The Community-based Care Transitions Program

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The Community–based Care Transitions Program (CCTP)

- The CCTP, created by section 3026 of the Affordable Care Act, provides $500M over 5 years to test models for improving care transitions for high risk Medicare beneficiaries.
- We currently have 47 communities projected to serve approximately 220,000 high risk Medicare beneficiaries across 21 states annually
- Our final review of applications for CY 2012 is scheduled for September 20, 2012

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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 measurable savings to the Medicare program and expand program beyond the initial 5 years

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The CCTP Partners

Who are these CCTP Participants?

Two types of primary applicants : 43 are CBOs, and 4 are high-readmissions hospitals, partnering with CBOs

1) Forty-three CBO lead applicants:
   - Includes AAAs, ADRCs, non-profit home and community-based service providers, physician hospital organizations, visiting nurse services, community health centers, and other Medicare providers

2) Four high-readmission hospital lead applicants:
   - St. John Providence Health System in Warren, MI, partnering with Adult Well-Being Services, a service provider of the Detroit AAA, and
   - Yale-New Haven Hospital, CT, in partnership with the AAA of South Central Connecticut and the Hospital of Saint Raphael in New Haven
   - Mount Sinai Hospital, NY, in partnership with the Institute for Family Health
   - New York Methodist Hospital, in partnership with Hills and Heights

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Who are these CCTP Participants?

- **Average number of hospital partners:** 4
- **Maximum number of hospital partners:** 10
- **Most prevalent interventions include:** CTI, Bridge Model, Aspects of Project RED and the BOOST Program, and the TCM
- Approximately 50% of programs offer supportive service packages to a subset of their high risk target population

- **Detailed information on all CCTP sites may be found at:** http://innovation.cms.gov/initiatives/Partnership-for-Patients/CCTP/partners.html

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Eligible Applicants

- Are statutorily defined as:
  - Acute Care Hospitals with high readmission rates in partnership with an eligible community-based organization
  - Community-based organizations (CBOs) that provide care transition services
- There must always be a partnership between at least one acute care hospital and one eligible CBO
- Critical access hospitals and specialty hospitals are excluded as feeder hospitals but could be part of the larger community collaboration

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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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Key Points

- Applicants are awarded 2-year agreements with continued participation dependent on achieving reductions in 30-day all cause readmission rates
- The CCTP builds on the care transition pilots completed in 14 states through the QIO 9th SOW
- The QIO 10th SOW includes tasks to build communities focused on care transitions and provide technical assistance to providers and CBOs interested in applying for the CCTP

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Payment Methodology for CCTP

- This is not a grant program
- CBOs will be paid a per eligible discharge rate for the direct service costs for the provision of care transition services
- CBOs will not be paid for discharge planning services already required by the Social Security Act
- Rate will not support ongoing disease management or chronic care management which generally require a PMPM fee

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Drivers of Poor Transitions and Readmissions

- Poor information transfer between providers
- Decreased patient and/or family activation
- A lack of a standard and known process for sharing patients among providers

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Lessons Learned from the QIO 9th SOW Care Transitions Pilot

- Importance of community collaboration
  - Providers talking, visiting each other, sharing
- Tailor solutions to fit community priorities
  - Community needs determine change
- Include patients and families
  - Incorporate beneficiaries when they are sick and healthy
- Public outreach activities
  - Storytelling to support data

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QIO Technical Assistance

- Community Coalition Formation
- Community-specific Root Cause Analysis
- Intervention Selection and Implementation
- Assist with an Application for a Formal Care Transitions Program

For assistance please locate your QIO care transitions contact at: http://cfmc.org/integratingcare under “Contact Us”
www.cfmc.org/caretransitions

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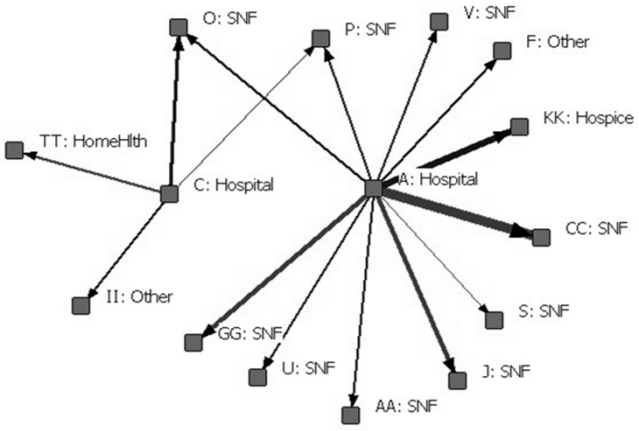
Social Network Analysis (SNA)

- **Tool Description**

  SNA maps are a visual depiction of the number of transitions that are shared between providers in the community

- **Tool Uses**
  - Used by several QIOs midway through the 9th SOW Care Transitions Theme
  - Can be used for provider recruitment & engagement and targeting interventions to highly problematic pairs
  - Can be recalculated over time to show improvement in transitions between sender/receiver pairs

Social Network Analysis



Community Specific Root Cause Analysis

Data Analysis
- Coalition Readmission rates
- Coalition Admission rates
- Hospital Readmission rates
- ED visit Rates
- Observation Stay Rates
- Mortality Rates
- Post acute care setting Readmission rates
- Disease specific readmission rates

– Process Mapping
– Chart Reviews
– Patient/Stakeholder feedback

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Additional Assistance for Communities not in a formal Care Transitions Program

- Provide quarterly community readmission metrics
- Host a State-wide Learning and Action Network
- Participate in Care Transitions Learning Sessions
- Use QIO developed tools and resources

The CCTP as Part of a Broader Initiative

Partnership for Patients: a nationwide public-private partnership that will help improve the quality, safety, and affordability of health care for all Americans.

By the end of 2013:

40% Reduction in Preventable Hospital Acquired Conditions

- 1.8 Million Fewer Injuries
- 60,000 Lives Saved

20% Reduction in Preventable 30-Day Readmissions

- 1.6 Million Patients Recover Without Readmission

Up to $35 Billion Dollars Saved in Three Years

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Questions?

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http://innovation.cms.gov/initiatives/Partnership-for-Patients/CCTP/partners.html

Additional information is available on our website:
http://innovation.cms.gov/initiatives/Partnership-for-Patients/CCTP/index.html

For further questions, please email:
CareTransitions@cms.hhs.gov

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