Care Coordination Program

Effective Date: 7/28/2014 Draft/Review Date: 6/9/2014

Policy

A. It is the policy of the ACO to demonstrate a meaningful commitment to the mission and success of the Medicare Shared Savings Program through the establishment and promotion of ongoing relationships between ACO Participants and Providers/Suppliers and Beneficiaries through a Care Coordination Program. The Care Coordination Program provides the framework for continuous and systematic Beneficiary assessment, monitoring, care coordination, disease coordination, and education as it relates to individual health conditions and self-care, with the aim of improving clinical outcomes.

Applicability

This policy and procedure applies to all Participants, Providers/Suppliers, and other individuals or entities performing functions or services related to the ACO's activities.

Procedure

A. **Purpose and Scope of the Care Coordination Program**

1. The Care Coordination Program is designed to ensure the ACO maintains responsibility for the quality, cost and overall care of the Beneficiaries assigned to the ACO. The ACO will work in collaboration with the Collaborative Health Systems (CHS) care coordination team to conduct the Care Coordination Program.
2. **Evidence Based Medicine:** The ACO's Care Coordination Program utilizes Evidence Based Medicine (EBM) to promote the health and wellness of Beneficiaries. The ACO will internally monitor the use and promotion of care coordination centered EBM to ensure that, where appropriate, the ACO is utilizing the most updated, evidence-based guidelines and practices.
3. **Beneficiary Engagement:** The Care Coordination Program will encourage Beneficiary education and self-management coordination. The Care Coordination Program will ensure that mechanisms are in place for Participants to request care coordination for Beneficiaries, when appropriate. The ACO will follow and communicate with the Beneficiary or his/her designated representative in a way that is comprehensible to the individual, providing the Beneficiary with the knowledge needed and allowing the Beneficiary to participate in his/her own medical decisions. Through the use of tools such as Annual Wellness Visits (AWVs), the ACO will promote beneficiary engagement through individualized care plans for and communication with Beneficiaries, taking into account a Beneficiary's personal and regional demographics and health status, and designed in a way as to create access to all aspects of care.
4. **Beneficiary Referrals:** In coordinating the Beneficiary's care, treatment, or services with multiple resources (both internal and external), the individual Beneficiary's needs will be

considered. The ACO and care coordination team will utilize available tools to identify and evaluate options and services provided to Beneficiaries from multiple sources, in concert with the ACO, in an effort to provide continuity of care across care settings and transitions. Referrals may be used to accurately diagnose, provide specialized services, or improve Beneficiary satisfaction. The Beneficiary and the Participant or Provider/Supplier will decide when a consultation is required or prudent based upon assessment, need for diagnosis, and/or potential treatment options. Beneficiary referrals are handled collaboratively, with input from the Beneficiary and his/her family, when appropriate.

5. **At-Risk Beneficiaries:** The ACO will identify Beneficiary risk and perform assessments to determine Beneficiary needs in order to provide appropriate care. No Beneficiary will be denied the highest quality treatment, education or care coordination due to his/her pattern of adherence, socioeconomic status, health condition, disease or disability (i.e., "at-risk" status). All ACO Participants and Providers/Suppliers may make requests for care coordination and work to ensure that Beneficiaries, regardless of health or risk status, receive timely, appropriate, cost-effective, and quality care.

B. **Promoting the Care Coordination Program**

1. The provision of care coordination will occur when a Participant, a Provider/Supplier, or a care coordinator makes every attempt to:

   a. Support timely, cost-effective, preventive, curative and palliative medicine by coordinating the Beneficiary's total healthcare needs;

   b. Effectively promote inpatient and outpatient diagnostic and therapeutic procedures for care delivery in appropriate settings;

   c. Work collaboratively with all healthcare providers and community resources to foster quality outcomes;

   d. Use evidence-based medicine and care coordination processes to determine Beneficiary needs;

   e. Work with other non-ACO providers to ensure transparency of care and to support safe and effective transitions between care settings; and,

   f. Educate Beneficiaries on the benefits of working through the Primary Care Physician (PCP) office for all healthcare services.

C. **Implementing the Care Coordination Program**

1. The implementation of care coordination consists of:

   a. Participants' and Providers'/Suppliers' roles;

   b. Care coordination process;

   c. Individual care plans;

   d. Disease coordination;

   e. Care transitions; and,

f. Requests for care coordination follow-up from Participants to the care coordination team.

2. **Role of Participants and Providers/Suppliers in Care Coordination**

   a. Participants and Providers/Suppliers are most often the direct source to the Beneficiary. Participants and Providers/Suppliers engage Beneficiaries in person, assess them physically, and often have the opportunity to interact with family and/or caregivers. Due to this position, Participants and Providers/Suppliers have the opportunity and obligation to assess Beneficiary needs for care coordination.

   b. Should the Participant or Provider/Supplier determine there is a need for Beneficiary care coordination, they will follow the care coordination process and make requests to the care coordination team, as appropriate.

   c. Participants, Providers/Suppliers or their designees will utilize care coordinators or available community resources to engage Beneficiaries in their care, provide optimal solutions to meet their needs and evaluate the process as the Beneficiary's care progresses.

3. **Care Coordination Process**

   The care coordination process is designed to promote the delivery of high quality, medically necessary and cost-effective healthcare for the population served by the ACO utilizing evidence-based medicine.

   a. Participants, Providers/Suppliers and care coordinators will engage Beneficiaries in order to assess their physical, psychosocial and environmental needs either telephonically or face-to-face utilizing available historical data and care coordination assessment tools.

   b. Participants, Providers/Suppliers and care coordinators will provide education to allow Beneficiaries every opportunity to have input into their treatment plans in order to increase understanding and compliance.

   c. Participants, Providers/Suppliers and care coordinators will collaborate with Beneficiaries; their caregivers and family members; other individuals or entities performing functions or services related to the ACO's activities; and community resources, including state, federal and regulatory social service agencies, to ensure all care needs are met in support of whole person health.

   d. Participants, Providers/Suppliers and care coordinators will monitor Beneficiaries' ongoing healthcare needs and outcomes to ensure Beneficiaries visit their PCPs on a recurring basis, achieve their best possible health and adhere to the care coordination process.

   e. The Care Coordination Process will also be used to promote Beneficiary engagement and education, and will also focus on preventative measures, such as:

      i. Influenza immunizations;

ii. Pneumococcal vaccination; and,

iii. Health screening opportunities: weight, depression, colorectal cancer, mammography and blood pressure.

4. **Individualized Care Plans**

An individualized care plan will be developed, as appropriate, to address unique and immediate Beneficiary needs based on historical data and care coordinator determination of the Beneficiary's clinical level.

a. AWVs are a useful tool for creating an individualized care plan, at no cost to the beneficiary, while promoting beneficiary engagement and bolstering the physician/patient relationship. These visits facilitate the collection of vital baseline data for individuals and provide valuable face-to-face interaction time between the provider and beneficiary to discuss the beneficiary's care plan and options.

b. Individualized care plans will be developed for Beneficiaries with chronic conditions or other high-risk factors.

c. The plan will be specifically tailored and customized for the individual Beneficiary and will address both psychosocial and physical issues. It will identify key clinical risk factors, which will be addressed through education and interventions in order to reach stated goals and outcomes.

d. The individualized care plan will provide guidance for education, referral and other supportive service needs in promoting Beneficiary health and wellness.

e. The individualized care plan will provide guidance to assist the Beneficiary with improving adherence to treatment plans and reducing the risk of unnecessary admission, thereby improving care and reducing costs.

f. Every effort will be made to ensure proper consideration of cultural diversity and language barriers to promote Beneficiary engagement. Translators are available during the care coordination process to assist when necessary to ensure Beneficiary participation in developing care coordination programs that are appropriate for the individual Beneficiary.

5. **Disease Coordination**

Care coordinators will utilize best practice standards for disease coordination based on assessment, needs and shared decision-making by the Beneficiary and his/her Participant or Provider/Supplier.

a. Utilizing best practice disease coordination guidelines and CMS quality measures for ACOs, the care coordinator will concentrate on the most prevalent region-specific chronic conditions and focus on closure of gaps that prevent the Beneficiary from obtaining optimal health.

b. The stratification process will identify Beneficiaries to be included in disease coordination.

c. A Beneficiary identified for disease coordination of a chronic condition or disease will be assigned to a care coordinator who will contact the Beneficiary to conduct interactive individual assessments.

d. To promote Beneficiary engagement, the Beneficiary will be included in the development of a care plan, which will address the identified gaps and establish goals to attain optimal health.

e. The care coordinator will facilitate referrals to community resources when a Beneficiary needs additional social services assistance.

f. The care plan and all processes, services and/or education provided will be documented in the appropriate care coordination documentation system.

6. **Care Transitions**

Care coordinators will assist with transitions of care to facilitate coordination and continuity of healthcare during movement between levels of care. This includes care coordination across and among primary care physicians, specialists, and acute and post-acute providers. Care transition activities include, but are not limited to:

a. Exchange of information with Participants and Providers/Suppliers, including inpatient admissions or pending discharges;

b. Collaboration with Beneficiaries, their families/caregivers, and the hospital staff, when possible, to ensure coordination of care and facilitate safe discharge to the appropriate level of care;

c. Identification and coordination of Beneficiary's durable medical equipment, medication, home health and transportation needs for seamless discharge back to the community;

d. A 'post-discharge call' to assess the Beneficiary's immediate post-inpatient needs. Based on identified needs, a telephonic or face-to-face follow-up will be scheduled with the Beneficiary. This may include, but is not limited to:

   i. Assessment of clinical and social needs;

   ii. Medication reconciliation;

   iii. Monitoring adherence;

   iv. Assessment of home safety, mobility, need for assistance with activities of daily living, with referral, as needed;

   v. Education of Beneficiary and caregiver on disease process and identification of early signs and conditions to report to the appropriate care provider;

   vi. Verification that Beneficiary received needed supplies and services;

   vii. Assistance with scheduling Beneficiary's follow-up appointment(s); and,

viii. Communication with the Beneficiary's Participant and/or Providers/Suppliers regarding Beneficiary's status.

7. **End of Life Care/Hospice**

   a. The ACO will support the terminally ill Beneficiary by providing direction to the Medicare hospice benefit and monitoring the admission process.

   b. The Beneficiary will be educated by the physician regarding his/her terminal illness.

   c. The Beneficiary must share in the decision to focus on comfort care rather than cure of illness after proper engagement and education have occurred.

   d. The Medicare approved hospice company will evaluate the appropriateness of need for hospice care. If the Beneficiary is transitioned to hospice care, necessary forms for hospice enrollment will be initiated by his/her physician and completed by the hospice staff.

   e. If the Beneficiary decides to dis-enroll from hospice or if improvement is noted so that hospice care ends, normal care coordination activities will resume. If illness progresses at a later time, re-enrollment for hospice care may occur.

8. **Processing Requests for Care Coordination Follow-up**

   The ACO may request care coordination for follow-up Participant and Provider/Supplier visits, inpatient stays or outpatient services. The collaboration will foster the communication and coordination of Beneficiary needs among all healthcare Participants, Providers/Suppliers, and other individuals or entities performing functions or services related to the ACO's activities upon receipt by care coordinators.

   a. Requests may be made by a Participant, a Provider/Supplier, or other individuals or entities performing functions or services related to the ACO's activities, either telephonically or in writing, when a Beneficiary's coordination need is identified.

   b. The request will include the reason and expectations for the request, the Beneficiary's diagnosis and any special instructions.

   c. The care coordinator will follow-up on the request with the Beneficiary, as appropriate, and document all activities in the care coordination documentation system.

   d. The care coordinator will communicate a status report and all care coordination activities to the appropriate requestor.

   e. The care coordinator will communicate and facilitate referral requests between Participants, Providers/Suppliers and other individuals or entities performing functions or services related to the ACO's activities, as requested.

D. **Implementing Care Coordination Activities Locally**

1. Define and describe any additional procedures for activities provided in practices, local settings or ACO specific.
2. Describe how the care coordination team will be included in training or updates related to these activities as the collaborative partner to ensure Beneficiary-centered care and continuity.
3. Describe how the activities will be tracked, charted and followed up on to ensure positive Beneficiary experiences.

E. **Non-Compliant Beneficiaries**

1. All Beneficiaries are provided the same level of high quality care and opportunities for care coordination. The focus of the ACO is to provide high quality care and consistent services that meet the needs of individual Beneficiaries.
2. Beneficiaries who choose a path of non-adherence will be offered multiple opportunities for education, care coordination and programs to improve their health. Those Beneficiaries who resolve to non-adherence will continue to be treated with respect and monitored by the ACO. When the opportunity to assist the Beneficiary arises, the ACO will respond, as needed.

F. **Evaluating and Updating Care Coordination Program**

1. The Care Coordination Program will be under the direction of the Clinical Director and the Medical Director.
2. The Care Coordination Subcommittee will perform ongoing assessment of the Care Coordination Program and its outcomes, and will recommend process improvements.
3. The Quality Improvement Subcommittee will meet quarterly to discuss utilization trends and quality indicators. This information will be used to continually improve the Care Coordination Program.
4. Care coordination will be a component of the overall Quality Improvement Program that continuously monitors and evaluates care and services provided to Beneficiaries.

Reporting

A. Care coordination documentation system reports and analytics utilization reports will be provided to the subcommittees at least quarterly and to the Governing Body as necessary.

Related Documentation

A. 42 CFR §425.108, §425.112, §425.204(c)(1)(ii), §425.204(d)(3), §425.304(a)(2), §425.316(b)

B. ACO Application Narratives: Promoting Beneficiary Engagement, Promoting Coordination of Care, Promoting Evidence-Based Medicine

C. ACO Terms & Definitions Policy

D. Care Coordination Subcommittee Charter

E. Care Coordination Request Form

F. NCQA Standards and Guidelines for the Accreditation of ACOs:

   1. AA 1, Element A: Arranging for Services

   2. PC 1 – Practice Capabilities

      a. Element D: Implement Evidence-Based Guidelines

      b. Element E: Care Management

      c. Element H: Test Tracking and Follow-Up

      d. Element I: Referral Tracking and Follow-Up

      e. Element K: Continuity

   3. CM 3 – Population Health Management

      a. Element A: Identifying Care Needs

      b. Element B: Providing Population Health Management

   4. CT 1, Element B: Process for Transitions

G. Social Security Act §1899(b)(2)(G), §1899(b)(2)(H), 1899(d)(3)

H. All adopted Care Coordination Subcommittee Policies