Quality Improvement Plan
Name: Health Colorado, Inc.
RAE: 4
Date: September 30, 2022

Health Colorado, Inc.

Quality Improvement Plan FY22-23

1. Purpose/Mission Statement

Health Colorado, Inc.'s (HCI) mission is to help people live their lives to the fullest potential. Everything we do is focused on improving the health of people under our care. Putting people at the center, HCI's system is built on a strong support structure of doctors, nurses, therapists, advocates, and mentors fulfilling members' behavioral, physical, and social health needs.

Who we are

HCI is a provider led locally driven community health plan that is focused on creating lasting change where we work and live.

Mission

Advancing individual and community health and wellness by creating a system of care that is accessible to every member we serve.

Our Promise

We are committed to individual empowerment and whole-person care.

We promise to support our Providers in quality care delivery.

We provide health equity to all.

Our Vision

At Health Colorado, we will improve the quality of life for the people we serve by advancing the highest quality, best practices in health care.

Our Values

Innovation: We seek creative ways to solve tough problems, embracing multiple points of view that challenge current ideas of what is possible.

Excellence: We care deeply about what we do resulting in work that surpass our stakeholders' expectations and needs, placing high standards of service, support, and compassion at the center of everything we do.

Compassion: We acknowledge, respect, and honor the fundamental value and dignity of all individuals. We demonstrate this in our decision-making and place inclusion as a priority. We acknowledge the diversity makes us better.

Accountability: We feel an obligation to act in the best interest of our community and the people we serve. We accept our responsibilities and believe accountability empowers others to succeed.

Partnership: We believe our ability to build trusted relationships with stakeholders and collaborate across communities breaks down silos and develops innovative strategies that improve the system of care and the health and wellness for everyone.

2. Quality Program Leadership

John Mahalik , Ph.D., MPA: Director of Quality Assurance [redacted]	**Jeremy White, MA:** Manager of BH Clinical Quality [redacted]
Stephanie Miller-Olsen BH Clinical Quality Audit Analyst, Senior [redacted]	**Courtney Hernandez, MS-HSV:** BH Clinical Quality Audit Analyst Senior [redacted]
Edward Arnold, MSN, BSN, BSE, CPHQ Performance Improvement Analyst [redacted]	**Andrea Zasowski** BH Clinical Quality Audit Analyst Senior [redacted]
Melissa Schuchman, MA: Business Info Analyst II [redacted]	

3. Year Objectives/Top Priorities

The top priorities for FY22-23 will be to address the continued improvement on key functional areas that relate to the RAE contract. Specific areas of focus are:

- Advance Health Colorado's Performance Measures Improvement Strategy and Goals
    - Promote excellent Bi-Directional HCPF Communication around Performance Measures

  - Improve timeliness and accuracy of internal performance measures data
  - Win on all performance measures

- Continued improvement on Key Performance Indicators (KPI) Measures
- Continued improvement on Performance Pool measures
- Continued improvement on Behavioral Health Incentive Program (BHIP) Measures
- Identification of a new Performance Improvement Project(s)
- Monitor progress on the goals written to in the HCI annual quality work plan
- Adapt to each contract amendment as necessary
- Identify areas for opportunities and potential roadblocks striving for solutions

Key Performance Indicators, Performance Pool Measures, and Behavioral Health Performance Incentive Measures

Performance measurement is a core function of HCI's Quality Management program. The primary goal of the Quality Management Program is to improve patient care and overall health outcomes, ensuring efficient utilization of services. Through data collection, measurement and analysis, and visualization of the aspects of care and service that demonstrate opportunities for improvement, HCI will identify and prioritize process improvement and quality improvement activities. Data collected for quality improvement projects and activities related to key indicators of quality, primarily focus on high-volume diagnoses or services and high-risk diagnoses, services, or special populations.

HCI strives to monitor provider performance based on the KPIs, behavioral health incentive program measures, and performance pool measures established by the Colorado Department of Health Care Policy & Financing (HCPF) for the RAE. Guided by HCI's Performance Measures Improvement Strategy and Goals, we seek to educate providers, staff, and stakeholders and to continue to develop interventions based upon our committee and provider recommendations as needed to improve performance. HCI will continue to share performance findings with its providers, staff, management team, and stakeholders through regular updates at the Quality Improvement Utilization Management (QIUM) Committee, the Care Coordination Committee, Health Neighborhood Collaborative, and the regional Performance Improvement Advisory Committee (PIAC), as well as work groups such as the Performance Measures Action Planning (PMAP) process and other meetings where applicable. HCI will work with practices, stakeholders, and other community organizations, as well as care coordination entities to evaluate performance and develop strategies to sustain continuous improvement.

HCI Performance Measures Improvement Strategy:

Health Colorado's senior leadership has established a performance measures improvement strategy in relation to RAE 4 contract-bound performance measures established by the Colorado Department of Health Care Policy and Financing (HCPF). Considering Health Colorado mission and population health strategic plan, the following strategic goals were developed in the Spring-Summer of 2022, serving as a framework for Health Colorado leadership and key stakeholders in FY 2022-23:

- *Performance Measure Strategy #1 – Excellent Bi-Directional HCPF Communication around Performance Measures* (HCI Performance Measures Strategy Workgroup)
  - *Element #1:* Ensure measure changes communicated to all pertinent parties

    - *Element #2:* Provide comprehensive feedback to HCPF on all measures (ex. Coding Gaps)

- *Performance Measure Strategy #2 – Improve timeliness and accuracy of internal performance measures data* (HCI Performance Measures Data Workgroup)
    - *Element #1:* Aggregate level visualization (dashboards) data for each measure (Slice by RAE level, Care Coordination Level, Provider level - group and practice), attention to equity in data slicing
    - *Element #2:* Provider/Practice level patient detail per measure
- *Performance Measure Strategy #3 – Win on all Performance Measures* (HCI Performance Measures Strategy Workgroup)
    - *Element #1:* Measure improvement prioritization
        - Prioritization Matrix – Strategy workgroup determines criteria (possible examples: how far from target, how many stakeholders required to improve measure, resources available, inter-related measures, finances)
    - *Element #2:* Effectively engage key stakeholders for improvement
        - Evaluate top performers (Gather Best Practice) and bottom performers (Facilitated Improvement) for Each Measure
    - *Element #3:* Process improvement facilitation (Dedicated Process Improvement Staff and Governance Structure)
        - Network/Practice Transformation (Primary Care and Behavioral Health) – Convene, motivate, and facilitate practices to improve practice level metrics and share best practice
        - RAE/Neighborhood Transformation (Performance Measures Action Plan (PMAP)) – Convene, motivate, and facilitate key stakeholders to improve RAE level measures
        - Care Coordination Transformation (Value Stream) - Convene, motivate, and facilitate key stakeholders to improve RAE level measures
    - *Element #4:* Effectively Incentivize Network to Perform on Key Measures
        - Clearly articulated funds flow to Provider/Key Stakeholder for performance
        - Facilitate engagement by providing meaningful/actionable data, improvement tools, and coaching

HCI Performance Measures Action Plan (PMAP):

The purpose of the HCI Performance Measures Action Plan (PMAP) process is to serve as a mechanism to further the HCI Performance Measures Strategy Work Group efforts and to drive performance improvement in collaboration with key RAE 4 stakeholders. Serving as a collaborative to promote continued learning and continued improvement, the HCI Performance Measures Strategy Work Group meets monthly and reports to the HCI QIUM Committee on a monthly basis.

Key stakeholders involved in the PMAP effort are HCI leadership, partners/providers, quality management staff, and members of the HCI QIUM Committee. The PMAP work group(s) will be led by a member of the HCI QIUM Committee and/or quality management staff. Over the course of FY 21-22, HCI senior leadership and members of the HCI QIUM Committee focused on establishing a strategic

framework to address performance measurement activity for RAE 4 on the following contract-based measures:

- *Key Performance Indicators (KPIs)*
- *Behavioral Health Incentive Program Measures (BHIPs)*
- *Performance Pool Measures (PPMs)*

Reviewing HCI performance in relation to benchmarks/goals/targets, the HCI Performance Strategy Work Group will periodically rank order measures, determining which measures to focus performance improvement activity within a rapid cycle framework. Building on the early PMAP work from FY21-22, HCI will now utilize the PowerBI application to analyze and visualize current performance by clinic/provider to identify sites with the greatest opportunity to impact measure success through process improvement activities. The PMAP work group(s) will be comprised of HCI leadership, quality management staff, and key RAE 4 partners/providers with opportunities for improvement, and may recruit partners/providers identified as strong performers to identify and document best practices as well. The PMAP work group(s) will report its activities in the monthly HCI QIUM Committee meetings, including review of HCI and provider-level performance data and identifying potential processes and countermeasures to increase overall performance.

The PMAP work group(s) will utilize the PowerBI dashboards along with the use of additional performance improvement tools (e.g., key drivers' diagram, failure mode, and effects analysis) to guide the work groups' efforts. The work group(s) will begin to focus on the measures that were prioritized for action in early FY22-23. HCI partner/provider representatives will be invited on an ad hoc basis to the work group meetings to review the performance data and make recommendations with feedback and support from the HCI QIUM Committee. Once a meaningful, manageable, and measurable set of interventions are identified and reviewed with the HCI leadership, the work group will coordinate with partners/providers to implement any measures and monitor performance over time, sharing their findings with the HCI QIUM Committee on a monthly basis. The work group will follow a rapid cycle, iterative process of planning, taking action (countermeasures), studying, and monitoring performance, and acting on what is learned.

PMAP Implementation Steps

The PMAP will be implemented (as described above) by the HCI Performance Measures Strategy Work Group using the following steps:

- Perform data analysis of key performance measures to identify intervention targets (KPIs, BHIPs, and PPMs).
- Identify and invite partner/provider representatives to review performance data and make recommendations for interventions.
- Process map transitions of care and work flows to identify gaps and promote standardization of clinical care and work.
- Develop implementation plan for targeted interventions.

- Coordinate with partners/providers to implement interventions and monitor/manage performance, using a pilot project methodology.
- Provide monthly updates on intervention results to the HCI Performance Measures Strategy Work Group and HCI QIUM Committee.
- Analyze/study results and make changes to implementation plan/strategy, as needed.
- Spread/disseminate generalizable findings to partners and provider organizations in RAE 4.

Performance Improvement Project

In the early months of FY22-23, HCI will close out the Performance Improvement Project (PIP) from FY21-22 that was conducted in collaboration with Valley-Wide Health in Alamosa. That PIP focused on improving the rates of Depression Screening and the Behavioral Health Follow-up Following a Positive Depression Screen. This PIP has been in progress for nearly two (2) years due to a hiatus directed by the Department in response to the Public Health Emergency. Following intervention testing and documentation of Plan-Do-Study-Act cycles by FY21-22, Module 4 of the Health Services Advisory Group (HSAG) methodology should be submitted in the second quarter of the FY22-23. This will document the results and lessons learned from the interventions implemented across these clinics. If clinically and programmatically significant improvements are observed, HCI will consider methods to disseminate these findings throughout the region. This will close out this PIP. Regardless of whether statistically significant improvement is achieved, the PIP illuminated how critical the process for appropriate coding is when evaluating process improvement using claims-based specifications. Attention to this portion of workflows related to Depression Screening as well as other claims-based measures will inform future efforts throughout the region.

The Department has communicated their intention to select a new topic for a PIP in FY22-23 with anticipated announcement in December 2022. The plan will require a clinical and a non-clinical PIP or a single PIP with both clinical and non-clinical performance indicators to align with CME Protocol 1. The HSAG PIP summit is slated to occur in early 2023. HCI plans to participate and develop appropriate PIP(s) by the estimated suspense date on July 1, 2023.

Audits

HCI conducts ongoing and random behavioral health audits based upon standardized audit tools to evaluate quality of care and compliance with the Health First Colorado (Colorado's Medicaid Program) documentation rules. The purpose of these audits is to ensure that contracted providers are meeting the guidelines established for service provision and that HCI maintains a high-performing network. The Colorado Department of Healthcare Policy and Financing requires us to evaluate the quality of care our members receive and the supportive documentation for claims. Audits may also be completed to ensure contractual compliance where needed. Where it is found that audit scores do not meet the minimum required threshold, HCI will educate the provider on deficiencies, offer training to the provider, require a corrective action plan (when warranted), re-audit the provider for continued improvement, and recoup funds if appropriate. These audit activities will continue in FY22-23.

HCI also undertakes a variety of activities aimed at evaluating and improving the quality of care for members. Provider treatment record documentation audits will continue quarterly, along with provider education in areas where scores indicate growth opportunities. If improvement is not seen, the corrective action process is initiated. Audits include a review of encounters/claims against the chart documentation.

Education on the topic of Health First Colorado documentation standards was offered to providers throughout the fiscal year and will continue throughout the next fiscal year. The same quality staff who conduct the documentation audits facilitated the educational forums. In addition to offering in-person documentation standards training to our providers, there were four (4) in-person, daylong trainings conducted by the auditors. Many providers had the opportunity to engage in specific discussions and ask clarifying questions about documentation standards. To provide further support, HCI has provided provider-specific training via Zoom to allow for a more personalized, agency-specific training experience for all staff. HCI will continue this education.

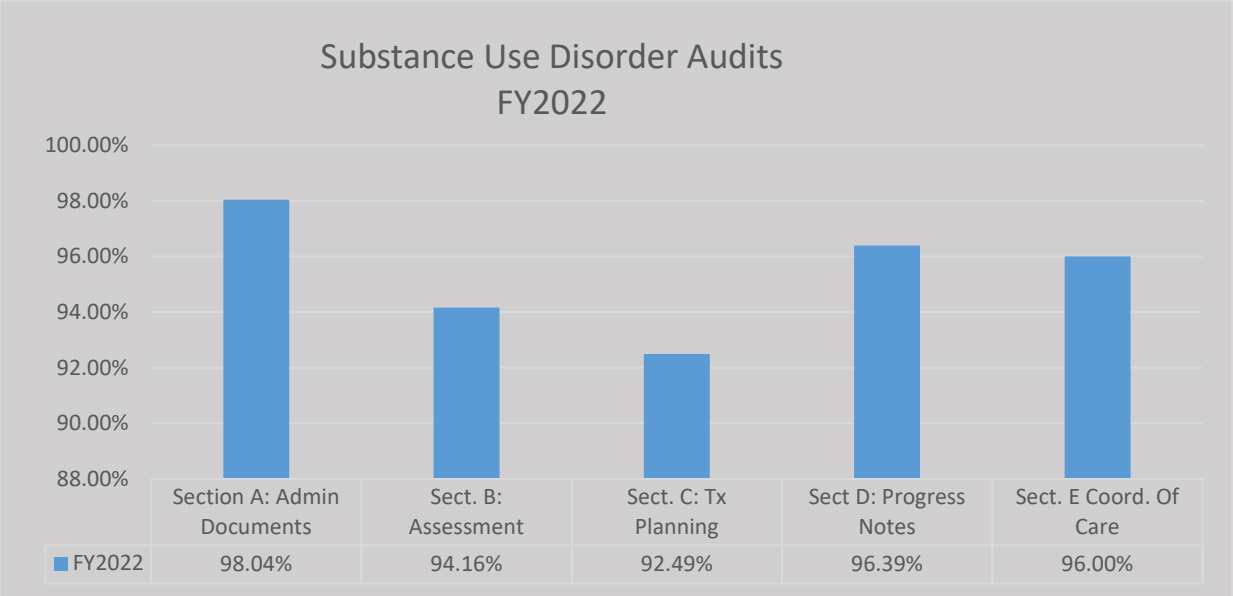
Examples of current audits include but are not limited to:

Substance Use Disorder (SUD) Audits

To date, eight (8) Substance Use Disorder (SUD) outpatient, Medication Assisted Treatment (MAT), and SUD Detox providers completed a SUD audit totaling fifty-eight (58) member charts. (See Audit Results in the following charts listed in the subsequent sections of this document). Regular and recurring audits and training will continue throughout the year to ensure proper documentation and support to our provider network.

SUD outpatient audits consist of reviewing five sections of the member chart (administrative, clinical assessment, treatment planning, progress notes, and coordination of care). In order to pass the audit, the member must meet medical necessity, and the provider must score eighty (80%) percent or better on each of the aforementioned sections. If the provider passes each section with eighty (80%) percent or better, the provider will be audited in one year. Providers who fail any category as outlined in the audit tool with seventy-nine (79%) percent or below will be audited in six (6) months. In addition to a review of written documentation, a claims review is completed to ensure services are provided in accordance with and meets the requirement of the Uniform Service Coding Standards (USCS). A failed audit could result in consequences to include, but not limited to, required education, recoupment, corrective action plan (CAP), and referral to Provider Relations or other licensing agency.

Recently, on June 29, 2022, an SUD documentation training was held for SUD providers. Several providers have also participated in individualized training sessions offered by HCI auditors.



Summary of SUD Performance

There has been significant improvement in SUD outpatient audit results; however, improvement needs to take place. Medical necessity: although not represented in the scoring algorithm, this represents the most common weaknesses in documentation requirements; however, there has been significant improvement in this area. SUD outpatient providers historically struggle with medical necessity for members who have recently been released from incarceration, as these members may not present with current SUD use, and auditors work diligently to provide further guidance to providers concerning what is required to meet medical necessity for this population, which can be attributed to improvement in this area.

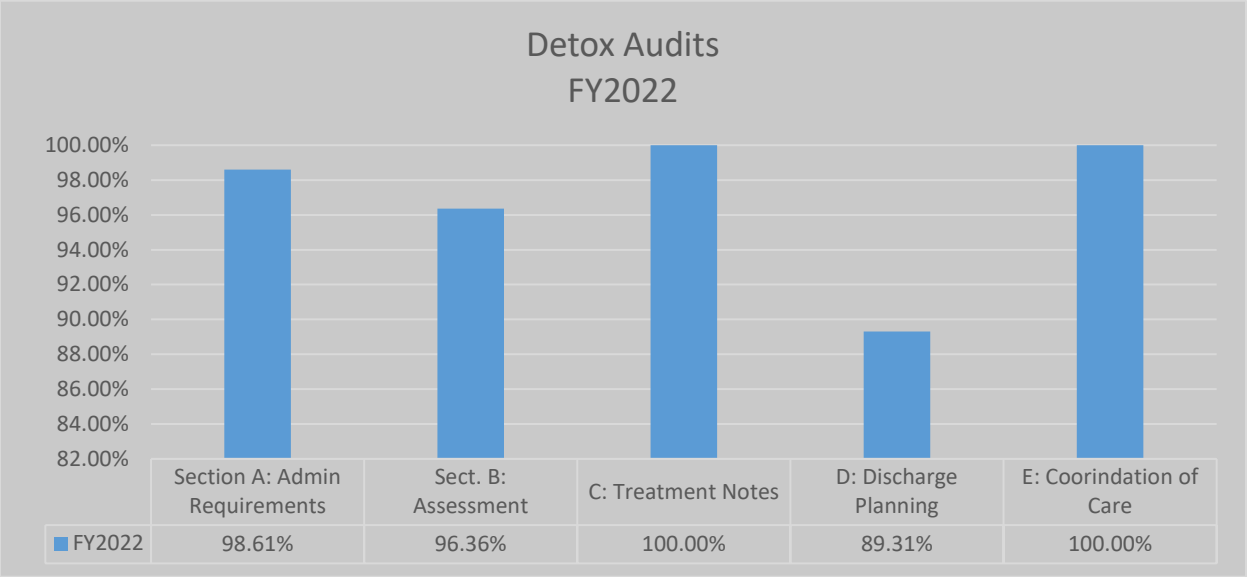
HCI offers in-person documentation training to its provider network quarterly and has implemented a strategy to reach out to providers with low or failing scores one (1) month after the audit is complete to offer further assistance. In addition, HCI also offers one on one documentation trainings to its network. This open communication allows for relationship building between practices and HCI.

Detox Audits

Detox audits consist of reviewing five sections of the member chart (Administrative, Clinical Assessment, Treatment Notes, Discharge Planning/Summary, and Coordination of Care). In order to pass the audit, the member must meet medical necessity, and score eighty (80%) percent or better on each of the aforementioned sections. If the provider passes each section with eighty (80%) percent or better, the provider will be audited in one year. Providers who fail any category as outlined in the audit tool with seventy-nine (79%) percent or below they will be audited in six (6) months. A failed audit could result in consequences to include, but not limited to, required education, recoupment, corrective action plan (CAP), and referral to Provider Relations or other licensing agency.

Although the categories for detox audits are similar in nature to SUD outpatient audits, there are several detox specific requirements reviewed that include but are not limited to; initial health screen, vital signs

check in accordance with standards based on member symptoms, Clinical Institute Withdrawal Assessment (CIWA), Clinical Opiate Withdrawal Scale (COWS), or other monitoring tools, readiness for change review, and referral to outpatient provider.



Summary of Detox Performance

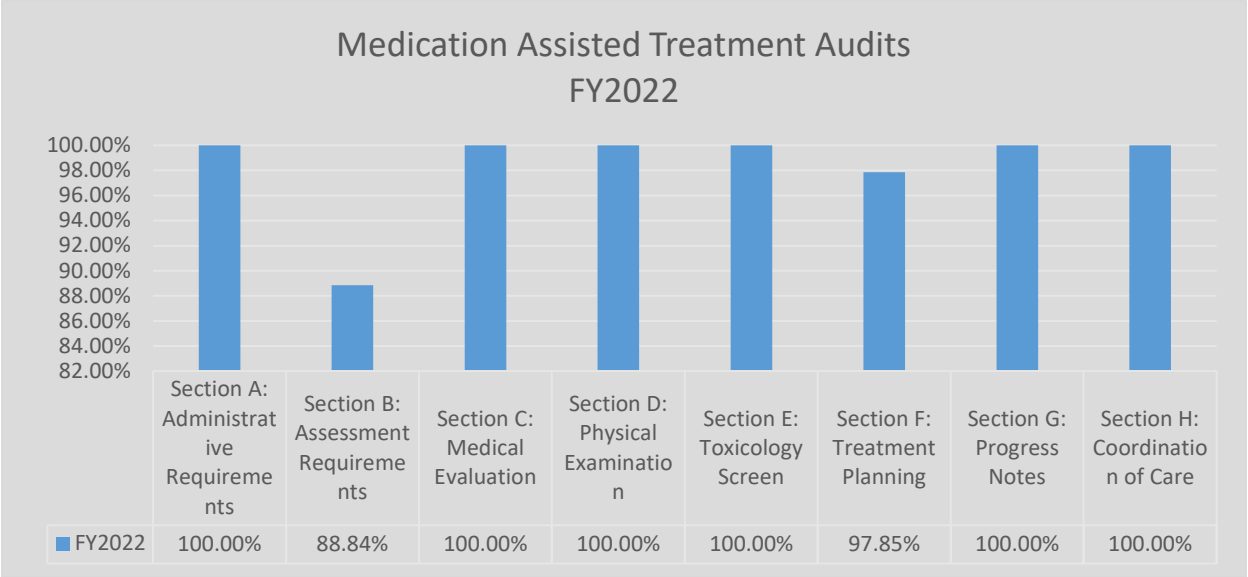
Overall, providers met the documentation standards, showing continued Improvement in all areas with exceptions of discharge planning.

A continued effort to work closely with detox providers to ensure passing scores will continue.

Medication Assisted Treatment (MAT)

Medication Assisted Treatment (MAT) audits consist of reviewing eight sections of the member chart (administrative, assessment, medical evaluation, physical examination, toxicology screen, treatment planning, progress notes, and care coordination). In order to pass the audit, the member must meet medical necessity and the provider must score eighty (80%) percent or better on each of the aforementioned sections. If the provider passes each section with eighty (80%) percent or better, the provider will be audited in one year. Providers who fail any category as outlined in the audit tool with seventy-nine (79%) percent or below they will be audited in six (6) months. A failed audit could result in consequences to include, but not limited to, required education, recoupment, corrective action plan (CAP), and referral to Provider Relations or other licensing agency.

Although the categories for MAT audits are similar in nature to SUD outpatient audits, there are several MAT specific requirements reviewed that include but are not limited to, medical evaluation, physical examination, and toxicology screening.



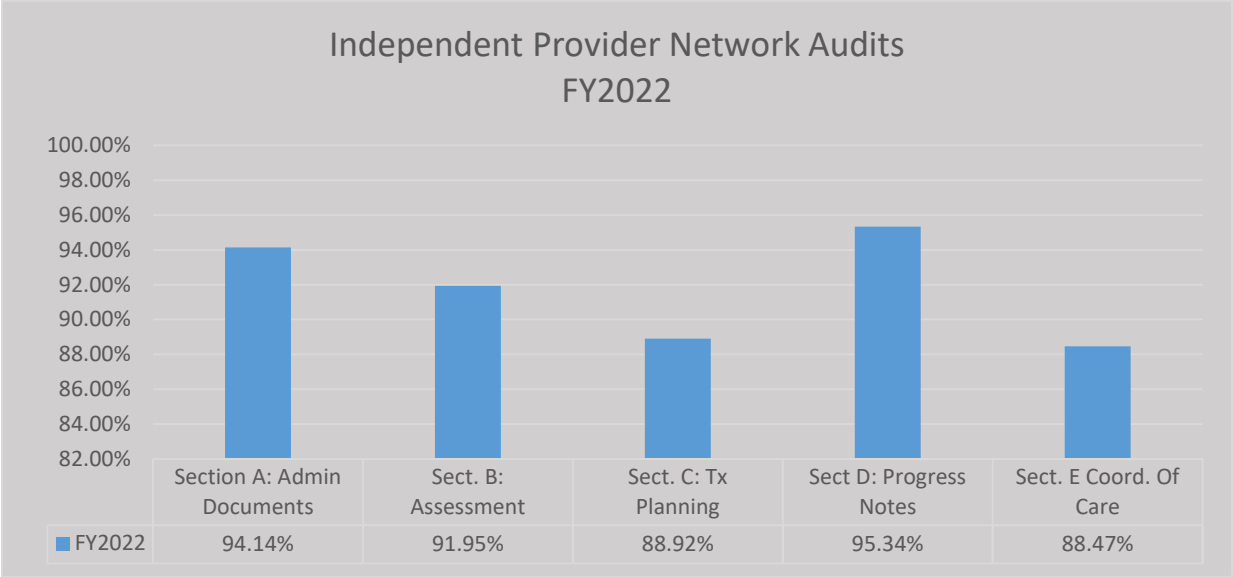
Summary of MAT Performance

MAT providers have made significant improvements in documentation for all domains increasing their scores in all areas whereas the previous year showed two failing domains. Due to the efficiency of these audits, HCI will continue the same audit procedures.

Mental Health Audits

Routine Mental Health audits continue to be completed for Region 4 Independent Provider Network (IPN) providers. To date, sixteen (16) providers have been audited. Of those sixteen (16) providers, five of those failed to meet the minimum passing score of eighty (80%) percent or better. Many providers have also participated in individualized training sessions offered by HCI auditors. See Audit Results in the following charts for an aggregate summary of provider performance. Regular and recurring audits and training will continue throughout the year in order to ensure proper documentation and support to our provider network will continue to be supplied.

Mental Health outpatient audits consist of reviewing five sections of the member chart (administrative, clinical assessment, treatment planning, progress notes, and coordination of care). In order to pass the audit, the member must meet medical necessity, and the provider must score eighty (80%) percent or better on each of the aforementioned sections. If the provider passes each section with eighty (80%) percent or better, the provider will be audited in two (2) years. Providers who fail any category as outlined in the audit tool with seventy-nine (79%) percent or below they will be audited in six (6) months. In addition to a review of written documentation, a claims review is completed to ensure services are provided in accordance with and meet the requirement of the Uniform Service Coding Standards (USCS). A failed audit could result in consequences to include, but not limited to, required education, recoupment, corrective action plan (CAP), and referral to Provider Relations or other licensing agency.



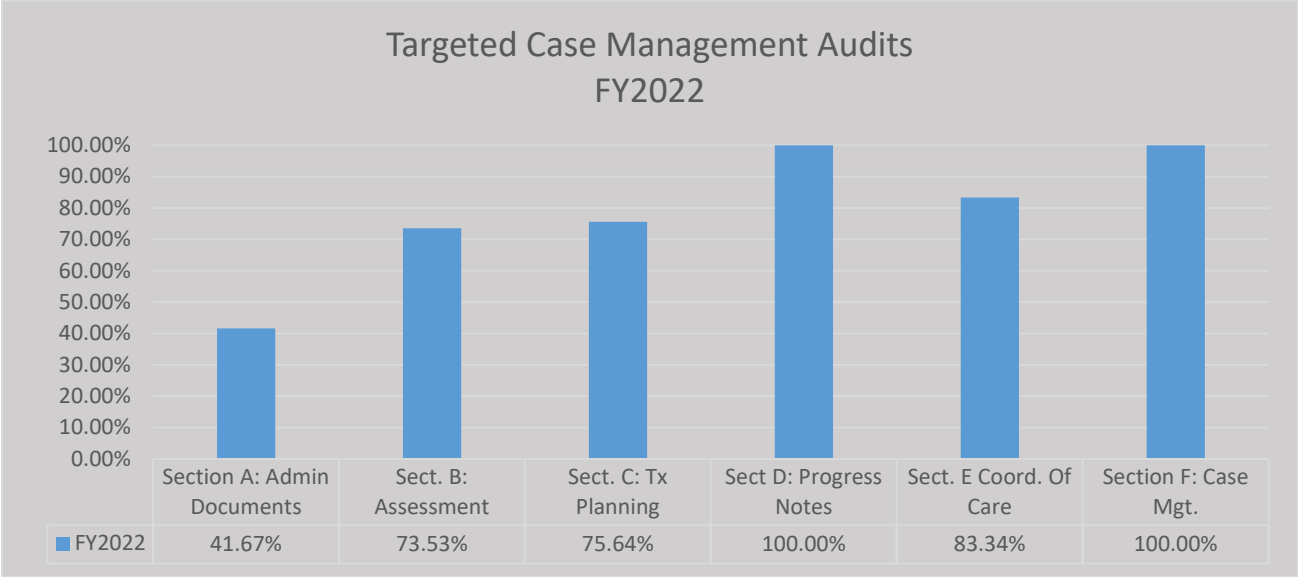
Summary of IPN Performance

Provider aggregate scores demonstrated improvement all areas. This can be attributed to increased focus on these elements during provider trainings throughout the year.

There will be continued focus on all areas of documentation standards through provider education, quarterly documentation standards training, and one-on-one trainings.

Targeted Case Management (TCM)

Targeted Case Management audits are similar in nature to substance use and mental health outpatient audits consist of reviewing the five (5) sections of the member chart (administrative, clinical assessment, treatment planning, progress notes, and coordination of care) and further including a review of requirements specific to the TCM billing requirement as outlined in the Uniform Service Coding Standards (USCS). In order to pass the audit, the member must meet medical necessity, and the provider must score eighty (80%) percent or better on each of the aforementioned sections. If the provider passes each section with eighty (80%) percent or better, the provider will be audited in one year. Providers who fail any category as outlined in the audit tool with seventy-nine (79%) percent or below they will be audited in six (6) months. In addition to a review of written documentation, a claims review specific to TCM is completed to ensure services are provided in accordance with and meet the requirement of the USCS. A failed audit could result in consequences to include, but not limited to, required education, recoupment, corrective action plan (CAP), and referral to Provider Relations or other licensing agency.



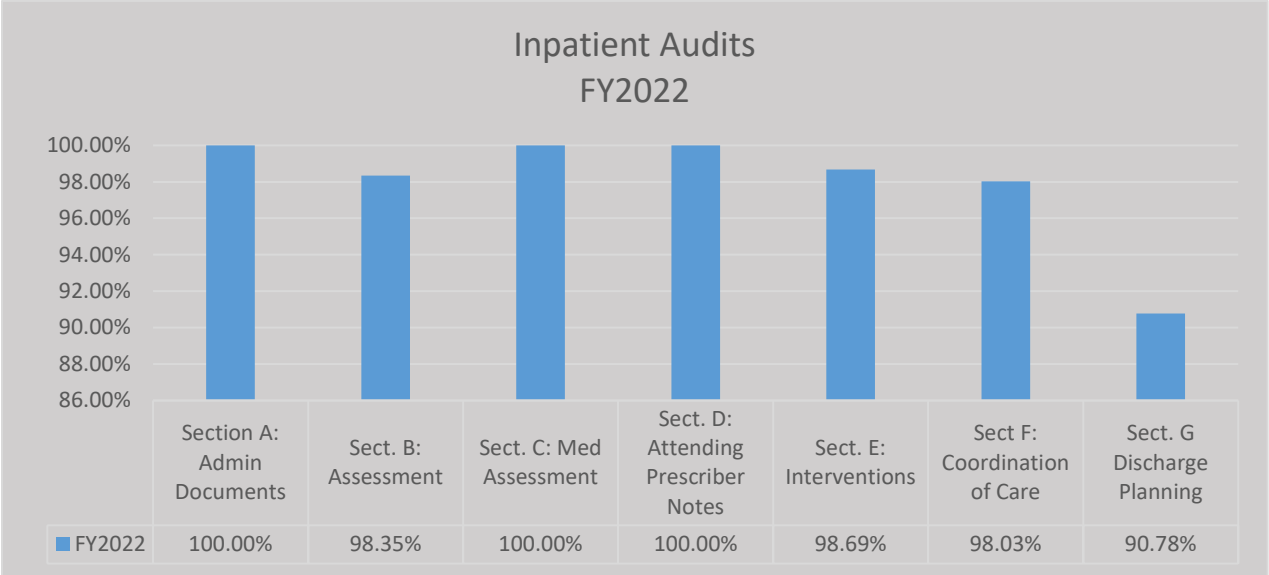
Summary of TCM Performance

There is a continued need for improvement in Targeted Case Management (TCM) audit results. Lacking and incomplete documentation was a significant source of the low scores. Treatment planning was generally weak in insuring objectives are measurable and goals are based on a level of change required to successfully complete treatment. Significant improvement was found in the documentation of case management services in accordance with USCS standards.

There will be continued focus on the areas of weakness through provider education, quarterly documentation standards training, and one-on-one trainings.

Inpatient Audits

Inpatient treatment audits consist of reviewing seven sections of the member chart (administrative, assessment, medical assessment, attending prescriber notes, daily interventions, coordination of care, and discharge planning). In order to pass the audit, the member must meet medical necessity, and the provider must score eighty (80%) percent or better on each of the aforementioned sections. If the provider passes each section with eighty (80%) percent or better, the provider will be audited in one year. Providers who fail any category as outlined in the audit tool with scores less than eighty (80%) percent they will be audited in six (6) months. A failed audit could result in consequences to include, but not limited to, required education, corrective action plan (CAP), and referral to Provider Relations or other licensing agency.



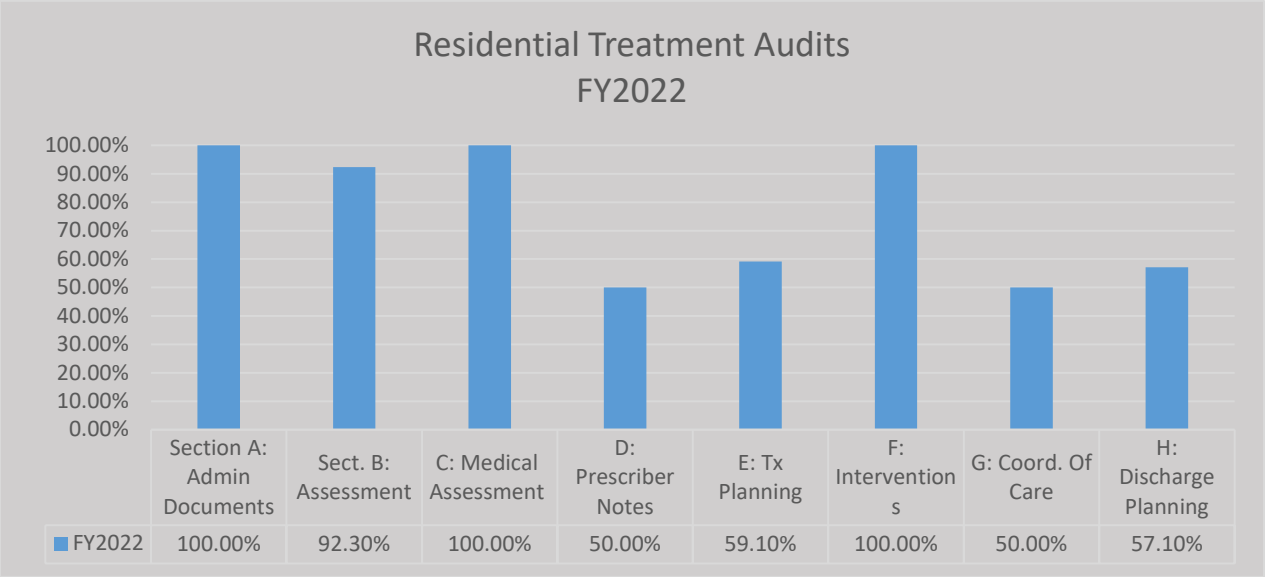
Summary of Inpatient Performance

Inpatient facilities continue to pass all domains required. Discharge planning was the lower scoring domain due to the lack of scheduling of follow-up appointments with outside providers.

There will be continued focus on the areas of weakness through provider education, quarterly documentation standards training, and one-on-one trainings.

Residential Treatment Center Audits

Residential treatment audits similarly to that of inpatient treatment audits consist of reviewing seven sections of the member chart (administrative, assessment, medical assessment, attending prescriber notes, interventions, coordination of care, and discharge planning). In order to pass the audit, the member must meet medical necessity, and the provider must score eighty (80%) percent or better on each of the aforementioned sections. If the provider passes each section with eighty (80%) percent or better, the provider will be audited in one year. Providers who fail any category as outlined in the audit tool with seventy-nine (79%) percent or below they will be audited in six (6) months. A failed audit could result in consequences to include, but not limited to, required education, corrective action plan (CAP), and referral to Provider Relations or other licensing agency.



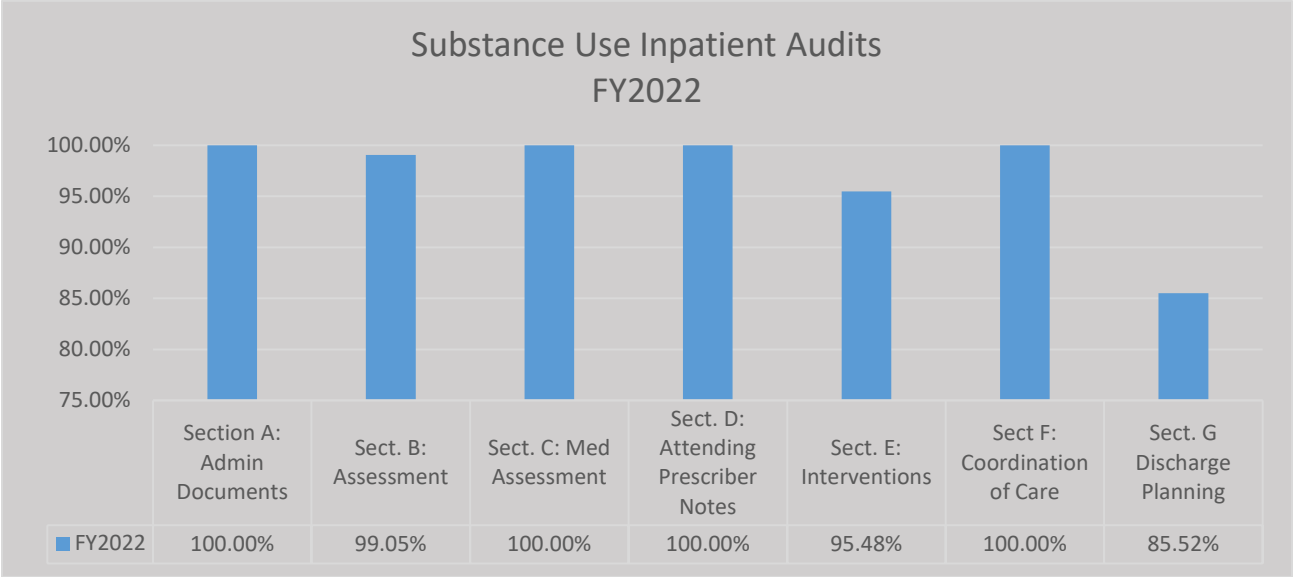
Summary of Residential Treatment Center Performance

Residential treatment showed some decline in several domains. Prescriber notes, treatment planning, care coordination and discharge planning were the lower scoring domains.

There will be continued focus on the areas of weakness through provider education, quarterly documentation standards training, and one-on-one trainings.

Substance Use Inpatient Audits

Substance use inpatient treatment audits consist of reviewing seven sections of the member chart (administrative, assessment, medical assessment, attending prescriber notes, daily interventions, coordination of care, and discharge planning). In order to pass the audit, the member must meet medical necessity, and the provider must score eighty (80%) percent or better on each of the aforementioned sections. If the provider passes each section with eighty (80%) percent or better, the provider will be audited in one year. Providers who fail any category as outlined in the audit tool with scores less than eighty (80%) percent they will be audited in six (6) months. A failed audit could result in consequences to include, but not limited to, required education, corrective action plan (CAP), and referral to Provider Relations or other licensing agency.



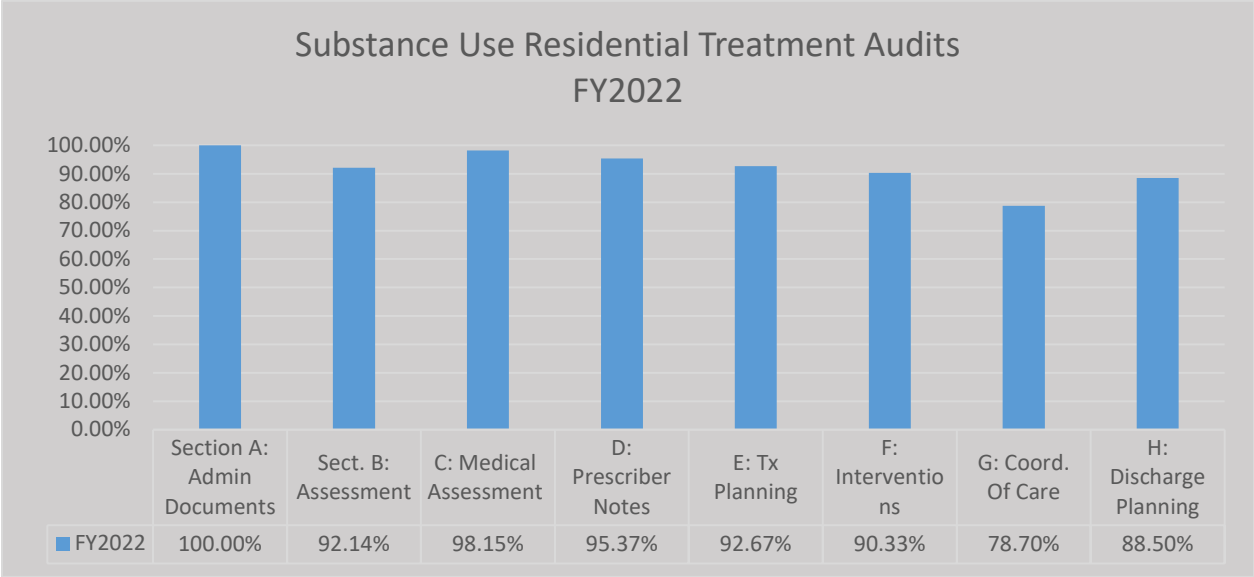
Summary of Substance Use Inpatient Performance

This was the first year this audit type has been completed. Substance use inpatient facilities passed all domains required.

There will be continued focus on the areas of weakness through provider education, quarterly documentation standards training, and one-on-one trainings.

Substance Use Residential Treatment Center Audits

Substance use residential treatment audits similarly to that of substance use inpatient treatment audits consist of reviewing seven sections of the member chart (administrative, assessment, medical assessment, attending prescriber notes, interventions, coordination of care, and discharge planning). In order to pass the audit, the member must meet medical necessity, and the provider must score eighty (80%) percent or better on each of the aforementioned sections. If the provider passes each section with eighty (80%) percent or better, the provider will be audited in one year. Providers who fail any category as outlined in the audit tool with seventy-nine (79%) percent or below they will be audited in six (6) months. A failed audit could result in consequences to include, but not limited to, required education, corrective action plan (CAP), and referral to Provider Relations or other licensing agency.



Summary of Substance Use Residential Treatment Center Performance

Substance use residential treatment passed all domains with exception of coordination of care. Substance use residential treatment providers have been trained to include care coordination as part of their treatment program to support improvement in FY22-23.

There will be continued focus on the areas of weakness through provider education, quarterly documentation standards training, and one-on-one trainings.

Care Coordination Audits

Care coordination involves identifying the needs of members especially those with complex care needs and chronic conditions and providing them with the care and resources that meet these needs. It is sub-divided into care navigation and care management. Care navigation entails removing barriers to accessing care that members may encounter and linking them up with services and resources that they need. On the other hand, care management entails supporting members with complex care needs and chronic conditions by ensuring they get the care they need, and they are engaged with the care process to improve their health outcomes. In FY22-23, care coordination entities will explicitly declare which subset(s) of care coordination they intend to deliver. The assignment of Complex members based on the new Complex definition effective 1/1/22 will factor in the level of service each entity will provide.

The results of the Process Improvement Experience (PIE) model for care coordination audits used in FY21-22 will inform the scheduling of audits within FY22-23, but must consider the services to be provided by each relevant entity within FY22-23. Early in FY22-23, HCI will validate that the PIE tool still aligns with HCI Care Coordination policy and revise elements, as appropriate, to isolate care management versus care navigation tasks. The intention of the PIE to facilitate organizational growth and recognize exceptional performance will continue, as reviews will be scheduled later in FY22-23 using the revised tool and revised plan.

External Quality Review Organization (EQRO)

In March of 2022, HCI underwent an external audit conducted by Health Services Advisory Group (HSAG) who is the EQRO contracted with the Department. There were four (4) standards reviewed. These four standards were:

- Coordination and Continuity of Care
- Member Rights, Protections and Confidentiality
- Member Information Requirements
- Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT)

The Coordination and Continuity of Care section as well as the Member Rights, Protections, and Confidentiality sections both earned perfect scores of 100%. The Member Information Requirements section and the EPSDT section both earned scores of 86%. All sections combined for an average compliance score of ninety-two (92%) percent.

HSAG noted several areas of strong performance for HCI across the four (4) standards audited. For the Coordination and Continuity of Care section, HSAG noted that, "HCI provided care coordination and continuity of care for all members in Region 4 through three levels of support: 1) primary care medical providers (PCMPs), 2) Accountable Care Coordination Entities, and 3) Beacon Health Options (Beacon) for complex case management. HCI's eight delegated Accountable Care Coordination Entities included High Plains Community Health Center, San Luis Valley Health, San Luis Valley Behavioral Health Group, Health Solutions, Valley-Wide Health Systems, Solvista Health, Southeast Wellness Works, and Plan de Salud del Valle. Each Accountable Care Coordination Entity signed the Primary Care Medical Provider Agreement, which designated the PCMP as the primary source for behavioral health and physical health care coordination and case management activities. For PCMPs unable to perform extensive care coordination for members with complex health needs, the delegated Accountable Care Coordination Entity would provide care coordination to those applicable members. Additionally, Beacon provided oversight of HCI's care coordination program as the administrative service organization (ASO). As the ASO, Beacon was able to support the delegated care coordination entities and members with complex and intense care needs. HCI's care coordination policies and procedures documented processes for care coordination and continuity of care for all members."

For the Member Rights, Protections, and Confidentiality section, HSAG noted that, "HCI delegated the administrative responsibility of member rights to Beacon. HCI's Member Experience Advisory Council (MEAC) and member engagement team worked to uphold the rights of members. Some of the responsibilities of the member engagement specialist were to discuss and resolve any issues relating to member rights, protection, and confidentiality. The Member Rights and Responsibility policy described the various channels used to notify members when there are revisions to HCI's policies. Members were informed of their rights through the member handbook, member newsletters, periodic informational forums, and website postings. Providers received information about member rights through policy statements, the provider manual, and provider emails and were required to display posters at office locations. In addition, members exercised their rights by providing feedback and suggestions, and may report complaints through the ethics hotline. Staff members stated that 90 percent of members report complaints through phone calls or in person."

For the Member Information Requirements section, HSAG noted that, "HCI delegated the administrative and operational processes related to member information to Beacon. The Member Information Requirements policy discussed Beacon's processes to ensure that member informational materials are provided in plain language and are culturally and linguistically appropriate. During the review, staff members stated that HCI uses the Flesch-Kincaid method to ensure sixth-grade readability levels and described how the MEAC participates in testing the format and language of member informational materials."

Finally, in the EPSDT section, HSAG noted that, "HCI delegated Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) administrative procedures to Beacon. Policies and procedures comprehensively addressed EPSDT services for members 20 and under and outlined the role of both behavioral health and PCMP providers within HCI's network. The provider handbook and contract agreements further detailed the role of providers in screening, assessing, referring, and treating members based on medical necessity and EPSDT requirements. Beacon staff members in the call center and in care coordinator roles were available to coordinate appointments and transportation as needed or connect the member back with their PCMP, therapist, specialist, or local agencies as appropriate. Staff members described helping members with transportation frequently."

With the findings presented by HSAG, HCI considers the annual EQRO audit to be a success. With that said, HSAG did provide corrective action plans to HCI for the Member Information Requirements section and the EPSDT section. HCI will work alongside HSAG in order to meet all corrective action deadlines and requirements.

411 Audits

In FY21-22, HCI conducted its annual Claims and Encounter Validation audit (411 audit). For the second year, the audited services categories s were inpatient services, psychotherapy services, and residential services.

Psychotherapy

As presented in the psychotherapy table below, HCI observed a high level of accuracy in the psychotherapy section of the audit. HCI achieved accuracy scores between eighty-five (85%) percent and ninety-nine (99%) percent, with an average percentage of accuracy of ninety-seven (97%) percent. HCI's strongest categories of performance, which all achieved accuracy scores of ninety-nine (99%) percent were:

- Procedure Code
- Service Category Modifier
- Unit
- Start Date
- End Date
- Appropriate Population
- Duration
- Staff Requirement

In order to continue with performance in the psychotherapy service category, HCI will continue to provide education to its provider network on documentation standards that are associated with the annual claims and encounter validation audit. As demonstrated in this audit, one encounter service category did fall below the established benchmark of ninety percent (90%). As a result, HCI has implemented a corrective action plan with the identified provider. The goal is to bring providers performance back into compliance with established standards. In addition, the provider will also be required to engage in the Quality Improvement Process (QUIP) project. The table below presents the audit-scoring summary for HCIs response data file for psychotherapy encounter lines.

Requirement Name	RAE Region Number	Service Category	Numerator	Denominator	%
'Procedure Code'	R4	Psychotherapy	135	137	99%
'Diagnosis Code'	R4	Psychotherapy	131	137	96%
'Place of Service'	R4	Psychotherapy	116	137	85%
'Service Category Modifier' (Procedure Modifier 1)	R4	Psychotherapy	136	137	99%
'Unit'	R4	Psychotherapy	136	137	99%
'Start Date'	R4	Psychotherapy	136	137	99%
'End Date'	R4	Psychotherapy	136	137	99%
'Appropriate Population'	R4	Psychotherapy	136	137	99%
'Duration'	R4	Psychotherapy	136	137	99%
'Staff Requirement'	R4	Psychotherapy	136	137	99%

Residential

As presented in the residential table below, HCI observed a very high level of accuracy in the residential section of the audit. HCI achieved accuracy sores ranging between ninety-seven (97%) percent and ninety-eight (98%) percent across all ten (10) encounter categories.

In order to continue with this level of high performance in the residential service category, HCI will continue to provide education to its provider network on documentation standards that are associated with the annual claims and encounter validation audit. In the event that performance on any encounter service categories fall below the established benchmark of ninety percent (90%), HCI will implement corrective action, plans to bring provider performance back into compliance with established standards.

As presented in the residential table below, HCI observed a high level of accuracy in the residential section of the audit. HCI achieved accuracy scores between ninety-seven (97%) and ninety-eight (98%)

percent, with an average percentage of accuracy of ninety-eight (98%) percent. HCI's strongest categories of performance, which all achieved accuracy scores of ninety-weight (98%) percent were:

- Procedure Code
- Place of Service
- Service Category Modifier
- Start Date
- End Date
- Appropriate Population
- Duration and Staff Requirement

The table below presents the audit-scoring summary for HCIs response data file for Residential encounter lines.

Requirement Name	RAE Region Number	Service Category	Numerator	Denominator	%
'Procedure Code'	R4	Residential	134	137	98%
'Diagnosis Code'	R4	Residential	133	137	97%
'Place of Service'	R4	Residential	134	137	98%
'Service Category Modifier' (Procedure Modifier 1)	R4	Residential	134	137	98%
'Unit'	R4	Residential	133	137	97%
'Start Date'	R4	Residential	134	137	98%
'End Date'	R4	Residential	134	137	98%
'Appropriate Population'	R4	Residential	134	137	98%
'Duration'	R4	Residential	134	137	98%
'Staff Requirement'	R4	Residential	134	137	98%

Inpatient

As presented in the inpatient table below, HCI observed a very high level of accuracy in the inpatient section of the audit. HCI achieved accuracy scores between ninety-six (96%) percent and one hundred (100%) percent. HCIs strongest categories of performance, which all achieved accuracy scores of one hundred (100%) percent, were:

- Principal Surgical Procedure Code and

- Revenue Code

HCI also demonstrated strong performance, achieving accuracy scores of ninety-nine (99%) percent in the following categories:

- Discharge Status
- Start Date and
- End Date

The table below presents the audit-scoring summary for HCIs response data file for Inpatient encounter lines.

Requirement Name	RAE Region Number	Service Category	Numerator	Denominator	%
'Principal Surgical Procedure Code'	R4	Inpatient	137	137	100%
'Primary Diagnosis Code'	R4	Inpatient	131	137	96%
'Revenue Code'	R4	Inpatient	137	137	100%
'Discharge Status'	R4	Inpatient	135	137	99%
'Start Date'	R4	Inpatient	136	137	99%
'End Date'	R4	Inpatient	135	137	99%

Based upon the scores presented within this document, HCI considers there to be a high level of validity and reliability between the submitted claims and encounters and the audited sample of randomly selected charts for the measurement period of July 1, 2020, through June 30, 2021. In an attempt to create a positive impact on the next 411 audit, HCI sent out training to providers on the 411 audits, its service categories, and common areas of concern. HCI will plan to conduct this activity in FY 22- 23 as well.

Potentially Avoidable Complications/Costs (PAC)

The Department dissolved PAC as a KPI program in FY22-23. Initiatives and progress related to the three (3) episodes of care described in last year's PAC Plan (SUD, diabetes, pregnancy) will be incorporated into FY22-23 Population Health and Condition Management Programs, as appropriate. The Department should update Care Improvement Opportunity Tool (CIOT) in FY22-23 and this data could inform condition management strategy along with Elli predictive analytics and other data sources.

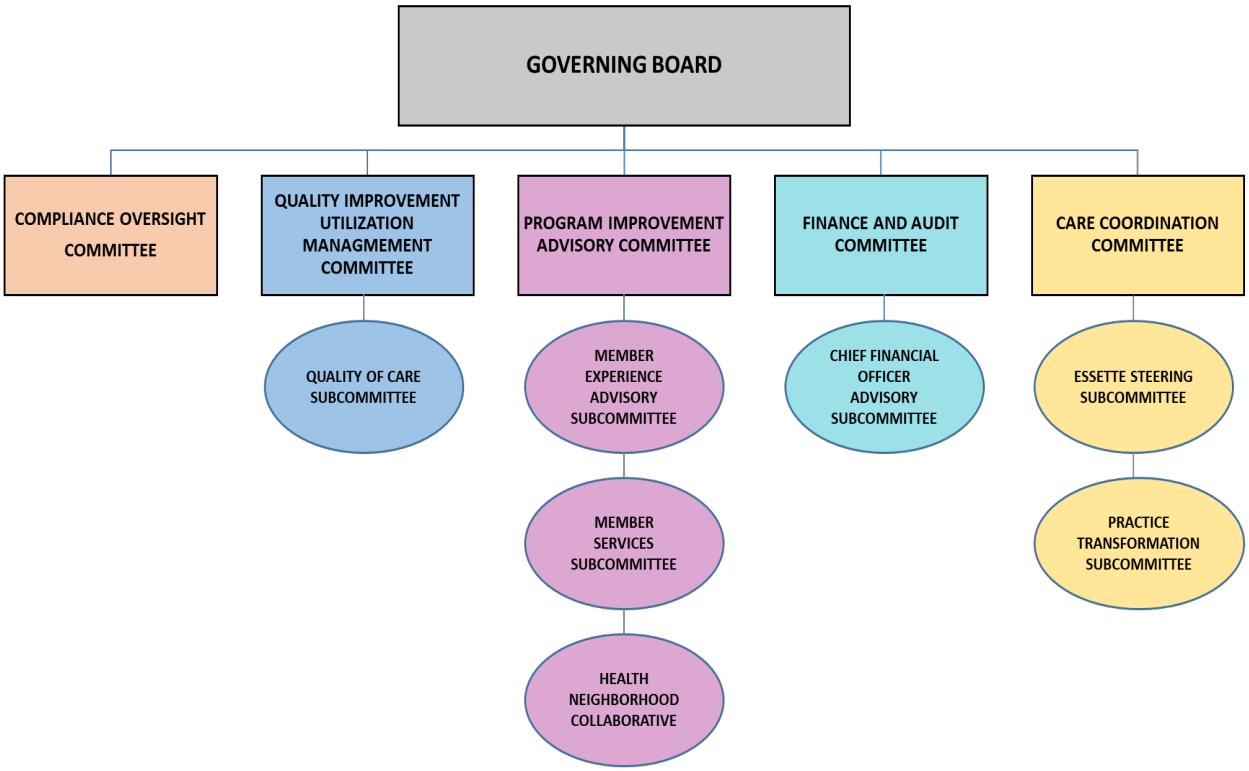
Committee and Subcommittee Structure

Various committees and subcommittees have been established to assist in meeting the goals of the Quality Management Program. Cross-representation on committees has been a key to effective committee work and having the Quality Director serving as a member of the Coordination of Care Subcommittee has provided insight into challenges, as well as improved clarity around the KPIs,

Performance Pool, and Behavioral Health Incentive measures. These are just a couple of examples of this cross-representation on committees.

As part of ongoing strategic planning efforts, HCI's Board of Directors and Program Officer will collaborate with HCI senior management to review and update the HCI Committee Structure in FY22-23 if necessary. The updated HCI Committee Structure aligns with HCI's Population Health strategic plan and informs HCI's approach to coordinating with stakeholders to meet its contractual obligations and actualizing HCI's goals and objectives in service of HCI members. Please see the below updated HCI Committee Structure.

Health Colorado, Inc. Committee Structure



In addition, ad-hoc meetings with providers have begun to get input from a point of care perspective and will continue. HCI has created a work plan for continued process improvement, which is reviewed quarterly at the HCI QIUM Committee. The details of the work plan are at the bottom of this Quality Improvement Plan Document.

Performance Measures Strategy and PMAP Work Groups

In FY20-21 and FY 21-22, HCI senior leadership held planning sessions to discuss problem-solving techniques surrounding specific KPI measures, Performance Pool, and Behavioral Health Incentive Program (BHIP) Measures. The HCI senior leadership planning sessions resulted in the establishment of the Performance Measures Strategy Work Group and the (PMAP) Work Group to address BHIP performance with BH providers in RAE 4 as initial focus in Phase I. A topic for discussion was emergency department (ED) utilization: what are the most common reasons for avoidable ED visits; what has been done to reduce avoidable ED visits; and what interventions have worked to reduce avoidable ED visits overall. At these meetings, stakeholders also came together to identify barriers to KPI performance, to understand potential roadblocks, and to address possible areas of strength that would directly affect a positive trend upon KPI performance. In addition, in FY21-22, stakeholder work groups were held with providers to discuss problem-solving techniques surrounding specific KPI measures and the impact that the COVID-19 pandemic had upon the performance on the measures. It was determined that the use of telehealth services was essential to providing continued care to our members. In an effort to educate providers about the use of telehealth and how to submit a claim with the telehealth place of service code, several provider support calls were held, and email alerts were distributed. At these calls, telehealth coding as well as provider specific questions were discussed. These efforts will continue and include the Performance Pool initiatives of HCPF as well. PMAP Phase II will focus on broadening the provider outreach to establish workflows that will improve performance measures outcomes.

Quality of Care Issues

Investigations of potential quality of care issues are conducted through the Quality Management Department, and findings are evaluated for appropriate follow-up, corrective action, and monitoring. Providers. HCI staff, Beacon staff, members, or other concerned parties can all report quality of care issues, typically through an Adverse Incident Report form submitted to the Quality Department or an immediate conversation with their supervisor or Human Resources. All quality of care issues are documented, as are the results of investigations. Corrective actions are tracked and monitored. Reporting, investigation, and tracking of adverse incidents through the Quality Management Department continued during FY21-22 and will continue with reporting to HCPF as required in FY22-23.

An adverse incident may feed into the quality of care process based on investigation results. All providers are required to report adverse incidents; HCI received sixty-one (61) adverse incident reports during FY21-22; an increase from the fifty-six (56) reported the previous year. These care-monitoring initiatives, along with treatment record reviews and training, are conducted with the goal of ensuring members receive the best care possible and will continue to be maintained by the HCI Quality of Care Committee in FY22-23.

Quality Improvement Plan
Name: Health Colorado, Inc.
RAE: 4
Date: September 30, 2022

FY21-22 was the first year HCI quality of care process was audited by HCPF. HCPF did not indicate any significant areas of concern with the quality of care process. HCI will continue to monitor and implement best practices. HCI continues to send a quarterly report to HCPF where we report on the founded Quality of Care (QOC) issues.

Performance Improvement Goals

Below is an assessment for quality management projects associated with the listed programs. Based upon consultation with HCPF and HCI leadership, it is important to note that recent 'status' information is included as HCI deems this information to be useful to inform updates into current quality planning.

Goal	Fiscal Year 22-23 Project/Initiative	Targeted Completion Date	Status
Performance Improvement Projects			
Depression Screening and Follow–up After a Positive Depression Screen. Part One: By June 30, 2022, increase the percentage of depression screens completed during well visits for members attributed to Valley-Wide ages 12 years and older from eleven (11.21%) percent to fifteen (15%) percent. Part Two: By June 30, 2022, increase the percentage of behavioral health follow-ups within thirty (30) days of a positive depression screen completed for members attributed to Valley-Wide ages 12 years and older, from twenty-five (25.15%) percent to thirty (30%) percent.	To improve access to behavioral health care, Health Colorado, Inc. (HCI) will target depression screening in primary care and subsequent behavioral health follow-up as its Performance Improvement Project (PIP). The effort will aim to increase the rate in which a provider within the Valley-Wide system will perform and bill for a depression screen at members' annual well-visit, as well as ensure any positive depression screen has a timely mental health service.	Module 4 Due: October 21, 2022	HCI received Module 3 approvals by HSAG to initiate intervention testing for both measures on September 29, 2021. Following active use of the Plan-Do-Study-Act methodology, a second Module 3 intervention was approved for the Depression Screening measure on April 19, 2022. Intervention testing is ongoing.

Quality Improvement Plan
Name: Health Colorado, Inc.
RAE: 4
Date: September 30, 2022

Goal	Fiscal Year 22-23 Project/Initiative	Targeted Completion Date	Status
Performance Measurement Data Driven Projects			
Potentially Avoidable Costs/Complications (PAC): The Department removed PAC as a KPI in FY22-23. There are no deliverables required and any ongoing work associated with the three (3) episodes of care from the FY21-22 PAC Plan (SUD, Diabetes, Pregnancy) will be incorporated into the appropriate Population Health &/or Condition Management deliverables.			
Achieve an improvement of 5% (Tier 2) or greater over fiscal year 2021 performance for each KPI. (Tier 1 = 1% improvement). Well Visits have quarterly goals and with no tiers. We report our most current results and will work with HCPF on tracking the recent Spec document changes.	**Behavioral Health Engagement** Tier 1 = 3.3% and Tier 2 = 3.4% **Dental Visits** Tier 1 = 35.5% and Tier 2 = 37.0% **Well Visits Part 1 (0-15 months)** Quarter 1 = 43.2%, Quarter 2 = 44.1%, Quarter 3 = 45.1%, and Quarter 4 = 46.0% **Well Visits Part 1 (15-30 months)** Quarter 1 = 50.6%, Quarter 2 = 52.1%, Quarter 3 = 52.8%, and Quarter 4 = 53.6% **Well Visits Part 2 (3-21 years)** Quarter 1 = 27.0%, Quarter 2 = 28.3%, Quarter 3 = 29.7%, and Quarter 4 = 31.1% **Prenatal Engagement** Tier 1 = 70.9% and Tier 2 = 73.7%	June 30, 2023	**Behavioral Health Engagement:** HCI rolling annual performance through March 2022 was 2.5% which did not meet either tier. **Dental Visits:** HCI rolling annual performance through March 2022 met Tier 1 at 36.7% HCI and DentaQuest continued to collaborate over FY21-22. The purpose of these meetings was to address how work conducted by DentaQuest could be leveraged to increase performance on the Dental KPI.

	Emergency Department Visits PKPY Tier 1 = 491.1 and Tier 2 = 471.3		**Well-Visits Part 1 (0-15 months):** HCI rolling annual performance through December 2021 (the most recent month reported) was 43.1%. This did not meet the goal for that quarter, but is an improvement over the September 2021 rate of 41.1%, which was also below the goal for that quarter. **Well Visits Part 1 (15-30 months):** HCI rolling annual performance through December 2021 (the most recent month reported) was 47.4%. This did not meet the goal for that quarter, but is an improvement over the September 2021 rate of 46.6%, also below the goal for that quarter. **Well Visits Part 2 (3-21 years):** HCI rolling annual performance through December 2021 (the most recent month reported) was 31.4%. This met the goal for that quarter, and was an improvement over the September 2021 rate of 30.5% and met

			the goal for that quarter. **Prenatal Engagement:** HCI rolling annual performance through March 2022 was 67.5% and did not meet the either tier **Emergency Department Visits PKPY:** HCI rolling annual performance through March 2022 was 461 visits/PKPY and met Tier 1 beginning in January 2022.
Achieve an improvement of 10% over the performance gap for each BH measure by June 30, 2023. The baselines and goals for BHIP measures have not been finalized by HCPF. We report the most recent here. We will be aligning our efforts with changes in the Spec document.	Baseline, goal, and performance **Engagement in Outpatient Substance Use Disorder (SUD) Treatment** Goal = 40.18% **Follow-up within 7 days of an Inpatient Hospital Discharge for a Mental Health Condition** Goal = 80.41% **Follow-up within 7 days of an Emergency Department (ED) Visit for Substance Use Disorder** Goal = 44.27% **Depression Screen Gate** Goal = 44.5% **Follow-Up after a Positive Depression Screen**	June 30, 2023	There are challenges with building performance measures codes due to outstanding questions with the state on the Spec Documents in addition to the state cutting off giving the RAEs quarterly data due to resource issues. Rates reported below are subject to change as there is better alignment of internal SQL code with the state code. The depression screen measure has particularly large differences between

	Goal = 45.38% **Behavioral Health Screening or Assessment for Children in the Foster Care System** Goal = 28.06% Referencing the HCI Performance Measures Improvement Strategy, HCI implemented the Performance Measures Action Planning Process (PMAP, Phase I) in FY21-22. The focus of PMAP, Phase I included coordinating with the RAE 4 CMHCs via monthly work group meetings to develop process improvement ideas and actions regarding the BHIP measures. Health Solutions focused in the PMAP, Phase I work group meetings on (2) BHIP measures: Follow-up within 7 days of an Inpatient Hospital Discharge for a Mental Health Condition and Behavioral Health Screening or Assessment for Children in the Foster Care System. San Luis Valley Behavioral Health Group focused in the PMAP, Phase I work group meetings on (2) BHIP measures: Engagement in Outpatient Substance Use Disorder (SUD) Treatment and Follow-up within 7 days of an Emergency Department (ED) Visit for Substance Use Disorder. Southeast Health Group focused in the PMAP, Phase I work group meetings on (3) BHIP measures: Engagement in Outpatient Substance Use Disorder (SUD) Treatment, Follow-up within 7 days of an Inpatient Hospital Discharge for a Mental Health Condition, and Behavioral Health Screening or Assessment for Children in the Foster Care System. Solvista focused in the PMAP, Phase I work group meetings on (1) BHIP measure: Engagement in		state and internal reported rates. Entering FY22-23, the HCI Performance Measures Strategy Group in coordination with the Quality Management and Data, Analytics and Reporting teams identified (2) key stakeholders to engage in PMAP, Phase II: Parkview and Peakview, focusing on (2) BHIP measures (Follow-up within 7 days of an Inpatient Hospital Discharge for a Mental Health Condition and Follow-up within 7 days of an Emergency Department (ED) Visit for Substance Use Disorder). After holding initial planning meetings with Parkview and Peakview leadership in August 2022, the PMAP, Phase II work groups will reconvene on a bi-monthly basis in September 2022. The intent is to build upon PMAP, Phase I efforts in FY21-22 to identify process improvement opportunities, standardize work, and spread promising/best practices to other

	Outpatient Substance Use Disorder (SUD) Treatment. Using RAE-, provider- and member-level dashboards, developed in the PowerBI environment, the PMAP work groups identified issues/challenges (e.g., COVID PHE, staffing, coding, and data sharing) and opportunities with additional stakeholders to outreach and coordination process improvement activities in relation to transitions of care for the BHIP measures: local, country human services departments, hospitals, and care coordination entities. Entering FY22-23, the PMAP process entered Phase II in which we built upon Phase I efforts and further employed provider-level data to identify key, high volume providers/organizations with whom to coordinate on developing process improvement activities to narrow performance gaps, improve performance on the BHIP measures (Follow-up within 7 days of an Inpatient Hospital Discharge for a Mental Health Condition and Follow-up within 7 days of an Emergency Department (ED) Visit for Substance Use Disorder), and spread promising/best practices to other providers/organizations in RAE 4 to positively impact performance and standardize work across Health Colorado's service region.		providers/organizations in RAE 4 to positively affect performance and standardize work across Health Colorado's service region. The PMAP, Phase II will continue into FY22-23, using data driven strategies (i.e., PowerBI dashboards) to identify other key stakeholders (i.e., providers/organizations) with which to partner on narrow performance gaps on other BHIP measures, using LEAN methodology and QI tools to inform our efforts. Engagement in Outpatient Substance Use Disorder (SUD) Treatment: HCI rolling annual performance in March 2022 was 47.9%, above the goal. Follow-up within 7 days of an Inpatient Hospital Discharge for a Mental Health Condition: HCI rolling annual performance in March 2022 was 66.3%, below the goal.

			Follow-up within 7 days of an Emergency Department (ED) Visit for Substance Use Disorder: HCI rolling annual performance in March 2022 was 34.5, below the goal. Depression Screen Gate: HCI rolling annual performance in March 2022 was below the goal at 24.4%. Follow-Up after a Positive Depression Screen: HCI rolling annual performance was above the goal in March 2022 with a rate of 47.0% Behavioral Health Screening or Assessment for Children in the Foster Care System HCI rolling annual performance was above the goal in March 2022 with a rate of 37.9% HCI staff continue to utilize the previously established point of contact for child welfare offices to connect with the individual county offices and attend

			regional director's meetings as well as RAE collaborative meetings with the Colorado Department of Human Services (CHDS).
Performance Pool Achieve an improvement of 10% over the performance gap for each PP measure by 6/30/2023. We demonstrate our current results and are setting up systems with the changes from HCPF for FY22-23.	**Preterm Birthrate** Goal = 10.4% **DOC Engagement** Goal = 19.1 (All RAEs) **Extended Care Coordination** Goal = TBD% **Asthma Medication Ratio** Goal = 44.0% Antidepressant Medication Management Part A – 12 weeks Goal = 64.7% **Antidepressant Medication Management Part B – 6 months** Goal = 43.7 **Contraceptive Care for Postpartum Women** Goal = 45.6 **Risk-Adjusted PMPM** Goal = $408	June 30, 2023	There are challenges with building performance measures codes due to changing Spec Documents. Rates reported below are subject to change as there is better alignment of internal SQL code with state code. **Preterm Birthrate:** HCI rolling annual performance ending in March 2022 was 11.1% and met the goal in each month. **DOC Engagement** HCI rolling annual performance ending in October 2021 (the most recent month reported) was 28.64%, which was above the goal each month. The rate for all RAEs combined met the goal with 19.47% in October 2021. The in-reach work connecting 1:1 pre-release contributes a lot to

			the follow-through. In addition, our strong working relationship with DOC made navigating and connecting with our members amid COVID a success and all efforts to enhance access to care for our members. **Extended Care Coordination:** Measure specifications and goals have not been finalized for this measure. **Asthma Medication Ratio:** HCI rolling annual performance was below the goal in December 2021 at 42.4%. **Antidepressant Medication Management Part A – 12 weeks** HCI rolling annual performance was below the goal in December 2021 at 63.9%. **Antidepressant Medication Management Part B – 6 months**

			HCI rolling annual performance was below the goal in December 2021 at 41.6% **Contraceptive Care for Postpartum Women** HCI rolling annual performance was below the goal in April 2022 at 31.0% **Risk-Adjusted PMPM** HCI rolling annual performance met goal in June 2022 at $374 PMPM.

Goal	Fiscal Year 22-23 Project/Initiative	Targeted Completion Date	Status
Member Experience of Care Improvement Driven Projects			
HCI will work with the Department to support survey initiatives, evaluate responses, and formulate interventions to address areas of low satisfaction.	HCI will continue to support the department in this initiative. CAHPS data is currently being tabulated and performance scores across categories are being aggregated. Based upon the survey results, HCI will identify areas of low performance and implement appropriate interventions in FY22-23 in order to affect RAE performance scores in FY23-24.	June 30, 2023	Survey results have been received and are being evaluated and formatted for presentation and review. Once the results are finalized, HCI will identify interventions that can increase satisfaction scores on future survey results by working directly with one of the

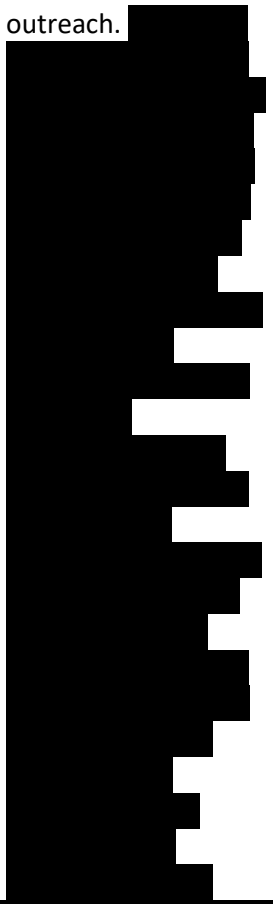
			facilities included in the survey.
	Your Opinion Matters is an internal survey that seeks to gain member insight into access related issues and opinions on satisfaction with services rendered.	June 30, 2023	Efforts to increase the response rate for the Your Opinion Matters survey were implemented. A poster advertising the survey was created. This poster was translated into Spanish in order to reach our Spanish Speaking population. Based upon member feedback, within the poster, HCI included a QR code with a link to the YOM survey. The posters was placed on HCI social media platforms. In addition, a Welltok text campaign was launched. The aim of the campaign was to be another option to reach members and to increase the survey response rates. HCI saw a large increase in member

			response rate because of the aforementioned campaigns. HCI went from under one-hundred (100) responses in two years to over three-hundred (300) responses in two months. HCI continues to conduct outreach to members who indicate on the survey that they would like a follow up contact. In FY21-22, wo-hundred and fifty-one (251) members have taken the survey and thirty-six (36) members have indicated that they would like to receive more information about their Health First Colorado Benefits or to speak to someone regarding their questions or concerns. That is an increase in 1700% of members seeking contact from FY20-21 to FY21-22. In addition, if there are downward trends detected in the survey responses, these trends will be reviewed at QIUM, and discussions will

			be held for possible interventions
			ECHO surveys were not conducted in SFY21-22, but may be incorporated in SFY22-23. HCI will present results regionally, and will look to work with clinical sites to improve performance as necessary.

Goal	Fiscal Year 22-23 Project/Initiative	Targeted Completion Date	Status
Over and Under Utilization of Services Projects			
Improve overutilization through implementation of COUP pilots; evaluate the effectiveness of the COUP pilot programs by increasing the number of members in the COUP pilot program recommended for lock-in status	The COUP Lock-in Diversion Program continues to operate in RAE Region 4 for COUP members to address overutilization of services. The COUP program continues to look at the over utilization of services that would make a member appropriate for lock-in services through the RAE. Collaborative efforts with all care coordination entities to monitor utilization continue to occur region wide.	June 30, 2023	The Client Overutilization Program (COUP, also known as "Lock-in") is a statewide surveillance and utilization control program that safeguards against unnecessary or inappropriate use of care or services. Successes: HCI continued efforts to monitor the utilization of services by members through the Client Overutilization Program (COUP) outreach and lock-in

			diversion and lock-in programs. Over the last quarter, there were [redacted] members on the Lock-in Diversion Program; [redacted] assigned [redacted] to Health Solutions; assigned to San Luis Valley Health; and [redacted] assigned to High Plains Community Health Center. [redacted] members were in the lock-in status and were assigned to Valley-Wide Health Systems, Inc. The current lock-in members have improved the frequency of their ED utilization. [redacted] lock-in member was no longer on the Q4 COUP lock-in diversion or COUP list. We cannot prove causation, but the fact that they are no longer on the COUP list points to decreased ED utilization. **Challenges:** In Q4 FY21-22, care coordinators successfully contacted ninety-one (91%) percent of complex COUP members and engaged thirty-five

			(35%) percent in ECC, which is a slight decline over the previous quarter. Because COUP lists are produced quarterly based on claims data with an additional lag time of up to six months, these lists usually contain outdated contact information. COUP outreach continues to have the highest percentage of unreachable members out of our care coordination outreach. 

			 Most of our members on the COUP list are on the list because they over-utilize the ED, not because they over-utilize or misuse pharmacy services. However, literature on lock-in programs and best practices from around the country indicate that lock-in interventions provide the most cost savings and outcome improvement if used as part of a broader drug utilization review strategy for members who overuse or misuse certain medications, primarily controlled substances. There is not much evidence of using these programs to decrease ED utilization. In addition, many of our COUP members receive secondary gains and benefits from their ED use when suffering from anxiety. We believe we will have greater impacts on

			decreasing ED usage through condition management, complex care management, and transitional care management-specific interventions over and above the COUP lock-in intervention. **Plans for Improvement:** Care coordinators continue to focus on an integrated, robust, whole-person care plan development and improvement to support COUP members on lock-in and the COUP list. In alignment with best practices, HCI care coordinators continue to focus our COUP lock-in intervention on members who have been on the COUP list for two consecutive quarters and have qualified for COUP Diversion by using six or more high-risk prescriptions, having filled prescriptions from three or more different pharmacies, or from three or more different prescribers. RAE 4 hopes to demonstrate that this focus will direct

			limited intensive resources to clients needing this level of support, and decrease emerging costs for the complex population. We have plans to build standardized transitional care workflows into Essette during FY22-23 for all care coordinators to use with COUP members. We have also started holding quarterly coup meetings with all of our delegated entities to share regional best practices, lessons learned, successes, challenges, and plans for improvement.
Monitor and improve underutilization through demonstrated through an improvement of 10% over the performance gap in identified BH measures	BH Incentive Measure 1—Engagement in OP SUD treatment—An initiation encounters plus two (2) or more services within thirty (30) days of the initiation. The RAE is collecting this data with specific provider-level detail. Poor performance on this indicator will direct follow-up efforts. The RAE is monitoring seven (7) day ambulatory follow-up after hospital discharge (BH Incentive Measure 2). Poor performance on this metric will result in QI/Clinical follow-up. Community Mental Health Centers (CMHCs) are provided with daily inpatient census and daily hospital discharge reports.	June 30, 2023	BH utilization trends by member, facility, and service type are monitored monthly and reviewed at the monthly QIUM committee. Chart audits are regularly conducted over a wide variety of service modalities. HCI audits mental health providers, substance use providers, residential treatment facilities, in-patient facilities, intensive outpatient facilities, and

			medication assisted therapy. All audits have a focus on the appropriateness of services provided in order to ensure proper utilization. Fraud, Waste and Abuse are also areas that these audits can point to. HCI will continue to monitor performance on these measures through the tracking and trending of performance data.

Quality Improvement Plan
Name: Health Colorado, Inc.
RAE: 4
Date: September 30, 2022

Goal	Fiscal Year 22-23 Project/Initiative	Targeted Completion Date	Status
Quality and Appropriateness of Care Furnished to Members with Special Health Care Needs Projects			
Auditing for EPSDT will occur during behavioral health treatment record audits. The goal for compliance with the question, "For clients under 21, evidence that provider educated client/parent about EPSDT services as needed", is 80% compliance.	Behavioral health providers are expected to complete assessments to identify and recommend treatment for individuals with special health care needs. Members with special needs are supported through case management where needed to assure care is well coordinated and communication between providers is occurring. Providers are audited for EPSDT compliance during regularly conducted chart audits.	June 30, 2023	Over FY21-22, auditing for EPSDT did occur during regular chart audits. HCI will continue to audit for EPSDT during behavioral health treatment record audits and aim for a compliance goal of 80% as well as include this as an area of focus on trainings.

Goal	Fiscal Year 22-23 Project/Initiative	Targeted Completion Date	Status
Quality of Care Monitoring			
Identify and address any and all potential Quality of Care issues and concerns.	HCI undertakes a variety of activities aimed at evaluating and improving the quality of care for members. The Quality of Care Committee (QOCC) is a sub-committee of the QIUM Committee. The purpose of this QOCC Committee is to identify, investigate, monitor, and resolve quality of care issues and patterns of poor quality within the system of care. Investigations of potential quality of care issues are conducted through the Quality Management	June 30, 2023	Investigations of potential quality of care issues are conducted through the Quality Management Department, and findings are evaluated for appropriate follow-up, corrective action, and monitoring. Providers and HCI staff can report quality of care issues, or other concerned parties typically through an Adverse Incident reporting form

	Department, and findings are evaluated for appropriate follow-up, corrective action, and monitoring. Provider treatment record documentation training, audits, and provider education are ongoing and occur individually in areas where scores indicate problems are evident. If improvement is not seen, the corrective action process is initiated. Audits include a review of encounters/claims against the chart documentation.		submitted to the Quality Department. All quality of care issues are documented, as are results of investigations. Corrective actions are tracked and monitored. Reporting, investigation, and tracking of adverse incidents through the Quality Management Department continued during the past fiscal year. An adverse incident may feed into the quality of care process based on investigation results. All providers are required to report adverse incidents; HCI received 61 adverse incident reports during FY21-22; an increase from [redacted] reported the previous year. These care-monitoring initiatives, along with treatment record reviews and training, are conducted with the goal of ensuring members receive the best care possible. **Progress\Interventions:** Meetings to evaluate quality of care issues and adverse events are

			scheduled quarterly or as needed. Quality of Care data is presented at the QIUM Committee where trends are analyzed. Training and education on QOCC and the adverse indecent reporting process is covered at all documentation training sessions. Overall, there has been a gradual increase in adverse incidents and a decrease in quality of care issues over the past year. Providers are reminded and trained on the Quality of Care Concerns and Adverse Incident reporting process at all quarterly documentation training events. We will continue to schedule quarterly trainings throughout FY22-23, the first of which is scheduled for September 29, 2022. The dates of the trainings provided in FY2022 were: • September 30, 2021 • December 30, 2021 • March 31, 2022 • June 29, 2022 Quality of care issues including concerns raised by the Department of Health

			Care Policy and Financing (Department), provider-raised concerns, member concerns, or RAE discovered concerns continue to be investigated thoroughly. HCI will continue to work with HCPF to address and report any concerns. HCI has finalized a process for QOC reporting to HCPF.
Goal	**Fiscal Year 22-23** **Project/Initiative**	**Targeted Completion Date**	**Status**
External Quality Review Driven Projects			
HCI will collaborate with Health Services Advisory Group. (HSAG) and the Department on the completion of the annual External Quality Review and complete corrective actions as determined by HSAG	Health Colorado underwent an external quality review organization (EQRO) audit in March of 2022 and will continue to undergo audits annually. Aggregate scores related to the annual FY20-21 EQRO audit for HCI netted an overall score of 94%. The individual scores presented below demonstrate HCI's dedication to excellence. VII. Provider Participation and Program Integrity: 94% VIII. Credentialing and Recredentialing: 94% IX. Sub contractual Relationships and Delegation: 75% X. Quality Assessment and Performance Improvement: 100%	The targeted completion date is determined by HSAG	Stemming from the FY21-22 EQRO audit, two standards were issued a corrective action. HCI has submitted the CAP plan for each of the corrective actions levied. HCI was issued 2 corrective actions related to partially met requirements. A CAP was requested for HCI to member materials to include all required components of a tagline. This stems from the following HSAG findings: The *Member Information Requirements* policy described procedures

	As a result of the annual audit, HCI was issued four (4) corrective action plans.		for ensuring that member informational materials contain taglines that are consistent with the member information requirements. However, some critical member materials did not include all required components of a tagline. • The cover sheet, welcome letter, and provider directory had taglines but did not have the entire tagline translated in Spanish. The newly pregnant member welcome letter, *HCI Brochure*, *Getting Started Flyer*, *Getting Started Pregnancy Guide*, *EPSDT Tip Sheet,* welcome letter, and *Care Coordination Fact Sheet* did not have a tagline in English and Spanish. • The second corrective action for this standard was that HCI must update the *EPSDT Tip Sheet* and any associated documents to include the correct *Bright Futures Guidelines* timeframe for annual well visits.

			Enhance annual non-utilizer outreach to ensure that it is timely and has a reasonable chance of reaching the member. This was related to the findings of: Although HCI generally informed the member of general EPSDT information; the *EPSDT Tip Sheet* in use throughout CY 2021 did not follow *Bright Futures Guidelines* timeframes for recommended teen well visits. The tip sheet stated two to three years, which should be annual recommended visits. Additionally, HCI did not consistently complete annual outreach for members who had not utilized EPSDT services in the prior 12-month period. Non-utilizer data submitted and staff reports during the interview both indicated that some annual outreach was untimely. Furthermore, the annual outreach process relied solely on text message outreach, which the reports indicated only reached approximately one in every five members according to the submitted non-utilizers report data and

			FY 2021–2022 second quarter *EPSDT Outreach Quarterly Report*. Staff members did not report using phone or mail outreach for annual outreach purposes in CY 2021. : The final CAP directed HCI to: • Update the *EPSDT Tip Sheet* and any associated documents to include the correct *Bright Futures Guidelines* timeframe for annual well visits. Enhance annual non-utilizer outreach to ensure that it is timely and has a reasonable chance of reaching the member. The findings used to support this corrective action are as follows: Although HCI generally informed the member of general EPSDT information; the *EPSDT Tip Sheet* in use throughout CY 2021 did not follow *Bright Futures Guidelines* timeframes for recommended teen well visits. The tip sheet stated two to three years, which should be annual recommended visits. Additionally, HCI did not consistently

			complete annual outreach for members who had not utilized EPSDT services in the prior 12-month period. Non-utilizer data submitted and staff reports during the interview both indicated that some annual outreach was untimely. Furthermore, the annual outreach process relied solely on text message outreach, which the reports indicated only reached approximately one in every five members according to the submitted non-utilizers report data and FY 2021–2022 second quarter *EPSDT Outreach Quarterly Report*. Staff members did not report using phone or mail outreach for annual outreach purposes in CY 2021. As of July 8th 2022, HCI has submitted the CAP plan to HSAG and is awaiting further instructions. In FY23, HCI will be submitting evidence of compliance with the following standards: Coverage and Authorization, Access, Grievance and Appeals we will see Enrollment and Disenrollment

			added as a new category to the review.
Annual Claims and Encounter Audit (411 Audit)	In order to assess the accuracy of submitted claims and encounters, each year HCI undergoes an annual claims and encounter validation audit. The purpose of this audit is to assess service coding accuracy in submitted claims and encounters. Three services categories were audited in FY21-22. Those categories were residential services, psychotherapy services, and inpatient services.	June 30, 2023	As in past 411 audits, HCI performed very well across the three service categories audits. Aggregate scores reflected a high level of confidence in accuracy of the submitted claims and encounters. HCI observed a high level of accuracy in all three sections of the audit. HCI achieved accuracy scores between 96% and 100% percent in all but one encounter service category. HCI had an average percentage of accuracy of 98%. HCI observed a high level of accuracy in the psychotherapy section of the audit. HCI achieved accuracy scores between ninety-four (85%) percent and ninety-nine (99%) percent, with an average percentage of accuracy of ninety-seven (97%) percent. HCI's strongest categories of performance, which all achieved accuracy scores of ninety-nine (99%) percent were: • Procedure Code • Service Category Modifier

			• Unit • Start Date • End Date • Appropriate Population • Duration • Staff Requirement HCI observed a high level of accuracy in the residential section of the audit. HCI achieved accuracy scores between ninety-seven (97%) and ninety-eight (98%) percent, with an average percentage of accuracy of ninety-eight (98%) percent. HCI's strongest categories of performance, which all achieved accuracy scores of ninety-nine (98%) percent were: • Procedure Code • Place of Service • Service Category Modifier • Start Date • End Date • Appropriate Population • Duration and Staff Requirement HCI observed a very high level of accuracy in the inpatient section of the audit. HCI achieved accuracy scores between ninety-six (96%) percent and one hundred (100%) percent. HCIs strongest categories of

			performance, which all achieved accuracy scores of one hundred (100%) percent, were: • Principal Surgical Procedure Code and • Revenue Code HCI also demonstrated strong performance, achieving accuracy scores of ninety-nine (99%) percent in the following categories: • Discharge Status • Start Date and • End Date In order to continue to see a high confidence in the accuracy of submitted claims and encounters, HCI created and disseminated training on the 411 audits to its provider network. It is believed that this training, when administered to the provider network, will generate continued high performance in future 411 audits. In addition, HCI will work with providers who fell below the ninety (90%) percent threshold in a quality improvement project as directed by the department.

Quality Improvement Plan
Name: Health Colorado, Inc.
RAE: 4
Date: September 30, 2022

Goal	Fiscal Year 22-23 Project/Initiative	Targeted Completion Date	Status
Internal Advisory Committees and Learning Collaborative Strategies and Projects			
Oversee and participate in current HCI committees that communicate best practices and share information and feedback that is key to the delivery of effective healthcare in the region.	The Regional Performance and Improvement Advisory Committee (PIAC) is comprised of members, family members, partners, providers, hospitals, community agencies and a variety of stakeholders who represent the populations of the region and local communities. The role of this committee is to guide and inform program administration to include, input into performance with a focus on performance measures, population health, program development, quality of care, and service. This committee serves the important function of vetting the annual Performance Improvement Plan, the Performance Improvement Project progress, and possible performance improvement initiatives that will directly affect the quality of member care, member engagement or member experience of care. Issues that might arise for discussion within the PIAC include but are not limited to: Member needs around medical care, transportation, community services such as food, peer support, financial assistance, clothing, and cultural and religious considerations.	June 30, 2023	In FY21-22, HCI participated in State PIAC meetings and held Regional PIAC meetings/learning collaboratives to further goals of communicating best practices and sharing/receiving feedback from stakeholders to improve healthcare delivery in region 4.HCI hosted three (3) regional PIAC meetings via Zoom, between July and December 2021, meetings were not held in November due to holidays. PIAC meeting minutes and documentation are posted on the HCI website for members, providers, and stakeholders. Access 2 Sign Language continues to provide interpretation for deaf and hard of hearing attendees. Each meeting includes updates from the Member Experience Advisory Subcommittee (MEAC), State PIAC updates, community updates, and In addition to our standing agenda items, HCI invites guest speakers to present on topics such as COVID vaccinations, forensic services, and the HCI population health plan. This approach allows attendees to learn about programs and initiatives in our region and to hear information directly from the subject matter experts. During this reporting period, PIAC topics included Key Performance Indicators (KPIs), oral health and dental benefits, Potentially Avoidable Costs (PAC) project episodes of care (substance use disorder (SUD) and maternity/pregnancy), COVID-19 updates, Unite Us Colorado, and

	In order to ensure the Quality Management program is effectively serving members and providers, Health Colorado will participate in multi-disciplinary statewide advisory committees and learning collaboratives for the purposes of monitoring the quality of the program overall and guiding the improvement of program performance. Health Colorado will also periodically hold learning collaboratives to educate and better understand network challenges related to performance improvement, initiatives and interventions, and other topics relevant to stakeholders.		Colorado Crisis Services (CCS) resources. The meetings also allow time for discussion of other relevant topics. In the July 2021 meeting, Dr. Brian Hill, HCI VP Medical Director/Chief Clinical Officer, presented on the RAE 4 Population Health Strategic Plan. Dr. Hill provided a definition of population health and improvement framework, which informs HCI's Population Health Plan and strategies. He noted the need to identify members with multiple conditions and social determinants of health (SDoH) in order to find members most likely to benefit from interventions and integrated care planning for each member. The group also learned more about the Practice Transformation (PT) effort, based upon National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH) and the Chronic Care Model (CCM). Halle Medina and Julia Cordova with AmeriCorp presented on the vaccine outreach and equity program, providing details on the program to outreach RAE 4 members and coordinate with community stakeholders to share information with members. RAE 4 performance measures were reviewed for FY 2021-22. The group received updates on care coordination and practice transformation (PT) activities, as well as provider and member support efforts. Community updates included the announcement of the Community Reinvestment Program and PAC planning. In the August 2021 meeting, State PIAC updates were provided along with Dr. Brian Hill speaking to RAE expectations

			in relation to the RAE 4 Population Health Strategy. He spoke to: stratification of the population based on health risk; placing additional focus on population health interventions for complex members; and allocation of a greater portion of administrative payments to providers who see more complex members. A representative from the Colorado Office of Behavioral Health (OBH) presented on the Forensic Program, providing details on services and efforts by the Court Services Program, the Forensic Support Team, Forensic Community-Based Services, and the Outpatient Restoration Program & Jail-Based Evaluation and Restoration Program. Updates were provided on member support activities along with Community and Provider updates (Night of Remembrance for International Overdose Awareness Day, Heart of Pueblo breakfast to support Spark the Change Colorado, IntelliRide contract for medical transport in Colorado). In the October 2021 meeting, Julia Duffer, HCI Director of Community Engagement, presented on the HCI Practice Transformation (PT) work with providers. The presentation included an overview and successes of the 2020-2021 Practice Transformation incentive and detailed HCI's new Practice Transformation incentive program. At the October meeting, Health Colorado announced a new community reinvestment grant opportunity, including applicant/proposal requirements and eligibility. Member Experience Advisory Subcommittee (MEAC) and community updates were provided to

			the group along with an announcement or a newly formed RAE leadership group starting in November 2021. HCI hosted two (2) regional PIAC meetings via Zoom, between January and June 2022. PIAC meeting minutes and documentation are posted on the HCI website for members, providers, and stakeholders. Access 2 Sign Language provides interpretation for deaf and hard of hearing attendees. Each meeting includes updates from State PIAC updates, our regional Member Experience Advisory Council (MEAC) updates, Health Neighborhood Forum updates, community and provider updates, and guest speakers to present on topics such as COVID vaccinations, forensic services, and the HCI population health plan. This approach allows attendees to learn about programs and initiatives in our region and to hear information directly from the subject matter experts. During this reporting period, HCI regional PIAC topics included Community Reinvestment Grant Awardees, Behavioral Health Expansion Plan – Workforce Development, HCI's Performance Measures Improvement Strategy, and HTP presentations. The meetings also allow time for discussion of other relevant topics. Successes: In the January 2022 meeting, Tina McCrory, HCI Chief Strategy Officer, Alma Mejorado, HCI Director of Contract Development, and Dr. John Mahalik, HCI Director of Quality Management presented on the Behavioral Health Expansion Plan, focusing on workforce development

			issues. Tina briefed the HCI PIAC on the Behavioral Health Expansion (BHE) plan with goals from the Behavioral Health and Managed Care Section Manager. One goal is BH Provider Expansion including expanding the provider network. Specific areas are highlighted within the slide presentation (e.g., Intensive SUD services (IOP & Residential, Intensive mental health services (ACT & IOP)). Tina also highlighted the Governor's Wildly Important Goals (WIGs) that includes a number of BH-related areas. These initiatives were informed by the Colorado Behavioral Health Assessment Regional Profile: Region 4 (https://drive.google.com/file/d/17Pzr-t-ZudX_Y1ECccQwMB0YnJnCrrSX/view) Tina McCrory briefed on some recent Senate Bills related to BH services. She highlighted HCI efforts to identify opportunity areas for application of American Rescue Plan Act (ARPA) funds. She also highlighted notes from the CDHS and OBH 2020 Stateside Behavioral Health Needs Assessment and how Community Reinvestment Grants and contracting efforts seek to address these issues. Alma briefed the HCI PIAC on the six (6) BHE targeted areas. Upon questioning on target area #1 seeking examples of services that are not available within the region, the following examples were provided: SUD 3.7 Withdrawal Management and eating disorder treatment. Dr. Mahalik presented material on Workforce Development issues. Current efforts are trying to generate ideas to develop both physical and behavioral health workforce. Some current programs within the region were highlighted. Dr. Mahalik stimulated discussion with

			some discussion questions: Discussion #1: What have you done or would like to do to improve behavioral health services in our region? Discussion Question #2: What are the behavioral health workforce needs in our region? In the April meeting, Dr. John Mahalik, HCI Director of Quality Management presented the HCI Performance Measures Improvement Strategy. He spoke to three (3) strategic goals and activities: Performance Measure Strategy 1: Excellent bi-directional HCPF communication around performance measures (HCI Performance Measures Strategy Workgroup). Performance Measure Strategy 2: Improve timeliness and accuracy of internal performance measures data (HCI Performance Measures Data Workgroup). Performance Measure Strategy 3: Win all performance measures (HCI Performance Measures Strategy Workgroup). The Performance Measures Improvement Strategy will be revisited in future HCI PIAC meetings as a means to promote bi-directional communication on HCI's PMAP efforts, including community stakeholders' valued input on HCI's approach to performance measurement strategy and process improvement activity for RAE 4.

Fiscal Year 2022-2023 Quality Management Work Plan Goals

The goals for the FY22-23 work plan have also been created and approved by the QIUM. The performance goals for FY22-23 are as follows.

FY 2023 Health Colorado, Inc. Quality Goals
GOAL #1: Further develop the continued monitoring of Key Performance Indicators (KPIs) and Behavioral Health Incentive Program measures (BHIPs) and Performance Pool measures (PPs). Implement targeted interventions where applicable.
GOAL #1A: Invite stakeholders to HCI Performance Measures work group, establish learning collaborative via HCI QIUM Committee and work group, target low performing measures.
GOAL #1B: Target low performing measures, identify countermeasures, monitor performance.
GOAL #2: Quarterly or when applicable, monitor results of performance improvement project.
GOAL #3: Conduct regularly scheduled documentation audits and offer education based upon audit results.
GOAL #4: Complete QM program documents annually
GOAL #4A: An evaluation on the progress on the previous year's goals will be completed and used to determine goals for the upcoming year.
GOAL #4B: Monitor progress on new goals over the course of the fiscal year and adjust goals, as needed.
GOAL #5: In collaboration with the Population Health team and RAE leadership, identify opportunities to expand upon the existing practice transformation framework and provide support to population health initiatives.
GOAL #6: Ensure monitoring of Member Surveys. Implement targeted interventions where applicable.
GOAL #7: Semi-annually or when applicable, monitor the average turnaround time for complaints and grievances
GOAL #8: Ongoing monitoring of EQRO activities. Implement targeted interventions where applicable.
GOAL #8A: Ongoing monitoring of Quality of Care concerns and activities. Implement targeted interventions where applicable.