Care Transformation Steering Committee

November 8, 2019

Agenda

1. Administrative Updates
   i. Update on CTI User Guide, FAQ, and CTI Assessment Form
   ii. CTI development timing
   iii. CRISP reporting demo
2. Discussion of CTI Thematic Area #1: Care Transitions
   i. Look back/look forward analysis
   ii. Final population definition
   iii. Operationalizing the CTI
3. Discussion of CTI Thematic Area #2: Palliative Care
   i. Proposal for initial population definitions
   ii. Next steps
4. Discussion of CTI Thematic Area #3: Primary Care Transformation
   i. Review proposed interventions and populations
   ii. Discuss clinical similarities of proposals
   iii. Next steps
5. Next CT-SC meeting
   i. Upcoming CTI Thematic Groups
   ii. CTI form deadline

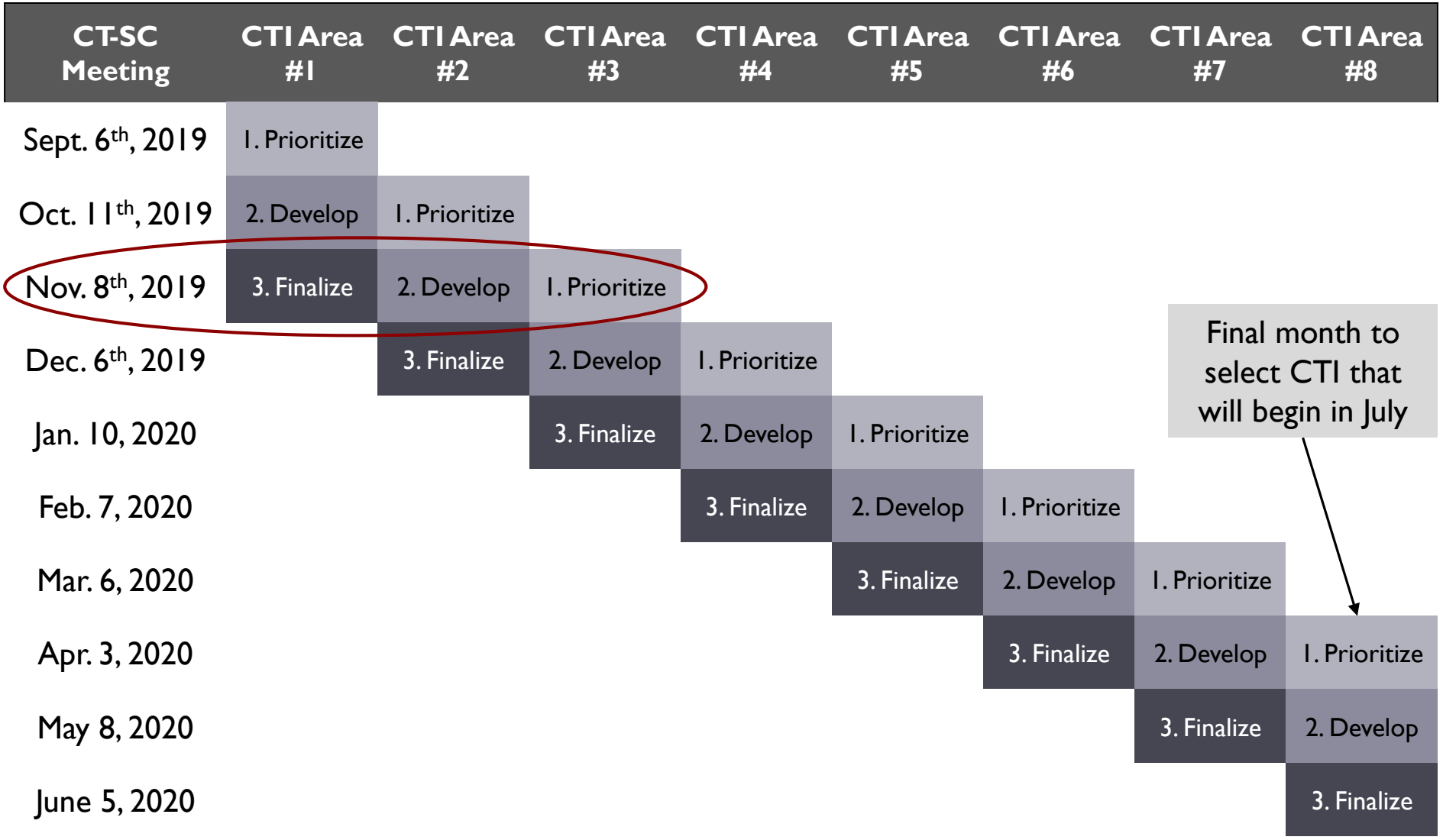
Administrative Updates

User Guide, FAQ, and Assessment Form

- HSCRC staff will share the User Guide and FAQ documents to stakeholders on Tuesday, November 12th.
  - Please provide additional questions and suggested topics by email to HSCRC.care-transformation@Maryland.gov.
  - Methodological questions will be addressed at the next TCOC Workgroup meeting.
- HSCRC staff has also updated the CTI Assessment Form, which is available as a handout.
- All will be available on the HSCRC website here: https://hscrc.maryland.gov/Pages/Care-Transformation-Steering-Committee.aspx

PLACEHOLDER FOR REPORTING DEMO

Schedule for Rolling CTI Development



CTI Thematic Area #1: Transitions of Care

Final 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 20 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	Look back/ Look forward
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 • APR-DRG / SOIs	Hospitals may submit an episode length of: 30, 60, 90, 120, 150, 180, or 365 days	• E&M touch by provider type pre-admission • First setting of care post discharge (MADE logic)
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	No look back or look forward

Look Back/Look Forward Analysis

- HSCRC staff developed a 'look back' and 'look forward' methodology to allow trigger parameters based on when beneficiaries obtained certain services, or lack there of, pre- or post-trigger.
- Hospitals will have the option to add this criteria to their Care Transitions CTI to further tailor cohorts closer to the actual intervention.
- Look back criteria is based off of E&M claims prior to admission, identifiable settings include:
  - Primary Care Physician
  - Other Outpatient Physician services
  - Home Health Agencies
  - Skilled Nursing Facilities
  - Assisted Living, Long Term Care
  - Acute Care (including ED, critical care, case management, transitional care)
  - Psychiatric Care Facilities
- Window for pre-trigger/look back can range 0-90 days

"Look Forward" Logic (MADE Logic)

- The window for a post trigger/look forward parameter will be for the duration of the CTI.
- Hospitals should note that the logic utilized assigns beneficiaries to the first occurring claim and cannot assign priority if multiple claims occur out of sequence.
  - For example, if a hospital chooses to focus on a CTI population based on those who are discharged to a community setting, but a beneficiary has a community claim followed thereafter by a SNF claim, the post discharge setting will remain community

Setting of Care Post-Discharge	IF …	Claim post-discharge occurs within
Long-term Stay (LTC, IP, IRF, etc.)	A claim associated with LTC, IP, IRF, or other settings of care	48 hours
Skilled Nursing Facility	SNF claim & No long-term stay	3 days
Home Health Agency	HHA claim & No SNF or long-term stay	14 days
Community Setting (OP, physicians office, etc.)	OP or Physician claim & no HHA, No SNF, or long-term stay	Any time in CTI window
No follow up care setting	None of the above	Any time in CTI 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

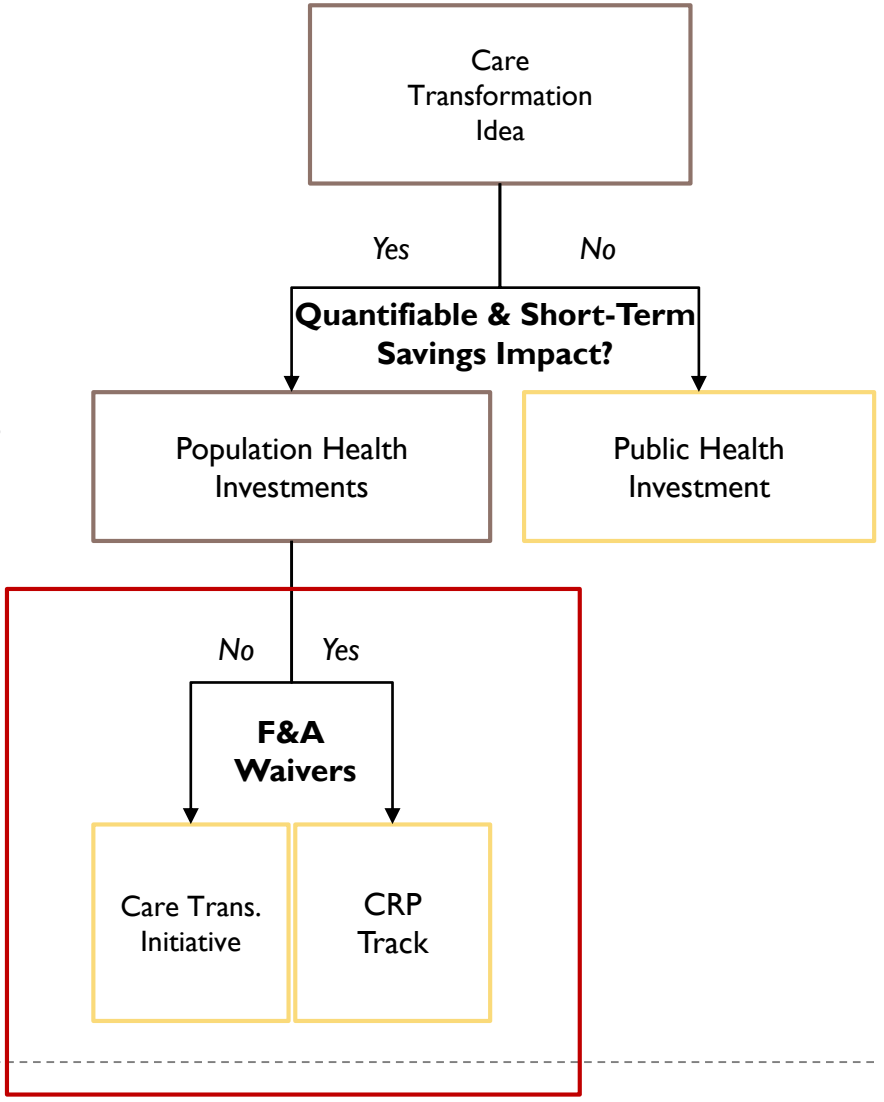
Submitter	Eligible Population	Intervention Trigger	Duration
St. Joseph's MC	Patients with a primary diagnosis of CHF AND more than one inpatient admission in the past 12 months	IP Admission	30 Days
University of Maryland MC	All patients excluding pregnancy or mental health as primary reason for admission; 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
Garrett Regional MC	Patients admitted for CHF or COPD	IP Admission	30 Days

Care Transitions CTIs using Look Back/Look Forward Criteria

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

Fraud and Abuse Waivers

- Do hospitals think fraud and abuse waivers would be necessary and/or helpful to implement the Care Transitions CTI?
- Potential reasons to seek fraud and abuse waivers:
  - To make incentive payments to clinicians
  - For additional flexibility when discharging to a SNF



Operationalizing the Care Transitions CTI

- Hospitals will be required to submit the following details confirming their desired specifications:
  - DRG/ICD-10 code lists
  - Zip codes
  - Prior utilization qualifications
  - Chronic conditions threshold
  - Episode length
  - Base period
  - Look back and look forward options
- HSCRC will release guidance to hospitals on the Care Transitions CTI within a week following this meeting.
  - Templates for submitting the details above are provided as a handout and available on the HSCRC website.
- Deadline for this submission: December 6, 2019 (1 month from today's meeting)
- The CTP will be available in January 2020 for the first CTI

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

Initial Population Definition for Palliative Care

- The Palliative Care CTI will be triggered by an Inpatient Admission at the hospital
  - HSCRC staff expect the Palliative Care CTI to encompass 9 of the initial CTI proposals
- Hospitals will then be allowed to submit a population definition that includes any combination of the following criteria:

	Age	Geographic Service Area	Number of Chronic Conditions	Prior Hospitalization / ED utilization	IP Events	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, 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 dx codes OR • A list of APR-DRG / SOIs OR • Preferred ROM designations OR • Length of stay qualifications	Hospitals may submit an episode length of: 30, 60, 90, 120, 150, 180, or 365 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	Use all diagnosis and DRG codes	90 day episode window

Other Potential Criteria

	NPI Attribution
Criteria Options	The hospital may provide a list of NPIs. Beneficiaries will be included if they receive a PFS service from that beneficiary during the course of their hospitalization stay.
Default if Criteria is not Specified	Use no NPI restriction.

- Palliative care services are difficult to identify in the data.
  - Medicare does not cover integrated palliative care by physicians
  - Typically, in Medicare models palliative care is identified by the companion E&M codes to the hospitalization when billed by the hospice and palliative medicine taxonomies
- If NPIs are provided the hospital must select a base-period during which the NPIs were practicing at the hospital.
  - HSCRC staff will explore methods to add new NPIs each year
  - This also avoids the possibility of changing coding behavior to affect selection into the CTI

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

Next Steps for Palliative Care CTI

- All other populations can be picked up with our current population definition categories.
  - HSCRC staff will work on identifying hospice post discharge
  - HSCRC staff will finalize the population definitions at the December CT-SC meeting
- REMINDER: All hospitals will be eligible to participate in the Palliative Care CTI.
  - HSCRC will release guidance to hospitals on the Palliative Care CTI following the December 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

CTI Thematic Area #3: Primary Care Transformation

Primary Care Transformation – Proposed Interventions

- Primary Care Transformation interventions took two forms:
  1. Multi-disciplinary teams (deployed by hospital or through EMS partnership) visit patients in their homes to perform the following interventions:
     - Conduct standardized assessments including a social, behavioral, and home safety evaluation
     - Help to address advanced care planning, behavioral health, caregiver burden, grief counseling, etc.
     - Help to address unmet clinical and social needs by linking residents to community services
     - Provide scheduled preventative care and chronic disease management
     - Tele-monitoring technology and medication monitoring to increase self-management
  2. Community-based teams provide comprehensive care coordination in PCP offices, including:
     - CHWs, SWs, pharmacists, and dieticians assist patients with medical and social needs
     - Care manager contacts patients 2 days after hospitalization to assist with medication reconciliation, assess risk, schedule PCP appointments, and other social services
     - Development of care improvement initiatives (e.g. extending hours of operation, hiring care coordinators/managers) for improving patient experience and clinical outcomes through PCMH
- HSCRC staff split these interventions into two CTI Thematic Areas: Office-Based Primary Care Transformation and Community-Based Primary Care Transformation
  - We will focus on Community-Based Primary Care Transformation first due to it having the plurality of proposals

Submitter	Eligible Population	Intervention Trigger	Duration
Frederick	Beneficiary receiving home health services through FMH Home Health	Enrolled in or discharged from FMH Home Health	TBD
Howard County General	Howard County Resident discharged to home or to home with home care AND patient billed for services provided at home (Place of service = 12 (home), 15 (mobile health unit))	Home health service	TBD
GBMC	3 or more chronic conditions AND serious illness diagnosis (to be aligned with CMMI Seriously Ill Population Payment Model) AND visit from provider in the program (NPI list)	Initial E&M home visit	TBD
JH Bayview	Baltimore City Resident discharged to home or to home with home care from JHBMC AND patient billed for services provided at home (Place of service = 12 (home), 15 (mobile health unit))	Hospital Discharge	90 Days
MedStar Hospitals	Reside in zip code catchment (21210, 21211, 21212, 21213, 21214, 21218, 21239, 21206) AND two or more chronic conditions (CMS CCW ICD-10 list) AND hospitalization in the past 12 months AND received subacute rehab services or episodic skilled nursing services in past 12 months AND ADL/IADL impairment (Claims Frailty Index (CFI)) AND patient is enrolled in program for primary care AND 2 home visits within 90 days	First visit claim (E/M code for a home visit) under clinicians' NPIs and/or TIN	365 Days
Peninsula Regional	Medicare 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 within 6 months	180 Days

Submitter	Eligible Population	Intervention Trigger	Duration
Capital Regional Health	Medicare FFS beneficiaries with greater than one inpatient or emergency department admission within the past 30 days	IP/ED Admission	30 Days
Charles Regional MC	Medicare FFS beneficiaries with 6 or more emergency department admissions in a 3 month period	ED Admission	90 Days
Shore Regional Health	Medicare FFS beneficiaries with 3 emergency department, or observation or inpatient visits within the past 6 months	IP Admission	365 Days
University of Maryland MC	Medicare FFS beneficiaries with a primary diagnosis of: respiratory system diseases; circulatory system diseases; endocrine, nutritional, metabolic and immunity disorders; digestive system diseases; genitourinary system diseases; and nervous system and sense organs diseases. Exclusions include pregnancy.	Hospital Admission or ED Evaluation	90 Days
Howard County General	Howard County Resident with 2+ ambulance transports to HCGH in 365 days	2nd billing for MIH Place of Service	TBD

Community-Based Primary Care Transformation: Discussion Questions

- Are these interventions sufficiently close to one another?
  - Is the intervention substantially different if the intervention is initiated after a hospital admission versus initiated after a home visit?
  - Is the 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. 30 days versus 90 days; 30 days versus 365 days)?
- Are these substantially different populations?
  - Is it clinically different to trigger based on a set of diseases vs. POS codes?
  - Is there a clinical significance to the different thresholds selected for number of ambulance transports (2 vs. 5)?
- How different are these interventions compared to others (Office-Based Primary Care Transformation, etc.) that target the same population?

Next Steps for Primary Care Transformation

- HSCRC Staff will create CTI population definitions based on the CT Steering Committee's feedback.
  - The initial population definitions will be shared at the December CT Steering Committee Meeting
  - The final population definitions will be shared at the January 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

Next Care Transformation Steering Committee Meeting

Additional CTI Proposals – Future Thematic Areas

CTI Thematic Area	Overview of Proposed Interventions
Office-Based Primary Care Transformation (4 Submissions)	Community-based teams provide comprehensive care coordination in PCP offices, including: • CHWs, SWs, pharmacists, and dieticians assist patients with medical and social needs • Care manager contacts patients 2 days after hospitalization to assist with medication reconciliation, assess risk, schedule PCP appointments, and other social services • Development of care improvement initiatives (e.g. extending hours of operation, hiring care coordinators/managers) for improving patient experience and clinical outcomes through PCMH
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

Remaining CTI Proposals

Submitter	Eligible Population	Intervention Trigger	Duration
JH Bayview	IP discharge to a list of SNFs AND reside in zip codes 21222 or 21224 AND receive IV antibiotic on day of hospital discharge AND NPI of at least 1 infectious disease attending during hospitalization	IP Discharge	60 Days
JH Bayview	3+ hospital encounters (IP, Observation, or ED) in the past year AND NPI of MD/NP providers in MESH	IP/Observation/ED Encounter	120 Days
JH Bayview	JHBMC and HCGH patients discharged from hospital or SNF post hospital, prior to ALF care	Hospital or SNF Discharge	90 Days
AAMC	All Medicare FFS patients discharged from SNF sub-acute stay	SNF Discharge	30 Days
AAMC	Medicare FFS patients with 5 or more current medications AND a diagnosis of CHF, COPD, or diabetes	TBD	TBD
MedStar Hospital	Adults with uncontrolled type 2 diabetes (A1C greater than or equal to 9%)	Hospital Discharge	TBD
GBMC	Encounter at GBMC HealthPartners or affiliated practices in past 18 months AND 1 or more acute care hospitalization(s) with principal diagnosis of type 2 diabetes AND diabetes education CPT within 30 days of acute care discharge	Hospital Discharge	TBD
Nexus Montgomery Hospitals	Medicare FFS patients who are residents of target buildings based on their address	Address	TBD

Categorization for Remaining CTI Proposals

- HSCRC staff believe the remaining CTI proposals will fit into three broad Thematic Areas
  1. Diabetes care management
  2. ALF and SNF case management
  3. Medication reconciliation programs
- Some of the remaining CTIs will also qualify under Thematic Areas in development if the definition criteria is expanded
  - Ex: allowing NPI touch as a restriction for Care Transitions
- With the current timeline, the HSCRC should be able to implement more than 90% of all CTIs we have today for the first Performance Period (beginning July 2020)

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 Nov 22nd to be considered at the Dec 6th CT Steering Committee Meeting
  - CTI proposals will be developed on a rolling basis, EARLIER submissions are better
- Future Meetings
  - Friday, December 6th, 2019, from 1-3 pm
  - Friday, January 10th, 2020, from 1-3 pm
  - Friday, February 7th, 2020, from 1-3 pm