ANNUAL PERFORMANCE IMPROVEMENT PLAN

FY16/FY17

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 FY16

Goal #1: Improve member health outcomes

Objective #1: 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**:** Objective was not met. Performance as of March 2016 is presented below. While COA continued with strategies to improve on this objective, numbers remain flat or decreased from FY15. COA will continue to analyze strategy and implement interventions to increase these numbers.

	March 2015	March 2016	FY16 Goal
RCCO 2	44.10%	44.1%	60%
RCCO 3	52.40%	51.4%	60%
RCCO 5	59.20%	57.1%	60%

- Strategies included:
  - COA continued to utilize and expand the use of the IVR (Interactive Voice Recording) campaign in the PCMP network for attributed members, and targeted outreach for members without well-child visits.
  - COA's Resource & Referral Coordination team periodically receives a list of children/families ages 3-9 years old that have not yet had their well child exams (verified via claims data). The coordinators attempt telephonic outreach with the family, discuss PCMP attribution if the family/child did not have PCMP, and discuss the importance of WCC exam.
  - COA sponsored health fairs

Objective #2: Decrease emergency room visits per 1000 members by at least 1% (per region) below the regional baseline.

- Results: Objective was met. The results from July 2014, March 2015, and March 2016 are presented below. RCCOs 2, 3, and 5 successfully met the objective of decreasing ER visits by at least 1%.

	July 2014	March 2015	March 2016	Percentage Points from Baseline
RCCO 2	759.4	813.9	783.2	(1.0%)
RCCO 3	720.1	743.9	719.0	(4.1%)
RCCO 5	816.7	866.2	868.7	(2.3%)

- Strategies included:
  - Utilization of real time data feeds through CORHIO
  - High risk ER utilization reports created from SDAC data and provided to the care management teams for strategic outreach and education.
  - Partnership with Dispatch Health and South Metro Fire Department in pilot targeted to decrease ER utilization.
  - Collaboration and coordination with PCMPs, BHOs, and ALTSS (SEP) for higher risk/ER utilizers.

Objective #3: Postpartum visits will increase at least 1% (per region) from the baseline.

- Results: Objective was met. The change in percent from March 2015 to March 2016 is presented below. COA met and exceeded goals in all RCCO regions and will continue with strategies that are producing results.

	July 2014	March 2015	March 2016	Percentage Points from Baseline	FY16 Goal
RCCO 2	63.6%	69.2%	73.4%	4.2%	1.0%
RCCO 3	61.6%	62.2%	64.2%	2.0%	1.0%
RCCO 5	59.0%	51.3%	56.5%	4.3%	1.0%

- Strategies included: COA continued working with practices (both on an individual basis and through provider forums) to provide education about this measure and identify barriers to better performance.

Objective #4: Decrease potentially preventable admissions (MMP KPI) with a minimum 1% from baseline for all 3 regions.

- Results: Objective was partially met (2 of 3 regions). Percentage point change from baseline is below.

	FY16 Goal	March 2016
RCCO 2	(1.0%)	(25.7%)
RCCO 3	(1.0%)	(11.8%)
RCCO 5	(1.0%)	(.8%)

- Strategies included: Strategic outreach of high risk MMP members to conduct in-person Service Coordination Plan (SCP) to identify barriers, needs, and potential opportunities for intervention.

Objective #5: Decrease 30-Day all-cause ER re-admissions (MMP KPI) to achieve Tier 1 performance in all three regions (minimum of 1% from baseline).

- Results: Objective was partially met (1 or 3 RCCO regions). Percentage point change from baseline is below.

	FY16 Goal	March 2016
RCCO 2	(1.0%)	5.4%
RCCO 3	(1.0%)	5.6%
RCCO 5	(1.0%)	(13.7%)

- Strategies included:
  - Utilization of CORHIO data feeds for MMP follow-up within 7 days of discharge from hospital or nursing facility by MMP team to conduct transitions of care.
  - Strategic outreach of high risk MMP members to conduct in-person Service Coordination Plan (SCP) to identify barriers, needs, and potential opportunities for care management intervention.

Objective #6: Improve depression screening in primary care (MMP KPI)

- Results: Objective not met. All three RCCO regions continue to pursue the goal of reaching at least the Tier 1 Target Rate as defined by the state KPI Gap Closure Target.

	FY16 Goal	March 2016
RCCO 2	11.42%	10.8%
RCCO 3	3.58%	2.4%
RCCO 5	3.62%	2.8%

- Strategies included: 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 similar model is being used with the MMP population.

Goal #2: Increase attribution of members

Objective #1: Increase attribution rates by minimum of 3 percentage points in each region.

- Results: Objective was not met. Percentage point change from baseline is below. After several periods of steady increase and/or stability in attribution, COA is starting to observe a slight decrease in attribution. COA has further analysis planned for FY17 in order to address this regression.

	July 2015	June 2016	FY16 Goal
RCCO 2	80.16%	81.91%	82.56%
RCCO 3	73.18%	75.16%	75.38%
RCCO 5	81.02%	76.04%	83.45%

- Strategies included:
  - Outreach campaigns for unattributed children ages 3-9 years old, including Interactive Voice Recording reminding them to get their well child exam.
  - Stratification of MMP population: high risk members are defined high risk if unattributed.
  - Co-location of a care manager in University Hospital's Emergency Department who assists members in coordination of care and encourages attribution and PCP connection.

Key Initiatives Targeted for FY17

Emergency Department Visits per 1000 FTE (RCCO KPI)

- Goal: Decrease emergency department (ED) visits per 1000 FTE by at least 1% (per Region) below the regional baseline.
- Key initiatives include:
  - Member outreach and engagement to decrease preventable ED visits
  - Identify strategic care management facility placement buildout for reduction in PPA and avoidable ER visits
  - Collaboration with regional FQHCs to target populations that historically over-utilize the emergency department

Postpartum Visits per 1000 FTE (RCCO KPI)

- Goal: Postpartum visits will increase at least 1% (per region) from the baseline.
- Key initiatives include:
  - Continue working with practices (both on an individual basis and through provider forums) to provide education about this measure and identify barriers to better performance.
  - The Population Health uses the Pregnant Women List and claims data to evaluate health considerations that could contribute to a higher risk pregnancy, such as mental health diagnoses, diabetes, and preeclampsia. This information is then shared with the care management team to help prioritize and strategize their member outreach efforts.
  - By looking at the disparities in performance between providers, COA can determine top performers to engage in a best practices discussion to assist the remaining practices. COA analyzes internal data to identify targeted intervention opportunities, including:
    - Unattributed vs attributed members
    - Delegated vs Non-Delegated providers
    - RCCO region vs RCCO region
  - Because practices are sometimes unaware that their members are pregnant, reports are being developed with COHRIO to provide accurate and timely pregnancy data to practices in order for them to be able to follow up with their member.
  - Because practices are sometimes unaware that their members have delivered, reports are being developed with COHRIO to provide timely delivery data.
  - Some practices are inaccurately coding their visits and are not receiving credit for their exams – COA is assisting them in developing a best practices coding guide for all to follow. COA found in one case (Denver Health), that a chart review along with a billing review improved their performance in this area by ~25%.
  - Some members may be unaware of the need and benefits of a post-partum exam. COA will explore ideas for a member education pamphlet and determine where it should be given to the member.

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

- Goal: 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.
- Key initiatives include:
  - Continue to utilize the Interactive Voice Response system to encourage families to schedule their child's exams.
  - Continue outreach to attributed and unattributed members to encourage use of this benefit.
  - By looking at the disparities in performance between providers, COA can determine top performers to engage in a best practices discussion to assist the remaining practices. COA analyzes internal data to identify targeted intervention opportunities, including:
    - Unattributed vs attributed members
    - Delegated vs Non-Delegated providers
    - RCCO region vs RCCO region
  - Creation of a Coding Best practices document will assist providers in getting "credit" for each of the well-child visits that are occurring
  - Geo-mapping to identify where locations of children who are not getting a well-child visit; this will allow for further barrier analysis
  - Practices will be working to have all customer-facing employees focus on scheduling for well child checks.
  - Incentive programs are being developed at the request of practices. Beginning in January of 2017, COA will pilot an incentive program utilizing gift cards for parents who bring their children in for a well-child visit. A "Phase 2" of this program is also being planned. COA will analyze the results of the program and potentially change outreach strategies and incentives to reach the maximum number of members.

Potentially Preventable Admissions (MMP KPI)

- Goal: Decrease potentially preventable admissions (MMP KPI) with a minimum 1% from baseline for all 3 regions.
- Key initiatives include: Continue strategic outreach of high risk MMP members to conduct in-person Service Coordination Plan (SCP) to identify barriers, needs, and potential opportunities for intervention.

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

- Goal: Decrease potentially preventable admissions (MMP KPI) with a minimum 1% from baseline for all 3 regions.
- Key initiatives include:
  - Continue utilization of CORHIO data feeds for MMP follow-up within 7 days of discharge from hospital or nursing facility by MMP team to conduct transitions of care.
  - Strategic outreach of high risk MMP members to conduct in-person Service Coordination Plan (SCP) to identify barriers, needs, and potential opportunities for care management intervention.
  - Engage member in transitions of care services after inpatient admission and following member for 30-days post discharge

Depression Screening (MMP KPI)

- Goal: Increase depression screenings in primary care setting to meet the Tier 1 Target Rate based on KPI Gap Closure target established by the state.
- Key initiatives include: Continue working with providers to identify barriers to billing depression screenings

Member Health Promotion and Prevention Screening

- Goal: Improve member utilization and screening rates for screening services promoting health prevention and promotion.
- Key initiatives include:
  - Postpartum Follow Up Reminder Campaign
  - Member outreach and engagement to improve preventative services screening rates
  - Member outreach and engagement to improve proactive management of chronic health conditions.

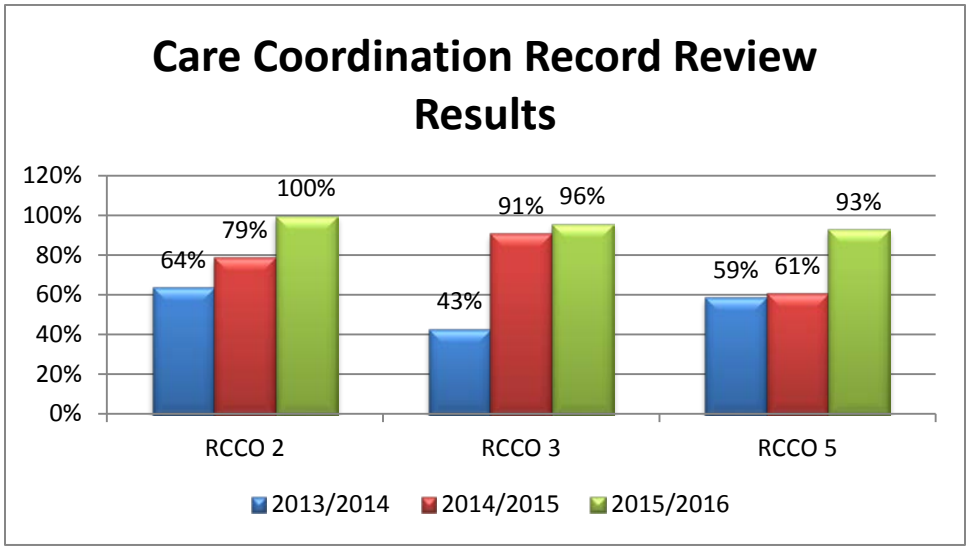
Unattributed Member Attribution and Engagement

- Goal: Improve attribution and engagement (i.e. utilization of a medical home) of currently unattributed members.
- Key initiatives include:
  - Unattributed adult outreach and engagement via multi-channel campaigns
  - Unattributed child outreach and engagement via multi-channel campaigns

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: Integration With Specialist Providers, Follow-up of Region-specific Special Projects, Integration With Behavioral Health Services/BHOs, and a Care Coordination Record Review. The care coordination record review focused on understanding the role of the Service Coordination Plan (SCP) in documenting and performing care coordination. Colorado Access scored 96 percent overall in this Care Coordination Record Review, the results are detailed below.



Based on feedback received during last 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 also began offering a menu of services that we can provider delegated and interested partners in assuming the responsibilities of care coordination for their patient population. These efforts contributed to the excellent scores on the Care Coordination Record Review this year.

EQRO ACTIVITIES AND RESULTS

Performance Improvement Project

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 three COA RCCO regions (2, 3, and 5) and the other overlapping BHOs (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.

Results and Analysis

FY16 saw some success for this project. The adolescent screenings have continued to improve according to collection of supplemental data from high volume providers. Region 3/BHI has gone live with their electronic referral system. Results on how this intervention will affect project outcomes should become more clear in FY17, as the system was rolled out live early in FY16, and continued to be piloted throughout FY16. Colorado Access has made progress in securing additional pilot sites, and hopes to work with Planned Parenthood for RCCO 2 on this project.

However, the billing and coding for depression screenings continues to be a barrier to capturing valid data for this project. ABC continues to address this barrier through provider awareness and interventions designed to encourage billing this service. In RCCO 2 experienced an exceptional barrier in that there were zero screenings billed during the baseline year. COA is therefore using calendar year 2015 as the baseline year for RCCO 2. Preliminary data does show that RCCO 2 has billed some screenings, so baseline data should be able to be collected with a valid denominator.

EQRO ACTIVITIES AND RESULTS

CAHPS

The following is a summary of the 2014 and 2015 Adults CAHPS performance highlights for each of the three COA RCCO regions. Adults were not surveyed in 2016 due to costs, but will be surveyed in 2017.

	Region 2		Region 3		Region 5	
	2014	2015	2014	2015	2014	2015
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 2016 Child CAHPS performance highlights for each of the three COA RCCO regions. Results are for all three RCCO Regions combined. Colorado Access had a response rate of 32.78% with a total number of respondents being 516.

RCCO Regions 2,3, and 5 Combined	2016
Rating of Health Plan	60.4%
Rating of all Health Care	71.5%
Rating of Personal Doctor	76.3%
Rating of Specialist Seen Most Often	68.5%
Getting Needed Care	87.1%
Getting Care Quickly	92.3%
How Well Doctors Communicate	97.7%
Customer Service	81.5%
Shared Decision Making	80.3%

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.

Colorado Access Quality and Performance Advisory Committee (QPAC) meetings continue to evolve, adding additional members from each region, as well as adding members of the provider community. This meeting continues to provide a venue for members to provide feedback about the Colorado Access RCCO program and for providers to have a forum to hear that feedback so as to shape provider policy in response.

EQRO ACTIVITIES AND RESULTS

HEDIS

The following represents HEDIS performance in 2016 for each of Colorado Access's three RCCO regions as compared to the ACC total. 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
Annual Dental Visit (all ages)		61.5%	64.30%	71.84%
Testing for Children with Pharyngitis		67.18%	78.09%	73.86%
Children and Adolescents Accessing Primary Care Provider (all ages)	12-24 months	94.25%	91.45%	94.32%
	25 months – 6 years	81.41%	79.48%	83.21%
	7-11 years	84.46%	82.82%	86.39%
	12-19 years	85.12%	81.86%	88.63%
Adults Accessing Preventative Care (all ages)		73.80%	66.26%	71.17%
Women Receiving Chlamydia Screening (all ages)		49.27%	57.00%	67.19%
Women Receiving Breast Cancer Screening		36.00%	43.89%	45.41%
Follow-up Care for Children Prescribed ADHD Medication	Initiation	38.10%	33.18%	32.87%
	Continuation	39.13%	33.14%	NA
Comprehensive Diabetes Care	A1c Testing	72.29%	71.01%	46.16%
	A1c Poor Control	99.62%	99.60%	99.81%
	A1c Control	0.19%	0.22%	0.08%
	Eye Exam Performed	32.77%	28.37%	28.84%
	Neuropathy Attention	78.96%	80.78%	79.57%
	BP Controlled	0.00%	0.00%	0.00%
Clients on Persistent Medications Receiving Annual Monitoring		83.36%	83.90%	85.90%
Use of Imaging Studies for Low Back Pain		73.77%	78.68%	78.99%
Pharmacotherapy Management of COPD	Corticosteroid	77.27%	75.90%	68.23%
	Bronchodilator	86.36%	86.32%	82.29%
Medication Management for People with Asthma (all ages)		46.77%	44.51%	45.25%
Disease Modifying Anti-Rheumatic Drug Therapy in RA		79.1%	85.53%	83.33%
Ambulatory Care (per 1000 members)	Outpatient Visits	297.45	244.59	267.44
	ED Visits	62.41	55.95	64.19
Inpatient Utilization (Total Inpatient)	Discharges/1000 MM	6.16	5.58	7.30
	Days per 1000 MM	24.96	24.25	35.31
	Average Length of Stay	4.05	4.34	4.84
Antibiotic of Concern of all Antibiotic Scripts (all ages)		39.22%	36.10%	35.42%
Frequency of Selected Procedures (per 1000 MM) (Average All Ages)	Bariatric Weight Loss Surgery	0.05	0.03	0.03
	Tonsillectomy (all)	0.69	.38	.48
	Hysterectomy (all)	0.13	0.11	0.13
	Cholecystectomy (all)	0.43	0.26	0.20
	Back Surgery (all)	0.85	0.59	0.45
	Mastectomy (all)	0.16	0.11	0.17
	Lumpectomy (all)	0.20	0.18	0.16

QUALITY IMPROVEMENT ACTIVITIES TABLE

Quality Improvement Activity	Purpose or objective	Metric	Goal	Owner	Target Completion Date
Increase well child visits for children 3-9 years of age	Improve member health outcomes	Percent who receive 1+ well child visit	60% (all regions)	Care Management	June 2017
Decrease ED visits	Improve member health outcomes	ED visits per 1000 members	Decrease by 1% per region below baseline	Care Management	June 2017
Increase post-partum visits	Improve member health outcomes	% from baseline	Increase by at least 1% from the regional baseline	Population Health	June 2017
Decrease potentially preventable admissions (PPA's)	Improve member health outcomes	% from baseline	Decrease by at least 1% from regional baseline	Care Management	June 2017
Decrease 30 day all cause ER Re-admission	Improve member health outcomes	% from baseline	Decrease by at least 1% from regional baseline	Care Management	June 2017
Improve depression screening in primary care	Improve member health outcomes	% from baseline	Increase by at least 1% point from regional baseline	Quality, RCCO, Provider Contract Management	June 2017
Increase child PCP visits	Improve member health outcomes	Percent of members	70% (all regions)	Care Management	June 2017
Increase attribution rates	Increase Attribution of Members	% of attributed members	3% increase in each region	Population Health	June 2017
Improve member utilization and screening rates for screening services	Improve member health outcomes	Screening and engagement rates with members with chronic conditions	Increase in screening rates across all three regions	Population Health	June 2017

PRACTICE SUPPORT PLAN

Summary of Practice Support Plan

Operational Practice Support Activities (OPS)
Contract managers and RCCO staff meet as requested with contracted PCMP's to provide information about RCCO, HCPF, care management and other timely initiatives. Practice Orientation Refreshers are scheduled as needed, and specific instruction geared to KPI improvements and data compliance, access to the SFTP and other elements of enhanced performance as included.

Network Newsletters: Colorado Access distributes a newsletter with specific information for the various network partners – hospitals, specialists, community partners, and PCMPs. This newsletter increases the 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.

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, including 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 2017 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. Information is provided in a face-to-face meeting and through a training manual that was developed in 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.

PRACTICE SUPPORT PLAN

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. The pilot has met with varying success, and brought forward development of a workflow to assure practice readiness. Physical space, patient check-in, role of the practice staff and EMR charting had to be customized for each site.

Colorado Access and the Mental Health Center of Denver are collaborating to promote and facilitate co-located arrangements with pediatric practices There are four PCMP's who began the integration program in 2016, and another six selected for outreach and implementation in 2017. Each practice has a unique model to fit their practice and population. Two share a full time MHCD staff person to meet the needs of the practices. One partnered with a Colorado Access Pay for Performance grant opportunity and MHCD to implement a FTE position and to subsidize it until credentialing and billing were established, which has now been accomplished.

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 Topics like implementation of the Access KP Project.

RCCO Provider & Community Forum: Colorado Access organizes a comprehensive meeting that includes a delegate meeting and an information and logistics meeting. Attendees receive program updates, community resources, and information specific to each practice's needs.

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 care managers visit homeless shelters to assist with attribution and complex care management needs
- South Metro Fire Department Pilot Program: designed to divert RCCO 911 ER admissions and establish follow up appointments with PCMP
- Colorado CONNECT, a twelve site pilot project, is launching in Westminster to deploy EMS staff as patient navigators, advocates and health coaches. The program was augmented by the City of Westminster adding a "Prescription for Play" feature to promote free or reduced access to park and recreation amenities for individuals and families identified by the EMS health navigators to be at risk of poor health outcomes such as childhood obesity or COPD.

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

PRACTICE SUPPORT PLAN

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 requests provider feedback as a part of each Provider meeting, and dedicated an entire Information meeting agenda to learning more about what practice supports are useful.

Care Coordination Metric Database: Colorado Access offers a database to all delegated providers that allow 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 hospitals from all 3 RCCO regions. Direct, daily hospital encounter data is received from Melissa Memorial Hospital and Yuma Hospital, plus ER data from Denver Health.

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

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.

Client or Member Materials (MM)

Interactive Voice Response Campaigns: Colorado Access utilizes IVR calls through a vendor to outreach and engage with members. Campaigns are used to both educate members on health promotion and remind them of when they may be due for a screening or other prevention service. Colorado Access also utilizes IVR calls to proactively engage with unattributed members and warm transfer them to the Resource and Referral team to select a medical home.

Prevention Perks: In order to help practices connect with their members, Colorado Access distributes "Prevention Perks" – an incentive for members to attend certain types of appointments or complete specific screening services. For example, members receive a prevention perk as part of their new member Medicaid packet, and can be "perked" a $10 gift card for completing an annual wellness visit.

PRACTICE SUPPORT PLAN ACTIVITIES TABLE

PRACTICE SUPPORT ACTIVITY	PURPOSE	POPULATION	% OF PCMPS REACHED	TARGET DATE
Network Newsletter	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%	Ongoing
Colorado CONNECT	OPS	Westminster	40%	Ongoing
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	Ongoing
Homeless Shelter Pilot Program	OPS	Homeless	Unknown	Ongoing
South Metro Fire Department Pilot	OPS	All	NA	Ongoing
Cultural Competency Training	OPS	All	NA	Upon request
Provider Feedback Surveys	OPS	All	100%	Ongoing
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
KPI Trending	CT	Attributed	100% delegates	Ongoing
Interactive Voice Response Campaigns	MM	High KPI users	7%	Ongoing