NHP

Health Neighborhood Forum

Tuesday, June 27, 2023

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Welcome

- *Overview and Housekeeping*

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Health Neighborhood Forum

Overview & Purpose

- *Purpose: Bring regional partners together to disseminate information, discuss key issues, learn from each other, and serve our regional members.*
- *Cadence: Quarterly in June, September, December, and March*

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Housekeeping

- **Please Sign-in to Chat**
- **Mute Your Microphone**
- **Questions?**
  Please raise your hand or use chat. We welcome the dialogue.

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Health Neighborhood Forum

An Overview of Northeast Health Partners

- *General Overview*
- *Care Coordination*
- *Population Health*
- *Quality*
- *Community Investment Grants*

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Today's Speakers

Raina Ali
Administrative Intern

Jen Hale-Coulson
Clinical Director

Alee LaCalamito
Population Health Program Coordinator

Roger Iyayi
Quality Manager

Natasha Lawless
Contract Manager

Brian Robertson
COO/Director of Quality

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Northeast Health Partners

Raina Ali

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RAE 101

What is a RAE & What is its Role?

NHP Overview

Who we are & What we do

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What is a Regional Accountable Entity?

- Every Health First Colorado member has a primary care provider and is assigned to a Regional Accountable Entity (RAE).
- RAEs are Managed Care Entities who have a contract with the State of Colorado to be responsible for coordinating Health First Colorado members' care ensuring members are connected with primary and behavioral health care and developing regional strategies to serve their communities.
- Raes provide care coordination for members and build behavioral and primary care provider networks to help connect members with care. RAEs pay providers for behavioral health services through a payment called capitation.

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Attribution

How are members attributed to a RAE?

Members are assigned to RAEs based on the location of their primary care provider (PCMP). Whichever region the PCMP practices in will determine the regional entity to which the member is assigned. Members can choose their PCMP, be attributed to a PCMP based on their Medicaid claims history, be attributed based on their geographic location or based on if a household member has a PCMP. Members can select a new PCMP at any time, but attribution will not switch until the month following the date of their selection.

Functions of the RAE

Members

Improving member health, wellness and life outcomes as well as promoting member choice and engagement

Financials

Cost-effective health care services; paying providers for the increased value & Quality they deliver our members

Collaboration

Coordination across settings and with various providers/partners to avoid duplication of efforts and unnecessary costs

Integrations

Whole-person care and integrated approach

Care Coordination

Strengthen coordination of services through team-based care and health neighborhoods

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Who is Northeast Health Partners?

- Northeast Health Partners (NHP) is a non-profit organization with founders from four healthcare providers in northeast Colorado.
  - 2 FQHCs & 2 CMHCs
- 100% of staff are Colorado based
- NHP subcontracts with Carelon for administrative services.
  - Data system management and provider network development

FQHCs:

sunrise COMMUNITY HEALTH

Salud Family Health Centers
EXCELLENCE. EVERY PATIENT. EVERY TIME.

CMHCs:

CENTENNIAL MENTAL HEALTH CENTER
Moving lives forward

NORTH RANGE BEHAVIORAL HEALTH
Where hope begins.

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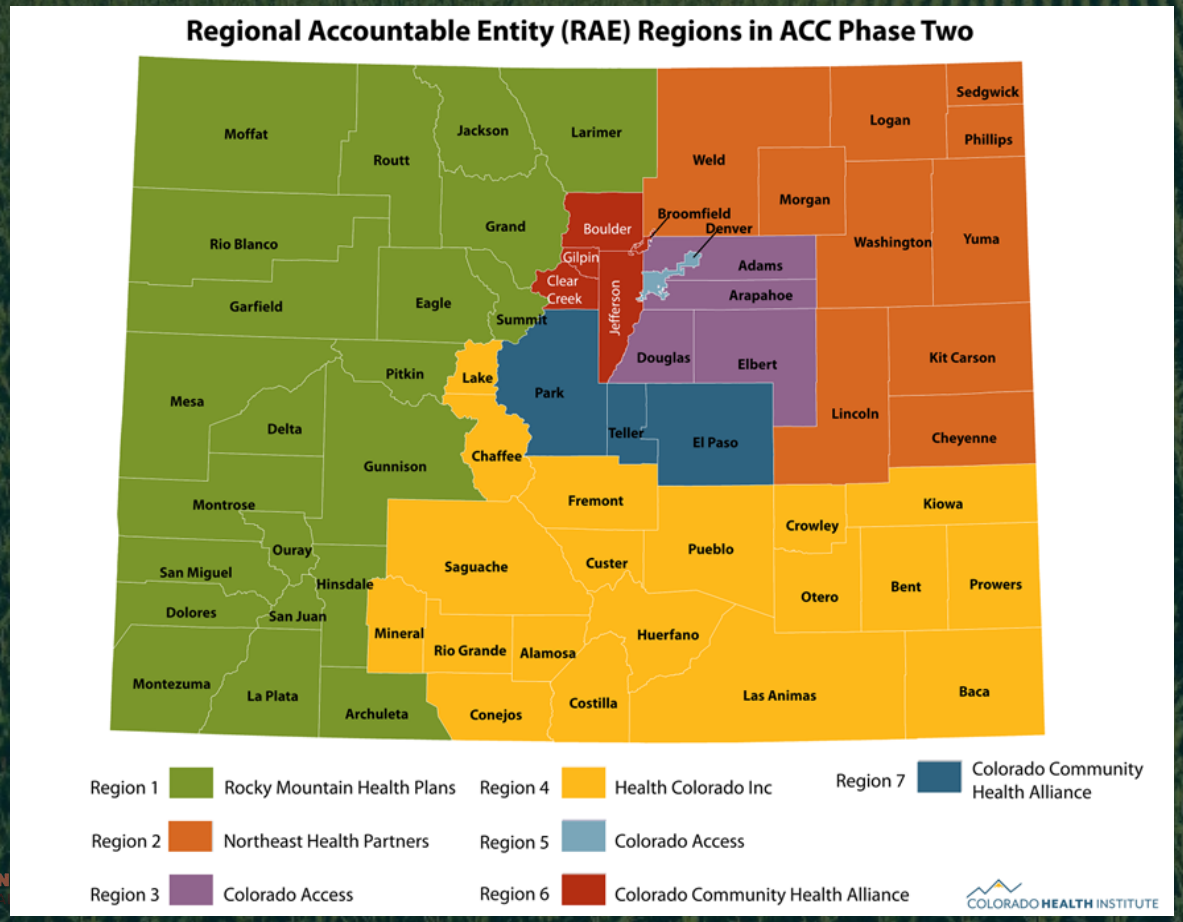
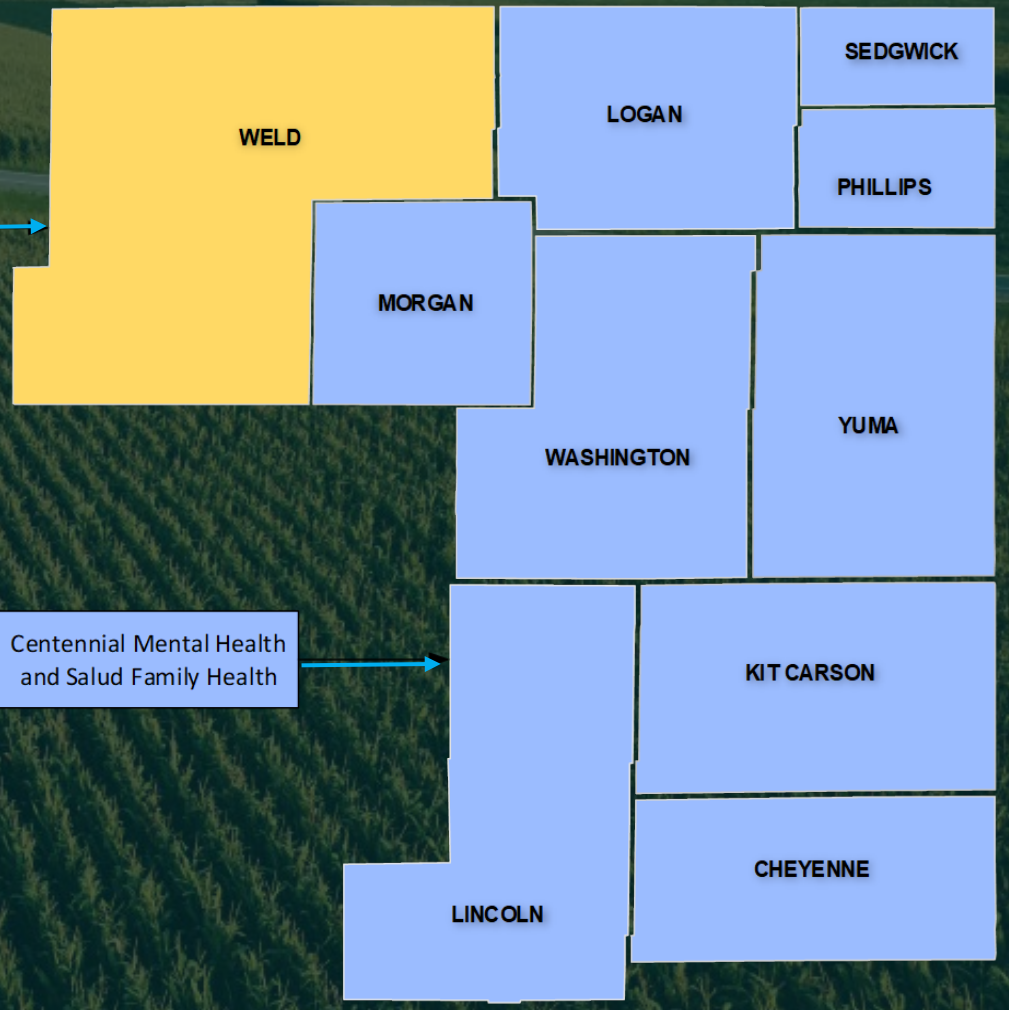
NHP is made up of 10 counties & 22,000 square miles

1 Urban
3 Rural
6 Frontier



North Range Behavioral Health and Sunrise Community Health



Centennial Mental Health and Salud Family Health

Provider Network

Behavioral Health Facilities[1]

128

PCMP Practices[2]

70

Behavioral Health Individual Practitioners[1]

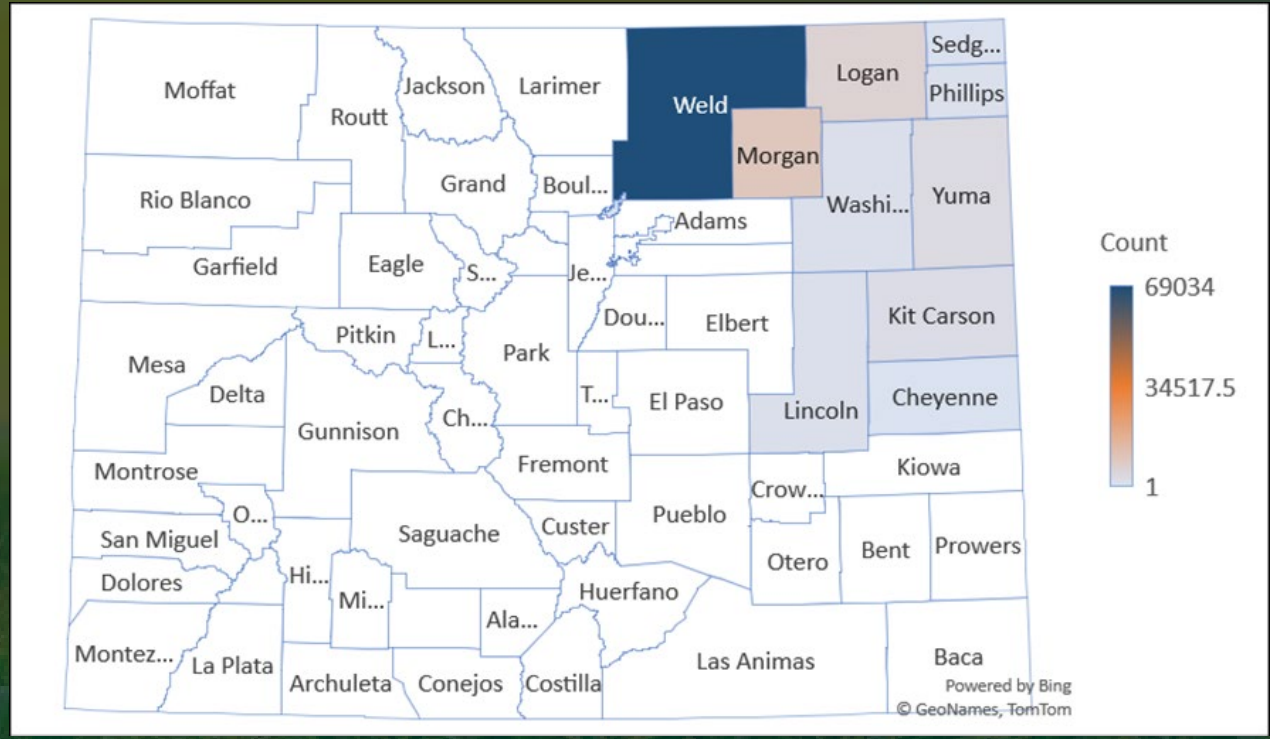
1,417

PCMP individual Providers[2]

368

[1] Data source for behavioral health network is NetworkConnect as of 3/14/2023
[2] PCMP data source is Network Adequacy Report as of 12/31/2022

NHPs Membership



Age	Count of NHP Membership	% of NHP Membership
Child: 0-12	27,983	26.51%
Adolescent: 13-17	11,785	11.16%
Adult: 18-69	61,079	57.87%
Older Adult: 70+	4,707	4.46%
Gender	**Count of NHP Membership**	**% of NHP Membership**
Female	56,488	53.5%
Male	49,066	46.5%
Unknown/Not Stated		
Total Enrollment	**105,554**	

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Health Literacy

We Believe knowledge is Power

Community Partnerships

- *Local Chamber of Commerce*
- *Local Public Health Agencies*
- *Department of Human Services*
- *Local Government Agencies*
- *Faith Based Entities*
- *Independent Providers*

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NHP Resources
northeasthealthpartners.org

- Address and Renewal Updates
- Benefits and Services
- Care Coordination

- Complaints & Appeals
- Care on Location
- Find a Provider

- Health & Wellness
- Rights & Responsibilities

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THANK YOU!

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Care Coordination

Jennifer Hale-Coulson

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FACT SHEET

Care Coordination

Northeast Health Partners Region 2

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Summary:

About the RAE: Northeast Health Partners (NHP) is a nonprofit organization with founders from four healthcare providers in northeast Colorado — two federally qualified health centers (Sunrise Community Health and Salud Family Health Centers) and two community mental health centers (Centennial Mental Health Center and North Range Behavioral Health). NHP subcontracts with Beacon Health Options for administrative services. Beacon is a national managed behavioral health care organization that provides many types of services to state Medicaid programs. For NHP, Beacon provides quality oversight, data system management and reporting, provider network development, information technology, financial management and more.

Background:

- NHP has created a comprehensive community-based system of care coordination/care management for physical health, mental health and substance use disorder services
- NHP delegates care coordination to *Accountable Providers* and *Designated Care Coordination Entities* in the region who serve as the centralized hub for member care management
  - *Family Physicians of Greeley*
  - *North Colorado Health Alliance*
  - *Peak Vista Community Health Center*
  - *Plan De Salud del Valle, Inc.*
  - *Sunrise Community Health*
- NHP care coordinators/managers address and coordinate care with a central focus on improving member health/access to care, preventing disease progression, and reducing unnecessary and/or avoidable utilization and costs
- NHPs care coordination model is a member- and family-centered, assessment driven, team-based approach designed to meet the needs of our members

Goals:

- Improve access to appropriate services and supports
- Reduce unnecessary use of costly services (e.g., out-of-home placements and lengths of stay)
- Employ health information technology to support service decision making
- Consider SDoH risk factors when assessing needs
- Engage members/families as partners in care decisions to improve their experience with care
- Integrated care/services
- Culturally appropriate, whole-person care

Care Coordinator Functions:

- Outreach/engagement
- Evidence-based care coordination screening & assessment
- Care Plan creation
- Establishing person/family engagement as a standard of care
- Collaboration with provider networks, including natural supports (closed-loop referrals)
- Coordination across settings to avoid duplication/ unnecessary costs and to improve member outcomes

Program Measurement:

The Care Coordination Entities level of performance is monitored on a monthly basis using a customized dashboard developed by NHP to evaluate extended care coordination of complex members, looking at care management outreach efforts and care coordination engagement. NHP carefully monitors the percentage of unique complex members engaging in Extended Care Coordination (ECC) monthly through analysis of monthly data, Fiscal Year to Date (FYTD) data, and rolling twelve (12) month data to ensure we were consistently hitting our targets and meeting performance goals.

Program Assessment:

Care Coordination Alignment with RAE Principles, Best Practices and Evidence-Based Contractual Obligations:

- NHP ensures care coordination entities are meeting contractually identified elements through an auditing process
- Entities must score 80% and higher for a passing score. Entities scoring below this benchmark are put on a Corrective Action Plan (CAP) which includes increased audits and a performance improvement plan (PIP) stipulating expectations for improved scoring
- Entities unable to improve documentation standards and demonstrate improved coordination of services in alignment with the RAEs principles will have a termination of their delegated care coordination contract
- *To date, none of our care coordination entities have failed an audit*

Priority Populations:

Populations with chronic/complex conditions who receive customized care coordination designed to address unique circumstances of individual members

- ***Foster Care***: NHP receives a weekly electronic submission from Weld County DHS for all members placed in foster care for immediate follow-up. Referrals are made upon placement of child (average time is 3 days)
- ***Justice Involved***: NHP provides in-reach programming at correctional facilities across the state and are working with DOC officials to reduce deaths among individuals in our region released from correctional facilities (focus on suicide and accidental due to OD). Efforts include member identification for those most at-risk 14 days post-release
- ***Homeless***: NHP has care coordinators assigned at the Housing Navigation Center placing unhoused members on the HMIS housing list and assisting members who need help with obtaining their birth certificate and/or identification in addition to providing care coordination and other resources
- ***Pregnant + Chronic Conditions***: NHP has a national maternity program, many regional programs, and has focused our PAC efforts on regional C-section reduction
- ***PDN***: NHP has developed a process to manage Prior Authorization Request (PAR) denials for Private Duty Nursing (PDN) and Pediatric Long-Term Home Health (PLTHH) includes a workflow for reaching members who have received a PDN denial or reduction and coordinating with Case Management Agencies (CMAs) to ensure members are receiving necessary care coordination
- ***SUD***: NHP has developed SUD care coordination standards of care, including enhanced referral requirements for navigation, care coordination, care management between providers, social service organizations, and community resources to ensure cross-system partnerships between providers. In addition, peer support groups (AA/NA, etc.) are offered as well as additional assistance to remove any identified barriers to treatment, such as lack of transportation to ensure the members needs are met
- ***Co-morbid Conditions (physical health conditions + mental health conditions: example diabetes + depression/anxiety)***: members are risk stratified to ensure those at highest risk for hospital admissions and ED visits are targeted for outreach from a RN care manager and receive a comprehensive health needs assessment to determine their level of knowledge regarding how to manage their co-morbid condition(s), including treatment indications and medication compliance as well as enrollment in care management programming

NHP Care Coordination

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Connecting

Connecting members with services and providers

Linking

Linking members to resources such as transportation, food assistance, housing and other social services

Assisting

Assisting members with understanding their medical conditions

Supporting

Supporting members in managing physical and behavioral health benefits

How Members Connect with Care Managers

Behavioral Health Care Managers	Complex Member Care Management	Physical Health Care Managers	Resource & Referral
Assigned upon hospitalization & assist with transitions of care	*Intensive care management for those needing specific, extended care management*	*Assigned through delegated care management process*	*Call: 888-502-4190 or email NorthEastHealthPartners @carelon.com*

SUCCESS

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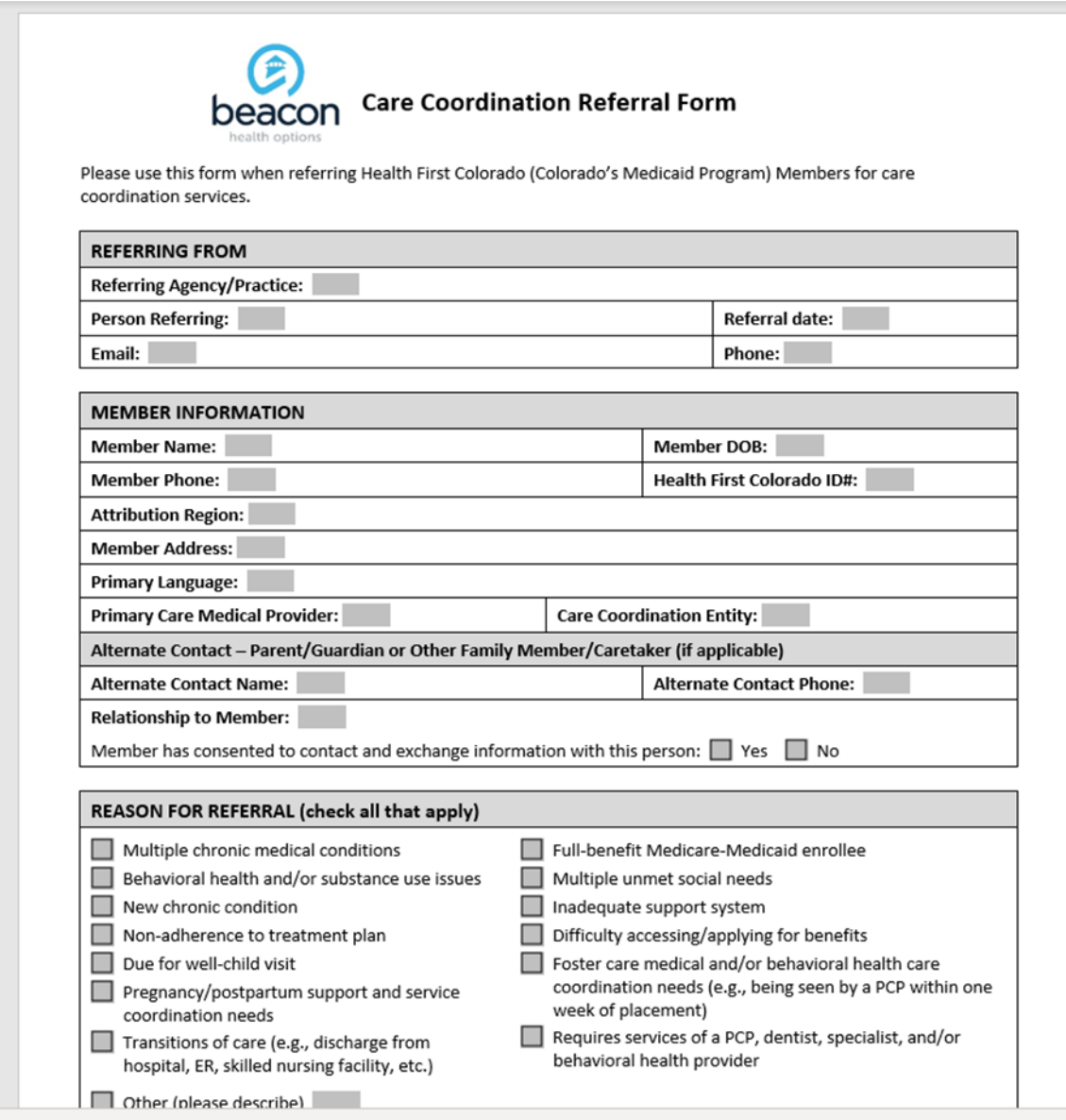
Care Management Referrals



beacon health options

Care Coordination Referral Form

Please use this form when referring Health First Colorado (Colorado's Medicaid Program) Members for care coordination services.

REFERRING FROM	
Referring Agency/Practice:	
Person Referring:	Referral date:
Email:	Phone:

MEMBER INFORMATION	
Member Name:	Member DOB:
Member Phone:	Health First Colorado ID#:
Attribution Region:	
Member Address:	
Primary Language:	
Primary Care Medical Provider:	Care Coordination Entity:
Alternate Contact – Parent/Guardian or Other Family Member/Caretaker (if applicable)	
Alternate Contact Name:	Alternate Contact Phone:
Relationship to Member:	
Member has consented to contact and exchange information with this person: ☐ Yes ☐ No	

REASON FOR REFERRAL (check all that apply)

- ☐ Multiple chronic medical conditions
- ☐ Behavioral health and/or substance use issues
- ☐ New chronic condition
- ☐ Non-adherence to treatment plan
- ☐ Due for well-child visit
- ☐ Pregnancy/postpartum support and service coordination needs
- ☐ Transitions of care (e.g., discharge from hospital, ER, skilled nursing facility, etc.)
- ☐ Other (please describe)
- ☐ Full-benefit Medicare-Medicaid enrollee
- ☐ Multiple unmet social needs
- ☐ Inadequate support system
- ☐ Difficulty accessing/applying for benefits
- ☐ Foster care medical and/or behavioral health care coordination needs (e.g., being seen by a PCP within one week of placement)
- ☐ Requires services of a PCP, dentist, specialist, and/or behavioral health provider

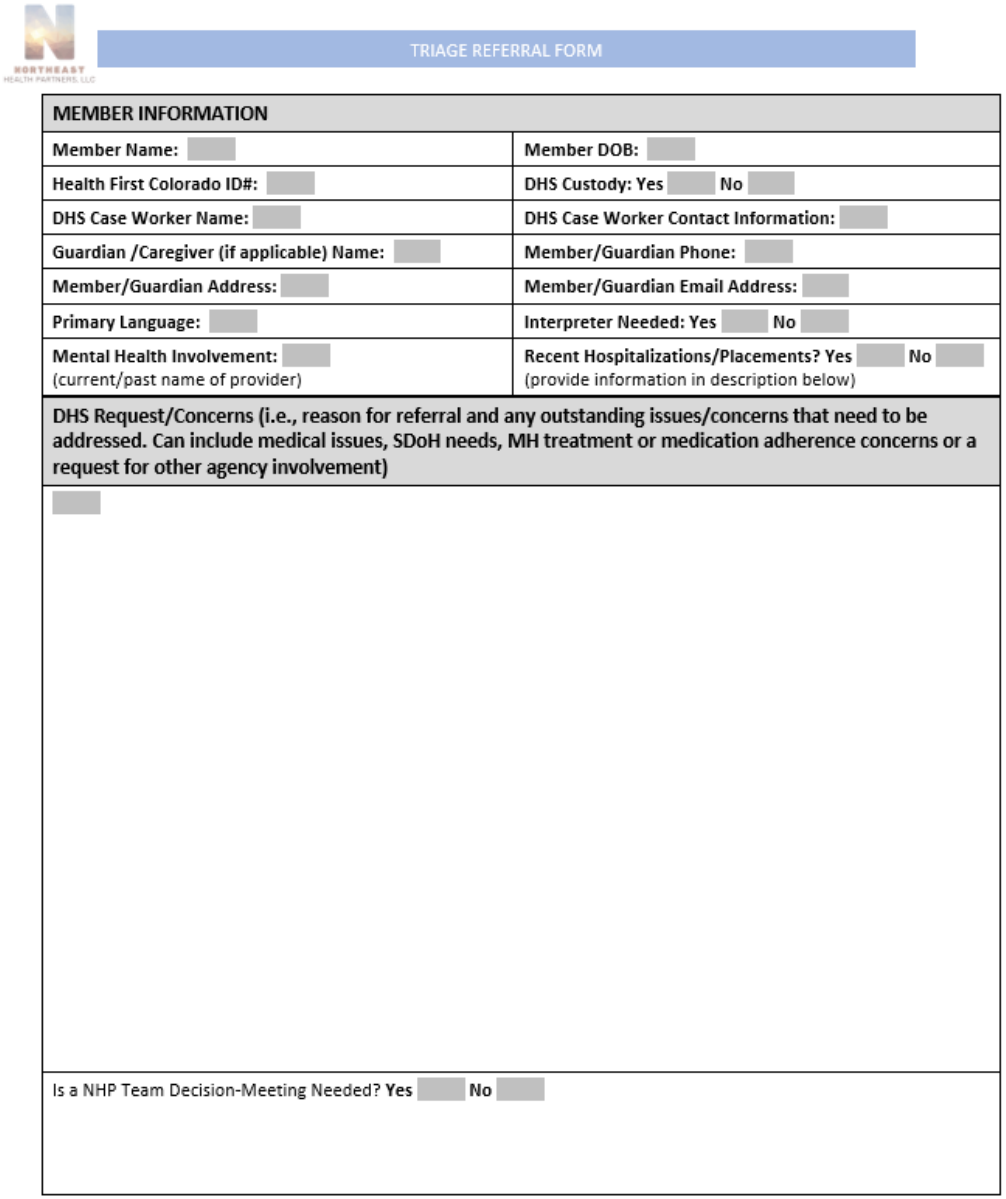
The care coordination referral form is completed by Carelon (*formerly Beacon Health Options*) and sent to the designated care coordination entity assigned to manage the member.

These forms are completed for every care coordination referral on behalf of the person (or member) making the request.

The care coordinator will outreach the referral within 48 hours of receiving the request.

*Due to 42 CFR Part 2, additional consent is needed to exchange substance use information with providers and external parties. NHP requires a *Release of Information (ROI)* to be completed if substance use/treatment and/or a SUD referral is part of the care coordination request. An ROI will be provided for any referrals falling under this criterion*

Direct Referrals to NHP



TRIAGE REFERRAL FORM

MEMBER INFORMATION	
Member Name:	Member DOB:
Health First Colorado ID#:	DHS Custody: Yes No
DHS Case Worker Name:	DHS Case Worker Contact Information:
Guardian /Caregiver (if applicable) Name:	Member/Guardian Phone:
Member/Guardian Address:	Member/Guardian Email Address:
Primary Language:	Interpreter Needed: Yes No
Mental Health Involvement: (current/past name of provider)	Recent Hospitalizations/Placements? Yes No (provide information in description below)

DHS Request/Concerns (i.e., reason for referral and any outstanding issues/concerns that need to be addressed. Can include medical issues, SDoH needs, MH treatment or medication adherence concerns or a request for other agency involvement)

Is a NHP Team Decision-Meeting Needed? Yes No

NHPs triage referral form can be completed by DHS and sent directly to NHP to nhpccreferrals@nhpllc.org request care coordination for any eligible member. Be sure to cc: Jen Hale-Coulson/Clinical Director at Jennifer@nhpllc.org to these referrals.

NHP will verify member Medicaid eligibility and R2 attribution prior to making the referral. We will reconnect with the person making the request if there are questions.

Once eligibility is confirmed, the care coordinator will outreach the referral within 48 hours of receiving the request.

*Due to 42 CFR Part 2, additional consent is needed to exchange substance use information with providers and external parties. NHP requires a *Release of Information (ROI)* to be completed if substance use/treatment and/or a SUD referral is part of the care coordination request. An ROI will be provided for any referrals falling under this criterion*

THANK YOU!

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Jen Hale-Coulson, MA, LPC

jennifer@nhpllc.org

970-237-2985

Population Health

Alexandra LaCalamito

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Population Health

Care Coordination & Complex Care

Foster Care
Justice-involved
Unhoused
People with Disabilities

Condition Management

Maternity
Diabetes
Depression
Anxiety
Asthma
COPD
Chronic Pain
CHF/CVD
Hypertension
Substance Use Disorder

Prevention, Wellness, Member Engagement

Well Care
Tobacco Cessation
Food Security
Family Planning
Member Engagement

Member ID & Risk Stratification | Cultural Competency | Access | Evidence-based/informed | Measurement

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Alexandra LaCalamito
alexandra@nhpllc.org
970-502-2299

Quality

Roger Iyayi

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Overview of Quality Activities

Performance Measures	Performance Improvement	Quality of Care	Auditing	State PIP Projects
• *KPIs* • *BHIP Measures* • *Performance Pool*	• *DMAIC Methodology, A3, PDSAs* • *Clinic Partnerships* • *Dashboards & Visualizations*	• *Quality of Care Reviews* • *Committee Refferals* • *State Reporting*	• *Chart Audits* • *Provider Training*	• *Social Determinants of Health & Follow-Up After ED Use for SUD*

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Quality Committees and Community Forums

How can we connect?

- *Regional PIAC*
- *Bimonthly QI/Pop Health Committee*
- *Bimonthly QM Committee*
- *Quality of Care Committee*
- *First Fridays*

Meet the Team

- *Brian Robertson, PhD – QI Director*
- *Roger Iyayi – Quality Manager*

Carelon Support:

- *John Mahalik, PhD – Quality Director*
- *Jeremy White – Quality Manager*
- *Melissa Schuchman – Quality Analyst*
- *Ed Arnold, RN – PI Analyst*
- *Michaela Smyth – PI Analyst*
- *Courtney Hernandez – QM Specialist*
- *Anna Pittar-Moreno – Quality Analyst*

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Roger Iyayi

roger@nhpllc.org

970-909-4525

Community Investment Grant

Natasha Lawless

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NHP Community Investment Grant

Mission

NHP is committed to the delivery of high quality, whole-person care and holds the strong belief that local communities are in the best position to make the changes that advance the health and quality of care for its members. For this reason, NHP offers financial support opportunities to local healthcare professionals, community organizations, and public health departments within the region who develop effective strategies to improve health, wellness, and life outcomes for Medicaid members

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Community Investment Grant

- Overview
- Eligibility Criteria
- Award Process

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Outcomes & Successes

FY21-22	FY22-23	FY23-24
4 AWARDEES	*4 AWARDEES*	*5 AWARDEES*
$131,610	*$*	*$195, 846*
Highlighted Awardee: Weld County Public Health and Environment	*Highlighted Awardee: Envision*	*Highlighted Awardee: Burlington Child Care Center*

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Natasha Lawless

natasha@nhpllc.org

970-324-4170

Next Meeting

Date & Time

September 26, 2023

12:00-1:00pm

Location & Link

In-person & Zoom

Location TBD

Topic

High Intensity Outpatient Treatment

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