Care Transformation Steering Committee

October 11, 2019

Agenda

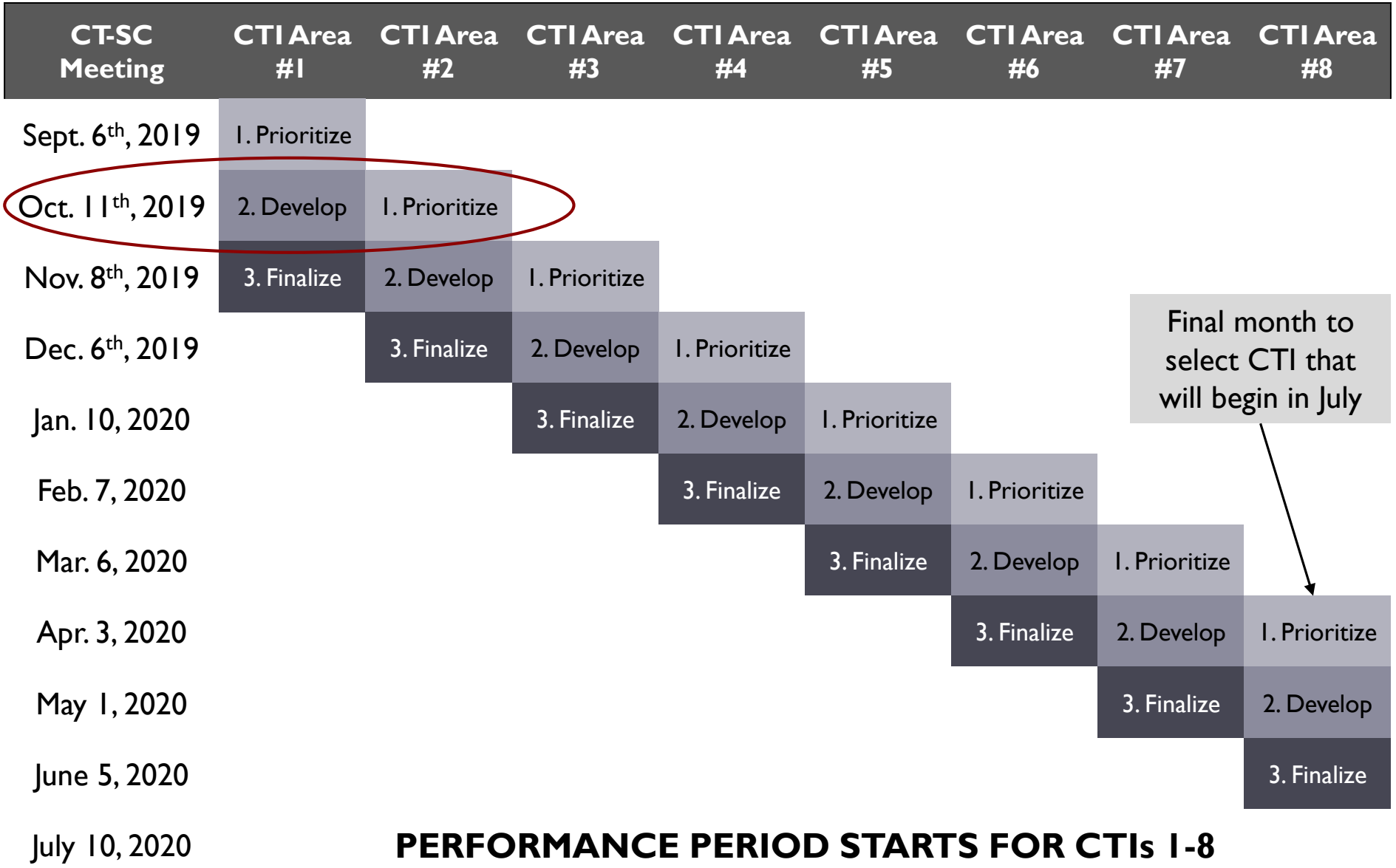
1. Administrative Updates
   i. Update on CTI User Guide
   ii. CTI development timing
   iii. Data sharing and tools
2. Discussion of CTI Thematic Groupings
   i. Identification by Interventions vs. Populations
   ii. Methodology for creating Thematic Groupings
3. Discussion of CTI Thematic Area #1
   i. Proposal for initial population definitions
   ii. Population not covered by the initial definition
4. Discussion of CTI Thematic Area #2
   i. Discuss of clinical similarity in population and interventions
   ii. Next steps
5. Next CT Steering Committee Agenda

Administrative Updates

User Guide and FAQ

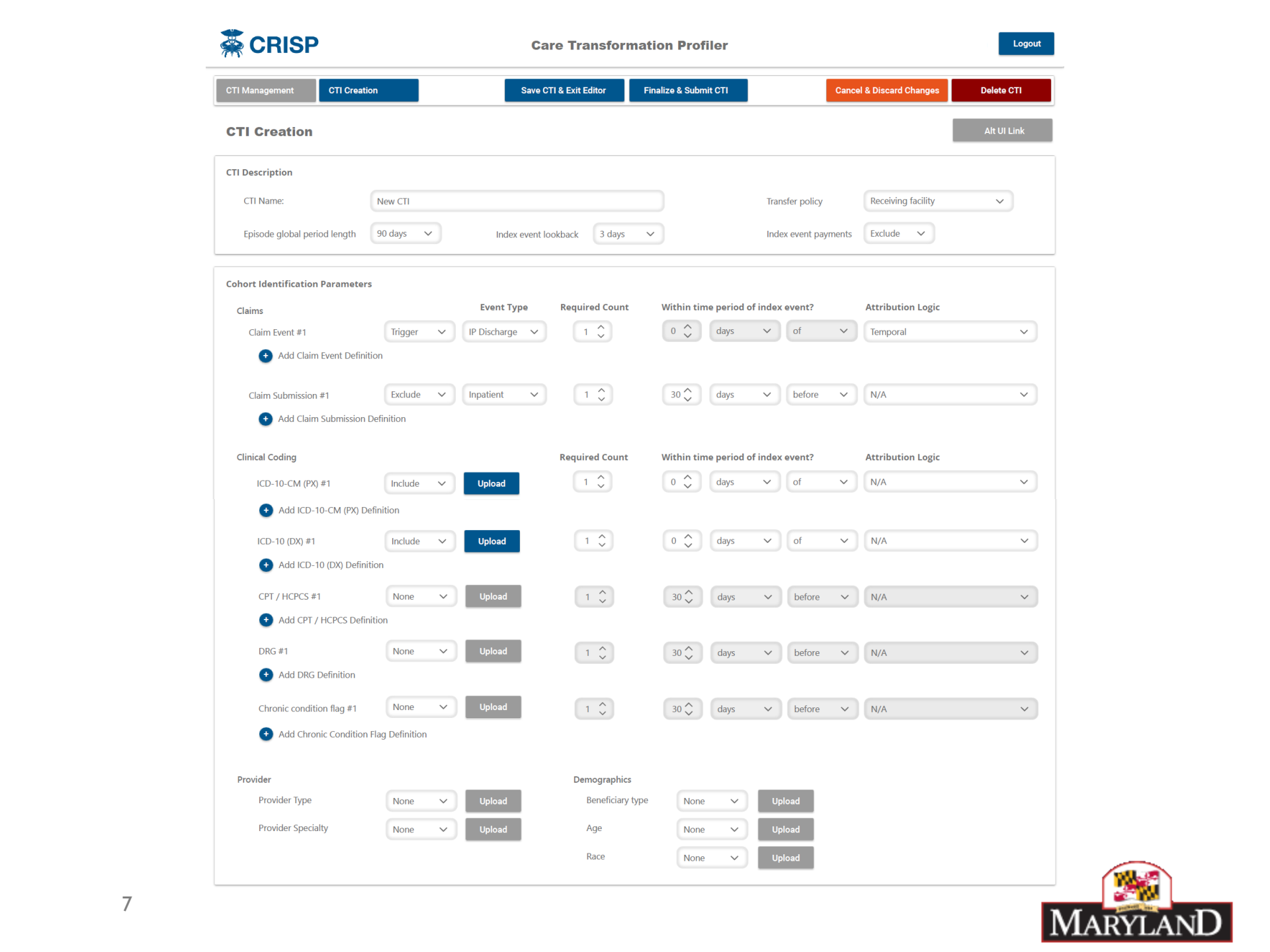
- HSCRC staff has shared User Guide and FAQ documents to stakeholders.
- Available on the HSCRC website here: https://hscrc.maryland.gov/Pages/Care-Transformation-Steering-Committee.aspx
- Please provide additional questions and suggested topics by email to HSCRC.care-transformation@Maryland.gov.

Schedule for Rolling CTI Development



Data Sharing and Tools

- HSCRC & CRISP will provide an automated view of each Hospital's performance in each CTI.
  - All hospitals will be able to aggregate non-PHI data on other hospitals in order to predict their MPA-RC Offset
  - The data will be updated each month with the most recent Medicare claims data
- The tool will provide hospitals with a view of:
  - Documentation for the hospitals to review their CTI population definitions
  - The target price and hospital aggregate performance versus the target price
  - The number of episodes initiated by CTI and by Hospital
  - The hospital costs of the episodes in the performance & baseline periods
  - Demographic breakdown of episodes in the performance & baseline periods
- The tool is expected to go live by January 1st 2020. HSCRC staff will provide additional details as the CRISP tool is finalized.


CRISP
Care Transformation Profiler
Logout
CTI Management
CTI Creation
Save CTI & Exit Editor
Finalize & Submit CTI
Cancel & Discard Changes
Delete CTI
CTI Creation
Alt UI Link
CTI Description
CTI Name:
New CTI
Transfer policy
Receiving facility
Episode global period length
90 days
Index event lookback
3 days
Index event payments
Exclude
Cohort Identification Parameters
Claims
Event Type
Required Count
Within time period of index event?
Attribution Logic
Claim Event #1
Trigger
IP Discharge
1
0
days
of
Temporal
Add Claim Event Definition
Claim Submission #1
Exclude
Inpatient
1
30
days
before
N/A
Add Claim Submission Definition
Clinical Coding
Required Count
Within time period of index event?
Attribution Logic
ICD-10-CM (PX) #1
Include
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days
of
N/A
Add ICD-10-CM (PX) Definition
ICD-10 (DX) #1
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of
N/A
Add ICD-10 (DX) Definition
CPT / HCPCS #1
None
Upload
1
30
days
before
N/A
Add CPT / HCPCS Definition
DRG #1
None
Upload
1
30
days
before
N/A
Add DRG Definition
Chronic condition flag #1
None
Upload
1
30
days
before
N/A
Add Chronic Condition Flag Definition
Provider
Provider Type
None
Upload
Provider Specialty
None
Upload
Demographics
Beneficiary type
None
Upload
Age
None
Upload
Race
None
Upload

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CTI Creation page, cont.

Other Parameters

For any cohort parameters that cannot be included using the template above, please describe below and upload any required definition files.

Other Criteria #1 — Upload

Other Criteria #2 — Upload

Episode Payment Exclusions & Adjustments

MD regulated payments - inpatient	Include
MD regulated payments - outpatient	Exclude
Part A/B readmission exclusion list	Exclude

CTI Description

Please provide a plain language description of the intended CTI definition for summary and validation use.

Mandatory Parameters (Informational Only)

Outlier winsorization (1st/99th percentile)	Yes
Outlier caps (3 standard deviations)	Yes
New technology add-on payments	Excluded
Blood clotting factors	Excluded
Medical device pass-through payments	Excluded
Carrier / hospice PBPM payments	Excluded
Zero / negative price claims	Excluded
Disaster / uncontrollable circumstance exclusion	Yes
Claim runout	3 months
Inflation / update factor method	BPCI Advanced method
Claim proration method	BPCI Advanced method
Episode overlap (between programs)	Mutually exclusive
Episode overlap (within CTI)	Mutually exclusive
TCOC savings overlap	TBD
Risk adjustment	MS-DRGs (hospital based)

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CRISP

Care Transformation Profiler

Logout

CTI Management | Cohort Creation | CTI Summary | CTI Detail | Export Analysis

Select CTI: Meals on Wheels

CTI Summary: Meals on Wheels

Participant: Peninsula Regional Medical Center

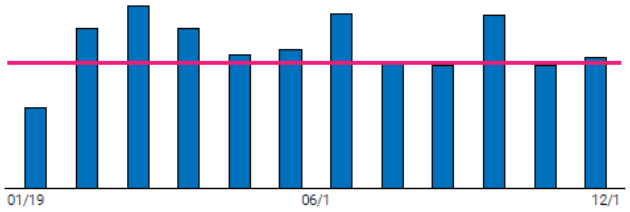
Performance Period: 2019-01-01 - 2019-06-30

All amounts standardized to performance period dollars

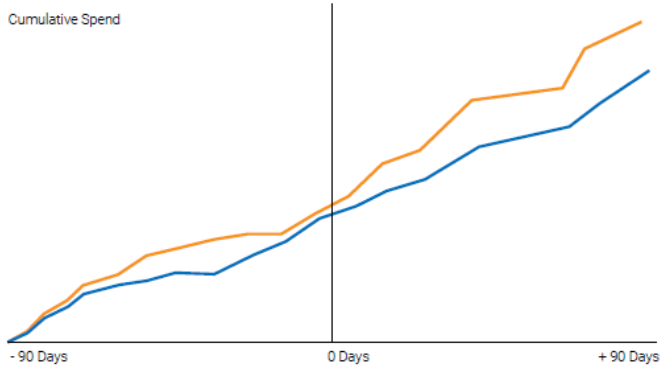
View population in MADE (requires PHI access for this facility)

	Baseline Period	Performance Period
Start Date	2018-01-01	2019-01-01
End Date	2018-06-30	2019-06-30
Beneficiaries	898	915
Beneficiary Episodes	1,159	1,245
Total Payments	$6,836,941	$6,323,355
PMPE	$5,899	$5,079
Target PMPE		$5,322
Savings PMPE		$820
Total Savings		$513,586
Total Savings %		7.5%
Inflation Factor		2.1%

Mean Episode Payment vs Target

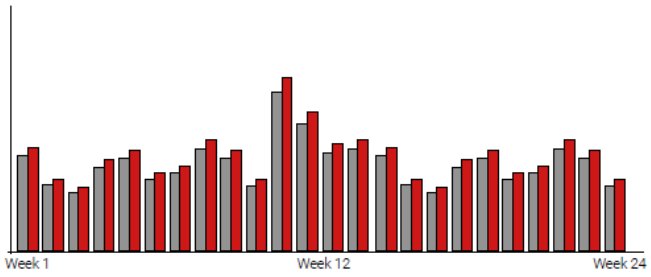


Cumulative Spend

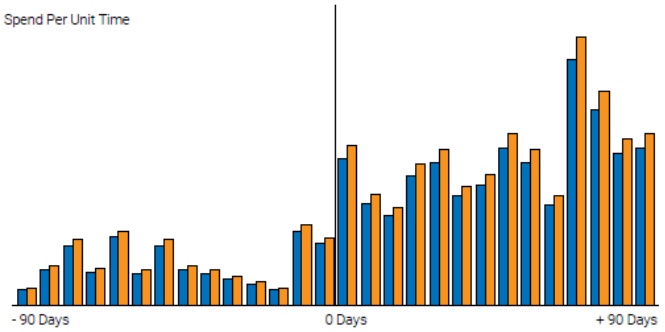


Outcome / Process Measure	Baseline Period	Performance Period
IP Count	119	121
ED Count	98	91
PAU Flag	57	44
Readmissions	32	29
Mortality	15	17
Follow-Up	535	612

ED Visits (per thousand)



Spend Per Unit Time



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Select CTI: Meals on Wheels

CTI Detail: Meals on Wheels

Participant: Peninsula Regional Medical Center

Performance Period: 2019-01-01 - 2019-06-30

All amounts standardized to performance period dollars

View population in MADE (requires PHI access for this facility)

Baseline Period *(2018-01-01 to 2018-06-30)*

Claim Type	Episodes	% of Total Episodes	Claim Payment Amount	% of Total Claim Payment Amount	Per Episode
Inpatient	566	7.4%	$1,775,268	45.1%	$2,220
Physician	1,179	76.3%	$2,009,429	25.0%	$1,178
Outpatient	211	18.8%	$1,769,249	11.2%	$304
SNF	449	2.6%	$476,883	10.6%	$287
HHA	839	3.6%	$415,638	4.8%	$130
Hospice	132	1.4%	$149,050	2.0%	$53
DME	300	17.1%	$93,902	1.3%	$36
Grand Total	**1,159**	**100.0%**	**$6,836,941**	**100.0%**	**$5,899**

Age	Male	Female	Total
< 65	32 (3.6%)	29 (3.2%)	29 (3.2%)
65 - 70	98 (10.9%)	105 (11.5%)	105 (11.5%)
70 - 75	218 (24.3%)	202 (22.1%)	202 (22.1%)
75 - 80	171 (19.0%)	179 (19.6%)	179 (19.6%)
80 - 85	12 (1.3%)	17 (1.9%)	17 (1.9%)
85 - 90	13 (1.4%)	15 (1.6%)	15 (1.6%)
> 90	12 (1.3%)	11 (1.2%)	11 (1.2%)
Null	342 (38.1%)	357 (39.0%)	357 (39.0%)
Total	**465**	**450**	**915**

Race Code Description	Beneficiaries
Null	29 (3.2%)
Asian	105 (11.5%)
Black	202 (22.1%)
Hispanic	179 (19.6%)
Native American	17 (1.9%)
Other	15 (1.6%)
Unknown	11 (1.2%)
White	357 (39.0%)
Total	**915**

County	Episodes	% of Total Episodes	Claim Payment Amount	% of Total Claim Payment Amount	Per Episode
Montgomery	566	7.4%	$1,775,268	45.1%	$3,220
Frederick	1,179	76.3%	$2,009,429	25.0%	$4,820
Howard	211	18.8%	$1,769,249	11.2%	$6,132
Carroll	449	2.6%	$476,883	10.6%	$4,920
Garrett	839	3.6%	$415,638	4.8%	$5,720
Kent	132	1.4%	$149,050	2.0%	$5,990
Other	300	17.1%	$93,902	1.3%	$5,620
Grand Total	**1,159**	**100.0%**	**$6,836,941**	**100.0%**	**$5,899**

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HHA	839	3.6%	$315,638	4.8%	$130
Hospice	132	1.4%	$149,050	2.0%	$53
DME	300	17.1%	$93,902	1.3%	$36
Grand Total	**1,245**	**100.0%**	**$6,323,355**	**100.0%**	**$5,079**

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85 - 90	13 (1.4%)	15 (1.6%)	15 (1.6%)
> 90	12 (1.3%)	11 (1.2%)	11 (1.2%)
Null	342 (38.1%)	357 (39.0%)	357 (39.0%)
Total	**458**	**440**	**898**

Race Code Description	Beneficiaries
Null	32 (3.6%)
Asian	98 (10.9%)
Black	218 (24.3%)
Hispanic	171 (19.0%)
Native American	12 (1.3%)
Other	13 (1.4%)
Unknown	12 (1.3%)
White	342 (38.1%)
Total	**898**

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Carroll	449	2.6%	$476,883	10.6%	$4,920
Garrett	839	3.6%	$415,638	4.8%	$5,320
Kent	132	1.4%	$149,050	2.0%	$5,290
Other	300	17.1%	$93,902	1.3%	$5,120
Grand Total	**1,245**	**100.0%**	**$6,323,355**	**100.0%**	**$5,079**

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Discussion of CTI Thematic Groupings

Discuss CTI Proposals

1. CT Steering Committee will discuss the grouping of CTIs into thematic area(s) based on the number of submissions

2. CT Steering Committee will assess the clinical differences between the submitted interventions and populations

Groupings of CTIs in a Thematic Area

	Are the proposed interventions clinically similar?		
Are the proposed populations clinically similar?		Yes	No
	Yes	1 CTI	1 CTIs
	No	2 CTIs*	2 CTIs

*The HSCRC may combine/unify populations in the future so everyone has an incentive to expand the CTIs' intervention and impact

Clarification: Identify Interventions vs. Populations

- The CTI process identifies populations that hospitals are accountable for. It is not intended to isolate the effect of two interventions that affect the same population.
  - It will be up to the hospitals to assess which interventions are most impactful
  - More sophisticated evaluation methods can be done retrospectively
- A hospital is welcome to submit multiple CTI Forms for interventions that cover the same population or submit a single form for the defined population
  - In the former case, the CTIs will be combined into a single CTI
  - In the latter case, the hospital should list all the interventions separately on the CTI Form

Submitter	Eligible Population	Intervention Description
Hospital A	Diagnosis of CHF, COPD, Diabetes, or Sepsis AND 3 or more IP or ED visits in prior 365 days	The transitional care coordinators follow patients for at least 30 days after discharge by making outreach calls, performing medication management and ensuring coordination of home visits.
Hospital A	Diagnosis of CHF, COPD, Diabetes, or Sepsis AND 3 or more IP or ED visits in prior 365 days	Community health workers act as liaison between communities and health care agencies by developing and implementing a care plan, connecting patients to culturally appropriate care, and addressing unmet social needs.

Upcoming CTI Thematic Areas

- HSCRC Staff reviewed the CTI submissions and grouped them into CTI 'Thematic Areas' to make the development process more efficient.
  - CTI Thematic Areas will be rank ordered based on the number of hospitals submitting proposals in that area
  - The rank order of CTI Thematic Areas could change based on the submissions that come in prior to the November meeting
- Feedback on the grouping of the CTI Thematic Areas is welcome.
  - Hospitals that have programs in upcoming Thematic Areas, but have not yet submitted a proposal are encouraged to do so
  - In the future, submissions will be publicly available prior to the meeting
- Based on the staff's methodology, CTI were grouped into 12 Thematic Areas for the purposes of development.
  - HSCRC Staff are considering ways to consolidate / expedite the number of CTI Thematic Areas that we can complete by July
  - Additional submissions are welcome at any time, but earlier increases the likelihood that they are included in CTIs for PY1

Methodology for Group CTI by Thematic Area

- The methodology for grouping CTI proposals was unscientific. HSCRC staff used the following algorithm:
  1. Group CTI by setting where the trigger occurs…
     - Hospital
     - Primary Care
     - Community
     - Etc.
  2. Identify similarities in how beneficiaries were restricted…
     - DRG / Diagnosis
     - NPI touch
     - Etc.
  3. Identify 'clusters' of similar restrictions that frequently occur together…
     - DRG / Prior hospitalization
     - Age / Touch with a palliative care consult
  4. Separate thematic groupings into clusters based on clinical interventions and difficulty of programming

Initial CTI Proposals – Thematic Areas

CTI Thematic Area	Overview of Proposed Interventions
Home Visits by Community Care Teams (8 Submissions)	Community care teams visit patients in their homes to perform the following interventions: • They conduct standardized assessments including a social, behavioral, and home safety evaluation • They help to address advanced care planning, behavioral health, caregiver burden, grief counseling, etc. • They help to address unmet clinical and social needs by linking residents to community services • They provide scheduled preventative care and chronic disease management Community-care teams were either deployed from the hospital directly following a hospitalization, or through a partnership with a local EMS provider, but the interventions appear similar.
Primary Care Transformation (7 Submissions)	Multi-disciplinary teams provide comprehensive care coordination including: • Execution of individualized plan of care and regular reassessments • Development of care improvement initiatives for patient experience and clinical outcomes • Tele-monitoring technology and medication monitoring to increase self-management Primary care interventions took two forms: 1) community-based care teams embedded at primary care practices; and 2) home visits by multidisciplinary teams. Both sets of clinical interventions aim to provide comprehensive clinical and psychosocial support to improve health outcomes and reduce utilization.
High Risk Clinics (6 submissions)	Special clinics deliver the following care to high risk patients: • Teams complete comprehensive assessments, develop plans of care, make office visits and house calls, and conduct weekly interdisciplinary care planning rounds • Connect the patient to other services/resources including community based organizations to address social needs, providing disease self-management education, and connecting patients to primary care providers and specialists • Multidisciplinary clinic teams include MDs, NPs, Nurse case managers, social workers, CHWs, Pharmacists, Pastoral Care, Health Behavioral Specialists, and psychiatrists

CTI Thematic Area #1: Transitions of Care

Care Transitions – Proposed Interventions

- Discharge planning in physician's office prior to surgery
- Hospital screening and assessment
- Home assessment or step-down level of care planning
- Post-hospitalization home visits
- Initiation of home-based medication reconciliation for patients with five or more medications
- Addition of mobility technician staff in hospital to decrease deconditioning during hospitalization
- Improved discharge coordination with hospitalist support
- Telehealth transition services
- Post-hospitalization disease management education
- Post-hospitalization referral to community care management and resources

Initial Population Definitions for Care Transitions

- The Care Transitions CTI will be triggered by an Inpatient Admission at the hospital
  - HSCRC staff expect the Care Transitions CTI to encompass 14 of the initial CTI proposals
  - ED initiated episodes will be handled separately
- Hospitals will then be allowed to submit a population definition that includes **any combination** of the following criteria:

	Geographic Service Area	Number of Chronic Conditions	Prior Hospitalization / ED utilization	Diagnosis / DRG	Episode Length
Criteria Options	Hospitals may provide a list of 5-digit zip-codes	• Indicate a number of chronic conditions, AND/OR • Hospital may provide a list of chronic conditions	• Prior hospitalization OR ED utilization threshold, AND/OR • Time window for how recent that utilization was	• Hospitals may submit a list of ICD -10 primary diagnosis codes OR • Hospitals may submit a list of APR-DRG / SOIs	Hospitals may submit an episode length: 30, 60, 90, 120, 150, 180, or 365 days
Default if Criteria is not Specified	Use no geographic restriction	Any condition and no threshold of chronic conditions	No requirement on prior utilization	Use all diagnosis and DRG codes	90 day episode window

Submitter	Eligible Population	Intervention Trigger	Duration
MedStar System Hospitals	All surgeries on joints.	IP Discharge	TBD
Holy Cross	Patients admitted to the hospital with a medical DRG and an SOI of 2 or 3 EXCLUDING those previously admitted to the hospital within the prior 30 days	IP Discharge	60 Days
Holy Cross Germantown	Patients admitted to the hospital with a medical DRG and an SOI of 2 or 3 EXCLUDING those previously admitted to the hospital within the prior 30 days	IP Discharge	60 Days
Howard County General	Residents of zip codes: 20723, 20794, 21042, 21043, 21044, 21045, 21046 and 21075	IP Discharge or ED Encounter	90 Days
Capital Region Health	Patients with a primary diagnosis of CHF, COPD, or Diabetes AND more than one inpatient admission within the past 30 days	IP Admission	30 Days
Charles Regional MC	Patients with a primary diagnosis of CHF, COPD, Diabetes, ESRD or sickle cell disease AND more than one inpatient visit in the past 30 days or more than 3 inpatient stays within the past 6 months	IP Admission	30 Days
Shore Regional Health	Patients with a primary diagnosis of CHF, COPD, or Diabetes AND more than one inpatient visit in the past 30 days	IP Admission	30 Days

Submitter	Eligible Population	Intervention Trigger	Duration
St. Joseph's MC	Patients with a primary diagnosis of CHF AND more than one inpatient admission in the past 12 months	IP Admission	30 Days
University of Maryland MC	All patients excluding pregnancy or mental health as primary reason for admission; new active chemotherapy patient; and/or organ transplant within the past 12 months	IP Admission or ED Encounter	90 Days
Baltimore Washington MC	Patients with a primary diagnosis of CHF, COPD, Diabetes, or Sepsis AND more than three inpatient admissions or ED visits in the past 12 months	IP Admission or ED Encounter	180 Days
Charles Regional MC	Patients with a primary diagnosis of CHF, COPD, Diabetes, ESRD or Sickle Cell Disease AND more than one inpatient visit in the past 30 days or more than 3 inpatient stays within the past 6 months	IP Admission	30 Days
Baltimore Washington MC	Patients with a primary diagnosis of CHF, COPD, Diabetes, or Sepsis AND more than three inpatient admissions or ED visits in the past 12 months	IP Admission or ED Encounter	60 Days
Totally Linking Care	Patients with a readmission discharge (2 or more Admissions during past 30 days) with 2+ chronic conditions	IP Discharge	365 Days

Example: Medical DRGs with SOI 2 or 3 over 90 days

Index Provider	# Episodes	Total Paid	Avg Paid
Adventist Shady Grove Medical Center	2,041	$31,793,898	$15,578
Adventist Washington Adventist Hospital	1,040	$15,771,579	$15,165
Anne Arundel Medical Center	3,415	$45,170,289	$13,227
Atlantic General Hospital	631	$8,703,389	$13,793
Bon Secours Hospital	274	$4,050,820	$14,784
CalvertHealth Medical Center, Inc.	981	$12,787,298	$13,035
Carroll Hospital Center	2,113	$32,944,655	$15,591
Doctors' Community Hospital	1,603	$27,035,088	$16,865
Fort Washington Hospital	559	$7,983,685	$14,282
Frederick Memorial Hospital	2,859	$39,800,550	$13,921
Garrett County Memorial Hospital	313	$4,118,164	$13,157
Greater Baltimore Medical Center	2,267	$33,616,096	$14,828
Holy Cross Germantown Hospital	507	$6,974,568	$13,757
Holy Cross Hospital	1,545	$22,433,418	$14,520
Howard County General Hospital	2,662	$35,272,029	$13,250
Johns Hopkins Bayview Medical Center	2,257	$36,900,725	$16,349
Johns Hopkins Hospital	2,338	$42,383,608	$18,128
Levindale Hospital	356	$6,069,748	$17,050
McCready Memorial Hospital	94	$1,552,955	$16,521
MedStar Franklin Square Medical Center	3,586	$55,830,939	$15,569
MedStar Good Samaritan Hospital	1,606	$23,561,576	$14,671
MedStar Harbor Hospital	964	$14,590,265	$15,135
MedStar Montgomery Medical Center	1,561	$24,610,977	$15,766
MedStar Saint Marys Hospital	1,303	$17,199,001	$13,200

Index Provider	# Episodes	Total Paid	Avg Paid
MedStar Southern Maryland Hospital Center	1,462	$20,273,473	$13,867
MedStar Union Memorial Hospital	1,293	$21,444,061	$16,585
Mercy Medical Center	733	$14,710,216	$20,069
Meritus Medical Center	2,533	$33,847,047	$13,362
Northwest Hospital Center	2,401	$41,479,287	$17,276
Peninsula Regional Medical Center	2,528	$37,673,977	$14,903
Saint Agnes Hospital	2,033	$32,434,776	$15,954
Sinai Hospital of Baltimore	2,009	$32,258,709	$16,057
Suburban Hospital	1,970	$29,377,622	$14,913
UM Baltimore Washington Medical Center	3,055	$42,949,807	$14,059
UM Charles Regional Medical Center	1,350	$18,175,498	$13,463
UM Harford Memorial Hospital	841	$11,699,881	$13,912
UM Laurel Regional Hospital	534	$8,182,997	$15,324
UM Medical Center	1,332	$29,389,149	$22,064
UM Medical Center Midtown Campus	444	$7,773,122	$17,507
UM Prince George's Hospital Center	1,069	$14,240,994	$13,322
UM Rehabilitation & Orthopaedic Institute	30	$570,812	$19,027
UM Shore Medical Center at Chestertown	528	$7,821,549	$14,814
UM Shore Medical Center at Easton	2,163	$33,007,908	$15,260
UM St. Joseph Medical Center	2,192	$31,784,518	$14,500
UM Upper Chesapeake Medical Center	2,067	$33,678,245	$16,293
Union Hospital of Cecil County	947	$14,079,231	$14,867
Western Maryland Regional Medical Center	1,789	$24,515,251	$13,703

Similar Care Transformation Initiatives

Submitter	Eligible Population	Intervention Trigger	Duration
St. Joseph's MC	Patients with no primary care physician AND more than one inpatient admission in the past 30 days	IP Admission	90 Days
Howard County General	Howard County resident with 2+ hospital encounters in 365 days (IP, ED, OBS) AND discharge to home or home care; excludes deceased patients	IP Admission, ED	180 Days
Howard Country General	Howard County residents discharged to a SNF in Howard County AND discharged to SNF	IP Discharge	30 Days
Nexus Montgomery	Patients admitted to one of the Nexus Montgomery hospitals with any medical and an SOI of 3 or 4 AND discharged to a participating SNF	IP Discharge	90 Days
MedStar System Hospitals	Baltimore City or County resident going home independently with a primary Diagnoses of CHF, COPD and Diabetes AND patients with a high-risk score and 3+ hospitalizations and/or ED visits in one year AND patient agrees to enroll in CHA program and home visits	IP Admission	30 Days
Peninsula Regional Medical Center	Patients diagnosed with HF, COPD, or Respiratory Failure AND have 2 or more inpatient admissions for the same diagnosis AND have specific social criteria including Wifi access along with the ability to use and comply with kit measurements and questions through iPad interactions	IP Admission	TBD

Next Steps for Care Transitions CTI

- HSCRC Staff will work on developing a 'lookback' and 'look forward' to identify whether a beneficiary has a certain claim type. This will allow the addition of extra criteria, such as:
  - Whether the beneficiary has a primary care physician (any office-based E&M claim);
  - Whether the beneficiary is discharged to the home (first claim post-discharge is NOT SNF).
- A similar framework for ED visits will be added.
- REMINDER: All hospitals will be eligible to participate in the Care Transition CTI.
  - HSCRC will release guidance to hospitals on the Care Transition CTI following the November CT Steering Committee Meeting
  - A hospital that cannot fit their population into this framework should submit a separate CTI form to the HSCRC for future consideration in another thematic area
- NOTE: All hospitals can choose a base period that began prior to their interventions. However, the earliest base period for a hospital that chooses a look-back (e.g. 3 hospitalization in the prior 12 months) is 2017.

CTI Thematic Area #2: Palliative Care

Palliative Care – Proposed Interventions

- Patients are screened by a care manager or treatment team for appropriateness for referral to the Goals of Care/Palliative Care Team
- The Palliative Care Team consults patient to determine appropriateness for services and coordinates with hospital attending and community primary care
- Care Managers across the continuum ensure smooth transitions and hand offs as well as coordinate with other care providers in the community, including: home health, hospice, and skilled nursing facilities
- Services include medical care, emotional and social support, advanced care planning, and education for individuals with serious illness
- Palliative Care Team completes goals of care discussion and MOLST forms
- Palliative Telehealth Connecting Hospital to Home (PATCH)
- Offer an incentive for Oncologist and Hospice Providers to discuss Hospice and/or Palliative Care Options to high utilizer patients

Submitter	Eligible Population	Intervention Trigger	Duration
Frederick	Diagnosis of a chronic condition (CHF, COPD, Cancer, Dementia, ESRD, End Stage Liver Disease, Stroke)	IP Admission	TBD
JH Bayview	80+ years old AND diagnoses of sepsis, malignancy, or respiratory failure AND hospice care post discharge AND NPI of at least 1/3 palliative physicians	Discharge	90 days
MedStar Hospitals	SOI/ROM of 3-4 AND LOS >= 4	Discharge	TBD
GBMC	85+ years old OR stage 3 or 4 cancer diagnosis OR dementia diagnosis OR hip fracture diagnosis	IP/ED Admission AND Palliative care consult billed by GBMC palliative care provider	TBD
Holy Cross Hospital	All medical DRGs with ROM = 4	IP Admission	180 days
Holy Cross - Germantown	All medical DRGs with ROM = 4	IP Admission	180 days
Howard County General	80+ years old AND 3+ chronic conditions AND Howard county resident	Discharge AND - dx code of Palliative care OR - NPI linked to Palliative consult	TBD
Johns Hopkins Hospital	75+ years old AND APR-DRG 720 (sepsis), 133(respiratory failure), and/or dx of cancer	IP Admission	TBD
Doctors Community Hospital	65+ years old AND high risk with 2+ Admissions, ED visits, or Obs visits during past 90 days AND inpatient oncology claim	IP/ED Discharge AND List of 6 Palliative NPIs	120 days

Palliative Care Submissions: Discussion Questions

- Are these interventions sufficiently close to one another?
  - Is the clinical intervention substantially different if the intervention is initiated after a hospital admission versus initiated after a hospital discharge?
  - Is the clinical intervention different if it is triggered based on episodes initiated by a list of NPIs?
  - Does a shorter or longer post-discharge window indicate that the intervention is clinically different (e.g. 90 days versus 120 days; 90 days versus 180 days)?
- Are these substantially different populations?
  - Is it clinically different to trigger based on a set of diseases vs. SOI or ROM?
  - Do any of the disease sets overlap or are each proposed set clinically different?
  - Are the interventions clinically different if the patient population is 65+, 75+, 80+, or 85+ years of age?
- How different are these interventions compared to others (Primary Care Transformation, etc.) that target the same population?

Next Steps for Palliative Care CTI

- HSCRC Staff will create CTI population definitions based on the CT Steering Committee's feedback.
  - The initial population definitions will be shared at the November CT Steering Committee Meeting
  - The final population definitions will be shared at the December CT Steering Committee Meeting
- Once the population definitions have been finalized, hospitals will be given the opportunity to indicate whether they want to participate.
  - Hospitals may participate in the CTI regardless of whether they were the ones to propose the CTI
  - The TCOC Workgroup will begin discussing methods to ensure that a hospital is "meaningfully" participating in the CTI that they indicated

Next Steps

Next Steps and Further Submissions

- Send questions and CTI Assessment form submissions to: hscrc.care-transformation@maryland.gov
- Staff intend an ongoing CTI proposals process
  - CTI proposals must be submitted by Oct 25th to be considered at the Nov 8th CT Steering Committee Meeting
  - CTI proposals will be developed on a rolling basis, EARLIER submissions are better
- Future Meetings
  - Friday, November 8th, 2019, from 1-3 pm
  - Friday, December 6th, 2019, from 1-3 pm
  - Friday, January 10th, 2020, from 1-3 pm