**CCIP Implementation Outline for Hospital**

**March 23, 2017**

| **Requirement** | **Steps** | **Existing Tools** |
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| **Structure Administration and Governance** | | |
| **Program Administration** | Identify the current staff member to serve as the CCIP Program Coordinator. |  |
| **Governance** | Determine if there is a pre-existing committee that can serve as the Care Redesign Program Oversight Committee   1. If so, determine if it meets the CCIP requirements regarding member participation, or adjust membership as needed. 2. If no existing committee is in place, recruit membership and form the Care Redesign Program Oversight Committee. |  |
| **Identify and Enroll Program Participants—Patients and Patient Designated Providers (PDPs)** | | |
| **Identify Your Program Participants** | Determine the selection criteria that will be used to identify high and rising need patients   1. Use default selection criteria defined in the CCIP Program Template, or 2. Use your own risk identification methodology. | CRISP PaTH Report allows credentialed hospital users access to identified patient information while filtering by utilization, chronic conditions, and other variables. |
| Analyze data to identify the high and rising need patients and the providers most likely to be their PDPs. Identifiable Medicare claims data (similar to CCLF available to ACOs) will be available at a later date. | CRISP PaTH Report.  Hospital data, including information not available in claims data, e.g., health risk appraisals or difficulty performing activities of daily living. |
| Group patients by likely PDPs and determine which providers you want to invite to participate in your program **based on your own criteria (i.e. relationship with hospital, number of patients etc.** Survey potential PDPs regarding required elements e.g. CEHRT**.** | CRISP is developing connectivity with ambulatory providers and is available to work with your hospital to identify prioritized practices within your community. |
| **Create PDP Recruitment Program** | 1. Identify who will reach out to the PDPs. 2. Train the outreach staff on the program, PDP responsibilities, patient enrollment process, technical reporting requirement (CMS approved EHR/CEHRT). 3. Determine the information you will share 4. Create communication vehicles to educate PDPs about the program, their responsibilities, and the hospital support for PDPs. 5. Develop patient enrollment materials for PDPs to use in recruiting patients. Patients can give verbal assent but it must be documented.  * Program information; * Disclosures and privacy/permissions to be signed; * Information on 24/7 access to care management; * Disclosure of potential copayments or cost shares; * Information on how to withdraw from the program; and * Brief HRA for the patient to complete upon enrollment.  1. Recruit PDPs. | CRISP may be able to support your data exchange.  CRISP will provide template communication materials for PDPs.  CRISP will provide template patient enrollment materials. |
| **Sign Up Participating PDPs with the Care Partner Agreement** | 1. Provide your PDPs with standard operating procedures including providing appropriate consent to share patient data through CRISP, notifying designated care manager to begin working with the patient, accessing and reviewing the care plan, communicating with the care manager, etc. 2. Clearly define the care interventions that the provider will oversee or perform:  * Each patient will complete an HRA and other needed assessment tools; * Develop and maintain a care plan for each patient; * Ensure medication management and education will be done as appropriate; and * Ensure that appointments are available for the patient within 7 days of inpatient discharge.  1. **Suggested but not required Care Interventions include:**  * **Administering pneumonia vaccines; and** * **Disease specific metrics monitoring such as HbA1C and BP.** |  |
| **Set up the Care Management Function** | | |
| **Estimate Number of Patients to Develop Staffing Model** | Use the risk identification methodologies and the provider recruitment list, estimate anticipated numbers of high and rising risk patients   1. Determine staff to patient ratios; and 2. **Determine number of RNs to be hired, social workers or community health workers (what type of staff do you want to have providing care management) or identify your needs to a sub-contractor if not hiring.** | CCIP Modeling Tool; CCIP Budget Calculator |
| **Develop Standard Operating Procedures for Ongoing Care Management** | SOPs should include:   1. How to create a care plan; 2. How to continually work an evolving care plan; 3. Documentation requirements; 4. Required patient contact per month; 5. PDP updates communication flow; 6. Triggers for additional assessments, medication reviews or PDP contact; 7. How to handle patients self-reported symptoms; 8. How discharge planning and transition planning will be handled; 9. How reporting and information will flow among and between PDP, care management staff, and CRISP. 10. **How to communicate with families regarding appointments, expectations, caregiving needs;** 11. **Health education resources for care managers;** 12. **How to gather patient feedback and manage patient grievances;** 13. **Identify processes for care plan development that may require several calls due to the stamina of the patient; and** 14. **Identify expectations when patient or family members are not responsive or participating in care plan development.** |  |
| **Determine How To Provide Patients with 24/7 Care Management Access** | 1. Ensure process is in place to educate PDPs, patients and family members so they are aware of how to reach care managers. 2. Develop system to monitor number of patients making use of after-hours and weekend contact of care managers. 3. Ensure staff are available to provide coverage and training in place to manage after hour and weekend calls. 4. **Determine if you will allow 24/7 access to the care plan and if so, how.** |  |
| **Identify Tools to use in Care Management** | Identify HRAs, other types of assessments or **tools and community resources to be used in care management.**   1. Train staff and PDPs on tools; and 2. Determine process and accountability for uploading completed/updated care plans to CRISP. |  |
| **Establish Tracking Processes** | Ensure there is a process in place for tracking and managing:   1. Care management outreach and timely follow-up; 2. Referrals; 3. Care transitions; 4. **Test results; and** 5. Preventive and social service needs. |  |
| **Hire (or Repurpose Existing) Care Management Staff** | 1. Develop care management training, supervision, and performance monitoring structure. 2. Identify competencies needed for care management functions and train/evaluate to ensure staff are performing as needed. 3. If care management is to be outsourced, identify potential care management providers and procure services that meet CCIP required functions. |  |
| **Establish Process to Initiate Care Management** | * 1. Care manager contacts patient and begins development of the care plan.   2. PDP direction.   3. Care plan must include detail on: * Addressing care gaps identified in the HRA; * Addressing functional limitations identified in the HRA and connects patient to community resources and records the resolution of the connection; * Identified care goals of the patient; * Identified if any caregivers in the home—is there any need for caregiver education? * Identified health education needs for patient, caregiver or family; * Medication review and reconciliation; * Identified transportation needs; and * Ensure patient understands how to get assistance 24/7. |  |
| **Establish Patient Enrollment Processes** | | |
| **Determine Patient Enrollment Process** | 1. Enrollment forms may be signed in PDP office or verbal agreement may be taken and documented in patient record:  * **Hospital calls patient, confirms PDP – explains program and asks patient to schedule PDP visit or,** * **Hospital gives list to PDP, office calls patient explains program and schedules visit** * **Hospital sets up additional process of reaching out to pre-identified patients who encounter the hospital**  1. Set up process for PDP office to send notification of patient enrollment to CRISP. 2. Set up process for care manager to contact patient within a certain timeframe of enrollment (48 hours). 3. Document standard operating procedures for above and provide to care management team and PDP office. |  |
| **Reporting** | | |
| **Determine Reporting to Support PDPs** | 1. Determine what reports will help PDPs identify gaps in care. 2. **Determine what reports will help PDPs monitor and improve performance, outside of what will be provided by program administrator.** 3. Set up continuing education about the program and its results 4. Gather feedback from providers to improve the program |  |
| **Metrics Reporting** | 1. Develop a system to provide the required monthly reporting to PDPs. 2. Determine how metric reports will be used to improve performance. |  |