COLORADO
Department of Health Care Policy & Financing

To: The ACC Program Improvement Advisory Committee (PIAC)
From: Provider and Community Experience (P&CE) Subcommittee
Date: October 2020
Subject: RAE-to-RAE Member Transitions of Care Process/Care Coordination Referral Form

Recommendation

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 Member RAE-to-RAE transition process.
- Use of standardized Care Coordination Referral Form/RAE-to-RAE Transitions of Care Process (see attached draft form).
- Use standardized RAE email to ensure that information is tied to RAE vs. individual working for the RAE.

Executive Summary

Each RAE has their own referral process and often information is lacking and/or next steps unclear. The use of this standardized document and adherence to workflow will improve health outcomes and ensure consistency for Members throughout the state.

Background

Discussions have highlighted transitions of care and inconsistencies between RAEs as a primary objective for resolution. The Care Coordination Workgroup of the P&CE Subcommittee met with the RAE delegates three times during meetings of the Provider and Community Experience Subcommittee in gathering information regarding the current RAE to RAE transition process and issues. The workgroup and co-chairs participated in six meetings to research, look at current data, discuss, incorporate the information from the RAEs and the P&CE Members in developing this recommendation. The transition process is challenging for providers and Members, including knowing who to contact for assistance, as well as not understanding Member needs prior to treatment. Additional concerns were Members being 'lost in transition' and experiencing gaps in care as a result. Adherence to treatment plans/medications was also a problem noted when transitions between RAEs fails. The following data is supportive of the current amount of transition occurring RAE-to-RAE, number of complex care Members that could be affected by the change:

- Overall, 12.83% (~146,007) changed RAEs during the last fiscal year
- 46% of the complex Members are currently in extended care coordination
- 3% (~33,760) of the ACC population is considered complex (according to the Department's definition of over $25/year)

Process

- A Member is identified in the process of transitioning to a different RAE;
- Current RAE care coordinator complete transition form and sends to identified new RAE;
- Upon receipt of referral form the new RAE care coordinator will contact current care coordinator to ensure access to ongoing treatment by completing warm hand-off between RAEs;
    - Referring and Receiving RAE care coordinator(s) determine next steps regarding finding a new medical home, and connecting with transferring PCMP and behavioral health provider to communicate ongoing and immediate treatment needs;
    - Referring and Receiving RAE care coordinator(s) determine next steps regarding helping the Member navigate reattribution; and
- Quarterly care management and provider survey to monitor referral program for the year 2021.

Strategy Screens:

How Members might be impacted by the process?

- The new process will ensure continuity of care for the Members.
- Preventing adverse outcomes by assisting with getting appointments and ability to get medication. Members will have more seamless transitions between RAEs and improved care coordination.
- Attending continuously to Member bio-psycho-social needs thereby, decreasing potential issues in physical or behavioral health, and the overall disruption in care if the social determinants are not addressed.

How specific Member populations will be impacted by the recommended process?

- For Members with complex and special needs it is important that transition from one RAE to another goes smoothly as to not interrupt care, prescriptions, behavioral health etc. and to be sure Member is supported with SDOH needs. The new process will ensure continuity of care for the Members.
- Preventing the need of a higher level of care for physical or mental health. This may be preventable if services could be easily continued.

How are providers impacted by the recommended process?

- Prevent issues with attribution and payment, inheriting Members in crisis.
- Less time is spent trying to obtain information; thereby, preventing disruption in care, providers not working at the top of their licenses.
- If the new case manager has access to the old case manager, they can help expedite medical records info for the new provider, making care transitions smoother.

How is equity advanced by the recommended process?

- A smooth transition ensures that all Members receive the services they need.
- Through smooth transition, all Members can obtain the correct type of care - it is individualized and meets their current expressed needs.

How is integration of physical and behavioral health addressed by the recommended process?

- Member information is coordinated in a way that all bio-psycho-social needs are examined and addressed.
- That is achieved through the warm hand off between RAEs and the form that lists both physical and behavioral health needs.

How is care coordination assured by the recommended process?

- Establishing a unified process and standards.
- Completion of new referral form containing Member strengths and needs.
- Establishment of a centralized email box at each RAE that is monitored by several managers to encourage delegation of case and care coordination between RAEs, which is currently lacking.

What are the costs, quality, and access implications by the recommended process?

- Appropriate care/coordination of care activities leads to decreased costs, increased population health, increased positive experiences of Members, and provider satisfaction.
- Members will not fall through the cracks, tests and services will not be duplicated, access to providers at the new RAE will improve with the new RAE case manager supporting the Member.
- No direct cost as RAES will monitor own email box. The process, monitoring and between RAEs will improve quality of RAE transitions. Members and providers will be provided with pertinent information that will lead to better access to care managers and continuity of care between RAEs.

How is success measured?

- Statewide consistency in care/workflow process will decrease complaints about Members falling through cracks due to transition from one RAE to another. Information can be gathered through quarterly care manager and provider surveys.
- Percentage of decrease in hospitalization or emergency room use of transitioned Members.

Implementation Timeline

- Approval and implementation of the transition process.
- When approved a sharing of appropriate care coordination email addresses and added to the transition form.
- All RAEs trained in the process.
- Development of a data collection process.

DRAFT

Care Coordination Transitions of Care (RAE to RAE) Referral Form

Please use this form when referring Health First Colorado (Colorado's Medicaid Program) Members transitioning between RAEs for care coordination services. ***Please follow-up/respond to the referring RAE within 2 business days of receiving this referral.***

REFERRING FROM	
Referring RAE: Choose a RAE	**Referral date:**
Person Referring: (name/number/email)	**Referring RAE-Lead Care Coordinator** *(name/number/email):*
RAE Receiving Referral: Choose A RAE	**Receiving RAE contact info** Choose an email

MEMBER INFORMATION	
Member Name:	Member DOB:
Member Phone:	Health First Colorado ID#:
Member Address:	Member Email Address:
Primary Language:	
COUP? If yes, are they locked-in?	COMPLEX?
Previous Primary Care Medical Provider: *(old RAE)*	New Primary Care Medical Provider: *(new RAE)*
Alternate Contact – Parent/Guardian or Other Family Member/Caretaker (if applicable)	
Alternate Contact Name:	Alternate Contact Phone:
Relationship to Member:	
Member has consented to contact and exchange information with this person: ☐ Yes ☐ No	

Care Coordination Needs (check all that apply and elaborate for any box checked)

- ☐ Multiple chronic medical conditions
- ☐ Behavioral health and/or substance use issues
- ☐ New chronic condition
- ☐ Non-adherence to treatment plan
- ☐ Due for well-child visit
- ☐ Pregnancy/postpartum support and service coordination needs
- ☐ Transitions of care (e.g., discharge from hospital, ER, skilled nursing facility, etc.)
- ☐ Full-benefit Medicare-Medicaid enrollee
- ☐ Multiple unmet social needs
- ☐ Inadequate support system
- ☐ Difficulty accessing/applying for benefits
- ☐ Foster care medical and/or behavioral health care coordination needs (e.g., being seen by a PCP within one week of placement)
- ☐ Requires services of a PCP, dentist, specialist, and/or behavioral health provider
- ☐ Urgent Medication Needs (Rx refills)
- ☐ Other (please describe)

OTHER NOTES/CONCERNS (i.e., outstanding medical issues, SDoH needs, MH treatment or medication adherence concerns that need to be addressed ASAP)

Systems of Care Involved with Member (check all that apply and elaborate for any box checked)

- ☐ Single-Entry Point (SEP)
- ☐ Community Centered Boards (CCB)
- ☐ Department of Human Services (DHS)
- ☐ Skilled Nursing Facility (SNF)
- ☐ Residential Treatment Facility (RTC)
- ☐ HCBS Care Manager
- ☐ Behavioral/Mental Health
- ☐ Other (please describe)
- ☐ Home Health Providers
- ☐ Private Duty Nurse (PDN)
- ☐ Foster Care
- ☐ Other HCBS Waiver Provider(s)
- ☐ Other Long-Term Services and Supports (LTSS)

Systems of Care (elaborate for any box checked, including name entity, name of person and contact information).