CMS- Masspro
Care Transitions Initiative

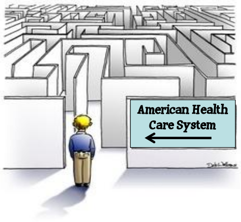
Moving Forward Together

This material was prepared by Masspro, the Medicare Quality Improvement Organization for Massachusetts, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily represent CMS policy. 10-ma-caretrans-11-08StaarPpt-Sept11

Objectives

At the completion of this presentation, participants will be able to:

- To describe the role providers can play in reducing preventable 30-day readmission.
- Define a community based care transitions team



National Quality Strategy

"Improving health and health care for all Medicare beneficiaries and promoting quality of care to ensure the right care at the right time."

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Care Transitions Initiative- 10 SOW

- To measurably improve the quality of care for Medicare beneficiaries who transition across care settings through a comprehensive **community effort.**
- **To reduce readmissions following hospitalization and to yield sustainable and replicable strategies to achieve high** value health care for Medicare beneficiaries.
  - Reduce preventable 30-day readmissions by 20% over the next 3 years

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Care Transitions Initiative

Work with communities to:

- Form effective care transitions coalitions
- Form statewide learning and action networks
- Reduce avoidable hospital readmissions
- Build capacity to qualify for funding through Section 3026 of the Affordable Care Act

Community teams sign a coalition charter with Masspro, signifying their commitment to the 10SOW and the goals of CMS. This is required even if only receiving technical assistance for 3026.

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Masspro – Care Transitions Initiative

- Measurement
  - Community readmission rates
  - Hospital readmissions rates
  - Post acute care setting readmission rates
  - Disease-specific readmission rates
  - ED Visit rates
  - Observation stay rates
  - Mortality rates
- Technical assistance in care transitions efforts
  - Root cause analysis to identify community specific causes for poor transitions
  - Identification of target population & selection of evidence based interventions aimed at identified drivers of poor transitions in the targeted population
  - Data analysis and trending

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Learning and Action Networks

- Providers and other health care stakeholders, including beneficiaries, working together to implement change and spread best practices through peer-to-peer learning and solution sharing.
  - Improvement collaboratives
  - All Teach-All Learn
  - Online interaction, tools, resources
  - Educational opportunities

Annual face-to-face meeting, 2-3 virtual meetings per year

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Why Care Transitions?

- Long-standing problem with high rate of readmissions, particularly in the Medicare population
- Multiple quality of care deficiencies observed with transitions of care from one setting or provider to another in numerous academic & healthcare policy papers
- Personal and public experiences with poor care transitions
- Increased focus among healthcare stakeholders on care coordination, payment silos, etc.

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Community Based Care Transitions Program

- Accepting applications on a rolling basis and will continue to award applications on a rolling basis as funding permits
- Preference is for a model with one CBO working with multiple acute care hospitals in a community 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

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QIO Role

If applicant does not receive funding:

- The CCTP panel will offer an opportunity for a short debrief
- Applicants may choose to invite Masspro to this debrief
- Applicants will be allowed to re-submit an application and may continue to get Masspro assistance as requested and needed
- Applicants who do not initially work with Masspro and are not accepted will receive guidance regarding the availability of Masspro technical assistance

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CCTP Application Components

1. Includes a Community Specific Root Cause Analysis (RCA)
   a. Implementation/Intervention Strategy
2. Organizational Structure and Capabilities- for the applicant and its partners
3. Previous Experience
4. Budget Proposal

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Root Cause Analysis

- Description of a comprehensive community specific root cause analysis including incorporating post acute care providers as appropriate
- Results of the root cause analysis are used to drive selection of the target population and the interventions
- Clear process for identifying high risk Medicare FFS beneficiaries to be targeted

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Not So Good RCA

Using RCA to Drive Intervention Selection – not so good example

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Good RCA

Using RCA to Drive Intervention Selection – good example

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Implementation Plan

- Implementation work plan with milestones
- Identify process for collecting, aggregating, and reporting quality measure data to CMS
- Description of how the applicant will ***align its care*** transition programs with care transition initiatives sponsored by other payers in their respective community
- Intervention implementation strategy- including how the intervention will be integrated into the discharge process without duplicating it

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- In spite of many evidence-based interventions, communities tended to focus on the two interventions that have received most publicity and public attention
  - Multi-faceted approach recommended
- There are many opportunities to broaden the scope of interventions

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Previous Experience

- Description of previous experience implementing care transitions interventions
- Includes evidence on the measurement strategies and outcomes of this work
- Training completed in any of the evidence based interventions
- Description of other efforts to reduce readmission

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Common Application Errors

- The applicant CBO does not meet the eligibility requirements to be a CBO, unclear documentation to support the applicant CBO meets the requirements of a CBO
- Board members and their affiliations are not identified
- Lack of a community specific RCA
- The RCA is present, but the methodology for targeting high risk beneficiaries & the selected interventions proposed are not tied back to the community specific RCA.
- Letters of support are missing from the application

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Correlating RCA to Interventions

Root Cause	Interventions
High HF readmission rates at all 4 target hospitals. Causes identified through claims data and interdisciplinary staff interviews ➢ Medication reconciliation issues ➢ Opportunity for more post acute f/u by HH based on claims data disposition codes ➢ Inconsistent disease specific teaching across settings ➢ Inconsistent transfer of appropriate information ➢ Timely PCP f/u ➢ Hospitalist contact with PCP	Transforming Care at the Bedside for patients with Heart Failure: ➢ Creating an Ideal Transition Home ➢ Medication reconciliation Identifying and involving family caregivers ➢ Teach Back ➢ CARE Tool/Transfer checklist ➢ HH referral/coaching ➢ Cardiology f/u ➢ NP f/u

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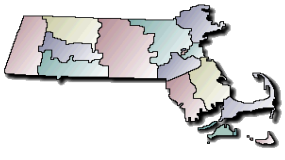
State of the State- MA



October 1, 2009- September 30, 2010
30 day Readmission rate = 19.7%

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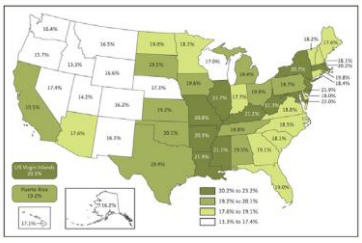
National Rates



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Admission/Readmissions by Setting

	MA	All States Median
Nursing Home Hospital admissions	14.8%	18.7
Nursing Home 30 day readmissions	19.5%	20.8
Home Health hospitalizations	34.1%	28.7
Acute Care 30 day readmissions	19.4%	17.5

Source: Commonwealth Fund, 2009

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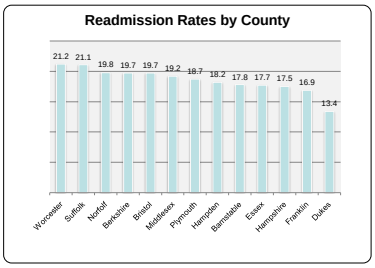
MA Counties

County	# Hospitals
Barnstable	1
Berkshire	4
Bristol	4
Dukes	1
Essex	5
Franklin	1
Hampden	6
Hampshire	1
Middlesex	13
Norfolk	4
Plymouth	4
Suffolk	10
Worcester	8



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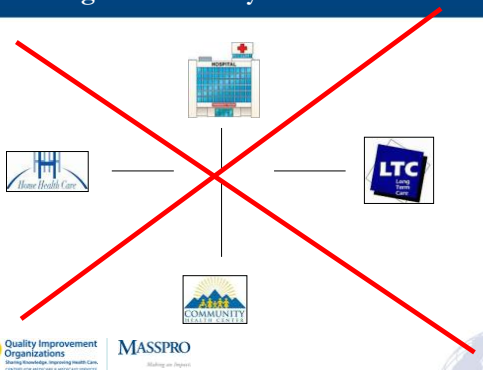
Defining a Community



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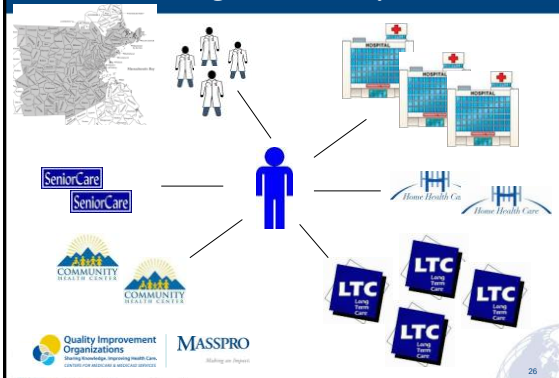

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Thank You!

commit to safe health care

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