Collaborative Initiatives Annual Report 2021-2022

Colorado Department of Health Care Policy and Financing & University of Colorado of Medicine Interagency Agreement

October 2022

School of Medicine
UNIVERSITY OF COLORADO **ANSCHUTZ MEDICAL CAMPUS**

COLORADO
Department of Health Care Policy & Financing

Contents

I. Executive Summary

Background

In fiscal year 2017-2018, The Department of Health Care Policy and Financing (the Department) entered into an Interagency Agreement (Agreement) with the University of Colorado School of Medicine (CUSOM) to provide supplemental funding to improve the health of Health First Colorado (Colorado's Medicaid Program) members in Colorado by increasing healthcare access. [1] This Supplemental Funding Program is a unique funding opportunity made possible through partnership between the state Medicaid agency and the publicly funded academic medical school. The Program is comprised of five Priority Areas which drive the development, implementation, and evaluation of access to care work (Figure 1).

One way this partnership seeks to increase access is through Collaborative Initiatives programming which focuses on improving outcomes for populations with complex health care needs. Two Collaborative Initiatives programs were developed and implemented during fiscal year 2021-2022. These programs include the **Jail Transitions of Care Program** and the **Unhoused Transitions of Care Program**.

Figure 1. Supplemental Funding Program Priority Areas.

[1] *This report provides details on the Collaborative Initiatives funding, for additional information regarding the comprehensive full year end report, please refer to the Supplemental Funding Program Report for 2021-2022.*

Key Outcomes of the Collaborative Initiatives Programs

Jail Transitions of Care Program

- Developed a Community Advisory Board (CAB) comprised of community experts with personal lived experience of being incarcerated.
- Completed an assessment of the needs and strengths that exist for people in the community who are connecting to medical care after being released from jail.
- Collaborated with the School of Public Health's Community Epidemiology & Program Evaluation Group to create a plan for evaluating services and impact.

Unhoused Transitions of Care Program

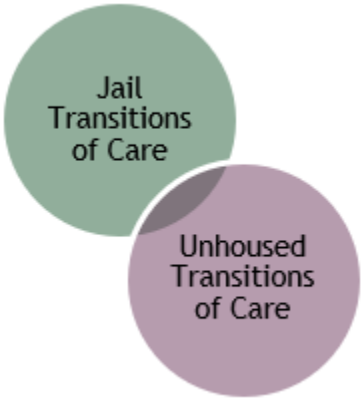
- Implemented the UCHealth's Housing Transitions Team (HTT) in Fall 2021. The program screened 339 patients, closed 257 cases, and successfully housed 43 patients.
- Established a partnership with Ascending to Health Respite Care (ATHRC) in Colorado Springs to collect data about the services provided for Health First Colorado members.

Next Steps

Collaborative Initiatives programming will continue to expand into the next fiscal year with updated scopes of work that include building upon lessons learned and stakeholder feedback. The project teams will remain focused on unhoused and jail populations. In addition to the two main transitions of care programs, CUSOM and the Department will partner with a community primary care practice to expand services with a mobile medical care unit.

II. Introduction

Beginning in Fall 2021, the Department and CUSOM began designing and implementing cross-sector collaborative programs to enhance transitions of care for members with complex health and social needs. Specifically, this work currently focuses on:



- Transitions of care programming for Medicaid members released from Arapahoe County Jail.
- Ensuring successful transitions for Medicaid members experiencing housing instability leaving the emergency room or hospital.

Transitions of Care

Transitions of care can be challenging for the unhoused and justice involved populations. Barriers such as disjointed Medicaid enrollment, stigma, and strained relationships with medical systems severely impact members' ability to obtain timely and quality medical care and social services that would otherwise promote or assist with engagement in medical care. Efforts to help with the healthcare transitions are often siloed and result in members receiving fragmented care. At the time of the inception of the Collaborative Initiatives, there were limited resources and programs focused on transitions of care.

Strong and sustainable transitions of care programs are essential for Medicaid members. Transitions from jail and the hospital setting can increase the risk of adverse health events or lapses in care due to miscommunications between care teams and increased logistical barriers for members. The Collaborative Initiatives programs seek to create a concerted and coordinated approach to transitions of care for Medicaid members. These two transitions of care models were agreed upon after extensive community engagement and an assessment of current models in Colorado.

Transitions of Care:
The movement of a patient from one setting of care to another. Settings of care may include hospitals, ambulatory primary care practices, ambulatory specialty care practices, long-term care facilities, home health, and rehabilitation facilities.

III. Jail Transitions of Care

July 1, 2021 - Current

Overview

The Jail Transitions of Care (Jail ToC) program aims to minimize the stress and difficulty of transitioning back into the community after incarceration by establishing relationships with individuals before they leave jail and support them in fulfilling their health and wellness goals post release.

The program works with the Arapahoe County Detention Center, a facility in Centennial, Colorado, with a maximum capacity of 1,458 individuals and onsite primary care, Medication Assisted Treatment (MAT), and jail based behavioral health services. This fiscal year was a building year for this program to accommodate the complexity around forming these interagency relationships and developing evidence-based workflows. When participants begin the program, the jail's medical team will refer individuals who need and want healthcare navigation and support to the Jail ToC's Peer Support Specialist and Health Navigator. This team approach will support clients in identifying and progressing towards their own health and wellness goals.

Peer & Health Navigator Positions

Health Navigators support and assist clients through disconnected systems by providing resources, education, and coordination needed to reduce barriers to healthcare.

Peers use their lived experience to provide hope, understanding, and advocacy for a client without an agenda or power differential.

Community Health Needs Assessment

To create meaningful programming, a Community Health Needs Assessment (CHNA) was conducted to capture the experiences and expertise of formerly incarcerated individuals and professionals working in the jails and reentry organizations. Responses to the CHNA survey were used to create an implementation plan to guide the program's services and priorities by revealing an authentic perspective on the facilitators and barriers to care. Based on these findings, the program established foundational strategies to increase engagement with members the encompass trust building, self-efficacy, education, and navigational support.

Strategies to Increase Levels of Engagement in Medical Care Upon Release

- Repair trust by building meaningful relationships with participants by hiring staff who have relatable lived experiences
- Promote self-efficacy and a sense of control by empowering participants to identify and work towards their own health goals
- Educate participants about health systems and medical conditions
- Role model positive coping skills and having hope through peer support
- Initiate rapport, connection, and navigational support with individuals before they leave jail to increase awareness of what services are available in the community and how to access those services
- Train, educate, and support community medical providers on the specific barriers, successes, needs, and experiences of formerly incarcerated individuals.

Community Advisory Board

The Jail ToC Community Advisory Board (CAB) is a group of community experts with personal lived experience of being incarcerated. The CAB was created to incorporate the voice of the community into the program and ensure accountability to adhering to the program's mission in an effective and ethical way. The program's alignment with the implementation plan will be routinely assessed by the CAB. Through these assessments, the CAB will assist the Jail ToC program team in directing programming towards the established implementation plan to ensure alignment with the needs, wants and feedback from the community.

Evaluation Plan

The evaluation of the Jail ToC's impact began in Summer 2022. This plan was developed in conjunction with the Community Epidemiology and Program Evaluation Group at the Colorado School of Public Health. The evaluation will measure the program's success and provide data to report and disseminate findings back to the community. The evaluation plan includes utilizing claims data, electronic health record data, and program service information to understand the medical needs of the participants.

IV. Unhoused Transitions of Care

July 1, 2021 - Current

Overview

The Unhoused Transitions of Care (Unhoused ToC) program seeks to identify opportunities to improve the connection to primary care and community resources for individuals transitioning out of the hospital setting to the streets or shelters. The objective of the Unhoused ToC Program is to develop a multipronged approach to address the health and wellness needs of unhoused individuals interfacing with Colorado's healthcare system and community partners. The Unhoused ToC Program is composed of two unique projects: UCHealth's Emergency Departments Housing Transitions Team (HTT) and Colorado Springs' Ascending to Health Respite Care (ATHRC).

All program development was informed from community outreach and engagement. Over this fiscal year, CUSOM and the Department collaborated with community partners and analyzed local, state, and national databases to further understand the growing needs, challenges, and potential solutions to better serve unhoused Medicaid members.

Specific objectives of the Unhoused ToC Program include:

- Engage and partner with current homeless healthcare access points and unhoused direct care providers to provide enhance transitions of care and community collaboration.
- Implement and evaluate a hospital program to support streamlined hospital transitions of care to the community.
- Partner with recuperative care facilities for knowledge and data sharing.
- Identify opportunities for additional Medicaid and state-wide support.

Community Engagement

June 2021 - Ongoing

At the forefront of this work was meeting with organizations, companies, and individuals that serve or work closely with individuals experiencing housing instability. CUSOM hosted structured cohort convenings (hosting 20+ organizations), on-site visits, focus groups, and partnership conversations. The purpose was to break down silos, encourage collaboration, and identify where there are gaps in serving this population. This group was able to set up referral systems, identify high need community locations for street-based care, and share best practices.

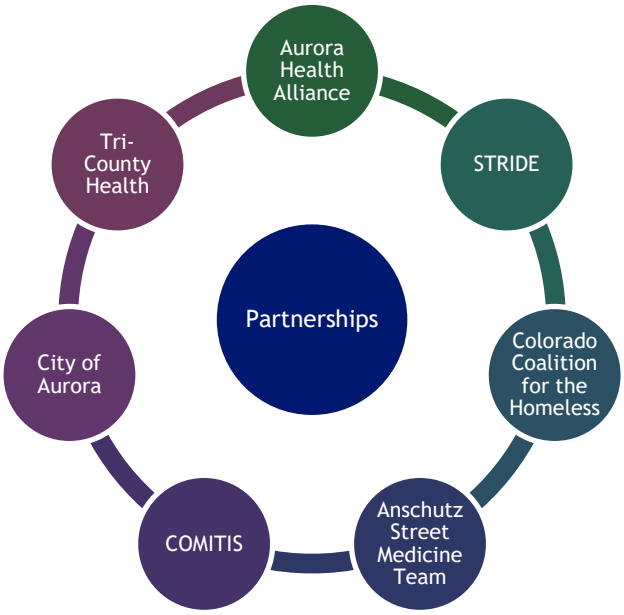


Figure 2. Community Partnerships. This is not an exhaustive list.

Two areas for opportunity were identified through community engagement:

- A need for community-based care that is sensitive to the distinct needs of unhoused individuals. Care needs to be offered in locations outside of traditional brick and mortar primary care clinics.
- Ongoing and consistent collaboration between organizations and service providers.

Housing Transition Team
August 2021 - Current

The Housing Transitions Team (HTT) launched this year at UCHealth and is comprised of a social work team focused on assisting unhoused members presenting in the emergency department or inpatient setting. The social work team connects members with community resources and referrals, primary care post hospitalization, and housing options. The social work team continues to work with the member after their discharge to ensure connection with community resources and appropriate follow up. Members are screened and tiered to ensure their individualized needs are addressed. Learn more about the HTT team- UCHealth Article.

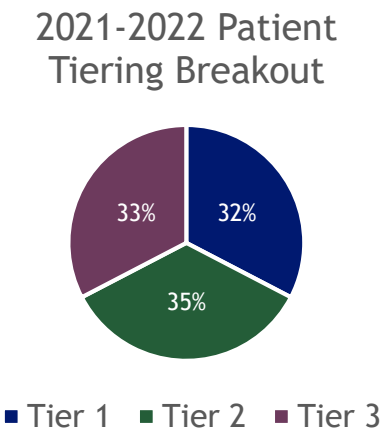
Project Goals

- Enhance care coordination efforts
- Improve linkage to community providers
- Reduce hospital lengths of stay and organizational costs
- Develop partnerships with the housing voucher programs
- Partner with local city governments and organizations to improve patient access to housing instability initiatives

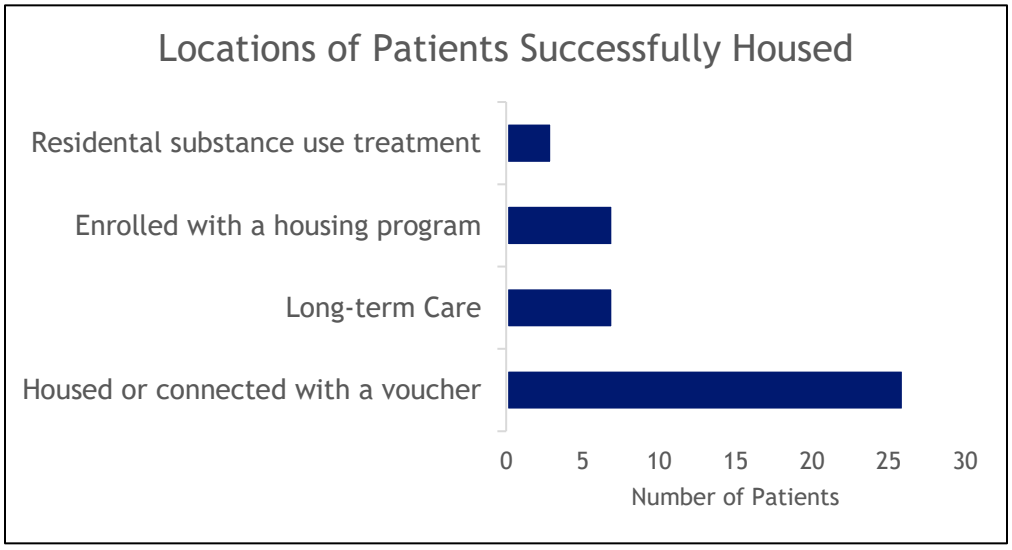
Outcomes

- **Improved discharge planning for patients**
    - Dedicated time building rapport and developing discharge plans with patients to promote their community stability to avoid readmission.
    - Worked alongside other social work primary care and specialty teams within UCHealth to help support patients with complex discharge needs.

- Developed a structure to triage patients ranging in support needed.
    - **Tier 1:** Patient is experiencing episodic housing insecurity and is referred to community resources.
    - **Tier 2:** Patient is experiencing barriers to accessing resources and HTT team assists with referrals.
    - **Tier 3:** Patient faces significant barriers to accessing resources and recurrent emergency department or hospitalizations.



- **Strong partnerships with community service providers**
    - Ongoing expansion of community partnerships with multiple organizations (Colorado Coalition for the Homeless, Denver Rescue Mission, Salvation Army, and Recovery Works) to facilitate continuity of care by bypassing wait lists, connecting directly with personnel responsive to patient needs in the community, and coordinating emergent support to prevent hospital readmissions.
- **Enhanced identification of patients needing social work support**
    - Number of patients consulted in the emergency department: 339 patients
    - Number of closed cases: 257 patients
    - Number of members successfully housed: 43



Recuperative Care

January 1, 2022 - December 31, 2022

Individuals experiencing housing instability need a safe place to recover upon leaving the hospital to recuperate and to receive follow up care. A partnership with Ascending to Health Respite Care (ATHRC), located in Colorado Springs, was established to inform policy decision making around recuperative care services. With this partnership, the Department and CUSOM worked together to learn more about the services provided at recuperative care locations, determine the impact on Medicaid members, and explore opportunities for state supported programming. Next steps include a comprehensive data analysis of recuperative care services provided.

What is Recuperative Care?

Recuperative care (also known as medical respite) is a community-based program that provides a safe place for individuals experiencing homelessness to heal from an illness or injury. These programs provide patients a clean and safe place to stay while also providing access to medical, behavioral health, and other supportive social services. This care delivery reduces extended hospital stays and leads to fewer hospital readmissions.

V. Next Steps

Collaborative Initiatives programming continues to expand into the next fiscal year with updated scopes of work that include building upon lessons learned and stakeholder feedback. The project teams will remain focused on unhoused and jail populations. Community feedback this year demonstrated the interest in supporting community-based medical care and non-traditional primary care models, such as mobile units, to provide real-time access to care. In addition to our current projects, CUSOM and the Department will partner with a local federally qualified health center to provide mobile unit medical care to locations where the unhoused and justice involved populations overlap.

Fiscal Year 2022-2023 Next Steps

Unhoused Transitions of Care

- Expansion of community-based primary care with local partners
- Continued partnership and evaluation of recuperative care services

Justice Involved Transitions of Care

- Begin screening and enrolling members into the program
- Continue CAB involvement to ensure alignment and identify needs of the Jail ToC program

Collaboration Across Both Programs

- Collaboration with community networks and medical providers
- Robust evaluation plans
- Understand how to expand these efforts into a statewide approach to other jail systems and unhoused communities through policy and additional programming
- Onboard additional staff to assist with program implementation and evaluation
- Data sharing with critical partners to continue to understand and evaluate the needs of these populations

For any questions or more information please contact:

CUSOM

upl@cumedicine.us

The Department of Health Care Policy and Financing

Devin Miller – CUSOM Population Health Unit Supervisor

Devin.miller@state.co.us