

## QIO Program:

# Integrating Care for Populations and Communities



### Improving Transitions of Care

Avoidable readmissions place a physical and emotional burden on patients and families, cost Medicare an estimated \$12 billion annually, and soon will create a financial liability for hospitals that accept Medicare reimbursement—while interventions for improving care transitions are both known and effective. The 14 communities nationwide that participated in a recent Quality Improvement Organization (QIO) Program initiative, for example, reduced admissions per 1,000 beneficiaries by 5.6%, compared to a 3.4% reduction in 52 peer communities.

As a result, health care providers and patient advocates across the country are focusing increased attention on improving transitions of care for every patient. The QIO Program is an ally in this effort. All hospitals and other provider settings should be encouraged to take advantage of QIO assistance from August 2011 through July 2014 to build a multi-stakeholder coalition, identify the root causes of readmissions, select an intervention, and put it into action.

### A Major Force for Improvement

QIOs in every state and territory, united in a network administered by the Centers for Medicare & Medicaid Services (CMS), have the flexibility to respond to local needs. At the same time, they offer providers the opportunity to contribute to broader health quality goals, such as those set by the U.S. Department of Health & Human Services' National Quality Strategy.

Current QIO Program initiatives are aligned with other major health quality improvement programs and can help providers improve the quality of care for Medicare beneficiaries who transition among care settings. In addition, by working with their local QIO, community care transitions coalitions may qualify for federal funding to continue their efforts.

### New Ways to Work Together

The latest in improvement science, including new models for accelerating and spreading change, has shaped the QIO Program's approach. This means providers have more and different ways to be a part of QIO initiatives. QIOs are functioning differently, too. Rather than limiting their role to technical assistance, they are convening statewide learning and action networks (LANs) that recognize everyone has knowledge that can contribute to better care. By participating in a LAN, health care providers can harness the power of a 24/7 community for addressing common challenges, connect with a peer facility for mentoring, and be the first to know about improvement breakthroughs—and how they can replicate them in their own facility or practice.

### Bold Goals for Better Care

Within 30 days of discharge, 17.6 percent of Medicare beneficiaries are re-hospitalized, and up to 76 percent of these readmissions may be preventable. Of beneficiaries who are readmitted within 30 days, 64 percent receive no post-acute care between discharge and readmission.

*Continued*



The QIO Program is an integral part of the U.S. Department of Health and Human Services' National Quality Strategy and is the largest federal program dedicated to improving health quality at the community level. As a major force and trustworthy partner for the continual improvement of health and health care for all Americans, QIOs work with patients, providers and practitioners across organizational, cultural and geographic boundaries to spread rapid, large-scale change. The work that QIOs perform spans every setting in which health care is delivered, even the critical transitions between those settings. The Program focuses on three aims: better patient care, better individual and population health, and lower health care costs through improvement.

## Quality Improvement Organization Program

[www.cms.hhs.gov/qualityimprovementorgs](http://www.cms.hhs.gov/qualityimprovementorgs)

[OCSQBox@cms.hhs.gov](mailto:OCSQBox@cms.hhs.gov)

---

## QIO Program:

# Integrating Care for Populations and Communities

---



Communities that join the QIO Program's initiative to integrate care for populations and communities will contribute to a three-year, 20% national reduction in readmissions within 30 days of hospital discharge. Participants can expect to benefit from membership in a local care transitions coalition comprised of hospitals, nursing homes, home health agencies, dialysis centers, hospices and palliative care facilities, senior advocates like area agencies on aging, and other local stakeholders. QIOs in every state and territory will convene these coalitions and provide technical support as they implement a comprehensive, fully integrated approach to reducing avoidable readmissions. Other benefits of participation include:

**Evidence-Based Interventions.** Each community will select one or more interventions from a set of multidimensional programs for improving care transitions whose effectiveness has been documented in the scientific and medical literature. These include the: Care Transitions Intervention<sup>SM</sup> (Eric Coleman), Transitional Care Model (Mary Naylor), Better Outcomes for Older Adults through Safe Transitions or "BOOST" (Society of Hospital Medicine), Best Practices Intervention Package for Transitional Care Coordination (Home Health Quality Improvement Initiative), Interventions to Reduce Acute Care Transfers or "INTERACT" (Florida Atlantic University), State Action on Avoidable Rehospitalizations or "STAAR" (Institute for Healthcare Improvement), Re-engineered Discharge or "Project RED" (Boston University), Geriatric Resources for Assessment and Care of Elders or "GRACE Team Care Model" (Indiana University), and the Bridge Model of Transitional Care (Illinois Transitional Care Consortium).

**Support for Sustainability.** To rapidly increase capacity for improving care transitions, QIOs are focusing their work on communities with high readmission rates that are not already supported by federal funding (such as the Administration on Aging's Aging and Disability Resource Center program and CMS' Community Based Care Transitions demonstration). QIOs will assist participating communities to build the structure and experience they need to qualify for funding through Section 3026 of the Affordable Care Act.

## Learn More and Become Involved

The QIO Program invites all providers, community stakeholders, beneficiaries, family members and caregivers to become partners in its new improvement initiatives. To express an interest, contact your local QIO. A directory is available online at [www.cms.gov/qualityimprovementorgs](http://www.cms.gov/qualityimprovementorgs). More information about the QIO Program's Integrating Care for Populations and Communities initiative is available online at [www.cfmcc.org/integratingcare](http://www.cfmcc.org/integratingcare).