Rocky Mountain Health Plans Care Coordination Overview

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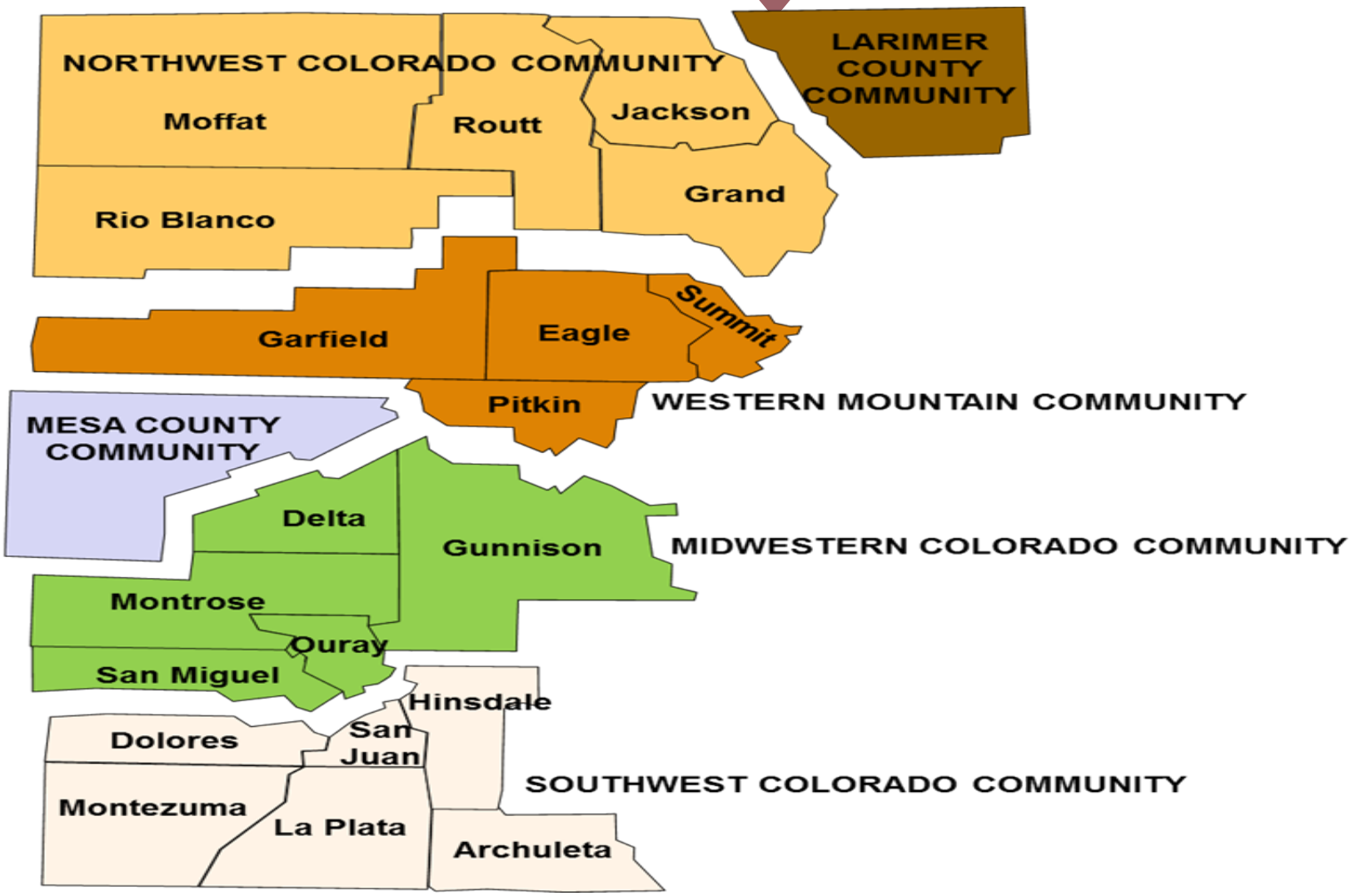
ROCKY MOUNTAIN HEALTH PLANS®

Rocky Mountain Health Plans Region 1



Our Care Coordination Teams

RMHP Care Coordinators

RMHP has our own team of Care Coordinators in various geographic communities throughout the state

Integrated Community Care Teams

RMHP partners with existing Community Care Coordination teams to perform our Care Coordination activities.

Partnerships with Community Agencies

RMHP partners share a data platform and have granted access to CMHCs, providers, Grand Junction Housing Authority and Garfield County Human Services.

Care Coordination Outreach

Clinical Events

- Inpatient Admissions
- Discharges
- Behavioral Health
- Emergency Department
- Crisis Line Call

Special Populations

- Complex
- High Risk Pregnancy
- Criminal Justice
- Foster Children
- COUP

Referrals

- One Call Line
- Inbound Calls
- Providers
- Self-Referral
- Community Organizations

Community Outreach

- Homeless Shelters
- Food Banks
- Parole Office
- Halfway House

RMHP Care Coordinators

RN Case Managers

Work directly with our population with the highest and most complex Physical Health Needs.

Available for staffing and consultations with team.

BH Professionals

Work collaboratively with our UM staff, inpatient facilities and the CMHCs, starting at the point of hospital admission, to begin timely discharge planning and coordinate TOC.

Social Workers

Assess and screen for Social Determinants of Health.

Connect members with Community Resources for Social Needs.

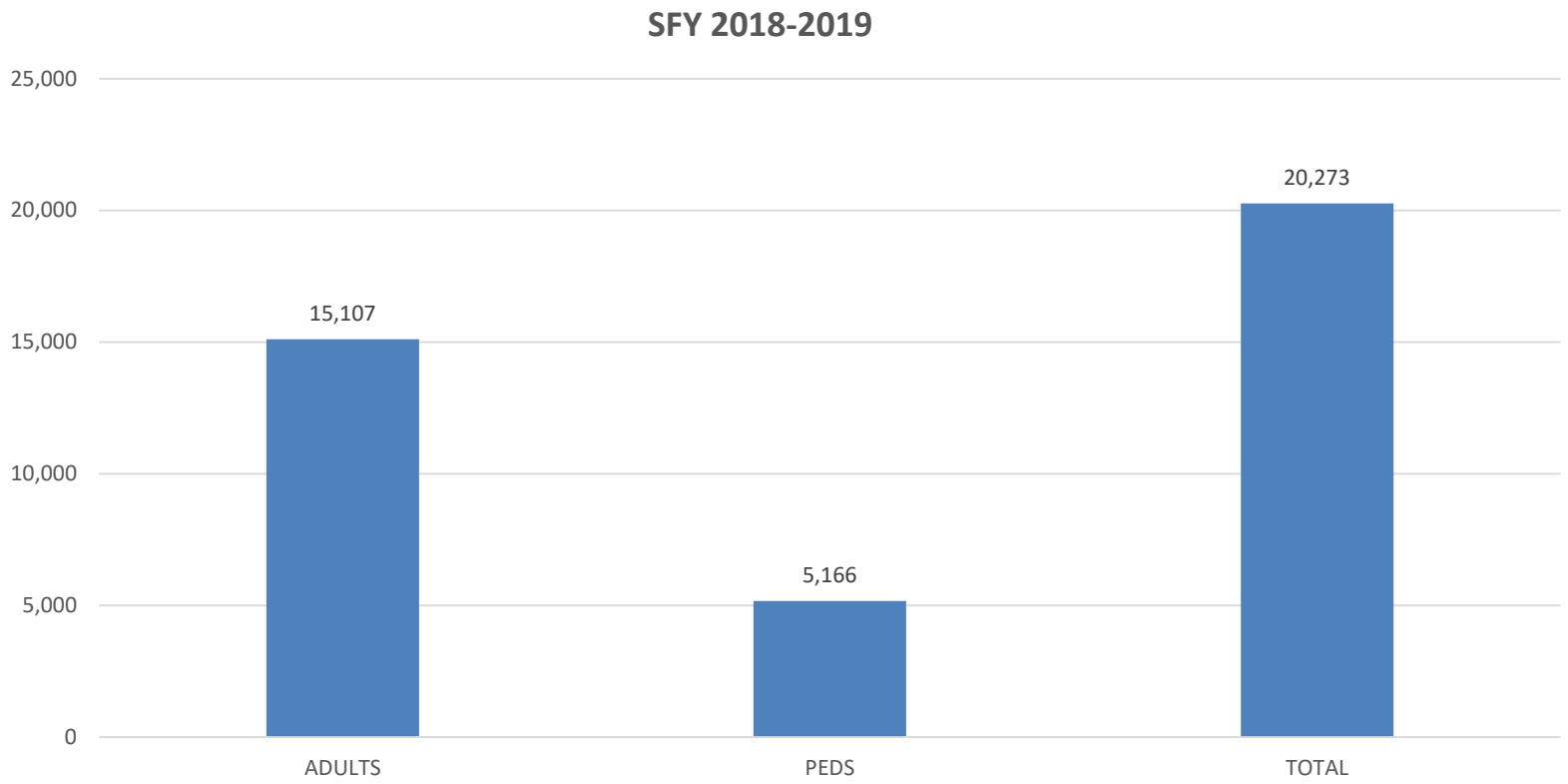
Outreach Coordinators

General Care Coordination and member education.

Connect members with Community Resources.

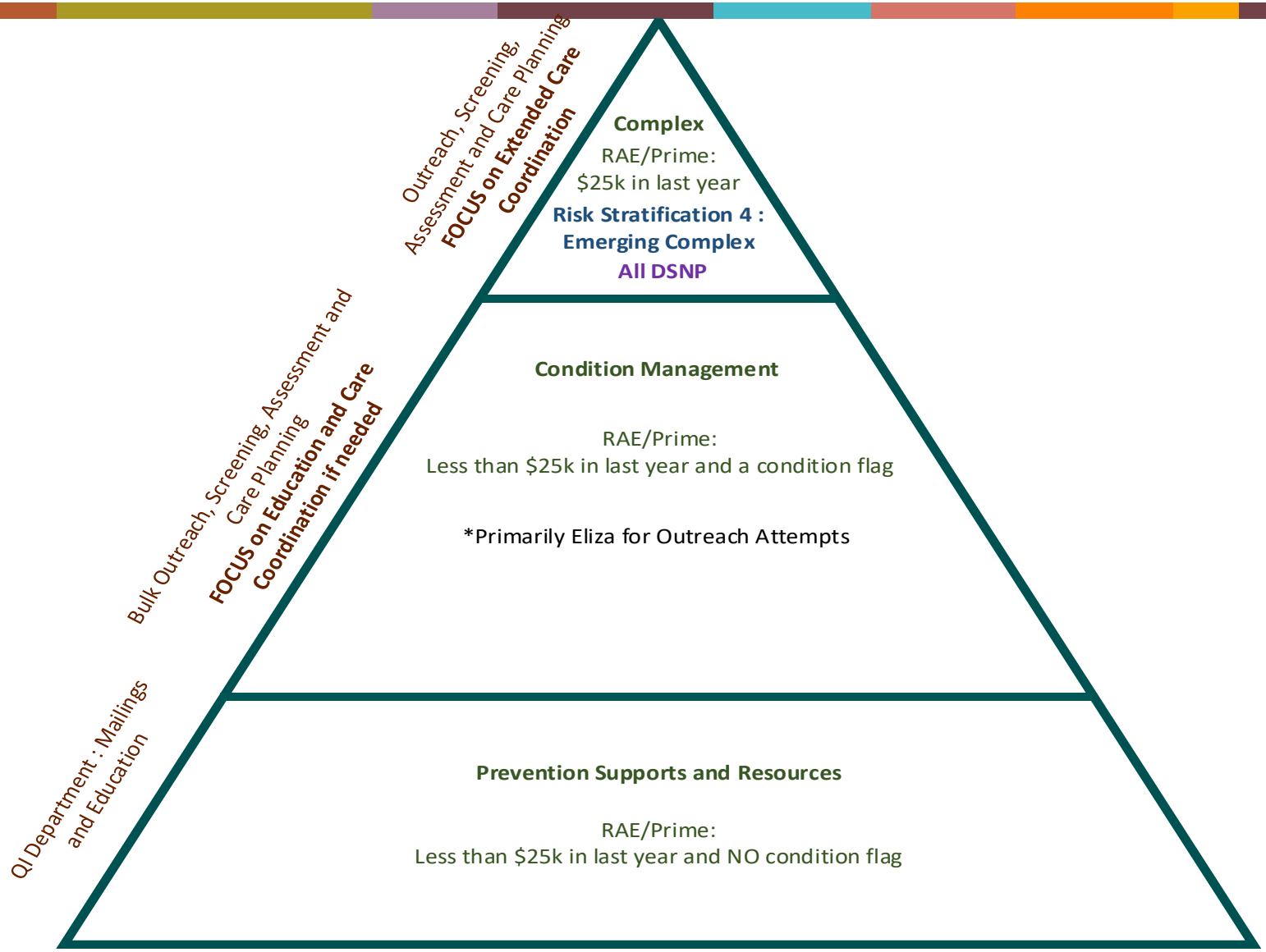
Spanish Speakers available.

SFY 2018-2019 Care Coordination



Total Unique Members with Extended Care Coordination

Pyramid Approach



Complex Segment Breakout

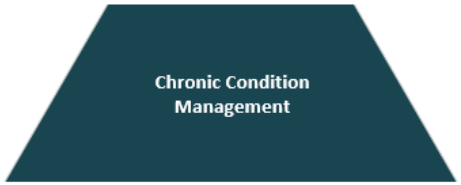
Definition :

- HCPF – 25k+ in annual utilization
- LA Risk Strat Model – Emerging Complex
- All DSNP Members (not included in counts due to accounted for in current program structure, similar interventions) : 869 Members

Intervention :

- Members dispersed into Sub Population Campaigns
- Outreached and Screened
- Focus on ID of needs and engaged in Extended Care Coordination supports (long term/care team based)
- ICP Created for all Members exhibiting needs
- All Members in a Monitoring status for minimum 6 months (clinical event and incremental outreach bases on acuity)

Condition Management Segment Breakout



Definition :

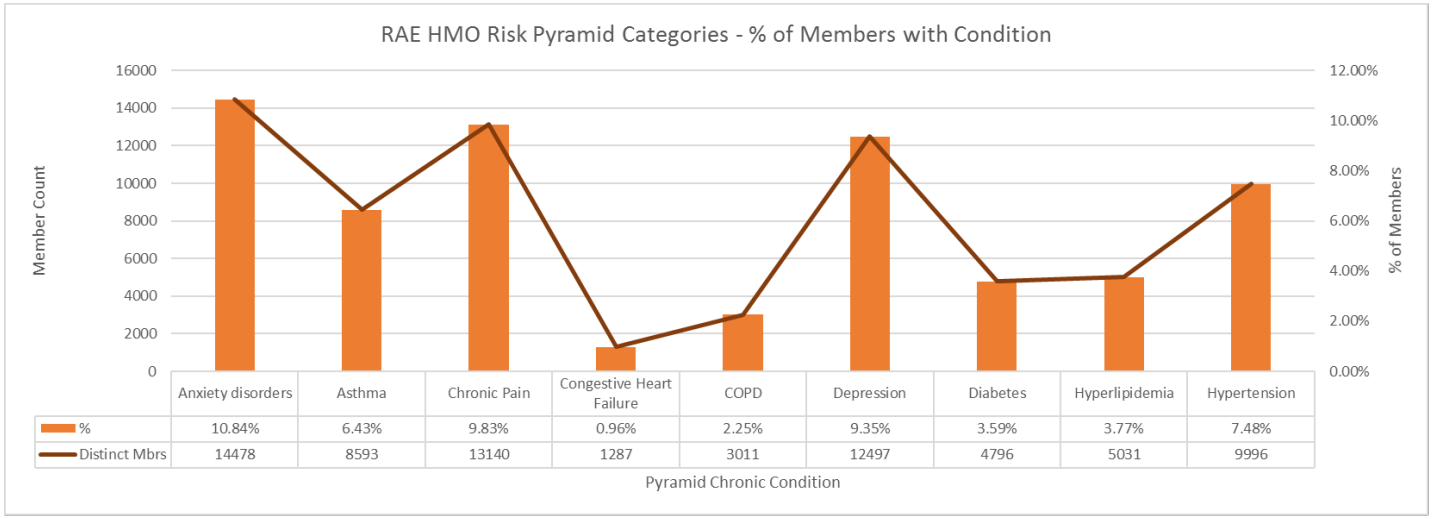
- HCPF – Less than 25k in annual utilization and a condition flag
- LA Risk Strat Model – None (only HCPF definition included)

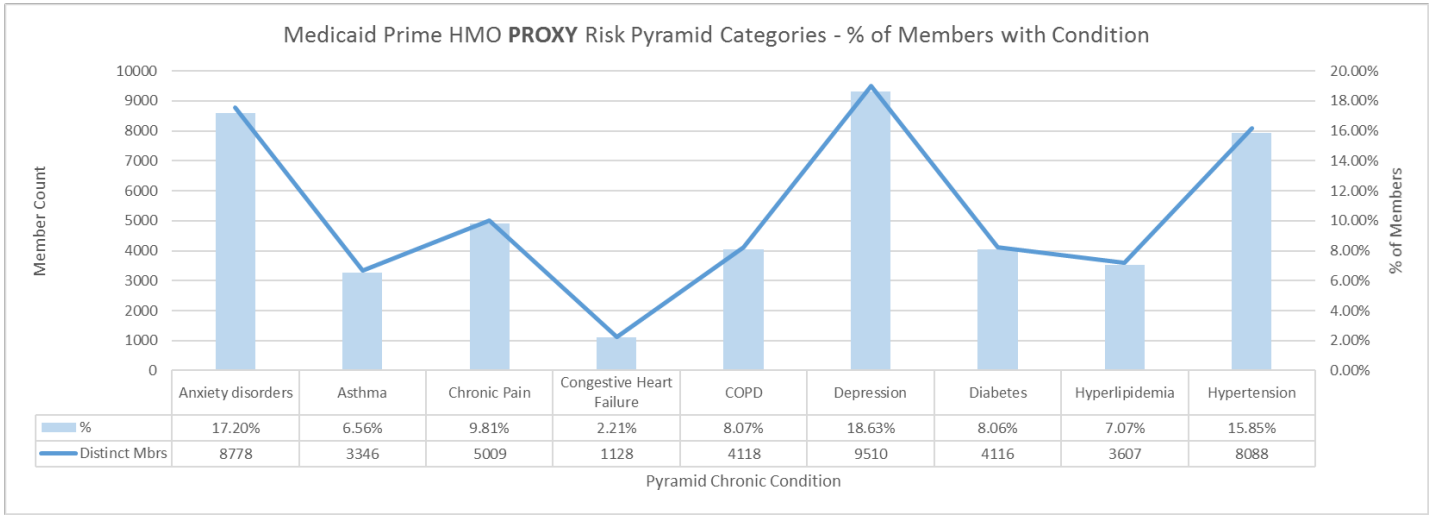
Intervention :

- TBD on focus pops and strategy
- Outreached and Screened
- ID if Member needs Complex/Extended Care Coordination
- Condition Education and Resources

Condition Management Segment Breakout

Chronic Condition Management





Prevention Segment Breakout

Definition :

- HCPF – Less than 25k in annual utilization and no condition flag
- LA Risk Strat Model – None (only HCPF definition included)

Intervention :

- Educational Mailing
- Gap closure
- QI/PT

Questions?