CRISP User Learning Collaborative: Care Transformation Initiative

April 30, 2021
11:00am – 12:30pm
Agenda

1. Administrative Updates
   a. Performance Year 1
   b. Ad-Hoc Reporting

2. Revisions to Palliative Care Intake Template

3. Intake Template Submission
   a. Look back / Look Forward
   b. Hierarchy Selection

4. MADE Roster

5. DRG Selection

6. Discussion and Questions
CRISP and hMetrix Resources

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5. Nathan Hedberg, Director of Product Strategy at hMetrix

Contact care.redesign@crisphealth.org or hscrc.care-transformation@maryland.gov for questions on CTIs
Administrative Updates
CTI PY 1 Submission Timeline

- Performance Year 1: July 1, 2021 – June 30, 2022

Next Steps:

- **Revise** Existing CTIs - Submissions must be received by HSCRC by Friday, May 14
- **Add** New CTIs - Submissions must be received by HSCRC by Friday, May 14
- **Drop** Existing CTIs - Submissions must be received by HSCRC by Friday, May 14
- **Unchanged** CTIs – Hospitals do not need to resubmit their CTIs and current submission will be considered final
Hospitals may submit new CTI by emailing the appropriate intake template to the HSCRC.

- Hospitals should use the Intake Templates that are on the HSCRC website, as there have been minor changes to the original templates.

- Hospitals may also revise their existing CTI submissions by emailing the appropriate intake template and indicating which CTI is being modified.
  - Hospitals should identify an existing CTI using the CTI’s full name as it appears in the CTP. E.g. “01-001 – Care Transitions-Readmission CTI”.

- Submissions are due by Friday, May 14
- Submissions should be sent to hsrc.care-transformation@maryland.gov
Request for Ad Hoc Analysis

- Hospitals that wish to estimate the CTI population for a new submission may submit a request to CRISP.
  - The results will be provided in excel. Ad hoc submissions will not be available in the CTP.

- To submit an ad hoc analytics request, hospitals should:
  - Email care.redesign@crisphealth.org and include the appropriate excel intake template with the desired specification.

- Analytics requests will take approximately 2 weeks, but the turnaround may be longer if the numerous requests are received simultaneously.

- Hospitals are therefore encouraged to submit analytics requests as soon as possible.
Revisions to the Palliative Care Intake Template
Numerous hospitals have indicated difficulties with the Palliative Care CTI.

- The HSCRC allowed hospitals the option of including a NPI List of their palliative care providers.
- However, the turnover in NPI – particularly relative to an early baseline – discouraged some hospitals from submitting NPI lists.

Without the NPI lists, the Palliative Care CTI and Care Transitions CTI criteria differ only slightly.

- If the hospital submits an NPI list, then the Palliative Care CTI includes patients that meet the hospitalization criteria (e.g. 3+ chronic conditions) AND has a touch with the listed NPI.
- If the hospital does not submit an NPI list, the Palliative Care CTI includes patients that meet the hospitalization criteria (e.g. 3+ chronic conditions).

In the later case, the Palliative Care population is functionally the same as a Care Transitions CTI. This cause both confusion and substantial overlaps between these CTI.
In order to reduce confusion, the Palliative Care CTI will now require a list of triggering NPIs.

- Physician still must appear in the baseline period and the performance period.
- The hospital may still submit general criteria as a workaround, but it will be treated as a Care Transition CTI in order to reduce confusion.

Requiring an NPI list of the Palliative Care CTI does not eliminate the overlaps problem, but it does simplify it.

- The overlap is anyone meeting the Care Transitions Criteria and seen by the NPI.
- Hospitals may decide which CTI those patients are attributed to.
180 day post acute total cost of care for high-risk medical population

• Trigger: IP Discharge
• Medical DRG
• NPI List: none

• Under the updated Palliative Care CTI definition, this CTI would be categorized as a Care Transitions since there is no NPI List

• How the hospital operationalizes this CTI and the intention of CTI remains unchanged

Example: 02-002
Intake Criteria Review: Lookback/Forward
Look Back and Look Forward Criteria

Hospitals can include and exclude beneficiaries based on touches with a provider or setting of care in the period before and/or after the triggering event.

Six settings are available in the look back criteria and four are available in the look forward criteria.

- For the look back setting, hospitals indicate the time window for their selections
- For the look forward setting, the time window is the duration of the episode
Example:
CTI Target Population: Beneficiaries discharged to community after admission
Look Forward: Include ‘Community’
Actual Population: Excludes those with home health care (not intention of CTI) and reduces total episodes

Recommendation:
Utilization of the look back or look forward criteria can really limit or change the output of the episodes. It is recommended to utilize these for very specific and targeted criteria
Intake Criteria Review: Hierarchy
• Overlap Methodology:

1. The overlaps that occur based on the same event will be removed by using a hierarchical assignment

   i. The default hierarchy will prioritize CTI with the least number of episodes in the baseline period
      
      i. In general, thematic areas will be prioritize by: Palliative Care, ED care, Care Transitions, PAC Touch, Geographic, Primary Care.
      
      ii. Within a thematic area, CTI that use more selection criteria will be prioritized over those with fewer criteria

   i. Each hospital/participant can select a custom hierarchical assignment or choose to go with the default
Example 1: Minimal Overlap

Hierarchy 1: Care Transition (01-002)
Trigger of IP Discharge with APR DRG 720
• Total Episodes before Overlap: 366
• Total Episodes after Overlap: 366

Hierarchy 2: Care Transition (01-001)
Trigger of IP Discharge with Chronic Condition of either COPD & HF
• Total Episodes before Overlap: 1,112
• Total Episodes after Overlap: 1,005

Overlap:
• 1 IP Discharge
• Sepsis DRG AND
• 1 CC

01-002
• 1 IP Discharge
• Sepsis DRG
• No CC limitation

01-001
• 1 IP Discharge
• 1 CC
• No Sepsis DRG
Example 1: Significant Overlap

Hierarchy 1: Emergency Care (05-001)
Trigger of ED Visit, lookback excluding Psych and including 2 prior IP Visits, and at least 1 chronic condition
• Total Episodes before Overlap: 4,927
• Total Episodes after Overlap: 4,927

Hierarchy 2: Care Transition (01-018)
Trigger of IP Discharge, lookback excluding Psych and including 2 prior IP Visits, and at least 1 chronic condition
• Total Episodes before Overlap: 2,562
• Total Episodes after Overlap: 919
Hierarchy Issues for Users:

- For CTIs with similar criteria, the hierarchy definition can cause number of episodes to plummet
  - Total episodes in CTI has implications for MSR, etc.

- After hierarchy is applied, the remaining population can be very different than the CTI criteria intended

- Recommendations:
  - Carefully review similarities in CTIs
  - Make sure criteria are separable
  - Analyze large swings in number of episodes

Please reach out to care.redesign@crisphealth.org, if needed, for additional assistance with your selected hierarchy
MADE Roster
MADE Roster Considerations

MADE Rosters are attributed at the hospital level. CTIs that are at a system level will not link directly from the CTP, but can access their rosters through MADE directly by selecting a specific hospital.

Beneficiaries are attributed to a hospital if they have a treatment relationship (i.e, IP or ER Visit or MPA Attribution)

• Overall, any beneficiary that is attributed either purely through geography or through referral is not going to be available in MADE

MADE will only show the most recent rolling 36 months of beneficiary detail

• Currently March 2018 through February 2021
• Hospitals may not be able to see all beneficiaries in the baseline, particularly as it relates to baseline periods of FY17 & FY18
MADE: Accessing Beneficiary - Level Details

Use ‘Standard View’

Roster is pre-selected, use dropdowns to change selection

Link to launch Population Navigator in MADE

View population in MADE (requires PHI access for this facility)
DRG Update
Hospitals may submit a list of DRGs as a criteria for their CTI.

New APR-DRG versions are issued each year, to coincide with the release of the new ICD diagnosis and procedure codes upon which the DRG logic relies.

The most recent DRG version at the start of each Performance Year will be used:
- The most recently released grouper version for July 2021 is APR-DRG Version 37.

Hospitals will be required to update DRGs to reflect most recent grouper version prior to the start of each performance year.

- PY1: APR-DRG Grouper Version 37
- PY2: APR-DRG Grouper Version 38
  - Prior to PY2 Hospitals will be required to update DRG submissions to reflect these changes.
Questions?
Thank you!

Next Meeting will be May 28, 2021 (will reschedule as needed)