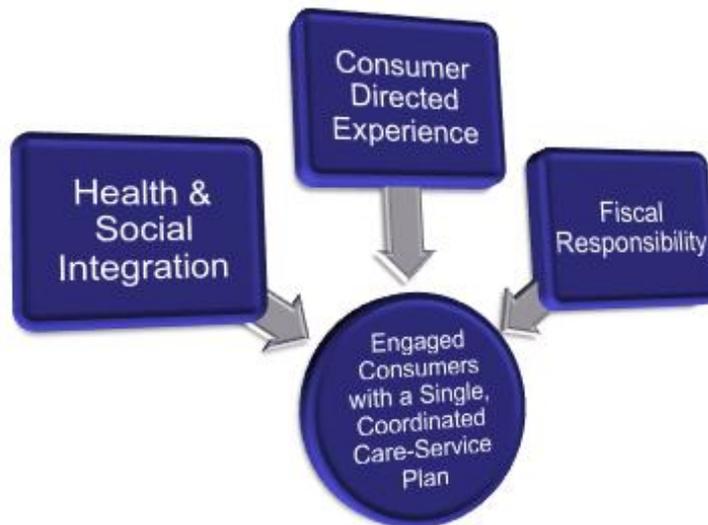


Care and Service Coordination for Long Term Services and Supports

Definitions, Principles and Provider Practice Recommendations



Care Coordination Subcommittee
Community Living Advisory Group

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Care Coordination Subcommittee Subcommittee Charter

Background on Care Coordination Subcommittee

A. CARE COORDINATION SUBCOMMITTEE - CHARTER STATEMENT¹

1. To Promote Continued Evolution of Independent Living (IL) and Quality of Life Principles into the Colorado Long Term Services and Supports (LTSS) system:

- **Social Service Agencies** including but not limited to Independent Living Centers, aging service providers, agencies serving children, Counties, 211, and;
- **LTSS Providers** including but not limited to Single Entry Points, Community Centered Boards, In Home Support Services, Assisted Living Facilities, Home Health Agencies, ADRC/ARCHs, Families, Advocates, Developmental Disability residential care, etc.

2. To Promote IL and LTSS values (*standards, guidelines, recommended practices*) to those whom the LTSS system coordinates with, including:

- **Medical Providers** including but not limited to Primary Care Medical Providers, Behavioral Health Organizations, Post-acute facilities, Skilled Nursing Facilities, Home Health, PACE, hospitals, psychiatric institutions, The Colorado Nursing and Medical Boards, etc.
- **State / Local Agencies** including but not limited to HCPF, CDPHE, DHS, RCCOs, Counties; as well as commercial and private market entities, housing and transit operators, etc.

3. To Increase Consumer Control over their care and life circumstances through self- activation, self-direction, self-care and self-reliance strategies.

4. To Promote a long-range LTSS Vision with the following goals:

- a) A well-coordinated medical, behavioral, and social services delivery system, with
- b) An unduplicated, single, unified care coordination plan for each consumer,
- c) Among all state agencies and private practice providers, in order to
- d) Improve the consumer experience, health status and, social integration, and fiscal responsibility objectives of the LTSS Triple Aim.

5. To Identify Systemic Care Coordination Issues and Solutions requiring legislation, agency, provider or policy changes to achieve operational efficiency and cost-effectiveness, including:

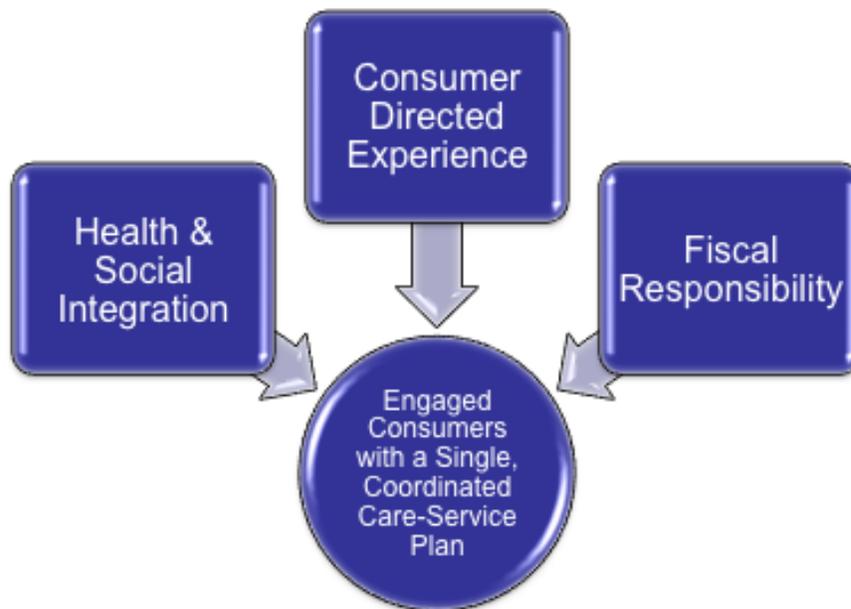
- **Data and analytics:** measure and manage program trends and care coordination, impact evaluation, e.g. service utilization, health status, goal attainment, quality, cost, etc.
- **Information Sharing:** system-wide, consistent, and secure data exchange
- **Agency capacity building:** case load, qualifications, training, efficiencies, standards, etc.
- **Workforce:** standards, training, compensation, working conditions, client safety, etc.

¹ HCPF Care Coordination webpage at: www.colorado.gov/cs/Satellite/HCPF/HCPF/1251631966990

B. LTSS TRIPLE AIM OBJECTIVES²

We have expanded the original definition, with its focus on medical care, to focus on LTSS Objectives and terminology. Section III below provides more detailed definitions of these three key **LTSS Triple Aim** principles.

- ❖ **Improved Consumer-direction, Experience:** Improving the consumer experience of medical, behavioral, health and social services through enhanced program performance and coordination affecting seniors, children and adults with disabilities.
- ❖ **Improved Health and Social Integration:** Improving and/or maintaining individual health and social well-being.
- ❖ **Fiscal Responsibility:** Decreasing costs associated by avoiding duplicative and non-value added services and unnecessary or unwanted medical care.



² Long-Term Services and Supports Strategic Planning Report, HCPF, June, 2012

Figure A.
LTSS Triple Aim Objectives
 Linking Consumers and Providers through
 Quality Performance Measures

Improved, Consumer-Directed Experience	Improved Health and Social Integration	Fiscal Responsibility
<i>Promoting self-direction and independent living across the medical, behavioral health and social service system, within home and community based programs, appropriate to each consumer's needs, capabilities and aspirations.</i>	<i>Promoting optimal health, independence and quality of life. Assuring the right services at the right time, by the right providers and/or natural community supports with quality metrics linking medical, behavioral and LTSS performance.</i>	<i>Lowering avoidable costs by reducing duplicative, unnecessary or unwanted medical care or social services. Lowering costs through self-care support; preventing secondary chronic conditions, disabilities and injuries.</i>
1. Independent Living	1. Early Periodic Screening, Diagnosis and Treatment for Children	1. Social Determinants of Health
2. Informed Consumer Choice	2. Accessibility: Adherence to Americans with Disabilities Act (ADA)	2. Personal Health Responsibility
3. Home and Community Living	3. Service Quality and Performance	3. Value-based Care/Services
4. Consumer/Family Centered	4. Cross-disability Inclusion	4. Cost Containment
	5. Metric Selection	5. Medical Cost Reduction through LTSS Providers

Figure B.

Care-Service Coordination Provider Practice Recommendations

Linking Consumers and All Providers with a Single, Coordinated Care-Service Plan

<i>People</i>	<i>Processes</i>	<i>Systems</i>
<p><i>System-wide training in disability cultural competency is reflected in Case Management Agency and RCCO HR policies and staff hiring; Seniors and Persons with Disabilities serve on agency Boards and committees.</i></p> <p><i>Disability Strategic Plans & benchmark are implemented.</i></p>	<p><i>Coordination protocols and quality metrics aim to utilize a single, coordinated care plan. Consumers and LTSS in-home work force support medical providers with consumer health promotion and risk reporting to help reduce potential crises and avoidable medical events.</i></p>	<p><i>Innovations and efficiencies in use of IT and data exchange are pursued through grant funding, LEAN processes, use of consumer flow sheets, shared best practices. ADA consultants are utilized to achieve facility, program and information accessibility and 508 Website Compliance.</i></p>
Medical Provider and Agency Commitment to Seniors and Disability Competencies	Care-Service Protocols	Care/Service Duplication
Case Management Competency	Care-Service Referrals	Data/Information Exchange
Consumer Engagement and Feedback	Psychosocial Resources	Coordination Flow Sheets
Advanced Care Planning	Case Management Team Membership	LEAN-based Operational Efficiencies
Life Care Plans - Comprehensive Consumer Support	A Single, Coordinated Care-Service Plan	Communications Technology
Patient Coaching and Peer-to-Peer Counseling	Ombudsman Role	Information Accessibility and Health Literacy
	Use of In-Home Personal Care Attendants for Patient Monitoring	Accessibility of Facilities and Services
	Transitions of Care: Bi-Directional Practices	
	Patient Coaching and Peer-to-Peer Counseling	

C. Definitional Notes

Service/Care

To reflect the need to blend different service delivery paradigms, with different historic and operational cultures, rules and regulations, the combined term “Care/Service Coordination” is used in the definitions, principles and practice recommendations that follow. Many in the disability community object to having the services they provide sound as though they are in anyway equivalent to care provided by medical providers. See definitions section.

Physical vs. Cognitive Limitations

Readers must be cognizant of the differences between people with physical limitations or “disabilities” who possess decision-making capabilities, versus persons with cognitive limitations. Many people with mental and cognitive disabilities can and do self-direct, some completely with accommodations and some with assistance. Others may require authorized representatives (ARs) or court appointed guardians, and are not able to self-direct. This paper focuses on persons with cognitive abilities sufficient to self-direct some or all of their care/service making decisions.

Terminology

Readers might take note of the care with which advocates for, and people of the “disability community” use terminology reflecting 30 years of disability civil rights activities, Federal policy and court decisions to shifting the discussion from the “medical model” to a more community-based, social model. These definitions attempt to bridge differences in health care industry nomenclature and that of the “Independent Living” movement.

Strategies for Improved Long Term Care and Service Coordination

II. Core Definitions: The Meaning of Care versus Service Coordination

Long Term Care Coordination is a consumer-directed, team approach to the integration of care, services and support for optimizing health and social outcomes.³

1. Care vs. Service Coordination

The term “care” (e.g. medical care) connotes activities performed *by* professionals such as physicians and nurses who *care for* individuals based on professional skills, evidence, experience and judgment.

2. LTSS Services

The term “services” connotes a range of activities performed by a community of long term social *service* agencies (“service providers”)⁴ and agency or family *supports* (Long Term Services and Supports or “LTSS”) with or without requiring professional level training or credentials (e.g. CNAs, Personal Care Providers, Family Care Givers, Home Health Aids, Attendants, etc.). Many of these services can be provided using a consumer -directed delivery model and thus do not always require a provider agency.

LTSS agencies and services providers aim to enhance the ability of youth, aged and disabled consumers to engage in community integration and self-care activities to the maximum extent possible. Services may include personal care attendants, Independent Living skills training (“Living Well with a Disability” or a chronic medical condition), advocacy, peer counseling, use of adaptive technology (AT), efforts to secure accessible and affordable housing and transportation, employment and an active community life, arranged or provided by natural/family supports, state and community social service agencies. Examples of direct care services may include assistance with activities of daily living (showering, toileting, dressing, medicine delivery and wound care, food prep and eating assistance, shopping, etc.)

3. Service Coordination

Service Coordination involves the 'wrap around' set of activities performed outside the medical environment whereby Case Management Agencies (CMA) assess needs and make arrangements with a range of LTSS Providers. LTSS agency services may serve to help avoid hospitalizations, readmissions, ER visits, institutional placements, and other avoidable medical costs.

³ Some elders and people with Intellectual/Developmental Disabilities (I/DD) do not direct, due to cognitive limitations, and utilize authorized representatives, advocates with power of attorney or guardianship.

⁴ This would include a fiscal intermediary for consumers on the CDASS program.

4. Coordination Protocols for Shared Participants

Care-Service Coordination involves making arrangements for, communicating with and monitoring between medical, behavioral and long-term care providers, according to each person-centered plan.

Care-Service Coordination tasks among providers, agencies and individuals to the extent practical, include:

- Identification of shared clients among providers and agencies.
- Understanding of individual and shared responsibilities.
- Prioritization of tasks and consumer need; medical, behavioral, social.
- Sharing information on each organization's knowledge of and experience with clients essential to the health and welfare of each client.
- Coordination of scheduled meetings and contact information and preferences sharing data to the extent feasible.
- Engaging family members and advocates as needed.
- Assigning care managers from organizations as needed and designating one designated "go to" person, so that the client does not need to manage or be managed by multiple care managers.
- Regular contact between providers, agencies and consumers/families once the client or authorized representative has agreed to such contacts.
- Agreement on shared support functions.
- Making referrals to competent, appropriate and geographically closest providers of specific services, including transportation support.
- Work toward a single, unified care and service plan shared among care and service providers.

These care/service coordination processes are *a work in progress*.⁵

⁵ See: "Written Protocols to Strengthen Relationships and Improve Coordination" Between Regional Care Collaborative Organizations (RCCOs), Single Entry Points (SEPs), Community Centered Boards (CCBs), and Behavioral Health Organizations (BHOs). HCPF's Medicare-Medicaid Enrollees Advisory Subcommittee approved three "Protocols" December 11, 2012 as working drafts, until such time as they are amended to better reflect a less medical and more LTSS and Independent Living perspective, with greater consumer/advocate input.

The LTSS Triple Aim

III. LTSS Triple Aim Principles

The following represents a Long Term Services and Supports and Independent Living perspective to care and service coordination organized under the framework of ‘The LTSS Triple Aim’.

A. Improved, Consumer-directed Experience

Promoting self-direction and independent living across the medical, behavioral health and social service system, within home and community based programs, appropriate to each consumer’s needs, capabilities and aspirations.

1. Independent Living

The care/service coordination team supports the principles of Independent Living which includes self-direction and self-care to promote consumer health, work and life goals, within budget constraints.⁶ This is a core principle.

2. Informed Consumer Choice

Care/service coordination processes adhere to informed consumer choice (shared decision- making) and evidence-guided practices to the extent practical.

3. Home and Community Living

Long term care facilities (e.g., skilled nursing facilities, ICF-ID/DD, etc.) adhere to State and Federal programs (e.g. Minimum Data Set 3.0) intended to promote consumer choice regarding community living options, with unimpeded access to transitional support services opportunities for those who choose to pursue such options (see HCPF Community Choice Transitions, based on a ‘cost-effectiveness’ test). Medical Providers are made aware of and support the Supreme Court’s 1999 Olmstead decision promoting lives lived in the least restrictive settings available.

4. Consumer/Family Centered

Medical and service providers enlist consumer and/or family and personal care attendant feedback (with consumer’s permission) about consumer control and other quality metrics using methods and tools validated by domain experts, seniors and people with a range of disabilities.

⁶ See one person’s definition of Independent Living in Attachment below.

B. Improved Health and Social Integration

*Promoting optimal health, independence and quality of life.
Assuring the right services at the right time, by the right providers and/or natural community supports with quality metrics linking medical, behavioral and LTSS performance.*

1. Early and Periodic Screening, Diagnosis and Treatment for Children

Providers and agencies recognize the importance of EPSDT as the critical Medicaid funded health support for low-income children. Medical and LTSS providers incorporate EPSDT services as part of any long-term care plan for children.

2. Accessibility, Adherence to Americans with Disabilities Act (ADA)

“Access to services” in health care typically addresses geographic/location issues and insurance coverage. “Access” for seniors and persons with disabilities means, “Can I get into a building, get services and information given my physical or cognitive limitations?” Successful acute and long-term care for seniors and persons with disabilities requires understanding of and adherence to ADA accessibility standards.

Toward this end, providers utilize standardized checklists to ensure a comprehensive approach to accessibility, safety and usability. This includes:

- Physical access assured through building accessibility audits;
- Program access that includes sign language interpretation and;
- Equipment access (e.g. x-rays, mammograms, etc.);
- Electronic communication following 508 Standards (Rehabilitation Act) and disability cultural competency for all medical and other staff that come in contact with consumers.

Providers, state and local government agencies modify their policies and procedures when necessary to assure clients have the opportunity to receive services in the most integrated setting.

3. Service Quality and Performance Metrics

Quality metrics for LTSS are based on quality of life and consumer experience, as defined by the individual, one consumer at a time. Endorsed clinical metrics based on evidence, used for medical management purposes (e.g. showing “improvements in physical health status”) may not be meaningful for people with life- long chronic conditions or physical disabilities. LTSS quality metrics reflect consumer choice and personal goals. Programs, not consumers or individual providers, are the target unit of analysis.

4. Cross-disability Inclusion

All disability populations receiving Medicaid-funded LTSS are addressed with these practice guidelines, regardless of physical, cognitive or behavioral disability. Programs aim to treat people with different disabilities with the same level of service and respect.

Focus is on experience of services provided (e.g. were services provided as needed and planned, not “how satisfied were you,” given a lack of awareness of alternatives). For example:

- “Did you lose days of your usual activities due to systems failures?”

- “Do you feel you have opportunities to enjoy social integration – ‘to have a life (if you want one) or do you believe you have to be sick and impaired to continue to receive services?’”

Objective is actionable results, system improvement, and improved care/services/supports experience for the consumer, and:

- Identifying gaps in services; provider communication/hand-off gaps.
- Continuous Quality Improvement - System Coordination
- Continuous quality improvement applies equally to the structure, process and outcomes of social agency performance among medical and behavioral health providers.

The focus is on interagency and provider coordination, targeting areas for improvement.

5. Metric Selection

Standardized quality (process and outcome) measurement tools are utilized when available to facilitate regional, state and national comparisons and maximize best practices, process and outcomes. Tools for assessing LTSS quality are validated as being culturally competent for aged and disabled people with a range of cognitive levels and functional capabilities. Such measures need to be developed that are relevant to seniors and people with disabilities as articulated in this document.

Metrics need to be simple, understandable, transparent, relevant to consumer service needs, values and preferences, and supported by stakeholders and advocates. Examples of issues important:

- Do you have access to primary care providers, quality attendant services and durable medical equipment; to a mental health provider that listen to your concerns?
- Do you feel you have been presented with options and the right to make your own decisions regarding treatment and service plans?

C. Fiscal Responsibility

Lowering avoidable costs by eliminating duplicative, unnecessary or unwanted medical care or social services. Lowering costs through self-care support; preventing secondary chronic conditions, disabilities and injuries.

1. Social Determinants of Health

LTSS programs recognize and address to the extent possible the “social and economic determinants of health” which includes issues of housing, transportation, poverty, nutrition, living conditions, and timely access to services.

2. Personal Health Responsibility

Care/Service providers and Single Entry Point agencies present consumers with information about program costs and assist consumers in making provider selection decisions, housing decisions and life-style changes that support fiscally responsible decisions by both agencies and individuals. Care/service coordinators strive to develop self-management knowledge, skills and confidence leading to personal health and financial responsibility for consumers, family members and advocates. Responsible decision-making by agencies and individuals can only take place with an

adequate level of empowerment and unbiased information provided by qualified counselors, care coordinators, providers and through peer-to-peer services.

3. Value-based Care/Services

Care/service coordinators have accountability for identifying service options that are the most cost-effective, evidence and value-based, providing conflict-free treatment options, housing, transportation and other service options when available.

- Consumer-direction includes educating individuals about how to select and manage their own services, including opportunities for housing, employment, transportation and medical treatments.
- Medical-based providers and care coordinators should utilize appropriate social agencies for all non-medical LTSS options, especially housing decisions.

4. Cost Containment

Care/service providers take into consideration the costs of alternative treatment options, housing, service and support options in order to maximize resources. Providers, agencies and consumers need to be made aware of opportunities to choose lower cost products or services and to help consumers make cost-conscious decisions so long as safety and quality are not sacrificed.

5. LTSS Provider Care Support Options

LTSS providers work with consumers whose personal attendants make regular, often daily in-home visits and meet with consumers in community settings. Such home care workers should be engaged to support minor health related, care coordination functions, given appropriate training and oversight. LTSS home workers might offer a range of minor medical observations and support services aimed at consumer health promotion, while providing early warning alerts to medical providers/care coordinators.

In the interest of improved health status and cost containment - in the absence of capitated managed care - State policy will include a study and report to the Community Living Advisory Group on how to most effectively engage individuals, families and/or LTSS providers in at-home health promotion, health status observation, performing “minor medical support tasks” and reporting of observations to providers when it is determined there is a possible risk of an ER visit or hospitalization that might reasonably be avoided.

- Examples of “minor medical support tasks” that might be performed, within the scope of home health aid skills training, may include such functions as: taking temperatures, assisting with medication and appointment reminders, assisting with tele-health and home monitoring equipment use, bowel care, etc.
- Program would include, as the default option, empowering consumers/families to more effectively self-direct and report concerns about potential care needs to attending medical or social agency providers. (An example of this is when a SPD reports an infected skin lesion to a caregiver, which the consumer or caregiver promptly report to a medical provider.)
- LTSS providers should be expected to participate in Regional Care Coordination Organization (RCCO) care coordination functions and participate in compensation agreements for value-added services that address RCCO Quality Measures and financial performance criteria.

Care-service Coordination Provider Practice Recommendations

- Such services would be identified in Work Force standards, and agency rules and regulations, based on reasonable safety and effectiveness criteria, completion of skills training, reporting requirements, and medical oversight as needed for identified clients.
- The clinical and financial implications of a range of health observation and reporting functions would be evaluated by DORA, state boards and other agencies resulting in enabling policies in HCPF-RCCO-CMA Cooperation and Business Agreements.

IV. Provider Practice Recommendations

A. PREAMBLE

Seniors, children and adults with disabilities (SPD), family members and advocacy groups (LTSS “stakeholders”) have the opportunity to review provider and agency care/service coordination protocols and actual local agency practices so as to reflect real world consumer experience and to provide insights to providers for continuous program improvement.

These “Provider Practice Recommendations” are organized under broad headings titled People, Processes and Systems so as to provide guidance to care and service for both acute care (Medical Model) and Long Term Care (Social Agency Model) providers as well as to policy makers, Legislators, and interested stakeholders.

B. PEOPLE

System-wide training in disability cultural competency is reflected in Case Management Agency and RCCO HR policies and staff hiring; SPD serve on agency Boards and committees. Disability Strategic Plans & benchmark are implemented.

1. Medical Provider and Agency Commitment to Senior and Disability Competencies

Medical Providers, Social Service Agencies, and LTSS Providers participate in aging and disability cultural competency trainings at all organizational levels, in the following ways:

- a) System-wide Training in Disability Cultural Competency
- b) Aging and Disability Training: RCCO and medical groups, their Boards, clinical staff (doctors and nurses), business office staff, committee members and contracted providers should receive training in disability cultural competency (including disability etiquette/sensitivity training), disability care best practices, LTSS, the principles of Independent Living, ADA regulations and Olmstead.
- c) Disability Expertise: In-service training should be performed by local aging and disability agencies, by people with disabilities, advocates and/or others with IL/LTSS expertise.
- d) Training Records of disability training are maintained and part of RCCO Disability Program, Quality or Strategic Plan documentation, and made available upon request.
- e) HR policies reflect efforts to employ people with disabilities, and/or people with disability expertise.
- f) Benchmarks: Provider organizations are evaluated by relevant benchmarks in aging and disability competency; determined by disability community leadership or a local disability controlled committee.
- g) Disability Strategic Plans are developed and reviewed every 3-5 years; document that plans and progress on aging and disability related accomplishments among RCCO staff, medical,

behavioral, and LTSS agencies in each region. If disability advisory group recommendations are not accepted, reasons should be provided in writing to the group.

2. Case Management Competency

Case Management Agencies and other LTSS service providers have staff with aging and disability training, experience and competencies. Evidence-based practices should be followed when available.

3. Consumer Engagement and Feedback

Providers and CMAs implement structured consumer, advocate, and family feedback through regional stakeholder community meetings, according to a scheduled plan that reflects local needs, to address system redesign opportunities; to improve care and service coordination activities; to improve accessibility and inclusion for people of varying ages, races, disabilities and gender-specific issues.

4. Advanced Care Planning

All consumers have the opportunity to engage with a provider or counselor of their choosing to develop an advanced care plan expressing their wishes and designating persons of their choosing to manage decisions involving life-sustaining medical treatments, hospital and hospice care.

5. Life Care Plans - Comprehensive Consumer Support

Comprehensive consumer support includes maximizing to the extent feasible opportunities to develop life plans and to secure rehabilitative and life skills training that support employment, transportation, social, personal care and other services and supports that enable consumers to live to their full life potential in the community. (See “Social Determinants of Health” above).

6. Patient Coaching and Peer-to-Peer Counseling

Independence, personal responsibility and self-care coaching along the lines practiced by Senior Resource Centers and Independent Living Centers is practiced or actively supported by agencies and medical providers with the aim of enhancing self-care activation, personal, behavioral and social well-being and community integration.

C. PROCESSES

Coordination protocols and quality metrics aim to utilize a single, coordinated care plan. Consumers and LTSS in-home work force support medical providers with consumer health promotion and risk reporting to help reduce potential crises and avoidable medical events.

1. Care/Service Protocols

The Care/Service Coordination should be structured around a formal assessment, a care and/or service plan, re-assessments and monitoring according to written and transparent agency protocols. Any required assessment must be outlined in the rules and must be developed with meaningful involvement of the disability community leadership.

2. Care/Service Referrals

Referrals should be made to providers of medical, behavioral or social services, or family/natural supports based on the best available geographic proximity to the consumer, impartial information and informed consumer choice.

3. Psychosocial Resources

Special attention is made to psychosocial issues and available resources will help medical providers more effectively manage individuals with complex chronic condition and behavioral needs.

4. Selection of Coordination Team

The choice of coordinators should be determined by written provider-agency Written Protocols and consensus, the needs and preferences of the consumer and/or designated representative(s), in all non-emergent situations. The defined care and service coordination “team” promotes active consumer and family engagement, encouraging self-direction and self-care practices, to the extent feasible for each consumer.

5. Case Management Team Membership

Once a person enters the Long Term Services System, he is likely to stay in that system for most or the rest of his life. Because of this, different perspectives need to ‘be at the table.’ This may include a case manager from a CMA, the consumer, family, friend, advocate, a health coordinator, a fiscal person, a mediator, etc.

6. A Single and Coordinated Care/System Plan

Team members should be cognizant of the LTSS Triple Aim, and attempt to seek consensus on a *single, coordinated, cross system care/service* plan.

7. Service and Care Transitions

Care and service transitions will be performed according to written protocols developed between RCCOs, agencies, Acute and LTSS providers, reflecting IL/LTSS principles and practices, reviewed by SPD advocates, and other stakeholders.⁷

8. Ombudsman’s Role

The Medicaid Ombudsman is to advocate for consumer complaints and/or mediate in the case of any disputes among providers and agency regarding care, service, coordination or referral disputes.

9. Use of In-Home Personal Care Attendants for Patient Monitoring

Medical offices and care coordinators utilize reports from Personal Care Attendants who work in patient’s homes, under the supervision of LTSS and Home Health Agencies to identify people at-risk of serious health and medical complications that might result in avoidable hospitalizations, ER visits and re-hospitalizations. Such collaboration between agencies and medical providers can only occur with the knowledge and informed consent of the client or authorized representative. For clients not under the supervision of care management agencies, contractual arrangements with agencies may be entered into for performing limited home care monitoring, under the supervision of medical providers, RCCO care coordinators or home health agencies.

⁷ See HCPF Community Care Transitions program guidelines and training materials.

10. Transitions of Care - Bi-Directional Practices

Transition of Care for Seniors and Persons with Disabilities from hospitals to sub-acute facilities and home settings are based on strong home and community- based practice models⁸.

Likewise, when people on HCBS/LTSS programs go *into* the hospital, information about their disability requirements must be provided as soon as possible. Examples of information that should be conveyed to hospitals includes: ventilator care, bowel and bladder programs; description of any physical, hearing and sight accommodations needed, daily home care routines, medications, behavioral health status, reliance on home and community services and supports, the availability or lack of natural family and community support, current and preferred living arrangements.

Such information should also be included in Advance Directives and incorporated into each client's Care Plan. (Note, even if hospitals are not able to meet the personal care needs of PWD, waiver rules do not permit PWD to pay for use of personal care attendants while in a hospital setting.)

Conveyance of such information upon hospital admission or readmissions, ER use or any sub-acute facility will improve care transitions, continuity of care, patient outcomes, while reducing duplication, avoidable and costly errors and omissions for SPD.

D. SYSTEMS

Innovations and efficiencies in use of IT and data exchange are pursued through grant funding, LEAN processes, use of consumer flow sheets, shared best practices. ADA consultants are utilized to achieve facility, program and information accessibility and 508 Website Compliance.

1. Service Duplication

Care and service providers seek to eliminate duplication of care coordinators, coordination processes and work toward a single care plan for each consumer.

2. Data/Information Exchange

Shared databases and/or information exchange should be utilized among client-authorized providers and business associates of HCPF (i.e. SEPs, CCBs, BHOs, RCCOs, Medical/Behavioral/LTSS Providers and others) without “using personal health information” as a barrier to consumer/authorized representative needs and desires.

3. Personal Health Records and Consumer Health Portals

Standardized personal health records should be a consumer-controlled and portable source of information for consumers, attendant care workers, care/service coordinators and providers, reflecting benefits available, eligibility, general health status, medical conditions and social services received, and other common informational elements of a user-friendly health/medical record made available in a 508 Compliant on-line portal as early as technically feasible.

⁸ Such as that Care Transitions Program[®] and Care Transition Intervention[®] developed by Eric Coleman, MD, MPH, at the University of Colorado Health Sciences Center

4. Coordination Flow Sheets

Coordination of care and services should be in accordance with shared patient “Coordination Flow Sheets.” Flow sheets should be developed to enhance coordination between the numerous types of medical and LTSS providers. If determined necessary to meet an individual’s needs, Individual Flow Sheets may be developed among care and service providers, LTSS personal care attendants, and natural family supports, when originated and controlled by the client or his authorized representative.

5. LEAN-based Operational Efficiencies

LEAN processes (process mapping to identify wasteful steps, duplication, and to achieve transfer and operational efficiencies) should be utilized between and among Agencies, Medical and LTSS providers given the complexity of interactions among consumers with complex needs. Process Mapping is used to understand and improve process flows. Technical assistance grant requests are pursued as needed.

6. Communications Technology

Medical and Service Providers, as well as Case Management Agencies (CMAs) should pursue innovations in technology that support consumer-provider and *peer-to-peer* communications for consumers interested in pursuing independence, self-care and social support. Use of technologies such as broadband video, social networking such as Google+, Skype, etc. can be cost-effective ways to provide support for people with complex care needs and transportation challenges.

Providers must employ an effective communication policy, allowing clients to choose their preferred communication methodology, including but not limited to allowing clients to communicate via email, text, or voice, and including a process to modify policies and preferences if required. (For example some clients can only function effectively with a specific, trusted and well trained person rather than a customer service staff due to the nature of their disabilities.)

7. Information Accessibility and Health Literacy

Medical and service information should be accessible to consumers, families and other authorized individuals through 508 Compliant electronic devices, including use of on-line resources; using evidence-based health literacy principles and ADA consultants when needed.

Policies and procedures are developed for accessing information in alternate formats, including reasonable timelines and steps for requesting service and personal health information. Alternate forms of print media are available upon request by persons with sight impairments. Listening devices for hard-of-hearing and competent signing services are provided upon request by persons who are hard- of- hearing or deaf.

Alternative forms of print are available on benefits, services, programs, treatment information and test results, classes, personal health information, etc. on 508 compliant websites. Alternative means of communication (text, phone, letter, e-mail, video relay for deaf) are available to choose from and utilized by provider and agency staff trained to offer and utilize such communication options. Enforcement will be monitored according to HCPF contracts, implemented by each provider by policies, procedures and written practice protocols; addressing the needs and preferences of persons with physical, cognitive and behavioral disabilities.

8. Accessibility of Facilities and Services

RCCO and provider offices are audited for accessibility and usability as needed to Improve/ensure consumer access. Information about physical, equipment and program accessibility is identified on RCCO, agency and provider websites to assist SPD seeking care; addressing issues such as public transit, parking lots, building access, path of travel, bathrooms, exam table and equipment assess; telephone, video and call center communications comport with the ADA; Universal Design is promoted for new medical office and building construction.

A contracted ADA coordinator is hired or consulted by each agency and RCCO, or shared among such agencies and RCCOs to review internal, provider and interagency accessibility related to treatment and care coordination. ADA coordinators will be available to facilitate the process of modification of policies, procedures and operating practices upon request by eligible clients and to assure that an interactive, disability friendly process is used by all RCCOs and their contractors.

ATTACHMENT A

Contributors to this Document

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ATTACHMENT B

Chronology: 2012-13 Work by CC Subcommittee

*See HCPF website Meeting Notes*⁹

2012

August: Discussion of interest in CC expressed by members, info needs, etc.

September: Discussion: What is CC, What is working, not working in CC, Handout of 2 CC articles provided by Chairs; group discussion on Person-centered care, CC experience concepts.

October: Decision to use Randall Brown definition of CC as starting point, 6-month proposed objectives presented to achieve definition consensus; use of IT/portal to support CC communication, models that work, CC costs/coverage.

Oct-Nov: On-line Survey to Subcommittee Members;
Survey Findings on Care Coordination Definition (23 pages of notes) compiled

November: Reviewed definitions offered for review; 6, 12, 18 month work. Presentation to /AC on definitions and RCCO contracts, SMART Objectives offered for consideration.

2013

December: Reviewed, endorsed initial CC Definition doc, approach by voice vote

January: Five votes taken endorsing CC Definitions, Practice Recommendations document

February: Review of Work Plans, new document concepts, language

March: CC Subcommittee Charter approved by voice vote, addition of Goals 4-9

April: Consensus vote to approve and advance CC Definitions and Work Plan to Community Living Advisory Group

⁹ <http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1251631966990>

ATTACHMENT C

SHORT –TERM SCOPE, FOCUS AND NEXT STEPS: 2013-2014

Phase 1 – Priority attention to RCCO/FBMME required

Promote understanding and adoption of these definitions and recommended practices; especially to help inform the medical/behavioral health community; *in light of new RCCO care coordination roles FBMME Demonstration project beginning Q2-2013:*

CC Subcommittee: Implementation Steps

Adopt: Seek broad agency and stakeholder consideration, consensus. Work group to revise, expand as needed; work with other HCPF work groups.

Apply: Work with HCPF on application of these principles to RCCO-Agency Care Coordination Protocols, Contract Amendments, Performance Metrics.

Assess: Focus on ACC Program Improvement Committee efforts and FBMME Subcommittee¹⁰ and develop recommended criteria for a “RCCO LTSS Competency

Assurances (Readiness)” with active LTSS community input for each local RCCO << to be completed not later than Q4 2013.

Phase 2 - 24 Month Work Plan Drafting

Refine CC Recommendations, with strategic level goals and work plan, operational metrics and monitoring approach, with TA as needed (see CC draft work plan)

Phase 3 - LTSS System Redesign and Workforce Capacity Building

The LTCAC/Community Living Advisory Group should undertake a process enhancing: a) *Entry Point* case manager systems, accountability, efficiency and caseload standards for improving system-wide quality and cost-effectiveness, and b) *Work Force* capacity building to promulgate standards and improved compensation to attract qualified LTSS workers.¹¹

¹⁰ The FBMME “Coordination of Care Work Group” was suspended after March 2012

¹¹ For example, a personal care provider for a SIS-6 DD client receives only \$11.76/hour for in home attendant services (procedure code S5150)

ATTACHMENT D

LTCAC Guiding Principles and Charge to Care Coordination Subcommittee

LTCAC's Guiding Principles¹²

- Focus on individual
 - Program meets individual needs
 - Self-directed
 - Choice
 - Options

- Living in most **integrated** setting **appropriate** to meet needs **of the individual**
 - Least restrictive
 - Compliance with Olmstead/independence

- Coordinated Care
 - Transition from service to service
 - Integrated between all systems / programs

- Access to care / streamline between programs
 - Timeliness
 - Transparency

- Sustainable
 - Cost
 - Funding

“Charge to Care Coordination Subcommittee” by LTCAC¹³

The Long Term Care Advisory Committee (LTCAC) created the Care Coordination Subcommittee in April 2012.

The LTCAC has charged the Care Coordination Subcommittee with:

Reviewing existing care coordination efforts and programs, and making recommendations regarding how to make care coordination more effective, with a focus on:

- Duplication and gaps in care coordination services
- Building upon effective care coordination efforts
- Training for care coordinators
- Case load
- Independence of care coordinators

¹² <http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1220351442908>

¹³ <http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1251631966990>

- Flexibility of care planning
- Care coordination in transitional situations

Working in concert with the Entry Point / Eligibility Subcommittee, since there will be overlap between these two initiatives.

Working across the major initiatives of the Department, such as Colorado Choice Transitions (CCT), the Medicaid Expansion project, Regional Care Collaborative Organization (RCCO) development, etc.