Accountable Care Collaborative Program

RCCO 6 – Community Meeting – Program Improvement Advisory Committee

15 April, 2014

These are the meeting minutes from the second 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 6 on April 15, 2014.

RCCO 6 Meeting in Lakewood, Jefferson County.
Location: St. Anthony's Hospital 11600 W. 2nd Pl. Lakewood, CO 80228

Attendees: [Advocates, providers, clients, CMHCs, FQHCs, dental, local public health, county, area agency on aging, RCCO.]

Abby Brookover, Adam Bean, Anita Rich, Anna Vigran, Beth Davis, Brandi Nottingham, Dan Fishbein, Dennis Lewis, Elizabeth Forbes, Gary Mazzaferro, Heather Logan, Heather Mathews, Janet Rasmussen, Jeff Johnson, John Talbot, Josie Dostie, Josie Dostie, Kathryn M. Jantz, Katie, Kevin J.D. Wilson, Kit Brekhus, Michele Lueck, Michelle Leke, Mindy Klowden, Pat Richfield, Rebecca Novinger, Regina Fetterolf, Sam Seligman, Todd Lessley, Tom Clay.

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1	**Introductions**	Adam Bean, CCHA, provided background on the Accountable Care Collaborative Program and introduced Michele Lueck of the Colorado Health Institute (CHI).
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." • The Strategic Plan is divided into five domains:

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		• 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**	• Comment: Materials should show families and children, rather than just a single adult patient. Right now, 60% of all RCCO patients are children. • Comment: Important to take into consideration the client / member's environment and the impacts it has on their care. Need to shift from deficit-based to strength-based and assess what assets exist while looking at the person as a whole entity, rather than simply as 'a disease state.' In the medical system, often we are trained to detect deficits; that is, to focus on "what's not there." "Need to focus on what *is* there." • Comment: Important to include the senior population and consider supports / strengths here. When developing requirements, recognize that families can be and should be

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		involved, rather than assuming that providers / RCCOs or others can make the decisions for them. • CHI and Department: How can RCCOs be incentivized to make changes, or to address some of the fundamental issues in the delivery system? • Comment: Payment questions aside, data sharing is a major roadblock. Between behavioral health and physical health, between hospitals and PCPs. • Comment: Biggest issue is lack of information between providers. Gaps in system are huge. Dental. Medical. Behavioral health. Lots of providers don't share medical records. Addiction programs – don't find any records anywhere. You can't coordinate care or make informed decisions without the information. Takes days to weeks to access records – and patients go somewhere else in that time. • Department: One option is a client portal for "consumer data." We would love to hear your thoughts about how best to communicate with clients and help to move data along. • Comment: Some providers, like the Clinica network, already have a portal. • Comment: Patient-facing IT systems will help to encourage health and healthy behavior. • Comment: It rests on providers and the system to make sure that patients, clients, members understand what's going on and what options exist. "That means learning to talk in language that laypeople understand. I'm a nurse by training, and if I go to the ER I'm overwhelmed." • Comment: Work to inform patients and their families, through technology, but also through audience-appropriate face-to-face interactions. • Comment: Returning to our discussion about providing care to the elderly. From the vantage point of the hospice system, we get a set amount of money and it is about navigating through the system with those resources. This is on the same track as care coordination, what's needed is to add the data piece. Records don't always follow

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		patients into hospice. These systems don't always work, so using care coordination, as with the ACC, is one way to help move data and records. • Comment: From the perspective of a community mental health center, clients should be aware if there is a decision to incentivize providers to do more or less of things. We don't want to create space between providers and patients. We should try to avoid "gaps in interests." • CHI: About program monitoring and evaluation, how does this figure into structuring the right incentives? • Comment: KPIs should reflect what the overall priorities are. • Comment: As a CMHC, important to focus on things like, for example, culturally-competent care. KPIs around behavioral health; if integration is a priority, then that should be reflected in the incentive payments and monitoring. • Comment: Glad to hear the HCPF is interested in data beyond simply claims. Process / clinical / outcomes. • Comment: From the perspective of a health department, it's exciting that HCPF is interested in these data sets and sources for KPIs, because they have so much data on-hand. So how do we know health is actually improving? Could we work with the state health Department? Incorporate new data sources? How do we all get to the "outcome" of health? • Comment: Indicators should also include social elements. Literacy, health care knowledge. • Comment: Moving away from claims measures sounds good, but that is what many of these systems [health care providers, payers, etc.] have done for a long time. • Comment: When developing incentives / KPIs, it is important to remember that many providers who care for the Medicaid population are not highly motivated by financial rewards. As a family doctor who sees many Medicaid clients, I try to help my patients not depend upon me. In the patient-centered medical home initiative, use a team-based

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		model of care. Try to include families as part of that team. Broaden this model by involving community resources. • Comment: The ACC also has a role to play in addressing the health needs of the homeless and those who have been involved in the criminal justice system. These populations cost the state a lot each year, and they traditionally have poor health outcomes for all that spending. The ACC / RCCOs have a role to play in addressing this. • Comment: The state should be paying for quality outcomes, rather than for process. • Comment: Add oral health to the RFP. About 25% of pediatric patients' first ER visits are related to a dental problem. • Comment: Many mental health / behavioral health services do not fall neatly within the carve-out system. • Comment: Need a preventive and "primary" behavioral health system, rather than one which only focuses on serious and long-term mental illnesses. • Comment: Right now, "integration" is a popular concept, but it often just means "colocation" at the point of care. This is better than the alternative, but payment needs to facilitate this type of true integration. • Comment: Necessary to have training, the ability to do "curbside consults" and the ability to have payment structured to allow this. • Comment: As a CMHC, there are clients we could see and help but don't want to make up a diagnosis just to be able to provide care. Behavioral health may play "an allied support role" for lots of other situations besides specific covered codes. There are HCPF barriers to integration of BH beyond the carve-out. When we serve people who need these cross system services, it is not financially sustainable. • Question: How do we bring the family in to these systems in a meaningful way? • Comment: Two-generation screening of, for example, pregnancy-related depression alongside developmental screening for a newborn.

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		• Comment: Can do screening during pregnancy and at the well child. Goes to payment reform. We must get away from FFS and move to system that looks at outcomes over time. • Comment: Returning to the behavioral health and integration discussion, BH care coordinators are really needed. There are many people who may not have a diagnosis for mental health (or they might) but they have behavioral issues nonetheless. These patients take up a lot of time and resources from many people across the system. Many experts are spending time working with these people, but what is needed is a single place to send these folks – a single contact. Not sure how this type of cross-system care coordination would be funded, but we need a simple system for coordinating between mental and physical health. • CHI and Department: Before we close, please give us a very brief snapshot—5 words or less—of advice as we move forward. Perhaps focus on the core principles that you would like the Department to focus on. • Comment: Please show me the data. • Comment: Please write a short RFP. • Comment: Pay now or pay later. • Comment: Systemic, if serious about integrating. • Comment: Respecting client input. • Comment: Coordination close to the patient/family. • Comment: Patient activation, patient/family centered, family defined broadly, integration, coordination, outcome-based. • Comment: Palliative care and chronic disease management elegant and key focus. • Comment: Outcomes, outcomes, outcomes. • Comment: Colocation does not mean / guarantee integration. • Comment: Empowerment, sustainability, families, primary care, outcomes.

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		• Comment: Patient-centered, primary care-driven. • Comment: ADT (hospital admission, discharge, transfer data), ADT, ADT. • Comment: Family-centric, transparent, integrated care. • Comment: Payment reform with behavioral health as equal partners, no wrong door. • Comment: Shared data, pay for quality.
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.