ACC Phase III Care Coordination

Behavioral Health and Integtration Strategies Subcommittee

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Presented by:

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Agenda

1. Finalizing Phase III Tiering
2. Tiering and Stratification Details
3. Additional Phase III Care Coordination program components

ACC Phase III Care Coordination Philosophy

Addresses the full range of members' physical health, behavioral health, oral health and health-related social needs.

Occurs at the point of care whenever possible, with RAEs providing wraparound support as necessary.

Available to all Health First Colorado members.

Designing Phase III Tiering

Standardize model across all RAEs.

Improve transparency and clarity with detailed tiering requirements.

Create a person-centered model that improves member care and outcomes.

Some felt the model was **too rigid**; others believed there was **too much flexibility.**

There was disagreement whether **too many** or **too few** conditions were noted for each tier.

Stakeholders believed that **member choice** should be prioritized and tiers should be designed to prevent members from rising to tier 3.

Landing on a launch model

1. Focusing on key care coordination activities
2. Respecting individual member experiences
3. Leveraging advanced RAE tools

Phase III Care Coordination Tiers

	Tier 1: Care Navigation	Tier 2: Care Coordination	Tier 3: Care Management
Population	**All members not in other tiers.**	**Members with rising risk:** • Members with rising risk as identified by RAE tools and providers.	**Members with complex needs:** • Highest risk members as identified by RAE tools. • Children/youth eligible for Colorado System of Care.
	Specific contractual requirements for monitoring and oversight of: • Children and youth: Foster care out-of-home placements, emancipation from foster care for up to one year, and complex health needs • Individuals enrolled with Case Management Agencies (those on waivers and receiving home-based services) • Individuals post release from Department of Corrections and Youth Offender System for one year • Individuals identified for Department of Justice At-Risk Diversion and Transition • Maternal health (pre- and post-natal) • Individuals who are unhoused		
Required Activities	Proactive and responsive interventions to assist members in accessing evidence-based preventative care services.	• Interventions to prevent members from requiring higher levels of care. • Care/Treatment plans	• Longitudinal, evidence-based and proven programs involving multidisciplinary care approaches. • Comprehensive Care Plan (unless they are not the lead care coordinating entity).
	• Care Transitions (including inpatient, residential, skilled nursing facility and other acute care settings) • Condition Management (including maternity, diabetes, asthma, hypertension and COPD)		
Monitoring/ Accountability	• Dental visits • Adult screenings • Well child visits • Child/adolescent immunizations	Tracking of: • Care/Treatment plans • Engagement	Performance standards for: • Care plans • Engagement
	• Hospital All-Cause Readmission • Transition of care follow-up appointments • Emergency department visit reduction • Behavioral health discharges		

Operational Considerations

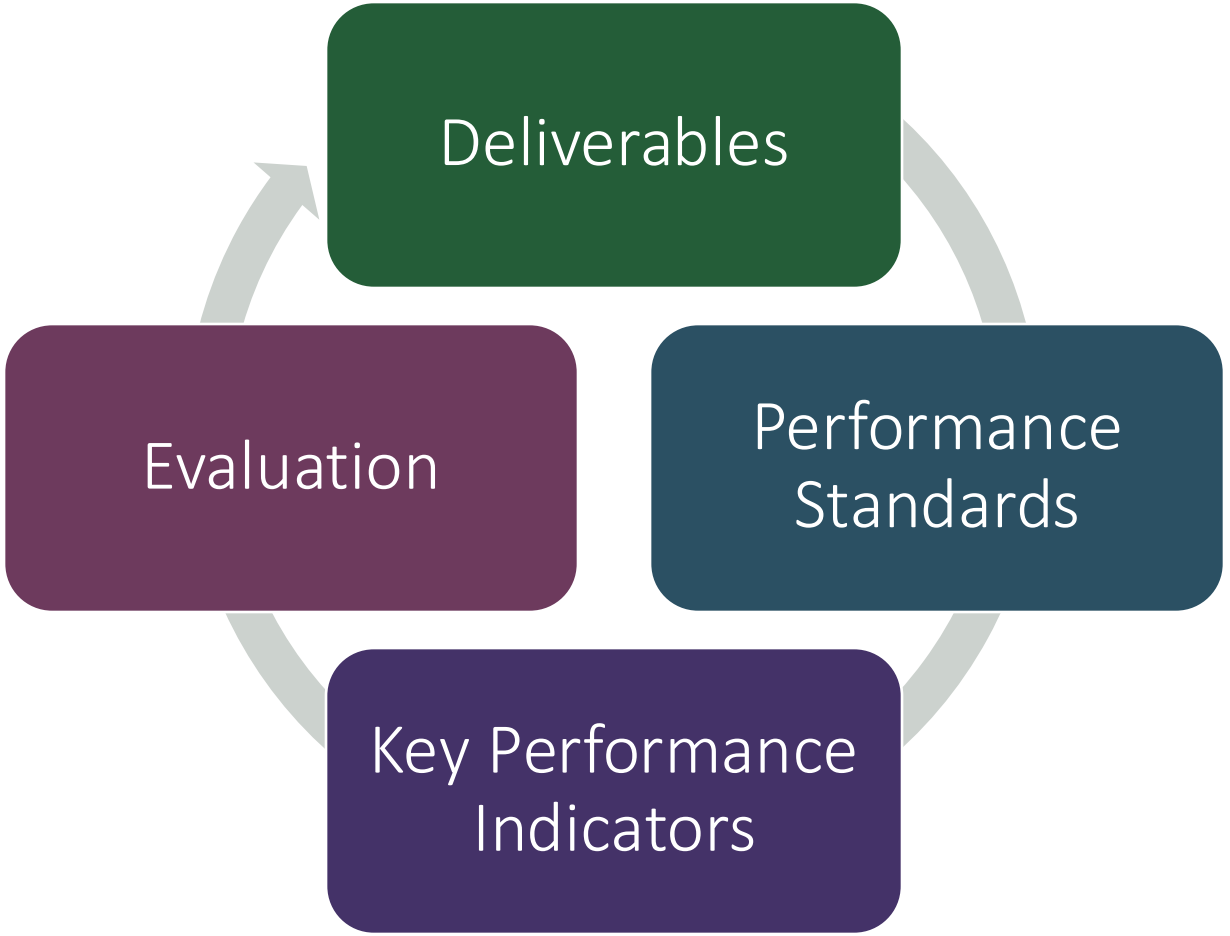
Administrative Burden

1. What is the burden of creating more detailed requirements for providers?
2. What is the burden of collecting certain types of care coordination data? Who is responsible?

Value

1. Do the more detailed requirements achieve our program goals?
2. How will care coordination data be used in a way that supports program goals?

Monitoring and Accountability



Additional Features of Care Coordination in Phase III

Care transitions

Collaboration with other entities/agencies, including CBOs

Improved monitoring and oversight for all care coordination activities

Questions?