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.

Required from Hospital: Background Components	
Title of Initiative	
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).	Remote Patient Monitoring is a device with technology to assess and transmit weight, BP, HR, and Oxygen saturations, daily. This allows staff to monitor patients determined to be high risk for readmission based on discharge diagnosis of HF, COPD, and Respiratory Failure and risk scoring in order to closely follow, determine, and address early changes of concern in order to avoid readmission.
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.	RPM staff identify patients at Inpatient Discharge with specific diagnosis. Daily downloads come from the home based device to a coordinator. Diagnosis based protocols are used to recognize any concerning trends or patient questions lead to a call and discussion with the patients PCP to address changes to care. This includes Pharmacy outreach for medication review at 72 hours after discharge.
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	Patients are identified as Medicare FFS, diagnosis appropriate (HF, COPD, Respiratory Failure) identified as high risk based on 2 or more inpatient admissions for the same diagnosis, in addition to having specific social criteria including WiFi access, ability to use and comply with kit measurements and questions through iPad interactions.
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	A triggering event with be an Inpatient Admission of a Medicare FFS beneficiary with a diagnosis of HF, COPD, or Respiratory Failure and determined to be high risk for readmission.
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.	