Colorado
Accountable Care Collaborative

FY 2015–2016 Site Review Report

for

Community Health Partnership (Region 7)

May 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. **Community Health Partnership** (**CHP**) began operations as a RCCO in July 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 FY 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. 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 **CHP**'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*	# *Partial*	# Unable to Determine	# *Not Applicable*	Score* (% of Yes Elements)
MMP Members	210	149	147	0	2	0	61	99%

* 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	204	175	171	0	4	29	98%
Care Coordination 2014–2015	80	62	48	1	13	18	77%
Care Coordination 2015– 2016	210	149	147	0	2	61	99%

* 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

CHP engaged in a variety of initiatives intended to improve the communication between referring providers and specialists and to improve the efficacy of the referral process. The general referral protocol for primary care medical providers (PCMPs) addressed information to be sent with the member referral to the specialist, follow-up scheduled with the member, and follow-up mechanisms with the specialist. Colorado Springs Health Partners (CSHP)—the primary source of specialist care for **CHP** members—and the BHO worked with **CHP** and PCMPs to develop numerous condition-specific protocols for high-volume or highly stressed specialty areas. All protocols were formatted to provide guidance to PCMPs with specifically defined information, tests, and treatment needed prior to consult as well as conditions/triage flags for referral. **CHP** has instituted a pay-for-performance program with 22 of 34 PCMPs to stimulate PCMPs to implement these referral protocols in their practices. Staff stated that the protocols were particularly useful for "downstreaming" some specialist care into primary care practices as well as reducing the performance of extreme levels of testing prior to specialist referral. Staff stated that both specialists and PCMPs have been very receptive to using the protocols and that further protocol development was planned for additional specialties and conditions.

CHP also engaged CSHP in a pay-for-performance project in FY 2015–2016 to stimulate improved communications between CSHP specialist providers and PCMPs, including disseminating specialty protocols, providing timely consultation reports to PCMPs, maintaining and expanding capacity of specialists to Medicaid clients, and developing specialty education videos for PCMPs. Staff stated that the financial incentive programs were intended to engage specialists in RCCO objectives through value-based reimbursement. **CHP** was participating with community partners to complete a feasibility study for a specialty clinic expansion project at Peak Vista Community Health Centers (Peak Vista) in order to reduce use of local hospital emergency departments (EDs) for access to specialist care. Staff anticipated that the primary challenges in successfully accomplishing this project would be related to Medicaid reimbursement for specialists and availability of specialists to voluntarily staff the clinic.

CHP also engaged in multiple pilot projects and community-based programs to expand specialized care services for members. **CHP** had applied RCCO staff and data resources as well as direct funding to support these programs. **CHP** distributed nearly $9 million in FY 2014–2015 to support local Medicaid providers and programs, which included the Colorado Springs Fire Department Community Assistance Referral Education Services (CARES) program; the Ascending to Health Respite Care (ATHRC) program; the Developmental Disability Health Center (DDHC); the Independence Center; the Pikes Peak Hospice & Palliative Care Advanced Illness Counseling program; and non-emergency medical transportation (NEMT) services. Staff stated that the purpose of these programs is to fill identified gaps in care in the system, and that all programs are considered to be financially sustainable beyond the expiration of available grant funds.

Observations/Recommendations

CHP actively engaged its primary care and specialist providers in developing and implementing referral protocols. The general protocol addressed the broad components of an effective referral, such as bi-directionally communicating vital information between the referring and consulting providers and adequate preparation and follow-up with the member. However, CSHP developed condition/diagnosis-specific protocols that thoroughly instructed the PCMPs regarding specific information to be evaluated, tests to be performed, and when to refer the member to a specialist. CSHP was motivated by the desire to improve the appropriateness and time required for referrals to already overburdened specialists and reported that the efficacy of referrals had improved since implementation of the protocols. PCMPs benefited by having access to information that would improve primary care management of the member for these specific conditions. Both primary care and CSHP providers were incented to participate in referral protocol initiatives through **CHP** pay-for-performance programs. **CHP** wisely implemented tracking and evaluation measures to determine the effectiveness of the referral protocol process. **CHP** also invested in a number of community programs that provided specialty services to clients with special needs, recognizing that not all special needs can be addressed through specialists and that gaps in care within the community need to be more comprehensively addressed. These programs were also robust and appeared to be effective in reducing the demand for specialist or hospital-based services for select populations. HSAG recommends that **CHP** and its providers continue to develop and implement protocols for additional conditions or diagnoses for which specialist care is scarce for Medicaid members, since neither the availability of an adequate number and type of specialists nor improved Medicaid reimbursement for specialists are likely.

Follow-Up of Region-Specific Special Projects

Activities and Progress

CHP was founded out of a coalition of providers and community organizations in El Paso County, which has the only significant concentration of population in the four-county RCCO Region 7 service area. All major healthcare providers are members of **CHP** and actively participate in **CHP** initiatives. In addition, the 24-year history of a coalition of trusted community organizations with similar goals and values resulted in **CHP** programs, projects, and initiatives that reflect the input and design of collaborative endeavors among these organizations as well as **CHP**'s commitment to use or enhance existing services in the community rather than invest in duplication of existing resources. As such, **CHP** often acted as the convener, facilitator, or funding support for multiple pilot programs and collaborative activities, as reflected in the special projects described below.

Relationship With the Health Information Exchange (HIE)

CHP has very ambitiously invested staff and financial resources in working with the Colorado Regional Health Information Organization (CORHIO) to develop an effective health information exchange for both the RCCO and community providers. **CHP** entered into a direct contract with CORHIO on behalf of its ambulatory providers to collaboratively develop a "technology solution" to interface between ambulatory provider electronic health record (EHR) systems and a community data repository within the CORHIO framework, facilitating community-wide exchange of patient

ambulatory clinical data. In addition, **CHP** is building a **CHP** proprietary data warehouse capable of receiving real-time admit, discharge, and transfer (ADT) data from CORHIO and integrating RCCO member clinical information with historical claims data. The proprietary data warehouse will provide RCCO care coordinators, practice transformation teams, delegated practices, and community healthcare providers with access to real-time data and provide a database for analytics and population health initiatives. Separate from these initiatives, **CHP** will be implementing a community care coordination tool that can be accessed and updated by all members of the health care team. **CHP** had prioritized five of the larger provider network practices for initial implementation of the technology but anticipated that by 2018 the technology would be completely deployed with all RCCO PCMPs and many other organizations that serve the Medicaid population in the area. **CHP** described efforts to integrate information from the respite care program and the CARES program. Staff members were quite enthused about **CHP**'s relationship with CORHIO and optimistic regarding the capabilities of the RCCO and its community partners to use the HIE to achieve multiple goals.

Dorcas Program and Faith-Based Clinics for Criminal Justice-Involved (CJI) Members

Staff reported that developing relationships and processes for CJI individuals has been an explorative and evolving process with iterative changes based on piloting various approaches to improve effectiveness. During 2015, **CHP** had not actively pursued relationships with Dorcas—a project to assist women being released from incarceration to transition successfully back into the community—nor the faith-based safety-net clinics for the uninsured. Representatives of the Dorcas project informed **CHP** staff in January 2015 that the primary objective at that time was to raise building funds for a housing project for clients and that it was premature to engage with the RCCO in a functional relationship. Similarly, while **CHP** staff had previously believed that many CJI members sought care from various faith-based clinics upon release from the corrections system, the SET Family Medical Clinic (SET) is the only Medicaid-certified faith-based facility. **CHP** did not pursue a direct relationship with SET to connect with CJI individuals because the clinic does not identify and is not aware of which clients may be CJI individuals.

As an alternative to these projects, **CHP** redirected efforts into alternative strategies to engage CJI members. **CHP** financially supported El Paso County Public Health and facilitated agreements—among the El Paso Sheriff's Office (Sheriff's Office), El Paso DHS, and El Paso Public Health—through which a DHS case manager and a public health (PH) care coordinator are assigned to the Criminal Justice Center (CJC) to enroll eligible persons in Medicaid and connect CJI members to necessary healthcare and social services before release from El Paso County Jail. Staff stated that beginning May 2016 a care coordinator team from AspenPointe and the RCCO will replace the CJC on-site PH care coordinator. In addition, the BHO criminal justice systems coordinator and **CHP** engaged in extensive education of staff in multiple Department of Corrections (DOC) facilities regarding Medicaid eligibility and services available to CJI Medicaid members. In addition, the RCCO and BHO provided monthly education forums directly to inmates in two corrections facilities and met face to face with prisoners prior to planned release to establish contact with a care coordinator, perform assessments of needs, make appointments for services needed after release, and obtain releases of information for medical records. This process was to be expanded to three additional facilities in April 2016. Staff described that one of the major challenges in this approach has been inaccuracy of DOC data concerning the residence of parolees upon release, necessitating that the BHO/RCCO care coordination teams meet with all anticipated parolees to establish with

individual CJI members where they will ultimately reside in order to link the member to the appropriate follow-up services.

ER Diversion Program: Co-Location of Care Coordination Resources in Local Emergency Departments

The Emergency Department Diversion (EDD) program was an established program between Peak Vista and Memorial Hospital to embed Peak Vista care managers in the hospital ED to engage Peak Vista clients regarding alternatives to using the ED for services. In 2013, **CHP** partnered with Peak Vista to expand the program to all local hospitals and to use Peak Vista diversion program staff to engage all RCCO members. During 2015, EDD staff documented over 13,000 face-to-face encounters with members in the EDs. At the time of HSAG review, EDD staff members were negotiating on-site operational processes to accommodate the emerging development of fast-track emergency department programs by the hospitals. Staff recognized that the objectives of fast-track programs may be in direct conflict with the objectives of the EDD program, thereby compromising EDD program effectiveness. A multi-organization task force was formed to examine other initiatives to divert members prior to them arriving in the ED. **CHP** also described that it financially supports the CARES program and the Respite Care Program as two community initiatives that contribute to reducing unnecessary ED utilization. **CHP** referred high ED utilizers for enrollment in the CARES program—program staff reported a 50 percent reduction in 9-1-1 calls, ER visits, and hospitalizations for members enrolled in the program. **CHP** provided a fee-based RCCO payment and grant funds to the community Respite Care Program—which receives referrals of chronically homeless individuals, provides temporary access to housing, and assigns a care manager to assist members with benefits and services that will enable more long-term housing solutions.

Observations/Recommendations

Each of the region-specific special projects described by **CHP** reflected **CHP**'s strategy to work collaboratively with all providers and community organizations to build a better system of care for the community. The efforts to work in partnership with CORHIO to build a centralized community database to facilitate exchange of member information among providers and ultimately other community organizations was ambitious, robust, and positively progressing. Successful completion of the "technology solution" will require continued commitment of all partners and significant expenditure of financial and staff resources. The project will provide benefits to all participants, delivering to the region a functional HIE with the potential for improving quality and efficiency of care, supporting many other health system goals, and providing CORHIO with applications that can advance the usefulness of and implementation of the HIE throughout the state. **CHP** has invested its resources thoughtfully in consideration of the shared goals of all parties.

Although **CHP** did not pursue relationships with Dorcas or faith-based clinics to engage CJI members, **CHP** pursued alternative strategies with the county jail and prison facilities that appeared to be more effective and far-reaching. By enlisting the services of DHS, the Sheriff's Office, and DOC staff, CJI members could be effectively enrolled in Medicaid and connected to necessary medical, behavioral, and support services prior to release. The participation of the BHO criminal justice coordinator, with expertise in corrections system operations, was a great asset in establishing relationships with corrections facility staff and developing a phased approach for systems

integration. While numerous issues are yet to be resolved, sustaining these efforts should result in successful integration of CJI members into the RCCO over time.

Similarly, the ED Diversion program through Peak Vista has been broadened to include support for other community programs that can contribute resources to members to prevent them from obtaining services through unnecessary access to the ED. Evolving dynamics of other community initiatives may impact use of the ED; therefore, it will be difficult for **CHP** to specifically attribute reduced utilization to the EDD program. In addition, **CHP** may need to further explore the potentially conflicting intent of ER fast-track programs in the community and the ultimate impact those may have on EDD program results.

Integration With Behavioral Health Services/BHOs

Activities and Progress

Colorado Health Partnerships is the primary BHO for the **CHP** region, including the AspenPointe Community Mental Health Center (CMHC) in Colorado Springs. Since the inception of the RCCO, AspenPointe has been a partner organization on **CHP**'s Board, participates on nearly every RCCO committee, provides the customer service call center functions to the RCCO, and actively participates in numerous collaborative initiatives with the RCCO as well as with other community providers. An estimated 60 percent of RCCO members who receive behavioral health services do so through AspenPointe. **CHP** and AspenPointe cooperated in numerous program development and operational activities which included community education and work groups to explore mental healthcare challenges in the community, developing a communitywide crisis response system to better transition members with mental health situations between emergency responders, HIE solutions for communications between behavioral and physical health providers, mental health First Aid training for **CHP** service center employees and community organization staff members, motivational interview training for PCMPs, bi-directional data sharing agreements to enable care coordination and population health analyses, education and trainings to enhance sharing of information between PCMPs and BHO providers, and initiating collaborative care coordination teams for members with co-morbid medical and behavioral conditions.

At the time of HSAG review, **CHP** reported that 15 PCMPs, including the largest PCMPs, had co-located or integrated behavioral health services. AspenPointe hired a nurse to participate in evaluation of individuals with primary medical needs. **CHP** and AspenPointe used the Integrated Practice Assessment Tool (IPAT) to assess the progressive levels of integrated behavioral and physical healthcare at individual practice locations. Staff members developed strategies specific to each individual practice to advance the integration of services, as appropriate, and emphasized the importance of designing appropriate strategies for each level of integration in the continuum. Staff members identified **CHP**'s vision as delivering "whole person" care through a number of mechanisms. **CHP**'s strategies for improving integrated care included increasing the number of integrated care sites, improving the information technology infrastructure to support integrated care, developing a "priority service" line from the **CHP** service center to AspenPointe, increasing attribution of members with co-occurring physical and behavioral health needs to integrated delivery providers, increasing use of the Patient Health Questionnaire-9 (PHQ-9) depression screening tool in primary care practices, and identifying data sources and capabilities for tracking

the effectiveness of integrated care. **CHP** also discussed results of co-location pilot projects with CSHP and Peak Vista. Other initiatives to address integrated care for members included on-site PCMP case conferences with the AspenPointe/RCCO care coordinator team to discuss care plans for members with co-occurring mental and physical health issues, access to the Colorado Psychiatric Access and Consultation for Kids (C-PACK) program to provide PCMPs with telepsychiatry consultation from child psychiatrists and initiating a pilot program with Peak Vista to provide PCMPs with telepsychiatry consultation for adults.

Staff members described major challenges encountered in BHO/RCCO integration activities as: physical health and behavioral health are two different systems of service with different coverage and benefit responsibilities and different perspectives and approaches to care; and the RCCO and BHO have two different payment systems, which require creative approaches for integrating behavioral and physical health services for individual members. **CHP** requested the BHO's ongoing participation in discussions regarding barriers to integrated behavioral and physical healthcare in the region. Barriers identified were a shortage of psychiatrists to provide medical management of behavioral health disorders; inability of small and rural practices to co-locate counselors into their practices; and inability of PCMPs to be reimbursed for a primary behavioral health interventions, including participation in telehealth programs. Staff stated that reimbursement issues related to all integrated practice models needed further exploration and resolution.

AspenPointe is also the designated crisis support center within Region 7. However, staff emphasized that the AspenPointe Crisis Stabilization Unit was only one component of a more global community response initiative that preceded the State-sponsored crisis support center system. In 2014, AspenPointe converted its crisis support program into a peer support model delivered within a comfortable living room-style atmosphere. The overall community response system also included a mobile response unit, the CARES program response team, and other local safety providers such as law enforcement and the community Respite Care Program. Numerous flow charts documented disposition and coordinated communications for varying degrees of crisis intervention. Staff members reported that the crisis stabilization unit was frequently accessed and was supported by the community as an important component of the communitywide crisis support system.

Observations/Recommendations

Only one CMHC of the Colorado Health Partnerships BHO is located in the **CHP** service area, and thus serves as the conduit for integration efforts between the BHO and the RCCO. **CHP** has a long-term organizational and functional relationship with AspenPointe CMHC, and both mutually participate in collaborative initiatives with other community organizations to improve overall health services for members of the community. Integrated care coordination efforts have been slow to develop but have accelerated with the designation of specific care coordination staff within AspenPointe. AspenPointe also participated in practice transformation efforts related to advancing integrated care delivery within PCMP locations, including providing behavioral health resources to PCMP offices when needed to support a co-location model of practice. While most larger Medicaid practices in the RCCO network provide co-located or integrated behavioral healthcare, **CHP** staff cautioned that co-location is not the most appropriate model for all practices and that a variety of integration models must be considered and adapted to each practice. Nevertheless, **CHP**'s strategies are designed to encourage progression of practices through the continuum of integrated care

models. **CHP** has engaged in a number of initiatives with AspenPointe over the years related to practice integration and a number of creative community programs to support specialized needs of members. More recently, cooperation to develop collaborative care coordination teams has evolved, perhaps even serving as a precursor to locating teams in select PCMP locations. It appeared that **CHP**'s close working relationship with AspenPointe will continue, while **CHP** and BHO leadership begin pursuing mechanisms for developing an integrated model for the Regional Accountable Entity associated with Accountable Care Collaborative 2.0 proposal. Major challenges will include determining how to align different reimbursement systems within one organization and how to align **CHP** with a BHO that overlaps with several regions while one partner CMHC is tightly aligned organizationally and operationally with **CHP**.

Care Coordination Record Reviews

Findings

HSAG conducted MMP member record reviews that focused on understanding the role of the Service Coordination Plan (SCP) in documenting and performing care coordination. All 10 records reviewed were part of the original sample selected by the Department and documented full SCP completion. **CHP** had programmed the elements of the SCP into an electronic database. Staff stated that **CHP** used this tool to document care coordination for all members, not just MMP members. Care coordinators completed the SCP online after completing a paper copy of the SCP when meeting with the client face to face. Peak Vista documented its care coordination assessment and interventions in the electronic medical record (EMR) through the medical record, care coordination notes, or a section that replicates (and prints) the hard copy SCP. The SCP document is auto populated or linked to some data already documented in other portions of the EMR (e.g., medications) and manually supplemented with information available in the Statewide Data Analytics Contractor (SDAC) database (e.g., hospitalizations, ER visits) and further assessment and care plan information required in the SCP form.

CHP scored 99 percent compliant with the care coordination requirements. Documentation indicated that members were cooperative with the SCP process although very few members demonstrated complex needs or identified unmet needs and goals. Many members were connected with the single entry point (SEP) or community centered board (CCB) case managers prior to the RCCO becoming involved. Overall, MMP members appeared well-connected to services and comfortable with the services being provided. In most cases, RCCO care coordinators contacted care coordinators and case managers from other agencies to ensure that members were receiving needed services, although no written care plan information was exchanged. (Staff noted that the SCP tool encouraged coordinators to reach out to other agencies.) When the member was already linked with an external care coordinator, well-established with services, and unable to identify any unmet needs, the RCCO care coordinator generally deferred to the CCB or SEP as the lead coordinator. In the sample of cases presented, reviewers noted that there was little if any need for coordinators to contact other providers involved in the member's care.

Reviewers noted that in two cases opportunities existed to contact either the care coordinator at AspenPointe or the SEP case manager to better coordinate services for the member. Staff explained that during much of the review period AspenPointe did not have designated care coordination staff,

relying on the therapist to coordinate needed services for the member, and that therapists generally did not respond to RCCO care coordinator inquiries. Staff stated that AspenPointe has since established care coordinator positions. Similarly, staff explained that for a significant period of time the SEP was not cooperative with sharing information and would not accept direct referrals from the RCCO, requiring that the member process all requests directly with the SEP. Through repeated attempts of **CHP** and the Department to work with SEP leadership, staff reported that communications were improving between RCCO and SEP care managers.

Observations/Recommendations

Based on the sample of cases reviewed on-site, it appears that many MMP members have limited care coordination needs or have needs already being met through other agencies or their providers. Many members reported being happy with their services and providers and had no or few unmet needs. In many cases, the primary role of the RCCO care coordinator was to complete the SCP document, periodically contact the external agency coordinator to offer assistance if needed, and update the SCP with the member in six months. However, staff did acknowledge that the SCP process was very useful for establishing a contact with the RCCO care coordinator that may lead to the member re-contacting the coordinator at a later time. This observation is in contrast to previous years' care coordination record reviews, in which members were stratified for care coordination intervention based on identification of complex medical, behavioral, and/or social needs and required extensive assistance from care coordinators.

Many members identified goals that were vague or nonactionable, such as "stay healthy," "walk better," or "find a better fit in a church." In two cases, potentially actionable goals were defined but the member declined any need or desire for assistance with those goals. It was unclear whether these types of goals were expressed because the member had no perceived unmet needs or whether the care coordinator might have explored needs or goals more thoroughly with the member to determine something more definitive. **CHP** may consider evaluating with care coordinator staff whether motivational interviewing or other techniques might improve the member's ability to define actionable goals.

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 **CHP** as the RCCO for Region 7. 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 **CHP**'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 **CHP** 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 **CHP** 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 **CHP** 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 Community Health Partnership (Region 7)

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:
CHP engaged in a variety of initiatives intended to improve communication between referring providers and specialists and to improve the efficacy of the referral process. The general referral protocol for PCMPs addresses information to be sent with the patient referral to the specialist, follow-up scheduled with the patient, and the follow-up mechanism with the specialist. In addition, Colorado Springs Health Partners (CSHP), which is the primary source of specialist care for CHP members, developed numerous condition-specific protocols for high-volume or highly stressed specialty areas including cardiology, neurology, gastro-intestinal, orthopedics, rheumatology, and podiatry. Colorado Health Partnerships—the BHO—has developed similar protocols for attention deficit hyperactive disorder (ADHD), depression, and anxiety. All protocols are formatted to provide guidance to PCMPs regarding specific information and tests

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needed prior to consult and treatment tried as well as conditions/triage flags that trigger a referral. Although CSHP authored the protocols, CHP adopted the protocols to guide referrals to any specialist (not just those affiliated with CSHP). All referral protocols and instructive videos are available on the CHP website. CHP instituted a pay-for-performance program to stimulate PCMPs to implement these protocols within their practices, which CHP verifies through periodic chart audits. Staff stated that both specialists and PCMPs have been very receptive to using the protocols and that protocol development is planned for additional specialties and conditions such as pain management. Staff stated that PCMPs, who employ an increasing number of physician extenders—i.e., nurse practitioners—find the protocols particularly useful for "downstreaming" some specialist care into primary care practices. An added benefit of the "tests to be performed" and "indicators for referral" sections of the protocols is the diminishing performance of extreme levels of testing, particularly by emergency departments (EDs), prior to specialist referral. CSHP reported that specialists have experienced more appropriate referrals, better-informed patients, and a reduction in no-shows due to adequate preparation of the member prior to a specialist appointment. The specialist referral process is further supported through the CHP service center, which maintains an updated list of specialist providers open to Medicaid members. The service center assists PCMPs with finding available specialists and ensures that members who call the service center looking for specialists are coordinating the referrals through their PCMPs. CHP care coordinators assist members with arranging transportation for specialist appointments and accompany members to the specialist appointments as necessary. Specialist offices call the member with appointment reminders.

At the time of the site review, staff reported that the PCMP pay-for-performance program quarterly chart audits confirmed that PCMPs are very specific about the information sent to the specialist and that PCMPs are receiving timely and adequate reports back from specialists. Staff stated that the current claims-based data from the Department do not allow RCCOs to track referrals to specialists, but CHP intends to develop a data-based tracking mechanism when more complete data are available through CORHIO.

CHP also engaged CSHP in a FY 2015–2016 pay-for performance project to stimulate improved communications between CSHP specialist providers and PCMPs, including disseminating specialty protocols, providing timely consultation reports to PCMPs, maintaining and expanding capacity of specialists to Medicaid clients, and developing specialty education videos for PCMPs. CHP's maintenance/expansion of specialty services has been accomplished through available telephone consultation with PCMPs, addition of specialty nurse practitioners, co-location of specialists (dermatology and podiatry) at PCMP offices, and maintaining open access to Medicaid clients. Staff stated that the financial incentive programs were intended to engage specialists in RCCO objectives through value-based reimbursement and not to provide an ongoing increase in Medicaid payments for specialists. CHP anticipates that the pay-for-performance program with CSHP will continue with periodically redefined performance measures.

At the time of the on-site review, CHP and community partners were completing a feasibility study for a specialty clinic expansion project at Peak Vista Community Health Centers (Peak Vista). Medicaid expansion and limited numbers of specialists participating in Medicaid have stressed overall community access to specialist care and increased the number of people seeking care from hospital emergency rooms (ERs). Area hospitals approached CHP for assistance in reducing the use of ERs for access to specialty care. The project included focus groups with specialists in the community to gather information

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regarding considerations for engaging specialists in expanding access to Medicaid members. Major considerations for the project include Medicaid reimbursement for specialists, willingness and availability of specialists to voluntarily staff the clinic on a rotating basis, overall financial requirements of establishing space and services to support a clinic, potential funding sources, and examining whether limited capacity in PCMP practices influences premature referrals to ERs. Staff anticipated multiple challenges in successfully accomplishing this project.

CHP also engaged in multiple pilot projects and community-based programs to expand specialized care services for members. CHP has applied RCCO staff and data resources as well as direct funding to support these programs. Staff described and provided documentation related to:

- The Community Assistance Referral Education Services (CARES) program through the Colorado Springs Fire Department, which provides paramedic interventions for members in the field to reduce unnecessary ER visits. CHP pays the CARES program for RCCO members referred to the program.
- CHP grant funds to support the development of non-emergency medical transportation (NEMT) services in the community.
- CHP grant to the Independence Center to purchase software for tracking members with disabilities in order to reduce the overall cost of care to Medicaid.
- CHP financial support for the Ascending to Health Respite Care (ATHRC) program, which provides CHP with access to recuperative care and temporary housing for homeless individuals, was extended through 2016. The RCCO has referred 132 members to this program.
- A pilot program with the Developmental Disability Health Center (DDHC).
- Funding support for the Advanced Illness Counseling program through Pikes Peak Hospice & Palliative Care being extended through 2017. The program provides end-of-life counseling to designated members.
- CHP-funded research through the Independence Center to evaluate access to care issues for persons with physical disabilities. CHP is considering funding additional equipment (such as height-adjustable exam tables and wheelchair-accessible scales) for offices to improve access for members with disabilities.
- Specialists are being integrated into some primary care practices. An endocrinologist has been integrated into a pediatric PCMP, and two additional practices are considering specialist integration.

Staff stated that the purpose of these programs is to fill identified gaps in care and encourage further collaboration among providers and the community. All programs are intended to be financially sustainable beyond the expiration of available grant funds.

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:

CHP entered into a direct contract with CORHIO on behalf of its ambulatory providers to collaboratively develop a technology solution to facilitate community-wide exchange of patient ambulatory clinical data. CHP is a financial and staff resource partner with CORHIO for this purpose. The technology solution is a direct interface between ambulatory provider electronic health record (EHR) systems and a community data repository within the CORHIO framework. CORHIO will accept electronic information from any provider EHR, convert the data into a common format, and store the information in a data repository which can be viewed by any healthcare provider through the CORHIO Web portal. CHP negotiated a very affordable provider-based participation fee with CORHIO. In addition, CHP is building a proprietary data warehouse capable of receiving real-time data from CORHIO, including acute care admission, discharge, and transfer (ADT) information. This direct feed of ADT information from CORHIO will replace the need for ADT information through the Department.

In addition to clinical information, the data warehouse will integrate historical claims data. The warehouse will provide RCCO care coordinators, practice transformation teams, delegated practices, and community healthcare providers with access to real-time data and a database for analytics to identify population health initiatives and reduce costs of avoidable healthcare encounters. Separate from these initiatives, CHP will be implementing a shared care coordination tool that can be accessed and updated by all members of the health team. It is anticipated that data from the warehouse will be available to users of the care coordination tool, and that some components of care coordination documentation will be stored in the warehouse. The CHP agreement with CORHIO allows CHP to prioritize for participation practices which included Peak Vista, AspenPointe, CSHP, Mountain View Medical Group (Mountain View), and Kids Are Great Pediatrics. Staff stated that gaps in data included information from specialists, from PCMPs that have not yet implemented the link to CORHIO, and from member churn in Medicaid eligibility. CHP was working with CORHIO to "buy" gap in care information for temporary ineligible periods for RCCO members. CHP anticipated that by 2018 the CORHIO/CHP technology would be completely deployed with all RCCO PCMPs and many other organizations that serve the Medicaid population in the area. At the time of the site review, CHP was working on applications to integrate information from the respite care program into the data warehouse; CHP and CORHIO were working with the CARES program to collect clinical information in the field through iPad technology, transmitting information to the data warehouse for reformatting, and making the information readily available to hospitals through CORHIO. Staff reported that the new technology has enabled CHP to obtain A1C laboratory results for reporting on key performance indicators (KPIs). CHP staff members were enthused about CHP's relationship with CORHIO and optimistic regarding the capabilities of the RCCO and its community partners to use the health information exchange (HIE) to achieve multiple outcomes. Staff stated that CHP's investment of financial resources to support CORHIO technology developments will allow other RCCOs to benefit from advancements in CORHIO's capabilities.

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

Contract References	Possible Discussion Topics
NONE	**TOPIC #1:** Potential relationships with DORCAS program and faith-based clinics for criminal justice-involved (CJI) individuals 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:

The purpose of the Colorado Springs Dorcas Life Education Project (Dorcas Project) is to assist women being released from incarceration to transition successfully back into the community. CHP staff met with representatives of the Dorcas Project in January 2015 to explore the possibility of aligning with Dorcas to ensure that this population is successfully enrolled in Medicaid and to offer RCCO assistance in linking women to necessary health services. At the time of this meeting, RCCO staff members were informed that the primary objective of Dorcas was to raise funds for building housing for the clients, and that until that objective was met it was premature to engage with the RCCO in a functional relationship. Therefore, CHP deferred its alignment with Dorcas to a more appropriate future date.

Staff described CHP's historic relationship with the faith-based SET Family Medical Clinics (SET) through the community-based Community Access to Coordinated Health (CATCH) program—in which AspenPointe, Peak Vista, CHP, and the CARES program participate—to identify opportunities for serving the low income, uninsured, and underinsured population in the community. While CHP staff had previously stated that many CJI individuals sought care from various faith-based clinics upon release from the corrections system, the SET clinic is the only Medicaid-certified faith-based facility. CHP has not pursued a direct relationship with SET to connect with CJI individuals because the clinic does not identify and is not aware of which clients may be CJI individuals. Therefore, during 2015, CHP redirected its efforts into alternative initiatives to engage CJI members as follows.

CHP entered into an agreement to support two health navigators at the El Paso County Health Department and the Department of Human Services (DHS) to connect members visiting those sites to a PCMP and to coordinate other needed services. A contract between the El Paso Sheriff's Office (Sheriff's Office)

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Contract References	Possible Discussion Topics

and DHS specified that a DHS case manager would be located in the Criminal Justice Center (CJC) to screen persons for Medicaid eligibility and enroll applicable CJI persons in Medicaid. An agreement between the Sheriff's Office and EL Paso County Public Health (Public Health) specified that Public Health would provide a care coordinator for assessment and referral to needed services for Medicaid members being released from jail. This multi-agency collaborative process enrolls persons in Medicaid before release from jail and connects the CJI member to necessary healthcare and social services. Staff stated that beginning May 2016 a care coordinator from AspenPointe will join the on-site assessment and education team and that the physical health care coordinator will be replaced with a RCCO care coordinator to ensure that Medicaid members are referred to appropriate services prior to release.
The Department of Corrections (DOC) established "re-entry pods" in each of its facilities to assist anticipated parolees with enrollment in Medicaid prior to release from prison. CHP was working with the area's BHO's—Colorado Health Partnerships—criminal justice systems coordinator to provide extensive educational efforts for corrections staff regarding Medicaid eligibility and services available to Medicaid members. In addition, the RCCO and BHO have teamed to provide monthly education forums to CJI members in two corrections facilities and to meet face to face with CJI members prior to release to establish contact with a care coordinator, perform assessments of needs, make appointments for services needed after release, and obtain releases of information from prisoners to obtain the members' medical records from the corrections facilities. Staff stated that meeting face to face with members has proven more effective than educating parole and corrections staff regarding Medicaid services and processes. Staff stated that this process was to be expanded to three additional facilities in April 2016. Staff described that one of the major challenges has been accuracy of data concerning the residence of parolees upon release. All data from the DOC indicate that the member is resident of Colorado Springs; therefore, the facility-based teams meet with all persons being released to perform member education and assessment, confirm the county of anticipated residence, and establish individual CJI members with appropriate follow-up services in Region 4 or Region 7, based on where they will reside. The BHO's criminal justice systems coordinator was facilitating an agreement with the DOC to improve the accuracy of the data, identify appropriate CJI members for the program, and establish parameters for data sharing between the DOC and the RCCO.

CHP documented multiple meetings in 2015 and 2016 with the DOC, parole offices, DHS, the BHO, El Paso County agencies, and the Canon City and Fort Lyons corrections facilities regarding transitioning CJI members from corrections back into the community. In addition, CHP developed educational materials and a transition referral form to facilitate these efforts. Staff reported that developing relationships and processes for CJI members has been an explorative and evolving process with iterative changes based on piloting various approaches to improve effectiveness.

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

Contract References	Possible Discussion Topics
NONE	**TOPIC #2:** ER Diversion program through co-location of care coordination resources in local emergency departments 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:

CHP staff described the evolving history of the Emergency Department Diversion (EDD) program, established as a program between Peak Vista and Memorial Hospital to embed Peak Vista care managers in the hospital ED to educate members about alternatives to the ED. In 2013 CHP partnered with Peak Vista to expand the program for a one-year pilot project that included the Memorial Central Hospital, Memorial Urgent Care, Penrose Main Hospital, and St. Francis Medical Center and to use Peak Vista staff to engage all RCCO members seeking care in local EDs. CHP supported the project through a pay-for-performance reimbursement to Peak Vista based on a 10 percent reduction in ED visits among high ED utilizer members (which they accomplished). During 2015, EDD staff documented over 13,000 face-to-face encounters with members in the EDs. Post-treatment on-site engagement with members allowed staff to identify reasons why the member used the ED (i.e., barriers to appropriate access to care), educate members about alternatives to using the ED, and distribute flyers regarding member attribution to a PCMP. Staff stated that operational processes were being negotiated with hospitals to accommodate the development of fast-track ED programs. Staff recognized that objectives of the fast-track programs (i.e., attracting increased patients by providing more convenient and efficient ER services) may directly conflict with the objectives of the EDD program, thereby compromising the motivation of hospitals to participate in EDD.

The outcome of the pilot project also resulted in recommendations to develop a multi-organization task force to develop processes to divert members prior to arriving in the ED, including enhanced care coordination efforts and further integration of mental health services in diversion initiatives. CHP described that it financially supports the CARES program and the Respite Care Program as two community initiatives that contribute to reducing unnecessary ED utilization. The CARES program provides interventions in the field in response to 9-1-1 calls (operated by the fire department) to prevent the necessity of

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

Contract References	Possible Discussion Topics
transporting an individual to the ED. The CARES program partners with many agencies (including the RCCO) which refer members for enrollment in the program. A community response team (CRT)—consisting of police, fire department medic, and behavioral health provider—has been developed to respond to 9-1-1 calls from select members and to conduct on-site screenings and transport members to the appropriate service locations. The program also conducts an extensive home visit with each enrolled member to identify social determinants of health, provide education, and develop a plan of care regarding appropriate use of the ED. CARES staff reported a 50 percent reduction in 9-1-1 calls, ER visits, and hospitalizations for members enrolled in the program. The fire department planned to hire nurse navigators to assist with the implementation of care plans for members with co-morbid behavioral and medical needs by meeting with other providers in person regarding those members' care plans. Outcomes of the program were to be measured through 9-1-1 call tracking and CORHIO data. CHP and CARES were working with CORHIO toward a common information system platform for sharing member information. CHP provided a fee-based RCCO payment and grant funds to the community respite care program—ATHRC—which receives referrals of chronically homeless individuals from hospital EDs, provides temporary access to housing, and assigns a care manager to implement the discharge plan and obtain appointments for services. A benefits coordinator also assists individuals with social security and housing applications, enabling transition to subsidized housing. The respite program had 12 beds and 4 additional hotel units for temporary housing placement, with individuals staying 14 to 26 days in temporary housing. The program was able to accommodate 50 percent of the 207 referrals received to date and was seeking federal funding to build a Housing and Urban Development (HUD) housing unit.	

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:

The CHP (RCCO) service area overlaps with portions of Colorado Health Partnership's BHO service area, including the AspenPointe Community Mental Health Center (CMHC) in Colorado Springs. Elbert County, within the RCCO region, was part of Access Behavioral Care's (ABC's) BHO service area. AspenPointe is a partner organization on the RCCO's Board, provides direct support functions to the RCCO (e.g., the customer service call center), and actively participates in numerous collaborative initiatives with the RCCO as well as other community providers. Although CHP does not participate on BHO committees, AspenPointe participates on nearly every RCCO committee. Both CHP and AspenPointe participated in planning and developing activities for community health programs, with CHP often playing the convener/facilitator role and AspenPointe providing behavioral health resources for initiatives. CHP and AspenPointe cooperated in numerous program development and operations which included:

- Community education and work groups to explore mental healthcare challenges in the community. CHP facilitated a provider-driven "mental health summit" (which included the University of Colorado Colorado Springs [UCCS], two hospitals, AspenPointe, and CHP, together with community organizations) and began identifying mechanisms to resolve mental health challenges in the community.
- Communitywide crisis response system to better transition members with mental health situations between emergency responders (e.g., CARES), hospitals, and AspenPointe. This project included development of communication protocols to facilitate co-managing of members among community provider organizations.
- Electronic HIE solutions among AspenPointe, Peak Vista, CSHP, and CHP.
- Mental health First Aid training provided by AspenPointe to the CHP service center employees and extended into community organizations. The training helped participants identify and assist individuals in mental health crisis. Staff members reported that 80 percent of Coloradans who have received mental health First Aid training are in Colorado Springs.

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

Contract References	Possible Discussion Topics
◆ Links to the National Alliance for Mental Illness' (NAMI's) Food for Thought educational sessions were added to the CHP website. ◆ A multi-faceted organization team convened to participate in a Lean process for improving community response for detoxification programs. CHP was working with El Paso County to determine a mechanism for Medicaid reimbursement for social detoxification programs. ◆ PCMPs' training on motivational interviewing. ◆ Educational programs and trainings to enhance sharing of information between PCMPs and BHO providers, including dispelling myths about data sharing and developing a mutually agreeable automated form and process for reporting mental health information to referring PCMPs every 90 days. An estimated 50 to 60 percent of RCCO members who receive behavioral health services do so through AspenPointe. The RCCO has a data sharing agreement with AspenPointe to enable care coordination for individual members and for population health analysis. Although care coordination services for "whole person" needs had been the RCCO's and its delegates' responsibility, AspenPointe implemented care coordinator positions in 2015 to support care coordination of members' behavioral health needs. An AspenPointe behavioral health care coordinator has been embedded into the CHP care coordination team and also provides support to the service center staff who assist members with accessing mental health service, participates in the practice transformation team, and provides resources to practices for behavioral health referrals. CHP and AspenPointe have been developing staff relationships and tools to support shared care coordination for members (e.g., release of information forms, care coordination form for reporting from the CMHC to the PCMP, a work flow for referrals from the PCMP to the CMHC, and a joint case review process for members with complex behavioral and physical health needs). Staff members described major challenges encountered in BHO/RCCO integration activities that included: physical health and behavioral healthcare systems are two different systems of service with different coverage and benefit responsibilities and different perspectives and approaches to care; the RCCO and BHO have two different payment systems, which require creative approaches for integrating behavioral and physical health services for individual members; and integrating care in rural areas of the region, where resources are scarce, requires unique solutions for different situations.
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	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 ◆ Increasing number of PCMPs with integrated BH ▪ C-PACK call center: consultation with child psychiatrist ◆ Increasing children attributed to PCMPs with integrated BH ◆ Increasing integrated BH/PH for at-risk adults ◆ Super-utilizers: Decreasing emergency department visits associated with chronic pain or BH issues

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

Contract References	Possible Discussion Topics
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) 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	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? ◆ 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?)

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

Contract References	Possible Discussion Topics
	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

Discussion and Observations:

CHP and AspenPointe use the Integrated Practice Assessment Tool (IPAT) to assess the varying levels of integrated behavioral and physical healthcare at individual practice locations. The IPAT includes progressive levels of practice integration defined as minimal collaboration, basic collaboration (either "at a distance" or "on-site"), close collaboration on-site with some systems integration, close collaboration approaching an integrated practice, and fully transformed/integrated practice. Staff stated that 15 PCMPs—including the largest PCMPs (Peak Vista, CSHP, and Dr. Johnson)—had co-located or integrated behavioral health services. Conversely, AspenPointe hired a nurse to participate in evaluation of individuals with primary medical needs. At the time of HSAG review, the CHP practice transformation team had assessed 16 additional practice locations, with three practices noted as having highly collaborative on-site behavioral and physical health services. Staff members developed strategies specific to each individual practice to advance the integration of services, as appropriate, and emphasized the importance of designing appropriate strategies for each level of integration in the continuum—co-location of providers may not be realistic or the most effective option for all practices. Staff members identified the vision as delivering "whole person" care through a number of mechanisms and the RCCO directed practice transformation support services to move practices along the integrated care continuum. CHP's strategies for improving integrated care included increasing the number of integrated care sites, improving the information technology infrastructure to support integrated care, developing a "priority service" line from the CHP service center to AspenPointe, increasing attribution of members with co-occurring physical and behavioral health needs to integrated delivery providers (as possible), increasing use of the PHQ-9 depression screening tool at primary care practices, and identifying data sources and capabilities for tracking the effectiveness of increasing member access to integrated care. CHP instituted a pay-for-performance program in 2016 to incent PCMPs to integrate use of the PHQ-9 in their practices.

CHP also submitted documentation and discussed results of co-location pilot projects with CSHP and Peak Vista.

- CSHP identified that medical patients with intense psychosocial issues—e.g., pain management patients— required excessive provider management and time. Therefore, with funding support from CHP, AspenPointe embedded a licensed professional counselor (LPC) in one clinic location to test the impact of on-site behavioral health assistance. Project evaluation documented increased satisfaction for members and physicians, deferred ED visits, increased

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Contract References	Possible Discussion Topics

access to CSHP for RCCO members, and $20,000 savings in member cost of care. The program was being expanded to three additional CSHP clinic locations for Medicaid and commercial members and being made available for an increasing number of conditions, such as insomnia.

- Peak Vista implemented a demonstration project in 2015 at one clinic site to develop an integrated care team to address the "whole person" needs of members with diabetes, hypertension, and coronary artery disease and to test patient outcome measures and different reimbursement methods.
- Peak Vista's Union Health Center implemented a multidisciplinary care team of behavioral health, medical health, pharmacy, and dental providers to test team-based care as a model for improved coordination of care for members.

CHP requested the BHO's ongoing participation in discussions regarding barriers to integrated behavioral and physical healthcare in the region including shortage of psychiatrists to provide medical management of behavioral health disorders, inability of small and rural practices to co-locate full-time counselors into their practices, inability of PCMPs to be reimbursed for a primary behavioral health diagnosis, and required copays to the PCMP for any office-based services. Staff stated that reimbursement issues related to all integrated practice models needed further exploration and resolution.

Other initiatives to address integrated care for members included:

- AspenPointe care coordinators are participating with RCCO care coordinators in on-site PCMP case conferences to discuss care plans for members with co-occurring mental and physical health issues. Staff members envision bi-directional and collateral care coordination processes evolving into integrated behavioral and physical health care coordination teams embedded in larger PCMP practices.
- PCMPs have access to the Colorado Psychiatric Access and Consultation for Kids (C-PACK) program for telepsychiatry consultation from child psychiatrists. CHP was considering a similar program for adult members. Initial implementation would focus at two or three Peak Vista sites and then expand to additional PCMPs. Staff stated that reimbursement issues for primary care mental health services needed to be addressed in relation to behavioral telehealth programs.

<u>Crisis Support Center</u>
AspenPointe is the crisis support center within Region 7. The RCCO care coordinators and service center staff members refer members to the crisis center as an alternative use of the ED. The statewide crisis hotline, CARES team, and community response team—mobile unit—also refer individuals to the crisis support center. Staff described the AspenPointe Crisis Stabilization Unit as only one component of a more global community response initiative that preceded the State-sponsored crisis support center system. Staff stated that the community crisis response initiative represented a paradigm shift from what the behavioral healthcare system traditionally offered to what the community needed. In October 2014, AspenPointe converted its crisis support program into a peer support model delivered within a comfortable living room-style atmosphere. The overall community response system also included a mobile response unit (enabled through the State crisis center grant funds), the CARES program response team, and other local safety providers such as law enforcement. Mobile teams provide on-site resources that reduced the need for medical clearance of individuals in crisis through local ERs. The community model addressed the need for respite

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

Contract References	Possible Discussion Topics

care, including four locations for residential care. The community initiative documented intervention protocols and numerous flow charts of disposition and coordinated communications for varying degrees of crisis intervention. Well-designed marketing materials promoted access to the crisis stabilization unit at AspenPointe as a safe environment where licensed professionals, peer specialists, and care coordinators could intervene with the individual and assist with referral to a broad range of services.

At the time of HSAG's review, the crisis stabilization unit was averaging more than 400 visits per month, with 17 percent requiring evaluation by a mental health practitioner and with the remaining visitors being connected to a peer counselor who could identify appropriate services. The crisis stabilization center carefully tracked the total number of clients, sources of referrals, days and times of center use, as well as other indicators. The majority of AspenPointe revenue was from Medicaid, and nearly 50 percent of crisis center visitors were able to be discharged home—with only limited need for psychiatric admission, ER admission, or mental health referral. Staff members were enthused with the communitywide involvement in developing a crisis support system for the region. A local media publication reported in February 2016 that the crisis support system was well-used.

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 Community Health Partnership (Region 7)

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

Table C-1—HSAG Reviewers and RCCO Participants

HSAG Review Team	Title
Katherine Bartilotta, BSN	Senior Project Manager
Rachel Henrichs	EQR Compliance Auditor
CHP Participants	**Title**
Amy Harder	Director, Community Strategies
Andrea Kedley	Lead Care Coordinator
Andrea Wood	Behavioral Health Coordinator, Colorado Springs Fire Department
Carol Bruce-Fritz	Chief Executive Officer
Cherie L Goby	Chief Operations Officer, Colorado Springs Health Partners
Chuck Cremeans	Supervisor, Community and Public Health
Colt Corman	Director of Clinical Operations, Peak Vista
Deb Knowles	Long Term Services and Supports Nurse Care Coordinator
Deborah Trout	Consultant
Fabian Mendoza	Care Coordinator, CHP
Gregory Morris	Chief Executive Officer, Ascending to Health Respite Care
Helen Rogers	Director of Clinical Operations, Peak Vista
Janet Winger	Chief Operations and Financial Officer
Jason DeaBueno	Vice President Health Services, AspenPointe
Jefferson Martin	Community and Public Health Administrator, Colorado Springs Fire Department
Jennifer S. West	Network Development Coordinator
Jim Calanni	Chief Technology Officer
Joe Farr	Director, Client Services
Joel Dickerman	Chief Medical Officer
Kathleen Kleinhuizen	Long Term Services and Supports Care Coordinator
Kathryn Dosch	Director, Healthcare Transformation
Laura Thomas	Manager, Community Projects and Pilots
Lori Williams	Care Coordinator Lead
Luz Tamayo	Manager, Transitional Care Coordination
Rebecca McCay	Vice President of Clinical Operations, Peak Vista
Ryan Smith	Senior Manager, AspenPointe (Service Center Manager)
Sarah Austin	Care Manager, Peak Vista
Sarah Quintana	Centralized Care Coordination Manager, Peak Vista

CHP Participants	Title
Shereeah Graves	Intern, Peak Vista
Susan Dymond	Director, Provider Services
Tina Gonzalez	Criminal Justice Systems Coordinator, Colorado Health Partnerships
Department Observers	**Title**
Anne Jordon	MMP Operations/Contract Manager
Christian Koltonski	Quality and Health Improvement Unit
Connor Carballido	Quality and Health Improvement Unit
Rachel DeShay	Contract Manager/Program Performance Specialist