



COLORADO

**Department of Health Care
Policy & Financing**

**FY 2014–2015 SITE REVIEW REPORT
EXECUTIVE SUMMARY**

for

**Community Health Partnership
(Region 7)**

April 2015

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



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Introduction and Background

The Colorado Department of Health Care Policy & Financing (the Department) introduced the Accountable Care Collaborative (ACC) Program in spring 2011 as a central part of its plan for Medicaid reform. The ACC Program was designed to improve the member and family experience, improve access to care, and transform incentives and the healthcare delivery process to a system that rewards accountability for health outcomes. Central goals for the program are (1) improvement in health outcomes through a coordinated, member-centered system of care; and (2) cost control by reducing avoidable, duplicative, variable, and inappropriate use of healthcare resources. A key component of the ACC Program was the selection of a Regional Care Collaborative Organization (RCCO) for each of seven regions within the State. **Community Health Partnership (CHP)** began operations as a RCCO in July 2011. The RCCOs provide medical management for medically and behaviorally complex members, care coordination among providers, and provider support such as assistance with care coordination and practice transformation for performance of medical home functions. An additional feature of the ACC Program is collaboration—between providers and community partners, between RCCOs, and between the RCCOs and the Department—to accomplish the goals of the ACC Program.

The Affordable Care Act of 2010 allowed for Medicaid expansion and eligibility based on 133 percent of the federal poverty level. Affected populations included parents of Medicaid-eligible children and adults without dependent children. The Department estimated that, as a result of Medicaid expansion, 160,000 additional members would be integrated into the RCCOs in phases. In addition, the Accountable Care Collaborative: Medicare-Medicaid Program demonstration project provided for integration of 32,000 new dually eligible Medicare-Medicaid members into the RCCOs, beginning September 2014. Effective July 2014, the RCCO contract was amended primarily to specify additional requirements and objectives related to the integration of ACC Medicare-Medicaid Program (MMP) enrollees.

Each year since the inception of the ACC Program, the Department has engaged Health Services Advisory Group, Inc. (HSAG), to conduct annual site reviews to evaluate the development of the RCCOs and to assess each RCCO's organizational successes and challenges in implementing key components of the ACC Program. This report documents results of the fiscal year (FY) 2014–2015 site review activities, which included delegation of care coordination, RCCO coordination with other agencies and provider organizations, and performance of individual member care coordination. This section contains summaries of the activities and on-site discussions related to each focus area selected for the 2014–2015 site review, as well as HSAG's observations and recommendations. In addition, Table 1-1 contains the results of the 2014–2015 care coordination record reviews. Table 1-2 provides a comparison of the overall 2014–2015 record review scores to the 2013–2014 record review scores. Section 2 provides an overview of the monitoring activities and describes the site review methodology used for the 2014–2015 site reviews. Appendix A contains the completed on-site data collection tool. Appendix B contains detailed findings for the care coordination record reviews. Appendix C lists HSAG, RCCO, and Department personnel who participated in the site review process.

To prepare for the on-site review activities, HSAG requested that **CHP** submit policies, procedures, and program descriptions that outline the care coordination activities performed by the primary care medical providers (PCMPs) or other entities; copies of delegation agreements; memorandums of understanding (MOUs) or other documents that describe the relationships related to performance of care coordination activities; audit or assessment forms and/or reports used to monitor delegated activities; and committee or team meeting minutes that demonstrate the interactions with delegates and partners concerning care coordination policies, procedures, and programs. HSAG also asked for lists of organizations and agencies with which the RCCO has an established relationship, and any documents that describe the nature of these relationships with the RCCO. HSAG carefully reviewed all documents submitted prior to the on-site review and used the information to guide interview discussions.

Summary of Results

The care coordination record reviews focused on two select populations: children with special needs and adults with complex needs. 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 1-1 presents the scores for **CHP**'s care coordination record reviews for each special population reviewed. 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)
Children With Special Needs	45	33	29	4	0	12	88%
Adults With Complex Needs	35	29	19	9	1	6	66%
TOTAL	80	62	48	13	1	18	77%

* 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 point value of 0.0)

Table 1-2 provides a comparison of the overall 2014–2015 record review scores to the 2013–2014 record review scores. Although most contract requirements remained the same for the two review periods, scores may have changed due to reformatting and clarifications in the record review tool.

Description of Record Review	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
Care Coordination 2013–2014	204	175	171	4	0	29	98%
Care Coordination 2014–2015	80	62	48	13	1	18	77%

* 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 point value of 0.0)

The Data Collection Tool (Appendix A) was used to capture the results of the pre-on-site document review and on-site discussions related to Delegation of Care Coordination and RCCO Coordination With Other Agencies/Provider Organizations. Following is a summary of results for each content area of the 2014–2015 review.

Summary of Findings and Recommendations by Focus Area

Delegation of Care Coordination

Activities and Progress

CHP is a stakeholder-driven organization formed through the partnership of major Medicaid providers and community organizations. The stakeholder leadership determined at the inception of the RCCO that care coordination should be delivered at the PCMP level and has signed a Delegation of Care Coordination Memorandum of Understanding (MOU) with eight PCMPs, including five that account for approximately 50 percent of the attributed RCCO enrollment. Each delegation agreement addresses components of a member assessment, functions associated with basic and complex levels of care coordination, RCCO responsibility for initial evaluation and annual audit site visits, PCMP responsibility for monthly reporting, payment methodologies, and voluntary termination. Staff stated that **CHP** has not delegated the responsibility for completing service coordination plans (SCPs) to the PCMPs and that delegated care coordination activities for MMP members are the same as those for other Medicaid members.

CHP noted that its stakeholder partnership with major PCMPs and community organizations, as well as the political environment of the community, demand that **CHP** remain sensitive to the diverse populations served by each PCMP and the need for PCMPs to maintain control of the operational processes for managing patients. Each PCMP has a slightly different model of care coordination driven by the funding streams of its total patient population as well as its resources and system capabilities. For this reason, the MOU delineates the core functions and deliverables of care coordination for RCCO members but does not impose specific operational approaches. Staff described delegation as a matrix of different levels of care coordination across the delegate PCMPs.

CHP employed three care coordinators and 12 health navigators. **CHP** structured the role of the RCCO care coordinators to assist delegates with complex care coordination. One care coordinator is assigned to each PCMP (delegated and non-delegated) and is responsible for supporting the PCMP with complex care coordination and providing care coordination education and guidance to practices. The health navigators provide outreach to unattributed members. Staff estimated that 25 percent of RCCO members are unattributed. During 2014, **CHP** also established patient navigation contracts with two county public health departments and a rural health center. **CHP** secured these arrangements with MOUs and provides payment for services.

CHP submitted examples of predelegation assessments performed for each of the eight PCMPs with which it has delegation agreements; however, the practice assessment tools were not consistent across practices due to the evolution of the process. Beginning June 2014, **CHP** implemented a comprehensive Initial Practice Questionnaire for onboarding new PCMPs that includes a full

medical home assessment. If the practice expresses interest in delegation of care coordination, the practice transformation team conducts a more thorough assessment of specific care coordination functions that align with the requirements in the delegation MOU. As part of **CHP**'s ongoing assessment of delegated practices, **CHP** reviews the delegate's monthly care coordination reports and audits five care coordination charts for each PCMP every six months. The practice transformation team provides coaching to correct deficiencies. The executive management team may choose to respond to repeated problems with formal reprimand, payment withhold, and, ultimately, de-delegation. RCCO staff also use the information in the Care Coordination Report (submitted to the Department) to obtain an overall view of delegated care coordination activities both to stimulate discussion with the individual practices concerning care coordination processes and to identify any gaps in processes. **CHP** holds a bimonthly care coordination meeting to share best practices in care coordination and obtain input regarding system-wide care coordination issues. However, the primary interaction between PCMPs and the RCCO is through the practice transformation teams.

Staff demonstrated the soon-to-be-implemented Crimson care management software that **CHP** will use to integrate member-specific care coordination information from all participating entities. Following pilot testing with Peak Vista, RCCO coordinators, AspenPointe, and the CARES program (implemented by the Colorado Springs Fire Department), **CHP** plans to expand access to other PCMPs and community providers.

Staff members described several system-level initiatives that may impact care management for select member populations. Examples of these initiatives include:

- ◆ The El Paso Department of Human Services (DHS) is examining policies related to where foster children will be allowed to receive their primary care, and that determination may require identifying and transitioning foster children at the PCMP level.
- ◆ **CHP** contracted with the Independence Center to research the most needed or desired long-term services and supports (LTSS) services for members with disabilities. **CHP** will use results of the research to enhance care coordination protocols.
- ◆ AspenPointe, Peak Vista, Colorado Springs Health Partners (CSHP), and The Resource Exchange are collaborating on the development of a health center for individuals with developmental disabilities.
- ◆ **CHP** extended its funding for the Advanced Illness Counseling program an additional year in anticipation of the increased needs of the MMP population.

Staff stated that the most challenging category of patients for care coordinators is that of members with complex needs who do not cooperate or follow through with care coordination efforts. **CHP** is considering developing guidelines for determining when to appropriately close a care coordination case.

Observations/Recommendations

The Delegation of Care Coordination MOU described a high level of core care coordination requirements for performing basic and complex care coordination. Examples of delegation assessment and audit tools applied to PCMPs were highly variable from practice to practice and

were more closely aligned with an assessment of medical home standards than specific comprehensive care coordination functions. Staff stated that the variability of tools was reflective of an evolving set of objectives and criteria designed to facilitate practice transformation and that the care coordination MOU was designed to allow flexibility in operational processes between PCMPs. Nevertheless, HSAG observed that the care coordination delegation MOU and RCCO assessment and audit documents appeared disconnected from the comprehensive care coordination characteristics and other care coordination requirements of the RCCO contract with the Department. For example, the Delegated Care Coordination chart audit template included review for traditional medical record components, care management processes (oriented to clinical management), risk-factor assessment, and referrals to support resources but did not include the comprehensive care coordination characteristics outlined in the RCCO contract (e.g., the requirements for care coordinator outreach to external care coordinators or provider organizations involved with the member to track and coordinate activities). Additionally, during care coordination record reviews, HSAG observed that documentation of PCMP-based care coordination also trended toward the traditional clinical model of assessment of needs, referral management, and follow-up rather than addressing comprehensive medical, behavioral, social, and cultural factors. While **CHP** demonstrated that it is appropriately sensitive to the diverse populations served by each PCMP and the need to for PCMPs to remain in control of their own operational processes, the RCCO's need to respond to its contract requirements with the Department may simultaneously risk compromise. HSAG recommends that **CHP** engage its leadership to work more assertively with its stakeholder and delegated PCMP practices to gain support for implementing care coordination expectations more closely aligned with the RCCO requirements. Accordingly, **CHP** should consider amendment of its Delegation of Care Coordination MOU and associated care coordination assessment and audit tools to reinforce these expectations and provide a basis for coaching practices toward these expectations.

RCCO Coordination With Other Agencies/Provider Organizations

Activities and Progress

CHP was created as a partnership of community and provider organizations. Its Board of Directors includes leadership from community organizations and establishes **CHP**'s strategic community health goals. Executive management identifies the specific types of partnerships needed to address those goals. Additionally, **CHP** identifies potential organizational relationships through community networking as well as in response to member needs and to fill gaps in contractual requirements.

CHP's approach to building relationships with organizations is to use one-on-one communications to identify areas of mutual need, work collaboratively to develop mechanisms to address those needs, and provide funding for implementation when appropriate. **CHP** has provided funding for pilot programs such as the Community Assistance, Referrals, and Education Services (CARES) program; Advanced Illness Counseling program; Center for WellBeing; Recuperative Care for homeless or at-risk members; and more. **CHP** envisions that its relationships with community organizations will continue to broaden (with more organizations serving common populations) and deepen (through more formalized processes) as the RCCO continues to gain recognition as an established entity in the provision of services to Medicaid populations. Staff described the major challenges in developing relationships with community organizations or agencies as managing the

staff time required to develop and maintain relationships, overcoming organizational fears that the RCCO wants to assume the roles of those organizations (e.g., care coordination), and addressing the perception that Medicaid is not a large enough component of an organization's business to demand attention.

CHP's process for identifying targeted relationships with agencies is primarily driven by the needs of members and other community populations and by RCCO contract requirements, while its process for developing those relationships generally parallels the approach used with community organizations. **CHP** has established business associate agreements (BAAs) or MOUs with the community-centered board (CCB), behavioral health organizations (BHOs), the El Paso Department of Human Services (DHS), county public health departments, the SEP agency, and the Independence Center. Agency relationships generally culminate in formal agreements due to data-exchange requirements. Agreements also delineate responsibilities of both parties and any related funding requirements.

The Southern Colorado AIDS Project (S-CAP) is the Colorado Department of Public Health and Environment's (CDPHE's) established Ryan White HIV/AIDS program for the region. **CHP** signed a BAA with S-CAP to allow the exchange of information regarding hospitalizations of shared clients. S-CAP has a strong case management program and serves as the primary care coordination resource for RCCO members with human immunodeficiency virus (HIV). Staff stated that there is minimal need for an ongoing functional arrangement between the organizations.

AspenPointe, **CHP's** behavioral health partner, had a program for the criminal justice involved (CJI) population that pre-dated the integration of the CJI population into the RCCOs. In addition, Peak Vista has ongoing patient relationships with some CJI members who, after release from jail, return to Peak Vista for healthcare services. Staff members stated that persons being released from jails also often seek services from one of the five faith-based clinics within the Colorado Springs area that serve the uninsured through the community partner, Community Access to Coordinated Health (CATCH), program. **CHP** is cultivating a relationship with Dorcas, a community-based program that assists females being released from jail with transition back into the community. Staff stated that while individuals being released from jail are eligible for Medicaid, the RCCO has not yet determined an effective mechanism for consistently identifying CJI individuals for enrollment in Medicaid or for providing necessary services early in the post-release period. **CHP** has identified providers and organizations with which to explore potential solutions to this challenging issue, but acknowledged that there is still a considerable amount of work to be accomplished.

CHP began developing relationships and data-sharing arrangements with numerous organizations over a year ago in anticipation of the integration of MMP members into the RCCO. **CHP** has dedicated staff to implement the MMP program and State-defined protocols with all applicable providers and entities and developed many of its pertinent MMP relationships prior to implementation of program. **CHP** receives daily admission, discharge, and transfer (ADT) information for its members from all hospitals in the region and, at the time of review, did not foresee the need to modify this process for MMP members. **CHP** had a BAA with the BHOs in the region and was also pursuing a BAA with Centennial Mental Health Center. These data-sharing agreements apply to all RCCO members, including the MMP population. **CHP** has also established or enhanced data-exchange agreements or MOUs with the CCB, the SEP, and Pikes Peak Hospice & Palliative Care.

CHP recently established referral communication protocols with the medical specialty provider network and some home health agencies, and has established relationships with some high-volume Medicaid skilled nursing facilities (SNFs). Staff described encountering inherent turf issues and a sense of competitiveness when developing new relationships for the MMP program and stated that the major challenge related to the MMP integration has been implementing the service coordination plans (SCPs). Nevertheless, **CHP** has expanded relationships with many agencies and organizations related to the MMP program.

During on-site interviews, HSAG queried staff related to **CHP**'s progress in both identifying Medicaid-eligible women who are pregnant for attribution to a PCMP and appropriate management of high-risk pregnancies. **CHP** stated that Academy Women's Healthcare and Peak Vista deliver the majority of babies born to Medicaid enrollees in the region. In addition, Healthy Communities has embedded staff in area hospitals to arrange needed services for Medicaid women and babies. RCCO staff members monitor ADT reports to identify when Medicaid members seek emergency services related to pregnancy and follow up to assist the member with attribution to a PCMP. **CHP** also identified the Dream Center and Mary's Health as community organizations that may offer an opportunity for identifying Medicaid members not connected to the provider network early in their pregnancy. Staff stated that the objective of identifying and connecting pregnant women to the health system is a community-wide concern due to a high infant mortality rate in the region.

Observations/Recommendations

CHP has benefited in the development of numerous formal and informal relationships with community organizations and agencies due to its community-based roots and the geographic concentration of the region. The **CHP** leadership structure includes representatives of community organizations; from its inception **CHP** has been highly interactive with regional agencies and organizations. Over time, **CHP** has developed relationships through continuous networking as well as targeted collaborative processes which meet the needs of RCCO members or contract requirements. **CHP** has participated as a funding source for several community-based pilot programs, which has enhanced the credibility and visibility of the RCCO. **CHP**'s history of engagement with community organizations and programs has established a solid foundation for integrating expansion populations such as MMP members and members with HIV.

CHP staff identified two of its partner organizations and five local clinics for the uninsured as organizations that likely come in contact with CJI members relatively soon after release from jails. However, **CHP** did not appear to be actively pursuing a plan for collaborations or initiating a process to develop mechanisms for identifying and enrolling CJI members in Medicaid. In addition, **CHP** did not describe efforts to establish direct linkages with the county jails. HSAG recommends that **CHP** and its partners prioritize collaborative efforts and consider including representatives from the local corrections facilities to actively pursue solutions to this problem.

Although **CHP** identified several points of service for pregnant Medicaid members in the community and has been exploring options, effective mechanisms for early engagement and integration of pregnant women into the RCCO provider network have not yet been successfully identified. Since **CHP** noted that this is a community-wide concern, HSAG recommends that **CHP** initiate a forum for community providers and pertinent organizations to further discussions and problem solving regarding outreach to Medicaid-eligible pregnant women. **CHP** might consider

involving the media or other public relations entities in solutions to communicate with and engage women in the healthcare system early in their pregnancies.

Care Coordination Record Reviews

Findings

HSAG reviewed five care coordination records for children with special health needs. One of the five children had very complex needs that required extensive coordination; it appeared that the child was receiving all of the necessary services. The other four cases were for children whose needs were not as complex; the care coordinator appeared to focus on coordinating medical referrals and obtaining results of the referrals. The overall compliance score for the children's care coordination record reviews was 88 percent.

HSAG also reviewed five care coordination records for adults with complex needs. One member only had minor health concerns and did not appear to need coordination of care services, while a second member appeared to need assistance with coordinating care, but was largely unresponsive to care coordination efforts. The other three members required and received care coordination for complex health needs. Most of the adult care coordination appeared to focus on addressing the member's clinical needs. HSAG also observed that care coordination was frequently performed by multiple staff—with no single individual responsible for oversight. Documentation was scattered throughout the medical record, and interviews with care coordinators indicated that activities and efforts were not always documented in the record. The overall compliance score for the adult's care coordination record review was 66 percent.

Observations/Recommendations

Reviewers noted that while many of the PCMPs reported being willing and able to conduct comprehensive care coordination for the RCCO members, actual care coordination appeared to be focused on coordinating the member's physical health needs and related documentation. HSAG recommends that **CHP** provide additional training and direction regarding the expectation that these organizations also document and coordinate their members' behavioral, social, and cultural needs.

Although all care coordination records reviewed included evidence that the majority of members received comprehensive assessment of risks and behavioral, physical, non-medical, and social needs, few records included this information in a central location. Pieces of the assessment were located throughout the traditional medical record. HSAG recommends that **CHP** work with its care coordination teams to develop a centralized location in the record to document identified needs and steps taken to address those needs.

HSAG observed several cases in which the RCCO care coordinator was actively engaged in working collaboratively with the PCMP coordinator to arrange services for the member, yet the care coordination record did not contain documentation of specific RCCO coordinator activities. This appeared to result in a poorly coordinated process for addressing the highly complex care needs of some members. **CHP** anticipates that the Crimson care management system will resolve barriers to documenting an integrated care coordination plan. However, the Crimson system is intended to be

pilot tested for a period of time prior to expansion to all PCMPs. Therefore, HSAG recommends that:

- ◆ **CHP** enhance training and communication mechanisms to ensure that a lead care coordinator is established for each member with complex care coordination needs and that the lead coordinator is accountable to obtain and document all pertinent care coordination information, including from external providers and care managers, in a consolidated member care coordination record.
- ◆ **CHP** ensure that all components of a comprehensive assessment and the elements pertaining to RCCO comprehensive care coordination requirements are incorporated in the Crimson software.
- ◆ **CHP** expedite the evaluation and testing of the Crimson system, expanding its use to all PCMPs and appropriate provider and community organizations as expeditiously as possible.