2018-2019

Practice Support Plan

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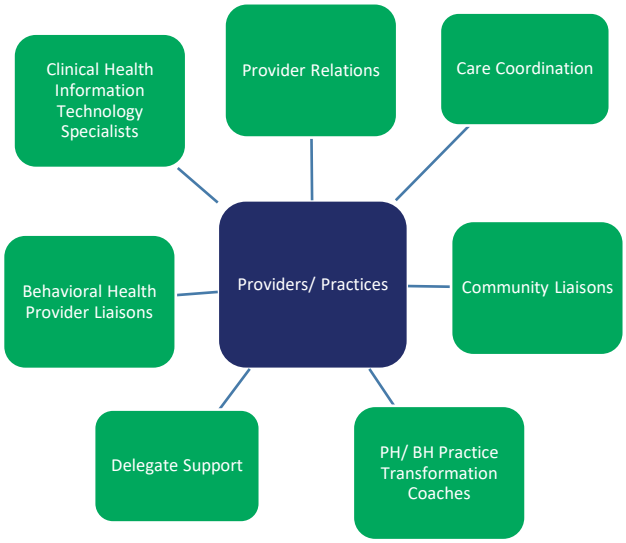
The Practice Support Plan outlines the annual activities the will be employed by Colorado Community Health Alliance (CCHA) to support physical and behavioral providers in Regions 6. The goal of this support plan is to support all network providers such as primary care providers, Community Mental Health Centers, independent behavioral health provider and Accountable Care Network providers which may include Federal Qualified Health Centers in achieving and sustaining the goals of the Colorado Accountable Care Collaborative (ACC).

Practice Support Team

CCHA's provider support team will be a multidisciplinary team dedicated to providing assistance to primary care and behavioral health care providers in navigating Health First Colorado (Colorado's Medicaid Program) and achieving the goals of the ACC program. Our practice support team will include the following:

Provider Relations Representatives:

- Contract with all network providers
- Assist all network providers, including primary care medical providers (PCMPs) and behavioral health (BH) providers, in navigating Health First Colorado
- Provide administrative support to providers including assistance with billing and coding issues, new policy changes, systems updates, etc.
- Advocate for providers and act as a liaison between the Department of Health Care Policy and Financing (HCPF) and the provider network



Care Coordinators:

- Provide comprehensive and integrated care coordination support with nurses, social workers, community health workers, and behavioral health care coordinators
- Help members navigate Health First Colorado and connect with medical and non-medical services (in person and/or via phone)
- Assist members to understand their benefits and choose a PCMP that best meets their needs
- Facilitate appointments with the PCMP and other specialists or specialty BH network providers
- Create member-centered care plans and wellness goals and coordinate services with the member's health neighborhood, including mental health, dental, LTSS providers, community resources, and other identified needs
- Co-locate care coordinators for eligible PCPMs with high volume CCHA membership
- Establish processes for PCMPs to refer members for care coordination services and provide timely communication to PCMPs on care plans, community resource involvement and patient/family goals
- Telephonic Care Coordination support for members to navigate their Health First Colorado benefits and connect to resources that meet their unique needs, including: locating primary care providers and specialists, assisting with and coordinating durable medical equipment referrals, educating on alternatives to the emergency room, and triaging more complex cases to Care Coordinators.

- Community Health Workers, or Senior Member Support Specialists, provide non clinical support to Health First Colorado Members in a community setting. They educate on appropriate utilization of healthcare services, provide and/or assist with resources tailored to the Members specific needs, assess for barriers to accessing care, and triage more complex cases to Care Coordinators.

Practice Transformation Coaches (PTC) (Physical & Behavioral Health)

- Support physical and behavioral providers and their staff with CCHA and/or ACC quality improvement (QI) activities
- Work with providers to establish a QI team within their office that meets at least monthly to review and engage QI activities
- Help practices adapt to changes and establish sustainable systems, processes, and workflows to deliver comprehensive, member and family-centered care
- Utilize data and continuous quality improvement techniques to achieve KPI and BH measure target goals
- Act as change agents to support providers and practice staff with ACC initiatives such as the Alternative Payment Methodology (APM), key performance indicators (KPIs), BH measures and encourage the integration of dental, behavioral and physical health, and public health
- Assist in helping primary care or behavioral health providers integrate BH or PH services into primary care or behavioral health practices, including assistance in developing new practice workflows and understanding and utilizing the new behavioral health six visit codes
- Work with practices on initiatives that support population health plan efforts, performance improvement plans and other State & public health initiatives
- Serve as a resource to providers who support members experiencing addiction and related behavioral health concerns
- Collaborate with community liaisons to broaden availability of community resources related to social determinants of health particularly affecting members with SUD and other systems barriers
- Work closely with care coordinators and community liaisons to identify barriers to coordinating behavioral health services
- Encourage and assist providers in offering SUD solutions including Medical Assisted Treatment and Pain Management services
- Assist PH and BH providers in accessing and appropriately using the Department's technological solutions, including the Colorado interchange, the BIDM, Data Analytics Portal (DAP), Member eligibility Portal, etc.
- Assist PCMP practices with state sponsored initiatives such as the State Innovation Model or Comprehensive Primary Care + (CPC+)

Community Liaisons:

- Establish relationships and collaborate with economic, social, educational, and other relevant organizations to promote health
- Work with providers on system navigation and educate them about medical and non-medical community-based resources such as diabetes and nutritional education classes, food and clothing banks, childcare services, housing, transportation, and older adult services
- Assist network providers with identifying health disparities and inequities within their patient population and help develop plans to improve the physical and behavioral health of members
- Connect and align network providers with evidence-based or promising practices identified through community projects such as the Colorado Opportunity Project

- Work within an integrated team of Practice Transformation Coaches, Care Coordinator & Provider Relations Representatives to help practices engage in population health efforts as indicated in the RAE Population Health Management

Clinical Health Information Technology Specialists:

- Help network primary care providers and practices pull data from electronic health records (EHRs) to create reports for outreach and population management
- Collaborate with practice transformation coaches to understand the EHR system and its capabilities
- Work with practices and their EHR vendors to leverage all the functionalities the system offers, and pull out appropriate data for quality improvement initiatives
- Support providers in connecting to the Regional health information exchange (HIE)
- Support providers in using specialty care Electronic consultation and referral tools

Accountable Care Network (ACN)

An Accountable Care Network is a network of qualified providers delegated by CCHA to fulfill the responsibilities of care coordination and population health management for their assigned members. Any provider that expresses interest in becoming an accountable care network provider will be assessed to see if they meet the criteria for ACN responsibilities. All ACNs are required to participate in ongoing evaluation and audit processes. No provider will be exempt from initial or ongoing assessments.

Accountable Care Network Support:

- Provide administrative and operational support
- Provide oversight and support around deliverable schedule and contractual obligations including care coordination, quality improvement, member engagement and population health
- Practice Transformation Coaching
- Support in bi-directional exchange of data on quality improvement metrics and performance
- Support coordination between RAE and ACN staff for care coordination and member services to ensure members have seamless access to services and support within the healthcare system and the health neighborhood
- Facilitate best practices and learnings between Regional Accountable Entity (RAE) and other ACNs
- Participate with the ACNs in special projects to promote members' physical and behavioral health
- Liaise information between HCPF, RAE, and ACN providers to ensure alignment on the ACC program and policies

Training and Education

Providers will receive ongoing education on a monthly, quarterly and yearly basis; topics will be identified through various channels i.e. from state and federal laws and regulations pertaining to Medicaid and/or Medicare, state contracts, NCQA standards, HCPF policy, the RAE policies and procedures, provider requests, committees, and other relevant sources. Trainings will be delivered through:

- Print communications (provider manual, newsletters, clinical and non-clinical educational materials)
- Provider page and resources on the CCHA Website
- In-person trainings (learning sessions, in-practice boot camps, Medicaid provider update meetings)
- Virtual trainings (live or recorded webinars)

- Provider open forums
- Provider orientations

Provider Manuals: Provider Manuals will serve as one of the sources which outline the requirements with which the provider must comply. Updated at least annually, or as needed. The provider manuals are specific to physical health and behavioral health. They are available via the CCHA website and provider memos or bulletins will be sent by email, standard U.S. Mail or fax and may serve to amend or update the information in the provider manual between editions.

Provider Orientation: New providers receive a formal orientation by the network relations representative. This orientation includes a review of the provider manual and CCHA policies and procedures. We make every effort to schedule initial training of newly Contracted Providers or Provider Groups within thirty (30) calendar days of their Participating Status Date or contract effective date, dependent on factors such as practice schedules. CCHA will communicate sessions offered to all providers via mailings and/or provider website postings. Training may be offered in either large group settings, virtually via webinars, or in-person. Provider orientations for behavioral health providers will include elements specific to capitated behavioral health such as utilization management and the claims submission process.

Medicaid Academy Trainings: Training will be conducted on the topics outlined below at least every six (6) months. Additionally, based on the needs of the region and the existing practice transformation resources available, CCHA will offer trainings, learning collaboratives, and/or other resources to support practices in achieving advanced Medical Home standards.

CCHA will also ensure that all Network Providers are fully trained on cultural and disability competency, to include:

- Health care attitudes, values, customs and beliefs that affect access to and benefit from health care services.
- The medical risks associated with the Member population's racial, ethnic and socioeconomic conditions.

At a minimum, provider training will address the following topics:

- General information about Medicaid and the Accountable Care Collaborative program
- Health First Colorado's eligibility and application process
- Medicaid benefits
- Member's rights
- Access to care standards
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT)
- CCHA's Population Health Management Plan
- Cultural competency and responsiveness
- Appeal and Grievance Processes for members and providers
- Quality improvement initiatives, including those to address population health
- Principles of recovery and psychiatric rehabilitation
- Trauma-informed care

- Program Integrity Requirements including Fraud, Waste and Abuse Program
- Other provider or subcontractor responsibilities
- Access to offices and appointment availability
- Emergency service responsibilities
- Member rights and responsibilities
- Long-term care services including availability of home and community based care (if applicable)
- Continue education programs including but not limited to Screening 3, Adverse Childhood Experiences, and other topics as appropriate (if applicable)
- Technical assistance on data and Health Information Technology such as:
  - CCHA's Care Coordination Tool
  - The BIDM System
  - Colorado interChange (MMIS)
  - Office of Behavioral Health's Colorado Client Assessment Record (CCAR) data collection tool
  - SIM and CPC data aggregator tool
  - Program Eligibility and Application Kit (PEAK) website and PEAKHealth mobile application
  - Regional health information exchange (HIE)
  - Electronic consultation and referral tools
- Other trainings that are available may include the following:
  - Covered services for enrollees served by the RAE
  - Available resources available for members and providers
  - Claim Submission and Financial Reimbursement Policies
  - Credentialing

CCHA will maintain records of each training including dates provided, materials covered, and the number and type of providers and office support staff participating in each session. Training records will include evidence of assessment of participant's satisfaction with the training, and where appropriate, understanding of the training material.

CCHA will hold a Medicaid Provider Update Meeting at least twice per year. These meetings will provide information and updates related to the ACC, quality performance and clinical education. CCHA will invite HCPF representatives to each meeting to speak directly with the provider community, answer questions and help providers understand the direction the ACC is heading. Training, educational opportunities and sharing of best practices among providers are also often included in these meetings.

CCHA will continuously monitor network adequacy for both PH and BH providers. In order to meet the needs of our members, CCHA is open to contracting any PCMPs located within regions 6 and 7, and has opened the BH network to any and all BH providers statewide that meet CCHA credentialing requirements and willingness to see Health First Colorado Members.

CCHA has a staffing model to support all PH and BH providers and will adjust as needed for the growing independent provider network.

Practice Transformation Support

Our practices transformation efforts are tailored to meet the needs of the individual practice. Our transformation philosophy is one size does not fit all. Prior to working with practices, the Practice Transformation Coaches coaches meet with the practice and/or BH providers to align expectations and define common goals. They then observe practice workflows and conduct an in-depth office system assessment. Information gathered will be used to determine the infrastructure, staffing ratios, practice panel size, and other pertinent resources available to the practice so CCHA can tailor its approach to supporting the practice. Understanding practices on the front end will enable CCHA to meet practices where they are and customize the CCHA support or approach accordingly. Coaching support will be tiered based on Medicaid attribution and number of members see by a BH provider.

Depending on the size and type of practice, the CCHA practice transformation team may utilize the the following tools or assessments to support transformational efforts:

Assessments –Assessment to understand office systems, processes, and target improvement effort areas. Assessments include a review of office systems, a staff questionnaire, and patient-cycle time observations. A summary report will be provided to the practice. Improvement and support efforts will be identified based on summary report and level of support needed. In addition to these baseline surveys, coaches and facilitators may also utilize a variety of assessments to better target improvement efforts including, but not limited to, empanelment, risk stratification, chronic disease-specific assessments, and office processes assessment.

Practice Quality Improvement Team – Practices will be asked to form a multidisciplinary improvement team that represents all areas of the practice and focuses on improving processes and health outcomes. The improvement team must include a physician champion, various staff members from different parts of the practice and the coach.

Annual Plan – Work with the Practice Quality Improvement team to create an annual quality improvement plan.

Process Redesign – Provide assistance with the redesign and improvement of processes and health outcomes. Utilize a variety of tools including process mapping, spaghetti diagrams, and PDSA cycles to identify bottlenecks or non-standardization in processes. Then work with the improvement team to develop and implement new processes in the care setting.

Electronic Health Record (EHR) – Provide support to implement and optimize EHR systems. Work with practices to implement EHRs and make strides toward meeting Alternative Payment Model (APM)/ Merit-Based Incentive Payment System (MIPS)/Meaningful Use criteria. Support will include developing strategies and processes that increase efficiencies and improve care for patients and their families. The implementation process includes the development of an annual plan to measure improvements, with an aim to measure electronically when possible by generating performance reports from EHRs, registries, and/or Business Intelligence and Data Management (BIDM). This entails assisting practices with EHR vendor selection, workflow analysis, EHR implementation (vendor provides primary project

management), evaluation of privacy and security policies, and monitoring progress toward the target goals.

Ongoing Evaluation and Improvement – Meet with practice improvement teams on a regular basis (at least monthly) to review data, identify barriers, and develop ongoing action plans for improvement. As part of the ongoing evaluation, CCHA has developed a data-driven practice-level scorecard used to monitor practice performance on key metrics including emergency department utilization, well-child visits, and access to care.

QI Tools

CCHA utilizes a number of quality improvement tools to assess current state, track activity, and implement improvement activities. These tools come from national organizations such as IHI, Toyota Production System, and lessons learned from previous coaching experiences. Listed below are some of the many tools we utilize in supporting our provider network.

Assessment Tools

Office Systems Review – This review is an in-person evaluation of the practice in its entirety to collect baseline and current state information on access to care, practice demographics, basic office workflow, and adoption of electronic tools.

Access to Care – Physical Health Providers - Panel size and third next available appointments will be collected quarterly to ensure access to care is available to members. Based on the results of this assessment, the coach/ facilitator will work with the practice quality improvement team to address gaps and monitor access measures on a regular basis. At a network level, third next available, by appointment type, will be measured on a bi-annual basis. For Behavioral Health Providers - Access to care will be measured by the time it takes to get an initial appointment and then the duration between the subsequent visits.

Framework for Integration of Whole Person Care – Coaching team will use this framework, adopted from Dr. Bodenheimer's The 10 Building Blocks of High-Performing Primary Care to support practices in their journey towards becoming a high-performing patient-centered medical home. This framework is also utilized by SIM and CPC+ practices in Colorado.

Cycle Time Analysis – Cycle time is a measure of the total time from beginning to end of a process in a physical health setting. Cycle time analysis also allows a practice to identify highly variable activities that are most likely to benefit from process redesign, and it establishes a baseline measure prior to redesigning office processes.

Addressing Gaps in Care – Gaps in care are the discrepancy between clinical guideline recommendation and the care that is actually provided. PTCs identify where gaps in care exist and help practices with workflows to reduce the gaps.

Supply/Demand – Help identify appropriate equilibrium for PCMP or BH provider capacity to deliver the right care, in the right setting, and at the right time. Supply focuses on practice resources, and demand focuses on member requests for appointments (external demand) and provider-requested follow-up (internal demand). Balancing supply and demand allows a practice to improve access for its patient panel.

Practice Staff Questionnaire – This survey was developed to reflect practice culture and readiness for change. The questionnaire is administered to all providers and staff in the practice. A summary report is created and reviewed with the practice's quality improvement team. The report is broken down into scores that address several practice-level indicators to describe a practice's culture including improvement and change culture, work relationships, change leadership, and practice chaos.

Clinical Tools

CCHA supports practices with a variety of clinical tools targeted to help providers and office staff improves the quality of patient care. These tools include the following:

Clinical Screening tools – Clinical screening resources and tools that are evidence based that will support providers deliver standardized care. Provide support with implementing processes to embed in EHR systems and workflows. Provide tools, resources, and training to support practice engage member care teams as well as motivational interviewing techniques to support behavior change and self-management. The care coordination team also conducts health risk assessments on behalf of the practice and uses results to develop a care plan with the provider and member.

Population Health Registries – CCHA will utilize the BIDM system and its population health registry to monitor preventive health and chronic disease screenings. CCHA will utilize these registries to help providers manage their patient populations and improve the care provided.

Member Materials

CCHA will provide practices with a variety of materials to support member education efforts and self-management of conditions. Additionally, practices will receive support to identify and promote Member engagement with regional efforts that address the social determinants of health and align with the Department's person and family-centered approach to care. These tools include the following:

Member Experience Surveys – CCHA will support the Department in administering the ECHO Survey and the CG-CAHPS Surveys by having coaches work with identified providers and members as approrpriate. Additionally, CCHA will use a variety of methods to collect member perception data and will work with providers, if a role in the facilitation of these tools is identified.

Educational Materials – Based on the needs identified in the care plan, the CCHA care coordination team will provide a variety of educational materials and resources to members on behalf of the practice. Additionally, CCHA has an online order tool for materials that each practice can view and select items to have in their practice such as Health First Colorado navigation pieces, disease-specific information, KPI education,prevention topics, and other member education materials. These are provided free of charge to the practice for them to use with their members.

Member Reminders – Practice transformation coaches assist practices to implement a variety of recall systems and techniques to ensure members are scheduling appointments for necessary care. For practices with an EHR, coaches will help them create a report to identify members who have not received care. Additionally, coaches will assist practices in targeting members that are not meeting the ACC performance metrics and will set up the process support for recall efforts.

Operational Practice Support – Practice transformation coaches identify areas where practices need additional support based on results of the aforementioned assessments. Coaches then target training needs and redesign efforts for each practice to help them meet principles of the medical home.

Performance Management & Monitoring

Practice transformation coaches will work with the quality improvement (QI) team to implement a monitoring system that helps understand and improve performance on key ACC criteria such as KPIs, BH measure, access to care, and health outcomes.

ACC Performance Measures - To assist providers in meeting ACC Performance Measures, dashboards will be provided to the QI teams that will inform the providers of their general member demographic and performance on the ACC performance measures. The dashboards will track ACC performance measures over a rolling 12-month period. This information will help providers with their member engagement processes by identifying trending issues and successes that are used to inform improvement strategies and best practices.

Annual Plan – Practice transformation coaches will setup practice annual plan review will be conducted to identify changes in the practice that may affect access to care and quality outcomes.

Access to Care Measure – Practice transformation coaches will work with practices to monitor access to care. When issues are identified, PTCs will meet with BH and PH practices monthly to implement ongoing continuous improvement activities to resolve the issue.

Data, Reports and Other Resources

CCHA will provide many types of data or reports to the provider network to assist in serving Members and engaging in practice transformation and QI efforts
This includes, but is not limited to, claims feeds, roster files, financial reconciliation data, demographics, examples of health screening tools and health risk assessments.

Standard Provider Directory – CCHA maintains a PCMP and BH directory in our data warehouse that is updated on a monthly basis. The directory outlines the provider network for the region and can be easily filtered by clinic location, provider specialty, county, and several other data points. This information is also in a searchable format on the CCHA website, CCHAcares.com.

Community Resource Directory – CCHA maintains a directory of community-based resources that provide social, economic, and behavioral supports to CCHA members. This may include resources such as food banks, utility assistance, public health programs, housing programs and shelter information, LTSS entities, Community Centered Boards and Single Entry Points, childcare assistance organizations and entry point information for a wide-range of entities that assist with social determinants. Information in the spreadsheet includes resource name, phone number, service area, program details, associated fees (if applicable), service exclusions, and contact information and is managed by the CCHA Community Resource Committee. Additionally, the CCHA website, CCHAcares.com, links to United Way's 2-1-1- resource directory as well as to several highly utilized services, such as county agencies.

Directory of Department Resources – CCHA maintains contact information for various state-affiliated agencies that provide resources to providers and members. CCHA staff are educated on the appropriate use of these resources and can direct providers and members to the proper agency or program. CCHA also provides Quick Reference Guides to practices that contain contact information for HCPF, community and ACC resources.

Link to Main ACC Web Page – The CCHA website, CCHAcares.com, provides a multitude of resources to members and providers. In addition to having searchable databases for participating providers, the website includes information on member rights and an anti-discrimination policy. There are links to HCPF's main web page and other state vendors.

High-Risk Member Lists – CCHA uses claims data and the BIDM system to identify members who are high utilizers and potentially high risk for admissions, ER visits, etc. These member lists are shared with providers to help engage in care coordination services.

BIDM Reports – CCHA assists practices with using BIDM reports and Client Over-Utilization Program (COUP) lists to identify members who need care coordination or additional support from the practices. These include, but are not limited to, members who have not been seen in the last six months, roster reports, and members who have a change in risk burden.

Online Provider Support

Website -The CCHA website, CCHAcares.com, has information for providers and members regarding CCHA, Health First Colorado, the ACC, and health resources. The website is available in English and Spanish and includes a robust provider directory, community resources, educational materials, a health library with hundreds of health topics, and other health care information. The CCHA Health Neighborhood Advisory Council minutes are also available on the website for providers to review and learn how to be involved.

Language Options – The website is currently in English and Spanish and can be changed by selecting the language at the top of the homepage. The website is also built with Google translate so that other languages can be translated by Google at the click of a button.

Patient Education – All Health First Colorado and vendor information is listed and explained on the website to help members navigate the resources available to them. Information about staying healthy, ER utilization, choosing a doctor, etc., is also included on the website.

Materials – CCHA has developed a wide array of practice support and member materials to help explain the ACC and educate members about their health. Practice materials include items such as a CCHA Quick Reference Guide, member PCMP cards, depression screening guides and tools, behavioral health referral guides, and KPI reference guides. Member materials include the Map to Medicaid brochures, care coordination brochures, prevention topics, behavioral health guides/referral information, general disease education materials, and KPI-specific topics. Examples of these materials are available upon request.

Value-based Payments and Incentives

Per Member Per Month Value-based Payment (PCMPs)

All providers serving Health First Colorado members are eligible for a per member per month (PMPM) payment. CCHA has elected to retain the current PMPM payment as indicated in the PCP and/or Accountable Care Network (ACN) agreements.

Beginning July 1, 2019, the PMPM will be transitioned to a value-based model. The PMPM amount will be based on performance and other factors.

In addition, all providers will have an opportunity to earn additional dollars for enhanced services and performance. This may include participation in innovations such as achieving the targets for the ACC performance measures, meeting enhanced requirements on the Primary Care Alternative Payment Methodology (APM), and/or participating in the State Innovation Model (SIM) or the Comprehensive Primary Care Plus (CPC+) programs.

CCHA Provider Incentive Program

CCHA is committed to reinvest in their contracted provider network. Two types of incentives will be available to CCHA network providers. The first incentive will be geared towards primary care providers. The second will be geared towards behavioral health providers. The goals of these incentive payments is to provide quality care and service to members. Both incentive payments will include the following elements:

- Clinical quality Indicators
- ACC performance measures
- Member outcomes
- Focus on prevention and primary care
- Integration of behavioral and physical health
- Efficient and appropriate utilization of services and benefits

Please note that funding for this incentive program is available only if the region meets metrics as a whole.