Key Partners Align to Improve Care Transitions and Reduce Rehospitalizations in Washington State

Readmitting patients to the hospital within a month of discharge is a frequent—and costly—occurrence. Not only is there a human cost due to the lack of coordination and communication during a transition of care, but there are also significant financial impacts. Avoidable hospital readmissions are estimated to cost the Medicare program billions of dollars each year.

In Washington State, two key partners – the state Aging and Long-Term Support Administration (leading the state's Aging and Disability Resource Center program) and Qualis Health (the Medicare Quality Improvement Organization) – recognized their shared interest in implementing community-based interventions to improve care coordination, and partnered to align their programs.

Aging and Long-Term Support Administration (ALTSA), within the Washington State Department of Social and Health Services coordinates the statewide network of Area Agencies on Aging (AAAs) and the locally tailored Aging and Disability Resource Centers (ADRCs), called *Community Living Connections*. ADRCs serve older adults and persons with disabilities, regardless of economic circumstances or healthcare coverage to understand and access services and supports in order to remain in their own homes and communities as long as possible. CMS has identified ADRCs as key facilitators in care transitions, options counseling, and assistance to increase opportunities for people who are at-risk of institutionalization to live in the community following a hospitalization. ALTSA currently allocates resources to support community-based care transitions services as an ADRC program priority.

For more information about ALTSA's ADRC services, see
http://www.adsa.dshs.wa.gov/professional/adrc/

Qualis Health is a nonprofit healthcare consulting firm serving as Washington's Medicare Quality Improvement Organization (QIO, a program of the national Centers for Medicare & Medicaid Services). Qualis Health partners with the public and private sectors to improve the quality, efficiency and value of healthcare, leveraging its expertise in evidence-based quality improvement methods. The QIO Program is largest federal program dedicated to improving health quality at the community level, including priority resources allocated to support community-based care transitions assistance. Qualis Health has proven expertise in care transitions, is a resource for using Medicare data at the community level, and has deep long-standing relationships with healthcare providers across the continuum.

For more information about Qualis Health's programs to reduce rehospitalizations, see
www.QualisHealthMedicare.org/Transitions

The Care Transitions Intervention

The Care Transition Intervention® (CTI) coaching model developed by the University of Colorado Denver's Eric Coleman, MD, MPH (www.care transitions.org), enhances the role of patients and caregivers in improving care transitions, and has been proven effective in reducing unnecessary rehospitalizations. Working with the Washington Aging and Long-Term Support Administration, Qualis Health developed the Aging and Disability Resource Center (ADRC) Care Transitions Intervention Tool Kit, a creative, user-friendly online resource that offers community organizations the tools they need to support a CTI program in their communities. See www.adsa.dshs.wa.gov/Professional/ADRC/documents/toolkit/Toolkit.pdf

Community Based Care Transitions Programs

The Community-based Care Transitions Program (CCTP), created by Section 3026 of the Affordable Care Act, tests models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries. The goals of the CCTP are to improve transitions of beneficiaries from the inpatient hospital setting to other care settings, to improve quality of care, to reduce readmissions for high risk beneficiaries, and to document measurable savings to the Medicare program. For more information and participating partner organizations see innovation.cms.gov/initiatives/CCTP/

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