Quantifying Care Transformation Initiatives (CTI)
Version: 8/29/19

Organization: Johns Hopkins Bayview Medical Center	**Submitter:** Carol C Sylvester, MS, RN, Vice President Care Management Services. 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	Outpatient Antibiotic Therapy Program
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).	Patients with complex, resistant and/or reoccurring infections are often discharged on IV antibiotics for 4 or more weeks post discharge. The most frail and/or with substance use disorder have the poorest support systems and are often discharged to care in a SNF but are often readmitted with relapses or additional infections.
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: Patients requiring long term IV antibiotics have plans of care determined by infectious disease specialists. Coordination of care for these patients will be provided by an interdisciplinary pharmacy team under the direction of infectious disease. Specific SNF partners have implemented best practices including telemedicine and care of persons with SUD and will be receiving these patients for care. The window is hospital discharge to 60 days post 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	• Discharged as inpatient from JHBMC to a skilled nursing facility – FutureCare Canton Harbor, North Point, and Charles Village as well as Genesis Heritage Center • Resides in zip codes 21222 and 21224 • Medicare FFS • Received IV antibiotic on day of hospital discharge • NPI of at least 1 infectious disease attending during hospitalization
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	• Discharge from JHBMC with above target population
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.