COLORADO
Department of Health Care Policy & Financing

Fiscal Year 2016–2017 Site Review Report

for

Integrated Community Health Partners

Region 4

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

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Summary of On-Site Discussions

Introduction and Background

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

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

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

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

Summary of Results

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

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

Summary of Findings and Recommendations by Focus Area

Community Partnerships/Collaboration

Lessons Learned—Successes and Challenges

Region 4 is comprised of 19 counties—one designated as urban, nine designated as rural, and nine designated as frontier. Geographical boundaries within the region naturally divide it into three sub-regions—the San Luis Valley, Pueblo, and the "East" (area south and east of Pueblo)—each with cultural nuances.

At the inception of the RCCO, the perception of communities throughout the region appeared to be that the State was displeased with the work being done by area agencies and that the RCCOs were formed to "clean it up." This perception created an unwelcoming environment for the RCCO—agencies were resistant and resentful. **ICHP** overcame this by partnering with the federally qualified health centers (FQHCs) and community mental health centers (CMHCs) already well established in the communities. **ICHP** staff members attended meetings across the region, sharing emergency room (ER) and well-child

visits data specific to each subregion while gathering information about issues facing each area, common interests, and opportunities for collaboration.

ICHP care coordinators noted that their relationships with the community centered boards (CCBs) and single entry points (SEPs) improved dramatically over the last few years. **ICHP** recognized that in some cases, introducing itself to members as an agency responsible for coordinating care confused members already receiving care coordination services from CCBs and SEPs. To address this issue when it arises, the **ICHP** care coordinator assesses the member's needs and makes a determination with the SEP/CCB about who should take the care coordination lead. In circumstances where the SEP/CCB is designated the lead care coordination entity, **ICHP** care coordinators assume the role of "coordinating the coordinators" to ensure that the lead entity and the member are both receiving the support they need. By taking a backseat approach when appropriate, **ICHP** allowed relationships with SEPs and CCBs to grow and strengthen organically. Today, **ICHP** care coordinators classify their relationships with area CCBs and SEPs as being very strong. These agencies frequently contact **ICHP** care coordinators for help with cases.

After hosting several MMP protocol meetings in areas south of Pueblo with little attendance, **ICHP** noted that its meetings conflicted with similar meetings already being held in the area. Rather than competing for attendance, it worked with the Aging and Disability Resource Center (ADRC) to combine meetings in Trinidad and La Junta and with the Chaffee County Health Coalition to align common goals and avoid duplication of effort and resources. **ICHP** provides this diverse and active group of agencies updates from the State, shares data and trends specific to the region, and helps to identify gaps in services and troubleshoot challenges facing these communities. The success of this shared format has prompted **ICHP** to propose similar shared forums within other communities.

One of the benefits to working in rural areas is that relationships among FQHCs, CMHCs, Departments of Human Services, Departments of Social Services, and child and adult protective services pre-dated the RCCOs. These agencies have been collaborating for years to address needs of shared members. In some areas of the region, care coordinators from each agency meet with one another as needed to address needs for specific cases, while directors meet quarterly to address system issues and track developments. These relationships continue to grow and strengthen as staff recognize efficiencies and streamline processes.

Other examples of community collaboration and involvement include **ICHP**'s participation in:

- Alliance for Food Access program, to improve access to fresh, healthy food. One element of this program offered gas stations grant funds to offset the cost of buying refrigerators and shelving needed to offer healthy options.
- Directing Others To Service (DOTS) program in collaboration with the Pueblo Fire Department, whereby first responders identify individuals who call 9-1-1 frequently for non-emergent medical issues; meet with them to assess their needs; and connect them with services more appropriate than the ED.

- Pueblo Interagency Community Council (PICC) and Pueblo Early Childhood Council (PECC), focused on reducing obesity-related chronic illness and reducing teen and unintended pregnancies.
- Southeast Colorado Transitions Consortium, a work group of professionals from hospitals; FQHCs; CMHCs; home health agencies; hospice; fire department; plus other individuals—all striving to identify and address causes of readmissions and inappropriate use of emergency departments (EDs).
- Rural Initiatives Program, Colorado Coalition for the Homeless, Wellspring Vineyard Christian Fellowship, Chaffee Housing Policy Advisory Committee, and Southeast Colorado Transitions Consortium, to address housing issues and deliver support services to homeless families and individuals.

During on-site interviews, **ICHP** staff members commented that implementation of the Colorado Opportunity Project allowed **ICHP** to work more closely with programs such as Women, Infants, and Children (WIC); Baby and Me, Tobacco Free; Nurse Family Partnership; Colorado Family Planning Initiative; Family Resource Network; and Temporary Assistance for Needy Families (TANF).

ICHP has experienced less success working with the criminal justice system. Staff members identified the lack of reliable data as being one of the major barriers to serving this population. Additionally, while the RCCO struggles to understand how the criminal justice system works, the criminal justice system is equally baffled by the operations of the healthcare system. Each county criminal justice system operates independently; therefore, **ICHP** is tasked with coordinating with 19 different agencies. This is one area that **ICHP** staff members felt the Department could have provided more direction and preparatory work by providing sheriff departments advance notification of the Medicaid initiative and providing RCCOs with contact information.

Moving forward, **ICHP** recognizes the enormous potential of working more closely with the faith-based community on initiatives to outreach members and to provide wellness and prevention programs. Additionally, **ICHP** began working with area schools to offer internships and to develop care coordination curriculum. **ICHP** also continues to work with area agencies to address the lack of transportation.

Observations and Recommendations

Years of perseverance have resulted in **ICHP**'s integration into the communities it serves as a valuable partner in promoting healthy communities. **ICHP** partnered with agencies already well-established and respected in the communities and then allowed those partners to operate autonomously with unwavering RCCO support. **ICHP** appears to be a respected and valuable partner in communities across the region.

Provider Network/Provider Participation

Lessons Learned—Successes and Challenges

ICHP is structured as a partnership among three FQHCs (Valley-Wide Health Systems, Inc. [Valley-Wide], High Plains Community Health Center, and Pueblo Community Health Center) and four CMHCs

(Health Solutions, San Luis Valley Behavioral Health Croup [SLVBHG], Southeast Health Group, and Solvista Health). This structure fosters involvement of each agency in all aspects of the RCCO. **ICHP**'s initial focus community included only FQHCs in Pueblo and Fremont counties. As it began to expand its provider network, **ICHP** found many providers unwilling to participate; providers had previously experienced failed managed care programs and were skeptical of the ACC/RCCO model. Nevertheless, **ICHP** slowly increased its network by targeting all pediatricians in the Pueblo area, all FQHCs, providers identified through claims systems as already serving Medicaid members, providers specifically requested by members, and providers in areas with little to no participation. Today, **ICHP**'s network covers all 19 counties and includes 48 primary care medical providers (PCMPs) with 108 sites and more than 300 rendering providers.

The chief executive officer of each **ICHP** partner organization sits on the **ICHP** board of directors. Providers from the FQHCs and CMHCs, as well as other PCMPs and rural health clinics, participate in **ICHP**'s Medical Management Committee. Additionally, executives, providers, and care coordinators participate in the Performance Advisory Committee to identify and design pilot programs, projects, and initiatives.

ICHP's partner, Valley-Wide, employs a variety of medical and dental practitioners. Seven of Valley-Wide's 16 clinics have co-located behavioral health providers, and Valley-Wide is beginning to place physical health providers at behavioral health clinics. Health Solutions also has co-located behavioral health services in several medical clinics, including one that specializes in treating substance use disorders (SUDs). SLVBHG has co-located behavioral health services in those clinics for which they also provide member care coordination; while Southeast Health Group, a CMHC, offers embedded medical services for the purposes of addressing member pain management, SUDs, and addiction. **ICHP** hopes to further expand the behavioral health co-location model; however, the co-location model demands a different approach to treatment, and staff expressed that challenges included ensuring a good fit between the behavioral health professional and the primary care staff; working with primary care practitioners who do not understand the value of integrating behavioral health services into their practices; and having an adequate work force in rural/frontier areas to provide staff necessary for integration.

Another challenge to implementing integrated practices relates to the inability of behavioral health providers to bill for services delivered in the medical system—i.e., a behavioral health provider will participate in a physical health appointment, but there is no allowable reimbursement. Clinics have been forced to implement creative solutions in order to financially sustain this model. For example, a behavioral health provider might spend half a day attending behavioral health appointments and the second half at the physical health clinic. Another scenario used allows the behavioral health provider to schedule designated behavioral health appointments throughout the day, although members attending these appointments are notified in advance that the clinician may be interrupted to address urgent behavioral health situations that arise within the clinic.

ICHP representatives stated that the co-location model was initially cumbersome—physical health providers did not know how to appropriately incorporate the behavioral health practitioner. However, this situation has evolved such that practitioners within clinics with co-located behavioral health services

have become so dependent on each other that they cannot imagine treating patients without co-located services. During early years of operation, **ICHP** approached performance improvement initiatives by expecting all providers to implement projects uniformly. Over the years, **ICHP** learned that many of its initiatives did not align with an individual provider's goals and initiatives. **ICHP** was viewed as policing practices, creating an atmosphere of resentment. In recent years, **ICHP** has shifted its focus to what the provider deems most important—**ICHP** asks providers, "What are you working on, and how can I help?" Staff reported that this approach has resulted in considerably more provider cooperation, translated into better outcomes, and transcended to providers requesting **ICHP** for assistance with their goals. Staff shared an example of implementing a program to improve early and periodic screening, diagnostic, and treatment (EPSDT) rates at one clinic. As rates improved, more providers started asking that the same program also be implemented at their clinics. At the time of the site review, two additional clinics were due to implement similar programs.

ICHP initiated a project to offer providers a facility disability assessment—**ICHP** sends a staff member to the clinic (no matter how remote) to assess the facility's compliance with Americans with Disabilities Act (ADA) specifications. After identifying areas where improvement is warranted, **ICHP** directs providers to resources for assistance with funding needed to make necessary changes. Improvements range from simple adjustments—i.e., how furniture is arranged in the waiting room—to parking lot renovations. In addition to ensuring more appropriate access for members with disabilities, this process allows **ICHP** to educate providers with disability competency training as well as updates on **ICHP** and statewide initiatives.

ICHP suggested that the Department's physical staff presence throughout the region has been a great benefit, with providers and stakeholders seeking more direct communication from the Department. **ICHP** suggested that ACC staff and contract managers visit clinics and attend community meetings. **ICHP** also suggested that the Department revisit its efforts to expand hospital participation in Colorado Regional Health Information Organization (CORHIO). **ICHP** staff estimated that several hospitals in its region still do not participate in the health information exchange, and it appears that no new recruitment has occurred over the last 18 months. Additionally, staff speculated that ongoing issues with attribution could be mitigated by allowing select staff from each RCCO to access the State data system and update it with accurate attribution and contact information as well as with member mortality data.

ICHP requested that the Department involve RCCOs and providers early in the process of identifying statewide initiatives, enabling RCCOs and providers to identify barriers early in the process. Staff referenced the Department's recent initiative to improve depression screenings as an example in which early collaboration could have alleviated frustrations—i.e., tracking mechanisms failed to account for FQHCs that bill bundle encounter rates with no way to account for depression screenings. **ICHP** provider partners referenced this as an example of a Department mandate that could inadvertently result in diverting attention away from providing a service to focusing on how to measure that same service.

Staff offered praise for the Department's tolerance of incremental improvements in practice transformations, stating that more than 30 different electronic health record systems are currently implemented in practices throughout its region.

Observations and Recommendations

ICHP seems to have improved relations with its diverse providers by adapting its approach to identify individual provider areas of concern and aligning those with **ICHP**'s initiatives. **ICHP** experiences less provider resistance, the provider receives help in areas meaningful to the practice, and the member receives enhanced care and better outcomes. As providers experience positive encounters with **ICHP**, they share those experiences with other providers, resulting in both simple paradigm shifts in provider relations and practice transformations.

Member Engagement

Lessons Learned—Successes and Challenges

ICHP staff defined "member engagement" as outreach to members (dialogue between member and care coordinator about healthcare) and as individuals' active participation in their own healthcare. Staff members stated that a member is engaged when he or she is medically and behaviorally stable (to the extent possible), is connected with a medical home, has support and advocacy, and is able to function at his or her highest potential in the given environment.

ICHP staff members stated that member engagement is primarily a function of providers interacting with their members. **ICHP** supports the providers with training, assessments, and feedback. For example, as part of the disability assessment, **ICHP** staff educated providers about issues facing people with disabilities and helped providers view situations from a member's perspective. **ICHP** also offers staff and providers training including motivational interviewing, solution-focused interventions, and a variety of cultural competency training. These trainings and provider awareness help to ensure that members' interactions with providers are positive.

ICHP also fosters member engagement by ensuring that customer service staff members are respectful, knowledgeable, and efficient. **ICHP** assists members by hosting prevention and wellness programs across the region. **ICHP**'s member services department hosts quarterly forums in each subregion. There, members are invited to meet with care coordinators, customer service, and other **ICHP** staff to ask questions and learn about health topics. **ICHP** staff members review member rights; discuss benefits and services available, and how to access them; and provide tools that members can use to better manage their health. Most importantly, **ICHP** staff ask members, "How can **ICHP** serve *you* better?"

ICHP increased the number of members who participate in the Performance Advisory Committee (PAC) from two to five, and staff members continue to actively recruit additional members. **ICHP** recently invited a member to share with the PAC his experiences as an immigrant; providers engaged the member with questions and appreciated the perspective. **ICHP** continued this theme of communicating the member perspective by including in its provider newsletters articles written by members.

Staff members stated that as the RCCO matured **ICHP** recognized that mailings and brochures do not engage members. **ICHP** staff engage members one on one, face-to-face in the doctor's office, in the

home, and in the community. Members suggested that **ICHP** engage members "where they are" by attending car shows and community baby showers. Over the past two years, **ICHP** care coordinators have increasingly transitioned to operating in the field.

ICHP staff suggested that the Department could improve member engagement by ensuring that Health First Colorado customer service calls are answered promptly and that staff members are courteous and helpful. The Department can also assist RCCOs by providing more timely and accurate data regarding member utilization, attribution, and contact information. **ICHP** commended the Department on its member newsletters, website, and the simplicity of the new handbook.

Observations and Recommendations

Member engagement has been one of **ICHP**'s focal points since its inception, and its approach has steadily evolved to address member engagement from multiple perspectives. **ICHP** helps to ensure positive member engagement by educating and training its staff, providers, and the members themselves. **ICHP** is enhancing member engagement by providing a forum that allows members to share about their personal experiences with the healthcare system. **ICHP** also requires that staff members who interact with members participate in ongoing educational opportunities to ensure that staff members are respectful, knowledgeable, and efficient. **ICHP** hopes to empower members by offering opportunities for prevention and wellness education throughout the year and across the region.

Care Coordination

Lessons Learned—Successes and Challenges

ICHP implemented full delegation of care coordination from the inception of its contract through the three FQHC and four CMHC partners. FQHCs provide care coordination for members attributed to their clinics. CMHCs provide care coordination for members attributed to non-FQHC medical practices located within the CMHC catchment areas. **ICHP** offered PCMPs the option of conducting care coordination; however, many declined after realizing the extensive scope of ACC-defined care coordination requirements. Approximately one year into the contract, **ICHP** hired additional staff and the CMHCs assumed primary responsibility for coordinating care for members affiliated with independent PCMPs. **ICHP** care coordination teams were assigned to their local community subregions; therefore, each team was afforded intimate understanding of the cultural nuances within the community. This understanding—paired with established, community-based relationships—proved exceptionally effective for care coordination activities, and these are believed to be the keys to **ICHP**'s successful outcomes. **ICHP**'s model for care coordination has remain unchanged since inception.

ICHP maximizes efficiencies of care coordinators by hosting monthly work groups where care coordinators from across the region meet to share information, troubleshoot difficult cases, and discuss upcoming meetings and events. Coordinators may participate in site visits and meetings across the region to share best practices.

Another critical component to successful care coordination is the ability of care coordinators to access clinic electronic health records (EHRs) when the care coordinator is embedded within a practice. One of the challenges to integrating care coordinators into practices is the misunderstanding of providers regarding the role of the care coordinators. **ICHP** stated that its independent clinics are not required to allow care coordinators access to records, staff, or patients. While some clinics allow appropriate access, other practitioners fail to see the value of care coordinators and underutilize them; and yet others require care coordinator "double-duty"—behavioral health services and care coordination. **ICHP** is working to overcome this barrier by educating providers about appropriate roles and benefits of care coordinators. Additionally, **ICHP** encourages networking among providers to spread the message from those practices which have embraced integrated care coordination to those practices that seem resistant.

Staff stated that care coordination challenges remain related to engaging particular member populations such as: those in the MMP, those involved with the criminal justice system, and those who have SUDs. Details include:

- The process of completing a service coordination plan (SCP) for every MMP member was a substantial burden that appeared duplicative and wasteful. Care coordinators invested countless hours collecting information already available in various documentation systems. In addition, **ICHP** encountered some insurmountable barriers accessing members in SNFs, completing SCPs, and establishing if **ICHP** or the SNF would serve as lead coordinator. **ICHP** found that most MMP members were already well engaged in services and that members who do require services will most likely be identified through an ER visit, provider referral, or transition of care.
- Struggles working with those involved with the criminal justice system related to lack of availability of accurate data, difficulties locating members, and obstacles encountered in assisting those members who are released from prison in Region 4 but live in a different region.
- **ICHP** identified that inadequate transition planning for members released from substance use treatment facilities resulted in members returning to communities with little to no follow-up care or support. Staff members stated that as members relapse they lose confidence in their abilities to recover; meanwhile, the healthcare system loses its financial investment in the member's treatment. Additionally, different sources of funding for SUD residential and outpatient treatment result in continuing care challenges and provider confusion.

Observations and Recommendations

ICHP staff members presented 10 coordination of care cases. Most of those cases involved members with extensive diagnoses and who appeared to truly benefit from coordinating care among multiple providers. Other care coordination services most commonly provided included transportation, housing, and assistance with filling out and tracking paperwork and applications. In every case, the member's willingness to participate proved critical to successful outcomes.

HSAG noted that, overall, care coordinators seemed to be more efficient than in prior years in addressing identified needs and services and speculated that these efficiencies were due to a more in-

depth understanding of resources available in the area and how to access them. Care coordinators' longevity with **ICHP** also likely contributed.

HSAG noted that care coordinators appeared to more widely embrace the comprehensive care coordination requirements of the RCCO contract—i.e., they addressed more than referrals to specialists, including attending to numerous behavioral and social needs. Record reviews demonstrated that care coordinators routinely assisted members with securing: transportation, housing, food, clothing, and financial assistance with utilities and prescriptions. Documentation has also improved greatly over the years, and records regularly included details such as the member's social and family supports and cultural considerations. **ICHP** records demonstrated a robust and effective system of care coordination.

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

Lessons Learned—Successes and Challenges

Since the inception of the ACC program, **ICHP** has participated in countless grants and program opportunities offered or enabled through the Department, other sources, or legislative actions. These included the Super Utilizers Program, the Enhanced Primary Care Medical Provider (EPCMP) initiative, the State Innovation Model (SIM), and the Client Overutilization Program (COUP). **ICHP** staff expressed confidence about their success in aligning Department-driven initiatives with the priorities of communities and providers.

When presented with a new opportunity, **ICHP** considers: how the project aligns with existing goals of **ICHP**, the Department, and **ICHP**'s communities; potential impacts on partners, providers, and member outcomes; availability of resources; how a project's impact will be measured and who will measure it; and whether or not the project promotes better integration. Internal staff members review new opportunities to determine viability before presenting them to the PAC, Medical Management Committee, and board of directors. **ICHP** presents opportunities to its committees in order to collect feedback and guidance regarding potential issues with implementation and to determine where the project best fits within **ICHP**'s model. **ICHP** believes that partner and provider support of **ICHP**'s involvement in a project is critical to successful implementation and outcomes. **ICHP** also relies on these committees to provide ongoing feedback as projects are implemented.

Once a project is approved for implementation, **ICHP** will conduct a pilot study with one or two willing partners or providers—preferably one in Pueblo and a second in a rural or frontier area. Implementing a pilot study allows **ICHP** to identify and address issues that may present during implementation and to determine amounts and types of resources required. This information is critical when deciding if a project should be continued and what other communities have the resources necessary to implement similar projects.

One key to the success of a project is the amount of provider interest exhibited. Like **ICHP**, providers also struggle with managing administrative oversight and monitoring of multiple programs and projects.

For this reason, **ICHP** no longer expects that all providers participate in all projects. **ICHP** staff work closely with providers to select and implement programs and projects that **ICHP** believes will help providers to achieve goals and priorities related to their specific practices. **ICHP** staff members acknowledged that because many of the Department's projects and initiatives (e.g., SIM and EPCMP) promised providers additional financial resources, **ICHP** used these projects to gain access to practices otherwise unwilling to work with **ICHP**.

ICHP credited the success of its programs to the flexible manner in which the Department allows each RCCO to operate. Additionally, **ICHP** staff members expressed gratitude for the availability and responsiveness of Department staff members. **ICHP** suggested that the Department could provide additional support by more frequently sending its staff members on provider site visits and to community meetings. In addition to demonstrating to **ICHP**'s partners and providers that the Department is committed to the RCCO programs, this kind of community involvement affords Department staff members a more comprehensive understanding of challenges encountered in the field.

ICHP staff suggested that the Department could better support RCCOs by allowing RCCOs and providers to give feedback and guidance prior to implementing new initiatives. RCCO staff members, community partners, and PCMPs have valuable information regarding what systems are already in place and how those systems can most efficiently and effectively be leveraged to meet Department goals. **ICHP** also suggested that the Department align key performance indicators (KPIs) with best practice literature and existing measures across programs. **ICHP** recommended that the Department streamline its communications with the RCCOs and noted that multiple committees and subcommittees tend to silo information channels.

Observations and Recommendations

ICHP has been actively engaged in Department initiatives, grants, and special projects as well as grant funding opportunities outside the Department. **ICHP** carefully ensures that its programs support the Department's ACC strategies, while addressing the needs of its partners, providers, and communities. This aligning of goals is made possible because of the Department's willingness to allow each RCCO autonomy in implementing specific programs. **ICHP** strives to demonstrate the value of this autonomy by carefully monitoring data and quickly terminating unsuccessful projects. **ICHP**'s close collaboration with the Department and partners contributes to a better system of healthcare.

Overview of Site Review Activities

The FY 2016–2017 site review represented the sixth contract year for the ACC program. The Department asked HSAG to perform an annual site visit to assess continuing development of **ICHP** as the RCCO for Region 4. During the initial six years of operation, each RCCO continued to evolve in operations, care coordination efforts, and network development in response to collaborative efforts, input from the Department, and ongoing implementation of statewide healthcare reform strategies. The FY 2016–2017 site visits focused on evaluating RCCO experiences and lessons learned related to diverse ACC stakeholders and regional characteristics—including community partnerships, provider participation, member engagement, and integration of multiple Statewide and regional priorities. In addition, HSAG gathered follow-up information on care coordination activities and strategies implemented by each RCCO. Through review of member care coordination cases, HSAG documented examples of RCCO-selected "best" cases of comprehensive care coordination. The Department also asked HSAG to offer observations and recommendations related to each ACC focus area reviewed.

Site Review Methodology

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

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

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

Appendix A. Focus Topic Interview Guide

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

Focus Topic 1: Community Partnerships/Collaboration

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

Focus Topic 2: Provider Network/Provider Participation

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

Focus Topic 3: Member Engagement

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

Focus Topic 4: Care Coordination

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

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

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

Appendix B. Record Review Summaries

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

Appendix C. Site Review Participants

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

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

HSAG Review Team	Title
Kathy Bartilotta, BSN	Senior Project Manager
Rachel Henrichs	External Quality Review (EQR) Compliance Auditor
ICHP Participants	**Title**
Alma Mejorado	Public Relations Director, Beacon
Becky Encizo	Chief Operations Officer; Performance Improvement Director
Charlotte Yianakopulos-Veatch	Health Solutions
Chris Senz	Chief Executive Officer, ICHP
Dan Samora	Valley-Wide Health Systems
Enid Agosto	Public Relations Manager
James H. Martinez	Valley-Wide Health Systems, Alamosa
Karla Cordova	System Integration Coordinator, ICHP
Kolbie Connally	Supervisor of Integrated Health, Health Solutions
Leova Villalobos	Valley-Wide Health Systems
Lisa Clements	Vice President of Transformation, Beacon
Lynne Bakalyan	Director, Member Services
Matthew Wilkins	Director of Integrated Healthcare, Health Solutions
Rebecca Hearst	Care Coordinator, Health Solutions
Robert Harasimowicz	Public Relations Manager
Sean Walsh	ICHP Quality
Terry Krow	ICHP
Tina Gage	ICHP
Vanessa Peck	Team Leader, ICHP
Vickie White	Care Coordinator, Valley-Wide Health Systems—Alamosa
Victoria Romero	Clinical Director, SLVBHG
Department Observers	**Title**
Christian Koltonski	HCPF
Michael Gratton	HCPF
Rahem Mulatu	HCPF
Sophie Thomas	ACC Communications, HCPF