COLORADO
Department of Health Care Policy & Financing

Annual Practice Support Plan
Instructions and Narrative Report

RAE Name	**Health Colorado, Inc.**
RAE Region #	**4**
Reporting Period	[SFY20-21 07/01/2020 – 06/30/2021]
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Purpose: Regional Accountable Entities (RAEs) are responsible for improving health outcomes and increasing value in their respective regions through supporting their Provider Network. As part of that responsibility, RAEs are required to provide practice support and transformation strategies to network providers. This report outlines each RAE's plan to accomplish this task.

Instructions: Please provide a narrative that outlines your strategic approach to supporting and transforming provider practices to increase value and to improve health outcomes and the experience of care of members. The narrative must include details regarding the following:

- the types of information and administrative support, provider trainings, and data and technology support offered and implemented with network providers.
- practice transformation strategies offered to network providers to help advance the Whole-Person Framework and to implement the Population Management Strategy; and
- the administrative payment strategies used to financially support and advance the capacity of network providers.

Where relevant, please provide supporting evidence for the respective approaches. Evidence can include but is not limited to: peer-reviewed research, operational excellence, and public feedback.

Please include how your strategy has or has not evolved since the previous year's submission. Please provide evidence to support these changes.

Please limit your plan to no more than five (5) total pages and use concise and concrete language.

Practice Support Plan Narrative

Instructions: Please provide a narrative that outlines your strategic approach to supporting and transforming provider practices to increase value and to improve health outcomes and the experience of care of members. This narrative must include the details outlined above.

Health Colorado, Inc. (HCI) philosophy is to ensure that all Members have consistent access to a high quality of care in Regional Accountable Entity (RAE) 4. Excellent patient care alone does not ensure the improvement of the overall health of the population served in RAE 4, nor does it make a practice successful. Clinical and operational alignment across the continuum of care is essential to a high-performing network that delivers the highest quality of care while managing the cost. HCI believes the best way to achieve a high-performing network is to make available a range of supports and trainings to our entire network of providers.

Practice Supports: Meeting Forums, Training, Resources

Provider Support Calls – HCI conducts monthly provider support calls through Zoom and uses these calls as an opportunity to train network providers on the Health First Colorado program. The calls include both contractually required trainings as well as other trainings that are educational to providers. Provider support calls offer updates or reminders to network providers of their contractual responsibilities or changes that impact their practice. This may include referencing information shared with providers on the Provider Handbook, Provider Alerts, or information available on the HCI website (www.healthcoloradorae.com). The information presented in the calls is shared with attendees through email and available on the website to use as a self-service training module.

Trainings include topics on Health First Colorado (Medicaid) Eligibility and Application Process; Health First Colorado Covered Benefits for State Plan and RAE responsibility; Access to Care Standards; EPSDT; the RAEs Population Management Strategy; Cultural Responsiveness; Member Rights; Grievances and Appeals; Quality Improvement Initiatives; mental health and substance use disorder (SUD) documentation standards, including those to address Population Management; Principles of Recovery and Psychiatric Rehabilitation; and Trauma-Informed Care. To include the use and proper submission of the Colorado Client Assessment Record (CCAR) for members or the current Colorado Office of Behavioral Health's data collection tool for mental health and SUD which have been on hold pending the launch of the new program, COMPASS. Other training or education content areas available include Care Coordination; Suicide Prevention; Condition Management; and Collaboration with Specialty Providers. Technology training has centered around the State's Data Analytics Portal (DAP) and ProviderConnect, the proprietary Beacon web portal for behavioral health utilization management and billing system. Previously, HCI's Provider Support calls had included both PCMPs as well as behavioral health providers.

In late 2019, HCI made the decision to host two separate provider support calls to ensure topics covered remain relevant to all attendees. Because of this change, we have seen an average of ten (10%) percent increase in attendance and plan to continue this format with the goal of increasing another ten (10%) percent. Behavioral health provider support calls are held at noon the second Friday of each month and provider support calls for PCMP network are held at noon the last Friday of each month.

Individualized Provider Training – Individualized education and additional training will be available based on the practice's request or identified need to aide their efforts to improve operations, health outcomes, and/or member experience. The primary point of contact, which may be either Primary Care Provider Quality Managers (PQM) for higher volume PCMP practices or HCI staff for smaller PCMP practices. HCI will coordinate on-site or virtual meetings to deliver the training with the practice. HCI is responsible for credentialing and reimbursement of behavioral health services, most requests for training have been for independent behavioral health providers and Community Mental Health Centers

(CMHCs). The implementation of APM has increased demand for individual training within our PCMP network.

Learning Collaboratives – In the upcoming year, HCI is implementing quarterly Learning Collaboratives for PCMP providers that will focus on the use and value of different quality improvement (QI) tools when applied to implementing or improving on Condition Management strategies as well as APM metrics. The Learning Collaboratives format will provide an active, social, contextual, and engaging forum to share lessons learned and best practices. We plan to start learning collaboratives in the second quarter of FY2021.

Provider Online Services - Through HCI's website, providers have an online, self-service application that contains training and other resources to access based on need, which is available on the HCI website. The website serves as an archive of previous trainings for reference and education. Additionally, HCI releases the annual Policy and Procedure Manual for Providers (Provider Manual) to inform them on Health First Colorado benefits, eligibility and application process, Grievance and Appeals, Liability of Payment, Practice Guidelines, Authorization Procedures, and Documentation Requirements. This information is also shared with providers through the provider support calls and provider alerts. As a result of provider feedback, HCI will create a provider manual specific for PCMPs and a separate manual for behavioral health providers, both of which will be available on the Provider section of the HCI website. The Provider Manual dedicated to PCMPs will focus on contractual requirements as well as HCPF's Data Analytics Portal (DAP), Key Performance Indicators (KPI), care coordination resources, and the range of administrative, data, and technology services to support practice transformation.

Provider Newsletter- HCI is developing a bi-monthly provider newsletter distributed via email to providers that will deliver relevant information on events, training, and tips on billing. We will utilize the reporting capability within Constant Contact to evaluate the success of content and distribution.

Practice Transformation

HCI recognizes that practices have competing priorities in addition to caring for their patients. Providers, practice managers, and support staff must balance care for empaneled patients, multiple payer requirements, population health data, staffing changes, quality outcome reporting, transitioning to value-based payment as well as technology and system interoperability. Value-based clinical and business models can enhance care coordination and increase provider accountability outcomes.[1] The structure and tools taught through Practice Transformation helps providers align current initiatives and simplify the process making success more attainable.

The HCI Practice Transformation philosophy is to engage with practices and utilize quality improvement tools to support them in achieving practice goals and regional priorities. Specific attention and action in the program offerings focus on Quadruple Aim enhancing patient experience, improving population health, reducing costs to optimize health system performance, and improving the health care provider's experience.[2]

HCI believes that practice improvement plans should leverage existing State and regional initiatives. This will guarantee that practice transformation efforts will help practices achieve what is most important to patient care and is tied to the current payment structure. Quality improvement activities will be focused

around the following: APMs, KPIs, Innovation Support Project (ISP), Models for Improvement, Chronic Disease Prevention, and use of evidence-based guidelines for condition management and the advancement of telehealth services.

Practice Transformation Coaches, also referred to as Provider Quality Managers (PQMs), establish sustained relationships with practices while teaching continuous quality improvement processes. PQMs can tailor support to address the unique needs of a particular practice based on its patient population, geography, practice goals, and health care context. Amid payment reform and logistic changes brought by COVID-19, facilitators can help practices coordinate and prioritize these activities. They include, but are not limited to, the following:

- Utilized as a single point of contact to support practices with optimizing practice workflows and systems.
- Ongoing support and coaching for quality improvement (QI) activities utilizing standard QI tools and develop the infrastructure and processes that lead to improved health outcomes.
- Assessment of and feedback to practices regarding organizational, clinical, and business functions to drive change
- Development and facilitation of practice QI teams
- Utilize practice assessments to identify opportunities within practices to be included in the annual quality improvement plan.
- Assist practices with improving performance related to Alternative Payment Model (APM) measure selection goals.
- Provide individualized support to practices to improve access to care, patient satisfaction, and behavioral health integration.
- Explore opportunities to include specialty care and behavioral health providers into the Practice Transformation strategy in the upcoming year.
- Teach practices how to utilize available data that support population health plan efforts and risk stratification of patients who are high risk.
- Work with practices to understand individual clinical pathways for condition management to develop standards of care successful in our region.

<u>Alternative Payment Model (APM) Support for Practices</u>
The Alternative Payment Model (APM) provides us with the opportunity to deepen our relationships with PCMPs and encourage the adoption of Practice Transformation principles. In regard to the 2019 APM measures, HCI had 30 practices with APM eligibility. During the reporting process, HCI conducted 28 virtual meetings with providers to support them in 2019 APM reporting. As a result, we successfully assisted in the eCQM reporting for 17 practices (8 requested an exemption), claims measure reporting for 24 practices (6 requested an exemption), and structural measure reporting for 25 practices (5 requested an exemption). As of September 2020, HCI is currently working with practices on support with the option to change to their 2020 APM measure sections.

HCI's Practice Transformation strategy with practices is modeled after the principles of the Patient Centered Medical Home (PCMH) model and includes working with practices on the following categories of practice improvement that all work together to drive efficiencies and eliminate waste:

- Team based care and practice organization

- Knowing and managing your patients
- Patient centered access and continuity
- Care management and support
- Care coordination and care transitions
- Performance measurement and quality improvement

Overall APM activities include:

- PQMs working with the 40 primary care practices that qualify for 2020 APM to support them in measure selection, tracking, and reporting.
- Practice readiness assessments to understand the competency for each practice in having defined and operationalized procedures that align with the structural measures.
- Education and support by PQMs on best practices and QI strategies for improving APM performance.
- The strategies employed to support each practice will depend on the APM measures selected, including engaging CORHIO for eCQM measures and periodic review of claims data.
- The APM structural measures are at the core of quality improvement strategies and support identified by practices.

The Quality Improvement tools utilized by HCI are primarily based on the LEAN model. The chart below is an example of different types of LEAN tools and how they can be applied:

Lean Tools	Summary
Bottleneck Analysis	Structured way of looking at workflows
Just-in-Time (JIT)	On-demand system of production
Value Stream Mapping	Analyzing and optimizing a process
Overall Equipment Effectiveness (OEE)	Measure of productive time
Plan-Do-Check-Act (PDCA)	Method to manage change
Error Proofing	Analysis tool based on prevention
Root Cause Analysis (RCA)	Method to get the foundation of an issue

Practice Transformation for Small Practices – We see higher engagement with practices that serve a high volume of Health First Colorado Members, for that reason PQMs prioritize outreach to APM participating PCMPs. HCI will leverage provider support calls to share information about practice transformation activities to include opportunities to connect with local and State resources, and other similar practices to learn how to maximize the DAP, educate on how to review their KPIs, capitalize on their care coordination entity's resources, and the range of administrative, data, and technology services supports. As small practices across the region have varying needs, HCI will use individualized provider training to deliver education and practice supports as part of the overall provider support plan for the region. Facilitation is necessary when introducing new tools that enable small practices to expand their capabilities. Through these efforts, HCI can assist in a robust set of patient-informed recommendations

to reflect the interplay between polypharmacy, social determinants of health, and chronic physical and behavioral health conditions to reduce emergency department visits and hospitalizations. [3]

Evolution of Our Approach to Practice Support CFY20-21
HCI consistently looks for opportunities to improve our customer service to our providers and build on lessons learned to ensure that we are evolving to meet the changing needs of our network of providers.

This past year, HCI had the opportunity to add staff and prioritized candidates with primary care experience. Adding this expertise has allowed us to deepen our understanding of clinic operations and build on the existing provider relationships of our new team members.

At the beginning of FY2020, HCI assessed the needs for the Network Assessment and Action Communication (NAAC) tool and update its specification for development. Through this process, it was evident that there was a gap in the management of PCP data. HCI required a system to maintain provider data to accurately track the practices and its rendering practitioners in order to understand its provider network and accurately report on it for purposes of network adequacy, attribution, and finance. As a result of this internal assessment, HCI refocused its first phase of the development to develop an online system to collect, store, and manage the provider data. Provider Data Management (PDM) system was launched in March 2020 and underwent modifications to meet the changes of the Network Adequacy Report requirements which were completed in July 2020. HCI is developing specifications and a timeline for phase two of the system for enhancements to be more functional and streamlined. HCI leveraged existing systems to track provider visits and progress in achieving the practice transformation plan. HCI is evaluating the effectiveness of these systems to determine if they are having full capabilities for practice transformation activities and continue to use these systems instead of proceeding with NAAC tool development.

Population Management Plan
All PCMP practices will be offered training regarding the Population Management Framework defined by HCPF as the paradigm for treating members via whole-person care and the Population Management Strategic Plan guiding implementation by HCI. Practices will be identified based on the volume of HCI members served with the top 10 practices receiving training in the coming year. Training will be conducted through provider forums and through printed materials accessible via HCI's website. Training specifically requested by providers will be offered on an as-needed basis.

In 2020, HCPF replaced their earlier focus with what is now described as the Population Management Framework. This focus on the individual as defined within the three tiers of Complex, Condition Management, and Wellness and Prevention allowed increased opportunity to focus more specifically on member needs. Members identified as experiencing emerging risk as a result of their health condition will receive outreach and available supports to prevent negative health outcomes. HCI will utilize texting campaigns, and "robo calls" to attempt outreach to every member. Guidance regarding access to member handbook, accessing a PCMP and local resources, and improving one's own health will be provided to each member.

The Population Management Strategic Plan involves the engagement of members and providers in supporting improved member health. HCI will continue our analysis of data received from HCPF to determine members most in need of immediate care and intervention, as well as those requiring

support for chronic conditions. Secondly, HCI will continue to refine our identification of programs and practices available within the region to address chronic conditions and to provide member support to manage those conditions. Evidence-based intervention for treating diabetes and supporting pregnant members will be made available regardless of the location of the member within the region. Finally, HCI will create opportunities for members to gain access to information and opportunities that support their health outcomes and engage them in improving their health literacy and knowledge of resources essential to their own wellbeing.

Administrative Payment Strategies

HCI is modifying PCMP contracts for the Fiscal Year Ending 2021 to be more reflective of the current initiatives as well the complexity of Members served. Our new contracts will provide standardized per member per month (PMPM) to all PCMP and will also provide an opportunity for practices to earn additional incentives that are based on performance.

- All in-network providers will be eligible to receive additional funding for contributing to the successful regional achievement of State defined KPIs, Performance Pool, and Behavioral Health Incentives in our region.
- Accountable PCMP contracts will have the added responsibility of providing comprehensive care coordination to Health First Colorado recipients and be eligible for a tiered reimbursement based on documentation of successful engagement of complex members in care coordination. HCI will use new accountable contracts to incentivize the adoption of Health Colorado's care coordination tool.
- Provider contracts will leverage standardized protocols to support the implementation and demonstration of use for evidence-based guidelines as well as referrals within the Health Neighborhood to support the management of our most prevalent conditions.

References

1. Kissam, S. M., Beil, H., Cousart, C., Greenwald, l. M., & Lloyd, J. T. (2019). States Encouraging Value-Based Payment: Lessons from CMS's State Innovation Models Initiative. Milbank Quarterly, 97(2), 506–542.
2. Bodenheimer T, Sinsky C. (2014). From Triple to Quadruple Aim: care of the patient requires care of the provider. Ann Fam Med. 2014; 12:573-576.
3. Phillips Jr, R. L., Cohen, D. J., Kaufman, A., Dickinson, W. P., Cykert, S., & Phillips, R. L., Jr. (2019). Facilitating Practice Transformation in Frontline Health Care. Annals of Family Medicine, 17, S2–S5.