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
INTRODUCTION TO CARE
TRANSITIONS THEMES

Linking to the mission of Title VI Programs
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.
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.


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.
Common Care Transition Themes

• Interdisciplinary Communication/Collaboration
• Transitional Care Staff
• Patient Activation
• Enhanced Follow-up
## Care Transition Themes: How Do They Relate to The Older Americans Act (OAA) and Title VI

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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
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
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
PARTNERSHIP FOR PATIENTS

The Community-based Care Transitions Program
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
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
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
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
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
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.
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
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)
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
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....
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
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.
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
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
Conclusion

• The program solicitation is now available on CMS program webpage at

• The program will run for 5 years with the possibility of expansion beyond 2015

• Please direct CCTP questions to CareTransitions@cms.hhs.gov
RESOURCES AND TECHNICAL ASSISTANCE
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
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
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
Resources: Care Transitions

- [http://www.cfmc.org/integratingcare/](http://www.cfmc.org/integratingcare/) (Care Transitions Quality Improvement Organization Support Center)
Resources: Affordable Care Act

- [http://www.healthcare.gov](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](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)