Innovation to Support Access to Recuperative Care in San Diego

To increase access to CalAIM's Recuperative Care and Short-Term Post Hospitalization Housing community supports services, 211 San Diego, PATH, Interfaith Community Services, Father Joes, HASDIC, and San Diego Wellness Collaborative worked together collaboratively to discuss the current state of workflows, referrals to Recuperative Care Units (RCU's) and overall enrollment in services. Additionally, this group identified opportunities and strategies to streamline information and processes with the goal of improving overall workflows, increase cross sector education, and create more efficient and equitable access to RCU's.

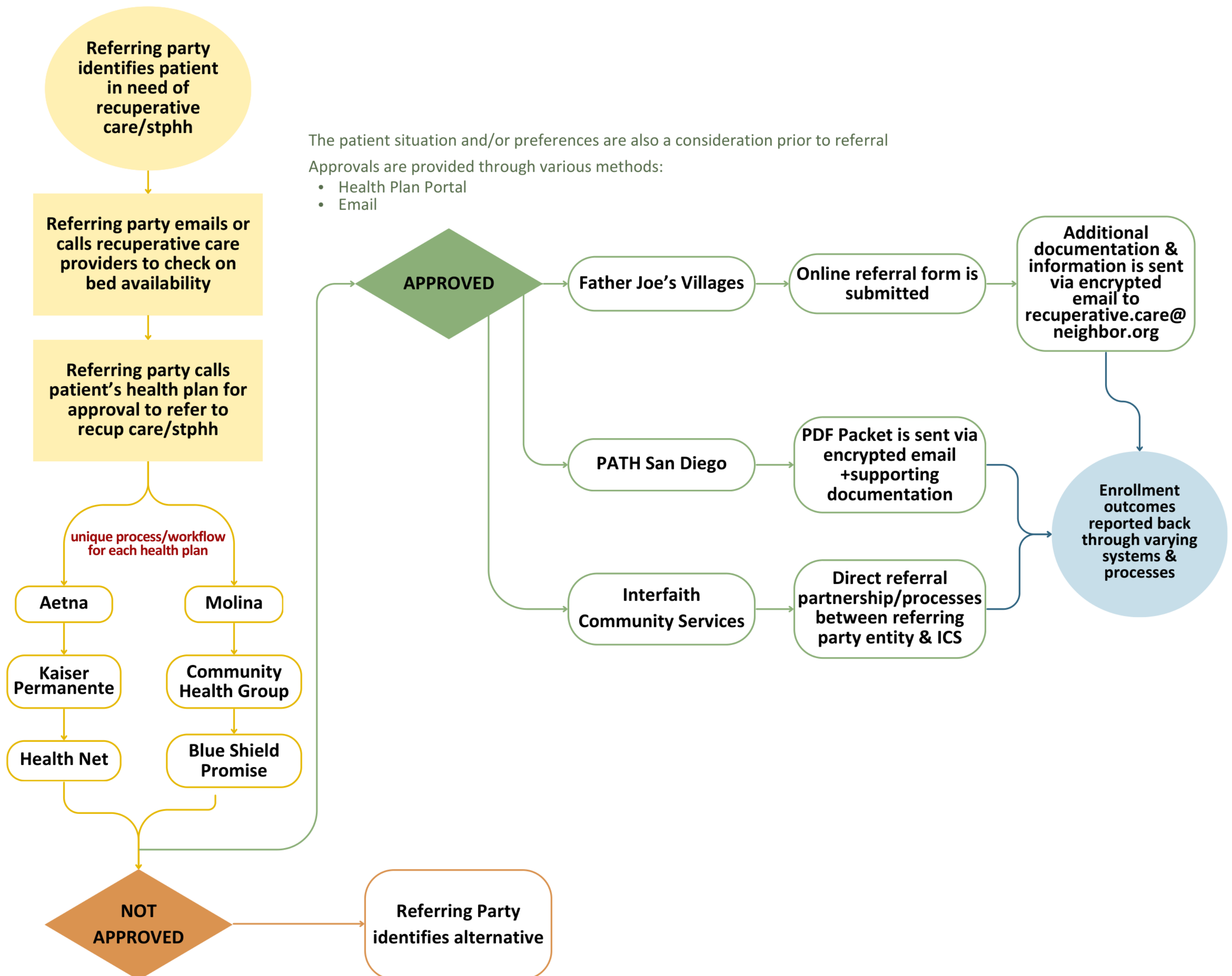
The following were completed collaboratively to identify the various infrastructure issues and to help propose solutions:

1. Review of the current state of referrals and referral workflows
2. Surveyed and/or interviewed the various stakeholders to gain insight into barriers or challenges with submitting referrals, authorizing referrals, or accepting/responding to referrals
3. Cross-referenced the various recuperative care intake processes (PATH, FJV, Interfaith) and questions with existing health plan eligibility criteria to create a standardized eligibility screener tool
4. Created draft eligibility screener tool to walkthrough various methodology and gather agreement from all stakeholders regarding question flow and formatting
5. Reviewed opportunities to integrate data from various sources, such as HMIS, to capture recuperative care bed usage and capacity by provider
6. Developed requirements to build standardized eligibility screening tool within CIE infrastructure to provide access to interested stakeholders
7. Designed a bed availability tool to support referral access, coordination and capacity

Current State of Referrals

In San Diego, there are currently 4 different health plans and 3 major non-profit recuperative care providers that accept referrals from health plans, hospitals, and community providers.

In the current state, there are varying methods to how a referring party can connect a client/patient to a recuperative care bed and is dependent on each health plan's specific requirements and each recuperative care provider's bed capacity, scope of services, and facility limitations. Due to the lack of a streamlined entry point to connect patients, delays in connecting patients are experienced and reported by all entities (referring party, health plan, RCU provider) throughout the referral process. Additionally, due to the current disjointed processes, there is a lack of transparency on where exactly in the process the gaps are most prevalent and overall understanding on the rates of successful referrals and enrollment in services.



Stakeholder Input on Referrals

The following strategies were used to gather input from all stakeholders:

- The three recuperative care and STPHH services providers in San Diego (PATH, Interfaith, and Father Joe's Villages) attended all workgroup meetings and provided input in all areas (current workflow, challenges, new screening and referral design, bed availability tool design)
- Interviews were conducted with three major hospital systems in San Diego County
- Interviews were conducted with the three Medi-Cal health plans
- Surveys and informal feedback from ECM and Community Support providers was collected

Identification of Challenges-Opportunities

The various stakeholders shared varying levels of challenges and provided insight on the varying points throughout the process that could create opportunities for streamlined processes.

FEEDBACK FROM HOSPITALS

Authorization Approvals

"Timely authorization approvals by health plans, including approvals only occur Monday-Friday when patients need discharge 24/7"

"Authorization approvals process is not able to be initiated until patient is medically ready to be discharged which creates delays in timely transfer/discharge of patient"

"Authorization approvals and outcomes are documented in varying systems or through varying ways (encrypted email vs. portal vs. fax)"

"Health plan coverage & authorization process for transportation from hospitals to RCU's sometimes require hospital to pay for transportation out-of-pocket, which is unsustainable for the hospital"

"Processes sometimes require strong liaison between hospital and health plan or escalation to/leveraging relationships with health plan leaders to ensure an authorization is approved timely and/or fully considered"

"Medical documentation/clinicals (Clinicals (PT notes, Chest X-ray, Discharge Summary/plan of care) is required by some health plans and recuperative care providers for approval of services and is often cumbersome and takes back and forth communication between health plan and hospital to verify eligibility"

FEEDBACK FROM HOSPITALS - continued

Eligibility & Capacity

Varying eligibility criteria, workflows and intakes required by health plan and RCUs creates confusion and decreases efficiency for hospital staff. Additionally, Some hospitals are unclear which health plans are contracted with which RCUs.

"Some health plans require referral to RCU first to confirm bed availability before sending authorization request form to health plan; other health plans require authorization through health plan as first step"

"Inconsistent information about bed availability - patients are being denied authorization due to lack of bed availability at RCU, although RCU's are reporting open capacity"

Some patients have preferences on type of shelter/recuperative care (e.g. congregate vs. non-congregate)

FEEDBACK FROM MANAGED CARE PLANS

Communication

"Back and forth communication between hospital and health plan or health plan and recuperative care to verify appropriateness and eligibility causes delays in turnaround time of authorizations and ultimately patient transfers."

i.e. Timeliness of response back from RCU regarding bed capacity and appropriateness of referral

Eligibility & Capacity

"Inconsistent referral processes from hospitals and community providers to recuperative care beds - some refer directly to the health plan for authorization first whereas others refer directly to RCU provider, bypassing the health plan"

i.e. Varying documentation required by RCUs

Lack of clarity by hospitals on requirements for recuperative care and necessary clinical documentation for approval by health plan and acceptance by recuperative care provider

"Contracted provider's overall bed capacity is limited--Health plans are looking into ways for RCU's to be able to expand bed capacity"

Member's change health plans in the middle of the month, creating issues with eligibility/authorizations and continuity of care.

FEEDBACK FROM RECUPERATIVE CARE UNIT PROVIDERS

One of the most common and significant themes identified through the interviews with recuperative care providers is that providers have not been at capacity for a majority of the time since the launch of CalAIM, although the community consistently reiterates that the level of need for recuperative care providers is high. Nevertheless, additional feedback was provided:

Communication

"Back and forth communication between RCU and health plan or RCU and hospital/referring party related to bed availability and overall capacity"

"Varying feedback loops through different systems causes confusion for RCU staff in gathering authorization # and approval dates for final placement"

Authorization Approvals

"Authorization approval process varies by health plan, i.e. some health plans do not provide authorization until RCU accepts patient, causing confusion in workflow"

"Non-coordinated authorization processes, including faxed forms and encrypted emails"

Referral Origin

"Primarily receiving referrals from hospitals or through internal sources, limited community referrals from other CalAIM service providers or community-based partners"

THROUGH LINES: A SUMMARY

Regardless of stakeholder, the most common challenges that came up through the interviews were:

1. Varying health plan requirements and workflows to access recuperative care units
2. Lack of transparency around bed availability and capacity by provider.
3. Delays in turnaround time of referrals and authorizations caused by:
   a. issues around referring parties understanding eligibility
   b. Documentation requirements for authorization approval and RCU acceptance

Proposed Solutions

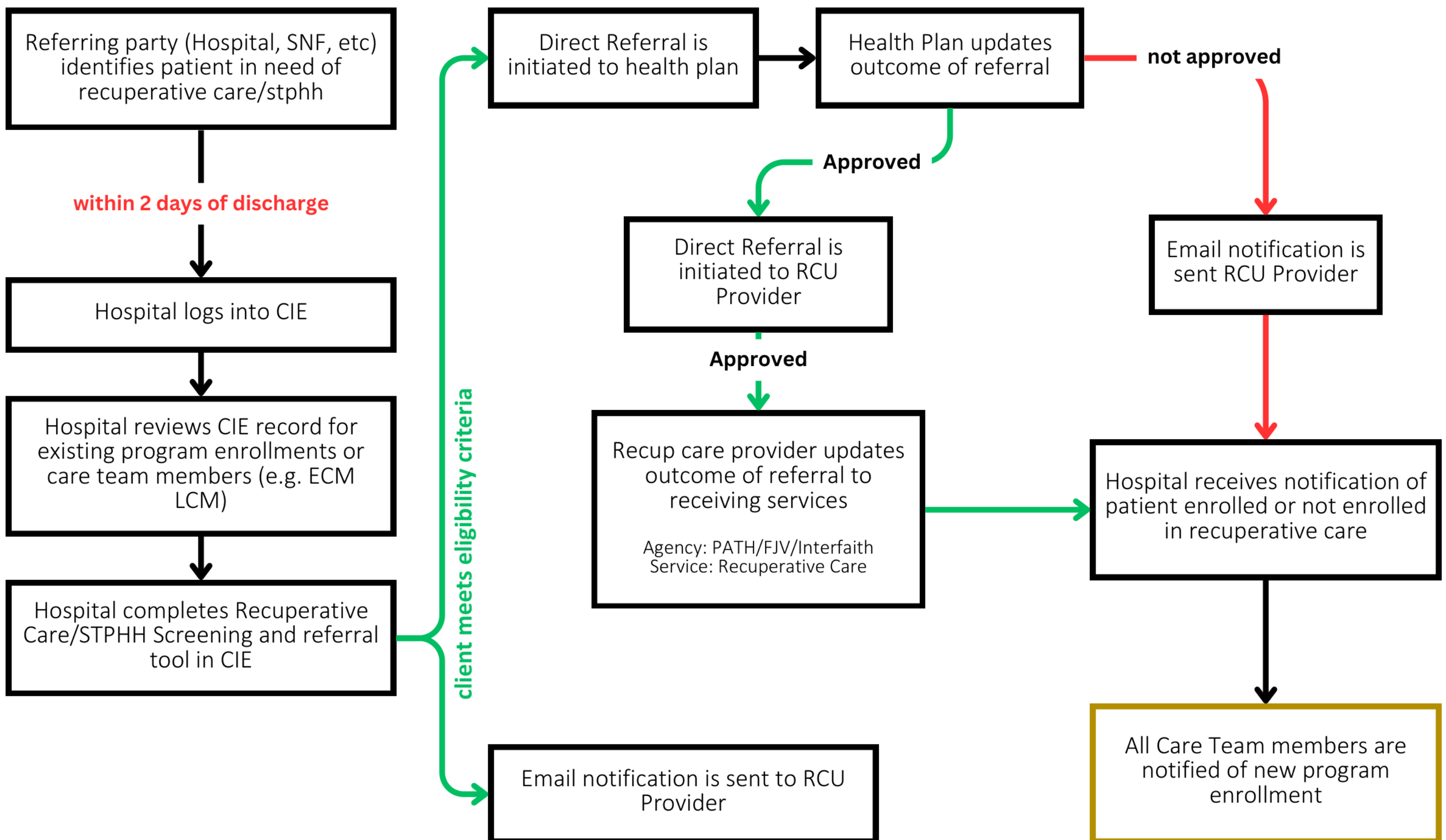
Through these exploratory conversations/interviews with the various stakeholders, the following are strategies that the workgroup will continue to prioritize:

1	Increased transparency of status of referral and point of enrollment or denial to improve feedback loop and help identify accurately the barriers to access
2	Common/unified screening and referral option that can help guide hospital and referring party staff in determining whether a patient meets the minimum requirements for a recuperative care stay
3	Additional transparency on RCU bed availability and capacity to help reduce the back and forth between hospital or health plan with the RCU to determine best placement
4	RCUs expand hours of operation to accommodate discharge and referrals after hours (5 pm-7:00 am)
5	Leverage existing technology (CIE/HIE) or build data integration with existing electronic health records or case management systems to adopt referral processes and increase referrals
6	Increase ER diversion by educating community-based organizations, CalAIM providers and Skilled Nursing Facilities about eligibility and referral flow for STPHH and Recuperative Care
7	MCPs adopt presumptive eligibility for recuperative care to increase access to services
8	MCPs without presumptive eligibility adopt a maximum of 72 hours turn around for authorization of services
9	Review HMIS/CES workflows in relation to Recuperative Care/STPHH program enrollments and suggest for community partners to reassess client and update their intake score, with the goal of potential reprioritization of housing placement

Outcome: 2-1-1 San Diego and the Community Information Exchange, in partnership with PATH, Interfaith, Father Joe's Villages, and the hospital association have drafted the following proposed ideal workflow.

In the ideal workflow, there is an additional pathway for hospitals and/or referring parties to access a common recuperative care screening tool that:

- Captures all of the necessary information required by the managed care plan and by the recuperative care provider
- Confirms that the patient does not meet any of the exclusionary criteria before proceeding
- Assesses the person's ADL needs and preferences for type of RCU (e.g. congregate vs. non-congregate)
- Provides guidance on clinical information needed along with overall next steps based on managed care plan requirements
- Leverages a bed availability tool within the flow to identify capacity information and is made available to referring party to help inform pathways to placement.



This solution would not replace any existing referral workflows outlined by the plans but could be supplemental with the goal of providing access to these services by any entity interested in a streamlined pathway. Additionally, there are many other challenges that cannot be solved through an updated workflow process, shared intake and bed availability tool. However, this is a first step in improving clarity in the process with the ultimate goal of improving access for members and decreasing the costs associated with hospital recidivism or delays in patient discharges.

Next Steps

Develop the tools and workflow processes within the CIE and engage with stakeholders to train, leverage and use these recommendations as an additional avenue to access recuperative care and stphh services. Additionally, apply lessons learned and best practices to improve access to other CalAIM community supports, developing similar processes to ensure no wrong door in connecting to CalAIM programs and benefits.

Considerations

RCU bed availability and capacity will be dependent on the RCU providing timely updates to 211/CIE and/or quality assuring the data that is being updated through CIE and other potential integrations.

Project Participants