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://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 measurable 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

• 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/itemidetail.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.cfmc.org/caretransitions/Default.htm](http://www.cfmc.org/caretransitions/Default.htm) (Care Transitions Quality Improvement Organization Support Center)
Resources: Affordable Care Act

- [http://www.healthcare.gov](http://www.healthcare.gov) (Department of Health and Human Services’ health care reform web site)