COMMUNITY CARE ALLIANCE

Regional Care Coordination Service

Preserving **Healthcare** Through **Transformation**

The Community Care Alliance (CCA) Regional Care Coordination program focuses on ACO Medicare lives and assists clinics in meeting measures for these lives.

Core Services

- Transitional Care Management
- Annual Wellness Visits
- Chronic Care Management
- Advance Care Planning
- Behavioral Health Management

Expectations of Your Practice

- Identify a point person to recruit and enroll patients into the program.
- Attend monthly Open Forum virtual meetings with Regional Care Coordinator.
- Provide the Regional Care Coordinator remote access to your EMR.
- Provide office space for the Regional Care Coordinator to conduct Annual Wellness Visits in the clinic at least one day per month.

Transitional Care Management

CCA's team of Care Coordinators help patients with complex medical needs transition from the hospital to a community setting. This important function helps eliminate gaps in patient care and reduce readmission rates.

Patient Values

- Improved Outcomes & Satisfaction
- Fosters Patient Engagement & Responsibility
- Feels More Connected to Care Team
- Personal Connection in Managing Discharge Tasks
- Sense of Relief to Have Assistance Navigating Health Care Systems

Provider/Practice Benefits

- Outcomes Improve & Are Shown Through Data
- Re-admission Rates Decrease
- Opens Opportunity for Chronic Care Management Conversation
- Opportunity to Ensure Completion of Annual Wellness Visit & HCC Recapture Completed
- Emphasizes Communication & Coordination

Some services (e.g., Annual Wellness Visits) are provided onsite at your practice while the rest are provided remotely.

Patient Centered

Annual Wellness Visit

Keeping our communities "well" is important to the CCA and the overall health of our population. Annual Wellness Visits are designed to help spot health risks, discuss preventative care, and formulate health goals for the patient.

Patient Benefits

- No co-Pay - Medicare Pays Provider Full Amount
- Annual Comprehensive Evaluation Focused on Overall Wellness & Prevention
- Early Disease Detection & Prevention
- Maximizes Wellness
- Prevents Accidents at Home
- Keeps Patients Out of the Hospital
- Delays the Need for Long-term Care
- Improved Relationship with Clinic

Provider/Practice Benefits

- Maintains Complete Medical History for Chronically Ill Patients
- Strengthens Primary Care Team/Patient Partnership
- Increases Patient Engagement Through Outreach & Education
- Provides Proactive Care to Patients, Captures HCC Gaps & Ensures Problem List is Current
- Creates a New & Sustainable Revenue Stream for Practice
- Provides Patient-centered Road Map for Care Coordination
- Key Component of Success in the ACO & Quality Metrics

Chronic Care Management

Improving the lives of both patients and physicians is important to the CCA. Our team helps patients manage chronic conditions to maintain quality of life and avoid trips to the emergency room, falls, or worsening health.

Patient Benefits

- Feels Connected to Clinic
- Patient Centered, Attainable Goals
- Regional Care Coordinator is Often Easier to Reach Directly
- Level of Comfort Calling Regional Care Coordinator to Triage vs Going Directly to ER/Urgent Care
- Improved Health & Better Management of Chronic Conditions

Provider/Practice Benefits

- Reduces Task Burden on Clinic Staff
- Improved Patient Health = Improved Data
- Overarching Goals Attained While Patient Works with Regional Care Coordinator
- Small Tasks are Managed, Lessening the Burden on Phone & To-do Lists
- Time Tracking & Information Preparation for Billing Claims is Handled
- Regional Care Coordinators are RNs & Provide Higher Level of Triage & Education
- Remote Model Provides More Focus on the Chronic Care Management Program, Less Distractions than In-person

How the Service Works

Your practice will recruit and enroll patients into care coordination and then pass the patients' information to the Regional Care Coordinator who will handle the on-going care coordination work.

The Regional Care Coordinator will then interact with patients primarily over the phone but will also do some in-person visits (e.g., Annual Wellness Visits).

The Regional Care Coordinator will document their time and effort in our care planning tool and provide copies of the reports to the practices.

A monthly billing report will be sent to the point person at your practice to bill for the Regional Care Coordinator's work. Practices will bill and collect for the services the patient receives.

The Regional Care Coordinator will document notes in your practice's EMR, so the patient's care team remains up to date on the patient and the care coordination work they are receiving, and your practice has the required documentation for billing.

CCA

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Reach out to Amber today to learn more!

Amber Christie, RN
Manager of Care Coordination
amber.christie@wha1.org
970.596.3649