About the QIO contract for the 10th SOW (Aug 2011 – July 2014), concerning care transitions
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(Note – there are a number of ambiguities and conflicts in the official announcement. There may well be additional FAQs being published – return to the website to check. Some of those clarifications may change the interpretations offered here.)

General overview –

- Every QIO will be involved
- A National Coordinating Center will provide support and specific services
- Unit of work will be ZIP-code defined communities (geographic definition)
- Outcomes include reduction in readmissions, admissions, and costs for FFS Medicare beneficiaries – in participating areas and statewide
- Evaluation contract includes comparison with uninvolved communities for care transitions and all other QIO targets (Section J, Attachment J-9) (Very problematic design in context of a national campaign)
- QIOs are to help all communities they enroll, and are to have targets quarterly for the first 8 quarters

Services of the QIOs

Recruit and educate communities – either pre-selected communities from a list at www.cms.gov/QualityImprovementOrgs/ [The link to the file with every state's communities is: http://www.cms.gov/QualityImprovementOrgs/04_Future.asp#TopOfPage
and click on "Integrated Care for Populations & Communities-Communities List [ZIP, 730KB]" under "Downloads" at the bottom of the page.]

- or a ZIP code defined community with these characteristics:
  - N of Medicare beneficiaries (solicitation did not say FFS but probably meant to include that qualification) of 35-140K, at least 1000 admissions per year and reasonably stable
  - Target providers (should have said hospitals) with overlap “on average” about 60%
  - 2-6 hospitals (1 In isolated areas)
  - Not more than 10% overlap with other community in the program, nor more than 10% in another state

  (Note – these are actually desirable characteristics, but they are presented as required characteristics. This would mean that many parts of the country are simply ineligible for help from the QIOs. In some cases, that is quite appropriate because the odds of success or of being able to track progress are slim. But in other cases, tests in difficult environments might be quite desirable. There may be other ways to pursue care transitions improvement activities in those difficult environments.)

- Two groups: communities that get into 3026 or another formal program, or communities invited to join the state's Care Transitions Learning Network (It is not actually clear whether a community that wanted help from the QIO but did not want to join in the Learning Network would be accommodated, but joining in probably has small enough burden that this won't be a major problem.)
- QIOs must state target N of communities to recruit per quarter for the first 8 quarters.
- Those communities not (yet) in a formal program get QIO help with
  - Coalition formation
    - Materials and consultation
    - Technical support for initial strategic plan – including deciding who to recruit among a long list, and working out a collaboration among them
    - Coalition charter with commitment to reduce "30 day readmissions" by 20% over three years (note that this did not require commitment to the 30 d rate of readmissions/admissions or of readmissions/1000 beneficiaries – which is probably good because many providers cannot reasonably compute one or the other. Note also that this is most reasonably interpreted as a relative reduction – from 20% to 16%, for example)
  - Root cause analysis – including data analysis, using SAS provided by NCC for
    - Proportion of Transitions table (at present only in the 30 d after admission) (note that the original proportion of transitions table was to apply to all transitions in a time period that involved a facility at one end or the other, and that perhaps this will be part of the upcoming contract for the National Coordinating Center)
    - Coalition readmission rates
    - Hospital readmission rates
    - Post-acute setting readmission rates
    - Disease-specific readmission rates
    - ED visit rates
    - Observation stay rates
    - Mortality rates
    - And also – process mapping, chart reviews, and patient/stakeholder feedback (Note that the exact definition of the rates above is controversial and probably will be decided largely by practical considerations affecting data availability and the capacity of the National Coordinating Center)
  - Intervention selection process – from J-16, Table 1, or a documented and justified alternative – including an initial intervention plan (note that the new Table 1 has a very creative and useful "part B" that cross-walks various intervention strategies to reports of various initiatives that use this strategy. Also note that there are strategies that did not come to prominence in the pilot program that will probably surface as the work proceeds, for example, enhancing community supports for housing and palliative care.

    Those are permitted with documentation of evidence in a justification. Sites are not limited to Table 1)
  - Application for a formal program
  - Quarterly readmission metrics – as above (note – presumably other metrics will be available as well – admission, costs)
  - Intervention performance measurement strategies
- Maintenance of a state specific CT link on QIO website that links to NCC and to state-specific materials (Note – there will be a variety of resources from other sources as well, and the NCC probably will be a referral central point)
- Respond to requests from providers and other stakeholders with FAQs and timely response to other questions
- Technical Assistance includes outreach, knowledge management (with requirement of resource list (p. 71))
- Method will use Care Reinvention through Innovation Spread (CRISP).
  - Will building
  - Engagement and maintenance
  - Retention and sustaining
  - With Innovation Spread Advisors in each QIO, who meet regularly across topics
  - And "Brand Ambassadors"
  - With Integrated Innovation Spread Strategy reports quarterly
    (Note that the CRISP initiative was not fully integrated into the Care Transitions initiative, so this aspect awaits some maturing in order to know what is involved)
- Contribute insights, including by giving talks and writing manuscripts
- Assisting others to solve problems
- State-wide Transitions Learning Network – at least 3 webinars and one in-person meeting annually – including social media (p. 66) and vignettes of high performers
- At least 3 SQUIRE reports
- Evaluation of the Learning and Action Networks –Commitments, engagement, activities, outcomes, participant evaluation, sustainability of improvement
- Beneficiary involvement and input is encouraged

Services of the NCC (RFP has not yet been issued)

- Reports of activities of the QIOs go through the NCC, NCC provides templates
- Participates in National Leadership Coordination Council, National Faculty Meeting (not clear if these are topic-specific), and National Learning Network Meetings – the latter two include leadership QIOs also as well as other providers
- Provides SAS code for analyses

Other related projects – Probably just for a few QIOs each

- State-Wide Community Healthcare Indicator Map;
- Patient and Family Engagement Campaign;
- Indices of Patient Care, Population Health, and Per Capita Cost;
- Community Engagement and Planning – with ensuing Implementation

Measures and targets for Care Transitions

- Proportion of proposed communities recruited and with charters (target 75%)
- Proportion of "eligible" communities that submit application for a formal program (Note - not clear what makes a community eligible) ((target: 50%)
- Percentage of eligible communities that are accepted into formal CT program (target: 25%)
- Percentage of communities that can demonstrate 4 time series graphs showing positive trending data for four unique interventions (Note – this is a very high bar for community action – and much is not clear as to how defined) (target: 25% by 18 mo, 75% final, 27th month)
- Percentage decrease in the rate of 30d rehospitalizations per 1000 FFS benes in ZIP codes, for communities participating in the Learning Collab (target 7% relative improvement from baseline of 10/2010 – 3/2011)
- Percentage decrease in the rate of hospitalizations per 1000 FFS benes in ZIP codes, for communities participating in the Learning Collab (target 5% relative improvement from baseline of 10/2010 – 3/2011)
- Percentage of state-wide readmissions per 1000 Medicare beneficiaries (did not say FFS)- same baseline – target: 2% relative improvement
- Percentage of state-wide admissions per 1000 Medicare beneficiaries (did not say FFS)- same baseline – target: 2% relative improvement
- Reduction in FFS costs for communities participating in Learning Network – same baseline – target: 2% relative improvement

Evidence-based Interventions – (Attachment J-16)

- By published report
    - Coleman CTI
    - Naylor TCM
    - BOOST
    - BPIP in HHAs
    - INTERACT in NHs
    - Transforming Care at the Bedside – IHI
- By intervention strategies
    - Standardizing processes
        - Info transfer at discharge

    - F/u care at discharge
    - Medication management
    - Plan of care
    - Telemedicine
    - Telephone follow-up
    - EHR/EMR
  - Systemic enhancements within a setting
    - Multi-disciplinary team, multifaceted interventions
    - Clinical protocols, best practices, regional guidelines
    - Enhanced palliative care
  - Patient, family, and caregiver support
    - Education
    - Coaching
    - PHR
    - Community supports – non-medical services

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.

RECOMMENDATIONS –

For persons working to improve care transitions –

1. See if your community is one of the ones listed as being pre-authorized as being eligible – check the list at www.cms.gov/QualityImprovementOrgs/.
2. If so – consider what it would take to build a community coalition to work on the area defined. If not – then consider whether you can approximate the criteria in the first bullet under "Services of the QIOs" above – using existing data. Consider whether you can see a way to build a suitable coalition, or to build upon a suitable coalition already existing. And then see if the QIO will run the overlap analysis for you and "pre-sign" your community up as one to work with, once their new contract starts in August. If the QIO cannot run the overlap calculation, then you might scout around for whether someone could – including the national coordinating center for the QIOs in the current contract, the Colorado Foundation for Medical Care. There will probably be a small cost to run this, and they probably won't be able to give you any information about specific patients or providers (except that the overlap is x% with these ZIP codes […] and these

providers […]). They may be allowed to recommend adjustments to your lists to optimize overlap.

3. If you can begin to see a way to proceed in your area, then catalog all the initiatives already tested or implemented to improve transitions – standard forms, HIE accord, PHRs, home care management for special populations like CHF, self-care education, etc. See how widespread they are and what the evidence is for them doing a good job. Are there strengths to build on? Are there leaders who are interested? Who else is working on this? What alliances and deals need to happen in order to go forward together with a prudent plan?
4. Stay abreast of developing knowledge. A “care transitions intro course” is available at www.healthcarevillage.org. Many sites including www.medicaring.org and www.cfmc.org/caretransitions have general information and a streamlined search engine.