Quantifying Care Transformation Initiatives (CTI)
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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	**Elder Medical 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 is delivered in the home setting for individuals with chronic or serious illness who are having trouble leaving their home. Medical Care is coordinated by a team of physicians, nurse practitioners, nurses and social workers in addition to offering guidance regarding Advanced Care planning.
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: Social Worker, Physician, or Case Manager in community or GBMC identifies patients who may benefit from Elder Medical Care. Referral is processed via the Gilchrist Care Navigation Center. Elder Medical Care RN Care Manager reviews the referral and coordinates a visit from an Elder Medical Care provider. During the initial visit, Provider establishes plan of care with the patient and other members of the interdisciplinary team to support both their physical and social needs. Ongoing assessments and visits occur based on individual plans of care. Care Partners: GBMC, Notre Dame School of Pharmacy, Catholic Charities, Lorien At Home, GBMC Health Partners
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	• 3 or more chronic conditions (CPT codes to be defined) • Serious Illness diagnosis (to be aligned with CMMI Seriously Ill Population Payment Model)
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	• Initial E/M Home visit from Elder Medical Care Provider
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.