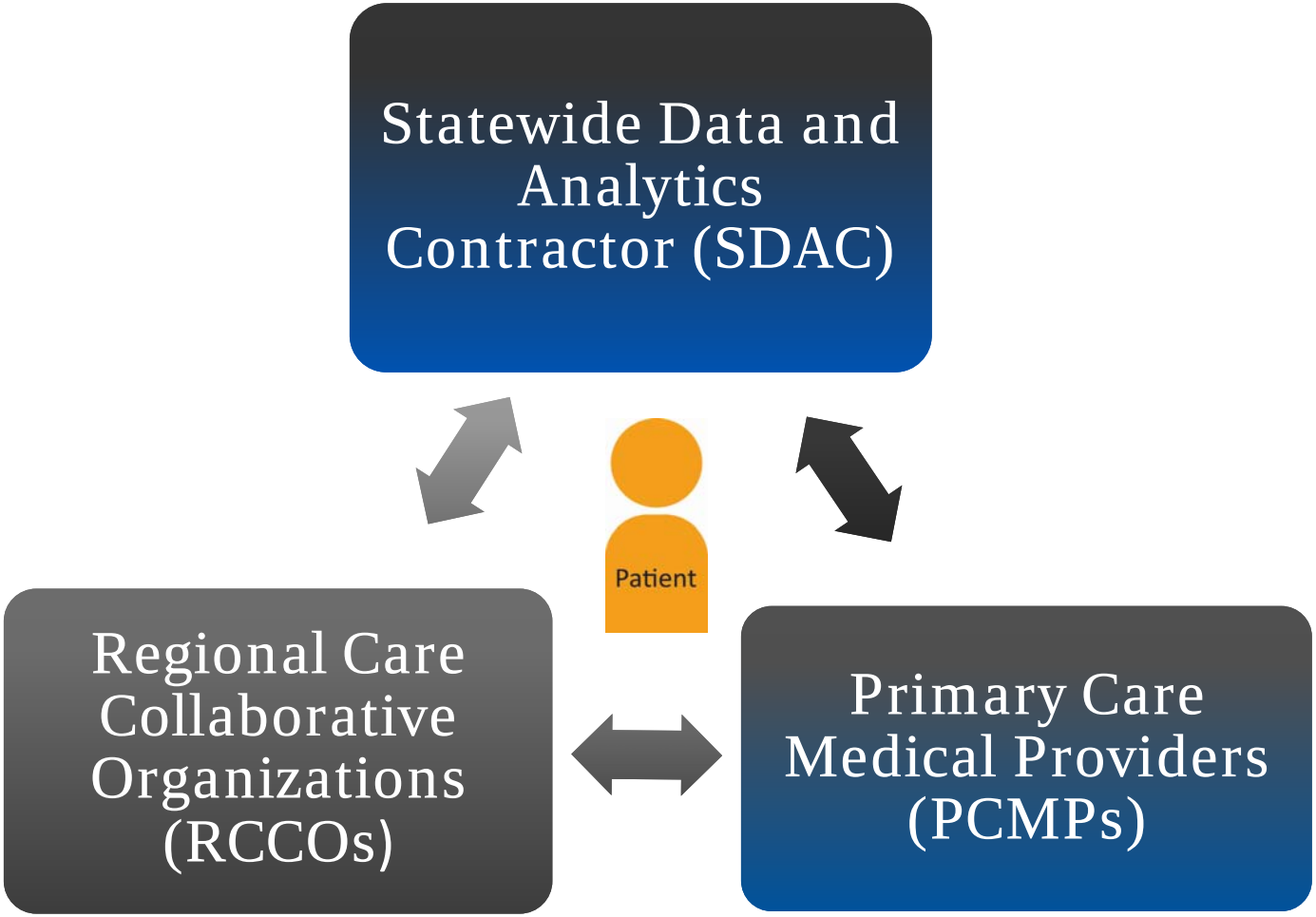
Colorado Adult Medicaid Quality Measures Grant

Our Mission:

Improving health care access and outcomes for the people we serve while demonstrating sound stewardship of financial resources

Components of the ACC



Components of the ACC

RCCO Responsibilities

Achieve desired **financial and health outcomes**

Ensure comprehensive care coordination and **a Medical Home level of care** for every Member through:

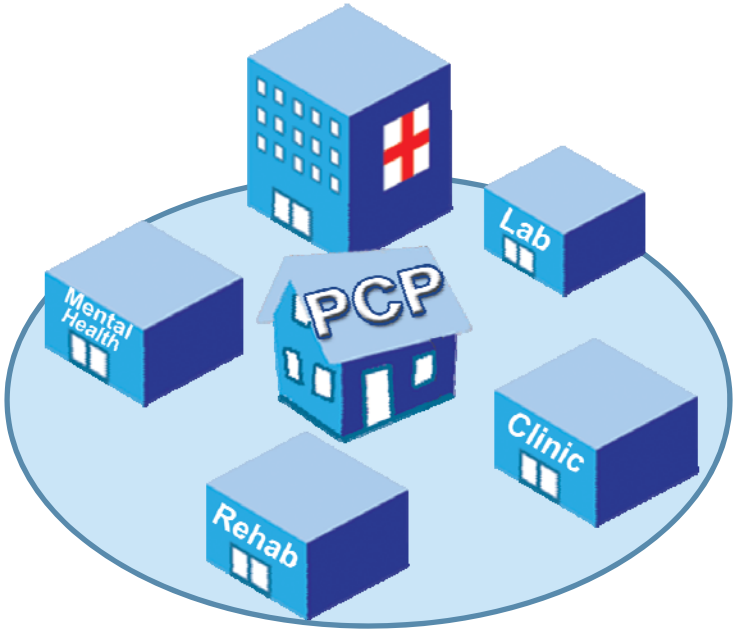
- Network Development/Management
- Provider Support
- Medical Management and Care Coordination
- Accountability/Reporting

Components of the ACC

PCMP serves as a Medical Home:

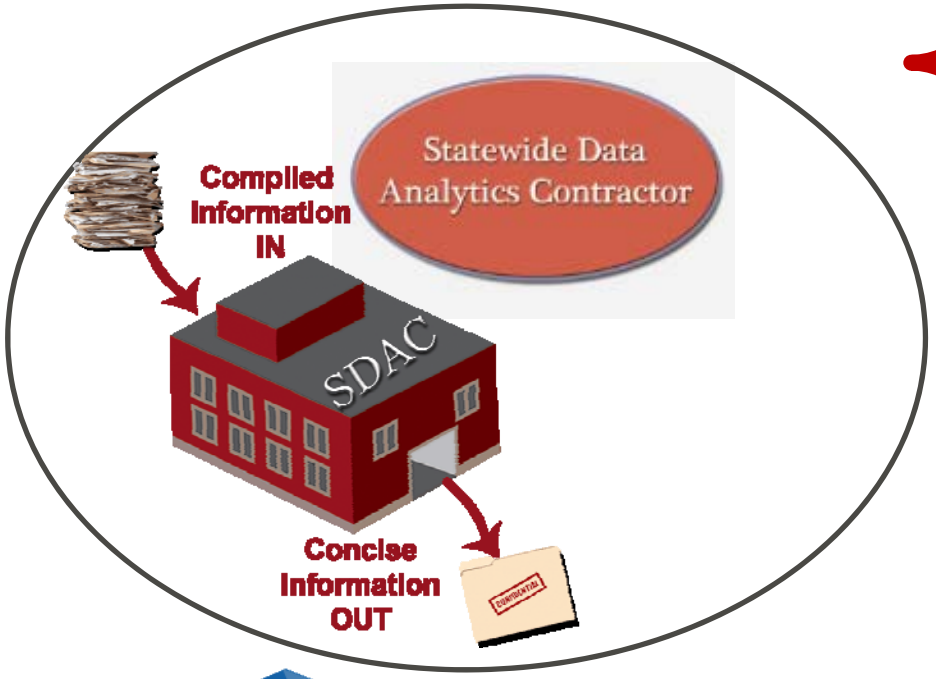
- Member/family centered
- Whole person oriented
- Coordinated
- Promotes client self-management
- Care provided in a culturally sensitive and linguistically sensitive manner
- Accessible

PCMP Responsibilities



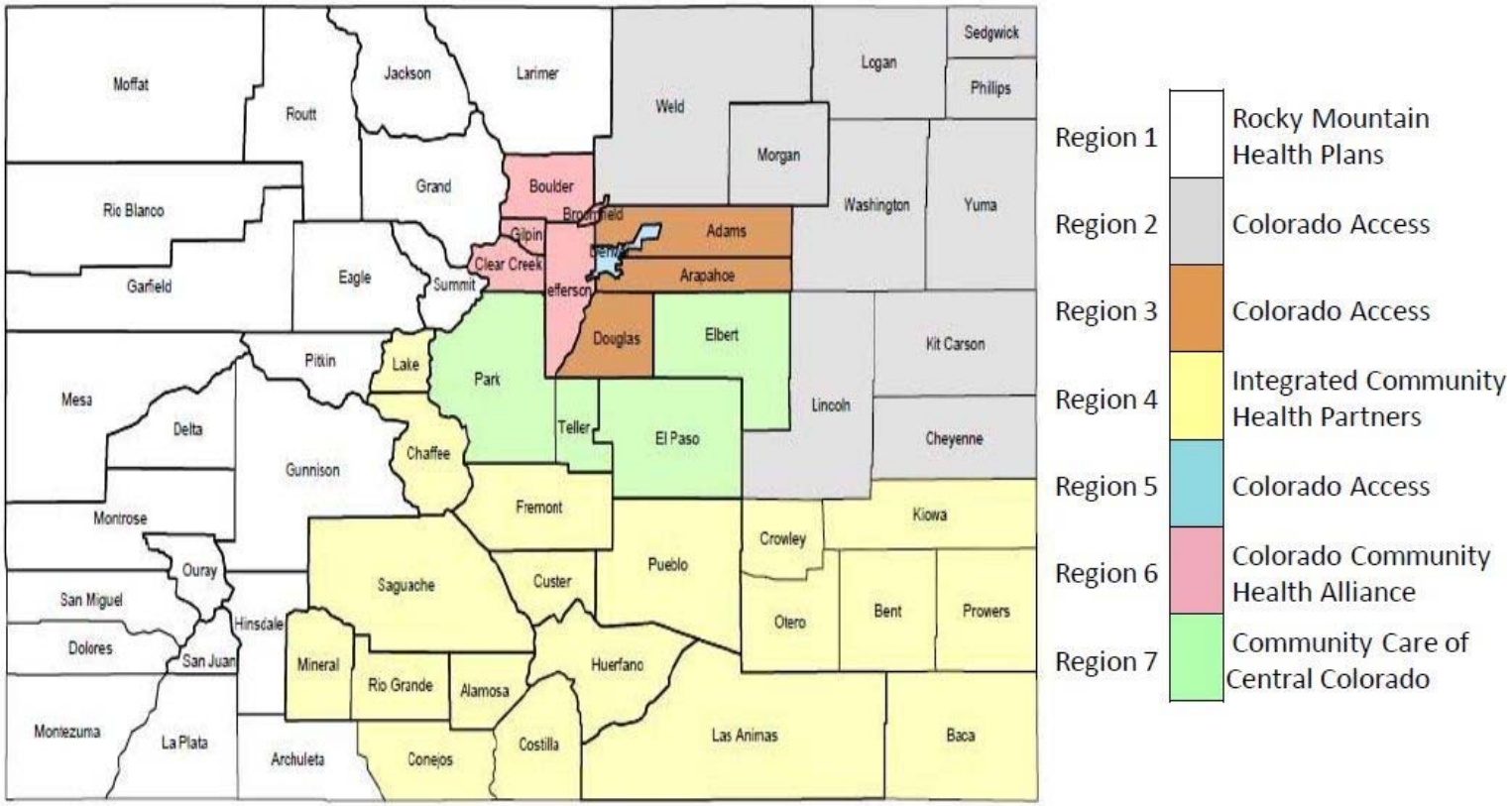
Components of the ACC

SDAC Responsibilities



- Data Repository
- Data Analytics & Reporting
- Web Portal & Access
- Accountability & Continuous Improvement

RCCO Map


Moffat
Routt
Jackson
Larimer
Weld
Logan
Sedgwick
Philips
Morgan
Washington
Yuma
Rio Blanco
Grand
Boulder
Gilpin
Clear Creek
Adams
Arapahoe
Garfield
Eagle
Summit
Douglas
Elbert
Kit Carson
Pitkin
Lake
Park
Mesa
Delta
Gunnison
Chaffee
Teller
El Paso
Lincoln
Cheyenne
Fremont
Montrose
Ouray
Saguache
Custer
Pueblo
Crowley
Kiowa
San Miguel
Hinsdale
Dolores
San Juan
Mineral
Rio Grande
Alamosa
Huerfano
Otero
Bent
Prowers
Montezuma
La Plata
Archuleta
Conejos
Costilla
Las Animas
Baca
Region 1
Rocky Mountain Health Plans
Region 2
Colorado Access
Region 3
Colorado Access
Region 4
Integrated Community Health Partners
Region 5
Colorado Access
Region 6
Colorado Community Health Alliance
Region 7
Community Care of Central Colorado

Adult Medicaid Quality Grant

→Collect on 24 Adult Quality Measures

→Implement Quality Improvement Projects

→Focus on Improving Care for Individuals diagnosed with diabetes and improving depression screening in primary care

ACCOMPLISHMENTS

- Development of Quality Dashboard within the SDAC
- 10 Quality Improvement Projects implemented within 6 of 7 RCCO regions
- 4 projects focused on Diabetes Care
- 5 projects focused on Depression Screening and Treatment
- 1 project focused on Patient Activation

RCCO 6
QI Project

ADULT MEDICAID QUALITY MEASURES (AMQM) GRANT PROGRAM

CCHA: Depression Initiative

Who is CCHA?

- CCHA was formed in 2010 to improve the quality, efficiency and delivery of healthcare for Coloradans
- CCHA is a collaboration between Centura Health, Physician Health Partners and Primary Physician Partners
- CCHA is the region 6 RCCO, which includes Jefferson, Boulder, Broomfield, Gilpin and Clear Creek counties

2013 AMQM Grant Partners

- **Colorado Community Health Alliance (CCHA)**
- **Foothills Behavioral Health Partners (FBHP)**
  - Manages mental health benefits for Medicaid enrollees in a 5 county area
  - Maintains a large provider network including individual providers and 2 Community Mental Health Centers
- **Primary Care Medical Providers (PCMPs)**
  - Primary care providers who serve CCHA members

Project Description

- Increase the screening and treatment of depression in the primary medical care setting
- Developed referral protocols between primary care medical providers (PCMPs) and FBHP
- Created materials for patients and providers to utilize

Results

- 4 practices are conducting regular depression screening processes and data collection
- More than 750 depression screenings have been completed in the PCMP office*
- PCMP practices involved in the initiative say the process improves patient care

*Not all practices have reported data

Successes

CCHA and FBHP have successfully developed:

- A sustainable process for screening and referring patients to BH treatment
- A viable process for PCMP and FBHP coordination of care
- A replicable process for conducting depression *and* other screening in the PCMP practice

Patient Impact

- A female patient was visiting the PCMP office at least twice a month for several months reporting symptoms of anxiety and depression
- Patient was screened for depression on 7/16/2013, resulting in a score indicative of BH treatment
- Patient was referred by the PCMP to FBHP that day
- After the referral, patient did not visit the office again until 11/26/2013 for a chronic care check-up
- Patient reported that she is engaged in BH treatment and is finding the therapy very helpful
- The patient continues to have psychotropic medication prescribed by the PCMP
- The patient was screened for depression, referred to BH treatment, and engaged in BH treatment,
  - **Dramatically decreased her PCMP visits *AND* reported positive results from the BH treatment!**

Thank you for your time!

Questions?

RCCO 2
QI Project

AMQM GRANT SHOWCASE

PATIENT PORTAL PROJECT | 02/11/14

TIM HITCHCOCK MBA, BUSINESS ANALYST
TODD LESSLEY MPH, RN, BSN, ACC MANAGER

SALUD FAMILY HEALTH CENTERS

MISSION DRIVEN

OUR PATIENTS

IMPACT

Salud
Family Health Centers

PATIENT PORTAL PROJECT

PURPOSE

BACKGROUND

ACCESS POINTS

AMQM MEASURES

Salud
Family Health Centers

Sign in

Password

Login

Forgot Password?

Salud Family Health Centers

The Salud Portal facilitates better communication with your health provider by allowing convenient 24/7 internet access. EL PORTAL DEL PACIENTE LE OFRECE MEJOR COMUNICACION ENTRE USTED Y SU DOCTOR 24/7 DESDE CUALQUIER LUGAR.

Using your secure portal you will be able to:

Medical History

Appointments

Request Refills from your doctor

healow Mobile App

Your health is in your hands... with healow

Learn More

Your health & online wellness platform

Download the Free healow app!

Available on the App Store

Available on Google play

Find us using our unique practice code on the healow app

HIJEAA

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Salud Family Health Centers

Powered by eClinicalWorks

COLLAPSE ALL

Dashboard

Medical records
- Lab / Diagnostic R...
- Visit Summary
- Personal Health Record
- PHR-View

My Account
- Personal Information
- Additional Information
- Reset Password

Messages
- Inbox
- Refill Requests
- Ask Doctor

Appointments
- Upcoming Appointments
- New Appointment
- Historical Appoint...

Questionnaires
- Medical History

My Devices

Switch To C

Hi Patient test,

Please remember that this service is for non-urgent communications only!
If you have an emergency needing clinical care, please dial **911**.

EL PORTAL DEL PACIENTE NO DEBE USARSE EN EMERGENCIAS. SI NECESITA ATENCION MEDICA URGENTE O INMEDIATA, LLAME AL **911**.

MORE

messages (2)

Subject:	Date:
RE:New Appointment Request	05/24/2013
RE:New Refill Request	05/23/2013

Create a message | View all messages

medical records

Personal Health Record can be requested by clicking on the Request PHR on the right side

Request PHR

View Medical Records

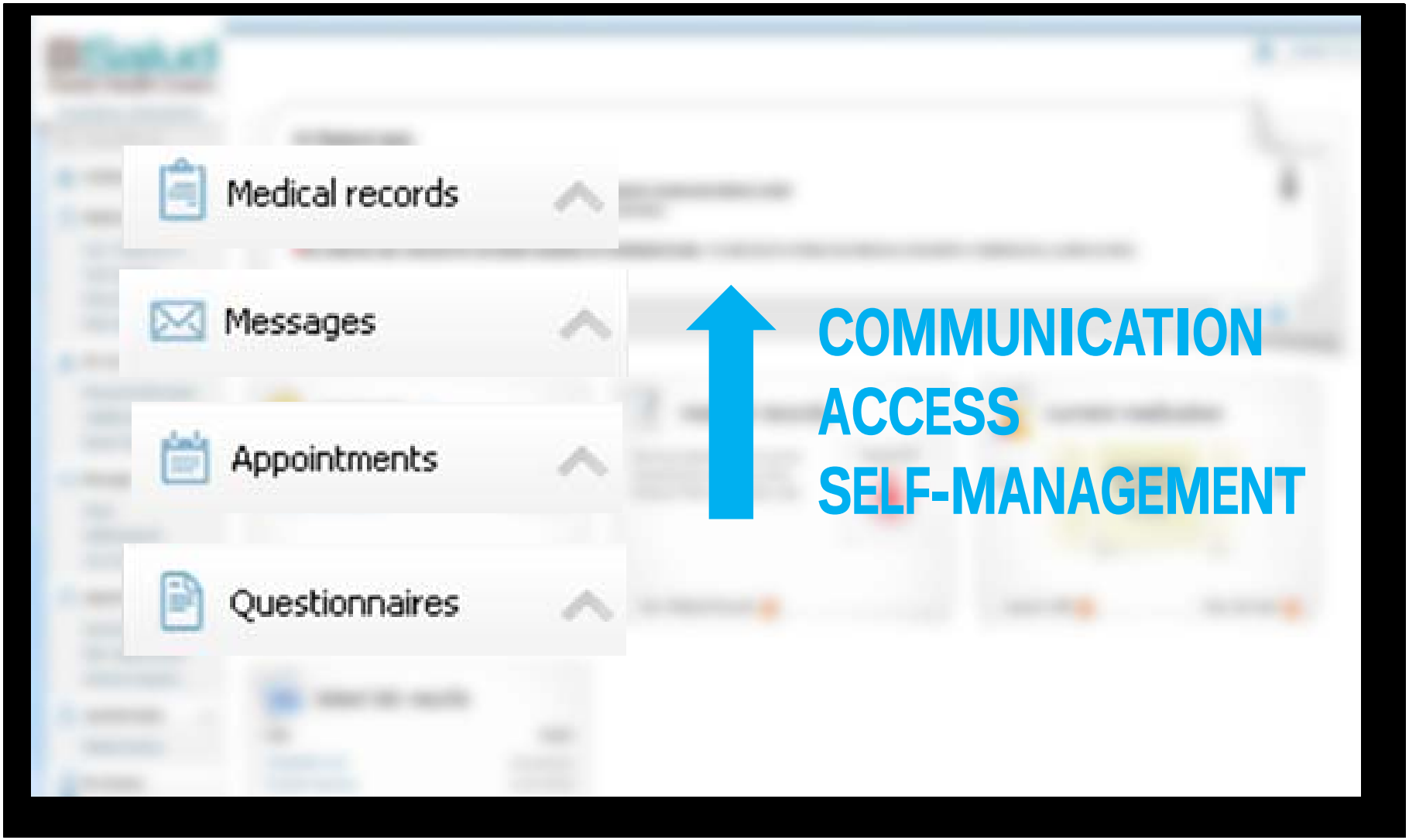
current medication

Amlodipine Besylate 2.5 MG

request refill | View all meds

latest lab results

Lab:	Date:
THINPREP PAP	12/10/2013
Toradol Injection	11/21/2013


Medical records
Messages
Appointments
Questionnaires
COMMUNICATION
ACCESS
SELF-MANAGEMENT

2013

180% INCREASE OF PATIENTS CONNECTED IN LAST 6 MONTHS

OVER 12,500 PATIENTS NOW HAVE ACCESS TO THEIR PATIENT PORTAL ONLINE 24/7

650 % INCREASE IN BIDIRECTIONAL COMMUNICATION

CONFIDENTIAL ONLINE **DEPRESSION SCREENING**

REQUEST **RX REFILLS ONLINE**

"CAN'T CONNECT FROM HOME?" KIOSKS IN EACH CLINIC TO PROVIDE ACCESS

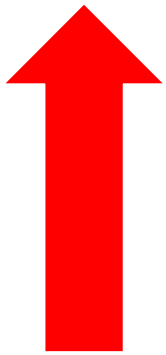
ACCESS PORTAL FROM **MOBILE DEVICE**

2014 & BEYOND

OVER 50% OF OUR PATIENT POP. WILL HAVE ACCESS

2340 BIDIRECTIONAL COMMUNICATION

2014 CLINICAL IMPLICATIONS:



COMMUNICATION
ACCESS
SELF-MANAGEMENT
PROVIDER EFFICIENCY

TRIPLE AIM (HEALTH OUTCOMES, COST & PATIENT EXPERIENCE)

PATIENT IMPACT

Salud
Family Health Centers

QUESTIONS?

Salud
Family Health Centers

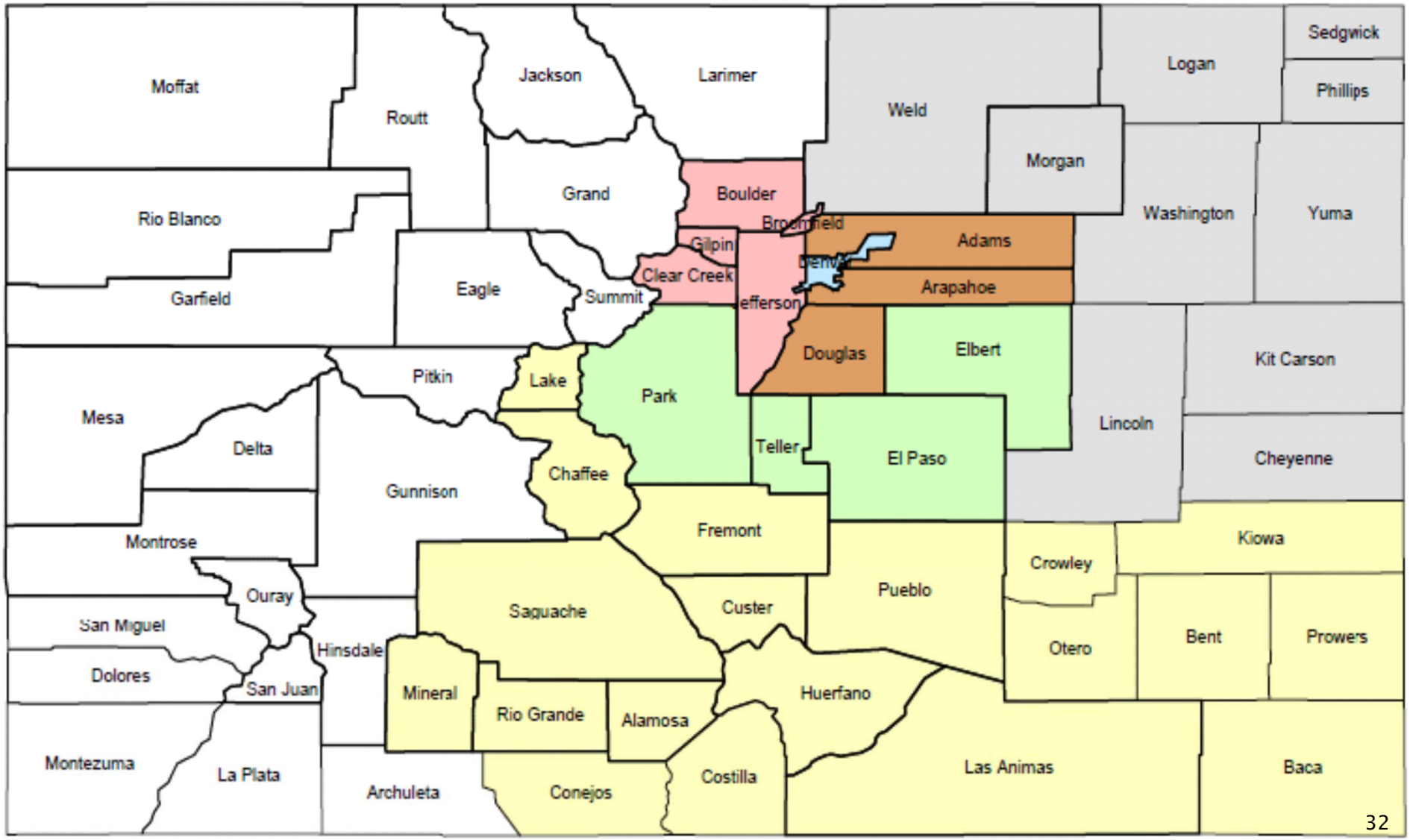
RCCO 4
QI Project

ICHP Integrated Software System

AMQM Grant Project
Showcase Presentation
February 11, 2014

Donna Mills, CEO
Chet Phelps, IT Director

CO Regional Care Collaborative Organizations (RCCO) Map



Who is ICHP?

- RCCO 4 – highly rural/frontier geography (20% of the State)
- 2 Administrative services organizations
- 4 Behavioral Health Centers
- 3 Federally Qualified Community Health Centers
- Combined service of over 60+ years in the communities we serve
- Membership is just North of 61k

Purpose of the Project

- Create a cross-organization, real-time data sharing system.
- Send & receive alert data.
- Send & receive care coordination notes.
- Identify other providers/care coordinators with whom to coordinate care for ICHP-RCCO clients.

INTEGRATED
Community Health Partners

ICHP's current KPI results –

- ICHP #1 Statewide in All cause 30 day readmits – 41.2% below 2011 benchmark
- ICHP ***ONLY*** RCCO that achieved any ER reduction – 3.2% below 2011 benchmark
- ICHP #3 Statewide in High Cost Imaging – 26.5% below 2011 benchmark

INTEGRATED
Community Health Partners

Success stories – Healthcare is Local

Thank You
for your participation.

Comments or Questions?

INTEGRATED
Community Health Partners

Quality Dashboard

- SDAC tool primary provides RCCOs cost and utilization data
- Quality Dashboard provides additional tool improving care for clients

RCCO5: Colorado Access - Dashboard - Microsoft Internet Explorer provided by Health Care Policy and Financing

https://www.coloradosdac.com/portal/dashboard.aspx?personaViewID=aco&userPkey=aco_id&userPkeyValue=5&clientAccessID=467

File Edit View Favorites Tools Help

Favorites | RCCO5: Colorado Access - Dashboard

Potentially Preventable Events

Performance Measure	Rolling 12 months 10/2012-09/2013	Program YTD 07/2013-09/2013	
Paid Preventable (PMPM $)	$51.10	$50.19	
Variance PPR Admits PKPY	1.0	1.3	Member List
Variance PPA Admits PKPY	3.1	1.3	Member List
Variance PPV Visits PKPY	13.3	27.8	Member List
Variance PPS PKPY	(265.2)	(153.0)	Member List

Rx Utilization

Performance Measure	Rolling 12 months 10/2012-09/2013	Program YTD 07/2013-09/2013	
Variance Rx Scripts PKPY	(235.2)	608.6	Member List
% Rx Generic Scripts	79.94 %	79.31 %	Member List

Quality Measures

Performance Measure	Rolling 12 months 10/2012-09/2013	Program YTD 07/2013-09/2013	
Adult Clients with Diabetes and annual HbA1c	62.3 %	--	Member List

Reports

- Care Management F
- Provider Panel Rep
- Recorded Gap: Chr
- Recorded Gap: Jum Burden
- Recorded Gap: Lacl Discharge Follow-u
- Recorded Gap: Nev
- Recorded Gap: No Last 6 Months
- Rx Report: Client U Detail

Supporting Resource

- Dashboard User Guide
- Clinical Risk Groups (CRGs)
- Overview: Potentially Preven (PPEs)
- Overview: Potentially Preven Readmissions (PPRs)
- Overview: Potentially Preven Admissions (PPAs)
- Overview: Potentially Preven Emergency Room Visits (PPVs
- An Introduction to Potentially Ancillary Services (PPSs)

Quality Data

Treo Population Health Segment	ACRG4 Description	RX Scripts	Readmits 7 Day	Readmits 14 Day	ER Visits	Diabetes	Months Medicaid Eligible	Elig for HbA1c Rate
At Risk	Significant Acute	5	0	0	1	N	12	N
Simple Chronic	Moderate Chronic	29	0	0	2	N	8	N
Complex Chronic	Dominant Chronic	31	0	0	0	Y	12	Y
Simple Chronic	Moderate Chronic	61	0	0	1	N	6	N
Complex Chronic	Dominant Chronic	16	0	0	0	N	5	N
Complex Chronic	Dominant Chronic	16	0	0	0	N	5	N
Simple Chronic	Moderate Chronic	4	0	0	1	N	12	N
Complex Chronic	Dominant Chronic	16	0	0	0	Y	9	N
Non User	Healthy & Non Users	0	0	0	0	N	4	N
At Risk	Minor Chronic	54	0	0	1	N	12	N
At Risk	Significant Acute	0	0	0	0	N	12	N
Non User	Healthy & Non Users	0	0	0	0	N	5	N
Simple Chronic	Moderate Chronic	0	0	0	1	N	12	N
Complex Chronic	Dominant Chronic	17	0	0	0	Y	12	Y

Year Two

→Additional Quality Tools in SDAC

→Year Two Awards for QI Projects

→Provide tools to support RCCOs as we transition Key Performance Indicators from cost and utilization to prevention and quality

Year Two Awards

RCCO	FOCUS	PROJECT DESCRIPTION
2 – COA/Salud	Depression screening	Three tier practice transformation including support staff administration of PHQ-2 depression screening, patient portal marketing and remote PHQ-2 screening through the patient portal.
3 – COA	HbA1c/Depression screening	Design & implement an internet-based advanced care management program at CO Access.
3 – COA/CCHAP	Depression screening	Coach medical homes to administer post-partum depression screening.
4 – ICHP	HbA1c	Develop a care mgmt. tool.
4 – ICHP	Depression screening	Integrate screening into practices software system.
6 – CCHA	HbA1c/Depression screening/Antidepressant medication management	Self-mgmt./group classes.
7 – CHP	Depression screening/Antidepressant medication management	Develop and implement pharmacist-based decision making education program.

Thank you