COLORADO
Department of Health Care Policy & Financing

# Fiscal Year 2016–2017 Site Review Report

*for*

# Rocky Mountain Health Plans

# Region 1

*August 2017*

*This report was produced by Health Services Advisory Group, Inc., for the Colorado Department of Health Care Policy & Financing.*

HSAG HEALTH SERVICES ADVISORY GROUP

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# 1. Summary of On-Site Discussions

## Introduction and Background

The Colorado Department of Health Care Policy & Financing (Department) implemented the Accountable Care Collaborative (ACC) program in spring 2011 as a central part of its plan for Health First Colorado (Colorado's Medicaid program) reform. The ACC promotes improved health for members by delivering care in an increasingly seamless way, making it easier for members and providers to navigate the healthcare system and to make smarter use of every dollar spent. Serving as the primary vehicle for delivering quality healthcare to Health First Colorado members, the ACC has shown real progress in creating a healthcare delivery program for improving health outcomes and care coordination while cultivating the member and family experience and reducing costs. The four primary goals of the ACC program are to (1) ensure access to a focal point of care or medical home for all members; (2) coordinate medical and nonmedical care and services; (3) improve member and provider experiences; and (4) provide the necessary data to support these goals, to analyze progress, and to move the program forward. A core component of the program involves partnerships with seven Regional Care Collaborative Organizations (RCCOs), each of which is accountable for the program in a designated part of the State. The RCCOs maintain a network of providers; support providers with coaching and program operations; manage and coordinate member care; connect members with medical and nonmedical services; and report on costs, utilization, and outcomes for their members. An additional feature of the ACC program is collaboration—among providers and community partners, among RCCOs, and between RCCOs and the Department—to accomplish program goals.

The State began enrollment of eligible adults through the Affordable Care Act of 2010; and ACC enrollment has grown to approximately one million members, including the Medicaid expansion population. Beginning in September 2014, the ACC: Medicare-Medicaid Program (ACC: MMP) demonstration provided for integration of individuals eligible for Medicare and Medicaid. All RCCO contracts were amended in July 2014 to specify additional requirements and objectives related to the integration of ACC: MMP members and to increase incentive payments while reducing guaranteed per member per month payments.

Each year since the inception of the ACC program, the Department has engaged Health Services Advisory Group, Inc. (HSAG), to conduct annual site reviews to evaluate the development of the RCCOs and to assess each RCCO's challenges and successes in implementing key components of the ACC program. This report, focused on **Rocky Mountain Health Plans** (**RMHP**), documents results for fiscal year (FY) 2016–2017 site review activities, which included evaluation of lessons learned—challenges and successes by each RCCO since inception of the ACC program—related to community partnerships and collaboration, provider networks and provider participation, member engagement, care coordination, and balancing Department-driven and community-driven priorities. In addition, the Department requested a presentation by each RCCO of care coordination cases demonstrating "best practice" examples of comprehensive care coordination. This section contains summaries of the activities and on-site discussions related to each focus area selected for the 2016–2017 site review as

well as HSAG's observations and recommendations. Section 2 provides an overview of the monitoring activities and describes the site review methodology used for the 2016–2017 site reviews. Appendix A contains the Focus Topic Interview Guide used to facilitate on-site discussions. Appendix B contains summaries of each care coordination case presentation. Appendix C lists HSAG, RCCO, and Department personnel who participated in the site review process.

## Summary of Results

The care coordination case presentations focused on a sample of Health First Colorado members with complex needs including but not limited to members of the ACC: MMP population, members with care coordination performed by delegated entities, and members who may have presented significant challenges to care coordinators. Care coordination cases were selected by each RCCO, and results were not scored. HSAG summarized results of each care coordination case in the Coordination of Care Record Review Tool, which documented member characteristics and needs, care coordinator activities, member engagement, involvement of other agencies and providers, and outcomes of care coordination efforts.

The Focus Topic Interview Guide (Appendix A) was used to stimulate on-site discussions of lessons learned related to the focus content areas: Community Partnerships/Collaboration, Provider Network/Provider Participation, Member Engagement, Care Coordination, and Balance Between Central (Department-Driven) ACC Priorities and Regional (Community-Driven) Priorities. Following are summaries of results for each content area of the 2016–2017 review.

## Summary of Findings and Recommendations by Focus Area

### *Community Partnerships/Collaboration*

#### Lessons Learned—Successes and Challenges

**RMHP** made collaborating with community partners a major theme in its operations since inception of the RCCO, beginning with designation of community-based care coordination teams (CCTs) which are guided by teams of local healthcare leadership. **RMHP**'s integration with community partners has since grown and become the foundation for multiple locally-driven and regionwide programs and projects of the RCCO. At the time of on-site review, **RMHP** listed 65 active community partners, excluding State agencies such as the Department of Corrections, single entry points (SEPs), and community-centered boards (CCBs). **RMHP** has secured its community partnership activities through formal agreements and memoranda of understanding (MOUs) to ensure that roles and responsibilities, as well as any applicable financial obligations, are clearly outlined.

**RMHP** is also working with eight SEPs and six CCBs across the region to address individual member-specific needs and, as applicable, to work collaboratively on special community-based program initiatives. **RMHP** described examples of programs with Options for Long Term Care (SEP) in Larimer County and with Strive (CCB) in Mesa County. Staff members stated that initial relationships with SEPs and CCBs were inhibited by Health Insurance Portability and Accountability Act of 1996 (HIPAA) concerns regarding data sharing. In order to facilitate these relationships, **RMHP** took the lead in sharing information with the CCBs and SEPs; had regular meetings at the local level with the CCTs, SEPs, and CCBs and with the regional **RMHP** Community Integration Team to understand the scope and services of each agency; and supported care teams in providing services to individual members. In addition, **RMHP** had a six-year, positive working history with the Strive CCB and allowed that relationship to influence **RMHP**'s interface with other CCBs. Staff reported that over the past two years the SEPs and CCBs have realized the value of working with the RCCO care coordinators and frequently reach out to the RCCO for assistance with individual members. HSAG observed such relationships in several of the on-site care coordination presentations.

Staff members stated that in multiple circumstances an individual care coordination case evolved into a communitywide initiative and sometimes resulted in associated funding resources. **RMHP** played a variety of roles in these initiatives—leader/organizer, active partner/participant, provider of staff expertise/resources, or funder/fiscal agent. **RMHP** highlighted several projects demonstrating recent collaborative community partnerships, as follows:

- Colorado Opportunity Project (COP)—Multiple community partners in the La Plata and Montezuma county area of southwest Colorado collaborated on four different projects—two projects to connect members to social determinants of health programs—e.g., the Supplemental Nutritional Assistance Program (SNAP); Women, Infants, and Children (WIC) program; Nursing Facility Transition (NFT) program; and Temporary Assistance for Needy Families (TANF)—and two projects to target assessment and referral of prenatal and postnatal women to social determinants of health programs.
- COP Pinon Project—a component of the above COP projects, the Pinon Project provides multiple services and classes through the Family Resource Center partner, including nutrition and cooking classes, parenting classes for parents of children of all ages, early education program, early learning center with developmentally appropriate activities, youth mentoring and suicide prevention programs for adolescents, emergency housing and utility assistance, and supervised parental visitation services.
- Intellectual and Developmental Disabilities (IDD) Crisis Services—a three-year pilot project to address gaps in the State crisis system for persons with disabilities. CCBs and community mental health centers (CMHCs) work collaboratively to assess developmentally disabled clients who are having crises, provide stabilization, and develop follow-up plans. Follow-up plans are also shared with schools, police department, and fire department, as applicable. Stabilization facilities or individualized care settings have been developed in both Larimer and Mesa counties.
- Essette Care Management (Essette) software—Care coordination efforts among community partners have been greatly enhanced by the implementation of the Essette system by all CCTs and some community organizations to communicate information about the member's care coordination

activities. The Essette system is also being used to capture data and track members in the COP Pinon Project. In addition, **RMHP** has partnered with the Quality Health Network (QHN) health information exchange to pilot a project with select primary care medical providers (PCMPs) and social service organizations to test software that will enable secure high-level communications across participating healthcare and community-based programs.

- Mobile dental van—**RMHP** funded Mountain Family Health Centers for a mobile dental van to expand provision of preventive and restorative oral health services throughout their service area.
- Larimer County Community Corrections halfway house project—Identified as an initiative of 30 local community agencies, **RMHP** partnered with community corrections and fire department paramedics to reduce the excessive emergency room (ER) utilization rate of halfway house residents. The program established a weekly "blood pressure" clinic in both the men's and women's halfway house. The clinic serves as a conduit to assess other member needs and connect them to **RMHP** care coordinators or to the MyDigital MD emergency physician telehealth application. Community Corrections has also implemented a medical treatment feedback form that accompanies the member to an emergency department (ED) visit and discourages prescription of narcotic medications by the ED. Since inception of the clinic, ED visits have been reduced by 45 to 60 percent every month. **RMHP** supported implementation of a similar program in a Montezuma County homeless shelter.
- Health engagement teams—Whole Health, a subsidiary of Mind Springs Health, employs and supports community health workers to work in the community as extensions of PCMP practices, targeting high ED utilizers.

**RMHP** staff credited the Department with partnering at the statewide level to facilitate relationships that meet shared regional and ACC strategies and when efficiencies can be better realized at a State level (e.g., criminal justice system, CCBs, and SEPs). **RMHP** also applauded the Department for resisting attempts to be prescriptive in processes and resources, affording development of community-based collaborative processes and programs. **RMHP** suggested that the Department should further pursue mechanisms for sharing raw data (e.g., long-term supports and services data)—not analytics—among agencies and with the RCCOs.

### Observations and Recommendations

**RMHP**, through collaborative community partnerships, has demonstrated strategies and commitment to act as leader, convener, funder, and/or participant in multiple community and regional initiatives. **RMHP** has developed a network of community partners across the region over time and will continue to do so. **RMHP** demonstrated patience and perseverance to overcome challenges in these relationships and has used the base of care coordination for individual members to launch broader community and agency cooperative ventures. **RMHP** stimulates pilot projects to test programs and solutions that may be transferrable to other communities. **RMHP**'s predominantly rural region not only necessitates diverse community-based solutions, but also enjoys the advantage of community partners that are inherently dedicated to serving the members and their communities-at-large. **RMHP** appears to have designed a robust, interactive, and inclusive RCCO partnership strategy with many effective outcomes.

## Provider Network/Provider Participation

### Lessons Learned—Successes and Challenges

From its inception, Region 1 has contracted with almost every primary care practice in the region, stating that the primary care practices serving Medicaid members preceded the ACC and that the RCCO was merely a new vehicle for member access to providers. Similarly, **RMHP** had a Medicaid managed care product operating on the Western Slope, which later transitioned into the Prime contract—a pilot payment reform program of the ACC. Regardless of the provider contracting source, approximately the same providers have been available to participate in the RCCO primary care network. Similarly, the specialist providers available in the region have been relatively unchanged. Due to the fact that it is difficult to attract new and additional providers to a largely rural region, **RMHP** has engaged over the past several years in a provider network strategy focused on expansion of capacity within the existing provider system. Believing that expanding capacity is dependent on improving efficiencies in practice operations, improving provider satisfaction, and increasing productivity through improved member outcomes, **RMHP** has committed to a strategy which incorporates the following elements: (1) implementation of an advanced practice training and support program, (2) providing data resources and information for provider decision-making, and (3) integrating physician extenders into primary care practices. The advanced practice training program is a multifaceted approach to practice transformation involving practice coaching for development of team-based care in practices and assisting providers to implement and use data systems and data-driven decisions in their practice. The program is a multi-year process of training and on-site support offered to select "qualified" practices. Initially implemented in association with the Comprehensive Primary Care Plus (CPC+) Initiative, the advanced practice program has expanded to 70 practices (including 30 specialist practices) during 2016. Mechanisms to integrate physician extenders into primary care practices has involved projects or pilot programs such as incorporating community health workers into primary care practices to extend primary care services into the community, funding care coordinators within primary care practices to improve efficiency of referrals and coordination of information with specialists, and downstreaming specialist expertise into primary care through telehealth.

For the past two to three years, **RMHP**'s primary focus has been integrating behavioral healthcare practitioners into practices. **RMHP** described this as "a small investment with significant returns" and has accelerated this process over the past year. This initiative is also associated with the State Innovation Model (SIM) grant. **RMHP** provides funding for practices to support salaries of behavioral healthcare providers integrated into a practice, and then allows the individual practice to determine how to structure and implement behavioral healthcare. **RMHP** invited physician representatives of two integrated PCMP practices—Pediatric Health Partners in Durango and Marillac Clinic (a federally qualified health center [FQHC]) in Mesa County—to the on-site review to provide testimony to the experience of operating in an integrated practice environment. Both practices stated that access to behavioral healthcare services for their members was an ongoing problem. Pediatric Health Partners has integrated behavioral healthcare practitioners into the care team for all members, to include support for parents of children dealing with behavioral issues. The practice also has a telehealth link to Children's Hospital psychiatrists. The presenting pediatrician stated that behavioral healthcare integration "normalizes"

mental health and social issues as components of whole-family health and stimulates innovation in other areas of the practice. Pediatric Health Partners also operates an outreach clinic in Silverton to address unmet behavioral healthcare needs in that community. The Marillac Clinic was still evaluating how to best structure member access to behavioral healthcare providers within their team practice environment. Both practices described that having behavioral healthcare specialists operating within the practice frees up significant time for primary care providers (PCPs) to care for other patients, enhances the overall services available to members in the practice, improves the quality of care to members, and improves satisfaction of providers with the overall practice environment. Both practices stated that team based care in an integrated practice environment is an important tool for recruiting additional primary care providers to the practice. **RMHP** has partnered with St. Mary's Hospital Medicine Residency program, which teaches future primary care physicians to operate in an integrated health team environment. The residency program provides an Integrated Health System (IHS) advisor to **RMHP**'s advanced practice team to work with practices on integrating behavioral healthcare into practice work flow.

The Marillac Clinic doubled in size within the past 12 months in response to the significant increase in the Medicaid population in Mesa County. Now serving 10,000 patients, this advanced practice provider implemented team based care and a new electronic medical record (EMR) system, and has invested in using data to operationalize quality improvement in patient care. The practice has also established a fellowship program for nurse practitioners. Physicians from the practice described the impact of implementing an active quality improvement program in the practice using outcome measures, evaluating care "from the ground up" through EMR data and using Plan-Do-Study-Act (PDSA) cycles for improvement. Physicians stated that "physicians want to practice in an environment that delivers quality healthcare; therefore, investing in quality improvement programs helps retain and grow providers within the practice."

On-site providers stated that challenges encountered by providers in growing their practices included:

- Limited funds to reimburse behavioral healthcare practitioners in a primary care practice.
- Time required for practitioners to convert and adapt to a team based practice and actively participate in data analysis and quality improvement activities.
- Workforce development—finding the right personalities to work within a team based environment, as well as limited access to behavioral healthcare providers that are an appropriate "fit" for a primary care practice.

Representatives of both practices stated that they needed **RMHP**'s support and resources to initiate and maintain practice transformation and that **RMHP**'s flexibility in allowing practices to define how each practice accomplishes its objectives was essential. **RMHP** staff members reiterated that practice transformation cannot be accomplished without additional investment, professional support, and payment reform.

Participants in the on-site interview offered that the Department has done the "right thing" by allowing the RCCO flexibility in how to support provider practices to meet the demands of increased capacity in the provider network and to improve the provider's practice experience of working with Medicaid

members. Providers also stated that practitioners appreciate the opportunity to participate in the Department's Medicaid work groups. Participants suggested that the following actions by the Department could positively influence provider participation in the Medicaid program:

- Clarify the State's intentions for reimbursement of PCPs. While Medicaid expansion created an exponential flow of new Medicaid members into practices, PCPs remain unclear about future reimbursement methodologies for primary care.
- Combine behavioral healthcare services with the rest of the primary care system. Separation of the behavioral health organization (BHO) from the rest of the provider system presents a problem for members in accessing services and for primary care providers in receiving reimbursement for behavioral healthcare services.
- Align coding, billing, and data sources across all pay sources whenever possible.
- Streamline attribution of members to practices—members being aligned with a practice but not attributed to that practice presents a major concern.
- Streamline programs and performance measures in order to reduce repetitive reporting and analysis.

### Observations and Recommendations

**RMHP** has invested significant financial and professional resources in a robust program for practice transformation, involving both PCMPs and specialists. Successful practice transformation is a time-consuming and lengthy process, to which **RMHP** has increasingly committed. **RMHP** does not envision that additional providers will be available to participate in the Medicaid provider workforce. Practice transformation appears to improve the capacity within the existing primary care network, enhances the satisfaction of Medicaid providers, and improves quality of care and access to needed services for members. **RMHP** is committed to continuing this initiative, but may need the continued partnership of the Department to enable the flexibility and financial mechanisms to do so (e.g., payment reform, grant funding).

## *Member Engagement*

### Lessons Learned—Successes and Challenges

**RMHP** invested in multifaceted approaches to increasingly engage members in the RCCO's objectives. **RMHP** implemented many traditional approaches to member engagement, such as a member website that includes communications and tools specific to members (e.g., newsletters, provider directory), quarterly member advisory council meeting for members and families to provide input, customer service welcome calls to all new members, RCCO member brochures available through multiple distribution points, general wellness and preventive care mailings and targeted "gaps in care" mailings to members, and outreach calls following an ED visit to determine member needs and educate members on alternatives to ED use.

**RMHP** conducted staff and provider trainings to improve competencies for providing services to Medicaid members, including Bridges Out of Poverty, cultural competency, disability-competent care,

and motivational interviewing. In 2013, PCMPs implemented patient activation measures within their practices; and participation of providers and members steadily increased between 2013 and 2016. As part of care coordination efforts to integrate members being discharged from the criminal justice system into Medicaid services, **RMHP** care coordination staff members participate in monthly orientation sessions for parolees to encourage them to select a PCMP and participate in care coordination. In 2015–2016, **RMHP** developed the MyDigital MD telehealth application to provide individual members with text or video access to an emergency physician who can provide urgent care advice in lieu of the member accessing the ED.

While all of these mechanisms for member engagement remain in place, **RMHP** determined that understanding member experience requires more than surveys, measurement, and committee meetings, and that the RCCO needed to move "beyond competent to conversant" with diverse member populations. Therefore, **RMHP** significantly elevated its member engagement processes in 2016 to more directly interact with representatives of diverse member populations and learn more about the needs and barriers for these populations. Staff members stated that, "the system does not need to engage members to meet RCCO objectives, rather the RCCO needs to understand how to meet members' objectives." To that end, **RMHP** participated in several initiatives designed to create a learning environment for meaningful input directly from diverse member populations, specifically focusing on members with disabilities, the deaf and hard-of-hearing community, and monolingual Spanish-speaking members. To demonstrate the RCCO's 2016 initiatives in this regard, **RMHP** invited members and representatives of various member communities to the on-site review to present input and describe outcomes of the following initiatives:

- "The Voice of Medicaid"—**RMHP** conducted a qualitative study based on interviews which gathered feedback from members in the field and "in their voices" regarding member experience with **RMHP** and the Medicaid system-at-large. Representatives of various community populations and the member advisory committee provided input into interpretation of the results, which were organized into the following categories: "accessing information, paperwork puzzle, prescriptions, provider access, provider care, care coordination, mixed emotions, envelope anxiety, and the realities of being poor."
- Monolingual Spanish-speaking community—As a subset of the Voice of Medicaid interviews and additional research conducted through leadership in the Spanish community (Julissa Soto), **RMHP** gathered information from the monolingual Spanish-speaking community regarding access to healthcare and social support needs. The process used "promotores" to informally engage members in the community and to identify the unique needs and perceptions of members who do not speak English.
- Forums with the deaf and hard-of-hearing community—**RMHP** engaged deaf and hard-of-hearing individuals through the Larimer County Group for Deaf Rights in Healthcare to understand and address barriers to care for the deaf community. The process included two town hall meetings with the deaf community, including one with providers, which identified the need for non-family interpreters at provider encounters. **RMHP** formed similar relationships on the Western Slope, which identified that no qualified interpreters were available and resulted in **RMHP** funding a certified interpreter through the Independent Living Center (ILC).

- Accountable Health Communities Model (AHCM)—In response to the AHCM federal grant opportunity, **RMHP** developed a consortium of numerous clinical, community, and advisory organizations to participate in providing leadership to systematically addressing social determinants of health and health disparities within Western Slope communities. **RMHP** staff members stated this leadership forum will have an ongoing role within the RCCO, regardless of the outcome of the grant proposal.

Participants in the on-site interview offered the following additional conclusions regarding understanding the member experience through these various learning environments:

- Care coordination and access to correct information remain key elements in successful member outcomes. However, the definition of care coordination varies throughout the system; and members remain fearful of using the system or care coordination, expressing that it is perceived that one is giving up control over "your services, your choices, and your life."
- Providing choice within those services important to members and possibly engaging more peer involvement in healthcare may improve meaningful member outcomes in the future.
- The definition of consumer-driven, member-focused care is based on what is meaningful to the individual; meeting people "where they are" is essential. Members need to assist the RCCO in understanding how to help members, rather than the RCCO educating members on how to use the system.
- Direct member input provides a fast track to member engagement and meaningful solutions.
- People who obtain information from members of particular populations should be skilled with those populations—i.e., those with different languages and cultures—and remain involved throughout the solution phase of projects and programs.
- Community partners coming together to design their own system of health services is the most effective mechanism for improving healthcare for members. The "system" should provide supports, not controls.

**RMHP** believes that member engagement is most meaningful and effective at the community or regional level—not the State level. **RMHP** suggested that the Department's production of measurements, charts, and graphs for RCCO response is a distraction from allowing networks and structures for member engagement to evolve in communities. However, the Department could facilitate sharing of local learning experiences and solutions among regions or statewide. **RMHP** staff suggested that the Department's strategy with the future Regional Accountable Entities (RAEs) should be to provide tools and resources to the RAEs to pursue flexible community-based solutions for ongoing change, citing that **RMHP** has learned that, "Communities do not need to be educated about the State agenda; the State needs to be educated about diverse communities."

### Observations and Recommendations

**RMHP** continuously evolved its member engagement strategies, from implementation of fundamental outreach communications to its most recent methodology of creating learning environments to directly engage members and representatives of member populations. **RMHP** also has begun to explore diverse member populations to understand their unique needs and develop both fast-track and ongoing solutions within communities. **RMHP** engaged both professional resources and persons with expertise in understanding specialized member communities—e.g., members with disabilities, families of members with autism, Latino members, members who are deaf or hard of hearing—in this process. The presence of member representatives at the on-site review provided the opportunity for Department and HSAG staff to experience direct input from members and participate in discussing solutions. HSAG recommends that the Department possibly consider endorsing a qualitative approach similar to the **RMHP** Voices of Medicaid study, administered through the individual RCCOs, as a mechanism to gather valuable information regarding the true member experience and to provide actionable results. Through both its care coordination interactions with members and forums for direct member feedback, **RMHP** identified and committed to understanding social determinants of health as a priority. **RMHP** appears to be at the forefront of advancing Medicaid member engagement.

## *Care Coordination*

### Lessons Learned—Successes and Challenges

RCCO Region 1 is an expansive geographic region covering the entire western region of the State and Larimer County on the front range. Most counties in the region are rural or frontier areas. Due to the diverse geography, **RMHP** has, from the inception of the RCCO, defined community-based CCTs to support the members assigned to PCMPs within a geographic area. The inaugural CCTs were located in four areas and designed to operate in partnership with existing care management structures operating in those vicinities, including public health departments, the North Colorado Health Alliance (NCHA), and the University of Colorado Health (UCH) system in Fort Collins. **RMHP** supported each team with resources, and all members and PCMPs unassigned to one of the existing CCTs received care coordination through the central **RMHP** team located in Mesa County. **RMHP** recognized that one early success of the CCT strategy was the integration and partnership of CCTs with local healthcare and community resources and leadership. As Medicaid ACC membership has steadily increased over the years, **RMHP** has added significant numbers of care coordination staff and dispersed those additional staff into existing teams, and established new teams in communities throughout the region. Each CCT is assigned to support all members residing within designated counties or (as in the UCH team) to support designated PCMP practices. While the CCT concept remains the focus of the structure and operation of care management, **RMHP** has also evolved to partner with select PCMPs that had capable care coordination structures within their practices. Examples include Mountain Family Health Centers, Axis Health Systems, and Dove Creek FQHC. In 2016, **RMHP** had nine CCTs supporting all members and PCMPs throughout the region. Funding to support care coordination has also increased over the years, to approximately 50 percent of the RCCO 1 budget.

While **RMHP** assumes ultimate accountability for care coordination performance and outcomes, each CCT has diffused authority to define functional approaches unique to the resources, community interests, and member characteristics associated with each geographic area. CCTs partner with **RMHP** and with community organizations and providers for projects unique to their communities. Staff members reported that the learning curve regarding ACC care coordination has been communitywide, resulting in many community programs now sending referrals to the CCTs. **RMHP** has developed a regionwide network of care coordination teams, leveraging local personnel and community resources to work with **RMHP** in care coordination efforts. **RMHP** staff described this approach as a powerful and productive resource for meeting the needs of members.

Accountability of the CCTs to ACC priorities and goals has been supported by **RMHP** data sources (e.g., member risk-level identification reports), funding, leadership, and clear training materials. **RMHP** regularly monitors the quality of work performed by the CCTs by auditing the care coordination data systems. **RMHP** holds quarterly regionwide CCT meetings to provide the teams with RCCO direction and to allow teams to share innovative ideas and approaches for CCT operations, problem solving, and program successes to avoid duplication of efforts. **RMHP** stated that during early development of the RCCO, CCTs operated in relative isolation, with HIPAA-driven concerns about what information or data could be shared. However, with the development of business associate agreements and **RMHP** investment in the Essette Care Management software, data sharing among the teams and between the teams and **RMHP** management has significantly improved consistency of performance. In addition, the Essette system, now implemented by most CCTs and some community partners, enables the member's care coordination record to be seamlessly shared among diverse members of the care coordination team and allows the record to follow the member when the member relocates and is transitioned to a new CCT. **RMHP** described that CCTs have evolved into operating as one integrated team.

Staff members stated that **RMHP** care coordination has also evolved the structure of CCTs to include multidisciplinary staff in order to meet the diverse medical, behavioral, and social support needs of members with complex needs. By 2016, most CCTs had incorporated nursing, behavioral healthcare, and social work professionals into their teams. In addition, community health workers have been trained and integrated into some of the teams. **RMHP** has also invested in "social determinants of health" as a primary factor in member's care coordination needs, leading to increased emphasis on developing active working relationships with community organizations and other agencies to meet individual member's needs. By working together to meet an individual member's complex needs, CCTs have accelerated their understanding of the roles, strengths, and weaknesses of various local resources, and have identified preferred providers and partners to enable resolution of both member and community issues on a systemwide level.

**RMHP** staff stated that within rural areas, lack of resources in general is a challenge and requires innovative solutions. **RMHP** informed that lack of transportation resources is a major issue in many communities, and described an initiative in the San Juan Basin area to organize two non-emergency medical transportation (NEMT) service providers where none were previously available.

**RMHP** identified the following member populations as particular challenges for care coordination teams:

- Members with pervasive behavioral healthcare issues (including traumatic brain injury)—members are often unreliable or inconsistent in meeting their needs; behaviors sometimes result in providers or agencies refusing to accept them; adequate behavioral healthcare resources are sometimes scarce.
- Members with chronic pain and opiate medication dependencies—some members do not want to change their medication management; member engagement is difficult and may be complicated by legal or safety issues.
- Members with housing needs—lack of housing alternatives for Medicaid members is a pervasive problem; in addition, no inpatient/residential facilities are available for members with substance abuse disorders.
- Members transitioning between providers, levels of care, or geographic locations—members may be lost in transition. To this end, over recent years **RMHP** has gained access to real-time data feeds of ER visits and hospital admissions and discharges across the State. In addition, the Essette system has enabled smooth transition of member care coordination records between care teams.

**RMHP** staff stated that the Department's greatest contribution to the RCCO's care coordination efforts has been the flexibility that the ACC program has allowed by defining goals and outcomes while not being prescriptive with the processes used to accomplish those outcomes. This design of the ACC model has enabled the RCCO to define mechanisms for care coordination that are integrated with community-based resources and to innovatively respond to diverse member populations and individual community needs. In addition, **RMHP** appreciates its partnership with the Department to resolve policy-driven issues and facilitating inter-agency relationships with State-driven agencies and programs such as the SEPs, CCBs, and the Colorado Department of Corrections. **RMHP** also noted the Department's assistance with breaking down barriers in developing NEMT services in a remote part of the State. **RMHP** also recognized the efforts of the Department to work with the statewide health information exchanges—Colorado Regional Health Information Organization (CORHIO) and Quality Health Network (QHN)—and development of the Statewide Data Analytics Contractor (SDAC) data to support the information needs of providers, care coordinators, and **RMHP** management. Conversely, **RMHP** described that when the Department becomes more prescriptive with processes—citing the Medicare Medicaid Program (MMP) care coordination requirements as an example--those processes may be in conflict with locally driven priorities or inadvertently redirect the use of limited resources or funding. **RMHP** sincerely believes and has invested in a local regional and community-based strategy, and expressed that the "best thing" the Department can do moving forward is to maintain the capability for the RCCO to innovate to accomplish effective care coordination for members.

## Observations and Recommendations

HSAG observed through **RMHP**'s on-site presentation of care coordination cases the following common themes associated with members with complex needs:

- All cases included behavioral and/or substance abuse issues.

- Homelessness or risk of homelessness was a common occurrence.
- Numerous providers and agencies were often involved in the member's care.
- Legal and financial challenges were common.
- Transportation assistance was generally required.
- Member engagement and family support systems were major factors in successes or challenges.
- RCCO care coordinators often served as lead coordinator because they do not have siloed responsibilities specific to individual healthcare, behavioral, or community agencies/organizations.
- Members often require individual accompaniment to appointments and personal assistance with applications and paperwork.
- Members with complex needs often consume enormous resources from the collective care coordination team.

**RMHP** made significant progress over the years based on learning and responding to the challenges associated with managing members' complex needs, including expanding and structuring CCTs to integrate appropriate professional disciplines, integrating effectively with other local agencies and community resources, and leveraging community-based personnel and resources to partner in meeting the RCCO's care coordination goals and member needs. **RMHP** supported its decentralized approach through support services such as data sharing, collaborative CCT team meetings and trainings, offering a shared care coordination data system to CCTs and community partners, and providing resources needed to support local CCT initiatives. This approach appears to have resulted in what the **RMHP** team described as "reciprocal accountability"— the CCTs to **RMHP** and **RMHP** to the CCTs—and has evolved into a cohesive network of CCTs across the region. The CCTs engaged leaders and organizations within their geographic areas to identify and resolve member and community service issues and to support the initiatives and goals of the ACC. **RMHP** brought to the on-site review members of their diverse care teams, who generally described enthusiasm for **RMHP**'s care coordination program and the resources that it brought to fill gaps in care coordination systems and support members within local areas of the region. While the rural characteristics of the region presented challenges in having or accessing necessary resources, **RMHP** embraced opportunities for innovative and collaborative responses to these challenges. **RMHP** also responded to "lessons learned" in managing specific member populations or operational challenges experienced by CCTs by continuously exploring, testing, and sharing solutions among the CCTs. **RMHP**'s approach appears to have minimized duplication of resources while encouraging transferability of best practices and projects across the region. In addition, **RMHP** tends to implement rather than excessively deliberate on challenges and solutions. HSAG observed that the depth, breadth, and influence of **RMHP**'s care coordination program and support systems have continuously and smoothly evolved and improved over time. The program appears to have evolved into a regionwide cohesive operation while maintaining community-responsive engagement and a locally-driven approach.

## Balance Between Central (Department-Driven) ACC Priorities and Regional (Community-Driven) Priorities

### Lessons Learned—Successes and Challenges

Since the inception of the ACC program, **RMHP** regularly pursued involvement in grants and program opportunities offered or enabled through the Department, other sources, or legislative actions. **RMHP**'s strategy is be opportunistic in engaging in special programs that complement the overall regional strategy for developing a better health system for Medicaid members and providers. **RMHP** leadership stated that its strategy is mission-driven and based on a commitment to integration of the financial, leadership, clinical, and cultural components of healthcare. As such, **RMHP** leadership does not consider any of the many programs and projects in which they participate to be in conflict with or duplicative of ACC priorities. **RMHP** staff members stated, "The ACC is sustainable because of the commitment of people in the system, and is not dependent on grants and other special programs." **RMHP**'s goals are to create connections and capacity using a variety of funding streams. The special programs and projects offered through the Department or other sources clearly provide resources to enable initiation and implementation of various components of **RMHP**'s mission. However, if those funding streams discontinue, staff members perceived that both the ACC and **RMHP**'s mission will continue. Staff members stated that being involved with multiple projects and programs is taxing, requiring multiple meetings, applications, implementation, evaluation, and reporting. However, **RMHP**'s pre-existing relationships with community organizations and leadership and a shared "partner attitude" enable the RCCO to pursue opportunities in an expedited manner. In addition, **RMHP** historically and currently is deliberate in data-driven evaluation of all programs and services.

**RMHP** has participated in or initiated numerous special programs or pilot projects to address the priorities of the ACC, including but not limited to:

- SIM—supports integration of BH practitioners into primary care.
- CPC+—supports practice transformation.
- Colorado Opportunity Project—supports four projects to connect members to social determinant programs.
- Prime—payment reform initiative applicable to a segment of RCCO members and providers.
- Medicare-Medicaid Program—supports integration of dual eligible members into the ACC.
- House Bill 15-1368, Cross-System Response for Behavioral Health Crises Pilot Project—supports the Intellectual and Developmental Disabilities Crisis Center.
- Health engagement teams—support community health workers to engage with high ED utilizers in the community.
- Criminal Justice Initiative—working with the DOC to coordinate Medicaid services for parolees.
- "Easy Care Colorado"—telehealth to increase capacity in specialist and primary care practices; supported by Colorado Health Foundation grant.

- Accountable Health Communities Model—engagement of diverse community partners and providers to provide leadership for projects to address regionwide social determinants of health; potentially supported by Centers for Medicare and Medicaid Innovation (CMMI) grant.

Staff members complimented the Department for identifying opportunities for the RCCO to participate in special programs and projects and for supporting **RMHP** in pursuit of other pilot opportunities such as payment reform. **RMHP** believes that such programs support multiple learning opportunities and innovative program development to strengthen the ACC model. **RMHP** encouraged the Department to continue pursuing innovation opportunities and advocating for payment reform. Again, **RMHP** stated that the best opportunities are those that allow RCCOs the flexibility to implement programs and projects that are a good "fit" with the unique needs and strategies of each region. **RMHP** also acknowledged the responsiveness of the Department to assist the RCCO in overcoming barriers with statewide organizations and processes, citing improvement in relations with CCBs; facilitating solutions to the NEMT problem in southwest Colorado; working with the Department of Corrections; facilitating access to health information exchange data; and providing seminars and education that bring together diverse groups, such as the disability community and the MMP conference. Going forward, **RMHP** requested that the Department share raw data from multiple State data bases and/or pursue mechanisms to develop crossover or combined program data sources to ease access to all meaningful Medicaid member data. In addition, **RMHP** desires that the ACC regions and the Department work collaboratively to formulate a proactive, policy-level response to anticipated changes in the national Medicaid program.

### Observations and Recommendations

**RMHP** has been consistently and actively engaged in Department initiatives, grants, and special projects, along with pursuing grant funding opportunities outside the Department, and will continue to do so. All programs in which **RMHP** participates are intended to support its ACC strategy, which **RMHP** states is mission-driven and not dependent on continuous funding of special initiatives. Nevertheless, many specific program opportunities have been complementary to **RMHP**'s strategy for Region 1 and have enabled resources to offset implementation costs and expedite implementation. **RMHP** wisely uses these programs and resources as an integral component of implementing **RMHP** objectives. **RMHP** also diligently applies data to evaluate results of program initiatives. **RMHP** desires that the Department and RCCO continue to work collaboratively to maintain the flexibility and innovation allowed through the ACC program to date in order to ensure that integrated healthcare for all Medicaid members and providers is truly transformative and achieves a better system of healthcare for all. HSAG anticipates that **RMHP** will continue to be a leader within the healthcare communities in its region.

## Overview of Site Review Activities

The FY 2016–2017 site review represented the sixth contract year for the ACC program. The Department asked HSAG to perform an annual site visit to assess continuing development of **RMHP** as the RCCO for Region 1. During the initial six years of operation, each RCCO continued to evolve in operations, care coordination efforts, and network development in response to collaborative efforts, input from the Department, and ongoing implementation of statewide healthcare reform strategies. The FY 2016–2017 site visits focused on evaluating RCCO experiences and lessons learned related to diverse ACC stakeholders and regional characteristics—including community partnerships, provider participation, member engagement, and integration of multiple Statewide and regional priorities. In addition, HSAG gathered follow-up information on care coordination activities and strategies implemented by each RCCO. Through review of member care coordination cases, HSAG documented examples of RCCO-selected "best" cases of comprehensive care coordination. The Department also asked HSAG to offer observations and recommendations related to each ACC focus area reviewed.

## Site Review Methodology

HSAG and the Department met on several occasions to discuss the site review process and finalize the focus areas and methodologies for review. HSAG and the Department collaborated to develop the Focus Topic Interview Guide and coordination of care case summary tool. The purpose of the site review was to explore with each RCCO the "lessons learned" since the inception of the ACC program regarding each focus topic—including changes over time, influence of recognized challenges and successes on RCCO operations, and the role of the Department in influencing RCCO operations. Site review activities included a desk review of documents related to each focus topic that were submitted by **RMHP** prior to the site visit. During the on-site portion of the review, HSAG conducted group interviews of key **RMHP** personnel using a semi-structured qualitative interview methodology to elicit information pertaining to the Department's interests related to each focus topic. The qualitative interview process encourages interviewees to describe experiences, processes, and perceptions through open-ended discussions and is useful in analyzing system issues and associated outcomes.

To continue the annual assessment of care coordination activities, on-site review included care coordination case presentations by RCCO staff members. The Department determined that FY 2016–2017 care coordination reviews would focus on demonstrating the best examples of RCCO care coordination activities and outcomes for members with complex needs. HSAG reviewed a sample of 10 care coordination cases selected and presented by the RCCO. HSAG completed an individual care coordination summary for each case. The Department determined that the care coordination record reviews would not be scored. HSAG considered results of care coordination presentations in documentation of findings related to the Care Coordination focus topic area.

Summary results and recommendations resulting from on-site interviews and care coordination case presentations are included in the Summary of On-Site Discussions.

# Appendix A. Focus Topic Interview Guide

This appendix includes the HSAG Focus Topic Interview Guide used to facilitate the on-site discussions.

## Focus Topic 1: Community Partnerships/Collaboration

- How are relationships with these community entities progressing:
  - County agencies?
  - SEPs/CCBs?
  - Other community organizations?
  - Do you feel like you could benefit from additional key relationships? (Specify.)
- How did you build these relationships over the past five years? Such as:
  - Methods of contact/communications
  - Techniques used to sustain
  - What has been the evolutionary process?
- How responsive are organizations to RCCO interests or priorities?
- What are some of the major areas of success?
  - How have those successes influenced operations, programs, and/or relationships?
- What have been some of the major challenges/lessons learned?
  - What solutions were considered or implemented as a result?
- Are there differences in successes or failures related to specific member populations? (If yes—describe.)
- How is "coordinating the coordinators" among agencies and organizations working for you?
  - Do you feel like you are successful in this? If not, what are the barriers?
- What has been most helpful from the Department to facilitate or influence your relationships with community partners?
- What could the Department have done differently to improve/facilitate the process or outcomes?
- What programs other than those associated with Department initiatives have you developed with community partners?
- Other lessons learned regarding community partnerships since RCCO implementation?

## Focus Topic 2: Provider Network/Provider Participation

- How has your provider network evolved over time?
- How are providers functionally involved with your RCCO? What is the current role of providers in your RCCO?
- How active are providers in RCCO initiatives?
- How receptive (or not) have providers been to the ACC?
  - In what areas?
- How has provider participation changed since inception of the RCCO?
- What have been some of the major areas of success with providers?
  - How have those successes influenced operations, programs, and/or relationships?
- What has been most helpful from the Department to facilitate or positively influence provider participation in the RCCO?
- What have been some of the major challenges/lessons learned?
  - What solutions were considered or implemented as a result?
  - What could the Department have done differently to improve/facilitate the process or outcomes?
- What could be done to improve the provider network or provider experience?
  - By the RCCO?
  - By the Department?

## Focus Topic 3: Member Engagement

- What is your RCCO's perspective/view of "member engagement?"
  - How do you define it?
  - What do you consider to be "member engagement"?
- In what areas does member engagement occur?
- What mechanisms do you use to engage members (including tools—e.g., Patient Activation Measures)?
- What have been some of the major areas of success in member engagement?
  - How have those successes influenced operations, programs, and/or relationships?
- What has been most helpful from the Department to facilitate or influence member engagement?
- What have been some of the major challenges/lessons learned?
  - What solutions were considered or implemented as a result?
- Are there differences in successes or failures related to specific member populations? (If yes—describe.)
- Is member engagement more appropriate at the State level or is it more effective at a local level?
- How has member engagement changed or evolved since inception of the RCCO? Why?
- What could the Department have done differently to improve/facilitate the process or outcomes of member engagement:
  - From the beginning?
  - Support needed going forward?

## Focus Topic 4: Care Coordination

- Please describe your model for delegation and care coordination.
  - How has it changed over time?
  - What do you consider the more successful features of your model?
    - How have those successes influenced operations, programs, and/or relationships?
  - What have been some of the less successful or challenging features?
    - What solutions were considered or implemented as a result?
- How much success have you had in holding your delegates accountable? (Describe.)
- Are there differences in care coordination successes or challenges related to specific member populations? (If yes—describe.)
- Describe other significant lessons learned since inception of RCCO (such as staffing, structure, communications, systems support).
- What has been most helpful from the Department to facilitate or influence your care coordination efforts?
- What could the Department have done differently to improve/facilitate the process or outcomes?

## Focus Topic 5: Balance Between Central (Department-Driven) ACC Priorities and Regional (Community-Driven) Priorities

- Has your RCCO focus changed over time regarding State-driven priorities versus local RCCO priorities? (If so, how?)
- How do you determine strategic priorities within the RCCO?
  - Which factors do you consider?
  - Which factors most influence your decisions?
- Explore the multitude of Department "projects" and programs implemented through the RCCOs (e.g., Colorado Opportunity Project, SIM).
  - How do you handle/integrate the multiple projects?
  - What influence have multiple projects had on RCCO operations?
  - Do you have data to determine whether or not initiatives are working?
  - How do you perceive sustainability of these programs?
- What lessons have been learned over time about the influence of State-driven priorities on RCCO strategic processes or priorities?
- What has been most helpful from the Department to facilitate balance of State-driven priorities and programs with RCCO community-driven objectives and operations?
- What could the Department have done differently to facilitate the process of balancing State-driven and regionally-driven priorities? What is needed from the Department to improve this process?

# Appendix B. Record Review Summaries

Based on the sensitive nature of the coordination of care record reviews, they have been omitted from this version of the report. Please contact the Colorado Department of Health Care Policy & Financing's Quality Unit for more information.

# Appendix C. Site Review Participants

Table C-1 lists the participants in the FY 2016–2017 site review of **RMHP**.

**Table C-1—HSAG Reviewers and RMHP and Department Participants**

| HSAG Review Team | Title |
|---|---|
| Katherine Bartilotta, BSN | Senior Project Manager |
| Rachel Henrichs | External Quality Review (EQR) Compliance Auditor |
| **RMHP Participants** | **Title** |
| Aaron Hankins | Medicaid Community Health Outreach Coordinator |
| Ashli Robertus | Medicaid Case Manager |
| Carlee Lindell | Medicaid Community Health Outreach Coordinator |
| Carol Ann Hendrikse | Project Manager, Care Management; RCCO Clinical Manager |
| Dale Renzi | Director, Provider Network Management |
| David Mok-Lamme | Senior Community Research Analyst |
| Eve Presler | RCCO Colorado Opportunity Project Liaison |
| Greg Coren | Manager, Western Slope Provider Relations and Provider Network |
| Heather Akins | Medicaid Case Manager |
| Jackie Hudson | Director, Quality Improvement |
| Kevin Fitzgerald | Chief Medical Officer |
| Lesley Reeder | Consultant/Steadman Group |
| Lori Stephenson | Director, Clinical Program Development and Evaluation |
| Louisa Wren | Senior Community Programs Leader, Community Integration |
| Marci O'Gara | Director, Customer Service |
| Melanie Malkewicz | Medicaid Case Manager; Supervisor, RMHP North Colorado CC |
| Mike Huotari | Vice President, Legal and Government Affairs |
| Nicole Konkoly | Program Development Specialist, Community Integration |
| Patrick Gordon | Associate Vice President, Community Integration |
| Rhonda Hastings | Program Logistics Coordinator |
| Sandy Dowd | Director, Care Management |
| Sharon Steadman | Consultant/Steadman Group |
| Sheila Wise | Human Resources Analyst |
| Sheila Worth | Human Resources Analyst |

| RMHP Participants | Title |
|---|---|
| Amy Gallagher | Director, Integrated Care—Mind Springs Health/Whole Health, LLC |
| Alison Sale | North Colorado Health Alliance |
| Christine Gallagher | North Colorado Health Alliance |
| Dr. Cecile Fraley | Pediatric Partners of the Southwest |
| Dr. John Whiteside | Chief Medical Officer, Marillac Clinic |
| Jenny Miller | Specialist for the Deaf and Hard of Hearing with DRS |
| Joanna Martinson | Northern Colorado Health Alliance |
| Julie Reiskin | Executive Director, Colorado Cross-Disability Coalition |
| Julissa Soto | Senior Consultant, PDF Consulting; Director, Latino Initiatives—American Diabetes Association, Colorado Chapter |
| Kalisha Crossland | Axis Health Systems |
| Karen Reinertsen | Department of Corrections—Adult Parole |
| Kay Ramachandran | Executive Director, Marillac Clinic |
| Kim Fairley | North Colorado Health Alliance |
| Laura Warner | Division Director, San Juan Basin Health Department |
| Lauren Carpenter | Outreach/Care Coordinator, NWCCP |
| Megan Johnson | Behavioral Health Specialist (SummitStone)-MACC Team |
| Megan Geraets | Outreach/Care Coordinator, NWCCP |
| Shawn Davis | Consultant and Evaluator, PDF Consulting Inc. |
| Stephen Thompson | Program Supervisor—Medicaid ACC and Healthy Harbors Program, PVHS/University of Colorado Health, Community Health Improvement Department (Fort Collins CCT) |
| Tim Hudner | Member of RMHP Western Slope Member Advisory Council |
| Yuly Torres | ADA, Latino Initiatives |
| **Department Observers** | **Title** |
| Ben Harris | ACC Contract Manager and Performance Specialist |
| Anne Jordan | Operations Specialist, Medicare-Medicaid Program; Contract Manager, Health Programs Office |
| Kathleen Homan | Policy and Outreach Specialist, Medicare-Medicaid Program |
| Russ Kennedy | Quality and Compliance Specialist |
| Patricia Connally | Quality and Compliance Specialist |