Annual Population Management Strategic Plan

Instructions and Narrative Report

RAE Name	**Rocky Mountain Health Plans (RMHP)**
RAE Region #	**1**
Reporting Period	**[SFY22-23 07/01/2022 – 06/30/2023]**
Date Submitted	**6/30/2022**
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Purpose: Regional Accountable Entities (RAEs) are responsible for managing and improving the health of their respective members. As part of that responsibility, RAEs are required to: utilize the Department's Population Management Framework to stratify their respective populations and provide appropriate interventions to members in each stratification level. Specific goals include improving member health, preventing disease progression, and reducing unnecessary and/or avoidable utilization and costs. This plan outlines each RAE's strategic approaches to accomplish these tasks and to meet the overall goals of ACC Phase II during the upcoming contract year.

The 10 Department-identified conditions are: maternity; diabetes; hypertension; chronic heart failure/cardiovascular disease; asthma; chronic obstructive pulmonary disease; anxiety; depression; chronic pain; and substance use disorder.

The 5 Department-identified essential components include: member identification & risk stratification; culturally competent specialized care team; facilitate access to appropriate medical services, resources, and community programs; delivery of evidence-based/informed interventions and/or local evidence-based programs or local promising initiatives; and program measurement and reporting toward target outcomes.

Instructions: Please provide a narrative that outlines your region's strategic approach to leverage resources to manage and address the needs of your member population. Where relevant, provide supporting evidence for the respective strategies. Address how your strategic approach has or has not evolved since the previous year's submission with evidence to support changes. This narrative must describe the RAE's planned strategies, including process and outcome goals, relative to care coordination and complex care management, condition management and prevention, wellness and member engagement.

1) Care coordination and complex care management – Please describe your region's plan to address and coordinate the health care and other needs of **members with complex care needs** (based on how you define that population in your region). Please be sure to address the 5 Department-identified essential components. Also describe how you plan to support complex members in the following subpopulations:

- Foster care/child welfare
- Justice-involved
- Homeless *(and how you are using the Homeless Management Information System (HMIS)*
- People with Disabilities (IDD & non-IDD)

<u>In addition to your other planned strategies, please include:</u> your plan to support members who have received Prior Authorization Request (PAR) denials for Private Duty Nursing (PDN) and Pediatric Long-Term Home Health (PLTHH) including 1) the RAE workflow for reaching members who have received a denial or reduction, 2) how the RAE will coordinate with Case Management Agencies (CMAs) to ensure members are receiving necessary care coordination, and 3) any plans for ongoing improvement. The PLTHH PAR requirement has been suspended through at least March 2024.

2) Condition management - Please describe your region's plan to manage the **10 Department-identified conditions** with RAE or practice-level programming that incorporates the 5 Department-identified essential components. Programming can be specific to a condition or could apply to co-occurring conditions.

- Please include your plans for managing transitions of care and members with emerging risk.
- Please include separate comprehensive descriptions of the programming for maternity and diabetes. The Department understands that programming for the other 8 conditions might include significant overlap and similar work. It is therefore acceptable to describe how the RAE addresses the 5 essential components for all condition management programming as a whole.
- Details unique to each condition can be described separately as needed. The bi-annual condition management and care coordination & complex care management reports will provide additional opportunities to describe details unique to each condition.

<u>In addition to your other planned strategies, please include:</u> your plan for how care coordination will be conducted when members are transitioning from one level of care to another along the SUD continuum including details on how members will be supported when they are discharged from residential or inpatient SUD treatment or withdrawal management services; 2) how care coordination will be conducted for members awaiting SUD treatment that is unavailable at the time they are determined to have medical necessity for a specific level of care (e.g. member may be on a wait list for a specific level of care where a bed is not currently available) including detail on what interim services will be provided while the member awaits the indicated level of care.

3) Prevention, wellness and member engagement – Please describe your region's plans to promote **prevention, wellness and member engagement**. Be sure to include your plans relative to well care; tobacco cessation; food security; family planning; and member engagement.

Strategic Plan Narrative

Rocky Mountain Health Plans (RMHP) is committed to reducing the complexity of health care delivery, by eliminating health disparities, and ensuring clinically appropriate and culturally competent programs are accessible throughout the state. Multiple factors including race/ethnicity, age, gender identity and the social, economic, and environmental systems that form communities can influence the distribution of health outcomes among a population[1]. These factors can lead to health inequities and negatively impact population health outcomes.

RMHP is committed to understanding and addressing health inequities and cultivating a health care delivery system that is available to all Regional Accountable Entity (RAE) Members[2]. As a health plan accredited by the National Committee for Quality Assurance (NCQA), RMHP maintains a comprehensive strategy for population health management that addresses Member needs in the following four areas:

- **Keep Members healthy**
- **Manage care for Members with emerging risk**
- **Focus on patient safety and outcomes across settings**
- **Manage multiple chronic illnesses**

These focus areas cover the entire continuum of care and are used to develop goals and interventions within different segments of the population[3]. The overarching focus of RMHP's population health strategy is to improve population health, enhance the Member experience, and decrease per capita cost[4] while promoting health equity among all Member populations.

Predictive Analytics to Support Member Identification and Risk Stratification

RMHP's population stratification model (Appendix A) creates subgroups according to risk level, diagnosis, and other factors to drive interventions, resources, and outcomes. This model was enhanced for SFY22-23 to focus on complex and condition management and maintain alignment with NCQA and Department requirements. The updated model uses an Optum predictive analytics tool called ImpactPro® (IPro) that creates a risk profile predictive of future costs and clinical need based on Member demographics, diagnostic information, and health care utilization data.

Figure 1: Population segments and definitions

RMHP's population stratification contains four segments:

1. **Complex:** Risk scores within the top 2.82% of the population
2. **Emerging complex:** Recent increase in IPro risk score but not in the top 2.82% of the population. Represents Members with a recent clinical event that might place them at higher risk compared to the general population.
3. **Condition:** Members with any of the Department's 10 identified conditions based on claims history and without an IPro risk score that places them in complex or emerging complex.

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[1] Krieger, 2011; Dunn and Hayes 1999

[2] Note: In this document, reference to *all RAE Members* includes *RAE* and *RAE Prime* population. If *RAE* or *RAE Prime* are referenced independently, that is the only population that applies to the program being described.

[3] National Committee for Quality Assurance, 2022 Health Plan Standards and Guidelines, Population Health Management Standards and Elements

[4] Institute for Health care Improvement (IHI)

4. **Wellness/prevention:** Includes all Members

A Member may fall within multiple segments. For example, a Member with diabetes who is low risk (i.e., IPro score does not place them into complex or emerging complex) will fall within the condition and wellness/prevention segments. However, a Member with diabetes who is high risk may fall within complex, condition, and wellness/prevention.

Health Equity and Culturally Responsive Specialized Care

Health equity is a top organizational priority and RMHP is working to address inequities in all aspects of population health management. Multiple strategies are in place to cultivate health equity:

- **Health Equity Team:** Individuals from each internal RMHP department appointed by RMHP leadership to ensure health equity is prioritized in all operations. This centralized team creates a coordinated space to understand the cultural context impacting RMHP Members.
- **Ambassadors for Belonging, Inclusion, Diversity and Equity (ABIDE):** Committee that provides a safe space for staff to come together and examine their values and provide suggestions and resources about how RMHP can be a more inclusive workplace and better serve its Members.
- **Health Equity Accreditation Council:** Committee responsible for overseeing RMHP's NCQA health equity accreditation, targeted for 2023.
- **Provider Network:** RMHP enhances payment to behavioral health providers who serve underserved populations (i.e., people of color, people who speak a non-English language, LGBTQIA+, rural and frontier populations with limited resources) as well as to Primary Care Medical Providers (PCMP) for attributed Members who are people of color or speak a non-English language. Additionally, in June 2022, PCMPs must attest to activities related to diversity, equity, and inclusion during the RAE tiering process.

RMHP understands that culture impacts Member perspectives related to health, perceptions of disease, health behavior, and attitudes towards the health care delivery system[5]. RMHP is committed to promoting health equity and the continuous pursuit of culturally competent programs that impact health outcomes and address racial and ethnic health disparities throughout the RAE 1 region and the state. RMHP will prioritize culturally responsive care delivery and continue to provide:

- **Cultural responsiveness training:** All RMHP care coordinators, providers, and community partners are offered cultural responsiveness training throughout the year with the goal of achieving culturally and linguistically appropriate care for Members.
- **Access to communication:** RMHP prioritizes access to language and auxiliary services including a language line. Additional services include Spanish speaking care coordinators, American Sign Language interpreters, and Communication Access Real-time Translation.
- **Culturally responsive Member resources:** Member materials and resources are provided in English and Spanish (e.g., diabetes gap reminder).
- **Community integration and partnerships:** RMHP is collaborating with the Colorado Cross-Disability Coalition and Western Slope Native American Resource Center on a project to equip respected tribal leaders in the region with information to promote access to home and community-based services and Consumer Directed Attendant Support Services. This communication pathway will have a positive impact on overall health outcomes for tribal Members with disabilities. In addition, through RMHP funding, two health navigators are working with the Ute Mountain Ute and Southern Ute tribal Members to help them access care.

[5] Adapted from minorityhealth.hhs.gov

Population Health and Clinical Quality Improvement

RMHP restructured its quality improvement program to ensure clinical quality improvement activities are directly aligned with care coordination and population health management strategy. In January 2022, RMHP formed internal quality improvement teams called Integrated Quality Workgroups (IQWGs). There are seven IQWGs that focus on specific populations and create interventions to improve health outcomes, address health equity, reduce health care costs and improve the Member and provider experience:

- Maternity/Women's Health
- Diabetes/Other Chronic Conditions
- Prevention/Older Adults
- Utilization
- Behavioral Health (BH)
- Member Experience
- Pediatrics

RMHP will organize population health strategic goals around this clinical quality improvement structure to create impactful Member, provider, and community-based interventions.

Value Based Contracting

RMHP is committed to supporting PCMPs throughout the RAE region 1 and offers value-based contracting programs that reward high-quality, high-value care and reimbursement through a payment structure designed to achieve better care, more efficient spending, and healthier communities. Practice transformation programs help PCMPs create the infrastructure needed to demonstrate outcomes that support population health management. The level (tier) to which a practice is designated impacts the value-based model available to them. If the assessment identifies an opportunity to improve, the RMHP clinical quality improvement team can help complete continuous quality improvement to support PCMP growth and development.

1) Care Coordination and Complex Care Management

The primary focus of RMHP's care coordination strategy is to provide comprehensive, integrated, and accessible support to all RMHP Members. Care coordination is aligned with RMHP's population stratification framework and is driven by Member identification, transitions of care support, evidence-based assessments, and integrated community partnerships. Care coordination staff work in multiple settings throughout the region and include specialized teams from multiple disciplines including nursing, behavioral health, pharmacy, and social work. RMHP care coordination strategy focuses on four primary populations:

- **Complex care**
- **Condition management**
- **Transitions of care**
- **Referrals from providers, community agencies or Member self-referrals**

Care coordinators complete evidence-based assessments (e.g., PHQ-9, GAD-7) that address physical and behavioral health needs, gaps in care, health care utilization, engagement with PCMPs, and Social Determinants of Health (SDoH). Each assessment is used to inform Member-centered care plans and activities including:

- **Extended Care Coordination (ECC):** Intensive bidirectional care coordination interventions

- **General Care Coordination:** Referral-based interventions and transitions of care
- **Health Education Communication**: Mailings, emails and other communication related to benefits, preventive health, and condition management

RMHP is committed to offering care coordination in communities where Members live and receive care to ensure access to community partners with a comprehensive understanding of local resources and the cultural, ethnic and community structures specific to their region. Local Integrated Community Care Teams (ICCTs) are a key part of the RMHP care coordination model. These community organizations provide care coordination services and increase capacity and Member engagement. Care coordinators assist Members with appointments, non-emergent medical transportation, and connections to community resources. RMHP care coordinators have access to PEAK Pro and can assist Members with applications to Supplemental Nutrition Assistance Program (SNAP) benefits and other resources available.

Care coordination activity is documented in Essette, the care coordination platform shared by teams throughout the region. Essette allows for ongoing review of care coordination outcomes, productivity, follow-up actions indicated in the care plan, and transitions of care alerts. It also supports the integration of evidence-based guidelines (see Table 1) through standardized assessments and care plan interventions.

Sources of evidence-based guidelines followed in care coordination and population health programs	
• American Academy of Family Physicians	• Centers for Disease Control and Prevention
• American Academy of Pediatrics	• Milliman Care Guidelines
• American College of Obstetrics & Gynecology	• Substance Abuse & Mental Health Services Administration
• American Diabetes Association	• United States Preventative Services Task Force
• American Psychological Association	

Table 1: Evidenced based guidelines

RMHP will continue to focus on whole person health, collaborate with practices, coordinate with the health neighborhood and complete ongoing continuous quality improvement to improve care coordination offered throughout the region.

Complex Care Management and Evaluation

RMHP uses monthly IPro rosters to identify all eligible adults and children with complex needs (see Figure 1). Members are defined as complex if the risk score is in the top 2.82%. IPro data is used to identify trends and areas of focus within the population. Priority subgroups are also identified including behavioral health diagnoses including substance use disorders (SUD), Department of Corrections (DOC), Client Overutilization Program (COUP) and the top 20 Members with the highest risk scores.

The evaluation process for care coordination programs includes monitoring outreach and care coordination data, reviewing utilization trends and gathering qualitative feedback from Members and care coordination staff. Evaluation of Member engagement is monitored in Essette and through monthly reporting from ICCTs. RMHP will continue to monitor volume of care coordination activity for Members enrolled in ECC provided by RMHP and/or ICCTs. Additionally, RMHP will continue to track ongoing results of outreach activities (e.g., unable to contact, no needs identified, declined assessment etc.). RMHP meets with internal and external care coordination teams on a weekly basis to obtain qualitative analysis about the care coordination process and to provide training and workflow updates based on feedback received.

Support for Specific Populations

- **Foster Care/Child Welfare**: RMHP's strategy to support Members involved in the child welfare system - including those in foster care placement - is centered around strengthening relationships and communication with each county Department of Human Service (DHS) agency. RMHP staff meets regularly with DHS directors and attend county Interagency Oversight Group and Collaborative Management Program meetings. Additionally, when RMHP care coordinators are alerted that a RAE 1 Member is placed in foster care, the care coordinators proactively contact each child welfare office and work with the county to ensure the Member has access to the most beneficial resources possible.
- **Justice-involved:** RMHP promotes direct collaboration with DOC facilities, behavioral health providers, and probation/parole clinicians to improve overall care coordination outcomes. Care coordinators will attempt outreach to all Members transitioning out of DOC facilities to screen for physical, behavioral, and social needs and assist with referrals to community resources. RMHP care coordinators work in collaboration with Department treatment coordination case managers to support Members and minimize duplication with the RAE. Additionally, RMHP continues the parole in-reach program with Mind Springs Health - a program that is a multi-systemic approach to support Members upon release from DOC with the goal to achieve connection to behavioral health and physical health services prior to release to the community.
- **Housing Instability:** RMHP's strategy for connecting with people experiencing homelessness and housing instability is to meet individuals in the community. Care coordinators visit local shelters and resource centers to provide care coordination and assist with access to health care and community-based resources. RMHP will research access and application of the Homeless Management Information System (HMIS) in care coordination workflows for this population.
- **People with Intellectual and Developmental Disabilities (IDD & non-IDD):** RMHP provides targeted care coordination to address physical, behavioral, and social needs for people with disabilities and continues to foster collaborative relationships with local Community Centered Boards (CCBs), Single Entry Points (SEPs), and the Colorado Cross-Disability Coalition. Children with special health care needs are identified and will continue to receive targeted care coordination outreach each month to assess needs and receive support services. In addition, RMHP is sponsoring an intensive training curriculum for behavioral health providers to become skilled in providing services for people with co-occurring behavioral health and IDD diagnoses.

Private Duty Nursing (PDN) and Pediatric Long-Term Home Health (PLTHH)

RMHP developed a specialized workflow to contact and coordinate care for Members who have received prior authorization request denials for PDN and PLTHH. Designated care coordination staff have been trained to use a focused workflow (Appendix B) and will work collaboratively with Case Management Agencies (CMA) in the region to determine the best next steps for the Member (including access to local resources and assistance with filing an appeal). An open line of communication has been established with all CMA PDN leads, RMHP will continue to foster these collaborative relationships with the goal of helping Members receive the most beneficial care possible.

Care Coordination and Complex Care Management Goals
1. Increase engagement in ECC for Members identified as Complex by 2% points in calendar year 2022.
2. Prepare data systems and reporting capabilities for SFY22-23 Complex metrics.
3. Using updated Complex metrics, analyze baseline performance data and set performance goals that are SMART (specific, measurable, achievable, relevant, and time-bound).

4. Continue to enhance communication and collaboration with local DHS to improve support for Members with multi-system involvement.
5. Increase number of Members released from a DOC facility who have a behavioral health appointment within 14 days and a physical health appointment within 30 days of release.
6. Increase number of care coordination staff with a physical presence in homeless resource centers to pre-COVID-19 standard.
7. Develop use of HMIS information in care coordination workflows.
8. Build upon current CCB and SEP relationships throughout the region to increase collaboration and communication with shared Member populations.

2) Condition Management

RMHP is committed to promoting access to culturally appropriate condition management programs that address each of the 10 Department-identified conditions. Members with one of the 10 Department-identified conditions may not have an IPro risk score that identifies them as complex or emerging complex; however, they will be identified in the condition population segment (see Figure 1). Each condition may also have specific identification criteria (e.g., high-risk pregnancy). RMHP supports programs that are grounded in a blend of evidence-based practices (see Table 1) and local or national programs. Condition management programs and initiatives are offered throughout the region by RMHP, local health care providers, and community organizations.

Maternity

Members who are pregnant are identified through multiple pathways, including claims data, assessment results, Early and Periodic Screening, Diagnostic, and Testing (EPSDT) data, eligibility category, or community, provider, and self-referrals. Members with a potential high-risk pregnancy are identified through membership or claims-based risk criteria including:

- under 17 years or over 40 years
- disability status
- pre-eclampsia
- sepsis
- pulmonary embolism
- deep vein thrombosis
- human immuno-deficiency virus
- obesity
- diabetes
- hypertension
- autoimmune disorders
- placenta abruption or placenta previa
- seizures
- multiples
- previous intrauterine fetal demise
- prior preterm delivery
- pregnancy with bleeding
- substance use

RMHP Maternity program interventions include four areas of focus:

- **Prenatal:** Connect Members to appropriate prenatal care while addressing barriers to access
- **High-risk management:** Address issues related to high-risk pregnancy status
- **Postpartum follow-up:** Screen for postpartum concerns, benefits education (EPSDT), and assist with scheduling follow-up appointments
- **Programmatic support: Connect** Members to local or national maternity programs

RMHP attempts to contact all Members identified as pregnant. If outreach is successful, an assessment is completed, and the Member receives ongoing care coordination and, when appropriate, referral to local maternity programs including:

- Prenatal Plus Program
- Nurse Family Partnership
- Women, Infants, & Children (WIC)
- SNAP

Members are encouraged to receive regular prenatal care and care coordination staff assist in removing barriers to care (e.g., transportation, scheduling, etc.). Care coordinators also conduct outreach and education after delivery to ensure the Member and newborn receive ongoing postpartum care. RMHP is committed to providing maternity programs to all Members in a culturally, linguistically, and socially appropriate manner. RMHP maternity care coordination staff receive annual cultural competency and responsiveness training and are committed to meaningful connections with local community providers based on the unique needs of each Member (see Health Equity and Culturally Competent Specialized Care, p.2).

RMHPs population health management strategy creates localized interventions at the Member, provider, and community level - these interventions apply to each population segment referenced in Figure 1.

Maternity program descriptions categorized by population segment (see Figure 1)

Complex

- **High-Risk Prenatal Program:** Members identified as high-risk receive outreach from a Maternity care coordinator who completes an assessment and provides intensive care coordination and education services focusing on access to care and risk mitigation. Available to all RAE and Child Health Plan Plus (CHP+) Members.

Condition Management

- **General Maternity Program:** Members identified through the Departments roster, EPSDT data, claims data, self-referral, and welcome screener results receive outreach from a Maternity care coordinator who completes an assessment and offers general care coordination including care plan/goal creation and follow-up as needed. Supplemented with EPSDT data. Available to all RAE and CHP+ Members.
- **SimpliFed:** In SFY21-22 Q4, RMHP began offering SimpliFed to RAE 1 Members. SimpliFed is an evidence-based tele-lactation consulting program that provides virtual breastfeeding and baby feeding support. Unlimited visits are available free of charge to Members. Services start in pregnancy and are designed to work in collaboration with hospital-based lactation services. RMHP's goal for SFY22-23 is to increase awareness of SimpliFed through targeted Member marketing and provider engagement. Available to all RAE and CHP+ Members**.**
- **Wellhop for Mom and Baby:** Wellhop is an application-based group prenatal program designed to provide pregnant Members with similar due dates support and education through group visit video conversations. Group leaders follow an evidence-based curriculum to facilitate discussions and work with Members. RMHP's goal for SFY22-23 is to increase participation in the program. Available to all RAE and CHP+ Members.

Wellness/Prevention

- **New Baby Educational Packet:** The new baby packet provides education to Member parents or guardians and includes information on baby-proofing the home, Centers for Disease Control and Prevention (CDC) recommended immunization schedules, and CDC recommended well child check schedules. Available to RAE Prime and CHP+ Members.
- **Postpartum Care Incentive:** The postpartum incentive is mailed to pregnant Members at 37-38 weeks' gestation. Members receive a brochure with information about the importance of follow-up care between 21 and 56 days after giving birth. If the Member returns the incentive

form verifying the follow-up assessment has been completed, they receive a gift card. Available to RAE Prime Members.

RMHP also supports its network of PCMPs and ICCTs who provide comprehensive maternity programs throughout the region.

- **Postpartum Program:** The Medicaid Accountable Care Collaborative (MACC) team in Larimer County offers a postpartum program focusing on infant and maternal wellness. This program offers home or hospital-based visits that include assessments, education, lactation support, and provider follow-up.
- **Prenatal Plus:** The North Colorado Health Alliance (NCHA) is a Prenatal Plus provider whose goal is to reduce low birthweight, infant mortality, and maternal mental health. This program works closely with RMHP care coordinators to coordinate services across the continuum of care. NCHA provides regular communication with local obstetrics (OB) providers to ensure continuity of care for participants.
- **Comprehensive Maternity:** 52% of RMHP's top tier PCMPs offer comprehensive maternity care including prenatal care, behavioral health screening/intervention, dental screening, deliveries, and postpartum management. Many of these practices offer care coordination, provide ongoing education, and contribute to maternity related clinical quality improvement outcomes.
- **Willow Collective:** RMHP financially supports this private practice and network of providers, with the shared goal of supporting maternal, infant, and early childhood mental health in Larimer County. Willow supports and counsels moms, dads, families, and other caregivers with their young children to build trust and establish new tools to break intergenerational patterns of trauma.

Emerging Best Practice: RMHP will continue to support and evaluate a Doula program in Larimer County at two Salud Family Health (Salud) clinics. Salud offers Doula services in English and Spanish including prenatal and postpartum visits, childbirth and breastfeeding classes and lactation consultation. Doula services focus on Members of color and are customized to meet individual Member needs. Doulas have been found to reduce the risk of preterm births, c-section and increase the rate of breastfeeding initiation, especially amongst low-income and racially/ethnically diverse Members.

Diabetes

RMHP's diabetes management program helps Members with diabetes maintain health and prevent complications through comprehensive interventions that promote self-management, health education and collaborative communication with their health care provider team. Members are referred to the program by PCMPs, RMHP clinical teams or self-referral. High-risk Members receive direct outreach from the RMHP clinical care coordination team. Initial program contact focuses on assessment of health history and social needs. If Members require ongoing care coordination, the RMHP team helps set individual goals that inform a diabetes care plan. Common care plan areas of focus include hemoglobin A1c (HbA1c) control, medication management, weight loss, diet, risk factors, and recommended diabetes screening. RMHP care coordinators remain engaged with Members to assess progress and provide support as needed. Members who meet the following criteria are targeted for outreach and participation in RMHP's diabetes management program:

- HbA1c > 9 or missing an HbA1c
- Hospitalization with diabetes as one of the primary diagnoses
- Diabetes diagnosis and no PCMP visit in the past 12-months

RMHP is committed to providing diabetes programs to all Members in a culturally and linguistically responsive manner. Latinx Members are the largest group of non-white Members with diabetes in the RAE 1 region. RMHP understands that Latinx Members may require a unique approach to diabetes management related to diet, physical activity, and other social influences. Care coordination staff receive cultural competency training and create individualized care plans that include meaningful connections with clinicians and community resources who serve the Latinx population. Cultural competence is an ongoing learning process and RMHP works closely with consultants and community groups to develop best practices for diabetes care throughout the region.

RMHP's care coordinators and disease management nurses encourage Member engagement with PCMPs and specialty providers. RMHP diabetes management programs support and reinforce the plan of care created by the Member's clinical care team. RMHP supports PCMPs to provide diabetes screening tests (HbA1c and retinal eye exam) at the point of care which decreases the need to access specialty care.

Diabetes program descriptions categorized by population segment (see Figure 1)

Complex

- **Complex Adult Case Management:** RMHP identifies Members who are complex, based on IPro scoring, and performs targeted outreach to engage in ECC. Complex Members typically have several comorbidities, including diabetes. If diabetes is an identified concern for a complex Member, then they are referred into the Diabetes disease management program while still receiving complex interventions. Available to all RAE and CHP+ Members.

Condition Management

- **Care Angel:** In SFY22-23 Q1, RMHP intends to launch Care Angel, an artificial intelligence and voice-enabled virtual nurse assistant. Care Angel will focus on diabetes condition management through Member engagement, needs identification, monitoring, gap closure and referral to resources including live RMHP care coordination staff. Care Angel will be available to all RAE and CHP+ Members.
- **Diabetes Disease Management Program**: Members with diabetes receive outreach from a nurse care coordinator who completes an initial assessment and provides care plan/goal creation and follow-up based on Member needs. Available to all RAE and CHP+ Members.
- **Diabetes Gaps in Care Program:** This PCMP-facing program is a rapid intervention program designed to assist PCMPs with diabetic care processes. PCMPs are provided with coaching support designed to identify gaps in their current systems and processes and to develop a work plan to address identified gaps. Focus on HbA1c testing, screening for diabetic retinopathy, family engagement, internal auditing, and sustainability. Participating practices are eligible to receive a financial incentive that is recommended to be used on testing equipment (e.g., retinopathy scanners).
- **Diabetes Medication Adherence Program:** Members with claims for drugs used to treat diabetes who have less than 60% documented adherence are contacted by a licensed clinical pharmacist or certified pharmacy technician to review medications and receive education on the importance of medication adherence.
- **Healthy.io:** In SFY 22-23 Q1, RMHP and Healthy.io will send home kidney test kits to Members identified as high-risk for kidney disease (i.e., Members with diabetes or hypertension who have no history of a kidney disease test in the past year). Kits will be offered free of charge and

Members use a smart phone app to detect previously unidentified kidney disease. Members and RMHP are notified of positive results and RMHP will partner with PCMPs and do direct Member outreach to facilitate appropriate confirmatory testing and follow-up. Available to all RAE Members.

- **Diabetes Medication Adherence Program:** Members with claims for medications used to treat diabetes who have less than 60% documented adherence are contacted by a licensed clinical pharmacist or certified pharmacy technician to review medications and receive education on the importance of medication adherence. Available to RAE Prime Members.

Wellness/Prevention

- **Diabetes Incentive Programs:** RMHP identifies Members for this program according to Health care Effectiveness Data and Information Set (HEDIS) technical specifications including Members who have not received a visit with their provider to address diabetes, Members who have not had diabetic retinopathy screening, and/or Members who have not had a HbA1c test. Members are mailed an educational form informing them of the importance of annual visits and screenings. Members return the form with a signature from their provider stating that the screening or visit has been done. If the completed form is returned, the Member is awarded a gift card. Available to RAE Prime Members.

RMHP also supports its network of PCMPs and ICCTs who provide comprehensive diabetes management programs throughout the region.

- **National Diabetes Prevention Program:** The MACC team in Larimer County offers a 12-week evidence-based lifestyle modification series provided by nationally certified instructors in English and Spanish.
- **Clinical Pharmacy Consultation:** Salud clinical pharmacists work alongside Members of the interdisciplinary care team and assist with medication therapy, patient education, shared medical appointments and hospital transitions. Clinical pharmacists provide collaborative drug therapy management (CDTM) protocols and medication management for diabetes, hypertension, asthma, cardiovascular disease, depression, and anxiety.
- **Comprehensive Diabetes Management:** 100% of RMHP's high performing PCMPs provide comprehensive diabetes management programs with risk stratification methodology to identify and care for Members with diabetes or coordinate with specialty providers as necessary.

Other Condition Management Programs

Effective condition management involves whole person care, integrating physical and behavioral health and management of multiple conditions, such as chronic obstructive pulmonary disease, hypertension, coronary artery disease, or depression. As previously indicated, RMHP's complex care management program is specifically designed to address the care of Members with multiple conditions and the following programs apply to multiple conditions.

Complex

- **Complex Behavioral Health Case Management**: Members who are identified as Complex and have a primary risk indicator related to depression, anxiety, SUD, or other behavioral health conditions are included within this program. Specialized staff outreach and engage this population. Available to all RAE and CHP+ Members.

- **Complex Pediatric Case Management:** RMHP identifies Members aged 20 years and under, who are complex based on IPro scoring and performs targeted outreach to engage in ECC. Pediatric complex Members may have one or multiple conditions including asthma, diabetes, anxiety, depression, or SUD. Screening and assessment are performed to identify Member focused goals which may include self-management, education, coordination, or referral, based on Member needs. Available to all RAE and CHP+ Members.

Condition Management

- **COUP:** The target population is any Member at risk from serious adverse effects from high-risk medications including high dose opioids or opioid use disorder. RMHP receives a list of Members who are eligible for the program from the Department. Interventions include intensive care coordination and referral to resources. Available to RAE Members.
- **Medication Review Program**: Includes two programs, medication review and opioid management. Medication review includes Members taking medications in four or more chronic drug classes including drugs used in the treatment of diabetes, hypertension, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), cardiovascular disease, (CVD), anxiety and depression. Opioid management includes Members establishing chronic opioid therapy and evidence of multiple prescribing providers, and polypharmacy. In both programs, Members are contacted by a licensed clinical pharmacist to discuss medications and receive education. The goal is to improve the effectiveness of the Member's drug regimen based on evidence-based guidelines. Available for RAE Prime and CHP+ Members.
- **Medication Adherence Program:** Medication adherence includes Members with claims for chronic disease drug classes with less than 60% documented adherence, drug classes include diabetes, CHF/CVD, and SUD. The goal of the program is to increase Member adherence with prescribed medications. Members are contacted by a licensed clinical pharmacist or certified pharmacy technician to review medications and receive education. Available for RAE Prime and CHP+ Members.
- **Healthy.io:** See full description in the diabetes section. Healthy.io also applies to hypertension, CHF/CVD, and kidney disease.
- **Drug Safety:** Targets Members at risk for serious adverse effects from high-risk medications including high dose opioids. This program generally applies to SUD, chronic pain, and anxiety. Interventions include physical and behavioral health care coordination. Members of this program are restricted to one pharmacy and one prescribing provider. Available to RAE Prime and CHP+ Members.
- **SUD Practice Transformation:** RMHP's Clinical Program Manager specializing in integrated behavioral health works with PCMPs to improve policies, workflows, and programs to support Members with SUD. Current work includes practice coaching and support through the Incentives and Support for Medication for Opioid Use Disorders program, this helps primary care practices increase access to medication for opioid use disorder and to build the confidence of waivered physicians to successfully support patients eligible for these medications.
- **Hub-and-spoke:** RMHP will continue to participate in the hub-and-spoke model for SUD in Larimer and Mesa counties. Members are identified through emergency department (ED) or hospitalization claims data or referrals from local community partners; once contacted they complete a treatment needs questionnaire and enroll into the program. Care coordination facilitates connections between regional hubs (e.g., SUD providers, medication-assisted treatment clinics). This coordination continues through the continuum of care through 30 days after discharge.

Wellness/Prevention:

- **Hypertension Incentive:** Hypertension incentive and education brochures are mailed to Members 18 – 85 years of age to educate them about hypertension and to encourage them to have their blood pressure evaluated at a provider's office. If the Member returns the incentive brochure with a signature from the provider indicating that testing has been completed, the Member is awarded a gift card. Available to RAE Prime Members.
- **Cancer Screening Incentive:** Based on HEDIS technical specifications, Members eligible for cancer (cervical and breast) screenings are mailed educational materials to encourage gap closure. If screening is completed and Members return their incentive forms with proof of screening, the Members are awarded gift cards. Available to RAE Prime Members.

Transitions of Care

- RMHP prioritizes support for Members during the transitions of care process. A direct interface with the health information exchange provides care coordination staff with real-time admission, discharge, and transfer data for all RAE Members. Care coordination staff attempt to contact all RAE Members upon notification of hospital admission while the Member is still in the hospital.
- RMHP will continue to support transitions of care through participation in the Hospital Transformation Program (HTP). HTP is supported by active engagement from 26 hospitals across the region. The aim of the program is to improve the quality of hospital care provided to Members by tying provider fee-funded hospital payment to quality-based initiatives, including:
    - Social needs screening
    - Follow-up appointment with a clinician and notification to the RAE within one business day
    - Develop and implement discharge planning and notification process for Members discharged from the hospital or emergency department with a diagnosis of mental illness or SUD
    - Screening and referral for perinatal and postpartum depression and anxiety and notification of positive screens to the RAE

  RMHP will continue to support HTP program goals over the next five years.

Emerging Risk

According to RMHPs population stratification framework, Members are considered to have emerging risk if they had a month to month increase in IPro score of 2 points. These Members likely had a recent clinical event or other concerning factor that caused this score change. RMHP will launch an emerging complex case management program in SFY22-23 to reach this vulnerable segment of the population and help Member's access wellness and prevention programs to impact the progression of risk.

Substance Use Disorder Transitions

- **Level of Care Transitions:** RMHP provides care coordination while Members are in a SUD level of care and while transitioning between levels of care. Staff regularly assess the appropriate level of care based on American Society of Addiction Medicine (ASAM) criteria and assist with Member needs while in treatment (e.g., obtaining medical appointments, resources to keep pets safe, assistance with obtaining the next level of medically appropriate treatment including transition to residential, outpatient, or sober living). The next level of care is secured for the Member prior to discharge.

- **Discharge Care Coordination:** Care coordination for Members that discharge is conducted by a dedicated SUD treatment care coordinator for inpatient, residential, or withdrawal management. The SUD care coordinator has access to case information, unaddressed needs identified during treatment and if the Member completed a release of information for additional care coordination at discharge. A screener is completed by the SUD care coordinator to identify additional needs and Members are linked to services as needed. A care plan is created for Members leaving inpatient or residential treatment, this care plan includes at least two achievable goals to maintain recovery and involves weekly contact for 30 days post-discharge. If there are still outstanding needs at the end of 30 days, the SUD care coordinator maintains contact until needs are met. Members with incomplete goals or those who are discharging from withdrawal management levels of care receive an initial care coordination call within 48 hours of discharge. In these cases, the SUD care coordinator maintains contact for 30 days post-discharge and uses screening tools and motivational interviewing to encourage SUD treatment when the Member is ready. Members are always left with the SUD care coordinator's contact information to reach out if they are ready for treatment. RMHP has a peer support specialist that also reaches out to Members at discharge. If the Member discharged successfully, the peer support focuses on maintaining recovery, helping the Member maintain motivation, and celebration of successes along the Member's path of recovery. If the Member had an unsuccessful discharge, the peer support would reach out to understand what happened, needs/wants, motivation for recovery, and connection to case management if the Member desires.
- **SUD Interim Services:** When a Member is on a wait list for SUD treatment, the SUD care coordinator reaches out to other facilities that offer the same level of care to determine if the Member can start treatment sooner. If there are no open options for the authorized level of care, the SUD care coordinator contacts the Member to schedule a different level of care or treatment option until the approved level of care is available. In addition, the SUD care coordinator provides resources and encourages the Member to attend peer support groups such as Alcoholics Anonymous, Life Ring, or Self-Management and Recovery Training. While the Member is on a wait list, the SUD care coordinator maintains weekly contact to provide encouragement, motivation, and remove any identified barriers to treatment. Additionally, while the Member is waiting for a level of care, RMHP's Peer Support Specialist reaches out to the Member to help build motivation for treatment and life in recovery, answer any questions, and be a general support as the Member waits. The Peer Support Specialist works with the SUD care coordinator if any needs are identified before treatment begins.

Condition Management Goals
1. Outreach 95% of the Members identified as emerging complex and engage with 20% of this population in ECC activities during calendar year 2022. 2. Medication Review Program: Pharmacy review of 50 Members per month during calendar year 2022. 3. Medication Adherence Program: Annual pharmacy review of 60 Members for Antidepressants, Antidiabetics, and SUD drug adherence. 4. Prepare data systems and reporting capabilities for SFY22-23 Condition Management Metrics. 5. Analyze baseline performance data and set SMART performance goals for: a. Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (>9.0%). b. Prenatal and Postpartum Care: Timeliness of Prenatal Care c. Prenatal and Postpartum Care: Postpartum Care

6. Continue to increase the rate of successful outreach by deploying practices such as using multiple contact methods for the Members and calling during 8am – 5pm weekday hours. The goal is to increase successful outreach rates by 2% in 2022.
7. Increase distribution of Member-facing material related to hypertension.
8. Increase distribution of Member-facing material related to cancer screening recommendations.

3) Wellness Promotion, Prevention Support, and Member Engagement

In addition to complex care coordination and condition management RMHP's population health management strategy focuses on wellness, prevention, and Member engagement.

Well Care: RMHP provides wellness education and outreach to Members throughout the lifespan, reminders are based on nationally recognized well care schedules (see Table 1).

- Child specific educational materials are mailed to RAE Prime and CHP+ Members during key points in the child's lifespan, between the Member's 1st and 18th birthday, at intervals based upon CDC recommended immunization and well child check schedules. Materials educate and promote child safety and include a variety of health education topics such as healthy habits, growth and development, and recommended immunizations.
- RAE Prime Members, age 18 to 21 years, receive a well young-adult educational brochure. The brochure provides education on healthy habits, emotional and physical safety and preventive care including screenings and immunizations.
- Incentive brochures are sent to 16-month-old RAE Prime Members with education on immunizations recommended before the second birthday. If the Member's parent or guardian returns the incentive form along with a copy of the Member's vaccine record verifying the recommended immunizations have been completed, the Member is awarded a gift card.
- Incentive brochures are sent to RAE Prime and CHP+ Members aged 10 to 17 to educate the Members on the importance of routine well visits with their health care provider. If the Member returns the incentive brochure with a signature from their provider verifying the visit took place within the required time frame, the Member is awarded a gift card.
- EPSDT materials are sent to all RAE Members who are pregnant or aged 0-20 years. Materials educate Members on EPSDT benefits and recommended screenings. Materials are sent upon eligibility, annually thereafter, and upon evidence of a gap. Additionally, newly pregnant, or recently delivered Members receive a call with information about the program.

The RMHP clinical quality improvement team supports practice transformation activities designed to improve PCMP well care and chronic disease prevention activities. RMHP works directly with practices to provide chronic condition self-management tools and shared decision-making aids to empower Members and their families/caregivers to take part in health care decisions. Practices are provided toolkits and education to help Members prevent and manage chronic conditions actives are evaluated through regular practice assessments and data analysis.

Tobacco Cessation: RMHP supports multiple tobacco cessation strategies including tobacco cessation, screening, and counseling by customer service, care coordination and the Care Angel program (see Diabetes Program Descriptions, p.9). OB screeners include questions about tobacco use and Members are referred to the Baby and Me Tobacco Free program. Members are provided information about the Health First Colorado tobacco cessation benefit, Colorado QuitLine and PCMP referrals that may help them achieve tobacco cessation goals. Tobacco cessation is included in the clinical quality measure

suites for multiple RMHP CQI programs and practices can choose to work on this as a key quality improvement metric. Tobacco cessation is also a common focus for shared decision-making discussions between providers and Members.

Food Security: RMHP addresses food security by regularly assessing Member needs through screenings at clinical sites and assessments conducted by RMHP staff. When a need for food is identified, RMHP connects Members with community resources that provide Members with access to healthy food. Care Coordinators promote food security and healthy eating resources through referrals to Cooking Matters programs, nutrition classes, Meals on Wheels, local food banks and registered dieticians; all referrals are tracked in RMHPs care coordination platform. RMHP diabetes programs provide guidance to Members about culturally appropriate diet options.

Family Planning: RMHP conducted an environmental assessment to determine cultural perceptions held by Latinx Members related to contraceptive methods, including long-acting reversible contraceptives (LARCs). This information was used to inform RMHPs strategy to improve access to LARCs and other family planning options throughout the region. RMHPs OB screener includes questions related to whether Members have had a conversation with their obstetric clinician about contraception, and if they haven't, care coordination is offered to connect the Member with their provider as appropriate. All Planned Parenthood clinics in Region 1 are contracted as PCMPs and are available to Members for family planning, education services and primary care.

Member Engagement: Community level Member engagement activities are driven by a network of Members who deepen RMHPs connections with the communities we serve. RMHP Member Advisory Councils (MAC) provide an effective structure to capture this perspective and are actively involved with the development of programs and policies. Member Advisory Councils representing Western Colorado and Larimer County meet regularly and are expanding to include the Spanish speaking community through a monolingual Spanish speaking Member council. The goal of this group is to convene Spanish-speaking RAE and CHP+ Members including parents and caregivers to provide input and help RMHP create solutions to challenging issues experienced by the community.

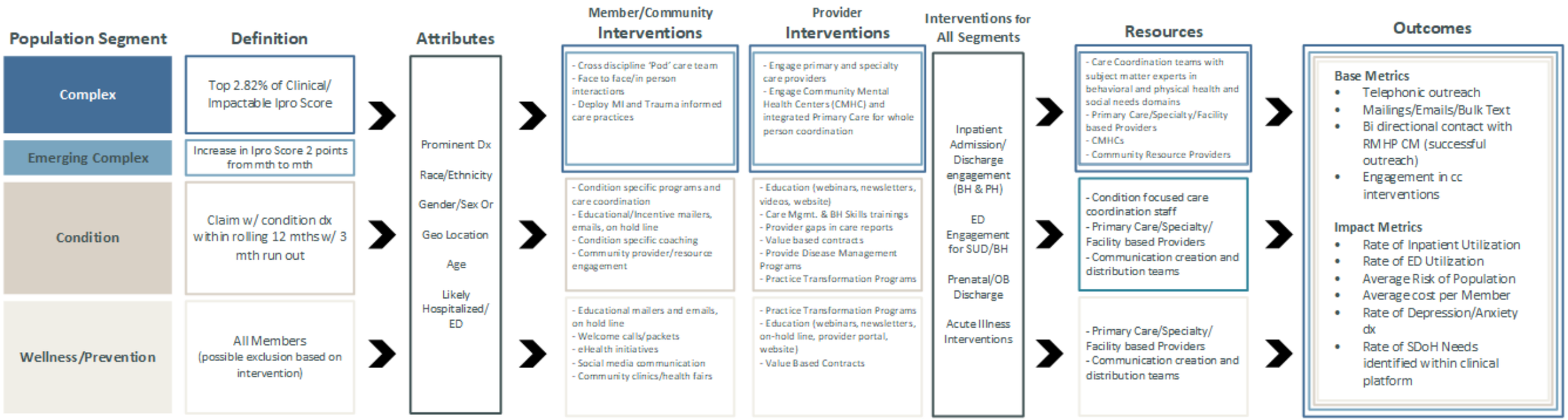
The cross-departmental Member Experience Advisory Committee (MEAC) provides RMHP with an understanding of the Member experience and creates an environment to influence RMHP operations and programs. Additionally, RMHP convenes internal workgroups that report up to the MEAC, including a Clinical Member Experience Quality Workgroup that focuses on clinical services-related interventions and is charged with driving improvement efforts around the Consumer Assessment of Health care Providers and Systems (CAHPS) survey.

RMHP's Regional Program Improvement Advisory Committee (PIAC) provides a structure for diverse community involvement and a forum for community Members to identify and prioritize population health challenges and discuss key components of RMHPs RAE contract deliverables.
RMHP also supports and actively participates in Deaf advocacy groups, called Bridging Communications, which meet regularly in Larimer County and Western Colorado to address issues experienced by Members who are Deaf and hard of hearing, with a focus on the needs of the Deaf community when accessing health care.

Wellness and Member Engagement Goal
1. RMHP will convene a Member Advisory Council for Spanish speaking Members by the end of 2022 with a minimum of 10 Members participating from Region 1.

2. Execute plan to an increase well care educational materials for RAE Members and other populations as needed.
3. Prepare data systems and reporting capabilities for SFY22-23 Wellness and Member Engagement metrics.
4. Analyze baseline performance data and set SMART performance goals for:
    a. Well-Child Visits in the First 30 Months of Life
    b. Child and Adolescent Well-Care Visits
5. Assess food security resources throughout the region and identify opportunities to improve access for all Members.

Appendix A:
RMHP Population Segmentation Model



COLORADO
Department of Health Care Policy & Financing

Appendix B:
Private Duty Nursing Program Workflow