# Northeast Health Partners/RAE 2

Care Coordination Oversight: Ensuring Quality and Compliance in R2

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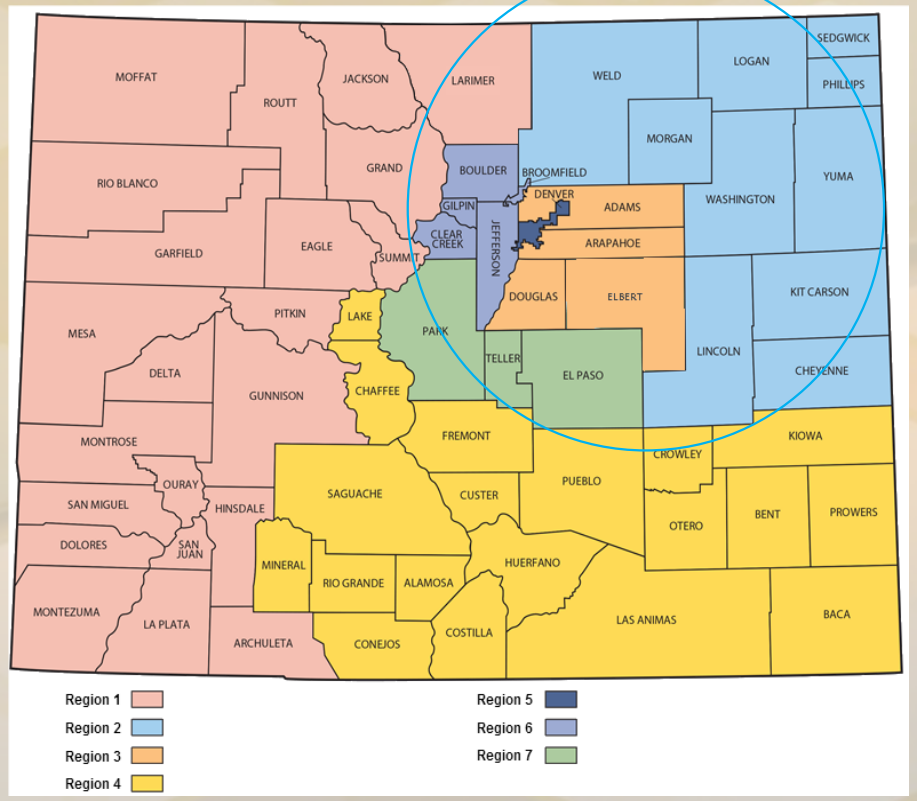
# NHP Manages Care for Medicaid Members Across 19.0% of Colorado's land space

- R2 Counties Served




- Counties served (19,815 mi$^2$; CO = 104,185 mi$^2$)
  - Cheyenne (1,781 mi$^2$)
  - Kit Carson (2,162 mi$^2$)
  - Lincoln (2,586 mi$^2$)
  - Logan (1,845 mi$^2$)
  - Morgan (1,294 mi$^2$)
  - Phillips (688 mi$^2$)
  - Sedgwick (549 mi$^2$)
  - Washington (2,524 mi$^2$)
  - Weld (4,017 mi$^2$)
  - Yuma (2,369 mi$^2$)

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# Coordination and Continuity of Care

## *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 UM staff, inpatient facilities and the CMHCs, starting at the point of hospital admission, to begin timely discharge planning and coordination of care

## *Care Coordinators*

Assess and screen for Social Determinants of Health. Connect members with Community Resources for Social Needs.

## *Outreach & Navigation Coordinators*

General Care Coordination and member education. Connect members with Community Resources.

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# Coordination and Continuity of Care

## Clinical Events

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

## Special Populations

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

## Referrals

- Inbound Calls
- Providers
- Self-Referral
- Community Organizations

## Community Outreach

- Homeless Shelters
- Food Banks
- Parole Office
- United Way

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# Coordination and Continuity of Care

Behavioral Health Transitions of Care Model:

Care Coordinators receive notification when members are hospitalized as well as discharge plan information once a member is stabilized/ready to transition to a lower level of care

Care Coordinators connect with members to ensure their needs were met, they understand discharge instructions and that aftercare appointments are made

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# Coordination and Continuity of Care

- Physical Health Transitions of Care Model:
  - Care Coordinators are assigned to support hospitals throughout the region
  - Referrals are received via CORHIO daily feeds and direct hospital referrals
  - Care Coordinators 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 Coordinators 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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# Care Coordination Compliance: R2

- Audits conducted every ***6 months*** to ensure alignment with best practices and contractual obligations, with the goal centering on ***member care*** through review of
  - Policies/Procedures follow contract requirements
  - Evidence of processes being implemented and/or have a mechanism to implement
  - Care Coordination staff understand requirements, can articulate processes and mechanisms to comply with requirements and what is described during the auditing process is consistent with policies/procedures and meeting minutes, etc.
  - Any scores of *80% or below requires a corrective action plan, which NHP follows until completion*
    - Care Coordinators are supported with specialized education and training

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# Care Coordination Compliance: R2

- NHPs Care Coordination Audit Tool mirrors HSAG requirements to ensure federal regulations as well as state (RAE) contract requirements are met
- Areas of focus center on:
  - the delivery of care
    - care coordination activities (deliberate and extended)
  - risk stratification
    - management of high-cost/high-need members (complex)
    - ability to address gaps in care
  - communication with other providers
  - outreach/engagement with members
  - attribution assistance
  - transitions of care/continuity of care
  - care planning and
  - policy/procedure review
    - organizational processes to include compliance with HIPAA

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# NHP Specialized Education & Care Coordination Training

| Training Topic (examples) |
| --- |
| Motivational Interviewing |
| SMART Goals |
| Cultural Competence/Health Equity |
| Resource Navigation |
| SBIRT (Screening, Brief Intervention, Referral to Treatment) |

- How does NHP chose education/training topics?
  - Trends noted from audits
  - Care Coordinator suggestions
  - Changes in state (RAE) contract including updated amendments from HCPF
  - Training opportunities offered by regional/state partners

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