COLORADO
Department of Health Care Policy & Financing

Annual Practice Support, Transformation and Communication Report
Instructions and Narrative Report

RAE Name	**Northeast Health Partners (NHP)**
RAE Region #	**2**
Reporting Period	FY23-24 07/01/2023-06/30/2024
Date Submitted	**06/03/2023**
Contact	**Brian Robertson**

Purpose: Regional Accountable Entities (RAEs) are responsible for improving health outcomes and increasing value in their respective regions through supporting their Provider Networks. As part of that responsibility, RAEs are required to maintain necessary communications with network providers and provide them practice support and transformation.

Instructions: In the narrative section below please concretely describe your achievements/successes, challenges, and any plans for change in strategy relative to:

- the types of information and administrative, data & technology **support** and trainings provided to network providers, including promoting the use of telehealth solutions and the Dept.-adopted eConsult platform (once adopted);
- the practice **transformation**, to advance the Whole-Person Framework and to implement the Population Management Strategy, provided to network providers; and
- your **communication**, both proactive and responsive, with network providers and other health neighborhood partners as dictated by section 3.9.2 of the contract and other oversight entities, as well as promoting communication among network providers.

RAEs may attach samples of communications and/or hyperlinks to online communications.

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Practice Support:

Achievements/Successes:

NHP's practice support team continues to provide training and education to providers and practices so they may deliver high standards of care to members. NHP utilizes communication tools to foster an open communication environment for providers to engage and receive information. Additionally, NHP offers documented trainings that are available live, and presentations are posted on NHP's website to allow easy access to provider trainings and communication.

Provider Training

NHP provided multiple opportunities for providers to attend various types of trainings in support of its mission to provide care for its regional members. NHP training opportunities consisted of monthly Provider Roundtable live webinars. Throughout the year, NHP provided trainings and resources on topics such as credentialing, billing and coding, practice transformation (PT), quality improvement (QI), clinical practice guidelines, and the substance use disorder (SUD) expanded benefit, to name a few. There were 26 provider training topics presented throughout the year. Provider trainings were posted on the NHP website along with the live webinars and presentations.

Attendance was recorded during the provider webinars and presentations. On average, twenty-eight (28) participants attended the live provider webinars. Of the participants attending the provider webinars, 100% responded that they were satisfied or very satisfied with the information presented. In addition, NHP created monthly provider newsletters that contained contact information, Colorado Department of Health Care Policy & Financing (HCPF) provider news, resources, and articles relevant to the RAE 2 region.

Further, providers have outreached NHP to inquire about provider file demographics updates, claims, credentialing, and contracting. NHP has held meetings with providers virtually and by phone to work through issues and concerns. Provider inquiries have been initiated and then acknowledged by Provider Relations staff within 48 hours or two business days. NHP will continue to resolve provider issues and concerns, whether simple or complex, in a timely manner per contract

Challenges:

Providers have expressed challenges with many organizations and state entities sending multiple communications. NHP is working to streamline communication materials to lessen the communication overload burden by mirroring state communications and information.

Plans for Change in Strategy:

NHP will continue to provide training and education tools to assist providers and practices. Training and education opportunities available to providers are monthly provider webinars, monthly provider newsletters, and provider alerts. This year, NHP will look to present more on

community resources available to providers, members and solicit feedback from providers for targeted discussion topics related to the RAE 2 region. Furthermore, NHP will encourage providers to utilize billing and coding resources on the HCPF website. We hope to encourage more participation in the provider roundtables by promoting their value of that venue during one-on-one calls with providers. In addition, providers can continue to contact NHP to inquire about issues or concerns.

Practice Transformation:

Achievements/Successes:

Through the voluntary PT Program, PT Coaches work closely with Primary Care Medical Providers (PCMP) and Behavioral Health (BH) practices to improve quality and experience while lowering costs of care for our members by assisting in developing, implementing, and monitoring improvement activities. NHP's PT program has two components: Primary Care PT and BH PT. Both programs operate in a similar structure, with differences only in some of the performance measures and population focus. Foundationally, both programs focus on QI, conduct an annual assessment, meet monthly with each participating practice, and hold quarterly learning collaboratives.

In FY23, 92% of PCMP practices in the network were engaged in the NHP PCMP PT program, with the majority of them meeting monthly. For FY23, five practices are enrolled in the BH PT program. We entered FY22-23 with the following goals:

- Practices achieve 70% of milestones.
    - PCMP incentive program: as of May 22, 2023, 71% of the incentive milestones have been achieved. The program ends June 30, 2023 and we expect practices to continue to make progress on the milestones.
    - BH PT incentive program: The incentive program ran in two phases:
        Phase I: July 1, 2022 to December 31, 2022
        Phase II: January 1, 2023 to June 30, 2023
- Establish a BH PT program.
    - BH PT went live on July 1, 2022. During Phase I, 80% of the incentive milestones were achieved. During Phase II, 42% of the incentive milestones have been achieved as of May 22, 2023. The program ends June 30, 2023 and we will continue to support practices as they make progress toward completing their milestones.
- Align PT milestones to Key Performance Indicators (KPI) and Behavioral Health Incentive Plan (BHIP) measures.
    - See "2023 PT Performance Measure Focus" section below
- Integrate Prescriber Tool implementation into PT.
    - 100% of all PCMPs have completed the Prescriber Tool Attestation
    - 44% have confirmed that they have Real-Time Benefit Inquiry (RTBI) capabilities that launch on July 1, 2023. Not all Electronic Medical Records (EMR) have the correct functionality for RTBI, including one practice currently using paper charts.

Practice Transformation Competency Assessment YoY results

Annually, PT Coaches outreach all contracted PCMPs and a subset of BH practices with an invitation to participate in the PT program. For those who choose to engage, PT Coaches complete a PT Readiness Assessment to start the fiscal year. The assessment is broken down into categories based off the NCQA's Patient-Centered Medical Home (PCMH) and Bodenheimer's Building Blocks. Each category is scored as either a 1 (not started), 2 (just beginning), 3 (actively addressing), or 4 (completed). The categories are:

- Leadership
- Data Driven QI
- Empanelment
- Team Based Care
- Patient and Family Engagement
- Population Management
- Continuity of Care
- Access
- Comprehensiveness and Care Coordination
- Value-Based Contracting
- Focus on Addressing Social Needs of Patients
- Focus on Telehealth
- Inclusivity and Equity
- Focus on SUD (BH Practices)

Outcomes from the assessment are used to track the progress of key competencies and identify focus areas for practice support plans. Assessments in July/August 2023 will be applied to FY23-24.

For PCMP assessments, all of the competencies increased except for Patient and Family Engagement and Continuity of Care. This was due to a few new practices being assessed in 2022 that were not included in the 2021 cycle. The overall score increased from 3.1 in 2021 to 3.5 in 2022. The largest improvements were in Leadership, Value-Based Contracting, Focus on Addressing Social Needs of Patients, and Focus on Substance Use Disorder.

Assessment Sections	2021 Assessment	2022 Assessment	% Increase
1. Leadership	2.3	3.2	36.4%
2. Data Driven QI	3.2	3.5	10.2%
3. Empanelment	3.0	3.2	6.7%
4. Team Based Care	3.1	3.7	17.7%
5. Patient and Family Engagement	3.2	3.0	-5.2%
6. Population Management	3.2	3.7	13.7%
7. Continuity of Care	4.0	3.2	-18.9%
8. Access	3.3	3.8	15.2%
9. Comprehensiveness and Care Coordination	3.0	3.5	15.4%
10. Value-Based Contracting	2.7	3.5	32.9%

11. Focus on Addressing Social Needs of Patients	2.5	3.5	38.7%
12. Focus on Substance Use Disorder	2.4	3.2	31.7%
13. Focus on Telehealth	3.0	3.7	22.4%
14. Inclusivity & Equity	2.7	3.5	31.1%
Overall Average Score (out of 4)	**3.1**	**3.5**	**13.2%**

BH Practice assessments were completed in the fall of 2022. The information from these assessments will serve as a baseline for ongoing annual assessments and will guide the focus for QI plans and Plan Do Study Act (PDSA) cycles, both part of the incentive program. All five participating practices completed the assessment. The highest competencies were identified in the Focus on Telehealth and Focus on SUD domains.

Assessment Sections	2022 BH PT Assessment RAE2
1. Leadership	2.9
2. Data Driven QI	2.6
3. Team Based Care	3.3
4. Patient and Family Engagement	3.0
5. Population Management	3.2
6. Access	3.4
7. Comprehensiveness and Care Coordination	3.0
8. Value-Based Contracting	2.3
9. Focus on Addressing Social Needs of Patients	3.5
10. Focus on Substance Use Disorder	3.8
11. Focus on Telehealth	4.0
12. Inclusivity & Equity	3.0
Overall Average Score (out of 4)	**3.2**

<u>Outcomes from the FY23 PCMP PT Incentive Program</u>

NHP created a PT incentive that aligns with the new Alternative Payment Models (APM) and focuses on primary care access and preventative care. NHP did this by supporting practices with utilizing a wellness registry that PT Coaches used to identify member level gaps in care. The registry, paired with the continued use of appropriate QI tools, aided in supporting workflow enhancement and outreach methods. PT Coaches supported practices with PDSA cycles to create workflows with the goal of outreaching members with gaps of care identified in the registry. Practices were supported in building a pre-visit plan and utilizing documented standing orders. Pre-visit planning tools were used to identify gaps in care including preventative screenings, immunizations, and condition-specific lab work. Standing orders were used to streamline teamwork and decrease the administrative burden on providers.

The FY23 PT incentive program also incorporated elements for data-driven improvement by setting attainable goals (based on baseline CY2021 data) to impact wellness visit rates tied to the KPIs and a selection of state-defined measures including diabetes, depression screening, high blood pressure, dental visits, and immunizations. Lastly, practices are incentivized to start

impacting behavioral health integration through completion of an Information Processing Aptitude Test (IPAT) for baseline assessment, a PDSA cycle, and a post-IPAT assessment. The annual incentive per PCMP practice was $9,500. FY outcomes will be calculated after the program ends on June 30, 2023. Below is the detailed structure of the FY23 PCMP PT incentive program.

PCMP PT Incentive Program Structure (FY23)

Milestone	Description	Requirements
1. Data-Driven Improvement	A. Wellness Visits Rate (KPI)	1. Using either EMR or DAP data, determine baseline (CY 2021), and then improve by 12% from 2021 baseline or reach 80%. Submit performance data by June 30, 2023.
	B. Choose one of these state defined measures:	1. Can use either EMR or DAP, determine baseline (CY 2021), and improve by 10% from baseline to the target goal or meet the target goal.
	Diabetes, CMS 122	-Diabetes: Target 19% (less than 19%)
	Depression Screening and Follow-up	-Depression Screening and Follow-up: Target 93%
	High Blood Pressure, CMS 165	-High Blood Pressure: Target 82%
	Dental visits, KPI	-Dental visits: Target 39.55%
	Immunizations, CMS 117	-Childhood Immunizations: Target 57%
2. Population Management	A. Wellness Registry/Report	1. Utilize a Registry/reports to identify patient-level gaps in care including:
		a. Well Visits
		AND
		b. At least one other care gap from the Milestone 1.B Measure selected.
		2. Using a PDSA process, create a workflow to outreach identified patients with gaps in care identified in the Registry
3. Team Based Care	A. Pre-visit Plan	1. Build a pre-visit planning tool for wellness visits to identify any gaps in care including:
		-Preventative Screenings
		-Immunizations
		-Condition-specific lab work, assessments, and/or diagnostics
		2. Provide two de-identified examples from two different quarters of a completed pre-visit planning tool.
	B. Standing Orders	1. Develop and utilize a documented standing order that streamlines teamwork for the measure chosen in 1.B.
		2. Provide a documented workflow describing your clinic's process for using standing orders.

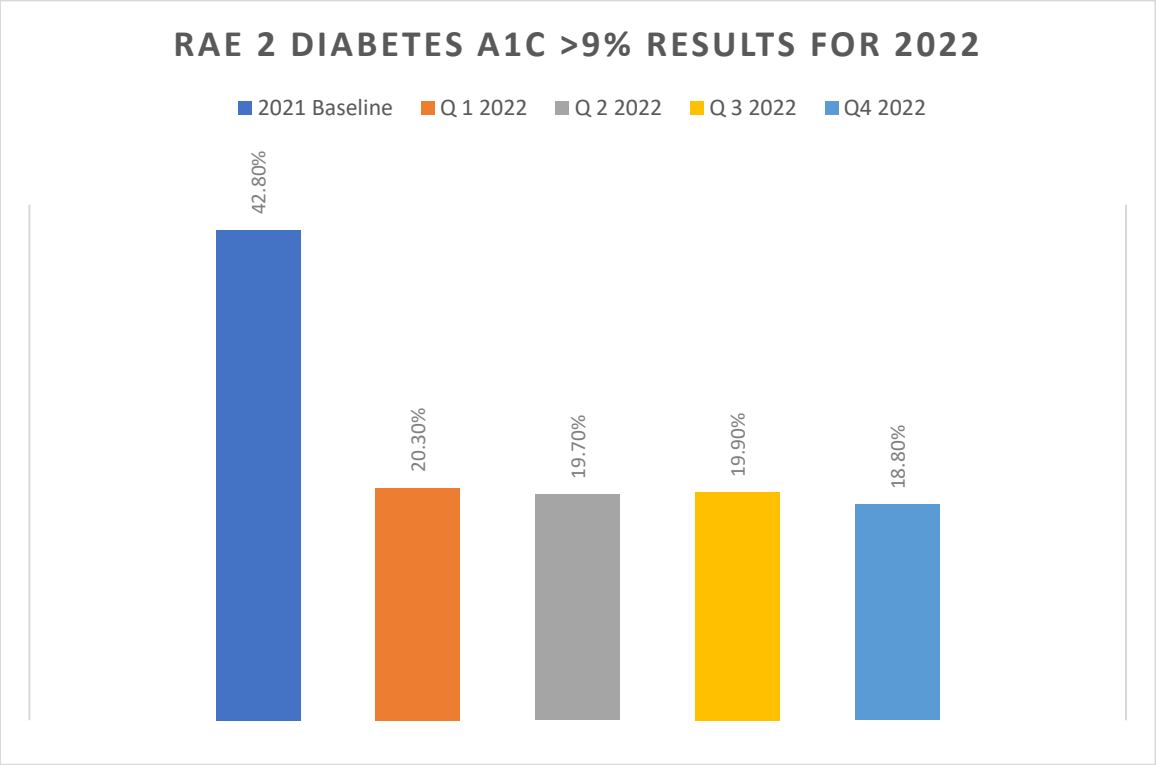
		3. Provide two de-identified patient examples from two different quarters of how a standing order has been implemented (for a total of four examples).
4. BH Integration and Engagement	A. BH Integration	1. Complete IPAT for baseline assessment
		2. Complete a PDSA to implement next steps for next level of BH integration
		3. Complete post improvement IPAT assessment and do one at least of the following:
		-Advance integration by one IPAT level
		-Maintain level-6 on the IPAT (the highest level)
		-Or attain >3% on BH Engagement KPI

Well Visit Performance Improvement Example Outcome

Since well visits have been a focus for consecutive incentive programs, we have calculated a successful outcome as a result of the PT program. Of the 21 practices that actively participated in the PT incentive program, 19 saw improvements in the KPI measure "Child and Adolescent Well-Care Visits, ages 3-21" over the course of calendar year 2022. We were able to improve this measure from 21.97% in CY2021 to 32.36% in CY2022 for an overall improvement of 10.39%.

2022 Diabetes Data Outcomes Based on PCMP PT efforts

NHP's diabetes program includes a diabetes workgroup (formed in 2021) which brought together network PCMPs to share their best practices and resources to support practices and members with diabetes management. We also hold individual monthly meetings with practices where PDSA cycles create workflows and strategies for diabetes management. The primary focus of these interventions is to impact CMS 122: Diabetes A1C Poor Control (>9%) with a goal of network performance below 19%. As seen in the diagram below, we were able improve this measure from 42.8% in CY2021 to 18.8% in CY2022.



Diabetes Program Success Story Example

The PT Coach worked with The Wray Clinic on Diabetes A1C Poor Control with a goal of 19% or lower. Since the practice developed Care Management, they have devoted a considerable amount of time working with the population that has diabetes. In 2018, their performance on the Diabetes A1C measure was at 35%. As of December 2022, their performance on this measure was 19%.

Outcomes from the FY23 BH PT Incentive Program

In addition to core PT competencies, we focused on the BHIP Indicator 1: SUD Engagement measure in the first year of the program. The annual incentive per practice in Phase 1 was $5,000, and in Phase 2 it was $6,500. Below is the detailed structure for both phases of the FY23 BH PT Incentive Program.

Phase 1: BH PT Incentive Program Structure (FY23 Q1 and Q2)

Milestone	Requirement(s)
BH PT Kick-off Participation	Attend June 17, 2022 kick-off event in person 8:30 AM to 1:00 PM
Practice Assessment	Practice Assessment to be completed with your coach **AND** identify one process to focus and improve on. Set SMART goal.
Quality Improvement	Develop written QI plan/strategy with your coach **AND** complete planning tool **OR** Team Assessment

Learning Collaborative	Practice to attend BH Learning Collaboratives
Indicator 1: SUD Engagement	Complete one PDSA cycle with PT coach with a focus on SUD engagement
Rewards and Recognition	Practice completes a Baseline Survey Tool with your team **AND** a PDSA on Rewards and Recognition **AND** provides example of Rewards and Recognition. Repeat survey
Patient Experience	Practice implements a patient experience survey **AND** uses data to assess their delivery of care as well as patient satisfaction with services

Phase 2: BH PT Incentive Program Structure (FY23 Q3 and Q4)

Milestone	Description	Requirements
Milestone 1	**Rewards and Recognition**	Practice completes a Baseline Survey Tool with your team AND a PDSA on Rewards and Recognition AND provides example of Rewards and Recognition. Repeat survey.
Milestone 2	**Patient Experience**	Practice implements a patient experience survey AND uses data to assess their delivery of care as well as patient satisfaction with services
Milestone 3	**SUD Engagement**	Cycle 2 PDSA (access, engagement, retention, evidenced-based training etc.) **Based on performance -** Increase baseline by _% or close the gap?
Milestone 4	**Visualization tool or PP (Antidepressant Medication Management)**	Practice develops a dashboard (referral tracking, retention, follow-up after cancel/no show) AND meets minimum of monthly and review data. Complete PDSA cycle

Challenges:

- Providers (especially PCMPs) note that they have an unmanageable number of measures with KPI, BHIP, PP, APM, and UDS measures.
- Accessing timely data: the five-month claims lag is a barrier to practices making changes to impact performance on the measures. We recommend a monthly data refresh with all claims data received to date.
- Focus performance on "active members" to provide a more accurate view of how the practice is actually doing on a measure.
- BHIP SUD Engagement: BH practices that are prescribing Buprenorphine and Naltrexone (as opposed to Methadone) are billing J0571-J0575 and J2315 under the medical side, which are not part of the numerator for SUD engagement. We strongly suggest adding these codes.

- Access to dental care for the Medicaid population in RAE 2 is limited, especially in the rural and frontier counties. In order to support access, HCPF will consider opening the KPI measure to PCMPs again.

Plans for Change in Strategy:

The PCMP PT Incentive program for FY24 goes live on July 1, 2023 and will have four mandatory milestones: Access to Care, Learning Collaboratives, Practice Assessment and Practice-Specific SMART Goal, and Screening for Depression. There are five additional milestones of which practices will choose one: Well Visits, Postpartum Engagement, Emergency Department (ED) Visits, Diabetes Management, and Controlling High Blood Pressure. The goal for the next phase of the incentive program is focused on improving access, engagement in PT, and performance improvement linked to KPIs and APM measures.

The BH PT incentive program for FY24 will go live on July 1, 2023. This phase of the incentive program has five milestones: Population Management/Performance Improvement with a focus on SUD Engagement, Coordinated Care, Performance Visualization, Learning Collaboratives, and the Practice Assessment. The goal for next year is to focus on improving SUD engagement performance for RAE 2, increase PT engagement, and improve coordination of care capacity.

Provider Communications:

Achievements/Successes:

NHP continues to use several communication methods to assist providers with information and education on topics to assist Health First Colorado members with their whole person care. NHP supported provider communication practices through monthly newsletters, live webinars, and provider email alerts. NHP hosted monthly live provider webinars for providers on topics covering the Colorado QuitLine, Zero Suicide, Crisis Resources, Access to Care standards, HCPF Revalidation, and Balance Billing/Overpayment information. There were twenty-six (26) provider training topics presented throughout the year. Provider trainings were posted on the NHP website along with the live webinars and presentations.

Attendance was recorded during the provider webinars and presentations. On average, twenty-eight (28) participants attended the live provider webinars. Of the participants attending the provider webinars, 100% responded that they were satisfied or very satisfied with the information presented. In addition, monthly provider newsletters have contained valuable resources and information to assist providers in whole person care not only for members but for providers as well. Our provider newsletters contain HCPF news, community events and training, and relevant articles to support providers navigating the care of Health First Colorado members.

Challenges:

Providers at times have outdated contact information on file with NHP. When Provider Relations staff meets one on one with providers, Provider Relations staff educates providers on the

importance of keeping updated contact information and instructs providers on how to update provider contact information in the provider portal.

Plans for Change in Strategy:

NHP is committed to a communication plan that involves all stakeholders, network providers, and members to service the Health First Colorado program and improve the health and welfare of members. NHP will continue the course to work with network providers so they are informed, educated, and trained to help serve members and address all of their healthcare needs. NHP delegates provider communication services to Carelon Behavioral Health.

Network Provider Communications

Network providers are vital to the delivery of healthcare to Health First Colorado members. Carelon Behavioral Health, on behalf of NHP, focuses on key communication streams to inform, educate, and train network providers on the Health First Colorado program. The six (6) areas of focus include the following:

- Provider roundtable live webinars
- Newsletters
- Provider alerts
- Website resources
- Provider support calls
- Provider and stakeholder forums

Provider Roundtable Live Webinars

Network providers are invited to participate in live webinars designed to educate and inform providers about HCPF programs including contractual obligations, billing and coding guidelines, NHP's provider handbook, policies and procedures, and community-based programs within the region. Providers can attend these virtual events by either video or telephone from any location. In addition, Provider Relations performs interactive polling during the live webinars to better understand providers' knowledge and capture feedback on future roundtable topics. The interactive polling system helps drive the overall experience and gives insight into the value the roundtables have for the providers. Attendance is tracked and any follow up concerns are addressed with the provider after the meeting by the Provider Relations team. Roundtable webinar invitations are sent monthly via provider newsletters and are listed on the NHP website with instructions on how to attend. More information can be found under the Providers tab on NHP's website.

Newsletters

NHP produces another proactive communication avenue through newsletters that are distributed twice a month electronically via email to both BH providers and PCMPs. The newsletters highlight important HCPF alerts, upcoming webinars, previous webinar topics, and new programs or resources catered to providers. These newsletters are intended to help bring awareness, education, and information about various programs and policies to providers serving Health First Colorado members. Every newsletter is posted in the Provider Communications section on the NHP website. NHP monitors newsletter read rates to evaluate the value of this communication.

Provider Alerts

NHP creates provider alerts when communication needs to be disseminated to providers in a timely manner. Provider alerts are intended to be a more urgent communication that may be time sensitive. All provider alerts are delivered via email to both BH providers and PCMPs.

Website Resources

NHP maintains a website that includes a section specific for providers. This section houses various resources providers can use to perform efficiently and provide high standards of care to members. The NHP website is organized with the following topics:

- How to Join Our Network
- Newly Contracted Provider Forms and Templates
- Clinical Practice Guidelines, Medically Necessary Guidelines (Behavioral Health and Medical Health)
- Clinical Best Practices
- Condition Management Series, Provider Communications (Webinars, Newsletters, and Training)
- Quality (KPIs and Incentive Programs)
- Electronic Resources (Provider Handbook and Policies)
- Substance Use Disorder Expanded Benefit
- Practice Transformation
- NHP's Contact Information, Customer Service, Care Coordination, Clinical and Claims Departments, and Credentialing/Re-credentialing process

Provider Support Calls

NHP encourages providers to contact us when they experience any issues. NHP's contracted network of providers can contact Provider Relations by calling a toll-free number or via email to receive information about contracts, credentialing, authorizations, claims, or to update their provider profile. The National Carelon Behavioral Health Customer Service and local Colorado Provider Relations contact information is listed on NHP's website under the Contact Us section of the Providers tab.

This Provider Relations toll-free number is answered by trained professionals and is open from 8 a.m. until 6 p.m. Eastern Time. All communications are logged into the inquiry system under the provider profile. The contact details can be reviewed to help with communication and responding to the provider's questions. Timely responsiveness to a provider is important to NHP. Confirmation of provider inquiries is acknowledged within 48 hours or two business days, and NHP strives for resolving provider issues within 30 days of the initial contact. However, issues that are more complex may take longer to resolve. All providers have the option to request a virtual meeting to review an issue or concern with a Provider Relations representative.

Provider and Stakeholder Forums

NHP will continue to host several provider and stakeholder forums throughout FY23-24 as an avenue for NHP, providers, community partners, and various stakeholders to share information and collaborate on ways to support members' health and wellness needs. These forums can also be used to address any local challenges or barriers providers may encounter when administering health care. Examples of the various meetings include:

- Health Neighborhood Forum
- Regional Program Improvement Advisory Committee (PIAC) meetings
- PT Learning Collaboratives
- Population Health Subcommittee meetings
- QI Subcommittee meetings
- First Friday Quality Forums

NHP's communication strategy to inform, educate, and train providers will continue to evolve as the providers' needs change throughout FY23-24. NHP will work directly with providers to bridge communications. Examples include modifying webinars to meet providers' interest in education topics, and offering one-on-one support calls to fully address unique provider issues to facilitate effective resolutions.