UMMS CTI Submittal: Transitional Nurse Navigator Program

The HSCRC is developing a process to quantify hospital care transformation efforts around the State to make incentive payments to hospitals through the Medicare Performance Adjustment (MPA). Currently, hospitals may receive incentive payments for the Episode Care Improvement Program (ECIP), which focuses on reducing post-acute care costs for 23 clinical episodes. The HSCRC will add incentive payments for hospital efforts, outside of ECIP, that reduce the Medicare Total Cost of Care (TCOC).

There are four fields which are required for hospital submission and an additional two which HSCRC staff will use in their review and approval of these care transformation efforts:

| **Required from Hospital: Background Components** | |
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| Overview<br>• Description of current or upcoming program/initiative which hospitals may be implementing to impact patient outcomes, population health and total cost of care performance under Global Budget Revenues (GBR). | **Overview:** Transitional Nurse Navigator Program (TNN) targeting high risk patients based on chronic conditions and/or previous hospital utilization. Transitional Nurse Navigators (TNNs) coordinate care of patients at high risk of readmission for at least 30 days after discharge by making outreach calls, performing medication management and ensuring coordination of home visits. TNNs also perform root cause analysis on readmissions to identify patient needs.<br><br>**UMMS Participating Hospitals**:<br>1) Baltimore Washington Medical Center<br>2) Capital Region Health<br>3) Charles Regional Medical Center<br>4) Shore Regional Health<br>5) St. Joseph's Medical Center<br>6) University of Maryland Medical Center |
| Defined Care Interventions<br>• Briefly describe a standardized intervention pathway to address unmet clinical or social needs.<br>• Identify care partners at the hospital, or in the community, who will implement the intervention. | **Intervention Pathway:**<br>1) High risk patients identified upon hospital inpatient and/ or emergency department admission and referred to TNN<br>2) TNN meets the patient at bedside to assess and determine needed resources.<br>3) Based on the assessment, in the hospital setting the TNN: |

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| | a. Refers patient to resources and schedules follow up appointments with Transitional Care Center and/or PCP/Specialist<br>b. Refers to Community Care Management Programs<br>c. Provides high level disease management education<br>4) Post-discharge, the TNN conducts patient outreach by:<br>a. Conducting follow up calls 1-2 business days after discharge<br>b. Following up with the patient telephonically on a weekly basis for at least one month after discharge<br><br>**Care Partners:**<br>1) Hospital-based TNNs<br>2) Hospital-based Care Plan Writers<br>3) Skilled Nursing Facility TNNs<br>4) Primary Care Providers<br>5) Specialists<br>6) Community Partners |
| **Required from Hospital: Analytic Components** | |
| Identifiable Intervention Population<br>• Medicare FFS beneficiaries only, until further payer data available<br>• Must be identifiable in Medicare claims based on clinical condition, patient history and/or other criteria; cannot be identified with an EHR or clinical data point, | **1) Baltimore Washington Medical Center**: Medicare FFS beneficiaries with primary diagnosis of Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), Diabetes, or Sepsis and greater than three inpatient admissions or ED visits in the past 12 months.<br>**2) Capital Region Health**: Medicare FFS beneficiaries with primary diagnosis of |

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| | COPD, CHF or Diabetes and more than one inpatient admission within the past 30 days.<br>**3) Charles Regional Medical Center**: Medicare FFS beneficiaries with primary diagnosis of CHF, COPD, Diabetes, End Stage Renal Disease, or Sickle Cell Disease, and greater than one inpatient visit in the past 30 days or greater than 3 inpatient stays within the past 6 months.<br>**4) Shore Regional Health:** Medicare FFS beneficiaries with primary diagnosis of COPD, CHF, or Diabetes, and more than one inpatient admission within the past 30 days.<br>**5) St. Joseph's Medical Center**: Medicare FFS beneficiaries with primary diagnosis of CHF and at least 1 inpatient visit within the past rolling 12 months<br>**6) University of Maryland Medical Center:** Medicare FFS beneficiaries. Exclusions include: pregnancy or mental health as primary reason for admission; new active chemotherapy patient; and/or organ transplant within the past 12 months. |
| Episode Trigger<br>• A "trigger" event, or combination of factors, to identify when a beneficiary is enrolled in the intervention<br>• Must be identifiable in Medicare claims; cannot be triggered with an EHR or clinical data point, | **1) Baltimore Washington Medical Cente**r: Inpatient or emergency department admission. Episode window is 6 months<br>**2) Capital Region Health: I**npatient admission. Episode window is 30 days. |

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| | 3) **Charles Regional Medical Center**: Inpatient admission. Episode window is 30 days.<br>4) **Shore Regional Health:** Inpatient admission. Episode window is 30 days.<br>5) **St. Joseph's Medical Center:** Inpatient admission. Episode window is 30 days.<br>6) **University of Maryland Medical Center:** Inpatient or emergency department admission. Episode window is 90 days. |
| **For HSCRC Analysis and Consideration:** | |
| TCOC Impact and Duration of Episode<br>• From the information above, HSCRC will estimate the TCOC savings related to the intervention by calculating the difference in costs for the intervention population before and after the intervention went into effect. | |
| Reconciliation Payments<br>• HSCRC staff will calculate the reconciliation payment that will be made to the hospital for the savings that they produce as part of a care transformation effort.<br>• The reconciliation payments will be included when the State calculates the TCOC run rate and the required savings for the TCOC Model. The costs may be offset through the MPA-EC in order to ensure any reconciliation payments will remain cost neutral and reward hospitals that meaningfully engage in care transformation efforts. | |