Quality Improvement Plan
Name: Colorado Community Health Alliance (CCHA)
RAE: Region 6
Date: September 30, 2022

1. Purpose/Mission Statement

Please describe your Organization's overall purpose/mission statement. Note: Only update this when applicable, when there are no updates, just copy and paste from a previous submission.

CCHA's Mission Statement:
Colorado Community Health Alliance's (CCHA) overall goal is to support a coordinated, patient-centered model of care to better serve the needs of Health First Colorado members, and as a result, improve health and life outcomes, optimize resources to avoid duplication of services, and reduce the cost of care.

2. Quality Program Leadership

Please list the individuals who are in your quality program. Please include their contact information. Note: Only update this when applicable, when there are no updates, just copy and paste from a previous submission.

Patti Payne, MD Medical Director Phone: [redacted] Email address: [redacted]	Kathryn Morrison Medicaid Quality Management Health Plan Director Phone: [redacted] Email address: [redacted]
Zula Solomon Director of Quality and Population Health Phone: [redacted] Email address: [redacted]	Camila Joao Clinical Quality Program Manager Phone: [redacted] Email address: [redacted]
Clara Cabanis Senior Manager of Strategy and Performance Phone: [redacted] Email address: [redacted]	Suzanne Kinney Clinical Quality Program Administrator Phone: [redacted] Email address: [redacted]
Cindi Terra Manager, Quality and Practice Transformation Phone: [redacted] Email address: [redacted]	Katie Mortenson CCHA Quality Program Manager Phone: [redacted] Email address: [redacted]

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3. Year Objectives/Top Priorities including a description of the techniques to improve performance, a description of the qualitative and quantitative impact the techniques had on quality and opportunities for improvement identified as well as newly identified opportunities for improvement

Accountable Care Collaborative (ACC) Performance Measures

CCHA is committed to improving the health outcomes of our most vulnerable populations. Our goal is to monitor and ensure the delivery of consistent, reliable, and integrated physical health (PH) and behavioral health (BH) services to members. Achieving CCHA's goal allows us to collectively achieve the Quadruple Aim goals that focus on population health, patient experience, per capita costs, and provider satisfaction. As described in detail in our annual quality improvement report, CCHA accomplished many of the established quality improvement work plan activities for SFY21-22, including the following:

- Concluded the intervention testing phase of the Performance Improvement Project (PIP) and achieved and surpassed intended targets for Depression Screening and Behavioral Health Follow-up after a Positive Screen. The overall process and implemented interventions produced the intended improvements and contributed to a positive outcome.
- Met the Well Visit KPI part 2 (well visits for children ages 3 - 21). In addition, CCHA identified issues in calculating the well visit measures and is working with the Department of Health Care Policy and Financing (HCPF) to recalculate them. CCHA also achieved the tier 2 goal for Emergency Department Utilization and met all Potentially Avoidable Complications KPI requirements for each of the four quarters.
- Distributed 100% of earned KPI incentive dollars to providers and the community.
- Met the target on one of five BH Incentive Measures for SFY20-21 in Region 6.
- Engaged nine behavioral health practices across both regions in the Social Determinants of Health Provider Incentive Plan (SDOHPIP) for calendar year 2022.
- Met Performance Pool goals related to asthma and depression medication adherence.
- Developed approved action plans to support HCPF priorities regarding prescriber tool implementation, the unwind of the public health emergency, monitoring COVID long-term, and engaging eHealth entities.
- Communicated Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results with providers and shared best practices related to access to care, patient-centered communication, and focused interventions.
- Completed all member grievance investigations within state requirements.
- Continued outreach for Client Overutilization Program (COUP) members where needed, in partnership with HCPF, and helped members transition across RAEs.
- Laid the groundwork to develop a chronic condition management program that covers the most prevalent chronic conditions identified within CCHA's population, including diabetes.
- Developed standardized reporting and information systems within the provider network to collect data on members engaged in condition management services with PCMP+ and ACN practices. Providers report quarterly, and CCHA implemented an internal reporting dashboard to help monitor member access to condition management services.
- Explored new member outreach modalities, strategies, and partnerships to engage specific populations. Worked with automated outbound call vendor to allow opt out options to align with the Telephone Consumer Protection Act while maximizing our outreach efforts.

- Participated in the first external review of Quality of Care Concerns with Health Services Advisory Group, Inc. (HSAG) and received recommendations for further program development.
- Achieved a score of 90% on Coordination and Continuity of Care, 100% for Member Rights, Protections and Confidentiality, 87% for Member Information requirements, and 86% for Early and Periodic Screening, Diagnostic, Treatment (EPSDT) services in the external quality review audit.
- Convened quarterly Regional Program Improvement Advisory Committee (PIAC) and Member Advisory Committee (MAC) meetings to solicit stakeholder feedback.

To further build on our SFY21-22 successes and overcome barriers we encountered, CCHA is using the Key Performance Indicators (KPIs) and the Behavioral Health Incentive Program as our measures of success, in addition to regular reporting on process and outcome measures related to care coordination. In SFY22-23, CCHA will use the following techniques to drive performance improvement:

Key Performance Indicators:

- Continue sharing internal reports to track interventions, show performance by region and provider, including updating baseline information when available.
- Identify and develop strategies for specific populations to address health inequities in each area of opportunity proposed by the Department. CCHA will also tailor interventions and work with community partners to address gaps in care for identified populations.
- Utilize practice transformation coaches to engage and educate primary care medical providers (PCMPs) on the ACC measures and programs.
- Engage ACN providers in Quarterly Leadership Meetings. The leadership meetings aid in collaboration at various levels, help CCHA understand provider support needs, and serve to ensure CCHA and ACN partners are aligned on performance goals.
- Educate providers and community partners on the new oral evaluation KPI through practice transformation coaching, provider newsletter, social media, and written coding materials.
- Continue supporting practices to improve operations, processes, KPI workflows and planning, proper billing and coding, member access, and provide electronic health record assistance, systems training, data and analytics, and continue with member-centered care.
- Leverage opportunities for alignment across programs (KPIs, condition management, Alternative Payment Model, Performance Pool, etc.).
- Scale up practice level quality improvement pilots that are successful to share best practices across the region.
- Distribute KPI incentive dollars to PCMPs through the Provider Incentive Program and to community partners through the Community Incentive Program.
- Continue to identify and collaborate with community partners and leverage community resources to support members, especially those related to new KPIs.
- Utilize feedback from the MAC and PIAC to inform interventions.
- Work with HCPF to troubleshoot identified challenges with methodology and work to accurately reflect network performance on the Data Analytics Portal (DAP).

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Behavioral Health Incentive Measures:

- Utilize BH practice transformation coaches to partner with key providers to identify solutions that address gaps in care for the BH incentive performance measures through provider-level BH data scorecards.
- Partner with hospitals in the Hospital Transformation Program (HTP) to better support members with substance use disorder (SUD) and assist with service planning and coordination at the time of discharge from the emergency department (ED).
- Increase access to the Care Coordination Specialized Transitions of Care (STOC) team to support discharge and aftercare planning for members stepping down from inpatient, withdrawal management, and residential substance use care.
- Maintain and improve the Post Inpatient Transition Screening (POINTS) process to provide care coordination and aftercare planning support to members discharging from inpatient placement for a mental health condition.
- Increase the rate of foster care members receiving BH assessment within 30 days by establishing a Regional Accountable Entity (RAE) notification protocol with county Departments of Human Services (DHS) at the time of placement to provide resources and facilitate access to appropriate services.

Performance Pool:

- Adjust Performance Pool dashboards to include new baselines and measures to share with providers.
- Maintain engagement and support for individual providers, including CCHA's Accountable Care Network (ACN), in implementing interventions, such as education around members using continuous glucose monitors.
- Continue working with community partners, other state agencies, and RAEs to develop workflows related to behavioral health engagement for members released from the Department of Corrections (DOC).
- Refine and test outreach methodologies to engage identified members and complex members, including working with our automated outbound call vendor to add opt out options to comply with the Telephone Consumer Protection Act.
- Support implementation and troubleshooting related to the prescription benefit tool and move providers who are ready into phase 2.
- Evaluate the effectiveness of the interventions and identify opportunities for improvement across all measures, using data to drive interventions.

Special Populations:

- Utilize improved metric tracking to test our work's effectiveness and identify improvement opportunities.
- Track and analyze social determinates of health to determine opportunities to impact health disparities related to SDOH, such as race, ethnicity, age, and other factors.
- Report on process and outcome measures related to special populations and care coordination programs.

- Review and analyze programs funded by CCHA's Community Incentive Program to identify community wide gaps in services in order to improve the CIP application criteria and applicant process.

Member Experience of Care:

- Expand member satisfaction surveys to include members seeing BH providers in the independent provider network (IPN).
- Based on CAHPS results, implement improvement efforts around access to care, patient-centered communication, and coordinating medical care. Share best practices related to these domains across the PCMP network.
- Utilize a data dashboard and stratification framework to outreach and support members with the Medicaid renewal process to ensure continuous benefit coverage once the public health emergency (PHE) ends.

Patient Safety and Quality:

CCHA's patient safety goals aim to:

- Promote safe clinical practices in all aspects of clinical care and service.
- Engage members and providers concerning patient safety in all aspects of patient interaction.
- Identify and implement system and process improvements that promote patient safety throughout the health plan and care delivery system.

Quality Management Committee (QMC):

To achieve these goals, CCHA created the Quality Management Committee in both regions during the contract's first year. This dynamic committee comprises CCHA internal staff and external community providers/stakeholders. The QMC provides program direction and oversight to ensure CCHA operates as a united entity that integrates clinical care, operations, management, and data systems. The QMC is the forum for interdepartmental participation and works to establish the long-term strategic vision for the Quality Management (QM) Program. This committee will evaluate the annual QM Program's overall effectiveness in the following areas:

- Member satisfaction: improve processes to measure and monitor member satisfaction.
- Monitor program performance using the following tools:
    - KPI, Behavioral Health Incentive Plan (BHIP), and Behavioral Health Quality Incentive Plan (BHQIP) measures. The Behavioral Health Quality Incentive Plan (BHQIP) is for our providers to earn incentives based on their performance.
    - PIP activity and results
    - Colorado Annual RAE BH Encounter Data Quality Review (411 Audit)
    - HSAG annual site audit results
    - Provider performance, including CCHA's Accountable Care Network
    - Grievances
    - Quality of care concerns
    - Critical incident reviews

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Member Grievances:
CCHA has a process in place to support member grievances and complaints for any matter relating to our contract, including a method to trend and track information, which is used to improve patient safety and quality, drive program improvement activities, modification, and development. CCHA's goals are:

- 90% timeframe compliance within the initial 15 business day review period
- 100% timeframe compliance within the extended 14 calendar day review period
- 100% of clinical grievances will be investigated by clinical staff

Quality of Care (QOC) Concerns:
CCHA has created a QOC process, which encourages timely and accurate submissions from our provider network and internal care management staff. In conjunction with CCHA's medical director, a severity level is assigned for each QOC, and an investigation that supports the severity level is completed on all cases. All QOCs are tracked, trended, and reported to our QMC, which is then used to promote patient safety and quality, and inform credentialing processes, network training, and program improvement activities. CCHA's goals are:

- Annual training of internal CCHA staff to identify QOC concerns: 80% of member-facing staff will receive QOC training.
- Participate in a Quality of Care Grievances (QOCG) external audit and implement improvement recommendations.
- Identify best practices ongoing to minimize the risk of QOC occurrences.
- Enhance provider education regarding QOC and critical incident identification and submission.

Please fill out the following template for all projects that are associated with the programs listed in the gray boxes.

Goal	State Fiscal Year 22-23 Project/Initiative	Targeted Completion Date	Action(s)
Performance Improvement Projects (PIP)			
Successfully complete final module for the Depression Screening and Follow-up after Positive Depression Screening PIP	Report out data on interventions tested to increase screening and follow-up	June 30, 2023	Submit deliverables by the determined due dates Provide feedback on the PIP process strengths and lessons learned for developing new clinical and non-clinical PIP targets to begin in July 2023
Performance Measurement Data-Driven Projects			
Key Performance Indicators: Achieve the tier 1 goal for three of the six KPIs	Engage with PCMPs and ACN providers in quality	June 30, 2023	Educate PCMPs and community partners about the KPI changes and update materials or use existing materials to support

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Goal	State Fiscal Year 22-23 Project/Initiative	Targeted Completion Date	Action(s)
	improvement processes Partner with community organizations to align efforts and processes to achieve KPI goals Collaborate with HCPF on data disparities		Update CCHA's Provider Incentive Program to increase engagement of PCMPs in practice transformation efforts to improve PCMP KPI performance and educate providers about the new KPI. Utilize care coordination to educate members to connect with appropriate services Incorporate feedback from the Performance Improvement Advisory Committee (PIAC) and Member Advisory Committee (MAC) to inform KPI interventions
Implement new and updated KPIs	Educate providers and community partners about the new oral evaluation KPI	December 31, 2022	Partner with DentaQuest on messaging and identify opportunities for collaboration Develop monthly dashboards that correspond with DAP data to give providers actionable member lists
BH Incentive Measures: Achieve benchmark improvements on four of the five BHIP quality metrics	Engage with BH and PH providers in quality improvement processes Partner with community organizations to align efforts and processes to achieve BHIP goals	June 30, 2023	Promote program information to encourage enrollment in BHQIP and distribute performance status and disburse financial incentives to high-performing providers Improve the POINTS process, identify opportunities for improvement and work with inpatient hospitals to

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Goal	State Fiscal Year 22-23 Project/Initiative	Targeted Completion Date	Action(s)
			promote consistent discharge coordination Increase access to the Specialized Transitions of Care (STOC) team to work with discharge follow-up plans for members stepping down from inpatient, residential, and withdrawal management care for SUD, analyze impact of the program Partner with hospitals in HTP to better support members with SUD, assist with service planning and coordination at the time of discharge from the ED Maintain and improve existing notification protocols and expand timely referral process for children entering foster care Practice transformation coaches will hold monthly quality improvement meetings to provide support and assistance to increase depression screening and follow-up
Meet at least one of the three non-medication adherence Performance Pool metrics	Engage ACN providers and SEPs/CCBs to align efforts on Performance Pool metrics	June 30, 2023	Develop processes to engage, share data and offer feedback to ACN providers, SEPs/CCBS and CCHA internal teams aiming to align efforts on Performance Pool metrics and engage members in care

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Goal	State Fiscal Year 22-23 Project/Initiative	Targeted Completion Date	Action(s)
			Hold quality, check-in and quarterly leadership meetings with ACNs to discuss successes and opportunities for improvement
Meet at least one medication adherence Performance Pool measure	Engage with PCMPs and ACN providers in quality improvement processes	June 30, 2023	Incorporate in provider dashboards Provide actionable member level data for PCMPs
Member Experience of Care Improvement Driven Projects			
Monitor member experience, perceptions, accessibility, and adequacy of services within the region for behavioral health	Review survey results with key stakeholders to determine how best to use survey results	June 30, 2023	Monitor member satisfaction measures developed by the CMHCs Begin member satisfaction survey of the members seeing BH providers in the IPN and analyze results
Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey: Improve member experience of care	Use CAHPS data to identify potential interventions and work with providers to implement and test	June 30, 2023	Share results with all practices, work with quality improvement teams to address areas of opportunity Share results with CCHA's PIAC and brainstorm areas of opportunity
Start measuring member experience of care with CCHA care coordination	Implement internal member experience questions to CC operations	June 30, 2023	Identify and implement tools to collect member experience data. Begin collecting baseline data. Analyze data for potential opportunities for improvement.

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Member Grievances: 90% of member grievances will be completed within 15 business days	Member grievance completion provides an opportunity for increased member satisfaction, identification of areas of improvement	Quarterly reporting, ongoing	Execute process and workflows in place, reporting to HCPF and QMC quarterly
Member Grievances: 100% of member grievances will be completed within the extended 14 calendar days	Member grievance completion provides an opportunity for increased member satisfaction, and identification of areas of improvement	Quarterly reporting, ongoing	Execute process and workflows in place, reporting to HCPF and QMC quarterly
Member Grievances: 100% of clinical grievances will be investigated by clinical staff	Clinical grievance process	Quarterly reporting, ongoing	Clinical grievance process will be transferred to clinical staff, reporting to HCPF and QMC quarterly
Mechanisms to Detect Overutilization and Underutilization of Services			
Client Overutilization Program (COUP): Attempt to outreach 100% of members identified by HCPF on the quarterly COUP lists and employ new outreach procedures, scripts, and workflows to engage members and collaborate with our primary care providers and pharmacies	Continue tracking outreach to quarterly COUP members	June 30, 2023	Continue assessing outreach strategy to effectively reach members Engage members in care coordination
COUP: Identify members who may benefit from lock-in and engage the assigned PCMP and member to initiate lock-in, as appropriate	Utilize COUP lock-in in collaboration with PCMPs	June 30, 2023	Provide annual training for care coordinators on the lock-in process and identify anyone engaged with care coordination that may be appropriate for lock-in

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Goal	State Fiscal Year 22-23 Project/Initiative	Targeted Completion Date	Action(s)
			Work with PCMPs to identify members that may be appropriate for lock-in Evaluate members who have been locked in for appropriateness for continued lock-in Collaborate with other RAEs when locked-in members transition between RAEs
Quality and Appropriateness of Care Furnished to Members with Special Health Care Needs			
Increase complex members engaged in extended care coordination	Engage ACN providers, Single Entry Points (SEP) and Community Centered Boards (CCBs) to align efforts on Performance Pool metrics Leverage community partnerships to help engage members	June 30, 2023	Test outreach mechanisms by tracking success rates and care coordination engagement Update workflows as appropriate Engage MAC and PIAC to advise around messaging Risk stratify members to prioritize outreach
Improve SDOH data capture to identify and link members to resources based on their identified needs	Redesign all health needs assessments and standardize collection of SDOH Engage and incentivize providers to consistently utilize FindHelp's platform for SDOH resources	June 30, 2023	Review questions and structure of assessments Train Care Coordination staff and test data collection and linking questions Collaborate with hospital systems in HTP to receive notifications of identified SDOH needs.

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Goal	State Fiscal Year 22-23 Project/Initiative	Targeted Completion Date	Action(s)
			Execute Social Determinants of Health Provider Incentive Plan (SDOHPIP) Utilize the FindHelp platform in care coordination activities and outreach campaigns to connect members to community-based organizations that offer food, health, housing, job training, and education programs
Close health care gaps related to diversity, equity, and inclusion for the four focus areas identified by HCPF (COVID-19 vaccination rates, maternity and perinatal health, behavioral health, prevention/population health)	Use data to identify disparities and inform interventions	June 30, 2023	Develop dashboards that can filter populations by diversity data Analyze data to identify trends and gaps Work with MAC, PIAC, and community partners to develop interventions Implement and test interventions
Quality of Care Concern Monitoring			
QOC: Participate in QOCG external audit and implement improvement recommendations	Ensure compliance with the Medicaid contract around the standards for Quality of Care concerns	June 30, 2023	Review and update current policies and procedures related to audit standards to ensure compliance and identify areas of improvement
QOC: Identify best practices ongoing to minimize the risk of QOC occurrences	Providers will share best practices at the quarterly QMC meetings to improve clinical outcomes	Quarterly, ongoing	Engage QMC participants to share best practices that improve clinical outcomes Complete annual training of internal CCHA staff to identify QOC concerns: 80%

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			of member-facing staff will receive QOC training
QOC: Enhance provider education regarding QOC and critical incident identification and submission	Utilize multiple channels for provider education, including provider bulletin, town hall meetings, and PIAC meetings	June 30, 2023	Submit information for provider bulletin at least semi-annually and through provider town halls as appropriate
External Quality Review Driven Projects			
Site Audits: Achieve a met score on all standards or complete any necessary corrective action plans (CAPs)	Ensure compliance with the Medicaid contract around these standards: Coverage and Authorization of Service, Adequate Capacity and Availability of Services, Grievances and Appeal Systems, and Enrollment and Disenrollment	June 30, 2023	Create workplan and timeline Review contract requirements Review current policies and procedures related to the audit standards to ensure compliance and identify areas of improvement Complete any required actions and follow up on previous year CAPs
411 Audit Quality Improvement (QuIP): Support improvement of providers' documentation to comply with Uniform Services Coding Standards (USCS) and requirements	Facilitate and oversee 411 Audit quality improvement processes	June 30, 2023	Work with HSAG to determine quality improvement targets Partner with providers to develop and implement improvement processes
Internal Advisory Committees and Learning Collaborative Strategies and Projects			
PIAC: Continue to utilize PIAC as a steering group to re-invest funding to support community programs and meet CCHA's focus areas	Continue to implement the Community Incentive Program application process through	December 31, 2022	Facilitate process established to reinvest funds Educate new voting members on the process

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	the voting committee		Recruit subject matter expert co-chairs to ensure a diverse stakeholder group is represented (behavioral health, physical health, HFC member, community organizations, health equity) Monitor current programs being funded to ensure quality outcomes and members' needs are met Disseminate funds through the application process
PIAC: Utilize PIAC to collect feedback from multiple different community and provider voices to support CCHA's Diversity Equity and Inclusion (DEI) strategies and activities to ensure all members receive culturally accessible and competent care	Provide data to the committee specific to DEI efforts	Quarterly, ongoing	Receive feedback from the committee on member and system level barriers to accessing care Prioritize barriers based on feedback from the committee and identify strategies to minimize challenges to accessing care
PIAC: Expand engagement opportunities for increased attendance via a virtual platform at PIAC	Identify ways to continue to engage stakeholders and Health First Colorado members	Quarterly, ongoing	Collaboration with the MAC coordinator to recruit more members and identify a member interested in attending State MAC meetings Utilize community liaisons to share PIAC meeting information with entities that have not attended PIAC

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			Continue to share information about PIAC via email, CCHA newsletter, and social media to ensure current partners and new partners are familiar with PIAC and specific information covered in each meeting Weigh benefits and challenges of continuing virtual meetings vs. in-person forums, adapt appropriately
MAC: Continue to recruit committee members that come from diverse backgrounds	Implement outreach for committee members	Quarterly	Proactively outreach possible committee members with diverse backgrounds to assess interest in joining MAC
MAC: Continue to utilize feedback from the MAC to enhance the services provided	Use direct member input to inform and improve operations	June 30, 2023	Engage members to identify short- and long-term opportunity areas for the member engagement plan Solicit the lived experience of members to identify ways to engage members most effectively in their health at the micro and macro levels while improving the member experience