**Program Objective**

Colorado Access and its contracted providers shall promote the primary objectives of the Enhanced Primary Care Case Management Services as outlined by Colorado Medicaid Department of Health Care Policy and Financing:

**Goal #1:** A reduction in potentially preventable hospital readmissions at 7, 30, and 90 days post-discharge.

**Goal #2:** A reduction in preventable (ambulatory care sensitive) and inappropriate emergency room visits.

**Goal #3:** A reduction in preventable (ambulatory care sensitive) inpatient admissions.

**Goal #4:** An increase in wellness visits and in the use of evidence-based prevention practices.

**Shared Responsibilities in Meeting these Goals**

**Goal #1: A reduction in potentially preventable hospital readmissions at 7, 30, and 90 days post-discharge**

**Colorado Access will Provide**

- Care management designed to provide transition of care activities such as facility-based member visits, post discharge follow up interventions and home visits. CoAcc is calling this program “Transition Access Program (TAP)” and it is based on Eric Coleman’s post-discharge interventions.
  - TAP will be provided to any Colorado Access PCCM member who is admitted into the hospital (with appropriate notification of hospitalization).

**PCP Network Providers will Provide**

- Access and availability to recently discharged members such that a PCP appointment can be scheduled within 7 days of discharge
- Bi-directional correspondence related to care management calls and patient hospitalization activity

**Hospital Providers will Provide**

- Real-time member data necessary to meet the objectives of the program and as agreed to by the hospital and Colorado Access. This may include items such as notice of admission, discharge dates, and emergency room use.

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Goal #2: A reduction in preventable (ambulatory care sensitive) and inappropriate emergency room visits

Colorado Access will provide
- Access to reports that identify members with high volumes of ER utilization. Care Managers will assess other medical care activities/needs and focus on self-management goals.
- CoAcc will provide to the high volume PCPs a list of their patients who have exceeded 3 ER visits in one quarter.
- Care managers will continue to provide community based support in certain high-volume clinics to be agreed upon by clinics and CoAcc.

PCP Network Providers will provide
- Access and availability to members such that a PCP appointment can be accommodated to avoid unnecessary ER visits.
- Education to members regarding after hours policy, process and access to PCP and urgent care.
- When access to care in the PCP site cannot be made available, PCPs will direct members to participating urgent care clinics in the vicinity when ER is not appropriate.
- Bi-directional correspondence related to care management calls and patient activity; including discussions about member ER utilization and availability of appointments and facilitating appointments.

Hospital Providers will provide
- Real-time member data necessary to meet the objectives of the program and as agreed to by the hospital and Colorado Access. This may include items such as notice of admission, discharge dates, and emergency room use.

Goal #3: A reduction in preventable (ambulatory care sensitive) inpatient admissions

Colorado Access will provide
- Care management designed to provide transition of care activities such as facility-based member contacts, post discharge interventions and home visits. CoAcc is calling this program “Transition Access Program (TAP)” and it is based on Eric Coleman’s post-discharge interventions. The program is designed to improve continuity of care between settings, improve member safety, improve member outcomes, and decrease avoidable hospital readmissions.
  - TAP will be provided to any Colorado Access PCCM member who is admitted into the hospital (with appropriate notification of hospitalization).

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• Care managers will have access to reports that identify members who have been admitted with ambulatory care sensitive conditions and will assess other medical care activities/needs and focus members on self-management goals.
• CoAcc will provide to the high volume PCPs a list of their patients who have been admitted with ambulatory care sensitive conditions.
• Care managers will continue to provide community based support in certain high-volume clinics to be agreed upon by clinics and CoAcc.

**PCP Network Providers will provide**

• High quality, evidence based care that assists the member in understanding their condition(s) and indications that their condition is worsening and how to respond to changes in condition such that future preventable hospital admissions can be avoided.
• Access and availability to members such that a PCP appointment can be accommodated.
• Education to members regarding after hours policy, process and access to PCP and urgent care.
• When access to care in the PCP site cannot be made available, PCPs will direct members to participating urgent care clinics in the nearby area when ER is not appropriate.
• Bi-directional correspondence related to care management calls and patient activity; including discussions about member ER utilization and availability of appointments and facilitating appointments.

**Hospital Providers will provide**

• Real-time member data necessary to meet the objectives of the program and as agreed to by the hospital and Colorado Access. This may include items such as notice of admission, discharge dates, and emergency room use.

*Goal #4: An increase in wellness visits and the use of evidence-based prevention practices*

**Colorado Access will provide**

• Access to reports that identify members who have not had a visit with their PCP and will conduct outreach to get members connected with PCPs.

**PCP Network Providers will provide**

• Access and availability to members.
• Outreach members who have not been to a PCP in a timeframe established by PCP and CoAcc.
• Other deliverables as agreed upon between the PCP and CoAcc.