COLORADO
Department of Health Care Policy & Financing

Annual Practice Support, Transformation and Communication Report
Instructions and Narrative Report

RAE Name	Health Colorado Inc. (HCI)
RAE Region #	4
Reporting Period	SFY23-24 [07/01/2023-06/30/2024]
Date Submitted	7/22/2024
Contact	Lori Roberts, CEO

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

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

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

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

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Practice Support:

Achievements/Successes:

HCI continues to use several communication methods to assist providers with information and education on topics to assist Health First Colorado members with their whole person care. HCI supported provider communication practices through monthly newsletters, live webinars, and provider email alerts. HCI hosted monthly live provider webinars for providers on topics covering the Colorado QuitLine, Zero Suicide, Crisis Resources, Access to Care standards, HCPF Revalidation, and Balance Billing/Overpayment information. There were twenty-six (26) provider training topics presented throughout the year. Provider trainings were posted on the HCI website along with the live webinars and presentations.

Attendance was recorded during the provider webinars and presentations. On average, twenty-eight (28) participants attended the live provider webinars. Of the participants attending the provider webinars, 100% responded that they were satisfied or very satisfied with the information presented. In addition, monthly provider newsletters have contained valuable resources and information to assist providers in whole person care not only for members but for providers as well. Our provider newsletters contain HCPF news, community events and training, and relevant articles to support providers navigating the care of Health First Colorado members.

Challenges:

Providers at times have outdated contact information on file with HCI. When Provider Relations staff meets one on one with providers, Provider Relations staff educates providers on the importance of keeping updated contact information and instructs providers on how to update provider contact information in the provider portal.

Plans for Change in Strategy:

HCI is committed to a communication plan that involves all stakeholders, network providers, and members to service the Health First Colorado program and improve the health and welfare of members. HCI will continue the course to work with network providers so they are informed, educated, and trained to help serve members and address all of their healthcare needs. HCI delegates provider communication services to Carelon Behavioral Health.

Network Provider Communications

Network providers are vital to the delivery of healthcare to Health First Colorado members. Carelon Behavioral Health, on behalf of HCI, focuses on key communication streams to inform, educate, and train network providers on the Health First Colorado program. The six (6) areas of focus include the following:

- Provider roundtable live webinars
- Newsletters

- Provider alerts
- Website resources
- Provider support calls
- Provider and stakeholder forums

Provider Roundtable Live Webinars

Network providers are invited to participate in live webinars designed to educate and inform providers about HCPF programs including contractual obligations, billing and coding guidelines, HCI's provider handbook, policies and procedures, and community-based programs within the region. Providers can attend these virtual events by either video or telephone from any location. In addition, Provider Relations performs interactive polling during the live webinars to better understand providers' knowledge and capture feedback on future roundtable topics. The interactive polling system helps drive the overall experience and gives insight into the value the roundtables have for the providers. Attendance is tracked and any follow up concerns are addressed with the provider after the meeting by the Provider Relations team. Roundtable webinar invitations are sent monthly via provider newsletters and are listed on the HCI website with instructions on how to attend. More information can be found under the Providers tab on HCI's website.

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Provider Alerts

HCI creates provider alerts when communication needs to be disseminated to providers in a timely manner. Provider alerts are intended to be a more urgent communication that may be time sensitive. All provider alerts are delivered via email to both BH providers and PCMPs.

Website Resources

HCI maintains a website that includes a section specific for providers. This section houses various resources providers can use to perform efficiently and provide high standards of care to members. The HCI website is organized with the following topics:

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- 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)
- Substance Use Disorder Expanded Benefit
- Practice Transformation
- HCI's Contact Information, Customer Service, Care Coordination, Clinical and Claims Departments, and Credentialing/Re-credentialing process

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HCI encourages providers to contact us when they experience any issues. HCI's contracted network of providers can contact Provider Relations by calling a toll-free number or via email to receive information about contracts, credentialing, authorizations, claims, or to update their provider profile. The National Carelon Behavioral Health Customer Service and local Colorado Provider Relations contact information is listed on HCI's website under the Contact Us section of the Providers tab.

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Provider and Stakeholder Forums

HCI will continue to host several provider and stakeholder forums throughout FY23-24 as an avenue for HCI, providers, community partners, and various stakeholders to share information and collaborate on ways to support members' health and wellness needs. These forums can also be used to address any local challenges or barriers providers may encounter when administering health care. Examples of the various meetings include:

- Health Neighborhood Forum
- Regional Program Improvement Advisory Committee (PIAC) meetings
- PT Learning Collaboratives
- Population Health Subcommittee meetings
- QI Subcommittee meetings
- First Friday Quality Forums

HCI's communication strategy to inform, educate, and train providers will continue to evolve as the providers' needs change throughout FY23-24. HCI will work directly with providers to bridge communications. Examples include modifying webinars to meet providers' interest in education

topics, and offering one-on-one support calls to fully address unique provider issues to facilitate effective resolutions.

Practice Transformation:

Achievements/Successes:

Through the voluntary Practice Transformation (PT) Program, PT Coaches work closely with Primary Care Medical Providers (PCMP) and Behavioral Health (BH) practices to improve quality and experience while lowering costs of care for our members by assisting in developing, implementing, and monitoring improvement activities. HCI's PT program has two components: Primary Care PT and BH PT. Both programs operate in a similar structure, with differences only in some of the performance measures and population focus. Foundationally, both programs focus on QI, conduct an annual assessment, meet monthly with each participating practice, and hold quarterly learning collaboratives.

In FY23/24, 93% of PCMP practices in the network were engaged in the HCI PCMP PT program, with the majority of them meeting monthly. For FY23/24, 12 practices are enrolled in the BH PT program.
We entered FY23-24 with the following goals:

- Practices achieve 70% of milestones in the PT Incentive Program. The clinical milestones for this FY were aligned to Key Performance Indicators (KPI) and Behavioral Health Incentive Plan (BHIP) measures.
    - PCMP incentive program: as of June 30, 2024, 83% of the incentive dollars have been earned. The annual incentive per PCMP practice was $10,000.
    - BH incentive program: as of June 30, 2024, 95% of the incentive milestones have been achieved.
- Integrate Prescriber Tool implementation into PT.
- Integrate eConsult Platform into PT.

Practice Transformation Competency Assessment YoY results

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

- Leadership
- Data Driven QI
- Empanelment
- Team Based Care
- Patient and Family Engagement
- Population Management
- Continuity of Care
- Access
- Comprehensiveness and Care Coordination

- Value-Based Contracting
- Focus on Addressing Social Needs of Patients
- Focus on Telehealth
- Inclusivity and Equity
- Focus on SUD

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

For PCMP assessments, all of the domains for FY 23-24 increased except for Patient and Family Engagement. The overall score increased from 3.32 in 2022 to 3.52 in 2023 as PCMP practices continue to develop year over year (an overall 6% increase).

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

Row Labels	2021	2022	2023	%Change
Access	3.06	3.46	3.71	0.24
Comprehensiveness and Care Coordination	2.79	3.16	3.59	0.43
Continuity of Care	3.00	3.54	3.73	0.20
Data Driven QI	2.43	3.39	3.52	0.13
Empanelment	2.85	3.71	3.78	0.06
Focus on Addressing Social Needs of Patients	3.83	3.08	3.29	0.21
Focus on Inclusivity & Equity	3.00	3.18	3.37	0.19
Focus on Substance Use Disorder	2.29	3.07	3.37	0.31
Focus on Telehealth	3.56	3.90	3.92	0.02
Leadership	2.50	3.26	3.42	0.15
Patient and Family Engagement	2.33	2.99	2.97	-0.02
Population Management	3.11	3.36	3.45	0.10
Team Based Care	3.04	3.44	3.59	0.16
Value-Based Contracting	3.25	3.18	3.41	0.23
Overall Average	2.88	3.32	3.52	

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

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

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

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

1. Access to Care. PCMP's reported third next available appointment data for 4 types of appointments- urgent care, outpatient follow up, non-urgent care and well care visits.
2. Attendance at HCI's quarterly Learning Collaborative. Four were held in FY 23-24 and topics included strategies for improving well child visits, UC Health's Chronic Pain Center of Excellence, Introduction to the High Plains Research Network, Depression Screening sharing of best practice, billing for depression screening, Introduction to eConsult Platform and HCPF Health Equity Vision and Priorities.
3. Practice Assessment and Setting SMART Goal for an area of improvement.
4. Screening for Depression and Follow up. Work done with PCMP to ensure workflow in place for capturing G-codes when depression screening was done as well as show performance improvement based on KPI.
5. Well Visits based on KPI. PI work completed with the goal to close gaps in care for members 0-15 months and 15-30 months or 3-21 years old.
6. One additional clinical measure- Diabetes A1c Control, Controlling High Blood Pressure or Childhood Immunizations. Process improvement work was performed to achieve improved outcomes in one of these measures.

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

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PCMP PT Incentive Program Structure (FY23-24)

Milestone Name	Description	Details
Access to Care	Report 3rd Next available appointment report to coach for: Urgent, Follow-up, non-urgent, and well visits	To be calculated and submitted quarterly during regular meetings with your coach.
	Have an active PDSA during any quarter where RAE Access standards are not met	The PDSA can be discussed in regular meetings with your coach
	Meet RAE Access Standards of: Appointment scheduling within: (a) Urgent Care – within 24 hours after the initial identification of need. (b) Outpatient follow up appointments – within 7 days after discharge from a hospital (c) Non-urgent, symptomatic care visit – within 7 days after the request (d) Well Care Visit – within 1 month after the request; unless an appointment is required sooner to ensure the provision of screenings in accordance with the Department's accepted Bright Futures schedules.	End-of-program access performance will be captured during April-June 2024. If all standards are met for this last report, the clinic will earn this part of the incentive.
Learning Collaboratives	Attend quarterly Learning Collaboratives.	Representatives must complete the post LC survey including their name and practice name.
	Additional incentives available to practices who present in a learning collaborative.	
Practice Assessment and Practice-Specific SMART Goal	Complete the Practice Assessment and SMART Goal with your coach	Generally completed between July 1, 2023 and September 30, 2023 with your coach in a practice transformation meeting
	Achievement of Smart Goal	SMART goal to be reassessed/adjusted (if needed) quarterly
Screening for Depression and Follow-up	Submit appropriate depression screen G-codes on Medicaid member claims	G-Codes: G8431 (POS) and G8510 (Neg), for claims submitted between 7/1/23 to 6/30/23.
	Close the gap by 10% or meet the RAE goal	Close the gap by 10% between your CY 2022 baseline and your CY 2023 performance on the Depression Screening Claims data (to be provided by coach). OR meet the RAE goal.
Well Visits: **0-15 months old OR**	Do a new PDSA to close well visit gaps with a focused age-range of members.	Some ideas:*Plan and execute an event that aligns with back to school/sports physicals where you can perform well visits.*Do a PDSA to verify you are using the correct codes to get credit on the Well

15-30 Months old OR 3-21 years old		Visit KPI. *Do an outreach campaign to patients with well visit gaps
	Close the gap by 10% or meet the RAE target on Child Well Visits First 15 months of life	Using claims-based KPI data, close the gap by 10% between your CY 2022 baseline and the RAE target with your CY 2023 performance on the Well Visits measure that you chose
	OR Close the gap by 10% or meet the RAE target on Child Well Visits 15-30 Months	
	OR Close the gap by 10% or meet the RAE target for Child and Child and Adolescent Well Visit Measure Ages 3-21	
Diabetes HgA1c Poor Control	Active work on meeting the measure	Examples: PDSA, workflow development, working a registry.
	Close the gap by 10% on the Diabetes A1c Measure or meet the State Goal	Close the gap by 10% between your CY 2022 baseline and the RAE target with your CY 2023 performance on the Diabetes A1c (poor control) measure. Practices will use eCQM data.
Controlling High BP	Active work on meeting the measure	Examples: PDSA, workflow development, working a registry.
	Close the gap by 10% on the Controlling High BP Measure or meet the State goal	Close the gap by 10% between your CY 2022 baseline and the RAE target with your CY 2023 the Controlling High BP Measure. Practices will use eCQM data.
Childhood Immunization Status (Combo 10)	Active work on meeting the measure	Examples: PDSA, workflow development, working a registry.
	Close the gap by 10% on the Controlling High BP Measure or meet the State goal	Close the gap by 10% between your CY 2022 baseline and the RAE target with your CY 2023 the Childhood Immunizations Measure. Practices can use either DAP or eCQM data.

Successes of the PT Incentive Program

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

- 29 of the 43 PCMPs improved KPI Well Child Visit rates.
- 18 of 19 PCMPs improved (lowered or maintained <19%) for Diabetes A1c Control for their population.
- 13 of 16 PCMPs improved Controlling Blood Pressure outcomes for their population.
- 3 out of 4 PCMPs improved Childhood Immunization rates.

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Outcomes from the FY23-24 BH PT Incentive Program
The BH practice transformation program chose to focus on the BHIP Indicator 1: Initiation and Engagement of Substance Use Disorder Treatment. The annual incentive per practice in the second iteration was $7,500. Outlined below is the comprehensive structure of the program for FY24 BH PT Program.

Milestone	Requirements Description	Outcome Requirements	HCI Incentive
Population Management/ Performance Improvement	SUD Engagement-Track SUD population and identify needs/gaps of care. Utilize a PDSA process to create a workflow to outreach identified clients, explore coding to impact performance, reduce no show rates, treatment engagement etc.	Using either agency EMR, or PowerBI (scorecard) Data determine baseline and then improve by 10% of 2022 baseline. Submit performance data by June 2024	**Tier 1 $1000**
			Tier 2 $1,500
		Tier 1: Complete at least one PDSA cycle	**Tier 3 $2,000**
		Tier 2: Close the gap by 10%	**Max possible: $2,000**
		Tier 3: Meet or exceed RAE target	
Integrated Care	PDSA cycle to develop process for shared expectations and exchange bi-directional information with PCP, work to develop a priority access protocol for clients referred by primary care.	Share two de-identified examples of referral/info exchange with PCP and/or share written process for priority access and provide an example.	**$2,000**
Performance Visualization Tool	Practice develops dashboard for tracking performance (SUD Engagement/Depression Screen Follow -up, measure based care tools, access, retention rates) and develops process for	Develop a performance visualization tool	**$1,500**
		OR	
		Provide a copy of the tool that you use to review performance data with clinical staff	

	sharing with clinical staff at least quarterly (Provider level performance)	**AND** Provide a list of quarterly scheduled meetings where data will be reviewed with staff	
Learning Collaboratives	Attend all 4 Learning collaboratives in FY 23-24	At least one practice representative attends each learning collaborative but does not have to be the same person each time. Representatives must complete the post LC survey including their name and practice name.	**$250 per learning collaborative Max of $1,000**
Practice Assessment	Complete the annual Practice Transformation assessment and complete PDSA to address any score that is a 1.	Generally completed between July 1, 2023 and September 30, 2023	**$500** to complete assessment
		AND	**$500** for SMART goal
			Max of $1,000
		Set SMART goal and review quarterly with coach	
			Total $7,500

The second iteration of the Behavioral Health Practice Transformation program began in July of 2023 and will conclude of June 2024. The number of participating practices is 12. The milestone completion rate was over 85%. On the Integrated Care Milestone practices completed assessments using the integrated practice assessment tool (IPAT) both before and after their PDSA intervention. The initial combined scores for integrated care were a 2.33 and the final scores were a 3.33 indicating an overall improvement of 42.9%. As shown above our incentive structure included a milestone on Population Management. The goal was to identify a priority population specifically members with SUD and identify needs as well as gaps of care. They were asked to complete a PDSA cycle to implement changes and assess effectiveness. Examples of successful PDSA's include:

- Advantage Treatment Centers had a goal of offering on-site MAT services therefore they have worked to establish a MOU with Porch Light Health formally known as Front Range.
- Compass Rose developed a new referral form and worked to establish relationships with a primary care provider close to their office. They also supplied the form to OBGYN

offices as they welcome women who are pregnant or in postpartum and are struggling with depression.
- Elevate Healthcare- Is in the process of establishing a MOU with the local community health center to offer MAT services to clients who are pregnant and using drugs. They also partnered with the Southern CO Harm Reduction Association and are set up to provide onsite services in the medical wing of the new Bessemer Wellness Center in Pueblo.

Other successes:
3 Quarterly Learning Collaboratives were held and a 4th one is scheduled for June 20, 2024. Topics included, Measure Based Care, Medical Necessity and Clinical Document Requirements, and Client Engagement and Retention. The learning collaboratives are well attended and per post meeting surveys approximately 87% of attendees are very satisfied and an average of 96% state the information presented is relevant to the work they are doing.

Challenges:

- Providers (especially PCMPs) note that they have an unmanageable number of measures with KPI, BHIP, PP, APM, and UDS measures.
- Accessing timely data: the five-month claims lag is a barrier to practices making changes to impact performance on the measures. We recommend a monthly data refresh with all claims data received to date.
- Focus performance on "active members" to provide a more accurate view of how the practice is actually doing on a measure.
- Lack of access to timely data for behavioral health providers as it related to BHIP's.
- Ongoing staff shortages and poor staff retention in the field of mental health and substance use.

Plans for Change in Strategy:

The PCMP PT Incentive program for FY24-25 goes live on July 1, 2024, and will have the same milestones as FY 23-24 with the addition of one new milestone: Health Equity. For this new milestone, the PCMP will be asked to use either practice-level data or HCPF data to identify a vulnerable population and to create a process improvement plan to help increase outcomes for one of the clinical measures in the program.
The goal for the next phase of the incentive program is focused on improving access, begin looking at health equity for the population, engagement in PT, and performance improvement linked to KPIs and APM measures.

The third iteration of the BH practice transformation program will begin July of 2024 and conclude in March of 2025 with a goal maintaining 12-14 practices. The program objectives will remain to challenge practices to engage in QI activities and innovation that positively impacts health outcomes. Milestones will once again include completing the annual practice assessment with a goal of improving their score in the category of "Focus on Addressing the Social Needs of Clients", holding quarterly learning collaboratives and a population management goal. New

milestones will include looking at health equity for their population and addressing team- based care to positively impact staff satisfaction and retention.

Provider Communications:

Achievements/Successes:

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Challenges:

We have noticed our average attendance declined over the last year. We are hoping to do more targeted roundtables and webinars to specific providers over FY25.

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One-on-One Provider Meetings:

HCI meets routinely with providers who are experiencing issues from claims payments to questions on adding a new provider, we will meet directly with the provider. Often times, HCI will have recurring meeting with a provider to ensure their ongoing issues are being addressed and resolved at the root-cause.

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