Rocky Mountain Health Plans

RAE Care Coordination

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United Healthcare Community Plan

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What RMHP Does

Regional Accountable Entity (RAE) for Region 1

- Western Slope + Larimer County

Administrative Service Organization (ASO) for Region 1

- Crisis Services
- Programs for children, youth & families

Managed Service Organization (MSO)

- Western Slope
- Sub-state Planning Areas 5 & 6

Case Management Agency

- Serve 19 counties

Regional Accountable Entity (RAE)

- Develop a network of Primary Care Medical Providers (PCMPs) to serve as medical homes
- Develop a contracted *statewide* network of behavioral health providers
- Administer HCPF's behavioral health benefit
- Promote the enrolled population's health and functioning
- Coordinate care across disparate providers, social, educational, justice, and other community agencies to address complex member needs that span multiple agencies and jurisdictions

Regional Accountable Entity (RAE) - Current

Regional Accountable Entity (RAE) - Future

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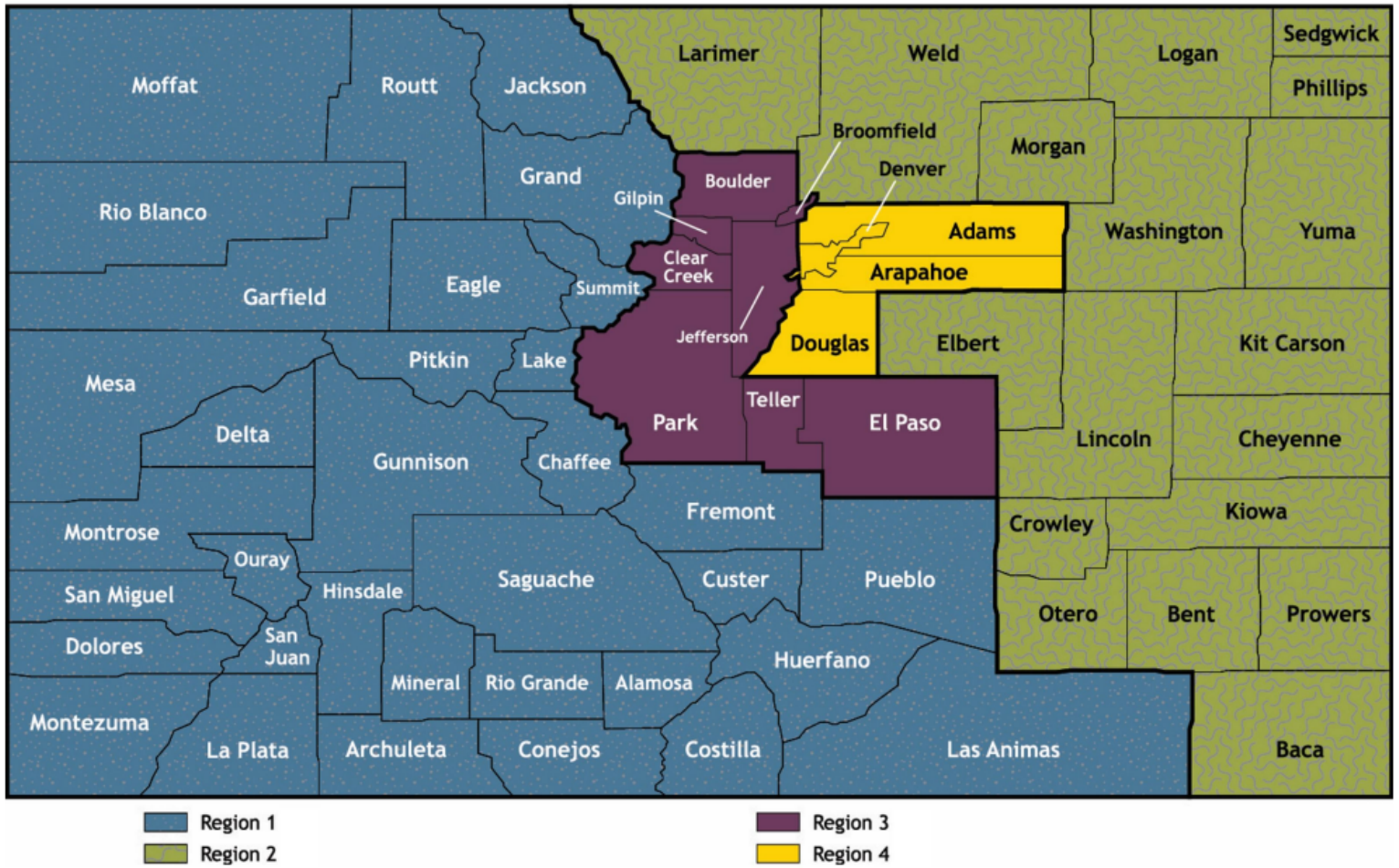
Figure 1 - ACC Phase III RAE Map



Care Coordination Teams

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The RMHP care coordination model includes internal care coordination staff, and a network of Integrated Community Care Teams (ICCT) based in locations throughout the region (e.g., CBO, FQHC, PCMP, Public Health) and provide a community and Member-centered approach to care coordination for our population.

- **Scope:** Specialty and general care coordination activities with multiple populations of focus including behavioral health/substance use, disease management, maternity, children and youth, housing, foster care, and transitions of care management.
- **Support and Oversight:** ICCTs have regular communication with RMHP through in-person site visits and quarterly integrated care team meetings. Ongoing connectivity with RMHP care coordination leadership to support operations, and Members with complex care needs.
- **Documentation & Tracking:** Care coordinators document assessments, care plans and Member interactions in Essette, RMHP's clinical care coordination (CM, CMA, UM) platform. Documentation is regularly reviewed and used for state reporting and continuity of care coordination.

25 RMHP and 13 ICCTs (44 Care Coordinators) throughout Region 1

Organizational partners

The Health Neighborhood

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Rocky Mountain Health Plans (RMHP) is committed to supporting a comprehensive health neighborhood that includes providers, hospitals, public health agencies, community organizations and other partners who promote access to high-quality, whole-person care for all Members.

Care Coordination and Case Management

- **Integrated Community Care Teams (ICCT) and Community Integration Agreements (CIA):** Network of community-based care coordination resources throughout the region in multiple settings (e.g., CBO, FQHC, public health).
- **Case Management Agency:** Collaboration and streamlined internal referral process between internal CMA and RAE Care Coordination. Teams share documentation platform, Essette. Regular meetings and streamlined referral process with each CMA in the region.
- **Transitions of Care:** Workflows based on ADT feeds. Relationships, with discharge planners, daily communication and rounding at physical health and behavioral health inpatient settings to ensure Members have access to timely follow-up care upon discharge.
- **Department of Corrections:** Care coordinators conduct virtual needs assessments and help Members connect with providers and set up necessary services and supports prior to release. This proactive approach ensures a smooth and successful transition back into the community.
- **Creative Solutions:** Specialized team including RAE, HCPF, DHS, CMA, school district, Momentum, Guardian ad litum, advocates, other community members as appropriate.

Organizational partners

The Health Neighborhood cont.

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Health Related Social Needs:

- **Community Based Organizations:** Partnerships with local public health, and other local organizations do address.
- **Community Paramedics:** UCHealth community paramedics program and Delta County Ambulance District.
- **Renewal:** Partnerships with multiple application assistance sites to support Members at risk of losing Medicaid benefits and assist with redetermination or connect Members with other health coverage options.

Physical Health:

- **Provider Network:** Comprehensive behavioral health, physical health and specialty network. Creative behavioral health access models.
- **Hospitals:** Strong relationships with all 26 hospitals in the region through the Hospital Transformation Program (HTP).
- **Colorado Specialty CareConnect (CSCC):** RMHP's eConsult platform.

Behavioral Health:

- **ASO & MSO:** Currently serve as the ASO and MSO and future BHASO. Internal programs include High-Fidelity Wraparound (HFW), Child & Youth Mental Health Treatment Act (CYMHTA), Crisis Services, Family First Prevention Services Act (FFPSA) and Crisis Resolution Team (CRT).
- **Provider Network:** Comprehensive network of behavioral health providers including CSNP, and other provider types.
- **Access to care:** Innovative programs that promote access to behavioral health services throughout the region.
- **Community Safety Net Provider (CSNP):** Weekly meeting and collaboration with each CSNP in the region.

Organizational partners

The Health Neighborhood cont.

Other Programs:

- **Colorado Cross Disability Coalition (CCDC):** Monthly meetings to address barriers and improve access to care coordination for people with disabilities.
- **Child Welfare:** RMHP has a dedicated liaison who meets regularly with county child welfare directors, and CMA leadership. These relationships promote awareness of community resources, and quick resolution of issues related to access.
- **Member Advisory Councils (MAC):** Multiple councils including youth advisory council, bridging communications, MAC en español
- **Nurse Family Partnership:** Meet with NFPs throughout the region and strong bidirectional referral process.
- **The Western Slope Native American Resource Center (WSNARC):** Provide care coordination and support services to Native American populations.
- **Health Information Exchange:** RMHP has a direct interface with QHN, and care coordination staff receive real-time ADT data. Care coordination teams also have access to the Community Resource Network (CRN), this social health information exchange is integrated with 211 and streamlines community resource referrals and tracking.

Region 1: At a Glance

Unique Needs of Members*

Behavioral Health	• Prevalent conditions: Depression, substance use disorder (SUD) • High rates of BH diagnoses including depression and suicidal ideation • Access to care in rural and frontier Colorado
Physical Health	• Prevalent conditions: Diabetes, Hypertension, Obesity, Sepsis (top IP diagnosis) • Maternity related diagnoses are frequent (inpatient and outpatient), WCC/IZ access • Access to care in rural and frontier Colorado
Health Related Social Needs	• Food security, safety, housing and transportation are the top social needs • Challenging geography and unpredictable weather • Limited access to community resources

**Highlights from CY2023 RMHP Population Health Management (PHM) Assessment*

Care Coordination Primary Components

Member Stratification

- Stratification of Members into categories utilizing RMHP's model for population stratification that considers both the National Committee for Quality Assurance (NCQA) stratification model and Health Care Policy and Finance's (HCPF) stratification model.

Clinical Event Management

- Support Members during Admissions/Discharges/Transfers from facilities, emergency department (ED) visits, and crisis calls.

Special Population Management

- Identify Members of special populations with similar needs to assess for needs and to coordinate care.

Referral Processing

- Receive referrals and follow-up in a timely manner; coordinate with outside resources and partners as needed.

Community Integration

- Integrate with Community Mental Health Centers, Independent Provider Network (IPN) providers, Primary Care Practices and other community entities to establish a repository of resources for the communities served.

RMHP Care Coordinators

RN Case Managers

- Assist Members with the most complex Physical Health Needs

Social Workers

- Social needs resource experts

BH Care Coordinators

- BH background
- Support Members with high BH acuity and needs
- Facilitate community meetings and creative solutions

Outreach Coordinators

- General Care Coordination and member education
- Language Line access

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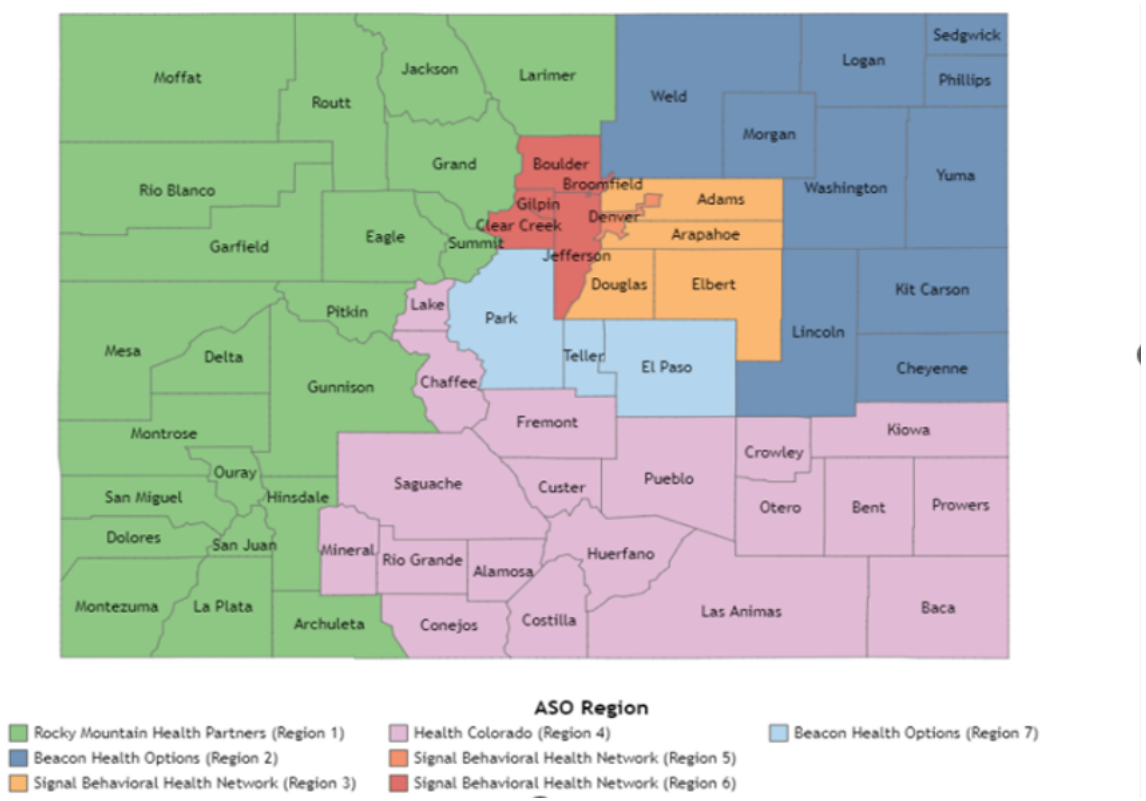
Administrative Services Organization (ASO)



Questions?

Thank You!