ANNUAL PERFORMANCE IMPROVEMENT PLAN

FY15/FY16

7.3 Performance Improvement. The Contractor shall submit an annual quality report and quality improvement plan to the Department for Approval.

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Quality Strategy Outline for FY15

Goal #1: Improve member health outcomes

Objective #1: During FY15, at least 60% of eligible children 3-9 years of age will receive at least one Well-Child visit during the measurement year in Regions 2, 3, and 5.

- Results: Performance as of March 2015 is presented below. **Objective not met.**

	March 2015	FY15 Goal
RCCO 2	44.10%	60%
RCCO 3	52.40%	60%
RCCO 5	59.20%	60%

- Strategies included:
  - COA launched an Interactive Voice Response (IVR) campaign for PCMP network utilization for attributed members.
  - COA deployed IVR calls to unattributed members in need of a well-child exam.
  - COA care managers conducted targeted calls to members in January 2015 (1467 outreached in Weld County, 164 outreached in Morgan County, and 845 in Denver County).

Objective #2: During FY15, emergency room visits per 1000 FTE will decrease at least 1% (per Region) below the regional baseline.

- Results: **Objective not met.** The results from July 2014 and March 2015 are presented below. ED rates actually experienced a significant increase that COA has also seen reflected in other lines of business as well, including the Behavioral Health Organization. It is speculated that this increase can be attributed to the previously uninsured Medicaid expansion population – issues with health literacy, the "warehousing" of previously unaddressed health issues, etc.

	July 2014	March 2015
RCCO 2	759.4	813.9
RCCO 3	720.1	743.9
RCCO 5	816.7	866.2

- Strategies included:
  - Colorado Access RCCO continues to address ED utilization. A workgroup has been established to specifically identify and target the root causes of this increase and to implement interventions within the RCCO population.
  - Coleman Model of Care for Transitions selected in June 2015 for implementation in July 2015, targeting populations transitioning from emergency and inpatient care to the home and community. COA is already experiencing increased engagement from members and providers across all three regions.
  - Implemented a connection with CORHIO to receive admit, discharge, and transfer (ATD) hospital data from 37 hospitals. This data is being provided daily to Care Management and delegates.

Objective #3: During FY15, postpartum visits will increase at least 1% (per region) from the regional baseline.

- Results: **Objective partially met.** As indicated below, COA met identified goals in Regions 2 and 3, but rates actually decreased in Region 5. COA will conduct further root cause analysis to determine why interventions were ineffective in region 5.

	July 2014	March 2015	% increase
RCCO 2	63.60%	69.20%	8.1%
RCCO 3	61.60%	62.20%	1.0%
RCCO 5	59.00%	51.30%	- 15.0%

- Strategies included: COA educated providers about the codes that are included in the calculation of this measure and the timeframe required for inclusion in the numerator. This education has occurred on an individual basis and as a part of the P3 and other provider meetings. Colorado Access has received feedback from multiple sources that PCMP internal processes do not meet the timeframe of the measure. For example, some PCMPs do the post-partum visit at 60 days to align with the well-child visit, which misses the required timeframe of 21-56 days.

Objective #4: During FY15, develop and implement an internet-based Diabetes self-management tool (with a depression screening component) for unattributed members that have not had an A1C test within the last 12 months.

- Results: Completed for all 3 regions, **objective met.**
- Strategies included: COA completed the web-based self-management tool in fall of 2014. RCCO adult unattributed members with a diabetes diagnosis were contacted directly by care management via telephone and offered the opportunity to complete the module (15% of those outreached completed at least one self-management module, 10% of those outreached completed a PHQ-9)

Objective #5: During FY15, COA internally derived care management metrics will be presented quarterly to the COA Quality Improvement Committee.

- Results: Data for Care Management metrics are generated, analyzed, and distributed on a monthly basis to the care management team. Metrics include: volume of outreach, volume of actual connection points for care coordination, health confidence, volume of specific interactions for targeted populations, etc. **Objective met.**

Goal #2: Improve member care experience

Objective #1: During FY15, 100% of members with "high intensity" hospital utilization patterns will be identified and receive a Care Manager intervention in order to decrease 30-day hospital all cause readmission rates in Regions 2, 3, and 5.

- Results: 100% of "high intensity" hospital utilization patterns received a care management intervention (an attempted contact, at minimum). **Objective met.**
- Other strategies included:
  - Implementation of the Coleman Model of Care Transitions program (as described above)
  - Implemented a connection with CORHIO to receive admit, discharge, and transfer (ATD) hospital data from 37 hospitals. This data is being provided daily to Care Management and delegates.
  - CoA worked closely with University Hospital Emergency Department to develop a model, outcome measures, payment, and contracting to co-fund two care manager positions in the emergency department. The job description was co-authored by UCH and CoA. The positions will be UCH employees and co-managed by UCH and CoA. These positions were posted at UCH in August 2015 and interviews will be set up as appropriate candidates are selected.

Objective #2: During FY15, 90% of PCMP network will provide new patient access to Routine, Non-Urgent, and Urgent care appointments within the HCPF contractual standard timeframes and after-hour access to care in Regions 2, 3, and 5.

- Results: All providers (100%) evaluated during FY15 were compliant with contractual timeframes for Routine, Non-Urgent, and Urgent care appointments. **Objective met.**
- Strategies included: COA utilized Secret Shopper process to evaluate samples of RCCO providers' ability to meet contractually required timeframes. Results were presented to each provider evaluated and to the COA Quality Improvement Committee.

Objective #3: During FY15, an increase will be seen in the number of members who receive follow-up care within 30 days of an inpatient discharge as compared to baseline for each region.

- Results: Results for each region are shown below. **Objective partially met (met in Region 2).**

	FY14	FY15	% increase
RCCO 2	46%	47%	2.1%
RCCO 3	49%	48%	-2.1%
RCCO 5	51%	50%	-2.0%

- Strategies included: As previously mentioned, COA implemented the Coleman model of transitions of care. However, the model was not fully implemented until late spring 2015, and therefore the intervention was not able to impact FY15 performance. COA expects to see an increase in performance in FY16.

Objective #4: During FY15, increased attention will be focused on researching and identifying evidence-based practices for ensuring that special populations are provided care by experts in their respective fields within Regions 2, 3, and 5.

- Results: **Objective met.**
- Strategies included:
  - Children and Youth with Special Health Care Needs (CYSHCN): COA conducted Sickle Cell Project with Children's Hospital Colorado (CHC) identifying 20 complex-need members and their families for targeted care management intervention and support. Project runs from January 2015 through December 2015.
  - Children with High Emergency Department (ED) Visits: COA Outreached 187 High Risk Prenatal, Post-partum, and NICU female members for targeted care management, and utilized CORHIO data to identify utilization to place in a high risk category for care management. COA is currently assessing additional methodologies for outreaching the high ED utilizer population through Interactive Voice Response and possible contract work with mobile, intensive medical and care management interventions at the community level.
  - High Utilizers of Emergency Department and Readmissions: Two care managers are assigned to this population, giving each care manager a caseload of about 55 (in line with the Coleman Model of Care Transitions caseload size). COA utilizes daily CORHIO reports to identify complex/chronic members that have 2 or more utilizations within the month for immediate outreach.
  - Homeless Adult Members: COA conducts outreach to locate targeted members and provide resource coordination for RCCO and/or ABC members in Denver and Arapahoe Counties. COA collaboratively assesses the individuals' needs across the health care system and social determinants of health to develop a care coordination plan.
  - COA utilized CORHIO data reports to stratify patients with Complex/Chronic, Moderate/Chronic and HIV for care management.

Objective #5: During FY15, 100% of high risk MMP members will complete a Service Coordination Plan (SCP) in person within 90 business days of the member's enrollment date within Regions 2, 3, and 5.

- Results: The SCP performance (both completed SCP and attempted SCP completion) is listed below. **Objective not met.**

	FY15 completed	FY15 attempts
RCCO 2	7.0%	40%
RCCO 3	10.0%	54%
RCCO 5	8.0%	53%

- Strategies included: COA implemented a process in which patient navigators scheduled the SCPs for the clinical care managers in the community. A web tool was developed for SCP stratification, scheduling, completion, and reporting. The staff and structure are firmly in place to sustain the implementation of initial and follow up SCPs using the web tool. While Colorado Access did not meet the identified goal for this objective, performance is consistent with local and national averages.

Goal #3: Improve Care Coordination, Integration, and Medical Neighborhoods

Objective #1: During FY15, 100% of PCMPs (in Regions 2, 3, and 5) that participate in the COA IVR Well-Child visit program will be provided member-level data for the members contacted during the IVR campaign (e.g., members who were contacted, outcome of the call).

- Results: 100% of providers participating in the IVR campaign are receiving member-level data for their respective members contacted. **Objective met**
- Strategies included: Seven provider clinics are currently participating in the IVR campaign, and each provider (100%) received customized reports about the outreach attempts and the success statistics.

Objective #2: During FY15, PCMP locations will achieve the status of delegated care management; in Region 2, three PCMPs will achieve delegation; in Region 3, two PCMPs will achieve delegation, in Region 5, one PCMP will achieve delegation.

- Results: Inner City (Regions 3, 5), Children's Health Place (Region 2). **Objective not met.**
- As a result of the previous year's HSAG site review, COA spent extensive time re-analyzing the delegation oversight process and re-designing the pre-delegation process and assisting providers in readiness preparations for delegation. Therefore, previously established goals were not met. However, COA has now developed and begun offering a menu of services that we can provide delegated and interested partners in assuming the responsibilities of care coordination for their patient population.

Objective 3: During FY15, COA will work with at least 11 practices that are located within the COA ACC region to increase the level of integration of care at the practice level.

- Results: COA is currently working with 12 practices on integrated care related activities (across all 3 regions). **Objective met.**
- Strategies included: COA conducted an integrated care need assessment in November 2014 with 25 providers that attended the Integrated Care Best Practices Meeting in July 2014. COA RCCO is also collaborating ABC and BHI on the PIP to improve depression screening rates and collaboration with behavioral health providers. In addition, several Learning Collaboratives were developed representing several organizations (FQHCs, CMHC, etc.): Integrated Care, Pediatric Integrated Care, and SUD Prevention

Objective #4: During FY15, COA will provide data on 100% of shared members to the Community Partners (mental health, CCB, SEP) in Regions 3 and 5 in order to assist with the identification of members, insight into utilization patterns, and to coordinate care management efforts. In FY15, COA will develop a plan and assess the feasibility of sharing the same information on common members with the mental health centers in Region 2.

- Results: **Objective not met**
- COA planned to leverage the Health Neighborhood Community Touchpoint List (CTP) as a means to create a more comprehensive dataset. This data was gathered from various partners but was not maintained. As such, we have chosen to discontinue the use of the use of the CTP list and determine next steps in data sharing with community and protocol partners.

Objective #5: During FY15, the number of hospitals that provide real-time data feeds to COA will increase; Region 2 will receive new feeds from 5 hospitals, Region 3 will receive new feeds from 4 hospitals, Region 5 will receive new feeds from 4 hospitals.

- Results: Implemented a connection with CORHIO to receive admit, discharge, and transfer (ATD) hospital data from 37 hospitals (each hospital serves members in all three regions). This data is being provided daily to Care Management and delegates. **Objective met.**

Objective #6: During FY15, COA will assess the provider network to identify opportunities for improving access to specialty care (e.g., behavioral health providers, pain management, etc.)

- Results: **Objective not met.**
- COA had planned to utilize the Clinical Referrals Protocol pilot to identify regional gaps in specialists and utilize the network assessment to inform the closure of gaps within specialty care. This process was implemented with a pilot group of PCMPs in fall 2014. However, the feedback from providers, members, and staff throughout the pilot was underwhelming. As a result, COA will revisit this process and collaborate with other RCCOs to align practices for the clinical referral protocol.

Goal #4: Increase attribution of members

Results: Despite continued exponential growth in the Medicaid membership in each of the three regions, COA successfully increased member attribution between 8-16% in each region. **Objective met.**

	Sept 2014	July 2015	% Increase
RCCO 2	72.65%	80.16%	9.4%
RCCO 3	66.90%	73.18%	8.6%
RCCO 5	68.34%	81.02%	15.7%

Strategies included:

- COA partnered with the BHOs in each COA region and Treatment Accountability for Safer Communities (TASC) to outreach members recently paroled from the Department of Corrections and assist with building a connection to a medical home. This also allows COA to assist these members with accessing prescription medications, behavioral health or substance abuse treatment, and establishing health literacy as quickly as possible after release.
- COA worked closely with University Hospital Emergency Department to develop a model, outcome measures, payment, and contracting to co-fund two care manager positions in the emergency department. The job description was co-authored by UCH and CoA. The positions will be UCH employees and co-managed by UCH and CoA. These positions were posted at UCH in August 2015 and interviews will be set up as appropriate candidates are selected.
- High risk MMP stratification identified those members that were not attributed to a PCMP. Through the SCP completion process, we assisted hundreds of individuals in being attributed to a medical home.
- Targeted outreach to unattributed youth ages 3-9 was implemented and expanded outreach is planned for FY16.

Key Initiatives Targeted for FY16

Emergency Department Visits per 1000 FTE (RCCO KPI)

- Goal: Achieve Tier 1 performance in each RCCO region (minimum of 1% over baseline)
- Key initiatives include: COA plans to continue utilizing the P3 report to educate providers about their KPI performance – not only performance to benchmark/incentives, but also as compared to other ACC providers/professional peers. In addition, COA hopes to implement a more robust quality coaching model/support in order to further assist providers in achieving the desired performance. Colorado Access is also collaborating with Banner Health ED facilities to outreach and hand-deliver member information, including education about choosing the right place to get care. This model has already been implemented in one Banner Health ED with plans for expansion.

Postpartum Visits per 1000 FTE (RCCO KPI)

- Goal: Continue to increase postpartum visits to a minimum of Tier 1 or 2 performance. For region 2 currently performing at Tier 2 status, COA identified a goal of a 3.8% increase.

	March 2015	Tier 1	Tier 2	FY16 Goal	% increase from FY15
RCCO 2	69.20%	59.60%	62.00%	72.0%	3.8%
RCCO 3	62.20%	66.60%	69.20%	66.6%	6.7%
RCCO 5	51.30%	66.00%	68.60%	66.0%	22.2%

- Key initiatives include: COA plans to continue working with practices (both on an individual basis and through provider forums) to provide education about this measure identify barriers to better performance.

Well-Child Checks for Children aged 3-9 (RCCO KPI)

- Goal: Achieve Tier 1 performance in all three regions (60%)

	March 2015	FY16 Goal	% increase from FY15
RCCO 2	44.10%	60.0%	26.5%
RCCO 3	52.40%	60.0%	12.7%
RCCO 5	59.20%	60.0%	1.3%

- Key initiatives include: COA will continue to utilize and expand the use of the IVR campaign in the PCMP network for attributed members, and targeted outreach for members without WCC visits. As mentioned above, COA also plans to continue using the P3 report to educate and motivate providers to improve their KPI performance in conjunction with a more robust quality coaching support.

Potentially Preventable Admissions (MMP KPI)

- Goal: Achieve minimum of Tier 1 performance in all 3 regions (minimum of 1% over baseline)
- Key initiatives include: COA's implementation of the Coleman Model of Care for Transitions has expanded to include the MMP population. In addition, the collaboration with Banner Health (as mentioned above) will also positively impact positively impact performance on this metric.

30-Day all-cause ER Re-admissions (MMP KPI)

- Goal: Achieve minimum of Tier 1 performance in all three regions (minimum of 1% over baseline)
- Key initiatives include: COA's implementation of the Coleman Model of Care for Transitions is expected to positively impact performance on this metric.

Depression Screening (MMP KPI)

- Goal: to be determined based on CY14 analysis
- Key initiatives include: All 3 RCCO regions have partnered with the overlapping BHO (ABC and BHI) in the statewide transitions of care performance improvement project. This project aims to improve the rates of depression screenings among adolescents and improve the transition from primary care to behavioral health when clinically appropriate. A core workgroup from each of these entities has been working diligently to identify barriers in this transition and meet with community and provider stakeholders to improve the transition from primary care to behavioral health, if clinically appropriate. The project has seen several early successes in supplemental, self-reported data, including an increase in the number of depression screenings being completed. The workgroup is in the process of securing pilot sites in each region to test out interventions such as electronic referrals. One test site (Region 3/BHI) has begun the pilot and is currently troubleshooting issues with the electronic referral system. Colorado Access hopes to secure a pilot site in each of the other 2 Regions during FY16. While this project is aimed at the RCCO population overall, it should significantly influence the rates of depression screenings among the MMP population as well.

Attribution Rates (internal COA initiative)

- Goal: Improve attribution rates by minimum of 5% in each region.

	July 2015	% Increase	FY16 Goal
RCCO 2	80.16%	3.0%	82.56%
RCCO 3	73.18%	3.0%	75.38%
RCCO 5	81.02%	3.0%	83.45%

- Key initiatives include: due to the success of interventions designed to increase attribution in FY15, COA plans to continue with a majority of the interventions previously mentioned, including outreaching members recently paroled from the Department of Corrections, outreaching unattributed youth ages 3-9, stratifying high risk MMP members for SCP completion, and the co-location of care managers in University Hospital's Emergency Department.

Child PCP Visits (internal COA initiative)

- Goal: Increase percent of RCCO child members who have visited their PCP (3 regions combined)

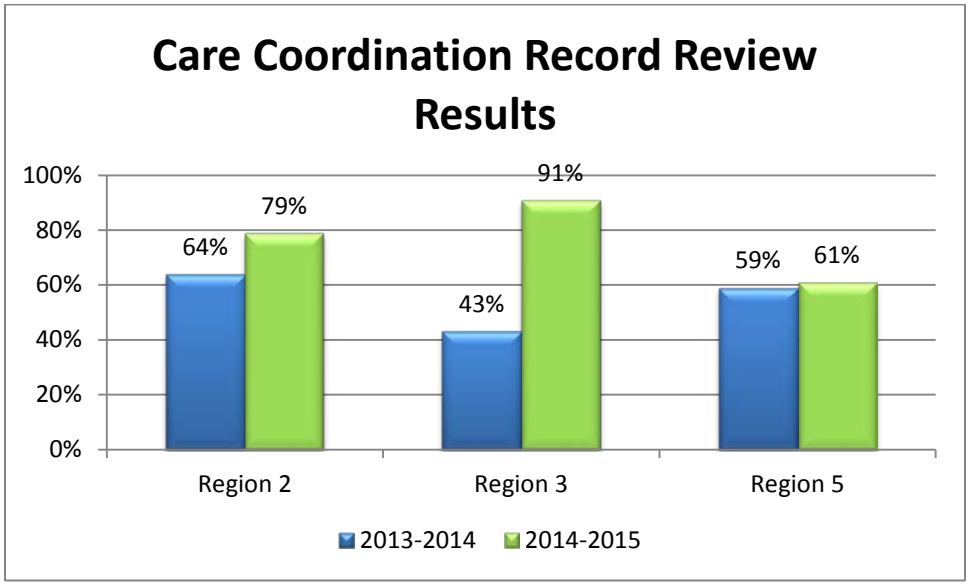
	FY14	% increase	FY15	% increase	FY16 Goal
% PCP visits	59.7%	8.8%	65.5%	6.4%	70.0%

- Key initiatives include: COA plans to outreach and education unattributed children in choosing a PCMP, the benefits of a medical home, and the benefits of regular well child exams. The WCC IVR campaign is also expected to positively impact performance on this metric.

EQRO Activities and Results

Site reviews

Colorado Access participated in the annual external and independent review of the quality of services covered under the RCCO contract. This year's review consisted of the following focus areas: Delegation of Care Coordination, RCCO Coordination with other Agencies/Provider Organizations, and a Care Coordination Record Review. The care coordination record review focused on two select populations: children with special needs and adults with complex needs.



Based on feedback received during this year's site visit, COA spent extensive time re-analyzing the delegation oversight process and re-designing the pre-delegation process to assisting providers in readiness preparations for delegation. COA has now developed and begun offering a menu of services that we can provider delegated and interested partners in assuming the responsibilities of care coordination for their patient population. COA plans to continue implementation of this more extensive pre-delegation process into FY16. In addition, COA is in the process of developing a more rigorous quality coaching strategy to assist delegates with practice and process improvements geared towards improving KPI and other care management performance goals.

EQRO ACTIVITIES AND RESULTS

Performance Improvement Projects

Adolescent Depression Screening and the Transition of Care to Behavioral Health

During FY15, Colorado Access developed a Performance Improvement Project (PIP) in collaboration with the 3 COA RCCO regions and the overlapping BHOs (ABC-Denver, ABC-NE, and Behavioral Healthcare, Inc.) aimed at improving adolescent depression screening and the transition of care to a behavioral health provider. Member who screen positive for depression (V40.9 with a 99420 CPT code) will be followed to determine if they attended a follow up visit with a behavioral health provider. A core workgroup from each of these entities has been working diligently to identify barriers in this transition and meet with community and provider stakeholders to improve the transition from primary care to behavioral health, if clinically appropriate. The project has seen several early successes in supplemental, self-reported data, including an increase in the number of depression screenings being completed. The workgroup is in the process of securing pilot sites in each region to test out interventions such as electronic referrals. One test site (Region 3/BHI) has begun the pilot and is currently troubleshooting issues with the electronic referral system. Colorado Access hopes to secure a pilot site in each of the other 2 Regions during FY16.

However, the billing and coding for the depression continues to be a barrier to capturing valid data for this project. Due to the continued issues with billing, coding, and capturing valid data, COA hopes to obtain supplemental data regarding the number of depression screenings being administered at high-volume FQHC providers such as Clinica, Salud, and Colorado Coalition for the Homeless during FY16.

EQRO ACTIVITIES AND RESULTS

CAHPS

The following is a summary of the 2014 Adults CAHPS performance highlights for each of the three COA RCCO regions. 2015 CAHPS results have not yet been distributed.

	Region 2	Region 3	Region 5
Rating of all Health Care	**	*	**
Rating of Personal Doctor	**	***	*****
Rating of Specialist Seen Most Often	*(+)	*(+)	*(+)
Getting Needed Care	**(+)	*	**
Getting Care Quickly	*(+)	*	***
How Well Doctors Communicate	****(+)	***	*****

(+) fewer than 100 respondents, caution should be exercised when interpreting these results

The following is a summary of the 2014 Child CAHPS performance highlights for each of the three COA RCCO regions. 2015 CAHPS results have not yet been distributed.

	Region 2	Region 3	Region 5
Rating of all Health Care	****	*	**
Rating of Personal Doctor	****	*	***
Rating of Specialist Seen Most Often	*****(+)	**(+)	****(+)
Getting Needed Care	**(+)	**	*
Getting Care Quickly	**	*	*
How Well Doctors Communicate	**	***	*

(+) fewer than 100 respondents, caution should be exercised when interpreting these results

Colorado Access is in the process of looking at CAHPS scores from across RCCO regions and developing interventions to improve individual region performance and performance across regions. Performance seems to vary significantly from region, despite significant overlap in shared member interactions with COA departments like Customer Service. More in depth analysis is needed to determine what drives such a variance in performance.

EQRO ACTIVITIES AND RESULTS

HEDIS

The following represents HEDIS performance in 2014 for each of Colorado Access's three RCCO regions as compared to the ACC total (2015 results have not yet been distributed). Performance often varies between regions, but a majority of measures perform at or above ACC average. Colorado Access will continue to monitor performance and implement targeted interventions accordingly. Many other efforts mentioned in this report are also designed to improve performance on various HEDIS metrics.

HEDIS Medicaid Measure		Region 2	Region 3	Region 5	ACC Total
Annual Dental Visit (all ages)		68.44%	70.13%	73.97%	67.09%
Testing for Children with Pharyngitis		71.13%	74.86%	64.14%	72.76%
Children and Adolescents Accessing Primary Care Provider (all ages)	12-24 months	96.77%	97.50%	97.71%	95.73%
	25 months – 6 years	85.11%	83.87%	83.56%	82.97%
	7-11 years	87.97%	84.24%	88.41%	86.33%
	12-19 years	86.19%	82.23%	88.82%	85.49%
Adults Accessing Preventative Care (all ages)		76.36%	72.45%	75.97%	74.51%
Women Receiving Chlamydia Screening (all ages)		53.06%	54.53%	66.80%	50.81%
Women Receiving Breast Cancer Screening		38.69%	42.90%	43.75%	40.28%
Adherence to Antipsychotics for individuals with Schizophrenia		69.70%	78.48%	72.09%	72.75%
Follow-up Care for Children Prescribed ADHD Medication	Initiation	18.92%	22.92%	NA	35.13%
	Continuation	NA	26.67%	NA	40.00%
Initiation/Engagement of AOD Treatment (ages 13+)	Initiation	29.82%	24.88%	30.83%	26.46%
	Engagement	9.63%	5.73%	5.12%	6.10%
Diabetes Screening for People with SCZ/BPD on Antipsychotics		77.78%	95.35%	93.06%	87.42%
Comprehensive Diabetes Care		75.72%	75.47%	47.57%	70.78%
Clients on Persistent Medications Receiving Annual Monitoring		81.93%	85.04%	83.07%	82.42%
Use of Imaging Studies for Low Back Pain		78.57%	77.99%	76.78%	78.38%
Pharmacotherapy Management of COPD	Corticosteroid	NA	66.18%	65.22%	64.45%
	Bronchodilator	NA	83.82%	86.96%	82.10%
Appropriate Medications for People with Asthma (all ages)		54.47%	62.08%	70.59%	59.61%
Disease Modifying Anti-Rheumatic Drug Therapy in RA		NA	85.94%	NA	74.65%
Ambulatory Care (per 1000 members)	Outpatient Visits	312.60	268.39	292.89	295.62
	ED Visits	60.06	57.03	66.93	62.66
Inpatient Utilization (Total Inpatient)	Discharges/1000 MM	9.02	6.11	7.76	6.88
	Days per 1000 MM	19.60	18.55	25.17	18.59
	Average Length of Stay	2.17	3.04	3.24	2.70
Antibiotic of Concern of all Antibiotic Scripts (all ages)		38.35%	34.69%	33.77%	36.91%
Frequency of Selected Procedures (per 1000 MM)	Bariatric Weight Loss Surgery	.19	.05	.04	.05
	Tonsillectomy (all)	.73	.37	.52	.49
	Hysterectomy (all)	.23	.10	.10	.18
	Cholecystectomy (all)	.60	.31	.33	.34
	Back Surgery (all)	.55	.52	.30	.49
	Mastectomy (all)	.14	.04	.07	.09
	Lumpectomy (all)	.25	.22	.16	.19

QUALITY IMPROVEMENT ACTIVITIES TABLE

Quality Improvement Activities

Quality Improvement Activity	Purpose or objective	Metric	Goal	Owner	Target Completion Date
Practice performance portfolios (P3)	Improve KPI performance	All KPIs	1% over baseline	Contract managers	Ongoing
Banner Health Outreach program	Improve KPI performance	ED rate/1000 MMP PPA	1% over baseline	RCCO Operations	Ongoing
Provider education (Postpartum visits)	Improve KPI performance	Postpartum visits/1000	Region 2: 72% Region 3: 66.6% Region 5: 66.0%	Contract managers	Ongoing
Interactive Voice Response (IVR) Campaign	Improve KPI performance	WCC 3-9	60% (all regions)	RCCO Operations	Ongoing
COA/TASC collaboration	Improve attribution	% attributed	Region 2: 82.56% Region 3: 75.38% Region 5: 83.45%	RCCO Care Management	Ongoing
Unattributed youth outreach	Improve attribution	% attributed	Region 2: 82.56% Region 3: 75.38% Region 5: 83.45%	RCCO Care Management	Ongoing
Co-location of care management in ED	Improve attribution	% attributed	Region 2: 82.56% Region 3: 75.38% Region 5: 83.45%	RCCO Care Management	Ongoing
Re-design of pre-delegation and delegation supports	Care Coordination	COA EQRO record review	85%	RCCO Care Management	6/30/16
Statewide Transitions PIP – Adol. Depression Screen and transition of care	Care Coordination	% screened % transitioned	Improvement over baseline	Quality	6/30/16

PRACTICE SUPPORT PLAN

Summary of Practice Support Plan

Operational Practice Support Activities (OPS)

Practice Performance Portfolios: Colorado Access ensures awareness of Key Performance Indicators (KPI) and provider focus on outcomes. Providers receive practice performance portfolios (P3) to explain the following:

- Their patients' use of the healthcare system compared to the ACC expected values
- Their patients' use of the healthcare system compared to similar practices as well as regional and statewide performance
- Individual practice performance analysis
- How KPIs are calculated and the inclusion/exclusion criteria

The P3 information will be reviewed annually (in person) with at least 50% of the contracted network. All delegates will receive the P3 report monthly (either electronically or in person). All other practices will receive the P3 report by request. All face-to-face meetings will include the Contract Manager, Medical Director, and Care Management.

Network Newsletters: Colorado Access distributes "news flash" newsletters specific to the various network partners – hospitals, specialists, community partners, and PCMPs. These newsletters increase general understanding about the ACC Program and Colorado Access's function as a RCCO. PCMP content also includes policies and procedures of the ACC program in addition to PCMP expectations.

Care Management Relationships: Colorado Access has developed care management programming for special populations, including physically or developmentally disabled, children and foster children, adults and the aged, non-English speakers, members with complex behavioral or physical health needs, members with HIV, MMP members, and members released from the Department of Corrections (DOC) or county jail system. Colorado Access is building and sustaining strong relationships with PCMPs through targeted and specialized outreach and interventions.

Member/PCMP RCCO Website: Colorado Access's website provides practice supports such as information about the ACC Program and Colorado Access RCCO, information about the principles of a Medical Home, PCMP Directories, clinical tools, client materials, operational practice supports, training opportunities, PCMP orientation materials, PIAC meeting schedules and meeting minutes, community resource list, online discussion forum, and a copy of the monthly newsflashes.

PRACTICE SUPPORT PLAN

Colorado Children's Healthcare Access Program (CCHAP):

- Core CCHAP practice-based work includes providing training, education, coaching, and consultation in alignment with HCPF's medical home principles for pediatric PCMPs
- Provides assistance to pediatric and family practices within COA RCCO regions, such as:
  - Pre-RCCO care management delegation planning, organization, coaching and training assistance
  - Post-delegation follow-up assistance, coaching, and training
  - Assistance with understanding KPI performance and integrating efforts into the practice/care management system to help improve KPIs
- CCHAP is focusing on the Well Child Check in 2016, including supporting practices with Well Child Check IVR calls

New Provider Orientation: Colorado Access provides information on the ACC Program to all new providers, including: ACC requirements, policies, and operational procedures. This complies with the current RCCO contract requirements and prepares newly contracted practices for when members are attributed.

Within one month of executing a contract, providers also receive information regarding benefit packages and coverage policies, prior authorization referral requirements, claims and billing procedures, eligibility and enrollment processes, and other operational components of service delivery. Currently, information is provided in a face-to-face meeting. A new training manual for this orientation was recently developed and will be submitted to HCPF for approval by the end of Q2 in FY16.

Within three months of PCMP agreement, the provider receives information on the ACC program and its requirements, policies, and operational procedures. Information is available in person, in paper form, or electronically. A revised 90-day orientation manual is planned for completion by Q3 of FY16.

Physical and Behavioral Health Integration:

- Telepsychiatry pilot project: This project connects a PCMP to child psychiatry via telemedicine. The patient will be able to meet with the psychiatrists and the physician will be able to consult with the psychiatrist twice per month. There are currently 6 pilot sites, each running a 12-month pilot process.
- Colorado Access and the Mental Health Center of Denver are collaborating to promote and facilitate co-located arrangements with pediatric practices

Practice Meetings: Colorado Access meets with providers to resolve practice questions about attribution and incentive payments and to ensure that all parties have an ongoing understanding of RCCO/ACC.

Instructional Webinars: Colorado Access develops and hosts educational webinars on topics of interest, including topics like The Medicaid Vision Benefit (by the Colorado Optometric Association) and Colorado Crisis Services and Enhanced Primary Care. All webinars are available on demand from the PCMP RCCO website.

PRACTICE SUPPORT PLAN

RCCO Provider & Community Forum: Colorado Access organizes a comprehensive meeting that includes a delegate meeting, an information and logistics meeting, and the Health Neighborhood meeting. Attendees receive program updates, community resources, and information specific to each group attending. The Health Neighborhood component also includes a de-identified case conference segment. These forums occur every other month (odd numbered months) from 10:00am-4:30pm.

Enrollment Reports: Colorado Access provides monthly enrollment reports to all MMP delegated providers and to additional clinics upon request via COA's shared file site.

Cross Systemic Care Coordination Conference (C3): Colorado Access facilitates an annual statewide opportunity for care managers across systems to participate and learn about other care management roles in various organizations. Topic examples include EPSDT, site benefits, Medicaid eligibility, health communities, pediatric and adult DME, and RCCO care management.

Pilot Programs:

- Homeless shelters: Colorado Access visits homeless shelters to assist with attribution and complex care management needs
- Dispatch Health/Metro Fire Department Pilot Program: designed to divert RCCO 911 ER admissions and establish follow up appointments with PCMP

Cultural Competency Training: Colorado Access offers cultural competency training to all practices upon request.

Provider Feedback Opportunities: Colorado Access seeks feedback from providers during meetings and various surveys in order to inform opportunities for improvement and shared information. Colorado Access completed a Provider Survey in May 2015 and plans to repeat the survey quarterly.

Care Coordination Metric Database: Colorado Access offers a database to all delegated providers that allows them to easily report care management metrics.

Other Provider Technical Support/Training: Colorado Access works diligently with providers to assure streamlined use of various tools such as the sFPT site, databases and web tools available to our providers.

Clinical Tools (CT)

Guiding Care Portal: Colorado Access provides member-specific clinical information to PCMPs including claims history, inpatient and ER utilization, and other diagnostic data. This centralized web portal allows practices to manage care management activities for RCCO members, including integrated care management, utilization management, provider referrals, pharmacy resources, provider portal, member risk prediction, stratification, and HEDIS measures.

Emergency Room Data Exchange: CORHIO data is currently being received from 37 hospitals from all 3 RCCO regions. Direct, daily hospital encounter data received from Melissa Memorial Hospital and Yuma Hospital, plus ER data from Denver Health.

Medicare/Medicaid Service Coordination Plan Web-Based Tool: Colorado Access created a fast, efficient, real-time tool that allows care manages to document the MMP SCP plans.

Service Coordination Plan Metric Database: Colorado Access created an efficient, effective, secure manner of reporting MMP metrics. This tool is currently being utilized by 23% of delegated providers use the tool's full functionality. 31% of delegated providers use read-only access.

Health Neighborhood Directory: Colorado Access is in the process of creating a comprehensive database that will include specialist and community partner information. The first phase is focused on profiling the organizations (demographics, admission requirements, services provided, accepting Medicaid patients, accepting Medicaid/Medicare patients, and the average wait time for an appointment. This tool is currently being tested internally, and the first phase of data is planned for Q3 of FY16.

KPI Trending: Colorado Access will provide detailed data on key performance indicators of the provider's choosing. This will allow providers to look at the claim level for members associated with the specific KPIs and to analyze data supplemental to the SDAC dashboards. This should be completed by Q2 of FY16.

Client or Member Materials (MM)

Interactive Voice Response Campaigns: Colorado Access utilizes monthly IVR calls through a vendor (Altegra) to outreach PCMP-specific members in need of a well-child check and allows for a warm transfer directly to the PCMP to schedule a visit. Colorado Access also utilizes IVR calls to provide education to members as needed about colorectal cancer screens, PCMP attribution, and MMP Town Hall meetings.

Wellness Appointment – Prevention Perk: In order to help practices connect with their members, Colorado Access sends out "Prevention Perks" – an incentive for members to attend wellness appointments with their PCMP. Members receive a $10 gift card when they complete a Health Risk Assessment and/or when they get an Annual Wellness Exam/Well-Child Exam. The forms for these "perks" are mailed to members within 30 days of enrollment.

PRACTICE SUPPORT PLAN ACTIVITIES TABLE

Practice Support Activities

Practice Support Activity	Purpose	Population	% of PCMPs Reached	Target Date
Practice Performance Portfolios (P3)	OPS	High KPI users	21% of PCMPs, 100% of delegates	Ongoing
Network "News flash"	OPS	NA	664 physicians; 188 hospital physicians; 500 Community partners	Ongoing
Colorado Access RCCO Website	OPS	All	100%	Ongoing
CCHAP practice and subcontracted work	OPS	Pediatric	29% PCMPs	Ongoing
New Provider Orientation – 30-day training manual	OPS	All	100%	12/31/15
New Provider Orientation – 90-day training manual	OPS	All	100%	3/31/16
Telepsychiatry Pilot Projects	OPS	All	6%	Ongoing
MHCD Co-location efforts	OPS	All	2%	Ongoing
Instructional Webinars	OPS	All	Unknown	Ongoing
RCCO Provider & Community Forums	OPS	All	100% delegates	Ongoing
Enrollment Reports	OPS	All	100% delegates	Ongoing
Cross-Systemic Care Coordination Conference (C3)	OPS	All	Unknown	6/2016
Homeless Shelter Pilot Program	OPS	Homeless	Unknown	Ongoing
Dispatch Health/Metro Fire Department Pilot	OPS	All	NA	Ongoing
Cultural Competency Training	OPS	All	NA	Upon request
Provider Feedback Surveys	OPS	All	100%	12/31/15
Care Coordination Metrics Database	OPS	All	100% of delegates	Ongoing
Other Provider Technical Support/Training	OPS	All	As needed	Ongoing
Guiding Care Portal	CT	All	2%	Ongoing
CORHIO Data Exchange	CT	All	165	Ongoing
MMP Service Coordination Plan Web-based Tool	CT	MMP	23% full function, 31% read-only	Ongoing
MMP Service Coordination Plan Metric Database	CT	MMP	100% delegated MMP Providers	Ongoing
Health Neighborhood Directory	CT	All	NA	Phase 1: 3/31/16
KPI Trending	CT	Attributed	100% delegates	12/31/15
Interactive Voice Response Campaigns	MM	High KPI users	7%	Ongoing
Wellness Appointment Prevention Perks	MM	All	NA	Ongoing