

Regional Accountable Entities (RAEs) for the Colorado Accountable Care Collaborative

Fiscal Year 2024–2025 PIP Validation Report

for

Colorado Access Region 5

April 2025

This report was produced by Health Services Advisory Group, Inc. for the Colorado Department of Health Care Policy & Financing.





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1. Executive Summary

Pursuant to 42 CFR §457.1250, which requires states' Medicaid managed care programs to participate in external quality review (EQR), the State of Colorado, Department of Health Care Policy and Financing (the Department) required its Regional Accountable Entities (RAEs) to conduct and submit performance improvement projects (PIPs) annually for validation by the State's external quality review organization (EQRO). Colorado Access Region 5, referred to in this report as COA R5, holds a contract with the State of Colorado for provision of healthcare services for Health First Colorado, Colorado's Medicaid program.

The purpose of a PIP is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in performance indicator outcomes that focus on clinical or nonclinical areas. For this year's 2024–2025 validation, COA R5 submitted two PIPs: Follow-Up After Hospitalization for Mental Illness (FUH) and Social Determinants of Health (SDOH) Screening. These topics addressed Centers for Medicare & Medicaid Services' (CMS') requirements related to quality outcomes—specifically, the quality, timeliness, and accessibility of care and services.

The clinical *FUH* PIP addresses quality, timeliness and accessibility of healthcare and services by improving follow-up visit rates after hospitalization for mental illness among COA R5 members 6 years of age and older. The topic, selected by COA R5 and approved by the Department, was supported by historical data. The PIP has one Aim statement that COA R5 stated as follows: "By June 30, 2025, use targeted *FUH* interventions to increase the percentage of seven-day follow-up visits after hospitalization among Region 5 members six years of age and older from 36.96% to 41.03%."

The nonclinical SDOH Screening PIP addresses quality and accessibility of healthcare and services for COA R5 members by increasing awareness of social factors that may impact member access to needed care and services. The nonclinical topic was mandated by the Department. The PIP has one Aim statement that COA R5 stated as follows: "By June 30, 2025, the Colorado Access CM [Care Management] team will utilize targeted interventions to increase the percentage of SDOH screenings among Region 5 members from 0% to 90%."

Table 1-1 outlines the performance indicators for each PIP.

Table 1-1—Performance Indicators

PIP Title	Performance Indicator			
FUH	The percentage of discharges for Region 5 members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and had a follow-up visit with a mental health provider within seven days after discharge.			
SDOH Screening	The percentage of Region 5 members who were screened for SDOH using the Core 5 SDOH screening tool.			



2. Background



Rationale

The Code of Federal Regulations at 42 CFR Part 438—managed care regulations for the Medicaid program and Children's Health Insurance Program (CHIP), with revisions released May 6, 2016, effective July 1, 2017, and further revised on November 13, 2020, with an effective date of December 14, 2020—require states that contract with managed care health plans (health plans) to conduct an EQR of each contracting health plan. Health plans include primary care case management entities (PCCM entities). The regulations at 42 CFR §438.358 require that the EQR include analysis and evaluation by an EQRO of aggregated information related to healthcare quality, timeliness, and access. Health Services Advisory Group, Inc. (HSAG), serves as the EQRO for the Department—the agency responsible for the overall administration and monitoring of Colorado's Medicaid program. Beginning in fiscal year (FY) 2018–2019, the Department entered into contracts with RAEs in seven regions throughout Colorado. Each Colorado RAE meets the federal definition of a PCCM entity.

In its PIP evaluation and validation, HSAG used the Department of Health and Human Services, CMS publication, Protocol 1. Validation of Performance Improvement Projects: A Mandatory EOR-Related Activity, February 2023 (CMS EQR Protocol 1). HSAG's evaluation of the PIP includes two key components of the quality improvement (QI) process:

- 1. HSAG evaluates the technical structure of the PIP to ensure that COA R5 designs, conducts, and reports the PIP in a methodologically sound manner, meeting all State and federal requirements. HSAG's review determines whether the PIP design (e.g., PIP Aim statement, population, sampling methods, performance indicator, and data collection methodology) is based on sound methodological principles and could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring sustained improvement.
- 2. HSAG evaluates the implementation of the PIP. Once designed, a RAE's effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions. Through this component, HSAG evaluates how well COA R5 improves its rates through implementation of effective processes (i.e., barrier analyses, interventions, and evaluation of results).

The goal of HSAG's PIP validation is to ensure that the Department and key stakeholders can have confidence that the RAE executed a methodologically sound improvement project, and any reported improvement is related to, and can be reasonably linked to, the QI strategies and activities conducted by the RAE during the PIP.

Department of Health and Human Services, Centers for Medicare & Medicaid Services. Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Mar 18, 2025.





Validation Overview

For FY 2024–2025, the Department required health plans to conduct PIPs in accordance with 42 CFR §438.330(b)(1). In accordance with §438.330 (d), RAE entities are required to have a quality program that (1) includes ongoing PIPs designed to have a favorable effect on health outcomes and beneficiary satisfaction and (2) focuses on clinical and/or nonclinical areas that involve the following:



Measuring performance using objective quality indicators



Implementing system interventions to achieve improvement in quality



Evaluating effectiveness of the interventions



Planning and initiating of activities for increasing or sustaining improvement

To monitor, assess, and validate PIPs, HSAG uses a standardized scoring methodology to rate a PIP's compliance with each of the nine steps listed in CMS EQR Protocol 1. With the Department's input and approval, HSAG developed a PIP Validation Tool to ensure uniform assessment of PIPs. This tool is used to evaluate each of the PIPs for the following nine CMS EQR Protocol 1 steps:

Table 2-1—CMS EQR 1 Protocol Steps

	Protocol Steps					
Step Number	Description					
1	Review the Selected PIP Topic					
2	2 Review the PIP Aim Statement					
Review the Identified PIP Population						
4	Review the Sampling Method					
5	Review the Selected Performance Indicator(s)					
6	Review the Data Collection Procedures					
7 Review the Data Analysis and Interpretation of PIP Results						
8	Assess the Improvement Strategies					
9	Assess the Likelihood that Significant and Sustained Improvement Occurred					



HSAG obtains the data needed to conduct the PIP validation from COA R5's PIP Submission Form. This form provides detailed information about COA R5's PIP related to the steps completed and evaluated for the 2024–2025 validation cycle.

Each required step is evaluated on one or more elements that form a valid PIP. The HSAG PIP Review Team scores each evaluation element within a given step as *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Assessed*. HSAG designates evaluation elements pivotal to the PIP process as critical elements. For a PIP to produce valid and reliable results, all critical elements must be *Met*.

In alignment with CMS EQR Protocol 1, HSAG assigns two PIP validation ratings, summarizing overall PIP performance. One validation rating reflects HSAG's confidence that the RAE adhered to acceptable methodology for all phases of design and data collection and conducted accurate data analysis and interpretation of PIP results. This validation rating is based on the scores for applicable evaluation elements in steps 1 through 8 of the PIP Validation Tool. The second validation rating is only assigned for PIPs that have progressed to the Outcomes stage (Step 9) and reflects HSAG's confidence that the PIP's performance indicator results demonstrated evidence of significant improvement. The second validation rating is based on scores from Step 9 in the PIP Validation Tool. For each applicable validation rating, HSAG reports the percentage of applicable evaluation elements that received a *Met* score and the corresponding confidence level: *High Confidence*, *Moderate Confidence*, *Low Confidence*, or *No Confidence*. The confidence level definitions for each validation rating are as follows:

1. Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP (Steps 1 Through 8)

- *High Confidence*: High confidence in reported PIP results. All critical evaluation elements were *Met*, and 90 percent to 100 percent of all evaluation elements were *Met* across all steps.
- *Moderate Confidence*: Moderate confidence in reported PIP results. All critical evaluation elements were *Met*, and 80 percent to 89 percent of all evaluation elements were *Met* across all steps.
- Low Confidence: Low confidence in reported PIP results. Across all steps, 65 percent to 79 percent of all evaluation elements were Met; or one or more critical evaluation elements were Partially Met.
- *No Confidence*: No confidence in reported PIP results. Across all steps, less than 65 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Not Met*.

2. Overall Confidence That the PIP Achieved Significant Improvement (Step 9)

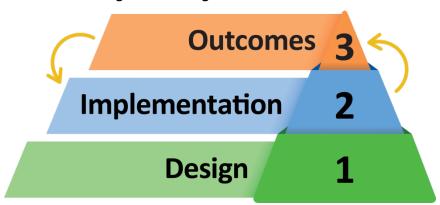
- *High Confidence*: All performance indicators demonstrated *statistically significant* improvement over the baseline.
- *Moderate Confidence*: One of the three scenarios below occurred:
 - All performance indicators demonstrated improvement over the baseline, and some but not all performance indicators demonstrated *statistically significant* improvement over the baseline.
 - All performance indicators demonstrated improvement over the baseline, and none of the
 performance indicators demonstrated statistically significant improvement over the baseline.



- Some but not all performance indicators demonstrated improvement over baseline, and some but not all performance indicators demonstrated *statistically significant* improvement over baseline.
- Low Confidence: The remeasurement methodology was not the same as the baseline methodology for at least one performance indicator or some but not all performance indicators demonstrated improvement over the baseline and none of the performance indicators demonstrated statistically significant improvement over the baseline.
- No Confidence: The remeasurement methodology was not the same as the baseline methodology for all performance indicators **or** none of the performance indicators demonstrated improvement over the baseline.

Figure 2-1 illustrates the three stages of the PIP process—Design, Implementation, and Outcomes. Each sequential stage provides the foundation for the next stage. The Design stage establishes the methodological framework for the PIP. The activities in this section include development of the PIP topic, Aim statement, population, sampling techniques, performance indicator(s), and data collection processes. To implement successful improvement strategies, a strong methodologically sound design is necessary.

Figure 2-1— Stages of the PIP Process



Once COA R5 establishes its PIP design, the PIP progresses into the Implementation stage (Steps 7–8). During this stage, COA R5 evaluates and analyzes its data, identifies barriers to performance, and develops interventions targeted to improve outcomes. The implementation of effective improvement strategies is necessary to improve outcomes. The Outcomes stage (Step 9) is the final stage, which involves the evaluation of statistically significant improvement, and sustained improvement based on reported results and statistical testing. Sustained improvement is achieved when performance indicators demonstrate statistically significant improvement over baseline performance through repeated measurements over comparable time periods. This stage is the culmination of the previous two stages. If the outcomes do not improve, COA R5 should revise its causal/barrier analysis processes and adapt QI strategies and interventions accordingly.







Validation Findings

HSAG's validation evaluates the technical methods of the PIP (i.e., the design, data analysis, implementation, and outcomes). Based on its review, HSAG determined the overall methodological validity of the PIP. Table 3-1 summarizes the health plan's PIPs validated during the review period with an overall confidence level of *High Confidence*, *Moderate Confidence*, *Low Confidence* or *No Confidence* for the two required confidence levels identified below. In addition, Table 3-1 displays the percentage score of evaluation elements that received a *Met* score, as well as the percentage score of critical elements that received a *Met* score within the PIP Validation Tool that HSAG has identified as essential for producing a valid and reliable PIP.

Table 3-1 illustrates the initial submission and resubmission validation scores for each PIP.

		Va	lidation Ratin	g 1	Va	lidation Rating	g 2
	Overall Confidence of A Acceptable Methodol Phases of the I		le Methodolo	gy for All	Overall Confidence That the PIP Achieved Significant Improvement		
PIP Title	Review ¹	Percentage Score of Evaluation Elements Met ²	Percentage Score of Critical Elements Met ³	Confidence Level ⁴	Percentage Score of Evaluation Elements <i>Met</i> ²	Percentage Score of Critical Elements <i>Met</i> ³	Confidence Level ⁴
FUH	Initial Submission	100%	100%	High Confidence	67%	100%	Moderate Confidence
FUII	Resubmission			The MCO di	d not resubmit.		
SDOH	Initial Submission	87%	89%	Low Confidence	67%	0%	Low Confidence
Screening	Resubmission	100%	100%	High Confidence	100%	100%	High Confidence

Table 3-1—2024–2025 PIP Overall Confidence Levels for COA R5

¹ **Type of Review**—Designates the PIP review as an initial submission, or resubmission. A resubmission means the MCO resubmitted the PIP with updated documentation to address HSAG's initial validation feedback.

² **Percentage Score of Evaluation Elements** *Met*—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met*).

³ **Percentage Score of Critical Elements** *Met*—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

⁴ **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.



The FUH PIP was validated through all nine steps of the PIP Validation Tool. For Validation Rating 1, HSAG assigned a High Confidence level for adhering to acceptable PIP methodology. COA R5 received Met scores for 100 percent of applicable evaluation elements in the Design (Steps 1–6) and Implementation (Steps 7–8) stages of the PIP. For Validation Rating 2, HSAG assigned a Moderate Confidence level that the PIP achieved significant improvement. HSAG assigned a level of Moderate Confidence for Validation Rating 2 because the performance indicator results demonstrated improvement in performance from baseline to the first remeasurement that was not statistically significant.

The SDOH Screening PIP was validated through all nine steps of the PIP Validation Tool. For Validation Rating 1, HSAG assigned a High Confidence level for adhering to acceptable PIP methodology. COA R5 received Met scores for 100 percent of applicable evaluation elements in the Design (Steps 1–6) and Implementation (Steps 7–8) stages of the PIP. For Validation Rating 2, HSAG assigned a High Confidence level that the PIP achieved significant improvement. HSAG assigned a High Confidence level for Validation Rating 2 because the performance indicator results demonstrated a statistically significant improvement over baseline performance at the first remeasurement.

Scores and feedback for individual evaluation elements and steps are provided for each PIP in Appendix B. Final PIP Validation Tools.



Analysis of Results

Table 3-2 displays data for COA R5's *FUH* PIP.

Table 3-2—Performance Indicator Results for the FUH PIP

Performance Indicator	(7/1/2	eline 2022 to 72023)	(7/1/2	urement 1 2023 to /2024)	(7/1/2	rement 2 2024 to 2025)	Sustained Improvement
The percentage of discharges for Region 5 members 6 years of age and older who were hospitalized for treatment of selected mental illness or	N: 476	37.0%	N: 509	40.8%			
intentional self-harm diagnoses and had a follow-up visit with a mental health provider within seven days after discharge.	D: 1,288	37.0%	D: 1,249	40.870			

N-Numerator D-Denominator

HSAG rounded percentages to the first decimal place.

For the baseline measurement period, COA R5 reported that the percentage of members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm



diagnoses and had a follow-up visit with a mental health provider within seven days after discharge was 37.0 percent.

For the first remeasurement period, COA R5 reported that the percentage of members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and had a follow-up visit with a mental health provider within seven days after discharge was 40.8 percent. The Remeasurement 1 results demonstrated an increase of 3.8 percentage points in the sevenday follow-up rate, which was not statistically significant.

Table 3-3 displays data for COA R5's SDOH Screening PIP.

Table 3-3—Performance Indicator Results for the SDOH Screening PIP

Performance Indicator	Baseline (7/1/2022 to 6/30/2023)		(7/1/2	rement 1 2023 to /2024)	rement 2 024 to 2025)	Sustained Improvement
The percentage of Region 5 members who were screened	N: 0	00/	N: 173	9.1%		
for SDOH using the Core 5 SDOH screening tool.	D: 2,170	0%	D: 1,901	9.170		

N-Numerator D-Denominator

HSAG rounded percentages to the first decimal place.

For the baseline measurement period, COA R5 reported that 0 percent of Region 5 members were screened for SDOH using the Core 5 SDOH screening tool.

For the first remeasurement period, COA R5 reported that 9.1 percent of Region 5 members were screened for SDOH using the Core 5 SDOH screening tool. The Remeasurement 1 results demonstrated a statistically significant increase in the percentage of eligible Region 3 members who were screened for SDOH of 9.1 percentage points.



Barriers/Interventions

The identification of barriers through barrier analysis and the subsequent selection of appropriate interventions to address these barriers are necessary steps to improve outcomes. COA R5's choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential to the overall success in improving PIP rates.

Table 3-4 displays the barriers and interventions documented by COA R5 for the *FUH* PIP.



Table 3-4—Barriers and Interventions for the FUH PIP

Table 5-4—Barriers and interventions for the FOH PIP						
Barriers	Interventions					
Care managers (CMs) faced barriers with the existing outreach program, including high workloads, insufficient time to serve members with complex needs, and high administrative burdens due to the large volume of members. To address these issues, the CM team streamlined their member outreach program to stratify members by risk. This aimed to reduce overall admissions and provide an additional touchpoint to high-needs members within seven days after discharge to promote connection to appropriate step-down care.	Care Management Behavioral Health Transitions of Care Program: Colorado Access improved the Care Management Behavioral Health Transitions of Care program, which is designed to identify and intervene with members using inpatient and residential behavioral health services, to connect them to follow-up appointments and prevent readmissions. Care managers coordinate care with providers, connect members with appropriate outpatient behavioral health services, and mitigate barriers to discharge or engagement in follow-up services.					
CMHCs identified the need for additional financial support to effectively allocate resources toward meeting this metric. Achieving a follow-up behavioral health appointment within seven days requires swift action and increased appointment availability. To meet this demand, CMHCs require enhanced funding to expand their behavioral health staffing. The introduction of this incentive has empowered CMHCs to better prioritize and fulfill the demands of this critical metric, ensuring timely and effective care for patients.	CMHC Value Based Payment Model: Colorado Access partnered with five CMHCs to participate in a value-based payment program that offers enhanced reimbursement for administering follow-up care to attributed members after an inpatient stay. These CMHCs use the above dashboard to collaborate with discharging hospitals and Colorado Access to coordinate outpatient follow-up visits within seven days of discharge for behavioral health conditions. CMHCs receive enhanced reimbursement for achieving performance goals related to the seven-day follow-up metric.					
Colorado Access recognized the opportunity to provide increased financial support and incentives, helping hospitals prioritize this important metric. By coordinating discharge with Community Mental Health Centers (CMHCs) to ensure a follow-up behavioral health appointment within seven days, additional funding enabled hospitals to expand behavioral health staffing. This support empowered hospitals to better align resources and improve continuity of care for high-needs patients.	Inpatient Behavioral Health Performance Program: Colorado Access partnered with nine inpatient hospitals to participate in a new payment model that offers hospitals enhanced reimbursement for coordinating follow-up after a member's inpatient stay. Hospitals use the above dashboard to successfully schedule follow-up appointments within seven days of discharge. The dashboard helps hospitals identify either a preestablished CMHC or new behavioral health provider with the capacity to see the member within seven days. These hospitals are incentivized with a tiered per diem percentage increase in reimbursement if they meet certain seven-day follow-up performance thresholds.					



Table 3-5 displays the barriers and interventions documented by COA R5 for the SDOH Screening PIP.

Table 3-5—Barriers and Interventions for the SDOH Screening PIP

Barriers	Interventions
Existing care management scripts ask members a variety of SDOH questions that do not cover all 5 SDOH core domains.	Standardization of SDOH questions by incorporating the Core 5 Screening Tool into all applicable care management scripts.



4. Conclusions and Recommendations



Conclusions

For this year's validation cycle, COA R5 submitted the clinical *FUH* and the nonclinical *SDOH Screening* PIP. COA R5 reported Remeasurement 1 performance indicator results for both PIPs, and both PIPs were validated through Step 9 (Outcomes stage). Both PIPs received a *High Confidence* level for adherence to acceptable PIP methodology in the Design and Implementation stages. In the Outcomes stage, the *FUH* PIP received a *Moderate Confidence* level and the *SDOH* PIP received a *High Confidence* level that the PIP achieved significant improvement.

HSAG's PIP validation findings suggest a thorough application of the PIP Design stage (Steps 1 through 6) for both PIPs. A methodologically sound design created the foundation for COA R5 to progress to subsequent PIP stages—collecting data and carrying out interventions to positively impact performance indicator results and outcomes for the project. In the Implementation stage (Steps 7 and 8), COA R5 accurately reported performance indicator data and initiated methodologically sound improvement strategies for both PIPs. In the Outcomes stage (Step 9), Remeasurement 1 results for the *FUH* PIP demonstrated an improvement in the seven-day follow-up rate that was not statistically significant. Remeasurement 1 results for the *SDOH Screening* PIP demonstrated statistically significant improvement over baseline results. COA R5 will report Remeasurement 2 indicator results for both PIPs and will progress to being evaluated for sustaining significant improvement for one PIP, *SDOH Screening*, in next year's validation.



Recommendations

Based on the validation of each PIP, HSAG has the following recommendations:

- Revisit causal/barrier analyses at least annually to ensure timely and accurate identification and prioritization of barriers and opportunities for improvement.
- Use QI tools such as a key driver diagram, process mapping, and/or failure modes and effects analyses to determine and prioritize barriers and process gaps or weaknesses, as part of the causal/barrier analyses.
- Use Plan-Do-Study-Act (PDSA) cycles to meaningfully evaluate the effectiveness of each intervention. The RAE should select intervention effectiveness measures that directly monitor intervention impact and evaluate measure results frequently throughout each measurement period. The intervention evaluation results should drive next steps for interventions and determine whether they should be continued, expanded, revised, or replaced.



Appendix A. Final PIP Submission Forms

Appendix A contains the final PIP Submission Forms that COA R5 submitted to HSAG for validation. HSAG made only minor grammatical corrections to these forms; the content/meaning was not altered. This appendix does not include any attachments provided with the PIP submission.







Demographic Information				
Managed Care Organization (MCO) Name: Colorad	do Access Region 5			
Project Leader Name: Sarah Thomas	Title: Senior Quality Improvement Consultant			
Telephone Number: <u>1-800-511-5010</u>	Email Address: sarah.thomas@coaccess.com			
PIP Title: Follow-Up After Hospitalization for Mental Illness (FUH)				
Submission Date: <u>10/31/2024</u>				
Resubmission Date (if applicable):				

Colorado Access Region 5 2024-25 PIP Submission Form State of Colorado







Step 1: Select the PIP Topic. The topic should be selected based on data that identify an opportunity for improvement. The goal of the project should be to improve member health, functional status, and/or satisfaction. The topic may also be required by the State.

PIP Topic: Follow-Up After Hospitalization for Mental Illness (FUH) – 7 Days: This performance improvement project (PIP) topic was one of the three options for the Region 5 behavioral health PIP mandated by the Colorado Department of Health Care Policy and Financing (the Department). Colorado Access chose FUH because it corresponds with established metrics, such as Healthcare Effectiveness Data and Information Set (HEDIS 61) and the Accountable Care Collaborative (ACC) Key Performance Indicators (KPI) incentive payment program for the RAEs.

[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Provide plan-specific data:

Follow-up after hospitalization for mental illness is a prioritized metric within Colorado Access. The metric gained momentum during the COVID-19 pandemic where the demand for behavioral health care needs drastically increased in almost every healthcare setting, including inpatient hospital settings. The demand for behavioral health care was exacerbated by the ongoing national shortage of behavioral health providers, which further worsened Colorado's mental health resources and put the state into a mental health crisis, with Children's Hospital Colorado declaring a "State of Emergency" for youth mental health in 2021. Colorado continues to display some of the highest prevalence of mental illness and lowest rates of access to care when compared to other states.^{3,4}

Colorado Access has observed a relatively steady and flat trend in FUH since 2022, with rates hovering between 35-39% for Region 5 members. As of June 30th, 2023, the baseline rate (July 1st, 2022-June 30th, 2023) for Region 5 FUH was 36.96%. Comparatively, the Region 5 baseline rate was 38.42% as of June 30th, 2022, with slight fluctuations occurring in the year between.

Follow-up after hospitalization for mental illness has been a difficult measure to improve, and there have been many identified barriers that impact this metric:

Colorado Access Region 5 2024-25 PIP Submission Form State of Colorado







Step 1: Select the PIP Topic. The topic should be selected based on data that identify an opportunity for improvement. The goal of the project should be to improve member health, functional status, and/or satisfaction. The topic may also be required by the State.

- Behavioral health staffing continues to be an issue with both inpatient and outpatient facilities. The lack of staff in inpatient hospitals limits the facility's ability to go the extra step to schedule a follow-up behavioral health appointment for a member at an outpatient facility within seven days of discharge. Similarly, there is a lack of staff in the outpatient behavioral health clinics, and therefore it is difficult to maintain appointment availability within seven days of discharge.
- Hospitals lack partnerships and connections with outpatient behavioral health facilities, and experience difficulty determining which
 members are already connected to outpatient behavioral health entities. This creates challenges for the hospitals to assist in scheduling
 follow-up behavioral health appointments.
- Once members are discharged, this metric relies on a member showing up for their follow-up behavioral health appointment. It is common
 to see a high number of missed appointments and late cancellations to behavioral health appointments, thus impacting the quick nature
 and short service completion timeframe required of this metric.
- The FUH denominator has been slowly increasing, with more members being admitted for inpatient mental health services. Many members experience frustration when trying to find outpatient behavioral health services, and the only way to receive timely services is by going to the emergency room, resulting in a subsequent inpatient admission for mental health. The increase in patients requiring inpatient admission causes a greater strain on hospital staff as it becomes challenging to provide adequate behavioral health staffing to provide timely and high-quality services.
- Member readmissions cause hospital staff exhaustion and burnout, therefore reducing the level of investment and priority in establishing follow-up care.
- Some hospitals elect to complete follow-up appointments with patients on the day of discharge to ensure that follow-up appointments
 are completed prior to the member's discharge. While this improves patient access and leads to fewer missed or canceled follow-up
 appointments, this type of follow-up appointment completed by the hospitals would not be captured within this metric as follow-up
 appointments completed on the day of discharge are excluded.

Describe how the PIP topic has the potential to improve member health, functional status, and/or satisfaction:

"In 2019, nearly one in five adults aged 18 and older in the U.S. had a diagnosed mental health disorder. Despite this, individuals hospitalized for mental health disorders often do not receive adequate follow-up care. Providing follow-up care to patients after psychiatric hospitalization can improve patient outcomes, decrease the likelihood of re-hospitalization and the overall cost of outpatient care.⁵"

Colorado Access Region 5 2024-25 PIP Submission Form State of Colorado Page A







Step 1: Select the PIP Topic. The topic should be selected based on data that identify an opportunity for improvement. The goal of the project should be to improve member health, functional status, and/or satisfaction. The topic may also be required by the State.

Maintaining a focus around increasing follow-up after hospitalization will reduce inequalities associated with access, and improve healthcare outcomes for members by delivering mental health services during the most critical period immediately after hospitalization. Providing follow up care is associated with improved medication adherence, decreased suicide risk, and increased long-term health care engagement, thus preventing readmissions. Colorado Access has placed a large emphasis on behavioral health programming by devoting resources to promoting follow-up visits after hospitalizations for our members. FUH align with NCQA and Centers for Medicare & Medicaid Services (CMS) priorities, which further solidifies Colorado Access' selection of this metric.

Sources:

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Colorado Access Region 5 2024-25 PIP Submission Form State of Colorado







Step 2: Define the PIP Aim Statement(s). Defining the Aim statement(s) helps maintain the focus of the PIP and sets the framework for data collection, analysis, and interpretation.

The statement(s) should:

- Be structured in the recommended X/Y format: "Does doing X result in Y?"
- The statement(s) must be documented in clear, concise, and measurable terms.
- Be answerable based on the data collection methodology and indicator(s) of performance.

Statement(s):

By June 30th, 2025, use targeted FUH interventions to *increase* the percentage of seven day follow-up visits after hospitalization among Region 5 members six years of age and older from 36.96% to 41.03%.

Colorado Access utilized the HEDIS Quality Compass to determine an appropriate Specific, Measurable, Attainable, Realistic, Time-bound (SMART) Aim goal¹. Colorado Access' current baseline rate of 36.96% is greater than the 50th percentile national benchmark for the HEDIS Medicaid FUH metric. Therefore, Colorado Access has chosen the 66.67th percentile national benchmark of 41.03% as our goal. Colorado Access further utilized the HSAG Quick Start Guide for Statistical Testing^{2,3} to verify this goal would yield statistically significant (95 percent confidence level, $p \le 0.05$) improvement over the baseline performance.

Sources:

- 1. Quality Compass NCQA. (2023, January 27). NCQA. https://www.ncqa.org/programs/data-and-information-technology/datapurchase-and-licensing/quality-compass/
- 2. Analyze a 2x2 contingency table. (n.d.), https://www.graphpad.com/quickcalcs/contingency1.cfm
- 3. Quick Start Guide for Statistical Testing (n.d.). https://www.hsag.com/contentassets/3f0180a5a4d84b73bea402165443cf50/pipvalquickstartstattestv1508.pdf

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Step 3: Define the PIP Population. The PIP population must be clearly defined to represent the population to which the PIP Aim statement(s) and indicator(s) apply.

The population definition must:

- Include the requirements for the length of enrollment, continuous enrollment, new enrollment, and allowable gap criteria.
- Include the age range and the anchor dates used to identify age criteria, if applicable.
- Include all inclusion, exclusion, and diagnosis criteria used to identify the eligible population.
- Include a list of diagnosis/procedure/pharmacy/billing codes used to identify the eligible population, if applicable. Codes identifying numerator compliance should not be provided in Step 3.
- Capture all members to whom the statement(s) applies.
- Include how race and ethnicity will be identified, if applicable.
- If members with special healthcare needs were excluded, provide the rationale for the exclusion.

* All population, enrollment inclusion, exclusion and diagnosis criteria are located within the HEDIS MY2023 Specification documents. What is outlined below has been directly taken from these HEDIS specification documents¹.

1. HEDIS Measures and Technical Resources - NCQA. (2023, October 4). NCQA. https://www.ncqa.org/hedis/measures/

Population definition:

All continuously enrolled Region 5 members six years of age and older who were discharged after being hospitalized for treatment of selected mental illness or intentional self-harm diagnoses from July 1st, 2022 – June 30th, 2025.

Enrollment requirements (if applicable):

Members must have continuous Medicaid enrollment from the date of discharge through 30 days after discharge.

Member age criteria (if applicable):

Ages six years and older as of the date of discharge.

Inclusion, exclusion, and diagnosis criteria:

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Step 3: Define the PIP Population. The PIP population must be clearly defined to represent the population to which the PIP Aim statement(s) and indicator(s) apply.

The population definition must:

- Include the requirements for the length of enrollment, continuous enrollment, new enrollment, and allowable gap criteria.
- Include the age range and the anchor dates used to identify age criteria, if applicable.
- Include all inclusion, exclusion, and diagnosis criteria used to identify the eligible population.
- Include a list of diagnosis/procedure/pharmacy/billing codes used to identify the eligible population, if applicable. Codes identifying numerator compliance should not be provided in Step 3.
- Capture all members to whom the statement(s) applies.
- Include how race and ethnicity will be identified, if applicable.
- If members with special healthcare needs were excluded, provide the rationale for the exclusion.

Inclusion Criteria: All continuously enrolled Region 5 members six years of age and older who were discharged after being hospitalized for treatment of selected mental illness or intentional self-harm diagnoses from July 1st, 2022 – June 30th, 2025.

- Inpatient discharge inclusion criteria: Members must have an acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm (Mental Illness Value Set; Intentional Self-Harm Value Set) on the discharge claim on or between the PIP measurement year. PIP measurement years include:
 - o Baseline: July 1^{st,} 2022 June 30^{th,} 2023
 - o Remeasurement Year 1: July 1^{st,} 2023 June 30^{th,} 2024
 - o Remeasurement Year 2: July 1st, 2024 June 30th, 2025

To identify acute inpatient discharges:

- 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
- 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
- 3. Identify the discharge date for the stay.

The denominator for this measure is based on discharges, not on members. If members have more than one discharge, include all discharges on or between the PIP measurement year.

Exclusion Criteria:

• Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).

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Step 3: Define the PIP Population. The PIP population must be clearly defined to represent the population to which the PIP Aim statement(s) and indicator(s) apply.

The population definition must:

- ◆ Include the requirements for the length of enrollment, continuous enrollment, new enrollment, and allowable gap criteria.
- Include the age range and the anchor dates used to identify age criteria, if applicable.
- Include all inclusion, exclusion, and diagnosis criteria used to identify the eligible population.
- Include a list of diagnosis/procedure/pharmacy/billing codes used to identify the eligible population, if applicable. <u>Codes identifying numerator compliance should not be provided in Step 3.</u>
- Capture all members to whom the statement(s) applies.
- Include how race and ethnicity will be identified, if applicable.
- If members with special healthcare needs were excluded, provide the rationale for the exclusion.
- Exclude discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 30-day follow-up period, regardless of the principal diagnosis for the readmission. These discharges are excluded from the measure because rehospitalization or direct transfer may prevent an outpatient follow-up visit from taking place.
- Exclude members who meet either of the following criteria:
 - Members in hospice or using hospice services anytime during the measurement year. Refer to HEDIS General Guideline 15:
 Members in Hospice.
 - o Members who died any time during the measurement year. Refer to HEDIS General Guideline 16: Deceased Members.

Diagnosis/procedure/pharmacy/billing codes <u>used to identify the eligible population</u> (if applicable): Members must have an acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm (Mental Illness Value Set; Intentional Self-Harm Value Set) on the discharge claim on or between the PIP measurement year. All diagnosis and billing codes are located in the identified value sets provided by HEDIS.

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Step 4: Use Sound Sampling Methods. If sampling is used to select members of the population (denominator), proper sampling methods are necessary to ensure valid and reliable results. Sampling methods must be in accordance with generally accepted principles of research design and statistical analysis. If sampling was not used, please leave table blank and document that sampling was not used in the space provided below the table.

The description of the sampling methods must:

- Include components identified in the table below.
- Be updated annually for each measurement period and for each indicator.
- Include a detailed narrative description of the methods used to select the sample and ensure sampling methods support generalizable

Measurement Period	Performance Indicator Title	Sampling Frame Size	Sample Size	Margin of Error and Confidence Level
MM/DD/YYYY- MM/DD/YYYY	Sampling was not used.			

Describe in detail the methods used to select the sample:

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Step 5: Select the Performance Indicator(s). A performance indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) must track performance or improvement over time. The indicator(s) must be objective, clearly, and unambiguously defined, and based on current clinical knowledge or health services research.

The description of the Indicator(s) must:

- Include the complete title of each indicator.
- Include the rationale for selecting the indicator(s).
- Include a narrative description of each numerator and denominator.
- If indicator(s) are based on nationally recognized measures (e.g., HEDIS, CMS Core Set), include the year of the technical specifications used for the applicable measurement year and update the year annually.
- Include complete dates for all measurement periods (with the month, day, and year).
- Include the mandated goal or target, if applicable. If no mandated goal or target enter "Not Applicable."

Indicator 1	The percentage of discharges for Region 5 members six years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and had a follow-up visit with a mental health provider within seven days after discharge.
	This indicator uses HEDIS methodology (Measurement Year 2023 specifications) published by NCQA. *HEDIS differences:
	 Specifications will be run with 12 month rolling rates (not calendar year which true HEDIS specifications use) Due to differences in timeline, we are using internal resources to collect this data (not our certified HEDIS vendor).
	This indicator was selected because it was one of the three options for the Region 5 behavioral health PIP mandated by the Department. Colorado Access chose FUH because the current baseline rate has ample room for improvement, and this metric corresponds with many established metrics, such as HEDIS and the ACC and KPI incentive payment program for the RAE's.
Numerator Description:	Number of Region 5 members who received a follow-up visit with a mental health provider within seven days after discharge. Do not include visits that occur on the date of discharge.

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Step 5: Select the Performance Indicator(s). A performance indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) must track performance or improvement over time. The indicator(s) must be objective, clearly, and unambiguously defined, and based on current clinical knowledge or health services research.

The description of the Indicator(s) must:

- Include the complete title of each indicator.
- Include the rationale for selecting the indicator(s).
- Include a narrative description of each numerator and denominator.
- If indicator(s) are based on nationally recognized measures (e.g., HEDIS, CMS Core Set), include the year of the technical specifications used for the applicable measurement year and update the year annually.
- Include complete dates for all measurement periods (with the month, day, and year).
- Include the mandated goal or target, if applicable. If no mandated goal or target enter "Not Applicable."

	0 7 11
Denominator Description:	Number of Region 5 members six years of age and older who were discharged after being hospitalized for treatment of selected mental illness or intentional self-harm diagnoses as of the end of the performance period.
Baseline Measurement Period	July 1 st , 2022 – June 30 th , 2023
Remeasurement 1 Period	July 1 st , 2023 – June 30 th , 2024
Remeasurement 2 Period	July 1 st , 2024 – June 30 th , 2025
Mandated Goal/Target, if	41.03%
applicable	Colorado Access utilized the HEDIS Quality Compass to determine an appropriate
	SMART Aim goal. Colorado Access' current baseline rate of 36.96% is greater than the 50 th percentile
	national benchmark for the HEDIS Medicaid FUH metric. Therefore, Colorado Access has chosen the
	66.67 th percentile national benchmark of 41.03% as our goal. Colorado Access further utilized the HSAG
	Quick Start Guide for Statistical Testing ^{2,3} to verify this goal would yield statistically significant (95
	percent confidence level, $p \le 0.05$) improvement over the baseline performance.

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Step 6: Valid and Reliable Data Collection. The data collection process must ensure that data collected for each indicator are valid and reliable.

The data collection methodology must include the following:

- Identification of data elements and data sources.
- When and how data are collected.
- How data are used to calculate the indicator percentage.
- A copy of the manual data collection tool, if applicable.
- An estimate of the reported administrative data completeness percentage and the process used to determine this percentage.

Data Sources (Select all that apply) []Manual Data [] Administrative Data [] Survey Data Data Source Fielding Method Data Source [X] Programmed pull from claims/encounters Personal interview [] Paper medical record] Supplemental data Mail abstraction Phone with CATI script Electronic health record query [] Electronic health record] Complaint/appeal 1 Phone with IVR abstraction] Pharmacy data Internet Record Type Telephone service data/call center data Other [] Outpatient Appointment/access data [] Inpatient Delegated entity/vendor data Other, please explain in] Other Other Survey Requirements: narrative section. Number of waves: Other Requirements Response rate: Data collection tool [X] Codes used to identify data elements (e.g., ICD-10, CPT codes)-Incentives used: attached (required for manual please attach separately - HEDIS Value Set attached record review) [] Data completeness assessment attached [] Coding verification process attached Estimated percentage of reported administrative data completeness at the time the data are generated: 95.01% complete.

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Step 6: Valid and Reliable Data Collection. The data collection process must ensure that data collected for each indicator are valid and reliable.

The data collection methodology must include the following:

- Identification of data elements and data sources.
- When and how data are collected.
- How data are used to calculate the indicator percentage.
- A copy of the manual data collection tool, if applicable.
- An estimate of the reported administrative data completeness percentage and the process used to determine this percentage.

Description of the process used to calculate the reported administrative data completeness percentage. Include a narrative of how claims lag may have impacted the data reported:

Data was calculated after 09/30/2023, with a 3-month delay to account for claims runout. The Colorado Access internal Incurred But Not Reported (IBNR) model uses historic claims volume and runout to estimate completion factors every month and calculates an estimate to reserve for claims incurred but not yet reported. The October 2023 IBNR report shows a 95.01% completion rate for June 2023 services. The October 2024 IBNR report shows a 94.96% completion rate for June 2024 services.

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In the space below, describe the step-by-step data collection process used in the production of the indicator results:

Data Elements Collected: Data elements were collected from Colorado Access's internal claims databases (HRP and Truven). There were 62 elements sourced from three sourced data tables:

Truven and HRP Database Collection

16 elements sourced from internal Region 5 enrollment tables:

- Medicaid ID, ACC Enrollment Indicator, Medicaid Number, Member Snapshot Date, Client Eligibility End Date, Enrollment Effective Date, and Enrollment End Date
- Primary Care Medical Providers (PCMP) Business Provider Name (Attributed Provider), PCMP MC Provider ID, and Member Snapshot Provider Name (Clinic Level Detail for Attributed Provider)
- Race Description, Gender Code, Client Date of Birth, Disabled Eligibility Type Indicator, Special Needs Indicator, and Pregnancy Indicator

46 elements sources from HRP and Truven claims tables:

- Denominator Claim ID, Numerator Claim ID, Denominator Claim Line Number, Numerator Claim Line Number, and Numerator Date (Claim First Service Date when record is in Numerator)
- Procedure Code, Procedure Code Description, Diagnosis 1-4 Codes, and Diagnosis 1-4 Descriptions
- Billing Provider Location ID, Billing Provider Location Name, Billing Vendor, Billing Vendor Tax ID, Billing Provider Medicaid ID,
 Billing Provider NPI, Billing Provider Type, Rendering Provider Location ID, Rendering Provider Location Name, Rendering Provider Type Code, Rendering Provider Type Description, Intake Provider Name
- Medicaid Number, Medicaid ID, Client Home City, Client Home State, Client Home County Name, Client Home Zip Code, Race Description, Gender Code, and Client Date of Birth
- Claims First Service Date, Claim Status Code, Claim Line Status Code, Most Recent Claim Indicator, Revenue Code, Paid Amount, Admission Date, Discharge Date, Bill Type Code, Place of Service Code, Claim Type, Claim Status, Claim Line Status, Service Category, Current Record Indicator, and Aid Code

Colorado Access then conducts additional calculations matched to the listed specification below to produce the FUH rate:

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In the space below, describe the step-by-step data collection process used in the production of the indicator results:

- Numerator Specifications: The FUH numerator follow the HEDIS methodology (Measurement Year 2023 specifications) published by NCQA¹. Both paid and denied claims are included. Please reference the HEDIS Value Set excel document for specific diagnosis and CPT codes. This is located on tab 3, "Value Set to Codes", under the Value Set Name column. Numerator specifications include multiple value sets, including:
 - o An outpatient visit (Visit Setting Unspecified Value Set) with (Outpatient POS Value Set) with a mental health provider.
 - o An outpatient visit (BH Outpatient Value Set) with a mental health provider.
 - An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) with (Partial Hospitalization POS Value Set).
 - o An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set).
 - A community mental health center visit (Visit Setting Unspecified Value Set; BH Outpatient Value Set; Observation Value Set; Transitional Care Management Services Value Set) with (Community Mental Health Center POS Value Set).
 - Electroconvulsive therapy (Electroconvulsive Therapy Value Set) with (Ambulatory Surgical Center POS Value Set;
 Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set).
 - o A telehealth visit: (Visit Setting Unspecified Value Set) with (Telehealth POS Value Set) with a mental health provider.
 - o An observation visit (Observation Value Set) with a mental health provider.
 - o Transitional care management services (Transitional Care Management Services Value Set), with a mental health provider.
 - o A visit in a behavioral healthcare setting (Behavioral Healthcare Setting Value Set).
 - o A telephone visit (Telephone Visits Value Set) with a mental health provider.
 - o Psychiatric collaborative care management (Psychiatric Collaborative Care Management Value Set).
- Denominator Specifications: The FUH denominator follows the HEDIS methodology (Measurement Year 2023 specifications) published by NCQA¹. Both paid and denied claims are included. Please reference the HEDIS Value Set excel document for specific diagnosis and CPT codes. This is located on tab 3, "Value Set to Codes", under the Value Set Name column. Denominator specifications include multiple value sets, including:
 - Mental Illness Value Set
 - o Intentional Self-Harm Value Set
 - Inpatient Stav Value Set

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In the space below, describe the step-by-step data collection process used in the production of the indicator results:

Nonacute Inpatient Stay Value Set

Reference: HEDIS Measures and Technical Resources - NCQA. (2023, October 4). NCQA. https://www.ncqa.org/hedis/measures/

Data Collection Process:

To extract the data, the Colorado Access Business Intelligence (BI) developer wrote a data extraction SQL code to pull claims from Colorado Access's internal claims databases (HRP) and Truven. The data extraction code reflects the baseline measurement period from July 1st, 2022 through June 30th, 2023. The "claims first service date" field, which corresponds to date of service, was used to account for all claims during the measurement period. For claims that have been adjudicated multiple times, claims were also filtered so that only the most recent adjudication was included in the dataset. Claim paid status was ignored; both paid and denied claims were included. For the approximate 62 attributes included in the data set from the two database sources, three tables were used to source the data: enrollment tables and two claims tables. Matching logic for Medicaid ID and RAE location indicator were applied during all table joins. Depending on database source, different attributes were sourced from different tables.

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Step 7: Indicator Results. Enter the results of the indicator(s) in the table below. For HEDIS-based/CMS Core Set PIPs, the data reported in the PIP Submission Form should match the validated performance measure rate(s).

Enter results for each indicator by completing the table below. P values must be reported to four decimal places (i.e., 0.1234). Additional remeasurement period rows can be added, if necessary.

Indicator 1 Title: The percentage of discharges for Region 5 members six years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider up within 7 days after discharge.

Measurement Period	Indicator Measurement	Numerator	Denominator	Percentage	Mandated Goal or Target, if applicable	Statistical Test Used, Statistical Significance, and p Value
July 1st, 2022 – June 30th, 2023	Baseline	476	1,288	36.96%	N/A for baseline	N/A for baseline
July 1st, 2023 – June 30th, 2024	Remeasurement 1	509	1,249	40.80%	41.03%	Chi Square with Yates Correction; we have not yet achieved statistically significant improvement; p value = 0.0548 (>0.05).
July 1st, 2024 – June 30th, 2025	Remeasurement 2					

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Step 7: Data Analysis and Interpretation of Results. Clearly document the results for each indicator(s). Describe the data analysis performed, the results of the statistical analysis, and a narrative interpretation of the results.

The data analysis and interpretation of indicator results must include the following for each measurement period:

- Data presented clearly, accurately, and consistently in both table and narrative format.
- A clear and comprehensive narrative description of the data analysis process, the percentage achieved for the measurement period for each indicator, and the type of two-tailed statistical test used. Statistical testing p value results must be calculated and reported to four decimal places (e.g., 0.1234).
- Statistical testing must be conducted starting with Remeasurement 1 and comparing to the baseline. For example, Remeasurement 1 to the baseline and Remeasurement 2 to the baseline. For purposes of the validation, statistical testing does not need to be conducted between measurement periods (e.g., Remeasurement 1 to Remeasurement 2).
- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
- A statement indicating whether factors that could threaten (a) the validity of the findings for each measurement period, including the
 baseline, and (b) the comparability of each remeasurement period to the baseline was identified. If there were no factors identified,
 this must be documented in Step 7.

Baseline Narrative:

The preliminary baseline data analysis revealed that 36.96% of Region 5 members six years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses had a follow-up visit with a mental health provider within seven days after discharge from July 1st, 2022-June 30th, 2023. Colorado Access utilized the HEDIS Quality Compass to determine an appropriate SMART Aim goal¹. Colorado Access' current baseline rate of 36.96% is greater than the 50^{th} percentile national benchmark for the HEDIS Medicaid FUH metric. Therefore, Colorado Access has chosen the 66.67^{th} percentile national benchmark of 41.03% as our goal. Colorado Access further utilized the *HSAG Quick Start Guide for Statistical Testing*^{2,3} to verify this goal would yield statistically significant (95 percent confidence level, p < 0.05) improvement over the baseline performance and determined that 41.03% would be an appropriate goal (an approximate increase of 53 Region 5 members).

Colorado Access does not foresee any factors affecting the validity of the data due to the use of standardized HEDIS methodology. Colorado Access does however anticipate that the expiration of the COVID-19 Public Health Emergency (PHE) will impact member demographics during the PIP remeasurement period. States began to terminate Medicaid enrollment for individuals who were no longer eligible beginning in

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Step 7: Data Analysis and Interpretation of Results. Clearly document the results for each indicator(s). Describe the data analysis performed, the results of the statistical analysis, and a narrative interpretation of the results.

The data analysis and interpretation of indicator results must include the following for each measurement period:

- Data presented clearly, accurately, and consistently in both table and narrative format.
- A clear and comprehensive narrative description of the data analysis process, the percentage achieved for the measurement period for each indicator, and the type of two-tailed statistical test used. Statistical testing p value results must be calculated and reported to four decimal places (e.g., 0.1234).
- Statistical testing must be conducted starting with Remeasurement 1 and comparing to the baseline. For example, Remeasurement 1 to the baseline and Remeasurement 2 to the baseline. For purposes of the validation, statistical testing does not need to be conducted between measurement periods (e.g., Remeasurement 1 to Remeasurement 2).
- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
- A statement indicating whether factors that could threaten (a) the validity of the findings for each measurement period, including the baseline, and (b) the comparability of each remeasurement period to the baseline was identified. If there were no factors identified, this must be documented in Step 7.

May of 2023. Colorado Access anticipates that the demographic populations of Health First Colorado and CHP+ MCO members will undergo a noticeable shift during PIP remeasurement year 1 due to the absence of continuous eligibility and the movement of members between health insurers and regions. These changes will significantly impact measure denominators throughout the PIP, and Colorado Access expects to see the CHP+ MCO member population increase, and Health First Colorado member population decrease. Colorado Access will continue to monitor demographic population changes and will adjust PIP interventions and programming according to the evolving needs of its members.

Sources:

- Quality Compass NCQA. (2023, January 27). NCQA. https://www.ncqa.org/programs/data-and-information-technology/data-purchase-and-licensing/quality-compass/
- 2. Analyze a 2x2 contingency table. (n.d.). https://www.graphpad.com/quickcalcs/contingency1.cfm
- 3. Quick Start Guide for Statistical Testing (n.d.). https://www.hsag.com/contentassets/3f0180a5a4d84b73bea402165443cf50/pipvalquickstartstattestv1508.pdf

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Step 7: Data Analysis and Interpretation of Results. Clearly document the results for each indicator(s). Describe the data analysis performed, the results of the statistical analysis, and a narrative interpretation of the results.

The data analysis and interpretation of indicator results must include the following for each measurement period:

- Data presented clearly, accurately, and consistently in both table and narrative format.
- A clear and comprehensive narrative description of the data analysis process, the percentage achieved for the measurement period for each indicator, and the type of two-tailed statistical test used. Statistical testing p value results must be calculated and reported to four decimal places (e.g., 0.1234).
- Statistical testing must be conducted starting with Remeasurement 1 and comparing to the baseline. For example, Remeasurement 1 to the baseline and Remeasurement 2 to the baseline. For purposes of the validation, statistical testing does not need to be conducted between measurement periods (e.g., Remeasurement 1 to Remeasurement 2).
- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
- A statement indicating whether factors that could threaten (a) the validity of the findings for each measurement period, including the
 baseline, and (b) the comparability of each remeasurement period to the baseline was identified. If there were no factors identified,
 this must be documented in Step 7.

Baseline to Remeasurement 1 Narrative: The preliminary baseline data analysis revealed that 40.80% of Region 5 members six years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses had a follow-up visit with a mental health provider within seven days after discharge from July 1st, 2023-June 30th, 2024. The data analysis was conducted using claims from Colorado Access's internal databases, with the required components of the analysis detailed in Step 6. This rate showed an 3.84% improvement over the baseline PIP rate of 36.96%. However, it has not surpassed the SMART Aim Region 5 goal of 41.03% and thus does not display statistically significant improvement (95 percent confidence level, *p* value = 0.0548). A two-tailed chi square test with yates' correction was used to calculate the p-value.

Colorado Access did not experience any factors affecting the validity of the data due to the use of standardized HEDIS methodology, nor were there factors that impacted the ability to compare remeasurement results to baseline results. However, Colorado Access observed that the expiration of the COVID-19 PHE impacted member demographics during the PIP remeasurement period. States began to terminate Medicaid enrollment for individuals who were no longer eligible beginning in May 2023, which affected the demographic populations of Health First Colorado and CHP+ MCO members during the PIP remeasurement year one. This was reflected in Colorado Access' data, with the overall Region 5 member population decreasing by 28% during state fiscal year (SFY) 23-24. Despite this decline, the FUH Region 5 denominator

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Step 7: Data Analysis and Interpretation of Results. Clearly document the results for each indicator(s). Describe the data analysis performed, the results of the statistical analysis, and a narrative interpretation of the results.

The data analysis and interpretation of indicator results must include the following for each measurement period:

- Data presented clearly, accurately, and consistently in both table and narrative format.
- A clear and comprehensive narrative description of the data analysis process, the percentage achieved for the measurement period for each indicator, and the type of two-tailed statistical test used. Statistical testing p value results must be calculated and reported to four decimal places (e.g., 0.1234).
- Statistical testing must be conducted starting with Remeasurement 1 and comparing to the baseline. For example, Remeasurement 1 to the baseline and Remeasurement 2 to the baseline. For purposes of the validation, statistical testing does not need to be conducted between measurement periods (e.g., Remeasurement 1 to Remeasurement 2).
- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
- A statement indicating whether factors that could threaten (a) the validity of the findings for each measurement period, including the baseline, and (b) the comparability of each remeasurement period to the baseline was identified. If there were no factors identified, this must be documented in Step 7.

fluctuated throughout the year, with both increases and decreases. The FUH rate had been steadily increasing over the past few years for various reasons (thoroughly outlined in Step 1 above), most notably the gradual increase in the FUH denominator as more members have been admitted for inpatient mental health services. Many members experience frustration when trying to find outpatient behavioral health services, often resorting to emergency room visits to receive timely care, which results in subsequent inpatient admissions for mental health.

Additionally, the HEDIS specifications for the FUH measure have fewer requirements for continuous eligibility, with the members only needing continuous enrollment from the date of discharge through 30 days after discharge, making membership changes less likely to impact eligibility for this measure. However, the recent decrease in the denominator, by a few hundred members, may be attributed to a delayed effect of the PHE unwind. The FUH denominator is based on the number of hospital discharges, with many members experiencing repeat admissions throughout the year. If certain members who frequently readmit were disenrolled from Medicaid, this could account for the decrease. We anticipate the PIP FUH denominator to continue declining before stabilizing in remeasurement year two, due to the overall decrease in Region 5 membership. The improvement in this rate is encouraging, driven by programmatic interventions targeting FUH, which are detailed below.

Baseline to Remeasurement 2 Narrative: N/A

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Appendix A: State of Colorado 2024-25 PIP Submission Form Follow-Up After Hospitalization for Mental Illness (FUH) for Colorado Access Region 5



Step 8: Improvement Strategies. Interventions are developed to target and address causes/barriers identified through the use of quality improvement (QI) processes and tools.

The documentation of Step 8 is organized into the following three sections:

- A. Quality Improvement (QI) Team and Activities Narrative Description
- B. Barriers/Interventions Table: Prioritized barriers and corresponding intervention descriptions
- C. Intervention Worksheet:
 - Intervention Description
 - o Intervention Effectiveness Measure
 - Intervention Evaluation Results
 - o Intervention Status

A. Quality Improvement (QI) Team and Activities Narrative Description OI Team Members:

- Sarah Thomas, Senior Quality Improvement Consultant at Colorado Access
- Stacy Stapp, Senior Quality Improvement Consultant at Colorado Access
- Lauren Ratliff, Senior Quality Improvement Consultant at Colorado Access
- Kathryn Burch, Director of Quality Improvement and Accreditation at Colorado Access
- Madhu Mallela, Senior Director of Quality Improvement and Health Outcomes at Colorado Access
- Health Outcomes/Program Analytics Team, Data Analysts at Colorado Access
- Beckie Lagerborg, Behavioral Health Program Manager at Colorado Access
- Jessica Cabral, Behavioral Health Program Manager at Colorado Access
- Sarrah Knause, Payment Reform Manager at Colorado Access
- Emily DeFrancia, Manager of Behavioral Health at Colorado Access

QI process and/or tools used to identify and prioritize barriers: The quality team used the Six Sigma DMAIC (Define, Measure, Analyze, Improve, and Control) model to identify the current state, prioritize barriers, and determine improvement opportunities. During the "Define" phase, the team discovered that although the Region 5 baseline measure is slightly higher than the 50th percentile of HEDIS national rankings, there is still ample room for improvement, with the baseline rate being less than 50%. In the "Measure" phase, the team identified trends

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Appendix A: State of Colorado 2024-25 PIP Submission Form Follow-Up After Hospitalization for Mental Illness (FUH) for Colorado Access Region 5



Step 8: Improvement Strategies. Interventions are developed to target and address causes/barriers identified through the use of quality improvement (QI) processes and tools.

The documentation of Step 8 is organized into the following three sections:

- A. Quality Improvement (QI) Team and Activities Narrative Description
- B. Barriers/Interventions Table: Prioritized barriers and corresponding intervention descriptions
- C. Intervention Worksheet:
 - Intervention Description
 - o Intervention Effectiveness Measure
 - Intervention Evaluation Results
 - o Intervention Status

within the FUH measure and noted that FUH has not improved since 2021, remaining stagnant over the past two years. The "Analyze" phase allowed Colorado Access to confirm the validity of the data, identify trends, and pinpoint current barriers. The team used quality tools such as root cause analysis (fishbone diagram) to highlight barriers and conducted brainstorming sessions to develop recommendations for improvement projects targeting FUH. Detailed barriers and interventions are listed in Step B below. The "Improve" phase began during remeasurement year one with the implementation of three improvement projects:

- 1. Revamping the Care Management Behavioral Health Transitions of Care program to stratify members by risk.
- 2. Partnering with five Community Mental Health Centers (CMHCs) to participate in a value-based payment (VBP) program that offers enhanced reimbursement for administering follow-up care to attributed members after an inpatient stay.
- 3. Partnering with nine inpatient hospitals to participate in a new payment model that offers hospitals enhanced reimbursement for coordinating follow-up after a member's inpatient stay.

Additionally, the development of a bidirectional dashboard system provides real-time discharge information to hospitals and CMHCs to support coordinated discharge planning. While not listed as a separate intervention, the dashboard is integral to the success of all three improvement projects, enhancing communication and collaboration across the board.

These interventions are ongoing and will be further analyzed to determine their individual impact on the improvement of FUH rates. They will be adapted and expanded based on the results.

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Appendix A: State of Colorado 2024-25 PIP Submission Form Follow-Up After Hospitalization for Mental Illness (FUH) for Colorado Access Region 5



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B. Barriers/Interventions Table: In the table below, list interventions currently being evaluated, and barrier(s) addressed by each intervention. For each intervention, complete a Step 8 Intervention Worksheet. The worksheet must be completed to the point of intervention progression at the time of the annual PIP submission.

Intervention Title	Barrier(s) Addressed	
Care Management Behavioral Health Transitions of	Care managers (CMs) faced barriers with the existing outreach	
Care Program	program, including high workloads, insufficient time to serve	
	members with complex needs, and high administrative burdens	

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COA-R5 CO2024-25 PIP-Val FUH Submission F1 0425





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Colorado Access improved the Care Management Behavioral Health Transitions of Care program, which is designed to identify and intervene with members using inpatient and residential behavioral health services, to connect them to follow-up appointments and prevent readmissions. Care managers coordinate care with providers, connect members with appropriate outpatient behavioral health services, and mitigate barriers to discharge or engagement in follow-up services. due to the large volume of members. To address these issues, the CM team streamlined their member outreach program to stratify members by risk. This aimed to reduce overall admissions and provide an additional touchpoint to high-needs members within seven days after discharge to promote connection to appropriate step-down care.

CMHC Value Based Payment Model

Colorado Access partnered with five CMHCs to participate in a value-based payment) program that offers enhanced reimbursement for administering follow-up care to attributed members after an inpatient stay. These CMHCs use the above dashboard to collaborate with discharging hospitals and Colorado Access to coordinate outpatient follow-up visits within seven days of discharge

CMHCs identified the need for additional financial support to effectively allocate resources toward meeting this metric. Achieving a follow-up behavioral health appointment within seven days requires swift action and increased appointment availability. To meet this demand, CMHCs require enhanced funding to expand their behavioral health staffing. The introduction of this incentive has empowered CMHCs to better

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Step 8: Improvement Strategies. Interventions are developed to target and address causes/barriers identified through the use of quality improvement (QI) processes and tools.

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for behavioral health conditions. CMHCs receive enhanced reimbursement for achieving performance goals related to the seven-day follow-up metric.

prioritize and fulfill the demands of this critical metric. ensuring timely and effective care for patients.

Inpatient Behavioral Health Performance Program

Colorado Access partnered with nine inpatient hospitals to participate in a new payment model that offers hospitals enhanced reimbursement for coordinating follow-up after a member's inpatient stay. Hospitals use the above dashboard to successfully schedule follow-up appointments within seven days of discharge. The dashboard helps hospitals identify either a pre-established CMHC or new behavioral health provider with the capacity to see the member within seven days. These hospitals are incentivized with a tiered per diem

Colorado Access recognized the opportunity to provide increased financial support and incentives, helping hospitals prioritize this important metric. By coordinating discharge with Community Mental Health Centers (CMHCs) to ensure a follow-up behavioral health appointment within seven days, additional funding enabled hospitals to expand behavioral health staffing. This support empowered hospitals to better align resources and improve continuity of care for high-needs patients.

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Appendix A: State of Colorado 2024-25 PIP Submission Form Follow-Up After Hospitalization for Mental Illness (FUH) for Colorado Access Region 5



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 - Intervention Status

percentage increase in reimbursement if they meet certain seven-day follow-up performance thresholds.

C. Intervention Worksheet: Intervention Effectiveness Measure and Evaluation Results

Complete a Step 8 Intervention Worksheet for each intervention currently being evaluated. The worksheet must be completed to the point of intervention progression at the time of the annual PIP submission.

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Demographic Information			
Managed Care Organization (MCO) Name: Colorado Access Region 5			
Project Leader Name: Sarah Thomas	Title: Senior Quality Improvement Consultant		
Telephone Number: <u>1-800-511-5010</u>	Email Address: sarah.thomas@coaccess.com		
PIP Title: Social Determinants of Health (SDOH) Screening			
Submission Date: <u>10/31/2024</u>			
Resubmission Date (if applicable): 1/22/2025			

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Step 1: Select the PIP Topic. The topic should be selected based on data that identify an opportunity for improvement. The goal of the project should be to improve member health, functional status, and/or satisfaction. The topic may also be required by the State.

PIP Topic:

Social Determinants of Health (SDOH) Screening: this performance improvement project (PIP) topic is mandated from the Colorado Department of Health Care Policy and Financing (the Department).

Provide plan-specific data:

This topic is timely and relevant, as Colorado Access is currently in the process of developing an organization wide comprehensive strategy to address Social Determinants of Health (SDOH) in partnership with communities and members. The goal is to create an aligned approach and standardized processes for evaluating and addressing SDOH needs. As part of this approach, we reviewed our existing inventory of SDOH initiatives and identified an opportunity to improve SDOH screenings completed with members internally by the Care Management (CM) team.

Our CM team employs a multi-disciplinary, team-based approach, supporting members across physical health, behavioral health, specialty, and SDOH. CM staff utilize targeted scripts, or intervention and interview templates, based on member diagnosis and/or acuity level to ensure consistent care delivery and to create collaborative care plan goals. Scripts generate a series of questions to aid CMs in identifying barriers to their health care needs and resolve care gaps via telephonic and electronic care coordination. Scripts are completed in the member-centric webbased healthcare management system HealthEdge, also known as GuidingCare. This platform offers health plans easy-to-use, next-generation data integration and workflow management tools that streamline workflows, facilitate coordination and collaboration, accelerate quality improvement, and promote provider and patient engagement. Colorado Access has been utilizing GuidingCare since 2018 to ensure all member touchpoints are documented and care is consistently coordinated.

A preliminary analysis of CM scripts revealed that they do not contain a standardized SDOH screening tool that encompasses the five HCPF required SDOH core domains: 1) Housing Instability, 2) Food Insecurity, 3) Transportation Problems, 4) Utility Help Needs, 5) Interpersonal Safety. Instead, the presence of SDOH-related questions varied by script. Our review determined that 100% of Region 5 CM scripts contained at least one SDOH question from the five SDOH core domains. However, none (0%) covered all five domains within a single script. In FY22-23, 2,170 Region 5 members were in contact with the CM team and completed an applicable script. Of those, 94% were asked at least one SDOH-related question from the five SDOH domains, and 0% of members were asked all five SDOH domains within one script.

Across the 14 applicable SDOH scripts used during FY22-23:

11 scripts included a question on food insecurity

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Step 1: Select the PIP Topic. The topic should be selected based on data that identify an opportunity for improvement. The goal of the project should be to improve member health, functional status, and/or satisfaction. The topic may also be required by the State.

- 10 scripts included a question on housing
- 9 scripts included a question on transportation
- 4 scripts included a question on utilities
- 2 scripts included questions on interpersonal safety

Colorado Access has identified the opportunity to improve SDOH screening within the organization by overhauling all SDOH questions within the CM scripts and incorporating the Core 5 Social Determinants of Health Screening Tool within all applicable CM scripts¹. The Performance Improvement Project (PIP) team evaluated a multitude of SDOH screening tools and determined the Core 5 screening tool was the best tool to use to ask questions to members over the phone; can easily be integrated into pre-established CM scripts and addresses all 5 SDOH core domains. Colorado Access can also build established resource and referral regulations based off SDOH question responses to better serve member needs.

Describe how the PIP topic has the potential to improve member health, functional status, and/or satisfaction:

"Nonmedical social factors such as food, housing, utilities, transportation, and safety significantly influence the health of Coloradans. Unmet social needs limit people from being active in their communities, diminish their overall well-being, and increase the likelihood that a person will develop a chronic disease and not be able to manage their care. These unmet needs are often disproportionately experienced by Black, Latino, and indigenous populations, and are exacerbated during a crisis, like the COVID-19 pandemic, when people experiencing disparities face even greater barriers to protecting their health²." SDOH have been shown to have a greater influence on health than either genetic factors or access to healthcare services³. Addressing disparities in SDOH is a critical step toward achieving health equity. Enhancing SDOH screening processes will ensure members have the opportunity to share their needs and get connected to resources that improve housing stability, food security, transportation access, utility assistance, and safety. This PIP focus has potential to improve social factors, reduce health inequities and increase access to resources for our members by addressing their social needs in a timely manner.

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Step 1: Select the PIP Topic. The topic should be selected based on data that identify an opportunity for improvement. The goal of the project should be to improve member health, functional status, and/or satisfaction. The topic may also be required by the State.

- 1. Core Determinants of Health Screening Tool, aka the "Core 5" BECHTEL & JONES. https://cdn.ymaws.com/www.ohioleaguefornursing.org/resource/resmgr/ohio action coalition/ph nurse leader project/Attachment B CDH Screening T.pdf.
- 2. Interoperable Social Health Information Exchange Ecosystem | Colorado Health Institute. (n.d.). Colorado Health Institute. https://www.coloradohealthinstitute.org/research/interoperable-social-health-information-exchange-SHIE.
- 3. Social determinants of health. (2022, December 8). Centers for Disease Control and Prevention. https://www.cdc.gov/about/sdoh/addressingsdoh.html#:~:text=SDOH%20have%20been%20shown%20to,higher%20risk%20of%20premature%20death.

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Step 2: Define the PIP Aim Statement(s). Defining the Aim statement(s) helps maintain the focus of the PIP and sets the framework for data collection, analysis, and interpretation.

The statement(s) should:

- Be structured in the recommended X/Y format: "Does doing X result in Y?"
- The statement(s) must be documented in clear, concise, and measurable terms.
- Be answerable based on the data collection methodology and indicator(s) of performance.

Statement(s):

By June 30th, 2025, the Colorado Access CM team will utilize targeted interventions to increase the percentage of SDOH screenings among Region 5 members from 0% to 90%.

Colorado Access utilized previous CM call center data to determine an appropriate Specific, Measurable, Attainable, Realistic, Time-bound (SMART) Aim goal. Colorado Access' baseline data shows that CM is completing SDOH questions in >90% of calls (as described in Step 1). Therefore, achieving SDOH screening in over 90% of scripts should be feasible once a standardized SDOH screening tool has been incorporated into all relevant CM scripts. This will also result in a statistically significant improvement over the baseline performance of 0%, with a confidence level of 95% and p-value < 0.05. Colorado Access utilized the HSAG Quick Start Guide for Statistical Testing^{1,2} to verify this goal would yield statistically significant (95 percent confidence level, $p \le 0.05$) improvement over the baseline performance.

Sources:

- 1. Analyze a 2x2 contingency table. (n.d.). https://www.graphpad.com/quickcalcs/contingency1.cfm
- 2. Quick Start Guide for Statistical Testing (n.d.). https://www.hsag.com/contentassets/3f0180a5a4d84b73bea402165443cf50/pipvalquickstartstattestv1508.pdf

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Step 3: Define the PIP Population. The PIP population must be clearly defined to represent the population to which the PIP Aim statement(s) and indicator(s) apply.

The population definition must:

- Include the requirements for the length of enrollment, continuous enrollment, new enrollment, and allowable gap criteria.
- Include the age range and the anchor dates used to identify age criteria, if applicable.
- Include all inclusion, exclusion, and diagnosis criteria used to identify the eligible population.
- Include a list of diagnosis/procedure/pharmacy/billing codes used to identify the eligible population, if applicable. Codes identifying numerator compliance should not be provided in Step 3.
- Capture all members to whom the statement(s) applies.
- Include how race and ethnicity will be identified, if applicable.
- If members with special healthcare needs were excluded, provide the rationale for the exclusion.

Population definition:

All actively enrolled Region 5 members from July 1st 2022 – June 30th, 2025 that the CM team encounters via a documented phone call.

Enrollment requirements (if applicable):

All actively enrolled Region 5 members during the PIP (July 1st 2022 – June 30th, 2025).

Member age criteria (if applicable):

All ages included.

Inclusion, exclusion, and diagnosis criteria:

Exclusion criteria include non-applicable scripts that would not be appropriate to contain SDOH questions. Example: standardized screening tools (PHQ-9, AHQ).

Diagnosis/procedure/pharmacy/billing codes used to identify the eligible population (if applicable): N/A

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Step 4: Use Sound Sampling Methods. If sampling is used to select members of the population (denominator), proper sampling methods are necessary to ensure valid and reliable results. Sampling methods must be in accordance with generally accepted principles of research design and statistical analysis. If sampling was not used, please leave table blank and document that sampling was not used in the space provided below the table.

The description of the sampling methods must:

- Include components identified in the table below.
- Be updated annually for each measurement period and for each indicator.
- Include a detailed narrative description of the methods used to select the sample and ensure sampling methods support generalizable results.

Measurement Period	Performance Indicator Title	Sampling Frame Size	Sample Size	Margin of Error and Confidence Level
MM/DD/YYYY- MM/DD/YYYY	Sampling was not used.			

Describe in detail the methods used to select the sample:

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Step 5: Select the Performance Indicator(s). A performance indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) must track performance or improvement over time. The indicator(s) must be objective, clearly, and unambiguously defined, and based on current clinical knowledge or health services research.

The description of the Indicator(s) must:

- Include the complete title of each indicator.
- Include the rationale for selecting the indicator(s).
- Include a narrative description of each numerator and denominator.
- If indicator(s) are based on nationally recognized measures (e.g., HEDIS, CMS Core Set), include the year of the technical specifications used for the applicable measurement year and update the year annually.
- Include complete dates for all measurement periods (with the month, day, and year).
- Include the mandated goal or target, if applicable. If no mandated goal or target enter "Not Applicable."

	0 7 11		
Indicator 1	The percentage of Region 5 members who were screened for Social Determinants of Health (SDOH) using the Core 5 SDOH screening Tool.		
	This indicator was selected because Region 5 members are currently not being asked SDOH questions in a standardized format during CM calls. The SDOH questions on CM scripts vary, and often only contain 1-2 questions that relate to the 4 SDOH core Domains. There are no scripts (0%) that contain SDOH questions with all four SDOH core domains. Therefore, 0% of members are currently being asked <u>all four SDOH</u> questions during one phone call/point of contact. This indicator is mandated from the Colorado Department of Health Care Policy and Financing (the Department).		
Numerator Description:	Number of Region 5 members that were screened for SDOH using the Core 5 SDOH screening Tool		
Denominator Description:	Number of Region 5 members that were in contact with the CM team through a documented interaction via an *applicable CM script in the CM documentation software HealthEdge GuidingCare. *Nonapplicable scripts include scripts that would not be appropriate to contain SDOH questions. Example: standardized screening tools (PHQ-9, AHQ).		
Baseline Measurement Period	July 1 st , 2022 – June 30 th , 2023		
Remeasurement 1 Period	July 1 st , 2023 – June 30 th , 2024		

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Step 5: Select the Performance Indicator(s). A performance indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) must track performance or improvement over time. The indicator(s) must be objective, clearly, and unambiguously defined, and based on current clinical knowledge or health services research.

The description of the Indicator(s) must:

- Include the complete title of each indicator.
- Include the rationale for selecting the indicator(s).
- Include a narrative description of each numerator and denominator.
- If indicator(s) are based on nationally recognized measures (e.g., HEDIS, CMS Core Set), include the year of the technical specifications used for the applicable measurement year and update the year annually.
- Include complete dates for all measurement periods (with the month, day, and year).
- Include the mandated goal or target, if applicable. If no mandated goal or target enter "Not Applicable."

Remeasurement 2 Period	July 1 st , 2024 – June 30 th , 2025
Mandated Goal/Target, if applicable	90% Colorado Access utilized previous CM call center data to determine an appropriate Specific, Measurable, Attainable, Realistic, Time-bound (SMART) Aim goal. Colorado Access' baseline data shows that CM is completing SDOH questions in >90% of calls (as described in Step 1). Therefore, achieving SDOH screening in over 90% of scripts should be feasible once a standardized SDOH screening tool has been incorporated into all relevant CM scripts. This will also result in a statistically significant improvement over the baseline performance of 0%, with a confidence level of 95% and p-value < 0.05.

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Step 6: Valid and Reliable Data Collection. The data collection process must ensure that data collected for each indicator are valid and reliable.

The data collection methodology must include the following:

- Identification of data elements and data sources.
- When and how data are collected.
- How data are used to calculate the indicator percentage.
- A copy of the manual data collection tool, if applicable.
- An estimate of the reported administrative data completeness percentage and the process used to determine this percentage.

Data Sources (Select all that apply) []Manual Data [X] Administrative Data [] Survey Data Data Source Fielding Method Data Source Programmed pull from claims/encounters Personal interview [] Paper medical record] Supplemental data Mail abstraction Electronic health record query Phone with CATI script [] Electronic health record] Complaint/appeal 1 Phone with IVR abstraction] Pharmacy data [] Internet Record Type [X] Telephone service data/call center data Other [] Outpatient Appointment/access data [] Inpatient Delegated entity/vendor data [] Other, please explain in] Other Other Survey Requirements: narrative section. Number of waves: Other Requirements Response rate: Data collection tool [] Codes used to identify data elements (e.g., ICD-10, CPT codes)-Incentives used: attached (required for manual please attach separately record review) [] Data completeness assessment attached [] Coding verification process attached Estimated percentage of reported administrative data completeness at the time the data are generated: 100% complete.

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Step 6: Valid and Reliable Data Collection. The data collection process must ensure that data collected for each indicator are valid and reliable.

The data collection methodology must include the following:

- Identification of data elements and data sources.
- When and how data are collected.
- How data are used to calculate the indicator percentage.
- A copy of the manual data collection tool, if applicable.
- An estimate of the reported administrative data completeness percentage and the process used to determine this percentage.

Description of the process used to calculate the reported administrative data completeness percentage. Include a narrative of how claims lag may have impacted the data reported: N/A – There is no lag time for call center data, as it is collected and recorded in real time. Incurred But Not Reported (IBNR) only applies to claims data, which does not pertain to this dataset.

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In the space below, describe the step-by-step data collection process used in the production of the indicator results:

Data Elements Collected: Data elements are collected in the member-centric web-based healthcare management system HealthEdge, also known as GuidingCare. This platform offers health plans easy-to-use, next-generation data integration and workflow management tools that streamline workflows, facilitate coordination and collaboration, accelerate quality improvement, and promote provider and patient engagement. The CM team has been using GuidingCare to record all member interactions since 2018. There were 12 data elements sourced from the HealthEdge GuidingCare system:

- Member Identification Number (ID)
- Line of Business
- Script ID
- Script Name
- Script Active
- · Question Number
- Question ID
- Question
- Option ID
- Option Value
- Suboption ID
- Suboption Value

Data Collection Process:

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In the space below, describe the step-by-step data collection process used in the production of the indicator results:

Scripts are completed in the HealthEdge GuidingCare system by all CM staff. Scripts are workflow dependent, and CM has a menu of script options to select from and chosen based on the specific population each CM staff supports. For example, if a CM team member supports the Transitions of Care program, they would utilize the Transitions of Care script that is tailored to the population that is stratified by service unitization into the Transitions of Care population. If a certain member is not in a particular program, the staff has a general script they can use to enter information into. Staff are encouraged to use their expertise to decide on the best script to fit the member's needs. The CM team performs member-centered care, and while they do their best to complete all questions on each script, a member may choose not to answer or complete the script and the CM team respects their decision. Therefore, not all questions may be completed on a given script. The data and answers from all CM scripts are recorded and housed in the HealthEdge GuidingCare data platform.

To extract the data, the Colorado Access Business Intelligence (BI) team wrote a data extraction SQL code to pull all recorded CM scripts from the Colorado Access internal HealthEdge data server. The data extraction code reflects the baseline measurement period from July 1st, 2022 through June 30th, 2023. The raw data was sent to the Quality team in a Microsoft Excel file to analyze for the PIP. The Quality team looked at each specific script and member to determine how many SDOH questions were answered during the baseline period. While all scripts were initially pulled, only applicable scripts were included in the SDOH analysis. Nonapplicable scripts include scripts that would not be appropriate to contain SDOH questions.

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Step 7: Indicator Results. Enter the results of the indicator(s) in the table below. For HEDIS-based/CMS Core Set PIPs, the data reported in the PIP Submission Form should match the validated performance measure rate(s).

Enter results for each indicator by completing the table below. P values must be reported to four decimal places (i.e., 0.1234). Additional remeasurement period rows can be added, if necessary.

Indicator 1 Title: The percentage of Region 5 members who were screened for Social Determinants of Health (SDOH) using the Core 5 SDOH screening Tool.

Measurement Period	Indicator Measurement	Numerator	Denominator	Percentage	Mandated Goal or Target, if applicable	Statistical Test Used, Statistical Significance, and p Value
July 1st, 2022 – June 30th, 2023	Baseline	0	2,170	0%	N/A for baseline	N/A for baseline
July 1st, 2023 – June 30th, 2024* *The SDOH screening tool was not implemented until May 8th, 2024 (further described in Step 7 below).	Remeasurement 1	173	1901	9.10%	90%	Chi Square with Yates Correction; Statistically Significant improvement; p value < 0.0001.
July 1 st , 2024 – June 30 th , 2025	Remeasurement 2					

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Step 7: Data Analysis and Interpretation of Results. Clearly document the results for each indicator(s). Describe the data analysis performed, the results of the statistical analysis, and a narrative interpretation of the results.

The data analysis and interpretation of indicator results must include the following for each measurement period:

- Data presented clearly, accurately, and consistently in both table and narrative format.
- A clear and comprehensive narrative description of the data analysis process, the percentage achieved for the measurement period for each indicator, and the type of two-tailed statistical test used. Statistical testing p value results must be calculated and reported to four decimal places (e.g., 0.1234).
- Statistical testing must be conducted starting with Remeasurement 1 and comparing to the baseline. For example, Remeasurement 1 to the baseline and Remeasurement 2 to the baseline. For purposes of the validation, statistical testing does not need to be conducted between measurement periods (e.g., Remeasurement 1 to Remeasurement 2).
- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
- A statement indicating whether factors that could threaten (a) the validity of the findings for each measurement period, including the
 baseline, and (b) the comparability of each remeasurement period to the baseline was identified. If there were no factors identified,
 this must be documented in Step 7.

Baseline Narrative:

The preliminary baseline data analysis revealed that there were 2,170 Region 5 members that were in contact with the CM team during FY22-23 and had an applicable SDOH script completed. 94% of these members were asked at least one SDOH related question from one of the four SDOH core domains, and 0% of members were asked all four SDOH core domain questions within one script*. It was therefore determined that Indicator 1: "The percentage of Region 5 members who were screened for Social Determinants of Health (SDOH) using the Core 5 SDOH screening Tool" is 0%, with 0 out of 2,170 members asked all four SDOH questions from the Core 5 Screening tool during one phone call/point of contact. Colorado Access utilized previous CM call center data to determine an appropriate Specific, Measurable, Attainable, Realistic, Time-bound (SMART) Aim goal. Colorado Access' baseline data shows that CM is completing SDOH questions in >90% of calls (as described in Step 1). Therefore, achieving SDOH screening in over 90% of scripts should be feasible once a standardized SDOH screening tool has been incorporated into all relevant CM scripts. This will also result in a statistically significant improvement over the baseline performance of 0%, with a confidence level of 95% and p-value < 0.05.

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Step 7: Data Analysis and Interpretation of Results. Clearly document the results for each indicator(s). Describe the data analysis performed, the results of the statistical analysis, and a narrative interpretation of the results.

The data analysis and interpretation of indicator results must include the following for each measurement period:

- Data presented clearly, accurately, and consistently in both table and narrative format.
- A clear and comprehensive narrative description of the data analysis process, the percentage achieved for the measurement period for each indicator, and the type of two-tailed statistical test used. Statistical testing p value results must be calculated and reported to four decimal places (e.g., 0.1234).
- Statistical testing must be conducted starting with Remeasurement 1 and comparing to the baseline. For example, Remeasurement 1 to the baseline and Remeasurement 2 to the baseline. For purposes of the validation, statistical testing does not need to be conducted between measurement periods (e.g., Remeasurement 1 to Remeasurement 2).
- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
- A statement indicating whether factors that could threaten (a) the validity of the findings for each measurement period, including the
 baseline, and (b) the comparability of each remeasurement period to the baseline was identified. If there were no factors identified,
 this must be documented in Step 7.

*Colorado Access revised the specifications for Indicator 1, reducing the required SDOH domains for a complete screening from five to four in Remeasurement Year 1, as detailed in the Remeasurement Year 1 Narrative. This change in specifications did not affect or alter baseline results.

Colorado Access does not foresee any factors affecting the validity of the data due to the use of the standardized data collection and reporting tool, HealthEdge GuidingCare. Colorado Access does however anticipate that the expiration of the COVID-19 Public Health Emergency (PHE) will impact member demographics during the PIP remeasurement period. States began to terminate Medicaid and CHP+ MCO enrollment for individuals who were no longer eligible beginning in May of 2023. Colorado Access anticipates that the demographic populations of Health First Colorado and CHP+ MCO members will undergo a noticeable shift during PIP remeasurement year 1 due to the absence of continuous eligibility and the movement of members between health insurers and regions. These changes will significantly impact measure denominators throughout the PIP, and Colorado Access expects to see the CHP+ MCO member population increase, and Health First Colorado member population decrease. Colorado Access will continue to monitor demographic population changes and will adjust PIP interventions and programming according to the evolving needs of its members.

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Step 7: Data Analysis and Interpretation of Results. Clearly document the results for each indicator(s). Describe the data analysis performed. the results of the statistical analysis, and a narrative interpretation of the results.

The data analysis and interpretation of indicator results must include the following for each measurement period:

- Data presented clearly, accurately, and consistently in both table and narrative format.
- A clear and comprehensive narrative description of the data analysis process, the percentage achieved for the measurement period for each indicator, and the type of two-tailed statistical test used. Statistical testing p value results must be calculated and reported to four decimal places (e.g., 0.1234).
- Statistical testing must be conducted starting with Remeasurement 1 and comparing to the baseline. For example, Remeasurement 1 to the baseline and Remeasurement 2 to the baseline. For purposes of the validation, statistical testing does not need to be conducted between measurement periods (e.g., Remeasurement 1 to Remeasurement 2).
- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
- A statement indicating whether factors that could threaten (a) the validity of the findings for each measurement period, including the baseline, and (b) the comparability of each remeasurement period to the baseline was identified. If there were no factors identified, this must be documented in Step 7.

Baseline to Remeasurement 1 Narrative:

The Year 1 remeasurement data analysis revealed that 9.10% of Region 5 members were asked all four SDOH core domain questions (food, housing, utilities, and transportation) within one script. This represents a 9.10% percentage point increase over the baseline PIP rate of 0%. and demonstrates a statistically significant improvement (95% confidence level, p-value < 0.0001). This p-value remained unchanged following reevaluation with the updated denominator and percentage in January of 2025. However, it has not met the SMART Aim goal of 90% for Region 5. A two-tailed chi-square test with Yates' correction was used to calculate the p-value.

Colorado Access decided to change the specifications for Indicator 1, reducing the number of required SDOH questions from five to four for a complete SDOH screening. This change aligns with HCPF's updated requirements, which no longer mandate the inclusion of "interpersonal safety" as a required CMS Core Domain for the PIP. Initially, Colorado Access intended to use the interpersonal safety question from the Core 5 Screening Tool. However, after conducting pilot tests and engaging with the CM team, concerns arose regarding the wording of the question. The original Core 5 interpersonal safety question was, "Are you worried that someone may hurt you or your family?" Colorado Access replaced this with two questions from the PRAPARE screening tool:

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Step 7: Data Analysis and Interpretation of Results. Clearly document the results for each indicator(s). Describe the data analysis performed, the results of the statistical analysis, and a narrative interpretation of the results.

The data analysis and interpretation of indicator results must include the following for each measurement period:

- Data presented clearly, accurately, and consistently in both table and narrative format.
- A clear and comprehensive narrative description of the data analysis process, the percentage achieved for the measurement period for each indicator, and the type of two-tailed statistical test used. Statistical testing p value results must be calculated and reported to four decimal places (e.g., 0.1234).
- Statistical testing must be conducted starting with Remeasurement 1 and comparing to the baseline. For example, Remeasurement 1 to the baseline and Remeasurement 2 to the baseline. For purposes of the validation, statistical testing does not need to be conducted between measurement periods (e.g., Remeasurement 1 to Remeasurement 2).
- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
- A statement indicating whether factors that could threaten (a) the validity of the findings for each measurement period, including the baseline, and (b) the comparability of each remeasurement period to the baseline was identified. If there were no factors identified, this must be documented in Step 7.
- Do you feel physically and emotionally safe where you currently live?
- In the past year, have you been afraid of your partner or ex-partner?

Due to the changes in the interpersonal safety questions during implementation—switching from one question to two—and because these questions are not answered as frequently as the other four SDOH questions (often due to it not always being appropriate for the situation or member on the call, potentially causing discomfort for both members and staff), Colorado Access decided not to include them in the overall PIP SDOH screening rate. Additionally, the most recent HEDIS Social Need Screening and Intervention (SNS) measure requires only three domains—food, transportation, and housing—further supporting this decision. Colorado Access has updated Indicator 1 in Steps 5 and 7 to reflect this change.

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Step 7: Data Analysis and Interpretation of Results. Clearly document the results for each indicator(s). Describe the data analysis performed, the results of the statistical analysis, and a narrative interpretation of the results.

The data analysis and interpretation of indicator results must include the following for each measurement period:

- Data presented clearly, accurately, and consistently in both table and narrative format.
- A clear and comprehensive narrative description of the data analysis process, the percentage achieved for the measurement period for each indicator, and the type of two-tailed statistical test used. Statistical testing p value results must be calculated and reported to four decimal places (e.g., 0.1234).
- Statistical testing must be conducted starting with Remeasurement 1 and comparing to the baseline. For example, Remeasurement 1 to the baseline and Remeasurement 2 to the baseline. For purposes of the validation, statistical testing does not need to be conducted between measurement periods (e.g., Remeasurement 1 to Remeasurement 2).
- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
- A statement indicating whether factors that could threaten (a) the validity of the findings for each measurement period, including the baseline, and (b) the comparability of each remeasurement period to the baseline was identified. If there were no factors identified, this must be documented in Step 7.

Additionally, logistical complications affected the measurement timeline. As mentioned in the Step 8 interventions, Colorado Access's internal HealthEdge GuidingCare system had not been upgraded since 2021. We identified an opportunity to enhance member services by upgrading our system, which had previously hindered the timely updating of CM scripts and workflows. The upgrade occurred in December 2023, allowing for the implementation of the new SDOH screening questions shortly thereafter. Following the upgrade, it took an additional four months to formulate, integrate, and QA test the new questions within the system. The SDOH screening tool was officially launched across all scripts on May 8, 2024. Therefore, the numerator and screening rate displayed above reflect SDOH screening data collected from May 8, 2024, to June 30, 2024, and consequently, the numerator for Remeasurement Year 1 is reduced. Before the May 8 launch, SDOH data was still being collected, but with significant variability in the CM scripts, which often contained only 1-2 questions related to the four SDOH core Domains. This led to a 0% SDOH screening rate for the months of July 2023 – April 2024, as none of the members were asked all four SDOH questions during a single phone call or point of contact. The denominator has been adjusted to reflect the scripts completed during that period.

Lastly, while the improvement from 0% to 9.10% is encouraging, we have not yet reached our goal of 90%, which we initially projected as achievable. A root cause analysis revealed that additional changes were made to the HealthEdge GuidingCare system scripts after the SDOH

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Step 7: Data Analysis and Interpretation of Results. Clearly document the results for each indicator(s). Describe the data analysis performed, the results of the statistical analysis, and a narrative interpretation of the results.

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- A clear and comprehensive narrative description of the data analysis process, the percentage achieved for the measurement period for each indicator, and the type of two-tailed statistical test used. Statistical testing p value results must be calculated and reported to four decimal places (e.g., 0.1234).
- Statistical testing must be conducted starting with Remeasurement 1 and comparing to the baseline. For example, Remeasurement 1 to the baseline and Remeasurement 2 to the baseline. For purposes of the validation, statistical testing does not need to be conducted between measurement periods (e.g., Remeasurement 1 to Remeasurement 2).
- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
- A statement indicating whether factors that could threaten (a) the validity of the findings for each measurement period, including the baseline, and (b) the comparability of each remeasurement period to the baseline was identified. If there were no factors identified, this must be documented in Step 7.

screening tool was launched. One key issue identified was that some scripts were marked as "activity complete" even when only a few questions were answered, rather than the entire script being completed. To address this, we have asked CMs to select "Successful" & "Activity Complete" only when all questions in the script are answered. If the script is not fully completed, CMs should select "Unsuccessful" & "Activity Partially Complete." We also discovered that the "Activity Partially Complete" option was removed from the Activity Outcome choices shortly after the SDOH screening tool was implemented. A request has been submitted to the GuidingCare team to reintroduce this option, and the system change went into production on October 15th, 2024.

Colorado Access did not experience any factors affecting the validity of the data due to the use of the standardized data collection and reporting tool, HealthEdge GuidingCare. However, Colorado Access observed that the expiration of the COVID-19 PHE impacted member demographics during the PIP remeasurement period. States began to terminate Medicaid enrollment for individuals who were no longer eligible beginning in May 2023, which affected the demographic populations of Health First Colorado and CHP+ MCO members during the PIP remeasurement year 1. This was reflected in Colorado Access data, with the overall Region 5 member population decreasing by 28% during SFY 23-24. Due to the declining Region 5 membership, the number of completed scripts for Region 5 members dropped from 2,170

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Step 7: Data Analysis and Interpretation of Results. Clearly document the results for each indicator(s). Describe the data analysis performed, the results of the statistical analysis, and a narrative interpretation of the results.

The data analysis and interpretation of indicator results must include the following for each measurement period:

- Data presented clearly, accurately, and consistently in both table and narrative format.
- A clear and comprehensive narrative description of the data analysis process, the percentage achieved for the measurement period for each indicator, and the type of two-tailed statistical test used. Statistical testing p value results must be calculated and reported to four decimal places (e.g., 0.1234).
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- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
- A statement indicating whether factors that could threaten (a) the validity of the findings for each measurement period, including the baseline, and (b) the comparability of each remeasurement period to the baseline was identified. If there were no factors identified, this must be documented in Step 7.

during the baseline period to 1,901 in remeasurement year 1. Colorado Access will continue to monitor demographic population changes and will adjust PIP interventions and programming according to the evolving needs of its members.

Baseline to Remeasurement 2 Narrative:

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Step 8: Improvement Strategies. Interventions are developed to target and address causes/barriers identified through the use of quality improvement (QI) processes and tools.

The documentation of Step 8 is organized into the following three sections:

- A. Quality Improvement (QI) Team and Activities Narrative Description
- B. Barriers/Interventions Table: Prioritized barriers and corresponding intervention descriptions
- C. Intervention Worksheet:
 - Intervention Description
 - o Intervention Effectiveness Measure
 - Intervention Evaluation Results
 - o Intervention Status

A. Quality Improvement (QI) Team and Activities Narrative Description

OI Team Members:

- Sarah Thomas, Senior Quality Improvement Consultant at Colorado Access
- Kathryn Burch, Director of Quality Improvement & Accreditation at Colorado Access
- Madhu Mallela, Senior Director of Quality Improvement and Health Outcomes at Colorado Access
- Jamie Zajac, Director of Care Management at Colorado Access
- Joy Twesigye, Vice President of Health Systems Integration at Colorado Access

QI process and/or tools used to identify and prioritize barriers: The Quality team applied the Six Sigma DMAIC (Define, Measure, Analyze, Improve, Control) model to systematically identify and prioritize barriers. In the "Define" phase, the team reviewed existing SDOH initiatives within the organization and identified a gap: the lack of a standardized SDOH screening tool in CM scripts. Key barriers included an outdated HealthEdge GuidingCare system, inconsistent SDOH questions, and a need to centralize resources and referrals. During the "Measure" phase, the team analyzed CM script data from 2018-2022, uncovering issues such as no consistent measurement of screening rates, SDOH needs, and manual data collection, which resulted in unreliable data. The team also found duplicative SDOH questions in various scripts, further complicating analysis. In the "Analyze" phase, the team reviewed the data and identified the opportunity to implement the Core 5 SDOH screening tool across all CM scripts while streamlining and eliminating redundancies. Finally, in the "Improve" phase, efforts began during the first year of remeasurement. The HealthEdge GuidingCare system was upgraded in

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Step 8: Improvement Strategies. Interventions are developed to target and address causes/barriers identified through the use of quality improvement (QI) processes and tools.

The documentation of Step 8 is organized into the following three sections:

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- C. Intervention Worksheet:
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 - Intervention Status

December 2023, followed by the official rollout of the Core 5 Screening Tool in CM scripts on May 8th, 2024. This standardization aims to improve consistency and effectiveness in identifying member needs related to SDOH.

B. Barriers/Interventions Table: In the table below, list interventions currently being evaluated, and barrier(s) addressed by each intervention. For each intervention, complete a Step 8 Intervention Worksheet. The worksheet must be completed to the point of intervention progression at the time of the annual PIP submission.

Intervention Title	Barrier(s) Addressed
Standardization of SDOH questions by incorporating the Core 5 Screening Tool into all applicable CM scripts.	Current state CM scripts ask a variety of SDOH questions that do not cover all four SDOH core Domains. The CM team aims to standardize SDOH questions by incorporating the Core 5 Screening Tool into all *applicable CM scripts used with member interactions. *Nonapplicable scripts include scripts that would not be appropriate to contain SDOH questions. Example: standardized screening tools (PHQ-9, AHQ).

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Step 8: Improvement Strategies. Interventions are developed to target and address causes/barriers identified through the use of quality improvement (QI) processes and tools.

The documentation of Step 8 is organized into the following three sections:

- A. Quality Improvement (QI) Team and Activities Narrative Description
- B. Barriers/Interventions Table: Prioritized barriers and corresponding intervention descriptions
- C. Intervention Worksheet:
 - Intervention Description
 - o Intervention Effectiveness Measure
 - Intervention Evaluation Results
 - o Intervention Status
- C. Intervention Worksheet: Intervention Effectiveness Measure and Evaluation Results

Complete a Step 8 Intervention Worksheet for each intervention currently being evaluated. The worksheet must be completed to the point of intervention progression at the time of the annual PIP submission.

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Appendix A1. Intervention Worksheets

Appendix A1 contains the completed Intervention Worksheets that COA R5 provided for validation. HSAG made only minor grammatical corrections to these forms and did not alter the content/meaning.







Managed Care Organization (MCO) Information		
MCO Name	Colorado Access 0k	
Region 5		
PIP Title	Follow-Up After Hospitalization for Mental Illness (FUH)	
Intervention Title	Inpatient Behavioral Health Performance Program	

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Instructions: Complete a separate worksheet for each intervention.

Intervention Description			
Intervention Title	Inpatient Behavioral Health Performance Program		
What barrier(s) are addressed?	Colorado Access recognized the opportunity to provide increased financial support and incentives, helping hospitals prioritize this important metric. By coordinating discharge with Community Mental Health Centers (CMHCs) to ensure a follow-up behavioral health appointment within seven days, additional funding enabled hospitals to expand behavioral health staffing. This support empowered hospitals to better align resources and improve continuity of care for high-needs patients.		
Describe how the intervention is culturally and linguistically appropriate.	The inpatient hospitals coordinate follow-up care by scheduling appointments that consider the member's cultural and linguistic needs. This includes selecting providers located near the member's home and ensuring the provider speaks the member's language or offers translation services. This approach helps to ensure that care is accessible and appropriate for the member's specific needs.		
Intervention Process Steps (List the step-by-step process required to carry out this intervention.)	In order to receive the enhanced payment, a facility must commit to active engagement with Colorado Access Utilization Management (UM) and Care Management (CM) teams during the rendering of inpatient services for Colorado Access members, as demonstrated by consistently following the processes outlined below. A facility must: 1. Demonstrate best practices related to use of UM processes and as outlined in the Colorado Access Provider Manual: a. Requests for all peer reviews are initiated by a physician. b. 2nd and 3rd level appeal requests include new clinical documentation that has not been previously submitted. c. Authorization is approved for all members prior to admission for an inpatient stay; the ratio of late-notice denials to timely authorizations should not exceed 1:20.		

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Intervention Description

- 2. Provide Colorado Access CM staff with a discharge document, within 24 hours of discharge, that includes a follow-up plan containing:
 - a. Written documentation that a seven-day follow-up appointment (either walkin or scheduled) was confirmed and communicated to member.
 - b. Written documentation of date and time of follow-up appointment, as well as name of provider and location.
 - c. Written documentation that this plan has been confirmed with the outpatient provider.
- 3. Demonstrates a model of care, care coordination, and continuity of care that is evidence based or utilizes promising practices and emphasizes collaboration with CMHCs and other behavioral health providers as appropriate, involves the member's family/guardians when appropriate, and centers on a communicative partnership with Colorado Access. Model of care program document to be submitted to Colorado Access upon request.
- 4. Engage in collaborative problem solving and accountability around shared members, communicating promptly around issues and concerns and responding to messages in a timely manner.
- 5. Commits to daily rounding and care by prescriber, with associated progress notes. Changes in care should take place as appropriate, including weekends, which include discharges from the facility.
- 6. Agree to meet regularly with Colorado Access to review progress and address barriers.
- 7. If a facility satisfactorily demonstrates its commitment to the collaborative principles outlined above, and meets established targets for the seven day post discharge follow up, it will be entitled to earn enhanced reimbursement for inpatient stays. There are two options for enhanced reimbursement, Tier 1 and Tier 2, based on performance. Tier 1 results in an increase to the per diem rate if performance of the seven day

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Intervention Description				
	follow-up measure reaches 45%. Tier 2 results in an increase to the per diem rate if performance on the seven day follow up measure reaches 65%. The increase is reflected in the subsequent designated performance period per diem rate.			
	8. For any performance period that performance measures are met, Colorado Access will increase the per diem rate by a designated percentage for meeting either Tier 1 or Tier 2 goals. The increase is initiated for the subsequent performance period.			
Intervention Start Date (MM/DD/YYYY)	July 1 st , 2019 Intervention End Date (MM/DD/YYYY) N/A – program is ongoing		N/A – program is ongoing	

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Intervention Effectiveness Measure					
Intervention Effectiveness Measure Title	<u>Combined</u> FUH Performance of Nine Inpatient Hospitals in the Behavioral Health Performance Program				
Numerator description (narrative)	The number of Region 3 and Region 5 members* who received a follow-up visit with a mental health provider within seven days after discharge <u>from one of the nine participating hospitals in the Inpatient Behavioral Health Performance program</u> . Visits occurring on the date of discharge are excluded.				
Denominator description (narrative)	The number of Region 3 and Region 5 members* aged six years and older who were discharged after hospitalization for treatment of selected mental illness or intentional self-harm diagnoses by the end of the performance period <u>from one of the nine</u> participating hospitals in the Inpatient Behavioral Health Performance program.				
Intervention Evaluation Period Dates (MM/DD/YYYY-MM/DD/YYYY)	Numerator Denominator Percentage				
07/01/22 - 12/31/22	533	1,700	31%		
01/01/23 - 06/30/23	852 1,477 58%		58%		
07/01/23 - 12/31/23	621 1,469 42%				
01/01/24 - 6/30/24	621	1,447	43%		

If qualitative data were collected, provide a narrative summary of results below.

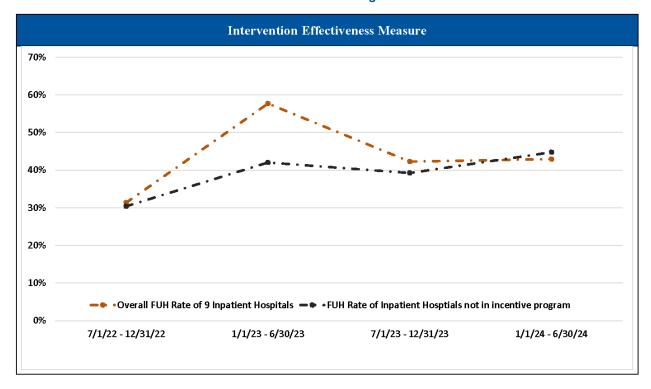
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^{*}Both Regions 3 and 5 are included in this intervention, which was designed to ensure that all lines of business are incorporated for tiering and payout.









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	Intervention Effectivene	ess Measure	
Intervention Effectiveness Measure Title	<u>Individual</u> FUH Performance of Nine Inpatient Hospitals in the Behavioral Health Performance Program		
Numerator description (narrative)	The number of Region 3 and Region 5 members* who received a follow-up visit with a mental health provider within seven days after discharge <u>from each of the nine participating hospitals in the Inpatient Behavioral Health Performance program</u> . Visits occurring on the date of discharge are excluded.		
Denominator description (narrative)	The number of Region 3 and Region 5 members* aged six years and older who were discharged after hospitalization for treatment of selected mental illness or intentional self-harm diagnoses by the end of the performance period <u>from each of the nine participating hospitals in the Inpatient Behavioral Health Performance program.</u>		
Intervention Evaluation Period Dates (MM/DD/YYYY-MM/DD/YYYY)	Numerator	Denominator	Percentage
	Hospital 1: 12	1: 39	1: 29.9%
	Hospital 2: 58 Hospital 3: 16	2: 160 3: 80	2: 31.7% 3: 20%
	Hospital 4: 120	4: 358	4: 34%
07/01/22 - 12/31/22	Hospital 5: 92	5: 314	5: 29%
	Hospital 6: N/A*	6: N/A*	6: N/A*
	Hospital 7: 162	7: 605	7: 27%
	Hospital 8: 46	8: 171	8: 27%
	Hospital 9: N/A*	9: N/A*	9: N/A*
	Hospital 1: 58	1: 135	1: 43%
01/01/23 - 06/30/23	Hospital 2: 101	2: 219	2: 46%
	Hospital 3: 41	3: 81	3: 51%

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Intervention Effectiveness Measure			
	Hospital 4: 178	4: 385	4: 46%
	Hospital 5: 143	5: 299	5: 48%
	Hospital 6: 75	6: 181	6: 41%
	Hospital 7: 8	7: 37	7: 22%
	Hospital 8: 130	8: 258	8: 50%
	Hospital 9: N/A*	9: N/A*	9: N/A*
	Hospital 1: 68	1: 170	1: 40%
	Hospital 2: 107	2: 212	2: 50%
	Hospital 3: 31	3: 89	3: 35%
	Hospital 4: 124	4: 285	4: 44%
07/01/23 - 12/31/23	Hospital 5: 111	5: 270	5: 41%
	Hospital 6: 74	6: 170	6: 44%
	Hospital 7: 8	7: 24	7: 33%
	Hospital 8: 62	8: 159	8: 39%
	Hospital 9: 36	9: 90	9: 40%
	Hospital 1: 63	1: 144	1: 44%
	Hospital 2: 125	2: 260	2: 48%
	Hospital 3: 27	3: 77	3: 35%
	Hospital 4: 117	4: 277	4: 42%
01/01/24 - 6/30/24	Hospital 5: 116	5: 304	5: 38%
	Hospital 6: 65	6: 137	6: 47%
	Hospital 7: 7	7: 23	7: 30%
	Hospital 8: 72	8: 151	8: 48%
	Hospital 9: 30	9: 76	9: 39%

Colorado Access Region 5 PIP Intervention Worksheet

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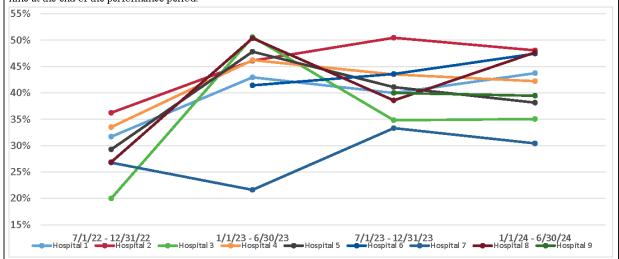




Intervention Effectiveness Measure

If qualitative data were collected, provide a narrative summary of results below.

*Two hospitals signed contracts in March and June 2023, respectively, increasing the hospital denominator from seven to a total of nine at the end of the performance period.



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Intervention Evaluation Results

What lessons did the MCO learn from the intervention testing and evaluation results?

The current program evaluation shows that inpatient hospitals participating in the incentive program are outperforming inpatient hospitals that are not involved, as evidenced by the run charts above. Of the nine inpatient hospitals, three have recently (07/01/23 - 12/31/2023) met the Tier 1 (45–52.8%) or Tier 2 (52.9% and above) FUH percentage goals, making them eligible for payout. Payouts for the period from 01/01/2024 - 06/30/2024 will be calculated in January 2025. As emphasis on this program continues to grow (described in more detail in the challenges section below), we anticipate that inpatient hospitals will increasingly strive to reach these tiers and achieve them more consistently, making this program more impactful.

Key lessons learned include:

- The importance of fostering closer relationships with inpatient hospitals to better support them in this work.
- Strengthening collaboration between inpatient hospitals and CMHCs to ensure smoother transitions and better outcomes.

What challenges were encountered?

Colorado Access recognizes that while this intervention was originally created in 2019, its implementation faced significant challenges due to the COVID-19 pandemic. These included program pauses, staff turnover, and a lack of prioritization, which hindered the program's progress during its beginning stages. Ongoing program challenges include:

- Staff Turnover at Hospitals and CMHCs: A major challenge is the high turnover rate among staff at inpatient hospitals. Strong relationships between CMHCs and hospitals often lead to better follow-up outcomes, but maintaining these relationships becomes difficult with frequent staff changes.
- HEDIS Specification Change: The change in HEDIS specifications, which no longer counted the discharge day visit, altered
 how we approached interventions. For example, during the pandemic, outpatient providers started seeing members on the day
 of discharge, in addition to scheduling them for the seven-day follow-up visit. The metric specification shift complicated this
 intervention.
- **Direct Care Coordination Paused:** When the program started in 2019, behavioral health hospitals would physically transport members to CMHCs or arrange taxis, resulting in more same-day follow-up visits. This direct connection contributed to higher success rates, as same-day discharge visits counted towards the metric. However, once the metric specification changed, continuing to support this intervention no longer made sense. As a result, inpatient hospitals have since discontinued this practice.

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Intervention Evaluation Results

- Scheduling Challenges between Hospitals and CMHCs: There is a lack of efficient technology for scheduling follow-up appointments. Hospitals and CMHCs must be available at the same time, often resorting to phone calls, which can lead to delays. A system-wide implementation of an online scheduling platform would streamline the process and reduce the time discharge planners spend coordinating care.
- Excessive Intake Packets Required by CMHCs: CMHCs often require extensive intake packets, with up to 40 printed pages,
 making it burdensome for inpatient hospital discharge planners. Simplifying these packets and reducing administrative barriers
 could improve follow-up outcomes and ease the scheduling process.
- Lack of Real-Time Notifications for Hospital Admissions and Discharges: Previously, CMHCs were unaware of their members' hospital admissions and discharges, making timely follow-up within the seven-day timeframe challenging. Additionally, hospitals were notified of members connected to CMHCs via email from Colorado Access CMs. These email notifications did not provide real-time data our hospitals needed to coordinate care quickly with CMHCs.
- Lack of Dashboard Utilization: While we've introduced a new dashboard (as noted in the section on resolving challenges)
 to mitigate the lack of real-time notifications, we have observed that certain hospitals are not effectively leveraging the
 dashboard for performance tracking and driving improvements.

How were the challenges resolved?

As the pandemic subsided, there has been renewed emphasis on the program. The original plan, which involved holding monthly meetings with inpatient hospital providers to review key metrics such as dashboard data, member-level trends, and collaboration with outpatient providers, is set to begin this fiscal year. These meetings aim to increase awareness of follow-up percentage variances, motivate and engage providers, and foster stronger collaboration with outpatient CMHCs and providers.

Several specific challenges have been addressed:

• Implementation of the Hospital and Community Mental Health Center seven-day follow-up dashboard: Last year, Colorado Access developed a bidirectional dashboard system that provides real-time discharge information to hospitals and CMHCs for coordinated discharge planning. This dashboard has eliminated barriers that hindered improvement in the seven-day FUH rate. The dashboard allows hospitals and CMHCs to identify members in real-time and coordinate effectively to schedule follow-ups. It has also saved time for our internal care management team by removing the need to notify hospitals of a member's of CMHC connection, thereby eliminating administrative burdens. This system enables a focus on higher acuity members, allowing for quicker intervention since both parties can directly access the dashboard. CMHCs can now view their

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Appendix A1-1: State of Colorado PIP Intervention Worksheet Follow-Up After Hospitalization for Mental Illness (FUH) for Colorado Access Region 5



Intervention Evaluation Results

members' hospitalizations in real-time and proactively coordinate post-discharge follow-up appointments. They can also monitor their seven-day follow-up performance rate more promptly. This dashboard has strengthened community partnerships between hospitals and outpatient behavioral health providers.

- Improved Dashboard Utilization: Efforts are underway to optimize the use of the dashboard by both hospitals and CMHCs, ensuring it becomes a more effective tool for monitoring and improving follow-up care.
- Value-Based Payment (VBP) Program: Colorado Access implemented a VBP program with CMHCs to engage hospitals more effectively, aligning financial incentives to complement the goals of the intervention. This program is listed as a separate PIP intervention.
- System Improvements and Role Clarity: Improvements in the system have started to emerge, particularly in the coordination between hospitals and CMHCs. The combined use of the dashboard and care management tiering system (separate PIP intervention) now provides a clearer, more comprehensive view of which entities (hospitals or CMHCs) are responsible for a member's follow-up, helping clarify roles and responsibilities.

By resolving these challenges, Colorado Access has been able to improve provider collaboration, increase follow-up care rates, and better understand the member experience, which will drive continued program improvement.

What successes were demonstrated through the intervention testing?

- The FUH metric is consistently higher for the nine hospitals participating in this program compared to those not involved.
- Over time, more hospitals have progressively met and exceeded the tiered payout thresholds, reflecting improved performance.
- Renewed efforts to revamp and enhance the program have contributed to its continued success and sustainability.
- **Connection to the CMHC VBP Program:** The integration of the CMHC VBP program has significantly boosted this intervention's impact, leading to better coordination and results.
- **Dashboard Utilization:** The creation and refinement of the dashboard has provided clearer data insights, supporting hospitals and CMHCs in improving performance.
- **Improved Relationships with CMHCs:** The program fostered stronger partnerships with CMHCs, enhancing collaboration and follow-up care coordination across providers.

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Select one intervention status: ☐ Adopt	
	X Adapt □ Abandon □ Continue
Rationale for Intervention Status Selected	
We have selected "Adapt" for this program because it is currently u touchpoints with inpatient hospitals. This is expected to lead to imprifrequent achievement of the target tiers, resulting in higher incentive whether these incentive measures are positively impacting performance.	roved FUH metrics for these hospitals and consequently more payouts. The program will continue to be evaluated to assess
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Managed Care Organization (MCO) Information		
MCO Name	Colorado Access Region 5	
PIP Title	Follow-Up After Hospitalization for Mental Illness (FUH)	
Intervention Title	Care Management Behavioral Health (BH) Transitions of Care (TOC) Program	

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Instructions: Complete a separate worksheet for each intervention.

Intervention Description			
Intervention Title	Care Management Behavioral Health (BH) Transitions of Care (TOC) Program		
What barrier(s) are addressed?	Care managers (CMs) faced barriers with the existing outreach program, including high workloads, insufficient time to serve members with complex needs, and high administrative burdens due to the large volume of members. To address these issues, the CM team streamlined their member outreach program to stratify members by risk. This aimed to reduce overall admissions and provide an additional touchpoint to high-needs members within seven days after discharge to promote connection to appropriate step-down care.		
Describe how the intervention is culturally and linguistically appropriate.	The Colorado Access CM team uses interpreter services in the BH TOC program to ensure that members' linguistic preferences are met. Care Managers also coordinate with both inpatient and community providers to communicate members' linguistic and cultural preferences and ensure they are considered and met. CM assessments include questions that invite members to share about any spiritual, linguistic, and cultural preferences.		
Intervention Process Steps (List the step-by-step process required to carry out this intervention.)	The modified BH TOC programming was developed in partnership with internal stakeholders to ensure strategic alignment across departments, maximize impact to key deliverables and metrics, and maintain clinical integrity and provider relationships. Steps 1-3 outline the development and approval of the TOC program changes. 1. CMs supporting the BH TOC program were consulted about proposed changes. CMs identified their top priorities in adjusted programming to be: lower volume of work, increased quality of intervention delivered to each member (including assertive connection to resources and earlier connection to caregivers of admitted youth), more time for telephonic clinical intervention with members (assessment, motivational interviewing, psychoeducation, ASQ screening, connecting members to resources, ensuring they are connected to wrap around services needed to be successful in the community), more time to serve complex members, and less administrative work. CMs agreed that the development of a more intentional BH TOC program would		

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Intervention Description

ensure they are doing meaningful work that contributes to positive member outcomes.

 Proposed stratification criteria were reviewed and approved by the Colorado Access Program Medical Director. Programming aligned with clinical needs of the BH TOC population and no quality concerns were identified. The below image outlines the new BH TOC Risk Stratification:





One hundred percent of members in BH tiers 1-4 are served by CM, whereas members in BH tier 5 receive typical discharge interventions from hospitals and outpatient providers, and are served by CM based on utilization management (UM) or provider referral. In the tiered system, 'complex' aligns with the Colorado Access definition, which includes members with chronic and co-morbid conditions while also considering age as a determining factor. 'High utilizing' refers to members with two or more admissions within 60 days, an industry standard.

3. The Behavioral Health clinical team (Directors of Quality, Practice Supports, UM, Payment Reform, and Sr Director of Behavioral Health Network Performance) reviewed proposed programming and confirmed alignment with strategic priorities in BH, particularly prioritization of children and youth.

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Intervention Description

4. New Care Management Workflow: The addition of stratifying members for risk will reduce the overall volume of admissions. Members in Tiers 1-4 will be served by care managers upon notification of admission. Members in Tier 5 will receive CM intervention only via UM or provider referral, and will receive typical discharge interventions from hospitals and outpatient providers, as mentioned above. The workflow will ensure members are outreached by CM within 1-2 business days of discharge to promote appointment attendance. A Colorado Access dashboard was also created to allow hospitals to view their own admitted members' Community Mental Health Center (CMHC) connection. This will remove administrative and documentation burden from CMs. CMs will also utilize the Keep, Consult, Refer process to ensure members are being served in the right CM program at the right time. Specific process steps for the CM team are shown in the below process map:



Intervention Start Date (MM/DD/YYYY)

04/01/2024

Intervention End Date (MM/DD/YYYY)

N/A - this is a continuous program

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Intervention Effectiveness Measure				
Intervention Effectiveness Measure Title	Inpatient Utilization and 7-Day Follow-up rates by Behavioral Health Tier			
Numerator description (narrative)	Number of Region 3 and 5 members, <u>stratified by behavioral health tier</u> , who received a follow-up visit with a mental health provider within seven days after discharge. Does not include visits that occur on the date of discharge.			
Denominator description (narrative)	Number of Region 3 and 5 members, <u>stratified by behavioral health tier</u> , six years of age and older who were discharged after being hospitalized for treatment of selected mental illness or intentional self-harm diagnoses as of the end of the performance period.			
Intervention Evaluation Period Dates (MM/DD/YYYY-MM/DD/YYYY)	Numerator Denominator Percentage			
Baseline Data, Pre-Intervention July 01, 2024 — September 30, 2022	334	1286	25.97%	
Baseline Data, Pre-Intervention October 01, 2024 – December 31, 2022	417	1242	33.57%	
Baseline Data, Pre-Intervention January 01, 2023 – March 30, 2023	570	1323	43.08%	
Intervention Start April 01, 2023 – June 30, 2023	Tier 1: 65 Tier 2: 48 Tier 3: 114 Tier 4: 107 Tier 5: 140	Tier 1: 99 Tier 2: 105 Tier 3: 182 Tier 4: 262 Tier 5: 347	Tier 1: 65.66% Tier 2: 45.71% Tier 3: 62.64% Tier 4: 40.84% Tier 5: 40.35%	
July 01, 2023 – September 30, 2023	Tier 1: 43	Tier 1: 74	Tier 1: 58.11%	

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Intervention Effectiveness Measure			
	Tier 2: 45	Tier 2: 124	Tier 2: 36.29%
	Tier 3: 92	Tier 3: 166	Tier 3: 55.42%
	Tier 4: 123	Tier 4: 309	Tier 4: 39.81%
	Tier 5: 134	Tier 5: 333	Tier 5: 40.24%
	Tier 1: 43	Tier 1: 74	Tier 1: 58.11%
	Tier 2: 59	Tier 2: 137	Tier 2: 43.07%
October 01, 2023 – December 31, 2023	Tier 3: 91	Tier 3: 169	Tier 3: 53.85%
	Tier 4: 105	Tier 4: 297	Tier 4: 35.35%
	Tier 5: 122	Tier 5: 304	Tier 5: 40.13%
	Tier 1: 65	Tier 1: 98	Tier 1: 66.33%
	Tier 2: 49	Tier 2: 119	Tier 2: 41.18%
January 01, 2024 – March 30, 2024	Tier 3: 104	Tier 3: 171	Tier 3: 60.82%
	Tier 4: 114	Tier 4: 288	Tier 4: 39.58%
	Tier 5: 117	Tier 5: 313	Tier 5: 37.38%
	Tier 1: 57	Tier 1: 78	Tier 1: 73.08%
	Tier 2: 49	Tier 2: 121	Tier 2: 40.50%
April 01, 2024 – June 30, 2024	Tier 3: 90	Tier 3: 137	Tier 3: 65.69%
	Tier 4: 125	Tier 4: 322	Tier 4: 38.82%
	Tier 5: 106	Tier 5: 285	Tier 5: 37.19%

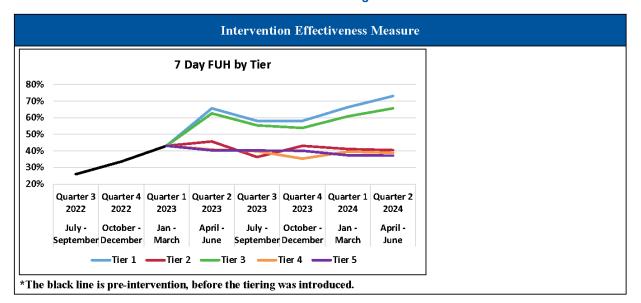
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Intervention Evaluation Results

What lessons did the MCO learn from the intervention testing and evaluation results?

- Targeted Interventions: The success of Tiers 1 and 3 suggests that targeted interventions and more intensive support for specific populations (like children) can significantly impact follow-up rates. The care management team's focus on these groups is yielding positive results, indicating the importance of prioritizing resources where they can have the most effect.
- **Population-Specific Strategies:** The lower follow-up rates in Tiers 2, 4, and 5 highlight the need for population-specific strategies. These tiers, which likely include more adults or populations with varying needs, might require different approaches or additional support to improve their follow-up rates. Adults also practice more autonomy in their care, such as deciding they don't need follow-up treatment. Engaging adults in discharge planning is crucial to ensure it aligns with their stage of change and is realistic.
- Care Management Team Focus: The effectiveness of prioritizing certain groups by the care management team indicates that the team's focus and approach are critical. Reviewing and potentially adjusting the strategies for lower-performing tiers could be beneficial. Additionally, implementing or enhancing feedback mechanisms to better understand the barriers faced by members in lower-performing tiers might provide insights into how to improve follow-up rates across all tiers.
- Continuous Improvement: The ongoing improvement in FUH rates for Tiers 1 and 3 suggests that continuous evaluation and adaptation of the program are essential. Ensuring that the tiering process remains flexible and responsive to emerging needs and data will help maintain and further enhance performance.

What challenges were encountered?

Several challenges were encountered during the implementation of the tiering process and throughout the intervention. As anticipated, lower-performing tiers, which include more difficult-to-engage populations, presented engagement challenges. This was expected due to both the inherent complexities of these populations and the allocation of fewer resources to these groups in favor of higher-priority populations. While this outcome aligns with the program's design, it underscores the inherent trade-offs in prioritizing certain populations over others based on need and resource availability.

Key challenges:

Pre-Tiering Identification and Prioritization: Before the implementation of the tiering system, there was no structured approach to identify, prioritize, and reach out to members for care management support. This lack of structure meant that

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Intervention Evaluation Results

resource allocation was inconsistent, and it was often unclear which members would receive care, making it difficult to target interventions effectively. While the strategy aimed to help everyone, it was consistent but unmanageable, ultimately sacrificing quality due to the overwhelming scope.

- Engagement Barriers in Lower Tiers: Populations in the lower tiers continued to face significant barriers to engagement, including logistical challenges such as unreliable phone/communication devices, transportation issues, and limited social support. These factors contributed to lower follow-up rates within these tiers. Additionally, clinical engagement barriers were present, such as many members being in the pre-contemplative stage of change, further hindering their participation in follow-up care.
- **Resource Allocation and Capacity:** The program highlighted the challenges of operating within finite resource constraints. The need to focus resources on high-priority populations, while effective in those tiers, presented limitations in the ability to address the needs of lower-priority groups.
- Operational Complexity: Implementing the tiered system introduced additional operational complexities. This included tracking and managing multiple tiers while ensuring consistent application of care management interventions. The system required enhanced data monitoring and additional training for staff to ensure effective execution.
- Ethical Considerations of Prioritization: The decision to prioritize certain populations over others, while grounded in data
 and program goals, brought attention to ethical considerations around equitable care. Balancing resource allocation with the
 goal of optimizing outcomes for all populations remains an ongoing challenge, however Colorado Access is pursuing
 innovative solutions to serve low risk populations.
- Adjustment Period: Both the care management team and the providers required an adjustment period as the new tiering system was rolled out. This temporary disruption impacted the initial operational efficiency of the program, though performance improved as processes stabilized.

How were the challenges resolved?

The challenges related to Pre-Tiering Identification and Prioritization were addressed through the development of a multi-faceted dashboard system by Colorado Access. This system provides real-time discharge information to hospitals and CMHCs to facilitate coordinated discharge planning. Members were automatically assigned to tiers within the dashboard, allowing CMs to focus on managing care rather than the tiering process. The dashboard also provides critical information such as the hospital the member was

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Intervention Evaluation Results

discharged from and any CMHC linkages, enabling CMs to efficiently initiate the process of care coordination and ensuring timely post-discharge care.

To further address resource limitations for lower-performing tiers, Colorado Access submitted a new Request for Proposal (RFP) to secure funding for a program focused on enhancing support for members in these tiers who are not engaged with Care Management. The proposed program aims to collaborate with selected CMHCs to implement a comprehensive mental health follow-up initiative. This initiative will target individuals recently discharged from mental health hospitalizations in lower tiers, ensuring a smoother transition from inpatient care to community-based support. The program seeks to strengthen the behavioral health continuum by providing timely and personalized follow-up with mental health providers at the appropriate level of care for each member. Selected CMHCs will be awarded up to \$600,000 to administer the program, which is expected to run for twelve months following the distribution of funds. The proposal is currently awaiting approval.

What successes were demonstrated through the intervention testing?

- Improved Follow-Up Rates for Priority Populations: The tiered system led to a significant improvement in follow-up appointment rates, particularly in Tiers 1 and 3, which primarily include the child population. The focus on higher-priority populations resulted in improved outcomes for these groups, demonstrating the effectiveness of targeted interventions.
- Efficient Use of Resources: By prioritizing high-need populations, the intervention allowed for more efficient allocation of limited resources. CMs were able to focus their efforts on members with the highest risk, leading to improved care coordination and more streamlined processes.
- Enhanced Data-Driven Decision Making: The introduction of the dashboard system enabled real-time access to critical discharge information, allowing for better coordination between hospitals, CMHCs, and CMs. This data-driven approach facilitated timely follow-up care, contributing to improved outcomes.
- Increased Coordination Between Healthcare Providers: The dashboard system improved coordination between hospitals, CMHCs, and CMs, ensuring smoother transitions from inpatient to outpatient care. This integration of care contributed to better outcomes and reduced the risk of members falling through the cracks post-discharge.
- Demonstrated Need for Tailored Interventions: The intervention testing highlighted the different needs of populations across tiers, reinforcing the importance of population-specific strategies. This insight led to further initiatives, such as the proposed mental health follow-up program for lower tiers, ensuring that future interventions are more targeted.

Colorado Access Region 5 PIP Intervention Worksheet

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Intervention Evaluation Results

- Positive Feedback from Care Managers: The streamlined tiering and dashboard system allowed CMs to work more efficiently, reducing administrative burdens and enabling them to focus on providing direct support to members. Feedback indicated improved job satisfaction and better member outcomes as a result.
- **Foundation for Future Program Expansion:** The successes in higher-priority tiers laid a strong foundation for the expansion of the program, including the development of new funding proposals and partnerships with CMHCs. This expansion aims to replicate the success seen in higher tiers for more difficult-to-engage populations in lower tiers.

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Appendix A1-2: State of Colorado PIP Intervention Worksheet



	Follow-Up After Hospitalization for Mental Illness (FUH) for Colorado Access Region 5
	Intervention Status
	Select one intervention status: X Adopt □ Adapt □ Abandon □ Continue
Rationale for Inte	rvention Status Selected
optimizing care material enhances coordinate resources and stream	"Adopt" for this program because it has proven to be an effective strategy for improving follow-up rates and magement resources. By focusing on high-need populations, the intervention enables targeted, data-driven care that tion between providers and improves health outcomes for members. The system's ability to prioritize limited mline processes for CMs ensures more efficient delivery of services while laying a strong foundation for expanding o-reach populations. The demonstrated successes in higher-priority tiers further validate the decision to adopt this er implementation.

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Managed Care Organization (MCO) Information		
MCO Name	Colorado Access Region 5	
PIP Title	Follow-Up After Hospitalization for Mental Illness (FUH)	
Intervention Title	Community Mental Health Center (CMHC) Value Based Payment (VBP) Model	

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Instructions: Complete a separate worksheet for each intervention.

Intervention Description			
Intervention Title	Community Mental Health Center (CMHC) Value Based Payment (VBP) Model		
What barrier(s) are addressed?	CMHCs identified the need for additional financial support to effectively allocate resources toward meeting this metric. Achieving a follow-up behavioral health appointment within seven days requires swift action and increased appointment availability. To meet this demand, CMHCs require enhanced funding to expand their behavioral health staffing. The introduction of this incentive has empowered CMHCs to better prioritize and fulfill the demands of this critical metric, ensuring timely and effective care for patients.		
Describe how the intervention is culturally and linguistically appropriate.	The intervention is culturally and linguistically appropriate because CMHCs tailor follow-up care to align with each member's unique cultural background. This includes a focus on language preferences, accommodating individuals with disabilities (such as those who are deaf or hard of hearing, or blind), and providing programs that foster community connections. These initiatives help members connect with their neighbors, learn new skills, and access the support they need to enhance their health and well-being. Additionally, CMHCs schedule appointments that respect cultural practices and ensure that healthcare providers either speak the member's language or offer translation services when necessary. By implementing these strategies, the intervention promotes equitable access to care, ensuring that services are both culturally sensitive and effective in meeting individual needs.		
Intervention Process Steps (List the step-by-step process required to carry out this intervention.)	1. Identification of CMHC Partners: The top five CMHCs, which are the most heavily utilized by our members, were selected to collaborate on a value-based payment program. The aim is to shift from a volume-based payment model to one focused on delivering targeted clinical care and achieving better health outcomes for Health First Colorado members, while reducing avoidable costs linked to managing complex behavioral health conditions.		

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Intervention Description				
	 Collaborative Meetings and Metric Selection: Several collaborative meetings were held with the Department of Healthcare Policy & Financing (HCPF), the respective CMHCs, and Colorado Access to align behavioral health priorities. Priority metrics, including the FUH metric, were selected, and baseline data was calculated to establish performance improvement thresholds. These thresholds determined the value-based payments earned by each CMHC. Ongoing Meetings and Performance Reviews: CMHCs attend routine monthly meetings with Colorado Access staff, with an additional combined CMHC meeting held bi-monthly. Individual meetings focus on reviewing metric performance, while all-center meetings address barriers (such as issues with hospitals or quality of care) and promote open communication. Discussions also focus on current quality improvement and performance improvement efforts related to improving seven-day FUH metric, as well as preparations for the next Accountable Care Collaborative (ACC) Phase III model. Final Performance Measurement and Payment Issuance: Final performance is measured, and after the claim's runout period, payments are issued based on the performance achieved by each CMHC. 			
Intervention Start Date (MM/DD/YYYY)	07/01/2023 Intervention End Date (MM/DD/YYYY) N/A – program is ongoing		N/A – program is ongoing	

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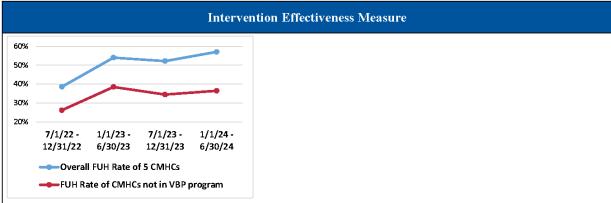
Intervention Effectiveness Measure				
Intervention Effectiveness Measure Title	Combined FUH Performance of Five CMHCs in the VBP Program			
Numerator description (narrative)	The number of Region 3 and Region 5 members* who received a follow-up visit with a mental health provider within seven days after discharge <u>from one of the five participating CMHCs in the Value Based Payment program</u> . Visits occurring on the date of discharge are excluded.			
Denominator description (narrative)	The number of Region 3 and Region 5 members* aged six years and older who were discharged after hospitalization for treatment of selected mental illness or intentional self-harm diagnoses by the end of the performance period <u>from one of the five</u> participating CMHCs in the Value Based Payment program.			
Intervention Evaluation Period Dates (MM/DD/YYYY-MM/DD/YYYY)	Numerator Denominator Percentage			
07/01/22 - 12/31/22	280	726	38.57%	
01/01/23 - 06/30/23	485	898	54.01%	
07/01/23 - 12/31/23	440	843	52.19%	
01/01/24 - 6/30/24	428 750 57.07%			
If qualitative data were collected, provide a narrative summary of results below.				

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*Both Regions 3 and 5 are included in this intervention, which was designed to ensure that all lines of business are incorporated for tiering and payout.

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Intervention Effectiveness Measure				
Intervention Effectiveness Measure Title	Individual FUH Performance of Five CMHCs in the VBP program			
Numerator description (narrative)	The number of Region 3 and Region 5 members* who received a follow-up visit with a mental health provider within seven days after discharge <u>from each of the five participating CMHCs in the Value Based Payment program</u> . Visits occurring on the date of discharge are excluded.			
Denominator description (narrative)	The number of Region 3 and Region 5 members* aged six years and older who were discharged after hospitalization for treatment of selected mental illness or intentional self-harm diagnoses by the end of the performance period from each of the five participating CMHCs in the Value Based Payment program.			
Intervention Evaluation Period Dates (MM/DD/YYYY-MM/DD/YYYY)	Numerator	Denominator	Percentage	
07/01/22 - 12/31/22	CMHC 1: 57 CMHC 2: 91 CMHC 3: 64 CMHC 4: 49 CMHC 5: 19	CMHC 1: 151 CMHC 2: 293 CMHC 3: 121 CMHC 4: 121 CMHC 5: 40	CMHC 1: 37.75% CMHC 2: 31.06% CMHC 3: 52.89% CMHC 4: 40.50% CMHC 5: 47.50%	
01/01/23 - 06/30/23	CMHC 1: 109 CMHC 2: 141 CMHC 3: 100 CMHC 4: 95 CMHC 5: 40	CMHC 1: 171 CMHC 2: 341 CMHC 3: 170 CMHC 4: 164 CMHC 5: 52	CMHC 1: 63.64% CMHC 2: 41.35% CMHC 3: 58.82% CMHC 4: 57.93% CMHC 5: 76.92%	

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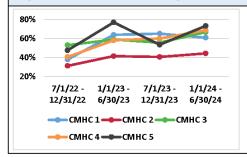






Intervention Effectiveness Measure				
07/01/23 - 12/31/23	CMHC 1: 119	CMHC 1: 183	CMHC 1: 65.03%	
	CMHC 2: 138	CMHC 2: 341	CMHC 2: 40.47%	
	CMHC 3: 65	CMHC 3: 117	CMHC 3: 55.56%	
	CMHC 4: 94	CMHC 4: 157	CMHC 4: 59.87%	
	CMHC 5: 24	CMHC 5: 45	CMHC 5: 53.33%	
01/01/24 - 6/30/24	CMHC 1: 99	CMHC 1: 163	CMHC 1: 60.74%	
	CMHC 2: 133	CMHC 2: 301	CMHC 2: 44.19%	
	CMHC 3: 72	CMHC 3: 108	CMHC 3: 66.67%	
	CMHC 4: 94	CMHC 4: 137	CMHC 4: 68.61%	
	CMHC 5: 30	CMHC 5: 41	CMHC 5: 73.17%	

If qualitative data were collected, provide a narrative summary of results below.



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Intervention Evaluation Results

What lessons did the MCO learn from the intervention testing and evaluation results?

The current program evaluation indicates that CMHCs participating in the VBP incentive program are outperforming non-participating CMHCs, as shown in the run charts above. Since the program's implementation on July 1, 2023, all but one CMHC has increased its FUH rate. Of the five participating CMHCs, four met their FUH target percentage goals between January 1, 2024, and June 30, 2024, and two have exceeded their enhanced target goals, making them eligible for payout.

Key Lessons Learned:

- Same-Day Appointments: CMHCs continue to face challenges with the program's requirement that same-day appointments
 do not count towards the FUH metric. Finding a balance between achieving the metric and providing high-quality care that
 meets the member's immediate needs, such as same-day appointments, remains a challenge. We are actively exploring ways
 to address this issue in a non-penalizing manner for the ACC Phase III model.
- Medicaid/Medicare Dual-Eligible Members: A recurring issue involves dual-eligible members (Medicaid and Medicare).
 When a follow-up visit is billed to Medicare, we often lose visibility into the claim, as Medicare may cover the entire visit.
 This results in these members being included in the denominator of the FUH metric but not in the numerator, skewing results.
 We are exploring potential solutions, including the possibility of removing dual-eligible members from the program to ensure accurate performance evaluation.

What challenges were encountered?

The challenges listed below highlight ongoing difficulties in communication and coordination between hospitals, CMHCs, and members, hindering the effectiveness of follow-up care.

Hospital and CMHC Barriers:

- **Relationship Building**: CMHCs struggle to build strong partnerships with hospitals, resulting in inconsistent discharge coordination and follow-up care. This leads to rushed efforts to schedule appointments within the required seven-day window.
- Lack of Commitment: CMHCs find it difficult to secure regular collaboration with hospital leads in behavioral health. High
 turnover in hospital management and medical records departments adds to the challenge, requiring continuous retraining and
 advocacy for cooperation.

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Intervention Evaluation Results

- Late Discharge Notices: Hospitals often notify CMHCs of a patient's discharge on the day it happens, making it difficult to coordinate timely follow-up care.
- Warm Hand-Offs: Without face-to-face "warm hand-offs" between hospitals and CMHCs, discharged members often disengage from care due to fear or unfamiliarity with services.
- False Appointments: Some hospitals provide discharge paperwork with false appointments, misleading both members and CMHCs.
- Coordination Without Releases: Hospitals sometimes refuse to coordinate care without completed releases of information, which complicates follow-up.
- **Premature Discharges**: CMHCs report cases where hospitals discharge members before they are stabilized, often due to bed shortages. Hospitals cite medical necessity while CMHCs feel the discharge may pose risks, especially when housing or other social issues are involved.

Member Barriers:

- Lack of Engagement: Many members are discharged with no intention of attending follow-up appointments, despite efforts by hospital coordinators to educate them about the importance of continued care.
- **Disinterest in Care**: Some members, particularly younger individuals or those experiencing their first mental health crisis, don't believe they need follow-up care.
- Family Opposition: Family members sometimes discourage patients from seeking care at mental health centers.
- **Social Determinants**: Members facing issues such as homelessness, lack of food, or poor social support prioritize basic survival over mental health appointments, making follow-up care less likely.

Additional CMHC-Specific Challenges:

- One CMHC faces challenges due to having a small denominator, split between another Regional Accountable Entity (RAE), which makes achieving performance goals more difficult with such a low sample size.
- Another CMHC has expressed that they have reached their performance peak and are entering "maintenance mode," where they no longer see room for further improvement.

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Intervention Evaluation Results

- One CMHC is resistant to adapting to new measure specifications, attributing their lack of improvement to these changes rather than adjusting their practices.
- The unwinding of PHE continuous coverage disrupted care for many centers more significantly than anticipated. Although more members were expected to re-enroll, there was a higher-than-expected number of disenrollments, further complicating care coordination and follow-up efforts.

How were the challenges resolved?

Several specific challenges have been addressed:

- Implementation of the Hospital and Community Mental Health Center seven-day follow-up dashboard: Last year, Colorado Access developed a bidirectional dashboard system that provides real-time discharge information to hospitals and CMHCs for coordinated discharge planning. This dashboard has eliminated barriers that hindered improvement in the seven-day FUH rate. The dashboard allows hospitals and CMHCs to identify members in real-time and coordinate effectively to schedule follow-ups. It has also saved time for our internal care management team by removing the need to notify hospitals of a member's of CMHC connection, thereby eliminating administrative burdens. This system enables a focus on higher acuity members, allowing for quicker intervention since both parties can directly access the dashboard. CMHCs can now view their members' hospitalizations in real-time and proactively coordinate post-discharge follow-up appointments. They can also monitor their seven-day follow-up performance rate more promptly. This dashboard has strengthened community partnerships between hospitals and outpatient behavioral health providers.
- Improved Dashboard Utilization: Efforts are underway to optimize the use of the dashboard by both hospitals and CMHCs, ensuring it becomes a more effective tool for monitoring and improving follow-up care.
- System Improvements and Role Clarity: Improvements in the system have started to emerge, particularly in the coordination between hospitals and CMHCs. The combined use of the dashboard and care management tiering system (separate PIP intervention) now provides a clearer, more comprehensive view of which entities (hospitals or CMHCs) are responsible for a member's follow-up, helping clarify roles and responsibilities.

Challenges currently being addressed:

• Improving Relationships Between CMHCs and Hospitals: For CMHCs that are resistant to further improvement or feel they've reached a performance plateau, we are intensifying efforts to re-engage them through focused attention and tailored

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Intervention Evaluation Results

support. This includes collaborating closely with these clinics to foster open dialogue, address their concerns, and support high standards of care. At the same time, we are prioritizing the strengthening of relationships between CMHCs and hospitals by establishing regular meetings to improve discharge coordination and follow-up care. Initial steps include facilitating direct conversations between the two parties, addressing concerns, and creating collaborative solutions to enhance communication and partnership moving forward.

- Potential Data Forum Between CMHCs and Hospitals: A proposed data forum, written into the contract as a requirement, would bring together CMHCs and hospitals to collaboratively review their data. The aim is to foster cooperation, reduce finger-pointing, and work together to improve follow-up care. The forum is still in development and will be implemented thoughtfully to avoid straining relationships.
- New Contract Language for Quality Audits on Discharge Plans: To address concerns about false appointments or a lack
 of care coordination, we are adding new language to CMHC contracts allowing for quality audits of discharge plans. This will
 help verify whether coordination issues are real and ensure appropriate steps are taken to address them.
- RFP to Address Unattributed Member Engagement: To support resource-limited, lower-performing CMHCs, Colorado Access submitted a new Request for Proposal (RFP) to secure funding for a program designed to enhance engagement with members who are not actively involved with Care Management (also mentioned in the transitions of care intervention form). This initiative aims to collaborate with select CMHCs to improve follow-up care for recently discharged mental health patients that are unattributed to a CMHC. The program would provide up to \$600,000 to participating CMHCs and is currently awaiting approval.
- CMHC Bonus Incentives: We continue to incentivize the 7-day FUH measure, excluding the day of discharge. Additionally, we have introduced an unannounced bonus for CMHCs that successfully meet their FUH gate measure. This bonus is determined by reviewing day-of-discharge visits that are not counted in the numerator but align with best practices, rewarding CMHCs for maintaining high-quality care standards despite changes in specifications. This incentive will not go into effect until July 2025.

What successes were demonstrated through the intervention testing?

The intervention testing yielded several notable successes:

Increased FUH Rates: Across participating CMHCs, FUH rates have shown improvement since the implementation of the
program, with many centers consistently increasing their performance.

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Intervention Evaluation Results

- Payout Eligibility: Some CMHCs have achieved their FUH performance targets, with two centers exceeding enhanced target goals, making them eligible for financial payouts through the value-based payment program.
- **Resilience During PHE Unwind:** Despite the challenges posed by the (PHE coverage unwind, which caused fluctuations in both numerator and denominator figures, FUH rates did not plummet. Instead, CMHCs demonstrated resilience by continuing to improve their rates, even while managing the additional burden of disenrollments and transitions in care.
- **High Performance in Youth Follow-Up Care:** In the age-stratified analysis, all centers performed exceptionally well in the 6–17-year-old age group, with FUH rates surpassing the HEDIS 90th percentile benchmark for this group. This demonstrates strong care continuity for younger members across the board.

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Intervention Status		
Select one intervention status:	□ Adopt X Adapt □ Abandon □ Continue	
Rationale for Intervention Status Selected		
We have chosen "Adapt" for this program because it is comore effective strategies for addressing the barriers they fac and we are committed to continuing this important work.	ontinuously evolving to better meet the needs of CMHCs and to identify be. While we have begun tackling some of these challenges, many remain,	
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Appendix A1-4: State of Colorado PIP Intervention Worksheet Social Determinants of Health (SDOH) Screening for Colorado Access Region 5



Managed Care Organization (MCO) Information		
MCO Name	Colorado Access Region 5	
PIP Title	Social Determinants of Health (SDOH) Screening	
Intervention Title	Standardization of SDOH questions by incorporating the CORE 5 Screening Tool into all applicable CM scripts	

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Appendix A1-4: State of Colorado PIP Intervention Worksheet Social Determinants of Health (SDOH) Screening for Colorado Access Region 5



Instructions: Complete a separate worksheet for each intervention.

Intervention Description		
Intervention Title	Standardization of SDOH questions by incorporating the CORE 5 Screening Tool into all applicable CM scripts.	
What barrier(s) are addressed?	Current Care Management (CM) scripts contain various Social Determinants of Health (SDOH) questions but lack consistency across all five core SDOH domains. This inconsistency not only makes it difficult to gather comprehensive, comparable data but also limits the support we can offer our members by not fully understanding their needs. By standardizing the SDOH questions through the incorporation of the CORE 5 Screening Tool into all applicable CM scripts, we ensure that we are asking the right questions and providing more holistic, effective care to our members.	
Describe how the intervention is culturally and linguistically appropriate.	Incorporating the CORE 5 Screening Tool allows us to ask targeted questions about social needs, many of which are shaped by broader effects of systemic inequities. By standardizing these questions, we gain deeper insights into critical aspects of members' lives—such as access to food, housing, and community support—that are not only influenced by cultural background but also by historical and institutional disparities. This approach ensures we can address social determinants of health in a way that acknowledges the structural challenges members face, allowing for more equitable, personalized, and effective care.	
	Additionally, CM staff are trained to approach sensitive topics in a manner that respects cultural norms and values, ensuring that questions are framed in a way that promotes trust and encourages honest responses. This approach also considers members' health literacy levels and disability needs (e.g., visual or hearing impairments), ensuring equitable access to care and support based on individual member needs.	
Intervention Process Steps (List the step-by-step process required to carry out this intervention.)	Upgrade and Optimization of the HealthEdge GuidingCare System The first step included upgrading and optimizing the internal Colorado Access HealthEdge GuidingCare system, which had not been updated since 2021. This system hindered the timely update of CM scripts and workflows. The upgrade,	

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Appendix A1-4: State of Colorado PIP Intervention Worksheet Social Determinants of Health (SDOH) Screening for Colorado Access Region 5



Intervention Description

completed in December 2023, enabled the incorporation of the SDOH Core 5 screening tool into the enhanced system and scripts. Originally listed as a separate intervention, this was later classified as a process step since it was necessary for implementing new SDOH screening questions and redesigning the scripts.

- Incorporation of CORE 5 and PRAPARE Screening Tools into Scripts
 Following the system upgrade, the CORE 5 and PRAPARE (interpersonal safety)
 screening tool questions were added to all relevant scripts. Each script had variations
 and duplicative questions, so this step involved synchronizing the addition of new
 questions across multiple scripts.
- 3. Creation of New Opportunities, Goals, and Interventions (OGIs)
 For each SDOH question that could potentially receive a positive response indicating a need for assistance, new OGIs were created for the CM team. This step required extensive collaboration across teams to ensure that the appropriate OGIs were designed for each SDOH question. Multiple Plan-Do-Study-Act (PDSA) cycles and iterations were conducted before final approval was granted.
- 4. Submission to HealthEdge GuidingCare Team for Implementation
 Once the final questions and OGIs were created, they were submitted to the
 HealthEdge GuidingCare team for implementation. Given the vast number of scripts,
 extensive quality assurance (QA) testing was conducted in QA and pre-production
 environments. Final approval and implementation were completed by May 8, 2024,
 with the entire process taking four months post-upgrade.
 In addition to technical implementation, change management efforts were undertaken
 with the CM team. This included notifying them about the changes, explaining why
 they were made, and how they would improve service to members. The team was
 trained on the new OGIs, the updated SDOH questions, and how to respond when a
 question received a positive answer, including guidance on what resources to provide
 to members in need.

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	Intervention	1 Description				
	Evaluation and QA thorough testing, so	ome script errors and missp	went live on May 8, 2024. Despite ellings were found after the launch, e errors were resolved by the end of			
	6. Creation of a Dashboard for SDOH Screening Metrics The Business Intelligence (BI) team developed a dashboard to automatically genera monthly data on SDOH screening rates. The dashboard provides detailed metrics, prioritizing Colorado Access-specific interests by displaying the percentages of identified SDOH needs among members. This helps in understanding the population needs and improving program structure while preparing community resources (community-based organizations (CBOs)) for the most reported needs.					
Intervention Start Date (MM/DD/YYYY)	05/08/2024	Intervention End Date (MM/DD/YYYY)	N/A – program is ongoing			

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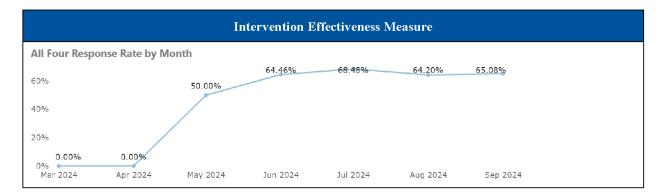
	Intervention Effectivene	ss Measure					
Intervention Effectiveness Measure Title	The percentage of Region 5 members who were screened for Social Determinants of Health (SDOH) using the Core 5 SDOH screening Tool. This measure aligns with what is reported in the submission forms, as there was no separate measure for this intervention. Monthly screening rates served as the primary indicator for determining whether members were being screened appropriately.						
Numerator description (narrative)	Number of Region 5 member screening tool.	s that were screened for SDOI	Husing the Core 5 SDOH				
Denominator description (narrative)	Number of Region 5 members that were in contact with the CM team through a documented interaction via an *applicable CM script in the CM documentation software HealthEdge GuidingCare. *Nonapplicable scripts include scripts that would not be appropriate to contain SDOH questions. Example: standardized screening tools (PHQ-9, AHQ).						
Intervention Evaluation Period Dates (MM/DD/YYYY-MM/DD/YYYY)	Numerator Denominator Percentage						
05/01/2024 - 05/31/2024	95	190	50.00%				
06/01/2024 - 06/30/2024	78	121	64.46%				
07/01/2024 - 07/31/2024	113	165	68.48%				
08/01/2024 - 08/31/2024	104	162	64.20%				
09/01/2024 - 09/30/2024	82	126	65.08%				
If qualitative data were collected, provide	a narrative summary of resu	lts below.					

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Intervention Evaluation Results

What lessons did the MCO learn from the intervention testing and evaluation results?

Colorado Access learned that implementing new questions into scripts is more complex than initially expected. This process requires substantial effort and resources, especially when working with systems like HealthEdge GuidingCare. The involvement of QA, preproduction, and production environments, along with the necessary steps for transitioning between each phase, can lead to significant delays. What was originally projected to take four to six weeks ended up taking four months.

Additionally, we discovered that even with detailed QA efforts from both the CM and GuidingCare teams, errors can still emerge post-production. For instance, a minor misspelling of the word "housing" in a script related to the housing SDOH question, impacted the accuracy of the data, as the data is pulled directly from the questions. As a result, May's screening rates were lower than expected due to the need to address these small errors.

Currently, screening rates are consistently between 60-65%, falling short of the original 90% goal. This prompted an investigation, and the lessons learned are discussed further in the "Challenges Encountered and Resolved" sections below.

What challenges were encountered?

After addressing smaller errors throughout May, we expected screening rates to rise. However, the rates only increased to around 60% and plateaued. Upon further QA and investigation, we discovered that the lower rate was due to scripts being marked as "Activity Complete" even when only a few questions were answered, rather than the entire script being fully completed.

We had originally instructed CMs to select "Successful" & "Activity Complete" only if the entire script, including all questions, was completed with the member. If not, they were advised to select "Unsuccessful" & "Activity Partially Complete." Since the CM team provides member-centered care, they respect members' decisions if they choose not to answer certain questions, resulting in partially completed scripts. In these cases, the CMs should record that the script was not fully completed. However, these half-completed scripts are currently being counted in the denominator for SDOH screening rates, which artificially lowers the screening rate. If a script is not fully completed, the SDOH screening questions are often left unanswered, contributing to the lower rate.

How were the challenges resolved?

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Intervention Evaluation Results

After further investigation, we discovered that the "Activity Partially Complete" option, which we had originally instructed CMs to select when a script was incomplete, had been removed from the Activity Outcome options during a recent optimization process by HealthEdge GuidingCare in June 2024. This change was made without full consideration of its impact on our screening rates.

To resolve this, Colorado Access requested that HealthEdge GuidingCare reinstate the "Activity Partially Complete" option. This update is scheduled for completion on October 15, 2024. Once reintroduced, we will communicate the change to all CM staff and reiterate the correct steps for selecting this option, emphasizing its importance. We anticipate that this adjustment will lead to an increase in screening rates and provide a more accurate reflection of our SDOH screening performance.

What successes were demonstrated through the intervention testing?

We are proud to have successfully integrated standardized screening questions into our system, which has significantly enhanced our ability to serve our members. Our CM team quickly adopted these questions, demonstrating strong commitment to the intervention. As an organization, we ensured that the questions were asked consistently across all scripts and prepared resources and partnerships with CBOs to refer members to when they indicated a need for assistance.

In addition to the Core 5 SDOH screening questions, we expanded our focus by including questions about additional resources like The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) and The Supplemental Nutrition Assistance Program (SNAP), tax credit resources, financial assistance, clothing, disability services, vocational support, baby supplies, and technology access. This broader scope allowed us to more comprehensively address our members' needs and connect them with appropriate resources.

Members expressed their appreciation to CMs, often stating how glad they were that these critical questions were being asked. This feedback highlighted the importance of addressing SDOH in our member interactions and underscored the positive impact this intervention has had on their overall experience and well-being.

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We have adopted this intervention as a permanent part of our CM approach because it has proven to be highly effective in improving the quality of care for our members by systematically addressing SDOH. The integration of standardized screening questions, along with the expansion beyond the Core 5 to include additional resources, has provided valuable insights into our members' needs and enabled us to connect them with appropriate community resources, enhancing their overall well-being. The positive feedback from members, along with the CM team's swift and seamless adoption of the new processes, demonstrates the	for Colorado Access Region 5
Rationale for Intervention Status Selected We have adopted this intervention as a permanent part of our CM approach because it has proven to be highly effective in improving the quality of care for our members by systematically addressing SDOH. The integration of standardized screening questions, along with the expansion beyond the Core 5 to include additional resources, has provided valuable insights into our members' needs and enabled us to connect them with appropriate community resources, enhancing their overall well-being. The positive feedback from members, along with the CM team's swift and seamless adoption of the new processes, demonstrates the	Intervention Status
We have adopted this intervention as a permanent part of our CM approach because it has proven to be highly effective in improving the quality of care for our members by systematically addressing SDOH. The integration of standardized screening questions, along with the expansion beyond the Core 5 to include additional resources, has provided valuable insights into our members' needs and enabled us to connect them with appropriate community resources, enhancing their overall well-being. The positive feedback from members, along with the CM team's swift and seamless adoption of the new processes, demonstrates the	Select one intervention status: X Adopt □ Adapt □ Abandon □ Continue
the quality of care for our members by systematically addressing SDOH. The integration of standardized screening questions, along with the expansion beyond the Core 5 to include additional resources, has provided valuable insights into our members' needs and enabled us to connect them with appropriate community resources, enhancing their overall well-being. The positive feedback from members, along with the CM team's swift and seamless adoption of the new processes, demonstrates the	Rationale for Intervention Status Selected
	We have adopted this intervention as a permanent part of our CM approach because it has proven to be highly effective in improving the quality of care for our members by systematically addressing SDOH. The integration of standardized screening questions, along with the expansion beyond the Core 5 to include additional resources, has provided valuable insights into our members' needs and enabled us to connect them with appropriate community resources, enhancing their overall well-being.
	The positive feedback from members, along with the CM team's swift and seamless adoption of the new processes, demonstrates the intervention's practicality and long-term sustainability. Moreover, the infrastructure and partnerships established to support this intervention ensure that we are well-positioned to continue meeting our members' needs effectively moving forward.

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Appendix B. Final PIP Validation Tools

Appendix B contains the final PIP Validation Tools provided by HSAG.







	Demographic Information						
MCO Name:	Colorado Access Region 5	Colorado Access Region 5					
Project Leader Name:	Sarah Thomas	Title:	Quality Improvement Program Manager				
Telephone Number:	1-800-511-5010	Email Address:	sarah.thomas@coaccess.com				
PIP Title:	Follow-Up After Hospitalization for Mental Illness (FUH)						
Submission Date:	October 31, 2024						
Resubmission Date:	Not Applicable						

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Evaluation Elements	Critical	Scoring	Comments/Recommendations
erformance Improvement Project Validation			
tep 1. Review the Selected PIP Topic: The PIP topic should be mprove member health, functional status, and/or satisfaction			nat identify an opportunity for improvement. The goal of the project should be to equired by the State. The PIP topic:
. Was selected following collection and analysis of data.			
/A is not applicable to this element for scoring.	C*	Met	
,		Results fo	r Step 1
Total Evaluation Elements**	1	1	Critical Elements***
Met	1	1	Mei
Partially Met	0	0	Partially Met
	0	0	Not Met
Not Met	U		

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*** This is the total number of critical evaluation elements for this step.

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Evaluation Elements	Critical	Scoring	Comments/Recommendations			
Performance Improvement Project Validation						
step 2. Review the PIP Aim Statement(s): Defining the statement interpretation. The statement:	ent(s) help	s maintain the fo	cus of the PIP and sets the framework for data collection, analysis, and			
. Stated the area in need of improvement in clear, concise, and neasurable terms. 1/A is not applicable to this element for scoring.	C*	Met				
Results for Step 2						
Total Evaluation Elements**	1	1	Critical Elements***			
Met	1	1	Met			
Partially Met	0	0	Partially Met			
Not Met	0	0	Not Met			
110717407	0		N/A (Not Applicable)			

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^{***} This is the total number of critical evaluation elements for this step.







Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
step 3. Review the Identified PIP Population: The PIP populatiospply, without excluding members with special healthcare nee		-	d to represent the population to which the PIP Aim statement and indicator(s)
. Was accurately and completely defined and captured all members to whom the PIP Aim statement(s) applied. WA is not applicable to this element for scoring.	C*	Met	
		Results for	Step 3
Total Evaluation Elements**	1	1	Critical Elements***
Met	1	1	Met
Partially Met	0	0	Partially Met
Not Met	0	0	Not Met
	0	0	N/A (Not Applicable)

*** This is the total number of critical evaluation elements for this step.

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Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 4. Review the Sampling Method: (If sampling was not use the population, proper sampling methods are necessary to pro	•		ent will be scored Not Applicable [N/A]). If sampling was used to select members i esults. Sampling methods:
I. Included the sampling frame size for each indicator.		N/A	
2. Included the sample size for each indicator.	C*	N/A	
Included the margin of error and confidence level for each indicator.		N/A	
4. Described the method used to select the sample.		N/A	
5. Allowed for the generalization of results to the population.	C*	N/A	
		Results fo	or Step 4
Total Evaluation Elements**	5	2	Critical Elements***
Met	0	0	Met
Partially Met	0	0	Partially Met
Not Met	0	0	Not Met
N/A (Not Applicable)	5	2	N/A (Not Applicable)

*** This is the total number of critical evaluation elements for this step.

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Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
• • • • • • • • • • • • • • • • • • • •	track perf	ormance or impi	titative or qualitative characteristic or variable that reflects a discrete event or a rovement over time. The indicator(s) should be objective, clearly and Irch. The indicator(s) of performance:
. Were well-defined, objective, and measured changes in sealth or functional status, member satisfaction, or valid process alternatives.	C*	Мет	
2. Included the basis on which the indicator(s) was developed, finternally developed.		N/A	
'		Results for	Step 5
Total Evaluation Elements**	2	1	Critical Elements***
Met	1	1	Met
Partially Met	0	0	Partially Met
Not Met	0	0	Not Met
N/A (Not Applicable)	1	0	N/A (Not Applicable)

^{***} This is the total number of critical evaluation elements for this step.

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Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
•			that the data collected on the indicator(s) were valid and reliable. Validity is an repeatability or reproducibility of a measurement. Data collection procedures
Clearly defined sources of data and data elements collected for the indicator(s). WA is not applicable to this element for scoring.		Mei	
A clearly defined and systematic process for collecting paseline and remeasurement data for the indicator(s). WA is not applicable to this element for scoring.	C*	Met	
 A manual data collection tool that ensured consistent and accurate collection of data according to indicator specifications. 	C*	N/A	
The percentage of reported administrative data completeness at the time the data are generated, and the process used to calculate the percentage.		Met	
		Results for	Step 6
Total Evaluation Elements**	4	2	Critical Elements***
Мет	3	1	Met
Partially Met	0	0	Partially Met
Not Met	0	0	Not Met
N/A (Not Applicable)	I	1	N/A (Not Applicable)

** This is the total number of critical evaluation elements for this step.

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Results for Step 1 - 6						
Total Evaluation Elements	14	8	Critical Elements			
Met	7	5	Met			
Partially Met	0	0	Partially Met			
Not Met	0	0	Not Met			
N/A (Not Applicable)	7	3	N/A (Not Applicable)			

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Evaluation Elements	Critical	Scoring	Comments/Recommendations
erformance Improvement Project Validation			
•	ough data a	nalysis and in	or each indicator. Describe the data analysis performed, the results of the statistic terpretation, real improvement, as well as sustained improvement, can be
I. Included accurate, clear, consistent, and easily understood information in the data table.	C*	Met	
Included a narrative interpretation of results that addressed all requirements.		Met	General Feedback: When describing the difference between the baseline and Remeasurement 1 indicator rates, the correct units is percentage points rather that percent.
Addressed factors that threatened the validity of the data eported and ability to compare the initial measurement with he remeasurement.		Met	
		Results fo	r Step 7
Total Evaluation Elements**	3	1	Critical Elements***
Met	3	1	Met
Partially Met	0	0	Partially Met
Not Met	0	0	Not Met
N/A (Not Applicable)	0	0	N/A (Not Applicable)

^{**} This is the total number of all evaluation elements for this step.

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^{***} This is the total number of critical evaluation elements for this step.







Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 8. Assess the Improvement Strategies: Interventions wer analysis. The improvement strategies were developed from a			uses/barriers identified through a continuous cycle of data measurement and data ment process that included:
A causal/barrier analysis with a clearly documented team, process/steps, and quality improvement tools.	C*	Met	
2. Interventions that were logically linked to identified barriers and have the potential to impact indicator outcomes.	C*	Met	
3. Interventions that were implemented in a timely manner to allow for impact of indicator outcomes.		Met	General Feedback: In the intervention worksheets, the health plan should align th Intervention Start and End Dates with the Intervention Evaluation Period Dates.
An evaluation of effectiveness for each individual intervention.	C*	Met	
5. Interventions that were adopted, adapted, abandoned, or continued based on evaluation data.		Met	
		Results fo	r Step 8
Total Elements**	5	3	Critical Elements***
Met	5	3	Met
Partially Met	0	0	Partially Met
Not Met	0	0	Not Met
N/A (Not Applicable)	0	0	N/A (Not Applicable)

^{**} This is the total number of all evaluation elements for this step.

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^{***} This is the total number of critical evaluation elements for this step.







Results for Step 7 - 8							
Total Evaluation Elements	8	4	Critical Elements				
Met	8	4	Меі				
Partially Met	0	0	Partially Met				
Not Met	0	0	Not Met				
N/A (Not Applicable)	0	0	N/A (Not Applicable)				

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Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
mprovement over baseline indicator performance. Sustained	improvem	ent is assessed a	ovement in performance is evaluated based on evidence that there was fter improvement over baseline indicator performance has been demonstrated. Periods demonstrate continued improvement over baseline indicator
The remeasurement methodology was the same as the baseline methodology.	C*	Mei	
There was improvement over baseline performance across all performance indicators.		Met	
8. There was statistically significant improvement (95 percent confidence level, $p < 0.05$) over the baseline across all performance indicators.		Not Met	The improvement in indicator results from baseline to Remeasurement 1 was not statistically significant.
 Sustained statistically significant improvement over baseline ndicator performance across all indicators was demonstrated hrough repeated measurements over comparable time periods. 		Not Assessed	Sustained improvement is not assessed until statistically significant improvement is demonstrated and remeasurement results are reported for a subsequent remeasurement period.
		Results for	Step 9
Total Evaluation Elements**	4	1	Critical Elements***
Met	2	1	Mei
Partially Met	0	0	Partially Met
Not Met	1	0	Not Met
N/A (Not Applicable)	0	0	N/A (Not Applicable)

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^{**} This is the total number of all evaluation elements for this step.

^{***} This is the total number of critical evaluation elements for this step.







Table B-1 2024-25 PIP Validation Tool Scores										
	for Follow-Up Aj	fter Hospita	lization for M	ental Illness fo	or Colorad	o Access Regi	ion 5			
Review Step	Total Possible Evaluation Elements (Including Critical Elements)	Total <i>Met</i>	Total Partially Met	Total Not Met	Total <i>N/A</i>	Total Possible Critical Elements	Total Critical Elements <i>Met</i>	Total Critical Elements Partially Met	Total Critical Elements <i>Not Met</i>	Total Critical Elements <i>N/A</i>
Review the Selected PIP Topic	1	1	0	0	0	1	1	0	0	0
Review the PIP Aim Statement(s)	1	1	0	0	0	1	1	0	0	0
Review the Identified PIP Population	l	1	0	0	0	1	l	0	0	0
Review the Sampling Method	5	0	0	0	5	2	0	0	0	2
Review the Selected Performance Indicator(s)	2	1	0	0	1	1	1	0	0	0
Review the Data Collection Procedures	4	3	0	0	1	2	1	0	0	1
7. Review Data Analysis and Interpretation of Results	3	3	0	0	0	1	1	0	0	0
Assess the Improvement Strategies	5	5	0	0	0	3	3	0	0	0
Assess the Likelihood that Significant and Sustained Improvement Occurred	4	2	0	1	0	1	1	0	0	0
Totals for All Steps	26	17	0	1	7	13	10	0	0	3

Table B—2 2024-25 Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP (Step 1 through Step 8) for Follow-Up After Hospitalization for Mental Illness for Colorado Access Region 5					
Percentage Score of Evaluation Elements Met *	100%				
Percentage Score of Critical Elements Met**	100%				
Confidence Level***	High Confidence				

Table B—3 2024-25 Overall Confidence That the PIP Achieved Significant Improvement (Step 9) for Follow-Up After Hospitalization for Mental Illness for Colorado Access Region 5						
Percentage Score of Evaluation Elements Met*	67%					
Percentage Score of Critical Elements Met**	100%					
Confidence Level***	Moderate Confidence					

The Not Assessed and Not Applicable scores have been removed from the scoring calculations.

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^{*} The percentage score of evaluation elements Met is calculated by dividing the total number Met by the sum of all evaluation elements Met, Partially Met, and Not Met.

^{**} The percentage score of critical elements Met, is calculated by dividing the total critical elements Met by the sum of the critical elements Met, Partially Met, and Not Met.

^{***} Confidence Level: See confidence level definitions on next page.







EVALUATION OF THE OVERALL VALIDITY AND RELIABILITY OF PIP RESULTS

HSAG assessed the MCO's PIP based on CMS Protocol 1 to determine whether the MCO adhered to an acceptable methodology for all phases of design and data collection, and conducted accurate data analysis and interpretation of PIP results. HSAG's validation of the PIP determined the following:

High Confidence: High confidence in reported PIP results. All critical evaluation elements were Met, and 90 percent to 100 percent of all evaluation elements

were Met across all steps.

Moderate Confidence: Moderate confidence in reported PIP results. All critical evaluation elements were Met, and 80 percent to 89 percent of all evaluation

elements were Met across all steps.

Low Confidence: Low confidence in reported PIP results. Across all steps, 65 percent to 79 percent of all evaluation elements were Met; or one or more

critical evaluation elements were Partially Met.

No Confidence: No confidence in reported PIP results. Across all steps, less than 65 percent of all evaluation elements were Met; or one or more critical

evaluation elements were Not Met.

Confidence Level for Acceptable Methodology:

High Confidence

HSAG assessed the MCO's PIP based on CMS Protocol 1 and determined whether the MCO produced evidence of significant improvement. HSAG's validation of the PIP determined the following:

High Confidence: All performance indicators demonstrated statistically significant improvement over the baseline.

Moderate Confidence: To receive Moderate Confidence for significant improvement, one of the three scenarios below occurred:

1. All performance indicators demonstrated improvement over the baseline, and some but not all performance indicators demonstrated

statistically significant improvement over the baseline.

2. All performance indicators demonstrated improvement over the baseline, and none of the performance indicators demonstrated

statistically significant improvement over the baseline.

3. Some but not all performance indicators demonstrated improvement over baseline, and some but not all performance indicators

demonstrated statistically significant improvement over baseline.

Low Confidence: The remeasurement methodology was not the same as the baseline methodology for at least one performance indicator or some but not all

performance indicators demonstrated improvement over the baseline and none of the performance indicators demonstrated statistically

significant improvement over the baseline.

The remeasurement methodology was not the same as the baseline methodology for all performance indicators or none of the performance No Confidence:

indicators demonstrated improvement over the baseline.

Confidence Level for Significant Improvement:

Moderate Confidence

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Demographic Information							
MCO Name:	Colorado Access Region 5						
Project Leader Name:	Sarah Thomas	Title:	Quality Improvement Program Manager				
Telephone Number:	1-800-511-5010	Email Address:	sarah.thomas@coaccess.com				
PIP Title:	Social Determinants of Health (SDOH) Screening						
Submission Date:	October 31, 2024	October 31, 2024					
Resubmission Date:	January 22, 2025						

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Critical	Scoring	Comments/Recommendations							
erformance Improvement Project Validation									
		t identify an opportunity for improvement. The goal of the project should be to uired by the State. The PIP topic:							
C*	Met								
	Results for	Step 1							
1	1	Critical Elements***							
1	1	Met							
0	0	Partially Met							
0	0	Not Met							
0	0	N/A (Not Applicable)							
	C*	selected based on data that. The topic may also be required. C* Met Results for S 1 1 1 1 0 0 0 0 0 0							

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Evaluation Elements	Critical	Scoring	Comments/Recommendations					
Performance Improvement Project Validation								
step 2. Review the PIP Aim Statement(s): Defining the statement (statement) terpretation. The statement:	ent(s) help:	s maintain the fo	ocus of the PIP and sets the framework for data collection, analysis, and					
. Stated the area in need of improvement in clear, concise, and neasurable terms. 1/A is not applicable to this element for scoring.	C*	Met						
Results for Step 2								
Total Evaluation Elements**	1	1	Critical Elements***					
Met	1	1	Met					
Partially Met	0	0	Partially Met					
Not Met	0	0	Not Met					
N/A (Not Applicable)	0	0	N/A (Not Applicable)					

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^{**} This is the total number of all evaluation elements for this step.

^{***} This is the total number of critical evaluation elements for this step.







Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
step 3. Review the Identified PIP Population: The PIP populatio opply, without excluding members with special healthcare nee		-	to represent the population to which the PIP Aim statement and indicator(s)
. Was accurately and completely defined and captured all members to whom the PIP Aim statement(s) applied. #/A is not applicable to this element for scoring.	C*	Met	
		Results for	Step 3
Total Evaluation Elements**	1	1	Critical Elements***
Met	1	1	Met
Partially Met	0	0	Partially Met
Not Met	0	0	Not Met
	0	0	N/A (Not Applicable)

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*** This is the total number of critical evaluation elements for this step.

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Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 4. Review the Sampling Method: (If sampling was not use the population, proper sampling methods are necessary to pro			will be scored Not Applicable $[N/A]$). If sampling was used to select members in lts. Sampling methods:
Included the sampling frame size for each indicator.		N/A	
2. Included the sample size for each indicator.	C*	N/A	
Included the margin of error and confidence level for each ndicator.		N/A	
Described the method used to select the sample.		N/A	
5. Allowed for the generalization of results to the population.	C*	N/A	
		Results for	Step 4
Total Evaluation Elements**	5	2	Critical Elements***
Met	0	0	Met
Partially Met	0	0	Partially Met
Not Met	5	2	Not Met
C" in this column denotes a critical evaluation element. ** This is the total number of all evaluation elements for this step. * This is the total number of critical evaluation elements for this step.	J		N/A (Not Applicable)

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Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
• • • • • • • • • • • • • • • • • • • •	track perfo	rmance or imp	itative or qualitative characteristic or variable that reflects a discrete event or a ovement over time. The indicator(s) should be objective, clearly and rch. The indicator(s) of performance:
. Were well-defined, objective, and measured changes in sealth or functional status, member satisfaction, or valid process alternatives.	C*	Met	
. Included the basis on which the indicator(s) was developed, finternally developed.		Met	
		Results for	Step 5
Total Evaluation Elements**	2	1	Critical Elements***
Met	2	1	Met
	0	0	Partially Met
Partially Met			
Partially Met Not Met N/A (Not Applicable)	0	0	Not Met N/A (Not Applicable)

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Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
•	•		that the data collected on the indicator(s) were valid and reliable. Validity is an epeatability or reproducibility of a measurement. Data collection procedures
Clearly defined sources of data and data elements collected for the indicator(s). N/A is not applicable to this element for scoring.		Met	
A clearly defined and systematic process for collecting baseline and remeasurement data for the indicator(s). N/A is not applicable to this element for scoring.	C*	Met	
3. A manual data collection tool that ensured consistent and accurate collection of data according to indicator specifications.	C*	N/A	
4. The percentage of reported administrative data completeness at the time the data are generated, and the process used to calculate the percentage.		N/A	
		Results for	Step 6
Total Evaluation Elements**	4	2	Critical Elements***
Met	2	1	Met
Partially Met	0	0	Partially Met
Not Met	0	0	Not Met
N/A (Not Applicable)	2	1	N/A (Not Applicable)

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Results for Step 1 - 6						
Total Evaluation Elements	14	8	Critical Elements			
Met	7	5	Met			
Partially Met	0	0	Partially Met			
Not Met	0	0	Not Met			
N/A (Not Applicable)	7	3	N/A (Not Applicable)			

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Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
	ough data	analysis and int	or each indicator. Describe the data analysis performed, the results of the statistical erroretation, real improvement, as well as sustained improvement, can be
Included accurate, clear, consistent, and easily understood information in the data table.	C*	Met	IISAG identified the following opportunities for improvement: •The health plan must update the baseline indicator results to reflect the updated measure specifications including four rather than five SDOH domains. •The health plan revised the Remeasurement 1 measurement period dates to 5/8/2024 – 6/30/2024. The annual measurement periods are state-mandated and cannot be changed. The health plan should correct the measurement periods to accurately reflect 7/1/2023 – 6/30/2024. •The health plan should recalculate the Remeasurement 1 results for the entire Remeasurement 1 period, 7/1/2023 – 6/30/2024. •The health plan should recalculate the Remeasurement 1 statistical testing results using data from the entire Remeasurement 1 period, 7/1/2023 – 6/30/2024. Resubmission January 2025: The health plan revised the Remeasurement 1 indicator attaistical testing results in the Step 7 Results table and addressed the initial feedback. The validation score for this evaluation element has been changed to Met.

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Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
	ough data	analysis and int	or each indicator. Describe the data analysis performed, the results of the statistical expretation, real improvement, as well as sustained improvement, can be
Included a narrative interpretation of results that addressed all requirements.		Met	HSAG identified the following opportunities for improvement: •The health plan should update the Baseline Narrative to reflect the shift in indicator specifications to include four rather than five SDOH domains. Any change in the baseline indicator results should also be reflected in the narrative. If the shift in indicator specifications did not change the baseline results, this fact should be stated in the Baseline Narrative. •The health plan should update the Baseline to Remeasurement 1 Narrative to reflect the correct measurement period dates, 7/1/2023 – 6/30/2024, and to correctly report indicator results for the entire measurement period. The health plan may include a description of the logistical challenges in shifting the case management scripts; however, indicator results must be reported for the entire measurement period. •When describing the difference between the baseline and Remeasurement 1 indicator rates, the correct units is percentage points, rather than percent. For example, there was an increase of 55.63 percentage points. Resubmission January 2025: The health plan revised the Baseline to Remeasurement 1 Narrative and addressed the initial feedback. The validation score for this evaluation element has been changed to Met.
 Addressed factors that threatened the validity of the data reported and ability to compare the initial measurement with the remeasurement. 		Met	

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Results for Step 7						
Total Evaluation Elements**	3	1	Critical Elements***			
Met	3	1	Met			
Partially Met	0	0	Partially Met			
Not Met	0	0	Not Met			
N/A (Not Applicable)	0	0	N/A (Not Applicable)			

^{* &}quot;C" in this column denotes a critical evaluation element.

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^{**} This is the total number of all evaluation elements for this step.

^{***} This is the total number of critical evaluation elements for this step.







Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 8. Assess the Improvement Strategies: Interventions were analysis. The improvement strategies were developed from an			uses/barriers identified through a continuous cycle of data measurement and data ment process that included:
A causal/barrier analysis with a clearly documented team, process/steps, and quality improvement tools.	C*	Met	
Interventions that were logically linked to identified barriers and have the potential to impact indicator outcomes.	C*	Met	
Interventions that were implemented in a timely manner to allow for impact of indicator outcomes.		Met	
An evaluation of effectiveness for each individual intervention.	C*	Met	General Feedback: This evaluation element was scored Met due to the extensive analysis of process-level results documented in the Intervention Worksheet for a single, system-wide intervention. The health plan should be aware that, for most interventions, overall performance indicator results should not be used as the Intervention Effectiveness Measure. In addition, for future Intervention Worksheet submissions, the health plan should update the Intervention End Date to specify the end of intervention testing for the PIP. If the health plan chooses to adopt an intervention, the Intervention End Date should reflect the date when the intervention was adopted as a standard practice and was no longer being tested as an intervention for the PIP.
5. Interventions that were adopted, adapted, abandoned, or continued based on evaluation data.		Met	General Feedback: The health plan reported that the intervention was adopted as a standard practice. For next year's validation, HSAG will expect new or revised interventions as part of the PIP submission to drive further improvement in indicator results.
		Results for	r Step 8
Total Elements**	5	3	Critical Elements***
Met	5	3	Met
Partially Met	0	0	Partially Met
Not Met	0	0	Not Met
N/A (Not Applicable)	0	0	N/A (Not Applicable)

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This is the total number of all evaluation elements for this step.
 This is the total number of critical evaluation elements for this step.







Results for Step 7 - 8						
Total Evaluation Elements	8	4	Critical Elements			
Met	8	4	Met			
Partially Met	0	0	Partially Met			
Not Met	0	0	Not Met			
N/A (Not Applicable)	0	0	N/A (Not Applicable)			

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Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
improvement over baseline indicator performance. Sustained	mprovem	ent is assessed at	ovement in performance is evaluated based on evidence that there was fter improvement over baseline indicator performance has been demonstrated. Periods demonstrate continued improvement over baseline indicator
The remeasurement methodology was the same as the baseline methodology.	C*	Ме1	In the Step 7 Baseline to Remeasurement 1 Narrative, the health plan stated that the indicator specifications were changed to reduce the number of SDOH domains from five to four; however, the Baseline Narrative refers to five domains. The health plan must apply the shift in measure specifications to the baseline measurement, as well as subsequent remeasurements to ensure the same methodology is used for all measurement periods. The health plan should revise the Step 7 baseline results in the data table and narrative to reflect comparable indicator results across measurement periods. HSAG recommends a technical assistance call to discuss the health plan's documented changes in measure specifications. Resubmission January 2025: The health plan revised the PIP documentation to reflect that the same measurement methodology was used at baseline and Remeasurement 1. The initial feedback was addressed and the validation score for this evaluation element has been changed to Met.
There was improvement over baseline performance across all performance indicators.		Met	
3. There was statistically significant improvement (95 percent confidence level, $p < 0.05$) over the baseline across all performance indicators.		Met	
 Sustained statistically significant improvement over baseline indicator performance across all indicators was demonstrated through repeated measurements over comparable time periods. 		Not Assessed	Sustained improvement is not assessed until statistically significant improvement is demonstrated and remeasurement results are reported for a subsequent remeasurement period.
		Results for	Step 9
Total Evaluation Elements**	4	1	Critical Elements***
Met	3	1	Met
Partially Met Not Met	0	0	Partially Met
	U	0	Not Met

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^{***} This is the total number of critical evaluation elements for this step.







Table B—1 2024-25 PIP Validation Tool Scores										
for Social Determinants of Health Screening for Colorado Access Region 5										
Review Step	Total Possible Evaluation Elements (Including Critical Elements)	Total <i>Met</i>	Total Partially Met	Total Not Met	Total N/A	Total Possible Critical Elements	Total Critical Elements <i>Met</i>	Total Critical Elements Partially Met	Total Critical Elements Not Met	Total Critical Elements <i>N/A</i>
Review the Selected PIP Topic	1	1	0	0	0	1	1	0	0	0
Review the PIP Aim Statement(s)	1	1	0	0	0	1	1	0	0	0
Review the Identified PIP Population	1	1	0	0	0	1	1	0	0	0
4. Review the Sampling Method	5	0	0	0	5	2	0	0	0	2
5. Review the Selected Performance Indicator(s)	2	2	0	0	0	1	1	0	0	0
6. Review the Data Collection Procedures	4	2	0	0	2	2	1	0	0	1
7. Review Data Analysis and Interpretation of Results	3	3	0	0	0	1	1	0	0	0
Assess the Improvement Strategies	5	5	0	0	0	3	3	0	0	0
Assess the Likelihood that Significant and Sustained Improvement Occurred	4	3	0	0	0	1	1	0	0	0
Totals for All Steps	26	18	0	0	7	13	10	0	0	3

Table B—2 2024-25 Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP (Step 1 through Step 8) for Social Determinants of Health Screening for Colorado Access Region 5					
Percentage Score of Evaluation Elements Met* 100%					
Percentage Score of Critical Elements Met**	100%				
Confidence Level***	High Confidence				

Table B—3 2024-25 Overall Confidence That the PIP Achieved Significant Improvement (Step 9) for Social Determinants of Health Screening for Colorado Access Region 5						
Percentage Score of Evaluation Elements Met * 100%						
Percentage Score of Critical Elements Met **	100%					
Confidence Level***	High Confidence					

The Not Assessed and Not Applicable scores have been removed from the scoring calculations.

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^{*} The percentage score of evaluation elements Met is calculated by dividing the total number Met by the sum of all evaluation elements Met, Partially Met, and Not Met.

^{**} The percentage score of critical elements Met is calculated by dividing the total critical elements Met by the sum of the critical elements Met, Partially Met, and Not Met.

^{***} Confidence Level: See confidence level definitions on next page.







EVALUATION OF THE OVERALL VALIDITY AND RELIABILITY OF PIP RESULTS

HSAG assessed the MCO's PIP based on CMS Protocol 1 to determine whether the MCO adhered to an acceptable methodology for all phases of design and data collection, and conducted accurate data analysis and interpretation of PIP results. HSAG's validation of the PIP determined the following:

High Confidence: High confidence in reported PIP results. All critical evaluation elements were Met, and 90 percent to 100 percent of all evaluation elements

were Met across all steps.

Moderate Confidence: Moderate confidence in reported PIP results. All critical evaluation elements were Met, and 80 percent to 89 percent of all evaluation

elements were Met across all steps.

Low Confidence: Low confidence in reported PIP results. Across all steps, 65 percent to 79 percent of all evaluation elements were Met; or one or more

critical evaluation elements were Partially Met.

No confidence: No confidence in reported PIP results. Across all steps, less than 65 percent of all evaluation elements were Met; or one or more critical

evaluation elements were Not Met.

Confidence Level for Acceptable Methodology:

High Confidence

HSAG assessed the MCO's PIP based on CMS Protocol 1 and determined whether the MCO produced evidence of significant improvement. HSAG's validation of the PIP determined the following:

High Confidence: All performance indicators demonstrated statistically significant improvement over the baseline.

Moderate Confidence: To receive Moderate Confidence for significant improvement, one of the three scenarios below occurred:

1. All performance indicators demonstrated improvement over the baseline, and some but not all performance indicators demonstrated

statistically significant improvement over the baseline.

2. All performance indicators demonstrated improvement over the baseline, and none of the performance indicators demonstrated

statistically significant improvement over the baseline.

3. Some but not all performance indicators demonstrated improvement over baseline, and some but not all performance indicators

demonstrated statistically significant improvement over baseline.

Low Confidence: The remeasurement methodology was not the same as the baseline methodology for at least one performance indicator or some but not all

performance indicators demonstrated improvement over the baseline and none of the performance indicators demonstrated statistically

significant improvement over the baseline.

No Confidence: The remeasurement methodology was not the same as the baseline methodology for all performance indicators or none of the performance

indicators demonstrated improvement over the baseline.

Confidence Level for Significant Improvement:

High Confidence

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