**Complex and Chronic Care Improvement Program Implementation Protocol**

**Performance Year 2017**

(Not approved by CMS – subject to continuing review process)

**Introduction**

The Complex and Chronic Care Improvement Program (CCIP) is designed to allow Participant Hospitals to support eligible physicians and practitioners (Care Partners) in the care management of High Need and Rising Need Patients (defined in Section D) with complex and chronic conditions. The CCIP provides necessary waivers that allow Participant Hospitals to share resources and financial incentives with participating Care Partners. Participant Hospitals will also receive comprehensive Medicare data to be used for care redesign. The resources and data provided by the Participant Hospital will help eligible Care Partners to access the Centers for Medicare & Medicaid Services (CMS) Chronic Care Management (CCM) fee for Medicare patients and are intended to align with the 2015 Medicare Access and CHIP Reauthorization Act (MACRA) requirements.

Each year, the Participant Hospital will submit an Implementation Protocol which describes the hospital’s CCIP program. The program must meet certain requirements which are outlined in this Program Template.

In the CCIP, participating Care Partners are defined as Patient Designated Providers (PDPs) and must meet the following criteria to be eligible as the Patient Designated Provider:

* Designated by a patient as the patient’s primary provider of care
* A family practice, general or specialist physician, clinical nurse specialist, or a nurse practitioner
* Provide services to beneficiaries who are within the service area of the Participant Hospital
* Have a National Provider Identifier (NPI); and
* Participate in the Medicare Program

The CCIP is designed to:

* Enable Participant Hospitals to provide care management resources and other Care Redesign Interventions to PDPs that provide care for patients with chronic and complex conditions.
* Allow Participant Hospitals to offer incentive payments to PDPs that provide care for patients with chronic and complex conditions.
* Promote and support collaboration and cooperation among hospitals and physicians/practitioners on behalf of patients.
* Promote data-driven, ongoing improvement in care delivery over time.
* Facilitate overall practice transformation towards patient-centered care that produces improved outcomes and meets or exceeds quality measures.
* Leverage common tools and technology including those developed by CRISP, such as the electronic notification system and analytics capabilities.

**Components of the Program: Required and Optional**

The CCIP consists of two major components: 1) Care Redesign Interventions and 2) Incentive Payments paid to PDPs. In order to participate in the program and thereby gain access to the associated waivers and Medicare data, the Participant Hospital must develop and deploy meaningful Care Redesign Interventions. Care Redesign Interventions include (i) resources and services the Participant Hospital will provide or make available to PDPs and (ii) activities performed by a PDP designed to improve the quality of care and reduce the need for admissions (“Care Intervention Activities”). Starting in Performance Year 2018, Participant Hospitals will have the option of offering cash Incentive Payments to PDPs.

**Care Redesign Interventions (Required Component of the CCIP Program)**

Care Redesign Interventions funded by the Participant Hospital will provide support to PDPs that serve patients with chronic and complex conditions. Care Redesign Interventions are offered at the outset of the program and continue throughout the duration of the program.

The Participant Hospital will deploy resources, such as risk stratification processes, health information technology for use in the creation of Care Plans and sharing information with providers, reports that provide meaningful and actionable data to PDPs for use in the care of patients, and care management staff and 24/7 telephone lines staffed by Care Managers to support the care of the PDP’s CCIP patients. Care coordination resources will assist PDPs in managing the care of patients, improving the quality of care, and reducing potentially avoidable admissions and readmissions. The program will improve the care of chronically ill and medically complex patients by working with the patient, family, and all care providers to achieve the patient’s stated health goals. The program will educate patients, coordinate care, assist patients in managing their conditions, and work to remove barriers to achieving the best possible health result. The care management program begins with a health risk assessment which is the starting point for the individualized Care Plan.

The PDP is responsible for directing the overall care of patients with chronic and complex conditions, actively working with the patient’s Care Manager, and participating in or overseeing required Care Intervention Activities, including;

* Completion of a Health Risk Assessment
* Completion and maintenance of a Care Plan
* Medication management and reconciliation
* Ensure that appointments are available for a patient within 7 days after a hospitalization discharge

Ideally PDPs will also employ best practices, including:

* Administering of pneumonia vaccines
* Monitoring and managing disease status indicators such as:
	+ ACE inhibitor and beta blocker therapy when LVEF is <40
	+ Set goals and monitor HgB A1C levels at least quarterly
	+ Develop hypertension plan and monitor goals

The PDP will use technology, tracking systems and communications processes that are agreed upon by the hospital and PDP to support the coordination of care.

**Incentive Payments Paid to PDPs (Optional Component of the CCIP Program)**

***Incentive payments will begin in 2018, if the hospital chooses to use them.***

Incentive payments are designed to promote alignment between the hospital and PDPs. To assist PDPs with financial support for care redesign, Participant Hospitals may share positive financial results with PDPs who are completing the required Care Intervention Activities of the program. Payouts are contingent upon certain requirements, including performing the defined activities at the provider level, reduced utilization, and total cost of care targets at hospital level.

# Implementation Protocol Instructions

Prior to completing this protocol please read the Complex and Chronic Care Improvement Program (CCIP) Template as it is intended to help aid in completion of this protocol. Please complete all required sections of this protocol as indicated in Section A.

The CCIP Program Template and the Implementation Protocol include detailed requirements that are referred to in the Participant Hospital’s Participation Agreement between CMS, the State, and Participant Hospital. The successful completion and approval of the Implementation Protocol by the State and CMS activates the Participant Hospital’s ability to access the necessary waivers needed to share resources and obtain patient-identified Medicare data, and offer Incentive Payments to Care Partners (PDPs) (optional starting in 2018).

In **Section A**, Participant Hospitals provide general information.

In **Section B**, provide a description of your Care Redesign Program Oversight Committee and PDP and patient participation in the CCIP.

In **Section C**, provide details of your model plan

In **Section D**, concisely explain your plan for putting in place the Care Redesign Interventions and how you intend to monitor them.

In **Section E**, provide an anticipated budget for the CCIP.

# A. Participant Hospital Information

**Date of Implementation Protocol submission**:

**Organization Name and D/B/A** **Name:**

**TIN:**

**CMS certification #(s) for organization:**

**Contact Person for Agreement:**

|  |  |
| --- | --- |
| **Name:** |  |
| **Title:** |  |
| **Street Address:** |  |
| **City, State, Zip:** |  |
| **Telephone:** |  |
| **Fax:** |  |
| **Email:** |  |

**Name the key personnel and describe the function of the key management personnel for this program.**

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| --- | --- |
| **Key Personnel** | **Responsibilities** |
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# Governance and CCIP Participation

See the Participation Agreement for a description and requirements of the Oversight Committee.

**Provide the names of your Care Redesign Program Oversight Committee members and their organization.**

|  |  |  |
| --- | --- | --- |
| **Name, Credentials** | **Job Title and Organization, if applicable**  | **Please check one to indicate who the member is representing:** |
| **Participant Hospital Employee** | **Physician Representative** | **Consumer Representative** |
|  |  | [ ]  | [ ]  | [ ]  |
|  |  | [ ]  | [ ]  | [ ]  |
|  |  | [ ]  | [ ]  | [ ]  |
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| **Please answer the following questions about how the Care Redesign Program Oversight Committee will provide oversight, guidance, and management to the Complex and Chronic Care Improvement Program.** |
| 1. How often will the Oversight Committee meet? (monthly, bi-monthly, quarterly, bi-annually) |  |
| 2. Does the member composition of your Oversight Committee meet the qualifications outlined in the Participation Agreement? |  |
| 3. Will the Oversight Committee be provided with progress/dashboard reports on program performance from hospital personnel involved in the program? |  |
| 4. If yes, how often will the Oversight Committee require these reports? (monthly, bi-monthly, quarterly, bi-annually, annually) |  |

# C. CCIP Model Plan

**Table 1. CCIP Model Plan (Each section requires a response)**

| **Category** | **Hospital changes to current care model** | **Describe planned interventions at a general level, if applicable (200 words or less)** |
| --- | --- | --- |
| **Infra-structure** | Define the information systems to track parameters required for the incentive payments, including quality measures |  |
| Define the information systems to support care redesign and information sharing  |  |
| Identify care management staff and their respective patient to staff ratios. Will the ratios be evaluated during the program? |  |
| Describe the supervision and monitoring of the care management staff. How will you ensure that the care management team follows the directives of the PDP? |  |
| Identify how care management staff needs will be met 24/7  |  |
| Describe how the care management team will coordinate with PDP existing care management staff. |  |
| How often will performance assessments be completed for care management staff? (bi-monthly, bi-annually, annually) |  |
| **Data**  | Develop approaches for sharing clinical and other key information (e.g., Comprehensive Medicare data) with PDPs  |  |
| Analyze monthly CMS claims data files |  |
| Use data to support incentive payments and processes |  |
| Do you plan to share the comprehensive Medicare data you will receive from CMS with PDPs? (check if yes) | [ ]  |
| If yes, how frequently will data be shared? (Monthly, every two months, quarterly) |  |
| How will the PDP access the Care Plan and be notified when an update has been made by the care manager? |  |
| Describe how you will use the data to enhance care coordination  |  |
| Define your process and frequency for monitoring your Care Redesign Interventions |  |
| Define how you will track and report the completion of the HRA. How will this be monitored? |  |
| **Processes; redesign care** | Use data to identify opportunities for improvement |  |
| Define Monitoring and Reporting process, including process and frequency for monitoring Care Redesign Interventions and the completion of a PDP’s Care Intervention Activities |  |
| Describe beneficiary screening process to identify needs and deficiencies  |  |
| Engage and educate beneficiaries, physicians, clinical staff, and others |  |
| Describe the process for creating the Care Plan, including participation of the PDP and the patient. |  |
| Describe process for care plan documentation and communication |  |
| What is your plan for providing a standardized Care Plan template to the care management team? |  |
| Is a process in place to ensure the HRA is completed at the beginning of the care plan development? (check if yes) | [ ]  |
| What is your plan for ensuring that Care Plans are kept current and uploaded into CRISP? (Please note if the Care Plan cannot be uploaded a Care Alert may be entered into CRISP.)  |  |
| What is the plan to ensure that care plans may be accessed by the doctors and care managers? |  |
| What is the plan to ensure that care plans may be accessed by the doctors and care managers? |  |
| Will the care manager have continuous contact with the patient as needed, or to satisfy the CCM requirement (20 minutes of care management activity) for the program’s duration (check if yes)  | [ ]  |
| Describe the high-level process in which the care manager engages the patient, determines Care Plan goals, and goal follow-up. In your description include goal setting, medication reconciliation, risk level assessment, and the identification of more extensive care management needs |  |
| How will a care manager determine a change in health status has occurred? What follow-up actions will be completed? |  |
| Will you use a specific tool to identify Activities of Daily Living (ADL) and Independent Activities of Daily Living (IADLS) deficiencies in patients or other supports needed? (check if yes)  | [ ]  |
| Will your care plan identify community resources and other non-medical providers to connect the patient to for needed services? (check if yes) | [ ]  |
| Have you developed care management policies and procedures for your staff? (check if yes) | [ ]  |
| If yes, do they include:Communication with the PDP (check if yes) | [ ]  |
| Communication with the care management team and other providers? (check if yes) | [ ]  |
| Handling of patient reported symptoms (check if yes) | [ ]  |
| Updates to the Care Plan (check if yes) | [ ]  |
| Medication review (check if yes) | [ ]  |
| Health education and promotion (check if yes) | [ ]  |
| Performance of additional assessments (check if yes) | [ ]  |
| Transitions of care (check if yes) | [ ]  |
| Securing a PDP appointment within 7 days of discharge from an inpatient admission (check if yes) | [ ]  |
| Patient feedback of a critical nature (check if yes) | [ ]  |
| Patient grievances (check if yes) | [ ]  |
| Communication with patients and their family members regarding planned hospital admissions, procedures, and expectations (check if yes) | [ ]  |
| A method for tracking care management outreach and timely follow-up, referral management, test results, and preventive and social needs (check if yes) | [ ]  |
| How will patient confidentiality be protected? |  |
| Ensurethat the care management team will ensure review of the discharge plan with the patient within 24 hours (check if yes) | [ ]  |
|  Ensurethat the discharge review will be documented, the discharge plan shared with the PDP, and Care Plan updated to reflect patient needs (check if yes) | [ ]  |
| **Heath Information Technology** | Do you currently have a care management platform in place? (check if yes) | [ ]  |
| **Ensure** that all PDPs are using a Certified Electronic Health Record (check if yes) | [ ]  |
| Are there documentation fields within the CEHRT that are required for billing of CCM or TCM for eligible beneficiaries? (check if yes) | [ ]  |
| How will you track the types of resources you are providing to your participating PDPs? How will you track the estimated costs of the provided resources? |  |

**Please answer the following questions about Patient Designated Provider (PDP) and patient participation in the CCIP.**

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| **Patient Designated Providers**  |
| 1. Have you developed a plan to engage and educate potential PDPs about the CCIP? |  |
| 2. Have you submitted a list of PDPs to CMS to go through the vetting process? |  |
| 3. If yes, how many PDPs were on the list submitted to CMS? |  |
| 4. Of those submitted, how many PDPs are not employed by the hospital? |  |
| 5. If no, when do you anticipate submitting your PDP list to CMS? |  |
| **Patient Participants** |
| 1. Are you going to use the CCIP best practice methodology to determine the criteria for High Need and Rising Need patients?  |  |
| 2. If you intend to use your own criteria for high and rising needs patients, define it here: |  |
| 3. How many High Need Patients have you identified for the program? (if available) |  |
| 4. What is your goal for High Need Patient enrollment? (given as a percentage)  |  |
| 5. How many Rising Need patients have you identified for the program? (if available) |  |
| 6. What is your goal for Rising Need Patient enrollment? (given as a percentage)  |  |

# D. Care Redesign Interventions

See Section C in the CCIP Program Template for a description of the Care Redesign Interventions expected under the CCIP.

**For each Care Redesign Intervention listed below, please supply the requested information and provide detailed responses, as applicable. Please limit each response to no more than 200 words per question.**

| **Required Care Redesign Hospital Resource**  | **Program Start**  | **By mid-Performance Year**  | **By end of Performance Year** |
| --- | --- | --- | --- |
| **Staffing** |
| 1. How many FTEs will staff your Care Management function? |  |  |  |
| 2. If RNs will be used, how many FTEs will be on staff? |  |  |  |
| 3. If social workers or mental health professional are used, how many FTEs will be on staff? |  |  |  |
| 4. If community health workers will be used, how many FTEs will be on staff? |  |  |  |

| **Required Care Redesign Interventions to be implemented by start of program** | **Response**  |
| --- | --- |
| 1. Define how you will track and report the completion of the Care Plan. How will this be monitored? |  |
| 2. Define how you will track and report updates to the Care Plan. How will this be monitored? |  |
| 3. Define how you will track and report completed medication reviews. How will this be monitored? |  |
| 4. Define how you will track and report physician visits within 7 days of discharge from an Inpatient admission? How will this be monitored? |  |
| 5. Define how you will track and report completed Care Transitions after an Inpatient Discharge. How will this be monitored? |  |

# E. Program Budget

Please see Section F in the CCIP Program Template for a description of the incentive program.

**1. What is the budget associated with the care management function of the CCIP? (Please limit your response to no more than 200 words.)**

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**2. Provide an estimate of the 2017 Performance Year per patient cost of the program by High Need and Rising Need Patient categories. (Please limit your response to no more than 200 words.)**

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**Signed and Approved by:**

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| --- | --- |
| Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **PARTICIPANT HOSPITAL**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Legal Name of Participant HospitalBy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name of Authorized Signatory\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Title |
| Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **CENTERS FOR MEDICARE & MEDICAID SERVICES**By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dr. Patrick Conway, Director, Center for Medicare and Medicaid Innovation |
| Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **HEALTH SERVICES COST REVIEW COMMISSION** By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Donna Kinzer, Executive Director, Health Services Cost Review Commission |