Quality Improvement Organizations
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CENTERS FOR MEDICARE & MEDICAID SERVICES

# National Initiative, Local Implementation—Improving Care Transitions

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# Objectives

- Present an overview of Centers for Medicare & Medicaid Services (CMS) national initiatives and local implementation efforts to reduce readmissions.
- Identify common elements of safe and effective care transitions.
- Discuss the importance of coordinated care transitions across medical- and community-based providers.

# *HSAG-California: Your Partner in Healthcare Quality*

- HSAG-California is the Medicare Quality Improvement Organization (QIO) for California.
- The QIO Program is the largest federal program dedicated to improving health quality at the community level.
- QIOs are a major force and trustworthy partner for improvement.

# *HSAG-California: Your Partner in Healthcare Quality (cont'd)*

- QIOs in every state and territory are united in a network administered by CMS.
- Current QIO initiatives run August 2011–July 2014.

# National Partnership for Patients


Reduce avoidable readmissions by 20 percent

Reduce healthcare-associated infections by 40 percent

By 2013

# The Hospital Readmission Problem

- 20 percent of Medicare fee-for-service (FFS) patients are readmitted within 30 days.
- Two-thirds of readmissions may be avoidable.
- The cost to Medicare for avoidable readmissions in 2004 was $17.4 billion.

# California Readmission Data

- Q4 2010 to Q1 2011 Readmissions Data
  - 3,429,614 Medicare FFS beneficiaries were admitted
  - 76,050 Medicare FFS beneficiaries were readmitted within 30 days
- Goal: Reduce avoidable readmissions by 20 percent by 2013
  - 15,495 Medicare FFS readmissions will be prevented



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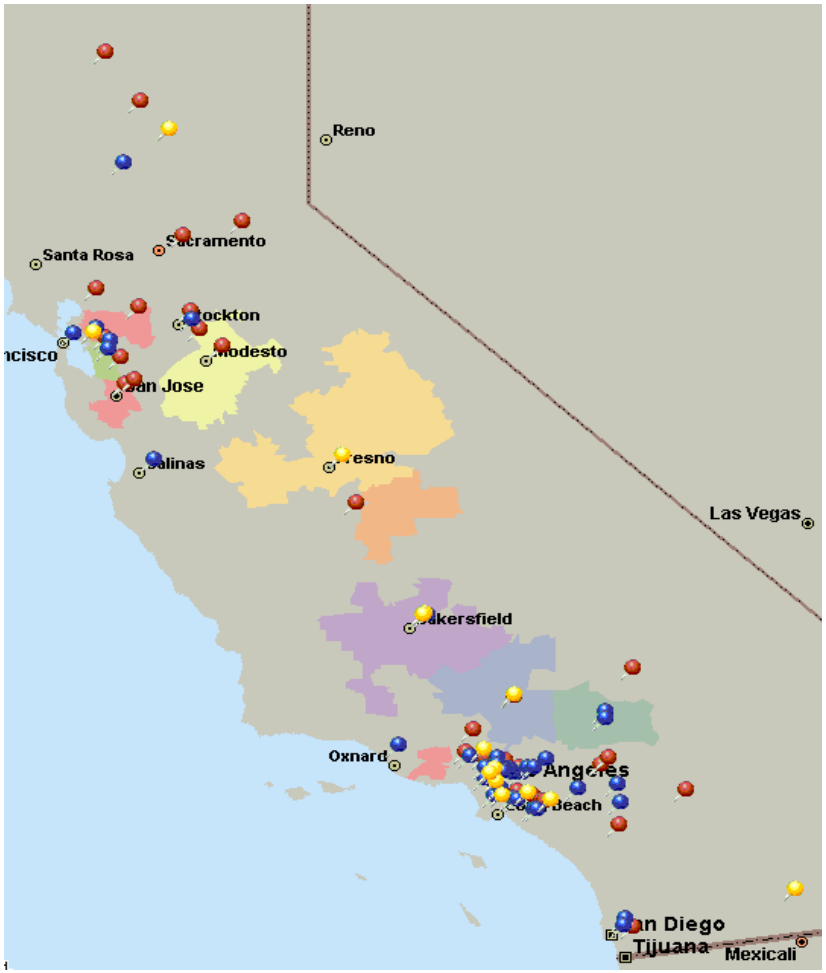
# California High-Readmission Hospitals and Communities




- **Red dots** represent high-readmission hospitals based on 2006–2009 CMS data.
- **Blue dots** represent high-readmission hospitals based on 2010 ISAT data.
- **Yellow dots** are high-readmission hospitals found on both lists
- **Colored regions** represent high-readmission communities.

# Hospital Readmission Penalties

- Effective October 1, 2012, high-readmission hospitals will be penalized based on avoidable readmissions of patients diagnosed with congestive heart failure, acute myocardial infarction, or pneumonia.
- Penalties are based on July 2008 to June 2011 data.
- Penalties will increase in FYs 2014 and 2015.
- CMS is still finalizing the rules on the penalties.
- Penalties will save Medicare $7 billion over 10 years through reductions in payments.

# Community-Based Care Transitions Program (CCTP)

- Section 3026 of the Affordable Care Act
- $500 million available
- Test models for improving care transitions for high-risk Medicare beneficiaries from the inpatient hospital setting to other care settings
- Multiple hospitals must partner with a community-based organization (CBO) that has care transition experience.

# Common Drivers for Readmissions

- Lack of standard discharge processes
- Patients did not understand/did not correctly take medications
- Lack of engagement or activation of patients and families
- Patients call 911 or return to emergency departments instead of accessing a different type of medical service
- Ineffective or unreliable sharing of relevant clinical information

# Interventions

- Care Transitions Intervention (CTI)
- Transitional Care Model (TCM)
- Better Outcomes for Older Adults through Safe Transitions (BOOST)
- Re-engineered Discharge (RED)
- Interventions to Reduce Acute Care Transfers (INTERACT)
- HomeMeds
- Home-Based Palliative Care Model

# Community Building

- The evidence-based interventions to improve care transitions all require cooperative activity by more than one provider.
- All communities must build cross-setting or multi-provider relationships to deploy, measure, and revise implementation strategies.
- Community building is the necessary groundwork to enable improvement.

## Medical Care


Medical Monitoring


Physician / Primary Care


Therapy/ Ancillary Care


Pharmacy


Diagnostic Services


Mental Health


Acute/ Hospital Care


Dental


Medical Transportation

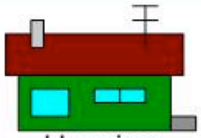

Education


Vision Care

## Supportive Services


Personal Assistance


Protective Supervision


Housing


Laundry


Shopping


Meals


Financial Assistance


Housekeeping


Home Maintenance


Home Modification


Intellectual Stimulation


Pet Care


Transportation


Companionship


Money Management


Recreation

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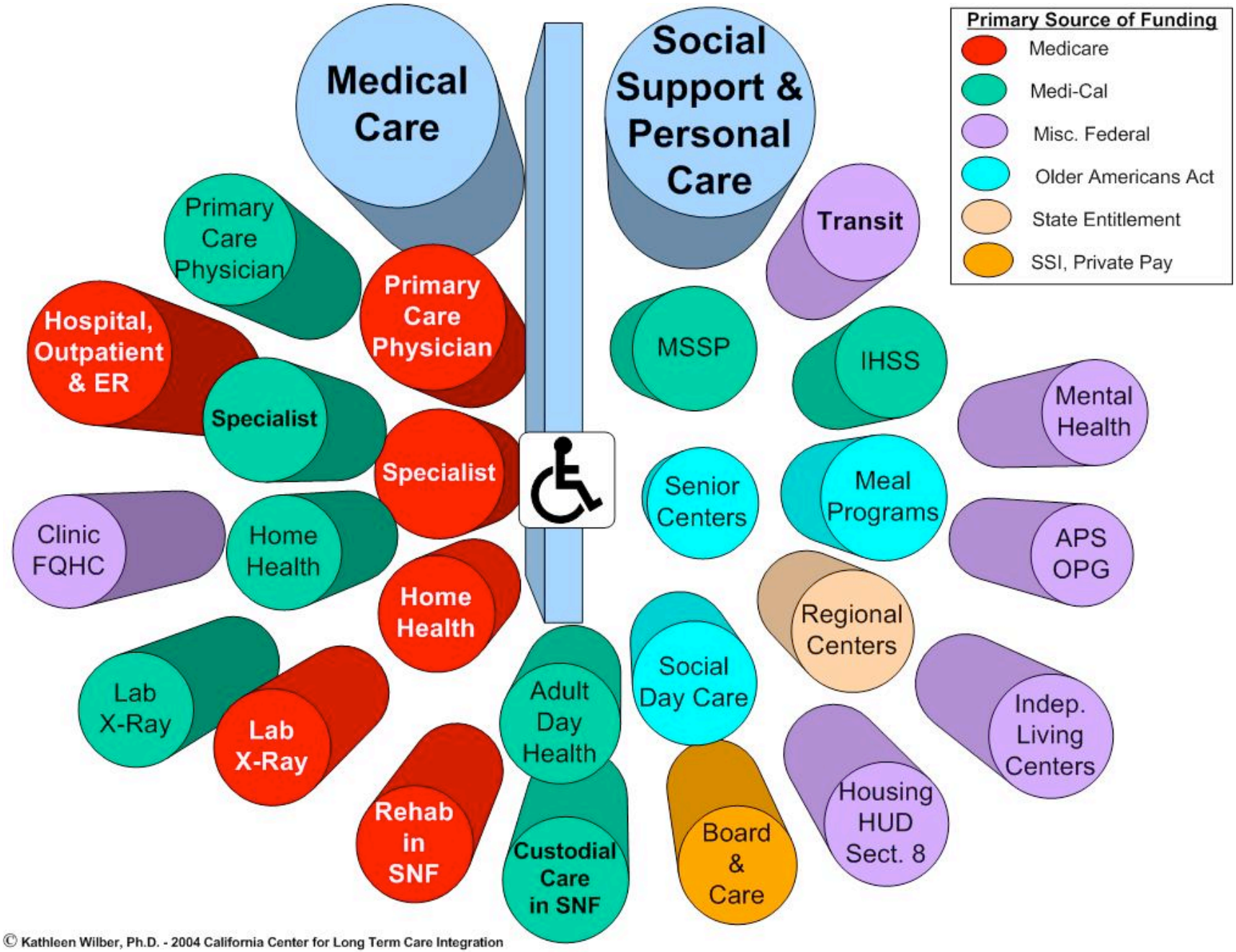
Primary Source of Funding
Medicare
Medi-Cal
Misc. Federal
Older Americans Act
State Entitlement
SSI, Private Pay
Medical Care
Social Support & Personal Care
Primary Care Physician
Primary Care Physician
Transit
Hospital, Outpatient & ER
Specialist
Specialist
MSSP
IHSS
Mental Health
Senior Centers
Meal Programs
Clinic FQHC
Home Health
Home Health
APS OPG
Regional Centers
Lab X-Ray
Lab X-Ray
Adult Day Health
Social Day Care
Indep. Living Centers
Rehab in SNF
Custodial Care in SNF
Board & Care
Housing HUD Sect. 8
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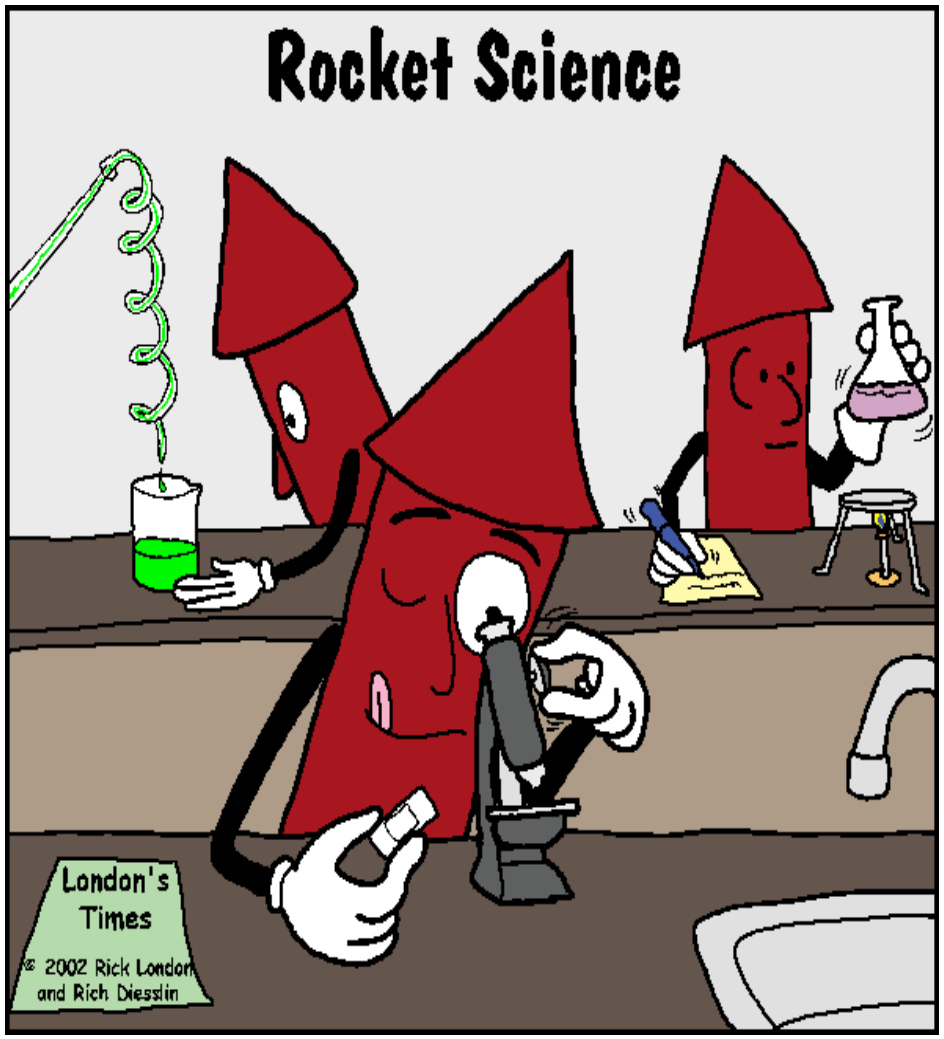
# Common Elements of Safe and Effective Care Transitions

- Medication reconciliation occurs.
- Patients and caregivers are involved and prepared.
- Person-centered care plans are communicated in a timely manner across settings.
- The sending provider maintains responsibility for the patient's care until the receiving clinician/ location confirms the transfer and assumes responsibility.

# Common Elements of Safe and Effective Care Transitions (cont'd)




*"Rocket science is helpful, but not required."*

***However,***
***none of these will work***
***unless . . .***

. . . an important element is present.

# Shared Accountability Throughout the Community

# Getting Started
## Patient-Centric, Community-Based Approach

# *Thank You!*

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