

# Chronic Care Improvement Program (CCIP) Reporting Tool

**Chronic Care Improvement Program (CCIP):** A program to manage chronic conditions by preventing and or minimizing the effects of the condition through patient self-management and integrated care in order to improve health outcomes and decrease costs.

## Medicare Advantage Organization (MAO) Information

<b>MAO Name</b>		
<b>Contract #</b>	<b>Identification #</b>	
<b>MAO Location</b>		
<b>Contact Person</b>	<b>Name</b>	
<b>Title</b>	<b>Telephone</b>	<b>Email</b>
<p><b>MAO Plan Type:</b> <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> PFFS <input type="checkbox"/> <b>SNP:</b> <input type="checkbox"/> <b>Other</b> _____</p> <p>_____ Chronic          (type) _____</p> <p>_____ Dual Eligible          _____ Institutional</p>		
<b>CCIP Initial Plan Approval Submission:</b>		
<input type="checkbox"/> <b>Yes</b> <b>State the length of time intended for the program:</b> _____		
<input type="checkbox"/> <b>No</b> <b>Subsequent Year Report #:</b> 1__ 2__ 3__ 4__ 5__		

<p><b>CCIP Title:</b> _____</p> <p><b>Provide a brief summary of the CCIP to include the specific clinical foci and expected outcomes.</b></p>
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# CCIP Reporting Tool

## PLAN

### A. Basis for selection

Describe the basis for selecting the specific chronic condition for the CCIP with anticipated or desired measurable outcomes.

<b>A1. Disease State</b> <i>ICD-9 code(s)</i>	<b>A2. Rationale for Selection</b>	<b>A3. Relevance to the Plan Population</b>	<b>A4. Anticipated Outcomes</b>

### **A5. Data Source(s) for Selected Chronic Condition** *(check all that apply):*

<input type="checkbox"/> Medical Records <input type="checkbox"/> Claims (Medical, Pharmacy, Laboratory) <input type="checkbox"/> Appointment Data <input type="checkbox"/> Plan Data (complaints, appeals, customer service) <input type="checkbox"/> Health Risk Assessment (HRA) Tools <input type="checkbox"/> Surveys (enrollee, beneficiary satisfaction, other) <input type="checkbox"/> Minimum Data Set (MDS) – Institutional SNP	<input type="checkbox"/> MAO Part C Reporting Requirements <input type="checkbox"/> Encounter Data <input type="checkbox"/> Audit Findings <input type="checkbox"/> Health Effectiveness Data Information Set (HEDIS®) <input type="checkbox"/> Health Outcomes Survey (HOS) <input type="checkbox"/> Consumer Assessment of Healthcare Providers and Systems (CAHPS®) <input type="checkbox"/> Registries (e.g., cancer, COPD) <input type="checkbox"/> Other Sources _____
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### B. Program Design

#### **B1. Population Identification Process:**

B1a. Describe the Target Population

B1b. Method of identifying members: *(drop down box)*

<input type="checkbox"/> Health risk assessment <input type="checkbox"/> Claims Data (Medical, Pharmacy, Laboratory) <input type="checkbox"/> Encounter Data <input type="checkbox"/> Enrollment Data <input type="checkbox"/> Utilization Management Data <input type="checkbox"/> Case Management Referrals <input type="checkbox"/> Surveys <input type="checkbox"/> Registry <input type="checkbox"/> Other _____
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B1c. Risk Stratification: (*patient acuity level*)    \_\_\_High    \_\_\_Medium    \_\_\_Low

B1d. Enrollment Method:    \_\_\_Opt in    \_\_\_Opt out

*Opt in – Member must ask for inclusion in program.*

*Opt out – Member automatically included in program and must ask to be excluded*

**B2. Evidence Based Medicine:** (*Provide current clinical practice guidelines and evidence-based treatment modalities, standards of care, evidence-based best practices, etc.*)

**B3. Care Coordination Approach:** (*Describe the model, e.g., integration, collaboration, community resources, and communication among team members including provider, patient, and CCIP team members.*)

**B4. Education:** (*Describe the method of education and the topics covered e.g., diabetes, COPD.*)

## B4a. Patient Self Management

	Method	Topics Covered	N/A
Training			
Support			
Monitoring			
Follow-up			
Other			

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## B4b. Provider Education

	Method	Topics Covered	N/A
<b>Training</b>			
<b>Support</b>			
<b>Monitoring</b>			
<b>Follow-up</b>			
<b>Other</b>			

## B5. Outcome Measures and Interventions:

<b>B5a. Goal:</b>	
<b>B5b. Benchmark:</b>	
<b>B5c. Goal:</b> <input type="checkbox"/> <i>Clinical</i> <input type="checkbox"/> <i>Utilization</i> <input type="checkbox"/> <i>Access</i> <input type="checkbox"/> <i>Quality of Life (QOL)</i> <input type="checkbox"/> <i>Satisfaction Survey</i> <input type="checkbox"/> <i>Other</i> _____  <i>Benchmark:</i> <input type="checkbox"/> <i>Baseline</i> <input type="checkbox"/> <i>Internal</i> <input type="checkbox"/> <i>External</i>	
<b>B5d. Intervention:</b>	
<b>B5e. Rationale for specific intervention related to goal or benchmark:</b>	
<b>B5f. Measurement Methodology:</b>	<b>B5g. Timeline:</b>

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**B6. Communication Sources including the Interdisciplinary Care Team and Patients:** *(Describe how the program integrates continuous feedback among all parties.)*

<b>B6a. Sources</b> <i>(Check all that apply.)</i>	
<input type="checkbox"/> Electronic Communications <i>(Website, portal, email, etc.)</i>	
<input type="checkbox"/> Telecommunications <i>(Phone calls, phone text messages, public media, etc.)</i>	
<input type="checkbox"/> Written Materials <i>(Brochures, provider newsletters, member newsletters, flyers, etc.)</i>	
<input type="checkbox"/> Surveys <i>(Satisfaction Survey, Comment Cards, Complaint Tracking, etc.)</i>	
<input type="checkbox"/> Face-to-face Patient Education	
<input type="checkbox"/> Other _____	
<b>B6b. Target Audience</b> <i>(Check all that apply.)</i>	
<input type="checkbox"/> Providers	<input type="checkbox"/> Care Team
<input type="checkbox"/> Patients	<input type="checkbox"/> Educator
<input type="checkbox"/> Family Members	<input type="checkbox"/> Other _____
<input type="checkbox"/> Case Manager	

**C. MAO CCIP Responsibility: (Medical Director)**

Name of Individual	Title	E-mail Address	Phone	Date of Approval

**D. CMS Regional Office Approval:**

**Yes**

**No** Reason: \_\_\_\_\_  
 \_\_\_\_\_

Name of Individual	Title	Date of Approval

*The above information will remain in the system for reporting in subsequent years.*

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## DO

**E. Program Implementation, Review and Revision** *(Provide the results or findings from each intervention, any barriers encountered, risk mitigation for the barriers identified and the anticipated impact on the goal or benchmark.)*

*Auto Populate from Demographics Section*

**Cycle Period:** \_\_\_ Year 1 \_\_\_ Year 2 \_\_\_ Year 3 \_\_\_ Year 4

**E1. Education:** *(Describe the actual method of education and the topics that were covered e.g., diabetes, COPD.)*

### E1a. Patient Self Management

	Method	Topics Covered	N/A
Training			
Support			
Monitoring			
Follow-up			
Other			

### E1b. Provider Education

	Method	Topics Covered	N/A
Training			
Support			
Monitoring			
Follow-up			
Other			

**E2. Intervention:** Describe the actions taken or intervention implemented to achieve the goal.

*Auto Populate from Plan Section*

**E3. Results or Findings:** Provide an analysis of the initial results or findings.

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**E4. Barriers Encountered:** Describe the barriers encountered. (e.g., modification to intervention, strata targeted, measurement method, clinical, financial, resources utilized)

**E5. Mitigation Plan for Risk Assessment:** Describe the actions taken to mitigate the barrier(s).

**E6. Anticipated Impact on the Goal and/or Benchmark:** Describe the impact you expect the risk mitigation to have on the goal and/or benchmark.

DRAFT

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## STUDY

**F. Results:** Complete the table below for each applicable measurement period.

<b>F1. Goal:</b> <i>(Auto populate from Section B5.)</i>							
<b>F2. Benchmark:</b> <i>(Auto populate from Section B5.)</i>							
F3. Timeline	F4. Dates of Implementation	F5. Sample Size or Percent of Total Population	F6. Numerator <i>(skip if not applicable)</i>	F7. Denominator <i>(skip if not applicable)</i>	F8. Total Percent or Result	F9. Other Data or Results	F10. Analysis of Results or Findings
Initial Period							
Re-measurement Period #1							
Re-measurement Period #2							
Re-measurement Period #3							
Re-measurement Period #4							



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## ACT

**G. Next Steps:** Identify the next steps based on the evaluation of the CCIP for this cycle, whether the goals were met or not met. *(Check all that apply.)*

**Action Plan** (drop down box):

**G1.  Continue the program with no change(s).**

**G2.  Continue the program with change(s).**

Describe the planned change(s):

**G3.  Develop a Quality Improvement Project (QIP) to study one or more aspects of the program.**

Describe the QIP:

**G4.  Discontinue the program.**

Reason for discontinuation:

**G5.  Re-evaluate and change the goal or benchmark selected.**

New Goal or Benchmark:

**G6.  Expand the program.**

Expansion plans:

Expected outcome:

Proposed timeline:

**G7.  Identify additional Interventions.**

New intervention:

Expected Outcome:

Proposed timeline:

**G8.  Re-evaluate data and criteria.**

Describe changes to data and criteria:

**G9.  Other**

Describe:

Your report is complete. Thank you for submitting your CCIP.

**SUBMIT**