COLORADO

Department of Health Care Policy & Financing

FY 2014–2015 Site Review Report Executive Summary

for

Integrated Community Health Partners (Region 4)

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

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Introduction and Background

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

The Affordable Care Act of 2010 allowed for Medicaid expansion and eligibility based on 133 percent of the federal poverty level. Affected populations included parents of Medicaid-eligible children and adults without dependent children. The Department estimated that, as a result of Medicaid expansion, 160,000 additional members would be integrated into the RCCOs in phases. In addition, the Accountable Care Collaborative: Medicare-Medicaid Program demonstration project provided for integration of 32,000 new dually eligible Medicare-Medicaid members into the RCCOs, beginning September 2014. Effective July 2014, the RCCO contract was amended primarily to specify additional requirements and objectives related to the integration of ACC Medicare-Medicaid Program (MMP) enrollees.

Each year since the inception of the ACC Program, the Department has engaged Health Services Advisory Group, Inc. (HSAG), to conduct annual site reviews to evaluate the development of the RCCOs and to assess each RCCO's organizational successes and challenges in implementing key components of the ACC Program. This report documents results of the fiscal year (FY) 2014–2015 site review activities, which included delegation of care coordination, RCCO coordination with other agencies and provider organizations, and performance of individual member care coordination. This section contains summaries of the activities and on-site discussions related to each focus area selected for the 2014–2015 site review, as well as HSAG's observations and recommendations. In addition, Table 1-1 contains the results of the 2014–2015 care coordination record reviews. Table 1-2 provides a comparison of the overall 2014–2015 record review scores to the 2013–2014 record review scores. Section 2 provides an overview of the monitoring activities and describes the site review methodology used for the 2014–2015 site reviews. Appendix A contains the completed on-site data collection tool. Appendix B contains detailed findings for the care coordination record reviews. Appendix C lists HSAG, RCCO, and Department personnel who participated in the site review process.

To prepare for the on-site review activities, HSAG requested that **ICHP** submit policies, procedures, and program descriptions that outline the care coordination activities performed by the primary care medical providers (PCMPs) or other entities; copies of delegation agreements, MOUs, or other documents that describe the relationships related to performance of care coordination activities; audit or assessment forms and/or reports used to monitor delegated activities; and committee or team meeting minutes that demonstrate the interactions with delegates and partners concerning care coordination policies, procedures, and programs. HSAG also asked for lists of organizations and agencies with which the RCCO has an established relationship, a description of the entity, special populations served, and the nature of the relations with the RCCO. HSAG carefully reviewed all documents submitted prior to the on-site review and used the information to help guide discussions.

Summary of Results

The care coordination record reviews focused on two select populations: children with special needs and adults with complex needs. HSAG assigned each requirement in the record review tools a score *of Met, Partially Met, Not Met, or Not Applicable*. HSAG also identified opportunities for improvement with associated recommendations for each record. Table 1-1 presents the scores for **ICHP**'s care coordination record reviews for each special population reviewed. Detailed findings for the record reviews are in Appendix B—Record Review Tools.

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

Description of Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score* (% of *Met* Elements)
Children With Special Needs	45	35	35	0	0	10	100%
Adults With Complex Needs	35	25	25	0	0	10	100%
TOTAL	80	60	60	0	0	20	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 point value of 0.0)

Table 1-2 provides a comparison of the overall 2014–2015 record review scores to the 2013–2014 record review scores. Although most contract requirements remained the same for the two review periods, scores may have changed due to reformatting and clarifications in the record review tool.

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

Description of Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Not Met*	# *Partially Met*	# *Not Applicable*	Score* (% of *Met* Elements)
Care Coordination 2013–2014	192	153	153	0	0	39	100%
Care Coordination 2014–2015	80	60	60	0	0	20	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 point value of 0.0)

The Data Collection Tool (Appendix A) was used to capture the results of the pre-on-site document review and on-site discussions related to Delegation of Care Coordination and RCCO Coordination With Other Agencies/Provider Organizations. Following is a summary of results for each content area of the 2014–2015 review.

Summary of Findings and Recommendations by Focus Area

Delegation of Care Coordination

Activities and Progress

ICHP delegates all core functions of care coordination—including assessing member needs, developing a care coordination plan, monitoring progress, and communicating information to various providers—to its seven partner federally qualified health centers (FQHCs) or community mental health centers (CMHCs). **ICHP** signed delegation agreements with each of the seven entities that delineated the overarching goals of RCCO care coordination and the delegated entity's specific responsibilities. The agreements included the RCCO's right to audit delegated activities and to terminate the contract for noncompliance. These agreements are updated annually based on RCCO contract requirements with the Department—with the most recent update including the requirement to complete service coordination plans (SCPs) for the Medicare-Medicaid Program (MMP) population.

ICHP aligns a care coordinator from each CMHC with a care coordinator from each FQHC to create seven care coordination teams. Each team is responsible to coordinate care for RCCO members attributed to its own organizations as well as provide care coordination support for members with complex needs attributed to other PCMP practices within its service area. Care coordinators are also responsible for managing care for unattributed members and pursuing attribution of members to PCMPs. This basic structure for care coordination within the region has been in place since the inception of **ICHP**. The RCCO's clinical care director oversees the regionwide care coordination program and provides support to the teams as needed. **ICHP**'s operational philosophy is to augment, but not hinder, local care coordination efforts by supporting local systems of care. Therefore, care coordination documentation systems varied among the delegates. The RCCO fosters and facilitates collaboration between the care coordination teams through the Care Coordination Workgroup.

The Care Coordination Workgroup meets monthly and is responsible for developing care coordination policies, defining procedures for consistent application across all PCMP offices, reviewing and improving key performance indicator (KPI) performance, identifying and resolving gaps in care coordination, and suggesting mechanisms to manage new member populations. Recent workgroup discussions included planning for implementation of the service coordination plans (SCPs) for Medicare-Medicaid Program (MMP) members and developing input for the design of the Crimson Care Management software system. The collaborative nature of the Care Coordinator Workgroup has enhanced the capabilities of individual teams as well as promoted consistency and increased standardization of some processes.

As the care coordination processes have matured, **ICHP** has expanded the role of care coordination teams to support communications and implement projects in the local communities. Care coordination activities have evolved to be tightly integrated with practice transformation and quality improvement activities across the region and provide an essential conduit between diverse local environments and RCCO leadership. **ICHP** views the care coordination teams as an invaluable resource for implementing RCCO objectives in communities throughout the region.

In 2015, **ICHP** will implement the Crimson Care Management software system. This software system—developed by and financially supported through **ICHP**—will promote consistency and integration of care coordination documentation by allowing all care coordinators and providers to enter and access information pertinent to care coordination in one consolidated file. The system will be implemented by all care coordination teams throughout the RCCO and will ultimately be offered to community agencies and other organizations participating in care coordination for RCCO members.

At the time of the review, **ICHP** had performed a full practice assessment of every provider in the network (164 practices) to evaluate the processes of each practice related to primary care medical home functions. During 2014, **ICHP** also assessed 137 practices for enhanced primary care factors. The **ICHP** practice transformation team performs the practice assessment through an on-site, face-to-face review using broadly defined criteria. Subsequently, a more detailed care coordination assessment is performed and the assigned **ICHP** care coordination team is introduced to the practice. Prior to delegating care coordination to the existing FQHC/CMHC teams, **ICHP** evaluated the organization's care coordination capabilities and systems.

ICHP monitors delegated care coordination functions annually using a detailed record review audit tool that incorporates the comprehensive care coordination characteristics defined in the RCCO contract with the Department. **ICHP** also monitors each delegated entity's KPIs from the State Data Analytics Contractor (SDAC) reports and through care coordination metrics submitted by the delegated care coordination teams to **ICHP** monthly. The metrics are aligned with the care coordination expectations outlined in the delegation agreement. **ICHP** meets with each practice or care coordination team to review the audit results, identify any concerns, and develop a plan for improvement when indicated. The **ICHP** Medical Management Team oversees and reviews the monitoring and audit results and reports to the COO and CEO any concerns or opportunities for improvement.

ICHP has been collecting care coordination metrics for submission to the Department in the Aggregated Care Coordination Metrics report since the early implementation of the care coordination program. The revised Care Coordination Report requirements, which include the categorization of care coordination activities by types of members, required that **ICHP** develop mechanisms to manually match eligibility information from the SDAC with individual members on the care coordination list submitted by the delegates. On a short-term basis, staff members stated that **ICHP** may not be able to capture some of the eligibility category information required in the report. Ultimately, **ICHP** intends to automate the Department's care coordination report through the Crimson Care Management system.

Staff members stated that the care coordination activities for MMP members are the same as for any other Medicaid member and that **ICHP** has not modified its core care management processes to

accommodate any special populations. However, **ICHP** does expect that a large proportion of MMP members will require complex care coordination, will impact the types of resources required, and will stimulate new relationships with community organizations and agencies. The two aspects of the MMP expansion that have dominated the time required of care coordination resources are attribution of members and completion of SCPs. Staff members reported that delegated care coordination teams are spending excessive amounts of time attempting contact with MMP members in order to properly attribute the member to a PCMP and complete the rather lengthy SCP. **ICHP** management is carefully tracking the completion process, evaluating barriers, and determining what can be done to expedite the process. **ICHP** intends to integrate the SCP document into the Crimson Care Management system where it can be readily shared with providers and community agencies.

Observations/Recommendations

At the inception of the ACC program, **ICHP** positioned care coordination as a central theme of the RCCO. **ICHP** has delegated all care coordination activities to community-based PCMP care coordination teams throughout the region. Care coordination team activities have evolved to become integrated with practice transformation and quality improvement initiatives across the region and to provide an essential conduit between diverse local environments and RCCO leadership. With the integration of MMP members into the RCCO, care coordination teams have also assumed responsibility for completing the SCPs for MMP members. It appears that **ICHP** has designed and nurtured a care coordination model that has continuously engaged providers and care coordinators in supporting RCCO objectives and improving services to members in local communities. **ICHP** has also benefited from very low staff turnover at both the management and local care coordination levels.

ICHP has a well-defined predelegation assessment process for evaluating PCMP care coordination capabilities which has been incorporated with the more comprehensive activities of the practice transformation team. **ICHP** also implemented regular auditing of delegated care coordination functions, which addresses the comprehensive care coordination requirements specified in the RCCO contact with the Department. During 2014, **ICHP** invested in the development of the Crimson Care Management (Crimson) system, which will integrate the documentation of care coordination from multiple users into a consolidated care management record and provide automated reporting of care coordination activities. Crimson implementation is intended in mid-2015.

ICHP continues to have issues related to lack of consistent and timely reporting of a member's admit, discharge, and transfer (ADT) information from hospitals or other facilities—which inhibits timely care coordinator follow-up or assistance with transitions of care. **ICHP** has identified that access to information in the Colorado Regional Health Information Organization (CORHIO) system is the best solution to this issue. Both the Crimson system and the CORHIO data link are intended to provide **ICHP** with essential information for further integrating the care coordination processes. However, since both of these technologies are in the pre-implementation phase and yet unproven, **ICHP** should continue to consider alternatives for achieving improved integration of the care coordination records and gaining access to timely ADT information for RCCO members.

ICHP staff stated that about 18 percent of members were unattributed and between 30 and 40 percent of RCCO members were attributed to the incorrect PCMP and/or had incorrect contact

information. Therefore, achieving accurate attribution of members requires a major consumption of care coordination resources. This situation has been further exacerbated by the addition of the MMP expansion population. **ICHP** should continue to work with the Department and its community partners to collaboratively pursue mechanisms to improve accurate attribution of members to PCMPs.

RCCO Coordination With Other Agencies/Provider Organizations

Activities and Progress

ICHP provided a list of numerous community organizations with which it has developed or is developing relationships concerning services for RCCO members or with which there are mutual interests of improving the long-term health of its communities. Much of the region is rural with limited resources yet has a community-oriented culture highly invested in local health systems and the wellbeing of the populations within its communities. The diverse demographics and geographically widespread characteristics of Region 4 make it challenging to manage staff resources needed to develop relationships and participate in programs with community organizations across the region. Key RCCO management staff, including the CEO, travel extensively within the region to orient community leaders and organizations to the role of the RCCO and develop personal relationships. Staff stated that care coordination teams have been invaluable for identifying key relationships within their communities. **ICHP**'s core strategies for building relationships have been to maintain high visibility, meet face-to-face and develop personalized relationships with organization leaders, and position the RCCO as a coordinator of community resources.

ICHP cited the major success factors in building community partner relationships as (1) creating a positive first impression by positioning the RCCO as an organization available to assist others with their self-identified needs; (2) establishing that the RCCO's role is to participate in improving the wellness of individual communities over the long term; and (3) bringing resources such as data systems, and funding to organizations in order to facilitate mutual goals. Staff stated that receptivity to the RCCO varies by organization—some organizations perceive the RCCO as threatening or having competing interests; whereas, others believe involvement with the RCCO is necessary to survive. Staff reported that the perception of the RCCO has evolved over several years—from no visibility or a negative stigma to recognition of the survivability of the RCCO as a key component of the Medicaid system. Staff stated that **ICHP**'s participation in State and federal demonstration grants has brought needed resources to communities through specific initiatives such as the region-wide opioid performance improvement project (PIP) and the regionwide community-based collaborative efforts to organize resources for MMP members.

A major challenge for **ICHP** has been balancing the time required to build and maintain relationships with the other goals and initiatives of the RCCO. Therefore, **ICHP** developed a strategic plan for aligning RCCO resources with identified high-priority needs of the region. **ICHP** is confident that it has established a positive foundation to support the long-term goal of engaging with a network of community organizations to improve community health in the region.

ICHP also identified numerous agencies throughout the region with which it has established relationships—including the county Departments of Human Services (DHS); the Area Agency on Aging; Single Entry Point (SEP); CCBs; behavioral health agencies, including the regional behavioral health organization (BHO); disability agencies; vocational training agencies; and public health departments. Initial outreach efforts focused on the larger agencies in the region, but have since transitioned to being driven by the initiatives and requirements of the RCCO. As MMP and criminal justice involved (CJI) expansion populations have been integrated into the RCCO, **ICHP** has identified new agency relationships needed to fill gaps in services. A particular challenge with establishing relationships with publicly funded agencies is the siloing effect created by separate funding sources and associated requirements. RCCO and agency contractual responsibilities may not always align.

Staff expressed that agency relationships are more complex, include more barriers, and require a more formal approach than those with community organizations. **ICHP**'s approach to developing relationships with agencies has been to encourage a mutual understanding of needs and responsibilities and to share resources, when possible, to address common concerns. Staff reported that agencies are gradually acknowledging that the RCCO is a significant component of the Medicaid system and that the RCCO may have value in coordinating resources related to mutual objectives. **ICHP** identified that the biggest challenges in working with agencies in general are turnover of agency staff and management, operational backlogs and "burnout" of personnel, entrenched and "broken processes" in agency operations, and a history of mistrust among agencies. **ICHP** is exploring opportunities to share technology resources with select agencies and has engaged numerous agencies to participate in specific RCCO or community-based initiatives across the region, including the development of collaborative protocols for the MMP population.

Special Populations:

The Ryan White program and related services for members with human immunodeficiency virus (HIV) were established in the region prior to initiation of the ACC program. Administered through the Pueblo Community Health Center (PCHC), the Ryan White program has an effective care coordination program for members in need of HIV services. **ICHP** care coordination teams have participated in Colorado Department of Public Health and Environment (CDPHE) statewide trainings and forums and have been oriented to the types of services available for HIV members. An ongoing referral relationship exists among providers, care coordinators, and the Ryan White program. Due to the sensitivity of its member information, the Ryan White program declined a data-sharing agreement with the RCCO. Although the RCCO remains remotely involved with HIV members, both **ICHP** and Ryan White staff are confident in the relationship between the two programs, and **ICHP** has no concern about the local programs or the services available for members within the region.

ICHP has partnered with Colorado Health Partnerships (CHP), the regional BHO, to conduct a joint, regionwide PIP to address care coordination and linking CJI members to Medicaid providers upon transition from county jails back to the community. All 19 counties in the region have been contacted to participate, and data-sharing agreements are being pursued. Due to the challenge of tracking admission and discharge of CJI members from the county jails, **ICHP** and the BHO will pilot test a data and communications system product (developed by Beacon Health Options) within four counties. If successful, the system use will expand to other counties and entities. The PIP is the

first step in exploring an effective mechanism for integrating CJI members from the county jail system into the Medicaid provider network.

Region 4 is also geographically aligned with the major prison population in the State. **ICHP** is coordinating with the Department's initiative with the Colorado Department of Justice to determine mechanisms for integrating persons released from the prison systems into the RCCO and BHO provider network. At the time of HSAG review, no short-term implementation plan had been defined.

During on-site interviews, HSAG queried staff related to **ICHP** progress both in identification of Medicaid-eligible women who are pregnant for attribution to a PCMP and appropriate management of high-risk pregnancies. Staff stated that PCHC delivers the majority of services to pregnant Medicaid enrollees in the region and that primary care providers are incented to refer pregnant women to PCHC. Women also seek services through the public health departments and some community-based organizations. However, identification of these members to the RCCO is based on timely access to data from these entities, which may be facilitated through the implementation of the Crimson Care Management system with community organizations and agencies. Staff also cited the complexity of psychosocial situations or cultural considerations that may prevent women from seeking engagement with the health system early in their pregnancy and which may further complicate the early identification process. On an ongoing basis, **ICHP** participates in health fairs for pregnant women to encourage early identification and engagement in RCCO programs.

During 2014, **ICHP** and the Department held community forums at four locations across the region to introduce providers, local agencies, and community organizations to the MMP demonstration program and begin discussing protocols to enable data sharing for MMP members. **ICHP** will continue the dialogue throughout 2015 through quarterly meetings in each of four communities. The purpose of the meetings is to develop an understanding of the role, purpose, or services of each participating organization and to collaboratively develop a 3-year community-based plan for coordinating care and services for MMP members. **ICHP** estimated that 100 attendees from agencies and community organizations not currently affiliated with **ICHP** will be involved in these community forums. **ICHP** intends to maintain consistency in its philosophy of positioning the RCCO as the convening entity for other organizations, facilitator of common interests and goals, and provider of resources (as possible) to enhance the local systems of care. **ICHP** expects the development of community networks for MMP members and the establishment of the multiple associated relationships unique to this population to be a long-term, ongoing process.

Observations/Recommendations

ICHP has been active and thoughtful in its approach to establishing relationships with community organizations and agencies since the inception of the RCCO. **ICHP** instituted a philosophy of approaching organizations in a manner that fosters understanding of the RCCO as well as identifies and supports other organizations' needs and goals. **ICHP** has dedicated considerable leadership energy to developing relationships on a community-specific basis. These efforts appear to have successfully established a foundation for collaborative activities. **ICHP** has remained consistent in its commitment to position the RCCO as a facilitator, coordinator, or provider of resources to enhance community health. In return, multiple communities have become engaged in and supportive of RCCO objectives and initiatives. The generally rural dynamics of the region present both unique opportunities and challenges. Staff stated that statewide and local policy decisions may

be required in order to overcome some of the barriers between agencies and the RCCO. However, it appears that **ICHP**'s stable leadership, integrated relationship with and support from the Department, community-based philosophy, and ability to respond to challenges in a flexible and innovative manner have positively influenced its relationships in the region. The sustainability of the RCCO has also begun to resonate with existing and potential partners. As Department-directed initiatives build, **ICHP** has recognized the need to align the expenditure of personnel resources with **ICHP** priorities and the needs and interests of **ICHP**'s communities. **ICHP** may be able to use some of its "political capital" to increasingly engage others to cooperate in the support of RCCO-led objectives to further engagement and services for special populations in the RCCO. **ICHP** may want to consider assigning specific staff "champions" to lead operational efforts related to integration of CJI, MMP, and pregnant women on a more short term-basis than may be enabled through a PIP, quarterly planning forums for MMP, or other collaborative initiatives.

Care Coordination Record Reviews

Findings

On-site care coordination record reviews demonstrated that member populations; community health resources; and systems of documentation and communication remain diverse between care coordination teams and service areas, reflective of **ICHP**'s support for local systems of care. **ICHP** care coordination record reviews scored 100 percent compliance with RCCO care coordination contract requirements. Overall, HSAG observed evidence of coordination among **ICHP** care coordinators and external providers and agencies working with the members. Care coordinators consistently documented regular efforts to contact members. Coordinators generally conducted and documented a thorough assessment of each member's needs. Common barriers encountered by care coordinators were the inability to contact the member due to invalid or disconnected telephone numbers and the member's unwillingness to participate in efforts and/or follow-through on referrals.

Observations/Recommendations

Overall, **ICHP**'s "team" approach to care coordination appears to be operating effectively across the region. However, it was noted in several record reviews that the CMHC and PCMP components of care coordination continue to be embedded in varying locations within the electronic record, such that there is not one location for a consolidated view of the care coordination processes. HSAG recognizes and applauds **ICHP**s intent to achieve an integrated record through the design and implementation of the Crimson Care Management system. However, pending **ICHP**'s evaluation of the success of the Crimson system, **ICHP** care coordinators should ensure that all applicable care coordination information is documented by the lead coordinator in one location.

HSAG also noted that the lack of access to ADT information was preventing care coordinators from assisting with members' transitions of care. In multiple pregnancy cases, the care coordinator was not aware of a member's high-risk delivery until after the baby was born and the member had been released from the hospital. **ICHP** has been working with CORHIO to accomplish a direct link that will enable timely access to hospital ADT and other member information throughout the region. Staff stated that the Department's collaboration with CORHIO may be a short-term source for this information. However, **ICHP** should continue to consider other alternatives if either of these sources of information prove to be unsatisfactory, and should prioritize these initiatives to the degree possible.