OneCare Vermont Accountable Care Organization, LLC
Board of Managers Meeting Agenda
August 20, 2019
4:30 p.m. – 6:30 p.m.
Central Vermont Medical Center – The Board Room

Time	Agenda Item	Presenter
4:30 p.m.	Call to Order	Steve Leffler
4:32 p.m.	Consent Agenda Items - Approval* *Vote to approve Consent Agenda Items*	Steve Leffler
4:35 p.m.	Governance • Banking Resolution* • Vacant Seat Nominations o FQHC* o SNF* *Vote to Approve Election of Nominees to fill the respective vacant Board seats as recommended by the Nominating Committee* • Executive Committee *Vote to Approve Appointment of two additional Board Members to the Executive Committee as recommended by the Nominating Committee* • Population Health Strategy Committee Membership* *Vote to Approve nominee as member of Population Health Strategy Committee as recommended by Nominating Committee*	Steve Leffler
4:45 p.m.	Policies • Care Coordination Policy for 2020* *Vote to approve policy as recommended by management*	Sara Barry
4:55 p.m.	Regulatory Update • CMMI Site Visit Recap	Vicki Loner
5:00 p.m.	Public Comment Move to Executive Session	Steve Leffler
6:25 p.m.	Votes 1. Vote to Approve 2018 VBIF Disbursement 2. Vote to Approve Innovation Fund Proposals 3. Vote to Approve CMS 2018 AIPBP Reconciliation 4. Vote to Approve Blue Cross Blue Shield 2018 QHP Settlement 5. Vote to Approve Vermont Medicaid Next Generation Settlement 6. Vote to Approve Board Governance Structure 7. Vote to Approve Executive Session Minutes from July 16, 2019	Steve Leffler
6:30 p.m.	Adjourn	Steve Leffler

*Denotes Attachment

Attachments:

1. Consent Agenda Items
    - Draft of OneCare Board of Manager Minutes from July 16, 2019
    - Board Committee Report outs
    - Monthly Financials May and June
    - CMO Corner
2. Banking Resolution
3. OneCare Care Coordination Policy 2020

ONECARE VERMONT ACCOUNTABLE CARE ORGANIZATION, LLC
BOARD OF MANAGERS MEETING
JULY 16, 2019

MINUTES

A meeting of the Board of Managers of OneCare Vermont Accountable Care Organization, LLC ("OneCare") was held at Central Vermont Medical Center on July 16, 2019.

I. Due to a lack of quorum, Tom Borys presented the ACO 101 Finance presentation beginning at 4:30 p.m. The presentation explained OneCare's budget development process and focused on three key aspects; 1) ACO Payer Contracts, 2) Internal Risk Sharing Model and 3) Population Heath Investments and Operating Costs (see presentation in packet for more detail). Managers asked to receive the presentation to tailor it for their respective communities.

II. Call to Order

Joe Perras, M.D., called the meeting to order at 5:45 p.m.

III. Minutes, Committee Reports

The consent agenda items were approved unanimously.

IV. Finance

The Finance Committee proposed changes to the Finance Committee Charter. A motion was made, which was seconded, and proposed revisions to the Finance Committee Charter were approved unanimously.

V. Green Mountain Care Board (GMCB)

Vicki Loner informed the Board that the GMCB has approved the budget guidance and certification guidance. OneCare management has been working with the GMCB to streamline the process. Certification will be due September 1 and budget is due October 1. The GMCB recently submitted the scale target report to CMMI and it is included in the Board materials packet. Additionally, the GMCB had stakeholders fill out a survey on regulatory alignment and will host a focus group to discuss the results. OneCare responded (responses included in the packet) and Kevin Stone will attend the focus group. CMMI will be in Vermont for a site visit that will include a discussion with parties involved in the All Payer Model. There will be a provider panel with representatives from the OneCare Network, as well as a discussion group regarding Payer Program alignment. Lastly, Kevin Stone shared that OneCare is working to schedule a meeting with the State Auditor to better understand the type of information the Auditor is seeking.

VI. Public Comment

There was no public comment.

VII. Executive Session

VIII. Voting

a. The motion to approve the Commercial Payer Term Sheet and authorize Management to enter into Negotiations was approved by a supermajority of the Board

b. The motion to approve the Executive Session Minutes from May 21, 2019 was approved by the supermajority of the Board.

IX. Adjourn

Upon a motion that was seconded, the meeting adjourned at 7:30 p.m.

Attendance:

OneCare Board Members

☒ Dan Bennett	☒ Joe Haddock, MD	☐ Judy Morton
☐ Jill Berry Bowen	☒ Tomasz Jankowski	☐ Pamela Parsons
☐ John Brumsted, MD	☒ Todd Keating	☒ Joseph Perras, MD
☐ Alison Calderara	☒ Sally Kraft, MD	☒ Judy Peterson
☒ Betsy Davis	☒ Steve LeBlanc	☐ Toby Sadkin, MD
☒ Tom Dee	☐ Steve Leffler, MD	☒ John Sayles
☒ Steve Gordon	☒ Sierra Lowell	

OneCare Risk Strategy Committee

☒ Claudio Fort	☐ Tom Manion	☐ Anna Noonan
☐ Jeffrey Haddock, MD	☒ Brian Nall	☒ Shawn Tester

OneCare Leadership and Staff

☒ Kevin Stone	☒ Tom Borys	☐ Martita Giard
☒ Vicki Loner	☒ Sara Barry	☒ Linda Cohen Esq.
☒ Norm Ward, MD	☐ Susan Shane	☒ Spenser Weppler
☒ Greg Daniels	☐ Joan Zipko	☒ Amy Bodette

OneCare Board of Manager Committee Report-outs For August

Executive Committee

At its August 7th meeting, the committee discussed the nominees to fill the FQHC and SNF seat on the Board. They approved the nominees to move to the full Board for election. They also approved to move the nominee for the Population Health Strategy Committee to the full board for election. The committee also discussed expanding the Executive committee by two members and approved the two additional nominees from the Board to move to the full Board for approval. An update was provided to the committee on the recent meeting with the State Auditor to answer their questions about OneCare and its model. They sent follow-up questions which OneCare plans to answer.

Finance Committee

At its August 14th meeting, the committee began to discuss the 2020 Budget. There was a review of 2019 performance YTD for the payer programs. There was a discussion of the risk mitigation methodology for 2019 and 2020. The committee reviewed the projected 2018 Reconciliation and Settlement amounts across the payer programs. There was discussion of nominees to fill vacancies on the committee as well as future meeting locations and dates. Lastly the monthly financial report for June was approved and will go to the full Board for approval.

Population Health Strategy Committee

At its August 5th meeting, the committee was provided and update on the Utilization Management Monthly Workgroup. A review of the 2018 VMNG and BCBSVT QHP Quality Measure Results and a review of the VBIF Payment Distributions were shared. The Population Health Strategy Selection Committee selected the Round 2 Innovation Fund Projects. The 2017 VBIF Quality Improvement Proposals Beneficiary Engagement Waivers were reported on. A GMCB 2020 Budget Update was also provided.

Patient & Family Advisory Committee

At its July 25th meeting, the committee heard a presentation by Dr. Ward on the OneCare Clinical Priorities and other Initiatives. A brief Legislative Update was also provided.

OneCare Vermont
Statement of Financial Position
For the Periods Ended

	5/31/2019	4/30/2019	Variance
ASSETS			
Current assets:			
Unrestricted Cash	5,672,403	2,004,923	3,667,479
GMCB Reserve	2,441,667	2,233,333	208,334
CMS Reserve-US Bank	4,157,956	4,155,054	2,903
VBIF	7,212,092	6,744,609	467,483
Advance Funding-Medicaid	9,875,967	9,996,491	(120,524)
Total Cash	29,360,085	25,134,410	4,225,675
Network Recievable	2,059,444	3,821,840	(1,762,396)
Network Recievable-Settlement	24,418,063	22,745,201	1,672,862
Other Receivable	6,086,961	4,905,342	1,181,619
Other Receivable-Settlement	5,904,399	5,904,399	0
Prepaid Expense	820,132	1,604,552	(784,420)
TOTAL ASSETS	**68,649,084**	**64,115,744**	**4,533,340**
LIABILITIES AND NET ASSETS			
Current liabilities:			
Accrued Expenses	2,018,282	2,033,021	(14,739)
Accrued Expenses -Settlement	26,244,575	26,244,575	0
Network Payable	17,740,022	16,714,326	1,025,696
Network Payable-settlement	4,405,502	2,065,355	2,340,147
Notes Payable	4,124,849	4,124,849	0
Deferred Income	609,475	1,141,602	(532,127)
Due to Related Parties - UVMMC	8,160,593	7,029,969	1,130,624
Due to Related Parties - DHH	169,835	169,835	0
Total Liabilities	**63,473,133**	**59,523,533**	**3,949,600**
Net assets:			
Unrestricted - UVMMC	687,160	687,160	-
Unrestricted - DHH	687,160	687,160	-
Current Year Profit to Date	3,801,631	3,217,892	583,740
Total net assets	**5,175,951**	**4,592,212**	583,740
TOTAL LIABILITIES AND NET ASSETS	**68,649,084**	**64,115,744**	**4,533,340**

OneCare Vermont

Surplus & Loss Statement

YTD May 2019

	Annual Budget	YTD Budget	YTD Prior Month	Current Month	YTD	YTD Budget/Actual Variance
Medicaid Admin - $6.50 PMPM	$ 5,570,683	$ 2,321,118	$ 1,909,388	455,429	$ 2,364,817	$ 43,699
Medicaid Complex Care Coordination	$ 5,500,000	$ 2,291,667	$ 1,653,265	387,600	$ 2,040,865	$ (250,802)
BCBS QHP PHM $3.25 PMPM	$ 664,677	$ 276,949	$ 239,558	259,045	$ 498,602	$ 221,653
BCBS ASO PHM $3.25 PMPM	$ 585,000	$ 243,750	$ -	-	$ -	$ (243,750)
SF PHM $3.25 PMPM	$ 526,140	$ 219,225	$ -	-	$ -	$ (219,225)
Medicare Shared Savings/Blueprint	$ 8,021,268	$ 3,342,195	$ 2,114,079	528,520	$ 2,642,598	$ (699,596)
Primary Prevention	$ 1,100,000	$ 458,333	$ 366,667	91,667	$ 458,333	$ 0
Informatics Infrastructure Support	$ 4,250,000	$ 1,770,833	$ 1,416,667	354,167	$ 1,770,833	$ 0
Misc. Revenue	$ -	$ -	$ 50,957	3,177	$ 54,133	$ 54,133
Participation Fees	$ 29,266,751	$ 12,194,480	$ 9,919,156	2,436,529	$ 12,355,685	$ 161,205
						$ -
Total Income	**$ 55,484,518**	**$ 23,118,549**	**$ 17,669,735**	**4,516,132**	**$ 22,185,867**	**$ (932,682)**
PHM Expense:						
Population Health Management Program	$ 5,638,685	$ 2,349,452	$ 1,885,244	437,847	$ 2,323,090	$ (26,362)
Complex Care Coordination Program	$ 9,651,694	$ 4,021,539	$ 2,911,354	734,961	$ 3,646,316	$ (375,224)
CPR Program Cost	$ 2,250,000	$ 937,500	$ 427,983	120,221	$ 548,204	$ (389,296)
Value-Based Incentive Fund	$ 7,852,589	$ 3,271,912	$ 2,500,636	609,119	$ 3,109,756	$ (162,156)
Primary Prevention Programs	$ 910,720	$ 379,467	$ 191,836	72,277	$ 264,113	$ (115,354)
Specialist Program Pilot	$ 2,000,000	$ 833,333	$ -	-	$ -	$ (833,333)
Innovation Fund	$ 1,000,000	$ 416,667	$ -	-	$ -	$ (416,667)
RCR	$ 375,000	$ 156,250	$ 89,583	20,833	$ 110,417	$ (45,833)
PCMH Legacy Payments - Blueprint	$ 1,865,544	$ 777,310	$ 621,179	154,793	$ 775,971	$ (1,339)
CHT Block Payment - Blueprint	$ 2,321,670	$ 967,362	$ 773,890	193,472	$ 967,362	$ 0
SASH- Blueprint	$ 3,834,054	$ 1,597,523	$ 1,288,018	322,005	$ 1,610,023	$ 12,500
Operating Expense:						
Salaries/Fringe	$ 8,404,320	$ 3,501,800	$ 2,089,905	510,223	$ 2,600,128	$ (901,671)
Purchased Services	$ -	$ -	$ 425,989	391,606	$ 817,595	$ 817,595
Contract & Maintenance	$ 2,899,264	$ 1,208,027	$ 275,207	1,640	$ 276,847	$ (931,180)
Lease & Rental	$ 397,795	$ 165,748	$ 101,457	25,364	$ 126,821	$ (38,927)
Utilities	$ -	$ -	$ 12,813	3,654	$ 16,467	$ 16,467
Other Expenses	$ 3,983,184	$ 1,659,660	$ 1,008,075	183,051	$ 1,191,126	$ (468,534)
Total Expenses	**$ 53,384,518**	**$ 22,243,549**	**$ 14,603,169**	**3,781,067**	**$ 18,384,236**	**$ (3,859,314)**
Net Income / (Loss)	**$ 2,100,000**	**$ 875,000**	**$ 3,066,566**	**735,066**	**$ 3,801,631**	**$ 2,926,631**

OneCare Vermont

Surplus & Loss Statement

YTD June 2019

	Annual Budget	YTD Budget	YTD Prior Month	Current Month	YTD	YTD Budget/Actual Variance
Medicaid Admin - $6.50 PMPM	$ 5,570,683	$ 2,785,342	$ 2,364,817	451,822	$ 2,816,639	$ 31,297
Medicaid Complex Care Coordination	$ 5,500,000	$ 2,750,000	$ 2,040,865	437,555	$ 2,478,420	$ (271,580)
BCBS QHP PHM $3.25 PMPM	$ 664,677	$ 332,339	$ 498,602	62,342	$ 560,944	$ 228,605
BCBS ASO PHM $3.25 PMPM	$ 585,000	$ 292,500	$ -	195,244	$ 195,244	$ (97,256)
SF PHM $3.25 PMPM	$ 526,140	$ 263,070	$ -	-	$ -	$ (263,070)
Medicare Shared Savings/Blueprint	$ 8,021,268	$ 4,010,634	$ 2,642,598	528,520	$ 3,171,118	$ (839,516)
Primary Prevention	$ 1,100,000	$ 550,000	$ 458,333	91,667	$ 550,000	$ 0
Informatics Infrastructure Support	$ 4,250,000	$ 2,125,000	$ 1,770,833	354,167	$ 2,125,000	$ 0
Misc. Revenue	$ -	$ -	$ 54,133	3,002	$ 57,134.42	$ 57,134
			$ -			
Participation Fees	$ 29,266,751	$ 14,633,375	$ 12,355,685	2,479,789	$ 14,835,474	$ 202,098
						$ -
Total Income	**$ 55,484,518**	**$ 27,742,259**	**$ 22,185,867**	**4,604,105**	**$ 26,789,972**	**$ (952,287)**
PHM Expense:						
Population Health Management Program	$ 5,638,685	$ 2,819,343	$ 2,323,090	1,025,944	$ 3,349,034	$ 529,692
Complex Care Coordination Program	$ 9,651,694	$ 4,825,847	$ 3,646,316	492,869	$ 4,139,185	$ (686,662)
CPR Program Cost	$ 2,250,000	$ 1,125,000	$ 548,204	156,731	$ 704,936	$ (420,064)
Value-Based Incentive Fund	$ 7,852,589	$ 3,926,294	$ 3,109,756	335,009	$ 3,444,765	$ (481,530)
Primary Prevention Programs	$ 910,720	$ 455,360	$ 264,113	72,568	$ 336,680.54	$ (118,679)
Specialist Program Pilot	$ 2,000,000	$ 1,000,000	$ -	-	$ -	$ (1,000,000)
Innovation Fund	$ 1,000,000	$ 500,000	$ -	71,091	$ 71,091	$ (428,909)
RCR	$ 375,000	$ 187,500	$ 110,417	20,833	$ 131,250	$ (56,250)
PCMH Legacy Payments - Blueprint	$ 1,865,544	$ 932,772.00	$ 775,971	154,793	$ 930,764	$ (2,008)
CHT Block Payment - Blueprint	$ 2,321,670	$ 1,160,834.75	$ 967,362	193,472	$ 1,160,835	$ 0
SASH- Blueprint	$ 3,834,054	$ 1,917,027.00	$ 1,610,023	322,005	$ 1,932,027	$ 15,000
Operating Expense:						
Salaries/Fringe	$ 8,404,320	$ 4,202,160	$ 2,600,128	501,306	$ 3,101,435	$ (1,100,725)
Purchased Services	$ -	$ -	$ 817,595	108,659	$ 926,254	$ 926,254
Contract & Maintenance	$ 2,899,264	$ 1,449,632	$ 276,847	1,640	$ 278,486	$ (1,171,146)
Lease & Rental	$ 397,795	$ 198,898	$ 126,821	25,364	$ 152,185	$ (46,713)
Utilities	$ -	$ -	$ 16,467	2,571	$ 19,038	$ 19,038
Other Expenses	$ 3,983,184	$ 1,991,592	$ 1,191,126	508,869	$ 1,699,995	$ (291,597)
Total Expenses	**$ 53,384,518**	**$ 26,692,259**	**$ 18,384,235**	**3,993,724**	**$ 22,377,960**	**$ (4,314,300)**
Net Income / (Loss)	**$ 2,100,000**	**$ 1,050,000**	**$ 3,801,631**	* **610,381**	**$ 4,412,012**	**$ 3,362,012**

OneCare Vermont
Statement of Financial Position

For the Periods Ended	6/30/2019	5/31/2019	Variance
ASSETS			
Current assets:			
Unrestricted Cash	9,966,587	5,672,403	4,294,184
GMCB Reserve	2,650,000	2,441,667	208,333
CMS Reserve-US Bank	4,157,956	4,157,956	-
VBIF	7,547,101	7,212,092	335,009
Advance Funding-Medicaid	9,875,967	9,875,967	0
Total Cash	34,197,611	29,360,085	4,837,527
Network Recievable	2,027,768	2,059,444	(31,676)
Network Recievable-Settlement	21,799,052	24,418,063	(2,619,011)
Other Receivable	6,642,814	6,086,961	555,853
Other Receivable-Settlement	5,904,399	5,904,399	-
Prepaid Expense	245,168	820,132	(574,965)
TOTAL ASSETS	**70,816,812**	**68,649,084**	**2,167,728**
LIABILITIES AND NET ASSETS			
Current liabilities:			
Accrued Expenses	2,224,017	2,018,282	205,735
Accrued Expenses -Settlement	26,248,370	26,244,575	3,794
Network Payable	18,576,129	17,740,022	836,107
Network Payable-settlement	4,405,502	4,405,502	-
Notes Payable	4,124,849	4,124,849	-
Deferred Income	73,604	609,475	(535,871)
Due to Related Parties - UVMMC	9,208,175	8,160,593	1,047,582
Due to Related Parties - DHH	169,835	169,835	-
Total Liabilities	**65,030,480**	**63,473,133**	**1,557,347**
Net assets:			
Unrestricted - UVMMC	687,160	687,160	-
Unrestricted - DHH	687,160	687,160	-
Current Year Profit to Date	4,412,012	3,801,631	610,381
Total net assets	**5,786,332**	**5,175,951**	**610,381**
TOTAL LIABILITIES AND NET ASSETS	**70,816,813**	**68,649,084**	**2,167,728**

1. **Bi-State Primary Care Association Medical Directors Meeting** (August 13th) - Dr. Ward presented a summary of OneCare Vermont programs to this clinical meeting. There was great opportunity for questions and answers and a very positive interchange. The groundwork for an excellent working relationship within the OneCare network was established.

2. **Accountable Care Learning Collaborative (ACLC)** (August 14th) – Dr. Ward presented a summary of OneCare Vermont's approach to risk stratification methods to a national Webinar. The Risk Adjustment Workgroup produced a Competency Orientation Guide as part of the ACLC's efforts to define the essential tasks for organizations trying to transition to value-based health care. (https://www.accountablecarelc.org/sites/default/files/Risk%20Stratification%20Committee%20COG%208.13.19.pdf).

3. **OneCare Educational Offerings** – Dr. Charles Maclean presented on July 23rd concerning opiate prescribing and tapering best practices. The "Noontime Knowledge" WebEx was attended by over 100 clinicians and was available for 1 CME credit. Cindy Bruzzese from the Vermont Ethics Network will present on August 27th about advanced directives and clinical cases of "serious conversations" from her long experience. On September 20th there will be a full day conference on Asthma/COPD open to anyone interested in learning about best practices. There will also be information on initiating a quality improvement project and participating in the upcoming Learning Collaborative on COPD/Asthma which kicks off in January 2020 and will be administered with our new E-Learning tool. Dr. Elisabeth Fontaine will present at Interdisciplinary Grand Rounds on September 10th on Lifestyle Medicine topics. Dr. Gilman Allen will be presenting on Sepsis Awareness and Protocols on September 17th.

4. **Vermont Retain Project** – OneCare continues to assist Dr. Karen Huyck, Occupational and Environmental Medicine, Dartmouth Hitchcock and her research team in recruiting clinicians to participate in this United States Department of Labor and Vermont Department of Labor project designed to optimize care of injured workers and reduce disability claims. The program offers free access to experienced workers compensation case managers to facilitate return to work. In addition the team is seeking patients and clinicians to participate in "Experience Groups" (a qualitative research method) to help design an optimal intervention for patients, clinicians, and employers.

5. **Ongoing Initiative Participation:**
    a. Green Mountain Care Board Health Resources Allocation Plan
    b. Green Mountain Care Board Primary Care Advisory Group
    c. Vermont Legislature - Act 17 of 2019 - An act relating to determining the proportion of health care spending allocated to primary care.
    d. Dental Access and Medicaid Reimbursement Rates Working Group
    e. Best practices for Urine Drug Screening workgroup – OCV, DVHA, BCBS
    f. Leveraging OneCare Vermont data analytics to support Vermont Child Health Improvement Program (VCHIP) collaborative on Attention Deficit Hyperactivity Disorder (ADHD)
    g. Laboratory Subcommittee – potential cost savings of molecular testing for influenza and group A strep

6. **Health Service Area Cost/Utilization Variation Report Follow-up –** Dr. Ward and members of the OCV analytic team traveled to Brattleboro and Randolph in July to solicit requests for next steps in more granular analysis of the standard reports. There is an open invitation for similar meetings at any Hospital Service Area.

OneCare Vermont Accountable Care Organization
Board of Managers Resolution

August 20, 2019

BE IT RESOLVED by the Board of Managers (the "Board") of OneCare Vermont Accountable Care Organization, LLC ("OneCare") as follows:

1. The Board hereby approves changing the OneCare banking resolution to remove Kevin Stone as OneCare Chief Executive Officer as he is no longer employed by OneCare Vermont.
2. The Board hereby approves changing Victoria Loner's title to Chief Executive Officer

OneCare Vermont

Policy Number & Title:	02-02 OneCare Advanced Community Care Coordination Payments
Responsible Department/s:	ACO Clinical and Quality Department, Finance Department
Author:	Sara Barry
Date Implemented:	7/1/2017
Date Reviewed/Revised:	08/20/19
Next Review Date:	12/2019

Purpose: A policy for calculating, distributing, suspending or terminating Advanced Community Care Coordination payments to OneCare Network Participants, Preferred Providers and Collaborators (collectively "Members" in this Policy) in accordance with OneCare Vermont's (OneCare) Care Coordination Model.

Policy Statement: This Policy describes the ways eligible Members are paid OneCare for performing Advanced Community Care Coordination activities for defined populations. Advanced Community Care Coordination activities are described in ACO Programs, Participant/Preferred Provider Agreements, or Collaborator Agreements, and in the OneCare Complex Care Coordination Expectations, Payment Information and Guidance (Attachment A) document.

Definitions:

ACO Program refers to a program and agreement between the ACO and a Payer for ACO Activities and alternative payment arrangements.

Care Coordination refers to the deliberate organization of patient care activities and sharing of information among all of the Members concerned with a patient's care. The goal is to achieve safer and more effective care. The patient's needs and preferences are known and communicated at the right time to the right people and used to provide safe and effective care.

Care Coordination Level refers to one of four categories – (1) low risk, (2) medium risk, (3) high risk, or (4) very high risk – and is defined by OneCare's data-driven approach to risk stratification. These Care Coordination Levels segment populations and identify individuals that may benefit from interventions and supports to improve their health and wellbeing as well as to address the total cost of care for the patient and the attributed population. An individual's Care Coordination Level is set annually, but may be revised as permitted by this Policy.

Revised Care Coordination Level refers to a change in the Care Coordination risk Level that is informed by clinical knowledge and judgment about an individual's life conditions or situations in that are new, changing, or unable to be captured through current risk stratification methods. This Revised Care Coordination Level may increase or decrease an individual's risk level from the original Care Coordination Level classification. A Revised Care Coordination Level must be documented in Care Navigator or other OneCare approved care coordination software along with appropriate justification. Once appropriately documented, an individual's Revised Care Coordination Level guides the level of interventions, programs, or payments in alignment with OneCare's Advanced Community Care Coordination program. OneCare may review and possibly override or reverse a Care Coordination Level to ensure alignment with OneCare's Population Health Care Model and program goals.

Care Conference refers to a meeting of health care professionals who are members of the Care Team of

an Attributed Life participating in the OneCare Care Coordination Program where care planning is actively evaluated, conducted, and documented in Care Navigator or other OneCare approved care coordination software. A Care Conference must include representatives of multiple organizations, at least two TINs.

Care Team refers to individuals with the appropriate training, skills, and abilities, who work collaboratively to support the patient's identification and achievement of goals for his/her care. Care Team members assist with task identification and completion, identify and remove barriers, and work cross-organizationally to promote whole-person care. Care Team members may include primary and specialty care providers, care coordinators, case managers, social workers, nurses, nutritionists, mental health counselors, or other professional and lay staff. For the purpose of OneCare's Advanced Community Care Coordination payment model, the Care Team refers to employees of primary care, home health, designated agencies for mental health and substance abuse, and the area agencies on aging who are contracted and in good standing with OneCare in order to receive supplemental payments associated with their role on the care team.

Care Managed refers to having a Lead Care Coordinator, identified by the patient, and a Shared Care Plan documented in Care Navigator or other OneCare approved care coordination software.

Care Navigator refers to OneCare's care coordination software platform designed to improve communication among Care Team members. It includes patient demographic and utilization data, assessments, Shared Care Plans, and notes/tasks to support engagement in care coordination. Care Navigator is the data source to identify payments to Members under OneCare's Advanced Community Care Coordination program and payment model.

Collaborator refers to any individual or entity that is: a) a contracted non-attributing provider or b) participating in the coordination of care and has entered into a collaborator agreement (which includes a Business Associate Agreement and a Data Use Agreement/ Addendum) with OneCare to perform services related to ACO Activities on behalf of or to OneCare.

Expected Outreach for Non-Engaged Patients refers to the expectation that Members facilitate regular, effective outreach to attempt to engage High and Very High Risk members in Care Coordination. The frequency of outreach varies by need and should be impacted by clinical judgement and availability of information on new or changing circumstances but should be at minimum monthly for High and Very High Risk individuals until such a time as a patient either engages in Care Coordination or declines participation. Engagement or declination should be documented in Care Navigator.

Expected Outreach for Engaged Patients refers to the expectation that Members facilitate regular effective outreach for patients engaged in Care Coordination and document this outreach in Care Navigator or in other methods agreed upon with OneCare. The outreach requirements listed below are the minimum expectations and should be expanded based upon patient needs. Minimum outreach for Care Managed individuals is:

Very High Risk Individuals – 12 times per year (i.e. monthly)
High Risk Individuals – 4 times per year (i.e. quarterly)
Medium Risk Individuals – 2 times per year (i.e. biannually)

Encounters refers to qualified interactions with Care Managed individual. Members are expected to document key patient encounters in Care Navigator in order to support the coordination of care and services across organizations. Encounters can be in-person in a variety of settings (e.g. office, facility, home, or community

setting) or virtual such as telehealth, phone calls or substantive written communications. Encounters include but are not limited to: primary care visits, specialist visits, home visits supporting coordination of care, transitions of care interactions, participation in self- management programs, and participation in community-based events.

High and Very High Risk Patients refers to the patient cohort that has been defined in the ACO Program. Generally, this is the top 16% of Attributed Lives in an ACO Program determined by risk stratification

Lead Care Coordinator refers to the professional on a Care Team whom a patient designates to take primary responsibility for organizing his/her care activities, creating the Shared Care Plan, scheduling and creating the agenda for Care Conferences, sharing information and delegating responsibilities in a clear fashion. The Lead Care Coordinator must be employed by or contracted by an eligible, in good standing OneCare Member and must hold the appropriate credentials as outlined in the ACO Programs or ensure such credentials are maintained by one or more other active Care Team members and ensure that pathways to appropriate escalation are in place if the Lead Care Coordinator selected by the patient is not licensed.

OneCare Population Health Care Model refers to the segmentation of populations by categories stated below and the designation of recommended care supports for each category:

- Category 1: Healthy / well majority (low)
- Category 2: Early onset / stable chronic illness (medium)
- Category 3: Full onset chronic illness and rising risk (high)
- Category 4: Complex / catastrophic high cost (very high)

Participant or Preferred Provider refers to a health care provider that has entered into a Participant /Preferred Provider Agreement with OneCare.

Risk Stratification refers to a data driven process that segments a population in an ACO Program into the four quadrants of OneCare's Population Health Care Model based on the identified risk of each individual patient attributed to the ACO Program. A risk rank is generated and thresholds are drawn as follows:

Very High Risk – the top 6% of the population with the highest risk rank (i.e. >94%-100%)
High Risk – the next 10% of the population by risk rank (>84%-94%)
Medium Risk – the next 40% of the population by risk rank (>44%-84%)
Low Risk – the 44% of the population with the lowest risk rank (0%-44%)

Generally the High and Very High Risk patient population is defined as the top 16% of patients identified by risk rank; however, this may vary by ACO Program.

Shared Care Plan refers to a structured tool used to identify and document (1) a patient's goals, barriers, and strategies with the Care Team member(s) responsible for each; (2) the timeframe for achieving goals and (3) the patient's prioritization of these goals/activities. A Shared Care Plan is used to facilitate the communication of information needed to coordinate across Care Team members. A Shared Care Plan is created when two goals and two tasks per goal are documented in Care Navigator or other OneCare approved care coordination software to meet the expectations of the Care Coordination Model. A Shared Care Plan should be routinely reviewed by the Lead Care Coordinator with the patient and appropriate Care Team members and updated as needed.

Supplemental Care Coordination Payments refers to payments that are made to qualifying Members by OneCare to support Care Coordination activities that generally do not receive reimbursement from Payers.

TIN refers to a Federal Taxpayer Identification Number, employer identification number or social security number in the case of a provider who bills Payers under his / her social security number.

Supplemental Care Coordination Payments

Payments will be made monthly. If a Member dissolves or is acquired by another non-eligible entity during the course of the Performance Year or if they are deemed to be non-compliant with their contractual requirements and /or program expectations by the OneCare's Population Health Strategy Committee they will no longer be eligible for Supplemental Care Coordination Payments.

1. **2019 and First Quarter of Performance Year 2020 for All Members Eligible for Supplemental Care Coordination Payments and Full Performance Year 2020 for Newly Contracted Participants and Preferred Providers Only**

   a. Level 1 Community Capacity Payments:
   In 2019 OneCare will allocate an annual capacity payment to each Health Service Area in its Network to be used to support project management for complex care coordination activities. A consulting services agreement detailing the responsibilities and payment terms, will be executed between OneCare and the participating Health Service Area agent that holds the Blueprint for Health Agreement for project management. No funds will flow before the agreement is executed. Level 1 Payments will not continue in 2020.

   b. Level 2 Team Based Complex Care Coordination Payments:
   The following types of Members may be eligible for Level 2 payments: i) Attributing Primary Care Physicians and Advanced Practice Providers; ii) Area Agencies on Aging; iii) Designated Mental Health Agencies; and iv) Home Health Agencies.

   A $15 Per Member Per Month (PMPM) payment based on attribution as follows:
      i. Attributing Primary Care Physicians and Advanced Practice Providers are eligible to receive payments based on their entire High and Very High Risk Attributed Populations.
      ii. Area Agencies on Aging are eligible to receive payments based on 25% of the High and Very High Risk Attributed Population in the Health Service Area(s) they serve.
      iii. Designated Mental Health Agencies are eligible to receive payments based on 60% of the High and Very High Risk Attributed Population in the Health Service Area(s) they serve.
      iv. Home Health Agencies are eligible to receive payments based on 45% of the High and Very High Risk Attributed Population in the Health Service Area(s) they serve.

   c. Level 3 Patient Activation and Lead Care Coordinator Payment
   The following types of Members may be eligible for Level 2 payments: i) Attributing Primary Care Physicians and Advanced Practice Providers; ii) Area Agencies on Aging; iii) Designated Mental Health Agencies; and iv) Home Health Agencies.

   This payment consists of two components:
      i. A one-time annual payment of $150 made to the TIN of the Participating Provider who establishes a Lead Care Coordinator relationship and a Shared Care Plan with a qualifying Attributed Life. If the Lead Care Coordinator is active for more than 12 months, the next annual payment will be made in the anniversary month of initial activation.

ii. An additional $10 PMPM payment to the TIN of the Participating Provider who establishes a Lead Care Coordinator relationship and a Shared Care Plan with a qualifying Attributed Life. This payment is effective the month the Lead Care Coordinator and Shared Care Plan are designated in OneCare's care coordination software systems and paid beginning in the following month. The PMPM payment will only be made for the months that the eligible patient is under active care coordination

b. Second, Third, and Fourth Quarters of Performance Year 2020 for All Returning Members Eligible for Supplemental Care Coordination Payments

For the second, third and fourth quarters of the 2020 Performance Year, when payer data relating to Attributed Lives for 2020 is available to OneCare, returning eligible Members will initiate care coordination activities for the 2020 cohort of High and Very High Risk Attributed Lives and be eligible to receive Supplemental Payments under this policy. Per Member Per Month payments will only be made for the months that the eligible patient is under active care management.

a. Lead Care Coordinator Per Member Per Month Payments:
OneCare will pay $80.00 PMPM to the TIN of an eligible Member that establishes a Lead Care Coordinator relationship and a Shared Care Plan with an adult Attributed Life and documents these events in Care Navigator or other OneCare approved care coordination software. The $80.00 PMPM is effective the month the Lead Care Coordinator and Shared Care Plan are designated in Care Navigator or other OneCare approved care coordination software and is paid beginning the following month.

b. Care Team Per Member Per Month Payments:
OneCare will pay $60.00 PMPM to the TIN of an eligible Member who participates in the Care Team and documents their active Care Team participation in Care Navigator or other OneCare approved care coordination software. The $60.00 PMPM is effective the month the Care Team member is designated in Care Navigator or other OneCare approved care coordination software for an actively Care Managed patient and is paid beginning the following month. In the unusual instance that multiple Care Team members are from the same primary care TIN, representatives from at least one other organization must participate on the Care Team for the TIN to be eligible for a second Care Team payment.

c. Care Conference – Lead Care Coordinator
A $300.00 annual payment will be made per Attributed Life to the TIN of an eligible Member who serves as the Lead Care Coordinator for a Care Managed High or Very High Risk patient when a qualifying Care Conference is conducted. The payment will be paid in the month following documentation of the qualifying Care Conference in Care Navigator or other OneCare approved care coordination software.

d. Care Conference – Care Team
A $150.00 annual payment will be made per Attributed Life to the TIN of an eligible Member who serves as an active Care Team member for a Care Managed High or Very High Risk patient when a qualifying Care Conference is conducted. The payment will be paid in the month following documentation of the qualifying Care Conference in Care Navigator or other OneCare approved care coordination software.

Monitoring

The Advanced Community Care Coordination program is supported by predicted rates of patient engagement in Care Coordination and will be monitored for outliers. If any Health Service Area's Care Managed rate

reaches 20% of the High and Very High Risk Population, OneCare will initiate a quality assurance review. Members assigned to that Health Service Area and receiving Supplemental Payments will be required to participate in that review. The purpose of the review will be to assess the Care Coordination procedures, process metrics, and outcomes achieved in that Health Service Area and/or in any participating TINs receiving Supplemental Care Coordination Payments through OneCare. The quality assurance review may result in confirmation of results and continuation of payments, possible expansion of payments, or corrective action, which may include a corrective action plan or other remedies such as repayment.

Actions/Responsibilities:
OneCare has developed a financial model to support Care Coordination activities for the high needs/high cost individuals. The payments are intended compensate participating Primary Care and community-based organizations to support care coordination activities for High and Very High Risk Attributed patients.

Members paid under this model must comply with the requirements outlined in the ACO Program of Payments, including but not limited to:

(a) Must comply with the requirements laid out in the table directly below for this payment before the beginning of the Performance Year.
(b) Only those Members that comply with all requirements are eligible for Supplemental Care Coordination payments;
(c) Members may be asked to provide reasonable documentation to demonstrate meeting these standards.

1. Member has identified one or more employed or community-shared resource staff whose role is to provide care coordination services for its attributed patient panel. Identified care coordination staff will: a. have each attended at least one care coordination training session in the past 12 months or Member can attest that all care coordination staff will participate in at least one training session in the current Performance Year; and b. utilize Care Navigator or other methods agreed upon with OneCare to create shared care plans and communicate among care team members.
2. Member routinely reviews lists of high/very high-risk patients and conducts outreach to engage patients in care coordination (OneCare estimates a 15% patient engagement rate).
3. Member facilitates regular effective outreach (i.e. 12x/yr for very high risk 4x/yr for high risk, 2x/yr for medium risk) for patients engaged in care coordination as per OneCare's care coordination model and documents this outreach in Care Navigator or in other methods agreed upon with OneCare.
4. Member's team-based care model includes defined roles and relationships with continuum of care partners (e.g. primary care, home health, designated agencies, skilled nursing facilities) and human services organizations (e.g. DCF, nutrition, housing, transportation).
5. Member participates in person-centered shared care planning and care conferences as necessary to facilitate the patient's goals of care.

6. As applicable, Primary Care Practice's team-based care model supports effective transitions of care by providing follow-up calls with patients following emergency department visits within two days and post-hospital discharge in-person visits between 7-14 days depending on acuity.

In addition, Members are expected to work collaboratively to develop, refine, and customize within and cross-organizational workflows to facilitate effective care management for Attributed Lives.

The aforementioned expectations are not exhaustive; thus OneCare Members eligible for this Supplemental Care Coordination Payments will be provided with an OneCare expectations document, technical specifications, and supports from OneCare's Clinical Department in order to assure expectations are met.

Payments

1) A monthly payment will be made to each eligible contracted, in good standing, TIN for each eligible High or Very High Risk individual, as defined by the ACO program, actively Care Managed for whom their employed staff serve as the Lead Care Coordinator (LCC) or Care Team (CT) Member as documented in Care Navigator or other agreed upon method.
2) A one-time annual payment will be made for each eligible contracted, in good standing TIN for completion of a Care Conference as documented in Care Navigator or other agreed upon method per the amounts detailed in the Policy above. If a patient dis-engages in Care Management and later re-engages, only one payment will be made in any one Care Coordination Program Year (i.e. April 1 to March 31 of the following year)
3) OneCare may stop or suspend payments to a Member in the event that the organization is no longer participating in the OneCare care coordination program or if the Member is determined to be non-compliant with the Advanced Community Care Coordination Payment program requirements and/or expectations.
    a. Suspending Payment due to suspected Member non- compliance with the Advanced Community Care Payment program requirements and / or expectations.
        i. If OneCare management identifies that a Member is potentially noncompliant with the program requirements and / or expectations, management will bring the matter to the attention of OneCare's Chief Medical Officer (CMO).
        ii. The CMO or designee will contact the entity to convey the concerns and set up an interview and discussion of the issue(s).
        iii. If the rationale for the suspected noncompliance is not compelling, the CMO or designee will conduct a review of the Member's care coordination procedures and practices, which may include a review of attributed member's charts.
        iv. The CMO or designee will prepare a report of findings and recommendations for the Population Health Strategy Committee (PHSC). If the CMO believes there is significant evidence that noncompliance may exist, the CMO's report may serve as the basis to suspend payments until a determination regarding compliance is rendered by the PHSC.
        v. PHSC will review the findings and recommendations of the CMO and make a determination of whether payments should be: a) continued, b) temporarily suspended until the provider meets expectations, or c) permanently stopped. The Member will be notified of the decision within three (3) business days of the action by the Committee.
        vi. Members may appeal the decision of the PHSC in accordance with the Participant Appeals Policy. The action of the PHSC will remain in effect until and unless reversed or modified in the appeal process.

b. Stopping payment due to a Member not meeting contract requirements for clinical criteria in the OneCare Care Coordination Program:
    i. Contracted Members are required to comply with the Care Coordination Program requirements. Such agreement is documented through signature on the Participant, Preferred Provider, or Collaborator Contract. Non-compliance will result in nonpayment.
c. Stopping payment due to Member eligibility changes in the OneCare Care Coordination Program:
    i. If a Member becomes non-participating in the Care Coordination Program with OneCare because the employing entity either dissolves or is acquired by another non-participating Member, payment will be made through the month that the Member was participating and will cease for the following month.
    ii. No appeals process is available for Members who become non-participating for reasons of practice dissolution or acquisition.
d. Stopping payment related to contract termination or because the Member dis-enrolled as a billing provider with an ACO Program:
    i. If OneCare terminates a contract or the Member dis-enrolls with an ACO Program, payments will be prorated and paid through the date that the Member was terminated by OneCare or dis-enrolled from the ACO Program.
    ii. In the circumstances above, the Member may appeal the proration amount, and follow the process as outlined in the Participant Appeals Policy.

References:
OneCare Vermont Participant Appeals Policy and Medicare Primary Care Alignment Strategy Procedure
Provider contracts and payer contracts
OneCare Complex Care Coordination Expectations and Payment Information and Guidance

Monitoring & Compliance: Shared between the Clinical and Finance Departments. The Clinical Department monitors compliance with the Advanced Community Care Coordination program. The Finance Department will monitor and audit the Supplemental Care Coordination payments.

Related Policies/Procedures: C02-05 Care Coordination, C02-06 Care Coordination Training and Responsibilities

Location on Shared Drive: S:\Groups\Managed Care Ops\OneCare Vermont\Policy and Procedures\Policies\Current Policies

Management Approval:

Sr. Director, Value Based Care Date

Director, ACO Finance and Analysis Date

Chief Medical Officer Date

Chief Operating Officer	Date
Chair, OneCare Board of Managers (Required)	Date

Attachments

Attachment A: OneCare Complex Care Coordination Expectations, Payment Information and Guidance

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Attachment A

OneCare Complex Care Coordination Expectations, Payment Information and Guidance

Dear Participant, Preferred Provider, or Collaborator:

OneCare is pleased to offer a complex care coordination payment opportunity in support of our vision to provide integrated, high-quality, person-centered, community-based care coordination. As an eligible organization in one or more OneCare payer programs, please review the enclosed information to learn how this impacts your organization financially and operationally. The enclosed communication outlines expectations as a member of our Accountable Care Organization (ACO) when supporting attributed individuals with complex care coordination needs. We welcome the opportunity to provide facilitation as needed in order to support the performance of these responsibilities.

The 2020 payment model was developed based on feedback from numerous stakeholders in OneCare's Network in order to advance the model from capacity-building to paying for value
Eligible organizations for 2020 include attributing primary care practices, the Area Agency on Aging, Home Health & Hospice and the Designated Mental Health Agency who participate with OneCare in each of the health service areas in OneCare's Network. The complex care coordination payments are in addition to current PMPM payments to participating primary care practices. Please note that unless otherwise mutually agreed upon and documented, the use of OneCare's care coordination software, Care Navigator, is required to participate in team-based care coordination. Care Navigator will serve as a data source upon which we will evolve the care coordination payment model to increasing focus on patient and care team outcomes. In addition to training in Care Navigator, OneCare collaborates with community partners to offer in-person Care Coordination Skills trainings on a variety of topics to support the care coordination program.

If you would like to discuss the care coordination program, please contact Robyn Skiff, Care Coordination Implementation Specialist (Robyn.Skiff@onecarevt.org 802-847-0606). We also encourage you to reach out to your local Care Coordination Core Team via your your OneCare Clinical Consultant for ongoing information sharing and support.

We truly appreciate your participation in the ongoing development of innovative ways to improve population health.
Sincerely,
Sara Barry, MPH
Sr. Director, Value Based Care

Complex Care Coordination Expectations, Payment Information and Guidance

This summary is intended to describe expectations under OneCare's four quadrant Care Coordination Model specifically related to additional payments for providing Care Coordination services to patients at High and/or Very High Risk[1] (i.e. categories 3 and/or 4) of morbidity or high cost utilization of healthcare services for January 1 to December 31, 2020. OneCare expects all Members to support a panel management approach to identifying and engaging individuals in obtaining appropriate health screenings, assessments and interventions. It is further expected that organizations participate in local development of standardized tools and workflows to implement the Care Coordination Model including protocols, clinical pathways and patient education.

For 2020, OneCare's, Medicaid, Medicare, and BCBS QHP complex care coordination programs will encompass the top 16% risk individuals (i.e. 10% of the population by payer for category 3 and 6% of the population by payer for category 4). All other Payer Programs Offered by OneCare are excluded from this program unless dully noted in writing by OneCare to Members.

Team-Based Care Coordination Payments

As a Member eligible to receive Supplemental Care Coordination Payments, serving as a Care Team Member you agree to:

1. Understand, align with and promote the Care Coordination Model.
2. Utilize Care Navigator, or other agreed upon method with OneCare, to guide care team and patient activities (including monitoring of risk stratification, claims and utilization data).
3. Ensure patient's access to a Primary Care provider; facilitate engagement with annual comprehensive health assessment.
4. Serve as a care team member:
    a. Actively coordinate care on behalf of patient as indicated
    b. Collaboratively support safe and timely transitions of care to include: timely medication reconciliation, communication with providers, and ensuring the individual's understanding of discharge instructions, referrals and care plans
    c. Participate in Care Conferences or care team meetings
    d. Assess need for and facilitate engagement in palliative and hospice care as needed
    e. Utilize Care Navigator for timely and accurate recording and communication of key care coordination activities, including:
        i. Identify oneself as a care team member
        ii. Populate demographics, patient preferences, strengths and challenges
        iii. Upload or complete relevant assessments
        iv. Record patient encounters: At least 4x/year for high risk individuals[2] ; or at least 12x/year for very high risk individuals
        v. Notify care team members of relevant patient status changes, events and encounters
5. Actively contribute to the creation of a person-centered Shared Care Plan.

[1] High/very high risk designation is determined annually in January by OneCare. Adjustments to the Care Coordination Level may be made by care team members throughout the year, but payments will only be made based on the annual designation of risk category.

[2] Patient encounters may be done by any member of the care team regardless of organization affiliation or affiliation with OneCare.

6. Actively participate in the design and refinement of community-specific workflows and care coordination work plans by participating in and/or providing input to local meetings, planning events and learning collaboratives.
7. Participate in local Care Coordination trainings and competency assessments.
8. Maintain necessary knowledge and skills to conduct effective patient-centered Care Coordination activities.
9. Monitor patient panels, conduct gap analyses and identify opportunities for performance improvement.
10. Monitor staff engagement/participation in Care Coordination activities and replace any staff deemed noncompliant in a timely manner so as to ensure appropriate patient-centered care.
11. Monitor Care Management rates for your TIN and your Health Service Area and participate in any OneCare assessments of compliance with the Care Model
12. Ensure your staff assigned to Care Teams are actively engaged in support of each individual's care plan with corresponding activities documented in Care Navigator or other OneCare approved method.

In addition, when staff from your TIN serve as the Lead Care Coordinator:

1. Ensure the patient's preferences in the selection of Lead Care Coordinator (LCC) are honored and record this role in Care Navigator. It is anticipated that there is a process to discuss patient outreach among care team members to identify an individual to conduct the initial outreach and activate the patient's engagement in Care Coordination. Once activated, the patient will be encouraged to review his/her care team members and identify the <u>one</u> individual s/he designates as the LCC. Note: if the LCC changes over time, the PMPM will follow the new LCC.
2. Perform all duties of care team members outlined in Care Team Member requirements above as appropriate.
3. Ensure all individuals receiving care coordination services have access to licensed clinical staff as indicated by educational need, provider request or change in clinical status. Also ensure very high risk individuals have an appropriately licensed[3] professional as part of the care team performing complex case management.
4. Ensure the LCC's active patient panel does not exceed 50 very high risk patients per 1.0 FTE.
5. Perform Lead Care Coordinator duties, including:
    a. Activate and regularly engage patients in care coordination as they allow.
    b. Ensure care team members coordinate and communicate to support person-centered care.
    c. Monitor and ensure key Care Coordination activities occur and are recorded in Care Navigator:
        1) Ensure care team members are accurately identified and listed
        2) Ensure minimum frequency of patient contacts based on Care Coordination Level (4x/year for high risk; or 12x/year for very high risk)[4] for individuals engaged in care coordination and ensure they are documented in Care Navigator or other agreed upon method
        3) Facilitate the creation of a person-centered Shared Care Plan (SCP) with at least two goals and two tasks per goal.
        4) Monitor and facilitate SCP task and goal attainment; update SCP to adapt to individual's

[3] Licensed staff may include physician assistants, registered nurses, therapists, social workers, mental health providers, and/or licensed alcohol and drug counselors.

[4] This contact may be made by any care team member regardless of organization affiliation.

changing needs and wishes.

5) Identify and address barriers to care and attainment of SCP goals; engage Care Team members as appropriate to address these challenges.

d. Convene and facilitate person-centered Care Conferences and Care Team meetings as needed and document them in Care Navigator or other agreed upon method.

6. Identify palliative and hospice care needs; coordinate care as indicated.
7. Continuously improve Care Coordination knowledge and skills by completing competency assessments and participating in training and professional development opportunities.
8. Monitor patient panels, conduct gap analyses and identify opportunities for performance improvement.