DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Room 303-D
200 Independence Avenue, SW
Washington, DC 20201

Media Affairs Office

MEDICARE NEWS

For Immediate release
April 13, 2009

Contact: CMS Office of Media Affairs
(202) 690-6145

MEDICARE ANNOUNCES SITES FOR PILOT PROGRAM TO IMPROVE QUALITY AS PATIENTS MOVE ACROSS CARE SETTINGS

14 Communities Funded to Reduce Rates of Hospital Re-admissions and ***"Fragmentation of Care"***

The Centers for Medicare & Medicaid Services (CMS) today announced the 14 communities around the nation that have been chosen for the Agency's Care Transitions Project, seeking to eliminate unnecessary hospital readmissions.

"Our data show that nearly one in five patients who leave the hospital today will be re-admitted within the next month, and that more than three-quarters of these re-admissions are potentially preventable," said CMS Acting Administrator Charlene Frizzera. "This situation can be changed by approaching health care quality from a community-wide perspective, and focusing on how all of the members of an area's health care team can better work together in the best interests of their shared patient population."

The goal of the Care Transitions Project is to improve health care processes so that patients, their caregivers, and their entire team of providers have what they need to keep patients from returning to the hospital for ongoing care needs. By promoting seamless transitions from the hospital to home, skilled nursing care, or home health care, this community-wide approach seeks, not only to reduce hospital readmissions but to yield sustainable and replicable strategies that achieve high-value health care for Medicare beneficiaries

"The Care Transitions Project is a new approach for CMS," said Barry M. Straube, M.D., chief medical officer for CMS and its Office of Clinical Standards & Quality director. "Rather than focusing on one global problem and trying to apply a one-size-fits-all solution across the country, Care Transitions experts will look in their own backyards to learn why hospital re-admissions occur locally and how patients transition between health care settings. Based on this community-level knowledge, Care Transitions teams will design customized solutions that address the underlying local drivers of re-admissions."

- more -

Communities in the following regions have been selected to participate in the Project: Providence, R.I.; Upper Capitol Region, N.Y.; Western Pennsylvania; Southwestern New Jersey; Metro Atlanta East, Ga.; Miami.; Tuscaloosa, Ala.; Evansville, Ind.; Greater Lansing Area, Mich.; Omaha, Neb.; Baton Rouge, La.; North West Denver, Colo.; Harlingen, Texas; and Whatcom County, Wash. The work of the Care Transitions Project will respond to the unique needs of each of the 14 communities.

Each of the Care Transitions communities is led by a state Quality Improvement Organization (QIO). QIOs work throughout the country as part of CMS's quality program to help health care providers, consumers and stakeholder groups to refine care delivery systems to make sure all Medicare beneficiaries get the high-quality, high-value health care they deserve. Each QIO in the project is required to work with partners to implement the following:

a) hospital and community system-wide interventions;
b) interventions that target specific diseases or conditions; and
c) interventions that target specific reasons for admission.

The following QIOs serve as Care Transitions leaders throughout the country: Quality Partners of Rhode Island; IPRO Inc. (in New York); Quality Insights of Pennsylvania; Healthcare Quality Strategies Inc. (in New Jersey); Georgia Medical Care Foundation Inc.; FMQAI (in Florida); AQAF (in Alabama); Health Care Excel (in Indiana); MPRO (in Michigan); CIMRO of Nebraska; Louisiana Health Care Review; Colorado Foundation for Medical Care; TMF Health Quality Institute (in Texas); and Qualis Health (in Washington).

CMS will monitor the success of this project by watching the rates at which patients in these communities return to the hospital. Re-admission rates for hospitals have been tracked by CMS for some time, and will be available to consumers later this year through the Hospital Compare Web site at http://www.hospitalcompare.hhs.gov.

The Care Transitions Project will continue in all 14 communities through summer 2011. For more information about the Care Transitions Project, visit http://www.cfmc.org/caretransitions/. To learn more about the work that QIOs are doing across the country, visit http://www.cms.hhs.gov/qualityimprovementorgs.