About the Community-Based Care Transitions Program – Section 3026 funding
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(Note – there are some areas where the solicitation is unclear or internally inconsistent. You should stay abreast of updated FAQs by subscribing to the email list at …. Where it seemed important, ambiguities in the solicitation are noted below.)

Overview:

- Program to pay Community-Based Organizations (CBOs) to improve hospital discharges
- Hospitals can apply with a CBO if they are high-readmission hospitals for their state (see list at …)
- CBOs can apply to work with any hospital(s) (no matter what the hospital(s)' rehospitalization rate(s))
- Must expect to save money overall – and probably to show savings (or the near likelihood of having savings to show) within two years
- Initial award is for two years, with annual continuation at that point
- List of evidence-based interventions is referenced at (Remington 2010), and there is actually another CMS list of evidence-based interventions in the QIO RFP at …
- The CBOs are expected to provide services "across the continuum of care" and must have formal agreements with a suitable array of partners
- Cost savings are estimated with simple avoided rehospitalizations – but it is not clear whether the assessment of the program will really use a more extensive accounting (including observation stays, medications, imaging, etc)
- CBOs must have a board that includes most stakeholders, including consumers.
- CBOs are preferred if they are AAAs or in rural or otherwise underserved areas
- Cannot duplicate services already required (see below); cannot pay twice for services being paid for in Patient Centered Medical Homes or other CMS initiatives
- Payment is on a blended rate, paid per eligible discharge – which can include infrastructure costs
- Will not pay for one beneficiary more than once in 6 months
- Applicant must describe targeting and intervention strategy and be willing to participate in collaborative learning and redesign (including data collection)

Some initial recommendations as to how to make this work:

- Emphasize the effects of low-cost interventions like getting the providers to know one another, standardizing their processes, and developing feedback from downstream to upstream providers about the quality of transitions
- Use add-on personnel catalytically when possible – to test a strategy or to adapt and train regular personnel

- Build new skills into existing personnel – especially important in enhancing skills of care managers already in place, or of community health workers already supporting self-care or chronic illness management
- Be wary of simply adding on personnel – keep them targeted on patients who do not have existing care management and who also have high risks – learn how to get them to leave the case when they have achieved all that they reasonably can (both because things are now well-settled and because things are never going to be well-settled)
- Recognize that some situations are going to stay high-risk and there is little to do about them; and that some situations require improvements outside of "health care" (like housing the homeless) that the coalition could lend its weight to
- Invest in training for self-care coaching, and start testing how to support patient/family activation when they are in the health care system and also in the community
- Look to build relationships with the chronic disease team in the local health department, the Area Agency on Aging (and/or the Aging and Disability Resource Center), the local "United Way" agencies, and the news media
- Look also to bring all relevant providers into the mix – home care, SNF, NH, hospice, physicians
- Beware of seeming to make gains by having more observation stays, more ER use, or many more hospice days. These will be added up at some point!
- Use this experience as a bridge toward more integrated care generally. It might end up with an ACO, or some other integration model, but the relationships forged in this work provide a very valuable "social capital" to the community as we face the need to serve many fragile people with constrained resources. Having shared standards, feedback loops, activated patients, self-care support, and so forth will all help.

Specific comments

The CBO

- The payee and critical partner.
- Must have "sufficient representation" of multiple health care stakeholders, including consumers on its Board – not clear what this will mean, but it does not mean zero, and it does not mean just the hospital or its health plan. If a CBO needs to expand its Board to qualify and otherwise wanted to do that, then do that before applying.
- Must have agreements with a conventional general hospital or hospitals. Other providers will also be needed, but agreements with the hospital(s) are absolutely required.
- Preference for Agency on Aging grantees – certain Area Agencies on Aging (see list….)

Why community-Based?

- Because you can fix only part of the foul-ups from within a hospital. The other partners have to agree as to standard process, supporting patient in self-care, feedback on quality, and other elements.
- Because the experience to date is that multi-party coalitions are moving along better than in-hospital checklists or other enhanced processes.
- Because working this way engenders care plans that cross settings, and that is the anchor of optimal care
- Because hospitals are mostly the failure mode for chronic care, so much of the work is about how to keep the patient well enough not to need the hospital.

Why pay "per patient?"

- Because that mode is a natural for CMS. This is a program, not a demo. It can continue if it works well. Other ways of paying would not be easy to extend into a permanent program.
- Some will object that the CBO can't take the risk on up-front costs that might not be reimbursed. That is often true. There may have to be some sharing of investments from health plans, hospitals, and others to get these projects off the ground (perhaps expecting that there will eventually be a return, or at least an avoidance of financial risk)

What's the "root cause" analysis?

- Every community working on this so far has found that failures arise from inadequate information transfer, passive patients with inadequate self-care, and non-standard processes (including having no feedback loops to correct shortcomings in upstream provider processes). But the details differ. Some communities have most bounce-backs from SNFs; others from patients without PCPs. Some communities have HIEs working for labs and X-rays, but these have not been adapted to provide notice of admission or ER use. You will have to know what gives rise to the snafus in your system.
- How can one do that? The most obvious way is to do some deep characterization of a sample of bounce-backs. Usually, just a small sample is quite illuminating (e.g., the last six readmissions at each of the three hospitals). In sharing those stories beyond those who served them, one has to do enough scrambling of identifiers and aggregating data that the patients are not identifiable.
- What else works? Working with claims data can give substantial insight quickly. One can probe for patterns, and then use programs that allow you to see the clinical course from the claims. If you have claims (or hospital discharge lists or surveillance data for disaster planning), then do these analyses. If not, then see if your QIO might help with Medicare FFS claims.
- You can also use the "root cause" analyses to forge the coalition and the relationships with the CBO that you'll need for the work to proceed.

What's the requirement for "informed consent" in the announcement?

- That is a very odd element for the announcement to have mentioned. One wonders if it was "left over" from an earlier template for a research project. Since the steps you are putting in place are not research on human subjects but quality improvement in operations management, the consent needed is just the consent needed for anything else being done with a patient. You might do well to establish a clear script, so patients know about the follow-up and the possibility of being interviewed. You might want to be sure to document the agreement. But most practices in the country do not require a formal consent for the currently more risky discharge process, so an improved discharge process should not require any more assiduous consent (except, perhaps, to forewarn the person that there may be follow-up and a request later for a survey).

Who should you target?

- Your application must state who you will target and why. The announcement lists "multiple chronic conditions, depression, and cognitive impairments" as examples.
- However, the real point is to tailor the interventions to the populations. Probably every Medicare beneficiary has reason enough to have a reliable discharge process with standard information transfer, transition of responsibility among physicians, timely follow-up, medication reconciliation, and caregiver assessment. But some patients are in very risky situations – no caregiver at home, track record of being unable to follow instructions, no PCP, etc. You probably want to tailor interventions to match the relevant categories (as informed by your root cause analysis).
- Depression and cognitive dysfunction (delirium and dementia) often have strong correlation with substantial use of health care, and they are often overlooked and not diagnosed or documented. Thus, you may need to test out some screening for these in order to sharpen your targeting.
- One word of caution in constructing your targets by disease – the "diagnosis" on the record for Medicare patients is often not so helpful in matching with the services needed. For example CHF as the diagnosis for a hospitalization is often not even really a significant part of the problems of a very elderly person with many problems – so managing this person with conventional algorithms for CHF will just waste resources. This person may have puffy ankles due to venous insufficiency and shortness of breath due to deconditioning -- along with ADL deficits, a worn-out caregiver, mild dementia, and postural dizziness. Managing fluid load is not the central issue!
- You can have multiple categories of eligible patients, and you can still propose a blended rate. For example, you could screen patients for activation and skills, and provide only a brief "reminder" session for those with high activation and skills – while providing coaching on activation and skills for those who respond, and supplementary services for persons who cannot learn at the present time and who do not have a suitable caregiver. On another dimension, you can provide access to the hospital record for persons whose next provider has that capability, and you can instead provide a written summary and phone call for questions to the next provider who does not yet have electronic access. The examples could go on, but the

main thing to note is that you have to have reasonably good evidence as to the likely costs and proportions in order to estimate your blended rate (or you could risk not having sufficient funds, or overspending and not being continued into the future).

What determines funding past the first two years?

- First and foremost, is there evidence of improvement. Did the CBO manage its resources in the patients' interests? Are processes clearly better? Is there reason to think that the improvements could be sustained? Do improvements affect all Medicare beneficiaries yet, or are they likely to do so? Are the improvements acting against disparities, or at least not worsening them? Would the principals know if there were shortcomings in quality – are they monitoring effects locally?
- Second, did the coalition comply with the requirements of the award? Are they providing the needed information to CMS? Are they developing SQUIRE-format reports and control charts? Are they attending the required collaborative meetings and contributing? Are they showing an interest in ongoing adaptation toward better processes, as discovered by others? Are they managing funds appropriately?
- Third, is there evidence that makes the claim believable that they are reducing costs? Are there reductions in rehospitalizations? Are there substantial increases in ER or observation stays? Within the first year, aggregate costs may well exceed baseline, given the costs of start-up, training, attending meetings, providing accounting and reports to CMS, interviewing beneficiaries, etc. But there should be a substantial decrease in rehospitalization without compensatory expansion of other obvious costs, and a reasonable justification for going forward.
- Fourth, does the coalition work well together? Have they developed processes that include working with data, setting priorities, sharing challenges, and finding solutions? Are they growing in understanding and command, rather than just being held together by this funding?
- Note that the renewals are annual after the first two years, so one might expect that data to guide the first renewal will have enough time lag that the decisions will be made on the first year's data (or the first 5 quarters). That consideration makes it likely that the first renewal will be nearly automatic, with opportunity only to stop programs that are clearly dysfunctional (including those that never really got started). But by the time of the second renewal (for the fourth year), the track record should be much more clear. Data from that fourth year of the program will be when CMS will have to be undertaking the most definitive of its analyses to see whether at least some models should be allowed to proceed into being permanent parts of the Medicare program. So, at that point, CMS will need awardees that are clearly making substantial gains and that have unambiguous data and descriptions. Programs with models that are too costly to sustain or having too little impact may well be discontinued or have to modify their approach in order to be eligible for the fourth or fifth year.
- Note also that this is not a demonstration project. It is set up to become a permanent part of Medicare without a pause for "end of project" analyses or additional Congressional action – if CMS and HHS decide that there is a way to continue that reduces costs and increases quality.

What are CMS's measures?

The ones published so far include

1. Outcome measures
    a. 30-d Risk-adjusted all-cause readmission rate (currently under development)
    b. 30-d unadjusted all cause readmission rate
    c. 30-d risk-adjusted AMI, HF, and Pneu readmissions

    COMMENT – These are quite problematic metrics. If you do a good job on care transitions, you initially probably decrease short-term readmissions, but soon, you also reduce admissions. The rates that CMS has been using outside of the QIO program use readmissions/admissions for an identified hospital. You see the problem! If you reduce admissions substantially, you can end up not changing (or even adversely changing) the rate while actually improving. One expects that CMS will be working on this challenge and there might be some modification to these metrics during the program. In addition, the risk-adjusted metrics that CMS has been using require a major time lag and often rely upon very small samples. Furthermore, they do not adjust for endogeneity of multiple diagnoses, nor for social situation (except for Medicaid dual status). Again, there may be improvements to the performance of the metrics during the program.

2. Process measures
    a. PCP follow-up within 7 days of hospital discharge
    b. PCP follow-up within 30 days of hospital discharge
    COMMENT – these are usually mapped in Medicare claims, so you should consider whether you have a major group of Medicare FFS patients whose follow-up will not be seen in Medicare claims – persons using VA or DOD facilities, or Indian Health Service, or FQHCs or public clinics. Being seen by a nurse who cannot bill but who is providing services on the model reported by Mary Naylor et al would also not be seen in the claim stream. IF these affect your plan, you might propose a local way to track success in rapid follow-up and see whether CMS would accept that report in addition to their standard report.

3. "HCAHP items" – (note – includes more than HCAHPS)
    a. HCAHPS on medication info
    b. HCAHPS on discharge info
    c. Care Transitions Measure (3 – item, see www.caretransitions.org....)
    d. Patient Activation Measure (13 –item, see www….)
    COMMENT – the blended rate will need to accommodate doing this survey, most likely. It is not noted whether the community could add items to this survey, though that will undoubtedly be desirable to do.

COMMENT - CMS has not proposed additional measures, but it is reasonable to hope that measures of care plan adequacy and continuity are being developed and would be implemented as they mature, so we would have measures that more directly reflect quality, as well as measures of utilization.

Patient Refusal

Some of the QIO projects had remarkable rates of patient refusal of coaching or of at-home follow-up – as much as 70% turn-down. Having the same person see the patient while still in the hospital seems to make a home visit much more acceptable, and more experienced coaches and nurses learned to assuage anxieties. Some patients are just too embarrassed to let a person presumed to be better educated and financed come to their humble abode. Others can't see why they can't manage everything. In any case, this effect can be critical to your estimates of likely costs and underscores why you need to have tested elements like this in order to give a reasonable estimate. If you have an intervention component that relies upon patient agreement in order to be implemented, you'll have to do some piloting in order to make a reasonable application.

One-intervention or multiple-intervention strategies

It is easiest to propose a simple "add-on" strategy that can more readily be described and for which the cost estimates are easier to generate. In areas with profoundly bad transitions, indeed, just doing this much may substantially reduce rehospitalization. However, in most situations, you will end up wanting to fix more aspects of the process and to implement, for example, strategies to forge relationships, to standardize processes, to move information reliably, and to enhance patient activation. Since such multifaceted interventions require more time to test, adapt, roll-out, train for, and support, their implementation will probably need to be staged. There is nothing in the solicitation that bars a complex plan of this sort, but it will need to be believable, and you will need to have enough experience to estimate the timing and the costs well.

What considerations generate preference for awards?

Beyond the obvious of doing better quality and saving funds, these are mentioned as adding positive consideration for your application:

1. Experience, prior training, confidence in estimates of impact and costs
2. Working with Agency on Aging grantees (AAAs and ADRCs)
3. Using intervention strategies that have substantial evidence

4. Rural, medically underserved, and small communities
5. Multiple high-readmission hospitals working with one CBO
6. Strong coordination with PCMH, ACO, and other local improvement initiatives, both to eliminate double-dipping and to enhance likelihood of success

Note on "near misses"

In the work on errors generally, tracking harms from errors often is slow going; but tracking "near misses" where something went wrong but the patient escaped actual harm provides much more opportunity for improvement. That has not yet been a strong intervention strategy in the work to date, but it seems likely to prove to be quite useful. Rather than just monitoring readmissions (the actual harm), one might affirmatively seek feedback from the patient and the "downstream" provider as to whether anything raised a risk or failed to provide seamless and safe care. The lack of feedback on care transitions quality is obvious in most settings, so finding ways to make it routine and valued might prove to be a very valuable and relatively low-cost intervention.

Note on targeting only FFS Medicare patients

Much of the early work has targeted patients by diagnosis (e.g., heart failure), by ZIP code (e.g., where the outcomes are being measured for the QIOs), or by part of the hospital (e.g., a particular ward or service). These are generally quite disorienting practices and hard to sustain, precisely because they undercut the commitment to doing it right, for every patient, every time. It is hard to generate the enthusiasm for high quality for one patient and then say it is "ok" to let the patient in the next bed have a poor quality continue. This does not mean that one cannot target interventions to match the seriousness and complexity of the patient's situation – of course, that is OK and makes sense. But it is very hard to generate high quality only for an arbitrary group in the hospital, perhaps excepting a short period for testing and adapting the processes needed. Thus, you do need to aim to treat all relevantly similar patients with the improved processes, even if the CCTP funding really cannot support all of the activities. Luckily, the most seriously affected patients tend to be Medicare patients, and actually tend to be FFS Medicare patients – but some are not. Thus, it behooves you to get other insurers to pitch in. Sometimes other insurers, payers, and philanthropies can help with start-up costs as well.

A note on the interaction between the QIO work and the Community-Based Care Transitions Program. The fact that the QIOs must bring many of their communities to the point of applying, and at least some to the point of getting an award, should mean that the CCTP will be enrolling communities for most or all of the first two years of the QIO SOW, starting in August 2011. This would also make sense in that it is likely that CMS wants to have nearly all of its CCTP awardees on board in the first two years, but probably only a manageable number in the first six months. More guidance on the time sequence for the CCTP is likely to be forthcoming as they gain some experience with it.