CRISP User Learning Collaborative: Care Transformation Initiative

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11:00am – 12:30pm

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Agenda

1. Report Findings: Pre-Implementation Evaluation of the Care Transformation Initiatives Program
2. Discussion

Maryland Model Analytics Project

Objective:

- To evaluate specific aspects of the Maryland Total Cost of Care (TCOC) model and care transformation efforts throughout the state
- To address one or more investigative analysis question
- To understand aspects of care redesign potential best practices, and areas of improvement for future consideration

Scope of Work:

- Care Transformation Initiative Year 1 Analysis:
  - Report should describe the strategies being pursued by hospitals, including key similarities and differences, comment on areas of spending that are not addressed by the proposed CTIs, comment on how the strategies pursued and not pursued map to the published research on successful care transformation, and consider socioeconomic status and race and/or ethnicity.

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Maryland Model Analytics

Pre-Implementation Evaluation of the Care Transformation Initiatives Program

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Background

- HSCRC established the CTI program to meet requirements of its Total Cost of Care model while allowing hospitals the flexibility to define their own episodes of care and test interventions to determine whether they reduce costs.
- Hospitals that conduct CTIs can earn additional payments by achieving savings for their defined episodes during a performance year.
- To fund these additional payments in a cost-neutral way, the state will reduce payments to all hospitals, including those that choose not to participate in the CTI program.

Background

CTIs are grouped into thematic areas based on similarities between the clinical interventions used, the settings where the triggering event occurs (such as a hospital or a primary care practice), and how the patient populations are defined.

- **Care Transitions**, which focus on transitional care management such as discharge coordination, home assessments, and telehealth transition services.
- **Community-Based Care**, which target the broader community, including community health workers, providers assigned to senior living buildings, or care coordination for patients transitioning to or from skilled nursing facilities (SNFs).
- **Emergency Care**, which focus on reducing ED visits for patients who are at high risk for ED use (such as high utilizers and individuals who have unmet social needs).
- **Palliative Care**, which focus on managing direct care of chronic pain patients, improving advanced care planning, and coordination with home health, hospice, and SNF.
- **Primary Care**, which is for hospitals that have programs to improve their primary care services, such as wrap-around services or completion of social, behavioral, and home safety assessments, or referrals to community resources.

Overview of the evaluation

- IMPAQ International (soon to be AIR) is evaluating the CTI program in two parts:
  - Part 1 of the evaluation reviews CTIs during the pre-implementation period. This evaluation describes *how hospitals designed their CTIs, identifies areas of spending that are (or are not) addressed by CTIs, assesses how CTIs align with published research on care transformation, and describes the extent to which CTIs address socioeconomic status and race and ethnicity*.
  - Part 2 will be a follow-up after the first year of the CTI program ends in June 2022. This evaluation will look at *which CTIs achieved savings, include feedback from participants, and offer recommendations on how the CTI program could be improved or expanded*.

Data Sources and Methods

- IMPAQ used a mixed-methods approach to evaluate the CTI program in the pre-implementation period.
  - Literature Review. an overview of care transformation efforts in the U.S. from the last 10 years. The review (1) identified studies of programs that aimed to reduce costs or encourage appropriate utilization of health care resources; and (2) examined how the clinical areas and interventions that are targeted in first-year CTIs compare to the published literature on care transformation.
  - Survey. We conducted a brief online survey (8 open-ended questions) of CTI participants to capture their perspectives during the pre-implementation phase. We fielded the survey to 76 contacts and received 21 responses.

Data Sources and Methods (cont.)

- Key Informant Interviews. One-hour interviews with CRISP and HSCRC staff to gather information on how the CTI program evolved, the policy goals of the program, and any challenges experienced in the lead-up to the launch of the program.
- CTI Data. Baseline information on each CTI, thematic area, target price for each episode, number of baseline episodes, summary of interventions, specific DRGs or conditions targeted, and the episode length.
- Social vulnerability and chronic condition indicators.
  - » Social Vulnerability Index (SVI) created by CDC – area deprivation
  - » CMS Mapping Medicare Disparities Tool – chronic conditions
  - » Hospitals' payer mix to identify high Medicaid rates.

Data Sources and Methods (cont.)

- Between late 2019 and the spring of 2021, hospitals submitted 253 CTIs.
- HSCRC ultimately approved 114 CTIs for implementation in 2021. At the time of this evaluation, 105 CTIs had been approved and had complete baseline data available for analysis. Part 2 of the evaluation will include all 114 CTIs.

Key Findings

CTIs cover 233,228 Medicare fee-for-service beneficiaries in Maryland, nearly a quarter of the 1 million beneficiaries who have Medicare Parts A and B coverage in any given month.

- Nearly 75 percent of first-year CTIs are in Care Transitions or Primary Care

Thematic Area	Number of CTIs	Total Number of Patients at Baseline
Care Transitions	**55**	35,612
Community-Based Care	10	29,985
Emergency Care	13	17,314
Palliative Care	6	986
Primary Care	**21**	149,331
Total	105	233,228

Key Findings

Episodes lasting 90 days are most common, while 365-day episodes account for nearly a quarter of CTIs and are concentrated in the Primary Care thematic area.*

Thematic Area	30 days	60 days	90 days	180 days	365 days
Care Transitions	6	10	29	8	2
Community-Based Care	1	2	5	0	2
Emergency Care	2	1	9	1	0
Palliative Care	0	0	3	1	2
Primary Care	0	0	1	1	19
Total	9	13	**47**	11	**25**

*HSCRC requires certain episodes (such as those that follow a panel of patients) to be 365 days, and hospitals do not have the option to change the length.

Key Findings

CTIs vary widely in the number of episodes available in baseline data. This variation reflects differences in patient populations and the length of episodes.

Thematic Area	Mean	Minimum	Maximum
Care Transitions	713	15	2,907
Community-Based Care	3,050	29	22,556
Emergency Care	1,624	13	5,531
Palliative Care	168	1**	342
Primary Care	7,262	82	32,525

**Baseline episode data are masked when there are fewer than 12 episodes.

Key Findings

The target price per episode depends on the number of available baseline episodes, the variation in costs for those episodes, patient complexity and care needs, and the types of costs that hospitals chose to include in the episode.

Thematic Area	Minimum	Mean	Median	Maximum
Care Transitions	$9,048	$34,438	$34,805	$87,369
Community-Based Care	$12,027	$27,378	$29,092	$43,831
Emergency Care	$8,203	$14,552	$11,165	$29,871
Palliative Care	$34,417	$48,808	$42,287	$88,197
Primary Care	$3,952	$14,562	$13,502	$35,182

Key Findings

Nearly all Maryland hospitals (90 percent) are participating in the CTI program, and most are motivated by the potential to earn savings.

- Hospitals are participating in CTIs to earn potential savings; to continue work they were already engaged in and be formally evaluated; to avoid financial penalties.
- About half of respondents said that their CTI was intended to address an area of high spending, while the other half said this was not the purpose of their CTI.

Key Findings

CTI thematic areas generally align with recent research on care transformation

- Most research focused on transitions of care or primary care; settings were similar to CTIs.
- Clinical studies mainly focused on reducing hospital admissions or readmissions after acute care stays and avoiding emergency department visits.

Key Findings

12 studies assessed changes in cost and 11 were successful; four were in Medicare population.

- One study showed reduction in costs for the Medicare program but an *increase* in costs for hospitals. Hospitals may encounter two obstacles to reducing costs, even while faced with reduced Medicare reimbursement:
  - Volumes for certain episodes are too low make the investments in care transformation worthwhile.
  - Certain models limit the ability nonhospital providers (such as physician groups, post-acute care providers, and management companies) to manage patients' care when it is not in the economic interest or the capability of an individual hospital to do so.

Key Findings

Gaps Between CTIs and Care Transformation Research

- Behavioral Health Integration: Our review of the literature identified three clinical studies of behavioral health integration in either the primary care or community settings, two of which resulted in cost savings.
  - Maryland Hospital Association acknowledged in their interview that behavioral health and addiction issues are known drivers of cost, but many hospitals are not focusing on behavioral health because the interventions are costly.

Key Findings

Gaps Between CTIs and Care Transformation Research

- Focus on cost reduction without measuring quality or patient outcomes: CTIs may demonstrate quality improvements before any cost reductions.
  - Process and outcome measures, which are widely used in value-based models, could be used to demonstrate near-term changes in clinical practice and possibly predict cost savings in future years.
  - HSCRC did not require quality measurement in the CTI program because hospitals are already required to report quality data through other programs, and because it could not identify quality measures prior to CTI submission.

Key Findings

CTIs are targeting chronic conditions that drive costs, but few are doing so in the primary care setting

- Research shows that care transformation efforts target patients with chronic conditions in primary care or community settings to avoid unnecessary hospitalizations or readmissions.
- The 51 CTIs that specify chronic conditions in their target patient population are heavily concentrated in Care Transitions.
- Only 5 of the 21 Primary Care CTIs include chronic conditions in their defined target population.

Key Findings

- Thirty-nine CTIs (37 percent) are being conducted by hospitals that are located in counties with high hospitalization rates for chronic conditions, and half are targeting chronic conditions.
- 13 primary care CTIs are in these counties, but only three target chronic conditions.

Key Findings

Hospitals can use different indicators to include patients with chronic conditions in their CTI population.

- This may be an area that HSCRC wishes to study in the future to determine how they affect the alignment of patients to a CTI.

Chronic Conditions	Number of CTIs that use chronic condition flags	Number of CTIs that use DRGs	Number of CTIs that use ICD-10 codes
COPD/Asthma	34	14	2
Chronic Kidney Disease	22	8	0
Diabetes	31	11	3
Heart Disease	21	16	2
Hypertension	20	7	0
All Major DRGs	N/A	6	N/A
Number of Unique CTIs	**39**	**14**	**4**

Key Findings

CTIs use many of the same interventions documented in care transformation research

- CTI applications included very brief descriptions of the interventions being used. Four CTIs did not describe any interventions, and 22 only describe one general intervention such as team-based care, making referrals, using data analysis, or conducting clinical assessments.
- To identify best practices among the CTIs, it will be important to identify interventions that had a measurable impact on costs and quality so they can be scaled across hospitals.

Key Findings

Clinical study interventions that align with CTIs

Intervention Type	Number of CTIs (Percentage of CTIs)	Number of studies (Percentage of studies)
Care coordination and care planning	63 (60%)	18 (51%)
Screening or referrals for social needs	36 (34%)	9 (26%)
Patient outreach, education, and follow-up	34 (32%)	13 (37%)
Data analysis, Enhanced EHR or Registry use	16 (15%)	8 (23%)
Medication Reconciliation or Medication Management	16 (15%)	5 (14%)
Home-based Care	11 (10%)	4 (11%)

Key Findings

Differences between CTI and Clinical Study Interventions

- Almost a third of CTIs (30) are using clinical assessments and early intervention to identify high-risk patients and provide tailored treatment plans.
- A third of clinical studies included interventions related to provider education, training, or financial incentives as part of care transformation, along with expanded patient access.

Key Findings

Half of all CTIs address SDOH, but opportunities exist to align more closely with local population needs.

- CTIs acknowledge SDOH, but in different ways:
  - descriptions state that they include patients with unmet social needs in their patient populations
  - SDOH-related interventions
  - include social service professionals or community organizations as part of the care team
- Survey responses offer indirect ways of addressing SDOH

Key Findings

Few hospitals that serve socially vulnerable and low-income populations are targeting SDOH through their CTIs.

- 12 Maryland hospitals whose service areas have high SVI rankings, and 10 are participating in CTIs (29 total CTIs). Half of these are targeting SDOH
- Twenty-one CTIs are being conducted in hospitals with high Medicaid revenue, seven of which explicitly include SDOH as part of the interventions.
- Addressing social factors remains a challenge. Not all hospitals have consistent screening practices or access to data on SDOH. While CTIs allow hospitals to test interventions that address SDOH, this program alone may not be able to address social factors.

Key Findings

Race and ethnicity are not explicitly mentioned in CTI descriptions.

- One third of all Maryland Medicare fee-for-service beneficiaries identify as Black, Indigenous, or Person of Color (BIPOC). Only 37 CTIs have baseline populations with a commensurate rate of BIPOC.
- Because race and ethnicity are social factors that contribute to health outcomes, there is opportunity for CTIs to acknowledge or address racial and ethnic disparities.

Key Findings

Care coordination and data utilization have been key challenges during the early implementation of the CTI program

- A majority of survey respondents described difficulties engaging with stakeholders or accomplishing the requirements of the program.
- Sharing, understanding, and applying data; trouble utilizing CTI care transformation dashboard or CTI reports. Hospital staff vary in their experience with utilizing data to support care transformation.

Conclusions

- More comprehensive descriptions of CTIs will help to articulate interventions and support the spread of best practices.
- Incorporating behavioral health into CTIs could address a major cost driver.
- Quality measurement could provide a more complete picture of CTIs' progress.
- CTIs could be better aligned with the socioeconomic conditions and prevalent health conditions of hospital service areas.

THANK YOU!

Questions?

Discussion

- *Interventions:*
  - *What types of interventions does your organization have in place to support CTIs?*
  - *Have you made any changes to CTI interventions since implementation?*
  - *How do you measure success of your interventions?*
  - *Should the HSCRC increase qualitative reporting on CTI interventions in order to increase the available information?*
- *Metrics:*
  - *Are the quality measures you track as part of broader HSCRC quality programs generally relevant to your CTIs? Do you track them specific to CTIs populations?*
  - *What other types of quality metrics do you consider?*
  - *What types of "real time" measurement is helpful in the operations of your CTI?*

Discussion

- *Alignment:*
  - *For primary care CTIs not focused on chronic conditions, what are the key areas of focus?*
  - *Does your CTI incorporate behavioral health? If so, how? If not, why?*
  - *Did you consider a behavioral health specific CTI? If not, why not? Are there program design elements that impact that decision?*
  - *Was your CTI designed to address SDOH? If so, how? If not, why?*

- *What are the major challenges your CTI is facing?*
- *For low volume CTIs, do you direct resources differently than high volume?*