Quality Improvement Plan
Name: Colorado Community Health Alliance (CCHA)
RAE: Region 7
Date: September 30, 2020

1. Purpose/Mission Statement

Please describe your Organization's overall purpose/mission statement. Note: Only update this when applicable, when there are no updates, just copy and paste from a previous submission.

CCHA's Mission Statement:
Colorado Community Health Alliance's overall goal is to support a coordinated, patient-centered model of care to better serve the needs of Health First Colorado members, improve health and life outcomes and optimize resources in an effort to avoid duplication of services and reduce the cost of care.

2. Quality Program Leadership

Please list the individuals who are in your quality program. Please include their contact information. Note: Only update this when applicable, when there are no updates, just copy and paste from a previous submission.

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3. Year Objectives/Top Priorities including a description of the techniques to improve performance, a description of the qualitative and quantitative impact the techniques had on quality and opportunities for improvement identified as well as newly identified opportunities for improvement

Accountable Care Collaborative (ACC) Performance Measures

CCHA is committed to improving the health outcomes of our most vulnerable populations. Our goal is to monitor and ensure the delivery of consistent, reliable, and integrated Physical Health (PH) and Behavioral Health (BH) services to members so we can collectively achieve the Quadruple Aim goals that focus on population health, patient experience, per capita costs, and provider satisfaction. To achieve this, we are using the Key Performance Indicators (KPIs), the Behavioral Health Incentive Program, and performance pool metrics as our measure of success. Below are descriptions of activities we are working on:

***Key Performance Indicators*:**

- Continue sharing internal reports to track interventions, show performance by region and provider including updating baseline information when available.
- Identify areas of opportunity regarding health disparities (e.g. gender, race, and geographic area).
- Utilize practice transformation coaches to engage and educate Primary Care Medical Providers (PCMPs) on the ACC measures and goals.
- Work with practices to improve practice operations, including process improvement, KPI workflows and planning, proper billing and coding, member access, electronic health record assistance, systems training, data and analytics, and transition to member-centered care.
- Distribute KPI incentive dollars to providers through the CCHA Provider Incentive Program and to community partners though the CCHA Community Incentive Program.
- Strategically identify community and health neighborhood partners who best support and align with the goals of the ACC and/or serve members in high risk populations.
- Support providers with resources through the COVID-19 pandemic.
- Support providers with providing telehealth visits and navigating changes in telehealth policies.
- Continue sharing Admission, Discharge, and Transfer (ADT) data with Single Entry Points (SEPs) and Community Centered Boards (CCBs).
- Engage specialists in the ACC and provide education on adding the referring provider's NPI to encounters.
- Utilize feedback from the Member Advisory Committee (MAC) and Performance Improvement Advisory Committee (PIAC) to inform interventions and identify inefficiencies.
- Develop a per-member-per-month (PMPM) payment methodology that incents outcomes and programming.
- Work with the Department of Health Care Policy and Financing (HCPF) to address KPI changes for State Fiscal Year 2021-2022 (SFY21).

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***Behavioral Health Incentive Measures*:**

- Partner with Community Mental Health Centers (CMHCs) and key providers to identify creative solutions that address gaps in care for the BH incentive performance measures through provider level BH data dashboards and establishment of a network transformation platform, which is utilizing data to drive quality focused transformation meetings.
- Partner with key stakeholders to better support members with Substance Use Disorder (SUD) that are being discharged from the Emergency Department (ED).
- Provide educational materials and complete virtual meet & greets with high volume EDs to educate providers on the importance of timely follow-up.
- Improve social determinants of health (SDOH) data capture on our Region 7 members.
- Increase rate of foster care members receiving BH assessment within 30 days by partnering with county Department of Human Services (DHS).

***Performance Pool*:**

- Develop interventions and strategies to address metrics.
- Develop Performance Pool dashboards to share with providers.
- Engage and support individual providers, including CCHA's Accountable Care Network in the implementation of interventions.
- Work with community partners, other state agencies and RAEs to develop workflows related to behavioral health engagement for members released from the Department of Corrections.
- Continue to refine outreach methodology to engage identified members.
- Identify and create educational materials for members related to their medications.
- Evaluate the effectiveness of the interventions and identify opportunities for improvement.

HCPF Priority Programs:

- **Diabetes:**
    - Continue to identify high-risk members and outreach to engage with CCHA's care coordination team.
    - Collaborate with providers on members with diabetes to create shared care plans and incent providers to develop programming that aligns with evidence-based program components.
    - Continue to refine interventions to achieve intended health outcomes.
    - Continue to identify community partners and resources to support members and providers manage diabetes.
    - Educate providers and community partners on our services and referral process.
- **Maternity:**
    - In accordance with EPSDT contract requirements, outreach all pregnant women and screen for risks or unmet needs.
    - Continue to refine data to identify women at risk for complex delivery to engage with CCHA's care coordination team.
    - Continue to refine interventions for prenatal women, post-partum women, and newborns to achieve intended health outcomes.
    - Identify community partners and resources.

    - Incent providers to develop programming that aligns with evidence-based program components.
    - Educate providers and community partners on our services and referral process.
- **Complex Care:**
    - Continue to outreach members with complex healthcare needs and provide support through CCHA's care coordination team or provide appropriate referrals for their needs.
    - Collaborate with community partners to identify ways to better care for members with complex health needs.
    - Engage and support individual providers, including the Accountable Care Network, in the implementation of interventions for these members.
- **Special Health Care Needs**
    - Collaborate with HCPF, DOC, and other RAEs to develop workflows to best address the justice-involved population.
    - Develop programs for members with diabetes, maternity, and complex members.
    - Collaborate with SEPs and CCBs to share ADT data for members who are on a Home and Community Based (HCBS) waiver and meet monthly to review cases on shared members.

Patient Safety and Quality:

CCHA's patient safety goals aim to promote safe clinical practices in all aspects of clinical care and service; to engage members and providers concerning patient safety in all aspects of patient interaction; and to identify and implement system and process improvements that promote patient safety and high quality care throughout the health plan and care delivery system. To achieve this CCHA has operationalized the following:

Quality Management Committee (QMC)*:*
Provides program direction and oversight to make sure CCHA operates as one combined entity that integrates clinical care, operations, management, and data systems. The QMC is the forum for interdepartmental participation and works to establish the long-term strategic vision for the Quality Management (QM) Program. This committee will evaluate the annual QI Program's overall effectiveness in the following areas:

- Member Satisfaction: Establish a process to measure and monitor member satisfaction
- Monitor program performance using the following tools:
    - KPI and BH incentive measures
    - PIP activity and results
    - HSAG annual site audit results
    - Provider performance, including CCHA's Accountable Care Network
    - Grievances
    - Quality of Care Concerns
    - CCHA administrative and service performance

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Member Grievances:
CCHA has a process in place to support member grievances and/or complaints for any matter relating to our contract including a process to trend and track information, which is used to improve patient safety and quality, drive program improvement activities, modification, and development. CCHA's goals are:

- 90% timeframe compliance within initial 15 business day review period
- 100% timeframe compliance within extended 14 calendar day review period
- 100% of clinical grievances will be investigated by clinical staff

Quality of Care (QOC) Concerns:
CCHA has created a QOC process, which encourages timely and accurate submissions from our provider network and internal care management staff. In conjunction with CCHA's Medical Director, a severity level is assigned for each QOCC and an investigation that supports the severity level is completed on all cases. All QOCCs are tracked, trended, and reported to our QMC, which is then used to promote patient safety and quality, and inform credentialing processes, network training and program improvement activities. CCHA's goals are:

- Annual training of internal CCHA staff to identify QOC concerns. 80% of member facing staff will receive QOC training.
- Investigate, analyze, track, and trend QOC issues—Identify trends and opportunities for program development and improvement in clinical care.
- Facilitate network provider meetings to discuss QOC trends and systemic opportunities for improvement.

Performance Improvement Projects (PIPs):
CCHA will use data to develop and implement strategies to address depression screenings and follow up after a positive depression screening.

Please fill out the following template for all projects that are associated with the programs listed in the gray boxes.

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Performance Improvement Projects			
Successfully complete modules one and two for the Depression Screening and Follow-Up after Positive Depression Screen PIP.	Use data and collaborate with partners to design, implement and refine interventions as needed.	June 30, 2021	Establish partnerships for successful attainment of SFY21 PIP targets. Use data to create a Smart AIM goal, identify potential partners, and detect opportunities for improvement. Submit all modules by the determined due dates.
Performance Measurement Data Driven Projects			
Key Performance Indicators: Work with HCPF to determine SFY21 KPI changes.	Collaborate with PCMPs and run data to provide meaningful feedback to HCPF.	June 30, 2021	Run data. Collect provider feedback. Train PCMPs on any changes and update KPI education materials.
Key Performance Indicators: Achieve Tier 1 goal for four of the seven KPIs.	Engage with PCMPs and ACN providers in quality improvement processes. Partner with community organizations to align efforts and processes to achieve KPI goals.	June 30, 2021	Leverage the Provider Incentive Program to increase engagement of PCMPs in practice transformation efforts to improve PCMP KPI performance. Share actionable data with practices and use this to create best practices. Utilize care coordination to educate members and connect them with appropriate services.

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			Incorporate feedback from the PIAC and MAC to inform KPI interventions. Support providers with using telemedicine to help achieve KPIs during the COVID-19 pandemic. Engage specialists in the ACC and provide education on adding referring provider NPI on encounters.
Improve social determinants of health (SDOH) data capture.	Reduce health disparities, improve health outcomes, and reduce cost.	June 30, 2021	Complete a market analysis to identify SDOH trends. Identify one means of consistent data collection.
BH Incentive Measures: Establish network transformation platform.	Support providers with targeted quality scorecards to facilitate improved metric performance.	June 30, 2021	Create provider-level data dashboards. Identify 1-3 high level providers and establish regular and ongoing quality focused transformation meetings. Identify common purpose and SMART goals aimed at improving health outcomes or reducing costs.
BH Incentive Measures: Increase the rate of foster care members receiving BH assessments within 30 days by 5%.	Establish an effective and collaborative referral process.	June 30, 2021	Complete memoranda of understanding (MOU) with county DHS to facilitate meaningful data sharing. Establish timely referral process with county DHS.

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BH Incentive Measures: Increase the rate of engagement in outpatient behavioral health care after an ED visit for a covered SUD by 5%.	Conduct outreach calls to members to support outpatient appointment setting within 7 days of discharge.	June 30, 2021	Establish internal outreach call process. Partner with local providers to facilitate timely access. Train ED staff on behavioral health incentive program, the measure and aftercare resources.
BH Incentive Measures: Increase the rate of engagement in outpatient behavioral health care after an ED visit for a covered SUD by 5%.	Engage ACN providers to align efforts on performance pool metrics	June 30, 2021	Develop interventions and strategies to address metrics. Participate in workgroups involving community partners and other state agencies.
411 Audit: Support improvement of providers' documentation to comply with USCS standards and requirements.	Facilitate and oversee 411 Audit Quality Improvement processes.	June 30, 2021	Work with HSAG to determine quality improvement targets. Partner with providers to develop and implement improvement processes.
Performance pool: Meet at least one medication adherence measure.	Engage with PCMPs and ACC providers in quality improvement processes.	June 30, 2021	Develop dashboards using actionable pharmacy data and share with providers. Identify and create educational material for members related to their medications.
Performance pool: Meet at least two of four core metrics.	Engage ACN providers to align efforts on performance pool metrics.	June 30, 2021	Develop interventions and strategies to address metrics. Participate in workgroups involving community partners and other state agencies.

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Goal	Fiscal Year 20-21 Project/Initiative	Targeted Completion Date	Action(s)
Member Experience of Care Improvement Driven Projects			
Monitor member experience, perceptions, accessibility and adequacy of services within the region for behavioral health.	Review survey results with key stakeholders to determine how best to use survey results.	June 30, 2021	Develop individual satisfaction measures that are specific to the CMHCs with input and collaboration from the CMHCs. Begin monitoring satisfaction results on an ongoing basis through monthly quality meetings.
CAHPS Survey: Improve member experience of care.	Use CAHPS data to identify potential interventions and work with providers to implement and test.	June 30, 2021	Share results with practices whose members were surveyed and work with quality improvement teams to address areas for opportunity.
Member Grievances: 90% of member grievances will be completed within 15 business days.	Member grievance completion provides an opportunity for increased member satisfaction, identification of areas of improvement.	Quarterly reporting, ongoing	Process and workflows in place, reporting to HCPF, QMC, MAC, and PIAC Committees on a quarterly basis.
Member Grievances: 100% of member grievances will be completed within the extended 14 calendar days.	Member grievance completion provides an opportunity for increased member satisfaction, identification of areas of improvement.	Quarterly reporting, ongoing	Process and workflows in place, reporting to HCPF, QMC, MAC, and PIAC Committees on a quarterly basis.
Member Grievances: 100% clinical grievances will be investigated by clinical staff.	Clinical grievance process.	Ongoing	Clinical grievance process will be transferred to clinical staff.

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Under and Over Utilization of Services Projects			
COUP: Attempt to outreach 100% of members identified by HCPF on the quarterly COUP lists and employ new outreach procedures, scripts, and workflows to engage members and collaborate with our primary care providers and pharmacies.	Continue tracking outreach to quarterly COUP members.	June 30, 2021	Continue assessing outreach strategy to best reach members. Engage members in care coordination.
COUP: Identify members who may benefit from lock-in, and engage the assigned PCMP and member to initiate lock-in, as appropriate.	Utilize COUP lock-in in collaboration with PCMPs.	June 30, 2021	Provide annual training for care coordinators on lock-in processes and identify anyone engaged with care coordination that may be appropriate for lock-in. Work with ACNs to identify members that may be appropriate for lock-in. Evaluate members who have been locked-in for appropriateness for continued lock-in.
Quality and Appropriateness of Care Furnished to Members with Special Health Care Needs Projects			
Foster care: Continue working to engage members in care coordination or appropriate Department of Human Services (DHS) resources.	Continue to engage members in foster care and connect to services.	June 30, 2021	Engaging and connecting members to appropriate services. Continue collaborating with DHS on joint trainings for case workers and CCs, including monthly meetings with county DHS leadership and CCHA care coordination.

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Goal	Fiscal Year 20-21 Project/Initiative	Targeted Completion Date	Action(s)
			Continue work with appropriate DHS offices to identify needs and connect to resources. Develop roles and responsibilities document for care coordination staff and community partners. Create a process to engage DHS in EPSDT related outreach for foster care outreach. Develop PCMP payment methodology that pays a higher per-member per-month (PMPM) payment for children in foster care.
Justice-involved population: attempt to outreach 100% of members released from DOC on the RAE list.	Track outreach to DOC released members.	June 30, 2021	Continue assessing outreach strategy to best reach members. Engage members in care coordination.
Justice-involved population: Increase engagement with DOC members and ensure that they are connected to appropriate resources in a timely manner.	Engage DOC released members in and connect to services.	June 30, 2021	Continue working with HCPF, DOC and other RAEs to create statewide workflows. Collaborate with other RAES to create a framework for statewide reporting. Develop PCMP payment methodology that pays a higher PMPM for members released from DOC.

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			Leverage community relationships to understand where members frequent in order to develop bi-directional referral work flows. Attempt to connect members with behavioral health services within 14 days of release.
Special Health Care Needs: Refine programs; identify, connect and engage members; and develop mechanisms to measure outcomes.	Refine programs, develop interventions, and evaluate effectiveness for members with diabetes, pregnant and post-partum women, and complex members.	June 30, 2021	Identify and engage high-risk members who will benefit from participation in each program. Develop and refine interventions to address member's needs and improve outcomes. Develop PCMP payment methodology that pays a higher PMPM for pregnant members. Develop PCMP payment methodology that incents PCMP program development based on evidence based components. Identify community partners and resources for members in each of these programs. Evaluate the effectiveness of the internal diabetes, maternity and complex member programs.

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			Work with SEPs and CCBs to share ADT data for HCBS waiver members and conduct complex case reviews monthly to discuss shared members.
Quality of Care Concern (QOC) Monitoring			
QOC: Increase collaboration with network providers to identify best practices to minimize quality of care concerns.	Providers will share best practices at the quarterly QMC meetings.	Quarterly	Engage QMC participants to share best practices that improve clinical outcomes. Share a minimum of 4 best practices with community partners.
QOC: Implement QOC/Critical Incident (CI) reviews with AspenPointe.	Analysis of QOC and CI events to identify any gaps or barriers in clinical care provision.	Reviews occur as serious incidences are identified	CCHA and AspenPointe will partner on reviews and establish a minimum quarterly meetings.
QOC: Enhance service coordination and linkage to SUD resources for high cost/high utilizing members with SUD conditions.	CCHA and AspenPointe will collaborate to identify any gaps in service/QOC concerns through focused case reviews.	June 30, 2021	Review medical records and conduct case reviews with AspenPointe.
External Quality Review Driven Projects			
Site Audits: Achieve a met score on all standards or successfully complete any necessary corrective action plans.	Ensure compliance with the Medicaid contract around these standards: subcontracts and delegation, provider participation and program integrity, credentialing and recredentialing, and quality assessment and performance improvement.	June 30, 2021	Review current policies and procedures related to the audit standards to ensure compliance and identify areas of improvement.

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Internal Advisory Committees and Learning Collaborative Strategies and Projects			
PIAC: Continue to utilize Program Improvement Advisory Committee (PIAC) as a steering group to re-invest funding to support community programs and meet CCHA's focus areas.	Continue to implement the Community Incentive Program application process through the voting committee.	December 31, 2020	Facilitate process established to reinvest funds. Educate new voting members on the process. Monitor current programs being funded to ensure quality outcomes and members needs are being met. Disseminate funds through the application process. Continue to refine process for awardees to report out to the PIAC on progress.
PIAC: Utilize feedback from PIAC to enhance services provided and increase access to care.	Provide data to the committee around CCHA KPIs, BH incentives as well as common trends for high cost members.	Quarterly	Receive feedback from committee on barriers to accessing care at the right level specifically through virtual platforms. Prioritize barriers based on feedback from the committee and identify strategies to minimize challenges to accessing care.
PIAC: Expand engagement opportunities for increased attendance via a virtual platform at PIAC.	Identify ways to continue to engage stakeholders and Health First Colorado members.	Quarterly	Collaboration with the MAC coordinator to recruit more members as well as identify a member that is interested in attending State MAC meetings. Utilize community liaisons to share PIAC meeting information with entities that have not attended PIAC.

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			Continue to share information about PIAC via email, CCHA newsletter, and social media to ensure current partners as well as new partners are familiar with PIAC and specific information covered in each meeting.
PIAC: Continue to recruit committee members that come from diverse backgrounds.	Implement outreach for committee members.	Quarterly	Proactively outreach possible committee members with diverse backgrounds to assess interest in joining PIAC.
MAC: Continue to utilize feedback from the Member Advisory Committee (MAC) to enhance services provided.	Use direct member input and member journey maps to inform and improve operations. Engage members to identify short- and long-term opportunity areas for the member engagement plan. Solicit the lived experience of members to identify ways to most effectively engage members in their health at the micro and macro levels while improving member experience.	June 30, 2021	Continue to hold quarterly meetings with CCHA members. CCHA continues to solicit members to join a virtual MAC in addition to the in-person MAC.