Welcome to the Care Transitions Learning Session

Shining Stars Series
Shining Stars Across the Nation
Webinar Series

• 2nd & 4th Thursdays at 3 PM ET

http://www.cfmc.org/integratingcare/learning_sessions.htm
www.cfmc.org/integratingcare
Highlighting best practices from around the country

Sharing successes leads to further improvement

“Reality is...success rarely ‘shows up’...it is lured and attracted day by day by the right actions, thinking, and heart.”

- Doug Firebaugh
Medicaid Programs and improving care transitions

State Medicaid Agencies (SMAs) and Home and Community based Services Providers (HCBS): partnering and improvement opportunities
SMAs: Improving care transitions: decreasing hospital readmissions/ preventable hospitalizations

Medicaid programs and their agents who provide care to Medicaid and dually eligible individuals play a critical role in care transitions and ensuring that adequate follow-up care and services are delivered to prevent re-hospitalizations and preventable hospitalizations.
Medicaid Grant Program

- **Person-Centered Hospital Discharge Planning Grants** – Active through September 2013 – assists States with the development and implementation of enhanced hospital discharge models and with increasing capacity of single entry points (including ADRCs). Participating States: AK, CA, HI, ID, KS, MD, MO, NC, OR, and SC

- Contact State Medicaid Agency
State Medicaid Agencies (SMAs): Programs that can help reduce hospital readmissions/ preventable hospitalizations & improve care transitions

• Most 1915c waiver programs
• ACA provisions (overview)
  – Section 2703 Health Homes
  – Section 2401 Community First Choice
  – Section 2403 Money Follows the Person
  – Section 10202: Balancing Incentive
  – Section 2701 Adult Health Quality
States are able to offer health home services for individuals with multiple chronic conditions or serious mental illness effective January 1, 2011

- Coordinated, person-centered care
- Primary, acute, behavioral, long term care, social services = whole person
- Enhanced FMAP (90%) is available for the health home services (first 8 quarters)
Medicaid ACA: Care Transitions

Section 2401: Community First Choice Option

- Adds Section 1915(k)
- Optional State Plan benefit to offer Attendant Care and related supports in community settings, providing opportunities for self-direction
- Does not require institutional LOC under 150% FPL
- Includes 6% enhanced FMAP
Medicaid ACA: Care Transitions

Section 2403: Money Follows the Person

- Now extends through 2019-transitions individuals from institutions to community based care and adds resources to balance LTC
- Enhanced Federal match for community services for first year following transition from facility
- 43 States and the District of Columbia now participating in the demonstration
Medicaid ACA: Care Transitions

Section 10202: Balancing Incentive Payments Program

• Designed to help states balance their system of long-term services and supports (LTSS)

• $3B awarded through increased Federal matching payments of 2% or 5% to States that:
  – Currently spend less than 50% or less than 25% of long-term care budgets on home and community-based services (HCBS)
Medicaid ACA: Care Transitions

Section 10202: Balancing Incentive Payments Program

• Participating States must commit to three structural changes:
  – Implement a No Wrong Door/Single Entry Point system
  – Use a Core Standardized Assessment Instrument
  – Implement Conflict Free Case Management standards
Affordable Care Act: Care Transitions
Section 2701: Adult Health Quality Measures

• Development of core set of quality measures for adults eligible for Medicaid.

• Establishment of a Medicaid Quality Measurement Program
  • Proposed rule comments received
  • Final rule January 2012-initial core set, more to be developed to fill gaps
  • Voluntary, most are claims based
Contact the SMA to see what programs are being implemented, where being implemented, who to contact and find out who the Medicaid home and community based services (HCBS) providers are in your community.

Assess: what aspects of your program and services impact care transitions for individuals who receive Medicaid HCBS when they are discharged from the hospital?

Assess: what aspects of your program impact hospital readmissions and preventable hospitalizations for Medicaid individuals in waivers or other State programs.

Partner: with Medicaid HCBS providers to improve care transitions, decrease hospital readmissions and preventable hospitalizations via
CMS: Community Services and Long-Term Supports
http://www.cms.gov/CommunityServices/01_Overview.asp#TopOfPage

State Medicaid Director Letters
http://www.cms.gov/SMDL/SMD/list.asp#TopOfPage

MFP Technical Assistance Website
http://mfp-tac.com/
Tap into other available quality improvement tools and other resources to improve care transitions:

www.hcbs.org Home and Community Quality Resources

Marybeth Ribar MS, RN, Technical Director, Division of Community Systems Transformation, Disabled and Elderly Health Programs Group

marybeth.ribar@cms.hhs.gov
Community–based Care Transitions Program

Juliana Tiongson, MPH

http://innovation.cms.gov/initiatives/CCTP/index.html
Community-based Care Transitions Program

The Community-based Care Transitions Program (CCTP), created by Section 3020 of the Affordable Care Act, tests models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries. The goals of the CCTP are to improve transitions of beneficiaries from the inpatient hospital setting to other care settings, to improve quality of care, to reduce readmissions for high-risk beneficiaries, and to document measurable savings to the Medicare program.

The CCTP Partners

Source: Centers for Medicare & Medicaid Services

There are currently 82 organizations participating in the CCTP. >> Read More
ADRC Care Transitions Program Update
February 28th, 2013

Caroline Ryan
Center for Disability and Aging Policy
U.S. Administration for Community Living
U.S. Department of Health and Human Services
caroline.ryan@acl.hhs.gov
Aging & Disability Resource Center

Systems Change Vision

“The vision is to have Resource Centers in every community serving as highly visible and trusted places where people of all ages and income levels can turn for information and options counseling on their long-term care options.”

-AoA/CMS 2003 ADRC Program Announcement
Investments in ADRC Care Transitions

- **2003**: AoA/CMS grants launch ADRC program, which included development of formal linkages with hospitals and nursing facilities.
- **2007**: Medicare funded 14 QIO care transition projects, 5 included ADRCs.
- **2008**: CMS Medicaid Hospital Discharge Planning grants to 10 ADRC states.
- **2009**: CMS Money Follows the Person grants to 24 ADRC states and DC.
- **2010**: 2010 ADRC Evidence Based Care Transitions Program.
- **2012**: Enhanced Options Counseling Program.
- **2012**: CMS Money Follows the Person grants to 14 additional ADRC states.
ADRC Care Transitions Activities

- 40 States currently conducting care transitions activities
- 8 States currently planning to conduct care transitions activities
- 3 States not reporting current or planned care transition activities

154 active sites, partnering with 355 hospitals
84 planning sites, partnering with 152 hospitals

- 10 states with CMS Hospital Discharge Planning Model grant
- 16 states with 2010 ADRC Option D Care Transitions grant
- 31 states participating in CMS Community-Based Care Transitions Program (CCTP)
Referrals to Long Term Services and Supports During Transitions
(n=739 participants and 2,129 referrals)

- Personal care/homemaker/choremaker services: 19%
- Home Delivered Meals: 15%
- Transportation: 15%
- Nutrition Services or Counseling: 14%
- Falls Management and Prevention: 13%
- Other Services and Supports: 11%
- CDSMP: 1%
- Alzheimer’s Programs: 2%
- Exercise Program: 2%
- Mental Health and Substance Misuse: 3%
- Caregiver Support: 5%

Data Source: ADRC Semi-Annual Report April – September 2012
Long Term Service and Support Needs During Transitions

Adult Day Care
Adult Literacy Programs
Adult Protective Services
Alzheimer’s Programs
Assistive Technology
Blood Pressure Monitor
Care Management
Caregiver Support
CDSMP
CHF Education
Community Clinics
Dental Care
DSMP
Exercise Program
Falls Management and Prevention
Financial Services
Food stamps/food bank
Health Eating
Health Information
Heating Assistance
Home Delivered Meals
Home Health
Home Injury/Risk Screenings
Hospice
Housing Assistance
IHSS
Legal Support
Low cost RX program
LTC Assistance
Medicaid
Medication Management
Mental Health and Substance Misuse
Nutrition Services or Counseling
Personal care/ homemaker/ choremaker
Respite Care
Rx coverage
Smoking Cessation
Social Security
Support Groups
Telephone Reassurance
Transportation
Care Transitions Program Partnerships
(n=122 ADRCs in 37 states)

- Home Health: 61%
- Quality Improvement Organizations (QIO): 60%
- Skilled Nursing Facility (SNF): 48%
- Primary Care Providers: 47%
- Hospital Association: 35%
- Managed Care Organization (MCO): 24%
- Pharmacy: 24%
- Patient Centered Medical Home: 16%
- Physician Medical Organization (PMO): 15%
- Accountable Care Organization (ACO): 11%
- Health Homes: 10%
- Community Health Center (CHC): 10%
- Hospital Engagement Network (HEN): 9%
- Pharmacy Association: 7%
- Health Information Exchange (HIE): 6%
- Beacon Community: 3%
Care Transitions Toolkit

Chapter One: Getting Started
Chapter Two: Taking Time to Plan
Chapter Three: Developing Effective Partnerships with Health Care Providers
Chapter Four: Measuring for Success
Chapter Five: Building Organizational Capacity
Chapter Six: Implementation and Day-to-Day Operations

Administration on Aging Care Transitions Toolkit
http://www.aoa.gov/AoARoot/AoA_Programs/HCLTC/ADRC_CareTransitions/Toolkit/index.aspx

ACL 2010 Evidence Based Care Transitions Program
http://www.acl.gov/Programs/Integrated_Programs/EvidenceCare/Index.aspx

ADRCs and Care Transitions
http://www.adrc-tae.org/tiki-index.php?page=CareTransitions
ONC: Using IT to Create Meaningful Transitions

Janhavi Kirtane Fritz, Director of Clinical Transformation, Beacon Community Program
Office of the National Coordinator for Health IT (ONC)

February 28, 2013
Office of the National Coordinator for Health Information Technology (ONC)

• Primary Federal entity charged with coordinating nationwide efforts to implement and use the most advanced health information technology (health IT)

• Strives to improve the healthcare system through:
  – Adoption of health IT and
  – Promotion of nationwide health information exchange

• Located within the Office of the Secretary for the U.S. Department of Health and Human Services (HHS)
The Beacon Community Program:
Where HITECH Comes to Life

17 diverse communities each funded ~$12-16M over 3 years to:

Build and strengthen health IT infrastructure and exchange capabilities - positioning each community to pursue a new level of sustainable health care quality and efficiency over the coming years.

Improve cost, quality, and population health - translating investments in health IT in the short run to measurable improvements in the 3-part aim.

Test innovative approaches to performance measurement, technology integration, and care delivery - accelerating evidence generation for new approaches.

EHR Adoption and Meaningful Use as the Foundation
9 communities are using HIT to connect a broader group of care and wellness partners

Public health: (5-CA, MN, UT, NY, NC)
LTPAC: (5 - MN, NY, RI, ME, PA)
Tele-monitoring: (4 – CA, IN, NY, MN)
EMS: (2: UT, CA)
Schools: (1 – MN)

Additional 4 Challenge Grants awarded to improve long term care and post acute care transitions: OK, MD, CO, MA
HealthBridge ED Alert Architecture

1. **Patient Hospital Visit**
   The patient goes to the hospital and is admitted to the ED.

2. **HealthBridge Integration**
   HealthBridge receives the ADT and matches on the patient. If the patient is part of a subject group, an alert will be created from one of the four options (A, B, C, D).

3. **Practice Follow-up**
   Practice receives preferred alert from HealthBridge and calls patient for a follow-up visit.

Source: Greater Cincinnati Beacon Community, Trudi Matthews
Keystone Beacon Community

**Needs**

- **Transitions of Care for LTPAC**
  - Acute discharge to skilled nursing facility (SNF)
  - Acute discharge to home health agency (HHA)
  - Nursing home discharge to home health
  - Nursing home transfer to emergency department

- **Electronic information barriers for post-acute care providers**
  - Majority nursing homes with no EHR
  - Nursing homes with EHR, but no HIE interfaces
  - HIE interfaces, but no standard CCD (SNF and HHA)

**Opportunities**

- **Skilled Nursing Facilities**
  - Required to submit Minimum Data Set (MDS) to CMS
    - Contains patient assessment information
    - MDS is unusable by clinicians

- **Home Health**
  - Required to submit Outcome and Assessment Information Set (OASIS) to CMS
  - Similar usage to MDS

- **Total Addressable Market (19,399)**
  - 12,565 - Medicare Skilled Nursing Facilities
  - 6,834 - Medicare Home Health Agencies

Source: January 2013 presentation by Jim Younkin, Project Director Keystone Beacon Community.
https://beaconcommunity.webex.com/beaconcommunity/lsr.php?AT=pb&SP=TC&rID=6302577&act=pb&rKey=2b876d68bd539c47
How can you put the IT in Transitions?

• Meaningful Use Stage 2 → **Meaningful transitions**

• Beacon Nation – What did we learn?
  – First change package: Creating **meaningful transitions** using admission, discharge, transfer feeds
  – Recruiting “Sister Communities” - Are you one?
  – kerri.petrin@hhs.gov

• KeyHIE Transform – Nursing homes and home health agencies can become information partners NOW
  – jryounkin@geisinger.edu

• LTPAC IT Community of Practice:
  – Elizabeth.PalenaHall@hhs.gov
How can you put the IT in Transitions?

For those who manage or maintain individually identifiable health data (e.g., providers, hospitals, payers, retail pharmacies) we invite you to pledge the following:

“We pledge to make it easier for individuals and their caregivers to have secure, timely, and electronic access to their health information. We further encourage individuals to use this information to improve their health and their care”

http://www.healthit.gov/pledge/

Lygeia.Ricciardi@hhs.gov
We want to hear from you! How are you putting the IT in Transitions?

Thank you!

Janhavi Kirtane Fritz (janhavi.kirtane@hhs.gov)
Health law’s rules help hospitals cut patient readmission rate

By N.C. Aizenman,

Over the past several months, America’s hospitals have achieved a feat that long seemed beyond reach: substantially reducing the share of patients who must return for treatment almost as soon as they are discharged.

According to statistics compiled by the Obama administration, the nationwide rate of hospital readmissions of Medicare patients within 30 days of discharge declined to about 17.8 percent by last November after remaining stuck near 19 percent over the five years that the data has been collected, and likely for decades prior to that.

Jonathan Blum, a top official at the Centers for Medicare and Medicaid Services, is scheduled to release the figures Thursday at a Senate Finance Committee hearing. In an interview, he argued that the drop — which has already kept tens of thousands of people out of the hospital — is largely the result of provisions in President Obama’s health-care law.

These provisions include new financial penalties that Medicare, the federal health program for the elderly and disabled, has begun imposing on hospitals with high readmission rates. They also include extra funding and incentives for hospitals and outpatient providers to do a better job of coordinating care for patients after they head home.

“What I think is exciting is that a couple years ago the general reaction to these policies was that it was impossible to reduce hospital readmissions,” Blum said. “And what this data shows me is that it is possible. . . . I believe that what we are seeing is a fundamental, structural change.”
PfP Hospitals Engaged, Reporting & Generating Results on Readmissions: January

- **Total Number of Short Stay, Acute Care Hospitals in the Nation**: 5,196
- **Total Number of Short Stay, Acute Care Hospitals in the PfP**: 3,699
- **Total Number of PfP Hospitals Committed To Reducing Readmissions**: 3,436 (92.9%)
- **Total Number of PfP Hospitals Reporting Readmissions Data to HEN**: 2,853 (77.1%)
- **Total Number of PfP Hospitals Showing Improvement or Sustained High Performance in Readmissions**: 483 (13.1%)
- **Total Number of PfP Hospitals Achieving Benchmark Status**: 39 (1.1%)

*percentages calculated using 3,699 as denominator*

Number of Hospitals

Sep. 2012 | 58
Oct. 2012 | 100
Nov. 2012 | 200
Dec. 2012 | 300
Jan. 2013 | 483
What Does Success Look Like and How Do We Accelerate Success Nationwide?

• More:
  – **Commitment** to 20% Readmissions Reduction
  – **Reporting** of Data
  – **Implementation** of evidence-based models and continuous QI
  – **Targeting** of high-risk patients, e.g., with polypharmacy, low patient activation, or on high risk meds such as opioids, hypoglycemics, anticoagulants (*hint: target high-risk but also measure all-cause*)
  – **Partnering** with downstream providers, social and aging services, other partners in the community
  – **Sharing** of successful practices and tools throughout CoP and beyond
  – **Success** and benchmark status in reducing readmissions

• **Hard stop policies**, e.g., perfect medication reconciliation for every patient before they leave the hospital

• **Others:** ongoing learning process
The Tri-Affinity Group: Work Together to Rapidly Spread Strategies to Reduce Adverse Drug Events and Medication-Related Readmissions

**Readmissions Affinity Group:**
- Reduce Readmissions by 20%;
- Improve discharge processes, strengthen cross-setting care and implement evidence-based models aimed at major readmission drivers; Identify champions / faculty / high performers to spread success

**Medication Safety Affinity Group:**
- Reduce Hospital Acquired Conditions (HACs), including Adverse Drug Events (ADEs);
- Target Opioids, Hypoglycemic Agents and Anticoagulants;
- Identify champions / faculty / high performers to spread success

**Rural Affinity Group:**
- Leverage the Agility and Nimbleness of Rural Hospitals to rapidly test strategies and spread success on both HAC and Readmission Aims of the Partnership
• Demonstrate the magnitude and significance of medication-related causes of readmissions

• Quickly field test solutions in rural hospitals and other settings with demonstrated agility in improving patient safety

• Identify key strategies that can be rapidly deployed nationally throughout Partnership for Patients networks to reduce medication-related readmissions

• LEARN FROM ONE ANOTHER – THE ANSWER IS IN THE ROOM!
1. Commit to individual and collective action to identify effective strategies to address major causes of medication-related readmissions and mechanisms for rapid spread  
   – Target: Today!

2. Identify from each HEN or partner 1-3 high-performing hospitals (or community collaboratives) and 1-3 expert faculty in reducing adverse drug events and medication-related drivers of readmissions.  
   – Target: March 19th

3. Develop ‘hard-stop’ policy that all hospitals could implement to reduce medication-related readmissions.  
   – Target: Q2

4. Develop toolkit for reducing medication-related readmissions.  
   – Target: Share Toolkit version 1.0 at healthcarecommunities.org by April 26, 2013

5. Others? How do you believe we can use these groups to best drive results?
Questions

• More Information:  
  http://partnershipforpatients.cms.gov/

• Contact:  
  mary.andrawis@cms.hhs.gov
Integrating Care for Populations & Communities QIO Program Aim

February 28, 2013

Shiree M. Southerland, PhD, RN, BSN
Integrating Care for Populations & Communities

Aims:

• Improve the quality of care for Medicare beneficiaries as they transition between providers

• Reduce 30 day hospital re-admissions (nationally)

• Reduce hospital admissions (nationally)
QIO Accomplishments as of January 31, 2013

<table>
<thead>
<tr>
<th># of Engaged Communities</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td># of Beneficiaries Living there</td>
<td>12,455,368</td>
</tr>
<tr>
<td># Formally Recruited Communities</td>
<td>222</td>
</tr>
<tr>
<td># Communities with Signed Coalition Charter</td>
<td>219</td>
</tr>
<tr>
<td># Applications Submitted</td>
<td>126</td>
</tr>
<tr>
<td># Communities Receiving Formal Funding</td>
<td>66</td>
</tr>
<tr>
<td># Recruited Hospitals</td>
<td>850</td>
</tr>
<tr>
<td># Recruited Nursing Homes</td>
<td>1,482</td>
</tr>
<tr>
<td># Recruited Home Health Agencies</td>
<td>880</td>
</tr>
<tr>
<td># Recruited Hospice Facilities</td>
<td>333</td>
</tr>
<tr>
<td># Recruited Dialysis Facilities</td>
<td>96</td>
</tr>
<tr>
<td># Recruited Outpatient Physicians</td>
<td>&gt; 1,914</td>
</tr>
</tbody>
</table>
National Coalition of QIO-recruited Communities Early Progress
Quarterly Readmissions per 1,000 Beneficiaries

9.1%
Access Resources

- Contact your QIO

- Join (and listen to archived) Care Transitions Learning Sessions
  http://www.cfmc.org/integratingcare/learning_sessions.htm

- Browse our Toolkit
  http://www.cfmc.org/integratingcare/toolkit.htm

- Check out what’s going on in your State
  http://www.cfmc.org/integratingcare/ct-efforts-map.htm