



CO L O R A D O

**Department of Health Care
Policy & Financing**

Fiscal Year 2016–2017 Site Review Report
for
Colorado Community Health Alliance
Region 6

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1. Summary of On-Site Discussions

Introduction and Background

The Colorado Department of Health Care Policy & Financing (Department) implemented the Accountable Care Collaborative (ACC) program in spring 2011 as a central part of its plan for Health First Colorado (Colorado’s Medicaid program) reform. The ACC promotes improved health for members by delivering care in an increasingly seamless way, making it easier for members and providers to navigate the healthcare system and to make smarter use of every dollar spent. Serving as the primary vehicle for delivering quality healthcare to Health First Colorado members, the ACC has shown real progress in creating a healthcare delivery program for improving health outcomes and care coordination while cultivating the member and family experience and reducing costs. The four primary goals of the ACC program are to (1) ensure access to a focal point of care or medical home for all members; (2) coordinate medical and nonmedical care and services; (3) improve member and provider experiences; and (4) provide the necessary data to support these goals, to analyze progress, and to move the program forward. A core component of the program involves partnerships with seven Regional Care Collaborative Organizations (RCCOs), each of which is accountable for the program in a designated part of the State. The RCCOs maintain a network of providers; support providers with coaching and program operations; manage and coordinate member care; connect members with medical and nonmedical services; and report on costs, utilization, and outcomes for their members. An additional feature of the ACC program is collaboration—among providers and community partners, among RCCOs, and between RCCOs and the Department—to accomplish program goals.

The State began enrollment of eligible adults through the Affordable Care Act of 2010; and ACC enrollment has grown to approximately one million members, including the Medicaid expansion population. Beginning in September 2014, the ACC: Medicare-Medicaid Program (ACC: MMP) demonstration provided for integration of individuals eligible for Medicare and Medicaid. All RCCO contracts were amended in July 2014 to specify additional requirements and objectives related to the integration of ACC: MMP members and to increase incentive payments while reducing guaranteed per member per month payments.

Each year since the inception of the ACC program, the Department has engaged Health Services Advisory Group, Inc. (HSAG), to conduct annual site reviews to evaluate the development of the RCCOs and to assess each RCCO’s challenges and successes in implementing key components of the ACC program. This report, focused on **Colorado Community Health Alliance (CCHA)**, documents results for fiscal year (FY) 2016–2017 site review activities, which included evaluation of lessons learned—challenges and successes by each RCCO since inception of the ACC program—related to community partnerships and collaboration, provider networks and provider participation, member engagement, care coordination, and balancing Department-driven and community-driven priorities. In addition, the Department requested a presentation by each RCCO of care coordination cases demonstrating “best practice” examples of comprehensive care coordination. This section contains summaries of the activities and on-site discussions related to each focus area selected for the 2016–2017

site review as well as HSAG’s observations and recommendations. Section 2 provides an overview of the monitoring activities and describes the site review methodology used for the 2016–2017 site reviews. Appendix A contains the Focus Topic Interview Guide used to facilitate on-site discussions. Appendix B contains summaries of each care coordination case presentation. Appendix C lists HSAG, RCCO, and Department personnel who participated in the site review process.

Summary of Results

The care coordination case presentations focused on a sample of Health First Colorado members with complex needs including but not limited to members of the ACC: MMP population, members with care coordination performed by delegated entities, and members who may have presented significant challenges to care coordinators. Care coordination cases were selected by each RCCO, and results were not scored. HSAG summarized results of each care coordination case in the Coordination of Care Record Review Tool, which documented member characteristics and needs, care coordinator activities, member engagement, involvement of other agencies and providers, and outcomes of care coordination efforts.

The Focus Topic Interview Guide (Appendix A) was used to stimulate on-site discussions of lessons learned related to the focus content areas: Community Partnerships/Collaboration, Provider Network/Provider Participation, Member Engagement, Care Coordination, and Balance Between Central (Department-Driven) ACC Priorities and Regional (Community-Driven) Priorities. Following are summaries of results for each content area of the 2016–2017 review.

Summary of Findings and Recommendations by Focus Area

Community Partnerships/Collaboration

Lessons Learned—Successes and Challenges

CCHA’s five county service area includes two Single Entry Points (SEPs)—Adult Care Management, Inc. (ACMI) in Boulder, Broomfield, Clear Creek, and Gilpin counties and Options for Long Term Care in Jefferson County—and two Community Centered Boards (CCBs)—Imagine! in Boulder County and Developmental Disabilities Resource Center (DDRC) in Jefferson, Broomfield, Clear Creek, and Gilpin counties. **CCHA** had established relationships with both SEPs, both CCBs, and public health agencies and Departments of Human Services (DHS) in all counties. Relationships with county public health programs included clinical services (e.g., immunizations, family planning); Healthy Communities; Nurse-Family Partnership; and Women, Infants, and Children (WIC). Relationships with DHS programs included child welfare, foster children, Temporary Assistance for Needy Families (TANF), Child Care Assistance Program (CCAP), and Supplemental Nutrition Assistance Program (SNAP). Agency relationships are primarily fostered through collaborative care coordination of shared members and are

secured through formal data sharing business associate agreements (BAAs). **CCHA** has established a single point of contact for each SEP and CCB.

Staff stated that **CCHA** experienced initial turf issues with SEPs and CCBs, which were concerned that the ACC was “taking over” care coordination for shared members. In addition, county agencies had been operating for many years prior to existence of the RCCO and had pre-established relationships with community leaders and safety-net providers in their areas. The multitude of programs managed through county agencies also made it difficult for the RCCO to get the attention of leadership. **CCHA** determined mechanisms, including implementing a community organization liaison position, to educate all county agencies regarding the RCCO and to determine and clarify roles of each entity in care coordination efforts. **CCHA** recognizes the SEP or CCB as the lead coordinator in collaborative efforts and supports the SEP by addressing care coordination gaps to fulfill members’ unmet needs. Staff described that collaborative care coordination was initiated through the Medicare Medicaid Program (MMP)—the SEP and **CCHA** care coordinators were assigned to make joint home visits to members either due for a SEP annual review or difficult for **CCHA** to locate. This process led to a bi-directional referral relationship between coordinators. In 2016, **CCHA** hosted meet and greet sessions with care managers of each SEP and CCB to promote cross-agency education and discussions of roles and responsibilities. These sessions generated increased bi-directional referrals. At the time of on-site review, **CCHA** and the SEPs were also collaborating to use the SEP case manager point of contact as an opportunity to introduce additional services to members. Staff described that building interagency relationships for effective care coordination was a multi-year “organic” process that required multiple contacts, staff perseverance, and successful interpersonal relationships to build and sustain. **CCHA** currently enjoys a productive relationship with SEPs, CCBs, and agencies. Staff members described that SEP partnerships have also generated further opportunities and introductions to multiple agencies and programs administered by the counties—i.e., one contact leads to another. **CCHA**’s maternity program—associated with the Colorado Opportunity Project (COP)—drove partnership arrangements with multiple county social support programs—Nurse-Family Partnership, WIC, and SNAP—and has evolved into additional collaborative opportunities.

Over the past several years, **CCHA** has employed “community liaisons” to maintain relationships with multiple community entities that provide services frequently needed by members—e.g., housing authorities, transportation vendors, food banks, Arc organizations, Head Start, Jefferson County Prosperity Project, school districts, Area Health Education Center (AHEC), Jefferson County Action Center, Mountain Resource Center, Senior Resource Center, the behavioral health organization (BHO), and community mental health centers (CMHCs).

CCHA provided several examples of collaborative projects with community partners, including:

- **CCHA** participates in the Boulder County Genesis and Genisister grant-funded programs, which encourage pregnant teens to remain in school and which conduct outreach efforts to prevent teen pregnancies.
- The Boulder County Hoarding Task Force (Boulder Public Health environmental division) identified through its home inspection program that some individuals exhibited obsessive compulsive

behaviors and depression and were not accessing mental health services. **CCHA** assigned a care coordinator to accompany code enforcers on home inspections to assess and engage persons in mental health services. **CCHA** also began working with Mental Health Partners (MHP) to improve referral processes and increase access to services.

- For over five years, **CCHA** has participated in the Jefferson County Hotspotting Alliance—a multi-organizational initiative to identify members and populations with complex care coordination needs.
- When the only primary care provider in Clear Creek County closed in 2016, the **CCHA** executive director met personally with the Clear Creek County executive director to facilitate a process for Centura Health to locate a primary care provider in Idaho Springs. The county funded a new clinic facility, opening June 2017. **CCHA** also used its key performance indicator (KPI) funds to procure a bus to transport members from Idaho Springs to Denver-based providers.
- In Gilpin County—which has no primary care providers, **CCHA** worked with the Nederland clinic to provide practice coaching and co-locate behavioral health (BH) providers in the practice. Staff members reported that access issues in this county have presented continuous challenges—e.g., provider medical board restrictions and lack of any non-emergency medical transportation (NEMT) services to transport members to Boulder.
- **CCHA** partnered with Boulder Valley School District to establish a well-child check incentive pilot program in an elementary school with a high Medicaid population. **CCHA** staff worked with school officials to determine appropriate incentives and design the program. Based on experience with the pilot program, **CCHA** was considering further collaboration with Boulder County Public Health to expand into school-based population health education for all students and possible investment in a mobile clinic.
- Jefferson County Action Center (Action Center) provides a wide range of social supports—e.g., shelters, food programs—to Medicaid and uninsured populations. **CCHA** provided funding and employee volunteers to support the Action Center’s annual Thanksgiving distribution of food and supplies, simultaneously providing information about **CCHA** and health topics. As a result, **CCHA** and the Action Center agreed to embed a **CCHA** care coordinator at the Action Center to engage members and connect them to services.
- As a result of the criminal justice involved (CJI) initiative to connect CJI members with BH services upon release from jail or prison, **CCHA** partnered with the Department of Corrections (DOC) and parole offices to identify members being released in Jefferson or Boulder counties. This initiative has evolved to include community-based organizations where CJI members receive services as the best potential locations to engage with CJI members to coordinate care. **CCHA** was participating in the Longmont Reentry Initiative for Boulder County and the DOC Intervention Community Corrections Program (halfway house program).

As a result of multiple collaborative community partnerships to coordinate care for members, **CCHA**’s initial focus on the primary care medical home (PCMH) has shifted to the “health neighborhood.” **CCHA** has a Health Neighborhood Advisory Committee which includes a variety of medical providers, all county public health departments, the DDRC, ACMI, Aging and Adult Services, and the Offender Program. **CCHA** maintains an extensive tracking system which documents the participants and goals of

each partnership in relation to provider groups, social determinants, LTSS, criminal justice, DHS, public health, and housing. Staff members stated that hundreds of members are being referred to resources through health neighborhood partners. Staff members stated that all counties consider homelessness to be a major priority issue going forward.

Staff members stated that, since inception of the RCCO, **CCHA** has experienced tremendous education and lessons learned regarding community partnerships. Building trust among organizations requires tremendous time, effort, and energy at both the leadership and individual staff levels. While **CCHA** initiated the community liaison position to outreach to any potential community-based care coordination partners, **CCHA** has evolved to understanding that the number of potential community partners is nearly unlimited—i.e., “it would take 50 community liaisons to nurture relationships with all organizations,” the level of engagement in partnerships differs from resource referral relationships, and challenges encountered are unique to each partnership. At the time of on-site review, **CCHA** had identified that limited staff resources have to be judiciously applied to the most productive partnerships; simultaneously, counties have large convoluted departmental and agency structures and community relationships, which require understanding and consideration. Staff stated that **CCHA**’s goal is to collaborate with community alliances and partners to strategically align goals across community service entities. **CCHA** intends, in 2017, to engage an external consultant to facilitate a strategic planning project with Jefferson County Public Health.

Staff members stated that RCCOs need the Department’s support to reduce barriers between State systems and provided examples of positive impact when the Department facilitated initiatives with the DOC and with the director of the Division of Housing. **CCHA** envisions that the Department could play a major future role in expanding interagency and community partnerships by encouraging RCCOs to bring community-identified issues to the Department to obtain support for high-priority community needs, inviting RCCOs and community partners—both leadership and individual staff—to provide input into Department level initiatives to bridge cross-agency relationships, and contractually requiring State agencies to partner across multiple systems. Staff members also stated that the presence of Department staff in the community “carries weight” with community partners and suggested that the Department elevate its visibility in local community partnership discussions.

Observations and Recommendations

CCHA has engaged in community partnership activities since inception of the RCCO and has built a solid foundation of numerous community and agency relationships to support both RCCO and local community objectives. While care coordination initiatives provided the initial stimulus for engaging with agencies and community organizations, **CCHA** has evolved into supporting many multi-agency initiatives to address complex health issues and implement new programs and services throughout the region. **CCHA** has determined that the health neighborhood, rather than the primary care medical home alone, will be a major area of focus wherein to address the complex needs of Medicaid members in the future. Working within a network of interagency and community relationships has accelerated the increase in **CCHA**’s opportunities and demands, requiring judicious application of limited RCCO resources as well as regionwide strategic alignment of priorities and objectives among community

partners. At the time of on-site review, **CCHA** intended to engage with Jefferson County Public Health in a collaborative, strategic planning project. HSAG observed that, given the importance of agency and community partnerships in fulfilling RCCO objectives, **CCHA** may also need to consider adding or refocusing internal resources for ongoing support of community partnerships.

Regarding future Department commitments, **CCHA** provided several suggestions that could enhance support of the RCCOs in aligning with agencies and community partners, including increasing visibility and participation of Department staff within the region and facilitating a State-level strategic planning initiative to align cross-agency objectives, roles, and responsibilities related to priority member and community needs.

Provider Network/Provider Participation

Lessons Learned—Successes and Challenges

CCHA is a partnership organization 40 percent owned by Primary Physician Partners (PPP) Independent Practice Association (IPA) and 50 percent owned by Centura Health. Physician Health Partners is the administrative services arm of the partnership and provides all administrative and practice support services associated with the RCCO. In the initial year of operations, the base of primary care medical providers (PCMPs) primarily consisted of primary care practices of PPP—265 providers at 62 locations. FQHCs and large practices—e.g., Kaiser Permanente Medical Group (Kaiser)—in the region initially opposed contracting with **CCHA** due to a challenging provider political environment—i.e., FQHCs assumed that they would be the medical home bases directly contracted with the ACC; other metropolitan area RCCOs were contracting with the same FQHCs; Kaiser wanted to “test” RCCO participation through Colorado Access; and the ACC/RCCO model was generally poorly understood. In addition, many private practices were initially interested in being able to limit their Medicaid panel sizes due to a perception that the practice would be overwhelmed with an influx of new Medicaid members. Additional challenges over the years included:

- Since inception, Clear Creek and Gilpin Counties have had limited or no PCMPs to recruit into the network.
- While Centura Health family practice residency programs participated in the network, working with other larger healthcare systems—SCL Health and HealthONE—to contract their primary care provider groups proved challenging and required several years to accomplish.
- Five large PCMPs in the region have declined to participate and remain ambivalent about their desire to participate in the Medicaid program. **CCHA** continues to solicit participation of these practices in the network.

During the initial years of operation, **CCHA** invested considerable energy in provider marketing and education regarding the RCCO concept. Despite ongoing challenges to network development, **CCHA** has steadily increased the number of PCMPs and practice sites. At the time of on-site review **CCHA** reported that 75 percent of all Medicaid providers in the region had contracted with **CCHA**; and the

provider network consisted of 1190 providers at 235 locations—including all large safety net providers, most practices with a large Medicaid population, and approximately 300 practitioners outside the boundaries of the region. FQHCs serve 20 percent of **CCHA**'s members. FQHCs Kaiser and Denver Health are considered primary partners and have been delegated practices since joining the network. The BHO, Foothills Behavioral Health Partners (FBHP), has also been an ongoing active participant in the **CCHA** program, and over half of **CCHA** members have access to integrated PCMP/BH services.

Most PCMP recruitment efforts are now focused on practices with fewer than 50 members, although the recruitment cycle tends to be longer because benefits of ACC participation are limited in practices with low member attribution. **CCHA** has shifted emphasis to building quality in-depth relationships with existing providers and is encouraging network providers to increase their Medicaid panel sizes. To that end, **CCHA** has significantly enhanced its provider transformation program to include on-site practice transformation teams assigned to individual practices and a provider incentive program. In addition, provider relations staff use testimonials from other PCMPs to convey that participating providers with open panels have not been overwhelmed by new Medicaid enrollees and that providers receive increased payments for their ACC Medicaid members. Care coordinators work with provider relations personnel to attempt equitable referral of complex and simple needs members among practices.

During early years of provider recruitment, **CCHA** identified having limited leverage to encourage provider participation in the RCCO and needing to define mechanisms to bring “value” to practices. Between 2011 and 2014, **CCHA** employed one full-time and two part-time practices coaches to work with practices related to improving general operations and attribution issues. Providers engaged with practice transformation increased from four to 34 practices, and practices with more than 100 attributed members were the focus. Between 2015 and 2017, **CCHA** shifted its focus to 40 practices with 350 or more attributed members and modified its transformation team to include three full-time practice coaches, one data analytics specialist, and one behavioral health integration specialist. Eighty percent of RCCO members are now served through practices receiving regular coaching. RCCO practice support activities include practice coaching, care coordination for members, and increased monetary incentives. Highly trained practice coaches meet with practices monthly, providing consultation on technical issues (e.g., billing and coding problems), assistance with Medicaid provider revalidation, and review of practice data reports and KPI performance; and establishing multidisciplinary QI teams. Care coordinators accompany practice coaches to on-site visits to offer collaborative team support. Data support teams have evolved from using State Data Analytics Contractor (SDAC) data to developing provider-friendly individual practice reports; and practice transition teams evaluate data, set goals with practices, and develop data-driven interventions. Practice teams facilitate data-sharing and sharing best practices among PCMPs and conduct an annual office systems review. Through these activities, **CCHA** staff realized the need for sensitivity related to issues being experienced by individual practices and that it could bring added value to practices by orienting support resources to address provider-defined needs and interests. Therefore, practice support teams now offer to assist practices with projects of the provider's choosing. Within recent years, practices have been overwhelmed with practice coaches associated with separate Department initiatives—i.e., the regional health coordinator with the COP and the clinical health information technology advisor with the State Innovation Model (SIM)—as well as

with other payor initiatives. In response, **CCHA** practice coaches have collaborated with other coaches working in each practice to align objectives and avoid duplication of efforts.

CCHA described its practice incentive program, implemented in 2016, which enables each PCMP practice to earn \$7500 pay for performance plus \$2500 for achieving two targeted KPIs. **CCHA** used its KPI reimbursements to fund the incentive payments. Practice agreements define structured criteria, performance thresholds, and related payments; and **CCHA** scored practices based on requirements for accepting a practice coach, participating in **CCHA** meetings, achieving KPIs, and adhering to quality improvement and population health practice transformation measures. **CCHA** developed a data dashboard for each practice to assist in tracking performance monthly. Staff stated that the practice incentive program is successful and that future incentive measures will align with enhanced PCMP (EPCMP) criteria and will include participation in an annual planning summit.

In addition to lack of primary care providers in Clear Creek and Gilpin counties, rural areas also lack social support services and behavioral health providers, and transportation services are nearly non-existent. **CCHA** is providing quality coaches to the PCMP clinic in Nederland to increase access and integrate behavioral health services through Jefferson Center for Mental Health. **CCHA** is working with Clear Creek County officials to open a new PCMP office in Idaho Springs; and Centura Health is working with the county to launch a ballot initiative to establish a healthcare district that will house county public health, DHS staff, and a primary care clinic. **CCHA** worked with Clear Creek County to procure a bus to provide NEMT services to members in the area.

In addition to individual practice initiatives, PCMPs participate in leadership forums, including ACC work groups and the **CCHA** Provider Advisory Council. While select physician leaders tend to participate in Department provider work groups, the advisory council is open to PCMPs, delegates, LTSS providers, and specialists. Staff stated that **CCHA** recognized that it needed to address provider-defined concerns and acknowledged that selecting agenda topics appropriate for a diverse group of providers posed a challenge. **CCHA** tracks and monitors all issues identified through provider relations and conducts a quarterly provider survey to obtain feedback on topics and agenda selection. Initial focus on primary care medical home had shifted to broader health neighborhood concerns. Recently, the provider advisory council was integrated with the Health Neighborhood Advisory Committee—a variety of providers plus county public health agencies, SEP, CCB, Aging and Adult Services, and Offender Program staff.

Staff members stated that gaining access to specialists will be a continuing challenge as long as Medicaid members compete for specialty access with patients in better-paying systems. From inception, Centura Health has provided **CCHA** members access to its specialists and is currently working with specialists to increase capacity for Medicaid patients. RCCOs cannot directly address specialist payment issues; therefore, to alleviate specialists' stressors associated with Medicaid visits, **CCHA** implemented improved provider referral mechanisms and assists members to prevent missed appointments and to improve productivity of appointments—e.g., attending appointments and arranging transportation. **CCHA** is considering working through PCMPs to determine a targeted list of preferred specialists as well as potentially leveraging specialist relationships through the PCMPs to accept increased Medicaid

referrals. Access to specialists is an all-payor communitywide issue; therefore, **CCHA** leadership members also participate in community alliances to address specialist access. **CCHA** is also considering some form of incentive payments for specialists. Staff members stated that access to specialists is more manageable in a capitated payment model or when bundling payments with primary care.

At the time of on-site review, **CCHA** noted that current or continuing challenges with provider access or participation included:

- Lack of home-based care providers.
- Access to behavioral health providers, particularly through MHP and in rural counties.
- Transportation barriers in rural areas.
- Provider panel limits—Several PCMPs are closed to new members due to panel limits. Large providers open to members have high Medicaid populations frequently served by mid-level practitioners who have a high turn-over rate. Smaller practices wish to cap panel size or see only existing Medicaid members.
- Practices' confusion around the recent provider revalidation process, continuing attribution of members to inappropriate providers, and recent Department information system conversion—resulting in claims payment delinquencies to providers—have imposed significant workload increases and distractions for provider support staff as they assist providers in remediating issues.
- Many practices have yet to achieve adequate performance as medical homes.
- Providers are frequently distressed about data requirements for ACC deliverables.

Despite the claims payment and provider portal issues associated with the Department's recent information system conversion, staff members noted that providers were adequately prepared for system changeover through the frequent updates, alerts, emails, and newsletters; the Department has been responsive to provider concerns escalated to the call center. Staff members also noted that Department-sponsored forums for provider participation in RCCO decisions are necessary and positively perceived by providers and suggested that the Department conduct community-based provider forums to roll out ACC 2.0 and educate providers about regional accountable entities (RAEs). Staff stated that transparency and involvement of Department personnel within individual regions strengthens provider relations with the RCCO. **CCHA** acknowledged that within the past two years the Department's attitude about sending staff representatives into the regions to engage with providers and staff in individual RCCOs has been positive and that such activity should continue to be encouraged. Additional suggestions to the Department for improving provider satisfaction and participation included:

- Department staff should go out into the provider community to familiarize themselves with the diversity of practices in the regions, rather than only visiting the best-performing practices. ACC 2.0 should continue the objective of supporting practices as they strive toward medical home performance.

- The Department should develop mechanisms to routinely obtain provider input when designing performance measures or other requirements—deliverables, payment models, systems changes—that impact providers.
- The Department should consider improving consistency in communications with providers by communicating directly to providers regarding major program initiatives that do not require region-specific adaptations, ensuring that provider input and messaging are communicated along the full continuum of internal departments and staff members.

Observations and Recommendations

Although not all Medicaid primary care providers in the region have elected to join the RCCO network, the metropolitan area counties appear to have an adequate number and diversity of providers—FQHCs, large provider systems, and smaller independent providers—to serve member needs. However, the rural counties have no or limited PCMPs available in the area, further complicated by lack of transportation for members. Within the metropolitan area, **CCHA** continues to be challenged with PCMPs who have reached capacity in panel limits and with operational expectations related to providers who have offices in multiple RCCO regions. These issues are uniquely metropolitan area concerns; therefore, HSAG observes that the current RCCOs, **CCHA** and Colorado Access, or future RAEs in the metropolitan area may need to consider working collaboratively to develop cross-regional alignment of those initiatives and activities that impact shared providers.

Staff stated that many PCMPs are still progressing along the continuum toward medical home standards. In order to facilitate this process, and to potentially increase capacity for Medicaid members within each practice, **CCHA** has invested in a progressively more sophisticated and robust practice transformation and support program as well as a reportedly successful practice incentive program. **CCHA** has also participated with partners in innovative initiatives to improve upon the scarcity of resources in the rural areas. **CCHA** was generally complimentary of the Department's efforts to respond to provider network concerns. **CCHA** also offered several suggestions for future Department efforts to improve provider satisfaction and participation, including increasing the visibility of Department staff with providers in the region, enhancing mechanisms for provider input into Department decisions prior to implementation of initiatives that impact providers, and working with the RCCOs to improve consistency of Department messaging to providers.

Member Engagement

Lessons Learned—Successes and Challenges

CCHA defines “member engagement” as “person- and family-centered interactions which invite the member to participate in his/her healthcare.” **CCHA** understands that engagement is not one-way communication; the member must “participate” in order to be considered engaged. As such, **CCHA** has designed appealing member-facing materials on a variety of topics—general **CCHA** information, maternity program, well-child visits, where to go for care (emergency department [ED] alternatives), social support resources, care coordination—which provide information on how members can interact with the Department, with community resources, with their doctor, and with care coordinators. Materials are distributed as “leave-behind” communications through various points of contact with the member—provider offices, community events, community service sites, county offices, and care coordinator visits. Staff stated that materials are heavily requested by providers and community partners. **CCHA** also uses extensive interactive voice response (IVR) calls to members to stimulate member interaction with the **CCHA** call center. Staff stated that IVR outreach calls generate a 4 percent to 6 percent response rate and, since 2013, have resulted in over 100,000 inbound calls to the call center. IVR outreach campaigns are targeted to specific member populations and have addressed PCMP attribution, well-child visits, maternity program, high-risk members, ED visit or hospitalization follow-up, and MMP appointments for completion of the Service Coordination Plan (SCP). All outreach communications are carefully designed to stimulate members to respond and engage in the healthcare system. **CCHA** solicits member input on IVR scripts and member materials through the Member Advisory Council and one-to-one interactions with members outside of meetings. Once a member contacts the call center, individual member “engagement” is initiated.

CCHA relies heavily on telephonic communication through the call center to develop a one-on-one relationship with members to engage them in their healthcare. Staff members stated that weekly call center monitoring revealed that the number one reason members contact the call center is to request basic information on **CCHA** and Health First Colorado. Staff members stated that “engagement” requires developing trust with the member, and staff have been trained to explain what **CCHA** is as well as to be thoughtful about what and how to ask members to best elicit a response. Once a basic trust is developed, the call center staff can then proceed to conduct assessments or to assist members with needed referrals, attribution to a PCMP, or triaging to care coordination staff.

Care coordination is a primary factor in member engagement and is conducted face to face with the member on a very in-depth level. Care coordinators commonly engage with members in their homes or—increasingly over recent years—in community settings or provider offices (see “Care Coordination” section of report) to “meet members where they are.” Care coordination processes are designed to encourage members to participate in their healthcare by allowing members to establish their own care plan goals and to independently pursue services whenever they are willing, capable, and motivated to do so. Member engagement is also facilitated, as necessary, by the care coordinator, throughout the relationship.

CCHA has established a Member Advisory Committee, through which members provide input into **CCHA** policy and program decisions and feedback on member communications—e.g., IVR scripts and written correspondence. Member advisory meetings are an open forum, although select members have been invited to participate when identified through care coordinators as demonstrating “systematic thinking” or when they may represent diverse member populations. **CCHA** surveys Member Advisory Committee participants to identify topics of interest to members. **CCHA** attempts to identify topics relevant to members but also meaningful to the RCCO. **CCHA** has also scheduled an upcoming telephonic townhall for members. Designed and facilitated through an externally contracted company, the townhall will be structured to inform members regarding **CCHA** services and programs and then incorporate diverse staff members answering member questions.

A growing strategy to engage members where they are is through community partners and schools who engage with members in the community. Staff members highlighted project examples as follows:

- DispatchHealth—emergency care providers offer on-demand urgent care to members in their homes or offices as an alternative to those members accessing the ED.
- AmeriCorps program—used volunteers to conduct door-to-door house calls to stimulate members to schedule well-child visits.
- Jefferson County Action Center—**CCHA** staff communicate with members to inform about **CCHA**; evolving to co-locate care coordination on-site.
- Increasing **CCHA** staff participation in local community events.
- COP maternity program—collaboration of community partners and providers to engage members in improving their health during pregnancy; includes member contact through organizations such as Healthy Communities and Nurse-Family Partnership.
- Emerald Elementary School pilot program provides avenue for **CCHA** staff to educate children on healthy diet choices and offers monetary incentives (for shoes and school supplies) to parents for scheduling well-child checks.

CCHA has continuously evolved its member outreach and engagement mechanisms throughout the term of the RCCO contract. Staff stated that **CCHA** learned that members crave information about the RCCO and services; Medicaid members generally experience health literacy issues; diverse population groups have differing needs; and formulating effective discussions with members is an “art form.” Initially, the call center attempted outbound calls to every member to encourage attribution and to conduct health screens for each. However, the call center moved to responding to IVR-stimulated inbound calls in order to achieve productive encounters with members. In addition, IVR calls and messages targeted specific member populations; call center activities were supported through data systems; and staff were trained in effective communication and engagement techniques. Most recently, select call center staff have been trained as subject-matter experts in specific program areas, and cross-training of staff is being pursued to expand the base of expertise. Similarly, **CCHA** has progressively improved its member website—through monitoring of member inquiries and other member input sources—to include information identified as that being most sought after by members. The most frequently visited Web page is “Find a Doctor,” and **CCHA** has added a section for links to community support resources. Staff members

stated that when they identify large categories of information that members ask for, they update the website with associated information. At the time of on-site review, **CCHA** was planning to integrate a link to the Explain Health portal, so that members could readily obtain information on thousands of health topics.

Staff members stated that early in the term of contract **CCHA** invited members and providers to participate in a multidisciplinary stakeholder advisory committee, but discovered that members were confused and intimidated by industry jargon and provider dialogues and did not actively engage. Therefore, **CCHA** implemented the Member Advisory Council as an improved forum for member input. While **CCHA** intends to continue engaging members through community-based partners, staff stated that most programs are initiated as pilot projects to determine their efficacy—for example, while the AmeriCorps project effectively engaged individual members, the program was discontinued due to the challenges associated with operationally managing volunteers. Staff members have also identified that some member populations are easier to engage than others, noting that Hispanic members present challenges with language and cultural norms; people who use the healthcare system are easier to locate and tend to be more engaged in healthcare; young, healthy members never use the system; and parents of children are too busy with everyday life to participate. Conversely, staff stated that MMP members were easier to contact and responded to calls.

CCHA desires to continuously enrich and expand its member engagement activities, acknowledging that RCCOs are only in the initial stages of understanding and effectively engaging members in the ACC. While engagement with individual members is most appropriate at the local level, staff members suggested that the Department should consider including the RCCO contact number on member ID cards and that the Nurse Advice Line point of contact be used to refer members back to the RCCO and/or use cross-referencing tools to align members with region-specific programs and services when appropriate. Staff also suggested that the Department consider mechanisms beyond the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys to obtain feedback from members. **CCHA** also foresees the need to elevate the use of technology to communicate with members—more than 80 percent of members have smartphones—complimenting the Department on the PEAK application and noting that RCCOs might build on phone applications. **CCHA** also recently initiated and is posting to a Facebook page. Staff suggested that member engagement remain a primary objective of the ACC in the future and that the Department, RAEs, providers, community organizations, and members should work together determine the appropriate role of each entity in member engagement.

Observations and Recommendations

CCHA's core strategies for engaging members in their healthcare are executed through the member call center and care coordination. However, effective and well-utilized member materials and IVR calls remain important support mechanisms for stimulating member contact with the RCCO or promoting members' self-pursuit of needed services. While initial attempts to engage members through telephonic outreach were minimally effective, **CCHA** reinvested in personnel and mechanisms to build a robust and increasingly sophisticated member engagement program through the call center. **CCHA** has used continuous learning experiences to reinvent and improve mechanisms for engaging with members, has

and will continue to increasingly engage members through collaborations with community partners, and foresees increasing use of technology applications in future endeavors. **CCHA** believes that effective member engagement is a challenging objective currently in its infancy compared to other objectives of the ACC program; and that the Department, RCCOs (RAEs), and other stakeholders have an opportunity to work together to improve both statewide and region-specific mechanisms to engage members. However, as long as **CCHA**'s definition of "member engagement" is "person- and family-centered interactions which invite the member to participate in his/her healthcare," it is likely that interaction with members individually at the local level will remain the most effective approach. **CCHA** might consider expanding efforts to obtain more direct feedback from members to confirm whether or not the RCCO's definition of member engagement and corresponding "push" strategies match Medicaid members' perceptions of healthcare priorities.

Care Coordination

Lessons Learned—Successes and Challenges

At the time of on-site review, approximately 65 percent of the member population—non-delegated and unattributed members—received care coordination services through the **CCHA** care coordinators (CCs), with the remaining 35 percent of members receiving care coordination through seven delegated PCMPs—including Kaiser, Metro Community Provider Network (MCPN), Salud Family Health Centers (Salud), Denver Health, Clinica Family Health (Clinica), Rocky Mountain Youth Clinic (RMYC), and Centura Health Family Residency program. Designated delegates have remained relatively consistent over most of the term of the contract. During on-site CC presentations, staff members described that delegated entities maintain their own unique processes for providing CC services to members. For example—Clinica Family Health (Boulder) assigned a multidisciplinary care team to meet members' complex needs, with different professionals assuming different roles and one member assigned as the lead coordinator; Denver Health has CCs embedded within each primary care clinic who provide care coordination to all members within that clinic. Delegates are invited to request **CCHA** CC assistance to support complex needs members, although staff members stated that rarely occurs. Members are also invited to directly contact **CCHA** if they would prefer that the **CCHA** staff member, rather than the delegate, serve as their primary CC. The **CCHA** care coordination program includes staff members with varying levels of expertise: Health Partner I staff are trained to perform telephonic outreach to members, provide screening, and either provide simple referral information to members or triage the members to more complex CC teams; Health Partner II staff are social workers (SW); and Health Partner III staff are registered nurses (RNs). Each complex CC team includes an SW and an RN. During 2016–2017 **CCHA** also defined designated programs of care coordination activities related to specialized needs of members—Complex Care Management, Transitions of Care, Maternity Care Management, ED Recall program, General Care Management, PCMP Selection/Resources, MMP program, Pediatric program, and Behavioral Health program—and assigned RN/SW teams to support each program. If a member is not classified into a special program area, the member is assigned to a low/medium or medium/high risk category; and RN/SW teams are assigned to support members according to geographic location. Members referred to care coordination by a PCMP are assigned to the CC "single point of contact" for

that PCMP. Staff members stated that this array of mechanisms for assigning members to a CC best aligns with meeting each member's diverse or specialized needs. Since inception of the RCCO contract, both the **CCHA** internal care coordination program and the delegate program have undergone several iterations of evolution, summarized as follows:

Internal Care Coordination

From inception, **CCHA**'s care coordination philosophy has been that the PCMP, in collaboration with the member, is the hub of effective care coordination. In addition, **CCHA** has conducted home-based visits, whenever possible, to perform face-to-face in-depth assessments and to initiate relationships with the members, a core value of the care coordination program. **CCHA** initiated its care coordination program using a model of telephonic outreach to all members to achieve attribution of members to PCMPs and to conduct a limited health risk assessment with each. Based on that limited assessment, the telephonic team offered a more in-depth home visit to each member and triaged the member to either a SW or RN to follow up with the member. The telephonic team also offered simple referrals—i.e., doctor, dentist—to a member and maintained follow-up with low-risk level members. At the time of on-site review, staff stated that the telephonic team now also includes Health Partner I specialists, who have been specifically trained in each of **CCHA**'s specialized care coordination programs and can provide special program expertise to the entire Health Partner I team. Initially, the member was also assigned to either an SW or an RN CC based on the predominant type of assessed needs, and not to a designated SW/RN team. Referral information through the system required one to two days for follow-up by the SW or RN. Relationships with external agencies—SEPs, CCBs—were limited.

Midway through the contract, **CCHA** began expanding and strengthening its relationships with external agencies and community organizations to perform care coordination support for other care managers involved with members. Simultaneously, **CCHA** recognized that face-to-face engagement with members through the PCMP was more efficient than individually arranged home visits. Therefore, **CCHA** co-located CCs in four of its high-volume Medicaid practices. **CCHA** has subsequently offered co-located CCs to its top 40 PCMPs, resulting in eight practices with weekly or multi-weekly presence of a CC in the practice and 17 practices with some kind of on-site CC support. **CCHA** also negotiated on-site placement of CCs in three high-volume hospitals or EDs to assist members with transitions following ED visits or maternity care. At the time of on-site review, **CCHA** was intending to co-locate a CC in the Westminster parole office and in the Jefferson County Action Center to engage members “where they are” in the community.

More recently, the care coordination program has evolved to organize CCs into program-specific teams (addressed preceding). In addition, over the past two to three years, **CCHA** expanded the diversity of professional expertise—e.g., behavioral health, long-term care services, social programs—in the CC staff it hired, not only to address its specialized program orientation, but to offer specialized consultation and expertise to the CC teams when addressing individual member needs and challenges. CCs also develop subject-matter expertise based on their care coordination experiences with individual members. Staff members stated that this diversity of expertise among CC staff has greatly enhanced the entire care

coordination program and has strengthened care coordination roles with external community partners and providers.

CCHAs care coordination documentation systems have also evolved significantly over the term of the RCCO contract. Following several years of maintaining text-based notes of CC activities with limited structure and format, **CCHA** invested in the Essette care management software. **CCHA** adapted the Essette system to accommodate the extensive assessment and care plan elements required for the MMP program, and continues to apply that care planning document as best practice for all members with complex care coordination needs. During 2015–2016, **CCHA** also developed program-based assessments to correlate with its specialized care coordination programs. Program-based assessments are applied when less extensive assessment questions are required—e.g., maternity program—to develop the member care plan. Through the Essette system, data gathered through any program assessment auto-populates all other applicable system assessments and care plans. In addition, the Essette system enables care coordination program data analysis and reporting. Staff stated that over six years **CCHA** has custom developed an extensive data warehouse oriented to primary care and health plan data needs. The data warehouse integrates data feeds from the Department and interfaces with the Essette system. Future data system goals of the care coordination program include allowing external partners to access **CCHA**'s care coordination tools, exploring mechanisms for provider electronic health records (EHRs) to update the member care coordination records with medications and care information, and ultimately designing a shared-member care coordination record with input from all community partners participating in the member's care. **CCHA** believes that “the future is bright” regarding shared data and data systems to enhance care coordination for members.

Delegate Care Coordination

At inception of the RCCO contract, **CCHA** delegated care coordination to the FQHCs, Kaiser, and Denver Health in an effort to remain aligned with the delegation strategy of other RCCO regions with whom these providers were contracted. Within the past two years, **CCHA** has designated Rocky Mountain Youth Clinic and the Centura Health Family Residency program as delegates that, with **CCHA** support, can develop the capabilities to perform as independent care coordination delegates. As qualified primary care medical homes, **CCHA** passed the entire per member per month (PMPM) payment to delegates and has essentially allowed those delegates to perform care coordination for members in a manner that could be uniformly applied to all Medicaid members within the individual practice—regardless of RCCO region of attribution—and that fit with the systems and operations in place within each independent entity. **CCHA** met regularly with delegates and used KPIs as measures of the delegates' care coordination performance.

Delegates have not experienced the same dynamic evolution of care coordination processes and systems demonstrated by **CCHA** over the years, partially inhibited by the continuing challenge of being associated with multiple RCCO regions and expectations. Nevertheless, **CCHA** has enhanced its internal processes to work with delegates to improve care coordination processes and programs and evolve toward increased accountability for the comprehensive care coordination requirements of the ACC. Staff members stated that the MMP program and associated SCP requirements revealed the

differences in delegate care coordination operations and provided an opportunity for **CCHA** to elevate its working relationship with each delegate. **CCHA** assigned a CC single point of contact for each delegate. In addition, **CCHA** developed and implemented:

- An assessment tool for potential future delegates to identify the infrastructure, assessment processes, and other capabilities of a practice to perform comprehensive care coordination and to identify gaps or areas in need of support from the RCCO care coordination program.
- Enhanced delegate contracts to more specifically outline expectations of performance (e.g., thresholds for KPIs), requirements to participate in meetings, and oversight by **CCHA** (e.g., audits).
- Ongoing audits of care coordination processes, including annual chart reviews of care coordination cases.
- A dedicated delegate partner liaison position to meet individually with delegates monthly, review their performance data, discuss upcoming programs or project opportunities, maintain Department deliverable requirements, and generally consult with delegates to assist them with needs and improvements.

Staff members stated that **CCHA** has reached the point of moving away from increasing the number of delegates to evaluating and improving the depth of its relationships with delegates. To that end, **CCHA** has developed a data dashboard for delegate practices; designated an IT single point of contact for each delegate to work with PCMP attribution issues; offered to fill gaps in delegate care coordination processes by integrating a **CCHA** CC as a single point of contact with each delegate to provide collaborative care coordination for members with complex needs, as necessary; and is working at the leadership level to identify mutual concerns and initiate cooperative special projects. Staff stated that **CCHA** continues to evaluate how to improve care coordination processes among delegates and how to increase accountability of delegates for RCCO care coordination. In the future, **CCHA** suggested that alignment of KPIs with complex care coordination requirements would drive increased accountability and also recognized the need for RCCO leadership to identify areas of mutual interest or concern and develop some cross-RCCO cooperative initiatives to enhance delegate performance. In addition, **CCHA** envisions that RAEs may be able to broaden use of the PMPM funds to accomplish more objectives.

CCHA identified that numerous lessons learned have led to modifications in operations and care coordination program design and will continue to do so. Some challenges noted were:

- The PCMH model of care coordination focuses primarily on management of clinical referrals for members and does not, in its entirety, meet the comprehensive ACC requirements—particularly for addressing social determinants of health and coordinating with multiple agencies and community organizations to meet member CC needs.
- Early challenges included PCMP's misunderstanding of the difference between RCCO care coordination and PCMH care coordination and the confusion created by differences in expectations among RCCOs.
- While **CCHA** held collaborative delegate meetings to share best practices among delegates, the widely diverse size and scope of delegate practices rendered this process ineffective. **CCHA** now pairs delegates, for mutual learning exchange, according to similar characteristics.

- PCMPs in which **CCHA** co-locates CC staff have to adjust to using CCs in the daily practice routines. **CCHA** has learned to define expectations of the practices in order to make the investment worthwhile to all, including scheduling a minimum of four CC visits per week, providing space for the CC to work, providing access to Wi-Fi and member records, and (ultimately) adjusting member appointments to coincide with availability of the CC.
- Staff turnover at RCCOs and within delegate sites (particularly at Denver Health) creates challenges in developing ongoing inter-organizational relationships at the CC level.
- Member transfer from one RCCO region to another is a challenge for those members, requiring a warm handoff between cross-regional CCs and follow-up to ensure that the member's needs are being met.
- Family-based rather than individual needs assessments are essential for understanding and addressing members' needs, especially MMP members, pediatric members, and members with complex needs.
- Contract amendments related to care coordination requirements and evolving priorities of the Department require RCCO operational adjustment and re-training of staff. The MMP program halted all other CC activities as resources were redirected.
- While the MMP program implementation mechanisms were a challenge, staff stated that the structure imposed by the MMP program was actually helpful in providing some guidance and consistency to the RCCOs regarding care coordination expectations. **CCHA** used this structure to modify care management documentation systems and develop closer relationships with delegates.
- Ongoing issues exist related to ability to contact members and with coordinating care for some population groups, including homeless persons and members with SUD. The Veyo transportation service is also unreliable and results in access issues with services and appointments.
- During the first several years of the contract, lack of hospital admit discharge transfer (ADT) data was a significant deterrent to care coordination processes. The Colorado Regional Health Information Organization (CORHIO) ADT data feed resulted in a massive project for the RCCO, requiring multiple iterations of workarounds to obtain reliable data and then to integrate that data into the care coordination system.
- Achieving a balance between evaluating the time-consuming content work of quality care coordination as opposed to outcome measures which are numbers driven—i.e., deliverables that focus on number of members, number of assessments, number of interventions—is a continuous tension. **CCHA** believes that pursuing mechanisms to evaluate the quality of care coordination efforts is critical.

Staff members provided for the Department's consideration several observations or suggestions that could facilitate RCCO's care coordination efforts in future years. RCCO care coordination programs need to be designed and implemented within local regions and considering the characteristics of provider and community partnerships in each region; however, the following should be taken into account:

- The Department may need to facilitate partnerships among the RCCOs to provide consistency for providers who have facilities located in multiple regions or for members who live in a county different from where they receive social services.
- Members are confused with the varied terminology used to describe care coordination—i.e., care coordination, care management, case management, health partners. The Department and affiliated Medicaid entities should strive for uniformity in language.
- Some methodology for statewide risk stratification of the broad member population would be helpful in guiding RCCOs, delegates, and other agencies toward a more uniform identification process for care coordination. Associated intervention techniques would be determined locally.
- The Department and RCCOs should work collaboratively to define KPIs that align with complex care coordination outcomes, thereby driving care coordination accountabilities more consistently across entities.

Observations and Recommendations

HSAG observed through **CCHA**'s on-site presentation of 10 care coordination cases, the following trends:

- Profile of member types: three delegated, seven RCCO CC; three children, seven adults (including four MMP members).
- Four of ten members were identified to the CC team through the SCP assessment process; three members were referred to **CCHA** by the PCMP; one case was referred to **CCHA** from another agency; two cases were identified through routine delegate processes.
- The profile of primary member needs included three members with significant physical disabilities; four members with multiple behavioral health conditions; three members with alcoholism, including two members who sustained injuries due to intoxication; and one member with cognitive issues. In addition, four cases identified multiple additional complex needs upon initial assessment.
- Two cases involved homelessness of the member, and two additional cases identified the need for housing resource information.
- Primary CC interventions were categorized as follows: Six cases were coordinated with mental health and/or substance abuse providers; four cases involved coordinating primarily with physical health (PH) providers; one case included coordinating extensive social and community supports; two members—both delegated cases—had limited care coordination needs.
- Additional patterns of CC interventions included that four cases involved transitions of care following ED visits, hospitalizations, or skilled nursing facility (SNF) care; three cases required repeated CC efforts resulting from interruption in care plans—e.g., hospitalizations or non-compliance issues; in four cases, the CC accompanied the member to multiple appointments or meetings; in three cases, the CC provided extensive education regarding member diagnoses or medications; in two cases, the CC provided additional services for other family members; in seven cases, the CC worked with external state agencies—three unrelated to referrals and four related to referral approvals; two cases involved transferring the member to a new PCMP.

- At the time of on-site review, outcomes of CC efforts demonstrated five successful cases, three partially successful cases, and four cases with ongoing challenges. In one case, the member refused to participate. Three cases were associated with extensive barriers or challenges. Two cases involved appeal of a BHO denial; one additional case involved an appeal of other denied services.

Over the life of the contract, **CCHA** has made continuous improvements in its internal care coordination organization and expertise offered to members. The **CCHA** internal care coordination program appears to be exemplary in meeting member's complex needs through investment in staff expertise, improved documentation and data systems, programs for special member populations, and establishment of strong, supportive relationships with providers and community partners. **CCHA** program innovations have now evolved to supersede the capabilities demonstrated by many delegated entities, which each maintain a unique model for care coordination appropriate to their organization and resources. The delegate program has undergone improvements in mechanisms for holding the delegates accountable to RCCO standards of care coordination; however, delegate relationships and progress continue to be hindered by the inter-urban presence of multiple RCCOs with varying delegate expectations. **CCHA** has responded by developing an attitude of support with delegates and other entities by offering designated CCs to support members in practices, sharing data resources, and offering on-site consultation through a delegated practice liaison. **CCHA** holds delegates accountable primarily through KPI performance. However, current KPIs are not well aligned with comprehensive care coordination objectives. **CCHA** desires, and will continue to be challenged by, defining mechanisms for evaluating the quality versus quantity of care coordination activities.

CCHA initially invested in the PCMH model of care coordination and passed all of its PMPM funds to delegates to perform in that capacity; however, **CCHA** now realizes that while medical homes play a significant role in coordinating member care, the PCMH model tends to be too clinically driven to serve Medicaid members' comprehensive needs. **CCHA**'s greatest future in expanding care coordination efforts lies within the collaborative relationships it has and will continue to develop among community agencies and partners with shared interest in improving the outcomes of members.

Balance Between Central (Department-Driven) ACC Priorities and Regional (Community-Driven) Priorities

Lessons Learned—Successes and Challenges

From inception, **CCHA** and its network providers have participated in all grants and special program opportunities presented through the Department, citing examples of the SIM, COP, Comprehensive Primary Care (CPC+), and AmeriCorps programs. In addition, **CCHA** has partnered with the Department to pursue Center for Medicare and Medicaid Innovation (CMMI) grant funds to obtain technical assistance on value-based payments to support integrated care for pregnant women. Simultaneously, **CCHA** has identified regional priorities through **CCHA**'s community partnerships, resulting in **CCHA** participation in an estimated 10 to 15 initiatives in each county of the region. Staff members stated that the priority-setting criteria for determining participation in Department or local

regional initiatives are Department mandates, county agency or community priorities, and member needs. In addition, **CCHA** considers programs associated with improving KPI performance priorities. Staff members stated that the manageable size of **CCHA** as well as integration of PPP—the primary care physician IPA—into the leadership structure of the organization has expedited strategic decisions regarding Department or regional initiatives. In addition, **CCHA** considers input from its Health Neighborhood Advisory Committee and participation in county health alliances and community boards of directors to evaluate opportunities with community partners. **CCHA** attempts to strategically and operationally integrate special programs and grants to support RCCO, provider, and/or community priorities. Staff described several examples:

- SIM grant funds stimulated the Union Square project to implement a new co-located BH/PH clinic site, integrating Jefferson County Mental Health, CMHC; Metro Community Health Partners, PCMP; and **CCHA** integrated care coordination. In addition, the SIM grant stimulated Clinica and MHP to develop an alternative model of integrating Clinica primary care services into an MHP delivery site. **CCHA** provides practice coaching to both sites. Staff members stated that grant funding enables development of models that do not conform to existing payment system methodologies.
- The alternative payment methodology (APM) quality measures initiative aligns with the CPC+ program.
- The COP stimulated the development of a maternity care coordination program with collaborative community partners in six counties.
- While RCCOs have been invested in primary care and community programs, federal funding through the Department’s Colorado Hospital Transformation Program stimulates integration of hospitals into ACC program goals.
- The CORHIO health information exchange project supported the real-time ED utilization data needs of the Jefferson County Hotspotting Alliance.
- The DispatchHealth (Dispatch) program provided **CCHA** with an urgent care alternative for high ED utilizers.
- The AmeriCorps project addressed the RCCO’s objective to increase well-child visits.

In addition, **CCHA** extends its KPI funds as appropriate to support select community and provider programs. Examples included the Genesis and Genisister teen pregnancy programs, bridge funding for the Arapahoe House detoxification program, NEMT transportation services in rural areas, and the practice incentive program. **CCHA** has formal contracts with each community partner or provider who receives over \$5,000 in funding. Contracts outline the expected benefits of each program for providers and members in exchange for funding or expenditure of RCCO resources, and availability of funding is associated with **CCHA** continuing to achieve its KPI goals.

Staff stated that sustainability of programs is another important consideration in its strategic decisions. Many programs are implemented as pilot projects to test feasibility and sustainability, and all program

outcomes are evaluated. Staff members stated that, due to lack of sustainability or unsatisfactory outcomes, multiple projects have been discontinued. Some examples follow:

- The AmeriCorps project was discontinued due to lack of reliability of a volunteer staff to be accountable to RCCO operational expectations.
- The pilot program with Walgreens to distribute free maternity care products to members was discontinued because the provider partner could not distinguish between Medicaid and other patients in the practice, and the **CCHA** determined that it was primarily subsidizing services to non-Medicaid members.
- Payments to providers based on EPCMP criteria were modified to focus on APM measures.
- The Dispatch partnership, an ED diversion project conducted through ED physicians providing urgent primary care to members in their homes, was altered mid-course to attempt to redirect members to their PCMP rather than them using on-site services of Dispatch providers.

CCHA described additional challenges associated with some Department driven projects:

- SIM grant funds are paid directly to practices, and the SIM project has engaged practice coaches—Health Team Works—and a regional health coordinator to work independently with practices to integrate BH and PH. This created potential conflict or overlap with **CCHA** practice coaches because **CCHA**'s practice transformation program works with practices on all RCCO initiatives and programs and provides incentive payments to providers based on accepting **CCHA** practice coaching. This circumstance created confusion and stress on providers trying to meet goals of multiple pay sources. (**CCHA** has adjusted its process to coordinate with all practice coaches operating in a given practice, to ensure consistency in coaching approaches.)
- While **CCHA**'s organizational partner—Centura Health—is positive about participation in the Colorado Hospital Transformation Program, other hospitals in the region have been difficult to engage, citing that health alliances are already configured to meet program objectives and that the hospital provider fee does not improve payment to hospitals for Medicaid members. Centura Health contacted the Colorado Hospital Association to request that they encourage hospital participation in the program. Staff members stated that project goals must be framed to assist hospitals with Medicaid payment issues and noted that integrating hospital objectives with the RCCO's primary care and community program goals will present many challenges and require extensive effort.
- Health alliances exist in every community in the region, are in different phases of maturity, have conflicting initiatives, and are generally unfamiliar with Medicaid objectives. Staff members noted that structure and associated resources are needed to move the alliances beyond meetings toward actual engagement in communitywide health initiatives. Staff members observed that coordination among the alliances—an alliance of the alliances—might be necessary in the future.
- Implementation of the APM not only changed payments to providers, but required that practices select quality measures for payment within a very short period of time. This process presented challenges for providers and practice coaches. Staff members stated that RCCOs need significant lead time to prepare providers and to offer practice coaching to implement changes impacting payments to practices.

While **CCHA** credited the Department with selecting grant opportunities and programs that support RCCO objectives, staff members cautioned that some initiatives may send practices in the wrong direction and that too many programs and practice coaches can overwhelm practices or diminish outcomes of the programs. In addition, staff acknowledged that the Department has done some good work related to payment reform mechanisms but that deliberate planning around payment reform was still necessary. **CCHA** suggested that in the future the Department be selective with the opportunities that it pursues, distinguish whether a program is optional or required, and involve RCCOs in planning implementation processes. Staff members stated that regular leadership meetings with the Department's ACC program manager are very valuable as opportunities for RCCO leadership to provide input into Department initiatives, meet with other Department project leaders, and anticipate upcoming changes in the ACC program. However, staff noted that previous opportunities for RCCO staff to exchange ideas and address issues—e.g., the original performance improvement advisory committee (PIAC) or the RCCO Operations Committee—have diminished over time. **CCHA** recommended that during phase 2.0 ACC operations the Department establish a new channel, perhaps similar to the Department's managed care quality committees, mandating RAEs to come together to share best practices or exchange ideas.

Most importantly, while innovation in community and provider strategies must be implemented through the individual RCCOs, staff suggested that the Department and the RAEs together develop a strategic plan to provide a structure for determining new programs and projects, to provide guidance to the individual RAEs as they prioritize multiple community, member, and provider-driven objectives; and to provide a forum for discussing payment reform.

Observations and Recommendations

CCHA has positively responded to and integrated Department initiatives and grant programs into regional priorities. Most programs and grants have resulted in productive outcomes with providers and community partners and improved services for members. Wisely, **CCHA** has implemented many programs as pilot projects and then evaluated them to determine long-term feasibility. **CCHA** encourages the Department to continue to pursue program opportunities complementary to ACC objectives. However, staff members suggested that the Department could diminish the chaos associated with balancing Department priorities with regional priorities as well as provider and RCCO operational issues by engaging RCCO staff in both strategic decision making regarding potential initiatives and in implementation planning, and by developing a Department strategic plan. HSAG recommends that the Department consider a strategic planning process with the RAEs to outline an overall vision, priorities, direction, and structure for ACC development which will, in turn, provide guidance for associated federal or State program opportunities as well as decisions specific to individual regions.

Overview of Site Review Activities

The FY 2016–2017 site review represented the sixth contract year for the ACC program. The Department asked HSAG to perform an annual site visit to assess continuing development of **CCHA** as the RCCO for Region 6. During the initial six years of operation, each RCCO continued to evolve in operations, care coordination efforts, and network development in response to collaborative efforts, input from the Department, and ongoing implementation of statewide healthcare reform strategies. The FY 2016–2017 site visits focused on evaluating RCCO experiences and lessons learned related to diverse ACC stakeholders and regional characteristics—including community partnerships, provider participation, member engagement, and integration of multiple Statewide and regional priorities. In addition, HSAG gathered follow-up information on care coordination activities and strategies implemented by each RCCO. Through review of member care coordination cases, HSAG documented examples of RCCO-selected “best” cases of comprehensive care coordination. The Department also asked HSAG to offer observations and recommendations related to each ACC focus area reviewed.

Site Review Methodology

HSAG and the Department met on several occasions to discuss the site review process and finalize the focus areas and methodologies for review. HSAG and the Department collaborated to develop the Focus Topic Interview Guide and coordination of care case summary tool. The purpose of the site review was to explore with each RCCO the “lessons learned” since the inception of the ACC program regarding each focus topic—including changes over time, influence of recognized challenges and successes on RCCO operations, and the role of the Department in influencing RCCO operations. Site review activities included a desk review of documents related to each focus topic that were submitted by **CCHA** prior to the site visit. During the on-site portion of the review, HSAG conducted group interviews of key **CCHA** personnel using a semi-structured qualitative interview methodology to elicit information pertaining to the Department’s interests related to each focus topic. The qualitative interview process encourages interviewees to describe experiences, processes, and perceptions through open-ended discussions and is useful in analyzing system issues and associated outcomes.

To continue the annual assessment of care coordination activities, on-site review included care coordination case presentations by RCCO staff members. The Department determined that FY 2016–2017 care coordination reviews would focus on demonstrating the best examples of RCCO care coordination activities and outcomes for members with complex needs. HSAG reviewed a sample of 10 care coordination cases selected and presented by the RCCO. HSAG completed an individual care coordination summary for each case. The Department determined that the care coordination record reviews would not be scored. HSAG considered results of care coordination presentations in documentation of findings related to the Care Coordination focus topic area.

Summary results and recommendations resulting from on-site interviews and care coordination case presentations are included in the Summary of On-Site Discussions.

Appendix A. Focus Topic Interview Guide

This appendix includes the HSAG Focus Topic Interview Guide used to facilitate the on-site discussions.

Focus Topic 1: Community Partnerships/Collaboration

- How are relationships with these community entities progressing:
 - County agencies?
 - SEPs/CCBs?
 - Other community organizations?
 - Do you feel like you could benefit from additional key relationships? (Specify.)
- How did you build these relationships over the past five years? Such as:
 - Methods of contact/communications
 - Techniques used to sustain
 - What has been the evolutionary process?
- How responsive are organizations to RCCO interests or priorities?
- What are some of the major areas of success?
 - How have those successes influenced operations, programs, and/or relationships?
- What have been some of the major challenges/lessons learned?
 - What solutions were considered or implemented as a result?
- Are there differences in successes or failures related to specific member populations? (If yes—describe.)
- How is “coordinating the coordinators” among agencies and organizations working for you?
 - Do you feel like you are successful in this? If not, what are the barriers?
- What has been most helpful from the Department to facilitate or influence your relationships with community partners?
- What could the Department have done differently to improve/facilitate the process or outcomes?
- What programs other than those associated with Department initiatives have you developed with community partners?
- Other lessons learned regarding community partnerships since RCCO implementation?

Focus Topic 2: Provider Network/Provider Participation

- How has your provider network evolved over time?
- How are providers functionally involved with your RCCO? What is the current role of providers in your RCCO?
- How active are providers in RCCO initiatives?
- How receptive (or not) have providers been to the ACC?
 - In what areas?
- How has provider participation changed since inception of the RCCO?
- What have been some of the major areas of success with providers?
 - How have those successes influenced operations, programs, and/or relationships?
- What has been most helpful from the Department to facilitate or positively influence provider participation in the RCCO?
- What have been some of the major challenges/lessons learned?
 - What solutions were considered or implemented as a result?
 - What could the Department have done differently to improve/facilitate the process or outcomes?
- What could be done to improve the provider network or provider experience?
 - By the RCCO?
 - By the Department?

Focus Topic 3: Member Engagement

- What is your RCCO’s perspective/view of “member engagement?”
 - How do you define it?
 - What do you consider to be “member engagement”?
- In what areas does member engagement occur?
- What mechanisms do you use to engage members (including tools—e.g., Patient Activation Measures)?
- What have been some of the major areas of success in member engagement?
 - How have those successes influenced operations, programs, and/or relationships?
- What has been most helpful from the Department to facilitate or influence member engagement?
- What have been some of the major challenges/lessons learned?
 - What solutions were considered or implemented as a result?
- Are there differences in successes or failures related to specific member populations? (If yes—describe.)
- Is member engagement more appropriate at the State level or is it more effective at a local level?
- How has member engagement changed or evolved since inception of the RCCO? Why?
- What could the Department have done differently to improve/facilitate the process or outcomes of member engagement:
 - From the beginning?
 - Support needed going forward?

Focus Topic 4: Care Coordination

- Please describe your model for delegation and care coordination.
 - How has it changed over time?
 - What do you consider the more successful features of your model?
 - How have those successes influenced operations, programs, and/or relationships?
 - What have been some of the less successful or challenging features?
 - What solutions were considered or implemented as a result?
- How much success have you had in holding your delegates accountable? (Describe.)
- Are there differences in care coordination successes or challenges related to specific member populations? (If yes—describe.)
- Describe other significant lessons learned since inception of RCCO (such as staffing, structure, communications, systems support).
- What has been most helpful from the Department to facilitate or influence your care coordination efforts?
- What could the Department have done differently to improve/facilitate the process or outcomes?

Focus Topic 5: Balance Between Central (Department-Driven) ACC Priorities and Regional (Community-Driven) Priorities

- Has your RCCO focus changed over time regarding State-driven priorities versus local RCCO priorities? (If so, how?)
- How do you determine strategic priorities within the RCCO?
 - Which factors do you consider?
 - Which factors most influence your decisions?
- Explore the multitude of Department “projects” and programs implemented through the RCCOs (e.g., Colorado Opportunity Project, SIM).
 - How do you handle/integrate the multiple projects?
 - What influence have multiple projects had on RCCO operations?
 - Do you have data to determine whether or not initiatives are working?
 - How do you perceive sustainability of these programs?
- What lessons have been learned over time about the influence of State-driven priorities on RCCO strategic processes or priorities?
- What has been most helpful from the Department to facilitate balance of State-driven priorities and programs with RCCO community-driven objectives and operations?
- What could the Department have done differently to facilitate the process of balancing State-driven and regionally-driven priorities? What is needed from the Department to improve this process?

Appendix B. Record Review Summaries

Based on the sensitive nature of the coordination of care record reviews, they have been omitted from this version of the report. Please contact the Colorado Department of Health Care Policy & Financing's Quality Unit for more information.

Appendix C. Site Review Participants

Table C-1 lists the participants in the FY 2016–2017 site review of **CCHA**.

Table C-1—HSAG Reviewers and CCHA and Department Participants

HSAG Review Team	Title
Kathy Bartilotta, BSN	Senior Project Manager
Rachel Henrichs	External Quality Review (EQR) Compliance Auditor
CCHA Participants	Title
Abby Brookover	Director of Communications
Amanda Mrkvicka	Health Partner II Pediatric Specialist
Andrea Skubal	Delegated Partners Liaison, CCHA
Cindi Terra	Manager of Quality and Practice Transformation, CCHA
David Brody	Medical Director, CCHA
Deb Munley	Senior VP of Clinical Services, PHP
Diana Lin	Health Partner II, Behavioral Health
Elizabeth Baskett	Executive Director, CCHA
Heather Brock	Community Liaison, CCHA
Janet Rasmussen	Vice President of Integrated Services, Clinica
Jenn Conrad	Manager of Care Coordination, Denver Health
Josie Dostie	Network Manager
Karin Stewart	Options for Long Term Care, Jefferson County
Kate Scott	Care Navigator, Rocky Mountain Youth Clinics
Katie Mortenson	Health Home Network Supervisor
Krista Newton	Manager, Outpatient Care Coordination
Lisa Canady	Denver Health
Luci Hunter	ACO Program Manager, Clinica
Lynn Scheidenhelm	Behavioral Health Clinical Manager, Clinica
Meghan Booth	Social Worker, Denver Health
Michelle Blady	Health Partner, CCHA
Patrece Hairston Peetz	Manager, Strategy and Partnerships
Patricia Warner	Health Partner III, Nurse
Ravenne Bye	Care Coordination Supervisor, SW/CCHA
Sabrina Hulko	Project Coordinator, CCHA

CCHA Participants	Title
Sarah Freeman	Care Navigation, Rocky Mountain Youth Clinics
Shannon Rosehart	Administrative Assistant
Sheryl Slankard	Health Partner II, Social Worker
Sophia Meharena	Pediatrician, Rocky Mountain Youth Clinics
Stephanie Fischer	Health Partner II, Complex Team
Stephanie Phibbs	RCCO Coordinator, Denver Health
Teresa Lind	Health Partner II, Maternity and Pediatric Specialist
Tony Olimpio	Care Coordination Services, CCHA
Department Observers	Title
Anne Jordon	MMP Team
Ben Harris	ACC Contract Manager
Kathleen A. Homan	MMP Policy and Outreach Specialist
Patricia Connally	Quality Improvement Specialist
Russ Kennedy	Quality/Compliance Specialist
Sophie Thomas	ACC Communications
Susan Mathieu	ACC Manager