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.

Please list all interventions applied to the population defined on this form. Multiple interventions can be directed at the same population, but a new population necessitates a new form and CTI.

Required from Hospital: Background Components	
Title of Initiative	**Transitional Home Visits_NP**
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).	**Transitional home visits are time-limited services to ensure continuity in health care services and avoid poor outcomes, particularly in high-risk populations. They can help to decrease total cost of care and improve quality and outcomes by reducing the risk of readmission and potentially avoidable utilization.**
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.	**A care team (consisting of a nurse practitioner) would follow-up with patients during the 30 day period post-discharge from a skilled nursing facility sub-acute stay. Follow-ups would consist of both telephone and in-person visits.**
Required from Hospital: Analytic Components	
Identifiable Intervention Population • Medicare FFS beneficiaries only, until • 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	**All Medicare FFS patients discharged from SNF sub-acute** • Identified Population 1. Age 65 and older 2. High risk with 2 or more Admissions, ED visits, or Obs visits during past 90 days. 3. All Medicare FFS patients discharged from SNF sub-acute stay 4. Duration is 90 days.
Episode Trigger • A “trigger” event, or combination of factors, to identify when a beneficiary is • Must be identifiable in Medicare claims; cannot be triggered with an EHR or clinical data point	**All Medicare FFS patients discharged from SNF sub-acute** • Identified Population 1. Age 65 and older 2. High risk with 2 or more Admissions, ED visits, or Obs visits during past 90 days.

	3. Identified in All Medicare FFS patients discharged from SNF sub-acute stay 4. Duration is 90 days.
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.	