COLORADO
Department of Health Care Policy & Financing

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

RAE Name	**Colorado Access**
RAE Region #	**3**
Reporting Period	**[SFY22-23]**
Date Submitted	**6/5/23**
Contact	**Lisa Hug**

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:

Throughout SFY 2022-2023, Colorado Access (COA) has continued its work to ensure that practices and providers have the tools and support necessary to deliver high-quality care to members. The practice support team addresses the demands of today's health care system by offering meaningful support. The team offers physical and behavioral health providers the assistance necessary to drive and sustain change which enhances patient experience, strengthens health outcomes, decreases costs and improves provider satisfaction.

Information & administrative support

COA continues collaboration with leaders throughout the health care system to share regional strategies. COA regularly engages its provider partners through the governing council, multiple provider workgroups and topic-specific forums. In an effort to move the governing council towards a more engaged and proactive approach, the group began reimplementing a collective impact model in Quarter 3 (Q3). Due to the urgency and constant evolution of the public health emergency (PHE), the governing council has primarily been used as a space to inform providers of important updates over the last three years. As the COVID-19 pandemic continues to shift, the governing council sees the need to restructure in order to take a more strategic and collaborative approach to addressing priority topic areas. Current governing council priorities include the continuous coverage unwind, enhanced clinical partner (ECP) workforce challenges, health equity strategy, and the behavioral health administration (BHA).

Additionally, provider forums were created to allow for organic processes to form between primary care medical providers (PCMPs), specialty providers, and hospitals. These processes tend to focus on timely communication and care coordination to ensure smooth transitions of care and wraparound support for members while reducing unnecessary care utilization. COA holds many opportunities for physical health and behavioral health providers to build stronger connections and better support members within the health neighborhood. Monthly provider resource groups offer a space for providers to share current trends and gain information on relevant topics. In Q2, provider resource groups focused on strategies for back-to-school vaccination campaigns and ways to best utilize motivational interviewing techniques to decrease COVID-19 vaccine hesitancy. Provider resource group meetings are recorded and made accessible to all providers on the provider Learning Management System (LMS).

In the reporting period, COA continued convening the bi-monthly Behavioral Health key performance index (KPI) workgroup which brings providers together based on their depression screening scores. COA worked with providers to prepare them for the new depression screen measure, which is included in all of the COA value-based payment models. The depression screen measure is the percentage of engaged members age 12 and older who are screened for depression using an age-appropriate standardized depression screening tool and, if positive, a follow-up plan is documented on the date of the eligible encounter. PCMPs are expected to use standardized screening tools, such as the Patient Health Questionnaire for Adolescents (PHQ-A), Beck Depression Inventory-Primary Care Version (BDI-PC), Mood Feeling Questionnaire (MFQ), Center for Epidemiologic Studies Depression Scale (CES-D), and Patient Health Questionnaire (PHQ-9). Typically, the workgroup focuses on engaging providers with lower scores as the goal

of the workgroup is to identify areas for improvement and increase depression screen performance. These collaborative meetings offer providers the opportunity to discuss ways to improve their behavioral health workflows and to bring a behavioral health related topic of their choosing to the group. The intent of these convenings is to address screening, billing, coding and process challenges impacting this measure, as well as scale best practices that positively impact performance improvement.

COA continues to utilize behavioral health practice facilitators to offer application support for providers struggling to meet quality metrics. Practice facilitators meet individually with providers who have an application in progress to create or improve administrative practices and procedures, develop new workflows to improve authorization procedures and/or transitions of care, develop and organize training plans and requirements, and develop clinical oversight processes. At this time, COA continues to permit all substance use disorder (SUD) providers who are validated by the State, and not yet contracted with COA, to render SUD treatment and receive out-of-network rates.

As previously reported, the new complex member definition for COA was implemented at the start of the reporting period on July 1, 2022. COA now defines adult complex members as individuals with four or more of eight priority health conditions: chronic pain, asthma, cardiovascular disease, depression or anxiety, diabetes, hypertension, substance use disorder, or chronic obstructive pulmonary disease. All COA dashboards, including the admissions, discharges, and transfers (ADT) dashboard, have incorporated this new definition, along with flags for complex members. In the reporting period, the COA practice support team focused on providing technical assistance to ECPs to support the shift of data and care coordination activities to the new complex member population. ECPs give ongoing feedback related to the implementation of the new definition. Many have expressed the helpfulness of the new definition in creating continuity of care and management of co-occurring chronic conditions. Some ECPs have expressed challenges when members do not fall within the parameters of the COA complex member definition but are determined as complex by the practice. COA continues to learn from its partners about potential limitations of the new complex member definition and works to better align definitions across the continuum of care.

COA also relies on its biannual complex member audits to understand the effectiveness of its current systems and areas in which processes could be improved. In Q1, the COA practice support team led an ECP audit. With the implementation of the new complex member definition, the COA practice support team used the August 2022 assessments as a learning opportunity to identify their new complex members, coach on the extended care coordination elements, and identify gaps in care for all practices. The practice support team assessed ECPs on the following criteria as related to extended care coordination (ECC): condition specific patient education; care plan documentation, communication, and accessibility; medication management documentation and accessibility; count of condition or care management visits over the past 12 months. COA had several key findings from the August audit. COA found that under the team-based care model, some of the requirements of ECC are performed by non-care management team members. It also found that condition education and medication management are often performed by the physician, and there was a large variation of outreaches for members depending on the type of practice. PCMP practices embedded within a hospital system had anywhere from six to 51 visits within the past 12 months. Those not within a larger system averaged closer to three to four visits. COA assessed communication among

ECPs and found most practices rely on a patient portal or after care summaries to communicate care plans to their members, and large systems tend to have an easier time-sharing information across specialists due to electronic medical record (EMR) access. The most unmet element found within the audit was documentation of patient centered goals. Most care plan templates within the EMRs pre-populate goals that often speak to treatment goals. While providers are asking patients and caregivers about their individualized goals, they are not consistently well documented for care teams to learn from and incorporate in their encounters. COA reviewed contract requirements with ECPs before the audit and focused on the requirements that each ECP must perform to pass. These requirements ranged from establishing an internal quality improvement (QI) team, embedding behavioral health care services in each clinic, documenting risk stratification processes, utilizing clinical registries and forecasting health disparity activities each organization is implementing or will implement within the next 12 months. The COA practice support team will continue to work with ECPs to ensure that gaps are addressed and all ECC requirements are met, with a particular focus on assisting ECPs with improving individual care plans and patient centered goals.

Data & technology support

The new COA portal and platform for provider data, PowerBI, incorporates self-service data visualization tools that aid primary care providers in comparing site level KPI trends to regional and cohort performance trends. In the reporting period, COA has worked on translating site-level trends to member-level reporting that show providers how their attributed members are counted for a given measure. COA has developed dashboards showing member-level performance on the organization's value-based administrative payment model metrics as well as site-level payment history across incentive programs. During the reporting period, COA also developed a dashboard to support ECPs in outreaching members related to the Continuous Coverage Unwind. The dashboard helps COA and ECPs assess provider capacity and better understand the volume of member outreach required. An example snapshot of the Continuous Coverage Unwind dashboard can be found below in Appendix B.

Practice facilitators provide regular messaging to PCMPs regarding the state's Prescriber Tool initiative which includes guidance on the purpose of the tool, and inquiries into the experience of practices with active tools on their EMR platforms including SureScripts. The Prescriber Tool initiative and the practice facilitators assessment of the tool's success in provider practices is an ongoing effort and partnership with the Colorado Department of Health Care Policy and Financing (the Department). COA makes continuous efforts to align provider priorities and standardize tools for measure improvement. In addition, practice support staff aided providers by maximizing funding potential in the value-based payment program. On a monthly basis, COA staff share with providers the Provider Enhanced Payment Report (PEPR) to focus on engaged members and coordinate the services they need. As a result of sharing lists of engaged members monthly, providers' value-based payments increased, which has improved staff satisfaction in the practices.

To further support value-based payment implementation, the Provider Metric Summary Tool (PMET) was developed to show cohort performance, regional comparison for multiple performance measures, and trendlines per metric. The tool has been expanded to show every

performance measure and show how providers are attributing. COA plans to add member-level details per metric to better support providers' quality improvement efforts. An example snapshot of the PMET can be found below in Appendix A. Additionally, a standardized value-based payment implementation toolkit has been developed and shared across the provider network and continues to be updated based on provider feedback.

Telehealth support

The Virtual Care Collaboration and Integration (VCCI) Program at COA continues to provide increased access to health care for its participating network providers. The VCCI Program allows PCMPs to refer members to be seen for short-term/brief intervention treatment over telehealth by VCCI clinicians and psychiatrists either within the primary care setting or directly in the member's home. The VCCI Program emphasizes coordination of care and works with each PCMP practice site to collaboratively create customized protocols that allow for the exchange of information with the member's medical home. The VCCI Program includes an eConsult component that allows its participating PCMPs to directly query a VCCI psychiatrist via asynchronous HIPAA-secure email for a rapid response to their psychiatric questions. The program also allows COA care managers to make referrals to VCCI for members that are unconnected to behavioral health care and works with COA care management to coordinate connections to primary care and manage referrals to long-term care and other resources as needed. The VCCI Program continues to expand and evolve its services to meet the increased need for behavioral health care. The VCCI Program incorporated further updates to its online scheduling provider portal, based on feedback from its PCMP partners, to increase efficiency for patient referrals and the sharing of clinical information through the HIPAA-secure web-based platform. Within this provider portal, scheduling, progress notes, consent forms, and demographic information can be shared to optimize the coordination of member care with PCMPs who participate in the VCCI Program.

Challenges:

Over the reporting period, COA has seen a general drop in telehealth utilization. This drop in utilization is due to an increase in the variety of available behavioral health resources and, as the nature of the COVID-19 pandemic continues to shift, a general increased desire to return to in-person care. The COA telehealth team has experienced barriers to working with community partners due to recent low utilization and high turnover of staff within several community organizations.

Plans for Change in Strategy:

In Q3, the VCCI Program partnered with the Pediatric Care Network to pilot VCCI with four of its primary care practice sites. Trainings and protocols have been completed for these sites and sites have started to utilize VCCI for consults and referrals. The VCCI Program is expanding care management referrals to include COA members that are identified by the COA transition of care team that are in need of psychiatric support after release from an inpatient hospital psychiatric stay. The VCCI Program is working closely with the COA diversity, equity, and inclusion (DE&I) team and its PCMP practices to identify community partners, like homeless shelters and community centers, where a program can be collaboratively developed to allow for telehealth

interventions to be provided on-site for members in need of short-term behavioral health support.

Practice Transformation:

Achievements/Successes:

Advancing the Whole-Person Framework

COA recognizes the importance of looking holistically at behavioral health, physical health and social determinants of health (SDoH) to improve member health outcomes. Leaning into the organization's commitment to enhancing health equity, a new behavioral health facilitation team has been formed to increase support for providers. One key area of support and transformation for this team has been occurring alongside the office of DE&I. A pilot program was created to ease the burden of supervision for behavioral health providers in primary care clinics that only employ one behavioral health provider and in some SUD facilities that employ a licensed clinician to supervise peers and non-licensed staff. COA requires that all SUD facilities employ at least one licensed clinician on staff who supervises unlicensed providers and is listed as the rendering provider on claims. The assistance provided by these supervision strategies increases access and ensures quality of care for members in Region 3.

As part of the ongoing Innovation Support Project in collaboration with the University of Colorado School of Medicine, practice support staff offer support on several initiatives including behavioral health integration, risk stratification, expansion of community resources, SUD services and telehealth in primary care. Currently there are 18 PCMPs participating in the Innovation Support Project, and COA serves as coach. In the reporting period, health equity milestones were incorporated to better support the diverse member population. Furthermore, ECP contracts now require that PCMPs have an integrated care clinician and practice facilitators are skilled in supporting behavioral health workflow implementation and optimization.

COA has also continued to carry forward the Department's potentially avoidable costs work (PAC) via "Access Health Connection" to continuously improve cross-system care and communication between hospitals and primary care providers. Through this work, convened and supported financially by COA, major hospital systems are paired with high-volume PCMPs that share many of the same members. A major goal is to reduce rapid hospital readmissions by fostering better care coordination between the systems. The program enhances care coordination of members with chronic diseases (specifically asthma, diabetes, and chronic obstructive pulmonary disease (COPD)), improves condition management and outcomes, and reduces PAC across the inpatient/outpatient continuum of care. Provider partners collaborate to design, develop, and implement system-level interventions such as enhancing data sharing and transitions of care workflows with the goal of reducing high-PAC services such as ER visits and readmissions. Two partner groups have been formed: the first (University of Colorado Hospital-Anschutz, Salud Family Health Center, STRIDE, and Clinical Family Health) addresses COPD and diabetes related episodes of care; the second (Children's Hospital of Colorado, Kaiser Permanente, Every Child Pediatrics, Doctors Care, and STRIDE) addresses asthma related episodes of care with a focus on medication management. In the reporting period, HealthOne and North Suburban entered into agreements to begin this work. HealthOne has since decided not to engage due to capacity. The program will be supported financially by COA. In addition, COA has led initiatives to connect network physical health and behavioral health providers with

complex members when there were three or more visits by a complex member to a behavioral health provider. COA provided an incentive and a forum for these "dyads" to discuss methods on improved coordination and communication.

During the reporting period, COA distributed $700,000 to support PCMPs through the implementation of the Vulnerable Populations Provider Support Payment. The Vulnerable Populations Provider Support Payment awards funding to PCMPs in RAE Regions 3 and 5 that seek to reduce health disparities, improve clinical outcomes, enhance the member experience, and reduce inappropriate utilization of health care services by increasing access to enhanced care for vulnerable populations. In 2022, funds were awarded to eligible practices who were delivering enhanced care to vulnerable populations such as those affected by homelessness, severe persistent mental illness, HIV, medically complex children and adolescents and marginalized groups. In 2023, COA will begin accepting proposals for new and additional Vulnerable Populations Provider Support Payment funds. Enhanced care projects will support availability of culturally appropriate care, housing and employment supports, integrated pharmacy, integrated dental care, onsite access to a food pantry, chronic condition education and medication adherence programs, and street medicine programs.

Provider workforce support and recruitment

Issues of workforce retention and burnout continue to be prominent among providers in the network. COA recognizes this challenge and continues to support providers' business operations and staffing needs in a variety of ways. COA supports by providing resources to reduce burnout professionally and operationally. COA also has positioned its practice supports and provider network services (PNS) provider-facing teams to train, educate and leverage core COA programs to support providers. These programs include contracting support, access to care standards, telehealth support, data, and value-based care programs and incentives.

Colorado Access continually monitors its network adequacy, and the contracting and provider network services teams work closely with the care management department to address any areas of concern. When there is a need in the network, COA actively recruits providers in those areas. COA also continues to get requests from new providers wanting to join the network; and if eligible, COA makes every effort to add them to its panel of providers. COA has hired a provider recruitment program manager to develop, implement, and direct a data driven strategy to recruit and maintain a provider network of culturally responsive providers based on the needs of Colorado Access members in their communities.

Currently, through a data-driven process, the provider recruitment program is determining the status of all providers with a particular focus on primary care and behavioral health. The PNS team continues to outreach providers that have not submitted a claim in the last 18 months to ensure they are still in business and accepting Health First Colorado (Colorado's Medicaid program) members, and to discuss what their capacity is for increasing access to appointments. This information is shared with care management, customer service, and utilization management departments to increase referrals to these identified providers. COA also works with ECPs to creatively address the recent workforce challenges experienced by many integrated care practices through collaboration in the governing council.

As part of ensuring an adequate network, COA has expanded its ability to evaluate and monitor access to care standards. This evolved model is built upon data and outcomes obtained from the Access to Care (formerly Secret Shopper) program and, specifically, data trends in practices that were not passing the standards for which they were being tested. It was recognized that rotating staff in the front office significantly contributed to challenges with adhering to the access to care standards. As a result, this new model will consist of a highly engaged and collaborative training program with providers that is targeted at all aspects of access to care requirements, including a specific dedication to training front office staff on Medicaid rules. COA believes that regular and consistent office training is the key to understanding and adhering to program requirements and will help practices be more successful with completing COA network monitoring programs.

Examples of training areas include appointment scheduling requirements developed for front office staff, or voice mail scripts to ensure appropriate referral messaging. Providers are randomly selected to participate in this COA-led training. Any practice that experiences turnover in staff key to access to care compliance (front office, office manager, etc.) will have training scheduled for all new staff within two weeks of notification. The intent of this system is to better understand what barriers practices are experiencing and to assist practices in creating an individualized improvement plan with the knowledge of these existing barriers. All trainings are made available on the COA Learning Management System (LMS) and are accessible to all providers at any time.

Challenges:

COA recognizes that there is a significant need to increase access to behavioral health providers with linguistic and cultural diversity. It is important that providers, both in the physical health and behavioral health space, be more representative of COA member populations. In order to bolster the availability of culturally response care within Colorado, COA is taking an upstream approach to building the talent pipeline and ensuring that culturally responsive training is an integral part of workforce development.

Plans for Change in Strategy:

In addition to recruitment strategies mentioned above that aim to strengthen the COA provider network and recruit additional providers with cultural and linguistic diversity, COA is currently working with the department of social work at Metro State University (MSU) in Denver to fund behavioral health workforce development programs. COA has agreed to fund a scholarship program for social work students at MSU who reflect the COA member population and who have an interest in pursuing a career in culturally responsive behavioral health care. The goal of the program is to provide viable career paths for students from historically marginalized backgrounds and create systems of support for students and young professionals entering into their career. COA believes that investing in students early on is important in building the talent pipeline of qualified, representative and culturally responsive behavioral health providers. The first MSU Social Work scholars' cohort is anticipated to begin in the fall of 2023. COA has

partnered with local organizations such as Maria Droste Counseling Center and Centus Counseling to provide internship and mentoring opportunities to scholarship students. COA plans to expand upon this work and build similar partnerships with other high education institutions and local health care providers within Region 3.

Provider Communications:

Achievements/Successes:

Provider Onboarding and Trainings

COA provides ongoing communication with its provider network through several channels. When a provider contract is executed, a provider relations representative conducts a phone introduction to initiate onboarding, provide an electronic orientation package, and check in periodically as necessary. PNS representatives conduct new provider training to all new practices within 60 days and offer ongoing training to those providers who need updates. Webinars are scheduled periodically throughout the year and providers may register for education on the COA website. Providers can access all provider-related training through the LMS. In SFY 22-23 COA saw higher provider training completions as compared to other years, largely due to the implementation of the new Access to Care training program and Cultural Responsiveness completion incentives. The resources, communication, and training given by the PNS team provide the provider network with the tools, resources, and knowledge to be administratively successful in their care for members, leading to improved outcomes and experience of care for their patients. Training, issues, and communication with providers are logged in the contact database to track and monitor progress and issue trends. Documenting these activities allows COA to make ongoing improvements to the onboarding program. PNS representatives are available to assist both internal and external staff through in-person meetings, phone, mail and email with questions and concerns.

COA practice facilitators and the PNS team are regularly engaged with providers and quickly respond to barriers providers could face which may impact access to care. Through this high touch team-based care model, practice facilitators and network managers are quickly able to see turnover in provider offices and help support onboarding of specific new hires with training focused on Medicaid rules and regulations, such as the access to care standards. Using Net Promoter Scores (NPS), COA conducts annual and quarterly provider satisfaction surveys. In SFY 2022-2023, COA conducted its first annual NPS survey. The practice support team received high provider ratings both individually and as a team. The practice support team utilizes feedback through the NPS survey to continuously improve team processes and maintain high levels of support. The practice support team plans to supplement provider surveys with quarterly check-ins to address any issues or barriers to engagement. The team will assess practices around their frequency of engagement, their utilization of data and their overall experience.

Electronic Communications

COA distributes a variety of electronic newsletters to its provider network. The quarterly "Navigator" delivers relevant information on topics such as provider partnerships, DE&I, health equity, industry trends, SDoH and telehealth. During the reporting period, the Navigator highlighted areas such as access to the Provider Portal, Healthy Mom Healthy Baby programming, care coordination, behavioral health workforce expansion and highlighted COA partnerships with community organizations such as Tepayac Community Health Center, Servicios de la Raza, Denver Indian Health and Family Services, and Kids First Health Care. The online Navigator has been redesigned in a magazine format that providers can digitally interact with each quarter. During the pandemic, a bi-monthly newsletter titled "COVID-19 Provider Update" was developed to distribute pertinent information regarding COVID-19, community resources, vaccines, and updates from the Department. In the reporting period, a new monthly newsletter was developed, titled "Provider Update." This newsletter communicates essential information about COA Health First Colorado and Child Health Plan *Plus* (CHP+) plans, provider networks, notifications from the Department, and COVID-19 updates. In the reporting period, the "Provider Update" focused on various aspects and upcoming changes related to the Continuous Coverage Unwind and implementation of the new COA claims system. Providers are automatically enrolled to receive "Provider Update" and "Navigator" but may choose to opt out. In the reporting period, COA experienced average open rates between 27-39% for Provider Update and Navigator communications. Open rates for these regular provider communications are on average higher than industry standards, which for health care communications is around 23%[1]. While there is always room for improvement in digital communications methods, data shows that communications are reaching providers and many are engaging with the monthly and quarterly newsletters from COA.

Disseminating Urgent Communications

COA has a system in place for disseminating urgent communications as needed. When an urgent situation or crisis has been identified, information is conveyed to providers immediately through a prominent website location, splash page messaging on the provider portal, and message on social media channels as appropriate. Further, the customer service team is also given a list of talking points to prepare for calls from providers as another way to convey urgent communication. An email blast is also sent to all providers directly, conveying the urgent communication. To accelerate internal approval of urgent messaging, key staff members are notified by email noted by high urgency, as well as a phone call to the person's office and cell phone. Further, to address any communication deficiencies, the marketing and communications team works with provider relations and customer service as appropriate to increase hours and staff, as well as have a communications person on standby to address any immediate needs for communication to providers. Written notices of material changes, including fee schedules and contracting provisions, are sent by mail and provider contracts are amended as needed. Unless the change is retroactive, notices are communicated at least 30 days in advance of changes. Retroactive changes are also communicated within 30 days from the date they are received.

[1] Email Marketing Benchmarks and Statistics for 2022 | Campaign Monitor

Receiving Provider Feedback

In addition to the previously mentioned annual and quarterly provider surveys, COA has several opportunities to gather feedback from network providers and regularly incorporates provider feedback into programming and operations. During the reporting period, COA hosted regular stakeholder meetings to discuss any changes being made to payment model structures. These meetings encourage feedback from providers and offer the space for providers to receive guidance and clarification about any upcoming changes. Additionally, COA hosted several meetings with providers to discuss changes to the complex pediatric member definition and incorporated provider feedback into the updated definition.

Beyond the aforementioned provider meetings, COA has several standard mechanisms in place to receive regular provider suggestions and guidance:

- PNS managers routinely conduct virtual site visits with network providers (hospitals, ancillary, specialty, behavioral health, and primary care).
- Providers may leave feedback through the COA website. Comments are directed to providernetworkservices@coaccess.com. This inbox is checked multiple times per day by provider network services and representatives who follow up with the provider by phone or email.
- PNS initiates face-to-face meetings as needed. Network providers participate in both formal and informal committees: Credentials Committee, Quality Performance Improvement Committee (QPAC), and Joint Operations Committees (informal).
- Provider forums are held throughout the year to provide important information relevant to the network and gather feedback from providers.

The PNS team is available Monday through Friday by phone, fax, or email to help participating providers and their staff regarding provider network questions or issues. Any provider questions or complaints are responded to and addressed by the provider's dedicated provider relations representative. Additionally, providers can call the customer service team Monday through Friday from 8:00 a.m. to 5:00 p.m. at 800-511-5010.

Challenges:

In the past year, COA has recognized the need for a more comprehensive and collaborative approach to its provider communication methods. Because many teams across the organization interact and communicate with the COA provider network, providers may receive disparate communications and messaging from various teams. Teams within the organization may also have access to differing provider contact lists, making it challenging to ensure communications are reaching providers through their accurate and up-to-date contact information.

Plans for Change in Strategy:

In the upcoming fiscal year, COA plans to take a deeper look at provider communications across the organization to address gaps and areas for improvement. The goal of this strategy level initiative is to assess all current provider distribution lists and the means in which information is collected and used, and to create a single source of truth for internal and external provider

distribution lists. This includes data from various departments including marketing, IT, operations, finance, health strategy and health system integration. This will better enable COA to appropriately target communication based on provider type, for example tailoring messaging for clinic front office staff, PCMPs, specialists, etc. This will also allow the organization to identify the areas in which provider communications and messaging needs to be updated based on audience. Additionally, COA plans to establish metrics to better track communications success and areas for improvement. The project will not include the development of new software but is meant to identify the processes and bottle necks that exist currently. This organization-wide strategy is an effort to communicate more effectively with providers and make information more easily accessible across the network.

Additionally, COA continues its participation in the department-initiated communication action team. Over the past two quarters, this team, which includes representation from the department, RAEs and key providers, convened to better understand the root causes of provider communications challenges across all involved partners. COA plans to utilize the learnings from this workgroup to inform future communications improvements.

SAMPLE COMMUNICATIONS:

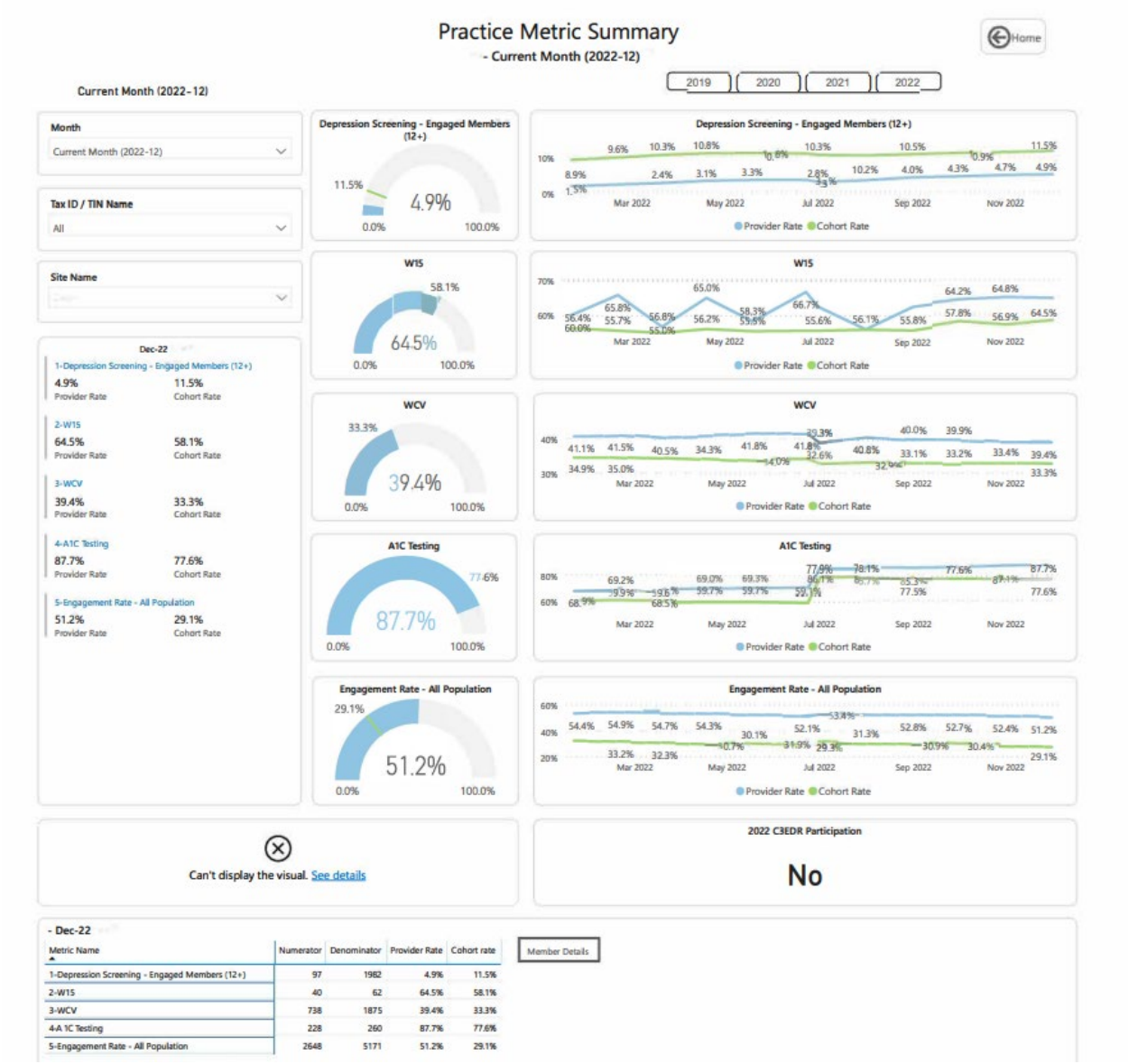
March 2023 Monthly Provider Update

January 2023 Quarterly Navigator

October 2022 Monthly Provider Update

COLORADO
Department of Health Care Policy & Financing

Appendix A: View of PMET Dashboard



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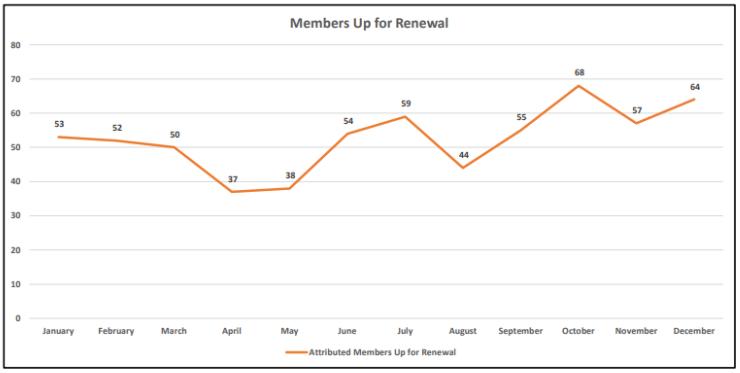
Appendix B: View of Continuous Coverage Unwind ECP Renewal Dashboard

Provider Location	
Provider MedicAid ID	
Provider System Name	
Provider Location Name	
Provider Type	PCMP
Attribution Cap	500
% of Attribution Cap	127%

Methodology for Outreach Hiring Needs Estimate
This estimate of hiring needs (Column H) is intended for ***ECP providers & not PCMP(+)'s***. Member outreach is only required for ***engaged members attributed to ECP providers***.
This estimate is based on a few key assumptions & generalizations and projects the required number of FTE's required to adequately outreach all the appropriate members.
Assumption: 20 business days per month
Assumption: Each outreach FTE will make 50 contacts/day.
Example: Let's say there are 600 members due for renewal in a given month for a given provider. In order to reach out once to each of those 600 members, that provider will have to make 30 calls every business day. Assuming one FTE can make 50 calls a day, this particular provider will only need 30/50 = 60% FTE to outreach MedicAid members.



Renewal Month	Utilizers	Engaged Members	Complex Members	Attributed Members Up for Renewal	Attributed Members Due for Outreach	Attributed Members to Contact per Business Day	Outreach Coordinator FTE's Required
January	44	[redacted]	[redacted]	53	-	-	-
February	36			52	-	-	-
March	44			50	-	-	-
April	34			37	-	-	-
May	33			38	-	-	-
June	47			54	-	-	-
July	51			59	-	-	-
August	39			44	-	-	-
September	51			55	-	-	-
October	63			68	-	-	-
November	50			57	-	-	-
December	59			64	-	-	-
Unspecified	[redacted]			[redacted]	-	-	-
Total	**557**	**236**	**35**	**637**	-	-	-