Provider and Community Subcommittee
March 12, 2020

Presenter:

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Who is Health Colorado, Inc.?

- *Health Colorado, Inc. (Health Colorado/HCI) is a purpose-built company that was created to serve the Department of Health Care Policy and Financing (the Department) and Colorado's Medicaid Members as the Region 4 Regional Accountable Entity (RAE). As a region, we identified a need for a new type of partnership bringing together local, experienced organizations that serve the physical and behavioral health needs of Members, as well as the care coordination, education, transformation, and administration needs of the Department and the local provider community. By joining forces with Valley-Wide Health Systems, Inc., Health Solutions, Beacon Health Options, Inc., San Luis Valley Behavioral Health Group, Solvista Health, and Southeast Health Group, this new partnership brings experienced Medicaid providers and service organizations together.*

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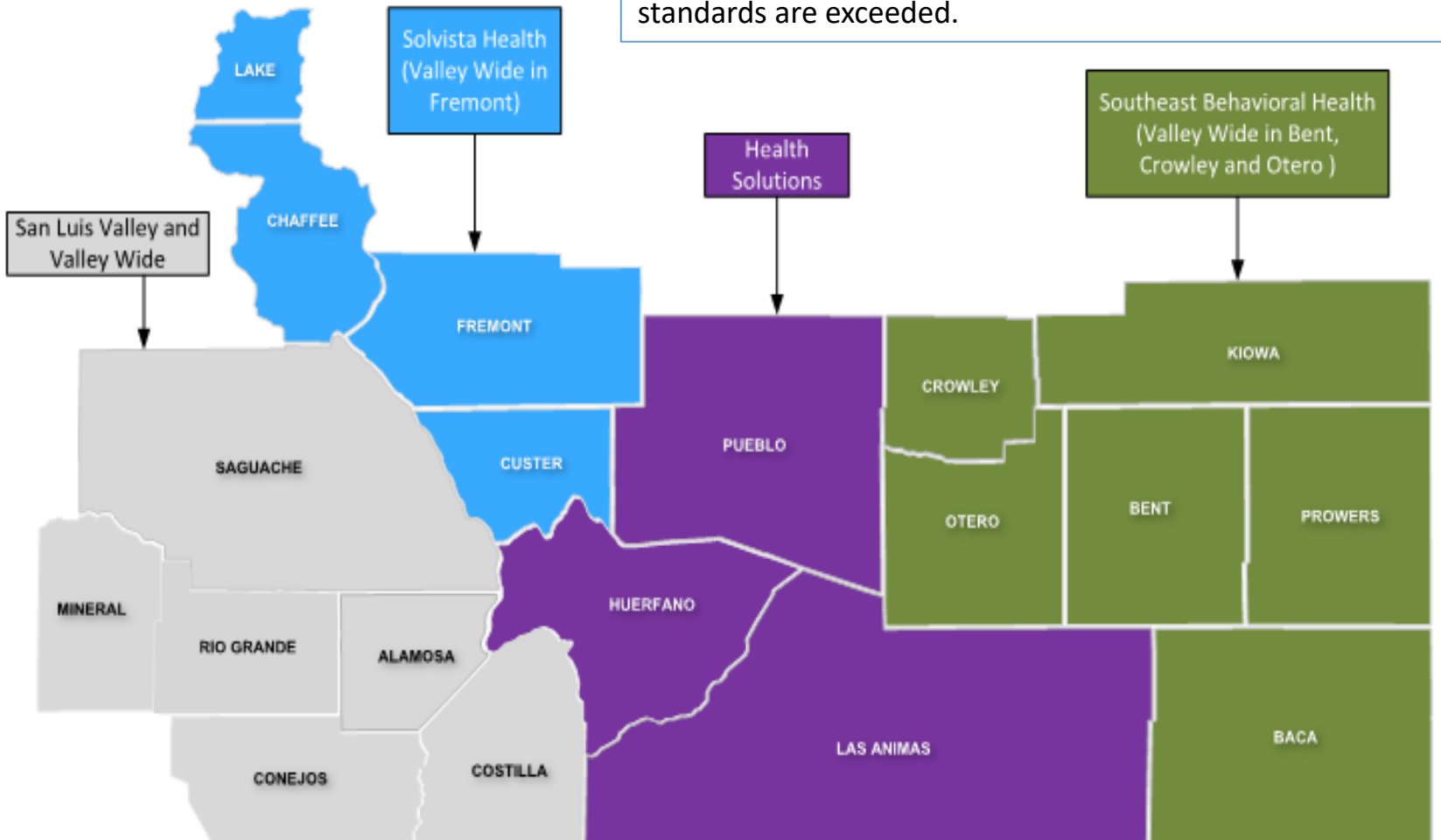
Who is Health Colorado?

Region 4—Health Colorado Service Area

11 of the state's 14 poorest counties exist in our region and transportation issues resulting from our geography and seasonal road conditions can complicate access even when network adequacy standards are exceeded.



- Serving members in 19 Counties
- Covering nearly 30,241 square miles
- Accountable for approx. 120,000 members

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Who are the Delegated Care Coordination Entities?

- Health Solutions
- High Plains
- Salud
- San Luis Valley Behavioral Health
- San Luis Valley Medical
- Solvista
- Southeast Health Group
- Valley Wide

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Care Coordination

- *Health Colorado, Inc. (HCI) continues to integrate behavioral and physical health care coordination, strengthen care support, and improve overall health among Medicaid members through its delegated care coordination model.*
- *Our belief is that care management must address members' medical, behavioral and social needs in an integrated fashion and address the full continuum of acute, chronic, long-term services and supports, and preventive health needs.*
- *HCI supports Core Components of a Unified Strategy for delivering care coordination, including a preemptive member-directed algorithm for assessment and intervention; hybrid workforce that integrates centralized and embedded Care Coordination; collaborative platform (Essette) with a low barrier of entry for use and an interoperable data model that is application-agnostic and can reach the point of care.*

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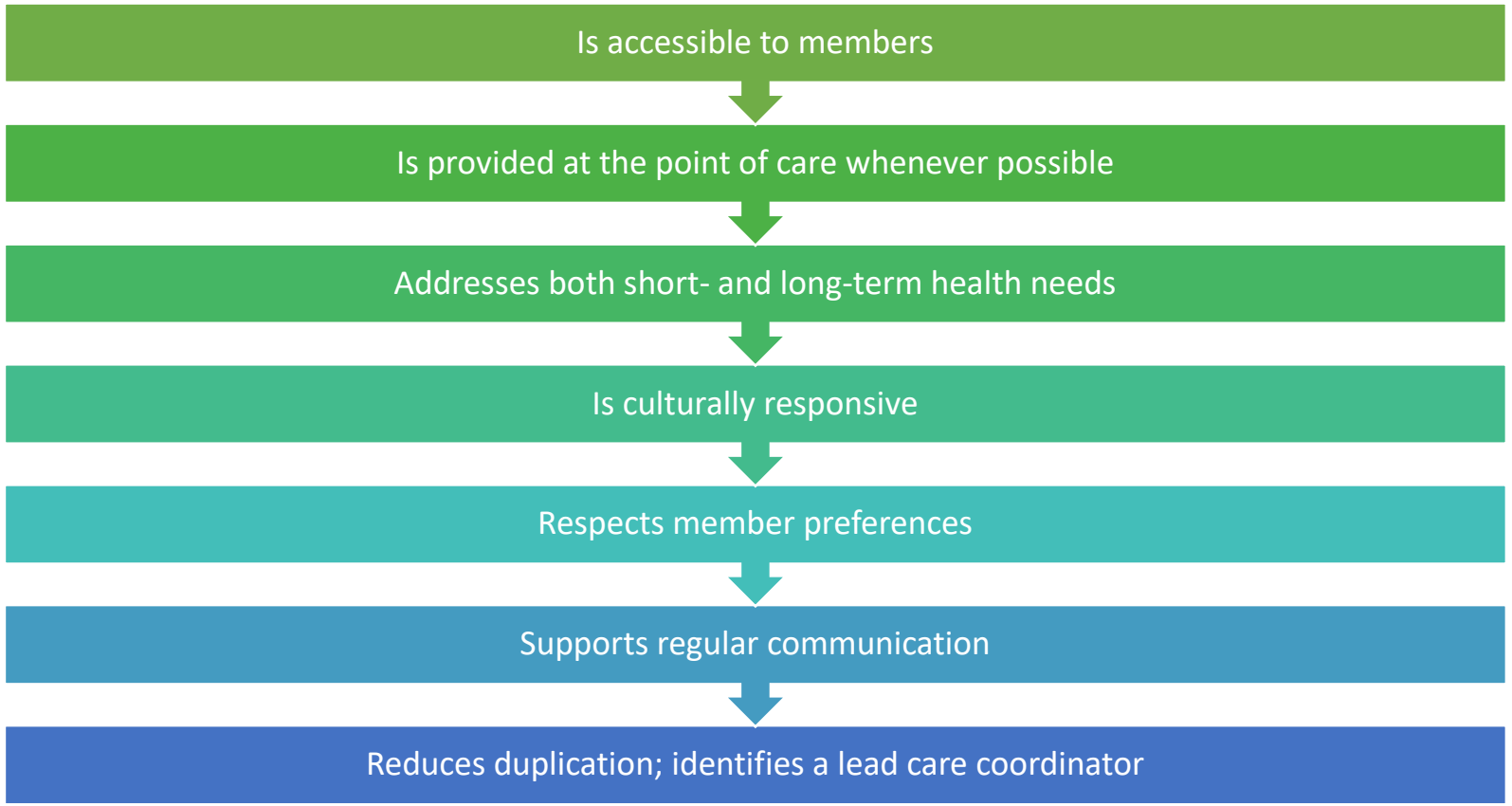
Care Coordination



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Care Coordination/Complex Members

HCI has developed an addendum across the region to provide enhanced care management to our most complex members with chronic medical conditions (ex: cardiovascular diseases, COPD, Hypertension, maternal health needs and diabetes, etc.) who will be specifically matched with team-based, patient-centered care management supports to assist them and their support systems in managing medical conditions more effectively.

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Care Coordination/Complex Members

Our goal centers on improving health outcomes for members with complex care needs, coalescing services and reducing duplication of efforts. Our desired outcomes for our complex members include:

- Improved active participation rates with attributed PCMP;
- Reduced inpatient admissions, readmissions and avoidable emergency department utilization;
- Reduced longer-term premature morbidity (complications) and mortality of the disease;
- Improved use of preventive measures such as well woman, well man, EPSDT and immunizations;
- Improved adherence to care plans addressing physical, behavioral, social and health care inequities;
- Improved members' perception of their quality of life;
- Increase appropriate utilization of outpatient services;
- Increase transitions from institutional care to community based care.

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Care Coordination

- SFY 18/19 data: Members who received care coordination 417,516 (total number members served FY18-19/not unique count)
- Care Coordination services provided include:
  - Deliberate care coordination interventions are available to the broader population and include tactics such as medical and social referrals, telephonic/electronic communications, etc.
  - Extended care coordination interventions are targeted to specific member groups who require more intense and prolonged assistance and includes interventions such as care planning, face-to-face visits, etc.

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Care Coordination (some examples)

- Transitions of care/Transitions of RAE/Transition between providers
- Collaboration w/ other providers & health team
- Nutrition Education/Diabetic Education
- Family Planning
- Pregnancy related CM (Nurse Family Partnership, Prenatal Plus, SWS)
- Medical record referral
- Advanced Directives Medical (MPOA, DNR, etc.)
- LGBTQ support
- Adult Protection Services/Child Protection Services
- Assistance with access to care, medical referrals/linkages
- Person centered planning and activities, assistance with
- Linking to Specialists (OT, PT, Speech, Ortho, Dental, Vision, Hearing, SNF, Nursing home, etc.)
- Victims advocacy
- Communication assistance (getting a cell phone, etc.)
- Pet related (service dogs, support dogs, immunizations, etc.)
- Transportation
- Food bank
- Hot meal services (Meals on Wheels, “Soup kitchens”, etc.)
- Housing
- Club House
- Department of Human Services (SNAP, SSI, SSDI, TANF, AND, LEAP, etc.)
- Bus passes
- Rent assistance
- Legal (Colorado Legal Services, driver’s license, birth certificates)
- Employment assistance
- Education linkage (GED, continuing education, PAT, BB3, etc.)
- Living environment and Safety (pest control, home modifications, etc.)
- Car repair help
- Literacy/Language
- Peer Support

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Care Coordination-Communication/Referrals

- Members are referred for care coordination when:
  - Identified by their PCMP,
  - By specific request from the RAE and/or HCPF,
  - Requested by DHS
  - Hospital discharge follow-up,
  - Transitioning from one RAE to another
  - Self-Referral,
  - Referred by another provider who is part of the member's health care team.
- HCI distributes information and sends alerts to the RAE's delegated Care Coordination entities and monitors assignment/assessment and follow-up.

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Care Coordination

- The HCI Care Coordinator is responsible for assessing or arranging for the assessment of the member's need for services (behavioral health/medical).
- The care coordinator shares the results of their assessment with other providers to prevent duplication of services and reduce the potential for fraud, waste and abuse. If a member is having difficulty arranging for medical/behavioral health care, HCI Care Coordinators will assist and make an appointment for the member, if needed.
- The HCI Care Coordinator is responsible for 'coordinating the coordinators' by acting as the lead and ensuring care team meetings and conference calls are held periodically and monitoring the provision of services, including outcomes, assessing appropriate changes or additions to services, and facilitating referrals for the member.

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Care Coordination w/ Specialty Care

- When/if it has been identified that a member has a need for a specialist, the care coordinator provides the member with options.
- HCI encourages member self-management when possible; however, will take the lead scheduling/following-up and securing transportation for the member when/if this level of support is needed.
- The care coordinator reconnects with the member after the appointment to ensure they are ‘closing the loop’ with the PCMP and care team regarding outcome and potential next steps as well as addressing any outstanding member needs.

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Care Coordination

- Successes: HCI has established longstanding partnerships among key safety net provider organizations serving members living in our region. These partnerships assist HCI with a deeper understanding about the administrative and clinical supports provided to our members. Additionally, HCI has facilitated strong partnerships at the local levels with Public Health Agencies, Nurse Family Partnerships, WIC, Working Together Program/Collaborative, Healthy Communities and Communities that Care. These partnerships work on the shared goal of increasing access to preventative services in the communities and across the region, as well as training and stigma reduction.
- Challenges: Bifurcated systems, access to care challenges and unnecessary utilization of services.
- Plans for Improvement: Encourage use of the Care Coordination Tool (Essette) to facilitate direct availability and necessary member care information across appropriate healthcare settings to increase optimal care planning and delivery for all providers involved in the member's care. Promote cross-systems access and communication among team members and service providers to encourage comprehensive person-centered coordination of care. Also, create and maintain active referral processes across services and settings establishing plans for proactive communication and closed loop referrals.

Contact Information

Please visit our website at:

https://www.healthcoloradorae.com/

Call our Care Coordination TFN:

888-502-4186

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