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

**Performance Year 2017**

**Margaret Brent Hospital**

(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**: March 16, 2017

**Organization Name and D/B/A** **Name: Margaret Brent Hospital dba Brent Hospital**

**TIN: 52-1234567**

**CMS certification #(s) for organization:** 334455

**Contact Person for Agreement:**

|  |  |
| --- | --- |
| **Name:** | Anna Landholm |
| **Title:** | Vice President, Brent Hospital Provider Network |
| **Street Address:** | 8674 W. Leonard Calvert Blvd. |
| **City, State, Zip:** | Morganza, MD 20660 |
| **Telephone:** | (240) 895-1234 |
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| **Email:** | alandholm@brenthospital.org |

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

|  |  |
| --- | --- |
| **Key Personnel** | **Responsibilities** |
| Anna Landholm | Project director, Care Partner liaison |
| Giles Smith | Project manager and administrative support |
| Howard Tubman | Marketing, communications |
| Felicia Douglas | IT and EHR technology support, data management, and liaison to CRISP |
| Trudy Tilghman | Oversight of care management (policy, function and personnel) |
| James Booth | Financial oversight  |

# 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** |
| Anna Landholm | Vice President, Brent Hospital Provider Network, Brent Hospital | [x]  | [ ]  | [ ]  |
| Cecil Calvert | CFO, Brent Hospital  | [x]  | [ ]  | [ ]  |
| Harriet Fleet, MD | CEO, Brent Hospital | [x]  | [ ]  | [ ]  |
| Kaitlyn Pierce  | Consumer Representative | [ ]  | [ ]  | [x]  |
| Peggy Stewart, MD | Private practice, Internal Medicine | [ ]  | [ ]  | [ ]  |
| Mathew Sousa, APN | Brent Hospital, Provider Network, Family Medicine | [ ]  | [x]  | [ ]  |
| Charlotte Hall, MD | Private practice, Infectious Disease | [ ]  | [x]  | [ ]  |

|  |
| --- |
| **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) | **Quarterly** |
| 2. Does the member composition of your Oversight Committee meet the qualifications outlined in the Participation Agreement? | **Yes** |
| 3. Will the Oversight Committee be provided with progress/dashboard reports on program performance from hospital personnel involved in the program? | **Yes** |
| 4. If yes, how often will the Oversight Committee require these reports? (monthly, bi-monthly, quarterly, bi-annually, annually) | **Quarterly** |

# 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 | Reports will be generated from Healthy Planet tracking completion of activities and required metrics. Brent Hospital care managers will be responsible for gathering pertinent data if information sits within the PDP EHR. |
| Define the information systems to support care redesign and information sharing  | Our Health Information Technology team will provide and make available reports via Healthy Planet that assess health care and medication utilization trends. The tools within Healthy Planet will allow our team to identify trends that exceed norms for patients with like demographics and DRGs. Care managers will work with these identified patients and the PDP to develop Care Plans specific to each patient in an effort to better manage utilization and outcomes. Specific factors will be assessed including: multiple primary care providers, use of specialists, extended inpatient stays, co-occurring diagnostic morbidities and medications prescribed and medications filled. |
| Identify care management staff and their respective patient to staff ratios. Will the ratios be evaluated during the program? | Care management staff will hire a combination of RNs, Social Workers and Community Health Workers. They will be trained in advance of recruiting patients. The ratios are the following: RNs or Social Worker (Care Managers) to patients 1/110Community Health workers to patients 1/149 Staffing ratios will be examined every quarter to ensure that quality care management is being provided.  |
| 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? | The Care Management Supervisor meets with each staff member weekly to review cases and monitor work. The supervisor has access to reports generated by Epic’s Healthy Planet, our Care Management platform to monitor activities of the care managers and reviews these reports in weekly supervision meetings with the responsible care manager. Care Plans authorized by the PDP will be used to assess if care managers are completing tasks as directed by the PDP. |
| Identify how care management staff needs will be met 24/7  | Care management staff will be available by phone and on-call to respond 24 hours per day. Our care management staff will provide their telephone numbers to their assigned patients for calls during regular business hours. Coverage will be provided during care manager absences. The care management staff will rotate 24/7 coverage. A dedicated phone number will be given to our patients. The dedicated phone line will be routed to the individual on call. The designated care manager will have access to all care plans through the hospital’s portal to ensure quality service. The volume of calls will be monitored to ensure the staffing is sufficient to handle 24/7 calls. |
| Describe how the care management team will coordinate with PDP existing care management staff. | Current Brent Hospital PDPs do not employ traditional care management staff due to practice size. Some do have staff responsible for referrals and other activities that a care manager would take on in a larger practice. Brent Hospital Care Management staff will be responsible for coordinating and communicating with staff who provide care management functions within PDP practices. Management staff assigned regionally across the county and spend time within the communities where patients reside and receive healthcare services. Volume and provider/patient need will dictate frequency at each office.  |
| How often will performance assessments be completed for care management staff? (bi-monthly, bi-annually, annually) | Annually |
| **Data**  | Develop approaches for sharing clinical and other key information (e.g., Comprehensive Medicare data) with PDPs  | Monthly performance reports including data related to the PDP’s patient panel will be provided. If the PDP office has the ability to receive reports electronically that is preferred. Relay of data will follow Brent Hospital Privacy Policies, HIPPA and HITECH regulations. |
| Analyze monthly CMS claims data files | The analytics team will develop reports and data for examination by leadership monthly. Reports may include total medical spend per patient, number of service providers, and readmissions etc. |
| Use data to support incentive payments and processes | Care managers will work with PDP staff to collect this information from the PDP’s EHR bi-annually unless it can be collected via CRISP. We will also make use of the registries available within Healthy Planet to track this information.In terms of the care management resources we provide to PDPs, we will track those on our CCIP budget that we’ll create, which will include the costs associated of all resources provided. |
| Do you plan to share the comprehensive Medicare data you will receive from CMS with PDPs? (check if yes) | [x]  |
| If yes, how frequently will data be shared? (Monthly, every two months, quarterly) | Monthly |
| How will the PDP access the Care Plan and be notified when an update has been made by the care manager? | PDPs without a CEHRT will be required to utilize the Brent Hospital CEHRT. Remote access will be offered and training provided to practices not currently using an EHR. PDPs will be able to access the patient health Care Plan through the Brent Hospital EHR or through CRISP. Care Managers will be responsible for ensuring PDPs are aware of significant activity in between outpatient visits through electronic alerts. PDPs will be required to ensure their staff are reviewing alerts and bringing alerts or pertinent information to the PDPs attention. |
| Describe how you will use the data to enhance care coordination  | Our Health Information Technology team will provide and make available reports via Healthy Planet that assess health care and medication utilization trends. The tools within Healthy Planet will allow our team to identify trends that exceed norms for patients with like demographics and DRGs. Care managers will work with these identified patients and the PDP to develop Care Plans specific to each patient in an effort to better manage utilization and outcomes. Specific factors will be assessed including: multiple primary care providers, use of specialists, extended inpatient stays, co-occurring diagnostic morbidities and medications prescribed and medications filled. |
| Define your process and frequency for monitoring your Care Redesign Interventions | The Care Management Supervisor will be responsible for providing a monthly report of activities. Reports will be pulled form Healthy Planet and adapted to reflect the requirements of the CCIP in addition to information we currently collect related to care management activities. These reports will be reviewed and monitored by the CCIP Project Director and quarterly summaries will be shared with the Care Redesign Program Oversight Committee. |
| Define how you will track and report the completion of the HRA. How will this be monitored? | Care managers will work with PDP staff to collect this information from the PDP’s EHR bi-annually. We will also make use of the registries available within Healthy Planet to track this information. |
| **Processes; redesign care** | Use data to identify opportunities for improvement | Reports provided to the Care Redesign Program Oversight Committee will be used to identify potential areas for program 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 | The Care Management Supervisor will be responsible for providing a monthly report of activities. Reports will be pulled form Healthy Planet and adapted to reflect the requirements of the CCIP in addition to information we currently collect related to care management activities. These reports will be reviewed and monitored by the CCIP Project Director and quarterly summaries will be shared with the Care Redesign Program Oversight Committee. |
| Describe beneficiary screening process to identify needs and deficiencies  | ADLs and IADLS are routinely assessed through the Brent Hospital Care Management screening tool that will be used with each patient in the CCIP. The Care Plan will incorporate referrals and a detailed plan to address any deficiencies identified. |
| Engage and educate beneficiaries, physicians, clinical staff, and others | The Brent Hospital Project Director who also serves as the Care Partner Liaison is responsible for ongoing engagement and education related to the CCIP. Materials provided by HSCRC, CRISP, MHA and others will be used to communicate with potential beneficiaries, physicians and other stakeholders. As needed, additional materials may be created, meetings and opportunities to share information related to the program will be pursued. |
| Describe the process for creating the Care Plan, including participation of the PDP and the patient. | Development of the Care Plan will be based on information gathered in the HRA, from results of the Brent Hospital care management screening tool, inputs provided by the patient, family members and care givers if consent has been provided, and review and recommendations by the PDP. The PDP, patient and care manager all will be asked to sign off on the Care Plan and updates as needed. |
| Describe process for care plan documentation and communication | Coordination and supporting necessary communication is the responsibility of the Brent Hospital Care Manger. Care managers will be expected to utilize Healthy Planet, standard workflows, and adapt communication alerts to each PDP as requested by the PDP. The care manager is responsible for documenting contact with both the patient and health professionals providing treatment, and notifying the PDP and other providers that new information has been communicated. It is anticipated that at a minimum assigned care managers will provide specific information or notifications to the PDP and their staff, and at other times PDPs will be interested in pursuing direct communication with providers. Care managers are trained on workflows tailored to protocols specific to chronic diseases, and healthcare delivery trends frequently encountered by high need patients which can be included in individualized care plans. |
| What is your plan for providing a standardized Care Plan template to the care management team? | A standardized care plan provided by EPIC will be used by all Care Managers. |
| Is a process in place to ensure the HRA is completed at the beginning of the care plan development? (check if yes) | [x]  |
| 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.)  | The Supervisor of the Care Managers will audit each week to ensure that updates are being made to the care plans. The care plans will be uploaded into CRISP every Friday.  |
| What is the plan to ensure that care plans may be accessed by the doctors and care managers? | The system can be accessed via the hospital portal or the web. |
| What is the plan to ensure that care plans may be accessed by the doctors and care managers? | The system can be accessed via the hospital portal or the web. |
| 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)  | [x]  |
| 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 | PDPs or their staff, will notify the Care Management supervisor when a new patient has consented to participate in the CCIP. Contact information for the patient will be passed on by the PDP staff along with urgent care management needs, and the Health Risk Assessment (HRA) if one has been completed. The Care Management supervisor will assign the patient to a dedicated care manager who will be responsible for completing the Care Plan. The care manager will contact the patient within 24 hours and complete the Brent Hospital care management screening tool. If indicated, within one week, a face to face contact with the patient will be completed. Patient engagement will be the focus of these initial contacts with the goal of identifying the patient and their family member’s preferences related to contact method, support and additional resources desired etc. Development of the Care Plan and goals will be based on the HRA, results of the care management screening tool, inputs provided by the patient, family members or care givers, assuming consent has been provided, and review and recommendations by the PDP. Medication reconciliation and care management goals will be directed by the PDP. |
| How will a care manager determine a change in health status has occurred? What follow-up actions will be completed? | A change in health status can potentially be triggered by a variety of events including an ED visit, change in level of care, and visits to the PDP or other providers. These events, indication by the PDP, or routine care management contacts may indicate the need to reassess health status and potentially update the Health Care Plan. As needed, a new HRA may be completed or re-assessment of the Care Management Screening Tool may be utilized. Results will determine needed changes to the Care Plan. |
| 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)  | [x]  |
| Will your care plan identify community resources and other non-medical providers to connect the patient to for needed services? (check if yes) | [x]  |
| Have you developed care management policies and procedures for your staff? (check if yes) | [x]  |
| If yes, do they include:Communication with the PDP (check if yes) | [x]  |
| Communication with the care management team and other providers? (check if yes) | [x]  |
| Handling of patient reported symptoms (check if yes) | [x]  |
| Updates to the Care Plan (check if yes) | [x]  |
| Medication review (check if yes) | [x]  |
| Health education and promotion (check if yes) | [x]  |
| Performance of additional assessments (check if yes) | [x]  |
| Transitions of care (check if yes) | [x]  |
| Securing a PDP appointment within 7 days of discharge from an inpatient admission (check if yes) | [x]  |
| Patient feedback of a critical nature (check if yes) | [x]  |
| Patient grievances (check if yes) | [x]  |
| Communication with patients and their family members regarding planned hospital admissions, procedures, and expectations (check if yes) | [x]  |
| A method for tracking care management outreach and timely follow-up, referral management, test results, and preventive and social needs (check if yes) | [x]  |
| How will patient confidentiality be protected? | Care Management Team members and PDPs will be required to abide by Brent Hospital’s Patient Privacy Policies. Training will be provided and anyone granted access to Healthy Planet must attest to maintaining patient confidentiality and upholding the Brent Hospital Privacy Policies. |
| Ensurethat the care management team will ensure review of the discharge plan with the patient within 24 hours (check if yes) | [x]  |
|  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) | [x]  |
| **Heath Information Technology** | Do you currently have a care management platform in place? (check if yes) | [x]  |
| **Ensure** that all PDPs are using a Certified Electronic Health Record (check if yes) | [x]  |
| Are there documentation fields within the CEHRT that are required for billing of CCM or TCM for eligible beneficiaries? (check if yes) | [x]  |
| 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? | In terms of the care management resources we provide to PDPs, we will track those on our CCIP budget that we’ll create, which will include the costs associated of all resources provided. |

**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? | **Yes** |
| 2. Have you submitted a list of PDPs to CMS to go through the vetting process? | **Yes** |
| 3. If yes, how many PDPs were on the list submitted to CMS? | **50** |
| 4. Of those submitted, how many PDPs are not employed by the hospital? | **12** |
| 5. If no, when do you anticipate submitting your PDP list to CMS? | **N/A** |
| **Patient Participants** |
| 1. Are you going to use the CCIP best practice methodology to determine the criteria for High Need and Rising Need patients?  | **Yes** |
| 2. If you intend to use your own criteria for high and rising needs patients, define it here: | **NA** |
| 3. How many High Need Patients have you identified for the program? (if available) | **500** |
| 4. What is your goal for High Need Patient enrollment? (given as a percentage)  | **60%** |
| 5. How many Rising Need patients have you identified for the program? (if available) | **2,500** |
| 6. What is your goal for Rising Need Patient enrollment? (given as a percentage)  | **60%** |

# 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? | 3.0 | 4.0 | 5.0 |
| 2. If RNs will be used, how many will be on staff? | 2.0 | 3.0 | 3.0 |
| 3. If social workers or mental health professional are used, how many will be on staff? | 0 | 0 | 1.0 |
| 4. If community health workers will be used, how many will be on staff? | 1.0 | 1.0 | 1.0 |

| **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? | The Care Manager’s Supervisor will run reports each week to ensure Care Plans are completed within the timeframes specified in the standard operating procedures. Care plans will be audited as part of the regular employee feedback sessions to insure high quality.  |
| 2. Define how you will track and report updates to the Care Plan. How will this be monitored? | The Care Manager’s Supervisor will run reports each week to ensure Care Plans are updated after each patient contact. Any delinquent entries discovered will be remedied and the Care Manager will be coached on timely entries.  |
| 3. Define how you will track and report completed medication reviews. How will this be monitored? | The Care Manager’s Supervisor will run reports each week to generate a count of medication reviews that were performed. During regular employee feedback sessions reasons for additional medication reviews will be discussed and examined against current Care Plans. During regular Care Plan audits quality issues, such as performing a medication review after an admission, report of patient issues or changes in medication will be discussed.  |
| 4. Define how you will track and report physician visits within 7 days of discharge from an Inpatient admission? How will this be monitored? | On a monthly basis, we will use claims data to determine if and when the patient sees a physician after a discharge. Any visits outside of the desired time period will result in coaching with the Care Manager. If no follow-up has occurred, remedial action will occur.  |
| 5. Define how you will track and report completed Care Transitions after an Inpatient Discharge. How will this be monitored? | The Care Manager’s Supervisor will run reports each week to identify discharges from an inpatient facility and to determine if a transition plan has been developed and is being implemented. Any deficiencies will be remedied immediately.  |

# 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.)**

|  |
| --- |
| We anticipate a total budget of $885,000 for PY2017 which includes the following:Care management staff plus associated costs (benefits, training etc.): 5FTE $500,000Administrative and management support: $150,000Technology investments, tailored reports: $200,000Patient supports (transportation assistance, misc.): $35,000  |

**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.)**

|  |
| --- |
| High Need cost per patient estimate: $885Rising Need cost per patient estimate: $248 |

**Signed and Approved by:**

|  |  |
| --- | --- |
| 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 |