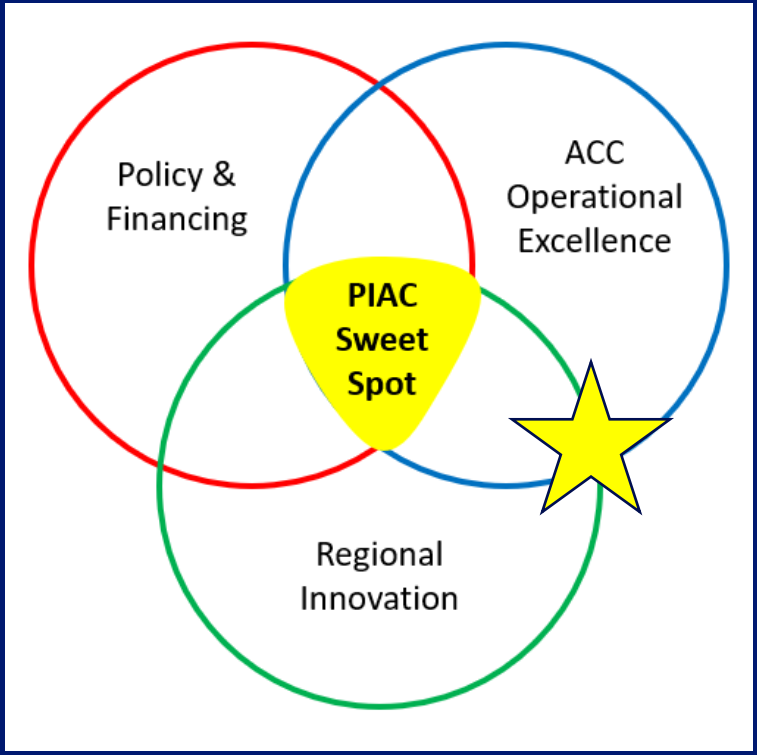
ACC PIAC Provider & Community Experience Subcommittee

August 12, 2021

PIAC's Strategic Focus Areas

- Responding to and understanding the impact of COVID
- Driving equity outcomes and reducing healthcare disparities
- **Supporting the implementation of the ACC's population management framework, specifically care coordination**
- Responding to the work of the Behavioral Health Task Force and impending Behavioral Health Administration
- Monitoring ACC performance outcomes vis-à-vis member experience

ACC PIAC Strategic Framework



PC&E Charge (purpose)

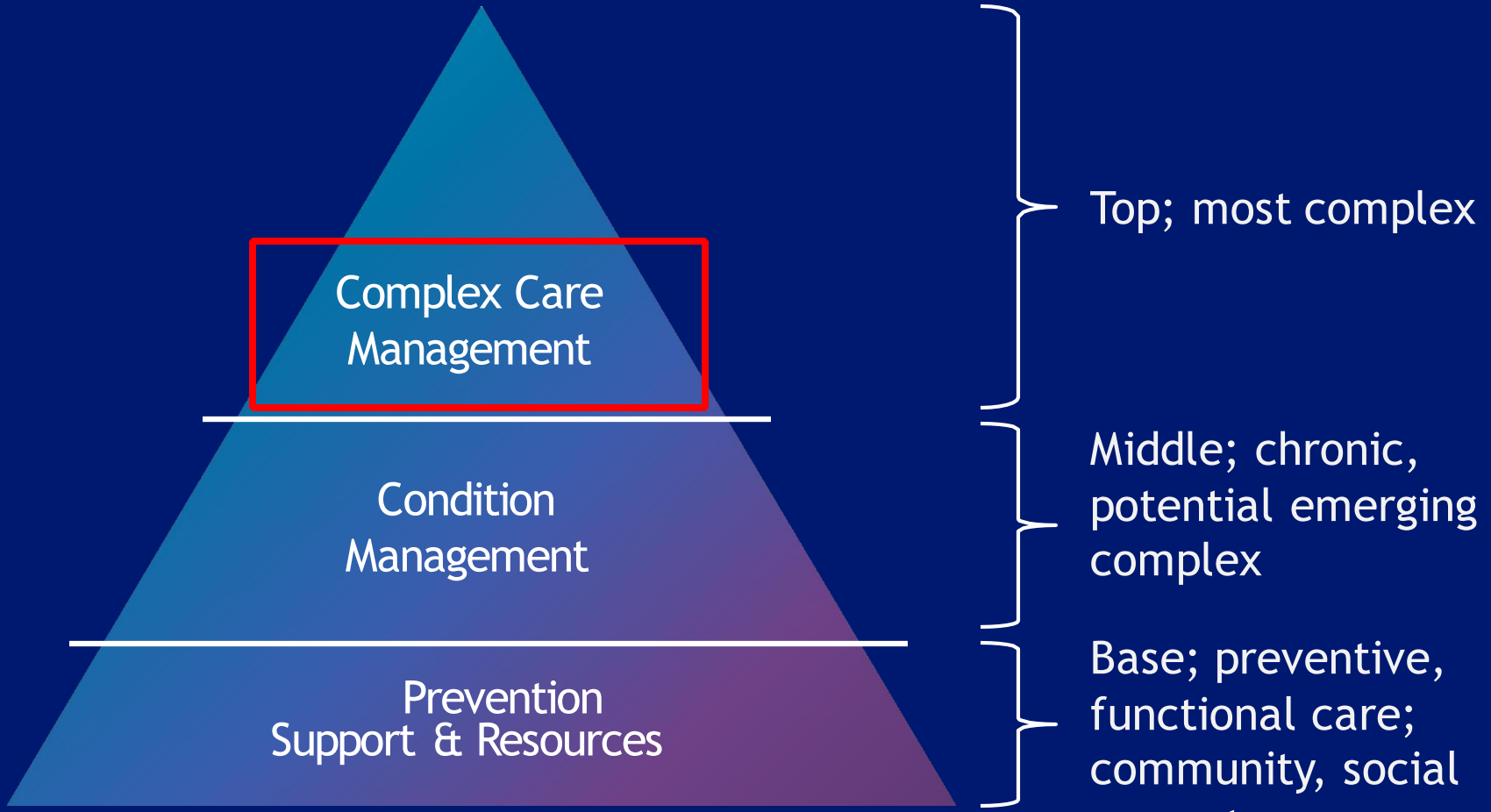
Current:

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.

Proposed: (*based on PIAC Strategic Focus areas & guidance from PIAC*):

To assess the experience of PCMPs, the Health Neighborhood and Community within the ACC by identifying, prioritizing, and investigating key challenges and potential solutions concerning the **Population Management framework.**

Statewide Approach to Addressing Member Health & Cost through Population Management



Population Management Framework

- Targeted interventions for populations and conditions to improve health and reduce cost
- Management of **11 conditions** based on prevalence, comorbidity and cost with specific focus on:
  - **Maternity, Diabetes, Complex Care**, Hypertension, Chronic Heart Failure, Asthma, COPD, Anxiety, Depression, Chronic Pain, SUD
- Higher level of services and coordination efforts with members with complex needs

PC&E Objectives

Proposed:

- Explore models, components and best practices for care coordination and chronic disease management within the population management framework in the context of both clinical care linkages and the social determinants of health.
- Explore how eConsults can support population management, increase access to specialty care and advance the Health Neighborhood.

For each Objective:
Program Relevance: How is this connected to our charge and the ACC? What is the contract citation?
Qualitative Data: What qualitative data from relevant deliverables could be used for our conversations?
Quantitative Data: What performance data could be used for our conversations?
Potential Work Products: What would be some potential outputs?

PC&E Charter Updates

- Additional proposed changes relative to:
  - Voting membership
  - Membership process

eConsults

Current RAE contract citations:

10.2.5.2. The Contractor shall promote the use of the Department-adopted electronic consultation software when adopted, through which specialists consult with PCMPs via a telecommunication platform. Electronic consultations allow specialists to receive reimbursement for timely review of clinical information and providing Member specific recommendations on how a PCMP may manage a condition and whether a specialty visit is required. Electronic consultations have been shown to increase appropriate access to specialty care, improve both physician satisfaction and Member experience, and improve overall quality of care.

10.2.5.2.1. The Contractor shall educate Health Neighborhood Providers regarding the utilization of electronic consultation as a method to mitigate incomplete work-ups, reduce inappropriate or unnecessary specialty care visits, and improve timeliness of communication.

Care Coordination

Current RAE Contract citations:

2.1.13 **Care Coordination** – The deliberate organization of Client care activities between two or more participants (including the Client and/or family members/caregivers) to facilitate the appropriate delivery of physical health, behavioral health, functional Long Term Services and Supports (LTSS) supports, oral health, specialty care, and other services. Care Coordination may range from deliberate provider interventions to coordinate with other aspects of the health system to interventions over an extended period of time by an individual designated to coordinate a Member's health and social needs.

11.3. **Care Coordination**

11.3.1. The Contractor shall ensure Care Coordination is available to Members in alignment with the Contractor's Population Management Strategic Plan and the Department's Population Management Framework. The Contractor shall use its own resources and Department insights to ensure active Care Coordination for Complex Members.

Care Coordination

11.3.2. The Contractor shall have a specific process to ensure that Specialty Drug (SRx) is managed away from outpatient hospitals into home infusion, where appropriate.

11.3.3. The Contractor's Care Coordination activities shall comprise:

11.3.3.1. A range of deliberate activities to organize and facilitate the appropriate delivery of health and social services that support Member health and well-being.

11.3.3.2. Activities targeted to specific members who require more intense and extended assistance and includes appropriate interventions.

11.3.4. The Contractor shall use a person- and family-centered approach to Care Coordination, which takes into consideration the preferences and goals of Members and their families, and then connects them to the resources required to carry out needed care and follow up.

11.3.5. The Contractor shall ensure that care is coordinated for the Member within a practice, as well as between the practice and other Health Neighborhood providers and Community organizations.

Care Coordination

11.3.6. The Contractor shall not duplicate Care Coordination provided through LTSS and HCBS waivers and other programs designed for special populations; rather, the Contractor shall work to link and organize the different Care Coordination activities to promote a holistic approach to a Member's care.

11.3.7. The Contractor shall ensure that Care Coordination:

11.3.7.1. Is accessible to Members.

11.3.7.2. Is provided at the point of care whenever possible.

11.3.7.3. Addresses both short and long-term health needs.

11.3.7.4. Is culturally responsive.

11.3.7.5. Respects Member preferences.

11.3.7.6. Supports regular communication between care coordinators and the practitioners delivering services to Members.

11.3.7.7. Reduces duplication and promotes continuity by collaborating with the Member and the Member's care team to identify a lead care coordinator for Members receiving Care Coordination from multiple systems.

Care Coordination

11.3.7.8. Is documented, for both medical and non-medical activities.

11.3.7.9. Addresses potential gaps in meeting the Member's interrelated medical, social, developmental, behavioral, educational, informal support system, financial and spiritual needs in order to achieve optimal health, wellness or end-of-life outcomes, according to Member preferences.

11.3.7.10. Aligns with the Contractor's Population Management Strategic Plan.

11.3.7.11. Protects Member privacy.

11.3.8. The Contractor shall ensure that care coordinators in the Contractor's network reach out and connect with other service providers and communicate information appropriately, consistently and without delay.

11.3.9. The Contractor shall reasonably ensure that all Care Coordination, including interventions provided by Network Providers and Subcontractors, meet the needs of the Member.

Care Coordination

11.3.10. The Contractor shall ensure that Care Coordination is provided to Members who are transitioning between health care settings and populations who are served by multiple systems, including, but not limited to, children involved with child welfare, Medicaid-eligible individuals transitioning out of the criminal justice system, Members receiving LTSS services, and Members transitioning out of institutional settings. To meet the needs of these Members, the Contractor shall:

11.3.10.1. Designate staff persons to serve as the Contractor's single point of contact with the different systems and settings.

11.3.10.2. Give designated staff persons the appropriate level of knowledge of the assigned system/setting to serve that population and solve Care Coordination problems for that population.

11.3.10.3. Provide specific guidance to care coordinators about each setting, regarding how to identify Members in the system/setting; how to provide Care Coordination services in the system/setting; and how to communicate with contact people in the system/setting to plan transitions, coordinate services, and address issues and Member concerns.

Care Coordination

11.3.10.4. Participate in special workgroups created by the Department or other state agencies to improve services and coordination of activities for populations served by multiple systems.

11.3.10.5. Implement programs and/or procedures to reduce unnecessary utilization of the emergency department for Members residing in Nursing Facilities and Members receiving end of life care.

11.3.11. For Members with intellectual and developmental disabilities who require services for conditions other than a mental health or substance use disorder, the Contractor shall assist the Member in locating appropriate services.

11.3.12. For Members with substance use disorders who require services not covered by Medicaid, the Contractor shall coordinate care with the state's Managed Service Organizations.

11.3.13. The Contractor shall coordinate care with the Colorado Crisis System to ensure timely follow-up outreach and treatment for enrolled Members who accessed crisis services.

Care Coordination

11.3.14. The Contractor shall assist care coordinators within the Contractor's network with bridging multiple delivery systems and state agencies.

11.3.15. The Contractor shall require additional support and guidance when the systems and providers engaged with a Member's complex care require leadership and direction.

11.3.16. The Contractor shall ensure that Care Coordination tools, processes, and methods are available to and used by Network Providers as described in Section 15.2.1.

Care Coordination

GOAL: Develop a foundation or core set of principles for care coordination that would tie into existing ECC definition, complex/priority populations, and contract regulations that can be used across regions/statewide.

- Identify best practices that glean results (defining results as reduced cost and/or improved outcomes---may not be both).
  - Informing caseload size that matches such practices.
- Define terms/identify standard language to describe the roles/responsibilities and services region-to-region. This clarification will provide clarity and level expectations for providers, Members as well as the community.
  - Care Management
  - Case Management
  - Navigation
  - Care Coordination
  - Care Coordinator
  - Community Health Worker

Next Steps

- Present proposed P&CE Charter revisions to PIAC in October for final approval
- Start work on developing a foundation or core set of principles for Care Coordination?
- Start to create a recommendation regarding the role/expectations of the RAEs relative to HCPF's eConsult program?