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

RAE Name	**Health Colorado Inc. (HCI)**
RAE Region #	**4**
Reporting Period	FY22-23 07/01/2022-06/30/2023
Date Submitted	**06/06/2023**
Contact	**Lori Roberts, CEO**

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 3.10.2 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.

Practice Support:

Achievements/Successes:

Health Colorado Inc. (HCI), Regional Accountable Entity (RAE) 4, supports and encourages provider practices through the Whole-Person Framework. All practice support activities (including Practice Transformation) falls under our Population Health Strategic Plan. In SFY23-24, we have created a "control plan" which will be used to measure the effectiveness of our interventions to guide any programmatic changes needed.

HCI continues to use a communication application to encourage an open communication avenue for providers to engage and receive information. HCI utilizes a provider inquiry system to log all provider communications within RAE 4. Providers can outreach HCI and inquire about provider file demographics updates, claims, credentialing, and contracting. In addition, providers can request a meeting by virtual or phone call methods to work through any issues or concerns. Every communication between the provider and HCI is entered into the Carelon communication application. Provider inquiries can range from simple to complex matters of concern. Provider Relations responds to a provider inquiry within 48 hours or two business days. HCI continues to resolve provider issues and concerns in a timely manner or within 30 days for more complex issues. HCI recognizes that some complex provider issues may require longer than 30 days to achieve resolution. Provider inquiries are tracked and analyzed monthly by HCI.

HCI also offers practice support through webinars and monthly newsletters. These communication avenues contain valuable information to assist providers in the Whole-Person approach. Information provided includes Colorado Department of Health Care Policy and Financing (HCPF) announcements, HCPF programs and resources, and HCI educational articles and community events.

Trainings for HCI providers are highly encouraged by HCI. Throughout the year, HCI presented 16 unique provider live webinar training topics including credentialing, billing and coding, practice transformation (PT), quality improvement (QI), clinical practice guidelines, and the substance use disorder (SUD) expanded benefit. HCI completed 10 provider live webinar trainings, which focused on HCPF specific topics. HCI records webinar attendance and has an average of 28 participants per month. After provider training live webinars, HCI asks participants how satisfied they were with the webinar. Webinar participants have responded that they were satisfied or very satisfied with the provider training topics and presentations.

HCI provider newsletters contain HCPF announcements, HCPF programs and resources, and HCI educational articles and community events in addition to contact information and the monthly webinar training schedule. The average read rate percentage for HCI newsletters in FY23 was 29%.

In addition, HCI provided data and technology support for providers. Providers have the option to use the Data Analytics portal to help guide Whole-Person care. The Health First Colorado Data Analytics portal can data mine for provider level comparisons of Key Performance Indicators (KPIs) and Healthcare Effectiveness Data Information Set (HEDIS). The portal can also analysis patient utilization, cost and pharmacy information displayed through dashboard. HCI promotes the use of the member summary tool to better assist providers with the Whole-Person care strategy. HCI trained providers on the Data Analytics portal through a live webinar this FY23 and posted the webinar on the HCI website for future provider reference.

HCI encourages the use of telemedicine appointments performed by providers. The ability for a provider to use telehealth improves the timeliness of appointments to see a Health First Colorado from any location. This allows for members to receive care while the member is unable to go to the provider office or facility. HCI will continue to encourage and train providers on how to be HIPAA compliant when utilizing telemedicine technology. HCI promoted telehealth capabilities in FY23 HCI newsletter.

Challenges:

Challenges in our region continue to be the high demand for specialty care across our region and the state, long wait times for appointment openings, and extended travel times for members. HCI continues to provide feedback to assist in developing the eConsult strategy for our members.

Plans for Change in Strategy:

HCI 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, HCI will look to present more on community resources available to providers within Region 4. Furthermore, HCI 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 during one-on-one calls with providers. In addition, providers can continue to contact HCI for any issues they are experiencing.

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. HCI's PT program consists of two parts: 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, 79% of PCMP practices in the network were engaged in the HCI PT program (defined as practices that participated in the incentive program and met at least one milestone to date). For SFY23, the following practices have been engaged in the PCMP PT Incentive Program:

327 MEDICAL PROF CORP
ADULT MEDICINE SPECIALISTS
AFFORDABLE HEALTH CLINIC, LLC
ARKANSAS VALLEY FAMILY PRACTICE
BUTTON FAMILY PRACTICE, PC
CARE FOR THE FAMILY
CASTILLO PRIMARY CARE
CATHOLIC HEALTH INITIATIVES CO
CHAMPIONS FAMILY MEDICAL, PLLC
CHILDREN'S CLINIC OF PUEBLO
CHRIS TRUJILLO, INC
COLORADO COALITION FOR THE HOM
COMFORT CARE FAMILY PRACTICE/QWIKCAREMD
FAMILY CARE SPECIALISTS, INC
FLORENCE MEDICAL CENTER, LLC
HEALTH SOLUTIONS MED CENTER
HIGH PLAINS COMMUNITY HEALTH
HUERFANO CTY HOSPITAL DISTRICT
JANDYCO LLC
KIOWA COUNTY HOSPITAL DISTRICT
MARC A SINDLER MD
MICHAEL T RENDLER PC
PARKVIEW ANCILLAR SERVICES
PLAN DE SALUD DEL VALLE, INC.
PLANNED PARENTHOOD SALIDA
PROWERS MEDICAL CENTER
PUEBLO COMMUNITY HEALTH CENTER
RICHARD RIVERA MDPC PUEBLO
RIO GRANDE HOSPITAL
ROCKY FORD FAMILY HLTH CTR LLC
ROCKY MOUNTAIN PRIMARY CARE CL
RYON MEDICAL
SALIDA HOSPITAL DISTRICT
SAN LUIS VALLEY HEALTH

SMALL WORLD PEDIATRICS
SOCO PRIMARY CARE CLINIC
SOLVISTA HEALTH CORP
SOUTHEAST COLORADO HOSPITAL
SOUTHEAST WELLNESS WORKS
SOUTHERN COLORADO CLINIC
ST. VINCENT GENERAL HOSPITAL
Steel City Pediatrics
STEPPING STONES PEDIATRICS
SUMMIT PRIMARY CARE
TED J PULS MD PC
TRINIDAD AREA HEALTH ASSN
UNIVERSITY FAMILY MED CENTER
VALLEY WIDE HEALTH SYSTEMS INC
VAUGHN D. JACKSON PLLC
WALSH MEDICAL CLINIC

For FY23, nine independent practices are enrolled in the BH PT program. Two Community Mental Health Centers (CMHC) meet with their PT Coach quarterly to discuss Behavioral Health Incentive Plan (BHIP) SUD engagement performance. These CMHCs are Health Solutions and San Luis Valley Behavioral Health Group (SLVBHG). The participating IPN practices are:

A New Leaf Therapy
Advantage Treatment Services
Compass Rose Counseling
Gateway to Success
RESADA
Rocky Mountain Behavioral Health
Servicio De La Raza
SolVista
State of Grace

HCI entered FY22-23 with the following goals:

- Practices achieve 70% of milestones.
    - PCMP incentive program: as of May 22, 2023, 75% 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: as of May 22, 2023, 69% 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.
- Establish a BH PT program.
    - BH PT went live on July 1, 2022.
- Align PT milestones to Key Performance Indicators (KPI) and BHIP measures.
    - See 2023 PT Performance Measure Focus section below
- Integrate Prescriber Tool implementation into PT.
    - 83% of all PCMPs have completed the Prescriber Tool Attestation.
    - 53% 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 those that are on paper charts.
    - As of May 22, 2023, 22% of Prescriber Tool funds have been earned. The incentive program ends June 30, 2023, and we expect practices to continue to make progress on the milestones.

<u>Practice Transformation Competency Assessment YoY results</u>
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 are generally completed from July through August each year (2023 assessments have not been conducted as of yet). This is a change from the previous year where they were completed between March and June each year. We found that FYQ4 was really focused on helping practices wrap up their final work on the incentive program and FYQ1 was a better time to focus on the annual assessment. For FY24, we are going back to incentivizing the assessment and improvement plans.

For PCMP assessments, all of the competencies increased across the network and the overall score increased from 2.9 in 2021 to 3.4 in 2022. The largest improvements were in Data Driven QI, Focus on SUD, and Inclusivity and Equity.

Assessment Sections	2021 HCI Assessment	2022 HCI Assessment	% increase
1. Leadership	2.8	3.2	15%
2. Data Driven QI	2.7	3.5	30%
3. Empanelment	3.1	3.6	18%
4. Team Based Care	2.9	3.5	20%
5. Patient and Family Engagement	2.4	2.9	18%
6. Population Management	3.1	3.4	13%
7. Continuity of Care	3.6	3.7	3%
8. Access	3.2	3.6	13%
9. Comprehensiveness and Care Coordination	2.9	3.3	13%
10. Value-Based Contracting	2.9	3.2	11%
11. Focus on Addressing Social Needs of Patients	2.7	3.2	19%
12. Focus on SUD	2.5	3.3	28%
13. Focus on Telehealth	3.5	3.8	8%
14. Inclusivity & Equity	2.6	3.3	25%
Overall Average Score (out of 4)	**2.9**	**3.4**	**17%**

BH Practice assessments were completed in the fall of 2022. The information from the assessment 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. Nine independent practices and two CMHCs completed the assessment.

Assessment Sections	2022 BH PT Assessment RAE4

1. Leadership	2.6
2. Data Driven QI	2.3
3. Team Based Care	2.8
4. Patient and Family Engagement	2.5
5. Population Management	2.9
6. Access	2.7
7. Comprehensiveness and Care Coordination	2.3
8. Value-Based Contracting	2.4
9. Focus on Addressing Social Needs of Patients	3.0
10. Focus on Substance Use Disorder	3.3
11. Focus on Telehealth	3.8
12. Inclusivity & Equity	2.6
Overall Average Score (out of 4)	**2.7**

Outcomes from the FY23 PCMP PT Incentive Program

HCI created a PT incentive that aligns with the new Alternative Payment Models (APM) and focuses on primary care access and preventative care. HCI 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 practice was $9,500. Below is the detailed structure of the FY23 PCMP PT incentive program. Outcomes will be calculated after the program ends on June 30, 2023.

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%

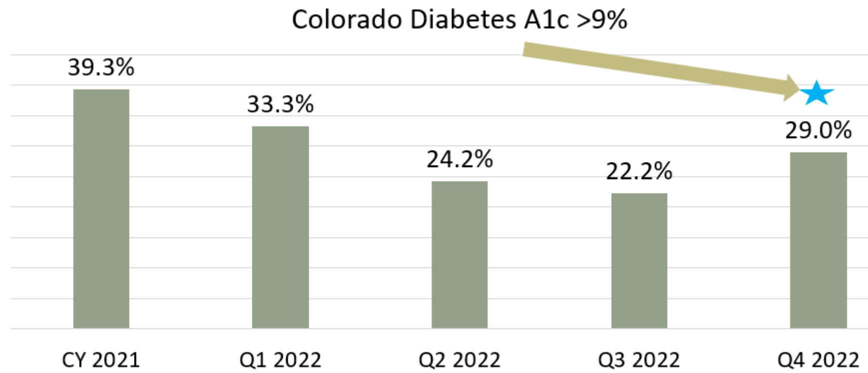
2. Population Management	A. Wellness Registry/Report	1. Utilize a registry/reports to identify patient-level gaps in care including:
		a. Well Visits
		AND
		b. At least one other care gap from the Milestone 1.B Measure selected.
		2. Using a PDSA process, create a workflow to outreach identified patients 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 30 practices that actively worked on the KPI measure "Child and Adolescent Well-Care Visits ages 3-21", 22 of the 30 practices saw an improvement over the course of calendar year 2022. We were able to improve this measure from 28.9% in CY2021 to 35.6% in CY2022 for an overall improvement of 6.7%.

2022 Diabetes Data Outcomes Based on PCMP PT efforts

HCI'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, during which 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%. In CY2022, HCI was able improve this measure from 39.3% in CY2021 to 29.0% in CY2022. Since the diabetes workgroup includes practices from RAE4 and RAE2, this data includes practices from both regions.



★ Diabetes A1c improved from 39.3% in 2021 to 29.0% in 2022

Diabetes Program Success Story Example

PT Coaches worked with Valley-Wide Health, which has multiple clinics across 10 counties in the HCI RAE. The Federally Qualified Health Center (FQHC) APM program and the Diabetes A1C poor control goal for 2022 was 30% or lower, and the PT goal was 19% or lower. For the Cesar Chavez Clinic, the CY2021 baseline was 27%. After working with their PT Coach, they were able to decrease this measure to 10.4% for CY2022. The focus of the work included the provider calling patients to discuss their medications, dietary habits, exercise, and making amendments to their treatment plan as needed.

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 was $7,000. Below is the detailed structure of the FY23 BH PT Incentive Program and the expected outcomes.

Behavioral Health Transformation Incentive Program Structure (FY23)

Milestone	Requirement(s)
BH Practice Transformation 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 & 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

Challenges:

The PT Teams spends more than 1,600 hours per year performing data entry including meeting tracking, APM progress tracking, incentive program tracking, KPI progress tracking, and tracking for other programs and initiatives in multiple

different spreadsheets and computer programs. HCI requires an efficient tracking system to streamline processes and capture information in one place, reducing redundancies and increasing access to outcome data.

Measure Management Challenges

- Align APM and RAE performance measures (KPIs and BHIPs) so that providers do not end up with an unmanageable number of measures and/or goals.
- Determine a maximum threshold of measures for PCMPs across all of the initiatives and programs.
- Timely data: update DAP data in real time to allow practices to make changes based on real-time member level data.
- Focus performance on "active members" to provide a more accurate view of how the practices are actually doing on a measure.
- BHIP SUD Engagement: BH practices that are prescribing Buprenorphine and Naltrexone (as opposed to Methadone) are billing J0571-J0575 & J2315 under the medical side, which are not part of the numerator for SUD engagement. We strongly suggest adding these codes.

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 4, increasing PT engagement, and improving coordination of care capacity.

Healthcare Transformation Software

- Use a portion of the PT Incentive Fund to purchase and maintain a user-friendly and connected Healthcare Transformation system to monitor support efforts and communicate outcomes across stakeholders and programs.

PT Pilot Funding

In addition to the PT milestone incentive program, HCI plans to support ongoing pilot opportunities. $100,000 is intended to act as a reserve for projects that the PT team may want to implement throughout the year.

The ARPA Home and Community Based Services (HCBS) Chronic Pain Project is under contract to provide peer-to-peer consultations. HCI will instruct PCMPs to contact the team for support if they are in need of immediate assistance with a pain patient.

Provider Communications:

Achievements/Successes:

Provider Communications are to ensure network providers are informed, educated, and trained to help serve members and address all their healthcare needs. HCI recognizes that network providers are vital to the Whole-Person healthcare care delivery for Health First Colorado Members. Carelon Behavioral Health, on behalf of HCI, focuses on communication for HCI providers to assist with information, education, and training.

In addition to provider communications, HCI invites other stakeholders in the broader Health Neighborhood to share information and collaborate on ways to support members' health and wellness needs. HCI continues to host the following meetings.

- Health Neighborhood Forum
- Regional Program Improvement Advisory Committee (PIAC) meetings
- Practice Transformation Monthly Practice Meetings
- Quarterly Learning Collaboratives
- QIUM Committee meetings
- Provider Webinars
- RAE 4 All Hospital Huddle (HTP)

BH network and primary care providers were invited to attend monthly live webinars. Each month HCI presented HCPF programs that include contractually obligated topics as well as provider requested topics to assist providers with success in their healthcare delivery. BH and primary care provider webinars are virtual events that anyone can attend either by video or by telephone from any location. Through interactive polling during the live webinars, the Provider Relations Department gauged providers' knowledge and satisfaction around the BH roundtable topics and found that providers were mostly satisfied with presented topics. The Provider Relations Department tracked webinar attendance and any concerns were addressed with the provider after the meeting.

HCI produces a monthly provider communication newsletter. The Provider Relations Department sent the newsletters electronically via email to both BH providers and PCMPs. These newsletters highlighted important HCPF announcements, upcoming webinars, previous webinar topics, and new programs and/or resources specific to providers. Every newsletter is posted to the HCI Website.
HCI used provider alert emails to share information that needed to be disseminated to providers in an urgent manner.

HCI hosts a website for network providers that houses various resources on the following topics:

- How to Join Our Network
- Newly Contracted Provider
- Forms and Templates
- Billing and Coding
- 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
- Contact Information for RAE 4, Customer Service, Care Coordination, Clinical, and Claims Departments

HCI offered additional provider trainings facilitated by Carelon and provider experts to educate, inform, and discuss a range of topics related to best practices and HCI policies. Providers had the opportunity to attend some recurring monthly webinars that included Managed Care 101, Provider Connect Overview, and Claims Submission Guidelines. Further, HCI offered exclusive trainings to include Credentialing/Re-credentialing overview.

HCI requests that providers contact us when they experience any issues or concerns. HCI's contracted network providers can contact the national Carelon Behavioral Health Customer Service telephone line or email to receive information about contracts, credentialing, authorizations, claims payments or denials, update their provider profile, or file a complaint. Contact information is located in the Contact Us section on the HCI website as well as in the HCI Provider Handbook. This Customer Service line is answered by trained professionals and is open from 8 a.m. to 6 p.m. Eastern Time.

Challenges:

HCI is dedicated to a provider 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. HCI will continue to outreach and encourage providers to update their contact information to improve participation in webinars, newsletters, and provider alerts. Every communication piece is vital to the Whole-Person healthcare delivery for Health First Colorado members. Providers have expressed challenges with many organizations and state entities sending multiple communications. HCI is

working to streamline communication materials to lessen the communication overload burden by mirroring state communications and information.

Plans for Change in Strategy:

The communication plan will continue to deliver resources and tools to network providers to help serve members and address all their healthcare needs. HCI engages and will continue to support, inform, educate, and train providers to assist in Whole-Person healthcare care delivery for Health First Colorado Members. HCI intends to maintain our successful strategies of monthly provider training live webinars, provider alerts, monthly newsletters, and website information during the next reporting period. HCI will continue to adapt to the ever-changing needs of our members by enhancing these mechanisms to reach our stakeholders, provider networks, and members.