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

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 to consider (workgroup to finish 04.05.21 & present to P&CE April 8):

4. Monitoring Plan
   a. *Do primary care coordinator document all Member/CC communications, goal progress, and updates on a regular basis? Assesses need for linkages to support overall health including, resources outside the health care system (e.g., SNAP, social services, housing, education resources)?*
5. Communication
   a. *What is the frequency of monitoring plan: at least one contact monthly and more often as appropriate? Frequency of monitoring plan: frequency of contact entirely depends on care plan goals? Bi-directional communication (i.e., face-to-face, telephone, text) is used primarily to converse with Member? Performs information transfer count (e.g., lab results transferred)?*
6. Length of Time
   a. *Do member remains in extended care coordination until they are no longer complex ($25k list)? Member remains in extended care coordination according to start/end date on their care plan?*
7. *Other yet to be identified domains?*

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.

Extended Care Coordination

- Next Steps…
  - The care coordination workgroup will meet a week early in April to finish working through remaining domains (monitoring plan, communication, length of time, etc) focusing on identifying activities and best practices.
    - Once finalized, the care coordination workgroup will bring back to PC&E for review/approval with plans for it to go to the PIAC in April.
    - While PIAC is reviewing, the Department will also be reviewing recommendation.

CARE COORDINATION PROCESS MAPPING