COLORADO
Department of Health Care Policy & Financing

Annual Network Management Strategic Plan

Instructions and Narrative Report

RAE Name	**Health Colorado, Inc.**
RAE Region #	**4**
Reporting Period	FY23-24 07/01/2023 – 06/30/2024
Date Submitted	**August 1, 2023**
Date Resubmitted	**September 25, 2023**
Contact	**Alma Mejorado**

Purpose: Regional Accountable Entities (RAEs) are responsible for managing and improving the health of their respective members. As part of that responsibility, RAEs are required: to develop, support and engage their provider networks and the broader health neighborhoods in these efforts; and to reward them financially respective to their efforts to improve member health outcomes and to increase value in their respective regions. This plan outlines each RAE's strategic approaches to accomplish these tasks and to meet the goals of ACC Phase II during the upcoming contract year.

Instructions: Please provide a narrative that outlines your strategic approach to leverage your regional resources to maximize the care delivery system and community to reduce costs and improve member health outcomes and the experience of care of members. Address how your strategic approach has or has not evolved since the previous year's submission with evidence to support these changes. The narrative must describe the RAE's planned strategies, including process and outcome goals, relative to: PCMP and behavioral health provider network development; practice support, transformation, and communication; health neighborhood and community engagement; and administrative payments and incentives.

1) **PCMP and behavioral health provider network** – Please describe your region's plan to develop your PCMP and behavioral health provider networks. Please be sure to address that which is required in the Network Adequacy Plan Deliverable Guidance.
2) **Practice support and transformation** - Please describe the types of information and administrative, data & technology support (including plans to promote the use of telehealth solutions and the Dept's eConsult platform [once adopted], trainings, and practice transformation, to advance the Whole-Person Framework and to implement the Population Management Strategy, that your region plans to provide network providers.

3) **Communication** – Please describe your region's plan to maintain necessary, both proactive and responsive, communication with network providers and other health neighborhood partners (and other oversight entities) as dictated by section 3.9.2 contract, as well as promoting communication among network providers. Please be sure to address communication with behavioral health providers, including rate changes and internal processes for responding to provider questions and complaints. *(Specific member-level grievances are captured in the Grievances and Appeals deliverable*).
4) **Health neighborhood and community** - Please describe your region's plan to engage, support (including financial), leverage, and advance the health neighborhood and community to ensure members timely and appropriate access to necessary services. Please be sure to address your plans to establish relationships and improve processes, communication, and collaboration with the health neighborhood and community including coordinating with crisis services, MSOs, etc. Also and increase appropriate and efficient utilization of specialty care.
5) **Administrative payments and incentives** - Please describe your region's plan to distribute administrative payments and incentive payments. Be sure to provide descriptions of your arrangements for PMPM Administrative Payments, Key Performance Indicator (KPI) and/or Performance Pool incentive payments to contracted PCMPs and Health Neighborhood entities. These arrangements should involve varying payment models and payment amounts for varying types of service. Please include your approach to pay and monitor performance of entities that provide care management for members with complex care needs. *(Include any larger documents or policies as attachments.)*

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Strategic Plan Narrative

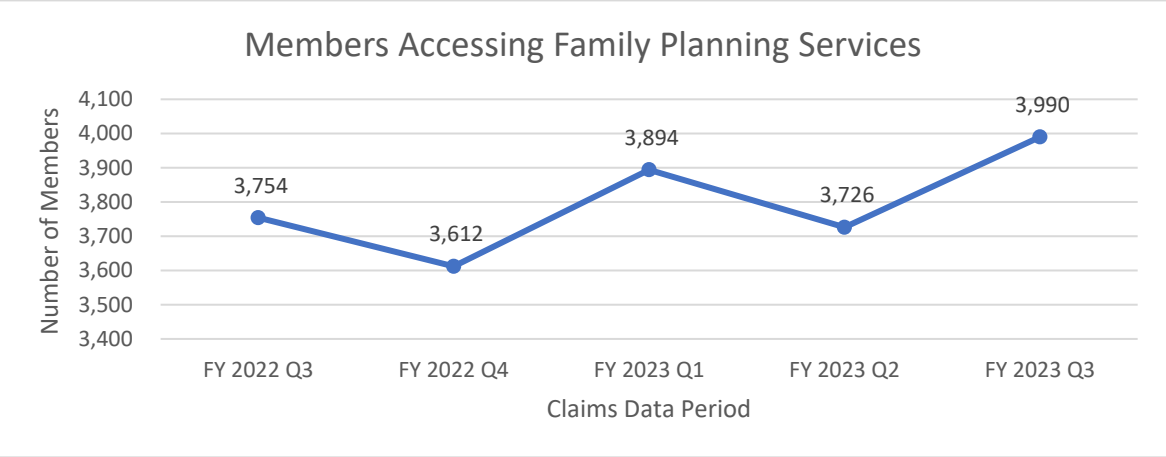
1. PCMP and Behavioral Health Provider Network Development

Health Colorado, Inc. (HCI) delegates network management responsibilities to Carelon Behavioral Health, Inc. (Carelon) which was formerly known as Beacon Health Options, Inc. For consistency, this plan will refer to HCI for all activities completed through Carelon. HCI's goal continues to be to create, administer, and maintain a statewide network of behavioral health providers and a network of primary care medical providers (PCMP) within the region, supported by written agreements, to serve the needs of Health First Colorado (Colorado's Medicaid program) members attributed to HCI. In order to achieve this goal, HCI monitors the existing network to assess adequate access to services, recruits available providers to address identified gaps in service, and manages provider data to ensure that accurate provider information is available to members.

Primary Care Network Development

HCI's plan for FY22-23 in the PCMP network was to strengthen the PCMP network in areas of need and ensure that the network contains a sufficient number of providers to serve members based on the maximum distance for county classification including adult and pediatric primary care, and family planning providers. During the fiscal year, HCI's network experienced changes due to provider retirement, organization mergers, location consolidations, or ownership changes. The changes did not result in a significant impact on the access to services as the majority of practitioners remained in the network. Further, HCI brought into the network one additional PCMP, Wayne Hudson DO Integrated Medicine, located in Lamar County.

HCI monitors member complaints to identify those regarding access to family planning services. Like FY21-22, in FY22-23 there were zero family planning services complaints. Finally, HCI continued to monitor the utilization of family planning based on available state claims data. The number of members who accessed family planning services in a 12-month period increased slightly, as illustrated in **Figure 1**.



Note: Data for FY22-23 Q4 is not available to report.

Figure 1

For FY23-24, HCI will carry over its goal to strengthen the PCMP network of adult and pediatric primary care providers to improve appointment availability for members. Further, HCI aims to enhance the network to contain a sufficient number of providers to serve members based on the maximum distance for county classification. To achieve this goal, HCI will utilize the following strategies:

- Target practices eligible for HCPF's Alternative Payment Model (APM).
- Review the DORA Registry and Enrollment Summary Report to identify providers with licensures that meet PCMP criteria.
- Leverage community connections through the Program Improvement Advisory Committee (PIAC) and Health Neighborhood collaborative to obtain information on potential providers within the region, with particular attention to those in the frontier and rural counties.

When a potential PCMP is identified, HCI will recruit the provider by educating them on the benefits of joining the network, including promotion of the Per Member Per Month (PMPM) payment based on the practice's attribution. This may provide a consistent monthly payment to support/offset non-revenue generating activities necessary to ongoing work in support of PCMP functions. Providers will be educated on practice support services that are available to network providers. HCI will also inform providers of opportunities to participate in incentive programs such as practice transformation (PT), which may result in additional funding.

All recruitment and contracting activities will be closely monitored to track progress towards network development and to provide early detection of any barriers to contract for these services. This will ensure that HCI's primary care network has the range of services available for RAE 4 members. HCI will track through internal process on the changes, barriers, and lessons learned in the implementation of the plan.

In the event that there are fewer than two practitioners that meet the PCMP standards within the defined area for members in rural and frontier counties, HCI may suggest that HCPF remove the time/distance requirements for those members as outlined in the contract between HCPF and HCI.

Behavioral Health Network Development

HCI continued the previous year's activities to increase the number of behavioral health providers in the network. In FY22-23, HCI focused on the goals of enhancing the network including intensive services, expanding telehealth access, and improving access to care within current network providers.

Further, HCI experienced an increase of 5.2% in the number of behavioral health providers in the network from Q4 of FY21-22 to Q4 of FY22-23.

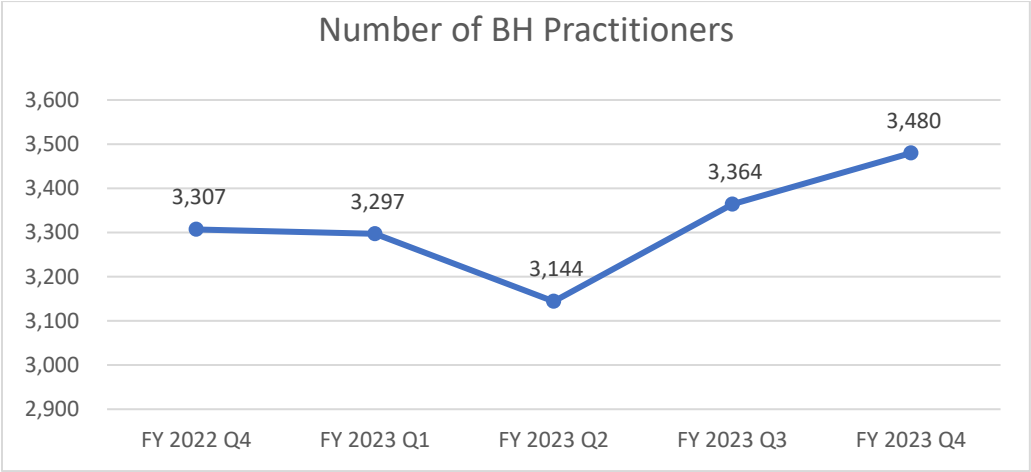


Figure 2

HCI deployed the following successful strategies which resulted in an increase in the network and other successes:

- Monitor reporting data on providers who render services to members through Single Case Agreements (SCAs) or track the providers who initiated the credentialing application and offer them technical support to complete the process to join the network.

As a result of this strategy, HCI saw an increase in the number of providers completing the contract and credentialing process and a reduction in the number of SCAs. As illustrated in **Figure 3**, although HCI saw a slight increase in SCAs during Q2 of FY23, HCI has retained a low number of providers receiving SCAs in Q4 of FY22-23 when compared to Q4 of FY21-22.

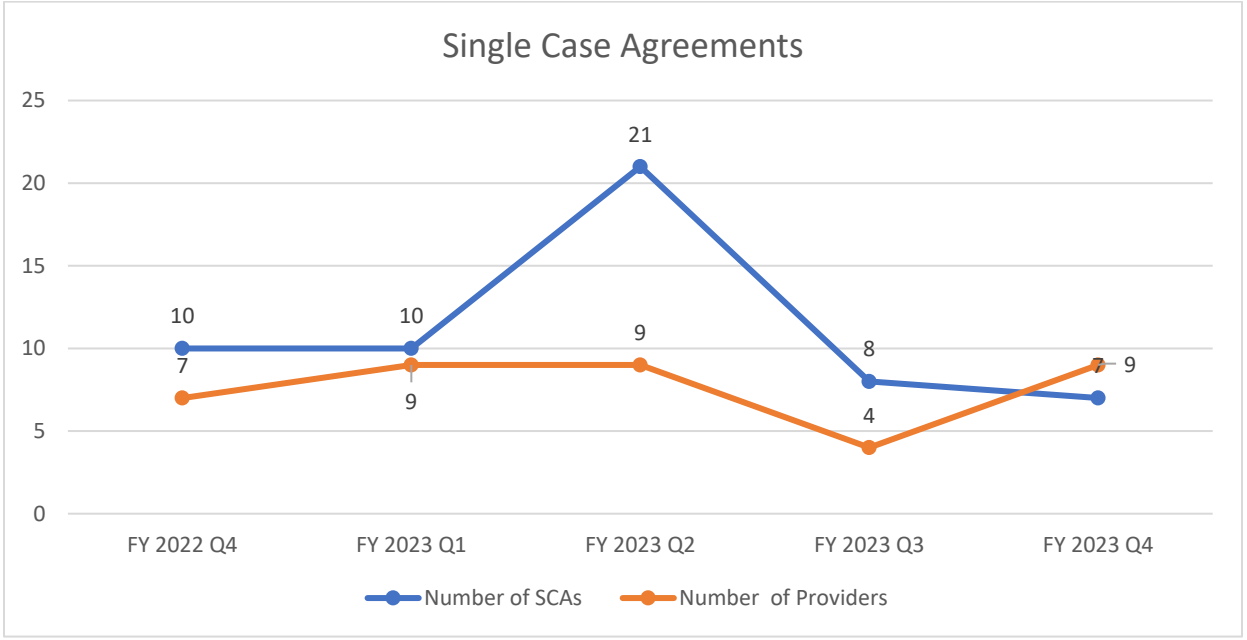


Figure 3

- Delegate credentialing to large groups with more than 75 providers and meet the delegation requirements. This will shorten the time it takes for providers to join the network.

  During FY22-23, HCI did not have groups that met the number of providers to be delegated.

- Monitor State data on newly enrolled Health First Colorado providers and invite them to join the network.

  Based on data received from HCPF, HCI outreached to newly licensed providers for residential and Substance Use Disorder (SUD) services. Further, HCI completed a comparison of Health First Colorado-enrolled providers and the existing behavioral health network. The available data does not contain a clear indicator that the provider offers high intensity outpatient services; therefore, HCI focused on providers

within the region. HCI analyzed the data for providers with a service location within the region that did not appear in our existing behavioral health network based on NPI. This analysis revealed about 619 practitioners, groups, and facilities. HCI also analyzed the data against the service locations in our network to identify which practitioners, groups, and facilities are part of an existing facility or group. According to this analysis, 47% of the practitioners, groups, and facilities may be part of a currently contracted facility or group. Since the data was based on NPI, these providers may already be in the network under different NPI, which pulled them into the report. HCI will reach out to these facilities and groups to validate whether the information is accurate. If the information is accurate, HCI will educate them on how to update their demographics and staff rosters to reflect within the network accurately. For providers that do not appear to be affiliated with a contracted facility or group (53%), HCI will initiate outreach efforts in Q1 of FY23-24 to identify the services offered and gauge interest in joining the network. Progress around these efforts will be reported in future deliverables.

- Work with network facilities to confirm all practice locations and services are part of the contractual agreement and are credentialed, as well as update the agreement with new services as necessary.

  HCI used the State data analysis as well as the SCA monitoring to identify facilities with services or locations that are not reflected on their contract for HCI. This resulted in zero SCAs for SUD residential services during Q4 of FY22-23.

- Seek partnerships with e-health entities, or telehealth-only groups, to enhance the network.

  HCI successfully expanded access to behavioral health services through technology by contracting with Bicycle Health and Charlie Health. Bicycle Health offers Medication Assisted Treatment (MAT) with Suboxone therapy by means of virtual healthcare using digital devices (phone, text, computers, and chat through their secure app). Charlie Health offers intensive outpatient (IOP) services for individuals of all ages with a special focus on children and youth. The services are available in person as well as virtually through telehealth. Further, HCI grew its unique partnership with Care on Location to support the HCI Health Neighborhood program as outlined in the Health Neighborhood & Community Engagement section of this plan.

  HCI experienced a decline in telehealth services for behavioral health services based on claims utilization data from Q4 of FY21-22 to Q4 of FY22-23, as indicated in **Figure 4** (blue line). However, HCI saw a slight increase in the behavioral health penetration rate during that same period, which is depicted in **Figure 4** (orange line). This data indicates that HCI members transitioned to accessing services through in-person modalities over the course of this time period.

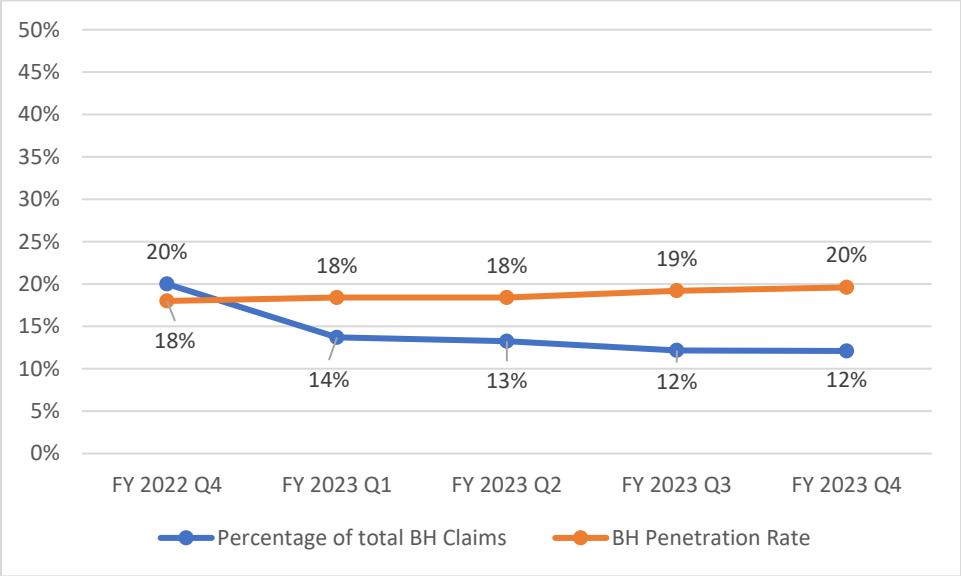


Figure 4

Further, HCI conducted a review of processes for providers requesting to join the network to achieve 90% of providers completing contracting and credentialing within 90 days of request. In FY23-24, HCI will rely on the following strategies to identify improvement opportunities and take steps to consistently meet the requirement.

- Streamline the workflow from contracting to credentialing to reduce the administrative timeframe.
- Improve the monitoring of provider requests to join Health First Colorado. This allowed for the capturing of providers that are nearing 90 days and have submitted all required documentation to ensure they go through the process.
- Create new reporting to identify any outliers, which is then used to identify workflow improvement opportunities.
- Provide a new reminder letter for providers that do not respond to missing documentation within requested timeframes. The letter also informs providers that their application will be closed if the missing documentation is not received within 80 days of the original request.
- Implement a survey for newly in-network providers to learn about their experiences. This survey will be issued randomly to a portion of the providers who join the network.

For FY23-24, HCI will focus behavioral health provider network development on enhancing the network, particularly around intensive services to align with the High Intensity Outpatient Plan. Our strategies to this end include the following:

- Identify, support, and contract with providers in the network that already offer High Intensity Treatment (HIT) or other behavioral health services and have the capacity, expertise, and regulatory abilities to add HIT services at current or new locations in the region.
- Identify, support and contract with providers in the network that already offer HIT services to members in the region, with particular attention to providers that can serve HCI members with SMI and/or SUD within Region 4 and have the capacity to offer additional units of existing HIT services at current locations in the region. These HIT services include high-fidelity wraparound services.
- Recruit providers located within Region 4 and not currently contracted to join the network.

All recruitment and contracting activities will be closely monitored to track progress towards network development and to provide early detection of any barriers to contract for these services. This will ensure that HCI's behavioral health network has a range of services available for RAE 4 members. HCI will track changes, barriers, and lessons learned in the implementation of the plan.

In the event that there are less than two practitioners that meet the behavioral health standards within the defined area for members in rural and frontier counties, HCI may recommend that HCPF remove the time/distance requirements for those members as outlined in the contract between HCPF and HCI.

Behavioral Health Providers Accepting Certifications

HCI conducted annual surveys of Community Mental Health Centers (CMHCs) to confirm acceptance of certifications and will continue to monitor changes in behavioral health providers. Based on the feedback received, there were no changes for the providers accepting certifications. HCI has seven CMHCs that accept mental health certifications, including Solvista Health and Southeast Health Group, servicing in RAE 4. North Range Behavioral Health, Mental Health Partners, The Center for Mental Health, Mind Springs Health, and Diversus Health are located outside of RAE 4. In the new fiscal year, HCI will work with CMHCs to seek opportunities to increase the acceptance of mental health certifications.

Provider Network Monitoring

HCI conducts a geographic access (GeoAccess) mapping analysis for time and distance from the member's residence to the closest available provider based on the county classification. HCI also calculates the provider-to-member ratios at the regional and county level by provider type. HCI uses the latest Quest Analytics, an industry-standard application for analysis.

For FY23-24, HCI's goal is to improve the number of providers that meet access to care standards, including appointment availability and accepting new members, by 5%. To achieve this goal, HCI will use the following two strategies:

- Work with providers to improve access
- Target provider recruitment.

Based on **Figure 5** and **Figure 6**, both behavioral health providers and PCMPs have a strong reporting of accepting new members through the year.

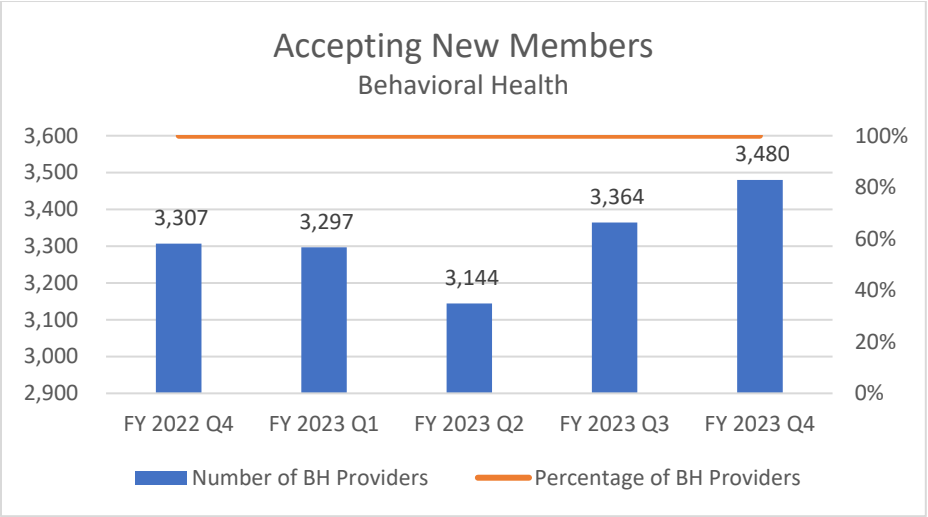


Figure 5

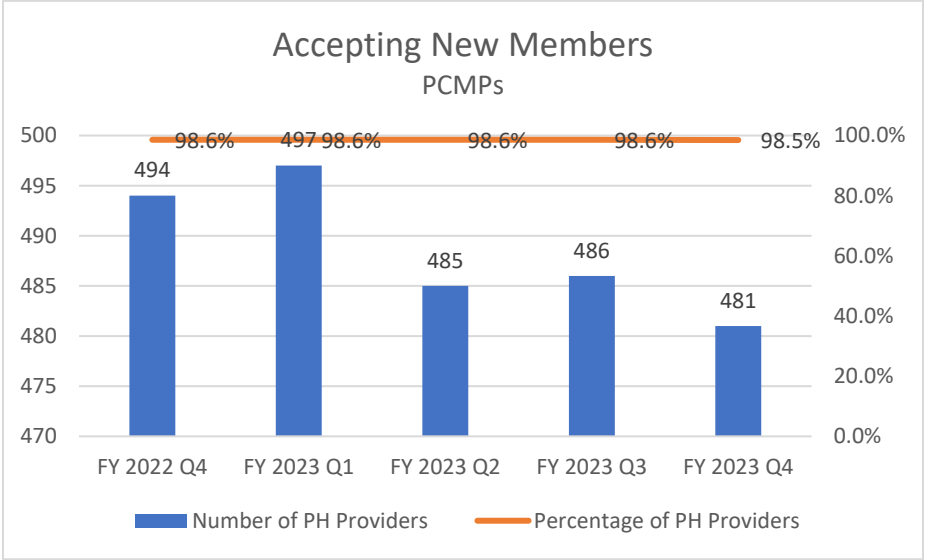


Figure 6

As illustrated in **Figure 7** and **Figure 8**, the behavioral health network saw an increase of providers with availability of extended hours with an improvement change of 36% from the Q4 of FY21-22 to Q4 of FY22-23. For PCMPs, there was no significant change in the availability of extended hours, which aligns with the fact that the network did not have significant changes from the previous fiscal year.

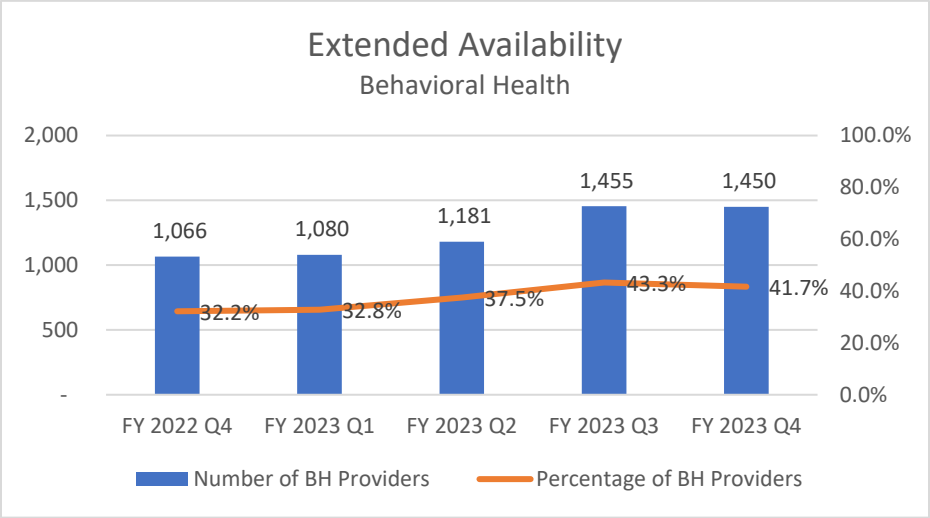


Figure 7

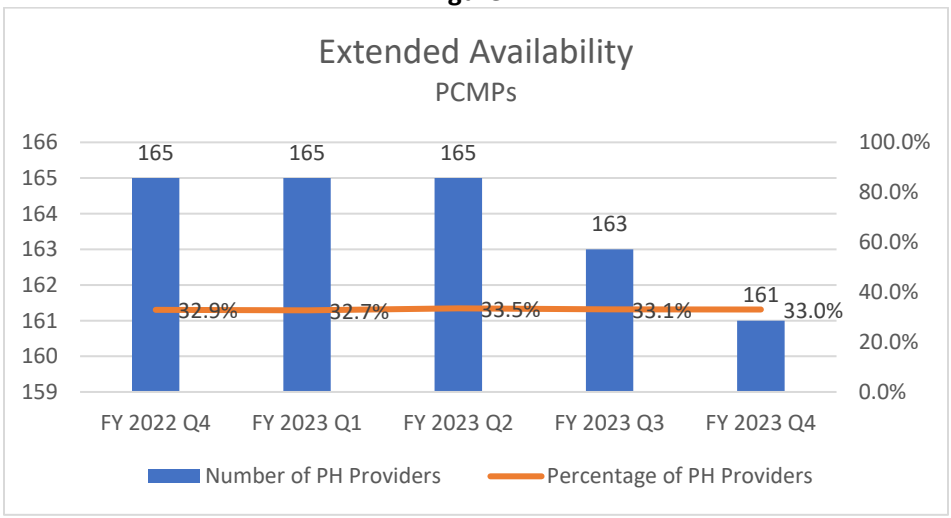


Figure 8

Appointment Availability

As required by Health First Colorado, both PCMPs and behavioral health providers are expected to maintain office hours that are convenient to the population served and are offered to all clients without payer discrimination. Based on the urgency of the request, PCMP appointments are expected to be available as follows:

- New and established routine appointments within seven days of the request
- Urgent access available within 24 hours of the request
- Within one month of a member's request for non-symptomatic care, unless an appointment is required sooner to ensure the provision of screenings in accordance with Early and Periodic Screening, Diagnostic and Treatment (EPSDT). Health First Colorado has adopted and follows the Bright Futures scheduling guidelines as the standard of care in the state.

For behavioral health providers, appointments are expected to be available as follows:

- New and established routine appointments within seven days after the member's request, including seven days after discharge from a hospitalization.
- Urgent access within 24 hours after the initial identification of need.
- Emergent access within 15 minutes by phone or one hour for face-to-face services within an urban area (two hours within a rural or frontier area).

Appointment availability is audited on a quarterly basis and all in-network providers are audited at least once during the fiscal year. Providers who are unable to demonstrate compliance are offered education and support on the appointment availability standards, and another audit is conducted within 90 days.

Ensuring that members have access to care within the identified timelines is clinically important as well as a driver for quality. Providers may receive a request for a corrective action plan (CAP) to identify how they will improve access should they not demonstrate improvement at the 90-day re-audit. During this process, providers will submit a written response and HCI will work with the provider to offer support and education. Ninety days after the CAP is accepted, providers will be audited to demonstrate improvement in meeting access to care standards. If a provider remains noncompliant, the provider will be recommended to the Quality Oversight Care Committee (QOCC) for review. Based on the QOCC review, a determination may include panel closures, suspension of referrals, a continuation of the CAP, or other activities deemed appropriate up to termination from the network.

Accepting New Members

HCI continues to monitor access to care for new members through access to care audits and reported member feedback. If a provider is unable to maintain access standards, HCI works with the provider to identify whether support is needed. Upon completion of this process, a subsequent audit is conducted to ensure the practice can meet access to care standards. Providers are educated through provider training and newsletter reminders about the option to update their status if they are not accepting new members. The provider's status can be changed back to accepting new members as soon as they are able to do so.

HCI will continue to educate providers on access standards for new members, continue to audit access to care, and where appropriate, recruit new providers into the network to maintain network adequacy.

Accessible Facilities

HCI utilizes provider data to identify provider locations as wheelchair accessible in the provider directory. The provider can update their demographic information through HCI's provider portal and the Council for Affordable Quality Healthcare, Inc. (CAQH) to indicate wheelchair accessibility for each of their practice locations.

HCI offers trainings on the HCI website to educate providers on how to directly update demographic information through the provider portal and CAQH. HCI integrates data from CAQH to maintain accurate records for network providers through HCI's administrative service organization (ASO) Carelon system, which populates the provider directory.

After-hours and Weekend Availability

HCI obtains information on after-hours and weekend availability through provider self-reporting in CAQH, which is displayed in the provider directory. Another method of monitoring after-hours and weekend availability is through the analysis of member complaints and grievances. HCI is working with providers to leverage telehealth services to expand hours and increase access to care.

Cultural and Health Equity Expertise

HCI obtains information about providers with cultural and health equity expertise through provider self-reporting and member complaints and grievances. Providers can report their languages, availability, and specialties such as LGBTQIA+, anxiety, mental/physical disabilities, family medicine, geriatric medicine, pediatric medicine, chronic pain, and eating disorders. Behavioral health providers report cultural competencies during initial credentialing and re-credentialing. PCMPs and behavioral health providers report cultural competencies during contracting and through practice assessments. Providers are able to update information through the ASO provider portal, which then populates the provider directory.

HCI trains providers on cultural inclusivity. HCI requests that behavioral health providers complete a cultural competency training and self-report this training in CAQH, which then is indicated within the provider directory. Providers can sign up on the Carelon website to access the training.

Provider Directory

HCI provider information available on the HCI website provider directory. The provider directory includes name, address, telephone number, email address, and website, if available. Members may also contact the Member Services Department to request a hard copy of the provider directory or electronic format by calling 888-502-4185.

The provider directory includes information for providers compliant with Americans with Disabilities standards, which includes physical access, reasonable accommodations, and accessible equipment. In addition, the provider directory details the provider's capacity to accept new Health First Colorado members, offer cultural and language expertise (including ASL), and after-hours/weekend appointment availability.

The provider directory is maintained and updated continuously to ensure that it is accurate based on the information available. Providers are expected to maintain their demographic and practice information in the HCI system and notify HCI when changes occur. HCI reinforces this requirement through provider training, during provider meetings, and through electronic communications. The provider directory on the HCI website is updated monthly.

PCMPs submit an Adds, Change, and Deletes form to Provider Relations with changes about their practice, rendering the provider's demographics as changes occur. HCI conducts a review of PCMP's demographic data during practice transformation assessments and educates the providers on how to submit changes in their practice. Additionally, when HCI identifies a change, Provider Relations contacts the provider to verify the information and submit the appropriate change.

For behavioral health providers, HCI uploads CAQH data, which is mined for updated demographic information and then reflected in the behavioral health provider's profile. When a behavioral health provider updates their CAQH profile, that information is gathered and the HCI system is updated, overriding what is currently in the system. Providers may also make changes directly into the system through the Provider Portal or by contacting Provider Relations with a change, which is submitted internally for data entry update. Finally, when HCI identifies a change, Provider Relations contacts the provider to verify the information and assists them with submitting the appropriate change.

Health Neighborhood Partners

In the Population Management Strategic Plan for FY22-23, HCI detailed the Population Management Strategic framework comprised of five main components: Care Coordination, Practice Transformation, Member Engagement, Quality Management, and Data Analytics and Reporting. A component of the Population Management Strategic Plan for FY22-23 is the enhanced Health Neighborhood.

The Health Neighborhood Forum is an opportunity to work together on shared initiatives in RAE 4 communities to address barriers and gaps in the system of care, and to align activities as a means of strengthening relationships in the healthcare system. HCI strives to develop communication channels to share and exchange information with community agencies and providers for collaboration and engagement in initiatives to optimize

member health and well-being. The Health Neighborhood Forum serves as a method to engage community partners in a meaningful way while identifying services and support for members. Invitations are sent to the following types of agencies: physical and behavioral health providers, hospitals, Long Term Services and Support (LTSS) providers, public health, home health, hospice providers, DentaQuest, Single Entry Points (SEP), and Area Agency on Aging. RAE 4 also includes the Interagency Oversight Groups (IOG), Collaborative Management programs; Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), Nurse-Family Partnership (NFP), Faith-Based Agencies, Community Centered Boards (CCB), Department of Human Services, homeless shelters, and local community agencies that assist with high-fidelity wraparound social support services.

2. Practice Support & Transformation

HCI supports and encourages provider practices through the whole-person framework. All practice support activities (including Practice Transformation) fall under our Population Health Strategic Plan. For FY23-24, we have created a "control plan" which will be used to measure the effectiveness of our interventions to guide any programmatic changes needed.

Practice Support

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

HCI also offers practice support through webinars and monthly newsletters. These communication avenues contain valuable information to assist providers in the whole-person approach. Information provided includes HCPF announcements, HCPF programs and resources, HCI educational articles and community events, contact information, and training schedules.

Trainings for HCI providers are highly encouraged by HCI. Throughout the year, HCI hosts live provider webinar training. Topics including credentialing, billing and coding, practice transformation, quality improvement (QI), clinical practice guidelines, and the SUD expanded benefit. HCI records webinar attendance and asks participants how satisfied they were with the webinar.

In addition, HCI offers data and technology support for providers. Providers have the option to use the Data Analytics Portal (DAP) to help guide whole-person care. The Health First Colorado DAP can data mine for provider level comparisons of KPI) and Healthcare Effectiveness Data

Information Set (HEDIS). The portal can also analyze patient utilization, cost, and pharmacy information displayed through the dashboard. HCI promotes the use of the member summary tool to better assist providers with the whole-person care strategy. HCI trained providers on the DAP through a live webinar during FY22-23 and posted the webinar on the HCI website for future provider reference.

HCI encourages the use of telemedicine appointments performed by providers. The ability of a provider to use telehealth improves the timeliness of appointments to see a Health First Colorado provider from any location. This allows for members to receive care even when they are unable to go to the provider office or facility. HCI will continue to encourage and train providers on how to be HIPAA compliant when utilizing telemedicine technology. HCI promoted telehealth capabilities in the FY22-23 HCI newsletter.

Last year, HCI was able to support all practices with attestations, RTBI testing, and building/designing the provider education. We do not currently have any Prescriber Tool activities planned for FY23-24 other than following up with practices that were not able to get RTBI working. During the June 2023 prescriber tool training, practices were notified that the Prescriber Tool is on hold until further notice.

Practice Transformation

The HCI practice transformation program plan for FY23-24 will continue to build on the success and lessons learned from the previous fiscal year. This team prides itself on maintaining positive relationships with our practices and increasing provider satisfaction for the RAE overall. Our efforts will continue to focus on engagement in the program, QI, and performance improvement. HCI will continue to offer practice transformation support to all in-network PCMPs and will be expanding to additional behavioral health practices this year. Practice transformation assessments will be conducted between August and October of 2023. The goals for the FY23-24 HCI practice transformation program are as follows:

- Practices achieve at least 70% of practice transformation incentive program milestones
- Minimum of 80% attendance rate at all four quarterly learning collaboratives
- Well Child Visits: using claims based KPI data, close the gap by 10% from the RAE target between the CY2022 baseline and CY2023 performance
- Depression Screening and Follow-up: using claims based KPI data, close the gap by 10% from the RAE target between CY2022 baseline and CY2023, or meet the RAE goal

The sections below outline HCI's plan for the following practice transformation activities:

- PCMP practice transformation incentive program
- Behavioral health practice transformation incentive program
- APM
- Practice transformation assessments

- Learning collaboratives
- Diabetes workgroup

FY23-24 PCMP Practice Transformation Incentive Program

The PCMP practice transformation Incentive program for FY23-24 goes live on July 1, 2023 and will have four mandatory milestones: Access to Care, Learning Collaboratives, Practice Assessment, and Screening for Depression. There are four additional milestones, of which practices will choose two: Well Visits, Diabetes Management, Controlling High Blood Pressure, and Childhood Immunizations. The goal for the next phase of the incentive program is focused on improving access, engagement in practice transformation, and performance improvement linked to KPIs and APM measures. Please refer to the FY23-24 PCMP practice transformation incentive program in **Table 1** below.

Table 1. PCMP Practice Transformation Incentive Structure (FY23-24)

Milestone Name	Description	Details	Incentive
Access to Care	Report third next available appointment report to coach for: urgent, outpatient follow-up, non-urgent, and well care visits	To be calculated and submitted quarterly during regular meetings with your coach.	**$200** per quarterly report AND PDSA (if needed) reported on time (for a max of $800)
	Have an active Plan Do Study Act (PDSA) during any quarter in which 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 seven days after discharge from a hospital (c) Non-urgent, symptomatic care visit – within seven days after the request (d) Well care visit – within one month after the request	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.	**$200**

Learning Collaboratives	Attend quarterly Learning Collaboratives.	Representatives must complete the post-learning collaborative survey including their name and practice name. Scheduled Learning Collaboratives: -September 14, 2023 -December 14, 2023 -March 7, 2024 -June 13, 2024	**$250** per learning collaborative attended (for a max of **$1,000**)
Practice Assessment and Practice-Specific SMART Goal	Complete the Practice Assessment and SMART Goal with your coach	Complete between July 1, 2023 and September 30, 2023	**$500**
	Achievement of Smart Goal	SMART goal to be reassessed/adjusted (if needed) quarterly.	**$500**
Screening for Depression and Follow-up	Submit appropriate depression screen G-codes on Health First Colorado member claims	G-Codes: G8431 – Screening for Depression Documented as Positive, AND Follow-Up Plan Documented G8510 – Screening for Depression Documented as Negative, Follow-Up Plan not Required Measurement period: Claims submitted between July 1, 2023 and May 30, 2024.	Draft (pending receipt of more data): **$10** for each G-code that is submitted on claims (up to a max amount of **$2,000**)
	Performance Goal TBD	More detail TBD, pending KPI specs and data from HCPF	Draft: **$500** if you close the gap by up to 4.9% from baseline, OR **$750** if you close the gap by 5-9.9%, OR **$1,000** if you close the gap by 10%+ or achieve RAE target.
Well Visits: **0-15 months old AND**	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	**$1,000**

15-30 Months old OR 3-21 years old		the correct codes to get credit on the Well Visit KPI. *Conduct 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 AND 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	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.	**$500** if you close the gap by up to 4.9% from baseline, OR **$750** if you close the gap by 5-9.9%, OR **$1,000** if you close the gap by 10%+ or achieve RAE target.
Diabetes HgA1c Poor Control	Active work on meeting the measure	Examples: PDSA, workflow development, working a registry.	**$1,000**
	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.	**$500** if you close the gap by up to 4.9% from baseline, OR **$750** if you close the gap by 5-9.9%, OR **$1,000** if you close the gap by 10% or achieve State goal
Controlling High BP	Active work on meeting the measure	Examples: PDSA, workflow development, working a registry.	**$1,000**
	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 Controlling High BP Measure. Practices will use eCQM data.	**$500** if you close the gap by up to 4.9% from baseline, OR **$750** if you close the gap by 5-9.9%, OR **$1,000** if you close the gap by 10% or achieve State goal

Childhood Immunization Status (Combo 10)	Active work on meeting the measure	Examples: PDSA, workflow development, working a registry.	**$1,000**
	Close the gap by 10% on the Childhood Immunizations 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 Childhood Immunizations Measure. Practices can use either DAP or eCQM data.	**$500** if you close the gap by up to 4.9% from baseline, OR **$750** if you close the gap by 5-9.9%, OR **$1,000** if you close the gap by 10% or achieve State goal
			Total Incentive Available: **$10,000**

Behavioral Health Practice Transformation Program

The behavioral health practice transformation incentive program for FY23-24 will go live on July 1, 2023. This phase of the incentive program has five milestones: Population Management/Performance Improvement with a focus on SUD Engagement, Coordinated Care, Performance Visualization, Learning Collaboratives, and the Practice Assessment. The goal for next year is to focus on improving SUD engagement performance for RAE 4, increasing practice transformation engagement, and improving coordination of care capacity. **Table 2** below is the FY23-24 behavioral health practice transformation incentive program structure.

Table 2. Behavioral Health Transformation Program Structure (FY23-24)

Milestone	Description	Requirements	NHP Incentive
1. Population Management/Performance Improvement	SUD Engagement – track population and identify needs/gaps of care. Utilize a PDSA process to create a workflow to outreach identified clients, verify correct coding to positively impact performance, reduce no show rates, enhance treatment engagement etc.	Using either Electronic Medical Records (EMR) or PowerBI data, determine baseline and then improve by 10% of CY 2022 baseline. Submit performance data by June 2024. Tier 1: Complete at least one PDSA cycle Tier 2: Close the gap by 10% Tier 3: Meet or exceed RAE target	Tier 1: **$1,000** Tier 2: **$1,500** Tier 3: **$2,000** Max possible: **$2,000**

2. Coordinated Care	PDSA cycle to develop process for shared expectations and exchange information with PCMP, work to develop a priority access protocol for clients referred by primary care	Share two de-identified examples of referral tracking/information exchange with PCMP and/or share written process for priority access and provide example.	**$2,000**
3. Performance Visualization Tool	Practice develops dashboard for tracking performance (SUD Engagement/Depression Screen Follow-up, measure-based care tools, access, no show, retention) and develops process for sharing with clinical staff at least quarterly	Develop a performance visualization tool with your coach 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	**$1,500**
4. Learning Collaboratives	Attend all 4 Learning collaboratives in FY23-24	At least one practice representative attends each learning collaborative but does not have to be the same person each time. Learning collaboratives are held each quarter during the fiscal year. Representatives must complete the post learning collaborative survey including their name and practice name.	**$1,000**
5. Practice Assessment	Complete the annual practice transformation assessment	Generally completed between July 1, 2023 and September 30, 2023, and set SMART goal to be reviewed quarterly with coach.	**$1,000**
			Total $7,500

Practice Transformation Annual Assessments

HCI practice transformation assessments will be conducted between August and October 2023. Results will be used to set improvement goals and track progress from previous assessments. The format of the assessment is mostly the same, with a few questions removed from the previous year. The categories remain the same and are as follows:

- 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

APM FY23-24

HCI supports APM practices with the selection of measures, PDSA cycles to impact their performance on those measures, and the attestation of structural measures. These efforts align with the practice transformation incentive program where possible. **Table 3** shows the frequency of APM measures being selected by HCI practices. We will use the remainder of CY2023 to support practices in their work to meet APM goals. We will support practices with structural measure attestations between September of 2023 and February of 2024. Lastly, we will help practices select measures for CY2024 in January of 2024.

Table 3. APM Measure Selection HCI

APM Measures	Selection Frequency
eCQM-Preventive Care and Screening: Screening for Depression and Follow-Up	39
Structural-Referral Tracking	37
Structural-Alternative Encounters	37
Structural-ED and Hospital Follow-Up	37
Structural-Availability of Appointments	36
eCQM-Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) (INVERTED, Lower is better)	36
eCQM-Controlling High Blood Pressure	35
eCQM-Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	31
eCQM-Breast Cancer Screening	27
Structural-Interdisciplinary Team	19
eCQM-Colorectal Cancer Screening	16
Structural-BH Integration	10
Structural-Improving Patient/Family Access	9
eCQM-Weight Assessment and Counseling for Nutrition & Physical Activity for Children & Adolescents	9
eCQM-Childhood Immunization Status (Combo 10)	5
eCQM-Cervical Cancer Screening	4
eCQM-Chlamydia Screening for Women	4
Structural-Patient Satisfaction	2
eCQM-Antidepressant Medication Management	1
Grand Total	394

Practice Transformation Learning Collaboratives

Quarterly practice transformation learning collaboratives are a forum for regional PCMPs to engage with each other about how to apply best practices and share lessons learned. Behavioral health practice transformation holds its own quarterly learning collaboratives for participating practices. For FY23-24, quarterly PCMP learning collaboratives will support the FY23-24 practice transformation incentive program milestones and practice attendance at the collaborative will be incentivized. The practice transformation team has a goal to include presentations and sharing of best practices from among the contracted providers to encourage shared learning. Possible topics may include strategies on implementing

depression screening and follow-up using evidence-based tools as well as capturing appropriate codes to indicate performance, panel discussions on clinical strategies to improve patient outcomes on selected KPI and APM measures, and strategies providers are implementing to improve member access to care.

Behavioral health practice transformation learning collaboratives will focus on measurement-based care, depression screening and follow-up, care coordination, and performance visualization.

In the FY22-23 Network Management Strategic Plan, HCI stated that we planned to develop a Peer Steering Committee comprised of practice representatives to assist with planning and development for the quarterly learning collaborative and Milestone Program development for physical and behavioral health practices. HCI reached out to practices for volunteers to participate in the committee; however, there was no interest so this did not come to fruition.

FY23-24 Diabetes Workgroup Plan

The diabetes workgroup, initiated by provider practices and facilitated by the practice transformation team, has been a successful forum for providers and teams to learn about diabetes resources, programming, and best clinical practice within the state and communities in Colorado. The plan for FY23-24 is to continue holding diabetes workgroup meetings, but to decrease to three times during the year based on provider input. Possible FY23-24 topics providers requested be covered on the annual needs assessment include financial assistance programs, patient and professional education, diet and lifestyle education, diabetes protocols for PCMP offices, and access to online learning and telehealth programs for patients and staff.

3. Communication

HCI is committed to communication with all stakeholders, members, and network providers to service the Health First Colorado program and improve the health and welfare of members. HCI's strategy is to continue current communication methods, which include webinar trainings, newsletters, and provider support calls.

The communication plan is to ensure that network providers are informed, educated, and trained to help serve members and address their healthcare needs. HCI delegates provider communication services to Carelon. The purpose of the communication plan is to outline stakeholders, network providers, and member communication proactive and responsive strategies. These strategies include targeting appropriate and current communications through delivery of HCI webinars, newsletters, and alert emails.

HCI communicates rate increases in a letter format that is then sent via email to the provider's contact email on file with Carelon.

Region 4 network providers are encouraged to attend the monthly provider roundtable live webinars. HCI presents HCPF programs that contain contractually obligated topics as well as credentialing, billing and coding, practice transformation, QI, clinical practice guidelines, and the SUD expanded benefit topics.

Provider roundtables are virtual events that anyone can attend by video or telephone from any location. Provider topics that come up through the contract changes will be incorporated into the training schedule. Trainings for HCI providers are highly encouraged by HCI. Throughout the year, HCI presented 16 unique provider live webinar training topics including credentialing, billing and coding, practice transformation, QI, clinical practice guidelines, and the SUD expanded benefit. HCI completed 10 provider live webinar trainings, which focused on HCPF-specific topics. The Provider Relations Department will continue to use interactive polling during the live webinars to gauge providers' knowledge and satisfaction of the behavioral health roundtable topics. After provider training live webinars, HCI asks participants how satisfied they were with the webinar. Webinar participants have responded that they were satisfied or very satisfied with the provider training topics and presentations. HCI records webinar attendance and has an average of 28 participants per month. Provider roundtable webinar invitations are sent via email monthly and are listed on the HCI website.

HCI produces proactive communication through monthly newsletters that are sent electronically via email to both behavioral health providers and PCMPs. The newsletters highlight important HCPF announcements, upcoming webinars, previous month's webinar topics, and new programs and/or resources specific to providers. These newsletters are intended to help bring information and education about new and existing programs and policies to providers serving Health First Colorado members. Every newsletter is posted to the Provider Communications section of the HCI website. The average read rate for HCI newsletters in FY22-23 was 29%.

HCI uses provider alert emails for information that needs to be disseminated to providers in an urgent manner. Urgent communication for HCI providers may include community health alerts, community programs, and new HCPF requirements. All provider alerts are sent by email to both behavioral health providers and PCMPs.

HCI utilizes Carelon's data portal, called Provider Connect. Providers may log into the portal to submit or review claims submissions, member eligibility and benefits, and claim status. In addition, providers can update demographic information. Information held in the provider portal connects to the provider directory. The provider directory is a searchable website that can drill down by location, specialty, ages treated, practitioner licensure, gender, race and ethnicity, languages, wheelchair access, and public transportation.

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

- How to Join Our Network
- Newly Contracted Provider

- Billing and Coding
- Clinical Practice Guidelines
- Medically Necessary Guidelines (Behavioral Health and Medical Health)
- Clinical Best Practices: Condition Management Series
- Provider Communications (Webinars, Newsletters, and Training)
- Quality (KPIs and Incentive Programs)
- Electronic Resources (Provider Handbook and Policies)
- SUD Expanded Benefit
- Practice Transformation
- Contact Information for RAE 4, Customer Service, Care Coordination, Clinical and Claims Departments

HCI facilitates additional training series to educate, inform, and discuss a range of topics related to best practices and HCI policies. Some reoccurring monthly webinars are Provider Connect Overview, Clinical Training, Cultural Competency training, Claims Submission guidance, and HCPF contractual topics. HCI newsletters contain webinar information and archived monthly webinars.

HCI requests providers contact us when they experience any issues or concerns. HCI contracted network providers can contact the National HCI Behavioral Health customer service telephone line or email to receive information about contracts, credentialing, authorizations, claims payments or denials, update their provider profile, or file a complaint. Contact information is located on the Contact Us section of the HCI website and is located in the HCI provider handbook. The Customer Service line is answered by trained professionals and is open 8 a.m. to 6 p.m. Eastern Time Monday through Friday. In addition, the provider relations staff will be conducting in-person Town Hall meetings for providers during FY24. These Town Hall meetings will include provider training presentations and opportunities for providers to connect with provider relations staff to hear concerns and assist with collaborative resolutions.

HCI utilizes various electronic media platforms such as our website, Facebook, Instagram, and LinkedIn to communicate relevant information to members, family members, and health care professionals. One example of relevant information includes our social media posts related to continuous coverage updates. HCI updates these platforms on a regular basis to ensure that current information is available to provide seamless care for our members. HCI revised our website to include multiple wellness and prevention health information resource sheets for members, family members, and health care professionals. The wellness resource sheets include information regarding EPSDT, dental, immunizations, and well visits. The prevention information sheets address breast cancer screening, Colorado QuitLine, family planning, vaping/smoking (teens), and women's sexual health. The behavioral health information sheets cover alcohol and substance use treatment, and the Social Determinants of Health (SDOH) information sheets include SNAP/WIC and care coordination information. HCI educates behavioral and physical health providers and encourages them to use these resources to disseminate to our members.

HCI facilitates "Getting Started" virtual meetings on the first Thursday of each month to all eligible members, family members, and health care professionals. This meeting is offered through a telephonic and/or video conferencing option based on member preference. The "Getting Started" meeting provides an overview of multiple benefit topics, including a presentation by DentaQuest. HCI's primary goal for this meeting is to provide education on the preventative health care benefits available to members so that members engage in their healthcare. Finally, HCI hosts a cultural competency/health equity roundtable twice a year for health care professionals, community stakeholders, CMHCs, and federally qualified health centers (FQHC). HCI's goal in hosting these roundtables is to create common language around health equity topics and determine best practices to develop the efficient delivery of health care services to our members. HCI is committed to aligning our health equity efforts with HCPF's health equity goals.

Member Services is available for HCI providers and members by telephone at 888-502-4185. In addition, providers can contact Clinical Services at 888-502-4185 or fax 719-538-1439 for assistance with utilization management requirements and processes for Health First Colorado members.

HCI will continue to adapt to the ever-changing needs via enhancing the mechanisms above to reach our stakeholders, provider networks, and members.

4. Health Neighborhood & Community Engagement

HCI has extended efforts during FY22-23 to continue providing quality access to care for members in our region. This has been made possible in part by the leveraging of essential collaborations with providers and with the community as a whole. Based on feedback from HCI community-based care coordination entities during monthly subcommittee meetings conducted during FY22-23, HCI has strengthened communication efforts and partnerships within the Health Neighborhood, which has resulted in improved care coordination and more productive utilization of community resources. HCI experienced numerous achievements throughout the course of this reporting period, as well as some challenges, and both are detailed in the report below. We anticipate many positive outcomes as we proceed into the next reporting period, and we are prepared to successfully meet any challenges that may arise.

For FY23-24, HCI has increased staffing specific to health neighborhood with two additional staff members who will focus on improving the health neighborhood and health equity. Our work with hospitals includes the identification of the best starting point for building a health neighborhood with specialty provider types. We expect this to have a specific on focus on diabetes and maternal medicine specialty care providers, and plan to align this work with the launch of e-Consult in February of 2024 as an incentive for participation. Additionally, our Health Neighborhood strategy includes finding solutions for members when a specialist or Primary Care location closes to ensure there are no gaps in care. We will also identify gaps in subpopulations from the data provided by HCPF with considerations surrounding county culture, capacity, and upstream factors. Through all efforts, language equity and accessibility efforts will be an area of focus throughout the entire RAE organization.

E-Health/Telehealth

HCI is contracted with e-Health Entity, a telehealth-only group, through Care on Location. HCI continued to meet with Care on Location regularly throughout FY22-23 and plans to do so into FY23-24. Care on Location is a unique partner because they support the HCI Health Neighborhood Program by serving members who otherwise may not be able to receive in-person services due to access to care availability or member preference. Care on Location's telehealth and mobile services enable HCI to reach that population. During FY23-24, HCI will continue to develop our established relationship with Care on Location. As part of our work with Care on Location, HCI will improve upon standard workflows for warm handoffs or providing information via e-fax, depending on the member's level of risk/need. Additionally, HCI will support bi-directional data sharing through Health Information Exchange (HIE). As detailed in the Hospital Transformation section below, the HIE consists of Colorado Regional Health Information Organization (CORHIO) and/or Contexture. Bi-directional data sharing will be conducted through the HIE or Provider Connect.

Hospital Transformation Program (HTP) Work

HCI is continuing efforts to lower Health First Colorado costs through reductions in avoidable hospital utilization and increased effectiveness and efficiency in care delivery. In addition, efforts are being made to accelerate hospitals' organizational, operational, and systems readiness. To this end, the RAE 4 liaison is collaborating with the PCMP and behavioral health practice transformation teams, as well as the care coordination and crisis teams, to foster partnerships between hospitals, health neighborhood, and community partners. This is accomplished by aligning goals and establishing systems for communicating member information. For FY23-24 the focus will continue be on ensuring that file sharing capabilities are in place via Provider Connect or the HIE, which consists of CORHIO and/or Contexture. Additional focus will be placed on establishing quality workflows for the four HTP measures that require RAE notifications, (RAH1, SW-CP1, SW-BH1, and CP6) and aligning efforts to address well visits for both adult and pediatric populations.

In addition to meeting with hospitals, HCI participated in a number of activities and meetings during FY22-23, contributing to the further success of the HTP work. One example is recurring meetings that HCI conducted with Contexture to implement a scope of work specific to HTP for data sharing. HCI also participated in Community Health Neighborhood Engagement (CHNE) activities as a key stakeholder, including the weekly Eastern Plains Health Care (EPHC) Consortium. HCI's HTP liaison attends a quarterly Rural Connectivity User Group, which concentrates on increased access to HIT resources and analytics for Rural Health Centers (RHC) and critical access hospitals (CAHs). HCI participated in the 2022 Colorado Hospital Association (CHA) Fundamentals of SDOH in Hospitals: Improving Health Equity Across Colorado as well as the CHA annual meeting, which is the largest gathering of hospitals and healthcare leads in the state. HCI plans to use the information and networking opportunities from these meetings to guide access to care efforts and support expanding the hospital's role in improving health equity across the region.

HCI reviewed existing patient workflows associated with the transition of care, care coordination, and access to care. We supported workflow development for a majority of the hospitals to help with post-discharge collaboration, and participated in post-discharge collaboration with CMHCs and delegated care coordination entities. A framework was developed for the discharge planning process, with a focus on unified technological solutions for member notifications. HCI's director of care coordination presented at the HTP All Hospital Huddle, informing the group of care

coordination support related to HTP goals and ways to connect with HCI for care coordination support needs. HCI created monthly hospital newsletters that include key dates and deadlines, RAE 4 updates, community engagement opportunities, and measure-specific guidance.

HCI is partnering with Care on Location to build a Bridge Care Program that will help strengthen HTP program initiatives as well as improve timely access to services for members in our region. This program will also support RAE 4 access to care standards that are amenable to telehealth modalities and care coordinators being able to connect patients directly to a care source. The program is intended to strengthen care transitions and bridge access to care gaps in a timely manner while also respecting local resources and workflows that already exist. With this program, HCI aims to extend access to care to members who fall through the cracks. Care on Location's Bridge Care program supports access to care and addressing care gaps by providing same day telemedicine access options for general care. The members stay attributed to their PCMP, the member data is shared with that PCMP to support continuity of care, and referrals can be made by the PCMP or care coordinator to decrease delays in patients receiving care if needed.

Care Coordination:
HCI continues to connect our care coordinators and providers through the practice transformation teams to further strengthen supports and relationships with providers. One example is the meeting in January 2023 with Southern Colorado Clinic. Collaborations between care coordination and practice transformation allow for stronger connections between PCMP practices and HCI's care coordination team, improving access and continuity of care for our members between providers. We are also exploring the possibility of holding a learning collaborative about care coordination with practice transformation and PCMPs engaged with practice transformation. It would consist of a large group session to highlight HCI's care coordination model, followed by breakout rooms with care coordination entities and the PCMPs they support.

HCI also connected with Dr. Brad Roberts, emergency department (ED) provider at Parkview and Chief Medical officer at Pueblo Department of Public Health and Environment (PDPHE), to discuss the RAE landscape. Further meetings were held with Dr. Roberts to specifically discuss RAE care coordination and identify opportunities for connection and improved coordination of care for shared Health First Colorado members.

Performance Measures Action Plan (PMAP) Workgroups
As part of the PMAP process, HCI initiated recurrent meetings with Peak View Hospital to improve performance on the inpatient mental health follow-up measure. Due to the importance of transitional care management for this measure, the workgroup includes personnel from Peak View Hospital, representation from a care coordination entity, and the CMHC Health Solutions. The work group has generated a process map beginning with admission to Peak View Hospital through completed follow-up with behavioral health services.

HCI also initiated recurrent meetings with Parkview Medical Center to raise performance on the SUD ED Follow-up measure. The work group includes clinical and non-clinical personnel from Parkview Medical Center, both medical and behavioral health providers, staff from the facility's quality team, and Health Solutions. The group has generated a process map from presentation at the ED to completed follow-up with behavioral health, and has started reviewing aggregated member-level data on measure performance to inform a FMEA. Efforts are being coordinated in

parallel with HTP initiatives focused on SUD discharge notifications. Starting in January 2023, the team formulated possible interventions to implement and test.

Diabetes Workgroup

HCI's diabetes workgroup is a forum that is held three to four times per year for PCMPs. The purpose of the work group is to share best practices, solve barriers to care, and learn skills and techniques that could be incorporated into a PCMP practice. Through this purpose and the goals of the group, the diabetes work group aims to reduce unnecessary specialty care utilization for member with diabetes by educating and supporting PCMPs.

The Health Neighborhood Forum

The Health Neighborhood Forum is an opportunity to work together on shared initiatives in RAE 4 communities. This forum provides a means to address barriers and gaps in the system of care, aligning activities and thereby strengthening relationships in the healthcare system. HCI strives to develop communication channels that allow us to exchange information with community agencies and providers. This communication allows for collaboration and engagement in initiatives to optimize member health and well-being. The Health Neighborhood Forum serves as a method to engage community partners in a meaningful way while identifying services and support for members. Invitations are sent to the following types of agencies: physical and behavioral health providers, hospitals, LTSS providers, public health, home health, hospice providers, DentaQuest, Single Entry Points (SEP), and Area Agency on Aging. RAE 4 also includes the Interagency Oversight Groups (IOG), Collaborative Management Program (CMP), Special Supplemental Nutrition Program for Women, Infants, and Children, Nurse-Family Partnership (NFP), Faith-Based Agencies, Community Centered Boards (CCB), Department of Human Services (DHS), homeless shelters, and local community agencies that assist with high-fidelity wraparound social support services. HCI plans to host one Health Neighborhood Forum per quarter in FY23-24; however, this may change depending on community-based provider needs and priority topics identified by HCI. Details of the Health Neighborhood Forum meetings are reported in the Health Neighborhood and Community Bi-Annual Report.

SEPs & CCBs

A SEP/CCB stakeholder meeting was held January 20, 2023. This meeting provided information about HCI's care coordination model, stratification of members, and how HCI collaborates with SEP/CCBs on member cases. We also discussed multi-system involved members and ways to contact HCI care coordination. HCI is monitoring HCPF's request for applications utilizing the funds provided through Section 9817 of the American Rescue Plan Act of 2021 (ARPA) to aid the connection of CMAs to Admission, Transfer, and Discharge (ADT) hospital data. HCPF is creating an optional grant-funded opportunity for interested CMAs (SEP Agencies, CCBs, and Private Case Management Agencies) who serve members enrolled in HCBS. HCI had already initiated work to exchange the ADT files with our CCBs and SEPs; however, this has been paused since it would duplicate these HCPF efforts. Once we have confirmation of which agencies are engaged, we will resume conversations with the agencies who are not engaged in the HCPF efforts. Based upon our conversations with our SEPs/CCBs Pueblo, Otero, Las Animas, The Resource Exchange (TRE), and StarPoint indicated interest in the data exchange.

Community Collaborations

SURE: SURE is a collective impact-modeled coalition working to reduce deaths, hospital utilization, and the drain on community resources related to substance (mis)use in Pueblo. They have an expansive network of local providers that are engaged in an effort to address substance (mis)use in Pueblo with a common goal to ensure that everyone in Pueblo County has access to substance use related knowledge, resources, and supports and feels safe discussing substance use. HCI has collaborated with the SURE team by providing quarterly mental health provider capacity reports to support the Pueblo County Partnerships for Data (PCPD) project. In accordance with the PCPD project, HCI data sets are aggregated and analyzed to better understand substance use issues and determine potential solutions/strategies for Pueblo County. Non-identified data analyses are distributed to PCPD partners and the public through public dashboards, presentations, press releases, emails, and meeting materials.

Care on Location and MOM Grant: Care on Location is a recent recipient of the Maternal Opioid Misuse (MOM) Grant. Close collaboration between Care on Location and HCI has been initiated in the prior fiscal year and will be advanced in the upcoming year. Care on Location has the goal to serve 5-10% more members in five counties in our region during FY22-23: Custer, Fremont, Huerfano, Las Animas, and Pueblo. Additional program goals are to connect members with regular sources of primary, behavioral, and specialty care as well as to increase behavioral health and SUD engagement. Care on Location has a telehealth-enabled mobile van with a trained community health worker and partners with a hosting organization or event to reach more of our community. One such hosting location is the Southern Colorado Harm Reduction Association (SCHRA) in Pueblo.

Pueblo's Partners in Health Care (PPH): Pueblo's Partners in Health Care (PPH) is a coalition that was formed with the purpose of creating a community-based transition of care program for Pueblo County that identifies and addresses barriers and determines interventions to support transitions of care across care settings. PPH aims to decrease inappropriate ED utilization and hospital readmissions, while engaging patients and their support systems as active decision-makers in their care delivery. Meetings occur monthly and include HCI, Health Solutions (HS), Pueblo Community Health Center (PCHC), Parkview, Pueblo Triple Aim, and Directing Others to Services (DOTS). The target population are members with six or more ED visits, ED utilization within six months, and whose PCMP attribution is to HS, Parkview, or PCHC. HCI contributes monthly member reports, which include the number of ED visits, costs by care setting, and recent claims history to assist with informed discussion and decision-making. Next steps for the meeting continuing into FY23-24 are to determine outreach and interventions, design a pilot, and monitor for 12 months.

Rio Grande Hospital Health and Wellness Board: The Rio Grande Hospital Health and Wellness Board is comprised of Health Neighborhood and community partners across San Luis Valley who meet monthly to discuss progress on the community health needs assessment. They also review updates and opportunities from more than 20 community and health neighborhood partners, including hospitals, CMHC, FQHCs, social supports and services, local jails, schools, and public health entities.

Crisis Services: HCI maintains the Senior Crisis Services Director position within Region 4. This position serves as a conduit, relaying information between the providers and the ASO/RAE, as HCI is the ASO that manages Colorado Crisis Services for our region. HCI's Senior Crisis Services Director conducts continuous outreach, training, education, and collaborations across our community.

A new pilot project started in Region 4 under the Crisis Services umbrella; The Crisis Resolution Team (CRT) went live on July 1, 2022 with the focus of targeting children and adolescents who have recently received Mobile Crisis Response services or had a psychiatric visit to the local ED. This program supports families with youth and young adults who are experiencing behavioral health challenges and would benefit from intensive, short-term (up to 42 days), in-home services and linkage to ongoing supports. Examples of CRT services include: a needs assessment, service planning, care coordination, crisis management, peer support, family skill building, individual/family therapy, psychiatry, and medication management. The overall mission is to keep youth and families together in their natural environments. The CRT aims to avoid hospital admission whenever possible by wrapping services around the family in an effective manner.

FY22-23 also brought about exciting support from the Behavioral Health Administration (BHA) to one of the Regional Assessment Centers (RAC) within Region 4. Solvista Health began planning for and then constructing the RAC in Salida prior to the COVID-19 global pandemic. During the summer of 2022, the BHA reached out to the Senior Crisis Services Director to determine whether a collaboration between the BHA, HCI, and Solvista could occur so that the RAC could benefit from funding. This funding would be used as seed money to help staff, equip, and open the RAC. As a result of the discussions amongst multiple entities, HCI was able to contract with the BHA to receive a $1,000,000 one-time grant to help support this RAC within Region 4.

This reporting period included the soft launch of the Medicaid Independent Assessor (IA) program on October 1, 2022. Further, the submissions from the Mobile Crisis Response Needs Assessment were completed from each CMHC provider on December 22, 2022. Both of these updates are expected to have had a positive impact on individuals requesting services across Region 4.

The Medicaid IA program launch was a joint venture among HCPF, the BHA, the RAE, and ASOs. Region 4 was the first to finalize the contract addendum between the RAE and the ASO within the state. The goal of the Medicaid IA program is to allow families with Medicaid to refer their children and adolescents to an IA who can help determine if a residential treatment option is appropriate and warranted. The Senior Crisis Services Director has worked in tandem with Region 4 RAE staff to help implement this program, which went live officially on January 1, 2023.

Common themes that emerged from crisis providers continued to revolve around workforce shortages and the struggle to find qualified candidates for open positions. Another theme included the need for additional funding in order to support the new requirements that will be going into effect with the BHA Rule Changes that are set to occur in the summer of 2023. The Senior Crisis Services Director has been working with Southeast Health Group, a CMHC in the southeast corner of the state, to get much needed high-fidelity wraparound services in place. This is another example of the collaboration that occurs across various entities, as the ASO, CMHC, and local CMP/IOG have all gathered to determine together how this program

will roll out in this large community. A referral process and a meeting cadence have also been determined, so that families most in need of these services can quickly and easily be referred. Referral sources include the school system, DHS, and local primary care/behavioral health agencies.

HCI Community Reinvestment Grant Program

The goals of the Community Reinvestment Grant program are to expand access to needed services, promote a more connected health neighborhood, avoid duplication of services, improve quality care and outcomes, enhance member experience, and positively impact the total cost of care. This program supports HCI's regional focus on improving the health and well-being of all residents by improving health, access, and costs for SDOH. HCI's focus areas when awarding grants are:

- Dental and well visits
- Condition management
- Maternal health
- Behavioral health and SUD access, support, and recovery
- SDOH

Eight recipients covering all 19 counties in our region were awarded grants between Q3 of SFY21-22 and Q2 of SFY22-23. This grant money was awarded in January of 2022. The organizations that received grants were required to report back to HCI throughout the entire grant period until December 2022 on the progress they were making toward their goals as well as outcomes they achieved as a result of the funds that were awarded to them. The total amount awarded was $1,797,356.40. Updates pertaining to the progress that has been made by these eight grant recipients are outlined in **Appendix A** at the end of this document.

In September of 2022, HCI hosted a learning collaborative, which included more than 50 Health Neighborhood and community partners across the region to discuss potential opportunities to share work and collaborate.

HCI Community Reinvestment Grant (Beginning October 2022)

HCI's strategic approach is anchored in a partnership philosophy, acknowledging that health care is local and must reflect the unique needs and pressing health issues of members and their respective communities. Grants awarded align with at least one of the priorities of the ACC program, KPIs, and/or behavioral health incentive measures.

HCI engaged the RAE 4 community both directly and indirectly to understand the diverse needs of the region, identify the root causes of inequities, and determine the direction of this grant cycle. HCI plans to use this information to collaborate with health care change agents in our communities, promoting both health and equity for our members, their support systems, and health care providers.

Significant health needs identified across the region during FY22-23 are:

- Access to primary and specialty care services and providers
- Prevention, education, and services to address high mortality rates, chronic diseases, preventable conditions and unhealthy lifestyles
- Access to affordable care and reducing health disparities among vulnerable and underserved populations
- Access to mental and behavioral health care services and providers
- COVID-19 transition from pandemic to endemic
- Need for increased emphasis on housing and transportation

Based upon these health needs HCI identified four key concepts for the fall 2022 grant cycle:

- Member and caregiver engagement
- Social and community integration
- Health care delivery
- Health care professional support

HCI implemented a number of strategies during the fall 2022 grant cycle, including a comprehensive grant application packet and three phase vetting process. A live community presentation and discussion was held on September 15-16, 2022. In addition, HCI hosted an in-person award presentation and orientation on September 30, 2022. Finally, the HCI Community Investment Learning Collaborative took place in December of 2022. This fruitful three-part meeting started with an ACC/RAE 4 101 training session, followed by an ACC 3.0 presentation and discussion by Colorado Health Institute (CHI). Grantee updates were also provided, including wins, barriers, and opportunities for support.

HCI had a record number of applications during this grant cycle and all counties were represented. We received positive responses from applicants on the grant application process. The total award amount is $1,000,000 and the performance period for those organizations awarded funds is October 3, 2022 to September 30, 2023. In total, 18 proposals were selected which are outlined in **Appendix B**.

Some of HCI's grant recipients provide COVID-19 vaccines, for example Chaffee County Public Health and Pueblo Cooperative Care Center (PCCC), details of which are included in the Monthly COVID-19 Vaccination Report. The grant funds issued to these organizations support efforts aligned with the education, purchase, administration, and distribution of the COVID-19 vaccine to populations served by the organizations awarded grant funds.

In addition to HCI's community reinvestment grants, we continue to provide financial support for various community events across our region. Some examples include:

- Dancing with the Starz Pueblo (Pueblo Diversified industries)
- Keeping the Dream Alive Annual Fundraiser (Rio Grande Hospital and Clinics)
- Hope and Recovery Festival (SLVBHG)
- Pueblo Pride Fest (Southern Colorado Equity Alliance)
- Starry Night Ball (Tu Casa Inc.)
- Pueblo County Peer Work Group (SURE)
- A Night of Remembrance (SCHRA & NeighborWorks)
- National Overdose Awareness Movie Night (PERCS Colorado)
- All Pueblo Reads Sponsorship – Underwriting Youth Mental Health Books (Pueblo Library)
- Annual Colorado Behavioral Health Care Council Networking/Reception Event
- 2022 Comedy Night (SECA)
- 2022 Candidate Forum Luncheon Sponsorship (Latino Chamber of Commerce)
- Take your Turkey to Work Day (Care and Share)
- Reflections Celebration and Tree Lighting (Sangre de Cristo Hospice)
- Share the Magic (La Puente in Partnership with Valley-Wide)

During FY23-24 HCI plans to administer the 2024 HCI Health and Wellness Grant, another round of community reinvestment funding. The RFP for this funding will be released in August of 2023, with applications being due September 15, 2023. HCI will award another $1,000,000 to community organizations across Region 4 to meet the needs of the communities that we serve. HCI will seek innovative and collaborative community-based solutions that will improve the health and well-being of RAE 4 members by increasing health equity and access to quality services while reducing unnecessary and/or avoidable utilization and costs. HCI's strategic approach is anchored in a partnership philosophy, acknowledging that health care is local and must reflect the unique needs and pressing health issues of members and their communities. Categories of interest will support county-specific needs and priorities supplied by county level data, direct feedback from key stakeholders and members throughout the region, and results from Community Health Needs Assessments (CHNAs). Grants awarded will align with at least one of the priorities of the ACC program, KPIs, and/or behavioral health incentive measures. Funding will begin on January 1, 2024 with the program period extending until December 31, 2024.

5. Admin Payments and Incentives

HCI will maintain our current PCMP payment strategy into FY23-24. The payment continues to streamline PMPM structure and separate PCMP and care coordination functions. This is the same as the payment structure developed in the Population Health Management Strategic Plan. This payment strategy for this year will include:

- PMPM Payment: Providers will receive one PMPM rate payment for all attributed members (both utilizers and non-utilizers) to support day-to-day clinic operations as a medical home for attributed patients.
- Practice Transformation Incentive: Practices receive these incentive payments after achieving predetermined practice transformation incentive goals.
- Performance Payments: These are incentive payments practice can earn that are tied to the achievement of KPIs and performance pool.
- Care Coordination Payments: care coordination entities that meet requirements will render care navigation functions for assigned members who are in the top percentile of our Chronic Population and care management functions for assigned members who are identified as complex members. Care coordination entities can render both care navigation and care management or select to only do care navigation based on the care coordination entities' demonstrated competencies and capacity.
- Community Reinvestment Grants: PCMPs are also eligible to apply for community reinvestment grants.

HCI's goal is to execute the FY24 Incentive Plan for providers and agencies that assist HCI in meeting performance goals for the betterment of members across the region.

TOTAL PRACTICES OR AGENCIES ELIGIBLE FOR ARRANGEMENT PROGRAM					109			
Type of Arrangement	**Arrangement Description**	**PMPM ($)**	**KPI ($)**	**Performance Pool ($)**	**Number of Participating Practice Sites**	**Percentage of Total Practice Sites**	**Eligibility requirements for practice participation**	**Additional Comments**
PCMP	All PCMPs will receive a PMPM rate for all attributed members to perform medical home functions. PCMPs can earn additional payments for performance, practice transformation, and can apply for community reinvestment grants. The Pay for Performance additional payments will be based on the clinically relevant metrics per measure group. PCMPs	$4.25	PCMPs can earn additional KPI incentives from practice transformation KPI initiatives. PCMPs can elect to participate in HCI practice transformation QI projects that align with HCI's goals of quality outcomes and	PCMPs can earn additional Performance Pool incentives dollars. PCMPs can elect to participate in HCI practice transformation QI projects that align with HCI's goals of quality outcomes and reducing cost of care.	109	100%	PCMPs that meet basic PCMP criteria. This includes: 1. Be enrolled as a provider in Health First Colorado. 2. Meet or exceed performance expectations.	One practice location from each PCMP Entity will be eligible to participate in practice transformation Incentive program. PCMP Entity may choose which of their practices will participate in the program. Selected practice will receive incentive payments

	are eligible to participate in the HCI practice transformation QI projects that align with HCI's goals of quality outcomes and reducing cost of care. PCMPs are also eligible to apply for community reinvestment grants.		reducing cost of care. Additionally, PCMPs are automatically eligible for the KPI incentives based on their attributed members included in the KPI Indicator as identified by HCPF. PCMPs are also eligible to apply for community reinvestment grants.	Additionally, PCMPs are automatically eligible for the Performance Pool incentives based on their attributed members included in the Performance Pool Indicator as identified by HCPF. PCMPs are also eligible to apply for Community Reinvestment Grants.				after achieving predetermined practice transformation incentive goals.
Care Coordination	Care Coordination Entities will be delegated for care coordination functions- care navigation and/or care management, based on provider selection and meeting requirements. Members are assigned to the delegated entities whether they are the attributed PCMP or not and stratified based by level of Complexity noted on the monthly file from HCPF. This payment will be in addition to the PCMP PMPM.	$70.00 PMPM for Care Management $33.25 PMPM for Care Navigation $0.45 PMPM All Others	Care coordination entities are eligible to receive a portion of the community reinvestment funds earned from KPI measures. This portion is Pay for Performance and will be based on MOU with clinically relevant	Care coordination entities are eligible to receive a portion of the community reinvestment funds earned from Performance Pool measures. This portion is Pay for Performance and will be based on MOU with clinically	40	37%	1. Be enrolled as a provider in the Colorado Medicaid program 2. Perform the spectrum of care coordination activities ranging from routine, one-time activities to long-term interventions including community-based care coordination activities.	

			metrics per measure group (KPIs).	relevant metrics per measure group (PP).			3. Create and submit a timely and comprehensive Care Coordination Activity report for all care coordination activities (not just complex) for assigned members including those members that are assigned to the care coordination entity and have another PCMP. This includes specialty populations as identified by the State (i.e., Criminal Justice, foster care) 4. Serve COUP Members. 5. Maintain open panels 6. Complete and submit COUP Report for applicable Members 7. Meet or exceed performance expectations.	

COLORADO
Department of Health Care Policy & Financing

I. APPENDIX A

COMMUNITY AGENCY	COUNTIES SERVED	INITIATIVE/FUNDING	UPDATES (JULY-DEC 2022)
Care on Location	Custer, Fremont, Huerfano, Las Animas, Pueblo	Partner with local community-based organizations to offer on-site access to COL physical and BH services **Funding: $498,800**	• Established partnerships with CoPPCAP to provide peer consultation for pediatric behavioral/mental health presenting in primary care settings as well as psychiatry and medication management for depression and anxiety • Two additional partnerships with Boulder Care (tele-SUD treatment) and Hope Mountain Behavioral Health (tele-behavioral therapy) are also being actively developed • Several meetings with partners in the community including Community Based Organizations (CBO), care coordination, PT, HTP, nurse navigation, and others to inform our work and strengthen our ties to the community • MobilTEK van – anticipate a formal launch date in Q1SFY23 and have several community partners interested in being a host site in RAE 4
Chaffee County Public Health	Chaffee, Lake, Fremont, Custer, Saguache	Mobile health clinic to provide health navigation, education, prevention, and early intervention services in partnership with First Street Family Health **Funding: $20,000**	• Implemented mobile medical and harm reduction clinic • Screening, wound care, immunizations, care navigation, etc. • Safe needle and syringe disposal, education, peer support, MAT • 80 unique members engaged
Friendly Harbor	Pueblo	Referrals for BH treatment court, veterans' health treatment court, and safe baby court to support. Increase access and engagement in BH services and SDOH **Funding: $82,000**	• Hired and trained three peer support staff members • Completed certification submission for all other peer support staff who are eligible • Successful Art Therapy and Community Meetings

Project Angel Heart	All 19 counties	Medically tailored meals and enhanced nutrition services for members with congestive heart failure, COPD, diabetes, and high-risk pregnancy **Funding: $104,900**	• Provided 3,220 meals to 170 RAE 4 members
Pueblo Triple Aim - DOTS	Pueblo	Educating 911 Super-Utilizers Project (DOTS) – Team members provide education to super-utilizers and the local community to proactively teach targeted communities. Adding this proposed technology component to equip and educate super-users will allow for growth of the DOTS program by increasing a patient's access to diverse healthcare options and their ability to manage their own healthcare needs **Funding: $72,437**	• [redacted] individuals received tablets • Technology specialist hired part time for tablet program and community support • [redacted] appointments with health care providers • Increased self-management skills • Increased use of patient portal for provider/patient communication • [redacted] pharmacy apps used • [redacted] referral appointments • Member information updated in portal • [redacted] members paid off remaining balances – financial literacy
Senior Resource Development Agency	Crowley, Custer, Fremont, Huerfano, Las Animas, Otero, Pueblo	Supporting Aging and Disability Resources Colorado (ADRC) activities and address the social and community context, aiming to increase social and community support through psychoeducational support groups. Increase members' healthcare access, referral services, and application assistance **Funding: $45,000**	• Provided information, referral and awareness resources for 5,000 clients • 6,000+ clients received in-depth options counseling • 370 completed Health First Colorado application/recertification • [redacted] members participated in two social support groups

Servicios de La Raza	All 19 counties, primarily Pueblo	Develop an onsite program for members in need of both Spanish/English BH. Address SDOH through individualized service plans to include affordable housing, transportation assistance, connections to childcare services, employment, financial literacy services, Health First Colorado enrollment, and services for individuals who identify as LGBTQ+. **Funding: $474,302.40**	• Four bilingual case managers increase access to BH services • Completed outreach events reaching more than 1,650 community members • Created BH marketing material fully bilingual • 51 members engaged in BH services • Share data with BH department via Thernest • Working with HCI BH Transformation Program • Two benefits specialists in place • Provided 350 backpacks to children • Partnered with COMOM to provide 1,000 people with free dental care • Care Manager (CM) participated in health equity task force. • CM completed LGBTQ CM training • Credentialed in July 2022
Southern Colorado Harm Reduction	Pueblo	Community center restoration and healing central hub in the Pueblo Bessemer neighborhood to enhance programs and services by offering equitable opportunities and care to individuals and families living with SUD by promoting wellness, support, and prevention **Funding: $499,917**	• Create a community center in Bessemer to increase access to health care, behavioral health care, SUD treatment, and social resources • Secure premises (community center) for safety including installation of garage door, security equipment, and obtaining appropriate insurance • Full replacement of roof, demolition of interior, and water damage mitigation • Installation of new electric and plumbing systems

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II. APPENDIX B

Organization	Counties Served	Project/Program/Funding	Updates (Oct-Dec 22)
Bits of Freedom	Alamosa, Conejos, Costilla, Rio Grande, Saguache	Purchase of an Equicizer and storage shed to be placed at Soaring Eagles Center for Autism (SECA). Instructor fee and volunteer training **Funding: $10,000**	• 8'x12' shed at SECA • Equicizer ordered - due April 2023 • Four hours of volunteer training and riding complete • 36 hours of equine assisted riding • 92 volunteer hours
Boys and Girls Club of the San Luis Valley	Alamosa, Conejos, Costilla, Rio Grande, Saguache	Create a community-wide database of service providers and clients through Unite Us platform, increasing organizations' capacity to address social needs and improve health across communities **Funding: $40,000**	• Hired and trained full time case manager • Implemented Unite Us system across 25 stakeholders • Integrated client systems with Valley-Wide Health
Care and Share	All except Lake	Operations for distribution center in Alamosa **Funding: $50,000**	• Grand Opening planned for May 2023 • Initial construction project complete • Pallet scales and forklifts ordered • Hired Center Manager
Care on Location	All	Bridge Care Program design, supporting transitions across care settings **Funding: $125,000**	• Care provision - referrals received for transitions program • Meetings w/stakeholders: Health Colorado PT and CC, Centura Hospital, San Luis Valley Health, Parkview Hospital • Reviewed initial data, claims data, quarterly reports, and industry insights • Colorado Rural Health Conference • Global Connections for Sustainable Telehealth
Court Appointed Special Advocates (CASA)	Pueblo, Chaffee, Custer, Fremont, Lake, Bent, Crowley, Otero	Program Coordinator, volunteer, and data infrastructure assistance, supporting health, development, and extracurricular activity advocacy for youth appearing before the courts in	• Volunteers attending school/IEP meetings • Agreement in place with YMCA, zoo, Sangre de Cristo Art Center – free access • Health advocacy for eye care, dental care and BH support

		the 10th, 11th, and 16th Judicial Districts because of abuse and/or neglect. **Funding: $44,000**	• Partner with Health Solutions for MH support • Need in home therapy options

Center for Restorative Programs	Alamosa, Conejos, Costilla, Rio Grande, Mineral	Purchase two vehicles (including a minivan to support members with disabilities) to provide reliable transportation to resources, outpatient treatment/services.
		
		Funding: $50,000
			• Purchased two vehicles Nov. 15, 2022:
			  ○ 2020 Dodge Grand Caravan with 54,345 miles for $24,499
			  ○ 2016 Honda CRV with 33,527 miles for $22,700
			  ○ Total purchase price of $47,199
			• Insured the vehicles and started using them immediately to increase availability and accessibility for participants to engage in accessing health care, transitions of care throughout the continuum of care, and support ongoing needs of those we serve.
			• Will obtain the license plates and registration in the first part of January

Center for Restorative Programs and Rio Grande Hospital	Alamosa, Conejos, Costilla, Rio Grande, Mineral, Saguache	Purchase the WeConnect Contingency program and platform, providing support to individuals enrolled in intensive case management **Funding: $100,000**	• CRP signed the contract for the WeConnect program platform • Intensive case managers were trained on the app. • Case managers also began utilizing the program during this time period
Chaffee County Public Health	Chaffee	Continue free mobile health clinic that provides health navigation, education, prevention, and early intervention services and programming, and direct services throughout the county. **Funding: $40,000**	• We gave out 32 boxes of Narcan in November, which is a 62% increase from October • Staff distributed over 180 fentanyl test strips, helping to protect clients from fentanyl overdose • Chaffee Community Clinic (CCC) had [redacted] new clients in the month of November, and CCC staff helped navigate [redacted] individuals to recovery programs and worked to link several individuals to BH services • Our dental health navigator conducted [redacted] overall screenings and [redacted] fluoride varnish applications during November • We have conducted several STI tests for our clients and offer treatment and linkage to care as needed.

			• 35 vaccines were given in Buena Vista and Salida in November
Weisbrod Memorial County Hospital	Kiowa	EMS recruitment and training. Employee Wellness Program **Funding: $35,000**	• [redacted] students enrolled in EMS courses – estimated completion February 2023 • Survey of staff to determine structure of wellness program – starting January 2023
Lake County DHS and Wraparound	Lake	Crisis Stabilization for families and youth experiencing homelessness through providing emergency hotel/motel shelter for McKinney Vento eligible families and youth. **Funding: $11,340**	• Provided emergency hotel shelter for [redacted] individuals and 49 nights • Only one motel and a hotel accept reservations for this population and are trauma informed and supportive • Lack of long-term shelter/ transitional housing
San Luis Valley Health	Alamosa, Conejos, Costilla,Rio Grande, Saguache, Mineral	Renovations for apartment complex with 11 units offering affordable housing to healthcare workforce **Funding: $100,000**	• Detailed timeline and budget to complete the remodeling of apartment units, to manage the project – complete • Policies and processes developed and implemented • 2.5 units are currently being remodeled and on track to be completed by Jan. 31, 2023
Pueblo Cooperative Care Center	Pueblo	Purchase and distribute co-op care packs and food sacks for Health First Colorado members experiencing homelessness **Funding: $60,000**	• 625 co-op care packs • Distributing free cell phones to clients • Parkview mobile nurses – health and welfare checks • Initiating services with Care on Location
Pueblo Triple Aim (PTA) – Educating 911 Super-Utilizers Project (DOTS)	Pueblo	Educating 911 Super-Utilizers Project Civilian position to co-manage and direct programming and make patient contacts. Extend funding for the part-time technology specialist function supporting the current tablet program **Funding: $80,500**	• Job posting created • Projected hire February 2023
Pueblo Triple Aim (PTA) – Pueblo's Partners in Health Care (PPH)	Pueblo	Support facilitation of the PPH: Working Toward Systemic Improvements in Healthcare Project **Funding: $19,500**	• Action plan created • Target population has been identified for ED utilization intervention

			• Created needs assessment survey – complete in January 2023 • Began analyzing policies and procedures starting with no-show across partner organizations. • Process mapped policies for Parkview, PCHC, and Health Solutions
Senior Resource Development Agency	Las Animas, Huerfano, Pueblo, Custer, Fremont, Crowley, Otero	Short-term case management, social support groups, health literacy education, Health First Colorado enrollment assistance **Funding: $30,000**	• 2313 Info and referral clients • 1472 In-depth options counseling • 210 Health First Colorado application assistance
Small Town Project	Bent, Crowley, Otero	Hire and train part time Director of Development and Food Pantry Manager, implement a food pantry management system and increase food distribution system **Funding: $40,000**	• Payroll and time tracking system implemented • All new-hire onboarding complete • Salesforce customer relationship management deployed • Services and hours extended
Southern Colorado Harm Reduction Association (SCHRA)	Pueblo	Expand staff and Community Center in Bessemer to increase access to health/behavioral health care, SUD treatment, education and employment, and social resources **Funding: $150,000**	• Continuing expansion on Bessemer Community Center
Southern Colorado Youth Development (SCYD)	Pueblo, Otero, Crowley	Sustain programming for 12 months. SCYD programming includes Motovate, youth development using minibikes as well as wi-fi connected “Lift Zone” **Funding: $15,000**	• Engaging new youth in program • Collaborating with community members/grant recipients