**Post-Acute Care for Complex Adults Program**

**(PACCAP)**

**Track Implementation Protocol**

**Performance Period Five (January 2020 – December 2020)**

**Hospital Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Submission Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# Introduction

The Post-Acute Care for Complex Adults Program (PACCAP) is a track under Maryland’s Care Redesign Program (CRP). PACCAP is designed to allow a hospital participating in CRP under a Participation Agreement to share resources and support care partners who care for Medicare beneficiaries with complex needs. Complex need beneficiaries include those whose conditions or care needs place them at a high risk of not being discharged from the hospital or preclude timely discharge from the hospital or accommodation in a more appropriate post-acute care setting.

PACCAP provides hospitals with an opportunity to share resources and care protocols with care partners who care for complex Medicare beneficiaries in the post-acute care setting. Currently, without additional supports or resource sharing across care settings, some complex Medicare beneficiaries are unable to be discharged, leading to extreme lengths of stay in hospital inpatient settings, potential quality detriments and lower patient satisfaction. PACCAP will address care pathways for complex Medicare patients and contribute to more Maryland Medicare beneficiaries receiving care in the most appropriate, comfortable and impactful setting for their health improvements post-hospitalization.

PACCAP promotes the following objectives:

* Resource Sharing: Create an opportunity for hospitals to further transform care and share resources across the care continuum to help complex need beneficiaries receive improved quality of care and experience while also reducing spending and extreme lengths of stay.
* Care Redesign: Support and encourage hospitals and their Care Partners who are interested in continuously reengineering care and sharing care protocols for complex patients.
* Data Analysis and Feedback: Identify patients in the hospital inpatient setting with complex clinical need or extraordinary length of stay (XX days and more) to appropriately target and address clinical needs for discharge to the post-acute care setting.
* Health Care Provider Engagement: Create environments that stimulate dissemination of care pathways across the care continuum and promote collaboration between hospitals and post-acute care facilities.
* Patient and Caregiver Engagement: Increase the likelihood of better health at lower cost through patient and caregiver education and ongoing communication throughout the clinical continuum of care.

# Hospital Role and Responsibilities

A hospital participating in PACCAP will act as the coordinating entity by facilitating coordination with and among Care Partners and sharing resources to post-acute providers as appropriate under the track and to meet the needs of beneficiaries. The requirements of PACCAP include, (1) implementing PACCAP’s Allowable Interventions ; (2) engaging Care Partners; (3) using CEHRT; (4) notifying patients about the program; and (5) reporting on all applicable quality measures.

1. **Allowable PACCAP Interventions.** Allowable PACCAP Interventions in this CRP are activities and processes the hospital may elect to implement based on the care partners they choose to engage and the needs of their complex beneficiaries. **Allowable PACCAP Interventions**

| **Intervention Category** | **Intervention** |
| --- | --- |
| **Clinical Care/**  **Care Redesign** | * Evidence-based protocols for complex need beneficiaries, for example for discharge planning and care pathways for patients with delirium. |
| * Implementation of enhanced coordination with post-acute care providers. |
| * Interdisciplinary team meetings to address complex patients’ needs and progress. |
| * Provision of therapy services, as appropriate, in the post-acute setting. For example, but not limited to, respiratory, physical and other therapy. |
| * Provide resources to facilitate credentialing in the post-acute setting. |
| * Provide bariatric resources to post-acute care facilities as necessary for complex beneficiaries. |
| * Provide FTEs to post-acute settings, such as geriatric nursing assistants, as appropriate for complex need patients. |
| **Beneficiary/**  **Caregiver Engagement** | * Patient education is provided pre-admission and addresses post-discharge options. |
| * Item and/or services that support the care of beneficiaries |
| **Care Coordination and Care Transitions** | * Identify any ADL and IADL deficiencies, as applicable. |
| * Complete a transitional care plan with the post-acute discharge facility. |
| * Assignment of a care manager/ coordinator/ navigator to follow patient across care settings (e.g., to help coordinate follow-up appointments and to connect patient to needed community resources). |
| * Develop, maintain and monitor care plans for complex need patients. |
| * Remote patient consultation monitoring. |

1. **Engagement of Care Partners.** The hospital may invite eligible Care Partners to participate in PACCAP. In accordance with the PA and the CRP Calendar, CMS must vet hospitals’ proposed Care Partners and must submit lists of certified Care Partners—i.e., those Care Partners that have signed Care Partner Arrangements—to the HSCRC and CMS.

1. **Health Information Technology (HIT).** Use of CEHRT is a required program element for hospitals and Care Partners to document and communicate clinical care with patients and other health care professionals. HIT will enable quality measurement, reporting and feedback, and use of electronic health records (EHRs) as a part of care redesign across treating health care providers.
2. **Patient Notification.** All patients admitted to a hospital participating in PACCAP will receive information stating that the hospital and its medical staff are participating in the program. However, the initiative will not affect beneficiaries’ freedom to choose their health care provider, meaning that beneficiaries may elect to see a provider or supplier that does not participate in PACCAP. Hospitals must inform beneficiaries about the initiative when they become eligible for PACCAP, prior to a hospital discharge to a post-acute care setting under the program, via letter to the beneficiary or in-hospital counseling.
3. **Monitoring and Reporting.** The State will measure and monitor care in hospitals’ selected PACCAP episodes to ensure that objectives are met in redesigning care, achieving quality measure thresholds and patient experience-of-care standards, and demonstrating improved care coordination. Hospitals will be expected to provide the State with ongoing monitoring information by tracking and reporting various measures of performance improvement efforts and operational metrics, including resource sharing with Care Partners, clinical quality, and patient experience of care. Such data may include, but are not limited to, system-level measures of complication, mortality, avoided hospital days, readmission rates and process measure improvement.

In addition to the CRP reporting requirements in the Participation Agreement, hospitals should include the following information specific to PACCAP in the CRP Report for Medicare beneficiaries:

|  | Required Metrics |
| --- | --- |
| Care Partner Enrollment and Activities | * Number of Care Partners participating in PACCAP * Record of resources distributed to care partners and beneficiaries treated * Care plans submitted to care partner and uploaded into CRISP |
| Hospital Utilization, Efficiency and Care Redesign Impact | * 30-day all-cause readmission rates * 90-day all-cause readmission rates * 30-day emergency room visit rates post discharge * 90-day emergency room visit rates post discharge * 7-day follow up with physician (specialist or PCP) * Average hospital LOS * Average post-acute facility LOS |
| Patient Safety and Patient Satisfaction | * Mortality Rates * HCAHPs scores |

The HSCRC and its third party administrator will produce most of these measures on behalf of hospitals.

# Care Partner Role and Responsibilities

Care Partners collaborate with hospitals to provide care in PACCAP, participate in Allowable PACCAP Interventions, and are paid separately by Medicare for their services. Hospitals may choose skilled nursing facilities (SNFs) or home health agencies (HHA) as their Care Partners. The Hospital should create and maintain written criteria used to select Care Partners, as required by the CRP Participation Agreement. Each potential Care Partner must meet, at a minimum, the following Care Partner Qualifications specific to PACCAP in addition to the Care Partner requirements described in the Participation Agreement:

1. A facility must have a Taxpayer Identification Number (TIN);
2. The provider must participate in the Medicare program;
3. The provider must be licensed;
4. The provider must use CEHRT and CRISP, Maryland’s health information exchange; and
5. The provider must pass the federal program integrity screening process.

Care Partners must sign a Care Partner Arrangement with the hospital and comply with all applicable requirements under the Participation Agreement.

A Care Partner may participate in multiple hospitals’ PACCAP programs.

# Intervention Resource Sharing and Incentive Payments

Intervention resources, or nonmonetary remuneration, may be offered by the Hospital to Care Partners at the outset of PACCAP and may continue throughout the duration of the PACCAP intervention, to be determined in each Implementation Protocol submission. Hospitals will provide nonmonetary remuneration as applicable to the elected interventions, to help bolster post-acute care facilities as they care for complex Medicare beneficiaries. The amount of nonmonetary remuneration provided to the Care Partners must not exceed the Intervention Resource Allocation (described in Section 5 below).

For the initial performance year, PACCAP will not include incentive payments or gainsharing arrangements between hospitals and care partners. Future updates may include incentive payments or gainsharing as necessary to facilitate complex beneficiary discharges to post-acute care settings and care redesign activities.

Medicare and hospitals will benefit from resource sharing through decreased total cost of care achieved through placing complex patients in the most appropriate, lower-cost setting of care outside of the hospital. PACCAP will also help to improve the care and comfort for Medicare beneficiaries for whom hospital-level care is no longer necessary, but nonmonetary remuneration is necessitated in the post-acute care setting for discharge to occur. Resources deployed in the post-acute care setting must be monitored and allocation should be recorded in a standard manner, subject to HSCRC and CMS review.

Track Implementation Protocol Instructions

Please complete all required sections of this Track Implementation Protocol.

**Section 1**, Hospital provides general information.

**Section 2**, Hospital provides a description of the key personnel and the CRP Committee responsible for PACCAP.

**Section 3,** Hospital provides information on the model plan.

**Section 4,** Hospitaldescribes the Intervention Resources it plans to use and indicates plans for tracking and maintaining records. **Section 5,** Hospital provides a high-level budget for PACCAP participation.

1. Hospital Information

**Date of Track Implementation Protocol Submission:**

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

**TIN:**

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

**Point of Contact:**

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

**Name the key personnel and describe the function of the key management personnel for PACCAP:**

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| --- | --- | --- |
| **Key Personnel** | **Title** | **Program Role/Responsibilities** |
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# 2. CRP Committee

Provide the names of your CRP Committee members. During each performance period, at least one CRP Committee member must be a Medicare FFS beneficiary living in the hospital’s service area.

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| --- | --- | --- | --- |
| **Name, Credentials** | **Job Title and Organization, if applicable** | **Check if Care Partner Rep** | **Check if Medicare Bene Rep** |
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**Provide an explanation of the following.**

| **Please answer the following questions about how the CRP Committee will provide oversight, guidance, and management for PACCAP.** | |
| --- | --- |
| 1. How often will the CRP Committee meet?  (monthly, bi-monthly, quarterly, bi-annually) |  |
| 2. How often will the CRP Committee receive progress/ dashboard reports on program performance?  (monthly, bi-monthly, quarterly, bi-annually, annually) |  |
| 3. How will the CRP Committee assist hospitals in selecting the allowable clinical episodes? |  |
| 4. How will the CRP Committee assist hospitals in selecting the Allowable PACCAP Interventions? |  |
| 5. How will the CRP Committee provide a forum for sharing ideas, identifying problems, and developing solutions between the hospital and its Care Partners? |  |
| 6. How will the CRP Committee offer the internal leadership to ensure the integrity of and opportunity for success of the CRP and each CRP Track in which the Hospital is participating? |  |
| 7. How will the CRP Committee conduct a qualitative analysis on the status of the Allowable PACCAP Interventions and offer suggestions to the hospital on how implementation could be improved? |  |

# 3. PACCAP Model Plan

Please briefly explain how the elements listed below will be executed.

| **Category** | **Changes to Current Care Model** | **Describe Program at a High Level (< 200 words)** |
| --- | --- | --- |
| **Infrastructure and HIT** | Please describe your process for engaging Care Partners. |  |
| How will you use CEHRT to document and communicate clinical care with patients and other health care professionals? |  |
| How will use of Electronic Health Records (EHRs) as a part of care redesign across treating health care providers help ensure coordination of care across settings? |  |
| How will use of HIT enable quality measurement, reporting and feedback? |  |
| **Data** | Please describe how your hospital will utilize monthly CMS data files in the care redesign program. |  |
| Please describe how data will be used to support the use of Intervention Resources. |  |
| **Care Redesign Processes** | Please describe the population that your hospital and Care Partners intends to focus on. |  |
| Please describe any care pathways or quality improvement programs that your Care Partners will implement as part of PACCAP. |  |
| Please describe the monitoring and reporting process. |  |
| Please describe your processes for communicating and educating physicians and clinical staff regarding PACCAP. |  |
| Please describe how you will use feedback from Care Partners in order to improve Allowable PACCAP Interventions. |  |

Define your process and frequency for monitoring a Care Partner’s completion of the Allowable PACCAP Interventions. How will you ensure that medically necessary care is not reduced in an effort to reduce Medicare FFS expenditures?

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How will you communicate Allowable PACCAP intervention performance results to Care Partners and the CRP Committee?

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# Tracking Intervention Resources

All Intervention Resources provided by the hospital to a care partner need to be recorded. Please check the Intervention Resources that will be provided and describe them. In the “measure” column, please indicate how you will track and report delivery of the Intervention Resources.

Please list and describe Allowable Interventions and Intervention Resources as applicable.

| **CRP Interventions** | **Intervention Resources** | **Please describe how the resources will be used to perform the Care Redesign Interventions in 200 words or fewer** | **How will you track/assure completion of this intervention?** |
| --- | --- | --- | --- |
| 1. Provision of Care Managers or other clinical personnel | Care managers will rotate on-call duty.  Personalized “sitter” support for patients.  SNF/HHA education and capacity development  Patient and family education support  Other |  |  |
| 1. Provision of Medical Supplies | Ventilators  Catheter devices  Enteral feeding devices  Rehab equipment  Beds  Other |  |  |
| 1. HIT Infrastructure | Care planning support  Standardized assessment tools  HIT tools for transitional care management  Other |  |  |

# PACCAP Budget

Please provide your budget for Intervention Resources that will be provided to your Care Partners. The budget is comprised of the total annual intervention resource costs in Section 4 above plus other costs associated with running PACCAP. See potential examples below.

HSCRC will set a hospital’s allowable Intervention Resource allocation to be equal to the hospital’s total annual PACCAP budget. The hospital will not be permitted to spend more than this limit during the performance period, but may spend less if necessary.

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| --- | --- |
| **Budget for Performance Period 1** | |
| Total Annual Intervention Resource Costs (from Section 4): |  |
| Annual Administrative and Management Support Costs: |  |
| **Total Annual PACCAP Budget:** |  |

1. **Potentially Avoidable Utilization (PAU) Savings**

The HSCRC will measure the PAU Savings by looking at the change in the number of beneficiary-days in the hospital for two populations: 1) those beneficiaries who have been in the hospital for more than 45 days; and 2) those beneficiaries whose first post-acute care setting is a SNF or HHA following discharge from the hospital. HSCRC will measure the year-over-year change in beneficiary-days from the previous year.

The HSCRC will measure PAU Savings for the hospital in order to assess the effectiveness of PACCAP. PAU Savings have no other bearing on the hospital or PACCAP.