Accountable Care Collaborative Program

RCCO 2 – Community Meeting – Program Improvement Advisory Committee

23 April 2014

These are the meeting minutes from the fifth community meeting to discuss the RCCO RFP. These stakeholder meetings are a collaboration of the Colorado Health Institute, the Colorado Department of Health Care Policy and Financing, clients, the Region, providers, advocates, and interested members of the public. The meeting took place in Region 2 on April 23, 2014.

RCCO 2 Meeting in Evans, Weld County.
Location: Sunrise Monfort Children's Clinic 2930 11th Ave. Evans, CO 80620

Attendees: [Advocates, clients, providers, FQHCs, health networks, hospital representatives, mental health providers, physical health providers, RCCO, specialists, vendors.]

Cammy, Casey King, Christy, Cindi Werner, Cindy Rider, Dave Rastatter, Debora Scott, Deborah, Dr. Lobinski, Drew Casper, Glenda Robertson, Grace, Guzman, Jeff Johnson, Jerri Donnovan, Jessica, Joanna Martinson, Justin Yeager, Kate, Kathryn Jantz, Kevin Dunlevy-Wilson, Kevin Madison, Lesley Brooks, Leslie, Liz Hickman, Luis, Mark Wallace, MaryLu Walton, Matt Lanphier, Meredith Wagner, Michael McCormick, Michelle Lueck, Michelle Prior, Myron Fargrain, Omar Gutierrez, Pat Knotter, Rebecca, Sandra Baker, Sandy Hash, Sandy Schmidt, Steve Brown, Sunrise Coumm, Tamara McCoy, Tammy Herbert, Tanya, Terri, Todd Lessley, Todd Solar, Veronica Martinez.

ITEM #	ISSUE	DISCUSSION
1	**Introductions**	Marc Wallace, M.D., Colorado Access, introduced Michele Lueck of the Colorado Health Institute (CHI) and staff in attendance from the Department of Health Care Policy and Financing.
2	**CHI Presentation**	Michele Lueck provided an overview of the current ACC Program, discussed the RCCO RFP, and the Department of Health Care Policy and Financing's Strategic Plan for the ACC. • There are three primary goals of the next iteration of the ACC: "transforming our systems from a medical model to a health model," "moving toward person-centered, integrated and coordinated supports and services," and "leveraging efficiencies to provide better quality care at lower costs to more people."

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		• The Strategic Plan is divided into five domains: • Delivery System Redesign (provide care in a more integrated and patient-centric way), • State Administrative Improvements (invest in improvements that support better quality and functionality), • Information Technology (leverage technology to evaluate, learn, and to adapt the system), • Payment Reform (test and innovate new models to pay for quality and value), and • Benefit Design (design the benefit package in a way that moves from a medical model to a health model). • While the Department is committed to adhering to the core principles of each domain, the manner through which the principles are operationalized into contract requirements is very open. Stakeholder meetings, such as this one, are intended to mold the commitments into concrete requirements. At the conclusion of the presentation, the conversation was opened to questions, comments, and discussion.
3	**Discussion of RFP**	• Question: Is there a plan in action to educate high users? "Lots of clients are getting lab work or antibiotics for the common cold." As a provider, I have spent decades trying to get away from prescribing antibiotics, keeping people out of high-cost settings… he has recently been able to get there. Further support would be very helpful. • Department and CHI: We need input as to what model is working in your region, and what is working for your practice. What have you tried? What has succeeded?

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		• Comment: There have been many attempts, but also many failures. "Run to ER because kid has coughed twice." The vast majority of "sick child" visits are for the common cold. "There is no reason to be accessing services for trivial ailments, but patients aren't often told what these are." Many practices are prescribing for viral process or sending out unnecessary prescriptions of broad-spectrum antibiotics. This program can and should address this as part of a public health campaign. • Comment: It appears that a massive public health campaign is necessary. It is a real challenge, especially when trying to preserve patients' choice at the same time. Can take care of things at night via ER. Private insurance incentivizes not going to ER. There is a different nuance with the Medicaid population. In short, we would love to see a statewide public health effort. • Comment: One of the original premises of using the triple aim: stratifying the population by complexity and level of resources required. Clients are at different stages of managing their own diseases. Are we looking at a model that is looking to stratify the population? Or will it all be the same pool for everyone? • Comment: As a practice with 24 providers, we've extended medical care from 5-9 PM (M-F) as well as weekend care. But PAs cannot see Medicaid clients without a physician in-house. Received calls from a mother after a child is discharged from ER. Can't schedule an appointment at 6 PM because there isn't a physician on duty. So she takes the child back to the ER because Medicaid will not allow the child to see a P.A. • Comment: We would like to see the Department be very demonstrative about two things. Information sharing. Giving guidance around when it's okay to share data (treatment, payment, operations). Very challenging to have institutions come together. HIPAA is seen as barrier. Calling from ER when we have their patient in our emergency bay. They were there [at the hospital] two nights ago. Need a release to get their medical records from the ER. Second, there needs to be a statewide campaign around when is the right time to go to the ER, when is the right time to go to primary care. Delineate what is a life-threatening emergency. Education around situations like "a fever of 103" is necessary.

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		• Question from CHI and the Department: Regarding IT concerns and data-sharing concerns – do these problems generally crop up around ER or primary care? What entities? What types of data are you trying to share? • Comment: All of the above, though hospitals are a bit stricter. Here in Weld County, we have had great success in getting an agreement signed. Successful, but time-consuming. The bigger problem, though, is for small institutions. When you have a clinic or other agency with a patient incoming, we need to talk with you about the client's data. Not only is it clinic to hospital data, but also clinic-clinic. Alliance-clinic. • Comment: Institutions (behavioral health and physical health) haven't always been doing a good job at data sharing. We can't get behavioral health care data. Half of our clients' issues are behavioral health in nature. • Comment: Actionable data is critical here. We're receiving tons of data – claims, massaging of the data. Sometimes isn't actionable enough. 8 of us shouldn't be replicating actionable data. What constitutes actionable data? What we need on the ground is actionable data. Old claims data. How is this resource-intensive patient going to be best-supported? Necessary to help communities respond in a reasonable way. • Comment: Also timeliness. We can't get data 6-months after a claim and act on it. Lag it terms of the state-based Medicaid claims data. Need to be cleaned first. Much of the timeliness issue could be fixed by "releasing the brakes" on how institutions can share data with one another. It's the data we get from Hospitals. That is most important. • Comment: We were in negotiations with [a hospital system] for over a year before getting ADT data from the 4 [hospital system] hospitals every day. Next step is ambulatory care data. Important because of their wide service net. Only a piece, but it's an important piece. Incremental progress/pressure might push it forward some more. Going to Centura with it, UC Health. Working on back-end data systems. We can't wait for CORHIO, so we're taking interim steps. • Question: Who has access to well-child check data?

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		• Comment: CO Access made 10,000 IVR calls. Roughly 45 providers. • Comment: On data sharing, hospitals need to contact PCMPs when a member hits the ER. • Comment: Hospitals use particular management software, hospitals are blinded to ACC attribution. RCCO runs a check and sends data back to hospitals. • Question from CHI and the Department: We've heard a lot about data sharing and medical management today. Regarding care coordination, what's working with the RCCO model? • Comment: When staff goes through hospital EHR to "tease out" the patient list and then outreach clients. Looking for social and medical triggers; look for transportation, housing, and Rx conflicts. Bridge those gaps and communicate with the provider. When a client is on a medication, but isn't taking the full dose because he or she is trying to make the Rx last, we try to intervene. • Comment: Regarding case management, close to what NCHA does, connect with intensive complex patient. Be present in that person's home. Learn what that client needs. Plenty of clients can't afford their co-pay. Need to follow up quickly with clients on the "complex list." • Comment: Much of this involves social elements: safety, shelter, and food. All of this should be noted in the next RFP. • Comment: When these disparate systems come together, it makes life easier for everyone. • Comment: I've been working with the RCCO for a while. It's necessary to bridge the information-sharing piece. HIPAA often makes this tough. Disconnect occurs when clients hit the hospital. Need data incoming. Lots of clients cycle in and out. • Comment: Has helped to put hospice on the radar, and the hospitals have helped too. But when a patient comes into hospice, they don't hear about other services that were provided prior to hospital discharge. Documents don't always follow, and so connections are often not made.

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		• Comment: County attorney and county commissioners have been great to work with on several of these issues. • Comment: Regarding case management at a family practice. Trying to implement phone based case-management system. • Comment: Slew of consultants and case managers for one person. We're replicating focused care managers, which replicates fragmentation. Care managers at the practice, at the RCCO, PCMP, LTC location, BH, ambulatory center. • Comment: To what extent can information actually solve this, though? And to what extent do systems need to be different? • Comment: Need a primary care provider at the core. One care manager needs to be the senior person; the care team should have a strata or hierarchy. • Comment: From a patient's view, by the time a fifth care manager or care coordinator call arrives, the patient is getting annoyed. • Comment: Echoing comments. There needs to be a lead care coordinator. Coordinate the coordinators. • Comment: Hope that we'll have stratified case management in the future, glad that's being embraced. Very important to have cross-boundary standards. • Comment: There remains a large problem with Larimer being in RCCO 1 and Weld being in RCCO 2. Many people live in one region and work in the adjacent region, or seek care in the adjacent region. Rocky and Access have worked well together; both have built upon local experts. "That's been great, but now we're dancing to a new step. Different common goals from what we used to have." • Comment: The Fort Collins / Loveland – Greeley division is an ongoing problem for providers. Not fair for KPIs when another RCCO is absorbing [expense or benefit]. • Comment: Regarding financial elements of the program, would put revised payment as a priority.

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		• Comment: Returning to the behavioral health question, we have a lot of rural and frontier counties. [Our RCCO's contract manager] spends a lot of time on the road working with providers. Many counties, there hasn't been a lot of action on enrollment or integration—it's been frustratingly slow on the behavioral health side. Want to be a part of this, but we are only involved with one provider. • Comment: Regarding future permutations, flexibility about how care coordination works is pretty important. Bringing care coordination capacity from Greeley and trying to apply them to the situation in Yuma doesn't make sense. You can't replicate the same care coordination model in both places. It is very important to make use of local strengths and resources. • Comment: It is quite helpful when clients are able to directly tell us what they need and we are able to supply this. Whether this be cell phones to be in touch with their provider, or gas cards to make it to an appointment. • Comment: Financing needs to be different at the point of care in order to allow providers to pay for the things that actually save money and improve care in the long-term. Whether that's a phone or supportive housing. • Comment: Regarding KPIs, until we can address the social determinants of health, being measured on many of these indicators isn't wholly reasonable—the underlying social component overshadows and ultimately influences the medical utilization.
4	**Closing Remarks**	Attendees were thanked for their participation. Those in attendance were welcomed to send additional comments and questions to **RCCORFP@state.co.us** The community meeting proceeded to finalize other business and was subsequently adjourned.