



Adult Medicaid Quality Grant

*Grantee Agency: Colorado Department of Health Care
Policy and Financing*

*Grant Period: December 21, 2012–March 19, 2015
(No-Cost Extension: December 21, 2014–March 19, 2015)*



QUALITY IMPROVEMENT PROJECT #1

TOPIC

Improving Mental Health by Increasing Screening and Follow-Up for Depression

TARGET POPULATION

Adults with undiagnosed depression.

SETTING

In 2013, Colorado Medicaid awarded 1-year “mini-grants” of up to \$100,000 to six projects across six of the seven Colorado Regional Care Collaborative Organizations (RCCOs). These projects included 60 of Colorado’s 64 counties. In 2014, five projects received 1-year mini-grants; these projects served six of the seven RCCOs and included 38 of Colorado’s 64 counties. Projects in both years were implemented in urban, rural, and frontier areas.

GOALS

- Establish a baseline rate for Screening for Clinical Depression and Follow-Up Plan.
- Increase the rate of Screening for Clinical Depression and Follow-Up Plan by 5%.
- Increase the rate of Antidepressant Medication Management by 5%.

INTERVENTIONS

Mini-grantees undertook distinct interventions or projects that were specific to their client populations and setting. Projects through the mini-grants were required to be sustainable at the end of the 1-year grant period. The projects focused on a variety of ways to increase depression screening and/or appropriate follow-up, including the following:

- **Health IT approaches:** Performed depression screening by phone; added printable depression screening tools to websites of practices without electronic health records (EHRs); digitized and implemented Patient Health Questionnaire-9 (PHQ-9) and Pregnancy-Related Depression Screening and linked results to EHRs; designed and implemented an internet-based advanced care management program; and developed and deployed an EHR-integrated patient portal through which patients can ask questions, update demographic information, schedule or cancel appointments, and access an online PHQ-9.
- **Education and training:** Created opportunities for providers to receive training on billing and coding, as well as selecting and using depression screening tools for their patients based on patient populations; planned, developed, and deployed training materials for providers; developed and implemented a pharmacist-based shared decisionmaking educational program to improve patient adherence to pharmacotherapy for major depressive disorder; provided coaching to medical homes on developing processes for behavioral health screening; provided training to increase recognition of depression symptoms; distributed informational materials to providers and practice managers (to medical homes) on Pregnancy-Related Depression Screening and managing positive depression screens; and conducted medical roundtables for primary care providers and practice staff on screening practices and protocols.
- **Outreach:** Sent provider outreach letters to inform the providers of depression screening billing codes; provided coaching to medical homes on developing processes for mental health screening; and helped medical homes integrate behavioral health in primary care settings through tactics such as depression screening tools and follow-up plans.

• Other RCCO interventions included:

- Developed and deployed a practical clinical curriculum for Insignia Health's Patient Activation Measure, which is used to predict future ER visits, hospital admissions and readmissions, and medication adherence based on patient-reported health characteristics and aimed at assessing patients' ability to self-manage health conditions.
- Developed and implemented referral protocols between primary health care practices and behavioral health organizations.
- Held block parties for medical and behavioral health professionals aimed at increasing depression screening and awareness of the needs of special populations (e.g., pregnant women, frail, elderly) and provider awareness of community care coordination resources.
- Designed and deployed a web-based advanced care management program for case managers.

RESULTS AND SUCCESSES

- Mini-grant interventions for Years 1 and 2 were completed. Each mini-grant's interventions are sustainable, and grantees will continue efforts to increase screenings and improved health outcomes for clients.
- Across RCCOs, improvements in depression screening and appropriate referrals were seen, and each RCCO was required to carefully track its interventions and report the results to Colorado Medicaid.
- Projects conducted in 2013 were instrumental in identifying different needs and targets for 2014 projects.
- At the end of 2013, six practices had fully implemented the Patient Activation Measure; in December 2014, that number increased to 27 practices.
- Salud Family Health Centers showed an increase of 26% in web-enabled patients over Year 1. By the end of 2014, Salud saw a 44% increase in depression screenings.
- Integrated Community Health Partners held eight block parties with 104 participants and reported successfully incorporating multiple depression screening tools into the practice workflow, such that all patients can have these screenings done when visiting their primary care provider.
- Screening tools were digitized through iPads; Colorado Access and Sister Joanna Bruner Family Medicine Center reported improvements in patient, provider, and staff satisfaction.
- Staff were trained on a Stanford University-based self-management program, the Chronic Disease Self-Management Program.

CHALLENGES AND BARRIERS TO SUCCESS

- RCCOs reported patient engagement challenges, such as patients refusing screening and/or treatment, language and communication difficulties (Spanish, Somali, Burmese), and lack of interest in computer use.
- RCCOs faced physician engagement challenges, which may be attributable to change fatigue due to many practice transformation activities co-occurring.
- Some RCCOs reported challenges in quantifying beneficiaries who have or have not been screened. However, by the end of Year 2 of the mini-grants, most RCCOs were able to report these numbers.
- Several RCCOs reported barriers to referring patients to behavioral health providers. Physicians noted that they did not feel comfortable screening for depression unless they had a place to refer patients for depression treatment.
- RCCOs reported challenges regarding reimbursements for the recently billable depression screening code. The depression screening code became billable during the grant period.



QUALITY IMPROVEMENT PROJECT #2

TOPIC

Improving Diabetes Care by Increasing the Annual Hemoglobin A1c Testing Rate

TARGET POPULATION

Adult Medicaid beneficiaries with diabetes.

SETTING

In 2013, 1-year mini-grants of up to \$100,000 were awarded to four projects across five Colorado RCCOs and included 39 of Colorado's 64 counties. In 2014, five projects received 1-year mini-grants of up to \$80,000; these projects served five regions and included 38 of Colorado's 64 counties. Projects in both years were implemented in urban, rural, and frontier areas.

GOALS

- Decrease the Diabetes Short-Term Complications Admission Rate by 5%.
- Increase the Hemoglobin A1c Testing rate by 10%.

INTERVENTIONS

Mini-grantees undertook distinct interventions or projects that were specific to their client populations and settings. Projects through the mini-grants were required to be sustainable at the end of the 1-year grant period. Diabetes projects included the following interventions:

- **Health IT approaches:** Implemented a cross-organization software system that was built to share patient monitoring and care coordination data in real time. The software generates alerts when patients need an HbA1c test or are recently discharged from the hospital for short-term diabetes complications. Implemented an interactive voice response (IVR) call campaign through which the IVR system (1) provided information about diabetes self-management and (2) performed a warm transfer to a case manager who offered to complete the diabetes self-management module and screen, if appropriate, for depression using the PHQ-9.
- **Education and training:** Held motivational interviewing training for care management staff; one RCCO provided staff members with training on the Stanford University-based Chronic Disease Self-Management Program. Developed tools and resources for care coordinators, clinical practices, and Medicaid beneficiaries to help manage risks related to adults with diabetes, and provided coaching to providers who wanted to implement group patient visits.
- **Outreach:** Held focus groups to identify barriers to care and motivating factors to seeking diabetes care, and provided classes to help beneficiaries with diabetes with disease management through education, cooking classes, and web-based software.
- **Other RCCO interventions included:**
 - Identified the most frequently billed diabetic complications.
 - Developed an enhanced care management tool to support beneficiaries at risk of hospitalization related to short-term diabetes complications.
 - Developed a diabetes community resource directory.
 - Salud Family Health Centers installed 30 workstations, trained approximately 500 staff, developed two training guides, trained two student volunteers, collaborated between six departments, and built one hospital partnership.

RESULTS AND SUCCESSSES

- Mini-grant funding for Years 1 and 2 has ended, and measurement of the interventions for those grants has been completed. Overall, grantees' project successes are still being determined. However, because these interventions were all developed to be sustainable,

Colorado Medicaid expects to see continued improvement in these areas. Many of the projects were also built to be expanded into other areas of need, which should also lead to continuously improving outcomes.

- Preliminary data from cross-organization software system implementation indicated a high level of acceptability of the system by clinicians. Clinicians expressed interest in the intervention and the software platforms for providers and patients.
- Classes in care management (51 active and 7 graduated), cooking matters (35 individuals completed), self-management education regarding diabetes (5 completions), and chronic disease (19 completions) were offered to individuals diagnosed with diabetes.
- A diabetes community resource directory was developed for patients and providers.
- Other results and successes overlapped with those of quality improvement project (QIP) #1 because RCCO efforts addressed depression and diabetes simultaneously.

CHALLENGES AND BARRIERS TO SUCCESS

- RCCOs reported challenges implementing the patient portal, including staff and patient engagement, age, language, culture differences, data challenges, and technical support.
- RCCO staff learned that taxis as the primary form of transportation presented a challenge for beneficiaries taking classes. Additional challenges for beneficiaries included the cost of food, homelessness, and other health issues.
- Practices needed to build robust patient recruitment and engagement strategies to support coaching and community health diabetes interventions.

PARTNERSHIPS



INTERNAL

- **Colorado Department of Human Services:** A data analyst supported by the Quality and Health Improvement unit developed a collaboration between the Colorado Department of Public Health and Environment for data supporting the birth certificate information and the Office of Behavioral Health with the Colorado Department of Human Services for data supporting depression measures.

PARTNERSHIPS (CONTINUED)



EXTERNAL

- **Colorado Community Health Alliance, Metro Community Provider Network, Sister Joanna Bruner Family Medicine Center, and Foothills Behavioral Health Partners** were included among the partners engaged for QIP #1.
- **Colorado Health Institute, the American Diabetes Association, Salud Family Health Centers, and Metro Community Provider Network** were included among the partners engaged for QIP #2.



DEVELOPING STAFF CAPACITY AND INFRASTRUCTURE

STAFF CAPACITY

- Colorado Medicaid had three grant-funded positions (grant manager, analyst, and program assistant). None of these positions were sustained beyond the grant period.
- Colorado Medicaid staff attended and provided trainings in data collection and analytics, as well as the Lean Six Sigma program.
- Colorado Access (RCCOs 3 and 5) partnered with Salud Family Health Centers to increase screenings for diabetes and depression by identifying and developing systems within their network to provide a patient portal. Salud Family Health Centers installed 30 workstations, trained approximately 500 staff, developed two training guides, trained two student volunteers, completed policies and procedures, collaborated among six departments, and built one hospital partnership.

INFRASTRUCTURE

- Colorado planned to develop a robust dashboard that would be accessible at the practice level, the regional level, and the state level to report administrative rates for performance measures. However, challenges with the contractor resulted in implementing dashboards at the practice level only.

LESSONS LEARNED

- Specific efforts are being made to continue alignment of the Medicaid Adult Core Set of Adult Health Care Quality Measures (referred to as the Medicaid Adult Core Set) and alignment of efforts between units in the department and between other departments in Colorado, which may include the Office of Behavioral Health in the Colorado Department of Human Services and the Colorado Department of Public Health and Environment.
- Trying to establish new partnerships in the first 6 months of the grant program or even the first year is extremely challenging.



DATA COLLECTION AND ANALYTICS

DATA COLLECTION

- Colorado successfully reported 21 of the Adult Core Set measures to the Centers for Medicare & Medicaid Services for both the 2013 and 2014 performance years, exceeding the minimum requirement of 15 measures.
- Processing claims data to use for quality improvement is difficult because of the run-out in claims data needed for accuracy and availability, as well as the lack of non-utilization data needed to measure quality metrics.

DATA ANALYTICS

- Stratified the Hemoglobin A1c Testing measure by urban/rural; stratified the Postpartum Care Rate measure by race/ethnicity, language, and urban/rural; stratified the Controlling High Blood Pressure measure by urban/rural.

LESSONS LEARNED

- Limitations with the Statewide Data Analytics Contractor (SDAC) revealed the need for tailoring dashboards (e.g., large-volume practices vs. small practices). The SDAC had multiple limitations in its software for what could be calculated. These limitations continue to affect web display and data dissemination of quality measures.
- The RCCOs and Colorado Medicaid discussed proper coding and billing of the depression screenings and how they are reflected in the SDAC. RCCOs reported that providers conducted depression screenings, but these were often not reflected in the SDAC. This is likely because the depression screening code was previously unbillable for Medicaid beneficiaries.



PROMISING PRACTICES

QUALITY IMPROVEMENT

Having a dedicated Adult Medicaid Quality (AMQ) Grant team to share information among RCCOs enhanced progress made on all projects.

Allowing RCCOs to build interventions that best suited the unique challenges within their own communities was a success. This approach allowed each RCCO the opportunity to tailor interventions for its populations and to include considerations on culture, language, age, and region.

Brown bag seminars and similar outreach events enhanced communication with different units within the Colorado Department of Health Care Policy and Financing and increased knowledge of the quality unit and quality measures.

A year-end summit of all the participants involved with the AMQ Grant was held. Each year, all of the projects presented successes and challenges of the different interventions, which created an excellent learning opportunity for participants to become aware of other programs and solutions being instituted for different populations by different areas of the state. Colorado Medicaid continues to build on those relationships between these organizations and to promote natural, collaborative growth of those alliances for continued improvement.

PLANS FOR SUSTAINABILITY

Mini-grantees designed and monitored interventions and conducted Plan-Do-Study-Act cycles to increase HbA1c testing and depression screening in different communities in the state. The projects were designed with sustainability in mind, and many included options for growth and use in other intervention types. For example, depression screening is a part of Salud Family Health Centers' continuous quality plan and is a National Quality Forum measure (NQF 0418); as such, the Salud Family Health Centers patient portal project is sustainable. The grant supported development of the infrastructure; continuing interventions will not be difficult.

QUALITY DIFFUSION

Grant activities led to an increase in Colorado Department of Health Care Policy and Financing staff members' understanding of quality measures and how they differ from utilization and cost measures. Increased staff knowledge in this area will be utilized in the development and implementation of state QI efforts in the future.