Quality Improvement Plan
Name: Colorado Community Health Alliance (CCHA)
RAE: Region 7
Date: September 30, 2021

### *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 (CCHA) overall goal is to support a coordinated, patient-centered model of care; and to serve better the needs of Health First Colorado members, improve health and life outcomes, optimize resources to prevent 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.***

| | |
|---|---|
| Melanie Rylander, MD<br>Medical Director<br>[redacted]<br>Email: [redacted] | Kathryn Morrison<br>Medicaid Quality Management Health Plan Director<br>Phone: [redacted]<br>Email address: [redacted] |
| Zula Solomon<br>Director of Quality and Population Health<br>Phone: [redacted]<br>Email address: [redacted] | Camila Joao<br>Clinical Quality Program Manager<br>Phone: [redacted]<br>Email address: [redacted] |
| Clara Cabanis<br>Senior Manager of Strategy and Performance<br>Phone: [redacted]<br>Email address: [redacted] | Suzanne Kinney<br>Clinical Quality Program Administrator<br>Phone: [redacted]<br>Email address: [redacted] |
| Cindi Terra<br>Manager Quality and Practice Transformation<br>Phone: [redacted]<br>Email address: [redacted] | Katie Mortenson<br>CCHA Quality Program Manager<br>Phone: [redacted]<br>Email address: [redacted] |

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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. As described in detail on our annual quality improvement report, CCHA accomplished many of the established quality improvement work plan activities in SFY20-21, including the following:

- Performance Improvement Projects led to updated workflows to increase annual well visits, targeted improvements to the quality of telehealth access and allowed for learning opportunities about leveraging our data.
- Achieved tier 2 goal for Emergency Department Utilization, part one of the health neighborhood KPI, and met all Potentially Avoidable Complications KPI requirements. We also met tier 1 for Dental Visits and Behavioral Health Engagement in the first quarter. Met targets for two of five Behavioral Health (BH) Incentive Measures annually.
- We have distributed 100% of the KPI incentive dollars out to providers and the community.
- Enrolled 64.76% of high-need members in extended care coordination with the help of our Accountable Care Network (ACN) providers.
- Supported providers through COVID using performance pool funds, practice transformation assistance, and telehealth support.
- Developed additional partnerships and enrolled 24 practices in the Behavioral Health Quality Incentive Program.
- Continued outreach for COUP members where needed, in partnership with the Department of Health Care Policy and Financing (HCPF).
- Continued collaborations and developed workflows with other RAEs, Department of Corrections (DOC), Department of Human Services (DHS), and HCPF to address the justice-involved.
- Updated diabetes program goals, documentation, resources and started receiving A1c laboratory data.
- Updated maternity program goals, documentation, resources and started outreaching high-volume, non-contracted OBYGNs.
- Began work to update our complex definition to identify high-need members and documentation in collaboration with HCPF.
- Continued to monitor and improve the Quality of Care concerns identification and reporting process.
- Achieved 100% score on the external quality review audit.
- Held quarterly Regional Program Improvement Advisory Committee (PIAC) and Member Advisory Committee (MAC) meetings to solicit stakeholder feedback.

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To further build on our SFY20-21 successes and overcome barriers we encountered, CCHA is using the KPIs and the Behavioral Health Incentive Program as our measures 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 to address health inequities and social determinants of health (e.g., gender, race, and geographic area).
- Continue utilizing practice transformation coaches to engage and educate primary care medical providers (PCMPs) on the ACC measures and programs.
- Educate providers and community partners on the new well visit KPI.
- Continue 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.
- Leverage opportunities for alignment across programs (Key Performance Indicators, Condition Management, Alternative Payment Model, Performance Pool, etc.).
- Scale up practice level quality improvement pilots that are successful to share best practices across the region.
- Distribute KPI incentive dollars to providers through the Provider Incentive Program and to community partners though the Community Incentive Program.
- Continue to identify and collaborate with community partners and leverage community resources to support members.
- Support providers with resources through the COVID-19 pandemic, including billing, coding telehealth visits, and becoming a vaccination site.
- Utilize feedback from the Member Advisory Committee (MAC) and Performance Improvement Advisory Committee (PIAC) to inform interventions.
- Work with HCPF to address KPI changes for SFY22-23.

**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 scorecards.
- Leverage existing CCHA practice transformation platform to support timely follow-up after a positive depression screening by providing coaches with regular PCMP performance status.
- Partner with key stakeholders to better support members with substance use disorder (SUD) and assist with service planning and coordination at the time of discharge from the emergency department (ED).
- Provide resources and information to EDs to educate providers on the importance of timely follow-up, available community resources and the SUD benefit expansion.
- Create a Specialized Transitions of Care (STOC) team to support discharge and aftercare planning for members stepping down from inpatient withdrawal management and residential substance use care.

- Expand the Post Inpatient Transition Screening (POINTS) process to the CMHC to provide care coordination and aftercare planning support to members discharging from inpatient placement for a mental health condition.
- Improve social determinants of health (SDOH) data capture of members to identify needs and link members to assistance.
- Improve timeliness of care coordination efforts by developing secure file exchange platforms with select network providers.
- Increase rate of foster care members receiving BH assessment within 30 days by establishing a RAE notification protocol with county DHS at the time of placement to provide resources and facilitate access to appropriate services.
- Partner with large volume Federally Qualified Health Centers (FQHCs) to increase rates of depression screening and follow-up after a positive screen.

**Performance Pool:**

- Adjust Performance Pool dashboards to include new baselines and measures to share with providers.
- Continue engaging and supporting individual providers, including ACN's, in the implementation of interventions.
- Continue working with community partners, other state agencies and RAEs to develop workflows related to behavioral health engagement for members released from DOC.
- Continue to refine outreach methodology to engage identified members.
- Educate providers on workflows and durable medical equipment (DME) benefits.
- Educate providers on the prescription benefit tool and help support implementation.
- Evaluate the effectiveness of the interventions and identify opportunities for improvement.

**HCPF Condition Management 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.
    - Continue to refine interventions to achieve intended health outcomes.
    - Continue to identify community partners and resources to support members and providers to manage diabetes.
    - Educate providers and community partners on our services and referral process.
    - Continue incorporating A1c data and using it to track member progress.
    - Share medication adherence data with PCMPs.
- **Maternity:**
    - Outreach all pregnant women who are at high-risk for a complicated delivery in addition to pregnant women on the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services list.
    - Assess members at the time of outreach to screen for care coordination needs and help them enroll with CCHA's care coordination team.
    - Continue to refine interventions for members who are pregnant, postpartum, and newborns to achieve intended health outcomes.

    - Identify community partners and resources.
    - Educate providers and community partners on our services and referral process.
    - Continue engaging with non-contracted OBGYNs to educate them about our care coordination services and referral processes.
- **High-need Member Care:**
    - Implement new definition for high-need members.
    - Update documentation processes both internally and with our ACNs to meet extended care coordination requirements.
    - Continue to outreach high-need members to provide support through CCHA's care coordination team or connect with appropriate providers and resources.
    - Continue collaborating with community partners to address member needs.
    - Continue engaging and supporting individual providers, including ACNs, in the implementation of interventions for these members.
    - Continue collaboration with Single Entry Points (SEPs) and Community Centered Boards (CCBs) to share Admission, Discharge and Transfer (ADT) data for members on a Home and Community-Based Service (HCBS) waiver members and meet monthly to review cases on shared members.
- **Special Health Care Needs**
    - Collaborate with HCPF, DOC, DHS, and other RAEs to develop workflows to best address the justice-involved and foster care populations.
    - Collaborate with SEPs and CCBs to share ADT data for HCBS waiver members and meet monthly to review cases on shared members.
    - Refine programs, develop interventions, and evaluate effectiveness for members with diabetes, pregnant and postpartum members, and high-need 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 throughout the health plan and care delivery system. To achieve this, CCHA is in the process of implementing the following:

*Quality Management Committee (QMC):*
The Quality Management Committee provides program direction and oversight to ensure CCHA operates as a united 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: improve processes to measure and monitor member satisfaction.
- Monitor program performance, using the following tools:
    - KPI, Behavioral Health Incentive Plan (BHIP) and Behavioral Health Quality Incentive Plan (BHQIP) measures. The Behavioral Health Quality Incentive Plan (BHQIP) is for our providers to earn incentives based on their performance.
    - PAC Plan and results

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- Performance Improvement Project (PIP) activity and results
- CO Annual RAE BH Encounter Data Quality Review (411 Audit)
- HSAG annual site audit results
- Provider performance, including CCHA's Accountable Care Network
- Grievances
- Quality of care concerns
- Critical incident reviews
- CCHA administrative and service performance

*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

*Critical Incident Reporting:*
To improve the quality, safety and well-being of its members and providers, CCHA requires that all critical incidents involving attributed members and programs be reported to CCHA within 24 hours of occurrence or discovery of the event. CCHA staff and network providers shall document and report incidents that are considered critical or adverse in nature, including significant events or conditions that may be of public concern and/or reasonably perceived as jeopardizing the health, safety and/or welfare of members, providers and/or staff. Incidents are reviewed to determine the appropriate response and identify opportunities to improve the quality of care delivered.

*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 QOC and an investigation that supports the severity level is completed on all cases. All QOCs 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 and execute corrective action plans with providers where necessary to address clinical quality concerns.

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

| Goal | State Fiscal Year 21-22 Project/Initiative | Targeted Completion Date | Action(s) |
|---|---|---|---|
| Performance Improvement Projects (PIP) | | | |
| PIP: Successfully complete the Intervention Testing module 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, 2022 | Develop, execute, and test interventions to improve performance towards PIP targets<br><br>Submit deliverables by the determined due dates |
| Performance Measurement Data-Driven Projects | | | |
| Key Performance Indicators: achieve tier 1 goal for three of the six KPIs | Engage with PCMPs and ACN providers in quality improvement processes<br><br>Partner with community organizations to align efforts and processes to achieve KPI goals | June 30, 2022 | Educate PCMPs and community partners about the KPI changes and update materials or use existing materials to support<br><br>Leverage CCHA's Provider Incentive Program to increase engagement of PCMPs in practice transformation efforts to improve PCMP KPI performance<br><br>Utilize care coordination to educate members to connect with appropriate services<br><br>Incorporate feedback from the Performance Improvement Advisory Committee (PIAC) and Member Advisory Committee (MAC) to inform KPI interventions |

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| Implement new well visit KPI | Educate providers and community partners about the new well visit KPI | December 31, 2022 | Develop dashboards to track progress by age groups and providers<br><br>Share Data Analytics Portal (DAP) data with providers<br><br>Update and identify existing educational materials for both providers and members |
| BH Incentive Measures: Improve the rate of depression screenings and depression screening follow up by a 10% gap closure between CCHA's performance and HCPF's goal | Develop and distribute internal dashboards data to support tracking and monitoring rates of depression screening | June 30, 2022 | Work with PCMP providers to implement workflows to complete depression screening to all members over 12 years old, as clinically indicated<br><br>Practice transformation coaches will provide support and assistance about BH issues and provide PCMP-specific performance scorecards. |
| BH Incentive Measures: Increase the rate of foster care members receiving BH assessments within 30 days by expanding notification protocol to additional counties | Establish RAE notification protocol with county DHS to provide resources and facilitate access to appropriate services | June 30, 2022 | Maintain and improve existing notification protocols and expand timely referral process to additional counties |
| Improve social determinants of health (SDOH) data capture to identify and link members to assist | Engage and incentivize BH providers to consistently utilize Aunt Bertha's platform for SDOH resources | June 30, 2022 | Expand enrollment in Social Determinants of Health Provider Incentive Plan (SDOHPIP)<br><br>Utilize Aunt Bertha platform in care coordination activities and |

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| | | | outreach campaigns to connect members to community-based organizations that offer food, health, housing, job training, and education programs |
| BH Incentive Measures: Increase performance on Follow-up After Hospital Discharge, Substance Use Treatment Engagement, and Outpatient Behavioral Health Care After an ED Visit for a Covered SUD by a 10% gap closure between CCHA's performance and HCPF's goal | Engage with BH and PH providers in quality improvement processes<br><br>Partner with community organizations to align efforts and processes to achieve BHIP goals | June 30, 2022 | Promote program information to encourage enrollment in Behavioral Health Quality Incentive Program (BHQIP) and distribute performance status and disburse financial incentives to high-performing providers<br><br>Improve POINTS process, identify opportunities for improvement and work with inpatient hospitals to promote consistent discharge coordination<br><br>Create a Specialized Transitions of Care (STOC) team to work with discharge follow-up plans for members stepping down from inpatient, residential, and withdrawal management care for substance use disorders (SUD)<br><br>Partner with key stakeholders to better support members with SUD, assist with service planning and coordination at the time of discharge |

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| | | | from the ED, incorporating telehealth connections |
| 411 Audit: Support improvement of providers' documentation to comply with Uniform Services Coding Standards (USCS) and requirements | Facilitate and oversee 411 Audit Quality Improvement processes | June 30, 2022 | Work with HSAG to determine quality improvement targets<br><br>Partner with providers to develop and implement improvement processes |
| Performance pool: Meet at least one medication adherence measure | Engage with PCMPs and ACN providers in quality improvement processes | June 30, 2022 | Develop dashboards using actionable pharmacy data and share with providers<br><br>Identify and create educational material for members related to their medications<br><br>Educate providers on the prescription benefit tool and help support implementation |
| Performance Pool: Meet at least two of four non-medication adherence metrics | Engage ACN providers to align efforts on Performance Pool metrics<br><br>Leverage community partnerships to help engage members | June 30, 2022 | Share strategy with ACN providers<br><br>Attend regional committees and work groups<br><br>Identify and create necessary educational materials |
| 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, 2022 | Develop individual satisfaction measures that are specific to the CMHCs with input and collaboration from the CMHCs |

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| | | | Begin monitoring satisfaction results on an ongoing basis through monthly quality meetings |
| Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey: Improve member experience of care | Use CAHPS data to identify potential interventions and work with providers to implement and test | June 30, 2022 | 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 quarterly |
| 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 quarterly |
| Member Grievances: 100% of clinical grievances will be investigated by clinical staff | Clinical grievance process | Quarterly reporting, ongoing | Clinical grievance process will be transferred to clinical staff reporting to HCPF, QMC, MAC, and PIAC committees quarterly |
| Mechanisms to Detect Overutilization and Underutilization of Services | | | |
| Client Overutilization Program (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 | Continue tracking outreach to quarterly COUP members. | June 30, 2022 | Continue assessing outreach strategy to effectively reach members<br><br>Engage members in care coordination |

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| primary care providers and pharmacies | | | |
| 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, 2022 | Provide annual training for care coordinators (CCs) on the lock-in process and identify anyone engaged with care coordination that may be appropriate for lock-in<br><br>Work with ACNs to identify members that may be appropriate for lock-in<br><br>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 | | | |
| Increase the number of members engaged in CCHA's diabetes program | Use member-driven goals to engage and maintain engagement of members | June 30, 2022 | CCs to complete motivational interviewing courses<br><br>Help members understand how to grocery shop for their diabetes<br><br>Pilot virtual diabetes self-management education classes |
| Use laboratory data to track member progress | Continue monitoring data over time<br><br>Add historical data where possible | June 30, 2022 | Work with HCPF and laboratories to access historical data if possible<br><br>Share data with PCMPs |
| Increase the number of members engaged in CCHA's maternity program | Refine program data and interventions | June 30, 2022 | Under EPSDT, outreach all pregnant members and screen for risks or unmet needs |

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| | OBGYN outreach<br><br>Community partnerships | | Outreach non-contracted OBGYNs to educate them on the RAEs and how they can refer members<br><br>Continue to refine data to identify members at risk for complicated delivery to engage with CCHA's care coordination team<br><br>Continue to refine interventions for prenatal and postpartum members and newborns to achieve intended health outcomes<br><br>Identify community partners and resources<br><br>Educate providers and community partners on our services and referral process |
| Work with HCPF to implement a new definition for high-need members | Implement CCHA's new high-need member definition<br><br>Gather baseline data in anticipation of reporting on the new definition | June 30, 2022 | Continue to outreach to high-need members and provide support through CCHA's care coordination team or connect with appropriate providers for their needs<br><br>Collaborate with community partners to address these members<br><br>Engage and support individual providers, including ACNs, in implementing interventions for these members |

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| | | | Collaborate with SEPs and CCBs to share ADT data for HCBS waiver members and meet monthly to review cases on shared members |
| 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, 2022 | Engaging and connecting members to appropriate services<br><br>Continue work with appropriate DHS offices to identify needs and connect to resources<br><br>Continue collaborating with DHS on joint training for caseworkers and CCs, including monthly meetings with county DHS leadership and CCHA care coordination<br><br>Create a process to engage DHS in EPSDT related outreach for foster care outreach<br><br>Share best practices as they relate to referrals and getting services across counties |
| Justice-involved Population: Increase engagement with DOC members and ensure they are connected to appropriate resources on time | Engage DOC released members in and connect to services<br><br>Identify single points of contact in parole offices to coordinate services, get updated contact information, etc. | June 30, 2022 | Continue working with HCPF, DOC, and other RAEs to create statewide workflows<br><br>Collaborate with other RAEs to create a framework for statewide reporting<br><br>Leverage community relationships to understand |

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| | | | where members frequent to develop bi-directional referral workflows<br><br>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 diabetes, pregnant and postpartum members, and high-need members | June 30, 2022 | Identify and engage high-risk members who will benefit from participation in each program<br><br>Develop and refine interventions to address members' needs and improve outcomes<br><br>Identify community partners and resources for members in each of these programs<br><br>Evaluate the effectiveness of internal diabetes, maternity, and high-need member programs<br><br>Work with SEPs and CCBs to share ADT data for HCBS waiver members and conduct complex case reviews for high-need members monthly to discuss shared members |
| Quality of Care Concern Monitoring | | | |
| Improve timeliness of care coordination efforts by developing Secure File Transfer Protocol (SFTP) | Establish SFTP sites for faster distribution of relevant and necessary health information to | June 30, 2022 | Ensure contractual permissions to exchange confidential information are in place |

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| with select network providers | attributed treatment providers | | Identify and partner with providers to receive and respond to the clinical needs of members identified |
| QOC: Identify best practices to minimize the risk of QOC occurrences | Providers will share best practices at the quarterly QMC meetings to improve clinical outcomes | Quarterly | Engage QMC participants to share best practices that improve clinical outcomes |
| QOC: Enhance provider education regarding QOC and critical incident identification and submission | Utilize multiple channels for provider education, including provider bulletins, town hall meetings, and PIAC meetings | June 2022 | Submit information for provider bulletin at least semi-annually and through provider town halls as appropriate |
| External Quality Review Driven Projects | | | |
| Site Audits: Achieve a met score on all standards or complete any necessary corrective action plans | Ensure compliance with the Medicaid contract around these standards: Coordination and Continuity of Care; Member Rights and Protections; Member Information; and, Early and Periodic Screening, Diagnostic, Treatment (ESPDT) | June 30, 2022 | Review current policies and procedures related to audit standards to ensure compliance and identify areas of improvement |
| Internal Advisory Committees and Learning Collaborative Strategies and Projects | | | |
| Program Improvement Advisory Committee (PIAC): Continue to utilize 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, 2021 | Facilitate process established to reinvest funds<br><br>Educate new voting members on the process<br><br>Monitor current programs being funded to ensure quality outcomes and members' needs are met |

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| | | | Disseminate funds through the application process<br><br>Continue to refine the process for awardees to report out to the PIAC on progress |
| PIAC: Utilize feedback from the PIAC to enhance services provided and increase access to care | Provide data to the committee around CCHA KPIs, BH incentives, and common trends for high-need members | Quarterly | Receive feedback from the committee on barriers to accessing care at the right level, specifically through virtual platforms<br><br>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 and identify a member interested in attending State MAC meetings<br><br>Utilize community liaisons to share PIAC meeting information with entities that have not attended PIAC<br><br>Continue to share information about PIAC via email, CCHA newsletter, and social media to ensure current partners and new partners are familiar with PIAC and specific information covered in each meeting |
| PIAC: Continue to recruit committee members that | Implement outreach for committee members | Quarterly | Proactively outreach possible committee |

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| come from diverse backgrounds | | | members with diverse backgrounds to assess interest in joining PIAC |