

Colorado
Accountable Care Collaborative

FY 2013–2014 SITE REVIEW REPORT
for
**Community Health Partnership
(Region 7)**

June 2014

– Draft Copy for Review –

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



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Introduction

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. **Community Health Partnership (CHP)** began operations as a RCCO in July 2011.

The Department has asked Health Services Advisory Group, Inc. (HSAG), an external quality review organization, to perform annual site reviews to monitor the progress of each RCCO's development and progress in implementing key features of the ACC Program. This report documents results of the FY 2013–2014 site review activities for the review period of January 1, 2013, through December 31, 2013. This section contains summaries of the findings as evidence of compliance, activities, and progress based on on-site discussions, and HSAG's observations and recommendations related to each of the focus areas reviewed this year. Section 2 provides an overview of the monitoring activities and describes the site review methodology used for the 2013–2014 site reviews. Appendix A contains the completed on-site data collection tool. Appendix B contains detailed findings for the care coordination record reviews. Appendix C contains the detailed results of the provider network capacity analysis. Appendix D lists HSAG, RCCO, and Department personnel who participated in some way in the site review process.

Summary of Results

HSAG assigned each requirement in the Provider Support section of the data collection tool a score of *Met*, *Partially Met*, or *Not Met*. HSAG also described findings for each requirement and identified opportunities for improvement with associated recommendations for requirements that were assigned a score of *Partially Met* or *Not Met*. Table 1-1 presents the scores for **CHP** for Provider Support contract requirements. A summary of the findings and recommendations is included in this section. For the Provider Network Development and Care Coordination focus areas, observations and results of on-site discussions based on document review and on-site focused interviews were not scored; however, they were captured on the data collection tool and summarized in this section.

Focus Area	Total Elements	Total Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score*
Provider Support	7	7	0	0	0	0	100%

*The overall percentages were obtained by adding the number of elements that received a score of *Met*, then dividing this total by the total number of applicable elements. *Partially Met* and *Not Met* scores received a 0.0 point value.

For the care coordination record reviews, HSAG assigned each requirement in the record review tools a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*. HSAG also identified opportunities for improvement with associated recommendations for each record. Table 1-2 presents the scores for **CHP**'s care coordination record reviews. Detailed findings for the record reviews are in Appendix B—Record Review Tools.

Description of Record Review	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
Care Coordination	204	175	171	4	0	29	98%

*The overall percentages were obtained by adding the number of elements that received a score of *Met*, then dividing this total by the total number of applicable elements. *Partially Met* and *Not Met* scores received a 0.0 point value.

Summary of Findings and Recommendations by Focus Area

Provider Support

Findings

Best Practice committee meeting minutes demonstrated system-level problem solving with representation from primary care medical providers (PCMPs), federally qualified health centers (FQHCs), and the RCCO leadership. The Best Practice Newsletter contained information about the RCCO, the ACC program in general, information on pertinent topics such as reducing no-shows, and links to national Web sites for additional information. **CHP** designed practice support activities to support providers in furnishing integrated care within a framework of the MacColl Chronic Care Model. Provider support activities were provider/practice-specific based on whether the practice was a delegate that performed care coordination or a PCMP desiring to provide a medical home but with no capacity to provide care coordination. **CHP**, as an organization comprised of numerous community partners, used a committee structure to provide support to the partners, problem-solve common issues affecting PCMPs, and further the RCCO's organizational goals. Committees that explored and problem-solved systems issues and organizational planning included:

- ◆ Care Coordination Committee
- ◆ Best Practices Committee
- ◆ Emergency Room (ER) Usage Committee (comprised of staff from area hospital ERs)

- ◆ Community Leadership Committee (comprised of leadership from the RCCO and community partners such as the partner FQHC and the area’s community mental health center [CMHC])
- ◆ Advisory Committee
- ◆ The Board of Directors

Activities and Progress

During the review period, **CHP** developed a structured “onboarding” process which includes five or six meetings with the provider and office staff to complete assessments and trainings, depending on the skill and interest level of the PCMP. The purpose of onboarding meetings is to bring the provider on board as a PCMP. Internal **CHP** staff who conduct onboarding activities include a practice support staff person with billing and administrative experience who can demonstrate to the provider and office staff how adoption of particular processes may improve efficiency or effectiveness within the office procedures and nurses with clinical and care coordination experience who can assist practices with members who have complex needs, provide care coordination mentoring, and assist with understanding the State Data Analytics Contractor (SDAC) data. Onboarding activities and training consist of the following, as needed:

- ◆ General education such as information about the RCCO or the partnership with AspenPointe (a CMHC), facts about the ACC program and medical home principles, and motivational interviewing.
- ◆ Education regarding opportunities for embedding or colocating behavioral health staff members within the medical practice.
- ◆ Helping providers understand the attribution process (materials include a written attribution guide for distribution).
- ◆ Care coordination mentoring.
- ◆ Clinic optimization such as providing specific forms and protocols for clinical or administrative processes.

Following the onboarding sessions, interested PCMPs may choose to participate in practice transformation activities conducted by HealthTeamWorks (HTW).

Significant progress was made over the past year in the Community Care (**CHP**’s product line name for the RCCO) Web site design. The Web site was easy to navigate and contained comprehensive tools and information for both members and providers.

Summary of Provider Support Tools

Clinical care guidelines included those for substance use, antibiotic use, asthma, cardiovascular disorders, COPD, contraception, diabetes, obesity, motivational interviewing, and preventive care. Screening tools included screenings for colorectal cancer and depression. During the on-site interview, **CHP** staff members reported that **CHP** staff use the SF-10[®] Health Survey and the SF-12[®] Health Survey for risk assessment. In addition, **CHP** was developing referral guidelines, which may be a creative way to streamline the referral process and encourage specialist participation in Medicaid, given a shortage of specialist providers. Member materials included tips for healthy living, tips for tobacco cessation, facts about obesity, information about how to obtain

behavioral health services, when to seek services at an ER, immunization guidelines, and how to manage diabetes and asthma.

Observations/Recommendations

CHP's processes were well-organized and thoughtful and included individualized support processes for each provider based on a continuum that was specific and responsive to each provider's assessed needs. **CHP** staff members described a variety of approaches to recruiting potential providers. **CHP** staff reported that, as a team, internal **CHP** staff and HealthTeamWorks (HTW) staff, "meet the provider where they are, and go from there." This flexibility in designing practice support activities resulted in consistency in compliance with requirements (all delegate PCMPs using a formal needs assessment) and a skilled provider network that meets the needs of members receiving care coordination, as evidenced by the on-site record review. **CHP**'s approach to practice support also seemed to leverage the somewhat encapsulated Region 7 service area, building strong community relationships, which resulted in PCMPs encouraging primary care providers, specialty providers, and Medicaid members to become involved with the ACC program.

The Community Care Web site was easy to navigate and contained a variety of resources, general information about the ACC program and the RCCO, and offered a link to a provider home page and a member home page with more specific information about the ACC program written to address providers and members, respectively. Each page contained a link to respective newsletters and handbooks.

CHP may want to consider having visit agenda templates and pharmacy standing order templates available on the Web site where other practice support tools are found. **CHP** may also want to consider linking receipt of materials to performance as a medical home as well as responding to specific requests. HSAG recommends that **CHP** evaluate its cultural competency training and consult with its partners to offer more pragmatic cultural competency training for PCMPs not affiliated with the larger primary care organization or the CMHC.

Provider Network Development

Activities and Progress

Over the past year, **CHP** has developed a robust recruitment strategy. **CHP** has been successful in recruiting a PCMP within Elbert County, one of many of the communities in **CHP**'s service area designated as health care professional shortage areas. **CHP** staff members described their strategy of contacting all providers within these areas and, as a result, reported very few providers in the service area unwilling to participate in the ACC program.

Initiatives underway to address increased member population and specifically to address the anticipated addition of expansion populations (i.e., adults without dependent children [AwDC] members and full benefit Medicare-Medicaid enrollee [FBMME] members) are:

- ◆ Beginning plans to work with the Serve, Empower, Transform (SET) clinic, a safety net provider, to development a specialty clinic serving the ex-offender population.

- ◆ Beginning plans to work with AspenPointe (**CHP**'s partner CMHC) to develop a treatment program designed to serve the specific needs of the homeless population.
- ◆ Targeted recruitment of two providers whose practices exclusively serve nursing home residents.
- ◆ Targeted recruitment of providers whose caseloads already include FBMME-eligible members.
- ◆ Recent hiring of an additional care coordination staff member to act as liaison to home health and community-based service agencies.

Other existing resources to support the expansion populations include a specialty health center providing primary care services to developmentally disabled (DD) individuals and an additional PCMP specializing in serving the DD population.

CHP's interim goals have been to build relationships between primary care and specialty providers to streamline referrals to specialty care and to remove barriers to obtaining access to care, particularly specialty care. Another essential component has been building relationships with the ancillary providers and community services that interface with the most vulnerable members of the community (e.g., emergency responders). Programs proven to improve overall community response to member needs are:

- ◆ The Wellness Center at AspenPointe—AspenPointe has developed a wellness center for members. The focus of the center is to provide groups and classes designed to improve life skills. Examples include smoking cessation, coping with divorce, cooking classes, parenting skills, weight management classes, and job skills training. Members may drop in without registering and may continue without interruption in these services even if eligibility changes. Staff reported that these offerings fill a gap and provide essential services to meet the members' immediate needs.
- ◆ Improved data sharing relationship with AspenPointe—Upon finalizing the formal data sharing agreement with AspenPointe, **CHP** partnered with AspenPointe to provide behavioral health expertise and support to **CHP** care coordination staff. AspenPointe staff members have provided trainings and **CHP** care coordinators have attended AspenPointe staffing meetings as needed to coordinate care.
- ◆ CARES Program—Formerly known as “Feet on the Street,” this program pairs medical personnel from the local fire department with hospital-based physicians (as needed) to conduct home visits to frequent emergency department utilizers. The purpose of the home visits may be medication reconciliation following an emergency room visit or hospitalization, safety checks, or to provide the member with alternatives to ER use for non-emergency issues.
- ◆ Development of Specialty Referral Guidelines—**CHP** was developing practice guidelines with PCMP input to provide direction and checklists as a resource for PCMPs to determine when referrals to specialists are warranted and as an assurance to specialist providers that referrals are appropriate.

Summary of Provider Network Capacity Analysis

HSAG used data from the PCMP network spreadsheet provided to the Department by the RCCO to conduct a high-level network analysis. The purpose of the Pivot Table analysis was to provide an accurate representation of the number of providers in each region by eliminating any duplicate

entries. In order for Pivot Table analyses to be performed accurately, the data in the selected sort fields being used to identify duplicate information must be complete and strictly formatted. Empty fields, inconsistent spelling or punctuation, data in the wrong field, etc., will result in inappropriate identification of duplicate fields. A cursory review of **CHP**'s data noted very few instances of inconsistencies or incomplete fields that could influence the accuracy of Pivot Table results. HSAG PivotTable results were similar to **CHP**'s Network Report. Differences in provider counts may be a result of **CHP**'s robust recruitment efforts and varying time periods of the data used.

CHP has developed a strategic plan to understand and address capacity and has enlisted the provider community, conducting community forums to discuss and define capacity. **CHP** surveyed its providers during the review period in an attempt to measure capacity.

Observations/Recommendations

CHP creatively and proactively developed approaches both to measure and to address potential capacity issues. **CHP** began strategically defining and attempting to measure capacity and involving the provider community in both defining and measurement attempts. **CHP** developed approaches to prepare for anticipated population increases due to Medicaid expansion and the FBMME demonstration project. **CHP** expressed a commitment to build relationships within the community (with specialists and community service providers) to positively impact where and how members receive services that impacts their health, whether the services are medical in nature or not. **CHP** also demonstrated a commitment to develop or collaborate with providers, service agencies, and medical facilities to create synergies that improve overall access to care.

Care Coordination

Activities and Progress

CHP had mechanisms to conduct risk assessments whether conducted by **CHP** service center staff or delegate PCMPs. **CHP** staff used the SF-10[®] Health Survey and the SF-12[®] Health Survey as indicated and PCMP providers used a variety of methods; however, it was clear from the on-site record review that PCMPs did consistently conduct risk assessment and identify members appropriate for care coordination services. **CHP** used a color-coding system to prioritize members (who identified themselves as “in poor health”) for performing health risk assessments. **CHP** also prioritized members experiencing transitions and members identified (using SDAC data) as CRG risk levels 4, 5, or 6.

CHP also had effective mechanisms to ensure that each member identified via the risk assessment as “in need of care coordination services”, received a needs assessments, whether conducted by **CHP** or a delegate PCMP.

Specialized care coordination or community-based programs included Complex Care Management, Advanced Illness Care Management, Behavioral Health Care Management for FBMME, the CARES program, chronic pain management, the Non-Emergency Medical Transportation (NEMT) program, TeleCare, the emergency department diversion program, and provider education regarding patient activation and motivational interviewing.

CHP care coordination staff and care coordination staff from delegate PCMPs and community partners meet regularly to discuss complex cases and problem-solve systems issues. In addition, the chart audit process alerts **CHP** to any performance issues with care coordination conducted by delegates. Staff members reported that, being a community with a limited number of hospitals and ERs, **CHP** has collaborated with the hospitals and is able to receive a daily census report

Summary of Record Reviews

The Department selected an original sample of 20 care coordination records using SDAC data to identify cases that appeared to have complex medical or medical/behavioral diagnoses, were high utilizers of services, or were involved in a transition of care. This sample included a cross-section of children. In addition to the sample identified by the Department, each RCCO was asked to identify an oversample of 10 records using its internal risk identification mechanisms and applying the same criteria. While on-site, HSAG determined that numerous records required exclusion from the SDAC sample. HSAG completed a review of 17 of 30 potential records for Region 7, including 7 of the 20 from the original SDAC sample and all 10 oversample records. A summary of the reasons that records were eliminated from the record review sample is included in Appendix B.

The records reviewed represented care coordination conducted at the RCCO and PCMP levels. Cases included members with relatively minor needs to members who required coordination with multiple providers. All records reviewed included a health risk assessment and a comprehensive assessment of needs including medical, non-medical, cultural, and linguistic. The care coordinators' notes indicated good coordination with providers and agencies involved with the member's care. This coordination between care coordinators proved especially helpful in instances where the member was reluctant or unable to communicate with the care coordinators. Good communication between agencies also helped reduce the risk of duplicating services.

HSAG scored 12 contract requirements for each care coordination record. Of the 174 applicable elements reviewed in the 17 records, **CHP** attained an overall score of 98 percent compliance with the care coordination contract requirements. Completed record review tools are located in Appendix B.

Observations/Recommendations

CHP had effective mechanisms for performing risk assessments to determine appropriateness for care coordination and mechanisms for performing comprehensive needs assessments for members identified for care management. The on-site review of care coordination records demonstrated that, in all cases, the member received a comprehensive needs assessment, whether performed by the PCMP delegate or **CHP**.

CHP had numerous mechanisms to involve and leverage a variety of systems of care. Care coordinators (as evidenced by the on-site record review) were cognizant of other systems involved in members' care and effectively contacted and coordinated with those systems.

Overview of Site Review Activities

The 2013–2014 site review represented the third contract year for the ACC Program. The Department asked HSAG to perform a site visit to assess each RCCO’s progress made during the previous year of operations toward implementing the ACC Program. During the initial three years of operations, each RCCO has evolved in operational activities, care coordination efforts, and provider network development in response to continuous collaborative efforts, input from the Department, and ongoing implementation of statewide health care reform strategies. The 2013–2014 site visits were focused on monitoring provider support activities, evaluating the continued development of provider network capacity, and assessing the effectiveness of care coordination processes. HSAG was asked to identify key activities and progress made since the previous site review, and to offer observations and recommendations related to each of the ACC Program focus areas reviewed.

Site Review Methodology

HSAG and the Department met on several occasions to discuss the site review process and finalize the focus areas and methodologies for review. HSAG and the Department collaborated to develop data collection tools that provided the parameters for the RCCO site review process. Initial site review activities included a desk review of documents submitted by **CHP** prior to the site visit. HSAG reviewed key documents, which consisted of program plans, provider support tools, and selected data reports. On-site review activities included a review of care coordination records. In addition, information was gathered during on-site interviews with key **CHP** personnel using a qualitative interview methodology. The qualitative interview process uses open-ended discussions that encourage interviewees to describe their experiences, processes, and perceptions. Qualitative interviewing is useful in analyzing systems issues and associated desired or undesired outcomes. The purpose of the site review was to document compliance with select provider support and care coordination contract requirements, evaluate **CHP**’s progress toward implementation of the ACC model of patient care, explore barriers and opportunities for improvement, and identify activities related to the integration of the Medicaid expansion populations. Data gathered from the desk review of **CHP** documents, as well as interviewer discussion guides, provided the basis for the open-ended discussions essential to the qualitative interview technique.

To evaluate the Provider Support focus area, HSAG reviewed the RCCO’s provider support tools and used the data collection tool to assign scores of *Met*, *Partially Met*, or *Not Met* to this focus area. HSAG included the results, summary information, and recommendations in the Executive Summary of this report. The data collection tool also includes narrative information and recommendations related to the Provider Network Development and Care Coordination focus areas, which were not assigned scores. Results, summary information, and recommendations for these two focus areas are also included in the Executive Summary.

To enhance the evaluation of care coordination processes, HSAG developed a care coordination record review tool with 12 contract-required criteria. HSAG reviewed 17 care coordination records based on a convenience sample of members identified as having complex medical or combined medical and behavioral health needs, children with complex needs, or transition of care needs, who were enrolled in the RCCO during the CY 2013 review period for a continuous period of six months. The Department selected 20 sample cases from the Statewide Data and Analytics Contractor (SDAC) data, and HSAG forwarded the sample list to **CHP** prior to the on-site visit. HSAG provided instructions to **CHP** to select an oversample of 10 additional records from internal data sources using the same criteria. A total of 17 records were selected on-site using a combination of the Department-selected records and the RCCO-selected records.

To enhance the provider network development discussions, HSAG conducted an independent analysis of the **CHP** network using an MS Excel pivot table analysis of the Primary Care Medical Provider (PCMP) network spreadsheet submitted to the Department in February 2014. The objective of the analysis was to evaluate network capacity by eliminating any duplication of individual provider locations in the RCCO network. In addition, HSAG conducted a written survey of each RCCO to identify the types of data that could be collected in the future regarding specialists and community organizations serving the RCCO population. Results of the HSAG provider capacity analysis were provided to **CHP** during the on-site review. Pivot tables are presented in Appendix C, and summary information is provided in the Executive Summary.

Appendix A. **Data Collection Tool**
for **Community Health Partnership (Region 7)**

The completed data collection tool follows this cover page.



Appendix A. Colorado Department of Health Care Policy and Financing
FY 2013–2014 Data Collection Tool
for Community Health Partnership (Region 7)

Provider Support		
Requirement	Desk Review/Discussion Items	Score
<p>1. The Contractor shall act as a liaison between the Department and its other contractors and partners and the providers. The Contractor shall assist providers in resolving barriers and problems related to the Colorado Medicaid systems, including, but not limited to all of the following:</p> <ul style="list-style-type: none"> ◆ Issues relating to Medicaid provider enrollment. ◆ Prior authorization and referral issues. ◆ Member eligibility and coverage policies. ◆ Primary Care Medical Provider (PCMP) designation problems. ◆ PCMP per member per month (PMPM) payments. <p><i>Contract:</i> <i>Exhibit A: 5.1.3</i></p>	<ul style="list-style-type: none"> ◆ Extent of RCCO support for: <ul style="list-style-type: none"> • Provider enrollment. • Authorization and referral issues. • Member eligibility/attribution. • PCMP designation. • PMPM payments. 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met
<p>Findings: CHP submitted materials used for PCMP training and support. Best Practice committee meeting minutes demonstrated system-level problem-solving with representation from PCMPs, FQHCs, and the RCCO leadership. The Best Practice Newsletter contained information about the RCCO, the ACC program in general, and information on pertinent topics such as reducing no-shows, as well as links to national Web sites for additional information. During the on-site discussion, CHP staff members described multiple methods and examples of problem-solving systems issues. Examples included assistance to a provider to problem-solve issues with the provider ID and inability to attribute members to the provider until the provider ID matched the State’s information and helping providers understand per member per month (PMPM) and key performance indicator (KPI) payments. CHP staff members reported that the contracting process between the PCMP and the State has significantly improved; instead of taking an average of 2 to 4 months to complete, it is taking an average of 2 weeks to 2 months. CHP staff members described lessons learned in designating certain qualifying providers as PCMPs. For example, although an OB/GYN provider qualifies as a medical home, thoughtful discussions must occur to ensure the provider’s willingness and capability to provide PCMP services such as well-care and non-OB/GYN-related sick care. After such consideration, CHP did contract with Planned Parenthood as a PCMP. CHP offered the observation that support from the Department in problem-solving issues with provider contracting has significantly improved over the last year in terms of both staff knowledge and responsiveness.</p>		
<p>Observations/Recommendations: CHP’s processes were well-organized and thoughtful with individualized support processes in place for each provider. CHP staff members described a variety of approaches to recruiting providers and potential providers. CHP provides materials and support based on specific and assessed needs. CHP’s approach to practice support also seemed to leverage community relationships to bring community providers together to create synergies that serve to support PCMPs.</p>		



Appendix A. Colorado Department of Health Care Policy and Financing
FY 2013–2014 Data Collection Tool
for Community Health Partnership (Region 7)

Provider Support		
Requirement	Desk Review/Discussion Items	Score
<p>2. The Contractor shall submit a Practice Support Plan, describing its annual activities, for Department review and approval. 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.</p> <p><i>Contract: Exhibit A: 5.2.1</i></p>	<ul style="list-style-type: none"> ◆ Practice Support Plan <ul style="list-style-type: none"> • How implemented • Evaluation of success ◆ Maintaining engagement of the majority of PCMPs ◆ Priority provider support plans (going forward) 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met
<p>Findings:</p> <p>CHP’s practice support plan described support activities designed to achieve an overarching goal of creating a patient-centered medical neighborhood. Support activities included interaction with PCMPs as well as community organizations, public health agencies, and social service agencies. Practice Support activities were designed to support providers in furnishing integrated care within a framework of the MacColl Chronic Care Model. Provider support activities were provider/practice-specific based on whether the practice was a delegate that performed care coordination or a PCMP desiring to provide a medical home but with no capacity to provide care coordination. CHP, as an organization comprised of numerous community partners, used a committee structure to provide support to the partners, problem-solve common issues affecting PCMPs, and further the RCCO’s organizational goals. The Care Coordination Committee included as attendees care coordinators from CHP and from delegate PCMPs and from community organizations that serve CHP members. The committee processed specific cases and examined systems issues impacting the care coordination process. Other committees that explored and problem-solved systems issues and organizational planning included:</p> <ul style="list-style-type: none"> ◆ Best Practices Committee ◆ Emergency Room (ER) Usage Committee (comprised of staff from area hospital ERs) ◆ Community Leadership Committee (comprised of leadership from the RCCO and community partners such as the partner federally qualified health center (FQHC) and the area’s community mental health center (CMHC)) ◆ Advisory Committee ◆ The Board of Directors <p>CHP staff reported that provider support goals for the upcoming fiscal year are:</p> <ol style="list-style-type: none"> 1. Continue to add providers to ensure accommodating the expansion population. 2. Develop and implement training on accessibility issues and cultural competency to accommodate the expansion and full benefit Medicare/Medicaid enrollees (FBMME) populations. 3. Work with practices to improve coding practices (particularly with regards to well-child visits). 		



Appendix A. Colorado Department of Health Care Policy and Financing
FY 2013–2014 Data Collection Tool
for Community Health Partnership (Region 7)

Provider Support		
Requirement	Desk Review/Discussion Items	Score
<p>Observations/Recommendations: CHP’s provider support activities were designed to provide support to providers on a continuum responsive to the needs of each provider. CHP staff reported that, as a team, internal CHP staff and HealthTeamWorks (HTW) staff, “meet the provider where they are, and go from there.” This flexibility in designing practice support activities has resulted in consistency in compliance with requirements (all delegate PCMPs using a formal needs assessment) and a skilled provider network that meets the needs of members receiving care coordination, as evidenced by the on-site record review.</p>		
<p>3. The Contractor shall offer support to PCMPs and providers, which may include comprehensive guidance on practice redesign to providing assistance with practice redesign and performance-enhancing activities.</p> <p><i>Contract:</i> <i>Exhibit A: 5.2.2</i></p>	<ul style="list-style-type: none"> ◆ RCCO activities implemented to assist providers in practice redesign <ul style="list-style-type: none"> • Specific activities • Number of providers • Resources dedicated • Mechanisms used • Monitoring mechanisms ◆ Medical home functions provided through the RCCO ◆ Medical home functions provided by the PCMPs 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met
<p>Findings: CHP staff members described a continuum of practice support activities. CHP staff members reported the organization’s willingness to take any willing provider and work with that provider starting at the skill and sophistication level presented. Staff members described the “onboarding” process to include 5 or 6 meetings with the provider and office staff to complete assessments and trainings, depending on the skill and interest level presented. The purpose of onboarding meetings is to bring the provider on board as a PCMP. Internal CHP staff members who conduct onboarding activities include a practice support staff person with billing and administrative experience and nurses with clinical and care coordination experience. CHP has three care coordination nurses who can assist practices with complex patients and with understanding the State Data and Analytics Contractor (SDAC) data. Meetings with the provider offices may occur with both types of team members (administrative and clinical) or separately, as needed. Early in the process, the goal is to build the relationship, then to show the provider/office staff how adoption of particular processes may improve efficiency or effectiveness within existing office procedures. Additional support is offered through the service center. To streamline referrals, providers may call to obtain assistance with determining which specialists participate with Medicaid. Concurrent with onboarding meetings, if the provider is interested, HTW begins assessing the practice for skill level regarding care coordination and medical home transformation. Following CHP onboarding activities and the initial assessment, HTW proceeds with practice transformation activities appropriate to the provider’s assessed level of skill and interest. Support activities are individualized and may include:</p> <ul style="list-style-type: none"> ◆ General education such as information about the RCCO or the partnership with AspenPointe and facts about the ACC program and medical home principles. ◆ Education regarding opportunities for embedding or colocating behavioral health staff members within the medical practice. ◆ Helping providers understand the attribution process (materials include a written attribution guide for distribution). 		



Appendix A. Colorado Department of Health Care Policy and Financing
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Provider Support		
Requirement	Desk Review/Discussion Items	Score
<ul style="list-style-type: none"> Helping providers understand the SDAC data and the PMPM and KPI payments. Care coordination mentoring. Clinic optimization such as providing specific forms and protocols for clinical or administrative processes, or LEAN training. <p>CHP staff members reported that practices established as PCMPs for a longer period of time need to receive less frequent visits; however, if CHP discovers during monitoring activities and audits that procedures have deteriorated, visits are scheduled for assessing issues and retraining. Staff members observed that approximately 85 percent of attributed members are receiving services from practices that have received or are receiving practice transformation support. Approximately 24 practices are on board as PCMPs and receiving some level of practice support or coaching, either from CHP internal staff or HTW, and about 10 to 12 practices are in the queue to become contracted PCMPs. Staff members also observed that CHP has practices that serve mostly Medicaid members or mostly non-Medicaid members and that techniques in working with these practices differ somewhat. CHP staff members stated that once providers have completed the onboarding process and understand the ACC program they tend to encourage their fee-for-service (FFS) patients to enroll in the ACC program. CHP also publishes a Best Practices newsletter to provide basic information and tips to providers, and was considering enhanced PMPM payments to providers that furnish more enhanced service. In addition, CHP staff reported that the RCCO works closely with other organizations involved with medical home principles and practice transformation, such as Healthy Communities and Colorado Children’s Healthcare Access Program (CCHAP).</p> <p>Observations/Recommendations: CHP leveraged the somewhat encapsulated Region 7 service area, building strong community relationships, which resulted in PCMPs encouraging primary care providers, specialty providers, and Medicaid members to become involved with the ACC program.</p>		
<p>4. The Contractor shall provide tools to the PCMPs and providers that may include any of the following:</p> <p>Clinical Tools:</p> <ul style="list-style-type: none"> Clinical care guidelines and best practices <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Clinical screening tools, such as depression screening tools and substance use screening tools <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Health and functioning questionnaires <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Chronic care templates <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Registries <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Other <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <p><i>Contract:</i> Exhibit A: 5.2.2.1; 5.2.1.1 through 5.2.1.3</p>	<p><i>Desk Review:</i> Samples, Internet links, or any documents which illustrate the specific types of tools being provided to PCMPs</p> <p><i>Discussion:</i></p> <ul style="list-style-type: none"> How tools are disseminated Frequency of use by providers Determining effectiveness of tools Determining priorities for tools Tools in development/future plans 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met



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Provider Support		
Requirement	Desk Review/Discussion Items	Score
<p>Findings: Clinical care guidelines included those for substance use, antibiotic use, asthma, cardiovascular disorders, chronic obstructive pulmonary disease (COPD), contraception, diabetes, obesity, motivational interviewing, and preventive care. Screening tools included screenings for colorectal cancer and depression. During the on-site interview, CHP staff members reported that the SF-10[®] Health Survey and the SF-12[®] Health Survey are administered to members by service center staff during inbound and outbound calls, seizing any opportunity to assess members for risk and appropriateness to receive care coordination services. Staff reported that tools are distributed during onboarding sessions and are available on the HTW and Community Care (CHP’s product line name for the RCCO) Web sites. Practices are provided specific handouts as needed and/or directed to the Web site for additional materials. On site, staff members also described development of referral guidelines to assist PCMPs with a decision framework for determining at what point referral to a specialist should occur. This is expected to lighten the load for specialists treating individuals who could potentially be treated by the PCMP via consultation and assistance from the specialist. Guidelines related to common conditions resulting in member referral to specialists in gastroenterology, orthopedics, cardiology, or neurology have been or were being developed at time of the site review. CHP was also developing referral guidelines for the most common conditions in behavioral health that result in referrals (depression, anxiety, and attention deficit disorder).</p>		
<p>Observations/Recommendations: CHP, in combination with its partner, HTW, had a comprehensive array of clinical support tools and practice guidelines. In addition, referral guidelines may be a creative way to streamline the referral process and encourage specialist participation in Medicaid, given a shortage of specialist providers.</p>		
<p>5. The Contractor shall provide tools to the PCMPs and providers that may include any of the following:</p> <p>Client Materials:</p> <ul style="list-style-type: none"> ◆ Client reminders <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No ◆ Self-management tools <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No ◆ Educational materials—specific conditions <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No ◆ Client action plans <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No ◆ Behavioral health surveys and other self-screening tools <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No ◆ Other <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <p><i>Contract:</i> <i>Exhibit A: 5.2.2.2; 5.2.1.1 through 5.2.1.3</i></p>	<p><i>Desk Review:</i> Samples, Internet links, or any documents which illustrate the specific types of tools being provided to PCMPs</p> <p><i>Discussion:</i></p> <ul style="list-style-type: none"> ◆ How tools are disseminated ◆ Frequency of use by providers ◆ Determining effectiveness of tools ◆ Determining priorities for tools ◆ Tools in development/future plans 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met



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Provider Support		
Requirement	Desk Review/Discussion Items	Score
<p>Findings: Member materials included Tips for Healthy Living, tips for tobacco cessation, facts about obesity, information about how to obtain behavioral health services, when to seek services at an ER, immunization guidelines, and how to manage diabetes and asthma. CHP had a brochure that listed client materials available. Materials were found on CHP’s Web site under the provider resources tab. Materials could also be found on the HTW Web site. On-site, CHP staff members stated that a variety of materials are also distributed to PCMPs during onboarding and provider support visits, based on the needs expressed by providers.</p>		
<p>Observations/Recommendations: CHP had a comprehensive array of client materials. CHP staff members described how materials are used and demonstrated good understanding of specific providers and their needs, to best support each provider.</p>		
<p>6. The Contractor shall provide tools to the PCMPs and providers that may include any of the following:</p> <p>Operational Practice Support:</p> <ul style="list-style-type: none"> ◆ Guidance and education on the principles of the medical home <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No ◆ Training on providing culturally competent care <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No ◆ Training to enhance the health care skills and knowledge of supporting staff <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No ◆ Guidelines for motivational interviewing <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No ◆ Tools and resources for telephone call and appointment tracking <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No ◆ Tools and resources for tracking labs, referrals, and similar items <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No ◆ Referral and transitions of care checklists <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No ◆ Visit agendas or templates <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No ◆ Standing pharmacy order templates <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No ◆ Other <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <p><i>Contract:</i> Exhibit A: 5.2.2.3; 5.2.1.1 through 5.2.1.3</p>	<p><i>Desk Review:</i> Samples, Internet links, or any documents which illustrate the specific types of tools being provided to PCMPs</p> <p><i>Discussion:</i></p> <ul style="list-style-type: none"> ◆ How tools are disseminated ◆ Frequency of use by providers ◆ Determining effectiveness of tools ◆ Determining priorities for tools ◆ Tools in development/future plans 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met



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Provider Support		
Requirement	Desk Review/Discussion Items	Score
<p>Findings:</p> <p>Training materials included comprehensive information about medical home principles, the ACC program, and motivational interviewing. On-site, staff members reported that presentations regarding medical home principles and the ACC are provided to a variety of groups and organizations including the local medical society, community service agencies such as home health agencies, other organizations that provide long-term services and supports, and potential PCMPs and current partners. Although CHP had a cultural diversity PowerPoint, the content was presented at a very high level. The PowerPoint would not be easily understood by most provider office staff members (in terms of pragmatic approaches or building competency in interacting with individuals from other cultures). CHP staff members stated that the RCCO is dependent on the larger PCMPs and partners (such as the CMHCs and the FQHCs) for having their own cultural competency training. CHP staff members also reported that the Bridges Out of Poverty training materials are frequently used and very helpful in understanding many of their clients.</p> <p>CHP staff reported that primary distribution of operational practice support tools occurs during practice transformation activities and are distributed based on the provider’s self-identified needs or requests stated on the practice assessment. Although during the during the on-site interview CHP staff reported that the RCCO has visit agenda templates and standing pharmacy order templates, staff did not provide these templates for review and they were not found on the RCCO or HTW Web sites. CHP staff reported that they have not received a request from any providers for these templates.</p>		
<p>Observations/Recommendations:</p> <p>CHP may want to consider having visit agenda templates and pharmacy standing order templates available on the Web site where other practice support tools are found. CHP may also want to consider linking receipt of materials to performance as a medical home as well as responding to specific requests. HSAG recommends that CHP evaluate its cultural competency training and consult with its partners to offer more pragmatic cultural competency training for PCMPs not affiliated with the larger primary care organization or the CMHC.</p>		
<p>7. The Contractor shall provide tools to the PCMPs and providers that may include any of the following:</p> <p>Data, Reports, and Other Resources:</p> <ul style="list-style-type: none"> ◆ Expanded provider network directory <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No ◆ Comprehensive directory of community resources <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No ◆ Directory of other Department-sponsored resources, such as the managed care ombudsman and nurse advice line <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No ◆ Link from main ACC Program Web site to the Contractor’s Web site of centrally <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 	<p><i>Desk Review:</i></p> <p>Samples, Internet links, or any documents which illustrate the specific types of tools being provided to PCMPs</p> <p><i>Discussion:</i></p> <ul style="list-style-type: none"> ◆ How tools are disseminated ◆ Frequency of use by providers ◆ Determining effectiveness of tools ◆ Determining priorities for tools ◆ Tools in development/future plans 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met



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Provider Support		
Requirement	Desk Review/Discussion Items	Score
located tools and resources ♦ Other <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <i>Contract:</i> <i>Exhibit A: 5.2.2.4</i>		
Findings: The CHP/Community Care Web site had a search function for finding providers. It was possible to search for primary care or specialty providers. Under the resources tab, it was possible to search for community resources by type of service needed (e.g., food, transportation, housing, and many others). Also on the Resources page was a link to HealthColorado and important Department phone numbers such as the ombudsman, the suicide hotline, Medicaid customer service, and the Nurse Advice Line.		
Observations/Recommendations: The Community Care Web site was easy to navigate and contained a variety of resources, general information about the ACC program and the RCCO, and offered a link to a provider home page and a member home page with more specific information about the ACC program written to address providers and members respectively. Each page also contained a link to respective newsletters and handbooks.		

Results for Provider Support							
Total	Met	=	<u>7</u>	X	1.00	=	<u>7</u>
	Partially Met	=	<u>0</u>	X	0.0	=	<u>0</u>
	Not Met	=	<u>0</u>	X	0.0	=	<u>0</u>
Total Applicable		=	<u>7</u>	Total Score	=	<u>7</u>	

Total Score ÷ Total Applicable	=	<u>100%</u>
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Follow-up—Provider Network Development	
On-site Discussion Topics	Pertinent Contract References
<p>1. Provider Network Capacity:</p> <ul style="list-style-type: none"> ◆ Efforts to grow/expand the network: <ul style="list-style-type: none"> • Number/location of targeted providers • Mechanisms to assist PCMPs to get enrolled • Diversity for expansion populations ◆ Capacity of PCMPs for new Medicaid members <ul style="list-style-type: none"> • Network analysis • Mechanisms to open/expand practices for Medicaid members ◆ Progress in relation to extended hours and urgent care alternatives in the network 	<p><i>Contract:</i> <i>Exhibit A: 4.1.1; 4.1.4; 4.2.1; 4.2.2; 4.3.3; 8.1.1.1; 2.2.5.1.4</i></p>
<p>Discussion: CHP’s Network Report dated January 2014 listed a total of 21 PCMPs, representing a total of 212 rendering practitioners. The report included ratios of PCMPs to attributed members (adult and pediatric) and stated that 78 percent of Region 7 members were attributed to ACC providers. The report indicated that seven large practices in El Paso county and one clinic in each of Teller and Park counties offered extended hours. The report listed no PCMPs in Elbert County, which shows 854 members. During the on-site interview, CHP staff members reported that the current PCMP network includes 24 PCMPs representing 229 rendering practitioners and that CHP has been successful in recruiting a PCMP within Elbert County although extended hours are not yet available there. As many communities in CHP’s service area are designated as health care professional shortage areas, CHP staff members reported understanding the importance of contacting all providers within these areas. Staff members reported low numbers (“a few”) of providers unwilling to participate in the ACC program.</p>	
<p>Observations: CHP has creatively and proactively developed approaches to both measure and address potential capacity issues.</p>	
<p>2. HSAG provider network capacity analysis results</p>	<p><i>Contract:</i> <i>Exhibit A: 4.1.1; 8.1.1.1</i></p>
<p>Discussion: HSAG used data from the PCMP network spreadsheet provided to the Department by the RCCO to conduct a high-level network analysis. The purpose of the PivotTable analysis was to provide an accurate representation of number of providers in each region by eliminating any duplicate entries. To achieve this, duplicates were eliminated as follows:</p> <ul style="list-style-type: none"> ◆ Number of providers within the entire region: when there was a duplicate first and last name. (The preferred method would have been to sort and eliminate providers based on individual rendering practitioner Medicaid ID, but this information was too often incomplete.) ◆ Number of providers within each county: when there was a duplicate first and last name and county (i.e., a provider with multiple locations would only be counted one time in each county). 	



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Pertinent Contract References

- ◆ Number of locations by region and county: when there was an identical address listed.

A similar analysis was performed to count the number of unique providers within the region and by county after eliminating providers who stated that they were not accepting new Medicaid members.

For PivotTable analysis to be performed accurately, the data in the selected sort fields being used to identify duplicate information must be complete and strictly formatted. Empty fields, inconsistent spelling or punctuation, data in the wrong field, etc., will result in inappropriate identification of duplicate fields. A cursory review of the source data noted very few instances of inconsistencies or incomplete fields influencing the accuracy of PivotTable results. HSAG PivotTable results were similar to CHP’s Network Report. Differences in provider counts may be a result of CHP’s robust recruitment efforts and varying time periods of the data used. Detailed PivotTable results, including county analysis and unique locations for care, are included in Appendix C of this report.

HSAG Total PivotTable Analysis:

- ◆ Total PivotTable removals from source document: 47
- ◆ Total unique providers in region: 224
- ◆ Total unique providers accepting Medicaid: 144

CHP’s Network Report included a list of providers in the region displayed by county. For illustration, a comparison of PivotTable results to providers listed in the report is as follows:

- ◆ CHP Network Report: Total unique providers in the region: 212
- ◆ HSAG PivotTable Analysis: Total unique providers in the region: 224

On-site CHP staff members reported that CHP developed a strategic plan to understand and address capacity. Staff members held community forums to discuss capacity and surveyed current providers in attempts to measure capacity. CHP staff acknowledged that capacity is a difficult concept to measure, understanding that the CHP service area is somewhat a “closed community” with its potential Medicaid members already being served by CHP’s PCMPs through safety net or other payor sources and mechanisms.

Observations:

CHP began strategically defining and attempting to measure capacity and involving the provider community in both defining and measurement attempts.



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On-site Discussion Topics	Pertinent Contract References
<p>3. PCMP Network for expansion populations:</p> <ul style="list-style-type: none"> ◆ Sufficiency of the network for expanding number of eligibles ◆ PCMP network configured to address the special needs of the following: <ul style="list-style-type: none"> • Full Benefit Medicare-Medicaid Enrollees (FBMME) • Disabled • Foster care • Adults without Dependent Children (AwDC) • Culturally diverse • Inmate population 	<p><i>Contract:</i> <i>Exhibit A: 4.1.1; 4.1.6; 4.3.3</i></p>

Discussion:
 Initiatives underway to address the increased member population and specifically to address the anticipated addition of expansion populations, adults without dependent children (AwDC) members and FBMME members are:

- ◆ Beginning plans to work with the Serve, Empower, Transform (SET) clinic, a safety net provider to develop a specialty clinic serving the ex-offender population.
- ◆ Beginning plans to work with AspenPointe (CHP’s partner CMHC) to develop a treatment program designed to serve the specific needs of the homeless population.
- ◆ Targeted recruitment of two providers whose practices exclusively serve nursing home residents.
- ◆ Targeted recruitment of providers whose caseloads already include FBMME eligible members.
- ◆ Recent hiring of an additional care coordination staff member to act as liaison to home health and community-based service agencies.

Other existing resources to support the expansion populations include a specialty health center providing primary care services to developmentally disabled (DD) individuals and an additional PCMP specializing in serving the DD population.

Observations:
 CHP has creatively and proactively developed approaches to prepare for anticipated population increases due to Medicaid expansion and the FBMME demonstration project.



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On-site Discussion Topics	Pertinent Contract References
<p>4. Medical Neighborhood</p> <p>Evolution of medical neighborhood/vision for the region:</p> <ul style="list-style-type: none"> ◆ Composition of medical neighborhood <ul style="list-style-type: none"> ● Continuum of delivery system providers/types of providers ● Impact of expansion populations ◆ Level of involvement/engagement of various providers <ul style="list-style-type: none"> ● Formal/informal relationships ● Information sharing challenges ◆ Progress related to the Specialist Referral Protocol joint planning project within the region 	<p><i>Contract:</i> <i>Exhibit A: 4.2.5; 6.1</i></p>
<p>Discussion:</p> <p>CHP staff members reported that the chief executive officer (CEO) leadership group representing the RCCOs brought in a national expert to address the medical neighborhood. Staff members described one of the goals of the ACC program as transforming medical care from care that exists in “silos” to care that is integrated and provided along a continuum of services that address the varying needs of a complex population. Essential to achieving this goal is building relationships between primary care and specialty providers to streamline referrals to specialty care and to remove barriers to obtaining access to care, particularly specialty care. Another essential component is building relationships with the ancillary providers and community services that interface with the most vulnerable members of the community (e.g., emergency responders). Achievement of these primary program goals is expected to create both a prepared system of providers and activated members. To this end, CHP has developed or collaborated in the development of several pilot projects to affect how members receive services and to improve overall community response to member needs. Examples are:</p> <ul style="list-style-type: none"> ◆ The Wellness Center at AspenPointe—AspenPointe has developed a wellness center for members to attend. The focus of the center is to provide groups and classes designed to improve life skills. Examples include smoking cessation, coping with divorce, cooking classes, parenting skills, weight management classes, and job skills training. Members may drop in without registering and may continue without interruption in these services if eligibility changes. Staff reported that these services fill a gap and provide essential services to meet the members’ immediate needs. ◆ Improved data sharing relationship with AspenPointe—Upon finalizing the formal data sharing agreement with AspenPointe, CHP partnered with AspenPointe to provide behavioral health expertise and support to CHP care coordination staff. AspenPointe staff members provided trainings and CHP care coordinators attended AspenPointe staffing meetings as needed to coordinate care. ◆ CARES Program—Formerly known as “Feet on the Street,” this program pairs medical personnel from the local fire department with hospital-based physicians (as needed) to conduct home visits to frequent emergency department utilizers. The purpose of the home visits may be medication reconciliation following an emergency room visit or hospitalization, safety checks, or to provide the patient with alternatives to ER use for non-emergency issues. ◆ Development of Specialty Referral Guidelines—CHP was developing practice guidelines with PCMP input to provide direction and checklists as a resource for PCMPs to determine when referrals to specialists are warranted and as an assurance to specialist providers that the referrals are appropriate. 	



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On-site Discussion Topics

Pertinent Contract References

CHP staff members reported noticing some positive results of activities, reporting some perceived improvements in access to care.

Observations:

CHP expressed a commitment to build relationships within the community (with specialists and community service providers) to positively affect where and how members receive services that impact their health, whether the services are medical in nature or not. CHP also demonstrated a commitment to develop or collaborate with providers, service agencies, and medical facilities to create synergies that improve overall access to care.



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Follow-up—Care Coordination

On-site Discussion Topics	Pertinent Contract References
<p>Discussion will be supplemented by scored care coordination record review</p> <p>1. Care Coordination Mechanisms</p> <ul style="list-style-type: none"> ◆ Mechanisms to identify members for coordination of care: <ul style="list-style-type: none"> ● Criteria used to define “most appropriate” members ● Sources of identifying members (use of State Data and Analytics Contractor) ● By RCCOs ● By PCMPs ◆ Assessment processes: <ul style="list-style-type: none"> ● Comprehensive ● Sufficient to identify needs of the RCCO expansion populations ● By RCCOs ● By PCMPs 	<p><i>Contract—All Regions:</i> <i>Exhibit A: 6.2.1; 6.2.1.1.2; 6.2.1.1.3; 6.2.1.1.4; 6.4.1</i></p> <p><i>Contract—Regions 1, 4, 6, 7:</i> <i>Exhibit A: 6.4.3.1.1; 6.4.2</i></p> <p><i>Contract—Regions 2, 3, 5:</i> <i>Exhibit A: 6.4.5.1.1; 6.4.4</i></p>

Discussion:

During the on-site interview, CHP staff members reported that CHP Service Center staff performed risk assessments during all calls with members, whether inbound, when a member calls for customer service assistance, or initiated outbound for the purpose of conducting risk assessments (using the SF-10[®] Health Survey and the SF-12[®] Health Survey). In addition, CHP mails health risk assessments to members. CHP staff work with providers to direct PCMPs to ask the “one” health question, to identify members who perceive their health as poor and to identify members potentially in need of care coordination services. Staff reported that records for members who identified themselves as having “poor health” are color-coded in the system for service center staff to prioritize for performing health risk assessments. Other priorities for conducting risk assessments to identify members for appropriateness of receiving care coordination services are members identified as high utilizers of ER services (defined as 10 or more ER visits in a month) and members identified as having a clinical risk group (CRG) level 4, 5, or 6 using SDAC data. On-site, staff members reported that CHP was problem-solving how to prioritize FBMME members and certain expansion populations such as ex-offenders, who may not appear in the SDAC data as CRG levels 4, 5, or 6, but may need care coordination during transitions.

Once the risk assessment identified a member for appropriateness for care coordination, CHP or the PCMP performed a comprehensive needs assessment. CHP submitted templates of needs assessments used by CHP and templates for each of the PCMPs to which care coordination services are delegated. Care management records reviewed on-site contained comprehensive needs assessments and program-specific needs assessments (such as a Prenatal Plus assessment). During the on-site interview, CHP staff members reported that CHP performs care coordination for members: not yet attributed to PCMPs, attributed to PCMPs without delegation agreements with CHP for care coordination, with complex needs beyond the capabilities for delegate PCMPs, and during transitions of care. Staff members reported that CHP has three registered nurse (RN) care coordinators, a human service care navigator providing care coordination to RCCO members, and an additional care navigator providing care coordination to the uninsured population.



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<p>Observations: CHP had effective mechanisms for performing risk assessments to determine appropriateness for care coordination and for performing comprehensive needs assessments for members identified for care management. The on-site review of care coordination records demonstrated that, in all cases, the member received a comprehensive needs assessment, whether performed by the PCMP delegate or CHP.</p>	
<p>2. Expansion populations and coordination of care</p> <ul style="list-style-type: none"> ◆ Impact of expanded RCCO-eligible populations or special needs groups on care coordination activities. Challenges and successes regarding: <ul style="list-style-type: none"> • Members who have a need for Home and Community-Based Services or other community-based services • Transition of care members • Complex cases that may require multiple services across the continuum of care • Members who have both behavioral and physical health needs • FBMME • AwDC • Foster care children • Integration of the inmate population ◆ Impact of expanded medical neighborhood relationships on the coordination of care: <ul style="list-style-type: none"> • At RCCO level • At PCMP level • How the RCCO/PCMP is organizing/cooperating to increase effectiveness of care coordination 	<p><i>Contract—Regions 1, 4, 6, 7:</i> <i>Exhibit A: 6.4.3.1.2; 6.4.3.1.3; 6.4.3.2.3; 6.4.3.2.4; 6.4.3.3</i></p> <p><i>Contract—Regions 2, 3, 5:</i> <i>Exhibit A: 6.4.3; 6.4.5.1.2; 6.4.5.1.3; 6.4.5.2.3; 6.4.5.2.4; 6.4.5.3</i></p> <p><i>Contract—Regions 3 and 5:</i> <i>Exhibit A: 6.4.5.1.4</i></p>
<p>Discussion: CHP developed population-specific pilot or ongoing programs to address special populations. Examples included Complex Care Management, Advanced Illness Care Management, Behavioral Health Care Management for FBMME, the CARES program, chronic pain management, the non-emergency medical transportation (NEMT) program, TeleCare, the emergency department diversion program, and provider education regarding patient activation and motivational interviewing. CHP staff members reported that many of the pilot projects were scientifically-designed to measure outcomes for practical decision making regarding continuance and effectiveness of the program. Eleven of 17 records reviewed by HSAG involved cases in which the members received or were referred for home health or community-based services. Eleven of 17 records reviewed involved transitions of care. Fifteen of 17 records involved members identified as having complex physical and/or behavioral health needs. Two members were ex-offenders and two members were residents of either a nursing home or skilled nursing facility.</p>	



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Follow-up—Care Coordination

On-site Discussion Topics	Pertinent Contract References
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CHP submitted a template PCMP delegation chart audit form designed to evaluate the effectiveness of care coordination performed by PCMP delegates. During the on-site interview, staff members reported that CHP pulls a random sample of charts from each PCMP delegate for this audit. Staff members reported that CHP is considering changes to this oversight process to include an initial site visit evaluating policies and procedures and the capacity to coordinate care with a chart audits, a follow-up at 6 months, and then audits annually or more often, based on performance.

Observations:

CHP demonstrated effective mechanisms to identify members appropriate for care coordination services, including members with complex behavioral and physical health needs and members of special populations.

3. Care Coordination Outcomes

- ◆ Systems/mechanisms used to coordinate information from multiple levels of care and delivery sites:
 - Sources of meaningful coordination of care information
 - Access to real-time member information
- ◆ Outcomes of care coordination efforts:
 - Defining effectiveness
 - Mechanisms for monitoring
 - RCCO level
 - PCMP level
 - Engaging multiple providers in improving outcomes

*Contract—All Regions:
Exhibit A: 6.4.1*

*Contract—Regions 1, 4, 6, 7:
Exhibit A: 6.4.2; 6.4.3.1.6*

*Contract—Regions 2, 3, 5:
Exhibit A: 6.4.4*

*Contract—Regions 3 and 5:
Exhibit A: 6.4.5.1.7*

*Contract—Region 2:
Exhibit A: 6.4.5.1.6*

Discussion:

During the on-site interview, staff members described a variety of projects and programs that ensured a coordinated system of care coordination. CHP submitted examples of care coordination meetings. On-site, CHP staff members reported that CHP care coordination staff and care coordination staff from delegate PCMPs and community partners meet regularly to discuss complex cases and problem-solve systems issues. In addition, the chart audit process alerts CHP to any performance issues with care coordination conducted by delegates. Staff members reported that, being a community with a limited number of hospitals and ERs, CHP has been able to collaborate with the hospitals and is able to receive a daily census report, enabling immediate notification of the need for coordinating of transitions. The on-site care coordination record review clearly demonstrated that care coordination performed by PCMP delegates followed the same policies and procedures as CHP-provided care coordination.

Observations:

CHP had numerous mechanisms to involve and leverage a variety of systems of care. Care coordinators (as evidenced by the on-site record review) were cognizant of other systems involved in members’ care and effectively contacted and coordinated with those systems.

Appendix B. **Record Review Tools**

for **Community Health Partnership (Region 7)**

During on-site care coordination record review, several records were eliminated from the sample selection list due to the records being inadequate or inappropriate for scoring the specific care coordination contract requirements. HSAG summarized in Table B-1 the reasons records were eliminated from the Department-selected SDAC sample. HSAG recommends that this information be used by **CHP** and the Department to further discussions concerning effectiveness of various sources for risk-identifying members appropriate for care management.

Table B-1—Reasons Records Were Eliminated from SDAC Sample	
Reason Record was Eliminated	Number of Records Eliminated
The member was not identified by CHP risk stratification methods as a candidate for care coordination (no care management documentation was available to evaluate).	2
Despite multiple attempts, care manager was unable to contact member or member refused care coordination.	1 ⁽¹⁾
HSAG reviewed the record but determined the member was not an appropriate candidate for complex care coordination.	2 ^(2, 3)
The member was not attributed to Region 7.	3
Unable to obtain record from PCMP for on-site review (no record was available to evaluate).	3
Member had no PCMP contact during review period (unable to locate member in system).	2
Total number of records eliminated from original sample of 20:	13

¹ Record #15: The member was an appropriate candidate for care coordination as high-cost, multiple admissions, 10+ ER visits, and was on the Top 200 list for complex care coordination. The member had chronic abdominal pain and was on a pain contract with the PCMP. The PCMP care coordinator contacted the member during an ER visit, but the member refused care coordinator involvement or follow-up.

² Record #10: The member was a healthy 6-year-old with controlled asthma and 1 ER visit

³ Record # 11: The member was a 22-month-old hospitalized once for respiratory syncytial virus (RSV). No needs or issues. Total cost was \$917.

The completed record review tools follow this page.



*Appendix B. Colorado Department of Health Care Policy and Financing
 FY 2013–2014 Coordination of Care Tool
 for Community Health Partnership (Region 7)*

Sample Number: # 1 _____

Reviewer: Kathy Bartilotta _____

Care Coordination Program Record Review		Score
Assessment		
1. The RCCO (or designee) assessed the member's: <ul style="list-style-type: none"> ◆ Health behavior risks. ◆ Health/medical needs. 	<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>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
Observations:		
<p>Member is a 22-year-old pregnancy patient of Academy Women's Services, a R7 PCMP. The PCMP, which has behavioral health services embedded in the office, referred the member to the Prenatal Plus care coordination program. The RCCO offered to support the PCMP in care coordination. The Prenatal Plus needs assessment was extensive and included medical, social, behavioral, and lifestyle behavior risks and needs. The assessment identified that the member had gestational diabetes and that she needed smoking cessation and behavioral health therapy.</p>		
2. The RCCO (or designee) assessed the member's: <ul style="list-style-type: none"> ◆ Non-medical needs. ◆ Linguistic and cultural needs. 	<i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1; 6.4.3.2.2 Regions 2, 3, 5: Exhibit A—6.4.5.1.1; 6.4.5.2.2</i>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
Observations:		
<p>The Prenatal Plus needs assessment included non-medical, linguistic, and cultural needs. The assessment identified that the member had history of sexual abuse and that her culture was Jewish but that she did not practice religion.</p>		



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Care Coordination Program Record Review		Score
Assessment		
<p>3. The RCCO (or designee) assessed current care coordination services provided to the member 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</i> <i>Regions 2, 3, 5: Exhibit A—6.4.4.1</i></p>		<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
Observations:		
<p>PCMP performed care management. The care manager arranged for the member to see the in-office behavioral health therapist at each prenatal office visit to provide support. No providers outside of PCMP were involved with the member’s care. The member refused all social/lifestyle support services offered by the PCMP. The PCMP arranged for the Healthy Communities organization, a RCCO community partner, to assess the member’s post-delivery needs.</p>		



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Care Coordination Program Record Review		Score
Intervention		
<p>4. The RCCO (or designee) worked with providers responsible for the member’s care to develop a plan for regular communication with those responsible for the member’s care coordination.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.2.3</i> <i>Regions 2, 3, 5: Exhibit A—6.4.4.3</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>The care manager arranged for the in-office behavioral health therapist to see member during each prenatal office visit. Communications were integrated into the office medical record.</p>		
<p>5. The RCCO (or designee) reasonably ensured that all care coordination services, including those provided by other individuals or entities, met the needs of the member.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.2.4</i> <i>Regions 2, 3, 5: Exhibit A—6.4.4.4</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>The care manager identified that the member needed community-based services, but the member did not follow-up or engage in referrals for smoking cessation classes or completing applications for Women, Infants and Children (WIC) program or for Social Security Disability Insurance (SSDI). Healthy Communities connected the member to WIC and SSDI after delivery of baby.</p>		
<p>6. The RCCO (or designee) provided necessary care coordination services not provided by another source.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.2.2</i> <i>Regions 2, 3, 5: Exhibit A—6.4.4.2</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>The member did not cooperate with referrals to services from other organizations.</p>		
<p>7. The RCCO (or designee) linked the member to medical and/or non-medical services, acted as a liaison between medical providers or between medical and non-medical providers, and/or served as a liaison between providers and the member.</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"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>The care manager referred the member to multiple social service agency programs and the Prenatal Plus program.</p>		



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Care Coordination Program Record Review		Score
Transitions		
<p>8. The RCCO (or designee) provided assistance during care transitions from hospitals or other care institutions to home- or community-based settings. This assistance promoted continuity of care.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3</i> <i>Region 2.: Exhibit A—6.4.5.1.3</i> <i>Regions 3, 5: Exhibit A—6.4.5.1.4</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations:		
The member’s pregnancy was uncomplicated and she delivered a healthy baby. Healthy Communities followed up with the mother after delivery to evaluate further needs and to assist with community programs such as WIC and SSDI.		
<p>9. The RCCO (or designee) provided assistance during other transitions, such as the transition from children’s health services to adult health services or from hospital or home care into a nursing facility.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3</i> <i>Region 2: Exhibit A—6.4.5.1.3</i> <i>Regions 3, 5: Exhibit A—6.4.5.1.4</i></p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable	
Observations:		
The member did not experience this type of transition during the review period.		
<p>10. The RCCO (or designee) documented and communicated necessary information about the member to the providers, institutions, and individuals involved in the transition.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3</i> <i>Region 2: Exhibit A—6.4.5.1.3</i> <i>Regions 3, 5: Exhibit A—6.4.5.1.4</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations:		
The RCCO and PCMP connected the member with Health Communities for services following delivery.		



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Care Coordination Program Record Review		Score
Continued Coordination/Follow-up		
11. The documentation clearly indicated that the RCCO’s (or designee’s) provision of care coordination services was responsive to the member’s needs. <i>Regions: 1, 4, 6, 7: Exhibit A—6.4.3.2.3</i> <i>Regions 2, 3, 5 : Exhibit A—6.4.5.2.3</i>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: Documentation included behavioral health visits and referrals to other services; however, the member did not actively engage. The member received an assessment for gestational diabetes, and the report was returned to PCMP and integrated into record. The member was noncompliant with recommendations.		
12. The RCCO (or designee) followed up with the member to assess whether the member has received the services needed and/or if the member is on track to reach his or her desired health outcomes. <i>Regions 1, 4, 6, 7 Exhibit A—6.4.3.1.6</i> <i>Region 2: Exhibit A—6.4.5.1.6</i> <i>Regions 3, 5: Exhibit A—6.4.5.1.7</i>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The PCMP care coordinator was in regular communication with the member throughout her pregnancy. After delivery, the member transferred to a different PCMP.		
Recommendations: The member had a healthy baby outcome and uncomplicated delivery. The member was referred to the Prenatal Plus program for assessment and was referred to various services as needed; however, the member was not cooperative with using any of the recommended services. HSAG has no recommendations.		

Results for Care Coordination Program Record Review—Sample #1					
Total	Met	=	<u>11</u>	X	1.00 = <u>11</u>
	Partially Met	=	<u>0</u>	X	0.0 = <u>0</u>
	Not Met	=	<u>0</u>	X	0.0 = <u>0</u>
	Not Applicable	=	<u>1</u>	X	NA = <u>0</u>
Total Applicable		=	<u>11</u>	Total Score	= <u>11</u>
Total Score ÷ Total Applicable					= <u>100%</u>



Appendix B. Colorado Department of Health Care Policy and Financing
FY 2013–2014 Coordination of Care Tool
for Community Health Partnership (Region 7)

Sample Number: #2 _____

Reviewer: Kathy Bartilotta _____

Care Coordination Program Record Review		Score
Assessment		
1. The RCCO (or designee) assessed the member's: <ul style="list-style-type: none"> ◆ Health behavior risks. ◆ Health/medical needs. <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.1.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: This member was identified as needing care coordination services because of high emergency department (ED) use. The member had high anxiety and needed help with pain management. The care coordination notes indicated that the member appeared to be drug-seeking through the ED. The care manager outreached to the member many times, but the member would not engage with care coordinators or the PCMP. The PCMP referred the member to pain management services, but the member would not go.		
2. The RCCO (or designee) assessed the member's: <ul style="list-style-type: none"> ◆ Non-medical needs. ◆ Linguistic and cultural needs. <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1; 6.4.3.2.2</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.1.1; 6.4.5.2.2</i></p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The member had behavioral health needs and struggled with many home-based stress situations. The member also had nutritional needs and was identified as having used alcohol, drugs, and tobacco. Because the member never engaged in active care management, the care manager was unable to conduct a more thorough assessment that included cultural needs.		
3. The RCCO (or designee) assessed current care coordination services provided to the member 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 align="right"><i>Regions 1, 4, 6, 7: Exhibit A— 6.4.2.1</i> <i>Regions 2, 3, 5: Exhibit A—6.4.4.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: Because the member would not engage with the PCMP or care coordination staff members, the community organizations coordinated with each other. The PCMP and ED providers tried to intervene in drug-seeking behaviors.		



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Care Coordination Program Record Review		Score
Intervention		
<p>4. The RCCO (or designee) worked with providers responsible for the member’s care to develop a plan for regular communication with those responsible for the member’s care coordination.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.2.3</i> <i>Regions 2, 3, 5: Exhibit A—6.4.4.3</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: Community organizations, ED providers, and the RCCO care manager coordinated with each other in an attempt to engage the member in the Client Over-Utilization Program (COUP) to monitor drug-seeking behavior. The member was referred to mental health services.</p>		
<p>5. The RCCO (or designee) reasonably ensured that all care coordination services, including those provided by other individuals or entities, met the needs of the member.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.2.4</i> <i>Regions 2, 3, 5: Exhibit A—6.4.4.4</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: Services offered appeared to meet needs of member, but the member only appeared to need/want narcotics.</p>		
<p>6. The RCCO (or designee) provided necessary care coordination services not provided by another source.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.2.2</i> <i>Regions 2, 3, 5: Exhibit A—6.4.4.2</i></p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable	
<p>Observations: The member would not engage in care management offered by the PCMP and RCCO.</p>		
<p>7. The RCCO (or designee) linked the member to medical and/or non-medical services, acted as a liaison between medical providers or between medical and non-medical providers, and/or served as a liaison between providers and the member.</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"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The member was linked to behavioral health and pain management services but was noncompliant with follow-through. The member stated that she just wanted medications.</p>		



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Care Coordination Program Record Review		Score
Transitions		
<p>8. The RCCO (or designee) provided assistance during care transitions from hospitals or other care institutions to home- or community-based settings. This assistance promoted continuity of care.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3</i> <i>Region 2,: Exhibit A—6.4.5.1.3</i> <i>Regions 3, 5: Exhibit A—6.4.5.1.4</i></p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable	
<p>Observations: The member did not have an inpatient hospitalization during the review period.</p>		
<p>9. The RCCO (or designee) provided assistance during other transitions, such as the transition from children’s health services to adult health services or from hospital or home care into a nursing facility.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3</i> <i>Region 2: Exhibit A—6.4.5.1.3</i> <i>Regions 3, 5: Exhibit A—6.4.5.1.4</i></p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable	
<p>Observations: The member did not experience this type of transition during the review period.</p>		
<p>10. The RCCO (or designee) documented and communicated necessary information about the member to the providers, institutions, and individuals involved in the transition.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3</i> <i>Region 2: Exhibit A—6.4.5.1.3</i> <i>Regions 3, 5: Exhibit A—6.4.5.1.4</i></p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable	
<p>Observations: The member did not experience transitions, although ER visits were monitored by the RCCO and providers.</p>		



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Care Coordination Program Record Review		Score
Continued Coordination/Follow-up		
11. The documentation clearly indicated that the RCCO’s (or designee’s) provision of care coordination services was responsive to the member’s needs. <i>Regions: 1, 4, 6, 7: Exhibit A—6.4.3.2.3 Regions 2, 3, 5 : Exhibit A—6.4.5.2.3</i>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: All points of service were communicating and sharing information to decrease the number of ED visits and member access to narcotics. The member’s perception of need was for narcotics. Data indicated that the ED visits decreased from 28 to 9 within the past year.		
12. The RCCO (or designee) followed up with the member to assess whether the member has received the services needed and/or if the member is on track to reach his or her desired health outcomes. <i>Regions 1, 4, 6, 7 Exhibit A—6.4.3.1.6 Region 2: Exhibit A—6.4.5.1.6 Regions 3, 5: Exhibit A—6.4.5.1.7</i>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable	
Observations: Despite multiple attempts, the member could not be contacted.		
Recommendations: Despite the member’s refusal to participate in active care management, visit the PCMP, or follow through with referrals for services, the cooperative efforts of community providers and organizations were successful in diminishing the member’s ER visits. This case demonstrated determination and commitment of care management resources toward managing the outcomes of risky and expensive health behaviors of the member. HSAG has no recommendations.		

Results for Care Coordination Program Record Review—Sample #2					
Total	Met	=	<u>6</u>	X	1.00 = <u>6</u>
	Partially Met	=	<u>1</u>	X	0.0 = <u>0</u>
	Not Met	=	<u>0</u>	X	0.0 = <u>0</u>
	Not Applicable	=	<u>5</u>	X	NA = <u>0</u>
Total Applicable		=	<u>7</u>	Total Score	= <u>6</u>
Total Score ÷ Total Applicable					= <u>86%</u>



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Sample Number: #7

Reviewer: Rachel Henrichs

Care Coordination Program Record Review		Score
Assessment		
1. The RCCO (or designee) assessed the member's: <ul style="list-style-type: none"> ◆ Health behavior risks. ◆ Health/medical needs. <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.1.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The RCCO assessed the member's needs and risks. This member suffered from chronic pain resulting from a gunshot wound.		
2. The RCCO (or designee) assessed the member's: <ul style="list-style-type: none"> ◆ Non-medical needs. ◆ Linguistic and cultural needs. <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1; 6.4.3.2.2</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.1.1; 6.4.5.2.2</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The PCMP documented the member's non-medical, linguistic, and cultural needs. The member was a single parent with legal issues and a history of multiple prison sentences.		
3. The RCCO (or designee) assessed current care coordination services provided to the member 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 align="right"><i>Regions 1, 4, 6, 7: Exhibit A— 6.4.2.1</i> <i>Regions 2, 3, 5: Exhibit A—6.4.4.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The PCMP's assessment of the member indicated that there were no other providers or agencies, outside of the emergency departments, with which the member was involved.		



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Care Coordination Program Record Review		Score
Intervention		
<p>4. The RCCO (or designee) worked with providers responsible for the member’s care to develop a plan for regular communication with those responsible for the member’s care coordination.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.2.3</i> <i>Regions 2, 3, 5: Exhibit A—6.4.4.3</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The PCMP referred the member to other providers, but the member did not follow up on referrals. The member did not appear to be working with any other providers.</p>		
<p>5. The RCCO (or designee) reasonably ensured that all care coordination services, including those provided by other individuals or entities, met the needs of the member.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.2.4</i> <i>Regions 2, 3, 5: Exhibit A—6.4.4.4</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The PCMP attempted multiple times to refer the member to specialists for help with chronic pain. The member did not follow through with any referrals, and the care coordination notes indicated that the member appeared to be seeking only narcotics.</p>		
<p>6. The RCCO (or designee) provided necessary care coordination services not provided by another source.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.2.2</i> <i>Regions 2, 3, 5: Exhibit A—6.4.4.2</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The PCMP referred the member to surgeons and physical therapists to address issues with the member’s shoulder; however, the member refused to follow through on referrals.</p>		
<p>7. The RCCO (or designee) linked the member to medical and/or non-medical services, acted as a liaison between medical providers or between medical and non-medical providers, and/or served as a liaison between providers and the member.</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"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The PCMP referred the member to surgeons and physical therapists to address issues with the member’s shoulder, but the member refused to follow through on referrals.</p>		



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Care Coordination Program Record Review		Score
Transitions		
8. The RCCO (or designee) provided assistance during care transitions from hospitals or other care institutions to home- or community-based settings. This assistance promoted continuity of care. <div align="right"> <i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3</i> <i>Region 2.: Exhibit A—6.4.5.1.3</i> <i>Regions 3, 5: Exhibit A—6.4.5.1.4</i> </div>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable	
Observations: The member was not hospitalized during the review period.		
9. The RCCO (or designee) provided assistance during other transitions, such as the transition from children’s health services to adult health services or from hospital or home care into a nursing facility. <div align="right"> <i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3</i> <i>Region 2: Exhibit A—6.4.5.1.3</i> <i>Regions 3, 5: Exhibit A—6.4.5.1.4</i> </div>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The member did not transition care during the review period.		
10. The RCCO (or designee) documented and communicated necessary information about the member to the providers, institutions, and individuals involved in the transition. <div align="right"> <i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3</i> <i>Region 2: Exhibit A—6.4.5.1.3</i> <i>Regions 3, 5: Exhibit A—6.4.5.1.4</i> </div>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable	
Observations: The member did not transition care during the review period.		



Appendix B. Colorado Department of Health Care Policy and Financing
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Care Coordination Program Record Review		Score
Continued Coordination/Follow-up		
11. The documentation clearly indicated that the RCCO’s (or designee’s) provision of care coordination services was responsive to the member’s needs. <i>Regions: 1, 4, 6, 7: Exhibit A—6.4.3.2.3</i> <i>Regions 2, 3, 5 : Exhibit A—6.4.5.2.3</i>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The member’s records showed that the PCMP attempted to address the member’s needs, but the member was not interested in services offered. After the PCMP refused to prescribe narcotics, the member left the practice.		
12. The RCCO (or designee) followed up with the member to assess whether the member has received the services needed and/or if the member is on track to reach his or her desired health outcomes. <i>Regions 1, 4, 6, 7 Exhibit A—6.4.3.1.6</i> <i>Region 2: Exhibit A—6.4.5.1.6</i> <i>Regions 3, 5: Exhibit A—6.4.5.1.7</i>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The member proved to be difficult to contact and was not interested in engaging in services offered. The care coordination notes indicated that the member appeared to only want prescription narcotics and that, after the PCMP refused to prescribe them, the member left the practice.		

Recommendations:
 This member did not follow through on the PCMP’s referrals to physical therapy or surgical consults. The member refused services despite the PCMP’s earnest attempts to engage the member. HSAG has no recommendations.

Results for Care Coordination Program Record Review—Sample #7					
Total	Met	=	<u>10</u>	X	1.00 = <u>10</u>
	Partially Met	=	<u>0</u>	X	0.0 = <u>0</u>
	Not Met	=	<u>0</u>	X	0.0 = <u>0</u>
	Not Applicable	=	<u>2</u>	X	NA = <u>0</u>
Total Applicable		=	<u>10</u>	Total Score	= <u>10</u>
		Total Score ÷ Total Applicable	=	<u>100%</u>	



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Care Coordination Program Record Review		Score
Assessment		
<p>3. The RCCO (or designee) assessed current care coordination services provided to the member 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</i> <i>Regions 2, 3, 5: Exhibit A—6.4.4.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>The Children’s Hospital Colorado care management team managed most of the member’s medical needs. The RCCO and PCMP care managers engaged The Resource Exchange (TRE), the community centered board (CCB), to organize non-medical needs. TRE contracted with Nursing Therapy of Southern Colorado. Team meetings were held regularly to review the member’s status and the PCMP received reports every two months. There was excellent coordination among the multiple providers, with no duplication of effort.</p>		



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Care Coordination Program Record Review		Score
Intervention		
<p>4. The RCCO (or designee) worked with providers responsible for the member’s care to develop a plan for regular communication with those responsible for the member’s care coordination.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.2.3</i> <i>Regions 2, 3, 5: Exhibit A—6.4.4.3</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The providers were well-organized in communications among themselves, and the RCCO and the PCMP were kept well-informed and involved. The PCMP made all referrals, such as for an MRI and an endocrinologist, upon recommendation by the medical teams.</p>		
<p>5. The RCCO (or designee) reasonably ensured that all care coordination services, including those provided by other individuals or entities, met the needs of the member.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.2.4</i> <i>Regions 2, 3, 5: Exhibit A—6.4.4.4</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: All teams involved with the member ensured that the member and family needs were met. The Resource Exchange arranged for a certified nurse assistant (CNA) to be in the home five days a week to support the family with caring for the member, performing activities of daily living (ADLs) and addressing safety issues. Parents attended a feeding clinic with the child.</p>		
<p>6. The RCCO (or designee) provided necessary care coordination services not provided by another source.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.2.2</i> <i>Regions 2, 3, 5: Exhibit A—6.4.4.2</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The delegate PCMP made referrals and coordinated with all specialty providers.</p>		
<p>7. The RCCO (or designee) linked the member to medical and/or non-medical services, acted as a liaison between medical providers or between medical and non-medical providers, and/or served as a liaison between providers and the member.</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"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The PCMP made all specialty referrals, the Children’s Hospital Colorado team organized all specialty clinics (e.g., feeding clinic and physical therapy services), and TRE arranged for all non-medical community services, including home care. Multi-disciplinary team meetings were held regularly among all entities.</p>		



Appendix B. Colorado Department of Health Care Policy and Financing
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Care Coordination Program Record Review		Score
Transitions		
<p>8. The RCCO (or designee) provided assistance during care transitions from hospitals or other care institutions to home- or community-based settings. This assistance promoted continuity of care.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3</i> <i>Region 2.: Exhibit A—6.4.5.1.3</i> <i>Regions 3, 5: Exhibit A—6.4.5.1.4</i></p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable	
<p>Observations: Prior to RCCO involvement, Healthy Communities contacted to assist the member with services needed after discharge from the hospital, post-delivery. The member was not hospitalized after joining the RCCO.</p>		
<p>9. The RCCO (or designee) provided assistance during other transitions, such as the transition from children’s health services to adult health services or from hospital or home care into a nursing facility.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3</i> <i>Region 2: Exhibit A—6.4.5.1.3</i> <i>Regions 3, 5: Exhibit A—6.4.5.1.4</i></p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable	
<p>Observations: The member did not experience this type of transition.</p>		
<p>10. The RCCO (or designee) documented and communicated necessary information about the member to the providers, institutions, and individuals involved in the transition.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3</i> <i>Region 2: Exhibit A—6.4.5.1.3</i> <i>Regions 3, 5: Exhibit A—6.4.5.1.4</i></p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable	
<p>Observations: The member’s transition was prior to member’s involvement in RCCO.</p>		



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Care Coordination Program Record Review		Score
Continued Coordination/Follow-up		
11. The documentation clearly indicated that the RCCO’s (or designee’s) provision of care coordination services was responsive to the member’s needs. <i>Regions: 1, 4, 6, 7: Exhibit A—6.4.3.2.3</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.2.3</i>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The member’s needs, goals, and services received were well-documented in the record. Continuity of care among multiple providers and services was well-coordinated.		
12. The RCCO (or designee) followed up with the member to assess whether the member has received the services needed and/or if the member is on track to reach his or her desired health outcomes. <i>Regions 1, 4, 6, 7 Exhibit A—6.4.3.1.6</i> <i>Region 2: Exhibit A—6.4.5.1.6</i> <i>Regions 3, 5: Exhibit A—6.4.5.1.7</i>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The member’s family was actively involved in the care of the child, care team meetings, and with the PCMP. Parents expressed goals and needs for support.		

Recommendations:
 Although much of the care management was initiated prior to the member’s involvement in the RCCO, this member’s care was intensively managed through the PCMP and multiple other teams of clinical and non-clinical providers and agencies.

Results for Care Coordination Program Record Review—Sample #12					
Total	Met	=	<u>9</u>	X	1.00 = <u>9</u>
	Partially Met	=	<u>0</u>	X	0.0 = <u>0</u>
	Not Met	=	<u>0</u>	X	0.0 = <u>0</u>
	Not Applicable	=	<u>3</u>	X	NA = <u>0</u>
Total Applicable		=	<u>9</u>	Total Score	= <u>9</u>
		Total Score ÷ Total Applicable	=	<u>100%</u>	



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Sample Number: #17

Reviewer: Kathy Bartilotta

Care Coordination Program Record Review		Score
Assessment		
1. The RCCO (or designee) assessed the member's: <ul style="list-style-type: none"> ◆ Health behavior risks. ◆ Health/medical needs. 	<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>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
Observations:		
The member is a 19-year-old with autism and cerebral palsy. The member is nonverbal. Health risks included unsafe behaviors, especially eating non-food items (e.g., rubber gloves), causing choking.		
2. The RCCO (or designee) assessed the member's: <ul style="list-style-type: none"> ◆ Non-medical needs. ◆ Linguistic and cultural needs. 	<i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1; 6.4.3.2.2</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.1.1; 6.4.5.2.2</i>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
Observations:		
The member lives with a foster care mother who has substance abuse issues. The member needs a CNA five days a week to assist with ADLs. The record noted that the member is Caucasian and English-speaking. Although in-depth cultural behaviors were not assessed, the member was a well-known, long-term client of the PCMP prior to enrolling in the RCCO.		
3. The RCCO (or designee) assessed current care coordination services provided to the member 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.	<i>Regions 1, 4, 6, 7: Exhibit A— 6.4.2.1</i> <i>Regions 2, 3, 5: Exhibit A—6.4.4.1</i>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
Observations:		
The member changed home care agencies, and the care coordinator contacted the new agency to establish a relationship with the agency and to ensure that services were implemented to meet the member's needs.		



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Care Coordination Program Record Review		Score
Intervention		
<p>4. The RCCO (or designee) worked with providers responsible for the member’s care to develop a plan for regular communication with those responsible for the member’s care coordination.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.2.3 Regions 2, 3, 5: Exhibit A—6.4.4.3</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The PCMP made a referral and received a report from speech therapy for a swallow evaluation. The record documented frequent communications with home care and other agencies to determine unmet needs.</p>		
<p>5. The RCCO (or designee) reasonably ensured that all care coordination services, including those provided by other individuals or entities, met the needs of the member.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.2.4 Regions 2, 3, 5: Exhibit A—6.4.4.4</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The record documented frequent communications with home care and other agencies to determine unmet needs.</p>		
<p>6. The RCCO (or designee) provided necessary care coordination services not provided by another source.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.2.2 Regions 2, 3, 5: Exhibit A—6.4.4.2</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The care coordinator arranged for purchase of a suction machine for member use in the home, due to the member’s choking problems.</p>		
<p>7. The RCCO (or designee) linked the member to medical and/or non-medical services, acted as a liaison between medical providers or between medical and non-medical providers, and/or served as a liaison between providers and the member.</p> <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"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The care coordinator linked the member to medical and non-medical services as needed.</p>		



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Care Coordination Program Record Review		Score
Transitions		
<p>8. The RCCO (or designee) provided assistance during care transitions from hospitals or other care institutions to home- or community-based settings. This assistance promoted continuity of care.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3</i> <i>Region 2.: Exhibit A—6.4.5.1.3</i> <i>Regions 3, 5: Exhibit A—6.4.5.1.4</i></p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable	
<p>Observations: The member had no hospitalizations or ER visits.</p>		
<p>9. The RCCO (or designee) provided assistance during other transitions, such as the transition from children’s health services to adult health services or from hospital or home care into a nursing facility.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3</i> <i>Region 2: Exhibit A—6.4.5.1.3</i> <i>Regions 3, 5: Exhibit A—6.4.5.1.4</i></p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable	
<p>Observations: The member was 19 years old, and although he transitioned from child to adult services, he remained in foster care and with same PCMP (who provided both pediatric and adult services).</p>		
<p>10. The RCCO (or designee) documented and communicated necessary information about the member to the providers, institutions, and individuals involved in the transition.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3</i> <i>Region 2: Exhibit A—6.4.5.1.3</i> <i>Regions 3, 5: Exhibit A—6.4.5.1.4</i></p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable	
<p>Observations: The care coordinator monitored to ensure that the placement was stable and that services remained in place.</p>		



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Care Coordination Program Record Review		Score
Continued Coordination/Follow-up		
11. The documentation clearly indicated that the RCCO’s (or designee’s) provision of care coordination services was responsive to the member’s needs. <i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.2.3</i> <i>Regions 2, 3, 5 : Exhibit A—6.4.5.2.3</i>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The care coordinator maintained frequent communications to monitor member safety and to ensure that assistance with ADLs was maintained.		
12. The RCCO (or designee) followed up with the member to assess whether the member has received the services needed and/or if the member is on track to reach his or her desired health outcomes. <i>Regions 1, 4, 6, 7 Exhibit A—6.4.3.1.6</i> <i>Region 2: Exhibit A—6.4.5.1.6</i> <i>Regions 3, 5: Exhibit A—6.4.5.1.7</i>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The care manager maintained frequent communications with the foster care mother and providers.		

Recommendations:
 The member required and received frequent monitoring of risky behaviors. This case was well-managed. HSAG has no recommendations.

Results for Care Coordination Program Record Review—Sample #17					
Total	Met	=	<u>9</u>	X	1.00 = <u>9</u>
	Partially Met	=	<u>0</u>	X	0.0 = <u>0</u>
	Not Met	=	<u>0</u>	X	0.0 = <u>0</u>
	Not Applicable	=	<u>3</u>	X	NA = <u>0</u>
Total Applicable		=	<u>9</u>	Total Score	= <u>9</u>
Total Score ÷ Total Applicable				=	<u>100%</u>



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Sample Number: #19 _____

Reviewer: Rachel Henrichs _____

Care Coordination Program Record Review		Score
Assessment		
<p>1. The RCCO (or designee) assessed the member's:</p> <ul style="list-style-type: none"> ◆ Health behavior risks. ◆ Health/medical needs. <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.1.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>The RCCO delegated this member's care coordination to the PCMP. The PCMP conducted a health risk and needs assessment in May 2012 and updated the assessment in June 2013. The member transferred to a different PCMP in late 2013. The RCCO provided evidence that the first PCMP transferred medical records to the new PCMP. Records also indicated that the new PCMP conducted a health risk and needs assessment in December 2013.</p>		
<p>2. The RCCO (or designee) assessed the member's:</p> <ul style="list-style-type: none"> ◆ Non-medical needs. ◆ Linguistic and cultural needs. <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1; 6.4.3.2.2</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.1.1; 6.4.5.2.2</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>The PCMP documented an assessment of non-medical, linguistic, and cultural needs in May 2012. The record indicated that the PCMP staff maintained an open and continual dialog with the member regarding non-medical needs.</p>		
<p>3. The RCCO (or designee) assessed current care coordination services provided to the member 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</i> <i>Regions 2, 3, 5: Exhibit A—6.4.4.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>The PCMP assessed with which providers and agencies the member was working. The PCMP obtained a release of information from the member's dental provider in an effort to coordinate services.</p>		



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Care Coordination Program Record Review		Score
Intervention		
<p>4. The RCCO (or designee) worked with providers responsible for the member’s care to develop a plan for regular communication with those responsible for the member’s care coordination.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.2.3</i> <i>Regions 2, 3, 5: Exhibit A—6.4.4.3</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The PCMP obtained a release of information from the member’s dental provider in an effort to coordinate services. The PCMP also referred the member to a neurologist and obtained follow-up notes from the specialist.		
<p>5. The RCCO (or designee) reasonably ensured that all care coordination services, including those provided by other individuals or entities, met the needs of the member.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.2.4</i> <i>Regions 2, 3, 5: Exhibit A—6.4.4.4</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The PCMP checked in with the member to ensure that services provided by the neurologist were sufficient.		
<p>6. The RCCO (or designee) provided necessary care coordination services not provided by another source.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.2.2</i> <i>Regions 2, 3, 5: Exhibit A—6.4.4.2</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The PCMP staff assisted the member with a grant application for dental work. The PCMP followed up with the member periodically to track application progress.		
<p>7. The RCCO (or designee) linked the member to medical and/or non-medical services, acted as a liaison between medical providers or between medical and non-medical providers, and/or served as a liaison between providers and the member.</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"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The PCMP linked the member to a neurologist and provided assistance with a grant application for dental work.		



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Care Coordination Program Record Review		Score
Transitions		
<p>8. The RCCO (or designee) provided assistance during care transitions from hospitals or other care institutions to home- or community-based settings. This assistance promoted continuity of care.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3</i> <i>Region 2.: Exhibit A—6.4.5.1.3</i> <i>Regions 3, 5: Exhibit A—6.4.5.1.4</i></p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable	
<p>Observations: The member was not hospitalized during the review period.</p>		
<p>9. The RCCO (or designee) provided assistance during other transitions, such as the transition from children’s health services to adult health services or from hospital or home care into a nursing facility.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3</i> <i>Region 2: Exhibit A—6.4.5.1.3</i> <i>Regions 3, 5: Exhibit A—6.4.5.1.4</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The RCCO provided documentation demonstrating that the initial PCMP transferred medical records to the member’s new PCMP to help maintain continuity of care.</p>		
<p>10. The RCCO (or designee) documented and communicated necessary information about the member to the providers, institutions, and individuals involved in the transition.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3</i> <i>Region 2: Exhibit A—6.4.5.1.3</i> <i>Regions 3, 5: Exhibit A—6.4.5.1.4</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The RCCO provided documentation demonstrating that the initial PCMP transferred medical records to the member’s new PCMP to help maintain continuity of care.</p>		



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Care Coordination Program Record Review		Score
Continued Coordination/Follow-up		
11. The documentation clearly indicated that the RCCO’s (or designee’s) provision of care coordination services was responsive to the member’s needs. <i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.2.3 Regions 2, 3, 5 : Exhibit A—6.4.5.2.3</i>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The member’s records showed that the PCMP addressed all medical and non-medical issues identified by the member.		
12. The RCCO (or designee) followed up with the member to assess whether the member has received the services needed and/or if the member is on track to reach his or her desired health outcomes. <i>Regions 1, 4, 6, 7 Exhibit A—6.4.3.1.6 Region 2: Exhibit A—6.4.5.1.6 Regions 3, 5: Exhibit A—6.4.5.1.7</i>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The PCMP’s documentation showed regular follow-up with the member to ensure that the member’s needs were being addressed.		

Recommendations:
 Although this member was not identified as needing comprehensive care coordination services, documentation showed that the PCMP was thorough in its assessment of the member’s needs and addressed each need adequately. The PCMP was also cooperative during the member’s transition to a new PCMP. HSAG has no recommendations.

Results for Care Coordination Program Record Review—Sample #19					
Total	Met	=	<u>11</u>	X	1.00 = <u>11</u>
	Partially Met	=	<u>0</u>	X	0.0 = <u>0</u>
	Not Met	=	<u>0</u>	X	0.0 = <u>0</u>
	Not Applicable	=	<u>1</u>	X	NA = <u>0</u>
Total Applicable		=	<u>11</u>	Total Score	= <u>11</u>
		Total Score ÷ Total Applicable	=	<u>100%</u>	



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Care Coordination Program Record Review		Score
Intervention		
<p>4. The RCCO (or designee) worked with providers responsible for the member’s care to develop a plan for regular communication with those responsible for the member’s care coordination.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.2.3</i> <i>Regions 2, 3, 5: Exhibit A—6.4.4.3</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The PCMP documented regular communication with both the Barbara Davis Center and the Children’s Hospital Colorado. The PCMP also documented conversations with the home health therapist and endocrinologist.</p>		
<p>5. The RCCO (or designee) reasonably ensured that all care coordination services, including those provided by other individuals or entities, met the needs of the member.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.2.4</i> <i>Regions 2, 3, 5: Exhibit A—6.4.4.4</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The PCMP documented regular communication with the child’s family and providers.</p>		
<p>6. The RCCO (or designee) provided necessary care coordination services not provided by another source.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.2.2</i> <i>Regions 2, 3, 5: Exhibit A—6.4.4.2</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The PCMP assisted the family with arrangements to obtain additional formula as soon as it was noted that the allowance provided through Women, Infants, and Children (WIC) program was not sufficient. The PCMP also assisted with living arrangements for the family while the child received treatment in Denver and made sure that the family had contact information for care coordinators located in Denver.</p>		
<p>7. The RCCO (or designee) linked the member to medical and/or non-medical services, acted as a liaison between medical providers or between medical and non-medical providers, and/or served as a liaison between providers and the member.</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"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The PCMP linked the member’s family to both medical and non-medical services.</p>		



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Care Coordination Program Record Review		Score
Transitions		
<p>8. The RCCO (or designee) provided assistance during care transitions from hospitals or other care institutions to home- or community-based settings. This assistance promoted continuity of care.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3</i> <i>Region 2.: Exhibit A—6.4.5.1.3</i> <i>Regions 3, 5: Exhibit A—6.4.5.1.4</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>The PCMP documented telephone calls with staff members at the Children’s Hospital Colorado in Denver, staff from the Barbara Davis Center, and doctor-to-doctor regarding discharge instructions. Furthermore, at the time of review, the medical team was preparing for the child’s bone marrow transplant in Denver. The PCMP team was working with staff at The Children’s Hospital Colorado and the Barbara Davis Center to ensure that the family had adequate accommodations while in Denver and that the family had contact information for care coordinators in Denver.</p>		
<p>9. The RCCO (or designee) provided assistance during other transitions, such as the transition from children’s health services to adult health services or from hospital or home care into a nursing facility.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3</i> <i>Region 2: Exhibit A—6.4.5.1.3</i> <i>Regions 3, 5: Exhibit A—6.4.5.1.4</i></p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>The member did not experience this type of transition during the review period.</p>		
<p>10. The RCCO (or designee) documented and communicated necessary information about the member to the providers, institutions, and individuals involved in the transition.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3</i> <i>Region 2: Exhibit A—6.4.5.1.3</i> <i>Regions 3, 5: Exhibit A—6.4.5.1.4</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>The PCMP documented telephone calls with staff members at the Children’s Hospital Colorado in Denver, staff from the Barbara Davis Center, and doctor-to-doctor regarding the child’s inpatient stay and related discharge instructions.</p>		



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Care Coordination Program Record Review		Score
Continued Coordination/Follow-up		
11. The documentation clearly indicated that the RCCO’s (or designee’s) provision of care coordination services was responsive to the member’s needs. <i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.2.3 Regions 2, 3, 5 : Exhibit A—6.4.5.2.3</i>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The PCMP staff was effective in coordinating this child’s care while not duplicating efforts of other agencies and providers.		
12. The RCCO (or designee) followed up with the member to assess whether the member has received the services needed and/or if the member is on track to reach his or her desired health outcomes. <i>Regions 1, 4, 6, 7 Exhibit A—6.4.3.1.6 Region 2: Exhibit A—6.4.5.1.6 Regions 3, 5: Exhibit A—6.4.5.1.7</i>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The PCMP documented regular follow-up with the family and with the member’s providers to ensure that the member’s needs were addressed.		

Recommendations:
 The PCMP did a commendable job coordinating this member’s care with the various agencies involved. HSAG has no recommendations.

Results for Care Coordination Program Record Review—Sample #20					
Total	Met	=	<u>11</u>	X	1.00 = <u>11</u>
	Partially Met	=	<u>0</u>	X	0.0 = <u>0</u>
	Not Met	=	<u>0</u>	X	0.0 = <u>0</u>
	Not Applicable	=	<u>1</u>	X	NA = <u>0</u>
Total Applicable		=	<u>11</u>	Total Score	= <u>11</u>

Total Score ÷ Total Applicable	=	<u>100%</u>
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Appendix B. Colorado Department of Health Care Policy and Financing
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Sample Number: Oversample (OS) #1

Reviewer: Kathy Bartilotta

Care Coordination Program Record Review		Score
Assessment		
<p>1. The RCCO (or designee) assessed the member's:</p> <ul style="list-style-type: none"> ◆ Health behavior risks. ◆ Health/medical needs. <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.1.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>The member was a 51-year-old with COPD, diabetes, and morbid obesity (over 400 lbs.) The member's son was the caregiver. The member was depressed due to his perception of being home-bound due to his obesity. The RCCO coordinator supported the PCMP care coordinator.</p>		
<p>2. The RCCO (or designee) assessed the member's:</p> <ul style="list-style-type: none"> ◆ Non-medical needs. ◆ Linguistic and cultural needs. <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1; 6.4.3.2.2</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.1.1; 6.4.5.2.2</i></p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>The member needed food delivered because she could not travel to the store and also had financial issues. Meals were provided through Project Angel Heart. The member could not get to the PCMP for appointments due to limited transportation opportunities related to obesity. Language was noted in the record, but there was no assessment of cultural beliefs/behaviors.</p>		
<p>3. The RCCO (or designee) assessed current care coordination services provided to the member 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</i> <i>Regions 2, 3, 5: Exhibit A—6.4.4.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>The RCCO care coordinator worked with the PCMP care coordinator. There were no other care coordinators involved.</p>		



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Care Coordination Program Record Review		Score
Intervention		
<p>4. The RCCO (or designee) worked with providers responsible for the member’s care to develop a plan for regular communication with those responsible for the member’s care coordination.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.2.3</i> <i>Regions 2, 3, 5: Exhibit A—6.4.4.3</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: Providers included home care for home-based physical therapy and treatment from AspenPointe. The RCCO care coordinator interacted frequently with providers and communicated information to the PCMP care coordinator.</p>		
<p>5. The RCCO (or designee) reasonably ensured that all care coordination services, including those provided by other individuals or entities, met the needs of the member.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.2.4</i> <i>Regions 2, 3, 5: Exhibit A—6.4.4.4</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The care coordinator conducted follow-up of all referrals, including home care PT and transportation. Communications were documented in the record and written home care reports were sent to the PCMP. The member called the care coordinator whenever she had needs.</p>		
<p>6. The RCCO (or designee) provided necessary care coordination services not provided by another source.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.2.2</i> <i>Regions 2, 3, 5: Exhibit A—6.4.4.2</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The record documented care coordination activities provided by the PCMP care coordinator and RCCO care coordinator.</p>		
<p>7. The RCCO (or designee) linked the member to medical and/or non-medical services, acted as a liaison between medical providers or between medical and non-medical providers, and/or served as a liaison between providers and the member.</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"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: Care coordinators arranged for transportation services, inpatient rehabilitation to improve transfers and standing, TeleCare diabetes support, Project Angel Heart meal preparation and delivery, and home care physical therapy. The care coordinators conducted frequent telephone communications with all providers.</p>		



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Care Coordination Program Record Review		Score
Transitions		
<p>8. The RCCO (or designee) provided assistance during care transitions from hospitals or other care institutions to home- or community-based settings. This assistance promoted continuity of care.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3</i> <i>Region 2.: Exhibit A—6.4.5.1.3</i> <i>Regions 3, 5: Exhibit A—6.4.5.1.4</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The member was hospitalized. Colorado Springs Health Partners (the member’s PCMP) has its own hospitalist team, who communicated with the CSHP care coordinator and documented all notes in the CSHP electronic health record, enabling continuity of care and a continuous flow of information.</p>		
<p>9. The RCCO (or designee) provided assistance during other transitions, such as the transition from children’s health services to adult health services or from hospital or home care into a nursing facility.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3</i> <i>Region 2: Exhibit A—6.4.5.1.3</i> <i>Regions 3, 5: Exhibit A—6.4.5.1.4</i></p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable	
<p>Observations: The member did not experience this type of transition.</p>		
<p>10. The RCCO (or designee) documented and communicated necessary information about the member to the providers, institutions, and individuals involved in the transition.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3</i> <i>Region 2: Exhibit A—6.4.5.1.3</i> <i>Regions 3, 5: Exhibit A—6.4.5.1.4</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The CSHP hospitalist team documented in the CSHP record, and the PCMP care coordinator communicated with all other providers, as applicable.</p>		



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Care Coordination Program Record Review		Score
Continued Coordination/Follow-up		
11. The documentation clearly indicated that the RCCO’s (or designee’s) provision of care coordination services was responsive to the member’s needs. <i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.2.3 Regions 2, 3, 5 : Exhibit A—6.4.5.2.3</i>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: All care coordinator documentation of needs, services, and contacts with providers and the member were documented in the record.		
12. The RCCO (or designee) followed up with the member to assess whether the member has received the services needed and/or if the member is on track to reach his or her desired health outcomes. <i>Regions 1, 4, 6, 7 Exhibit A—6.4.3.1.6 Region 2: Exhibit A—6.4.5.1.6 Regions 3, 5: Exhibit A—6.4.5.1.7</i>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The care coordinator documented numerous (almost weekly) telephone interactions with the member to discuss needs and progress.		

Recommendations:
 HSAG had no recommendation for this case.

Results for Care Coordination Program Record Review—Sample OS #1					
Total	Met	=	<u>10</u>	X	1.00 = <u>10</u>
	Partially Met	=	<u>1</u>	X	0.0 = <u>0</u>
	Not Met	=	<u>0</u>	X	0.0 = <u>0</u>
	Not Applicable	=	<u>1</u>	X	NA = <u>0</u>
Total Applicable		=	<u>11</u>	Total Score	= <u>10</u>
		Total Score ÷ Total Applicable	=	<u>91%</u>	



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Sample Number: OS #2

Reviewer: Rachel Henrichs

Care Coordination Program Record Review		Score
Assessment		
1. The RCCO (or designee) assessed the member's: <ul style="list-style-type: none"> ◆ Health behavior risks. ◆ Health/medical needs. <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"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The PCMP was responsible for coordinating this member's care. The member had been receiving services from the PCMP since March 2011. The PCMP conducted a health risk and needs assessment at every appointment.		
2. The RCCO (or designee) assessed the member's: <ul style="list-style-type: none"> ◆ Non-medical needs. ◆ Linguistic and cultural needs. <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1; 6.4.3.2.2 Regions 2, 3, 5: Exhibit A—6.4.5.1.1; 6.4.5.2.2</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The PCMP identified and noted the member's non-medical, linguistic, and cultural needs.		
3. The RCCO (or designee) assessed current care coordination services provided to the member 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 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>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The PCMP documented coordination efforts with Colorado Springs Health Partners (CSHP), AspenPointe, the CARES program, the Lighthouse intensive outpatient program, and the Colorado Department of Human Services.		



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Care Coordination Program Record Review		Score
Intervention		
<p>4. The RCCO (or designee) worked with providers responsible for the member’s care to develop a plan for regular communication with those responsible for the member’s care coordination.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.2.3 Regions 2, 3, 5: Exhibit A—6.4.4.3</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: This member was difficult to contact for various reasons. As such, contact notes described comprehensive coordination between the agencies involved in this member’s care. As soon as one agency had an update or documented contact with the member, that agency would update the others to ensure all involved providers were up-to-date on the member’s status. The RCCO care manager, PCMP care manager, and a representative from the CARES program participated in a comprehensive home visit.</p>		
<p>5. The RCCO (or designee) reasonably ensured that all care coordination services, including those provided by other individuals or entities, met the needs of the member.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.2.4 Regions 2, 3, 5: Exhibit A—6.4.4.4</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The PCMP notes included updates from the behavioral health care provider and from specialists and calls to/from the RCCO care coordinator. Notes also indicated the PCMP and RCCO care managers coordinated regularly with representatives from the CARES program.</p>		
<p>6. The RCCO (or designee) provided necessary care coordination services not provided by another source.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.2.2 Regions 2, 3, 5: Exhibit A—6.4.4.2</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The RCCO and PCMP care managers worked with the member’s landlord to address issues with bedbugs and with Ecumenical Social Ministries (ESM) to obtain financial assistance for prescriptions. The care managers worked with the member to address transportation issues and to provide education regarding domestic abuse. The care managers worked with the member to find temporary housing, which proved exceptionally difficult due to the member’s assault charges.</p>		



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Care Coordination Program Record Review		Score
Intervention		
<p>7. The RCCO (or designee) linked the member to medical and/or non-medical services, acted as a liaison between medical providers or between medical and non-medical providers, and/or served as a liaison between providers and the member.</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"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The care managers linked the member to several medical and non-medical services and advocated on the member’s behalf to expedite services.</p>		



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Care Coordination Program Record Review		Score
Transitions		
<p>8. The RCCO (or designee) provided assistance during care transitions from hospitals or other care institutions to home- or community-based settings. This assistance promoted continuity of care.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3</i> <i>Region 2.: Exhibit A—6.4.5.1.3</i> <i>Regions 3, 5: Exhibit A—6.4.5.1.4</i></p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable	
<p>Observations: No transition of care was documented during 2013.</p>		
<p>9. The RCCO (or designee) provided assistance during other transitions, such as the transition from children’s health services to adult health services or from hospital or home care into a nursing facility.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3</i> <i>Region 2: Exhibit A—6.4.5.1.3</i> <i>Regions 3, 5: Exhibit A—6.4.5.1.4</i></p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable	
<p>Observations: No transition of care was documented during 2013.</p>		
<p>10. The RCCO (or designee) documented and communicated necessary information about the member to the providers, institutions, and individuals involved in the transition.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3</i> <i>Region 2: Exhibit A—6.4.5.1.3</i> <i>Regions 3, 5: Exhibit A—6.4.5.1.4</i></p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable	
<p>Observations: No transition of care was documented during 2013.</p>		



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Care Coordination Program Record Review		Score
Continued Coordination/Follow-up		
11. The documentation clearly indicated that the RCCO’s (or designee’s) provision of care coordination services was responsive to the member’s needs. <i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.2.3</i> <i>Regions 2, 3, 5 : Exhibit A—6.4.5.2.3</i>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: Notes in the member’s record indicated that care coordinators worked well with each other to address the member’s needs without duplicating efforts.		
12. The RCCO (or designee) followed up with the member to assess whether the member has received the services needed and/or if the member is on track to reach his or her desired health outcomes. <i>Regions 1, 4, 6, 7 Exhibit A—6.4.3.1.6</i> <i>Region 2: Exhibit A—6.4.5.1.6</i> <i>Regions 3, 5: Exhibit A—6.4.5.1.7</i>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The most challenging aspect of addressing this member’s needs appeared to be the member’s unwillingness to cooperate with recommendations. The care management team followed up with the member and with each other regularly to ensure that all possible was being done to assist the member.		

Recommendations:
 The emergency department diversion team followed up with the member after every emergency department visit. As a result of the team’s efforts, the member’s ED visits declined from more than 50 in 2013 to fewer than 6 during the first few months of 2014. The care coordinators communicated with each other regularly and kept complete documentation. The care provided was comprehensive. HSAG has no recommendations.

Results for Care Coordination Program Record Review—Sample OS #2					
Total	Met	=	<u>9</u>	X	1.00 = <u>9</u>
	Partially Met	=	<u>0</u>	X	0.0 = <u>0</u>
	Not Met	=	<u>0</u>	X	0.0 = <u>0</u>
	Not Applicable	=	<u>3</u>	X	NA = <u>0</u>
Total Applicable		=	<u>9</u>	Total Score	= <u>9</u>
		Total Score ÷ Total Applicable	=	<u>100%</u>	



Appendix B. Colorado Department of Health Care Policy and Financing
FY 2013–2014 Coordination of Care Tool
for Community Health Partnership (Region 7)

Sample Number: OS #3

Reviewer: Rachel Henrichs

Care Coordination Program Record Review		Score
Assessment		
1. The RCCO (or designee) assessed the member's: <ul style="list-style-type: none"> ◆ Health behavior risks. ◆ Health/medical needs. <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.1.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: This member was attributed to the PCMP in March of 2013. The PCMP's assessment of health risks and needs identified uncontrolled diabetes, drug and alcohol abuse, and multiple suicide attempts.		
2. The RCCO (or designee) assessed the member's: <ul style="list-style-type: none"> ◆ Non-medical needs. ◆ Linguistic and cultural needs. <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1; 6.4.3.2.2</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.1.1; 6.4.5.2.2</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The PCMP conducted a thorough and ongoing assessment of non-medical, linguistic, and cultural needs.		
3. The RCCO (or designee) assessed current care coordination services provided to the member 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 align="right"><i>Regions 1, 4, 6, 7: Exhibit A— 6.4.2.1</i> <i>Regions 2, 3, 5: Exhibit A—6.4.4.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The RCCO delegated care coordination to the member's PCMP. The PCMP care manager documented coordination efforts with Cedar Springs, Penrose Hospital, and the CARES program.		



Appendix B. Colorado Department of Health Care Policy and Financing
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for Community Health Partnership (Region 7)

Care Coordination Program Record Review		Score
Intervention		
<p>4. The RCCO (or designee) worked with providers responsible for the member’s care to develop a plan for regular communication with those responsible for the member’s care coordination.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.2.3</i> <i>Regions 2, 3, 5: Exhibit A—6.4.4.3</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The member’s record documented coordination efforts between the PCMP care manager, Cedar Springs, Penrose Hospital, and the CARES program.</p>		
<p>5. The RCCO (or designee) reasonably ensured that all care coordination services, including those provided by other individuals or entities, met the needs of the member.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.2.4</i> <i>Regions 2, 3, 5: Exhibit A—6.4.4.4</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The care manager attempted regular follow-up calls with the member and spoke frequently to other agencies involved in the member’s care.</p>		
<p>6. The RCCO (or designee) provided necessary care coordination services not provided by another source.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.2.2</i> <i>Regions 2, 3, 5: Exhibit A—6.4.4.2</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The care manager attempted to find the member housing.</p>		
<p>7. The RCCO (or designee) linked the member to medical and/or non-medical services, acted as a liaison between medical providers or between medical and non-medical providers, and/or served as a liaison between providers and the member.</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"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The care manager referred the member to an endocrinologist (member never followed through) and sought out housing options.</p>		



Appendix B. Colorado Department of Health Care Policy and Financing
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for Community Health Partnership (Region 7)

Care Coordination Program Record Review		Score
Transitions		
<p>8. The RCCO (or designee) provided assistance during care transitions from hospitals or other care institutions to home- or community-based settings. This assistance promoted continuity of care.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3</i> <i>Region 2.: Exhibit A—6.4.5.1.3</i> <i>Regions 3, 5: Exhibit A—6.4.5.1.4</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The care manager visited the member in the hospital multiple times and coordinated discharge plans with hospital staff.</p>		
<p>9. The RCCO (or designee) provided assistance during other transitions, such as the transition from children’s health services to adult health services or from hospital or home care into a nursing facility.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3</i> <i>Region 2: Exhibit A—6.4.5.1.3</i> <i>Regions 3, 5: Exhibit A—6.4.5.1.4</i></p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable	
<p>Observations: The member did not experience this type of transition during the review period.</p>		
<p>10. The RCCO (or designee) documented and communicated necessary information about the member to the providers, institutions, and individuals involved in the transition.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3</i> <i>Region 2: Exhibit A—6.4.5.1.3</i> <i>Regions 3, 5: Exhibit A—6.4.5.1.4</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The member’s record included multiple calls between care managers; discharge summaries; and documentations of meetings between the RCCO, the PCMP, the hospital care managers, and the member.</p>		



Appendix B. Colorado Department of Health Care Policy and Financing
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Care Coordination Program Record Review		Score
Continued Coordination/Follow-up		
11. The documentation clearly indicated that the RCCO’s (or designee’s) provision of care coordination services was responsive to the member’s needs. <i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.2.3</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.2.3</i>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The care managers involved with this member’s care made extensive attempts to address this member’s needs. The member was noncompliant with all recommendations.		
12. The RCCO (or designee) followed up with the member to assess whether the member has received the services needed and/or if the member is on track to reach his or her desired health outcomes. <i>Regions 1, 4, 6, 7 Exhibit A—6.4.3.1.6</i> <i>Region 2: Exhibit A—6.4.5.1.6</i> <i>Regions 3, 5: Exhibit A—6.4.5.1.7</i>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The care managers followed up regularly with each other and made frequent attempts to contact the member. Unfortunately, the member’s repeated noncompliance eventually resulted in the member’s death.		

Recommendations:
 The care managers appeared to do all they could to coordinate this member’s care. HSAG has no recommendations.

Results for Care Coordination Program Record Review—Sample OS #3					
Total	Met	=	<u>11</u>	X	1.00 = <u>11</u>
	Partially Met	=	<u>0</u>	X	0.0 = <u>0</u>
	Not Met	=	<u>0</u>	X	0.0 = <u>0</u>
	Not Applicable	=	<u>1</u>	X	NA = <u>0</u>
Total Applicable		=	<u>11</u>	Total Score	= <u>11</u>
		Total Score ÷ Total Applicable	=	<u>100%</u>	



Appendix B. Colorado Department of Health Care Policy and Financing
FY 2013–2014 Coordination of Care Tool
for Community Health Partnership (Region 7)

Sample Number: OS #4

Reviewer: Rachel Henrichs

Care Coordination Program Record Review		Score
Assessment		
1. The RCCO (or designee) assessed the member's: <ul style="list-style-type: none"> ◆ Health behavior risks. ◆ Health/medical needs. 	<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>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
Observations:		
The PCMP conducted a full health risk assessment in May 2013 and again in September 2013. This member is a male-to-female transgender with a history of traumatic brain injury, pseudoseizures, and anxiety.		
2. The RCCO (or designee) assessed the member's: <ul style="list-style-type: none"> ◆ Non-medical needs. ◆ Linguistic and cultural needs. 	<i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1; 6.4.3.2.2</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.1.1; 6.4.5.2.2</i>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
Observations:		
The PCMP conducted an assessment of the member's non-medical, linguistic, and cultural needs. The member's electronic health record included an alert notifying staff that the member identifies with the Mennonite religion and further clarified that this required that the member be treated by female providers and/or that a family member be present during the examination. The member asked for help with communicating with specialists and the PCP.		
3. The RCCO (or designee) assessed current care coordination services provided to the member 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.	<i>Regions 1, 4, 6, 7: Exhibit A— 6.4.2.1</i> <i>Regions 2, 3, 5: Exhibit A—6.4.4.1</i>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
Observations:		
The member's record included correspondence to and from the member's endocrinologist, neurologist, and neuropsychologist.		



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Care Coordination Program Record Review		Score
Intervention		
<p>4. The RCCO (or designee) worked with providers responsible for the member’s care to develop a plan for regular communication with those responsible for the member’s care coordination.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.2.3</i> <i>Regions 2, 3, 5: Exhibit A—6.4.4.3</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The PCMP maintained notes from all member visits with specialists in the member’s electronic health record. This indicated good coordination between the PCMP and specialists.</p>		
<p>5. The RCCO (or designee) reasonably ensured that all care coordination services, including those provided by other individuals or entities, met the needs of the member.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.2.4</i> <i>Regions 2, 3, 5: Exhibit A—6.4.4.4</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The member’s electronic health record included notes from all of the member’s specialists. The care coordinator followed up with the member regularly to ensure that the member’s needs were being addressed.</p>		
<p>6. The RCCO (or designee) provided necessary care coordination services not provided by another source.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.2.2</i> <i>Regions 2, 3, 5: Exhibit A—6.4.4.2</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The PCMP provided all care coordination services. The care manager worked with the member’s PCP to obtain a medical exemption letter to excuse the member from jury duty.</p>		
<p>7. The RCCO (or designee) linked the member to medical and/or non-medical services, acted as a liaison between medical providers or between medical and non-medical providers, and/or served as a liaison between providers and the member.</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"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The care manager attended neurology, neuropsychology, and endocrinology appointments with the member to help ensure that the member’s needs were addressed.</p>		



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Care Coordination Program Record Review		Score
Transitions		
<p>8. The RCCO (or designee) provided assistance during care transitions from hospitals or other care institutions to home- or community-based settings. This assistance promoted continuity of care.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3</i> <i>Region 2.: Exhibit A—6.4.5.1.3</i> <i>Regions 3, 5: Exhibit A—6.4.5.1.4</i></p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable	
<p>Observations: No transition of care was documented during 2013.</p>		
<p>9. The RCCO (or designee) provided assistance during other transitions, such as the transition from children’s health services to adult health services or from hospital or home care into a nursing facility.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3</i> <i>Region 2: Exhibit A—6.4.5.1.3</i> <i>Regions 3, 5: Exhibit A—6.4.5.1.4</i></p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable	
<p>Observations: No transition of care was documented during 2013.</p>		
<p>10. The RCCO (or designee) documented and communicated necessary information about the member to the providers, institutions, and individuals involved in the transition.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3</i> <i>Region 2: Exhibit A—6.4.5.1.3</i> <i>Regions 3, 5: Exhibit A—6.4.5.1.4</i></p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable	
<p>Observations: No transition of care was documented during 2013.</p>		



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Care Coordination Program Record Review		Score
Continued Coordination/Follow-up		
11. The documentation clearly indicated that the RCCO’s (or designee’s) provision of care coordination services was responsive to the member’s needs. <i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.2.3</i> <i>Regions 2, 3,5 : Exhibit A—6.4.5.2.3</i>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The care manager appeared to address all member needs in a culturally-sensitive manner.		
12. The RCCO (or designee) followed up with the member to assess whether the member has received the services needed and/or if the member is on track to reach his or her desired health outcomes. <i>Regions 1, 4, 6, 7 Exhibit A—6.4.3.1.6</i> <i>Region 2: Exhibit A—6.4.5.1.6</i> <i>Regions 3, 5: Exhibit A—6.4.5.1.7</i>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The care manager followed up with the member regularly and with the member’s specialty providers to ensure the member received the services needed.		

Recommendations:
 Care coordination in this case was effective and well-documented. HSAG has no recommendations.

Results for Care Coordination Program Record Review—Sample OS #4					
Total	Met	=	<u>9</u>	X	1.00 = <u>9</u>
	Partially Met	=	<u>0</u>	X	0.0 = <u>0</u>
	Not Met	=	<u>0</u>	X	0.0 = <u>0</u>
	Not Applicable	=	<u>3</u>	X	NA = <u>0</u>
Total Applicable		=	<u>9</u>	Total Score	= <u>9</u>
		Total Score ÷ Total Applicable	=	<u>100%</u>	



*Appendix B. Colorado Department of Health Care Policy and Financing
 FY 2013–2014 Coordination of Care Tool
 for Community Health Partnership (Region 7)*

Sample Number: OS #5

Reviewer: Rachel Henrichs

Care Coordination Program Record Review		Score
Assessment		
1. The RCCO (or designee) assessed the member's: <ul style="list-style-type: none"> ◆ Health behavior risks. ◆ Health/medical needs. <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"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The PCMP conducted a health risk assessment in May 2013 and again in December 2013. The member had had multiple strokes and was unable to care for her five children. The member was referred to the care management program after Colorado Department of Human Services removed the member's children from the home.		
2. The RCCO (or designee) assessed the member's: <ul style="list-style-type: none"> ◆ Non-medical needs. ◆ Linguistic and cultural needs. <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1; 6.4.3.2.2 Regions 2, 3, 5: Exhibit A—6.4.5.1.1; 6.4.5.2.2</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The PCMP conducted a thorough assessment of the member's non-medical, linguistic, and cultural needs.		
3. The RCCO (or designee) assessed current care coordination services provided to the member 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 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>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The PCMP documented the agencies and providers with which the member was working.		



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Care Coordination Program Record Review		Score
Intervention		
<p>4. The RCCO (or designee) worked with providers responsible for the member’s care to develop a plan for regular communication with those responsible for the member’s care coordination.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.2.3</i> <i>Regions 2, 3, 5: Exhibit A—6.4.4.3</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The care manager documented regular communication with the member’s home health care provider and documented doctor-to-doctor conversations related to the member’s issues with prescriptions.</p>		
<p>5. The RCCO (or designee) reasonably ensured that all care coordination services, including those provided by other individuals or entities, met the needs of the member.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.2.4</i> <i>Regions 2, 3, 5: Exhibit A—6.4.4.4</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The care manager collected the member’s discharge summaries and worked with the member to ensure the member scheduled and attended follow-up appointments with specialists, occupational therapists, and physical therapists.</p>		
<p>6. The RCCO (or designee) provided necessary care coordination services not provided by another source.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.2.2</i> <i>Regions 2, 3, 5: Exhibit A—6.4.4.2</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The care manager provided the member with information regarding smoking cessation, arranged for behavioral health visits at the PCMP location, assisted with applications for meal assistance, assisted with contingency arrangements for the member’s five children, arranged for school supplies for the children, and helped procure a handicap placard.</p>		
<p>7. The RCCO (or designee) linked the member to medical and/or non-medical services, acted as a liaison between medical providers or between medical and non-medical providers, and/or served as a liaison between providers and the member.</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"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The care manager documented numerous links to medical and/or non-medical services and regularly acted as a liaison between the member and her providers.</p>		



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Care Coordination Program Record Review		Score
Transitions		
<p>8. The RCCO (or designee) provided assistance during care transitions from hospitals or other care institutions to home- or community-based settings. This assistance promoted continuity of care.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3</i> <i>Region 2.: Exhibit A—6.4.5.1.3</i> <i>Regions 3, 5: Exhibit A—6.4.5.1.4</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The care manager obtained a discharge summary after the member was discharged from Penrose Hospital and followed up with the member to ensure compliance with the instructions.</p>		
<p>9. The RCCO (or designee) provided assistance during other transitions, such as the transition from children’s health services to adult health services or from hospital or home care into a nursing facility.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3</i> <i>Region 2: Exhibit A—6.4.5.1.3</i> <i>Regions 3, 5: Exhibit A—6.4.5.1.4</i></p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable	
<p>Observations: The member did not require “other” transitions during the review period.</p>		
<p>10. The RCCO (or designee) documented and communicated necessary information about the member to the providers, institutions, and individuals involved in the transition.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3</i> <i>Region 2: Exhibit A—6.4.5.1.3</i> <i>Regions 3, 5: Exhibit A—6.4.5.1.4</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The care manager was not involved in the discharge planning; however, the care manager did contact the hospital after the member was discharged to obtain the paperwork and then followed up with the member.</p>		



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Care Coordination Program Record Review		Score
Continued Coordination/Follow-up		
11. The documentation clearly indicated that the RCCO’s (or designee’s) provision of care coordination services was responsive to the member’s needs. <i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.2.3</i> <i>Regions 2, 3, 5 : Exhibit A—6.4.5.2.3</i>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The care manager consistently documented the services provided to this member. Documentation indicated the care manager was responsive to the member’s needs.		
12. The RCCO (or designee) followed up with the member to assess whether the member has received the services needed and/or if the member is on track to reach his or her desired health outcomes. <i>Regions 1, 4, 6, 7 Exhibit A—6.4.3.1.6</i> <i>Region 2: Exhibit A—6.4.5.1.6</i> <i>Regions 3, 5: Exhibit A—6.4.5.1.7</i>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The care manager followed up regularly with the member to ensure the member’s needs were addressed. After the member’s situation stabilized, the care manager made sure the member had all contact information and then closed the file. After the case was closed, the member did call the care manager to request assistance with scheduling an appointment. This is an indication of the good relationship that the care manager developed with the member.		

Recommendations:
 The care manager was effective in coordinating this member’s needs. HSAG has no recommendations.

Results for Care Coordination Program Record Review—Sample OS #5					
Total	Met	=	<u>11</u>	X	1.00 = <u>11</u>
	Partially Met	=	<u>0</u>	X	0.0 = <u>0</u>
	Not Met	=	<u>0</u>	X	0.0 = <u>0</u>
	Not Applicable	=	<u>1</u>	X	NA = <u>0</u>
Total Applicable		=	<u>11</u>	Total Score	= <u>11</u>

Total Score ÷ Total Applicable		=	<u>100%</u>
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—Draft Copy for Review—



*Appendix B. Colorado Department of Health Care Policy and Financing
 FY 2013–2014 Coordination of Care Tool
 for Community Health Partnership (Region 7)*

Sample Number: OS #6

Reviewer: Kathy Bartilotta

Care Coordination Program Record Review		Score
Assessment		
1. The RCCO (or designee) assessed the member's: <ul style="list-style-type: none"> ◆ Health behavior risks. ◆ Health/medical needs. 	<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>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
Observations: This member was managed by a PCMP very involved with its patients and which attracts a large number of high-risk members. The PCMP manages its own patients and has an in-office care manager. The member is a 29-year-old with hemophilia, with chronic pain from an orthopedic condition, and who is obese. The record indicated that the member had excessive health care costs. The member has multiple specialty providers, including ongoing care from the Rocky Mountain Cancer Center's hematologists, the Children's Hospital Colorado hemophilia and orthopedics clinics.		
2. The RCCO (or designee) assessed the member's: <ul style="list-style-type: none"> ◆ Non-medical needs. ◆ Linguistic and cultural needs. 	<i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1; 6.4.3.2.2 Regions 2, 3, 5: Exhibit A—6.4.5.1.1; 6.4.5.2.2</i>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
Observations: The member had transportation needs and needs to lose weight. Cultural needs were not assessed. High-priority needs were medical in nature.		
3. The RCCO (or designee) assessed current care coordination services provided to the member 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.	<i>Regions 1, 4, 6, 7: Exhibit A— 6.4.2.1 Regions 2, 3, 5: Exhibit A—6.4.4.1</i>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
Observations: The PCMP received ongoing correspondence from the Children's Hospital Colorado regarding services being organized through the Children's Hospital Colorado clinic. The Children's Hospital Colorado also communicated recommendations for services (such as home physical therapy) that were then arranged by the PCMP.		



Appendix B. Colorado Department of Health Care Policy and Financing
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Care Coordination Program Record Review		Score
Intervention		
<p>4. The RCCO (or designee) worked with providers responsible for the member’s care to develop a plan for regular communication with those responsible for the member’s care coordination.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.2.3</i> <i>Regions 2, 3, 5: Exhibit A—6.4.4.3</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>The PCMP and the Children’s Hospital Colorado clinic care coordinators were in frequent communication, and worked as a team to organize necessary services. The PCP communicated directly with other medical providers regarding referrals and to obtain feedback. The PCMP had a referral tracking system to follow up on member appointments and to obtain feedback from other providers.</p>		
<p>5. The RCCO (or designee) reasonably ensured that all care coordination services, including those provided by other individuals or entities, met the needs of the member.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.2.4</i> <i>Regions 2, 3, 5: Exhibit A—6.4.4.4</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>The PCMP and the Children’s Hospital Colorado clinic care coordinators were in frequent communication and managed a coordinated plan of care.</p>		
<p>6. The RCCO (or designee) provided necessary care coordination services not provided by another source.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.2.2</i> <i>Regions 2, 3, 5: Exhibit A—6.4.4.2</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>The member had medical transportation needs and needed a dental referral, which were both organized by the PCMP. Medical needs were managed through close communication between the PCMP and specialists, with local medical needs arranged by the PCMP and specialty medical needs arranged through the Children’s Hospital Colorado clinics in Denver.</p>		



Appendix B. Colorado Department of Health Care Policy and Financing
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Care Coordination Program Record Review		Score
Intervention		
<p>7. The RCCO (or designee) linked the member to medical and/or non-medical services, acted as a liaison between medical providers or between medical and non-medical providers, and/or served as a liaison between providers and the member.</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"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>The PCMP made arrangements for most non-medical services and coordinated with the Children’s Hospital Colorado clinics and specialists regarding medical referrals. For example, the member had frequent ER visits for chronic hip pain. The Children’s Hospital Colorado orthopedic clinic evaluated and provided ongoing treatment for the hip pain and referred the member to counseling for narcotics use.</p>		



Appendix B. Colorado Department of Health Care Policy and Financing
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Care Coordination Program Record Review		Score
Transitions		
<p>8. The RCCO (or designee) provided assistance during care transitions from hospitals or other care institutions to home- or community-based settings. This assistance promoted continuity of care.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3</i> <i>Region 2.: Exhibit A—6.4.5.1.3</i> <i>Regions 3, 5: Exhibit A—6.4.5.1.4</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>The member was hospitalized at the University of Colorado Hospital. The Children’s Hospital Colorado clinic conducted discharge planning, and the PCMP followed up with the member to determine if the member had additional resource needs, had updated medications, and had had a follow-up appointment. The RCCO also followed up with the member following ER visits.</p>		
<p>9. The RCCO (or designee) provided assistance during other transitions, such as the transition from children’s health services to adult health services or from hospital or home care into a nursing facility.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3</i> <i>Region 2: Exhibit A—6.4.5.1.3</i> <i>Regions 3, 5: Exhibit A—6.4.5.1.4</i></p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>The member did not experience this type of transition.</p>		
<p>10. The RCCO (or designee) documented and communicated necessary information about the member to the providers, institutions, and individuals involved in the transition.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3</i> <i>Region 2: Exhibit A—6.4.5.1.3</i> <i>Regions 3, 5: Exhibit A—6.4.5.1.4</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations:</p> <p>All information about the member’s care, including information from the Children’s Hospital Colorado clinics and activities and PCMP interventions and care coordination were maintained in the electronic medical record.</p>		



*Appendix B. Colorado Department of Health Care Policy and Financing
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 for Community Health Partnership (Region 7)*

Care Coordination Program Record Review		Score
Continued Coordination/Follow-up		
11. The documentation clearly indicated that the RCCO’s (or designee’s) provision of care coordination services was responsive to the member’s needs. <i>Regions: 1, 4, 6, 7: Exhibit A—6.4.3.2.3 Regions 2, 3, 5: Exhibit A—6.4.5.2.3</i>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The record documented interventions and outcomes but did not include documentation of the actual underlying assessment of comprehensive member needs. Needs were identified in an iterative manner as they were identified and then met throughout the ongoing management of the member’s conditions. All documentation was retained in the electronic medical record.		
12. The RCCO (or designee) followed up with the member to assess whether the member has received the services needed and/or if the member is on track to reach his or her desired health outcomes. <i>Regions 1, 4, 6, 7 Exhibit A—6.4.3.1.6 Region 2: Exhibit A—6.4.5.1.6 Regions 3, 5: Exhibit A—6.4.5.1.7</i>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The member had a care coordinator (CC) appointment at the PCMP every three months to review needs and resources and to update the plan as needed. The care coordinator contacted the member between CC appointments at least monthly. Documentation noted that the member was very engaged and positive about health outcomes.		

Recommendations:
 This was a complex medical management case which required coordination of local medical and non-medical resources with specialty resources being provided through the Children’s Hospital Colorado clinics in Denver. While it appears that all member needs were assessed and met as needed, documentation might be improved if the assessed needs (which drove the interventions and outcomes) were more clearly documented.

Results for Care Coordination Program Record Review—Sample OS #6					
Total	Met	=	<u>9</u>	X	1.00 = <u>9</u>
	Partially Met	=	<u>2</u>	X	0.0 = <u>0</u>
	Not Met	=	<u>0</u>	X	0.0 = <u>0</u>
	Not Applicable	=	<u>1</u>	X	NA = <u>0</u>
Total Applicable		=	<u>11</u>	Total Score	= <u>9</u>
Total Score ÷ Total Applicable = <u>82%</u>					



Appendix B. Colorado Department of Health Care Policy and Financing
FY 2013–2014 Coordination of Care Tool
for Community Health Partnership (Region 7)

Sample Number: OS #7

Reviewer: Kathy Bartilotta

Care Coordination Program Record Review		Score
Assessment		
1. The RCCO (or designee) assessed the member's: <ul style="list-style-type: none"> ◆ Health behavior risks. ◆ Health/medical needs. <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.1.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The member was a 43-year-old with severe developmental delays (functioning at approximately a 10-year-old level) due to microcephaly and possible encephalopathy. The member also has diabetes, hypertension, and obesity.		
2. The RCCO (or designee) assessed the member's: <ul style="list-style-type: none"> ◆ Non-medical needs. ◆ Linguistic and cultural needs. <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1; 6.4.3.2.2</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.1.1; 6.4.5.2.2</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The member has been in the RCCO since July 2012 and was well-known to the PCMP. The member was identified as a high ER utilizer in April 2013. The PCMP was providing care management but requested assistance from the RCCO care manager. The member lived with an elderly mother, the “matriarch” of a large Hispanic family. The sister was very involved with member, but brothers stayed uninvolved. The member runs away from home frequently (often goes to the ER), and the mother has been diagnosed with a terminal illness.		
3. The RCCO (or designee) assessed current care coordination services provided to the member 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 align="right"><i>Regions 1, 4, 6, 7: Exhibit A— 6.4.2.1</i> <i>Regions 2, 3, 5: Exhibit A—6.4.4.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The PCMP and RCCO care coordinators worked together to arrange services. The member needed a safer home environment. The member was also bored at home, which contributed to his running away. The Resource Exchange (TRE) was involved to assess the member for placement in a care facility or new home environment. ER physicians, who saw the member frequently, were also involved.		



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Care Coordination Program Record Review		Score
Intervention		
<p>4. The RCCO (or designee) worked with providers responsible for the member’s care to develop a plan for regular communication with those responsible for the member’s care coordination.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.2.3</i> <i>Regions 2, 3, 5: Exhibit A—6.4.4.3</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: All providers and agencies worked collaboratively to develop a plan of care and were in frequent communication.</p>		
<p>5. The RCCO (or designee) reasonably ensured that all care coordination services, including those provided by other individuals or entities, met the needs of the member.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.2.4</i> <i>Regions 2, 3, 5: Exhibit A—6.4.4.4</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The member was eligible for many wrap-around services. The Resource Exchange conducted a skilled needs assessment for placement in an alternative home environment. The member received mental health services through the PCMP (BH services colocated at the PCMP’s office) and arrangements were made for the member to receive bereavement counseling services. Care coordinators arranged a court appointment for designation of a guardian ad litem. There were frequent communications with the family. The family also received education about diabetes management.</p>		
<p>6. The RCCO (or designee) provided necessary care coordination services not provided by another source.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.2.2</i> <i>Regions 2, 3, 5: Exhibit A—6.4.4.2</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The PCMP and RCCO care coordination team managed the member’s needs, involved the TRE, and arranged for a court appointment and provision of in-office BH services. A team of people worked together to meet the member’s needs and to facilitate the member’s transition.</p>		



Appendix B. Colorado Department of Health Care Policy and Financing
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Care Coordination Program Record Review		Score
Intervention		
<p>7. The RCCO (or designee) linked the member to medical and/or non-medical services, acted as a liaison between medical providers or between medical and non-medical providers, and/or served as a liaison between providers and the member.</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"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The ER physicians and hospital staff routinely notified the PCMP of hospital visits. TRE was in frequent communication with the RCCO and the PCMP. The member needed a host home, with home care visits. TRE also arranged for the member to attend a day program five days a week.</p>		



Appendix B. Colorado Department of Health Care Policy and Financing
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Care Coordination Program Record Review		Score
Transitions		
<p>8. The RCCO (or designee) provided assistance during care transitions from hospitals or other care institutions to home- or community-based settings. This assistance promoted continuity of care.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3</i> <i>Region 2.: Exhibit A—6.4.5.1.3</i> <i>Regions 3, 5: Exhibit A—6.4.5.1.4</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations:		
The member had one hospitalization for bronchitis and was then discharged to home. The hospital notified the PCMP of the hospitalization, and the PCMP arranged for a follow-up appointment.		
<p>9. The RCCO (or designee) provided assistance during other transitions, such as the transition from children’s health services to adult health services or from hospital or home care into a nursing facility.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3</i> <i>Region 2: Exhibit A—6.4.5.1.3</i> <i>Regions 3, 5: Exhibit A—6.4.5.1.4</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations:		
The member was in need of a host home for the developmentally disabled, which required a waiver application and arrangements for home-based services and a day-program. The member also required a court-appointed guardian ad litem. The care coordination team assisted the member and family through the complex and lengthy process.		
<p>10. The RCCO (or designee) documented and communicated necessary information about the member to the providers, institutions, and individuals involved in the transition.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3</i> <i>Region 2: Exhibit A—6.4.5.1.3</i> <i>Regions 3, 5: Exhibit A—6.4.5.1.4</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations:		
The member ultimately changed to a new PCMP (Peak Vista) which has a disability clinic within. All information was transferred and communicated to the new PCMP.		



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Care Coordination Program Record Review		Score
Continued Coordination/Follow-up		
11. The documentation clearly indicated that the RCCO’s (or designee’s) provision of care coordination services was responsive to the member’s needs. <i>Regions: 1, 4, 6, 7: Exhibit A—6.4.3.2.3</i> <i>Regions 2, 3, 5 : Exhibit A—6.4.5.2.3</i>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: Documentation in the care coordination record was thorough.		
12. The RCCO (or designee) followed up with the member to assess whether the member has received the services needed and/or if the member is on track to reach his or her desired health outcomes. <i>Regions 1, 4, 6, 7 Exhibit A—6.4.3.1.6</i> <i>Region 2: Exhibit A—6.4.5.1.6</i> <i>Regions 3, 5: Exhibit A—6.4.5.1.7</i>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The member was a long-time client of the PCMP. The PCMP care coordinator and RCCO care coordinator co-managed coordination of member needs and were in frequent contact and communication with the member and family.		

Recommendations:
 This member had complex social and medical needs, with many providers and agencies involved. The member needs were thoroughly assessed and a team was organized to assist the member with multiple services. Care coordination in this case was well-organized and well-documented.

Results for Care Coordination Program Record Review—Sample OS #7					
Total	Met	=	<u>12</u>	X	1.00 = <u>12</u>
	Partially Met	=	<u>0</u>	X	0.0 = <u>0</u>
	Not Met	=	<u>0</u>	X	0.0 = <u>0</u>
	Not Applicable	=	<u>0</u>	X	NA = <u>0</u>
Total Applicable		=	<u>12</u>	Total Score	= <u>12</u>
Total Score ÷ Total Applicable				=	<u>100%</u>



*Appendix B. Colorado Department of Health Care Policy and Financing
 FY 2013–2014 Coordination of Care Tool
 for Community Health Partnership (Region 7)*

Sample Number: OS #8

Reviewer: Kathy Bartilotta

Care Coordination Program Record Review		Score
Assessment		
1. The RCCO (or designee) assessed the member's: <ul style="list-style-type: none"> ◆ Health behavior risks. ◆ Health/medical needs. <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"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The member was a 14-year-old with diabetes and scoliosis. The member received diabetic management through the Barbara Davis Center. The member was well-known to the PCMP (a patient since 2005). The RCCO and PCMP care manager worked together to assist with member needs. The health risks included nutrition issues due to poverty.		
2. The RCCO (or designee) assessed the member's: <ul style="list-style-type: none"> ◆ Non-medical needs. ◆ Linguistic and cultural needs. <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1; 6.4.3.2.2 Regions 2, 3, 5: Exhibit A—6.4.5.1.1; 6.4.5.2.2</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The member had poverty issues and family dynamics issues. Although the mother was responsible for the member's care, the member moved back and forth between parents. An older sister had addiction problems. The member's language was also noted.		
3. The RCCO (or designee) assessed current care coordination services provided to the member 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 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>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The RCCO contacted all involved providers. The Barbara Davis Center arranged member referrals for GI problems and eye exams. All notes from the Barbara Davis Center were retained in the member record. The member had an orthopedics evaluation and follow-up PT after a knee injury.		



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Care Coordination Program Record Review		Score
Intervention		
<p>4. The RCCO (or designee) worked with providers responsible for the member’s care to develop a plan for regular communication with those responsible for the member’s care coordination.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.2.3</i> <i>Regions 2, 3, 5: Exhibit A—6.4.4.3</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The school nurse provided the PCMP with notes regarding the member’s diabetic monitoring and health status. The notes from the Barbara Davis Center were forwarded to the PCMP. All documentation from home-based rehabilitation services was in the record.</p>		
<p>5. The RCCO (or designee) reasonably ensured that all care coordination services, including those provided by other individuals or entities, met the needs of the member.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.2.4</i> <i>Regions 2, 3, 5: Exhibit A—6.4.4.4</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The member was depressed and isolated due to adolescent peer concerns about her diabetes. The care coordinator performed a Patient Health Questionnaire (PHQ) and arranged for family counseling services with AspenPointe.</p>		
<p>6. The RCCO (or designee) provided necessary care coordination services not provided by another source.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.2.2</i> <i>Regions 2, 3, 5: Exhibit A—6.4.4.2</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The RCCO care coordinator arranged for home visits for health education through DHS and coordinated the appointments with the health department. The care coordinator (CC) traveled to attend these appointments with the member. The CC made arrangements with social services for the member to attend a diabetes camp and a ski trip.</p>		
<p>7. The RCCO (or designee) linked the member to medical and/or non-medical services, acted as a liaison between medical providers or between medical and non-medical providers, and/or served as a liaison between providers and the member.</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"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The care coordinator arranged for services to address the member’s health education needs and social activities to help the member understand and accept her diabetes. The Barbara Davis Center monitored and managed most of the member’s medical needs.</p>		



Appendix B. Colorado Department of Health Care Policy and Financing
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Care Coordination Program Record Review		Score
Transitions		
<p>8. The RCCO (or designee) provided assistance during care transitions from hospitals or other care institutions to home- or community-based settings. This assistance promoted continuity of care.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3</i> <i>Region 2.: Exhibit A—6.4.5.1.3</i> <i>Regions 3, 5: Exhibit A—6.4.5.1.4</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The member was hospitalized with diabetic ketoacidosis, and the discharge plan recommended that the member have a continuous glucose monitor (not covered by Medicaid). The coordinator followed up with the Barbara Davis Center and assisted with preparing documentation to justify approval of reimbursement for the glucose monitor.</p>		
<p>9. The RCCO (or designee) provided assistance during other transitions, such as the transition from children’s health services to adult health services or from hospital or home care into a nursing facility.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3</i> <i>Region 2: Exhibit A—6.4.5.1.3</i> <i>Regions 3, 5: Exhibit A—6.4.5.1.4</i></p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable	
<p>Observations: The member did not experience this type of transition.</p>		
<p>10. The RCCO (or designee) documented and communicated necessary information about the member to the providers, institutions, and individuals involved in the transition.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3</i> <i>Region 2: Exhibit A—6.4.5.1.3</i> <i>Regions 3, 5: Exhibit A—6.4.5.1.4</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The care coordinator communicated with the Barbara Davis Center to provide information about the member’s hospitalization and discharge plan.</p>		



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Care Coordination Program Record Review		Score
Continued Coordination/Follow-up		
11. The documentation clearly indicated that the RCCO’s (or designee’s) provision of care coordination services was responsive to the member’s needs. <i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.2.3</i> <i>Regions 2, 3, 5 : Exhibit A—6.4.5.2.3</i>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The member needed better management of diabetes and the care coordinator arranged for the member to stay in her own home with diabetic education. The care coordinator documentation was thorough.		
12. The RCCO (or designee) followed up with the member to assess whether the member has received the services needed and/or if the member is on track to reach his or her desired health outcomes. <i>Regions 1, 4, 6, 7 Exhibit A—6.4.3.1.6</i> <i>Region 2: Exhibit A—6.4.5.1.6</i> <i>Regions 3, 5: Exhibit A—6.4.5.1.7</i>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The care coordinator was in frequent contact with the member.		

Recommendations:
 This case was well-managed, with the care coordinator responding to the sensitivities of an adolescent living with a difficult chronic disease. By addressing the member’s social, psychological, and health education needs, the member will potentially be able to better manage her health in the future.

Results for Care Coordination Program Record Review—Sample OS #8					
Total	Met	=	<u>11</u>	X	1.00 = <u>11</u>
	Partially Met	=	<u>0</u>	X	0.0 = <u>0</u>
	Not Met	=	<u>0</u>	X	0.0 = <u>0</u>
	Not Applicable	=	<u>1</u>	X	NA = <u>0</u>
Total Applicable		=	<u>11</u>	Total Score	= <u>11</u>
			Total Score ÷ Total Applicable	=	<u>100%</u>



Appendix B. Colorado Department of Health Care Policy and Financing
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for Community Health Partnership (Region 7)

Sample Number: OS #9

Reviewer: Rachel Henrichs

Care Coordination Program Record Review		Score
Assessment		
1. The RCCO (or designee) assessed the member's: <ul style="list-style-type: none"> ◆ Health behavior risks. ◆ Health/medical needs. <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.1.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: This member has been affiliated with RCCO Region 7 since August 2011 and has moved between PCMPs several times. The PCMP conducted a health needs and risk assessment in May 2013 and asked the member for updates during every appointment.		
2. The RCCO (or designee) assessed the member's: <ul style="list-style-type: none"> ◆ Non-medical needs. ◆ Linguistic and cultural needs. <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1; 6.4.3.2.2</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.1.1; 6.4.5.2.2</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: This member was one of the first members to participate in the CARES program, formerly known as “Feet on the Street”. In addition to a health risk and needs assessment, CARES staff also conducted a thorough assessment of the member's non-medical, linguistic, and cultural needs.		
3. The RCCO (or designee) assessed current care coordination services provided to the member 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 align="right"><i>Regions 1, 4, 6, 7: Exhibit A— 6.4.2.1</i> <i>Regions 2, 3, 5: Exhibit A—6.4.4.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The care manager's notes indicated that she conducted a thorough assessment of the agencies and individuals involved in the member's care and what services each agency and individual was providing.		



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Care Coordination Program Record Review		Score
Intervention		
<p>4. The RCCO (or designee) worked with providers responsible for the member’s care to develop a plan for regular communication with those responsible for the member’s care coordination.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.2.3</i> <i>Regions 2, 3, 5: Exhibit A—6.4.4.3</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The care manager’s contact notes demonstrated regular communication with the member’s primary care provider, the CARES program, staff at the long term care facility, and staff at the skilled nursing facility.</p>		
<p>5. The RCCO (or designee) reasonably ensured that all care coordination services, including those provided by other individuals or entities, met the needs of the member.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.2.4</i> <i>Regions 2, 3, 5: Exhibit A—6.4.4.4</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The care manager spoke with the member and the member’s providers regularly to ensure that the member’s needs were being addressed.</p>		
<p>6. The RCCO (or designee) provided necessary care coordination services not provided by another source.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.2.2</i> <i>Regions 2, 3, 5: Exhibit A—6.4.4.2</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The care manager carefully monitored services provided to the member to ensure all needs were addressed. She noticed that the member was not in contact with any of his church’s members or leaders, so she contacted the member’s church and requested that a pastor visit the member in the skilled nursing facility. The care manager also followed up with the member to confirm that the pastor visited him.</p>		
<p>7. The RCCO (or designee) linked the member to medical and/or non-medical services, acted as a liaison between medical providers or between medical and non-medical providers, and/or served as a liaison between providers and the member.</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"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The member was receiving comprehensive services through the CARES program. The care manager monitored these activities carefully to identify any gaps in service; however, few gaps appeared. The care manager was able to link the member to a pastor from his church.</p>		



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Care Coordination Program Record Review	Score
Intervention	
<p>Shortly after the member moved to the skilled nursing facility, the care manager noted that the member missed a medical appointment. The care manager called the member to ask why. After the member explained he got confused, the care manager called the care manager at the skilled nursing facility. The RCCO care manager compared notes regarding the member’s behaviors with the care manager at the skilled nursing facility to evaluate a potential decline in cognitive ability. The RCCO care manager continued to follow up with the member and staff at the skilled nursing facility to monitor his progress.</p>	



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for Community Health Partnership (Region 7)

Care Coordination Program Record Review		Score
Transitions		
<p>8. The RCCO (or designee) provided assistance during care transitions from hospitals or other care institutions to home- or community-based settings. This assistance promoted continuity of care.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3</i> <i>Region 2.: Exhibit A—6.4.5.1.3</i> <i>Regions 3, 5: Exhibit A—6.4.5.1.4</i></p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable	
Observations:		
The member did not transition from a hospital to a home- or community-based setting during the review period.		
<p>9. The RCCO (or designee) provided assistance during other transitions, such as the transition from children’s health services to adult health services or from hospital or home care into a nursing facility.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3</i> <i>Region 2: Exhibit A—6.4.5.1.3</i> <i>Regions 3, 5: Exhibit A—6.4.5.1.4</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations:		
The member was living in a long term care facility when he became very sick and was hospitalized for two months. After his release from the hospital, the member required too much care for return to the long term care facility. The care manager monitored the process of enrolling the member into a skilled nursing facility. The CARES team negotiated for the waiver of fees charged by the long term facility while the member was hospitalized and physically moved the member’s belongings to the skilled nursing facility. The care manager monitored the situation carefully and was ready to intervene if needed.		
<p>10. The RCCO (or designee) documented and communicated necessary information about the member to the providers, institutions, and individuals involved in the transition.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3</i> <i>Region 2: Exhibit A—6.4.5.1.3</i> <i>Regions 3, 5: Exhibit A—6.4.5.1.4</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations:		
The care manager monitored the transition of this member’s care from assisted living facility to the hospital to the skilled nursing facility, thoroughly documented the transitions, and provided needed information to the member’s providers.		



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Care Coordination Program Record Review		Score
Continued Coordination/Follow-up		
11. The documentation clearly indicated that the RCCO’s (or designee’s) provision of care coordination services was responsive to the member’s needs. <div align="right"> <i>Regions: 1, 4, 6, 7: Exhibit A—6.4.3.2.3</i> <i>Regions 2, 3, 5 : Exhibit A—6.4.5.2.3</i> </div>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The care manager’s notes indicated that she was aware of the member’s needs and ensured that all needs were being addressed.		
12. The RCCO (or designee) followed up with the member to assess whether the member has received the services needed and/or if the member is on track to reach his or her desired health outcomes. <div align="right"> <i>Regions 1, 4, 6, 7 Exhibit A—6.4.3.1.6</i> <i>Region 2: Exhibit A—6.4.5.1.6</i> <i>Regions 3, 5: Exhibit A—6.4.5.1.7</i> </div>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The care manager followed up with the member and all of the member’s providers regularly to ensure that the member’s needs were addressed.		

Recommendations:
 This care manager did a commendable job managing this member’s care. HSAG has no recommendations.

Results for Care Coordination Program Record Review—Sample OS #9					
Total	Met	=	<u>11</u>	X	1.00 = <u>11</u>
	Partially Met	=	<u>0</u>	X	0.0 = <u>0</u>
	Not Met	=	<u>0</u>	X	0.0 = <u>0</u>
	Not Applicable	=	<u>1</u>	X	NA = <u>0</u>
Total Applicable		=	<u>11</u>	Total Score	= <u>11</u>
			Total Score ÷ Total Applicable	=	<u>100%</u>

—Draft Copy for Review—



Appendix B. Colorado Department of Health Care Policy and Financing
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for Community Health Partnership (Region 7)

Sample Number: OS #10

Reviewer: Rachel Henrichs

Care Coordination Program Record Review		Score
Assessment		
1. The RCCO (or designee) assessed the member's: <ul style="list-style-type: none"> ◆ Health behavior risks. ◆ Health/medical needs. <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.1.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The PCMP documented a health risks and needs assessment in October 2013. The member suffered from uncontrolled diabetes. Her denial of the disease contributed to her noncompliance with diet and medication.		
2. The RCCO (or designee) assessed the member's: <ul style="list-style-type: none"> ◆ Non-medical needs. ◆ Linguistic and cultural needs. <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.1; 6.4.3.2.2</i> <i>Regions 2, 3, 5: Exhibit A—6.4.5.1.1; 6.4.5.2.2</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The PCMP documented an assessment of the member's non-medical, linguistic, and cultural needs. The cultural assessment documented veteran status, tribal affiliation, the member's housing situation, religious affiliation, language, ethnicity, and race. The member identified transportation needs.		
3. The RCCO (or designee) assessed current care coordination services provided to the member 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 align="right"><i>Regions 1, 4, 6, 7: Exhibit A— 6.4.2.1</i> <i>Regions 2, 3, 5: Exhibit A—6.4.4.1</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The care manager's notes documented regular communication with home health care workers; hospital staff; and care managers with the dialysis center, the nephrologist, and hospice.		



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Care Coordination Program Record Review		Score
Intervention		
<p>4. The RCCO (or designee) worked with providers responsible for the member’s care to develop a plan for regular communication with those responsible for the member’s care coordination.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.2.3 Regions 2, 3, 5: Exhibit A—6.4.4.3</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: The care manager coordinated an intervention that included care managers from the hospital, the nephrologist, hospice, and the dialysis center, as well as the member, her husband, and her parents. Notes also documented regular communication between the PCMP care manager and care managers at other agencies.</p>		
<p>5. The RCCO (or designee) reasonably ensured that all care coordination services, including those provided by other individuals or entities, met the needs of the member.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.2.4 Regions 2, 3, 5: Exhibit A—6.4.4.4</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: Notes in this member’s record demonstrated communication among all involved providers. The care team identified which agency the member identified with most and then coordinated as many efforts and services through that agency as possible. For example, the team recognized that the member seemed to connect better with the dietitian at the dialysis center. Counseling services provided through Peak Vista were discontinued and replaced with alternative behavioral health services more suited to the member’s needs.</p>		
<p>6. The RCCO (or designee) provided necessary care coordination services not provided by another source.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.2.2 Regions 2, 3, 5: Exhibit A—6.4.4.2</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
<p>Observations: Comprehensive documentation from all agencies involved in this member’s care helped eliminate duplication of efforts. Examples of this could be seen in the coordination related to obtaining a new blood pressure cuff and oxygen supplies for the member. Also, the PCMP care manager worked with the member to design a task list. The care manager was careful to include a variety of daily, weekly, and monthly tasks (for example: eat breakfast, go for a walk, get hair done, date night) in an effort to keep the member from focusing on her disease and toward focusing more on her life. The care manager also helped arrange for telephonic behavioral health services.</p>		



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Care Coordination Program Record Review		Score
Intervention		
<p>7. The RCCO (or designee) linked the member to medical and/or non-medical services, acted as a liaison between medical providers or between medical and non-medical providers, and/or served as a liaison between providers and the member.</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"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations:		
<p>The care manager helped connect the member with numerous services including home health care, behavioral health services, and transportation services. The care manager also arranged for the member to receive hospice services in an attempt to help her accept her diagnosis.</p>		



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Care Coordination Program Record Review		Score
Transitions		
<p>8. The RCCO (or designee) provided assistance during care transitions from hospitals or other care institutions to home- or community-based settings. This assistance promoted continuity of care.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3</i> <i>Region 2.: Exhibit A—6.4.5.1.3</i> <i>Regions 3, 5: Exhibit A—6.4.5.1.4</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations:		
The care manager was notified within 24 hours when the member was admitted to the hospital. The care manager made sure all discharge reports were filed in the member’s electronic health record.		
<p>9. The RCCO (or designee) provided assistance during other transitions, such as the transition from children’s health services to adult health services or from hospital or home care into a nursing facility.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3</i> <i>Region 2: Exhibit A—6.4.5.1.3</i> <i>Regions 3, 5: Exhibit A—6.4.5.1.4</i></p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable	
Observations:		
No “other” transitions were documented within the review period.		
<p>10. The RCCO (or designee) documented and communicated necessary information about the member to the providers, institutions, and individuals involved in the transition.</p> <p align="right"><i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.1.3</i> <i>Region 2: Exhibit A—6.4.5.1.3</i> <i>Regions 3, 5: Exhibit A—6.4.5.1.4</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations:		
The member’s record included evidence that the care manager distributed the member’s discharge reports to all involved providers.		



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Care Coordination Program Record Review		Score
Continued Coordination/Follow-up		
11. The documentation clearly indicated that the RCCO’s (or designee’s) provision of care coordination services was responsive to the member’s needs. <i>Regions 1, 4, 6, 7: Exhibit A—6.4.3.2.3 Regions 2, 3, 5: Exhibit A—6.4.5.2.3</i>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The care manager implemented some “out of the box” ideas in an effort to help this member acknowledge her diagnosis and begin to seek care. The care manager was responsive to the member’s needs.		
12. The RCCO (or designee) followed up with the member to assess whether the member has received the services needed and/or if the member is on track to reach his or her desired health outcomes. <i>Regions 1, 4, 6, 7 Exhibit A—6.4.3.1.6 Region 2: Exhibit A—6.4.5.1.6 Regions 3, 5: Exhibit A—6.4.5.1.7</i>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable	
Observations: The care manager’s notes documented regular follow up with the member and her providers to ensure that the member stayed on track in meeting her health outcome goals.		

Recommendations:
 The care manager did an excellent job coordinating this member’s care. HSAG has no recommendations.

Results for Care Coordination Program Record Review—Sample OS #10					
Total	Met	=	<u>11</u>	X	1.00 = <u>11</u>
	Partially Met	=	<u>0</u>	X	0.0 = <u>0</u>
	Not Met	=	<u>0</u>	X	0.0 = <u>0</u>
	Not Applicable	=	<u>1</u>	X	NA = <u>0</u>
Total Applicable		=	<u>11</u>	Total Score	= <u>11</u>
Total Score ÷ Total Applicable					= <u>100%</u>

Appendix C. Provider Network Capacity Analysis for Community Health Partnership (Region 7)

The following tables represent the results of an MS Excel pivot table analysis of the PCMP network for Region 7, based on the PCMP network spreadsheets provided to the Department by the RCCO. The purpose of the analysis was to provide an accurate representation of the number of providers in each RCCO region by eliminating duplicate entries. These tables are presented only to demonstrate the potential outcomes of using MS Excel pivot tables to analyze the network, with the understanding that data integrity in the source documents is essential to ensure accuracy of future results.

Table C-1 illustrates the methodology HSAG used to calculate the number of providers for each region. For the purpose of counting the number of unique providers in each region, providers were counted one time, regardless from how many office locations they work. The table illustrates that Dr. Valdez has two practice locations, so HSAG deleted the highlighted location prior to the count.

Table C-1—Example of Duplicate Providers Eliminated Before Calculating Unique Providers by Region				
Provider Location (LINE 1)	Provider Location (CITY)	Provider Location (COUNTY)	Practitioner (LAST NAME)	Practitioner (FIRST NAME)
555 E. Pikes Peak Ave., Ste. 200	Colorado Springs	El Paso	Valdez	Maria
8580 Scarborough Dr., Ste. 120	Colorado Springs	El Paso	Valdez	Maria

Table C-2—Number of Unique Providers Serving Region 7	
Non-physician practitioner	1
Nurse practitioner	26
Osteopath	18
Other	3
Physician	140
Physician assistant	36
Grand Total	224

Table C-3—Number of Unique Providers Serving Region 7 Accepting New Medicaid Members	
Nurse practitioner	23
Osteopath	9
Other	3
Physician	78
Physician assistant	31
Grand Total	144

When calculating the number of providers in each county, HSAG allowed for instances where a provider might have multiple locations in multiple counties. In these instances, HSAG counted each provider one time in each county. However, none of the Region 7 providers had practice locations in more than one county.

Table C-4—Region 7 Unique Providers by County	
El Paso	206
Elbert	7
Park	3
Teller	8
Grand Total	224

Table C-5—Region 7 Unique Providers by County Accepting New Medicaid Members	
El Paso	131
Elbert	7
Park	3
Teller	3
Grand Total	144

Table C-6 illustrates the methodology HSAG used to calculate the number of unique practice locations per county. For the purpose of counting the number of unique practice locations in each county, the highlighted rows were deleted. Each address was counted one time, regardless of how many providers practiced in that location.

Table C-6— Example of Duplicate Locations Eliminated Before Calculating Unique Locations by County				
Provider Location (LINE 1)	Provider Location (LINE 2)	Provider Location (COUNTY)	Practitioner (LAST NAME)	Practitioner (FIRST NAME)
555 E. Pikes Peak Avenue	Suite 200	El Paso	Maynard	Edward
555 E. Pikes Peak Avenue	Suite 200	El Paso	Valdez	Maria
555 E. Pikes Peak Avenue	Suite 200	El Paso	Mulder	Erica
8580 Scarborough Drive	Suite 120	El Paso	Bagnall	Kerri
8580 Scarborough Drive	Suite 120	El Paso	Valdez	Maria

Table C-7—Number of Unique Provider Locations Serving Region 7	
El Paso	51
Elbert	1
Park	2
Teller	3
Grand Total	57

Appendix D. **Site Review Participants**
for **Community Health Partnership (Region 7)**

Table D-1 lists the participants in the FY 2013–2014 site review of **CHP**.

Table D-1—HSAG Reviewers and RCCO Participants	
HSAG Review Team	Title
Barbara McConnell, MBA, OTR	Director, State & Corporate Services
Katherine Bartilotta, BSN	Project Manager
Rachel Henrichs	Project Coordinator
CHP Participants	Title
Allan Olipane	Chief Operating Officer
Barbara Young	Provider Relations Manager, AspenPointe Health Network
BJ Dempsey	Quality Improvement Coordinator, HealthTeamWorks
Brandi Haws	Clinical Director, AspenPointe Health Network
Carol Bruce-Fritz	Chief Executive Officer
Carol Solomon-Smith	Manager of Care Coordination
Christian Koltonski	Quality Health Improvement Unit, Colorado Department of Health Care Policy and Financing
Cindy Jacha	University of Colorado Colorado Springs, CHP Board
Elizabeth Baskett	Reform Section Manager, Colorado Department of Health Care Policy and Financing
Jameson Smith	Board Chair, CHP
Janet Vaupel	Chief Administrative Officer
Jill Law	Board of CHP, EPCPH Director
Joe Farr	Integrated Care Manager, CHP
Department Observers	Title
Russell Kennedy	Quality and Compliance Specialist