Care Transformation Steering Committee

July 10, 2020

Agenda

1. Administrative Updates
    1. COVID Updates
    2. Timeline for the CTI Policies
    3. Review of Initial CTI Data
    4. Methodological Changes
2. Discussion of CTI Thematic Area #5: Emergency Care CTI
    - i. Final Population Definition
    - ii. Operationalizing the CTI
3. Update on Miscellaneous CTI
4. Next CT-SC Meeting
    - i. Upcoming CTI Thematic Groups
    - ii. CTI deadlines

Administrative Updates

COVID updates

- We recognize that hospitals are facing significant upheaval during the COVID-19 crisis.
- HSCRC is committed to being flexible and will work to make sure that CTIs work well for hospitals during this period of transition by:
  - Excluding CY2020 as a baseline period.
    - Hospitals should not use a baseline period of CY2020.
    - Hospitals may instead use CY2019 as the baseline period (performance period will remain CY2021).
  - Welcoming CTI proposals from hospitals that address COVID-related impacts.
    - For example, if hospital has increased its use of telehealth, hospital may submit proposal for a telehealth-focused CTI.
    - Working on alternate methodology to traditional pre-post methodologies.

Reminder: New Timeline for the CTI

- CTI start dates:
  - Care Transformation CTI delayed until January 1, 2021.
  - The first CTI performance period will be six months (January 1, 2021 through June 30, 2021).
  - Following performance periods will use fiscal years (e.g. PP2 will be July 1, 2021 through June 30, 2022).
- Final deadline for developed CTI Thematic Areas pushed to October 2020.
  - Initial deadlines for CTIs will be used to generate baseline data for hospitals to review before finalizing their submission in October.
  - Final Intake Templates for **ALL CTI** will be due on October 8 and begin January 1, 2021.

Data Releases for CTI

- HSCRC & CRISP have made the CTI baseline data for the preliminary Care Transition CTI.
  - Hospitals can review their data through the CRISP CRS Reports.
  - HSCRC has published all CTI submissions for all hospitals. This includes the criteria that the hospitals have selected and the number of episodes in the baseline period.
- The Palliative Care CTI will be available next week. Other preliminary CTI data will be made available on a rolling basis.
- HSCRC will hold a user group meeting to review CTI submissions in August. This meeting will:
  - Discuss the implications of small sample sizes in CTIs (e.g. Minimum Savings Rate, etc.).
  - Review common issues in CTI submissions.
  - Suggest strategies to increase the number of CTI episodes.

Data on the first CTI is available in the CTP

Care Transformation Profiler

Willem Daniel | Logout

CTI Management | State Summary | CTI Report

Reset Report

State Summary

Participant: All

Thematic Area / CTI: All

Baseline Time Period: All

State Summary

Convening Entity	Thematic Area	CTI Name	Episodes Initiated	Total Payments
Adventist Fort Washington Medical Center	Care Transitions	004:60-Day Post-Acute Resource Utilization	13	$300,825
Adventist Shady Grove Medical Center	Care Transitions	005:60-Day Post-Acute TCOC Population Discharged to Home	2,239	$20,084,952
Adventist White Oak Medical Center	Care Transitions	005:60-Day Post-Acute TCOC Population Discharged to Home	1,237	$12,573,938
Anne Arundel Medical Center	Care Transitions	023:Care Transitions Interventions	807	$12,690,388
Atlantic General Hospital	Care Transitions	039:High Risk Diagnosis Specific COPD Complex Interventional and Referral Planning	118	$2,628,387
Calverthealth Medical Center	Care Transitions	024:Collaborative Activation of Resources and Empowerment Services (CARES) Sepsis Program	229	$2,063,053
Frederick Health Hospital	Care Transitions	022:Community-Ambulatory Care Management	260	$10,016,062
Grace Medical Center	Care Transitions	036:Diabetes Care Transition Initiative	<11	$88,985
Greater Baltimore Medical Center	Care Transitions	025:Improving Transitions of Care for Complex, Comorbid, and High Risk Patients	3,071	$98,237,494
Holy Cross Health	Care Transitions	028:60-Day Post-Acute TCOC for Mid-Rising-Risk Population Discharged to Home	302	$2,917,452
	Care Transitions	028:60-Day Post-Acute TCOC for Mid-Rising-Risk Population Discharged to Home	1,065	$9,976,089
Howard County General Hospital	Care Transitions	047:Transitional Care Management for Rising Risk Patients - Modified Geographic Model	1,725	$46,962,767
		048:Transitional Care Management for Rising Risk Patients	1,039	$35,068,517
Johns Hopkins Bayview Medical Center	Care Transitions	003:Geriatric Surgery Care Pathway	353	$9,849,018
		050:Together in Care	369	$9,596,635
Johns Hopkins Hospital	Care Transitions	050:Together in Care	179	$4,957,018
		051:Heart Failure Bridge Clinic	166	$4,697,372
		053:Transition Guides	604	$4,879,084
Lifebridge Health	Care Transitions	036:Diabetes Care Transition Initiative	215	$10,861,787
		037:Heart Failure Care Transition Initiative	350	$13,000,166
		038:Improving Outcomes for Osteoporosis-related Fracture Care	<11	$92,490
	Care Transitions	036:Diabetes Care Transition Initiative	166	$8,578,176
		037:Heart Failure Care Transition Initiative	270	$12,197,339

© hMetrix

Future Methodology Changes

- The existing CTI methodology is flexible enough to accommodate many existing interventions.
- However, it does not easily accommodate some types of interventions. For example:
  - Requiring that an NPI touch be present in the base period is a substantial limitation for interventions that involve embedding physicians in different care settings.
  - Churning NPIs will also be an issue of other interventions.
- The initial methodology uses beneficiaries in the baseline period to set the target price in the performance period so NPI touch is needed in both periods.
- HSCRC will explore alternative methodologies that do not require the NPI touch in the baseline period.
  - Target price set based on actuarial methods (e.g. MA or PACE methodology).
  - Attribution methodologies will be used in the performance period only.

Timing

- HSCRC initially decided to use a pre/post approach in order to limit selection effects. Future alternative methodologies may not be appropriate for all interventions.
- Alternative methodologies will not be available for the first performance period. The earliest feasible implementation is July of 2021.
  - HSCRC will present initial methodological options at the August Steering Committee meeting.
  - Hospitals may then submit CTI proposals that use the alternative approaches.
  - Implementation protocols will not be available until the Winter / Spring.
- This may be useful for hospitals that:
  - Want to avoid the 2020 baseline period.
  - Have interventions like hospital at home, independence at home, or PACE-like models.

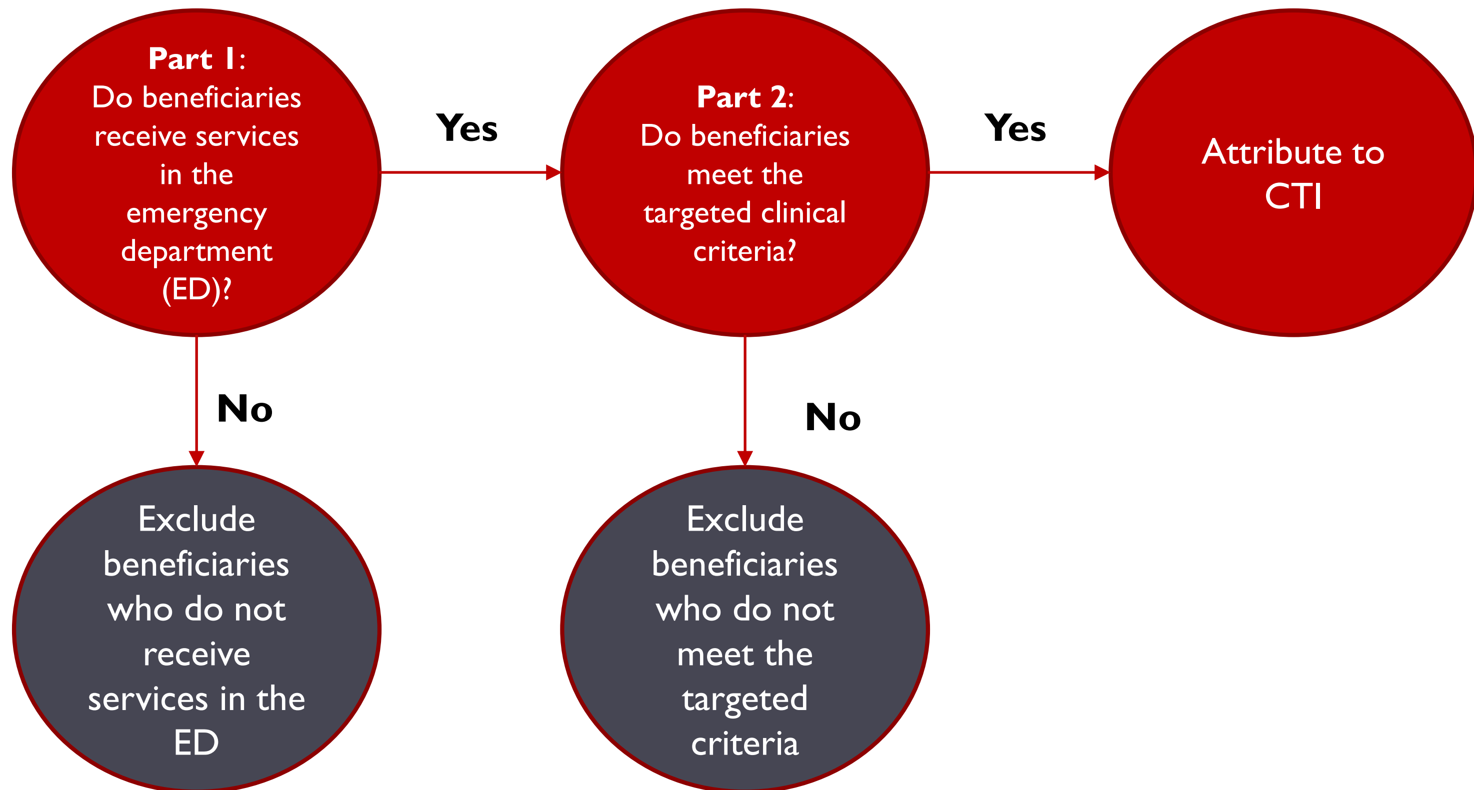
Questions and Discussion

CTI Thematic Area #5:
Emergency Care

Schedule for Rolling CTI Development

CT-SC Meeting	Care Transitions	Palliative Care	Primary Care Transformation	Community-Based Care	Emergency Care
Sept. 6th, 2019	1. Prioritize				
Oct. 11th, 2019	2. Develop	1. Prioritize			
Nov. 8th, 2019	3. Finalize	2. Develop	1. Prioritize		
Dec. 6th, 2019		3. Finalize	2. Develop	1. Prioritize	
Jan. 10, 2020			2. Develop	2. Develop	
Feb. 7, 2020			3. Finalize	3. Finalize	1. Prioritize
Mar. 6, 2020					2. Develop
Apr. 3, 2020					
May 8, 2020					
July 10, 2020					3. Finalize

Overview: Triggering a Emergency Care Transformation CTI



Part 1: Selecting the Triggering Condition

- Emergency Care CTI is targeted to patients that received care in an emergency department
- Patients attributed to the CTI via an ED discharge during the baseline period
  - Identified in claims data using RCC values or HCPCS codes
    - RCC: '045X' OR
    - HCPCS: '99281','99282','99283','99284','99285'
- Hospitals have several options to define whether an ED discharge is included in the Emergency Care CYI

Part 1: Selecting the Triggering Condition, cont.

- Hospitals have the option to attribute patients to the CTI for:
  - *Option 1:* any ED discharge, whether it resulted in an IP stay or not
  - *Option 2:* ED discharge that resulted in an IP stay
  - *Option 3:* ED discharge that did not result in an IP stay

Beneficiary receives services in the emergency department (ED) and is discharged from the ED

Option 1: Beneficiary discharged from ED, regardless of where they were discharged to (combines option 2 + 3)

Example: beneficiary receives care in an ED. Beneficiaries would be included whether they were admitted to the hospital or sent home.
Broadest option to maximize number of episodes

Option 2: Beneficiary discharged from ED and admitted for an inpatient (IP) stay

Example: beneficiary receives care in an ED. Their condition warrants being admitted to the hospital.
Best fits interventions focused on populations with more serious conditions that might require IP treatment.

Option 3: Beneficiary discharged from ED and ***not*** admitted for an IP stay

Example: beneficiary receives care in an ED. Their condition does not warrant being admitted to the hospital.
Best fits interventions focused on populations with frequent ED usage that did not result in IP treatment.

Part 2: Final Population Definition for Emergency Care

- Emergency Care CTI is triggered by an ED discharge. Hospitals then have the following options to define the population:

	Age	Geographic Service Area	Number of Chronic Conditions	Prior Hospitalization / ED utilization	Look back	Episode Length
Criteria Options	Hospitals determine the age range their intervention targets	Hospitals may provide a list of 5-digit zip-codes	• Indicate a number of chronic conditions (CCs) • Hospital may provide a list of CCs • Option to indicate primary diagnosis ICD-10 codes • **See slide 12 & 13 for options**	• Prior IP stays OR ED visits OR observation visits AND/OR • Time window for how recent that utilization was	• E&M Touch by provider type (primary care, HHA, SNF, PAC, psychiatric) pre-admission • **See slide 14 for options**	• Hospitals may submit an episode length of: 30, 60, 90, 120, 150, or 180 days
Default if Criteria is not Specified	All Medicare beneficiaries (65+)	Use no geographic restriction	Any condition and no threshold of chronic conditions	No requirement on prior utilization	No look back	30 days

Selecting chronic conditions

Hospitals have the option to select CCs from the list of CCs in the intake form.

Hospitals may also select the number of chronic conditions that are required to be attributed to the CTI. Entering a "1" will indicate that beneficiaries with ANY of the selected CCs will be included. Entering "2" or more will indicate that beneficiaries with ALL of the selected CCs will be included.

Table 1. To trigger for specific chronic conditions select those conditions below ("yes" for include, "no" for exclude):

Chronic Condition	Trigger
Acquired Hypothyroidism	No
Acute Myocardial Infarction	No
Alzheimer's Disease	No
Alzheimer's Disease, Related Disorders, or Senile Dementia	No
Anemia	No
Asthma	No
Atrial Fibrillation	No
Benign Prostatic Hyperplasia	No
Cancer, Colorectal	No
Cancer, Endometrial	No
Cancer, Breast	No
Cancer, Lung	No
Cancer, Prostate	No
Cataract	No
Chronic Kidney Disease	No
Chronic Obstructive Pulmonary Disease	Yes
Depression	No
Diabetes	No
Glaucoma	No
Heart Failure	No
Hip / Pelvic Fracture	No
Hyperlipidemia	No
Hypertension	Yes
Ischemic Heart Disease	No

AND

Table 2. Indicates the minimum # of chronic conditions, from those marked "yes" at left, required for inclusion of beneficiary in the CTI:

# of Chronic Conditions Required
2

Example: a hospital wants to focus on beneficiaries with hypertension and *COPD. They would select those CCs from the list and enter "2" for the number of CCs. (If the hospital wanted to focus on beneficiaries with hypertension OR COPD, they would enter "1" for the number of CCs.)*

Selecting chronic conditions, cont.

Alternatively, hospitals have the option to indicate primary diagnosis ICD-10 codes.

DX code
J40
J41.0
J41.1
J41.8
J42
J43.0
J43.1
J44.8
J44.9

Example: a hospital wants to focus on beneficiaries with COPD. They entered diagnosis codes associated with COPD.

Choosing CCs versus diagnosis codes

CC flag

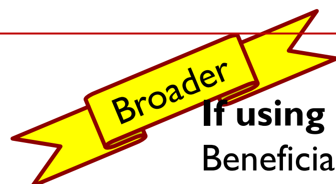
- Would capture any beneficiary that had met the criteria for number of visits with the related diagnosis during the previous year
- *Example: would capture beneficiaries with a COPD CC flag. COPD CC flag was established by a beneficiary having at least one inpatient, SNF, or home health claim, or two Part B claims with a COPD code in any position during the 1-year reference period.*

Diagnosis codes

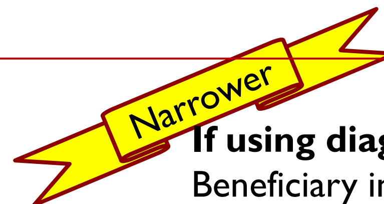
- Would pick up only those beneficiaries that received the diagnosis code as their primary diagnosis *during the trigger ED visit.*
- *Example: would capture beneficiaries whose primary diagnosis was COPD during the trigger ED visit. Would not capture beneficiaries with a prior COPD primary diagnosis.*

-1 year

ED VISIT



If using CC flag:
Beneficiary included because CC flag was established in the year prior to the ED visit



If using diagnosis codes:
Beneficiary included because primary diagnosis was applied *at this moment in time*

Lookback criteria

- Hospitals have options to identify intervention beneficiaries via look back, i.e. beneficiaries with a claim with the indicated provider type within the specified time window prior to inclusion in the Emergency Care CTI
- Hospital can choose the following optional lookback criteria *if it fits their specific intervention*:

Lookback care setting	Definition	Best Use
Primary care	E&M touch, with or without taxonomy restrictions prior to the ED trigger event	*Best fits interventions that require bene to have an identified primary care provider prior to the ED trigger event (or NOT have an identified PCP prior to the ED trigger event)*
HHA	Part A claim with a facility type of HHA prior to the ED trigger event	*Best fits interventions focused on home-bound beneficiaries or those otherwise needing home care.*
SNF	Part A claim with a facility type of SNF prior to the ED trigger event	*Best fits interventions focused on beneficiaries needing skilled nursing care.*
Acute care	Part A claim with a facility type of hospital; ED visit or IP stay prior to the ED trigger event	*Best fits interventions focused on reducing high ED or inpatient hospital utilization.*
Psychiatric care	Part A claim with a facility type of psychiatric care facility prior to the ED trigger event	*Best fits interventions focused on ED utilization due to psychiatric needs.*
Ambulance transports	Ambulance claim prior to the ED trigger event (specify # of days prior to the trigger event)	*Best fits interventions focused on ED utilization with high ambulance utilization.*

Lookback Criteria for ED / MIH CTI

Look Back		
Pre-ED discharge	**Action**	**Window**
Ambulance transports	Include	365

- Hospitals can choose a lookback criteria based on prior ambulance transports in order to identify patients in their MIH program.
  - Patients that the have been transported via ambulance 2+ times may approximate the target population.
  - This is an imperfect substitute for 911 calls. I.e. 6+ 911 calls may translate into approx. 2 ambulance transports.
- Hospitals may also use the lookback to identify high utilizers.

Lookback criteria example

CTI proposal included the following lookback:

Patients who have 2 or more ambulance transports to hospital in 365 days

The hospital would complete the lookback tab of the intake template to indicate that their lookback was focused on ambulance transports with a lookback window of 365 days.

Submitter	Eligible Population	Intervention Trigger	Duration
Howard County General	18 + years AND Howard County Resident AND 1 or more hospital encounters (IP, ED, OBS) in 365 days	IP or ED admission or observational stay	90 days
Capital Region Health	Beneficiaries with greater than 1 IP or ED admission within the past 30 days	IP or ED admission	30 days
Charles Regional MC	Beneficiaries with 6 or more ED admissions in a 3 month period	ED admission	90 days
UMMC	Beneficiaries with a primary diagnosis of respiratory system diseases OR circulatory system diseases OR endocrine, nutritional, metabolic, and immunity disorders OR digestive system diseases OR genitourinary system diseases OR nervous system and sense organs diseases AND exclude pregnancy	Hospital admission or ED evaluation	90 days
Peninsula Regional	Beneficiary with 3 or more EMS calls within zip codes 21801 or 21804 with transport to the ED in the previous 6 months for non-life threatening medical issues	5th EMS call with billed transport to Medicare for a non-life threatening condition	6 months
UMMS: Baltimore Washington Medical Center	Beneficiaries with primary diagnosis of CHF, COPD, Diabetes, or Sepsis and greater than 3 inpatient admissions or ED visits in the past 12 months.	IP or ED admission	6 months
UMMS: University of MD Medical Center	All Medicare beneficiaries, excluding those with primary diagnosis of pregnancy or mental health condition; new active chemotherapy patients; and/or organ transplant	IP or ED admission	90 days
Frederick	Beneficiaries with COPD, CHF, or sepsis with existing relationship with specified NPIs.	IP or ED admission or observational stay	TBD

Operationalizing the Emergency Care CTI

- Hospitals will be required to submit the following details confirming their desired specifications:
  - Part 1:
    - Hospitals will attribute beneficiaries with ED discharge, with option to limit to IP stay or no IP stay
  - Part 2:
    - Age
    - Geographic service area
    - Number of chronic conditions
    - Prior utilization
    - Lookback
    - Episode length
- HSCRC will release the Intake Template to hospitals for the Emergency Care CTI by July 17, 2020
- Initial deadline for this submission: August 14, 2020

Discussion of Upcoming or Planned Changes

Modifications to existing CTIs

- We continue to develop additional modifications to existing CTIs. These will include:
  - Modifications to Care Transitions CTI:
    - Care Transitions for MDPCP attributed beneficiaries
    - Care Transitions initiated by an ED visit
    - Care Transitions for patients that have a touch with a particular NPI
    - Care Transitions for patients that are discharged to a particular SNF
    - Care Transitions for beneficiaries between certain ages
    - Care Transitions for ESRD population
  - Modification to the Primary Care CTI:
    - Medicare beneficiaries with 2 or more visits to a primary care doctor (from NPI list) in the 12 months prior to the performance period
    - Medicare beneficiaries with 1 or more visits to a primary care doctor (from NPI list) in the 18 months prior to the performance period

Questions and Discussion

CRISP Care Management Tools

July 10, 2020

7160 Columbia Gateway Drive, Suite 100
Columbia, MD 21046
877.952.7477 | info@crisphealth.org
www.crisphealth.org

User Story

- I'm an outpatient physician caring for one of my patients with COPD. She was recently hospitalized outside of my system with a COPD exacerbation.

- I login to CRISP to view her discharge summary and any new relevant information. I see a new Care Alert that describes she was added to a CTI for COPD exacerbations that utilizes Community Health Workers and focuses on medication adherence and smoking cessation.

- I also see her Care Team widget now includes information about the program including name and contact information for the program's Care Manager.

- After discussing with my patient, a member of my team reaches out to the Care Manager to discuss changes to her medication regimen and follow up plans.

ENS Roster with Care Management Fields for CTIs

- CTIs can display patient care management information on CRISP's Point of Care tools via the Encounter Notification Service (ENS).
- ENS allows users to submit a roster (panel) of their patients via a manual spreadsheet or automated interface.
- Additional patient level fields can be submitted on this roster.
  - Care Program
  - Care Manager
  - Care Manager Contact Information
- These fields display at point of care and can serve as an alert for other providers seeing the patient that they are enrolled in a CTI cohort (or other care management program)

Unified Landing Page: Patient Snapshot/Care Team

Care Team

Organization	Organization Phone	Care Manager	Phone	PCP	Program	Status
Proyecto Salud						Active Subscriber
Hospital A	Contact Information if Provided			DAVID ALDEN SMITH	Hospital A CTI	Disenrolled
Kaiser Maryland Medicaid MCO				DAVID ALDEN SMITH	HEALTHCHOICE	Disenrolled
Kaiser Maryland Medicaid MCO				DAVID ALDEN SMITH	HEALTHCHOICE	Enrolled

CRISP

CRISP InContext EHR Embedded App

CRISP InContext

- MEDICATION MANAGEMENT
- CLINICAL DATA
- CARE COORDINATION
- DATA FROM CLAIMS
- CRISP PORTAL

FRODO BAGGINS

Male | May 6, 1989 | Probable | 34121 RING LANE, COLUMBIA, MD 21045 | 1 Infection Control Alerts VIEW

CARE TEAM | ADVANCE DIRECTIVES

2 Care Alerts VIEW

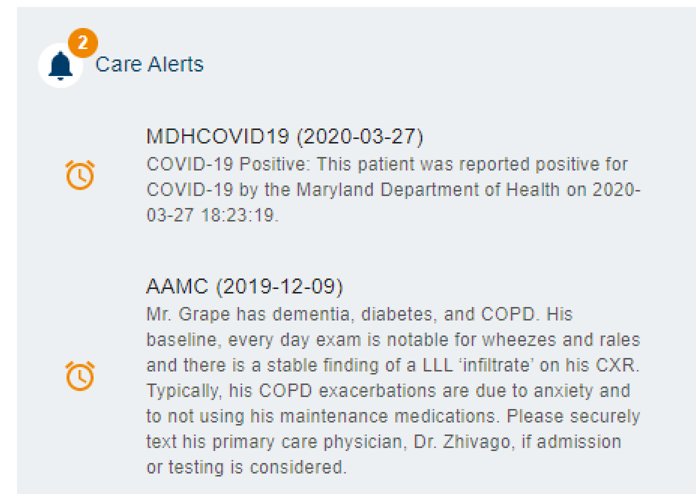
Care Team

Source	Text
Aledade Inc.	Care-Program: Hospital A CTI Program End-Date: 2021-02-26 12:00 a. Care-Manager: Mr. Frankenstein. Phone: 443-443-4442. Email: testcareprogmg

Rows per page: 25 | 1-1 of 1

Care Alerts for CTI Interventions

- CTIs can leverage Care Alerts to share a patient's care management enrollment.
- Care Alerts are typically a short description of critical information for patient care generated by CRISP participants within their EHR.
- Care Alerts can be accessed through CRISP Incontext within the EHR or via the CRISP Unified Landing Page (ULP).



Questions and Discussion

Next Steps

Next Steps and Further Submissions

- Send questions, CTI assessment form submissions, and CTI Intake Templates to: hscrc.care-transformation@maryland.gov
- Emergency Care Intake Template will be published by July 17.
  - A preliminary Intake Template will be due back to HSCRC by August 14.
  - A final Intake Template will be due on October 10.
- Future Meetings
  - Next CT Steering Committee will be August 14.
  - HSCRC and CRISP will be hosting a User Group meeting in August. Date TBD.