Colorado
Accountable Care Collaborative

FY 2013–2014 Site Review Report

for

Rocky Mountain Health Plans (Region 1)

June 2014

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

HSAG HEALTH SERVICES ADVISORY GROUP

3133 East Camelback Road, Suite 300 ◆ Phoenix, AZ 85016
Phone 602.264.6382 ◆ Fax 602.241.0757

CONTENTS

Introduction

The Colorado Department of Health Care Policy and Financing (the Department) introduced the Accountable Care Collaborative (ACC) Program in spring 2011 as a central part of its plan for Medicaid reform. The ACC Program was designed to improve the client and family experience, improve access to care, and transform incentives and the health care delivery process to a system that rewards accountability for health outcomes. Central goals for the program are (1) improvement in health outcomes through a coordinated, client-centered system of care, and (2) cost control by reducing avoidable, duplicative, variable, and inappropriate use of health care resources. A key component of the ACC Program was the selection of a Regional Care Collaborative Organization (RCCO) for each of seven regions within the State. The RCCOs provide medical management for medically and behaviorally complex clients; care coordination among providers; and provider support such as assistance with care coordination, referrals, clinical performance, and practice improvement and redesign. **Rocky Mountain Health Plans** (**RMHP**) began operations as a RCCO in June 2011.

The Department has asked Health Services Advisory Group, Inc. (HSAG), an external quality review organization, to perform annual site reviews to monitor the progress of each RCCO's development and progress in implementing key features of the ACC Program. This report documents results of the FY 2013–2014 site review activities for the review period of January 1, 2013, through December 31, 2013. This section contains summaries of the findings as evidence of compliance, activities, and progress based on on-site discussions, and HSAG's observations and recommendations related to each of the focus areas reviewed this year. Section 2 provides an overview of the monitoring activities and describes the site review methodology used for the 2013–2014 site reviews. Appendix A contains the completed on-site data collection tool. Appendix B contains detailed findings for the care coordination record reviews. Appendix C contains the detailed results of the provider network capacity analysis. Appendix D lists HSAG, RCCO, and Department personnel who participated in some way in the site review process.

Summary of Results

HSAG assigned each requirement in the Provider Support section of the data collection tool a score of *Met*, *Partially Met*, or *Not Met*. HSAG also described findings for each requirement and identified opportunities for improvement with associated recommendations for requirements that were assigned a score of *Partially Met* or *Not Met*. Table 1-1 presents the scores for **RMHP** for Provider Support contract requirements. A summary of the findings and recommendations is included in this section. For the Provider Network Development and Care Coordination focus areas, observations and results of on-site discussions based on document review and on-site focused interviews were not scored; however, they were captured on the data collection tool and summarized in this section.

Table 1-1—Summary of Scores							
Focus Area	Total Elements	Total Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score*
Provider Support	7	7	7	0	0	0	100%

*The overall percentages were obtained by adding the number of elements that received a score of *Met*, then dividing this total by the total number of applicable elements. *Partially Met* and *Not Met* scores received a 0.0 point value.

For the care coordination record reviews, HSAG assigned each requirement in the record review tools a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*. HSAG also identified opportunities for improvement with associated recommendations for each record. Table 1-2 presents the scores for **RMHP**'s care coordination record reviews. Detailed findings for the record reviews are in Appendix B—Record Review Tools.

Table 1-2—Summary of Care Coordination Record Review Scores							
Description of Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Care Coordination	132	109	108	1	0	23	99%

*The overall percentages were obtained by adding the number of elements that received a score of *Met*, then dividing this total by the total number of applicable elements. *Partially Met* and *Not Met* scores received a 0.0 point value.

Summary of Findings and Recommendations by Focus Area

Provider Support

Findings

The Provider Support Plan stated that **RMHP** provider relations (PR) staff serve as a "one-stop-shop" to help providers in Region 1 navigate the Accountable Care Collaborative (ACC) program administrative systems and processes. **RMHP** served as a liaison between providers and the Department to resolve recurring problems. The Practice Support Plan also described provider support activities in the areas of operational practice support and clinical practice support. The **RMHP** provider Web site included numerous educational resources and practice support tools available to all primary care medical providers (PCMPs). Staff explained that Community Care Teams (CCTs) are collaborative teams of providers and community leaders who have come together to assist **RMHP** and the community to define a delivery system uniquely appropriate for Medicaid members in that area, and to engage community partners as necessary to meet those objectives. Each CCT contains a care coordination team that supports PCMPs by coordinating care for members with complex needs. The care coordination teams also assist PCMP offices with prior authorizations, referrals, finding specialists, and locating other community resources to support patients' needs. The plan described the care coordination teams as the most valuable resource for clinical support of participating PCMPs.

Activities and Progress

Staff stated that providers experienced only limited problems with most ACC administrative processes, with the exception of the PCMP contracting process. **RMHP** assisted providers with enrollment in the ACC by meeting with them to answer questions, clarifying language in the Department's PCMP contract, and providing information on how the RCCO can support providers in meeting ACC contract requirements. **RMHP** developed a member identification (ID) card to assist providers with determining member eligibility and attribution.

RMHP designed a comprehensive Practice Transformation Program to assist practices, over several years, with transformation to patient-centered medical home (PCMH) functions and improved operational performance. The program has three structured levels of participation: Foundations, Masters Level 1, and Masters Level 2. **RMHP** also provided support for practices seeking National Committee for Quality Assurance (NCQA) PCMH accreditation. In April 2014, 95 practitioners were involved in some level of practice transformation, and an additional 50 practitioners were being recruited for participation. **RMHP** committed numerous staff members with diverse areas of expertise to assist practices. Masters Level 1 and Masters Level 2 practices have memorandum of understanding (MOU) agreements with **RMHP** that outline practice deliverables and cost-reimbursement provided by **RMHP**. In addition, **RMHP** developed CCTs in six of the more populated geographic areas of the region to support PCMPs with coordination of community resources and to oversee coordination for complex care management members. Staff stated that CCTs promote a community leadership commitment to the ACC.

Summary of Provider Support Tools

The **RMHP** ACC Web site for providers was easy to navigate and included an extensive listing of (and links to) every clinical, client, operational, and data support tool in the **RMHP** provider support library. While all materials in the **RMHP** resource library were accessible through the Web site, **RMHP** primarily introduced operational support tools to practices through the practice transformation teams, who work with practices on methods to implement and integrate the tools into practice workflow. Numerous tools and materials were available to providers as follows:

Clinical Tools—**6 of 6 of the categories of tools listed in the RCCO contract**:

- Clinical care guidelines and best practices
- Clinical screening tools, such as depression and substance use screening tools
- Health and functioning questionnaires
- Chronic care templates
- Registries
- Other: Care Coordination Teams

Client Materials—**5 of 5 of the categories of tools listed in the RCCO contract**:

- Client reminders
- Self-management tools
- Educational materials—specific conditions

- Client action plans
- Behavioral health surveys and other self-screening tools

Operational Practice Support—**9 of 10 of the categories of tools listed in the RCCO contract:**

- Guidance and education on the principles of the medical home
- Training on providing culturally competent care
- Training to enhance the health care skills and knowledge of supporting staff
- Guidelines for motivational interviewing
- Tools and resources for telephone call and appointment tracking
- Tools and resources for tracking labs, referrals, and similar items
- Referral and transitions of care checklists
- Visit agendas or templates
- Other: Practice Transformation Program

Data, Reports, and Other Resources—**4 of 4 of the categories of tools listed in the RCCO contract:**

- Expanded provider network directory
- Comprehensive directory of community resources
- Directory of other Department-sponsored resources, such as the managed care ombudsman and Nurse Advice Line
- Link from main ACC Program Web site to the contractor's Web site of centrally located tools and resources

Observations/Recommendations

RMHP demonstrated active engagement with PCMPs through regular contact and availability of assigned provider relations representatives to assist providers with any Medicaid administrative issues. The **RMHP** ACC Web site was very comprehensive and included numerous links and resources regarding the Medicaid and ACC systems, the PCMHs, and **RMHP** practice support tools. **RMHP** staff members stated that they intended to upgrade the Web site in 2014 to make it more interactive for providers. **RMHP** implemented a well-defined, robust program for transforming PCMP practices into high-functioning PCMHs over time. The CCTs demonstrated that they are a great asset to providers in the support of clinical care through coordinating care for members with complex needs, particularly social and community support needs. **RMHP**'s commitment to practice transformation and support extends well beyond specific RCCO contract requirements. **RMHP** should continue to actively recruit as many practices as possible into the practice transformation programs and assertively grow the staff resources as required to address the diverse needs of multiple practices.

Provider Network Development

Activities and Progress

The RCCO Network Adequacy Report analyzed numerous indicators of adequacy of the PCMP network, focusing on variables that were of particular interest in Region 1, such as ratios of providers to unattributed members, provider locations within Health Professional Shortage Areas (HPSAs), and providers accepting new Medicaid members within the five counties with the highest Medicaid expansion populations. The number of after-hours or urgent care centers increased minimally over the past year. **RMHP** stated that working with PCMP practices to expand after-hours/urgent care access is preferable to expanding contracts with hospital-based urgent care centers. The Network Adequacy Report noted that 73 percent of providers across the region were taking new Medicaid members. However, staff stated that while most practices remain open to Medicaid members, **RMHP** is concerned that many practices in the region are at or near capacity.

The Medicaid population in Region 1 grew by 117 percent during 2013 to 67,000 members. The percentage of unattributed members has increased to 44 percent. Because many of the Medicaid expansion populations have no claims history with Medicaid, there was no data to support attribution of these members to an existing PCMP, contributing to the increase in the number of unattributed members. The targeted recruitment list included all Full Benefit Medicare-Medicaid Enrollee (FBMME) providers, as identified by the Department, as well as additional providers being targeted for the payment reform initiative line of business (referred to by **RMHP** as "Prime") contract. **RMHP** anticipated that Prime will be a major source of additional practices for the RCCO (**RMHP** required that Prime providers also be RCCO providers), including a potential for 37 additional practitioners in Mesa and Montrose counties. **RMHP** prioritized recruitment of all school-based health centers and other alternative providers into the network. **RMHP** had a well-organized process and dedicated staff resources committed to an active recruitment and contracting process and engaged the Department to assist in contracting with some providers in FBMME gap areas. Staff stated that the RCCO provider support and practice transformation efforts are the ACC benefits that most influence additional providers to participate. During 2013, **RMHP** facilitated and invested in the development of Community Health Worker (CHW) programs in various communities to serve as extensions of primary care and community mental health services for select complex need members. A diverse team of providers from the community provides oversight of trained layperson CHWs in local communities.

To address the special needs of some of the Medicaid expansion populations, **RMHP** increased its partnerships with diverse community organizations, primarily through the CCTs in local communities. **RMHP** was targeting relationships related to the FBMME population (e.g., single entry point [SEP] agencies, independent living centers, and other providers of services for the elderly and disabled) throughout the region. **RMHP** was beginning to reach out to county agencies to determine how to improve parolee transitions into the community. **RMHP** staff stated that the foster care population continues to be a challenge due to lack of coordination in the State, county, and local community systems and services, and limited availability of resources at all levels. **RMHP** was examining the potential of replicating the Healthy Harbors program, active in Larimer County, to other communities. **RMHP** anticipated that the number of care coordination staff will increase throughout the region to support the increased volume and specialized needs of the expansion populations.

RMHP views the medical neighborhood as a collaborative alliance of provider and community organizations within local communities geographically dispersed throughout the region. **RMHP** developed CCTs and medical neighborhoods in the major population centers, where staff stated that 95 percent of the RCCO population were located. CCTs are engaging diverse providers and community organizations to participate in the development of the local health system for the Medicaid population. While considerable effort is required to organize providers and community leaders in a collaborative effort, **RMHP** maintained that local leadership and participation of community partners was essential to the long-term sustainability and effectiveness of the medical neighborhood. **RMHP** stated that it will prioritize engaging specialists to participate as partners in the RCCO delivery system in 2014. **RMHP** initiated discussions with hospital systems and was exploring innovative mechanisms to engage specialists in a meaningful way, such as potential downstreaming of some specialist care into the PCMPs. **RMHP** considers the provision of support for practice transformation, care coordination, and improved communications in specialty practices to be applicable to specialist interests, but described that gaining access to specialists is a complex issue.

Summary of Provider Network Capacity Analysis

Preliminary results of the MS Excel Pivot Table analysis of the provider network for Region 1 were presented to **RMHP** staff during the on-site review. HSAG explained the methodology of Pivot Table analysis and that lack of data integrity in the source document (obtained through the Department) rendered actual data accuracy unreliable. The reports could only be used to indicate the potential of using a Pivot Table approach to analyze provider capacity. **RMHP**'s assessment was that most practices in Region 1 are already operating at or near capacity. **RMHP** works with practices through the Practice Transformation Program to build new operational efficiencies that may expand the capacity for new Medicaid members over time. Review of the Pivot Table results stimulated discussions regarding the best methodology for defining and measuring true provider capacity for integrating new Medicaid members. **RMHP** suggested that historical measures of capacity, such as provider-to-member ratios, were not meaningful and that a uniform determination regarding a meaningful measure of capacity in practices would be critical to further analysis of statewide PCMP capacity. **RMHP** also cautioned that the cost/benefit of collecting the information should be considered.

In addition, staff members discussed the proposed spreadsheets for the collection of data regarding specialists and community organizations. Staff members suggested that the criteria concerning which providers or organizations should be included in the reports needed to be clearly defined and that the intended use of specialist or community organization databases should be understood so that the cost/benefit of collecting and maintaining the data could be evaluated.

Observations/Recommendations

RMHP was actively engaged in recruiting additional practices into the RCCO network. **RMHP** targeted all providers in the region not already contracted, with particular emphasis on both FBMME providers, as identified by the Department, and providers that will contract with the Prime network. **RMHP** anticipated that the Prime project would be the major source of adding practitioners who would also serve as RCCO providers. **RMHP** had a well-organized process and dedicated staff and resources committed to an ongoing recruitment process and engaged the

Department to assist in contracting with some providers in FBMME gap areas. While most practices remain open to Medicaid members, **RMHP** is concerned that many practices in the region are at or near capacity, and it has instituted a Practice Transformation Program to ultimately increase operational efficiencies and practice capacity for additional members. The CCTs, who support PCMPs in managing members with complex needs, were also considered major attributes in recruiting additional providers and in encouraging practices to accept additional Medicaid members. **RMHP** initiated innovative approaches (e.g., developing CHW programs and contracting with school-based health clinics) to expand primary care in communities.

RMHP focused on the development of medical neighborhoods in the higher population geographic areas through the CCTs, who are engaging diverse providers and community organizations to participate in the development of a local health system for the Medicaid population. To address the special needs of specific expansion populations (FBMME, children, and parolees), CCTs have engaged diverse community organizations, and **RMHP** has been pursuing agreements with appropriate State, county, and community agencies for exchange of data and collaborative care coordination efforts. **RMHP** described efforts as challenging and ongoing, involving negotiation of complex relationships among various provider and community organizations.

Care Coordination

Activities and Progress

RMHP developed CCTs in six of the more populated areas of the region to support the PCMPs in those communities with care coordination. PCMPs in other geographic areas are supported by the **RMHP** care managers. **RMHP** does not formally delegate PCMPs to perform care coordination, although some high-functioning medical home PCMPs have care coordination capabilities. **RMHP** implemented a risk stratification system based on claims data to identify risk indicators from demographic data, diagnoses, utilization of services, and costs of care. Cases are sorted into five levels of potential intervention; Level 4 and Level 5 include complex care management and transition of care cases, which are referred to the care coordination teams and **RMHP** care managers. In addition, any PCMP or community organization involved with the member may refer a complex needs patient to RCCO care managers. **RMHP** developed a comprehensive needs assessment tool for members identified for complex care coordination that addressed nine categories of needs, including those specified in the RCCO contract. This assessment or its equivalent was used by many of the CCTs and is considered by **RMHP** to be the standard assessment for members throughout the region. **RMHP** also defined protocols for managing transition of care cases and follow-up with high emergency department (ED) utilizers. However, many hospitals in the region do not consistently inform **RMHP** of admissions, discharges, and transfers (ADTs) for timely follow-up. **RMHP** established a 2014 priority to increase the number of hospitals with agreements to provide real-time data to identify ADTs. **RMHP** instituted a "coordinate the coordinators" process as a priority component of the care management program. Care coordinators outreach to other providers and community organizations involved with the member to coordinate care manager activities, and they regularly communicate with other care managers throughout the care coordination process. In some communities, **RMHP** has integrated CHWs, who provide care coordination of complex behavioral and social needs for members to whom they are assigned. The CHWs are considered a low-cost, high-impact extension of CCTs and

PCMPs for individualized support of select members. **RMHP** expected to decrease ED utilization and increase use of community support services through the CHW programs.

In relation to the special needs of some of the Medicaid expansion populations, including FBMME, foster children, Adults without Dependent Children (AwDC), and the corrections population, **RMHP** stated that access to member data from other state agencies is a high-priority concern. **RMHP** was working with the Department and county agencies to define and implement formal data-sharing arrangements. CCTs have also developed collaborative relationships with community-based organizations that have the necessary expertise to effectively serve the special populations. **RMHP** facilitated quarterly forums for the CCTs to discuss best practices, opportunities, challenges, tools, and strategies for specific populations. Staff stated that the overall growth in Medicaid volume has had more impact on the care coordination system and resources than the special needs of the expansion groups. **RMHP** projected expansion of care coordination personnel resources in 2014. In addition, **RMHP** dedicated specific staff to improve attribution of members.

RMHP was monitoring coordination of care outcomes at a high level through the key performance indicator (KPI) reports, and some CCTs instituted tracking mechanisms to measure coordination of social and other services that cannot be measured through claims-based data. However, **RMHP** was continuing to explore and evaluate the most meaningful measures of the outcomes of care coordination on the Medicaid populations. Staff stated that effective measures must consider the changing population demographics, the varied community-specific processes of the CCTs, and the integration of care coordination processes with other organizations.

Summary of Record Reviews

The Department selected the original sample of care coordination records using the Statewide Data Analytics Contractor (SDAC) data to identify cases that appeared to have complex medical or medical/behavioral diagnoses, were high utilizers, or were transition of care cases, including a cross-section of children. In addition, all RCCOs were asked to identify an oversample of 10 records using their internal risk-identification mechanisms and applying the same criteria. When on-site, HSAG determined that numerous records must be excluded from the sample because care coordination had not been performed and could not be evaluated. HSAG completed a record review on only one of the original sample of 20 records and reviewed all 10 of the oversample records. Many of the original sample records were disqualified because members did not meet the selection criteria for six months of enrollment in the RCCO. In addition, medical records of members in the original sample included ER and PCMP records that did not demonstrate the need for complex care coordination and did not include documentation of active care coordination. A summary of reasons that records were eliminated from the record review sample is included in Appendix B.

HSAG scored 12 contract requirements for each care coordination record. Of the 132 elements reviewed in the 11 records, **RMHP** scored 99 percent compliance with the care coordination contract requirements.

Other noted patterns included:

- Many care coordinators communicated actively with involved providers and agencies, as well as the member. The **RMHP** "coordinate the coordinators" process was evident and appeared effective.
- All records included a comprehensive assessment of member needs and documented multiple interventions and frequent communications with providers, members, and families.
- Care coordinators often remained engaged with members over a long period of time in order to adequately assist members with multiple complex needs.

The detailed care coordination record review tools are included in Appendix B.

Observations/Recommendations

Overall, **RMHP** demonstrated that it implemented an effective system for identifying, assessing needs, and coordinating care for members with complex care needs. **RMHP** developed an effective risk-stratification methodology for identifying potential candidates for complex care coordination. PCMPs or community organizations involved with the member could also make care coordination referrals to the CCTs. The selection of cases for care coordination record reviews using the SDAC data (sample provided by the Department) resulted in a significant number of member records being eliminated from the sample list. HSAG recommends that **RMHP** and the Department further examine the effectiveness of using the SDAC reports to identify individual members appropriate for care coordination and also ensure that **RMHP** risk stratification methods are identifying all appropriate candidates.

Review of care coordination records identified through **RMHP** risk stratification methods included a comprehensive assessment and demonstrated that member needs were intensively managed by the CCTs or **RMHP** care managers. **RMHP**'s policy to "coordinate the coordinators" in complex care management cases was also evident in the record reviews and appeared very effective.

RMHP described active efforts in local communities to engage a variety of community organizations and agencies to address the integration of Medicaid populations with special needs, although **RMHP** indicated that data-sharing and coordination arrangements can be complex and time-consuming. Simultaneously, the rapid increase in overall volume of the Medicaid-eligible population has strained care coordination resources. Therefore, **RMHP** may want to consider accelerating the addition of staff resources required to perform complex care coordination for the rapidly expanding Medicaid populations.

RMHP monitored coordination of care outcomes at a high level through the SDAC KPI reports, and **RMHP** is continuing to explore and evaluate the most meaningful measures of the outcomes of care coordination in the Medicaid populations. **RMHP** is encouraged to continue experimenting with collecting and analyzing measures of effective care coordination processes across the region and to collaborate with the Department and other RCCOs to ultimately define meaningful, consistent measures across all RCCOs.

Overview of Site Review Activities

The 2013–2014 site review represented the third contract year for the ACC Program. The Department asked HSAG to perform a site visit to assess each RCCO's progress made during the previous year of operations toward implementing the ACC Program. During the initial three years of operations, each RCCO has evolved in operational activities, care coordination efforts, and provider network development in response to continuous collaborative efforts, input from the Department, and ongoing implementation of statewide health care reform strategies. The 2013–2014 site visits were focused on monitoring provider support activities, evaluating the continued development of provider network capacity, and assessing the effectiveness of care coordination processes. HSAG was asked to identify key activities and progress made since the previous site review, and to offer observations and recommendations related to each of the ACC Program focus areas 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 data collection tools that provided the parameters for the RCCO site review process. Initial site review activities included a desk review of documents submitted by **RMHP** prior to the site visit. HSAG reviewed key documents, which consisted of program plans, provider support tools, and selected data reports. On-site review activities included a review of care coordination records. In addition, information was gathered during on-site interviews with key **RMHP** personnel using a qualitative interview methodology. The qualitative interview process uses open-ended discussions that encourage interviewees to describe their experiences, processes, and perceptions. Qualitative interviewing is useful in analyzing systems issues and associated desired or undesired outcomes. The purpose of the site review was to document compliance with select provider support and care coordination contract requirements, evaluate **RMHP**'s progress toward implementation of the ACC model of patient care, explore barriers and opportunities for improvement, and identify activities related to the integration of the Medicaid expansion populations. Data gathered from the desk review of **RMHP** documents, as well as interviewer discussion guides, provided the basis for the open-ended discussions essential to the qualitative interview technique.

To evaluate the Provider Support focus area, HSAG reviewed the RCCO's provider support tools and used the data collection tool to assign scores of *Met*, *Partially Met*, or *Not Met* to this focus area. HSAG included the results, summary information, and recommendations in the Executive Summary of this report. The data collection tool also includes narrative information and recommendations related to the Provider Network Development and Care Coordination focus areas, which were not assigned scores. Results, summary information, and recommendations for these two focus areas are also included in the Executive Summary.

To enhance the evaluation of care coordination processes, HSAG developed a care coordination record review tool with 12 contract-required criteria. HSAG reviewed 20 care coordination records based on a convenience sample of members identified as having complex medical or combined medical and behavioral health needs, children with complex needs, or transition of care needs, who were enrolled in the RCCO during the CY 2013 review period for a continuous period of six months. The Department selected the 20 sample cases from the Statewide Data and Analytics Contractor (SDAC) data, and HSAG forwarded the sample list to **RMHP** prior to the on-site visit. HSAG provided instructions to **RMHP** to select an oversample of 10 additional records from internal data sources using the same criteria.

To enhance the provider network development discussions, HSAG conducted an independent analysis of the **RMHP** network using an MS Excel pivot table analysis of the Primary Care Medical Provider (PCMP) network spreadsheet submitted to the Department in February 2014. The objective of the analysis was to evaluate network capacity by eliminating any duplication of individual provider locations in the RCCO network. In addition, HSAG conducted a written survey of each RCCO to identify the types of data that could be collected in the future regarding specialists and community organizations serving the RCCO population. Results of the HSAG provider capacity analysis were provided to **RMHP** during the on-site review. Pivot tables are presented in Appendix C, and summary information is provided in the Executive Summary.

Appendix A. Data Collection Tool
for Rocky Mountain Health Plans (Region 1)

The completed data collection tool follows this cover page.

Provider Support

Requirement	Desk Review/Discussion Items	Score
1. The Contractor shall act as a liaison between the Department and its other contractors and partners and the providers. The Contractor shall assist providers in resolving barriers and problems related to the Colorado Medicaid systems, including, but not limited to all of the following: ◆ Issues relating to Medicaid provider enrollment. ◆ Prior authorization and referral issues. ◆ Member eligibility and coverage policies. ◆ Primary Care Medical Provider (PCMP) designation problems. ◆ PCMP per member per month (PMPM) payments. *Contract:* *Exhibit A: 5.1.3*	◆ Extent of RCCO support for: • Provider enrollment. • Authorization and referral issues. • Member eligibility/attribution. • PCMP designation. • PMPM payments.	☒ Met ☐ Partially Met ☐ Not Met

Findings:

The Provider Support Plan stated that RMHP provider relations (PR) staff serves as a "one-stop-shop" to help providers in Region 1 navigate the Accountable Care Collaborative (ACC) program administrative systems and processes, including assisting providers with understanding Colorado Medicaid policies, benefits and coverage, prior authorization and referral requirements, claims and billing procedures, eligibility and enrollment processes, and other operational components of the ACC. Staff members stated that RMHP has dedicated PR representatives (based on geographical regions) who make semiannual field visits to each provider in the region. In addition, RMHP served as a liaison between providers and the Department to resolve recurring problems and provided Primary Care Medical Providers (PCMPs) with a monthly roster/attribution report, a monthly Care Management Analysis Tool (CMAT) report, and a monthly population report through the provider portal. Staff members stated that RMHP had four dedicated PR staff and that a variety of other staff with specific areas of expertise (i.e., Practice Transformation Team and community care teams [CCTs]) were also regularly engaged to support PCMPs. PR representatives conducted a welcome call or on-site visit with new providers to orient the practices to the SDAC and other support tools and provided resources to help with the member attribution process. The RMHP ACC Web site and ACC Provider Manual included information on numerous ACC/Medicaid administrative processes, including verification of member eligibility, claims and reimbursement, prior authorization and referral, and the State and RMHP PCMP agreements. The RMHP Web site provided active links to the Department Web site.

RMHP staff members stated that ACC member identification cards were distributed to all RCCO members to assist providers with differentiating members among multiple lines of business and to assist with confirming ACC member eligibility and attribution. If the member had not selected a PCMP and the State had not attributed the member to a PCMP, the card prompted the member to contact RMHP Customer Service for assistance in selecting a PCMP. Staff

Provider Support

Requirement	Desk Review/Discussion Items	Score
members stated that RMHP was working with the Department to obtain information on individual practitioner attribution instead of practice/group level attribution and will print PCMP assignment on the identification card after that issue is resolved. Staff discussed the process for assisting providers with enrollment into the ACC as a persistent and progressive personal interaction process from making multiple verbal contacts to answer questions about the ACC to sending out hardcopy materials and then assisting providers with the completion of the application. The RMHP Contracting Team meets weekly to establish recruitment targets and to review progress. Staff members stated that the language in the State PCMP contract was a deterrent to provider contracting because it implies many onerous participation requirements that can be alleviated through the RCCO support processes. In order to foster completion of the contracting process, PR personnel follow up with providers by describing to them how the RCCO supports their practices. Staff also stated that RMHP enlisted the support of the Department to engage providers with whom contracting has been unusually difficult (e.g., Grand River medical group in Rifle). Staff confirmed that once the contracting process is accomplished, there have been very few problems related to the designation of providers as PCMPs in the State systems. Similarly, RMHP has not received complaints from providers regarding per member per month (PMPM) payments or authorization and referral issues.		
Observations/Recommendations: RMHP demonstrated active engagement with PCMPs through regular contact and availability of assigned Provider Relations representatives to assist providers with any Medicaid administrative issues. The RMHP ACC Web site also included numerous links and resources regarding Medicaid and ACC systems. Staff stated that providers experienced limited problems with most ACC administrative processes, with the exception of the PCMP contracting process. RMHP assisted providers with enrollment in the ACC by meeting with providers to answer questions, "de-mystifying" language in the Department's PCMP contract, and providing information on how the RCCO can support providers in meeting ACC contract requirements. RMHP developed a Member ID card to assist providers with member eligibility and attribution.		

2. The Contractor shall submit a Practice Support Plan, describing its annual activities, for Department review and approval. These practice support activities shall be directed at a majority of the PCMPs in the Contractor's region and may range from disseminating a practice support resource to its PCMP network to conducting formal training classes for PCMPs relating to practice support.
 	
Contract:
Exhibit A: 5.2.1
	◆ Practice Support Plan
	  • How implemented
	  • Evaluation of success
	◆ Maintaining engagement of the majority of PCMPs
	◆ Priority provider support plans (going forward)
		☒ Met
		☐ Partially Met
		☐ Not Met

Findings: The Practice Support Plan described provider support activities related to operational practice support and clinical practice support. Staff stated that the plan is specific to RCCO providers and has been fully implemented for the majority of PCMPs. The plan described the local CCTs as the most valuable resource for		

Provider Support		
Requirement	**Desk Review/Discussion Items**	**Score**
clinical support of participating PCMPs. The CCTs provide care coordination for complex care management members and can also assist PCMP offices with prior authorizations, referrals, finding specialists, and finding other community resources to support patients' needs. RMHP's central Care Management Team serves as the point of contact for the CCTs and also supports providers in managing patients not served by CCTs. The Practice Support Plan stated that dedicated PR representatives support the operational needs of practices. Additionally, staff described the Practice Transformation Program as the most robust operational practice support provided to individual PCMPs. RMHP also provides SDAC support as needed, including coordination of SDAC trainings. RMHP provides workshops and/or town hall style meetings throughout the region. Workshops presented in 2013 included Bridges Out of Poverty training and training on Disability Awareness and Effective Communication presented by the Colorado Cross-Disability Coalition. The plan also stated that RMHP distributes a bi-monthly ACC provider newsletter, cultural competency newsletter, and provider bulletins. The RMHP Web site included extensive information concerning the ACC program and processes and provided access to a well-organized library of RMHP provider support tools, including medical home educational materials, clinical guidelines, client support tools, and practice transformation tools. Staff stated that RMHP prioritized redevelopment of the Web site in 2014 to make the application more interactive with providers.		
Observations/Recommendations: The RMHP Practice Support Plan documented the various support activities provided to practices including PR representatives assigned to each PCMP, operational and clinical support tools, and the provision of CCTs to assist PCMPs with complex care management. The RMHP provider Web site included numerous educational resources and practice support tools available to all PCMPs. Staff described a robust Practice Transformation Program, also available to all PCMPs and designed to assist practices with developing patient-centered medical home (PCMH) competencies. Staff stated that face-to-face interactions with providers are the best mechanism for determining practice support needs and appropriate tools for individual practices. At the time of the review, RMHP estimated that 70 percent of practices require some level of RCCO staff support for PCMH functions.		
3. The Contractor shall offer support to PCMPs and providers, which may include comprehensive guidance on practice redesign to providing assistance with practice redesign and performance-enhancing activities. *(Regions 2, 3, 5 only)* The Contractor shall conduct a needs assessment for each PCMP in the Contractor's PCMP network and provide tools to each PCMP, as necessary, based on the needs assessment, to increase the PCMP's readiness to become a more effective medical home for the Contractor's members.	*(All RCCOs)* ◆ RCCO activities implemented to assist providers in practice redesign • Specific activities • Number of providers • Resources dedicated • Mechanisms used • Monitoring mechanisms ◆ Medical home functions provided through the RCCO ◆ Medical home functions provided by the PCMPs	☒ Met ☐ Partially Met ☐ Not Met

Provider Support		
Requirement	**Desk Review/Discussion Items**	**Score**
Contract: *Exhibit A: 5.2.2*	*(Regions 2, 3, 5 only)* ◆ Medical home needs assessment for PCMPs • Proportion of PCMPs assessed • Specific medical home functions assessed • Specific assessment mechanisms • How assessment results are applied within the RCCO	

Findings:

The Provider Support Plan stated that RMHP collaborates with individual PCMP practices to provide data, tools, and concepts to build their capabilities to provide a medical home model for primary care combined with an enhanced care coordination approach. Staff described that the overall process of PCMP engagement progressed from face-to-face contact and formal PR staff visits through awareness of RCCO processes and participation in provider initiatives to recruitment into the PCMH Practice Transformation Program and learning collaboratives. The Provider Tools Library on the RMHP Web site included numerous educational materials and tools related to medical home functions. Staff stated that most tools are introduced to the practice by RMHP staff during the practice transformation program and that the use of provider support tools distributed solely through the Web site was minimal.

Staff discussed extensively the comprehensive RMHP Practice Transformation Program, designed to assist providers (over the course of several years) to achieve increasing levels of medical home performance. The program has three structured levels of participation: Foundations, Masters Level 1, and Masters Level 2. RMHP also provided support for practices seeking NCQA PCMH accreditation, and has several practices engaged in a four-year Centers for Medicare & Medicaid Services (CMS) pilot project to develop advanced primary care practices. The Foundations level includes basic education and assessment of practice processes relative to PCMH and is available to all PCMPs.

RMHP actively recruits practices to engage in the Foundations level. Masters Level 1 and Masters Level 2 are based on assessment of practice readiness and capabilities to transition into using new operational and clinical processes. Staff stated that establishing and maintaining engagement of practices is dependent on tailoring activities to the individual practice's needs, goals, and objectives. A comprehensive practice assessment is applied to practices to determine the level of PCMH functioning and to identify high-priority needs. The assessment is applied only to practices engaged in the Practice Transformation Program. Masters Level participants are facilitated through on-site engagement between staff members from RMHP and practices twice per month to develop and implement processes, conduct training, or analyze data. The Practice Transformation Team included five dedicated quality improvement advisors and two clinical systems analysts. The enhancement of care coordination capabilities is a component of the Masters Level 1 program. Masters Level programs require a Memorandum of

Provider Support		
Requirement	**Desk Review/Discussion Items**	**Score**
Understanding (MOU) between RMHP and the practice, which outlines specific practice deliverables and reporting requirements. RMHP provides a financial stipend for practice participation in order to offset some of the costs for complying with the deliverables of the practice development program. The Network Adequacy Report stated that there were five practices engaged in the Foundations level, two practices in Masters Level 1, two practices in Masters Level 2, and two practices in the PCMH preparation program. Staff stated that there were 95 individual practitioners across the region engaged in some level of the Practice Transformation Program, and that RMHP was actively recruiting an additional 50 practitioners into the program. Of those, staff reported that half are actively engaged in practice improvement, and half are just beginning to engage. Approximately 49 percent of RCCO members are attributed to practices engaged in practice transformation activities. The goal is to increase the number of members who are attributed to the more advanced practices. RMHP submitted reports used to track the number of providers engaged in some level of practice transformation and the number of members attributed to those practices. In addition, RMHP tracks progress of practices in PCMH functions through the reporting of deliverables outlined in the MOUs. Other RCCO practice support activities are designed to bridge the gap between PCMPs' capabilities and fully functioning medical home capabilities. While a few advanced practices can assume all PCMH capabilities, staff stated that 70 percent of practices still require some level of RCCO support, particularly through the CCTs. Staff stated that even PCMPs performing care coordination functions within the practice will refer complex cases to the CCTs or RCCO care managers.		
Observations/Recommendations: RMHP has committed numerous staff with diverse areas of expertise to assist practices with transformation to PCMH functions and to improve operational performance. The Performance Transformation Program involves a structured, multi-year process in which practices are encouraged to participate and are actively engaged with MOUs defining practice deliverables. RMHP provides financial support to offset some of the costs of program participation. Staff stated that 95 practitioners were involved in some level of practice transformation and that an additional 50 practitioners were being recruited for participation. In addition, RMHP's development of CCTs in six of the more populated geographic areas of the region to support PCMPs with coordination of community resources and to perform care coordination for complex care management members is considered the most valuable RCCO practice support resource.		

Provider Support

Requirement	Desk Review/Discussion Items	Score
4. The Contractor shall provide tools to the PCMPs and providers that may include any of the following: Clinical Tools: ◆ Clinical care guidelines and best practices ☒ Yes ☐ No ◆ Clinical screening tools, such as depression screening tools and substance use screening tools ☒ Yes ☐ No ◆ Health and functioning questionnaires ☒ Yes ☐ No ◆ Chronic care templates ☒ Yes ☐ No ◆ Registries ☒ Yes ☐ No ◆ Other ☒ Yes ☐ No *Contract:* *Exhibit A: 5.2.2.1; 5.2.1.1 through 5.2.1.3*	*Desk Review:* Samples, Internet links, or any documents which illustrate the specific types of tools being provided to PCMPs *Discussion:* ◆ How tools are disseminated ◆ Frequency of use by providers ◆ Determining effectiveness of tools ◆ Determining priorities for tools ◆ Tools in development/future plans	☒ Met ☐ Partially Met ☐ Not Met

Findings:

The Provider Support Plan stated that CCTs in focus communities are the most important clinical support provided to participating PCMPs. As an example, staff described that activities for the north Larimer team included providing direct behavioral health services, reviewing medication management with PCMPs and specialists, and developing comprehensive member care plans that address medical, social, and behavioral health needs. The Provider Support Plan stated that disease management programs are available to support PCMPs in caring for their patients with diabetes, chronic obstructive pulmonary disease (COPD), asthma, and high-risk pregnancy. RMHP generated gaps in care reports that PCMPs could use to schedule preventive care appointments. The RMHP ACC provider Web site was easy to navigate and included an extensive listing and links to numerous clinical support tools. RMHP also submitted evidence of many clinical care guidelines, clinical assessments, and self-screening tools for multiple conditions, and care planning articles and templates. RMHP promoted its Web site resources to providers through a variety of vehicles and provider newsletters included reprints of specific clinical guidelines. Staff stated that clinical guidelines were most effectively introduced to practices by the Quality Improvement (QI) Advisor Team, who worked with practices to develop a workflow for incorporating guideline use. RMHP staff worked closely with practices to implement registry functionality ranging from simple MS Excel documents to imbedded electronic medical record registries. RMHP staff stated that if practices were not engaged in some level of practice transformation, use of provider support tools was minimal.

Observations/Recommendations:

RMHP provided evidence of support to PCMPs that included an extensive library of clinical support tools. The RMHP ACC Web site for providers was easy to navigate and included an extensive listing of (and links to) every clinical support tool in the RMHP provider support library.

Provider Support

Requirement	Desk Review/Discussion Items	Score
5. The Contractor shall provide tools to the PCMPs and providers that may include any of the following: Client Materials: ◆ Client reminders ☒ Yes ☐ No ◆ Self-management tools ☒ Yes ☐ No ◆ Educational materials—specific conditions ☒ Yes ☐ No ◆ Client action plans ☒ Yes ☐ No ◆ Behavioral health surveys and other self-screening tools ☒ Yes ☐ No ◆ Other ☐ Yes ☐ No *Contract:* *Exhibit A: 5.2.2.2; 5.2.1.1 through 5.2.1.3*	*Desk Review:* Samples, Internet links, or any documents which illustrate the specific types of tools being provided to PCMPs *Discussion:* ◆ How tools are disseminated ◆ Frequency of use by providers ◆ Determining effectiveness of tools ◆ Determining priorities for tools ◆ Tools in development/future plans	☒ Met ☐ Partially Met ☐ Not Met

Findings:

RMHP submitted the following examples of client materials: depression, substance abuse, and abuse screenings; patient action plans; diabetes education; suggestions on how to interact with a doctor; and self-management tools for medication, asthma, weight/diet control, and diabetes. The ACC provider Web site also included immunization reminders. Time frames used for client reminders were based on HEDIS technical specifications.

The RMHP ACC Web site for providers was easy to navigate and included links to every tool in the RMHP provider support library, including numerous client materials. Staff stated that the most effective method of distributing client tools is to tell providers about them during one-on-one interactions and working with the practices in the Practice Transformation Program. Members are provided client materials based on the member's readiness to change. RMHP was introducing practices to the use of the patient activation measure (PAM). Staff stated that client tools are primarily distributed through primary care practices, but they are also given to members by the CCTs and community health workers during their interactions with members and by the RCCO support staff, as appropriate. RMHP staff stated that community organization partners are also a source for additional client materials.

Observations/Recommendations:

RMHP provided evidence of providing PCMPs access to an extensive library of client materials. The RMHP ACC Web site for providers was easy to navigate and included an extensive listing of (and links to) every client support tool in the RMHP provider support library.

Provider Support

Requirement	Desk Review/Discussion Items	Score
6. The Contractor shall provide tools to the PCMPs and providers that may include any of the following: Operational Practice Support: ◆ Guidance and education on the principles of the medical home — ☒ Yes ☐ No ◆ Training on providing culturally competent care — ☒ Yes ☐ No ◆ Training to enhance the health care skills and knowledge of supporting staff — ☒ Yes ☐ No ◆ Guidelines for motivational interviewing — ☒ Yes ☐ No ◆ Tools and resources for telephone call and appointment tracking — ☒ Yes ☐ No ◆ Tools and resources for tracking labs, referrals, and similar items — ☒ Yes ☐ No ◆ Referral and transitions of care checklists — ☒ Yes ☐ No ◆ Visit agendas or templates — ☒ Yes ☐ No ◆ Standing pharmacy order templates — ☐ Yes ☒ No ◆ Other — ☒ Yes ☐ No *Contract:* *Exhibit A: 5.2.2.3; 5.2.1.1 through 5.2.1.3*	*Desk Review:* Samples, Internet links, or any documents which illustrate the specific types of tools being provided to PCMPs *Discussion:* ◆ How tools are disseminated ◆ Frequency of use by providers ◆ Determining effectiveness of tools ◆ Determining priorities for tools ◆ Tools in development/future plans	☒ Met ☐ Partially Met ☐ Not Met

Findings:

RMHP submitted examples of numerous operational practice support tools retained in the RMHP provider support library. Staff discussed in detail the robust Practice Transformation Program, which provides hands-on assistance for practices transforming to PCMHs. The RMHP ACC Web site included a listing of (and links to) an extensive number of tools in the RMHP provider support library, including numerous PCMH education resources, cultural competency training programs, and specific practice transformation operational tools. While all materials were accessible through the Web site, RMHP's practice transformation teams primarily introduced operational support tools to practices and worked with practices on methods to implement and integrate the tools into practice workflow. Staff also stated that many of the more advanced practices have their own operational support tools.

Provider Support

Requirement	Desk Review/Discussion Items	Score
Observations/Recommendations: RMHP provided support to PCMPs transitioning to PCMHs, as evidenced by the extensive library of operational practice support tools. The RMHP ACC Web site for providers was easy to navigate and included a listing of (and links to) every operational support tool in the RMHP provider support library.		
7. The Contractor shall provide tools to the PCMPs and providers that may include any of the following: Data, Reports, and Other Resources: ◆ Expanded provider network directory ☒ Yes ☐ No ◆ Comprehensive directory of community resources ☒ Yes ☐ No ◆ Directory of other Department-sponsored resources, such as the managed care ombudsman and nurse advice line ☒ Yes ☐ No ◆ Link from main ACC Program Web site to the Contractor's Web site of centrally located tools and resources ☒ Yes ☐ No ◆ Other ☐ Yes ☐ No *Contract:* *Exhibit A: 5.2.2.4*	*Desk Review:* Samples, Internet links, or any documents which illustrate the specific types of tools being provided to PCMPs *Discussion:* ◆ How tools are disseminated ◆ Frequency of use by providers ◆ Determining effectiveness of tools ◆ Determining priorities for tools ◆ Tools in development/future plans	☒ Met ☐ Partially Met ☐ Not Met
Findings: Staff explained that each local CCT developed a comprehensive resource directory of community services within its local delivery area. Rather than just a listing of community services, these community resource directories included organizations with which the CCT had developed a relationship and which were engaged as partners in local CCT efforts. Staff stated that CCTs and PCMPs used the contact list extensively when coordinating care for members. The RMHP ACC provider Web site included links to specific community resources, the Department Web site, text descriptions of Medicaid programs, and a searchable RCCO provider directory, which listed practitioners, urgent care centers, hospitals, and pharmacies. Staff stated that RMHP clinical systems analysts work with practices involved in the Practice Transformation Program to enhance the use of electronic health records, facilitate use of population data reports and registries, and teach providers how to use SDAC data to identify members for care coordination or other disease management interventions. The Practice Transformation Team also routinely reviewed practice performance profiles with each practice.		

Provider Support		
Requirement	**Desk Review/Discussion Items**	**Score**
Observations/Recommendations: RMHP provided support to PCMPs regarding the use of data, reports, and directories of ACC services. The RMHP ACC Web site for providers was easy to navigate and included links to directories and the Department's ACC Web site.		

Results for Provider Support						
Total	Met	=	7	X	1.00	= 7
	Partially Met	=	0	X	0.0	= 0
	Not Met	=	0	X	0.0	= 0
Total Applicable		=	7	**Total Score**		= 7

Total Score ÷ Total Applicable	= 100%

Follow-up—Provider Network Development

On-site Discussion Topics	Pertinent Contract References
1. Provider Network Capacity: ◆ Efforts to grow/expand the network: • Number/location of targeted providers • Mechanisms to assist PCMPs to get enrolled • Diversity for expansion populations ◆ Capacity of PCMPs for new Medicaid members • Network analysis • Mechanisms to open/expand practices for Medicaid members ◆ Progress in relation to extended hours and urgent care alternatives in the network	*Contract:* *Exhibit A: 4.1.1; 4.1.4; 4.2.1; 4.2.2; 4.3.3; 8.1.1.1; 2.2.5.1.4*

Discussion:

The RCCO Network Adequacy Report analyzed the number of PCMPs by county, average distance from members to providers, provider locations offering after-hours care, and ratios of providers to attributed and unattributed members. The report also focused on provider locations within Health Professional Shortage Areas (HPSA), which constitutes 16 of the 22 counties in Region 1. The report analyzed providers who are accepting new Medicaid members for the five counties with the highest Medicaid expansion populations. The report noted that 73 percent of providers across the region were accepting new Medicaid members and that contracting with RMHP's payment reform initiative line of business (referred to by RMHP as "Prime") may result in an increase of 37 new RCCO providers in Mesa and Montrose counties. The report also noted that two new Federally Qualified Health Centers (FQHCs) were opening in the region. Staff stated that practices are required to notify RMHP when closed to new Medicaid members. While some private practices are not open to new members, the FQHCs remain open to RCCO members and will expand capacity as necessary. Staff stated that new providers are allowed to join the ACC and limit their Medicaid patients to those currently in the practice. However, RMHP believes that as new providers become familiar with the CCTs and the RCCO practice support initiatives, those practices may expand their limits on Medicaid populations. RMHP believes that practices must ultimately engage in practice transformations that improve efficiency of operations in order to expand capacity for Medicaid members.

The targeted referral list included all providers identified by the Department as Full Benefit Medicare-Medicaid Enrollee (FBMME) providers, as well as additional providers being targeted for the Prime contract. Staff stated that Prime will be a major source of additional practices for the RCCO because all Prime providers must also be RCCO providers, and practices will be required by contract to remain open to both Prime and RCCO members. Staff also stated that a number of RCCO members have a PCMP not currently contracted in the network and that those providers are recruited. RMHP prioritized the recruitment of all school-based health centers and other alternative providers. The number of after-hours and urgent care facilities in the network remained relatively unchanged over the past year—26 percent of PCMP locations offered weekend and/or evening accessibility. Staff stated that urgent care facilities, particularly within hospital emergency rooms (ERs), are not a preferable model to the delivery of comprehensive care (including urgent care) in primary care practices. RMHP will continue to work with providers to expand capacity for after-hours and urgent care through practice transformation initiatives.

Follow-up—Provider Network Development

On-site Discussion Topics	Pertinent Contract References
Staff described the process for recruiting new PCMPs into the network as a progressive series of contacts to "pull" the providers into the RCCO. The Provider Relations Team meets bimonthly to determine priority contacts and to track progress. Once a practice has been prioritized, the PR representative maintains frequent contact to determine progress toward contracting and attempts to make the process as simple as possible. Staff stated that providers have many questions concerning the ACC and that language in the Department's PCMP contract has deterred providers from completing the contracting process. To alleviate concerns, the PR representatives describe the role of the RCCO in supporting practices to meet contract requirements. Staff stated that the RCCO provider support and practice transformation efforts are benefits of the ACC that most influence additional providers to participate. Upon contract completion, RMHP initiates a one-on-one onboarding process with the practice administrator to orient the practice to reporting processes, attribution, and financial aspects of ACC. As the relationship progresses, RMHP introduces support materials and engages the practice in an assessment of operations, which ultimately serves to recruit the practice into the Practice Transformation Program. Staff stated that, as the Medicaid population grows, increased RCCO revenues will provide for expansion of PCMP practice support resources. During 2013, RMHP facilitated and invested in the development of Community Health Worker (CHW) programs in various communities, to serve as extensions of primary care and community mental health services for select complex need members. CHWs are laypersons highly trained to provide individualized peer support, make connections with necessary social support systems, and expedite member access to needed mental health services. CHWs are targeted to work with members who may have complex social and behavioral circumstances that serve as barriers to effective clinical care and self-management and contribute to high-cost utilization. A diverse team of providers from the community provides oversight of CHWs in local communities. RMHP expected to decrease ER use and increase use of community support services through the CHW programs. RMHP described CHW functions as a low-cost, high-return extension of primary care services.	

Observations:

RMHP was actively engaged in recruiting additional practices into the RCCO network and has targeted all providers in the region that are not already contracted, with particular emphases on FBMME providers identified by the Department and providers that will contract with the Prime network. RMHP anticipated that the Prime project would be the major source of additional RCCO practitioners. RMHP has a well-organized process and dedicated staff committed to an ongoing recruitment process and has engaged the Department to assist in contracting with some providers in FBMME gap areas. The majority of counties in the region are considered HPSAs. While most practices remain open to Medicaid members, RMHP is concerned that many practices in the region are at or near capacity. To address this concern, RMHP instituted a Practice Transformation Program for the higher volume providers intended to increase operational efficiencies and, ultimately, increase practice capacity. The CCTs, who support PCMPs in managing members with complex needs, were also considered a major attribute in recruiting additional providers and encouraging practices to accept additional Medicaid members. RMHP has invested heavily in expanding primary care capabilities through development of CHW programs in several communities.

Follow-up—Provider Network Development

On-site Discussion Topics	Pertinent Contract References
2. HSAG provider network capacity analysis results	*Contract:* *Exhibit A: 4.1.1; 8.1.1.1*

Discussion:

HSAG used data from the PCMP network spreadsheet provided to the Department by the RCCOs to conduct a high-level network analysis. The purpose of the Pivot Table analysis was to provide an accurate representation of the number of providers in each region by eliminating any duplicate entries. To achieve this, duplicates were eliminated as follows:

- Number of providers within the entire region: when there was a duplicate first and last name. (The preferred method would have been to sort and eliminate providers based on individual rendering practitioner Medicaid ID, but this information was too often incomplete.)
- Number of providers within each county: when there was a duplicate first and last name and county (i.e., a provider with multiple locations would only be counted one time in each county).
- Number of locations by region and county: when there was an identical address listed.

A similar analysis was performed to count the number of unique providers within the region and by county after eliminating providers who stated they were not accepting new Medicaid members.

For Pivot Table analysis to be performed accurately, the data in the selected sort fields being used to identify duplicate information must be complete and strictly formatted. Empty fields, inconsistent spelling or punctuation, data in the wrong field, etc., will result in inappropriate identification of duplicate fields. During attempts at Pivot Table analysis, HSAG discovered that quality control of data fields had not been performed on the PCMP spreadsheet HSAG received from the Department. A cursory review of the source data noted numerous instances of inconsistencies or incomplete fields, thereby influencing the accuracy of Pivot Table results. Department staff stated that the Department performs a similar Pivot Table analysis of the PCMP spreadsheets, but Department staff must manually review each line of data to eliminate duplicate entries.

Due to lack of data integrity in the source documents, HSAG cautioned RMHP staff that the specific data results could not be considered reliable and that the tables should only be viewed as a preliminary insight into potential differences in network analysis results if duplicates were removed using Pivot Table methodology. Detailed Pivot Table results, including county analysis and unique locations for care, are included in Appendix C of this report.

RMHP Network Analysis Report:
Total unique providers in the region: 529

HSAG Total Pivot Table Analysis:
Total removals from source document: 112

Follow-up—Provider Network Development

On-site Discussion Topics	Pertinent Contract References

Total unique providers in region: 424
Total unique providers accepting Medicaid: 342

During on-site discussions of provider capacity analysis, RMHP stated that although practices remain open to new members, RMHP's assessment is that most practices in Region 1 are already operating at capacity and have very limited ability to absorb the growing Medicaid population. Staff stated that in Larimer County, one of the highest Medicaid population growth areas, Banner Health, closed all of its practices to new Medicaid members; the University of Colorado practices (with the exception of the residency program) are closed to new Medicaid members; and the Northern Colorado Kaiser group is closed to new Medicaid members. RMHP monitors member complaints and scheduling guidelines as mechanisms to evaluate the ability of providers to respond to member demands ongoing, but RMHP does not consider these as adequate measures of capacity. RMHP works with practices engaged in the Practice Transformation Program to build new processes that increase operations efficiency in order to expand the capacity for new Medicaid members over time. RMHP offered that a determination regarding a meaningful measure of capacity in practices would be critical to further analysis of network capacity. Further, it would be necessary to have a consistent definition applied by all practices. RMHP suggested that provider-to-member ratios were not meaningful, nor was monitoring access through appointment standards, because these measures do not take into account other populations being served by the practice, length of time a provider spends with a member, or the individual patient mix and characteristics of members attributed to the practice. If a definition and measurement could be agreed upon, RMHP cautioned that the cost of collecting information be considered in comparison to intended use of data.

HSAG surveyed each RCCO to determine the ability of the RCCO to collect specifically defined data regarding specialists and community organizations. Although RMHP indicated that it could collect data applicable to each of the fields defined within the survey document, staff members offered the following comments:

- Both specialist and community organization Medicaid Rendering ID numbers would be difficult to obtain in the absence of a RCCO contract with those organizations. For specialists, it would be much better to capture the national provider identifier (NPI) number, but the Department's Medicaid Management Information System (MMIS) does not provide for collection of those data.
- There should be a clear definition of which providers should be included in the reports.
  - What would be the criteria for the level of specialist participation with the RCCO (i.e., actively engaged with the RCCO or just a specialist providing services to RCCO members in the region)?
  - Which community organizations should be included in the report? Would there be a requirement that the organization hold a formal agreement with the RCCO? Should there be a claims analysis that identifies that services were provided to RCCO members? (Staff members stated that RMHP establishes a "partnership" relationship with community providers to whom they refer members for services.)
- The Department and RCCOs should clearly establish the specific data being requested of specialists and community organizations and evaluate the cost/benefit of collecting the data.

Follow-up—Provider Network Development

On-site Discussion Topics	Pertinent Contract References
Observations: Comparisons of the preliminary Pivot Table analysis results to the traditional network adequacy analysis performed by RMHP were inhibited by data integrity issues in the source documents used by HSAG to produce the Pivot Table results. Nevertheless, review of these results stimulated discussions regarding the best methodology for defining and measuring true provider capacity for integrating new Medicaid members. RMHP stated that most practices in Region 1 are already operating at capacity (not specific to Medicaid members) and that increasing capacity in provider practices would ultimately depend on improving the efficiency and operations within each practice. RMHP suggested that determining a meaningful measure of capacity in PCMP practices would be critical and would need to be consistently applied in all practices. If a definition and measurement could be agreed upon, RMHP cautioned that cost of collecting information should be considered in comparison to intended data use. Similarly, staff agreed that the data to be included in specialist or community organization databases should be clearly defined and applied consistently across all RCCOs, and the cost/benefit of collecting and maintaining the data should be evaluated.	
3. PCMP Network for expansion populations: ◆ Sufficiency of the network for expanding number of eligibles ◆ PCMP network configured to address the special needs of the following: • Full Benefit Medicare-Medicaid Enrollees (FBMME) • Disabled • Foster care • Adults without Dependent Children (AwDC) • Culturally diverse • Inmate population	*Contract:* *Exhibit A: 4.1.1; 4.1.6; 4.3.3*
Discussion: RMHP reported that the Medicaid population grew by 117 percent during 2013 to 67,000 members; 56 percent of the Medicaid population in Region 1 are children. The proportion of unattributed members increased with the expansion of members; 44 percent of members in Region 1 were unattributed as of April 2014. To address the special needs of some of the Medicaid expansion populations, staff members stated that RMHP will increase its partnerships with diverse community organizations, primarily through the CCTs in local communities. The Network Adequacy Report stated that RMHP was targeting relationships related to FBMME demonstration, increasing partnerships with disability organizations, and developing relationships to improve parolee transitions into the community. RMHP staff stated that the foster care population continues to be a challenge due to the lack of coordination with the State, county and local community systems and services, and availability of limited resources at all levels. The frequent location change of foster care children also caused fragmentation of services. Staff	

Follow-up—Provider Network Development

On-site Discussion Topics	Pertinent Contract References

stated that RMHP engaged the Healthy Harbors program in the Larimer County area as a successful collaborative model for managing foster care, and teams are being developed in other areas to define a community-wide approach for addressing foster care issues. RMHP was expanding contracts with school-based health centers, which RMHP also considered an important link to early intervention in the behavioral health needs of children.

Staff stated that RCCO network providers across the region were interested in supporting the FBMME population and that many rural providers already treat a high volume of these members. The RCCO's provision of care coordination services to support the complex needs of this population is viewed by providers as a significant asset. Staff stated that primary efforts related to the FBMME population have been directed at establishing relationships with single entry point (SEP) agencies, independent living centers, and other providers of services for the elderly and disabled throughout the region. RMHP targeted recruitment of the Grand River medical group to fill a network gap for the FBMME population and requested assistance from the State in completing the contracting negotiations. In addition, RMHP has been working weekly with the hospital and independent practice association (IPA) in the Cortez area to expand the PCMP network for FBMME members.

Staff noted that rapid turnover and lack of preparatory discharge resources for county inmate populations presented challenges related to successful integration of the corrections population into the RCCO. RMHP was working with various county Department of Human Services (DHS) offices and tracking the State's initiatives with the Department of Corrections to determine the best mechanisms for identifying, locating, attributing, and providing necessary care coordination services to county and State parolees.

Observations:

RMHP explained that the rapid increase in Medicaid-eligible members due to Medicaid expansion caused some PCMPs to temporarily close their practices to new Medicaid members. In addition, the number of unattributed members has disproportionately grown, due to the lack of information concerning the demographic and medical history of expansion members. Regarding management of the expansion populations' special needs (FBMME, children, and the corrections population), CCTs have engaged diverse community organizations to participate in the expansion of the medical neighborhood in local communities. RMHP has also been pursuing agreements with appropriate State, county, and community agencies for exchange of data and collaborative care coordination efforts. RMHP anticipated the number of care coordination staff will increase throughout the region to support increased volume and specialized needs of the expansion populations. RMHP described efforts as challenging and ongoing, involving negotiation of complex relationships among various provider and community organizations.

Follow-up—Provider Network Development

On-site Discussion Topics	Pertinent Contract References
4. Medical Neighborhood Evolution of medical neighborhood/vision for the region: ◆ Composition of medical neighborhood • Continuum of delivery system providers/types of providers • Impact of expansion populations ◆ Level of involvement/engagement of various providers • Formal/informal relationships • Information sharing challenges ◆ Progress related to the Specialist Referral Protocol joint planning project within the region	*Contract:* *Exhibit A: 4.2.5; 6.1*

Discussion:

Staff stated that RMHP views the medical neighborhood as a collaborative alliance of provider and community organizations within diverse geographic areas across the region. RMHP's philosophy is that health care systems are organized as an extension of the community. RMHP stated that the "communitizing" of Medicaid systems within the State is a superior model of delivering services to the Medicaid population. Through the CCTs, RMHP formed alliances with essential community partners and engaged established community leaders to develop and sustain these alliances. Because Region 1 spans 23 counties, RMHP focused CCT and medical neighborhood development in the major population centers. Staff stated that 95 percent of the RCCO population was located in geographic areas with CCTs. Staff explained that development of a CCT required considerable local community and provider contacts to organize a collaborative effort, but that the participation of community partners enhanced the sustainability and effectiveness of the team. The RCCO and community partners also collectively participate in and provide financial support for cooperative community initiatives, such as the provision of transportation services.

RMHP described an example of developing the medical neighborhood for FBMME members, citing that CCTs are meeting with long term services and support (LTSS) agencies and organizations such as community centered boards (CCBs), SEPs, area agencies on aging, community mental health centers (CMHCs), independent living centers, hospitals, long-term nursing facilities, and home health providers to discuss relationships with the RCCO, develop communication channels, and set collective priorities.

In 2014, staff stated that RMHP will be specifically focused on the integration of specialists and expansion of specialty care in the medical neighborhoods, working through local IPAs and hospital systems to gain access to specialists and determining best methods to engage them in the community's medical neighborhood. Staff stated that formal agreements or contracts between primary care providers and specialists are not widely implemented at this point. Staff stated that very complex relationships among specialists and other providers and organizations must be considered and that urban and rural relationships with specialists are varied. Staff stated there are also many challenges with filling specialty care gaps. CCTs were examining approaches for expanding specialist

Follow-up—Provider Network Development	
On-site Discussion Topics	**Pertinent Contract References**
care either by downstreaming some aspects of specialist care into the PCMP or by co-management of patients by specialists and PCMPs. Staff expressed that Medicaid reimbursement for specialists may need to be examined and shifted over time toward more population-based methods. RMHP also suggested that specialist practices need practice transformation assistance to improve efficiencies and capacity; RMHP is tracking specialty care support tools and processes being developed by national specialty organizations. Staff stated that there is growing awareness among specialists regarding the need for improved communications and coordination with all participants in the medical neighborhood, and RMHP will be pilot testing various methods to improve coordination.	
Observations: RMHP focused on the development of medical neighborhoods in some of the higher population geographic areas through the CCTs, who are engaging diverse providers and community organizations to participate in the development of the local health system for the Medicaid population. RMHP initiated innovative approaches, such as the development of CHW programs and contracting with school-based health systems, to expand primary care. RMHP stated that engaging specialists to participate as partners in the RCCO delivery system will be a priority in 2014. RMHP initiated discussions with hospital systems and is exploring innovative mechanisms to engage specialists in a meaningful manner, such as potential downstreaming some specialist care into the PCMPs. RMHP considers the provision of support for practice transformation, care coordination, and improved communications with other providers to be applicable to specialist interests, but it described that gaining access to specialists is a complex issue.	

Follow-up—Care Coordination

On-site Discussion Topics	Pertinent Contract References
Discussion will be supplemented by scored care coordination record review 1. Care Coordination Mechanisms ◆ Mechanisms to identify members for coordination of care: • Criteria used to define "most appropriate" members • Sources of identifying members (use of State Data and Analytics Contractor) • By RCCOs • By PCMPs ◆ Assessment processes: • Comprehensive • Sufficient to identify needs of the RCCO expansion populations • By RCCOs • By PCMPs	*Contract—All Regions:* *Exhibit A: 6.2.1; 6.2.1.1.2; 6.2.1.1.3; 6.2.1.1.4; 6.4.1* *Contract—Regions 1, 4, 6, 7:* *Exhibit A: 6.4.3.1.1; 6.4.2* *Contract—Regions 2, 3, 5:* *Exhibit A: 6.4.5.1.1; 6.4.4*

Discussion:

The RMHP Strategy for Care Coordination document outlined the processes of care management for each of the five levels of risk stratification. Community-based care coordination teams located in several areas throughout the region are organized around a "medical neighborhood" model for care management and care coordination. Care coordination teams maximize the providers' abilities to take on complex patients, and approaches vary according to a community's unique needs and resources. CCTs have developed relationships with community organizations specific to needs in each community. Staff stated that RMHP has six CCTs throughout the region, with the most mature team in Larimer County and the newest team in the Garfield/Pitkin County area. RMHP anticipated a seventh CCT would be implemented in Summit County. Staff stated that 95 percent of Region 1 members reside in areas with CCTs. RMHP's Care Management Team supports the community-based care coordination teams as necessary and provides care management for members not served by CCTs. Although RMHP does not formally delegate PCMPs to perform care coordination, some high-functioning medical home PCMPs have care coordination capabilities. Each local care coordination team and the RMHP care management team have dedicated resources that vary according to size of the community and configuration of partners in the community. For example, Larimer has 7.8 full-time employees (FTEs), Durango has 2.0 FTEs, and RMHP Care Management has 3 FTEs. In addition, staff stated that all teams have a variety of other resources they can access as needed (e.g., behavioral health coordinators, community service workers, and county and other agency case managers). RMHP expected all care coordination staff numbers to increase in 2014 in response to Medicaid expansion.

The ACC Stratification for Care Coordination policy described five levels of risk into which members are stratified using the RMHP Case Management Index (CMI):

Follow-up—Care Coordination

On-site Discussion Topics	Pertinent Contract References

- Level 1 – Preventive care
- Level 2 – Chronic disease, but well managed
- Level 3 – Multiple chronic conditions or frequent ED utilizer requiring support for improved self-management
- Level 4 –Complex care needs requiring intensive care management
- Level 5 – Inpatient transition of care

Staff explained that the Case Mix Index (CMI) was based on claims data similar to SDAC data used to identify risk indicators from demographic data, diagnoses, utilization of services, and costs of care. The process resulted in a Case Management Activity Tool (CMAT) report which identified cases with "potential" need for care management and was used by the CCTs or RCCO care managers to prioritize cases for care management. RMHP customer service staff conducted a brief health risk screening during member welcome calls and referred any cases with potential care management needs to RCCO care management staff. In addition, PCMPs may refer any complex needs patient to a CCT or RCCO Care Management at any time. Staff stated that Levels 1, 2, and 3 were managed by PCMPs, and members identified as Levels 4 and 5 were eligible for either complex care management or transition of care follow-up. Some members categorized as Level 3 were also eligible to be entered into either the coronary artery disease or diabetes disease management program or into the high ER utilizer follow-up program. Staff stated that when a Level 4 or 5 member is attributed to a high-functioning PCMH, RCCO care managers call to confirm that the practice has identified the member as a candidate for care coordination.

Staff stated that many hospitals have been unwilling or unable to provide consistent real-time data to the RCCO for effective transition of care management. Staff stated that hospitals with historical relationships with RMHP's other product lines (Mesa area and Centura hospitals) have developed a mechanism for timely notification of admissions and discharges to RMHP. However, other hospitals, particularly tertiary care facilities and small rural hospitals, were noted as problematic. RMHP stated that a priority for 2014 is completion of formal agreements with numerous high-volume hospitals in the region to consistently provide timely notification to the RCCO of admissions, discharges, and ER visits. Short-term, development of alert mechanisms was considered the only solution, although staff stated that, long-term, a functioning health information exchange would be the ultimate solution.

RMHP also confirmed that reliable identification of pregnant members who may be candidates for high-risk pregnancy care coordination is a continuing problem. Welcome call health risk assessments screen for pregnancy; however, referrals from providers or other agencies involved with the member were noted as the only other notification sources.

The Comprehensive Needs Assessment policy outlined the comprehensive needs assessment and care plan components to be applied to all members in Level 4 or Level 5. The comprehensive needs assessment included 49 items covering cultural/linguistic needs, medical conditions, heath behavior risks, functional status, social and community support needs, mental health, and cognitive status. RMHP also submitted a variety of additional assessment tools being applied

Follow-up—Care Coordination	
On-site Discussion Topics	**Pertinent Contract References**
within individual CCTs. Staff explained that CCTs and PCMPs may use additional or alternative assessment tools, but that the RCCO comprehensive needs assessment was the standard for the region and that all other tools must screen for similar elements. The Transition of Care policy outlined the components of the transition of care plan to be applied to all members being discharged from an inpatient facility if the RCCO is alerted to the pending discharge by the facility. When notified, RCCO care managers work with hospital care managers to define a discharge plan and follow up with the member. Care management record reviews documented that a comprehensive needs assessment was conducted for complex care management cases.	
Observations: RMHP developed an effective risk-stratification methodology for identifying potential candidates for complex care coordination through the local CCTs or RMHP care managers. PCMPs or community organizations involved with the member may also make referrals to the CCTs. RMHP developed a comprehensive needs assessment for members identified for complex care coordination, which is applied by all the CCTs and considered the standard across the region. On-site care coordination record reviews demonstrated that members identified by RMHP risk stratification had very complex needs, were thoroughly assessed, and were intensively managed by care coordinators. Care managers also have protocols for managing transition of care cases and follow-up with high emergency department utilizers, but hospitals in the region do not consistently inform RMHP of admissions, discharges, and transfers (ADTs). RMHP established a 2014 priority to increase the number of hospitals with agreements to provide real-time data to identify ADTs.	
2. Expansion populations and coordination of care ◆ Impact of expanded RCCO-eligible populations or special needs groups on care coordination activities. Challenges and successes regarding: • Members who have a need for Home and Community-Based Services or other community-based services • Transition of care members • Complex cases that may require multiple services across the continuum of care • Members who have both behavioral and physical health needs • FBMME • AwDC • Foster care children • Integration of the inmate population ◆ Impact of expanded medical neighborhood relationships on the coordination of care: • At RCCO level • At PCMP level • How the RCCO/PCMP is organizing/cooperating to increase effectiveness of care coordination	*Contract—Regions 1, 4, 6, 7:* *Exhibit A: 6.4.3.1.2; 6.4.3.1.3; 6.4.3.2.3; 6.4.3.2.4; 6.4.3.3* *Contract—Regions 2, 3, 5:* *Exhibit A: 6.4.3; 6.4.5.1.2; 6.4.5.1.3; 6.4.5.2.3; 6.4.5.2.4; 6.4.5.3* *Contract—Regions 3 and 5:* *Exhibit A: 6.4.5.1.4*

Follow-up—Care Coordination

On-site Discussion Topics	Pertinent Contract References

Discussion:

The Network Adequacy Report described that RMHP's Care Management Team and the local CCTs targeted those members who would benefit most from intensive care coordination services, both in terms of improving care quality and reducing care costs related to inappropriate utilization patterns. The report stated that all care coordination staff received appropriate training about the unique needs and challenges of the special expansion populations, and that CCTs developed collaborative relationships with community-based organizations that have the necessary expertise to effectively serve these populations. RMHP also facilitated quarterly meetings as a forum for the care coordination teams to discuss best practices, opportunities, challenges, tools, and strategies for specific populations. In preparation for the State's Demonstration to Integrate Care for the FBMME population, the report described that RMHP has been meeting with organizations serving this population throughout the region, including the SEP agencies, CCBs, behavioral health organizations (BHOs), CMHCs, home health agencies, hospice programs, hospitals, and other providers to establish protocols for data sharing and care coordination for shared clients. RMHP developed MOUs for data/information sharing, shared care coordination, and communications regarding the FBMME population. Staff stated that next steps included the continued development and finalization of MOUs with community partners.

Staff stated that rapidly increasing enrollment in the Medicaid population presented several challenges for care coordination. Not only are there considerably more members to manage, but the RCCO has no demographic or clinical history on many of the members included in the expansion populations, since they were not previously Medicaid eligible. Therefore, it is difficult to project the new populations' special needs. RMHP stated that the large and growing number of unattributed members (due to Medicaid expansion over the past year) negatively impacts the ability to provide care coordination services. RMHP established dedicated care coordination resources to contact unattributed members and improve attribution to PCMPs. In addition, PCMP practices have been actively engaged in attribution efforts, and members have been instructed to contact RMHP customer service, rather than HealthColorado, to assist with successful completion of the attribution process.

Staff stated that the overall growth in Medicaid volume has had much more impact on systems and resources than the needs of special expansion groups. While RMHP projected an expansion of care coordination personnel resources in 2014, RMHP was hesitant to add resources until the local CCTs have an opportunity to evaluate the specific types of expertise that may be needed in each community. RMHP is working within communities to define the best mechanisms for controlled expansion of resources. Staff stated that managing the rapid increase in the Medicaid population has strained the case management resources of all agencies, thereby making cooperative efforts essential for maximizing the resources within all systems. RMHP has placed major emphasis on "coordinating the coordinators" within the care management program. Before engaging with the member, the care coordinator reaches out to all other entities with whom the member may be involved to confirm services already being provided and to establish the cooperative care coordination roles. RMHP developed a Care Team Coordination Plan to document all contact persons and care coordinators that may be involved with a complex care management member.

To address the needs of special expansion populations such as FBMME, foster care children, or parolees, RMHP described that access to member data from other State agencies is a high-priority concern. These special populations overlap into multiple state systems, and the processes of other agencies are often

Follow-up—Care Coordination	
On-site Discussion Topics	**Pertinent Contract References**
difficult to navigate. To accommodate the FBMME population, CCTs were meeting with agencies to explore mechanisms to identify a member's need for home-based services before the member requires admission to a hospital or long term care (LTC) facility. Staff stated that the CCTs were also evaluating the best home health agency partners in each community. RMHP plans to expand community worker programs to assist FBMME members with non-skilled support needs, providing an extension of traditional home health services.	
Observations: All care coordination staff members have received appropriate training on the unique needs and challenges of the special expansion populations (i.e., FBMME, foster children, and the corrections population). CCTs are developing collaborative relationships with community-based organizations with the necessary expertise to effectively serve these populations and are coordinating care management efforts with these organizations. RMHP instituted a "coordinate the coordinators" approach as a priority in the care management program. CHWs are also considered an effective extension of the care coordination programs for members with complex social or behavioral needs. In relation to the special needs expansion populations, RMHP stated that access to member data from other state agencies is a high-priority concern, that many state and county systems are difficult to navigate, and that RMHP is working with the Department and county agencies to identify data-sharing arrangements. RMHP assigned dedicated staff to improve attribution of members.	
3. Care Coordination Outcomes ◆ Systems/mechanisms used to coordinate information from multiple levels of care and delivery sites: • Sources of meaningful coordination of care information • Access to real-time member information ◆ Outcomes of care coordination efforts: • Defining effectiveness • Mechanisms for monitoring • RCCO level • PCMP level • Engaging multiple providers in improving outcomes	*Contract—All Regions:* *Exhibit A: 6.4.1* *Contract—Regions 1, 4, 6, 7:* *Exhibit A: 6.4.2; 6.4.3.1.6* *Contract—Regions 2, 3, 5:* *Exhibit A: 6.4.4* *Contract—Regions 3 and 5:* *Exhibit A: 6.4.5.1.7* *Contract—Region 2:* *Exhibit A: 6.4.5.1.6*
Discussion: As stated in previous sections of this report, RMHP continues to experience challenges in gaining access to real-time or meaningful data to facilitate effective care coordination for some Medicaid populations, including high-risk pregnancy, ER visits, hospital admissions and discharges, and historical demographic and clinical information for many of the expansion populations. Short-term, RMHP is developing relationships with multiple agencies and provider systems and using business associate agreements to facilitate exchange of member information.	

Follow-up—Care Coordination

On-site Discussion Topics	Pertinent Contract References
The Coordination of Care Plan outlined several outcome measures related to the coordination of care, with benchmarks for performance in client satisfaction and key utilization measures. However, staff stated that those measures have not been implemented across the region, and RMHP is still evaluating the best measures of the impact of care coordination on the Medicaid population. RMHP is examining the value of measuring targeted penetration rates for care coordination of specific population groups and desired throughput measures (i.e., transition of members out of care coordination support). Staff also stated that the CCTs' varying levels of maturity and community-specific processes must be considered in the determination of region-wide outcome measures. The Larimer County CCT tracks reduction in ER utilization of members receiving care management, types and level of success of various resources provided through care coordinators to individual members, and anecdotal client satisfaction feedback. RMHP monitors population utilization measures through the SDAC key performance indicators (KPIs) and internal reports of the total costs of care associated with diagnosis categories. However, psychosocial services and care coordination interventions are not reflected in claims data, making the claims database an inadequate source for measuring care coordination outcomes. Staff stated that RMHP will continue to explore and evaluate effective measures of care coordination outcomes throughout 2014.	
Observations: Coordination of Care Outcomes are being monitored at a high level through the KPI reports, and some CCTs have instituted tracking mechanisms to measure coordination of social and other services that cannot be measured through claims-based data. However, RMHP continues to explore and evaluate the most meaningful measures of the outcomes of care coordination in the Medicaid populations, which must consider the changing population demographics, the varied community-specific processes of the CCTs, and the integration of care coordination processes with other organizations.	

During on-site care coordination record review, several records were eliminated from the sample selection list due to the records being inadequate or inappropriate for scoring the specific care coordination contract requirements. HSAG summarized in Table B-1 the reasons records were eliminated from the Department-selected SDAC sample. HSAG recommends that this information be used by **RMHP** and the Department to further discussions concerning effectiveness of various sources for risk-identifying members appropriate for care management.

Table B-1—Reasons Records Were Eliminated from SDAC Sample

Reason Record Was Eliminated	Number of Records Eliminated
The member did not meet the selection criteria for six months of continuous enrollment in the RCCO.	10[1]
The member was not identified by **RMHP** risk stratification methods as a candidate for care coordination (no care management documentation was available to evaluate).	9[2]
Despite multiple attempts, the care manager was unable to contact the member to initiate care coordination.	3
The member was not attributed to Region 1.	1
Total number of records eliminated from original sample of 20:	**19**

[1] Some records in this category were also counted in other categories.

[2] Two cases concerned pregnancies of which **RMHP** was made aware only after the babies were born. Four cases were stratified by **RMHP**'s system as being Level 1 (requiring only preventive/wellness care) and three cases were stratified as being Level 2 or Level 3 (disease self-management).

The completed record review tools follow this page.

Sample Number: #2 **Reviewer:** Kathy Bartilotta

Care Coordination Program Record Review	Score
Assessment	
1. The RCCO (or designee) assessed the member's: ◆ Health behavior risks. ◆ Health/medical needs. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1* *Regions 2, 3, 5: Exhibit A—6.4.5.1.1*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The member was a foster child born prematurely and living with an aunt. The child's needs were being managed by the PCMP, a home care agency, and a developmental agency. The record documented assessment of the member's health risks and medical needs.	
2. The RCCO (or designee) assessed the member's: ◆ Non-medical needs. ◆ Linguistic and cultural needs. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1; 6.4.3.2.2* *Regions 2, 3, 5: Exhibit A—6.4.5.1.1; 6.4.5.2.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The child's comprehensive needs were assessed through the developmental agency. The member's non-medical, linguistic, and cultural needs were documented in the record.	
3. The RCCO (or designee) assessed current care coordination services provided to the member to determine if the providers involved in each member's care are providing necessary care coordination services and which care coordination services are insufficient or are not provided. *Regions 1, 4, 6, 7: Exhibit A— 6.4.2.1* *Regions 2, 3, 5: Exhibit A—6.4.4.1*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The member's record indicated that the care manager coordinated with the home care agency and that the PCP received regular reports from the developmental agency and the home care agency.	

Care Coordination Program Record Review	Score
Intervention	
4. The RCCO (or designee) worked with providers responsible for the member's care to develop a plan for regular communication with those responsible for the member's care coordination. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.3* *Regions 2, 3, 5: Exhibit A—6.4.4.3*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The record contained ample documentation to demonstrate that the care manager at the PCMP communicated regularly with the care managers from the home health care (HHC) and developmental agencies.	
5. The RCCO (or designee) reasonably ensured that all care coordination services, including those provided by other individuals or entities, met the needs of the member. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.4* *Regions 2, 3, 5: Exhibit A—6.4.4.4*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The member's care record documented frequent communications and interactions with the member's family, and notes in the home care record indicated that member needs were met.	
6. The RCCO (or designee) provided necessary care coordination services not provided by another source. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.2* *Regions 2, 3, 5: Exhibit A—6.4.4.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The PCMP also made referrals for speech therapy and for Synagis. The care manager frequently communicated with the member to identify any services still needed, but the PCP, home care agency, and developmental agency were meeting all needs.	
7. The RCCO (or designee) linked the member to medical and/or non-medical services, acted as a liaison between medical providers or between medical and non-medical providers, and/or served as a liaison between providers and the member. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.2* *Regions 2, 3, 5: Exhibit A—6.4.5.1.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The member's care coordination record documented numerous referrals for medical and non-medical services.	

Care Coordination Program Record Review	Score
Transitions	
8. The RCCO (or designee) provided assistance during care transitions from hospitals or other care institutions to home- or community-based settings. This assistance promoted continuity of care. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3* *Region 2,: Exhibit A—6.4.5.1.3* *Regions 3, 5: Exhibit A—6.4.5.1.4*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
Observations: The member did not require a transition of care during the review period.	
9. The RCCO (or designee) provided assistance during other transitions, such as the transition from children's health services to adult health services or from hospital or home care into a nursing facility. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3* *Region 2: Exhibit A—6.4.5.1.3* *Regions 3, 5: Exhibit A—6.4.5.1.4*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
Observations: The member did not require a transition of care during the review period.	
10. The RCCO (or designee) documented and communicated necessary information about the member to the providers, institutions, and individuals involved in the transition. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3* *Region 2: Exhibit A—6.4.5.1.3* *Regions 3, 5: Exhibit A—6.4.5.1.4*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
Observations: The member did not require a transition of care during the review period.	

Care Coordination Program Record Review	Score
Continued Coordination/Follow-up	
11. The documentation clearly indicated that the RCCO's (or designee's) provision of care coordination services was responsive to the member's needs. *Regions:1, 4, 6, 7: Exhibit A—6.4.3.2.3* *Regions 2, 3,5 : Exhibit A—6.4.5.2.3*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The member's care plan goals for home care documented both medical and social status and needs. The record indicated that the member's aunt is comfortable with home care visits and told the care manager that providers were "doing everything right."	
12. The RCCO (or designee) followed up with the member to assess whether the member has received the services needed and/or if the member is on track to reach his or her desired health outcomes. *Regions 1, 4, 6, 7 Exhibit A—6.4.3.1.6* *Region 2: Exhibit A—6.4.5.1.6* *Regions 3, 5: Exhibit A—6.4.5.1.7*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The PCMP record confirmed that the home care agency was in frequent contact with the member and the member remained on track.	

Recommendations:

The care coordinator did a great job managing this member's care. HSAG has no recommendations.

Results for Care Coordination Program Record Review—Sample #2							
Total	Met	=	9	X	1.00	=	9
	Partially Met	=	0	X	0.0	=	0
	Not Met	=	0	X	0.0	=	0
	Not Applicable	=	3	X	NA	=	0
Total Applicable		=	9	**Total Score**		=	9

Total Score ÷ Total Applicable	=	100%

Sample Number: Oversample (OS) #1 **Reviewer:** Kathy Bartilotta

Care Coordination Program Record Review	Score
Assessment	
1. The RCCO (or designee) assessed the member's: ◆ Health behavior risks. ◆ Health/medical needs. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1* *Regions 2, 3, 5: Exhibit A—6.4.5.1.1*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager conducted a thorough assessment of the member's health needs and risks. The member had high ER utilization, a history of back and kidney problems, and experienced significant anxiety. Health behavior risks included noncompliance issues and difficulty with communications.	
2. The RCCO (or designee) assessed the member's: ◆ Non-medical needs. ◆ Linguistic and cultural needs. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1; 6.4.3.2.2* *Regions 2, 3, 5: Exhibit A—6.4.5.1.1; 6.4.5.2.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The health risk assessment included a thorough assessment of the member's non-medical and cultural needs, including transportation needs, employment opportunities, and noncompliance with behavioral health providers.	
3. The RCCO (or designee) assessed current care coordination services provided to the member to determine if the providers involved in each member's care are providing necessary care coordination services and which care coordination services are insufficient or are not provided. *Regions 1, 4, 6, 7: Exhibit A— 6.4.2.1* *Regions 2, 3, 5: Exhibit A—6.4.4.1*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager notes documented that the care manager was communicating with community agencies involved with the member and communicating with the member several times weekly.	

Care Coordination Program Record Review	Score
Intervention	
4. The RCCO (or designee) worked with providers responsible for the member's care to develop a plan for regular communication with those responsible for the member's care coordination. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.3* *Regions 2, 3, 5: Exhibit A—6.4.4.3*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The RCCO care manager documented communication with care coordinators at other agencies and with the member's providers.	
5. The RCCO (or designee) reasonably ensured that all care coordination services, including those provided by other individuals or entities, met the needs of the member. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.4* *Regions 2, 3, 5: Exhibit A—6.4.4.4*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager conducted ongoing assessments of the member's care needs through frequent interactions with the member and the member's care providers.	
6. The RCCO (or designee) provided necessary care coordination services not provided by another source. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.2* *Regions 2, 3, 5: Exhibit A—6.4.4.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager used an assessment tool that helped identify needed services. The care manager arranged for any services not being provided by another source.	
7. The RCCO (or designee) linked the member to medical and/or non-medical services, acted as a liaison between medical providers or between medical and non-medical providers, and/or served as a liaison between providers and the member. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.2* *Regions 2, 3, 5: Exhibit A—6.4.5.1.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The record documented many referrals to and coordination of community resources, medications, and provider appointments.	

Care Coordination Program Record Review	Score
Transitions	
8. The RCCO (or designee) provided assistance during care transitions from hospitals or other care institutions to home- or community-based settings. This assistance promoted continuity of care. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3* *Region 2,: Exhibit A—6.4.5.1.3* *Regions 3, 5: Exhibit A—6.4.5.1.4*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager followed up with the member post ER visit to assess any new medications and to ensure that the member would follow up with his PCP appointment.	
9. The RCCO (or designee) provided assistance during other transitions, such as the transition from children's health services to adult health services or from hospital or home care into a nursing facility. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3* *Region 2: Exhibit A—6.4.5.1.3* *Regions 3, 5: Exhibit A—6.4.5.1.4*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
Observations: The member did not require other transitions during the review period.	
10. The RCCO (or designee) documented and communicated necessary information about the member to the providers, institutions, and individuals involved in the transition. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3* *Region 2: Exhibit A—6.4.5.1.3* *Regions 3, 5: Exhibit A—6.4.5.1.4*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager documented communication about the member's ER visit through e-mails, telephone calls, and in-person meetings with other providers, including the behavioral health provider.	

Care Coordination Program Record Review	Score
Continued Coordination/Follow-up	
11. The documentation clearly indicated that the RCCO's (or designee's) provision of care coordination services was responsive to the member's needs. *Regions:1, 4, 6, 7: Exhibit A—6.4.3.2.3* *Regions 2, 3,5 : Exhibit A—6.4.5.2.3*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager clearly documented that care coordination services were responsive to the member's needs.	
12. The RCCO (or designee) followed up with the member to assess whether the member has received the services needed and/or if the member is on track to reach his or her desired health outcomes. *Regions 1, 4, 6, 7 Exhibit A—6.4.3.1.6* *Region 2: Exhibit A—6.4.5.1.6* *Regions 3, 5: Exhibit A—6.4.5.1.7*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager documented frequent communication with both provider and member to ensure that the member remained on track to reach desired health goals.	

Recommendations:

The care manager did a great job managing this member's care. HSAG has no recommendations.

Results for Care Coordination Program Record Review—Sample OS #1							
Total	Met	=	11	X	1.00	=	11
	Partially Met	=	0	X	0.0	=	0
	Not Met	=	0	X	0.0	=	0
	Not Applicable	=	1	X	NA	=	0
Total Applicable		=	11	**Total Score**		=	11

Total Score ÷ Total Applicable	=	100%

Sample Number: OS #2 **Reviewer:** Kathy Bartilotta

Care Coordination Program Record Review	Score
Assessment	
1. The RCCO (or designee) assessed the member's: ◆ Health behavior risks. ◆ Health/medical needs. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1* *Regions 2, 3, 5: Exhibit A—6.4.5.1.1*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The member was referred to the care manager by the provider. The care manager conducted a thorough assessment of the member's health risks and needs. The member had multiple chronic care problems and behavioral health problems and was noncompliant with managing her medical problems. The member's husband was also being care managed.	
2. The RCCO (or designee) assessed the member's: ◆ Non-medical needs. ◆ Linguistic and cultural needs. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1; 6.4.3.2.2* *Regions 2, 3, 5: Exhibit A—6.4.5.1.1; 6.4.5.2.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager conducted a thorough assessment of the member's non-medical, linguistic, and cultural needs. The member was impoverished, had transportation needs, and often missed appointments.	
3. The RCCO (or designee) assessed current care coordination services provided to the member to determine if the providers involved in each member's care are providing necessary care coordination services and which care coordination services are insufficient or are not provided. *Regions 1, 4, 6, 7: Exhibit A— 6.4.2.1* *Regions 2, 3, 5: Exhibit A—6.4.4.1*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager assessed and documented information obtained from the clinic electronic health record (care coordinator has access). The clinic coordinated care for services provided within the clinical system and referred the member to the RCCO for other services.	

Care Coordination Program Record Review	Score
Intervention	
4. The RCCO (or designee) worked with providers responsible for the member's care to develop a plan for regular communication with those responsible for the member's care coordination. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.3* *Regions 2, 3, 5: Exhibit A—6.4.4.3*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The member was re-engaging in mental health services. The care coordinator communicated with the member's other medical providers.	
5. The RCCO (or designee) reasonably ensured that all care coordination services, including those provided by other individuals or entities, met the needs of the member. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.4* *Regions 2, 3, 5: Exhibit A—6.4.4.4*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager followed up with the member and communicated with the member's providers to ensure that services provided were meeting the member's needs.	
6. The RCCO (or designee) provided necessary care coordination services not provided by another source. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.2* *Regions 2, 3, 5: Exhibit A—6.4.4.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager conducted a comprehensive assessment of the member's needs. The care coordination record documented multiple priorities and interventions.	
7. The RCCO (or designee) linked the member to medical and/or non-medical services, acted as a liaison between medical providers or between medical and non-medical providers, and/or served as a liaison between providers and the member. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.2* *Regions 2, 3, 5: Exhibit A—6.4.5.1.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager assisted the member in arranging for the member's home to be made wheelchair-accessible and for the member to receive home- and community-based services (HCBS), mental health services, and HHC.	

Care Coordination Program Record Review	Score
Transitions	
8. The RCCO (or designee) provided assistance during care transitions from hospitals or other care institutions to home- or community-based settings. This assistance promoted continuity of care. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3* *Region 2,: Exhibit A—6.4.5.1.3* *Regions 3, 5: Exhibit A—6.4.5.1.4*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
Observations: No transition of care was necessary during the review period.	
9. The RCCO (or designee) provided assistance during other transitions, such as the transition from children's health services to adult health services or from hospital or home care into a nursing facility. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3* *Region 2: Exhibit A—6.4.5.1.3* *Regions 3, 5: Exhibit A—6.4.5.1.4*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
Observations: No transition of care was necessary during the review period.	
10. The RCCO (or designee) documented and communicated necessary information about the member to the providers, institutions, and individuals involved in the transition. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3* *Region 2: Exhibit A—6.4.5.1.3* *Regions 3, 5: Exhibit A—6.4.5.1.4*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
Observations: No transition of care was necessary during the review period.	

Care Coordination Program Record Review	Score
Continued Coordination/Follow-up	
11. The documentation clearly indicated that the RCCO's (or designee's) provision of care coordination services was responsive to the member's needs. *Regions:1, 4, 6, 7: Exhibit A—6.4.3.2.3* *Regions 2, 3,5 : Exhibit A—6.4.5.2.3*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager referred the member to multiple medical and non-medical services based on the needs identified in the member's health assessment.	
12. The RCCO (or designee) followed up with the member to assess whether the member has received the services needed and/or if the member is on track to reach his or her desired health outcomes. *Regions 1, 4, 6, 7 Exhibit A—6.4.3.1.6* *Region 2: Exhibit A—6.4.5.1.6* *Regions 3, 5: Exhibit A—6.4.5.1.7*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager documented frequent interactions with the member to ensure that the member remained on track to reach her desired health outcomes.	

Recommendations:

The RCCO care manager did a great job managing this member's care. HSAG has no recommendations.

Results for Care Coordination Program Record Review—Sample OS #2							
Total	Met	=	9	X	1.00	=	9
	Partially Met	=	0	X	0.0	=	0
	Not Met	=	0	X	0.0	=	0
	Not Applicable	=	3	X	NA	=	0
Total Applicable		=	9	**Total Score**		=	9

Total Score ÷ Total Applicable	=	100%

Sample Number: OS #3 **Reviewer:** Kathy Bartilotta

Care Coordination Program Record Review	Score
Assessment	
1. The RCCO (or designee) assessed the member's: ◆ Health behavior risks. ◆ Health/medical needs. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1* *Regions 2, 3, 5: Exhibit A—6.4.5.1.1*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The member was referred to care management by the provider. The care manager conducted a thorough assessment of the member's health risks and needs. The member was hospitalized in late 2012 with stroke and pulmonary embolism, had been in rehabilitation, and has HHC. Risks included obesity and inability for physical activity.	
2. The RCCO (or designee) assessed the member's: ◆ Non-medical needs. ◆ Linguistic and cultural needs. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1; 6.4.3.2.2* *Regions 2, 3, 5: Exhibit A—6.4.5.1.1; 6.4.5.2.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager assessed the member's non-medical and cultural needs.	
3. The RCCO (or designee) assessed current care coordination services provided to the member to determine if the providers involved in each member's care are providing necessary care coordination services and which care coordination services are insufficient or are not provided. *Regions 1, 4, 6, 7: Exhibit A— 6.4.2.1* *Regions 2, 3, 5: Exhibit A—6.4.4.1*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager documented communications with multiple community agencies, including rehabilitation and medical equipment providers.	

Care Coordination Program Record Review	Score
Intervention	
4. The RCCO (or designee) worked with providers responsible for the member's care to develop a plan for regular communication with those responsible for the member's care coordination. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.3* *Regions 2, 3, 5: Exhibit A—6.4.4.3*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager documented active engagement with the member's multiple care providers.	
5. The RCCO (or designee) reasonably ensured that all care coordination services, including those provided by other individuals or entities, met the needs of the member. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.4* *Regions 2, 3, 5: Exhibit A—6.4.4.4*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager followed up regularly with the member and the member's providers to ensure that the member's needs were being addressed.	
6. The RCCO (or designee) provided necessary care coordination services not provided by another source. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.2* *Regions 2, 3, 5: Exhibit A—6.4.4.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager conducted an ongoing gap analysis to identify those needed services not being addressed. The care manager intervened to address multiple service needs.	
7. The RCCO (or designee) linked the member to medical and/or non-medical services, acted as a liaison between medical providers or between medical and non-medical providers, and/or served as a liaison between providers and the member. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.2* *Regions 2, 3, 5: Exhibit A—6.4.5.1.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager assisted the member to obtain medical and non-medical services. The care manager arranged for appointments with providers and attended appointments with the member.	

Care Coordination Program Record Review	Score
Transitions	
8. The RCCO (or designee) provided assistance during care transitions from hospitals or other care institutions to home- or community-based settings. This assistance promoted continuity of care. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3* *Region 2,: Exhibit A—6.4.5.1.3* *Regions 3, 5: Exhibit A—6.4.5.1.4*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager worked with the member, hospital staff, and staff at a rehabilitation center to arrange for rehabilitation services post hospitalization.	
9. The RCCO (or designee) provided assistance during other transitions, such as the transition from children's health services to adult health services or from hospital or home care into a nursing facility. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3* *Region 2: Exhibit A—6.4.5.1.3* *Regions 3, 5: Exhibit A—6.4.5.1.4*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
Observations: The member did not experience any "other transitions" during the review period.	
10. The RCCO (or designee) documented and communicated necessary information about the member to the providers, institutions, and individuals involved in the transition. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3* *Region 2: Exhibit A—6.4.5.1.3* *Regions 3, 5: Exhibit A—6.4.5.1.4*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager coordinated with care managers at the hospital and at the rehabilitation facility to ensure a smooth transition of care.	

Care Coordination Program Record Review	Score
Continued Coordination/Follow-up	
11. The documentation clearly indicated that the RCCO's (or designee's) provision of care coordination services was responsive to the member's needs. *Regions:1, 4, 6, 7: Exhibit A—6.4.3.2.3* *Regions 2, 3,5 : Exhibit A—6.4.5.2.3*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager's notes indicated that the care coordinator was addressing all of the member's identified needs.	
12. The RCCO (or designee) followed up with the member to assess whether the member has received the services needed and/or if the member is on track to reach his or her desired health outcomes. *Regions 1, 4, 6, 7 Exhibit A—6.4.3.1.6* *Region 2: Exhibit A—6.4.5.1.6* *Regions 3, 5: Exhibit A—6.4.5.1.7*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager followed up with the member frequently to ensure that the member remained on track to reach desired health outcomes.	

Recommendations:

The care manager did a great job addressing this member's needs. HSAG has no recommendations.

Results for Care Coordination Program Record Review—Sample OS #3							
Total	Met	=	11	X	1.00	=	11
	Partially Met	=	0	X	0.0	=	0
	Not Met	=	0	X	0.0	=	0
	Not Applicable	=	1	X	NA	=	0
Total Applicable		=	11	**Total Score**		=	11

Total Score ÷ Total Applicable	=	100%

Sample Number: OS #4 **Reviewer:** Kathy Bartilotta

Care Coordination Program Record Review	Score
Assessment	
1. The RCCO (or designee) assessed the member's: ◆ Health behavior risks. ◆ Health/medical needs. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1* *Regions 2, 3, 5: Exhibit A—6.4.5.1.1*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: Member had 23 ER visits. The care manager conducted a thorough assessment of the member's health risks and needs. Member falls, is confused about medications, and is noncompliant with behavioral health therapies.	
2. The RCCO (or designee) assessed the member's: ◆ Non-medical needs. ◆ Linguistic and cultural needs. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1; 6.4.3.2.2* *Regions 2, 3, 5: Exhibit A—6.4.5.1.1; 6.4.5.2.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager conducted an assessment of the member's non-medical and cultural needs. Member is homeless; sleeps outside.	
3. The RCCO (or designee) assessed current care coordination services provided to the member to determine if the providers involved in each member's care are providing necessary care coordination services and which care coordination services are insufficient or are not provided. *Regions 1, 4, 6, 7: Exhibit A— 6.4.2.1* *Regions 2, 3, 5: Exhibit A—6.4.4.1*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager identified multiple providers not communicating with each other. The care manager assessed what was being done and by whom and identified that the member needed coordination of providers and medications, with reminders.	

Care Coordination Program Record Review	Score
Intervention	
4. The RCCO (or designee) worked with providers responsible for the member's care to develop a plan for regular communication with those responsible for the member's care coordination. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.3* *Regions 2, 3, 5: Exhibit A—6.4.4.3*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager worked with the residency clinic to organize a plan of care for the member and to establish collaborative goals with the member.	
5. The RCCO (or designee) reasonably ensured that all care coordination services, including those provided by other individuals or entities, met the needs of the member. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.4* *Regions 2, 3, 5: Exhibit A—6.4.4.4*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The member expressed that his priority goals were employment and medical care. All other needs were identified through the comprehensive needs assessment and included social and substance abuse-related needs. The member became very engaged with the care manager's recommendations.	
6. The RCCO (or designee) provided necessary care coordination services not provided by another source. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.2* *Regions 2, 3, 5: Exhibit A—6.4.4.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager conducted a thorough assessment of needs and services provided by various agencies and identified needed services not being addressed. The care manager, a behavioral health specialist, provided direct behavioral health services to the member. The care manager worked with the member, agencies, and providers to ensure that other needs were met.	
7. The RCCO (or designee) linked the member to medical and/or non-medical services, acted as a liaison between medical providers or between medical and non-medical providers, and/or served as a liaison between providers and the member. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.2* *Regions 2, 3, 5: Exhibit A—6.4.5.1.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager was very active in coordinating effective medical and non-medical interventions with necessary providers and the member.	

Care Coordination Program Record Review	Score
Transitions	
8. The RCCO (or designee) provided assistance during care transitions from hospitals or other care institutions to home- or community-based settings. This assistance promoted continuity of care. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3* *Region 2,: Exhibit A—6.4.5.1.3* *Regions 3, 5: Exhibit A—6.4.5.1.4*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager followed up after ED visits to ensure that the member had medications and to coordinate follow-up appointments.	
9. The RCCO (or designee) provided assistance during other transitions, such as the transition from children's health services to adult health services or from hospital or home care into a nursing facility. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3* *Region 2: Exhibit A—6.4.5.1.3* *Regions 3, 5: Exhibit A—6.4.5.1.4*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
Observations: The member did not experience this type of transition.	
10. The RCCO (or designee) documented and communicated necessary information about the member to the providers, institutions, and individuals involved in the transition. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3* *Region 2: Exhibit A—6.4.5.1.3* *Regions 3, 5: Exhibit A—6.4.5.1.4*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager documented frequent communications with providers regarding member status and progress.	

Care Coordination Program Record Review	Score
Continued Coordination/Follow-up	
11. The documentation clearly indicated that the RCCO's (or designee's) provision of care coordination services was responsive to the member's needs. *Regions:1, 4, 6, 7: Exhibit A—6.4.3.2.3* *Regions 2, 3,5 : Exhibit A—6.4.5.2.3*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager designed interventions to address the needs identified in the assessment and by the member. The care manager documented the needs and interventions in a care plan.	
12. The RCCO (or designee) followed up with the member to assess whether the member has received the services needed and/or if the member is on track to reach his or her desired health outcomes. *Regions 1, 4, 6, 7 Exhibit A—6.4.3.1.6* *Region 2: Exhibit A—6.4.5.1.6* *Regions 3, 5: Exhibit A—6.4.5.1.7*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager documented frequent contact with the member to ensure he stayed on track to reach personal goals and health outcomes. The member used the care coordination program for ongoing support needs.	

Recommendations:

Based on the notes in the record, the care manager appeared to have a very positive ongoing relationship with the member. The care manager did a fantastic job coordinating this member's care. HSAG has no recommendations.

Results for Care Coordination Program Record Review—Sample OS #4							
Total	Met	=	11	X	1.00	=	11
	Partially Met	=	0	X	0.0	=	0
	Not Met	=	0	X	0.0	=	0
	Not Applicable	=	1	X	NA	=	0
Total Applicable		=	11	**Total Score**		=	11

Total Score ÷ Total Applicable	=	100%

Sample Number: OS #5 **Reviewer:** Kathy Bartilotta

Care Coordination Program Record Review	Score
Assessment	
1. The RCCO (or designee) assessed the member's: ◆ Health behavior risks. ◆ Health/medical needs. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1* *Regions 2, 3, 5: Exhibit A—6.4.5.1.1*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The member was an adolescent foster care child in seven previous foster care homes. The member was involved in the Healthy Harbors program. Healthy Harbors documented the previous provider history and a narrative assessment. The member had significant behavioral health issues. The record included a thorough assessment of the member's health risks and needs.	
2. The RCCO (or designee) assessed the member's: ◆ Non-medical needs. ◆ Linguistic and cultural needs. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1; 6.4.3.2.2* *Regions 2, 3, 5: Exhibit A—6.4.5.1.1; 6.4.5.2.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager documented a thorough assessment of the member's non-medical and cultural needs, including behavioral and community support needs as well as the member's political and religious opinions.	
3. The RCCO (or designee) assessed current care coordination services provided to the member to determine if the providers involved in each member's care are providing necessary care coordination services and which care coordination services are insufficient or are not provided. *Regions 1, 4, 6, 7: Exhibit A— 6.4.2.1* *Regions 2, 3, 5: Exhibit A—6.4.4.1*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The Healthy Harbors care manager communicated between multiple providers involved in the member's care.	

Care Coordination Program Record Review	Score
Intervention	
4. The RCCO (or designee) worked with providers responsible for the member's care to develop a plan for regular communication with those responsible for the member's care coordination. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.3* *Regions 2, 3, 5: Exhibit A—6.4.4.3*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: There were multiple providers and systems of care involved with the member, and the care manager maintained frequent interactions with all providers.	
5. The RCCO (or designee) reasonably ensured that all care coordination services, including those provided by other individuals or entities, met the needs of the member. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.4* *Regions 2, 3, 5: Exhibit A—6.4.4.4*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager closely monitored interactions between providers and systems involved in the member's care to ensure that the member's needs were being addressed.	
6. The RCCO (or designee) provided necessary care coordination services not provided by another source. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.2* *Regions 2, 3, 5: Exhibit A—6.4.4.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager closely monitored interactions between providers involved in the member's care and intervened as necessary to provide services not being provided by another agency.	
7. The RCCO (or designee) linked the member to medical and/or non-medical services, acted as a liaison between medical providers or between medical and non-medical providers, and/or served as a liaison between providers and the member. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.2* *Regions 2, 3, 5: Exhibit A—6.4.5.1.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager followed the member's care carefully and acted as a liaison between multiple providers and agencies and the foster family.	

Care Coordination Program Record Review	Score
Transitions	
8. The RCCO (or designee) provided assistance during care transitions from hospitals or other care institutions to home- or community-based settings. This assistance promoted continuity of care. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3* *Region 2,: Exhibit A—6.4.5.1.3* *Regions 3, 5: Exhibit A—6.4.5.1.4*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
Observations: The member did not require transition from a hospital setting during the review period.	
9. The RCCO (or designee) provided assistance during other transitions, such as the transition from children's health services to adult health services or from hospital or home care into a nursing facility. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3* *Region 2: Exhibit A—6.4.5.1.3* *Regions 3, 5: Exhibit A—6.4.5.1.44*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The member was transitioning from child to adult services. The care manager was assisting the member with putting services in place to assist with moving out on his own.	
10. The RCCO (or designee) documented and communicated necessary information about the member to the providers, institutions, and individuals involved in the transition. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3* *Region 2: Exhibit A—6.4.5.1.3* *Regions 3, 5: Exhibit A—6.4.5.1.4*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager arranged and attended team meetings with all of the individuals involved in the member's care.	

Care Coordination Program Record Review	Score
Continued Coordination/Follow-up	
11. The documentation clearly indicated that the RCCO's (or designee's) provision of care coordination services was responsive to the member's needs. *Regions:1, 4, 6, 7: Exhibit A—6.4.3.2.3* *Regions 2, 3,5 : Exhibit A—6.4.5.2.3*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager addressed needs identified by the member. The care manager also addressed anticipated member needs related to transitioning out of the home and from child to adult services.	
12. The RCCO (or designee) followed up with the member to assess whether the member has received the services needed and/or if the member is on track to reach his or her desired health outcomes. *Regions 1, 4, 6, 7 Exhibit A—6.4.3.1.6* *Region 2: Exhibit A—6.4.5.1.6* *Regions 3, 5: Exhibit A—6.4.5.1.7*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager documented frequent communications with the member and grandparents to ensure the member remained on track to reaching his desired health and social outcomes.	

Recommendations:

The care manager did a great job coordinating this member's care. HSAG has no recommendations.

Results for Care Coordination Program Record Review—Sample OS #5							
Total	Met	=	11	X	1.00	=	11
	Partially Met	=	0	X	0.0	=	0
	Not Met	=	0	X	0.0	=	0
	Not Applicable	=	1	X	NA	=	0
Total Applicable		=	11	**Total Score**		=	11

Total Score ÷ Total Applicable	=	100%

Sample Number: OS #6 **Reviewer:** Rachel Henrichs

Care Coordination Program Record Review	Score
Assessment	
1. The RCCO (or designee) assessed the member's: ◆ Health behavior risks. ◆ Health/medical needs. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1* *Regions 2, 3, 5: Exhibit A—6.4.5.1.1*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager documented both a thorough assessment of the member's health risks and needs in August 2012 and ongoing assessments since then. The care manager documented a home visit in April 2013.	
2. The RCCO (or designee) assessed the member's: ◆ Non-medical needs. ◆ Linguistic and cultural needs. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1; 6.4.3.2.2* *Regions 2, 3, 5: Exhibit A—6.4.5.1.1; 6.4.5.2.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager documented both a thorough assessment of the member's non-medical, linguistic, and cultural needs in August 2012 and ongoing assessments since then. The care manager documented a home visit in April 2013.	
3. The RCCO (or designee) assessed current care coordination services provided to the member to determine if the providers involved in each member's care are providing necessary care coordination services and which care coordination services are insufficient or are not provided. *Regions 1, 4, 6, 7: Exhibit A— 6.4.2.1* *Regions 2, 3, 5: Exhibit A—6.4.4.1*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager documented regular communication with the member's medical and non-medical providers to ensure that the member's needs were being addressed.	

Care Coordination Program Record Review	Score
Intervention	
4. The RCCO (or designee) worked with providers responsible for the member's care to develop a plan for regular communication with those responsible for the member's care coordination. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.3* *Regions 2, 3, 5: Exhibit A—6.4.4.3*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager documented regular calls to the member's primary care provider confirming and making appointments on behalf of the member. The care manager appeared to have a truly collaborative relationship with the member's HHC provider, as evidenced by regular two-way communication.	
5. The RCCO (or designee) reasonably ensured that all care coordination services, including those provided by other individuals or entities, met the needs of the member. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.4* *Regions 2, 3, 5: Exhibit A—6.4.4.4*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager documented frequent calls to the member and his providers to ensure that the member's needs were being addressed.	
6. The RCCO (or designee) provided necessary care coordination services not provided by another source. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.2* *Regions 2, 3, 5: Exhibit A—6.4.4.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager provided regular assistance scheduling transportation and appointments. The care manager also identified the member's need for assistance with yard work and snow removal and assisted the member with arranging to have these services provided.	
7. The RCCO (or designee) linked the member to medical and/or non-medical services, acted as a liaison between medical providers or between medical and non-medical providers, and/or served as a liaison between providers and the member. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.2* *Regions 2, 3, 5: Exhibit A—6.4.5.1.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager documented multiple instances of providing links to medial and non-medical services and of acting as a liaison between providers.	

Care Coordination Program Record Review	Score
Transitions	
8. The RCCO (or designee) provided assistance during care transitions from hospitals or other care institutions to home- or community-based settings. This assistance promoted continuity of care. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3* *Region 2,: Exhibit A—6.4.5.1.3* *Regions 3, 5: Exhibit A—6.4.5.1.4*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
Observations: No transition of care was documented during the review period.	
9. The RCCO (or designee) provided assistance during other transitions, such as the transition from children's health services to adult health services or from hospital or home care into a nursing facility. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3* *Region 2: Exhibit A—6.4.5.1.3* *Regions 3, 5: Exhibit A—6.4.5.1.4*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
Observations: No transition of care was documented during the review period.	
10. The RCCO (or designee) documented and communicated necessary information about the member to the providers, institutions, and individuals involved in the transition. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3* *Region 2: Exhibit A—6.4.5.1.3* *Regions 3, 5: Exhibit A—6.4.5.1.4*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
Observations: No transition of care was documented during the review period.	

Care Coordination Program Record Review	Score
Continued Coordination/Follow-up	
11. The documentation clearly indicated that the RCCO's (or designee's) provision of care coordination services was responsive to the member's needs. *Regions:1, 4, 6, 7: Exhibit A—6.4.3.2.3* *Regions 2, 3,5 : Exhibit A—6.4.5.2.3*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager provided clear and extensive documentation of the member's needs and of how the manager worked with the member to address those needs.	
12. The RCCO (or designee) followed up with the member to assess whether the member has received the services needed and/or if the member is on track to reach his or her desired health outcomes. *Regions 1, 4, 6, 7 Exhibit A—6.4.3.1.6* *Region 2: Exhibit A—6.4.5.1.6* *Regions 3, 5: Exhibit A—6.4.5.1.7*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager documented multiple calls weekly to the member and his providers. As the care manager addressed the member's most immediate needs, the frequency of calls lessened but continued to be regular.	

Recommendations:

The care manager did a great job coordinating this member's care. HSAG has no recommendations.

Results for Care Coordination Program Record Review—Sample OS #6							
Total	Met	=	9	X	1.00	=	9
	Partially Met	=	0	X	0.0	=	0
	Not Met	=	0	X	0.0	=	0
	Not Applicable	=	3	X	NA	=	0
Total Applicable		=	9	**Total Score**		=	9

Total Score ÷ Total Applicable	=	100%

Sample Number: OS #7 **Reviewer:** Rachel Henrichs

Care Coordination Program Record Review	Score
Assessment	
1. The RCCO (or designee) assessed the member's: ◆ Health behavior risks. ◆ Health/medical needs. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1* *Regions 2, 3, 5: Exhibit A—6.4.5.1.1*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager documented a thorough assessment of the member's health risks and needs.	
2. The RCCO (or designee) assessed the member's: ◆ Non-medical needs. ◆ Linguistic and cultural needs. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1; 6.4.3.2.2* *Regions 2, 3, 5: Exhibit A—6.4.5.1.1; 6.4.5.2.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager documented a thorough assessment of the member's non-medical, linguistic, and cultural needs.	
3. The RCCO (or designee) assessed current care coordination services provided to the member to determine if the providers involved in each member's care are providing necessary care coordination services and which care coordination services are insufficient or are not provided. *Regions 1, 4, 6, 7: Exhibit A— 6.4.2.1* *Regions 2, 3, 5: Exhibit A—6.4.4.1*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager documented telephone calls to the member's primary care provider, mental health therapist, and long term care case manager.	

Care Coordination Program Record Review	Score
Intervention	
4. The RCCO (or designee) worked with providers responsible for the member's care to develop a plan for regular communication with those responsible for the member's care coordination. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.3* *Regions 2, 3, 5: Exhibit A—6.4.4.3*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager documented regular communication with the member's providers.	
5. The RCCO (or designee) reasonably ensured that all care coordination services, including those provided by other individuals or entities, met the needs of the member. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.4* *Regions 2, 3, 5: Exhibit A—6.4.4.4*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager documented regular calls to the member to ensure that the member's needs were being addressed.	
6. The RCCO (or designee) provided necessary care coordination services not provided by another source. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.2* *Regions 2, 3, 5: Exhibit A—6.4.4.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager assisted the member with housing needs.	
7. The RCCO (or designee) linked the member to medical and/or non-medical services, acted as a liaison between medical providers or between medical and non-medical providers, and/or served as a liaison between providers and the member. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.2* *Regions 2, 3, 5: Exhibit A—6.4.5.1.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager documented a telephone call to the member's landlord, on the member's behalf. The care manager also provided the member with alternative, low-income housing options.	

Care Coordination Program Record Review	Score
Transitions	
8. The RCCO (or designee) provided assistance during care transitions from hospitals or other care institutions to home- or community-based settings. This assistance promoted continuity of care. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3* *Region 2,: Exhibit A—6.4.5.1.3* *Regions 3, 5: Exhibit A—6.4.5.1.4*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
Observations: No transition of care was documented during the review period.	
9. The RCCO (or designee) provided assistance during other transitions, such as the transition from children's health services to adult health services or from hospital or home care into a nursing facility. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3* *Region 2: Exhibit A—6.4.5.1.3* *Regions 3, 5: Exhibit A—6.4.5.1.4*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
Observations: No transition of care was documented during the review period.	
10. The RCCO (or designee) documented and communicated necessary information about the member to the providers, institutions, and individuals involved in the transition. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3* *Region 2: Exhibit A—6.4.5.1.3* *Regions 3, 5: Exhibit A—6.4.5.1.4*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
Observations: No transition of care was documented during the review period.	

Care Coordination Program Record Review	Score
Continued Coordination/Follow-up	
11. The documentation clearly indicated that the RCCO's (or designee's) provision of care coordination services was responsive to the member's needs. *Regions:1, 4, 6, 7: Exhibit A—6.4.3.2.3* *Regions 2, 3,5 : Exhibit A—6.4.5.2.3*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager documented frequent communication with the member and appeared to address the member's concerns, requests, and needs.	
12. The RCCO (or designee) followed up with the member to assess whether the member has received the services needed and/or if the member is on track to reach his or her desired health outcomes. *Regions 1, 4, 6, 7 Exhibit A—6.4.3.1.6* *Region 2: Exhibit A—6.4.5.1.6* *Regions 3, 5: Exhibit A—6.4.5.1.7*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager documented regular calls to the member. The care manager was supportive and helpful to the member while encouraging member self-sufficiency.	

Recommendations:

The care manager did a great job coordinating this member's care. HSAG does not have any recommendations.

Results for Care Coordination Program Record Review—Sample OS #7							
Total	Met	=	9	X	1.00	=	9
	Partially Met	=	0	X	0.0	=	0
	Not Met	=	0	X	0.0	=	0
	Not Applicable	=	3	X	NA	=	0
Total Applicable		=	9	**Total Score**		=	9

Total Score ÷ Total Applicable	=	100%

Sample Number: OS #8 **Reviewer:** Rachel Henrichs

Care Coordination Program Record Review	Score
Assessment	
1. The RCCO (or designee) assessed the member's: ◆ Health behavior risks. ◆ Health/medical needs. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1* *Regions 2, 3, 5: Exhibit A—6.4.5.1.1*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager documented a thorough assessment of the member's health risks and needs.	
2. The RCCO (or designee) assessed the member's: ◆ Non-medical needs. ◆ Linguistic and cultural needs. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1; 6.4.3.2.2* *Regions 2, 3, 5: Exhibit A—6.4.5.1.1; 6.4.5.2.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager documented a thorough assessment of the member's non-medical, linguistic, and cultural needs.	
3. The RCCO (or designee) assessed current care coordination services provided to the member to determine if the providers involved in each member's care are providing necessary care coordination services and which care coordination services are insufficient or are not provided. *Regions 1, 4, 6, 7: Exhibit A— 6.4.2.1* *Regions 2, 3, 5: Exhibit A—6.4.4.1*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager documented telephone calls to the Loveland Community Health Center's disease management team, behavioral health provider, and the member's home- and community-based services (HCBS) care manager. The care manager also met with the member's HHC provider and primary care provider.	

Care Coordination Program Record Review	Score
Intervention	
4. The RCCO (or designee) worked with providers responsible for the member's care to develop a plan for regular communication with those responsible for the member's care coordination. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.3* *Regions 2, 3, 5: Exhibit A—6.4.4.3*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager documented regular communication with the member's providers.	
5. The RCCO (or designee) reasonably ensured that all care coordination services, including those provided by other individuals or entities, met the needs of the member. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.4* *Regions 2, 3, 5: Exhibit A—6.4.4.4*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager followed up regularly with the member and the member's provider to ensure that the member's needs were being addressed.	
6. The RCCO (or designee) provided necessary care coordination services not provided by another source. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.2* *Regions 2, 3, 5: Exhibit A—6.4.4.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager assisted the member with appointments for HCBS, HHC, and eye glasses.	
7. The RCCO (or designee) linked the member to medical and/or non-medical services, acted as a liaison between medical providers or between medical and non-medical providers, and/or served as a liaison between providers and the member. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.2* *Regions 2, 3, 5: Exhibit A—6.4.5.1.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager advocated on the member's behalf for HCBS and HHC services and intervened when the care manager suspected that the member was being treated unfairly.	

Care Coordination Program Record Review	Score
Transitions	
8. The RCCO (or designee) provided assistance during care transitions from hospitals or other care institutions to home- or community-based settings. This assistance promoted continuity of care. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3* *Region 2,: Exhibit A—6.4.5.1.3* *Regions 3, 5: Exhibit A—6.4.5.1.4*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager coordinated with the member's home health care agency to determine whether services would continue after discharge from the hospital.	
9. The RCCO (or designee) provided assistance during other transitions, such as the transition from children's health services to adult health services or from hospital or home care into a nursing facility. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3* *Region 2: Exhibit A—6.4.5.1.3* *Regions 3, 5: Exhibit A—6.4.5.1.4*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
Observations: No "other transition" of care was documented during the review period.	
10. The RCCO (or designee) documented and communicated necessary information about the member to the providers, institutions, and individuals involved in the transition. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3* *Region 2: Exhibit A—6.4.5.1.3* *Regions 3, 5: Exhibit A—6.4.5.1.4*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager coordinated with the member's home health care agency to discuss member concerns regarding home care services and to determine whether agency services would continue after discharge from the hospital.	

Care Coordination Program Record Review	Score
Continued Coordination/Follow-up	
11. The documentation clearly indicated that the RCCO's (or designee's) provision of care coordination services was responsive to the member's needs. *Regions:1, 4, 6, 7: Exhibit A—6.4.3.2.3* *Regions 2, 3,5 : Exhibit A—6.4.5.2.3*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager proved to be a strong advocate for the member. She checked in with the member regularly and coordinated with medical and non-medical providers to ensure that the member received appropriate services.	
12. The RCCO (or designee) followed up with the member to assess whether the member has received the services needed and/or if the member is on track to reach his or her desired health outcomes. *Regions 1, 4, 6, 7 Exhibit A—6.4.3.1.6* *Region 2: Exhibit A—6.4.5.1.6* *Regions 3, 5: Exhibit A—6.4.5.1.7*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager documented regular calls to member and member's medical and non-medical providers to ensure that the member's needs were being addressed. It appeared that the care manager intervened any time she felt the member was being treated unfairly.	

Recommendations:

The care manager did a great job coordinating this member's care. HSAG does not have any recommendations.

Results for Care Coordination Program Record Review—Sample OS #8							
Total	Met	=	11	X	1.00	=	11
	Partially Met	=	0	X	0.0	=	0
	Not Met	=	0	X	0.0	=	0
	Not Applicable	=	1	X	NA	=	0
Total Applicable		=	11	**Total Score**		=	11

Total Score ÷ Total Applicable	=	100%

Sample Number: OS #9 **Reviewer:** Rachel Henrichs

Care Coordination Program Record Review	Score
Assessment	
1. The RCCO (or designee) assessed the member's: ◆ Health behavior risks. ◆ Health/medical needs. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1* *Regions 2, 3, 5: Exhibit A—6.4.5.1.1*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager documented a thorough assessment of the member's health risks and needs in October 2012 and updated the document in October 2013.	
2. The RCCO (or designee) assessed the member's: ◆ Non-medical needs. ◆ Linguistic and cultural needs. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1; 6.4.3.2.2* *Regions 2, 3, 5: Exhibit A—6.4.5.1.1; 6.4.5.2.2*	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager documented a thorough assessment of the member's non-medical needs but did not document an assessment of the member's linguistic and/or cultural needs.	
3. The RCCO (or designee) assessed current care coordination services provided to the member to determine if the providers involved in each member's care are providing necessary care coordination services and which care coordination services are insufficient or are not provided. *Regions 1, 4, 6, 7: Exhibit A— 6.4.2.1* *Regions 2, 3, 5: Exhibit A—6.4.4.1*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager appeared to be coordinating services with the member's primary care provider, various specialists, the HHC nurse, and behavioral health provider. The care manager attended appointments with the member to ensure that services provided were meeting the member's needs.	

Care Coordination Program Record Review	Score
Intervention	
4. The RCCO (or designee) worked with providers responsible for the member's care to develop a plan for regular communication with those responsible for the member's care coordination. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.3* *Regions 2, 3, 5: Exhibit A—6.4.4.3*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager documented regular communication with the member's medical and non-medical providers.	
5. The RCCO (or designee) reasonably ensured that all care coordination services, including those provided by other individuals or entities, met the needs of the member. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.4* *Regions 2, 3, 5: Exhibit A—6.4.4.4*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager followed up regularly with providers and agencies involved in the member's care to ensure that the member's needs were being addressed.	
6. The RCCO (or designee) provided necessary care coordination services not provided by another source. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.2* *Regions 2, 3, 5: Exhibit A—6.4.4.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager assisted the member with requests for home- and community-based services and with filling out applications and paperwork required by various providers.	
7. The RCCO (or designee) linked the member to medical and/or non-medical services, acted as a liaison between medical providers or between medical and non-medical providers, and/or served as a liaison between providers and the member. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.2* *Regions 2, 3, 5: Exhibit A—6.4.5.1.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager pursued several options to address the member's home health care needs and housing options.	

Care Coordination Program Record Review	Score
Transitions	
8. The RCCO (or designee) provided assistance during care transitions from hospitals or other care institutions to home- or community-based settings. This assistance promoted continuity of care. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3* *Region 2,: Exhibit A—6.4.5.1.3* *Regions 3, 5: Exhibit A—6.4.5.1.4*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
Observations: No transition of care was documented during the review period.	
9. The RCCO (or designee) provided assistance during other transitions, such as the transition from children's health services to adult health services or from hospital or home care into a nursing facility. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3* *Region 2: Exhibit A—6.4.5.1.3* *Regions 3, 5: Exhibit A—6.4.5.1.4*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
Observations: No transition of care was documented during the review period.	
10. The RCCO (or designee) documented and communicated necessary information about the member to the providers, institutions, and individuals involved in the transition. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3* *Region 2: Exhibit A—6.4.5.1.3* *Regions 3, 5: Exhibit A—6.4.5.1.4*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
Observations: No transition of care was documented during the review period.	

Care Coordination Program Record Review	Score
Continued Coordination/Follow-up	
11. The documentation clearly indicated that the RCCO's (or designee's) provision of care coordination services was responsive to the member's needs. *Regions:1, 4, 6, 7: Exhibit A—6.4.3.2.3* *Regions 2, 3,5 : Exhibit A—6.4.5.2.3*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager addressed the needs identified in the assessment, identified by the member, and anticipated by the care manager.	
12. The RCCO (or designee) followed up with the member to assess whether the member has received the services needed and/or if the member is on track to reach his or her desired health outcomes. *Regions 1, 4, 6, 7 Exhibit A—6.4.3.1.6* *Region 2: Exhibit A—6.4.5.1.6* *Regions 3, 5: Exhibit A—6.4.5.1.7*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager documented regular calls to member to ensure that the member remained on track to reach desired health outcomes and social goals.	

Recommendations:

The care manager did a great job coordinating this member's care. HSAG recommends that the RCCO revise its assessment documents to include an assessment of members' linguistic and cultural needs.

Results for Care Coordination Program Record Review—Sample OS #9							
Total	Met	=	8	X	1.00	=	8
	Partially Met	=	1	X	0.0	=	0
	Not Met	=	0	X	0.0	=	0
	Not Applicable	=	3	X	NA	=	0
Total Applicable		=	9	**Total Score**		=	8

Total Score ÷ Total Applicable	=	89%

Sample Number: OS #10 **Reviewer:** Rachel Henrichs

Care Coordination Program Record Review	Score
Assessment	
1. The RCCO (or designee) assessed the member's: ◆ Health behavior risks. ◆ Health/medical needs. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1* *Regions 2, 3, 5: Exhibit A—6.4.5.1.1*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager documented an assessment of the member's health risks and needs.	
2. The RCCO (or designee) assessed the member's: ◆ Non-medical needs. ◆ Linguistic and cultural needs. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1; 6.4.3.2.2* *Regions 2, 3, 5: Exhibit A—6.4.5.1.1; 6.4.5.2.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager assessed the member's non-medical, linguistic, and cultural needs.	
3. The RCCO (or designee) assessed current care coordination services provided to the member to determine if the providers involved in each member's care are providing necessary care coordination services and which care coordination services are insufficient or are not provided. *Regions 1, 4, 6, 7: Exhibit A— 6.4.2.1* *Regions 2, 3, 5: Exhibit A—6.4.4.1*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager documented telephone calls to the member's medical and non-medical providers.	

Care Coordination Program Record Review	Score
Intervention	
4. The RCCO (or designee) worked with providers responsible for the member's care to develop a plan for regular communication with those responsible for the member's care coordination. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.3* *Regions 2, 3, 5: Exhibit A—6.4.4.3*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager communicated with the member's providers regarding the member's care.	
5. The RCCO (or designee) reasonably ensured that all care coordination services, including those provided by other individuals or entities, met the needs of the member. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.4* *Regions 2, 3, 5: Exhibit A—6.4.4.4*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The member identified several issues with providers and medical needs. The care manager called the member's providers and followed up with the member the same day with confirmation of these conversations.	
6. The RCCO (or designee) provided necessary care coordination services not provided by another source. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.2* *Regions 2, 3, 5: Exhibit A—6.4.4.22*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager spoke to DHS on the member's behalf to discuss home health care options.	

Care Coordination Program Record Review	Score
Intervention	
7. The RCCO (or designee) linked the member to medical and/or non-medical services, acted as a liaison between medical providers or between medical and non-medical providers, and/or served as a liaison between providers and the member. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.2* *Regions 2, 3, 5: Exhibit A—6.4.5.1.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager documented an intervention between the member's pharmacy and the primary care provider to address issues the member was having with medications. The care manager also contacted the member's primary care provider, a specialist, and DHS on the member's behalf to address other issues.	

Care Coordination Program Record Review	Score
Transitions	
8. The RCCO (or designee) provided assistance during care transitions from hospitals or other care institutions to home- or community-based settings. This assistance promoted continuity of care. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3* *Region 2,: Exhibit A—6.4.5.1.3* *Regions 3, 5: Exhibit A—6.4.5.1.4*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
Observations: RMHP was not aware of the member's hospitalizations until after discharge.	
9. The RCCO (or designee) provided assistance during other transitions, such as the transition from children's health services to adult health services or from hospital or home care into a nursing facility. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3* *Region 2: Exhibit A—6.4.5.1.3* *Regions 3, 5: Exhibit A—6.4.5.1.4*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
Observations: No "other transition" of care was documented during the review period.	
10. The RCCO (or designee) documented and communicated necessary information about the member to the providers, institutions, and individuals involved in the transition. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3* *Region 2: Exhibit A—6.4.5.1.3* *Regions 3, 5: Exhibit A—6.4.5.1.4*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
Observations: RMHP was not aware of the member's hospitalization until after discharge.	

Care Coordination Program Record Review	Score
Continued Coordination/Follow-up	
11. The documentation clearly indicated that the RCCO's (or designee's) provision of care coordination services was responsive to the member's needs. *Regions:1, 4, 6, 7: Exhibit A—6.4.3.2.3* *Regions 2, 3,5 : Exhibit A—6.4.5.2.3*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager's documentation indicated that the care manager was responsive to the member's needs.	
12. The RCCO (or designee) followed up with the member to assess whether the member has received the services needed and/or if the member is on track to reach his or her desired health outcomes. *Regions 1, 4, 6, 7 Exhibit A—6.4.3.1.6* *Region 2: Exhibit A—6.4.5.1.6* *Regions 3, 5: Exhibit A—6.4.5.1.7*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager documented follow-up with the member to confirm the member received services and that the member was on track to reach desired health outcomes.	

Recommendations:

HSAG does not have any recommendations.

Results for Care Coordination Program Record Review—Sample OS #10							
Total	Met	=	9	X	1.00	=	9
	Partially Met	=	0	X	0.0	=	0
	Not Met	=	0	X	0.0	=	0
	Not Applicable	=	3	X	NA	=	0
Total Applicable		=	9	**Total Score**		=	9

Total Score ÷ Total Applicable	=	100%

The following tables represent the results of an MS Excel PivotTable analysis of the PCMP network for Region 1, based on the PCMP network spreadsheets provided to the Department by the RCCO. The purpose of the analysis was to provide an accurate representation of the number of providers in each RCCO region by eliminating duplicate entries. However, HSAG identified data integrity issues in the source document, which affected the accuracy of the numerical counts of providers. Therefore, these tables are presented only to demonstrate the potential outcomes of using MS Excel pivot tables to analyze the network, with the understanding that data integrity in the source documents would need to be improved to ensure accuracy of future results.

Table C-1 illustrates the methodology HSAG used to calculate the number of providers for each region. For the purpose of counting the number of unique providers in each region, the highlighted rows were deleted (e.g., Dr. Bender is counted only one time, regardless of how many practice locations he has).

Table C-1—Example of Duplicate Providers Eliminated Before Calculating Unique Providers by Region

Provider Location (LINE 1)	Provider Location (CITY)	Provider Location (COUNTY)	Practitioner (LAST NAME)	Practitioner (FIRST NAME)
4674 Snow Mesa Dr., Ste. 140	Fort Collins	Larimer	Bender	John
3850 N. Grant Ave., Ste. 100	Loveland	Larimer	Bender	John
4100 E Mississippi, Ste. 110	Glendale	Arapahoe	Bender	John

Table C-2—Number of Unique Providers Serving Region 1

Nurse practitioner	45
Osteopath	5
Other	5
Physician assistant	70
Physician	299
Grand Total	**424**

Table C-3—Number of Unique Providers Serving Region 1 Accepting New Medicaid Members

Nurse practitioner	40
Osteopath	4
Other	5
Physician assistant	60
Physician	233
Grand Total	**342**

Table C-4 illustrates the methodology HSAG used to calculate the number of providers by county. For the purpose of counting the number of unique providers in each county, the highlighted rows were deleted (e.g., Dr. Bender is counted only one time in Larimer County, though the example shows two locations. He is also counted one time in Arapahoe County).

Table C-4—Example of Duplicate Providers Eliminated Before Calculating Unique Providers by Region

Provider Location (LINE 1)	Provider Location (CITY)	Provider Location (COUNTY)	Practitioner (LAST NAME)	Practitioner (FIRST NAME)
4674 Snow Mesa Dr., Ste. 140	Fort Collins	Larimer	Bender	John
3850 N. Grant Ave., Ste. 100	Loveland	Larimer	Bender	John
4100 E Mississippi, Ste. 110	Glendale	Arapahoe	Bender	John

Table C-5—Region 1 Unique Providers by County	
Arapahoe	3
Archuleta	6
Delta	6
Dolores	3
Douglas	3
Eagle	13
Garfield	41
Gunnison	5
Hinsdale	2
La Plata	22
Larimer	171
Mesa	80
Moffat	10
Montezuma	5
Montrose	7
Rio Blanco	8
Routt	30
San Miguel	9
Summit	18
Grand Total	**442**

Table C-6—Region 1 Unique Providers by County Accepting New Medicaid Members	
Arapahoe	3
Archuleta	6
Delta	6
Dolores	3
Douglas	3
Eagle	11
Garfield	41
Gunnison	5
Hinsdale	2
La Plata	12
Larimer	113
Mesa	79
Moffat	10
Montezuma	5
Rio Blanco	8
Routt	26
San Miguel	9
Summit	18
Grand Total	**360**

Table C-7 illustrates the methodology HSAG used to calculate the number of unique practice locations per county. For the purpose of counting the number of unique practice locations in each county, the highlighted rows were deleted. Each address was counted one time, regardless of how many providers practiced in that location.

Table C-7— Example of Duplicate Locations Eliminated Before Calculating Unique Locations by County					
Provider Location (LINE 1)	**Provider Location (LINE 2)**	**Provider Location (CITY)**	**Provider Location (COUNTY)**	**Practitioner (LAST NAME)**	**Practitioner (FIRST NAME)**
1 Mercado Street	Suite 160	Durango	La Plata	Murphy	Joseph
1 Mercado Street	Suite 160	Durango	La Plata	Pirnat	Martin
1 Mercado Street	Suite 160	Durango	La Plata	Stensen	Erika
1014 Centre Ave		Fort Collins	Larimer	Bradley	Kara
1014 Centre Ave		Fort Collins	Larimer	DeYoung	Douglas

Table C-8—Number of Unique Provider Locations Serving Region 1	
Arapahoe	1
Archuleta	1
Delta	5
Dolores	1
Douglas	1
Eagle	4
Garfield	6
Gunnison	1
Hinsdale	1
La Plata	4
Larimer	40
Mesa	10
Moffat	2
Montezuma	2
Montrose	1
Rio Blanco	1
Routt	10
San Miguel	2
Summit	5
Grand Total	**98**

Appendix D. Site Review Participants
for Rocky Mountain Health Plans (Region 1)

Table D-1 lists the participants in the FY 2013–2014 site review of **RMHP**.

Table D-1—HSAG Reviewers and RCCO Participants	
HSAG Review Team	**Title**
Barbara McConnell, MBA, OTR	Director, State & Corporate Services
Katherine Bartilotta, BSN	Project Manager
Rachel Henrichs	Project Coordinator
RMHP Participants	**Title**
Patrick Gordon	Associate Vice President
Sharon Steadman	Consultant
Pauline Casey	Senior Program Operations Leader
Janie Dunckley	Community Partnerships Coordinator, Northwest Colorado Community Health Partnership (Community Care Team serving Routt, Moffat, Jackson, Grand, and Rio Blanco counties)
Leah Hemeyer	Integrated Behavioral Health Clinician, Mind Springs Health/Care Coordination Team Lead for the Northwest Colorado Community Health Partnership (Community Care Team serving Routt, Moffat, Jackson, Grand, and Rio Blanco counties)
Mike Huotari	Vice President, Community Integration and Health Care Reform
Sandy Dowd	Director, Care Management
Nicole Konkoly	Program Development Specialist, Community Integration
Carol Ann Hendrikse	RCCO Clinical Manager
Kevin Fitzgerald	Chief Medical Officer
Jill Bystol	Quality Assurance Compliance Coordinator (telephonic)
Candace Duran	Quality Assurance Manager (telephonic)
Dale Renzi	Director, Provider Network Management (telephonic)
Greg Coren	Provider Network Manager—Western Slope (telephonic)
Lori Stephenson	Director, Clinical Program Development and Evaluation
Jackie Hudson	Director, Quality Improvement
Cynthia Mattingly	Practice Transformation Manager
Stephen Thompson	Program Supervisor, Medicaid ACC and Healthy Harbors Program, PVHS/University of Colorado Health, Community Health Improvement Department (Fort Collins Community Care Team)

Table D-1—HSAG Reviewers and RCCO Participants	
RMHP Participants	**Title**
Nicole Teel	Care Coordination Specialist, PVHS/University of Colorado Health, Community Health Improvement Department (Fort Collins Community Care Team) (telephonic)
Erin Stalker	Nurse Practitioner, PVHS/University of Colorado Health, Community Health Improvement Department (Fort Collins Community Care Team) (telephonic)
Megan Johnson	Behavioral Health Specialist, Touchstone Health Partners (Fort Collins Community Care Team) (telephonic)
Joleen Zaczek	Care Coordination Specialist, PVHS/University of Colorado Health, Community Health Improvement Department (Fort Collins Community Care Team) (telephonic)
Karen Ramirez	Healthy Harbors Care Coordinator, PVHS/University of Colorado Health, Community Health Improvement Department (Fort Collins Community Care Team) (telephonic)
Department Observers	**Title**
Russell Kennedy	Quality and Health Improvement Unit
Murielle Romine	Reform Unit
Leah Jardine	ACC Team
Elizabeth Baskett	Reform Unit
David Ducharme	Reform Unit
Hanna Schum	Contract Manager