

2016 Data Report

Colorado Medicaid Health Specific Measures



*Measuring More
of What Matters*



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Executive Summary

The Department of Health Care Policy and Financing administers Health First Colorado, Colorado's Medicaid Program. The Department collects qualitative and quantitative data on the Health First Colorado population annually to identify health outcomes and to allow for the implementation of data driven health improvement programs. The Department also collaborates with other Colorado state health agencies to address health disparities and focus on areas of need through collaborative programs that improve health delivery systems for Health First Colorado members.

In order to uphold the highest standard of care, we regularly evaluate programs and services that Health First Colorado provides to its members. Using standardized techniques of evaluation and measurement, we set benchmarks, identify trends and establish performance targets. These techniques help Colorado's state health agencies to obtain actionable population health data that has the potential to improve the lives of many Coloradans.

Our data indicate Health First Colorado is performing exceptionally well in a number of areas. For example, 78 percent of Health First Colorado members answered on a satisfaction survey that they were able to receive needed care during the six months preceding the survey. Furthermore, 87 percent of members indicated that their clinicians communicated well with them during a behavioral health visit. Positive scores for maternal health indicators demonstrate that 70 percent of new mothers enrolled in Health First Colorado received postpartum care.

Efforts such as family planning education, contraceptive uptake, and the Nurse Family partnership program have also potentially contributed to improving maternal health outcomes by reducing the teen pregnancy rate among women aged 15-17 who were members of Health First Colorado. The teen pregnancy rate for women 15-17 dropped from 13.7 per 1,000 in State Fiscal Year (FY) 2012-13 to 9.4 per 1,000 in FY 2013-14.

Our data also indicate that Health First Colorado needs to improve in certain areas. The rate of well-child and oral health visits is below the 80 percent federal requirement threshold. Well-child visits can provide preventive screenings for children to ensure their growth and development is on the right path. Oral health is inexorably tied to overall physical health and well-being.

Preventive health services for adults are also tremendously important to mitigate the risks of chronic and potentially life threatening diseases. Screenings for cancer can help identify disease early, reducing treatment costs and potential mortality. Breast and

cervical cancer screening rates for women enrolled in Health First Colorado are only at 32.4 percent and 56.6 percent respectively. Evidence based guidelines provide health professionals with information on when and how often these screenings should occur. It is important that these guidelines are followed so that any diseases can be identified and treated early.

Health First Colorado is a strong advocate for preventive care and strives to use resources to positively impact the lives of its members. A good example is the Adult Medicaid Quality Grant, which distributed funding to local partners to improve diabetes related health outcomes. Due to the effectiveness of the grant, in 2015, 43.6 percent of Health First Colorado members with type 2 diabetes were better able to control their blood sugar levels, compared to 37.2 percent in 2014. Poorly controlled blood sugar levels increase the risk of developing diabetes-related complications. We continue to work with our members and partners to improve health outcomes through improved diabetes management.

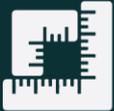
Health First Colorado strives to achieve the triple aim of improving health outcomes and member experience, and lowering per capita costs. Continuous monitoring and evaluation of our health care programs is key in achieving the goals of the triple aim.

This report summarizes and outlines quality indicators for Behavioral Health Organizations and Regional Care Collaborative Organizations. Additional quality measures are organized by life stage as Health First Colorado serves a diverse population from early childhood through late adulthood.



ICON KEY

The following information boxes are specific guides for each metric.



DEFINITION OF MEASURE

Provides information such as numerator, denominator, data source and year, and eligible population included in the metric.



STRATEGIES FOR IMPROVEMENT

Strategies for improving health care performance on specific measures.



COMPONENTS OF CARE

Components of a specific measure such as tests conducted during well-child visits.

How to use this report

This report provides summaries of data collected by the Colorado Department of Health Care Policy and Financing (HCPF). Data sources include the Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) measures, Performance Improvement Projects, Behavioral Health Performance measures, and any other data that obtained from the Health First Colorado claims reporting system.

The goal of this report is to summarize data that impact the health of Coloradans and provide actionable information that has the ability to improve health outcomes.

The data provided in this report can support:

- Data-based decision making.
- Shifting resources to areas of need.
- Informing health care providers on Health First Colorado health outcomes.
- Educating Colorado about the importance of preventative health care.
- Improving access to health care providers in medically underserved areas
- Setting quality health improvement targets, sharing data that allows for comparisons, creating opportunities for providers to make changes at the practice level, and comparisons to state and national averages.

How to read the measures

Measures are usually expressed as rates or percentages, based on the number of Health First Colorado members who have received a specific service, in proportion to all clients who should have received it.

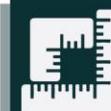
Example: Well-child visits in the first 15 months of life

The denominator is the eligible population—the number of children who turned 15 months during the measurement. The numerator is the number of children in the eligible population who received one well-child visits during the first 15 months of life. If the eligible population (denominator) was 100 of which 60 had one well-child visit (numerator), the rate would be 60/100, or 60%.



QUANTITATIVE DATA SOURCE DEFINITIONS

The Department of Health Care Policy and Financing uses numerous data sources and programs to evaluate the health of Health First Colorado members. Each data source is vital to measuring and assessing the effectiveness of the Health First Colorado delivery system. Below you will find descriptions of the qualitative and quantitative data sets that Health First Colorado utilizes to measure health.



DEFINITION OF MEASURE

Quantitative data is numerical. It is acquired through counting or measuring.

What is HEDIS?

HEDIS (the Healthcare Effectiveness Data and Information Set) is a set of standardized performance measures used by health plans to measure the performance of care and service. HEDIS is maintained by the National Committee for Quality Assurance, a not-for-profit organization committed to evaluating and publicly reporting on the quality of managed care and fee-for-service organizations. HEDIS measures look at how many of a plan's enrollees are receiving care that meets national standard. Many of the measures focus on preventative care, such as childhood vaccinations and mammograms. Other measures look at chronic illnesses such as asthma or diabetes. HEDIS metrics published in this report reflect overall Health First Colorado rates, which include managed care and fee-for-service.

What is EPSDT?

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children and youth ages 20 and under including adults who are pregnant, who are enrolled in Health First Colorado. EPSDT is key to ensuring that children and youth receive appropriate preventive, dental, behavioral health, developmental and specialty services.

States are required to provide comprehensive services and furnish all Health First Colorado coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions, based on certain federal guidelines. EPSDT is made up of the screening, diagnostic, and treatment services.

What is CAHPS\ECHO?

The consumer experience is captured annually by the administration of two surveys taken from the family of surveys developed by the Agency for Healthcare Research and Quality (AHRQ). Health First Colorado adult and child members are surveyed using the Consumer Assessment of Healthcare Providers and Systems (CAHPS) questionnaire. Behavioral Health consumers are also surveyed using the Experience of Care and Health Outcomes (ECHO) questionnaire. These surveys are administered every spring with results available in the fall. These results are compared to national benchmarks and state averages in order to direct program and process improvement of the consumer experience.

What is the Statewide Data Analytics Contractor (SDAC)

The SDAC is responsible for providing secure electronic access to clinically actionable data to the Regional Care Collaborative Organizations (RCCOs) and Primary Care Medical Providers (PCMPs) to help them meet the goals of the Accountable Care Collaborative (ACC) – to improve health outcomes and reduce costs.

What are BHO Performance Measures?

Performance measures evaluate the effectiveness of Behavioral Health Organizations (BHOs) using validated indicators. Reporting of measures is conducted annually. Additional performance measures may be requested by the Department or the Centers for Medicare & Medicaid Services (CMS). The BHOs and the department work together to develop agreed-upon measurement criteria, reporting frequency and other required components.



QUALITATIVE DATA SOURCE DEFINITIONS



DEFINITION OF MEASURE

Qualitative data can be arranged into categories that are not numerical. It is mainly collected through interviews, focus groups, surveys and observations.

What is the National Core Indicators- Aging and Disabilities (NCI-AD)?

NCI-AD is an initiative designed to support states' interest in assessing the performance of their programs and delivery systems and improving services for older adults, individuals with physical disabilities, and caregivers. NCI-AD is a collaborative effort among the National Association of States United for Aging and Disabilities (NASUAD), the Human Services Research Institute (HSRI), and the National Association of State Directors of Developmental Disabilities Services (NASDDDS). Like the developmental disability (DD) service system's National Core Indicators (NCI), NCI-AD's primary aim is to collect and maintain valid and reliable data that give states a broad view of how publicly-funded services impact the quality of life and outcomes of service recipients.

What are Performance Improvement Projects (PIPs)?

PIPs, are the method health plans use to improve clinical and non-clinical services. PIPs provide a structured approach to measuring performance, implementing change to improve performance, and measuring the resulting outcomes. Changes that lead to favorable sustained results become permanent standards, practices, or procedures. Changes that are not successful should be revised and re-measured so that improvements are made.

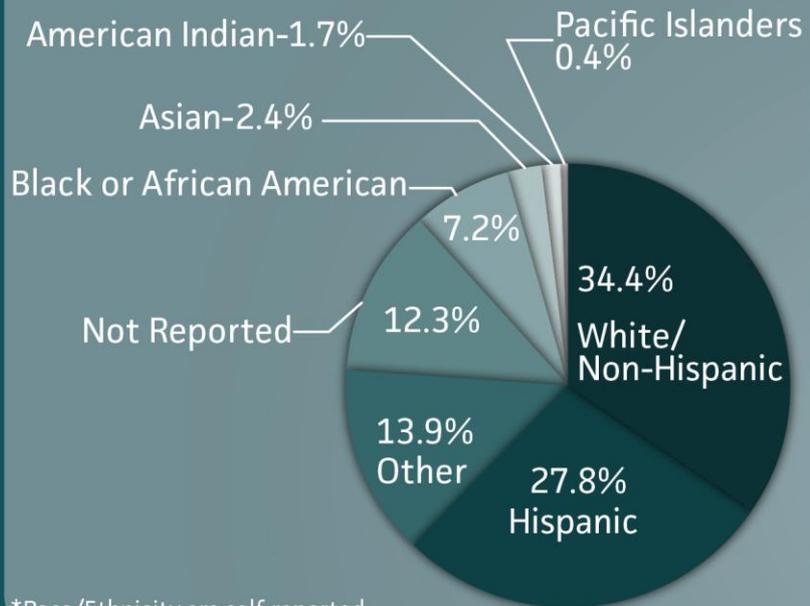
What are Testing Experience and Functional Tools (TEFT)?

TEFT is a planning grant which includes an experience survey field test on multiple Community-Based Long-Term Services and Supports (CB-LTSS) programs for validity and reliability; a demonstration of personal health records (PHR) systems with beneficiaries of CB-LTSS, and identification, evaluation and harmonization of electronic Long-Term Services and Supports (e-LTSS) standards in conjunction with the Office of National Coordinator Standards and Interoperability Framework. Also, we will work with our stakeholders to explore the possibility of field-testing the CARE tool in conjunction with another grant project.



Health First Colorado Demographic Characteristics March 2016

Race/Ethnicity

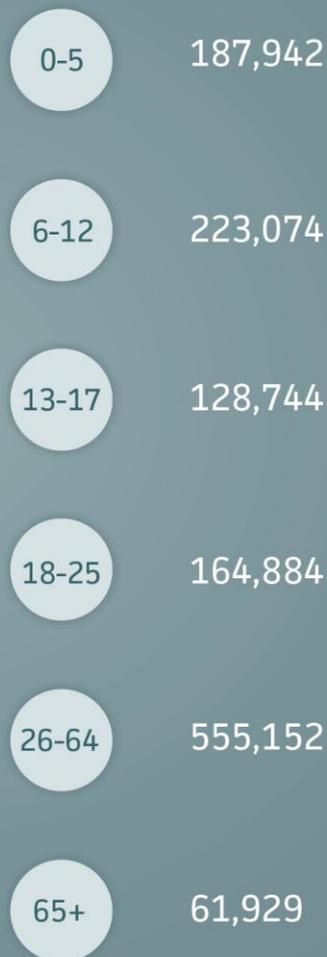


*Race/Ethnicity are self-reported.

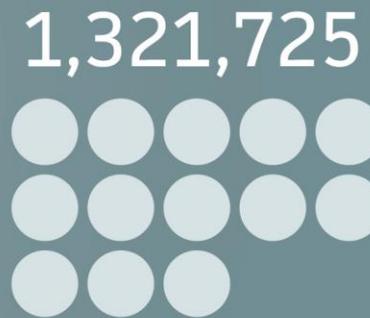


Health First Colorado Population

Population by Age



Total Health First Colorado Population





Behavioral Health Organizations





Behavioral Health Organizations

The Community Behavioral Health Services program is a statewide managed care program that provides comprehensive behavioral health and substance use disorder services to Health First Colorado members. The Department contracts with Behavioral Health Organizations (BHOs) to arrange and/or manage medically necessary behavioral health services to its members. Health First Colorado members are automatically enrolled in a BHO when they receive eligibility, based on where they live in the state.

Service Delivery

The BHOs are required to ensure that services are provided through a well-organized service delivery system. The service delivery system includes mechanisms for ensuring access to high quality, general and specialized care, from a comprehensive provider network. The BHOs' provider network includes Community Mental Health Centers (CMHCs), Federally Qualified Health Centers (FQHCs), hospitals, substance use disorder treatment facilities, and other providers. The BHOs' network also includes essential community providers, other private/not-for-profit providers, as well as providers with experience in serving individuals with complex needs, e.g. individuals with dual diagnoses and those

with chronic physical conditions in addition to behavioral health needs. Within its service delivery system, the BHOs promote the provision of behavioral health services by primary care physicians and behavioral health systems of care. Colorado's public behavioral health system currently includes seventeen (17) CMHCs, five (5) BHOs and six (6) specialty clinics.

BHO Performance Measures

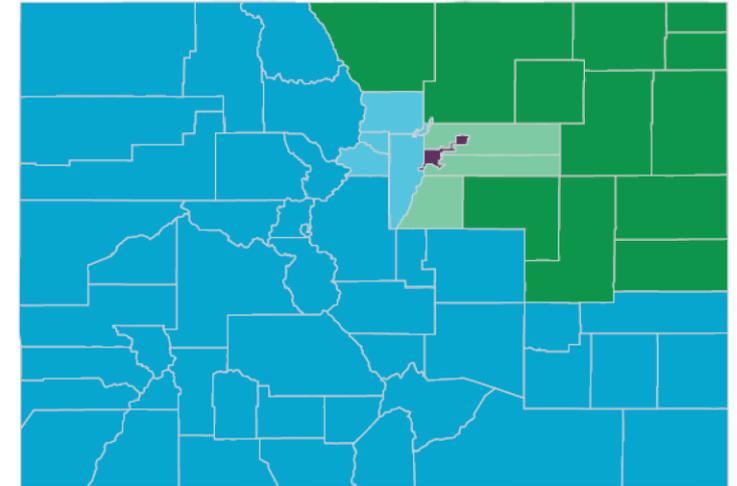
BHO performance is measured through validated metrics. These metrics are collected annually and provide an overview of how effectively the BHOs are taking care of their populations who need mental health and substance use disorder treatment.

BHO Enrollment Data



Source: FY 15/16 Network Adequacy Report Q2

BHO Map



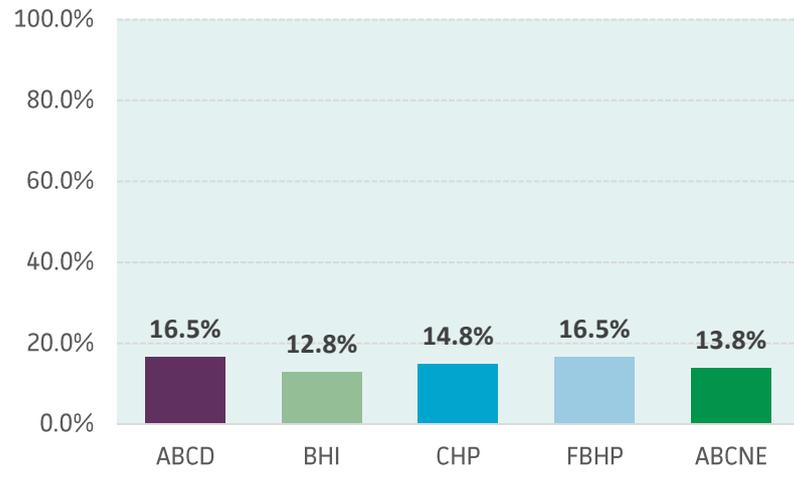


DEFINITION OF MEASURE

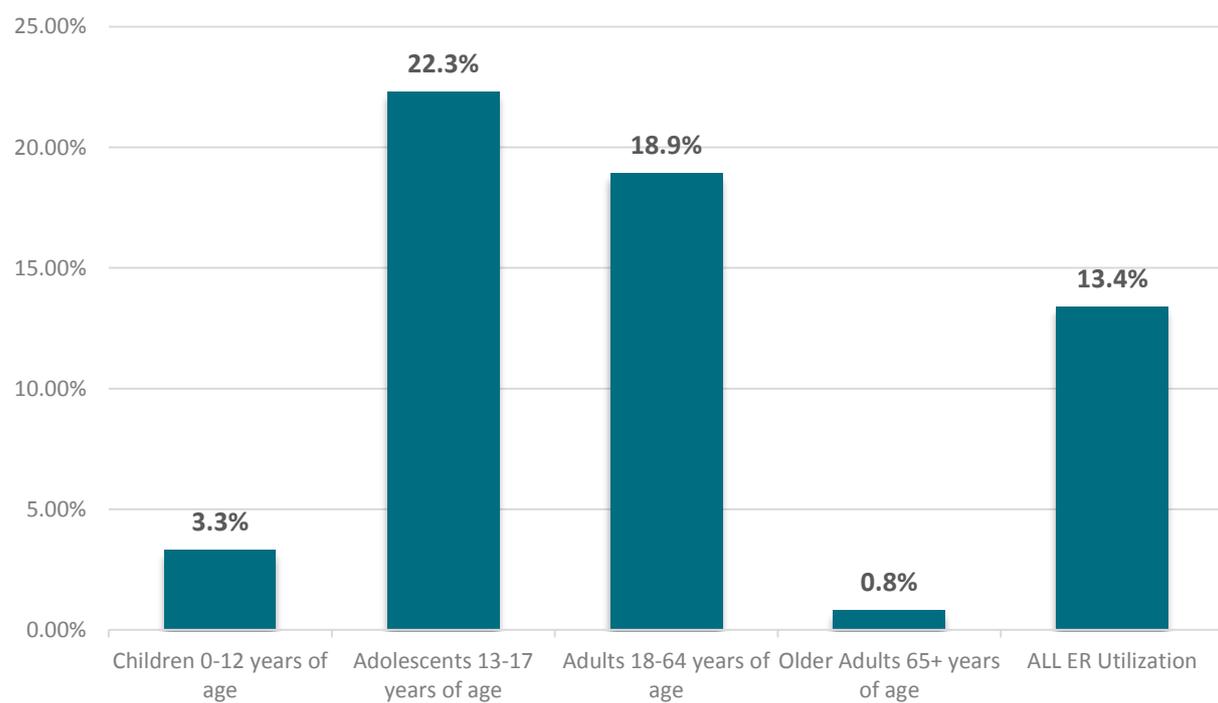
Percent of BHO Members with one contact (paid or denied) in a specified fiscal year (12-month period)

(Data Source: Performance Measures FY 2014-15)

BHO Utilization Rate (All Ages) FY 2014-15



BHO Emergency Room Utilization by Age Group, FY 2014-15



DEFINITION OF MEASURE

Numerator- BHO members (by age group) who had an ER visit,

Denominator- All BHO members by age group

(Data Source: Performance Measures FY 2014-15)



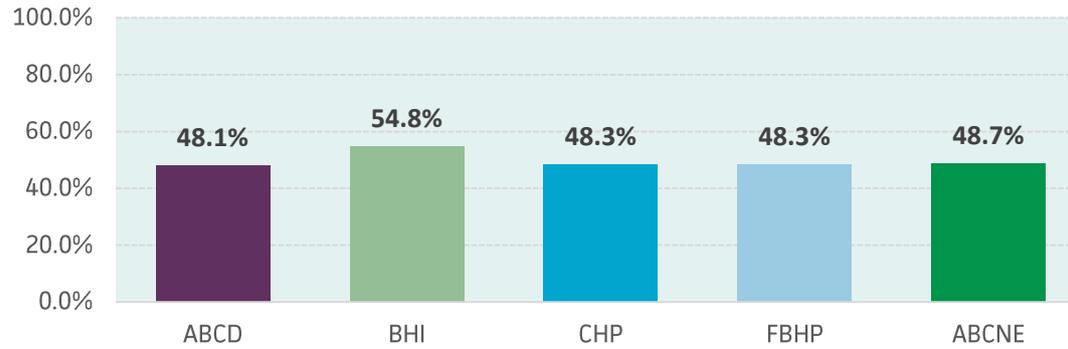
DEFINITION OF MEASURE

The percentage of members diagnosed with a covered mental health diagnosis who were engaged by the BHO through four engagement services within 45 days of initial visit or episode.

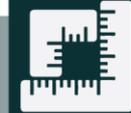
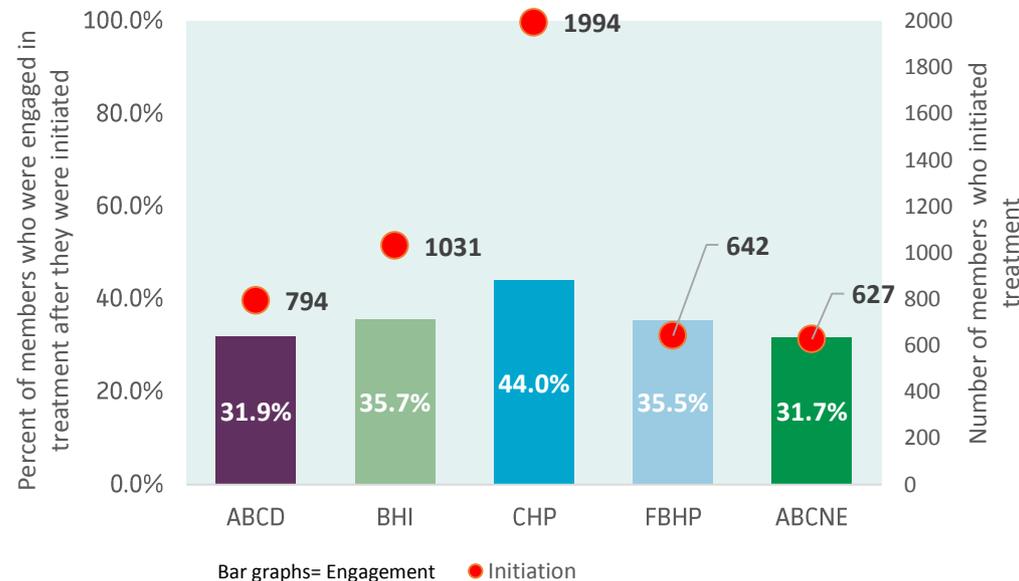
The initial visit may be counted as the first engagement service.

(Data Source: Performance Measures FY 2014-15)

Overall Mental Health Engagement/Individuals accessing behavioral health services with 4 visits in 45 days FY 2014-15



All Ages Initiation and Engagement of Alcohol and Other Drug Dependence Treatment FY 2014-15



DEFINITION OF MEASURE

The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following.

Initiation of AOD Treatment. The percentage of members who initiate treatment through an outpatient visit or intensive outpatient encounter within 14 days of the diagnosis.

Engagement of AOD Treatment. The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.

(Data Source: Performance Measures FY 2014-15)



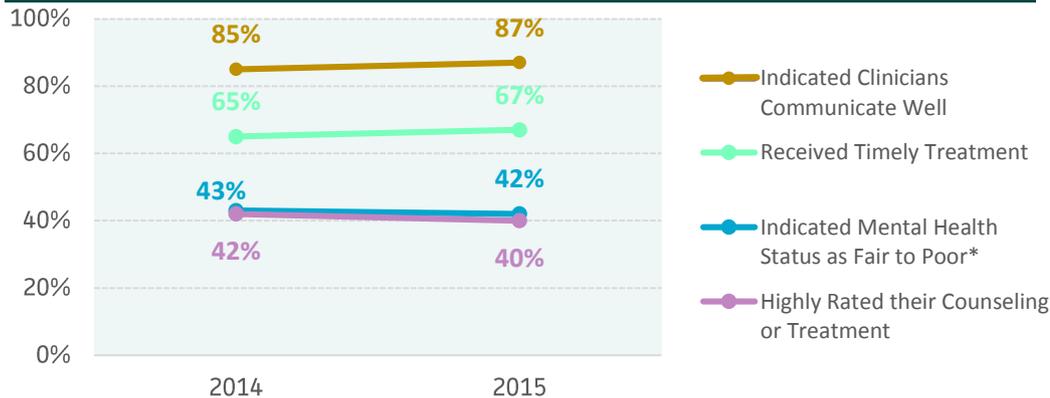
Experience of Care and Health Outcomes (ECHO®) Survey

The ECHO metrics outlined below are composite metrics that have been calculated by combining related survey questions to create a single measure. The methodology for each measure is as follows:

- Indicated Clinicians Communicated Well
 - In the last 12 months, how often did the people you went to for counseling or treatment listen carefully to you?
 - In the last 12 months, how often did the people you went to for counseling or treatment explain things in a way you could understand?
 - In the last 12 months, how often did the people you went to for counseling or treatment show respect for what you had to say?
 - In the last 12 months, how often did the people you went to for counseling or treatment spend enough time with you?
 - In the last 12 months, how often did you feel safe when you were with the people you went to for counseling or treatment?
 - In the last 12 months, how often were you involved as much as you wanted to be in your counseling or treatment?
- Received Timely Treatment
 - In the last 12 months, when you needed counseling or treatment right away, how often did you see someone as soon as you wanted?
 - In the last 12 months, not counting times you needed counseling or treatment right away, how often did you get an appointment for counseling or treatment as soon as you wanted?
- Indicated Mental Health Status as Fair or Poor
 - In general, how would you rate your overall mental health
- Highly Rated their Counseling or Treatment
 - Respondents were asked to rate all their counseling or treatment on a scale of 0 to 10, with 0 being the “worst counseling or treatment possible” and 10 being the “best counseling or treatment possible.”

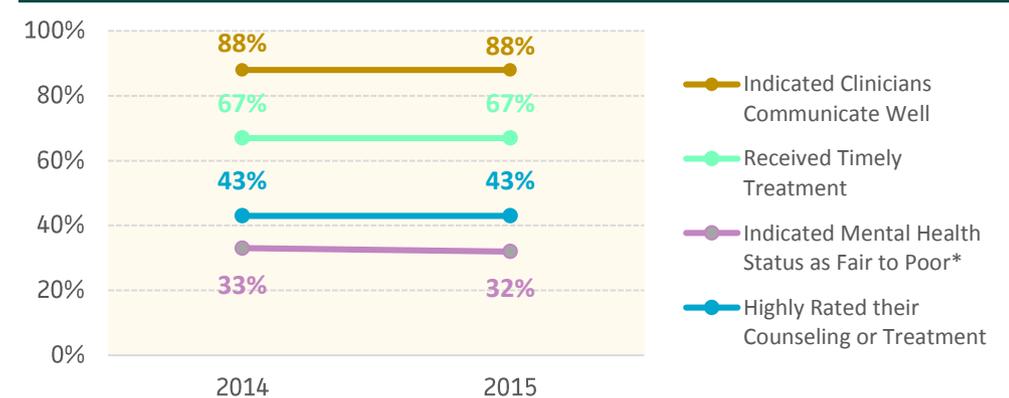
The ECHO survey is administered to Health First Colorado and indigent adults and children who have had at least one behavioral health service at any of the five BHOs in the previous year in order to measure the consumer experience. The summer of 2016 will mark the third year of administering this survey.

Adult ECHO Survey Questions 2015



*scores of 9 or 10 on a scale of 0 to 10

Youth ECHO Survey Questions 2015



Regional Care Collaborative Organizations





The Accountable Care Collaborative (ACC)

The ACC is designed to provide a person-centered approach to care by connecting members to medical and community resources, minimizing the barriers to access. The goal is better health outcomes at lower costs.

The ACC is composed of seven Regional Care Collaborative Organizations (RCCOs) throughout Colorado.

The RCCOs develop a network of Primary Care Medical Professionals (PCMPs) and support them with coaching and information. They also manage and coordinate member care; connect members with non-medical services; and report on costs, utilization and outcomes for their population of members. As of April 2016, there were 1,015,386 Health First Colorado members enrolled in the ACC.

Using Data in New Ways

Accountability is central to the ACC. The ACC is using existing data to learn about the needs of its population, how health care services are used, and how the ACC can improve health outcomes and contain costs. The State-wide Data and Analytics Contractor (SDAC) uses claims data to answer these questions.

Paying for Value

Payment is a powerful way to set into motion changes to the health care system. The ACC uses a hybrid of several payment strategies to shift the health care system from its current focus on delivering a high volume of services to getting the most value possible and rewarding for

outcomes. The program's strategy is incremental; payments that reward providers for the wise use of services and good health outcomes are gradually added. This incremental strategy is intentional, it is a way to gradually strengthen and build Colorado's health care infrastructure to adjust to a new way of thinking about care.

► Key Performance Indicators

RCCOs and PCMPs receive incentive payments based on their region's performance in certain key metrics. For FY 2015-16, these included:

1. reducing the number of emergency room visits;
2. increasing the number of children ages 3-9 who receive annual well-child checkups; and
3. increasing the number of women who receive postpartum care after delivery

► Performance Pool

RCCOs are eligible to receive additional payment based on their relative performance in certain areas. For FY 2014-15, RCCOs were measured on their performance in increasing the number of follow-up care appointments for clients within 30 days of discharge from a hospital.

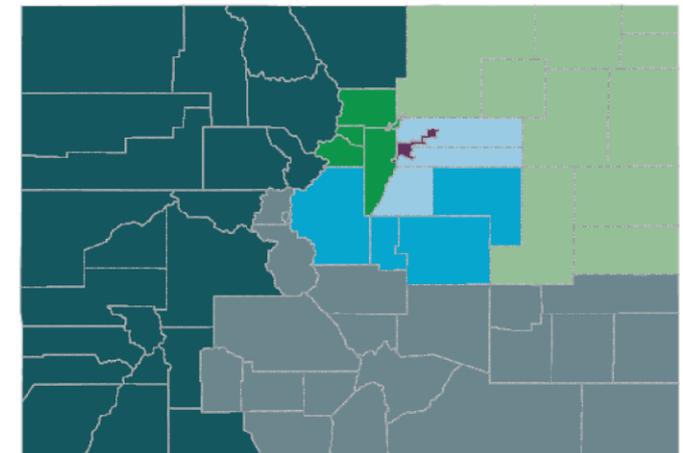
► Adjusted RCCO Payment for Clients without a Medical Home

RCCOs receive a reduced PMPM payment for each client who has remained unattributed to a medical home for six months or longer. The reduction is meant as an incentive for RCCOs to focus on finding a medical home for clients who don't have one. The number of clients linked to a PCMP increased by 10 percentage points during FY 2014-15.

► Enhancing Primary Care

Beginning in July 2014, PCMPs who were validated as meeting five of nine enhanced practice factors were eligible to receive an additional 50 cents per-member-per-month (PMPM) payment. Factors include items such as performing behavioral health screenings, offering extended office hours, tracking the status of and following up on specialty referrals, and developing person-centered care plans. For FY 2014-15, 265 practices were validated as enhanced PCMPs.

RCCO Map



ACC Enrollment in Detail





KPI Payment Incentive Summary (2/2015- 1/2016)

Each KPI has its own performance target. RCCOs that meet the target are eligible for incentive payments. This payment methodology provides incentives for PCMPs to provide preventive health care for their patient population.

1. Emergency Room Visits

None of the RCCOs reached the tier 2 rate of a 5 percent decrease in utilization; however, four of the seven RCCOs achieved Tier 1 for improvement (1 percent decrease in utilization).

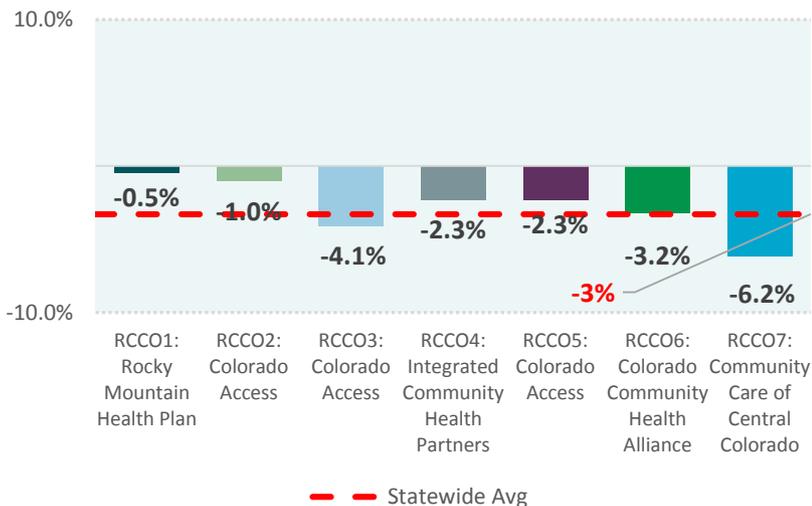
2. Well-Child Visits (Ages 3-9)

While this measure remains a top priority for all RCCOs, none of them were able to achieve the 60 percent tier 1 target for improvement. The Department continues to work with RCCOs on efforts to improve data to reflect visits that may not be counted due to billing inconsistencies.

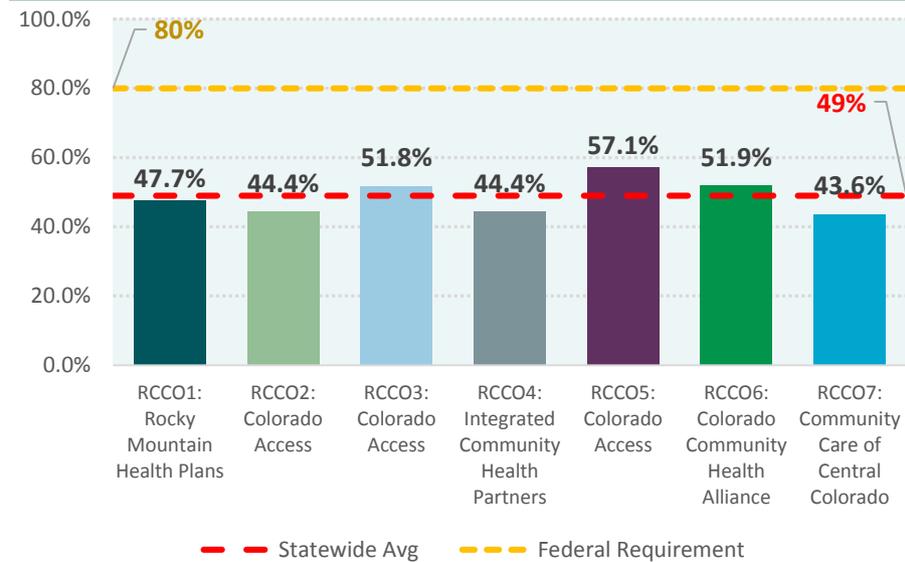
3. Postpartum Care

RCCO 2 achieved the tier two target, and two of the seven RCCOs received payment for achieving the tier one goal, while the remaining RCCOs all showed some improvement. The tier 1 and 2 goals for this measure are specific to each RCCO and based on performance improvement over the previous year.

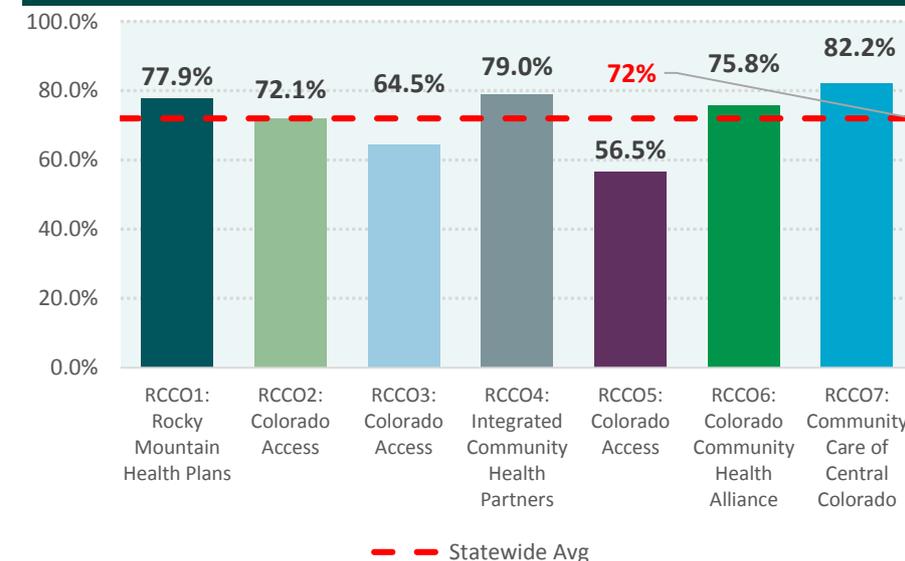
ER Visits – % difference from baseline, January 2016



Completed Well-Child Visit (Ages 3-9), January 2016



Postpartum Care, January 2016



Source: State Data Analytics Contractor

Health First Colorado Data





Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys

CAHPS data is representative of the Health First Colorado managed care, RCCO, fee-for-service (FFS), and Non-FFS populations.

Consumer experience of Health First Colorado members is measured annually by administering the CAHPS surveys. The focus on three global ratings and one composite rating helps direct program and process improvement.

DEFINITION OF MEASURE

Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist Seen Most Often (Global Measure)

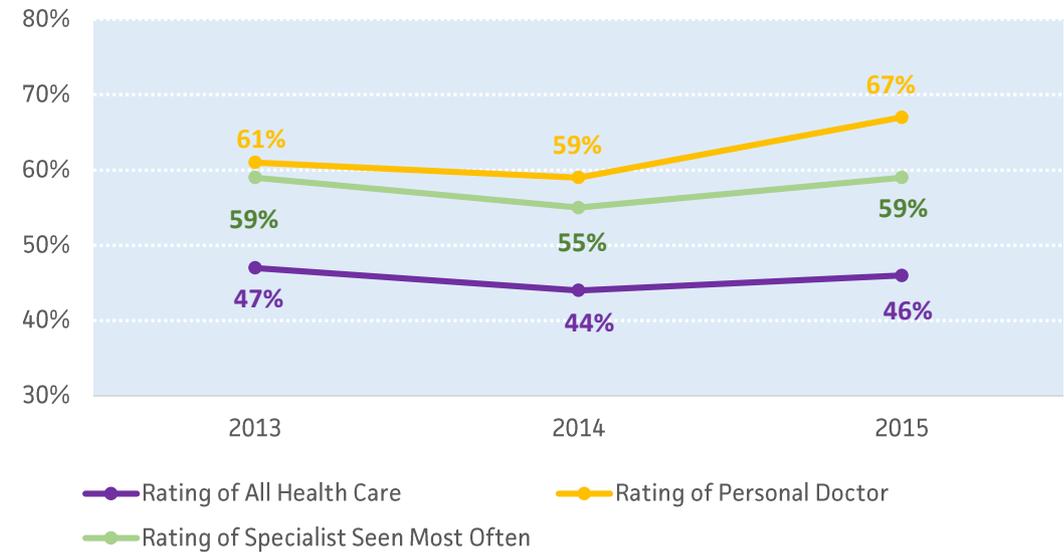
Adult Health First Colorado members were asked to rate all their health care, personal doctor and specialist seen most often on a scale of 0 to 10, with 0 being the worst care possible and 10 being the best care possible. Top-level responses are defined as those responses with a rating of 9 or 10.

(Data Source: CAHPS 2013-15)

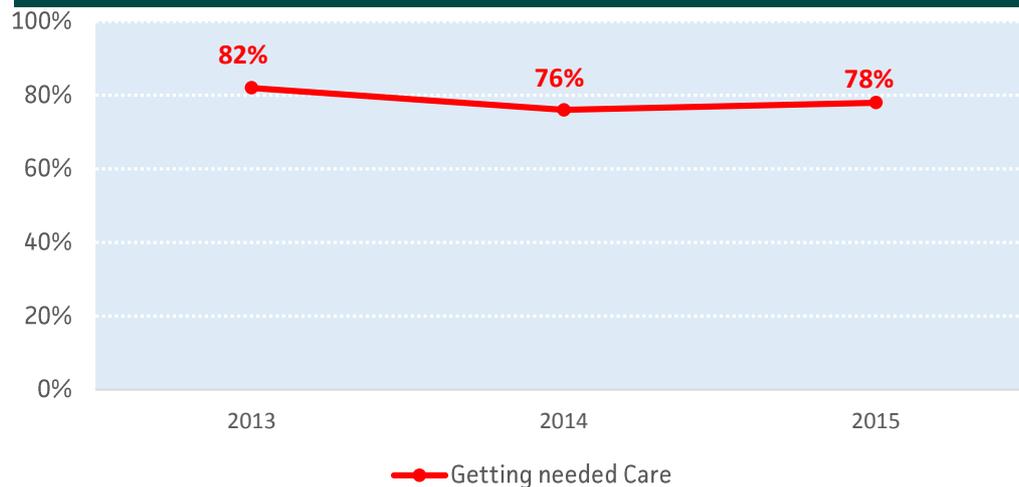
Rate differences have not been assessed for statistical significance in the overall Health First Colorado CAHPS rates reported below. They have only been calculated for the fee-for-service and managed care populations. For detailed additional rates and methodology, please visit the HCPF CAHPS website.

<https://www.colorado.gov/pacific/hcpf/client-satisfaction-surveys-cahps>

Client Rating of Health care, Personal Doctor and Specialist (Adults) Calendar Year (CY) 2013-2015



Getting Needed Care (Adults), CY 2013-2015



DEFINITION OF MEASURE

Getting Needed Care (Composite Measure)

Adult Health First Colorado members were asked two questions to assess how often it was easy to get needed care. In the last 6 months, how often was it easy to get the care, tests, or treatment you needed? And, In the last 6 months, did a doctor or other health provider order a blood test, x-ray, or other test for you? For each of these questions a top-level response is defined as a response of "usually" or "always."

(Data Source: CAHPS 2013-15)



CAHPS data is representative of the Health First Colorado managed care, RCCO, fee-for-service (FFS), and Non-FFS populations.

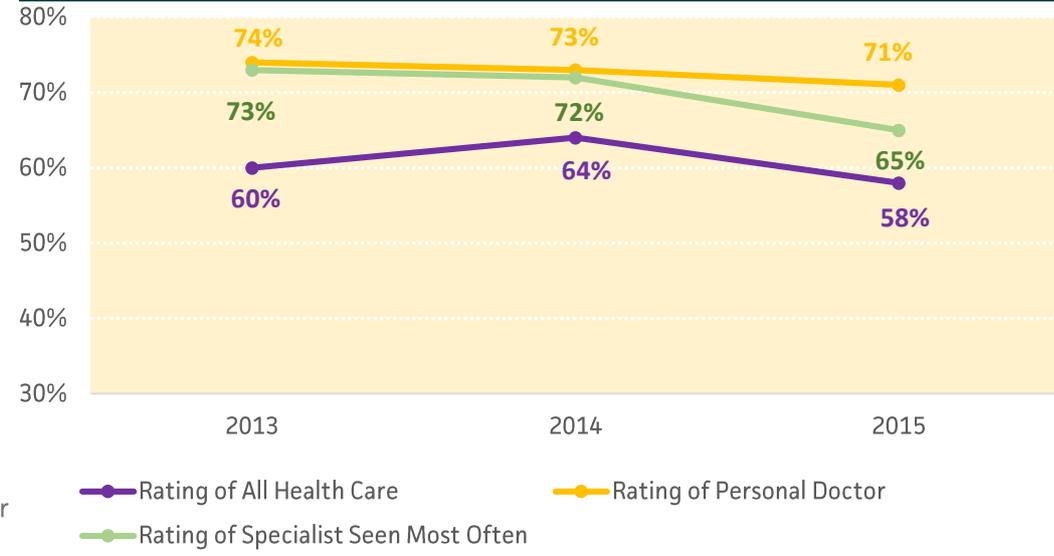
DEFINITION OF MEASURE

Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist Seen Most Often (Global Measure)

Children enrolled in Health First Colorado were asked to rate all their health care, personal doctor and specialist seen most often on a scale of 0 to 10, with 0 being the worst care possible and 10 being the best care possible. Top-level responses are defined as those responses with a rating of 9 or 10.

(Data Source: CAHPS 2013-15)

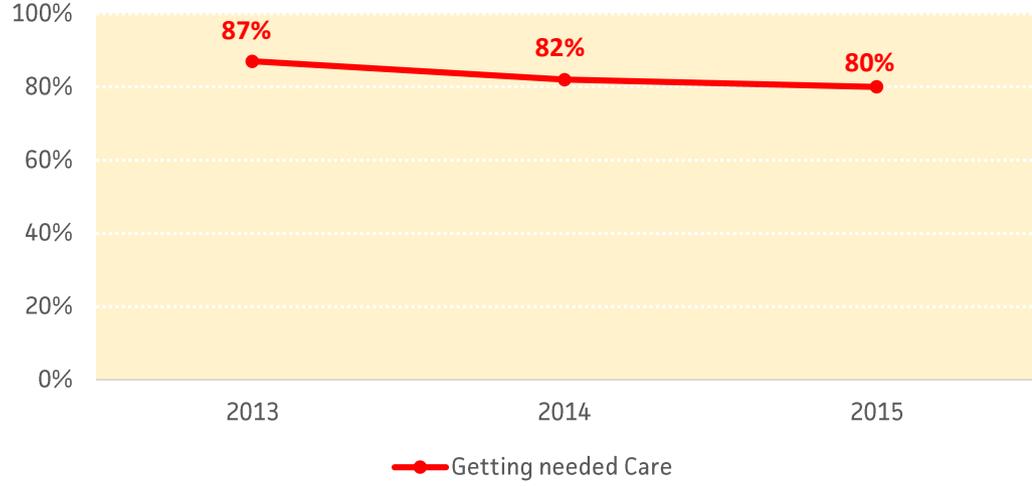
Client Rating of Health care, Personal Doctor and Specialist (Children) CY 2013-2015



Rate differences have not been assessed for statistical significance in the overall Health First Colorado CAHPS rates reported below. They have only been calculated for the fee-for-service and managed care populations. For detailed additional rates and methodology, please visit the HCPF CAHPS website.

<https://www.colorado.gov/pacific/hcpf/client-satisfaction-surveys-cahps>

Getting Needed Care (Children), CY 2013-2015



DEFINITION OF MEASURE

Getting Needed Care (Composite Measure)

Children enrolled in Health First Colorado were asked two questions to assess how often it was easy to get needed care. In the last 6 months, how often was it easy to get the care, tests, or treatment you needed? And, In the last 6 months, did a doctor or other health provider order a blood test, x-ray, or other test for you? For each of these questions a top-level response is defined as a response of "usually" or "always."

(Data Source: CAHPS 2013-15)



Performance Improvement Projects

A Performance Improvement Project (PIP) is a concentrated effort on a particular problem in one area of the health plan; it involves gathering information systematically to clarify issues or problems, and intervening for improvements. The health plan conducts PIPs to assess services in areas that the facility identifies as needing improved care and attention. In FY 2014/15, the Department required each BHO, managed care plan, and RCCO to conduct a PIP related to **Transitions of Care**.

Health Plan/ Region	Topic	% Score of Evaluation Elements Met	% Score of Critical Elements Met	Overall Validation Status
Managed Care				
Denver Health	Improving Follow-Up Communications Between Referring Providers and Pediatric Obesity Specialty Clinics	93	100	Met
Rocky Mountain Health Plans	Improving Transitions of Care for Individuals Recently Discharged from a Corrections Facility	100	100	Met
Behavioral Health Organizations				
Colorado Access/ Access Behavioral Care Northeast	Adolescent Depression Screening and Transition of Care to a Behavioral Health Provider	100	100	Met
Behavioral Healthcare, Inc.	Adolescent Depression Screening and Transition of Care to a Behavioral Health Provider	100	100	Met
Colorado Health Partnerships	Improving the Rate of Completed Behavioral Health Services Within 30 Days After Jail Release	100	100	Met
Foothills Behavioral Health Partners	Improving Transition from Jail to Community-Based Behavioral Health Treatment	100	100	Met
Colorado Access/ Access Behavioral Care Denver	Adolescent Depression Screening and Transition of Care to a Behavioral Health Provider	100	100	Met
Regional Care Collaborative Organizations				
Rocky Mountain Health Plans	Improving Transitions of Care for Individuals Recently Discharged from a Corrections Facility	100	100	Met
Colorado Access	Adolescent Depression Screening and Transition of Care to a Behavioral Health Provider	100	100	Met
Colorado Access	Adolescent Depression Screening and Transition of Care to a Behavioral Health Provider	100	100	Met
Integrated Community Health Partners	Improving the Rate of Completed Behavioral Health Services Within 30 Days After Jail Release	91	83	Partially Met
Colorado Access	Adolescent Depression Screening and Transition of Care to a Behavioral Health Provider	100	100	Met
Colorado Community Health Alliance	Depression Screening and Transition to a Behavioral Health Provider	100	100	Met
Community Care of Central Colorado	Medical respite Care for Homeless RCCO Members Discharged from Hospital Inpatient Stay	88	100	Met



Health First Colorado Suicide Rate

DEFINITION OF MEASURE

The Colorado Department of Public Health and Environments death certificates were used to estimate the Health First Colorado suicide rate. Health First Colorado client IDs were matched to death certificates that indicated death by suicide.

(Data Source: Health First Colorado Claims Data)

“Suicide is a serious public health problem that causes immeasurable pain, suffering, and loss to individuals, families, and communities nationwide. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Suicide prevention efforts seek to:

- Reduce factors that increase the risk for suicidal thoughts and behaviors
- Increase the factors that help strengthen, support, and protect individuals from suicide

Ideally, these efforts address individual, relationship, community, and societal factors while promoting hope, easing access into effective treatment, encouraging connectedness, and supporting recovery.”

Source: Substance Abuse and Mental Health Services Administration



STRATEGIES FOR IMPROVEMENT

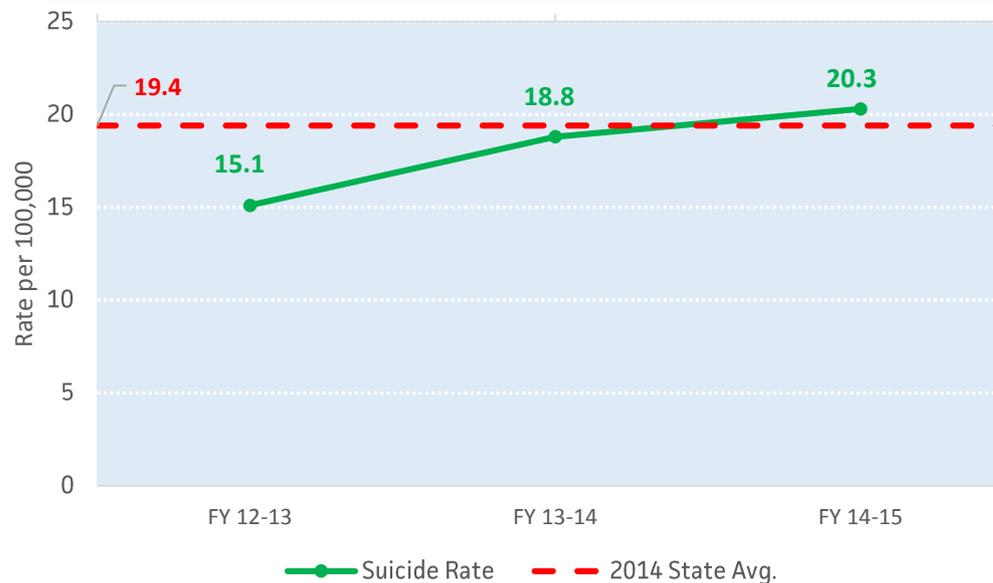
- Early identification of behavioral health problems and treatment.
- Follow-up care and community support.
- Training for health workers.
- Physical and behavioral health integration.
- Evidence-based preventive measures.

Source: World Health Organization

The increase in the suicide rate is mostly attributed to the Health First Colorado expansion population. In fiscal year 14-15, the expansion population accounted for 31% of the Health First Colorado Population, yet accounted for 59% of the suicides in that year. The suicide rate for the Health First Colorado non-expansion population in fiscal year 14-15 was 12.8 per 100,000.

(Expansion Population: Those who enrolled as a result of the expansion of Medicaid eligibility outlined in the Accountable Care Act and authorized by the Colorado General Assembly in 2013.)

Colorado Medicaid Suicide Rate FY 2013-15

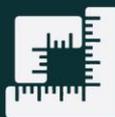


Family Formation





Timeliness of Prenatal Care



DEFINITION OF MEASURE

This measure is used to assess the percentage of live births during the measurement year for women that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization.

(Data Source: HEDIS 2013-15)

“Preventive medicine is fundamental to prenatal care. Healthy diet, counseling, vitamin supplements, identification of maternal risk factors and health promotion must occur early in pregnancy to have an optimal effect on outcome. Poor outcomes include spontaneous abortion, low-birth-weight babies, large-for-gestational-age babies and neonatal infection. Early prenatal care is also an essential part of helping a pregnant woman prepare to become a mother. Ideally, a pregnant woman will have her first prenatal visit during the first trimester of pregnancy. Some women enroll in an organization at a later stage of pregnancy; in this case, it is essential for the organization to begin providing prenatal care as quickly as possible.”

Source: Agency for Healthcare Research and Quality



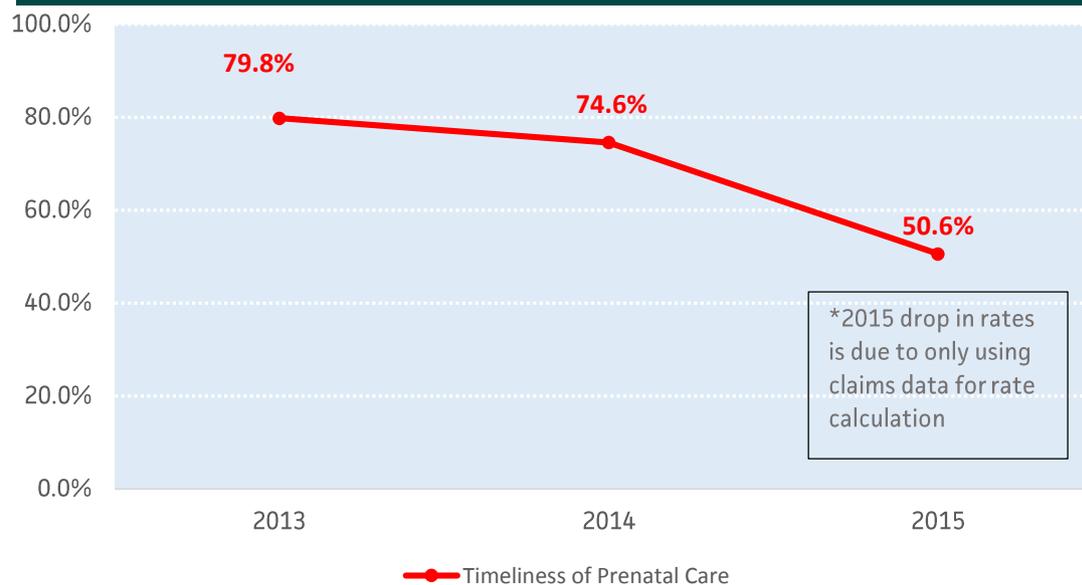
STRATEGIES FOR IMPROVEMENT

- Counseling women to engage in healthy behaviors such as reproductive life planning, folic acid consumption, and proper nutrition.
- Counseling women to avoid certain risks (such as alcohol consumption, smoking, prescription and over-the-counter teratogenic drug use, excess vitamin intake, undernutrition, and exposure to toxic substances)
- Develop outreach strategies to increase prenatal care utilization.

Source: Centers for Disease Control and Prevention

In 2015, the timeliness of the prenatal care measure was calculated using administrative methodology. In 2013 and 2014, the measure was calculated using a hybrid methodology, which includes a chart review. Therefore, there is a significant decrease in the 2015 data.

Timeliness of Prenatal Care, CY 2013-15





Postpartum Care

“The American College of Obstetricians and Gynecologists recommends that women see their health care provider at least once between four and six weeks after giving birth. The first postpartum visit should include a physical examination and is an opportunity for the health care practitioner to answer parents' questions, and give family planning guidance and counsel on nutrition.”

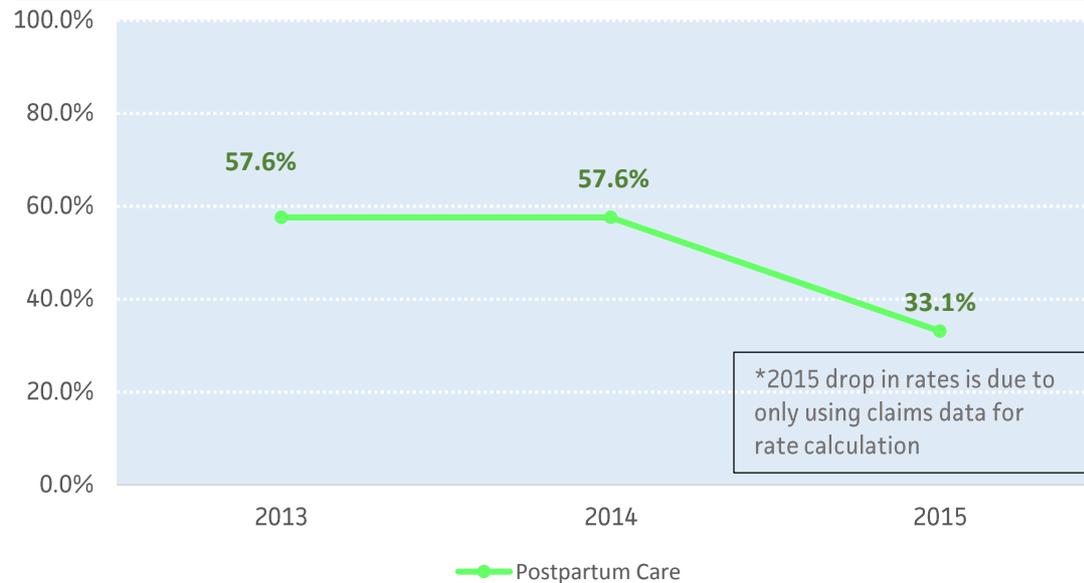
Source: Agency for Healthcare Research and Quality

DEFINITION OF MEASURE

This measure is used to assess the percentage of deliveries during the measurement year that had a postpartum visit on or between 21 and 56 days after delivery.

(Data Source: HEDIS 2013-15)

Postpartum Care, CY 2013-15



*The postpartum care measure is a KPI that has an incentive payment tied to it if the RCCOs reach a specific goal.

Incentive payments use SDAC data to assess performance.

The HEDIS postpartum measure on this page should not be compared to the SDAC measure, due to different calculation methodologies.

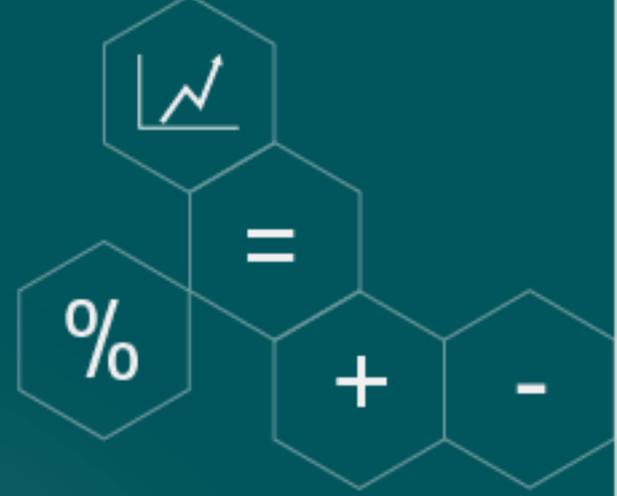


STRATEGIES FOR IMPROVEMENT

- Identify community supports.
- Provide maternal health information packets.
- Provide information by telephone and mail.
- Provide regular telephone follow-up.
- Distribute postpartum depression screening and treatment guidelines for PCPs and OB/GYNs.

Source: Centers for Disease Control and Prevention

In 2015, the postpartum care measure was calculated using administrative methodology. In 2013 and 2014, the measure was calculated using a hybrid methodology, which includes a chart review. Therefore, there is a significant decrease in the 2015 data.



Children and Adolescents





Childhood Immunization

DEFINITION OF MEASURE

This measure included all children enrolled at least 12 months before their 2nd birthday who turned 2 years old during the measurement year. The percentage shows how many of these children received appropriate immunizations.

(Data Source: HEDIS 2013-15)

Childhood immunization is one of the most beneficial, low-risk and cost-effective steps we can take to protect the health of our children. Colorado's vaccination rates are generally similar to the national Medicaid rates, but there is still room for improvement. Incomplete vaccination can leave children vulnerable to diseases that haven't been common in the United States for decades such as measles, mumps, that still threaten children, but that still threaten children in countries where vaccines are not as widely available. Health care workers and parents must work together to make sure children are protected from these illnesses.

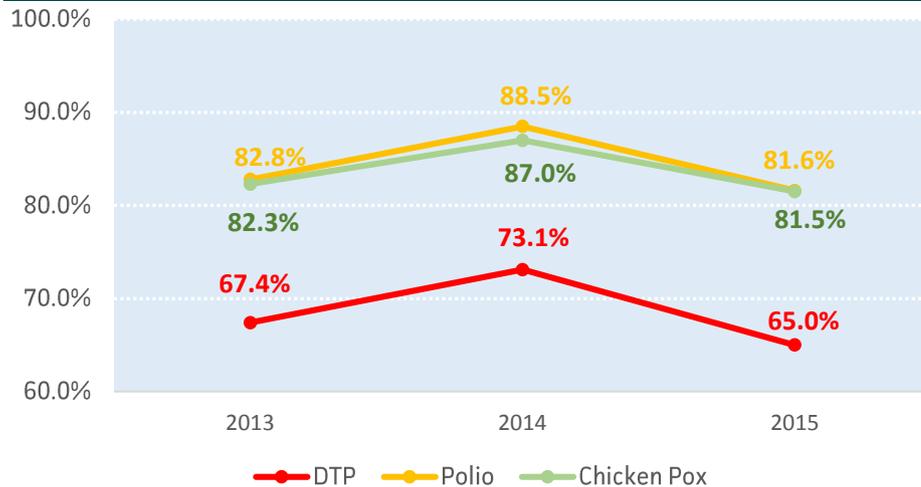


STRATEGIES FOR IMPROVEMENT

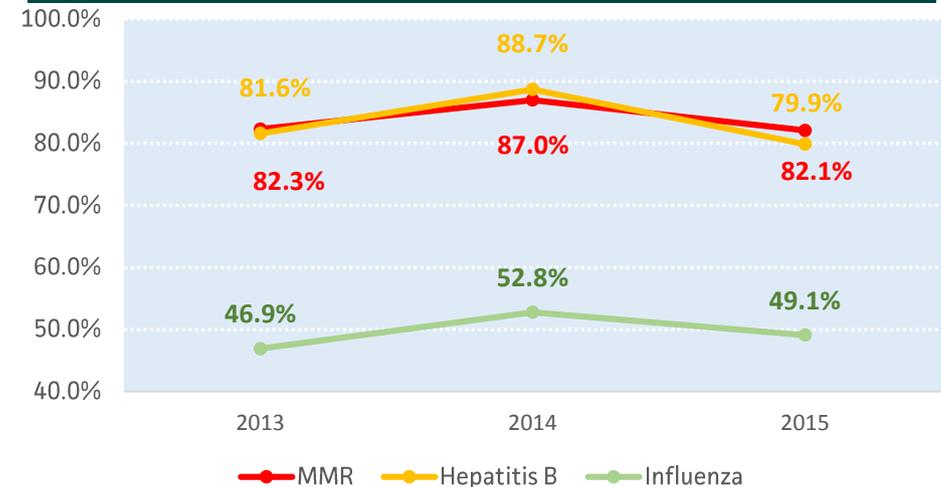
- Assess immunization status and give needed vaccinations during every office visit.
- Give multiple vaccinations whenever possible.
- Outreach to parents through a reminder system.
- Document all vaccinations delivered in schools and health departments.
- Inform immunization providers about their performance.
- Utilize the Colorado Immunization Information System (CIIS).

*Data for 2013 and 2015 were calculated using administrative methodology. Rates for 2014 were estimated using hybrid methodology which includes chart review. Administrative methodology may cause under reporting that can lead to lower reporting rates.

DTP, Polio, and Chicken Pox Vaccinations, CY 2013-15



MMR, Hepatitis B, and Influenza Vaccinations, CY 2013-15





Well-Child Visits



DEFINITION OF MEASURE

This measure includes the total number of well-child screenings received during the federal fiscal year for individuals who were eligible for screenings based on the state periodicity schedule.

(Data Source: EPSDT FFY 14-15)

“Well-child visits are of particular importance during the first year of life, when an infant undergoes substantial changes in abilities, physical growth, motor skills, hand-eye coordination and social and emotional growth. Regular check-ups are one of the best ways to detect physical, developmental, behavioral and emotional problems. They also provide an opportunity for the clinician to offer guidance and counseling to the parents.”

Although Colorado lags behind federal requirements for EPSDT well-child visits, there are continuous efforts to increase the rate at which children visit their doctor for preventative health care services.

Source: Agency for Healthcare Research and Quality



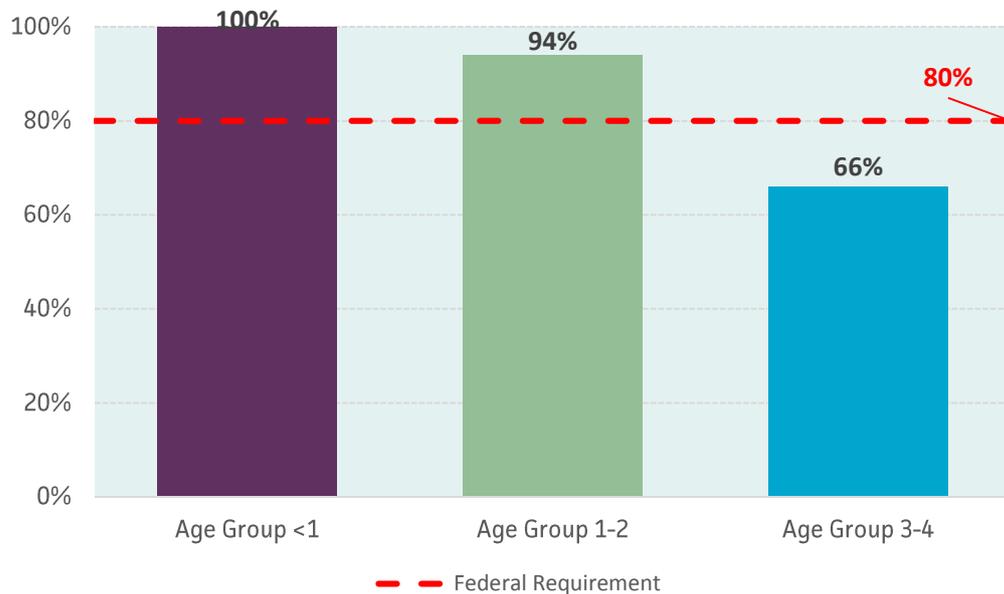
STRATEGIES FOR IMPROVEMENT

- Publish state periodicity schedule to increase awareness of services offered
- Inform parents and families on the importance of well-child visits.
- Use correct billing codes for well-child visits.
- Work with school-based and community health centers.
- Engage Key Community stakeholders.

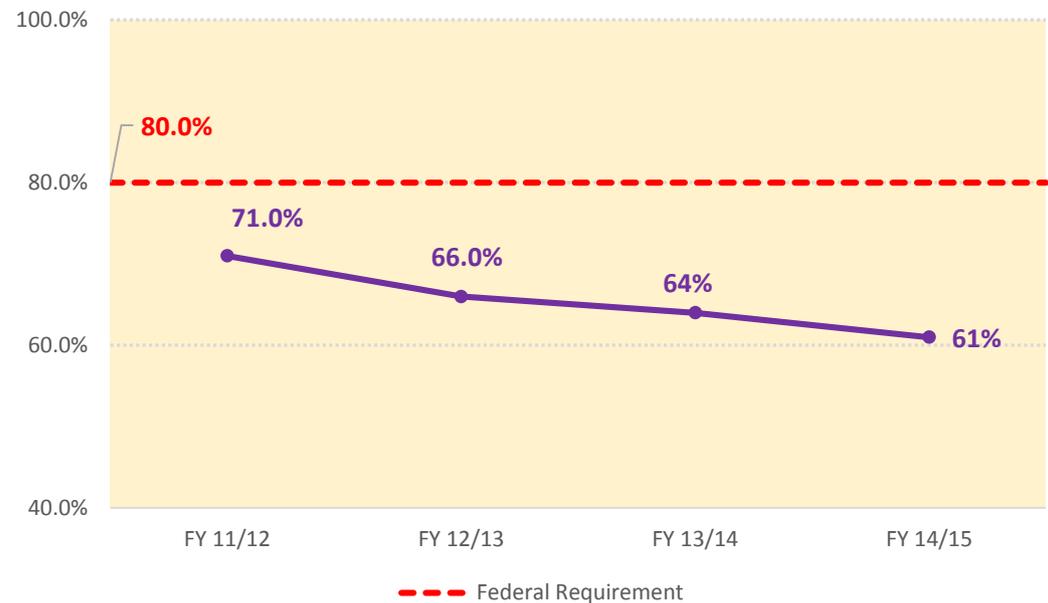
Source: Centers for Medicare & Medicaid Services

*The Statewide Data Analytics Contractor (SDAC) uses different methodology to calculate well-child visits. Therefore comparative analysis between EPSDT and SDAC data should be conducted with caution.

Well-Child Visit Rates for Children 0-5 in Colorado, FFY 2014-15

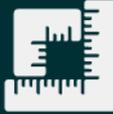


Well-Child Visit Rates for Children 0-20 in Colorado, FFY 2011-15





Children Receiving Any Dental or Oral Health Services



DEFINITION OF MEASURE

This measure includes the total of unduplicated individuals receiving dental or oral health services during the measurement year.

(Data Source: EPSDT FFY 2014-15)

“Oral health is often overlooked as an important overall component of health. Tooth decay is the most common chronic disease among children age 5 and under. If left untreated, pain and infection from tooth decay can cause problems with nutrition, speaking and learning. In addition, poor oral health has been linked to poor performance in school, poor social relationships, and less success later in life. Populations especially vulnerable to dental caries are children with special health care needs as well as children from low socio-economic backgrounds. Early diagnosis and treatment of dental caries, will ensure the health and well-being of a child.”

Source: Colorado Cross Agency Collaborative: Measuring Child Health, 2015

Colorado requests that a child start seeing an oral health provider by age one or at the eruption of the first tooth.

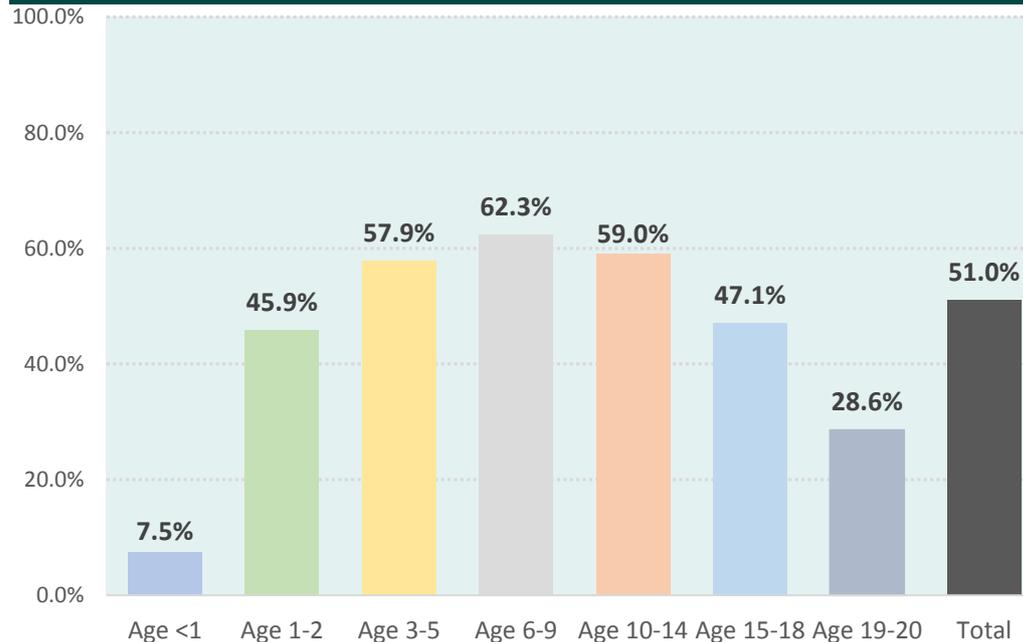


STRATEGIES FOR IMPROVEMENT

- Notify parents of their child’s dental benefits and the importance of oral health, during well-child visits.
- Improving access to care by providing assistance with establishing dental homes for people in the community.
- Track overdue visits and follow up with parents when necessary.
- Support improved access to oral health care for the underserved.
- Send reminders, such as postcards, emails and text messages when a client is due for a visit.

Source: American Dental Association

Children Receiving Any Dental or Oral Health Services, FFY 2014-15

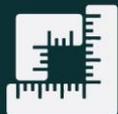




Depression Screening

“Depression is among the leading causes of disability in persons 15 years and older. It affects individuals, families, businesses, and society and is common in patients seeking care in the primary care setting. Depression is also common in postpartum and pregnant women and affects not only the woman but her child as well.”

U.S. Preventive Services Task Force



DEFINITION OF MEASURE

This measure represents unique screens that were billed to Health First Colorado Fee-For-Service during the measurement year, this does not include managed care encounters. Medicare-Health First Colorado members were not included.

(Data Source: Health First Colorado Claims Data)



STRATEGIES FOR IMPROVEMENT

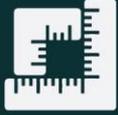
- Provide depression screens during primary care visits.
- Integrate physical and behavioral health into one service setting.
- Provide screenings at all touch points.

Depression Screenings by Age Group, FY 13-15





Adolescent Well-Visits



DEFINITION OF MEASURE

This measure is used to assess the percentage of enrolled members 12 through 21 years of age who had at least one comprehensive well visit with a primary care practitioner or an obstetrics and gynecology practitioner during the measurement year.

(Data Source: HEDIS 2013-15)

Well-care visits give health care providers a great opportunity to help teenagers who are at risk for many preventable health problems. During these visits doctors have the opportunity to discuss nutrition, physical activity and screen for depression and safety (including substance abuse and sexuality). All of the leading causes of adolescent non-fatal and fatal incidents are avoidable and well-care services are one way for teens to get the help they need beforehand.

Counseling and treatment can help adolescents avoid or recover from a number of problems including addictive behaviors like alcohol abuse, smoking and drug use; eating or behavioral disorders; sexually transmitted diseases and pregnancy.

The American Academy of Pediatrics recommends parents leave the room for a portion of the exam so that adolescents may freely discuss confidential health issues with their healthcare provider. This helps to ensure that important health concerns will not be overlooked due to a teen's concern for privacy, and provides a "bridge" toward becoming an adult and handling health issues independently.

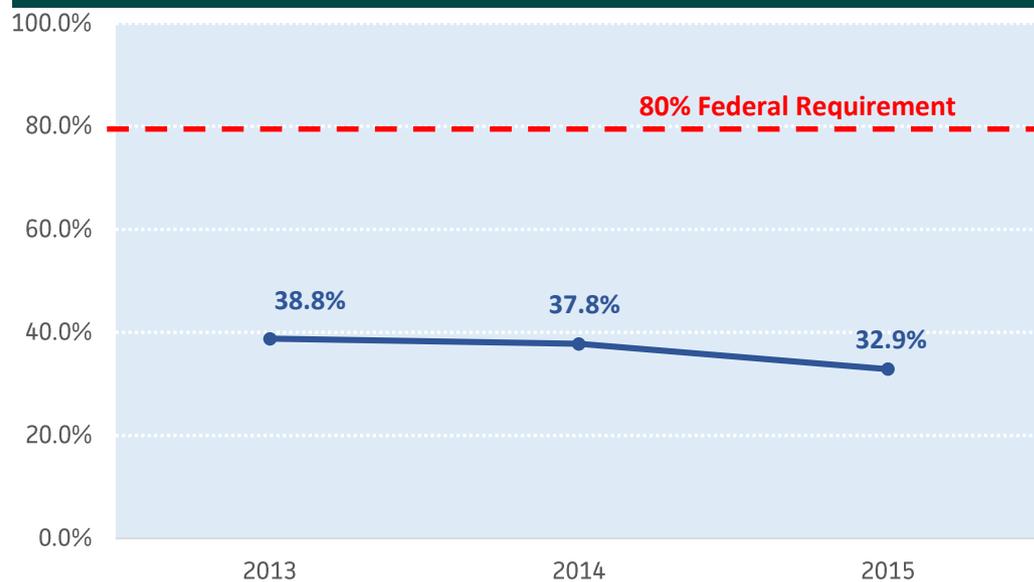


STRATEGIES FOR IMPROVEMENT

- Motivate adolescents to make and keep well visit appointments.
- Inform parents and families on the importance of well visits.
- Encourage adolescent friendly practices.
- Create adolescent friendly materials.
- Use episodic and acute care to increase well-care visits
- Use social networking for outreach.
- Work with school-based and community health centers.

Source: Centers for Medicare & Medicaid Services

Adolescent (Ages 12-21) Well-Visit Rates, 2013-15



What's the Difference Between a Well-care Exam and a Sports Physical?

Local high schools require athletes to provide proof of an annual physical exam in order to participate in high school sports. A sports physical is simply an exam that helps determine if it is safe for the athlete to participate in a particular sport. An annual well-care exam gives doctors a chance to perform a thorough physical exam and health assessment. It's also a good chance to address important adolescent issues.

Source: Colorado Cross Agency Collaborative: Measuring Child Health, 2015



Teen Pregnancies

DEFINITION OF MEASURE

This measure assesses the number of women between the ages of 15-17 who gave birth to a live child.

(Data Source: (Birth certificate FY 2012-13)

“Less favorable socioeconomic conditions, such as low education and low income levels of a teen's family, may contribute to high teen birth rates. Teens in child welfare systems are at higher risk of teen pregnancy and birth than other groups. For example, young women living in foster care are more than twice as likely to become pregnant than those not in foster care.

Teens need access to youth-friendly contraceptive and reproductive health services and support from parents and other trusted adults, who can play an important role in helping teens make healthy choices about relationships, sex, and birth control. Efforts at the community level that address social and economic factors associated with teen pregnancy also play a critical role in addressing racial/ethnic and geographical disparities observed in teen births in the US.”

Source: Center for Disease Control and Prevention

STRATEGIES FOR IMPROVEMENT

- Provide medically accurate, comprehensive sex education to youth
- Ensure youth have access to all FDA approved contraceptives such as condoms, the pill or long acting reversible contraceptives.
- Provide information on strategies supporting youth in delaying child bearing until adulthood.

Health First Colorado Teen Births per 1,000 (Ages 15-17) , 2013-15



The Department works collaboratively through various interagency (CDPHE, CDHS, and CDE) workgroups to prevent unintended teen pregnancies by:

- Making accurate reproductive health information available to all youth and their families.
- Encouraging youth to make informed reproductive health decisions, respecting their confidentiality yet encouraging parental involvement.
- Identifying and supporting youth and families in accessing statewide resources to aid and encourage safe and healthy life choices.
- Supporting health care providers in creating youth-friendly services and clinical care environments.



Adults





Breast Cancer Screening

In Colorado, an estimated 3,780 new cases of breast cancer were diagnosed in 2014, according to the American Cancer Society, and as many as 530 women died from the disease. Breast cancer is most common in women over 50. Women whose breast cancer is detected early have more treatment choices and better chances for survival.

Mammography screening has been shown to reduce mortality by 20 to 30 percent among women 40 and older. A mammogram can reveal tumors too small to be felt by hand; it can also show other changes in the breast that may suggest cancer.

DEFINITION OF MEASURE

This measure is used to assess the percentage of women 50 to 74 years of age who had a mammogram to screen for breast cancer.

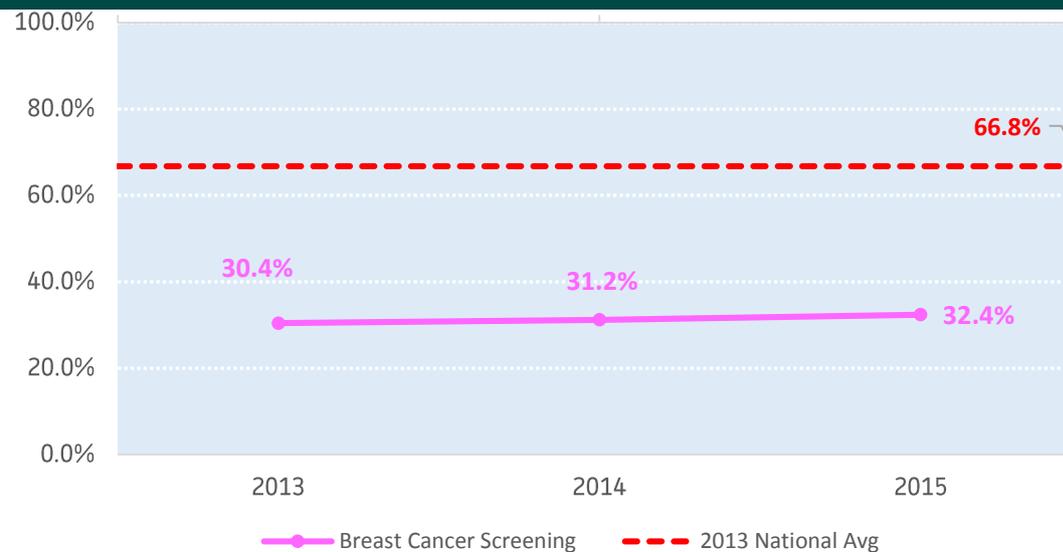
(Data Source: HEDIS 2013-15)

STRATEGIES FOR IMPROVEMENT

- Educate women about breast and cervical cancer screening through traditional media and new communication avenues like social media.
- Use state and local health departments' existing infrastructure to monitor the provision of screening services in every community.
- Develop more systematic approaches to cancer screening to organize health care providers' efforts.

Source: Centers for Disease Control and Prevention

Breast Cancer Screening, CY 2013-15





Cervical Cancer Screening



DEFINITION OF MEASURE

This measure includes women ages 21 to 64 who were screened for cervical cancer during the measurement year.

(Data Source: HEDIS 2013-15)

“Multiple studies indicate that over 50 percent of cervical cancers occur in women who have never been screened. At the same time, many women are screened for cervical cancer more frequently than is supported by the evidence, resulting in significant unnecessary health care expenditures and patient inconvenience. Therefore, it is this population that the guideline is intended to impact the greatest. Significant risk factors for cervical cancer are failure to be screened on a regular basis and a previously abnormal Pap test within the last five years.

Most guidelines call for women to begin having regular pap smears and pelvic exams at age 21, or within three years of the first time they have sexual intercourse.”

Source: Agency for Healthcare Research and Quality



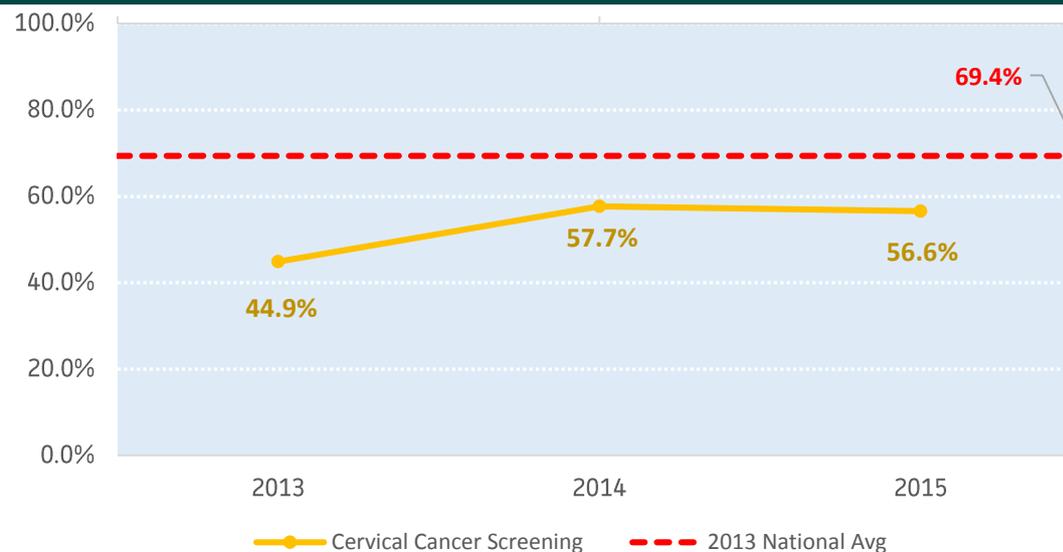
STRATEGIES FOR IMPROVEMENT

- Educate patients about the need for Pap smears starting no later than age 21.
- Provide follow-up care for abnormal Pap smear results.
- Create links to referral sites and screening centers for follow-up of abnormal tests.
- Create outreach strategies using social media.

Source: Centers for Disease control and Prevention

*Data for 2013 was calculated using administrative methodology. Rates for 2014 and 2015 were estimated using hybrid methodology which includes chart review. Administrative methodology may cause under reporting that can lead to lower reporting rates.

Cervical Cancer Screening, 2013-15





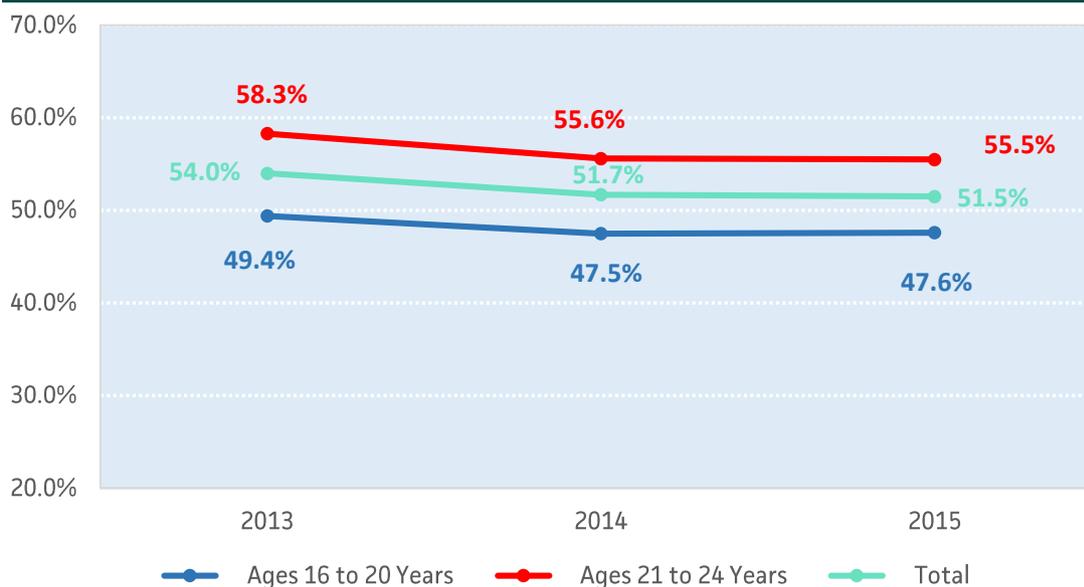
Chlamydia Screening

“Chlamydia trachomatis is the most common sexually transmitted disease (STD) in the United States (U.S.). The Centers for Disease Control and Prevention (CDC) estimates that approximately three million people are infected with chlamydia each year. Risk factors associated with becoming infected with chlamydia are the same as risks for contracting other STDs (e.g., multiple sex partners). Chlamydia is more prevalent among adolescent (15 to 19) and young adult (20 to 24) women.

Screening is essential because the majority of women who have the condition do not experience symptoms. The main objective of chlamydia screening is to prevent pelvic inflammatory disease (PID), infertility, and ectopic pregnancy, all of which have very high rates of occurrence among women with untreated chlamydia infection. The specifications for this measure are consistent with current clinical guidelines, such as those of the U.S. Preventive Services Task Force (USPSTF) (2001).”

Source: Agency for Healthcare Research and Quality

Chlamydia Screening, CY 2013-15



DEFINITION OF MEASURE

Percentage of women 16 to 24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

(Data Source: HEDIS 2013-15)



STRATEGIES FOR IMPROVEMENT

- Annual chlamydia screening of all sexually active women younger than 25 years, as well as older women with risk factors such as new or multiple sex partners, or a sex partner who has a sexually transmitted infection.
- Educate patients about symptoms and treatment.
- Educate patients about safe sex and abstinence.

Source: Centers for Disease Control and Prevention

*Data for 2014 and 2015 were calculated using administrative methodology. Rates for 2013 were estimated using hybrid methodology which includes chart review. Administrative methodology may cause under reporting that can lead to lower reporting rates.



Diabetes Care

DEFINITION OF MEASURE

HbA1c Control

This measure is used to assess the percentage of members 18 to 75 years of age with diabetes (type 1 and type 2) whose most recent hemoglobin A1c (HbA1c) level is less than 8.0% (controlled).

Blood Pressure Controlled

percent of patients with diabetes who had a blood pressure reading of less than 140/90mm Hg.

(Data Source: HEDIS 2013-15)

“Diabetes is one of the most costly and highly prevalent chronic diseases in the United States (U.S.). Approximately 26.5 million Americans have diabetes, and seven million of these cases are undiagnosed. Complications from the disease cost the country nearly \$245 billion annually. In addition, diabetes is the seventh leading cause of death in the U.S. (American Diabetes Association, 2013). Many complications, such as amputation, blindness, and kidney failure, can be prevented if detected and addressed in the early stages.

Source: Agency for Healthcare Research and Quality

The Adult Medicaid Quality Measures Grant distributed funding to a number of organizations in Colorado to improve diabetes management of its populations. Projects included designing patient portals to notify patients with diabetes to come in for their annual HbA1c lab test, implementing educational courses on healthy lifestyles, diabetes self-management and blood glucose monitoring, and creating cross-organizational data sharing systems to allow provider notification of their members with diabetes. Due to these initiatives a significant trend in the increase of HbA1c control can be observed during the measurement years.

STRATEGIES FOR IMPROVEMENT

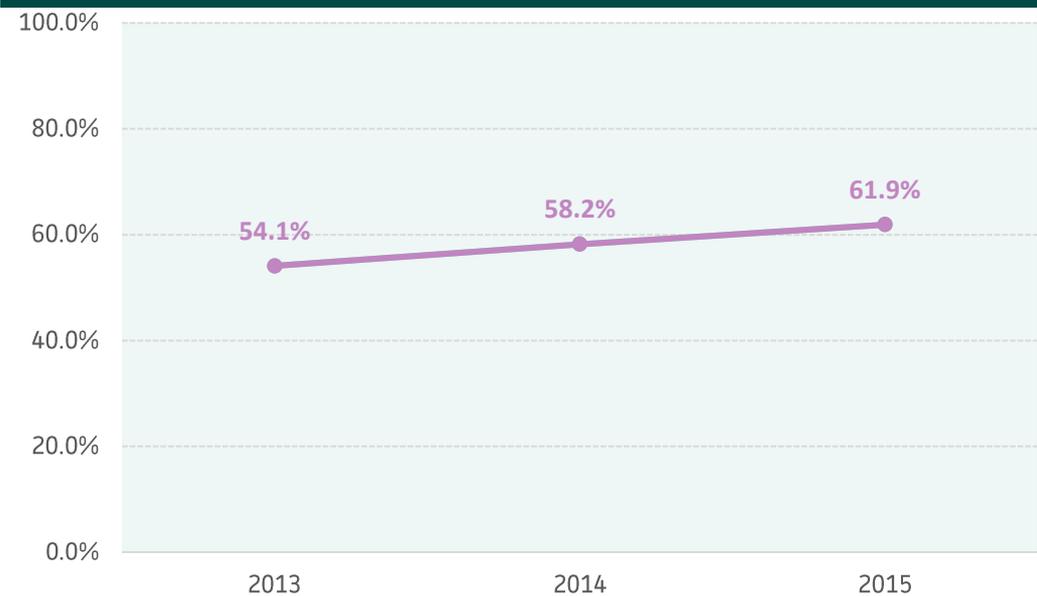
- Improve quality of clinical care for populations with greatest diabetes burden and risk to improve control of A1C, blood pressure, and cholesterol, and to promote tobacco cessation.
- Increase access to sustainable self-management education and support services for populations with greatest diabetes burden and risk to improve control of A1C and blood pressure.

Source: Centers for Disease Control and Prevention

HbA1c Control (<8.0%), CY 2013-15



Blood Pressure Controlled <140/90 mm Hg, CY 2013-15





Anti-depressant Medication Management

“In a given year, an estimated 20.9 million American adults suffer from a depressive disorder or depression. Without treatment, symptoms associated with these disorders can last for years, or can eventually lead to death by suicide or other causes. Fortunately, many people can improve through treatment with appropriate medications.

According to the American Psychiatric Association, successful treatment of patients with major depressive disorder is promoted by a thorough assessment of the patient and close adherence to treatment plans. Treatment consists of an acute phase, during which remission is induced; a continuation phase, during which remission is preserved; and a maintenance phase, during which the susceptible patient is protected against the recurrence of a subsequent major depressive episode.

When pharmacotherapy is part of the treatment plan, it must be integrated with the psychiatric management and any other treatments that are being provided. Patients who have started taking an antidepressant medication should be carefully monitored to assess their response to pharmacotherapy as well as the emergence of side effects, clinical condition and safety. Factors to consider when determining the frequency of patient monitoring include the severity of illness, the patient's cooperation with treatment, the availability of social supports and the presence of comorbid general medical problems. In practice, the frequency of monitoring during the acute phase of pharmacotherapy can vary from once a week in routine cases to multiple times per week in more complex cases.

Patients who have been treated with antidepressant medications in the acute phase should be maintained on these agents to prevent relapse.”

Source: Agency for Healthcare Research and Quality

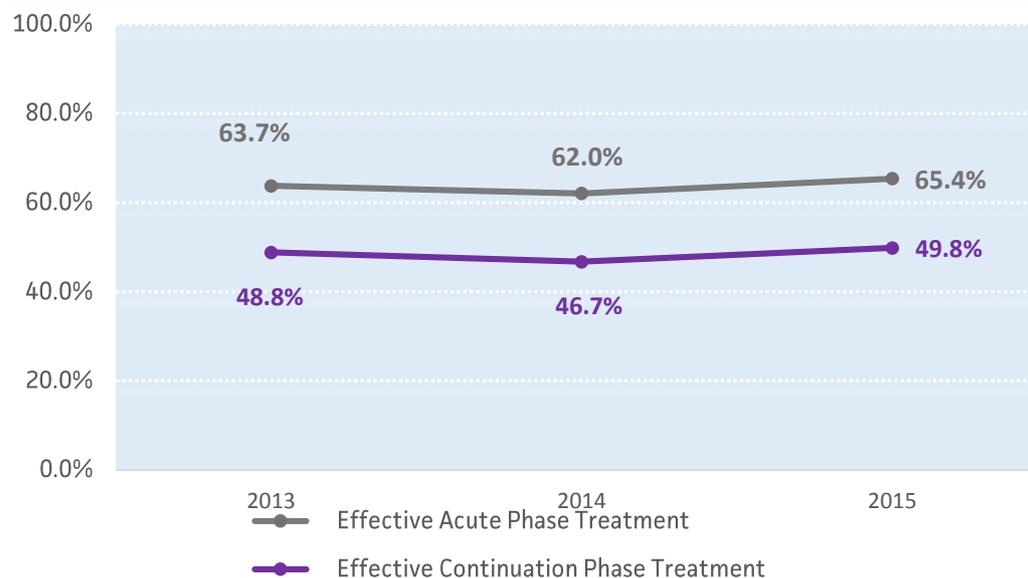
DEFINITION OF MEASURE

Effective acute phase treatment
percentage of members 18 years of age and older with a diagnosis of major depression who were treated with antidepressant medication and who remained on an antidepressant medication for at least 84 days (12 weeks).

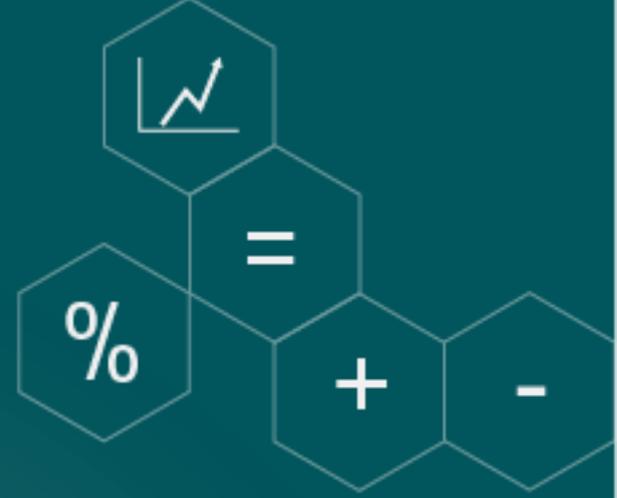
Effective continuation
phase treatment percentage of members 18 years of age and older with a diagnosis of major depression who were newly treated with antidepressant medication and who remained on an antidepressant medication for at least 180 days (6 months).

(Data Source: HEDIS 2013-15)

Antidepressant medication management, CY 2013-15



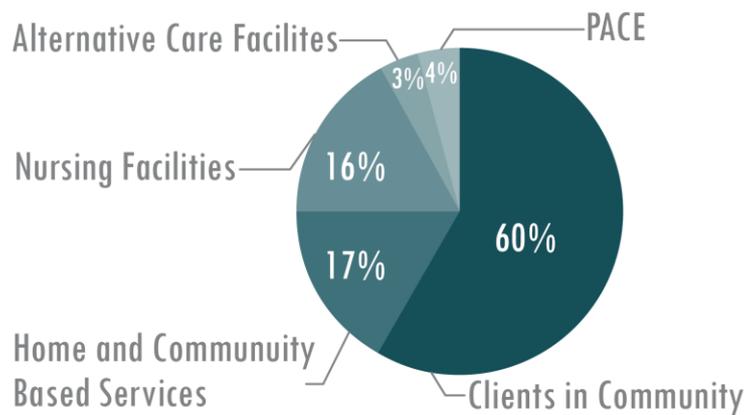
Adults 65 and older





Service Setting for Older Adults

Service Setting for Health First Colorado Older Adult (65+) Members FY 14-15



Nursing Facilities

Nursing facilities provide long-term care and rehabilitation services for patients of all ages including those 65 and older. They are also called long-term care facilities or nursing homes.

Alternative Care Facilities

Alternative Care Facilities (ACF) are any assisted living residence that is certified to receive Health First Colorado reimbursement. In an ACF, residents have as much independence as they want with the knowledge that personal care and support services are available if needed. ACFs are designed to provide residents with assistance with basic activities of daily living (ADLs), such as bathing, grooming, dressing and more. ACFs differ from nursing homes in that they don't offer complex medical services.

Home and Community Based Services

Home and Community Based Services, provide opportunities for Health First Colorado beneficiaries to receive services in their own home or community. These programs serve a variety of targeted population groups, such as the adults 65 and over and people with behavioral health problems, intellectual or developmental disabilities, and/or physical disabilities.

PACE (Program of All-inclusive Care for the Elderly)

PACE is a Medicare and Health First Colorado program that helps people meet their care needs in the community instead of going to a nursing home or other care facility. Participants must be 55 or older, live in the service area of a PACE organization, need nursing home-level of care and be able to live safely in the community with help from PACE.



Accountable Care Collaborative (ACC): Medicare-Medicaid Program (MMP)

ACC: MMP Summary

Clients who receive both Medicare and Medicaid rely almost entirely on government programs to help meet their health needs. A significant proportion of these clients have multiple chronic conditions and face limitations such as developmental disabilities, physical disabilities, cognitive impairments, and face housing isolation. Compared to members not receiving Medicare benefits, they generally require a higher level of care but face more barriers to receiving the right services at the right time and place. The system serving Medicare-Medicaid enrollees is fragmented, which can result in unnecessary and duplicative services. The Accountable Care Collaborative: Medicare-Medicaid Program (ACC: MMP) gives the Department an opportunity to better meet the needs of Medicare-Medicaid enrollees by helping reduce barriers to appropriate care.

The ACC: MMP began its enrollment process in September 2014 with a phased-in approach to ease the transition of these new clients into the ACC. Nearly 32,000 clients were eligible for the Program at the start, so this phased-in approach enabled RCCOs to plan accordingly for the influx of new clients in need of care coordination. As of May 2016, there are 24,860 clients enrolled.

One of the tools used in the ACC: MMP is a Service Coordination Plan (SCP). The SCP is a tool that helps coordinate client care across providers. The SCP lays out a clear path for reaching the client's health goals after identifying any gaps in care or duplicative services. Care coordinators use a person-centered approach to connect clients to the right medical and non-medical services and supports so they can get what they need to achieve their personal goals.

RCCOs continue to work with clients' providers to coordinate care and close gaps. The ACC: MMP also formalizes a process whereby RCCOs are working with providers of long-term services and supports. RCCOs are forging new provider and community relationships to make the fragmented Medicare-Medicaid systems work better for ACC: MMP clients.

Additionally, the ACC: MMP introduces new pay-for-performance incentives in the ACC designed specifically to improve outcomes for MMP clients. The measures are Depression Screening, Potentially Preventable Admissions and 30 Day All Cause Readmissions. The Department is working to evaluate and understand the impacts of the ACC program on this population. For FY 2014-15, an initial comparison of clients enrolled between 0-6 months and 7-12 months in the program shows:

- The rate of all-cause 30 day readmission rate for clients in the program for 7-12 months is 10 percent lower than for those in the program 0-6 months.
- The rate of Potentially Preventable Admissions for clients enrolled in the program for 7-12 months is 95 percent lower than for those in the program 0-6 months.

MMP Client Experience

Telephone Town Hall

The Department is reaching out to clients to determine how the program is working for them. On April 21, 2015, the Department hosted its first ACC client telephone town hall. The Department called 26,617 ACC: MMP clients and asked them to participate. The majority of the hour-long call was used to take and answer questions from ACC: MMP clients. Some highlights include:

- 3,129 clients participated in the over the phone call and another 80 participated via an internet call-in option.
- 18 client questions were answered during the live call.
- 82 percent of respondents indicated that having a care coordinator and care coordination would be helpful.
- 89 percent of respondents stated that this event was either 'somewhat' or 'very helpful'.
- Clients whose questions did not get addressed in the town hall were able to leave a message and get their questions answered after the call.

Survey

In August of 2015, the Department worked with the Center for Research Strategies to conduct a phone survey of 1,000 MMP clients. The purpose of the survey was to gather information about client experiences with care coordination in the program. These results provided a window into what was working and areas for improvement within the program. In particular:

- 39.7 percent of respondents had heard about the MMP.
- 32 percent of respondents remember receiving materials about the program in the mail.
- 27 percent of respondents know that they have a care coordinator or remember being contacted by someone offering to help connect them with health care services.
- 83 percent of respondents felt that their primary care doctor and other doctors are working together.



National Core Indicators for the Aging and Disabled

The State of Colorado is committed to improving the quality of services for older adults. In May 2016, the Colorado Department of Healthcare Policy and Financing (HCPF) and Colorado Department of Human Services (CDHS) released initial results for the first National Core Indicators Aging and Disabilities Adult Consumer Survey (NCI-AD) in Colorado. This survey measures the needs and experiences of older Coloradans who participate in long-term services and supports (LTSS) and Older Americans Act programs.

The survey results will help HCPF and CDHS with quality improvement initiatives over time, strategic planning, and legislative and funding prioritization. According to the state-specific report and comparisons to the national average (representing the six states participating in the shortened data collection cycle), Colorado ranks **better in 9 indicators**, the **same in 29 indicators**, and **worse in 12 indicators**.

Key Findings

- Colorado performs higher than the NCI-AD average when it comes to **decision-making assistance**. Specifically, 52 percent have a Durable Power of Attorney (43 percent NCI-AD avg), 55 percent have health care proxy (42 percent NCI-AD avg), and 48 percent have a living will (36 percent NCI-AD avg). Performance on this indicator of *planning for the future* is critical for our clients to pursue a meaningful and high quality life.
- Colorado is performing well related to some indicators of **Service Coordination**. Specifically, clients know who to call to get information if their needs change and they need different services and supports. Many individuals have a family member who assists with care. These results align well with current initiatives such as Consumer Direction workgroup and No Wrong Door as well as the Person-and-Family Centeredness initiatives.
- Colorado ranks higher than **all** other states in providing services to enhance **Self Direction of Care** - people can choose or change what services they get and determine how often and when they get them.

Though a more thorough analysis is necessary to identify benchmarks, this initial year of reporting will serve as a solid baseline for future years of implementation. For more information about this report, visit the Departments website co.gov/HCPF

