Colorado
Accountable Care Collaborative

FY 2015–2016 Site Review Report

for

Colorado Community Health Alliance (Region 6)

April 2016

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

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Introduction and Background

The Colorado Department of Health Care Policy & Financing (the Department) introduced the Accountable Care Collaborative (ACC) program in spring 2011 as a central part of its plan for Medicaid reform. The ACC program was designed to improve the member and family experience, improve access to care, and transform incentives and the healthcare delivery process to a system that rewards accountability for health outcomes. Central goals for the program are to (1) improve member health; (2) improve member and provider experience; and (3) contain costs by reducing avoidable, duplicative, variable, and inappropriate use of healthcare resources. A key component of the ACC program was the selection of a Regional Care Collaborative Organization (RCCO) for each of seven regions within the State. **Colorado Community Health Alliance** (**CCHA**) began operations as a RCCO in October 2011. The RCCOs develop a network of providers; support providers with coaching and information; manage and coordinate member care; connect members with non-medical services; and report on costs, utilization, and outcomes for their populations of members. An additional feature of the ACC program is collaboration—between providers and community partners, between RCCOs, and between the RCCOs and the Department—to accomplish the goals of the ACC program.

The Affordable Care Act of 2010 allowed for Medicaid expansion and eligibility based on 133 percent of the federal poverty level. In addition, the Accountable Care Collaborative: Medicare-Medicaid Program (MMP) demonstration project provided for integration of new dually eligible Medicare-Medicaid members into the RCCOs beginning September 2014. The RCCO contract was amended in July 2014 primarily to specify additional requirements and objectives related to the integration of ACC Medicare-Medicaid Program (MMP) enrollees.

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 successes and challenges in implementing key components of the ACC program. This report documents results of the fiscal year (FY) 2015–2016 site review activities, which included evaluation of the RCCO's efforts regarding integration with specialist providers, integration with behavioral health services and behavioral health organizations (BHOs), and performance of individual MMP member care coordination. In addition, the Department requested a follow-up discussion of select focus projects implemented by each RCCO. This section contains summaries of the activities and on-site discussions related to each focus area selected for the 2015–2016 site review, as well as HSAG's observations and recommendations. In addition, Table 1-1 contains the results of the 2015–2016 MMP care coordination record reviews. Table 1-2 provides a comparison of the overall 2015–2016 record review scores to the previous two years' record review scores. Section 2 provides an overview of the monitoring activities and describes the site review methodology used for the 2015–2016 site reviews. Appendix A contains the completed on-site data collection tool. Appendix B contains detailed findings for the care coordination record reviews. Appendix C lists HSAG, RCCO, and Department personnel who participated in the site review process.

Summary of Results

The care coordination record reviews focused on a sample of the MMP population who had a completed service coordination plan (SCP). HSAG assigned each question in the record review tools a score of *Yes, No, Partially, Unable to Determine,* or *Not Applicable*. HSAG also included, as necessary, comments for each element scoring *No, Partially,* or *Unable to Determine* and included any other pertinent reviewer observations. Table 1-1 presents the scores for **CCHA**'s care coordination record reviews. Detailed findings for the record reviews are in Appendix B—Record Review Tools.

Table 1-1—Summary of Care Coordination Record Review Scores

Description of Record Review	# of Elements	# of Applicable Elements	# *Yes*	# *No*	# *Partially*	# *Unable to Determine*	# *Not Applicable*	Score* (% of Yes Elements)
MMP Members	210	174	168	4	2	0	36	97%

* The overall percentages were obtained by adding the number of elements that received a score of *Yes*, then dividing this total by the total number of applicable elements. (*No* and *Partially* scores received a point value of 0.0; *Unable to Determine* was included with *Not Applicable*.)

Table 1-2 provides a comparison of the overall 2015–2016 record review scores to the previous two years' record review scores. Although most care coordination requirements of the RCCO contract and MMP contract were similar, some 2015– 2016 scores may have varied from previous years' reviews due to specific service coordination plan requirements for the MMP population.

Table 1-2—Comparison of Care Coordination Record Review Scores

Description of Record Review	# of Elements	# of Applicable Elements	# *Met (or Yes)*	# *Not Met (or No)*	# *Partially Met (or Partially)*	# *Not Applicable (or Unable to Determine)*	Score* (% of *Met/Yes* Elements)
Care Coordination 2013–2014	168	131	91	24	16	37	69%
Care Coordination 2014–2015	80	57	41	13	3	23	72%
Care Coordination 2015– 2016	210	174	168	4	2	36	97%

* The overall percentages were obtained by adding the number of elements that received a score of *Met/Yes*, then dividing this total by the total number of applicable elements. (*Partially Met/Partial* and *Not Met/No* scores received a point value of 0.0)

The Data Collection Tool (Appendix A) was used to capture the results of the pre-on-site document review and on-site discussions related to the focus content areas: Integration with Specialist Providers, Follow-up of Region-specific Special Projects, and Integration with Behavioral Health Services/BHOs. Following is a summary of results for each content area of the 2015–2016 review.

Summary of Findings and Recommendations by Focus Area

Integration With Specialist Providers

Activities and Progress

Centura Health, **CCHA**'s ownership partner, provided increased access to associated specialty providers for **CCHA** members. Staff members stated that general availability of specialists for Medicaid members is limited by the nature of the subspecialist environment, which is overburdened, physician-centric, profit-oriented, and plagued by myths regarding treatment of Medicaid members. While **CCHA** acknowledged it cannot control or contribute to improved reimbursement for specialists, **CCHA** implemented practical measures to assist primary care medical providers (PCMPs) and members by supplying the member with all necessary tools for an effective and efficient specialist referral. **CCHA** was also attending forums and provider alliances throughout the region and attempting to dispel myths regarding the complexity, general health, and unreliability of Medicaid members. **CCHA** considered using the Colorado Medical Society (CMS) "compact" with specialists, but determined that subspecialists are not interested in signed agreements. At the time of the site review, **CCHA** had not adopted formal specialist referral protocols. The **CCHA** physician advisory council, which included subspecialist representatives, continues to consider mechanisms for financially incentivizing specialist care. **CCHA** participated in several pilot programs intended to increase access to specialists for the underserved and provided care coordination and some funding support. Staff members stated that one of the most promising initiatives for increasing access to specialists is the e-consult program, which is being facilitated through the Colorado Regional Health Information Organization (CORHIO) and will offer PCPs direct consultation with subspecialists and eliminate the need for face-to-face consultation between the subspecialist and the patient.

Observations/Recommendations

CCHA demonstrated that it had excellent medical director leadership which offered insight into the subspecialist environment as well as the ability to engage specialists in physician-to-physician communications. **CCHA** participated in various strategies to improve access to specialist services for Medicaid members. **CCHA** staff members are innovative yet realistic regarding mechanisms to improve access to specialists, and they foresee implementation of an "e-consult" program as one of the most effective strategies for realizing significant cost savings, improving the efficiency of subspecialist operations, and further disseminating subspecialist expertise throughout the delivery system.

Follow-Up of Region-Specific Special Projects

Activities and Progress

Relationship With the Health Information Exchange

Through the activities of its other lines of business, Physician Health Partners' (PHP's) information technology staff members have been engaged with CORHIO since 2011, which includes receiving

aggregate information directly from CORHIO for tracking PHP member hospital data. Simultaneously, **CCHA** also has been receiving admit, discharge, and transfer (ADT) data feeds through the Department's contract with CORHIO and comparing the accuracy of the information received through both data feeds. **CCHA** staff determined that the member identification (ID) match in the feed from the Department is only 60 percent accurate and includes incomplete or inaccurate information for individual members. **CCHA** suggested solutions to the Department and CORHIO, but the issue has not been resolved. Therefore, **CCHA** was not able to use the Department-facilitated CORHIO data feed as a reliable source for timely ADT data from hospitals, and it has continued to develop a number of "work-around" solutions that are resource intensive, inefficient, and unsatisfactory.

Practice Performance Scorecard

The practice performance scorecard project was applicable to all PHP contracted members (not just RCCO members) and was intended to provide a snapshot of practice performance in several categories: practice operations, medical home functions, Medicaid-specific functions, health information management functions (e.g., electronic health records [EHRs], patient registries), and quality parameters (e.g., key performance indicators [KPIs]). The scorecard was intended to stimulate follow-up discussion with the practices and was distributed quarterly with an annual, on-site, face-to-face discussion between practice physicians and **CCHA**'s medical director. Staff stated that the scorecard program has been evolving and has undergone several revisions for improving the value of the type and presentation of data. After working with six practices, PHP realized that the information in the scorecards needed to be more robust and actionable, and improve engagement with members. Staff stated that **CCHA** also needed to establish meaningful incentives to stimulate practice responsiveness. **CCHA** was examining the potential of an incentive-based practice engagement program in which each practice would identify its own goals to be tracked through the scorecard, with progress toward meeting those goals translated into value-based payments. Staff reported that the revised scorecard would soon be expanded to include 20–25 practices. The scorecard program remains a work in progress.

Partnership With Vivage Quality Health Partners

Vivage Quality Health Partners (Vivage) owns and operates numerous skilled nursing facilities (SNFs) in or near the **CCHA** service area, and 75 to 80 percent of Vivage clients are Medicaid members. Vivage facilities serve the largest proportion of **CCHA** SNF residents. During 2015, **CCHA** and Vivage initiated a collaborative pilot project that would capitalize on the care coordination resources and unique areas of expertise in each organization to improve shared clients' transition of care from SNFs back to the community. The focus of the pilot project was to define mechanisms for identifying shared members, and to define a functional relationship between the **CCHA** care coordination staff and the Vivage facility case managers. **CCHA** described some challenges in the development process, including identifying and developing contacts with the maze of long-term services and supports (LTSS) providers in the service area. However, at the time of the on-site review, **CCHA** and Vivage had identified over 30 members for collaborative care coordination, developed processes for interfacing between Vivage and **CCHA**, and defined workflows with several LTSS providers and SEPs. The mutual objective of Vivage and **CCHA** is to revise the program based on pilot project results and to expand it to additional RCCOs, SNFs, and LTSS providers.

Observations/Recommendations

Although the practice performance scorecard and Vivage partnership projects remained in the pilot testing stage, **CCHA** made significant progress in 2015, and both programs were nearing full implementation and/or expansion. **CCHA** demonstrated a thoughtful approach to each project, including the ability for leadership to engage with its partners to cooperatively and continuously improve processes, achieve mutual goals, and attain meaningful outcomes.

The inability to resolve issues related to accuracy of the ADT information in the data feed from CORHIO continued to limit the usefulness of the data, resulting in frustration and the expenditure of considerable resources to obtain reliable ADT data. Because the Department contracted (and is paying for) services through CORHIO, HSAG recommends that **CCHA** continue to work with the Department, and that the Department consider working with CORHIO to develop mechanisms to improve the quality of the product being delivered to the RCCOs.

Integration With Behavioral Health Services/BHOs

Activities and Progress

Since the inception of the ACC program, **CCHA** and Foothills Behavioral Health Partners (FBHP), the behavioral health organization (BHO) for Region 6, have been actively and continually engaged in activities related to shared members. This long-term relationship has provided a strong foundation for BHO/RCCO integration that has naturally evolved over time. In addition, FBHP's community mental health center (CMHC) partners—Jefferson County Mental Health (JCMH) and Mental Health Partners (MHP)—are the hub of strategic and functional relationships with **CCHA**, as well as with community providers and organizations. The BHO, CMHCs, and **CCHA** have mutual visions, goals, and enthusiasm regarding integrating care for Medicaid members. The primary integration efforts have been focused on collaborative care coordination and co-location of behavioral and physical health providers. Through the resources of the CMHCs, **CCHA** and FBHP co-located CMHC providers in 27 PCMP locations, including the federally qualified health centers (FQHCs). In addition, within the past year, Clinica Colorado (Clinica), one of the region's FQHCs, embedded physical health providers at MHP's wellness center. A major, grant-funded project enabled development of a fully integrated adult health home for members with severe mental illness, with the participation of Metro Community Health Partners (MCHP)—another of the region's FQHCs—providing physical health services, JCMH providing behavioral health services, and Arapahoe House providing substance abuse services. This new practice location was approved as a RCCO PCMP. When possible, **CCHA** care coordinators refer members with physical and behavioral health needs to co-location practices. Staff stated that the BHO, CMHCs, and RCCO were also focusing efforts on population health initiatives to identify members with unmet behavioral health needs and develop alternatives for engaging members in services "where they are." Staff members cited the Bridges to Care mobile health team project, co-location of care coordinators in hospital emergency rooms, and mental health first-aid training of **CCHA** call center staff as examples of population health initiatives for members with behavioral health needs.

CCHA and FBHP had signed agreements to share data and care coordination information. **CCHA** supported care coordination for members with complex needs and collaborated with CMHC care

managers to procure social and community services for their members. **CCHA** co-located health partners (care coordinators) in several practice sites. **CCHA** and FBHP collaborated to improve depression screenings throughout the network, and they reported that screenings significantly improved in practices with co-located behavioral health professionals. JCMH trained its providers co-located in pediatric practices to conduct postpartum depression screenings for mothers attending newborn appointments. **CCHA** has an inherent relationship with the community crisis centers through JCMH and MHP, which are the designated crisis centers in the region.

The ultimate goal of both the BHO and the RCCO was to achieve a fully integrated behavioral and physical health organization for the Regional Accountable Entity (RAE) envisioned in ACC 2.0. Staff noted that one of the challenges of integration is sustaining the financial resources required to maintain the new delivery models for transforming healthcare delivery, which may require a payment reform initiative as a component of the ACC 2.0 contract. **CCHA** and FBHP leadership were meeting regularly to define an organizational structure to achieve their goals.

Observations/Recommendations

CCHA and FBHP's long-standing relationship and shared geographic boundaries have been an asset in building a strong foundation for developing an integrated delivery system. The executive leadership at both organizations, hired within the past year, is firmly committed to achieving the goal of merging the BHO and RCCO into a single integrated entity. Furthermore, the CMHCs and FQHCs, in particular, have been planning and implementing integrated care delivery for years, and they offer the resources and innovation that make integrated behavioral and physical healthcare actionable. All organizations share the vision that offering integrated behavioral and physical health services at the point of service is the best model for delivering and managing healthcare for members, and they have acted on that vision through continually implementing additional sites of integrated care delivery. By extending tested models of co-location to additional PCMPs, while simultaneously supporting members with collaborative care coordination resources, these organizations are gradually transforming healthcare delivery in the region. In addition, all parties actively participate with community organizations to further explore new and innovative opportunities to extend and improve services to the underserved population. While the provider community is the hub of resources for implementation, the RCCO and BHO facilitate and provide administrative support and resources to the initiatives. One of the challenges going forward will be reimbursement mechanisms and the ability to financially sustain new and innovative models of care without grant-funded support. However, all parties appear to be fully engaged and committed to achieving their collaborative goals through the unique contributions that each partner can offer.

Care Coordination Record Reviews

Findings

HSAG conducted MMP member record reviews that focused on understanding the role of the SCP in documenting and performing care coordination. Eight of the 10 records reviewed were part of the sample of 10 pulled by the Department, and two were from the oversample. HSAG eliminated two of the sampled cases—one in which the member refused to complete the assessment and then moved from the area, and a second in which the member expired prior to completing the SCP.

CCHA erroneously reported to the Department that these SCPs had been completed. HSAG found nine of the 10 records reviewed to be 100 percent compliant with the coordination of care requirements; the 10th record—assigned to a **CCHA** delegate—was only 65 percent compliant. This resulted in an overall 97 percent compliance with the care coordination requirements. **CCHA** integrated the elements of the SCP into its Essette care management system, while delegated entities incorporated the SCP into their electronic medical record (EMR) either by scanning it in or by modifying the delegates' software. **CCHA** completed SCPs during scheduled member home visits, and delegates engaged members during member visits to the clinic. Record reviews confirmed that **CCHA** and its delegates were routinely documenting all elements of the SCP, which included a comprehensive assessment, member goals, action items, and documentation of other agencies working with the member. Documentation indicated that care coordinators focused actions on member-defined goal(s). Several reviewed cases involved coordination with agencies—especially single entry points (SEPs) and community centered boards (CCBs)—that were already working with the member and meeting the majority of the member's needs and goals. The RCCO care coordinators documented outreach to these agencies to confirm and obtain the member's service plan. RCCO coordinators addressed any identified gaps and/or assisted with addressing newly identified member goals. In several cases, the member had limited additional needs or declined assistance from the RCCO care coordinator. When ongoing care coordination was not required, the care coordinator scheduled a six-month SCP update. Lack of real-time ADT information resulted in some ER visits and hospitalizations being identified three months after occurrence, negating the opportunity for proper assistance with transition of care and follow-up. In most cases, the elements of the SCP appeared to support the care coordination plan, and reviewers considered members' care needs well-managed.

Observations/Recommendations

CCHA implemented the Essette care management software in 2015 and customized the system to accommodate RCCO care coordination requirements, including the SCP. Similarly, MCPN and Salud—delegated FQHCs—enhanced their EMRs to consolidate care coordination information in a designated section for easy access to a concise care coordination record. Although the actual SCP tool did not serve as the care coordination record, **CCHA** and delegates agreed that the SCP tool was useful for informing modifications to the systems and served as a guide for understanding the essential elements of comprehensive care coordination. **CCHA** demonstrated excellent leadership, expertise, and enthusiasm among care coordination staff. Compared to previous years' on-site reviews, **CCHA** made significant improvements in performing and documenting comprehensive care coordination. Improvements were particularly apparent in outreach to agencies and provider organizations already involved with the member, avoiding unnecessary duplication, and identifying and addressing gaps in services.

Staff noted, and reviewers confirmed, that some elements of the SCP appeared duplicative, unnecessary, or inconsistent with the natural flow of activities, and may contribute to inefficiencies in the process. For example, care coordinators documented verbal communications with other agencies involved in the member's care, although there was limited exchange of written documentation; member-defined goals tended to be singular and not require prioritization; many members had well-established and ongoing involvement with providers or agencies/organizations that are meeting their needs, and have little need for—or decline assistance with—additional services; and not all hospitalizations and emergency room visits qualify as "critical incidents" that

necessitate update to or alteration of the care coordination plan. Staff members suggested that after completing a comprehensive needs assessment, the member's level of need and/or degree of unmet goals should determine if the remaining elements of the SCP warrant completion. HSAG recommends that, as the MMP demonstration project evolves, **CCHA** staff members work with the Department to examine mechanisms for determining efficient application of the full SCP for a meaningful number of clients.

Overview of Site Review Activities

The FY 2015–2016 site review represented the fifth 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 6. During the initial five years of operation, each RCCO continued to evolve in operations, care coordination efforts, and network development in response to continual collaborative efforts, input from the Department, and ongoing implementation of statewide healthcare reform strategies. The FY 2015–2016 site visits focused on evaluating RCCO activities related to integration with specialist providers, integration with behavioral health services, and Medicare-Medicaid Program (MMP) member care coordination activities. In addition, HSAG gathered follow-up information on select special projects that had been implemented by each RCCO within the past two to three years. Through review of member records, HSAG evaluated the effectiveness of individual MMP member care coordination, including the implementation of the Service Coordination Plan (SCP). The Department asked HSAG to identify initiatives and methodologies implemented by the RCCOs in response to key contract objectives and 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 record review tool and the data collection tool, which provided the parameters for the on-site interviews. The purpose of the site review was to document compliance with select care coordination contract requirements, evaluate **CCHA**'s mechanisms for integrating with the BHO in the region and integrating behavioral healthcare for members, identify activities related to the involvement of specialists in the care of RCCO members, obtain updates of the progress in select special projects implemented by each RCCO, and explore challenges and opportunities for improvement related to each focused content area. Site review activities included a desk review of documents submitted by **CCHA** prior to the site visit. These documents consisted of program plans, written procedures, tracking documents, and any formal agreements related to each of the focus areas. During the on-site portion of the review, HSAG interviewed key **CCHA** personnel using a semi-structured qualitative interview methodology to elicit information concerning mechanisms for implementing the objectives and requirements outlined in the ACC contract. The qualitative interview process encourages interviewees to describe their experiences, processes, and perceptions through open-ended discussions and is useful in analyzing system issues and associated outcomes. The assessment of RCCO activities related to integration with behavioral health services was conducted through a joint interview of RCCO and BHO staff.

To continue the annual evaluation of care coordination processes, on-site review activities included care coordination record reviews. The Department determined that FY 2015–2016 care coordination record reviews would focus on the MMP population. HSAG developed a care coordination record

review tool based on contract requirements and the instructions for completing the required individual member SCP.

HSAG reviewed a sample of 10 care coordination records (selected by the Department's MMP program staff from the MMP report) of members with a SCP completed during the 2015 review period. The Department forwarded the sample lists of 10 records plus 10 oversample records to **CCHA** and HSAG prior to the on-site visit. HSAG completed an individual record review tool for 10 MMP members during the on-site visit. Although completion of the SCP document was not the focus of the record review, HSAG used SCP information, as available, when assessing the member's overall care coordination. HSAG assigned each question in the review tool a score of *Yes*, *No*, *Partially*, *Unable to Determine*, or *Not Applicable* and entered reviewer comments, as necessary, related to each evaluation element within the tool.

The completed data collection tool includes narrative information and recommendations related to on-site discussion of the RCCO's integration with specialty care, integration with behavioral health services/BHOs, and progress on two special projects. The special project topics were selected by the Department from projects identified by the RCCO during previous years' on-site reviews. These topics were different for each RCCO. Summary results and recommendations resulting from the on-site interviews as well as the care coordination record reviews are also included in the Executive Summary.

Appendix A. Data Collection Tool

for Colorado Community Health Alliance (Region 6)

The completed data collection tool follows this cover page.

Section I—Integration with Specialist Providers

Contract References	Possible Discussion Topics
Group 1: The Contractor shall reasonably ensure that Members in the Contractor's Region have access to specialists promptly and without compromising the Member's quality of care or health. RCCO and MMP Contracts—4.2.5 The Contractor shall ensure that all PCMPs refer members to specialty care as appropriate and ensure that clinical referrals are completed between PCMPs and specialists/referred providers. RCCO and MMP Contracts—6.1.1 The Contractor shall develop and maintain a written protocol for clinical referrals to facilitate care coordination and sharing of relevant member information. RCCO and MMP Contracts—6.1.1.1 The Contractor shall allow the PCMPs with which it contracts to refer Members to any specialists enrolled in Medicaid, including those not associated with the Contractor or another RCCO. RCCO and MMP Contracts—6.1.2	◆ Incentives to stimulate specialist involvement ◆ Initiatives to address shortages ◆ Expanding accessibility of specialist care ▪ Telemedicine ▪ Downstreaming services into PCMPs ▪ Transporting specialists to rural or remote areas ▪ Relationships with hospital systems ▪ Other ◆ Successes and challenges in integrating with specialists and/or maintaining capacity for Medicaid members ◆ Mechanisms for monitoring specialist involvement/responsiveness, if any ◆ Referral protocols ▪ What are they? ▪ How have they been implemented? ▪ What is degree of success of using protocols (including feedback from specialists/PCMPs)? ◆ Plans, strategies, or solutions moving forward

Discussion and Observations:
Centura Health, with 50 percent ownership of CCHA, employs numerous specialists and provides specialty provider access to CCHA members. In addition, CCHA compiled a list of specialist providers who are open to Medicaid members. The list is reconfirmed monthly with providers and is available for reference when members call to request access to specialists or for care coordinators to align members with a specialist appropriate to their needs. CCHA limits access to the list of specialists to internal staff in order to limit the number of referrals to any one specialist and to ensure that PCPs are referring members appropriately and with all required information for an efficient specialist evaluation. Staff members stated that if care coordinators are involved with a member seeking specialist services, the care coordinator will facilitate the referral by educating the member on the necessity to share information with

Section I—Integration with Specialist Providers

Contract References	Possible Discussion Topics

the specialist, ensure that necessary paperwork is completed and available to the specialist, ensure the member has transportation to the appointment, and accompany the member to the specialist appointment if necessary. These initiatives are intended to improve the efficiency of the specialty referral process for members and for specialists by supplying the member with all information needed for a comprehensive examination. CCHA explored using the Colorado Medical Society (CMS) "compact" with specialists as a mechanism for establishing protocols between referring physicians and specialists and determined that subspecialists are not interested in signed agreements. CCHA has not adopted formal protocols to date. The CCHA physician advisory council continues to examine referral protocols that will not disrupt established referral relationships between PCPs and specialists.

Staff members stated that general availability of specialists for Medicaid members is limited by the nature of the subspecialist environment, which is overburdened, physician-centric, profit-oriented, and plagued by myths regarding Medicaid members. CCHA acknowledged that the RCCO is not in a position to improve reimbursement to specialists; therefore, CCHA's strategy has been to appeal to the specialists' compassion and to initiate methods of making Medicaid referrals easier and more cost-efficient for specialists. To that end, CCHA participates in several provider health alliances in part to educate specialists and dispel myths regarding the complexity, general health, and unreliability of Medicaid patients, as well as to offer processes for improving the efficacy of Medicaid referrals. CCHA participates in the Colorado Coalition for the Underserved, described as the "alliance of alliances," which focuses on specialty care needs and super-utilizer issues. The CCHA physician advisory council, which includes subspecialist representatives, also continues to consider mechanisms for financially incenting specialist care. CCHA participates in pilot programs intended to increase access to specialists for the underserved, such as the Boulder County Health Improvement Collaborative, which is piloting a process for engaging specialists and behavioral health providers in the FQHCs, and determining how to interface with specialists at Boulder County Hospital. CCHA was participating in a pilot program with St Anthony's Hospital and Panorama Orthopedics, which is experimenting with very specific protocols for referring a limited number of Medicaid members to an ortho-trauma clinic. CCHA provided care coordination support and some funding support for these programs. CCHA stated that one of the most promising initiatives is the e-consult program being facilitated through the Colorado Regional Health Information Organization (CORHIO), which will offer subspecialist consultation with PCPs rather than face-to-face consultation with the patient. The Department is examining mechanisms for reimbursement of providers for e-consults, which does not currently exist. However, e-consults have the potential for significant cost savings, improving the efficiency of subspecialist operations, and further disseminating subspecialist expertise throughout the delivery system.

Section II—Follow-up of Region-specific Special Projects

Contract References	Possible Discussion Topics
NONE	Relationship of RCCO with the health information exchange—Colorado Regional Health Information Organization (CORHIO) or Quality Health Network (QHN) ◆ Describe the RCCO's relationship with the health information exchange (HIE) ▪ How the relationship was developed ◆ Agreement between the RCCO and the HIE ▪ HIE "user/participant"? ▪ Receive information/contribute information? ▪ Functional relationship—how information is received from the HIE (e.g., direct interface, Web portal, member list/inquiry) ◆ Type of data received from the HIE ▪ How RCCO is using/applying the information ▪ Has access to information replaced previous mechanisms of provider notifications/alerts? ▪ Any data or components of the delivery system that are missing/incomplete/gaps? ◆ Successes and challenges of relationship with HIE: ▪ Is exchange working smoothly? ▪ Describe value(s) of the relationship ▪ Difficulties experienced (potential solutions) ◆ Do you envision an expanded/evolving role of the HIE in meeting the future needs of the RCCO? ▪ Status of any planned/anticipated data exchange functions

Section II—Follow-up of Region-specific Special Projects

Contract References	Possible Discussion Topics

Discussion and Observations:

CCHA has a long-standing relationship with CORHIO through the activities of Physician Health Partners (PHP) and PHP's other lines of business. The PHP information technology staff members have been working with CORHIO and the PHP primary care network since 2011 to facilitate the connection of primary care practice sites to the HIE hospitals. CCHA has 28 hospitals in its RCCO service area. The goals of PHP's efforts with CORHIO have been to assist practices with directly connecting to the HIE for practice-specific information and to receive aggregate data that are useful for tracking members' hospital use. CCHA also has been receiving admit, discharge, and transfer (ADT) data feeds through the Department's contract with CORHIO and comparing the data feeds received through the Department with PHP's direct CORHIO data feed. The CCHA member identification (ID) match in the feed from the Department is only 60 percent accurate, while the member ID for the PHP network—which uses a different methodology for identifying members—is a 97 percent match. Through tracking and analysis of the different lists, CCHA has determined that the criteria used by CORHIO to identify members associated with each individual RCCO is too complex and subject to error. CCHA suggested that the CORHIO data be sorted using the members' health plan ID. However, the mechanisms for accomplishing this had not been defined or implemented to date. As a result, CCHA has dedicated staff resources to manually review and sort the member data received from CORHIO to accurately identify CCHA members. In addition, the data feed received from CORHIO includes incomplete or inaccurate information for individual members, limiting the usefulness of the information for care coordination and follow-up. Staff stated that this "garbage in/garbage out" phenomena is beyond CCHA's control and may only be corrected through implementation of data quality standards by CORHIO. Over the past year, CCHA conducted various "work-around" approaches for these issues, including assigning a staff member to work on-site with hospital records personnel to help them correctly identify CCHA members. CCHA also maintains direct relationships with hospital discharge planners and some emergency departments to identify members for transition of care planning and follow-up care coordination needs. Staff reported that until issues concerning the accuracy of ADT information can be resolved, the data feed from CORHIO through the Department has limited use and results in continued frustration and considerable expenditure of RCCO resources to obtain reliable ADT data.

Section II—Follow-up of Region-specific Special Projects

Contract References	Possible Discussion Topics
NONE	**TOPIC #1:** Practice Performance Scorecard Get an update on the project as follows: ◆ How/why this project was selected/initiated ◆ Current status of implementation ◆ Potential impact of program on members ◆ Potential impact on the RCCO ◆ Potential impact on service providers ◆ Realized or anticipated successes to date ◆ Realized or anticipated challenges to date

Discussion and Observations:

CCHA's scorecard program originally included 15 non-delegated practices with more than 500 CCHA members. PHP's quality improvement department continually works with all PHP practices, of which CCHA members are only one component of the overall population of patients in the practice. Therefore, the scorecard was designed to provide data regarding practice performance in overall operations, medical home functions, Medicaid-specific functions, health information management functions (electronic health records [EHRs], patient registries), and quality parameters (emergency room visits, postpartum visits, and well-child visits).

During 2015, CCHA evaluated and modified its provider scorecard project to improve the type and presentation of data to practices. The initial practice scorecard showed data/"numbers" that were primarily associated with key performance indicators (KPIs). In an attempt to make the data more meaningful for providers, CCHA presented KPI information in a visual, graphic format. CCHA quality coaches presented and reviewed scorecard data, along with a written synopsis and recommendations from the CCHA medical director, with practice staff quarterly. The PHP medical director and quality team conducted an annual site visit to review the information physician-to-physician. The redesigned scorecard is intended to stimulate discussion with practices regarding what the practice was "doing" to impact performance in the various categories.

After working with six practices, PHP realized that the scorecard information needed to be more robust and actionable, and relate to engaging with members. Staff stated that CCHA also needs meaningful incentives to stimulate practice responsiveness. At the time of HSAG's review, PHP had established a goal to increase the value and frequency of the data to practices through dashboard reports and a scorecard that includes more than KPIs. Staff reported that the revised scorecard project would soon be expanded to include 20–25 practices. CCHA was also examining options for an incentive-based practice engagement

Section II—Follow-up of Region-specific Special Projects

Contract References	Possible Discussion Topics
program in which each practice would choose its own goals (aligned with RCCO objectives), and be assigned points for making progress toward accomplishing chosen goals; the points would translate into value-based payments to practices. The scorecard would then be designed to track practice-specific progress toward goals. CCHA also shares scorecard information with delegated practices; however, because delegated practices are larger and tend to be more sophisticated, CCHA has an alternative strategy to encourage cooperation among delegates to share best practices. Staff stated that the scorecard strategy is evolving and continuously improving, but it remains a work in progress.	
NONE	**TOPIC #2:** Partnership with Vivage Quality Health Partners—development of program for transition of care from SNF to community-based providers Get an update on the project as follows: ◆ How/why this project was selected/initiated ◆ Current status of implementation ◆ Potential impact of project on members ◆ Potential impact on the RCCO ◆ Potential impact on service providers ◆ Realized or anticipated successes to date ◆ Realized or anticipated challenges to date

Discussion and Observations:
Vivage Quality Health Partners (Vivage) owns and operates numerous skilled nursing facilities (SNFs) across the State, with 12–13 facilities in or near CCHA's service area. Vivage facilities provide care to approximately 2,000 clients, of whom 75 to 80 percent are Medicaid clients. The largest proportion of Medicaid long-term care members in the CCHA region are transitioning through Vivage facilities. CCHA determined that the top five facilities serving its approximately 3,000 MMP members are Vivage facilities. Vivage staff stated that Vivage's objective is to transition clients back to the community as quickly as possible, although some clients stay longer than necessary primarily due to complicated financial and social needs. The collaboration between CCHA and Vivage was initiated after individuals at each organization who had a pre-existing, professional relationship identified that CCHA and Vivage served a mutual population and had mutual motivations for member outcomes. CCHA and Vivage have unique areas of expertise that contribute to a

Section II—Follow-up of Region-specific Special Projects

Contract References	Possible Discussion Topics
member's successful transition of care from a SNF back to the community. Vivage employs case managers and social workers at each facility (with oversight by a system-wide Vivage transition care coordinator) to help identify and coordinate member needs and services with providers involved in the member's care, including preparation of all complex paperwork. CCHA care coordinators have relationships with long-term services and supports (LTSS) providers and the two single entry points (SEPs) for coordinating home and community-based services (HCBS). CCHA and Vivage initiated a pilot project to define processes for identifying shared members, and to define a functional relationship between the CCHA care coordination staff and the Vivage facility case managers. In addition, Vivage agreed to accept CCHA referrals of members with difficult placement issues. Staff stated that challenges with developing the program included identifying shared clients; identifying LTSS providers in the service area (which have varying levels of case management); training involved staff; and educating/re-educating LTSS providers about the role of the RCCO. At the time of HSAG's review, CCHA and Vivage had identified 31 shared members for collaborative care coordination. Vivage had defined a workflow and protocol for interfacing with CCHA that involved RCCO care coordinators in care planning and discharge planning from the time a member is admitted to a Vivage facility. CCHA defined workflows with several LTSS providers and the SEPs. The ultimate objective is to revise the program based on pilot project results, for Vivage to expand the process to other RCCOs, and for CCHA to expand the process to other SNFs and LTSS providers.	

Section III—Integration with Behavioral Health Services/Behavioral Health Organizations

Contract References	Possible Discussion Topics
Group 1: The Contractor shall create, document, and maintain a Communication Plan to communicate with all behavioral health managed care organizations (BHOs) with which it has relationships. RCCO and MMP Contracts—4.3.1 The PIAC includes members representing the behavioral health community. RCCO Contract—7.4.1.3.6 If the Member has an existing case manager through another program, such as behavioral health program, then the Contractor shall coordinate with that individual on how best to coordinate care through a single care coordinator. RCCO and MMP Contracts—6.4.3 The care plan shall include a behavioral health component for those clients in need of behavioral health services. RCCO and MMP Contracts—6.4.5.1.1.1 For members who have been released from the Department of Corrections (DOC) or county jail system, the Contractor shall coordinate with the members' BHO to ensure continuity of medical, behavioral, and pharmaceutical services. RCCO and MMP Contracts—6.4.5.2.6	General structure of RCCO/BHO/CMHC relationships ◆ How many BHOs does the RCCO work with? (How many RCCOs does the BHO(s) work with?) ◆ Is there formal organizational alignment? ▪ Ownership/partnership? ▪ Are there MOUs or contracts between the organizations? ▪ Is there a financial relationship? ◆ Do formally defined accountabilities/responsibilities exist between the organizations? ◆ How long have these relationships been in place? Functional relationships/operational interface ◆ Does the BHO participate in committees, boards, or joint planning related to RCCO strategic or operational decision making? (RCCO in BHO decision making?) ◆ Shared systems? ◆ Are there reporting responsibilities or data shared among the organizations? ◆ How extensive are the collaborative processes? ▪ Outline the functional areas of collaboration—how processes work ▪ How do these processes impact members (e.g., transparency, degree of coordination/overlaps, any feedback from members)? ▪ Care coordination—walk through the processes • Sharing information (verbal/documentation) • Designating a lead coordinator • Deciding how to share care coordination duties

Section III—Integration with Behavioral Health Services/Behavioral Health Organizations

Contract References	Possible Discussion Topics
Integrated care coordination characteristics include: Ensuring that physical, behavioral, long-term care, social and other services are continuous and comprehensive and the service providers communicate with one another in order to effectively coordinate care. RCCO and MMP Contracts—6.4.5.3.1 The Contractor shall ensure coordination between behavioral health and physical health providers. RCCO and MMP Contracts—6.4.11	• Who generally identifies the member with complex behavioral and/or physical health needs? • Who initiates the care coordination process? ▪ Describe how these collaborative processes have evolved; what do you anticipate going forward? ▪ What are the opportunities/successes to date related to collaborative responsibilities? ▪ What are the challenges related to collaborative processes?

Discussion and Observations:
CCHA and Foothills Behavioral Health Partners (FBHP)—the region's behavioral health organization (BHO)— share the same geographic boundaries, and although the BHO and RCCO are not aligned through ownership or formal agreements, the two organizations have partnered in related activities and through initiatives for shared members since CCHA was designated as the RCCO. This long-term relationship provided the foundation for integration that naturally evolved over time. Fundamental to this relationship is the structure of FBHP, in which the two CMHCs in the region—Jefferson County Mental Health (JCMH) and Mental Health Partners (MHP)—share ownership and actively participate in functional responsibilities. Both CMHCs are the hub of strategic and functional relationships within their communities, including long-standing relationships with the FQHCs, and they provide behavioral health resources in many other provider locations. Both CMHCs are active, innovative, and expanding resources for underserved populations in the west metropolitan counties. CCHA brings the primary care network to the region, including the FQHCs, extended physical health relationships, and care coordination for members with behavioral and physical health needs. CCHA and FBHP work collaboratively to provide Medicaid members with comprehensive health services.

The BHO, CMHCs, and CCHA have mutual visions and goals regarding integrating care for improved member outcomes. FBHP and CCHA representatives participate on the advisory committees of each entity and on a joint Data Governance Committee. CCHA has quarterly operations meetings with the CMHCs to review numerous agenda items, including mutual operational initiatives and services for shared members. CCHA and FBHP have implemented a continuum of integrated services from collaborative care coordination to co-location of behavioral and physical health providers. CCHA and the CMHCs jointly developed care coordination workflows. CCHA and BHO providers do not share EHRs or administrative information systems. CCHA has a business associate agreement (BAA) with FBHP to enable information sharing in compliance with Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements. A professional services agreement between CCHA and FBHP states that CCHA provides data to FBHP for analysis of members'

Section III—Integration with Behavioral Health Services/Behavioral Health Organizations

Contract References	Possible Discussion Topics
physical and behavioral needs into four quadrants—variances of high to low physical health and behavioral health needs. Although mechanisms for data sharing are technically limited by HIPAA requirements and the need to maintain separate billing and reimbursement mechanisms, member releases of information (ROIs) are routinely obtained to enable sharing of essential care coordination information. CCHA, the BHO, and the CMHCs have engaged in numerous initiatives to integrate behavioral and physical healthcare for members. Both CCHA and the BHO also participate regularly in numerous community alliances throughout the region to explore more effective approaches for delivering services to the community and the Medicaid population, and to offer services or funding support as appropriate. Staff stated that the ultimate goal is to achieve a fully integrated behavioral and physical health organization for the Regional Accountable Entity (RAE) envisioned in ACC 2.0, and that leadership of both CCHA and FBHP are meeting regularly to define a structure to achieve this goal.	
Group 2: The Contractor shall ensure that its network includes providers or PCMPs with the interest and expertise in serving the special populations that include members with complex behavioral or physical health needs RCCO and MMP Contracts—4.1.6.5 The Contractor shall distribute materials (provided by the Department) related to behavioral health and BHOs to all of the PCMPs in the Contractor's PCMP Network. RCCO and MMP Contracts—5.2.1 Enhanced Primary Care Standards include: ◆ The PCMP provides on-site access to behavioral health care providers. ◆ The PCMP collects and regularly updates a behavioral health screening (including substance use) for adults and adolescents. ◆ The practice has documented procedures to address positive screens and agreements with behavioral healthcare providers to accept referred patients. RCCO Contract—Exhibit F1 (4) and (5)	General level of behavioral health (BH) integration into medical practices or with other providers throughout network Special programs/initiatives: update of programs in Integrated Care Report ◆ Expand co-location of BH services into PCMPs: five additional sites ◆ Collaborative care coordination with BHO: ▪ Members with BH and PH diagnosis ▪ Members with serious mental illness (SMI) diagnosis ▪ Members with bipolar/schizophrenia diagnosis ◆ Co-branding of member/provider materials Get a brief update on each initiative above as follows: ◆ How/why this project was selected/initiated ◆ Current status of implementation ◆ Realized or anticipated successes to date ◆ Realized or anticipated challenges to date ◆ Potential impact on members when program completed ▪ How many members? Degree of importance/significance in member care and services?

Section III—Integration with Behavioral Health Services/Behavioral Health Organizations

Contract References	Possible Discussion Topics
Behavioral Health Integration Report: ◆ The Contractor shall submit to the Department a report that includes an environmental scan of current practices, challenges, and new strategies for integration of behavioral and physical healthcare for all covered populations. RCCO Contract—8.2.1.1	◆ Potential impact on practitioners/other service organizations ▪ If BH/PH practice integration: • Where do the resources come from? • To whom are these practitioners accountable? • How available are resources to members? • How do co-located practitioners interact in patient care or the dynamics of office operations? Crisis Support Services system: ◆ How does the RCCO/BHO coordinate with the Crisis Support Services network? ◆ How are members informed by RCCO/BHO? ◆ How does the referral system work between the RCCO/BHO and crisis centers? ◆ What are your challenges/successes in working with the center(s)? ◆ Do you have a sense of how effective the crisis network might be? (Do you know if members use the center(s)? Any feedback from members?) Overall successes/challenges in integrating BHOs/mental health providers with RCCO/physical health providers Overall impact of integration efforts on members ◆ Any way to monitor/assess? (Any feedback from members?) Going forward—Strategies for integration of behavioral and physical healthcare for all covered populations

Section III—Integration with Behavioral Health Services/Behavioral Health Organizations

Contract References	Possible Discussion Topics

Discussion and Observations:

The projects described in the CCHA Integrated Care Report to the Department primarily focused on either collaborative care coordination initiatives or expanding the co-location of behavioral health providers into PCMP locations. Staff confirmed that the fundamental strategy for BHO and RCCO integration of behavioral and physical health services is the co-location or integration of both physical and behavioral health providers in PCMP locations. The CMHCs have already initiated this process by fully integrating JCMH's behavioral health services at Metro Community Provider Network (MCPN) clinics, and MHP's services at Salud and Clinica clinics. In addition, within the past year, Clinica embedded physical health providers within the MHP wellness center to provide primary care services to members receiving services at the MHP center. The FQHCs and CMHCs conducted ongoing, joint, planning activities. Staff stated that 20 percent of CCHA members receive services through one of these FQHCs. In addition, CCHA facilitated and supported co-location of CMHC providers in 27 PCMP locations. A significant number of these PCMPs are pediatric practices that have a high proportion of Medicaid members. The CMHCs employ the behavioral health professional and assume the billing and reimbursement functions. However, when on-site, the behavioral health provider functions as an integral part of the PCMP health team. The co-located behavioral health provider is also able to refer members to all CMHC resources, such as special programs and CMHC care coordination for social and community services. The functional behavioral and physical health co-location model varies according to the PCMP. In all cases, the behavioral health provider agrees to provide services to patients associated with all payors in the PCMP practice, not just Medicaid members. CCHA and the CMHCs have assertively pursued the implementation of co-located behavioral health and physical health providers, adding five additional sites during 2015. CCHA also co-located its health partners (care coordinators) in several practice sites as a member of the health team for members in need of housing, transportation, food, or other social services. Staff stated that these health teams offer a good balance of comprehensive resources for members. CCHA care coordination staff encourages members with complex behavioral and social needs to obtain services through one of the FQHCs or a co-location site.

CCHA and FBHP have a mutual goal of improving depression screenings performed by PCMPs and ensuring members receive needed behavioral health services. Staff reported that screenings have significantly improved in practices with co-located behavioral health professionals, and that the presence of a behavioral health provider in the practice eliminates the nearly 80 percent gap in member follow-up on referrals from a primary care practice to a CMHC. JCMH also trained its co-located providers in pediatric practices to conduct postpartum depression screenings on mothers attending newborn pediatric appointments.

A major project enabled through grant funds was development of an additional collaborative practice location at Union Square in Jefferson County, which is an integrated adult health home for members with severe mental illness. MCPN provides physical health services, JCMH provides behavioral health services, and Arapahoe House provides substance abuse services. All entities encourage members with severe mental illness to use this site for services. The site also offers care coordination, has unified treatment plans, and allows for shared records among participating providers. CCHA facilitated the designation of the integrated practice site as a PCMP for the RCCO. CCHA will refer members with complex behavioral and physical health needs to this PCMP for services and provide support for care coordination.

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Contract References	Possible Discussion Topics

Staff stated that going forward, the BHO, CMHCs, and RCCO will focus planning efforts on population health initiatives, and they described community-based programs to identify members with unmet behavioral health needs and develop approaches for engaging members "where they are," rather than at the mental health centers. The RCCO's and BHO's ultimate collaborative goal is for all members to be screened and connected to needed services. Staff described several initiatives to engage members in behavioral health services in the community:

- Bridges to Care is a grant-funded program to dispatch a mobile team of physical and behavioral health providers to evaluate and provide services to members in their home. The grant includes very specific referral criteria for this service. MCPN and JCMH are partnered in this initiative.
- The hot-spotting alliance of CCHA and the CMHCs is testing a model of co-locating care coordinators in local hospital emergency rooms to identify CCHA/BHO members seeking services and engage the member in follow-up services.
- The CMHCs provided CCHA call center staff with mental health first-aid training to help staff identify callers who may be in a behavioral health crisis and those who are postpartum, and to refer those members to appropriate providers for services and/or screening.

Staff stated that CCHA supports all of these initiatives by educating PCMPs on options available for behavioral health services, sending reminders to PCMPs regarding behavioral health screenings (e.g., depression screenings), creating bidirectional communication capabilities among providers, and establishing care coordination workflows between CCHA and each CMHC. CCHA hired a care coordinator with expertise in behavioral health and intended to add a second behavioral healthcare coordinator and have one aligned with each CMHC. CCHA and FBHP defined a performance improvement project (PIP) focused on evaluating the effectiveness of four different models of delivering integrated behavioral and physical health services. Staff stated that one of the challenges going forward is sustaining the financial resources required to maintain these new models for transforming healthcare delivery, which may require altered reimbursement capabilities within the current Medicaid system and/or require a payment reform initiative as a component of ACC 2.0 contract.

While most of the initiatives address the needs of members in Jefferson and Boulder counties, staff acknowledged that needs exist in the outlying counties, but that fewer resources are available in those areas. CCHA and the BHO/CMHCs will continue to explore community-based solutions for engaging members in needed behavioral health services in Clear Creek and Gilpin counties, and noted that they are working with physical health providers in those areas on co-located behavioral health services. Staff stated that Clear Creek County started building a new healthcare clinic with medical services on the first floor and JCMH behavioral health services and government social support agencies (e.g., Women, Infants, and Children [WIC] and Healthy Communities) on the second floor. Meanwhile, care coordinators are available to assist members in outlying areas with access to needed services.

JCMH and MHP are designated crisis centers in the State community crisis support center network, providing CCHA an inherent relationship with the crisis centers. CCHA/CMHC care coordination workflows address member referral to the crisis centers, as needed. CCHA care coordinators alert the CMHC care coordinators when a referral occurs, and the CMHC coordinator follows up with the member to ensure that care needs are met and reports back to the CCHA

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Contract References	**Possible Discussion Topics**
coordinator. Staff members stated that there is further opportunity for CCHA to establish a more direct relationship with the crisis centers, track crisis center referrals or walk-ins, and mutually explore challenges experienced with referrals to the crisis centers. At the time of HSAG's review, CCHA care coordinators had scheduled an on-site visit to the Lakewood crisis center. To date, CCHA had not identified any significant concerns related to the State's crisis center system.	

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 Department of Health Care Policy and Financing's Quality Unit for more information.

Appendix C. Site Review Participants

for Colorado Community Health Alliance (Region 6)

Table C-1 lists the participants in the FY 2015–2016 site review of **CCHA**.

Table C-1—HSAG Reviewers and RCCO Participants

HSAG Review Team	Title
Katherine Bartilotta, BSN	Senior Project Manager
Rachel Henrichs	EQR Compliance Auditor
CCHA Participants	**Title**
Abigail Hardt	MCPN, Clinical Care Coordinator
Amanda Mrkvicka	CCHA, Health Partner II
Amy Deweese	MHP, Director of Integrated Services
Analisa Cole	CCHA, Nurse Health Partner
Bob Dyer	FBHP, Chief Executive Officer
Brandi Nottingham	CCHA, Care Management Manager
Dan Fishbein, PhD	JCMH, Vice President for Corporate Development and Corporate Compliance Officer
Elizabeth Baskett	CCHA, Executive Director
Glenn Smith	CCHA, Director of Technical Problems
Heather Logan	MCPN, Director of Accountable Care
Heather Terhark	Vivage, Director of Sales and Marketing
Jamie Haney	MCPN, Manager of Accountable Care
Jim Kuemmerle	JCMH, Manager of Integrated Care
Karen Valentine	Denver Health, Director of Intensive Care Management
Ken Soda MD	CCHA, Chief Medical Officer
Krista Newton	CCHA, Health Partner Supervisor
Mario Rivera	Denver Health, Care Manager Assistant
Mary Kilfoyle	Denver Health, Care Manager
Meg Taylor	CCHA, Behavioral Health Program Manager
Monica Rodriguez	Salud, Care Manager
Nikole Ordway	CCHA, Health Partner II
Patty Warner	CCHA, Health Partner II
Rachel King	Salud, Care Management Program Manager
Ravenne Bye	CCHA, Health Partner
Sabrina Hulko	CCHA, Administrative Assistant
Department Observers	**Title**
Anne Jordan	MMP, Contract Manager
Katie Mortenson	Quality and Health Improvement Unit
Matt Vedal	Policy and Outreach Specialist
Rachel Deshay	RCCO Contract Manager/Program Performance Specialist