Care Coordination Oversight for Quality and Compliance

CCHA – Regions 6&7

September 8, 2022

CC Quality and Compliance Oversight

Quality and compliance need to be part of both program development and operations. Here are some of the ways that we do that at CCHA:

- Program Descriptions
- Condition Management Framework
- Auditing
- Provider Network

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Program Descriptions

- Purpose statement
- Goals and objectives
  - Complex example: # of complex members engaged in ECC, # of members outreached with at least two modalities, system research to address what is contributing to the member's complex needs.
- Risk stratification
- Outreach and engagement efforts (following Telephone Consumer Protection Act requirements)
- Care plan development and procedures
  - Includes reminders to establish a lead CC, collaborate with members and all involved in their care, tailor interventions for member capacity and preferences.
- Documentation requirements
- Program evaluation and outcomes
  - Complex example: completion of member goals, identify barriers and needs, utilization patterns, engagement with PCMP, and ECC performance pool goal

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Condition Management Framework

- Ties all programs back together with overall goals
  - Whole person approach
    - Social determinants of health, behavioral health, community resources, benefit education
  - Chronic condition management
  - Medication management
  - Healthy lifestyle education
    - Healthy eating, exercise, sleep, stress management
  - Access to PCP
  - Healthcare system utilization
  - Caregiver education

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Auditing

- Cases in Essette are audited monthly by supervisors and peers
- Need to meet 90% of elements to pass
- Elements include:
  - Assessments (assessing and correctly documenting medical needs, BH needs, SODH, linguistic and cultural needs, screening for depression and anxiety)
  - Care plan (goals and interventions, monthly updates, follow up on previous cases)
  - Tasks (include due dates and complete dates, EPSDT)
  - Documentation (Lead CC, contacts updated regularly, member/family contacts)
  - Blue Ribbon (ROIs, records, etc.)

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Provider Network: Complex Example

- ACN providers use monthly rosters/the following indicators from CCHA to prioritize member outreach and engagement in care coordination services
  - Priority 1: the identified Complex Members
  - Priority 2: members with DM who are not part of complex definition
  - Priority 3: the remaining members
- CCHA monitors ACN services to ensure members are appropriately engaged in care coordination activities. Mechanisms for monitoring and accountability include:
  - Monthly reporting on member-level activities including: ECC, outreach, medical and social referrals, members who are unreachable or who have opted out of care coordination
  - Essette ACN Shared Case Assessment is used for monitoring the number and type of cases CCHA is supporting, including reason for case support, which helps identify potential issues/training needs
  - Case audits to review ACN care coordination activities, workflows, and documentation practices
  - Standing and ad hoc meetings to discuss performance and operations related to care coordination responsibilities, complex cases for which support is needed and/or multiple entities are involved, or KPI/quality improvement efforts

Thank you!