COLORADO

Case Study

Super-Utilizers

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EXECUTIVE SUMMARY

Super-utilizers are patients who use the healthcare system with extraordinary frequency and drive up healthcare costs. Their care consumes a disproportionate share of U.S. healthcare spending, and these costs have been increasing. Although the specific definition of super-utilizer varies, these individuals frequently have multiple co-occurring chronic and mental health conditions; struggle with the socioeconomic challenges of poverty and unemployment; experience food, housing, and transportation insecurity; lack of education; and have poor access to dependable primary and supportive care. Due to these challenges, super-utilizers typically incur higher healthcare spending through increased emergency department visits and/or hospital inpatient readmissions.

Health outcomes for super-utilizers are not proportionately better than those of non-super-utilizers, despite the significant amount of resources being spent to provide their care. Evidence is mounting that team-based care coordination, appropriate medical and behavioral health treatment, and planned transitions between facilities and providers can reduce costs associated with super-utilization and improve super-utilizers' health outcomes.

In 2013, Colorado state officials at the highest levels, including the governor and state agency leaders, came together to address this issue. As part of this effort, they leveraged a unique opportunity offered by the National Governors Association's Center for Best Practices: the Developing State-Level Capacity to Support Super-Utilizers Policy Academy. Colorado formed a core team to implement the policy academy's activities, including officials from the Department of Health Care Policy and Financing (the state's Medicaid agency), the Department of Public Health and Environment, and other related state agencies. They used the policy academy's technical assistance to enhance existing, innovative Medicaid delivery infrastructure and interventions underway in Colorado's regional care collaborative organizations (RCCOs). The goal of the RCCOs is to implement interventions that achieve the three-part aim: improving the quality of health, improving the quality of care they receive, and reducing the per capita costs of their healthcare for the Medicaid population. Each RCCO collaborates with different types of healthcare providers, local public health agencies, and community organizations in their region. With best practices gleaned from the policy academy, RCCOs leveraged their existing infrastructure to provide targeted care coordination at the community level for the highest utilizers of healthcare resources.

Colorado highlighted that a key lesson learned was the benefit of leveraging existing policies and partnerships. Partnerships between state officials and their agencies, including Medicaid and public health, helped the statewide collaboration create a coordinated strategy, which interviewees cited as important given the geographic distribution of the RCCOs. In addition, this initiative was unique in that the policy academy did not provide funding and only provided targeted technical assistance. The lack of dedicated funding was a challenge for this time and resource intensive endeavor at the state level and additional funds would have enabled greater partnerships with the community. In addition, engagement of local public health agencies varied across the RCCOs, ranging from general awareness and support of RCCO activities to serving as a partner in either the super-utilizer interventions or other RCCO initiatives. This variation was in part due to local capacity and resources. However, interviewees noted a continued need to understand how public health agencies at both the state and local level can support super-utilizer interventions, including how to link them with community and population health interventions on an ongoing basis.

Executive Summary

Formal results from the Colorado super-utilizations pilots are still forthcoming; however, interviewees noted that this information will be critical as they develop future financial models for sustaining these efforts. One consideration for sustainability planning is how the state should reimburse RCCOs to incentivize these interventions, as the majority of the savings were accrued to the state in this pilot, while most costs were borne by the RCCOs.

GLOSSARY OF ACRONYMS

ACC	Accountable Care Collaborative
ASTHO	Association of State and Territorial Health Officials
CMS	Centers for Medicare and Medicaid Services
CHP+	Child Health Plan Plus
CHIP	Children's Health Insurance Program
HCPF*	Colorado Department of Health Care Policy and Financing
CDHS	Colorado Department of Human Services
CDPHE	Colorado Department of Public Health and Environment
CARES	Community Assistance Referral and Education Services
ED	Emergency Department
FOTS	Feet on the Street
NGA	National Governors Association
PAM	Patient Activation Measure
PMPM	Per-Member-Per-Month
PCMP	Primary Care Medical Provider
RCCO	Regional Care Collaborative Organization
RWJF	Robert Wood Johnson Foundation
SIM	State Innovation Model
SDAC	Statewide Data Analytics Contractor

*Colorado Medicaid

INTRODUCTION

Project Overview

With support from the de Beaumont Foundation, ASTHO has created a series of six case studies designed to describe successful collaborations between state public health departments and Medicaid agencies in which a state implemented an innovative policy change. For the purpose of this series, success is defined as demonstration of—or evident promise of—improvements in population health, cost savings to Medicaid, or both.

ASTHO and the de Beaumont Foundation convened a diverse expert group in May 2014 and provided essential guidance in choosing the programs featured in the series of case studies. This case study describes the innovations undertaken in Colorado to better identify and manage individuals who are the highest utilizers of healthcare resources, known as "super-utilizers."

The de Beaumont Foundation

The de Beaumont Foundation believes that a strong public health system is essential. The foundation works to transform the practice of public health through strategic and engaged grant-making. Programs funded by the foundation build the capacity and stature of the public health workforce, improve public health infrastructure, and advance the distribution and relevancy of information and data in the field. Please visit www.debeaumont.org for more information.

ASTHO

ASTHO is a 501(c)(3) nonprofit membership association serving the chiefs of state and territorial health agencies and the more than 100,000 public health staff that work in those agencies. Its mission, from which its organizational strategy flows, is to transform public health within states and territories to help members dramatically improve health and wellness. ASTHO tracks, evaluates, and advises members on the impact and formation of policy—public or private—pertaining to health that may affect state or territorial health agencies' administration and provides guidance and technical assistance to its members on improving the nation's health. ASTHO supports its members on a wide range of topics based on their needs, including, but not limited to, ASTHO's leadership role in promoting health equity, integrating public health and clinical medicine, responding to emergencies, and bringing voluntary national accreditation to fruition through the Public Health Accreditation Board. Please visit www.astho.org for more information.

METHODS

Interviews

The project team interviewed 10 individuals involved in the development and implementation of Colorado's super-utilizer program in the following roles:

- Seven Colorado Department of Health Care Policy and Financing (HCPF, Colorado's Medicaid agency) employees, including the executive leadership, two policy strategists, a policy analyst, a program evaluator, and an administrator involved with the two participating Regional Care Collaborative Organizations (RCCOs).
- One person from the Colorado Department of Public Health and Environment (CDPHE).
- One person from the Office of Behavioral Health for the Colorado Department of Human Services (CDHS).
- One local RCCO leader.

A project team member, Lisa Dulsky Watkins, led forty-five minute to one-hour phone interviews using identical questions from a standardized interview tool. Two additional team members served as note-takers, listening to and documenting each conversation. The interviews were recorded and, if necessary, transcribed for clarification. Data gathered from each interview was recorded into a data collection tool for analysis.

Document Review

With assistance from the interviewees and through independent research, the team collected government resources, news articles, and educational material on the case study topic. Project team members selected the most relevant documents for further review. All documents are listed in the references.

DATA MANAGEMENT

Data Synthesis

The project team developed three tools to facilitate data collection for the case studies: (1) the interview instrument, (2) the interview data collection tool, and (3) the document review data collection tool. These items are located in the appendices.

The interview instrument (see Appendix 2) included a structured set of questions designed to address the domains of interest suggested by the expert group (see Appendix 1), and focused on three primary domains: the interviewee's interaction with the policy change, the processes by which the policy change was implemented, and the impact of the policy change. Following each interview, the two note-takers entered their notes into the interview data collection tool (see Appendix 3), which designated where content from the interview fit best into the various coding categories. Next, the two note-takers collaborated to create a consensus document for each interview. To do this, they compared summary documents and reached agreement regarding any discrepancies in their accounts of the content of the interview and categorization of the content. The primary interviewer then reviewed the consensus document. The team created a similar tool to gather information from documents reviewed for each case study (see Appendix 4). The document was double-coded by two researchers and reviewed by a third, primary researcher.

Data Analysis

The project team entered interview content and consensus data collection tool ocuments into NVivo 10 (QSR International, Cambridge, MA), a qualitative research software, assigning codes and reviewing the content from the interviews and documents. These codes facilitated organization and analysis for each case study in the series and the cross-case study analysis. The team used a multiple-case replication approach to examine major points of interaction between Medicaid and public health which resulted in (1) population health improvement or (2) Medicaid cost savings.[1] Additionally, the team analyzed interview and document review data to examine points of convergence and divergence, with respect to the processes and drivers of several significant policy changes at the state and local levels.

COLORADO BACKGROUND

Demographics

According to 2014 estimates, Colorado has approximately 5.4 million residents, 69.4 percent of whom are non-Hispanic white, 21 percent Hispanic, 4.4 percent black, 3 percent Asian, and 1.6 percent American Indian.[2] It is a geographically large state, covering just over 100,000 square miles in the southwest of the United States.[3] Eighty-seven percent of its population is concentrated in urban centers, with the highest density in the Denver-Aurora-Boulder area. Other urban population centers are located around the cities of Colorado Springs, Fort Collins, Pueblo, and Grand Junction.[4,5] The remainder of the population lives primarily in rural areas.[6] As of March 2015, 1.2 million Colorado residents are enrolled in Medicaid and Child Health Plan Plus (CHP+), Colorado's Children's Health Insurance Program. This is a 57.3 percent increase in enrollees compared to prior to the 2013 Medicaid expansion.[i,7,8]

Administrative Infrastructure

HCPF, CDPHE, and CDHS all have vital public health functions in Colorado. HCPF manages the operations of Medicaid and CHP+.[9] CDPHE handles some record keeping and the intersection of public health and the environment.[10] CDHS oversees many social services, including the Office of Behavioral Health.[11]

In 2011, HCPF launched Colorado Medicaid's primary healthcare program, the Accountable Care Collaborative (ACC).[12] ACC aims to ensure access to a focal point of care or medical home for enrollees; coordinate medical and nonmedical care and services; improve Colorado Medicaid client and provider experiences; and provide necessary data to analyze progress.[13] It created and uses a unique structure consisting of RCCOs, primary care medical providers (PCMPs), and the statewide data analytics contractor (SDAC).[14]

RCCOs provide coordinated care for Medicaid clients by connecting them with local healthcare providers and other community and social services.[15] There are seven regions in Colorado and one RCCO in each region, and they have the relationships necessary to implement local initiatives.[16] Their goals are to develop a network of providers (both formal and informal, including primary care, behavioral health, etc.); support those providers with coaching and information; manage and coordinate member healthcare; connect members with nonmedical social services (including housing assistance); and report on costs, utilization, and outcomes for their member populations.[17,18]

RCCOs serve as a "testing ground for ideas" for Colorado healthcare initiatives.[19] One RCCO employee noted "One of the nice things about our seven RCCOs is that each RCCO has approached their charge a little differently…in dealing with data and care coordination."[20] RCCO managers meet monthly to share their experiences, and can apply the lessons learned from other RCCOs locally. These regional variations allow the state to test and evaluate a variety of approaches before determining what to share

[i] The federal Affordable Care Act allowed states to raise the minimum income for Medicaid eligibility, which Colorado opted to do.

statewide.[21] Moreover, this model may give communities a voice and ensure that a statewide approach will consider each region's unique resources.

Through contractual agreements with RCCOs, PCMPs are medical access points for ACC beneficiaries.[22] PCMPs provide non-urgent acute medical care, health maintenance and prevention, management of chronic conditions, and health education.[23] They refer and track their patients for specialty medical care, including behavioral health, and to community resources that fall outside the clinical system.[24,25]

SDAC is the Health Insurance Portability and Accountability Act-compliant health information technology contractor that analyzes Medicaid and some Medicare claims data.[26] This enables state and local level Medicaid and public health officials and local care providers to see patterns in healthcare utilization.[27]

The ACC payment structure is innovative and multi-faceted. Fee-for-service billing remains in effect for all medical services that PCMPs provide.[28] However, new models include paying each RCCO a per-member-per-month (PMPM) payment for a variety of activities, such as providing care coordination services, offering practice and administrative support, distributing educational materials, holding community forums and focus groups, developing and implementing local programming to enhance health outcomes and decrease unnecessary utilization, developing formal and informal networks, and working with nonmedical resources and agencies.[29] PCMPs also receive PMPM payments for medical home services.[30] In addition, there are incentive payments for achieving key performance indicators. In the past, key performance indicators have included reducing emergency department (ED) visits, hospital readmissions, and the utilization of medical imaging.[31] For 2015-16, metrics include well-child visits from ages 3-9 and postpartum care completion rates.[32]

ACC has a program improvement advisory committee comprised of stakeholders who make recommendations regarding access to care, healthcare programming, costs of care, and satisfaction of ACC members.[33] It currently has four subcommittees focused on health impact on lives, health improvement, bridging systems, and provider and community issues.[34,35]

Super-Utilizer Innovations Already in Progress

Prior to participating in the National Governors Association's (NGA) Super-Utilizer Policy Academy, Colorado identified ongoing regional and local initiatives that addressed the state's super-utilizer population.[36] These initiatives varied in their population definition: one targeted clients with the highest total cost of care, while others looked for high numbers of ED visits, pharmaceutical utilization, or inpatient hospitalizations.[37] They also differed in their intervention mechanisms. Some depended more heavily on in-home visits, while others used specialized clinics.[38] Many of them shared common threads, such as using multidisciplinary teams comprised of patient navigators, mental health professionals, nurses, and physicians; focusing on improved care coordination, connection with community resources, and patient education; and a goal of reducing preventable healthcare costs.[39]

THE IMPACTS OF SUPER-UTILIZATION IN COLORADO

The cost of treating individuals with chronic diseases is dramatically higher than for the rest of the population. In 2013, the Centers for Medicare and Medicaid Services (CMS) reported that 1 percent of the U.S. population accounted for 22 percent of total annual U.S. healthcare expenditures and that 1 percent of Medicaid beneficiaries accounted for 25 percent of total Medicaid expenditures.[40] Additionally, 83 percent of the Medicaid beneficiaries in that top 1 percent have three or more chronic conditions.[41]

CMS defined super-utilizers as beneficiaries with "complex, unaddressed health issues and history of frequent encounters with healthcare providers."[42] These beneficiaries often have mental health conditions or face socio-economic barriers, such as poverty, lack of education, or housing insecurity.[43] For a variety of reasons, these beneficiaries often receive medical care in acute care settings, such as EDs. These delivery points are not only more expensive, but are unlikely to have the capacity to identify or manage factors contributing to the patients' underlying social determinants of health.[44]

There is growing evidence that care coordination, planned transitions between facilities and providers, and appropriate treatment can reduce costs from super-utilization. For example, a North Carolina study showed that patients with complex chronic conditions who received local targeted care coordination were 20 percent less likely to experience a readmission during the subsequent year than clinically similar patients who received usual care.[45]

There are national efforts underway to address the super-utilization issue. Jeffrey Brenner, executive director of the Camden Coalition of Healthcare Providers—a nonprofit that aims to improve health and reduce costs—developed the concept and use of "hotspotting," or mining data to identify super-utilizers at the micro-local level.[46] His successful methods involve contacting patients at the point of care, providing additional care and support (often in their homes), and connecting them with outpatient resources.[47] At the state level, Medicaid agencies in North Carolina, Maine, and Vermont, among others, have partnered with care management programs and primary care providers to deliver coordinated care to super-utilizers, weaving in support for treating behavioral health conditions and social services.[48]

Like the rest of the nation, Colorado has spent a disproportionate amount of its healthcare and social service dollars on complex patients. Examining its claims data in 2012, the state found that a small number of its Medicaid clients accounted for a high proportion of healthcare services, at least partially "due to fragmentation and lack of coordination."[49] A HCPF employee noted that this "cohort of people…fail to see improved health outcomes that should accompany those [healthcare] services."[50] A CDHS leader said that the super-utilizer patients "stress the system and show us inadequacies in delivering appropriate services.…[Super-utilizers are] a canary in a coal mine."[51]

CDHS and HCPF launched a plan to ultimately serve "the clients that are at the highest tier of utilization or cost of the Medicaid program…and better address inefficiencies in the system and communication and coordination across systems."[52]

DEVELOPMENT, INTERVENTIONS, AND IMPLEMENTATION OF THE POLICY CHANGE

DEVELOPMENT

In 2008, HCPF submitted a formal budget action to establish the Medicaid Value-Based Care Coordination Initiative. In 2009, the Colorado legislature passed the Healthcare Affordability Act, which led to state-based expansion of Medicaid and CHP+ for children, pregnant women, and individuals with disabilities.[53] RCCO contracts were awarded in late 2010.[54]

The NGA-Supported Super-Utilizer Policy Academy

In 2013, NGA received a $300,000 grant from the Robert Wood Johnson Foundation (RWJF) and $152,000 from the Atlantic Philanthropies to fund the Super-Utilizers Policy Academy.[55,56] The policy academy is a highly interactive, team-based, multi-state process for helping a select number of states develop and implement an action plan to address a complex public policy issue.[57] Participating states receive guidance and technical assistance from NGA staff and faculty experts as well as from consultants from the private sector, research organizations, and academia.[58] Its efforts are intended to help states scale from community-based initiatives to a statewide program.

NGA's Super-Utilizers Policy Academy is "designed to assist states in creating the regulatory environment, data systems, workforce, financing structures and stakeholder relationships to support the delivery of high-quality and comprehensive services for super-utilizers."[59] In July 2013, NGA selected Colorado—along with Alaska, Kentucky, New Mexico, Puerto Rico, West Virginia, and Wisconsin—to participate in the policy academy.[60] NGA used its funding to support (a) multi-state convenings; (b) an expert roundtable that convened national experts and state and federal partners to offer insights, develop technical assistance tools, and provide technical assistance to states in developing a strategic action plan and executing on that plan; (c) in-state, NGA-facilitated meetings; (d) webinars; and (e) ongoing telephone technical assistance throughout the policy academy.[61] Colorado established a core team to work on policy academy activities, which consisted of officials from HCPF, CDPHE, CDHS (including the Office of Behavioral Health), the Colorado Department of Local Affairs, and the governor's office.[62]

Development, Interventions, and Implementation of the Policy Change

Colorado's core team worked with policy academy experts to define the team's objectives.[63] Their mission was "to improve healthcare delivery efficiencies and outcomes for Colorado Medicaid clients whose complex needs have not been met despite unnecessarily high utilization of the healthcare system" through six goals:[64,65]

1. Identify the super-utilizer population with clearly-defined and quantifiable criteria.

2. Develop a broad statewide super-utilizer framework that dovetails with existing regional efforts and infrastructure and identify best practices that can be replicated.

3. Consistent with the Colorado State Innovation Model (SIM), develop integrated initiatives combining physical and behavioral health with social needs.

4. Create partnerships at the state, regional, and local levels to leverage resources across departments and the public, private, and nonprofit sectors.

5. Develop policy levers and reimbursement mechanisms to allow for effective interventions for super-utilizer populations.

6. Develop meaningful population data that can drive interventions and measure successes.

Describing NGA's role, a Colorado core team member said "We wanted to use the NGA project to make sure that the RCCOs have the tools to support this population. The infrastructure of the NGA project allowed us to have focused conversations about the population."[66]

Identifying Super-Utilizer Characteristics - A Collaborative Effort Using Data Analysis

To identify super-utilizer criteria, HCPF worked with SDAC, ACC's data arm, as part of a workgroup.[67,68] In summer 2013, the workgroup completed a literature review, finding that most interventions identified ED utilization as one criterion. It found that between five and 10 ED visits per year was an appropriate criterion, and that more than 10 resulted in a sample size too small.[69] The group then conducted a robust data evaluation using an algorithm through which SDAC identified the high-utilizer population.[70] The evaluation confirmed that a criterion of six or more ED visits in the last 12 months would yield a manageable intervention population.

The workgroup used 3M™ predictive analysis software, which revealed a correlation between a high number of prescription drugs in the previous 12 months and preventable healthcare spending.[71] Possible explanations for this correlation include the presence of chronic conditions, medication mismanagement, or drug-seeking behavior.[72]

Throughout fall 2013, the workgroup continued its analysis, incorporated stakeholder feedback, and determined that the following criteria and exclusions would best indicate "a high likelihood of inappropriate, unnecessary, or un-coordinated care."[73]

CRITERIA FOR SUPER-UTILIZER INCLUSION	CRITERIA FOR SUPER-UTILIZER EXCLUSION
Adults	Children
Six or more ED visits within the last 12 months, in addition to 30 or more prescription drugs in the last 12 months.	Pregnant women
	Dialysis patients
	Oncology patients

Source: Colorado Department of Health Care Policy and Financing. "Colorado Super-Utilizer Strategic Plan." 2014. Provided by the Colorado Department of Health Care Policy and Financing on 11-13-2015.

Developing a Statewide Super-Utilizer Framework

Colorado's super-utilizer programs utilized ACC's statewide RCCO infrastructure.[74] HCPF, CDPHE, and CDHS conducted local and statewide outreach to get a broad consensus on identification criteria and options for managing super-utilizers, and officials sought input from other interested parties as they convened a stakeholder group.[75]

The stakeholder group, which included the core team, worked to achieve consensus and to create a plan.[76] The stakeholder group also included RCCO partners, consumers, PCMPs, emergency medicine and behavioral health specialists, and representatives of the insurance industry, hospitals, and professional organizations.[77]

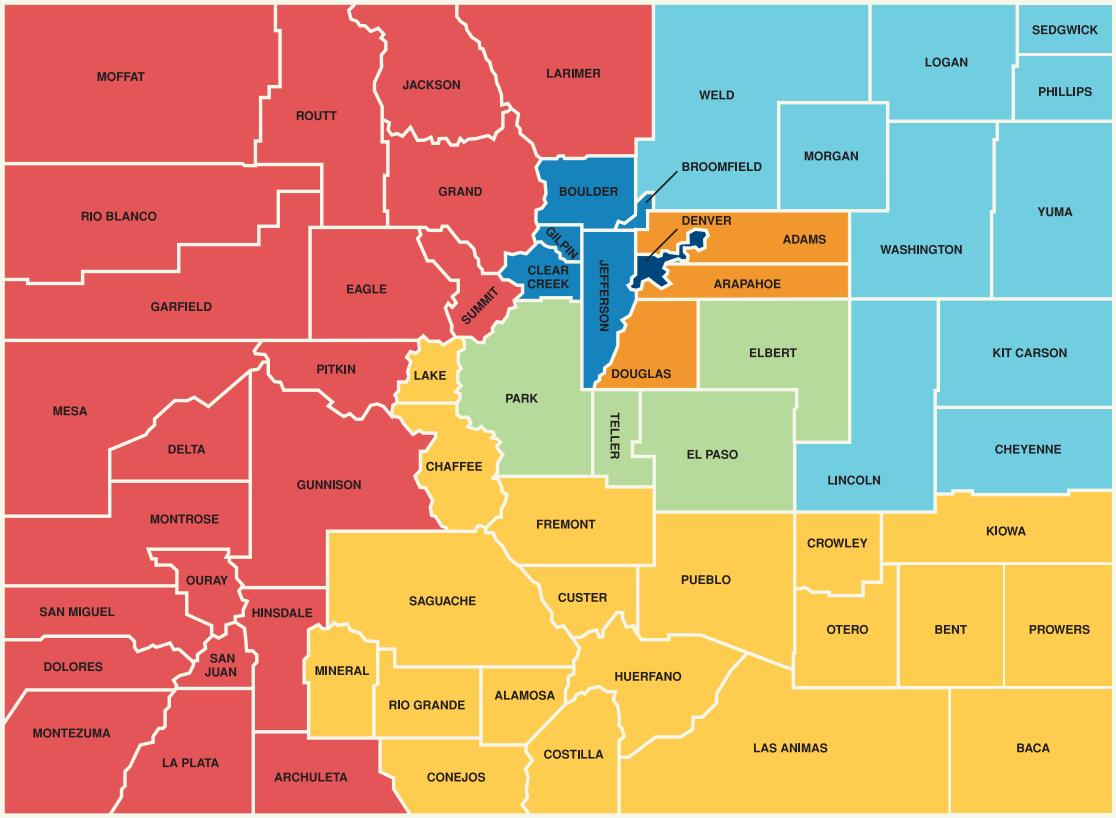
From the outset, the healthcare community was supportive of the project and interested in addressing super-utilizer issues. A core team member said "I was flabbergasted by all the community support we got. I was really impressed by how many people were very, very interested in this project."[78] In response, Colorado officials assembled a group of healthcare system stakeholders to help create partnerships. According to a HCPF employee, "They helped us design a high-level overview of what an intervention should look like."[79]

During the NGA-supported super-utilizer program's initial development, communication at the state level between agencies and core team members largely took place in face-to-face meetings, which helped facilitate communication and feedback.[80,81] A CDPHE employee recalled that there were regularly scheduled meetings at the state level until the pilot program's kick-off.[82] Once the pilot began, formal meetings to discuss the project were less frequent and most meetings were informal. Describing this work with other agencies, a core team member said "Having a carved-out space to facilitate these conversations was very meaningful. At the executive level, there have always been frequent in-person meetings, but at the staff level, there is less of that, [so] having the space for these conversations was key."[83]

NGA's technical assistance could be used to support a statewide project or pilots in certain regions, as indicated by the state's strategic action plan. If successful, the pilot models had the potential to be scaled and implemented statewide.[84] The core team reached out to the seven RCCOs, and selected two as pilots due to staffing constraints and technical assistance availability.[85,86] A public health official said "We wanted to find RCCOs that had a philosophical commitment to what we wanted to do and the resources to be able to deliver it."[87] Collaborators also had to consider how natural disasters might impact the projected implementation timelines because fires and floods had occurred that year in some areas of the state.[88]

Core team members wanted to enroll a critically-sized population from both urban and rural areas.[89] By October 2013, the core team selected RCCOs 4 and 7, which combined accounted for roughly 40 percent of Colorado's super-utilizer population, as the pilot sites.[90] By November 2014, the core team stated that there were just over 3,600 ACC clients in Colorado who met the super-utilizer criteria.[91] Of the 3,600 ACC super-utilizers, RCCO 4 was home to 450 clients, and RCCO 7 was home to 600.[92]

Colorado's Accountable Care Collaborative Regional Care Collaborative Organization Map



Region 1 Rocky Mountain Health Plans
Region 2 Colorado Access
Region 3 Colorado Access
Region 4 Integrated Community Health Partners
Region 5 Colorado Access
Region 6 Colorado Community Health Alliance
Region 7 Community Care of Central Colorado

Source: Colorado Interviewee #1, Personal Communication, November 12, 2015.

Interventions

At the time of their selection by the core team, the pilot sites had their own super-utilizer intervention programs in place. RCCO 4 had a system for its clients that stratified them into one of four care coordination tiers based on a member's total annual cost, ED visits, and inpatient hospitalizations.[93] Care coordinators reached out to members placed into tier 4 to provide in-depth care.[94] RCCO 7 utilized multiple intervention programs to address its super-utilizer population, including an ED pain management pilot and diversion teams, care coordination at PCMPs, and the "Feet on the Street (FOTS)" pilot, which was a 12-month project designed to prevent hospital readmissions and reduce inappropriate use of EDs.[95,96]

Implementation

The NGA-supported super-utilizer pilots began in July 2014. Although the statewide stakeholder group and NGA continued to play key roles, the implementation work centered around RCCOs. Once working relationships were established and the pilots began, there was less need for formal, scheduled workgroup and stakeholder meetings. Colorado's Super-Utilizer Strategic Plan identified the following series of tasks for the interventions at the RCCO level:[97]

1. HCPF uses a monthly report to filter super-utilizer clients living in Pueblo or Colorado Springs. This list of eligible clients is randomized, split into intervention and control groups, and sent via encrypted email to the respective RCCOs.

2. Once a member agrees to participate, a RCCO care coordinator schedules and completes an in-home visit, including a psychosocial evaluation.

3. The care coordinator asks the member to share his or her goals for the program and records those goals.

4. The care coordinator administers the Patient Activation Measure (PAM), which would evaluate whether the client had the knowledge, skills, and confidence to manage his or her own health and healthcare. This metric is measured at the beginning of the intervention, periodically throughout the intervention, and post-intervention, and the formal report incorporates these scores. Colorado is interested in how activation corresponds with a client's health and healthcare utilization.[98]

5. The care coordinator performs a prescription medications review.

6. The care coordinator completes a community care plan linking the client's medical, behavioral, and socioeconomic needs and resources.

7. The care coordinator assists the member with making and keeping primary care and behavioral health appointments, as needed.

8. RCCO care coordinators ensure adherence to the community care plan by maintaining frequent communication with members, using PAM's Coaching for Activation to help them reach their goals, and helping members access the healthcare system effectively.

9. PCMPs contracted with RCCOs to provide medical home services throughout the intervention and coordinate the client's health needs across specialties and along the continuum of care.

As noted previously, there were some differences between the two pilot sites, some of which became more apparent as the program evolved. RCCO 4 uses the "I Can Help People" care coordination software, which tracks the client's healthcare utilization and care-coordination-related activities. RCCO 7 also adopted this software for its pilot. RCCO 7's community assistance referral and education services (CARES) program uses many of the same tools and processes of the FOTS model. Notably, the CARES program uses the definition of super-utilizer required for the NGA-supported super-utilizer pilot. Within the CARES Program, PAM replaced the FOTS model's Patient Activation Assessment.[99,100]

Mental Health and Substance Abuse Treatment

PCMPs provide the backbone of the patient-centered medical home for RCCO clients, despite the fact that their behavioral health and social services needs can go unmet in clinical settings because mental health and substance abuse treatment services in Colorado Medicaid are "carved out," (i.e., these services are reimbursed differently than physical health services.)[101] These discrepancies in reimbursement can result in inefficacies in the system.[102] In RCCO 7, this disparity is addressed through a referral process outside of the primary care practice. "Responsibility lies with primary care providers to get the care the patient needs. Care coordinators are responsible for social services," said one employee, remarking on the continued importance and the centrality of the care team in connecting patients with resources that help with the social determinants of health.[103] This RCCO employee continued, stating "People get the right care at the right time. … The patient has a team they can reach if they are having a non-emergent situation that needs to be addressed."[104]

State leaders have also increasingly paid attention to this issue. In June 2015, Colorado Gov. John Hickenlooper commended six Colorado health insurers and the state's Medicaid program for their commitment to adopting reforms that set the stage for broader integration of behavioral and physical healthcare in Colorado in alignment with its SIM grant, underscoring the recognition of the topic's importance.[105]

Policy and Reimbursement

The NGA-supported super-utilizer pilots were implemented in alignment with ACC's existing and already effective infrastructure.[106] Under these pilots, no statewide or regional policy changes were made to reimbursement or other policies in Colorado.

Funding

The policy academy was not a grant program, so NGA provided technical assistance instead of direct funding. The state contributed financially through its ACC payment infrastructure for Medicaid beneficiaries. Overall, financial viability rests on the assumption that a super-utilizer model has the potential to improve the quality metrics. Modest additional support came through the state when HCPF purchased the PAM license, as well as access to PAM's Coaching for Activation. The remaining money for the intervention came from RCCO and PCMP budgets.

EVALUATION

Evaluation of the two NGA-supported super-utilizer pilots contributed to better understanding and meeting the super-utilizer population's medical and social needs. A public health official said "The evaluation's goal is to support the providers' capacity to develop the principles of a medical home approach, and to really understand how to use data to improve performance, and to provide education, webinars, and learning circles for the providers, [as well as] to provide community-based support."[107]

Funding

The Colorado Medicaid budget provided no additional funding, though existing staff resources were dedicated to the evaluation.[108]

Methods

As the NGA-supported super-utilizer pilots were developed and implemented in Colorado, core team members worked with stakeholder group participants to create the evaluation plan, using super-utilizer client groups and control client groups.[109] They assessed efficacy by determining the speed at which someone who meets the super-utilizer criteria returns to normal levels of utilization with and without the intervention.[110] They also evaluated which admissions and ED visits are preventable.[111]

It was challenging to measure the impact of a particular intervention in this setting where several innovations were in place concurrently. To address this, the evaluation divided eligible ACC members into control and intervention groups. RCCO staff wanted to target clients who were most likely to benefit from the use of resources. The Medicaid department wanted a formal control group for measurement purposes. Breaking the total population into control and intervention groups addressed both concerns.[112]

Evaluation

The evaluation plan included use of a robust measurement protocol identifying all clients statewide who met the super-utilizer protocol criteria, as well as a 12-month claims history of each client, including:[113]

- ED visits.
- Inpatient costs.
- Outpatient costs.
- Prescription medications.
- Prescription medication costs.
- PCMP visits.
- Wellness checks.
- HBa1c testing for patients with diabetes.

The evaluation plan also included use of PAM as a qualitative component.[114] By incorporating PAM surveys from the intervention clients, the evaluation was to track the improvement of PAM scores during and after the intervention, and to identify any trends that corresponded with improvements in health or healthcare utilization.[115] This report also was to incorporate data on client/care coordinator communication, including frequency of client communication and consistency of care coordinators.[116]

Results

Formal evaluation comparing NGA super-utilizer pilot clients to control groups over a 12-month period is still ongoing. One HCPF employee involved with the research said that they have seen a decrease in total costs of care, but it has not been determined if the decrease is due to the intervention.[117] A completed evaluation is expected in 2016.[118]

LESSONS LEARNED

Leveraging existing policy is creative and efficient

NGA's Super-Utilizer Policy Academy highlighted the fruitful working relationships within state government, specifically between the Medicaid, public health, and health policy arms, with support from the governor's office. In turn, this led to centered, focused outreach to the geographically far-flung local communities where the groundwork occurred. According to a HCPF official, "Because a lot of this was convened through NGA, and our executive was involved in many ways, it was easier to convene stakeholders. The governor was involved, and is technically all of our boss. We also have good relationships between Medicaid, public health, and human services. [It] helps to expedite things having a mutual political interest involved."[119]

High-level leadership is critical

Leadership at the top was essential to this work's success. From the governor to Medicaid and public health, leaders from the highest levels of government prioritized collaboration to meet the super-utilizer population's needs. Having leadership support across different cabinet agencies facilitates the work happening on the ground and creates a sense of urgency for collaboration. Per a CDPHE official, "The key is that Medicaid is very engaged in the conversation and they are interested in this high-cost population. There continues to be a positive shift to looking outside of the healthcare setting at the social determinants of health that impact the individuals and their families, which might be the true problem."[120] According to the same source, having the highest-level Medicaid officials involved in the project helped "people to understand that this has the buy-in of leadership, that it is important, that it will impact care" and can be extrapolated to engagement of other departments.[121]

Lack of dedicated funding is a challenge

Multiple interviewees stated that a lack of dedicated funding for a project that is time and resource intensive was challenging.[122,123,124,125] A HCPF leader noted "There are a lot of things that Medicaid and public health take on because they are the right thing or labors of love, but it is hard to make them sustainable without the funding or ongoing support for that."[126] Although RCCOs are community-based organizations, additional funding could have allowed for greater partnerships with local public health and other community organizations that could address the social determinants of health needs for this population. It points to the need for further consideration around planned, long-term funding mechanisms.

Sustainability is essential, but can be elusive

Super-utilizer core team members said it was difficult to develop sustainable policy levers and to create reimbursement mechanisms that allow for effective interventions for super-utilizer populations.[127,128] One challenge was that the policy academy lasted only a year.[129]

For reimbursement mechanisms, a CDHS leader suggested requiring RCCOs to provide specific services for super-utilizers, and withholding payments if they do not as an incentive to keep the staff focused.[130] RCCO interventions frequently had costs that outstripped their normal funding mechanism. The pilot was structured so that most savings accrued to the state, while most costs were borne by the RCCOs. A Medicaid official asserted that if RCCOs are reimbursed a portion of state savings, policymakers should also recognize that, as the system becomes more efficient, less and less of the "savings" will be available to be shared each year.[131] This official believes that rather than just relying on shared savings in the future, payments to the RCCOs should also reflect the higher cost of the intensive interventions necessary to reduce overutilization and save the state's money.[132] Colorado is participating in a second round of an NGA-supported policy academy, prompting one HCPF employee to say "I think this would be a great opportunity for broad policy levers, to see if you could get more bang for your buck."[133]

The need for demonstrated impacts through credible evaluation came up as a barrier to sustainability, even with the enthusiasm around the pilot. A CDHS employee said "Right now, it's too early to know what will be sustainable as a financial model. First, we need to demonstrate efficacy and cost containment, and then figure out financial and policy levers to employ, entice, or coerce our RCCOs to buy into this proven practice."[134] Taking the next steps to a more holistic approach—such as folding in the social determinants of health—may be affected by lack of predictability in funding. "How can we look at the broader landscape of how we are providing supports and services?" asked a public health official.[135] This public health official further stated "We need to think about how serving this population in the next RCCO rebid might lead to alternatives to the current fee-for-service payments that would make more money available for care coordination."[136]

Participants in the pilot's planning and implementation expressed concern that the ground gained would be lost without substantial and tangible support from high levels of state leadership. One Medicaid staff member said "It would be a mistake if we lost momentum, if in the next iteration, we did not go after the big policy changes. It takes will and political capital. If you are not willing to take a few risks, you will not see the outcomes you want."[137]

However, taking risks to make substantial policy changes can be challenging. An interviewee from HCPF noted that although regulatory changes or additional funding would be unlikely, a budget-neutral proposal that hinged on demonstration of cost savings could be successful.[138]

Behavioral health funding "carve-out"

In Colorado, mental health and substance use treatment services are reimbursed differently than physical health services. This discrepancy can lead to inefficiencies in the system.[139] In 2017, both the RCCOs and behavioral health contractors will undergo a rebid, which may allow modification that can facilitate more seamless care.[140] HCPF announced in October of 2015 that both RCCO and behavioral health organizations will be integrated in 2017 into a single entity to improve client, family, and provider experience.[141]

ENGAGEMENT AND PROGRAM DEVELOPMENT

The role of public health

Several interviewees said that public health's roles in the project varied, especially at the local level. One public health official stated "Participation in the workgroup was the main role of the public health department. They provided guidance on components of the pilot, of measures, and feedback on the potential intervention. There is still confusion as to what the role of public health could be in impacting this population."[142] This individual noted public health's charge was to ensure "clear linkages between interventions and community and population health interventions," but the path to get to that point was not always clear.[143]

It was noted that "there is not an effective way to plug in county public health directly in to the super-utilizers pilot. The county public health does not provide direct care. But they have knowledge and awareness, and they support [the model]."[144]

Interviewees also identified positive lessons about partnerships between RCCOs and public health at the local level, and cited previous, unrelated projects where RCCOs and public health have successfully collaborated. One interviewee noted "The realization about how to work with different public health agencies differently has been helpful. They are a small community, and the local public health agency has been partnering with the RCCO to get dental care for Medicaid beneficiaries. They are working on post-pregnancy help for new moms. They have started a nice collaboration between RCCOs and local public health agencies. One of the nice things with these pilot programs within the RCCOs is that they learn from one another and say I want to do that too."[145]

Reflecting on the change in the patient landscape following Medicaid expansion, a leader at HCPF said "I think public health has long been pushed aside and there was a fair bit of mistrust. It took a while, particularly at the state level, to sort of understand that because we did the Medicaid expansion, the people that local public health used to work with were now Medicaid clients."[146] Experience with the RCCO pilots has revealed the differing capacities of the local public health agencies.

Informed by the super-utilizer pilot and need to better define public health's role at the community level in working with at-risk populations, CDPHE pursued an Association of Maternal and Child Health Programs technical assistance grant to define the roles of Medicaid, state and local public health, and RCCOs in serving the care coordination needs of children and youth with special healthcare needs. In addition, ACC partnered with CDPHE to develop a new Improving and Bridging Systems Subcommittee to continue to identify barriers across systems with the goal of addressing the super-utilizer population's needs.[147]

Achieving a balance in creating a multi-stakeholder working group

Stakeholder meetings were well-attended and had diverse attendances, but one core team member said that there were "too many different types of people at the meetings. There was an exciting generation of ideas, but we needed a separate focus to solicit input from clients and community advocates."[148] Another interviewee noted that in Colorado there is an ethos to engage many stakeholders, saying: "It brings strength to the project, but it can be a really long time before everyone sings the same tune."[149]

Identifying the target population

Despite clear eligibility criteria, a HCPF employee noted that it can be difficult to know who to target, stating that the real key is preventing high utilization in the first place.[150] If there is a change in the right direction, "is it simply a regression to the mean? We need to continually ask, 'what is the make-up of the individuals who are driving costs?'"[151]

IMPLEMENTATION

Competing priorities

Multiple interviewees noted that competing priorities among RCCOs and regional service providers took away momentum from and interest in the NGA-supported super-utilizer pilots.[152,153,154] The ongoing Center for Medicare and Medicaid Innovation Demonstration to provide care to individuals eligible for both Medicare and Medicaid, which launched around the same time as the super-utilizer pilot, resulted in some overlap in the target population.[155] A CDPHE employee recalled that this similar focus was confusing.[156] A CDHS employee observed that it was difficult to sustain momentum when the work seems redundant.[157]

Social determinants of health and limited resources

Health status depends on more than access to medical care. The NGA-supported super-utilizer pilot's blending of socioeconomic and traditional medical and behavioral health assessments and interventions prioritizes the social determinants of health.

However, even with the pilots' integrated model, competition for the limited resources available to social services and public health activities caused tensions. In RCCOs, staff involved with the pilots expected more interest from community resource providers, such as housing.[158] A RCCO employee said "It is hard to get someone to break out of their silo. …The state promised immediate intervention to address the [nonclinical] issues of the clients we serve, but this has not happened. We are still hamstrung by the limitations of resources."[159] In response, in 2015, the state has begun implementing the Colorado Opportunity Project to help address these issues.[160]

The burden of documentation

Although it is essential to learn about patients' needs in order to better serve them, these efforts need to be supported. In Colorado, the frontline personnel administer the PAM tool, but this data entry process can be time and labor-intensive. A care coordinator reported that it can take more than 10 separate attempts to contact clients to complete the measures.[161] During the pilots' development phase, HCPF considered having the RCCO care coordinators collect information via additional surveys to assess clients' psychosocial and social determinants status, which would have been useful supplemental information.[162] However, according to a HCPF staff person, there was "push back on how much time all that would take, so we pulled back on documentation."[163]

Impacts on staff

Serving in enhanced central coordinating roles can wear on providers and allied professionals. It is important to find ways to avoid overburdening them, especially in rural areas where there are smaller pools of potential service providers. One interviewee noted "Training and support for the staff doing the direct care coordination is huge. There is a lot of burnout. We need to think about how as state agencies we support these individuals. The organizations that hired them do not necessarily have these supports. There could be a state role for coordinating support training."[164]

EVALUATION

Result release timing

The delay in evaluation results (not available at the time of this publication) creates challenges for both quality improvement and policy planning. However, evaluation of healthcare payment and delivery reform models are often not immediately available due to the time it takes to develop and implement reform.

Transferability

Interviewees said that the statewide public process and local negotiations with service providers offer lessons for other states considering this type of intervention.[165,166] A HCPF employee noted "I think that other states could learn from the process that we have gone through …establishing criteria, designing an intervention, and working to implement the intervention. We have had to overcome roadblocks. These are all transferable lessons."[167]

CONCLUSION

Leveraging existing innovations through the statewide ACC and local level RCCOs enabled Colorado to capitalize on NGA's technical assistance opportunity on super-utilizers. NGA's Super-Utilizer Policy Academy highlighted the fruitful working relationships within state government, specifically between the Medicaid, public health, and health policy arms. At the local level, the existing infrastructure of the RCCOs and relationships between patients, practices, and allied health and social service providers was leveraged rather than replicated, creating efficiencies. Staff requirements for any project, whether at the central administration or at the local sites where services are delivered, consume finite resources. Advanced planning and creative leveraging of the infrastructure already in-place served this project well.

Leadership at the pinnacle of the state, starting with the governor, was essential to this work's success. Medicaid and public health leaders not only recognized the value of the ideas, but they supported and facilitated collaboration to meet the super-utilizer population's needs. A sense of urgency was created and conveyed. In turn, this led to centered, focused outreach to the geographically far-flung local communities where the groundwork occurred.

The pilots' multi-stakeholder engagement and community provider participation were key components. Striking a workable balance between a respectful, inclusive process and the unavoidable complexity of giving heed to variable viewpoints is a formidable task. Creating consensus, time-consuming as it was, provided a clear source of enthusiasm and engagement.

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[152] Colorado Interviewee #1. Interview conducted by Lisa Dulsky Watkins, MD. Feb. 9, 2015.

[153] Colorado Interviewee #6. Interview conducted by Lisa Dulsky Watkins, MD. March 17, 2015.

[154] Colorado Interviewee #8. Interview conducted by Lisa Dulsky Watkins, MD. March 25, 2015.

[155] Colorado Interviewee #6. Interview conducted by Lisa Dulsky Watkins, MD. March 17, 2015.

[156] *Ibid*.

[157] Colorado Interviewee #8. Interview conducted by Lisa Dulsky Watkins, MD. March 25, 2015.

[158] Colorado Interviewee #5. Interview conducted by Lisa Dulsky Watkins, MD. March 16, 2015.

[159] *Ibid*.

[160] Colorado Department of Health Care Policy and Financing. "The Colorado Opportunity Project. Available at https://www.colorado.gov/pacific/hcpf/colorado-opportunity-project. Accessed 4-15-2016.

[161] Colorado Interviewee #3. Interview conducted by Lisa Dulsky Watkins, MD. Feb. 19, 2015.

[162] Colorado Interviewee #4. Interview conducted by Lisa Dulsky Watkins, MD. Feb. 23, 2015.

[163] *Ibid*.

[164] Colorado Interviewee #9. Interview conducted by Lisa Dulsky Watkins, MD. March 26, 2015.

[165] Colorado Interviewee #4. Interview conducted by Lisa Dulsky Watkins, MD. Feb. 23, 2015.

[166] Colorado Interviewee #10. Interview conducted by Lisa Dulsky Watkins, MD. March 26, 2015.

[167] Colorado Interviewee #4. Interview conducted by Lisa Dulsky Watkins, MD. Feb. 23, 2015.

Appendix 1 - de Beaumont Medicaid-Public Health Expert Group Members

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Appendix 1 - de Beaumont Medicaid-Public Health Expert Group Members

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Rita Vandivort-Warren
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Kathy Vincent
ASTHO Consultant

Kristen Wan Rego
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Amber Williams
Safe States Alliance

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INTERVIEW INSTRUMENT

Thank you for talking with me today. This interview is being conducted as part of a series of case studies that will reflect collaboration between Medicaid and public health that have yielded (or promise to yield) cost savings to Medicaid and/or improvements to population health. Do you have any questions at this time?

I would like to read a brief disclosure statement to you. If it sounds good, we'll get started.

Disclosure statement: This interview will last for approximately an hour. As explained to you earlier, your participation is absolutely voluntary. You can decline to answer any question, and if you wish to discontinue your participation at any time during the interview process, please feel free to do so. With your permission, we would like to record this interview. This recording will only be used to confirm our notes, and will be deleted once the project is completed. Your identity will be confidential and any reports generated from this session will include only de-identified responses. Before verbally consenting to participate in this interview, I would like to make sure that you feel you understand the purpose of this project and have had the chance to ask any questions you'd like. If you do not have any questions, with your consent, we will begin the interview, and it will be recorded. (Consent)

In the course of this interview, we will be asking you several questions about [NAME OF POLICY CHANGE] which I'll call "policy change" for short. The questions will include how the policy change started, how implementation happened, and what the outcomes have been.

1. **What is your role in your agency, and how did you come to be aware of the policy change?**

2. **What was the problem the policy change sought to address?**

   a. (Identify vision, mission and values)

3. **In two or three sentences, could you summarize what the policy change was?**

4. **Thanks for the overview. As part of this case study, I'll be trying to figure out when the various stages of the policy change occurred.**

   a. Can you outline a timeline of the process?

   b. Were there any missteps identified during the implemetation process you've described?

      i. How were they identified?

      ii. How were they overcome?

5. **What were the mechanisms of the policy change's implementation? The 2 areas we have already identified are engagement of partners and types of tools. If there were other mechanisms, please share them.**

   a. Engagement of partners

      i. What external partners/stakeholders were engaged,and how? (Examples could include political, governmental and special interest groups, CMS,others.) Were they were key to the process?

      ii. What internal partners and staff were engaged andprimarily responsible? Were they co-located?

   b. Tools

      i. What methods of communication were used? Examples include face-to-face, conference calls, webinars, shared electronic files, public meetings

      ii. What kinds of policy tools were used?

1. Regulatory/statutory (State or local? Funded?)

2. CMS/Medicaid (Waiver, and what kind? State Plan Amendment? Other?)

3. Payer alignment

6. **There is commonly some kind of "course correction" over time in complex projects such as yours. Did this occur in your case?**

   a. Were the initial goals of the collaboration modified? If so, how?

   b. Were the original strategies significantly changed? If yes, describe.

7. **Evaluation**

   a. How did you measure outcomes of the policy change?

   b. Are there any outcomes attributable to that policy change?

   c. Is there funding dedicated to evaluation? If so, where does the funding come from (in-kind, etc.)?

8. **Sustainability**

   a. Is there a mechanism in place to address sustainability?

      i. If so, please describe. Has it been successful?

My final questions are about extrapolating from your experience with this policy change to others. I'm going to ask you to think about missteps, and how transferable you feel this policy change is to other locales.

9. **What from this process could be useful to other states or local entities considering similar approaches?**

10. **What was the impact of the type of policy vehicle on the implementation process?**

11. **In addition to the missteps identified earlier, if any, were there other things you might have done differently?**

    a. If so, how were they identified?

    b. How were these issues overcome?

Appendix 3 - Interview Data Collection Tool

Interview respondent name:
Interview ID #:
State:

Case:
Date:
Note taker:

Question number	Helpful hints Use semicolons to separate distinct concepts	Question Take full notes here	Summary Provide short summaries here, use quotation marks to indicate verbatim quotes, otherwise paraphrase.
1.		What is your role in your agency, and how did you come to be aware of the policy change?	Role
	Ignore role, focus on awareness		
2.		What was the problem the policy change sought to address?	Problem
	Identify vision, mission, values		
3.		In two or three sentences, could you summarize what the policy change was?	Summarize policy change
	Summarize policy change in as few distinct steps as possible		
4a.		Can you outline a timeline of the process?	Timeline
	Critical. Report each step by month and year, if possible. Use numbered list		
4b.		Were there any missteps identified during the implementation process you've described? How were they identified? How were they overcome?	Missteps
	Separate responses into distinct misstep identification and solution (use semicolons)		
5.		What were the mechanisms of the policy change's implementation?	Mechanisms of Implementation
	The 2 areas we have already identified are engagement of partners and types of tools (below). If there were other mechanisms, please share them.		

Question number	Helpful hints Use semicolons to separate distinct concepts	Question Take full notes here	Summary Provide short summaries here, use quotation marks to indicate verbatim quotes, otherwise paraphrase.
5ai.		What external partners/stakeholders were engaged, and how? (Examples could include political, governmental and special interest groups, CMS, others.) Were they were key to the process?	External engagement
	External to home agency (could include other governmental actors)		
5aii.		What internal partners and staff were engaged and primarily responsible? Were they co-located?	Internal engagement
	Internal to the home agency only		
5bi.		What methods of communication were used?	Communication methods
	Options include: face-to-face, conference calls, webinars, shared electronic files, public meetings		
5bii.		What kinds of policy tools were used?	Policy tools
	Options include: Regulatory/statutory (State or local? Funded?) CMS/Medicaid (Waiver, and what kind? State Plan Amendment? Other?) Payer alignment		
6.		Did course corrections occur? Were the initial goals of the collaboration modified? If so, how? Were the original strategies significantly changed? If yes, describe	Course corrections
	Modified goals, strategies, and tactics. Concise summaries		
7a.		How did you measure outcomes of the policy change?	Measure outcomes/Evaluation
	Separate concrete impact measures from process measures		

Question number	Helpful hints Use semicolons to separate distinct concepts	Question Take full notes here	Summary Provide short summaries here, use quotation marks to indicate verbatim quotes, otherwise paraphrase.
7b.		Are there any outcomes attributable to that policy change?	Attributable outcomes/Evaluation
	Yes/No, and what?		
7c.		Is there funding dedicated to evaluation? If so, where does the funding come from (in-kind, etc)?	Funding for Evaluation
	Yes/No, and what kind?		
8.		Is there a mechanism in place to address sustainability? If so, has it been successful?	Sustainability
	Yes/No, and what?		
9.		What from this process could be useful to other states or local entities considering similar approaches?	Transferability
	Focus on short phrases		
10.		What was the impact of the type of policy vehicle on the implementation process?	Impact of policy vehicle type
	Make sure it's attributable to vehicle specifically, otherwise "No Impact attributable" is OK		
11.		In addition to the missteps identified earlier, if any, were there other things you might have done differently? If so, how were they identified? How were these issues overcome?	Missteps
	Will be combined with codes above. Separate responses into distinct misstep identification and solution		

Appendix 4: Document Review Data Collection Tool

Document name:
Document ID #:
State:

Case:
Date:
Note taker:

Question number	Question Take full notes here	Summary Provide short summaries here, use quotation marks to indicate verbatim quotes, otherwise paraphrase.
1.	What was the problem the policy change sought to address?	Problem
2.	What was the policy change?	Summarize policy change
3.	What was the timeline of the process?	Timeline
4.	What were the mechanisms of the policy change's implementation?	Mechanisms of Implementation
5.	What external partners/stakeholders were engaged, and how? (Examples could include political, governmental and special interest groups, CMS, others.) Were they were key to the process?	External engagement
6.	What internal partners and staff were engaged and primarily responsible?	Internal engagement

Question number	Question Take full notes here	Summary Provide short summaries here, use quotation marks to indicate verbatim quotes, otherwise paraphrase.
7.	What kinds of policy tools were used?	Policy tools
8.	What was the impact of the type of policy vehicle on the implementation process?	Impact of policy vehicle type
9.	Is there a mechanism in place to address sustainability? If so, has it been successful?	Sustainability
10.	How are outcomes of the policy change measured?	Measure outcomes/Evaluation
11.	Are there any outcomes attributable to that policy change?	Attributable outcomes/Evaluation
12.	About this document Document format - Web, print, other?	
12a.	About this document. Publicly available?	
12b.	About this document. Working document?	
12c.	About this document. Publicity material? If so, target audience?	
12d.	About this document. Author and title?	
12e.	About this document. Other information?	

Timeline

2008

- November: HCPF submitted a formal budget action to establish the Medicaid Value-Based Care Coordination Initiative.

2009

- April: Legislature passed the Healthcare Affordability Act, expanding Medicaid coverage.

2010

- December: HCPF awarded seven RCCO contracts.

2011

- May: HCPF implemented the Accountable Care Collaborative.

2013

- RCCO 7 partnered with Colorado Springs Fire Department to implement the FOTS Care Transitions Pilot.
- April: RWJF and Atlantic Philanthropies granted funding for NGA Policy Academy meetings to address super-utilizer issues.
- July: NGA selected Colorado to participate in the Super-Utilizer Policy Academy.
- August: NGA's Developing State-Level Capacity to Support Super-Utilizers Policy Academy Meeting held.
- HCPF, through SDAC, identified criteria for super-utilizer inclusion and exclusion.
- October: Stakeholders discussed implementation of pilots in RCCO 4 and RCCO 7.

2014

- July: Super-utilizer pilots began in RCCO 4 and RCCO 7.

2015

- March: 1.2 million CO residents enrolled in Medicaid and CHP+, a 57.3 percent increase from 2013.
- May: CO provided PAM training for super-utilizer care coordinators.

2016

- December: Formal evaluation of the super-utilizer pilot is expected by the end of the year.

2017

- July: RCCOs and behavioral health contractors will undergo a re-bid.

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