

Colorado  
Accountable Care Collaborative

**FY 2012–2013 SITE REVIEW REPORT**  
*for*  
**Integrated Community Health Partners  
(Region 4)**

June 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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<b>1. Overview .....</b>	<b>1-1</b>
Background .....	1-1
Site Review Methodology .....	1-1
<b>2. Executive Summary .....</b>	<b>2-1</b>
Overall Summary of Findings .....	2-1
Summary of Findings by Standard .....	2-2
Summary of Record Reviews .....	2-4
<b>Appendix A. Data Collection Tool .....</b>	<b>A-i</b>
<b>Appendix B. Record Review Tools .....</b>	<b>B-i</b>

## 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. **Integrated Community Health Partners (IChP)** 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 **IChP**.

## 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 **ICHP** 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.

## 2. Executive Summary

### for Integrated Community Health Partners (Region 4)

### 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	4	2	0	0	0	92%
II Follow-Up: Access to Care/Medical Home	4	4	3	1	0	0	0	94%
Record Reviews	110	103	85	13	2	3	7	93%
<b>Overall Score</b>	<b>120</b>	<b>113</b>	<b>92</b>	<b>16</b>	<b>2</b>	<b>3</b>	<b>7</b>	<b>93%</b>

\*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**

**ICHP** care coordinators and primary care medical provider (PCMP) case managers were very active and engaged with the members. **ICHP**'s philosophy of person centeredness and treating the whole person was evident in care plans and interactions between care coordinators and members. HSAG found evidence of strong communication between **ICHP** management staff and the care coordinators as well as among the care coordinators. In instances where members were identified as receiving services from other agencies that provide care coordination, **ICHP** coordinators documented coordination between agencies in the member's record. **ICHP** created a care coordination workgroup as a method for care coordinators at the different PCMPs to problem solve system issues as well as process difficult cases.

Integration of behavioral health and physical health care is a clear strength in this region. The collocation model used at **ICHP**'s major PCMPs promotes sharing between behavioral health and physical health providers, and using the community mental health center's case managers for care coordination for smaller PCMPs allows those PCMPs to benefit from the expertise of the behavioral health care coordination model.

**ICHP** was actively problem solving and pursuing solutions to barriers and difficulties from using various case management documentation systems. Its use of data and development of creative solutions allows **ICHP** to plan for future initiatives as well as identify members for care management quickly.

#### **Recommended Actions**

HSAG recommends that **ICHP** develop a method to document in a member's record whether or not the member is involved with community-based organizations or other service agencies that may perform care coordination or case management activities. HSAG reminded **ICHP** staff that cultural assessment is broader than linguistic needs or requests for translation services. HSAG recommended that every member's medical record include an assessment of the member's culture, values, and belief systems.

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

### **Strengths**

**ICHP** had a well-distributed PCMP network to serve the majority of the more populated areas of the **ICHP** Region. **ICHP**'s provider network consisted of several FQHCs and clinics that had multiple satellite facilities distributed across the region and has begun supplementing this network with smaller practices that accept Medicaid members. Many PCMPs were well versed in medical home concepts and had established medical home systems and processes. Many PCMPs had behavioral health practitioners on-site and/or a collaborative working relationship with local behavioral health entities. **ICHP**'s PCMP recruitment strategy targeted Medicare providers (to support the integration of the Medicare/Medicaid dual eligible population) and pediatricians (in preparation of the anticipated Colorado Children's Healthcare Access Program [CCHAP] reimbursement differential elimination). In addition, **ICHP** was working to encourage smaller PCMP practices to open and expand their panel of Medicaid members. **ICHP** anticipated that much of the expanded Medicaid population can be accommodated within the existing network.

Practitioners must endorse the concepts of the RCCO to be eligible for the network. **ICHP**'s primary recruitment strategy has been to offer support resources to practices to ease the burden of participation in the RCCO. **ICHP** has been customizing its support resources to complement individual practices' existing systems and processes. **ICHP** invested in innovative information systems applications and care coordination approaches that add value to practices while enhancing the performance of the RCCO.

Staff and leadership have spent significant time and resources establishing personal, trusted relationships with providers. **ICHP**'s philosophy of building a system from the "bottom up" requires acknowledging what works within the system and developing resources to fill gaps, not imposing new systems and processes on PCMPs. **ICHP** defined and implemented a variety of operational and clinical tools and trainings that are offered as options to practices. **ICHP** was considering development of a provider portal on the Web site for secure distribution of proprietary materials and information. **ICHP** performed individual PCMP assessments of medical home functions and used these assessments to guide a plan of action for each practice. Staff stated that approximately 80 percent of PCMPs adequately perform medical home functions, and the remaining 20 percent are smaller practices that will continue to need a higher level of support.

**ICHP** was addressing concerns regarding availability of specialists in the **ICHP** Region through innovative approaches, such as the Medical Neighborhood grant, and through cross-regional RCCO collaborative initiatives. **ICHP** identified and established positive specialist relationships for RCCO members and was considering implementation of a memorandum of understanding with specialists to communicate RCCO expectations and processes.

Members may access any urgent care facility for after-hours care. One hospital in Pueblo established an urgent care facility within its emergency department (ED). Most rural areas of the region have very limited access to after-hours urgent care. Staff stated that the cultural orientation of Medicaid members in the **ICHP** Region is to seek after-hours and urgent care in the ED and that

changing this culture will be challenging. **ICHP** monitored PCMPs for appointment availability and after-hours triage services.

### Recommended Actions

HSAG recommended that **ICHP** define a detailed master plan and schedule for development and implementation of the Practice Support Strategy, and continue to pursue a provider portal for distribution of clinical tools and reports.

HSAG recommended that **ICHP** continue exploring mechanisms to expand access to after-hours and urgent care and better publicize to members the availability and locations of after-hours and urgent care facilities.

## Summary of Record Reviews

### Strengths

The on-site review of 10 care coordination record reviews demonstrated that **ICHP's** care coordinators' efforts at connecting with members and arranging care were persistent and creative. While the assessments were not always consistent in form or organization, HSAG found evidence that some level of assessment was being conducted for every member. **ICHP's** care coordinators collaborated with outside agencies to ensure maximum support for each member. A noteworthy example is a case in which the care coordinator worked with the member's parole officer. Another case noted a care plan that included participation from the local ED. HSAG even noted **ICHP's** efforts to keep a bus stop located outside of a PCMP from being removed.

### Recommended Actions

HSAG recognized **ICHP's** efforts at organizing information from a variety of paper and electronic systems to understand and provide services and referrals to meet its members' needs. HSAG encouraged **ICHP** to continue to support one of its large PCMP organizations in developing a care coordination module within the electronic health record that includes a comprehensive care coordination assessment. HSAG also encouraged **ICHP** to continue to develop processes that would allow **ICHP** care coordinators to create a comprehensive care plan for each member, whether in hard copy or electronic format. **ICHP** may want to consider taking into consideration any behavioral health or physical assessments, and then adding to the documentation any assessment information specific to care coordination. HSAG recommended that **ICHP** work with this PCMP to ensure that the care plan template includes an overall, comprehensive care plan with long- and short-term goals.

HSAG acknowledged the need to respect the member's decision not to participate in active care coordination and the need for **ICHP** to focus care coordination efforts on those members who desire to participate. HSAG recommended that care coordinators actively arrange referral appointments for members whenever possible, and consistently follow up with other providers to determine follow-through by the member. HSAG also encouraged **ICHP** to ensure that essential member contacts were documented, whether using paper or electronic systems.

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

The completed data collection tool for Region 4 follows this cover page.



*Appendix A. Colorado Department of Health Care Policy and Financing  
 FY 2012–2013 Data Collection Tool  
 for Integrated Community Health Partners (Region 4)*

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"> <li>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.</li> </ul> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.3.            Regions 2, 3, 5: Exhibit A—6.4.5.3.1</i></p>	<p>Documents:</p> <ul style="list-style-type: none"> <li>Policies or procedures which address integration of services or communication among providers/entities</li> <li>Comprehensive needs assessment documents</li> <li>Written program plans, training materials, or other documents which address comprehensive and integrated care services</li> </ul> <p>Discussion/Findings Will Include:</p> <ul style="list-style-type: none"> <li>Documents reviewed</li> <li>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"> <li>At the individual member level</li> <li>At the delivery system level</li> </ul> </li> </ul> <p>Additional Discussion May Include:</p> <ul style="list-style-type: none"> <li>Discussion of continued challenges to sharing/communication of member information among providers. How is this being addressed?</li> </ul>	<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><b>Findings:</b></p> <p>Documents reviewed:</p> <ul style="list-style-type: none"> <li>Formal System of Care Coordination Plan: ICHP’s formal care coordination plan required by the Department. The plan was comprehensive and well organized.</li> <li>Behavioral Health Integration Report: This report described the quality initiatives planned for the target populations. The adult project is for members receiving opiates from five or more pharmacies or prescribers and is designed to decrease the number of prescriptions written. There were also projects for adults and children diagnosed with diabetes, designed to reduce the cost of care through care coordination and member education.</li> <li>Care Coordination Operations Work Group Attendance Roster and Meeting Minutes: The minutes demonstrated discussion of current Accountable Care Collaborative topics and ICHP care coordination operations.</li> <li>Care Coordination Needs Assessment policy: The policy outlined the context of the member needs assessment designed to identify members’ care coordination needs.</li> </ul>		



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<b>Standard I—Care Coordination/Care Management</b>		
<b>Requirement</b>	<b>Desk Review/Discussion Items</b>	<b>Score</b>
<ul style="list-style-type: none"> <li>◆ PCMP Needs Assessment Form: Comprehensive Needs Assessment form provided to PCMPs that do not already have a mechanism for comprehensive needs assessment.</li> <li>◆ Trainings and PowerPoint Presentations:               <ul style="list-style-type: none"> <li>• Accountable Care Organization (ACO) Introductory Training: Introduction to the ACO program and ICHP.</li> <li>• Motivational Interviewing for Behavioral Health Changes: Used both in the context of assisting PCMPs in behavior change and practice transformation, as well as for PCMPs and staff to understand and work with PCMP members with behavioral health and substance abuse issues.</li> <li>• PowerPoint Presentation for the Care Coordination Operations Meeting: Introduction to the statewide data analytics contractor (SDAC) data.</li> <li>• Introduction to Person-Centered Planning: Intended for PCMPs for increased understanding of whole person approaches to treatment.</li> <li>• Mental Health First Aid: For PCMPs and staff (particularly front office staff) to improve understanding of how to deal with mental health issues (as a layperson) and particularly crises.</li> </ul> </li> <li>◆ Web Site Review: The ICHP Web site included a vast amount of information, trainings, and the provider and member handbook; and it was easy to navigate.</li> <li>◆ Project Gallagher: Project description of development, intended testing, and implementation of an electronic tool designed to allow PCMPs and other treatment team members to exchange contact notes and alerts indicating that members received care.</li> <li>◆ Data Handout and Metric Template: Printout of the ICHP dashboard and metrics for reviewing and understanding ICHP data.</li> </ul>		
<p><b>Additional Discussion:</b></p> <p>ICHP’s major PCMPs are federally qualified health centers (FQHCs) with multiple locations and have on-site case managers and/or care coordinators. As FQHCs, these providers offer behavioral health and primary care on-site. The on-site case managers are able to easily coordinate between providers and facilitate team discussions when needed. In addition, ICHP included in the partnership a community mental health center, designated as a PCMP, to coordinate care for PCMPs that do not have on-site case management, or as a backup to the FQHC case management programs.</p> <p>ICHP staff and partners described the ICHP philosophy to use a whole person approach to treatment and care coordination. Staff reported that Valley-Wide (a PCMP and FQHC) uses the Person-Centered Planning process and implemented meetings with the team and member to plan care, while other partners are using the training and information about the Person-Centered Planning process as a philosophy when working with members.</p>		



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**Standard I—Care Coordination/Care Management**

Requirement	Desk Review/Discussion Items	Score
<p>2. Comprehensive care coordination characteristics include:</p> <ul style="list-style-type: none"> <li>◆ Assessing the member’s health and health behavior risks and medical and non-medical needs</li> <li>◆ Determining if a care plan exists and creating a care plan if one does not exist and is needed.</li> <li>◆ 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.</li> </ul> <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"> <li>◆ How members are assessed to identify needs</li> <li>◆ Policies and procedures regarding stratification/tier levels for care coordination</li> <li>◆ Care Coordination Plan</li> <li>◆ Tracking referrals to non-medical services</li> </ul> <p>Discussion/Findings Will Include:</p> <ul style="list-style-type: none"> <li>◆ Documents reviewed.</li> <li>◆ Examples.</li> <li>◆ Information collected on-site from Care Coordination File Reviews.</li> <li>◆ The process for identifying members appropriate for care coordination services.</li> </ul> <p>Additional Discussion May Include:</p> <ul style="list-style-type: none"> <li>◆ How PCMPs identify members appropriate for complex care management.</li> <li>◆ Whether the RCCO staff or PCMPs perform the assessment.</li> <li>◆ Explore the role of non-medical services in providing care coordination to the RCCO’s population.</li> </ul>	<p> <input type="checkbox"/> Met  <input checked="" type="checkbox"/> Substantially Met  <input type="checkbox"/> Partially Met  <input type="checkbox"/> Not Met  <input type="checkbox"/> Not Applicable         </p>

**Findings:**

Documents reviewed:

- ◆ Comprehensive Coordination of Care policy: Overview of ICHP Care Coordination practices.
- ◆ Transportation pamphlet: Example of member materials regarding transportation services.
- ◆ ICHP Referral Data Transmissions: Graph of tracking data from referrals from each of the larger PCMPs.
- ◆ Web site review—Community Resources page: The Community Resources page was easy to access from the member tab and from the main page and was very comprehensive.
- ◆ ICHP Stratification Rationale: Description of rationale for placing members into tier categories, which is used to identify members who are appropriate to receive care coordination activities.



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Requirement	Desk Review/Discussion Items	Score
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**Additional Discussion:**

Members were identified for care coordination services using SDAC and ICHP’s own data. In addition, several of the cases reviewed were referred by the primary care provider (PCP) or other providers within the PCMP site. Each of ICHP’s large PCMPs (FQHCs) had its own system for assessing member needs. Some PCMP sites were using an existing electronic health record (EHR), while some were using a combination of paper and electronic means to document assessments and care coordination activities. Sites that were using the EHR for assessment and documentation varied as to whether the assessment was purely a medical assessment or if it included a case management module that incorporated assessment and care planning for comprehensive, system, community, and nonmedical situations and needs. The functionality of the case management modules varied across PCMP sites. Although it appeared from records reviewed that care coordinators and case managers informally knew whether the member was receiving case management services from other organizations or systems, it was not consistently well documented that the case manager inquired or assessed whether the members received services from community agencies or other care systems, particularly in the EHRs that used a traditional medical model of documentation rather than a case management module. When other case managers or care coordinators were identified, coordination between case managers was well documented.

Care coordinators creatively used the data system to determine when member appointments were so that they could meet members at these appointments for initial contact, if telephone contact had not been successful. ICHP staff and partners reported that “cold calling” members often met with less success in engaging members in the care coordination process than personally meeting the member following a PCP appointment. Staff reported that as an organization, ICHP is prioritizing initial contact with Tier 4 members first, and then Tier 3 members. Care coordinators reported that data used to prioritize daily care coordination activities were SDAC data, data from the Colorado Regional Health Information Organization (CORHIO) data exchange system, ICHP’s own database, and the EHR. In addition to the assessment template in the EHRs, several PCMP sites also performed a HARMS-8 assessment and/or the PHQ-9 as appropriate.

ICHP staff described a program in development that uses CMS grant monies to have a “Medical Neighborhood Block Party.” The concept is to bring primary care and specialty physicians together in a social venue to discuss the accountable care program and patient referrals, as well as barriers to accomplishing patient referrals.

One of ICHP’s partners that provided care coordination service was one of the area’s community mental health centers. Staff discussed the dynamic that individuals or agencies may not have direct SDAC access unless they are designated as a PCMP or a RCCO. To bridge the gap and ensure that these care coordinators have the data essential to performing care coordination activities, ICHP’s technology staff members have created an ICHP database. SDAC data are downloaded to this database and the community mental health center care management staff members have access to the database.



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<b>Standard I—Care Coordination/Care Management</b>		
<b>Requirement</b>	<b>Desk Review/Discussion Items</b>	<b>Score</b>
<p>3. Comprehensive care coordination characteristics include:</p> <ul style="list-style-type: none"> <li>◆ 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.</li> </ul>	<p>Desk Review:</p> <ul style="list-style-type: none"> <li>◆ Transition of Care policies and procedures or Plans</li> <li>◆ Examples of “transition of care” cases</li> </ul> <p>Discussion/Findings Will Include:</p> <ul style="list-style-type: none"> <li>◆ Documents reviewed.</li> <li>◆ How are “transition of care” members identified?</li> <li>◆ How is the transition plan (or processes) communicated to providers and all individuals/entities involved in the transition of members between levels of care?</li> </ul> <p>Additional Discussion May Include:</p> <ul style="list-style-type: none"> <li>◆ What is the status of access to real-time data for care coordination follow-up? (hospitalizations, ED visits)</li> <li>◆ Do you track/evaluate the impact of transition management on readmissions?</li> </ul>	<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><b>Findings:</b></p> <p>Documents reviewed:</p> <ul style="list-style-type: none"> <li>◆ Formal System of Care Coordination Plan: Described specific methods of transitional care planning, which included in-person follow-up, medication reconciliation, and member assessment updates.</li> <li>◆ Transitional Planning Policy: The policy described the processes unique to care coordination during member transitions.</li> <li>◆ Transition of Care Plan: ICHP’s program plan for care transitions. The plan described sources of historical and real-time data and their uses as well as the philosophy to preserve existing PCMP systems.</li> <li>◆ Project Gallagher: Project description of development, intended testing, and implementation of an electronic tool designed to allow PCMPs and other treatment team members to exchange contact notes and alerts indicating that members received care.</li> </ul>		
<p><b>Additional Discussion:</b></p> <p>ICHP staff and partners had several methods of identifying members in transition and in need of specific care coordination activities to facilitate transitions and minimize ER visits and readmissions. The team stated that electronic systems and data for identification and communication are essential to the process. ICHP has partnered with the area’s hospitals to ensure timely communication when ICHP members present for services to the ER or are admitted. Hospitals use</p>		



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**Standard I—Care Coordination/Care Management**

Requirement	Desk Review/Discussion Items	Score
	<p>CORHIO’s electronic system to post member activity. The RCCO has access and can determine if RCCO members have had ER visits or hospital admissions. Staff stated that if the electronic system is not working properly, hospital staff fax or call the RCCO to alert RCCO care coordinators of member activity. One challenge to this system is when members have not yet chosen a PCP. Another challenge occurs when system data do not yet reflect a RCCO Region 4 PCMP; as a result, the hospitals are unaware that the RCCO should be notified. ICHP has been developing an electronic system designed to alert any RCCO partner or team member of member activity with services or care management/case management. The project is called “The Gallagher Project” and is a Web-based database located on a secure site with multiple levels of password protection. Hospitals, PCMPs, or other service providers would post activity (e.g., ER visit, PCP appointment, case management contact) to the database. When care coordinators enter the system, they are “alerted” of the activity with the member that occurred and thereby have real-time information to use for care coordination or case management. At the time of the site review, the project was ready to enter the beta testing phase, with plans to begin the project rollout with the start of the new fiscal year in July and functional with most hospitals and PCMPs by year-end.</p> <p>ICHP described another pilot project that will place a staff member, called a “Community Action Team” member, in a hospital emergency room to provide care coordination, transition services, or ER diversion when appropriate to RCCO members.</p> <p>ICHP technology staff members are also exploring data and population statistics to develop prediction models that may be useful for providing preventive care and avoiding high-cost services and transitions.</p>	



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Requirement	Desk Review/Discussion Items	Score
<p>4. Client/Family-Centered characteristics include:</p> <ul style="list-style-type: none"> <li>◆ Providing care and care coordination activities that are linguistically appropriate to the member and are consistent with the member’s cultural beliefs and values.</li> </ul> <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"> <li>◆ Applicable policies and procedures</li> <li>◆ Training materials</li> <li>◆ Evidence of training individuals responsible for care coordination</li> </ul> <p>Discussion/Findings Will Include:</p> <ul style="list-style-type: none"> <li>◆ Documents reviewed.</li> <li>◆ Processes for telephone translation and translation during care coordination activities.</li> <li>◆ How the RCCO ensures that care is culturally sensitive.</li> <li>◆ How the RCCO includes deaf and hard of hearing as a culture and training or case examples that demonstrate.</li> </ul>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p><b>Findings:</b></p> <p>Documents reviewed:</p> <ul style="list-style-type: none"> <li>◆ Cultural Competency policy: The policy described the processes for responding to members and providing telephone translation services for non-English-speaking members. The policy also described assessing members for translation needs.</li> <li>◆ Web site Review: Trainings related to culture and diversity were available on the Web site from both the main page and the provider tab.</li> <li>◆ Cultural Competency PowerPoint trainings: The trainings submitted for review were found on the Web site and were comprehensive, describing aspects of culture, beliefs, and values.</li> <li>◆ PowerPoint: Population analysis of the ICHP Region.</li> </ul>		
<p><b>Additional Discussion:</b></p> <p>Although ICHP was prepared to respond to members’ linguistic needs via the telephone translation line vendor, on-site record review indicated that assessments that were performed were either specific medical or behavioral health assessments and inconsistently assessed members’ cultural and linguistic needs and values. Assessment for cultural needs should explore members’ beliefs and value systems, beyond linguistic needs. ICHP staff reported that ICHP is analyzing population statistics and looking for trends, and will be making plans for outreach programs. ICHP stated that it has the capability to add features to the tier system if it is determined that cultural or linguistic needs are a risk factor for a particular member.</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"> <li>◆ Providing care coordination that is responsive to the needs of special populations, including:               <ul style="list-style-type: none"> <li>• The physically or developmentally disabled.</li> <li>• Children and children in foster care.</li> <li>• Adults and older adults.</li> <li>• Non-English speakers.</li> <li>• All expansion populations, as defined in Colorado House Bill 09-1293, the Colorado Health Care Affordability Act.</li> <li>• Members in need of assistance with medical transitions.</li> <li>• Members with complex behavioral or physical health needs.</li> <li>• Transitional aged youth.</li> </ul> </li> </ul> <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"> <li>◆ Applicable policies and procedures or plans</li> </ul> Discussion/Findings Will Include: <ul style="list-style-type: none"> <li>◆ Documents reviewed.</li> <li>◆ How special populations are identified and served.</li> </ul> Additional Discussion May Include: <ul style="list-style-type: none"> <li>◆ Explore how foster children, AwDC, and dual eligible populations are impacting the system.</li> <li>◆ Describe unique needs or approaches used.</li> </ul>	<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
<b>Findings:</b> Documents reviewed: <ul style="list-style-type: none"> <li>◆ Formal System of Care Coordination Plan: The plan described ICHP’s system of developing local care coordination teams that are able to understand the dynamics in a specific community and the resources available in that community.</li> <li>◆ Care Coordination Operations Work Group Attendance Roster and Meeting Minutes: The minutes demonstrated discussion of current ACO topics and ICHP care coordination operations.</li> </ul>		
<b>Additional Discussion:</b> ICHP staff and partners described the capability of the data system to identify special populations, which PCMP individual members are assigned to, and capacity for additional members. Although ICHP staff members feel that since ICHP’s larger PCMPs are safety net providers and are likely serving the majority of the expansion population already, ICHP continues recruitment to ensure capacity for Medicaid expansion populations. Staff described relationships with the Department of Human Services (DHS) to facilitate coordination for foster care children.		



*Appendix A. Colorado Department of Health Care Policy and Financing  
 FY 2012–2013 Data Collection Tool  
 for Integrated Community Health Partners (Region 4)*

**Standard I—Care Coordination/Care Management**

Requirement	Desk Review/Discussion Items	Score
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ICHP staff and partners described the Care Coordination Operations Workgroup, which began as a workgroup to bring together leaders within the ICHP partnership for training and problem solving. The number of participants in the group has increased, and the agenda has expanded. The group has transitioned into processing difficult cases and problem solving community- and member-level care coordination challenges. Staff reported that the group has grown too large, and ICHP feels the need to redesign its purpose once again. The group is focusing its purpose toward organizational-level problem solving and developing a Web site designed to support care coordinators, by posting trainings, tools, and other resources. At the time of the review, the refocus of this workgroup had not been implemented.

<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"> <li>◆ Tools used for assessing care coordination capabilities of PCMP practices</li> <li>◆ Communications to PCMPs regarding care coordination requirements</li> <li>◆ PCMP care coordination oversight tools</li> <li>◆ Policies and procedures regarding assessment of PCMP or delegation oversight</li> </ul> <p>Discussion/Findings Will Include:</p> <ul style="list-style-type: none"> <li>◆ Documents reviewed.</li> <li>◆ Description of who provides care coordination and how care coordination is shared between the PCMPs and the Contractor.</li> <li>◆ Does the oversight of care coordination include the elements of comprehensive care coordination as outlined in requirements #2 and #3?</li> <li>◆ 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?)</li> <li>◆ How does the RCCO know if the delegated care coordination services are sufficient and consistently provided?</li> </ul>	<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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*Appendix A. Colorado Department of Health Care Policy and Financing  
 FY 2012–2013 Data Collection Tool  
 for Integrated Community Health Partners (Region 4)*

**Standard I—Care Coordination/Care Management**

Requirement	Desk Review/Discussion Items	Score
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**Findings:**  
 Documents reviewed:

- ◆ Formal System of Care Coordination Plan: The plan described supporting PCMPs in continuing existing case management or care coordination processes.
- ◆ PowerPoint: ICHP and the Care Coordination Process: Overview of ICHP identification of members and processes.
- ◆ Audit Tool and Protocol: Sample tool used for PCMP chart audits.

**Additional Discussion:**  
 The care coordination cases reviewed on-site were from several of ICHP’s large PCMP clinics, which were FQHCs. These PCMPs had case management and embedded or collocated physical health and behavioral health treatment. ICHP described a dynamic relationship with these PCMPs’ sites through the Care Coordination Workgroup. Each PCMP had its own system for documenting and tracking care coordination contacts. The ICHP management staff members assist these PCMPs in member identification and identification of resources for effective care coordination. ICHP also began assessing and contracting with smaller PCMPs. The care coordination group at the area’s community mental health center effectively acts as ICHP’s care coordination staff providing the care coordination and case management the smaller PCMPs are not yet able to perform.

ICHP staff described the availability of provider support staff to assist smaller PCMPs with practice transformation and reported that chart audits are performed periodically at all PCMPs to ensure that medical record-keeping meets ICHP standards.

**Recommended Actions:**  
 Care coordinators and case managers were generally making use of the PCP medical assessments or the mental health assessment that may have been performed. This being an excellent practice, in the spirit of the ACO program, HSAG recommends that ICHP consider adding a supplemental care coordination “mini assessment” or developing a protocol for inclusion of specific information in care coordination contact notes that more fully addresses two issues:

- ◆ It should be documented that the care manager specifically asked or assessed whether the member was involved with community-based organizations or other service agencies that may perform care coordination or case management activities. Although care coordinators were aware of whether the members received services from community agencies or other care systems when presenting cases, this was not consistently well documented, particularly in the EHRs that used a traditional medical model of documentation rather than a case management module. When other case managers or care coordinators were identified, coordination between case managers was well documented.
- ◆ Assessment for cultural needs is broader than linguistic needs or requests for translation services. Assessments should explore members’ beliefs and value systems. Although information about race and language was present in the assessment in some cases, HSAG recommends that ICHP develop a set of questions to more fully explore member culture, values, and beliefs.



*Appendix A. Colorado Department of Health Care Policy and Financing*  
**FY 2012–2013 Data Collection Tool**  
*for Integrated Community Health Partners (Region 4)*

<b>Results for Standard I—Care Coordination/Care Management</b>					
<b>Total</b>	Met	=	<u>4</u>	X	1.00 = <u>4</u>
	Substantially Met	=	<u>2</u>	X	.75 = <u>1.5</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>
<b>Total Applicable</b>		=	<u>6</u>	<b>Total Score</b>	= <u>5.5</u>

<b>Total Score ÷ Total Applicable</b>		=	<u>92%</u>
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*Appendix A. Colorado Department of Health Care Policy and Financing  
 FY 2012–2013 Data Collection Tool  
 for Integrated Community Health Partners (Region 4)*

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"> <li>◆ Network adequacy report</li> <li>◆ Targeted Provider Recruitment list</li> <li>◆ Applicable policies and procedures</li> </ul> <p>Discussion/Findings Will Include:</p> <ul style="list-style-type: none"> <li>◆ Documents reviewed.</li> <li>◆ Anticipated geographic or capacity issues.</li> </ul> <p>Additional Discussion May Include:</p> <ul style="list-style-type: none"> <li>◆ Explore status of PCMP network development and provider recruitment within the entire region.</li> <li>◆ How are gaps being identified?</li> <li>◆ Unique recruitment strategies; responses from targeted providers?</li> </ul>	<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><b>Findings:</b>            Documents reviewed:</p> <ul style="list-style-type: none"> <li>◆ Network Access Analysis Report: Provided statistical analysis and geo-access maps of adult and pediatric medical practitioners in Region 4. The PCMP Network is well distributed throughout the ICHP Region to cover the major population concentrations, primarily through a system of clinics.</li> <li>◆ The Network Adequacy Report: Stated that recently contracted providers were either located in a geographic area of need or see an inordinate quantity of Medicaid beneficiaries. At the time of the review, the PCMP network consisted of 227 practitioners across the ICHP Region; 217 of those were accepting new Medicaid members into their practice.</li> <li>◆ Targeted PCMP Recruitment List.</li> <li>◆ List of ICHP Providers with Members: Displayed number of enrolled members by PCMP.</li> </ul>		
<p><b>Additional Discussion:</b>            ICHP reported that the PCMP network tripled in size over the last year. ICHP was in the contracting process with two additional large practices in Trinidad that serve more than 500 Medicaid members. In areas that do not have contracted PCMP practices, ICHP verified that members were accessing PCMPs in nearby counties of other RCCO regions. The provider network clinics were well staffed and invested in the concepts of the medical home model. PCMPs had developed working relationships with the behavioral health providers in the local communities for care coordination and/or had behavioral health providers</p>		



*Appendix A. Colorado Department of Health Care Policy and Financing  
 FY 2012–2013 Data Collection Tool  
 for Integrated Community Health Partners (Region 4)*

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

Requirement	Desk Review/Discussion Items	Score
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located at the PCMPs. In addition, the network included smaller independent PCMP practices that had limited Medicaid panels and less developed practice infrastructures. Frontier areas of the ICHP Region had limited or no providers to recruit. ICHP stated that network development strategies in these areas will require the definition of a different model of care through grants and other innovative initiatives over time. ICHP staff believed existing network providers were already serving many of the anticipated Medicaid expansion population.

The Provider Network Subcommittee identified specific practitioner targets for recruitment. In addition, ICHP conducts outreach to providers requested by members. The targeted recruitment list included potential Medicare providers identified by the Department in anticipation of the integration of the Medicare/Medicaid dual eligible population. PCMPs must understand and endorse the concepts of the RCCO to be considered eligible to participate. ICHP is confident that the Children’s Medical Home pediatric practices will join the RCCO once the Colorado Children’s Healthcare Access Program (CCHAP) Medicaid incentive is discontinued.

Staff stated that practitioners are often unaware of the direction of the Colorado Medicaid program and projected requirements for future participation in the Medicaid program. ICHP was educating potential providers during the recruitment process to understand the intended path—that all Medicaid and health reform-driven expansion populations will be served through the ACO model. In addition to new PCMP recruitment, staff stated that smaller practices need to be persuaded to open their Medicaid panels to absorb additional RCCO members. ICHP visited practices to develop a relationship, sometimes using peer-to-peer contacts with providers. The primary PCMP recruitment strategy was to offer the support resources of ICHP professional staff and systems to lighten the burden of participation in the RCCO. Smaller practices see value in information system applications that would otherwise be unaffordable, and assistance with care coordination for complex members. Availability of data about the services provided to patients is also an attractive feature. Staff stated that the most effective recruitment component is “word of mouth,” and ICHP’s reputation for assisting practices was beginning to circulate among providers.

Staff members believed the major reasons providers are not interested in the RCCO are (1) the practice has a small Medicaid enrollment and wants to close out its Medicaid business, and (2) some PCMPs are still skeptical of the longevity of the ACC program and the amount and value of the effort involved if the ACC model does not survive. In addition, ICHP is concerned that once a PCMP has contracted with the RCCO, it takes approximately 120 days for the State to complete its contract with the provider, which is required before ICHP can integrate the provider into its panel.

Nearly 20 percent of the RCCO members are unattributed to a PCMP, despite comprehensive approaches to member outreach. ICHP staff stated that ICHP is considering adding member e-mail and text messaging to its outreach efforts. ICHP was attempting to identify and update contact information for unattributed members through emergency room (ER) visits. ICHP staff members explained that they use risk stratification of the unattributed members to prioritize efforts for those members who are in most need of having an assigned PCMP for care. Staff stated that a large number of unattributed are children who were assigned to the RCCO in large numbers in January and do not yet have a claims history to identify pre-existing providers. Foster children are also a challenge to attribute.



*Appendix A. Colorado Department of Health Care Policy and Financing  
 FY 2012–2013 Data Collection Tool  
 for Integrated Community Health Partners (Region 4)*

Standard II—Follow-Up : Access to Care/Medical Home		
Requirement	Desk Review/Discussion Items	Score
<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="center"><i>Exhibit A—4.2.5            42CFR438.6(k)(3)</i></p>	<p>Desk Review:</p> <ul style="list-style-type: none"> <li>◆ Tracking documents for referrals to specialists/other providers</li> <li>◆ Applicable policies and procedures</li> </ul> <p>Discussion/Findings Will Include:</p> <ul style="list-style-type: none"> <li>◆ Documents reviewed.</li> <li>◆ How does the RCCO monitor access to specialists?</li> <li>◆ What is the RCCO’s assessment of the availability of specialists for RCCO members?</li> </ul> <p>Additional Discussion May Include:</p> <ul style="list-style-type: none"> <li>◆ What are the barriers or challenges you have encountered and what responses/approaches have been implemented?</li> <li>◆ 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?</li> </ul>	<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><b>Findings:</b></p> <p>Documents reviewed:</p> <ul style="list-style-type: none"> <li>◆ The Provider Handbook: The handbook informed PCMPs of their responsibility to refer members to specialty care and to follow up with the specialist to track completion of the referral and document efforts to reschedule missed specialty appointments. PCMPs may refer members to any Medicaid specialty provider.</li> <li>◆ Referral Data Transmissions Report: Documented total referrals for larger PCMP practices.</li> <li>◆ Sample Referral Data Report: Tracked individual referrals per PCMP, where referred (specialist), reason for referral, and referral follow-up status.</li> </ul> <p><b>Additional Discussion:</b></p> <p>ICHP maintained an indirect relationship with specialists in the ICHP Region, primarily relying on established PCMP referral relationships. ICHP customer service personnel and care coordinators assist with specialist referrals. Through this process, ICHP has been identifying receptive/preferred specialists and creating relationships that enhance access to specialist services. ICHP was considering implementing a memorandum of understanding with Medicaid specialists to communicate expectations and processes. ICHP had been working collaboratively with other RCCO regions and the State to clarify RCCO referral protocol requirements and remove barriers for specialists who are willing to work with Medicaid members.</p>		



*Appendix A. Colorado Department of Health Care Policy and Financing  
 FY 2012–2013 Data Collection Tool  
 for Integrated Community Health Partners (Region 4)*

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

Requirement	Desk Review/Discussion Items	Score
<p>ICHP determined gaps in specialist availability or lack of “prompt” access to specialists indirectly through:</p> <ul style="list-style-type: none"> <li>◆ Member requests for assistance obtaining timely specialist appointments.</li> <li>◆ Provider complaints regarding unavailability of specialists or lack of response.</li> <li>◆ Tracking members who leave the ICHP Region to see a specialist.</li> </ul> <p>ICHP identified a shortage of specialists in child psychiatry, neuropsychology, pain management, urology, and neurology. ICHP stated that members and providers learned that specialist care is often more readily available through an ER visit. ICHP described the Medical Neighborhood grant, which is designed to bring together PCP and specialty practitioners in an informal setting for networking and to improve relationships between PCPs and specialists in the ICHP Region.</p>		
<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"> <li>◆ At a minimum, the Contractor’s PCMP network provides for 24-hour-a-day availability of information, referral, and treatment of emergency conditions.</li> <li>◆ The PCMP provides triage by a clinician 24 hours per day, seven days per week (to meet access to care standards).</li> </ul> <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"> <li>◆ Lists of emergency, urgent care, and after-hours care facilities available to members</li> <li>◆ Applicable policies and procedures</li> <li>◆ Provider communications regarding 24/7 access to after-hours clinicians</li> <li>◆ Results of assessment/monitoring of availability of 24/7 triage by clinician</li> </ul> <p>Discussion/Findings Will Include:</p> <ul style="list-style-type: none"> <li>◆ Documents reviewed.</li> <li>◆ Progress obtained/status in after-hours and urgent care availability since previous review?</li> <li>◆ How is availability of urgent care/after-hours communicated to members?</li> <li>◆ What proportion of RCCO members have access to after-hours care (i.e., if PCMPs have after-hours care only for their own patients)?</li> <li>◆ How is after-hours care availability monitored?</li> </ul> <p>Additional Discussion May Include:</p>	<p> <input type="checkbox"/> Met  <input checked="" type="checkbox"/> Substantially Met  <input type="checkbox"/> Partially Met  <input type="checkbox"/> Not Met  <input type="checkbox"/> Not Applicable         </p>



*Appendix A. Colorado Department of Health Care Policy and Financing  
 FY 2012–2013 Data Collection Tool  
 for Integrated Community Health Partners (Region 4)*

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

Requirement	Desk Review/Discussion Items	Score
	<ul style="list-style-type: none"> <li>◆ Discuss innovative approaches/continuing challenges in provision of urgent/after-hours care.</li> </ul>	

**Findings:**  
 Documents reviewed:

- ◆ Emergent/After-Hours Facility List: Documented the facility and hours of operation for all 24/7 emergency services and extended hours of operation for urgent care. Very few providers were listed as having extended hours or urgent care.
- ◆ ICHP Web site: Listed emergency services of all types (police, hospitals, and crisis centers) in the Community Resource tab of the member page. The provider page included the Emergency After-hours Facility List. The Provider Directory did not include a list of urgent care facilities.
- ◆ ICHP Provider Handbook: Communicated the requirement that PCMP practices provide extended hours on evenings and weekends for after-hours urgent care, the requirement that PCMPs provide 24-hour-a-day availability of information for treatment of emergency conditions, and the requirements for appointment availability.
- ◆ Access to Care Survey Script: Outlined the process for ICHP staff to conduct PCMP monitoring calls for after-hours triage information and for appointment access for various types of conditions (urgent, non-urgent, and routine).
- ◆ Access to Care Redacted Table: Reported results of monitoring calls to a random sample of provider offices.
- ◆ Provider Letters (examples): Provided feedback to individual providers on the results of monitoring calls.
- ◆ ICHP Completed Monitoring Report: Documented that 51 providers had been surveyed regarding appointment access standards, and 29 providers had been surveyed regarding after-hours triage services.

**Additional Discussion:**  
 RCCO members may access any available urgent care facility. Some larger PCMP locations had after-hours care and some were allowing time for walk-in appointments during office hours. One Pueblo hospital instituted an urgent care program in its ER. Staff stated that the Medicaid culture oriented members to seek after-hours or urgent care through ERs. Many rural areas in Region 4 had no urgent care or extended hour facilities, necessitating that members go to the local ER for care. Staff stated that provision of after-hours urgent care in rural areas will require the creation of a different model for services that does not currently exist. Staff stated that SDAC data codes all hospital-based urgent care visits as ER visits, making it difficult to track the use of urgent care verses ER visits. ICHP would like to see the differentiation of urgent care from ER visits in the data, to avoid being “penalized” for hospital-based urgent care initiatives.

ICHP monitored appointment access standards in all PCMP practices over the past year; and ICHP also monitored after-hours triage services in some, but not all, practices. Staff explained that ICHP allows practices to be enrolled in the network for some time before beginning to monitor compliance, to avoid the early impression of RCCO-imposed controls over PCMP processes. Staff stated that feedback to practices regarding monitoring calls stimulated a quick and positive response to correct any identified deficiencies.



*Appendix A. Colorado Department of Health Care Policy and Financing  
 FY 2012–2013 Data Collection Tool  
 for Integrated Community Health Partners (Region 4)*

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

Requirement	Desk Review/Discussion Items	Score
<p>4. Transition to Medical Home:            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"> <li>◆ Operational practice support</li> <li>◆ Clinical tools</li> <li>◆ Client or member materials</li> </ul> <p align="right"><i>Exhibit A—5.2.1</i></p>	<p>Desk Review:</p> <ul style="list-style-type: none"> <li>◆ Practice Support Plan</li> <li>◆ Practice Assessments for Medical Home Capabilities</li> <li>◆ Applicable policies and procedures</li> </ul> <p>Discussion/Findings Will Include:</p> <ul style="list-style-type: none"> <li>◆ Documents reviewed.</li> <li>◆ What is the overall network capacity for medical home functions? What are practice assessments results?</li> <li>◆ How are practice assessments translated into a Support Plan? (Individual/system-wide)?</li> <li>◆ What has been provided to practices regarding the Medical Home model?</li> </ul> <p>Additional Discussion May Include:</p> <ul style="list-style-type: none"> <li>◆ Innovative approaches/significant achievements?</li> <li>◆ What are foreseeable objectives/achievements in PCMP medical home performance?</li> <li>◆ How have practice transformation efforts and activities impacted the organization’s resources?</li> </ul>	<ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> Met</li> <li><input type="checkbox"/> Substantially Met</li> <li><input type="checkbox"/> Partially Met</li> <li><input type="checkbox"/> Not Met</li> <li><input type="checkbox"/> Not Applicable</li> </ul>

**Findings:**  
 Documents reviewed:

- ◆ Practice Support Strategy: Defined a package of specific clinical support tools and strategies for support of practices transforming to certified Patient-Centered Medical Homes. The document had an overview description, including a guide for planning of individual activities, but it did not include a detailed implementation timeline.
- ◆ The Provider Manual: Included a description of the ICHP medical home model of care.
- ◆ The Provider Communications Plan: A description of various methods used by ICHP to communicate with and educate providers.
- ◆ ICHP Web site: Included a link to a health information library for members and PCMPs, a very comprehensive Community Resource Directory, and provider information and trainings on the medical home model. The provider Web site did not include any practice guidelines or clinical tools.
- ◆ PCMP practice assessments (examples): Comprehensive evaluation criteria related to medical home functions and responsibilities, which are applied as a readiness evaluation of PCMP practices after contact completion.



*Appendix A. Colorado Department of Health Care Policy and Financing*  
**FY 2012–2013 Data Collection Tool**  
*for Integrated Community Health Partners (Region 4)*

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

Requirement	Desk Review/Discussion Items	Score
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**Additional Discussion:**

Staff stated that ICHP’s philosophy from inception was to build a “bottom-up” rather than top-down system of care. Staff stated that establishing a personal and trusting relationship with each PCMP is ICHP’s first priority. ICHP continued to execute its bottom-up strategy by recognizing and incorporating systems and processes already established in network PCMPs. ICHP supplemented those activities through ICHP resources. Once a PCMP relationship is established, a formal practice assessment is conducted for each PCMP to determine the level of performance as a medical home. The ICHP practice support team customized a plan of action and resources to be provided to each practice. ICHP practice support staff members are available to each practice to continually promote the RCCO resources available to support PCMPs.

Practice assessments were performed on every PCMP in the network. Staff reported that approximately 80 percent of the practices were performing adequately as medical homes, while the remaining 20 percent were most likely going to be dependent on ICHP support long-term. Region-wide practice enhancement tools continue to be developed and made available to all PCMPs. Staff presented an overview of the Gallagher Project (secure Web-based software program), which will offer PCMPs access to real-time alerts regarding member encounters at any access point in the provider network. In addition, software was being developed to allow care coordination notes to be entered and integrated from anywhere in the network. Staff reported that ICHP is pursuing the development of a secure provider portal on the ICHP Web site for provider access to guidelines, tools, or data reports. Staff stated that practice transformation and enhancement programs have a significant impact on ICHP resources, particularly related to face-to-face meetings with PCMPs over a broad geographic area.

**Recommended Actions:**

HSAG recommended that ICHP continue to pursue innovative strategies to enhance prompt and responsive access to specialists for RCCO members.

HSAG recommended that ICHP develop strategies to expand and promote access to after-hours and urgent care in the provider network and that the member Web site or Provider Directory include a well-publicized listing of urgent care facilities available to members.

HSAG recommended that ICHP create a master action plan and schedule for implementation of activities related to individual practice support plans, as well as region-wide support activities.

HSAG recommended that ICHP continue to pursue the potential for a Web site provider portal for clinical tools, guidelines, and reports.



*Appendix A. Colorado Department of Health Care Policy and Financing*  
**FY 2012–2013 Data Collection Tool**  
*for Integrated Community Health Partners (Region 4)*

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

<b>Total</b>	Met	=	<u>3</u>	X	1.00	=	<u>3</u>
	Substantially Met	=	<u>1</u>	X	.75	=	<u>.75</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>
<b>Total Applicable</b>		=	<u>4</u>	<b>Total Score</b>	=	<u>3.75</u>	

<b>Total Score ÷ Total Applicable</b>		=	<u>94%</u>
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*Appendix B.* **Record Review Tools**  
*for Integrated Community Health Partners (Region 4)*

The record review tools for Region 4 follow this cover page.



*Appendix B. Colorado Department of Health Care Policy and Financing  
 FY 2012–2013 Record Review Tool  
 for Integrated Community Health Partners (Region 4)*

Sample Number: Y\*\*\*\*\* (1)

Reviewer: Katherine Bartilotta

Care Management Program Record Review		Score
<b>Identification</b>		
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	
<b>Observations:</b> The member was identified through data that documented multiple ER visits and a five-day hospitalization for migraine headaches. (The PCMP clinic obtains and manually enters a summary of information from all ER visits into the member’s EHR.) The member was also referred by the PCP to care coordination, since the member was not seeking services from the PCMP.		
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            Regions 2, 3, 4, 5: Exhibit A—6.4.3            (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	
<b>Observations:</b> The member was co-assigned to the care coordinator of the PCMP and the care coordinator from the mental health center, who worked in tandem. The care coordinators were sent to find the patient in the community to engage the member with the PCMP and care coordination services.		



*Appendix B. Colorado Department of Health Care Policy and Financing*  
**FY 2012–2013 Record Review Tool**  
*for Integrated Community Health Partners (Region 4)*

Care Management Program Record Review		Score
<b>Assessment</b>		
<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><b>Observations:</b></p> <p>The record included an assessment. The member—a long-time resident of the community—rotated on and off Medicaid/ICHP eligibility. Since the member was known to the PCMP clinic, a specific assessment or documentation of other agencies that may have served the member was not considered necessary.</p>		
<p>2. Did the assessment address the member’s:</p> <ul style="list-style-type: none"> <li>◆ Health status?</li> <li>◆ Health behavior/risks?</li> <li>◆ Medical and non-medical needs?</li> </ul> <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><b>Observations:</b></p> <p>When this member sought medical services from the PCMP, a comprehensive intake assessment of the member’s physical and psychosocial history was documented in the record. During the clinic visit, clinic staff performed a face-to-face Hospital Admission Risk Multiplier Screen (HARMS-8) assessment and Patient Health Questionnaire Depression Assessment (PHQ-9) on the member, which evaluated all of the required elements.</p>		



*Appendix B. Colorado Department of Health Care Policy and Financing*  
**FY 2012–2013 Record Review Tool**  
*for Integrated Community Health Partners (Region 4)*

Care Management Program Record Review		Score
<b>Development of a Care Treatment Plan</b>		
<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><b>Observations:</b></p> <p>The record documented the care plan and included wellness health education by health coaches for the member’s risky health habits, engaging the member in seeing the PCMP as an alternative to using the ER for physical health needs and referral to mental health services. The care plan reflected input from multiple team members.</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><b>Observations:</b></p> <p>The care coordinators were unable to fully engage the member in care coordination services. The member refused referral to mental health services. There were no needs for nonmedical, community-based supports identified. The member was successfully engaged with the PCMP for treatment of medical needs.</p>		



*Appendix B. Colorado Department of Health Care Policy and Financing*  
**FY 2012–2013 Record Review Tool**  
*for Integrated Community Health Partners (Region 4)*

Care Management Program Record Review		Score
<b>Development of a Care Treatment Plan</b>		
<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 type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p><b>Observations:</b></p> <p>The assessment did not have specific questions regarding culture, beliefs, or values systems. Care management staff for this particular PCMP reported that assessments do not routinely evaluate the member’s culture, beliefs, or 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><b>Observations:</b></p> <p>Staff stated that the stigma associated with seeking mental health services in a small town is often a barrier to completing mental health referrals. Staff stated that collocation of behavioral health providers in PCMP practices diminishes the stigma associated with seeking mental health services and is a strategy being pursued with the mental health provider organization. Member-specific barriers included the age of the member (18) and the member’s belief that she “didn’t need anything.” The member refused mental health services.</p>		



*Appendix B. Colorado Department of Health Care Policy and Financing*  
**FY 2012–2013 Record Review Tool**  
*for Integrated Community Health Partners (Region 4)*

Care Management Program Record Review		Score
<b>Provision of Care/Case Management Services</b>		
<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><b>Observations:</b>            The member was actively engaged in seeking physical health services from the PCMP rather than the ER. The member was never fully engaged in care coordination services and denied the need for other 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"> <li>◆ Complex behavioral or physical health needs</li> <li>◆ The member has physical or developmental disabilities</li> <li>◆ The member is a child or foster child</li> <li>◆ The member is an adult or is aged</li> <li>◆ The member is non-English-speaking</li> <li>◆ The member was in need of assistance with medical transitions</li> </ul> <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><b>Observations:</b>            The member’s assessed needs were not associated with any of the defined special needs groups.</p>		



*Appendix B. Colorado Department of Health Care Policy and Financing  
 FY 2012–2013 Record Review Tool  
 for Integrated Community Health Partners (Region 4)*

Care Management Program Record Review		Score
<b>Provision of Care/Case Management Services</b>		
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              Region 2: Exhibit A—6.4.5.1.6              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	
<b>Observations:</b> The member was difficult to contact outside of clinic visits and did not respond to multiple follow-up contact attempts. The member's ER use was monitored via data reports. ER visits were significantly diminished, thereby resolving the need for active care coordination.		

Results for Care Management Record Review					
<b>Total</b>	Met	=	<u>9</u>	X	1.00 = <u>9</u>
	Substantially Met	=	<u>0</u>	X	.75 = <u>0</u>
	Partially Met	=	<u>0</u>	X	.50 = <u>0</u>
	Not Met	=	<u>1</u>	X	0.0 = <u>0</u>
	Not Applicable	=	<u>1</u>	X	NA = <u>NA</u>
<b>Total Applicable</b>		=	<u>10</u>	<b>Total Score</b>	= <u>9</u>

<b>Total Score ÷ Total Applicable</b>		=	<u>90%</u>
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*Appendix B. Colorado Department of Health Care Policy and Financing*  
**FY 2012–2013 Record Review Tool**  
*for Integrated Community Health Partners (Region 4)*

Sample Number: S\*\*\*\*\* (2)

Reviewer: Barbara McConnell

Care Management Program Record Review		Score
<b>Identification</b>		
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	
<b>Observations:</b> The case manager at the hospital contacted ICHP after a sudden increase in the number of hospitalizations. The member was discussed during the ICHP Region’s weekly care coordination meetings, which included care coordinators/case managers from the area hospitals and ICHP community partners.		
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	
<b>Observations:</b> The care coordination record demonstrated that the ICHP care coordinator had met with the member, and that the member occasionally called the care coordinator.		



*Appendix B. Colorado Department of Health Care Policy and Financing*  
**FY 2012–2013 Record Review Tool**  
*for Integrated Community Health Partners (Region 4)*

Care Management Program Record Review		Score
<b>Assessment</b>		
<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><b>Observations:</b></p> <p>The record included an assessment. At the time of the assessment, certain ICHP partners used an electronic health record (EHR) exclusively. Others that were transitioning to an EHR used a combination of paper and electronic records, or multiple electronic records that did not yet interface with each other. Since behavioral health issues were a factor with this member, the care manager determined whether a behavioral health care manager was involved, and then attempted a referral to the community mental health center (CMHC), although the member declined treatment.</p>		
<p>2. Did the assessment address the member’s:</p> <ul style="list-style-type: none"> <li>◆ Health status?</li> <li>◆ Health behavior/risks?</li> <li>◆ Medical and non-medical needs?</li> </ul> <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><b>Observations:</b></p> <p>The assessment incorporated information from the primary care contacts as well as from specialists who were treating the member. The assessment also included behavioral risk factors and community and psychosocial needs.</p>		



*Appendix B. Colorado Department of Health Care Policy and Financing  
 FY 2012–2013 Record Review Tool  
 for Integrated Community Health Partners (Region 4)*

Care Management Program Record Review		Score
<b>Development of a Care Treatment Plan</b>		
1. Does a care plan exist, whether developed by the Contractor, a PCMP, or community agency?  <p align="center"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1              Regions 2, 3, 5: Exhibit A—6.4.5.1.1</i></p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<b>Observations:</b> The ICHP partner agency that worked with this member did not have a formalized care coordination plan. This organization was working with a blend of paper and electronic information that the care coordinators used to perform care coordination tasks. The EHR was designed using a medical model of documentation, and each contact included a plan field, rather than having an overall longer term care plan. The plan statement within each contact was appropriate to the member’s needs.		
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="center"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.2              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	
<b>Observations:</b> The member had been referred to a pain management specialist for degenerative disk disease, to an endocrinologist for treatment of his diabetes, and to a diabetic educator. The record included referrals for behavioral health and substance abuse treatment; however, the member did not accept these referrals and did not attend appointments made.		



*Appendix B. Colorado Department of Health Care Policy and Financing*  
**FY 2012–2013 Record Review Tool**  
*for Integrated Community Health Partners (Region 4)*

Care Management Program Record Review		Score
<b>Development of a Care Treatment Plan</b>		
<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><b>Observations:</b></p> <p>The record included an assessment of cultural, family, and linguistic history. The care coordinator also asked the member about preferences regarding the gender of his provider. Interventions incorporated information from the assessment, as appropriate.</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><b>Observations:</b></p> <p>As transportation can be an issue in this region, transportation was assessed, although the member indicated that he had a car and plenty of gas.</p>		



*Appendix B. Colorado Department of Health Care Policy and Financing*  
**FY 2012–2013 Record Review Tool**  
*for Integrated Community Health Partners (Region 4)*

Care Management Program Record Review		Score
<b>Provision of Care/Case Management Services</b>		
<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><b>Observations:</b>            Although the member had initiated contact with the care coordinator, he declined many of the care coordinator’s attempts to engage him in the active 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"> <li>◆ Complex behavioral or physical health needs</li> <li>◆ The member has physical or developmental disabilities</li> <li>◆ The member is a child or foster child</li> <li>◆ The member is an adult or is aged</li> <li>◆ The member is non-English-speaking</li> <li>◆ The member was in need of assistance with medical transitions</li> </ul> <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><b>Observations:</b>            Following hospitalizations, the member was provided follow-up PCP appointments; however, he did not attend the appointments and often presented to the hospital instead for readmission or emergency care. The member had diabetes and chronic pain issues and had been referred to specialists and disease management educational programs with which he had not complied. The member also had a history of incarceration. The care coordinator had followed the member during incarceration to ensure that outreach could occur upon the member’s release.</p>		



*Appendix B. Colorado Department of Health Care Policy and Financing*  
**FY 2012–2013 Record Review Tool**  
*for Integrated Community Health Partners (Region 4)*

Care Management Program Record Review		Score
<b>Provision of Care/Case Management Services</b>		
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	
<b>Observations:</b> The care coordinator followed up after each scheduled follow-up PCP appointment no show (post hospitalization), often discovering that the member had either been readmitted or had returned to jail.		

Results for Care Management Record Review					
<b>Total</b>	Met	=	<u>10</u>	X	1.00 = <u>10</u>
	Substantially Met	=	<u>1</u>	X	.75 = <u>.75</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>
<b>Total Applicable</b>		=	<u>11</u>	<b>Total Score</b>	= <u>10.75</u>
<b>Total Score ÷ Total Applicable</b>				=	<u>98%</u>



*Appendix B. Colorado Department of Health Care Policy and Financing*  
**FY 2012–2013 Record Review Tool**  
*for Integrated Community Health Partners (Region 4)*

Sample Number: J\*\*\*\*\* (3)

Reviewer: Barbara McConnell

Care Management Program Record Review		Score
<b>Identification</b>		
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	
<b>Observations:</b> The member was identified for case management following a hospital admission and then discussed in ICHP’s weekly care coordination meeting.		
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	
<b>Observations:</b> Following numerous attempts to reach the member by telephone, the care coordinator met with the member following a PCP appointment at the PCMP organization. The care coordinator was then able to make an appointment to meet with the member in her home. The record demonstrated interaction between the care coordinator and the member.		



*Appendix B. Colorado Department of Health Care Policy and Financing*  
**FY 2012–2013 Record Review Tool**  
*for Integrated Community Health Partners (Region 4)*

Care Management Program Record Review		Score
<b>Assessment</b>		
<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 type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p><b>Observations:</b>            A comprehensive care coordination assessment was not present in the record. The care coordinator used the information obtained from the crisis assessment conducted by the behavioral health provider.</p>		
<p>2. Did the assessment address the member’s:</p> <ul style="list-style-type: none"> <li>◆ Health status?</li> <li>◆ Health behavior/risks?</li> <li>◆ Medical and non-medical needs?</li> </ul> <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 type="checkbox"/> Met <input checked="" type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p><b>Observations:</b>            The assessment in the record was the mental health/behavioral health crisis plan. The assessment was mental health focused and did not include a comprehensive assessment of nonmedical needs.</p>		



*Appendix B. Colorado Department of Health Care Policy and Financing*  
**FY 2012–2013 Record Review Tool**  
*for Integrated Community Health Partners (Region 4)*

Care Management Program Record Review		Score
<b>Development of a Care Treatment Plan</b>		
<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 type="checkbox"/> Met <input checked="" type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p><b>Observations:</b></p> <p>The EHR did not include a comprehensive care plan; however, the EHR was used to document care coordination contacts. Each contact note had a care plan section within the note, which the care coordinator used for short-term goals.</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><b>Observations:</b></p> <p>This member was homebound and lived with her husband. Although the member verbalized a wish to participate in care coordination activities, the husband appeared to intervene, answering the telephone, and then the member did not return the care manager’s telephone calls. The care manager was able to meet with the member at a PCP appointment and arrange for the ICHP Region’s assertive community treatment team to provide care in the home.</p>		



*Appendix B. Colorado Department of Health Care Policy and Financing*  
**FY 2012–2013 Record Review Tool**  
*for Integrated Community Health Partners (Region 4)*

Care Management Program Record Review		Score
<b>Development of a Care Treatment Plan</b>		
<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><b>Observations:</b></p> <p>The record included documentation that demonstrated cultural, family, and linguistic history; and religious and spiritual beliefs had been assessed. The member’s treatment plan with her therapist incorporated prayer, as the member felt that this would improve her mood.</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><b>Observations:</b></p> <p>The record included documentation that demonstrated transportation and access to basics needs such as food; ability to pay for heat was also assessed. The member had no specific needs that required community resources.</p>		



*Appendix B. Colorado Department of Health Care Policy and Financing*  
**FY 2012–2013 Record Review Tool**  
*for Integrated Community Health Partners (Region 4)*

Care Management Program Record Review		Score
<b>Provision of Care/Case Management Services</b>		
<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><b>Observations:</b></p> <p>The record indicated that the care planning team continued to assess the family dynamics. The member verbalized a desire to participate in care coordination activities; however, the husband appeared to be the primary communicator. The community treatment team had been successful providing services in the home, and the care coordinator had been successful communicating with the member following PCP appointments.</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"> <li>◆ Complex behavioral or physical health needs</li> <li>◆ The member has physical or developmental disabilities</li> <li>◆ The member is a child or foster child</li> <li>◆ The member is an adult or is aged</li> <li>◆ The member is non-English-speaking</li> <li>◆ The member was in need of assistance with medical transitions</li> </ul> <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><b>Observations:</b></p> <p>The member has had frequent hospitalizations. The husband takes her to the follow-up PCP appointments. The member receives home health treatment and assertive community treatment in her home.</p>		



*Appendix B. Colorado Department of Health Care Policy and Financing*  
**FY 2012–2013 Record Review Tool**  
*for Integrated Community Health Partners (Region 4)*

Care Management Program Record Review		Score
<b>Provision of Care/Case Management Services</b>		
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	
<b>Observations:</b> The care coordinator catches the member after PCP appointments and follows up with the community treatment team, since telephone contact with this member is a challenge.		

Results for Care Management Record Review					
<b>Total</b>	Met	=	<u>8</u>	X	1.00 = <u>8</u>
	Substantially Met	=	<u>2</u>	X	.75 = <u>1.5</u>
	Partially Met	=	<u>1</u>	X	.50 = <u>.5</u>
	Not Met	=	<u>0</u>	X	0.0 = <u>0</u>
	Not Applicable	=	<u>0</u>	X	NA = <u>NA</u>
<b>Total Applicable</b>		=	<u>11</u>	<b>Total Score</b>	= <u>10</u>
<b>Total Score ÷ Total Applicable</b>				=	<u>91%</u>



*Appendix B. Colorado Department of Health Care Policy and Financing  
 FY 2012–2013 Record Review Tool  
 for Integrated Community Health Partners (Region 4)*

Sample Number: Y\*\*\*\*\* (4)

Reviewer: Barbara McConnell

Care Management Program Record Review		Score
<b>Identification</b>		
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	
<b>Observations:</b> The member had been receiving both physical health (PH) and behavioral health (BH) services at a PCMP site that has collocated services. The care manager became involved when the member told her PCP that the family friend who had provided her transportation to her appointment had forced an unwanted kiss on her. The care manager notified adult protective services and arranged alternate transportation for that day and began working with the member on an ongoing basis.		
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            Regions 2, 3, 4, 5: Exhibit A—6.4.3            (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	
<b>Observations:</b> The member worked with the care coordinator to solve specific issues; however, the care coordinator acknowledged that the member was more bonded with her mental health therapist, and worked closely with the therapist.		



*Appendix B. Colorado Department of Health Care Policy and Financing*  
**FY 2012–2013 Record Review Tool**  
*for Integrated Community Health Partners (Region 4)*

Care Management Program Record Review		Score
<b>Assessment</b>		
<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 type="checkbox"/> Met <input checked="" type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p><b>Observations:</b></p> <p>There was not a mechanism for a comprehensive care coordination assessment. There was an assessment performed by the therapist. When the care coordinator became involved, she discovered that the PCP had ordered new equipment, but that there had been no follow-through by the equipment vendor, due to loss of telephone and inability to contact the member.</p>		
<p>2. Did the assessment address the member’s:</p> <ul style="list-style-type: none"> <li>◆ Health status?</li> <li>◆ Health behavior/risks?</li> <li>◆ Medical and non-medical needs?</li> </ul> <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 type="checkbox"/> Met <input checked="" type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p><b>Observations:</b></p> <p>Although there was not a single care coordination assessment document, the care coordinator had access via various electronic and paper records to the PCP’s assessment and the behavioral health assessment, which assessed all the required domains.</p>		



*Appendix B. Colorado Department of Health Care Policy and Financing*  
**FY 2012–2013 Record Review Tool**  
*for Integrated Community Health Partners (Region 4)*

Care Management Program Record Review		Score
<b>Development of a Care Treatment Plan</b>		
<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 type="checkbox"/> Met <input checked="" type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p><b>Observations:</b></p> <p>There was not a comprehensive care coordination plan that addressed overall and long-term goals; however, the contact notes within the EHR indicated that there was a short-term goal stated within each contact note, which addressed the member’s immediate needs.</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><b>Observations:</b></p> <p>The member was referred to Adult Protective Services and the Medicaid transportation vendor. In addition, the member was receiving physical therapy, specialty care from a urologist, and had transitioned from a non-supportive home environment to an assisted living setting just prior to referral to care coordination. The care coordinator also expedited the new equipment order that had been stalled in the system.</p>		



*Appendix B. Colorado Department of Health Care Policy and Financing*  
**FY 2012–2013 Record Review Tool**  
*for Integrated Community Health Partners (Region 4)*

Care Management Program Record Review		Score
<b>Development of a Care Treatment Plan</b>		
<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 type="checkbox"/> Met <input checked="" type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p><b>Observations:</b></p> <p>Although the mental health assessment evaluated cultural and linguistic needs, a comprehensive assessment and care plan may have more adequately addressed issues arising from the member’s family dynamics and physical limitations (cerebral palsy). For example, the care coordinator acknowledged the member’s need to address her social skills.</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><b>Observations:</b></p> <p>The record indicated that transportation continued to be a struggle given the member’s limited mobility. Not all the vendor’s vehicles are equipped to transport her, which makes scheduling around this and the meal schedule at the assisted living facility difficult. The care coordinator continues her efforts in appropriate scheduling.</p>		



*Appendix B. Colorado Department of Health Care Policy and Financing*  
**FY 2012–2013 Record Review Tool**  
*for Integrated Community Health Partners (Region 4)*

Care Management Program Record Review		Score
<b>Provision of Care/Case Management Services</b>		
<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><b>Observations:</b>            The member was interactive with the care coordinator, the PCP at the PCMP organization, and the mental health therapist.</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"> <li>◆ Complex behavioral or physical health needs</li> <li>◆ The member has physical or developmental disabilities</li> <li>◆ The member is a child or foster child</li> <li>◆ The member is an adult or is aged</li> <li>◆ The member is non-English-speaking</li> <li>◆ The member was in need of assistance with medical transitions</li> </ul> <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><b>Observations:</b>            The member received PCP visits, new equipment (crutches, wheelchair), was transitioned to an assisted living facility after turning 18, and was referred to a urologist and to adult protective services.</p>		



*Appendix B. Colorado Department of Health Care Policy and Financing*  
**FY 2012–2013 Record Review Tool**  
*for Integrated Community Health Partners (Region 4)*

Care Management Program Record Review		Score
<b>Provision of Care/Case Management Services</b>		
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 type="checkbox"/> Met <input checked="" type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<b>Observations:</b> The care coordinator reported that she had recently followed up with the member to verify that the member received all of the new equipment; however, the contact was not yet documented in the record.		

Results for Care Management Record Review					
<b>Total</b>	Met	=	<u>6</u>	X	1.00 = <u>6</u>
	Substantially Met	=	<u>5</u>	X	.75 = <u>3.75</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>
<b>Total Applicable</b>		=	<u>11</u>	<b>Total Score</b>	= <u>9.75</u>
<b>Total Score ÷ Total Applicable</b>					= <u>89%</u>



*Appendix B. Colorado Department of Health Care Policy and Financing*  
**FY 2012–2013 Record Review Tool**  
*for Integrated Community Health Partners (Region 4)*

Sample Number: W\*\*\*\*\* (5)

Reviewer: Katherine Bartilotta

Care Management Program Record Review		Score
<b>Identification</b>		
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	
<b>Observations:</b> The member had been a long-term client of the PCMP clinic but had been out of the system for some time. Upon re-engagement, a physical assessment update by the PCP identified that the member was depressed and wished to lose weight. The member was referred to the clinic’s health coach to manage the member’s weight loss goal.		
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	
<b>Observations:</b> The member was assigned to the health coach as the care coordinator, as the member did not have intensive care coordination needs.		



*Appendix B. Colorado Department of Health Care Policy and Financing*  
**FY 2012–2013 Record Review Tool**  
*for Integrated Community Health Partners (Region 4)*

Care Management Program Record Review		Score
<b>Assessment</b>		
<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 type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p><b>Observations:</b></p> <p>The record included an assessment. The member was a long-time resident of the community, and since the member was known to the PCMP clinic, a specific assessment or documentation of other agencies that may have served the member was not considered necessary.</p>		
<p>2. Did the assessment address the member’s:</p> <ul style="list-style-type: none"> <li>◆ Health status?</li> <li>◆ Health behavior/risks?</li> <li>◆ Medical and non-medical needs?</li> </ul> <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><b>Observations:</b></p> <p>The Hospital Admission Risk Multiplier Screen (HARMS-8) assessment and Patient Health Questionnaire Depression Assessment (PHQ-9) were administered to the member. Both assessments were negative for risks that required intensive care coordination, although the member specified the self-management goal of weight loss and was referred to the health coach.</p>		



*Appendix B. Colorado Department of Health Care Policy and Financing*  
**FY 2012–2013 Record Review Tool**  
*for Integrated Community Health Partners (Region 4)*

Care Management Program Record Review		Score
<b>Development of a Care Treatment Plan</b>		
<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><b>Observations:</b></p> <p>The health coach developed a plan for the member’s self-management goal of weight loss. The health coach provided weight management education and referred the member to community resources to assist in weight loss. The plan and interventions were documented in the clinic EHR.</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><b>Observations:</b></p> <p>The health coach referred the member to the local Get Lean program and a local program that assists members with health club memberships.</p>		



*Appendix B. Colorado Department of Health Care Policy and Financing*  
**FY 2012–2013 Record Review Tool**  
*for Integrated Community Health Partners (Region 4)*

Care Management Program Record Review		Score
<b>Development of a Care Treatment Plan</b>		
<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 type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p><b>Observations:</b></p> <p>The assessment did not have specific questions regarding culture, beliefs, or values systems. Care management staff for this particular PCMP reported that assessments do not routinely evaluate the member’s culture, beliefs, or 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 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><b>Observations:</b></p> <p>The health coach discussed the member-specific barriers to weight loss with the member. No regional barriers to weight loss were identified.</p>		



*Appendix B. Colorado Department of Health Care Policy and Financing*  
**FY 2012–2013 Record Review Tool**  
*for Integrated Community Health Partners (Region 4)*

Care Management Program Record Review		Score
<b>Provision of Care/Case Management Services</b>		
<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><b>Observations:</b>            The member was actively engaged in identifying weight loss concerns and establishing the self-management goal of weight loss.</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"> <li>◆ Complex behavioral or physical health needs</li> <li>◆ The member has physical or developmental disabilities</li> <li>◆ The member is a child or foster child</li> <li>◆ The member is an adult or is aged</li> <li>◆ The member is non-English-speaking</li> <li>◆ The member was in need of assistance with medical transitions</li> </ul> <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><b>Observations:</b>            The member did not have needs associated with any of the specified special needs groups.</p>		



*Appendix B. Colorado Department of Health Care Policy and Financing  
 FY 2012–2013 Record Review Tool  
 for Integrated Community Health Partners (Region 4)*

Care Management Program Record Review		Score
<b>Provision of Care/Case Management Services</b>		
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              Region 2: Exhibit A—6.4.5.1.6              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	
<b>Observations:</b> The health coach followed up with the member many times to track the member’s progress toward the defined goal of the plan.		

Results for Care Management Record Review					
<b>Total</b>	Met	=	<u>7</u>	X	1.00 = <u>7</u>
	Substantially Met	=	<u>0</u>	X	.75 = <u>0</u>
	Partially Met	=	<u>1</u>	X	.50 = <u>.5</u>
	Not Met	=	<u>1</u>	X	0.0 = <u>0</u>
	Not Applicable	=	<u>2</u>	X	NA = <u>NA</u>
<b>Total Applicable</b>		=	<u>9</u>	<b>Total Score</b>	= <u>7.5</u>

<b>Total Score ÷ Total Applicable</b>		=	<u>83%</u>
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*Appendix B. Colorado Department of Health Care Policy and Financing*  
**FY 2012–2013 Record Review Tool**  
*for Integrated Community Health Partners (Region 4)*

Sample Number: J\*\*\*\*\* (6)

Reviewer: Barbara McConnell

Care Management Program Record Review		Score
<b>Identification</b>		
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	
<b>Observations:</b> Care management received a call from the ER after the member presented to the ER as suicidal. A crisis mental health evaluation was performed and the crisis therapist referred the member to care coordination.		
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	
<b>Observations:</b> The care coordinator initially introduced herself to the member. The member dropped out of mental health services briefly. The care coordinator called to assist the member in re-engaging in treatment. The member did return to treatment.		



*Appendix B. Colorado Department of Health Care Policy and Financing*  
**FY 2012–2013 Record Review Tool**  
*for Integrated Community Health Partners (Region 4)*

Care Management Program Record Review		Score
<b>Assessment</b>		
<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 type="checkbox"/> Met <input checked="" type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p><b>Observations:</b>            There was no comprehensive care coordination assessment, although the care coordinator used the information from the mental health assessment.</p>		
<p>2. Did the assessment address the member’s:</p> <ul style="list-style-type: none"> <li>◆ Health status?</li> <li>◆ Health behavior/risks?</li> <li>◆ Medical and non-medical needs?</li> </ul> <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 type="checkbox"/> Met <input checked="" type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p><b>Observations:</b>            The assessment present in the record was a mental health crisis evaluation completed in the ER and did not evaluate longer-term needs or more global health issues.</p>		



*Appendix B. Colorado Department of Health Care Policy and Financing*  
**FY 2012–2013 Record Review Tool**  
*for Integrated Community Health Partners (Region 4)*

Care Management Program Record Review		Score
<b>Development of a Care Treatment Plan</b>		
<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 type="checkbox"/> Met <input checked="" type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p><b>Observations:</b></p> <p>The PCMP organization was using an EHR, which had a section for goal statements and plan statements within each contact note. The plan statements were focused and short-term, rather than an overall comprehensive plan of care.</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><b>Observations:</b></p> <p>The focus for care coordination for this member was to re-engage the member in therapy. The member was referred to a psychiatrist for a medication evaluation. Other needs had not yet been assessed.</p>		



*Appendix B. Colorado Department of Health Care Policy and Financing*  
**FY 2012–2013 Record Review Tool**  
*for Integrated Community Health Partners (Region 4)*

Care Management Program Record Review		Score
<b>Development of a Care Treatment Plan</b>		
<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><b>Observations:</b></p> <p>The record demonstrated that cultural, family, and linguistic history had been assessed. While there were no specific interventions required at that time, the care coordinator indicated plans for future exploration into family dynamics of alcoholism and the member’s defensiveness about his small stature (a family trait).</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><b>Observations:</b></p> <p>Transportation was a problem for this member. The member was given bus tokens. Care coordination staff reported that the transit system had indicated that the bus stop in front of the PCMP’s office was going to be removed. The staff went to the city and deterred this action.</p>		



*Appendix B. Colorado Department of Health Care Policy and Financing*  
**FY 2012–2013 Record Review Tool**  
*for Integrated Community Health Partners (Region 4)*

Care Management Program Record Review		Score
<b>Provision of Care/Case Management Services</b>		
<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><b>Observations:</b>            The member was responsive to the care coordinator when she contacted him to assist in re-engaging in treatment.</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"> <li>◆ Complex behavioral or physical health needs</li> <li>◆ The member has physical or developmental disabilities</li> <li>◆ The member is a child or foster child</li> <li>◆ The member is an adult or is aged</li> <li>◆ The member is non-English-speaking</li> <li>◆ The member was in need of assistance with medical transitions</li> </ul> <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><b>Observations:</b>            The member had substance abuse issues as well as bipolar disorder. The member declined a referral for substance abuse treatment; therefore, the care coordinator and therapist are working on a plan to provide only mental health services. The crisis assessment at the ER identified the member as appropriate for inpatient treatment for suicidal behavior and thoughts. Following the hospitalization, the member was scheduled for a follow-up appointment, which he missed. The care coordinator then contacted the member and assisted with reconnecting him with therapy.</p>		



*Appendix B. Colorado Department of Health Care Policy and Financing  
 FY 2012–2013 Record Review Tool  
 for Integrated Community Health Partners (Region 4)*

Care Management Program Record Review		Score
<b>Provision of Care/Case Management Services</b>		
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              Region 2: Exhibit A—6.4.5.1.6              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	
<b>Observations:</b> The record indicated monthly follow-up telephone calls with the member.		

Results for Care Management Record Review					
<b>Total</b>	Met	=	<u>8</u>	X	1.00 = <u>8</u>
	Substantially Met	=	<u>3</u>	X	.75 = <u>2.25</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>
<b>Total Applicable</b>		=	<u>11</u>	<b>Total Score</b>	= <u>10.25</u>

<b>Total Score ÷ Total Applicable</b>		=	<u>93%</u>
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*Appendix B. Colorado Department of Health Care Policy and Financing  
 FY 2012–2013 Record Review Tool  
 for Integrated Community Health Partners (Region 4)*

Sample Number: R\*\*\*\*\* (7)

Reviewer: Katherine Bartilotta

Care Management Program Record Review		Score
<b>Identification</b>		
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	
<b>Observations:</b> The member was identified as a Tier 4 risk level due to multiple ER visits.		
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            Regions 2, 3, 4, 5: Exhibit A—6.4.3            (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	
<b>Observations:</b> The member record demonstrated that the member was assigned to a care coordinator, who met with the member face-to-face.		



*Appendix B. Colorado Department of Health Care Policy and Financing  
 FY 2012–2013 Record Review Tool  
 for Integrated Community Health Partners (Region 4)*

Care Management Program Record Review		Score
<b>Assessment</b>		
<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            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><b>Observations:</b>            The member had recently moved to the community and was a new PCMP member. The PCMP conducted a thorough assessment of needs on intake to the clinic.</p>		
<p>2. Did the assessment address the member’s:</p> <ul style="list-style-type: none"> <li>◆ Health status?</li> <li>◆ Health behavior/risks?</li> <li>◆ Medical and non-medical needs?</li> </ul> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1            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><b>Observations:</b>            A Hospital Admission Risk Multiplier Screen (HARMS-8) Assessment was conducted on the member during the initial intake interview with the member. (HARMS-8 assesses the member’s physical, behavioral, and non-medical/social needs.) The assessment identified that the member was obtaining ER services for stress-related complaints resulting from the family dynamics surrounding a recent divorce and her son’s related psychosocial needs. (The children are not Medicaid members.)</p>		



*Appendix B. Colorado Department of Health Care Policy and Financing*  
**FY 2012–2013 Record Review Tool**  
*for Integrated Community Health Partners (Region 4)*

Care Management Program Record Review		Score
<b>Development of a Care Treatment Plan</b>		
<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><b>Observations:</b></p> <p>The member was advised concerning alternatives to using the ER for care needs, and the member was enrolled with the PCMP. The care coordinator referred the member to the local mental health clinic for services. The care coordinator also provided the member resources related to her son’s needs to assist in alleviating some of the member’s stress related to her son’s issues. The care plan and actions taken were documented in the EHR.</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><b>Observations:</b></p> <p>The member was linked to the PCMP and referred to the local mental health clinic. The care coordinator provided information regarding online school resources for the member’s son.</p>		



*Appendix B. Colorado Department of Health Care Policy and Financing*  
**FY 2012–2013 Record Review Tool**  
*for Integrated Community Health Partners (Region 4)*

Care Management Program Record Review		Score
<b>Development of a Care Treatment Plan</b>		
<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><b>Observations:</b></p> <p>The member was a middle-aged white female who speaks English. The member indicated she has strong religious beliefs, and since she is a member of a church, she needed no specific intervention from care coordination related to her religious needs. The member stated she was very confident about handling all medical needs and desired minimal intervention by the care coordinator.</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><b>Observations:</b></p> <p>There were no barriers to the member’s health identified in the Contractor’s region. All services assessed as required to meet the member’s needs were available in the region, including mental health services and access to after-hours care at the PCMP. The primary barrier to the care coordination plan was the difficulty engaging the member in implementing the referrals provided by the care coordinator.</p>		



*Appendix B. Colorado Department of Health Care Policy and Financing*  
**FY 2012–2013 Record Review Tool**  
*for Integrated Community Health Partners (Region 4)*

Care Management Program Record Review		Score
<b>Provision of Care/Case Management Services</b>		
<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><b>Observations:</b>            The member participated in a face-to-face assessment and suggested plan of care with the care coordinator. Staff stated that the member did not formally acknowledge agreement with the plan of care.</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"> <li>◆ Complex behavioral or physical health needs</li> <li>◆ The member has physical or developmental disabilities</li> <li>◆ The member is a child or foster child</li> <li>◆ The member is an adult or is aged</li> <li>◆ The member is non-English-speaking</li> <li>◆ The member was in need of assistance with medical transitions</li> </ul> <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><b>Observations:</b>            The member did not have needs aligned with any of the defined special needs groups.</p>		



*Appendix B. Colorado Department of Health Care Policy and Financing*  
**FY 2012–2013 Record Review Tool**  
*for Integrated Community Health Partners (Region 4)*

Care Management Program Record Review		Score
<b>Provision of Care/Case Management Services</b>		
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 type="checkbox"/> Met <input checked="" type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<b>Observations:</b> The member did not respond to follow-up calls despite multiple attempts by the care coordinator; when finally contacted, the member made it apparent that she was capable of handling her own medical and family needs and resisted the care coordinator’s offers of assistance. The care coordinator “overlooked” making contact with the mental health clinic to determine whether the member had followed up with the referral to mental health services, although staff stated that follow-up was a routine part of the care coordination process for most members.		

Results for Care Management Record Review					
<b>Total</b>	Met	=	<u>9</u>	X	1.00 = <u>9</u>
	Substantially Met	=	<u>1</u>	X	.75 = <u>.75</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>
<b>Total Applicable</b>		=	<u>10</u>	<b>Total Score</b>	= <u>9.75</u>
<b>Total Score ÷ Total Applicable</b>				=	<u>98%</u>



*Appendix B. Colorado Department of Health Care Policy and Financing*  
**FY 2012–2013 Record Review Tool**  
*for Integrated Community Health Partners (Region 4)*

Sample Number: M\*\*\*\*\* (8)

Reviewer: Barbara McConnell

Care Management Program Record Review		Score
<b>Identification</b>		
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	
<b>Observations:</b> The member was referred to care coordination by the PCP following multiple ER visits. This was a chronic pain patient that had numerous ER visits to obtain pain medication. The physician placed the member on an emergency department (ED) pain treatment plan, which means that the ERs are to send the member to the PCP to obtain medications.		
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	
<b>Observations:</b> The record indicated that the care coordinator had met with the member initially, but that subsequently the member refused to work with the care coordinator, as she was upset about the ED pain treatment plan.		



*Appendix B. Colorado Department of Health Care Policy and Financing*  
**FY 2012–2013 Record Review Tool**  
*for Integrated Community Health Partners (Region 4)*

Care Management Program Record Review		Score
<b>Assessment</b>		
<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><b>Observations:</b>            The care coordinator met with the member once following a PCP appointment and spoke with the member on the telephone; however, the member declined to engage in care coordination activities, and the care coordinator was unable to adequately assess the member’s needs. The care coordinator offered to assist the member with transferring to another PCMP, which she refused. The member was subsequently discharged from the PCMP organization due to dangerous and abusive behavior toward the PCP and the office staff.</p>		
<p>2. Did the assessment address the member’s:</p> <ul style="list-style-type: none"> <li>◆ Health status?</li> <li>◆ Health behavior/risks?</li> <li>◆ Medical and non-medical needs?</li> </ul> <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 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><b>Observations:</b>            Not applicable. An assessment was not completed.</p>		



*Appendix B. Colorado Department of Health Care Policy and Financing  
 FY 2012–2013 Record Review Tool  
 for Integrated Community Health Partners (Region 4)*

Care Management Program Record Review		Score
<b>Development of a Care Treatment Plan</b>		
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            Regions 2, 3, 5: Exhibit A—6.4.5.1.1</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	
<b>Observations:</b> The member was not compliant with assessment and care coordination activities; therefore, a care plan could not be developed.		
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            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	
<b>Observations:</b> The care coordinator referred the member to a gynecologist and offered to refer the member to a different PCMP organization. The member did not attend appointments.		



*Appendix B. Colorado Department of Health Care Policy and Financing  
 FY 2012–2013 Record Review Tool  
 for Integrated Community Health Partners (Region 4)*

Care Management Program Record Review		Score
<b>Development of a Care Treatment Plan</b>		
3. Do the care plan interventions reflect the member’s cultural and/or linguistic needs, beliefs, and values?  <div 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> </div>	<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	
<b>Observations:</b> Not applicable. Without an assessment, the care coordinator was unable to develop a care plan.		
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?  <div 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> </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	
<b>Observations:</b> The care coordinator was able to ascertain that the member had a husband who was able to transport her to services, but the care coordinator was unable to fully assess the member’s needs.		



*Appendix B. Colorado Department of Health Care Policy and Financing*  
**FY 2012–2013 Record Review Tool**  
*for Integrated Community Health Partners (Region 4)*

Care Management Program Record Review		Score
<b>Provision of Care/Case Management Services</b>		
<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><b>Observations:</b>            The care coordinator made several attempts to engage the member in care coordination activities; however, the member declined.</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"> <li>◆ Complex behavioral or physical health needs</li> <li>◆ The member has physical or developmental disabilities</li> <li>◆ The member is a child or foster child</li> <li>◆ The member is an adult or is aged</li> <li>◆ The member is non-English-speaking</li> <li>◆ The member was in need of assistance with medical transitions</li> </ul> <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><b>Observations:</b>            Following ER visits, the care coordinator attempted to engage the member in care coordination activities and schedule PCP appointments; however, the member declined.</p>		



*Appendix B. Colorado Department of Health Care Policy and Financing  
 FY 2012–2013 Record Review Tool  
 for Integrated Community Health Partners (Region 4)*

Care Management Program Record Review		Score
<b>Provision of Care/Case Management Services</b>		
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              Region 2: Exhibit A—6.4.5.1.6              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	
<b>Observations:</b> Several attempts were made.		

Results for Care Management Record Review					
<b>Total</b>	Met	=	<u>8</u>	X	1.00 = <u>8</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>3</u>	X	NA = <u>NA</u>
<b>Total Applicable</b>		=	<u>8</u>	<b>Total Score</b>	= <u>8</u>

<b>Total Score ÷ Total Applicable</b>		=	<u>100%</u>
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*Appendix B. Colorado Department of Health Care Policy and Financing*  
**FY 2012–2013 Record Review Tool**  
*for Integrated Community Health Partners (Region 4)*

Sample Number: N\*\*\*\*\* (9)

Reviewer: Katherine Bartilotta

Care Management Program Record Review		Score
<b>Identification</b>		
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	
<b>Observations:</b> The member was a well-known patient of the PCMP clinic prior to ICHP membership. The member had very complex medical and psychosocial needs and risky behaviors associated with substance abuse and violence. The member had a history of multiple arrests over her adult life and has been in and out of the Medicaid system. The member had multiple ER visits for medical needs and seeking pain medication. The PCP referred the member to ICHP care coordination.		
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	
<b>Observations:</b> The member was previously being managed and her care coordinated by the PCMP. The PCP referred the member to care coordination, but the member was incarcerated before she could be formally assigned to a care coordinator.		



*Appendix B. Colorado Department of Health Care Policy and Financing*  
**FY 2012–2013 Record Review Tool**  
*for Integrated Community Health Partners (Region 4)*

Care Management Program Record Review		Score
<b>Assessment</b>		
<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><b>Observations:</b></p> <p>Prior to referral to care coordination, the member had established a pain contract with the PCMP to control drug-seeking behavior. The member was periodically receiving counseling and care through the corrections system and various mental health clinics. The PCMP had involved the member’s probation officers in the care coordination plan, as appropriate, over the years.</p>		
<p>2. Did the assessment address the member’s:</p> <ul style="list-style-type: none"> <li>◆ Health status?</li> <li>◆ Health behavior/risks?</li> <li>◆ Medical and non-medical needs?</li> </ul> <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><b>Observations:</b></p> <p>The member’s ER visits were routinely monitored and entered into the electronic health record (EHR), which provided assessment of the member’s medical and psychosocial health status and risks. The member also had multiple PCMP visits. The member’s health record included a detailed assessment of multiple health needs and care management approaches. The Hospital Admission Risk Multiplier Screen (HARMS-8) assessment was not performed due to the member’s frequent exits and re-entries into the Medicaid system. The Patient Health Questionnaire Assessment (PHQ-9) was administered and indicated a possible suicidal risk. The PCMP referred the member to mental health services.</p>		



*Appendix B. Colorado Department of Health Care Policy and Financing*  
**FY 2012–2013 Record Review Tool**  
*for Integrated Community Health Partners (Region 4)*

Care Management Program Record Review		Score
<b>Development of a Care Treatment Plan</b>		
<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><b>Observations:</b></p> <p>The care plan included a previously defined pain management contract that required the member to have appointments and assessments with the PCMP rather than seeking care/medication through the ER. The care plan included multiple physical and mental health appointments and evaluations for the member in response to the most recent assessment of medical and behavioral health needs.</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><b>Observations:</b></p> <p>Care coordinators scheduled and were coordinating multiple physical and mental health appointments and evaluations for the member in response to assessed medical and behavioral health needs. A psychiatric consultation was completed and written reports were communicated between the PCMP and mental health provider. The local ER coordinated with the PCMP regarding the member’s pain contract. Local law enforcement was integrated into the plan, as appropriate.</p>		



*Appendix B. Colorado Department of Health Care Policy and Financing*  
**FY 2012–2013 Record Review Tool**  
*for Integrated Community Health Partners (Region 4)*

Care Management Program Record Review		Score
<b>Development of a Care Treatment Plan</b>		
<p>3. Do the care plan interventions reflect the member’s cultural and/or linguistic needs, beliefs, and values?</p> <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 type="checkbox"/> Met <input checked="" type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p><b>Observations:</b>            The member was a white, middle-aged, English-speaking female with a long-term history with the PCMP clinic and a well-known history of substance abuse, domestic violence, and law enforcement encounters. Cultural needs were not considered applicable for specific assessment. The assessment did not have specific questions regarding culture, beliefs, or values systems. Care management staff for this particular PCMP reported that assessments do not routinely evaluate the member’s culture, beliefs, or 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="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 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><b>Observations:</b>            The member’s history of being in and out of the corrections system (and, therefore, in and out of the Medicaid system), provide frequent interruptions to consistent care coordination. The member was incarcerated again prior to the implementation of the ICHP care coordination plan.</p>		



*Appendix B. Colorado Department of Health Care Policy and Financing*  
**FY 2012–2013 Record Review Tool**  
*for Integrated Community Health Partners (Region 4)*

Care Management Program Record Review		Score
<b>Provision of Care/Case Management Services</b>		
<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><b>Observations:</b>            The member was an active participant in the development of the care plan and had made several medical and mental health appointments.</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"> <li>◆ Complex behavioral or physical health needs</li> <li>◆ The member has physical or developmental disabilities</li> <li>◆ The member is a child or foster child</li> <li>◆ The member is an adult or is aged</li> <li>◆ The member is non-English-speaking</li> <li>◆ The member was in need of assistance with medical transitions</li> </ul> <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><b>Observations:</b>            The member had very complex behavioral and medical needs, and multiple medical and psychiatric appoints had been arranged to address the member’s assessed needs. The member’s multiple physical and behavioral needs had been managed through the PCMP over many years. The member’s legal issues resulted in many interruptions to consistent care management, and multiple agencies and care providers were engaged in managing the member’s needs. The PCMP was unable to fully implement the most current care coordination plan due to member incarceration and exit from the Medicaid system.</p>		



*Appendix B. Colorado Department of Health Care Policy and Financing*  
**FY 2012–2013 Record Review Tool**  
*for Integrated Community Health Partners (Region 4)*

Care Management Program Record Review		Score
<b>Provision of Care/Case Management Services</b>		
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	
<b>Observations:</b> The care coordinators made multiple attempts to follow up with the member. However, the member was arrested prior to implementation of the plan of care and is no longer Medicaid-eligible.		

Results for Care Management Record Review					
<b>Total</b>	Met	=	<u>10</u>	X	1.00 = <u>10</u>
	Substantially Met	=	<u>1</u>	X	.75 = <u>.75</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>
<b>Total Applicable</b>		=	<u>11</u>	<b>Total Score</b>	= <u>10.75</u>
<b>Total Score ÷ Total Applicable</b>				=	<u>98%</u>



*Appendix B. Colorado Department of Health Care Policy and Financing*  
**FY 2012–2013 Record Review Tool**  
*for Integrated Community Health Partners (Region 4)*

Sample Number: F\*\*\*\*\* (13)

Reviewer: Katherine Bartilotta

Care Management Program Record Review		Score
<b>Identification</b>		
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	
<b>Observations:</b> The member was identified through data indicating multiple emergency room visits and by the PCP referral to care coordination for acute and chronic medical conditions, substance abuse, and noncompliance with recommended appointments for care.		
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	
<b>Observations:</b> The member record demonstrated that the member was assigned to the care coordinator at the local clinic.		



*Appendix B. Colorado Department of Health Care Policy and Financing*  
**FY 2012–2013 Record Review Tool**  
*for Integrated Community Health Partners (Region 4)*

Care Management Program Record Review		Score
<b>Assessment</b>		
<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><b>Observations:</b></p> <p>The assigned care coordinator communicated with the substance abuse/mental health counselor at the clinic. The member record also incorporated the comprehensive home-based assessment and plan conducted by the PCP and a home health care agency assessment and plan.</p>		
<p>2. Did the assessment address the member’s:</p> <ul style="list-style-type: none"> <li>◆ Health status?</li> <li>◆ Health behavior/risks?</li> <li>◆ Medical and non-medical needs?</li> </ul> <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><b>Observations:</b></p> <p>The PCP’s member assessment was detailed and addressed the member’s medical status, health behaviors, and medical and nonmedical needs. The care coordinator also administered a Hospital Admission Risk Multiplier Screen (HARMS-8) assessment and Patient Health Questionnaire Depression Assessment (PHQ-9). The assessments identified the member as having current serious medical and nutrition problems, several risky health behaviors, and nonmedical needs such as transportation and assistance with mobility and daily home services.</p>		



*Appendix B. Colorado Department of Health Care Policy and Financing*  
**FY 2012–2013 Record Review Tool**  
*for Integrated Community Health Partners (Region 4)*

Care Management Program Record Review		Score
<b>Development of a Care Treatment Plan</b>		
<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><b>Observations:</b></p> <p>The electronic health record (EHR) included a detailed plan by the PCP, which addressed each of the member’s identified physical and social support needs. The record also identified needs for multiple referrals for medical assessment and social 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><b>Observations:</b></p> <p>The PCMP and the care coordinator arranged for required medical appointments, transportation, referrals to community providers including social service agencies and home care services, and for the care coordinator to accompany the member to appointments.</p>		



*Appendix B. Colorado Department of Health Care Policy and Financing*  
**FY 2012–2013 Record Review Tool**  
*for Integrated Community Health Partners (Region 4)*

Care Management Program Record Review		Score
<b>Development of a Care Treatment Plan</b>		
<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 type="checkbox"/> Met <input type="checkbox"/> Substantially Met <input type="checkbox"/> Partially Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p><b>Observations:</b></p> <p>The member was a white, middle-aged, English-speaking female with a long-term history with the clinic. The assessment did not have specific questions regarding culture, beliefs, or values systems. Care management staff for this particular PCMP reported that assessments do not routinely evaluate the member’s culture, beliefs, or 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><b>Observations:</b></p> <p>The primary barrier to the member’s health was noncompliance with arranged appointments and interventions, the member’s weakened physical condition, and lack of family supports. These needs were actively addressed by the care team including a home-based assessment by the PCMP and the care coordinator accompanying the member from home to specific services.</p>		



*Appendix B. Colorado Department of Health Care Policy and Financing*  
**FY 2012–2013 Record Review Tool**  
*for Integrated Community Health Partners (Region 4)*

Care Management Program Record Review		Score
<b>Provision of Care/Case Management Services</b>		
<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><b>Observations:</b>            The member actively participated in the assessment and plan but provided unreliable assessment information and identified only limited concerns and goals for improvement. Despite active referrals and interventions by the care coordinator and multiple attempts to get the member to engage in health care services, the member was repeatedly unwilling to follow through with appointments and avoided contact with the care coordinator.</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"> <li>◆ Complex behavioral or physical health needs</li> <li>◆ The member has physical or developmental disabilities</li> <li>◆ The member is a child or foster child</li> <li>◆ The member is an adult or is aged</li> <li>◆ The member is non-English-speaking</li> <li>◆ The member was in need of assistance with medical transitions</li> </ul> <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><b>Observations:</b>            The plan of care addressed the complex behavioral and physical needs of the member, but the plan was not successfully implemented due to member noncompliance.</p>		



*Appendix B. Colorado Department of Health Care Policy and Financing  
 FY 2012–2013 Record Review Tool  
 for Integrated Community Health Partners (Region 4)*

Care Management Program Record Review		Score
<b>Provision of Care/Case Management Services</b>		
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	
<b>Observations:</b> The care coordinator and other members of the health care team (the health coach) conducted multiple outreach attempts and made multiple repeated attempts to get the member into the system for care, including making personal visits to the member’s home. However, the member repeatedly avoided contact and did not follow through with agreed-upon plans and appointments.		

Results for Care Management Record Review					
<b>Total</b>	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>1</u>	X	0.0 = <u>0</u>
	Not Applicable	=	<u>0</u>	X	NA = <u>NA</u>
<b>Total Applicable</b>		=	<u>11</u>	<b>Total Score</b>	= <u>10</u>

<b>Total Score ÷ Total Applicable</b>		=	<u>91%</u>
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