REGION 3 PERFORMANCE IMPROVEMENT ADVISORY COMMITTEE

Wednesday, June 5, 2019
Colorado Access

Committee Business

1. Approval of March meeting minutes – *Kelly Marshall*
2. Approval of Committee Charter – *Kelly Marshall*
3. Approval of Leadership Positions – *Kelly Marshall*
4. Selection of staggered terms – *Molly Markert*
5. Member Advisory Council visit schedule update – *Julia Mecklenburg*

Leadership Proposal for Consideration and Approval

Chair: Addison McGill, HealthOne Behavioral Health Services

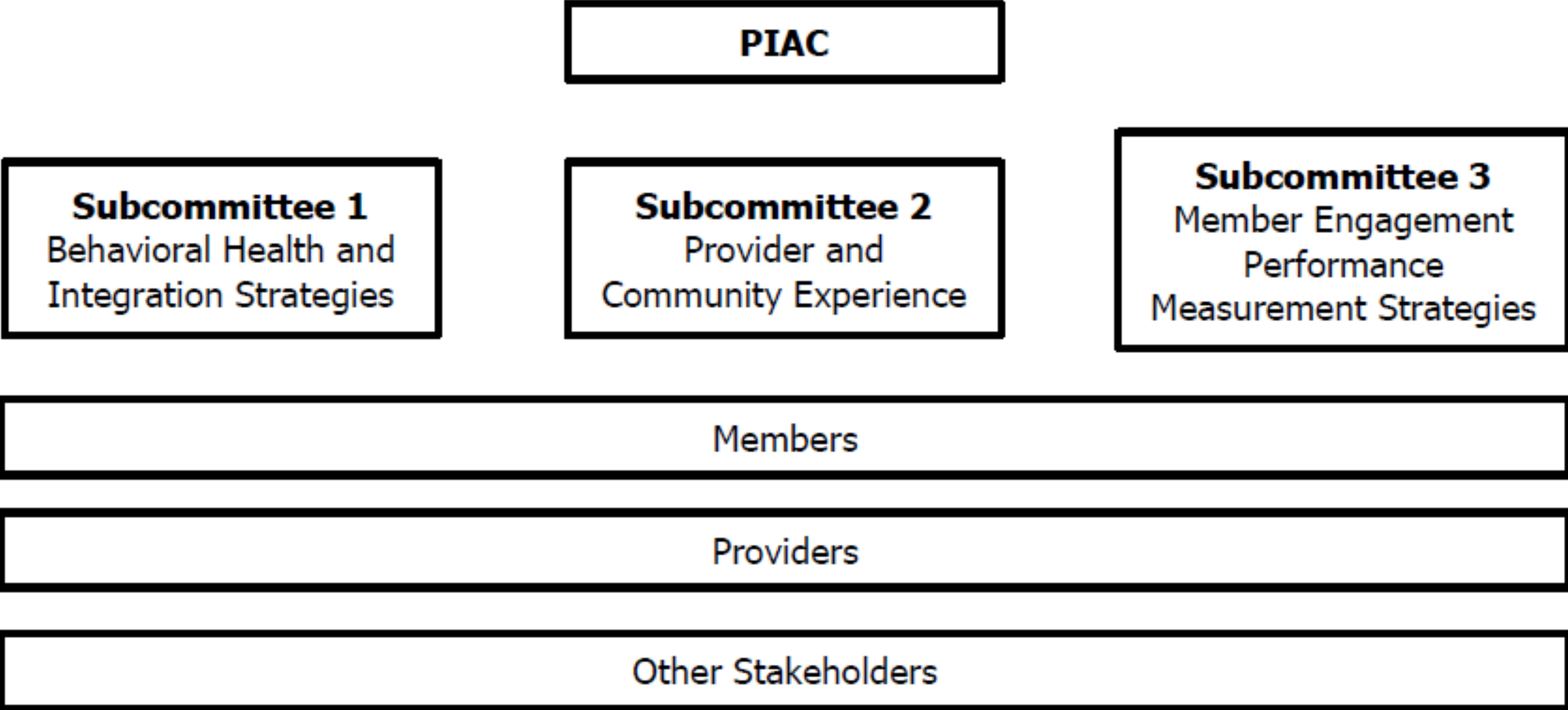
Vice Chair/Member Chair and Liaison to the Member Advisory Council: Marc Ogonosky, Health First Colorado Member

R3 Governing Council Representative #1: Harry Budisidharta, Asian Pacific Development Center

R3 Governing Council Representative #2: Daniel Darting, Signal Behavioral Health Network

State PIAC Representative: Shera Matthews, Doctor's Care

State PIAC Update



REGIONAL PERFORMANCE – PHYSICAL HEALTH CONCEPTUAL OVERVIEW

PAY FOR PERFORMANCE – PHYSICAL HEALTH

- Catherine Morrisey and Shelby Kiernan

AGENDA

1. Enrollment and Demographics
2. Physical Health Measures (5 out of 7)
    - Current Performance
    - Current Intervention Planning
3. Feedback and Discussion

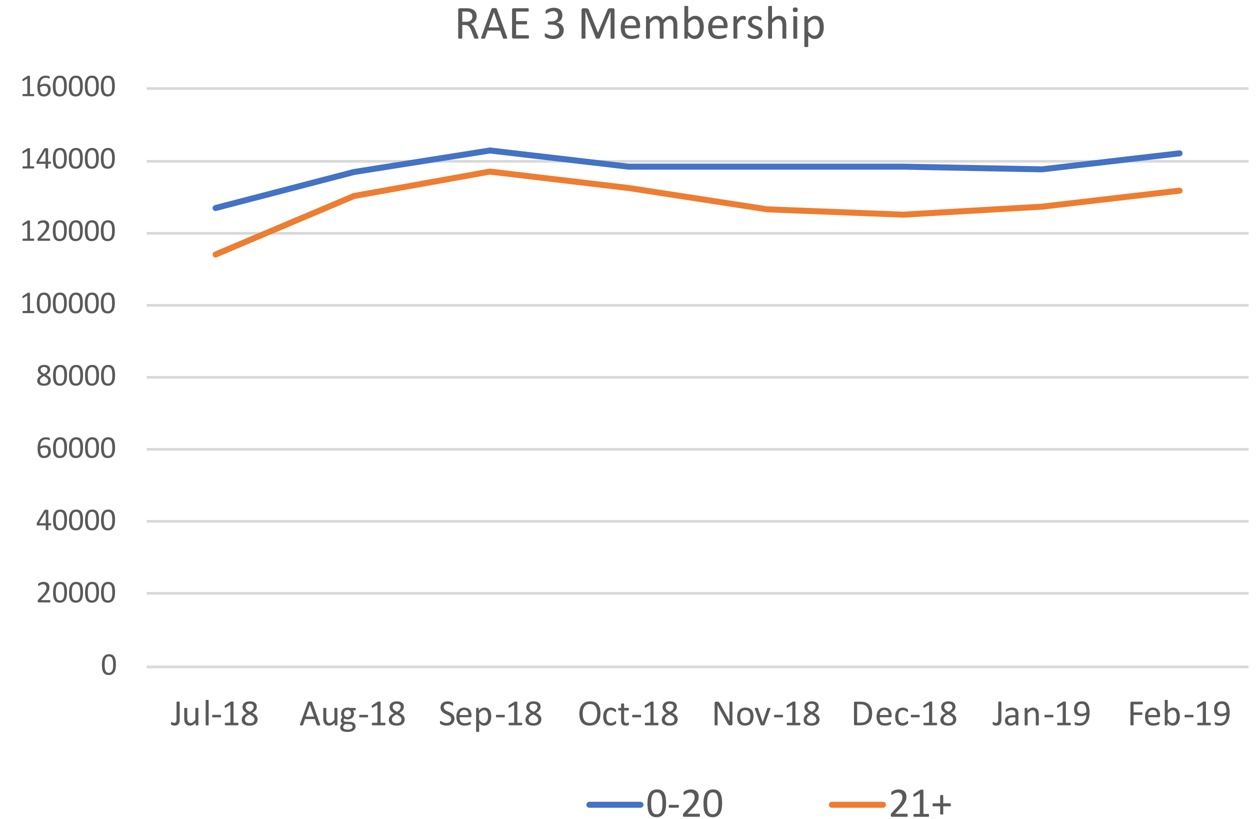
Region 3 Current Enrollment = 274,947 Lives *(as of Feb 28, 2019)*

Demographics

By Age Category	
0-10	30%
11-20	22%
21-64	44%
65+	4%

By Race	
White	24%
Black/African American	7%
Asian	3%
Hispanic/Latino	15%
Multiple Categories	41%
Other/Unknown	10%

(As of Dec 31, 2018)



Majority of members identify as non-white

54.2% identify as female

Pay for Performance Measures

PHYSICAL HEALTH

Today

1. Dental visits
2. Wellness visits
3. Prenatal engagement
4. Emergency Department (ED) Utilization
5. Health Neighborhood
6. Potentially Avoidable Costs
7. Behavioral health engagement

BEHAVIORAL HEALTH

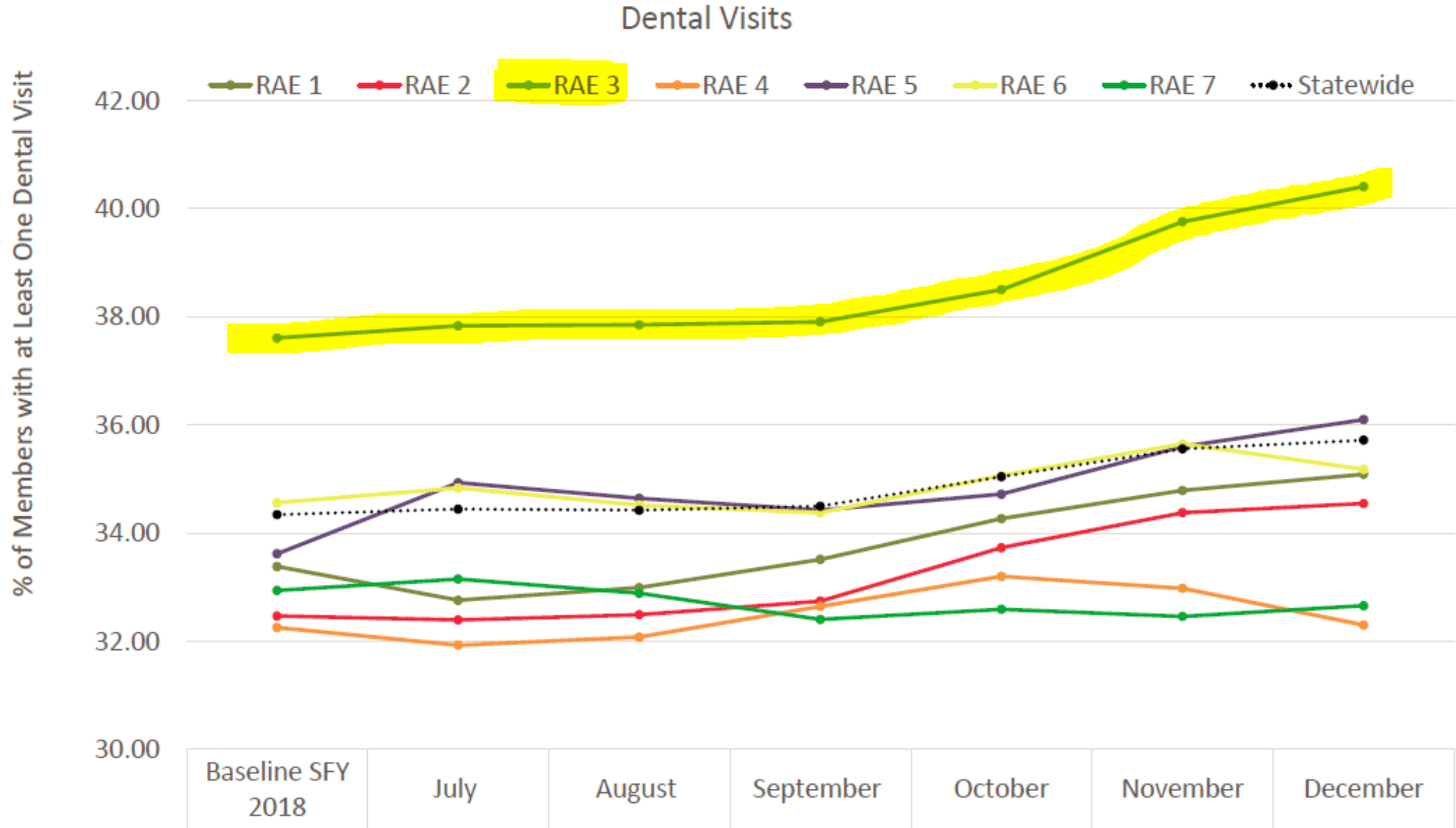
1. Engagement in Substance Use Disorder (SUD) Treatment
2. 7-Day Follow-Up After Inpatient Discharge for Mental Health
3. 7-day Follow-Up After ED Visit for SUD
4. Follow-Up After a Positive Depression Screen
5. Behavioral Health Screen/Assessment for Foster Care Members

Physical Health Pay for Performance Measures

SFY1819 Performance
Q1 Regional Comparison for Payout

ACC Incentive Payment FY 18-19 Quarter 1									
RAE	Emergency Department	Health Neighborhood	Care Compact	BH Engagement	Dental	Prenatal Engagement	Well Visits	Incentive PMPM Amount	Payment Amount
RAE 1	-0.26%	-4.24%	TBD	TBD	0.39%	-1.16%	0.31%	$0	**$0**
RAE 2	-1.23%	0.47%	TBD	TBD	0.84%	2.54%	-1.84%	$1.712	**$229,711.02**
RAE 3	0.67%	-3.73%	TBD	TBD	0.80%	1.09%	-0.74%	$0.856	**$351,253.61**
RAE 4	-1.58%	-0.65%	TBD	TBD	1.21%	8.30%	1.11%	$3.710	**$727,837.08**
RAE 5	0.82%	-8.34%	TBD	TBD	2.40%	4.92%	-3.12%	$1.712	**$326,216.46**
RAE 6	0.48%	-6.14%	TBD	TBD	-0.54%	2.49%	-0.68%	$0.856	**$190,775.44**
RAE 7	1.09%	-7.27%	TBD	TBD	-1.62%	11.73%	-2.54%	$1.142	**$301,434.33**
								Grand Total	**$2,127,227.94**

Dental Visits: Percent of distinct count of members who received professional dental services. This includes dental services from both medical and dental claims.



Intervention Planning Work with CCHAP/Dental

- Contract with Colorado Children's Health Access Plan (CCHAP)
- Increasing dental services within pediatric practices
  - Focus is on getting pediatric practices “live” on Cavity Free at 3
  - Currently engaged with 36 practices in RAE 3 and 5
  - Now actively engaged 10 practices based that are in different stages of training to implementation

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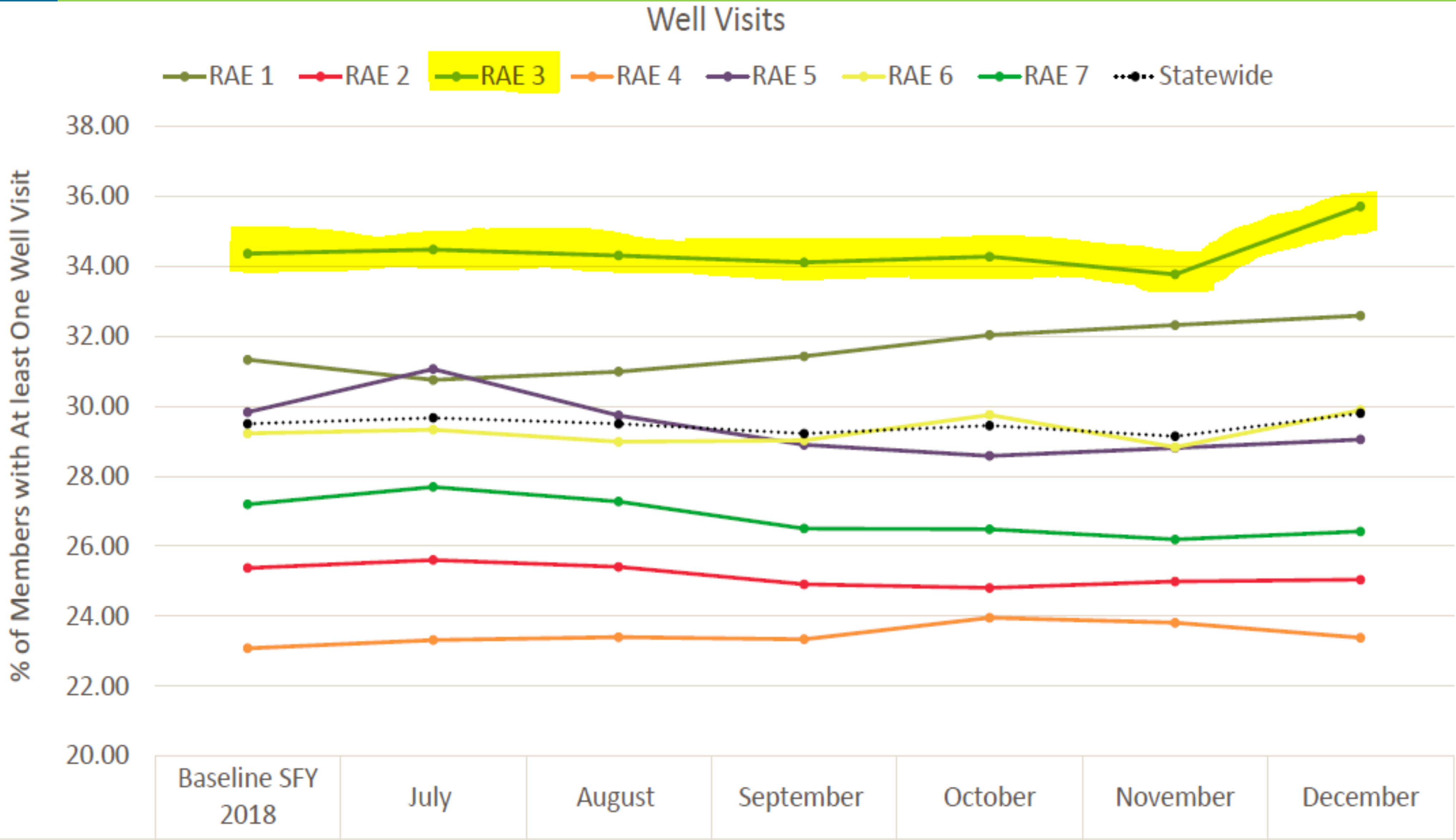
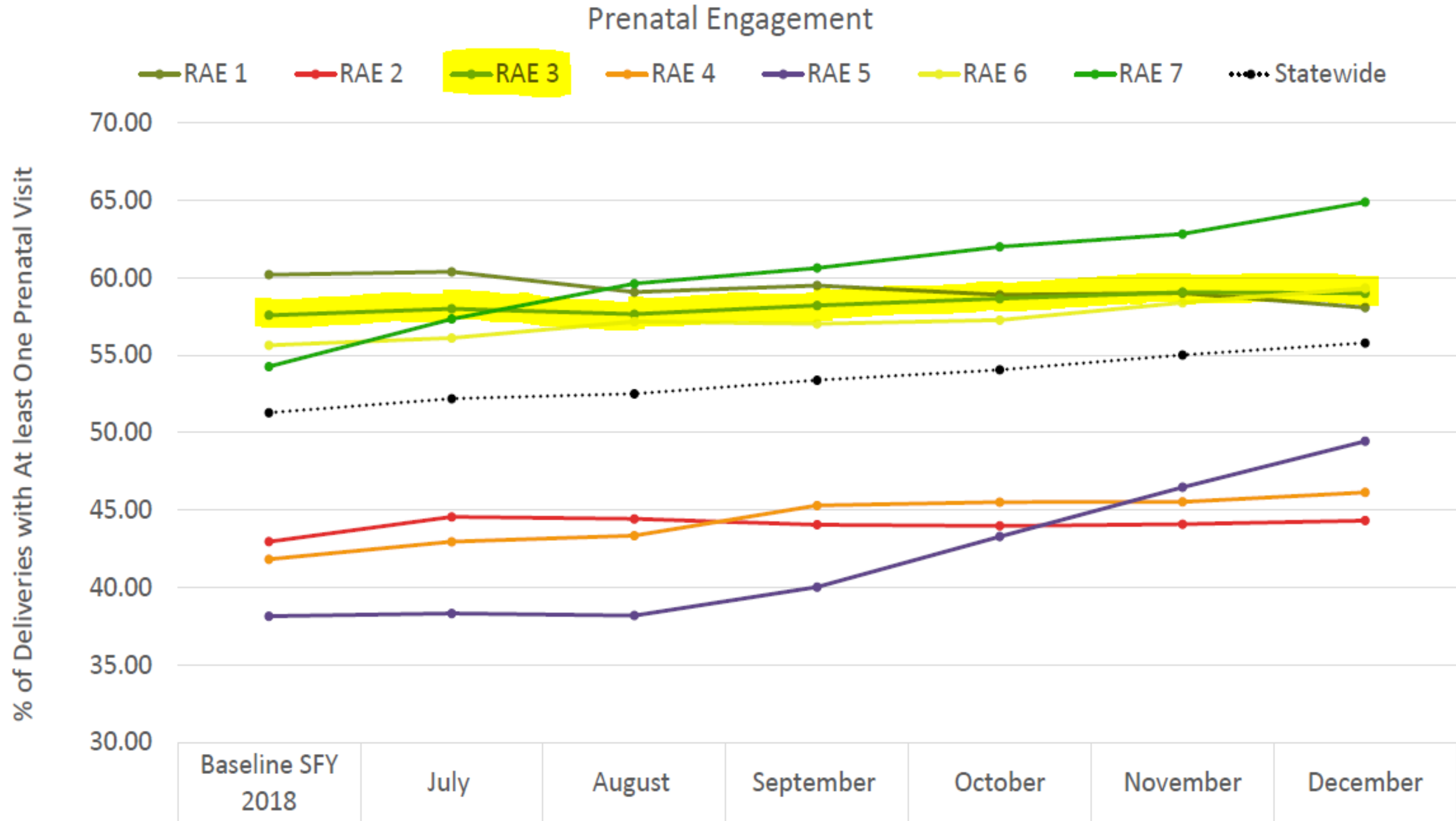
Well Visits:
Percent of distinct members who received a well visit within the 12-month evaluation period



Interventions In-Progress: Well Visits

- Focus is on getting practices access to and comfortable with using data (State's Data Analytics Portal 'the DAP')
  - Development of member outreach cross-walking different data sets and reports for phone number and addresses
  - Practices need the data to be able to do outreach
- Sequential scheduling of dental/well visits for integrated sites
- Alignment of Performance Improvement Projects (PIP) for members ages 10-14
  - Providers include Stride Health and Bruner.

Prenatal Engagement: Percent of members who received a prenatal visit during pregnancy.



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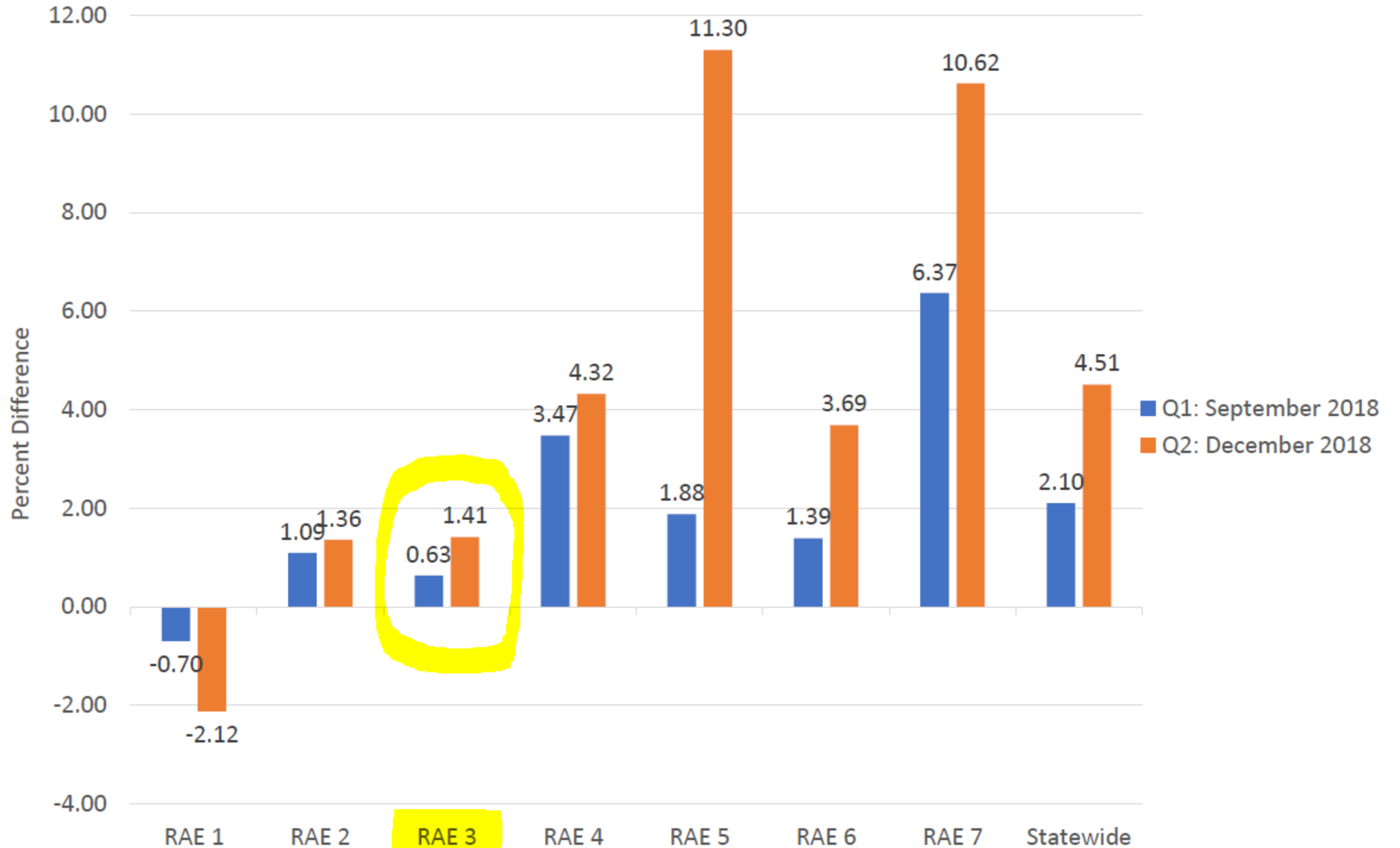
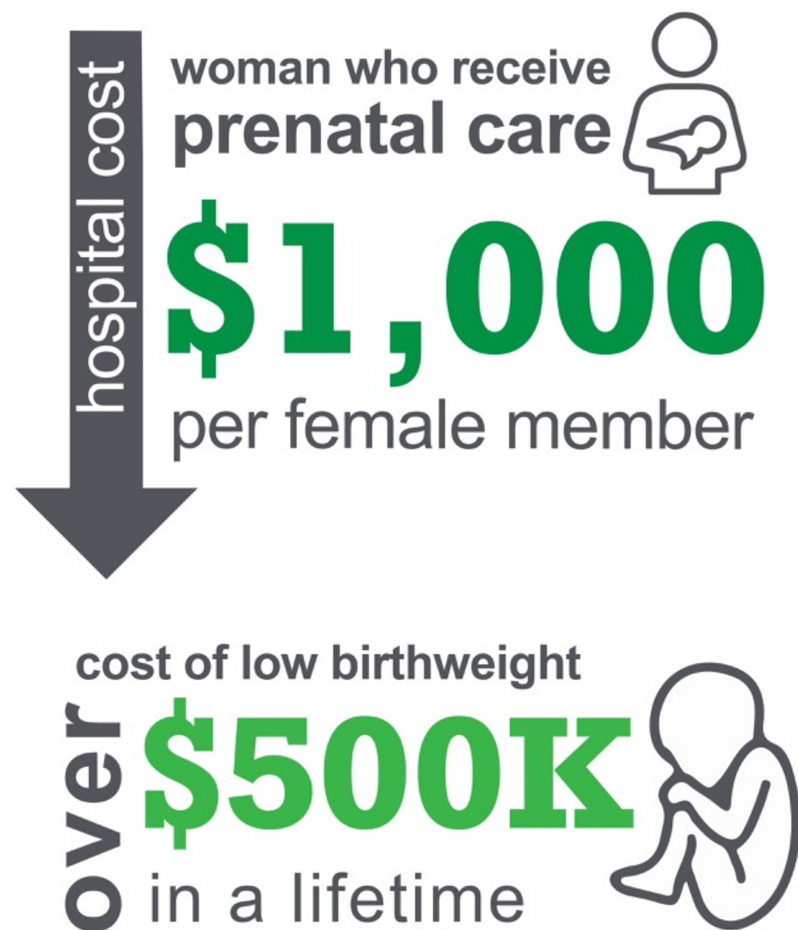


PERINATAL WOMEN: A KEY OPPORTUNITY



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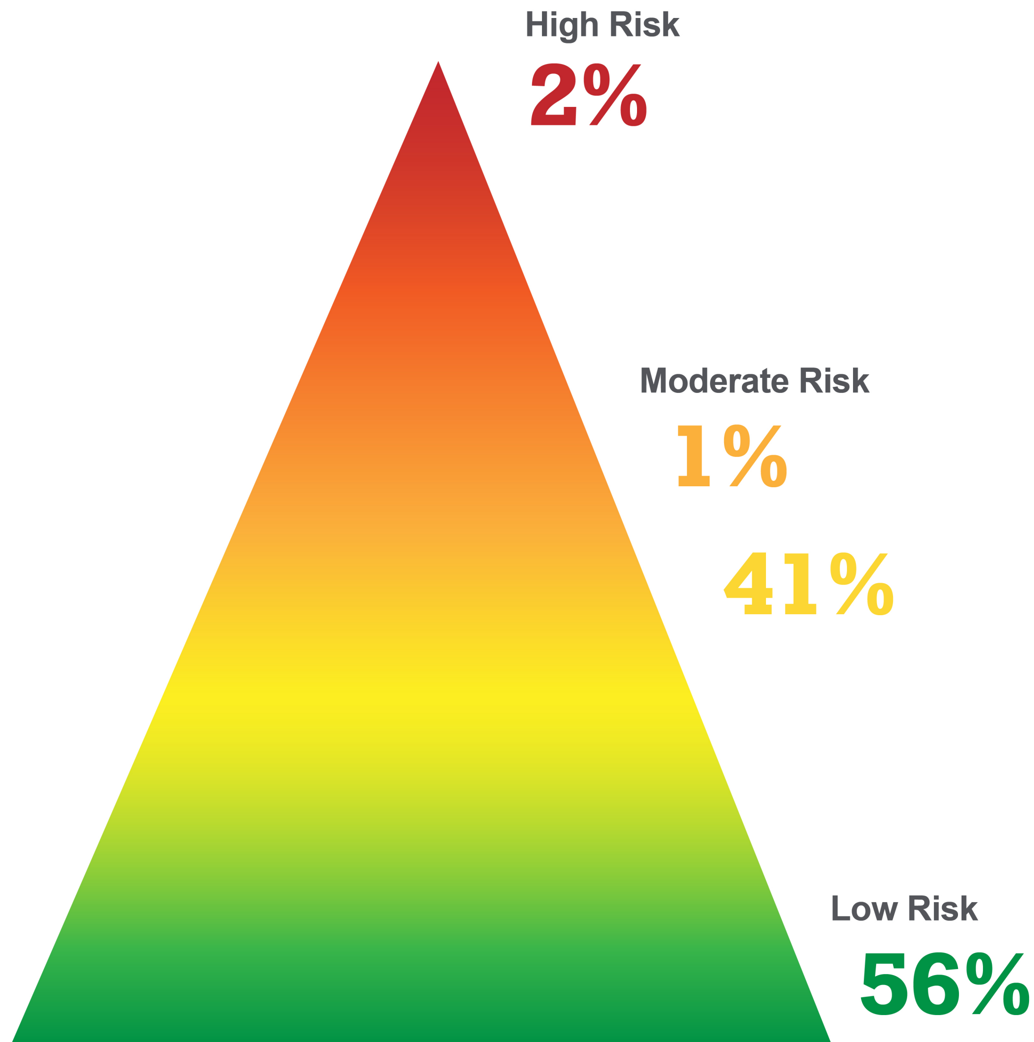
HEALTHY MOM, HEALTHY BABY



How Members are Identified

- Monthly pregnancy registry, referrals from inpatient discharge floors, four quadrant model and supplemental data sets
- Women <21 years old are referred to care management for outreach (versus digital engagement or direct mail)
- Region 3 - 25% births covered by COA
- Region 5 - 20% live births covered COA

<u>Intervention Goals</u>

- Engagement in prenatal services within first trimester
- Promote WIC enrollment
- Prompts for pre/post natal cadence of appointments
- Assessments and referrals for medical/non-medical services
- Identification/intervention for behavioral health services

Extrapolated from Population Health Management Plan submitted and approved by HCPF in 10.2018.

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HEALTHY MOM, HEALTHY BABY ENGAGEMENT RESULTS

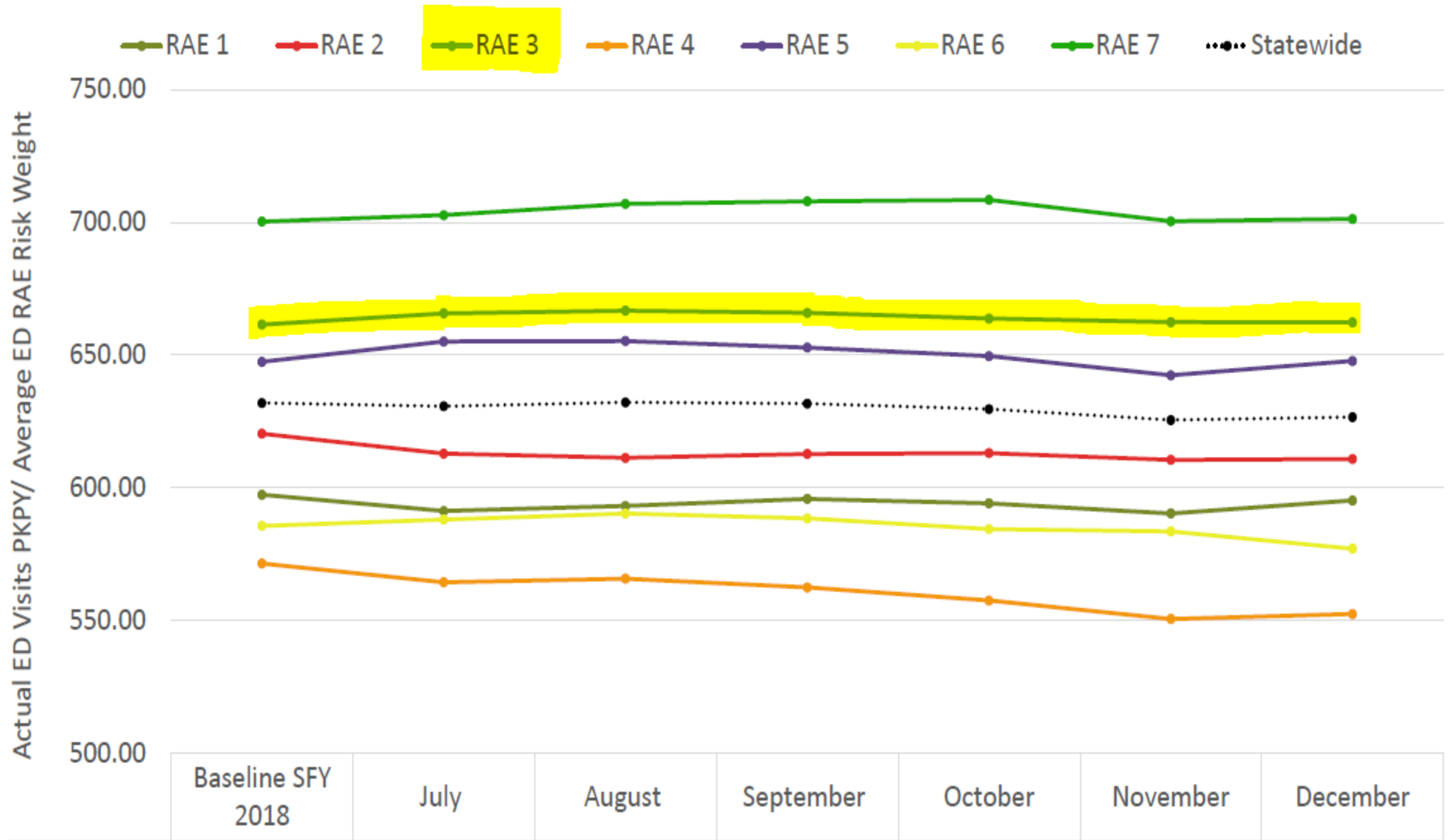
Engagement Results

- All pregnant women enrolled (approx. 650 newly pregnant women/month)
- 95% receive technologically based perinatal-specific interventions
  - Interactive voice response (98% completion rate)
  - Text-based programming (100% completion rate)
  - 5% receive individual, intensive care coordination
  - Age 21 or younger
  - High behavioral health and/or physical health need (4-quadrant model)

Program Outcomes

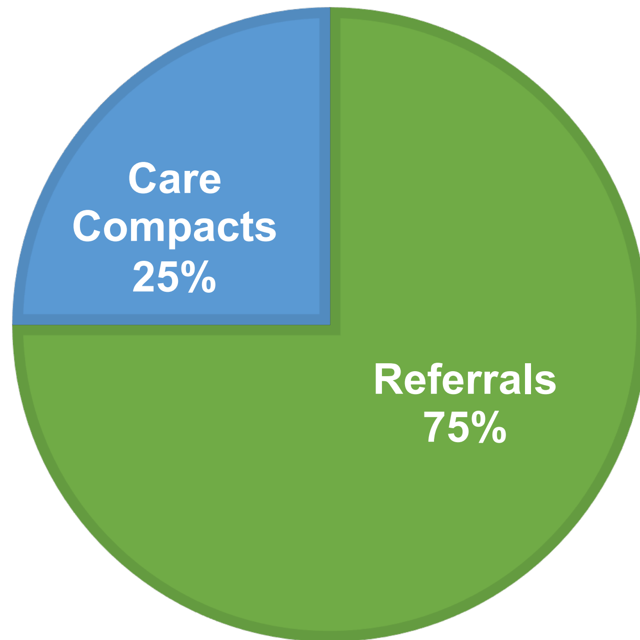
- WIC and Baby and Me Tobacco Free enrollment
- Breastfeeding, tobacco cessation and peer support
  - Support family planning in place at time of delivery—follow Colorado's Family Planning Initiative
- LARC-focused interventions screening for and intervening in pregnancy-related depression

Emergency Department Visits: Number of visits for every thousand members per year.



Health Neighborhood Measure: Two Parts

Goal: To improve communication and coordination between primary care providers and specialists



1. Care Compact

Percentage of RAE's primary care providers with Care Compacts (documented agreements) with specialists that outlines communication and coordination processes for shared patients.

2. Referrals

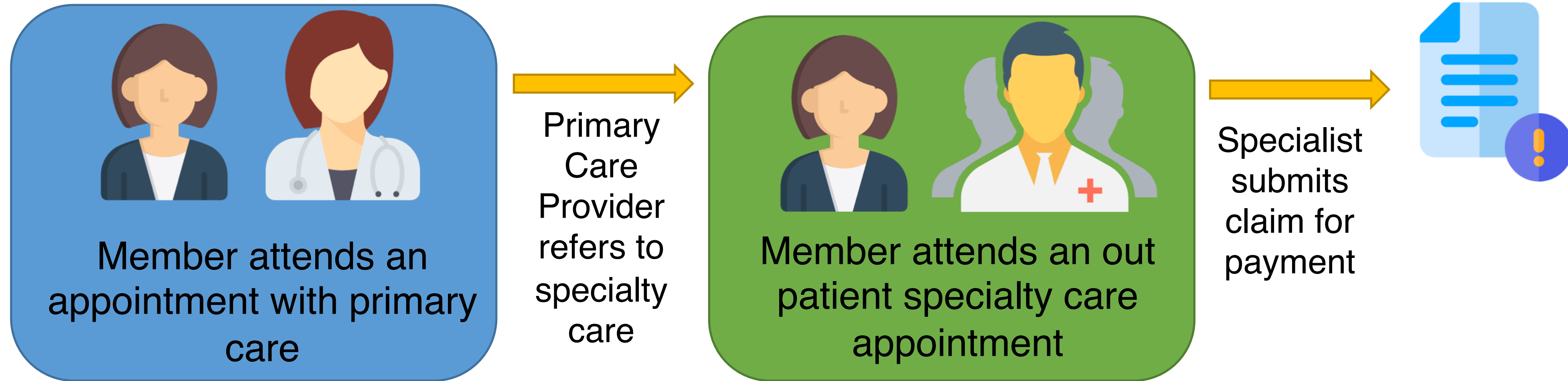
Percentage of members who had an outpatient visit with a specialist who saw a primary care provider within 60 days prior to the specialist visit and included a referring primary care provider on the claim

Health Neighborhood: Part 1 CARE COMPACTS

Collaborative Care Management	
Mutual Agreement	
Define responsibilities between PCMP, specialist and patient. Clarify who is responsible for specific elements of care (drug therapy, referral management, diagnostic testing, care teams, patient calls, patient education, monitoring, and follow-up). Give and accept respectful feedback when expectations, guidelines and standard of care not met.	
Expectation	
Primary Care	Specialty Care
◻ Suggests type of behavioral health referral and educates the patient on the goals as well as the rationale for the referral and how it effects the overall treatment plan ◻ Suggests that patient sign a release of information so treatment progress and plans of care can be coordinated. ◻ Resumes care of patient when patient returns from specialist care and acts on care plan developed by specialist.	◻ Review information sent by PCP. ◻ Sends timely reports to PCP to include a care plan, follow-up and test results as outlined in ◻ Review Specialist care summary in lieu of the patient agreeing to have behavioral health treatment summaries shared with the PCMP ◻ Suggests and supports timely follow up with the PCMP for both behavioral health and regular wellness visits

Count of Care Compacts:
Region 3 = 12
Region 5 = 48

Health Neighborhood: Part 2 REFERRALS



CALCULATION:

Denominator "Event" = Any **specialty care appointment**

Numerator "Event" = The Primary Care Provider appointment IF that appointment was within 60 days of the specialty care appointment **AND** the Primary Care Provider was listed as the referring provider on the specialty claim

Health Neighborhood: Part 2 REFERRALS

Submit Professional Claim: Step 1

* Indicates a required field.

Claim Type: Professional

Provider Information

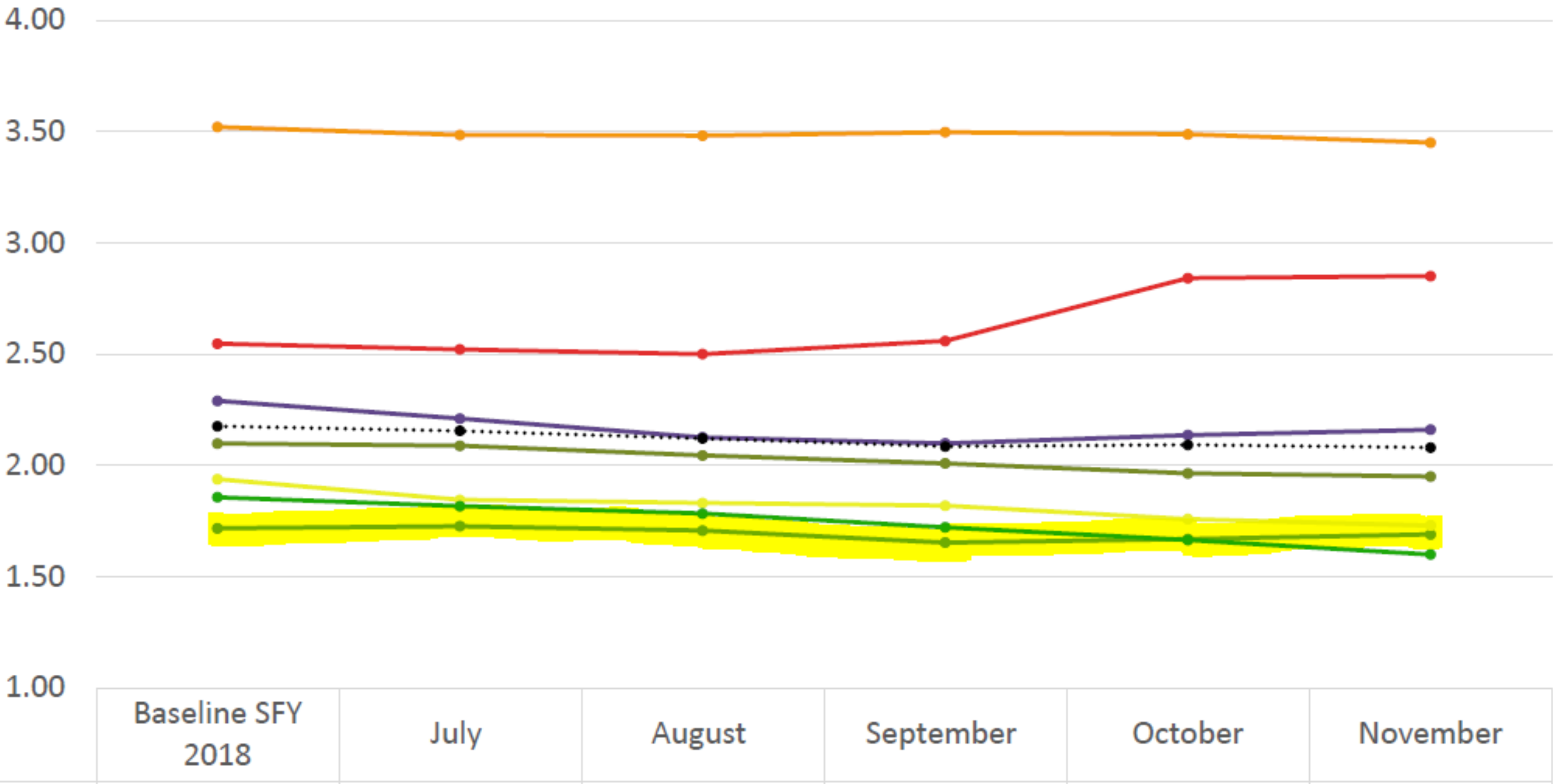
Billing Provider ID
Taxonomy: Emergency Medicine
Referring Provider ID — ID Type
Taxonomy
ID Type
ID Type — Name _

Last Name _ — First Name _
Birth Date _
Address
City
State — Zip Code

Billing Provider – Organization, such as a clinic, that receives payment on behalf of the individual who is providing the service.

The "Referring Provider ID" is an optional field. Providers may provide this information if the information is relevant to the claim.

The specialist's claim **must include** the referring provider's ID, and that provider must match a Primary Care Provider that the member saw within 60 days prior.



Health Neighborhood pt. 2
RAE 1
RAE 2
RAE 3
RAE 4
RAE 5
RAE 6
RAE 7
Statewide
Percentage of Outpatient Specialist Visits with a PCMP visit within 60 days prior to the Specialist Visit AND a referral from the PCMP to the specialist
4.00
3.50
3.00
2.50
2.00
1.50
1.00
Baseline SFY 2018
July
August
September
October
November

Interventions In-Progress: Health Neighborhood

Part 1 interventions – Care Compacts

Submitted Compacts	Region 3	Region 5
Q1	50	15
Q2	102	43
Q3	114	91

Increase was a direct result of provider assessment and outreach efforts by Practice Support team:

- Partnerships with Community Mental Health Centers
- Review and amending of existing agreements between primary and specialty care to meet State requirements
- Partnership with other RAEs to support practices and share data to meet this deliverable

Part 2 interventions – Specialty Referrals

Denver Health/Kaiser effort

Collective Impact Approach

Regions 3 and 5 Governing Councils

Mutually Reinforcing Activities

Health Strategy Committee
COA Aligned Task Forces and Workgroups

Wellness and Dental Visits

Health Neighborhood, Part 2 (Referrals) – Coding

Chronic Obstructive Pulmonary Disease (COPD)

with Hypertension and Depression/Anxiety

Pediatric Asthma

with Depression /Anxiety

Diabetes

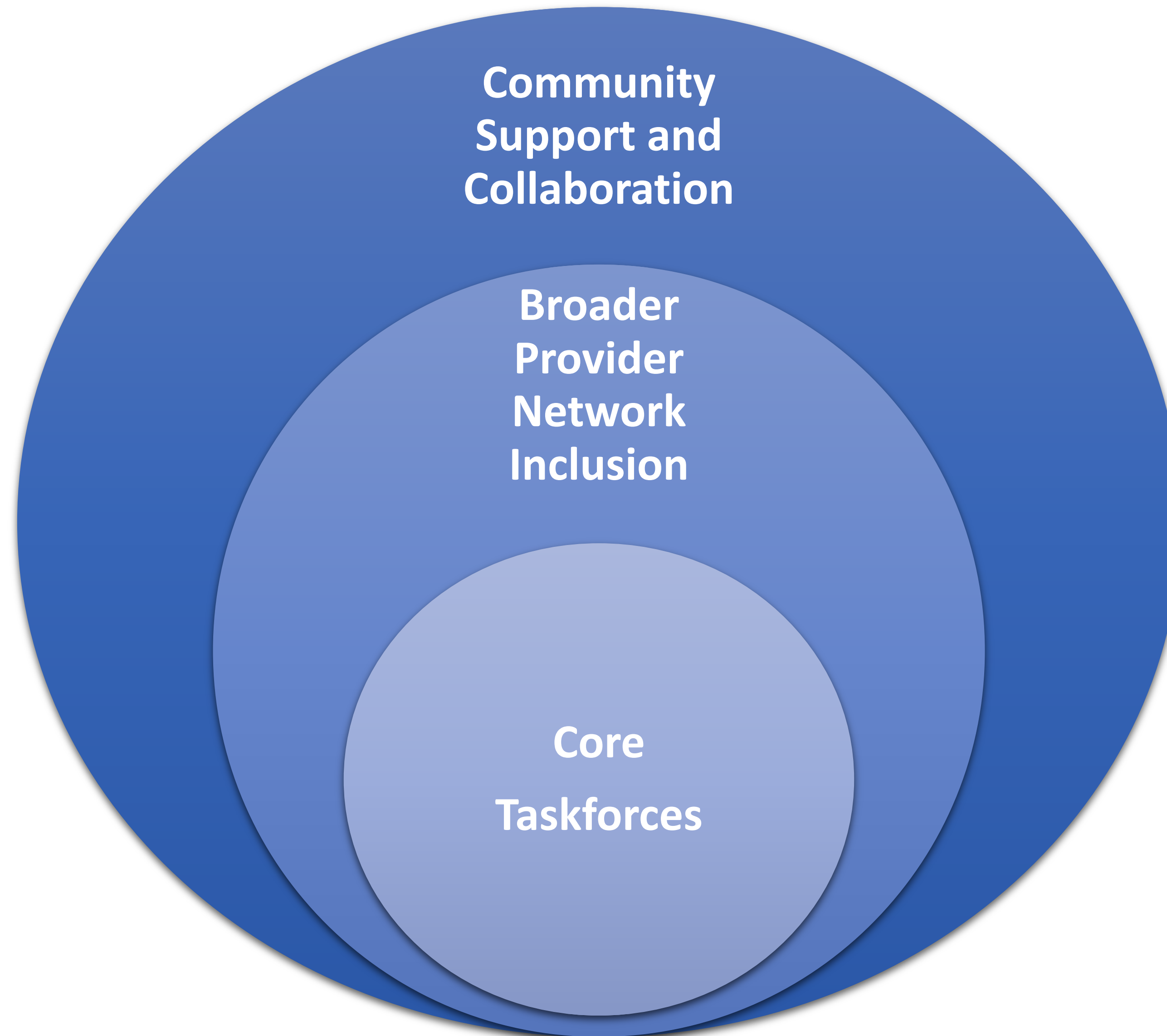
with Hypertension and Depression/Anxiety

Potentially Avoidable Conditions Measure

Health Strategy Committee – Membership

Member	Title/Position	Organization
Jill Atkinson	Clinical Director of Integrated Outpatient Services	Community Reach
Rachel Everhart	Director of Clinical and Operational Data Management, Analysis and Reporting-Ambulatory Care Services	Denver Health
Devra Fregin	Practice Administrator	Kids First Pediatrics
Heather Logan	Director of Accountable Care	Stride Health
Carlos Madrid	Senior Manager, Medicaid Clinical Operations	Kaiser
Justin Wheeler	VP of Clinical Services	Clinica
Wes Williams	Vice President and Chief Information Officer	Mental Health Center of Denver
Chase Gray	Senior Director of Health Services	Colorado Access
Krista Beckwith	Senior Director of Population Health, Quality & Evaluation	Colorado Access
Kim Nordstrom	Medical Director, Behavioral Health	Colorado Access
Kelly Marshall	Director of Community & External Relations	Colorado Access

Evolution of Regional Involvement



Discussion and Feedback

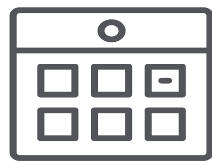
- Q&A for understanding
- General feedback on the measures
- Collecting information about related efforts and potential collaborations

REGIONAL PERFORMANCE – PHYSICAL HEALTH CONCEPTUAL OVERVIEW

PRIMARY CARE PROVIDER NETWORK PERFORMANCE

- Rob Bremer

COA's Provider Network for Region 3 & Region 5



pcmp sites **113**

regions **3&5**

enhanced clinical partner sites **15**

receive additional funds for higher level care coordination, reporting, and participation

113 contracted entities in regions 3 & 5

68% only have **1** clinic site

32% have **2-37** clinic sites

257 unique clinic sites

40% have 1,000+ attributed members

COA Practice Support Services

The role of the practice support team is to work directly with provider offices to help support work with pay for performance measures and contract deliverables.

Support examples include:

- Electronic Health Record Supports
- Clinical Registries
  - Asthma, Breast Cancer, Cervical cancer, COPD, Deliveries, Diabetes, HPV, Pregnancy
- EngageME – Telephonic Member Outreach Program
- Healthy Mom/Healthy Baby Program
- Virtual Behavioral Telehealth Program
- Workflow redesign support
- Data collection/analysis
- Current/Future state process mapping
- Scorecards to assess success and trending
- Quality improvement coaching

Enhanced Clinical Partner (ECP) – Minimum Criteria

- Drawn directly from RAE requirements with the State.
- Translated into clinic level requirements for primary care providers (Contract Addendums 1 & 2).
- Will be used to assess compliance as well as the readiness for providers who want to be added as an ECP in the future.

Performance Evaluation Process - Scorecard

- Practice-level performance will be captured through a formal scorecard process.
- The Practice Support team will be administering a **baseline Scorecard** in June to capture provider performance baselines for the entire regional primary care network.
- This scorecard will include a review of performance on:
  - Pay for performance measures
  - Contract compliance
  - Care coordination reports (for ECPs only)
- The scorecard outcomes will be shared with providers

PRACTICE PERFORMANCE SCORECARD (SFY 2018-19)

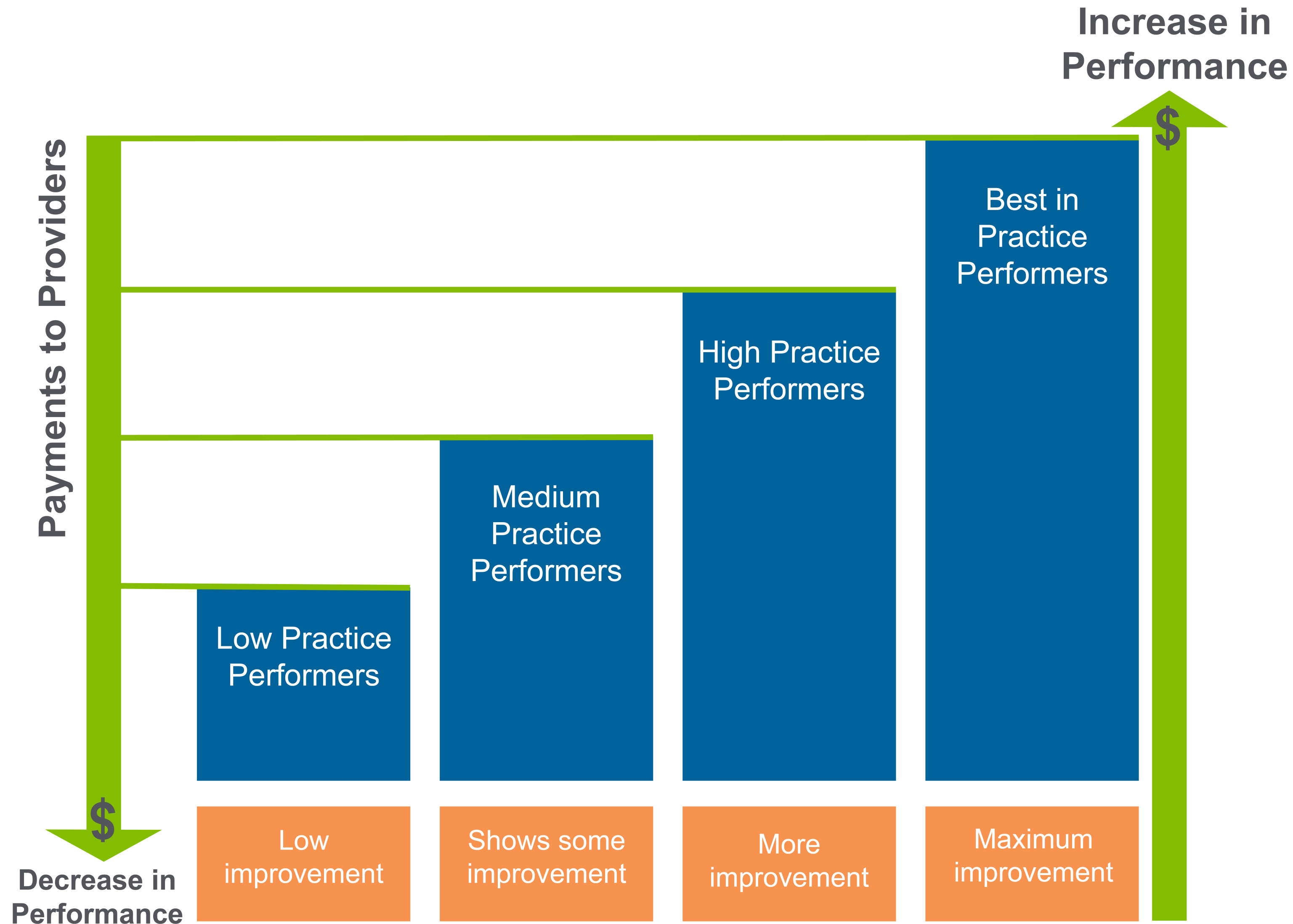
	Scorecard Measurement Highlights
✓	Report submission accuracy/timeliness/improvement
✓	Care compact meets requirements
✓	Member referrals meet 5 day response
✓	ECP and/or PCMP criteria
✓	Assess best practices and cost containment initiatives
✓	Practice quality meetings taking place
✓	Regular quality meetings taking place
✓	Practice showing regular improvement in all areas

Scorecard: Future State

- COA’s intent next year is to enhance the scorecard to tie outcomes to incentive payment qualification.

- The goal will be to evaluate practice sites quarterly using the scorecard methodology.

VALUE-BASED PAYMENT DRAFT FRAMEWORK/PHILOSOPHY



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