Written Protocols to Strengthen Relationships and Improve Coordination Between Skilled Nursing Facilities (SNFs) and Regional Care Collaborative Organizations (RCCOs)

Intent

The protocols are designed to be bi-directional and collaborative. They are relevant to the Demonstration to Integrate Care for Full Benefit Medicare-Medicaid Enrollees (the Demonstration) and may be useful to the Accountable Care Collaborative (ACC) Program as a whole. Initial protocols utilize systems and data currently available while reflecting a commitment to continuous improvement.

Process

- Facilitate a meeting between Skilled Nursing Facilities (SNFs) and RCCO representatives who volunteer to participate and represent their broader interests.

- Discuss contractual roles and responsibilities, common and differing elements of care coordination, and ways to work together to better serve their shared clients.

- Prepare a preliminary draft of protocols.

- Meet again or communicate electronically to review the draft, answer questions, and resolve outstanding issues.

- Revise the draft and share with broader constituencies for additional input and comment.

- Submit written protocols as recommendations to the Demonstration's Advisory Subcommittee and the Department of Health Care Policy and Financing (the Department).

Elements

The purpose of the protocols is to foster collaboration between SNFs and RCCOs to better serve their shared Medicare-Medicaid beneficiaries and Medicaid clients. These protocols foster the SNF and RCCO common aims of (1) improving health outcomes for individuals, (2) improving client experience through enhanced coordination and quality of care, and (3) decreasing unnecessary and duplicative services and resulting costs.

SNF and RCCO core activities include (1) identification of shared clients, (2) understanding coordination responsibilities, (3) prioritization of shared clients, (4) contact and communication, and (5) mutually agreed upon support functions.

Identification of Shared Clients

The following process will occur monthly or as needed with a SNF designee and the RCCO Contract Manager or designee serving as the primary points of contact:

- The SNF will check the client's eligibility at time of admission to the SNF utilizing the Medicaid web portal and identify RCCO affiliation if present.

- The SNF will notify the appropriate RCCO of the client's admission within three business days or the timeframe mutually agreed upon (see diagram and notes in Attachment A).

- RCCO Contract Manager or designee and SNF designee will coordinate efforts on client discharge planning to ensure the client's needs and wishes are being addressed (see diagram and notes in Attachment A).

- As soon as possible or within three days prior to discharge, the SNF will contact the RCCO to coordinate a meeting with the client, family, and/or designated representative and to ensure an individualized approach to the client's transition of setting and services.

Understanding Coordination Responsibilities

- SNFs will continue to fulfill their responsibilities for clients, which include, but may not be limited to, activities such as skilled services, coordinating services with physicians; obtaining prior authorizations; facilitating transitions of care from one facility to another or to and from home and community; and providing other client support as needed.

- RCCOs will continue to fulfill their contractual responsibilities for clients, which include, but may not be limited to, activities such as coordinating medical and non-medical care; attending physician or specialist visits with the client as requested and appropriate; making referrals to sources for housing, food, and dental care; providing system navigation support; establishing care plans for goals clients would like to achieve; connecting clients with medical homes; and providing other client support as needed.

Prioritization of Shared Clients

- No less than quarterly, SNFs and RCCOs will prioritize shared clients based on each organization's knowledge of and experience with the clients.

- SNFs and RCCOs will schedule meetings to ensure that they organize coordination activities for the top tiers of individual clients appearing on each organization's priority list.

Contact and Communication

- As the client expresses choices in navigating service needs, SNFs and RCCOs will incorporate the individual client's preferences whenever possible; discuss each priority client's care coordination and transition needs; determine which organization fulfills the majority of those needs; identify the appropriate primary care coordination manager; have additional conversations; and engage other resources as needed.

- SNFs and RCCOs will use data analysis and client feedback to identify trends or types of situations where coordinated care management works well and does not work well.

- SNFs and RCCOs will utilize these discussions and trends to streamline care coordination and transition activities in a way that maximizes client outcomes and permits the care management team to apply resources effectively and efficiently.

- SNFs and RCCOs will consider assigning care managers from both organizations to shared clients in a way that facilitates conversations and activities with individual clients and between SNFs and RCCOs.

Mutually Agreed Upon Support Functions

- SNFs and RCCOs will continue to explore additional ways to support each other and the clients they serve.

- Such collaboration may include but not be limited to activities such as RCCOs providing access to the Primary Care Medical Provider (PCMP) directory to identify a list of possible medical homes for clients in search of a primary care physician and SNFs helping RCCOs find clients and assist in connecting them with medical homes.

Timeline

SNFs and RCCOs support the following timeline:

- Develop and share protocols with their broader constituencies (September 2013).

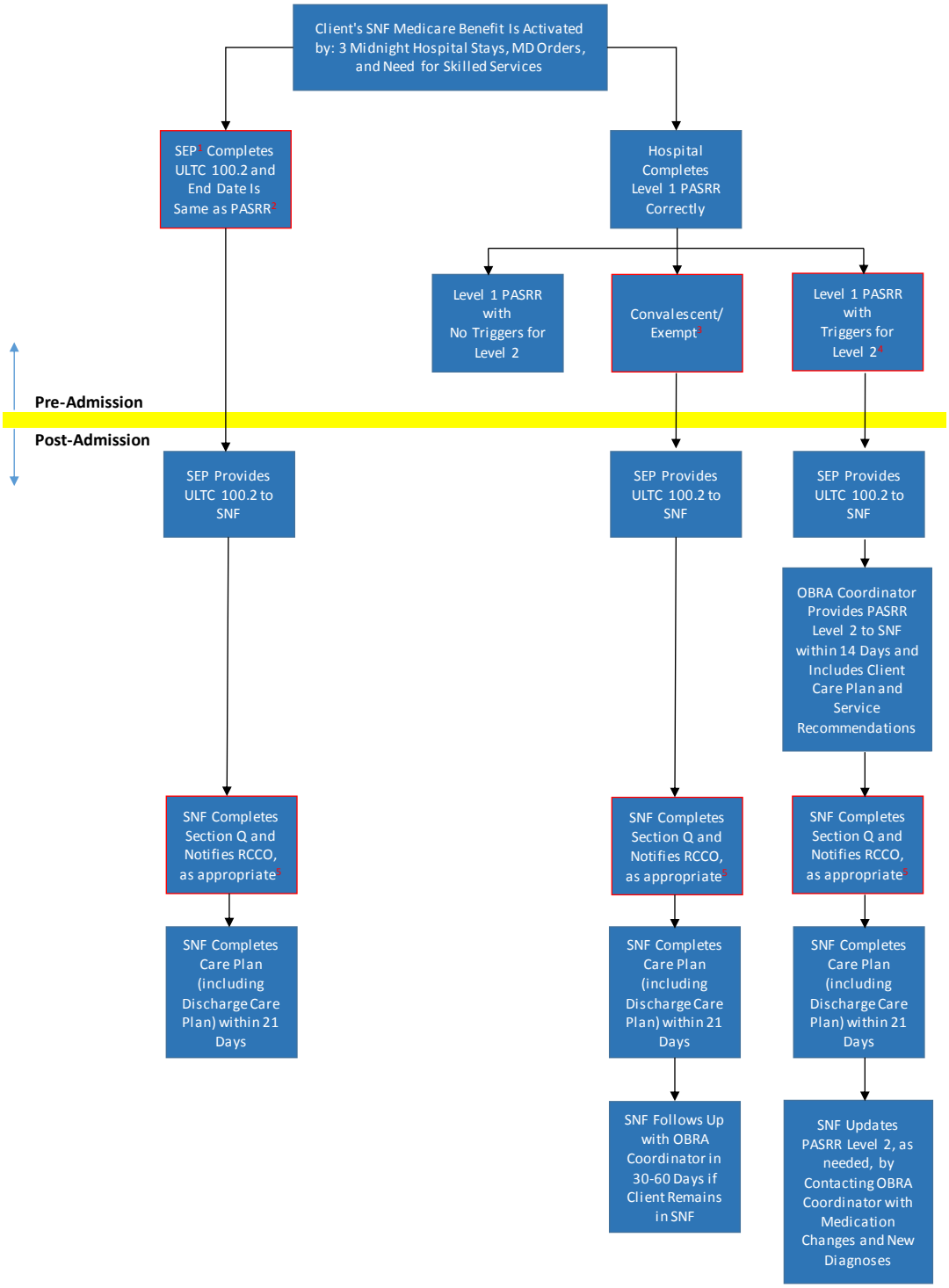
- Present protocols in final draft form to the Demonstration's Advisory Subcommittee (December 2013).

- Recommend protocols to the Department (December 2013/January 2014).

- Implement protocols for testing (January 2014).

- Assess protocols quarterly and make any necessary adjustments (April 2014 and thereafter).

Attachment A: Skilled Nursing Facility (SNF) Pre-Admission and Post-Admission Process



Notes:

1. SEP completes ULTC 100.2 before or upon admission to SNF for clients who are in co-pay days and need Medicaid to pay co-pays.
2. This applies only to Convalescent/Exempt outcomes.
3. Convalescent/Exempt stays are 30-60 days that apply to individuals with major mental illness, intellectual disability, or developmental disability.
4. The PASRR has Level 2 triggers, but the individual will not receive those services while in the SNF due to the short length of stay.
5. Completion of Section Q determines discharge preference and potential. Typically, three possibilities are:
   a. Discharge is not a goal, but long-term maintenance is.
   b. Discharge is a goal, but the client is not ready. The care plan is targeted toward discharge with periodic reassessments by the care team (SNF, RCCO, client, etc.). The SEP will complete a new ULTC 100.2, and the RCCO will assist with community services and supports.
   c. Discharge is a goal, and the client is ready. The SNF will notify the Utilization Review Contractor (URC), Single Entry Point agency (SEP), and RCCO, as appropriate, of intent to discharge.