COLORADO
Department of Health Care Policy & Financing

Fiscal Year 2016–2017 Site Review Report

for

Community Health Partnership

Region 7

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

HSAG HEALTH SERVICES ADVISORY GROUP

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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 **Community Health Partnership** (**CHP**), 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

CHP was initially structured as a partnership organization with community providers and community organizations. From inception, **CHP** was built on a foundation of established relationships with community organizations. Over time, those relationships have grown—due to networking among various agencies and community providers—and have steadily matured as the RCCO has convened and/or funded multiple collaborative initiatives within its region. During the early years, most relationships were informally defined; however, **CHP** progressed to formalizing program-related relationships through written agreements that specified roles, accountabilities, and funding.

CHP has extended nearly 63 percent of its RCCO contract revenue to support collaborative initiatives that fill gaps in services or build better systems of care—e.g., care coordination processes—for Medicaid members. Much of the collaboration between agencies and community partners has been

driven by the need for care coordination for shared members with complex needs. Ongoing multi-agency care coordination for individual members stimulates stronger relationships among individual staff members across agencies. In addition, collaborative organization-level strategies have resulted in a variety of models for care coordination throughout the region in order to use the resources and expertise available within communities and, increasingly, to engage members within community provider organizations. (See "Care Coordination" section of report.) In addition to care coordination resources, one of **CHP**'s major contributions to community collaborative initiatives and individual community partners has been provision of valuable member healthcare and services data otherwise unavailable to partners but available to the RCCO through the State Data Analytics Contractor (SDAC); Colorado Regional Health Information Organization (CORHIO); Behavioral Health Organization (BHO); and more recently, the Department's Benefits Utilization System (BUS) data system. **CHP**'s health information exchange (HIE) objectives include developing mechanisms to share care coordination records and select database information with community partners.

CHP has established relationships with Rocky Mountain Options for Long Term Care—Single Entry Point (SEP), The Resource Exchange—Community Centered Board (CCB), El Paso Department of Human Services (DHS), and county public health agencies in El Paso and Teller counties. Most relationships were instigated or enhanced by shared care coordination objectives. **CHP** has a six-year history with The Resource Exchange, related to a number of successful initiatives. Although **CHP** experienced some early difficulties in working with the SEP, staff members reported that the relationship has strengthened over time, with the SEP increasingly making referrals to **CHP** care coordinators. **CHP** shares admit, discharge, transfer (ADT) data and claims information with the SEP; and **CHP** now has access to the Department's BUS data. **CHP** has longstanding agreements with Teller County Public Health and Environment (TCPHE) and Rocky Mountain Rural Health (RMRH) to provide navigation services for members and with El Paso County Public Health to provide care coordination for foster children and families. Staff stated that the "No Wrong Door" concept has been "years in the making" among these and other community organizations. Staff reported that all organizations' staff members have developed a cross-system mentality as a result of working relationships.

CHP invited multiple community partners to provide input into the on-site review discussions, including El Paso DHS, El Paso County Public Health, RMRH, Area Agency on Aging, Urban Peak, Colorado Department of Corrections (DOC), Catholic Charities, and The Resource Exchange. Staff members and community partners described several collaborative initiatives which illustrated both successes and challenges in community partnerships, as follows:

- A major community collaborative to improve access to resources for the disabled included DHS, The Independence Center, Area Agency on Aging, AspenPointe, Silver Key (transportation), **CHP**, the SEP, and the CCB to apply for grant funds that would enable streamlining and redirecting existing funds into an improved model of services for members. The proposed model was presented to the State Legislature in August 2014. The project was inhibited by delays in federal funding to the State. As local enthusiasm for the project increased, the group retained a consultant to assist with the RFP; however, ultimately, reduced funding allocations to county agencies—i.e., El Paso County's

"philosophy" limits the use of tax-supported funds for social services—resulted in diminished financial resources to support the project; and it was determined to be unsustainable with grant support. Nevertheless, participants stated that the collaborative process strengthened relationships across all agencies.

- RMRH was initially engaged by **CHP** to conduct member outreach and navigation services. Staff described Park County as a vast rural region with a unique population—i.e., "people live rurally for a reason," two-thirds of the population is on Medicaid, and the county has no clinical services. Initial focus was on attribution of members to a Primary Care Medical Provider (PCMP), which did increase from 26 percent to 65 percent; however, members did not follow up with PCMP visits. In the course of outreaching to members, staff discovered that transportation issues—members had vehicles but could not afford gas—prohibited members from accessing services. Park County agencies and communities collaborated to support RMRH to study transportation solutions. As a result, RMRH used community health workers and a mobile van to provide health screenings throughout the county, improve health literacy, and use the screenings to instigate follow-up services with RMRH. In addition, the collaborative identified an alternative non-Medicaid funding source for mileage reimbursement to members. Staff stated that project outcomes indicated a need for Department reassessment of the per-capita rate for non-emergency medical transportation (NEMT) services or mechanisms for funding for other sources of transportation in rural areas.
- El Paso DHS Child Welfare Division manages foster care services for a large population of children and families and has 150 case workers executing benefits with multiple systems. DHS developed a relationship with the RCCO in 2013. DHS discovered that the RCCO had data that could be used to stratify and target members for DHS case management. DHS and the RCCO executed a business associate agreement (BAA) to allow exchange of shared member information for care coordination. The El Paso County Public Health is co-located with DHS. **CHP** funded a public health department position to perform care coordination for foster children and families on behalf of and in conjunction with DHS and the RCCO. DHS and the BHO provider also had a history of unsuccessful experiences, which was improved through the RCCO's integrated relationship with AspenPointe and other BH providers in the community. The DHS interview participant stated that the RCCO's leadership has been invaluable in improving DHS/BHO relations and in convening and collaborating among various community organizations.
- **CHP** approached Urban Peak—services and shelter for homeless youth—to develop a collaborative initiative to attach this population, all of whom are eligible for Medicaid, to Medicaid benefits, healthcare, and other resources. The **CHP** service center has embedded a care coordinator within Urban Peak to enable direct contact with the youth, building trusting relationships, and eventually educating members about how to use the Medicaid system and services. The coordinator serves as a conduit to all other agencies, as necessary. Networking among the youth members has been the key to successfully engaging more members in services. This partnership was driven by identifying that the organizations had shared members and a mutual interest in improving services and outcomes for those members.

- The community care case manager for the DOC works collaboratively with RCCO care coordination staff to engage parolees in Medicaid services. While the DOC processes the parolee's applications for Medicaid, recently enhanced by the Department's policy of presumptive eligibility, RCCO care coordination staff network with individual paroles at pre-release meetings to coordinate needed post-release services for members. The DOC case manager emphasized the urgency of connecting members to services as soon as possible after release. However, members are difficult to contact after release for ongoing care coordination; and many gaps in services and information exist between the Medicaid and DOC agencies.

Staff participating in the on-site interview identified common challenges in community partnership collaboration, including:

- While El Paso County Public Health and DHS are co-located, these offices are located in an area not easily accessible to members without transportation.
- Varying industry language used among agencies complicates cross-system communications.
- Through numerous collaborative initiatives, participants have recognized that integrated care involves more than behavioral and physical health service integration. However, many initiatives at the local level have been inhibited by the siloing of priorities, responsibilities, operational functions, and funding streams within multiple state agencies. Participants suggested that integration of agencies is essential and has to be enacted at from the State level. A "No Wrong Door" system among State agencies and departments to align objectives and funding as well as to integrate performance measures would be very advantageous for advancing local regional reforms in the healthcare system.

Interview participants suggested that future Department activities to support an integrated healthcare model should consider:

- Integrating the multiple voices of community organizations and agencies into the leadership and strategic structures established by the Department.
- Recognizing financial disincentives in the system which inhibit the integrated healthcare model.
- Aligning funding and functional responsibilities among agencies to support an integrated community care model.
- Implementing presumptive eligibility of Regional Accountable Entity (RAE) members for benefits needed anywhere in the Medicaid system.
- Integrating performance measures systemwide.
- Developing a Department process to elevate and mimic at the State level the initiative to coordinate RAEs with multiple agencies and organizations and to address mechanisms to "de-silo" funding, incentives, and responsibilities to support integrated care models within the regions.

Observations and Recommendations

CHP's structure and philosophy of integrating with community partners from inception of the RCCO have advanced its efforts and experiences with community partnerships and collaboration. **CHP** has facilitated and successfully integrated with multiple community partners to coordinate care and deliver improved services to members throughout the region. Many individual program and project initiatives have been successfully implemented and sustained. As importantly, all community partners agree that the relationships developed through collaboration have laid the foundation for a community-driven integrated healthcare system. Execution of some collaborative programs have been compromised or complicated by misalignment of funding sources, financial incentives, data systems, or priorities of the multiple partners—much of which needs to be addressed at higher levels of State agencies and departments. Using the lessons learned and experiences realized through the ACC 1.0 contract, the Department has an opportunity during the ACC 2.0 contract period to elevate collaboration among agencies and community organizations to the statewide leadership level. HSAG recommends that the Department embrace this challenge in order to advance integrated care statewide and remove some of the barriers discovered within the regions.

Provider Network/Provider Participation

Lessons Learned—Successes and Challenges

The size and scope of **CHP**'s PCMP network increased significantly from inception of the RCCO through 2014, but has remained relatively stable since that time. In its first year of operation, the PCMP base consisted of **CHP**'s partner organizations—Peak Vista Community Health (Peak Vista) and Colorado Springs Health Partners (CSHP). Between 2011 and 2013, the network grew to 11 PCMPs, including Federally Qualified Health Centers (FQHCs) and independent providers with large Medicaid populations in El Paso County, and continued to expand. In 2013 and 2014, in response to Medicaid expansion, the network grew to over 40 practices, and incorporated providers in Park, Teller, and Elbert counties. PCMP provider agreements required the practices to remain open to Medicaid members; however, practices were allowed to temporarily suspend attribution of new Medicaid members in cases when the practice reached capacity or experienced a disproportionate member/provider ratio. At the time of on-site review, staff members estimated that 50 percent of practices were closed to new Medicaid members, and 50 percent remained open, with half of those—25 percent of the total—fluctuating between open and closed to new Medicaid members. Staff described other dynamics of the PCMP network, including: many smaller practices were willing to grow the Medicaid population in their practices; some community-based provider systems—e.g., Serve Empower Transform (SET) Clinic were applying to be PCMPs; urgent care clinics within local emergency departments (EDs) drew members away from PCMPs; the FQHC serving members in Park and Elbert counties merged with Peak Vista; in 2016, two of the larger Medicaid practices either closed or were sold; and, of the 96 practices in the region, 33 declined to join the network.

PCMPs participate in leadership of the RCCO through the Community Care Advisory Group, which provides input to the **CHP** Board of Directors; the Performance Improvement Advisory Group; and special program initiative committees. Several PCMP representatives participate in Department-level meetings. All practices are invited to participate in the quarterly "Best Practice" forums. Twelve of the larger practices are delegated to perform care coordination. Thirty-eight practices participated in some level of practice transformation. **CHP** focused on opportunities for additional reimbursement to stimulate entry or active participation in the RCCO.

CHP initiated practice support services through a contract with HealthTeamWorks and Colorado Children's Healthcare Access Program (CCHAP), but several years ago transitioned to providing internal resources for practice transformation. The **CHP** Practice Transformation Team provides training and works one on one with practices to optimize opportunities for additional reimbursement, which include delegation of care coordination, key performance indicators (KPIs), **CHP** pay-for-performance (P4P) measures, and enhanced primary care medical home factors. Over the years, practices have also participated in grants and special programs such as Comprehensive Primary Care (CPC and CPC+) and State Innovation Model (SIM) programs. In addition to its own practice transformation initiatives, **CHP** maintains an ongoing relationship with and provides funding to the El Paso Medical Society to support practices with trainings on billing and coding, staff development, credentialing, and other areas of expertise offered by the medical society. **CHP** also offers monthly provider newsletters as well as regular provider webinars and trainings, which include important RCCO updates and information to enhance provider services.

CHP's P4P measures are structured to anticipate which opportunities may be presented to practices in the future and to prepare practices to successfully participate through preliminary P4P incentives. P4P measures are determined annually based on input from providers in the Best Practice forums. Examples included integration of practices into the HIE and integrating Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys into practices. Staff members reported that 87 percent of PCMPs participated in P4P in 2015 and 80 percent in 2016, including 64 percent participation in the HIE measure. Practices that have been delegated by the RCCO to perform care coordination have developed an intense one-on-one relationship with **CHP**'s practice transformation team as enhancements in provider accountability requirements have evolved year after year. Staff members stated that delegates have commonly upgraded their electronic health record (EHR) systems to integrate care coordination requirements.

Staff members described several lessons learned regarding provider participation in the RCCO, including:

- Early in the contract, and continuing occasionally through the years, lack of provider awareness regarding the RCCO inhibited recruitment. Provider staff turnover requires continual re-education of practice staff members and results in fluctuating commitment to RCCO priorities.
- Purchase of practices by corporations results in uncertainty of commitments to participate in RCCO initiatives.

- Marketing communications to providers introduced many new acronyms, resulting in much confusion to providers.
- Practices with small Medicaid populations will increase participation if given appropriate provider support.
- Providers most actively engage in RCCO objectives associated with financial incentives.
- RCCOs must be sensitive to how much participation they expect from practices when providers are not being adequately reimbursed to care for Medicaid clients.

CHP has been successful in various programs and projects to enhance provider participation and improve primary care for members:

- **CHP** worked collaboratively with AspenPointe CMHC to implement a BH referral and two-way communication methodology between PCMPs and the BH provider. **CHP** reinforced with PCMPs the need for member depression screenings through the P4P program.
- **CHP** has a three-year history of working with PCMPs to co-locate BH therapists within PCMP practices, further facilitated through the SIM project. **CHP** organized its practice transformation resources to support the SIM program and conducted an Integrated Performance Assessment Process (IPAP) evaluation with each practice.
- The regional health connector (RHC) position is located within the **CHP** offices. **CHP** worked with the RHC to simplify community health assessments, create a community resource roadmap for providers and **CHP** care coordinators, and implement a community resource service center for providers. The RHC's relationship with non-RCCO providers, such as UCHealth, has expanded **CHP**'s relationships with additional providers in the community.
- **CHP** has worked with select providers to integrate specialty expertise into PCMP practices. CSHP and Peak Vista adapted their EHR systems to support such integration.

CHP identified that several early and ongoing marketing communications directed to providers, which contained language and acronyms unfamiliar to providers, created confusion for those providers; presented challenges to provider recruitment; and resulted in ongoing challenges for RCCO provider relations staff, who are competing for the limited time and attention of providers. In addition, practices are increasingly experiencing the administrative burden of participating in multiple RCCO programs and initiatives. More recently, conversion of the Department's claims payment system has resulted in significantly delayed payments to providers for services rendered, eliciting a negative emotional reaction from participating providers. These circumstances have occurred simultaneously with additional RCCO provider expectations such as recertification of enhanced primary care medical provider (EPCMP) status, completion of an extensive EHR interoperability questionnaire, the recertification process for Medicaid providers, and other RCCO projects. Staff stated that when providers are not being properly paid, they respond poorly to additional RCCO and Department expectations.

Staff members provided suggestions that the Department may consider to improve provider experience with the ACC program:

- Ensure timely payments to providers for claims, KPI performance, and other financially-related factors of the RCCO program.
- Consider the achievability of performance metrics prior to implementation—e.g., well-child visits—and consider payments for providers who maintain metrics that are already performing at a high level.
- Develop marketing communications for providers that are well-designed "facing" materials and use consistent, clearly defined language; keep communications simple and do not change common industry language to make it unique to the Medicaid program.
- Improve the timeliness of information from the Department concerning new programs or changes in programs that impact providers—e.g., EPCMP criteria received three months before annual measures were due is not an effective approach to practices; conversely, the lead time for completing recredentialing requirements was very beneficial.
- Consider more frequent visits from Department staff to the region for interaction with providers. Face-to-face visits improve the credibility of the Department with providers.

Observations and Recommendations

CHP's provider network and provider-related activities are primarily focused in the region's population base of El Paso County. While adequate numbers of providers exist in the network, **CHP** may experience challenges with the capacity of practices to accept new members. From inception of the RCCO, **CHP** has been engaged in a challenging provider environment, experiencing competing priorities and alliances among local community providers and an overall stressed capacity in primary care and specialty practices. **CHP** has responded in an innovative, flexible, and supportive manner in its engagement with local providers and has facilitated numerous programs and initiatives to benefit practices and improve services for Medicaid members.

PCMPs are highly sensitive to reimbursement-related issues, responding either positively to financial incentives and opportunities for increased reimbursement for Medicaid members or negatively to lack of timely payments. Increasing RCCO priorities, frequent changes in priorities or provider expectations, and inadequate advance notification of program changes have resulted provider perceptions that the RCCO is reactive rather than proactive in its approach, presenting eventual challenges to provider relations. **CHP**'s practice transformation team has provided an effective mechanism for developing practice-specific relationships, customized support services for practices, and engagement of providers in response to RCCO initiatives. **CHP** appears to have "buffered" providers as much as possible from unanticipated changes and requirements of participating in the RCCO program.

In accordance with **CHP**'s observations and suggestions, HSAG recommends that the Department consider improving the provider experience by ensuring timely payments to providers, improving timeliness of communications regarding RCCO program changes and initiatives, providing ample time

for implementation at the practice level, simplifying and clarifying language used by the Medicaid program, and more frequently dispatching Department staff to the region as representation of State-level support for the RCCO program and providers.

Member Engagement

Lessons Learned—Successes and Challenges

CHP defined member engagement as "meeting people where they are," which was interpreted as understanding and assisting members to meet their needs—not the RCCO's interpretation of needs—and encouraging members to take active roles in their personal health. Staff members stated that individual interactions with members, such as through the service center or care coordination, focus on identifying the member's hierarchy of needs first. While initially the RCCO focused on getting information about the RCCO and Medicaid benefits out to members, **CHP** has progressively transitioned to meeting with members face to face, and has increasingly focused on engaging members at varying points of service within the community. **CHP** continues to provide outreach information and activities to members through newsletters; welcome letters; outreach calls; and through asking the one health question, "How do you rate your health?" to prioritize members for care coordination. However, the more substantial mechanisms for member engagement are executed through individual interactions with members in the service center, through care coordination, in community locations, and through community partners—e.g., criminal justice locations, detoxification programs, food banks, and homeless shelters. Staff members stated that approximately four to five members regularly participate in the **CHP** Performance Improvement Advisory Committee (PIAC); and minutes indicated that **CHP** has obtained member feedback on topics including care coordination, member communications, member surveys, and further ideas on member engagement. **CHP** also conducted focus groups regarding barriers to cancer screening, which identified transportation, lack of trust in providers, and "low on priority list" as common concerns. As a result, **CHP** employed a mobile mammography unit to provide cancer screenings and identified specific events and organizations through which health education materials could reach the target population.

Staff members described a number of lessons learned over the years of RCCO operations:

- At inception of RCCO, the service center focused on attribution of members to a PCMP. However, members did not contact the service center for attribution; they contacted the service center because they needed resources.
- Patient activation varies according to individual member needs at the time of engagement**.**
- Face-to-face contact is an important factor in building trust with members in order to stimulate member activation in assuming responsibilities for their own health.
- Hierarchy of needs varies according to population groups. Mass communications should be streamlined to target needs of specific population groups.

- Improving members' abilities to activate and sustain activation is a step-by-step process. When interacting with members, first provide information on benefits, then begin to ask questions to assess needs.
- Members have multidimensional touch points of engagement within the system; one member may respond to one source, while another member responds to an alternative source.
- Engaging members through community partners builds on the trust and relationships already in place with members and reduces redundancies in member engagement to enhance care coordination.
- Direct member participation in leadership forums provides valuable insight and feedback regarding member perspectives on RCCO activities and member needs.

In response to lessons learned, **CHP** has initiated a variety of mechanisms designed to enhance member engagement. **CHP** embedded care coordinators in some PCMPs and EDs to enable deeper conversations with members than individual providers can offer. Simultaneously, **CHP** continues to work with providers to educate them that care coordination is not just a clinical referral model, but includes a bigger role for providers. Recently, **CHP** implemented the CAHPS member survey within provider locations to solicit timely member feedback about where and when members interact with the system. Motivational interview training, offered to providers and staff, helped to stimulate transition of practices and other organizations to implement more effective one-on-one relationships with members. In recent years, **CHP** has moved assertively to work with community partners to locate care coordinators in community organizations where members receive services. **CHP** processes learning experiences related to needs of specific populations and is using data to move beyond mass communications to target outreach to specific populations. **CHP**'s information technology staff have performed cross-walking of information available through multiple systems as a first step toward developing a "whole person"—social, medical, behavioral health—database. Based on member feedback, **CHP** plans to move PIAC meetings to various community locations in order to engage different member populations to explore what is meaningful to more members.

CHP invited several community partners and a PIAC member representative to the on-site interview to describe examples of member engagement activities in the community.

- Urban Peak homeless shelter for youth has embedded a **CHP** care coordinator on site to build a trusting relationship with members, inform them of the benefits available through Medicaid, and assist them with accessing services as needed.
- Catholic Charities Marian House food bank experiences 15,000 visits per month, including services to between 1,500 and 2,000 RCCO members. Many members are chronically homeless or reside in transitional housing, often without phones. Interview participants described this population as moving from crisis to stability. **CHP** provides an on-site care coordinator to interact with members, who are often unsure of where to obtain Medicaid services. Members who need medical intervention are referred to a medical provider or receive minor medical services on-site. Members who need more intense care coordination can be referred to a **CHP** care coordinator. Staff members stated that trust is an important factor with these members, who benefit from being able to see the same face at the same place every visit. The program has increased communications with these members and

provided high visibility for the RCCO as some members share information with and make recommendations to other members of the homeless population.

- Ascending to Health Respite Care (ATHRC) serves a higher acuity of needs within its respite care program for homeless members transitioning from acute medical conditions. The shelter includes medical beds with on-site physician assistants. Similar to other homeless outreach programs, **CHP** provides an on-site care coordinator to work with members regarding their care coordination needs, with an immediate focus on member health goals. Staff described that building a trusting relationship with these members is "a process" occurring over time. Staff members described that recent activities included going into the community to seek out homeless members face to face and to encourage those members to use services and supports for the homeless.
- The member representative to the PIAC stated, "You get one chance to successfully relate to any member on initial engagement," adding that "you have to be able to talk with people on their level," not always possible through professionals. Similarly, all care coordination programs with the homeless population (described preceding) noted that member acceptance and activation were stimulated by members networking with each other to describe successful experiences. The PIAC representative has suggested that **CHP** develop a peer mentoring program to engage members to work with other members. Catholic Charities was pursuing a Colorado Health Foundation grant to develop a peer relationship program.

Staff members stated that **CHP** has always had a member-driven focus; however, early in the contract period, Department "marketing" constraints and KPIs dominated the focus of RCCO activities. **CHP** responded to these constraints by attempting to engage members through its PCMP and community partners, but stated that this was not as effective as direct RCCO involvement, due to initial lack of familiarity with the RCCO and its objectives. Staff stated that as the Department's philosophy changed and became more flexible regarding member engagement and information, **CHP**'s approaches also became more multidimensional. **CHP** identified that having participation of local community partners has been essential for identifying gaps in services and sharing resources to improve gaps in services for members, expressing that the right combination of people available to address member needs and interests must be locally determined. Staff suggested that the Department continue to maintain local flexibility in member engagement initiatives and avoid limiting member engagement by Department-defined measures. However, staff defined that the Department's role in member engagement should include member communications and materials at enrollment; while the RCCO's primary role is to shepherd individual members through the delivery system and continue to be a convener and collaborator among community-based organizations. To that end, staff suggested the Department further enhance the PEAKHealth mobile application or other systems to update member contact information, as "members cannot be engaged if they cannot be contacted."

Observations and Recommendations

CHP has used its community partner relationships to advantageously explore and learn about both gaps in services and the hierarchy of needs of special member populations, and has continuously refocused its approaches for engaging with members. **CHP** has identified face-to-face individual interactions as

essential for effective member engagement through care coordination and the service center and has increasingly supported resources to engage members at various points of service within the community. However, staff have recognized that motivation of members to assume responsibility for their own health is often a slow and complex process. **CHP** has also engaged in obtaining more formal feedback from members through member participation in PIAC, focus groups, and surveys. HSAG recommends that **CHP** advance opportunities to develop a peer mentoring program to further enhance the ability to engage with widely diverse individual needs of various member populations. **CHP** clearly perceives that member engagement must be a locally driven process, but identified a number of ways in which the Department could support local RCCO efforts to engage members.

Care Coordination

Lessons Learned—Successes and Challenges

CHP has progressively transformed through several "eras" of care coordination for members. At inception of the RCCO, **CHP** determined that its large PCMP partners—Peak Vista and Colorado Springs Health Partners—to which most Medicaid members were attributed, had the capability to perform care coordination through medical home models of practice. Therefore, **CHP** delegated care coordination to these practices and maintained only a small, internal care coordination staff to support these practices in performing care coordination. In addition, **CHP** staffed and trained those in the member service center to support care coordination by focusing on attribution of members to primary care practices and assisting members and providers with referrals to specialists. Early lessons learned from this model included recognition that the primary care medical home (PCMH) model of care coordination deployed in most practices was actually a case management model focused on clinical referral management, which did not fulfill the model of complex care coordination defined in the RCCO contract with the Department.

As the number of PCMPs participating in the network increased, additional larger practices also desired to receive the reimbursement afforded through delegated care coordination; and some smaller practices needed care coordination of members to be performed through the RCCO. **CHP** increased its internal care coordination staff and developed a practice transformation program to train and support practices in expanding care coordination to adequately address the comprehensive care coordination requirements of the RCCO. During this same period, in order to provide care coordination that might diminish the necessity to seek care through the ED, **CHP** increased its focus on identifying and following up with members who frequently used the ED. As part of this initiative, **CHP** partnered with the fire department and other community organizations in the Community Assistance, Referrals, and Education Services (CARES) program to divert members from ED utilization. In addition, **CHP** contracted with RMRH and TCPHE to provide health navigation services to members in remote and sparsely populated counties of the region.

During the later years of operations (2015 to date), the status of delegated practices was as follows: 2015—nine delegates serving 54 percent of RCCO members; 2016—14 delegates serving 61 percent of delegated members; 2017—12 delegates serving 57 percent of RCCO members. **CHP** additionally

incorporated community organization partners into its care coordination model to provide care coordination to members wherever they are receiving services within the community. Examples include, but are not limited to, contracted arrangements with Urban Peak shelter for homeless youth; ATHRC for homeless adults; Developmental Disabilities Health Center (DDHC), for members with intellectual and developmental disabilities; El Paso County Office of the Sheriff, for referral of criminal justice-involved (CJI) members; and El Paso County Public Health, for foster families and children. In addition, **CHP** dispatched some care coordinator staff to point-of-care locations such as hospital EDs and decentralized primary care locations (e.g., Health Center at Moreno).

Through this evolutionary process, **CHP** reported many lessons learned that influenced internal operations. Lessons included:

- Providers were trained through multiple mechanisms (e.g., PCMH) to incorporate the case management concept of care coordination into their practices. However, the industrywide concept of care coordination has changed, particularly in relation to Medicaid members. Practices were not equipped to perform the more advanced model of comprehensive care coordination, particularly with meeting members' needs for social supports.
- Care coordination documentation systems varied among delegated practices, and practices were not prepared to modify systems to accommodate a portion of their entire patient populations.
- Practices are paid to perform delegated care coordination; therefore, many practices wanted to participate in delegation. However, **CHP** needed to hold the delegates accountable for the payments extended to the delegates. This required **CHP** to expand training, practice transformation, and other support services to the delegates.
- Practices must all demonstrate a similar concept of complex care coordination; **CHP** must provide consistent messaging to practices regarding complex care coordination requirements.
- Evolving care coordination mechanisms in practices required multiple system changes. **CHP** implemented, over time, multiple changes in practice support based on "filling the needs of the moment." Staffing requirements increased. Staff turnover at both **CHP** and within practices as well as multiple iterations of databases slowed progress.
- Service center staff members discovered that members did not contact **CHP** in response to the need for attribution; rather, members contacted the service center to receive care coordination and assistance with social determinants of health.
- The need for internal **CHP** care coordination staff steadily increased over time and required alignment with the diverse needs of special populations.

In response to lessons learned, **CHP** adapted its internal operations to support comprehensive care coordination for the RCCO population.

- Delegate practice support activities gradually evolved to incorporate increasing mechanisms for accountability. From initially providing generalized education and coaching to practices, **CHP** transitioned to an enhanced delegation contract with practices—which defined complex care coordination requirements in accordance with the RCCO contact with the Department, required care

coordination policies and procedures and data reporting to **CHP**, and incorporated formal **CHP** audits of delegate care coordination activities. **CHP** continued to provide on-site practice coaching and used audit results in an instructive manner with practices. Next steps, to be implemented in July 2017, will be modification of the delegate care coordination contract to include more definitive expectations: practices will be required to define a minimum of two "triggers" for identification of members for care coordination, one of which must be transitions of care; each practice must have a care coordination plan that reflects the capabilities of the practice and characteristics of its RCCO member population (e.g., advanced practices must address behavioral health and social needs of members); and practices' care coordination plans must include specific required elements. **CHP** will facilitate increased sharing of best practices and tools among delegated practices. **CHP** care coordinators will also be teamed with delegate care coordinators to address care coordination for members with complex needs.

- Internal **CHP** care coordination staffing has increased significantly over the years, from an initial two to three coordinators to 15 care coordinators in 2017. In addition, **CHP** has employed care coordinators with a variety of professional backgrounds, to expand the breadth of knowledge and expertise related to specific member populations. This has enabled cross-training and allowed internal staff to access each other as specialized resources. **CHP** is pairing coordinators with diverse backgrounds with community organizations serving specialized populations. **CHP** will also continue to locate coordinators in dispersed provider locations and will pair **CHP** coordinators with delegates to perform as a care coordination team in support of members with complex needs. Similarly, the service center staff roles have evolved to perform more significant health navigator roles and participate as part of the care coordination teams to assist members with complex needs. Select service center staff have also been deployed to provide services in community locations such as the Urban Peak homeless youth shelter and the criminal justice center.
- **CHP** has also transitioned through multiple iterations of internal care coordination documentation systems—from hard copy documents to development of an Access database to capture assessments and care coordinator notes, to exploration of various vendor software systems. In 2015 and 2016, **CHP** considered, then rejected, procurement of the Crimson Care Management system. Effective July 2017, **CHP** will implement the Eccovia Solutions ClientTrack case management system. In addition, through the HIE in the region (developed by **CHP** in partnership with CORHIO), ClientTrack and database information will be available, "pushed" by **CHP**, to community partners and providers to afford sharing of care coordination information and other data to support coordination of services for members.

CHP described that delegates and **CHP** have evolved care coordination activities to the current point where—through the collaborative efforts of the providers, **CHP**, and community partners—care coordination for Medicaid members with complex needs is much more effective and responsive.

CHP staff stated that future care coordination goals include moving from rudimentary measures of care coordination outcomes—e.g., ER visits, readmissions rates, numbers of care coordination interventions—to defining mechanisms for measuring the "value" of care coordination to members. **CHP** recognizes the challenge of defining and measuring "value" (a qualitative/quantitative equation),

but feels it is critical for RCCOs to attempt to do so. In addition, **CHP** foresees broadening care coordination initiatives beyond members with complex needs to include mechanisms for engaging the Medicaid population with lower level needs in an endeavor to "get upstream" to connect members to needed services prior to their conditions or situations becoming complex.

Staff suggested that the Department appropriately abstained from defining prescriptive tools and care coordination techniques, which necessarily vary across providers and according to the diversity of the Medicaid population. However, staff stated that the Department could have assisted RCCOs and providers by providing a clearer and more consistent description and set of expectations regarding comprehensive care coordination from inception of the contract.

Observations and Recommendations

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

- Profile of member types: four delegated, six RCCO care coordination; one child, nine adults (including three MMP members).
- Primary needs of members: physical health—two members; behavioral health—two members; social needs—one member; physical/behavioral/social—two members; physical/social—two members; behavioral/social—one member. In addition, two of the 10 members had legal issues.
- Three of 10 cases involved homelessness of the member.
- Member engagement was high in four cases, moderate or inconsistent in three cases, and low in three cases.
- Care coordination needs were minimal in two cases, moderately complex in four cases, and very complex in four cases.
- Eight cases were complicated by lack of cooperation or responsiveness by providers or agencies: PCMP—two cases; BHO—two cases; Veteran's Administration (VA)—two cases; SEP—one case; care facility—one case.

CHP has rapidly evolved through several phases of growth and iterative improvements in care coordination processes over the term of the RCCO contract. By assertively responding to lessons learned and by working collaboratively with providers and community partners, **CHP** has evolved into a multifaceted model of care coordination to serve Medicaid members in the region. In addition, **CHP** has invested in developing increasingly sophisticated resources to support care coordination, including specialized staff, enhanced databases and software systems, and care coordination "team" relationships with partners. **CHP** has improved upon the siloing of case management and care coordination activities among providers, agencies, and community organizations by integrating its activities and objectives with those entities. Ironically, the premise of the PCMH as the center of the most effective care coordination for members has diminished over time through recognition that clinical models of case management are insufficient to address the social determinants of health that are the priority needs of many Medicaid members. **CHP** has incorporated the concept of "it takes a village" into many of its strategies, including

its care coordination program. Nevertheless, HSAG observed that **CHP**'s work with delegate providers has improved the understanding and accountability of providers to meet RCCO care coordination requirements; **CHP** has assertively engaged in mechanisms for doing so, and will need to continue these initiatives into the future. While care coordination will encounter ongoing challenges and barriers, **CHP** has built a collaborative foundation that should enable care coordination systems and processes across the community to progress toward increasing consistency and efficiency. Care coordination initiatives will most likely continue to be largely focused in El Paso County, due to the sparse population of members and providers in outlying counties of the region. **CHP** has already identified and organized resources and objectives to appropriately advance care coordination for members in anticipation of a new contract with the Department to establish a Regional Accountable Entity (RAE).

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

Lessons Learned—Successes and Challenges

CHP has participated in numerous Department- or locally-driven programs, pilot projects, and initiatives over the term of its RCCO contract, including State Innovation Model (SIM), Colorado Opportunity Project (COP), No Wrong Door, four iterations of the Client Over-Utilization Program (COUP), integrating with DHS Child Welfare for foster care members, Extension for Community Healthcare Outcomes (ECHO) e-consult program, Medicare-Medicaid Program (MMP), Comprehensive Primary Care (CPC), criminal justice involved (CJI) member integration, Healthy Communities/care coordination integration, Enhanced PCMP (EPCMP) program, NEMT system, and adult quality measures. In addition, **CHP** has initiated or supported many local initiatives and community-based programs, citing CARES, Development Disabilities Health Clinic, and ATHRC as examples. Staff stated that both **CHP** and the community at large have cultures which do not fear failure and are "willing to try anything." In addition, the smaller size of the region, the streamlined and smaller size of the **CHP** organization, lack of a long-term organizational history, and established community relationships afforded **CHP** the "nimbleness" to quickly respond and implement pilot projects and become "good partners with the State." From inception, the Department defined priorities, dollars, and deliverables while local communities within the region determined methods of implementation. Staff stated that factors such as cost/benefit, political environment, Department-mandated participation, and local healthcare needs were primary considerations in strategic decisions. In addition, programs such as SIM (i.e., integrated physical and behavioral health practice development) were seen as supportive of other established **CHP** goals and objectives. **CHP** assertively pursued its own HIE initiative (in partnership with CORHIO) in advance of the Department's initiative to define an HIE roadmap. **CHP**'s chief technology officer now leads the Department's HIE initiative. **CHP** expressed minimal enthusiasm for its COP project, "Promote Middle Class by Middle Age," stating that the five program focus areas were randomly defined, repetitive of other initiatives, and included an unrealistic time frame for rollout to participants.

Staff stated that **CHP** has learned from all pilot projects and programs in which it has engaged. For example, the community health respite program, ATHRC, introduced the importance of considering sustainability of programs; and **CHP**'s criteria for participating in new community projects now requires a sustainability plan. **CHP** has also provided technical assistance to existing programs to promote sustainability beyond RCCO funding resource availability. Additional lessons learned included:

- Opportunities to participate in special programs and projects have evolved over time, requiring continuous layering of one project on top of another. **CHP** foresees the need for a longer term strategic plan to facilitate a more cohesive process and continuity among multiple programs.
- Practices are experiencing an increasing administrative burden of simultaneously participating in multiple projects that are not aligned or do not have aligned reporting requirements and measures. **CHP** has recently advised individual providers to participate only if the specific program meets the needs of the practice.

Within the last two years, **CHP** has recognized the need to more deliberately evaluate each project's outcomes and assess the value of the multiple projects and programs in which it has engaged. In 2016 and 2017, **CHP** delayed initiation of new projects in order to perform evaluation, become more intentional in decision making, and focus on fewer projects with higher quality outcome potential.

CHP credited the MMP program with executing the best rollout process and delivering value to RCCOs and members. Staff also cited the SIM program and the regional health coordinator position as examples of statewide initiatives that anticipated the need to address all payors and all providers in order to effect changes in the delivery system at large. **CHP** observed that the Department is in the unique position of having a statewide perspective and identifying fiscal concerns and opportunities for the Medicaid program, and stated that it would be advantageous for the Department to focus on developing a master strategic plan for the State—longer than a year-to-year horizon—that would guide RCCOs in determining less reactive and more proactive approaches with local strategies and priorities. In addition, staff suggested that the Department include RCCO, community, and member representatives in decisions concerning what initiatives to pursue and associated implementation plans. Department-level decisions concerning programs and projects might consider (1) developing long-term, consistent themes that will minimize disruption to practices; (2) determining how to best assess the "value" of specific projects; and (3) assessing potential sustainability. Staff also suggested that future Department-level efforts include "de-siloing" of finances and functions within multiple agencies and systems and identifying and aligning similar priorities among State agencies. Staff provided an example of the need to align social determinants of health KPIs, incentives, and funding across providers and community organizations by creating a flexible pool of funds to be shared by providers and the community. **CHP** observed that, following RAE contract awards, the Department may also need to consider re-engaging in mechanisms to encourage transparency among RAEs and stimulate sharing of deliverables, best practices, and data across RAEs.

Observations and Recommendations

From inception of the RCCO, **CHP** has enthusiastically responded to opportunities to: participate in every Department-driven program initiative, serve as a pilot implementation site for a variety of programs, and self-initiate grants and programs to meet local healthcare needs. Many of these programs have benefitted providers, members, and the health system of the community. Nevertheless, due to the continuous rollout of initiatives over time, participants have grown weary of the administrative burden associated with simultaneously managing multiple and changing initiatives. **CHP** foresees the need for both the Department and the RCCO to move toward a longer-term strategic plan to guide selection and implementation of new programs, as well as more deliberate evaluation of the value of each program in furthering statewide goals or regional healthcare objectives. Such efforts will require both the Department and the RCCO to independently pursue efforts for establishing such a plan, as well as collaboration between the Department and the regions to develop a shared vision and decision-making process. Implementation should continue to be determined at the regional and local community levels through the collaborative efforts of the RCCO and its partners. HSAG observes that a longer-term, strategically-driven process would improve the ability to achieve balance between State-driven and regionally-driven priorities.

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 **CHP** as the RCCO for Region 7. 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 **CHP** prior to the site visit. During the on-site portion of the review, HSAG conducted group interviews of key **CHP** 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 **CHP**.

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

HSAG Review Team	Title
Kathy Bartilotta, BSN	Senior Project Manager
Rachel Henrichs	External Quality Review (EQR) Compliance Auditor
CHP Participants	**Title**
Allison Marler	Community Care Case Manager—Department of Corrections/Parole
Andrea Kedley	Interim Manager of Care Coordination, CHP
Audrey Field	Deputy Director, Urban Peak
Barbie McBee	Program Director, Rocky Mountain Rural Health
Carmen Luttrell	Vice President, Nursing Operations—Peak Vista
Carrie Schillinger	Program Director, Pikes Peak Area Council of Governments Area Agency on Aging
Cathy Wilson–O'Donnell	Practice Administrator, Dr. Sean O'Donnell Family Practice
David A. Ervin	Chief Executive Officer, The Resource Exchange
Diana Atcheson	Care Coordinator, CHP
Dr. Matthew Caywood	Child Welfare Operations Manager, El Paso County Department of Human Services
Katherine M. Fitting, MD	Medical Director and Board of Directors, Rocky Mountain
Kim Ball	Technology Director, CHP
Lori Williams	Lead Care Coordinator, CHP
Melanie Hendrickson	Lead Care Coordinator, MMP—CHP
Ronnye Goodman	Registered Medical Assistant, Dr. Sean O'Donnell Family Practice
Ryan Smith	Senior Manager, Service Center—Aspen Pointe
Sarah Rose Quintana	Centralized Care Coordination Manager, Peak Vista
Susan Dymond	Manager, Network Development, CHP
Tracy Haas	Chief Medical Officer, CHP
Christina Brown	Practice Support Team Manager, CHP
Christine Matheny	Grants and Contracts Manager, CHP
Janet Winger	Chief Financial Officer, CHP
Aimee Cox	Chief Executive Officer, CHP

CHP Participants	Title
Jim Calanni	Chief Technology Officer, CHP
Amy Yutzy Harder	RCCO Contract Manager
Cassie Acquista	Care Coordinator, CHP
Ivy Rios	Care Coordinator, Value Care Family Practice
Katey Burdick	Care Coordinator, SET Family Practice
Kathleen Kleinhuizen	Care Coordinator, CHP
Jennifer West	Network Development Coordinator, AspenPointe
Diana Atcheson	Care Coordinator, CHP
Evan Caster	Care Coordinator, CHP
Andy Barton	President and Chief Executive Officer, Catholic Charities
Kim Silvey	Member, CHP
Kelley Vivian	Strategic Initiatives Officer, El Paso Public Health
Fabian Mendoza	Care Coordinator, CHP
Lance Scoffield	Project Manager, Eccovia Solutions
Zinna Burke	Business Analyst, Eccovia Solutions
Department Observers	**Title**
Christian Koltonski	Community Care, HCPF
Krista Fuentes	Policy and Program Specialist, HCPF
Michael Gratton	Quality and Health Improvement, HCPF
Morgan Anderson	Health Policy Analyst, HCPF
Tim Gaub	Contract Manager, HCPF
Kathleen Homan	Policy Analyst, HCPF
Jen Karr	Health Policy and Regulatory Specialist, HCPF