COLORADO
Department of Health Care Policy & Financing

To: Accountable Care Collaborative Program Improvement Advisory Committee
From: Carol Plock and Morgan Honea
Date: October 16, 2017
Subject: Care Coordination and Community Partnerships Recommendations

Executive Summary: In August 2017, Health Services Advisory Group (HSAG) presented their findings from their annual RCCO site visits. These site reviews and their subsequent findings focused on five topic areas. The Program Improvement Advisory Committee (PIAC) tasked the Improving and Bridging Systems (IBS) subcommittee to review the care coordination findings from the perspective of adults as well as the community partnership findings. IBS created the following recommendations based on HSAG's findings.

Care Coordination:

1. It is important that RCCOs and RAEs **NOT assume that PCMH's can perform adequate care coordination for those with complex needs** – other resources will be needed
    - Given that PCMHs are feeling overburdened, it is also important to assure that expectations for their changes are narrow, focused, and evidence-based

2. Knowing that there are not enough resources to provide care coordination for every patient, it is important to **prioritize both populations and interventions**, based on proven (evidence-based) outcomes for those with complex needs and those at high risk.
    - KPIs should then be tied to the prioritized populations and interventions

3. In prioritizing (or stratifying) **populations**, it is important to select those populations where interventions can make a significant difference, in both areas:
    - Those with complex needs
    - Those at high risk

4. In prioritizing **interventions**, it is important to utilize evidence on proven strategies that deliver the most impact. Having some common rules to apply to both the stratifying of populations and interventions (in order to focus on areas of most impact), without being totally prescriptive, would be helpful.

    - Ideally, we'd like to see a '**Matrix of Intervention'** created that would help guide us in what interventions to prioritize to what populations to have the most impact (based on evidence of outcomes)

- And – it is important to coordinate with initiatives working on similar goals (SIM, CPC+, Evidence SW, practice transformation initiatives), recognizing that their goals may differ some from ours.

5. **Better utilizing new and emerging data points** would be incredibly useful in analyzing the best approaches to be used with those with complex needs, including such things as:
    - Some communities utilize these types of data:
        - Defining high cost, high needs patients and their characteristics
        - Total cost of care
        - Potentially preventable care? Did we lose PPEs with change in data system?
        - Inappropriate use of ED
    - One community has defined six populations to target (e.g., foster care, refugees, IDD, LTSS, DOC, homeless).
        - What would we find if we looked at the data for those populations? Would that capture most of our high cost/high needs patients, or would it leave out many high-needs, high-cost patients for whom effective interventions exist?
        - Can we identify those populations in our data?

6. It is critically important to **remove the barriers to Behavioral Health providers contributing data** to this analysis.

7. Where RCCOs have delegated care coordination to others, it is important that delegates receive **clear guidance about expectations for care coordination**, including level of intervention (low, moderately intensive, intensive), populations, and anticipated outcomes.

8. Group strongly supports the recommendation that the Department facilitate relationships with other state agencies that **break down barriers to data-sharing, and streamline interagency paperwork**, particularly with behavioral health, DOC (and all criminal justice), and LTSS providers.

9. One area where there appears to be **strong consensus that changes could be made in the health system that would make a significant difference in both health and cost: Substance Use Disorder (SUD) and Pain Management**, and particularly in providing adequate, accessible, quality, evidence-based:
    - Identification
    - Intervention
    - Treatment
    - There may be a need to both identify service overlaps and service gaps

- Training in such methods as SBIRT and Medication-Assisted Treatment are important

Community Partnerships:

1. Is it possible to **better attach incentives to outcomes**? For example:
   - Partners are always more willing to assist when funding is attached, and it doesn't always need to be a lot
   - For Substance Use Disorders Treatment, is there a way to provide incentives to providers to provide more of what is needed?
   - Can there be flexible pools to incentivize other providers, or clients (within Medicaid rules)?
     - One way to do that may be to use KPI bonus funding, which becomes the property of the provider or RCCO
     - Do other states have waivers that allow, for example, more utilization of Medicaid funds to assist in housing?

2. Providing **models for data-sharing agreements and information sharing protocols** would be highly useful.

3. Again, it is important to **prioritize the areas that would have the most impact**. For example, "work with criminal justice" can mean SO many things. Identifying WHAT work with WHAT part of the system would make a big difference. Work with prisons? Jails? Courts? Judges? Probation? Parole? What changes would make the biggest difference? One example was having those in county jails receive assessments for substance use disorder, with connections to treatment as they walked out the door (or even better – some receiving treatment before they come out).

4. Creativity in **developing effective SUD approaches, and the development of good partnerships with effective SUD providers** is essential

5. **Housing is an important community partner**, though it is difficult to determine how this funding could be used for housing, beyond making connections between clients and housing partners. Have other states successfully used waivers for housing?

6. How community partners receive information about this approach makes a big difference.
   - Assuring a **consistent, understandable way of explaining the ACC** at the local, state, and RCCO/RAE level would be helpful.
   - Initial education and good relationships with partners is essential (primary care, behavioral health – both public and private, SUD only providers, and housing, are top priorities)