COLORADO
Department of Health Care Policy & Financing

To: The ACC Program Improvement Advisory Committee (PIAC)
Cc: The Department of Health Policy and Financing
From: Provider and Community Experience Subcommittee
Date: October 2020
Subject: RAE to RAE Transitions of Care Process/Care Coordination Referral Form

Executive Summary
The Provider and Community Experience Subcommittee is seeking to formalize a statewide RAE to RAE transition workflow to establish pathways for continuity of care and enhanced communication processes. Currently, 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 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 providers fails.

Process
- A member is identified in process of transition to a different RAE;
- Current RAE care coordinator complete transition form and send 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?
- 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.
- The new process will ensure continuity of care for the Members.

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

- Members who experience RAE changes due to hospitalizations, social determinants of health, or frequent provider changes will have more continuity of care.
- Preventing the need of a higher level of care for physical or mental health. This may be preventable if services could be easily continued. The social determinants of health may also be impact and could lead to disruption in housing or food security. Basically, people may not have a positive experience, overall population health decreases, and costs can increase. This is the opposite of meeting the goals of the Triple Aim. Additionally, providers may become frustrated, disrupting the goals of the Quadruple Aim.
- 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.

How are providers impacted by the recommended process?

- Prevent issues with attribution and payment, inheriting members in crisis.
- Members who experience RAE changes due to hospitalizations, social determinants of health, or frequent provider changes will have more continuity of care.
- Less time is spent trying to obtain information; thereby, preventing disruption in care, providers not working at the top of their licenses, and bringing the transition process in alignment with the Quadruple Aim.
- 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?

- Members with social determents of health that lead to RAE changes will experience more equity and continuity of care.
- Through smooth transition, members can obtain the correct type of care- it is individualized and meets their current expressed needs.
- A smooth transition ensures that the member receives the services they need.

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

- The form lists both physical and behavioral health needs and care managers will be able to address both when assisting with RAE transfers.
- Through smooth transition, member information is coordinated in a way in which care for all bio-psycho-social needs are examined and addressed.
- Transition of care warm handoffs ensure that the new RAE knows what physical and BH needs the Member has and can support them Member with both needs.

How is care coordination assured by the recommended process?

- Establishing a unified process and standards.
- With the new referral form.

- By encouraging more coordination between RAEs and ensuring there is 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.
- There would be a stronger opportunity for appropriate care coordination activities when new providers and care managers are appraised of members' strengths and needs.

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

- Decreasing high cost care, hospital, and emergency department utilization as a result in preventing gaps in care and coordination.
- 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.
- Appropriate care/coordination of care activities leads to decreased costs, increased population health, increased positive experiences of members, and provider satisfaction. Alignment with the Quadruple Aim.
- 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.

How is success measured?

- Percentage of decrease in hospitalization or emergency room use after transition.
- Through quantitative and qualitative data. This may include number of times "communication loops" were closed, patient satisfaction surveys, provider satisfaction, longitudinal data of patients' health/claims, number of ER/hospital visits pre/post transition, number of prescriptions, etc. There needs to be a high emphasis of the appropriate data collection (e.g. what data will get the answer to the question we are asking), instead of more data for data's sake.
    - 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.

Recommendations

- Standardized Care Coordination Referral Form/RAE to RAE Transitions of Care Process (see attached form).
- Standardized RAE email to ensure that information is tied to RAE vs. individual working for the RAE.
- HCPFs support and recommendation for statewide RAE adoption.

Measure for Success

- Percentage of decrease in hospitalization or emergency room use after transition.
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Implementation Timeline

The form is nearly completed (lacking general care coordination emails from every RAE) and can be disseminated and explained to all RAEs once approved by the state. This would be considered a long-term solution to the current problem existing regarding this process.