Annual Quality Report

State Fiscal Year 2023-2024

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 70,000 eligible members as of the end of state fiscal year (SFY) 2023/2024 (July 1, 2023 – June 30, 2024). NHP is the only nonprofit RAE with a designated 501(c)(3) status and was founded by four safety-net provider organizations serving the region: Sunrise Community Health, Salud Family Health Centers, North Range Behavioral Health, and Centennial Mental Health Center.

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 initiatives across physical health, behavioral health, and care coordination to ensure programmatic decision-making is data-driven, efficient, strategically aligned, and focused on continual improvement. This report summarizes the activities, deliverables, accomplishments, barriers, and major programmatic impacts within the NHP QI program through SFY23/24.

Report Changes

This report has few changes when compared to the previous year's report, but some changes were made to reflect the broadening scope of Quality Improvement work. The most significant change to the report is the inclusion of a health equity section to align with both the state and our own health equity strategy. It should be noted that this section only includes highlights of health equity activities and outcomes as detailed information around health equity activities are captured in a separate report.

In alignment to the health equity section, this report includes a more detailed analysis of demographic information. Previous reports noted age groups, gender, language, and county of residence for regional demographics, and this report includes more information around language, race, and ethnicity.

NHP Quality Improvement Program Overview

The Quality Improvement program creates and oversees regional activities focused on improving service delivery to regional members. In SFY23/24, the QI team met performance goals, provided contract deliverables on time, and expanded community collaborations to improve healthcare delivery for regional members. Carelon Behavioral Health continued to provide administrative support for the QI Program with oversight maintained by the NHP Director of QI, Dr. Brian Robertson. QI Program activities include the following components:

- External Quality Review Organization (EQRO) audits 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 Management Committee, the Quality Improvement/Pop Health Committee, and the Regional Program Improvement Advisory Committee (PIAC)
- Alignment of activities across population health, condition management, and member engagement
- Performance Measurement Action Plan (PMAP) and independent performance improvement (PI) activities
- Integration with NHP Population Health strategic planning efforts
- Integration with NHP Health Equity strategic planning efforts

Pandemic Impact of Quality Indicators

The pandemic officially ended during the SFY22/23 year, but the impacts of the pandemic continue to ripple across years. Notably, enrollment plummeted from an all-time high of about 114,000 members to a near all-time low of less than 75,000 members. As the state's smallest RAE, performance rates become more sensitive to fluctuations with smaller populations. However, with the ease of the pandemic and the close of the PHE, we are seeing several performance rates return to pre-pandemic levels.

Department Structure, Committees and Regional Quality Meetings

Quality Management Committee and Quality Improvement/Population Health Committee

NHP developed two quality committees in September of 2020, and has been holding these committee meetings bi-monthly on alternating months since that time. The Chief Clinical Officer (CCO), Dr. Mark Wallace, continues to chair the Quality Improvement and Population Health Committee with co-chaired support provided by the Director of Quality Improvement. Alternatively, the Quality Management (QM) Committee is chaired by the Director of Quality Improvement and is co-chaired by the CCO.

These two committees include administrators and clinicians from physical and behavioral health groups and community-based organizations from across the region. Topics of discussion in these meetings were focused on performance measurement reviews, performance improvement opportunities, focused messaging to members and public health campaigns, grievances and appeals, population health initiatives, health equity, clinical support work such as the Practice Transformation (PT) and the Hospital Transformation Program (HTP), and other topics of interest from Health Care Policy & Financing (HCPF). One of the key focus areas of SFY23/24 was Phase III of the Accountable Care Collaborative (ACC Phase III).

Performance Improvement Advisory Committee (PIAC)

The regional Performance Improvement Advisory Committee (PIAC) is an avenue for members' voices and perspectives to be incorporated into regional quality initiatives. Chaired by the Director of Quality Improvement and Co-Chaired by the regional representative at the state PIAC, the regional PIAC met quarterly in SFY23/24. Voting membership includes active health neighborhood partners and regional Medicaid members. In alignment to the two quality committees mentioned previously, topics of discussion included reviews of performance measurement, performance improvement opportunities, targeted messaging and public health campaigns, grievances and appeals, population health initiatives, health equity, clinical support work such as the Practice Transformation (PT) and the Hospital Transformation Program (HTP), and other topics of interest from Health Care Policy & Financing (HCPF) such as ACC Phase III.

First Fridays Quality Forum

Is a community forum chaired by the Director of Quality Improvement where our community partners which include providers, clinicians, medical staff, community members join once a month to collaborate, focus on improvement, share resources and identify any barriers within our region. We work as a collaborative approach to improve the overall sustainability, health and wellbeing of our region.

Key Metrics Table

Key metrics and results are noted below in Table 1. This table shows performance goals for the fiscal year, most recent performance rates, and performance for the previous fiscal year to show year-over-year performance changes.

Table 1. Key Metrics Table

Key Performance Indicators (KPIs)[1]	SFY23/24 Goal[2,3]	SFY23/24[4]	SFY22/23
Depression Screen & Follow-up Plan	24.12%	18.23%	N/A
Dental Visits	51.16%	51.75%	48.68%
Well Visits (0-15 Months)	60.02%	56.87%	56.02%
Well Visits (15-30 Months)	55.11%	62.15%	59.24%
Well Visits (3-21 Years)	37.36%	39.73%	35.28%
Timeliness to Prenatal Care	59.74%	61.47%	N/A
Timeliness to Postpartum Care	45.68%	62.15%	N/A
Risk-Adjusted PMPM[5]	N/A	N/A	$409.49
Emergency Department (ED) Visits	610.26	654.78	622.03
Performance Pool	**SFY23/24Goal[6]**	**SFY23/24[7]**	**SFY22/23[8]**
Extended Care Coordination (ECC)[12]	81.76%	-	89.22%
Pre-Mature Birth Rates	10.95%	10.11%	8.30%
BH Engagement for Members Releasing from State Prisons (DOC)	23.90%	-	31.64%
Asthma Medication Ratio	49.03%	51.45%	46.18%
Anti-Depressant Medication Management (A)	64.20%	68.72%	69.43%
Anti-Depressant Medication Management (B)	42.56%	42.45%	43.26%
Contraceptive Care for Postpartum Women	34.53%	25.91%	40.86%
Behavioral Health Incentive Program (BHIP)	**SFY23/24 Goal[9]**	**SFY23/24[10]**	**SFY22/23[11]**
Substance Use Disorder (SUD) Engagement[12]	11.17%	-	11.62%
7-Day Follow-Up After an Inpatient Visit (MH)	24.93%	43.9%	21.62%
7-Day Follow-Up After an ED Visit for SUD	23.49%	27.1%	20.65%
BH Follow-Up After a Positive Depression Screen in Primary Care	84.83%	53.9%	83.84%
Gate measure: Depression Screen Claims Volume	45.50%	27.0%	10.82%
BH Screen/Assessment for Members in Foster Care	18.08%	13.0%	14.38%

Key Accomplishments in SFY23/24

NHP has had several accomplishments throughout the year. These accomplishments and activities are noted below in

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

[2] Goals reflect either the Tier 1 performance targets or the final quarterly target.

[3] Colorado Health Care Policy & Financing. KPI SFY23-24 Baselines and Targets.

[4] Results are based on the most recently available data and are not reflective of the full fiscal year due to data delays.

[5] Goals are based on a HCPF average and are not known. Results are based on Q4 performance.

[6] Colorado Health Care Policy & Financing. Regional Accountable Entity Performance Pool Specification Document: SFY 2023-2024. Version 4.

[7] State-calculated fiscal year Performance Pool Measures are expected in December. Rates are reflective of the most recent calculations.

[8] Colorado Health Care Policy & Financing. *SFY23 FINAL PERFORMANCE V2.*

[9] Regional Accountable Entity Behavioral Health Incentive Specification Document: SFY 2023-2024. Version 3. November 1, 2023.

[10] BH Incentive measures are delayed due to a 90-day claims runout. Data represent estimates based on internal calculations through May of 2024.

[11] Colorado Heath Care Policy & Financing. Regional Accountable Entity Behavioral Health Incentive Program Specification Document, FY 2024-2025. Version 1. June 12, 2024.

[12] This measure is still being calculated internally.

Table 2 and are broken down by project initiative.

Table 2. Key Accomplishments from SFY23/24

Project	Accomplishments
Key Performance Indicators	• The Dental visit KPI was met for the first time since before the COVID-19 pandemic • Well Visits were met for the first time since before the COVID-19 pandemic • New measures (prenatal and postpartum timeliness) were met starting in Quarter 2 • We maintained our position as having the lowest Risk-Adjusted PMPM in the state
Performance Improvement	• Dental rates are 40% higher • Well Visits for members aged 0-15 months improved by 30% since Q1 SFY22 • Well Visits for members aged 15-30 months improved by 30% since Q1 SFY22 • Well Visits for members aged 3-21 years improved by 29% since Q1 SFY22 • Timeliness to Prenatal Care improved by 10% between Q1 and Q2 • Timeliness to Postpartum Care improved by 10% between Q1 and Q2 • Coding "tip sheets" were developed to help simplify specification documents • Assessed ED acuity using CPT codes
Practice Transformation	• Continued milestone alignment to performance measures • Maintained Behavioral Health Practice Transformation and added two new clinics to participate in the program
Hospital Transformation	• Implemented a data transmission process for hospitals to send data to the RAE if they were not connected to Contexture • Enhanced the data transmission process by developing a secure portal for data transmissions • Providing training to regional partners on the portal • Started receiving test data from Contexture
Behavioral Health Incentives	• Scores will not be finalized at the time of this report's submission, but we anticipate reaching goals for SUD Engagement, Follow-Up After an ED Visit for SUD, and Follow-Up After Positive Depression Screen
Performance Pool	• Scores will not be finalized at the time of this report's submission, but we anticipate reaching goals for Extended Care Coordination, Preterm Birth Rate, Asthma Medication Management, Behavioral Health visit after Department of Corrections Release, and Contraceptive Care
411 Audit	• Overall, scores of 95%, 94%, and 99% were received on the 411 audit. • Only one section fell below the 90% threshold and required a QUIP in SFY25 • A QUIP was not required in SFY24
PIP	• Implemented both of the State's PIPs. • We started receiving Social Determinants of Health (SDOH) data from the region's two CMHCs. • Identified regional hospitals to develop process mapping exercises for process improvements on the follow-up after an ED visit for Substance Use Disorder.
Clinical Documentation Audits	• 94% of all audits received passing scores
Quality of Care	• Increased the frequency of meetings to accommodate grievance reviews into the QOC process

Key Initiatives for SFY23/24

NHP has several key initiatives for SFY23/24 based on previous performance, key successes, and new initiatives. These initiatives are noted below in Table 3 and are discussed in more detail in the SFY23/24 Quality Plan.

Table 3. Key Initiatives for SFY23/24[13]

Project	SFY23/24 Goal / Activity
411 Audit	• Continue to maintain high inter-rater reliability with HSAG over-reads • Successfully pass the 411 Audit without receiving a QUIP • Solid audit results and an over read agreement rate ranging from 90-100%
All performance measures	• Continue reporting on regional performance across quality committees • Continue aligning Practice Transformation activities to impact KPIs and BHIP measures ▪ Maintain huddles with clinics and hospital consortiums within our region • Assess performance across demographic groups in alignment with the Health Equity Strategy • Develop targeted interventions for equity disparity gap closures in partnership with the regional Health Equity Committee • Update tip sheets for providers to help with coding practices and to quickly understand performance measures • Pilot HDMS Enlight as a real-time performance measurement and population health data platform • Expand HDMS Enlight to regional providers and administrators for performance visualizations • Support providers in receiving raw data on performance • Connect physical health providers and behavioral health providers to impact health outcomes on a system level
Behavioral Health Incentives Program Measures (BHIP)	• Improve performance on the Depression screening (Gate) measure and Follow-up for Positive Depression Screening measures • Achieve regional goals for the BH Screen/Assessment for children entering Foster Care • Improve performance on the ED SUD measure in alignment with the state PIP • Map processes at hospitals to collect and send Release of Information documentation for the ED SUD measure in alignment to the state PIP • Establish clinic-level performance improvement initiatives for lagging performance • Develop BHIP-specific balanced scorecards
Performance Pool (PP)	• Maintain the highest regional performance in Extended Care Coordination • Maintain a premature birth rate that is lower than the state average, the state Medicaid average, and the national average • Maintain strong performance in Department of Corrections (DOC) BH Engagement Measure • Meet regional goals for Asthma Medication Ratio • Meet Regional goals for Anti-Depressant Medication Management • Meet Regional Goals for Contraceptive Care Management • Establish clinic-level performance improvement initiatives for lagging performance
Key Performance Indicators	• Maintain the lowest rate among RAEs on the Risk-Adjusted Per Member Per Month (PMPM) measure • Meet regional goals for prenatal/post-partum care • Meet regional goals for well visits (all ages)

[13] This table is included in the Northeast Health Partners' SFY23/24 Quality Improvement Plan.

Project	SFY23/24 Goal / Activity
	• Maintain strong performance on the Risk-Adjusted PMPM Performance Measure • Continue meeting Dental KPI with DenTriage and DentaQuest • Continue sending DAP charts and action lists directly to practices to identify areas for improvement
Performance Improvement	• Facilitate bi-weekly meetings with our two largest FQHC and identified an area of improvement for depression screenings. A new workflow was developed for the practices as well as automation utilization for coding within the EMR Implement other targeted Performance Improvement activities to address performance barriers as needed • Implement performance "huddles" with practices
PIP (Performance Improvement Project)	• Improve performance over baseline for the clinical and non-clinical PIPs • Conduct process mapping exercises with regional hospitals to improve the capture rate of Release of Information documentation for SUD members released from the ED.
Quality of Care	• Continue current QOC committee meeting frequency and reporting. • Develop a new process workflow for QOC • Incorporate the new state auditing tool into documentation audits.
Practice Transformation Program (PT)	• Build on Practice Transformation work from SFY23/24 • Expand the Behavioral Health Practice Transformation program to include more practices participating in the program • Align milestone activities to performance measures better meet goals • Align PT activities with Value Based Payments • Disseminate eConsults information to practices
Hospital Transformation Program (HTP)	• As needed, continue to provide training to practices on how to send data to NHP if Contexture is not operational. • Build initial reports for internal analysis
Health Equity Alignment	• Align improvement activities to the Prenatal/Post-Partum, Prevention, and Behavioral Health workgroups in the Health Equity Committee • Establish new outreach strategies to improve communication and community connections to close disparity gaps across performance measures

Section 2: NHP Population Characteristics and Penetration Rates

Our regional membership underwent substantial change during the fiscal year, largely due to the drop in membership with the continued close of the Public Health Emergency. These changes are detailed below.

Enrollment Changes

The PHE continued to end during the fiscal year, which had tremendous impacts to the enrollment and attribution. Enrollment peaked during the fiscal year in August with 104,000 members and fell almost 30% to a low of less than 74,000 by the end of the fiscal year. By the end of SFY23-24, enrollment was lower than pre-COVID levels and a full 35% lower than our peak enrollment of over 114,000 members in April of 2023. Membership trends are detailed below in Figures 1 and 2.

Figure 1. Enrollment by Month, SFY23/24

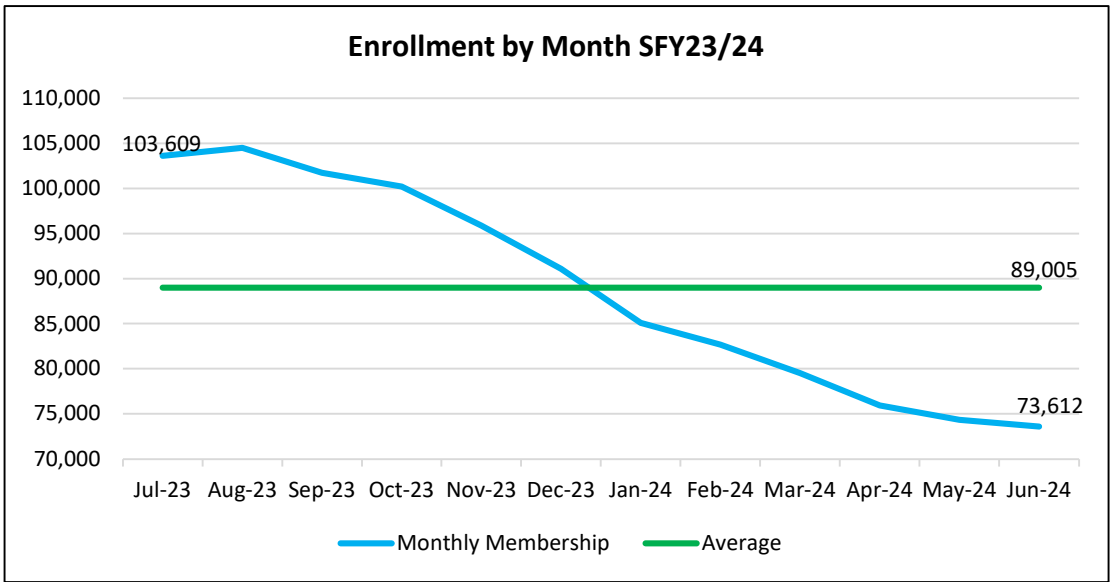
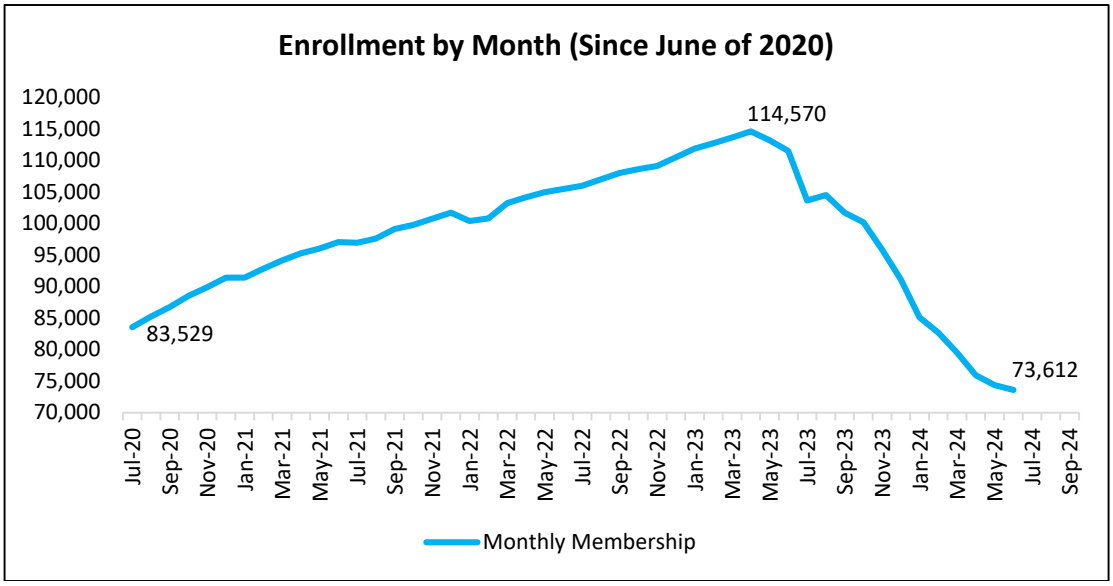


Figure 2. Enrollment by Month, since June of 2020



Demographic Characteristics

Member demographics have been relatively stable across years, but fluctuations were noticed in the past fiscal year due to the drop of membership. Specifically, we saw the biggest impacts in the percentage of members who were under 18 years of age. The percentage of members aged 0-12 years increased from 26% in SFY22/23 to over 30% in SFY23/24, and the number of children aged 13-17 years increased from 11% in SFY22/23 to over 13% in SFY23/24.

The PHE unwind reduced the number of members across all age groups. However, children under the age of 18 were not impacted at the same rates as older members. For example, the total number of members ages 0-12 years dropped from 27,472 in SFY22/23 to 21,757 in SFY23/24. This represents a 21% reduction in the total number of children covered under Medicaid in the region. The number of members aged 13-17 years fell by 18%, members aged 18-69 years fell by 38%, and members aged over 70 years fell by 52% across fiscal years.

Table 4. Regional Membership Demographics[14]

Age	Count of NHP Membership	% of NHP Membership
0-12	21,757	30.3%
13-17	9,509	13.3%
18-69	38,263	53.3%
70+	2,227	3.1%
Gender	**Count of NHP Membership**	**% of NHP Membership**
Male	32,656	45.5%
Female	39,100	54.5%
Other	0	0%
Race/Ethnicity	**Count of NHP Membership**	**% of NHP Membership**
American Indian/Alaska Native	346	0.5%
Asian	1,431	2.0%
Black/African American	1,873	2.6%
Hispanic/Latino	30,807	42.9%
Native Hawaiian	217	0.3%
Other People of Color	2,489	3.5%
Unknown	7,269	10.1%
White/Caucasian	27,324	38.1%
Total Enrollment	**71,756**	

Regional Distribution of Members

The membership distribution across the regional counties is found in Figure 2. Overall, little change was noted between SFY22/23 and SFY23/24. Weld county, the region's only urban county, continued to have the largest membership density of any county within the region. Morgan and Logan Counties, two rural counties within the region's borders, had the next highest population densities. Interestingly, Yuma, a frontier county within the region, had more Medicaid members than Washington, the region's only other rural county. This shift may be the result of multiple factors including population shifts, economic shifts, or fewer reenrollment applications being processed in Washington County.

Membership breakdowns are noted in both Figures 3 and 4. Figure 3 notes our regional membership density by county, and Figure 4 notes the numerical count by county.

[14] Slight variations in population and attribution counts are due to different datasets.

Figure 3. Regional Membership Distribution, by County

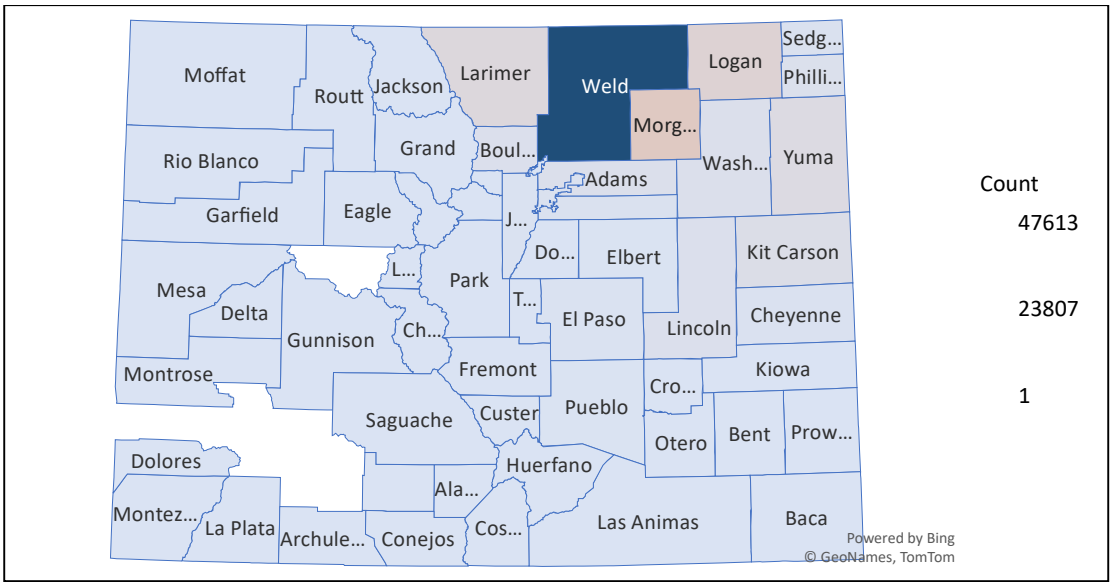
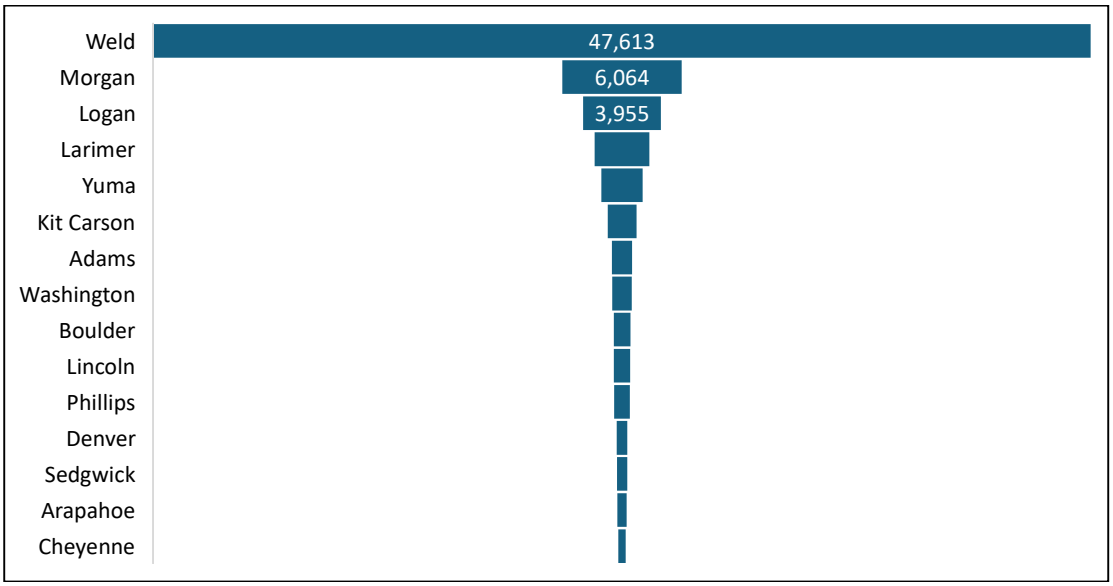


Figure 4. Membership Distribution by County.[15]



Behavioral Health Penetration Rates

Overall, behavioral health penetration rates improved since the previous fiscal year with an average penetration rate of 19.9% in SFY23/24. This rate represents a 14% improvement over the SFY22/23 penetration rate. Year-over-year improvement was also seen across all rate groups. The largest improvements were seen for those coded as Elderly (28% improvement), Adults with Dependent Children (18% improvement), and Children (11% improvement).

Additionally, we saw substantial increases in behavioral health penetration rates for all ethnicities in SFY23/24. Among demographic groups, the largest year-over-year improvements were seen for our Native American (43% improvement) population. This demographic was not noted in our previous year's report for behavioral health penetration but had the highest utilization rates of all demographic groups (27%).

[15] Unshown data points include Larimer County (2,801), Yuma (2,103), Kit Carson (1,478), Adams (1,042), Washington (999), Boulder (859), Lincoln (838), Phillips (810), Denver (552), Sedgwick (535), Arapahoe (496), and Cheyenne (392).

Much of the improvement in penetration rates are due to enhanced outreach and utilization of behavioral health platforms such as Wisdo, continued expansion of telemedicine platforms, and continued ease of COVID restrictions. Behavioral health penetration rates are charted below for Overall Rates (Figure 5), Rate Groups (Figure 6), Ethnicity (Figure 7), and Age Groups (Figure 8).

Figure 5. Behavioral Health Penetration Rates, Overall

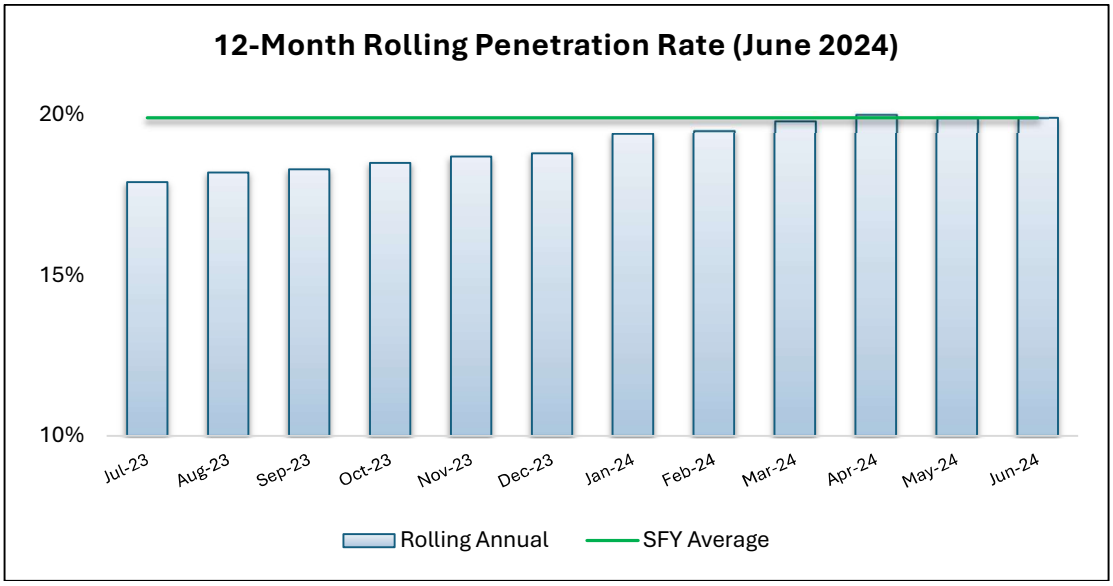


Figure 6. Behavioral Health Penetration Rates, by Rate Group

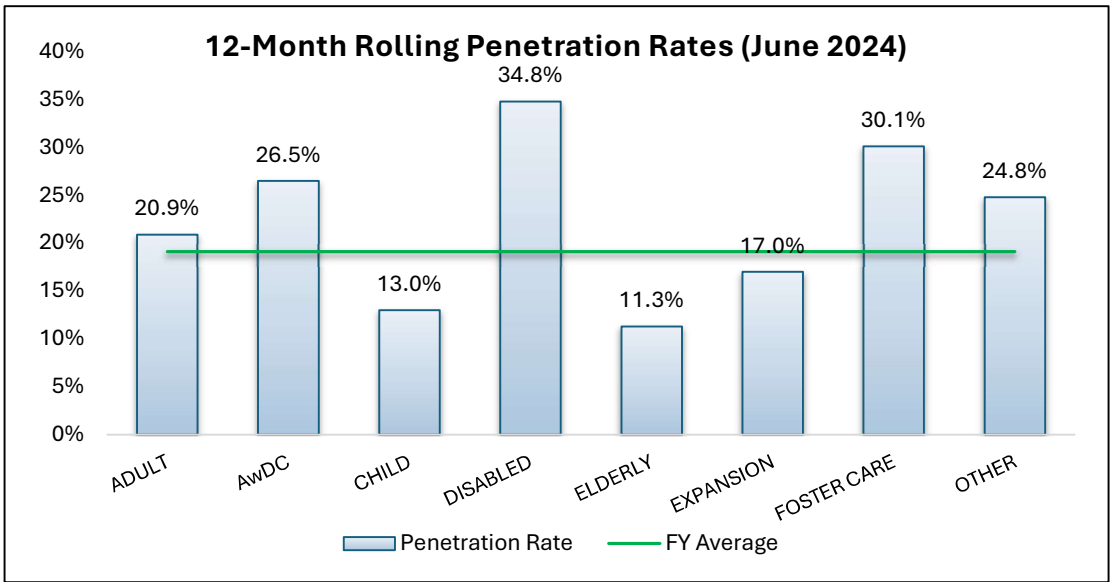


Figure 7. Behavioral Health Penetration Rates, by Ethnicity

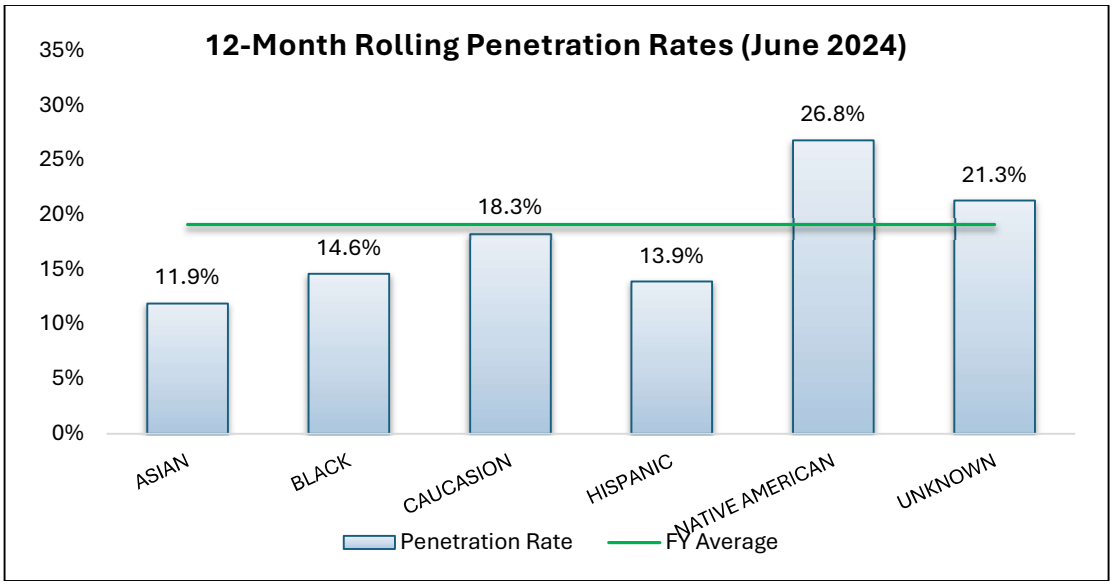
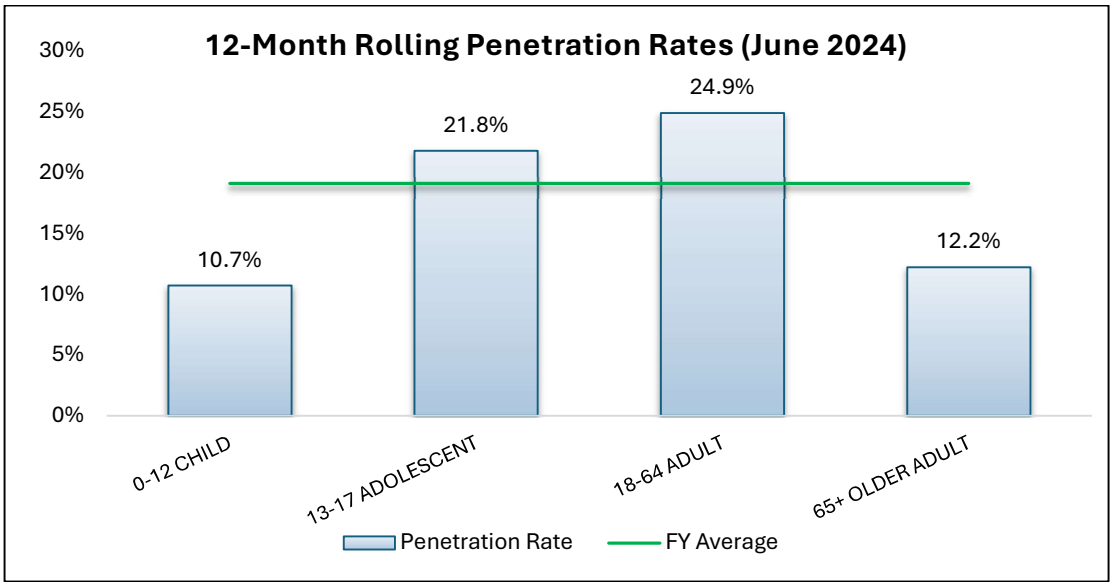


Figure 8. Behavioral Health Penetration Rates, by Age Group



Section 3: Compliance Monitoring

External Quality Review Organization Audit (EQRO Audit)

NHP participated in the annual compliance audit with Health Services Advisory Group (HSAG). The audit reviews 12 standards over a three-year cycle, and the following requirements were reviewed in the SFY23/24. Overall scores for each of these sections are found below in Table 5.

- Standard V: Member Information Requirements
- Standard VII: Provider Selection and Program Integrity
- Standard IX: Subcontractual Relationships and Delegation VI:
- Standard X: Quality Assessment and Performance Improvement

Table 5. EQRO Standards and Regional Performance

Standard	RAE Performance
Standard V: Member Information Requirements	100%
Standard VII: Provider Selection and Program Integrity	75%
Standard IX: Subcontractual Relationships and Delegation	50%
Standard X: Quality Assessment and Performance Improvement	100%

Summary of Required Actions and CAP Status

For the Provider Selection and Program Integrity standard, NHP met twelve of the fourteen requirements. Four of those requirements were found to be partially met. The required actions as a result of the audit include:

- Carelon is required to revise its policy to state that it does not discriminate against providers based on their license or certification. It also needs to include terms like "excluded, suspended, and debarred" in its policies to ensure it doesn't have any key personnel who are excluded from federal activities.
- NHP must revise the PCMP agreement to ensure healthcare professionals are not restricted from advising or advocating for their patients on various aspects of their health status, treatment options, risks, benefits, and the right to participate in decisions.
- While NHP can delegate some compliance activities, the strategy, monitoring, and oversight must be overseen by NHP itself. NHP also needs to improve its documentation of internal compliance monitoring procedures.
- For the Subcontractual Relationships and Delegation standard, NHP met two of the four requirements. Two of those requirements were found to be partially met.
- NHP is required to specify its oversight and monitoring process in its agreement with Carelon. This includes setting benchmarks and expectations for the tasks delegated to Carelon.
- NHP must also carry out continuous monitoring to ensure that Carelon meets these benchmarks and expectations. Furthermore, NHP needs to ensure that its delegation agreement aligns with its own policies and procedures.

At the time of this report's submission, HSAG has approved of NHP's corrective action plan and each of these actions are actively in progress.

Encounter Data Validation (411) Audit

Inpatient Services

As presented in Table 6, NHP observed a very high level of accuracy in the inpatient section of the audit. NHP netted accuracy scores between 95.2% and 100% percent.

Table 6. Inpatient Service Category Scoring Summary

Requirement Name	Service Category	Numerator	Denominator	Percent
'Primary Diagnosis Code'	Inpatient	123	137	89.8%
'Revenue Code'	Inpatient	137	137	100.0%
'Discharge Status'	Inpatient	131	137	95.6%
'Start Date'	Inpatient	137	137	100.0%
'End Date'	Inpatient	124	137	90.5%

Psychotherapy Services

As presented in Table 7, NHP observed a high level of accuracy in the psychotherapy section of the audit with an average score of 94.2%. NHP netted accuracy scores between 67.2% and 99.3%.

NHPs' strongest categories of performance, which all netted accuracy scores of 97.8%, were the following:

- Diagnosis Code
- Procedure Code
- Service Category modifier
- Unit
- Start Date
- End Date
- Appropriate Population
- Duration
- Staff requirement

One encounter category fell below the 90% accuracy threshold. This encounter category was Place of Service (POS). The common error found was related to the new POS rules surrounding use of the 02 versus the 10 place of service code; specifically, the information surrounding documentation of where the member was when the service occurred. Facilities that were found to fall below the established threshold will receive training on the new requirements. In addition, this requirement will become an additional focus on the quarterly documentation trainings.

Table 7. Psychotherapy Service Category Scoring Summary

Requirement Name	Service Category	Numerator	Denominator	Percent
'Procedure Code'	Psychotherapy	128	137	93.4%
'Primary Diagnosis Code'	Psychotherapy	135	137	98.5%
'Place of Service'	Psychotherapy	92	137	67.2%
'Service Category Modifier' (Procedure Modifier 1)	Psychotherapy	133	137	97.1%
'Unit'	Psychotherapy	136	137	99.3%
'Start Date'	Psychotherapy	135	137	98.5%
'End Date'	Psychotherapy	135	137	98.5%
'Appropriate Population'	Psychotherapy	136	137	99.3%
'Duration'	Psychotherapy	125	137	91.2%
'Staff Requirement'	Psychotherapy	136	137	99.3%

Residential Services

As presented in Table 8, NHP observed a very high level of accuracy in the residential section of the audit. NHP netted accuracy scores ranging from 97.1% to 100% across all ten of the encounter categories.

Table 8. Residential Service Category Scoring Summary

Requirement Name	Service Category	Numerator	Denominator	Percent
'Procedure Code'	Residential	137	137	100.0%
'Primary Diagnosis Code'	Residential	133	137	97.1%
'Place of Service'	Residential	134	137	97.8%
'Service Category Modifier' (Procedure Modifier 1)	Residential	137	137	100.0%
'Unit'	Residential	137	137	100.0%
'Start Date'	Residential	137	137	100.0%
'End Date'	Residential	137	137	100.0%
'Appropriate Population'	Residential	137	137	100.0%
'Duration'	Residential	137	137	100.0%
'Staff Requirement'	Residential	137	137	100.0%

Based upon the scores presented, NHP considers there to be a high level of validity and reliably between the submitted claims and encounters and the audited sample of a majority of the randomly selected charts for the measurement period of July 1st of 2022 through September 30th of 2023.

Improvement Opportunities

Improvement opportunities were noted as a result of the audit. These opportunities include:

- The updated audit tool should be continuously reviewed and edited for ease of use and accuracy.
- Inter-rater reliability (IRR) training has proven valuable, allowing for auditor substitution when necessary. This training will remain part of the audit preparation process.
- Provider training should be evaluated and enhanced, particularly focusing on areas of underperformance.
- A training should be created for providers to better understand and implement the correct place of service coding for telehealth services.
- Providers contributing to lower rates in the place of service category for psychotherapy encounters should be identified, and educational or corrective actions should be implemented as needed.
- Quality improvement projects aimed at clinical service delivery should be identified. This could involve requesting corrective action plans, deploying targeted training to providers, conducting chart audits, and tracking and trending results to inform future audits and training activities.

Provider Audits

The NHP QI Department conducts audits across care coordination, physical health, and behavioral health contract compliance. The QI program also collaborated with other Regional Accountable Entities (RAEs) and the Department of Healthcare Policy & Finance (HCPF) to standardize the outpatient mental health provider audit tools to create consistency for provider audits throughout the state. Details about these audits are outlined below.

Care Coordination Audits

NHP continued to utilize the model for care coordination split out for Accountable and Contributing providers. Accountable providers have 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. 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 and Peak Vista. In this SFY, Audits were conducted across three (3) care coordination entities: NCHA, Salud and Family Physicians of Greeley. (Peak Vista no longer contracted to be a care coordination entity in SFY23-24.)

The audit plan was similar to previous years with the tool simply revalidated with the most current Care Coordination and Opt Out Policies, both approved 7/1/23. In line with previous years, two (2) samples were audited for each entity where the first focused on the delivery of care coordination services and the second focused on appropriate documentation for members who opted out of services. The Care Coordination sample included four (4) sections:

- Assessment/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, and appropriate goal-setting.
- Care Coordination Evidence: Evidence displaying 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.
- COUP: Member education on the importance of contacting the Primary Care Medical Provider (PCMP) for non-emergent services and/or the Nurse Advice Line, if the member is on the Client Overutilization Program (COUP) list
- Policies and Procedures: All expectations related to the care coordinator's role, including required training, and communication/outreach requirements with members.

The first iteration of semi-annual care coordination audits for SFY23-24 occurred in August 2023 (Family Physicians of Greeley) and September/October 2023 (NCHA and Salud). The Family Physicians of Greeley audit was scheduled early to validate the full implementation of documentation templates associated with the Corrective Action Plan (CAP) in the previous SFY. No follow-up on the Corrective Action Plan issued to Peak Vista in April 2023 was needed as they did not provide care coordination services in SFY23-24. All three (3) entities successfully scored greater than eighty (80%) percent on each of the four (4) sections of the audit in addition to the Opt Out samples. Aggregate results were presented at the NHP Care Coordination meeting in October 2023. This briefing highlighted consistent strengths, opportunities, and provided recommendations to target areas of opportunity. The second iteration of audits occurred in April 2024 for all three (3) entities. All three (3) entities again successfully scored greater than eighty (80%) percent on each of the four (4) sections of the audit in addition to the Opt Out samples.

Behavioral Health Documentation Audits

NHP conducts ongoing and random behavioral health audits based upon standardized audit tools to evaluate quality of care and compliance with the Health First Colorado (Colorado's Medicaid Program) documentation rules. Audits include a review of encounters/claims against the chart documentation for claim validation. 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. HCPF requires NHP to evaluate the quality of care our members receive and the supportive documentation for claims. Where it is found that audit scores do not meet the minimum required threshold, NHP will educate the provider on deficiencies, offer training to the provider, require a corrective action plan (CAP) when warranted, re-audit the provider for continued improvement, and recoup funds if appropriate. In FY23-24, majority of providers passed with an overall audit score of 80% or better showing continuous improvement and expected to improve in FY24-25 as these audit activities will continue. To ensure consistency across Regional Accountable Entities

(RAEs) for documentation audit standards, NHP worked on a collaborative team to ensure all documentation requirements in the audit tool match the appropriate state and federal guidelines for documentation requirements. Provider treatment record documentation audits will continue quarterly, along with provider education in areas where scores indicate growth opportunities.

Education on the topic of Health First Colorado documentation standards was offered to providers throughout the fiscal year and will continue through the next fiscal year. The same Quality Improvement staff who conduct the documentation audits facilitated the educational forums. In addition to offering individualized documentation standards training to our providers, there were four large scale multi-provider training courses conducted by the auditors. Many providers had the opportunity to engage in specific discussions and ask clarifying questions about documentation standards. NHP has implemented provider-specific training via Zoom to offer further support and allow for a more personalized, agency-specific training experience for all staff. In addition to documentation training, auditors conduct educational audits to help providers understand how their documentation would be evaluated in an official audit. This process offers providers the opportunity to identify and rectify any potential deficiencies. NHP will continue these educational opportunities into FY24-25.

Substance Use Disorders Audits

In February 2024, Health Services Advisory Group (HSAG) completed their findings report for the SUD Denial audit. HSAG found that the Utilization Management (UM) team's documentation was not specific to "continued stay" or "transfer/discharge" criteria. Treatment plans were also not included in the clinical documentation that was submitted by the provider, nor included in UM documentation.

In response to HSAG's findings, the NHP trained the UM team on enhancing SUD documentation. This included treatment plan review and consideration when making determinations, as well as including full ASAM criteria, specifically "continued stay" vs "transfer/discharge" when reviewing authorization requests. NHP is also utilizing a dedicated Medical Director in an effort to improve consistency and understand 19 determinations and clinical documentation.

EPSDT Audit

In February 2024, Health Services Advisory Group (HSAG) completed a chart audit for Early and Periodic Screening, Diagnostic and Treatment (EPSDT). There were 3 components to the audit – a desk review of all our written materials, a sample of 10-15 post denial charts, and 10-15 non-utilizer charts.

Desktop Procedural Findings

NHP received a score of 92% for the desktop section, which detailed all Utilization Management (UM) and EPSDT policies and procedures, as well as EPSDT educational training materials. HSAG made the following recommendations:
HCPF to provide and require the use of an EPSDT checklist as a best practice to ensure all aspects of the EPSDT medical necessity definition is considered when determining medical necessity. NHP will implement any EPSDT checklist that HCPF provides.

- NHP to have explicit documentation of how the EPSDT definition was implemented throughout our records. NHP will provide additional trainings to our UM team of clinical care managers on the need to document the EPSDT medical necessity criteria that was considered in any capitated behavioral health treatment denial made for our EPSDT eligible members.

Post Denial Charts

NHP scored 67% on the post denial chart section. HSAG recommended that:

- HCPF work with RAEs to standardize the definitions of medical necessity denial and administrative denial. NHP will contact HCPF to participate in a meeting that addresses these definitions about administrative denials and will implement the recommendations.
- The RAEs to update the Notice of Adverse Benefit (NOABD) template to include all federal, state and contractually required information (e.g., appeal rights, clinical criteria used to make the denial determination) and to discuss

any concerns regarding readability requirements and HCPFs brand guidelines with HCPF. NHP will collaborate with HCPF to identify if there are plans for the state to standardize this template to maintain consistency for Health First Colorado members.

- HCPF may choose to expand the NOABD template to require the RAEs to include specific member next steps, including help with appointments and availability of transportation. NHP will implement any changes to the NOABD template to include the specific next steps for members.
- HCPF to consider defining a minimum expectation for care coordination outreach attempts, methods of outreach, and time frame the case should remain open to allow adequate time for a response from each outreach. NHP will look to HCPF for guidance on this minimum expectation. Additionally, NHP will discuss with care coordination agencies the expectations that additional time may be needed to follow up with referrals for care coordination related to a behavioral health denial.
- NHP to enhance its UM software capabilities and implementation of a more standardized and detailed way to document a secondary review of EPSDT, in addition to InterQual or ASAM, prior to issuing a denial. NHP will reeducate our clinical care managers to review and document EPSDT criteria in the CONNECTS system if the member is not meeting Interqual or ASAM criteria prior to reviewing with one of our medical doctors.
- NHP to update its UM procedures to include administrative denials (any denial, in whole or in part, of payment for a service that involves anything other than a clean claim issue) to ensure members are informed of decisions about their healthcare and informed of appeal rights. NHP has initiated contact with HCPF to confirm that all obligations regarding adverse benefit determinations are being met. HCPF has relayed that they are looking into this issue with HSAG and intend to organize a technical assistance call involving HCPF, HSAG, and the RAEs. NHP will remain engaged with this technical assistance call and implement any suggested recommendations.
- NHP considers the addition of a minimum time the care coordination case remains open in addition to its policy requirement three outreach attempts and at least two outreach modalities.

Non-Utilizer Charts

NHP scored 63% in the non-utilizer chart section. HSAG made the following recommendations as a result of the audit:

- HCPF explore additional new member outreach and assessment opportunities and consider requiring the RAEs to engage in additional assessment opportunities with special focus on members with special health care needs and high-risk scores. NHP will continue to collaborate with HCPF on creative ideas and opportunities.
- HCPF to clarify report specifications regarding what counts as "successful" for mailing, phone, IVR, text, email, and other commonly used methods of outreach. HCPF recently updated their EPSDT quarterly reporting template which has identified new definitions of successful. NHP will follow the new report specifications in reporting our outreach attempts.
- NHP to review and further adapt its assessment tools to ensure the member/parent/guardian has ample opportunity to communicate any healthcare needs. NHP will evaluate additional assessment tools to utilize to enhance members' opportunities to communicate their healthcare needs.
- NHP to administer quality checks both internally and with the texting vendor to ensure consistent outreach is occurring to the non-utilizer members, including when the first outreach attempt is unsuccessful. NHP is working with our data team to ensure that our texting vendor has household identifier numbers so that multiple outreaches can be made to various family members that need well visit reminders. NHP is devising a strategy to reassess the outreach lists to identify members who were not successfully contacted through IVR during the previous reporting period, due to reasons such as no answer, a busy signal, or abrupt hang-ups. If these non-utilizing members continue to appear on our database as not having attended a wellness or dental visit, NHP plans to reattempt outreach using our IVR system. This tactful approach ultimately ensures that no member is overlooked, and all members receive complete outreach for their essential healthcare needs.

Quality of Care Grievance Audit

Health Services Advisory Group, Inc. (HSAG) conducted a Quality-of-Care Grievance (QOCG) audit in an effort to understand complaints about potential quality of care issues and to gather information regarding the processes for addressing QOCGs. A total of nine (9) QOCG cases were reviewed by HSAG during the audit, and the results of the audit are still pending.

The Center for Medicare and Medicaid Services (CMS) definition of a QOCG is:
A type of grievance that is related to whether the quality of covered services provided by the health plan or provider meets professionally recognized standards of health care including whether appropriate health care services have been provided in appropriate settings. Examples of a QOCG included in any instances where an enrollee infers or states that they believe they were misdiagnosed, treatment was not appropriate, and/or they received, or did not receive, care that adversely impacted or had the potential to adversely impact their health.

Section 4: Performance Improvement

Key Performance Indicators (KPIs)

Overall, KPI performance has improved over the past few years and continued to improve in the SFY23-24 fiscal year. Notably, Well Visits and Dental Visits were both met for the first time since the start of the COVID-19 pandemic. With continued efforts to meet one-on-one with practices to identify coding supports, performance improvement activities, and strategically aligning activities across programs, we anticipate continued success in reaching performance goals.

Well Visits

We saw significant improvement in well visit rates over the past few years with nearly 30% improvement across the three measures over the past two years. Much of this success is due to targeted outreach and communications with community members. Notably, many practices are encouraging well visits in lieu of sports physicals which has impacted both well visit rates and vaccination rates in those communities. Performance rates for well visits can be found in Figures 9, 10, and 11.

Figure 9. Well Visit Rates for Members Aged 0-15 Months

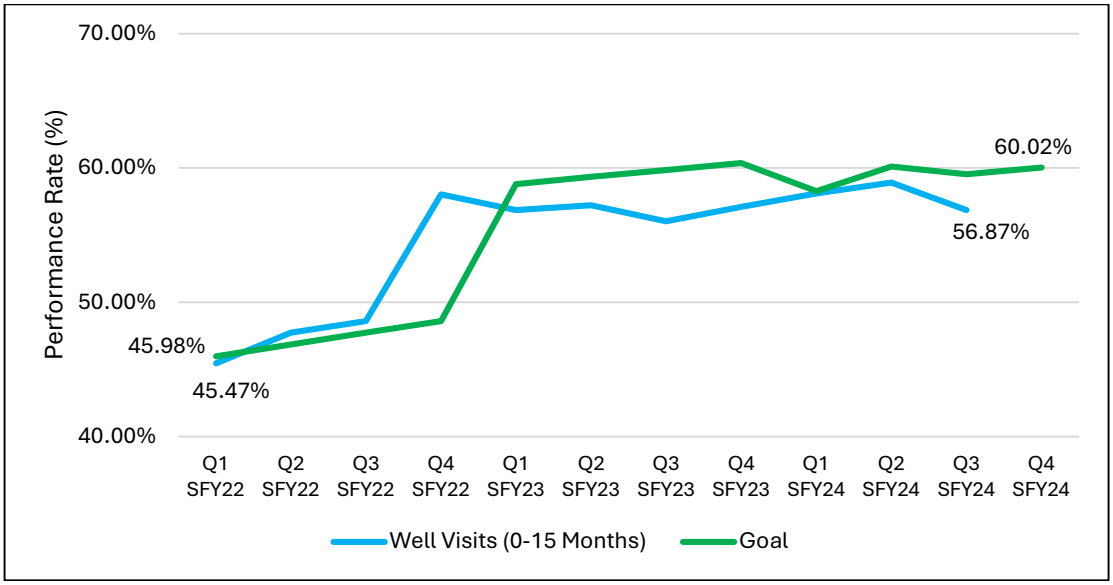


Figure 10. Well Visit Rates for Members Aged 15-30 Months

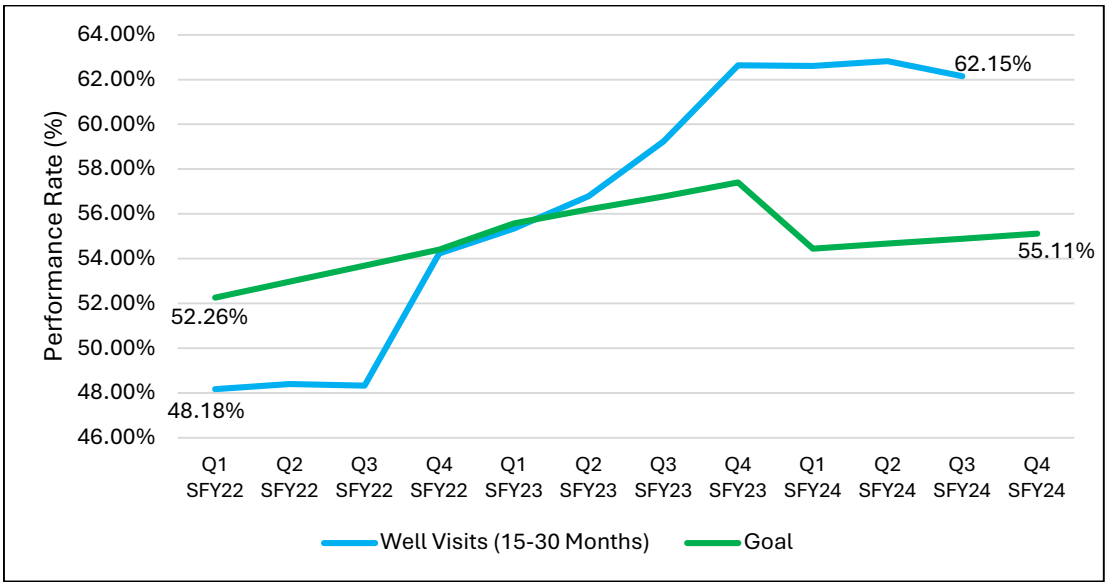
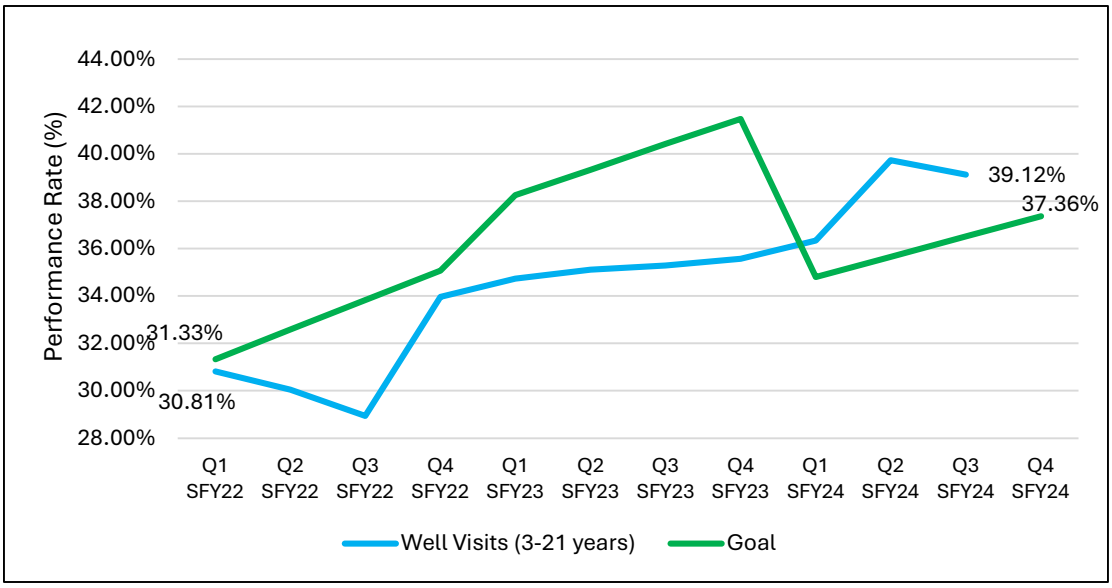


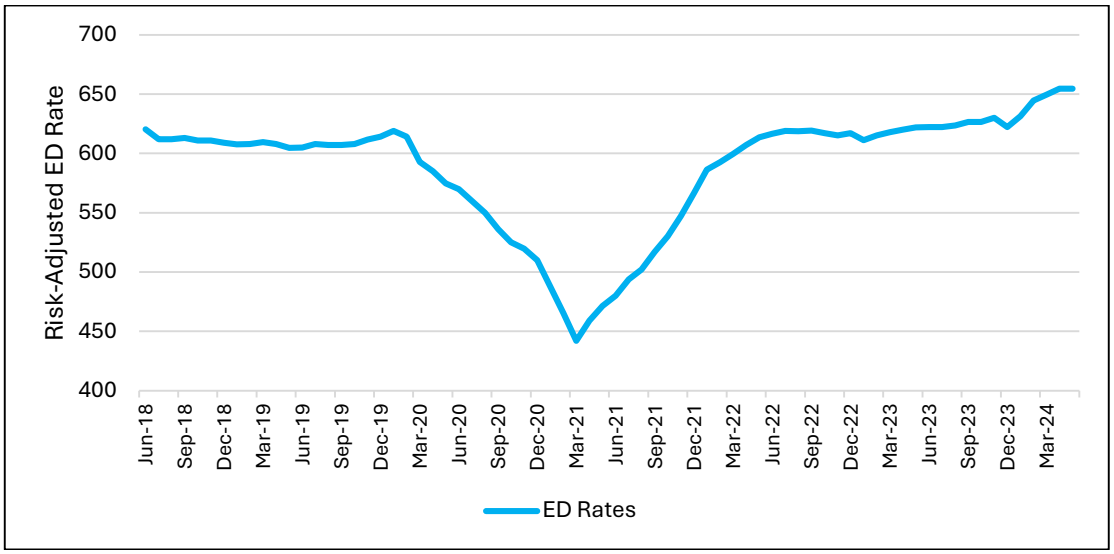
Figure 11. Well Visit Rates for Members Aged 3-21 Years



ED Visits

As noted in previous reports, ED visits have been rising since COVID-19 restrictions were eased. We saw a return to pre-pandemic levels in SFY23, but a continued increase in ED rates in SFY24. Much of this can be due to the lack of urgent care centers in the region. However, we also saw higher rates of RSV and influenza during the fiscal year, which may have contributed to increased ED rates in the spring months. As a whole, practices have alternative avenues of care including after-hours care, Nurse Advice Lines, and telemedicine to help curb ED usage for regional members. We will also continue to promote alternative avenues to members in an effort to reduce ED utilization. Figure 12 notes ED visit rates across time.

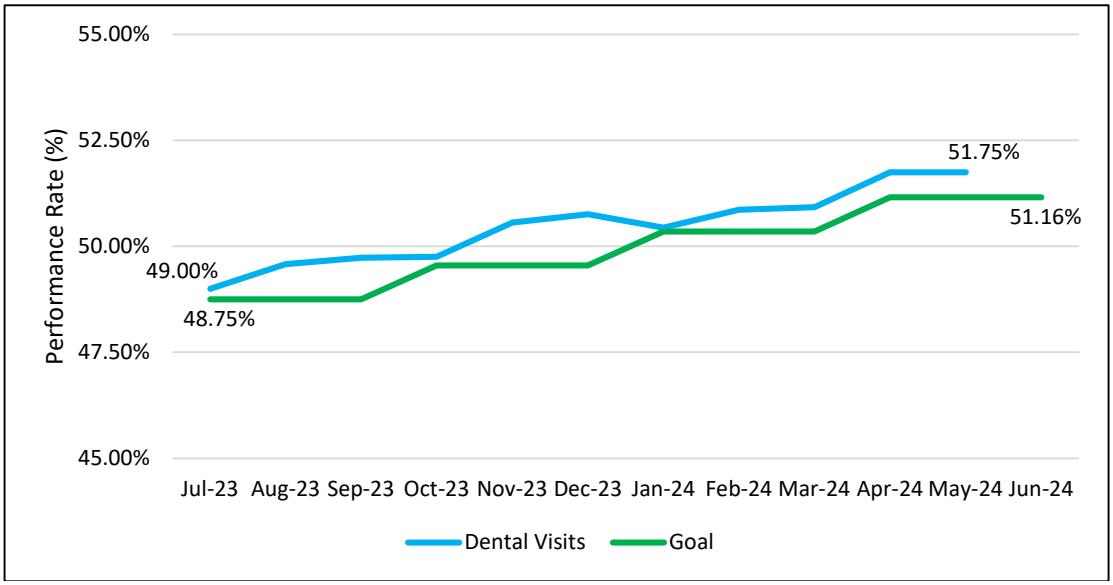
Figure 12. ED Rates Across Time



Dental Visits

Dental visits have been steadily rising over the past several years, and we have implemented several different projects to improve dental access with COVID-19. A recent analysis found that the number of dentists in the region had dropped during COVID-19. As a result, we created multiple avenues to increase access to care including promoting dental care at Federally Qualified Health Centers, connecting mobile dentistry to regional practices, and working with DenTriage to launch teledentistry. Additionally, access to dental care expanded with the addition of new dentists in the FQHCs. Each of these activities has helped to increase dental access and dental rates in the region as noted below in Figure 13.

Figure 13. Dental Rates



Timeliness to Prenatal Care and Timeliness to Postpartum

Timeliness to prenatal and postpartum care are two new measures for the SFY23/24 fiscal year. Neither of these measures were met in Quarter 1, but both measures saw sharp improvements (10% each) to meet quarterly goals for Quarter 2. While the measures lack historical data due to being newly implemented in the fiscal year, results for timeliness to prenatal care and timeliness to postpartum care are found in Figures 14 and 15, respectively.

Figure 14. Timeliness to Prenatal Care

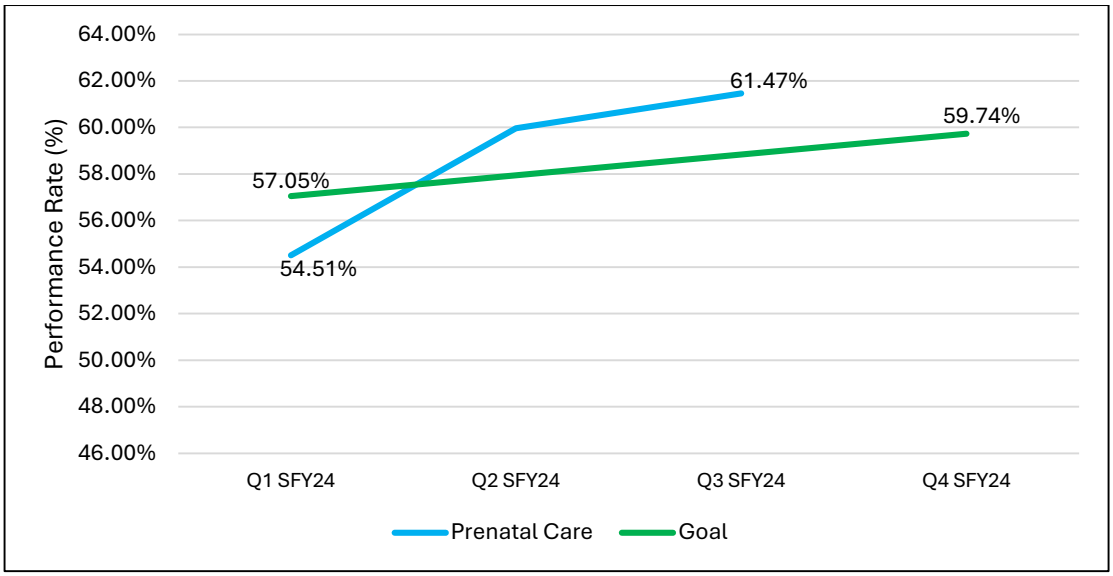
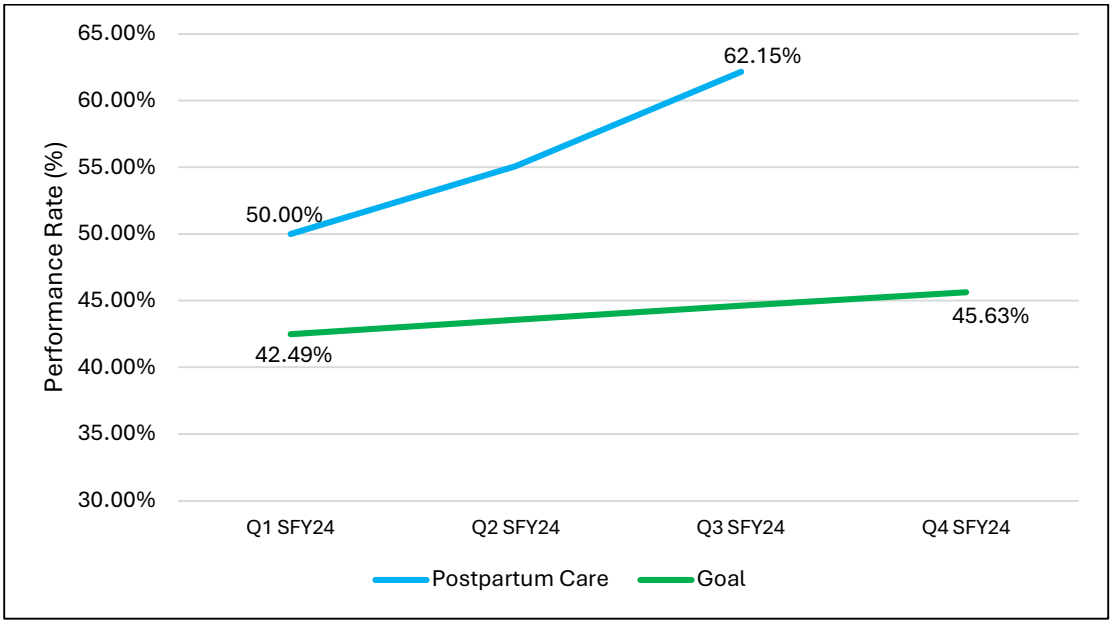


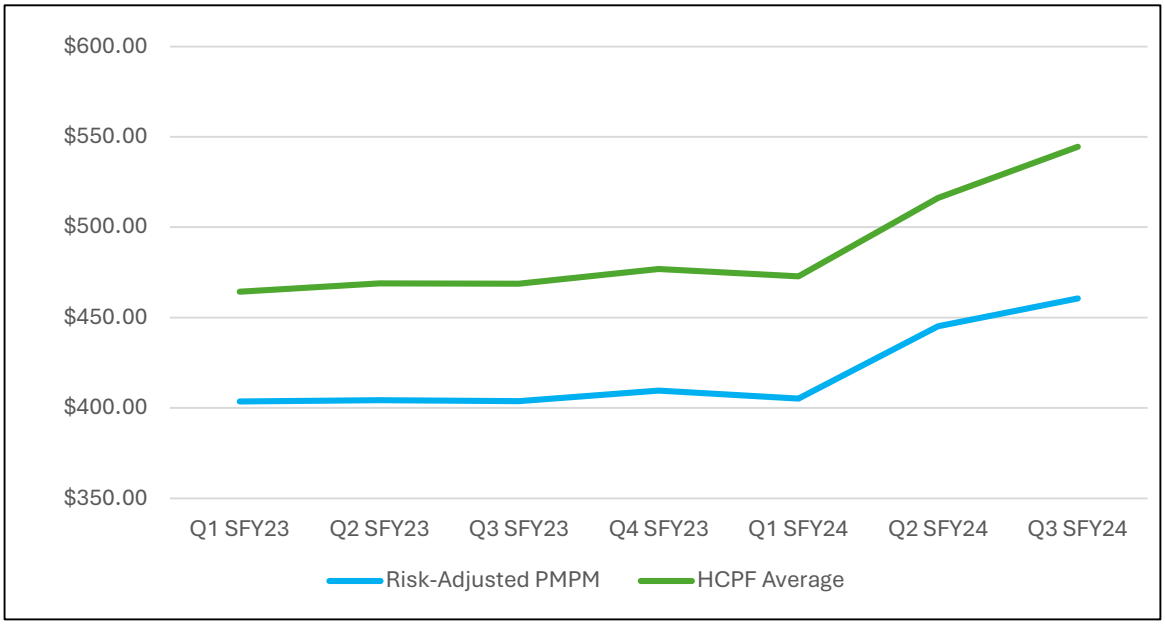
Figure 15. Timeliness to Postpartum Care



Risk-Adjusted PMPM

Regionally, we maintained our position as having the lowest Risk-Adjusted PMPM in the state; a position we have held since the measure was first introduced in SFY22 as a Performance Pool measure. Overall, our rate has risen over 10%, from an all-time (KPI) low of $403.63 in Q1 SFY22/23 to a high of $460.65 in Q3 SFY23/24. While rates have been rising across all RAEs, our rates have not risen as much as the state average. Across that same time span, the state average has risen over 17%. A chart for the Risk Adjusted PMPM spanning fiscal years 2022-2023 and 2023-2024 is included below in Figure 16.

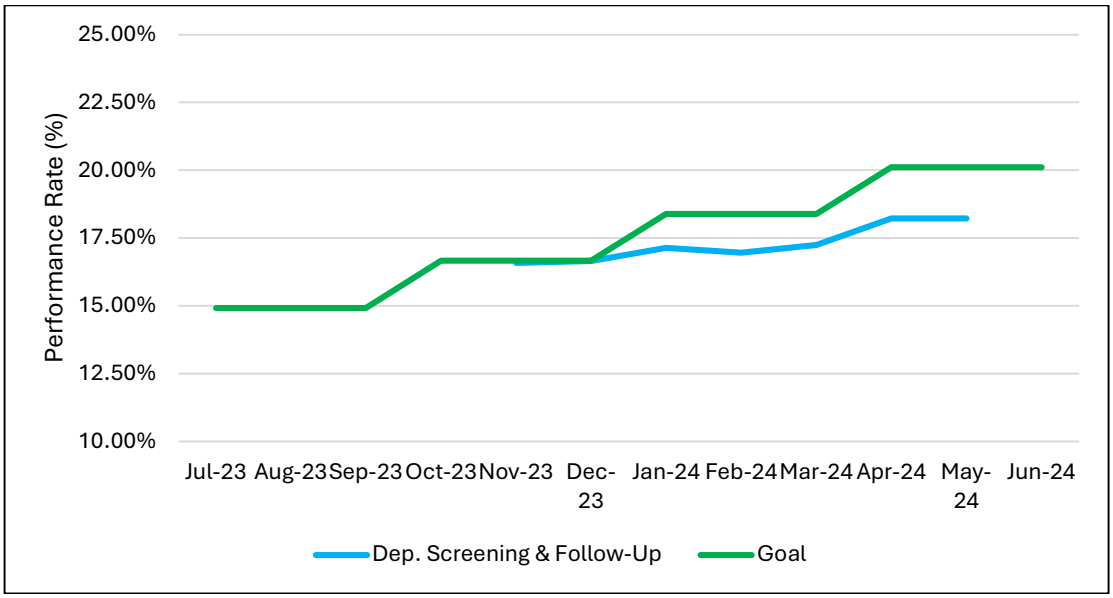
Figure 16. Risk Adjusted PMPM Rates



Depression Screening & Follow-Up Plan

This is a new measure for the fiscal year, and validated data was limited as a result. Additionally, the measure caused some degree of confusion with regional partners due its similarity to the Behavioral Health Incentive Plan (BHIP) measure. However, the NHP team worked to provide education and resources to reginal practices to help with coding practices and some practices built automatic workflows into their Electronic Medical Records (EMR) to document procedural codes. Results of this effort are still being tracked, but regional performance is noted below in Figure 17.

Figure 17. Depression Screening & Follow-Up Plan



Performance Pool

As with KPIs, Performance Pool measures have continued to rise over the fiscal year with several measures expected to exceed performance goals. Much of these results are due to enhanced provider support, providing education and materials on coding practices, and continued alignment across programs. Performance and results for these measures are noted below.

Medication Adherence

Performance rates for all medication adherence measures has improved across all three metrics including both Anti-Depressant Medication Management measures and the Asthma Medication Ratio measure. Data calculations are delayed as these are quarterly measures, but performance rates are noted below for all three measures in Figures 18, 19, and 20.

Figure 18. Anti-Depressant Medication Management, 12-Weeks

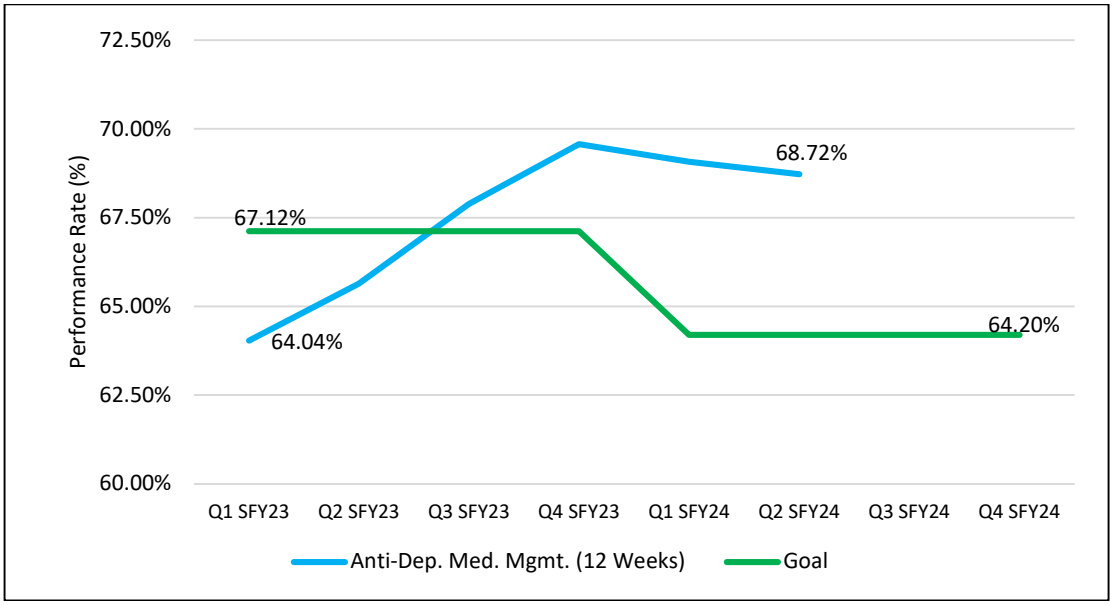


Figure 19. Anti-Depressant Medication Management, 6-Months

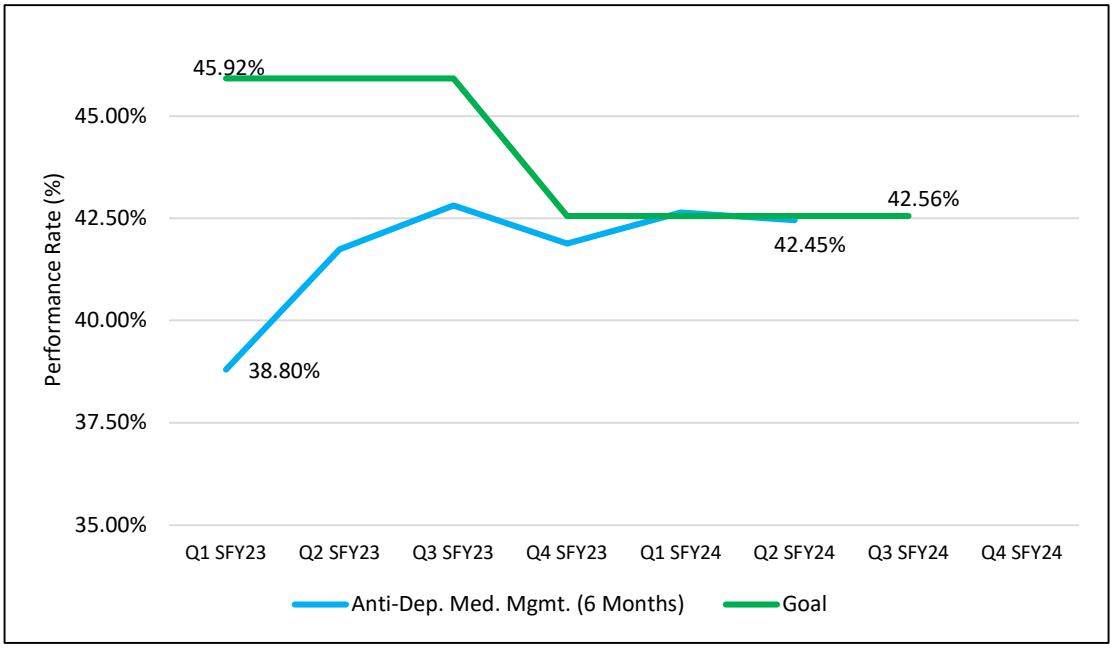
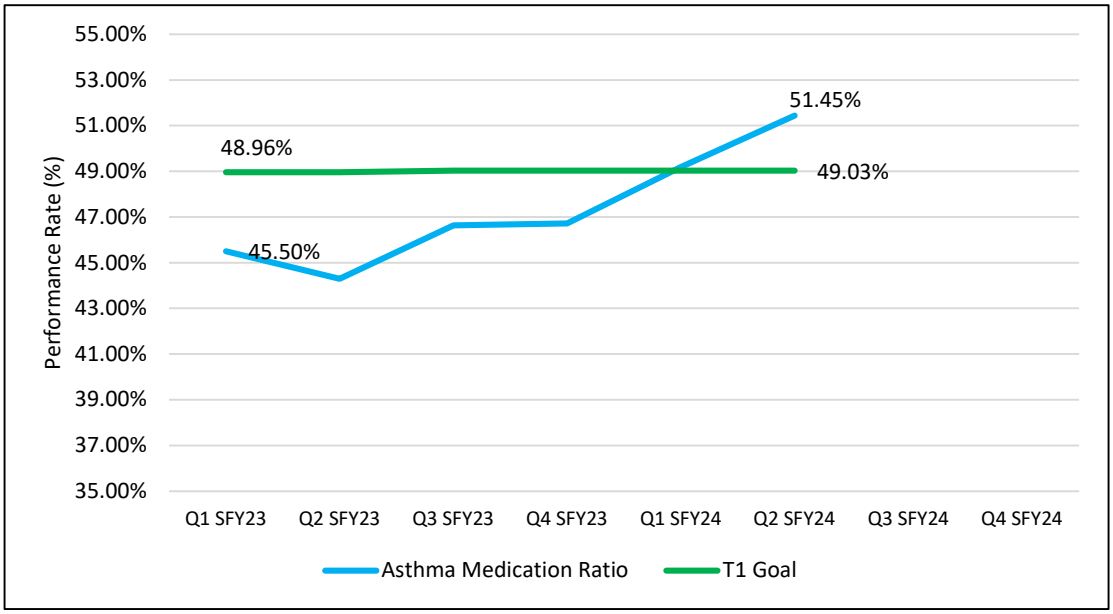


Figure 20. Asthma Medication Ratio



Preterm Birth Rate

NHP had stellar performance on the Preterm Birth Rate measure for SFY22/23. We were the only region to meet the measure, posting a rate of only 8.3%. This rate was lower than the Colorado Medicaid average, the US average, and the Colorado average. Preterm birth rate is calculated internally and validated with state data. As of August of 2024, the regional rate has remained steady at 8.2%. This measure is not charted due to limited validated data from the state.

Behavioral Health Incentive Program (BHIP)

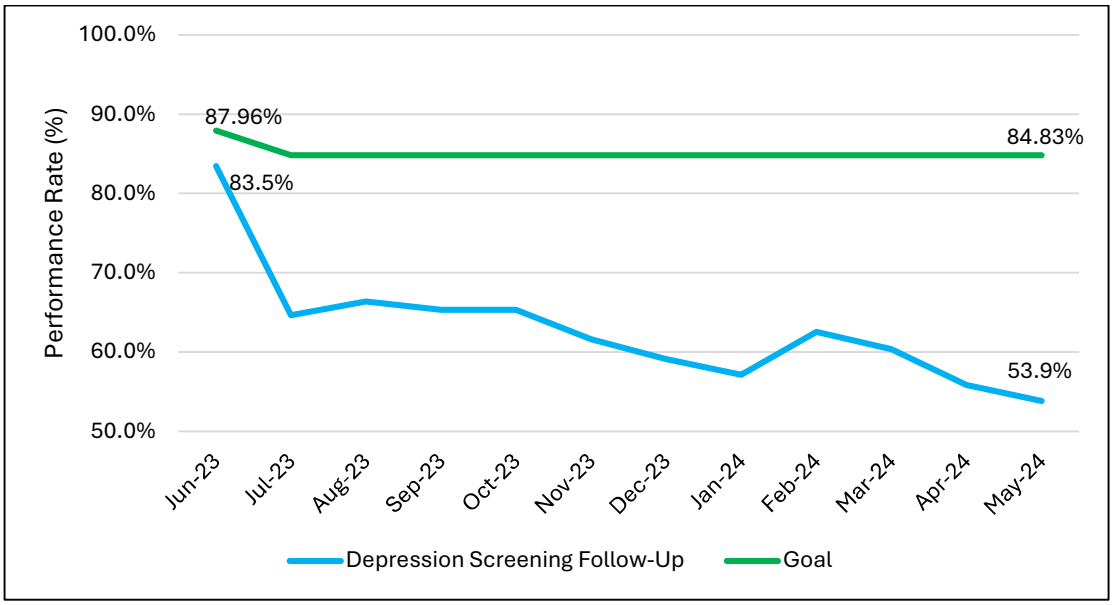
The BHIP program saw changes to three different measures in SFY24. The Substance Use Disorder (SUD) Engagement measure, the 7-Day Follow-up After Mental Health Discharge, and the 7-Day Follow-up After an ED Discharge for SUD were all transitioned to standardized measures for the fiscal year. As a result, goals and performance for these measures are significantly different from previous years. However, NHP anticipates meeting measures for both SUD measures.

Follow-Up after a Positive Depression Screen in Primary Care

While the performance measure for a follow-up visit after a positive depression screening in a primary care office is unchanged from previous years, the Behavioral Health engagement KPI measure was changed to standardized measure on having a follow-up plan documented after a positive depression screen. This KPI measure is similar to the BHIP measure but includes different coding sets.

Figure 21 notes the Follow-Up After Positive Depression Screening rates for the fiscal year. As NHP has been the top-performing RAE in this measure over the past few years, the decline in the follow-up rate has been of interest. The decline in the performance rate may be due to different coding practices on the physical health side, but may also be due to changes in specification coded and/or a loss of membership during the PHE unwind. The exact cause of this decline is still being assessed and we have performance improvement activities established within the Practice Transformation program in SFY24/25 to increase performance rates.

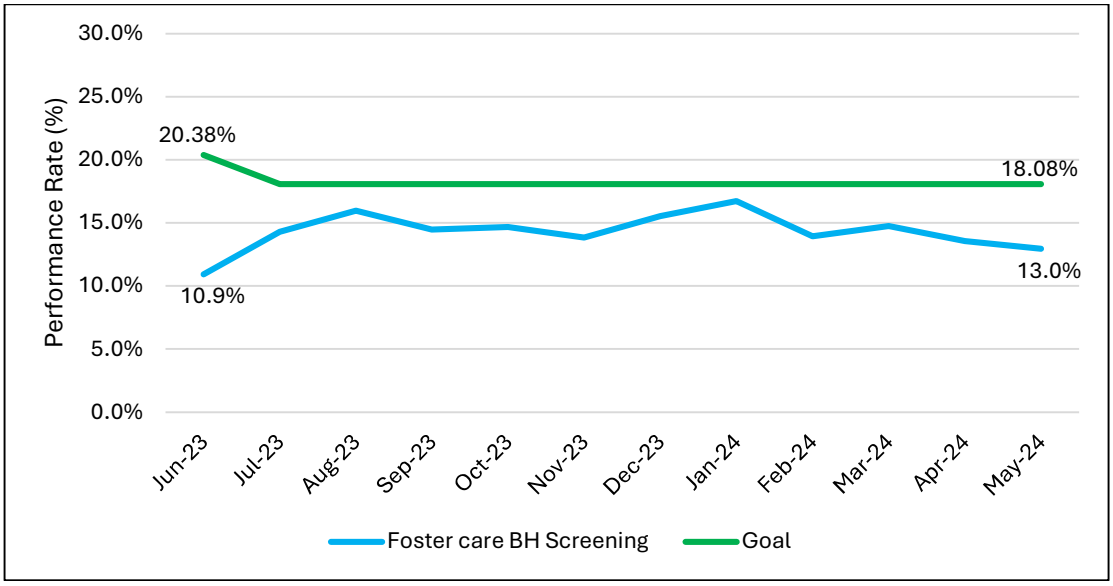
Figure 21. Follow-Up After Positive Depression Screening



BH Screen/Assessment for Members in Foster Care

As noted in Figure 22, the behavioral health assessment after a child enters foster care was slightly under the performance goal for the year. One of the primary challenges with this measure is the low denominator of qualifying members in the region despite having efficient processes to screen and treat foster care children expeditiously. For example, we have streamlined communication process between the Department of Human Services (DHS), care coordinators, our largest Federally Qualified Health Center (FQHC) and Community Mental Health Center (CMHC); who are also clinically integrated. Regional processes ensure members are seamlessly seen for both physical and mental health services upon entry into foster care.

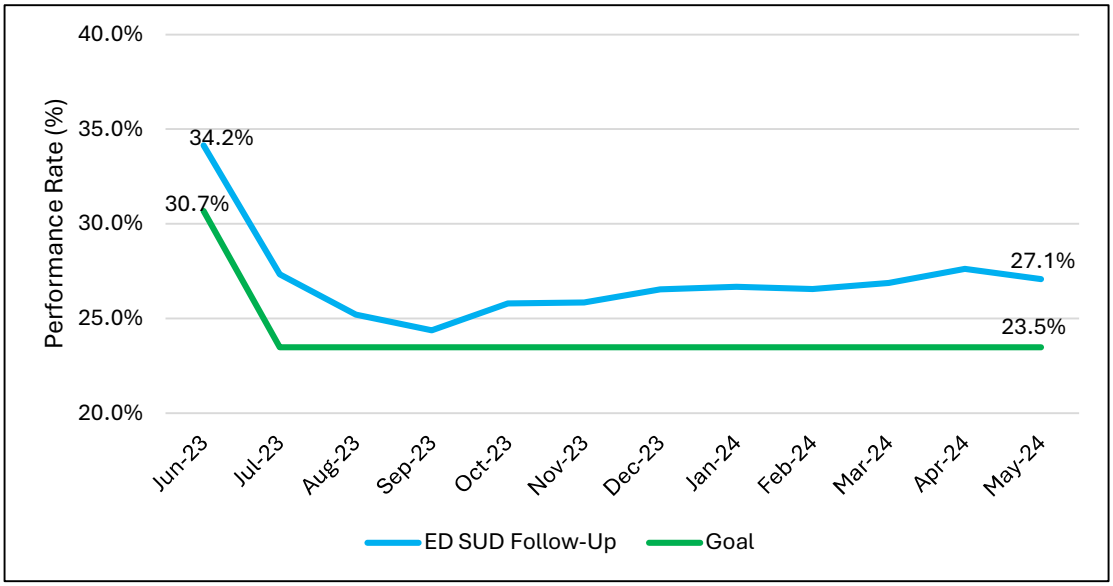
Figure 22. Behavioral Health Assessment for Members in Foster Care



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

NHP has consistently met performance goals for SUD engagement and follow-up. Regional success is due to embedded care coordinators at hospitals, emphasis on SUD engagement with practice transformation, and enhances efforts to impact SUD engagement after an Emergency Department discharge through the Hospital Transformation Program. The follow-up after an ED discharge for SUD is also a focus of the state Performance Improvement Project (PIP), and SFY24/25 will feature additional work to improve performance rates through this project. Performance results are noted below in Figure 23.

Figure 23. SUD Engagement after an ED Visit for SUD



Performance Measure Impacts to Health Equity

With the implementation of the Health Equity Strategy in SFY23/24, we began looking at performance measures with a specific emphasis on the demographic groups outlined in the Health Equity Strategy. As part of our health equity efforts, we developed a health equity task force in October of 2023 and then developed specific workgroups to help develop and implement strategic activities to close gaps in care. As a result, significant improvements were seen across multiple demographic groups.

Details of the health equity strategy, plan, and activities are not included here as health equity has a separate deliverable and reporting structure. However, notable improvements will be mentioned here. Table 9 notes the improvements we found in our identified populations, and Table 10 notes improvement across various demographic groups as a result of our efforts.

Table 9. Health Equity Impacts on Focused Populations

Metric	Target Group	Baseline	Improvement
Timeliness to Prenatal Care	Rural/Frontier Counties	51%	5.9%
Timeliness to Postpartum Care	Rural/Frontier Counties	31%	71.0%
Oral Evaluation	Rural/Frontier Counties	36%	5.6%
Hospital Discharge Follow-Up for Mental Health: 7 Days	Disabled	16%	37.5%
Hospital Discharge Follow-Up for Mental Health: 30 Days	Disabled	28%	85.7%
Well Child Visits: 15-30 Months	Rural/Frontier Counties	31%	71.0%
Well Child Visits: 3-21 Years	Rural/Frontier Counties	29%	20.7%

Table 10. Health Equity Impacts on Demographic Groups

Metric	Target Group	Baseline	Improvement
Timeliness to Prenatal Care	Black, Indigenous, and People of Color (BIPOC)	56%	15.0%
Timeliness to Postpartum Care	American Indian/Alaska Native	25%	300.0%
Oral Evaluation	Hispanic/Latinx	54%	4.0%
Well Child Visits: 0-15 Months	Hispanic/Latinx	58%	5%
Well Child Visits: 15-30 Months	Hispanic/Latinx	59%	10.0%
Well Child Visits: 3-21 Years	Hispanic/Latinx	30%	21.0%
Post ED Follow-Up for Mental Health Illness: 7 Days	Black/African American	31%	22%
Post Discharge Follow-Up for Mental Health Hospitalization: 7 Days	Black, Indigenous, and People of Color (BIPOC)	7%	280%
Post ED Follow-Up for SUD: 7 Days	Other People of Color	13%	107%

Performance Improvement Projects (PIPs)

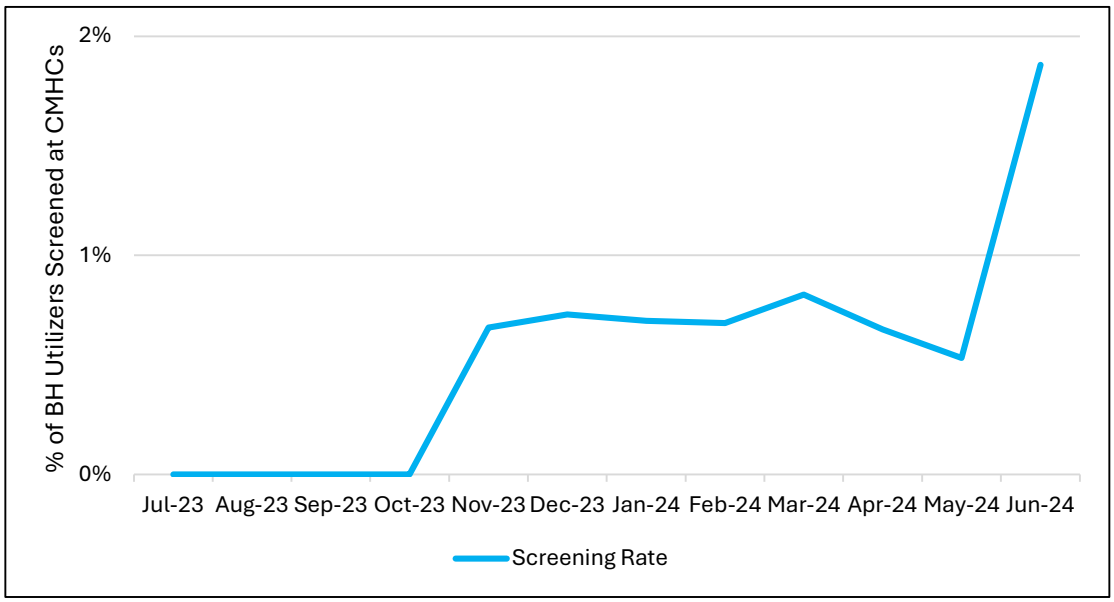
State PIP (Screening for Social Determinants of Health)

This Performance Improvement Project (PIP) was directed by the Department and began in SYF23/24. The interdisciplinary team included representatives from 2 CMHCs within the region: North Range Behavioral Health and Centennial Mental Health due to the volume of members they provide behavioral health services to. NHP followed the guidelines provided by Health Services Advisory Group (HSAG) and the Plan-Do-Study-Act (PDSA) methodology.

The baseline data demonstrated the need for a standardized approach to Social Determinants of Health (SDoH) screening in our region's healthcare system. NHP coordinated with North Range Behavioral Health and Centennial Mental Health to create a standardized screening and reporting process. The intervention involves screening members at the start of treatment, when completing a clinical assessment update, and utilizing required questions on the Colorado Client Assessment Record (CCAR). Centennial Mental health began testing the new screening and reporting system in November 2023. Demonstrating success at Centennial Mental Health, North Range Behavioral Health was set to start testing in April of 2024 but, due to competing priorities, they were delayed until June of 2024.

Early results found in Figure 24 suggest the standardized screening and reporting process is effective. The team will continue to monitor and adjust the intervention as needed to ensure significant improvement is achieved and sustained.

Figure 24: Screening for Social Determinants of Health Among Behavioral Health Utilizers at CMHCs



State PIP (Follow-Up After Emergency Department Visit for Substance Use)

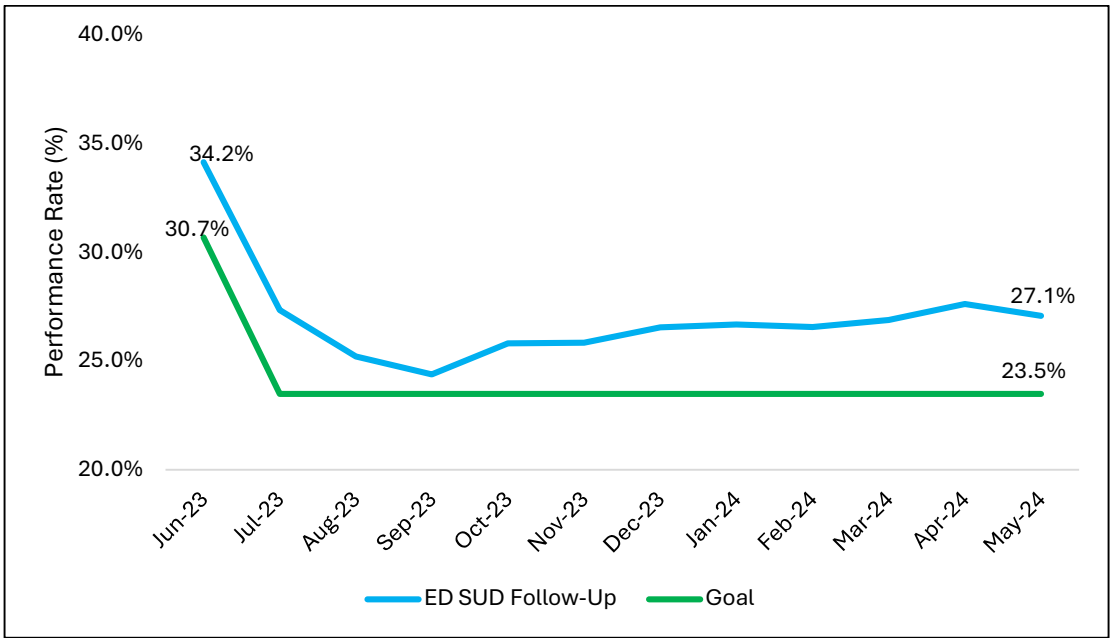
This Performance Improvement Project (PIP) began in SFY23/24 and was selected by NHP from a list of options provided by the Department. The PIP's focus was to increase the percentage of follow-ups within 7 days of an emergency department (ED) visit for members aged 13 and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose. Our goal for this SFY was to analyze PIP related data, identify opportunities and barriers to improve, pinpoint potential partners and work toward continued and sustained improvement.

While brainstorming key drivers it was determined that provider education regarding measure specification would be worthwhile as many stakeholders reported uncertainty around the codes and events that qualify for this goal. Therefore, our intervention focused on creating tip sheets and disseminating them to providers. A challenge encountered during the testing phase was ensuring all necessary providers received the tip sheet and the right personnel at each provider site had access to it. NHP attempted to resolve this challenge by regularly informing stakeholders in various forums about the PIP, measure specifications and best practices to meet our goal. As early data suggests (see Figure 25) this intervention did not achieve the results we aimed for however, qualitative data suggests that providers found the tip sheet helpful in understanding what needs to be done to achieve the goal and to build internal reports to track performance.

One barrier that NHP identified was that Emergency Departments were not collecting Release of Information to be able to coordinate care with other providers. NHP is currently discussing this barrier with Emergency Departments to identify potential interventions to improve this process.

Our goal for the PIP is 30.5%. The data from June 2023 is 26.8% and June 2024 is at 27.5%, this is using 30-day claim lag as we are still waiting on 90-day claim lag data.

Figure 25: Follow-Up After Emergency Department Visit for Substance Use



Other Performance Improvement Projects

Balanced Scorecards SFY23/24

We continued to distribute its balanced scorecards to practices monthly. The only changes made to the scorecards were related to new measures and layout changes. We received feedback from one of our providers that the charts were hard to read and offered a suggestion for improvement. We incorporated the suggestion and received positive feedback on the update. The balanced scorecards continue to receive positive feedback from providers.

Coding Tip Sheets

One of the challenges we saw with the move to standardized measures was the removal of specific codes to meet measures. Instead, providers were given documents on child and adult core sets. Providers were then required to work with six different specification documents to identify codes (KPIs, BHIPs, Performance Pool, Adult Core Sets, Child Core Sets, and Health Equity specification documents). To help streamline and pare down the information in the specification documents, we developed coding "tip sheets" to help practices identify procedural and diagnosis codes to help meet performance measures. These tip sheets have also been well received from providers.

2022-2023 411 QuIP Results

NHP was not directed to complete a QUIP related to the 411 claims and encounters validation audit. All scores based upon the internal audit netted scores over the 90% threshold. Additionally, the overread that was conducted noticed some areas of disagreement; however, there was not a need to conduct a QUIP due to audited elements creating a low sample size.

Section 5: Member & Family Experience

Member Satisfaction

CAHPS Survey

NHP participates in the annual Consumer Assessment of Healthcare Professionals and Systems (CAHPS) survey. The results for SFY22/23 showed a low response rate for both the child and adult surveys. As a result, NHP began disseminating information across the region about the SFY22/23 CAHPS survey. Information was presented at the Member Engagement Advisory Committee (MEAC), the Quality Improvement/Population Health Committee, the Quality Management Committee, and the regional PIAC.

NHP's objective for reporting period SFY22-23 Q3Q4 (01/01/2023 – 06/30/2023) was to educate providers on the importance of referring members to smoking cessation programs and benefits. This goal was based on 2022 data from the CAHPS survey which revealed an opportunity for improvement. NHP's PT coaches distributed a Frequently Asked Questions (FAQ) about the Colorado QuitLine sheet and the updated Colorado QuitLine member tip sheet to our practices. Further, NHP added these documents to our provider newsletter. NHP reviewed 2023 CAHPS data and notes a slight increase of members being advised by their doctors to quit smoking. Compared to 53.8% of members in 2022, this figure rose to 57.6% according to the 2023 CAHPS survey.

Weld County's Tobacco Education and Prevention program implemented the rolling eight-week "Freedom From Smoking" sessions as part of an adult smoking cessation program from the American Lung Association. This program, available to all Weld County residents, is considered to be the gold standard in smoking cessation programs. It is offered as a group program, online, or through a self-paced pamphlet. Group participants work through the quitting process together under the direction of an expert "Freedom From Smoking" facilitator. People who attend the group program are six times more likely to be tobacco-free one year later than those who attempt to quit on their own. Additional smoking cessation resources, specifically those that target teens and pregnant mothers, are posted on the Weld County Government website.

Weld County's Trusted Adult Start the Conversation online classes were offered during Q3Q4 on Tuesday evenings and Thursday afternoons via Zoom. These ongoing classes are offered every three months (February, May, August, and November) to parents, caregivers, school workers, community-based leaders, and youth-serving leaders. These types of programs have historically had trouble maintaining consistent participation. To combat this, they have implemented a gift card raffle to those who register and attend.

NHP aligned our efforts with CDPHE to enhance our smoking cessation tip sheet which outlines the Colorado QuitLine benefits. This tip sheet includes Prenatal Plus information for our pregnant members and My Life My Quit information for our teen members. Additionally, NHP has a "teen-friendly" information sheet with a QR code that links to My Life My Quit. These resources are available in both English and Spanish on NHP's website. NHP collaborated with the CDPHE Tobacco Cessation Intervention Coordinator during this reporting period to provide additional education and outreach to health care professionals regarding the Colorado QuitLine. NHP hosted the CDPHE's Tobacco Cessation Intervention Coordinator at our March 23, 2023 care coordination meeting to review the Colorado QuitLine resources.

NHP also facilitated a training for behavioral and physical health providers at a provider roundtable on April 14, 2023. NHP's goals for these trainings were aimed at educating health care professionals on the Colorado QuitLine, how to refer members to the program, and boosting the awareness and utilization of the Colorado Quitline. These trainings included an overview of services available such as internet, text, and phone options for youth, American Indian, and behavioral health populations. Further, the training included information about Health First Colorado benefits, various referral approaches, and a question/answer session.

NHP met our objective to obtain and analyze data around members enrolled in the Colorado Quitline provided by CDPHE. During this reporting period, the number of Health First Colorado members enrolled in the Colorado QuitLine in Region 2 increased by 3.9%, from 128 members in the previous reporting period to 133 members this reporting

period. Web enrollments increased by 27.86% and phone enrollments decreased by 17.91%. The increase in overall NHP member enrollments indicates that our education efforts were successful during this reporting period.

NHP also met our objective to promote WCDPHE smoking cessation classes on our social media sites. These smoking cessation classes were also provided as an additional resource to care coordinators and PT coaches. NHP continued our Virgin Pulse Text2Quit broad-based text campaign as part of our member engagement efforts toward tobacco cessation. In Q3Q4, 106,763 messages were sent to 2,503 members. Of these, 753 opted out which resulted in a 70% retention rate. "Smoked" was the most frequently used keyword, and 81 members used at least one key word. Members engaged in the program smoked an average of 12 cigarettes a day. NHP noted that five members request information on Nicotine Replacement Therapy (NRT).

During SFY23-24 Q1Q2 (07/01/2023 – 12/31/2023) reporting period, NHP concentrated our prevention and wellness efforts on smoking cessation during November of 2023. NHP hosted CDPHE's Tobacco Cessation Intervention Coordinator, Keith Cooper, at our "Getting Started" webinar on November 2, 2023. Keith provided an overview of the Colorado Quit Line program. Members, family members and health care professionals who were unable to attend the training can view the slide deck and recording on the Calendar and Events tab of NHP's website.

Additional efforts in November of 2023 included the distribution of our Colorado QuitLine health information sheets to health care professionals in our provider newsletters and on our social media sites. NHP promoted these resources at community meetings, PT meetings, QI meetings, member advocate meetings, and care coordination meetings.

NHP reviewed the data for members who enrolled in the Colorado QuitLine during Q1Q2 FY23-24 and notes a 21.80% increase in enrollments from Q3Q4 FY22-23. During this reporting period, 57 members enrolled via phone and 105 enrolled online. NHP sent 51,702 Text2Quit text messages to 2,568 members during Q1Q2FY23-24, with the goal of providing additional smoking cessation options for our members. NHP notes that 712 new members were identified for this campaign, and there was an 88.4% retention rate.

NHP will measure the efforts of our outreach which occurred during FY23-24 Q1Q2 in the prevention/wellness/member engagement deliverable in Q3Q4. CAHPS results for adults and children are noted below in Figures 26 and 27, respectively.

Figure 26. Adult Rating of 59.02% for all Health Care Satisfaction

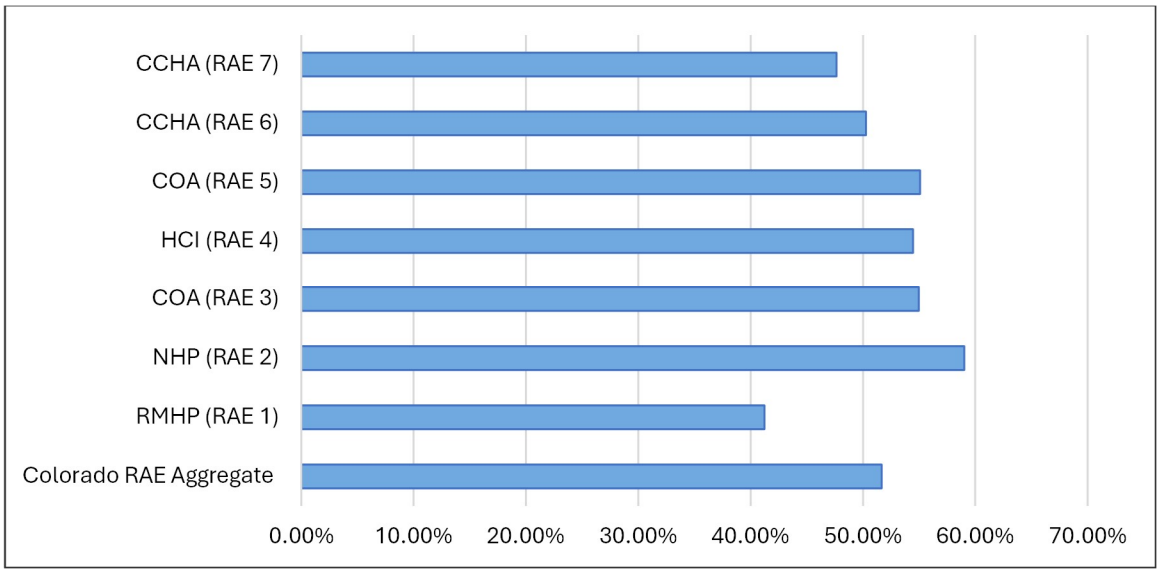
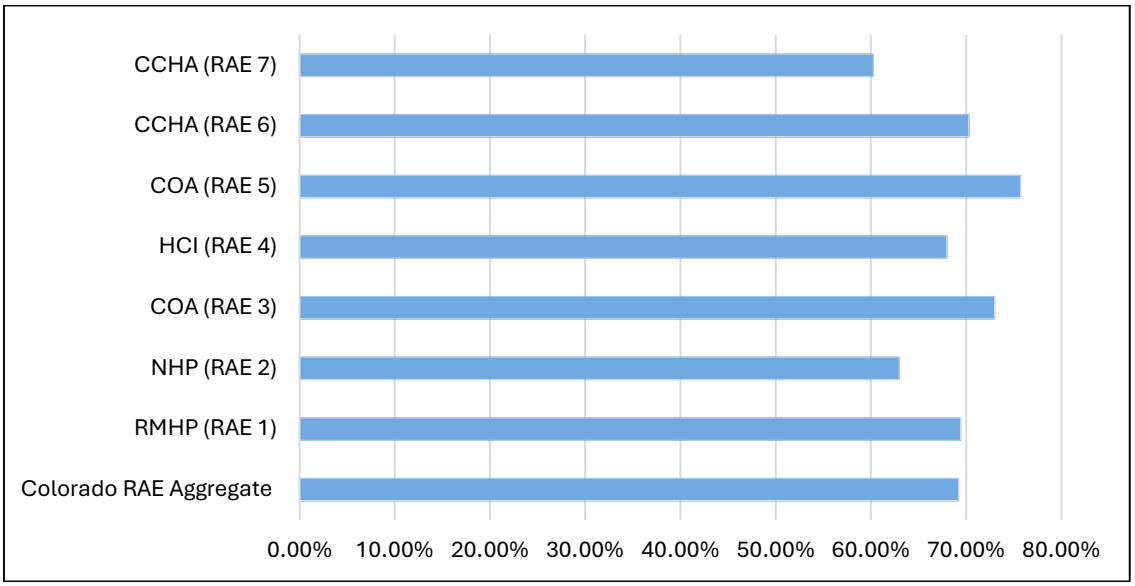


Figure 27. Child Rating of 62.92% for all Health Care Satisfaction



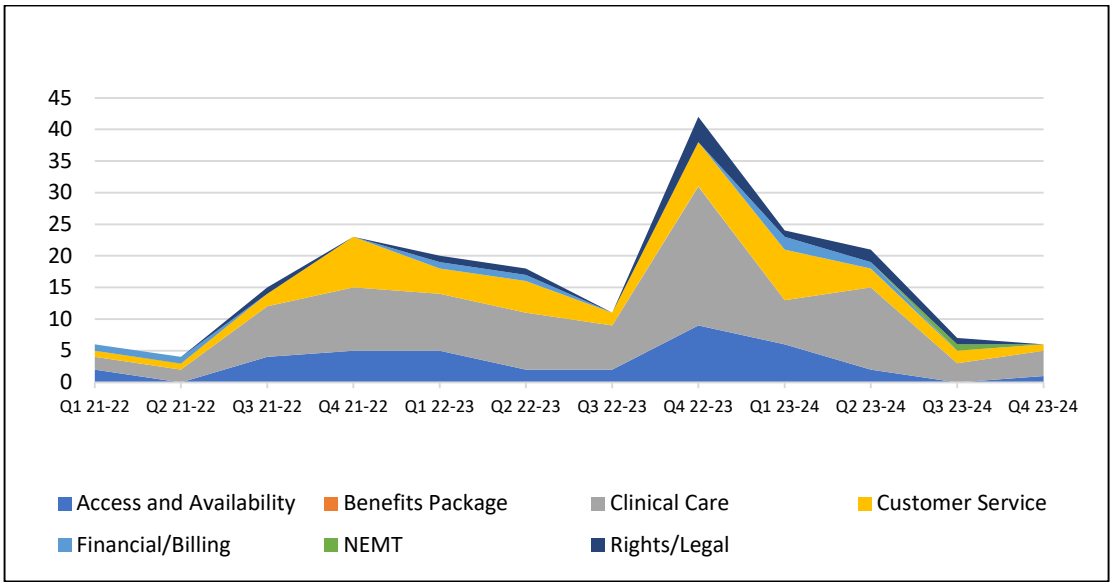
Grievances and Appeals

Acting on behalf of NHP, Carelon Behavioral Health handles the processing and resolution of any grievances or appeals received from the member. Specific data related to these are tracked by Carelon Behavioral Health. If any patterns are recognized, they are observed, monitored, and presented at quarterly regional quality meetings. Throughout FY23-24, NHP educated members, families, and health care professionals on members' rights to how to file a grievance through member outreach/onboarding, individual interactions, and professional meetings/presentations.

NHP processed 26 grievances during SFY 23/24, a significant decrease of 71% from SFY 22/23. Of the members who filed a complaint, 100% received an acknowledgment letter within two working days and a resolution letter within the required time frame, and 89% of these members were satisfied with the results of their complaint. The average turnaround time to resolve a complaint was 7.97 days. NHP is committed to resolving member complaints as quickly as possible and communicating the resolutions to the members promptly.

NHP received fifty (50) appeal requests during SFY 23/24. Seventeen (17) of these appeal requests were not processed because they were received after the sixty (60) day deadline and/or they did not include a signed Designated Client Representative (DCR) form. For the thirty-three (33) processed appeals, ten (10) were expedited appeals and were resolved within the seventy-two (72) hour time frame and twenty-three (23) were standard appeals and were resolved within the ten (10) working days. Sixteen (16) denials were upheld (meaning services remained denied) and seventeen (17) denials were overturned (meaning services were authorized).
NHP continued to chart grievances to better surface trends as seen in Figure 28 below.

Figure 28. Grievance Trends for SFY22/23 and SFY23/24



Quality of Care Concerns

Investigations of potential quality of care issues are conducted through the Quality 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, which is typically through an Adverse Incident reporting form submitted to the Quality Department. All Quality-of-Care issues are documented as are the results of the subsequent investigations. Corrective actions are also tracked and monitored. Incident reporting, investigations, and tracking adverse incidents continued during the past fiscal year and will continue in future fiscal years with reporting to HCPF as required. During SFY23-24, a new process for following up on adverse incidents that did not meet the definition or criteria for a potential quality of care grievance was implemented. This initiative aimed to ensure that all pertinent information was gathered to determine whether further investigation was warranted.

NHP received twenty-two quality of care concerns in SFY23-24, two of which resulted in a Corrective Action Plan (CAP) being imposed on 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 SFY24-25. NHP will update all workflows, Policies and Procedures, and investigatory processes to comply with the HCPF QOCG contract.

Section 6: Hospital and Practice Transformation

Hospital Transformation Program

Some hospitals in Region 2 are not yet connected to Contexture/CORHIO for data collection. This poses challenges for secure data collection and transmission between the hospital and NHP. To address this, NHP has been actively working on improving communication and data sharing processes. We have established a standard, secure notification system to help hospitals comply with their reporting requirements for HTP measures. Currently, we have activated our HTP portal and successfully connected all hospitals in the Eastern Plains to our secure notification platform that they utilize daily. The HTP program tracks several key measures through Contexture, with hospitals reporting data to the Regional Accountable Entities (RAE). These measures include:

- RAH1: Ensuring that a follow-up appointment with a clinician is scheduled before discharge and notifying the RAE within one business day.
- SW-CP1: Conducting social needs screenings for patients admitted to the hospital and ensuring appropriate follow-up for identified social needs post-discharge.
- CP6: Screening for perinatal and post-partum depression and anxiety and notifying the RAE of any positive screens.
- SW-BH1: Collaboratively developing and implementing a discharge planning and notification process with the RAE for patients with mental illness or substance use disorders who are discharged from the hospital or emergency department.

These measures are part of the ongoing efforts to improve care coordination and address specific patient needs effectively. By targeting reductions in avoidable hospitalizations, improving care coordination, and addressing social determinants of health, HTP aims to build a more efficient and effective healthcare system. We will continue to advance these efforts in the next reporting period to overcome the connectivity issues faced by these hospitals.

Practice Transformation Program

Our Practice Transformation (PT) program has two components: Primary Care PT and Behavioral Health PT. Both programs operate in a similar structure, with slight differences in performance measures and population focus. Both programs focus on quality improvement, include annual assessments, monthly meetings with each participating practice, and hold quarterly learning collaboratives. Detailed information about the PT program can be found in the Annual Network Plan[16] and the Annual Practice Support, Transformation, and Communication Report.[17]

In FY23/24, 88% of PCMP practices in the network were engaged in the NHP PCMP PT program and five practices were enrolled in the BH PT program. The FY23-24 PT program had the following goals:

- Practices achieve 70% of milestones in the PT Incentive Program. The clinical milestones for this FY were aligned to Key Performance Indicators (KPI) and Behavioral Health Incentive Plan (BHIP) measures.
- Integrate Prescriber Tool implementation into PT.
- Integrate eConsult Platform into PT.

Our PT incentive program aligns with the Alternative Payment Models (APM) and Key Performance Indicators (KPI) measures focused on primary care access and preventative care. The incentive program consisted of the following milestones:

- Access to Care. PCMP's reported third next available appointment data for 4 types of appointments- urgent care, outpatient follow up, non-urgent care and well care visits.
- Attendance at NHP's quarterly Learning Collaborative. Four were held in FY 23-24 and topics included strategies for improving well child visits, UC Health's Chronic Pain Center of Excellence, Introduction to the High Plains

[16] Northeast Health Partners. *Annual Network Management Strategic Plan, SFY24-25.*

[17] Northeast Health Partners. *Annual Practice Support, Transformation, and Communication Report, SFY24-25.* Submitted to HCPF on July 22, 2024.

Research Network, Depression Screening sharing of best practice, billing for depression screening, Introduction to eConsult Platform and HCPF Health Equity Vision and Priorities.

- Practice Assessment and Setting SMART Goal for an area of improvement.
- Screening for Depression and Follow Up. Work done with PCMP to ensure workflow in place for capturing G-codes when depression screening was done as well as show performance improvement based on KPI.
- Well Visits based on KPI. PI work completed with the goal to close gaps in care for members 0-15 months and 15-30 months or 3-21 years old.
- One Additional Clinical Measure. Diabetes A1c Control, Controlling High Blood Pressure or Childhood Immunizations. PI work was performed to achieve improved outcomes in one of these measures.

As a result, significant progress was made in all of the clinical measures. Examples of these impacts include:

- 6 practices were able implement new workflows for depression screening and follow-up and successfully drop G-codes on claims.
- 18 of the 22 PCMPs improved KPI Well Child Visit rates.
- 11 of 12 PCMPs improved (lowered or maintained <19%) for Diabetes A1c Control for their population.
- 2 of 2 PCMPs improved Controlling Blood Pressure outcomes for their population.
- 4 out of 6 PCMPs improved Childhood Immunization rates.

The second iteration of the Behavioral Health Practice Transformation program began in July of 2023 and concluded in June 2024. The number of participating practices remained the same at 5. One of the key goals was to identify a priority population, specifically members with SUD, and identify needs as well as gaps of care. Practices completed PDSA cycles to implement changes and assess effectiveness. Clinics also completed assessments using the integrated practice assessment tool (IPAT) both before and after their PDSA intervention. The initial combined scores were a 2.8 and the final scores were a 3.8 showing a 35% improvement in their scores and work towards integrated care. Finally, the milestone completion rate was 95% up from 64% previously. See below for 2023-2024 program milestones.

Milestone Name	Description	Details
Practice Assessment	Complete the annual Practice Transformation Assessment and complete a SMART Goal	Complete SMART Goal and review progress quarterly with coach.
Learning Collaboratives	Attend all 4 learning collaboratives	Representatives must complete the post LC survey including their name and practice name.
Integrated Care	Complete PDSA cycle to develop process for shared expectations with PCP, work to develop priority access for clients referred by primary care	Share written process for priority access and/or share two de-identified examples of referral/info exchange with PCP.
Population Management	SUD population and address treatment initiation within 14 days and engagement of treatment within 34 days	Identify SUD priority population. Complete PDSA to create workflow to address needs.
Performance Visualization Tool	Practice develops a dashboard for tracking area of performance	Develop a performance visualization tool and provide a list of quarterly scheduled meetings where data will be reviewed.