Quality Improvement Plan
Name: Colorado Community Health Alliance (CCHA)
RAE: Region 6
Date: September 30, 2019

1. Purpose/Mission Statement

Please describe your Organization's overall purpose/mission statement. Note: Only update this when applicable, when there are no updates, just copy and paste from a previous submission.

CCHA's Mission Statement:
Colorado Community Health Alliance's overall goal is to support a coordinated, member-centered model of care to better serve the needs of Health First Colorado members, improve health and life outcomes and optimize resources in an effort to avoid duplication of services and reduce the cost of care.

2. Quality Program Leadership

Please list the individuals who are in your quality program. Please include their contact information. Note: Only update this when applicable, when there are no updates, just copy and paste from a previous submission.

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3. Year Objectives/Top Priorities including a description of the techniques to improve performance, a description of the qualitative and quantitative impact the techniques had on quality and opportunities for improvement identified as well as newly identified opportunities for improvement

Accountable Care Collaborative (ACC) Performance Measures

CCHA is committed to improving the health outcomes of our most vulnerable populations. Our goal is to monitor and ensure the delivery of consistent, reliable, and integrated Physical Health (PH) and Behavioral Health (BH) services to members so we can collectively achieve the Quadruple Aim goals that focus on population health, member experience, per capita costs, and provider satisfaction. To achieve this we are using the Key Performance Indicators (KPIs) and the Behavioral Health Incentive Program as our measure of success. In addition CCHA will continue to partner with the Department of Health Care Policy & Financing (HCPF) on evolving program goals, as established through the performance pool. Below are descriptions of activities we are working on:

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Key Performance Indicators:

- Create internal reports to track performance by region and provider.
- Identify areas of opportunity by specific population (e.g. gender and geographic area).
- Utilize practice transformation coaches to engage and educate Primary Care Medical Providers (PCMPs) and dental providers on the ACC performance measures.
- Work with practices to improve practice operations, including process improvement, KPI workflows and planning, proper billing and coding, member access, electronic health record assistance, systems training, data and analytics, and transition to member-centered care.
- Distribute KPI incentive dollars to providers through the Provider Incentive Program and to community partners though the Community Incentive Program.
- Identify and collaborate with community partners via CCHA community liaisons and leverage community resources to support members.
- Educate specialists on adding referring provider NPI on encounters.
- Utilize feedback from the Member Advisory Committees (MAC) and Program Improvement Advisory Committees (PIAC) to inform interventions.
- Use multi-modal efforts to engage unverified members.

Behavioral Health Incentive Measures:

- Partner with Community Mental Health Centers (CMHCs) and key providers to identify creative solutions that address gaps in care for the BH incentive performance measures.
- Partner with hospital systems to identify members being discharged with behavioral health needs and connect them to care coordination resources.
- Collaborate with our health neighborhood to support community programs related to behavioral health to provide extended services and support at the local level.
- Create a behavioral health care coordination model that reduces barriers to care and promotes integrated and whole person care.
- Create behavioral health programs in connection with our community that focus on early identification, appropriate referral to ongoing care, and integrated behavioral and physical health services.
- Support network providers utilizing practice transformation coaches to improve workflows; offering expertise and resources to enhance performance and redesigning processes.

Performance Pool:

CCHA's performance pool plan was approved in June 2019 and CCHA is currently working to implement the interventions defined in the plan. The interventions were designed to uniquely engage members to attain their individual goals and promote healthy behaviors. In State Fiscal Year 2019-2020 (FY20), CCHA will target care coordination efforts on the monthly performance pool list with a focus on members who either:

- Have a behavioral health diagnosis co-occurring with at least one of the following chronic illnesses: Asthma, Chronic Obstructive Pulmonary Disease (COPD), Diabetes Mellitus; or
- Are on a home and community based services waiver, but are not in extended institutional care.

Additionally CCHA will work with Accountable Care Network (ACN) providers to better understand outreach methodology and leverage potential best practices in engaging members in care coordination. CCHA's performance pool plan interventions will be tracked using outcome and process measures.

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In order to achieve performance improvement, CCHA will implement a series of interventions such as:

- Determine appropriate outreach methodology to engage identified members.
- Assess and enroll the target population in the appropriate care coordination program.
- Engage and support individual providers, including ACNs, in the implementation of interventions.
- Evaluate the effectiveness of the interventions and identify opportunities for improvement.

Member Safety and Quality:
CCHA's patient safety goals aim to promote safe clinical practices in all aspects of clinical care and service; to engage members and providers concerning member safety in all aspects of member interaction; and to identify and implement system and process improvements that promote member safety throughout the health plan and care delivery system. To achieve this, CCHA implemented the following:

Quality Management Committee (QMC):
Provides program direction and oversight to make sure CCHA operates as one combined entity that integrates clinical care, operations, management, and data systems. The QMC is the forum for interdepartmental participation and works to establish the long-term strategic vision for the Quality Management (QM) Program. This committee evaluates the annual QI Program's overall effectiveness in the following areas:

- Member Satisfaction: establish a process to measure and monitor member satisfaction.
- Monitor program performance, using the following tools:
    - KPI and BH measures
    - Performance Improvement Project activity and results
    - Health Services Advisory Group annual site audit results
    - Provider performance, including ACNs
    - Grievances
    - Quality of Care Concerns
    - CCHA administrative and service performance

Member Grievances:
CCHA has a process in place to support member grievances and/or complaints for any matter relating to our contract including a process to trend and track information, which is used to improve member safety and quality, drive program improvement activities, modification, and development. CCHA's goals are:

- 90% timeframe compliance within initial 15 business day review period
- 100% timeframe compliance within extended 14 calendar day review period
- 100% of clinical grievances will be investigated by clinical staff

Quality of Care (QOC) Concerns:
CCHA has created a QOC process, which encourages timely and accurate submissions from our provider network and internal care management staff. In conjunction with CCHA's Medical Director, a severity level is assigned for each QOC and an investigation that supports the severity level is completed on all cases. All QOCs are tracked, trended, and reported to our QMC, which is then used to promote member safety and quality, and inform credentialing processes, network training and program improvement activities. CCHA's goals are:

- Annual training of internal CCHA staff to identify QOC concerns. 80% of member facing staff will receive QOC training.
- Investigate, analyze, track, and trend QOC issues: Identify trends and opportunities for program development and improvement in clinical care.
- Facilitate network provider meetings to discuss QOC trends and systemic opportunities for improvement.

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Performance Improvement Projects (PIPs):
CCHA has chosen a physical health and behavioral health PIP, each under the global topic of Access to Care, as provided by HCPF. The physical health PIP focuses on increasing well visits for children between 15-18 years of age. A pediatric practice with opportunity for improvement has been identified and engaged. Modules one, two and three have been validated and CCHA is working with the practice to start testing interventions identified in module three.

CCHA has identified the behavioral health PIP as, "Supporting member's engagement in mental health services following a positive depression screening". Additionally, stakeholders have been identified. Currently, CCHA is working towards final approval of Module 3, which includes review of current state workflows, a failure mode and effects analysis, failure mode priority ranking, and intervention determination.

Please fill out the following template for all projects that are associated with the programs listed in the gray boxes.

Goal	Fiscal Year 19-20 Project/Initiative	Targeted Completion Date	Action(s)
Performance Improvement Projects			
Physical health PIP: Increase well visits in children attributed to the identified pediatric practice between 15-18 years of age from [redacted]% to [redacted]%.	Implement interventions and use the Plan-Do-Study-Act method to test and refine interventions.	June 30, 2020	Submit modules 4 and 5 in June 2020. Track outreach efforts by mode (phone, email, portal) for effectiveness and follow member to see who came in for an annual well visit. Measure impact of Saturday clinics on annual well visit rates. Identify members who have signed up for the patient portal based on outreach.
Behavioral health PIP: Increase the percentage of members who had a follow-up BH assessment visit within 30 days following a positive depression screening at identified practice.	Analyze baseline data to identify target goals for FY20.	December 31, 2019 (to allow for adequate claims run-out time)	Collaborate with IT on accurate collection of data.
Behavioral health PIP: Successfully complete modules 3, 4, and 5.	Completion of modules.	June 30, 2020	Continue collaboration with identified practice.

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Performance Measurement Data Driven Projects			
Achieve Tier 2 goal for four of the seven KPIs.	Engage with PCMPs and ACN providers in quality improvement processes. Partner with community organizations to align efforts and processes to achieve KPI goals.	June 30, 2020	Leverage the Provider Incentive Program to increase engagement of PCMPs in practice transformation efforts in improve PCMP KPI performance. Utilize care coordination to educate members and connect them with appropriate services. Continue partnerships with Healthy Communities and other community entities and use feedback from the PIAC and MAC to inform KPI interventions. Educate the community on KPI and collectively identify areas for alignment.
Improve rate of follow-up after positive depression screen by 5%, with a minimum screening rate of 7%.	Support member engagement in mental health services following a positive depression screening.	June 30, 2020	In partnership with a local CMHC, implement standard referral workflows at 30 co-located sites. Establish a baseline of performance. Review proxy measures on a monthly basis with CMHCs to determine success.
Improve rate of follow-up within 7 days of an inpatient hospital discharge for a mental health condition by 5% for CHMCs.	Support member engagement in mental health services following an inpatient admission.	June 30, 2020	Implement standard work around utilization of CPT code H0002. Establish a baseline of utilization. Measure outcomes of H0002 utilization on a monthly basis w/ CMHCs.
Increase the rate of foster care members receiving BH assessments within 30 days.	Evaluate the effectiveness of the Foster Care Notification project in Boulder County.	June 30, 2020	Perform monthly count of members referred to care coordination.

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Increase percentage of high cost members in care coordination from baseline.	Outreach and engagement in care coordination services to members in the high cost population.	June 30, 2020	Enabled flag for members that appear on Admission, Discharge and Transfer (ADT) list who are also on high cost member list to outreach and enroll in care coordination.
Member Experience of Care Improvement Driven Projects			
Monitor member experience, perceptions, accessibility and adequacy of services within the Region (ECHO survey) for behavioral health.	Review survey results with key stakeholders to determine how best to use survey results.	June 30, 2020	Review survey results with key stakeholders. Determine how results play a role in program and intervention implementation in an effort to improve member satisfaction.
Improve member experience of care as evidenced by CAHPS survey.	Use CAHPS data to identify potential interventions and work with providers to implement and test.	June 30, 2020	Practice transformation coaches share data with practices whose members were surveyed. Track third next available appointments on a quarterly basis to measure access to care. Conduct quarterly care coordination audits with all Accountable Care Network providers.
90% of member grievances will be completed within 15 business days.	Member grievance completion provides an opportunity for increased member satisfaction, identification of areas of improvement.	Quarterly reporting, ongoing	Process and workflows in place, reporting to HCPF, QMC, MAC, and PIAC on a quarterly basis.
100% of member grievances will be completed within the extended 14 calendar days.	Member grievance completion provides an opportunity for increased member satisfaction, identification of areas of improvement.	Quarterly reporting, ongoing	Process and workflows in place, reporting to HCPF, QMC, MAC, and PIAC on a quarterly basis.
All clinical grievances will be investigated by clinical staff.	Clinical grievance process	Ongoing	Clinical grievance process will be transferred to clinical staff.

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Under and Over Utilization of Services Projects			
Successful outreach to 45% of the members identified by HCPF on the quarterly COUP lists and employ new outreach procedures, scripts, and workflows to engage members and collaborate with our primary care providers and pharmacies.	Continue tracking outreach to COUP members on a quarterly basis.	June 30, 2020	Develop new outreach procedures, scripts, and workflows to engage members and collaborate with our primary care providers and pharmacies.
Initiate member lock-in and develop a process whereby care coordination team members can proactively identify members for potential lock-in status as part of their regular care coordination program activities.	Lock in member identification by care coordination.	June 30, 2020	Policy and procedure for lock in process drafted Ensure care coordination team is trained on lock-in procedure. Collaborate with providers to monitor and manage care for members who are locked in.
Recruit at least 5 providers to serve as lock-in providers.	Educate providers on what it means to be a lock-in provider, and offer technical assistance.	June 30, 2020	CCHA is working with providers to serve as lock-in providers. Providers have requested more information on how the lock-in program will work.
Quality and Appropriateness of Care Furnished to Members with Special Health Care Needs Projects			
Increase the rate of foster care members receiving BH assessments within 30 days by 2.5%.	Evaluate the effectiveness of the Foster Care Notification project in Boulder County.	June 30, 2020	Perform monthly count of members referred to QM for further action by care coordination.
Increase collaboration between CCHA care coordination and Boulder and Jefferson County Departments of Human Services (DHS).	CCHA Rounds Calls / Community Review Team (CRT) meetings.	June 30, 2020	Continue Rounds and CRT meetings.
Increase collaboration regarding complex case management between Boulder County DHS and CCHA.	Initiate population-specific workgroups.	June 30, 2020	Convene population-specific workgroups.

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Increase member engagement by building upon the sophistication and value of partnerships with reentry organizations, including Colorado Department of Corrections (CDOC), community corrections, county jails, and non-profit support organizations.	Collaborate with CDOC, counties, community correction, county jails, and re-entry facilities to identify and support members transitioning back to the community.	June 30, 2020	Build upon FY19 efforts. Continue to identify and engage valued community partners and leverage their expertise.
Quality of Care Concern (QOC) Monitoring			
Annual training of internal CCHA staff to identify actual QOC cases. 80% of member facing staff will receive QOC training.	Support the timely and proper identification of potential versus actual QOC issues.	June 30, 2020	Training sessions for utilization management and care coordination staff will be scheduled between January and June 2020.
Continue to investigate, analyze, track and trend QOC issues.	Identify and address QOCs and use them to improve quality of clinical for our members.	Quarterly	Investigation and monitoring is ongoing.
Facilitate network provider meetings to discuss QOC trends and systemic opportunities for improvement.	Collaborate with network providers to identify necessary actions in response to QOC issues impacting the care and safety of members.	Ongoing as indicated by track, trend, and analysis of quarterly QOC data.	Engage network providers in quality meetings, as necessary, when a trend is identified.
External Quality Review Driven Projects			
Complete Corrective Action Plan from FY19 audits successfully.	Address all required actions from FY19 audit.	December 31, 2019	Ensure CCHA website and provider directory are fully readable and accessible. Enhance provider communications for BH providers related to EPSDT-related capitated BH services for members ages 20 and under. Ensure that medical necessity criteria for utilization management (UM) decisions pertaining to EPSDT-related

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			services are consistent with CCHA's EPSDT policy.
Continue to score at or above 90%.	Ensure compliance with RAE contract regarding: grievances and appeals, network adequacy and, access to care, and utilization management.	June 30, 2020	Review policies and procedures related to the audit standards to ensure compliance and identify areas of improvement.
Internal Advisory Committees and Learning Collaborative Strategies and Projects			
Utilize PIAC as a steering group to re-invest funding to support community programs and meet CCHA's focus areas.	Implement the Incentive Application Process through the PIAC.	December 31, 2019	Implement process established to reinvest funds. Educate PIAC voting members on the process and organize a platform for the voting members to decide on each application. Disseminate funds through the application process. Develop a process for awardees to report out to the PIAC on progress.
Utilize feedback from PIAC to enhance services provided and increase access to care.	Provide data to PIAC around CCHA KPIs, BH incentives as well as common trends for high cost members.	Quarterly	Receive feedback from committee on barriers to accessing care at the right level. Prioritize barriers based on feedback from the committee and identify strategies to minimize challenges to accessing care.

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Expand engagement opportunities for increased attendance at PIAC	Identify ways to continue to engage stakeholders and Health First Colorado members.	Quarterly	Collaborate with the Member Advisory Committee (MAC) to recruit more Health First Colorado members. Identify a member that is interested in attending State PIAC meetings. Utilize CCHA community liaisons to share PIAC meeting information with entities that have not attended PIAC. Continue to share information about PIAC via email, CCHA newsletter, and social media to ensure current and new partners are familiar with PIAC and specific information covered in each meeting.
Continue to utilize feedback from the Member Advisory Committee (MAC) to enhance services provided.	Use direct member input and member journey maps to inform and improve operations. Engage members to identify short- and long-term opportunity areas to improve member engagement. Solicit the lived experience of members to identify ways to most effectively engage members in their health at the micro and macro levels while improving the member experience.	June 30, 2020	Continue to hold quarterly MAC meetings to engage CCHA members. CCHA continues to solicit members to join a virtual MAC in addition to the in-person MAC.