Region 7

CCHA Annual Quality Report

State Fiscal Year 2022-2023

(SFY22-23)

September 29, 2023

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Section 1: Executive Summary

Colorado Community Health Alliance's (CCHA) overall goal is to support a coordinated, patient-centered model of care to serve Health First Colorado (Colorado's Medicaid Program) members. In addition, we aim to improve health outcomes and optimize resources to avoid duplication of services and reduce the cost of care. CCHA's quality improvement program intends to support CCHA's goal by providing an ongoing, comprehensive, and integrated system that allows departments to work collaboratively and share information. This approach enables implementing and maintaining a continuous quality assessment, measurement, interventions, and re-measurement of service and outcome-related measures.

During State Fiscal Year 2022-2023 (SFY22-23), CCHA accomplished many of the work plan goals established. This annual report provides a mechanism to determine how much the quality improvement activities during SFY22-23 contributed to our members' overall quality of care and service. It also helps CCHA focus on opportunities for improvement in operational processes, health outcomes, and satisfaction of members and providers. CCHA is committed to continuously enhancing the quality of our members' services and is constantly working on identifying ways to achieve this.

During SFY22-23, CCHA continued supporting efforts to increase COVID-19 vaccination amongst members, particularly those experiencing health disparities, supported providers becoming vaccination sites when needed, and partnered with community organizations to help with vaccination efforts.

CCHA also started efforts to engage members and educate them about their need to participate in the Health First Colorado (HFC) renewal process, update their contact information, what to expect, how to submit their application, or, if they are no longer eligible for HFC, where and how to sign up for alternative coverage.

In addition, as part of our work to reduce health disparities, CCHA analyzed the data received from the Department of Health Care Policy and Financing (HCPF or the Department) to identify populations with health disparities to enhance, align efforts and start to plan interventions. Our successes in SFY22-23 are highlighted below, and CCHA's opportunities for improvement are detailed in our Quality Improvement Plan for SFY23-24.

During SFY22-23, CCHA achieved the following:

- Successfully concluded the Performance Improvement Project (PIP) to increase rates of depression screening and behavioral health follow-up after a positive screen. The implemented interventions were effective in promoting and/or achieving intended improvements and contributed to a positive outcome. These lessons will be used to attain the depression screening and follow-up Key Performance Indicator (KPI) implemented in July 2023.
- Partnered with high-volume providers on Quality Improvement Projects (QUIP) to improve compliance with documentation requirements and the accuracy of claims data submissions. All providers achieved 100% compliance with technical documentation requirements for targeted elements, meeting the intended goals and successfully concluding the project.
- Engaged behavioral health (BH) practices in Practice Transformation coaching to expand the reach and scope of provider assistance channels by establishing specific, designated touchpoints for recurring Quality Improvement (QI) assistance and performance monitoring, as well as credentialing and educational support.

- Implemented the new Behavioral Health Facility Incentive Program (BHFIP), with participation from five hospitals with value-based quality metrics on readmission rates and outpatient follow-up.
- Awarded incentive funds to eligible providers participating in the calendar year 2022 (CY2022) Behavioral Health Quality Incentive Program (BHQIP) for improving quality, service, and utilization goals.
- Sponsored workforce development and program expansion for Community Mental Health Center (CMHC). Funds were dedicated to subsidizing benefits intended to bolster employers' competitiveness by attracting and retaining talent through recruitment, turnover reduction, and skillset development strategies.
- Met the target on one of the five BH Incentive Measures for SFY22-23 in Region 7 (R7).
- Established and distributed CY2022 Community Incentive Program (CIP) funding to 22 innovative projects that address high-priority community and member needs.
- Met the prenatal care KPI for three of the four quarters plus oral evaluation in quarter one (Q1) and quarter two (Q2).
- Distributed 100% of earned KPI incentive dollars to providers and the community.
- Met Performance Pool goals related to asthma and contraceptive care medication adherence in addition to Extended Care Coordination (ECC) engagement. Region 7 also partially met the depression medication adherence measure.
- Communicated to providers results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey and shared best practices related to access to care, patient-centered communication and focused interventions.
- Engaged Community Mental Health Centers (CMHCs) to obtain member satisfaction feedback through routine surveys and to use results to inform improvement strategies.
- Implemented provider satisfaction survey among the primary care medical provider (PCMP) and community partner network to assess satisfaction and experience working with CCHA as a RAE.
- Implemented member experience surveys for those who have interacted with CCHA Member Support Services (MSS) and Care Coordination (CC).
- Continued outreach for members identified for the Client Overutilization Program (COUP), in partnership with HCPF and helped members who were locked-in transition across RAEs.
- Began laying the groundwork for our regional Diversity, Equity, and Inclusion plan.
- Developed standardized reporting and information systems within the provider network to collect data on members engaged in condition management services with PCMP+ and Accountable Care Network (ACN) practices. Providers report quarterly, and CCHA implements an internal reporting dashboard. The dashboard helps to improve the monitoring of the overall performance.
- Achieved compliance review scores of 94% for Coverage and Authorization of Services, 100% for Adequate Capacity and Availability of Services, 74% for Grievance and Appeal Systems, and 100% for Enrollment and Disenrollment.
- Continued quarterly regional Program Improvement Advisory Committee (PIAC) meetings in addition to hosting an in-person event.
- Increased frequency of the Member Advisory Committee (MAC) to bimonthly meetings, per member feedback.

Section 2: Mission Statement and Team Leadership

CCHA Vision Statement

Colorado Community Health Alliance's overall vision is to provide guidance and support to Health First, Colorado members, providers and community partners through innovative, collaborative, results-driven partnerships and programs.

Quality Program Leadership

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Section 3: Performance Improvement Projects

A Performance Improvement Project (PIP) focuses on a particular problem involving systematic data gathering and developing interventions to achieve improvements. Health Services Advisory Group (HSAG) redesigned its approach to the PIPs to emphasize improving healthcare outcomes and processes by integrating quality improvement science. This approach guided CCHA to use a rapid-cycle improvement method to pilot small changes. To follow this methodology, HSAG developed a series of four modules to conduct the PIP activities. This PIP process is structured to last 24 months and has four phases: PIP Initiation, Intervention Determination, Intervention Testing with Plan-Do-Study-Act (PDSA), and PIP Conclusions.

CCHA worked on one Behavioral Health Performance Improvement Project (BH PIP), as directed by HCPF. The subtopics selected for the BH PIP were depression screenings of members 12 years or older and referrals from primary care to BH following a positive depression screening. They ended in June 2022 and are described in further detail below.

Behavioral Health Performance Improvement Project

Depression Screening and Follow–up After a Positive Depression Screen

The BH PIP focused on increasing the rates of depression screening for members 12 years or older (Rate 1) and increasing the percentage of members who have a follow-up BH service within 30 days of a positive depression screening (Rate 2) by their PCMP. An initial review of CCHA's internal follow-up tracking report indicated that 62.08% of members 12 years or older who received an outpatient primary care service at one Federally Qualified Health Center (FQHC) clinic had a depression screening. In addition, 72.1% of the members screened received a qualifying behavioral health service within 30 days of a positive depression screening. This FQHC is identified as one of the largest providers in the region and serves a significant volume of CCHA members, thus representing a high potential for impact on health outcomes for the region. The goal was to achieve statistically significant improvements over baseline rates by increasing depression screening to 63.53% and the follow-up rate to 75.74% by June 30, 2022.

Techniques Used to Improve Performance

Depression screening and follow-up after positive screen processes were mapped to inform a Failure Modes and Effects Analysis (FMEA) and identified failure modes were utilized to inform and test interventions to improve targeted rates. The PIP team identified an improvement opportunity to engage members who refused to complete the depression screen. As the intervention to improve screening rates, the practice determined that the Patient Health Questionnaire 9 (PHQ-9) script used by staff to engage members who refuse the screen will be reviewed and updated to enhance its efficacy to communicate the benefits of timely identification and early intervention in managing depression symptoms. Provider training and guidance to support patient education and motivation is expected to decrease patient hesitancy and promote engagement; thus, reducing rates of patient refusals and increasing rates of depression screening at the practice.

A review of the practice's coding protocol was conducted to ensure the utilization of eligible codes and identified subclinical screens (5-9 scores) coded as G8431 (Positive Screen code). This protocol was intended to facilitate symptom monitoring when a behavioral health follow-up service was not clinically indicated. As a result, subclinical screens were included in the follow-up denominator but never received a referral for BH follow-up, therefore, not qualifying for the numerator. To resolve this issue, the first intervention tested was to exclude false-positive screens by creating a "Watchful Waiting" category to the depression screen follow-up list on the PHQ-9 form in the electronic health record (EHR) for screening scores 5-9.

Excluding "Watchful Waiting" members from the Rate 2 denominator intended to ensure only true positive screens (10+ score) were included in the measurement group for follow-up by a behavioral health provider, thus, enhancing the providers' ability to quickly identify, respond to and refer members with greater need.

Goals for SFY22-23

Goal	Project/Initiative	Targeted Completion Date
Successfully complete the 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

Status and Results

The statistically significant SMART Aim goal for depression screening was achieved as well as clinically significant improvements. The new refusal script decreased the rate of refusal for patients by 0.11% during the intervention period, but this improvement did not meaningfully impact rates of depression screening at the practice level due to the low volume of impacted members. The downward trend indicates continued reduction in refusals should be expected with the continued use of the revised script.

Despite the small intervention population, the intervention provides valuable insight into patient engagement and staff's adherence to clinical protocols. Improving the script for response to patient refusals for screening allowed members to receive patient education and improved care for the early detection of depression. These effects were achieved despite the numerous changes that occurred in the 24 months of this project which impacted the original intervention design, including the seminal healthcare event of the COVID-19 pandemic. The agility of the providers and quality improvement staff made it possible to implement impactful improvements possible amid these circumstances.

Rates of follow-up after a positive depression screening showed a significant improvement following implementation of a "Watchful Waiting" category for subclinical depression screens. The statistically significant target originally established was achieved, sustained for 7 months, and exceeded by 4.76 percentage points in the final month of testing. The utilization of the "Watchful Waiting" category to identify subclinical screens provides valuable insights into population health, expedites patient identification, and facilitates oversight to ensure proper response to patient needs. Further, the ability to verify and monitor adherence to the depression screening guidelines helped demonstrate standards of patient care were sustained despite unprecedented staffing challenges and is expected enhance patients' clinical outcomes. These strategies establish a programmatic structure that reinforces the utilization of empirically supported recommendations for depression management.

Internal tracking tools the practice uses to gauge compliance with the depression screening requirements showed a higher compliance rate compared to the claims-based PIP outputs. Variations in covered benefits for distinct payer sources and discrepancies in measure specifications and calculation methodology between different incentive programs the practice participates in created competing objectives for process improvement, limited the feasibility of altering workflows, and led to duplicative work to fulfill documentation requirements. Due to discrepancies between the PIP performance calculation methodology and the provider's standard workflow, outcomes may not accurately reflect the provider's performance in the provision of targeted services.

Goal for SFY23-24

Goal	Project/Initiative	Targeted Completion Date	Action(s)
Successfully submit PIP Submission Forms for the clinical and non-clinical PIPs	Use data and collaborate with partners to design, implement, and refine interventions as needed.	June 30, 2024	Define target populations and goals for clinical and non-clinical PIPs. Develop interventions to improve performance towards PIP goals. Timely submission of deliverables to HSAG and the Department.

Section 4: Performance Measurement Data-Driven Projects

CCHA is committed to improving the health outcomes of our whole population. Our goal is to monitor and ensure the delivery of consistent, reliable, and integrated physical health (PH) and BH services to members to collectively achieve the Quadruple Aim goals that focus on population health, patient experience, per capita costs, and provider satisfaction. We use the Key Performance Indicators (KPIs), Behavioral Health Incentive Program (BHIP), and Performance Pool measures to gauge success.

Key Performance Indicators Definitions

- BH Engagement – percent of members that access BH services in primary care settings or under the Capitated BH Benefit within the 12-month evaluation period
- Oral Evaluation (OE) – the percentage of enrolled children under age 21 who received a comprehensive or periodic oral evaluation within the measurement year
- Well Visits (WV)
    - Part one: children who had six or more well visits on or before their 15-month birthday or had two or more visits between their 15- and 30-month birthdays
    - Part two: children and adolescents with one or more well visits during the performance period
- Prenatal Engagement (PV) – women who gave birth and received a prenatal visit during pregnancy within the 12-month evaluation period
- Emergency Department (ED) Visits PKPY (risk-adjusted) – number of emergency department visits per thousand per year (PKPY), risk-adjusted.
- Risk-Adjusted Per Member Per Month (PMPM) – total spent on Medicaid claims and capitations during a 12-month period weighted by population average risk score

Techniques Used to Improve Performance

In SFY22-23, CCHA struggled to meet most of the KPIs, though there was some improvement. CCHA worked with providers to close gaps that resulted in members not getting services throughout the COVID-19 pandemic but continued to struggle with an ever-increasing attribution related to the public health emergency (PHE). CCHA expanded its KPI strategy for SFY22-23 to include community partners

and add a diversity, equity, and inclusion focus to start identifying and addressing vulnerable populations who are not meeting the regional average for well visits, oral evaluation, and prenatal care.

CCHA's practice transformation coaches (PTCs) continued working with all practices with more than 300 attributed members and implemented a Provider Incentive Program. In SFY22-23, the PCMP and ACN incentive programs were updated to focus solely on KPI performance and ongoing quality improvement activities in conjunction with monthly meetings with their PTC.

CCHA utilizes a balance of Data Analytics Portal (DAP) data and internal KPI dashboards with member outreach lists to track KPI performance, create trends, and close gaps. Through the DAP, CCHA tracks KPI performance at the RAE level and validates data to ensure our internal dashboards are accurate. CCHA internal dashboards are used by PCMPs, community partners, and care coordinators (CCs) to drive interventions using more timely data and member lists that drive outreach activities. Discrepancies in data calculations continued in SFY22-23. In January 2023, CCHA received the first quarter of well visit data from HCPF and realized that CCHA's internal estimates and the DAP had significantly different rates of well visits. CCHA did a deep dive into our calculations and found that our calculations and the DAP were using different interpretations of the continuous eligibility exclusions, with the DAP including 1200 members that CCHA determined should be excluded. CCHA sent member-level examples to HCPF and continues to communicate regularly about these differences. Additionally, some larger PCMPs have identified members who have had well visits but are not getting credit in the DAP. In particular, one FQHC sent examples through Colorado Access and CCHA for HCPF to review.

Similar disparities related to prenatal visits continued into SFY22-23. CCHA determined that practices using the global billing code, 59400, are not included in the numerator with an explanation from the DAP that prenatal services occurred after the delivery date. This is clearly a mistake in calculations, but CCHA is hopeful that this issue will be resolved as we move to timely prenatal and postpartum care measures in SFY23-24 and updating billing guidance concerning additional dates of services for global billing encounters.

CCHA continues to reinvest all earned KPI incentive dollars into the PCMPs and community partners who helped us achieve the KPI goals. As mentioned above, CCHA adapted our Provider Incentive Program geared towards PCMP providers, with over 300 members attributed to their practice, funded by 75% of earned KPI funds. The remaining 25% of earned KPI dollars is used to support our Community Incentive Program (CIP), which is available to community partners or providers for projects outside the scope of their contract. Community partners are encouraged to apply for CIP through an annual application process through the regional Program Improvement Advisory Committee (PIAC). Applications for CY2024 CIP funding, which will be awarded in early 2024, opened following an informational meeting in May 2023. The SFY23-24 application has specific key priority areas which focus on maternal care, preventative care, oral care, and behavioral health, all with a focus on KPI alignment, including a focus on vulnerable populations in support of the DEI work happening throughout the region.

Behavioral Health Engagement

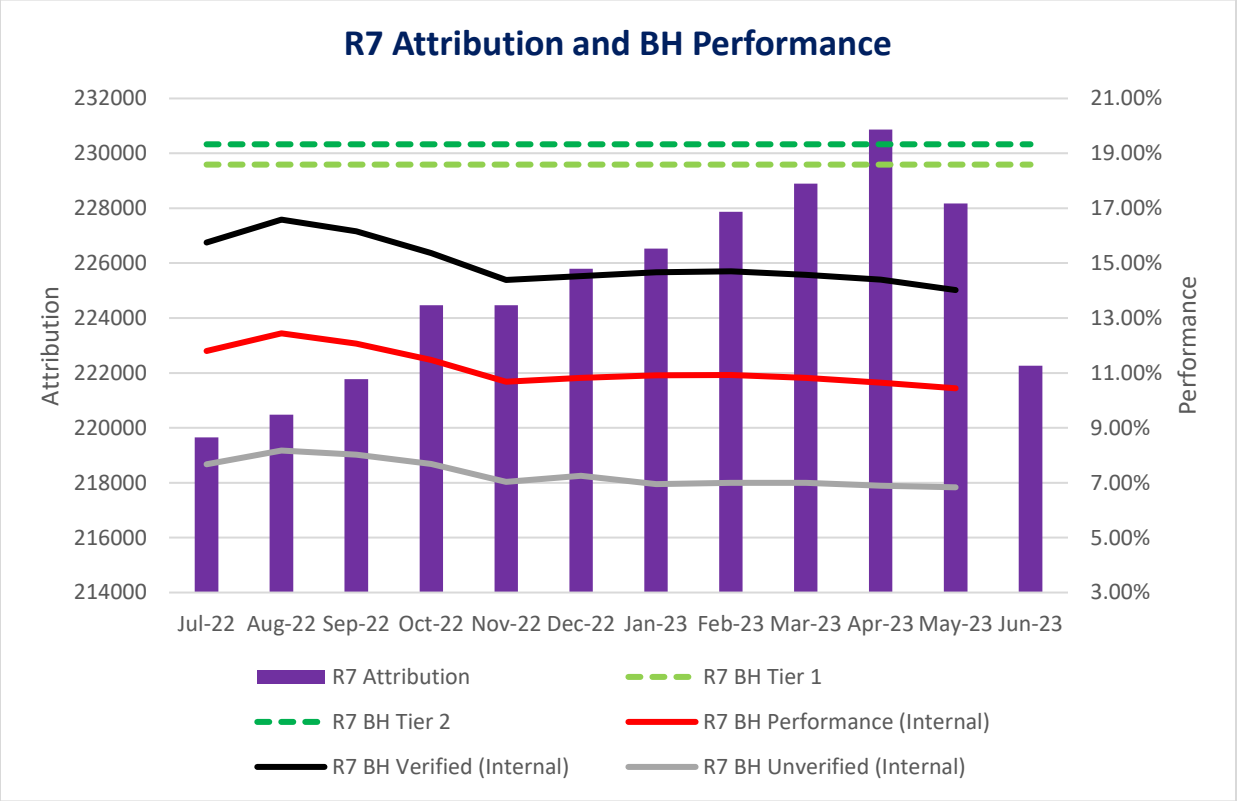
CCHA did not meet the targets for BH Engagement in SFY22-23. CCHA maintains ongoing collaboration and regular meetings with large-volume providers in the region to establish processes intended to increase coordination within the network and support engagement in BH services for members. Practice transformation coaches have been onboarded to expand the reach and scope of provider assistance channels by establishing specific, designated touchpoints for recurring QI assistance and performance monitoring, as well as credentialing and educational support.

To increase the percentage of members accessing BH services, CCHA sponsored workforce development and program expansion with Community Mental Health Centers. Funds were dedicated to subsidizing benefits intended to bolster employers' competitiveness by attracting and retaining talent through recruitment, turnover reduction, and skillset development strategies. Activities included, but were not limited to:

- Paying hiring bonuses to new employees
- Creating an employee referral program
- Automating employment application
- Rewarding diversity in interview panels
- Providing bonuses and cost of living stipends to existing staff
- Supporting a loan repayment program
- Reimbursing educational, credentialing and licensure expenses
- Creating spaces for on-site employee self-care to support wellness and in-person service delivery
- Offering training and professional development opportunities through local and national conferences, and advanced behavioral health training in evidence-based practices (e.g., suicide prevention and intervention, Motivational Interviewing, Dialectical Behavior Therapy, Eye Movement Desensitization and Reprocessing (EMDR) therapy)

Since implementation, providers have reported expedited recruitment and ability to fill positions, a higher volume of qualified applicants, and an average decrease in staff turnover of approximately 9.6%. Over 70 staff members have benefited from training, 229 staff from investments in employee wellness, and 25 clinical leaders from bonuses and development in clinical supervision.

Figure 1. Behavioral Health KPI Results SFY22-23



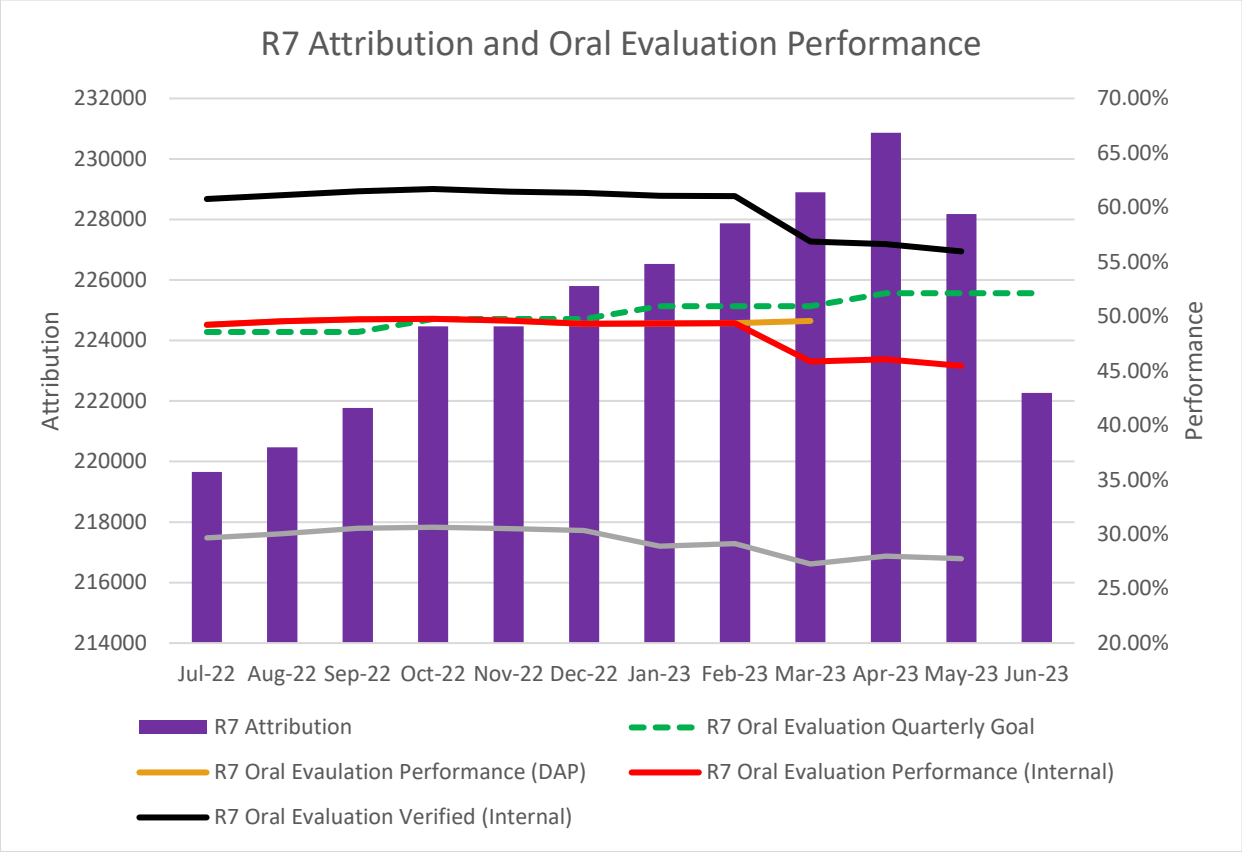
Lessons Learned and Opportunities for Improvement

The processes implemented to improve access and facilitate member engagement in BH care during SFY22-23 were insufficient to maintain the same level of performance CCHA obtained in prior years due to the continuous increase in membership volume. Workforce shortages have also generated additional constraints in access throughout PH and BH systems. CCHA will continue to support strategies to alleviate workforce constraints, promote access, and improve PCMP billing and coding for BH visits. CCHA will help providers interested in implementing co-located BH providers or connecting PCMPs with external BH providers.

Oral Evaluation, Dental Services

CCHA met this measure in Q1 and Q2, however, Internal projections do not look favorable in terms of the increasing quarterly goals for quarter three (Q3) and quarter four (Q4), though internal calculations are artificially low due to missing taxonomy information.

Figure 2. Oral Evaluation, Dental Visit KPI Results SFY22-23



Lessons Learned and Opportunities for Improvement

- Early in the year, CCHA PTCs worked with PCMPs to educate them about the new oral evaluation KPI and ensure they had reliable dental resources to refer their patients to.
- PTCs also work with PCMPs to ensure that part of their workflow includes asking about the most recent dental visit and using that opportunity to educate members about the importance of regular oral evaluations and connect them with dentists, when appropriate.
- We have received regular feedback from FQHCs indicating that their standard dental workflows have been interrupted by difficulty hiring dental hygienists. CCHA continues to monitor this situation and provide referral resources and other support as appropriate.
- Internally, CCHA has added the most recent dental visit to the member look-up report used by care coordinators, so they can address gaps and help connect members in need with a dental provider.
- As part of CCHA's developing Diversity, Equity, and Inclusion (DEI) plan, CCHA has identified that members in less urban counties experience more significant gaps in regular oral evaluations. CCHA has begun reaching out to dental providers in less urban counties and mobile dental providers to create potential partnerships as we continue to develop this plan in SFY23-24.
- In meeting with some of the mobile dental providers and FQHCs, CCHA has received a lot of feedback that dental hygienists, who are practicing at the top of their scope, are very limited in their ability to impact the KPI because they are only able to bill DO145 for members who are under age 3. This is unfortunate because these providers often open the door to engage members in dental care. Still, there are not always reliable dental providers nearby for them to

get complete care. For example, these mobile providers may be the best option in less urban counties with gaps in dental care, but without them being able to impact the KPI, CCHA must balance the need for care for vulnerable populations versus (vs.) who can influence the KPI.

Well Visits

CCHA met WV for 15-30 months in each quarter but failed to meet 0-15 months or 3-20. However, both CCHA and our PCMPs have noticed significant differences in internal calculations vs. the DAP, and continues to work with HCPF to address these differences. CCHA is hopeful that with some changes to the calculations, we will meet 0-15 months.

Figure 3. Well Visits Part 1 0-15 Months KPI Results from SFY22-23

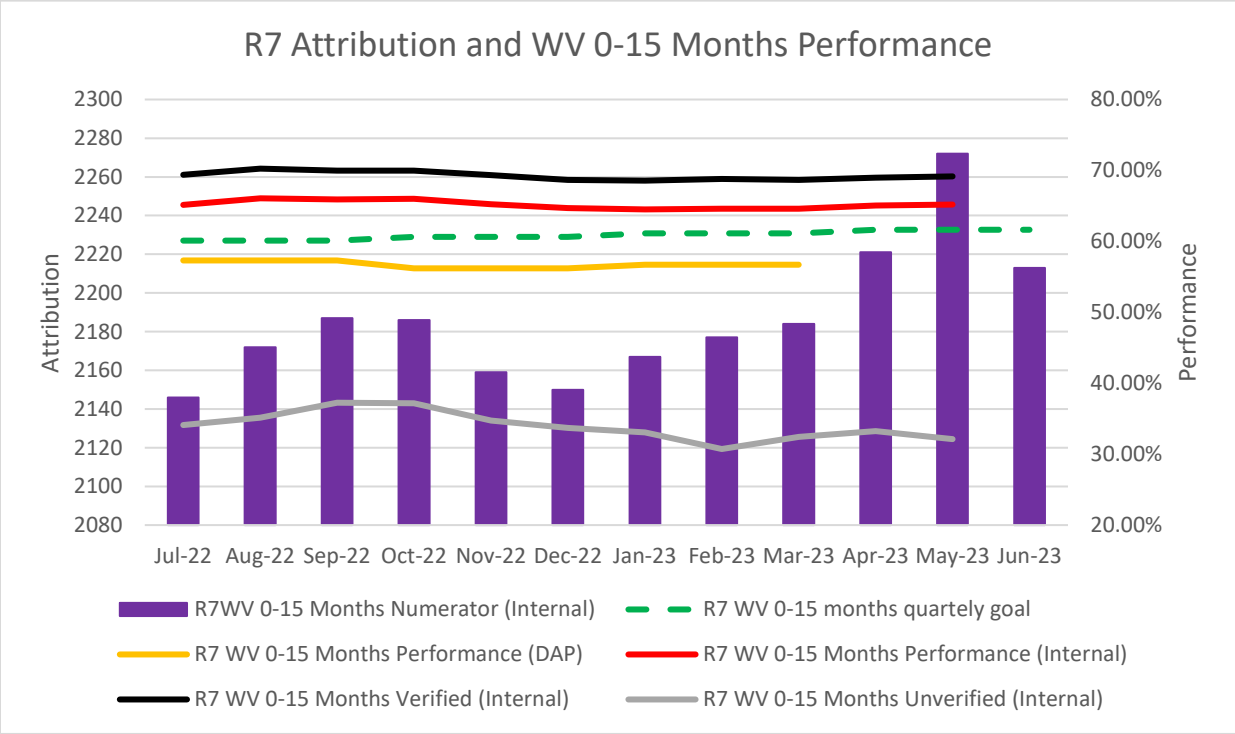


Figure 4. Well Visits Part 1 15-30 Months KPI Results from SFY22-23

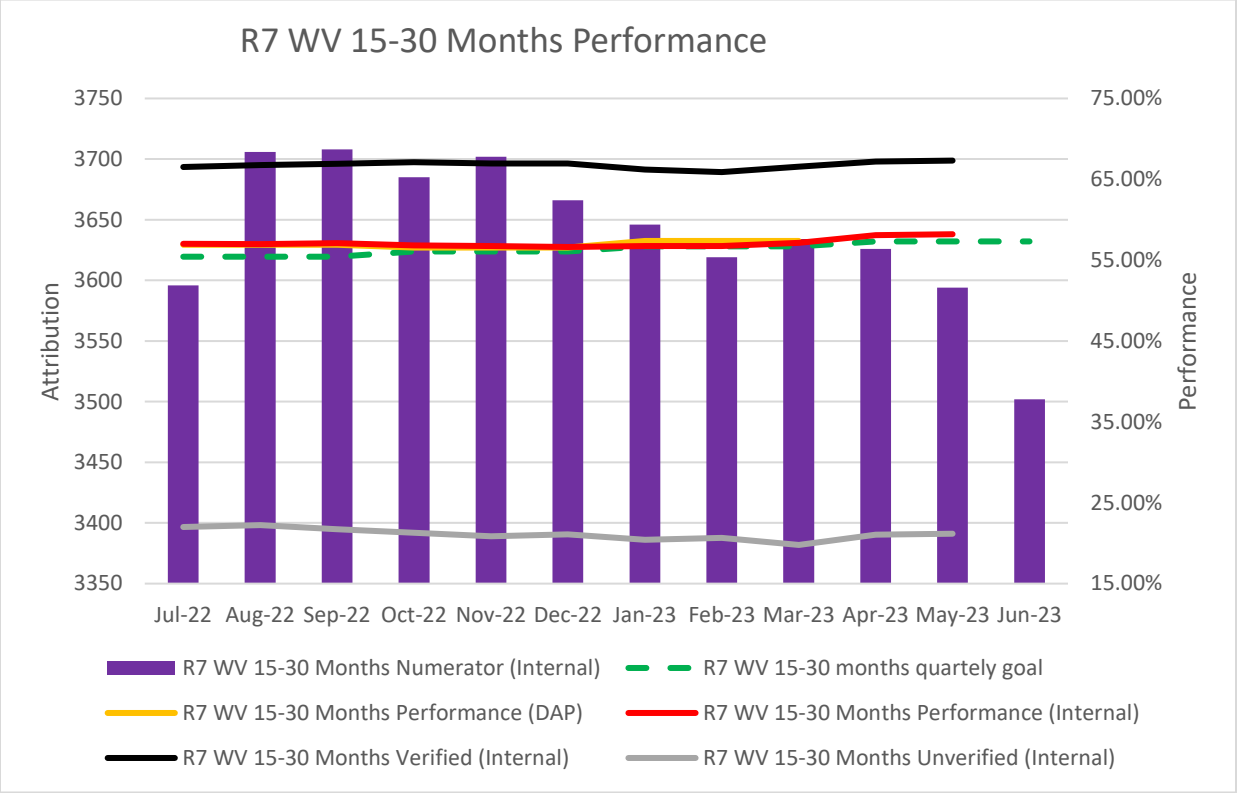
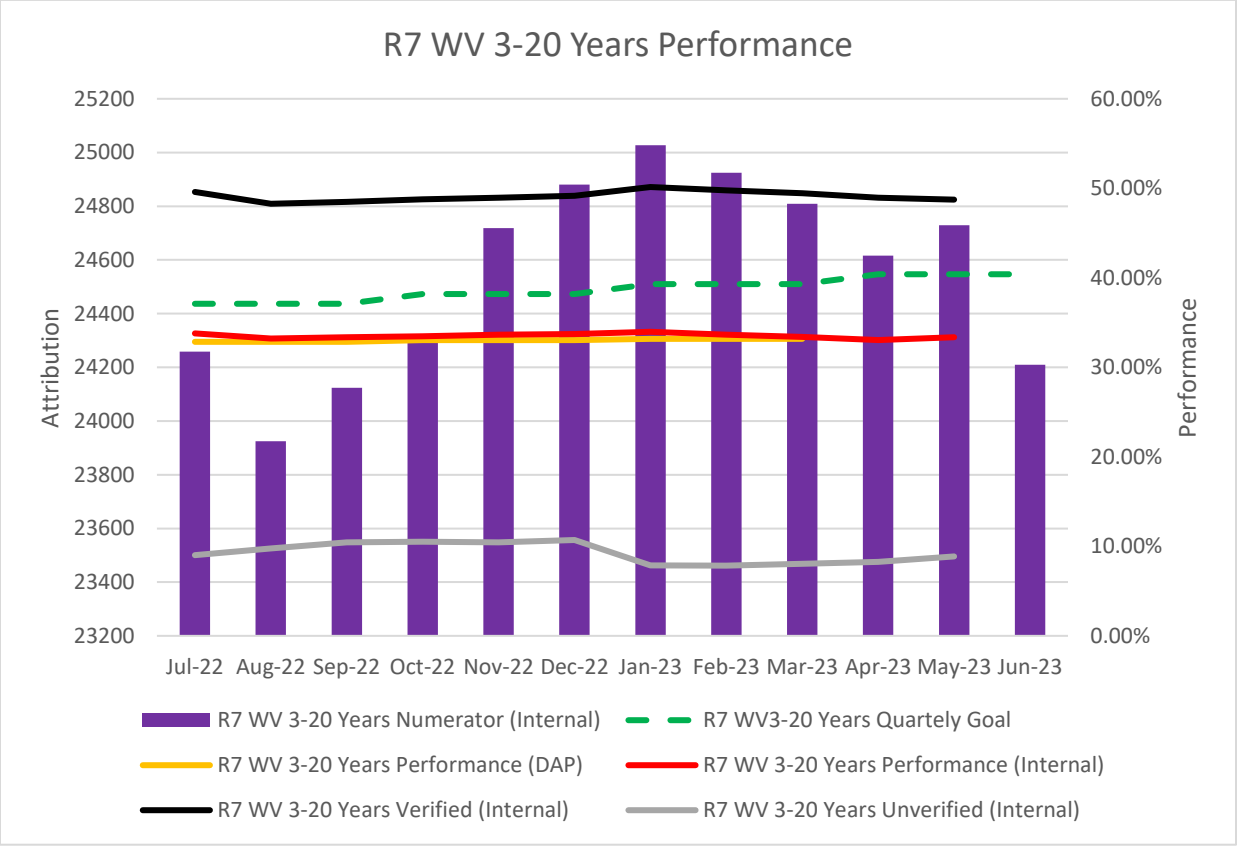


Figure 5. Well Visits Part 2 3-20 Years KPI Results from SFY22-23



Lessons Learned and Opportunities for Improvement

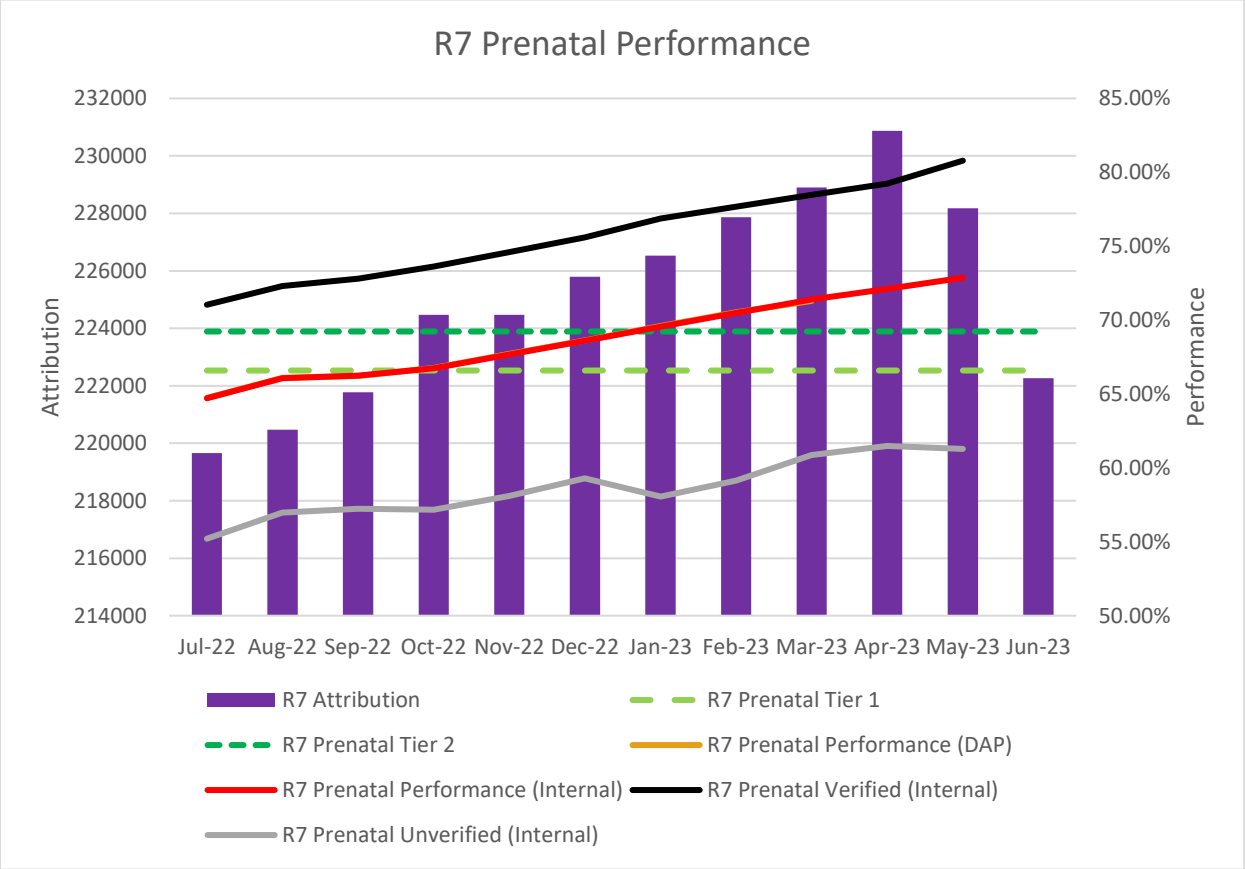
In addition to working with HCPF to address measure calculation issues:

- As you can see from the data above, particularly the data for 0-15 month WV, there is a substantial difference between our internal calculations vs. what we see in the DAP. Additionally, we have heard from several providers that they show members as passing the KPI in their electronic health records (EHRs), but not in the DAP. In January 2023, CCHA conducted a deep dive into the data differences and found 1200 members, aged 0-15 months, in the DAP data who were not included in CCHA's data due to continuous eligibility criteria. CCHA shared these findings with HCPF along with several member examples and continues to communicate regularly with HCPF to determine how we can address these differences in data.
- Internally, CCHA has added the most recent well visit to the member look-up report that care coordinators use so they can address any gaps and help connect members in need with a dental provider.
- CCHA added a page to CCHAcares.com that educates members on the importance of well visits and preventative oral care. A link to this page, www.cchacares.com/wellvisit, was included in a mass text outreach effort in May to promote preventive health.
- PTCs encouraged improvement activities for all PCMPs not meeting the regional quarterly tier goal for the well visit KPIs. They worked with the PCMPs to create visit workflows and implement and refine recall efforts, including sharing monthly lists of members due for WV.
- CCHA also noticed low well visit rates for certain members involved in the foster care system. CCHA has identified that this is primarily amongst children who have been adopted and will continue to work on a solution to improve these low rates in SFY23-24.

Prenatal Visits

CCHA missed the prenatal visit KPI in Q1 of SFY22-23, but met tier 2 for Q2 and Q3, 24 and is expecting to meet tier 2 for Q4 as well.

Figure 6. Prenatal Visits KPI Results from SFY22-23



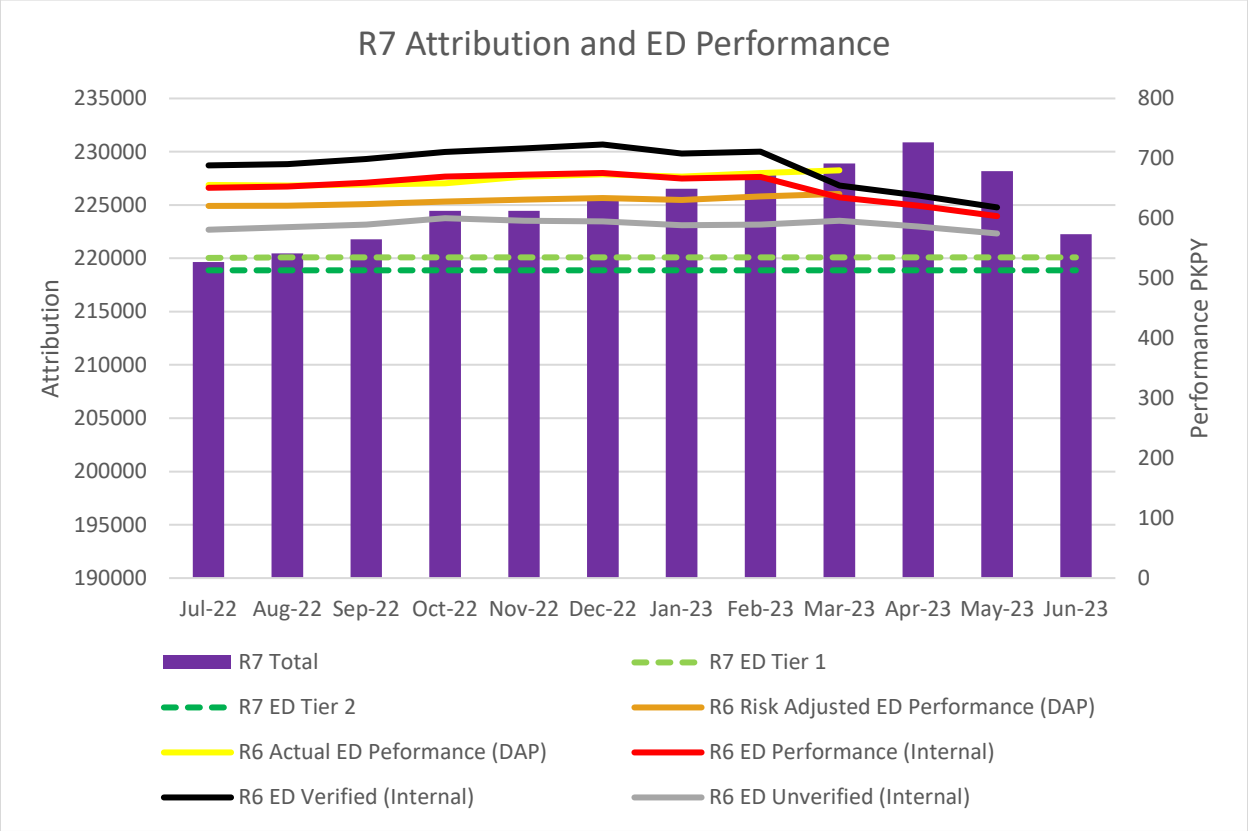
Lessons Learned and Opportunities for Improvement

- CCHA includes all pregnant members in our complex definition and outreaches all newly complex members, prioritized by their enrollment date. During this outreach, Member Support Services staff educate members about the importance of early prenatal visits and help connect them to obstetrics and gynecology providers (OBGYNs) and obtain transportation, if needed.
- Starting in Spring SFY22-23, nurse care coordinators took over the outreach to high-risk pregnant members with direct phone calls. They also educate members about the importance of early prenatal visits and help connect them to OBGYNs or maternal and fetal medicine specialists, if appropriate.
- CCHA continues to monitor claims data where PCMPs may have failed to add a TH modifier to identify a prenatal visit and appropriately coached providers to ensure all prenatal visits count toward the KPI and address any potential billing opportunities with PCMPs.
- In SFY23-24, CCHA will work with providers to understand the new timely prenatal and postpartum KPI and share any updated billing information with providers.

Emergency Department Utilization

CCHA failed to meet the ED utilization KPI in FY22-23. The trend of ED utilization continues going up; as a result, we did not achieve tier 1 or 2 for any quarter.

Figure 7. Emergency Department Utilization KPI Results from SFY22-23



Lessons Learned and Opportunities for Improvement

- This KPI was extremely challenging this year since the baseline was from the peak of the COVID-19 pandemic when healthcare utilization rates were far from normal.
- CCHA revised the "Where to Go for Care" guide. It was broadly shared with all network PCMPs, who can order it for free on CCHAcares.com, and care coordinators are giving it to members when appropriate.
- CCHA started working on a new ED outreach strategy that aligns better with our complex definition and identifies members most needing an intervention. We expect to implement this new strategy in the fall of SFY23-24.

Risk-Adjusted PMPM

CCHA did not meet this KPI in Q1 or Q2 in SFY22-23, and we do not currently have any predictions for Q3 and Q4. CCHA will continue to learn more about how this measure is calculated and prioritize work on the above KPIs to reduce complications that lead to avoidable costly care.

Goals for SFY22-23

Goal	Project/Initiative	Targeted Completion Date
Key Performance Indicators: Achieve the goal for three of the six KPIs	Engage with PCMPs and ACN providers in quality improvement processes.	June 30, 2023

	Partner with community organizations to align efforts and strategies to achieve KPI goals. Collaborate with HCPF on data disparities.	
Implement new and updated KPIs	Educate providers and community partners about the new oral evaluation KPI.	December 31, 2022

Status and Results

By March 2023, CCHA had not met the KPI tier 1 goal for three of the seven KPIs. Please see Table 1 for the most current performance data.

Table 1. KPI Performance from SFY22-23

Region 7	WV P1		WV P2	OE	PV	ED (Risk Adjusted)	BH Engagement	Risk Adjusted PMPM
	0-15 months*	15-30 months*	3-20 years*					
FY21-22Q4	56.38%	56.83%	34.03%	37.26%	64.22%	620.429	17.13%	
FY22-23Q1	57.32%	56.92%	32.85%	49.72%	66.22%	624.017	16.95%	$486.99
FY22-23Q2	56.20%	56.56%	33.04%	49.32%	68.62%	633.705	16.99%	$599.13
FY22-23Q3	56.72%	57.38%	33.18%	49.59%	71.30%	640.758	16.71%	$489.63

Opportunities for Improvement

CCHA continuously strives to achieve tier 2 goals for all KPI metrics. While we did not meet our regional goals in SFY22-23, we saw performance improvement for most KPIs in the last two quarters of SFY22-23. Therefore, CCHA will continue to modify interventions, apply lessons learned from SFY22-23, and thoughtfully implement new KPIs to meet our goals for SFY23-24.

Goals for SFY23-24

Goal	Project/Initiative	Targeted Completion Date	Actions
KPIs: Achieve goals for three of the six KPIs	Engage with PCMPs and ACN providers in quality improvement processes.	June 30, 2024	Update CCHA's Provider Incentive Program to increase engagement of PCMPs in practice transformation efforts to improve PCMP KPI performance.

	Partner with community organizations to align efforts and strategies to achieve KPI goals. Collaborate with HCPF on data disparities.		Utilize care coordination to educate members to connect with appropriate services. Share member-level data with providers to inform and support their quality improvement activities.
Implement new KPIs	Educate providers and community partners about the new depression screening and follow up and the timely prenatal and postpartum care KPIs.	December 31, 2023	Educate PCMPs and community partners about the KPI changes. Work with providers to automate depression screening codes when they are completed at every visit. Educate providers about new global billing guidelines related to maternity care. Update CCHA KPI Member lists to include member-level data for the new KPIs.

Behavioral Health Incentive Measures

- Engagement in Outpatient Substance Use Disorder (SUD) Treatment – patients newly diagnosed with a SUD should be seen at least twice on or within 30 days for follow-up visits. All visits must be documented with a primary SUD diagnosis.
- Follow-up within seven days of an Inpatient Hospital Discharge for a Mental Health Condition – patients hospitalized for treatment of a primary covered mental health diagnosis should be seen on an outpatient basis by a mental health provider within seven days.
- Follow-up within seven days of an Emergency Department (ED) Visit for Substance Use Disorder – patients who have been discharged from an ED episode for treatment of a covered SUD should be seen on an outpatient basis by a BH provider within seven days.
- Gate measure – Depression Screening: patients 12 years or older who receive outpatient primary care should be screened for depression.
- Follow-Up after a Positive Depression Screen – patients should be engaged in mental health services within a primary care setting within 30 days of screening positive for depression.
- Behavioral Health Screening or Assessment for Children in Foster Care System – foster care recipients should receive a BH screening or assessment within 30 days of enrollment in the Accountable Care Collaborative.

Techniques Used to Improve Performance

CCHA is committed to expanding regional programs and interventions to improve our performance related to the BH Incentive Measures. CCHA spent SFY22-23 expanding partnerships and supporting ongoing expectations for improved performance and clinical outcomes.

Throughout the year, CCHA prioritized the following efforts:

- Expanded the Behavioral Health Quality Incentive Program (BHQIP) to financially reward high-performing providers to improve performance on clinical quality indicators, including follow-up after hospital discharge and substance use engagement.
- Added the Behavioral Health Facility Incentive Program (BHFIP) with value-based quality metrics to improve outcomes on discharge from inpatient placement and reduce hospital readmissions.
- Maintained the Specialized Transitions of Care (STOC) team to outreach members and facilities to support discharge for members receiving inpatient and residential substance use treatment.
- Finalized performance improvement projects to improve rates of depression screening and follow-up after a positive screen.
- Initiated an outreach process to El Paso County Department of Human Services (DHS) caseworkers to offer and promote timely connections to BH providers for newly enrolled foster care children.
- Established a referral pathway with a designated provider to facilitate access to BH screening for foster care children in El Paso County.
- Onboarded BH practice transformation coaches to enhance our transformation efforts and collaborate with high-volume BH providers to support quality improvement activities, understand measurement benchmarks, establish workflows, monitor, and improve performance.
- Collaborated with hospital systems in the Hospital Transformation Program (HTP) to improve notifications and hand-offs for members visiting the ED and inpatient for BH diagnoses.

Goals for SFY22-23

Goal	Project/Initiative	Targeted Completion Date
BH Incentive Measures: Achieve benchmark improvements on four of the five BHIP quality metrics.	Engage BH and PH providers in quality improvement processes. Partner with community organizations to align efforts and processes to achieve BHIP goals.	June 30, 2023

Substance Use Treatment Engagement and BH Follow-up after an ED visit for SUD

To respond to the region's BH needs, CCHA's STOC program provides deliberate care coordination support. It facilitates effective discharge planning for members transitioning from higher levels of care (HLOC, inpatient, residential, and withdrawal management) for a SUD event into indicated BH aftercare. STOC's care coordinators, outreach care specialists, and peer support specialists collaborate with members, facilities, and treatment teams to promote access to a BH follow-up service within seven days from discharge, to overcome barriers to treatment engagement and ultimately reduce HLOC utilization through enhanced opportunities for effective condition management in lower acuity care.

Through regular meetings and case reviews, CCHA works to forge consistent collaborative relationships with stakeholders and facilitate improved coordination of services for shared members. CCHA continues to develop and improve referral pathways through formalized workflows with partners to

increase efficiency, access to care, reduce duplication and costs, and improve member experience and outcomes.

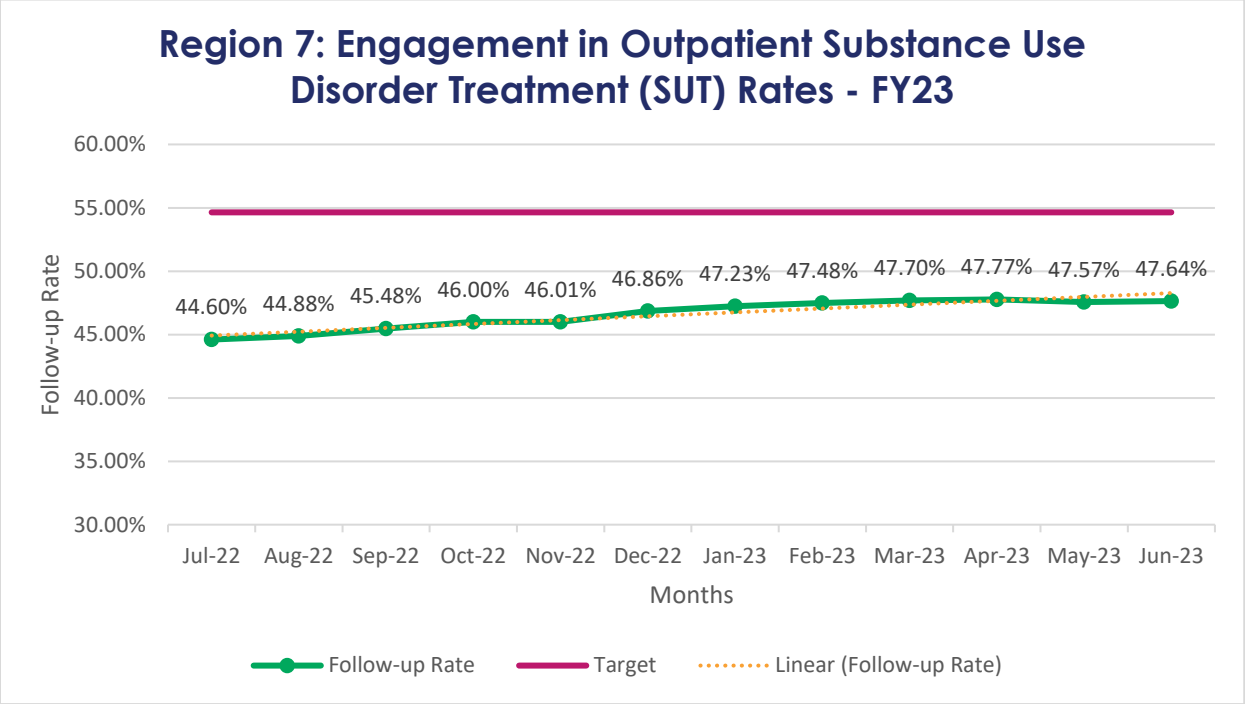
CCHA's strategy also leverages the BHQIP to financially reward eligible BH network providers for improving performance on clinical quality indicators, including reduction of ED utilization for attributed members and substance use treatment engagement. High-performing providers who meet pre-determined quality, service, and utilization goals are eligible to receive incentive payments annually. BH practice transformation coaches collaborate with BH providers to support quality improvement activities, understand measurement benchmarks, establish workflows, monitor, and improve performance.

CCHA established and maintained regular collaborative meetings with several SUD facilities, CMHCs, and HTP partners to strengthen referral pathways, establish social needs screening and other strategies to promote follow-up after ED visits.

CCHA worked with Centura to create a resource document to be included in the discharge packet provided to members discharging with a mental illness or substance use disorder diagnosis. CCHA also worked with Centura to develop a warm-handoff process for Centura to notify CCHA when a member discharges from an episode for treatment of alcohol use disorder.

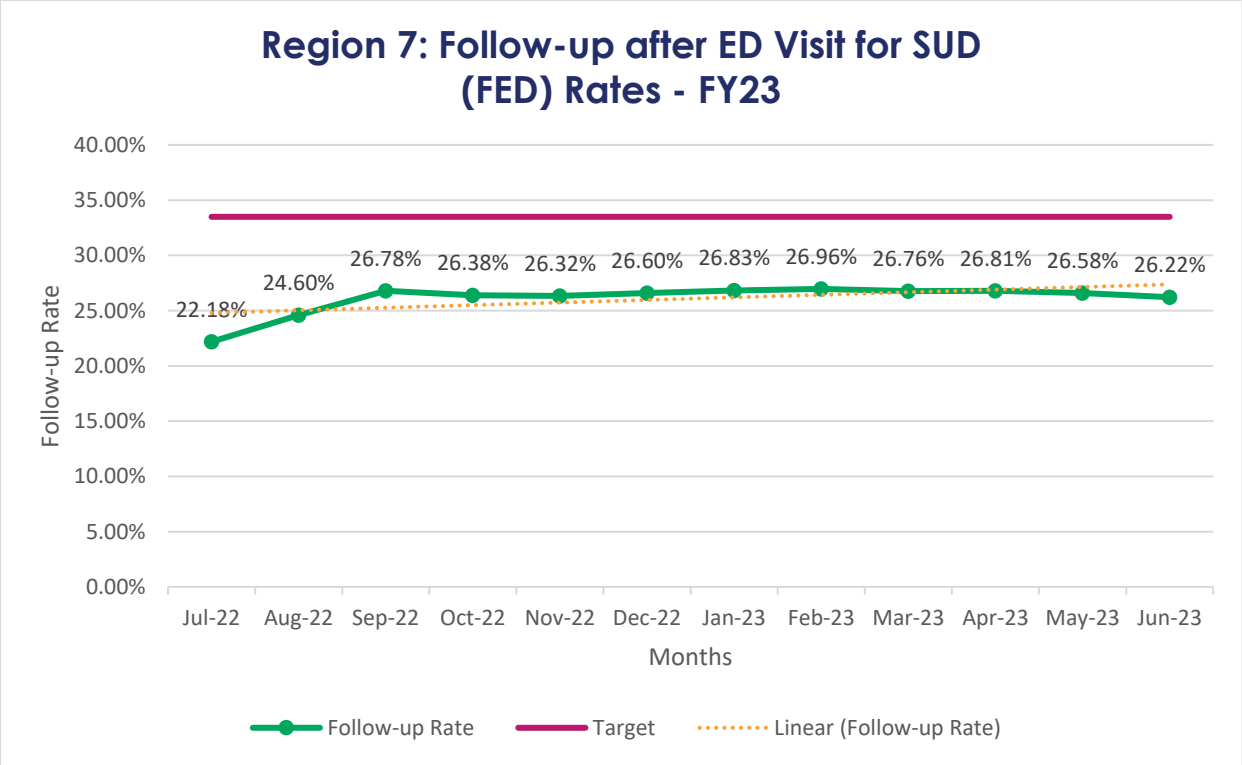
Preliminary data results do not indicate Region 7 will achieve improvement goals on engagement in SUD treatment or follow-up in outpatient BH care after an ED visit for SUD. However, given that rates of Engagement in SUD Treatment are within the historically observed margin of error, CCHA anticipates this measure target will be met in Region 7. Internal projections data for both measures are demonstrated in the graphs below.

Figure 8. Engagement in Outpatient Substance Use Disorder Treatment Results from SFY22-23



** Outcomes on graph are cumulative and include results from prior months of SFY22-23.*
*** Preliminary results. Official outcomes are calculated by HCPF in Spring 2024.*

Figure 9. Follow-up within Seven Days of an ED Visit for a SUD Results from SFY22-23



** Outcomes on graph are cumulative and include results from prior months of SFY22-23.*
*** Preliminary results. Official outcomes are calculated by HCPF in Spring 2024.*

Lessons Learned and Opportunities for Improvement

In the current reporting period, 433 cases were enrolled in STOC to receive care coordination assistance through contact with members, guardians and/or placement facilities. The STOC team worked to increase its success in reaching members directly while in care or after discharge in addition to working with the facilities to plan for discharge. This effort increased rates of direct contact with members from 27% in the SFY22 measurement to 51.73% during the SFY22-23 time frame. CCHA attributes this improvement to our ongoing commitment to building relationships with our SUD providers. The STOC program remains ongoing, and performance will continue to be monitored to inform data-driven adjustments to the STOC strategy.

CCHA awarded incentive funds to eligible providers participating the CY2022 BHQIP for achieving improvement targets on measures including ED utilization and Initiation and Engagement in Substance Use Disorder Treatment. All providers regularly receive specific performance status and practice transformation assistance to capitalize on improvement opportunities. The response from providers has been positive, as evidenced by engagement in coaching support and increased enrollment in the program. As a result, CCHA exceeded its BHQIP enrollment goal, increasing the number of participating providers by 42.5% in CY2023. CCHA will continue to promote the incentive program, support providers, and incentivize improvements to advance performance on quality care measures.

Follow-up after Inpatient Hospital Discharge for Mental Health (MH) Condition

In addition to supporting the improvement efforts for substance use treatment engagement, CCHA's BHQIP also financially rewards eligible BH network providers for increasing rates of follow-up after inpatient hospital discharge and reducing acute BH inpatient readmission rates. To augment this process in CY2023, CCHA implemented a new BHFIP with value-based quality metrics on readmission rates and outpatient follow-up offered to BH facilities (such as psychiatric hospitals, freestanding mental health facilities and acute care hospitals with psychiatric units).

BH practice transformation coaches collaborate with BH providers and facilities to support quality improvement activities, understand measurement benchmarks, establish workflows, monitor, and improve performance. During this fiscal year, coaches supported a total of 142 behavioral health practices this year, with 77 in Region 7.

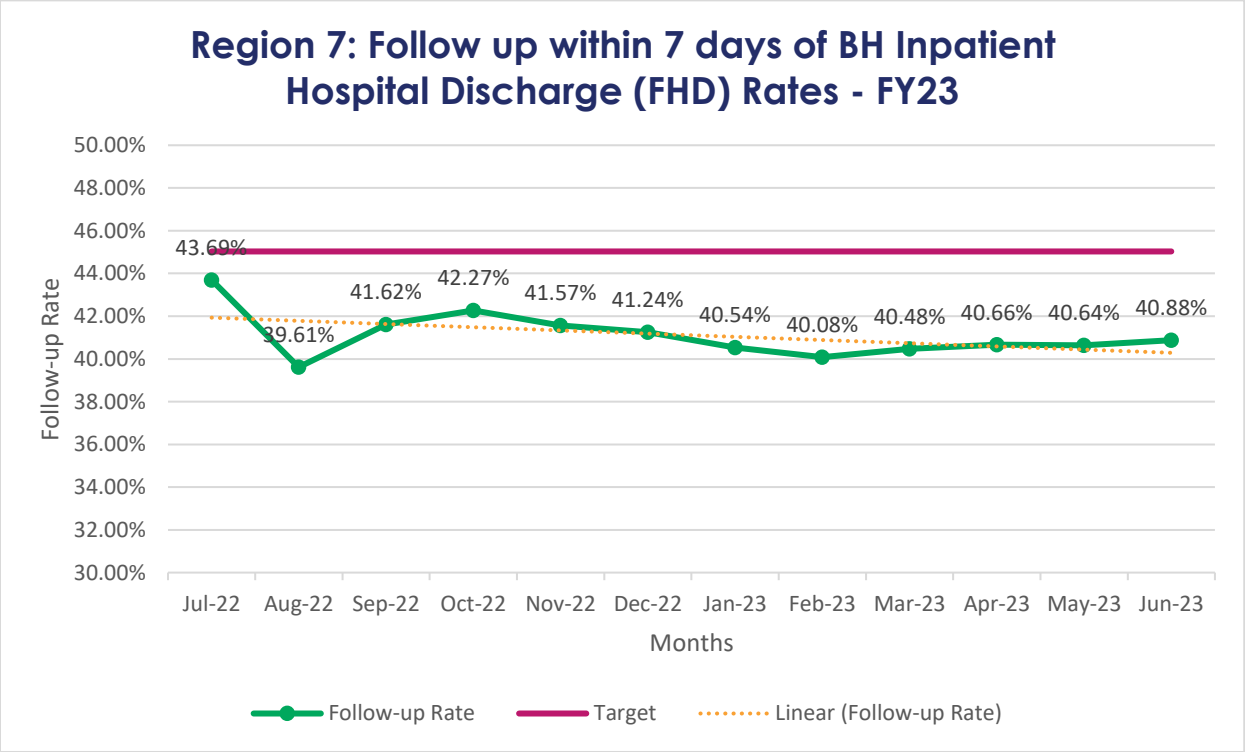
High-performing providers who meet pre-determined quality, service, and utilization goals are eligible to receive incentive payments annually. Enrolled providers receive quarterly scorecards with their performance as well as member level details to promote continuous quality improvement activities. CCHA awarded incentive funds to eligible providers participating the CY2022 BHQIP for achieving improvement targets, and exceeded its BHQIP enrollment goal, increasing the number of participating providers by 42.5% in CY2023.

In Region 7, CCHA collaborates with a high-volume CMHC to define and enhance clinical pathways that support existing clients' transition out of inpatient placements. A Transitional Care Track has been developed with the goal of facilitating members' timely access to outpatient therapy and psychiatric services after a hospital stay. The program has been successfully implemented with the CMHC's Acute Treatment Unit (ATU), but they are still working through barriers to establishing collaboration with external psychiatric hospitals.

To promote timely notification, CCHA uses a secure file transfer protocol (SFTP) site for faster distribution of health data to notify attributed care coordinators/providers of relevant information on members' clinical care and service level utilization. The client's primary therapist, psychiatrist or the

last clinician involved in the case within 6 months are notified when an open client shows up on census to ensure proper discharge planning and coordination occur. Preliminary data results indicate these efforts have not been sufficient to meet benchmark rates of follow-up after inpatient hospital discharge for a MH condition. Internal calculations of regional performance for Follow up after Inpatient Hospital Discharge rates are displayed in the graph below.

Figure 10. Follow-up within 7 days of BH Inpatient Hospital Discharge



** Outcomes on graph are cumulative and include results from prior months of SFY22-23.*
*** Preliminary results. Official outcomes are calculated by HCPF in Spring 2024.*

Lessons Learned and Opportunities for Improvement

A Transitional Care Track (TCT) performance dashboard was developed to evaluate the availability and effectiveness of programming in reestablishing and maintaining engagement after hospital discharge. The CMHC's ATU data shows a significant reduction in utilization of acute and crisis services during and after TCT support, and an increase in utilization of counseling and psychiatry when compared to pre-TCT levels. CCHA will partner with the CMHC on a Performance Improvement Project (PIP) to improve rates of follow-up after hospital discharge to establish discharge pathways from psychiatric hospitals and inform a coordinated response that reduces duplication of efforts.

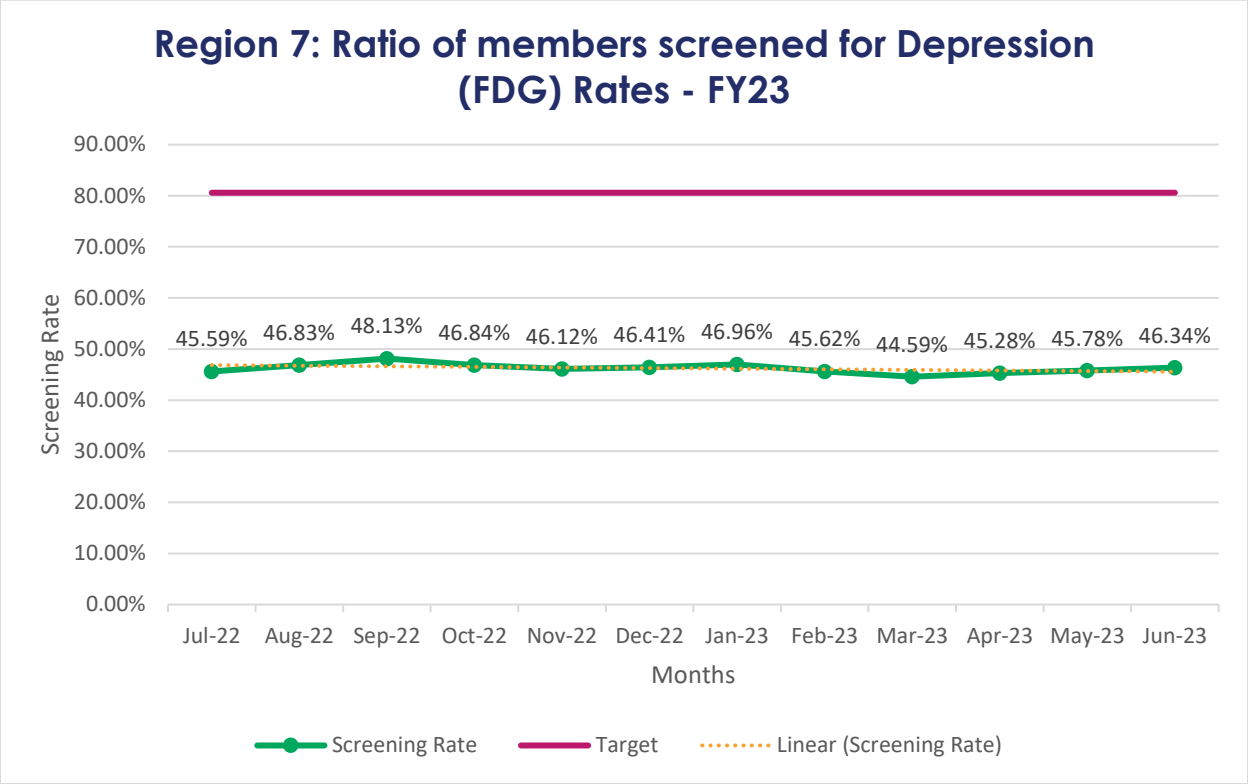
Depression Screening and Follow-up After Positive Depression Screen

CCHA partnered with large-volume FQHCs for process improvement to increase rates of depression screening and follow-up after a positive depression screen. A description of the interventions and results of the PIP initiative are described in the Performance Improvement Projects section.

In addition, practice transformation coaches established collaborative meetings with 77 practices in Region 7 to aid with BH issues, implement workflows to complete depression screenings for all members over 12 years old and facilitate referrals for BH follow-up support, as clinically indicated.

Internal calculations project the target for Depression Screening and Follow-up After Positive Screen during SFY22-23 was not achieved, as demonstrated below.

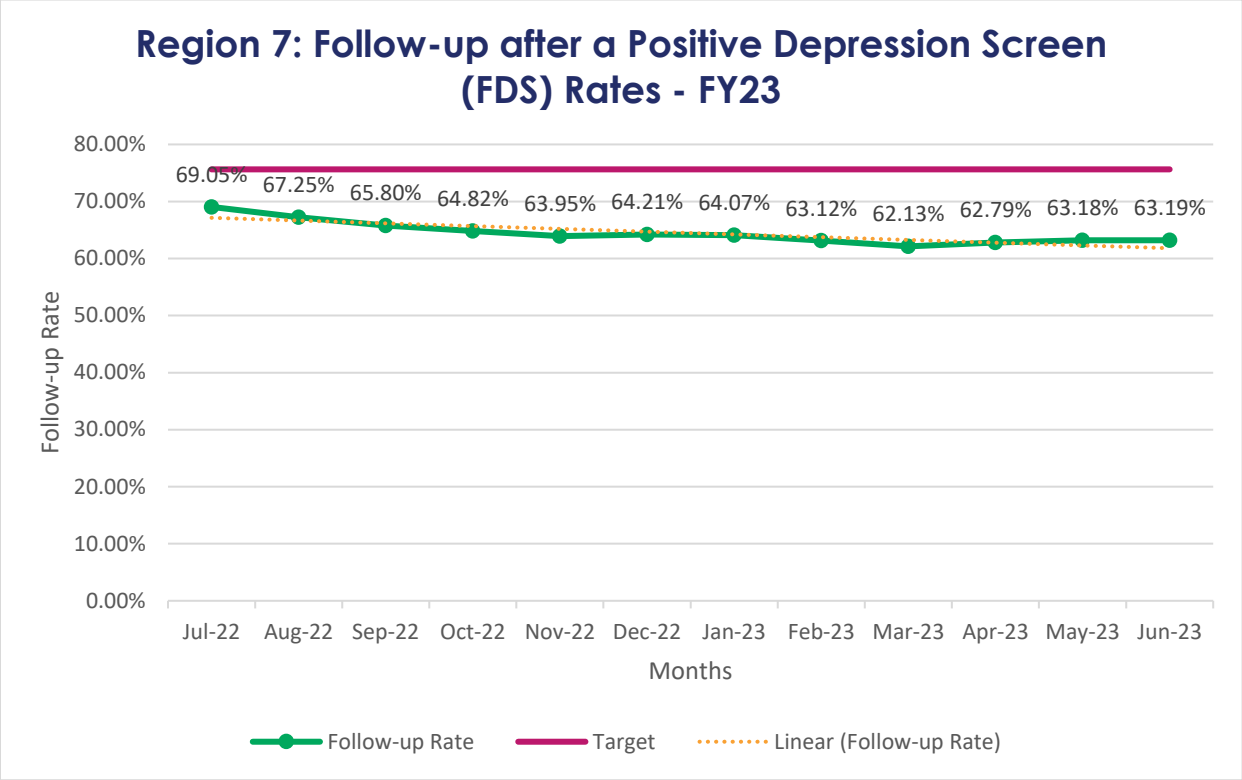
Figure 11. Rate of members screened for depression



** Outcomes on the graph are cumulative and include results from prior months of SFY22-23.*

*** Preliminary results. HCPF calculates official outcomes in Spring 2024.*

Figure 12. Follow-up after a Positive Depression Screen



** Outcomes on the graph are cumulative and include results from prior months of SFY22-23.*
*** Preliminary results. HCPF calculates official outcomes in Spring 2024.*

Lessons Learned and Opportunities for Improvement
Internal tracking tools the PIP partner uses to monitor compliance with the depression screening requirements showed a higher compliance rate compared to the claims-based PIP outputs. Variations in covered benefits for distinct payer sources and discrepancies in measure specifications and calculation methodology between different incentive programs create competing objectives for process improvement, limited the feasibility of altering workflows, and duplicative work to fulfill documentation requirements. Due to discrepancies between the measure's performance calculation methodology and the provider's standard workflow, outcomes may not accurately reflect the provider's performance in the provision of targeted services.

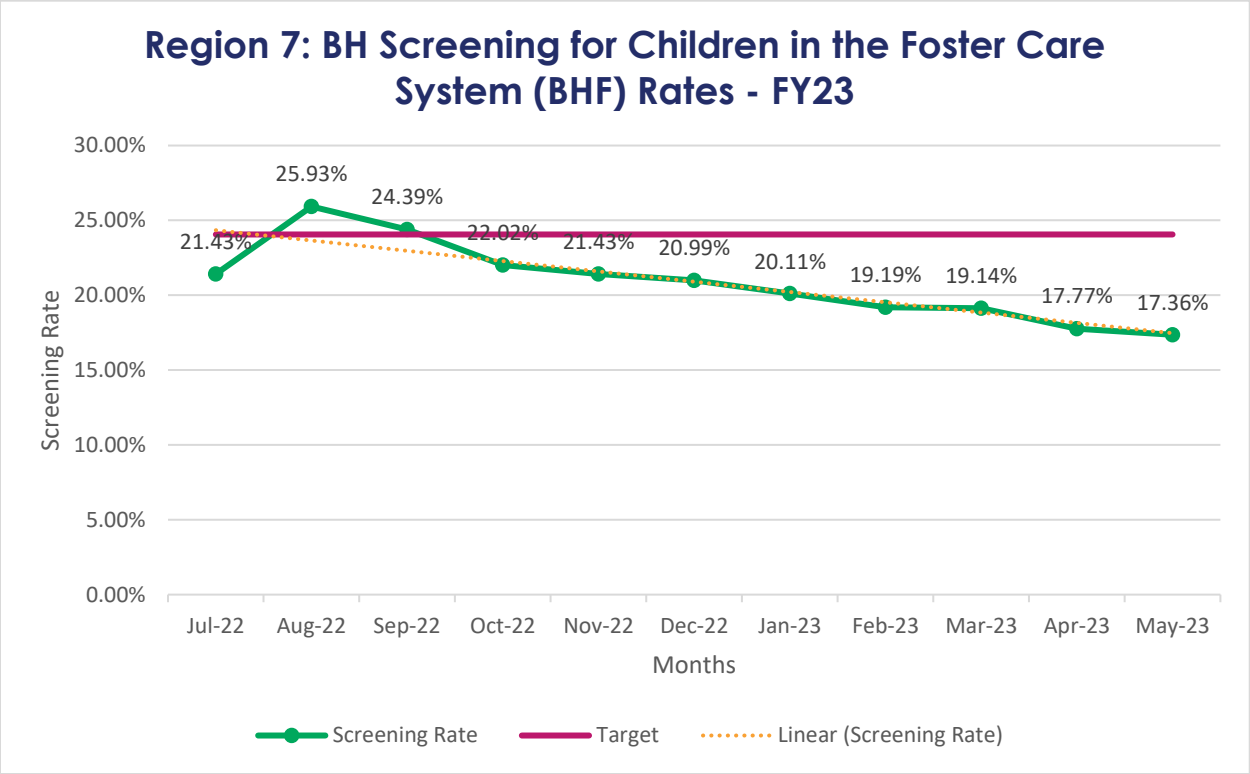
Some providers continue to struggle implementing operational changes to capture their depression screening process through billed G-codes. This may be further exacerbated with this measure's transition from the BHIP specifications to the CMS Core Measure Set in SFY23-24 as well as competing requirements for the same target set forth in the SFY23-24 Key Performance Indicators. The acceptance of supplemental data is a valuable tool for being able to capture the full picture of quality activities taking place in the space of universal depression screening. CCHA's practice transformation coaches will continue working with network providers to implement improvement strategies and adjust processes to match the incentive measures' calculation methodologies.

BH Incentive Measures: Maintain and improve existing notification protocols and expand timely referral process for children entering foster care
CCHA successfully established a process to obtain regular kinship/foster care placement notifications from El Paso County DHS to expedite the identification of members entering the system. In SFY22-23,

the CCHA Care Coordination team began outreaching DHS caseworkers of members who are five years or older to promote timely access to behavioral health support through education, resources and/or to directly assist members without an identified provider.

CCHA partnered with a BH provider in Region 7 and instituted a specific clinical pathway to facilitate access a to BH screening to support prevention or early identification of concerns, bolster adjustment, and mitigate the risk of further or future disruption. Preliminary data results indicate these efforts have not been sufficient to meet benchmark rates of BH Screening or Assessment for Children in Foster Care. Internal projections data for the measure is demonstrated in the graph below.

Figure 13. BH Screening for Children in the Foster Care System



** Outcomes on graph are cumulative and include results from prior months of SFY22-23.*
*** Preliminary results. Official outcomes are calculated by HCPF in Spring 2024.*

Lessons Learned and Opportunities for Improvement

- Calculation issues related to the dynamic nature of the enrollment data set continue to influence low compliance reporting in our interim calculations. The metric as calculated by HCPF is likely to be higher than the internal projections above.
- Claims data show screening rates are trending upward in SFY22-23 compared to the opposite trajectory observed in CY2022, which may be indicative of the project's positive impact on engagement rates. CCHA care coordinators have encountered challenges reaching El Paso DHS caseworkers to offer BH screening services and obtain authorization to outreach placement providers to provide referrals. Further, manual placement notifications are susceptible to errors and delays that negatively impact performance.
- While efforts for collaboration with DHS have increased, there are continued barriers with navigating the consent to receive the BH screening service considering the foster care system involvement. This causes several delays in initiating services and pushes a significant amount of

BH access out beyond the first 30 days. CCHA continues to negotiate compliant and streamlined consent procedures with counties and behavioral health providers to impact this access delay.

- CCHA will continue to collaborate with DHS leadership and routinely verify service claims for performance monitoring and identification of improvement opportunities to promote timely access to BH screening services for children in foster care.

Status and Results

Internal performance data on all BHIP measures for SFY22-23 show that as of July 2023, CCHA is not projected to achieve targets on BH Incentive measures in Region 7. However, given that rates of Engagement in SUD Treatment are within the historically observed margin of error, CCHA anticipates this measure target will be met in Region 7. These outcomes are based on internal data calculations, and the final results will be provided by HCPF and validated through HSAG in Spring 2024.

Table 2. BH Incentive Program Data from SFY22-23

Region 7	SFY22-23 as of August 2023							
Measure Name	**DEN**	**NUM**	**RATE**	**Target Rate*** **	**Hits to Target**	**HCPF Goal* (SFY21-22)**	**R7 Base (SFY20-21)**	**Improvement****
Engagement in Outpatient Substance Use Disorder Treatment (SUT)	5,653	2,693	47.64%	54.64%	Not Met	59.51%	54.10%	0.54%
Follow-up Appointment within 7 days of IP Hospital Discharge for MH Condition (FHD)	2,544	1,040	40.88%	45.03%	Not Met	77.47%	41.42%	3.61%
Follow-up Appointment within 7 days of ED Visit for Substance Use Disorder (FED)	2,883	756	26.22%	33.49%	Not Met	40.14%	32.75%	0.74%
Depression Screening Rate (FDS Gate Measure)	24,749	11,469	46.34%	80.58%	Not Met	87.76%	79.78%	0.80%
Follow-up after Positive Depression Screen (FDS)	8,441	5,334	63.19%	75.63%	Not Met	95.80%	73.39%	2.24%
Behavioral Health Screening or Assessment for Children in Foster Care System (BHF)	288	50	17.36%	24.06%	Not Met	36.42%	23.29%	1.31%

** HCPF Goal is 10% improvement on top performer's score.*
*** Improvement is based on (HCPF Goal - Base Rate) x 10%*
**** Target Rate = Base Rate + Improvement Rate*

Goals for SFY23-24

Goal	Project/Initiative	Targeted Completion Date	Action(s)
BH Incentive Measures: Achieve benchmark improvements on four of the five BHIP quality metrics.	Engage BH and PH providers in quality improvement processes. Partner with community organizations to align efforts and processes to achieve BHIP goals.	June 30, 2024	Promote program information to encourage enrollment in BHQIP and BHFIP, distribute performance status and disburse financial incentives to high-performing providers. Adjust processes and performance tracking tools to align BHIP measures with

Goal	Project/Initiative	Targeted Completion Date	Action(s)
			Centers for Medicare and Medicaid Services (CMS) Core Measure specifications. Maintain 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. Practice transformation coaches will hold regular quality improvement meetings to provide support and assistance to increase depression screening and follow-up. Maintain and improve existing notification protocols and expand timely referral process for children entering foster care.

Performance Pool

In addition to the KPIs and the BHIP, HCPF uses remaining unearned funds to create flexible funding opportunities through the Performance Pool. These Performance Pool funds reinforce and align evolving program goals and address cost drivers. For example, in SFY22-23 Performance Pool measures included:

- Extended Care Coordination (ECC)
- Premature Birth Rates
- Behavioral Health Engagement for Members Releasing from State Prisons
- Risk-Adjusted PMPM
- Asthma Medication Ratio
- Antidepressant Medication Management
- Contraceptive Care for Postpartum Women

Techniques Used to Improve Performance

Extended Care Coordination

CCHA continued work on our complex high-need member definition that was approved in Fall 2021 and met the ECC performance measure in both regions.

Complex members are outreached using multiple modalities to attempt to engage them in care coordination. A health risk assessment is used to identify the members' needs, goals, and social

determinants of health (SDOH), and a care plan is created based on the results. This plan includes deliberate services focused on meeting the member's medical, behavioral, and social needs in a culturally responsive manner that respects member preferences and is provided at the point of care whenever possible.

ACN practices must achieve performance goals to receive incentive payments earned as a region. Among additional metrics that help drive performance, ACN providers must achieve target goals for engaging their complex high-need members in ECC. CCHA sends the ACNs monthly rosters with all complex members assigned first priority. Each month ACNs report back to CCHA with the list of members who were outreached and/or engaged in ECC. Additionally, CCHA communicates regularly with ACNs on shared members.

Number of Premature Births

CCHA created an algorithm to identify pregnant members at high-risk for a complicated delivery, including premature birth. CCHA prioritizes outreach to these members who meet the following criteria:

- Eclampsia
- Diabetes
- Non-English speaking
- Age <21 or >35
- Black/African American and Native American
- SUD
- 1+ inpatient admission
- 2+ ED visits
- Members referred by their providers

CCHA outreaches all pregnant members to conduct a health needs assessment, educate on the importance of timely prenatal care, connect to OBGYNs and Maternal and Fetal health providers, and connect with care coordination when needed. Additionally, in the spring of 2023, CC nurses started direct outreach to high-risk pregnant members to improve engagement in CC services. So far, these efforts are going well, and we hope to have definitive data through an evaluation of our Maternity program.

BH Visits for Members Releasing from DOC

Also described below in Section 7, we discuss how we assist these members in getting the care they need, our outreach efforts, and the challenges related to this measure.

Medication Adherence

CCHA updated dashboards for the three medication adherence measures and created a member list. Flags on the list can be used to identify non-compliant members so that, with PTC support, the practice can develop interventions to support these members. CCHA also created PCMP-level dashboards that show whether the practices meet these measures. PTCs share these tools with PCMPs and help implement quality improvement efforts, such as outreach to non-compliant members.

Goals for SFY22-23

Goal	Project/Initiative	Targeted Completion Date
Meet at least one of three non-medication adherence Performance Pool metrics	Engage ACN providers and Single Entry Points (SEPs)/Community Centered Boards (CCBs) to align efforts on Performance Pool metrics.	June 30, 2023
Meet at least one medication adherence Performance Pool measure	Engage with PCMPs and ACN providers in quality improvement processes.	June 30, 2023

Status and Results

As shown in Table 3 below, CCHA projects that we met the goals for asthma, half of the depression medication adherence, and contraceptive care performance. We will continue to monitor these measures in SFY23-24.

While we are confident in our projections that we have met ECC, we are awaiting calculations for Premature Birth Rate and BH DOC. CCHA does not currently have projections for these measures.

Table 3. Performance Pool Data

Region 7	Goal	Current Performance
ECC	47.5%	55.95%
Premature Birth Rate*	10.4%	TBD
BH DOC*	19.14%	TBD
Rx Asthma	53.8%	55.81%
Rx Depression: Acute Continuous	 70.8% 51.5%	 70.53% 53.07%
Rx Contraceptive Care	24.2%	24.32%

**CCHA does not have projections for these measures - awaiting final calculations from HCPF.*

Opportunities for Improvement

In SFY22-23, CCHA will continue to focus on ECC to see improved performance. We will strategize around measures that we did not meet once we receive the final data.

Goals for SFY23-24

Goal	Project/Initiative	Targeted Completion Date	Action(s)
Meet the target for at least one of the three non-medication adherence Performance Pool metrics	Engage ACN providers, PCMPs, and the Single Entry Point and Community Centered Board agencies (SEPs/CCBs) to align efforts on Performance Pool metrics.	June 30, 2024	Continue monthly complex case reviews with entities including SEPs, CCBs, PCMPs, ACNs, behavioral health facilities, and community partners when applicable to address barriers and find solutions to meet member needs. Hold quarterly check-ins and leadership meetings with ACNs to discuss successes, barriers, and opportunities for improvement.
Meet the target for at least one medication adherence Performance Pool measure	Engage with PCMPs and ACN providers in quality improvement processes.	June 30, 2023	Continue sharing actionable member level data with PCMPs and ACNs.

Section 5: Member Experience of Care Improvement-Driven Projects

Member and family involvement and input into the Quality Improvement Program are vital to improving members' experience of care service improvement. CCHA's Quality Improvement Program involves monitoring members' experience, perceptions, accessibility, and adequate services within the region using Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys as well as grievances data and surveys of member experience from our CMHCs. In addition to these surveys, CCHA utilizes the regional Member Advisory Committee (MAC) and the regional Performance Improvement Advisory Committee (PIAC) (see Section 10 for more information) to solicit stakeholder feedback.

Behavioral Health Experience of Care

CCHA engaged the CMHCs to develop tools for measuring member satisfaction through routine surveys and to use results to inform improvement strategies.

Techniques Used to Improve Performance

The CMHC utilized the Press Ganey reputation management platform to distribute satisfaction surveys and better understand member's experience and satisfaction of behavioral health services provided.

Goal for SFY22-23

Goal	Project/Initiative	Targeted Completion Date
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

Status and Results

All members currently at one CMHC receive an electronic survey about the care received every six weeks if a service is provided within that period. 30,745 surveys were distributed via text messages/emails, depending on the individual's preferred method of communication per the EHR. Additional touchpoints are available for members placed at the ATU. 1,408 survey responses and 2,169 insights (social media, surveys, testimonials) were received in SFY22-23. 94% of clients reported a positive or neutral response, and remaining feedback was qualified as negative. Average Patient Feedback Score (PFS) increased from 3.9 to 4.1 in SFY22-23 (out of 5), indicating improvement from the all-time rate of 2.9. A new Net Promote Score metric was included this fiscal year, resulting in a 56.79 score and slightly below the healthcare average of 58 points. All responses are reviewed by the Marketing department, and negative responses/feedback are routed to the appropriate practice manager at the designated location for outreach to help address any concerns.

Opportunities for Improvement

Using text messages or email facilitates a higher volume of participation from the clients served by the CMHC. The member satisfaction data collected provided insight into progress, strength, and improvement areas.

Daily surveys provide real-time feedback that can reflect the impact of process changes and allows for intervention to address and resolve concerns in a timely manner. Overall feedback has been positive and indicates members are satisfied with the service experience. In SFY22-23, a small downturn in sentiment was observed due to initial challenges experienced with the implementation of Same Day Access. Findings also confirm the detrimental impact of staff turnover on clients, validating the importance of workforce retention strategies currently underway.

CCHA is still in the process of developing a similar text-based satisfaction survey for members receiving care in the Independent Provider Network (IPN), to include outpatient and hospital care settings. and plans to launch this in the next fiscal year.

Goal for SFY23-24

Goal	Project/Initiative	Targeted Completion Date	Action(s)
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, 2024	Monitor member satisfaction measures developed by the CMHC. Develop a member satisfaction survey of the members seeing BH providers in the

			Independent Provider Network (IPN) and analyze results.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey

In SFY22-23, HCPF discontinued the use of the CAHPS Clinician & Group Survey (CG-CAHPS) in favor of the Consumer Assessment of Health Providers and Systems Health Plan Survey to gain insight into the member experience for members receiving services through Health First Colorado. CCHA reviewed the results of this new survey and used them to inform quality improvement activities described below.

Techniques Used to Improve Performance

CCHA collaborated with HCPF to provide a sample frame of eligible members in the file structure requested by HSAG. CCHA also notified our practices through PTCs, used our provider newsletter, and updated our website banner to inform members and providers of the CAHPS survey timeline and encourage participation. Of a total sample of 1,594 eligible records, 149 responded resulting in a 9.35% response rate for adults. Of a total sample of 1,960 eligible records, 192 responded resulting in a 9.80% response rate for pediatrics.

Goal for SFY22-23

Goal	Project/Initiative	Targeted Completion Date
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
Start measuring member experience of care with CCHA care coordination	Implement internal member experience questions to care coordination operations	June 30, 2023

Status and Results

CCHA received data from the 2022 CAHPS survey, which can be found below in the following tables. CCHA was not able to compare previous CAHPS data with the survey change but was able to identify strengths and opportunities for improvement compared with global ratings and the Colorado RAE aggregate.

Overall, CCHA found that, though we have been working on appointment availability with PCMPs, there is still room for improvement in getting care quickly. PTCs have been working with practices over the last few years to look at the third next available appointments, which has helped with appointment availability, so in SFY22-23 they focused on cycle times to look for efficiencies in PCMP workflows to reduce wait times for patients. We hope to see improvement in the next round of CAHPS.

Table 4. Adult CAHPS Survey Results SFY22-23 Adult Composite Measures

Composite Measures	CO RAE Aggregate		R6		R7	
Getting Needed Care	★	80.9%	★★★	85.2%	★	89.9%
Getting Care Quickly	★	78.9%	★	78.2%	★	77.3%
How Well Doctors Communicate	★	91.3%	★★	91.2%	★★★	97.7%
Customer Service	★	86.7%	★★★★★	92.4%	★★★★★	93.1%
Individutal Item Measure						
Coordination of Care	★	79.7%	★	72.3%	★	79.2%
Stars	Percentiles					
★★★★★	Excellent: at or above the 90th percentile					
★★★★	Very Good: at or between the 75th and 89th percentiles					
★★★	Good: at or between the 50th and 74th percentiles					
★★	Fair: at or between the 25th and 49th percentiles					
★	Poor: below the 25th percentile					

Table 5. Pediatric CAHPS Survey Results SFY22-23 Pediatric Composite Measures

Composite Measures	CO RAE Aggregate		R6		R7	
Getting Needed Care	★	80.2%	★★★★★	91.2%	★	71.5%
Getting Care Quickly	★★	84.9%	★★	85.2%	★★	84.4%
How Well Doctors Communicate	★★	93.6%	★★★	95.6%	★★	93.7%
Customer Service	★	86.0%	★	85.1%	★	86.4%
Individutal Item Measure						
Coordination of Care	★	82.3%	★★★	89.0%	★	75.6%
Stars	Percentiles					
★★★★★	Excellent: at or above the 90th percentile					
★★★★	Very Good: at or between the 75th and 89th percentiles					
★★★	Good: at or between the 50th and 74th percentiles					
★★	Fair: at or between the 25th and 49th percentiles					
★	Poor: below the 25th percentile					

Opportunities for Improvement

In addition to the wait times addressed above, CCHA also noticed an opportunity to improve scores for care coordination, and although customer service scored high for the adult population, there was room for improvement in the pediatric population. In alignment with the goals we set last year, CCHA implemented two surveys to measure member experience of care with CCHA Care Coordination, which will be discussed in detail in the section below.

Goal for SFY23-24

Goal	Project/Initiative	Targeted Completion Date	Action(s)
CAHPS Survey: Improve member experience of care	Use CAHPS data to identify potential interventions and work with providers to implement and test.	June 30, 2024	Share results with all practices, and work with quality improvement teams to address areas of opportunity.

CCHA Care Coordination Member Experience Surveys

In SFY22-23, CCHA launched two surveys to help better gain insight into our member experience in their interactions with the CCHA Care Coordination Team.

In the fall of SFY22-23 CCHA launched our Member Support Services (MSS) Survey. Following an interaction with an MSS team member, members are prompted to fill out an automated survey that asks the following questions:

1. Were you satisfied with outcome of call? (Yes/No)
2. Was agent helpful and friendly? (Yes/No)
3. Did you understand what was communicated? (Yes/No)
4. How likely are you to reach out to CCHA again in the future? (Scale of 1-5, with 1 not very likely, 5 very likely)

In January, CCHA launched a second survey for members who have a case closed after working with one of CCHA's care coordinators (CCs). This survey is via text message to the member and asks the following:

1. You recently received support from CCHA, we would like to hear how we did. Reply Yes or No to complete the survey.
2. Overall, how satisfied are you with the CCHA services you received?) (5 Very Satisfied. 4 Satisfied. 3 I'm not sure. 2 Dissatisfied. 1 Strongly Dissatisfied)
3. I am better able to manage my health and health care after working with CCHA. (5 Strongly Agree. 4 Agree. 3 I'm not sure. 2 Disagree. 1 Strongly Disagree)
4. My situation is better because of CCHA. (5 Strongly Agree. 4 Agree. 3 I'm not sure. 2 Disagree. 1 Strongly Disagree)

Goal for SFY22-23

Goal	Project/Initiative	Targeted Completion Date
Start measuring member experience of care with CCHA care coordination	Implement internal member experience questions to CC operations.	June 30, 2023

Status and Results

Immediately upon launching these surveys, CCHA began collecting baseline data. Since the MSS survey was launched first, we were able to review the first quarter of data (11/1/22-2/28/23) in March. These results are summarized below:

- Data 11/22-2/23:
  - 3542 surveys initiated
  - 588 surveys completed or partially completed = 17% completion or partial completion rate
- Question #1: 588 responses
  - 320/588 satisfied with outcome = 54%
  - 269/588 not satisfied with outcome = 46%
- Question #2: 546 responses
  - 359/546 said agent was helpful and friendly = 66%
  - 187/546 said agent was not helpful and friendly = 34%
- Question #3: 521 responses
  - 346/521 said they understood what was communicated = 66%

    - 175/521 said they did not understand what was communicated = 34%
- Question #4: 439 responses
    - 244/439 likely or very likely to call CCHA again = 56%
    - 27/439 neutral about calling CCHA again = 6%
    - 168/439 not likely or not very likely to call CCHA again = 38%

As CCHA reviewed this data, we found some puzzling information. For instance, some of our highest rated MSS team members got low scores for helpful and friendly, which led us to ask if the problem was if they could help or were unfriendly. To help us better understand how members may interpret this survey, we presented the questions and the data to our Member Advisory Committee (MAC) in April. The MAC offered some great feedback. MAC feedback includes the following:

- The survey should be only 3-4 questions.
- Having helpful and friendly together in question #2 is really asking two different questions that should not be combined.
- They thought asking about what was helpful is more important than what they could understand (question #3).
- Question #4 is misleading because there is a difference between calling and you had a good experience and calling back because your issue wasn't resolved, and you need more assistance.

CCHA shared these insights internally, and the next steps are outlined in the opportunities for improvement section below.

As of March, we pulled the first data from the CC survey and found only a 1-2% engagement rate. To increase this, we have added scripting for CCs to share with members at the time of case closure that says, "CCHA is going to send you a survey via text message within about a week after I close your case. The survey is just three questions and takes less than a couple minutes to complete. It would mean a lot to us if you would share your feedback, as it is one of our primary ways of understanding your satisfaction and the effectiveness of our services. It is also a way for us to identify improvement opportunities and understand where we are doing well, so we can better manage our programs. If you could take a couple of minutes to respond to the survey, we would really appreciate it. Thanks!" We will continue to track engagement rates with this new scripting and adjust as needed.

Opportunities for Improvement

As a result of the MAC feedback received related to the MSS survey, CCHA reviewed recommendations for simplifying the survey and will launch the following updated survey in early SFY23-24:

1. Did we help you today (Yes/No)
2. Was the person you talked to friendly? (Yes/No)
3. If you need help in the future, how likely are you to reach out to CCHA? (1 for very likely, 2 for somewhat likely, 3 for neutral, 4 for somewhat unlikely, 5 for very unlikely)

CCHA will start collecting data based on the new questions and take action as appropriate.

As for the Care Coordination survey, CCHA is hopeful that by prompting members to answer the survey, we will get more data. CCHA plans to share that data with the MAC, similarly to how we shared the MSS survey data, and make changes to the survey or CC processes and workflows based on MAC recommendations.

Goal for SFY23-24

Goal	Project/Initiative	Targeted Completion Date	Action(s)
Care Coordination (CC) and Member Support Services (MSS) Member Experience Survey	Continue to collect, review, and refine data to inform member satisfaction interventions and identified opportunities for improvement.	June 30, 2024	Analyze data on a regular basis to guide interventions for improvement of satisfaction. Share data with MAC and incorporate their feedback into workflows and processes.

Member Grievances

A member grievance is defined as an expression of dissatisfaction about any matter other than an adverse benefit determination, including but not limited to the quality of care or services provided and aspects of interpersonal relationships such as rudeness of provider or employee or failure to respect the member's rights. CCHA has a process to support member grievances for any matter relating to the contract, including an approach to trend and track information used to improve patient safety and quality, and drive program improvement activities, modification, and development.

Techniques Used to Improve Performance

The quality management and MSS departments continue to work closely to ensure that all the necessary information is collected by MSS staff to process a grievance.

During SFY22-23, CCHA continued to identify trends and report quarterly to HCPF and the Quality Management Committee (QMC). In addition, CCHA shared high-level grievance trends with the MAC and PIAC to receive feedback from members, network providers, and health neighborhood and community partners on how CCHA can improve its program.

Goals for SFY22-23

Goal	Project/Initiative	Targeted Completion Date
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
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, identification of areas of improvement	Quarterly reporting, ongoing
Member Grievances: 100% of clinical grievances will be investigated by clinical staff	Clinical grievance process	Quarterly reporting, ongoing

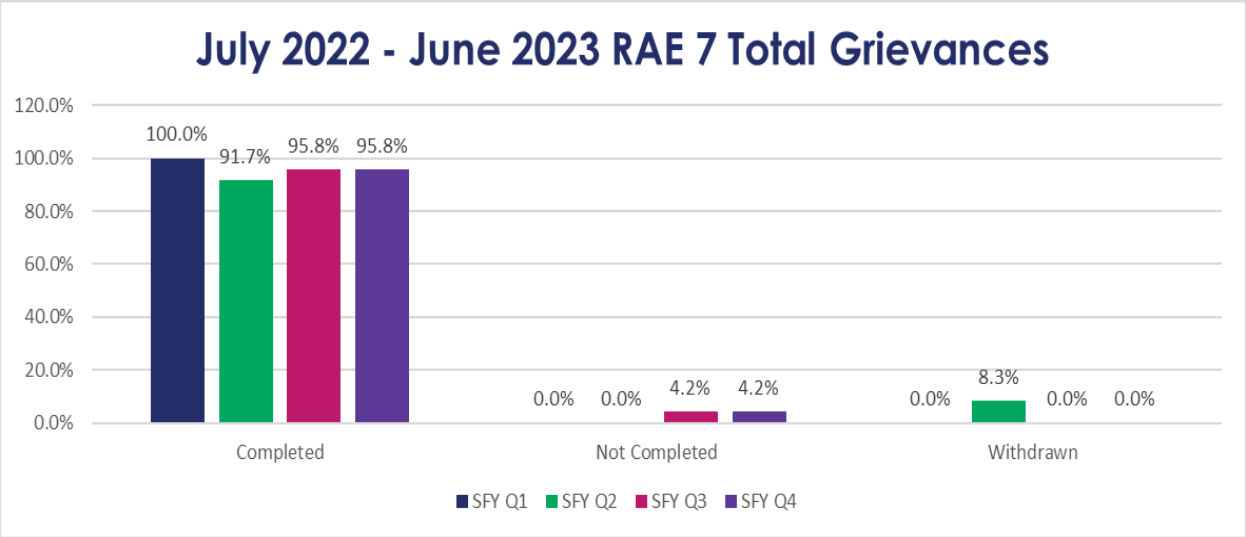
Qualitative and Quantitative Impact

During SFY22-23, 71 grievances were investigated; of those, 63 were standard grievances and eight were extended grievances. Of the standard grievances, 100% were completed within 15 business days, exceeding the goal of 90%. Of the extended grievances, 100% were completed within the additional 14 calendar days, meeting the goal of 100%.

Status and Results

Of the 71 total grievances for SFY22-23, 68 (96%) were closed following investigation; two cases were not completed as we were unable to contact the member and one case was withdrawn per the member's request.

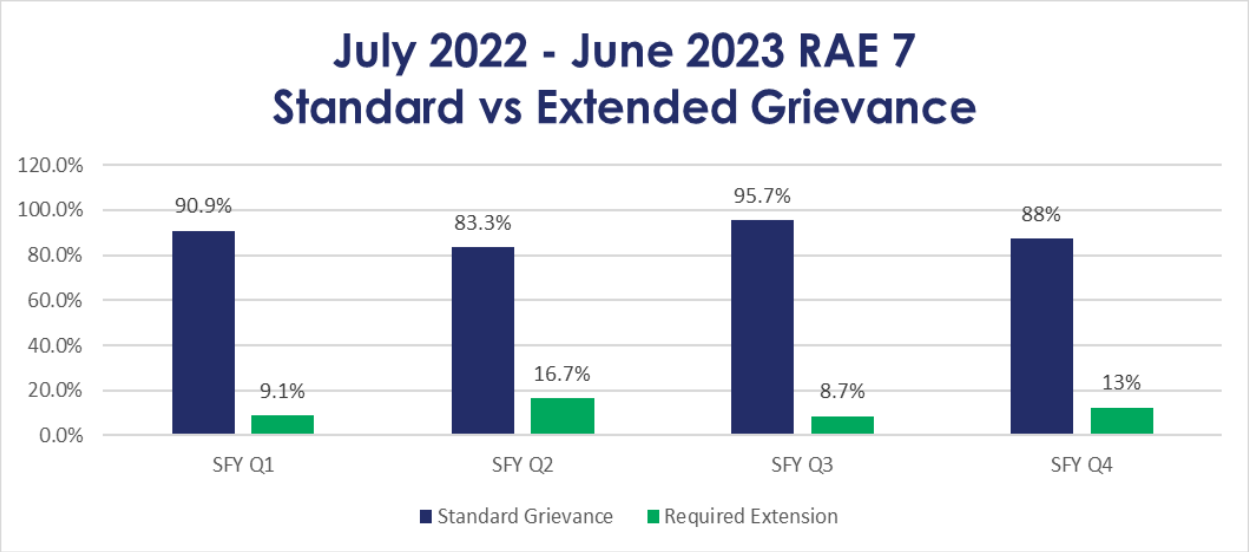
Figure 14. Grievance Resolution Outcomes for SFY22-23



Completion Timeframe

Of the 71 grievances investigated and completed in the four quarters, 63 were completed within the state requirement of 15 business days; eight of the total grievances required the use of the state-allowed extension of 14 additional calendar days, all of which were closed within 14 days.

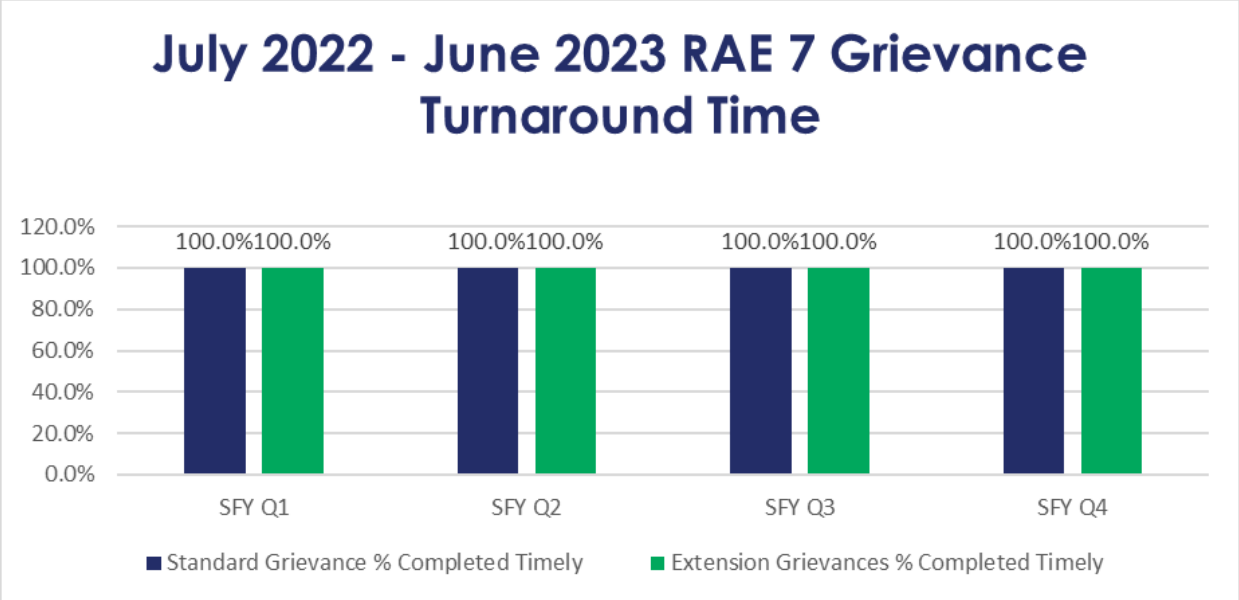
Figure 15. Grievance Completion Timeframe Outcomes for SFY22-23



Turnaround Time

Of the 71 standard grievances closed in the four quarters, 63 were closed within the 15 business day requirements. In addition, eight of the total grievances required the use of the state-allowed extension of 14 additional calendar days, all of which were closed within that timeframe.

Figure 16. Grievance Turnaround Time Outcomes for SFY22-23



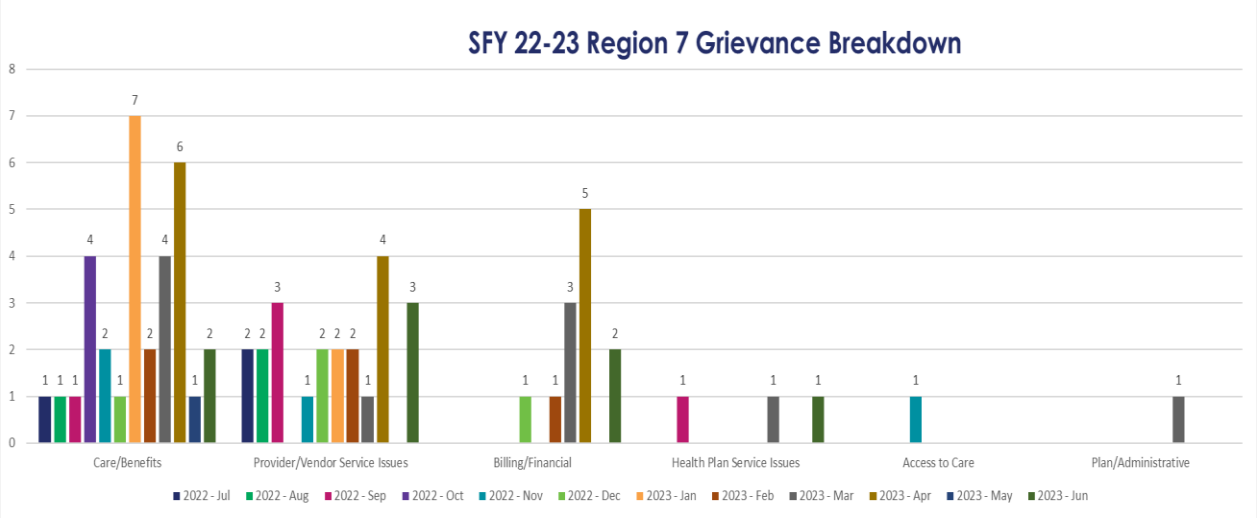
Category Breakdown

Reviewing the grievances on a year-to-date basis, the grievance category with the highest volume for the four quarters concerned Care/Benefits (32 grievances). Within this category, the issues involved:

- Treatment dissatisfaction (26)
- Delay in treatment (2)
- Couldn't obtain prescription (2)
- Late or misdiagnosis (1)

- Discrimination - insurance status (1)

Figure 17. Grievances by Category



Opportunities for Improvement

In SFY22-23, the Grievance and Appeals (G&A) department completed several overviews for internal partnering units to ensure grievances and appeals were identified and routed appropriately to G&A. This included our call center partners and case management teams.

We continue to have all administrative grievances reviewed and responded to by a G&A analyst. In addition, all clinical grievances are reviewed and responded to by a G&A registered nurse. CCHA will continue monitoring its grievance internal documentation system to ensure that all grievances are discovered and processed on time.

Furthermore, CCHA will continue to analyze the grievance types and providers to identify trends. This data will be shared with HCPF, QMC, MAC, and PIAC to continue obtaining feedback from members, network providers, and health neighborhood partners on how CCHA can improve processes and programs.

Goals for SFY23-24

Goal	Project/Initiative	Targeted Completion Date	Action(s)
Member Grievances: 90% of member grievances will be completed within 15 business 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 CCHA's Quality Management Committee (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, 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	Maintain the clinical grievance process.	Quarterly reporting, ongoing	Clinical grievance process will be transferred to clinical staff, reporting to HCPF and QMC quarterly.

Section 6: Mechanisms to Detect Overutilization and Underutilization of Services

Client Over-Utilization Program (COUP)

The COUP program is a statewide utilization program that strives to prevent unnecessary or inappropriate use of services. Through this program, the utilization profile of members is analyzed, allowing for the identification of members who are over-utilizing the allowable medical benefits offered by Health First Colorado. When there is documented evidence of over-utilization of allowable medical benefits, the program aims to assist members in receiving appropriate care coordination services and selecting an appropriate PCMP.

Techniques Used to Improve Performance

CCHA received a list from HCPF detailing members who over-utilized pharmacy and emergency department services on a quarterly basis. Health First Colorado members may be placed in COUP whose utilization of Medicaid benefits without medical necessity has exceeded any of the following parameters for three months.

- Use six or more high-risk prescriptions, filled prescriptions from three or more different pharmacies, *and* filled prescriptions from three or more different prescribers;
- Four or more visits to the emergency department (ED);
- Combination of both, i.e., six or more high-risk prescriptions, filled prescriptions from three or more different pharmacies, filled prescriptions from three or more different prescribers *and* four or more visits to the ED; or,
- A RAE or PCMP referral or care analysis indicating overutilization.

This year, CCHA conducted staff training to provide a refresher on the overall COUP program and our internal policy and remind everyone of the lock-in option. Staff also check COUP status on every new referral and take necessary steps with the member.

Goals for SFY22-23

Goal	Project/Initiative	Targeted Completion Date
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
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

Status and Results

CCHA outreached 2,679 COUP Members in Region 7 through automated outbound calls. 874 of these members were successfully contacted, which is a 33% success rate.

Opportunities for Improvement

CCHA continues to assess its strategy around members who appear on the COUP list and how to engage them best. For example, CCHA continued to use automated outbound calls this year after learning that we could reach more members this way. CCHA has found that these automated outbound calls have resulted in several inbound calls to our call center from interested members. Additionally, CCHA continues to review and utilize the MAC to get feedback on the script used for automated outbound calls to COUP members as language is updated and will continue to do so going forward.

Regarding lock-in functionality, CCHA continues to work with providers and HCPF to better understand system functionality, decision-making authority, and outcomes for member lock-in. CCHA will continue to monitor members as they are locked in to ensure member and provider satisfaction and member access to care. CCHA collaborates with other RAEs to support lock-in members transitioning between RAEs.

Goals for SFY23-24

Goal	Project/Initiative	Targeted Completion Date	Action(s)
COUP: Identify members who may benefit from lock-in and engage the assigned PCMP and member to initiate lock-in, as appropriate	Monthly outreach to all COUP members by Member Support Services.	June 30, 2024	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. Work with PCMPs to identify members that may be appropriate for lock-in.

Goal	Project/Initiative	Targeted Completion Date	Action(s)
			If needed, collaborate with other RAEs when locked-in members transition between RAEs.

Section 7: Quality and Appropriateness of Care Furnished to Members with Special Health Care Needs

CCHA utilizes a whole-person care approach to provide timely and comprehensive care coordination support to members with the highest needs. Our integrated physical and behavioral health team coordinates care to assess, understand, and support members' physical, behavioral, and social needs. In addition, CCHA convenes and collaborates with the member's care team and health neighborhood, including medical, developmental, behavioral, financial, educational, spiritual, and cultural communities, as well as the member's family or informal support system. This integrated approach is crucial to creating effective care plans, improving members' quality of care and outcomes while proactively managing costs, encouraging and respecting member choice, increasing access to services, and ensuring member safety, independence, and responsibility.

Complex Members
In SFY21-22, HCPF approved the following complex member definition and in SFY22-23, CCHA continued work to address the needs of this complex population.

CCHA identifies the following members as complex high-need:

- Members with diabetes with a comorbid behavioral health (BH) diagnosis and high physical health (PH) needs
- Members with asthma with a comorbid BH diagnosis and high PH needs
- Members who are pregnant
- Members under the age of two who were born prematurely
- Members who were incarcerated within the last year
- Members involved in foster care
- Pediatric members with greater than $25k spend in a year
- Adults with greater than $25k spend in a year who also have one or more of the following conditions:
    - Neurological disorders (stroke, traumatic brain injury, spinal cord injury, dementia/Alzheimer's disease)
    - Congestive heart failure (CHF)
    - Homelessness history
    - Intellectual or developmental disability (IDD) or serious mental illness (SMI)
- High-need member referrals from PCMPs, community partners, and HCPF requiring extensive care coordination time and resources.

Additional complex members may be referred to CCHA by PCMPs or community organizations or be self-referred. Once members are engaged and assessed, they will be referred to the program that best fits their needs.

Techniques Used to Improve Performance

CCHA's care coordination teams include PH and BH care coordinators who have experience providing culturally competent care to this population and complete ongoing education to stay current on best practices. Specifically, care coordinators who support CCHA's complex high-need members have expertise with complicated and multi-system-involved individuals and their families. CCHA care coordinators use shared decision-making to create a care plan with members with the following considerations:

- Work to complete a thorough health needs assessment with members to identify member needs, preferences, and goals, including SDOH needs.
- Collaborate with the member's care team to create a shared care plan. It includes PCMPs, specialists, BH providers, SEPs/CCBs, the DHS, durable medical equipment (DME) companies, probation, parole, district attorneys, community advocates, and other community providers.
- Assess members for SDOH needs through member intake surveys and health needs assessments.

Additionally, CCHA works closely with ACN partners to ensure the continuity of care coordination services, particularly among complex high-need members and priority populations identified by CCHA and HCPF. Standing meetings are held with each ACN provider monthly to discuss contracted responsibilities, performance, member issues/care coordination support needs, reporting, etc.

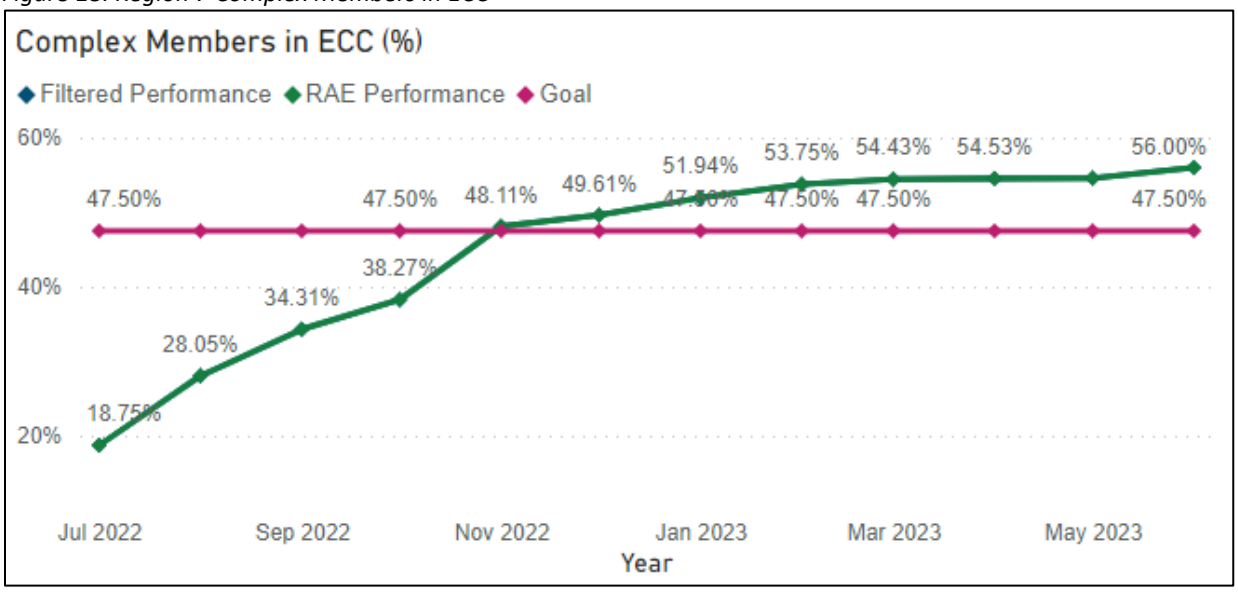
Goal for SFY22-23

Goal	Project/Initiative	Targeted Completion Date
Increase complex members engaged in extended care coordination	Engage ACN providers, SEPs, and CCBs to align efforts on Performance Pool metrics. Leverage community partnerships to help engage members.	June 30, 2023
Improve SDOH data capture to identify and link members to resources based on their needs.	Redesign all health needs assessments and standardize the collection of SDOH. Engage and incentivize providers to consistently utilize FindHelp's platform for SDOH resources.	June 30, 2023

Status and Results

In SF22-23, CCHA met their Performance Pool goal of 45.50% with a final performance in June of 56%.

Figure 18. Region 7 Complex Members in ECC



Opportunities for Improvement

CCHA's strategies remain relevant and effective, as evidenced by the above-mentioned successes. However, our strategy continues developing to meet our member populations' changing needs, address barriers encountered, and align with state-driven priorities. In SFY23-24, CCHA plans to incorporate the following changes in its care coordination approach:

- CCHA will work to develop a system to measure and analyze member satisfaction through CCHA's post-call and care coordination surveys.
- CCHA will continue to operationalize monthly outreach campaigns for the PHE Continuous Enrollment Unwind initiative to provide members with education and support in updating their addresses and completing the re-enrollment process.
- CCHA will work to identify opportunities to enhance culturally competent communications and resources for members whose preferred language is Spanish to improve member engagement and reduce disparities.
- CCHA is working to develop a dashboard to measure and analyze SDOH needs and gaps in resources.

Goals for SFY23-24

Goal	Project/Initiative	Targeted Completion Date	Action(s)
Continue to engage complex members in ECC	90% of members identified as complex high-need will be outreached during the reporting period. CCHA will work to engage complex high-need members in extended care coordination, surpassing the goal specified by	June 30, 2024	CCHA will work to identify opportunities to enhance culturally competent communications and resources for members whose preferred language is Spanish to improve member engagement and reduce disparities.

Goal	Project/Initiative	Targeted Completion Date	Action(s)
	the Department, as defined in the Performance Pool specification document. 90% of members engaged in care coordination will be assessed for SDOH needs.		CCHA is working to develop a dashboard to measure and analyze SDOH needs and gaps in resources.

Diversity, Equity, and Inclusion (DEI)

CCHA is responsible for completing a regional Health Equity plan that aligns with the Department's Health Equity Plan. This plan aims to address health equity and decrease identified disparities for members from underserved and marginalized communities. For the Health Equity Plan, the Department identified the following priority focus areas:

- COVID-19 vaccination rates
- Maternity and perinatal health
- Behavioral health
- Prevention

Status and Results

While the DEI plan was originally scheduled to be due in July 2023, data was provided by the Department later than initially anticipated and, therefore, the DEI plan submission was pushed back to December 31, 2023. To initiate our DEI plan, CCHA began analyzing data received from HCPF in May and identifying populations with health disparities. As we continue to develop this plan, we will include any identified disparate populations in our annual quality plan and report going forward into SFY23-24.

Goal for SFY22-23

Goal	Project/Initiative	Targeted Completion Date
Close healthcare 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

Goal for SFY23-24

Goal	Project/Initiative	Targeted Completion Date	Action(s)
Develop DEI Plan	Use data provided by HCPF to identify populations with health disparities and create plan to address these disparities.	December 31, 2023	Utilize both HCPF and internal data to identify populations with disparities. Identify areas of opportunity to partner with providers and community entities to address these disparities. Hold listening sessions with members and advocates to identify areas of cultural responsiveness and where there are successes and opportunities.

Section 8: Quality of Care Concerns Monitoring

Quality of Care (QOC) concerns include all potential or actual occurrences that may impact the care outcome. Issues can fall into the following categories: treatment/diagnosis issues such as incorrect treatment or poor coordination of care for high-risk members, patient safety incidents including preventable injury or suicide attempt requiring medical attention, professional conduct or competence, service utilization issues such as premature discharge, medication issues, or delay of care. These concerns can be raised by HCPF, providers, or CCHA staff. CCHA has created a QOC process that encourages timely and accurate submissions from our provider network and internal CCHA staff.

Techniques Used to Improve Performance

CCHA has developed a robust QOC process that relies on diligent internal staff and external stakeholders to identify and report quality issues. In SFY22-23, a majority of QOCs originated from internal CCHA staff. In addition to the internal team, CCHA has continued to work with external stakeholders to create an environment where quality issues become training opportunities to encourage external reporting.

Once referred, CCHA does a comprehensive review of the QOC issue and completes a QOC summary that is routed to the medical director(s) (MDs) for consideration. The medical director(s) reviews all QOC referrals and assigns a severity rating based on the findings. Based on the severity level and medical record review, the Quality Management (QM) department and medical director determine appropriate follow-up steps.

To improve the identification and reporting of quality issues, the QM department focused on CCHA staff training during SFY22-23. In addition to training internal staff, information has been disseminated through the CCHA website and BH Provider Manual. Additionally, there have been quality meetings with CMHCs and other community providers regarding provider responsibilities for reporting QOC occurrences.

In Region 7, CCHA reports quarterly QOC data and trends at one high volume CMHC. CCHA meets with other providers when a trend is identified. The purpose of these ad hoc meetings is to review issues contributing to a high volume of QOCs and to identify systemic opportunities for improvement.

CCHA is working to improve the capture of QOCs through annual staff training, identification of QOCs in Integrated Clinical Rounds, and QOC reviews at quarterly QMC meetings, which are attended by community providers in both regions. CCHA is continuously investigating, analyzing, and tracking QOC occurrences. The QM department performs trending to monitor performance over time (quarter-over-quarter and year-to-date). A significant trend is defined as three or more commonalities in a quarter or six or more in a year. This data is the basis for quarterly trending reports that are reviewed in the QMC meetings. Opportunities for improvement are identified to improve the quality of care for members. Quarterly trending reports are submitted to HCPF for review. In addition, CCHA collaborates with HCPF by reporting serious incidents that may have had a negative impact on specific members or pose a current or future risk to all members.

Qualitative and Quantitative Impact

In SFY22-23, CCHA completed the following activities to improve the QOC identification and reporting processes for internal staff and external providers and to strengthen collaboration with community partners.

- CCHA continued to refine the QOC and Critical Incident policies to improve consistency across the organization and provider network.
- The Quality department conducted annual QOC-Grievance Training in January 2023 for CCHA staff to increase understanding of QOC issues and processes and to increase competency in identifying/reporting QOCs.
- All submitted QOCs were investigated, analyzed, and trended. Detailed quarterly reports were created to analyze trends within the provider network and to identify areas needing improvement.
    - In Region 7, there were 28 QOCs processed during SFY22-23. The highest number of QOCs was for delay of care (3), poor discharge planning (3) and possible abuse (3). There were no annual trends by type or volume.
- QOC reports were presented at the quarterly QMC for review and identification of opportunities for improvement. The QMC is charged with oversight of the QOC process. The medical director(s) outreached facility medical directors, as needed, to discuss clinical care issues affecting CCHA members.

Additional activities undertaken during SFY22-23 included:

- The CCHA Quality staff and MDs met with one residential treatment center (RTC) facility on 10/26/2023 to review QOC cases, corrective action plans (CAP), and trends. There was review of the center's policies related to contraband, supervision, and elopement prevention and about opportunities for continued collaboration. Of note, there has been a substantial decrease in QOC occurrences at the facility since that meeting.

- CCHA has continued to participate in critical incident reviews with the CMHCs to identify any potential QOC issues. There has been increased reporting by one CMHC over the past year. This can be attributed, in part, to an increased understanding about the purpose of the QOC review process. This has strengthened collaboration between CCHA and the CMHC.
- In Region 7, CCHA convened meetings with two high volume inpatient providers during SFY22-23 to review QOC trends.
- The CCHA Quality staff and MDs met with one inpatient facility on 9/22/2022 to review a QOC trend by volume (three cases in a quarter). CCHA met with this facility again on 5/02/2023 to review trending data for the rolling 12-month period, as seven cases had been processed.
- CCHA met with a second inpatient facility on 5/02/2023 to review trending data for the rolling 12-month period (seven cases). This review included three level "3" cases with corrective action plans.
- In addition, CCHA met with a CMHC on 9/15/2022 to review quarterly QOC data. Meetings will continue as cases are identified and processed to identify opportunities for system improvements.
- The QOC Triggers List was reviewed in QMC meetings for both regions to afford providers an opportunity for input. These clinical triggers are prompts for providers to submit QOC concerns.
- Meetings with all providers will be arranged whenever a trend is identified or when a serious case warrants discussion/corrective action.

The above initiatives have resulted in a robust, collaborative review process between the Quality department, medical directors, internal CCHA staff, and external providers.

Goals for SFY22-23

Goal	Project/Initiative	Targeted Completion Date
QOC: Participate in Quality of Care Grievance (QOCG) external audit and implement improvement recommendations	Ensure compliance with the Medicaid contract around the standards for Quality of Care concerns.	June 30, 2023
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
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

Status and Results

QOCG: Participate in QOCG external audit and implement improvement recommendations
CCHA successfully participated in the SFY21-22 QOCG Audit. There was not an audit during SFY22-23. CCHA has worked to implement specific recommendations from the SFY21-22 QOCG Audit including tracking of member demographic data, updating the QOC policy to include timeframes for QOC completion, role of care coordinators for outreaching members, and a definition of QOCs.

Additionally, CCHA is now providing the Credentialing Department will annual information about substantiated QOCs which may be useful in the re-credentialing process.

CCHA attended the QOCG Learning Collaborative on 1/17/2023 and presented a QOC Strengths, Weaknesses, Opportunities, and Threats (SWOT) Analysis, overview of the QMC, and discussion about corrective action plans. CCHA has also attended all HCPF meetings (Integrated Quality Improvement Committee (IQUIC) and ad hoc) concerning the new QOCG process. Our staff have submitted questions and concerns and have provided feedback about the new HCPF QOC Notification Form.

QOC: Identify best practices to minimize the risk of QOC occurrences
Quarterly QMC meetings serve as a primary avenue for identifying best practices. QMC attendees have offered best practice examples and suggestions in these meetings. One example is how providers have been utilizing hybrid service delivery since the pandemic. Region 6 and Region 7 medical directors attend their respective QMC meetings to offer their clinical expertise in identifying optimal clinical care.

In Region 7, the CMHC presented a case at the May 2023 QMC describing how same day access to their crisis team helped avert a potential school shooting. The member was able to get the immediate support needed. Same day triage, crisis assessment and referral is a best practice.

In Region 7, CCHA meets with the CMHC to review QOC occurrences and critical incidents as a trend is identified. These discussions are designed to focus on best practices and system improvements.

A focus on sharing best practices will continue during SFY23-24.

The Quality department conducted annual QOC-Grievance Training in January 2023 for CCHA staff to increase understanding of QOC issues and processes and to increase competency in identifying/reporting occurrences. Overall staff attendance included 130 care coordinators, peer support specialists, utilization management, and member support services staff that serve in both Region 6 and Region 7. This represents 92% of CCHA staff and shows a major increase from the 63 staff who attended last year. Attendance surpassed the target of 80% of member- facing staff to receive QOC training.

QOC: Enhance provider education regarding QOC and critical incident identification and submission
CCHA has provided information in the BH Provider Manual and on the CCHA website about how providers can submit QOCs. This process is discussed at all quarterly QMC meetings and ad hoc meetings with community providers. CCHA has updated an article for the BH Provider Bulletin about how providers can submit QOCs. Providers can access these articles at: CCHAcares.com/newsletters. CCHA will continue to identify channels through which provider education can be offered.

Opportunities for Improvement
CCHA will continue collaboration with network providers to identify best practices to minimize quality of care concerns. This is a standing agenda item at the quarterly QMC meetings. Best practices will also be identified through focused QOC reviews and trend meetings with CMHCs and community providers.

CCHA will emphasize the capture of QOCs through internal staff training, identifying QOCs in Integrated Clinical Rounds, and more focused provider education about identifying and submitting potential QOCs and critical incidents to CCHA.

The clinical quality program administrator will continue to partner with the provider network to review cases with potential quality and safety concerns. This will also be used as a forum for discussing QOC trends and systemic opportunities for improvement.

CCHA will meet with network providers to share QOC trends as they are identified. The purpose and focus of meetings will be to collaborate on solutions to any identified quality of care issues that appear to represent a clinical or service delivery pattern.

Goals for SFY23-24

Goal	Project/Initiative	Targeted Completion Date	Action(s)
QOCG: Participate in QOCG external audit and implement improvement recommendations	Ensure compliance with the Medicaid contract around standards for Quality of Care concerns.	June 30, 2024	Review and update current policies and procedures related to audit standards to ensure compliance, and identify areas for improvement.
Implement new reporting processes/standards for QOCs as defined by the Medicaid contract	Ensure compliance with reporting requirements and timeframes for QOC submission.	June 30, 2024	Submit QOC Notification forms and supporting documentation as required by the Medicaid contract.
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: 90% of member--facing staff will receive QOC training.
QOC: Enhance provider education regarding QOCG identification and submission	Utilize multiple channels for provider education, including provider bulletin and provider meetings.	June 30, 2024	Submit information for provider bulletin at least semi-annually and leverage other avenues to educate providers, such as the BH provider education series.

Section 9: External Quality Review-Driven Projects

CCHA had its periodic evaluation to determine compliance with federal Medicaid managed care regulations and managed care contract requirements via an external quality review site visit in SFY22-23, conducted by Health Services Advisory Group (HSAG). HSAG reviewed activities on four standards:

Coverage and Authorization of Services, Adequate Capacity and Availability of Services, Grievances and Appeal Systems, and Enrollment and Disenrollment.

Goal for SFY22-23

Goal	Project/Initiative	Targeted Completion Date
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

Status and Results

Table 6 below represents CCHA's audit score for each standard.

Table 6. SFY22-23 External Quality Review Results

Standard		# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
I.	Coverage and Authorization of Services	32	32	30	2	0	0	94%
II.	Adequate Capacity and Availability of Services	14	14	14	0	0	0	100%
VI.	Grievance and Appeal Systems	35	35	26	9	0	0	74%
XII.	Enrollment and Disenrollment	5	5	5	0	0	0	100%
	Totals	**86**	**86**	**75**	**11**	**0**	**0**	**87%**

Standard I – Coverage and Authorization of Services

Summary of Strengths

- CCHA's documentation expectation for utilization review of co-occurring and non-covered diagnosis had been expanded to include additional notes from internal staff and providers to show evidence of member-specific considerations.
- CCHA followed up with any passing thresholds with additional training for specific staff members.
- Staff members were able to speak to increased and decreased utilization trends and presented forecasting of upcoming utilization due to changes in funds and the end of the public health emergency.
- Member notices of adverse benefit determination demonstrated improvement in member-friendly language.

Opportunities for Improvement/Required Actions

- HSAG recommends that CCHA formalize documentation of claim nuances and instances where emergency services claims are allowed to pass through. CCHA should use this documentation to guide claims adjudication processes going forward.

Standard II – Adequate Capacity and Availability of Services

Summary of Strengths

- CCHA monitors expected membership increases and decreases with the anticipated end of the public health emergency, and discussed expected utilization increases due to expanding benefits with plans to support this increased utilization.
- CCHA increased reimbursement rates for commonly billed behavioral codes in partnership with Diversus Health and implemented an access tracking mechanism for open beds.
- The network management team, communication team, community liaisons, coaching, member support services, and quality staff members all collaborated to support the provider network, recruit and execute contracts, and support members in accessing services. Members were informed of their right to seek a second opinion, at no cost to the member.
- CCHA has multiple trainings and shared online resources on their website related to cultural competency.

Opportunities for Improvement/Required Actions

- CCHA should continue to work with HCPF to identify ways to improve time and distance compliance standards for SUD.
- CCHA needs to ensure that they have annual plans to review network adequacy validation with leadership for oversight, monitoring and feedback.
- CCHA should add minimum hours of 8 am to 5 pm for behavioral providers in their provider agreements and provider manuals to clearly communicate that expectation with providers.
- HSAG recommends increasing efforts to monitor the behavioral health network adherence to timely appointment standards.

Standard VI – Grievance and Appeal Systems

Summary of Strengths

- CCHA reports using software to help review, document, and track grievances and appeals, in addition to team-based reviews that include directors, managers, nurses, and other staff.
- CCHA has an extensive staff training and vetting process to ensure that each reviewer has relevant credentials to review special clinical cases.
- CCHA adheres to timeframe standards and has a process to review late appeal requests for emergent circumstances.

Opportunities for Improvement/Required Actions

- CCHA should expand the grievances and appeals section in the Physical Health Provider Manual to match the information provided in the Behavioral Health Provider Manual.
- HSAG recommends that CCHA use extensions in instances where more information is needed to give the member more time to respond.

Standard XII – Enrollment and Disenrollment

Summary of Strengths

- CCHA includes live outreach telephone calls for certain at-risk groups.

- CCHA offers Lyft rides for members with immediate and unique transportation needs.
- CCHA staff work directly with Department of Human Services staff and county staff to step in when additional support is needed.
- CCHA offers onboarding training and ongoing support and training related to EPSDT.
- CCHA provided program descriptions that outline risk stratification, referral processes, and other details about care plans and community resources. These descriptions also include monitored program outcomes.

Opportunities for Improvement/Required Actions

- HSAG identified no opportunities for improvement or recommendations for this standard.

Table 7 below represents CCHA's audit score for record reviews.

Table 7. SFY22-23 Summary of Scores for Record Reviews

Record Reviews	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)
Denials	100	74	70	4	26	95%
Grievances	60	55	55	0	5	100%
Appeals	60	58	49	9	2	84%

Goal for SFY23-24

Goal	Project/Initiative	Targeted Completion Date	Action(s)
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: Member Information Requirements, Provider Selection and Program Integrity, Subcontractual Relationships and Delegation, and Quality Assessment and Performance Improvement.	June 30, 2024	Review contract and federal managed care requirements with applicable teams. Review operational 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.

Section 10: Internal Advisory Committees and Learning Collaborative Strategies and Projects

CCHA values feedback from Health First Colorado members, health neighborhood and community partners, and the provider network. CCHA strives to convene a diverse network of Health First Colorado members, providers, community organizations, and other service providers to solicit feedback to improve health, access, cost, and satisfaction and utilizes the regional PIAC and MAC to do so.

CCHA aligned reporting structures across the MAC and the regional PIAC to ensure consistency and communication between these committees. At least one representative from the MAC participates in the regional PIAC to share information across committees, and the PIAC coordinator reports to CCHA's leadership to ensure the feedback voiced is communicated to leadership.

Program Improvement Advisory Committee (PIAC)

The regional PIAC is held quarterly and is meant to engage stakeholders and provide guidance on improving the health, access, cost, and satisfaction of members and providers in Region 7. At a minimum, the PIAC includes members, members' families or caregivers, PCMPs, BH providers, health neighborhood provider types, and other individuals representing advocacy and community organizations, local public health, and child welfare interests.

If a member is interested in joining the PIAC, they can participate as a voting or non-voting member. The purpose of identifying voting members is to identify engaged stakeholders who will consistently attend PIAC meetings for one year and participate in approving decisions funneled through the committee. All individuals who have applied to be voting members over the last several years were accepted. Non-voting members can still participate in PIAC and not commit to consistent attendance. They will not play a role in voting on decisions made through PIAC but will still be able to voice their opinions and feedback on any topics the committee reviews. All community members are welcome to attend the meetings regularly or ad hoc.

Techniques Used to Improve Performance

CCHA continues to use a multi-prong approach to recruit members to the regional PIAC. This approach is essential to CCHA as it aligns with the belief that some members are better engaged through connection with community stakeholders. The PIAC is crucial to this process as it connects members to the RAE and educates and engages relevant community stakeholders. The PIAC coordinator is now the same person as the coordinator of the MAC to align recruitment efforts. CCHA is utilizing the MAC to educate members on CCHA departments and responsibilities through 2023, hoping that one or two additional members can be recruited for the PIAC in 2024. Once a member expresses interest, a simple onboarding will be completed. CCHA stall will be outreaching each member after PIAC to follow up on how the meeting went. Currently, 1-2 members in both regions are voting members.

As noted in section 4, the PIAC decides which projects are funded through the Community Incentive Program funds. Through this work, our members and community partners learn about the KPIs and become engaged in the work to improve our performance.

Qualitative and Quantitative Impact

Successes:

- March 2023: DentaQuest presented on their role and the ambassador program in which CCHA held breakout sessions and asked who or what type of organizations could benefit from the

training. CCHA collected specific organizations or types of organizations and provided that to DentaQuest.

- June 2023: CCHA held their first in-person networking event in place of the virtual PIAC. Community partners and providers joined us, and CCHA's PTCs and CCs joined to network and learn about resources. We received great feedback on how everyone enjoyed it.
- Starting in the fall of 2023, the PIAC will be focusing on our Diversity, Equity and Inclusion plan. We plan to educate the group on the expectation around DEI set by HCPF, bring in expert speakers, and use this group to get input on our plan and where there are unmet needs.
- We also began making our PIAC follow-up emails more robust to include resources, follow up items to conversations, and more.

Challenges:

- CCHA has identified challenges in aligning efforts between the state Member Experience Advisory Council (MEAC) and regional PIAC.
- CCHA convenes a large and diverse group through PIAC, and CCHA strives to ensure content presented and discussed is relevant and applicable to all participants.
- Meetings are often packed with information and include breakout sessions so not all members receive all of the information. CCHA is working to close that gap by providing follow up after meetings.

Goals for SFY22-23

Goal	Project/Initiative	Targeted Completion Date
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 the voting committee.	December 31, 2022
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

Status and Results

The Region 7 PIAC continued to meet virtually three times in SFY22-23 and was well attended each quarter. In response to feedback received last year that some members are uncomfortable with the virtual platform, CCHA hosted an in-person event that was well attended and plans to hold at least one similar event annually.

One of the main functions of the PIAC is to help determine where CCHA spends KPI dollars intended for community partners. A summary of CIP projects for the 2023 awardees is listed in Table 8 below. In 2023, CCHA awarded $1.71 million to 19 innovative community entities in Region 7 via the CCHA CIP.

Table 8. Summary of CIP projects for 2023

Entity	Project Highlights
Aspen Mine Center	$59,442 to increase Health First Colorado member engagement to ensure they have uninterrupted care during the PHE unwind process.
Boys and Girls Club of the High Rockies	$43,362 to prevent youth suicide by providing mental health services and access to care for both youth members and their families.
Casa Inmigrante – Julissa Soto	$100,000 to focus on decreasing barriers to vaccine access and physical and behavioral health access among Latinos/Latinos, Monolingual Spanish Speakers and mixed-status families. Additionally, they will focus on updating member information in preparation for the end of the PHE.
Catholic Charities of Central Colorado	$20,000 to enhance the capabilities of the Penrose-St. Francis Faith Community Nurse Programming at the Marian House and Helen Hunt Campuses.
Conifer Counseling and Therapy Services	$50,000 to support the Park County Mental Health Alliance in outreach, education, evaluation and data collection.
Eye Love Care	$193,210 to expand their free basic eyewear program to all Health First Colorado members over the age of 21 and begin creating mobile units to service communities with needs.
Forge Evolution	$43,362 to assess and meet the behavioral health needs of at-risk youth and help them reintegrate into the community with goals, plans and a firm foundation for success.
Inside Out Youth Services	$42,362 to plan and design a new Whole Health Hub for lesbian, gay, bisexual, transgender, queer, intersex, asexual and two-spirit (LGBTQIA2+) youth.
Peak Family Transport	$68,000 to offer services to those with more complex disabilities and educate members in the PHE unwind efforts and changes.
Peak Vista Community Health Centers	$127,070 to achieve overall engagement in the PHE unwind and ensure members' care is not interrupted.
Pikes Peak Elder Justice Center	$42,362 to expand new engagement strategies that are inclusive, creative, sustainable and directly address identified member vulnerabilities (low-socioeconomic status, lack of regular access to health services and psychosocial isolation).
Rocky Mountain Rural Health	$21,732 to assist Health First Colorado members in Park County navigate the changes and updates resulting from the PHE unwind.
Serenity Recovery Connection	$130,000 to expand peer recovery support services to the Emergency Department and Neonatal Intensive Care Unit at Memorial Hospital North.
The Independence Center	$74,000 to expand staff to support high-risk members (elderly, individuals with disabilities with high support needs, individuals with no access to technology or little/no technology skills, and individuals at increased risk of homelessness) in gaining and maintaining access to Health First Colorado.

The Patterson Center for Resiliency	$74,900 to expand their Intensive Trauma Treatment Program to reduce hospitalizations, improve chronic mental health outcomes and provide the appropriate level of care for trauma.
The Resource Exchange (TRE)	$70,750 to enhance work with their Cross-systems Care Integration model for people with Intellectual and Developmental Disabilities and the disabled community.
Wee Cycle	$163,000 to expand their mobile distribution of diapers, wipes, baby food and formula to Health First Colorado members in El Paso County.
Women Partnering	$40,000 to increase reach, visibility and credibility to respond to unmet needs of vulnerable women and children in the Colorado Springs area.
YMCA of the Pikes Peak Region	$300,000 to expand their outreach and program efforts throughout all of CCHA's eight counties using an eHealth-based model.

Goal for SFY23-24

Goal	Project/Initiative	Targeted Completion Date	Action(s)
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 the voting committee.	December 31, 2023	Align CIP applications to compliment CCHA and HCPF priorities.
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 members receive culturally accessible and competent care	Provide data to the committee specific to DEI efforts.	Quarterly, ongoing	

Member Advisory Committee (MAC)

The MAC is one of the mechanisms CCHA uses to involve members in their care and receive feedback about the healthcare system. CCHA aims to recruit a diverse group of Health First Colorado members who bring personal member experiences and are not actively engaged with CCHA in another forum or stakeholder group. As stated above, the MAC and PIAC use similar engagement strategies to identify members for each committee, including referrals from the HCPF Member Experience Advisory Council, health neighborhood and community partners, and CCHA Care Coordination and Member Support Services teams. Per the MAC members' request, we now meet every other month, rather than quarterly. CCHA facilitates a meeting and then sends an engagement email on the off months with

education, opportunities, etc. CCHA has also switched to cross-regional meetings to ensure the same information is being shared, which the MAC members have approved of and seem to enjoy.

Techniques Used to Improve Performance

CCHA works to engage a variety of members in the MAC. The MAC utilizes various activities to solicit member input in the large group and small group setting to make sure members' voices are heard. This year, CCHA received feedback from the MAC on several important topics, outlined below.

Goal for SFY22-23

Goal	Project/Initiative	Targeted Completion Date
MAC: Continue to recruit committee members that come from diverse backgrounds	Implement outreach for committee members.	Quarterly
MAC: Continue to utilize feedback from the MAC to enhance the services provided	Use direct member input to improve operations.	June 30, 2023

Status and Results

CCHA had 12 CCHA MAC attendees this year.

- CCHA gathered member feedback on several topics:
  - Review of CCHA, who we are and what services we provide, and introduction to the Member facing teams.
  - Member rights
  - Member satisfaction surveys and results.
- CCHA is continuing to provide a combined virtual webinar session for both regions to allow for more diverse discussion and insights.

Opportunities for Improvement

- In-person MAC meetings have not been brought back as a participation option, given that many MAC members have expressed hesitation with returning to in-person meetings. we only hold virtual meetings with a call-in option. CCHA may follow up with a survey on specific topics, if needed. Each MAC meeting includes a feedback survey within the week to collect insight, barriers, and more. CCHA will track these outcomes. CCHA records each meeting with MAC member approval for note taking. The recording is not shared, but each member receives meeting notes.
- CCHA will continue to recruit members from diverse backgrounds to ensure that many perspectives are included in the MAC.

Goal for SFY23-24

Goal	Project/Initiative	Targeted Completion Date	Action(s)
MAC: Continue to recruit committee members that come from diverse backgrounds	Implement outreach for committee members.	Quarterly, ongoing	Proactively outreach possible committee members with diverse backgrounds to assess interest in joining the MAC.

MAC: Continue to utilize feedback from the MAC to enhance the services provided	Use direct member input to improve operations.	June 30, 2024	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 member experience. Include MAC participants in DEI listening sessions.

Section 11: Quality and Compliance Monitoring Activities

411 Audit: Support *Provider Documentation Improvement to Comply with USCS Standards and Requirements*

The RAE BH Encounter Data Quality Review, also known as the 411 Audit, is conducted each year to verify network BH providers' compliance with documentation standards outlined in the Uniform Service Coding Standards (USCS) manual.[1] 411 encounters in three categories are randomly selected for review. In 2022, those service categories were inpatient (INP), psychotherapy (PSYC) and residential (RESID) services. The compliance threshold for improvement interventions in each element was 90%. A review of service records for the 2022 411 Audit identified the following data elements below 90% accuracy.

Table 9. 411 Encounter Data Elements below 90%

Region 7	
Inpatient (INP)	
Element	**Percent**
Discharge Status	57.66%
Psychotherapy (PSYC)	
Element	**Percent**
Place of Service	83.94%
Residential (RESID)	
Element	**Percent**
Place of Service	83.21%

[1] The title of the USCS manual was updated in July 2023 to the State Behavioral Health Services Manual (SBHS).

Techniques Used to Improve Performance
Although these scores reflect the region's performance, CCHA partnered with one provider per service category whose specific audit scores demonstrated improvement opportunities in the same elements found below threshold in the region. An extensive review of documentation procedures was conducted to determine failure modes and causes, availability and accuracy of staff training, and the internal audit and oversight processes in place to inform intervention development. Failure modes were prioritized based on the likelihood of occurrence, certainty of cause, greatest ability to implement correction, extent of the potential benefit of the resolution, and risk of detrimental impact or poor outcomes in the provision of services.

Qualitative and Quantitative Impact
Upon execution, additional encounters were randomly selected for review for three months following the intervention to ensure corrections were successful in resolving deficits. The interventions effectively improved data accuracy; all providers achieved 100% compliance with technical documentation requirements for elements targeted in the Quality Improvement Project (QUIP), meeting the intended goals and successfully concluding the project.

In addition, CCHA continuously assesses and enhances its multifaceted approach to promote ongoing improvements to the accuracy of encounter data submissions. In addition to website postings and the monthly News and Updates newsletter sent to providers by CCHA, a Behavioral Health Provider Bulletin is regularly distributed to augment our communication strategy with specific content relevant to behavioral health providers, including changes to billing and coding practices, information on resources, educational materials, training opportunities, and contact information for their practice representatives. The Behavioral Health Provider Open Mic Calls are hosted by CCHA's Provider Experience team and serve as another forum available to share updates and respond to providers' questions about CCHA and the Health First Colorado program.

Goals for SFY22-23

Goal	Project/Initiative	Targeted Completion Date
411 Audit QUIP: Support improvement of providers' documentation to comply with USCS standards and requirements	Facilitate and oversee 411 Audit quality improvement processes.	June 30, 2023

Status and Results
Since the 2022 audit cycle, a Behavioral Health Provider Education Series was established to feature a new topic of interest each month, such as changes to the USCS manual and information on the FY22-23 411 Audit. Findings, scores, mock audit exercises and general education were reviewed to further advance providers' familiarity, comprehension, and proficiency with audit standards and requirements.

Opportunities for Improvement
CCHA developed and disseminated guidelines throughout the year as well as with the request for records to provide additional clarity on audit requirements, common mistakes, and a self-audit checklist to facilitate providers' review of their submissions. Upon completion of the encounter data validation phase of the 2023 audit, practice-level scorecards with the providers' results on each audited

element were furnished to all audited providers to notify participants of their performance and to guide necessary corrections.

Furthermore, service claims are regularly reviewed to identify practices that may benefit from additional assistance. Behavioral health practice transformation coaches work with identified providers to notify them of investigation findings, promote knowledge, and collaboratively work to enhance compliance with billing requirements and reduce the number of denied claims. CAPs have been utilized as needed to provide the structure, clarity of expectations and accountability for established improvement efforts.

Goal for SFY23-24

Goal	Project/Initiative	Targeted Completion Date	Action(s)
411 Audit QUIP: Support improvement of providers' documentation to comply with USCS standards and requirements	Facilitate and oversee 411 Audit quality improvement processes.	June 30, 2024	Work with HSAG to determine quality improvement targets. Partner with providers to develop and implement improvement processes.

Mental Health Parity External Quality Review Audit

HSAG reviewed 10 inpatient and 10 outpatient adverse benefit determination (ABD) records for each of the RAEs to determine whether each RAE demonstrated compliance with specified federal and state managed care regulations as well as their own policies and procedures. Overall, CCHA improved by 11% by implementing improvements in 2021.

Techniques Used to Improve Performance

Overall, the statewide average score for the mental health parity (MHP) audit increased from 93% in the CY2021 record reviews to 96% in the CY2022 record reviews. In Region 7, the following strengths were identified:

- Requirement that all UM reviewers, including MDs pass 90% interrater reliability standards.
- Records denying for lack of clinical had requests for additional clinical documented.
- All notices of adverse benefit determination (NoABDs) used member-friendly language.
- Identified the EPSDT desktop procedure that refers members under the age of 21 and RTC to Care Coordination as a best practice.

Status and Results

Table 10. Mental Health Parity External Quality Review Audit Results

Regional Accountable Entity	2021 Total Score	Category of Service	Compliance Score	2022 Total Score
Region 7 CCHA	81%	Inpatient Outpatient	90% 93%	92% ▲

Opportunities for Improvement

The following recommendations were made for continued improvement in Region 7:

- Improved consistency with peer-to-peer offers being documented.
- Non-compliance with listing all six dimensions in NoABDs (this is resolved as of May 2023).
- Improved consistency in sending NoABDs in a timely manner.
- Continue working on readability of NoABDs.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Audit

The purpose of the SFY22-23 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services audit was to determine whether the managed care entities (MCEs):

1. Had policies, procedures, trainings, reports, and relevant documents that were aligned with EPSDT federal regulations and specific State requirements.
2. Conducted outreach to EPSDT eligible members who were identified as "non-utilizers" because they had not received any EPSDT services within the 12-month period prior to the annual anniversary date of their enrollment.
3. Included EPSDT considerations when making medical necessity determinations prior to denying authorization for services.

Overall, CCHA was described as having more ESDPT-specific considerations than other RAEs and found our rate of completion to be even higher than what we reported.

Techniques Used to Improve Performance

The following were identified as best practices for CCHA:

- CCHA used a staggered attempt and greater than two outreach attempts with non-utilizers.
- CCHA denial criteria includes EPSDT considerations.
- In the second half of the reporting period there was improved consistency in utilizing the EPSDT desktop procedure.
- Warm handoffs from UM to CC were done well, however, completed inconsistently.

Status and Results

Table 11. EPSDT Audit Report Results

Regional Accountable Entity	Desk Review Score	Non-Utilizer Score	Post-Denial Score	Percentage of Criteria in Evidence
Region 7 CCHA	100%	86%	73%	86%

Opportunities for Improvement

HSAG made the following recommendations for improvement:

- While there is a process to complete risk assessments for members, there were no risk assessments for anyone in the non-utilizer sample, making it difficult for HSAG to ascertain if we are following our process.
- There was no evidence that non-utilizers received services following outreach. CCHA could improve documentation of services offered and received.
- CCHA could improve in consistently following the process to request additional clinical information.
- CCHA could improve in consistently sending timely NoABD letters.

- CCHA may want to consider adding an EPSDT flyer to notices for members within the eligible age range.
- CCHA could improve in consistently working with providers to inform them of EPSDT services including non-covered services.

Inpatient and Residential Substance Use Disorder Service Denial Determination Analysis

HSAG was contracted to review SUD denials, which excluded denials of claims for technical issues, to determine determinations of SUD inpatient and residential levels of care using the following American Society of Addiction Medicine (ASAM) levels of care. HSAG sampled 33% of the denials submitted, which resulted in the review of 18 denial files.

Status and Results

HSAG identified the following strengths in Region 7:

- Overall 83% compliance
- HSAG agreed with all CCHA denial decisions.
- HSAG identified 13 cases that could have resulted in overutilization if they had not gone through the UM process.
- Out of 18 cases, 17 met timely provider notification.
- Only one case where a member was not sent a NoABD letter, 17 letters were provided a NoABD.

Opportunities for Improvement

HSAG Recommended the following opportunities for improvement:

- Improved timeliness in sending out NoABD Letters - Out of 18 cases, only 10 NoABD letters were sent on time.
- Encourage continued ASAM training for providers.
- NoABD template language needs to include ASAM dimension descriptions for denial.

Goal for SFY23-24

Goal	Project/Initiative	Targeted Completion Date	Action(s)
Participate in all Department mandated audits and analysis	Receive a met or improved status for all audits and analysis.	June 30, 2024	Review areas of opportunity and implement recommendations.

Primary Care, Health Neighborhood & Community Customer Satisfaction Survey

To better understand and quantify the impact that CCHA has on the PCMP network and community, CCHA implemented our first primary care, healthy neighborhood & community customer satisfaction survey.

Techniques Used to Improve Performance

The survey was sent to 159 PCMP or Community Stakeholder entities on May 23, 2023, and ended on June 12, 2023.

Qualitative and Quantitative Impact
92 entities responded for a 58% response rate. 54% of respondents were PCMPs and 46% were Community Stakeholders. The roles of respondents were 46% office administrators, 16% direct care providers, 1% care managers, and 36% other.

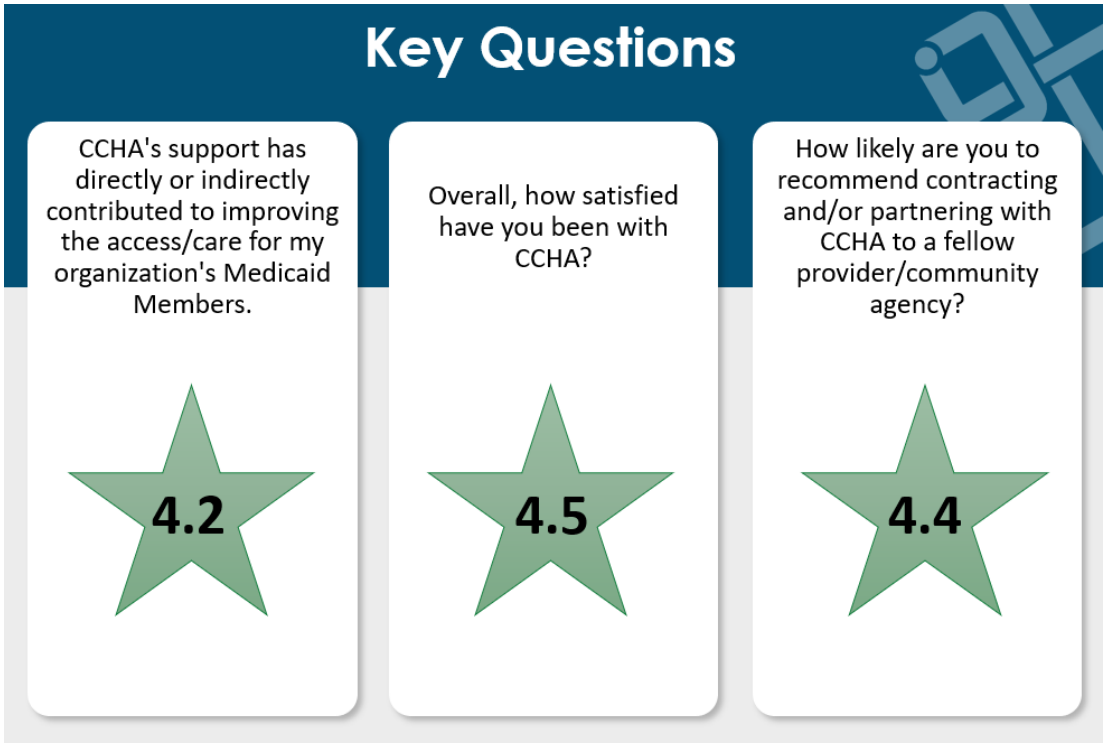
Goal for SFY22-23
This goal was not developed in our plan last year.

Status and Results
Table 12 below represents the overall results from the PCMP and Community Stakeholder survey.

Table 12. SFY22-23 PCMP and Community Stakeholder Survey

QUESTION	TOTAL	WEIGHTED AVERAGE
CCHA staff are easily accessible for information, referrals, and support.	**88**	**8.57**
CCHA staff respond quickly to address my needs.	**89**	**8.67**
CCHA staff are friendly.	**89**	**9.06**
CCHA staff are helpful.	**89**	**8.89**
CCHA's communications are informative and helpful.	**89**	**8.35**
CCHA keeps me informed of changes that affect my practice and/or organization.	**89**	**8.45**
CCHA staff are knowledgeable and answer questions consistently and accurately.	**89**	**8.58**
When I have a question or issue, I know who to contact at CCHA for help.	**89**	**8.64**
I know how/where to access the CCHA resources and information needed to serve Medicaid members effectively.	**89**	**7.88**

CCHA also identified the following key questions as most important to our overall goals for supporting PCMPs and Community Stakeholders. These questions are based on a 5-star rating with a weighted scale of 1-10.

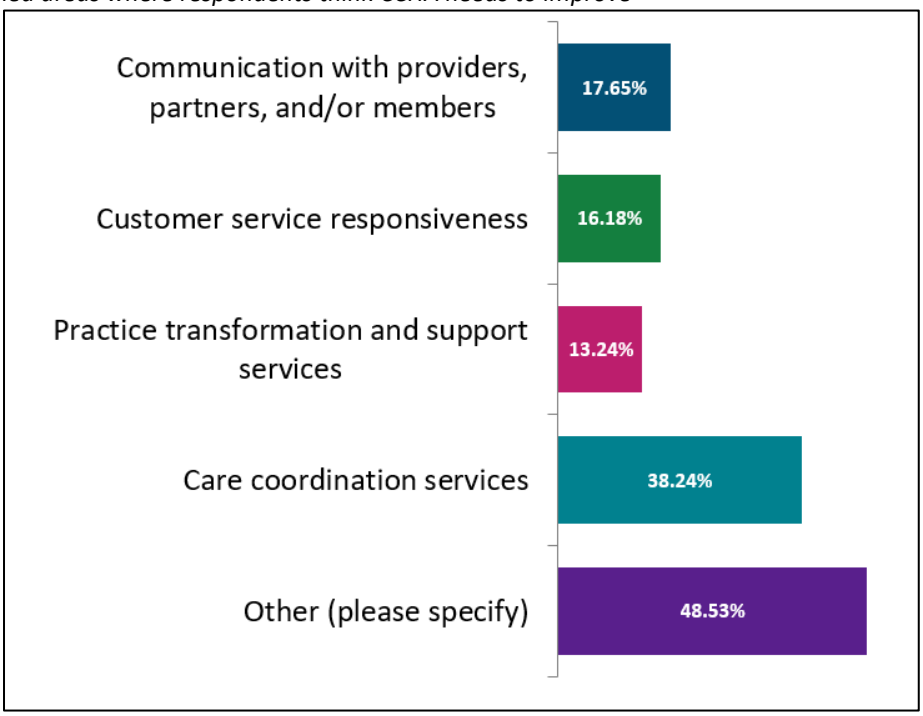


Opportunities for Improvement

Areas of opportunity identified through the survey include:

- Creating a more robust onboarding process and better tracking of staff turnover (in order to ensure new staff are properly trained and can access reports).
- Include specialty and BH providers.
- Identify better ways to utilize the PIAC voting members' expertise in the region and work to ensure members are kept informed of strategies and challenges facing CCHA.
- Other identified areas for potential CCHA improvement included the following:

Figure 19. Identified areas where respondents think CCHA needs to improve



Goal for SFY23-24

Goal	Project/Initiative	Targeted Completion Date	Action(s)
Continue the Primary Care, Health Neighborhood & Community customer satisfaction survey	Evaluate engagement of CCHA's PMCP network and community partners. Identify areas of opportunity for action planning.	June 30, 2024	Utilize data to identify opportunities and areas of improvement. Analyze data to guide interventions to improve satisfaction.