Provider and Community Experience
Care Coordination Workgroup

Recommendation: RAE to RAE Transition of Care Referral Process

August 13, 2020

Contents of Care Coordination Workgroup Presentation

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Purpose:
RAE to RAE Transitions of Care Referral Process

*These are workgroup identified purposes to be used in development of purpose statement

- Purpose is to formalize a statewide RAE to RAE transition policy to:
  - Establish pathways for continuity of care and enhance communication process
  - Prevent Health complications, adverse events, as a result of ongoing unmet needs, gaps in care, medication and other necessary treatment.
  - Create a more seamless process and encourage transfers of care between RAEs so members and providers feel supported in the process.

Purpose continued…

- To provide a smooth transition between RAEs for members that ensures members' bio-psycho-social needs continue to be met.
- Capitalize on the care manager and member relationship during the transition by assisting providers and members with understanding the process, why this occurred, and how they can be connected with a care manager at the new RAE. This process will provide an overview of information to get the new RAE connected to the member and encourage a "warm handoff" to encourage continuity of care and member/provider satisfaction
- To make sure Members in transition do not fall through the cracks

Current RAE – RAE Transitions Issues and Barriers:

- **Barriers and Issues**
  - Lack of performance measurements
  - Lack of consistent process and identified contact
  - Difficulty identifying members
  - The new RAE does not receive timely information about members who moved and are now in their RAE region. The new RAE does not receive the contact info for the previous RAE case manager who managed the Members' care

Issues and Barriers… continued

- The process is challenging for providers and members. This often involves the member needing to initiate transition to a different RAE. Providers can assist; however, this often involves needing to be, or on the phone, with the member. There are often long wait times or unanswered phones. This leads to disruption in care.
- Lack of continuity of care and members being “lost” in transition resulting in gaps in care, treatment, and medication.

Recommendation:
RAE to RAE Transitions of Care Process

- Statewide use of unified Care Coordination Transitions of Care referral form
- Standardized RAE referral email in each region
- Establish a care manager and provider survey to gather data points – number of members transitioning between RAEs and number of adverse events i.e. hospitalizations, emergency department visits, delay in establishment of medical home

RAE to RAE Transition Process

- **Process**
  - Identify person in process of transition to a different RAE
  - Current RAE CM -assist with finding a new medical home as needed, and connect with transferring PCP and behavioral health communicate ongoing immediate treatment needs
  - Current RAE CM assist with new attribution when possible
  - Current RAE CM complete transition form and send to identified new RAE
    - Each RAE to establish "generic referral email address
    - Form to list email contacts per RAE and instructions for completion
  - Upon receipt of referral form the new RAE CM contact current CM to ensure access to ongoing treatment by completing warm hand-off between RAEs
  - Quarterly care management and provider survey to monitor referral program for the year 2021.

PIAC Provider and Community Experience Subcommittee Strategy Screens:

- In order to identify and address specific criteria of the subcommittee's charge, the subcommittee will incorporate the following strategy screens as part of its operations and will incorporate them in any subsequent objectives, processes and products:

RAE to RAE Transitions of Care Process

Screening strategy: How do we measure up?

- How will members be impacted by the recommended process?
  - ***Preventing*** *adverse outcomes by assisting with getting appointments and ability to 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*

Screening strategy continued…

- How will specific member populations 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*

Screening strategy continued…

- 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.*

Screening strategy continued…

- 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*

Screening Strategy Continued…

- 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.*

Screening Strategy Continued…

- 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.*

Screening Strategy Continued…

- What are the cost, quality and access implications by 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*

Screening Strategy Continued…

- How is success measured for recommended process ?
  - *Percentage of transition forms used*
  - *Percentage of increase hospitalization or emergency room use after transition*
  - *Provider feedback*
  - *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.*
  - *Quarterly care manager and provider surveys*
  - *We will not receive complaints about members falling through crack due to transition from one RAE to another*

Care Coordination Transitions of Care (RAE to RAE) Sample Referral Form

- Attached form, additional edits, including instructions and RAE contacts to be added.

- Form is meant to be easy for CM to complete and enough information to start the CM assignment process and contact current RAE for warm hand-off

Recommended Standardized RAE Email

To be included on the form and process added to RAE website