Colorado
Accountable Care Collaborative

FY 2015–2016 Site Review Report

for

Rocky Mountain Health Plans (Region 1)

June 2016

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

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Introduction and Background

The Colorado Department of Health Care Policy & 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 member and family experience, improve access to care, and transform incentives and the healthcare delivery process to a system that rewards accountability for health outcomes. Central goals for the program are to (1) improve member health; (2) improve member and provider experience; and (3) contain costs by reducing avoidable, duplicative, variable, and inappropriate use of healthcare 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. **Rocky Mountain Health Plans** (**RMHP**) began operations as a RCCO in June 2011. The RCCOs develop a network of providers; support providers with coaching and information; manage and coordinate member care; connect members with non-medical services; and report on costs, utilization, and outcomes for their populations of members. An additional feature of the ACC program is collaboration—between providers and community partners, between RCCOs, and between the RCCOs and the Department—to accomplish the goals of the ACC program.

The Affordable Care Act of 2010 allowed for Medicaid expansion and eligibility based on 133 percent of the federal poverty level. In addition, the Accountable Care Collaborative: Medicare-Medicaid Program (MMP) demonstration project provided for integration of new dually eligible Medicare-Medicaid members into the RCCOs beginning September 2014. The RCCO contract was amended in July 2014 primarily to specify additional requirements and objectives related to the integration of ACC Medicare-Medicaid Program (MMP) enrollees.

Each year since the inception of the ACC program, the Department has engaged Health Services Advisory Group, Inc. (HSAG), to conduct annual site reviews to evaluate the development of the RCCOs and to assess each RCCO's successes and challenges in implementing key components of the ACC program. This report documents results of the fiscal year (FY) 2015–2016 site review activities, which included evaluation of the RCCO's efforts regarding integration with specialist providers, integration with behavioral health services and behavioral health organizations (BHOs), and performance of individual MMP member care coordination. In addition, the Department requested a follow-up discussion of select focus projects implemented by each RCCO. This section contains summaries of the activities and on-site discussions related to each focus area selected for the 2015–2016 site review, as well as HSAG's observations and recommendations. In addition, Table 1-1 contains the results of the 2015–2016 MMP care coordination record reviews. Table 1-2 provides a comparison of the overall 2015–2016 record review scores to the previous two years' record review scores. Section 2 provides an overview of the monitoring activities and describes the site review methodology used for the 2015–2016 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 lists HSAG, RCCO, and Department personnel who participated in the site review process.

Summary of Results

The care coordination record reviews focused on a sample of the MMP population who had a completed service coordination plan. HSAG assigned each question in the record review tools a score of *Yes, No, Partially, Unable to Determine,* or *Not Applicable*. HSAG also included, as necessary, comments for each element scoring *No, Partially,* or *Unable to Determine* and included any other pertinent reviewer observations. Table 1-1 presents the scores for **RMHP**'s care coordination record reviews. Detailed findings for the record reviews are in Appendix B—Record Review Tools.

Table 1-1—Summary of Care Coordination Record Review Scores

Description of Record Review	# of Elements	# of Applicable Elements	# *Yes*	# *No*	# *Partial*	# Unable to Determine	# *Not Applicable*	Score* (% of Yes Elements)
MMP Members	210	151	147	0	4	3	56	97%

* The overall percentages were obtained by adding the number of elements that received a score of *Yes*, then dividing this total by the total number of applicable elements. (*No* and *Partially* scores received a point value of 0.0; *Unable to Determine* was included with *Not Applicable*.)

Table 1-2 provides a comparison of the overall 2015–2016 record review scores to the previous two years' record review scores. Although most care coordination requirements of the RCCO contract and MMP contract were similar, some 2015–2016 scores may have varied from previous years' reviews due to specific service coordination plan requirements for the MMP population.

Table 1-2—Comparison of Care Coordination Record Review Scores

Description of Record Review	# of Elements	# of Applicable Elements	# *Met (or Yes)*	# *Not Met (or No)*	# *Partially Met (or Partially)*	# *Not Applicable (or Unable to Determine)*	Score* (% of *Met/Yes* Elements)
Care Coordination 2013–2014	132	109	108	0	1	23	99%
Care Coordination 2014–2015	80	62	58	0	4	18	94%
Care Coordination 2015–2016	210	151	147	0	4	59	97%

* The overall percentages were obtained by adding the number of elements that received a score of *Met/Yes*, then dividing this total by the total number of applicable elements. (*Partially Met/Partial* and *Not Met/No* scores received a point value of 0.0)

The Data Collection Tool (Appendix A) was used to capture the results of the pre-on-site document review and on-site discussions related to the focus content areas: Integration with Specialist Providers, Follow-up of Region-specific Special Projects, and Integration with Behavioral Health Services/BHOs. Following is a summary of results for each content area of the 2015–2016 review.

Summary of Findings and Recommendations by Focus Area

Integration with Specialist Providers

Activities and Progress

The concentration of specialists in the RCCO 1 region is primarily in the population centers of Grand Junction, Durango, and Fort Collins. Primary care medical providers (PCMPs) had established relationships and patterns of referral with preferred specialist practices. Although **RMHP** endorsed the referral protocols and tools recommended by the American College of Physicians (ACP), and some physician organizations have independently adopted these tools; **RMHP** did not mandate implementation of referral protocols and practice compacts among physician groups. **RMHP** believed that, to be effective and sustainable, referral processes must be locally agreed to and adopted between individual primary care and specialist practices. **RMHP**'s strategy for strengthening referral relationships between PCMPs and specialists was being implemented through its practice transformation program. **RMHP** provided PCMPs with financial incentives to participate in the practice transformation program, which included implementing team-based care and developing referral relationships and practice work flows with selected specialist practices. During 2015, **RMHP** implemented a pilot program to test the concept of developing referral guidelines, agreements, and collaborative work flows between a large pediatric practice and an asthma specialty practice. Depending on the results of the pilot project and further interest of primary care and specialty providers, **RMHP** intended to expand the practice transformation referral initiative to include additional high-volume specialist practices. Staff stated that the response of specialists to the concept of implementing bi-directional referral agreements with PCMPs varied.

RMHP engaged in additional activities intended to improve access to specialty care throughout the region. Care coordinators make arrangements for members to access specialist care both inside and outside the network and intervene on behalf of a member when barriers to accessing specialists are identified. **RMHP** had contracts with almost all specialists in the Mesa County area for its Prime line of business, and provider contracts specified that participating specialists must also be open to all RCCO members. Additionally, **RMHP** was considering approaches for disseminating specialist knowledge into PCMP practices, including specialist/PCMP co-management of members, eConsult programs, and Extension for Community Healthcare Outcomes (ECHO) consultation and education programs. Staff stated that all initiatives to improve access to specialists in the region require a thoughtful approach due to the overall shortage of specialists and unique challenges presented within a predominantly rural/frontier geographic area.

Observations/Recommendations

The reviewer agrees that **RMHP**'s strategy of facilitating the development of referral relationships among select PCMPs and specialist groups may be the most effective approach for sustainable referral arrangements. However, HSAG recommends that **RMHP** also consider placing further emphasis on encouraging additional PCMPs to self-initiate adoption of agreements with preferred specialist groups. To that end, **RMHP** may consider distributing a toolkit of the ACP tools and adding a lessons learned component—e.g., specialists experienced increased efficiencies and

expanded access for patients; practice work flows must be addressed to accommodate effective implementation; and face-to-face dialogue and agreements between practice groups strengthen the relationships between PCMPs and preferred specialists and could more rapidly enhance referral relationships between specialists and less-advanced PCMP practices.

Follow-up of Region-specific Special Projects

Activities and Progress

Relationship with the health information exchange

As a founding member of Quality Health Network (QHN), **RMHP** has been directly participating with QHN on developing health information exchange (HIE) applications for **RMHP** and its providers since 2006. Since 2006, QHN has been expanding its provider and community partner participation and advancing its technological architecture. Core services provided by QHN were "identity matching" individual members and normalizing data received from multiple sources for exchange among users. QHN established a technology connection with Colorado Regional Health Information Organization (CORHIO) to share information between the two major state HIE networks. **RMHP** received all HIE data through QHN and did not use the direct data feeds from CORHIO facilitated through the Department. **RMHP** received real-time admit, discharge, and transfer (ADT) data and hospital notes from nearly all hospitals in the region as well as ambulatory data summaries for **RMHP** members from all active QHN users—which includes 1600 practitioners. QHN interfaced ADT data directly with **RMHP**'s Essette care management system for the care coordination teams and with the Crimson Care software for access by other agencies. Staff stated that QHN's technology platform enabled open access to users and ease of interfacing with multiple systems, although connecting with multiple practice electronic health record (EHR) systems remains a primary challenge. **RMHP** and QHN collaborated on the *IndiGO* project—being tested in three PCMPs—to combine Medicaid data from the RCCO with practice EHR data and which included a predictive risk modeling capability. **RMHP** was also pursuing the development of a virtual clinic process through QHN which will enable **RMHP** contracted providers to provide eConsults to members, clinics, or the care coordination teams (CCTs). Staff stated that involving additional payor and provider participants in QHN was necessary to support ongoing HIE development; **RMHP** anticipated that the evolving statewide multi-payor initiative would stimulate increased participation. **RMHP** was enthused about its working relationship with QHN and the many future applications that may be afforded through QHN technology.

Expanding the Healthy Harbors program to other communities

Healthy Harbors (HH)—a program to meet the healthcare needs of children involved in child protective services—was developed and funded through University of Colorado Health (UC Health) in Larimer County. **RMHP** funded two HH coordinators fully integrated into the UC Health CCT and four large PCMPs in Larimer County. HH staff worked closely with the county Department of Human Services (DHS). HH coordinators developed particular expertise in managing the complex needs and characteristics of this population, which include a high level of psychosocial needs, association with multiple community agencies and services, and lack of consistent and complete health histories. During HSAG's on-site review, staff members provided an overview of the

program and outcome measures, which documented a significant contribution to the improved health of the target population. HH developed a toolkit of information to engage communities to develop similar programs. However, **RMHP** had not yet expanded the program into other Region 1 communities or CCTs, nor had UC Health expanded the HH program to other areas. Staff members stated that expansion of projects such as HH was strategically targeted according to the appropriate "fit," resource availability, and community readiness.

Transferability of the Hilltop/B4 Babies program to other communities

The Hilltop B4 Babies & Beyond (B4 Babies) program has been operating in Mesa County since 1990 as a mechanism to link uninsured and underinsured expectant mothers with Medicaid or CHP+ insurance, prenatal care, education, and community resources. A 2014 report of program outcomes data documented the characteristics of the program population and a significant reduction in pre-term and low-birthweight babies compared to the general population. In 2016, **RMHP** facilitated expansion of the program to La Plata and Archuleta counties through the San Juan Basin Health Department (SJBHD). Staff stated that expansions of projects such as B4 Babies were strategically targeted according to appropriate "fit," resource availability, and readiness within various communities. **RMHP** did not engage in a deliberate "rollout" of the B4 Babies across the region, but will explore further opportunities for expanding the program through its partnership with local public health agencies and other organizations that provide care coordination services.

Observations/Recommendations

RMHP had a long-term, in-depth relationship with QHN, and the two organizations were collaborating on numerous targeted initiatives. **RMHP** recognized that QHN's technology platform advanced the capabilities of connecting numerous numbers and types of providers with the RCCO in support of RCCO initiatives. **RMHP** will continue to promote the QHN through its collaborative technology initiatives, but acknowledged that establishing statewide standards would better enable integration with numerous practice EHRs.

RMHP made limited progress with transferring the B4 Babies and HH programs to other areas within the region, citing **RMHP**'s strategic priorities and its emphasis on only introducing programs to communities demonstrating a readiness to adopt such programs. At the time of the on-site review, the B4 Babies program appeared to have been successfully implemented in one additional sub-region. HH staff desired to identify opportunities and mechanisms for expanding the program. The HH program is associated with the CCT in Larimer County; therefore, HSAG recommends that **RMHP** consider opportunities to expand the program integration with additional CCTs. HSAG also suggested that **RMHP**, the Department, and UC Health might collaborate on creative mechanisms—e.g., consultative outreach services, eConsult technology—to extend the knowledge and experience of HH staff to other CCTs or PCMPs and to introduce the program statewide. It appears that the HH program would provide valuable expertise and services for families and members of this unique population, wherever they reside.

Integration With Behavioral Health Services/BHOs

Activities and Progress

The majority of the Region 1 geographic area overlaps with Colorado Health Partnership (CHP)—the behavioral health organization (BHO)—which is owned by the participating community mental health center (CMHC) partners, several of which are located in Region 1. Therefore, all collaborative operations between the CMHCs in the region and **RMHP** also represent an inherent alignment with the BHO. The Larimer County subsection of Region 1 overlaps with the Access Behavioral Care—Northeast (ABC-NE) BHO. **RMHP** conducts strategic and operational activities both directly with CHP administration and governance as well as with select CMHCs. Administrative level data—e.g., budgets, planning documents, and financial operations—are shared between organizations. Although **RMHP** does not directly participate on CHP's boards or committees, representatives from Mind Springs Health (one of CHP's partner CMHCs) participate on **RMHP**'s Medicaid and Safety Net Executive Committee; and CMHCs are actively engaged in the CCTs. **RMHP** executed business associate agreements with CHP and the CMHCs, enabling sharing of a large amount of data and information for program analysis and member care coordination. CCTs throughout the region have integrated behavioral health expertise and information into their care coordination activities. The specific models of integrating behavioral and physical healthcare coordination are driven by local resources and provider relationships and vary among the CCTs. **RMHP** views CCTs as the care team model for the ACC.

RMHP also described the Mind Springs Health Whole Health initiative, which trains and oversees community health workers (CHWs) who work within select PCMPs as part of the care teams. CHWs are assigned to provide community-based care coordination to members with extensive psychosocial needs. The role of the CHW is to motivate behavioral changes for improved health and assist members with navigating the system. Axis Health employed two CHWs embedded in each of its integrated federally qualified health center (FQHC)/CMHC clinic sites. **RMHP** remains positive regarding the value of CHWs as an asset for primary care practices, integrated care teams, and communities.

RMHP stated that 12 to 15 practices were receiving payments to support the integration of behavioral healthcare into primary care practices. Staff estimated that 20 to 25 percent of all RCCO members had access to integrated behavioral health/physical health services. During the on-site review, **RMHP** staff highlighted the experiences of several primary care practices that had on-site behavioral health professionals integrated within their practices. **RMHP** stated that practices transition through multiple evolutions of integration and that practices across the region are at varying levels along the continuum. **RMHP**s goal in 2015–2016 was to move primary care practices beyond behavioral health co-location to "ownership" of behavioral health practitioners in comprehensive primary care practices. **RMHP** financially incents select advanced practices to hire behavioral health personnel and implement shared medical record documentation, with the expectation that these practices will financially sustain themselves over time. **RMHP** also promoted development of integrated behavioral health/physical health practices through a variety of grant programs and other initiatives. Staff members reported that early "lessons learned" regarding integration of behavioral health practitioners into primary care practices included that on-site behavioral health therapists may positively impact primary care shortages by relieving primary care

physicians (PCPs) of the time-consuming behavioral health aspects of member care; behavioral health in primary care is a completely different practice model and environment for behavioral health therapists, requiring that practices identify the "right fit" when employing behavioral health professionals; finding and recruiting behavioral health personnel to work in primary care practices is a challenge; practice-based care coordinators are important resources for improving the efficiency of behavioral health practitioners; and global reimbursement mechanisms will be required to sustain integrated care practices.

The state-designated crisis support centers in Region 1 include three CMHCs on the Western Slope and one in Fort Collins. Each center provided a traditional crisis hotline and walk-in crisis support services, and all were collectively able to cover a broad geographic region with mobile response units. Transitional inpatient care was available in Grand Junction, and short-term housing options for respite care were available in Grand Junction and Fort Collins for persons with longer-term crisis support needs. In 2016, **RMHP**—in partnership with several CMHCs and community centered boards (CCBs)—received a grant for a pilot program to enhance existing crisis support services to better serve individuals with intellectual/developmental disabilities. The pilot program will integrate professionals with expertise working with individuals with intellectual/developmental disabilities into 24/7 crisis support services and build a continuum of services for individuals with intellectual/developmental disabilities appropriate for post-crisis support. **RMHP** educated all CCTs regarding the crisis support system and its expansion to serving individuals with intellectual/developmental disabilities. The **RMHP** CCTs have ongoing relationships with the CMHCs in their service area and may obtain feedback from the CMHCs regarding any members who used the crisis center.

Observations/Recommendations

RMHP used a multi-faceted approach to support the integration of behavioral health into PCMPs, including education, CHWs, and financial incentives. **RMHP** intended all of its initiatives to apply to all payor sources aligned with the practice, not just **RMHP**. **RMHP**'s partnership with the family practice residency program in the region anticipates the long-term "payback" of exposing residents who may ultimately participate in a provider practice within the region to the integrated practice model. All of these initiatives are worthy of note as best practices. **RMHP** strategically moved practices to the "ownership" of behavioral health practitioners. Lessons learned from these practices appear to be very valuable in guiding future integration efforts. However, given the acknowledged difficulty of recruiting behavioral health practitioners for employment by primary care practices and the prematurity of the reimbursement environment to adequately sustain behavioral health in primary care, **RMHP** may want to enhance its partnership with the BHO and/or CMHCs throughout the service area to employ additional behavioral health resources for co-location in primary care practices. Nevertheless, HSAG acknowledges **RMHP**'s thoughtful approach to addressing the challenges associated with developing integrated care options in a primarily rural region.

Care Coordination Record Reviews

Findings

HSAG conducted MMP member record reviews that focused on understanding the role of the service coordination plan (SCP) in documenting and performing care coordination. All 10 records reviewed were part of the original sample selected by the Department, and each documented full SCP completion. Nine of 10 SCPs were documented in the **RMHP** Essette care management system, which has been programmed to include all elements of the SCP plus additional supplemental information. **RMHP**'s overall compliance with the care coordination requirements was 97 percent, with nine of 10 records scoring 100 percent. Five records were for members who demonstrated no or limited needs or whose needs were entirely addressed by other entities. When the member was already linked with an external care coordinator, well established with services, and unable to identify any unmet needs, the RCCO care coordinator generally deferred to the external case manager—single entry point (SEP), CCB, skilled nursing facility (SNF), or PCMP—as the lead coordinator. Members were generally cooperative with the completion of the SCP, but in several cases **RMHP** used information from the SEP's uniform long term care (ULTC) form. Two of 10 members interacted with the RCCO care coordinator but were uncooperative either in completing the SCP or with care coordinator efforts.

Observations/Recommendations

RMHP thoroughly customized its Essette care management software to accommodate the SCP, and it was used by most RCCO care managers. Based on the sample of cases reviewed on-site, it appeared that many MMP members have limited care coordination needs or have needs that are already being addressed by other agencies or their providers (e.g., SNF, host home, or PCMP). In these cases, the completion of the SCP appeared to be useful in introducing the RCCO care coordinator to the member, although the SCP was completed primarily for required documentation purposes and/or was duplicative of other agencies' involvement with the member. **RMHP** may consider collaborating with the Department and other RCCOs to streamline the SCP process for those members who have few unmet needs or goals. In cases where the member demonstrated complex needs or any unmet needs, the RCCO care coordinator remained involved and worked closely with the SEP or CCB, as applicable. Overall, HSAG observed that **RMHP** thoroughly completed the SCP and performed care coordination as needed.

Overview of Site Review Activities

The FY 2015–2016 site review represented the fifth contract year for the ACC program. The Department asked HSAG to perform an annual site visit to assess continuing development of **RMHP** as the RCCO for Region 1. During the initial five years of operation, each RCCO continued to evolve in operations, care coordination efforts, and network development in response to continual collaborative efforts, input from the Department, and ongoing implementation of statewide healthcare reform strategies. The FY 2015–2016 site visits focused on evaluating RCCO activities related to integration with specialist providers, integration with behavioral health services, and Medicare-Medicaid Program (MMP) member care coordination activities. In addition, HSAG gathered follow-up information on select special projects that had been implemented by each RCCO within the past two to three years. Through review of member records, HSAG evaluated the effectiveness of individual MMP member care coordination, including the implementation of the Service Coordination Plan (SCP). The Department asked HSAG to identify initiatives and methodologies implemented by the RCCOs in response to key contract objectives and to offer observations and recommendations related to each ACC focus area reviewed.

Site Review Methodology

HSAG and the Department met on several occasions to discuss the site review process and finalize the focus areas and methodologies for review. HSAG and the Department collaborated to develop the record review tool and the data collection tool, which provided the parameters for the on-site interviews. The purpose of the site review was to document compliance with select care coordination contract requirements, evaluate **RMHP**'s mechanisms for integrating with the BHO in the region and integrating behavioral healthcare for members, identify activities related to the involvement of specialists in the care of RCCO members, obtain updates of the progress in select special projects implemented by each RCCO, and explore challenges and opportunities for improvement related to each focused content area. Site review activities included a desk review of documents submitted by **RMHP** prior to the site visit. These documents consisted of program plans, written procedures, tracking documents, and any formal agreements related to each of the focus areas. During the on-site portion of the review, HSAG interviewed key **RMHP** personnel using a semi-structured qualitative interview methodology to elicit information concerning mechanisms for implementing the objectives and requirements outlined in the ACC contract. The qualitative interview process encourages interviewees to describe their experiences, processes, and perceptions through open-ended discussions and is useful in analyzing system issues and associated outcomes. The assessment of RCCO activities related to integration with behavioral health services was conducted through a joint interview of RCCO and BHO staff.

To continue the annual evaluation of care coordination processes, on-site review activities included care coordination record reviews. The Department determined that FY 2015–2016 care coordination record reviews would focus on the MMP population. HSAG developed a care coordination record

review tool based on contract requirements and the instructions for completing the required individual member SCP.

HSAG reviewed a sample of 10 care coordination records (selected by the Department's MMP program staff from the MMP report) of members with a SCP completed during the 2015 review period. The Department forwarded the sample lists of 10 records plus 10 oversample records to **RMHP** and HSAG prior to the on-site visit. HSAG completed an individual record review tool for 10 MMP members during the on-site visit. Although completion of the SCP document was not the focus of the record review, HSAG used SCP information, as available, when assessing the member's overall care coordination. HSAG assigned each question in the review tool a score of *Yes*, *No*, *Partially*, *Unable to Determine*, or *Not Applicable* and entered reviewer comments, as necessary, related to each evaluation element within the tool.

The completed data collection tool includes narrative information and recommendations related to on-site discussion of the RCCO's integration with specialty care, integration with behavioral health services/BHOs, and progress on two special projects. The special project topics were selected by the Department from projects identified by the RCCO during previous years' on-site reviews. These topics were different for each RCCO. Summary results and recommendations resulting from the on-site interviews as well as the care coordination record reviews are also included 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.

Section I—Integration with Specialist Providers

Contract References	Possible Discussion Topics
Group 1: The Contractor shall reasonably ensure that Members in the Contractor's Region have access to specialists promptly and without compromising the Member's quality of care or health. RCCO and MMP Contracts—4.2.5 The Contractor shall ensure that all PCMPs refer members to specialty care as appropriate and ensure that clinical referrals are completed between PCMPs and specialists/referred providers. RCCO and MMP Contracts—6.1.1 The Contractor shall develop and maintain a written protocol for clinical referrals to facilitate care coordination and sharing of relevant member information. RCCO and MMP Contracts—6.1.1.1 The Contractor shall allow the PCMPs with which it contracts to refer Members to any specialists enrolled in Medicaid, including those not associated with the Contractor or another RCCO. RCCO and MMP Contracts—6.1.2	◆ Incentives to stimulate specialist involvement ◆ Initiatives to address shortages ◆ Expanding accessibility of specialist care ▪ Telemedicine ▪ Downstreaming services into PCMPs ▪ Transporting specialists to rural or remote areas ▪ Relationships with hospital systems ▪ Other ◆ Successes and challenges in integrating with specialists and/or maintaining capacity for Medicaid members ◆ Mechanisms for monitoring specialist involvement/responsiveness, if any ◆ Referral protocols ▪ What are they? ▪ How have they been implemented? ▪ What is degree of success of using protocols (including feedback from specialists/PCMPs)? ◆ Plans, strategies, or solutions moving forward

Discussion and Observations:
The availability of specialists throughout the RCCO 1 service area varied greatly between the rural regions and the population centers of Grand Junction, Durango, and Fort Collins, all of which have tertiary care centers that attract specialist practices. Members in the region also accessed specialists in the Denver area. Within the region, PCMPs have relationships with and demonstrate patterns of referral to preferred specialist practices. RMHP submitted documents—*Community Referral Program* and *Foundations Practice Transformation* provider manual—that included specialist referral protocols and tools similar to those recommended by the American College of Physicians. Although RMHP endorsed these tools for adoption between PCMPs and specialists, it

Section I—Integration with Specialist Providers

Contract References	Possible Discussion Topics

did not mandate use of referral protocols or practice compacts. Staff stated that the referral tools had been adopted by some physician organizations in the region, such as the independent practice associations (IPAs) in Mesa County and Cortez. However, RMHPs strategy for strengthening referral relationships between PCMPs and specialists was being implemented through RMHP's Practice Transformation program. RMHP financially incented PCMPs to participate in meeting all deliverables of the Foundations Practice Transformation (Foundations) program, including implementing team-based care in practices and developing relationships and practice work flows with selected specialist practices which enable sustainable implementation of bi-directional referral protocols. The practice transformation team facilitated face-to-face meetings between PCMPs and their high-volume specialists to encourage dialogue and agreement on referral processes and information flow practice-to-practice. Recognizing that practice capabilities and approaches vary widely among PCMPs and specialists, RMHP believes referral processes must be locally adopted if they are to be effective and sustainable. The Foundations program was available to all physician practices associated with all RMHP's lines of business, with operational processes developed to be applicable in multi-payor systems—rather than limited to members of the RCCO or any other RMHP contracts.

During 2015, RMHP implemented a pilot program—*Medical Neighborhood Initiative*—to test the concept of developing referral guidelines, agreements, and collaborative work flows between Western Colorado Pediatric Associates and the Allergy and Asthma Center of Western Colorado. RMHP staff reported that the outcomes strengthened the relationship between practices, and specialists noticed increased efficiencies that expanded access for members. Depending on the final results of the pilot project and further interest of primary care and specialist providers, RMHP anticipated expansion of the practice transformation referral initiative to include additional high-volume specialist practices. RMHP surveyed its PCMPs to choose high-volume specialist practices targeted for this initiative. Staff stated that responses of specialists to the concept of implementing bi-directional referral agreements with PCMPs span from the "early adopters" to practices that question the necessity of developing formal processes for referrals. Therefore, RMHP anticipated that full implementation would evolve over time.

Staff also described the following additional activities to improve access to specialty care throughout the region:

- Care coordinators' interventions and planning include arranging for members' access to specialist care both in and out of network, arranging transportation (as needed), accompanying members to specialist appointments(as needed), and following up with each member to determine if he or she had acted on referrals to specialists.
- RMHP staff members participate in weekly management meetings to examine individual members' barriers to accessing specialists and will intervene with a specialist when necessary to facilitate timely access. This forum also identifies barriers that might best be addressed through programs developed for select member populations. Staff cited the development of an inpatient adolescent care center and the Hilltop B4 Babies & Beyond program as examples of specialty program initiatives supported by RMHP.
- RMHP contracts with specialists along the Western Slope to participate in its "Prime" provider network. These contracts specified that participating specialists must accept all RCCO members. Staff stated that RMHP is contracted with nearly all specialist practices in its Prime contract service area.

Section I—Integration with Specialist Providers

Contract References	Possible Discussion Topics
	• RMHP was discussing potential programs to further disseminate specialist knowledge into PCMP practices, including specialist/PCMP co-management of members, eConsult programs, and Extension for Community Healthcare Outcomes (ECHO)-type consultation and education programs. • RMHP was discussing options to rotate specialists through the FQHCs, including a satellite FQHC location in Montrose. • RMHP facilitated mechanisms to routinely bring a Denver-based subspecialist to the Grand Junction area. Staff stated that a tertiary care center is required to attract subspecialists to population centers in the region to see patients. In addition, some specialists based in Grand Junction travel to rural areas to see patients, enabled through existing professional relationships between providers. Staff stated that initiatives to improve access to specialists are complex due to the overall shortage of specialists and the unique challenges presented within a predominantly rural/frontier geographic area and require a thoughtful approach.

Section II—Follow-up of Region-specific Special Projects

Contract References	Possible Discussion Topics
NONE	Relationship of RCCO with the health information exchange—Colorado Regional Health Information Organization (CORHIO) or Quality Health Network (QHN) ◆ Describe the RCCO's relationship with the health information exchange (HIE) ▪ How the relationship was developed ◆ Agreement between the RCCO and the HIE ▪ HIE "user/participant"? ▪ Receive information/contribute information? ▪ Functional relationship--How information is received from the HIE (e.g., direct interface, web portal, member list/inquiry) ◆ Type of data received from the HIE ▪ How RCCO is using/applying the information ▪ Has access to information replaced previous mechanisms of provider notifications/alerts? ▪ Any data or components of the delivery system that are missing/incomplete/gaps? ◆ Successes and challenges of relationship with HIE: ▪ Is exchange working smoothly? ▪ Describe value(s) of the relationship ▪ Difficulties experienced (potential solutions) ◆ Do you envision an expanded/evolving role of the HIE in meeting the future needs of the RCCO? ▪ Status of any planned/anticipated data exchange functions

Section II—Follow-up of Region-specific Special Projects

Contract References	Possible Discussion Topics

Discussion and Observations:

RMHP had a relationship with Quality Health Network (QHN) dating back to 2004 as a founding member of QHN and has been directly participating with QHN on developing health information exchange (HIE) applications for RMHP and its providers since 2006. QHN has been financially supported through grants and local financial partners and outlines a scope of work annually with reporting to and monitoring oversight of the partners. Since 2006, QHN has been expanding its provider and community partner participation and advancing its technological architecture. Core services provided by QHN are identity matching—the capability to identify unique members through a combination of clinical and administrative data—and data quality improvement—upstream cleaning of data for conformity and normalizing of data received and exchanged with users. QHN does not operate in Larimer County, where providers are affiliated with CORHIO, or in Durango, where the hospital system and providers participate in the Centura Health electronic record system. QHN has established a technology connection with CORHIO to share information between the two major state HIE networks. RMHP receives all HIE data through QHN; the RMHP care coordination teams in Durango have direct access to the Centura Health electronic record system. RMHP does not use the direct data feeds from CORHIO facilitated through the Department. QHN matches the RMHP membership (all lines of business) to data in the HIE from other service providers daily. RMHP receives real-time admit, discharge, and transfer (ADT) data from all hospitals in the region (except the Craig and Steamboat Springs hospitals) as well as hospital notes and ambulatory data summaries—notes and summary level encounter data—from all active users, including 1600 practitioners and 60 electronic health record systems (EHRs). Staff stated that QHN's technology platform enables open access to users and ease of interfacing with multiple systems (except practice-level EHRs). Data exchanges with EHRs are more difficult to set up due to a multitude of challenges and are therefore limited to summary information. Staff stated that the State needs to establish uniform, statewide technology standards to improve HIE functionality. Other challenges encountered while developing the QHN were users' needs to define their specific data needs and applications in order to drive data extracts and exchange functions and getting participants to work together on a defined data set in order to improve data quality.

RMHP worked with QHN to interface ADT data directly into the Essette care management system (for care coordination teams) and the Crimson Care software (for community service and public health agencies). RMHP and QHN collaborated on the *IndiGO* project, in which QHN combines Medicaid data from the RCCO with practice EHR data and which has a predictive risk modeling capability. RMHP was testing the predictive risk modeling for diabetes and cardiovascular disease in three advanced PCMP practices. Staff stated that RMHP supports the development of such applications in QHN and then shares the applications and data with all QHN users. RMHP was also pursuing through QHN the development of a virtual clinic process which enables RMHP contracted providers to provide eConsults to members, clinics, and care coordination teams (CCTs), attempting to divert members from using the ER. RMHP's and QHN's vision is to ultimately offer this application to any clinic in the region and enable members to virtually access their own providers. RMHP was enthused about its relationship with QHN and the many future applications that may be afforded through QHN's technology. Staff members stated that involving additional payor and provider participants in QHN was necessary to support ongoing HIE development and were anticipating that the evolving statewide multi-payor initiative to migrate to combined clinical and administrative data platforms would stimulate increased participation.

Section II—Follow-up of Region-specific Special Projects

Contract References	Possible Discussion Topics
NONE	**TOPIC #1:** Expanding the Healthy Harbors (foster care) program to other communities ◆ How/why this project was selected/initiated ◆ Current status of implementation ◆ Potential impact of program on members ◆ Potential impact on the RCCO ◆ Potential impact on service providers ◆ Realized or anticipated successes to date ◆ Realized or anticipated challenges to date

Discussion and Observations:

UC Health in Larimer County developed and funded Healthy Harbors (HH)—a program to meet the healthcare needs of children involved in child protective services. RMHP funded two full-time care coordination positions for the HH program as part of its care coordination Community Integration Agreement with the UC Health CCT. HH coordinators are fully integrated into the northern Larimer County CCT and into the care teams of four large PCMPs in the Larimer County service area. These coordinators provide comprehensive assessment of physical, behavioral, and social needs and intensive care coordination for applicable members assigned to those PCMPs. HH coordinators have developed particular expertise in managing the unique needs of this population of children, which includes high level of psychosocial needs, association with multiple community agencies and services, and lack of consistent and complete health histories. HH staff has close working relationships with the county Department of Human Services (DHS) and access to the DHS website for communications and tracking members. Staff reported that 40 percent of the referrals to HH are directed from DHS, with an additional 40 percent received from the four PCMP practices. The HH program has the participation of a multi-organizational community advisory committee and is led by a family practice physician. During HSAG's site review, staff provided an overview of the program and results of tracking outcomes of the program, which documented a significant contribution to the improved health of the target population. HH developed a toolkit of information to engage communities to develop similar programs for children including developing a multi-organizational community support group and obtaining funding sources. HH presented this information to various public health groups and professional associations; however, the program had not defined a mechanism for actively marketing the program or disseminating staff expertise to additional geographic areas, primarily due to the intense demands for existing HH staff members to maintain services to their own clients. HH staff enthusiastically support the extension of the program into other areas of the State and would like to find a mechanism for introducing it to other DHSs and community collaborative initiatives. RMHP had not pursued expansion of the program into other communities in Region 1, but staff stated that RMHP's growing relationships with public health agencies and community collaborative initiatives provided an opportunity to introduce the program to communities that may express a readiness to commit to a similar initiative.

Section II—Follow-up of Region-specific Special Projects

Contract References	Possible Discussion Topics
NONE	**TOPIC #2:** Transferability of the Hilltop/B4 Babies program (early intervention for pregnant women) to other communities in the Region ◆ How/why this project was selected/initiated ◆ Current status of implementation ◆ Potential impact of project on members ◆ Potential impact on the RCCO ◆ Potential impact on service providers ◆ Realized or anticipated successes to date ◆ Realized or anticipated challenges to date

Discussion and Observations:

The B4 Babies & Beyond (B4 Babies)—a program to link uninsured and underinsured expectant mothers with Medicaid or CHP+ insurance, prenatal care, education, and community resources—has been operating in Mesa County since 1990. A 2014 report of program outcomes data documented the characteristics of the program population and a significant reduction in pre-term and low-birthweight babies compared to the general population. In 2016, RMHP facilitated expansion of the program to La Plata and Archuleta counties through the San Juan Basin Health Department (SJBHD), which expanded the role of the Healthy Communities family health coordinators to assist pregnant women with enrollment in Medicaid or CHP+, connecting members to essential community resources, and navigating the healthcare system. The program outreached to local hospitals' labor and delivery units; pediatricians; and the Women, Infants, and Children (WIC) supplemental nutrition program to identify at-risk members for enrollment into the program. The local RCCO CCT provides comprehensive care management for high-risk members—documented in the Essette care management system—and uses RCCO claims data to identify high-risk members for referral to the program. RMHP applied its intermediary role as a convener of community organizations and initial funding support to stimulate implementation of the program in this community. At the time of the HSAG on-site review, the SJBHD program had been fully operational for one month and mechanisms were in place for tracking outcomes through public health department data. Staff members stated that RMHP was not engaged in a deliberate "rollout" of the B4 Babies across the region; rather that expansions of similar projects throughout the region were strategically targeted according to the appropriate "fit," resource availability, and readiness within various communities. RMHP will explore further opportunities for expanding the B4 Babies program through its partnership with local public health agencies and other community-based care coordination entities.

Section III—Integration with Behavioral Health Services/Behavioral Health Organizations

Contract References	Possible Discussion Topics
Group 1: The Contractor shall create, document, and maintain a Communication Plan to communicate with all behavioral health managed care organizations (BHOs) with which it has relationships. RCCO and MMP Contracts—4.3.1 The PIAC includes members representing the behavioral health community. RCCO Contract—7.4.1.3.6 If the Member has an existing case manager through another program, such as behavioral health program, then the Contractor shall coordinate with that individual on how best to coordinate care through a single care coordinator. RCCO and MMP Contracts—6.4.3 The care plan shall include a behavioral health component for those clients in need of behavioral health services. RCCO and MMP Contracts—6.4.5.1.1.1 For members who have been released from the Department of Corrections (DOC) or county jail system, the Contractor shall coordinate with the members' BHO to ensure continuity of medical, behavioral, and pharmaceutical services. RCCO and MMP Contracts—6.4.5.2.6	General structure of RCCO/BHO/CMHC relationships ◆ How many BHOs does the RCCO work with? (How many RCCOs does the BHO(s) work with?) ◆ Is there formal organizational alignment? ▪ Ownership/partnership? ▪ Are there MOUs or contracts between the organizations? ▪ Is there a financial relationship? ◆ Do formally defined accountabilities/responsibilities exist between the organizations? ◆ How long have these relationships been in place? Functional relationships/operational interface ◆ Does the BHO participate in committees, boards, or joint planning related to RCCO strategic or operational decision making? (RCCO in BHO decision making?) ◆ Shared systems? ◆ Are there reporting responsibilities or data shared among the organizations? ◆ How extensive are the collaborative processes? ▪ Outline the functional areas of collaboration—how processes work ▪ How do these processes impact members (e.g., transparency, degree of coordination/overlaps, any feedback from members)? ▪ Care coordination—walk through the processes • Sharing information (verbal/documentation) • Designating a lead coordinator • Deciding how to share care coordination duties

Section III—Integration with Behavioral Health Services/Behavioral Health Organizations

Contract References	Possible Discussion Topics
Integrated care coordination characteristics include: Ensuring that physical, behavioral, long-term care, social and other services are continuous and comprehensive and the service providers communicate with one another in order to effectively coordinate care. RCCO and MMP Contracts—6.4.5.3.1 The Contractor shall ensure coordination between behavioral health and physical health providers. RCCO and MMP Contracts—6.4.11	• Who generally identifies the member with complex behavioral and/or physical health needs? • Who initiates the care coordination process? ▪ Describe how these collaborative processes have evolved; what do you anticipate going forward? ▪ What are the opportunities/successes to date related to collaborative responsibilities? ▪ What are the challenges related to collaborative processes?

Discussion and Observations:
The majority of the Region 1 geographic area overlaps with the Colorado Health Partnership (CHP) BHO, which is owned by the participating community mental health centers (CMHCs). Therefore, collaborative operations between the CMHCs in the region and RMHP also represent an inherent alignment with CHP. In addition, Larimer County overlaps with the Access Behavioral Care—Northeast (ABC-NE) BHO. The CHP service area is also geographically aligned with Regions 4 and 7, and the ABC-NE BHO is also aligned with Region 2. RMHP conducts strategic and operational activities both directly with CHP administration and governance as well as with select CMHCs and West Slope Casa—an organization owned by three CMHCs in the Western Slope area. RMHP described strategic initiatives with CHP created during development of the payment reform pilot project (RMHP's "Prime" line of business), and beginning collaborative work on how to expand global payment for the ACC 2.0 contract with components of the CHP partners and geographic service area. In addition, RMHP was engaged in numerous strategic operational activities with West Slope Casa and Mind Springs Health. Administrative-level data—e.g., budgets, planning documents, and financial operations—are shared between organizations. CHP entities actively participate in the Prime line of business. RMHP does not directly participate on the boards or committees of CHP, although RMHP and CMHC executives conduct numerous meetings, with information represented to CHP through the CMHC partner CEOs. Mind Springs Health representatives participate on RCCO committees, including Prime and various oversight committees; and CMHCs are actively engaged in the Community Care Teams that provide oversight of the local care coordination teams (CCTs). Staff stated that business associate agreements have been executed among the RCCO, CHP, and the CMHCs—enabling data and information sharing (e.g., claims, utilization, and risk stratification data and mental health center population-level data) with the Community Care Teams and mental health centers, and supporting member care coordination by the CCTs. RMHP, the mental health centers, and RCCO providers also participate in and share information through QHN.

Section III—Integration with Behavioral Health Services/Behavioral Health Organizations

Contract References	Possible Discussion Topics

Care Coordination Teams throughout the region had integrated behavioral health expertise and information into their care coordination activities. The specific models of integrated CCTs are driven by local resources and provider relationships. The north Larimer County CCT, associated with UC Health primary care practices, had a behavioral health care manager from SummitStone Health Partners embedded in the CCT. The Northern Colorado Health Alliance (NCHA) CCT, providing care coordination for multiple primary care practices in south Larimer County and/or affiliated with Banner Health, employed a behavioral health care manager embedded in the CCT. The south Larimer County CCT was associated with Sunrise Health, a FQHC delivering integrated physical and behavioral health, as well as several PCMPs affiliated with Banner Health. The Axis Health System, which operates a co-located FQHC and CMHC, provides care coordination for members in the Cortez/Durango region; and Mountain Family Health, an FQHC in Glenwood Springs, developed integrated behavioral health within its five clinic locations and provides a CCT for its clinics and surrounding PCMPs. All CCTs integrate behavioral, medical, and community healthcare coordination for members and share care coordination information and documentation among behavioral, physical, and social support providers. RMHP views the CCTs as the care team model for the ACC. Staff members stated that the CCTs have deepened relationships between the RCCO and primary care providers across the region and have promoted a better understanding and appreciation for integrated care delivery for members.

RMHP also described Mind Springs Health's Whole Health initiative, which trains and oversees Community Health Workers (CHWs)—six in Mesa County, one in Montrose, and two in Garfield County—who work as part of the care teams within select PCMPs. CHWs are assigned to provide community-based care coordination to members with extensive psychosocial needs. Members are admitted into the program based on defined qualifications and referred through the PCMPs. Members with intense behavioral and social needs often have difficulty accessing appropriate services and navigating the health system. The role of the CHW is to work with the member over a one-year period to motivate behavioral changes for improved health and assist the member with navigating the system. Whole Health CHWs use fleet vehicles for transporting members to needed services. Staff reported that the ability to provide transport for members has been a major enhancement to the program, particularly in areas where transportation services are limited or non-existent. CHW qualifications are not educational degree-driven, but are based on genuine interest and aptitude to work with this unusually challenging clientele. The Whole Health program had enrolled approximately 200 RCCO members at the time of review. The program was tracking patterns of needs to determine data-driven factors for identifying members most appropriate for enrollment. Mind Springs defined parameters within which CHW intervention is appropriate and provides high-touch individual and group supervision of workers. Axis Health also employed two CHWs—one embedded in each of its integrated clinic sites—to motivate improved health by reaching out to community-based services. RMHP remained positive about the value of CHWs as a behavioral health improvement asset for primary care practices, integrated care teams, and communities.

Section III—Integration with Behavioral Health Services/Behavioral Health Organizations

Contract References	Possible Discussion Topics
Group 2: The Contractor shall ensure that its network includes providers or PCMPs with the interest and expertise in serving the special populations that include members with complex behavioral or physical health needs RCCO and MMP Contracts—4.1.6.5 The Contractor shall distribute materials (provided by the Department) related to behavioral health and BHOs to all of the PCMPs in the Contractor's PCMP Network. RCCO and MMP Contracts—5.2.1 Enhanced Primary Care Standards include: ◆ The PCMP provides on-site access to behavioral health care providers. ◆ The PCMP collects and regularly updates a behavioral health screening (including substance use) for adults and adolescents. ◆ The practice has documented procedures to address positive screens and agreements with behavioral healthcare providers to accept referred patients. RCCO Contract—Exhibit F1 (4) and (5) Behavioral Health Integration Report: ◆ The Contractor shall submit to the Department a report that includes an environmental scan of current practices, challenges, and new strategies for integration of behavioral and physical healthcare for all covered populations. RCCO Contract—8.2.1.1	General level of behavioral health (BH) integration into medical practices or with other providers throughout network. Special programs/initiatives: update of programs in Integrated Care Report ◆ Fully integrated BH provider in Pediatric Partners of the Southwest ◆ Community Mental Health Workers (Mind Springs) integrated into primary care practices (for adults with high risk PH/BH needs) ◆ Managing members with dual diagnosis and complicating social needs (three practices with integrated BH) Get a brief update on each initiative above as follows: ◆ How/why this project was selected/initiated ◆ Current status of implementation ◆ Realized or anticipated successes to date ◆ Realized or anticipated challenges to date ◆ Potential impact on members when program completed ▪ How many members? Degree of importance/significance in member care and services? ◆ Potential impact on practitioners/other service organizations ▪ If BH/PH practice integration: • Where do the resources come from? • To whom are these practitioners accountable? • How available are resources to members? • How do co-located practitioners interact in patient care or the dynamics of office operations? Crisis Support Services system:

Section III—Integration with Behavioral Health Services/Behavioral Health Organizations

Contract References	Possible Discussion Topics
	◆ How does the RCCO/BHO coordinate with the Crisis Support Services network? ◆ How are members informed by RCCO/BHO? ◆ How does the referral system work between the RCCO/BHO and crisis centers? ◆ What are your challenges/successes in working with the center(s)? ◆ Do you have a sense of how effective the crisis network might be? (Do you know if members use the center(s)? Any feedback from members?) Overall successes/challenges in integrating BHOs/mental health providers with RCCO/physical health providers Overall impact of integration efforts on members ◆ Any way to monitor/assess? (Any feedback from members?) Going forward—Strategies for integration of behavioral and physical healthcare for all covered populations

Discussion and Observations:

Practice Integration

RMHP promoted and supported development of integrated behavioral and physical health practices through a variety of grant programs and other funding sources. RMHP staff stated that practices transition through multiple evolutions of integrated behavioral and physical health beginning with training, then moving to co-location of practitioners, and next developing into fully integrated behavioral and physical health teams—and that practices across the region were in varying levels of this continuum. RMHP invested in variety of economic initiatives—crossing all lines of business—to promote practice integration including:

- The RCCO supports CCTs and CHWs to connect members to needed services and to support behavioral health changes in members.
- RMHP's Practice Transformation program supports the transition of practice operations and EHR systems to accommodate integrated care teams in advanced primary care practices.
- The Prime program utilizes its global payment model to enable community mental health providers to participate in shared savings payment programs.
- RMHP is a partner in an initiative with St Mary's Hospital (SMH) Family Practice Residency and University of Colorado Family Medicine program in

Section III—Integration with Behavioral Health Services/Behavioral Health Organizations

Contract References	Possible Discussion Topics

a grant project to do some on-site training regarding the various levels of integrated care in small rural practices on the Western Slope. The program accepts three to four practices per quarter into the program.

- RMHP pays select advanced practices to hire behavioral health personnel who document all care in the practice medical record; Sustaining Healthcare Across integrated Primary care Efforts (SHAPE) project and State Innovation Models (SIM) grant funds are used to sustain the "ownership" model, reimbursed through practice budgets for team-based care.
- The family practice residency program at St Mary's Hospital was engaged in training practitioners to work in an integrated behavioral and physical health model of care by integrating behavioral health practitioners into the on-site clinic. St. Mary's Hospital provided resources to support the program. Staff stated that exposing residents to integrated care prepares them for the future model of primary care delivery and that graduates from the residency program often remain at practices within Region 1. RMHP and residency program leadership worked together to develop concepts associated with comprehensive primary care practices that could be incorporated into the residency training program.

At the time of on-site review, RMHP stated that Primary Care Partners in Grand Junction had an on-site behavioral health therapist at each of its two practice locations—Foresight Family Physicians employed a full-time behavioral health practitioner and a part-time therapist through Mind Springs, Pediatric Partners of the Southwest (Durango) had integrated two full-time behavioral health practitioners, and Mountain Family Health had recently hired three behavioral health practitioners and had two on-site Mind Springs employees. Axis Health operates an integrated FQHC and CMHC. Mind Springs also reported that it is considering integrating primary care providers into its mental health center. RMHP was providing fiscal support to 12 to 15 practices for the integration of behavioral healthcare, with the expectation that these practices will eventually be financially able to sustain this integrated care model. Staff estimated that 20 to 25 percent of all RCCO members had access to integrated services.

Staff members shared some early "lessons learned" during integration of behavioral health practitioners into primary care practices, including:

- By addressing the behavioral health aspects of member care, on-site behavioral health therapists increase access to primary care providers (PCPs)—positively impacting the primary care shortage.
- Primary care practices offer a vastly different culture and environment for behavioral health practitioners, requiring the right "fit" of behavioral health personnel. Many opportunities exist for brief interactions and interventions in primary care compared to the traditional extended therapy session model.
- Every practice reported that behavioral health personnel are exceedingly busy with patient care responsibilities. Practice-based care coordinators are essential to relieve the behavioral therapist of follow-up responsibilities with members.
- Finding and recruiting behavioral health resources that are appropriate for primary care was a major challenge. Licensed professional counselors (LPCs) are more appropriate than higher-trained professionals to support the regular behavioral health issues of primary care patients.
- Billing codes for behavioral health in primary care practices are not adequate to sustain integrated care without the support of additional grant funds.

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RMHP's goal in 2015–2016 was to move primary care practices beyond co-location to "ownership" of behavioral health services in comprehensive primary care practices. Staff reported that the number of practices with integrated behavioral health was growing but that resources are limited. RMHP believes the ACC 2.0 contract should reimburse the integrated care team model through global payment mechanisms.

Crisis Support Services

The state-designated crisis support centers in Region 1 included three West Slope Casa CMHCs—Axis Health System (Durango), The Center for Mental Health (Montrose), Mind Springs Health (Grand Junction)—and SummitStone Health Partners (Fort Collins). West Slope Casa CMHCs serve a 21-county region on the Western Slope. Each center staffs a 24/7 crisis hotline, walk-in crisis stabilization services, and mobile crisis intervention services. The statewide crisis hotline, operated in Denver, will also warm transfer calls to the local crisis hotline at the centers. Mind Springs' 11-bed transitions unit can provide up to five days of crisis stabilization care to individuals who require 24-hour intensive behavioral health crisis intervention. In addition, respite care housing is available in Grand Junction or Fort Collins, supported by consultation from professional staff at Mind Springs or SummitStone, respectively. The crisis center and mobile unit staff members connect individuals to behavioral, medical, or community resources as necessary.

RMHP educated all CCTs regarding the crisis support system. The RMHP CCTs have ongoing relationships with the CMHCs in their service areas and may obtain feedback from the CMHCs regarding any members who have used the crisis center. Marketing information concerning crisis center services is available through the CMHCs. Staff stated that communities and RMHP members are aware of the crisis support system and that they believe that individuals are readily accessing crisis support services.

In 2016, RMHP was awarded the Intellectual/Developmental Disabilities Crisis Pilot Program in partnership with several CMHCs and community centered boards (CCBs) to expand the services crisis support centers provide to include services for individuals with intellectual/developmental disabilities. Additionally, the pilot program will help expand temporary residential placement capacity on the Western Slope and in Larimer County on the Front Range. Working with community partner organizations, the pilot program will integrate professionals with expertise in working with individuals with intellectual and developmental disabilities into 24/7 crisis support services, connecting these individuals with appropriate post-crisis support services—especially home and community-based services (HCBS).

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

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

Table C-1 lists the participants in the FY 2015–2016 site review of **RMHP**.

Table C-1—HSAG Reviewers and RCCO Participants

HSAG Review Team	Title
Katherine Bartilotta, BSN	Senior Project Manager, State & Corporate Services
Mary Wiley, BSW, RN, M.Ed.	Project Director, State & Corporate Services
Rachel Henrichs	EQR Compliance Auditor, State & Corporate Services
Barbara McConnell, MBA, OTR (telephonic participant in opening session)	Executive Director, State & Corporate Services
Rodd J. Mas (telephonic participant in opening session)	Vice President, State & Corporate Services
RMHP Participants	**Title**
Amy Gallagher	Mind Springs Health/Whole Health, LLC
Angela Engle	Quality Improvement Compliance Specialist
Beth King	Associates in Family Medicine
Carol Schlageck	Primary Care Partners
Carol Ann Hendrikse	Project Manager, Care Management, and RCCO Clinical Manager
Cecile Fraley	Pediatric Partners of the Southwest
Curtis Fleming	Staff Attorney
Cyndi Dodds	SummitStone Health Partners
Dale Renzi	Director, Provider Network Management
Daniel Grossman	Manager, Internal Audit
David Klemm	Member Experience Manager
Eve Presler	RCCO Colorado Opportunity Project Liaison
Gary Schreiner	Behavioral Health Manager, Mountain Family Health Centers
Greg Coren	Western Slope Provider Relations Manager and Provider Network Manager
Jackie Hudson	Director of Quality Improvement
Jazz Garrison	Northern Colorado Health Alliance
Joanna Martinson	Northern Colorado Health Alliance
Jolene Singer	Mountain Family Health Centers
Judy Narenkivicius	Credentialing Compliance Coordinator
Kalisha Crossland	Axis Health Systems
Karen Ramirez	University of Colorado Health—Fort Collins Care Team
Kelli Steinkirchner	PNM Project Coordinator
Kelsy Hurley	Credentialing Coordinator Team Lead

RMHP Participants	Title
Kendra Peters	RCCO Marketing and Communications Coordinator
Kevin Fitzgerald	Chief Medical Officer
Kila Watkins	Complex Case Management/Disease Management Manager
Lesley Reeder	Consultant, Steadman Group
Lisa Barnes	Foresight Family Physicians
Lisa Barrett	San Juan Basin Health Department
Lori Stephenson	Director of Clinical Program Development and Evaluation
Marc Lassaux	Quality Health Network
Marci O'Gara	Director of Customer Service
Mike Huotari	Vice President of Legal and Government Affairs
Nancy Steinke	Clinical Policy Manager
Nicole Konkoly	Program Development Specialist, Community Integration
Nora Foster	Compliance/Audit Coordinator
Patrick Gordon	Associate Vice President, Community Integration
Pauline Casey	Senior Program Operations Leader
Randall Reitz	St. Mary's Family Medicine
Rhonda Hastings	Program Logistics Coordinator
Sandy Dowd	Director of Care Management
Sarada Leavenworth	Axis Health Systems
Sharon Raggio	Mind Springs Health
Sharon Steadman	Consultant, Steadman Group
Stephen Thompson	University of Colorado Health—Fort Collins Care Team
Department Observers	**Title**
Teresa Craig (telephonic)	Contract Manager, CHP+
Chavanne Lamb	Contract Manager, Payment Reform Pilot Program
Katie Mortensen	Quality and Health Improvement Unit
Matt Vedal	Policy and Outreach Specialist