Community Care Alliance

Member driven solutions for local population health
ACO Objectives/Required Functions

• QA/QI Program led by qualified healthcare professional
• Promote Evidence-Based Medicine
• Promote Patient Engagement
• Report on Quality and Cost Measures
• Promote Care Coordination across physicians, acute, and post-acute providers
• Patient centeredness
ACO Care Planning

• Care planning is a critical component of care coordination
• Proactive management and care planning for high-risk patients has been shown to improve outcomes and reduce the cost of care
• Written care plans are a tool for providers and the care team to document and share a plan of care with a patient and/or family.
eClinicalWorks (eCW)
ACO Care Plan Requirements

• Patient-centered care plan based on a physical, mental, cognitive, psychosocial, functional and environmental (re)assessment and an inventory of resources and supports; a comprehensive care plan for all health issues.

• Electronically capture and share care plan information, making it available in a timely manner within and outside the billing practice as appropriate (can include fax)

• Providers may choose the format in which the care plan is provided to patients.

• A copy of the plan of care must be given to the patient and/or caregiver.
# Care Coordination and Care Plan Audit Tool

**Practice Name:** ___________________________  
**Date:** ___________________________

**Report Submitted By:** ___________________________

**Quarter:** (circle one)  
1\(^{st}\)  2\(^{nd}\)  3\(^{rd}\)  4\(^{th}\)

## Care Coordination

<table>
<thead>
<tr>
<th>Quarterly Count</th>
<th>Yearly Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of care plans completed</td>
<td></td>
</tr>
<tr>
<td>Total Number of patients enrolled in care coordination</td>
<td></td>
</tr>
<tr>
<td>- Number of patients enrolled in Chronic Care Management (billing CCM – CPT Code 99490)</td>
<td></td>
</tr>
<tr>
<td>- Number of patients enrolled in Transitional Care Management (billing TCM – CPT Code 99495, 99496)</td>
<td></td>
</tr>
</tbody>
</table>

## Care Planning

<table>
<thead>
<tr>
<th>Yearly Count</th>
<th>Yearly Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Care Plans Completed</td>
<td></td>
</tr>
<tr>
<td>Number of care plans submitted for audit (de-identified) – 1 care plan per 50 patients or maximum of 10</td>
<td></td>
</tr>
</tbody>
</table>

**Care Plan documentation MUST include the following elements:**

- The care plans are patient specific not disease specific
- The care plans address top concerns/issues, needs, barriers, medications, etc. identified in the total needs assessment or...
Care Coordination and Care Plan Auditing Process

- CCA will monitor CCM claims in eCW
- Care Plans will be audited on a quarterly basis
- 5-10 care plans and/or Patient Needs Assessments/HRAs (based on attribution) from each practice will be audited:
  - Practices will submit de-identified patient needs assessments/HRAs to CCA
  - Practices will submit de-identified care plans to CCA
  - CCA will provide feedback/auditing results to the practice
Thank you!

Marnell Bradfield, Director Operations

Marnell.Bradfield@communitycarealliance.com