Quantifying Care Transformation Initiatives (CTI)
Version: 7/10/19

Organization: Johns Hopkins Bayview Medical Center	**Submitter:** Carol C Sylvester, MS,RN csylves2@jhmi.edu

This form allows hospitals to propose a Care Transformation Initiatives (CTI) to the HSCRC. There are four fields which are required for hospital submission and an additional two which HSCRC staff will fill out. Please submit the form hscrc.care-transformation@maryland.gov.

Required from Hospital: Background Components	
Title of Initiative	Home-based Primary Care
Overview • 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).	Primary care and palliative care for older, homebound individuals. Participants receive an initial in-home assessment including full history and physical exam and a social, behavioral, and home safety evaluation. Participants are assigned a MD/NP and receive monthly or bimonthly house calls. An interdisciplinary care team (RN, LCSW, CHW) supports the patient by addressing needs related to advanced care planning, behavioral health, caregiver burden, grief counseling, connection to resources, etc.
Defined Care Interventions • Briefly describe a standardized intervention pathway to address unmet clinical or social needs. • Identify care partners at the hospital, or in the community, who will implement the intervention.	Pathway: Participants remain in JHOME until they choose to return to a different PCP, move out of the catchment area, move to a nursing home, or until end-of-life Care partners: Johns Hopkins Home-based Medicine (JHOME) at Johns Hopkins Home Care Group
Required from Hospital: Analytic Components	
Identifiable Intervention Population • Medicare FFS beneficiaries only, until further payer data available • 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.	• Medicare FFS beneficiaries • Baltimore City Zip Codes • 65+ years old • Include only patients discharged to home or to home with home care from JHBMC
Episode Trigger • A "trigger" event, or combination of factors, to identify when a beneficiary is enrolled in the intervention • Must be identifiable in Medicare claims; cannot be triggered with an EHR or clinical data point	• Hospital discharge • Patient Billed for services provided at home (Place of service = 12 (home)), 15 (mobile health unit) • In home care for 90 days post discharge
For HSCRC Analysis and Consideration:	
TCOC Impact and Duration of Episode • From the information above, HSCRC will estimate the TCOC savings related to the initiatives by calculating the difference in costs for the intervention population before and after the initiative went into effect.	
Reconciliation Payments • HSCRC staff will calculate the reconciliation payment that will be made to the hospital for the savings that they produce as part of a CTI.	

- 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 CTIs.