Colorado
Accountable Care Collaborative

# FY 2012–2013 Accountable Care Collaborative Site Review Aggregate Report

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*This report was produced by Health Services Advisory Group, Inc. for the Colorado Department of Health Care Policy and Financing.*

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# 1. Overview

## Background

The Colorado Department of Health Care Policy and Financing (the Department) introduced the Accountable Care Collaborative (ACC) Program in spring 2011, as a central part of the Department's plan for Medicaid reform. The ACC Program was designed to improve the client and family experience, improve access to care, and transform incentives and the health care delivery process into a system that rewards accountability for health outcomes. Central goals for the program are improvement in health outcomes through a coordinated, client-centered system of care and cost control by reduction of avoidable, duplicative, variable, and inappropriate use of health care resources. A key component of the ACC Program was the selection of a Regional Care Collaborative Organization (RCCO) for each of seven regions within the State. The RCCOs provide medical management for medically and behaviorally complex clients; care coordination among medical, non-medical, and community-based providers; as well as provider support such as assistance with care coordination, referrals, clinical performance, and practice improvement and redesign.

## Methodology

In spring 2013 Health Services Advisory Group, Inc. (HSAG), performed a site review of each RCCO to assess the RCCO's progress toward implementing the ACC Program during its second year of operations. HSAG was asked to identify successes and barriers and make recommendations for improvement. This report documents the aggregate findings and recommendations.

The site review process consisted of a comprehensive evaluation of each RCCO related to Care Coordination and Care Management (Standard I) and Follow-Up on Access to Care/Medical Home (Standard II).

The purpose of the site reviews was to evaluate the RCCOs' progress toward implementation of the ACC model of patient care and explore barriers and improvement opportunities to collaborate with the Department to ensure the success of the ACC Program. The site review process included a desk audit of specific key documents from the RCCO prior to the site visit, on-site review of care coordination records, and on-site interviews of key RCCO personnel related to care coordination and care management (Standard I) and continued progress made on improving access to care and medical home standards (Standard II). HSAG used a qualitative interview methodology to elicit information regarding successes and perceived barriers in implementing the ACC Program. The qualitative interview process is the use of open-ended discussion that encourages interviewees to describe their experiences, processes, and perceptions. Qualitative interviewing is useful in analyzing systems issues and related desired or undesired outcomes. This technique is often used to identify strengths, evaluate performance differences, and analyze barriers. HSAG then analyzed information obtained during the on-site interviews to identify common experiences or concerns across RCCO regions, developing RCCO-specific and statewide recommendations for continued successful implementation of Colorado's ACC Program.

## Glossary

**The Department**—The Colorado Department of Health Care Policy and Financing
**ACC**—Accountable Care Collaborative
**AwDC**—Adults without Dependent Children
**BHO**—Behavioral Health Organization
**CCB**—Community Centered Board
**CCHA**—Colorado Community Health Alliance
**CCHAP**—Colorado Children's Healthcare Access Program
**CCT**—Community Care Team
**CHP**—Community Health Partnership
**CLAS**—Culturally and Linguistically Appropriate Services
**CMHC**—Community Mental Health Center
**DHS**—Department of Human Services
**ED**—Emergency Department
**EHR**—Electronic Health Record
**EPSDT**—Early and Periodic Screening, Diagnosis, and Treatment
**ER**—Emergency Room
**FBHP**—Foothills Behavioral Health Partners
**FQHC**—Federally Qualified Health Center
**HIPAA**—Health Insurance Portability and Accountability Act of 1996
**HRA**—Health Risk Assessment
**HSAG**—Health Services Advisory Group
**ICHP**—Integrated Community Health Partners
**MCPN**—Metro Community Provider Network
**MCS**—Metro Crisis Services
**MHCD**—Mental Health Center of Denver
**MOU**—Memorandum of Understanding
**NRBH**—North Range Behavioral Health
**PCMH**—Patient-Centered Medical Home
**PCMP**—Primary Care Medical Provider
**PCP**—Primary Care Provider
**RCCO**—Regional Care Collaborative Organization
**RMHP**—Rocky Mountain Health Plans
**SDAC**—Statewide Data Analytics Contractor
**SPMI**—Severe and Persistent Mental Illness
**TOC**—Transition of Care
**UPI**—University Physicians, Inc.

# 2. Trends Related to Discussion Themes

In the 2011–2012 contract year, HSAG identified five key characteristics or attributes of the ACC Program essential to success of the program. These characteristics were Medical Home/Integration of Care (Care Coordination), Network Adequacy, Outcomes Measurement, Member Involvement, and Collaboration. HSAG then organized information obtained during the interviews to identify trends and made recommendations appropriate for an evolving statewide ACC effort.

In the 2012–2013 contract year, the Department and HSAG determined that the focus of the annual review of RCCOs was Medical Home/Integration of Care (Care Coordination) and Network Adequacy. The remainder of this report analyzes the aggregated information obtained during the site review process related to these two domains. In addition, information related to collaboration that was obtained during on-site interviews has been trended, although collaborative processes were not thoroughly explored as a focus of the HSAG review. Trends related to Member Involvement and Outcomes Measurement were not reviewed during this contract year.

## Medical Home/Integration of Care (Care Coordination)

All regions, except Region 1, described multiple PCMP locations with on-site integration of behavioral health services for members and/or integration of physical health providers into mental health centers. All regions described this approach as a very positive contribution to the delivery of integrated services. Within Region 1, behavioral/physical health integration was addressed through the coordination of care by Community Care Teams, which included the local mental health organizations. All regions reported that they were continuing efforts to expand access to integrated on-site physical/behavioral health services.

All regions, except Region 7, were working with respective county departments of human services or other organizations concerning the attribution and coordination of care for foster care children.

All regions, except Region 7, had pursued formal data-sharing agreements or arrangements with providers in the region to facilitate coordination of care and alleviate HIPAA concerns. Data-sharing mechanisms varied by geographic area and the type of provider (e.g., hospitals, mental health centers, PCMPs). Some approaches were manual and some were through electronic health records (EHRs) or automated communication software.

All regions had made progress on building relationships to obtain real-time information regarding member hospitalizations or emergency department visits, in order to facilitate timely transition of care processes. Region 7 (CHP) and Region 1 (RMHP) reported significant success; Region 6 (CCHA) and Region 4 (ICHP) reported progress with select facilities; and Regions 2, 3, and 5 (all Colorado Access) reported limited progress.

All regions had active system-level programs related to cultural competency and linguistic needs. The three Colorado Access regions reported that the network included PCMPs with cultural capabilities appropriate for the RCCO membership. Region 4 and Region 2 reported that the rural culture was distinctive and well understood by the PCMPs in the rural counties. On an individual

member basis, none of the regions demonstrated that the assessment of member needs included the member's cultural beliefs and values, beyond language.

All regions identified members for care coordination services primarily through data sources. All regions, except Region 7, documented some level of health risk screening of members. However, only Region 1 consistently performed or documented a comprehensive assessment of member needs that addressed all of the requirements needed to complete comprehensive care coordination plans. Only Region 1 documented member-level assessment of care coordination services that may be provided through other agencies. Care management records demonstrated that diverse interventions were being actively pursued by care coordinators in all regions, except Region 6 and Region 7. All regions demonstrated member involvement in care planning and interventions.

Delegation of care management varied between regions. Regions 2, 3, and 5 (all Colorado Access) reported that 50 percent of members were attributed to delegated PCMPs. Region 1 (RMHP) delegated care management to sub-regional Care Coordination Teams. Region 4 (ICHP) delegated care management to FQHCs and clinics. Region 6 (CCHA) and Region 7 (CHP) delegated care management only to the network FQHCs, which CHP reported accounted for most of Region 7's RCCO members.

Delegation oversight in all regions was variable and informal. At the time of review, no region had conducted formal post-delegation audits to assess adequacy of care coordination provided by individual PCMPs. Most regions preferred a more "hands-off" approach, such as monitoring outcome metrics and/or meeting regularly with delegated entities to consult or problem-solve. The three Colorado Access regions (2, 3, and 5) and ICHP (Region 4) described the configuration and regular meetings of delegated PCMP care coordinator workgroups, which staff stated provided RCCO insight into delegated PCMP care coordination operations. All regions were dealing with diverse care management documentation systems within the network.

All regions were actively engaged in numerous innovative pilot programs, collaborations, or systemwide initiatives to address challenges related to specialty care, community agency involvement, coordination of care, or medical home development.

## Network Adequacy

All seven regions expanded their PCMP network within the past year, some with many providers and some with fewer providers, but all strategically or geographically important practices. Region 1, Region 2, and Region 4 remain challenged by the development of the PCMP network in the rural/frontier areas. Region 2, Region 3, Region 4, Region 5, and Region 7 expressed confidence that the existing PCMP network is adequate to integrate the expanding Medicaid populations in the foreseeable future.

All regions described continued active efforts by the RCCO to successfully recruit new PCMPs. All regions focused recruitment over the past year on Medicare/Medicaid providers for the full-benefit Medicare-Medicaid enrollees' population. In addition, all regions, except Region 7, focused on recruiting pediatric practices. All regions reported that recruitment was enhanced by the decision to discontinue the financial incentive for Colorado Children's Healthcare Access Program (CCHAP)

participation. Region 6 and Region 7 also targeted providers by Medicaid volume, and Region 1 targeted providers who have been requested by members. All regions, except Region 6, were also focused on expanding the Medicaid panels within existing contracted providers.

All regions stated that the best recruitment strategy has been the offer to provide practice support resources, particularly care coordination services. Regions 1, 2, 3, 4, and 5 were also incorporating messaging concerning the future direction of Colorado Medicaid and implications of Medicaid expansion. While all regions meet the minimum contract requirements related to after-hours triage, the availability and promotion of urgent care or after-hours care varies by region. Region 1 reported availability of extended hours at 40 percent of the PCMPs in the network, although many areas in this widely dispersed geographic region do not have after-hours or urgent care facilities. Region 7 had availability of PCMP extended hours in several locations, as well as access to urgent care in a major hospital ED, all of which are accessible to the majority of the members in the region. Region 6 promoted member access to many available urgent care facilities in the region. Regions 2, 3, 4, and 5 had limited availability of extended-hour PCMPs for most members, and either limited relationships with or limited availability of urgent care facilities for many members within the regions. However, these RCCOs were continuing to pursue options for urgent care and after-hours relationships.

All regions, except Region 6, described concerns related to the shortage of select types of specialists within their regions and consistently identified a shortage of pain management specialists. In addition, all regions, except Region 6, described general concerns related to open panels or timely access to specialists for Medicaid members. None of the regions had pursued formal relationships with specialists (i.e., MOUs); however, all regions were tracking trends related to referrals to particular specialists, and some were considering developing more formal relationships with specialists in the future.

All regions were customizing practice support resources to the needs of individual PCMPs. Region 1, Region 2, Region 3, Region 5, and Region 6 had not conducted comprehensive medical home assessments of all PCMP practices. Region 4 and Region 7 completed assessments but had not consistently used results to define individual PCMP or systemwide practice support plans. Intensive targeted efforts by the RCCO to transition individual practices to meet all Department-defined medical home standards were varied. Region 1 described a variety of system support activities that were implemented in select PCMPs, which were often associated with other grant or special program initiatives in which RMHP was invested (e.g., Comprehensive Primary Care initiative, Beacon Community Program). Region 7 had invested in the intensive transformation process for one large PCMP. Region 4 invested in the development of customized information system applications to facilitate RCCO-oriented needs in select practices. All regions stated that the practice transformation approach was to offer select practice support services as needs are identified or requested through relationships with PCMPs. Regions 2, 3, 4, 5, and 7 all reported that they estimate that all or most PCMPs in the region (with the exception of several small PCMPs) will ultimately be capable of performing as fully functioning medical homes. Region 1 and Region 6 estimated that only, or primarily, FQHCs would be able to perform as medical homes, due to a large number of smaller practices in their RCCO networks.

## Collaboration

Each region described numerous pilot projects, collaborative efforts, or innovative development processes in which the RCCO was engaged. Examples (from all regions) included, but were not limited to the following:

- ED Diversion program through the fire department emergency medical response personnel.
- PCMP care coordinator presence in the local ED to enhance ED diversion.
- Collaboration among local providers to develop protocols for specialist care to be delivered by PCPs.
- Collaborative efforts to address regional pain management program needs, engaging in medical neighborhood initiatives.
- Working with hospitals to obtain real-time admission and discharge data.
- Working with community centered boards to coordinate care management services.
- Developing data-sharing agreements to overcome HIPAA concerns.
- Working with county agencies on foster care children issues.
- Visiting homeless shelters to identify Adults without Dependent Children (AwDC) members for the RCCO program.
- Developing cost-effective IS software applications to support PCMP communications and reporting.
- Advocating for mental health centers with embedded physical health professionals to be designated as PCMPs for members with severe mental illness.
- Defining magnet practices for foster care children.

Region 1, Region 2, Region 3, Region 4, and Region 5 organized work groups of delegated PCMP care coordinators and community agency care coordinators to enhance and organize effective care coordination efforts for members.

All regions continued to participate in Department-organized collaborative committees, as well as RCCO cross-regional program development or problem-solving projects.

# 3. Conclusions and Overall Recommendations

## Conclusions

All RCCOs continue to move forward with new network development, building relationships with diverse community providers, and engaging in explorative and innovative activities, in preparation for integrating the Medicaid expansion populations. PCMP recruitment activities have become more challenging over time, as the Medicaid-experienced and reform-receptive providers have been previously engaged by the RCCOs. RCCOs remain committed to providing value-added services to the PCMPs and maintaining a non-invasive, non-prescriptive approach with PCMPs' pre-established processes and systems. The Department and the RCCOs have embraced the performance outcome orientation to evaluating RCCO performance. To that end, RCCOs have been hesitant to perform detailed on-site audits of PCMP delegated processes, and prefer to define meaningful outcome metrics for monitoring performance. RCCOs remain high-energy organizations as they simultaneously integrate a growing number of Medicaid populations and initiate numerous new projects and relationships in efforts to transform the delivery system for Colorado Medicaid clients.

The RCCOs have become significantly better organized and resourced in the past year related to care coordination programs. RCCOs continue to look for opportunities to delegate care management functions to capable PCMPs while providing centralized staff resources to support the care management of members assigned to non-delegated PCMPs. RCCOs are working with many diverse care coordination processes and documentation systems. All RCCOs have engaged in region-wide initiatives focused on improving and streamlining care coordination among multiple provider entities and agencies. All RCCOs have developed some type of collaborative group or process to review and discuss more complex members and situations. HSAG encouraged the RCCOs to continue these efforts to ensure creative problem solving for members with challenging and complex needs.

Because care coordination is such an essential characteristic of ACC success, HSAG conducted care coordination case reviews to determine whether the Department requirements for comprehensive care management were being performed at the member level. HSAG appreciates the challenges associated with contacting and managing complex Medicaid clients. Nevertheless, results of case reviews indicated areas for improvement that were common across RCCOs, and verified inconsistencies in processes across regions and between delegated PCMPs within regions. Therefore, meaningful metrics for evaluating the quality of care coordination services being provided to members, as well as meaningful measures of outcomes of the care coordination process, need to be defined. HSAG provides recommendations as follows.

## Overall Opportunities for Improvement and Recommendations

Health risk screenings or other applied assessments must consistently screen for health status, health risk behaviors, and both medical and non-medical needs. In addition, a comprehensive needs assessment should be performed for all members who are referred for complex care management. This should include a detailed assessment of the above elements, as well as an assessment of the member's cultural beliefs and values, and whether there are other agencies/providers involved in managing the member's care. Because comprehensive needs assessments were not consistently performed in six out of seven regions, there is an opportunity for a collaborative RCCO project to define a master comprehensive assessment tool that could be used as a guide for RCCO care coordinators, as well as delegated PCMPs and other care coordination entities.

While all RCCOs either had or were developing a process for obtaining releases of information from members to decrease barriers encountered when attempting to contact other providers or service agencies, all RCCOs should prioritize development and use of releases of information to ensure timely coordination with multiple providers.

All RCCOs should develop more robust mechanisms for oversight of delegated PCMP care coordination processes through performing periodic audits of delegated PCMPs and by defining meaningful metrics and outcome measures to monitor the quality of care coordination being provided to members. Because several RCCOs expressed interest in defining meaningful outcome measures, HSAG recommends that the RCCO leadership and the Department evaluate whether an opportunity exists for a collaborative effort to define meaningful care coordination metrics on a statewide basis.

All RCCOs should continue to develop their networks as outlined in interview discussions, and carefully monitor the capacity of the networks to continue to integrate the growing membership of the Medicaid expansion populations. The Department might consider developing public and provider messaging to stimulate increased PCMP and specialist participation. Messaging would convey the evolving role of the RCCOs in delivering care to expanded eligible populations and in reforming the Colorado delivery system for state-supported health care clients.

All RCCOs should continue efforts to obtain real-time information from hospitals and other entities to facilitate transition of care planning for members.

The RCCOs and the Department should continue to work collaboratively to remove barriers and pursue innovative solutions for increased access to after-hours and urgent care. In addition, the Department and RCCOs should continue to pursue mechanisms to improve the attribution of members to PCMPs.

All RCCOs should perform a periodic formal assessment of PCMP medical home functions to determine the progress and effectiveness of the varied practice support services being offered by the RCCOs, and to confirm the status of medical home performance in the statewide ACC program.

## Region 1—Rocky Mountain Health Plans (RMHP)

| Standard I—Care Coordination/Care Management *for* Rocky Mountain Health Plans (Region 1) | |
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| **Summary of Strengths** | ◆ RMHP divided Region 1 into five smaller, community-focused areas and contracted with an organization in each area to manage the care coordination efforts for that community. These designated sub-regional organizations partner with physical and behavioral health providers and community service agencies in each area to form Community Care Teams (CCTs). The RMHP team provides all care coordination in the Grand Junction area and in the other counties not covered by one of the five CCTs.<br>◆ Each CCT integrated the local mental health center into the team, which facilitated the integration of care between behavioral and physical health providers.<br>◆ Each CCT was allowed to use the care coordination methods it deemed most suitable for its community/region. RMHP oversaw and worked with the teams to educate and encourage development of comprehensive assessments.<br>◆ RMHP's five CCTs worked on developing relationships with discharge planners at area hospitals and described several initiatives related to improving care coordination for members accessing hospital and emergency department (ED) services.<br>◆ One CCT engaged lay Hispanic/Latino community members (trained to provide basic health education in the community) to educate target audiences about health issues affecting their community. |
| **Summary of Opportunities for Improvement and Recommendations** | ◆ RMHP should consider working with the CCTs to enhance assessment of cultural and spiritual beliefs and values to ensure robust care plans that address all facets of cultural needs. |

| Standard I—Care Coordination Record Reviews *for* Rocky Mountain Health Plans (Region 1) | |
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| **Summary of Strengths** | ◆ Members were referred into the care coordination program by emergency departments, physical health providers, behavioral health providers, outside agencies, and through claims data.<br>◆ All of the files reviewed by HSAG included comprehensive assessments that covered physical and behavioral health status, risks, and needs; cultural and/or linguistic needs, beliefs, and values; and non-medical needs such as assistance with food, shelter, and transportation.<br>◆ There was ample documentation of all services provided, as well as attempts to provide services, and documentation of regular communications between members and care coordinators. |
| **Summary of Opportunities for Improvement and Recommendations** | ◆ RMHP may want to consider working with the CCTs to enhance assessment of cultural and spiritual beliefs and values to ensure robust care plans that address all facets of cultural needs. |

| Standard II—Follow-Up: Access to Care/Medical Home *for* Rocky Mountain Health Plans (Region 1) | |
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| **Summary of Strengths** | ◆ PCMP locations were distributed throughout the geographically broad region. RMHP reported that 10 additional locations had been added to the network. Nearly 75 percent of the contracted PCMPs were accepting new patients, with a lower percentage in the Larimer County focus community. In some rural counties, members did not have access to care within 30 miles of their homes.<br>◆ RMHP recruitment efforts targeted pediatric practices and providers who serve Medicare-Medicaid dual-eligible members. In addition, member requests for particular providers were targeted, particularly within Larimer County. Hospitals in the frontier areas agreed to notify RMHP of any new provider moving into an area in order for RMHP to initiate RCCO contracting conversations.<br>◆ Recruitment conversations are individualized and strategically nuanced to each provider's priorities, with emphasis on the provider's ability to maintain maximum control while gaining experience in an evolving new program.<br>◆ RMHP described some difficulty in obtaining specialty care. Staff stated it is not uncommon for the RCCO to send members to Denver or Durango to obtain specialist care.<br>◆ The network provided for extended hours and access to after-hours urgent care. Thirty-nine percent of the PCMP locations offered extended hours on weekends and/or evenings. Provider triage coverage was assessed via the patient-centered medical home (PCMH) practice monitoring tool. RCCO member communications encouraged use of urgent care facilities as an alternative to ER visits.<br>◆ Practice support activities included dissemination of support resources and formal training classes for providers. The RCCO is positioning all practices to use sophisticated analytics, but is tailoring its approach and coaching to each practice's individual needs and readiness.<br>◆ Staff reported that, with the exception of FQHCs in the regions, the majority of PCMPs in Region 1 are smaller practices that are not equipped to meet medical home standards or provide care coordination. |
| **Summary of Opportunities for Improvement and Recommendations** | ◆ There were no recommendations for improvement related to the Access to Care/Medical Home requirements. |

## Region 2—Colorado Access

| Standard I—Care Coordination/Care Management *for* Colorado Access (Region 2) | |
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| **Summary of Strengths** | ◆ Colorado Access actively pursued implementing integrated behavioral and physical health services in clinics, developing and executing data-sharing agreements with multiple provider entities, and facilitating collaborative efforts to improve the provision of integrated care for members.<br>◆ Approximately 70 to 80 percent of the members in Region 2 received services from primary care medical providers (PCMPs) with integrated behavioral health services.<br>◆ The RCCO was working with county departments of human services (DHS) and some social service agencies targeted at integrating care coordination for foster care children.<br>◆ Colorado Access signed memorandum of understanding (MOU) data-sharing agreements with the community centered boards (CCBs) in all regions and began discussions related to coordinating care management functions.<br>◆ Colorado Access executed data-sharing MOUs with provider and community entities to alleviate concerns about compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and began sharing lists of RCCO clients to identify members common to both organizations.<br>◆ Colorado Access organized a collaborative effort among care managers from various systems to collectively define integrated care management processes.<br>◆ The majority of RCCO members eligible for case management services were identified through data, followed by care manager outreach to complete the health risk assessment (HRA). A more comprehensive assessment of member needs is intended to follow the HRA screening.<br>◆ Approximately 50 percent of members were assigned to PCMPs delegated to perform care management services, which included routine and intensive care management and transitions of care. The remaining 50 percent were supported through Colorado Access care managers, who are assigned to support specific PCMP practices.<br>◆ RCCO staff members were confident in the general level of cultural competency in the provider network, particularly in the larger PCMPs that are experienced with serving the Medicaid population, and in outlying areas where providers are well versed in the rural culture.<br>◆ Colorado Access implemented numerous initiatives and engaged in system-wide planning related to care coordination for various special needs populations. |

| Standard I—Care Coordination/Care Management *for* Colorado Access (Region 2) | |
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| | ◆ Colorado Access continued working with hospitals to obtain real-time information concerning member discharge from the hospital in order to perform transition of care (TOC) management.<br>◆ Colorado Access was evaluating the best metrics for tracking the outcomes of the TOC program, as well as the delegated care management programs. |
| **Summary of Opportunities for Improvement and Recommendations** | ◆ HSAG recommended that Colorado Access review HRA questions for consistency, as appropriate, to ensure screening of health status, health behaviors, and non-medical needs.<br>◆ Colorado Access should ensure that care managers perform and document a comprehensive assessment for members in need of care coordination services to guide the interventions in the care coordination plan.<br>◆ Care coordination assessments of member needs should include assessment of the member's cultural beliefs and values (i.e., beyond language) that may impact the member's health or the care plan. Once assessed, identified cultural characteristics should be incorporated into the care plan interventions.<br>◆ Colorado Access must also develop a mechanism to identify and document whether other care managers are involved in the member's care.<br>◆ HSAG recommended that Colorado Access communicate/educate delegated entities regarding the elements of care coordination contract requirements to ensure that Department contract requirements related to care coordination are being incorporated into delegated PCMP care management processes.<br>◆ HSAG encouraged Colorado Access to continue its efforts with hospitals and other entities to define mechanisms to timely identify members who are transitioning from one level of care to another.<br>◆ HSAG recommended that Colorado Access implement mechanisms to ensure that the transition of care plan is documented and communicated to the PCMP and other involved providers.<br>◆ HSAG encouraged Colorado Access to continue to pursue meaningful measures regarding the effectiveness of transition of care management by both Colorado Access and delegated PCMPs. HSAG also recommended that Colorado Access continue to pursue the development of meaningful metrics for monitoring the effectiveness of delegated care coordination functions. |

| Standard I—Care Coordination Record Reviews *for* Colorado Access (Region 2) | |
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| **Summary of Strengths** | ◆ In most cases, some form of a health risk screening was performed for each member.<br>◆ Care managers appeared to do an excellent job, overall, of actively engaging the member and actively pursuing interventions with providers and community service agencies.<br>◆ There was documentation of multiple follow-up calls by the care coordinator to the member to ensure appointments were made and kept. Care coordinators also documented multiple calls to vendors. |
| **Summary of Opportunities for Improvement and Recommendations** | ◆ The HRAs used by Colorado Access did not address a member's behaviors that might put the member at risk for health complications, and not all of the assessments thoroughly addressed the member's non-medical needs. Colorado Access should ensure its HRAs or other assessments clearly address the member's health status, health risk behaviors, and both medical and non-medical needs.<br>◆ Individual member's cultural beliefs and values were not being formally assessed or documented, and were not consistently addressed in care plans. Colorado Access must ensure it evaluates and documents the member's cultural beliefs and values.<br>◆ Most of the substantive content of the care plan was documented in care coordinator notes, and interventions were not specifically related to assessed member needs or care plan goals. In addition, in several cases, care coordination plans were noted to be episodic, addressing only the immediate needs, rather than the comprehensive needs, of the member. Colorado Access should ensure each member's record includes a care plan that reflects the member's assessed needs and appropriate interventions. |

| Standard II—Follow-Up: Access to Care/Medical Home *for* Colorado Access (Region 2) | |
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| **Summary of Strengths** | ◆ Colorado Access reported significant growth in the provider network across all three Colorado Access regions, including a large majority of practices with open panels for RCCO members. Colorado Access analyzed the network data and determined that it has sufficient capacity in the existing PCMP network to integrate the expanding RCCO populations into the foreseeable future.<br>◆ The unavailability of PCMPs in some rural counties within Region 2 was the primary recruitment priority, with particular emphasis in the Burlington area and the Yuma Hospital District.<br>◆ Colorado Access has targeted recruitment of full-benefit Medicare-Medicaid enrollees' providers and pediatric practices in all regions.<br>◆ Staff stated that RCCO relationships with specialists are primarily managed through the PCMP's pre-established referral networks. The large hospital systems in the region (in Weld and Larimer counties) have purchased many specialist practices and control the specialist environment. Specialists often are flown into the rural areas as an outreach effort by the larger hospital systems.<br>◆ Formal relationships with specialists through other Colorado Access lines of business overlap with the RCCO regions. Those relationships are leveraged when necessary to supplement access to specialists in the RCCO.<br>◆ Colorado Access is exploring methods of providing performance incentives to stimulate specialists and hospitals to respond to the needs of RCCO members.<br>◆ The RCCO has engaged in regional initiatives related to the shortage of particular specialist services, such as pain management services.<br>◆ Colorado Access is conducting analysis of the most frequently used specialists for RCCO members in anticipation of building more direct relationships with those specialists in the future.<br>◆ There is access to after-hours/urgent care in some of the more populous areas in the region, although most rural areas have little access to after-hours care with the exception of hospital ERs. Colorado Access has considered analyzing the reasons that members seek after-hours and urgent care to guide effective solutions.<br>◆ Staff reported that all major clinics in the region are adequately performing all medical home functions. Approximately 70 percent of all RCCO members are receiving care through these PCMPs.<br>◆ PCMP care coordination capabilities have been the focus of PCMP practice assessments in support of continued delegation of care |

| Standard II—Follow-Up: Access to Care/Medical Home *for* Colorado Access (Region 2) | |
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| | management functions. Through close ongoing relationships between the RCCO contract managers and individual PCMPs, needs and PCMP readiness for practice assistance and transformation services were being identified, and the RCCO was providing resources accordingly.<br>◆ Within the rural areas, the RCCO has begun to engage HealthTeamWorks and Colorado Children's Healthcare Access Program CCHAP to assist practices in transition.<br>◆ Colorado Access anticipated that all currently contracted practices in the region will eventually be capable of performing as a medical home. |
| **Summary of Opportunities for Improvement and Recommendations** | ◆ HSAG encouraged Region 2 to continue its network development efforts as described, and to monitor the expanding Medicaid membership over time to anticipate changing provider network needs.<br>◆ HSAG encouraged Colorado Access to use the analysis of reasons that members seek after-hours care to pursue innovative solutions for the provision of increased access to after-hours care throughout the region.<br>◆ HSAG recommended that, at some appropriate time in the future, Colorado Access consider performing a more formal assessment of PCMPs' medical home functions to ensure that all medical home standards outlined by the Department are being met. |

## Region 3—Colorado Access

| Standard I—Care Coordination/Care Management *for* Colorado Access (Region 3) | |
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| **Summary of Strengths** | ◆ Colorado Access actively pursued implementing integrated behavioral and physical health services in clinics, developing and executing data-sharing agreements with multiple provider entities, and facilitating collaborative efforts to improve the provision of integrated care for members.<br>◆ Approximately 60 percent of PCMP practices across all three Colorado Access regions had some form of integrated behavioral health care. Eight of Region 3's PCMP sites offered integrated or embedded behavioral health services. In addition, several community mental health centers (CMHCs) had embedded physical health practitioners on-site. Colorado Access and the behavioral health organization (BHO) for the region exchanged common member information to enable coordination between behavioral health and medical providers.<br>◆ The RCCO was working with county DHS and social service agencies targeted at integrating care coordination for foster care children.<br>◆ Colorado Access signed MOU data-sharing agreements with the CCBs in all regions and began discussions related to coordinating care management functions.<br>◆ Colorado Access completed data-sharing MOUs with provider and community entities to alleviate HIPAA concerns and was sharing lists of RCCO clients to identify members common to both organizations.<br>◆ Colorado Access organized a collaborative effort among care managers from various systems to collectively define integrated care management processes.<br>◆ The majority of RCCO members eligible for care management services were identified through data, followed by care manager outreach to complete the HRA. A more comprehensive assessment of member needs is intended to follow the HRA screening.<br>◆ Approximately 50 percent of members were assigned to PCMPs delegated to perform care management services, including routine and intensive case management and transitions of care. The remaining 50 percent were being supported through Colorado Access care managers, who are assigned to support specific PCMP practices.<br>◆ RCCO staff members were confident in the general level of cultural competency in the provider network, particularly in the larger PCMPs that are highly experienced with serving the Medicaid population, as well as providers who target specific niche populations (e.g., refugees). |

| Standard I—Care Coordination/Care Management *for* Colorado Access (Region 3) | |
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| | ◆ Colorado Access implemented numerous initiatives and engaged in system-wide planning related to care coordination for various special needs populations.<br>◆ Colorado Access continued working with hospitals to obtain real-time information concerning member discharge from the hospital in order to perform TOC management.<br>◆ Colorado Access was evaluating the best metrics for tracking the outcomes of the TOC program, as well as the delegated care management programs. |
| **Summary of Opportunities for Improvement and Recommendations** | ◆ HSAG recommended that Colorado Access review HRA questions for consistency, as appropriate, to ensure screening of health status, health behaviors, and non-medical needs.<br>◆ Colorado Access should ensure that care managers perform and document a comprehensive assessment for members in need of care coordination services to guide the interventions in the care coordination plan.<br>◆ Care coordination assessments of member needs should include assessment of the member's cultural beliefs and values (i.e., beyond language) that may impact the member's health or the care plan. Once assessed, identified cultural characteristics should be incorporated into the care plan interventions.<br>◆ Colorado Access must also develop a mechanism to identify and document whether other care managers are involved in the member's care.<br>◆ HSAG recommended that Colorado Access communicate/educate delegated entities regarding the elements of care coordination contract requirements to ensure that Department contract requirements related to care coordination are being incorporated into delegated PCMP care management processes.<br>◆ HSAG encouraged Colorado Access to continue its efforts with hospitals and other entities to define mechanisms to timely identify members who are transitioning from one level of care to another.<br>◆ HSAG recommended that Colorado Access implement mechanisms to ensure that the transition of care plan is documented and communicated to the PCMP and other involved providers.<br>◆ HSAG encouraged Colorado Access to continue to pursue meaningful measures regarding the effectiveness of transition of care management by both Colorado Access and delegated PCMPs. HSAG also recommended that Colorado Access continue to pursue the development of meaningful metrics for monitoring the effectiveness of delegated care coordination functions. |

| Standard I—Care Coordination Record Reviews *for* Colorado Access (Region 3) | |
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| **Summary of Strengths** | ◆ In most cases, some form of a health risk screening was performed for each member.<br>◆ Care managers appeared to do an excellent job, overall, of actively engaging the member and actively pursuing interventions with providers and community service agencies.<br>◆ There was documentation of multiple follow-up calls by the care coordinator to the member to ensure appointments were made and kept. Care coordinators also documented multiple calls to vendors. |
| **Summary of Opportunities for Improvement and Recommendations** | ◆ The HRAs used by Colorado Access did not address a member's behaviors that might put the member at risk for health complications, and not all of the assessments thoroughly addressed the member's non-medical needs. Colorado Access should ensure its HRAs or other assessments clearly address the member's health status, health risk behaviors, and both medical and non-medical needs.<br>◆ Individual member's cultural beliefs and values were not being formally assessed or documented, and were not consistently addressed in care plans. Colorado Access must ensure it evaluates and documents the member's cultural beliefs and values.<br>◆ Most of the substantive content of the care plan was documented in care coordinator notes, and interventions were not specifically related to assessed member needs or care plan goals. In addition, in several cases, care coordination plans were noted to be episodic, addressing only the immediate needs, rather than the comprehensive needs, of the member. Colorado Access should ensure each member's record includes a care plan that reflects the member's assessed needs and appropriate interventions. |

| Standard II—Follow-Up: Access to Care/Medical Home *for* Colorado Access (Region 3) | |
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| **Summary of Strengths** | ◆ Colorado Access reported significant growth in the provider network across all three Colorado Access regions, including a large majority of practices with open panels for RCCO members. Colorado Access analyzed the network data and determined that it has sufficient capacity in the existing PCMP network to integrate the expanding RCCO populations in the foreseeable future.<br>◆ Colorado Access has targeted recruitment of full-benefit Medicare-Medicaid enrollees' providers and pediatric practices in all regions. Within Region 3, the focus of recruitment was on multi-practitioner pediatric practices, many of which already operate as children's medical homes.<br>◆ Staff stated that RCCO relationships with specialists are primarily managed through the PCMP's pre-established referral networks. University Physicians, Inc. (UPI), Denver Health, and Kaiser Permanente (Kaiser) have particularly good systems for accessing specialists, but access is primarily limited to members who are assigned to those PCMPs.<br>◆ Formal relationships with specialists through other Colorado Access lines of business overlap with the RCCO regions. Those relationships are leveraged when necessary to supplement access to specialists in the RCCO.<br>◆ Colorado Access is exploring methods of providing performance incentives to stimulate specialists and hospitals to respond to the needs of RCCO members.<br>◆ The RCCO has engaged in regional initiatives related to the shortage of particular specialist services, such as pain management services.<br>◆ Colorado Access is conducting analysis of most frequently used specialists for RCCO members in anticipation of building more direct relationships with those specialists in the future.<br>◆ Metro Community Provider Network (MCPN) opened a new after-hours clinic, available to all Medicaid members. RCCO staff was pursuing a relationship with a new multi-location urgent care provider in the region.<br>◆ Colorado Access has considered analysis of the reasons that members seek after-hours and urgent care to guide effective solutions.<br>◆ PCMP care coordination capabilities have been the focus of PCMP practice assessments in support of continued delegation of care management functions. Through close ongoing relationships between the RCCO contract managers and individual PCMPs, needs and PCMP readiness for practice assistance and transformation services were being identified, and the RCCO was providing resources accordingly.<br>◆ Staff anticipated that all but two or three currently contracted practices in Region 3 will eventually be capable of performing as a medical home. |

| Standard II—Follow-Up: Access to Care/Medical Home *for* Colorado Access (Region 3) | |
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| **Summary of Opportunities for Improvement and Recommendations** | ◆ HSAG encouraged Region 3 to continue its network development efforts as described, and to monitor the expanding Medicaid membership over time to anticipate changing provider network needs.<br>◆ HSAG encouraged the RCCO to continue to work with the UPI PCMP to determine mechanisms that will open UPI clinics to an increasing number of RCCO members.<br>◆ HSAG encouraged Colorado Access to continue to pursue strategies to stimulate access to specialists for RCCO members, including access to specialists through UPI and Denver Health.<br>◆ HSAG recommended that the RCCO continue to pursue accessible alternatives for after-hours and urgent care in the region.<br>◆ HSAG recommended that, at some time in the future, Colorado Access perform a more formal assessment of PCMPs' medical home functions to ensure that all medical home standards outlined by the Department are being met. |

## Region 4—Integrated Community Health Partners (ICHP)

| Standard I—Care Coordination/Care Management *for* Integrated Community Health Partners (Region 4) | |
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| **Summary of Strengths** | ◆ Many PCMPs had behavioral health practitioners on-site and/or a collaborative working relationship with local behavioral health entities.<br>◆ ICHP care coordinators and PCMP care managers were active and engaged with the members in the care planning process.<br>◆ ICHP coordinators documented coordination with other agencies involved in providing care coordination to the member.<br>◆ ICHP created a care coordination workgroup as a method for care coordinators at the different PCMPs to problem-solve system issues, as well as process difficult cases.<br>◆ Collocation of behavioral health and physical health services in the major PCMPs in the region promoted the sharing of information among providers. In addition, partner CMHC care managers conducted care coordination for some smaller PCMPs.<br>◆ ICHP was pursuing innovative solutions to challenges arising from PCMPs using various case management documentation systems. ICHP used data and developed creative software solutions to identify members for care management quickly. |
| **Summary of Opportunities for Improvement and Recommendations** | ◆ HSAG recommended that ICHP develop a method to document whether or not the member is involved with community-based organizations or other service agencies that may perform case management activities for the member.<br>◆ HSAG recommended that every member's record include an assessment of the member's culture, values, and belief systems (beyond language/translation needs). |

| Standard I—Care Coordination Record Reviews *for* Integrated Community Health Partners (Region 4) | |
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| **Summary of Strengths** | ◆ Care coordination record reviews demonstrated that ICHP's efforts at connecting with members and arranging care were persistent and creative.<br>◆ Some level of assessment was being conducted for every member.<br>◆ ICHP's care coordinators collaborated with outside agencies to ensure maximum support for each member.<br>◆ HSAG acknowledged and encouraged ICHP to continue supporting one of its large PCMPs in the development of an EHR care coordination module that incorporates a comprehensive care coordination assessment. |
| **Summary of Opportunities for Improvement and Recommendations** | ◆ HSAG recommended that ICHP develop processes that would allow care coordinators to create and document a comprehensive care plan for each member in need of care coordination services.<br>◆ HSAG recommended that care coordinators actively arrange referral appointments for members whenever possible, and consistently follow up with other providers to determine follow-through by the member.<br>◆ HSAG recognized ICHP's efforts to organize information from a variety of paper and electronic systems to understand and provide services and referrals to meet its members' needs.<br>◆ HSAG acknowledged that ICHP discontinued care coordination efforts if it was the member's decision not to participate, and recognized ICHP's decision to focus care coordination efforts on those members who desire to participate. |

| Standard II—Follow-Up: Access to Care/Medical Home *for* Integrated Community Health Partners (Region 4) | |
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| **Summary of Strengths** | ◆ ICHP had a well-distributed PCMP network to serve the majority of the more populated areas of the ICHP Region. ICHP's provider network consisted of several FQHCs and clinics with multiple satellite facilities, and ICHP has begun supplementing this network with smaller practices.<br>◆ PCMP recruitment targeted pediatric practices as well as Medicare/Medicaid providers to support the dual-eligible population. In addition, ICHP was working to encourage smaller PCMP practices to open and expand their panel of Medicaid members.<br>◆ Practitioners must endorse the concepts of the RCCO to be eligible for participation in the network.<br>◆ ICHP anticipated that much of the expanded Medicaid population can be accommodated within the existing network.<br>◆ ICHP's primary recruitment strategy has been to offer support resources to practices to ease the burden of participation in the RCCO.<br>◆ ICHP has been customizing its support resources to complement individual practices' existing systems and processes. ICHP performed individual PCMP assessments of medical home functions and used these assessments to guide a plan of action for each practice.<br>◆ ICHP invested in innovative information systems applications and care coordination approaches that add value to practices, acknowledging what processes work within the system and developing resources to fill gaps.<br>◆ Staff reported that many PCMPs were well versed in medical home concepts and had established medical home systems and processes. Approximately 80 percent of PCMPs adequately perform medical home functions, and the remaining 20 percent are smaller practices that will continue to need a higher level of support.<br>◆ ICHP was addressing concerns regarding availability of specialists in the region through innovative approaches, such as the Medical Neighborhood grant, and through cross-regional RCCO collaborative initiatives.<br>◆ ICHP had established positive specialist relationships for RCCO members and was considering implementation of a memorandum of understanding with specialists to communicate RCCO expectations and processes. |

| Standard II—Follow-Up: Access to Care/Medical Home *for* Integrated Community Health Partners (Region 4) | |
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| | ◆ Members may access any urgent care facility for after-hours care. One hospital system established an urgent care facility within its emergency department (ED). Most rural areas of the region have very limited access to after-hours urgent care. |
| **Summary of Opportunities for Improvement and Recommendations** | ◆ HSAG recommended that ICHP define a detailed master plan and schedule for development and implementation of the practice support strategy, and continue to pursue a provider portal for distribution of clinical tools and reports.<br>◆ HSAG recommended that ICHP continue exploring mechanisms to expand access to after-hours and urgent care and better publicize to members the availability and locations of after-hours and urgent care facilities. |

## Region 5—Colorado Access

| Standard I—Care Coordination/Care Management *for* Colorado Access (Region 5) | |
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| **Summary of Strengths** | ◆ Colorado Access actively pursued implementing integrated behavioral and physical health services in clinics, developing and executing data-sharing agreements with multiple provider entities, and facilitating collaborative efforts to improve the provision of integrated care for members.<br>◆ Approximately 60 percent of PCMP practices across all three Colorado Access regions have some form of integrated behavioral health care. In Region 5, Mental Health Center of Denver (MHCD) integrated a physical health practitioner into the mental health center. In addition, MHCD provides on-site behavioral health services at several PCMP clinics. Colorado Access and the behavioral health organization (BHO) for the region exchanged common member information to enable coordination between behavioral health and medical providers.<br>◆ The RCCO was working with county DHS and social service agencies targeted at integrating care coordination for foster care children.<br>◆ Colorado Access signed MOU data-sharing agreements with the CCBs in all regions and began discussions related to coordinating care management functions.<br>◆ Colorado Access completed data-sharing MOUs with provider and community entities to alleviate HIPAA concerns and was sharing lists of RCCO clients to facilitate identification of shared members.<br>◆ Colorado Access organized a collaborative effort among care managers from various systems to collectively define integrated care management processes.<br>◆ The majority of RCCO members eligible for care management services were identified through data, followed by care manager outreach to complete the HRA. A more comprehensive assessment of member needs is intended to follow the HRA screening.<br>◆ Approximately 50 percent of members were assigned to PCMPs delegated to perform care management services, including routine and intensive care management and TOC. The remaining 50 percent were being supported through Colorado Access care managers, who are assigned to support specific PCMP practices. |

| Standard I—Care Coordination/Care Management *for* Colorado Access (Region 5) | |
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| | ◆ RCCO staff members were confident in the general level of cultural competency in the provider network, particularly in the larger PCMPs that are highly experienced with serving the Medicaid population, as well as providers who target specific niche populations (e.g., refugees).<br>◆ Colorado Access has implemented numerous initiatives and is engaged in systemwide planning related to care coordination for various special needs populations.<br>◆ Colorado Access continues to work with hospitals to obtain real-time information concerning member discharge from the hospital in order to perform transition of care (TOC) management.<br>◆ Colorado Access is evaluating the best metrics for tracking the outcomes of the TOC program, as well as the delegated care management programs. |
| **Summary of Opportunities for Improvement and Recommendations** | ◆ HSAG recommended that Colorado Access review HRA questions for consistency, as appropriate, to ensure screening of health status, health behaviors, and non-medical needs.<br>◆ Colorado Access should ensure that care managers perform and document a comprehensive assessment for members in need of care coordination services to guide the interventions in the care coordination plan.<br>◆ Care coordination assessments of member needs should include assessment of the member's cultural beliefs and values (i.e., beyond language) that may impact the member's health or the care plan. Once assessed, identified cultural characteristics should be incorporated into the care plan interventions.<br>◆ Colorado Access must also develop a mechanism to identify and document whether other care managers are involved in the member's care.<br>◆ HSAG recommended that Colorado Access communicate/educate delegated entities regarding the elements of care coordination contract requirements to ensure that Department contract requirements related to care coordination are being incorporated into delegated PCMP care management processes.<br>◆ HSAG encouraged Colorado Access to continue its efforts with hospitals and other entities to define mechanisms to timely identify members who are transitioning from one level of care to another.<br>◆ HSAG recommended that Colorado Access implement mechanisms to ensure that the transition of care plan is documented and communicated to the PCMP and other involved providers. |

| Standard I—Care Coordination/Care Management *for* Colorado Access (Region 5) | |
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| | ◆ HSAG encouraged Colorado Access to continue to pursue meaningful measures regarding the effectiveness of transition of care management by both Colorado Access and delegated PCMPs. HSAG also recommended that Colorado Access continue to pursue the development of meaningful metrics for monitoring the effectiveness of delegated care coordination functions. |

| Standard I—Care Coordination Record Reviews *for* Colorado Access (Region 5) | |
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| **Summary of Strengths** | ◆ In most cases, some form of a health risk screening was performed for each member.<br>◆ Care managers appeared to do an excellent job, overall, of actively engaging the member and actively pursuing interventions with providers and community service agencies.<br>◆ There was documentation of multiple follow-up calls by the care coordinator to the member to ensure appointments were made and kept. Care coordinators also documented multiple calls to vendors. |
| **Summary of Opportunities for Improvement and Recommendations** | ◆ The HRAs used by Colorado Access did not address a member's behaviors that might put the member at risk for health complications, and not all of the assessments thoroughly addressed the member's non-medical needs. Colorado Access should ensure its HRAs or other assessments clearly address the member's health status, health risk behaviors, and both medical and non-medical needs.<br>◆ Individual member's cultural beliefs and values were not being formally assessed or documented, and were not consistently addressed in care plans. Colorado Access must ensure it evaluates and documents the member's cultural beliefs and values.<br>◆ Most of the substantive content of the care plan was documented in care coordinator notes, and interventions were not specifically related to assessed member needs or care plan goals. In addition, in several cases, care coordination plans were noted to be episodic, addressing only the immediate needs, rather than the comprehensive needs, of the member. Colorado Access should be ensuring each member's record includes a care plan that reflects the member's assessed needs and appropriate interventions. |

| Standard II—Follow-Up: Access to Care/Medical Home *for* Colorado Access (Region 5) | |
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| **Summary of Strengths** | ◆ Colorado Access reported significant growth in the provider network across all three Colorado Access regions, including a large majority of practices with open panels for RCCO members. Colorado Access analyzed that it has sufficient capacity in the existing PCMP network to integrate the expanding RCCO populations in the foreseeable future.<br>◆ Colorado Access targeted recruitment of full-benefit Medicare-Medicaid enrollees' providers and pediatric practices in all regions.<br>◆ Colorado Access advocated for the Department to consider allowing CMHCs to be designated as PCMPs for members with severe and persistent mental illness (SPMI).<br>◆ Staff continued working with the Department to explore solutions to the legislatively mandated passive enrollment process, which assigns Medicaid enrollees to the Denver Health managed care line of business upon enrollment or re-enrollment. This requirement has negatively impacted PCMP recruitment in Region 5.<br>◆ Staff stated that RCCO relationships with specialists were primarily managed through the PCMP's pre-established referral networks. University Physicians, Inc. (UPI), Denver Health, and Kaiser Permanente (Kaiser) have particularly good systems for accessing specialists, but access was primarily limited to members who are assigned to those PCMPs.<br>◆ Formal relationships with specialists through other Colorado Access lines of business overlap with the RCCO regions. Those relationships are leveraged, when necessary, to supplement access to specialists in the RCCO.<br>◆ Colorado Access was exploring methods of providing performance incentives to stimulate specialists and hospitals to respond to the needs of RCCO members.<br>◆ The RCCO has engaged in regional initiatives related to the shortage of particular specialist services, such as pain management services.<br>◆ Colorado Access was conducting analysis of the most frequently used specialists for RCCO members in anticipation of building more direct relationships with those specialists in the future.<br>◆ The RCCO participated in an initiative to develop a community-wide, after-hours/urgent care behavioral care hotline for PCMPs to call to obtain a referral or triage a member.<br>◆ Colorado Access has considered analysis of the reasons that members seek after-hours and urgent care to guide effective solutions. |

| Standard II—Follow-Up: Access to Care/Medical Home *for* Colorado Access (Region 5) | |
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| | ◆ PCMP care coordination capabilities were the focus of PCMP practice assessments in support of continued delegation of care management functions. Through close ongoing relationships between the RCCO contract managers and individual PCMPs, needs and PCMP readiness for practice assistance and transformation services were being identified, and the RCCO was providing resources accordingly.<br>◆ Staff anticipated that all but three to five currently contracted PCMPs in Region 5 will eventually be capable of performing as a medical home. |
| **Summary of Opportunities for Improvement and Recommendations** | ◆ HSAG encouraged Region 5 to continue its network development efforts as described, and to monitor the expanding Medicaid membership over time to anticipate changing provider network needs.<br>◆ HSAG encouraged Colorado Access to continue to pursue strategies to stimulate access to specialists for RCCO members, including access to specialists through UPI and Denver Health.<br>◆ HSAG recommended that the RCCO continue to pursue accessible alternatives for after-hours and urgent care in the region.<br>◆ HSAG recommended that, at some appropriate time in the future, Colorado Access consider performing a more formal assessment of PCMPs' medical home functions to ensure that all medical home standards outlined by the Department are being met. |

## Region 6—Colorado Community Health Alliance (CCHA)

| Standard I—Care Coordination/Care Management *for* Colorado Community Health Alliance (Region 6) | |
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| **Summary of Strengths** | ◆ In Region 6, Foothills Behavioral Health Partners (FBHP) has located behavioral health clinicians at five PCMP practices, and CCHA has identified five additional practices interested in such a relationship. FBHP also has behavioral health clinicians collocated at the federally qualified health centers (FQHCs) in the region. Some behavioral health sites have collocated physical health providers.<br>◆ CCHA shared claims data with FBHP to enhance the risk level stratification process.<br>◆ Analysis of data was the primary method used to identify members appropriate for care coordination services.<br>◆ CCHA receives daily electronic alerts of inpatient admissions and emergency department (ED) visits from Centura and Health One hospitals.<br>◆ Culturally and Linguistically Appropriate Services (CLAS) training was conducted for CCHA employees and 18 PCMP practices.<br>◆ CCHA engaged in relationships with several agencies to improve services to special needs populations, including foster care children, children with special needs identified through Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), and members who are pregnant. Staff stated that a community resource specialist had been hired within the past year to build relationships with specific community-based agencies.<br>◆ CCHA staff members have been meeting with CCBs and have been negotiating business associate agreements to be able to do data sharing to identify members for care management. |
| **Summary of Opportunities for Improvement and Recommendations** | ◆ Care coordination documentation did not demonstrate distribution of home visit reports to the assigned PCP or ongoing communication with providers. CCHA needs to develop a protocol or policy for ongoing communication with PCPs, specialists, and behavioral health providers, and the mechanism for documenting such communication in the care coordination records.<br>◆ HSAG recommended that CCHA develop a process to evaluate members' ability to follow through with referral information (e.g., match expectations to member skills) and follow up with members immediately after the provision of referral information. |

| Standard I—Care Coordination/Care Management *for* Colorado Community Health Alliance (Region 6) | |
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| | ◆ HSAG recommended that CCHA develop a mechanism to more thoroughly assess members' cultural values and beliefs and ensure that those needs are addressed via care planning with the member.<br>◆ CCHA must also develop a mechanism to identify and document whether other care managers are involved in the member's care.<br>◆ HSAG encouraged CCHA to continue the process of identifying a new care coordination documentation and management program that includes a risk assessment, a comprehensive needs assessment, and more robust documentation capabilities.<br>◆ CCHA should prioritize building relationships with the numerous hospitals and health systems in the metropolitan area to enhance obtaining real-time data regarding ED visits and inpatient admissions. CCHA might also want to consider developing a mechanism to inform PCPs of member admissions.<br>◆ HSAG recommended that CCHA enhance its processes for delegation oversight to ensure that the delegated PCMP includes each of the required elements of care coordination. |

| Standard I—Care Coordination Record Reviews *for* Colorado Community Health Alliance (Region 6) | |
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| **Summary of Strengths** | ◆ CCHA used statewide data analytics contractor (SDAC) data to identify members for outreach activities.<br>◆ Health partners used a standardized HRA form during initial outreach contacts with members.<br>◆ Members with more complex needs were assigned to social worker and/or nurse health partners, who attempted home visits following completion of the initial HRA. |
| **Summary of Opportunities for Improvement and Recommendations** | ◆ CCHA had begun to outreach members through letters when health partners were unable to reach the member by telephone. HSAG recommended that CCHA also consider communicating with PCPs (or other providers) to engage members during office appointments.<br>◆ Member assessments completed during home visits reflected member-reported information only, and did not include accurate or complete clinical information about the member. HSAG recommended that the assessment also contain information collected from chart review, data review, and other sources to |

| Standard I—Care Coordination Record Reviews *for* Colorado Community Health Alliance (Region 6) | |
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| | thoroughly communicate the member's health status to all members of the care coordination team.<br>◆ The HRA assessed member linguistic and communication needs, but not the broad cultural values and beliefs of the member. HSAG recommended that CCHA develop a process to more fully explore all aspects of members' cultural needs.<br>◆ Care coordination records did not reflect an active care planning process with comprehensive care plans and goals. HSAG recommended that CCHA care coordinators proactively engage the member in setting care plan goals and document active care plan interventions and discussions with members in the contact notes.<br>◆ Regular follow-up with members was inconsistent and/or not well documented. Long intervals between contacts with the member were noted in some cases.<br>◆ HSAG recommended that health partners be less passive in community referrals by offering to assist members in placing a call or with completing applications, rather than just supplying a list of resources or a telephone number.<br>◆ There was little or inconsistent documentation that PCPs and other providers were contacted regarding care coordination for members. HSAG recommended that care coordinators document each contact with the member, as well as attempts to contact providers and community agencies. CCHA should be more assertive in building relationships with providers, coordinating all care, not just in response to ED visits and unplanned hospitalizations.<br>◆ Case review indicated a reactive rather than proactive approach for coordinating TOCs. Documentation demonstrated that care coordinators were not proactive in contacting members or hospital staff while the member was hospitalized or building relationships during the hospitalization to more effectively manage the transition. HSAG recommended that care coordinators obtain releases of information from members and more assertively build coordinator-to-coordinator relationships with inpatient and ED facility staff within all hospital systems in the region to improve notification of admission of CCHA members. |

| Standard II—Follow-Up: Access to Care/Medical Home: Summary of Strengths *for* Colorado Community Health Alliance (Region 6) | |
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| **Summary of Strengths** | ◆ CCHA reported that there were 91 PCMPs in the region, including 10 pediatric practices, and 90 percent of the practices were accepting new Medicaid members. Staff stated that provider-member ratios in the existing network were adequate.<br>◆ PCMP recruitment efforts were focused on practices with 50 or more Medicaid members. CCHA was in discussion with several children's medical home practices and comprehensive primary care providers, and reported that it was preparing for the integration of full-benefit Medicare-Medicaid enrollees.<br>◆ Staff reported that the primary incentive for providers to join the RCCO was the availability of care management services to support provider practices.<br>◆ Region 6 providers and members had enhanced access to specialists through the Centura network.<br>◆ CCHA was tracking claims data to identify specialists being used by members and key specialty areas on which to focus. CCHA was identifying specialist use and referral patterns that had already been established within enrolled practices, and staff used this information to facilitate referrals for members.<br>◆ Staff remained sensitive to overloading any specialist with too many Medicaid members.<br>◆ CCHA reported that it had partnered with 29 urgent care centers for after-hours care.<br>◆ The Practice Support Plan identified a variety of tools used to provide practice support (office system review, access to care review, cycle time analysis, etc.) and referenced a variety of clinical tools and guidelines.<br>◆ CCHA practice improvement coaches meet with each practice and provide services based on an evaluation of where the practice is on the continuum of performance as a medical home.<br>◆ CCHA staff reported that its contracted PCMPs generally do not have the infrastructure and technology required to provide care coordination, and only the six FQHCs have been delegated for medical home functions. |
| **Summary of Opportunities for Improvement and Recommendations** | ◆ HSAG encouraged CCHA to further enhance its Web site for providers to include resources such as member reminders, patient education materials, information on motivational interviewing and patient self-management, clinical care guidelines, and best practices. |

## Region 7—Community Health Partnership (CHP)

| Standard I—Care Coordination/Care Management *for* Community Health Partnership (Region 7) | |
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| **Summary of Strengths** | ◆ CHP made significant progress toward assessing the capabilities of its PCMPs with regard to care management, and the role of CHP staff to supplement the PCMP care management programs. CHP has partnered with PCMPs, assessed PCMP capabilities, and provided practice support and training to enhance care coordination functions.<br>◆ CHP initiated five pilot projects that were innovative responses to RCCO challenges (e.g., preventing inappropriate ER visits) and will provide valuable information for continued program development.<br>◆ The two primary PCMPs in El Paso County have integrated on-site behavioral health clinicians to provide services to members. |
| **Summary of Opportunities for Improvement and Recommendations** | ◆ HSAG recommended that CHP evaluate PCMP member assessment and care-planning tools to determine if PCMP tools or supplemental CHP tools require enhancement. Decisions would be unique for each PCMP.<br>◆ CHP should ensure that assessment and care planning tools address community-based or social service benefits the member may be receiving so that CHP can coordinate with other agencies providing these services.<br>◆ CHP should ensure that comprehensive assessment and care planning addresses the member's linguistic/translation needs and cultural values and beliefs.<br>◆ HSAG encouraged CHP to evaluate its risk stratification system and processes for identifying members appropriate for case management services to ensure that it captures members that may be at high risk for complex needs (in addition to high ED use).<br>◆ HSAG encouraged CHP to enhance its care coordination documentation to more clearly and sequentially outline care coordination events and contacts. |

| Standard I—Care Coordination Record Reviews *for* Community Health Partnership (Region 7) | |
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| **Summary of Strengths** | ◆ CHP had recently implemented its care coordination program and was in the process of assessing the program's procedures and efficacy.<br>◆ CHP used real-time data from the local hospital ERs and data from the SDAC to identify members for the care coordination program, which was focused on members with multiple ER visits.<br>◆ CHP care coordinators documented contacts with the member and the PCMP's care managers. |
| **Summary of Opportunities for Improvement and Recommendations** | ◆ Assessments conducted at the PCMP level predominantly focused on managing the physical and medical services of the member. Most assessments did not adequately address the need for community-based resources or programs, assessment of psychosocial issues, or the member's cultural or linguistic needs. It was unclear whether the case manager adequately assessed whether the member was involved with other agencies with which the care coordinator would need to communicate. While on-site, the PCMP care coordinator submitted a recently revised care coordination assessment that included many of the requirements previously omitted. HSAG recommended that CHP work with the PCMP to continue developing the revised care coordination assessment and implement a similar assessment region-wide.<br>◆ HSAG recommended that CHP complete data-sharing agreements with the BHO and/or more assertively pursue obtaining release of information permissions from members, in order to facilitate coordination of care.<br>◆ CHP's care coordination program was focused primarily on members with multiple ER visits. HSAG recommended that CHP evaluate mechanisms to ensure that high-risk members with a risk indicator related to diagnoses or other factors unrelated to ER visits are included in care management. |

| Standard II—Follow-Up: Access to Care/Medical Home *for* Community Health Partnership (Region 7) | |
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| **Summary of Strengths** | ◆ The Region 7 provider network was adequately aligned with the majority of the RCCO population in the region, which is highly concentrated in El Paso County. CHP added several additional PCMPs in the past year to supplement the two primary multi-location PCMPs of Peak Vista and Colorado Springs Health Partners.<br>◆ There is a general shortage of primary care providers (PCPs) in the local community, and many providers wish to limit the size of their Medicaid panels. Staff stated that these dynamics create an ongoing challenge to expanding the size and capacity of the PCMP network. CHP was engaged in a local collaborative effort with other community leaders to increase the number of primary care practices in the area.<br>◆ CHP targeted all PCMPs with more than 10 Medicaid members for recruitment and was focused on expanding the network to accommodate the projected integration of the expanded Medicaid population, including the full-benefit Medicare-Medicaid enrollees' population.<br>◆ CHP staff stated that the PCMPs that have dominant Medicaid populations tend to be those most likely to absorb new members.<br>◆ Region 7 staff stated the best recruitment strategy is to promote the "free" resources of the RCCO for practice transformation or other services that can benefit all patients in the practice.<br>◆ All specialist providers within Region 7 are also operating at capacity. CHP had an active referral assistance program to enhance the effectiveness of the referral process and increase access to specialist providers.<br>◆ CHP was initiating an innovative strategy to develop specialist clinical protocols for PCMPs, which could relieve some of the caseload burden on specialists.<br>◆ Staff stated that the community has been oriented to seeking after-hours and urgent care through emergency rooms (ER). Some hospitals had developed urgent care facilities within their EDs. CHP was engaged in several pilot projects to divert members from inappropriate use of the ER.<br>◆ CHP performed a formal comprehensive medical home assessment on all PCMP practices and used results to design support strategies appropriate for individual PCMPs.<br>◆ CHP was providing intensive medical home transformation services to one large PCMP. |

| Standard II—Follow-Up: Access to Care/Medical Home *for* Community Health Partnership (Region 7) | |
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| | ◆ CHP developed a MOU for use with medical home qualified PCMPs to specify care coordination requirements, medical home responsibilities, and the reimbursement for delegated functions.<br>◆ CHP had implemented an improved Web site for members and providers and was considering a secure provider portal for dissemination of RCCO-specific tools and information. |
| **Summary of Opportunities for Improvement and Recommendations** | ◆ CHP should carefully evaluate and monitor the capacity to expand Medicaid enrollment within the existing provider network.<br>◆ CHP might consider messaging for PCMPs regarding the direction of Medicaid under health care reform and the potentially changing characteristics of the traditional Medicaid population. This information may serve as an inducement for additional providers to consider participation in the RCCO or expansion of their Medicaid panels.<br>◆ HSAG recommended that CHP more prominently display urgent care information and locations on the RCCO Web site and/or in the provider directory. CHP may also need to consider mechanisms to expand after-hours care through PCMPs within the network.<br>◆ HSAG recommended that CHP evaluate the practice support needs of the entire provider network and more aggressively offer productive support activities to more PCMPs.<br>◆ HSAG recommended that CHP enhance the practice support plan by defining a specific development and implementation schedule for the activities outlined in the plan. |