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

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.

Organization: The Johns Hopkins Hospital	
Submission Contact: Melissa Richardson, VP, Care Coordination, mricha17@jhmi.edu	
Required from Hospital: Background Components	
Title of Initiative(s)	JHH Heart Failure (HF) Bridge Clinic
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).	An interdisciplinary team of a physician, nurse practitioner, pharmacist and community health worker team up to provide care to adult patients diagnosed with HF, with a focus on those with recent hospitalizations or outpatient decompensations. Goals are to improve adherence to evidence based guideline directed medical therapy and provide close monitoring and follow up to reduce hospitalizations and thus total cost of care. The clinic program provides patient education on self-management, an outpatient resource (to avoid ED), outpatient intravenous diuretics for mild HF decompensations, lab monitoring, medication counseling, linkage community resources and support for healthy lifestyle management.
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.	The intervention includes three components: 1. **Early Identification:** Patients hospitalized with heart failure will be outreached by a RN care navigator, provided HF education and appointing in the HFBC prior to discharge. 2. **Protocolized Care:** Patients will be managed in HFBC under a clinical care pathway and seen within 1 week of hospital discharge, and then weekly for the first 30 days after discharge. 3. **Home-based Care Services**: Patients at risk will be offered goal- directed nurse transition guide and/or remote patient monitoring services. Care partners will include inpatient providers such as hospitalists, outpatient primary care providers and JH Home Care Group.
Required from Hospital: Analytic Components	
Identifiable Intervention Population • Medicare FFS beneficiaries only, until further payer data available	Medicare FFS beneficiaries (age $\geq$ 18 yrs.)

• 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	
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	• Inpatient discharge from JHH for APR DRG-194 (HF) **AND** • NULL claim for SNF, LTCF, LTAC, Acute Rehab same day or next day 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.	