# Supporting Elders across Settings

## Care Transitions Opportunities and Tribal Organizations

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# Agenda

- Introduction to Care Transition Themes: Linking to your mission
- The Partnership for Patients and Community-based Care Transitions Program
- Resources and Technical Assistance

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# INTRODUCTION TO CARE TRANSITIONS THEMES

Linking to the mission of Title VI Programs

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# 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.

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# Home and Community Based Services and Hospital Readmissions

- In a study evaluating the home food environment of hospital-discharged older adults, 1/3 of participants reported being unable to both shop and prepare meals
- Greater volume of attendant care, homemaking services and home-delivered meals is associated with lower risk of hospital admissions

Anyanqu, Ucheoma O., Sharkey, Joseph R., Jackson, Robert T. (2011) Home Food Environment of Older Adults Transitioning From Hospital to Home. *Journal of Nutrition in Gerontology and Geriatrics* 30:105-121.
Xu, Huiping et al. (2010) Volume of Home-and Community-Based Medicaid Waiver Services and Risk of Hospital Admissions. *Journal of American Geriatric Society*

# 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.

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# Common Care Transition Themes

- Interdisciplinary Communication/Collaboration
- Transitional Care Staff
- Patient Activation
- Enhanced Follow-up

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# Care Transition Themes: How Do They Relate to The Older Americans Act (OAA) and Title VI

### *Interdisciplinary Teams & Service Coordination*

- Coordination of services (medical/ human services)
- Workforce development and training
- Planning
- Partnerships
- Coordination of benefits

### *Enhanced Follow-Up*

- Case Management/ Care Coordination
- In-home services
- Home-delivered meals
- Transportation
- Monitoring/assistive devices
- Medication management
- Disease prevention & health promotion

### *Patient/Client Activation*

- Assessments
- Self-directed care/coaching
- Health/nutrition education
- Insurance counseling
- Family caregiver support, counseling, training

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# OAA Services within Care Transition Themes:
## Interdisciplinary Teams and Service Coordination

- Coordination services (seamlessly bridging medical & human services)
- Workforce development & training (standards)
- Develop area and  strategic plans including business development
- Create new partnerships, especially with health systems
- Coordinate access to benefits

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# OAA Services within Care Transition Themes:

## Enhanced Follow-Up

- Case management/Care coordination
  - Develop, implement, monitor individual service plans
- In-home services
  - Home health
  - Personal Care
  - Homemaker
  - Visiting/telephone reassurance
  - Chore
- Nutrition/home-delivered meals
- Transportation
- Monitoring/assistive devices
- Medication management
- Disease prevention/health promotion
  - Health risk assessment
  - Chronic Disease Self Management Programs
  - Evidence-based programs
  - Home injury screenings

# OAA Services within Care Transition Themes:

## Patient/Client Activation

- Comprehensive assessments, including home and caregiver assessments
- Self-directed care/coaching
- Health and nutrition education
- Public benefits and insurance counseling
- Family caregiver support, counseling, training

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# Why the Work of Title VI Programs Is So Critical to Care Transitions

- Unique and trusted position in the community for over 30 Years
- Knowledge of community services
- Knowledge of elders and caregivers
- Service provision skills
- Quality assurance and outcomes

# Why Care Transitions Is So Critical to the Mission of Title VI Programs

- Core mission of maximizing independence for at-risk Elders
- Need to engage in changing long-term care landscape
- New revenue stream
- Existing program participants are high risk for Readmission

# Care Transitions: Opportunities and Considerations for the Tribal Organizations

- **Capacity:** To expand your business model, develop and sustain new partnerships, establish fee for service billing systems
- **Human Resources:** To expand and enhance existing operations (quick turnaround/possible 24/7 services)
- **Partnership/Provider Relations:** To respond to broad scope of care transitions service needs
- **Culture Change:** To expand your organization's position- a new way of doing the business your agency/staff/providers have been doing

# Lessons Learned from Successful Care Transition Programs within the Aging Network: Partnership Strategies

- Engage Leadership
- Cross Training
- Staff Co-location
- Written Protocols
- Formalized Partnerships
- Leverage Strengths

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# PARTNERSHIP FOR PATIENTS

## The Community-based Care Transitions Program

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# 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

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# 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://www.healthcare.gov/center/programs/partnership/join/index.html

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# 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 measureable savings to the Medicare program

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# Eligible Applicants

- Are statutorily defined as:
  - Community-based organizations (CBOs) that provide care transition services
  - Acute Care Hospitals with high readmission rates in partnership with a community based organization
- There MUST be a partnership between the acute care hospitals and the CBO

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# 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
  - Must be a legal entity, i.e., have a taxpayer ID number - for example, a 501(c)3) - so they can be paid for services they provide
  - Must be physically located in the community it proposes to serve
- Preference is for model with one CBO working with multiple acute care hospitals in a community
- A self-contained or closed health system does not qualify as a CBO

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# Entities that may be a CBO

- Area Agencies on Aging
- Aging and Disability Resource Center (ADRCs)
- Tribal Organizations
- Federally Qualified Health Centers (FQHCs)
- A coalition representing a collaboration of community healthcare providers - if a legal entity is formed
- Some post-acute care providers may qualify- with evidence that there is board representation that comes from outside of that provider entity.

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# 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

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# 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)

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# Application Requirements

- Strategy and Implementation Plan
  - Includes  a Community-Specific Root Cause Analysis (RCA)
- Organizational Structure and Capabilities- for the applicant and its partners
- Previous Experience
- Budget Proposal

# 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
- Applicants claiming preference for working in rural areas, small communities, or serving medically- underserved populations should provide evidence to support that claim

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# Care Transitions Models

- Care Transitions Intervention℠
- Transitional Care Model
- Bridge Program
- BOOST (Better Outcomes for Older Adults through Safe Transitions)
- GRACE (Geriatric Resources for Assessment and Care of Elders)
- Project RED (Re-engineered Discharge)

And others….

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# Organizational Structure

- Description of the financial, legal, and organizational structure of the partnership between the hospital and the CBO
- Process for if and how CBO fees will be shared with the hospital or other community providers
- Explanation of  internal monitoring processes for the management and delivery of care transition services
- Include protocols detailing financial controls for Medicare payments

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# Capabilities

- Formal agreements are presented for all downstream providers identified as partners in the initiative
- Applicant provides letters of support signed by the CFO, CEO, and operations manager for discharge/case management at each hospital named as a partner in the application.
- Justification for applicant to qualify as a CBO
- Support for claiming program preferences as noted above

# 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 readmissions
  - May include discharge process redesign or the use of electronic health information systems and tools.

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# Budget Guidance

- **This is not a grant program**
- CBOs will not be paid for discharge planning services already required under the Social Security Act and stipulated in the CMS Conditions of Participation
- CBOs may only include the direct service costs for the provision of care transition services to high-risk Medicare beneficiaries (including dual eligibles)
- You do not have to use the worksheet provided however you need to provide the information contained in the budget worksheet

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# Common Application Errors

- The applicant 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 and the selected interventions proposed are not tied back to the community-specific RCA.
- Letters of support are missing from the application
- Budget

# Common Budget Errors

- Building a budget like a grant and including costs for training, evaluation, equipment, overhead, and so on
- Payments between providers for referrals
- Incentive payments to providers for good will and cooperation

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# Conclusion

- The program solicitation is now available on CMS program webpage at http://www.cms.gov/DemoProjectsEvalRpts/MD/itemdetail.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

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# RESOURCES AND TECHNICAL ASSISTANCE

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# Coming Soon: AoA Care Transitions Resource Page

- New webpage for organizations looking for care transitions program information within the Aging Network
  - Toolkit and webinars
  - Funding opportunities
  - Basics and background
  - Publically available technical assistance resources

Will be live very soon! Available from AoA's Tools and Resources webpage: http://aoa.gov/AoARoot/AoA_Programs/Tools_Resources/index.aspx

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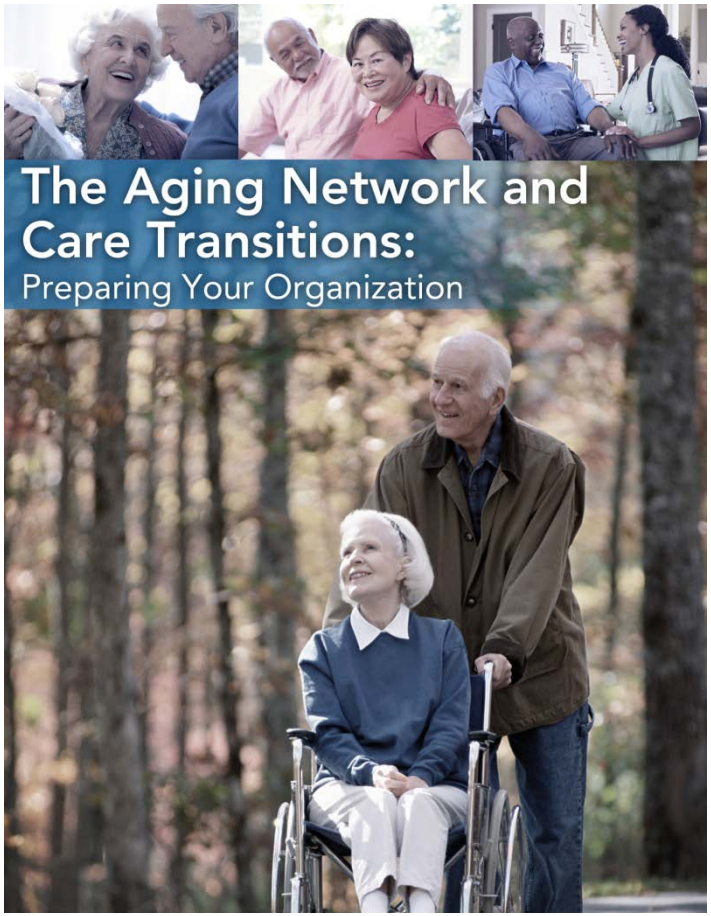
# AoA Care Transitions Toolkit




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

http://www.aoa.gov/AoARoot/AoA_Programs/HCLTC/ADRC_CareTransitions/Toolkit/index.aspx

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# Technical Assistance:
## Quality Improvement Organizations (QIO)

- Coalition/charter building
- Root Cause Analysis
- Social Network Analysis
- Measurement strategy and data analysis
- Logic model development
- Learning and Action Networks
- Webinar learning sessions and archives

http://www.cfmc.org/integratingcare/Default.htm

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

ICPC
Integrating Care for Populations & Communities

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# Resources: Care Transitions

- http://www.healthcare.gov/center/programs/partnership/index.html (Partnership for Patients)
- http://www.cms.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?itemID=CMS1239313 (Community-based Care Transitions Program)
- http://www.aoa.gov/Aging_Statistics/Health_care_reform.aspx (AoA's Health Reform web page)
- http://www.adrc-tae.org/tiki-index.php?page=CareTransitions (AoA's Aging and Disability Resource Centers and care transitions)
- http://www.cfmc.org/integratingcare/ (Care Transitions Quality Improvement Organization Support Center)
- http://www.ltqa.org/wp-content/themes/ltqaMain/custom/images//Innovative-Communities-Report-Final-0216111.pdf (Innovative Communities report from the Long-Term Quality Alliance)

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# Resources: Affordable Care Act

- http://www.aoa.gov/Aging_Statistics/Health_care_reform.aspx (AoA's Health Reform web page)
- http://www.healthcare.gov (Department of Health and Human Services' health care reform web site)
- http://www.thomas.gov/cgi-bin/bdquery/D?d111:1:./temp/~bdsYKv::|/home/LegislativeData.php?n=BSS;c=111| (Affordable Care Act text and related information)

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