COLORADO
Department of Health Care Policy & Financing

To: The Department of Health Care Policy & Financing
From: ACC Program Improvement Advisory Committee's (PIAC) Provider and Community Experience (P&CE) Subcommittee
Date: April 2021
Subject: Extended Care Coordination

Executive Summary
At the request of the Department, the P&CE Subcommittee with support from its Care Coordination Workgroup, worked to identify key components and best practices for RAE *Extended Care Coordination*. Those key components include: Responsibility; Assessment; Care Plan; Monitoring Plan; Communication; and Length of Time.

Background
Currently the ACC broadly defines 2 types of care coordination:

- *Deliberate Care Coordination* - A range of deliberate activities to organize and facilitate the appropriate delivery of health and social services that support member health and wellbeing; and
- *Extended Care Coordination* - Activities targeted to specific members who require more intense and extended assistance and includes appropriate interventions.

Extended Care Coordination (ECC) is intended to be a more intense form of care coordination for higher acuity members. In practice ECC has been operationalized by the RAEs to be a care plan or a face-to-face intervention.

Measurement and Timeline
Currently ECC is the primary way the Department measures, through a performance pool metric, how the ACC program is managing care for a specific set of high cost and high acuity members as identified by the Dept. The Dept. requested expedited input from the PC&E Subcommittee relative to what they determine should be the key components and best practices for Extended Care Coordination in the ACC program.

Recommendation
The P&CE Subcommittee proposes the following key components and best practices for Extended Care Coordination:

1. Responsibility
    a. Best Practice: 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: 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.

4. Monitoring Plan
    a. Best Practice: Care coordinator documents essential communications, goal progress, and updates. The care coordinator 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: 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 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.