



CARE COORDINATION WORKGROUP

Extended Care Coordination (ECC):
The Path Toward A Shared Definition

Extended Care Coordination



Extended Care Coordination is defined as: Activities targeted to specific members who require more intense and extended assistance



Extended Care Coordination includes appropriate interventions such as care planning, face-to-face visits, etc.



PC&E, with support of the Care Coordination Workgroup, is recommending key components and best practices for Extended Care Coordination



WORKGROUP SUMMARY

Extended Care Coordination: Key Components and Best Practices

Care Coordination Workgroup Summary

- Workgroup identified areas of importance such as creating definitions, having clear and common language and identifying best practices.
- RAEs are finding alignment across the domains after additional discussions and identification of best practices.
- Examples:
 - RAEs agree that an 'administrative' or 'preliminary' assessment/care plan can be initiated on the member when establishing services/ensure care management/care coordination occurs expeditiously.
 - RAEs also agree that the care plan is a 'living document' that is constantly evolving. Given the nature of this, as well as the goal of member-centered assessments + care planning creating a more 'comprehensive' assessment is a process that can take several sessions to accomplish; however, a lot of valuable coordination of care is happening from the start.

ECC: Key Components and Best Practices

Workgroup identified domains (responsibility, assessment and care plan) and focused on activities, key components and best practices.

1. Responsibility

- a. Best Practice: The RAEs assign a primary care coordinator to each member enrolled in care coordination to avoid duplication of care and ensure succinct services.

2. Assessment

- a. Best Practice: The RAEs complete an assessment and include other forms of information (e.g., screenings, data) when available.

3. Care Plan

- a. Best Practice: A care plan (is a living document) that identifies individual goals, is measurable and defines success as we continue outlining needs with the member.
 - i. The care plan is actionable with SMART goals for improving member health and wellbeing (care plans evolve overtime/best practice identifies SMART goals; however, the initial care plans may not be as robust).
 - ii. The Best Practice is to have a care plan that is created with member direction, family or care team when available (e.g., they drive the process, etc.). More often, the care plan begins with research/data collection starting with current systems in place; ADT information, etc. Care Coordinators also work with the members care team/other systems of care involved with the member. As care plan evolves, the member has more input/driving the process.
 - iii. SEP, CCB, or other care plans/treatment plans are integrated, and coordination is documented when available/shared with care coordinator (integrate/collaborate/negotiate roles with these entities--physical plan may not be shared)
 - iv. Outreach to members enrolled in care coordination occurs after ADT notifications. If the member is not enrolled in care coordination, outreach is driven by member stratification and/or if they are a priority population.

ECC: Key Components and Best Practices

Remaining domains finished on 04.05.21:

4. Monitoring Plan

- a. Best Practice: The RA ECC documents essential communications, goal progress, and updates. The RAE also provides ongoing assessment/reassessment for linkages to support overall health including, resources outside the health care system (e.g., SNAP, social services, housing, education resources).

5. Communication

- a. Best Practice: RAEs identify Bi-directional communication (i.e., face-to-face, telephone, text) is used primarily to converse with Members as a preferred method.
 - i. Care Coordinator ensures that care is coordinated for the Member within a practice, as well as between the practice and other Health Neighborhood providers and Community organizations, and is communicating regularly with the Member's care team, including when a member is transitioning out of RAE care coordination.
 - ii. Frequency of monitoring plan & contact entirely depends on care plan goals.

6. Length of Time

- a. Best Practice: Member remains in extended care coordination until member driven care plan goals are met.

Extended Care Coordination

- Next Steps...
 - Bringing to PC&E for review/approval (today) with plans for it to go to the PIAC in April.
 - While PIAC is reviewing, the Department will also be reviewing recommendation.