Colorado
Accountable Care Collaborative

FY 2014–2015 Site Review Report Executive Summary

for

Colorado Access (Regions 2, 3, and 5)

June 2015

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

HSAG HEALTH SERVICES ADVISORY GROUP

3133 East Camelback Road, Suite 100 ◆ Phoenix, AZ 85016-4545
Phone 602.801.6600 ◆ Fax 602.801.6051

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 (1) improvement in health outcomes through a coordinated, member-centered system of care; and (2) cost control 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. **Colorado Access** began operations as a RCCO for Region 2 in May 2011, for Region 3 in June 2011, and for Region 5 in July 2011. The RCCOs provide medical management for medically and behaviorally complex members, care coordination among providers, and provider support such as assistance with care coordination and practice transformation for performance of medical home functions. 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. Affected populations included parents of Medicaid-eligible children and adults without dependent children. The Department estimated that, as a result of Medicaid expansion, 160,000 additional members would be integrated into the RCCOs in phases. In addition, the Accountable Care Collaborative: Medicare-Medicaid Program demonstration project provided for integration of 32,000 new dually eligible Medicare-Medicaid members into the RCCOs, beginning September 2014. Effective July 2014, the RCCO contract was amended 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 organizational successes and challenges in implementing key components of the ACC Program. This report documents results of the fiscal year (FY) 2014–2015 site review activities, which included delegation of care coordination, RCCO coordination with other agencies and provider organizations, and performance of individual member care coordination. This section contains summaries of the activities and on-site discussions related to each focus area selected for the 2014–2015 site review, as well as HSAG's observations and recommendations. In addition, Table 1-1 through Table 1-3 contain the results of the 2014–2015 care coordination record reviews. Table 1-4 through Table 1-6 provide a comparison of the overall 2014–2015 record review scores to the 2013–2014 record review scores. Section 2 provides an overview of the monitoring activities and describes the site review methodology used for the 2014–2015 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 two select populations: children with special needs and adults with complex needs. 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 1-1, Table 1-2, and Table 1-3 present the scores for **Colorado Access**' care coordination record reviews for each special population reviewed in each region. Detailed findings for the record reviews are in Appendix B—Record Review Tools.

Table 1-1—Summary of Care Coordination Record Review Scores for Region 2

Description of Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score* (% of *Met* Elements)
Children With Special Needs	36	23	21	2	0	13	91%
Adults With Complex Needs	35	34	24	6	4	1	71%
TOTAL	71	57	45	8	4	14	79%

HSAG reviewed four child records and five adult records.

Table 1-2—Summary of Care Coordination Record Review Scores for Region 3

Description of Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score* (% of *Met* Elements)
Children With Special Needs	54	43	39	4	0	11	91%
Adults With Complex Needs	28	22	20	2	0	6	91%
TOTAL	82	65	59	6	0	17	91%

HSAG reviewed six child records and four adult records.

Table 1-3—Summary of Care Coordination Record Review Scores for Region 5

Description of Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score* (% of *Met* Elements)
Children With Special Needs	45	27	14	11	2	18	52%
Adults With Complex Needs	35	27	19	5	3	8	70%
TOTAL	80	54	33	16	5	26	61%

HSAG reviewed five child records and five adult records.

* 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 point value of 0.0)

Table 1-4, Table 1-5, and Table 1-6 provide a comparison of the overall 2014–2015 record review scores to the 2013–2014 record review scores. Although most contract requirements remained the same for the two review periods, scores may have changed due to reformatting and clarifications in the record review tool.

Table 1-4—Comparison of Care Coordination Record Review Scores for Region 2

Description of Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score* (% of *Met* Elements)
Care Coordination 2013–2014	72	64	41	9	14	8	64%
Care Coordination 2014–2015	71	57	45	8	4	14	79%

Table 1-5—Comparison of Care Coordination Record Review Scores for Region 3

Description of Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score* (% of *Met* Elements)
Care Coordination 2013–2014	114	115	49	32	34	29	43%
Care Coordination 2014–2015	82	65	59	6	0	17	91%

Table 1-6—Comparison of Care Coordination Record Review Scores for Region 5

Description of Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score* (% of *Met* Elements)
Care Coordination 2013–2014	132	111	66	27	18	21	59%
Care Coordination 2014–2015	80	54	33	16	5	26	61%

* 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 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 Delegation of Care Coordination and RCCO Coordination With Other Agencies/Provider Organizations. Following is a summary of results for each content area of the 2014–2015 review.

Summary of Findings and Recommendations by Focus Area

HSAG conducts staff interviews applicable to **Colorado Access** RCCO regions 2, 3 and 5 simultaneously. Regions 3 and 5 combined comprise the majority of the Denver metropolitan area. Region 2 covers the northeast quadrant of the state and, with the exception of Weld County, is primarily rural. Unless otherwise noted in the narrative, the information gathered is applicable to all three **Colorado Access** regions.

Delegation of Care Coordination

Activities and Progress

Colorado Access had executed written delegation agreements with 13 total primary care medical providers (PCMPs) across the three RCCO regions. The entities delegated to perform care management represent the larger PCMP clinic systems in the regions, and 10 of the 13 PCMPs received delegation status prior to 2014. Staff estimated that 45 percent of members across the three regions are associated with practices delegated for care coordination (although that proportion is slightly higher in Region 2, at 60 percent). **Colorado Access** provides care coordination services for the remaining 55 percent of its members. During 2014, **Colorado Access** significantly increased staffing levels for internal care management from 11 full-time equivalents (FTEs) to 58 FTEs and also restructured care coordination teams to target care coordination for special population groups (e.g., the refugee/immigrant population, members with HIV/AIDS, transitions of care [TOCs], and members in the Medicare-Medicaid Program [MMP]). **Colorado Access** defined three optional categories of delegated care management activities—intensive care management, TOC, and MMP care plan. All 13 delegates perform intensive care management, 12 of 13 perform TOCs, and 7 of 13 perform MMP care plans (including completion of the service coordination plan [SCP]). During 2014, **Colorado Access** revised its delegation agreement template to specify the care coordination responsibilities associated with each category of care management and to incorporate the requirements of **Colorado Access**' revised RCCO contract with the Department. In addition, **Colorado Access** updated its pre-delegation assessment tool to reflect the new comprehensive care coordination requirements outlined in the delegation agreement. **Colorado Access** did not implement the revised documents with the pre-established delegates, but will apply them to any new applicant for delegation of care coordination. For entities that were delegates prior to 2014, **Colorado Access** amended the previously executed delegation agreement to include the MMP requirements and revised the required reporting metrics. **Colorado Access** continues to have discussions with additional PCMPs concerning their readiness to apply for delegation of care coordination. Staff stated that the revised pre-delegation assessment tool has resulted in some potential applicants reconsidering their capabilities for assuming care coordination responsibilities. **Colorado Access** is also evaluating an alternative model of delegation to accommodate future relationships with local community-based partnership alliances (particularly in the Region 2 rural areas) or other non-PCMP entities.

Colorado Access continues to informally explore care coordination relationships with external entities, and in 2014 hosted a *Cross-systemic Care Coordination Conference* to increase understanding of the care coordination roles and functions of multiple organizations and to discuss

cross-system collaboration for care management. **Colorado Access** had Business Associate Agreements (BAAs) that enable data sharing and shared client lists with 22 community agencies and providers. **Colorado Access** also implemented several care coordination pilot projects with select providers and was evaluating them for potential transferability to other organizations.

The revised pre-delegation assessment tool was thorough and aligned with the "evolved" understanding of care coordination requirements for which RCCOs are contractually responsible. The pre-delegation process for each applicant includes an on-site visit to evaluate the systems for support of the care coordination requirements, identify gaps, conduct training, and establish payment or financial incentives for delegated functions. Staff members stated that this preparatory process and practice coaching may involve a lengthy engagement with the practice.

During 2014, **Colorado Access** also developed a chart audit tool for an annual assessment of delegate care coordination performance. **Colorado Access** applied the chart audit criteria to internal RCCO care coordination records and plans to audit all delegated entities before the end of 2015. The chart audit tool will allow for an assessment of 17 comprehensive care coordination criteria, and corrective action plans will be developed for identified deficiencies. The chart audit will supplement other ongoing oversight activities that include reviewing delegates' monthly care coordination metrics, monitoring enhanced primary care reports, and delegate participation in bi-monthly Care Management (CM) Delegation Committee meetings. **Colorado Access** uses the CM Delegation Committee meetings as an opportunity to provide ACC program updates and education about any system-wide changes in RCCO care coordination priorities, to stimulate interactive care coordination discussions, and to encourage delegates to share best practices. The CM Delegation Committee discussions also assist **Colorado Access** with identifying needs for operational tools and supports for care coordination. During 2014, **Colorado Access** developed a comprehensive member needs assessment tool that incorporated many detailed elements of medical, behavioral, functional, social, and cultural needs. **Colorado Access** implemented the tool internally in July 2014, introduced it to delegates for educational purposes, and made it available to all delegates for optional implementation.

Colorado Access had admit, discharge, transfer (ADT) data sharing arrangements with many independent hospitals throughout the regions and (effective in 2015) access to Colorado Regional Health Information Organization (CORHIO) data from hospitals and other providers. **Colorado Access** passes ADT data for RCCO members to the applicable delegate. Due to the amount of data and inconsistency in the types of data submitted to **Colorado Access** from multiple sources (including CORHIO), it is necessary for **Colorado Access** to sort and reformat the information from all sources before distributing it to delegates. In 2014, **Colorado Access** established the TOC Team to develop and implement improved TOC mechanisms that may be transferable to the delegates. Staff stated that coordination with external community organizations and agencies is a relatively new concept in PCMP-based care coordination and remains a challenge for most delegates. **Colorado Access** encourages delegates to report any barriers encountered when working with external organizations.

Each delegate is allowed to stratify members for referral to care management based on internal systems and data available within the individual practice, and processes varied across PCMPs—some used data from internal claims and/or Statewide Data Analytics Contractor (SDAC) risk scores, all responded to referrals from the primary care provider (PCP), but only a few identified

members through a health risk assessment tool. **Colorado Access**' goal is to create a more robust system of care coordination through individual practice coaching and group trainings. Staff stated that increased training and support of delegates can be accomplished as the frequency of major ACC program changes is diminished.

Delegates submit the Department-required care coordination metrics reports to **Colorado Access** monthly; however, delegates are not able to accurately report information by population category or tier level for every member. **Colorado Access** detected an under-reporting issue in early reports and has been carefully monitoring the accuracy of these reports and working with delegates to explore solutions for improving data reliability. Similarly, **Colorado Access** receives monthly MMP metrics from those practices delegated to perform care coordination for MMP members. **Colorado Access** provides care coordination, including completion of SCPs, for all unattributed members and those members attributed to non-delegated MMP practices. **Colorado Access** designated a specialized SCP team and developed a web-based SCP tool used by delegates and **Colorado Access** staff. Staff reported that **Colorado Access** has received positive feedback from PCMPs regarding the web-based SCP tool. SCPs are completed through in-person interviews. Of the members outreached to complete the SCP, 60 to 70 percent declined participation or could not be reached. At the time of HSAG review, delegates had completed SCPs for 11 percent of the total MMP population, and **Colorado Access** had completed SCPs for 7 percent of the non-delegated MMP population. Nevertheless, staff reported that members are providing positive feedback regarding face-to-face interviews and establishing a connection to care managers. **Colorado Access** anticipates the SCP team's experiences will be valuable in informing care coordination for other ACC populations.

Observations/Recommendations

Staff stated that implementing the revised delegation agreement with each previously delegated PCMP requires cumbersome and time-consuming legal review and negotiations for all parties. However, the revised delegation agreement explicitly defines expectations related to the current care coordination requirements of the RCCO contract with the Department. Therefore, HSAG recommends that **Colorado Access** implement the revised delegation agreement (or a similar accountability document) with all delegate PCMPs. HSAG suggests that this will focus the delegates' attention on the comprehensive care coordination requirements that have "evolved" since the inception of the ACC.

Colorado Access also revised its pre-delegation assessment tool to more accurately evaluate a potential delegate's ability to meet the more contemporary care coordination criteria represented in the current ACC contract requirements, help **Colorado Access** identify gaps in delegates' skill levels, and facilitate improvements in processes. HSAG recommends that **Colorado Access** evaluate its established delegates with the revised pre-delegation assessment tool and engage delegates in opportunities for improvement. Furthermore, because a significant proportion of members are receiving care coordination through established delegated practices, **Colorado Access** may want to consider temporarily suspending delegation of care coordination to additional new applicants. This would allow **Colorado Access** to more effectively apply training and support resources to ensure that existing delegates are adequately performing care coordination in accordance with the "evolved" standards and requirements of the RCCO contract.

While care coordination record reviews documented that an individual care coordinator was assigned to work with each member, some PCMPs and **Colorado Access** have organized care coordination resources according to specialized programs or targeted population groups. Therefore, some members with complex needs work with multiple care coordinators and do not have a consistent point of contact. In addition, this organizational approach requires that care coordinators within a practice (or within **Colorado Access**) work as a team, making "coordinating the coordinators" internally as well as externally a challenge. HSAG recommends that **Colorado Access** and its PCMPs ensure that a "lead" coordinator be assigned and accountable to oversee all care coordination activities applicable to any individual member.

Colorado Access had and will continue to implement memorandums of understanding (MOUs) and other mechanisms to facilitate collaborative data sharing and care coordination with multiple agencies and provider organizations (as indicated in the RCCO Coordination With Other Agencies/Provider Organizations section below). While **Colorado Access** collects ADT data from hospitals and shares appropriate information with its delegates, it also needs to identify a mechanism to collect and disseminate appropriate information from other agencies and organizations. HSAG recommends that **Colorado Access** develop mechanisms to ensure that any arrangements for collaborative care coordination with outside agencies and organizations are integrated into the delegate care coordination processes, recognizing that delegates are responsible for more than 45 percent of its members.

RCCO Coordination With Other Agencies/Provider Organizations

Activities and Progress

Colorado Access listed 180 community organizations and agencies in Regions 3 and 5 and 98 community organizations and agencies in Region 2 with which it has relationships of varying degrees—from introductory RCCO presentations to formal MOUs and/or BAAs. Staff stated that the possibilities for relationships with organizations number in the thousands. **Colorado Access** targeted priority relationships through a variety of mechanisms including data sources, care coordinators, community organization networking, and strategic objectives. During 2014, the initiation of the MMP program stimulated an expansion of outreach efforts to home health agencies, skilled nursing facilities (SNFs), hospitals, and other organizations to develop protocol relationships. **Colorado Access** established a Health Neighborhood Division to managerially focus oversight and organization of community partnerships across all regions and initiated bi-monthly Health Neighborhood meetings in all regions. These meetings are intended to include any agency/organization with which the **Colorado Access** RCCOs have contact, with the purposes of exploring barriers and solutions regarding access to care and determining how to work together as a community to address issues and mutual objectives. Health Neighborhood meetings in Region 2 are held in three geographic sub-regions as partnerships with other established community health groups. Care coordination partnerships or other relationships that involve sharing member information require formal BAAs or MOUs. MOUs are also executed when financial payments occur between organizations or when a specific collaborative project has been defined. **Colorado Access** described a number of collaborative pilot projects implemented with community providers and agencies. **Colorado Access** is implementing a customer relationship management (CRM) database and developing a Health Neighborhood Directory to assist with tracking and managing

numerous organizational relationships. Staff identified factors that contribute to a successful community partnership including mutually aligned missions and goals, the RCCO's growing reputation in communities, financial incentives, providing needed data for initiatives, and persistent staff attention to follow-through and building trust. **Colorado Access** staff identified that creating and maintaining relationships with a multitude of community organizations requires a substantial amount of staff time and resources. Other significant challenges included: community organizations' limited understanding of RCCO roles and responsibilities; legal review and HIPAA concerns that impede execution of formal agreements; political and operational environments within various health industry groups (e.g., community centered boards [CCBs], single entry points [SEPs], and home health providers); shifting priorities of both **Colorado Access** and a partnering organization; and fears among agencies that they may be replaced by the RCCO or that the State may impose rate adjustments. Unique to Region 2, challenges include: many communities are averse to engaging in any perceived government-driven changes to the local healthcare systems; some county governments own the healthcare systems, and decisions are made by county commissioners; and many rural communities are faced with a shortage of or financially strained healthcare resources. Region 2 staff works one-on-one to continually build trusting relationships with diverse community leaders and is tracking and supporting local collaborative partnerships that are emerging to address concerns about how to sustain health services in these communities. **Colorado Access** acknowledged that Department initiatives such as introducing RCCOs to statewide industry groups (CCBs, SEPs, Health Facilities Advisory Council) and implementing contract or financial incentives are very helpful.

The Colorado Department of Public Health and Environment Ryan White educational summit in 2014 introduced the RCCOs to the Colorado AIDS Project programs in various geographic areas. **Colorado Access** executed a data sharing/care coordination agreement with the Colorado AIDS Project, applicable to all three RCCO regions. However, the functional relationship between the RCCO and the Colorado AIDS Project has not yet been defined due to loss of communication between **Colorado Access** and the contact person at the Colorado AIDS Project. Staff stated that **Colorado Access** needs to revisit and elevate the priority of re-engaging the Colorado AIDS Project. **Colorado Access** hired a care manager specifically for the HIV population in 2015 and began evaluating the best methods to stratify this population for RCCO care coordination. Staff stated that most members with HIV are unattributed because they are receiving care through infectious disease clinics. **Colorado Access** is attempting to contract with four infectious disease clinics in Regions 3 and 5. The Northern Colorado AIDS Project is the primary provider of services to members with HIV in Region 2 and takes responsibility for coordinating services. The major issue is attributing members to appropriate PCMPs. The Banner Health infectious disease clinic and mental health centers in the region have declined contracting as PCMPs. Going forward, **Colorado Access** would like to develop a broader base of provider and community relationships related to this population.

Colorado Access noted that the Department's initiative with the Department of Corrections was designed to pursue solutions for the integration of prison parolees into Medicaid and the RCCO, but that the initiative had not progressed due to staffing changes in the Department. Therefore, **Colorado Access** had not made further progress regarding paroled or criminal justice involved (CJI) enrollees. **Colorado Access** contract managers have met with Arapahoe, Douglas, and Denver counties. Each county has processes in place for ensuring that persons being released from jail are efficiently enrolled in Medicaid. Within Region 2, RCCO staff began contacting every local county

parole/probation office to discuss mechanisms to connect members to local mental health centers, but the process of working through each county has proved too cumbersome. The RCCOs cannot intervene with care coordination or PCMP attribution services until the member is assigned to the RCCO (up to three months following enrollment in Medicaid). However, passive enrollment of the member into a behavioral health organization (BHO) enables the mental health centers to engage the member in treatment. Therefore, **Colorado Access** has been working with the Access Behavioral Care (ABC) BHOs and affiliated mental health centers to identify collaborative mechanisms for engaging CJI members soon after release from jail. At the time of the HSAG on-site review, effective mechanisms had not been defined to close the gap in time between the member's release from prison or jail and assignment to the RCCO. Staff members suggested that the Department refresh the position for CJI program coordination to assist with policy level or system-wide solutions applicable to CJI persons being released from prisons or jails.

During on-site interviews, HSAG asked staff about **Colorado Access**' progress in identifying Medicaid-eligible pregnant women for attribution to PCMPs and about **Colorado Access**' appropriate management of high-risk pregnancies. **Colorado Access** described the following activities:

- **Colorado Access** used a variety of information sources to identify Medicaid women who are pregnant, including the Department's report of new Medicaid enrollees who self-reported pregnancy. In addition, to facilitate identifying pregnant Medicaid enrollees to the RCCOs, **Colorado Access** already had or was pursuing MOUs with community providers where pregnant Medicaid enrollees might seek health services. These providers included the Denver County, Tri-County, and Region 2 public health clinics; Planned Parenthood of the Rocky Mountains; Healthy Communities; and the regional Access Behavioral Care BHOs.
- **Colorado Access** analyzes the SDAC data to determine PCMP attribution for members who are pregnant. If unattributed, **Colorado Access** outreaches to members to assist in attribution. If attributed, **Colorado Access** messages the PCMP to ensure that the member is receiving obstetrical care. The SDAC data are also used to identify high-risk pregnancies, which are then referred to the **Colorado Access** Healthy Mom/Healthy Baby program for care management.
- **Colorado Access** has developed a specialized care management team for care coordination of high-risk pregnancy members or for post-delivery coordination of services for members with complex needs. Care managers refer members to the Nurse-Family Partnership programs to arrange for home-based care or home-visitor programs.
- **Colorado Access** is pursuing relationships with local Women, Infants, and Children (WIC) agencies to enlist them to post information in WIC offices about the RCCO and the importance of well-child visits.
- **Colorado Access** is working with providers to assess the reasons for low incidence of postpartum visits (e.g., coding issues or women in rural areas seeking delivery services outside the area).

Colorado Access staff members stated that, to date, between 7,500 and 8,000 MMP members are assigned to the three **Colorado Access** regions, with the highest proportion residing in Adams County and Region 2. **Colorado Access** developed relationships and/or care coordination/data sharing MOUs with numerous organizations involved in caring for MMP members, including

affiliated mental health centers and BHOs, hospitals, SEPs, and CCBs in each region. **Colorado Access** serves as the BHO in Regions 2 and 5 and the SEP in Regions 3 and 5 and has been developing mechanisms to coordinate activities internally among the RCCO, SEP, and BHOs in order to avoid duplication of individual contacts with members. **Colorado Access** designated a specialized team of care managers within the RCCO care management department for completion of SCPs. **Colorado Access** staff uses a web-based tool to complete the SCP. **Colorado Access** receives ADT information directly from 14 hospitals and in 2015 began supplementing the ADT data with information from CORHIO for additional hospitals. **Colorado Access** invites all hospitals, SEPs, and CCBs in each region to attend the Health Neighborhood meetings. Staff stated the primary challenges in working with CCBs or SEPs relate to the different contracted mandates and purposes of the agencies. **Colorado Access** listed 149 home health agencies and 23 hospice organizations that operate in the three RCCO regions. **Colorado Access** is outreaching to all home health agencies to gather information on services provided, and Region 2 hosted a home health roundtable discussion to initiate conversations related to home healthcare coordination. **Colorado Access** invites home health and hospice organizations to participate in Health Neighborhood meetings. **Colorado Access** engaged several home health agencies and hospice providers to pilot test a fax notification form for RCCO members entering or leaving home care. Staff stated that home health agencies appear receptive to care coordination support from the RCCO. However, home health agencies have expressed concern about State rate reductions for MMP members should their services be perceived as ineffective. **Colorado Access** was in the preliminary stages of exploring relationships with SNFs, which number 71 throughout the regions. **Colorado Access** did not have MOUs with SNFs and had made only limited RCCO introductory presentations. Staff stated that the approach with SNFs is to develop further understanding of system-level issues that the RCCO may help to resolve, and TOC (SNF to home/community) issues must be systematically explored. Within Region 2, staff described that the RCCO needs to explore how it can support the financial needs of nursing homes in rural communities to ensure business survival. As additional MMP members are enrolled in the ACC, **Colorado Access** will begin using SDAC data to identify priority SNF relationships.

Observations/Recommendations

Colorado Access identified a multitude of diverse agencies and organizations with which to engage in a variety of ways to meet the ACC objectives and requirements. At the time of the review, **Colorado Access** had implemented an all-inclusive approach to develop a broad foundation of relationships from which partnerships may be defined. **Colorado Access** established a Health Neighborhood Division to oversee and organize community partnerships across all regions. **Colorado Access** is implementing a customer relationship management (CRM) system to assist with managing multiple staff contacts with many external organizations. HSAG cautions, however, that a database tool alone does not ensure successful implementation of functional relationships. In addition, staff interviews demonstrated that, to date, relationships with the majority of organizations have been high-level discussion and presentation-oriented and that staff may be vulnerable to the distractions that result from engaging with so many organizations and strategic objectives simultaneously. HSAG recommends that **Colorado Access** strengthen its partnership initiatives by strategically focusing resources and consider assigning staff "champions" to work with select organizations to complete agreements and to implement functional relationships with high-priority organizations and agencies.

In recognition of the unique political and local-control environment in communities across the region, Region 2 developed a style of engaging with potential partners that is sensitive to the nuances of organizational dynamics within the region. In order to further the success of engaging with local and regional partners, HSAG encourages **Colorado Access** to create alliances and establish collaborative processes whenever possible through RCCO resources and messaging that are regionally based, rather than through Denver-based corporate initiatives or statewide initiatives, or, as appropriate, using established partners (e.g., North Colorado Health Alliance or Banner Health) as a base for outreach activities and communications.

Care Coordination Record Reviews

Findings

Colorado Access asked delegates to submit lists of members engaged in complex care coordination for selection of the sample for on-site record reviews. Of the 30 members selected by the Department for on-site record review, 12 (six in Region 2, two in Region 3, and four in Region 5) were omitted because the member did not have complex needs, received no care management, or was not a patient in the designated PCMP practice. Furthermore, in an attempt to obtain sufficient records from the oversample, an additional 19 records (12 from Region 2 and seven from Region 5) were reviewed and omitted for the same reasons. As necessary, the sample was supplemented on-site with care coordination records from the **Colorado Access** RCCOs.

HSAG reviewed five adult and four child records for Region 2, four adult and six child for Region 3, and five adult and five child records for Region 5.

Results of record reviews were as follows:

Across the three regions, **Colorado Access** had a score of 78 percent compliance with comprehensive care coordination requirements. Region 2 had a compliance score of 79 percent, Region 3 had a compliance score of 91 percent, and Region 5 had a compliance score of 61 percent.

Individual record review results are detailed in Appendix B of this report.

Observations/Recommendations

Colorado Access allows delegates to target members for care coordination based on internal systems and data available within the individual practice, and processes used vary across PCMPs. Based on difficulties with the sample lists submitted by delegates, HSAG recommends that **Colorado Access** carefully review how each delegate stratifies members with complex needs and implement a system to evaluate whether all members who qualify are referred for care coordination.

Each delegate presented the records chosen for review; therefore, HSAG was able observe how delegates navigate the system used for care management. Many delegates tracked care coordination activities within the member's electronic health record (EHR). Primary care EHRs are not designed to document and track complex care coordination activities; therefore, information appeared disjointed and was often difficult for care coordinators to locate. HSAG recommends that **Colorado Access** work with delegates to identify more efficient ways to document care coordination

activities, such as consolidating care coordination needs and interventions in a designated or easily accessible location in the EHR.

During 2014, **Colorado Access** developed a comprehensive needs assessment tool that was implemented mid-year by **Colorado Access** care coordinators and has been shared with delegates for education and optional implementation. While HSAG recognizes the need to allow delegates to apply their own systems of care coordination, **Colorado Access** should consider using this tool in the annual chart audit of delegate care coordination records to ensure that delegate systems are documenting a similar comprehensive assessment of member needs and to reinforce the components of a comprehensive assessment. **Colorado Access** should also increase training and information to ensure that delegates understand that cultural values and behaviors include more than the member's language, ethnicity, or religion, and that comprehensive cultural information is documented in the record. In addition, **Colorado Access** should ensure that future chart audits conducted by **Colorado Access** assess outreach to external care coordinators and agencies.

During on-site record review presentations, Kaiser (a delegate PMHP for **Colorado Access**) staff members stated that Kaiser uses an episodic model of care management, primarily based on assessment and referral from the PCP. This model of care management was demonstrated in record reviews (this review period as well as previous review cycles) as referral of the member to a select care management program (e.g., social work, nutrition counseling, autism, pediatric), followed by attention to the specific reason for the referral. Once the member was referred to care management, there generally was neither evidence of a more comprehensive assessment of the member's broader needs nor reference to interventions to address needs beyond those for which the PCP had originally made the referral. This model of addressing isolated needs as they are recognized in a PCP visit does not meet the RCCO's comprehensive care coordination requirements and does not necessarily ensure that all member care coordination needs are identified and addressed. While the Kaiser model of care coordination may be appropriately designed for the majority of Kaiser's members (most of whom are non-Medicaid), **Colorado Access** should provide further consultation or training with Kaiser to improve and implement processes for a non-episodic comprehensive care coordination system for RCCO Medicaid members with complex needs.