COLORADO
Department of Health Care Policy & Financing

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

RAE Name	**Colorado Access (COA)**
RAE Region #	**5**
Reporting Period	[SFY23-24 07/01/2023 – 06/31/2024]
Date Submitted	**7/19/24**
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Purpose: Regional Accountable Entities (RAEs) are responsible for improving health outcomes and increasing value in their respective regions through supporting their Provider Networks. As part of that responsibility, RAEs are required to maintain necessary communications with network providers and provide them practice support and transformation.

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

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

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

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Practice Support:

Achievements/Successes:

Information & administrative support

Colorado Access (COA) supports providers in building and maintaining a consistent and engaged presence of Health First Colorado members on their panels. The practice support team takes a Quadruple Aim approach to addressing the demands of today's health care system by offering physical and behavioral health providers the assistance necessary to drive change, enhance member experience, improve health outcomes, decrease costs, and increase provider well-being and satisfaction[1]. COA supports providers of all sizes and continues to utilize a team-based approach to best support medium and small provider groups. COA supports primary care medical providers (PCMPs) in engaging fully with their members and works with practices to develop and maintain systems that advance the priorities and measures of the Department of Healthcare Policy and Financing (the Department) and support well-care screenings, care coordination, and health related social needs (HRSN) or specialty care referrals.

COA holds many opportunities for physical health and behavioral health providers to build stronger connections and better support members within the Region 5 health neighborhood. COA regularly engages its provider partners through the Integrated Network Provider Advisory Council (INPAC) (formerly called the Joint Governing Council), provider workgroups, and topic-specific forums. Current and upcoming INPAC priorities include topics such as Accountable Care Collaborative (ACC) Phase III, Connected Care Collaborative (C3) Workgroup, Key Performance Indicators (KPIs) and Payment Models, Diversity Equity and Inclusion (DEI) Strategy and Policy Changes, and updates from the Department of Healthcare Policy and Financing (the Department). Through June 2023, COA hosted bi-monthly Behavioral Heath Key Performance Indicator (KPI) workgroups which brought providers together based on their depression screening scores to improve scores and share best practices. Based on analysis conducted following the conclusion of the workgroup, thirteen out of seventeen providers saw improvements in depression screening rates and practices that were part of the KPI workgroup cohort showed higher depression screening rates than non-cohort practices after the workgroup, indicating that these workgroups were a successful intervention in driving measure improvement.

In SFY23-24, COA expanded its behavioral health practice support team to better serve its contracted providers. To enhance COA's focus on behavioral health outcomes and metrics, a manager and an additional practice facilitator were added to the team. COA's three behavioral health practice facilitators are dedicated to supporting practice transformation activities for providers engaged in COA's five behavioral health incentive measures and performance pool programs. As demonstrated by the success of Department of Corrections (DOC) measure improvement, COA has continued to build its team to move this model forward and drive success in other measures. COA believes this expansion will continue to strengthen COA's ability to collaborate with providers and achieve positive behavioral health outcomes for members. Practice facilitators continue to meet individually with providers who have a contract application

[1] Bodenheimer, T., & Sinsky, C. (2014). From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider. *The Annals of Family Medicine, 12*(6), 573–576. https://doi.org/10.1370/afm.1713

in progress to create or improve administrative practices and procedures, develop new workflows to improve authorization procedures and/or transitions of care, organize training plans and requirements, and clinical oversight processes.

In August 2023, COA conducted its biannual Enhanced Clinical Provider (ECP) audit. The focus of the audit was on charts for complex members enrolled in care coordination services between January 2023 and June 2023. Throughout the review, COA's Practice Support team evaluated members involved in Extended Care Plan Activities. The momentum towards standardizing Individual Care Plans within ECPs is evident, along with efforts to train internal care management teams uniformly in patient assessment. However, challenges arise from the transition of electronic health record (EHR) systems among some entities, potentially leading to incomplete capture of encounter types. Looking ahead, improvements in coding encounter types for the next ECP chart review, aligning with fiscal year payment requirements, are anticipated by the practice support team.

In the reporting period, COA also began piloting a three-tiered provider engagement model that prioritizes practice support and coaching around preventative care, chronic disease management, care coordination, integrated care, and value-based care. This tiered model allows for flexibility with three different levels of practice support that respect providers' individual transformation goals, offering opportunities to partner in areas where collaboration makes a meaningful impact on providers' success and the health of COA members.

Tier 1: PCMP Partner

- Receives support from COA's Practice Support team and regular email communications.
- Providers must engage two times per year with COA's Practice Support team and must submit required documentation on time.

Tier 2: PCMP Clinical Partner

- Receives support from COA's Practice Support team and regular communication from an assigned practice facilitator.
- Providers must meet with assigned practice facilitator at least once a quarter per calendar year and must include a decision-maker/provider champion.
- Providers must demonstrate improvement in at least one clinical quality improvement area and must submit required documentation on time.

Tier 3: PCMP Advanced Clinical Partner

- Receives support from COA's Practice Support team and regular communication from an assigned practice facilitator.
- Providers must meet with assigned practice facilitator at least six times per calendar year and must include a decision-maker/provider champion.
- Providers must participate in peer learning/clinical improvement workgroups convened up to four times per calendar year.
- Providers must demonstrate improvement in at least two clinical quality improvement areas and must submit required documentation on time.

PCMP Advanced Clinical Partners will participate in peer workgroups that will serve as a venue for collaborating and sharing best practices to drive performance and inform opportunities. Upcoming peer workgroups will be focused on depression screening and follow-up, well visits and HbA1c diabetes control. Compensation will be awarded to each organization for attending all four workgroups within a calendar year.

COA's provider portal and platform for provider data, PowerBI, incorporates self-service data visualization tools that aid primary care providers in comparing site level KPI trends to regional and cohort performance trends. COA translates site-level trends to member-level reporting to show providers how their attributed members are counted for a given measure. COA's dashboards show member-level performance on the organization's value-based administrative payment model metrics as well as site-level payment history across incentive programs. In the reporting period, COA implemented a number of enhancements to its provider dashboards to allow for enhanced data visualizations that include metric numerators, denominators and member-level details. Other existing dashboards include Provider Metrics, KPIs, and ECP Extended Care Coordination Encounters.

COA has also made several enhancements to help providers better understand attribution and its impact on measures and programming. COA developed a Community Mental Health Center (CMHC) attribution report in order to support outreach to members by CMHCs. COA also developed a new dashboard to compare provider attribution to member attribution caps. Practice facilitators received complaints from providers stating that they are attributed more members than the maximum attribution that is established in their contracts, resulting in heavy patient loads and decreased performance on key metrics (i.e., well visits, depression screenings, etc.). This dashboard was designed to help COA's practice support team gain a better understanding of the magnitude of the problem and the impact on individual providers.

To further support value-based payment implementation, the Provider Metric Summary Tool (PMET) has continued to be enhanced to show cohort performance, regional comparison for multiple performance measures, and trendlines per metric. The tool has been expanded to show every performance measure and now includes member-level details per metric to better support providers' quality improvement efforts. Additionally, a standardized value-based payment implementation toolkit has been developed and shared across the provider network and continues to be updated based on provider feedback. COA also makes continuous efforts to align provider priorities and standardize tools for measure improvement. Providers use the Provider Enhanced Payment Report (PEPR), a month-end report, to reconcile cap payments from the current month and extract data to conduct member outreach. Providers can determine how members get attributed specifically to their practices. COA's provider network services and practice support staff also use these reports to show providers their member attribution over time.

COA has continued to promote the use of the Department adopted eConsult platform among its provider network and has worked to gather feedback from providers regarding interest in and barriers to use of the platform. Several providers have cited time, capacity, duplication of efforts, and administrative burden as existing barriers and have noted the importance of integration with existing EHR systems. Direct provider feedback related to perceived barriers is included in the supplemental spreadsheet for this report. Additionally, COA practice facilitators have shared the Department's messaging about the newly launched Prescriber Tool Initiative with its network of PCMPs, has reinforced key points around timelines, and continues to encourage participation in this payment initiative. COA has addressed questions and concerns about accessing the platform and has elevated anything beyond its knowledge base to either the Department's pharmacy team or the contractor managing the Prescriber Tool dashboard.

Finally, COA remains a foundational partner for regional Social Health Information Exchange (SHIE) efforts and has been active in engaging providers in planning and adoption efforts. COA is a champion and key funder of the Metro Denver Connected Community of Care initiative, convened by the Colorado Health Institute. With COA's support and engagement, the partnership has jointly developed four regional strategic plans for the SHIE: an Implementation Plan, an Accountability Plan, a Sustainability Plan, and a Community Engagement Plan. COA will continue to build a strong training and technical assistance foundation for the SHIE in close collaboration with local partners and state agencies. COA's practice facilitators have the expertise and have built the trust to support effective SHIE implementation within COA's network.

Telehealth support

COA's Virtual Care Collaboration and Integration (VCCI) program continues to provide increased access to behavioral health care with participating network providers. The VCCI program allows PCMPs to refer members to be seen for short-term/brief intervention treatment over telehealth by VCCI clinicians and psychiatrists either within the primary care setting or directly in the member's home. The VCCI program emphasizes coordination of care and works with each PCMP practice site to collaboratively create customized protocols that allow for the exchange of information with the member's medical home. The VCCI program includes an eConsult component that allows its participating PCMPs to consult directly with a VCCI psychiatrist via asynchronous Health Insurance Policy and Accountability Act (HIPAA)-secure email for a rapid response to their psychiatric questions. The program also allows COA care managers to make referrals to VCCI for members that are unconnected to behavioral health care. In addition, the VCCI program partners with community organizations, including The Delores Project and Catholic Charities, to increase access to care for their unique populations which include: families, children, women, transgender and nonbinary individuals experiencing homelessness. For these community partners, telehealth services are rendered on-site after workflows and protocols are collaboratively developed to meet the unique needs of the community organization's member population. Integrating VCCI services into community organizations allows members to receive their care in a place where they feel comfortable, increasing access to care by providing options for members who may be experiencing health related social needs such as transportation. To monitor the utilization of VCCI's behavioral health services, Salesforce is used as the Electronic Health Record system, which allows for the creation of fields and easy reporting tools to capture usage and member information. Salesforce's "Community" platform, which is HIPAA compliant, is also utilized as an online portal that allows participating practices to make referrals, see their own practice data, and share information to advance the coordination and integration of care between VCCI's behavioral health team and the participating primary care practices. COA educates providers on new telehealth rules through webinars and provider resource groups hosted by its practice support team.

Challenges:

COA seeks opportunities to address administrative burden for providers and barriers to care for members wherever possible. COA is invested in streamlining access to care through its VCCI program, allowing for expedited referral processes that reduce burden for providers and empower members seeking behavioral health care to complete a self-referral process.

COA's members, care managers, and customer service teams have provided the feedback that at times a provider may be listed in the provider directory as "accepting new patients" but, upon contacting the provider, they discover that the provider is no longer accepting Medicaid. To further ensure access to care, COA monitors claims data closely – particularly instances when providers stop billing for services over the course of a year. Through this process, COA can identify which providers to outreach for re-engagement opportunities.

Plans for Change in Strategy:

COA plans to develop and implement a self-referral process within its VCCI program. This initiative aims to empower COA's care managers, VCCI practices, and community partners to offer a user-friendly and HIPAA compliant self-referral option as a resource for accessing VCCI's virtual behavioral health therapy services. An intake form would be sent directly to members by providers, care managers and community partners, empowering and enabling members to enroll in the VCCI program and seek immediate care from a VCCI clinician. COA will work with existing VCCI community partners, such as Catholic Charities and the Delores Project, to customize self-referral forms for each practice site. These forms will facilitate direct access to VCCI services and will provide tech-based solutions through specific applications for triage and scheduling. Implementation of these self-referral options will include the establishment of standardized processes, protocols, training modules, marketing strategies and informational resources for providers, care managers, and community partners. This will help ensure appropriate referrals, smooth transitions of care and increased access to services.

In response to feedback regarding inactive providers listed as accepting new patients, COA's provider recruitment and contracting team has developed a provider re-engagement strategy to ensure that members have access to the necessary care without the need to contact multiple providers to find a provider that can serve them. In the coming fiscal year, COA will pilot this re-engagement strategy which will involve communication and outreach to contracted providers who have not submitted a claim within 12 months to inquire about billing barriers and availability. COA will use its zero claims dashboard to identify providers for outreach. Through this process, COA will increase outreach to providers to better assess its current network and provide re-engagement opportunities for providers who have not seen Medicaid members in at least one year. The goal of this process is to increase access to care for members and maintain effective relationships with providers through engagement and education. These efforts will also aim to reduce administrative and resource costs associated with maintaining relationships with inactive providers and enhance the integrity of COA's network integrity by ensuring that providers actively contribute to members' access to care.

Practice Transformation:

Achievements/Successes:

Advancing the Whole-Person Framework

COA recognizes the importance of looking holistically at behavioral health, physical health, and HRSN to improve member health outcomes. With the implementation of the HB22-1302 Integrated Care Grant, COA is committed to ongoing coaching and support of network practices who are tied to the grant. The grant will increase providers' capacity to support, improve and

expand integrated behavioral health services in Colorado. COA practice facilitators serve as the Practice Transformation Organization for 12 provider organizations with 20 practice sites and collaborate with care teams as they design and implement new processes and interventions to expand access to care and treatment for mental health substance use disorders in integrated physical care settings. Practice facilitators assist assigned practices in developing and achieving goals, implementing, and tracking improvements based on the Building Blocks of Behavioral Health Integration and the practice's BHI-1302 grant application to the Department. The following are examples of work practices have achieved within the reporting period, with the support of COA's practice facilitators:

- Himalaya Family Medicine moved to a new office suite in 2023 which they designed to have dedicated office space for an onsite behavioral health provider. They hired an LPC in the fall of 2023 and started an outreach campaign via texts, emails and phone calls to their patient panel announcing the addition to their clinic staff. Clinic administration have been pleased by the higher-than-anticipated response rate to these outreaches. They have received in-person training on coding and billing for behavioral health services and have strengthened their depression screening workflow. COA's practice facilitator supported the training opportunities and depression screening workflows.

- Parker Pediatrics used funds to bring in doctoral psychology students to assist with BH integration expansion, as their PCMP has had a psychologist on staff for the past few years. In addition, they have hired a coordinator to assist with the administrative aspects of the BH integration, such as appointment scheduling. They have also expanded their PHQ-9 and PSC-17 screening efforts, which included training their clinical and administrative teams to develop and implement new processes that went live in February 2024. They also used funds to switch EHRs and decided to implement EPIC PedsConnect. Weekly Wednesday meetings began in early 2024 with EPIC to build and customize the platform in preparation for the go-live in June 2024. COA's practice facilitator has worked closely with Parker Pediatrics to support all of these various initiatives. The practice facilitator supported these screening efforts by reviewing data and setting goals on how to increase screenings.

COA remains committed to continuous improvement of cross-system care and communication between hospitals and primary care providers. Access Health Connections (AHC) brings together major area inpatient hospitals and PCMPs to enhance care coordination of members with chronic disease after hospital admission, improve condition management and outcomes, and reduce potentially avoidable costs across the inpatient/outpatient continuum of care. Provider partners collaborate to design, develop, and implement system-level interventions such as enhanced data sharing and transitions of care workflows with the goal of reducing unnecessary emergency department (ED) visits and readmissions. Provider partner groups have continued work to collaborate on shared patient populations, focusing on COPD, diabetes and asthma related episodes of care and improving transition from pediatric to adult outpatient care.

COA also works with all Region 5 hospitals collectively on the Hospital Transformation Program (HTP) in order to maintain a regional approach, rather than only focusing on smaller hospital catchment areas. This allows for mutually reinforcing activities to increase the overall benefit to members. COA has continued to host regular HTP meetings that include all regional hospitals as well as representatives from Contexture, the Department, and the Colorado Hospital

Association. These meetings also include key COA leadership who are available to problem-solve and support creative solutions when discussing HTP measures for Region 3. Additionally, COA hosts monthly office hours to allow for hospital-specific discussions as needed. COA has continued to partner with Contexture to receive notifications from the hospitals to meet the requirement of HTP measures and is currently receiving notifications for four measures including results of social determinants of health (SDOH) screening and perinatal and postpartum depression. COA staff have developed internal processes to interface with members with a positive screen for one of these measures either through existing care management outreach or through expansion of existing programming. COA care managers continue to participate in hospital complex care committees to allow for collaborative discharge planning for high risk shared members.

COA recognizes that many providers have been and continue to be overwhelmed by acute care needs and thus is invested in utilizing its data to understand existing and potential gaps within primary care. The COA practice support and care management teams then address these gaps through training, resource development, and dissemination of well-care information. Additionally, COA has piloted the Connected Care Collaborative (C3) with a goal of developing a more collaborative approach to care coordination across all partner organizations and developing a shared data system that enables effective care coordination. The goal of the C3 is to connect these members to a PCMP, reduce utilization of high-cost services and ultimately improve health outcomes by establishing a medical home. COA plans to utilize this collaborative framework to, in the short-term, improve care coordination, improve shared data systems, and facilitate a stronger culture of collaboration as partners. Long-term goals include improved health outcomes for members, reduced costs of care for highest need patients, digging deeper into the data, and adding Denver Health patient data to the data pool as well as adding the element of "complex patients."

Also in the reporting period, COA's practice support team focused its efforts on awarding funding to select PCMPs in Regions 3 and 5 that seek to reduce health disparities, improve clinical outcomes, enhance the member experience, and reduce inappropriate utilization of healthcare services by increasing access to enhanced care. This funding came from administrative rate increases from the previous year. In Q2, a total of six PCMPs were awarded funding from COA that will support projects over the next year. These practices include Denver Indian Health and Family Services, Evans Medical Center, Denver Health, STRIDE, Colorado Coalition for the Homeless, and Tepeyac Community Health Center. All awarded PCMPs serve both Region 3 and Region 5 members. Each PCMP has a unique focus area geared towards achieving better health outcomes through increased access to enhanced care services for medically and socially underserved populations. In the reporting period, COA staff led an extensive review process of provider applications, selected the six providers and worked with these providers to establish biannual data reporting requirements and supported successful project implementation. COA's practice facilitators will continue to support their practices with the implementation of the work taking place, and progress updates will be available through 2024. These strategically invested funds will support COA members at increased risk for adverse health outcomes including, but not limited to, refugee, unhoused, medically fragile and/or non-English speaking populations. Through this work and the required reporting from funded providers, COA hopes to capture the member experience and identify current and emerging needs for enhanced care.

- Denver Indian Health and Family Services plans to implement a quality improvement project focused on administering depression screenings in their dental services department. They have seen success with administering depression screenings in the primary care setting, which is what prompted them to expand screenings in their dental services department to increase the number of patients provided with the opportunity to be screened for depression.

- Evans Medical Center has hired a Community Health Navigator to assist patients with the Medicaid application and renewal process. The Community Health Navigator will also support patients within Social Determinants of Health (SDOH) areas, such as transportation, food insecurity, housing, etc. Lessons learned from this program will support future policy changes in allowing community health workers to bill for services.

- Denver Health is aiming to enroll at least 500 Black patients, of which at least 250 will be COA members, into the ProBP program. They will track the number of Black patients who are given or offered a ProBP blood pressure measuring device or ordered a home blood pressure monitoring flowsheet. In addition, they will track the percentage of Black patients with hypertension who have controlled blood pressure. They also plan to monitor the number of Black patients who have completed health-related social needs screening or opted out of screening. Patients who are successfully contacted will have a completed care plan that addresses their identified health-related social needs.

- STRIDE will use the Enhanced Care funding towards medical, dental, pharmacy, and behavioral health care access to at least 360 refugee patients through patient navigation and team-based care. A total of 25% of the 360 refugee patients will engage with a minimum of one service. The Refugee Care Coordinators will work with at least 25% of refugee patients and limited English proficiency patients to ensure education and access to social determinants of health-enhanced care services.

- Colorado Coalition for the Homeless will be implementing two remote prescription medication dispensing systems. They are aiming to raise medication adherence rates by 5% (baseline 72%, goal 77%) and Indian Health Services (IHS) patient satisfaction (baseline 4.46/5.00).

- Tepeyac Community Health Center is focusing on Medicaid patients with diabetes who have an A1c > 9% at the beginning of the period. They are going to measure how the percentage has changed by the end of the one-year program. They will also track the unique number/percentage of all patients with diabetes who have visited a registered dietician (RDN). Patients who have an RDN visit will receive a brief survey and data will be reported to Colorado Access. Tepeyac will collect 5 vignettes that capture the qualitative experience of the patients. The goal is to demonstrate how RDN visits, grocery store vouchers, cooking classes, and other interventions impact patients and their ability to manage their diabetes.

Additionally, COA continued to work with all five of the metro area CMHCs, AllHealth, Aurora Mental Health & Recovery, Community Reach, Jefferson Center for Mental Health, and WellPower, to begin a new 18-month CMHC value based payment program focused on improvements in safety net provider quality, follow up after hospitalization for mental illness, adherence to antipsychotic medications for individuals with schizophrenia, antidepressant

medication management, and initiation and engagement of substance use disorder treatment; along with suicide screening and safety planning. The CMHC value-based payment model began in July 2023 and prioritizes improving outcomes and accessibility of care, shifting from transactional care to a system where payers, health systems and providers are incentivized by the value of care and outcomes, rather than by the volume of care provided. The design of the CMHC value-based payment program involved significant provider collaboration and communication. Beginning January 2024, COA will include adherence to antipsychotic medications for individuals with schizophrenia, antidepressant medication management, and initiation and engagement of substance use disorder treatment in the program measure suite. COA has signed a contract with Owl Health to promote measurement-based care (MBC) in behavioral health and is removing the financial barrier through subsidizing the cost for the platform. This is an evidence-based model that will provide vast opportunity to incorporate non-claims-based data into COA's behavioral health value-based payment models (examples include: therapeutic alliance data, time to remission, services rendered after recovery). All five CMHCs are currently in the process of implementing MBC using Owl Health platform. COA hopes that through the implementation of this value-based payment (VBP) program and the measurement-based care tool, treatment will be more measurable, cost of care will decrease, and members will have a quicker time to remission. COA knows that this type of model and program has the potential to have great impact, as COA has collected data to inform this programming through the pilot it conducted with Aurora Mental Health.

In the reporting period, COA also partnered with the Department to execute on several alternative payment model (APM) programs and areas of focus. COA's practice support team participated in the APM2 design review team, which included partner meetings intended to enhance the program for future iterations. COA also participated in Practice Innovation Program's Train the Trainer: Value Based Payment Learning Collaborative. These trainings focused on expanding COA's knowledge of advanced payment model programs and tools to help practices succeed. Through COA's efforts, the team increased the number of participating practices in the APM2 program. COA also participated in the Payment Alternatives for Colorado Kids (PACK) design review team, attending partner meetings intended to build a pediatric value-based care model that mimics the APM1 model.

Provider workforce support and recruitment

COA continues to direct a data driven strategy to recruit an accessible and culturally responsive provider network based on the needs of COA members and their communities. Recruitment efforts are grounded in data utilization and engagement of cross-departmental teams, including Care Management, Community Engagement, Customer Service, Quality Improvement, DEI, Member Services, Contracting and Credentialing, Practice Support and Provider Network Services (PNS). COA's provider recruitment team uses information collected through these channels to identify gaps within the network and opportunities for outreach and recruitment, based on feedback from members, community partners and the health neighborhood. COA is dedicated to contracting with qualified providers with diverse backgrounds, language abilities and specializations to build a high-performing, high-quality network that meets the needs of our members. The ultimate goal is to build and maintain a network of providers with which our members feel comfortable engaging.

In response to the shortages in network capacity for behavioral health services in languages other than English, COA has developed the Behavioral Health Language Services Initiative

program, which was piloted in the fall of 2023 and has since moved into full programming. This initiative allocates additional funding for behavioral health providers who provide services in languages other than English. COA recognizes that the health care system is biased towards English proficiency. This financial incentive supports providers' culturally responsive efforts of recruitment, staffing and other clinical operations. Organizations that meet the provider eligibility requirements and service qualifications are eligible for a 10% increase from traditional reimbursement rates on qualified services upon completion of an online training (including how to use the billing modifier) and attestation form. This initiative was developed to better support practices with a multilingual workforce and was launched as a direct result from provider feedback received through COA's *Sobremesa* provider group.

COA has also focused investments on providers that will expand services for Black, Indigenous and People of Color (BIPOC) members, through a request for proposal (RFP) that aims to increase the behavioral health network capacity and opportunities for engagement for BIPOC providers. This RFP will engage practices that demonstrate a willingness and plan to:

- Recruit and retain new BIPOC behavioral health providers into their practice;
- Administer training in cultural humility and responsiveness to all providers;
- Establish a plan for cultural responsiveness training, and/or;
- Include services specifically tailored to BIPOC members through community partner input.

Four providers were selected through the RFP process and a total of $690,000 in funding has been awarded. These providers serve a mix of BIPOC adult, adolescent, and child members, and LGBTQIA+ youth. COA plans to monitor and evaluate these programs and based on outcomes, plans to continue increasing opportunities and financial incentives for providers who serve marginalized populations and/or provide services in languages other than English. Initiatives such as these are part of COA's provider recruitment and retention strategies, creating avenues for providers to sustainably serve Health First Colorado members while acknowledging and compensating providers who demonstrate culturally responsive care delivery.

COA also continues to partner with the department of social work at Metro State University (MSU) in Denver to fund behavioral health workforce development programs. COA has funded a scholarship program for social work students at MSU who reflect the COA member population and who have an interest in pursuing a career in culturally responsive behavioral health care. The goal of the program remains to provide viable career paths for students from historically marginalized backgrounds and create systems of support for students and young professionals entering into their career. The first cohort of the scholarship program, which includes 24 students, completed their first year and have entered into internship and mentorship opportunities with local provider partners such as Maria Droste Counseling Center and Centus Counseling, among several others. In the coming year, COA plans to measure impact of this program and based on the top 20 provider organizations into which MSU social work students are placed, COA will verify which are contracted with COA, initiate recruitment of those not already contracted, and work to further understand gaps and opportunities to diversify COA's provider network.

Challenges:

COA recognizes challenges that providers experience related to aggregated metric-based data and is working to develop a Health Plan Reporting tool that will streamline access to this data, ensure timely and efficient reporting, improving healthcare delivery, transparency, and operational performance.

Plans for Change in Strategy:

COA plans to implement its Health Plan Reporting Tool, which will serve as a comprehensive metrics and reporting system that provides reports and data internal to COA. This tool will include a provider portal that will allow providers to see reports and dashboards for their members that aggregate data at the member level, location level and organization level. This will help improve the performance of providers and deliver metric-based data. COA will pilot a provider portal within the Health Plan Reporting Tool for a select group of providers to gather feedback and integrate system improvements as needed. The tool will then be rolled out to PCMPs, PCMP+ and ECPs.

Provider Communications:

Achievements/Successes:

COA provides ongoing communication with its provider network through several channels and continues to work towards a more comprehensive and collaborative approach to its communication strategies. When a provider contract is executed, a provider network services (PNS) representative conducts a phone introduction to initiate onboarding, provide an electronic orientation package, and check in periodically as necessary. PNS representatives conduct new provider training for all new practices within 60 days and offer ongoing training to providers who need updated training and education. Informational webinars are scheduled periodically throughout the year and providers may register for educational sessions on the COA website. Providers can also access all provider-related training through the Learning Management System (LMS). The resources, communication, and training given by the PNS team provide the provider network with the tools, resources, and knowledge to be administratively successful in their care for members, leading to improved outcomes and experience of care for their patients. COA continues its Access to Care training program and Cultural Responsiveness training completion incentives. Training, feedback, and communication with providers are logged in the contact database to track and monitor progress and issue trends. Documenting these activities allows COA to make ongoing improvements to onboarding and education programs. PNS representatives are available to assist both internal and external staff through in-person meetings, phone, mail, and email with questions and concerns.

COA's practice facilitators and PNS team are regularly engaged with providers and quickly respond to any barriers providers could face which may impact access to care. Through this high-touch team-based care model, practice facilitators and network managers are quickly able to see turnover in provider offices and help support onboarding of specific new hires with training focused on Medicaid rules and regulations, such as access to care standards. Using Net Promoter Scores (NPS), COA conducts annual and quarterly provider satisfaction surveys. The practice support team utilizes feedback through the NPS survey to continuously improve team processes and maintain high levels of support. In SFY23-24, COA's provider engagement team

earned an NPS score of 94.3 (out of 100), demonstrating COA's commitment to continued growth of its provider engagement team, comprehensive multi-channel training opportunities, and individualized provider support. This score is considered world-class on national measures of provider satisfaction.

Electronic Communications

COA distributes a variety of electronic newsletters to its provider network. COA's quarterly interactive provider newsletter, now called *Connections*, delivers relevant information on topics such as provider partnerships, engagement opportunities, news from the Colorado Access Foundation, industry trends and culturally responsive care. During the reporting period, the *Connections* newsletter highlighted areas such as food security screenings, vaccine outreach, Denver Health's Access Transformation Outreach Program (ATOP), support for justice-involved members, Colorado Access Foundation updates, and Black Birthing Design Challenge updates. COA also continues to distribute its monthly *Provider Update* newsletter, which communicates essential information about COA Medicaid and Child Health Plan Plus (CHP+) plans, education and training opportunities, and notifications from the Department. Providers are automatically enrolled to receive the *Provider Update* and *Connections* but may choose to opt out at any time.

Disseminating Urgent Communications

COA has a system in place for disseminating urgent communications as needed. When an urgent situation or crisis has been identified, information is conveyed to providers immediately through a prominent website location, splash page messaging on the provider portal, and messaging on social media channels as appropriate. Further, the customer service team is also given a list of talking points to prepare for calls from providers as another way to convey urgent communication. An email blast is also sent to all providers directly, conveying the urgent communication. To accelerate internal approval of urgent messaging, key staff members are notified by high urgency email, as well as a phone call to the person's office and cell phone. To address any communication deficiencies, COA's marketing and communications teams work with provider relations and customer service as appropriate to increase hours and staff, as well as have a communications person on standby to address any immediate needs for communication to providers. Written notices of material changes, including fee schedules and contracting provisions, are sent by mail and provider contracts are amended as needed. Unless the change is retroactive, notices are communicated at least 30 days in advance of changes. Retroactive changes are also communicated within 30 days from the date they are received.

Receiving Provider Feedback

COA offers several opportunities to gather feedback from network providers and regularly incorporates provider feedback into programming and operations. Such opportunities include partner meetings to discuss any changes being made to payment model structures. These meetings encourage feedback from providers and offer the space for providers to receive guidance and clarification about any upcoming changes.

Beyond provider meetings previously mentioned, COA has several standard mechanisms in place to receive regular provider suggestions and guidance:

- PNS managers routinely conduct virtual site visits with network providers (hospitals, ancillary, specialty, behavioral health, and primary care).

- Providers may leave feedback through the COA website. Comments are directed to ProviderNetworkServices@coaccess.com. This inbox is checked multiple times per day by provider network services and representatives who follow up with the provider by phone or email.
- PNS initiates face-to-face meetings as needed. Network providers participate in both formal and informal committees: Credentials Committee, Quality Performance Improvement Committee, and Joint Operations Committees.
- Provider Forums are held throughout the year to provide important information relevant to the network and gather feedback from providers, for example the *Sobremesa* provider group.

Challenges:

While COA recognizes the importance of whole-person care, it also acknowledges that the approach to communication is different for physical and behavioral health providers and requires the delivery of tailored information and engagement of providers.

Plans for Change in Strategy:

In SFY24-25, COA plans to conduct a gap analysis to review existing provider communications. This will include an internal analysis of current content, messaging, and processes, as well as engagement of providers to understand their perceived gaps in information. COA plans to continue its efforts to develop systems infrastructure and consolidate provider data, ensuring accurate and up-to-date contact lists for all providers. The ultimate goal is to clearly communicate the information providers need to effectively work with COA and its members. COA is committed to bi-directional learning of the provider experience and will continue to partner with providers in co-creating transformative provider communications and engagement opportunities.

COA engages providers to collect qualitative and quantitative data by leveraging annual provider surveys and provider resource groups to identify opportunities to integrate provider components into COA's population health programmatic approaches. COA has analyzed recent data to understand provider needs and has worked on developing a provider-focused intervention that contributes to program success and that will be mutually beneficial for shared goals. Through well visit programming, COA plans to increase and ensure health literacy. COA plans to incorporate additional outreach and engagement opportunities for members, such as interactive virtual programming, events, health fairs and opportunities for members to connect with providers. COA is actively working on integrating additional language preferences into its digital engagement programming and is exploring the idea of engaging community health workers to focus on prevention efforts in the community.

Communication Samples:

Quarterly *Connections Newsletter*

Monthly *Provider Update*