Goals

1. Improve care received by Colorado Medicaid’s highest-need, highest-cost clients
   - Improve patient linkage with PCP medical home
   - Increase care coordination across systems of care
   - Provide necessary supports to ease care transitions
   - Assist members in navigating care needs, self management, and addressing psycho-social barriers (e.g. Transportation, scheduling appointments)
   - Empower care manager to serve as member advocate
   - Retain member-provider-health-plan relationships

2. Decrease cost of care
   - Decreased use of inappropriate specialty or ER utilization
   - Decreased admissions for Ambulatory Care Sensitive Conditions
   - Decrease readmissions
Target Population

- **Colorado Medicaid clients**
  - 21 years of age or older
  - Aged, Needy, Disabled or Blind
  - Residents in one of five counties (Adams, Arapahoe, Boulder, Broomfield and Denver)

- **Exclusions**
  - Dual eligible clients
  - Residents in nursing homes
  - Persons qualifying for Developmental Disabilities or Brain Injury waivers
Identification & Stratification

- Clients identified by State of Colorado
- MDRC random assignment 70%/30%
- Passive Enrollment of 70% into CoAcc
  - Clients receive notification via mail
- CDPS (Kronick) Scores
  - Prior year costs
  - Diagnoses
  - Top 20% defined highest cost/highest risk
CRICC Enrollee Attributes

- Top 5 chronic conditions:
  - Diabetes
  - Hypertension
  - Chronic Obstructive Pulmonary Disease
  - Osteoarthritis
  - Asthma

- Future risk costs: 3.24
- Future risk of inpatient stay: 3.48
- Average age 44
Study Design

- Two-year study (from date of enrollment)
- 2,300 clients enrolled
- Intent-to-treat
  - Passive enrollment notification letter designates study group
- Random assignment
  - Study = Colorado Access
  - Control group = Medicaid FFS
- Compare utilization, costs, member & provider satisfaction
- CHF Grant: seven care managers & internal evaluator
- All CoAcc clients eligible for enhanced care management
Parameters for Intervention Design

- Accept any-willing provider model
  - Concerns from disability community about disruption of care
- Provide CM through various care delivery systems
  - Members seek care through FQHC, residency clinics, individual PCP practitioners, specialists or ER care and care manager needs to be accessible to the member at each point
- Establish strategies for contracting and incentivizing provider engagement
Care Management Intervention

- **Provision of Care Management**
  - Provide: (1) telephonically; (2) in the community (home, hospital, nursing facility); or (3) in the clinic to effectively reach clients
  - Ensure flexibility to accommodate how clinics integrate care management into their facilities

- **Staffing**
  - Nurse supervisors
  - Care management pods based on high-volume clinic
  - Weekly multidisciplinary consultations

- **Targeting clients**
  - CDPS and health risk assessment used initially
  - Recently incorporating risk prediction software (IPRO)
Care Management Interventions Continued

- **Health Risk Assessment**
  - Assess conditions and future risks
  - Care planning initiation including social support & ADL
  - Establish ongoing monitoring needs (case by case)

- **Motivational interviewing used to promote self-management/client education about conditions**

- **Transitions of Care**

- **Access to timely information**
  - Inpatient census and UM process
  - Working with hospitals on ER census
Case Example

- 50-year-old female on oxygen, legally blind, diabetes, fibromyalgia, and arthritis
- History of hospitalization for COPD and high blood sugar
- Member’s care is inconsistent with different PCP each visit; scheduled every two days for blood sugar testing (600)
- Since enrolling in CRICC:
  - Member no longer on oxygen
  - Blood sugars improved but still high 100s to low 200s.
  - Member’s affect is brighter and appears more hopeful
  - Member reporting consistency in PCP care
  - No emergency room or inpatient visits since March 2009
Challenges

- Targeting appropriate resources for members as their health needs evolve
- Care management model consistency that accommodates range of member and clinic needs
- Impacting outcomes in relatively short timeframe (locate clients, engage, build trust, change behaviors, see results)
- Determining the best way to share member information with PCPs
- Negotiating physical health/mental health data sharing
- Identifying the best staffing model and notification methods for transition of care activities
EARLY RESULTS
Hospital Admissions

Admits per 1,000

Jun-08  Jul-08  Aug-08  Sep-08  Oct-08  Nov-08  Dec-08  Jan-09  Feb-09  Mar-09  Apr-09  May-09

-  50.00
   100.00
   150.00
   200.00
   250.00
   300.00
   350.00

Linear (Admits per 1,000)
Primary Care Visits

PCP Visits per 1,000

PCP Visits per 1,000
Linear (PCP Visits per 1,000)
Outpatient Hospital

Outpatient Hospital Srvcs Cost PMPM

Outpatient Hospital Srvcs Cost PMPM

Linear (Outpatient Hospital Srvcs Cost PMPM)
Pharmacy
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