# Care Coordination

## Program Definitions and Reference Guide

| Term | Description | Expectations and Requirements |
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| **Triannual Care Coordination Reporting** | Triannual reporting of all attributed individuals with complex care needs who are actively engaged within the reporting period under the team-based complex care coordination model. The care model seeks to engage individuals in obtaining care-managed status as defined below. At OneCare's discretion, triannual reporting may also include a periodic brief narrative report describing program progress, successes and challenges. Alare managed lives, year to date, on program up until reporting period should be included. | **Submission 1:**<br>Due Friday April 18, 2025 for reporting period January 1 through March 31, 2025.<br>**Submission 2:**<br>Due Friday August 22, 2025, for reporting period April 1 through July 31, 2025.<br>**Submission 3:**<br>Due Friday January 23, 2026 for reporting period August 1 through December 31, 2025. |
| **Care Managed Individuals** | Refers to a person-centered practice with a focus on deliberate, non-duplicative coordination of care with two or more providers to include the individual. To be considered Care managed an individual must have both a designated lead care coordinator and a shared care plan. | To include an attributed life in triannual reporting the individual must have a lead care coordinator and a shared care plan. |
| **Care Team Conference (CTC)** | Intended to engage the care team and individual/family to assess goals and progress, identify barriers and solutions, share information, provide education, review gaps in care, plan upcoming tasks, and work cross-organizationally. | A care team conference should be reported if the conference meets the definition below and occurred within the current calendar year and/or reporting period. The care team conference (CTC) may occur in person, over the phone and/or via telehealth modes. CTCs are appropriate, and often necessary, to coordinate care for most care managed individuals. The individual/family should be included in the CTC. |
| **Care Management Start and Stop Date** | Triannual reporting process metric. | CM start date- Date the individual began care coordination in your program, if still actively engaged in complex team-based care. Generally, this date will not be any greater than 2 years in the past.<br>CM stop date- Date the individual completed their shared care plan goals established for complex team-based care |

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| | | coordination and was 'graduated to self-management; or date the individual was discharged from your program for reasons including relocation/moved/unable to contact, absence of active engagement with care team across time, or similar. If the individual is still active, leave stop date blank. |
| **Shared Care Plan** | Shared care planning reflects a longitudinal planning process in collaboration with care team members from other organizations/disciplines that outlines goals, tasks required to complete those goals, prioritized concerns, as well as barriers/plan to address barriers. | All individuals that are submitted for triannual reporting should have evidence of a shared care plan in their record.<br>Evidence of a shared care plan includes:<br>• Listing care team members from other organizations on your care plan<br>Documentation within the organizations EMR referencing collaboration with or goals for the patient set by care team members from other organizations/disciplines |
| **Level of Intensity** | Triannual reporting process metric. Refers to the expectation there be regular effective outreach to attempt to engage members in Care Coordination. While the frequency of outreach varies by need and will be informed by clinical judgement and availability of information on new or changing circumstances, the minimum frequency reported on for an individual in the triannual reporting must be met and demonstrated in the annual data validation audit. | • Monthly: Minimum of monthly engagement<br>• Quarterly Minimum of quarterly engagement<br>• Bi-Annually: Minimum twice annual engagement<br>• Annually: Minimum of annual engagement |