

RCCO	Population	Type of Integration	Proposed Interventions	Targeted Outcomes	Partners
1	Children				
	Adults: AWDC	The RCCO and CMHCs will fully-integrate financially, operationally and clinically to support the proposed interventions. Behavioral health providers are fully integrated within several comprehensive primary care sites within the region, with financial and organization support from the RCCO and the CMHCs. Additionally, the RCCO and CMHCs are working to implement several Behavioral Outreach Specialists who will work to integrate and extend supports and therapies outside the walls of primary care and community mental health settings, and provide continuity for clients in home, peer and community settings, “in-between” traditional clinical encounters.	<p>Patients will be stratified based on the four quadrant model:</p> <p>Quadrant 1 (Low physical &amp; Low behavioral diagnostic complexity) - Depression screening, Substance abuse screening, Motivational interviewing, Patient coaching, Pain protocols</p> <p>Quadrant 2 (Low physical &amp; High behavioral diagnostic complexity) - Trans-disciplinary care management, Substance abuse screening, Patient coaching, Outreach services, Pain protocols</p> <p>Quadrant 3 (High physical &amp; Low behavioral diagnostic complexity) - Trans-disciplinary care management, Depression screening, Substance abuse screening, Motivational interviewing, Patient coaching, Pain protocols</p> <p>Quadrant 4 (High physical &amp; High behavioral diagnostic complexity) - Trans-disciplinary care management, Depression screening, Substance abuse screening, Motivational interviewing, Patient coaching</p>	<ul style="list-style-type: none"> <li>• 4.5% - 7.0% reductions in emergency department utilization (depending upon population quadrant);</li> <li>• 2.0% - 4.5% reductions in inpatient hospital utilization (depending upon population quadrant);</li> <li>• 1.0% - 2.0% reductions in detox utilization (depending upon population quadrant); and,</li> <li>• .8% - 1.5% reduction in crisis intervention services (depending upon population quadrant).</li> </ul>	<p>Participating PCMPs, CHP, CO West, Inc, Midwestern CO Community Mental Health Centers, LPHAs, University of CO Denver Department of Family Medicine, Collaborative Family Healthcare Association, CO Health Foundation (Evaluation funder for S.H.A.P.E. demonstration.</p>
	Other: Full-Benefit Medicare/Medicaid beneficiaries				
2	Children	Integrated and Co-located Behavioral Health Services at Sunrise Community Health	Behavioral health interventions conducted by North Range Behavioral Health staff members include outreach, screenings (PHQ-9, GAD-7, CORS and the CAGE), brief therapy, establishing self-management goals, case management, patient consultation and education, phone contacts and groups. Consultation with the Opioid Oversight Committee, involving evidence based, effective and ethical treatment of chronic pain patients is also provided (NCHA, 2012).	<p>The goal of this project is to increase access to primary care and behavioral health services through the provision of integrated health care services at a patient’s point of entry into a community wide system.</p> <ol style="list-style-type: none"> <li>1. Provide early assessment, diagnosis, and intervention for patients who may be at risk for a major mental illness and/or an increased substance abuse;</li> <li>2. Provide targeted short term behavioral interventions, i.e. cognitive behavioral or solution focused techniques, for of patients referred by primary care providers.</li> <li>3. Provide educational, behavior change, and support groups for patients with chronic illness, such as diabetes and cardiovascular disease, as directed by the primary care providers.</li> <li>4. Provide consultation and education to primary</li> </ol>	<p>The four main partners in this project are:</p> <ol style="list-style-type: none"> <li>1) North Colorado Health Alliance;</li> <li>2) North East Behavioral Health Partnership;</li> <li>3) North Range Behavioral Health; and</li> <li>4) Sunrise Community Health.</li> </ol>

				care providers regarding patients who might be exhibiting symptoms that may be related to either a mental illness or substance abuse crisis. (NCHA, 2012)	
	Adults	Embedded Primary Care Services at North Range Behavioral Health	The interventions provided in the embedded model of care consist of primary care medical services provided by a nurse practitioner and two medical assistants. Due to the site location of this project, North Range Behavioral Health is also able to offer comprehensive integrated and co-located behavioral health services.	The goal of this project is to increase access to primary care and behavioral health services through the provision of integrated health care services at a patient's point of entry into a community wide system. 1. Provide primary care services to community members who identify North Range Behavioral Health as their medical home; 2. Provide consultation and education to primary care providers regarding patients who might be exhibiting symptoms that may be related to either a mental illness or substance use disorder.	The four main partners in this project are: 1) North Colorado Health Alliance; 2) North East Behavioral Health Partnership; 3) North Range Behavioral Health; and 4) Sunrise Community Health.
	Other	Integrated and Co-located Behavioral Health Services at Plains Medical Center	Behavioral health interventions proposed, but not yet implemented by CMHC staff members include outreach, screenings, brief therapy, establishing self-management goals, case management, patient consultation and education, phone contacts and groups. A Master's Level Behavioral Health Therapist will be hired and placed in the Limon clinic 4 days per week and the Flagler clinic 1 day per week. A full time Case Manager position has been posted to provide care coordination and behavioral health navigator services for clients seeking services at the Limon office of PMC. This agreement between CMHC and PMC includes bi-directional protocols for referral methods and communication between the two agencies. The feasibility of two other projects is currently being evaluated: 1) placing a part time Master's Level Behavioral Health Therapist in the PMC Kiowa office; and 2) video-conference psychiatric consultation for the practitioners and patients at PMC offices.	Due to the current developmental status of this project, these outcomes have yet to be determined. Development of these indicators will occur over the next 6 month cycle.	The partners in this project are Centennial Mental Health Center, Northeast Behavioral Health Partnership and Plains Medical Center.
3	Child and Adolescent members attributed to Mountainland Pediatrics who need behavioral health care	Community Reach Center child/family clinicians are fully integrated into the workflow at Mountainland. The clinician is available for short-term, solution focused behavioral health interventions with a child and/or family, and immediate consultation with Mountainland medical providers. A child or family that is in need of more comprehensive or intensive behavioral health care is referred back to Community Reach Center, but bi-directional communication and coordination of care is maintained with the medical providers.	Available short term, solution focused individual and family therapy, care coordination, immediate behavioral health consultation, assistance with managing behavioral health emergencies, and bidirectional clinical communication.	To be established once Mountainland Pediatrics receives client attribution and they have access to available SDAC utilization, cost and clinical risk data. Outcomes will be focused on ACC Key Performance Metrics and overall cost of care.	Community Reach Center Mountainland Pediatrics RCCO Region 3 Behavioral Healthcare, Inc.
	Adults: consumers who are enrolled in	The ADMHN Nurse Practitioner is fully integrated into the flow of behavioral health	We have engaged ADMHN in assisting us with getting unattributed Region 3 ACC members connected to a PCMP. We are encouraging	Until which point that ADMHN would be designated as a PCMP, Colorado Access will	Colorado Access Region 3 ADMHN

	<p>RCCO Region 3 and are currently receiving behavioral health services through Arapahoe Douglas Mental Health Network</p>	<p>care services. A consumer may attend groups or individual appointments with their psychiatrist or therapist, then meet with the Nurse Practitioner to follow up on other medical conditions, receive wellness checks and health education services. Communication between the medical and behavioral health providers is seamless and bi-directional.</p>	<p>the Department to consider designating ADMHN as a PCMP in the ACC program given their medical home and integrated care capabilities. If approved, the ADMHN Nurse Practitioner at ADMHN would be an option for ACC enrolled members to select as their PCMP and medical home. Members would be offered the opportunity to select any PCMP in the ACC network.</p> <p>Currently, Colorado Access provides ADMHN with the names of the PCMPs their ACC enrolled consumers have been attributed to so that MH clinicians know who to coordinate behavioral and physical health care services. Additionally, we provide lists of Region 3 unattributed members who receive services at ADMHN and requested their assistance in helping these members select and engage with an ACC participating PCMP.</p>	<p>work with ADMHN to share available SDAC data for the purpose of identifying high need/high cost common members and coordinating care management efforts. Collaboration would focus on “hotspotting” efforts and reducing ER utilization, inpatient readmissions, high cost imaging services, and reducing overall cost of care.</p>	<p>Behavioral Healthcare, Inc.</p>
	<p>Adult Medicaid members who are attributed to Metro Community Provider Network and need integrated behavioral health services.</p>	<p>Aurora Mental Health Center clinicians are fully integrated into the workflow at MCPN. The clinician is available for short-term, solution focused behavioral health interventions with a consumer and/or family, and immediate consultation with MCPN medical providers. A consumer or family that is in need of more comprehensive or intensive behavioral health care is referred back to Aurora Mental Health Center, but bi-directional communication and coordination of care is maintained with the medical providers.</p>	<p>Available short term, solution focused individual and family therapy, care coordination, immediate behavioral health consultation, assistance with managing behavioral health emergencies, and bidirectional clinical communication. MCPN and AuMHC have established a process for “hotspotter” review for members who have high and/or preventable emergency room utilization. AuMHC and MCPN are also collaborating in the development of an integrated care clinic in Aurora that will specialize in serving refugee populations.</p>	<p>Focus on impacting ACC Key Performance Indicators of reducing unnecessary ED utilization, 30 day inpatient readmissions, use of high cost imaging services, and overall cost of care.</p>	<p>RCCO Region 3 Metro Community Provider Network Aurora Mental Health Center Behavioral Healthcare, Inc.</p>
<p>4</p>	<p>Children (Age 0-20): Diagnosed with Diabetes as of January 1, 2013.</p>	<p>Our initial goal is to gather and share data with the entire integrated care coordination team, who can then assist in determining the care coordination needs of the individual member. Each child will have an assigned care coordinator. The assigned care coordinator will work with all aspects of treatment to promote improved health care. The integrated care coordination team will work together to deliver care, education and training to families regarding medication compliance, health risks, and behavior modification. Both behavioral and physical health teams will work on the education and training interventions in an integrated, seamless approach.</p>	<p>Our proposed interventions will include:</p> <ul style="list-style-type: none"> <li>• Identifying the target population.</li> <li>• Assigning the Member to an integrated care coordination team.</li> <li>• Providing education to improve adjustment, self-care and metabolic control.</li> <li>• Offering psycho-social interventions focused on coping skills and peer support.</li> <li>• Teaching family interventions, which can help in the reduction of parent child conflict about diabetes management and care. ( Family interventions may also included focus on assisting parents on compliance, interaction in school, education at school, and symptom identification and management when away from home.)</li> </ul> <p>Educating parents and school-based teams regarding risk factors, disease presentation, identification of poor metabolic control, and medication side effects.</p>	<p>We will be using the SDAC data. Based on potentially preventable events, we would like to reduce total cost of care by 8%. The baseline will be the total cost of care (for the preceding 12 months) for the identified population as of January 1, 2013 and the re-measure will be the total cost of care for the identified population at the 12 month interval, after implementation. The study question we are trying to answer is: Will the integrated psychosocial and educational outreach reduce total cost of care for youth aged 0-20 with a diabetes diagnosis?</p>	<p>Behavioral Health Centers, FQHCs, PCMPs, Colorado Health Partnerships, LLC (BHO), Other Community Agencies as indicated by assessment.</p>

<p><b>ICHP</b> Members who are receiving opiates from five or more prescribers/pharmacies as of the initial measurement date of January 1, 2013</p>	<p>For the initial phase of this project, we decided to focus on working with prescribers verses members to begin with. . Educating prescribers on chronic pain management and the risk of opiate abuse will be a key focus. We will also alert prescribers when their patients are utilizing multiple prescribers for treatment and when they are getting their prescriptions filled at multiple pharmacies. We will also educate prescribers on when opiate use transitions into opiate abuse and when to make a referral to a mental health provider. Educating providers who practice in physical health, behavioral health, and pain management will allow us to combat this issue from multiple fronts, while we simultaneously work with the integrated care team on outreach and data sharing.</p>	<p>After identifying the members, prescribers and pharmacies involved in the project, the proposed interventions can be carried out in a two-phased process. When considering the impact of interventions, it appears that providers would initially have more impact on the population, as they are the primary source for accessing these medications. Consequently, providing providers with a consistent guideline and recommendation on how to work with members within this population would be the focus of Phase I, which would also include:</p> <ul style="list-style-type: none"> <li>• Conducting trainings with prescribers.</li> <li>• Providing education on medication alternatives and programs available to prescribers.</li> <li>• Looking into ongoing medication alternatives.</li> <li>• Coordination of referral options to community resources</li> <li>• Notifying care coordinators when the identified member can be referred to COUP, Pharmacy RX for once a year review and potentially appropriate treatment program.</li> <li>• Utilizing the disease management program for chronic pain.</li> <li>• Offering training on Motivational interviewing to care coordinators and prescribers.</li> <li>• Incorporating input from both behavioral health and physical health entities the development of educational and training materials.</li> <li>• The second phase of interventions would primarily focus on the Members of this population and would include: Verifying that appropriate Members are participating in the COUP program.</li> <li>• Increasing the number of Members who are on a Narcotics Contract within the PCMP practice.</li> <li>• Initiating referrals to substance abuse services, when appropriate.</li> </ul> <p>Education and training on how to most effectively cope with pain management issues.</p>	<p>For Phase I: Does provider education, consistent application of guidelines and the use Motivational Interviewing techniques decrease the number of prescriptions written by 10% after the first 12 months of implementation? The baseline will be the number of opiate prescriptions written for the total eligible population as of January 1, 2013 and the re-measure will be the total number of opiate prescriptions written for identified population at the 12 month interval, after implementation.</p> <p>For Phase II: Does member education, utilization of the COUP program, and increasing the number of Members on a Narcotics Contract decrease the number of ER visits by 10% after the first 12 months of implementation? The baseline will be the number of ER visits (for the preceding 12 months) for the identified population as of January 1, 2013 and the re-measure will be the total number of ER visits for the identified population at the 12 month interval, after implementation.</p>	<p>Behavioral Health Centers, FQHCs, PCMPs, Colorado Health Partnerships, LLC (BHO), Other Community Agencies as indicated by assessment. Prescribers, pharmacy and Chronic Pain organizations.</p>
<p>Adults (Age 21+): Diagnosed with Diabetes as of January 1, 2013.</p>	<p>Our initial goal is to gather and share data with the entire integrated care coordination team, who can then assist in determining the care coordination needs of the individual member. Based on our current tier stratification methodology, high risk adults will have the involvement of a care coordinator. Care coordinators will work with all aspects of treatment to promote improved health care.</p>	<p>Our proposed interventions will include:</p> <ul style="list-style-type: none"> <li>• Identifying the target population.</li> <li>• Assigning Members to integrated care coordination teams.</li> <li>• Encouraging involvement in the disease management program.</li> <li>• Educating Members to improve adjustment, self-care and metabolic control.</li> <li>• Offering psycho-social interventions focused on coping skills and peer support.</li> <li>• Integrating the multidisciplinary group of providers.</li> </ul>	<p>We will be using the SDAC data. Based on potentially preventable events, we would like to reduce total cost of care by 3%. The baseline will be the total cost of care (for the preceding 12 months) for the identified population as of January 1, 2013 and the re-measure will be the total cost of care for the identified population at the 12 month interval, after implementation. The study question we are trying to answer is: will the integrated psychosocial and educational</p>	<p>Behavioral Health Centers, FQHCs, PCMPs, Colorado Health Partnerships, LLC (BHO), Other Community Agencies as indicated by assessment.</p>

		<p>The care coordination team will work together to: integrate the delivery of care; educate and train regarding medication compliance; assess health risks; and assess behavior change. (For purpose of this study, behavioral health integration does not necessitate that a member have a specific behavioral health diagnosis.) Both behavioral health and physical health providers will participate in the development of training, as well as the implementation of educational interventions.</p> <p>In addition, there will be increased monitoring of diabetic patients on antipsychotics, as well as monitoring patients for metabolic syndrome.</p>	Assessing for psychiatric problems and other comorbidities and initiating referrals, as appropriate.	outreach reduce total cost of care for adults aged 21+ with a diabetes diagnosis?	
5	<p>Child and Adolescent ACC members who receive primary care services at Bruner Medical Clinic</p>	<p>The MHCD child/family clinician is fully integrated into the workflow at Bruner. The clinician is available for short-term, solution focused behavioral health interventions with a child and/or family, and immediate consultation with the Bruner medical providers. A child or family that is in need of more comprehensive or intensive behavioral health care is referred back to MHCD, but bi-directional communication and coordination of care is maintained with the medical providers.</p> <p>The success of this model will be expanded to include on-site behavioral health services for adult patients at Bruner in the third quarter of FY 2013.</p>	Available short term, solution focused individual and family therapy, care coordination, immediate behavioral health consultation, assistance with managing behavioral health emergencies, and bidirectional clinical communication.	As this initiative is relatively new, we have not yet identified specific indicators, but will work toward evaluating the impact of integrated behavioral and physical care in ACC KPI measures. We anticipate that this model will result in fewer unnecessary ER utilization for either behavioral health or medical issues as families will have access to coordinated care, improved support in managing both their behavioral health and medical conditions, and seek urgent care at Bruner rather than the ER.	Access Behavioral Care Bruner Family Medicine Mental Health Center of Denver RCCO Region 5
	<p>Adults enrolled in Region 5 who receive behavioral health services from MHCD</p>	<p>The UPI Nurse Practitioner at MHCD is fully integrated into the flow of behavioral health care services. A consumer may attend groups or individual appointments with their psychiatrist or therapist, then meet with the Nurse Practitioner to follow up on other medical conditions, receive wellness checks and health education services.</p> <p>Communication between the medical and behavioral health providers is seamless and bi-directional.</p>	<p>We have engaged MHCD in assisting us with getting unattributed Region 5 ACC members connected to a PCMP. Generally, efforts have been directed to connect members with the integrated UPI Nurse Practitioner, although members are offered the opportunity to select other PCMPs if they so choose. These efforts are the focus of a Performance Improvement focus study for ABC, results of which will be submitted to the Department at the end of February.</p> <p>In addition, we provide MHCD with the names of the PCMPs their consumers have been attributed to so that MH clinicians know who to coordinate behavioral and physical health care services.</p>	Data analysis is underway for the Performance Improvement Focus study that ABC is conducting. Analysis will focus on the degree to which this collaboration results in unattributed ACC members in Region 5 and successfully connected to a PCMP, be that the integrated UPI Nurse Practitioner or another contracted PCMP. Focus study results will be submitted to the Department in late February, 2013.	Access Behavioral Care Mental Health Center of Denver University Physicians, Inc. RCCO Region 5
	<p>Adult and youth members receiving primary care services</p>	<p>Full integration of behavioral health treatment and consultation services to Pediatrics, OB/GYN, Family Medicine and Internal</p>	<p>Readily available behavioral health consultation to Kaiser primary care providers, care management, bidirectional clinical communication/coordination. The BMS will also be involved in</p>	<p>Will be established after this program launches in spring, 2013, but will be include the impact of reducing Key Performance Indicators in the</p>	<p>Kaiser Access Behavioral Care RCCO Regions 3 and 5</p>

	through Kaiser	Medicine clinics.	mental health screening, including teen depression screening, pulmonary rehabilitation depressing screening, and post-partum care. The BMS will participate in high ED Utilizers care conferences to identify interventions to reduce unnecessary use of ED services. Finally, the BMS will be involved in a variety of mental health research projects within the Kaiser system.	ACC program	
6	All ACC RCCO 6 Clients receiving or in need of behavioral health and physical health services with focus on specific PCMP/BH integrated locations.	Co-location	Client will receive behavioral health services within their PCMP's office and care coordination as appropriate. This reduces the likely hood that clients will not follow up with a behavioral health service or referral and produces greater collaboration between PCMP and behavioral care providers.	Outcomes should yield an increase PCMP site specific appropriate behavioral health service delivery and care coordination of referrals to more specialized behavioral health services along with increased usage by the PCMP's population. Also, greater integration between physical health and behavioral health is evident.	Foothills Behavioral Health Partners, Jefferson Center for Mental Health and Mental Health Partners.
	RCCO 6 area Members , age 18+, with severe mental illness (diagnosed with schizophrenia, schizoaffective, or bipolar disorder with at least two prescriber visits annually).. The target population is based on FBHPartner Focus Study, in collaboration with CCHA, titled "Improving Healthcare Coordination/Care Management for Members with Severe Mental Illness."	Enhanced healthcare coordination management.	The Focus Study interventions, in collaboration with FBHPartners include: <ol style="list-style-type: none"> <li>1. Establish and implement procedures to increase this study population's enrollment in CCHA and through their enrollment develop and implement intensive care coordination services between FBHPartners' provider MHCs and the study populations attributed PCMP</li> <li>2. Develop and implement procedures, between CCHA and FBHPartners, to share physical health data, in order to help providers focus healthcare coordination efforts</li> <li>3. Through above interventions expand FBHPartners Healthcare Management Program for this population, which includes a specific care management guideline, and a health monitoring registry to ensure implementation of this guideline. plan.</li> </ol>	Targeted improvement measures include; <ul style="list-style-type: none"> <li>• Increase % enrolled in CCHA</li> <li>• Increase % with assigned PCMP</li> <li>• Increase % with ambulatory visit</li> <li>• Increased % with care coordination between behavioral care provider and PCMP evidenced by medical record audit</li> </ul> <p>Increase % with health information to determine health risk, as evidenced through medical record audit.</p>	Foothills Behavioral Health Partners
	Other	All ACC RCCO 6 Clients receiving or in need of behavioral health and physical health services	By conducting regular analysis and mutually identifying and stratifying total RCCO population we will jointly plan and provide integrated services to clients with behavioral health needs in RCCO 6.	Targeted Outcomes: <ol style="list-style-type: none"> <li>1. Identify patients with behavioral health needs using available SDAC and BHO data</li> <li>2. Stratify the level of need of patients within the population</li> <li>3. Develop and provide clinically appropriate solutions for each quadrant to direct care coordination assignment</li> <li>4. Reduce clinically unnecessary care</li> <li>5. Improve health as measured by Triple Aim goals</li> <li>6. Integrate care to follow client choice</li> </ol>	Foothills Behavioral Health Partners, Jefferson Center for Mental Health and Mental Health Partners.

7	<p>Children: Aged 5-18 (SF-10 Intervention)</p>	<p>The SF-10™ Health Survey psychosocial summary (PSS-10) and Physical Health Summary (PHS-10) scores are reported to the primary care practices after administration and scoring. If appropriate, a member is referred to the BHO for services if indicated by responses to the survey or request by the member. A policy identifying the criteria for a MH referral has been established.</p> <p>AspenPointe has integrated behavioral health providers embedded in the two largest PCMP practices for RCCO 7. Behavioral Health providers are co-located at Peak Vista and Dr. Johnson, and efforts are underway to co-locate a behavioral health provider at Colorado Springs Health Partners. Additionally, the Service Center for RCCO 7 is co-located with the Call Center for the Mental Health Center of AspenPointe. The co-location of these providers/services allows for the easy transfer of SF-10 information and integration of services.</p>	<p>The SF-10™ Health Survey for Children (SF- 10) is a brief, 10-item, parent- or guardian-completed assessment designed to measure the physical and psychosocial functioning of children aged 5 to 18 years. The SF-10 is the short form of the Child Health Questionnaire™ (CHQ™ ; ) developed in the early 1990s as a comprehensive, generic measure of functional health and well-being in children and adolescents.</p> <p>According to Quality Metrics: measures of children’s health-related quality of life (HRQOL) are used to monitor children’s health status over time and to document the impact of health conditions, injuries, interventions, and treatments on their physical and psychosocial health. The SF-10 meets this need by providing an HRQOL tool that is easy to administer, score, and interpret. During its development, the goal was to construct an assessment that is brief, reliable and valid, and comprehensive in its coverage of those content areas relevant to children’s physical and psychosocial well-being.</p> <p>The SF-10 provides two summary scores: Psychosocial Summary (PSS-10) and Physical Health Summary (PHS-10). The Psychosocial Summary includes items related to psychosocial health: role limitation (due to emotional or behavioral problems rather than physical health), self-esteem (child’s satisfaction with friendships and life overall), global measure of behavior, and mental health. The Physical Health Summary (PHS-10) includes items related to physical health.</p> <p>INTERVENTION: an attempt will be made to administer the SF-10 for all children ages 5-18 and enrolled in RCCO 7. The first phase will be to administer the SF-10 for children being linked to a PCMP, followed by the tool being administered for children receiving non-medical care coordination through the Service Center, and then for all children enrolled in the region. The SF-10 will be re-administered on a yearly basis.</p>	<p>The goal of this intervention is to screen all children ages 5-18 enrolled in RCCO 7 for needed physical and psychosocial interventions. The tool allows for an integrated assessment of needs utilizing one tool.</p>	<p>AspenPointe Health Network, PCMPs, and BHO</p>
	<p>Adults</p>	<p>The SF-12™ Health Survey (SF-12) domain and component summary measures are reported to the primary care practices after administration and scoring of the survey. As appropriate, a member is referred to the BHO for services when indicated by responses to the survey or request by the member.</p> <p>AspenPointe has integrated behavioral health providers embedded in the two largest PCMP practices for RCCO 7. Behavioral Health providers are co-located at Peak Vista and Dr. Johnson, and efforts are underway to co-locate</p>	<p>The SF-12 is a 12 question survey used to measure eight domains of health-related quality of life HRQOL). The information obtained from the eight health domain scales is aggregated to provide summary measures of the member’s physical and mental health. The Health Domain Scales include: Physical Functioning, Role-Physical, Bodily Pain, General Health, Vitality, Social Functioning, Role-Emotional, and Mental Health.</p> <p>The Summary Measures include the Physical Component Summary and Mental Component Summary. The Physical Component Summary (PCS) is a single score that can be used as an overall measure of physical health. The Mental Component Summary (MCS) is a single score that serves as an overall assessment of mental health.</p>	<p>The goal of this intervention is to screen adults enrolled in RCCO 7 for needed physical and mental health interventions. The tool allows for an integrated assessment of needs utilizing one tool. A policy identifying the criteria for a MH referral has been established.</p> <p>The goals of the Chronic Disease Management program are to:</p> <ul style="list-style-type: none"> <li>enroll and engage a rolling caseload of 60 members with targeted chronic</li> </ul>	<p>AspenPointe, PCMPs, BHO</p>

	<p>a behavioral health provider at Colorado Springs Health Partners. Additionally, the Service Center for RCCO 7 is co-located with the Call Center for the Mental Health Center of AspenPointe. The co-location of these providers/services allows for the easy transfer of SF-10 Health Survey information.</p> <p>The Chronic Disease Management intervention is fully integrated through the nurse care manager who becomes a virtual member of the PCMP care team.</p>	<p>INTERVENTION: an attempt will be made to administer the SF-12 for all adults enrolled in RCCO 7. The first phase will be to administer the SF-12 for adults being linked to a PCMP, followed by the tool being administered to all adults receiving non-medical care coordination through the Service Center, and then to all adults enrolled in the region. The tool will be re-administered on a yearly basis.</p> <p>INTERVENTION: Telephonic Chronic Disease Management will be offered to members. The target population is members with chronic conditions as identified through the Clinical Risk Groups (CRGs) provided through TREO data as well as using Emergency Department high utilization data. The program will offer chronic disease management support to identified Community Care members through: bio-psychosocial assessments, disease specific screenings, telephonic disease management support, motivational interviewing, screening for co-occurring mental health, assessment of patient activation and engagement in their care. The nurse care manager will act as an extender of the physician’s office through telephonic intervention. This intervention allows for the critical screening for mental health issues (i.e. depression, anxiety) in members who have chronic physical health conditions. The program will work with the member and provider to engage the member in needed services (both physical and behavioral health).</p>	<p>diseases into the program</p> <ul style="list-style-type: none"> <li>• Reduce disease specific symptoms/severity</li> <li>• Screen members for co-occurring mental health conditions</li> <li>• Improve coordination of care for members with chronic conditions</li> <li>• Improve health outcomes</li> <li>• Improve self-management of chronic conditions</li> </ul>	
<p>TOP 270 Emergency Department Utilizers</p>	<p>RCCO 7 has staff co-located at both Memorial University and Penrose Hospitals as part of the Emergency Department Diversion Program. In addition to the co-located staff, ED usage data is provided daily by the hospitals and acted upon by the RCCO 7 care coordination team that are fully integrated with the PCMP care managers in the region.</p>	<ol style="list-style-type: none"> <li>1.) Emergency Department Diversion Program</li> <li>2.) Top 270 Emergency Department Utilizers Care Management Program</li> <li>3.) “Feet on the Street” Pilot Program with the CSFD, Memorial University and Penrose Hospitals. Utilization of the clinical expertise of Paramedic/RN staff to assist with care management activities in the development of a medical neighborhood, for ACO Members.</li> </ol>	<p>All three interventions will be assessed on the quality metrics outlined for each program and based on Member and PCMP satisfaction, reduction in 30-day readmission rate, and ED utilization rates amongst top utilizers. Trending reports will be generated and distributed to participating PCMPs. The numerator is the number of visits pre-interventions and the denominator is the number of visits post-interventions. The outcomes we are hoping to see is a reduction in ED utilization and a connection back to the Medical home with improved care coordination with this difficult population.</p> <p>The question we are trying to answer is: Can a coordinated and targeted effort amongst providers, directed at RCCO -7 high utilizers of services, be case managed in a new way so as to improve satisfaction, reduce ED utilization and 30-day readmissions?</p>	<p>Memorial University Hospital, Penrose Hospital, PCMPs, BHO, AspenPointe</p>

				<p>Additionally, the three interventions also serve to target a population that often reports co-occurring physical and mental health conditions. Through targeting this population, information can be gathered and care effectively coordinated for integrated care.</p> <p>See Attached Pilot Appendix B &amp; C.</p>	
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