Colorado
Accountable Care Collaborative

FY 2013–2014 Site Review Report

for

Integrated Community Health Partners (Region 4)

July 2014

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

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CONTENTS

Introduction

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

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

Summary of Results

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

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

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

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

Table 1-2—Summary of Care Coordination Record Review Scores							
Description of Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Care Coordination	192	153	153	0	0	39	100%

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

Summary of Findings and Recommendations by Focus Area

Provider Support

Findings

During 2013, **ICHP** assisted providers in resolving barriers and problems related to the Colorado Medicaid systems in the following areas: processing of online enrollment applications, correcting inaccuracies in attribution of members to primary care medical providers (PCMPs), and engaging Medicaid members to join the ACC or to select attribution to a PCMP. **ICHP** staff remained readily available to providers to explain Medicaid processes and to assist with resolution of individual practitioner's issues. The **ICHP** Practice Support Plan outlined the specific 2013–2014 initiatives related to practice support that included provider and staff training, clinical support tools, client materials, and data resources. Staff stated that **ICHP** distributed provider support materials through the **ICHP** provider Web site and through provider relations staff and care coordination teams working with individual practices. All tools are available to all providers. The Care Coordination Workgroup and Medical Management Committee provided guidance for the development or promotion of specific educational materials, provider tools, or member resources.

ICHP applied a comprehensive patient-centered medical home (PCMH) assessment to each PCMP in the network and reviewed gaps in PCMH performance, as defined in the Department's medical home standards, with the practice. **ICHP** used results of the practice assessment to define a customized plan for practice transformation activities within each PCMP, taking into consideration

each practice's defined priorities and readiness to transition specific medical home functions. **ICHP** staff members were actively engaged with practice managers within each practice, and RCCO staff also met quarterly with all practice managers in the region to evaluate progress and needs related to practice transformation.

Activities and Progress

Staff stated that collaboration with the Department to resolve issues related to timely enrollment of providers, correcting attribution of members to PCMPs, extending Medicaid eligibility for children to one year, and HealthColorado's transition to electronic attribution requests have all been very helpful in resolving provider frustrations with Medicaid systems. **ICHP** developed tools such as referral protocols to enhance referral communications between providers, and monthly member roster lists to assist PCMPs. Pediatricians' fears that their Medicaid rolls might be overwhelmed with the surge of new children entering the Medicaid system in 2013 have subsided. Staff stated that the RCCO's liaison role with the Department and resolution of problems on behalf of PCMPs contributed to the credibility of the RCCO with PCMPs.

ICHP hosted quarterly meetings with practice managers to identify additional practice support needs and to share technical support resources. Development of practice support materials was prioritized according to specific community population needs or was aligned with focused **ICHP** projects and program initiatives, which included the PCMP co-pay voucher program, the National Governor's Association Super-Utilizer pilot program, medical neighborhood block parties/seminars to promote community-wide depression screenings, and community-developed behavioral and physical health integration projects related to adults with diabetes, children with diabetes, and pain management/opioid use.

ICHP offers members and providers the Achieve Solutions online library of information, which includes over 3,000 articles on more than 200 health topics, including self-screening and self-management tools. **ICHP** identified and highlighted Achieve Solutions content related to specific **ICHP** initiatives such as diabetes, depression, and pain management and content pertaining to the special Medicaid expansion populations such as full benefit Medicare-Medicaid enrollees (FBMME), human immunodeficiency virus (HIV), children, and members with chronic mental illness. Achieve Solutions and other member materials were promoted to providers through newsletters and may be downloaded by practitioners to give to members. Tracking reports show that hits to the Achieve Solutions library have been continuously increasing.

ICHP developed an Internet-accessible software system, "I Can Help People" (ICHP) to provide an integrated care coordination record to all PCMPs, community mental health centers (CMHCs), care coordinators, select community organizations, and other providers involved with RCCO members. **ICHP** made continuous improvements to the system from its inception. Use of the software, which is readily accessible to all providers, has steadily increased and staff reported that approximately 50 percent of PCMPs are actively using the system.

ICHP conducts internal practice manager transformation meetings within each PCMP to evaluate the status of progress toward PCMH functions. Staff stated that the performance of each practice evolves year to year and results in revisions to individual transformation plans. **ICHP** engaged Colorado Children's Healthcare Access Program (CCHAP) to conduct customized pediatric

practice assessments and to establish individualized practice growth plans with each practice. Staff stated that access to and use of data is a core component of every PCMP transformation plan. Integrated behavioral health/physical health RCCO care coordination teams provide support to all PCMPs for management of complex care coordination cases. This support service is considered a significant asset in PCMPs' abilities to function as PCMHs. Staff stated that, with the administrative and care coordination support of the RCCO, approximately 85 percent of Region 4 members are assigned to PCMH-functioning PCMPs. **ICHP**'s Medical Management Committee was exploring the concept of a five-step tiered program for development of PCMPs into true integrated care providers.

Summary of Provider Support Tools

ICHP provided a wide array of clinical and operational practice support tools, client materials, and data resources to PCMPs, including most outlined in the RCCO contract. Many materials were available through the **ICHP** Web site, although the primary method of distribution was through the community-based care coordination teams, quarterly practice manager meetings, or community-based trainings conducted throughout the region. In addition, **ICHP** developed clinical tools aligned with their participation in numerous innovative projects and contributed significant resources to the development of data systems and reports to support PCMPs. Practice support resources included:

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

- Clinical care guidelines and best practices
- Clinical screening tools, such as depression screening tools and substance-use screening tools
- Health and functioning questionnaires
- Chronic care templates
- Registries
- Other: **ICHP** care coordination software system

Client Materials—**5 of 6 of the categories of tools listed in the RCCO contract**:

- Self-management tools
- Educational materials—specific conditions
- Client action plans
- Behavioral health surveys and other self-screening tools
- Other: Transition of Care member packets

Operational Practice Support—**8 of 9 of the categories of tools listed in the RCCO contact:**

- Guidance and education on the principles of the medical home
- Training on providing culturally competent care
- Training to enhance the health care skills and knowledge of supporting staff
- Guidelines for motivational interviewing
- Tools and resources for telephone call and appointment tracking

- Tools and resources for tracking labs, referrals, and similar items
- Referral and transitions of care checklists
- Visit agendas or templates

Data, Reports, and Other Resources—**5 of 5 of the categories of tools listed in the RCCO contract:**

- Expanded provider network directory
- Comprehensive directory of community resources
- Directory of other Department-sponsored resources, such as the managed care ombudsman and nurse advice line
- Link from main ACC Program Web site to the Contractor's Web site of centrally located tools and resources
- Other: **ICHP** care coordination software and **ICHP** dashboard

Observations/Recommendations

Medicaid administrative processes have resulted in periodic concerns among providers throughout 2013 and 2014. **ICHP** staff responded to the concerns by educating and assisting PCMPs to resolve issues and by acting as a liaison with the Department to communicate and collaboratively resolve PCMP concerns. **ICHP** staff stated that most issues were resolved and that PCMPs perceive the RCCO's ability to act on their behalf with the Department as a positive attribute of the RCCO program. Diverse **ICHP** staff members were actively engaged in providing practice support tools and trainings to PCMPs and assisting practices in transforming to functioning medical homes. **ICHP**'s quarterly practice management meetings provided direction to the RCCO regarding needs for specific practice support processes and assisted with the dissemination of information and implementation of best practices in PCMPs across the region. The integrated behavioral health/physical health care coordination teams, operating in diverse geographic areas throughout the region and supporting all PCMPs, significantly advanced the ability of PCMPs to perform as PCMHs. **ICHP** made significant progress in the organization of practice support resources and development of customized practice transformation plans appropriate for each PCMP.

ICHP's participation in numerous innovation grants and special projects generated the development of clinical tools to support these programs. In addition, the **ICHP** software system provided significant support for care coordination of members throughout the region. **ICHP** provided a variety of client materials and operational support tools to practices, including nearly all outlined in the RCCO contract. Many client resources were available to members through the Achieve Solutions online library of thousands of educational articles, self-screening tools, and self-management tools. Many operational support tools and trainings were available through the **ICHP** Web site, although the primary method of distribution was through the community-based care coordination teams, quarterly practice manager meetings, or community-based training sessions held throughout the region. **ICHP** also provided a variety of data resources to practices. PCMP access to and use of data has been a significant commitment of **ICHP** since inception of the RCCO. Statewide Data Analytics Contractor (SDAC) training, ongoing development of helpful reports and dashboard data for PCMPs, and the development and continued enhancement of the innovative **ICHP** software system for tracking member care across multiple providers and agencies have been

significant contributions to PCMP support in a predominantly rural region with many small practices.

Provider Network Development

Activities and Progress

Staff reported that, during 2013, the Medicaid population in Region 4 increased 53 percent to nearly 70,000 members, and the number of practices in the network increased 17 percent, including 15 new PCMPs. **ICHP** had 93 PCMP practices with a total of 287 providers serving the 19-county region. The majority of providers were accepting new Medicaid members. **ICHP** was contracted with most major Medicaid providers in the region. The targeted provider list included nine FBMME practices and one pediatrics practice. **ICHP** had a well-defined continuum of provider recruitment activities that included reaching out to providers to explain the ACC program, discussing Medicaid expansion, and offering **ICHP** support with management of Medicaid members. The Region 4 geographic area is aligned with the behavioral health organization (BHO) network in the same region, enabling a unique partnership between the CMHCs and PCMPs for care coordination activities. Staff stated that **ICHP** supports providers with training, data resources, and care coordination resources that many PCMPs would not otherwise have. Although the majority of Medicaid expansion population members were unattributed, staff stated that many of the adults in the expansion populations were existing members of network providers. Therefore, RCCO staff encouraged practices to maintain open Medicaid panels so that these members could be successfully attributed to PCMPs. **ICHP** implemented mechanisms to assist with attribution of members to the appropriate PCMPs. Staff stated that, overall, the major impact of Medicaid expansion on the provider network has been the providers' ability to receive payment for existing patients who were previously uninsured.

To address the needs and services for the special expansion populations, **ICHP** was working on recruiting the internal medicine practices identified by the Department to support the FBMME population. Staff noted that FBMME members tend to be high utilizers requiring increased care coordination and who have existing relationships with specialists and community organizations that need to be considered. **ICHP** intended to operationalize services for FBMME members on a local community basis, using systems and community and provider relationships already in place. Staff stated that providers for the FBMME population appear willing to participate in the program as long as RCCO support resources remain available. **ICHP** retained the services of CCHAP to support pediatric practices with influx of new Medicaid children, including foster children, into practices in 2013. Region 4 is geographically located in areas with an inordinately high number of persons being released from the corrections system. The regional BHO and RCCO are working collaboratively to ensure identification of members and access to care for parolees. Many members of this population were pre-existing patients within the FQHCs. However, **ICHP** is working with the Department of Corrections and with select counties on a pilot basis to enable early identification of members being released from facilities, referral to care coordination for transportation, and appointment arrangements. **ICHP** has also simultaneously engaged in many focused initiatives and pilot programs to address additional high-priority needs within the region, including adults and children with diabetes, superutilizers, depression screening, and pain management and opiate use.

ICHP was pursuing the concept of developing community-based medical neighborhoods that engage diverse providers and community organizations that have existing relationships within their respective communities. The local integrated care coordination teams are well-positioned to identify and foster relationships among the participants in the medical neighborhoods. **ICHP** staff traveled to many communities throughout the region in 2013 to engage medical neighborhoods in participating in special initiatives related to specific community-based population needs. **ICHP** used surveys of specialists to identify gaps in specialist services within various geographic areas and to develop referral protocols based on "what specialists want" from referring providers and Medicaid members. In order to address gaps in specialist services, **ICHP** was exploring the Extension for Community Healthcare Outcomes (ECHO) tele-health program and other innovative approaches. **ICHP** did not envision the need to structure formal agreements between medical neighborhood participants unless it is necessary for sharing of member information.

Summary of Provider Network Capacity Analysis

Preliminary results of the Excel Pivot Table analysis of the provider network for Region 4 were presented to **ICHP** staff during the on-site review. HSAG explained the methodology of Pivot Table analysis used to eliminate duplicate entries of providers or locations within the overall region and by county. HSAG explained that the lack of data integrity in the source document provided by the Department rendered the accuracy of the actual data results unreliable, and the reports could only be used to indicate the potential of using a Pivot Table approach to analyze provider capacity. During on-site discussions, **ICHP** stated that the capacity of PCMPs to integrate an increasing number of Medicaid members was based on a number of variables, including the "illness burden" of members. Staff suggested that the shift in needs of Medicaid members due to expansion populations might also make it difficult for PCMPs to assess capacity for Medicaid members. In addition, providers are generally unaware of their practice capacity, and individual providers define capacity inconsistently. Staff suggested that wait times for appointments may be a better measure than "slots" available for new Medicaid members. Staff emphasized that any meaningful measure of true capacity in the provider network would need to consider many variables and that the value of such a measure might be further considered by the Department.

Observations/Recommendations

ICHP remained actively involved with the recruitment of appropriate PCMPs into the provider network. Since most Medicaid providers in the region have been contracted, **ICHP** concentrated on contracting with select PCMPs such as FBMME providers and was working with PCMPs to maintain open panels for addition of unattributed members of the Medicaid expansion populations. **ICHP** staff members were not concerned about current capacity of the provider network to serve the needs of the Medicaid population in the region. **ICHP** appeared to have thoughtfully considered the impact of Medicaid expansion on the provider system in the region. **ICHP** has enthusiastically engaged in numerous initiatives to address the unique challenges presented by Medicaid expansion, particularly related to attribution of members, the FBMME and corrections populations, and other special needs of Medicaid members in the region. Most initiatives involved the integration of mental health and physical health services enabled by collaboration of the RCCO and the BHO and facilitated by the integrated care coordination teams. **ICHP** was also evaluating specialist relationships and gaps in specialist services within the region and was exploring multiple innovative approaches to improve access to specialist services for Medicaid members. **ICHP** staff had a clear

vision of building medical neighborhoods within local communities and acted on this plan by establishing care coordination teams within communities across the region, engaging diverse community providers to participate in focused RCCO initiatives, and providing training programs and seminars for multiple agencies and providers across the region.

Care Coordination

Activities and Progress

ICHP care coordination teams consisted of a care coordinator from the FQHC and one from the CMHC functioning as integrated care teams (ICTs) in geographically diverse communities across the region. Furthermore, the CMHC care coordination teams also support all independent PCMPs within the network. **ICHP** provides the financial support and direction for all RCCO care coordination personnel and activities. All PCMPs are supported by care coordination teams in the management of complex care coordination members. In addition, each local care coordination team identified and engaged with community organizations and other providers within their geographic area and facilitated RCCO projects, developed innovative care coordination approaches, and fostered partnerships within each community. A region-wide Care Coordination Operations Group met monthly to share best practices and to provide a conduit for communication between local communities and providers and the RCCO. A risk stratification algorithm assigned members to one of four care coordination tiers based on a member's total annual cost, ER visits, and inpatient hospitalizations. All Tier 4 members were targeted for in-depth needs assessment. Members could also be assigned for care coordination due to the need for transitions of care, referral from a PCMP or community organization, or because the member belonged to a vulnerable population (e.g., foster care). Staff also stated that population-based care coordination, focused on actively managing specific groups in the population (e.g., members with chronic pain or diabetes), showed significant potential in managing member outcomes. **ICHP** developed a comprehensive assessment of medical, behavioral, social, cultural, and community service needs, which was integrated into some of the care coordination documentation systems. However, because FQHCs and other PCMPs may have pre-established assessment and care coordination records embedded in their electronic record systems, some care teams used other assessment tools combined with documentation of the member's psychosocial history, medical history, and other important data as the basis of comprehensive assessment. In 2013, **ICHP**'s CMHC partner providers developed the Integrated Registry of Care (IROC) that incorporates the **ICHP** software system, the **ICHP** tier system, and other meaningful data sources into a real-time dashboard to support care coordination. **ICHP** began pilot testing the system in April 2014 with the largest CMHC provider and intends to expand the system to the other ICTs upon completion of the pilot. The Web-based **ICHP** software system allows providers to enter notes and alerts (that are visible to all other providers involved with the member) related to member activities and needs. The **ICHP** software has been continuously upgraded in functionality, and **ICHP** is consistently evaluating the system's application to new populations and special member tracking needs. **ICHP** had well-defined transition of care protocols for planning and follow-up with members moving from one care setting to another. The two largest hospitals in the region transmit daily ACC member census reports, including emergency room (ER) visits, to the RCCO. In addition, the Colorado Regional Health Information Organization (CORHIO) will provide RCCO access to real-time admit, discharge, and transfer (ADT) information for 8 of 14 hospitals in the region, effective June 2014.

The significant increase in Medicaid-eligible members over the past year resulted in the commitment of an increased number of RCCO care coordinators. In addition, most Medicaid expansion members were unattributed to PCMPs, so **ICHP** committed special care coordination resources to contact unattributed members with a high tier ranking and assist them with attribution and care coordination. **ICHP** anticipated that the FBMME population will tend to have higher tier rankings and that ICTs will need to identify and develop relationships with a number of new agencies and specialty providers associated with these members. Similarly, **ICHP** is pursuing relationships with providers and agencies associated with the corrections population, members with HIV, and other special expansion populations. **ICHP** is examining possible shifts in mechanisms for information exchange to enable effective care coordination among these various entities. In addition to the RCCO-defined Key Performance Indicators (KPIs), **ICHP** has been collecting 11 measures of care management outcomes and trending these measures by geographic area and PCMP since January 2012. Staff stated that the value of these outcome measures is yet to be determined.

Summary of Record Reviews

The Department selected the original sample of care coordination records using SDAC data to identify cases that appeared to have complex medical or medical/behavioral diagnoses, were high utilizers, or involved transition of care, including a cross-section of children. In addition to the sample identified by the Department, each RCCO was asked to identify an oversample of 10 records using its internal risk identification mechanisms and applying the same criteria. While on-site, HSAG determined that numerous records required exclusion from the sample because care coordination had not been performed and could not be evaluated. HSAG completed a total of 16 of 30 potential record reviews for Region 4, including 6 of the 20 from the original SDAC sample and all 10 oversample records. A summary of the reasons that records were eliminated from the record review sample is included in Appendix B.

HSAG scored 12 contract requirements for each care coordination record. Of the 192 elements reviewed in the 16 records, **ICHP** attained an overall score of 100 percent compliance with the care coordination contract requirements. Records in the sample included cases from each of the FQHC/CMHC integrated care teams in the region. Cases were documented in electronic care coordination files operated by the various FQHCs. The Spanish Peaks team and all independent PCMP practices were supported through the IROC software.

Other patterns noted in the record reviews included:

- A comprehensive needs assessment was documented in each care coordination record and identified needs appeared to be thoroughly addressed in the care coordination plan, based on the member's identified priorities.
- Although care coordination documentation systems varied between care teams, availability of essential behavioral health and physical health information was evident in all systems and substantiated the effectiveness of integrated behavioral health/physical health care teams.
- When a member's needs were primarily related to mental health, the CMHC care coordinator took the lead on care coordination, avoiding behavioral health confidentiality conflicts in the development of an integrated care plan.

- Most high-priority needs for members requiring complex care coordination were focused on social needs and required linking of members and sharing information with multiple community or social service resources.
- Particularly in rural communities, outreach and cooperative activities among multiple providers and community organizations seemed to be enhanced by the pre-established familiarity and working relationships among all entities.

Observations/Recommendations

ICHP's community-based behavioral and physical health care coordination teams appeared to be an effective model of care coordination for members with complex needs. Because complex needs members often receive services through both the CMHC and FQHC, the model allows for successful integration of mental health and physical health information and for effective care coordinator contacts with the member. When the member was able to be successfully engaged, care coordinators completed comprehensive health needs assessments and linked the member with community organizations, programs, and other agencies to address social support needs. This process was enhanced by familiarity of the care teams with local service providers. Local care coordination teams also facilitated relationships among community providers and organizations for special RCCO projects or development of innovative care coordination solutions responsive to unique community needs and cultures. **ICHP** was actively preparing for care coordination challenges that may be associated with the special expansion populations, including the development of relationships with additional community organizations, providers, and agencies typically engaged with those populations. **ICHP** committed additional care coordination resources to respond to increased volume and emerging needs presented by Medicaid expansion, including a process to incorporate unattributed members.

ICTs are a critical RCCO resource for the support of PCMHs, members, and communities. **ICHP** was actively involved in the development of mechanisms to obtain and share information with diverse community providers and agencies, including real-time ADT information. **ICHP** created and continuously upgraded the **ICHP** software system for tracking and communicating care coordination information among multiple providers and agencies without the need to systematically integrate with a variety of electronic record systems. The **ICHP** software system was implemented by a steadily increasing number of providers in the region and was an increasingly powerful tool for care coordination activities. The Integrated Registry of Care (IROC), implemented and tested by the Spanish Peaks ICT, demonstrated successful integration of comprehensive care coordination documentation from multiple sources into one care coordination record. **ICHP** continued to dedicate information technology personnel to the development and enhancement of information technology and data resources to support care coordination of members. As appropriate, HSAG recommended that **ICHP** pursue both expansion of these systems to include an ever-increasing number of providers and agencies and continued adaptation of the systems to support care coordination needs of special expansion populations.

Overview of Site Review Activities

The 2013–2014 site review represented the third contract year for the ACC Program. The Department asked HSAG to perform a site visit to assess each RCCO's progress made during the previous year of operations toward implementing the ACC Program. During the initial three years of operations, each RCCO has evolved in operational activities, care coordination efforts, and provider network development in response to continuous collaborative efforts, input from the Department, and ongoing implementation of statewide health care reform strategies. The 2013–2014 site visits were focused on monitoring provider support activities, evaluating the continued development of provider network capacity, and assessing the effectiveness of care coordination processes. HSAG was asked to identify key activities and progress made since the previous site review, and to offer observations and recommendations related to each of the ACC Program focus areas reviewed.

Site Review Methodology

HSAG and the Department met on several occasions to discuss the site review process and finalize the focus areas and methodologies for review. HSAG and the Department collaborated to develop data collection tools that provided the parameters for the RCCO site review process. Initial site review activities included a desk review of documents submitted by **ICHP** prior to the site visit. HSAG reviewed key documents, which consisted of program plans, provider support tools, and selected data reports. On-site review activities included a review of care coordination records. In addition, information was gathered during on-site interviews with key **ICHP** personnel using a qualitative interview methodology. The qualitative interview process uses open-ended discussions that encourage interviewees to describe their experiences, processes, and perceptions. Qualitative interviewing is useful in analyzing systems issues and associated desired or undesired outcomes. The purpose of the site review was to document compliance with select provider support and care coordination contract requirements, evaluate **ICHP**'s progress toward implementation of the ACC model of patient care, explore barriers and opportunities for improvement, and identify activities related to the integration of the Medicaid expansion populations. Data gathered from the desk review of **ICHP** documents, as well as interviewer discussion guides, provided the basis for the open-ended discussions essential to the qualitative interview technique.

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

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

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

Appendix A. Data Collection Tool

for Integrated Community Health Partners (Region 4)

The completed data collection tool follows this cover page.

Provider Support

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

Findings:

During 2013, ICHP providers experienced delays in the processing of RCCO provider enrollments by the Department. Staff members stated that providers were initially experiencing up to 90-day turnaround times in processing of paperwork by the Department, but that this time period has since been reduced to 2–3 weeks. In addition, some providers had no online access or experienced problems with login information. ICHP assisted providers with completing the electronic application and forwarded information to the Department. ICHP used the interim between submission of the provider enrollment and completion of the process by the Department to educate and orient providers to RCCO and PCMP responsibilities.

Staff stated that member eligibility issues improved since the transition by the State to 12 months of continuous Medicaid eligibility for children. ICHP was working with providers to conduct monthly reviews of PCMP Medicaid member rosters compared to the monthly attribution list from the Department and assisting providers with implementing necessary corrections. Staff anticipated that the reconciliation report from TREO and the Department's intent to process member attributions more frequently would further improve the attribution process. In addition, Health Colorado's transition to using electronic attribution requests from members and providers rather than fax forms and spreadsheets should enhance this process. Staff stated that the cumbersome attribution processes were very frustrating to providers but issues have been resolved and processes improved through collaborative efforts with the Department. Staff stated that because pediatricians feared the Medicaid expansion would overwhelm their practices with new Medicaid members, they established maximum capacity limits (caps) for Medicaid members. However, staff reported that fears had diminished, and most pediatricians had eliminated the caps. ICHP and its subcontractor, Colorado Children's Healthcare Access Program (CCHAP), had been educating and assisting PCMPs to analyze the true impact of Medicaid members on practices and the potential financial benefits of having an increased number of Medicaid enrollees in their practices.

Provider Support

Requirement	Desk Review/Discussion Items	Score
Staff stated that some PCMPs were confused by the per-member-per-month (PMPM) payment for ACC members as opposed to traditional Medicaid members. ICHP advised providers: to check ACC eligibility for all Medicaid members and encourage members, as appropriate, to join the ACC; and to process ACC member enrollment forms during the office visit. Staff stated that confidence in the PMPM payment mechanisms increased as more Medicaid members from a practice enrolled in the ACC program. ICHP had not received PCMP complaints regarding the amount of PMPM payments, citing that ICHP's care coordination model and provision of administrative support tools offset providers' concerns of being overburdened by RCCO responsibilities. Staff members stated that PCMPs had not expressed concerns with RCCO prior authorization procedures; however, home health agencies did. ICHP assisted PCMPs as necessary with referrals to specialists and developed referral protocols to enhance referral communications between specialists and PCMPs. Overall, ICHP staff were readily accessible to PCMPs to resolve Medicaid and ACC administrative issues and to represent PCMP concerns with the Department. Staff stated that the RCCO's liaison role with the Department and resolution of problems on behalf of PCMPs contributed to the credibility of the RCCO with PCMPs.		
Observations/Recommendations: Medicaid administrative processes resulted in periodic concerns among providers throughout 2013 and 2014, most notably with the online provider enrollment system and delays in processing enrollments, as well as confusion regarding member ACC eligibility and accuracy of member attribution to PCMPs. However, ICHP staff responded by educating PCMPs and assisting them with resolving issues. ICHP also served as a liaison with the Department to communicate and collaboratively resolve PCMP concerns as necessary. ICHP staff stated that most issues were resolved and that PCMPs perceive the RCCO's ability to act on their behalf with the Department as a positive attribute of the RCCO program.		
2. The Contractor shall submit a Practice Support Plan, describing its annual activities, for Department review and approval. These practice support activities shall be directed at a majority of the PCMPs in the Contractor's region and may range from disseminating a practice support resource to its PCMP network to conducting formal training classes for PCMPs relating to practice support. *Contract:* *Exhibit A: 5.2.1*	◆ Practice Support Plan • How implemented • Evaluation of success ◆ Maintaining engagement of the majority of PCMPs ◆ Priority provider support plans (going forward)	☒ Met ☐ Partially Met ☐ Not Met
Findings: The ICHP Practice Support Plan and accompanying work plan outlined the 2013–2014 initiatives related to practice support, including: ◆ *Provider and staff training through face-to-face meetings and webinars on Medicaid processes, the SDAC dashboard, the ICHP*		

Provider Support		
Requirement	**Desk Review/Discussion Items**	**Score**

software system. ICHP staff held quarterly meetings with practice managers to identify additional practice support needs and to share technical support resources. Staff explained that frequent staff turnover in practices required ongoing re-training of office staff concerning RCCO processes.

- *Clinical tools such as clinical care guidelines, best practices for chronic conditions, screening tools, questionnaires, and registries*. ICHP provided mental health first aid and training in motivational interviewing. ICHP clinical guidelines focused on priorities specific to Region 4 and were often associated with special programs and grant initiatives in the region.
- *Client materials posted on the ICHP Web site and distributed to PCMP providers for their use with members*. The Achieve Solutions Web site, linked to the member section of the ICHP Web site, contained self-management tools and assessments that members may access at their convenience. The Member Affairs Committee and Member Advocates/Stakeholders Committees provided feedback to ICHP concerning the most useful self-management and self-screening tools for members.
- *Data and other resources such as SDAC dashboard training, availability of KPI reports and incentive payments to PCMPs, and PCMP roster reports*. The ICHP software system, available to all PCMP providers through the Internet, enabled providers to communicate, track, and report the care provided to members they serve.

Staff stated that provider support materials were distributed through the ICHP provider Web site or through provider relations staff or care coordination teams working with individual practices. ICHP used provider newsletters to promote availability of resources to PCMPs. The Care Coordination Workgroup and Medical Management Committee provided guidance for the development or promotion of specific educational materials, provider tools, or member resources. Tools were often aligned with specific strategic priorities or upcoming events. Materials and provider support activities were accessible to all PCMPs. Practice managers met collectively with RCCO staff quarterly to share best practice ideas and to identify tools that need to be developed for PCMP support. ICHP prioritized practice support tools according to the needs of local populations. ICHP attempted to use education and support resources already in the market so that providers receive information that can be consistently applied to all patient populations in their practice.

Observations/Recommendations:
The ICHP practice support plan outlined a variety of tools, materials, trainings, and data resources provided by the RCCO to support the PCMPs in practice performance. Tools were disseminated through care coordination teams, provider relations staff, or the ICHP Web site, and were accessible to all PCMPs in the network. ICHP staff also met quarterly with practice managers to identify additional practice support needs and to share technical support resources. Tools targeted for development were often aligned with Region 4 strategic program priorities.

Provider Support		
Requirement	**Desk Review/Discussion Items**	**Score**
3. The Contractor shall offer support to PCMPs and providers, which may include comprehensive guidance on practice redesign to providing assistance with practice redesign and performance-enhancing activities. *(Regions 2, 3, 5 only)* The Contractor shall conduct a needs assessment for each PCMP in the Contractor's PCMP network and provide tools to each PCMP, as necessary, based on the needs assessment, to increase the PCMP's readiness to become a more effective medical home for the Contractor's members. *Contract:* *Exhibit A: 5.2.2*	*(All RCCOs)* ◆ RCCO activities implemented to assist providers in practice redesign • Specific activities • Number of providers • Resources dedicated • Mechanisms used • Monitoring mechanisms ◆ Medical home functions provided through the RCCO ◆ Medical home functions provided by the PCMPs *(Regions 2, 3, 5 only)* ◆ Medical home needs assessment for PCMPs • Proportion of PCMPs assessed • Specific medical home functions assessed • Specific assessment mechanisms • How assessment results are applied within the RCCO	☒ Met ☐ Partially Met ☐ Not Met

Findings:

ICHP applied a comprehensive patient-centered medical home (PCMH) assessment to each PCMP in the network. Provider relations personnel assessed practices on enrollment and reviewed with the practice gaps in PCMH performance, as defined in the Department's medical home standards. ICHP staff used results of the practice assessment to define a customized plan for practice transformation activities within each PCMP, taking into consideration each practice's defined priorities and readiness to transition specific medical home functions. Staff stated that access to and use of data by the practice was a core component of every PCMP transformation plan but that each practice established its own plan beyond the data component. ICHP engaged CCHAP to conduct a practice assessment customized to pediatric practices and to establish an individualized practice growth plan with each practice. ICHP conducts internal practice manager transformation meetings with each PCMP to evaluate when a provider has met, partially met, not met, or never will meet specific PCMH functions. Staff stated that the assessment of each practice evolves year to year, resulting in changing goals and approaches in individual transformation plans. The ICHP Practice Engagement Workflow documented a progressive approach for engaging with practices, beginning with assisting providers with contracting, followed by practice assessment and orientation, assignment of a practice transformation team to address identified gaps and priorities, and regular follow-up by provider

Provider Support		
Requirement	**Desk Review/Discussion Items**	**Score**
relations personnel. ICHP's Medical Management Committee was exploring the concept of a five-step tiered program for development of PCMPs into true integrated care providers. Staff stated that, due to the generally poor economic conditions across the region, it is not difficult to convince providers to take advantage of RCCO support services. However, staff described that there is a "critical mass "of Medicaid members within a practice required to stimulate a PCMP to actively engage in practice transformation. Staff explained that access to data to assist PCMPs in managing Medicaid members is an entirely new concept for most PCMPs, and that PCMPs have positively embraced the availability of RCCO data. RCCO staff members provide on-site orientation to data reports, with multiple follow-up visits. Integrated behavioral health and physical health RCCO care coordination teams provide support to all PCMPs for management of complex care coordination cases. In addition, approximately 50 percent of the PCMPs were participating in the I Can Help People (ICHP) software system to support care coordination of members. Staff stated that, with the provision of care coordination and administrative support from the RCCO, approximately 85 percent of Region 4 members were assigned to PCMH-functioning PCMPs. ICHP staff also believed that the development of medical neighborhoods in communities will positively affect any gaps in PCMH functions.		
Observations/Recommendations: ICHP was actively engaged with each PCMP to assess PCMH capabilities and develop a customized practice transformation support plan based on the priorities and readiness of each practice to transform practice functions. Individualized PCMP transformation plans evolve from year to year with each practice's accomplishments and changing goals. ICHP staff members were engaged with practice managers within each practice, and RCCO staff also met quarterly with all practice managers in the region to evaluate progress and needs related to transformation. ICHP care coordination teams supported all PCMPs in the performance of care coordination for complex need members, significantly advancing the ability of PCMPs to perform as PCMHs. The participation of large FQHCs in the ICHP network contributed to ICHPs assessment that 85 percent of Medicaid members receive care through functioning PCMH providers.		

Provider Support

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

Findings:

ICHP submitted evidence of numerous types of clinical guidelines, educational resources, and clinical assessments and screenings. Many clinical care guidelines and other clinical support tools focused on priorities, special programs, or grant initiatives of Region 4, such as diabetes management for adults and children, chronic pain management, PCMP depression screenings, asthma, well-child visits and immunizations, and chronic mental illness. Care coordinators accumulated guidelines in a secure Google Web site, and numerous tools were available to providers on the ICHP Web site. Tools and resources customized for the pediatrics population were also available online or through CCHAP provider support personnel. ICHP promoted availability of and access to clinical tools through provider newsletters.

The Internet-accessible ICHP software system was developed to provide an integrated care coordination record to providers and was readily available to all PCMPs, CMHCs, care coordinators, select community organizations, and other providers involved with RCCO members. Staff stated that system use steadily increased over the past year, with approximately 50 percent of practices actively using the system. Staff also described ICHP's participation in numerous special programs and innovative initiatives to improve systems of care for focused populations, including the PCMP co-pay voucher program, the National Governor's Association Super-Utilizer pilot program, medical neighborhood block parties/seminars to promote community-wide depression screenings, and community-

Provider Support

Requirement	Desk Review/Discussion Items	Score
developed behavioral and physical health integration projects related to adults with diabetes, children with diabetes, and pain management and opioid use. Staff stated that ICHP developed additional clinical tools and other resources associated with these programs, including enhancement of information systems such as patient registries for pain management and adults with diabetes. ICHP also developed a tracking registry for children with diabetes to monitor compliance with American Diabetes Association (ADA) guidelines and well-child visit guidelines. ICHP made enhancements to the ICHP software system and was considering additional enhancements to assist with region-wide, multi-disciplinary monitoring of specialized populations.		
Observations/Recommendations: ICHP provided a variety of clinical support tools to practices, including all outlined in the RCCO contract. ICHP's participation in numerous innovation grants and special projects generated development of clinical tools to support these programs. In addition, the ICHP software system provided significant support for care coordination of members throughout the region.		
5. The Contractor shall provide tools to the PCMPs and providers that may include any of the following: Client Materials: ◆ Client reminders ☐ Yes ☒ No ◆ Self-management tools ☒ Yes ☐ No ◆ Educational materials—specific conditions ☒ Yes ☐ No ◆ Client action plans ☒ Yes ☐ No ◆ Behavioral health surveys and other self-screening tools ☒ Yes ☐ No ◆ Other: Transition of Care member packets ☒ Yes ☐ No *Contract:* *Exhibit A: 5.2.2.2; 5.2.1.1 through 5.2.1.3*	*Desk Review:* Samples, Internet links, or any documents which illustrate the specific types of tools being provided to PCMPs *Discussion:* ◆ How tools are disseminated ◆ Frequency of use by providers ◆ Determining effectiveness of tools ◆ Determining priorities for tools ◆ Tools in development/future plans	☒ Met ☐ Partially Met ☐ Not Met
Findings: The ICHP Web site member page included downloadable self-management and chronic disease education materials. The Web site included a link to the Achieve Solutions online library of information, including over 3,000 articles covering more than 200 health topics including self-screening tools. ICHP identified and highlighted Achieve Solutions content related to specific ICHP initiatives such as diabetes, depression, and pain management and content pertaining to special needs of Medicaid expansion populations such as full benefit Medicare-Medicaid enrollees (FBMME), human immunodeficiency virus (HIV), children, and members with chronic mental illness. The Member Affairs Committee and the Member Advocates and Stakeholder Committee review		

Provider Support

Requirement	Desk Review/Discussion Items	Score
client materials and determine which topics to include on the ICHP Web site. ICHP promoted Achieve Solutions and other member materials to providers through provider newsletters. Practitioners may download the materials to give to members. ICHP tracks the number of Web site hits by topic area and specific content area quarterly to determine trends in member interests. Staff stated that trends appear to be associated with topic areas being strategically promoted through the newsletter. In addition, ICHP developed member materials in conjunction with preventive outreach programs to members at risk for breast cancer, diabetes, prostate cancer, and postpartum depression. ICHP made over 11,000 outreach calls to members in 2013. ICHP was pilot testing a transition of care protocol with members being discharged from Parkview hospital. The members were provided a packet of information to stimulate consideration of what they will need to care for themselves after discharge. CCHAP was developing a similar protocol specific to discharge of premature-birth babies. Staff stated that PCMPs have not requested ICHP to provide client reminder materials for mass distribution.		
Observations/Recommendations: ICHP provided a variety of client materials and support tools to practices, including most of those outlined in the RCCO contract. Many client resources were available to members through the Achieve Solutions online library of thousands of educational articles, self-screening tools, and self-management tools, which could be downloaded and printed by PCMPs to distribute to members.		
6. The Contractor shall provide tools to the PCMPs and providers that may include any of the following: Operational Practice Support: ◆ Guidance and education on the principles of the medical home ☒ Yes ☐ No ◆ Training on providing culturally competent care ☒ Yes ☐ No ◆ Training to enhance the health care skills and knowledge of supporting staff ☒ Yes ☐ No ◆ Guidelines for motivational interviewing ☒ Yes ☐ No ◆ Tools and resources for telephone call and appointment tracking ☒ Yes ☐ No ◆ Tools and resources for tracking labs, referrals, and similar items ☒ Yes ☐ No ◆ Referral and transitions of care checklists ☒ Yes ☐ No	*Desk Review:* Samples, Internet links, or any documents which illustrate the specific types of tools being provided to PCMPs *Discussion:* ◆ How tools are disseminated ◆ Frequency of use by providers ◆ Determining effectiveness of tools ◆ Determining priorities for tools ◆ Tools in development/future plans	☒ Met ☐ Partially Met ☐ Not Met

Provider Support

Requirement	Desk Review/Discussion Items	Score
◆ Visit agendas or templates ☒ Yes ☐ No ◆ Standing pharmacy order templates ☐ Yes ☒ No ◆ Other ☐ Yes ☒ No *Contract:* *Exhibit A: 5.2.2.3; 5.2.1.1 through 5.2.1.3*		

Findings:

The ICHP Web site provider page included medical home education information and links to PCMH certification information, links to the Department Web site, multiple consent forms and forms for PCMP choice or discharge from the PCMP, practice assessment education and checklists, and provider and practice staff trainings and newsletters, including videos, PowerPoint presentations, and webinars on multiple topics. ICHP also submitted examples of practice improvement tools, such as missed appointment tracking and care coordination tools that are maintained in the secure Google online library and distributed to providers as needed. ICHP also distributed medical home development tools to practices at care coordination team meetings and quarterly practice manager meetings. ICHP conducted PowerPoint trainings for providers related to the Americans with Disabilities Act (ADA), motivational interviewing, and cultural competency, and implemented a rotating schedule for special topic trainings throughout the region.

Observations/Recommendations:

ICHP provided a variety of operational practice support tools, including most of those outlined in the RCCO contract. Many materials were available through the ICHP Web site, although the primary method of distribution was through the community-based care coordination teams, quarterly practice manager meetings, or community-based trainings conducted throughout the region.

7. The Contractor shall provide tools to the PCMPs and providers that may include any of the following: Data, Reports, and Other Resources: ◆ Expanded provider network directory ☒ Yes ☐ No ◆ Comprehensive directory of community resources ☒ Yes ☐ No ◆ Directory of other Department-sponsored resources, such as the managed care ombudsman and nurse advice line ☒ Yes ☐ No ◆ Link from main ACC Program Web site to the Contractor's Web site of centrally	*Desk Review:* Samples, Internet links, or any documents which illustrate the specific types of tools being provided to PCMPs *Discussion:* ◆ How tools are disseminated ◆ Frequency of use by providers ◆ Determining effectiveness of tools ◆ Determining priorities for tools ◆ Tools in development/future plans	☒ Met ☐ Partially Met ☐ Not Met

Provider Support		
Requirement	**Desk Review/Discussion Items**	**Score**
located tools and resources ◆ Other: ICHP care coordination software and ICHP dashboard ☒ Yes ☐ No *Contract:* *Exhibit A: 5.2.2.4*		

Findings:

The ICHP Web site included a searchable PCMP database and listing of urgent care facilities in the region, a detailed Colorado Community Resource Directory, and links to many different pages on the Department's Web site (ACC, Medicaid Provider Services, Ombudsman, Medicaid Providers, SDAC, EPSDT). Staff stated that PCMP training for use of the statewide data analytics contractor (SDAC) reports was initiated through Treo Solutions and followed up by ICHP management. ICHP implemented a regular schedule for SDAC trainings throughout the region. In addition, information technology personnel conducted training for provider participation in the ICHP software system and the ICHP dashboard. The ICHP software system provides care coordination communications and member tracking for practices without sophisticated electronic health record systems. The ICHP dashboard provides member data to behavioral health providers who do not have access to the SDAC reports. ICHP was developing a mechanism to provide monthly PCMP-specific KPI reports to each practice. Staff stated that use of data systems and reports is a fundamental component of PCMH performance and practice transformation activities. As such, ICHP was committed to ongoing development of data systems and reports to assist in performance enhancement.

Observations/Recommendations:

ICHP provided a variety of data resources to practices, including all outlined in the RCCO contract. PCMP access to and use of data has been a significant commitment of ICHP since inception of the RCCO. SDAC training, ongoing development of helpful reports and dashboard data for PCMPs, and the development and continued enhancement of the innovative ICHP software system for tracking member care across multiple providers and agencies have been significant contributions to PCMPs in the predominantly rural region.

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

Total Score ÷ Total Applicable	=	100%

Follow-up—Provider Network Development

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

Discussion:

The network adequacy report stated that ICHP had contracted with 15 additional PCMPs that either represented an area of specialty need (e.g., pediatrics) or served an inordinate number of Medicaid beneficiaries. At the time of on-site review, staff reported that during 2013, the Medicaid population in Region 4 had increased 53 percent to nearly 70,000 members, and the number of practices in the network had increased by 17 percent. ICHP had 93 PCMP practices with a total of 287 providers serving the 19-county region. The network adequacy report stated that 236 providers were accepting new Medicaid members. In counties where members do not have access to an ICHP provider, providers in other RCCO networks are serving those members, and ICHP staff communicated with those RCCOs to ensure coordination of care for members. The report stated that the addition of a second provider in Baca County closed the gap in that area, and ICHP expected to complete contracting with additional practices in Trinidad and Las Animas counties. There were 10 PCMP clinics across the region that provided evening or weekend services. The Region 4 geographic area aligned with the BHO network in the same region, enabling a unique partnership between the community mental health centers (CMHCs) and PCMPs for care coordination activities. ICHP engaged PCMPs by reaching out to explain the ACC program, discuss Medicaid expansion, and offer support with Medicaid members. Staff stated that ICHP supports providers with training and care coordination resources that many PCMPs would not otherwise have. Although most of the major Medicaid providers in the region have been contracted, staff stated that ICHP only pursues quality providers who desire to be part of a reformed system of care. The targeted provider list included nine FBMME practices and one pediatrics practice.

Staff stated that provider capacity is growing in the region, as all FQHCs are expanding, CMHCs are integrating primary care providers into their clinics, and an increasing number of providers are coming into the region through residency programs. Although the majority of the Medicaid expansion population members were unattributed (nearly 21,000), staff stated that many of the adults in the expansion populations were already in the health care system and being treated by existing network providers. Therefore, RCCO staff encouraged practices to maintain an open Medicaid panel, so that expansion members already in practices can be successfully attributed to the PCMP. Staff stated that in 2013, pediatricians were fearful that the influx of children into the system would result in a disproportionate number of new Medicaid members and increased financial risk to practices. Many pediatricians closed or strictly limited their Medicaid panels. However, ICHP staff reported that providers have not experienced a negative impact and have since reopened their Medicaid panels.

Follow-up—Provider Network Development

On-site Discussion Topics	Pertinent Contract References
Observations: ICHP remained actively involved with the recruitment of appropriate PCMPs into the provider network. Since ICHP already has contracts with most Medicaid providers in the region, it concentrated on contracting with select PCMPs, such as FBMME providers, and began working with PCMPs to maintain open panels for addition of unattributed members of the Medicaid expansion populations. ICHP staff was not concerned about the current capacity of the provider network to serve the needs of the Medicaid population in the region.	
2. HSAG provider network capacity analysis results	*Contract:* *Exhibit A: 4.1.1; 8.1.1.1*

Discussion:

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

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

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

In order for Pivot Table analysis to be performed accurately, the data in the selected sort fields being used to identify duplicate information must be complete and strictly formatted. Empty fields, inconsistent spelling or punctuation, data in the wrong field, etc., will result in inappropriate identification of duplicate fields. During attempts at Pivot Table analysis, HSAG discovered that data field quality control had not been performed on the PCMP spreadsheet HSAG received from the Department. A cursory review of the source data noted numerous instances of inconsistencies or incomplete fields influencing the accuracy of the Pivot Table results. Due to the lack of data integrity in the source documents, HSAG cautioned ICHP staff that the specific data results could not be considered reliable, and the tables should only to be viewed as a preliminary insight into potential differences in network analysis results if duplicates were removed using Pivot Table methodology.

Detailed Pivot Table results, including county analysis and unique locations for care, are included in Appendix C of this report.

Follow-up—Provider Network Development

On-site Discussion Topics	Pertinent Contract References
HSAG total Pivot Table analysis: Total Pivot Table removals from source document: 29 Total unique providers in region: 226 Total unique providers accepting Medicaid: 210 The ICHP Network Analysis Report included a calculation of providers in the region displayed by county. For illustration, a comparison of Pivot Table results of individual providers in the region when displayed by county follows: ICHP Network Analysis Report: Total unique providers in the region: 529 HSAG Pivot Table analysis: Total unique providers in the region: 239 During on-site discussion, ICHP stated that the capacity of PCMPs to integrate an increasing number of Medicaid members was based on a number of variables, including the "illness burden" of new members coming into practices. Staff suggested that the shift in the needs of Medicaid members due to the expansion populations might make an assessment of Medicaid capacity difficult for PCMPs to predict. In addition, staff stated that providers generally are unaware of their practice capacity and that individual providers define capacity inconsistently. Staff suggested that perhaps wait times for appointments may be a better measure than "slots" available for new Medicaid members. In addition, staff stated that the configuration of the emerging medical neighborhoods in communities may adjust the burden on PCMPs, and that some of the primary care needs of special expansion populations might be met through other providers. For example, the FBMME population may have many of its needs met through specialists or community organizations. Staff emphasized that any meaningful measure of true capacity in the provider network would need to consider many variables and would require precise definitions and very consistent application across the RCCOs. Staff also suggested that the Department should perhaps carefully consider whether such an endeavor is a priority compared to other current RCCO commitments.	
Observations: Comparisons of preliminary Pivot Table analysis results to the ICHP network adequacy analysis report demonstrated that the methodologies used to analyze the provider network and/or the data used in making similar calculations were not consistent between the two approaches. Nevertheless, review of Pivot Table results stimulated discussions regarding the best methodology for defining and measuring true provider capacity for integrating new Medicaid members. ICHP noted that numerous variables, such as the illness burden of patients in practices, shifts in the mix of the Medicaid population due to the expansion, and the potential impact on PCMP capacity due to medical neighborhoods and participation of other providers in the provision of primary care services to some members, would need to be considered in the measurement of provider network capacity. In addition, staff agreed that any measure would need to be strictly	

Follow-up—Provider Network Development	
On-site Discussion Topics	**Pertinent Contract References**
defined and consistently applied across all RCCOs and PCMPs. Staff also suggested that, given the challenges of such an endeavor, the Department may want to evaluate the relative priority of measuring provider network capacity compared to other RCCO objectives.	
3. PCMP Network for expansion populations: ◆ Sufficiency of the network for expanding number of eligibles ◆ PCMP network configured to address the special needs of the following: • Full Benefit Medicare-Medicaid Enrollees (FBMME) • Disabled • Foster care • Adults without Dependent Children (AwDC) • Culturally diverse • Inmate population	*Contract:* *Exhibit A: 4.1.1; 4.1.6; 4.3.3*

Discussion:

During 2013, the overall Medicaid population in Region 4 expanded by 53 percent to 69,500 members; 21,000 members of the expansion population entered the RCCO as unattributed to a PCMP. With the assistance of the Department, ICHP identified unattributed members in the SDAC data and, as claims data became available, ICHP assigned members to a risk tier level. Care coordinators reach out to Tier 3 and 4 members to assist them in selecting a PCMP and to conduct a needs assessment. Staff stated that most Medicaid expansion members are existing patients of PCMPs throughout the region, even if they are not attributed. Therefore, ICHP sorted unattributed members geographically and sent lists of unattributed members to the care coordination teams and providers in respective geographic areas to identify a member's provider and get members attributed to the correct practice. Staff stated that the major impact of Medicaid expansion on the provider network has been the ability of providers to receive payment for existing patients that were previously uninsured.

To address the special needs and services of the FBMME population, ICHP was working on recruiting the internal medicine practices identified by the Department. Staff stated that many other FBMME members were already existing patients of PCMPs. Staff stated that ICHP was working with the Department to obtain data on the predicted number of eligible FBMMEs in the region or by PCMP, which would be very helpful in recruiting efforts and for preparing providers and the RCCO for integration of these members. Staff noted that FBMME members tend to be high utilizers and therefore will impact care coordination resources. In addition, members may have existing relationships with specialists and community organizations that need to be considered. ICHP will be supporting PCMPs in the completion of the individual service coordination plans (SCPs) required for the FBMME demonstration project, which will be resource-intensive and costly. Staff stated that providers for the FBMME population appear willing to participate in the demonstration project as long as RCCO support resources remain available. ICHP intended to operationalize services for FBMME members on a local community-wide basis and use systems and relationships already in place within communities.

Follow-up—Provider Network Development

On-site Discussion Topics	Pertinent Contract References

Likewise, most foster children are established patients within PCMPs throughout the region. ICHP has retained the services of CCHAP to support pediatric practices with the integration of new members and provision of necessary support services. CCHAP has developed guidelines and related resources for transitioning foster care children from youth to adult services that have been distributed to PCMPs through the provider newsletter.

Region 4 is geographically located in areas with an inordinately high number of persons being released from the corrections system. ICHP determined that the region's participation in the statewide transitions of care performance improvement project (PIP) will focus on the corrections population. Region 4 was working with the regional BHO to ensure identification of and access to care for parolees. Region 4 staff speculated that many members of this population are existing patients within the FQHCs. Staff stated that providers in the Pueblo area will establish business associate agreements (BAAs) with the Department of Corrections (DOC), enabling records from the corrections system to be compared to Medicaid membership files in order to identify members common to both systems. The ICHP software system may be used by state and county agencies to electronically alert providers and ICHP of members who are being released from the corrections facilities. In addition, ICHP was working with select counties on a pilot basis to identify RCCO-eligible parolees before they are released and connect the member to a RCCO care coordinator to conduct an assessment, and arrange for provider appointments and transportation for the member.

Staff stated that conflicting Medicaid policies and priorities and the Department's multiple innovation projects have been resource-consuming and made it challenging for RCCOs to achieve some of the initial objectives of the ACC. Nevertheless, ICHP simultaneously implemented many focused initiatives and pilot programs to address the diverse and high-priority needs of the RCCO members in their region, including: the National Governor's Association Super Utilizer project; a PCMP co-pay voucher system, approved by CMS; CMS mini-grants for depression screenings and diabetes management, which included medical neighborhood block parties (seminars) for depression screening and RCCO/BHO integration for both children and adult diabetes programs; RCCO/BHO integration to address opioid use and pain management; a RCCO/BHO/DOC collaborative for the transition of care PIP; development of a data dashboard to share ICHP SDAC data with the CMHCs; and continued enhancement of the ICHP software to support coordination of care and member tracking throughout the network.

Observations:
ICHP staff appeared knowledgeable about the impact of Medicaid expansion on the provider system in the region, and thoughtfully and enthusiastically engaged in numerous initiatives to address the unique challenges presented by Medicaid expansion. Staff stated that most members of the expansion populations are existing patients within the PCMPs. ICHP began care coordination initiatives to assist members with attribution to their existing PCMP and to provide care coordination for members who remain unattributed. Initiatives to address the unique challenges of integrating services for special expansion populations primarily focused on FBMME members and the corrections population. In addition, ICHP identified other priority needs of Medicaid members in their region and engaged providers and community organizations in programs to address depression screening, diabetes management, pain management, and abuse of opiate substances. Most initiatives involve the integration of mental health and physical health services, enabled by the collaboration of the RCCO and the BHO in the region, and facilitated by the physical and mental health care coordination teams.

Follow-up—Provider Network Development

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

Discussion:

ICHP supports the concept of community-based medical neighborhoods, which engage diverse providers and community organizations that have existing relationships within their respective communities. The Integrated Care Teams (ICTs), who provided care coordination support within various geographic areas, are well-positioned to identify and foster relationships among the participants in the medical neighborhoods. When gaps in the continuum of services are identified, ICHP and the medical neighborhood can work collectively to target and engage additional service providers. Staff stated that many of the smaller rural communities in the region have naturally-occurring medical neighborhood relationships. ICHP staff did not envision structuring formal agreements between medical neighborhood participants, unless necessary for sharing of member information. ICHP staff traveled to many communities throughout the region in 2013 to engage local medical neighborhoods to participate in depression screenings. ICHP also initiated efforts to re-build broken relationships between providers when necessary. Staff stated that, broadly defined, reform of the health care system and operationalizing medical neighborhoods requires positive relationships among multiple providers and agencies.

ICHP conducted a survey of PCMPs within five counties (Alamosa, Fremont, Prowers, Pueblo, and Rio Grande) in order to identify availability and gaps in specialist services, as well as to identify specific specialist providers being used by PCMPs. Survey results identified that unmet specialist needs varied by geographic area, although pain management specialist services were consistently needed in all areas. Staff stated that efforts to directly engage specialists is challenging due to hospital ownership of many specialty practices. ICHP used the Colorado Medical Society specialist survey regarding "what specialists want" from referring providers and Medicaid members. ICHP used survey results to guide development of written referral protocols that include provision of clinical information and pretesting by PCMPs, educating members on how to prepare for an appointment, and assisting members with transportation to scheduled appointments with specialists. In order to address gaps in specialist services, ICHP was exploring the Extension for Community Healthcare Outcomes (ECHO) tele-health program and other innovative approaches, such as subcontracting of specialists to rural areas. Long-term, ICHP and the RCCO Leadership Group

Follow-up—Provider Network Development	
On-site Discussion Topics	**Pertinent Contract References**
(RLG) are working with the Department and Colorado Medical Society to evaluate the potential for developing a transparent payment structure among providers and for measurement of outcomes by community.	
Observations: ICHP staff members had a clear vision of building medical neighborhoods within local communities and acted on this plan by establishing local care coordination teams within communities across the region, engaging diverse community providers in care coordination efforts or participation in focused special program efforts, and traveling to a number of geographic areas to invite participation by multiple agencies and providers in training programs and seminars. ICHP was researching specialist relationships and gaps in services within the region and was exploring multiple innovative approaches to improve access to specialist services for Medicaid members.	

Follow-up—Care Coordination

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

Discussion:

Care coordination structure: Region 4 is geographically aligned with the BHO in the region, and the governing structure of ICHP was designed as a partnership between the four FQHCs, the four CMHCs, and ValueOptions. From its inception, the ICHP care coordination model was designed as a collaboration between the FQHC care coordinators and the CMHC care coordinators to form an ICT to provide support to PCMPs in diverse geographic areas across the region. PCMPs are not formally delegated to perform care coordination, because all RCCO providers and clients are supported by the local ICT. While ICT staff members remain an integral component of each FQHC and CMHC, ICHP provides the financial support and direction for the ICTs. The Care Coordination Expectations document outlined the RCCO-wide standards for care coordination to ensure consistency in key operations. The Spanish Peaks care coordination team was also assigned to provide support to all independent PCMPs within the network, which represent approximately 40 percent of the care coordination workload for that team. Each local care coordination team identified and engaged with community resource providers within their area, and facilitated RCCO projects, developed innovative care coordination approaches, and fostered partnerships within each community. A region-wide Care Coordination Operations Group met monthly to share best practices and provide a conduit for communication between local communities and providers and the RCCO. At the time of review, ICHP was financially supporting 26 RCCO care coordinators and related activities. ICHP reported that the number of coordinators was expected to increase by an additional 13–14 staff during fiscal year 2014–2015.

Identification of members for care coordination: The ICHP Formal System of Care Coordination plan outlined the risk stratification algorithm for assigning members to one of four care coordination tiers based on data defining a member's total annual cost, number of ER visits, and number of inpatient hospitalizations. The plan stated that the algorithm and process may be modified in the future to best align with the SDAC Clinical Risk Groups (CRGs). The

Follow-up—Care Coordination

On-site Discussion Topics	Pertinent Contract References
ICHP Stratification Rationale document outlined the scoring structure for identifying members for care coordination from the SDAC data: total cost more than $20,000 (20 points); $10,000 to 20,000 (10 points); more than one hospitalization (10 points); more than 10 ER visits (20 points); and four to nine ER visits (10 points). Members could also be assigned to a higher tier by the PCMP due to the need for transition of care or because the member belongs to a vulnerable population (e.g., foster care). Care coordinators could also reassign a member to different tier if necessary. The plan described the care coordination activities that may be associated with each respective tier. All Tier 4 members are targeted for in-depth needs assessment. ICHP distributed member tier lists to each PCMP and CMHC for follow-up or referral to care coordination. ICTs identified shared members between the PCMP and CMHC, determined how each organization will provide support, and how care coordination will be implemented. Staff also stated that population-based care coordination, focused on actively managing specific groups in the population (e.g., members with chronic pain or diabetes), has shown significant potential in managing member outcomes. Staff noted that a population-health approach shifts the priorities for care coordination from Tier 4 to Tiers 2 and 3. Assessment: the PCMP or CMHC administered a comprehensive assessment to Tier 4 RCCO members at the time of tier placement, when changes occur in the member's condition, or when requested by a PCMP or CMHC. The ICHP Formal System of Care Coordination plan described multiple assessment tools. ICHP developed a comprehensive assessment of medical, behavioral, social, and community service needs (such as housing and transportation), as well as assessment of cultural needs and beliefs. PCMPs may also use other comprehensive assessment tools embedded in their EHR systems, such as the SF-12® or Hospitalization Admission Risk Monitoring System (HARMS-8), but also must include documentation of the member's psychosocial history, medical history, and other important data. Once assessed, needs are addressed in a care plan—developed with members and their families—that prioritize interventions based on the member-defined goals most likely to promote increased positive health outcomes. The care plan is updated on each member visit to the PCMP or care coordinator interaction with the member. Assessments of member needs are maintained in the care coordination record so that additional needs can be addressed when high-priority goals are met and to ensure that lower-priority needs are not overlooked. Staff stated that most high-priority needs of Tier 4 members are social needs, and that linking members with community and social service resources is critical to providing quality coordinated care. ICHP continuously builds a knowledge base of community care providers, case management agencies, and other available resources and services on a community-specific basis.	

Observations:
The structure of the ICHP community-based care coordination teams allows for behavioral, physical, and social support needs to be addressed in the care coordination plan. The health needs assessment tools were comprehensive. The tier stratification system identified all high-utilizer members for care coordination, and other complex needs members may be identified through the PCMPs, CMHCs, or other community organizations. Local care coordination teams facilitate relationships among community providers and organizations for special focus projects of the RCCO, as well as member care coordination. The ICHP care coordination system appeared to be comprehensive and effective for engaged members, inclusive of community-based resources, and responsive to unique community needs and cultures.

Follow-up—Care Coordination

On-site Discussion Topics	Pertinent Contract References
2. Expansion populations and coordination of care ◆ Impact of expanded RCCO-eligible populations or special needs groups on care coordination activities. Challenges and successes regarding: • Members who have a need for Home and Community-Based Services or other community-based services • Transition of care members • Complex cases that may require multiple services across the continuum of care • Members who have both behavioral and physical health needs • FBMME • AwDC • Foster care children • Integration of the inmate population ◆ Impact of expanded medical neighborhood relationships on the coordination of care: • At RCCO level • At PCMP level • How the RCCO/PCMP is organizing/cooperating to increase effectiveness of care coordination	*Contract—Regions 1, 4, 6, 7:* *Exhibit A: 6.4.3.1.2; 6.4.3.1.3; 6.4.3.2.3; 6.4.3.2.4; 6.4.3.3* *Contract—Regions 2, 3, 5:* *Exhibit A: 6.4.3; 6.4.5.1.2; 6.4.5.1.3; 6.4.5.2.3; 6.4.5.2.4; 6.4.5.3* *Contract—Regions 3 and 5:* *Exhibit A: 6.4.5.1.4*

Discussion:

Staff stated that the significant increase in Medicaid-eligible members over the past year resulted in the commitment of additional care coordination resources across the region. ICHP management anticipated staff resources would continue to increase from 24 to an estimated 38 staff in the upcoming year. Since members of the Medicaid expansion populations did not have sufficient claims history with the Department, the majority of expansion members remain unattributed to a PCMP. ICHP developed a tier report of all unattributed members, sorted geographically, that is distributed to all PCMPs in the respective geographic area to identify members in their existing practices that need to be attributed. In addition, ICHP committed care coordinator resources to attempt direct contact with members who have a Tier 3 or Tier 4 ranking, assist members with attribution to a PCMP, perform a needs assessment, and refer the member to the appropriate care coordination team when indicated.

Staff stated that the FBMME population tends to have higher service utilization and will therefore have higher tier rankings. In addition, the Service Coordination Plan (SCP) requirements for FBMME members are extensive and are anticipated to require significant care coordination resources. Staff noted that FBMME members may also have existing relationships with, or be receiving primary care services from, a number of community providers or specialists,

Follow-up—Care Coordination

On-site Discussion Topics	Pertinent Contract References
thereby necessitating the need to identify and develop relationships with a number of new agencies and providers. Similarly, ICHP was pursuing relationships with community providers and agencies related to managing the needs of the corrections population, members with HIV, and other special expansion populations. These expanded relationships will entail a shift in how information is exchanged among various organizations. However, staff stated that most members have an existing relationship (although unattributed) with PCMP practices, and that the ICHP FQHC/CMHC organizational structure and integrated mental health and physical health care coordination model is uniquely positioned to accommodate the needs of many of the special expansion populations.	
Observations: ICHP was actively engaged in preparing for the care coordination challenges that may be associated with the special expansion populations, including the development of relationships with additional community organizations, providers, and agencies. The community-based, geographically distributed ICTs can identify and respond to the high-priority needs of members residing in their geographic areas. ICHP has committed additional care coordination resources to respond to the increased volume and emerging needs presented by Medicaid expansion, including a process to incorporate unattributed members into the system. The ICTs are a critical RCCO resource for the support of PCMPs, members, and communities.	
3. Care Coordination Outcomes ◆ Systems/mechanisms used to coordinate information from multiple levels of care and delivery sites: • Sources of meaningful coordination of care information • Access to real-time member information ◆ Outcomes of care coordination efforts: • Defining effectiveness • Mechanisms for monitoring • RCCO level • PCMP level • Engaging multiple providers in improving outcomes	*Contract—All Regions:* *Exhibit A: 6.4.1* *Contract—Regions 1, 4, 6, 7:* *Exhibit A: 6.4.2; 6.4.3.1.6* *Contract—Regions 2, 3, 5:* *Exhibit A: 6.4.4* *Contract—Regions 3 and 5:* *Exhibit A: 6.4.5.1.7* *Contract—Region 2:* *Exhibit A: 6.4.5.1.6*
Discussion: The ICHP Formal System of Care Coordination plan stated that management of care transitions represents one of the most significant components in the ACC model. The plan defined transitions between various settings of care, including the movement of patients through various lifespan settings, such as transitions from adolescent to adult health care systems, the transition of members released from criminal justice systems, and transition of living arrangements for the elderly. The plan described that transition of care management included: provision of in-person follow-up; medication reconciliation; scheduling a PCMP visit;	

Follow-up—Care Coordination

On-site Discussion Topics	Pertinent Contract References

performing health risk/needs assessments, as appropriate; and communicating member transition of care information to the member's providers, institutions, and individuals involved. Staff stated that the two largest hospitals in the region transmit daily ACC member census reports, including ER visits, to the RCCO. In addition, 8 of the 14 hospitals in the Region will be interfacing with the Colorado Regional Health Information Organization (CORHIO) effective June 2014, which will provide RCCO access to real-time admit, discharge, and transfer (ADT) information. Staff stated that six hospitals agreed to work with the RCCO on information technology interfaces to create a chart link on ICHP members. Staff stated that rural hospitals readily share information with local care coordination teams due to pre-existing cooperative community and provider relationships.

The plan described that, in the absence of all participating organizations having the ability to share data electronically, many participating PCMP and CMHCs created their own solutions for sharing care coordination information, including encrypted e-mails, coordination of points of contact and verbal exchanges over the telephone, and other HIPAA-compliant alternatives. One such endeavor was the RCCO creation and implementation of the "I Can Help People" (ICHP) software system. This Web-based database allows providers to enter notes and alerts related to member activities and needs that are visible to all organizations involved with the member via secure login. During the on-site interview, staff demonstrated that the system has color-coded alerts categorized by ER/hospital encounters; care delivery activities, such as referrals, labs, and pharmacy orders; and member services encounters, such as eligibility confirmations and PCMP changes. Any organization/provider with a member claim is designated as automatically eligible for access to the member file. Participants can also apply for an approved login identification code, and PCMPs and care coordinators may access the system as frequently as they desire. Since inception, the system has been in a continuous state of revisions and improvements, including the ability to interface with large provider EHR systems, the ability for ADT data to auto-populate the files, and the ability for the care coordinators to document a member's hospital discharge plan or potentially link to the full care coordination plan. Staff reported that this system of alerts has been effective for PCMPs and care coordinators to identify "Doctor hoppers" and "ER shoppers," as well as create a multidisciplinary, multi-agency system for tracking care coordination. ICHP was considering developing flags for agencies involved with the care of special populations.

The ICHP Care Coordination Metrics Template Definitions document outlined 11 measures of care management interventions, such as number of members with completed assessments, number of members with an updated care plan, number of member receiving transition of care, number of members referred to community resources, etc. Staff stated that members flagged for outcome tracking included all Tier 3 and Tier 4 members, members with 30 or more prescriptions, members with more than six ER visits, members with no PCMP visit in the last12 months, and members diagnosed as having diabetes, asthma, depression, or anxiety. Outcome data were trended and compared by geographic area and by PCMP. ICHP has been measuring outcomes since January 2012. Staff stated that the value of these outcome measures was yet to be determined. ICHP also continued to work with its PCMPs and CMHCs, as well as the Department and the SDAC, around tracking and measuring the four required KPI targets. Staff reported that ICHP was the first RCCO to receive incentive payments for reduction in ER visits.

Follow-up—Care Coordination

On-site Discussion Topics	Pertinent Contract References
Observations: ICHP was actively engaged in the development of mechanisms to obtain information from diverse community providers and agencies to support coordination of care. ICHP staff anticipated ADT information from hospitals would soon be available electronically from 8 of 14 hospitals in the region. The nature of rural community alliances facilitated the development of multiple of mechanisms for sharing of information essential for effective care coordination. ICHP created and continuously upgraded the ICHP software system for tracking and communicating care coordination information among multiple providers and agencies involved with members' care. The ICHP software system has been implemented by a steadily increasing number of providers in the region and is an increasingly powerful tool for care coordination activities. ICHP monitored outcomes of care coordination through KPIs and additional measures, and will continue to evaluate meaningful measures of effective care coordination with the Department, other RCCOs, and providers.	

Appendix B. Record Review Tools
for Integrated Community Health Partners (Region 4)

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

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

Reason Record was Eliminated	Number of Records Eliminated
The member was not identified by ICHP risk stratification methods as a candidate for care coordination (no care management documentation was available to evaluate).	1
Despite multiple attempts, care manager was unable to contact or engage member in care coordination.	4 (1, 2, 3, and 4)
HSAG reviewed the record but determined the member was not an appropriate candidate for complex care coordination.	5 (5, 6, 7, 8 and 9)
The member was not attributed to Region 4 (unable to access record).	2
The member was unattributed to a PCMP (unable to access record).	1
The member ID number was inaccurate (member record could not be located).	1
Total number of records eliminated from original sample of 20:	**14**

[1] Record #2: The member came in for pregnancy test. The test was positive so Pueblo Community Health Center conducted a full assessment (health risks and needs, culture, linguistics, and non-medical). The member was homeless. The care manager offered the member information on housing, shelters, soup kitchens, etc. The member was not committed to the program and was completely unengaged.
[2] Record #3: The mother delivered a baby in January 2012 and didn't come back to the PCMP until December 2012 with another pregnancy, UTI, and herpes. The mother delivered that baby in March 2013, came in for two postpartum visits, and then never came back.
[3] Record #9: The member was identified as Tier 3 and high cost. The member was being seen by the CMHC but would not respond to multiple care coordinator contact attempts. The member was no-show for a meeting set up to conduct a needs assessment.
[4] Record #18: The only appointment for this member was in February 2013. The RCCO could not locate the member after February 2013. According to SDAC data, the member has not accessed services since February 2013. For this reason, the RCCO believes the member may have died.
[5] Record #4: The member was a healthy 12-year-old.
[6] Record #5: The RCCO did not know about the infant's hospitalization for pneumonia until after discharge, and when the care coordinator contacted the family (January 2014) the member was doing well and had no needs. If there had been needs, all of care coordination would have occurred in 2014 (outside the review period). The child has met all of her well-care appointments, is current on immunizations, and is meeting all milestones.
[7] Record #6: The member was born in Denver with a severe medical condition, which was corrected with surgery before discharge. The child attended all well-child visits, has met all developmental milestones, and is up-to-date on immunizations. No care coordination required.
[8] Record #10: The member was a healthy non-utilizer.
[9] Record #14: The RCCO was unaware of this member until 2014. There were several ER visits in late 2013. The RCCO made multiple unsuccessful attempts to contact the family in 2014 and mailed guidance on proper use of the ER. Otherwise, the child is healthy with no chronic conditions.

The completed record review tools follow this page.

Sample Number: #1 **Reviewer:** Kathy Bartilotta

Care Coordination Program Record Review	Score
Assessment	
1. The RCCO (or designee) assessed the member's: ◆ Health behavior risks. ◆ Health/medical needs. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1* *Regions 2, 3, 5: Exhibit A—6.4.5.1.1*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care coordinator unsuccessfully attempted outreach to the member several times between 10/2013 and 1/2014, and then was alerted to the member's frequent ER visits. The care coordinator was able to engage the member on 2/2014 for completion of a comprehensive assessment using the ICHP assessment tool. BHO assessments also available in system. The assessment included medical conditions and health behavior risks. The member's needs were primarily mental health.	
2. The RCCO (or designee) assessed the member's: ◆ Non-medical needs. ◆ Linguistic and cultural needs. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1; 6.4.3.2.2* *Regions 2, 3, 5: Exhibit A—6.4.5.1.1; 6.4.5.2.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The assessment included non-medical needs and cultural beliefs.	
3. The RCCO (or designee) assessed current care coordination services provided to the member to determine if the providers involved in each member's care are providing necessary care coordination services and which care coordination services are insufficient or are not provided. *Regions 1, 4, 6, 7: Exhibit A— 6.4.2.1* *Regions 2, 3, 5: Exhibit A—6.4.4.1*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The member was managed by the integrated team of a BHO care coordinator and a FQHC care coordinator.	

Care Coordination Program Record Review	Score
Intervention	
4. The RCCO (or designee) worked with providers responsible for the member's care to develop a plan for regular communication with those responsible for the member's care coordination. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.3* *Regions 2, 3, 5: Exhibit A—6.4.4.3*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care coordinators held regular joint staffings with mental health and physical health providers. Behavioral health is integrated at the facility.	
5. The RCCO (or designee) reasonably ensured that all care coordination services, including those provided by other individuals or entities, met the needs of the member. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.4* *Regions 2, 3, 5: Exhibit A—6.4.4.4*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: Goals of the care plan were established with the member during the assessment process. The member needed to attend all mental health appointments and decrease ER visits. Tracking and follow-up of missed appointments and ER visits was documented in record.	
6. The RCCO (or designee) provided necessary care coordination services not provided by another source. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.2* *Regions 2, 3, 5: Exhibit A—6.4.4.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The member wanted to lose weight. The care coordinator arranged for the member to join a community fitness program.	
7. The RCCO (or designee) linked the member to medical and/or non-medical services, acted as a liaison between medical providers or between medical and non-medical providers, and/or served as a liaison between providers and the member. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.2* *Regions 2, 3, 5: Exhibit A—6.4.5.1.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The medical provider was the FQHC and the mental health provider was the CMHC, which are integrated into one facility, and the care coordinators from each organization work as a team. Routine care coordinator staffings were held with all providers. All information about the member, including attendance at the fitness program, was entered into the care coordination system, which integrated with the electronic health record at the facility.	

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

Care Coordination Program Record Review	Score
Continued Coordination/Follow-up	
11. The documentation clearly indicated that the RCCO's (or designee's) provision of care coordination services was responsive to the member's needs. *Regions:1, 4, 6, 7: Exhibit A—6.4.3.2.3* *Regions 2, 3,5 : Exhibit A—6.4.5.2.3*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The record documented careful tracking and follow-up of member appointments and interactions with the member to ensure the member had no additional needs and was progressing.	
12. The RCCO (or designee) followed up with the member to assess whether the member has received the services needed and/or if the member is on track to reach his or her desired health outcomes. *Regions 1, 4, 6, 7 Exhibit A—6.4.3.1.6* *Region 2: Exhibit A—6.4.5.1.6* *Regions 3, 5: Exhibit A—6.4.5.1.7*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The record documented careful tracking and follow-up of member appointments and interactions with the member to ensure the member had no additional needs and was progressing. ER visits diminished and the member was attending mental health appointments.	
Recommendations: This was a fairly straightforward case of assisting the member to maintain appointments and reduce ER visits. HSAG had no recommendations.	

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

Total Score ÷ Total Applicable	=	100%

Sample Number: #12 **Reviewer:** Kathy Bartilotta

Care Coordination Program Record Review	Score
Assessment	
1. The RCCO (or designee) assessed the member's: ◆ Health behavior risks. ◆ Health/medical needs. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1* *Regions 2, 3, 5: Exhibit A—6.4.5.1.1*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The member was a Tier 3 based on a high number of ER visits for pain management. The member had back pain and was receiving pain medications. The member was seeing multiple PCMPs. The care coordinator attempted multiple unsuccessful contacts to follow up with member regarding ER visits and was finally able to make an appointment for assessment. Medical needs and health risks were assessed. The member wanted a pain management doctor and needed dental care.	
2. The RCCO (or designee) assessed the member's: ◆ Non-medical needs. ◆ Linguistic and cultural needs. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1; 6.4.3.2.2* *Regions 2, 3, 5: Exhibit A—6.4.5.1.1; 6.4.5.2.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The assessment included non-medical needs and cultural beliefs. The member was unemployed but did not want assistance with employment.	
3. The RCCO (or designee) assessed current care coordination services provided to the member to determine if the providers involved in each member's care are providing necessary care coordination services and which care coordination services are insufficient or are not provided. *Regions 1, 4, 6, 7: Exhibit A— 6.4.2.1* *Regions 2, 3, 5: Exhibit A—6.4.4.1*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care coordination alert system allowed tracking of the member through multiple PCMPs. The care coordinator contacted multiple PCMP offices and talked with ER staff concerning drug-seeking behaviors. The care coordinator attributed the member to one PCMP and arranged an appointment. The member was managed by an integrated PH/BH care coordination team.	

Care Coordination Program Record Review	Score
Intervention	
4. The RCCO (or designee) worked with providers responsible for the member's care to develop a plan for regular communication with those responsible for the member's care coordination. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.3* *Regions 2, 3, 5: Exhibit A—6.4.4.3*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care coordinator contacted multiple PCMP offices and talked with ER staff concerning drug-seeking behaviors. Mental health services were arranged (within same facility). Information from all providers in the community was integrated within Integrated Registry of Care (IROC) care coordination system.	
5. The RCCO (or designee) reasonably ensured that all care coordination services, including those provided by other individuals or entities, met the needs of the member. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.4* *Regions 2, 3, 5: Exhibit A—6.4.4.4*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care coordinator followed up regularly with member regarding appointments and progress.	
6. The RCCO (or designee) provided necessary care coordination services not provided by another source. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.2* *Regions 2, 3, 5: Exhibit A—6.4.4.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care coordinator referred the member to Comfort Dental for dental care.	
7. The RCCO (or designee) linked the member to medical and/or non-medical services, acted as a liaison between medical providers or between medical and non-medical providers, and/or served as a liaison between providers and the member. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.2* *Regions 2, 3, 5: Exhibit A—6.4.5.1.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: There is a natural liaison relationship among providers in the community, facilitated through the integrated information system for tracking member services and care coordination. The member was linked to dental services, PCMP, and mental health.	

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

Care Coordination Program Record Review	Score
Continued Coordination/Follow-up	
11. The documentation clearly indicated that the RCCO's (or designee's) provision of care coordination services was responsive to the member's needs. *Regions:1, 4, 6, 7: Exhibit A—6.4.3.2.3* *Regions 2, 3,5 : Exhibit A—6.4.5.2.3*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The documentation in the care coordination system was extensive and complete related to tracking of referrals, appointments, and contacts with the member.	
12. The RCCO (or designee) followed up with the member to assess whether the member has received the services needed and/or if the member is on track to reach his or her desired health outcomes. *Regions 1, 4, 6, 7 Exhibit A—6.4.3.1.6* *Region 2: Exhibit A—6.4.5.1.6* *Regions 3, 5: Exhibit A—6.4.5.1.7*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: It was difficult for the care coordinator to maintain direct communication with the member, despite frequent multiple follow-up attempts. However, the member would return calls periodically to maintain reasonable contact.	
Recommendations: This was a case of outreaching to the member and aligning the member with appropriate providers rather than going to the ER for pain management. HSAG had no recommendations.	

Results for Care Coordination Program Record Review—Sample #12							
Total	Met	=	9	X	1.00	=	9
	Partially Met	=	0	X	0.0	=	0
	Not Met	=	0	X	0.0	=	0
	Not Applicable	=	3	X	NA	=	0
Total Applicable		=	9	**Total Score**		=	9

Total Score ÷ Total Applicable	=	100%

Sample Number: #13 **Reviewer:** Rachel Henrichs

Care Coordination Program Record Review	Score
Assessment	
1. The RCCO (or designee) assessed the member's: ◆ Health behavior risks. ◆ Health/medical needs. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1* *Regions 2, 3, 5: Exhibit A—6.4.5.1.1*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: Although there was no formal health risk assessment document, care management notes indicated that the PCMP and its care managers conducted ongoing assessments of the member's health needs and risks.	
2. The RCCO (or designee) assessed the member's: ◆ Non-medical needs. ◆ Linguistic and cultural needs. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1; 6.4.3.2.2* *Regions 2, 3, 5: Exhibit A—6.4.5.1.1; 6.4.5.2.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: While there was no formal assessment of needs conducted, the care manager notes indicated the care manager did conduct ongoing assessments of the member's non-medical needs and made notes of the member's cultural behaviors. Non-medical needs documented by the care manager included transportation and telephone. This member was noncompliant with medications and frequently missed appointments. She appeared to be using the emergency department as her primary source for pain medication.	
3. The RCCO (or designee) assessed current care coordination services provided to the member to determine if the providers involved in each member's care are providing necessary care coordination services and which care coordination services are insufficient or are not provided. *Regions 1, 4, 6, 7: Exhibit A— 6.4.2.1* *Regions 2, 3, 5: Exhibit A—6.4.4.1*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The member's PCMP was responsible for coordinating the member's care. The record indicated that the local emergency department was the only other provider/agency from whom the member sought services.	

Care Coordination Program Record Review	Score
Intervention	
4. The RCCO (or designee) worked with providers responsible for the member's care to develop a plan for regular communication with those responsible for the member's care coordination. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.3* *Regions 2, 3, 5: Exhibit A—6.4.4.3*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The member's only source of care, outside of the PCMP, was the local emergency department. The PCMP contacted the emergency department and implemented an "emergency department treatment plan." The emergency department agreed to only treat acute pain and not provide the member with any oral pain medication. The emergency department staff agreed to refer the member back to her PCMP for pain medication.	
5. The RCCO (or designee) reasonably ensured that all care coordination services, including those provided by other individuals or entities, met the needs of the member. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.4* *Regions 2, 3, 5: Exhibit A—6.4.4.4*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The member was noncompliant, disengaged, and difficult to contact. The care manager logged many attempts to contact the member following emergency room visits.	
6. The RCCO (or designee) provided necessary care coordination services not provided by another source. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.2* *Regions 2, 3, 5: Exhibit A—6.4.4.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager offered the member transportation options and gave the member information for a low-cost cellular phone service.	
7. The RCCO (or designee) linked the member to medical and/or non-medical services, acted as a liaison between medical providers or between medical and non-medical providers, and/or served as a liaison between providers and the member. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.2* *Regions 2, 3, 5: Exhibit A—6.4.5.1.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager worked with staff in the emergency departments to develop a treatment plan for the member and offered the member information regarding transportation services and low-cost cellular phone service.	

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

Care Coordination Program Record Review	Score
Continued Coordination/Follow-up	
11. The documentation clearly indicated that the RCCO's (or designee's) provision of care coordination services was responsive to the member's needs. *Regions:1, 4, 6, 7: Exhibit A—6.4.3.2.3* *Regions 2, 3,5 : Exhibit A—6.4.5.2.3*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager's documentation demonstrated attempt to address the member's needs. Unfortunately, the member was not engaged or compliant with recommendations or medications.	
12. The RCCO (or designee) followed up with the member to assess whether the member has received the services needed and/or if the member is on track to reach his or her desired health outcomes. *Regions 1, 4, 6, 7 Exhibit A—6.4.3.1.6* *Region 2: Exhibit A—6.4.5.1.6* *Regions 3, 5: Exhibit A—6.4.5.1.7*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager logged numerous calls to the member's mother and boyfriend in attempts to follow up with the member on recommendations and referrals for care. The member was difficult to contact and rarely compliant.	
Recommendations: The care manager's notes indicated she made numerous valiant yet unsuccessful attempts to engage this member. HSAG has no recommendations.	

Results for Care Coordination Program Record Review—Sample #13							
Total	Met	=	9	X	1.00	=	9
	Partially Met	=	0	X	0.0	=	0
	Not Met	=	0	X	0.0	=	0
	Not Applicable	=	3	X	NA	=	0
Total Applicable		=	9	**Total Score**		=	9

Total Score ÷ Total Applicable	=	100%

Sample Number: #15 **Reviewer:** Kathy Bartilotta

Care Coordination Program Record Review	Score
Assessment	
1. The RCCO (or designee) assessed the member's: ◆ Health behavior risks. ◆ Health/medical needs. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1* *Regions 2, 3, 5: Exhibit A—6.4.5.1.1*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The member was Tier 4 and unattributed. The member's listed address was a homeless shelter. There was no contact information for the member, so a letter was sent to the homeless shelter, and the member returned the call. An assessment was performed, indicating depression, suicidal thoughts, back pain, and frequent urinary infections. The member was planning to have surgery. The care coordinator assisted the member to get attributed to a PCMP (Kaiser) through HealthColorado; the case was referred to the ICHP care coordinator at Kaiser.	
2. The RCCO (or designee) assessed the member's: ◆ Non-medical needs. ◆ Linguistic and cultural needs. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1; 6.4.3.2.2* *Regions 2, 3, 5: Exhibit A—6.4.5.1.1; 6.4.5.2.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The member needed home care after planned surgery. The member had a cell phone with limited minutes. The member used a taxi for transportation.	
3. The RCCO (or designee) assessed current care coordination services provided to the member to determine if the providers involved in each member's care are providing necessary care coordination services and which care coordination services are insufficient or are not provided. *Regions 1, 4, 6, 7: Exhibit A— 6.4.2.1* *Regions 2, 3, 5: Exhibit A—6.4.4.1*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The BHO was actively engaged with the member due to extensive mental health needs: bipolar, suicide attempts, hallucinations. Detailed BHO information was not available to the care coordinator, but the Kaiser care coordinator communicated with BHO coordinator.	

Care Coordination Program Record Review	Score
Intervention	
4. The RCCO (or designee) worked with providers responsible for the member's care to develop a plan for regular communication with those responsible for the member's care coordination. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.3* *Regions 2, 3, 5: Exhibit A—6.4.4.3*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The Kaiser care coordinator and BHO coordinator worked together. The Kaiser coordinator communicated with hospital and surgical providers to do pre-planning for spinal fusion discharge needs. The care coordinator followed up with providers regarding missed appointments and ER alerts.	
5. The RCCO (or designee) reasonably ensured that all care coordination services, including those provided by other individuals or entities, met the needs of the member. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.4* *Regions 2, 3, 5: Exhibit A—6.4.4.4*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The member needed multiple appointments and was not reliable to make appointments. Kaiser does not allow appointments to be arranged by anyone other than the member. The member was difficult to reach due to limited cell phone minutes. The care coordinator worked with the member to encourage the member to make appointments; ultimately, the member would call Kaiser to make appointments for high-priority needs.	
6. The RCCO (or designee) provided necessary care coordination services not provided by another source. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.2* *Regions 2, 3, 5: Exhibit A—6.4.4.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care coordinator ensured that the member had transportation (taxi). The care coordinator worked with providers within Kaiser system and tracked appointments/missed appointments. The BHO handled the member's mental health needs. The member was difficult to contact due to limited cell phone minutes. The care coordinator perhaps could have attempted to arrange more cell phone minutes for member.	

Care Coordination Program Record Review	Score
Intervention	
7. The RCCO (or designee) linked the member to medical and/or non-medical services, acted as a liaison between medical providers or between medical and non-medical providers, and/or served as a liaison between providers and the member. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.2* *Regions 2, 3, 5: Exhibit A—6.4.5.1.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care coordinator linked the member to services as much as possible, but the member often did not make appointments with providers within Kaiser, and Kaiser required that the member make the member's own appointments. The member was difficult to reach.	

Care Coordination Program Record Review	Score
Transitions	
8. The RCCO (or designee) provided assistance during care transitions from hospitals or other care institutions to home- or community-based settings. This assistance promoted continuity of care. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3* *Region 2,: Exhibit A—6.4.5.1.3* *Regions 3, 5: Exhibit A—6.4.5.1.4*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The member had surgery for spinal fusion. The care coordinator contacted the hospital discharge planner to determine the discharge plan for the member. The care coordinator contacted the member after discharge to determine status and to connect the member to Kaiser for a follow-up appointment.	
9. The RCCO (or designee) provided assistance during other transitions, such as the transition from children's health services to adult health services or from hospital or home care into a nursing facility. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3* *Region 2: Exhibit A—6.4.5.1.3* *Regions 3, 5: Exhibit A—6.4.5.1.4*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
Observations: The member did not experience this type of transition.	
10. The RCCO (or designee) documented and communicated necessary information about the member to the providers, institutions, and individuals involved in the transition. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3* *Region 2: Exhibit A—6.4.5.1.3* *Regions 3, 5: Exhibit A—6.4.5.1.4*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care coordinator was unable to convey much mental health information to the hospital discharge planner or Kaiser providers due to HIPAA limitations, but the care coordinator communicated post-discharge information to the BHO care coordinator. Kaiser internal providers, programs, and services are documented in the electronic health record. The RCCO transferred all information to a new ICHP care coordinator within Kaiser.	

Care Coordination Program Record Review	Score
Continued Coordination/Follow-up	
11. The documentation clearly indicated that the RCCO's (or designee's) provision of care coordination services was responsive to the member's needs. *Regions:1, 4, 6, 7: Exhibit A—6.4.3.2.3* *Regions 2, 3,5 : Exhibit A—6.4.5.2.3*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The documentation in the care coordination record included assessment, the member's priority goals, comprehensive care coordination notes (including attempts to reach the member), and tracking of the member through the Kaiser information system.	
12. The RCCO (or designee) followed up with the member to assess whether the member has received the services needed and/or if the member is on track to reach his or her desired health outcomes. *Regions 1, 4, 6, 7 Exhibit A—6.4.3.1.6* *Region 2: Exhibit A—6.4.5.1.6* *Regions 3, 5: Exhibit A—6.4.5.1.7*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care coordinator made multiple attempts to reach the member, which were often unsuccessful, but post-discharge contact confirmed that member was satisfied. The BHO remained actively engaged with member. The member did not want assistance with homelessness.	
Recommendations: This appeared to be a difficult case to manage due to the member's intensive mental health issues, which were managed through the BHO. Much information was protected. In addition, while services within Kaiser could be well tracked and coordinated as necessary by the Kaiser-based ICHP coordinator, the member was unreliable in scheduling all necessary appointments, and the Kaiser system would not allow the coordinator to make appointments on behalf of the member. The member was difficult to reach due to limited cell phone minutes and was homeless. Nevertheless, the care coordinator did the best job possible within the limitations in communications, and the member attended mental health appointments and completed a major back surgery successfully.	

Results for Care Coordination Program Record Review—Sample #15							
Total	Met	=	11	X	1.00	=	11
	Partially Met	=	0	X	0.0	=	0
	Not Met	=	0	X	0.0	=	0
	Not Applicable	=	1	X	NA	=	0
Total Applicable		=	11	**Total Score**		=	11

Total Score ÷ Total Applicable	=	100%

Sample Number: #16 **Reviewer:** Kathy Bartilotta

Care Coordination Program Record Review	Score
Assessment	
1. The RCCO (or designee) assessed the member's: ◆ Health behavior risks. ◆ Health/medical needs. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1* *Regions 2, 3, 5: Exhibit A—6.4.5.1.1*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: Member was high tier risk with extensive medical history. The member had been hospitalized in intensive care for a medical problem previous to identification for care coordination. The assessment documented that the member had multiple providers (rheumatology, neurology) and pain medications. The member had a therapist for bipolar, anxiety, and post-traumatic stress disorders.	
2. The RCCO (or designee) assessed the member's: ◆ Non-medical needs. ◆ Linguistic and cultural needs. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1; 6.4.3.2.2* *Regions 2, 3, 5: Exhibit A—6.4.5.1.1; 6.4.5.2.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The member had food/nutrition needs and was unemployed. The member used multiple assistance programs: food stamps, disability assistance (SSI), and child support. The member wanted to lose weight and get exercise.	
3. The RCCO (or designee) assessed current care coordination services provided to the member to determine if the providers involved in each member's care are providing necessary care coordination services and which care coordination services are insufficient or are not provided. *Regions 1, 4, 6, 7: Exhibit A— 6.4.2.1* *Regions 2, 3, 5: Exhibit A—6.4.4.1*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The member was co-managed by coordinators from the PCMP and CMHC. The CMHC coordinator was the lead coordinator and therefore had access to BHO information.	

Care Coordination Program Record Review	Score
Intervention	
4. The RCCO (or designee) worked with providers responsible for the member's care to develop a plan for regular communication with those responsible for the member's care coordination. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.3* *Regions 2, 3, 5: Exhibit A—6.4.4.3*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care coordinators gathered information from multiple specialists and agencies.	
5. The RCCO (or designee) reasonably ensured that all care coordination services, including those provided by other individuals or entities, met the needs of the member. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.4* *Regions 2, 3, 5: Exhibit A—6.4.4.4*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The member reported that mental health interventions were going well. The member was receiving benefits from multiple social support programs.	
6. The RCCO (or designee) provided necessary care coordination services not provided by another source. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.2* *Regions 2, 3, 5: Exhibit A—6.4.4.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care coordinator referred member to local food pantries.	
7. The RCCO (or designee) linked the member to medical and/or non-medical services, acted as a liaison between medical providers or between medical and non-medical providers, and/or served as a liaison between providers and the member. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.2* *Regions 2, 3, 5: Exhibit A—6.4.5.1.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care coordinators communicated with specialist providers as necessary and the integrated BH/PH care coordination team ensured coordination and communications between the CMHC and PCMP. The care coordinators connected the member to food pantries.	

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

Care Coordination Program Record Review	Score
Continued Coordination/Follow-up	
11. The documentation clearly indicated that the RCCO's (or designee's) provision of care coordination services was responsive to the member's needs. *Regions:1, 4, 6, 7: Exhibit A—6.4.3.2.3* *Regions 2, 3,5 : Exhibit A—6.4.5.2.3*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care coordination record included a detailed assessment of needs; contacts with the member, providers, and community agencies; and confirmation that the member had access to multiple support benefits.	
12. The RCCO (or designee) followed up with the member to assess whether the member has received the services needed and/or if the member is on track to reach his or her desired health outcomes. *Regions 1, 4, 6, 7 Exhibit A—6.4.3.1.6* *Region 2: Exhibit A—6.4.5.1.6* *Regions 3, 5: Exhibit A—6.4.5.1.7*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The record documented frequent communications with the member. The member was actively engaged with mental health services and reported that services were going well. At the time of review, the member had transitioned from Tier 4 to Tier 3.	
Recommendations: HSAG had no recommendations related to this case.	

Results for Care Coordination Program Record Review—Sample #16							
Total	Met	=	9	X	1.00	=	9
	Partially Met	=	0	X	0.0	=	0
	Not Met	=	0	X	0.0	=	0
	Not Applicable	=	3	X	NA	=	0
Total Applicable		=	9	**Total Score**		=	9

Total Score ÷ Total Applicable	=	100%

Sample Number: #20 **Reviewer:** Kathy Bartilotta

Care Coordination Program Record Review	Score
Assessment	
1. The RCCO (or designee) assessed the member's: ◆ Health behavior risks. ◆ Health/medical needs. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1* *Regions 2, 3, 5: Exhibit A—6.4.5.1.1*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The member was a 10-year-old child with congenital cardiac problems: Tier 3-4. The member had an extensive medical history with multiple providers, including the Children's Hospital pediatric clinic. The member's needs were assessed on 11/2013, and all needs appeared to be met. The member had ER visits in 2/2014 for bronchial pneumonia, and the care coordinator contacted the mother to check on the member's status.	
2. The RCCO (or designee) assessed the member's: ◆ Non-medical needs. ◆ Linguistic and cultural needs. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1; 6.4.3.2.2* *Regions 2, 3, 5: Exhibit A—6.4.5.1.1; 6.4.5.2.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: A comprehensive assessment was performed, including non-medical and cultural needs.	
3. The RCCO (or designee) assessed current care coordination services provided to the member to determine if the providers involved in each member's care are providing necessary care coordination services and which care coordination services are insufficient or are not provided. *Regions 1, 4, 6, 7: Exhibit A— 6.4.2.1* *Regions 2, 3, 5: Exhibit A—6.4.4.1*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care coordinator attempted contacts with the Children's Hospital clinic care coordinators. Staff reported that making contact with Children's Hospital care coordinators is often difficult, but their experience was that Children's Hospital coordinators tended to have all necessary health care services in place. Staff reported that ICHP care coordinators were working through CCHAP to determine mechanisms to improve communications with Children's Hospital care coordinators and providers.	

Care Coordination Program Record Review	Score
Intervention	
4. The RCCO (or designee) worked with providers responsible for the member's care to develop a plan for regular communication with those responsible for the member's care coordination. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.3* *Regions 2, 3, 5: Exhibit A—6.4.4.3*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: Most health care providers for the member were associated with Children's Hospital pediatric clinics. See note in #3.	
5. The RCCO (or designee) reasonably ensured that all care coordination services, including those provided by other individuals or entities, met the needs of the member. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.4* *Regions 2, 3, 5: Exhibit A—6.4.4.4*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care coordinator researched the services being provided to the member and double-checked them against the needs assessment to fill any identified gaps.	
6. The RCCO (or designee) provided necessary care coordination services not provided by another source. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.2* *Regions 2, 3, 5: Exhibit A—6.4.4.2*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
Observations: It appeared that the member's needs were being adequately met with existing services. The care coordinator followed up with the member's mother after ER visits to determine if there was any change in the member's needs. No additional needs were identified.	
7. The RCCO (or designee) linked the member to medical and/or non-medical services, acted as a liaison between medical providers or between medical and non-medical providers, and/or served as a liaison between providers and the member. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.2* *Regions 2, 3, 5: Exhibit A—6.4.5.1.2*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
Observations: It appeared that the member's needs were being adequately met with existing services. No additional needs were identified.	

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

Care Coordination Program Record Review	Score
Continued Coordination/Follow-up	
11. The documentation clearly indicated that the RCCO's (or designee's) provision of care coordination services was responsive to the member's needs. *Regions:1, 4, 6, 7: Exhibit A—6.4.3.2.3* *Regions 2, 3,5 : Exhibit A—6.4.5.2.3*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: Most of the member's health care needs were being met through Children's Hospital providers. The care coordinator researched the services being provided to the member and double-checked them against the needs assessment, determining that the member's needs were being met.	
12. The RCCO (or designee) followed up with the member to assess whether the member has received the services needed and/or if the member is on track to reach his or her desired health outcomes. *Regions 1, 4, 6, 7 Exhibit A—6.4.3.1.6* *Region 2: Exhibit A—6.4.5.1.6* *Regions 3, 5: Exhibit A—6.4.5.1.7*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care coordinator followed up frequently with the member's mother to track the member's progress after ER visits and to determine whether there was any change in the member's needs.	
Recommendations: Due to the member's ongoing medical conditions, the member will probably always be a high tier, high cost case. However, the member's health care needs were being adequately met through The Children's Hospital pediatric providers. HSAG has no recommendations.	

Results for Care Coordination Program Record Review—Sample #20							
Total	Met	=	7	X	1.00	=	7
	Partially Met	=	0	X	0.0	=	0
	Not Met	=	0	X	0.0	=	0
	Not Applicable	=	5	X	NA	=	0
Total Applicable		=	7	**Total Score**		=	7

Total Score ÷ Total Applicable	=	100%

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

Care Coordination Program Record Review	Score
Assessment	
1. The RCCO (or designee) assessed the member's: ◆ Health behavior risks. ◆ Health/medical needs. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1* *Regions 2, 3, 5: Exhibit A—6.4.5.1.1*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The member was high tier with multiple providers. The member had multiple ER visits for neck pain. The PCMP discussed ER visits with the member, but the member was no show for appointments with the PCMP for pain management. The member had mental health issues: depression and relationship issues. The member changed PCMPs, but the care coordinator also transferred to the new PCMP with the member. It required multiple outreach attempts by the care coordinator to engage the member in care coordination.	
2. The RCCO (or designee) assessed the member's: ◆ Non-medical needs. ◆ Linguistic and cultural needs. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1; 6.4.3.2.2* *Regions 2, 3, 5: Exhibit A—6.4.5.1.1; 6.4.5.2.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The assessment had to be performed in an episodic manner because the member could not tolerate extended interaction sessions. Needs included transportation, socialization, home and community-based services (HCBS) for home cleaning, and medical equipment.	
3. The RCCO (or designee) assessed current care coordination services provided to the member to determine if the providers involved in each member's care are providing necessary care coordination services and which care coordination services are insufficient or are not provided. *Regions 1, 4, 6, 7: Exhibit A— 6.4.2.1* *Regions 2, 3, 5: Exhibit A—6.4.4.1*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: Care coordination was provided by the ICHP Kaiser coordinator working with CMHC care coordinators.	

Care Coordination Program Record Review	Score
Intervention	
4. The RCCO (or designee) worked with providers responsible for the member's care to develop a plan for regular communication with those responsible for the member's care coordination. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.3* *Regions 2, 3, 5: Exhibit A—6.4.4.3*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: Care coordination involved multiple providers and agencies. The member received services through the CMHC and had a private psychiatrist. The member was transferred from the residency program to Kaiser for improved stability of providers engaged with the member. The PCMP initiated an Emergency Department Treatment Plan (pain contract) so that the ER would send the member to the PCMP for pain management. The care coordinator worked with the CMHC to get the member referred to the "Clubhouse" program for socialization and peer support.	
5. The RCCO (or designee) reasonably ensured that all care coordination services, including those provided by other individuals or entities, met the needs of the member. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.4* *Regions 2, 3, 5: Exhibit A—6.4.4.4*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The member's identified needs and priorities were addressed by the care coordinators.	
6. The RCCO (or designee) provided necessary care coordination services not provided by another source. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.2* *Regions 2, 3, 5: Exhibit A—6.4.4.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care coordinator (CC) assisted the member in making appointments and provided appointment reminders to the member. The CC assisted the member in application preparation for HCBS services, paperwork completion for durable medical equipment (DME), and PCPM transfer.	

Care Coordination Program Record Review	Score
Intervention	
7. The RCCO (or designee) linked the member to medical and/or non-medical services, acted as a liaison between medical providers or between medical and non-medical providers, and/or served as a liaison between providers and the member. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.2* *Regions 2, 3, 5: Exhibit A—6.4.5.1.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The CC acted as a liaison between the member and the PCMP, social programs, and HCBS services because the member's mental health behaviors prevented the member from completing and organizing tasks or having effective communications. The CC assisted with transportation needs to specialists in Denver and referred the member to the Colorado QuitLine.	

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

Care Coordination Program Record Review	Score
Continued Coordination/Follow-up	
11. The documentation clearly indicated that the RCCO's (or designee's) provision of care coordination services was responsive to the member's needs. *Regions:1, 4, 6, 7: Exhibit A—6.4.3.2.3* *Regions 2, 3,5 : Exhibit A—6.4.5.2.3*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The record included thorough documentation of the assessed needs, coordination with the member and the member's providers, and arrangements for multiple services. When the member became engaged in active care coordination, ER visits were reduced.	
12. The RCCO (or designee) followed up with the member to assess whether the member has received the services needed and/or if the member is on track to reach his or her desired health outcomes. *Regions 1, 4, 6, 7 Exhibit A—6.4.3.1.6* *Region 2: Exhibit A—6.4.5.1.6* *Regions 3, 5: Exhibit A—6.4.5.1.7*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: Once the member accepted care coordination, communications with the member were frequent, and ultimately the member began to take responsibility for following up with his own needs, making appointments and establishing connections.	
Recommendations: This very committed approach to identifying and meeting the member's behavioral, social, and medical needs produced significant improvement in the member's appropriate use of services and abilities to function effectively. Great success.	

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

Total Score ÷ Total Applicable	=	100%

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

Care Coordination Program Record Review	Score
Assessment	
1. The RCCO (or designee) assessed the member's: ◆ Health behavior risks. ◆ Health/medical needs. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1* *Regions 2, 3, 5: Exhibit A—6.4.5.1.1*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The member was Tier3 for chronic conditions (multiple sclerosis) with no inpatient admissions or ER visits. The member had multiple medical visits and received home health services for injections. The member was difficult to engage initially, with multiple unsuccessful outreach attempts and research by the care coordinator for new contact information. The ICHP comprehensive needs assessment was used, which included medical, behavioral, social, and cultural needs. The member needed pain management, and the PCMP was trying to reduce the member's high-dosage pain medications.	
2. The RCCO (or designee) assessed the member's: ◆ Non-medical needs. ◆ Linguistic and cultural needs. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1; 6.4.3.2.2* *Regions 2, 3, 5: Exhibit A—6.4.5.1.1; 6.4.5.2.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The member's needs were primarily social and non-medical, including transportation, financial issues, and assistance in getting to appointments. The member was doing quite well until significant family issues presented challenges. The member's daughter was incarcerated, the member had to assume care of the grandchildren, and the member's father entered hospice care.	
3. The RCCO (or designee) assessed current care coordination services provided to the member to determine if the providers involved in each member's care are providing necessary care coordination services and which care coordination services are insufficient or are not provided. *Regions 1, 4, 6, 7: Exhibit A— 6.4.2.1* *Regions 2, 3, 5: Exhibit A—6.4.4.1*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The ICHP worked with the member's caseworker at the Department of Social Services (DSS) concerning care of the grandchildren.	

Care Coordination Program Record Review	Score
Intervention	
4. The RCCO (or designee) worked with providers responsible for the member's care to develop a plan for regular communication with those responsible for the member's care coordination. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.3* *Regions 2, 3, 5: Exhibit A—6.4.4.3*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care coordinator and the PCMP arranged for the member to see a pain management provider in Loveland. Most of the care coordination was associated with family needs in caring for the grandchildren.	
5. The RCCO (or designee) reasonably ensured that all care coordination services, including those provided by other individuals or entities, met the needs of the member. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.4* *Regions 2, 3, 5: Exhibit A—6.4.4.4*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The high-priority needs were pain management for the member and caring for the grandchildren's needs. The care coordinator worked as a liaison with the DSS case worker, including arrangements for court appearances for guardianship.	
6. The RCCO (or designee) provided necessary care coordination services not provided by another source. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.2* *Regions 2, 3, 5: Exhibit A—6.4.4.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care coordinator assisted the member with researching and applying to HCBS for services, clothing, and other needs for the family, including obtaining dental services for the children. The care coordinator assisted with school issues with the children, such as obtaining birth certificates and car seats. The care coordinator arranged for the member's transportation to pain management appointments in Loveland.	
7. The RCCO (or designee) linked the member to medical and/or non-medical services, acted as a liaison between medical providers or between medical and non-medical providers, and/or served as a liaison between providers and the member. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.2* *Regions 2, 3, 5: Exhibit A—6.4.5.1.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care coordinator acted as a liaison and arranged for many medical and non-medical services for the member and the grandchildren.	

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

Care Coordination Program Record Review	Score
Continued Coordination/Follow-up	
11. The documentation clearly indicated that the RCCO's (or designee's) provision of care coordination services was responsive to the member's needs. *Regions:1, 4, 6, 7: Exhibit A—6.4.3.2.3* *Regions 2, 3,5 : Exhibit A—6.4.5.2.3*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The documentation in the record was very thorough regarding interactions with the member, providers, and agencies concerning the member's needs and interventions.	
12. The RCCO (or designee) followed up with the member to assess whether the member has received the services needed and/or if the member is on track to reach his or her desired health outcomes. *Regions 1, 4, 6, 7 Exhibit A—6.4.3.1.6* *Region 2: Exhibit A—6.4.5.1.6* *Regions 3, 5: Exhibit A—6.4.5.1.7*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The member and care coordinator had frequent interactions regarding the needs of the family and the member. The member freely contacted the care coordinator regarding any additional needs, including the need for emotional support when the member's father (in hospice care) died.	
Recommendations: The care coordinator assumed responsibility for coordinating the needs of the entire family. The case was very thoroughly managed as a "partnership" between the member and care coordinator. It was remarkable that there were no occurrences of hospitalizations or ER visits.	

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

Total Score ÷ Total Applicable	=	100%

Sample Number: OS #3 **Reviewer:** Rachel Henrichs

Care Coordination Program Record Review	Score
Assessment	
1. The RCCO (or designee) assessed the member's: ◆ Health behavior risks. ◆ Health/medical needs. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1* *Regions 2, 3, 5: Exhibit A—6.4.5.1.1*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: This member was referred to the care management program by her PCP. She was diagnosed with mononucleosis and did not seem to be recovering. The member suffered from pain and chronic fatigue. The care manager assessed the member's health risks and needs.	
2. The RCCO (or designee) assessed the member's: ◆ Non-medical needs. ◆ Linguistic and cultural needs. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1; 6.4.3.2.2* *Regions 2, 3, 5: Exhibit A—6.4.5.1.1; 6.4.5.2.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager documentation indicated having conducted an assessment of the member's non-medical, cultural, and linguistic needs.	
3. The RCCO (or designee) assessed current care coordination services provided to the member to determine if the providers involved in each member's care are providing necessary care coordination services and which care coordination services are insufficient or are not provided. *Regions 1, 4, 6, 7: Exhibit A— 6.4.2.1* *Regions 2, 3, 5: Exhibit A—6.4.4.1*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: Contact notes with various providers indicated that the care manager assessed what services the member was receiving.	

Care Coordination Program Record Review	Score
Intervention	
4. The RCCO (or designee) worked with providers responsible for the member's care to develop a plan for regular communication with those responsible for the member's care coordination. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.3* *Regions 2, 3, 5: Exhibit A—6.4.4.3*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager worked with staff at the emergency departments to develop and implement a treatment plan that specified the member is not to be given prescriptions for pain medications but treated for acute symptoms and referred to her primary care for follow-up.	
5. The RCCO (or designee) reasonably ensured that all care coordination services, including those provided by other individuals or entities, met the needs of the member. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.4* *Regions 2, 3, 5: Exhibit A—6.4.4.4*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager followed up with the member after learning that the member missed an appointment for a computed tomography (CT) scan and assisted with rescheduling. The care manager also made arrangements for the behavioral health care agency to notify the care manager if the member missed any scheduled appointments.	
6. The RCCO (or designee) provided necessary care coordination services not provided by another source. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.2* *Regions 2, 3, 5: Exhibit A—6.4.4.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager assisted the member with scheduling (and rescheduling) the CT scan and follow-up appointments with an ear, nose, and throat (ENT) specialist. The care manager also arranged for the member's transportation to these appointments.	
7. The RCCO (or designee) linked the member to medical and/or non-medical services, acted as a liaison between medical providers or between medical and non-medical providers, and/or served as a liaison between providers and the member. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.2* *Regions 2, 3, 5: Exhibit A—6.4.5.1.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager arranged for the member to seek care from an ENT specialist, coordinated with the emergency departments to develop a treatment plan, and assisted the member with making transportation arrangements.	

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

Care Coordination Program Record Review	Score
Continued Coordination/Follow-up	
11. The documentation clearly indicated that the RCCO's (or designee's) provision of care coordination services was responsive to the member's needs. *Regions:1, 4, 6, 7: Exhibit A—6.4.3.2.3* *Regions 2, 3,5 : Exhibit A—6.4.5.2.3*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager's referrals and services were responsive to the member's needs.	
12. The RCCO (or designee) followed up with the member to assess whether the member has received the services needed and/or if the member is on track to reach his or her desired health outcomes. *Regions 1, 4, 6, 7 Exhibit A—6.4.3.1.6* *Region 2: Exhibit A—6.4.5.1.6* *Regions 3, 5: Exhibit A—6.4.5.1.7*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager followed up with the member and the member's providers to ensure that the services provided addressed the member's needs.	
Recommendations: The care manager did a good job coordinating this member's care. HSAG has no recommendations.	

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

Total Score ÷ Total Applicable	=	100%

Sample Number: OS #4 **Reviewer:** Rachel Henrichs

Care Coordination Program Record Review	Score
Assessment	
1. The RCCO (or designee) assessed the member's: ◆ Health behavior risks. ◆ Health/medical needs. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1* *Regions 2, 3, 5: Exhibit A—6.4.5.1.1*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: This member suffered from severe mental health issues and had a history of suicide attempts. She was not compliant with her medications and her mental instability led to the removal of her children by protective services. Numerous agencies were involved with this member in an attempt to ensure her safety and stabilize her mental status. Although no formal assessment was documented, the PCMP care manager's notes identified the member's health risks and needs.	
2. The RCCO (or designee) assessed the member's: ◆ Non-medical needs. ◆ Linguistic and cultural needs. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1; 6.4.3.2.2* *Regions 2, 3, 5: Exhibit A—6.4.5.1.1; 6.4.5.2.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The PCMP documented the member's non-medical, linguistic, and cultural needs as identified through interaction with the numerous agencies with which the member was involved.	
3. The RCCO (or designee) assessed current care coordination services provided to the member to determine if the providers involved in each member's care are providing necessary care coordination services and which care coordination services are insufficient or are not provided. *Regions 1, 4, 6, 7: Exhibit A— 6.4.2.1* *Regions 2, 3, 5: Exhibit A—6.4.4.1*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The PCMP care manager noted the various agencies from which the member was receiving services. These agencies included the community mental health center, adult protective services, and the DSS.	

Care Coordination Program Record Review	Score
Intervention	
4. The RCCO (or designee) worked with providers responsible for the member's care to develop a plan for regular communication with those responsible for the member's care coordination. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.3* *Regions 2, 3, 5: Exhibit A—6.4.4.3*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: HSAG reviewed the PCMP care manager's notes and the CMHC care manager's notes for this member. Both care managers did a good job communicating with each other and documented the correspondence in the member's record.	
5. The RCCO (or designee) reasonably ensured that all care coordination services, including those provided by other individuals or entities, met the needs of the member. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.4* *Regions 2, 3, 5: Exhibit A—6.4.4.4*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The PCMP care manager corresponded regularly with the care manager at the CMHC and at the various residential facilities (acute treatment units and long-term care centers) to be sure that the member's needs were being addressed.	
6. The RCCO (or designee) provided necessary care coordination services not provided by another source. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.2* *Regions 2, 3, 5: Exhibit A—6.4.4.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The PCMP and CMHC care managers worked together to ensure that the member had safe living arrangements. The member moved in and out of group homes, shelters, acute treatment units, and long-term care facilities. The care managers coordinated efforts to ensure that the member had access to safe housing.	
7. The RCCO (or designee) linked the member to medical and/or non-medical services, acted as a liaison between medical providers or between medical and non-medical providers, and/or served as a liaison between providers and the member. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.2* *Regions 2, 3, 5: Exhibit A—6.4.5.1.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care managers advocated on the member's behalf to various facilities to ensure the member's access to safe housing.	

Care Coordination Program Record Review	Score
Transitions	
8. The RCCO (or designee) provided assistance during care transitions from hospitals or other care institutions to home- or community-based settings. This assistance promoted continuity of care. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3* *Region 2,: Exhibit A—6.4.5.1.3* *Regions 3, 5: Exhibit A—6.4.5.1.4*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
Observations: The member did not transition from hospital to home during the review period.	
9. The RCCO (or designee) provided assistance during other transitions, such as the transition from children's health services to adult health services or from hospital or home care into a nursing facility. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3* *Region 2: Exhibit A—6.4.5.1.3* *Regions 3, 5: Exhibit A—6.4.5.1.4*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The member transferred from an acute treatment unit to a long-term care facility in August of 2013. The care managers worked together to make arrangements for this transfer.	
10. The RCCO (or designee) documented and communicated necessary information about the member to the providers, institutions, and individuals involved in the transition. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3* *Region 2: Exhibit A—6.4.5.1.3* *Regions 3, 5: Exhibit A—6.4.5.1.4*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care managers communicated the necessary information to ensure a smooth transition.	

Care Coordination Program Record Review	Score
Continued Coordination/Follow-up	
11. The documentation clearly indicated that the RCCO's (or designee's) provision of care coordination services was responsive to the member's needs. *Regions:1, 4, 6, 7: Exhibit A—6.4.3.2.3* *Regions 2, 3,5 : Exhibit A—6.4.5.2.3*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care managers' documentation clearly demonstrated their relentless provision of services for this member. The care managers monitored the member carefully and as soon as they recognized the member was unable to care for herself, they made arrangements for the member to be admitted to a safe facility.	
12. The RCCO (or designee) followed up with the member to assess whether the member has received the services needed and/or if the member is on track to reach his or her desired health outcomes. *Regions 1, 4, 6, 7 Exhibit A—6.4.3.1.6* *Region 2: Exhibit A—6.4.5.1.6* *Regions 3, 5: Exhibit A—6.4.5.1.7*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: Continual coordination between coordinators ensured that the member's needs were being addressed.	
Recommendations: This case proved to be difficult due to the member's unwillingness to cooperate and her apparent inability to fully comprehend her illness and how to address it. The care managers' close communication with each other was instrumental in ensuring this member's health and safety. HSAG has no recommendations.	

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

Total Score ÷ Total Applicable	=	100%

Sample Number: OS #5 **Reviewer:** Rachel Henrichs

Care Coordination Program Record Review	Score
Assessment	
1. The RCCO (or designee) assessed the member's: ◆ Health behavior risks. ◆ Health/medical needs. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1* *Regions 2, 3, 5: Exhibit A—6.4.5.1.1*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: This member was referred to the care coordination program by her PCP because she needed more intensive behavioral health services than the PCP was able to provide. The RCCO care manager conducted a thorough assessment of health needs and risks.	
2. The RCCO (or designee) assessed the member's: ◆ Non-medical needs. ◆ Linguistic and cultural needs. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1; 6.4.3.2.2* *Regions 2, 3, 5: Exhibit A—6.4.5.1.1; 6.4.5.2.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The comprehensive assessment conducted by the care manager included non-medical, linguistic, and cultural needs.	
3. The RCCO (or designee) assessed current care coordination services provided to the member to determine if the providers involved in each member's care are providing necessary care coordination services and which care coordination services are insufficient or are not provided. *Regions 1, 4, 6, 7: Exhibit A— 6.4.2.1* *Regions 2, 3, 5: Exhibit A—6.4.4.1*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The comprehensive assessment conducted by the care manager included an assessment of with which providers and agencies the member was engaged.	

Care Coordination Program Record Review	Score
Intervention	
4. The RCCO (or designee) worked with providers responsible for the member's care to develop a plan for regular communication with those responsible for the member's care coordination. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.3* *Regions 2, 3, 5: Exhibit A—6.4.4.3*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager's notes demonstrated coordination between physical and behavioral health providers and the RCCO care manager.	
5. The RCCO (or designee) reasonably ensured that all care coordination services, including those provided by other individuals or entities, met the needs of the member. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.4* *Regions 2, 3, 5: Exhibit A—6.4.4.4*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager checked in with the member at least monthly to ensure the member's needs were being addressed.	
6. The RCCO (or designee) provided necessary care coordination services not provided by another source. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.2* *Regions 2, 3, 5: Exhibit A—6.4.4.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager worked with the member's PCP to arrange referrals for the member's chronic pain. The care manager also ensured that the member had adequate services to address her behavioral health needs.	
7. The RCCO (or designee) linked the member to medical and/or non-medical services, acted as a liaison between medical providers or between medical and non-medical providers, and/or served as a liaison between providers and the member. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.2* *Regions 2, 3, 5: Exhibit A—6.4.5.1.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager worked with the member's care team to ensure adequate pain management and behavioral health services.	

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

Care Coordination Program Record Review	Score
Continued Coordination/Follow-up	
11. The documentation clearly indicated that the RCCO's (or designee's) provision of care coordination services was responsive to the member's needs. *Regions:1, 4, 6, 7: Exhibit A—6.4.3.2.3* *Regions 2, 3,5 : Exhibit A—6.4.5.2.3*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager's notes indicated that she thoroughly addressed the member's needs, as identified in the comprehensive needs assessment.	
12. The RCCO (or designee) followed up with the member to assess whether the member has received the services needed and/or if the member is on track to reach his or her desired health outcomes. *Regions 1, 4, 6, 7 Exhibit A—6.4.3.1.6* *Region 2: Exhibit A—6.4.5.1.6* *Regions 3, 5: Exhibit A—6.4.5.1.7*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager telephoned the member at least once a month to follow up on the member's progress and to address any newly-identified needs.	
Recommendations: The care manager conducted a thorough assessment of the member's needs and used that information to develop a care plan. The member was responsive to services offered and engaged with the care manager at least monthly. HSAG has no recommendations.	

Results for Care Coordination Program Record Review—Sample OS #5							
Total	Met	=	9	X	1.00	=	9
	Partially Met	=	0	X	0.0	=	0
	Not Met	=	0	X	0.0	=	0
	Not Applicable	=	3	X	NA	=	0
Total Applicable		=	9	**Total Score**		=	9

Total Score ÷ Total Applicable	=	100%

Sample Number: OS #7 **Reviewer:** Kathy Bartilotta

Care Coordination Program Record Review	Score
Assessment	
1. The RCCO (or designee) assessed the member's: ◆ Health behavior risks. ◆ Health/medical needs. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1* *Regions 2, 3, 5: Exhibit A—6.4.5.1.1*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The member was a 40-year-old with bereavement issues, PTSD, depression, and a drug overdose in September 2012. The member was already being seen for mental health services and managed by the CMHC prior to being identified to the RCCO care coordinator for multiple ER visits (headaches, anxiety). The member had previously been assessed with tools used by the CMHC and was comprehensively assessed using the ICHP needs assessment tool in October 2013.	
2. The RCCO (or designee) assessed the member's: ◆ Non-medical needs. ◆ Linguistic and cultural needs. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1; 6.4.3.2.2* *Regions 2, 3, 5: Exhibit A—6.4.5.1.1; 6.4.5.2.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The member had osteoarthritis resulting in needs for assistance with activities of daily living (ADLs). The member had multiple home-based family issues, nutritional needs, and dental needs. The member's primary needs were mental health and social/non-medical needs.	
3. The RCCO (or designee) assessed current care coordination services provided to the member to determine if the providers involved in each member's care are providing necessary care coordination services and which care coordination services are insufficient or are not provided. *Regions 1, 4, 6, 7: Exhibit A— 6.4.2.1* *Regions 2, 3, 5: Exhibit A—6.4.4.1*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The member was co-managed by the FQHC and CMHC care coordinators. Because the member's issues were primarily mental health related, the CMHC coordinator was the lead. The care coordinators conducted a staffing every two weeks to review needs and progress.	

Care Coordination Program Record Review	Score
Intervention	
4. The RCCO (or designee) worked with providers responsible for the member's care to develop a plan for regular communication with those responsible for the member's care coordination. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.3* *Regions 2, 3, 5: Exhibit A—6.4.4.3*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The local hospital provided ER and admission data to the clinic (located in the hospital). The PCMP provided occasional referrals (e.g., podiatry) and sent information to the specialist and received reports back. Many services were to programs associated with the CMHC or community-based services. The nature of the small-town environment is that interactions and communications among providers/organizations are easily facilitated.	
5. The RCCO (or designee) reasonably ensured that all care coordination services, including those provided by other individuals or entities, met the needs of the member. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.4* *Regions 2, 3, 5: Exhibit A—6.4.4.4*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The member was referred to the Healthier Living Colorado program for chronic disease self-management. The member was referred through the CMHC to the Choices program, a community program assisting with daily skills-building and providing peer support to members. Transportation was available to appointments through the CMHC.	
6. The RCCO (or designee) provided necessary care coordination services not provided by another source. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.2* *Regions 2, 3, 5: Exhibit A—6.4.4.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The member transferred therapists within the CMHC, and the care coordinator attended appointments with the member to increase the member's comfort level with the new therapist. The member transferred living environments, and the care coordinator evaluated housing options with the member.	

Care Coordination Program Record Review	Score
Intervention	
7. The RCCO (or designee) linked the member to medical and/or non-medical services, acted as a liaison between medical providers or between medical and non-medical providers, and/or served as a liaison between providers and the member. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.2* *Regions 2, 3, 5: Exhibit A—6.4.5.1.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care coordinator supported the member in preparation of applications for SSI and SSDI benefits; however, the member is expected to take responsibility for completing the tasks (part of therapeutic approach). The care coordinator prepared a list of courses, activities, and community services that could benefit the member. The care coordinator linked the member to many medical and non-medical services. (See observation notes for #5 and #6.)	

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

Care Coordination Program Record Review	Score
Continued Coordination/Follow-up	
11. The documentation clearly indicated that the RCCO's (or designee's) provision of care coordination services was responsive to the member's needs. *Regions:1, 4, 6, 7: Exhibit A—6.4.3.2.3* *Regions 2, 3,5 : Exhibit A—6.4.5.2.3*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care coordination record included: detailed notes regarding the assessment of member needs, various programs and services provided to the member, and integration of written reports from other providers (exception: BH health record information).	
12. The RCCO (or designee) followed up with the member to assess whether the member has received the services needed and/or if the member is on track to reach his or her desired health outcomes. *Regions 1, 4, 6, 7 Exhibit A—6.4.3.1.6* *Region 2: Exhibit A—6.4.5.1.6* *Regions 3, 5: Exhibit A—6.4.5.1.7*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The record documented frequent communication between the care coordinator and member regarding needs and progress.	
Recommendations: This was a very well-coordinated case for a member with complex psychological and social support needs and demonstrated the advantage of having an integrated BH/PH care coordination model.	

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

Total Score ÷ Total Applicable	=	100%

Sample Number: OS #8 **Reviewer:** Kathy Bartilotta

Care Coordination Program Record Review	Score
Assessment	
1. The RCCO (or designee) assessed the member's: ◆ Health behavior risks. ◆ Health/medical needs. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1* *Regions 2, 3, 5: Exhibit A—6.4.5.1.1*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The member is a Tier 4 with multiple ER visits related to alcohol use. The member had a hip fracture and replacement, which included two hospitalizations. The member has been receiving services through the CMHC since 2010 for anorexia, depression, and alcoholism.	
2. The RCCO (or designee) assessed the member's: ◆ Non-medical needs. ◆ Linguistic and cultural needs. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1; 6.4.3.2.2* *Regions 2, 3, 5: Exhibit A—6.4.5.1.1; 6.4.5.2.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The member was difficult to engage. A simple assessment was conducted in May 2013 and a more comprehensive assessment in January 2014. The member would not leave the house and would not attend appointments.	
3. The RCCO (or designee) assessed current care coordination services provided to the member to determine if the providers involved in each member's care are providing necessary care coordination services and which care coordination services are insufficient or are not provided. *Regions 1, 4, 6, 7: Exhibit A— 6.4.2.1* *Regions 2, 3, 5: Exhibit A—6.4.4.1*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The member was co-managed by the FQHC/CMHC care coordination team. The team meets every two weeks to discuss the member's care plan and progress.	

Care Coordination Program Record Review	Score
Intervention	
4. The RCCO (or designee) worked with providers responsible for the member's care to develop a plan for regular communication with those responsible for the member's care coordination. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.3* *Regions 2, 3, 5: Exhibit A—6.4.4.3*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The PCMP and CMHC were in regular contact through the care coordination team. The team contacted DSS regarding approval for home services to assist the member with home chores and to arrange for the member's transportation. The member was supposed to have physical therapy after hip surgery but did not attend appointments.	
5. The RCCO (or designee) reasonably ensured that all care coordination services, including those provided by other individuals or entities, met the needs of the member. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.4* *Regions 2, 3, 5: Exhibit A—6.4.4.4*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The plan included follow-up on all missed appointments, but the member only sporadically engaged with the care coordinator.	
6. The RCCO (or designee) provided necessary care coordination services not provided by another source. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.2* *Regions 2, 3, 5: Exhibit A—6.4.4.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The team contacted DSS regarding approval for home services to assist the member with home chores and to arrange for the member's transportation. After the member's second hospitalization, the CMHC care coordinator provided transportation from the hospital in Colorado Springs to home. The member was offered home-based mental health services. The member was discharged from the hospital with an order for home health services, but the agency refused to accept the member due to safety concerns (fall risks). The care coordinators tried to arrange for member transfer to a long-term care assisted-living environment for safety and assistance, but the member refused.	

Care Coordination Program Record Review	Score
Intervention	
7. The RCCO (or designee) linked the member to medical and/or non-medical services, acted as a liaison between medical providers or between medical and non-medical providers, and/or served as a liaison between providers and the member. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.2* *Regions 2, 3, 5: Exhibit A—6.4.5.1.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care coordinators attempted to link the member to multiple medical and non-medical services, but the member did not comply with most recommendations and would not leave home for appointments.	

Care Coordination Program Record Review	Score
Transitions	
8. The RCCO (or designee) provided assistance during care transitions from hospitals or other care institutions to home- or community-based settings. This assistance promoted continuity of care. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3* *Region 2,: Exhibit A—6.4.5.1.3* *Regions 3, 5: Exhibit A—6.4.5.1.4*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The member had two hospitalizations for hip surgeries in Colorado Springs. The care coordinator contacted the hospital discharge planner before discharge to discuss the member's medications and discharge plans, including home health and home-based mental health services and transportation home from the hospital. The member fell and re-fractured the hip and was transported from the local ER to Penrose Hospital for a hip replacement surgery. Discharge plans were similar to the first hospitalization, but the home care agency refused to accept the member due to safety concerns (alcohol-induced falls). The care coordinators attempted to arrange placement in a long-term care facility, but the member refused.	
9. The RCCO (or designee) provided assistance during other transitions, such as the transition from children's health services to adult health services or from hospital or home care into a nursing facility. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3* *Region 2: Exhibit A—6.4.5.1.3* *Regions 3, 5: Exhibit A—6.4.5.1.4*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care coordinators researched and attempted to arrange transfer of the member to a safer long-term care living environment, but the member refused.	
10. The RCCO (or designee) documented and communicated necessary information about the member to the providers, institutions, and individuals involved in the transition. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3* *Region 2: Exhibit A—6.4.5.1.3* *Regions 3, 5: Exhibit A—6.4.5.1.4*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care coordinators communicated with the local providers involved in the member's discharge plan. The care coordinators were intimately involved in the transition, but the member would not cooperate with the plan of care.	

Care Coordination Program Record Review	Score
Continued Coordination/Follow-up	
11. The documentation clearly indicated that the RCCO's (or designee's) provision of care coordination services was responsive to the member's needs. *Regions:1, 4, 6, 7: Exhibit A—6.4.3.2.3* *Regions 2, 3,5 : Exhibit A—6.4.5.2.3*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The record clearly documented attempts to arrange services responsive to the member's needs, but the member frequently did not attend appointments or follow through on other services.	
12. The RCCO (or designee) followed up with the member to assess whether the member has received the services needed and/or if the member is on track to reach his or her desired health outcomes. *Regions 1, 4, 6, 7 Exhibit A—6.4.3.1.6* *Region 2: Exhibit A—6.4.5.1.6* *Regions 3, 5: Exhibit A—6.4.5.1.7*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care coordinators made multiple attempts to contact the member on an ongoing basis, but the member only sporadically engaged and would not follow through with recommendations for services. At time of review, the care coordinator was trying to arrange for dental services for the member, but the member was again not responding to outreach contact attempts.	
Recommendations: The care coordinators expended many resources attempting to accommodate the member's needs and improve the member's health outcomes. However, the member only sporadically engaged and would not cooperate with recommendations due to alcoholism and mental health issues. Nevertheless, the care coordinators did not intend to discontinue care management and will continue to attempt contacts with the member. The care coordination team did an excellent job in difficult circumstances.	

Results for Care Coordination Program Record Review—Sample OS #8							
Total	Met	=	12	X	1.00	=	12
	Partially Met	=	0	X	0.0	=	0
	Not Met	=	0	X	0.0	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	12	**Total Score**		=	12

Total Score ÷ Total Applicable	=	100%

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

Care Coordination Program Record Review	Score
Assessment	
1. The RCCO (or designee) assessed the member's: ◆ Health behavior risks. ◆ Health/medical needs. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1* *Regions 2, 3, 5: Exhibit A—6.4.5.1.1*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager documented a thorough assessment of the member's health risks and needs. The member had been diagnosed as having thyroid cancer, narcolepsy, and behavioral health and substance abuse issues.	
2. The RCCO (or designee) assessed the member's: ◆ Non-medical needs. ◆ Linguistic and cultural needs. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1; 6.4.3.2.2* *Regions 2, 3, 5: Exhibit A—6.4.5.1.1; 6.4.5.2.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager documented a thorough assessment of the member's non-medical, linguistic, and cultural needs. The care manager also documented the member's hobbies and made a point of incorporating them into the member's care plan.	
3. The RCCO (or designee) assessed current care coordination services provided to the member to determine if the providers involved in each member's care are providing necessary care coordination services and which care coordination services are insufficient or are not provided. *Regions 1, 4, 6, 7: Exhibit A— 6.4.2.1* *Regions 2, 3, 5: Exhibit A—6.4.4.1*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager documented the agencies from which the member was receiving services.	

Care Coordination Program Record Review	Score
Intervention	
4. The RCCO (or designee) worked with providers responsible for the member's care to develop a plan for regular communication with those responsible for the member's care coordination. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.3* *Regions 2, 3, 5: Exhibit A—6.4.4.3*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager obtained a release of information from the member that allowed the care manager to discuss the member's care with her providers. The care manager met with the PCMP every 4 to 6 weeks and attended medical appointments with the member.	
5. The RCCO (or designee) reasonably ensured that all care coordination services, including those provided by other individuals or entities, met the needs of the member. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.4* *Regions 2, 3, 5: Exhibit A—6.4.4.4*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager documented regular communication with the member and her providers to ensure that the member's needs were addressed.	
6. The RCCO (or designee) provided necessary care coordination services not provided by another source. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.2* *Regions 2, 3, 5: Exhibit A—6.4.4.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager worked with the member to arrange transportation services and to pursue disability benefits.	
7. The RCCO (or designee) linked the member to medical and/or non-medical services, acted as a liaison between medical providers or between medical and non-medical providers, and/or served as a liaison between providers and the member. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.2* *Regions 2, 3, 5: Exhibit A—6.4.5.1.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The member indicated that she felt confused and caught between two specialists who disagreed on the appropriate level of care. The care manager worked with the member's PCMP to arrange for the member to be evaluated by a third specialist in Denver.	

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

Care Coordination Program Record Review	Score
Continued Coordination/Follow-up	
11. The documentation clearly indicated that the RCCO's (or designee's) provision of care coordination services was responsive to the member's needs. *Regions:1, 4, 6, 7: Exhibit A—6.4.3.2.3* *Regions 2, 3,5 : Exhibit A—6.4.5.2.3*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager's documentation clearly indicated that services provided were responsive to the member's needs. The care manager worked with the member to conduct a thorough assessment of needs and used that information to develop the care plan. The member was involved in the process and the care manager was careful to respect the member's desires and priorities.	
12. The RCCO (or designee) followed up with the member to assess whether the member has received the services needed and/or if the member is on track to reach his or her desired health outcomes. *Regions 1, 4, 6, 7 Exhibit A—6.4.3.1.6* *Region 2: Exhibit A—6.4.5.1.6* *Regions 3, 5: Exhibit A—6.4.5.1.7*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager documented frequent follow up with the member and the member's providers to ensure that the services received met the member's needs. Furthermore, the care manager's careful monitoring of the member's care allowed her to intervene in instances when the services did not meet the member's needs.	
Recommendations: This care manager did a great job coordinating the member's care. HSAG has no recommendations.	

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

Total Score ÷ Total Applicable	=	100%

Sample Number: OS #12 **Reviewer:** Rachel Henrichs

Care Coordination Program Record Review	Score
Assessment	
1. The RCCO (or designee) assessed the member's: ◆ Health behavior risks. ◆ Health/medical needs. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1* *Regions 2, 3, 5: Exhibit A—6.4.5.1.1*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: This member was a client of the Valley Wide FQHC for more than 15 years and had been working with the care manager prior to Medicaid eligibility. The care manager had conducted a comprehensive needs assessment and updated the assessment continually as needed. The most recent full assessment was conducted in 2013.	
2. The RCCO (or designee) assessed the member's: ◆ Non-medical needs. ◆ Linguistic and cultural needs. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1; 6.4.3.2.2* *Regions 2, 3, 5: Exhibit A—6.4.5.1.1; 6.4.5.2.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager had a well-established relationship with the member and had documented the member's linguistic and cultural needs. The care manager continually assessed the member's non-medical needs.	
3. The RCCO (or designee) assessed current care coordination services provided to the member to determine if the providers involved in each member's care are providing necessary care coordination services and which care coordination services are insufficient or are not provided. *Regions 1, 4, 6, 7: Exhibit A— 6.4.2.1* *Regions 2, 3, 5: Exhibit A—6.4.4.1*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager had comprehensive documentation of providers and agencies from which the member was receiving care and services.	

Care Coordination Program Record Review	Score
Intervention	
4. The RCCO (or designee) worked with providers responsible for the member's care to develop a plan for regular communication with those responsible for the member's care coordination. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.3* *Regions 2, 3, 5: Exhibit A—6.4.4.3*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager's notes indicated regular communication with the member's health care providers to ensure ample services without duplication.	
5. The RCCO (or designee) reasonably ensured that all care coordination services, including those provided by other individuals or entities, met the needs of the member. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.4* *Regions 2, 3, 5: Exhibit A—6.4.4.4*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: Care manager notes indicated having spoken with the member weekly. The care manager appeared to provide the member with much needed moral support and guidance on addressing health concerns. The care manager spoke with the member's providers regularly to ensure that the member's needs were addressed.	
6. The RCCO (or designee) provided necessary care coordination services not provided by another source. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.2* *Regions 2, 3, 5: Exhibit A—6.4.4.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager assisted the member with scheduling appointments and transportation. The member was scheduled to have surgery in a different city soon after the site review ended. The care manager had arranged overnight accommodations for the member's family so that they could be close to the member during her hospitalization.	

Care Coordination Program Record Review	Score
Intervention	
7. The RCCO (or designee) linked the member to medical and/or non-medical services, acted as a liaison between medical providers or between medical and non-medical providers, and/or served as a liaison between providers and the member. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.2* *Regions 2, 3, 5: Exhibit A—6.4.5.1.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager assisted the member with finding new primary care provider, scheduling appointments with specialists, arranging transportation, and understanding and filling out necessary paperwork. The care manager regularly facilitated exchange of records between the PCMP and specialists.	

Care Coordination Program Record Review	Score
Transitions	
8. The RCCO (or designee) provided assistance during care transitions from hospitals or other care institutions to home- or community-based settings. This assistance promoted continuity of care. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3* *Region 2,: Exhibit A—6.4.5.1.3* *Regions 3, 5: Exhibit A—6.4.5.1.4*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager spoke to the discharge planner at the hospital prior to the member being released after scheduled surgery and followed up regularly with the member after discharge to ensure that discharge plans were followed.	
9. The RCCO (or designee) provided assistance during other transitions, such as the transition from children's health services to adult health services or from hospital or home care into a nursing facility. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3* *Region 2: Exhibit A—6.4.5.1.3* *Regions 3, 5: Exhibit A—6.4.5.1.4*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
Observations: The member did not experience this type of transition during the review period.	
10. The RCCO (or designee) documented and communicated necessary information about the member to the providers, institutions, and individuals involved in the transition. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3* *Region 2: Exhibit A—6.4.5.1.3* *Regions 3, 5: Exhibit A—6.4.5.1.4*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager spoke to the discharge planner prior to the member's discharge in 2013. The care manager also noted conversations with hospital staff prior to the member's inpatient stay, which was scheduled to occur soon after the site review.	

Care Coordination Program Record Review	Score
Continued Coordination/Follow-up	
11. The documentation clearly indicated that the RCCO's (or designee's) provision of care coordination services was responsive to the member's needs. *Regions:1, 4, 6, 7: Exhibit A—6.4.3.2.3* *Regions 2, 3,5 : Exhibit A—6.4.5.2.3*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager's notes indicated a well-established relationship with the member. The care manager was very responsive to the member's needs by providing educational materials, assistance with scheduling appointments and transportation and navigating the health care system, and providing overall moral support.	
12. The RCCO (or designee) followed up with the member to assess whether the member has received the services needed and/or if the member is on track to reach his or her desired health outcomes. *Regions 1, 4, 6, 7 Exhibit A—6.4.3.1.6* *Region 2: Exhibit A—6.4.5.1.6* *Regions 3, 5: Exhibit A—6.4.5.1.7*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care coordinator followed up with the member and her providers regularly to ensure that the member's needs were addressed. The care manager documented the member's need for behavioral health services and recognized the member's reluctance to seek them. The care manager worked with the member to develop easy-to-reach goals and gently, but continually, encouraged the member to seek support for her depression.	
Recommendations: The care manager did a great job coordinating care for this member. HSAG has no recommendations.	

Results for Care Coordination Program Record Review—Sample OS #12						
Total	Met	=	11	X	1.00	= 11
	Partially Met	=	0	X	0.0	= 0
	Not Met	=	0	X	0.0	= 0
	Not Applicable	=	1	X	NA	= 0
Total Applicable		=	11	**Total Score**		= 11

Total Score ÷ Total Applicable	= 100%

Sample Number: OS #13 **Reviewer:** Rachel Henrichs

Care Coordination Program Record Review	Score
Assessment	
1. The RCCO (or designee) assessed the member's: ◆ Health behavior risks. ◆ Health/medical needs. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1* *Regions 2, 3, 5: Exhibit A—6.4.5.1.1*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The member's assessment identified multiple risks and needs including depression, posttraumatic stress disorder, liver disease, and substance abuse disorder. The assessment was updated every six months.	
2. The RCCO (or designee) assessed the member's: ◆ Non-medical needs. ◆ Linguistic and cultural needs. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1; 6.4.3.2.2* *Regions 2, 3, 5: Exhibit A—6.4.5.1.1; 6.4.5.2.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The member's needs assessment reviewed non-medical, linguistic, and cultural needs. The assessment identified a variety of needs including transportation and telephone. The assessment was updated every six months.	
3. The RCCO (or designee) assessed current care coordination services provided to the member to determine if the providers involved in each member's care are providing necessary care coordination services and which care coordination services are insufficient or are not provided. *Regions 1, 4, 6, 7: Exhibit A— 6.4.2.1* *Regions 2, 3, 5: Exhibit A—6.4.4.1*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The member's assessment listed the names and telephone numbers for all providers from whom the member was receiving services, including physical health specialists, behavioral health providers, primary care provider, dental provider, and the agencies with which the member was engaged. The assessment was updated every six months.	

Care Coordination Program Record Review	Score
Intervention	
4. The RCCO (or designee) worked with providers responsible for the member's care to develop a plan for regular communication with those responsible for the member's care coordination. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.3* *Regions 2, 3, 5: Exhibit A—6.4.4.3*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager's notes indicated regular communication between the physical and behavioral health care managers and between the physical health care manager and the physical health specialists.	
5. The RCCO (or designee) reasonably ensured that all care coordination services, including those provided by other individuals or entities, met the needs of the member. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.4* *Regions 2, 3, 5: Exhibit A—6.4.4.4*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The physical and behavioral health care managers communicated with each other regularly and spoke with the member at least once monthly to ensure that the member's needs were being addressed.	
6. The RCCO (or designee) provided necessary care coordination services not provided by another source. *Regions 1, 4, 6, 7: Exhibit A—6.4.2.2* *Regions 2, 3, 5: Exhibit A—6.4.4.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care managers worked with the member to obtain low-cost cellular telephone service. The care managers also assisted the member with transportation to out-of-town appointments.	
7. The RCCO (or designee) linked the member to medical and/or non-medical services, acted as a liaison between medical providers or between medical and non-medical providers, and/or served as a liaison between providers and the member. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.2* *Regions 2, 3, 5: Exhibit A—6.4.5.1.2*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care managers' notes indicated good communication between providers. The PCMP followed up regularly with the member's specialists to obtain copies of records. The care managers ensured that the member's electronic health record remained up-to-date.	

Care Coordination Program Record Review	Score
Transitions	
8. The RCCO (or designee) provided assistance during care transitions from hospitals or other care institutions to home- or community-based settings. This assistance promoted continuity of care. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3* *Region 2,: Exhibit A—6.4.5.1.3* *Regions 3, 5: Exhibit A—6.4.5.1.4*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
Observations: The member did not transition care from a hospital during the review period.	
9. The RCCO (or designee) provided assistance during other transitions, such as the transition from children's health services to adult health services or from hospital or home care into a nursing facility. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3* *Region 2: Exhibit A—6.4.5.1.3* *Regions 3, 5: Exhibit A—6.4.5.1.4*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager provided the member assistance choosing a new provider after the member's provider moved out of town. After a few months, the member decided not to keep the new provider. The care manager helped the member with transportation arrangements so that the member could obtain care from his original, now out-of-town, provider.	
10. The RCCO (or designee) documented and communicated necessary information about the member to the providers, institutions, and individuals involved in the transition. *Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3* *Region 2: Exhibit A—6.4.5.1.3* *Regions 3, 5: Exhibit A—6.4.5.1.4*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care manager worked with the member and his providers to ensure transfer of medical records and to arrange transportation services.	

Care Coordination Program Record Review	Score
Continued Coordination/Follow-up	
11. The documentation clearly indicated that the RCCO's (or designee's) provision of care coordination services was responsive to the member's needs. *Regions:1, 4, 6, 7: Exhibit A—6.4.3.2.3* *Regions 2, 3,5 : Exhibit A—6.4.5.2.3*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care managers' notes indicated that the member was easy to work with. The care managers used the thorough assessment of member needs to develop a care plan. The care plan was updated every six months to ensure that the services provided addressed the member's needs.	
12. The RCCO (or designee) followed up with the member to assess whether the member has received the services needed and/or if the member is on track to reach his or her desired health outcomes. *Regions 1, 4, 6, 7 Exhibit A—6.4.3.1.6* *Region 2: Exhibit A—6.4.5.1.6* *Regions 3, 5: Exhibit A—6.4.5.1.7*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Observations: The care managers' notes indicated that they spoke to the member a minimum of once monthly. The care managers tracked the member's appointments and followed up with the member both after appointments with specialists and in the event that the member missed any appointments.	
Recommendations: The care managers did a great job working together and with the member to ensure that the member's needs were addressed without duplicating efforts. HSAG has no recommendations.	

Results for Care Coordination Program Record Review—Sample OS #13							
Total	Met	=	11	X	1.00	=	11
	Partially Met	=	0	X	0.0	=	0
	Not Met	=	0	X	0.0	=	0
	Not Applicable	=	1	X	NA	=	0
Total Applicable		=	11	**Total Score**		=	11

Total Score ÷ Total Applicable	=	100%

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

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

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

Provider Location (LINE 1)	Provider Location (CITY)	Provider Location (COUNTY)	Practitioner (LAST NAME)	Practitioner (FIRST NAME)
201 Kendall Drive	Lamar	Prowers	Abbott	John
302 Main St.	Wiley	Kiowa	Abbott	John
3676 Parker Blvd., Ste. 260	Pueblo	Pueblo	Beauman	John
3937 Ivywood Lane	Pueblo	Pueblo	Beauman	John

Table C-2—Number of Unique Providers Serving Region 4

Nurse practitioner	54
Osteopath	16
Other	1
Physician assistant	38
Physician	117
Grand Total	**226**

Table C-3—Number of Unique Providers Serving Region 4 Accepting New Medicaid Members

Nurse practitioner	51
Osteopath	15
Other	1
Physician assistant	37
Physician	106
Grand Total	**210**

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

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

Provider Location (LINE 1)	Provider Location (CITY)	Provider Location (COUNTY)	Practitioner (LAST NAME)	Practitioner (FIRST NAME)
201 Kendall Drive	Lamar	Prowers	Abbott	John
302 Main St.	Wiley	Kiowa	Abbott	John
3676 Parker Blvd., Ste. 260	Pueblo	Pueblo	Beauman	John
3937 Ivywood Lane	Pueblo	Pueblo	Beauman	John

Table C-5—Region 4 Unique Providers by County

Alamosa	25
Baca	4
Bent	3
Chaffee	9
Conejos	3
Costilla	1
Crowley	3
Custer	2
Denver	3
Fremont	16
Huerfano	6
Kiowa	3
Lake	3
Las Animas	3
Mineral	1
Otero	10
Prowers	20
Pueblo	102
Rio Grande	13
Saguache	9
Grand Total	239

Table C-6—Region 4 Unique Providers by County Accepting New Medicaid Members	
Alamosa	25
Baca	4
Bent	3
Chaffee	9
Conejos	3
Costilla	1
Crowley	3
Custer	2
Denver	3
Fremont	16
Huerfano	6
Kiowa	3
Lake	3
Las Animas	3
Mineral	1
Otero	10
Prowers	17
Pueblo	89
Rio Grande	13
Saguache	9
Grand Total	223

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

Table C-7—Example of Duplicate Locations Eliminated Before Calculating Unique Locations by County				
Provider Location (LINE 1)	**Provider Location (CITY)**	**Provider Location (COUNTY)**	**Practitioner (LAST NAME)**	**Practitioner (FIRST NAME)**
201 Kendall Drive	Lamar	Prowers	Abbott	John
201 Kendall Drive	Lamar	Prowers	Hillman	Meagan
201 Kendall Drive	Lamar	Prowers	Middaugh	Louise
300 Colorado Avenue	Pueblo	Pueblo	Barris	Michael
300 Colorado Avenue	Pueblo	Pueblo	Knudsen	Rona K

Table C-8—Number of Unique Provider Locations Serving Region 4	
Alamosa	5
Baca	1
Bent	2
Chaffee	2
Conejos	1
Costilla	1
Crowley	1
Custer	1
Denver	1
Fremont	8
Huerfano	2
Kiowa	2
Lake	2
Las Animas	2
Mineral	1
Otero	4
Prowers	5
Pueblo	29
Rio Grande	5
Saguache	3
Grand Total	78

Appendix D. Site Review Participants
for Integrated Community Health Partners (Region 4)

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

Table D-1—HSAG Reviewers and RCCO Participants	
HSAG Review Team	**Title**
Katherine Bartilotta, BSN	Project Manager
Rachel Henrichs	Project Coordinator
ICHP Participants	**Title**
Enid Agosto	Provider Relations Representative
Mona Allen	Performance Improvement Director
Andrea Carlstrom	Business Project Coordinator, West Central Mental Health
Claire Chadwell-Bell	Regional Clinical Care Director
Crystal Cook	Care Coordinator, High Plains Community Health Center
Michelle Denman	Director, Provider Relations
Michelle East	Integrated Services Program Coordinator, Pueblo Community Health Center
Kat Fitzgerald	Quality Management Auditor
Haline Grublak	Director, Member Services
Ava Hoffman	Care Coordinator
Cindy Jimenez	Behavioral Health Manager, Pueblo Community Health Center
Susan Lamont	Patient Liaison, Prowers Medical Center
Jody McCasland	System Analyst, West Central Mental Health Center
Kristi Meyer	Program Supervisor, West Central Mental Health Center
Donna Mills	Chief Executive Officer
Donald Moore	ICHP Board Member (telephonically)
Tammy Moruzzi	Registered Nurse Care Coordinator
Tammy Payne	Care Coordinator, Valley-Wide Health Systems, Inc. (telephonically)
Chet Phelps	Information Technology
Anita Rich	Colorado Children's Healthcare Access Program
Melissa Richardson	Executive Assistant to Chief Executive Officer
Lori Roberts	Chief Operating Officer
Victoria Romero	Clinical Director, San Luis Valley Mental Health Center
Anne Russell	Supervisor, Southeast Mental Health Services
Charmayne Sandoval	Care Coordinator, West Central Mental Health Center
Kari Snelson	Chief Compliance Officer, West Central Mental Health Center

Table D-1—HSAG Reviewers and RCCO Participants	
Leova Villalobos	Care Coordinator, Valley-Wide Health Systems, Inc. (telephonically)
Heather White	Integrated Healthcare Supervisor, Spanish Peaks Behavioral Health Center
Charlotte Yianakopulos-Veatch	Spanish Peaks Behavioral Health Center, Chief Clinical Officer
Department Observers	**Title**
Elizabeth Baskett	Reform Section Manager
Rachel DeShay	Region 4 Contract Manager
Kaitlin Forthofer	Title not provided
Russell Kennedy	Quality and Health Improvement Unit
Christian Koltonski	Quality Health Improvement Specialist
Dustin Moyer	Program Associate
Mark Queirolo	Integrated Health Specialist
Sophie Thomas	Reform Section, Colorado Department of Health Care Policy and Financing
Matt Vedol	Title not provided
Van Wilson	Project Manager, FBMME Demonstration
JD Belshe	Policy 8 Program Analyst