are statutorily defined as:
  - Acute Care Hospitals with high readmission rates in partnership with a community based organization
  - Community-based organizations (CBOs) that provide care transition services
- There must be a partnership between the acute care hospitals and the CBO

Definition of CBO

- Community-based organizations that provide care transition services across the continuum of care through arrangements with subsection (d) hospitals
  - Whose governing bodies include sufficient representation of multiple health care stakeholders, including consumers

Key Points

- CBOs will use care transition services to effectively manage transitions and report process and outcome measures on their results
- Applicants will not be compensated for services already required through the discharge planning process under the Social Security Act and stipulated in the CMS Conditions of Participation

Preferences

- Preference will be given to proposals that:
  - include participation in a program administered by the AoA to provide concurrent care transition interventions with multiple hospitals and practitioners
  - provide services to medically-underserved populations, small communities and rural areas

Considerations

- Applicants must address:
  - how they will align their care transition programs with care transition initiatives sponsored by other payers in their respective communities
  - how they will work with accountable care organizations and medical homes that develop in their communities

Additional Considerations

- Consideration will be given to hospitals whose 30-day readmission rate on at least two of the three hospital compare measures (Acute Myocardial Infarction [AMI], Heart Failure [HF], Pneumonia [PNEU]) falls in the fourth quartile for its state
  - You can find this data at: http://www.cms.gov/DemoProjectsEvalRpts/downloads/CCTP_FourthQuartileHospsbyState.pdf
- Applicants are required to complete a root cause analysis

Payment Methodology

- CBOs will be paid a per eligible discharge rate
- Rate is determined by:
  - the target population
  - the proposed intervention(s)
  - the anticipated patient volume
  - the expected reduction in readmissions (cost savings)

Performance Measurement

- Awardees will need to demonstrate reduced 30-day all-cause readmission rates
- Awardees will be required to attend up to 3 face-to-face learning collaboratives each year in Baltimore

Conclusion

- The program solicitation is now available on our program webpage at http://www.cms.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?itemID=CMS1239313
- The program will run for 5 years with the possibility of expansion beyond 2015
- Please direct CCTP questions to CareTransitions@cms.hhs.gov

Resources: Care Transitions

- http://www.healthcare.gov/center/programs/partnership/index.html (Partnership for Patients)
- http://www.cms.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?itemID=CMS1239313 (Community-based Care Transitions Program)
- http://www.adrc-tae.org/tiki-index.php?page=CareTransitions (AoA's Aging and Disability Resource Centers and care transitions)
- http://www.cfmc.org/caretransitions/Default.htm (Care Transitions Quality Improvement Organization Support Center)
- http://www.ltqa.org/wp-content/themes/ltqaMain/custom/images//Innovative-Communities-Report-Final-0216111.pdf (Innovative Communities report from the Long-Term Quality Alliance)

Resources: Affordable Care Act

- http://www.aoa.gov/Aging_Statistics/Health_care_reform.aspx (AoA's Health Reform web page – where webinar recording, transcripts and slides are stored)
- http://www.healthcare.gov (Department of Health and Human Services' health care reform web site)
- http://www.thomas.gov/cgi-bin/bdquery/D?d111:1:./temp/~bdsYKv::|/home/LegislativeData.php?n=BSS;c=111| (Affordable Care Act text and related information)