# Provider and Community Experience Subcommittee

## 2020 Debrief and Charter Review

January 2021

# Purpose/Charge

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.

# 2020 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.

## Presentations/Discussions:

- Access Monitoring and Review Plan
- Telemedicine Stakeholder Engagement Process
- HCPF and CU School of Medicine's eConsult Program

## ➢ Access to Specialty Care Workgroup

Co-Chairs: Lila Cummings & Vicente Cardona

# 2020 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.

## Presentations/Discussions:

- Telemedicine Stakeholder Engagement Process, including provider trainings
- Primary Care Alternative Payment Model for 2021
- COVID-19
- Interim Provider Payment Program

# 2020 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.

## Presentations/Discussions:

- ACC Population Management Framework & Care Coordination expectations
- RAE Care Coordination Models

## ➢ Care Coordination Workgroup

Co-chairs: Joanna Martinson & Jen Hale-Coulson

Identified 10 priority areas of focus:

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. - PCE Recommendation approved by State PIAC in Oct. 2020.**
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.

# Discussion

***Are there areas we need to pivot away from or lean into more?***

# Charter Review