3.12.2020

Colorado Access Care Coordination Model/Program

ACCESS MANAGEMENT SERVICES LLC

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Colorado Access Behavioral Health Care Management

- Behavioral Health Transitions of Care Model:
  - Behavioral Health Care Managers are assigned to hospitals and follow every RAE 3/RAE 5 member admitted
    - If a member is attributed to a Mental Health Center (MHC), the MHC may provide care management for the member
  - Care Managers coordinate with
    - Hospitals
    - Providers
    - Directly with members
    - GOAL: ensure members are connected to care upon discharge. This includes but is not limited to ensuring members complete intakes at MHC's, referring them to appropriate therapists based on modalities, psychiatrists, connecting to SEP services.

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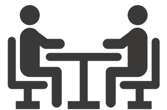
Colorado Access Behavioral Health Care Management

- Behavioral Health Transitions of Care Model:

Care Management receives referrals from Utilization Management. Providers submit a Prior Authorization for to UM. UM then notifies Care Management of care management needs.



Some care managers are co-located in the hospitals to provide increased communication regarding member needs, recommendations, and continuity of care.

Care managers connect with members post discharge to ensure their needs were met and that aftercare appointments are made.

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Colorado Access Behavioral Health Care Management

- Extended Care Coordination:
  - Care managers provide extended care coordination for complex members who have:
    - Rapid readmits
    - Creative Solutions Calls
    - Medical needs
    - Ongoing stressors that require attention past the transition from the hospital to the community.
    - A need to admit to Fort Logan
    - Multiple system involvement
    - Ongoing provider needs

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- How to Connect to Care Management
  - If a member is psychiatrically hospitalized:
    - Care management will receive an admit notification from utilization management and that member who is psychiatrically hospitalized will be connected to a care manager.
  - If the member is not hospitalized, you may email BHCareManagement@coaccess.com and a care manager will be assigned to you.

Colorado Access Physical Health Care Management

Physical Health Transitions of Care:

- Care managers work with Region 3 and Region 5 members who have been admitted to the hospital for a physical health condition.
- Care managers are assigned to support hospitals in the Denver Metro Area
- Referrals are received via CORHIO daily feeds and direct hospital referrals
- Care managers work with the hospital, members and their provider teams to ensure once the member is discharged that they have the right resources, follow up, and care in place.
- Care managers may meet the members in their homes, at providers appointments, or in the community
- Assessments and care plans are developed to fit the member’s unique needs

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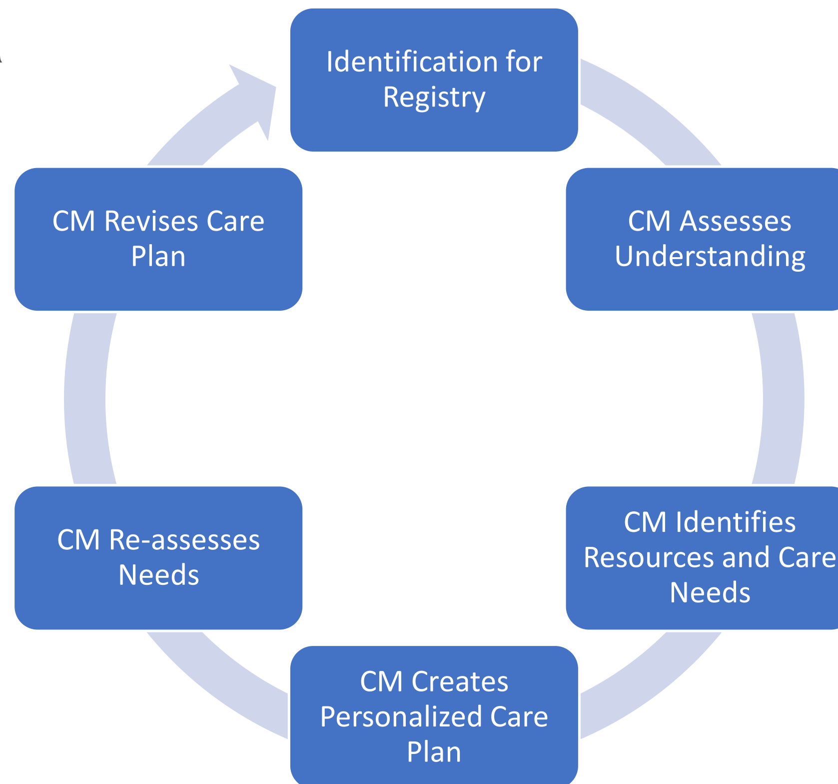
COA Physical Health Care Management

Clinical Registry Work (for both RAE members and CHP members):

- Colorado Access has condition specific clinical registries which are part of our Potentially Avoidable Costs program aka PAC:
  - Diabetes
  - Asthma
  - COPD



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COA Physical Health Care Management

Healthy Mom Healthy Baby(for both RAE members and CHP members)

- Care managers assist pregnant women with:
  - Ensuring appropriate care/support throughout their pregnancy as well as postpartum
  - Care managers identify gaps and barriers and assist members in mitigating those barriers

- Assessments and care plans are developed to fit the member's unique needs

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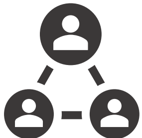
Colorado Access COUP Program

- COUP Members

  - Care Management targets members who are identified as members with excessive patterns of inappropriate pharmaceutical use and emergency department utilization. CM prioritize working with these members in order to assist with over-utilization or in appropriate use of these services.

Care Management works with these identified members to assist with connecting them to an appropriate Primary Care Medical Provider



Care Management performs assessments on identifying social determinants of health for COUP members and assist with getting them connected to resources and other providers as needed.

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Colorado Access Criminal Justice Program

- Criminal Justice
  - Care Management targets members who are transitioning from incarceration back to the community by connecting these members with services, providing referrals and ensuring connection with community-based care.
  - Care Management has worked on creating relationships with county human services departments to offer a more direct approach with connecting to members and understanding their needs.
  - Care Management performs assessments on identifying social determinants of health for Criminal Justice members and assists with getting them connected to resources, primary care medical provider, and other providers in the community as needed.

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Colorado Access- EPSDT and Child Welfare Programs

EPSDT

- A care manager is assigned to assist providers and members when requested services are "Not a Covered Benefit"
- This care manager assists community partners with understanding funding of and the coordination for benefits under the RAE.

Child Welfare

- A care manager is assigned to assist Department of Human Services with needs of member's in foster care or involved with child welfare.
- DHS can reach out directly to this care manager to assist with needs when a member is not hospitalized or does not meet criteria of other programs.

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Strengths and Challenges

- Strengths for Care Coordination
  - Collaboration with Community Mental Health Centers
  - Partnerships with multiple counties and Department of Human Services
  - Improved quality of chronic disease management
  - Better access to specialty care.
- Challenges for Care Coordination
  - SUD/42 CFR
  - Larger population of members experiencing homelessness
  - Social Determinants such as income, education, literacy, physical environments, etc.

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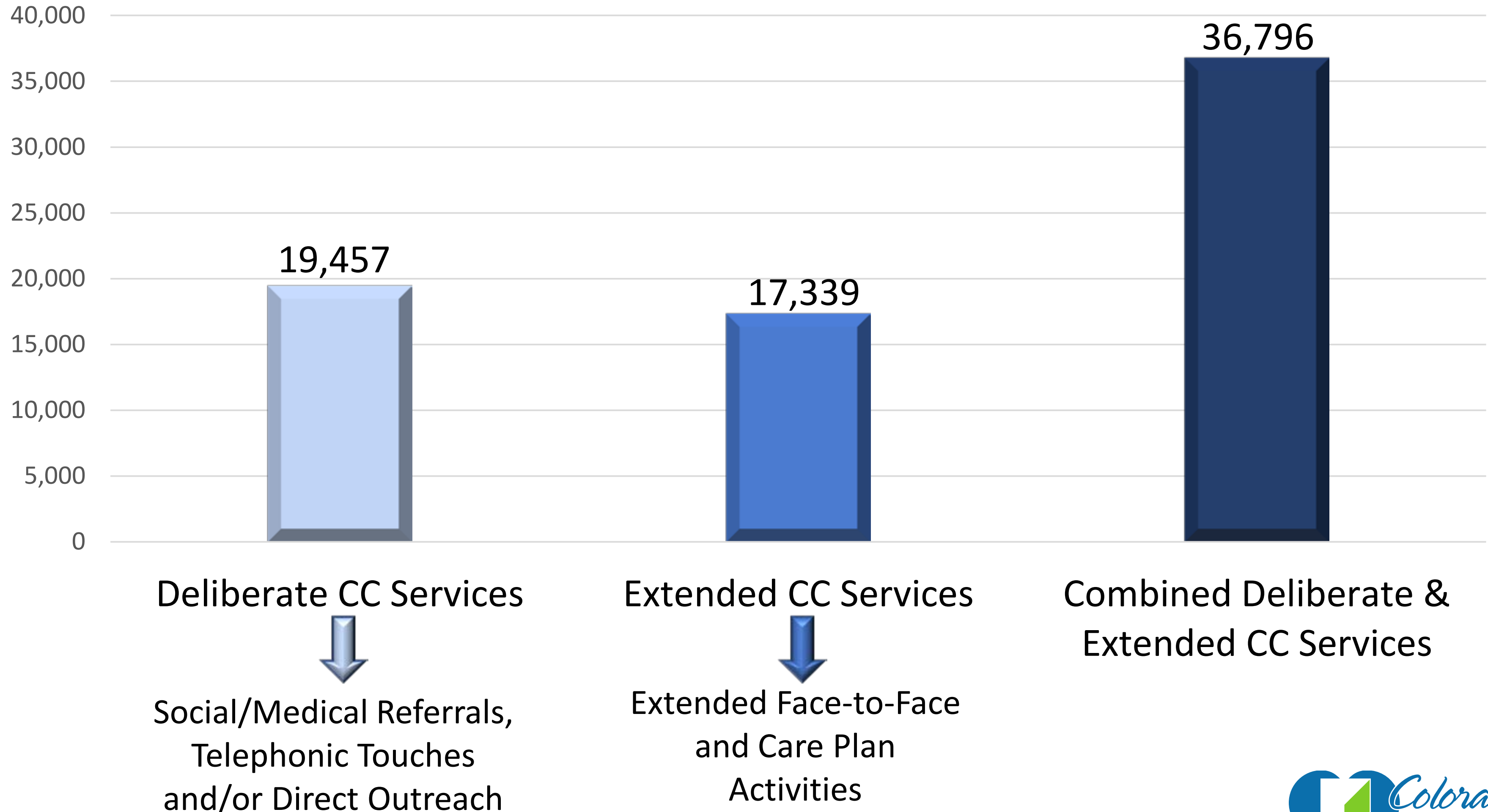
SFY 18/19 Care Coordination Data



SFY 18/19 Care Coordination Data