Enhanced Care Coordination (ECC)

Presented by Benefit Managers:

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ECC Basics Agenda

- What is ECC
- Benefits of ECC
- Report/explanation of columns
- Expectations

What is ECC

A Care Coordination model that targets members based on their clinical conditions, utilization, and risk factors.

- Increased clinical focus

- Utilizing tools (eg. impact report, gaps in care, admissions reports)

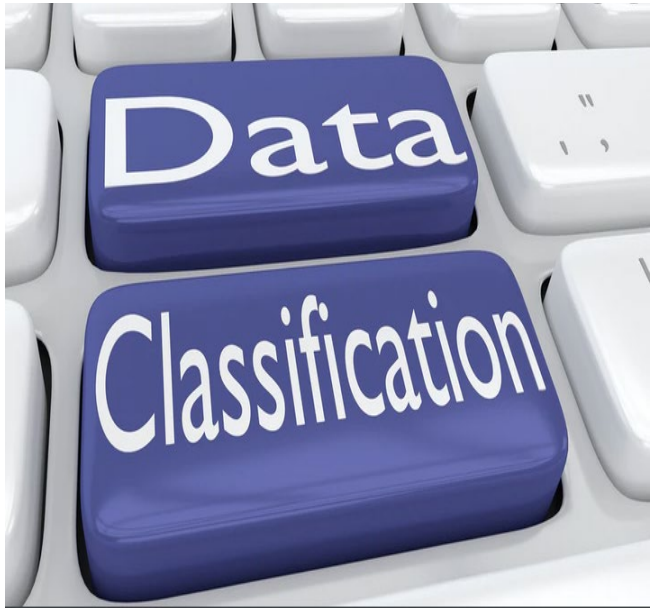
- Flexible model that targets members with increased intervention as needed based on their medical and mental health needs.

- Frequent contact with high risk, medically complex members to improve outcomes, assist with navigating health care system, and maximize quality of life.

Benefits of ECC

- Research shows that applying interventions at the right time will have a significant impact on the quality of a members life, as well as reduce costs.

Determination of Ratings



- Based on the claims information for the last 12 months
- Care levels determined by utilization, overall claim cost, number of chronic conditions, and overall risk

ECC Care Levels

1

- Highest risk members
- High level of intervention

2

- At highest risk for decline
- Highest level of intervention, in hopes of reversing trend, improving outcomes

3

- New members default to level 3
- Base model of intervention
- Focus on prevention and quality primary care

4

- Low level of intervention
- Focus on prevention and relationship building

	A	B	D	I	J	K	L	M	N	O	P	Q	R
1	MKT_BUSN_SEG_DESCR	CARE_SYSTEM	CARE_LEVEL	MEMBER_FIRST_NAME	MEMBER_LAST_NAME	TOTALALLOWED	GENERIC_DRUG_COUNT	IP_STAY_COUNT	ER_VISIT_COUNT	ENROLL_ADJ_CRI	CHRNC_COND_CNT	CMPLX_MAL_INDC	IMPCT_INDX_SCORE
2	MSHO	[redacted]	1	[redacted]	[redacted]	47223.89	16		1	5.352285447	6	N	50.66666667
3	MSHO	[redacted]	1	[redacted]	[redacted]	32294.65	23	2	2	2.925402261	21	N	67.16666667
4	MSHO	[redacted]	1	[redacted]	[redacted]	39607.63	11			4.746947918	8	N	44.16666667
5	MSHO	[redacted]	3	[redacted]	[redacted]	12584.46	7			1.450390057		N	15.66666667
6	MSHO	[redacted]	1	[redacted]	[redacted]	22334.05	17		2	5.585135344	8	N	57.33333333
7	MSHO	[redacted]	1	[redacted]	[redacted]	51649.73	8			3.64676955	8	N	40.83333333
8	MSHO	[redacted]	2	[redacted]	[redacted]	23071.01	9			2.864559488	7	N	34.16666667
9	MSHO	[redacted]	3	[redacted]	[redacted]	5891.13	6			1.220589134	3	N	13.16666667
10	MSHO	[redacted]	1	[redacted]	[redacted]	43254.16	29		1	5.202094036	15	N	61.5
11	MSHO	[redacted]	2	[redacted]	[redacted]	7441.94	15			1.911754297	16	N	37.33333333
12	MSHO	[redacted]	1	[redacted]	[redacted]	126969.85	35			8.472755721	11	Y	60.83333333
13	MSHO	[redacted]	1	[redacted]	[redacted]	86255.36	23		2	6.066713167	11	N	68.5
14	MSHO	[redacted]	1	[redacted]	[redacted]	20136.29	16			4.880515484	9	N	45.66666667
15	MSHO	[redacted]	2	[redacted]	[redacted]	3752.13	7		3		4	N	26.66666667
16	MSHO	[redacted]	1	[redacted]	[redacted]	31184.06	14			5.165216691	12	N	49.33333333
17	MSHO	[redacted]	1	[redacted]	[redacted]	52322.51	16			7.771193964	10	N	53.83333333
18	MSHO	[redacted]	3	[redacted]	[redacted]	2814.3	4		2		4	N	20.16666667
19	MSHO	[redacted]	3	[redacted]	[redacted]	11316.3	7			1.644591435	7	N	24.83333333
20	MSHO	[redacted]	3	[redacted]	[redacted]	3414.15	8		1		4	N	18.5
21	MSHO	[redacted]	1	[redacted]	[redacted]	19585.36	13			4.497039855	7	N	40.66666667
22	MSHO	[redacted]	1	[redacted]	[redacted]	14612.79	23			4.136519556	11	N	47
23	MSHO	[redacted]	3	[redacted]	[redacted]	8078.64					6	N	13
24	MSHO	[redacted]	3	[redacted]	[redacted]	2615.39	10			1.027170918	5	N	16.33333333
25	MSHO	[redacted]	1	[redacted]	[redacted]	59568.03	34		1	5.802471286	14	N	63.83333333
26	MSHO	[redacted]	2	[redacted]	[redacted]	43913.55	10			4.153389918	5	N	38.16666667
27	MSHO	Fairvie	1	LAVONNE	[redacted]	30598.98	25		3	4.838365499	11	N	65.5

Hid columns C, E, F, G, H in order to present applicable columns

ECC Report Categories	
Label	Meaning
CARE_LEVEL **Column D**	○ Level 1 is highest risk/utilization. ○ Level 2 is Medium risk/utilization, this group has a higher number of recommended activities due to them being "at risk" of moving to level 1. ○ Levels 3 & 4 is Low risk/utilization.
TOTALALLOWED **Column K**	Total allowed in claims in last 12 months (rolling 12 month, not calendar year)
GENERIC_DRUG_COUNT **Column L**	Number of generic drugs filled in past 12 months
IP_STAY_COUNT **Column M**	Number of inpatient hospitalizations in past 12 months
ER_VISIT_COUNT **Column N**	Number of ER visits in past 12 months
ENROLL_ADJ_CRI **Column O**	The Cost Resource Index (CRI) is a relative score with values from 1 to 40+ predicting the expected future total cost of each member for a one year period of time following the retrospective measurement period. The index is relative to the average cost for all members, so for example, a person with a CRI = 20.0 would have a predicted cost 20 times the average cost patient (average CRI = 1.0).
CHRNC_COND_CNT **Column P**	Number of member's chronic conditions, as identified by claims in past 12 months
CMPLX_MAL_INDC **Column Q**	Yes/No indicator for whether member has a malignancy diagnosis per claims.
IMPCT_INDX_SCORE **Column R**	Another risk score, ranking members from low risk to high risk. The higher the number, the greater the member's risk for functional/medical decline.

	I	J	S	T	U	V	W	X	Y	Z	
1	MEMBER_FIRST_NAME	MEMBER_LAST_NAME	UNIQUE_PROVIDER_COUNT	PSYCHOTHERAPY_SERVICE	BIPOLAR_DISORDER_COND	BIPOLAR_DISORDER_UNTREATED_RX	DEPRESSION_COND	DEPRESSION_UNTREATED_RX	SCHIZOPHRENIA_COND	SCHIZOPHRENIA_UNTREATED_RX	P
2		[redacted]	7	0	**NP**		**NP**		NP		
3			8	0	**ICD**	Y	**TRT**	N	ICD		
4			1	0	NP		NP		NP		
5			2	0	NP		NP		NP		
6			4	0	NP		**Rx**		NP		
7			1	0	NP		TRT	N	NP		
8			4	0	NP		TRT	N	NP		
9			1	0	NP		Rx		TRT	N	
10			5	0	**TRT**	N	**BTH**		TRT	N	
11			2	0	NP		NP		NP		
12			13	0	NP		Rx		NP		
13			7	0	NP		TRT	N	NP		
14			6	0	NP		BTH		NP		
15			2	0	**ICD**		NP		NP		
16			5	0	NP		**ICD**	Y	NP		
17			5	0	NP		NP		NP		
18			3	0	NP		NP		NP		
19			2	0	NP		NP		NP		
20			3	0	NP		Rx		NP		
21			2	0	NP		TRT	N	NP		
22			1	0	ICD		NP		NP		
23			0	0	NP		NP		ICD		
24			4	0	NP		BTH		NP		
25			4	0	NP		ICD	Y	NP		
26			2	0	NP		NP		NP		Y

Mental Health Indicators – Schizophrenia, Bipolar, Depression	
Label	**Meaning**
NP	Condition is not present
TRT	Condition is present, as evidenced by member receiving treatment for that condition.
ICD	Condition is present, based on at least one claim submitted with that diagnosis, but no evidence of member receiving treatment specifically for that condition.
RX	Condition is present, member has received medication to treat condition but has not received other treatment based on claims.
BTH	Condition is present, and there are claims and medication prescribed to treat that condition.
Y	Condition is present, and member has not received appropriate medication(s) to treat that condition.
P	Condition is present and potentially untreated. Member either is not receiving appropriate medication or is not filling medication timely.
N	Condition is present and is treated. Member has received both treatment and medication for condition.
D	Condition is present but likely untreated because medication has been discontinued. More than 120 days have lapsed since last medication fill.

This report stratifies membership into four care levels: 1, 2, 3, or 4. **The purpose of this report is to gain a clearer clinical picture of their members, their utilization, and risk factors**.

The report also includes a grid with recommended care coordination activities for members in each care level. This does not change what a Care Coordinator (CC) must do, but rather points to resources and recommendations for best practices of managing at risk members in order to decrease unnecessary hospitalizations and improve quality of care.

Medica Enhanced Care Coordination (ECC) Recommendations

**See attachment

Updated 7/1/2021

Medica Enhanced Care Coordination (ECC) Recommendations*
Applies to All Institutional & Community Members

Timeline for assessments, care plans and other requirements remain the same. Regardless of care level, care plan should be monitored and updated as needed when care coordinator has contact with member and/or with changes in member's condition.			
Care Level	1	2	3 & 4
	New enrollment and members missing from the report will be defaulted to a Care Level 3.		
Additional Telephonic Contacts for Community Members based on level	Every other month	Monthly	Every 6 months
Additional Telephonic Contacts for institutional members	Every 6 months		
Members in an inpatient Hospitalization	Current transition process and follow up telephonically with member within 2 weeks post notification of discharge.	Current transition process and after discharge to home CC must attempt face to face visit within 5 business days and if feasible attend post hospital PCP visit. *For MSHO only, LSS readmission benefit if eligible	Current transition process and follow up telephonically with member within 2 weeks post notification of discharge.
ER 3 or > in 6 months, 10 or > in last year, or IP 4 or > in last year	**Suggested for members who have had multiple Emergency Room (ER) visits or Inpatient (IP) hospitalization, regardless of care level:** -During call or face to face visit with the member, discuss ER or IP reasons/utilization with member. -Provide education on *When and Where to Get Care*, document found on Care Coordinator website -Facilitate PCP visit if no preventive health visit in last year or no PCP visit post hospitalization -Assist member in establishing care with a PCP if needed **Suggested support for Level 1& 2 Members** -Attend PCP visit with member. If member is not interested, communicate to PCP re: member's ER and/or IP utilzation		
Available Resources to Consider	-Clinical Liaison consult -Clinical consult requested through Clinical Liaison (telephonic review of complex cases) -Interdisciplinary Team Consult, sign up in Sharefile (multidisciplinary team review of complex cases) -Referral to Complex Case Mgmt, Disease Management,and/or Tobacco Cessation, see referral form on Care Coordinator website titled *Complex Case Management/Health Support Referral Form*		
Definition: Institutional members are defined as members residing in SNF, customized living memory care unit, an ICF/DD, or a group home with on site 24 hour staffing. Community members are defined as all members not residing in an institution, regardless of waiver			

*The purpose of this document is not to cover contractual requirements, but rather to provide care coordinators with additional interventions that Medica recommends in managing members who have multiple chronic conditions, multiple hospitalizations and/or ER visits and are considered to be at risk members.

Examples of interventions:

- A member was in the hospital for elevated blood sugars; you follow up with member and find out their glucometer quit working a month ago and they did not follow up to get it repaired or get a new one. **Intervention: assist member with equipment needs and follow up with Diabetes maintenance.**

- Member calls you stating that they have taken several falls in the last week; thankfully nothing serious happened YET! **Interventions: investigation of cause of falls, follow up with Primary Care Physician (PCP), contact pharmacist to review medications, Physical Therapy to assess equipment needs/strength, Nurse Practitioner consult, home visit to assess environment, food security etc.**

- Member has had 30 Emergency Room (ER) visits in the last six months. The member's complaints are vague and they are sent home. You find out that the visits are generally in the nighttime hours. You speak to member and they state they are not sleeping well at night and become anxious**. Intervention: update PCP, consult with member's mental health providers or Medica Behavioral Health if appropriate, assist member with ideas to relax before bedtime, etc**

Know the resources to assist members to maintain their best life!

Supplemental benefits: visit the Medica CC site https://www.medica.com/care-coordination/policies-and-guidelines

Benefits Guidelines —

- Adult Day Services and Adult Day Services Bath (MSHO and MSC+) – (PDF)
- Benefit Guideline Bridging (PDF)
- Condition-Based Health Education with CHW Solutions (PDF)
- Durable Medical Equipment (DME) – (PDF)
- Extended PCA (PDF)
- FOODRx with Second Harvest Heartland (PDF)
- Gloves (PDF)
- Home Care Nursing Service (formerly Private Duty Nursing) (MSHO and MSC+) – (PDF)
- Homemaking (PDF)
- Hospice (PDF)
- Housing Stabilization Services (PDF)
- Incontinence Products (PDF)
- Independent Living Skills and Independent Community Living Skills (PDF)
- Nutritional Products (MSHO, MSC+, SNBC) – (PDF)
- Reemo Smartwatch (MSHO Supplemental Benefit) – (PDF)
- Re-Admission Prevention Benefit Guideline (MSHO) – (PDF)
- Supplemental Benefits – 2021 (PDF)
- Memory Fitness Program (MSHO & ISNBC Supplemental Benefit) – (PDF)

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To be the trusted health plan of choice for customers, members, partners and our employees.

VISION

To be trusted in the community for our unwavering commitment to high-quality, affordable health care.

VALUES

Customer-Focused • Excellence • Stewardship • Diversity • Integrity

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Thank you for your time