Provider and Community Experience Subcommittee

Program Improvement Advisory Committee

Presented by: Anita Rich

October 2020

Purpose/Charter

To assess the experience of providers and community-based organizations (CBOs) within the ACC by identifying, prioritizing, and investigating key challenges and solutions to best support and build capacity within providers and CBOs, to foster collaboration and development of a health neighborhood between providers, CBOs, and RAEs, and to leverage their collective strengths in broader regional and state improvement work.

Current Voting Membership

ACC PIAC Provider and Community Experience Subcommittee Voting Membership		
Name	Organization	Representing
Joanna Martinson	North Colorado Health Alliance	Co-chair (PIAC member)
Kathie Snell	Aurora Mental Health Center	Co-chair
Cathryn Griffith	Family member of Health First Colorado member	Member or family member of Health First CO member
Shera Matthews	Doctors Care	Family Practice
Pat Cook	CO Gerontological Society	Older adults/seniors
Michelle Hoye	MindSprings Health	Behavioral health
Jamie Haney	Developmental Disabilities Resource Center	HCBS/LTSS
Andrea Loasby	Children's Hospital Colorado	Pediatrics
Lila Cummings	Colorado Hospital Association	Hospitals
		Public health
Gail Nehls	Envida	Community-based Organization
Carolyn Green, MD	Retired provider	At-large
Anita Rich	Retired/community member	At-large

Objectives

1) Strengthen the Health Neighborhood through exploring access to specialty care, Non-emergent Medical Transportation (NEMT), Hospital Transformation Program, and other relevant efforts/programs.

2) Understand the best practices and outstanding challenges to supporting and transforming practices and their relationships with CBOs in the provision of care to Health First Colorado members and their families.

3) Explore the current models and programming for care coordination and chronic disease management within Colorado in the context of both clinical care linkages and the social determinants of health.

Current Objective #1 Work

Objective #1: Strengthen the Health Neighborhood through exploring access to specialty care, Non-emergent Medical Transportation (NEMT), Hospital Transformation Program, and other relevant efforts/programs.

- Discussion with Betsy Holt and Tracy Johnson on the Telemedicine Stakeholder Engagement Process.
- Discussion with HCPF staff and the CU School of Medicine regarding their eConsult program.

➢ Access to Specialty Care Workgroup

Co-Chairs: Lila Cummings & Vicente Cardona
Met on 7/30/20, 8/27/20 and 9/24/20

Current Objective #2 Work

Objective #2: Understand the best practices and outstanding challenges to supporting and transforming practices and their relationships with CBOs in the provision of care to Health First Colorado members and their families.

- Discussion with Betsy Holt and Tracy Johnson on the Telemedicine Stakeholder Engagement Process, including provider trainings.

- Discussion with Colorado Health Institute staff (contracted with HCPF) regarding the Primary Care Alternative Payment Model for 2021.

Current Objective #3 Work

Objective #3: Explore the current models and programming for care coordination and chronic disease management within Colorado in the context of both clinical care linkages and the social determinants of health.

- Care Coordination Workgroup

  Co-chairs: Joanna Martinson & Jen Hale-Coulson
  Met on 7/2/2020, 7/14/2020, 8/11/2020, 8/25/2020, 9/8/2020, and 9/22/2020.

  10 priority areas of focus identified:

1) Improve the timeliness and relevancy (location, availability, feasibility for family) of care coordination provided to children & youth with complex mental health/behavioral health needs prior to & following discharge from the hospital.
2) Increase the care coordinator presence and role in problem solving for access to services & supports, with and for members who live in rural communities and struggle to find timely, adequate, reliable, and relevant mental and behavioral health services.
3) Improve the timeliness and relevancy (location, availability, feasibility for family) of care coordination provided to children and youth with complex physical health needs who are in the care of families who live in rural communities, and are also lacking in resources and knowledge.
4) Identify best practices that glean real results (reduced cost, improved outcomes). And then a caseload size that matches such best practices.
5) How to communicate to the State what we are doing to demonstrate effective work.
6) Standardize a process of transfer of members services from RAE-to-RAE.
7) Identify quality benchmarks/components for care coordination and care management across the State.
8) Identify a set of care coordination principles that can be used statewide.
9) Define care management and care coordination. At least have standard language to describe the services so the language is the same region-to-region to provide clarity and level expectations for regions and Members as well as the community.
10) Create consistency in communication: RAEs with each other; RAEs with providers, physical, and behavioral; and RAEs with Community organizations. Required elements and protocols for communication between all parties and organizations involved with an individual and family regarding services they would be, are or will be receiving.

P&CE Recommendation to PIAC

The P&CE Subcommittee is seeking to formalize a statewide RAE-to-RAE Member transition process and standardized referral form. This will establish pathways for continuity of care and enhanced communication processes regarding physical or behavioral health needs.

- HCPFs support and recommendation for a statewide RAE-to-RAE Member transition process.

- Use of standardized Care Coordination Referral Form/RAE-to-RAE Member Transitions of Care Process.

- Use standardized RAE email to ensure that information is tied to RAE vs. individual working for the RAE.

(*see P&CE Recommendation Memo*)

Discussion/ Questions

Contact us!

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