The ACC and Care Coordination:

Proceedings from the Second SNAC Lab
June 28, 2012

Introduction

The Colorado Health Institute (CHI) and its Safety Net Advisory Committee (SNAC) convened the second SNAC Lab on June 28, 2012 to discuss the role of care coordination in Colorado's Medicaid Accountable Care Collaborative (ACC). Because little quantitative data on the ACC is available, CHI's insight was developed through more than 20 key informant interviews with ACC stakeholders, including health care providers, care coordinators and representatives from all seven Regional Care Collaborative Organizations (RCCOs). Jeff Bontrager, CHI's Director of Research on Coverage and Access, began the SNAC Lab with a presentation: *What Tools are in the Toolbox? Care Coordination in Colorado's Accountable Care Collaborative*. SNAC participants then engaged in a facilitated discussion on how care coordination occurs on the ground, as well as promising practices. In addition, CHI followed up on questions that arose during the first SNAC Lab about the role of oral health in the ACC.

Goals

- To understand the ACC's "organization DNA," or the financial and legal arrangements that allow care coordination to occur in Colorado communities, and how this may lead to varied outcomes within RCCOs

- To share care coordination strategies and provide a forum for identifying innovative approaches, promising practices, challenges and lessons learned

- To synthesize input from the SNAC Labs and develop a shared body of knowledge for state health policy leaders, future initiatives and other states

The Presentation

The SNAC Lab coincided with the Supreme Court's ruling on the Affordable Care Act. Michele Lueck, CHI's President and CEO, gave a short presentation on the ruling's implications for

Colorado. Many SNAC Lab participants stayed after the meeting adjourned to discuss its impact further.

Jeff's presentation on care coordination provided three main points:

- There is limited evidence on the cost effectiveness of care coordination programs.
- The ACC uses three basic models of care coordination.
- There are opportunities for greater integration of oral health services into the ACC.

Studies suggest care coordination programs, especially those with strong in-person contact, may improve care quality and patient outcomes but may not always decrease costs. However, care coordination focusing on patients with particularly complex needs has achieved cost savings. Accordingly, the ACC must consider the patients with which it focuses its care coordination efforts. Along a continuum of patients requiring medical and social supports services, there may be a target population for which care coordination yields the best patient outcomes as well as cost savings. RCCOs may use the Statewide Data and Analytics Contractor (SDAC) data, as well as other data sources, to target patients by illness burden. Additionally, care coordinators have explained that patients who are receptive to the care coordinator's role and are willing to implement a care plan benefit most from care coordination. CHI created a short video of interviews with care managers from one RCCO, though representatives from all seven RCCOs have been interviewed. The care managers discussed their daily responsibilities, for which patients care coordination works best and patient success stories.

A variety of care coordination tools are being used in the ACC:

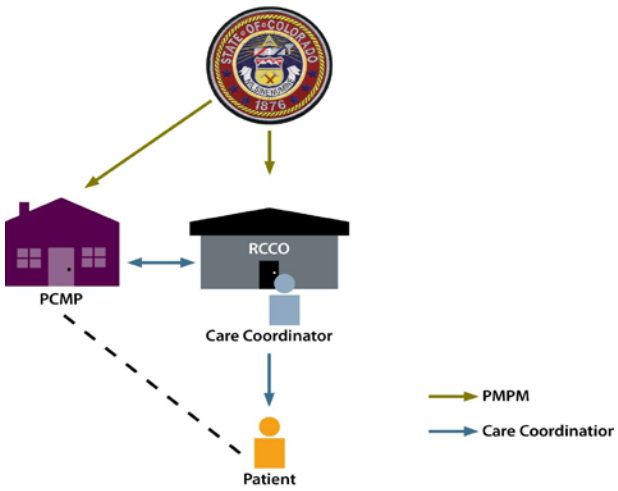
- *Evidence-based practices*
    - RCCOs use evidence-based care coordination methods established in the scientific literature and used by other states, such as North Carolina, with extensive experience coordinating care.
- *Assessing patient risk tiers*
    - Patients are organized by risk tier, such as healthy/nonusers, pregnant women, and those with significant acute or minor chronic conditions. Care coordination efforts focused on patients in higher risk tiers may produce cost savings and help achieve metric goals, such as decreasing emergency department visits, hospital readmissions and high-cost imaging.
- *Targeted scheduling*
    - Care coordinators may have regular office hours at a medical home to assist patients with social supports needs during their regular appointments. Appointment scheduling can be targeted for when the clinician and care coordinator are both available, allowing the patient's medical and social supports needs to be addressed in one appointment.
- *Multidisciplinary care teams*
    - Care coordinators often come from diverse disciplines, including medicine,

social work, behavioral and public health. The collective expertise on the care team may help patients with complex medical and social supports needs.

- *Combining data resources*
  - The RCCO and PCMPs are forming data-sharing agreements with hospitals, specialists, mental health clinics and other facilities to provide data on patient behavior in real time that supplements the SDAC data, which is not immediately available.
- *Community-driven approaches*
  - The ACC allows communities to adapt their care coordination practices to suit their needs. Local innovation may produce best practices that could be disseminated throughout Colorado.
- *Integration of services*
  - PCMPs may aim to provide a "one-stop shop" where patients can receive oral and behavioral care, and public health information.

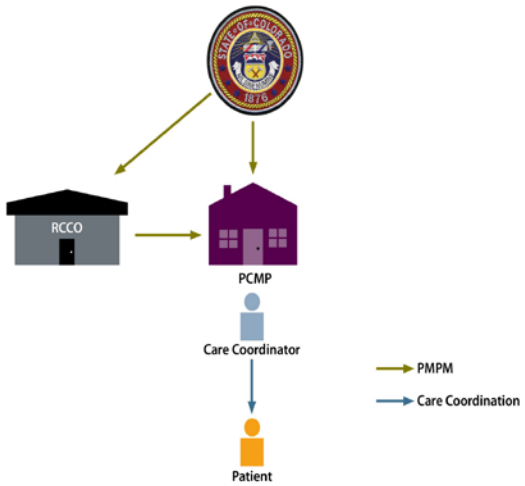
CHI, to begin to understand the ACC's organizational DNA, identified three basic models of care coordination being tested throughout the state (see Figures 1 – 3). The Colorado Department of Health Care Policy and Financing provides per-member, per-month (PMPM) payments to the RCCOs and primary care medical providers (PCMPs) for care coordination and medical home services, respectively (represented by the green arrows). However, in some RCCOs, PMPM payments may be pooled or redirected to finance the care coordination provided to the patient (represented by the blue arrow). House Bill 12-1281, passed during the recent legislative session, may promote further innovation in care coordination by providing opportunities for different payment structures, including global payments.

Figure 1. RCCO-based care coordination.



In Figure 1, the RCCO, working with the PCMP, provides the care coordination services. For example, Colorado Community Health Alliance, a RCCO serving much of Denver, provides care coordination services for many of its PCMPs, especially those with no previous experience coordinating care.

Figure 2. Delegated care coordination



As illustrated in Figure 2, the RCCO may redirect some or all of their PMPM payment for select patients and delegate the care coordination services to a qualified PCMP. The PCMP must have considerable experience and resources to fulfill care coordination duties due to extensive experience coordinating care. PCMPs that are Federally Qualified Health Centers (FQHCs) commonly receive delegation. For example, Colorado Access, a RCCO that serves three ACC regions, often delegates care coordination duties to FQHCs.

Figure 3. Community-based care coordination

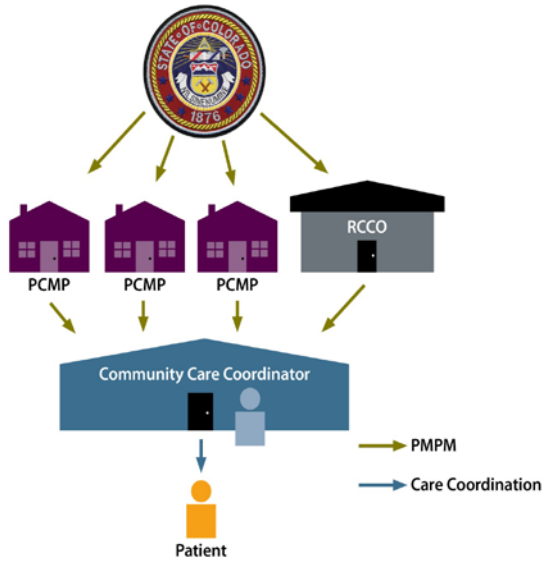
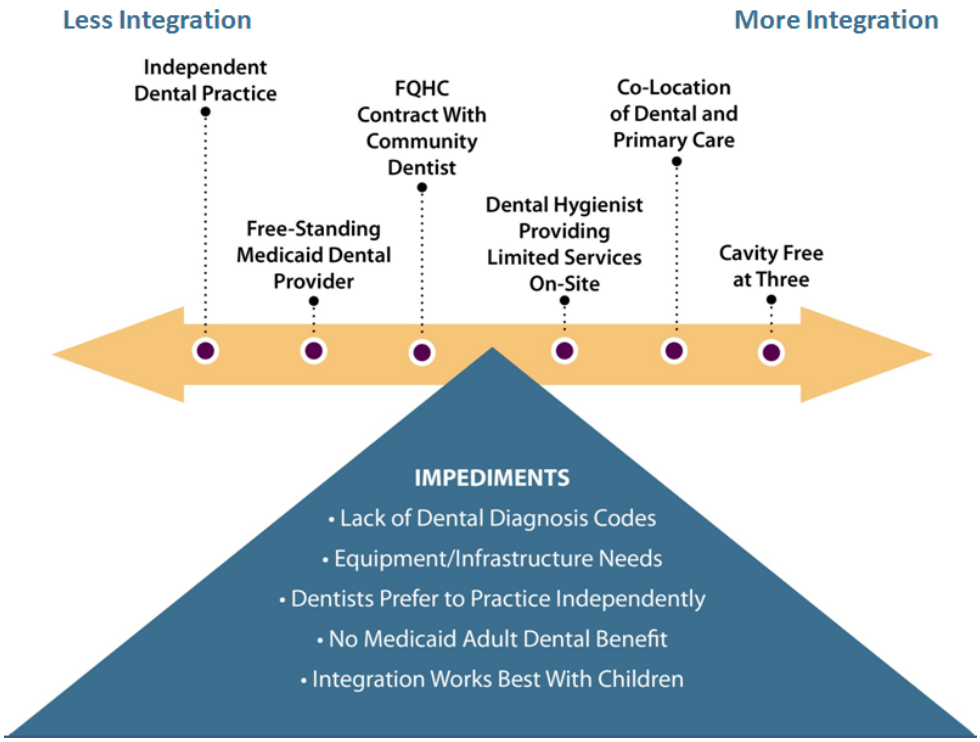


Figure 3 displays an arrangement in which the RCCO and PCMPs pool their PMPM payment to fund a community entity that provides the care coordination services. This model is used by Rocky Mountain Health Plans (RMHP), the RCCO for Colorado's largest ACC region. RMHP and some of its PCMPs pool their PMPM funds to finance a care coordination team.

During the first SNAC Lab, concern was raised over what opportunities oral health providers have to participate, especially due to the relationship between poor oral health and other

diseases. Jeff submitted that oral health is often a matter of integration, and the degree to which integration with primary medical care occurs. Figure 4 displays a continuum of approaches to providing oral health services and their integration/interaction with primary care. Challenges to such integration were identified as well.

Figure 4. Integration of dental and primary care.



Future SNAC Labs will feature segments on behavioral and public health integration in the ACC.

The Discussion

The following is a summary of the discussion after Jeff's presentation.

Care coordinators' training and variations on the care coordination theme

A RCCO executive explained that there is no standard or required training for ACC care coordinators, a point that was shared by other RCCO representatives. The scope of the care coordinators varies based on their level of education, training and licensure. Care coordinators are often social workers, registered nurses, behavioral health workers and others who have experience in philanthropy organizations. An executive of a safety net clinic organization voiced a curiosity to learn more about how care coordinators are different from patient navigators, care managers and promotoras. CHI will do more research to address this question in a future SNAC Lab.

Balancing providing care coordination and cost

Patients vary among their care coordination needs. Typically, children require little support besides an annual health risk assessment. Some adult patients, especially those with disabilities or intensive behavioral health needs, require focused support. According to a RCCO executive, a care coordinator may have as many as 600 patients on their docket; however, only those with the greatest and most urgent care coordination needs may be contacted. The RCCOs financial limitations may greatly influence the number of patients who are engaged. There is a balance between providing more care coordination services to more patients while remaining cost-saving. The delegated care coordination model may provide solutions for RCCOs with limited budgets by taking advantage of existing care coordination infrastructure at PCMPs.

Care coordination is enhanced through real-time information

A RCCO representative explained that care coordination cannot be effective without real-time information on patient behavior. Absent any supplemental communication, since the SDAC data originates from claims data, there is typically a three-month lag between a past patient event and when the RCCO may learn of the event. Without further innovation, this could decrease the RCCO's ability to impact metrics. The RCCO representative also voiced a desire to deploy more care managers to the most acute risk groups.

Oral health integration

An oral health representative explained that, without proper diagnostic codes, it is difficult to determine how many emergency department and hospital admissions and readmissions were due to an oral health care need. Another participant added that rural dental care is a major challenge due to a lack of providers. A RCCO executive stated that new payment models may provide opportunities for oral health service integration into the ACC despite the lack of Medicaid dental benefits for adults. Dental education historically has emphasized being an independent businessperson; however, new changes within the curriculum and in the real world may help.

Attachment 1: List of SNAC Lab attendees – June 28, 2012

Sharon Adams, *ClinicNET*
Neysa Bermingham, *Kaiser Permanente Colorado*
Abby Brookover, *Physician Health Partners* and *Colorado Community Health Alliance*
Colleen Church, *Caring for Colorado Foundation*
Karen Cody Carlson, *Oral Health Colorado*
Patrick Gordon, *Rocky Mountain Health Plans*
Aubrey Hill, *Colorado Coalition for the Medically Underserved*
Terri Hurst Greene, *Colorado Behavioral Health Council*
Mark Johnson, *Colorado Association of Local Public Health Officials*
Michele Lueck, *Colorado Health Institute*
Gretchen McGinnis, *Colorado Access*
Michelle Mills, *Colorado Rural Health Center*
Jenny Nate, *Center for Improving Value in Health Care*
Maureen O'Brien, *Colorado Foundation for Medical Care*
Kristen Pieper, *Colorado Consumer Health Network*
Annie Wohlgenant, Consultant
Gary VanderArk, MD, *Colorado Coalition for the Medically Underserved*

CHI Staff:

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