Bundled Payments for Care Improvement Advanced | BPCI Advanced

CARE REDESIGN PLAN (CRP)

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE & MEDICAID INNOVATION

BPCI Advanced Care Redesign Plan

CONTENTS

INTRODUCTION 2

INSTRUCTIONS 2

CARE REDESIGN PLAN 3

I. General Information 3

II. Attestation Requirement for Participation. 4

A. Use Certified EHR Technology 4

B. Compliance Plan 4

C. Participant Profile 4

III. Model Plan 5

IV. Care Redesign Interventions: Primary Drivers for Success 7

A. Clinical Practice Redesign 7

B. Patient Engagement. 8

C. Healthcare Provider Engagement 8

D. Data Analysis and Feedback 9

E. Other Interventions not Previously Listed: 10

INTRODUCTION

Pursuant to Article 4.2 of the BPCI Advanced Participation Agreement, the Participant must furnish care according to a Care Redesign Plan (CRP), accepted by CMS in accordance with Article 4 of the Participation Agreement, as a condtion of participation in the Bundled Payments for Care Improvement Advanced (BPCI Advanced) Model. For this purpose, the Participant must submit a annual Care Redesign Plan (CRP), using this template, to describe with particularity the Participant's specific planned interventions and changes to the Participant's current healthcare delivery system, subject to CMS review and acceptance.

The Care Redesign Plan (CRP) consists of four sections:

I. **General Information –** Requests basic information about the Participant.

II. **Attestation Requirements for Participation –** Enables the Participant to attest to meeting the various requirements for participation in the Model, as defined in the Participation Agreement.

III. **Model Plan -** Identifies the basic organizational infrastructure and processes needed to operationalize BPCI Advanced within the Participant's organization and among its Episode Initiators and Participating Practitioners.

IV. **Care Redesign Interventions: Primary Drivers for Success –** Identifies the planned interventions and changes to the Participant's current healthcare delivery system, the intervention's priority and corresponding timeframe for implementation.

INSTRUCTIONS

- Please complete all four sections of the CRP template. Mandatory fields within each section will be indicated with an asterisk (*).
- Convener Participants must complete sections III and IV taking into consideration their overall Model implementation plan and drivers of success across all of their Episode Initiators (EIs) and Participating Practitioners.
- No attachments to this document will be accepted.
- The CRP will be due once a year – 30 days before the start of the Model Year.
- The Participant must submit the completed CRP, including the certification signed by an authorized executive to CMS, via the BPCI Advanced Portal https://app1.innovation.cms.gov/bpciadv/.
- Questions about this document or the process for completion should be directed to the BPCI Advanced Team at BPCIAdvanced@cms.hhs.gov.

CARE REDESIGN PLAN

I. General Information

Please complete the following fields that identify the BPCI Advanced Participant, its associated identifiers, and basic demographic information. For fields that are not applicable to your organization, please indicate "N/A".

Submission Date of Care Redesign Plan*:

BPCI Advanced BPID*:

Organization Name*:

Organization "Doing Business As" name (if different from Organization Legal Name)*:

Organization Address:

Street Address*:

City, State, Zip*:

Role (Select one)*: (•) Non-Convener Participant ( ) Convener Participant

Start Date of Participation in the Model (MM/DD/YYYY)*:

Primary Contact:

Primary Contact Name*:

Primary Contact Title*:

Telephone*:

Email*:

Identifiers*:

TIN: NPI: CCN (if applicable):

Participant Type*:

(•) Acute Care Hospital ( ) Physician Group Practice

( ) Other (Specify)

Affiliation (Select one)*:

( ) Hospital or Health System ( ) University or Academic Health System

( ) Independent/No Affiliation ( ) Other (Specify)

Location*: ( ) Urban / Suburban ( ) Rural

II. Attestation Requirement for Participation

Please review, in full, the Bundled Payments for Care Improvement Advanced Participation Agreement, which details the requirements to which the Participant must attest pursuant to this section. The Participant must respond to all questions in Section II by certifying compliance and/or non-compliance, as applicable, from the Start Date through the date of certification.

A. Use Certified EHR Technology

From Article 4.4 "As of the Start Date, the Participant shall use CEHRT, and shall require its Participating Practitioners to use CEHRT, in a manner sufficient to meet the applicable requirements of the Advanced Alternative Payment Model criterion under 42 C.F.R. § 414.1415(a)(1)(i), including any amendments thereto. Prior to the start of each Model Year, during the Agreement Performance Period, the Participant is required to certify, as part of the Participant's Care Redesign Plan, its intent to use CEHRT throughout the Model Year in a manner sufficient to meet the requirements as set forth in 42 CFR § 414.1415(a)(1)(i)."

Participant certifies its use of CEHRT in compliance with Article 4.4 of the Agreement ◯ *Yes* ◯ *No*

B. Compliance Plan

From Article 13.2 "The Participant shall have a compliance plan that addresses the prevention, detection, and correction of fraud and abuse and noncompliance with the terms and conditions of this Agreement. The Participant shall update its compliance plan to reflect changes in applicable statutes, regulations, and Model requirements, including any amendments to this Agreement. The Participant may modify, use, and share its existing compliance plans or the compliance plans of a DownstreamEpisode Initiator, NPRA Sharing Partner, or BPCI Advanced Entity to meet the requirements of this section."

Participant certifies it has a compliance plan in compliance with Article 13.2 of the Agreement

◯ *Yes* ◯ *No*

C. Participant Profile

From Article 5.5 "The Participant shall maintain a Participant Profile using the template provided to the Participant by CMS in accordance with…Article 5.5." As such, the Participant must indicate each Clinical Episode for which the Participant has committed to be held accountable and, to the extent the Participant is a Convener Participant, each Episode Initiator that will be participating in BPCI Advanced pursuant to an agreement with the Participant for the applicable Model Year. The Participant may update the Participant Profile on an annual basis beginning with the Model Year that starts on January 1, 2020, and at such other times specified by CMS, as described in Article 5.5(c). The last opportunity to update the Participant Profile is prior to the Model Year starting on January 2021.

Participant certifies it maintains a Participant Profile in compliance with Article 6.5 of the Agreement

◯ *Yes* ◯ *No*

III. Model Plan

The Model Plan identifies the basic organizational infrastructure and processes needed to operationalize BPCI Advanced within the Participant's organization and among its Episode Initiators and Participating Practitioners. The purpose of this plan is to capture the Participant's overall strategic planning to implement BPCI Advanced. Participant responses can be general but need to include key elements that distinguish their plan. Responses to all questions in Section III are required.

A. Describe how your organization has established executive accountability, specifically identify the key project management team to operationalize BPCI Advanced.*

B. Define the information systems your organization is using to track the parameters required for the reporting of quality measures and supporting Care Redesign.*

C. Describe how your organization is developing approaches to sharing clinical and other key information with providers and suppliers across each Clinical Episode.*

D. Describe your organization's process for providing beneficiary notifications in accordance with the Participation Agreement.*

E. Is your organization employing a formal model of quality improvement in your practice (e.g., Plan-Do-Study-Act, Lean, Six Sigma)? If so, please describe.*

F. Describe whether your organization is implementing a new process for reporting to CMS as required under the terms of the Participation Agreement, including quality measures.*

IV. Care Redesign Interventions: Primary Drivers For Success

Care Redesign Interventions refer to the planned interventions and changes to the Participant's current healthcare delivery system. Participants are responsible for planning and implementing Care Redesign interventions, including ensuring participation and coordination of the Participant's Episode Initiators, Participating Practitioners, NPRA Sharing Partners, and NPRA Sharing Group Practice Practitioners, as applicable.

The interventions listed below are categorized by their Primary Drivers for Success:

- Clinical Practice Redesign
- Patient Engagement
- Provider /Supplier Engagement
- Data Analysis and Feedback

The Drivers aim to create healthcare savings while maintaining or improving healthcare quality. Responses to each question will indicate the intervention's priority within the Participant's organization and, if applicable, corresponding timeframe. The Participant may prioritize a given intervention as High, Medium, or Low. The timing field specifies the timeframe that the intervention will be utilized for each care intervention; either within six or 12 months. For interventions that are not listed below, additional free text boxes are located at the end of this section to accommodate Participant-specific interventions. Documenting intervention priorities allows for CMS to better understand those interventions currently in place, anticipated changes and prospective development, and those interventions that are not a priority and thus unlikely to be implemented.

Responses to all fields in Section IV are required, except for the free text intervention boxes located at the end of this section. For interventions that are not applicable, the "Not a Priority" option should be selected. For interventions that are currently implemented, the "In Place" selection should be selected.

A. Clinical Practice Redesign

1. Diagnosis-triggered or Clinical Episode-specific care pathways or protocols*

   Select

2. Care processes common to multiple diagnoses or episodes*

   Select

3. Use of computer-based clinical decision support system to generate case-specific advice*

   Select

4. Interdisciplinary care*

   Select

5. Telehealth*

   Select

6. Enhanced availability of care*

   Select

7. Management of comorbid conditions*

   Select

8. Addressing socio-economic barriers to care

Select

Provide detailed information on proposed and current clinical practice redesign interventions:

B. Patient Engagement

1. Patient/Caregiver coaching*

Select

2. Shared decision-making – Training of clinical staff on shared decision-making and communications*

Select

3. Patient risk screening and risk mitigation*

Select

4. Discharge destination planning*

Select

Provide detailed information on proposed and current patient engagement strategies:

C. Healthcare Provider Engagement

1. Patient-level coordination between acute care and PAC settings*

Select

2. Patient-level coordination with primary care providers*

Select

3. Patient-level coordination with specialty care providers*

Select

4. Care Manager, Patient Navigator, or Case Manager*

Select

5. Clinician follow-up*

Select

6. Medication reconciliation during care transitions*

Select

7. Optimization of discharge or transition summaries – Using structured communications (such as forms or standard reports) between care settings to enable information flow and seamless transitions*

Select

8. Clinical staff leadership development*

Select

9. Clinical and administrative staff engagement*

Select

Provide detailed information on proposed and current healthcare provider engagement initiatives:

D. Data Analysis and Feedback

1. Use of CEHRT*

Select

2. Data-driven analytic or feedback approach*

Select

3. Holding regular team meetings to review data and plan improvement cycles to redesign care processes and workflow*

Select

4. Incorporating review of data with clinical and administrative leadership as a routine component of our management process*

Select

5. Sharing team/provider-identified data across other teams/providers within your organization*

Select

Provide detailed information on proposed and current data analysis and feedback initiatives:

E. Other Interventions not Previously Listed:

1.
2.
3.

Provide detailed information: