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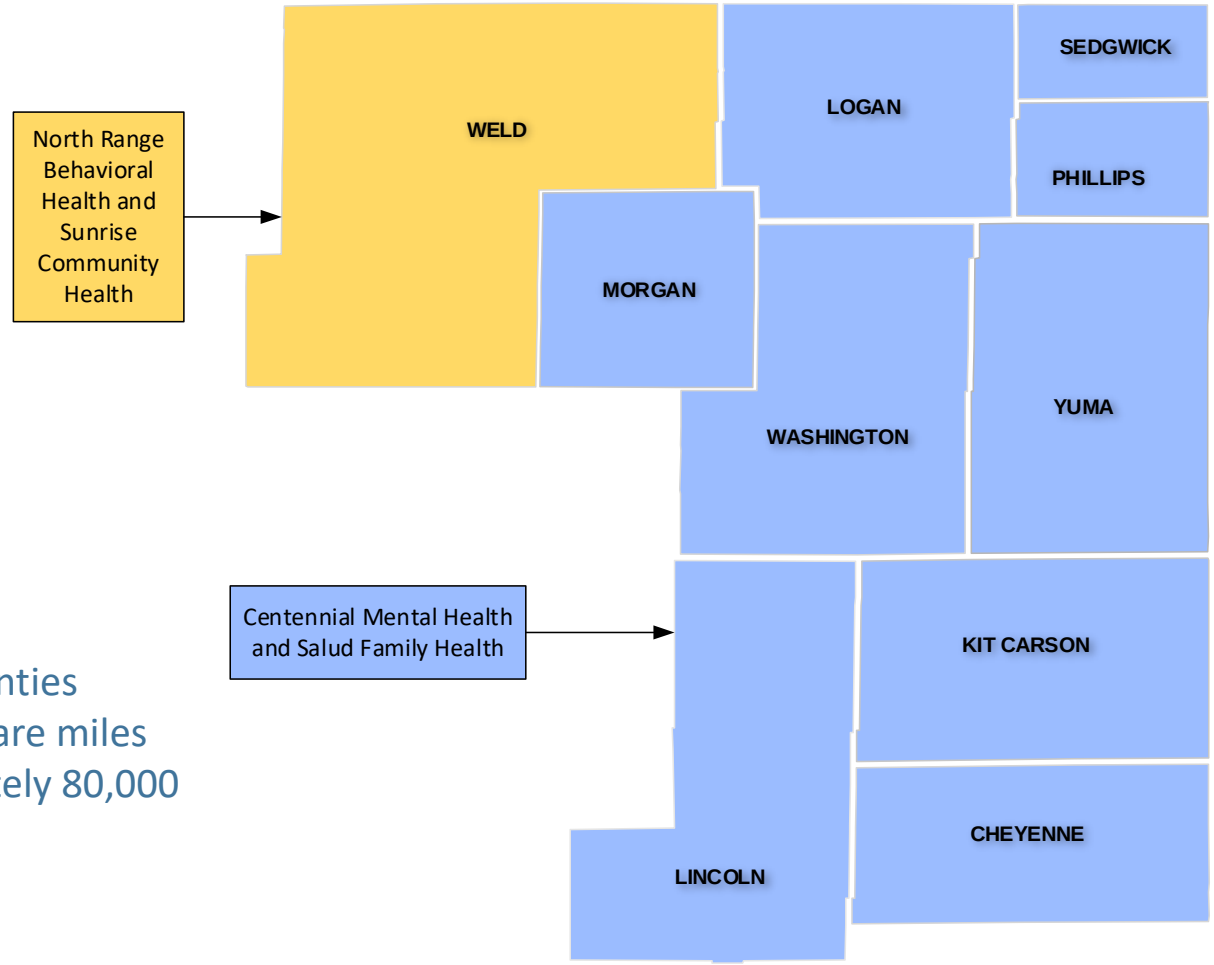
Provider and Community Subcommittee
March 12, 2020

- **Presenters:**
- **Kari Snelson, LCSW, Executive Director, NHP**
- **Joanna Martinson, RN, Director of Care Coordination NCHA**
- **Jen Hale-Coulson, LPC, Director of Care Coordination, Beacon Health Options**

Who is Northeast Health Partners?

Region 2 – Northeast Health Partners Service Area



- Serving members in 10 Counties
- Covering nearly 20,000 square miles
- Accountable for approximately 80,000 members

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Unique Regional Factors

Suicide Rates	Higher for rural populations Agricultural communities more than double that of veterans
Poverty Rates	Range between 14-25 % Free and reduced lunch rates on average 50%
Refugee/ Immigrant Populations	Particularly Somali, Burmese in Weld; also the migrant farmworker Increased barriers for care delivery, social determinants of health
Public Charge Rule	Families disenrolling in programs that could be impacted by proposed changes to PCR

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Care Coordination

- Northeast Health Partners has a local, coordinated care delivery system that provides access to quality care and incorporates primary care, specialty care, and care coordination of complex 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.
- NHPs Delegated Care Coordination Model consists of three tiers:
  - Accountable, Collaborative and Contributing.
  - Accountable providers' attributed membership drives a significant proportion of regional membership and providers possess the greatest level of capability to impact the complex members and regional KPI's as well as demonstrating the capacity to provide full continuum of community care coordination for Members.
  - Collaborative providers' offer enhanced services and may be on a path to alternative payment model with HCPF. These practices participate in some care coordination and population health activities with the RAE.
  - Contributing providers' meet minimum Medicaid Medical Home requirements and provide basic services. *Regionally, care coordination for all PCMPs in the bottom two tiers is 100% delegated to NCHA. NCHA also provides care coordination for members attributed to Sunrise FQHC.*

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Who are the Delegated Care Coordination Entities?

- North Colorado Health Alliance Is the primary NHP Care Coordination provider
- Delegated Providers:
  - Sunrise
  - Peak Vista
  - Salud
  - Family Physicians of Greeley

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Care Coordination

Is accessible to members

Is provided at the point of care whenever possible

Addresses both short- and long-term health needs

Is culturally responsive

Respects member preferences

Supports regular communication

Reduces duplication; identifies a lead care coordinator

Care Coordination

SFY 18/19 data: Members who received care coordination 248,850

54.4% of complex members were engaged in care coordination *prior to* identification

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 Examples

- Securing DME (Oxygen tanks, shower chairs, canes, walkers, wheel chairs, etc.)
- Linking to Specialists (OT, PT, Speech, Ortho, Dental, Vision, Hearing, SNF, Nursing home, etc.)
- 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)
- Smoking cessation
- Bariatric/weight loss
- Advanced Directives Medical (MPOA, DNR, etc.)
- LGBTQ support
- Adult Protection Services/Child Protection Services
- Home furnishings
- LEAP
- Immigrant Refugee Center

- Transportation
- Food bank
- Hot meal services (Meals on Wheels, "Soup kitchens", etc.)
- Housing
- Club House
- Department of Human Services (SNAP, SSI, SSDI, TANF, AND, etc.)
- 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
- Communication assistance (getting a cell phone, etc.)
- Victims advocacy
- Literacy/Language
- Peer Support
- Pet related (service dogs, support dogs, immunizations, etc.)

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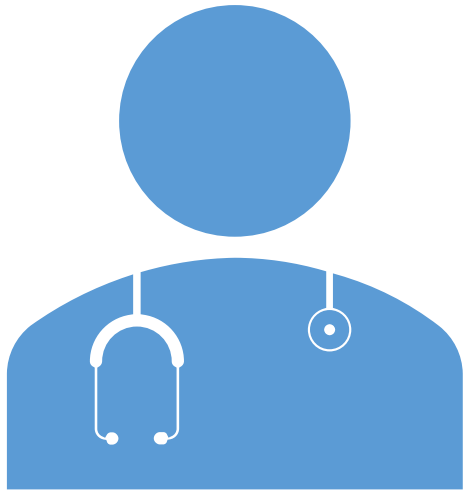
Care Coordination-Communication/Referrals



- Members are referred for care coordination when:
  - Identified by their PCMP,
  - By specific request from the RAE and/or HCPF:
    - Complex and Emerging Members
  - Requested by DHS
  - Hospital discharge follow-up,
  - Transitioning from one RAE to another
  - Self-Referral,
  - Or by another provider who is part of the member's health care team.
- Beacon 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 NHP Care Coordinator is responsible for assessing or arranging for the assessment of the member's need for services, coordinating mental health/behavioral health and medical services rendered by multiple providers, coordinating services with other agencies/providers (including human service agencies and providers), and referring to other agencies and providers, as appropriate.

If a member is having difficulty arranging for medical/behavioral health care, NHP Care Coordinators will assist and make an appointment for the member, if needed.

The NHP Care Coordinator is responsible 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

What constitutes a high quality referral or transition?	
Safe	Planned and managed to prevent harm to members from medical or administrative errors.
Timely	Members receive needed transitions and care coordination services without unnecessary delays.
Member-centered	Responsive to member and family needs and preferences.
Efficient	Limited to necessary referrals, and avoids duplication of services.
Equitable	The availability and quality of transitions and referrals should not vary by the personal characteristics of members.

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Care Coordination

- Successes:
  - Ability to receive real time referrals from partner agencies regarding members.
  - Due to extensive relationships, able to engage significant members of community/health neighborhood in care.
  - Knowledge of resources and utilization of community to avoid replication/duplication has been key.
  - Local level of intervention in region.
  - Care Coordinators have assembled to organize group visits to members, an opioid oversight committee, Extension for Community Healthcare Outcomes (ECHO) and other community engagement programs for chronic diseases as a way to communicate with providers and track common members.
- Challenges:
  - Attribution
  - Changing requirements
  - Size of region and requirements
  - Funding model changes
  - Access to necessary specialty care/chronic disease management
  - Providers still on paper records

- Plans for Improvement: NHP will work with PCMP's to refer Medicaid members to the higher quality, lower cost site alternative (Center of Excellence) for specific and common procedures. Also, building capacity in our region and improving systems in rural/frontier similar to the programming occurring in Greeley.

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Contact Information

Please visit our website at:

www.northeasthealthpartners.org

Call our Care Coordination line:

888-502-4190

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