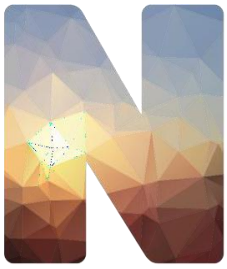

NORTHEAST
HEALTH PARTNERS, LLC

# SFY20/21 Quality Report

Northeast Health Partners, LLC

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# Section 1. Executive Summary

Northeast Health Partners, LLC (NHP) is the Regional Accountable Entity (RAE) for Region 2; the northeast portion of Colorado representing 10 counties spanning more than 20,000 square miles and including more than 90,000 eligible members. NHP was founded by four provider organizations that serve the region: Sunrise Community Health, Salud Family Health Centers, North Range Behavioral Health, and Centennial Mental Health Center. NHP also utilizes Beacon Health Options (Beacon) as its contracted Administrative Services Organization (ASO).

The Quality Improvement (QI) program at NHP is responsible for programs and initiatives focusing on improving health outcomes for Health First Colorado (Medicaid) members. The QI program at NHP spans performance tracking, business intelligence, practice transformation, care coordination, and population health to ensure programmatic decision-making is data-driven, efficient, strategically aligned, and focused on continual improvement.

This report seeks to summarize the activities, deliverables, accomplishments, barriers, and major programmatic decisions within the NHP QI Program through state fiscal year (SFY) 2020/2021 (i.e., July 1, 2020 – June 30, 2021). Activities around COVID-19 will also be included where warranted. This document serves as a review of what the region historically accomplished, and a blueprint for the SFY 21/22 NHP Quality Plan.

## NHP Quality Improvement Program Overview

The QI Program at NHP is responsible for overseeing, creating, and administering quality improvement activities across the region. In SFY19/20, NHP's QI Program continued to meet programmatic and regional needs associated with improved health outcomes of members, provide contract deliverables on time, and ensure better healthcare delivery.

Administrative support for the QI Program remained under Beacon Health Options, with all activities and oversight provided by the NHP Director of QI. QI Program activities included the following:

- External Quality Review Organization (EQRO) audit and subsequent post-audit activities;
- Overseeing the Encounter Data Validation (411) audit and subsequent post-audit activities;
- Managing Performance Improvement Projects (PIPs);
- Chairing/co-chairing committees, including the Quality Improvement Committee (QIC) and Regional Program Improvement Advisory Committee (PIAC);
- Development and completion of milestones associated with the Potentially Avoidable Complications (PAC) work;
- Alignment across PAC, population health, and condition management;
- Performance Measurement Action Plan (PMAP); and
- Integration with NHP Population Health strategic planning efforts.

## Impact of COVID-19 on Quality Indicators

COVID-19 arrived in the United States in early 2020 and continues to impact the county more than a year and a half later. Numerous efforts to prevent the spread of COVID-19 were underway in SFY19/20, and the advent of the vaccines helped shift efforts toward prevention and vaccine delivery. A primary focus of these efforts was to vaccinate any willing individual, to vaccinate homebound members, and to ensure equitable delivery of the vaccine to Members of Color (MOC - those members who identify as black/African American, Hispanic, Native Hawaiian/Pacific Islander, Asian, and mixed races). NHP has been working diligently throughout SFY20/21 to connect with at-risk COVID members to ensure their needs are met.

### *Vaccine Delivery*

NHP care coordinators were critical to the success of vaccine delivery through their efforts to expand vaccination opportunities. These efforts included reducing transportation barriers, improving language accessibility, and by dispelling false information and mistrust. Some of the efforts utilized to these ends included:

- Emphasizing locally driven initiatives with local community partnerships
- Home delivery of vaccines to homebound members
- Mobile vaccine clinics and vaccine busses
- Vaccine facts communicated through multiple platforms

### *Vaccine Equity*

Among the goals for vaccine delivery was an equitable distribution of vaccines to the region's MOC population. NHP focused on reducing vaccine hesitancy through a combination of interventions, including engaging community members, community leaders, leveraging social media, and providing training to health care professionals. One of the key elements within this engagement included trusted messengers, individuals embedded in the community who could provide public health messaging to their community, to better improve the uptake of health services. Partnerships also included local organizations such as the Community Navigation Program and the Refugee Center of Northern Colorado to help ensure messages were crafted and received in a manner that was understandable so members could make informed decisions about the vaccine. Through these efforts, NHP has successfully:

- Delivered vaccines to targeted communities and groups;
- Delivered over 52,000 COVID-19 vaccines (shots) through the end of July 2021;
- Reached out (100%) to all homebound members and provided vaccinations to all homebound members (and family members/caregivers) who wanted it; and
- Led all RAEs in the equitable distribution of the vaccine to MOC.

### *Delta Variant*

In recent months, the Delta variant has grown to become the most dominant strain of COVID-19 and is now responsible for more than 90% of the infections. Clinics and hospitals are again seeing a surge in patient volumes, and limited resources (such as ventilators and bed space) as a result. While the impact of the Delta variant (or future variants) is unknown, efforts around education, vaccines, and vaccine delivery will continue.

### *Impact on Performance Measures*

Interestingly, the advent of COVID-19 directly impacted three performance measures: Well Visits, Dental Visits, and ED Visits. Each of these measures dropped significantly with the pandemic for various reasons. Not only were opportunities for appointments limited during the pandemic, but they were also impacted by both pandemic restrictions and fear of the disease. Vaccination efforts were underway in the early part of 2021, which directly corresponds to increased performance on each of these three areas metrics beginning in February of 2021. Vaccine delivery, targeted messaging, back-to-school, and eased restrictions play a significant part of the increase for these measures. However, the recent impact of the Delta variant may be a contributor to the increase in ED visits. Each of these measures will be closely monitored in SFY21/22.

## Department Structure and Committees

### *Quality Improvement and Population Health Committees*

As noted in the previous year's Quality Report, NHP's Quality Improvement and Population Health Committee launched in January 2019, chaired by NHP's Chief Clinical Officer (CCO) and NHP's Director of QI. Due to challenges providers faced during the 2020 calendar year the Quality Management Committee, was formed in September of 2020. The QM Committee is chaired by NHP's Director of Quality and co-chaired by NHP's Chief Clinical Officer, and its formal charter was approved in January of 2021.

Since September of 2020, these two committees alternated monthly meetings, offering representation and insight from both physical and behavioral health clinicians from across the region. Meeting participants represented regional hospital systems, Federally Qualified Health Plans (FQHCs), Community Mental Health Centers (CMHCs), the North Colorado Health Alliance (NCHA), NHP, and Beacon Health Options. Topics of discussion included reviews of performance measurement, performance improvement opportunities, Potentially Avoidable Complications (PAC) efforts, public health campaigns and targeted messaging, grievances and appeals, Population-Health initiatives such as Practice

Transformation (PT), the Hospital Transformation Program (HTP), and other topics of interest from Health Care Policy & Financing (HCPF).

### *Performance Improvement Advisory Committee (PIAC)*

The regional Performance Improvement Advisory Committee (PIAC) served as an avenue for members' voices and perspectives to be incorporated into NHP's quality initiatives. Chaired by NHP's Director of QI, the group met quarterly in SFY20/21. Consistent with the previous year, the committee's voting membership included East Morgan County Hospital, Frontier House, Weld County Long Term Care (LTC), North Colorado Family Medicine (Banner Health), Health Communities, Hillcrest Center & the Towers, Nurse Family Partnership, Salud Family Health Services, North Range Behavioral Health, Women, Infant, Children (WIC), NCHA, Cavity Free at Three, and Envision. The Regional PIAC also has many organizations that participated in the meeting through non-voting capacities.

The regional PIAC worked to establish a formalized charter and by-laws that set parameters for its work and which topics the PIAC will review going forward. Activities and deliverables related to population health, performance improvement, and specific areas that need member feedback were identified as top priorities. In SFY20/21, the PIAC helped uncover stakeholder feedback and concerns regarding COVID-19 and the efforts around the Public Health Emergency (PHE) ending, stakeholder engagement opportunities in the Regional PIAC, and health equity in alignment with state initiatives.

NHP noted a desire to increase the number of members represented in the PIAC's voting membership and identify a Co-Chair. NHP implemented a gift card program in February 2019 to help incentivize members to participate in the regional PIAC and began to explore opportunities to increase regional participation. The impact of COVID-19 paused in-person visits, but gift card efforts continue for community members who are present during video/telephone conferencing. A survey was also administered throughout the region to assess interest and engagement in PIAC, the perceived value of the regional PIAC meeting, and interest in engaging in future regional PIAC meetings. These efforts are continuing into the SFY21/22 year where we may see impacts on increased participation from members and clinical groups, an added voting member, and a Co-Chair identified.

Key accomplishments of the PIAC are captured below for reference. While NHP intends to continue the strengths and accomplishments noted in SFY20/21, additional opportunities to enhance the role of the regional PIAC are captured in more depth in the annual Quality Plan.

- Ongoing review of performance improvement measures;
- Continued alignment with state initiatives and priorities such as a focus on diversity; and
- Continued efforts to increase engagement with the PIAC from regional organizations and members.

## Key Metrics Table

A summary of performance measures is included in Table 1 below, with specific date ranges and data sources noted in footnotes. Additional context to the region's efforts on specific performance measures are in the Performance Measure Summary section of this report.

Table 1. Key Metrics Table

| Key Performance Indicators (KPIs)[1] | Tier 1 Goal[2,3] | SFY20/21[4] | SFY19/20[3] |
|---|---|---|---|
| Behavioral Health (BH) Engagement | 1.28% | 1.20% | 1.27% |
| Dental Visits | 38.72% | 37.02% | 38.34% |
| Well Visits | 25.55% | 24.41% | 22.88% |
| Prenatal Engagement | 45.85% | 63.07% | 45.40% |
| Emergency Department (ED) Visits | 1.00% | -22.05% | -9.75% |
| Health Neighborhood (*claims portion) | 2.74% | 2.48% | 2.74% |
| **Performance Pool** | **SFY20/21 Goal[5]** | **SFY20/21[6]** | **SFY19/20[7]** |
| Extended Care Coordination (ECC) | 65.03% | 73.12 | 64.07% |
| Pre-Mature Birth Rates | 8.87% | 11.48% | 9.896% |
| BH Engagement for Members Releasing from State Prisons (DOC) | 13.39% | 18.75% | 10.56% |
| Mental Health (MH) Inpatient Visits/1000 | 8.19 | 6.21 | 1.46 |
| **Behavioral Health Incentive Program (BHIP)** | **SFY20/21 Goal[8]** | **SFY20/21[9]** | **SFY19/20[10]** |
| Substance Use Disorder (SUD) Engagement | 43.20% | 44.37% | 42.34% |
| 7-Day Follow-Up After an Inpatient Visit (MH) | 75.65% | 45.99% | 74.23% |
| 7-Day Follow-Up After an ED Visit for SUD | 40.14% | *[11] | 39.25% |
| BH Follow-Up After a Positive Depression Screen in Primary Care | 54.71% | 88.90% | 53.25% |
| *Gate measure: Depression Screen Claims Volume* | *10.94%* | *[12] | *3.88%* |
| BH Screen/Assessment for Members in Foster Care | 23.76% | 25.00% | 21.50% |

## Key Accomplishments in SFY20/21

Included in Figure 2 below is a high-level summary of activities that occurred in SFY20/21 that NHP identifies as a key accomplishment. These are discussed in more depth throughout this report, and many carry into the SFY21/22 Quality Plan document.

[1] KPIs are calculated by Truven and reflect a rolling 12-month methodology.

[2] NHP opted to capture its Tier 1 performance targets, as this is the minimum performance required for achieving the goals.

[3] Colorado Health Care Policy & Financing. *The Accountable Care Collaborative (ACC) Key Performance Methodology: SFY2020-2021 (V11)*. October 29, 2020.

[4] Number ae based on the Colorado Data Analytics Portal supplied by IBM Watson for 12-month rolling averages through May of 2021.

[5] Colorado Health Care Policy & Financing. *Regional Accountable Entity Performance Pool Specification Document: SFY2020-2021 (V4).*

[6] State-calculated fiscal year Performance Pool Measures are expected in December. These rates are calculated internally except for DOC.

[7] Colorado Health Care Policy & Financing. *Performance Pool Workbook FY1920 FINAL PERFORMANCE.*

[8] Colorado Health Care Policy & Financing. *Regional Accountable Entity Behavioral Health Incentive Specification Document, SFY2020-2021.*October 12, 2020.

[9] BH Incentive measures are delayed due to a 90-day claims runout. Data represent estimates based on internal calculations through May of 2021.

[10] Colorado Health Care Policy & Financing. *BH Incentive Plan Measures FY1920 Performance.* Accesses from the ACC External Site at https://cohcpf.sharepoint.com/sites/RAE/DataAnalytics/Forms/ByIncentiveProgram.aspx

[11] This data point is calculated by the state and has not yet been received.

[12] The gate measure is not currently being tracked but will be added to the SFY21/22 performance tracking.

Table 2. Key Accomplishments from SFY20/21

| Project | Accomplishment |
|---|---|
| Health Neighborhood | Achieved Tier 2 goal of the Health Neighborhood KPI (July through December 2020) and Tier 1 (January 2021) and was the only RAE to meet its goal for the claims-based portion. |
| Emergency Department Visits | Achieved Tier 2 goal for reduction of Emergency Department Visits. |
| Prenatal Engagement | Achieved Tier 2 goal. |
| Potentially Avoidable Complications (PAC) | PAC Plan was accepted without edits, and all milestones associated with PAC work were achieved without edits. |
| Extended Care Coordination | Scored the highest of all RAEs on the Extended Care Coordination (ECC) Performance Pool measure in SFY18/19 and SFY19/20. |
| DOC BH Engagement | One of the top performing RAEs in DOC BH Engagement. |
| MH Inpatient Admissions | Achieved the goal in all months for MH Inpatient Admissions. |
| QI and Population Health Committee | Utilized robust clinical representation from the region to inform strategy and analysis associated with KPIs. |
| COVID-19 Efforts for Homebound and MOC | • Reached 100% of the homebound members.<br>• Delivered a higher proportion of vaccines to the region's MOC members and had the highest MOC distribution difference across all RAEs. |
| HSAG Audit | Achieved a perfect score (17 of 17) on the Quality Section of the HSAG audit. |

## Key Initiatives for SFY21/22

The QI program at NHP established key initiatives for SFY21/22 based on evaluating its accomplishments to-date, identifying gaps and barriers that were observed during the previous fiscal year. Initiatives for SFY21/22 are noted at a high level below in Table 3. Additional details around these goals can be found in the SFY21/22 Quality Plan.

Table 3. Key Initiatives for SFY21/22[13]

| Project | SFY21/22 Goal / Activity |
|---|---|
| 411 Audit | Improve on inter-rater reliability with HSAG overreads. |
| All performance measures | • Establish a single source for reporting and visualizing performance on KPIs, BHIP, Performance Pool measures.<br>• Improve access to performance reports and action items across KPIs and incentive measures.<br>• Refine and improve enhanced reporting through Power BI and/or other systems to enable performance visualizations and deeper-level performance assessments.<br>• Partner with individual clinics/sites to establish targeted performance improvement activities for lagging performance indicators.<br>• Solidify the PMAP process for targeted performance improvement efforts. |
| Behavioral Health Incentives | • Continue performing at or above the regional target for SUD Engagement and 7-Day Follow-Up after an ED Visit for SUD measures.<br>• Achieve regional goals for the BH Screen/Assessment for Foster Care Members.<br>• Develop reporting to performance and action items across BHIP incentive measures.<br>• Establish clinic-level performance improvement initiatives for lagging BHIP performance.<br>• Increase the total volume of depression screens billed in primary care helping achievethe gate measure associated with the depression screen incentive measure.<br>• Explore BH Assessments with Members in Foster Care to improve performance. |

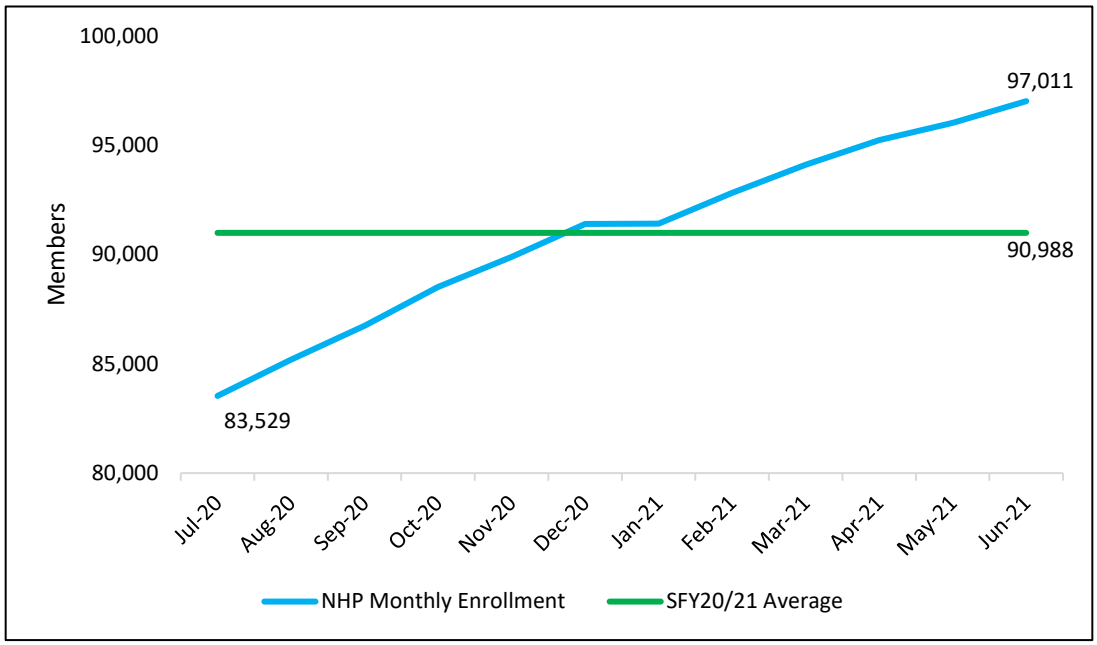
[13] This table is included in the Northeast Health Partners' SFY21/22 Quality Improvement Plan.

| Project | SFY21/22 Goal / Activity |
|---|---|
| | • Solidify the PMAP process for targeted performance improvement efforts. |
| Performance Pool | • Maintain strong performance in Extended Care Coordination.<br>• Maintain strong performance in DOC. |
| PAC | • Achieve all milestones associated with PAC work with scores above 90. |
| Performance Improvement | Establish independent performance improvement projects to meet KPI, BHIP, and PP measures to meet:<br>• 3 out of 5 KPI metrics<br>• 3 out of 5 BHIP measures<br>• 3 out of 7 Performance Pool Measures |
| PIP | • Study the impact of the PIP plan at Sunrise on BH Screening and Follow-up measures. |
| ED Visits | • Understand the growing trend in ED utilization that began in February of 2021. |
| Practice Transformation Program | • Expand on Practice Transformation work from SFY21/22. |
| Hospital Transformation Program | • Work with hospitals to identify current processes and streamline processes in alignment with the Hospital Transformation Program. |

## Section 2: NHP Population Characteristics and Penetration Rates

NHP's eligible membership population grew from 82,281 at the end of SFY18/20 to 97,011 members as of June 30, 2021. During SFY20/21, NHP's eligible membership population average over 90,000 for the fiscal year with enrollment eligibility climbing in each successive month of the fiscal year.[14] This trend is summarized below in Figure 1.

**Figure 1. SFY20/21 NHP Total Enrollment, by Month**

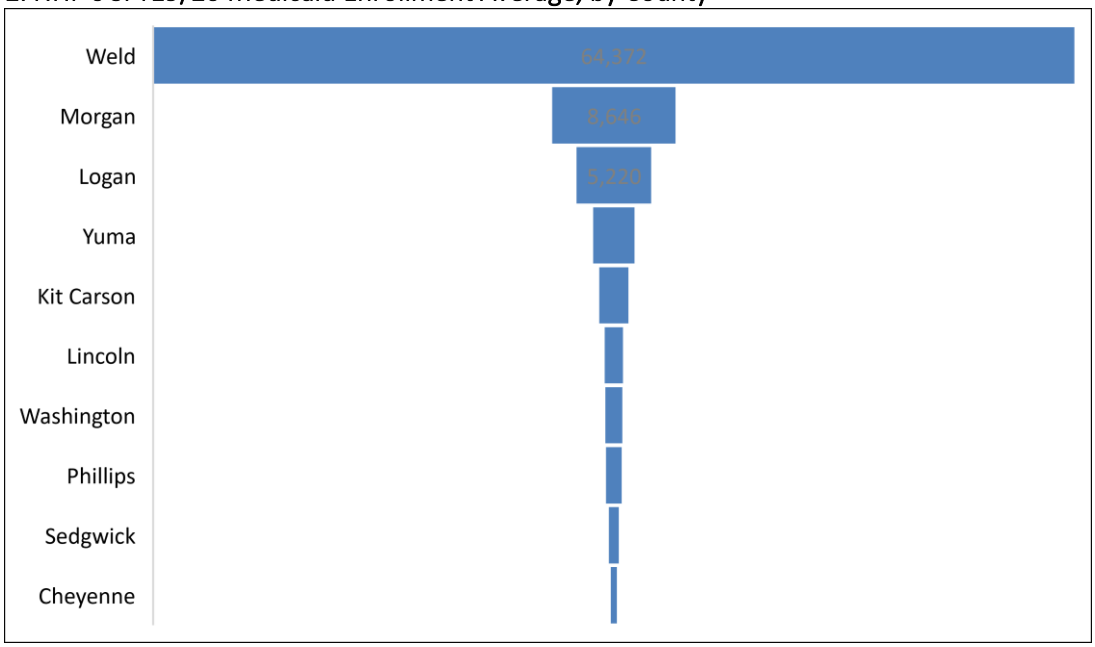



The NHP region spans across 10 counties in the northeast part of Colorado, including Weld, Morgan, Logan, Yuma, Kit Carson, Lincoln, Washington, Philips, Sedgwick, and Cheyenne counties. Weld County is the only urban county in the region, and accounts for the largest proportion of members. Morgan, Logan, and Phillips counties are designated as rural, and the remaining counties (Sedgwick, Washington, Yuma, Kit Carson, Lincoln, and Cheyenne) are designated as frontier counties based on the Colorado Rural Health Center.[15] Membership counts across each of these counties are visualized in Figures 2 and 3 below.

[14] Members have continuous enrollment during COVID-19 contributing to the continual rise in membership.

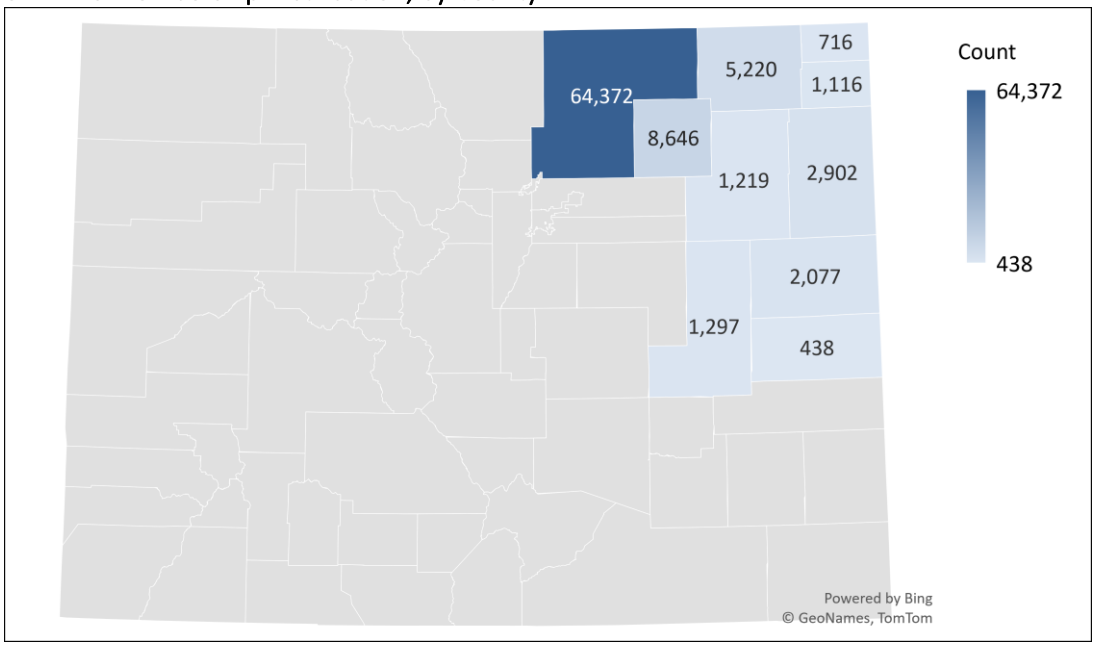
[15] Colorado Rural Health Center. *Colorado County Designations, 2016.* Accessed on 9/24/2021 from: https://www.colorado.gov/pacific/sites/default/files/PCO_CHSC_CountyDesignations_2016.pdf

Figure 2. NHP's SFY19/20 Medicaid Enrollment Average, by County




** Data not shown: Yuma County (2,902), Kit Carson County (2,077), Lincoln County (1,297), Washington County (1,219), Phillips County (1,116), Sedgwick County (716), and Cheyenne County (438).*

Figure 3. NHP's Membership Distribution, by County




**Counties: Weld (64,372), Morgan (8,646), Logan (5,220), Yuma (2,902), Kit Carson (2,077), Lincoln (1,297), Washington (1,219), Phillips (1,116), Sedgwick (716), and Cheyenne (438).*

## Aid Categories and Demographic Characteristics

Table 4 shows the breakdown of NHP member population. The region is closely split between males and females with makes accounting for just over 51% of the members, while females account for almost 45%. Almost 60% of the members are over the age of 19. Table 4 represents a snapshot of NHP's membership as of June 30, 2021, across age and gender.

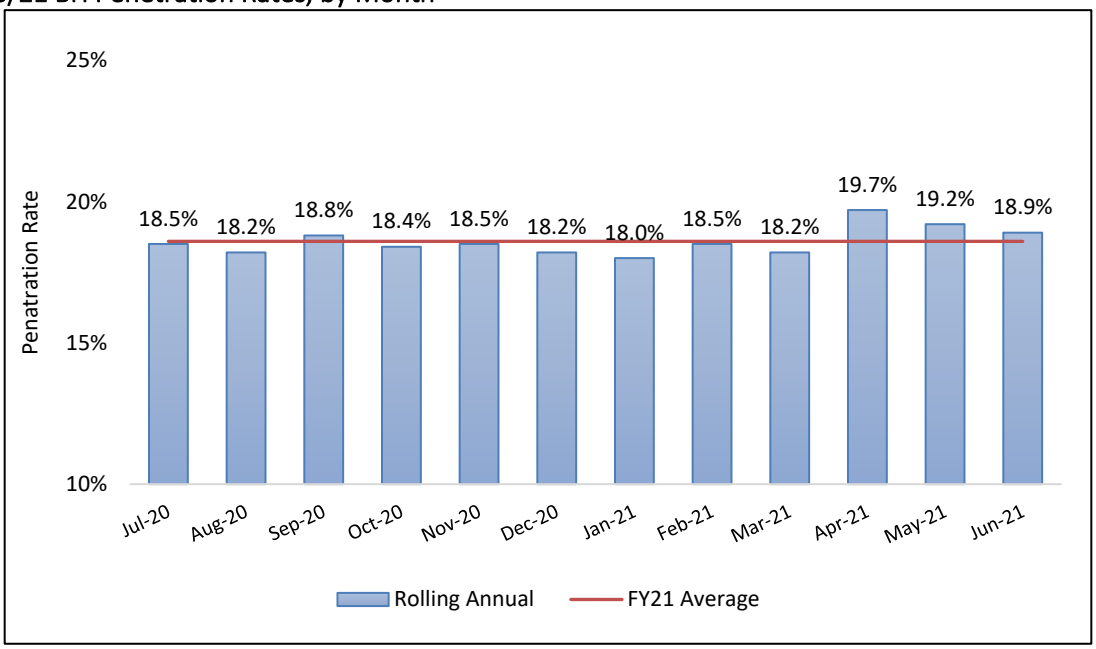
Table 4. NHP's Membership Demographics

| Age | Count of NHP Membership | % of NHP Membership |
|---|---|---|
| Child: 0-12 | 29,558 | 30.47% |
| Adolescent: 13-17 | 10,714 | 11.04% |
| Adult: 18-69 | 54,419 | 56.10% |
| Older Adult: 70+ | 2,320 | 2.39% |
| **Gender** | **Count of NHP Membership** | **% of NHP Membership** |
| Female | 50,171 | 51.72% |
| Male | 43,325 | 44.66% |
| Unknown/Not Stated | 3,515 | 3.62% |
| **Total Enrollment** | **97,011** | |

## Penetration Rates

The Behavioral Health Penetration Rates refers to the percent of members with at least one behavioral health contact during the fiscal year. The average penetration rate for SFY20/21 was 18.6%; slightly lower than the 20.6% seen in SFY19/20. Figure 4 below captures the annual rolling average of the penetration rate. The previous fiscal year saw a sharp decline in March of 2020 corresponding to the pandemic. Rates in SFY20/21 have remained relatively stable through the year, but improved beginning in April of 2021. This improvement may be related to the COVID-19 vaccine rollout and eased pandemic restrictions seen as a result. Some of the rates may come to be adjusted, thus ongoing monitoring is needed to determine the true impact of COVID-19 and the vaccine on penetration rates in the region.[16]

Figure 4. SFY20/21 BH Penetration Rates, by Month




[16] Claims run-out refers to the time in which claims for services are submitted, processed, and paid. These activities may take up to five months to finalize. This should be considered across all penetration rate data presented in this report. NHP anticipates the SFY20/21 penetration data to be finalized by November 30, 2021, but monitors monthly variation in reported numbers to understand the true impact of claims run-out on reported rates.

Penetration rates broken down by age, eligibility type, and overall average helps NHP better target interventions that may improve members' access to timely and appropriate services that meet their needs. Figures 5 and 6 below show the penetration rate by aid category and age, respectively.

Figure 5: SFY20/21 BH Penetration Rates, by Aid Category

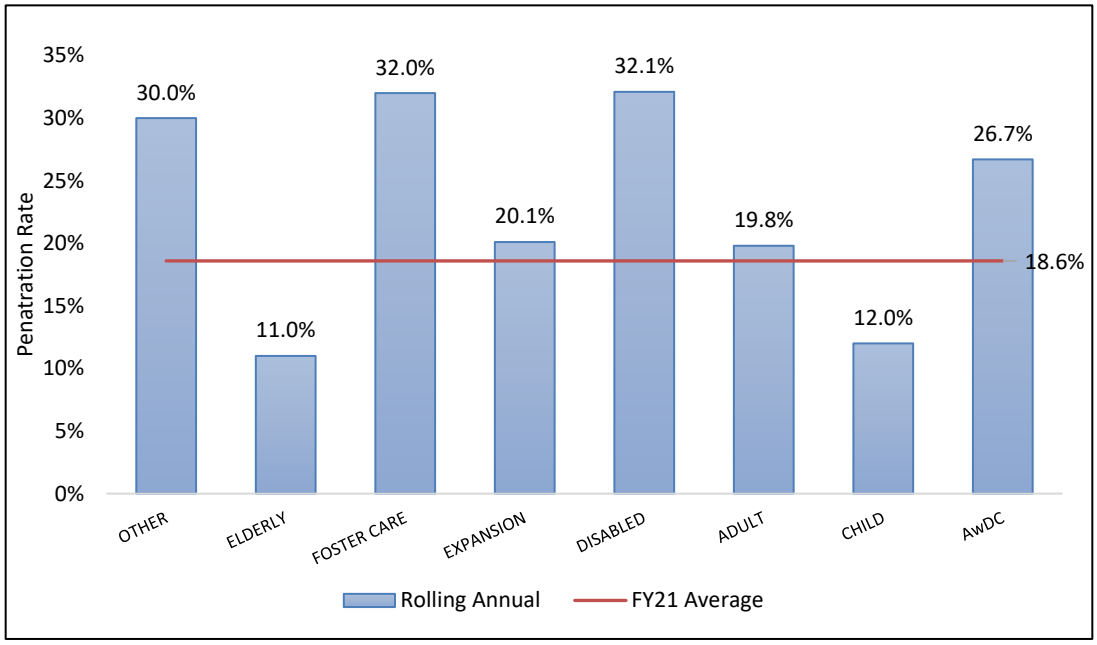
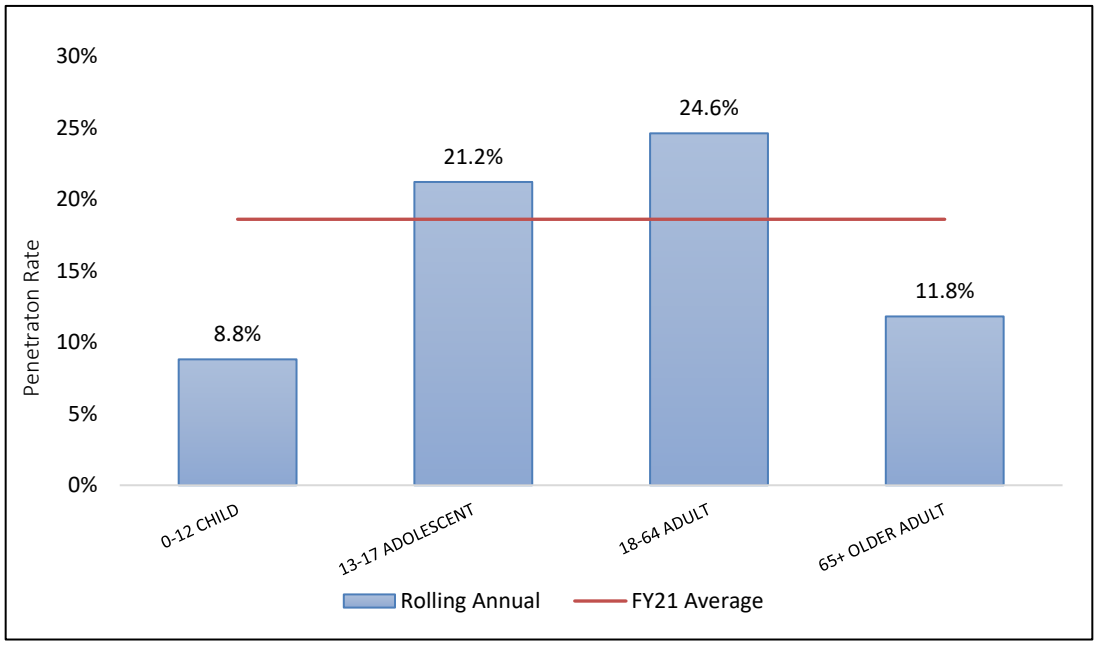



Figure 6: SFY20/21BH Penetration Rates, by Age




Penetration rates will continue to be monitored in SFY21/22. With the growth of the COVID-19 Delta variant, tracking overall penetration rates across member demographics will be critical to understanding how members are engaging in in behavioral health services in a revitalized pandemic. These rates will also be helpful to assess which member groups might be less inclined to utilize behavioral health services through virtual formats.

# Section 3: Network Adequacy and Availability

NHP created, administers, and maintains a network of primary care medical providers (PCMPs) and behavioral health providers to serve the needs of regionally attributed Medicaid members. To meet this goal, NHP leverages existing contracts with providers and continually recruits new providers to better ensure members have access to both primary care and behavioral health services.

One of NHP's goals during the SFY20/21 year was to meet time and distance standards for physical and behavioral health care services. NHP utilized GeoAccess to analyze time and distance between members and practices to assess this standard on a quarterly basis. Overall, NHP maintained a strong network for physical and behavioral health and worked to address gaps in services. These efforts included updating practitioner lists which added healthcare providers to Weld County, and improved OB-GYN services. In Weld County, OB-GYN services increased from 0% in the first quarter to 89% in the fourth quarter.

Additional analyses using the Department of Regulatory Agency (DORA) Registry, MCO Reports, and a survey to Department of Human Services (DHS) directors showed limited availability of independent practitioners in the region in the following:

- The majority (95%) of the providers identified were part of contracted entities;
- No independent practitioners with behavioral health licensures in specific counties within the region (i.e., Cheyenne, Phillips, and Yuma);
- Approximately 80 providers identified, primarily in Weld County, did not have practices within the listed counties; demonstrating the data was outdated; and
- Of the providers listed in the DORA registry, 14 were identified for potential recruitment; however, they did not respond to outreach efforts via phone or email as no face-to-face outreach was conducted due to the COVID-19 pandemic.

## Ensuring Availability

As required by Health First Colorado, both PCMPs and behavioral health providers are expected to maintain business hours that are convenient to the population served and are offered without payer discrimination. Appointments are expected to be available based on the nature of the service including:

- Routine appointments within 7 days of the request;
- Urgent access is available within 24 hours of the request; and
- Emergent access for behavioral health providers is available within 15 minutes by phone or one hour for face-to-face services within an urban area (or within two hours for a rural or frontier area).

Ensuring service availability is both clinically important and a driver for quality. Appointment availability is audited on a quarterly basis and all in-network providers are audited at least once during the fiscal year. Providers who are unable to demonstrate compliance are provided education on the appointment availability standards and reaudited within 90 days. Providers may receive a request for a written corrective action plan (CAP) should fail to demonstrate improvement at the 90-day re-audit time period. If a CAP is requested, healthcare providers will develop a written response outlining the access issue and their steps to improve access. NHP then works with the provider to offer support and education in a collaborative effort to better meet members' needs. Providers are re-audited 90 days after the CAP is accepted to assess improvement in meeting access to care standards. If a provider remains non-compliant, the provider will be recommended for review to the Quality Oversight Care Committee (QOCC). Based on the QOCC review, recommended actions could include panel closures, suspension of referrals, continuation of the CAP, or other activities deemed appropriate up to termination from the network.

One of NHP's goals during the SFY20/21 fiscal year was a 10% increase the percentage of primary care and behavioral health providers within the region to help meet the appointment availability standards. When comparing the audits conducted for PCMP locations in the first quarter versus the fourth quarter of the fiscal year, we found an overall

improvement for appointment availability for new and established members, and for practices that met that all standards. NHP found a slight drop in the clinics that offered same day appointments. The results are captured below in Table 5.

Table 5. Network Availability Changes for Primary Care

| Metric | First Quarter | Fourth Quarter |
|---|---|---|
| Availability within standards for new Medicaid member | 54% | 81% |
| Availability within standards for established Medicaid member | 83% | 81% |
| Offered same day appointments | 92% | 88% |
| Met all the standards | 54% | 81% |

For the behavioral health network, NHP found an overall reduction in the appointment availability standards from first to fourth quarter auditing. NHP outreached providers and reviewed expectations related to appointment availability. Providers reported reduced capacity and full caseloads throughout the year due to higher demand and an increased number of members continuing to engage in services. NHP has been conscientious in this outreach as, unfortunately, some of the full caseloads are due to limited space, limited face-to-face capacity within offices, and the comfortability and willingness for members to attend appointments with individuals based on COVID-19 vaccine status. To combat these issues, NHP includes expanding access to care for existing network providers in the SFY20/21 Behavioral Health Expansion Plan.[17] NHP notes that this expansion will be achieved through several means including continuing to support telemedicine, potential rate renegotiations, and expanding behavioral health in non-traditional settings. The results of network availability for behavioral health for the SFY20/21 year are as follows:

Table 6: Network Availability Changes for Behavioral Health

| Metric | First Quarter | Fourth Quarter |
|---|---|---|
| Availability within standards for new Medicaid member | 35% | 22% |
| Availability within standards for established Medicaid member | 48% | 22% |
| Offered same day appointments | 35% | 22% |
| Met all the standards | 35% | 22% |

## Accepting New Members

Access for new members is an important part of maintaining member engagement. During the previous fiscal year, 93% of PCMPs reported accepting new members in the first quarter and 94% reported accepting new members in the fourth quarter. All behavioral health practitioners reported accepting new members throughout the year.

NHP continues to educate providers about notifying the RAE regarding any changes to their ability to accept new members. Providers can notify NHP to temporarily close their panels to new members. In those cases, NHP removes the practitioner from clinical referrals. NHP monitors the network for access to new Medicaid members as follows:

- Conducting access to care audits to determine if PCMP and behavioral health providers offer appointment availability within the standard; and
- Soliciting feedback from members or through Family Affairs when a provider not currently in the network offers appointments within the standard.

[17] Northeast Health Partners. Behavioral Health Expansion Plan: July 1, 2021 – June 30, 2022.

# Section 4: Compliance Monitoring

Compliance monitoring activities were managed NHP alongside various departments at Beacon Health Options, including Quality, Care Coordination, and Provider Relations. Specific activities related to these efforts are included below.

## External Quality Review Organization Audit (EQRO Audit)

The annual SFY20/21 EQRO site review, which evaluated compliance with NHP's Medicaid contract requirements, was completed in April of 2021. The following standards were reviewed as part of the audit:

- Standard VII: Provider Participation and Program Integrity;
- Standard VIII: Credentialing and Recredentialing;
- Standard IX: Subcontractual Relationships and Delegation; and
- Standard X: Quality Assessment and Performance improvement

The Provider Participation and Program Integrity and the Credentialing and Recredentialing sections both met 94% of the required elements. The Subcontractual Relationships and Delegation section met 75% of its required elements, and the Quality Assessment and Performance Improvement section met 100% of the required elements. These scores resulted in a composite score of 94%. Health Services Advisory Group (HSAG) noted several areas of strength in the 2020/21 site review report.[18]

### *Summary of Required Actions and CAP Status*

NHP initiated activities specific to areas that resulted in a CAP in SFY20/21. These activities will continue into SFY21/22 and are expected to be finalized in calendar year 2021. Required actions cited in the CAP included:

- NHP must update informational materials to clarify that, while an individual provider may have such objections, NHP as an organization does not. Furthermore, NHP should provide additional information stating that, if the provider objects to services, the member should be referred to NHP to be assigned to a different provider if needed.
- NHP's policy, processes, and procedures must ensure representation of denied NHP practitioner file applications are selected and reviewed by credentialing management during the annual audit to ensure that no discrimination occurs on behalf of the NCC and/or reviewer.
- NHP must implement a written process for confirming that listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, certification (including board certification, if applicable), and specialty.
- NHP must update contracts and delegated agreements to include the detailed language specified in 42 CFR 438.230(c)(3) to meet this requirement.

## Encounter Data Validation (411) Audit

NHP participated in the Encounter Data Validation (411) audit in SFY20/21. This audit randomly selects 137 encounters from three distinct program categories (resulting in 411 total records) to ensure data accuracy. Three service program categories were selected by the Department for review in this year's audit, including the following:

- 137 institutional encounters from Inpatient services
- 137 professional encounters from Psychotherapy services and
- 137 professional encounters from Residential services.

Prior to any records being reviewed, training was conducted to ensure consistency across each of the auditors. The

[18] Colorado Department of Health Care Policy and Financing. *Fiscal Year 2020-2021 Site Review Report for Northeast Health Partners Region 2.* June 2021.

following topics were included in various training activities in preparation of the 411 audit:

- The annual BH Encounter Data Quality Review Guidelines
- Scoring criteria for the various audit fields
- Review of the Uniform Service Coding Standards Manuals that applied to the review period

NHP also reviewed 30 records as part of its interrater reliability (IRR) training and process. Each of these 30 records were reviewed across NHP's auditors to ensure consistent scoring. Internally-calculated IRR was 86.7%. Any inconsistencies were addressed in training and in some instances, the Health Services Advisory Group (HSAG) was outreached for additional clarification and interpretation. NHP's auditors included:

- Courtney R. Hernandez, MS-HSV
- Kylanne Briggs, LCSW
- Rhonda Borders, LCSW

NHP's scores fell below the 90% compliance threshold for the Psychotherapy service category, prompting an internal Corrective Action Plan (CAP) with one behavioral health organization and additional quality improvement activities through the Department's Quality Improvement Project (QuIP). A summary of indicators reviewed below in Table 7 shows the combined service categories scoring below the 90% compliance threshold.

Table 7. Summary Indicators for the 411 Audit[19]

| Requirement Name | RAE Name | Service Category | Numerator | Denominator | % |
|---|---|---|---|---|---|
| 'Procedure Code' | NHP | Psychotherapy | 109 | 137 | 80% |
| 'Diagnosis Code' | NHP | Psychotherapy | 113 | 137 | 82% |
| 'Place of Service' | NHP | Psychotherapy | 103 | 137 | 75% |
| 'Service Category Modifier' (Procedure Modifier 1) | NHP | Psychotherapy | 109 | 137 | 80% |
| 'Unit' | NHP | Psychotherapy | 112 | 137 | 82% |
| 'Start Date' | NHP | Psychotherapy | 113 | 137 | 82% |
| 'End Date' | NHP | Psychotherapy | 113 | 137 | 82% |
| 'Appropriate Population' | NHP | Psychotherapy | 113 | 137 | 82% |
| 'Duration' | NHP | Psychotherapy | 113 | 137 | 82% |
| 'Staff Requirement' | NHP | Psychotherapy | 113 | 137 | 82% |

Another key goal for NHP was to achieve a near-perfect agreement with HSAG on IRR for the 411 audit. Perfect agreement was achieved in 32 of 36 data elements. Breakdowns of audit results are found below in Tables 8, 9, 10, and 11.[18]

Table 8. Interrater Reliability for Inpatient Services

| Data Element | Score |
|---|---|
| Principal Surgical Procedure | 100% |
| Diagnosis Code | 100% |
| Revenue Code | 100% |
| Discharge Status | 0% |
| Service Start Date | 75% |
| Service End Date | 75% |

[19] Colorado Health Care Policy & Financing. *Fiscal Year 2020-2021 Regional Accountable Entity 411 Encounter Data Validation Over-Read Report for RAE 2: Northeast Health Partners.* June 2021.

Table 9. Interrater Reliability for Ambulatory Inpatient Services

| Data Element | Score |
|---|---|
| Procedure Code | 100% |
| Diagnosis Code | 100% |
| Place of Service | 100% |
| Service category Modifier | 16.7% |
| Unit | 100% |
| Service Start Date | 100% |
| Service End Date | 100% |
| Population | 100% |
| Duration | 100% |
| Staff Requirement | 100% |

Table 10. Interrater Reliability for Psychotherapy Services

| Data Element | Score |
|---|---|
| Procedure Code | 100% |
| Diagnosis Code | 100% |
| Place of Service | 100% |
| Service category Modifier | 100% |
| Unit | 100% |
| Service Start Date | 100% |
| Service End Date | 100% |
| Population | 100% |
| Duration | 100% |
| Staff Requirement | 100% |

Table 11. Interrater Reliability for Residential Services

| Data Element | Score |
|---|---|
| Procedure Code | 100% |
| Diagnosis Code | 100% |
| Place of Service | 100% |
| Service category Modifier | 100% |
| Unit | 100% |
| Service Start Date | 100% |
| Service End Date | 100% |
| Population | 100% |
| Duration | 100% |
| Staff Requirement | 100% |

## Provider Audits

Beacon Health Options, on behalf of the NHP QI Department, conducts audits across care coordination, physical health, and behavioral health contract compliance. While there is consistent auditing of providers in the areas noted, follow-up in the form of corrective action plans and provider training has been consistent.

### *Care Coordination Audits*

NHP's delegated care coordination model consists of two different groups: Accountable and Contributing. Membership attributed to Accountable providers accounts for a significant portion of regional membership.

Accountable providers possess the greatest level of capability to impact the complex members and regional KPIs as well as demonstrate the capacity to provide the full continuum of community care coordination for members. Contributing providers meet minimum Medicaid Per Member Per Month (PMPM) requirements and provide basic services. This provider group has a small medical panel size with limited volume to drive regional performance outcomes. Care coordination for all Contributing PCMPs is delegated to North Colorado Health Alliance (NCHA). NCHA also provides care coordination for members attributed to Sunrise Community Health.

Accountable entities and NCHA were audited to evaluate the care coordination activities provided to members using the updated audit that was initiated in SFY19/20. These audits utilized a random sample of members identified as needing complex care coordination across the region's four care coordination entities, and subsequent auditing against the following four domains:

- Care Plan Elements: All member demographic data is accounted for, as well as meaningful supplemental information that addresses social determinants, cultural specifics, and physical/behavioral health care needs;
- Care Coordination Evidence: Evidence showcasing that the care plan takes into consideration preferences and goals stated by the member, timely follow-up with members/families, dates in which care coordination activities occurred, identification of medical, behavioral, or social needs that the care coordinator helped identify/connect;
- Connection and Education: The importance of contacting the Primary Care Provider (PCP) for non-emergent services and/or Nurse Advice Lines, and evidence of at least three outreach attempts; and
- Policies and Procedures: All expectations related to the care coordinator's role, including required trainings, and communication/outreach requirements with members.

These audits reviewed care plan elements to ensure the delegated care coordination entities were completing critical activities associated with member outreach and engagement. In SFY20/21, each of the four care coordination entities were audited once, with a passing score of 80% or higher required. All four of these entities met expectations. Due to the passing scores, all four entities will be audited again in the twelve months.

### *Practice Assessments*

In previous years, NHP utilized a three-tier contract with providers: Accountable, Collaborative, and Contributing. Accountable and Contributing practices were noted above under Care Coordination Audits. However, those designated as Collaborating were practices that participated in advanced care coordination and population health activities. NHP discontinued this contracting tier for the SFY20-21 year. The decision to remove the Collaborative level was two-fold. First, practices overall scored low on the elements surrounding care coordination and Information Technology (IT) to move into an Accountable level and have delegation for Care Coordination. Second, this structure better aligns with the current care coordination structure. As a result, NHP shifted the function of practice assessments to focus on Practice Transformation

### *Behavioral Health Documentation Audits*

NHP conducts random audits on behavioral health practices to evaluate quality of care and compliance with the Health First Colorado (Colorado's Medicaid Program) documentation rules. This includes an audit of the Independent Provider Network (IPN), Substance Abuse Disorder (SUD) Outpatient, Medication Assisted Treatment (MAT), Targeted Case Management (TCM) documentation, Intensive Outpatient (IOP), Residential Treatment (RTF), Inpatient Treatment (IP), and SUD Detox providers. The purpose of these audits is to ensure that contracted providers are meeting the guidelines established for service provision and that NHP maintains a high performing network.

Audits are completed as required by the Colorado Department of Healthcare Policy and Financing and ensure contractual compliance. If audit scores do not meet the minimum required threshold, NHP provides education to the provider about the deficiencies, offers training to the provider, re-audit the provider for continued improvement, potentially require the provider to create a corrective action plan (CAP) if warranted, and potentially recoup funds. Audits follow Health First Colorado and Office of Behavioral Health (OBH) standards including:

- Administrative Standards;
- Assessment Standards;
- Treatment Planning;
- Progress Note Documentation; and
- Care Coordination.

Medication-Assisted Treatment (MAT) Services are also audited against additional standards including Medication Evaluation, Physical Examination, and Toxicology Screening. To date, no specific trends are emerging in terms of providers scoring consistently low or high on specific standards.

Education on documentation standards was offered throughout the fiscal year and will continue throughout the next fiscal year. These education sessions are provided by the same staff conducting the audits, and providers had the opportunity to engage with the educators to ask clarifying questions about documentation standards. To provide further support, NHP has provided provider-specific training via Zoom to allow for a more personalized, agency-specific training opportunity.

# Section 5: Performance Improvement

The Department maintained the following three types of performance measure programs during SFY20/21: Key Performance Indicators (KPIs), Performance Pool, and Behavioral Health Incentive Program (BHIP). Annual performance summaries for each of these measures can be found in the Key Metrics Table, with high-level overview provided on specific measures below.

## Key Performance Indicators (KPIs)

NHP aimed to provide timely and ongoing monitoring of its performance measures with regional providers and stakeholders. These updates were shared through the regional Quality Management (QM) Committee, Regional PIAC, and with individual providers at monthly quality-related meetings including the Community Mental Health Center Monthly Quality Meetings, and the Region 2 Care Coordination Subcommittee. These updates were instrumental in helping NHP to meet performance goals across 3 KPI and 3 BHIP measurements. Additionally, NHP developed a KPI dashboard in Power BI to supplement the Colorado Data Analytics Portal (CDAP) for quick-reference on performance tracking and for deeper-dive assessments at the practice-level.

## Potentially Avoidable Complications (PAC)

NHP maintained focus on the following three episodes of care in its SFY20/21 PAC work: Diabetes, Pregnancy, and Depression/Anxiety. The details of these initiatives are outlined below, and ongoing efforts around these initiatives are captured in the SFY21-22 Quality Plan.

### *Diabetes*

As an expansion to the previous year's PAC plan, NHP established 3 key initiatives around establishing a Diabetes Self-Management and Education Support (DSMES) program in the region. These efforts centered around researching DSMES programs in the area, establishing a DSMES program in the region, and evaluating its impact. Unfortunately, the impact of COVID-19 required a shift in priorities for our regional partners as establishing a DSMES program was not possible with pandemic priorities and activities. NHP instead shifted its focus and offered a regional approach to improving diabetes management by establishing the Diabetes Management & Outcomes Improvement grant opportunity. This competitive funding opportunity was used to generate ideas and fund innovative projects across the region targeting diabetes outcomes. The Request for Proposals (RFP) was distributed regionally in May of 2021, applications were scored in June on 2021, and award notices were sent to awardees in July of 2021 for project implementation in the first quarter of SFY21/22. Project recipients and highlights are noted below:

- North Colorado Health Alliance will establish a CDC-recognized Diabetes Prevention Program (DPP) that will be initially piloted and then expanded to serve the Region 2 population.
- East Philips County Hospital District will expand an already-existing CDC-recognized DPP program to a DSMES program recognized by the American Diabetes Association (ADA).
- Associates in Family Medicine will establish a DSMES program accredited by the Association of Diabetes Care & Education Specialists (ADCES).
- Peak Vista will onboard a tri-county's only registered dietician (RD) and have that dietician obtain certification as a diabetes educator.
- Wray Community Hospital District will continue an existing Diabetes Self-Management Training (DSMT) program.

### *Pregnancy*

NHP expanded on the pregnancy/maternity dashboard that was created during the previous year's PAC plan and looked for ways to expand data access and understanding. Among these efforts was the formalized data sharing agreement with Colorado Department of Public Health and Environment (CDPHE) to better understand rates of Cesarean-section (C-section) deliveries in Region 2. PAC deliverables centered around data sharing agreements, lessons learned, and an initial analysis of CDPHE data. The data analysis yielded several findings including:

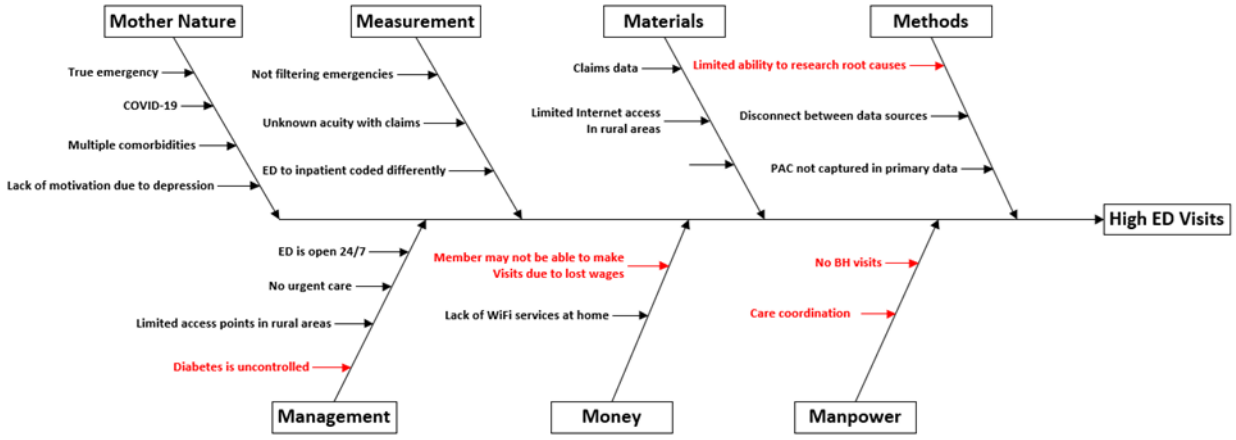
- The financial burden of delayed prenatal care is evident, leading to potential interventions that could be precluded by earlier prenatal engagement.
- Earlier prenatal care also provides greater opportunities to fully address other interventions shown to decrease the rates of preterm deliveries (e.g., pre-eclampsia).
- The clinical reasons for c-sections, particularly among first-time births, is not well understood; providing opportunities to collaborate with clinicians to further assess root causes and to develop targeted interventions.

### *Depression/Anxiety*

As mentioned in the previous year's PAC plan, NHP initially established a work group to develop a quality improvement initiative around diabetes with comorbid depression and anxiety, but the advent of COVID-19 did not allow for the work to be conducted. However, one resulting impact of those efforts was the need to gain better insight into the prevalence of the disease. This effort was rolled into the SFY20-21 PAC plan documenting the steps leading to a defined intervention. To better design an intervention, an analysis of the diabetes registry (a previous year's deliverable) was explored in connection with Prometheus data.[20] This Initial analysis showed:

- Statistically higher proportions of members with either depression alone or comorbid depression and anxiety having uncontrolled diabetes when compared to those with anxiety alone;
- No statistical difference between diabetes type for the three combinations of depression and anxiety (diabetes with depression alone, anxiety alone, or comorbid depression and anxiety), pointing to equal proportions of Type I and Type II diabetics across the three groups, but unequal proportions of members with controlled diabetes;
- Comparing ED costs and visits between members with Type I and Type II diabetes shows those with Type II diabetes had significantly higher average ED costs and statistically higher average ED visits than the Type I diabetics. These results indicate that Type I diabetics have a higher proportion of uncontrolled members, but the Type II diabetics account for a greater cost burden; and
- A need to partner with area hospitals to assess factors related to ED visits for members with diabetes and comorbid depression and anxiety.

Figure 9. Initial Ishikawa Diagram for Root Cause Analysis




[20] SFY20-21 Diabetes Milestone 3 PAC report submitted on June 30, 2021: *Steps to Establishing a Quality Initiative for Members with Diabetes-Depression-Anxiety.*

Table 12. t-Tests Results Comparing ER Counts and Costs

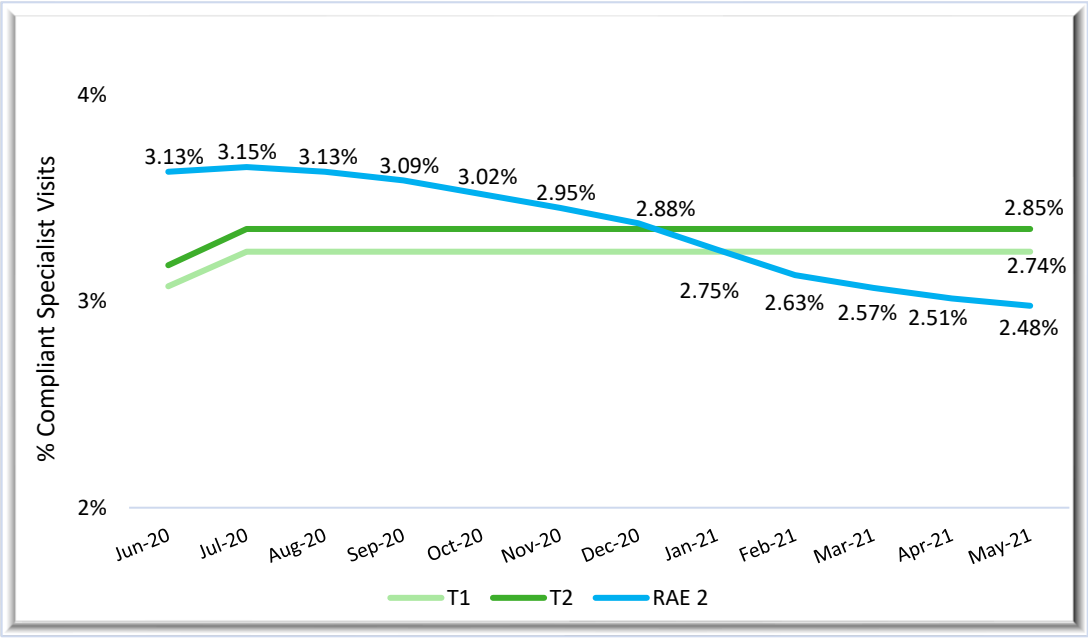
| | Anxiety | Anxiety & Depression | p-value |
|---|---|---|---|
| Average ED Cost | $319 | $513 | *p < 0.05* |
| Average ED Count | 1.9 | 2.96 | *p < 0.01* |
| | **Depression** | **Anxiety & Depression** | **p-value** |
| Average ED Cost | $289 | $513 | *p < 0.01* |
| Average ED Count | 1.43 | 2.96 | *p < 0.001* |

## Health Neighborhood

This is a measure that NHP had mixed results between the two requirements. As depicted in the table below, beginning in FY21 (July 1, 2020) NHP was meeting Tier 2 goals at the end of SFY19/20 and in the beginning part of SFY20/21 although with a slightly downward trajectory. The Tier 2 threshold was crossed in January of 2021, and the trajectory continued to decline throughout the fiscal year. This anomaly cannot be attributed to COVID-10 as performance was above the threshold several months after the advent of it. However, the reduction in office visits seen throughout COVID-19 may have impacted the ability to refer to a specialist within the specified time period.

The Care Compact aspect of this measure specifically saw a decline in performance, indicating a lower number of care compacts established or renewed within the region starting in July of 2020. Throughout SFY20/21, NHP revised its Care Compact initiative to focus on notifying PCPs which specialty providers that were serving a high volume of their attributed Health First Colorado members. In Q1-Q3, all PCPS identified for targeted outreach in this strategy received communications. Beginning in Q4, a personal check-in with those who had not completed a care compact was conducted with the intent of providing individualized support to practices in completing meaningful care compacts. However, on June 8, 2021, an announcement was made noting the Health Neighborhood measure, including care compacts, would not be continued in SFY21/22. Despite the discontinuation, outreach efforts to discuss care compacts were continued through the end of the fiscal year.

Figure 10. Health Neighborhood Performance (Compliance with Specialty Visits)[21]



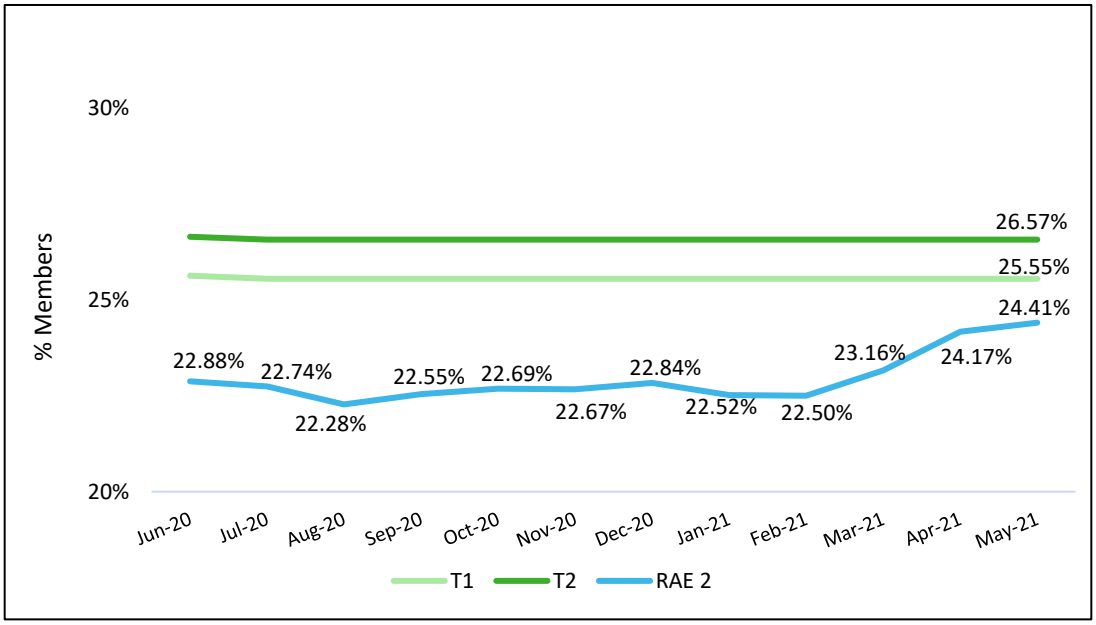

[21] Data extracted by Beacon Health Options from the Colorado Data Analytics Portal (CDAP).

## Well Visits, ED Visits, and Dental Visits

Well Visits and ED Visits were a topic of interest in SFY20/21 to understand barriers to achieving Tier 2 status. These two measures, however, took similar paths during the COVID-19 era, but with vastly different results. Volumes for both measures in addition to Dental Visits fell following COVID-19. As a result, ED visits met Tier 2 goals, but Well Visits and Dental Visits continued to fall below that threshold. These trends were largely due to COVID-19 fears, pandemic restrictions, limited availability for in-person appointments, and community efforts to limit exposure to the virus through lockdowns and social distancing requirements. In-depth analysis on barriers to achieving Tier 2 status was not conducted for two reasons. First, ED visits achieved this status and maintained it throughout the year. Second, the impact of COVID-19 was still evident at both the clinic and member-levels.

Interestingly, volumes for both measures began to increase starting in February of 2021, corresponding to the COVID-19 vaccine rollout and eased restrictions with the pandemic. Efforts to support these trends in SFY21/22 include targeted messaging to help continue driving these measures upward with vaccine availability and reduced restrictions. Among these targeted messages include dental visits, well visits, and annual vaccinations as part of back-to-school activities. Figures 11, 12, and 13 below illustrate performance on these three measures.

Figure 11. Well Visit Performance[22]




[22] Data extracted by Beacon Health Options from the Colorado Data Analytics Portal (CDAP).

Figure 12. ED Visit Performance[14]

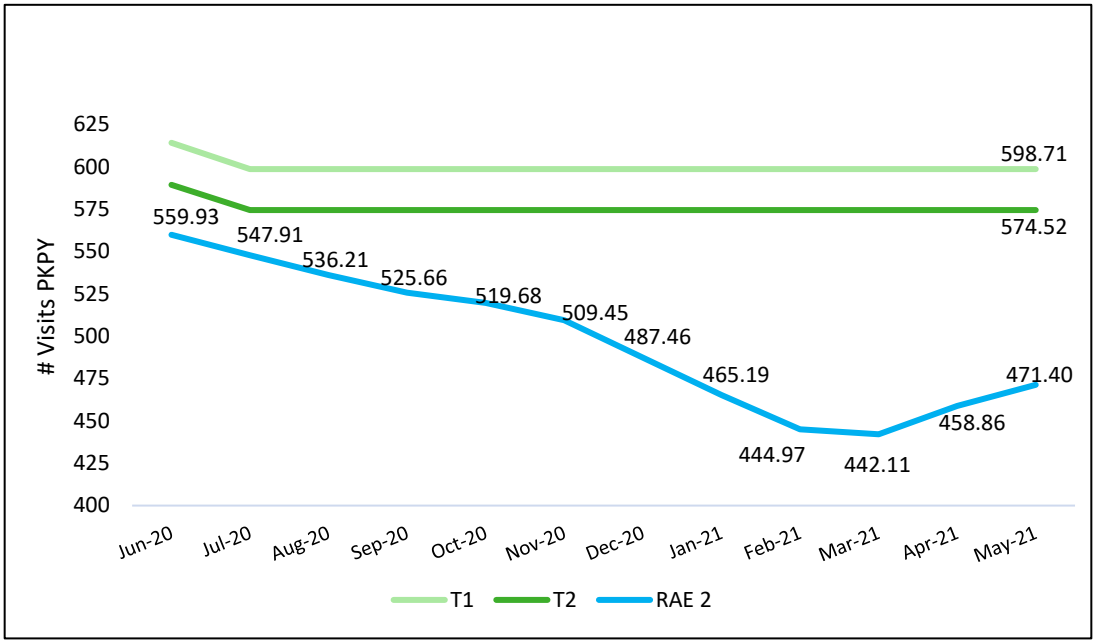
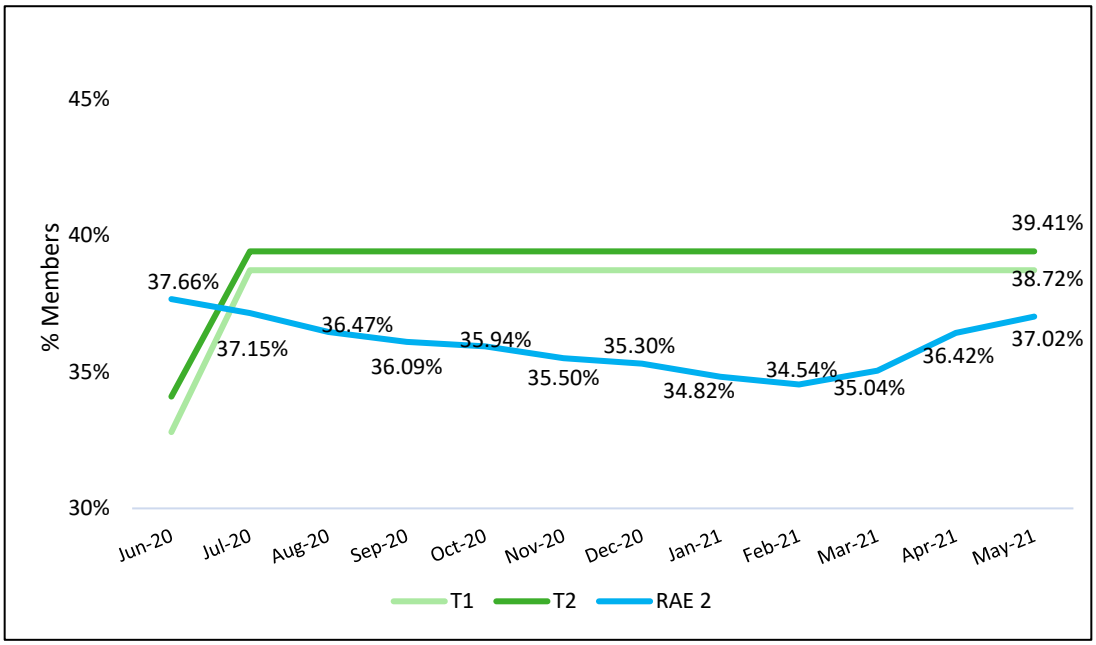



Figure 13. Dental Visit Performance[23]




[23] Data extracted by Beacon Health Options from the Colorado Data Analytics Portal (CDAP).

## Performance Pool

Performance Pool rates provided by the Department are included in the Key Metrics Table of this report. In SFY20/21, NHP met three of the seven metrics for both Quarter 1 and Quarter 2 based on internal calculations and anticipates maintaining that level of performance through the remainder of the SFY20/21 reporting period. Performance Pool data is provided by the state and has not yet been received at the time of this report. NHP anticipates meeting performance goals for:

- Extended Care Coordination
- BH Engagement for Members Releasing from State Prisons
- Inpatient Psychiatric Discharges

Inpatient Psychiatric Discharges is being removed from the SFY21/22 metric list, but efforts to maintain performance for Extended Care Coordination and BH engagement after being released from prison, in addition to expanded efforts around new performance metrics are outlined in the SFY21-22 Quality Plan.

### *Medication Adherence*

One of the key initiatives outlined in the SFY20/21 Quality Plan was to identify three Medication Adherence Measures, develop internal calculations, and track performance across time. The chosen measures were Antidepressant Medication Management, Pharmacy Quality Alliance: Portion of Days Covered: RASA, and All Classes, and Pharmacy Quality Alliance: Portion of Days Covered: Diabetes All Class. Two of these selections were removed from the Performance Pool measures for the SFY21/22 year. The SFY21/22 medication adherence measures are: Asthma Medication Ratio, Anti-Depressant Medication Management, and Contraceptive Care Post-Partum, and visual reporting is slated to start in October.

## Behavioral Health Incentive Program (BHIP)

The Behavioral Health Incentive Program (BHIP) for SFY 20/21 included the same five measures as the previous fiscal year: Substance Use Disorder (SUD) Engagement, 7-Day Follow-Up After an Inpatient Visit for Mental Health, 7-Day Follow-Up After an ED Visit for SUD, Behavioral Health Follow-Up within 30 Days After a Positive Depression Screen, and Behavioral Health Screen/Assessment for Members in Foster Care.

The timing of these incentive measures is important to note, as these measures are calculated by the state annually and we will not know our true performance until early 2022. Due to these annual calculations, NHP calculates these internally and shares performance updates on a quarterly basis through regional committees and meetings with key stakeholders. From this work, quality improvement initiatives can be identified, as well as data and reporting needs that provide meaningful insights to regional barriers and opportunities.

### *Follow-Up after a Positive Depression Screen in Primary Care*

To qualify for payout on this measure, NHP must have demonstrated that it billed for depression screens in at least 10.94% of all outpatient primary care visits. NHP performs very well on this measure. Clinics report high levels of screening, but low levels of coding to capture their effort through claims data. This topic, along with the screening measure, is the focus of the annual Performance Improvement Project (PIP).

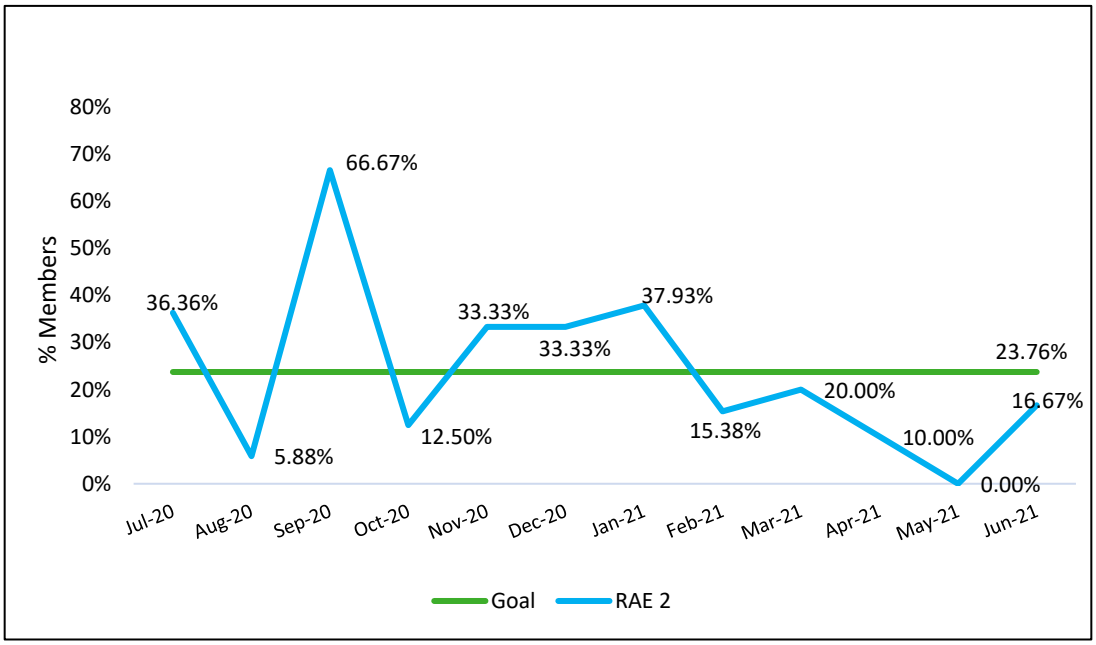
Efforts are underway at several sites to change coding/billing practices, and performance improvement efforts are underway to capture process variations across the region to determine more effective practices. Additional efforts have been underway to have personnel at high-performing sites give presentations on their practice's clinical workflows to better illuminate and potentially mirror effective processes at other clinics.

### *BH Screen/Assessment for Members in Foster Care*

NHP met the measure in 5 of the last 12 months with an upward trajectory in the early part of the fiscal year. However, one of the challenges with meeting this measure are low denominators (average of 10.5 in the past 12 months), and efficient processes that potentially have a negative impact due to timing of screening and foster care designation. NHP's

performance trends downward, but the denominators can easily impact monthly and rolling performance. Performance improvement opportunities may be found by exploring the timing between screening and a member's foster care status which will be explored in SFY21/22 under the Performance Measures Action Plan (PMAP). NHP's performance is charted below in Figure 14.

Figure 14. BH Follow-Up for Members in Foster Care[24]




### *SUD Engagement and 7-Day Follow-Up After an ED Visit for SUD*

Continuing to perform at or above the regional target for both Substance Use Disorder (SUD) metrics were noted in the SFY20/21 Quality Plan. SUD Follow-Up After an Emergency Department (ED) Visit for SUD performed very well during the 2020 fiscal year, meeting goals performance goals for three out of the four quarters, based on state calculations. However, performance peaked the third quarter of 2020, and performance fell below the threshold for the last quarter. This trend is directly related to the advent of Covid-19, having impacted most of the country in March of 2020 (SFY20 Q3). Current performance on this metric is unknown as the HCPF provides the calculation for the measure.

SUD Engagement, on the other hand has largely trended along the target for the last quarter, albeit slightly below the threshold. Interestingly, this metric was not impacted by pandemic; remaining relatively stable throughout the year. This is important to note in that while most clinics and were limiting appointment availability resulting in performance drops (well visits and dental visits as two examples), outpatient services for SUD were able to maintain their performance and even exceeded the threshold for the 4$^{th}$ quarter. Telemedicine may have played a critical role in maintaining performance for outpatient SUD services.

Performance on the two SUD measures are captured below in Figures 15 and 16.

[24] Internal calculation from Beacon Health Options.

Figure 15. 7-Day Follow-Up After an ED Visit for SUD[25]

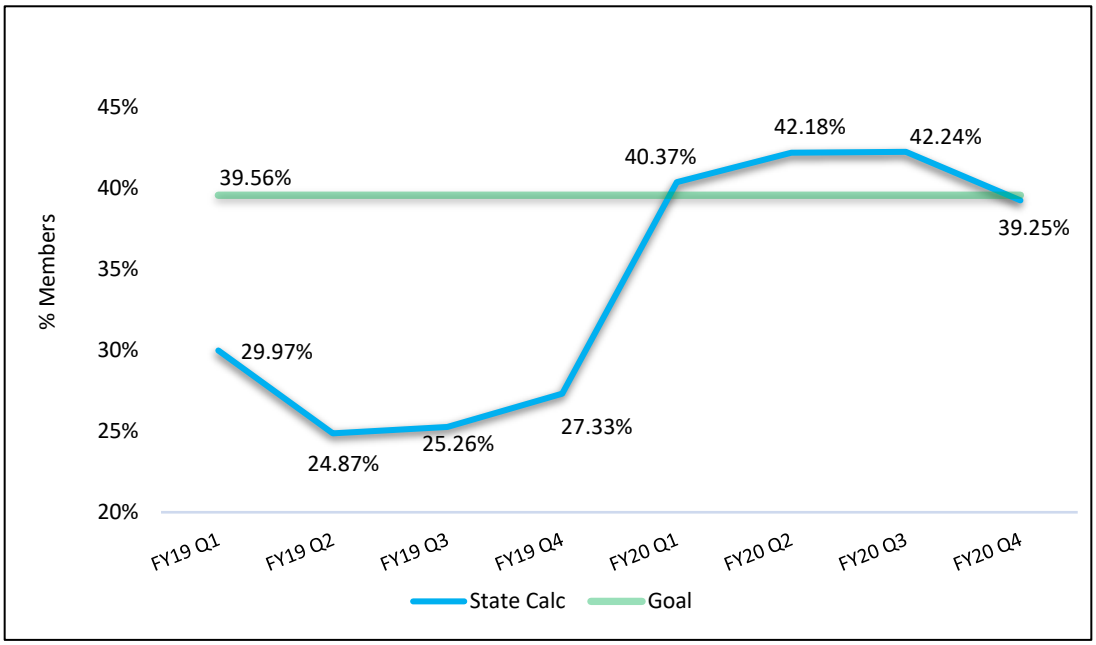
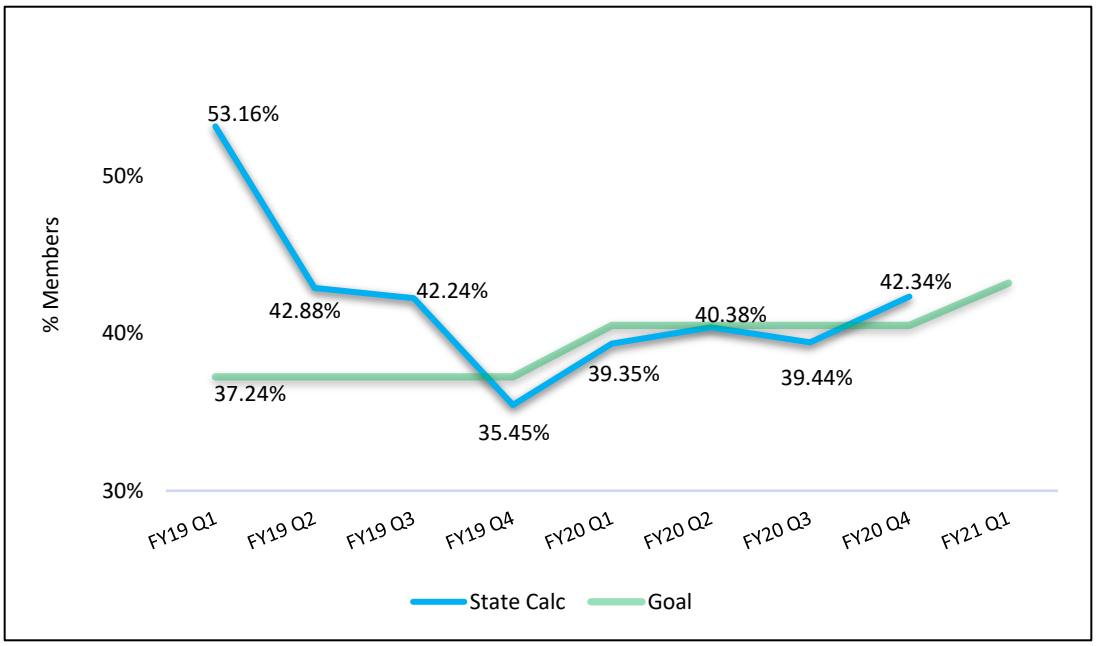



Figure 16. SUD Engagement[26]




## Performance Improvement Projects (PIPs)

NHP's Performance Improvement Project (PIP) was initiated in SFY20/21and will be finalized in SFY21/22 following a pause in the program directed by the Department due to competing priorities during the onset of the National Health Emergency (i.e., COVID). At the direction of the department, NHP began work on a PIP that addressed Behavioral Health Follow-Up

[25] This measure is calculated by the state and runs behind due to claims lag.

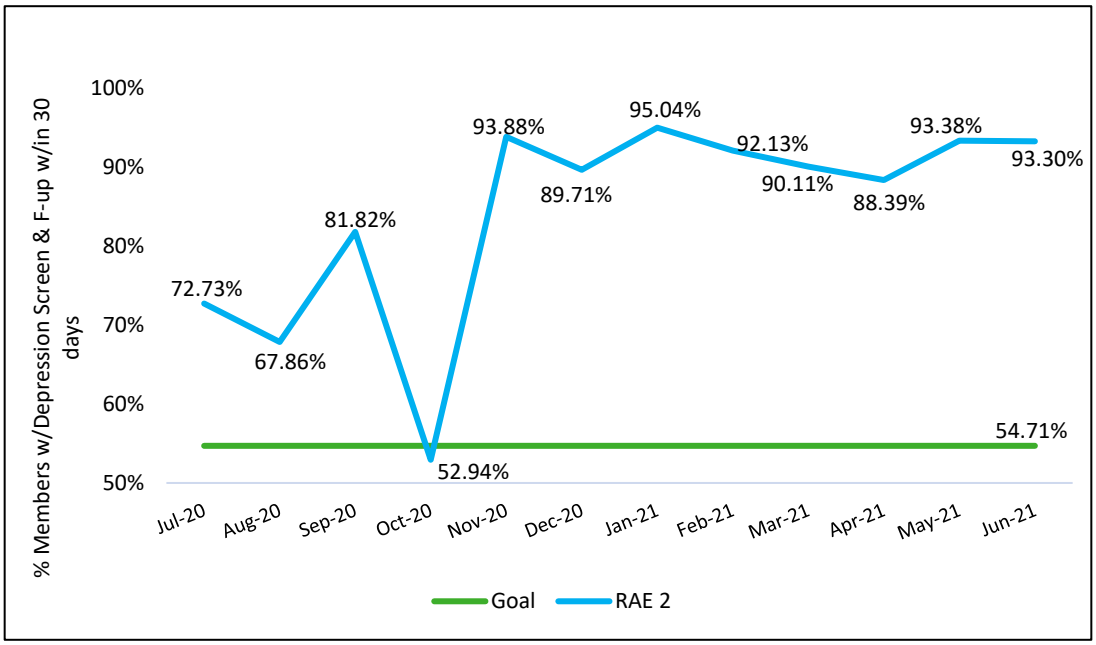
[26] Internal calculations matching the state calculations has been ongoing, and accuracy was achieved in Quarter 1 of SFY9/20.

after a Depression Screen in Primary Care, and measurement specific to this PIP aligned with the BHIP measure. Performance on this measure can be found in Figure 17.[27]

The focus of the current PIP is increasing depression screening and increasing mental health engagement after a positive depression screening. To improve access to behavioral health care, Northeast Health Partners (NHP) will target depression screening in primary care and subsequent behavioral health follow-up as its PIP. The effort will aim to increase the rate in which a provider in NHPs region complete and bill for a depression screen at members' annual well visit, as well as ensure any positive depression screen has a timely mental health service. This topic with the two (2) embedded measures was mandated by the Department. To select an appropriate size and scope practice for this program, a narrow focus provider was recruited: Sunrise Clinic (Monfort Family Clinic).

The team successfully wrote objectives for each measure and the Module 1 submission was accepted by HSAG. Subsequently, the team created process maps for both the screening measure and the follow-up measure, identified failure modes, and associated key drivers for success. These were described in the Module 2 submission that was also accepted by HSAG. The team started the current fiscal year seeking approval for the proposed interventions and Module 3 was approved by HSAG on September 15th to begin intervention testing.

**Figure 17. Depression Screening Follow-Up[28]**




## Telemedicine Services Across Performance Measures

Another key initiative outlined in the SFY20/21 Quality Plan was to assess telemedicine services across KPIs and incentive measures. The rise of the COVID-19 Delta variant is creating significant challenges in the healthcare industry. As such, the need to access and understand telemedicine services will be critical to ensure both access to service and reduced risk of exposure to COVID-19. Continuing this effort will be included in the SFY21/22 Quality Plan as we assess the impact of the Delta variant (and other potential variants) on service utilization and need.

[27] Follow-up performance exceeds the performance threshold, but NHP has not previously met the screening gate measure.

[28] Internal calculation from Beacon Health Options.

## 2020-2021 411 QuIP Results

NHP implemented a Quality Improvement Plan (QuIP) based on the 2020 411 QuIP Audit for Prevention and Early Intervention Service Encounters, Club House/Drop-In Service Encounters, and Residential Service Encounters. As noted in the audit, NHP's results varied across measures, but were improved following the implementation of targeted improvement activities between November of 2021 and January of 2021. Interventions included two Corrective Action Plans (CAP) and training on the technical requirements for documenting service codes. As a result, scores improved from baselines in every measure for each category except for Place of Service for Residential Service Encounters which fell from 86.1% at baseline to 80% after January of 2021. These results are captured below in Tables 13, 14, and 15.[29]

Table 13. Prevention/Early Intervention Service Outcomes

| Encounter Data Type Below 90% | Baseline | After Intervention November 2020 | After Intervention December 2020 | After Intervention January 2021 |
|---|---|---|---|---|
| Procedure Code | 16.8% | 80% | 80% | 60% |
| Diagnosis Code | 51.8% | 80% | 100% | 100% |
| Place of Service | 53.3% | 100% | 80% | 100% |
| Service Program Category | 49.6% | 80% | 80% | 60% |
| Units | 56.9% | 80% | 80% | 60% |
| Start Date | 57.7% | 100% | 100% | 100% |
| End Date | 57.7% | 100% | 100% | 100% |
| Appropriate Population | 57.7% | 100% | 100% | 100% |
| Duration | 57.7% | 80% | 80% | 60% |
| Allow Mode of Delivery | 57.7% | 100% | 100% | 100% |
| Staff Requirement | 57.7% | 100% | 100% | 100% |

Table 14. Club House/Drop-In Service Outcomes

| Encounter Data Type Below 90% | Baseline | After Intervention November 2020 | After Intervention December 2020 | After Intervention January 2021 |
|---|---|---|---|---|
| Procedure Code | 0.0% | 100% | 100% | 10% |
| Diagnosis Code | 47.4% | 100% | 60% | 100% |
| Place of Service | 47.4% | 100% | 60% | 100% |
| Service Program Category | 46.0% | 100% | 60% | 100% |
| Units | 46.7% | 100% | 100% | 100% |
| Start Date | 46.7% | 100% | 100% | 100% |
| End Date | 46.7% | 100% | 100% | 100% |
| Appropriate Population | 47.4% | 100% | 100% | 100% |
| Duration | 46.7% | 100% | 100% | 100% |
| Allow Mode of Delivery | 47.4% | 100% | 100% | 100% |
| Staff Requirement | 47.4% | 100% | 100% | 100% |

Table 15. Prevention/Early Intervention Service Outcomes

| Encounter Data Type Below 90% | Baseline | After Intervention November 2020 | After Intervention December 2020 | After Intervention January 2021 |
|---|---|---|---|---|
| Procedure Code | 14.6% | 100% | 100% | 100% |
| Place of Service | 86.1% | 60% | 40% | 80% |

[29] Northeast Health Partners. Quality Improvement Process (QUIP) Submission Form, Phase 2 (Submitted on March 12, 2021).

# Section 6: Member & Family Experience

## Member Satisfaction

Member and family experience was incorporated into the NHP QI Program through a number of activities that span across Beacon Health Options' Member and Family Engagement and Quality Departments, and the NHP QI Department.These activities were guided by member surveys, grievances and appeals, QOCs, and critical incident reporting.

### *CAHPS Survey*

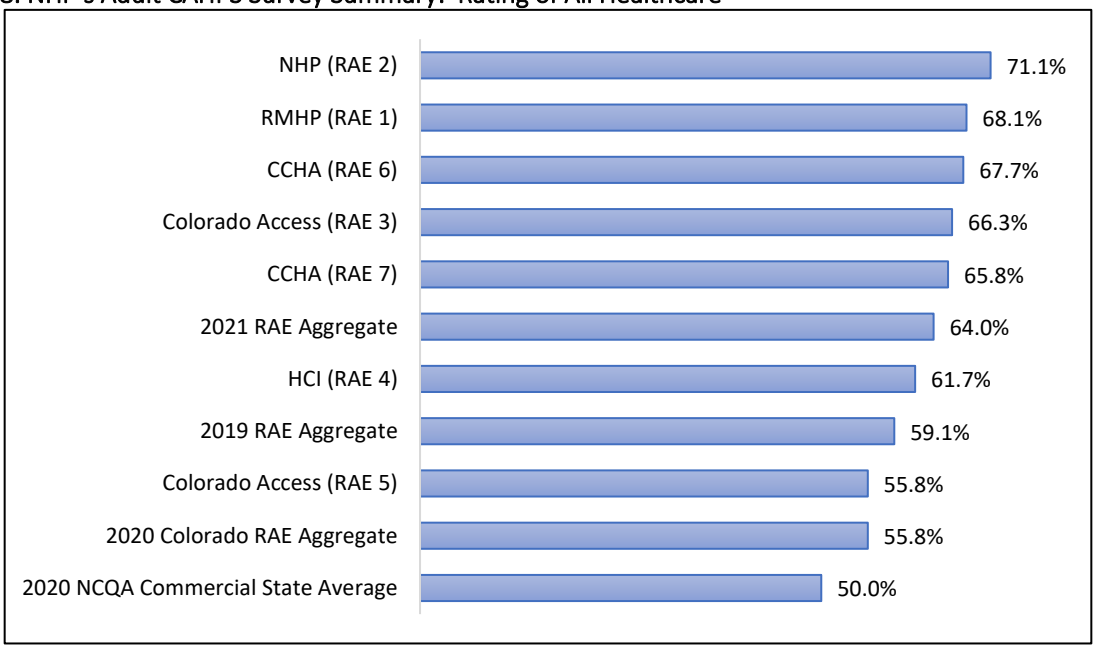
NHP utilized member experience data collected through the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey to develop specific resources and interventions that are specific to the documented experience of members. These opportunities were identified by NHP leadership with Beacon Health Options providing administrative oversight to any subsequent materials, trainings, oroutreach.

The CAHPS survey for adults showed the region was significantly higher than the ACC RAE aggregate scores on Rating of a Provider, Rating of all Health Care, Getting Timely Appointments, Care, and Information, Provider Customer Service:  Helpful, Courteous, and Respectful Office Staff, and Saw Provider Within 15 Minutes of Appointment. There was statistically significant improvement for Banner in rating of all health care, rating of health plan, and received health care and mental health care in the same place. NHP observed variation across the two providers included in the survey.

The survey for child members shows that RAE performance in two areas declined: Rating of Provider and Providers' Use of Information to Coordinate Patient Care. In addition, two areas were significantly lower than the ACC RAE Aggregate score on Rating of a Provider and How Well Providers Communicate with Parents or Caretakers.

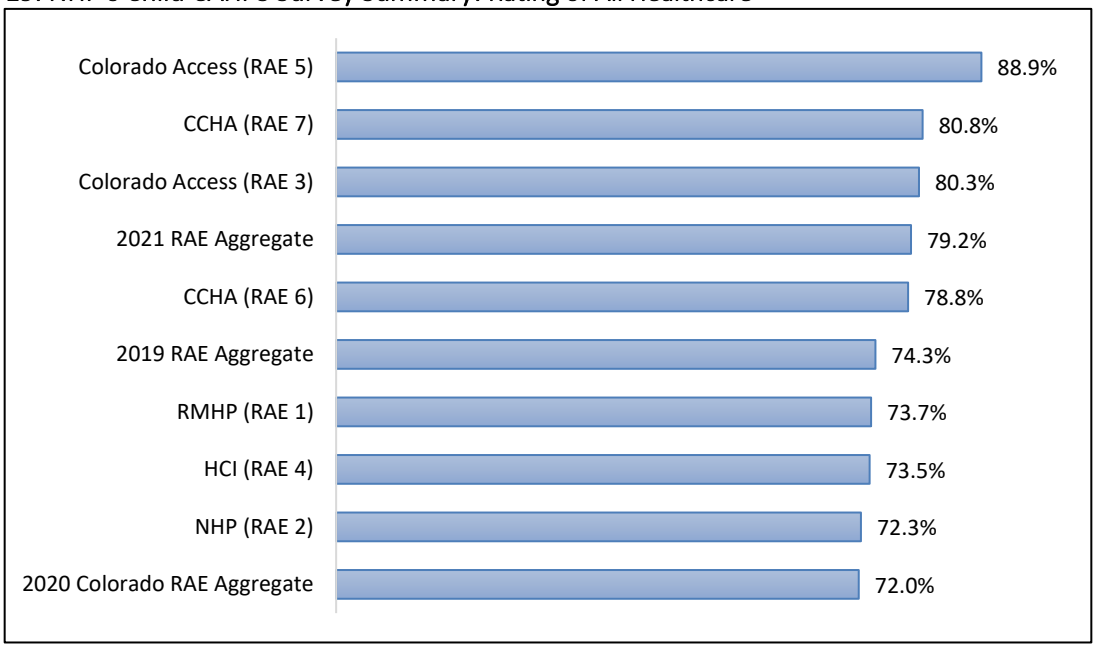
Performance charts for adults and children for Rating of all Healthcare are captured in Figures 18[30] and 19,[31] respectively. NHP intends to bring these survey results to regional committees to provide additional avenues for feedback that can help contextualize any noted improvements or opportunities presented by the surveys.

Figure 18. NHP's Adult CAHPS Survey Summary:  Rating of All Healthcare




[30] Colorado Department of Health Care Policy & Financing. *2021 Colorado Patient-Centered Medical Home Survey Adult Report.* August 2021.
[31] Colorado Department of Health Care Policy & Financing. *2021 Colorado Patient-Centered Medical Home Survey Child Report.* August 2021.

Figure 19. NHP's Child CAHPS Survey Summary: Rating of All Healthcare [32]




NHP reviewed this finding and learned that one provider surveyed is in the process of implementing online scheduling, a process that will include automated responses from the provider's office about upcoming appointments. In SFY20/21, NHP intends to bring these survey results to regional committees to provide additional avenues for feedback that can helpcontextualize any noted improvements or opportunities presented by the surveys.

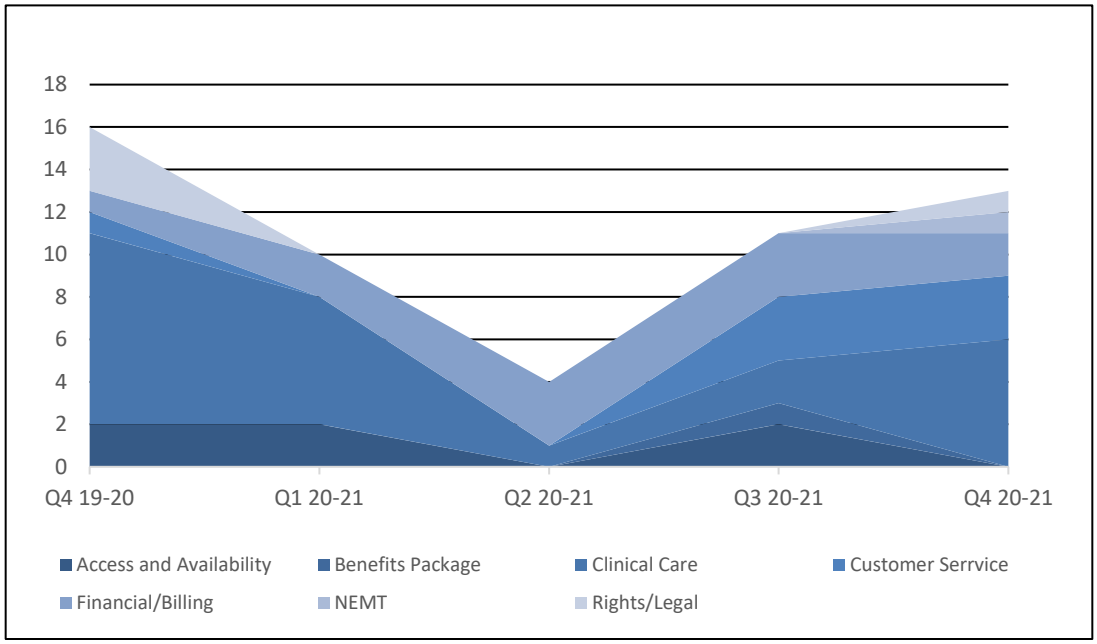
### *Grievances and Appeals*

Beacon Health Options, on behalf of NHP, processes and completes any grievances and appeals received. Data specific to both are tracked by Beacon Health Options and any identified trends are monitored and presented at regional committees on a quarterly basis. Overall SFY 20/21 saw fewer grievances than the year prior. There were 41 grievances filed compared to 49 filed in SFY 19/20. There were 16 Appeals requested for SFY 20/21. For the sixteen (16) appeals, twelve (12) denials were upheld (meaning services remained denied), one (1) denial was overturned (meaning services were authorized), two (2) denials were modified, and one (1) appeal was withdrawn.

In SFY20/21 NHP began charting grievances to better surface trends as seen in Figure 20 below. While the number of grievances and appeals remain low for NHP, there were several trends that emerged after the fourth quarter of SFY20/21. Billing errors were found to carry over from Q3 to Q4, and issues with clinical care grew from Q3 to Q4. Customer service was also noted as an issue since Q2 of SFY20/21. Education was given to providers in Q3, and more in-depth discussion is set for discussion in the Quality Management Committee Meetings around customer service and clinical care for performance improvement interventions.

[32] Colorado Department of Health Care Policy & Financing. *2021 Colorado Patient-Centered Medical Home Survey Child Report.* August 2021.

Figure 20. Grievance Trends for SFY20/21




### *Quality of Care Concerns*

Investigations of potential quality of care issues are conducted through the Quality Management Department, and findings are evaluated for appropriate follow-up, corrective action, and monitoring. Providers, NHP staff, or other concerned parties can all report quality of care issues, typically through an Adverse Incident reporting form submitted to the Quality Department. All Quality of Care issues are documented, as are results of investigations. Corrective actions are tracked and monitored. Reporting, investigation, and tracking of adverse incidents through the Quality Management Department continued during the past fiscal year and will continue with reporting to HCPF as required.

NHP received six (6) quality of care reports in SFY20/21 one of which resulted in a Corrective Action Plan (CAP) being required of the provider. These care-monitoring initiatives, along with treatment record reviews and training, are conducted with the goal of ensuring members receive the best care possible and will continue to be maintained by the Quality Management Department in FY22.

# Section 7: Hospital and Practice Transformation

The Hospital Transformation Program (HTP) was restarted on April 1 of 2021 after being placed on hiatus due to COVID-19. Applications were due at the end of April. NHP's region has 13 hospitals participating in the HTP program, 7 of which are part of an HTP consortium. With HTP efforts launching toward the end of SFY2021, these efforts are continuing into the SFY2022 year. Much of the early efforts will involve engagement, understanding various processes within individual hospitals, and process variations across the hospitals. This will help ensure consistent and streamlined activities across the region to better support hospitals in this initiative.

## Practice Transformation

The Practice Transformation (PT) initiative was also launched in SFY20/21. The PT program utilizes quality improvement tools to help individual practices achieve performance goals as measured by improvements in satisfaction, patient outcomes, and/or cost of care. The Practice Transformation initiative is built on a collaborative partnership between practices and Practice Transformation "Coaches." The PT program is structured in phases utilizing Bodenheimer's Building Blocks of High-Performing Primary Care.[33] Coaches work with practices to set goals around milestones and work together to achieve those milestones. Milestones included completing Practice Assessments for Quality, Developing a QI Strategy, Attending learning collaboratives, and completing a PDSA (Plan-Do-Study-Act) project. As a result, SFY20/21 achievements with the PT program include:

- 21 of 23 practices met the requirements for participating in the 2020 APM program; 18 practices participated;
- 13 of the 18 sites achieved all milestones;
- The practices have had a high level of engagement and have voiced appreciation for the program;
- Participating practices were able to learn about PDSA (Plan-Do-Study-Act) activities in the region through learning collaboratives as part of the PT program; and
- Practices voicing interest in continuing the program.

The PT program will continue in SFY21/22 and these efforts are captured on the SFY21/22 Quality Plan. These next year's activities build on the previous milestones to include Developing a QI Team, Establishing Rewards and Recognition around Quality, Collecting Patient Experience Surveys, Assessing Team-Based Care, and Utilizing Performance Visualization Tools.

[33] Bodenheimer T, Ghorob A, Willard-Grace R, and Grumbach K. 2014. The 10 building blocks of high-performing primary care. *Annals of Family Medicine, 12* (2): 166-171.