

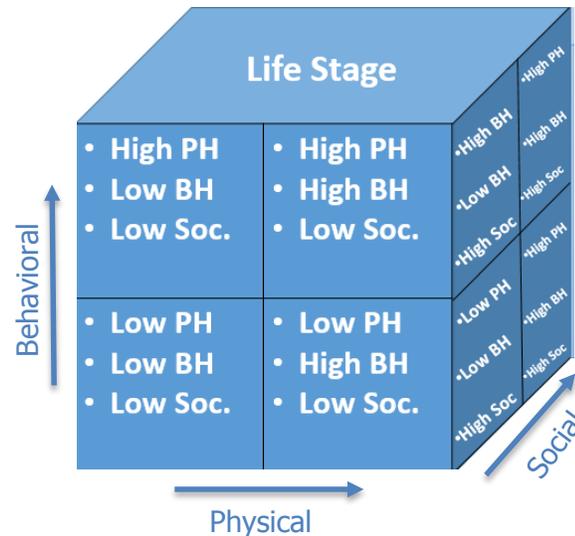


# ACC 2.0: Addressing Unique Population Needs

August 2015

To ensure that individuals and families enrolled in Medicaid and the Accountable Care Collaborative have the appropriate supports and services to meet their needs, the Department aims to enhance the approach to care coordination services delivered by the Regional Accountable Entities (RAE).

The proposed strategy was informed by the Request for Information results, which strongly advocated for including behavioral and social needs as areas of focus for care coordination support. Our current proposed strategy is based on the four-quadrant model that has been expanded to include social needs (see cube to the right) and a recognition of the key life stages of individuals and families, based on the Colorado Opportunity Project.



| Opportunity Project Life Stages | Age Range      |
|---------------------------------|----------------|
| <b>Family Formation</b>         | Pregnant Women |
| <b>Early Childhood</b>          | 0-5            |
| <b>Middle Childhood</b>         | 6-11           |
| <b>Adolescence</b>              | 12-17          |
| <b>Transition to Adulthood</b>  | 18-29          |
| <b>Adulthood</b>                | 30-40          |
| <b>Older Adult</b>              | 40-60          |
| <b>Elderly</b>                  | 60-75          |
| <b>Frail Elderly</b>            | 75+            |

Each RAE will have a strategy for coordinating care (i.e., what types of services/care coordination is needed and how frequently) for clients at each life stage and at each level of need. The RAE, or its delegate, will conduct the level of need assessment, taking into account the client’s own health goals, when a new client is enrolled in the ACC. The intervention models for each life stage and level of care, developed by the RAE or its delegates, will be evidence-based.

The Department would like to gather information from the PIAC regarding this proposed strategy. Specifically:

- What benefits and challenges do you see with the proposed strategy of care coordination that is targeted based on physical, behavioral, social and life stages needs?

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- What is the best way to understand the needs of clients in communities so that care coordination can be appropriately structured and delivered?
- Should the Department require standardized processes for care coordination or allow each RAE to propose their own?
- There are many social needs to consider, what should we focus on? (e.g. housing, accessible food, transportation)

