Care Coordination and Community Case Management Partner Meeting

To ensure the *right care*, in the *right order*, at the *right time*, in the *right setting*

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Today's Objectives

- What is Integrated Community Health Partners (ICHP)
- Colorado's Accountable Care Collaborative Program
- ICHP Care Coordination
- HCPF Required Care Coordination (CC) Activities
- Community CC and Case Management Team
- Opportunities

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Integrated Community Health Partners (ICHP)

- Region 4 Regional Care Collaborative Organization (RCCO)
- Partnership between:
  - CCMCN and FQHCs
  - ValueOptions, Inc., and
  - SyCare, LLC and Community Mental Health Centers
- Local Region Partners:
  - PCMPs
  - Hospitals
  - Home Health
  - Behavioral/Mental Health
  - Organizations willing to partner around CC efforts

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Colorado's Accountable Care Collaborative (ACC) Efforts

- Comprised of primary care providers, RCCOs, and state wide data, and analytics contractor
- PCMPs provide medical homes
- Together, the RCCOs and PCMPs will provide:
  - Medical management, particularly for medically and behaviorally complex clients
  - Care coordination among PCMPs, specialists, referrals, and community resources
  - Improved clinical performance, practice improvement, and redesign

Core Colorado ACC Elements

- Taking a *Regional Approach* to managing, providing, and coordinating care
- Supporting principles of the *Patient-Centered Medical Home* model and Integrated *Provider Networks*
- The provision of high-quality *Medical Management* and *Care Coordination* services

Core Colorado ACC Elements

- An unrelenting focus on *Accountability* to improve outcomes and control costs;
- A focus on continuous improvement and *Innovation*, constant learning, and sharing best practices;
- Analysis and application of informatics and benchmarking to review, measure, and compare utilization, outcomes and costs, (through *Statewide Data and Analytics Contractor*) and;
- A commitment to *Continuous Improvement.*

Colorado's ACC Primary Program Goals

- To improve health outcomes of Medicaid Clients through a coordinated, patient/client/family-centered system that proactively addresses Members health needs, whether simple or complex.
- To demonstrate a 7% reduction in aggregate costs by reducing avoidable, duplicative, variable, and inappropriate use of health care resources.

To Reach These Goals…

RCCOS will focus on the following CO ACC Objectives:

1) Expand access to comprehensive primary care.

2) Provide a focal point of care/Medical Home for all Members including coordinated and integrated access to other services.

3) Ensure a positive Member and provider experience and promote Member and provider engagement.

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To Reach These Goals…

RCCOS will focus on the following CO ACC Objectives:

4) Effectively apply an unprecedented level of statewide data and analytics functionality to support transparent, secure data-sharing and enable the near-real-time monitoring and measurement of health care costs and outcomes.

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Patient-Centered Medical Home

- A health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family.
- Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it.
- Care is culturally and linguistically appropriate .

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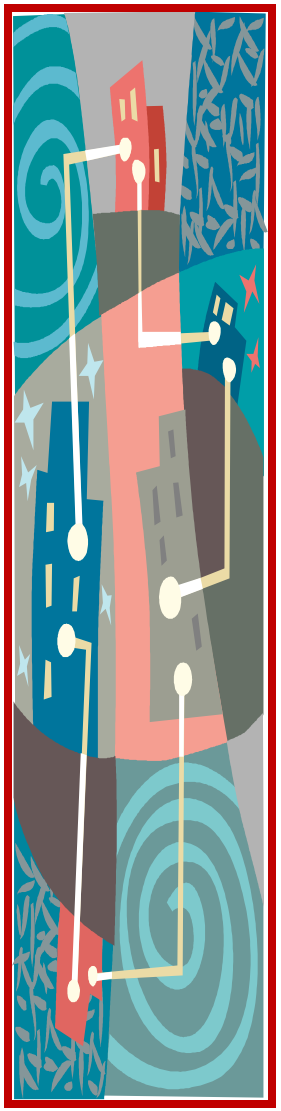
Care Coordination within a PCMH Model

- Responsibility to:
  - Be informed of community resources
  - Actively reach out and connect
  - Serve as a link for our members
  - Communicate consistently and often
  - Operate with members' best interest in mind



Care Coordination within a PCMH Model

- ***Link community resources*** with Members to facilitate referrals and respond to their needs.
- ***Establish referrals*** (protocols and agreements) with a variety of resources to best meet Members' needs.
- ***Support and track 'transitions of care'*** with/for Members- into and out of the hospital, emergency department, and pediatric care into adult services.

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Care Coordination within a PCMH Model

- ***Follow-up after ER/ED visit or hospital discharge*** with Members WITHIN- (identify time preference) within a few days (preferably within 24-36 hours).
- ***Maintain dynamic communication*** with Members and their families, especially around transition and care plans, as well as test results.
- ***Provide intensive care management services*** and support for highly complex Members.

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Integration of Meaningful Use, ACO, and PCMH

- The Medical Home model is an integral component of the ACO Program.
- Some Meaningful Use and PCMH Measures align.
- It is anticipated that ACO Quality Measures will also align with MU and PCMH Measures.

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Coleman Care Coordination Model

- Focus on ‘Care Transitions’
- Model based on 4 pillars:
  - Medication – Self-Management
  - Dynamic Patient-Centered Record
  - Follow-Up
  - Red Flags

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Core Colorado ACC Focus Areas

- Assist Providers with Referral Process
- Support Medical Management
- Promote Member Empowerment, Healthy Lifestyle Choices, and Informed Decision-Making
- Assure Care Coordination
- Meet the Goals of Care Coordination

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Colorado ACC Performance Goals

- HCPF's 3 Initial Performance Measures
  1) Emergency Room Visits per 1,000 (full time enrollees)
  2) Hospital Re-admissions per 1,000 " " "
  3) Outpatient Service Utilization per 1,000 " " "
- ICHP Identified CC Measure:
  4) Care coordination between PCP and other providers.

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Community Care Coordination & Case Management Teams (Local Partner Teams)

- To deliver efficient and coordinated care that improves overall health of Members.
- Comprised of representatives from PCMPs (including FQHCs), regional mental health centers, hospitals, home health, etc.
- Focus on Care Planning to demonstrate HCPF goals.
- Establish communication and planning expectations.

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Working Together

- Communication Regarding
  - Admissions
  - Diagnostic Testing
  - Transitions of Care
  - Discharge Planning
  - Medication Changes

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Next Steps & Contact Information