ENHANCED COMMUNITY CARE MANAGEMENT

WHAT IS ECCM

Enhanced Community Care Management (ECCM) is a non-billable service currently offered for Highmark Medicare Advantage, Highmark Individual ACA, and HealthyWay members to support the most complex and vulnerable patients. Started in 2016, the goal of the program is to help members live their best lives possible while maintaining their independence in the community.

The ECCM team of health care professionals works in collaboration with a member's primary care physician (PCP), specialists, pharmacists, and others to coordinate care. The ECCM interdisciplinary team of clinicians and care coordinators are highly trained in health literacy and motivational interviewing which provides a unique approach to care by helping patients identify small steps that can lead to successful management of their medical conditions.

ECCM has managed thousands of high-risk Highmark members since its' inception. It has consistently made Total Cost of Care (TCOC) more efficient while receiving over 90% patient satisfaction.

HOW ECCM WORKS

ECCM helps members at high risk and with serious illness.

For members with care coordination and transition of care needs, a Care Coordinator will:

- Work with the member to identify barriers to self-managing their chronic conditions
- Assist with ensuring the member understands their disease and diagnosis
- Help the member understand test results and what to expect from upcoming procedures
- Help manage the member's appointments
- Support the member with medication management
- Assist the member with social determinants of health

For members who have advanced illness and need Supportive and Palliative Care, a team of Advanced Practice Providers (APPs), Registered nurses (RNs), Social Workers (SWs), and Care Coordinators will:

- Create a whole-person-advance care plan (centered on the member and their family)
- Help with pain and symptom management through medical and non-medical interventions in coordination with the member's Primary Care Physician (PCP)
- Provide more frequent check-ins

- Help with care plan support, including monitoring of conditions and when to take medications
- Provide the family caregiver with education, counseling, and/or respite
- Assist with decision making, clarifying care priorities, and helping to match treatment and services to the member's goals
- Assist with social determinants of health

HOW TO REFER A MEMBER TO ECCM

If you have a patient who you believe could benefit from ECCM, please refer them through any of these channels:

- Epic: Ambulatory Referral to ECCM
- Phone: 844-438-3226 (844-GET-ECCM)
- Fax: 844-978-2756
- Email: eccmreferrals@highmark.com
- Care Port
- Highmark's HHUM Portal

WHERE TO GET MORE INFORMATION

If you have any questions, the ECCM team can be reached at 844-438-3226 (844-GET-ECCM).