The Era of Care Transitions at CMS

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Objectives

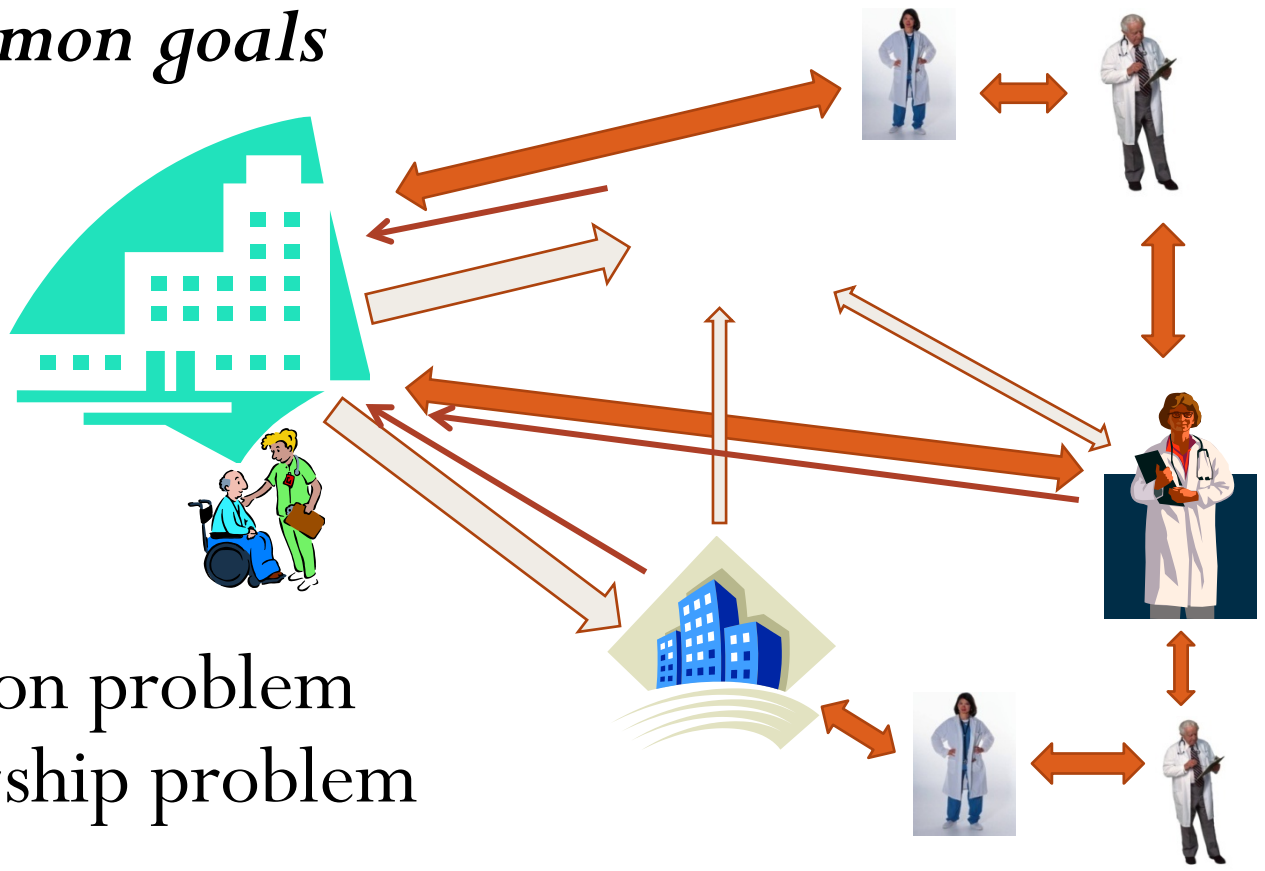
- Overview of the Care Transitions Implementation at CMS
- The Partnership for Patients Campaign
- Key Learning from the 3 year QIO CT Project
- Actions you can take now

Care Transitions at CMS: 2011

- Early QIO Work (2006/2007/2008)
- Hospital Inpatient Quality Reporting Program
- Extended QIO Work (2011-2014)
- ACA Section 3026: Community Based Care Transitions Program
- ACA Section 3025: High Readmissions Hospital Penalty
- Revision of the Hospital CoPs (2011)
- Partnership for Patients: Innovation Center Work

Why do hospitals have unwanted readmissions?

Lack of community infrastructure, and leadership, to achieve common goals



It's a coordination problem
It's also a leadership problem

CMS is Changing

5 New Centers and Functions Added in 1 Year

1. Center for Strategic Planning, Tony Rodgers
2. Center for Program Integrity, Peter Budetti
3. Center for Medicare and Medicaid Innovation, Rick Gilfillan
4. Center for Consumer Information and Insurance Oversight, Steve Larsen
5. Federal Coordinated Health Care Office, Melanie Bella

- Center for Medicare, Jon Blum
- Center for Medicaid, CHIP, and S&C, Cindy Mann
- Office of Clinical Standards and Quality, Patrick Conway, MD

CMS Vision

CMS is a major force and a trustworthy partner for the continual improvement of health and health care for all Americans.

Affordable Care Act Provision with Quality Focus

Value based purchasing

- 3001 - Hospital value-based purchasing
- 3006 - Value-based purchasing for SNF
- 3014 - Quality and efficiency measurement
- 10301 - Develop a plan to implement VBP for ambulatory surgical centers
- 10326 - Pilot testing for pay-for-performance

Hospital readmissions

- 3025 - Hospital readmissions reduction program
- 3026 - Community-based care transitions program

Healthcare acquired conditions

- 2702 - Payment adjustment for health care-acquired conditions
- 3008 - Payment adjustment for conditions acquired in hospitals

Accountable care organizations

- 2706 - Pediatric accountable care organization demonstration project
- 3022 - Medicare Shared Savings Program

Dual eligibles

- 2602 - Providing federal coverage and payment coordination for dual eligible beneficiaries

Preventative services

- 4103 - Annual wellness visit providing a personalized plan
- 4104 - Removing barriers to preventive services
- 4105 - Evidence-based coverage of preventive services

Coordination of care

- 2703 - State option to provide health homes for enrollees with chronic conditions
- 2704 - Demonstration project to evaluate integrated care around a hospitalization

Long term care

- 2401 - Community first choice option
- 2402 - Removal of barriers to providing home and community based services
- 2403 - Money follows the person rebalancing demo
- 2404 - Protection for recipients of home and community-based services against spousal
- impoverishment
- 10202 - Incentives for states to offer home community based serviced

Public reporting

- 10303 - Development of outcome measures
- 10327 - Improvements to the physician quality reporting system -- also see Provision 3002
- 10331 - Public reporting of performance information

Quality reporting initiative

- 2701 - Adult health quality measures
- 3002 - Improvements to the physician quality reporting system.
- 3004 - Quality Reporting for Long Term Care Hospitals (LTCH), inpatient rehabilitation
- hospitals, and hospice programs
- 3005 - Quality reporting for PPS-exempt cancer hospitals
- 10322 - Quality reporting for psychiatric hospitals

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Partnership for Patients:
An Overview

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The *Affordable Care Act* Improves Health Care Quality

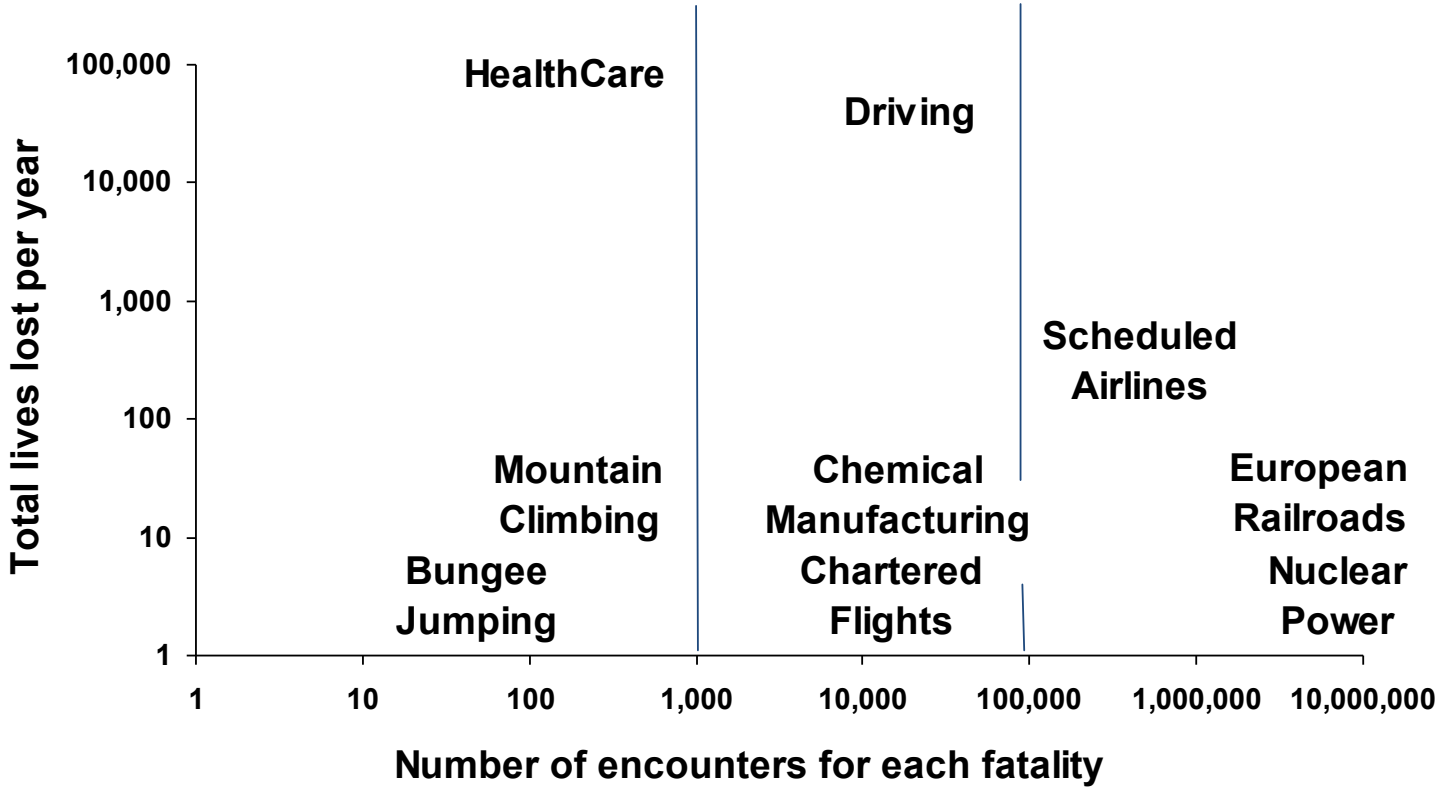
- The Affordable Care Act (ACA) is best known for fixing broken health insurance laws and helping to cover millions of previously uninsured Americans.

- What many people don't know is all of the ways the new law is also reducing costs while improving the experience of being a patient, being a caregiver, and being a health care provider.

- *The Partnership for Patients: Better Care, Lower Costs* is one example of how Secretary Sebelius is using provisions of the ACA to make health care in America safer, more efficient, and less costly.

How Hazardous Is Health Care?

(Leape)



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Partnership for Patients
Better Care, Lower Costs

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 dollars over three years.

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Some of our Partners

Hospitals:

- Ascension Health and its 65 hospitals
- Catholic Healthcare West and its 40 hospitals
- Hospital Corporation of America and its 163 hospitals
- Kaiser Foundation Hospitals and its 35 hospitals
- Tenet Healthcare Corporations and its 49 hospitals
- Department of Veterans Affairs and its 171 hospitals Virginia Mason Hospital & Medical Center
- American Hospital Association
- Federation of American Hospitals
- National Association of Public Hospitals and Health Systems

Clinicians:

- American Academy of Pediatrics
- American Academy of Family Physicians
- American Board of Medical Specialties
- American College of Physicians
- American College of Surgeons
- American Medical Association
- American Nurses Association
- American Society of Health-System Pharmacists
- National Hispanic Medical Association

Consumer Organizations:

- Campaign for Better Care
- National Partnership for Women and Families
- National Patient Safety Foundation

Unions:

- AFL-CIO
- UAW Retiree Medical Benefits Trust

Employers

- Business Roundtable
- CalPERS
- Catalyst for Payment Reform
- The Dow Chemical Company
- General Electric
- Healthcare Leadership Council
- Honeywell
- IBM
- Intel Corporation
- Johnson & Johnson
- Motorola Solutions, Inc.
- National Business Coalition on Health
- National Business Group on Health
- Pacific Business Group on Health
- Safeway
- Starbucks
- Walmart
- Xerox

Health Plans:

- Aetna
- America's Health Insurance Plans
- BlueCross BlueShield Association
- Cigna
- Group Insurance Commission, Commonwealth of Massachusetts

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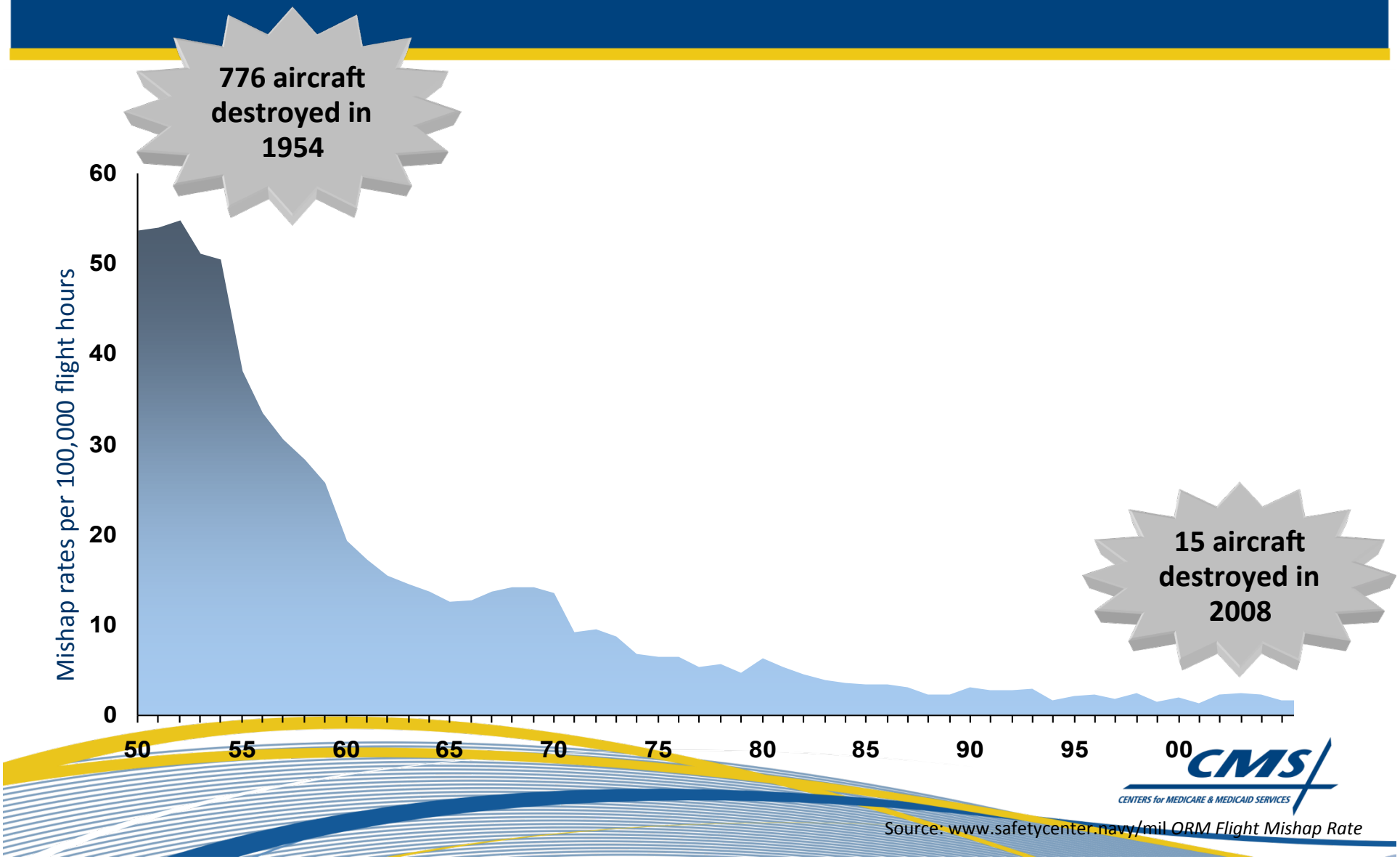
We now have two Aims over 3 yrs:

1. Reduce all cause patient harm by 40%

2. Reduce unnecessary hospital Admissions by 20%

Naval Aviation Mishap Rate



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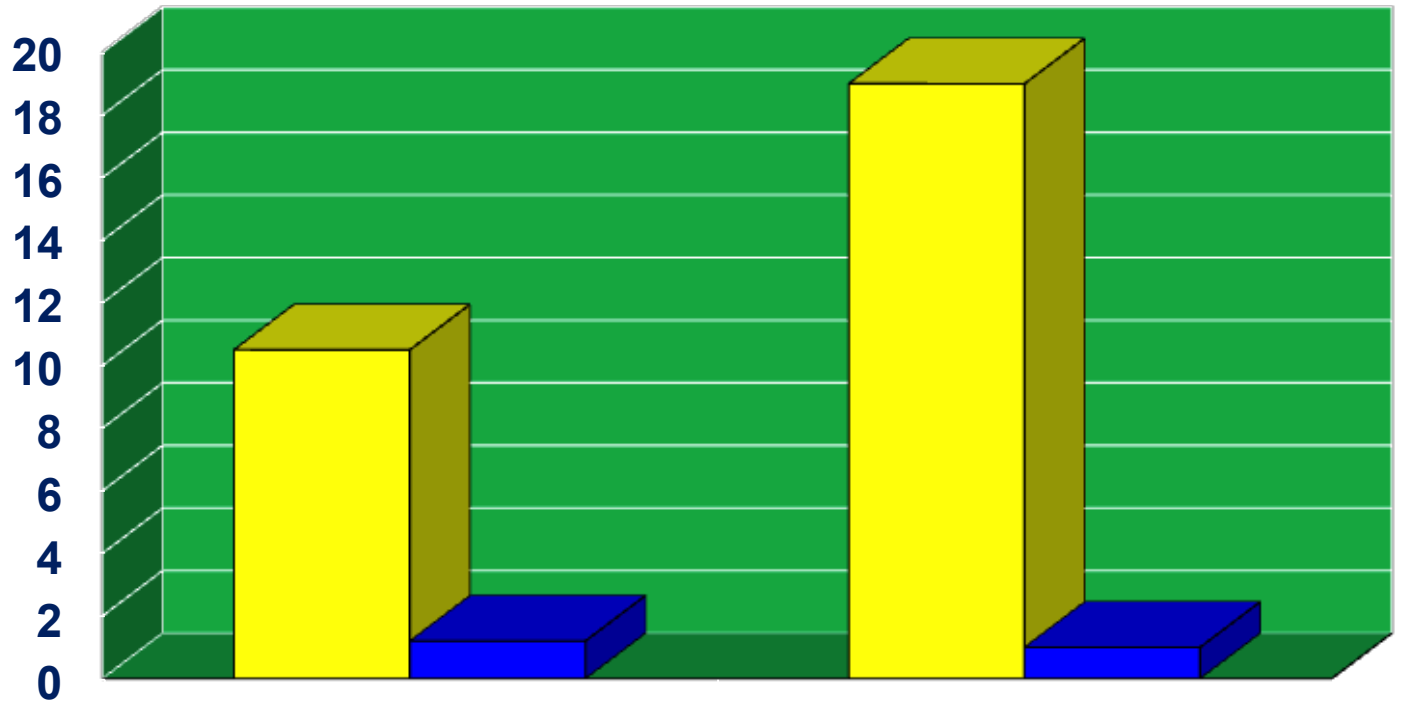
Source: www.safetycenter.navy/mil *ORM Flight Mishap Rate*

Central Line Associated Bloodstream Infections (CLABs)

(from Rick Shannon, MD, West Penn Allegheny Health System)



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Preventing Central Line Infections

- Hand hygiene
- Maximal barrier precautions
- Chlorhexidine skin antisepsis
- Appropriate catheter site and administration system care
- No routine replacement

Ascension Health Harm Reduction

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14 QIOs with 14 Target Communities

- AL: Tuscaloosa
- CO: Northwest Denver
- FL: Miami
- GA: Metro Atlanta East
- IN: Evansville
- LA: Baton Rouge
- MI: Greater Lansing area
- NE: Omaha
- NJ: Southwestern NJ
- NY: Upper capital
- PA: Western PA
- RI: Providence
- TX: Harlingen HRR
- WA: Whatcom county

Community Characteristics

- Baseline 30-day Readmission Rates
  - 13.6% to 21.4%
- Communities vary greatly/chosen based on a variety of factors to learn about diverse communities
  - Geographic size
  - Medicare Beneficiary population
  - Number of Transitions experienced
  - Baseline community cohesiveness
  - Opportunity to address disparities

Totals among 14 communities

- 70 Hospitals
- 277 Skilled Nursing Facilities
- 316 Home Health Agencies
- 89 Other types of Providers (Dialysis, Hospice, etc.)

- 666 Zip Codes
- 1,125,649 Medicare Beneficiaries

Drivers of Poor Transitions

Low patient activation

- Health literacy
- Self-management skills, tools
- Motivation; locus of control

Lack of standardized, known process

- Patient discharge, handover
- Internal workflow

Inadequate cross-setting information transfer

- Delays
- Inaccuracies
- Missing information

CMS's Table of Interventions

http://www.cfmc.org/caretransitions/files/Care_Transition_Article_Remington_Report_Jan_2010.pdf

Evidence Based Interventions

- Care Transitions Intervention[SM]
- CMS Discharge Checklist
- INTERACT II
- Transitional Care Nursing Model
- Project RED
- BOOST
- Best Practices Intervention Package (BPIP)
- Transforming Care at the Bedside (TCAB)

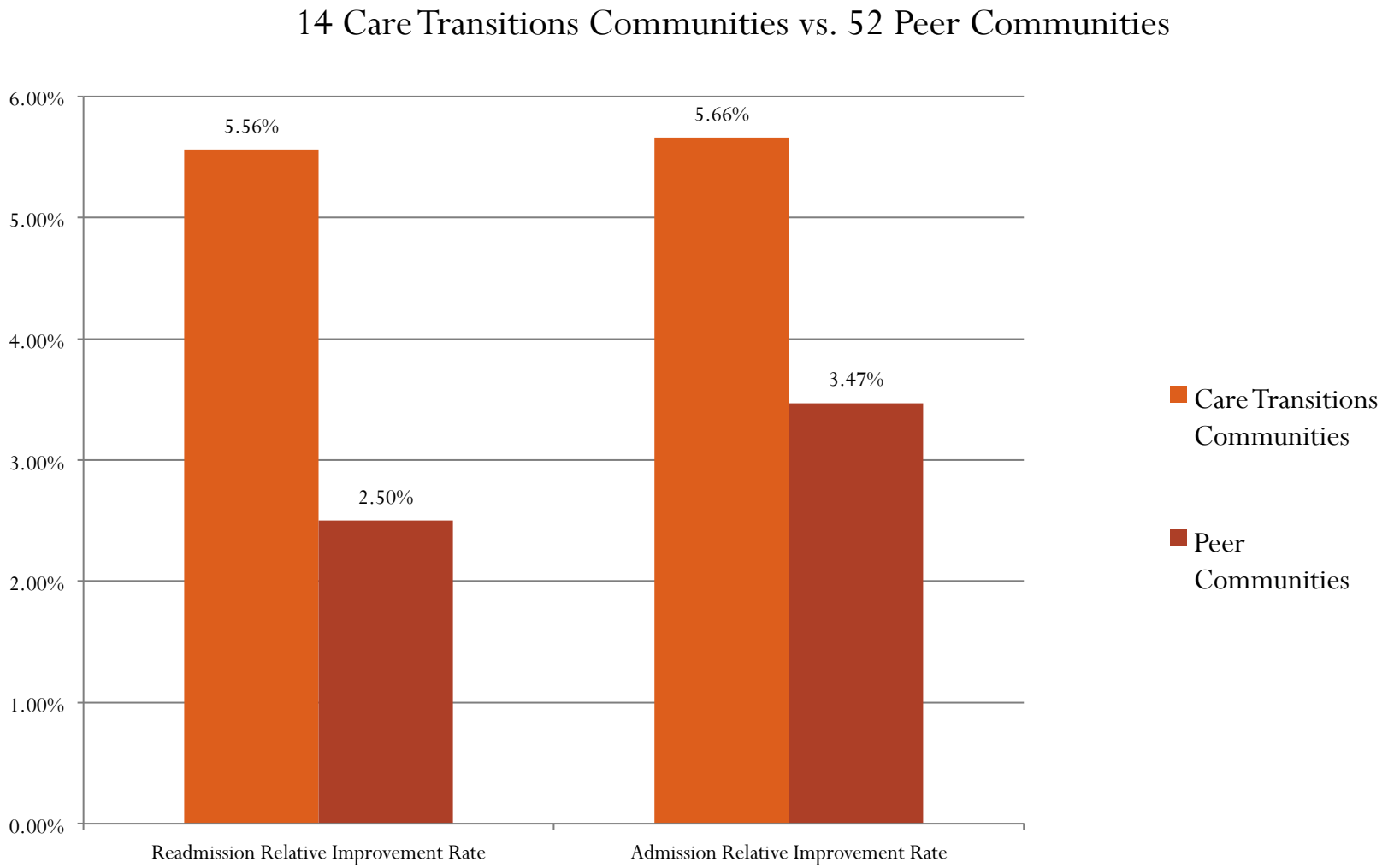
Results

Preliminary Results

- Population-based measures of **readmission** are reduced
- Population-based measures of **admission** are reduced
- **Hospital readmissions work reduces hospital admissions**
- Nursing Home and Home Health utilization has increased slightly
- Preliminary **cost-savings** are very promising

Preliminary Results*: Relative Improvement

July 2007-June 2008 compared to July 2009-June 2010

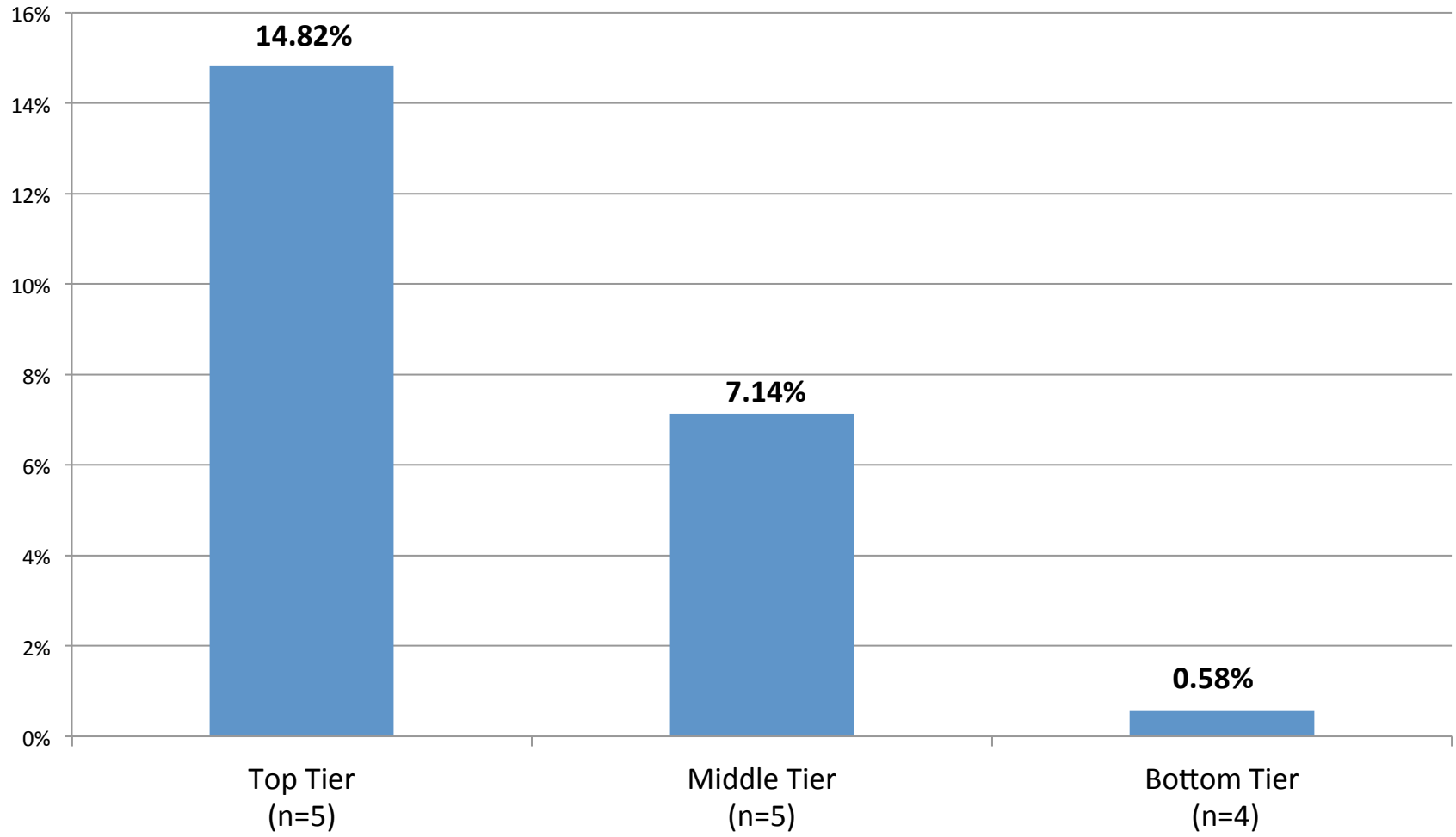


*Results were developed to help guide the Care Transitions Theme. These are not formal findings about the success of the QIO Program (individual QIOs or collectively) in relation to QIOs' obligations under their CMS contracts.

Readmissions per 1000

Relative Improvement Rate

Oct 2007-Mar 2008 compared to Oct 2009-Mar 2010



Lessons Learned

- Importance of community collaboration
  - Providers talking, visiting each other, sharing
- Tailor solutions to fit community priorities
  - Community needs determine change
- Include patients and families
  - Incorporate beneficiaries when they are sick and healthy
- Public outreach activities
  - Storytelling to support data

Organization of Future QIO Work

Drivers of Change

"How the work will be done"

Learning and Action Networks

- Breakthrough Collaboratives
- Patient Engagement and Stories
- Campaigns
- Technical Assistance
- Learning Laboratories

Focused Technical Assistance

- On-site Visits
- Intensive Consultation
- Distribution of Resources

Care Reinvention through Innovation Spread

- Identification of stakeholder
- Spread Strategies
- Multi-media management

Strategic Aims

"What will be done"

Beneficiary-Centered Care

- Case Review
- Patient and Family Engagement

Improve Individual Patient Care

- **Patient Safety –Reduce HACs by 40%**
- Improving Quality through Value Based Purchasing

Integrate Care for Populations

- **Care Transitions that Reduce Readmissions by 20%**
- **Using Data to Drive Dramatic Improvement in Communities**

Improve Health for Populations and Communities

- Prevention through screening and immunizations
- Prevention in Cardiovascular Disease

Other Rapid Cycle Projects

Integrate Care for Populations and Communities

- ***Reducing 30-day readmission rates by 20% over 3 years***
- *QIOs will implement the following initiative…*
  - *Care Transitions Resulting in Reductions in Hospital Readmissions*- QIOs will provide technical assistance for the purpose of capacity and readiness building for communities that are seeking to reduce readmissions and participate in the various Care Transition demonstrations, pilots and programs. QIOs will also build coalitions with the goal of reducing 30-day readmission rates by 20% over 3 years

CMS Care Transitions Programs: 2011

Program	Setting	Content /Intent
Innovation Center Patient Safety Program	Hospital	Testing models and opportunities gained from consultation with the best in the nation or other resources to prepare hospitals to contribute to better transitions (care plans, discharge plans, etc). Testing payment models that advance the field of care transitions. Disseminating learnings to those in the field (such as other health care systems, QIOs, Community Based Organizations) to spread across the country.
QIO SOW	Multiple communities	Identifying communities that have the potential to be successful in managing care transitions to reduce readmissions, emergency department visits and overall hospitalizations leveraging the learnings from the 9th SoW. Working with the communities to help them organize and ready themselves to manage care transitions (and take part in section 3026). Continuing to work with those communities not selected for funding on the first rounds of 3026 but still in need of care transition assistance.
Section 3026 Care Transitions Program	Selected communities and hospitals	Working closely with communities selected on the basis of the criteria outlined in the application specifications for Section 3026 programs. Working with community based organizations and hospitals to reduce all-cause readmissions using funding and known interventions as outlined in 3026.

Ten things a Motivated Hospital CEO can do now:

1) Institute routine readmissions reviews (TCAB)
2) Institute routine readmission risk assessment on admission
3) Promote 'time since last hospitalization' as a vital sign
4) Review % capture of PCP on ED admissions
5) Employ a transitions coach
6) Consider policies for synchronizing transfer of responsibility
7) Add the CTM to the HCAHPS survey
8) Visit partner facilities
9) Start a cross-setting workgroup for reliable transfers
10) Engage with a community-based organization(s)

10 Things a Motivated Community Can Do Now:

1. Identify your community- Healthcare community including Broader critical stakeholders – Home Based Services Providers!!!
2. Create a collaborative forum to find an easier way
3. Create a collaborative forum that includes patients and families
4. Exchange quality data routinely
5. Create a standard communication process
6. Institute an expectation of visiting each other
7. Identify the sickest people and review their care pattern
8. Think about integrating coaching/personalized advocacy
9. Implement a community-standard PHR and expect (measure) it
10. Capture the CTM instead of the typical post acute care follow up call

Useful Links

www.cfmc.org/caretransitions:

Care Transitions theme website

Patient and Provider Resources

Learning Sessions

Toolkit

http://www.healthcare.gov/center/programs/partnership/index.html

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