

Colorado
Accountable Care Collaborative

FY 2015–2016 SITE REVIEW REPORT

for

**Integrated Community Health
Partners
(Region 4)**

May 2016

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



3133 East Camelback Road, Suite 100 • Phoenix, AZ 85016-4545
Phone 602.801.6600 • Fax 602.801.6051

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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 to (1) improve member health; (2) improve member and provider experience; and (3) contain costs 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 develop a network of providers; support providers with coaching and information; manage and coordinate member care; connect members with non-medical services; and report on costs, utilization, and outcomes for their populations of members. 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. In addition, the Accountable Care Collaborative: Medicare-Medicaid Program (MMP) demonstration project provided for integration of new dually eligible Medicare-Medicaid members into the RCCOs beginning September 2014. The RCCO contract was amended in July 2014 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 successes and challenges in implementing key components of the ACC program. This report documents results of the fiscal year (FY) 2015–2016 site review activities, which included evaluation of the RCCO's efforts regarding integration with specialist providers, integration with behavioral health services and behavioral health organizations (BHOs), and performance of individual MMP member care coordination. In addition, the Department requested a follow-up discussion of select focus projects implemented by each RCCO. This section contains summaries of the activities and on-site discussions related to each focus area selected for the 2015–2016 site review, as well as HSAG's observations and recommendations. In addition, Table 1-1 contains the results of the 2015–2016 MMP care coordination record reviews. Table 1-2 provides a comparison of the overall 2015–2016 record review scores to the previous two years' record review scores. Section 2 provides an overview of the monitoring activities and describes the site review methodology used for the 2015–2016 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.

Summary of Results

The care coordination record reviews focused on a sample of the MMP population who had a completed service coordination plan. HSAG assigned each question in the record review tools a score of *Yes*, *No*, *Partially*, *Unable to Determine*, or *Not Applicable*. HSAG also included, as necessary, comments for each element scoring *No*, *Partially*, or *Unable to Determine* and included any other pertinent reviewer observations. Table 1-1 presents the scores for **ICHP**'s care coordination record reviews. Detailed findings for the record reviews are in Appendix B—Record Review Tools.

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

Description of Record Review	# of Elements	# of Applicable Elements	# Yes	# No	# Partial	# Unable to Determine	# Not Applicable	Score* (% of Yes Elements)
MMP Members	210	133	129	3	1	0	77	97%

* The overall percentages were obtained by adding the number of elements that received a score of *Yes*, then dividing this total by the total number of applicable elements. (*No* and *Partially* scores received a point value of 0.0; *Unable to Determine* was included with *Not Applicable*.)

Table 1-2 provides a comparison of the overall 2015–2016 record review scores to the previous two years' record review scores. Although most care coordination requirements of the RCCO contract and MMP contract were similar, some 2015–2016 scores may have varied from previous years' reviews due to specific service coordination plan requirements for the MMP population.

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

Description of Record Review	# of Elements	# of Applicable Elements	# Met (or Yes)	# Not Met (or No)	# Partially Met (or Partially)	# Not Applicable (or Unable to Determine)	Score* (% of Met/Yes Elements)
Care Coordination 2013–2014	192	153	153	0	0	39	100%
Care Coordination 2014–2015	80	60	60	0	0	20	100%
Care Coordination 2015–2016	210	133	129	3	1	77	97%

* The overall percentages were obtained by adding the number of elements that received a score of *Met/Yes*, then dividing this total by the total number of applicable elements. (*Partially Met/Partial* and *Not Met/No* 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 the focus content areas: Integration with Specialist Providers, Follow-up of Region-specific Special Projects, and Integration with Behavioral Health Services/BHOs. Following is a summary of results for each content area of the 2015–2016 review.

Summary of Findings and Recommendations by Focus Area

Integration With Specialist Providers

Activities and Progress

ICHP's geographic region does not have an abundance of specialist providers, with the majority of specialists located in Pueblo. Members also access specialists in Denver and Colorado Springs. Members living in the outlying portions of the region often have transportation issues related to specialist appointments, and care coordinators throughout the region are available to assist members. Access to specialists has been primarily based on personal referral relationships among providers. **ICHP** staff have been very active in community-based work groups that have been established to evaluate and improve access to specialists in the region, including Health of Pueblo and *Access to Specialty Care*. Although access to specialists is an all-payor concern, specialty providers have identified lower reimbursement and concerns about Medicaid member behaviors—i.e., no show for appointments or lack of preparation for appointments—as Medicaid member issues. **ICHP** has engaged in several initiatives related to improving access to specialists specifically for Medicaid members. **ICHP** has developed and implemented specialist referral protocols and supporting tools for providers and members. A toolkit designed to facilitate the bi-directional communication process between primary care medical providers (PCMPs) and specialists included a referral checklist, referral response checklist, “Getting Ready for Your Specialist Appointment” member form, and a guide to PCPs to prepare the member for a referral. **ICHP** had also engaged providers in several telemedicine initiatives to enhance the capabilities of PCMPs to address some specialty needs of members. These included the University of Colorado ECHO program, New Mexico-based ECHO pain management program, and the Colorado Psychiatric Access and Consultation for Kids (C-PACK) program. **ICHP**'s hospital partners in the region were also evaluating mechanisms to impact specialist services. **ICHP**'s staff members were continually exploring creative ideas to increase access to specialists, and provider committees were developing a cohesive **ICHP** strategy for future endeavors to improve access to specialist care.

Observations/Recommendations

Although there is no short-term solution for the statewide shortage of specialists in general, **ICHP** has a particular challenge with a shortage of specialty care in sparsely populated areas of the region. Protocols to address specialist concerns related to Medicaid referrals had been implemented, and special programs to improve PCMP access to specialist consultations as well as other creative solutions were continually being explored. **ICHP** should continue to evaluate the effectiveness of implementing the referral protocols in primary care practices and consider a mechanism to obtain feedback from specialists regarding the impact of the protocols on specialist receptivity to Medicaid referrals. **ICHP** might also work directly with its hospital partners in Pueblo to explore mechanisms for “preferential” access to hospital-based specialists and/or to encourage deployment of specialists to more rural areas within the region.

Follow-Up of Region-Specific Special Projects

Activities and Progress

Relationship With the Health Information Exchange (HIE)

ICHP had a direct contract with the Colorado Regional Health Information Organization (CORHIO) to receive RCCO member health information exchange (HIE) information from CORHIO and to develop mechanisms to integrate the data into the **ICHP** database. At the time of on-site review, **ICHP** was using the CORHIO admission, discharge, and transfer (ADT) file provided through the Department and reported that the transmission was working smoothly. Going forward, **ICHP** will work with CORHIO to integrate hospital ADT information directly into the Crimson Care Management system. The next priority for **ICHP** is to begin receiving laboratory data through CORHIO as the first component of building a clinical data repository. Ultimately, **ICHP**'s goal is to obtain all **ICHP** member data and information gathered in the CORHIO system and integrate applicable information into the electronic health record (EHR) systems of the providers. **ICHP** was also examining the cost and value of stimulating additional practices to participate in CORHIO. **ICHP** considered its partnership with CORHIO to be a significant asset in building a functional HIE for the entire provider community.

Crimson Care Management System

The Crimson Care Management system has three major components—a patient-level clinical data warehouse, claims analysis software, and a care coordination application. **ICHP** viewed the Crimson Care Management system as a population health system and a “very high-value data set” for the RCCO and its providers. **ICHP** selected the Crimson Care Management system due to its unique capability to provide integrated ambulatory care information from multiple sources to a broad base of service providers, agencies, or other designated users. **ICHP**'s goal was to design a system able to leverage all available sources of information and get the information into the hands of users through HIE functions, including direct interface with provider EHRs. At the time of HSAG review, **ICHP** defined being in the technical-development stage of this long-term project and characterized the data integration component as requiring the most attention from information technology (IT) staff resources to validate data and progressively correct identified technical problems. **ICHP** had implemented the clinical application with two federally qualified health centers (FQHCs). **ICHP** had programmed and was using the care coordination application to support completion of the MMP Service Coordination Plan (SCP) tool and had scheduled pilot testing of the full application for all members. Staff described the challenges associated with provider participation in the fully designed system, particularly in a region with many small practices. **ICHP** staff members understand that system design and implementation are very ambitious and will require a continuous commitment of staff and financial resources, but were enthused about the ultimate potential of the IT system strategy to support improved outcomes for **ICHP** members.

Patient Registries for Pain Management, Adults With Diabetes, Children With Diabetes

ICHP developed patient registries—i.e., databases of members who met the criteria for being included in special focus projects—for children and adults with diabetes as well as for those members receiving pain management. Each registry was configured through a data pull from the Statewide Data Analytics Contractor (SDAC) database of members that met the criteria for each program and was refreshed periodically to update members still eligible for the project. **ICHP** distributed lists of members to the care coordination teams associated with the members' PCMPs, who followed up with members to execute the interventions defined in study protocols. Interventions were tracked in the registry database. **ICHP** discussed each registry in the context of the overarching project:

- ◆ *Diabetes Monitoring in Members Taking Antipsychotic Medication* interventions included outreach to members to encourage HbA1c screening. **ICHP** completed and retired this project prior to HSAG on-site review.
- ◆ *Children With Diabetes* interventions included a member needs assessment, nutritional counseling, family education regarding necessary medical monitoring services, and referring the member to needed services.

Staff reported that Regions 1 and 7 were also adopting the database and project for implementation.

- ◆ *Opioid Dependence in Chronic Pain Management* interventions included referring the member to Medication Assisted Treatment (MAT) programs and other necessary social support services. At the time of HSAG review, **ICHP** was focused on identifying enough MAT/pain management providers and appropriate local social support resources to enable implementation of the protocols.

Observations/Recommendations

ICHP's contract with CORHIO was one component of an ambitious project to develop the Crimson Care Management system as a multifaceted population health system to support the goals of **ICHP**, including HIE with provider EHR systems. **ICHP** IT staff members were applying a methodical approach for developing, testing, and implementing the various components of the system. **ICHP** understands the challenges of stimulating rather than dictating participation of providers in a region with many small provider practices and the long-term commitment of staff and financial resources required to achieve system design and implementation.

The patient registries were intended to accommodate the objectives of special projects implemented in the region, and were discontinued at the completion of the projects. HSAG recommends that in order to facilitate ongoing provider tracking and improvement of patient outcomes of select populations, **ICHP** should consider the potential for maintaining the registries as useful components of the Crimson Care Management system and HIE described above.

Integration With Behavioral Health Services/BHOs

Activities and Progress

The ownership and Board of Managers consists of CMHCs, FQHCs, Beacon Health Options, and Colorado Community Managed Care Network. All of these organizations also participate on all committees. From **ICHP**'s inception as a RCCO, FQHCs and CMHCs in any given geographic area have operated as integrated care coordination teams and regularly collaborate, both formally and informally, on **ICHP** projects. The CMHCs are also the network providers in Colorado Health Partnerships (CHP) BHO. The entirety of Region 4 geographically overlaps with CHP, and Beacon Health Options provides administrative support to both **ICHP** and CHP. The major overlap in structure, geography, and functional responsibilities of CHP and **ICHP** has been a major strength in achieving behavioral and physical health integration both historically and looking forward to the development of a Regional Accountable Entity (RAE). **ICHP** staff specifically described a number of examples of functional collaboration between the CMHCs and FQHCs. Staff stated that some challenges in integrating behavioral and physical health systems are related to differences in reimbursement systems, provider perspectives, and methods of health record documentation (i.e., EHRs). Staff stated that the **ICHP**/BHO strategy is to make operational changes to enable members and providers to experience the benefits of integrated care.

ICHP estimated that 39 PCMPs have on-site behavioral health services for members, and that more than 17 PCMPs regularly conduct behavioral health screening and/or developmental screening for children. The majority of the integrated practices were co-location models; most had a full-time behavioral health practitioner on-site and documented member engagements in the PCMP medical record. In addition, some CMHCs have integrated or co-located physical health practitioners. Staff stated that between 80 and 85 percent of members have access to co-located behavioral and physical healthcare services.

Both **ICHP** and the BHO encouraged the advancement of practices to a fully integrated model by providing practice transformation, technical support, and financial incentives. The BHO Integration Incentive Program applied financial support for practices to move along the continuum of practice integration reflected in the Integrated Practice Assessment Tool (IPAT); **ICHP** had established pay-for-performance programs related to achieving the measures defined in the State Innovation Model (SIM) grant. The shared **ICHP** and BHO vision for the RAE is to build health teams throughout the region, supported by an integrated infrastructure. Staff described a variety of initiatives for advancing practice integration, including a Valley Wide Health Systems medical clinic built within the San Luis Valley Behavioral Health Group (SLVBHG) CMHC to provide on-site access to physical health services for behavioral health clients, numerous FQHC sites staffed by partner CMHCs, and the Colorado Psychiatric Access and Consultation for Kids (C-PACK) child psychiatry consultation program.

The Health Solutions CMHC in Pueblo is the only State-designated crisis center in the region. The center has a mobile unit through which licensed clinicians may be deployed to a broad geographic area to assist a person in crisis. Care coordinators may refer members to the crisis center, as appropriate; and all care coordinators had been educated and had disseminated the crisis support center information throughout the provider network. In addition to the State-designated crisis

center, all CMHCs within the region offered walk-in crisis services. **ICHP** and BHO call centers had work-flow protocols for immediately connecting a member in crisis to the BHO Clinical Department for assessment and directing the member to a place of safety. **ICHP** staff members were not aware of how extensively crisis center services were used or how well received they were within the community.

Care Coordination Record Reviews

Findings

HSAG conducted MMP member record reviews that focused on understanding the role of the SCP in documenting and performing care coordination. All 10 records reviewed were part of the original sample selected by the Department and documented full SCP completion. **ICHP** had programmed the MMP SCP tool into the Crimson Care Management system for all care coordinator teams to document the elements of the SCP. **ICHP** scored 97 percent overall compliance with the SCP requirements, with eight of 10 records scoring 100 percent. The two cases which included areas for improvement were associated with coordinators who were inexperienced and had not had adequate training at the time the SCPs were completed. Many members were previously connected with external Community Centered Board (CCB) or Single Entry Point (SEP) case managers prior to the RCCO becoming involved. In most cases, RCCO care coordinators contacted care coordinators and case managers from other agencies to ensure that members were receiving needed services. The CCBs in the region were particularly adept at meeting members' comprehensive needs for services and maintained ongoing relationships with members. In one case, the member declined further involvement with the RCCO care coordinator. In one case, there was opportunity for improvement in care coordination, but the case resulted in a generous score due to circumstances beyond control of the care coordinator.

During on-site review, staff members offered additional observations and noted experiences with the SCP process, including:

- ◆ CMHC care coordinators were assigned to complete SCPs on unattributed members, which resulted in member confusion and hesitancy due to the unsolicited contact by a mental health center.
- ◆ Some care coordinator teams hired separate staff members to complete the SCPs, some of whom were inexperienced and required additional training to understand that the SCP served as an active care coordination plan, not just a documentation tool. Staff stated that additional training had been provided.
- ◆ When member needs were already being met or other coordinators were already involved with the member, members sometimes questioned the need for the SCP process.
- ◆ The SCP was found to be a good tool for identifying social determinants and for stimulating outreach to other case managers involved with the member—"coordinating the coordinators."
- ◆ Staff questioned whether completion of the entire SCP document was appropriate for some types of members once it had been established that the member had limited unmet needs or was associated with an organization that provided ongoing care coordination, such as a long-term care facility, the State hospital, or a CCB.

Observations/Recommendations

Based on the sample of cases reviewed on-site, it appears that many MMP members have limited care coordination needs or have needs already being met through other agencies or their providers. Many MMP members were long-term patients of the FQHC. When a member's needs were being adequately addressed through providers, family, or other agencies prior to care coordinator engagement with the member, the completion of the SCP seemed duplicative of other resources involved with the member and served only to introduce the RCCO coordinator to the member and/or other members of the team as an additional resource. When members' needs were limited or already being adequately addressed, member goals were often vague or not actionable, possibly indicating that members felt compelled to identify goals when they had none. HSAG recommends that the Department consider these characteristics of MMP members in future instructions regarding the use and application of the SCP. HSAG recommends that **ICHP** ensure that all care coordinators are trained and understand that the purpose of the SCP is to serve as an active care coordination plan, rather than simply a documentation tool. Staff stated that management learned of several opportunities for improvement in SCP processes during preparation for the on-site audit; therefore, HSAG recommends that **ICHP** consider conducting periodic internal audits of SCPs to continue to identify and correct any concerns related to the SCP process.

Overview of Site Review Activities

The FY 2015–2016 site review represented the fifth contract year for the ACC program. The Department asked HSAG to perform an annual site visit to assess continuing development of **ICHP** as the RCCO for Region 4. During the initial five years of operation, each RCCO continued to evolve in operations, care coordination efforts, and network development in response to continual collaborative efforts, input from the Department, and ongoing implementation of statewide healthcare reform strategies. The FY 2015–2016 site visits focused on evaluating RCCO activities related to integration with specialist providers, integration with behavioral health services, and Medicare-Medicaid Program (MMP) member care coordination activities. In addition, HSAG gathered follow-up information on select special projects that had been implemented by each RCCO within the past two to three years. Through review of member records, HSAG evaluated the effectiveness of individual MMP member care coordination, including the implementation of the Service Coordination Plan (SCP). The Department asked HSAG to identify initiatives and methodologies implemented by the RCCOs in response to key contract objectives and to offer observations and recommendations related to each ACC focus area reviewed.

Site Review Methodology

HSAG and the Department met on several occasions to discuss the site review process and finalize the focus areas and methodologies for review. HSAG and the Department collaborated to develop the record review tool and the data collection tool, which provided the parameters for the on-site interviews. The purpose of the site review was to document compliance with select care coordination contract requirements, evaluate **ICHP**'s mechanisms for integrating with the BHO in the region and integrating behavioral healthcare for members, identify activities related to the involvement of specialists in the care of RCCO members, obtain updates of the progress in select special projects implemented by each RCCO, and explore challenges and opportunities for improvement related to each focused content area. Site review activities included a desk review of documents submitted by **ICHP** prior to the site visit. These documents consisted of program plans, written procedures, tracking documents, and any formal agreements related to each of the focus areas. During the on-site portion of the review, HSAG interviewed key **ICHP** personnel using a semi-structured qualitative interview methodology to elicit information concerning mechanisms for implementing the objectives and requirements outlined in the ACC contract. The qualitative interview process encourages interviewees to describe their experiences, processes, and perceptions through open-ended discussions and is useful in analyzing system issues and associated outcomes. The assessment of RCCO activities related to integration with behavioral health services was conducted through a joint interview of RCCO and BHO staff.

To continue the annual evaluation of care coordination processes, on-site review activities included care coordination record reviews. The Department determined that FY 2015–2016 care coordination record reviews would focus on the MMP population. HSAG developed a care coordination record

review tool based on contract requirements and the instructions for completing the required individual member SCP.

HSAG reviewed a sample of 10 care coordination records (selected by the Department's MMP program staff from the MMP report) of members with a SCP completed during the 2015 review period. The Department forwarded the sample lists of 10 records plus 10 oversample records to **ICHP** and HSAG prior to the on-site visit. HSAG completed an individual record review tool for 10 MMP members during the on-site visit. Although completion of the SCP document was not the focus of the record review, HSAG used SCP information, as available, when assessing the member's overall care coordination. HSAG assigned each question in the review tool a score of *Yes*, *No*, *Partially*, *Unable to Determine*, or *Not Applicable* and entered reviewer comments, as necessary, related to each evaluation element within the tool.

The completed data collection tool includes narrative information and recommendations related to on-site discussion of the RCCO's integration with specialty care, integration with behavioral health services/BHOs, and progress on two special projects. The special project topics were selected by the Department from projects identified by the RCCO during previous years' on-site reviews. These topics were different for each RCCO. Summary results and recommendations resulting from the on-site interviews as well as the care coordination record reviews are also included in the Executive Summary.

Appendix A. **Data Collection Tool**
for Integrated Community Health Partners (Region 4)

The completed data collection tool follows this cover page.



*Appendix A. Colorado Department of Health Care Policy & Financing
 FY 2015–2016 Data Collection Tool
 for Integrated Community Health Partners (Region 4)*

Section I—Integration with Specialist Providers

Contract References	Possible Discussion Topics
<p>Group 1: The Contractor shall reasonably ensure that Members in the Contractor’s Region have access to specialists promptly and without compromising the Member's quality of care or health. <p align="right">RCCO and MMP Contracts—4.2.5</p> <p>The Contractor shall ensure that all PCMPs refer members to specialty care as appropriate and ensure that clinical referrals are completed between PCMPs and specialists/referred providers. <p align="right">RCCO and MMP Contracts—6.1.1</p> <p>The Contractor shall develop and maintain a written protocol for clinical referrals to facilitate care coordination and sharing of relevant member information. <p align="right">RCCO and MMP Contracts—6.1.1.1</p> <p>The Contractor shall allow the PCMPs with which it contracts to refer Members to any specialists enrolled in Medicaid, including those not associated with the Contractor or another RCCO. <p align="right">RCCO and MMP Contracts—6.1.2</p> </p></p></p></p>	<ul style="list-style-type: none"> ◆ Incentives to stimulate specialist involvement ◆ Initiatives to address shortages ◆ Expanding accessibility of specialist care <ul style="list-style-type: none"> ▪ Telemedicine ▪ Downstreaming services into PCMPs ▪ Transporting specialists to rural or remote areas ▪ Relationships with hospital systems ▪ Other ◆ Successes and challenges in integrating with specialists and/or maintaining capacity for Medicaid members ◆ Mechanisms for monitoring specialist involvement/responsiveness, if any ◆ Referral protocols <ul style="list-style-type: none"> ▪ What are they? ▪ How have they been implemented? ▪ What is degree of success of using protocols (including feedback from specialists/PCMPs)? ◆ Plans, strategies, or solutions moving forward

Discussion and Observations:

ICHP submitted documents that demonstrated, and staff interviews confirmed, that the ICHP region has an inadequate number of specialist providers. The majority of specialists are located in Pueblo—the only population concentration in the geographic region. Members also access specialists in Denver and Colorado Springs. Therefore, RCCO members living in the outlying portions of the region often have transportation issues related to specialist appointments. Staff stated that the Council of Governments (COG) provides medical transportation between Trinidad, Walsenburg, and Pueblo and that care coordinators throughout the region are available to assist members with transportation and other referral needs. Three additional independent providers—one each in Springfield, Lamar, and Alamosa—have arranged for rotating specialists from the Colorado Springs area to be available on-site in their clinic locations. Staff



Appendix A. Colorado Department of Health Care Policy & Financing
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Section I—Integration with Specialist Providers

Contract References	Possible Discussion Topics
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stated that access to specialists has been primarily based on personal referral relationships among providers. Pre-established working relationships between ICHP leadership and select specialists have also been applied to enhance access to specialists for some members. ICHP staff members were very active in community-based work groups established to evaluate and improve access to specialists in the region. The Health of Pueblo work group requested that ICHP educate Medicaid members regarding the elements of a successful specialist appointment and was establishing an all-payor population health database to evaluate the types of additional specialists needed in the region. The Access to Specialty Care work group was examining the potential for The Children’s Hospital to distribute specialist services across the region through satellite offices. ICHP staff believed that both of these community-based initiatives would positively impact specialist care in the region. Staff stated that access to specialists is an all-payor concern, and not specific to Medicaid. However, specialty providers have identified lower reimbursement and concerns about Medicaid member behaviors—i.e., no shows and lack of preparation for appointments—as Medicaid member issues. ICHP engaged in several initiatives related to improving access to specialists, specifically for Medicaid members. ICHP staff developed and implemented specialist referral protocols and supporting tools for providers and members. Using the American College of Physicians (ACP) recommendations for referral checklists and provider referral agreements, ICHP developed a toolkit designed to facilitate the bi-directional communication process between PCMPs and specialists. The toolkit included a referral checklist (e.g., referring physician contact information, patient demographic and scheduling information, referral urgency, referral type, pertinent clinical data), a referral response checklist (e.g., diagnoses, medication/equipment changes, results of diagnostic testing, procedures performed, recommended follow-up), a patient form titled, “Getting Ready for Your Specialist Appointment,” and a guide for PCPs to prepare the member for a referral appointment. Beginning in 2014, the ICHP Performance Improvement Team developed a relationship with each PCMP site for the purposes of implementing a referral protocol and soliciting input from specialists regarding the referral protocols. Staff stated that ICHP is not prescriptive in the application of the referral tools but makes the toolkit available to providers on the ICHP website. The member handout is also available to members on the ICHP website, through care coordinators, and in PCMP offices. In 2015, ICHP conducted a chart audit at five ICHP partner providers to ensure compliance with referral protocols. Although all providers met benchmark measurements, ICHP identified an opportunity to institute provider “alerts” to ensure proper flow of clinical documentation and follow-up.

ICHP had also engaged providers in several telemedicine initiatives to enhance the capabilities of PCMPs to address some specialty needs of members. These included:

- ◆ Five provider locations participated in educational programs through the University of Colorado-based Extension for Community Health Outcomes in Colorado (ECHO Colorado) program related to epilepsy, food safety, diabetes, management of tuberculosis, pediatric endocrinology, and hepatitis C.
- ◆ The University of New Mexico-based Project ECHO Chronic Pain and Headache Program provided education and weekly multidisciplinary consults for select PCMPs’ pain management cases.
- ◆ Twenty-one PCMP practices engaged in access to child psychiatry consultations through the Colorado Psychiatric Access and Consultation for Kids (C-PACK) program. Practice engagement was paid for by Colorado Health Partnerships (the regional BHO) and facilitated through the RCCO. ICHP was also considering participation in a similar program for adult members with psychiatric needs.



*Appendix A. Colorado Department of Health Care Policy & Financing
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Section I—Integration with Specialist Providers

Contract References	Possible Discussion Topics
<p>ICHP’s hospital partners in the region were evaluating mechanisms to impact specialist services. Memorial Hospital was considering satellite offices for specialty care. Parkview Medical Center and St Mary-Corwin Medical Center were buying specialist practices and recruiting additional specialists to the region. ICHP staff members described attending a community-wide “think tank” to explore creative ideas to increase access to specialists, and ICHP was considering an alternative to purchase “slots” in specialist schedules that could be used as needed for referred ICHP members. ICHP was also using data to evaluate the need for specialists, including a study of members with repeat emergency department (ED) visits for the same diagnosis, to determine whether timely access to a specialist may have prevented the need for repeat ED visits. Staff stated that the Provider Network Committee and the Medical Management Committee were working collaboratively to develop a cohesive ICHP strategy and action plan (anticipated for release in April 2016) for future endeavors to improve access to specialist care in the region.</p>	



Appendix A. Colorado Department of Health Care Policy & Financing
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Section II—Follow-up of Region-specific Special Projects

Contract References	Possible Discussion Topics
NONE	<p>Relationship of RCCO with the health information exchange—Colorado Regional Health Information Organization (CORHIO) or Quality Health Network (QHN)</p> <ul style="list-style-type: none"> ◆ Describe the RCCO’s relationship with the health information exchange (HIE) <ul style="list-style-type: none"> ▪ How the relationship was developed ◆ Agreement between the RCCO and the HIE <ul style="list-style-type: none"> ▪ HIE “user/participant”? ▪ Receive information/contribute information? ▪ Functional relationship—how information is received from the HIE (e.g., direct interface, Web portal, member list/inquiry) ◆ Type of data received from the HIE <ul style="list-style-type: none"> ▪ How RCCO is using/applying the information ▪ Has access to information replaced previous mechanisms of provider notifications/alerts? ▪ Any data or components of the delivery system that are missing/incomplete/gaps? ◆ Successes and challenges of relationship with HIE: <ul style="list-style-type: none"> ▪ Is exchange working smoothly? ▪ Describe value(s) of the relationship ▪ Difficulties experienced (potential solutions) ◆ Do you envision an expanded/evolving role of the HIE in meeting the future needs of the RCCO? <ul style="list-style-type: none"> ▪ Status of any planned/anticipated data exchange functions



Appendix A. Colorado Department of Health Care Policy & Financing
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Section II—Follow-up of Region-specific Special Projects

Contract References	Possible Discussion Topics
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Discussion and Observations:
 ICHP had a direct contract with the Colorado Regional Health Information Organization (CORHIO) to receive RCCO member health information exchange (HIE) information and develop mechanisms to integrate all data received into the ICHP database. At the time of the site review, ICHP received the daily ADT file from the HIE (through the Department) as an Excel flat file with face sheets from the hospitals attached. The information was transmitted through the Beacon information system and then to ICHP. Staff stated that the transmission from CORHIO involved a significant volume of data, but the transmission process was working smoothly. ICHP staff’s only concern was that the ADT data were not always timely, perhaps because hospitals are not entering data at the point of service in a timely manner. Going forward, hospital ADT information will be integrated directly into ICHP’s Crimson Care Management system. Staff stated that when the HIE data is directly interfaced with the Crimson system, ICHP will need to build a mechanism to screen the data against the member eligibility files.

The next priority for ICHP is to begin receiving laboratory data through CORHIO as the first component of building a clinical data repository. Ultimately, ICHP’s goal is to have all ICHP member data and information gathered in the CORHIO system—“if they have it, we want it.” Once the data are received from CORHIO, ICHP’s goal is to get the information into the hands of the users. ICHP was working with CORHIO to develop options for extracting data from the Crimson database and integrating information into the providers’ electronic health record (EHR) systems. To that end, ICHP would like to stimulate additional practices to participate in CORHIO and was examining the cost and value for small practices. ICHP believes that the HIE can be a significant asset for the entire provider community. Staff stated that the data integration functions and design of capabilities to interface with multiple systems throughout the region require a major commitment of IT staff and financial resources. Staff reported a positive working relationship with CORHIO and considered its partnership with CORHIO to be a significant asset in achieving its goals.

NONE	<p>TOPIC #1: Development of patient registries for pain management, adults with diabetes, children with diabetes</p> <p>Get an update on the project as follows:</p> <ul style="list-style-type: none"> ◆ How/why this project was selected/initiated ◆ Current status of implementation ◆ Potential impact of program on members ◆ Potential impact on the RCCO ◆ Potential impact on service providers ◆ Realized or anticipated successes to date ◆ Realized or anticipated challenges to date
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Discussion and Observations:

ICHP developed a patient registry for children with diabetes, one for adults with diabetes, and one for pain management as components of more comprehensive pilot projects or focus studies in the region. Each registry is a database of members who met the criteria for being included in the respective project, and provides a mechanism for tracking the study population. Therefore, each registry was discussed within the context of the overarching program.

Diabetes Monitoring in Members Taking Antipsychotic Medication

- ◆ The objective was to identify adults on antipsychotic medication and have community care coordinators reach out to each member to ensure that he/she was receiving periodic HbA1c testing (an indicator of developing diabetes).
- ◆ ICHP configured the registry by a data pull from the SDAC members who were more than 21 years of age and regularly taking antipsychotic medications. The registry was refreshed annually and eligible members added to the study population. Lists of members were distributed to the care coordination teams associated with the member’s PCMPs, who outreached to members to encourage HbA1c screening.
- ◆ Challenges included behavioral health and physical health providers involved with the members’ care who did not necessarily agree on best practices for this population and who did not agree on which provider (behavioral health or physical health) was responsible to order and follow up on the screening. Behavioral health providers were not comfortable with follow-up of medical laboratory findings, and physical health providers were not comfortable with antipsychotic medications. The member, therefore, was caught in the middle.
- ◆ ICHP met its performance objectives for this study and retired the project prior to HSAG’s site review. The registry database design and staff focus were transitioned to the Children With Diabetes project.

Children With Diabetes

- ◆ ICHP configured the registry by conducting a data pull from the SDAC members who were 20 years old or younger with a diagnosis of diabetes. The registry was refreshed every six months to remove members no longer eligible for Medicaid. However, in the interest of continuity and accounting for Medicaid eligibility “churn,” members were not necessarily removed from the program. The registry included 191 children in 2015.
- ◆ Care coordinators associated with the child’s attending PCMP conducted personal follow-up with the member/family to do a needs assessment; conduct nutritional counseling; provide education materials regarding HbA1c testing, immunizations, eye examinations, and well-child visits; and refer the member to services, if needed. Interventions were tracked in the study database.
- ◆ At the end of 2015, ICHP began monitoring HbA1c testing and added referrals for behavioral health counseling to the protocols. Community mental health centers (CMHCs) provided training to medical health providers regarding lifestyle-changing issues that may require referral to behavioral health.
- ◆ Care coordinators communicated with the PCMPs regarding outcomes of outreach to families.
- ◆ Culture was a major factor in the effectiveness of education and follow-through of the family/member.



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<ul style="list-style-type: none"> ◆ HSAG inquired whether the registry could be useful as a statewide program or expanded to other RCCOs. Staff stated that Regions 1 and 7 were adopting the database and project for implementation. <p>At the time of the site review, ICHP was considering implementing a registry and a similar best practice management program for children with Asthma.</p> <p><u><i>Opioid Dependence in Chronic Pain Management</i></u></p> <ul style="list-style-type: none"> ◆ ICHP configured this registry by conducting a data pull from the SDAC members who had five or more opiate prescriptions from five or more prescribers. The registry was refreshed every six months. In July 2015 the registry had 1851 members. ◆ The project was initiated in 2014 and has developed in phases. Phase 1 (2014) focused on prescriber interventions—education, participation in the University of New Mexico’s Project ECHO Chronic Pain and Headache Program, developing and sending member alerts to prescribers, and behavioral health referrals. Phase 2 (July 2015) included adoption of Medication Assisted Treatment (MAT) programs as the intervention of choice and assigning care coordinators to follow up with members in the registry, make referrals to MAT programs, and assist members with referrals to other social support agencies as needed. ◆ Challenges included low member motivation to enter alternative treatment programs, availability of sufficient MAT/pain management providers and appropriate social support resources (particularly in outlying areas) to accommodate the referrals according to best practice protocols, and provider misunderstandings regarding medication regulations and reimbursement issues. The most recent data refresh indicated that 300 members previously included were no longer on the registry, which prompted concerns as to the reason for such a significant reduction in eligible members. ◆ Staff stated that the ongoing project will continue to evolve to focus on members and geographic areas with the most potential for outcomes. The most significant outcomes are individual member medical and psychological stability, preventable future health problems, and reduced overall costs of healthcare. 	
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<p>NONE</p>	<p>TOPIC #2: Crimson Care Management system—strengths/weaknesses and status of implementation (2015)</p> <p>Get an update on the project as follows:</p> <ul style="list-style-type: none"> ◆ How/why this project was selected/initiated ◆ Current status of implementation ◆ Potential impact of project on members ◆ Potential impact on the RCCO ◆ Potential impact on service providers ◆ Realized or anticipated successes to date ◆ Realized or anticipated challenges to date
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<p>Discussion and Observations:</p> <p>ICHP staff described the Crimson Care Management system as a population health system and a “very high-value data set” for the RCCO and its providers. There are three major components to the system—a patient-level clinical data warehouse, claims analysis software, and the Crimson care coordination application.</p> <ul style="list-style-type: none"> ◆ The clinical data warehouse facilitates exchange of clinical information with EHR systems by centralizing and standardizing clinical data and transmitting clinical outcomes to the EHRs. ICHP will initiate the clinical application with the federally qualified health centers (FQHCs)—two FQHCs have already been implemented—with Valley Wide Health Systems (Valley Wide) and possibly SyCare to be implemented in the near future. ◆ The claims analysis software provides claims-based analysis of SDAC data to perform risk-modeling and track utilization patterns and claims-based outcome measures. ◆ The coordination of care application combines data imported from EHRs, ADT data from CORHIO, and care coordinator input into a consolidated document and transmits the information back through CORHIO to provider EHRs. The MMP SCP tool was programmed as one piece of this application. Pilot testing of the full application for all members was scheduled for May 2016. <p>ICHP selected the Crimson Care Management system because it has demonstrated a unique capability throughout the country to provide integrated ambulatory care information from multiple sources to a broad base of service providers, agencies, or anyone provided access. Staff explained that current data availability from single sources have gaps in information. For example, the HIE lacks ambulatory care data, provider practice electronic record systems cannot be extended beyond the practice, payor information is limited to the payor line of business, and community care coordinator files reflect input from only one source. ICHP’s goal is to design a system able to leverage all available sources of information to improve member outcomes.</p> <p>At the time of HSAG’s review, ICHP was in the technical development stage of this long-term project. Staff characterized the data integration component as requiring the most work, requiring a progressive process of validating data input flows and correcting any data issues as they are identified. For example, CORHIO data on hospital visits were duplicating hospital visit activity reported in the SDAC and definition of member care coordination needs and risk levels required development of a special application. Other challenges included that, while ICHP care coordination is entirely delegated to providers (FQHCs and CMHCs), ICHP is a provider-run organization and management does not have the authority/luxury of requiring providers to use the Crimson care coordination application. Therefore, ICHP must develop the system as a provider and community asset that can improve outcomes (e.g., social barriers) of members in the community. The benefit for members will be that continuity of care from one point of service to another can be improved through one vehicle. Staff reported that anecdotal feedback from PCMPs is two-fold: the system cannot cause additional burden on the work flow of providers and “this is where healthcare technology needs to go!” ICHP staff members understand that the system design and implementation are very ambitious and will require a continuous commitment of staff and financial resources, but expressed significant enthusiasm for the project and strategy.</p>	
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Section III—Integration with Behavioral Health Services/Behavioral Health Organizations

Contract References	Possible Discussion Topics
<p>Group 1: The Contractor shall create, document, and maintain a Communication Plan to communicate with all behavioral health managed care organizations (BHOs) with which it has relationships. <p align="right">RCCO and MMP Contracts—4.3.1</p> <p>The PIAC includes members representing the behavioral health community. <p align="right">RCCO Contract—7.4.1.3.6</p> <p>If the Member has an existing case manager through another program, such as behavioral health program, then the Contractor shall coordinate with that individual on how best to coordinate care through a single care coordinator. <p align="right">RCCO and MMP Contracts—6.4.3</p> <p>The care plan shall include a behavioral health component for those clients in need of behavioral health services. <p align="right">RCCO and MMP Contracts—6.4.5.1.1.1</p> <p>For members who have been released from the Department of Corrections (DOC) or county jail system, the Contractor shall coordinate with the members’ BHO to ensure continuity of medical, behavioral, and pharmaceutical services. <p align="right">RCCO and MMP Contracts—6.4.5.2.6</p> </p></p></p></p></p>	<p>General structure of RCCO/BHO/CMHC relationships</p> <ul style="list-style-type: none"> ◆ How many BHOs does the RCCO work with? (How many RCCOs does the BHO(s) work with?) ◆ Is there formal organizational alignment? <ul style="list-style-type: none"> ▪ Ownership/partnership? ▪ Are there MOUs or contracts between the organizations? ▪ Is there a financial relationship? ◆ Do formally defined accountabilities/responsibilities exist between the organizations? ◆ How long have these relationships been in place? <p>Functional relationships/operational interface</p> <ul style="list-style-type: none"> ◆ Does the BHO participate in committees, boards, or joint planning related to RCCO strategic or operational decision making? (RCCO in BHO decision making?) ◆ Shared systems? ◆ Are there reporting responsibilities or data shared among the organizations? ◆ How extensive are the collaborative processes? <ul style="list-style-type: none"> ▪ Outline the functional areas of collaboration—how processes work ▪ How do these processes impact members (e.g., transparency, degree of coordination/overlaps, any feedback from members)? ▪ Care coordination—walk through the processes <ul style="list-style-type: none"> ● Sharing information (verbal/documentation) ● Designating a lead coordinator ● Deciding how to share care coordination duties



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<p>Integrated care coordination characteristics include: Ensuring that physical, behavioral, long-term care, social and other services are continuous and comprehensive and the service providers communicate with one another in order to effectively coordinate care. RCCO and MMP Contracts—6.4.5.3.1</p> <p>The Contractor shall ensure coordination between behavioral health and physical health providers. RCCO and MMP Contracts—6.4.11</p>	<ul style="list-style-type: none"> • Who generally identifies the member with complex behavioral and/or physical health needs? • Who initiates the care coordination process? ▪ Describe how these collaborative processes have evolved; what do you anticipate going forward? ▪ What are the opportunities/successes to date related to collaborative responsibilities? ▪ What are the challenges related to collaborative processes?

Discussion and Observations:
 ICHP was founded by a coalition of CMHCs and FQHCs across the region. The ownership and Board of Managers consisted of four CMHCs (Health Solutions, San Luis Valley Behavioral Health Group, Solvista Health, and Southeast Health Group), three FQHCs (High Plains Community Health Center, Pueblo Community Health Center, and Valley Wide), Colorado Community Managed Care Network, and Beacon Health Options. This leadership of safety-net providers is responsible for the vision and financial direction of ICHP, providing direction and establishing priorities for “whole person” care in the region. All of these organizations also participate on all Board of Manager’s subcommittees, and the FQHCs and CMHCs in any given geographic area regularly collaborate—formally and informally—on ICHP projects. Significantly, the integrated coordination of care teams throughout the region consists of staff from both the FQHC and CMHC in each sub-geographic area.

The entirety of Region 4 geographically overlaps with a single BHO—Colorado Health Partnerships. Colorado Health Partnerships’ BHO service area also overlaps with portions of two other RCCO regions. The BHO’s contracted CMHCs play an active role within each RCCO region. Beacon Health Options staff provide administrative support services for both ICHP and Colorado Health Partnerships. This major overlap in both structure and functional responsibilities is a major strength in achieving behavioral and physical health integration both historically and looking forward to the development of a Regional Accountable Entity (RAE) to support ACC 2.0.

During on-site interviews, ICHP staff described a number of areas of functional collaboration between the CMHCs and FQHCs, including:

- ♦ A San Luis Valley Behavioral Health Group (SLVBHG) care coordinator and a Valley Wide FQHC physical health care coordinator function as a collaborative care coordination team (CCT) and are co-located in all Valley Wide medical clinics in their shared geographic area. If the member’s primary needs are behavioral, the behavioral health care coordinator is designated as the lead coordinator; in all other cases the FQHC assumes the lead



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<p>coordinator role. CCTs meet monthly to review cases for all members receiving care coordination. A similar CMHC/FQHC collaborative care coordinator team model exists in all other geographic areas in the region. Health Solutions has 15 care coordinators, each embedded in the PCMP practices they are assigned to support, including non-FQHC PCMPs.</p> <ul style="list-style-type: none"> ◆ In addition to care coordination for members with complex needs, the CCTs outreach all patients with select diagnoses/conditions (e.g., diabetes, obesity, and chronic pain) to provide protocol-driven interventions associated with ICHP’s special projects and programs. ICHP maintains registries of these populations, and protocols always include both behavioral and physical health components (see description of projects in Section II—Follow-up of Region-specific Special Projects). ◆ Through SyCare—an organization for overview and coordination of CMHCs in the region—CMHCs share best practices that encourage transferability of programs and services among CMHCs. ◆ In response to the opioid dependence project, CMHCs, FQHCs, and community partners began forming alliances within multiple geographic regions to address issues of opioid dependency and identify resources for MAT programs and other social support services. Staff stated that locally-driven strategies are essential due to varying community and provider resources in each location and noted that partnerships often are more readily formed in the more rural/frontier areas of the region. Each initiative is being jointly supported by ICHP and the BHO. <ul style="list-style-type: none"> ▪ In the Pueblo area, Health Solutions was developing an opioid treatment clinic with MAT services. ▪ In the San Luis Valley, State legislature representatives, providers (e.g., Valley Wide), law enforcement, and other community leaders formed a task force to examine best approaches for policy and treatment programs. ▪ In Lamar, the CMHC and FQHC partnered to obtain a \$3 million grant to develop a MAT program that will serve a wide geographic area. ICHP anticipated that this program would be the first program in the region to begin providing MAT services to members. ▪ ICHP sponsored education forums in which Vivitrol and Suboxone drug representatives educate pharmacists and prescribers regarding regulations and reimbursement issues. <p>Staff stated that some of the challenges with integrating behavioral and physical health arise from the established cultures of two different systems of care delivery—e.g., differing benefits and reimbursement systems, differing provider perspectives and treatment modalities, and different methods of health record documentation (i.e., EHRs). In addition, the members in physical health systems and behavioral health systems have different needs and expectations, and mechanisms for engaging and empowering members vary. The ICHP/BHO strategy is to make operational changes (such as developing integrated EHRs or integrated health teams that support providers and members) that enable members and providers to see the benefits of integrated care.</p>	



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<p>Group 2: The Contractor shall ensure that its network includes providers or PCMPs with the interest and expertise in serving the special populations that include members with complex behavioral or physical health needs RCCO and MMP Contracts—4.1.6.5</p> <p>The Contractor shall distribute materials (provided by the Department) related to behavioral health and BHOs to all of the PCMPs in the Contractor's PCMP Network. RCCO and MMP Contracts—5.2.1</p> <p>Enhanced Primary Care Standards include:</p> <ul style="list-style-type: none"> ◆ The PCMP provides on-site access to behavioral health care providers. ◆ The PCMP collects and regularly updates a behavioral health screening (including substance use) for adults and adolescents. ◆ The practice has documented procedures to address positive screens and agreements with behavioral healthcare providers to accept referred patients. <p align="right">RCCO Contract—Exhibit F1 (4) and (5)</p> <p>Behavioral Health Integration Report:</p> <ul style="list-style-type: none"> ◆ The Contractor shall submit to the Department a report that includes an environmental scan of current practices, challenges, and new strategies for integration of behavioral and physical healthcare for all covered populations. <p align="right">RCCO Contract—8.2.1.1</p>	<p>General level of behavioral health integration into medical practices or with other providers throughout network</p> <p>Special programs/initiatives: update of programs in Integrated Care Report</p> <ul style="list-style-type: none"> ◆ BHO/RCCO collaborative care coordination: children with diabetes ◆ Diabetes screening for members taking antipsychotic medications ◆ High utilizers: opiate medications <p>Get a brief update on each initiative above as follows:</p> <ul style="list-style-type: none"> ◆ How/why this project was selected/initiated ◆ Current status of implementation ◆ Realized or anticipated successes to date ◆ Realized or anticipated challenges to date ◆ Potential impact on members when program completed <ul style="list-style-type: none"> ▪ How many members? Degree of importance/significance in member care and services? ◆ Potential impact on practitioners/other service organizations <ul style="list-style-type: none"> ▪ If BH/PH practice integration: <ul style="list-style-type: none"> ● Where do the resources come from? ● To whom are these practitioners accountable? ● How available are resources to members? ● How do co-located practitioners interact in patient care or the dynamics of office operations? <p>Crisis Support Services system:</p> <ul style="list-style-type: none"> ◆ How does the RCCO/BHO coordinate with the Crisis Support Services network? ◆ How are members informed by RCCO/BHO?



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	<ul style="list-style-type: none"> ◆ How does the referral system work between the RCCO/BHO and crisis centers? ◆ What are your challenges/successes in working with the center(s)? ◆ Do you have a sense of how effective the crisis network might be? (Do you know if members use the center(s)? Any feedback from members?) <p>Overall successes/challenges in integrating BHOs/mental health providers with RCCO/physical health providers</p> <p>Overall impact of integration efforts on members</p> <ul style="list-style-type: none"> ◆ Any way to monitor/assess? (Any feedback from members?) <p>Going forward—Strategies for integration of behavioral and physical healthcare for all covered populations.</p>

Discussion and Observations:

Using the enhanced PCMP factor definitions, ICHP estimated that 39 PCMPs have on-site behavioral health services for members; and that more than 17 PCMPs regularly conduct behavioral health screening and/or developmental screening for children, including all FQHCs and a growing number of independent practices. ICHP also uses the Integrated Practice Assessment Tool (IPAT) to assess the varying levels of integration within practices. The majority of the integrated practices are co-location models—some PCMP locations have behavioral health practitioners that rotate to the practice on a part-time basis, but most co-located practices have a full-time behavioral health practitioner on-site and document member engagements in the PCMP medical record. In addition, some CMHCs have integrated or co-located physical health practitioners, either employed by the CMHC or provided through the FQHC. Staff stated that between 80 and 85 percent of members have access to co-located behavioral and physical healthcare services. The CMHCs support co-located behavioral health practitioners by employing the practitioners and assuming financial responsibility for behavioral health encounters. Primary care providers in CMHCs self-bill through the fee-for-service system.

Both ICHP and the BHO encouraged the advancement of practices to a fully integrated model by providing technical support, practice transformation tools, and education; as well as through financial incentives from the BHO and ICHP. The BHO Integration Incentive Program applies financial support for practices to move along the continuum of practice integration reflected in the IPAT; ICHP has established pay-for-performance programs related to achieving



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the measures defined in the State Innovation Model (SIM) grant. Although the specific interim goals and measures of performance of these financial incentive programs may differ, ICHP’s and the BHO’s ultimate goals are aligned. Staff stated that a variety of initiatives were in place for advancing practice integration in 2016.

- ◆ Valley Wide has a behavioral health therapist staffed at each clinic to ensure that behavioral health services and screenings are available to clinic patients.
- ◆ Health Solutions provides behavioral health services within Pueblo Community Health Center and at the Mount Carmel Health and Wellness Center in Trinidad.
- ◆ C-PACK telehealth child psychiatry consultation is available to all PCMPs.
- ◆ The BHO is working collaboratively with Medicaid agencies throughout the region to develop client services and care coordination processes.
- ◆ Opening in June 2016, Valley Wide built a medical clinic within the SLVBHG CMHC—a clinic within a clinic—so that behavioral health clients who are not inclined to seek medical services will have facilitated, on-site access to physical healthcare. Bi-directional practitioner communications, facilitated through a shared EHR, will enhance whole-person care.

The shared ICHP and BHO vision for the RAE is to build health teams throughout the region, supported by an integrated infrastructure.

Crisis Support Services

The Health Solutions CMHC in Pueblo is the only State-designated crisis center in the region. The center has a mobile unit through which licensed clinicians and care coordinators may be deployed to make house calls or meet an individual in crisis wherever they are. The mobile unit may be deployed to a broad geographic area. The Health Solutions crisis team gave the RCCO care coordinator work group a presentation about the crisis support service system in the region. Care coordinators are connected to all major provider locations and are able to disseminate the information throughout the provider network. In addition, care coordinators may refer members to the crisis center, as appropriate. Health Solutions crisis center staff coordinate all appropriate continuing care for individuals visiting the crisis center. ICHP obtains feedback from the crisis center applicable to RCCO members. ICHP included crisis center contact information on its website. ICHP staff member were not aware of how extensively crisis center services were used or how well received they were within the community.

In addition to the State-designated crisis center, all CMHCs within the region offer walk-in crisis services. ICHP and BHO call centers (both operated by Beacon Health Options) have processes that direct every caller—including those in crisis—to an appropriate place within the BHO system. Call center staff have work-flow protocols for immediately connecting a member in crisis to the BHO Clinical Department, which employs licensed clinicians to assess the member and direct the member to a place of safety within his or her local area.

Appendix B. **Record Review Tools**
for **Community Health Partnership (Region 7)**

Based on the sensitive nature of the coordination of care record reviews, they have been omitted from this version of the report. Please contact the Department of Health Care Policy and Financing's Quality Unit for more information.

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

Table C-1 lists the participants in the FY 2015–2016 site review of **ICHP**.

Table C-1—HSAG Reviewers and RCCO Participants

HSAG Review Team	Title
Katherine Bartilotta, BSN	Senior Project Manager
Rachel Henrichs	EQR Compliance Auditor
ICHP Participants	Title
Chloe Bailey (phone)	Care Coordinator
Chris Senz (phone)	Chief Executive Officer
Claire Chadwell-Bell	Regional Clinical Care Director
Haline Grublak	Director of Member and Family Affairs
Jason Gueer (phone)	Chief Executive Officer, Colorado Community Managed Care Network
Jessica Provost	Provider Relations Manager
LaCrecia Smith	Care Coordinator, San Luis Valley Behavioral Health Group (SLVBHG)
Leova Villalobos	Care Coordinator Supervisor, Valley-Wide Health Systems, Inc.
Lori Roberts	Chief Operations Officer
Matthew Wilkins	Care Coordinator Supervisor, Health Solutions
Rebecca Encizo	Director of Performance Improvement
Tammy Moruzzi	Care Coordinator, Solvista Health
Victoria Romen	Clinical Director, SLVBHG
Wendy Segar	Care Coordinator, SLVBHG
Department Observers	Title
Christian Koltonski	Quality and Health Improvement Unit
Conner Carballido (phone)	Quality and Health Improvement Unit
Murielle Romine (phone)	Program Innovation
Matt Vedal	Program Innovation
Sophie Thomas	ACC Contract Manager