

Colorado
Accountable Care Collaborative

FY 2012–2013 SITE REVIEW REPORT
for
**Rocky Mountain Health Plans
(Region 1)**

July 2013

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



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Background

The Colorado Department of Health Care Policy and 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 client and family experience, improve access to care, and transform incentives and the health care delivery process to a system that rewards accountability for health outcomes. Central goals for the program are (1) improvement in health outcomes through a coordinated, client-centered system of care, and (2) cost control by reducing avoidable, duplicative, variable, and inappropriate use of health care 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. The RCCOs provide medical management for medically and behaviorally complex clients; care coordination among providers; and provider support such as assistance with care coordination, referrals, clinical performance, and practice improvement and redesign.

In spring 2011, Health Services Advisory Group, Inc. (HSAG), performed a readiness review of each RCCO to assess the RCCO's ability to provide services to Medicaid clients and to identify any operational deficiencies. **Rocky Mountain Health Plans (RMHP)** began operations as a RCCO in June 2011. The Department has requested that HSAG perform annual site visits to assess each RCCO's progress made during the previous year of operations toward implementing the ACC Program. HSAG was asked to identify successes and barriers encountered and make recommendations for improvement. This report documents the findings and recommendations as a result of the 2013 site review for **RMHP**.

Site Review Methodology

HSAG and the Department met on several occasions to discuss the site review process and finalize the standards for review. HSAG and the Department collaborated in the development of data collection tools that provided the parameters for the RCCO site review process. The site review process included a desk audit of specific key documents from the RCCO prior to the site visit, on-site review of care coordination records, and on-site interviews of key RCCO personnel related to care coordination and care management (Standard I) and continued progress made on improving access to care and medical home standards (Standard II).

To enhance the evaluation of Standard I—Care Coordination and Care Management, HSAG reviewed medical records for a random sample of 10 members identified by the Department as having complex medical and behavioral health needs.

The purpose of the site review was to evaluate the RCCO's progress toward implementation of the ACC model of patient care, explore barriers and opportunities for improvement, and identify opportunities for collaboration with the Department to ensure the success of the ACC Program. Key documents reviewed consisted of policies, procedures, status reports, and program plans submitted

by the RCCO. The majority of the evaluation of **RMHP** was based on data gathered on-site using a qualitative interview methodology. The qualitative interview process is the use of open-ended discussion that encourages interviewees to describe their experiences, processes, and perceptions. Qualitative interviewing is useful in analyzing systems issues and related desired or undesired outcomes. This technique is often used to identify strengths, evaluate performance differences, and conduct barrier analysis. Data gathered from the review of RCCO documents and on-site record reviews provided the catalyst for the open-ended discussions essential to the qualitative interview technique.

Overall Summary of Findings

Table 2-1—Summary of Scores

Standard	Total Elements	Total Applicable Elements	# Met	# Substantially Met	# Partially Met	# Not Met	# Not Applicable	Score*
I Care Coordination/ Care Management	6	6	6	0	0	0	0	100%
II Follow-Up: Access to Care/Medical Home	4	4	4	0	0	0	0	100%
Record Reviews	110	105	105	0	0	0	5	100%
Overall Score	120	115	115	0	0	0	5	100%

* The overall percentages were obtained by adding the number of elements that received a score of *Met* to the weighted score for the elements that received a score of *Substantially Met* (multiplied by 0.75) and the weighted score for the elements that received a score of *Partially Met* (multiplied by 0.50), then dividing this total by the total number of applicable elements.

Summary of Findings by Standard

Standard I—Care Coordination/Care Management

Strengths

RMHP divided Region 1 into five smaller, community-focused areas and contracted with an organization in each area designated to manage the care coordination efforts for that community. These designated organizations partner with providers and service agencies in their region to form Community Care Teams (CCTs). Each team includes the area's Medicaid behavioral health provider or community mental health center (CMHC). **RMHP** allowed each community to use the methods it deemed most suitable for its region. **RMHP** collects the assessment templates from each team and works with the teams to educate and encourage development of comprehensive assessments that meet medical home standards.

To ensure that it provides care and care coordination activities that are linguistically appropriate to its members and are consistent with members' cultural beliefs and values, one of **RMHP**'s CCTs includes a promotor. Promotoras are lay Hispanic/Latino community members who receive specialized training to provide basic health education in the community, although they are not professional health care workers. While most of their work entails educating target audiences about health issues affecting their community, they also provide guidance in accessing community resources associated with health care.

RMHP's five CCTs have worked on developing relationships with its area hospital discharge planners. The Loveland Team has developed a "hotspotters" group comprised of professionals from the participating hospitals who are working through Health Insurance Portability and Accountability Act of 1996 (HIPAA) issues to ensure access to real-time data in compliance with regulations. The ED Planning Committee at Poudre Valley meets monthly to discuss members who are high emergency department (ED) utilizers, plan creative approaches to engage these members in care coordination, and discuss coordinating care for these members. The Colorado West Community Mental Health Center developed an intervention targeted to decrease recidivism for patients seeking detoxification. The care coordinator meets the member in the detoxification facility and encourages engagement in care coordination and substance abuse treatment. **RMHP** staff stated that immediate information and care coordination visits while still in detox treatment are essential to the member's success.

Recommended Actions

While **RMHP**'s cultural training programs were varied and in-depth, **RMHP** may want to consider working with the CCTs to enhance assessment of cultural and spiritual beliefs and values to ensure robust care plans that address all facets of cultural needs.

Standard II—Follow-Up: Access to Care/Medical Home

Strengths

RCCO staff members described the various initiatives they are using to increase the number of contracted providers in the network. They described efforts to target pediatric practices and providers who serve Medicare/Medicaid dual eligible members in anticipation of the integration of an increased number of enrollees from these populations into the RCCO. Also, **RMHP** has arranged with hospitals in the frontier areas to notify them of any new provider moving into an area seeking privileges. The recruitment conversations are individualized and strategically nuanced to each provider's priorities. RCCO staff members reported that their provider relations focus is not limited to up-front recruiting, but that ongoing communication and problem resolution of any issue, large or small, is crucial. **RMHP**'s message to providers is that they can retain maximum control, but if they enter the program at an early stage, they will evolve with it, bridge the gaps, and begin to gain qualitative experience.

All contracted providers were required to provide continuous triage coverage, and this was assessed via the patient-centered medical home (PCMH) practice monitoring tool. The RCCO reported that nearly 39 percent (22 of 57) of its primary care medical provider locations offered weekend and/or evening availability. The **RMHP** RCCO Web site included a searchable provider directory that included hours of operation, including extended or weekend hours.

The five **RMHP** practice support advisors were available to all providers via e-mail, telephone, and face-to-face visits. The practice support activities ranged from dissemination of support resources to **RMHP**'s network to conducting formal training classes for primary care medical providers (PCMPs). The RCCO is addressing efforts to position all practices to use sophisticated analytics to reach goals, but is tailoring its approach and coaching to where each practice is on the continuum. **RMHP** also made available a wide variety of Web-based resources for its providers such as member reminders; patient education materials; information on motivational interviewing and patient self-management; clinical care guidelines and best practices; RCCO provider newsletters; and materials from the February 2013 Medical Neighborhood summit, Making a Medical Neighborhood Happen.

Recommended Actions

There were no recommended actions for this standard.

Summary of Record Reviews

RMHP collected from its PCMPs a list of all members who were participating in the coordination of care program. **RMHP** then submitted this list to the Department, and the Department used random sampling to select 10 records plus an oversample of five records. The Department was forced to pull its sample from a partial list of members enrolled in the care coordination program because one PCMP refused to send its list of coordination of care members to **RMHP**.

Strengths

The care coordination files documented that members were referred into the program by emergency departments, physical health providers, behavioral health providers, outside agencies, and through claims data. All of the files reviewed by HSAG included comprehensive assessments that covered physical and behavioral health status, risks, and needs; cultural and/or linguistic needs, beliefs, and values; and non-medical needs such as assistance with food, shelter, and transportation.

Care coordination records included ample documentation of all services provided, as well as attempts to provide services. HSAG observed documentation of regular communications between members and care coordinators. This regular communication was more frequent with members with complex cases.

Recommended Actions

There were no recommended actions resulting from the record reviews.

Appendix A. **Data Collection Tool**
for Rocky Mountain Health Plans (Region 1)

The completed data collection tool for Region 1 follows this cover page.



Appendix A. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Data Collection Tool
for Rocky Mountain Health Plans (Region 1)

Standard I—Care Coordination/Care Management		
Requirement	Desk Review/Discussion Items	Score
<p>1. Integrated Care Coordination characteristics include:</p> <ul style="list-style-type: none"> 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. <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.3.</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.3.1</i></p>	<p>Documents:</p> <ul style="list-style-type: none"> Policies or procedures which address integration of services or communication among providers/entities Comprehensive needs assessment documents Written program plans, training materials, or other documents which address comprehensive and integrated care services <p>Discussion/Findings Will Include:</p> <ul style="list-style-type: none"> Documents reviewed Description of current status of processes and how behavioral, social service, and physical care entities are engaged in integrated care: <ul style="list-style-type: none"> At the individual member level At the delivery system level <p>Additional Discussion May Include:</p> <ul style="list-style-type: none"> Discussion of continued challenges to sharing/communication of member information among providers. How is this being addressed? 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>Findings:</p> <p>Documents reviewed:</p> <ul style="list-style-type: none"> Comprehensive Needs Assessment Policy: The policy described the assessment process, which included communication with the referral source, the member/family, the primary care medical provider (PCMP), principal providers, and involved agencies or services to effectively develop a comprehensive treatment plan. ACC Communication Policy: Described RMHP’s processes and the use of RMHP’s Case Management Analytical Tool (CMAT) to communicate with PCMPs and the Community Care Teams (CCTs) for identification of members and who will be actively targeted for care management. The Four Quadrant Model: A pictorial representation of a theoretical model for integrated health care. Community Delegation Agreement Template: The agreement template is used to establish relationships with the community entity responsible for coordinating the team that provides care coordination in each CCT area. 		



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Standard I—Care Coordination/Care Management

Requirement	Desk Review/Discussion Items	Score
<ul style="list-style-type: none"> ◆ Statement of Commitment: The statement is used to identify community partners in the CCTs. ◆ RCCO Provider and Community Resource Relationship Report: The report described each CCT and the community partners and care management resources and contact within each community. 		
<p>Additional Discussion:</p> <p>RMHP divided Region 1 into five smaller, community-focused areas and contracted with an organization in each area designated to coordinate the care coordination efforts for that community. These organizations partnered with providers and service agencies in their region to form CCTs. RMHP’s five CCTs are as follows:</p> <ul style="list-style-type: none"> ◆ In North Larimer County, several partners came together to form the Medicaid Accountable Care Collaborative (MACC) team. The primary organizations are the Health District of Northern Larimer County (the convening organization), primary care clinics (including Salud Family Health Centers, The Family Medicine Center [the Poudre Valley Residency Program], and Associates in Family Medicine), Touchstone Health Partners (the area’s community mental health center [CMHC]), and the Poudre Valley Health System Foundation. The MACC team coordinates care for levels 3B, 4, and 5, and can be more behavioral-health focused due to Touchstone’s involvement and care coordinators who are Touchstone case managers. One valuable addition to the MACC team is the Healthy Harbors program that provides care coordination to children. The program began providing services to foster care children and has expanded to include children at risk for foster care placement. The RMHP case management program coordinates care when needed for levels 1 through 3A and conducts initial contact for unattributed members for this community. ◆ In South Larimer County and Loveland, the CCT is an extension of the Region 2 CCT (where Regions 1 and 2 are adjacent). The registered nurse (RN) in Loveland coordinates care for Banner Health and the Sunrise Clinic (for levels 3B, 4, and 5). RMHP case managers coordinate care for levels 1 through 3A and the unattributed members in this community. Other community partners include the Berthoud Primary Care Clinic, Touchstone Health Partners, and the Northern Colorado Health Alliance as the project coordinator. ◆ In Routt and Moffat counties, the CCT includes the Northwest Visiting Nurses Association (VNA) (the convening organization), Colorado West Regional Mental Health Center (the care coordination project coordinator), and several primary care clinics (Yampa Valley Medical Associates, Steamboat Springs Family Medicine, Steamboat Medical Group, and the Northwest Colorado VNA Community Health Center). This team works with all levels and any member referred; however, RMHP works with the team on particularly difficult cases. ◆ For Durango and the surrounding communities, the team consists of the Southwest Colorado Area Health Education Center, Axis Behavioral Health, the San Juan Basin Health Department, and several primary care clinics (including Pediatric Partners of the Southwest, Health Services Clinic at Mercy Hospital, Pagosa Springs Rural Health Center, and Mercy Family Medicine). The San Juan Basin Health Department has a nurse navigator that coordinates care for levels 3B, 4, and 5, with RMHP providing care coordination for lower-level members in that community. ◆ In Eagle, Garfield, and Pitkin counties, the team includes PCMPs of Mountain Family Health Centers (in Basalt, Glenwood Springs, and Rifle), Glenwood Medical Associates, and the Castle Valley Children’s Clinic. Staff reported that a new federally qualified health center (FQHC) in Glenwood Springs 		



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	<p>coordinates care for level 3B, 4, and 5 members seen by the FQHC. RMHP’s care coordination department coordinates care for all lower-level members and non-FQHC members in those communities. Staff members reported that Region 1 had recently expanded into Summit County having developed a relationship with the safety net clinic there.</p> <ul style="list-style-type: none"> ◆ The RMHP team provides all care coordination in the Grand Junction area and the other counties not covered by one of the five CCTs. <p>Each team includes the area’s Medicaid behavioral health provider or CMHC, and in some communities, the CMHC provides staffing for care coordination. In the Routt/Moffat County CCT, Colorado West will be adding a care coordinator and extender personnel due to expansion of the community’s population and increased penetration in that area.</p> <p>Staff stated that each team has a different level of capacity for electronic health records (EHRs) and for working with members with complex behavioral health needs. Staff stated that RMHP’s care coordination fills in the gaps identified with each team. RMHP has been working with the San Juan Basin Health Department to assist them in moving toward a more integrated model with mental health. RMHP has also been assisting the San Juan Basin Health Department in filling in the gaps resulting from limitations with the EHR.</p>	



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<p>2. Comprehensive care coordination characteristics include:</p> <ul style="list-style-type: none"> ◆ Assessing the member’s health and health behavior risks and medical and non-medical needs ◆ Determining if a care plan exists and creating a care plan if one does not exist and is needed. ◆ The ability to link members both to medical services and to non-medical, community-based services, such as child care, food assistance, services supporting elders, housing, utilities assistance, and other non-medical supports. This ability to link may range from being able to provide members with the necessary contact information for the service to arranging the services and acting as a liaison between medical providers, non-medical providers, and the member. <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1 Regions 2, 3, 5: Exhibit A—6.4.5.1</i></p>	<p>Desk Review:</p> <ul style="list-style-type: none"> ◆ How members are assessed to identify needs ◆ Policies and procedures regarding stratification/tier levels for care coordination ◆ Care Coordination Plan ◆ Tracking referrals to non-medical services <p>Discussion/Findings Will Include:</p> <ul style="list-style-type: none"> ◆ Documents reviewed. ◆ Examples. ◆ Information collected on-site from Care Coordination File Reviews. ◆ The process for identifying members appropriate for care coordination services. <p>Additional Discussion May Include:</p> <ul style="list-style-type: none"> ◆ How PCMPs identify members appropriate for complex care management. ◆ Whether the RCCO staff or PCMPs perform the assessment. ◆ Explore the role of non-medical services in providing care coordination to the RCCO’s population. 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>Findings:</p> <p>Documents reviewed:</p> <ul style="list-style-type: none"> ◆ Assessments: Assessments used by each CCT varied based on the needs of each community and team. Assessments reviewed included: <ul style="list-style-type: none"> ▪ PHQ-9 ▪ Southwest ▪ Poudre Valley ▪ RMHP Assessment ▪ HARMS-8 		



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Requirement	Desk Review/Discussion Items	Score
	<ul style="list-style-type: none"> ◆ Stratification for Care Coordination Policy: The policy described RMHP’s levels of care management and included a description of patient needs and associated appropriate care coordination activities for each care management level. ◆ Statewide data analytics contractor (SDAC) Risk Stratification Model: Risk categories as identified by analysis of data in the SDAC system. ◆ Comprehensive Needs Assessment Policy: The policy described the importance of a comprehensive assessment of member needs to develop care plans that can link members to appropriate medical and non-medical services including child care, food assistance, services supporting elders, housing, and utilities assistance. ◆ Case Management Process Policy: The policy included the protocols for use of the RMHP computer program for case management (applicable to cases managed by RMHP’s care management team). ◆ Care Coordination Action Plan/Care Plan (Poudre Valley): Provided an example of one CCT’s care plan documentation. ◆ Care Coordination Levels: Description of RMHP’s care coordination levels. ◆ Complexity Assessment Grid: Example of one CCT’s assessment to determine needs and associated level of care coordination. ◆ Community Referral List (Poudre Valley)/United Way 211(Larimer County)/Master Resource List: Tracking reports used for tracking referrals to community resources and lists of referral sources distributed to care coordinators and teams. ◆ Screen Shot of RMHP Case Management Electronic Record. ◆ Population Reports: Reports routinely provided to CCTs to provide information on patient stratification for care coordination at a population-wide level. ◆ Case Management Analytical Tool (CMAT): Used to assist CCTs in targeting members for care coordination. 	

Additional Discussion:

RMHP staff members reported that the RMHP care coordination team works with each of the CCTs to determine where RMHP is needed to fill gaps in processes or tools, allowing each community the opportunity to provide care coordination in its own community as much as possible. To that end, staff reported that RMHP does not prescribe what assessments must be used, but it collects the assessments from each team and works with the teams to educate and encourage development of comprehensive assessments that meet medical home standards. On-site review of care coordination records demonstrated that the assessments reviewed met medical home standards, adequately assessing medical and non-medical needs and exploring services members may already be receiving.

While each team has particular strengths and community resources, RMHP “back fills” to ensure comprehensive care coordination. Each team had a robust community resource list available in hard copy and online. Staff members reported that community forums are held twice a year for the community resource agencies such as the single entry point agencies, Department of Human Services (DHS), and public health, who are thus far not involved with the RCCO. The purpose of these forums is to provide the opportunity for these agencies to meet with the RCCO community partners and to create interest and provide education



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Requirement	Desk Review/Discussion Items	Score
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about the ACC model of health care delivery. Staff members stated that the plan for the next community forum will be a discussion regarding the coordination process between the CCTs and sharing of processes and ideas with the community. Staff members agreed that transportation continues to be a problem in outlying areas of the counties, and in one CCT the care coordinators are providing transportation as a last resort.

RMHP staff stated that customer services staff are used to make welcome calls to all new RCCO Region 1 members based on the receipt of the RCCO roster from the State. Staff members prioritize RCCO members who are not assigned a primary care provider (PCP). The purpose of the calls is to explain the Accountable Care Collaborative (ACC) Program and the RCCO, ensure that the member has a PCP, and determine if an assessment for appropriateness of care coordination is warranted. Staff also stated that if customer services staff are unable to reach members via the telephone, letters are sent to attempt contact.

<p>3. Comprehensive care coordination characteristics include:</p> <ul style="list-style-type: none"> ◆ Providing assistance during care transitions from hospitals or other care institutions to home- or community-based settings or during other transitions, such as the transition from children’s health services to adult health services or from hospital or home care to care in a nursing facility. This assistance shall promote continuity of care and prevent unnecessary re-hospitalizations and document and communicate necessary information about the member to the providers, institutions, and individuals involved in the transition. 	<p>Desk Review:</p> <ul style="list-style-type: none"> ◆ Transition of Care policies and procedures or Plans ◆ Examples of “transition of care” cases <p>Discussion/Findings Will Include:</p> <ul style="list-style-type: none"> ◆ Documents reviewed. ◆ How are “transition of care” members identified? ◆ How is the transition plan (or processes) communicated to providers and all individuals/entities involved in the transition of members between levels of care? <p>Additional Discussion May Include:</p> <ul style="list-style-type: none"> ◆ What is the status of access to real-time data for care coordination follow-up? (hospitalizations, ED visits) ◆ Do you track/evaluate the impact of transition management on readmissions? 	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
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Findings:

Documents reviewed:

- ◆ Community Newsletter: An article featuring a case history of a Region 1 member in Larimer County.
- ◆ Transitions of Care Policy: The policy described processes for identifying members transitioning between levels of care, processes for assessing those members, and care coordination activities associated with coordinating transitions of care.



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Requirement	Desk Review/Discussion Items	Score
<ul style="list-style-type: none"> ◆ RMHP Transitions of Care Workflow Diagram: Diagram of RMHP’s transition of care processes. ◆ MACC Team Transition of Care Process Policy: An example of a specific CCT transition of care policy for a team that uses community-specific processes. ◆ Screen Shots of Data Transmissions Related to Transitions of Care: Examples of electronic data transfer by hospitals of members needing transition of care. ◆ Transition Readiness Assessment: Assessment used for RMHP transition-of-care level members. 		

Additional Discussion:

RMHP staff members reported that, while obtaining real-time data necessary to coordinate member transitions remains difficult, each CCT has developed strategies to obtain the information. The RMHP care coordination team obtains daily census information from the hospitals via the electronic record and feeds the information to the teams. The particular data transfer method or electronic record varies between the hospital systems. In addition, the teams have worked to develop relationships with the hospital discharge planners within their own communities. Emergency department (ED) admission information remains the most difficult to obtain. Different CCTs have community-specific solutions. For example, the Loveland team has developed a “hotspotters” group comprised of professionals from the participating hospitals who are working through HIPAA issues to ensure access to real-time data in compliance with regulations. The ED Planning Committee at Poudre Valley meets monthly to discuss members who are high ED utilizers and plan creative approaches to engage these members in care coordination and discuss coordinating care for these members. RMHP is piloting a Quality Health Network (QHN) subscription program in Grand Junction, whereby electronic alerts are driven by patient identification numbers the subscriber registers. RMHP hopes to be able to use this system in its other CCTs soon. Glenwood Springs may be the next community to have this capability. Another creative program designed to engage members in care coordination, decreasing high ED utilization, is the Colorado West intervention targeted to decrease recidivism for patients seeking detoxification. The care coordinator meets the member in the detoxification facility and encourages engagement in care coordination and substance abuse treatment. RMHP staff stated that immediate information and care coordination visits while the member is still in detox treatment is essential to the member’s success.



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Requirement	Desk Review/Discussion Items	Score
<p>4. Client/Family-Centered characteristics include:</p> <ul style="list-style-type: none"> ◆ Providing care and care coordination activities that are linguistically appropriate to the member and are consistent with the member’s cultural beliefs and values. <p align="right"><i>Regions 1, 4, 6: Exhibit A—6.4.3.2 Regions 2, 3, 5: Exhibit A—6.4.5.2</i></p>	<p>Desk Review:</p> <ul style="list-style-type: none"> ◆ Applicable policies and procedures ◆ Training materials ◆ Evidence of training individuals responsible for care coordination <p>Discussion/Findings Will Include:</p> <ul style="list-style-type: none"> ◆ Documents reviewed. ◆ Processes for telephone translation and translation during care coordination activities. ◆ How the RCCO ensures that care is culturally sensitive. ◆ How the RCCO includes deaf and hard of hearing as a culture and training or case examples that demonstrate. 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>Findings:</p> <p>Documents reviewed:</p> <ul style="list-style-type: none"> ◆ Trainings: Variety of trainings available for CCT and PCMP use, or available for RMHP to conduct. <ul style="list-style-type: none"> ▪ Culturally Effective Toolkit ▪ Bridges Out of Poverty ▪ Healthcare for People with Disabilities ▪ Health Team Works Consumer Assessment of Healthcare Providers and Systems (CAHPS®) training ▪ Partnering in Self-Management Toolkit ▪ Shared Decision-Making ▪ Negotiation Roadmap 		
<p>Additional Discussion:</p> <p>RMHP staff members reported that RMHP and the CCTs have access to the language line for telephone calls in any language. Staff members also reported that each CCT developed community relationships with interpreters and also has bilingual staff members. In addition, the MACC team has a promotora who works with the team. Care Coordination staff members reported that a recent query of RMHP data had revealed that two members within Region 1 require interpretation for American Sign Language. Staff reported that gaps remain in outlying areas, but they have been able to fill these needs through CCT partnerships, when needed. On-site review of care coordination records demonstrated that language was addressed in the assessments. The cultural assessment was inconsistent between records, with some assessing cultural values and beliefs well and other cultural assessments limited to language spoken.</p>		



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Standard I—Care Coordination/Care Management		
Requirement	Desk Review/Discussion Items	Score
5. Client/Family-Centered characteristics include <ul style="list-style-type: none"> ◆ Providing care coordination that is responsive to the needs of special populations, including: <ul style="list-style-type: none"> • The physically or developmentally disabled. • Children and children in foster care. • Adults and older adults. • Non-English speakers. • All expansion populations, as defined in Colorado House Bill 09-1293, the Colorado Health Care Affordability Act. • Members in need of assistance with medical transitions. • Members with complex behavioral or physical health needs. • Transitional aged youth. <p align="right"><i>Regions 1, 4, 6: Exhibit A—6.4.3.2 Regions 2, 3, 5: Exhibit A—6.4.5.2</i></p>	Desk Review: <ul style="list-style-type: none"> ◆ Applicable policies and procedures or plans Discussion/Findings Will Include: <ul style="list-style-type: none"> ◆ Documents reviewed. ◆ How special populations are identified and served. Additional Discussion May Include: <ul style="list-style-type: none"> ◆ Explore how foster children, AwDC, and dual eligible populations are impacting the system. ◆ Describe unique needs or approaches used. 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
Findings: Documents reviewed: <ul style="list-style-type: none"> ◆ Comprehensive Needs Assessment Policy: The policy described how RMHP uses the CMAT, obtaining utilization data and internal member-specific data to combine with the SDAC data to identify special needs populations for prioritizing members for care coordination. ◆ Healthy Harbors Materials: A program description, assessment forms, and tools used by a service agency that provides care coordination for foster care children; an example in one CCT. ◆ San Juan Basin Materials: An assessment form and tools used by the San Juan Basin Health Department providing care coordination for that community. These materials describe specific processes associated with programing designed to serve children with special needs; an example in one CCT. ◆ North Larimer County Inventory of Services: A list of services for older adults that is provided to members in Larimer County. 		



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Standard I—Care Coordination/Care Management

Requirement	Desk Review/Discussion Items	Score
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Additional Discussion:
 RMHP developed the Case Management Analytical Tool (CMAT), which combines the SDAC data, the State’s utilization data, and RMHP’s real-time patient data to provide the teams data regarding their population, PCMP assignments, and updated risk levels. These data are provided to the teams daily. The data can be sorted by CCT, PCMP practice, risk score, eligibility category, demographic data, diagnoses, prescriptions, and multiple other parameters. Care coordination staff from the MACC reported relying on the data and capabilities of this tool daily. The tool can be used to run population reports and assist the teams in understanding their population and develop community relationships accordingly. RMHP staff members reported that statistics showed that Region 1’s counties are low income and, therefore, RMHP expects that the Medicaid expansion population’s enrollment will impact Region 1 significantly. RMHP described preparation activities. One example cited was beginning to network with hospice agencies, home health agencies, and other community groups to develop protocols for serving the dual eligible/full benefits population. Other initiatives involved working closely with the counties’ DHS to ensure current information on the foster care population.

<p>6. The Contractor ensures (and may allow its PCMPs or other subcontractors to provide) care coordination for its members, necessary for the members to achieve their desired health outcomes in an efficient and responsible manner.</p> <p><i>Exhibit A—6.4.1</i></p> <p>The Contractor assesses current care coordination services provided to each of its members to determine if the providers involved in each member’s care are providing necessary care coordination services and which care coordination services are insufficient or are not provided.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.2.1 Regions 2, 3, 5: Exhibit A—6.4.4.1</i></p> <p><i>42CFR438.6(l)</i></p>	<p>Desk Review:</p> <ul style="list-style-type: none"> ◆ Tools used for assessing care coordination capabilities of PCMP practices ◆ Communications to PCMPs regarding care coordination requirements ◆ PCMP care coordination oversight tools ◆ Policies and procedures regarding assessment of PCMP or delegation oversight <p>Discussion/Findings Will Include:</p> <ul style="list-style-type: none"> ◆ Documents reviewed. ◆ Description of who provides care coordination and how care coordination is shared between the PCMPs and the Contractor. ◆ Does the oversight of care coordination include the elements of comprehensive care coordination as outlined in requirements #2 and #3? ◆ How is oversight performed (e.g., is the PCMP care plan documented in a system accessible to the RCCO? Is an on-site audit being performed?) 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Substantially Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Not Applicable</p>
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Appendix A. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Data Collection Tool
for Rocky Mountain Health Plans (Region 1)

Standard I—Care Coordination/Care Management

Requirement	Desk Review/Discussion Items	Score
	<ul style="list-style-type: none"> ◆ How does the RCCO know if the delegated care coordination services are sufficient and consistently provided? 	

Findings:
 Documents reviewed:

- ◆ RCCO Reciprocal Accountability Review Program Policy: Material developed as part of RMHP’s Reciprocal Accountability Review Program that is in development. The policy outlined parameters for data sharing and reporting between RMHP and the CCTs and PCMPs.
- ◆ Reciprocal Accountability Review Program Description.
- ◆ Physicians Services Agreement: The agreement included language regarding medical home and care coordination requirements.
- ◆ ACC Care Coordination Requirements: Practice Assessment based on the ACC care coordination requirements.
- ◆ Master’s Program Description.

Additional Discussion:
 RMHP uses a community delegation agreement to document the relationship with the CCT and participating organizations. The agreement documents accountabilities; delineates resources, budgets, and reporting requirements; and identifies community-specific goals and plans. RMHP staff members reported that there is significant variation in the CCTs (the lead organizations) and processes employed. For the last year, RMHP has worked to increase the CCTs’ responsibility for increasing penetration in their own communities. RMHP developed a new accountability structure and began cross community learning groups that will meet quarterly. Staff reported that RMHP is working on a comprehensive curriculum that may roll out to the CCTs next year to bring more consistency between teams, although variations will remain due to community-specific resources and needs.

Care Coordination staff reported that the majority of PCMPs in Region 1 are smaller practices that are not equipped to meet medical home standards or provide care coordination, with the exception of the FQHCs in the region. Staff reported that RMHP uses metrics to monitor the CCTs and PCMP that provide care coordination. Monitoring includes metrics on outreach efforts to increase penetration, ED utilization, inpatient admissions, and member attribution to a PCMP.

Recommended Actions:
 While RMHP’s cultural training programs were varied and in-depth, RMHP may want to consider working with the CCTs to enhance assessment of cultural and spiritual beliefs and values to ensure robust care plans that address all facets of cultural needs.



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Results for Standard I—Care Coordination/Care Management					
Total	Met	=	<u>6</u>	X	1.00 = <u>6</u>
	Substantially Met	=	<u>0</u>	X	.75 = <u>0</u>
	Partially Met	=	<u>0</u>	X	.50 = <u>0</u>
	Not Met	=	<u>0</u>	X	0.0 = <u>0</u>
	Not Applicable	=	<u>0</u>	X	NA = <u>NA</u>
Total Applicable		=	<u>6</u>	Total Score	= <u>6</u>

Total Score ÷ Total Applicable		=	<u>100%</u>
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*Appendix A. Colorado Department of Health Care Policy and Financing
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 for Rocky Mountain Health Plans (Region 1)*

Standard II—Follow-Up : Access to Care/Medical Home

Requirement	Desk Review/Discussion Items	Score
<p>1. The Contractor’s PCMP Network has a sufficient number of PCMPs so that each member has a choice of at least 2 providers within his or her zip code or within 30 minutes of driving time, whichever area is larger. (If there are less than two medical providers qualified to be a PCMP within the area defined above, for a specific member, then the requirements shall not apply to that member).</p> <p align="right"><i>Exhibit A—4.2.1</i></p>	<p>Desk Review:</p> <ul style="list-style-type: none"> ◆ Network adequacy report ◆ Targeted Provider Recruitment list ◆ Applicable policies and procedures <p>Discussion/Findings Will Include:</p> <ul style="list-style-type: none"> ◆ Documents reviewed. ◆ Anticipated geographic or capacity issues. <p>Additional Discussion May Include:</p> <ul style="list-style-type: none"> ◆ Explore status of PCMP network development and provider recruitment within the entire region. ◆ How are gaps being identified? ◆ Unique recruitment strategies; responses from targeted providers? 	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable</p>

Findings:

Documents reviewed:

- ◆ Network Adequacy Report: Listed 347 total practitioners in 62 provider locations distributed throughout the geographically broad region. Of the 62 locations, 46 PCMPs were accepting new RCCO members (74 percent), except in Larimer and Routt counties (50 percent). Ten PCMP practices had been added since the previous report, all outside the Larimer County focus community. Many of the counties in the region have been designated as Primary Care Health Professional Shortage Areas (HPSA) by the Department of Health and Human Services. The report analysis described the various initiatives in which RMHP is engaged to increase the number of contracted providers in the network, and RMHP has targeted both pediatric practices and providers who serve Medicare/Medicaid dual eligible members in anticipation of the integration of an increased number of enrollees from these populations into the RCCO.
- ◆ The Managed Care Accessibility Analysis: Analyzed the distance to PCMPs for members in all counties and cities within the region. All members had access to a provider within 30 miles in the suburban areas. Some members within rural areas did not have access within 30 miles, although most of them resided in areas with very small RCCO member populations. Some exceptions were the Walden, Granby, and Gunnison/Crested Butte areas where 80 to 100 members resided and had to travel over 50 miles to the nearest PCMP.
- ◆ Targeted Recruitment List: Included providers widely distributed throughout the region. There were 70 PCMP locations listed. The list indicated there were many member-requested targeted providers.



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Standard II—Follow-Up : Access to Care/Medical Home

Requirement	Desk Review/Discussion Items	Score
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Additional Discussion:

RCCO staff members described the various initiatives they are using to increase the number of contracted providers in the network. They described efforts to target pediatric practices and providers who serve Medicare/Medicaid dual eligible members in anticipation of the integration of an increased number of enrollees from these populations into the RCCO. The RCCO combines provider/practice names from various sources into one active provider recruitment list. The provider relations team reviews the list weekly and, using utilization and attribution data and by identifying providers who are already contracted, actively pursues those providers with the highest priority. In many instances, providers have a pre-existing relationship with RMHP under another line of business. One predominant recruitment barrier has been potential providers’ perceptions of what accepting Medicaid will mean to their practices. The recruitment conversations are individualized and strategically nuanced to each provider’s priorities. The RCCO informs providers that the RCCO is the future track for Medicaid. Potential providers are encouraged to join even though their patient volume may be low in order to become an active participant in the design process. Providers are encouraged to join early so that they will have an opportunity to gain ground-level experience and have the data and care coordination resources available. The RCCO has found that recruiting pediatric practices has been a bigger challenge due to current reimbursement issues. RMHP staff members described that they were able to obtain a contract with pediatric partners in Durango. The practice was said to have agreed to join even though there was not a financial incentive for them; rather, they joined in order to have a leadership role and to have a “seat at the table” as the RCCO system evolves.

Staff members reported that it is imperative to make sure that every provider-RCCO experience is positive. Staff members described a situation in Delta, Colorado (Surface Creek Family Practice) involving a delayed Medicaid payment for a Comprehensive Primary Care (CPC) initiative provider. Although the payment amount was not large, the issue generated significant negative communication in the provider community. RCCO staff members reported their provider relations focus is not limited to up-front recruiting, but that ongoing communication and problem resolution of any issue, large or small, is crucial. The RCCO strives to capitalize on and accentuate the CCT role in provider communication. In Estes Park, the RCCO noted that a couple of additional practices joined the RMHP network primarily to be part of the CPC initiative. The RCCO stated that in these instances, staff members explain the RCCO’s broader goals and strive to correct any misperceptions. The RCCO actively encourages practices to be open to Medicaid. Staff members have found that participation follows a bell curve; progressive practices are open to Medicaid, while other practices remain undecided. The RCCO’s message to providers is that they can retain maximum control, but that if they enter the program at an early stage, they will evolve with it, bridge the gaps, and begin to gain qualitative experience.

In Fort Collins, there have been numerous member requests for specific providers. The RCCO stated that when a member requests a provider, the provider relations department contacts the requested practice. If a PCP is identified who is not enrolled, RCCO staff attempt to enroll the provider. If the provider declines, the recruitment is set aside until another member requests that provider. The RCCO has found that sometimes after the fifth or sixth contact, the provider will come onboard. The RCCO staff members reported that although they had reviewed the issue, they had seen no clear trend or patterns other than the member having a longstanding relationship with that provider or other family members having been treated by the provider.



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Standard II—Follow-Up : Access to Care/Medical Home

Requirement	Desk Review/Discussion Items	Score
<p>Staff members described how providers in two counties in the heart of the RMHP system exhibit very different receptivity to the RCCO recruitment efforts. In Mesa County, several practices have joined the RCCO. The RCCO reported that while those contracting efforts had not been contention-free, the process had nevertheless been forward-looking. Conversely, in Montrose County, many providers were described to be “circling their wagons” and erecting fortresses. Practices in Montrose County have declined participation in the RCCO, citing the better reimbursement they receive from the extant health maintenance organization (HMO) contracts they hold. RCCO staff reported that they consistently try to bring the reality of Medicaid expansion to the discussion. Nevertheless, the providers in Montrose have indicated they will not join at this time.</p> <p>RCCO staff described that providers are given information on the advantages of RCCO enrolled members. The member will have a support coordinator who will work with the member and the provider, and the support coordinator will follow up with member’s unmet needs in the community, communicate the plan of care among providers, attend medical visits if desired, and attend behavioral health visits to facilitate communication between providers.</p> <p>The frontier areas of the RCCO’s region described that their penetration percentage was relatively low. They described that while potential providers seemed verbally receptive to contracting with the RCCO, actual contracts were not being signed and returned. The RCCO stated it was adopting an attitude of patience and persistence in following up with those practices. The RCCO recognizes that in rural areas, provider practices do not have robust administrative support systems. For example, they might not have the availability of an attorney to review the contract to assure them of its advantages. The RCCO has arranged with hospitals in the frontier areas to notify them of any new provider moving into an area seeking privileges. During the interview, staff members stated that RCCO members are receiving the community standard of care in rural and frontier areas; the available providers serve everyone.</p>		
<p>2. The Contractor reasonably ensures that members in the Contractor’s region have access to specialists and other Medicaid providers promptly, without compromising the member’s quality of care or health.</p> <p align="right"><i>Exhibit A—4.2.5 42CFR438.6(k)(3)</i></p>	<p>Desk Review:</p> <ul style="list-style-type: none"> ◆ Tracking documents for referrals to specialists/other providers ◆ Applicable policies and procedures <p>Discussion/Findings Will Include:</p> <ul style="list-style-type: none"> ◆ Documents reviewed. ◆ How does the RCCO monitor access to specialists? ◆ What is the RCCO’s assessment of the availability of specialists for RCCO members? <p>Additional Discussion May Include:</p> <ul style="list-style-type: none"> ◆ What are the barriers or challenges you have encountered and what responses/approaches have been implemented? 	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable</p>



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for Rocky Mountain Health Plans (Region 1)

Standard II—Follow-Up : Access to Care/Medical Home

Requirement	Desk Review/Discussion Items	Score
	<ul style="list-style-type: none"> ◆ Is there a mechanism to assess whether access to specialists or other providers (or lack thereof) compromises the member’s quality of care or health? 	

Findings:
 Documents reviewed:

- ◆ Network Adequacy Report: Described, in very general terms, the sources for access to specialists within each major geographic sub-area in the region (e.g., Larimer County: North Colorado Independent Practice Association (IPA), University Hospital, Children’s Hospital).
- ◆ Samples of Care Coordination Team Referral Tracking: Showed types of referrals and referral patterns facilitated by the Care Coordination teams.
- ◆ Milestone VI Documents: Indicated that RMHP is planning to include enhanced coordination of referrals between PCMPs and specialists as one of the initiatives in the Medical Neighborhood project. Milestone is a CPC initiative project, which includes approximately one third of the RCCO providers. (The CPC initiative is a Medicare initiative which offers providers a bonus payment for coordination of care.)

Additional Discussion:
 The RCCO described that it strives to ensure that members in its region have access to specialists, sometimes with difficulty due to the lack of enhanced funding for specialty care. The RCCO reported some difficulty in obtaining specialty care, even in its home area (Grand Junction). Staff members described that most specialists do not accept Fee-For-Service (FFS) Medicaid, and that it is not uncommon for the RCCO to send patients to Denver or Durango for specialist care. In those instances, the RCCO ensures that the member has assistance from DHS for transportation and lodging for initial and follow-up visits. The RCCO identified that the most needed specialty types include orthopedics; neurology; and eye, ear, nose, and throat (EENT). Staff members described how they are trying to build their own specialist resource lists. They also described RCCO plans to develop medical neighborhood referral protocols, using a standardized set of expectations and definitions, community-based health information exchange (HIE), and effective point-to-point communications.



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Requirement	Desk Review/Discussion Items	Score
<p>3. The Contractor’s PCMP network provides for extended hours on evenings and weekends and alternatives for emergency room visits for after-hours urgent care.</p> <ul style="list-style-type: none"> ◆ At a minimum, the Contractor’s PCMP network provides for 24-hour-a-day availability of information, referral, and treatment of emergency conditions. ◆ The PCMP provides triage by a clinician 24 hours per day, seven days per week (to meet access to care standards). <p align="right"><i>Exhibit A—4.2.2, Exhibit B—2a 42CFR438.6(k)(1)</i></p>	<p>Desk Review:</p> <ul style="list-style-type: none"> ◆ Lists of emergency, urgent care, and after-hours care facilities available to members ◆ Applicable policies and procedures ◆ Provider communications regarding 24/7 access to after-hours clinicians ◆ Results of assessment/monitoring of availability of 24/7 triage by clinician <p>Discussion/Findings Will Include:</p> <ul style="list-style-type: none"> ◆ Documents reviewed. ◆ Progress obtained/status in after-hours and urgent care availability since previous review? ◆ How is availability of urgent care/after-hours communicated to members? ◆ What proportion of RCCO members have access to after-hours care (i.e., if PCMPs have after-hours care only for their own patients)? ◆ How is after-hours care availability monitored? <p>Additional Discussion May Include:</p> <ul style="list-style-type: none"> ◆ Discuss innovative approaches/continuing challenges in provision of urgent/after-hours care. 	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

Findings:

Documents reviewed:

- ◆ Physician(s) Medical Services Agreement (ACC Medicaid Members Only): Requires the provision of 24/7 triage coverage by PCMPs, and requires that providers work with RMHP or other providers for the provision of extended hours and urgent care services.
- ◆ Call First Community Outreach Project Description: Described the Mesa County community outreach campaign to encourage members to call the doctor before going to the emergency room, and raised awareness of urgent care facilities in the area as an alternative to after-hours emergency room visits. Since launching the campaign in April 2009, nonemergent emergency room visits decreased by 24.1 percent from the same period in the previous year.



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Standard II—Follow-Up : Access to Care/Medical Home

Requirement	Desk Review/Discussion Items	Score
<ul style="list-style-type: none"> ◆ Milestone II Change Package: Described the provision of telephone access to clinicians in the practice who have real time, 24/7 access to the practice’s medical record . Milestone is a CPC initiative project, which includes approximately one third of the RCCO providers. ◆ CAHPS® Adult Primary Care Survey: Described questions related to member perception of timely response to questions when an after-hours call was made to the PCMP. RMHP uses the CAHPS to monitor provider after-hour triage services. ◆ RMHP ACC Web site: Member page included to link to all providers who have extended hours in the “urgent care” section of the searchable provider directory. ◆ North Larimer County CCT Document: Listed urgent care/ walk-in clinics (5) in Ft Collins/Loveland area. 		
<p>Additional Discussion:</p> <p>The RCCO PCMH network provided for extended hours on evenings and weekends and alternatives for emergency room visits for after-hours urgent care. All contracted providers were required to provide continuous triage coverage , and this was assessed via the PCMH practice monitoring tool. The RCCO reported that nearly 39 percent (22 of 57) of it primary care medical provider locations offered weekend and/or evening availability. The RMHP RCCO Web site included a searchable provider directory as well as a .pdf version that could be printed. The directory included hours of operation, including extended or weekend hours. The Web site informed members that urgent care centers were good options for minor injuries, infections, and illnesses and provided information on how to find the closest one using the searchable provider directory.</p>		
<p>4. Transition to Medical Home:</p> <p>The contractor has a Practice Support Plan, describing its annual activities. These practice support activities shall be directed at a majority of the PCMPs in the Contractor’s region and may range from disseminating a practice support resource to its PCMP network to conducting formal training classes for PCMPs relating to practice support. These activities shall include at least one activity relating to each of the following topics:</p> <ul style="list-style-type: none"> ◆ Operational practice support ◆ Clinical tools ◆ Client or member materials <p align="right"><i>Exhibit A—5.2.1</i></p>	<p>Desk Review:</p> <ul style="list-style-type: none"> ◆ Practice Support Plan ◆ Practice Assessments for Medical Home Capabilities ◆ Applicable policies and procedures <p>Discussion/Findings Will Include:</p> <ul style="list-style-type: none"> ◆ Documents reviewed. ◆ What is the overall network capacity for medical home functions? What are practice assessments results? ◆ How are practice assessments translated into a Support Plan? (Individual/system-wide)? ◆ What has been provided to practices regarding the Medical Home model? 	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



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Standard II—Follow-Up : Access to Care/Medical Home

Requirement	Desk Review/Discussion Items	Score
	Additional Discussion May Include: <ul style="list-style-type: none"> ◆ Innovative approaches/significant achievements? ◆ What are foreseeable objectives/achievements in PCMP medical home performance? ◆ How have practice transformation efforts and activities impacted the organization’s resources? 	

Findings:
 Documents reviewed:

- ◆ RMHP Annual Practice Support Plan, September 30, 2012: Described the provider onboarding process and materials, functions of the RMHP provider relations representatives who provide education for all providers in the network, functions of the professional relations staff members who provide administrative support, a description of provider operational support materials on the Website, and a description of various activities undertaken to improve network adequacy.
- ◆ Practice Assessments for Medical Home Capabilities: These documents included:
 - Patient Centered Medical Home (PCMH) clinician assessment and sample report.
 - PCMH practice monitoring tool used to monitor leadership, staff engagement, quality improvement team functioning, measures, population management, patient centered care, team-based care, coordination of care, access and scheduling, integration of behavioral health, and practice climate (morale, confidence, etc.).
- ◆ National Committee for Quality Assurance (NCQA) Assessment Requirements.
- ◆ Full Gap Analysis for 2011 NCQA Standards for PCMH.
- ◆ RMHP Care Coordination Grid of Partner Entities.
- ◆ RMHP ACC Web site: A very robust well-organized site for providers with numerous easily accessible education and training resources (medical home, care team development, practice workflows, patient registries), clinical guidelines and tools, and member information materials.
- ◆ The RMHP ACC provider pages of its Web site: Includes operational information and tools:
 - Numerous resources as references for implementing PCMH processes.
 - Listing of community resources available throughout Region 1 communities.
 - Two targeted performance improvement activities: linking members to PCMPs and using local CCTs and PCMPs to build robust care coordination and care management programs for all RCCO members with complex care needs.
- ◆ RMHP Care Coordination Grid of Partner Entities: Illustrated the survey results of assessment of care coordination resources available in each partner organization participating in the local CCT.
- ◆ Examples of tools for practice assessment of Medical Home functions from NCQA and the University of Colorado.



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Standard II—Follow-Up : Access to Care/Medical Home

Requirement	Desk Review/Discussion Items	Score
<p>Additional Discussion: <u>Practice Support:</u> RMHP had a Practice Support Plan that described its annual activities. The five RMHP practice support advisors were available to all providers via e-mail, telephone, and face-to face visits. The practice support activities ranged from dissemination of support resources to RMHP’s network to conducting formal training classes for PCMPs. The RCCO had developed local community care teams (CCTs) in each focus community to support patients with complex needs. RMHP’s care management team serves as the point of contact for the CCTs and also supports providers and patients in areas not served by CCTs. RMHP’s team of five practice advisors worked with practices to assess individual practice needs and starting points. Over the past year, RMHP provided intensive recruiting efforts to encourage providers who were eligible to apply for the CPC initiative. At the time of the on-site interview, the RCCO reported that approximately one third of its providers were in the CPC Initiative (CPCI). RMHP assisted providers with completing the EHR data extraction and validation, risk adjustment and patient stratification, quality improvement processes and reporting, practice-based care management and care coordination, measuring patient experience, and achieving meaningful use data milestones.</p> <p>RMHP provided a matrix that illustrated which providers were CPCI, Masters, or Foundation level; the practice milestones achieved; and goals on which each practice was working. For example, a practice in Durango had completed a risk stratification activity. The practice had 24/7 access and an on-call nursing group available, and the practice was beginning to implement a referral tracking quality activity. RMPH designed its approach to meet each provider or practice “where it was,” to troubleshoot potential problems, and to quickly resolve any issues.</p> <p>The RCCO staff members stated that providers have found the practice-level data the RCCO gives them to be very valuable. In January 2013, RMHP's QI Department sent Gaps in Care reports to all PCMPs in the region, reporting gaps in care identified for their attributed members using Healthcare Effectiveness Data and Information Set (HEDIS®) technical specifications. The reports were compiled using State claims data, paid through October 2012. The RCCO has a sophisticated data reporting system and can offer services to providers including reports from IndiGO (a risk-stratification and predictive-modeling software program that uses algorithms to outline a patient’s risk of adverse health events such as stroke to estimate the health impact of treatments, based on evidence from clinical trials) and Crimson Care Registry. The latter is a master patient-registry tool which aggregates data from all providers connected to the HIE so that treating physicians can gain a comprehensive, longitudinal view of care quality for their patients. The registry enables practices to identify patients who are due for preventive or chronic care services, undertake outreach efforts to schedule appointments, offer patients services during office visits, and meet quality reporting requirements. RCCO staff members reported that to date, the programs are being used by 11 medical practices. The RCCO described that there is significant variation in practice data platforms. RCCO staff members use a system advisor and data analyst to obtain data available on the front end and manage a process leading to data extraction on the back end. Staff members provided examples of how some practices were very sophisticated, and others were just beginning to understand the use of a single measure and how monitoring it could improve care and/or efficiency. RCCO staff members drew an analogy with higher education. Parents work hard with their school age children not because of what they will accomplish in grade school, but because it is the foundation for higher education and subsequent careers. Likewise, RCCO efforts in provider education, practice coaching, and technical support expended on practices just</p>		



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Standard II—Follow-Up : Access to Care/Medical Home

Requirement	Desk Review/Discussion Items	Score
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beginning to implement a single measure now will pay off in future years as their experience and knowledge base broaden. The RCCO is addressing efforts to bring all practices into a position to use sophisticated analytics to reach goals, but tailors its approach and coaching to where each practice is on the continuum.

Clinical Tools and Member Materials:

The RCCO also made available a wide variety of Web-based resources for its providers such as member reminders, patient education materials, information on motivational interviewing and patient self-management, clinical care guidelines and best practices, RCCO provider newsletters, and materials from the February 2013 Medical Neighborhood summit, Making a Medical Neighborhood Happen. The RMHP ACC provider section of its Web site includes numerous materials to assist providers to build and strengthen PCMHs, including:

- ◆ Disease management programs to support PCMPs in caring for patients with diabetes, chronic obstructive pulmonary disease (COPD), asthma, and high-risk pregnancy; online guidelines and tools for an evidence-based approach to care management for chronic conditions.
- ◆ A slide presentation describing concrete steps toward practice transformation and how to apply to and obtain NCQA recognition as a PCMH practice.
- ◆ The American Academy of Family Physicians (AAFP) *Tools and Tips for PCMH Recognition*, a detailed practice checklist in the domains of quality measures, patient experience, health information technology, and practice organization.
- ◆ Information on the importance of, and how to establish patient registries for population management.
- ◆ Information and tools for developing quality improvement teams and efficient practice workflows.
- ◆ Resources for providing culturally competent care.
- ◆ Resources for providing care for people with disabilities.

Results for Standard II—Follow-Up: Access to Care/Medical Home

Total	Met	=	<u>4</u>	X	1.00	=	<u>4</u>
	Substantially Met	=	<u>0</u>	X	.75	=	<u>0</u>
	Partially Met	=	<u>0</u>	X	.50	=	<u>0</u>
	Not Met	=	<u>0</u>	X	0.0	=	<u>0</u>
	Not Applicable	=	<u>0</u>	X	NA	=	<u>0</u>
Total Applicable		=	<u>4</u>	Total Score	=	<u>4</u>	

Total Score ÷ Total Applicable		=	<u>100%</u>
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Appendix B. **Record Review Tools**
for Rocky Mountain Health Plans (Region 1)

The record review tools for Region 1 follow this cover page.



Appendix B. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Record Review Tool
for Rocky Mountain Health Plans (Region 1)

Sample Number: O***** (1)

Reviewer: Barbara McConnell

Care Management Program Record Review		Score
Identification		
1. What event(s) or condition(s) triggered the member’s identification/referral to receive intensive care/case management services? <div align="right"><i>Exhibit A—6.4</i></div>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: This member was referred by multiple professionals concurrently. The care coordination department at RMHP identified via data that the member was in the hospital and alerted San Juan Basin Health Department—the Community Care Team (CCT). The case manager at the hospital and the home and community-based services (HCBS) case manager also called the CCT case manager.		
2. Was the member assigned an individual to be a care coordinator, and was the member made aware of that assignment? <div align="right"> <i>Region 1: Exhibit A—6.4.8</i> <i>Regions 2, 3, 4, 5: Exhibit A—6.4.3</i> <i>(Not in R6, R7)</i> </div>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The care coordinator spoke with the case manager at the hospital, then called the member following his discharge from the hospital and left a message. The member returned the call, and the care coordinator scheduled a home visit to conduct the initial assessment.		



Appendix B. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Record Review Tool
for Rocky Mountain Health Plans (Region 1)

Care Management Program Record Review		Score
Assessment		
<p>1. Was there an assessment present in the Contractor’s care management documentation system that assessed current care coordination services provided to the member and the sufficiency of those services? Did the assessment address whether a care plan exists (from another agency)?</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.2.1 and 6.4.3.1.1</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.1.1 and 6.4.4.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>There was a section on the assessment that specifically addressed whether the member was involved with other medical, service, or support providers. At the time of admission to the care coordination program, the member had an HCBS case manager. The RMHP care coordinator contacted and coordinated efforts with the HCBS case manager.</p>		
<p>2. Did the assessment address the member’s:</p> <ul style="list-style-type: none"> ◆ Health status? ◆ Health behavior/risks? ◆ Medical and non-medical needs? <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.1.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>The completed assessment had sections that addressed medical and psychosocial needs (including behavior that presents a health risk) as well as activities of daily living and need for community support.</p>		



Appendix B. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Record Review Tool
for Rocky Mountain Health Plans (Region 1)

Care Management Program Record Review		Score
Development of a Care Treatment Plan		
<p>1. Does a care plan exist, whether developed by the Contractor, a PCMP, or community agency?</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.1.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>The care plan was developed by the care coordinator at San Juan Basin Health Department (RMHP’s CCT for that geographical area) with input from the hospital case manager and the HCBS case manager.</p>		
<p>2. Did the care coordinator link members to medical services and to non-medical, community-based supports? This may include acting as a liaison between medical and non-medical service providers.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.2</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.1.2</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>The care coordinator referred this member to the behavioral health provider for this area. Initially, the care coordinator also recommended a referral to Alcoholics Anonymous (AA); however, at that time, the member was not open to attending AA. Likewise, the care coordinator also recommended a referral for dental care, but the member indicated that he was not ready at that time. The care coordinator recommended a diabetic education program. After completing the assessment, however, the care coordinator discovered that the member could not read or write, so the care coordinator provided diabetic education verbally for the member. Eventually, the member agreed to substance abuse treatment and at the time of the site review, the member was in a rehabilitation program for substance abuse for a four-month course of treatment.</p>		



Appendix B. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Record Review Tool
for Rocky Mountain Health Plans (Region 1)

Care Management Program Record Review		Score
Development of a Care Treatment Plan		
3. Do the care plan interventions reflect the member’s cultural and/or linguistic needs, beliefs, and values? <p align="right"><i>Regions 1, 6, 7: Exhibit A—6.4.3.2.2</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.2.2</i> <i>Regions 4: Exhibit A—6.4.3.1.2</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: An assessment for cultural and linguistic needs was part of the overall assessment. There were no specific cultural needs identified; however, the care plan was designed to be responsive to the member’s inability to read or write. The care coordinator attended the intake meeting at the behavioral health provider facility and assisted with completing forms. The care coordinator also met with the member to read mail from Medicaid or the Social Security Administration and to ensure the member understood the communication.		
4. Did the Contractor identify barriers to the member’s health that exist in the Contractor’s region and address those barriers for the member? <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.3.3.4</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.3.3.4</i></p>	<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable	
Observations: Primary barriers to care for this member were member-specific. The member had peripheral neuropathy secondary to poorly controlled diabetes, and he had difficulty walking. Reluctance to seek help with substance abuse and his inability to read or write also presented barriers to care.		



Appendix B. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Record Review Tool
for Rocky Mountain Health Plans (Region 1)

Care Management Program Record Review		Score
Provision of Care/Case Management Services		
<p>1. Were the member and the member’s family, if applicable, active participants in the member’s care, to the extent the member/family were willing and able?</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.2.1</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.2.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>The member participated in goal setting and began checking his blood-sugar-level and attending appointments regularly. The member eventually agreed to inpatient substance rehabilitation following initial refusal, and after several detox admissions—sometimes resulting in an ER visit.</p>		
<p>2. If the member had any of the following special needs, was the provision of care coordination services responsive to those needs?</p> <ul style="list-style-type: none"> ◆ Complex behavioral or physical health needs ◆ The member has physical or developmental disabilities ◆ The member is a child or foster child ◆ The member is an adult or is aged ◆ The member is non-English-speaking ◆ The member was in need of assistance with medical transitions <p align="right"><i>Regions 1, 4, 7: Exhibit A—6.4.3.2.3</i> <i>Regions 2, 3: Exhibit A—6.4.5.2.3</i> <i>Regions 6: Exhibit A—6.4.3.2.3.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>This member had complex behavioral and physical health needs. The care coordinator assisted the member with transitions: several times following a detox stay, following ER visits, and into the inpatient rehabilitation program. The care coordinator spoke with the HCBS case manager and treatment facility personnel to accomplish the admission, and assisted with arranging transportation (from Durango to Denver).</p>		



*Appendix B. Colorado Department of Health Care Policy and Financing
 FY 2012–2013 Record Review Tool
 for Rocky Mountain Health Plans (Region 1)*

Care Management Program Record Review		Score
Provision of Care/Case Management Services		
3. Did the Contractor follow up with the member to assess whether the member has received the services needed and if the member is on track to reach his or her desired health outcomes? <div style="text-align: right;"> <i>Regions 1, 4, 5, 6, 7: Exhibit A—6.4.3.1.6</i> <i>Region 2: Exhibit A—6.4.5.1.6</i> <i>Region 3: Exhibit A—6.4.5.1.7</i> </div>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The care management documentation system contained documentation of numerous contacts with the member and other case managers involved at various points in the care management process, particularly following referrals and transitions.		

Recommendations Related to the Provision of Care/Case Management Services:
 There were no recommendations noted for this record.

Results for Care Management Record Review					
Total	Met	=	<u>10</u>	X	1.00 = <u>10</u>
	Substantially Met	=	<u>0</u>	X	.75 = <u>0</u>
	Partially Met	=	<u>0</u>	X	.50 = <u>0</u>
	Not Met	=	<u>0</u>	X	0.0 = <u>0</u>
	Not Applicable	=	<u>1</u>	X	NA = <u>NA</u>
Total Applicable		=	<u>10</u>	Total Score	= <u>10</u>
Total Score ÷ Total Applicable				=	<u>100%</u>



Appendix B. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Record Review Tool
for Rocky Mountain Health Plans (Region 1)

Sample Number: G***** (2)

Reviewer: Barbara McConnell

Care Management Program Record Review		Score
Identification		
1. What event(s) or condition(s) triggered the member’s identification/referral to receive intensive care/case management services? <div align="right"><i>Exhibit A—6.4</i></div>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: This patient was identified for care coordination via claims data, which indicated that the member had a poorly controlled chronic illness and high emergency room (ER) utilization, and was at risk for an inpatient hospitalization.		
2. Was the member assigned an individual to be a care coordinator, and was the member made aware of that assignment? <div align="right"><i>Region 1: Exhibit A—6.4.8</i> <i>Regions 2, 3, 4, 5: Exhibit A—6.4.3</i> <i>(Not in R6, R7)</i></div>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The documentation demonstrated that the care coordinator telephoned the member to begin the assessment and schedule a face-to-face meeting to complete the assessment. The care coordinator then met the member at a local coffee house. Subsequent documentation demonstrated that telephone contact with the member was approximately weekly with face-to-face contact approximately monthly, often following PCP appointments, where the care coordinator knew the member would be and could “catch” him.		



Appendix B. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Record Review Tool
for Rocky Mountain Health Plans (Region 1)

Care Management Program Record Review		Score
Assessment		
<p>1. Was there an assessment present in the Contractor’s care management documentation system that assessed current care coordination services provided to the member and the sufficiency of those services? Did the assessment address whether a care plan exists (from another agency)?</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.2.1 and 6.4.3.1.1</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.1.1 and 6.4.4.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The assessment indicated that the member was receiving food stamps and supplemental security income (SSI).</p>		
<p>2. Did the assessment address the member’s:</p> <ul style="list-style-type: none"> ◆ Health status? ◆ Health behavior/risks? ◆ Medical and non-medical needs? <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.1.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The completed assessment had sections that addressed medical and psychosocial needs (including behavior that presents a health risk) as well as activities of daily living and need for community support.</p>		



Appendix B. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Record Review Tool
for Rocky Mountain Health Plans (Region 1)

Care Management Program Record Review		Score
Development of a Care Treatment Plan		
<p>1. Does a care plan exist, whether developed by the Contractor, a PCMP, or community agency?</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.1.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>The Medicaid Accountable Care Collaborative (MACC) team, a RMHP contractor for care coordination in Northern Larimer County, developed the care plan, with input from the member’s PCP and specialty providers.</p>		
<p>2. Did the care coordinator link members to medical services and to non-medical, community-based supports? This may include acting as a liaison between medical and non-medical service providers.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.2</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.1.2</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>The care coordinator referred the member to a pain management specialist for chronic pain secondary to a traumatic foot injury, and to a nurse specialist for diabetic education. The member was also referred to a neurologist and a podiatrist, and received orthotics. The member also participated in a weekly exercise (walking) program conducted by the care coordinator.</p>		



Appendix B. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Record Review Tool
for Rocky Mountain Health Plans (Region 1)

Care Management Program Record Review		Score
Development of a Care Treatment Plan		
3. Do the care plan interventions reflect the member’s cultural and/or linguistic needs, beliefs, and values? <p align="center"><i>Regions 1, 6, 7: Exhibit A—6.4.3.2.2</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.2.2</i> <i>Regions 4: Exhibit A—6.4.3.1.2</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The assessment addressed cultural beliefs and values and linguistic needs. The member indicated that he was of Navajo descent but was not active with his tribe, although he refuses immunizations due to his cultural background. No other adjustments were assessed to be required in response to cultural or linguistic needs.		
4. Did the Contractor identify barriers to the member’s health that exist in the Contractor’s region and address those barriers for the member? <p align="center"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.3.3.4</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.3.3.4</i></p>	<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable	
Observations: No barriers to obtaining health care or participating in care coordination activities were identified. The member had adequate transportation and drove himself to appointments.		



Appendix B. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Record Review Tool
for Rocky Mountain Health Plans (Region 1)

Care Management Program Record Review		Score
Provision of Care/Case Management Services		
<p>1. Were the member and the member’s family, if applicable, active participants in the member’s care, to the extent the member/family were willing and able?</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.2.1</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.2.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The member was an active participant and attended all appointments, as well as care coordination activities.</p>		
<p>2. If the member had any of the following special needs, was the provision of care coordination services responsive to those needs?</p> <ul style="list-style-type: none"> ◆ Complex behavioral or physical health needs ◆ The member has physical or developmental disabilities ◆ The member is a child or foster child ◆ The member is an adult or is aged ◆ The member is non-English-speaking ◆ The member was in need of assistance with medical transitions <p align="right"><i>Regions 1, 4, 7: Exhibit A—6.4.3.2.3</i> <i>Regions 2, 3: Exhibit A—6.4.5.2.3</i> <i>Regions 6: Exhibit A—6.4.3.2.3.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The member was on SSI for his physical disability. Prior to care coordination involvement, he was receiving pain management medication through the PCP and no other services. The MACC care coordinator initiated the referrals to the appropriate specialists.</p>		



Appendix B. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Record Review Tool
for Rocky Mountain Health Plans (Region 1)

Care Management Program Record Review		Score
Provision of Care/Case Management Services		
3. Did the Contractor follow up with the member to assess whether the member has received the services needed and if the member is on track to reach his or her desired health outcomes? <div style="text-align: right;"> <i>Regions 1, 4, 5, 6, 7: Exhibit A—6.4.3.1.6</i> <i>Region 2: Exhibit A—6.4.5.1.6</i> <i>Region 3: Exhibit A—6.4.5.1.7</i> </div>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: There were numerous contacts with the member and other health care providers documented in the care coordination record.		

Recommendations Related to the Provision of Care/Case Management Services:
 There were no recommendations noted for this record.

Results for Care Management Record Review					
Total	Met	=	<u>10</u>	X	1.00 = <u>10</u>
	Substantially Met	=	<u>0</u>	X	.75 = <u>0</u>
	Partially Met	=	<u>0</u>	X	.50 = <u>0</u>
	Not Met	=	<u>0</u>	X	0.0 = <u>0</u>
	Not Applicable	=	<u>1</u>	X	NA = <u>NA</u>
Total Applicable		=	<u>10</u>	Total Score	= <u>10</u>
Total Score ÷ Total Applicable				=	<u>100%</u>



Appendix B. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Record Review Tool
for Rocky Mountain Health Plans (Region 1)

Sample Number: Y***** (3)

Reviewer: Barbara McConnell

Care Management Program Record Review		Score
Identification		
1. What event(s) or condition(s) triggered the member’s identification/referral to receive intensive care/case management services? <div align="right"><i>Exhibit A—6.4</i></div>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: This was a referral from RMHP. The member had contacted the RMHP customer service line to ask for help managing her multiple diagnoses (bipolar disorder, Meniere’s disease, kidney disease, attention deficit disorder [ADD] and osteosclerosis). Also, the member’s son had Asperger’s syndrome.		
2. Was the member assigned an individual to be a care coordinator, and was the member made aware of that assignment? <div align="right"><i>Region 1: Exhibit A—6.4.8</i> <i>Regions 2, 3, 4, 5: Exhibit A—6.4.3</i> <i>(Not in R6, R7)</i></div>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The care coordinator called the member to set up a meeting to complete the assessment. The initial meeting took place at the care coordinator’s office. The member indicated that her primary concerns were keeping herself organized and managing multiple provider appointments and appointments for her son.		



Appendix B. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Record Review Tool
for Rocky Mountain Health Plans (Region 1)

Care Management Program Record Review		Score
Assessment		
<p>1. Was there an assessment present in the Contractor’s care management documentation system that assessed current care coordination services provided to the member and the sufficiency of those services? Did the assessment address whether a care plan exists (from another agency)?</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.2.1 and 6.4.3.1.1</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.1.1 and 6.4.4.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>The assessment addressed the member’s involvement with the Parent-Child Interaction Center, the Foundation for the Disabled, Touchstone Mental Health Partners, and various community resource service agencies, and that the member was receiving Section 8 housing and Social Security Disability.</p>		
<p>2. Did the assessment address the member’s:</p> <ul style="list-style-type: none"> ◆ Health status? ◆ Health behavior/risks? ◆ Medical and non-medical needs? <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.1.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>The completed assessment had sections that addressed medical and psychosocial needs (including behavior that presents a health risk) as well as activities of daily living and need for community support.</p>		



Appendix B. Colorado Department of Health Care Policy and Financing
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for Rocky Mountain Health Plans (Region 1)

Care Management Program Record Review		Score
Development of a Care Treatment Plan		
<p>1. Does a care plan exist, whether developed by the Contractor, a PCMP, or community agency?</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.1.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>The Medicaid Accountable Care Collaborative (MACC) care coordinator developed the care plan with input from other agencies involved and reflected the member-identified priorities.</p>		
<p>2. Did the care coordinator link members to medical services and to non-medical, community-based supports? This may include acting as a liaison between medical and non-medical service providers.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.2</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.1.2</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>The member’s food stamps lapsed, and the care coordinator assisted the member with getting the food stamps reinstated. The care coordinator helped the member search for autism schools for her son and apply for the adopt-a-family program, for Christmas gift assistance. The care coordinator also helped the member get organized and prepared for an individualized education program (IEP) meeting at her son’s school.</p>		



Appendix B. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Record Review Tool
for Rocky Mountain Health Plans (Region 1)

Care Management Program Record Review		Score
Development of a Care Treatment Plan		
<p>3. Do the care plan interventions reflect the member’s cultural and/or linguistic needs, beliefs, and values?</p> <p align="right"><i>Regions 1, 6, 7: Exhibit A—6.4.3.2.2</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.2.2</i> <i>Regions 4: Exhibit A—6.4.3.1.2</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>The assessment addressed cultural values and beliefs and linguist needs. The member indicated that she receives support from her church and needed no further assistance with cultural or spiritual needs.</p>		
<p>4. Did the Contractor identify barriers to the member’s health that exist in the Contractor’s region and address those barriers for the member?</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.3.3.4</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.3.3.4</i></p>	<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>Barriers identified to this member receiving care were member-specific barriers. She had significant difficulty staying organized due to her bipolar disorder and ADD. The member did not drive but was comfortable with riding her bike or taking the bus.</p>		



Appendix B. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Record Review Tool
for Rocky Mountain Health Plans (Region 1)

Care Management Program Record Review		Score
Provision of Care/Case Management Services		
<p>1. Were the member and the member’s family, if applicable, active participants in the member’s care, to the extent the member/family were willing and able?</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.2.1</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.2.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: There were multiple examples in the case record of the member’s active participation and engagement in her own health care and in the care coordination process.</p>		
<p>2. If the member had any of the following special needs, was the provision of care coordination services responsive to those needs?</p> <ul style="list-style-type: none"> ◆ Complex behavioral or physical health needs ◆ The member has physical or developmental disabilities ◆ The member is a child or foster child ◆ The member is an adult or is aged ◆ The member is non-English-speaking ◆ The member was in need of assistance with medical transitions <p align="right"><i>Regions 1, 4, 7: Exhibit A—6.4.3.2.3</i> <i>Regions 2, 3: Exhibit A—6.4.5.2.3</i> <i>Regions 6: Exhibit A—6.4.3.2.3.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The member had complex physical health and behavioral health needs. Just prior to the site review, the member had had surgery following an accident (hit by a car while on her bike). The care coordinator assisted her with transition from the hospital and a referral to an orthopedist. The comprehensive care plan addressed the member’s needs and reflected her priorities for addressing those needs.</p>		



Appendix B. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Record Review Tool
for Rocky Mountain Health Plans (Region 1)

Care Management Program Record Review		Score
Provision of Care/Case Management Services		
3. Did the Contractor follow up with the member to assess whether the member has received the services needed and if the member is on track to reach his or her desired health outcomes? <div style="text-align: right;"> <i>Regions 1, 4, 5, 6, 7: Exhibit A—6.4.3.1.6</i> <i>Region 2: Exhibit A—6.4.5.1.6</i> <i>Region 3: Exhibit A—6.4.5.1.7</i> </div>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: There were numerous contacts with the member and other health care providers documented in the care coordination record.		

Results for Care Management Record Review					
Total	Met	=	<u>10</u>	X	1.00 = <u>10</u>
	Substantially Met	=	<u>0</u>	X	.75 = <u>0</u>
	Partially Met	=	<u>0</u>	X	.50 = <u>0</u>
	Not Met	=	<u>0</u>	X	0.0 = <u>0</u>
	Not Applicable	=	<u>1</u>	X	NA = <u>NA</u>
Total Applicable		=	<u>10</u>	Total Score	= <u>10</u>
			Total Score ÷ Total Applicable	=	<u>100%</u>



Appendix B. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Record Review Tool
for Rocky Mountain Health Plans (Region 1)

Sample Number: I***** (4)

Reviewer: Barbara McConnell

Care Management Program Record Review		Score
Identification		
1. What event(s) or condition(s) triggered the member’s identification/referral to receive intensive care/case management services? <div align="right"><i>Exhibit A—6.4</i></div>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: This member was identified for care coordination via data review. The member was identified as having hypertension, diabetes, anxiety disorder, asthma, bipolar disorder, previous knee replacement surgery, history of transient ischemic attacks (TIAs), suicidal ideations, and post-traumatic stress disorder (PTSD), and having had 12 emergency department (ED) visits with 3 inpatient hospitalizations. ED visits and hospitalizations were related to falls with injury while intoxicated.		
2. Was the member assigned an individual to be a care coordinator, and was the member made aware of that assignment? <div align="right"> <i>Region 1: Exhibit A—6.4.8</i> <i>Regions 2, 3, 4, 5: Exhibit A—6.4.3</i> <i>(Not in R6, R7)</i> </div>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: After reviewing the data, the care coordinator called the primary care provider (PCP) to touch base regarding the PCP’s feelings about care coordination for this member. The PCP encouraged the care coordinator to contact the member. The care coordinator then called the member and scheduled a visit at the member’s home to complete the initial assessment.		



Appendix B. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Record Review Tool
for Rocky Mountain Health Plans (Region 1)

Care Management Program Record Review		Score
Assessment		
<p>1. Was there an assessment present in the Contractor’s care management documentation system that assessed current care coordination services provided to the member and the sufficiency of those services? Did the assessment address whether a care plan exists (from another agency)?</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.2.1 and 6.4.3.1.1</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.1.1 and 6.4.4.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>The assessment indicated that the member was involved with Preferred Home Health, and Touchstone Mental Health Partners, and that the member had a home and community-based services (HCBS) case manager and home health nurse, Section 8 Housing, supplemental security income (SSI), and food stamps.</p>		
<p>2. Did the assessment address the member’s:</p> <ul style="list-style-type: none"> ◆ Health status? ◆ Health behavior/risks? ◆ Medical and non-medical needs? <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.1.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>The completed assessment had sections that addressed medical and psychosocial needs (including behavior that presents a health risk) as well as activities of daily living and need for community support.</p>		



Appendix B. Colorado Department of Health Care Policy and Financing
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for Rocky Mountain Health Plans (Region 1)

Care Management Program Record Review		Score
Development of a Care Treatment Plan		
<p>1. Does a care plan exist, whether developed by the Contractor, a PCMP, or community agency?</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.1.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>The Medicaid Accountable Care Collaborative (MACC) team care coordinator developed the care plan with input from the other agencies and providers involved with the member.</p>		
<p>2. Did the care coordinator link members to medical services and to non-medical, community-based supports? This may include acting as a liaison between medical and non-medical service providers.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.2</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.1.2</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>The care coordinator worked with HCBS to reestablish housekeeping services (through HCBS) the member had lost. A significant stressor for the member was that approximately one month prior to entering the care coordination program, the member’s husband and adult son had both died (within two days of each other) from alcoholism. The care coordinator attempted to refer the member for grief counseling, which she was not open to at the time. The care coordinator also assisted the member with obtaining eyeglasses from the Lion’s Club.</p>		



Appendix B. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Record Review Tool
for Rocky Mountain Health Plans (Region 1)

Care Management Program Record Review		Score
Development of a Care Treatment Plan		
<p>3. Do the care plan interventions reflect the member’s cultural and/or linguistic needs, beliefs, and values?</p> <p align="right"><i>Regions 1, 6, 7: Exhibit A—6.4.3.2.2</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.2.2</i> <i>Regions 4: Exhibit A—6.4.3.1.2</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The assessment addressed cultural values and beliefs and linguist needs. There were no cultural or linguistic needs identified.</p>		
<p>4. Did the Contractor identify barriers to the member’s health that exist in the Contractor’s region and address those barriers for the member?</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.3.3.4</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.3.3.4</i></p>	<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable	
<p>Observations: Barriers to the member obtaining care were member-specific. The member was not open to grief counseling, which clearly impacted her alcohol use and resultant overall health behaviors.</p>		



Appendix B. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Record Review Tool
for Rocky Mountain Health Plans (Region 1)

Care Management Program Record Review		Score
Provision of Care/Case Management Services		
<p>1. Were the member and the member’s family, if applicable, active participants in the member’s care, to the extent the member/family were willing and able?</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.2.1</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.2.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: This member was intermittently active with her care and care coordination activities. The care coordinator experienced periods of time that she was unable to reach the member; however, when the member did answer the telephone, she was willing to talk yet remained unwilling to seek grief counseling services.</p>		
<p>2. If the member had any of the following special needs, was the provision of care coordination services responsive to those needs?</p> <ul style="list-style-type: none"> ◆ Complex behavioral or physical health needs ◆ The member has physical or developmental disabilities ◆ The member is a child or foster child ◆ The member is an adult or is aged ◆ The member is non-English-speaking ◆ The member was in need of assistance with medical transitions <p align="right"><i>Regions 1, 4, 7: Exhibit A—6.4.3.2.3</i> <i>Regions 2, 3: Exhibit A—6.4.5.2.3</i> <i>Regions 6: Exhibit A—6.4.3.2.3.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The member had complex behavioral and physical health needs. The care plan was responsive to those needs at a level the member was willing to accept and remain engaged.</p>		



Appendix B. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Record Review Tool
for Rocky Mountain Health Plans (Region 1)

Care Management Program Record Review		Score
Provision of Care/Case Management Services		
3. Did the Contractor follow up with the member to assess whether the member has received the services needed and if the member is on track to reach his or her desired health outcomes? <div style="text-align: right;"> <i>Regions 1, 4, 5, 6, 7: Exhibit A—6.4.3.1.6</i> <i>Region 2: Exhibit A—6.4.5.1.6</i> <i>Region 3: Exhibit A—6.4.5.1.7</i> </div>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: There were numerous contacts with the member and other health care providers documented in the care coordination record. In addition, for periods when the member was not answering calls, there was documentation of attempts to re-engage the member.		

Results for Care Management Record Review					
Total	Met	=	<u>10</u>	X	1.00 = <u>10</u>
	Substantially Met	=	<u>0</u>	X	.75 = <u>0</u>
	Partially Met	=	<u>0</u>	X	.50 = <u>0</u>
	Not Met	=	<u>0</u>	X	0.0 = <u>0</u>
	Not Applicable	=	<u>1</u>	X	NA = <u>NA</u>
Total Applicable		=	<u>10</u>	Total Score	= <u>10</u>
Total Score ÷ Total Applicable				=	<u>100%</u>



Appendix B. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Record Review Tool
for Rocky Mountain Health Plans (Region 1)

Sample Number: K***** (5)

Reviewer: Barbara McConnell

Care Management Program Record Review		Score
Identification		
1. What event(s) or condition(s) triggered the member’s identification/referral to receive intensive care/case management services? <div align="right"><i>Exhibit A—6.4</i></div>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: This member was identified for care coordination via data review. The member was identified as having diabetes, history of stroke, history of heart valve replacement, seizures, depression, developmental delay, borderline personality disorder, and high utilization (33 emergency department [ED] visits in 12 months).		
2. Was the member assigned an individual to be a care coordinator, and was the member made aware of that assignment? <div align="right"><i>Region 1: Exhibit A—6.4.8</i> <i>Regions 2, 3, 4, 5: Exhibit A—6.4.3</i> <i>(Not in R6, R7)</i></div>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The care coordinator e-mailed the provider at Family Medicine (the PCMP), then called the member to schedule a home visit for completion of the initial assessment.		



Appendix B. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Record Review Tool
for Rocky Mountain Health Plans (Region 1)

Care Management Program Record Review		Score
Assessment		
<p>1. Was there an assessment present in the Contractor’s care management documentation system that assessed current care coordination services provided to the member and the sufficiency of those services? Did the assessment address whether a care plan exists (from another agency)?</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.2.1 and 6.4.3.1.1</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.1.1 and 6.4.4.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>The assessment indicated that the member was involved with Foothills Gateway, Inc. (FGI), the area’s Community Centered Board (CCB) serving individuals with developmental disabilities; Touchstone Mental Health Partners; and Spectrum, a community service agency. The assessment also indicated that the member was receiving Section 8 housing, certified nursing assistance, and home health services from HCBS.</p>		
<p>2. Did the assessment address the member’s:</p> <ul style="list-style-type: none"> ◆ Health status? ◆ Health behavior/risks? ◆ Medical and non-medical needs? <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.1.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>The completed assessment had sections that addressed medical and psychosocial needs (including behavior that presents a health risk) as well as activities of daily living and need for community support.</p>		



Appendix B. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Record Review Tool
for Rocky Mountain Health Plans (Region 1)

Care Management Program Record Review		Score
Development of a Care Treatment Plan		
<p>1. Does a care plan exist, whether developed by the Contractor, a PCMP, or community agency?</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.1.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>The care plan was developed by the Medicaid Accountable Care Collaborative (MACC) team care coordinator, with input from the other agencies involved in the planning.</p>		
<p>2. Did the care coordinator link members to medical services and to non-medical, community-based supports? This may include acting as a liaison between medical and non-medical service providers.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.2</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.1.2</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>The care coordinator initiated referrals to a neurologist, a podiatrist, a dentist, assisted living, and the Community Paramedical Program (a program consisting of visits from an emergency medical technician (EMT) for members with high ED or 911 utilization).</p>		



Appendix B. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Record Review Tool
for Rocky Mountain Health Plans (Region 1)

Care Management Program Record Review		Score
Development of a Care Treatment Plan		
<p>3. Do the care plan interventions reflect the member’s cultural and/or linguistic needs, beliefs, and values?</p> <p align="right"><i>Regions 1, 6, 7: Exhibit A—6.4.3.2.2</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.2.2</i> <i>Regions 4: Exhibit A—6.4.3.1.2</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>The assessment addressed cultural values and beliefs and linguist needs. The member indicated that the developmental disabilities (DD) community is important to her. She has been married for 20 years. Care Coordination is working with her to help her understand how she can continue her relationship with her husband if she moves to assisted living and they are no longer living together.</p>		
<p>4. Did the Contractor identify barriers to the member’s health that exist in the Contractor’s region and address those barriers for the member?</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.3.3.4</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.3.3.4</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>The barrier identified for this member was that while there were many agencies and case managers working with this member, they were not coordinating with or communicating with each other to ensure a comprehensive plan of care. The MACC care coordinator worked with each agency, coordinating the whole and working through possible issues of reluctance to share plans and processes with other agencies.</p>		



Appendix B. Colorado Department of Health Care Policy and Financing
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for Rocky Mountain Health Plans (Region 1)

Care Management Program Record Review		Score
Provision of Care/Case Management Services		
<p>1. Were the member and the member’s family, if applicable, active participants in the member’s care, to the extent the member/family were willing and able?</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.2.1</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.2.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The member was actively involved in her care and direction of her care plan.</p>		
<p>2. If the member had any of the following special needs, was the provision of care coordination services responsive to those needs?</p> <ul style="list-style-type: none"> ◆ Complex behavioral or physical health needs ◆ The member has physical or developmental disabilities ◆ The member is a child or foster child ◆ The member is an adult or is aged ◆ The member is non-English-speaking ◆ The member was in need of assistance with medical transitions <p align="right"><i>Regions 1, 4, 7: Exhibit A—6.4.3.2.3</i> <i>Regions 2, 3: Exhibit A—6.4.5.2.3</i> <i>Regions 6: Exhibit A—6.4.3.2.3.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The member had complex physical and behavioral health needs and developmental and physical disabilities. The care coordinator helped the member at the Social Security office, faxed ED visit reports to the Home Health nurse, and called the PCP following ED visits. The care coordinator also attended PCP visits with the member.</p>		



Appendix B. Colorado Department of Health Care Policy and Financing
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for Rocky Mountain Health Plans (Region 1)

Care Management Program Record Review		Score
Provision of Care/Case Management Services		
3. Did the Contractor follow up with the member to assess whether the member has received the services needed and if the member is on track to reach his or her desired health outcomes? <div style="text-align: right;"> <i>Regions 1, 4, 5, 6, 7: Exhibit A—6.4.3.1.6</i> <i>Region 2: Exhibit A—6.4.5.1.6</i> <i>Region 3: Exhibit A—6.4.5.1.7</i> </div>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: There were numerous contacts with the member and other health care providers documented in the care coordination record.		

Results for Care Management Record Review					
Total	Met	=	<u>11</u>	X	1.00 = <u>11</u>
	Substantially Met	=	<u>0</u>	X	.75 = <u>0</u>
	Partially Met	=	<u>0</u>	X	.50 = <u>0</u>
	Not Met	=	<u>0</u>	X	0.0 = <u>0</u>
	Not Applicable	=	<u>0</u>	X	NA = <u>0</u>
Total Applicable		=	<u>11</u>	Total Score	= <u>NA</u>
Total Score ÷ Total Applicable				=	<u>100%</u>



Appendix B. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Record Review Tool
for Rocky Mountain Health Plans (Region 1)

Sample Number: D***** (6)

Reviewer: Diane Somerville

Care Management Program Record Review		Score
Identification		
1. What event(s) or condition(s) triggered the member’s identification/referral to receive intensive care/case management services? <div align="right"><i>Exhibit A—6.4</i></div>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: This patient was referred from Associates in Family Medicine; the patient was referred for pain-related depression subsequent to a motor vehicle accident.		
2. Was the member assigned an individual to be a care coordinator, and was the member made aware of that assignment? <div align="right"> <i>Region 1: Exhibit A—6.4.8</i> <i>Regions 2, 3, 4, 5: Exhibit A—6.4.3</i> <i>(Not in R6, R7)</i> </div>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The member was assigned a nurse practitioner care coordinator. The member was aware of and accepting of care coordination.		



Appendix B. Colorado Department of Health Care Policy and Financing
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for Rocky Mountain Health Plans (Region 1)

Care Management Program Record Review		Score
Assessment		
<p>1. Was there an assessment present in the Contractor’s care management documentation system that assessed current care coordination services provided to the member and the sufficiency of those services? Did the assessment address whether a care plan exists (from another agency)?</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.2.1 and 6.4.3.1.1</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.1.1 and 6.4.4.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The care coordination assessment documented that no other agency was providing care coordination services for the member.</p>		
<p>2. Did the assessment address the member’s:</p> <ul style="list-style-type: none"> ◆ Health status? ◆ Health behavior/risks? ◆ Medical and non-medical needs? <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.1.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The care plan assessment addressed the member’s health status. The member’s history included a motor vehicle accident with subsequent chronic pain and depression. She suffers from migraine headaches as well. She stated that pain was her constant companion and she did not feel like her previous therapist believed her or took her concerns seriously.</p> <p>The care plan assessment addressed the member’s behavior/ health risks. The member has had a volatile relationship with her boyfriend that possibly included domestic violence. There was a question whether the patient was abusing pain medications; the member had recently lost her job. The care plan addressed the medical and non-medical needs. A referral for physical therapy was made, and a referral for Touchstone Health Partners was offered.</p>		



Appendix B. Colorado Department of Health Care Policy and Financing
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for Rocky Mountain Health Plans (Region 1)

Care Management Program Record Review		Score
Development of a Care Treatment Plan		
<p>1. Does a care plan exist, whether developed by the Contractor, a PCMP, or community agency?</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.1.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>The care plan present in the record addressed a referral to physical therapy and to behavioral health counseling. Furthermore, the care coordinator facilitated a referral to a gastroenterologist and ensured that the necessary records were forwarded.</p>		
<p>2. Did the care coordinator link members to medical services and to non-medical, community-based supports? This may include acting as a liaison between medical and non-medical service providers.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.2</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.1.2</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>Although referrals were made for the member for physical therapy and counseling, she had not followed through on either one at the time of the review. This was partially due to the member’s legal difficulties that required her to live away from her home in Fort Collins and drive her son to and from school every day from her temporary residence in Milliken, Colorado.</p>		



Appendix B. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Record Review Tool
for Rocky Mountain Health Plans (Region 1)

Care Management Program Record Review		Score
Development of a Care Treatment Plan		
<p>3. Do the care plan interventions reflect the member’s cultural and/or linguistic needs, beliefs, and values?</p> <p align="right"><i>Regions 1, 6, 7: Exhibit A—6.4.3.2.2</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.2.2</i> <i>Regions 4: Exhibit A—6.4.3.1.2</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>The assessment identified that the member was an English-speaking female with several years of college education who had a history of domestic violence. The member was noted to be a single parent of a five-year-old son. She had some extended family support from her mother, but her mother did not live in Fort Collins. The member worked intermittently and therefore lived on the fringes of poverty. She had a home and car.</p>		
<p>4. Did the Contractor identify barriers to the member’s health that exist in the Contractor’s region and address those barriers for the member?</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.3.3.4</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.3.3.4</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>The care notes identified that all services the member needed were available in the region; there were no barriers to care.</p>		



Appendix B. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Record Review Tool
for Rocky Mountain Health Plans (Region 1)

Care Management Program Record Review		Score
Provision of Care/Case Management Services		
<p>1. Were the member and the member’s family, if applicable, active participants in the member’s care, to the extent the member/family were willing and able?</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.2.1</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.2.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The member’s family was supportive but did not reside locally. The member agreed to care coordination services but was not ready to follow through with the referrals or interventions.</p>		
<p>2. If the member had any of the following special needs, was the provision of care coordination services responsive to those needs?</p> <ul style="list-style-type: none"> ◆ Complex behavioral or physical health needs ◆ The member has physical or developmental disabilities ◆ The member is a child or foster child ◆ The member is an adult or is aged ◆ The member is non-English-speaking ◆ The member was in need of assistance with medical transitions <p align="right"><i>Regions 1, 4, 7: Exhibit A—6.4.3.2.3</i> <i>Regions 2, 3: Exhibit A—6.4.5.2.3</i> <i>Regions 6: Exhibit A—6.4.3.2.3.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The member was an adult with minimal care coordination needs. She was not involved with any agency other than her medical provider.</p>		



Appendix B. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Record Review Tool
for Rocky Mountain Health Plans (Region 1)

Care Management Program Record Review		Score
Provision of Care/Case Management Services		
3. Did the Contractor follow up with the member to assess whether the member has received the services needed and if the member is on track to reach his or her desired health outcomes? <div style="text-align: right;"> <i>Regions 1, 4, 5, 6, 7: Exhibit A—6.4.3.1.6</i> <i>Region 2: Exhibit A—6.4.5.1.6</i> <i>Region 3: Exhibit A—6.4.5.1.7</i> </div>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The coordinator followed up with the member and kept the case open for several months. The member received referrals for her identified needs. The member’s primary care provider changed during the review period, and the care coordinator provided an update to the current provider and attended office visits with the member. The member and coordinator had established e-mail contact and the member knows how to become re-engaged in coordination services as necessary.		

Results for Care Management Record Review					
Total	Met	=	<u>11</u>	X	1.00 = <u>11</u>
	Substantially Met	=	<u>0</u>	X	.75 = <u>0</u>
	Partially Met	=	<u>0</u>	X	.50 = <u>0</u>
	Not Met	=	<u>0</u>	X	0.0 = <u>0</u>
	Not Applicable	=	<u>0</u>	X	NA = <u>NA</u>
Total Applicable		=	<u>11</u>	Total Score	= <u>11</u>
		Total Score ÷ Total Applicable	=	<u>100%</u>	



Appendix B. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Record Review Tool
for Rocky Mountain Health Plans (Region 1)

Sample Number: W***** (7)

Reviewer: Diane Somerville

Care Management Program Record Review		Score
Identification		
1. What event(s) or condition(s) triggered the member’s identification/referral to receive intensive care/case management services? <div align="right"><i>Exhibit A—6.4</i></div>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: This member was referred by Family Medical Center (FMC) for multiple social issues and no income.		
2. Was the member assigned an individual to be a care coordinator, and was the member made aware of that assignment? <div align="right"> <i>Region 1: Exhibit A—6.4.8</i> <i>Regions 2, 3, 4, 5: Exhibit A—6.4.3</i> <i>(Not in R6, R7)</i> </div>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The member was assigned a care coordinator and identified that she would like assistance with accessing counseling services.		



Appendix B. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Record Review Tool
for Rocky Mountain Health Plans (Region 1)

Care Management Program Record Review		Score
Assessment		
<p>1. Was there an assessment present in the Contractor’s care management documentation system that assessed current care coordination services provided to the member and the sufficiency of those services? Did the assessment address whether a care plan exists (from another agency)?</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.2.1 and 6.4.3.1.1</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.1.1 and 6.4.4.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>During the on-site record review, the coordination team stated that this member referral was made/accepted early in the program and that as a Level IV, it would not be the kind of referral they would focus on now.</p> <p>The assessment identified that the member’s primary concerns were about her son. The notes indicated that the member was not involved in other agencies at the time other than FMC.</p>		
<p>2. Did the assessment address the member’s:</p> <ul style="list-style-type: none"> ◆ Health status? ◆ Health behavior/risks? ◆ Medical and non-medical needs? <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.1.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>The assessment addressed the member’s health status, which was not clinically complicated; she had allergies, was obese, and had a history of depression. Her health-related behavior risks included occasional marijuana use. She had no mobility issues. No medical needs were identified, and the assessment indicated that the member wanted counseling and to be able to move out of her mother’s home where she lived with her son.</p>		



Appendix B. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Record Review Tool
for Rocky Mountain Health Plans (Region 1)

Care Management Program Record Review		Score
Development of a Care Treatment Plan		
<p>1. Does a care plan exist, whether developed by the Contractor, a PCMP, or community agency?</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.1.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>The contractor’s record included a care plan. The assessment indicated that no other agencies were providing services to the member other than FMC. The record indicated there were coordinating exchanges between the care coordinator and the FMC referral source regarding the member’s care plan; the coordinator attends weekly meetings at FMC. The care plan’s goals were to work with the member on relationship issues, to help her use coping skills and self-esteem to avoid harmful relationships, and to stay engaged with her son’s therapist. The care plan identified a referral to Touchstone Health Partners (THP) for counseling services.</p>		
<p>2. Did the care coordinator link members to medical services and to non-medical, community-based supports? This may include acting as a liaison between medical and non-medical service providers.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.2</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.1.2</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>The care coordination notes documented that the member was linked to counseling, job training, and a Boys and Girls Club (for her son). The member was able to secure an internship at a day program and was subsequently hired.</p>		



Appendix B. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Record Review Tool
for Rocky Mountain Health Plans (Region 1)

Care Management Program Record Review		Score
Development of a Care Treatment Plan		
<p>3. Do the care plan interventions reflect the member’s cultural and/or linguistic needs, beliefs, and values?</p> <p align="right"><i>Regions 1, 6, 7: Exhibit A—6.4.3.2.2</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.2.2</i> <i>Regions 4: Exhibit A—6.4.3.1.2</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>The assessment indicated that the member was of the Christian faith, was an English-speaking single mother who was unemployed and lacking confidence and job skills. She lived with her mother and had a school-aged child. The member was provided with referrals to Touchstone Health Partners for counseling. She was referred to the workforce center to build her job skills, which previously included only fast food experience.</p>		
<p>4. Did the Contractor identify barriers to the member’s health that exist in the Contractor’s region and address those barriers for the member?</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.3.3.4</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.3.3.4</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>The member had a vehicle, there were no barriers to meeting her goals, and all necessary services were available in the area.</p>		



Appendix B. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Record Review Tool
for Rocky Mountain Health Plans (Region 1)

Care Management Program Record Review		Score
Provision of Care/Case Management Services		
<p>1. Were the member and the member’s family, if applicable, active participants in the member’s care, to the extent the member/family were willing and able?</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.2.1</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.2.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The member’s mother was emotionally and financially supportive of the member; the member and her son lived with her mother. During the coordinator’s home visits with the member, her mother would take the son to another location so the coordinator and the member could converse without interruption.</p>		
<p>2. If the member had any of the following special needs, was the provision of care coordination services responsive to those needs?</p> <ul style="list-style-type: none"> ◆ Complex behavioral or physical health needs ◆ The member has physical or developmental disabilities ◆ The member is a child or foster child ◆ The member is an adult or is aged ◆ The member is non-English-speaking ◆ The member was in need of assistance with medical transitions <p align="right"><i>Regions 1, 4, 7: Exhibit A—6.4.3.2.3</i> <i>Regions 2, 3: Exhibit A—6.4.5.2.3</i> <i>Regions 6: Exhibit A—6.4.3.2.3.1</i></p>	<input type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable	
<p>Observations: The member did not have any of the above special needs.</p>		



Appendix B. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Record Review Tool
for Rocky Mountain Health Plans (Region 1)

Care Management Program Record Review		Score
Provision of Care/Case Management Services		
3. Did the Contractor follow up with the member to assess whether the member has received the services needed and if the member is on track to reach his or her desired health outcomes? <div align="right"> <i>Regions 1, 4, 5, 6, 7: Exhibit A—6.4.3.1.6</i> <i>Region 2: Exhibit A—6.4.5.1.6</i> <i>Region 3: Exhibit A—6.4.5.1.7</i> </div>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The member’s case was closed in the RMHP system; the member’s telephone number may have been changed. The member does know how to contact care coordination services, and the care coordinator attends weekly meetings at FMC and will therefore be aware if the member needs future coordination services.		

Results for Care Management Record Review					
Total	Met	=	<u>10</u>	X	1.00 = <u>10</u>
	Substantially Met	=	<u>0</u>	X	.75 = <u>0</u>
	Partially Met	=	<u>0</u>	X	.50 = <u>0</u>
	Not Met	=	<u>0</u>	X	0.0 = <u>0</u>
	Not Applicable	=	<u>1</u>	X	NA = <u>NA</u>
Total Applicable		=	<u>10</u>	Total Score	= <u>10</u>

Total Score ÷ Total Applicable		=	<u>100%</u>
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Appendix B. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Record Review Tool
for Rocky Mountain Health Plans (Region 1)

Sample Number: Y***** (8)

Reviewer: Diane Somerville

Care Management Program Record Review		Score
Identification		
1. What event(s) or condition(s) triggered the member’s identification/referral to receive intensive care/case management services? <div align="right"><i>Exhibit A—6.4</i></div>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The member was referred directly from the primary care provider; the behavioral health specialist thought the member would benefit from additional therapy.		
2. Was the member assigned an individual to be a care coordinator, and was the member made aware of that assignment? <div align="right"> <i>Region 1: Exhibit A—6.4.8</i> <i>Regions 2, 3, 4, 5: Exhibit A—6.4.3</i> <i>(Not in R6, R7)</i> </div>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The assigned coordinator contacted the member to make an appointment to meet in the member’s home. The care coordinator met with the member and completed the majority of the assessment. She informed the member that there would also be a nurse coordinator as well to help address medication issues. The member was agreeable to the assignments.		



Appendix B. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Record Review Tool
for Rocky Mountain Health Plans (Region 1)

Care Management Program Record Review		Score
Assessment		
<p>1. Was there an assessment present in the Contractor’s care management documentation system that assessed current care coordination services provided to the member and the sufficiency of those services? Did the assessment address whether a care plan exists (from another agency)?</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.2.1 and 6.4.3.1.1</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.1.1 and 6.4.4.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>The patient was referred from Salud, an NCQA-recognized Patient Centered Medical Home (PCMH) organization. The patient was active in treatment with Salud, and the behavioral health specialist there felt that, due to the patient’s high anxiety level, she would benefit from additional therapy. Care coordination helped direct the member to Touchstone Health Partners (THP) where she became involved in a support group. She was active in Alcoholics Anonymous (AA) and had a sponsor.</p>		
<p>2. Did the assessment address the member’s:</p> <ul style="list-style-type: none"> ◆ Health status? ◆ Health behavior/risks? ◆ Medical and non-medical needs? <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.1.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>The assessment addressed the member’s health status, health risks, medical needs, and non-medical needs. The patient was recovering from ankle surgery; she had numerous diagnoses including fibromyalgia, neck pain, and sleep apnea. She had a history of alcohol dependence, heroin addiction, anxiety, depression, and bipolar disorder. She had previously undergone knee surgery, a tonsillectomy, appendectomy, and a breast cyst removal. She had had 19 emergency department (ED) visits in the prior 12 months. The assessment noted she needed a referral to an orthopedist, glasses, and dental work. The member was receiving food stamp assistance.</p>		



Appendix B. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Record Review Tool
for Rocky Mountain Health Plans (Region 1)

Care Management Program Record Review	Score
Development of a Care Treatment Plan	
1. Does a care plan exist, whether developed by the Contractor, a PCMP, or community agency? <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.1.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
Observations: There was a care plan and progress notes regarding completion of each item. The plan included: <ol style="list-style-type: none"> Referral to Touchstone for anxiety. Exercise for fibromyalgia. Coordinating a referral to an orthopedist. Continuing physical therapy. Involving the member in a support group at Touchstone. Pain management for post ankle surgery and a request for home health care (pending). Coordinating treatment for sleep apnea. Follow-up with neurology for treatment of chronic neck pain. A smoking cessation program. The member requires frequent communication by telephone and home visits to manage anxiety. 	
2. Did the care coordinator link members to medical services and to non-medical, community-based supports? This may include acting as a liaison between medical and non-medical service providers. <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.2</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.1.2</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
Observations: The care coordinator linked the member to medical services and to non-medical, community-based supports as identified above; this was well documented in the record's progress notes.	



Appendix B. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Record Review Tool
for Rocky Mountain Health Plans (Region 1)

Care Management Program Record Review		Score
Development of a Care Treatment Plan		
<p>3. Do the care plan interventions reflect the member’s cultural and/or linguistic needs, beliefs, and values?</p> <p align="right"><i>Regions 1, 6, 7: Exhibit A—6.4.3.2.2</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.2.2</i> <i>Regions 4: Exhibit A—6.4.3.1.2</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>The assessment and progress notes identified that the patient was an English-speaking high school graduate with some college who had lived in the same home for 10 years. It was noted that the member was impoverished and that she had a history of tobacco and heroin addiction and came from a background that included domestic violence and numerous physical and surgical issues. The care plan interventions reflected the member’s needs and values.</p>		
<p>4. Did the Contractor identify barriers to the member’s health that exist in the Contractor’s region and address those barriers for the member?</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.3.3.4</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.3.3.4</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>The care plan identified the member’s needs; all identified needs were being met in the local community. The member was receiving support from a variety of sources: specialty referrals, rehabilitative treatment, behavioral health counseling and a support group, AA, Timberline Church, and friends. Prior to engagement with care coordination services, the member had had 19 prior ED visits in the previous 12 months. Since being involved with care coordination, the member had had only two ED visits between January 2013 and the record review in May 2013.</p>		



Appendix B. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Record Review Tool
for Rocky Mountain Health Plans (Region 1)

Care Management Program Record Review		Score
Provision of Care/Case Management Services		
<p>1. Were the member and the member’s family, if applicable, active participants in the member’s care, to the extent the member/family were willing and able?</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.2.1</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.2.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The member’s parents provided some financial help by paying the mortgage. They live out of state and are elderly. The member’s son was not willing to be an active participant in the member’s care. The member was an active participant.</p>		
<p>2. If the member had any of the following special needs, was the provision of care coordination services responsive to those needs?</p> <ul style="list-style-type: none"> ◆ Complex behavioral or physical health needs ◆ The member has physical or developmental disabilities ◆ The member is a child or foster child ◆ The member is an adult or is aged ◆ The member is non-English-speaking ◆ The member was in need of assistance with medical transitions <p align="right"><i>Regions 1, 4, 7: Exhibit A—6.4.3.2.3</i> <i>Regions 2, 3: Exhibit A—6.4.5.2.3</i> <i>Regions 6: Exhibit A—6.4.3.2.3.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The member had complex behavioral and physical health needs. The provision of care coordination services was responsive to those needs as evidenced through the care plan and progress notes. Appropriate referrals and follow-up contacts were documented in the record.</p>		



Appendix B. Colorado Department of Health Care Policy and Financing
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for Rocky Mountain Health Plans (Region 1)

Care Management Program Record Review		Score
Provision of Care/Case Management Services		
3. Did the Contractor follow up with the member to assess whether the member has received the services needed and if the member is on track to reach his or her desired health outcomes? <div align="right"> <i>Regions 1, 4, 5, 6, 7: Exhibit A—6.4.3.1.6</i> <i>Region 2: Exhibit A—6.4.5.1.6</i> <i>Region 3: Exhibit A—6.4.5.1.7</i> </div>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: At the time of the review, the record notes documented that the member was fully engaged in care coordination services and maintained almost daily contact with the care coordinator. The notes reflected that the member was keeping appointments and was compliant with her medical regime.		

Results for Care Management Record Review					
Total	Met	=	<u>11</u>	X	1.00 = <u>11</u>
	Substantially Met	=	<u>0</u>	X	.75 = <u>0</u>
	Partially Met	=	<u>0</u>	X	.50 = <u>0</u>
	Not Met	=	<u>0</u>	X	0.0 = <u>0</u>
	Not Applicable	=	<u>0</u>	X	NA = <u>NA</u>
Total Applicable		=	<u>11</u>	Total Score	= <u>11</u>
Total Score ÷ Total Applicable				=	<u>100%</u>



Appendix B. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Record Review Tool
for Rocky Mountain Health Plans (Region 1)

Sample Number: L***** (9)

Reviewer: Diane Somerville

Care Management Program Record Review		Score
Identification		
1. What event(s) or condition(s) triggered the member’s identification/referral to receive intensive care/case management services? <div align="right"><i>Exhibit A—6.4</i></div>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The triggering event was a referral from the hospital where the patient was admitted for complications with diabetes control.		
2. Was the member assigned an individual to be a care coordinator, and was the member made aware of that assignment? <div align="right"> <i>Region 1: Exhibit A—6.4.8</i> <i>Regions 2, 3, 4, 5: Exhibit A—6.4.3</i> <i>(Not in R6, R7)</i> </div>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The member was assigned a care coordinator who met with him at the hospital; the patient reported that he could use some assistance, agreed to care coordination services, and signed a release of information document.		



Appendix B. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Record Review Tool
for Rocky Mountain Health Plans (Region 1)

Care Management Program Record Review		Score
Assessment		
<p>1. Was there an assessment present in the Contractor’s care management documentation system that assessed current care coordination services provided to the member and the sufficiency of those services? Did the assessment address whether a care plan exists (from another agency)?</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.2.1 and 6.4.3.1.1</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.1.1 and 6.4.4.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>There was an assessment in the care management documentation system that addressed the care coordination services being provided to the member. The assessment identified that the member was receiving services from Touchstone Health Partners, home health services, and Meals on Wheels. The progress notes reflected that there was communication and coordination with the patient’s medical provider and the community agencies.</p>		
<p>2. Did the assessment address the member’s:</p> <ul style="list-style-type: none"> ◆ Health status? ◆ Health behavior/risks? ◆ Medical and non-medical needs? <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.1.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>The assessment addressed the member’s health status of diabetes, mental illness, substance abuse disorder, his medical history and treatment issues, current community providers, and family support. The assessment described that the member has had Type 1 diabetes since early adolescence. He has received numerous community services, including home health care who was visiting the member’s home three times a day to check blood sugar levels. The assessment identified that the member had a history of polysubstance abuse and a psychiatric diagnosis of schizoaffective disorder.</p>		



Appendix B. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Record Review Tool
for Rocky Mountain Health Plans (Region 1)

Care Management Program Record Review		Score
Development of a Care Treatment Plan		
<p>1. Does a care plan exist, whether developed by the Contractor, a PCMP, or community agency?</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.1.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>There was a care plan for the member that related directly to a problem list. The care plan addressed maintaining the member in the community through better control of his diabetes, provision of referrals to specialty care providers (endocrinology, cardiology, and podiatry), transportation provision, and coordination with the home health nurse and the member’s brother and sister who care for him.</p>		
<p>2. Did the care coordinator link members to medical services and to non-medical, community-based supports? This may include acting as a liaison between medical and non-medical service providers.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.2</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.1.2</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>The care coordinator helped make arrangements for cataract surgery, arranged for transportation appointments, and made referrals to an endocrinologist, a cardiologist, and a podiatrist.</p>		



Appendix B. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Record Review Tool
for Rocky Mountain Health Plans (Region 1)

Care Management Program Record Review		Score
Development of a Care Treatment Plan		
3. Do the care plan interventions reflect the member’s cultural and/or linguistic needs, beliefs, and values? <i>Regions 1, 6, 7: Exhibit A—6.4.3.2.2</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.2.2</i> <i>Regions 4: Exhibit A—6.4.3.1.2</i>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The care plan interventions reflected that the coordinator worked with the member’s extended Hispanic family members who were willing to provide support to the member. It was important to the family to care for the member themselves, but they had difficulty making this happen until the Care Coordination team helped with coordinating medical treatment, medication, in-home services, and transportation.		
4. Did the Contractor identify barriers to the member’s health that exist in the Contractor’s region and address those barriers for the member? <i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.3.3.4</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.3.3.4</i>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The member had multiple complex issues, including financial. The care coordinator helped find money for the prescription copay and delivered medication to the member. The member had a previous unsuccessful out-of-home placement, so Care Coordination was able to coordinate multiple medical and community services to enable the member to stay in a family member’s home.		



Appendix B. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Record Review Tool
for Rocky Mountain Health Plans (Region 1)

Care Management Program Record Review		Score
Provision of Care/Case Management Services		
<p>1. Were the member and the member’s family, if applicable, active participants in the member’s care, to the extent the member/family were willing and able?</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.2.1</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.2.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The member and his brother and sister were very involved.</p>		
<p>2. If the member had any of the following special needs, was the provision of care coordination services responsive to those needs?</p> <ul style="list-style-type: none"> ◆ Complex behavioral or physical health needs ◆ The member has physical or developmental disabilities ◆ The member is a child or foster child ◆ The member is an adult or is aged ◆ The member is non-English-speaking ◆ The member was in need of assistance with medical transitions <p align="right"><i>Regions 1, 4, 7: Exhibit A—6.4.3.2.3</i> <i>Regions 2, 3: Exhibit A—6.4.5.2.3</i> <i>Regions 6: Exhibit A—6.4.3.2.3.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The member had complex behavioral health and physical health needs, and care coordination services resulted in better compliance with medical care and enabled the member to remain in the community.</p>		



Appendix B. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Record Review Tool
for Rocky Mountain Health Plans (Region 1)

Care Management Program Record Review		Score
Provision of Care/Case Management Services		
3. Did the Contractor follow up with the member to assess whether the member has received the services needed and if the member is on track to reach his or her desired health outcomes? <div align="right"> <i>Regions 1, 4, 5, 6, 7: Exhibit A—6.4.3.1.6</i> <i>Region 2: Exhibit A—6.4.5.1.6</i> <i>Region 3: Exhibit A—6.4.5.1.7</i> </div>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The contractor followed up with the member and his family. Services were in place, including home health three times a day, and the member and his family knew how to contact Care Coordination if further assistance was desired. The care coordinator followed up with an update report to the medical provider regarding services being provided and the member’s status.		

Results for Care Management Record Review					
Total	Met	=	<u>11</u>	X	1.00 = <u>11</u>
	Substantially Met	=	<u>0</u>	X	.75 = <u>0</u>
	Partially Met	=	<u>0</u>	X	.50 = <u>0</u>
	Not Met	=	<u>0</u>	X	0.0 = <u>0</u>
	Not Applicable	=	<u>0</u>	X	NA = <u>NA</u>
Total Applicable		=	<u>11</u>	Total Score	= <u>11</u>
Total Score ÷ Total Applicable				=	<u>100%</u>



Appendix B. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Record Review Tool
for Rocky Mountain Health Plans (Region 1)

Sample Number: Y**** (10)

Reviewer: Diane Somerville

Care Management Program Record Review		Score
Identification		
1. What event(s) or condition(s) triggered the member’s identification/referral to receive intensive care/case management services? <div align="right"><i>Exhibit A—6.4</i></div>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The case had initially been referred to the Community Care Team (CCT) by the member’s physician. The member’s diagnoses included chronic obstructive pulmonary disease (COPD), and the member needed oxygen support. However, because the member was homeless, the CCT was unable to locate him until he was hospitalized. The care manager met the member in the hospital. The member had had approximately 25 emergency department (ED) visits prior to his care coordination start date.		
2. Was the member assigned an individual to be a care coordinator, and was the member made aware of that assignment? <div align="right"> <i>Region 1: Exhibit A—6.4.8</i> <i>Regions 2, 3, 4, 5: Exhibit A—6.4.3</i> <i>(Not in R6, R7)</i> </div>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The member was referred directly to the team from his physician. The assigned care coordinator met the member when he was hospitalized, and the member agreed to service coordination.		



Appendix B. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Record Review Tool
for Rocky Mountain Health Plans (Region 1)

Care Management Program Record Review		Score
Assessment		
<p>1. Was there an assessment present in the Contractor’s care management documentation system that assessed current care coordination services provided to the member and the sufficiency of those services? Did the assessment address whether a care plan exists (from another agency)?</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.2.1 and 6.4.3.1.1</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.1.1 and 6.4.4.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>The assessment indicated that the member was a homeless adult male in his early 50’s who had alcohol dependence, cardiac problems, and COPD. The assessment noted that the member was active with Touchstone Health Partners and the Murphy Center for Hope and that the coordinator was in frequent contact with those providers. The assessment documented RMHP’s coordination of services, including transportation to Greeley for treatment and obtaining oxygen support for the member.</p>		
<p>2. Did the assessment address the member’s:</p> <ul style="list-style-type: none"> ◆ Health status? ◆ Health behavior/risks? ◆ Medical and non-medical needs? <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.1.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>The assessment noted that the member had COPD, alcohol dependence, and cardiac issues. It documented that the patient had seizures when detoxing and that care coordination efforts attempted to ensure that detoxification would occur in a medical facility. The care coordinator was able to help obtain oxygen for the member to use at his shelter. The member required surgery, and care coordination assisted with transportation for follow-up care.</p>		



Appendix B. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Record Review Tool
for Rocky Mountain Health Plans (Region 1)

Care Management Program Record Review		Score
Development of a Care Treatment Plan		
<p>1. Does a care plan exist, whether developed by the Contractor, a PCMP, or community agency?</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.1.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: A care plan existed and was updated as goals were met or changed. Care plan goals were for transportation and securing oxygen for use at the Murphy Center for Hope.</p>		
<p>2. Did the care coordinator link members to medical services and to non-medical, community-based supports? This may include acting as a liaison between medical and non-medical service providers.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.2</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.1.2</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The care coordinator communicated with the member’s physician regarding oxygen needs as well as behavioral health and shelter providers.</p>		



Appendix B. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Record Review Tool
for Rocky Mountain Health Plans (Region 1)

Care Management Program Record Review		Score
Development of a Care Treatment Plan		
<p>3. Do the care plan interventions reflect the member’s cultural and/or linguistic needs, beliefs, and values?</p> <p align="right"><i>Regions 1, 6, 7: Exhibit A—6.4.3.2.2</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.2.2</i> <i>Regions 4: Exhibit A—6.4.3.1.2</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The care plan noted that member was from a culture of poverty, was homeless, and was English-speaking.</p>		
<p>4. Did the Contractor identify barriers to the member’s health that exist in the Contractor’s region and address those barriers for the member?</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.3.3.4</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.3.3.4</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations The region’s detoxification center is in Greeley. However, the member would have medical complications when detoxing (e.g., seizures, cardiac issues). The care coordinator worked with his treatment team to try to ensure any future detoxifications would occur in a medical facility.</p>		



Appendix B. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Record Review Tool
for Rocky Mountain Health Plans (Region 1)

Care Management Program Record Review		Score
Provision of Care/Case Management Services		
<p>1. Were the member and the member’s family, if applicable, active participants in the member’s care, to the extent the member/family were willing and able?</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.2.1</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.2.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>The assessment noted that the member’s only family was his elderly father who was only peripherally involved; the member could stay with his father if it was extremely cold and no other shelter was available.</p>		
<p>2. If the member had any of the following special needs, was the provision of care coordination services responsive to those needs?</p> <ul style="list-style-type: none"> ◆ Complex behavioral or physical health needs ◆ The member has physical or developmental disabilities ◆ The member is a child or foster child ◆ The member is an adult or is aged ◆ The member is non-English-speaking ◆ The member was in need of assistance with medical transitions <p align="right"><i>Regions 1, 4, 7: Exhibit A—6.4.3.2.3</i> <i>Regions 2, 3: Exhibit A—6.4.5.2.3</i> <i>Regions 6: Exhibit A—6.4.3.2.3.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>The member had complex physical health needs compounded by alcohol dependence and homelessness. As noted, care coordination assisted with ensuring that the member had oxygen at his shelter and that detoxification would occur in a medical facility.</p>		



Appendix B. Colorado Department of Health Care Policy and Financing
FY 2012–2013 Record Review Tool
for Rocky Mountain Health Plans (Region 1)

Care Management Program Record Review		Score
Provision of Care/Case Management Services		
3. Did the Contractor follow up with the member to assess whether the member has received the services needed and if the member is on track to reach his or her desired health outcomes? <div style="text-align: right;"> <i>Regions 1, 4, 5, 6, 7: Exhibit A—6.4.3.1.6</i> <i>Region 2: Exhibit A—6.4.5.1.6</i> <i>Region 3: Exhibit A—6.4.5.1.7</i> </div>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The care coordinator is able to remain in contact with the member via a voice mail system through the Murphy Center for Hope. The care coordinator accompanies the member to doctor appointments and stays in touch regularly with the member.		

Results for Care Management Record Review					
Total	Met	=	<u>11</u>	X	1.00 = <u>11</u>
	Substantially Met	=	<u>0</u>	X	.75 = <u>0</u>
	Partially Met	=	<u>0</u>	X	.50 = <u>0</u>
	Not Met	=	<u>0</u>	X	0.0 = <u>0</u>
	Not Applicable	=	<u>0</u>	X	NA = <u>NA</u>
Total Applicable		=	<u>11</u>	Total Score	= <u>11</u>
Total Score ÷ Total Applicable				=	<u>100%</u>