COLORADO
Department of Health Care Policy & Financing

Annual Practice Support, Transformation and Communication Report

Instructions and Narrative Report

RAE Name	Northeast Health Partners
RAE Region #	2
Reporting Period	SFY23-24 [07/01/2023-06/30/2024]
Date Submitted	07/22/2024
Contact	Dr. Brian Roberston

Purpose: Regional Accountable Entities (RAEs) are responsible for improving health outcomes and increasing value in their respective regions through supporting their Provider Networks. As part of that responsibility, RAEs are required to maintain necessary communications with network providers and provide them practice support and transformation.

Instructions: In the narrative section below please concretely describe your achievements/successes, challenges, and any plans for change in strategy relative to:

- the types of information and administrative, data & technology **support** and trainings provided to network providers, including promoting the use of telehealth solutions and the Dept.-adopted eConsult platform (once adopted);
- the practice **transformation**, to advance the Whole-Person Framework and to implement the Population Management Strategy, provided to network providers; and
- your **communication**, both proactive and responsive, with network providers and other health neighborhood partners as dictated by section 3.9.2 of the contract and other oversight entities, as well as promoting communication among network providers.

RAEs may attach samples of communications and/or hyperlinks to online communications.

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Practice Support:

Achievements/Successes:

NHP supported our providers and practices through a variety of avenues during FY23-24 to facilitate their ability to deliver high-quality healthcare for our reginal members.

NHP understands the valuable impact financial support holds for providers, therefore, we continued to offer several financial opportunities to providers through our Practice Transformation and incentive payment programs and via our Community Investment Grant opportunity. By allowing providers to earn additional revenue through incentive payments and grant sponsorships, providers were permitted to supplement workforce and operational costs, enhance overall practice operations, and foster financial sustainability.

NHP also engaged providers in a multitude of provider and community forums to enhance regional collaboration, share data and information, and to discuss strategies to improve the health and wellness of our region. Many of these forums included cross agency representatives, as well as participants from many county types, including urban, rural and frontier regions. Through collaboration in these venues, providers benefited from being able to network, build partnerships, and share resources and best practices among peers that are designed to improve the delivery of healthcare to Health First Colorado members. Examples of these shared forums include our Health Neighborhood Forum, Program Improvement Advisory Committee, Health Equity Committee, Population Health and Quality Committees, and Care Coordination Subcommittee.

Our region's rural and frontier providers often face additional technology challenges and throughout FY23-24, we continued to offer technical assistance and information technology resources. Most notably, the development and implementation of our secure, Hospital Transformation Program provider portal and desk-help support. Through this process, NHP established a data-sharing system with over 10 regional hospitals who were not yet connected to the Colorado Regional Health Information Organization (CORHIO, a Contexture organization) to timely notify the Department and NHP of members who meet program criteria. We offered one-on-one training with hospital staff, diagnosed and resolved technical problems, and created a provider support ticketing system to address any future challenges.

Ongoing educational and training opportunities remained a key component of our practice support strategy. By offering technical and professional trainings, we help providers adhere to state and federal guidelines, utilize appropriate billing techniques, build clinical skillsets, and promote professional development. Throughout FY23-24, over 26 provider trainings were hosted to help inform providers of the ever-evolving healthcare landscape, share clinical best practices, and familiarize providers state and local resources.

In addition to ongoing trainings, NHP used a variety of platforms to communicate with our providers, including provider newsletters, Constant Contact communications, our website, and our provider call center.

Challenges:

When the Public Health Emergency (PHE) continuous coverage requirement was lifted in the spring of 2023, Region 2 experienced a decrease in our attributed membership which also impacted our providers. Due to the confusion and loss of coverage with Health First Colorado benefits, providers have reported spending a significant amount of time outreaching and supporting Health First Colorado members to troubleshoot eligibility and enrollment problems, assist with renewal paperwork, and re-engage members in care. Along with the loss in membership came a financial impact that compounded staffing and administrative challenges.

Plans for Change in Strategy:

NHP developed two additional opportunities to financially support providers in FY23-24 that will be deployed in FY24-25. The first is an eConsult incentive program to encourage primary care providers to effectively coordinate appropriate specialty care for members through the use of the Department's eConsult platform. The second initiative includes disbursement of funds through a grant opportunity for efforts that address challenges resulting from the PHE and decrease in membership. These programs include system enhancements, additions to workforce, and member outreach and prevention programs.

NHP's communication strategy to inform, educate, and train providers will continue to evolve as providers' needs evolve throughout FY24-25. NHP will work directly with providers to bridge communications as needed on an ongoing basis.

Additional efforts FY24-25 regarding provider and practice support will be outlined in our Annual Network Management Strategic Plan FY24-25.

Practice Transformation:

Achievements/Successes:

Through NHP's Practice Transformation (PT) Program, PT Coaches work closely with Primary Care Medical Providers (PCMP) and Behavioral Health (BH) practices to improve the quality of care delivered and the provider-member experience. Designed to improve the quality healthcare delivered in the region, PT coaches assist in developing, implementing, and monitoring improvement activities with our regional providers. NHP's PT program has two components: Primary Care PT and BH PT. Both programs operate in a similar structure, with differences only in some of the performance measures and population focus. Foundationally, both programs focus on Quality improvement (QI), conduct an annual assessment, meet monthly with each participating practice, and hold quarterly learning collaboratives.

In FY23-24, 88% of PCMP practices in our network were engaged in the PCMP PT program and 5 practices were enrolled in the BH PT program.

We entered FY23-24 with the following goals:

- Practices achieve 70% of milestones in the PT Incentive Program.
- The clinical milestones for this FY were aligned to Key Performance Indicators (KPI) and Behavioral Health Incentive Plan (BHIP) measures.
- Integrate Prescriber Tool implementation into PT.
- Integrate eConsult Platform into PT.

As of June 2024, 75% of the PCMP incentive program incentive milestones have been met and 84% of the incentive milestones have been achieved in the BH incentive program.

Practice Transformation Competency Assessment Year-Over-Year Results

Annually, PT Coaches outreach contracted PCMPs and BH practices with an invitation to participate in the PT program. For those who choose to engage, PT Coaches complete a PT Readiness Assessment to start the fiscal year. The assessment is broken down into domains based off the NCQA's Patient-Centered Medical Home (PCMH) and Bodenheimer's Building Blocks. Each category is scored as either a 1 (not started), 2 (just beginning), 3 (actively addressing), or 4 (completed). The categories are:

- Leadership
- Data Driven QI
- Empanelment
- Team Based Care
- Patient and Family Engagement
- Population Management
- Continuity of Care
- Access
- Comprehensiveness and Care Coordination
- Value-Based Contracting
- Focus on Addressing Social Needs of Patients
- Focus on Telehealth
- Inclusivity and Equity
- Focus on SUD

Outcomes from the assessment are used to track the progress of key domains and identify focus areas for practice support plans. Assessments in August/September 2024 will be applied to FY24-25.

For PCMP assessments, all the domains for FY 23-24 increased except for Empanelment. The overall score increased from 3.42 in 2022 to 3.59 in 2023 as PCMP practices continue to develop year over year.

Participating behavioral health agencies improved or stayed the same in all categories with the most growth in Value Based Contracting, and Data Driven QI. The overall score increased from a 3.1 in 2022 to a 3.4 in 2023 for an overall 10% improvement.

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Practice Assessment Aggregate Data

Assessment Domains	Average of Score 2021	Average of Score 2022	Average of Score 2023	Change Since 2021
Access	3.12	3.56	3.79	21%
Comprehensiveness and Care Coordination	2.91	3.40	3.67	26%
Continuity of Care	3.00	3.52	3.63	21%
Data Driven QI	2.70	3.40	3.57	32%
Empanelment	2.95	3.67	3.65	24%
Focus on Addressing Social Needs of Patients	3.22	3.30	3.57	11%
Focus on Inclusivity & Equity	2.67	3.37	3.47	30%
Focus on Substance Use Disorder	2.50	3.18	3.39	35%
Focus on Telehealth	3.40	3.85	3.94	16%
Leadership	2.44	3.24	3.40	39%
Patient and Family Engagement	2.69	3.08	3.15	17%
Population Management	3.13	3.50	3.55	13%
Team Based Care	3.06	3.51	3.64	19%
Value-Based Contracting	3.50	3.38	3.53	1%
Overall Average	2.98	3.42	3.59	21%

Results of the 2022 Practice Self-Assessment
BH Year Over Year Improvements Working With PT

Domains	Average Score of 2022	Average Score of 2023	% Change from 2022
Leadership	3.2	3.5	11%
Data Driven QI	2.3	3.0	32%
Team Based Care	3.2	3.6	12%
Patient and Family Engagement	3.1	3.3	9%
Population Management	3.3	3.4	1%
Access	2.9	3.4	16%
Comprehensiveness and Care Coordination	3.0	3.1	5%
Value Based Contracting	1.8	2.6	46%
Focus on Addressing Social Needs of Patients	3.3	3.7	13%
Focus on Substance Use Disorder	3.9	4.0	2%
Focus on Telehealth	4.0	4.0	0%
Inclusivity & Equity	2.7	3.5	31%
Overall Average Score	3.1	3.4	10%
Percent Complete (Percent of 4/Completed)	39.2%	52.9%	35%

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Outcomes from the FY23-24 PCMP PT Incentive Program

NHP created a PT incentive program that aligns with the Alternative Payment Models (APM) and Key Performance Indicators (KPI) and focused on primary care access and preventative care. The incentive program consisted of the following milestones:

- Access to Care: PCMPs reported third next available appointment data for 4 types of appointments - urgent care, outpatient follow up, non-urgent care and well care visits.
- Quarterly Learning Collaborative Attendance: four learning collaboratives were held in FY23-24. Topics included strategies for improving well child visits, UC Health's Chronic Pain Center of Excellence, introduction to the High Plains Research Network, depression screening best practices, billing practices for depression screening, introduction to the Department's eConsult Platform, and review of the Department's Health Equity Plan.
- Practice Assessment and SMART Goal Setting: an area of improvement for practices.
- Screening for Depression and Follow Up: Engaging PCMPs to create workflows for capturing G-codes when conducting depression screenings and showing performance improvement based on KPIs.
- Well Visits: Program Improvement (PI) work with the goal to close gaps in care for members 0-15 months and 15-30 months or 3-21 years old.
- Additional Clinical Measure: select one additional measure, Diabetes A1c Control, Controlling High Blood Pressure or Childhood Immunizations. PI work was performed to achieve improved outcomes in one of these measures.

The annual incentive per PCMP practice was $10,000. FY outcomes will be calculated after the program ends on June 30, 2024 and data is collected.

Below is the detailed structure of the FY23-24 PCMP PT incentive program.

PCMP PT Incentive Program Structure (FY23-24)

Milestone Name	Description	Details
Access to Care	Report 3rd Next available appointment report to coach for: Urgent, Follow-up, non-urgent, and well visits	To be calculated and submitted quarterly during regular meetings with your coach.
	Have an active PDSA during any quarter where RAE Access standards are not met	The PDSA can be discussed in regular meetings with your coach

	Meet RAE Access Standards of: Appointment scheduling within: (a) Urgent Care – within 24 hours after the initial identification of need. (b) Outpatient follow up appointments – within 7 days after discharge from a hospital (c) Non-urgent, symptomatic care visit – within 7 days after the request (d) Well Care Visit – within 1 month after the request; unless an appointment is required sooner to ensure the provision of screenings in accordance with the Department's accepted Bright Futures schedules.	End-of-program access performance will be captured during April-June 2024. If all standards are met for this last report, the clinic will earn this part of the incentive.
Learning Collaboratives	Attend quarterly Learning Collaboratives.	Representatives must complete the post LC survey including their name and practice name.
	Additional incentives available to practices who present in a learning collaborative.	
Practice Assessment and Practice-Specific SMART Goal	Complete the Practice Assessment and SMART Goal with your coach	Generally completed between July 1, 2023 and September 30, 2023 with your coach in a practice transformation meeting
	Achievement of Smart Goal	SMART goal to be reassessed/adjusted (if needed) quarterly
Screening for Depression and Follow-up	Submit appropriate depression screen G-codes on medicaid member claims	G-Codes: G8431 (POS) and G8510 (Neg), for claims submitted between 7/1/23 to 6/30/23.
	Close the gap by 10% or meet the RAE goal	Close the gap by 10% between your CY 2022 baseline and your CY 2023 performance on the Depression Screening Claims data (to be provided by coach). OR meet the RAE goal.
Well Visits: **0-15 months old** **OR** **15-30 Months old** **OR** **3-21 years old**	Do a new PDSA to close well visit gaps with a focused age-range of members.	Some ideas:*Plan and execute an event that aligns with back to school/sports physicals where you can perform well visits.*Do a PDSA to verify you are using the correct codes to get credit on the Well Visit KPI. *Do an outreach campaign to patients with well visit gaps
	Close the gap by 10% or meet the RAE target on Child Well Visits First 15 months of life	Using claims-based KPI data, close the gap by 10% between your CY 2022 baseline and the RAE target with your CY 2023 performance on the Well Visits measure that you chose
	OR Close the gap by 10% or meet the RAE target on Child Well Visits 15-30 Months	
	OR Close the gap by 10% or meet the RAE target for Child and Child and Adolescent Well Visit Measure Ages 3-21	

Diabetes HgA1c Poor Control	Active work on meeting the measure	Examples: PDSA, workflow development, working a registry.
	Close the gap by 10% on the Diabetes A1c Measure or meet the State Goal	Close the gap by 10% between your CY 2022 baseline and the RAE target with your CY 2023 performance on the Diabetes A1c (poor control) measure. Practices will use eCQM data.
Controlling High BP	Active work on meeting the measure	Examples: PDSA, workflow development, working a registry.
	Close the gap by 10% on the Controlling High BP Measure or meet the State goal	Close the gap by 10% between your CY 2022 baseline and the RAE target with your CY 2023 the Controlling High BP Measure. Practices will use eCQM data.
Childhood Immunization Status (Combo 10)	Active work on meeting the measure	Examples: PDSA, workflow development, working a registry.
	Close the gap by 10% on the Controlling High BP Measure or meet the State goal	Close the gap by 10% between your CY 2022 baseline andthe RAE target with your CY 2023 the Childhood Immunizations Measure. Practices can use either DAP or eCQM data.

Successes of the PT Incentive Program:

22 PCMP sites/systems participated in the PT program in FY 23-24, only 3 sites/systems chose not to participate. Significant progress was made in all the clinical measures. Examples of forward progress include:

- 6 practices implemented new workflows for depression screening and follow-up and successfully dropped G-codes on claims.
- 18 of the 22 PCMPs improved KPI Well Child Visit rates.
- 11 of 12 PCMPs improved (lowered or maintained <19%) for Diabetes A1c Control for their population.
- 2 of 2 PCMPs improved Controlling Blood Pressure outcomes for their population.
- 4 out of 6 PCMPs improved Childhood Immunization rates.

<u>Outcomes from the FY23-24 BH PT Incentive Program</u>

The BH practice transformation program chose to focus on the BHIP Indicator 1: Initiation and Engagement of Substance Use Disorder Treatment. The annual incentive per practice in the second iteration was $7,500.

Outlined below is the comprehensive structure of the program for FY23-24 BH PT Program.

Milestone	Requirements Description	Outcome Requirements	NHP Incentive
Population Management/ Performance Improvement	SUD Engagement-Track SUD population and identify needs/gaps of care. Utilize a PDSA process to create a workflow to outreach identified clients, explore coding to impact performance, reduce no show rates, treatment engagement etc.	Using either agency EMR, or PowerBI (scorecard) Data determine baseline and then improve by 10% of 2022 baseline. Submit performance data by June 2024	**Tier 1 $1000**
			Tier 2 $1,500
		Tier 1: Complete at least one PDSA cycle	**Tier 3 $2,000**
		Tier 2: Close the gap by 10%	**Max possible: $2,000**
		Tier 3: Meet or exceed RAE target	
Integrated Care	PDSA cycle to develop process for shared expectations and exchange bi-directional information with PCP, work to develop a priority access protocol for clients referred by primary care.	Share two de-identified examples of referral/info exchange with PCP and/or share written process for priority access and provide an example.	**$2,000**
Performance Visualization Tool	Practice develops dashboard for tracking performance (SUD Engagement/Depression Screen Follow -up, measure based care tools, access, retention rates) and develops process for sharing with clinical staff at least quarterly (Provider level performance)	Develop a performance visualization tool	**$1,500**
		OR	
		Provide a copy of the tool that you use to review performance data with clinical staff	
		AND	
		Provide a list of quarterly scheduled meetings where data will be reviewed with staff	
Learning Collaboratives	Attend all 4 Learning collaboratives in FY 23-24	At least one practice representative attends each learning collaborative but does not have to be the same person each time. Representatives must complete the post LC survey including their name and practice name.	**$250 per learning collaborative Max of $1,000**
Practice Assessment	Complete the annual Practice Transformation assessment and complete PDSA to address any score that is a 1.	Generally completed between July 1, 2023 and September 30, 2023	**$500** to complete assessment
		AND	**$500** for SMART goal
			Max of $1,000
		Set SMART goal and review quarterly with coach	
			Total $7,500

The second iteration of the Behavioral Health Practice Transformation program began in July of 2023 and concluded in June 2024. As shown above, the BH PT incentive structure included a milestone on Population Management, with the goal to identify a priority population, specifically, members with SUD and to identify gaps of care. Providers were asked to complete a PDSA cycle to implement changes and assess effectiveness. All 5 of the participating practices have completed the requirements for this milestone.

Examples of successful PDSAs include:

Creative Counseling recognized the importance of expanding services and collaborating with another agency to positively benefit their clients. They established a partnership with a local Medication Assisted Treatment (MAT) provider to broaden the scope of resources and to give access to a "system of treatment". As of June of 2024, they had 84 active participants receiving both counseling and MAT services which is approximately a 1/3 of their total population.

Similarly, Advantage Treatment Centers had a goal of offering seamless transitions and fostering a continuum of care from inpatient residential to high intensity outpatient services to traditional outpatient services. They developed the ENACT Program aimed at justice involved members to nurture recovery and resilience by offering offense- specific outpatient treatment and community collaborations.

New Pathways to Wellness and Recovery wanted to identify a high priority population and providing wrap around services to those members. They focused on intravenous drug users, pregnant women who use drugs and men and women with children. They developed a high priority track that included being assigned a case manager, PEER recovery coach and a mental health counselor. They were assessed for MAT services, social needs and resources for parent education and support and were connected to services and supports appropriately

Shared Successes:
The BH PT program hosted three 4 Quarterly Learning Collaboratives throughout FY23-24. Topics included, measure-based care, medical necessity and clinical document requirements, and member engagement and retention strategies. The learning collaboratives are well attended and per post meeting surveys, approximately 88% of attendees were very satisfied and an average of 97% stated the information presented as relevant to the work they were doing.

Challenges:

Many of the challenges experience throughout FY23-24 were consistent with challenges of the past. For example,

- Providers continue to note an unmanageable number of performance measures with KPI, BHIP, PP, APM, and UDS measures.
- Providers continue to struggle with accessing timely data. The five-month claims lag is a barrier to practices making changes to impact performance on the measures.
- Across the board, providers face ongoing staff shortages and poor staff retention, especially in the field of mental health and substance use.
- Timely services for members who need a higher level of care and/or psychiatric medication.

Plans for Change in Strategy:

The PCMP PT Incentive program for FY24-25 will have the same milestones as the FY23-24 program, with the addition of one new milestone: Health Equity. For this new milestone, the PCMP/practices will be asked to use either practice-level data or the Department's data to identify a vulnerable population and to create a process improvement plan to help increase outcomes for one of the clinical measures in the program. Goals for the next phase of the incentive program will be focused on improving access, enhancing health equity for specific populations, engaging in PT, and performance improvement linked to KPIs and APM measures.

The third iteration of the BH practice transformation program will begin July of 2024 and conclude in March of 2025 with a goal of including 5-8 practices. The program objectives will remain the same and will challenge practices to engage in QI activities and to foster innovation that positively impacts health outcomes. Milestones will once again include completing the annual practice assessment with a goal of improving their score in the category of Focus on

Addressing the Social Needs, hosting quarterly learning collaboratives and a population management goal. New milestones will include enhancing health equity for specific populations and addressing team-based care to positively impact staff satisfaction and retention.

Provider Communications:

Achievements/Successes:

Network providers are vital to the delivery of healthcare to Health First Colorado members. NHP deploys a vast range of communication tactics to make sure our providers are informed of policy changes, educated on best clinical practices, and are up to date on billing and coding practices.

Throughout FY23-24, NHP deployed the communication strategies as outlined in our Annual Network Management Strategic Plan FY23-24. This included hosting monthly provider trainings designed to educate and inform providers about contractual obligations, billing and coding guidelines, provider handbooks, policies and procedures, and community-based programs within the region. Training topics shared with providers throughout the year included Health First Colorado programs, access to care standards, billing and overpayment concerns, condition management and prevention programs, and contracting and credentialing processes. All provider webinars were recorded and are achieved on the NHP website on the RAE Roundtables tab for future reference.

To inform providers of upcoming webinars, new programs or resources, and local community events, NHP distributed a monthly newsletter tailored directly to our providers. These newsletters are intended to help bring awareness, education, and information about various programs and policies to providers serving Health First Colorado members. Every newsletter is posted in the Provider Communications section on the NHP website.

NHP and the network team continued to meet routinely with providers who were interested in joining the network, those who were experiencing claims or billing issues and/or those providers who needed additional support. We continued to answer provider inquiries via the provider call center and electronically via email. We continued to share resources and tools, such as the information contained in the provider section of our website, including the various resources providers can use to perform efficiently and provide high standards of care to members. Examples of resources provided included information on how to join the NHP network, provider forms, clinical practice guidelines, condition management programs, and achieved provider communications such as webinars and newsletters.

Challenges:

As provider needs and challenges evolve, NHP must remain nimble and innovative with our communication and support strategies. We must continue to engage and advocate on behalf of providers and mitigate the problems in which we have control over in a swift manner.

Additionally, due to time constraints and lack of workforce, we experienced a decline in our provider webinar attendance rates.

Plans for Change in Strategy:

NHP's communication strategy continues to center on provider satisfaction. NHP will administer provider satisfaction surveys to better understand the unique and regional challenges of our providers and collaboratively discuss strategic solutions to better need our providers' needs. Through this feedback, NHP will selectively choose training and communication information to best support our providers needs and interest.

NHP will continue to implement communication strategies as outlined in the Annual Network Management Strategic Plan FY24-25.