



Healthy Communities Evaluation Project
Final Report and Program Recommendations

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1. Executive Summary

The Colorado Department of Health Care Policy and Financing (Department) manages a statewide program called “Healthy Communities” to ensure that children and pregnant women receiving Medicaid or Child Health Plan Plus (CHP+) benefits in Colorado receive the preventive health care they need.

The Healthy Communities program is charged with reaching out to families with children, and pregnant women newly enrolled in Medicaid or CHP+; to explain their benefits and help them find a medical home/primary care provider. During this initial orientation they also discuss the importance of well-child visits with families, and then follow up over time with reminders when it is time for a well-child visit. In recent years Healthy Communities was also tasked with identifying and enrolling eligible families, helping them navigate the system, and troubleshooting issues with their program coverage.

About This Report

Upleaf was hired by Department in April of 2015 to conduct an evaluation of the Healthy Communities program. The purpose of the evaluation was to help the Department identify high-value activities for the program with an emphasis on health outcomes as opposed to a focus on the activities themselves which had been the traditional program model. Upleaf was also asked to examine examples of Pay-For-Performance incentive models and make recommendations about how such models may be incorporated into the Healthy Communities program. One of the Department's objectives is that these recommendations would help boost Early and Periodic Screening, Diagnostic and Testing (EPSDT) outcomes among children receiving Medicaid benefits. Finally, Upleaf was also asked to identify areas of duplication between the Healthy Communities program and the Regional Care Collaborative Organizations (RCCOs), and make recommendations to help eliminate duplication.

The evaluation conducted by Upleaf included surveys with Healthy Communities clients and staff, interviews with program stakeholders, background research, review of program documents, and mapping of EPSDT-related indicators. Throughout the process we received feedback from Healthy Communities clients, contractors, partners, RCCO managers, national EPSDT experts, and other stakeholders. This report presents a summary of key evaluation findings and recommendations. Please refer to the report annexes for detailed results of the surveys, research and mapping conducted by Upleaf.

Program Recommendations

After carefully reviewing all of the evaluation findings, we issued ten recommendations. Each of these recommendations is outlined in more detail in Section 5 of this report. The data that supports these recommendations can be found in both Section 4 of this report and in the annexes.

The ten recommendations from this evaluation of the Healthy Communities program are:

1. Prioritize Healthy Communities activities that directly support EPSDT outcomes
2. Refocus RCCOs on access issues, providers, and difficult clients
3. Review program funding levels to account for the large increase in caseload and implement a Pay-For-Performance incentive program with some of the additional funds
4. Focus messaging and activities on age groups with lowest EPSDT rates and ensure consistent program coverage in areas of the state with a high volume of children receiving Medicaid benefits
5. Maximize the data integration and automation capabilities of the Healthy Communities Client Relationship Management (CRM) System
6. Ensure that information about well-child visits and benefits is easily accessible online
7. Standardize activities across all Healthy Communities contractors
8. Better integrate the Healthy Communities program into other Department initiatives
9. Align sports physicals with well-child visit requirements
10. Examine the crossover between HealthColorado and Healthy Communities on-boarding procedures

Implementing these recommendations will help Department (a) Boost Colorado's EPSDT screening rates; (b) Eliminate duplication of effort across programs; (c) Invest resources more efficiently, and (d) Enable Healthy Communities to play an important supporting role for the state's seven RCCOs.

2. Healthy Communities Program Overview

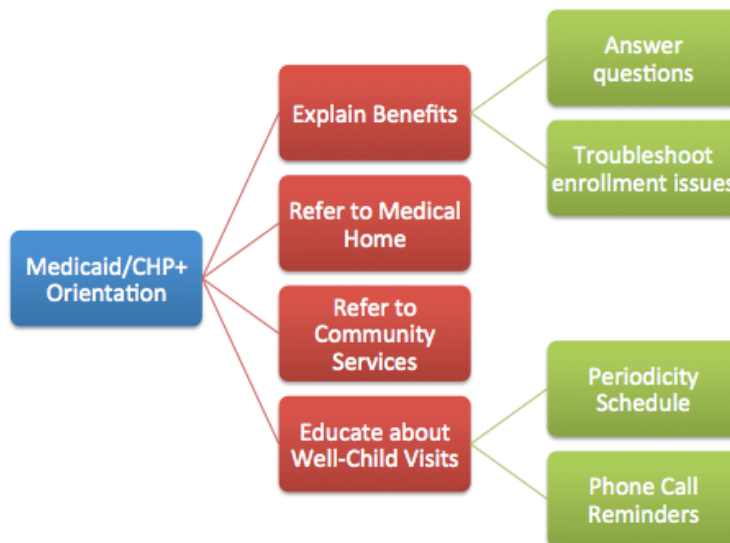
The goal of the Healthy Communities program is to improve the health of Medicaid and CHP+ beneficiaries (children, youth age 20 and under, and pregnant women) by promoting preventive care and screening services.

Healthy Communities Program Activities

Healthy Communities teams have a physical presence in most counties across the state. They play an important role in both the Medicaid and CHP+ programs by welcoming families to Medicaid/CHP+, explaining their new benefits, referring them to an appropriate medical home and other community services, and educating them about the importance of regular well-child visits and other preventive care.

After the initial orientation, Healthy Communities teams continue to follow up with families to help ensure that they meet the recommended schedule for their children’s well-child visits. They also answer questions about benefits and help troubleshoot issues with client enrollment or provider claims, and clarify questions about letters families receive.

Figure 1: Current Healthy Communities Services



Strong Local Relationships. Healthy Communities Family Healthy Coordinators (FHCs) have traditionally built strong relationships with families on Medicaid/CHP+. Staff from some sites visit women in the hospital after they’ve given birth to help get the children enrolled in Medicaid and explain the benefits they’ll receive. Others organize events at schools in low-income areas to inform families about Medicaid/CHP+ and the importance of well-child visits. FHCs call families regularly to follow up on children, and receive walk-ins at their offices. Organizations such as the RCCOs and local public health agencies turn to Healthy Communities when they have difficulty reaching a

family, because the Healthy Communities database tends to have the most updated contact information due to their frequent interactions with clients.

Program Value. These personal interactions that occur locally through the Healthy Communities program are an asset to the Medicaid and CHP+ programs. The in-depth orientation they provide to newly enrolled families reinforces the importance of preventive care. Such interactions can positively affect the family's health-seeking behavior and health outcomes for years. The program complements the work of the RCCOs by providing orientation, referrals and follow-up to most families with children receiving Medicaid benefits. This allows the RCCO teams to focus on ensuring access to health care and addressing the urgent needs of a smaller number of families that require intensive case management.

Recent Strains on the Program. In recent years this core focus of the Healthy Communities program - initial orientation and follow-up - has been increasingly strained due to a rise in caseload and additional responsibilities. The program caseload has risen 159% since 2007 while the program budget has only increased by 26% . Staffing in most counties has not increased since 2007, making it more difficult for newly enrolled families to receive the in-depth orientation they need. In recent years Healthy Communities teams have also been asked to focus on identifying individuals and families in their communities who may be eligible for a medical assistance program but are not currently enrolled, and helping them through the application process, as well as troubleshooting issues they may have with their Medicaid or CHP+ coverage. The increased caseload, coupled with the additional responsibilities, have made it a challenge for the program to continue to increase Colorado's EPSDT outcomes to the levels expected by the U.S. Centers for Medicare and Medicaid Services (CMS).

This evaluation project explored how to best refocus the Healthy Communities program to boost EPSDT performance and increase program efficiency. Concrete recommendations for the way forward can be found in Section 5 of this report.

3. Evaluation Objectives & Methodology

Upleaf was hired by Department in April of 2015 to conduct a short but intensive evaluation of the Healthy Communities program, and provide concrete recommendations to improve the overall program and boost EPSDT outcomes.

The evaluation project began in April 2015 and concluded in June 2015 when the final report was submitted. We explored a number of different areas to identify practical, cost-effective and evidence-based approaches that are compatible with Colorado's existing programs and health care infrastructure.

Project Objectives

The Healthy Communities evaluation project was to:

1. Identify activities that have the highest impact on well-child visits and other preventive care;
2. Make recommendations for how to refocus the program on "high-value" activities;
3. Recommend a pay for performance reimbursement model for Healthy Communities contractors;
4. Clarify responsibilities of Healthy Communities contractors and RCCO contractors, and recommend ways to eliminate duplication of effort; and
5. Recommend ways to adjust the Healthy Communities CRM system to support program improvements and efficiencies.

Evaluation Methodology

The evaluation project explored quantitative and qualitative feedback from stakeholders, as well as a host of other relevant documents, reports and case studies. We examined the Healthy Communities program from a variety of perspectives, explored the differences/overlap in RCCO and Healthy Communities contracts, and reviewed best practices from other states to identify recommendations for how to improve EPSDT outcomes in the state of Colorado.

Upleaf research for this evaluation project included:

- **Client Survey.** A total of 1,136 parents/guardians of children receiving Medicaid benefits were surveyed by FHCs during the course of their regular day-to-day interactions. The six-question survey was completed by clients from 43 counties in Colorado, providing valuable insight into barriers to and motivators of well-child visits statewide. The Client Survey report and recommendations can be viewed in **Annex A**.
- **Healthy Communities Team Survey.** Upleaf conducted an online survey of Healthy Communities team members to understand how FHCs spent their time, what challenges they faced, what they felt priorities were for the program, and which barriers/motivators were most important for well-child visits in their

counties. The survey was completed by 37 Healthy Communities team members. The report with recommendations can be found in **Annex B**.

- **EPSDT Mapping & Analysis.** Upleaf mapped out EPSDT data from Colorado's 2013 CMS-416 report by county, age group and other factors to understand the distribution of Medicaid-eligible children, identify trends, and determine how to best move the needle on EPSDT from a mathematical perspective. The report and EPSDT maps can be found in **Annex C**.
- **Background Research & Incentive Recommendations.** We reviewed reports and case studies from Colorado and around the country related to Medicaid EPSDT, pay-for-performance compensation models, healthcare reform in Colorado, budget history and much more to better understand how to best boost EPSDT outcomes in Colorado. This report also includes recommendations for a pay for performance incentive structure for Healthy Communities contractors. The complete report can be found in **Annex D**.
- **Stakeholder Interviews.** In-person and telephone interviews were conducted with Department managers, RCCO managers, Healthy Communities managers and staff, experts in state health policy at the national level, program managers from other states/counties, and other community stakeholders. A total of 31 people were interviewed as part of this evaluation, with most interviews averaging an hour or more in duration. Upleaf took notes on each of the interviews, which helped inform the other reports and final recommendations. A list of interviewees and brief summary of the interviews can be found in **Annex E**.
- **Contract Analysis.** Upleaf compared Healthy Communities and RCCO contracts side-by-side to identify areas of overlap and better understand the scope of each program in order to make recommendations regarding how to avoid overlap between the two programs.

Once all of these reports and interviews were completed, we reviewed the different findings and condensed them into this final report that highlights the most salient results and recommendations.

4. Evaluation Findings

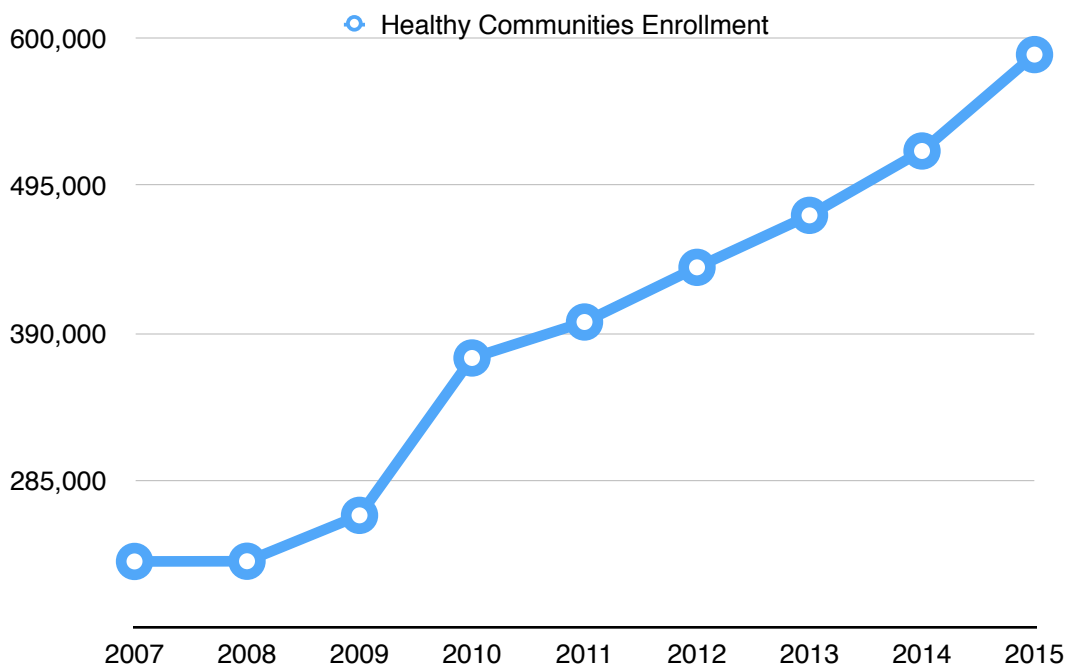
The most important findings from the Healthy Communities evaluation project are summarized in this section of the final evaluation report. Please see the annexes of this report for a more detailed presentation and analysis of evaluation findings.

A. Medicaid Enrollment Growth & Spending

Colorado has experienced significant growth in Medicaid enrollment due to expanded eligibility criteria. According to preliminary data from March 2015, over 1.2 million Coloradans were enrolled in Medicaid or CHP+ representing a net increase of 57% when compared to average enrollment in July through September of 2013.¹

The Healthy Communities Medicaid caseload more than doubled from FY2007 to FY2014, from 227,296 to 519,368 respectively. In May of 2015 the total Healthy Communities caseload was already at more than 570,000, and represented nearly 50% of all Medicaid enrollees.²

Figure 2: Healthy Communities Caseload Growth by Year



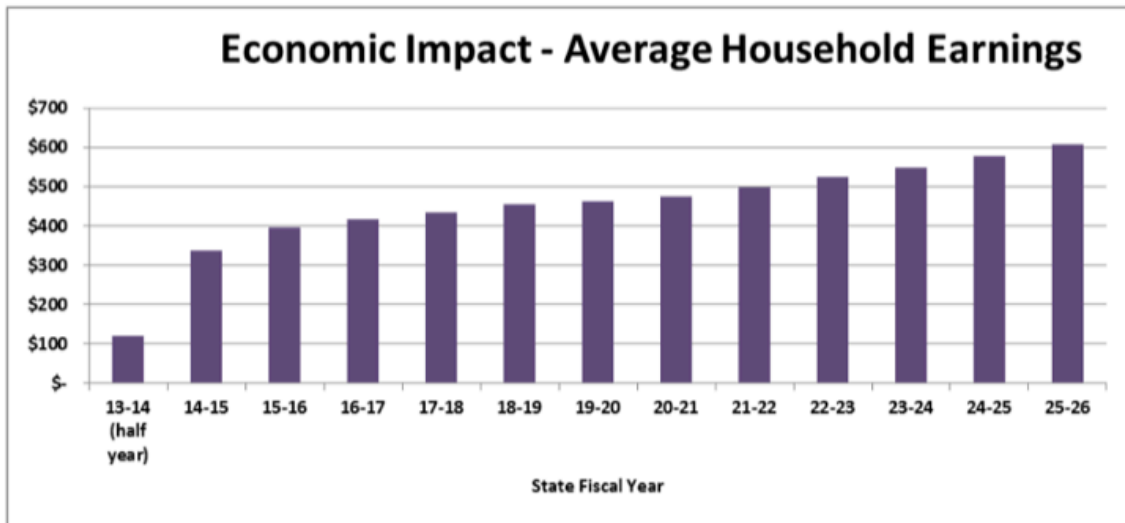
Future Savings from Preventive Care. As a result of this significant growth in enrollment, Colorado is also spending more on Medicaid services. Each Medicaid-eligible child costs Colorado an average of \$1,807 per year; the

¹ Overview of Colorado's Medicaid Program. Accessed June 17, 2015: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/colorado.html>

² Healthy Communities Salesforce CRM System Report, May 2015.

average cost per adult Medicaid enrollee is \$7,501.³ While these costs to the state are significant, the Medicaid enrollee’s increase in household earnings through improved health and stability has been well-documented.⁴ The Colorado Health Foundation estimates that this larger economic base will increase tax revenue from individual income tax, sales tax, use tax, and corporate income tax. Together, these taxes could generate an additional \$128 million in FY 2025-26. The Colorado Health Foundation’s analysis suggests that in FY 2025-26 household earnings will be, on average, \$608 higher as a result of Medicaid expansion.⁵

Figure 3: Annual Increases in Colorado Household Earnings Due to Medicaid Expansion⁶



Studies regarding economic impact of youth on Medicaid suggest that improving EPSDT outcomes will benefit Colorado financially in both the short and long-term. A 2001 study by Hakim and Bye in *Pediatrics* confirmed that when children were up-to-date for age on their schedule of well-child visits, they were less likely to have an avoidable hospitalization, which tends to be quite costly. Even children who were not up-to-date, but had sporadic preventive care visits saw mild benefits. These effects held regardless of race, level of poverty, or health status.⁷

Kay Johnson and Jill Rosenthal writing for The Commonwealth Fund and National Academy for State Health Policy demonstrate that a “growing body of evidence suggests that prevention and early intervention are substantially less costly than life-long special education and treatment.” Further, they emphasize that through early identification

3 Young K, Rubowitz R, Rouhani S, Garfield R. “Medicaid Per Enrollee Spending: Variation Across States.” Henry J. Kaiser Family Foundation. January 28, 2015. <http://kff.org/medicaid/issue-brief/medicaid-per-enrollee-spending-variation-across-states/>

4 Brown, David W., Amanda E. Kowalski, and Ithai Z. Zvir. “Medicaid as an Investment in Children: What is the Long-Term Impact on Tax Receipts.” National Bureau of Economic Research. Working Paper No. 20835. January 2015. <http://www.nber.org/papers/w20835>

5 Charles Brown Consulting Inc. “Medicaid Expansion: Examining the Impact on Colorado’s Economy.” The Colorado Health Foundation. https://www.statereturn.org/sites/default/files/medicaid_expansion_examining_the_impact_on_colorado_s_economy_2.11.2013.pdf

6 Ibid

7 Hakim, RB and BV Bye. “Effectiveness of compliance with pediatric preventive care guidelines among Medicaid beneficiaries.” *Pediatrics*. July 2001. 108(1): 90-97. <http://www.ncbi.nlm.nih.gov/pubmed/11433059>

and intervention, providers and parents can better influence children’s “development and readiness to learn at school, their risk of certain adult diseases, and their future social and economic productivity.”⁸

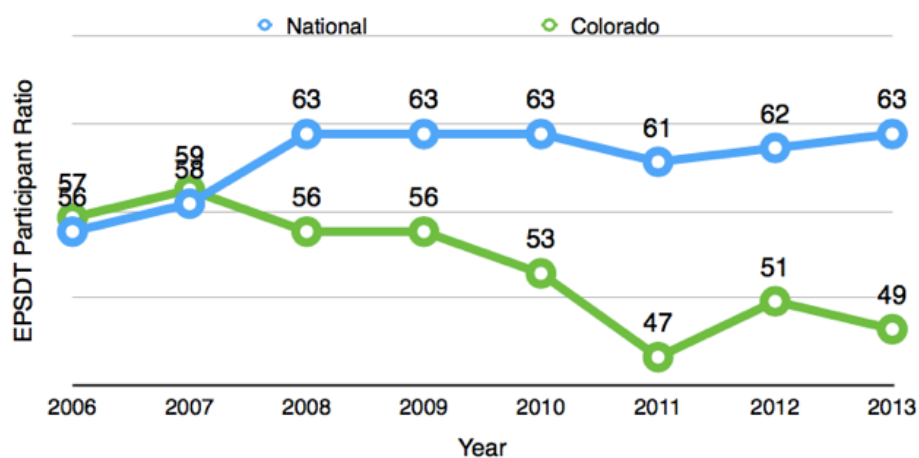
This research and other studies outlined in Section 2 of the research report found in **Annex D** suggest that Colorado is wise to invest in increasing well-child visits. Not only can preventive care for children help control short-term Medicaid costs, it can generate additional tax revenue for the state over the long-term due to increased earnings by Medicaid recipients as they grow into healthy adults.

B. Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

The national Centers for Medicare & Medicaid Services (CMS) require every state to submit an annual report documenting the number of children with Medicaid benefits (age 20 and under) who have received the recommended Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits. One of the core EPSDT benefits is well-child visits that follow a recommended age-specific periodicity schedule. Outcomes are tallied using Medicaid claims data and reported in the CMS 416 report.

The Federal government requests that states meet an 80% **Screening Ratio** and also maintain a high **Participant Ratio**. The **Screening Ratio** looks at the population as a whole and is calculated by dividing the total number of well-child screenings reported in the claims database by the total number of expected well-child screenings based on the ages of children receiving Medicaid benefits in Colorado. The **Participant Ratio** is by contrast a measure of individual EPSDT participation, and defines how many children received the well-child visits and screenings recommended for their age. The participant ratio is a more accurate indicator of overall preventive care among Colorado’s children as it allows us to see how many children received the recommended preventive care services. The screening ratio is less exact but is easier to calculate and used nationally for comparison.

Figure 4: Colorado vs National EPSDT Participant Ratio



8 Johnson, Kay and Jill Rosenthal. “Improving Care Coordination, Case Management, and Linkages to Service for Young Children: Opportunities for States.” The Commonwealth Fund and National Academy for State Health Policy. April 2009.

Colorado’s EPSDT Results. In 2013, the most recent year with available data, Colorado’s screening ratio was at only 64% while the national average was 86%. Colorado’s participant ratio was at 49%, while the national average was 63%. This means that less than half of all Colorado children receiving Medicaid benefits had their recommended well-child visits. The graph in Figure 4 above shows Colorado rates slightly above the national average in 2006 and 2007, followed by a continued decline while Healthy Communities’ caseloads grew and the program budget remained the same. CHP+ was added to Healthy Communities’ responsibilities in 2010, which may have also contributed to the 2011 dip in the participant ratio.

Upleaf analyzed the 2013 CMS 416 report in detail, to examine screening and participant ratios by county, age group, Healthy Communities contractor, and even compare results with density of primary care providers. We mapped out the results visually to help identify and understand trends. The results of these mapping exercises and further insights into Colorado’s EPSDT ratios and trends can be found in **Annex C**.

EPSDT Trends by Type of County. There are some notable trends in EPSDT results by type of county. As a general trend across Colorado, urban counties tend to have higher participant and screening ratios, followed by rural and then frontier counties (frontier counties have six or fewer inhabitants per square mile), as seen in the table below.

Figure 5. Average EPSDT Results By Type of County⁹

Type of County	Avg # Eligibles	Avg Screening Ratio	Avg Participant Ratio	Total Counties
Urban Counties	26,133	0.62	0.43	17
Rural Counties	2,594	0.53	0.39	24
Frontier Counties	659	0.42	0.34	23

The average number of Medicaid-eligible children in urban counties is ten times greater than the average number of eligible children in rural counties. In turn, the number of eligible children in frontier counties is on average only 25% that of rural counties. Screening ratios and participant ratios decrease consistently as population density decreases.

C. How to Move the Needle on EPSDT Outcomes

After mapping out screening and participant ratios by county, we found no consistent trend to indicate that any one Healthy Communities contractor or RCCO contractor had contributed to significantly increasing or decreasing EPSDT results. We then proceeded to analyze EPSDT results by age group and location to identify other potential strategies to help increase Colorado’s EPSDT outcomes.

We examined screening and participant ratios by age group and created a weighted average to get a sense of where changes could most impact the overall EPSDT participant ratio. Based on this analysis, we found that the 6-9 and 10-14 age groups had both the highest number of eligible children and best likelihood of improving the

⁹ EPSDT Outcomes Mapping Report. Upleaf, 2015. Annex C.

overall EPSDT outcomes in the state. These two age groups together account for 46% of all eligible Medicaid children in Colorado. Adding the 15-18 age group brings that cohort to nearly 60%. We recommend prioritizing these vulnerable age groups accordingly, with targeted messaging and campaigns appealing to children and parents.

Figure 6: Colorado 2013 EPSDT Results by Age Group¹⁰

	Age <1	Age 1-2	Age 3-5	Age 6-9	Age 10-14	Age 15-18	Age 19-20
Eligible Population	29,898	62,198	96,325	117,820	119,981	72,208	19,698
Percentage of Total	6%	12%	19%	23%	23%	14%	4%
Participant Ratio	93%	77%	60%	38%	40%	31%	19%
Weighted Average	0.40%	2.76%	7.44%	14.10%	13.89%	9.62%	3.08%

By May of 2015 the total number of children enrolled in Medicaid in Colorado was 570,104. Recognizing that changes in EPSDT results in some key counties could result in large increases in Colorado’s overall EPSDT rates, we identified the counties with the largest number of eligible children and assigned them a weighted average based on their 2013 EPSDT outcomes.

We found that just twelve counties in Colorado account for 85% of all children with Medicaid benefits. Program managers and supervisors should follow these twelve counties closely (require high-impact activities, review reports regularly, conduct frequent site visits) as their performance has a significant impact on overall state results.

Figure 7. Twelve Priority EPSDT Counties¹¹

County	2015 Eligible Population	Share of Eligibles	Weighted Avg.	Aggregate Share
Denver	86,550	15.18%	10.17%	15.18%
Adams	76,815	13.47%	6.60%	28.66%
El Paso	70,641	12.39%	6.57%	41.05%
Arapahoe	67,906	11.91%	5.84%	52.96%
Jefferson	40,424	7.09%	3.62%	60.05%
Weld	35,229	6.18%	3.21%	66.23%
Mesa	18,102	3.18%	2.89%	69.40%
Larimer	26,562	4.66%	2.47%	74.06%
Pueblo	25,234	4.43%	2.43%	78.49%
Boulder	21,552	3.78%	1.97%	82.27%
Douglas	11,598	2.03%	1.06%	84.30%
Montrose	6,047	1.06%	0.93%	85.36%

Beyond the findings from Upleaf’s mapping analysis, we turned to the National Academy for State Health Policy (NASHP) to help identify strategies that have been successful in other states for boosting EPSDT rates, and

¹⁰ EPSDT Outcomes Mapping Report. Upleaf, 2015. Annex C.

¹¹ Ibid

examined relevant case studies. The states that have been most successful at boosting EPSDT rates have some strategies in common¹²:

- Sophisticated marketing, promotion and educational materials
- Age-specific education and reminders (i.e. letting parents know what type of screening will happen at each well-child visit, what doctors are checking for and why it's important)
- Financial incentives for providers that are accompanied by cultural shifts and other programmatic changes
- Sharing performance data with providers, along with clear information on EPSDT results and billing codes
- Strong partnerships between different stakeholders

Another recommended strategy was implemented by Hawaii, Tennessee and Iowa. Each of these states boosted EPSDT results by aligning sports physical requirements with well-child exams and informing providers of this change.¹³

All of these recommendations are presented and discussed in more detail in the research report in **Annex D**. NASHP recommends that Colorado use the Bright Futures¹⁴ educational materials from the American Association of Pediatrics, which are written at a suitable level for Medicaid families and include important core messages. Colorado has already adopted the Bright Futures periodicity schedule.

D. Current Healthy Communities Team Activities

Healthy Communities teams reported how they were currently spending their time, on average, in an online survey conducted by Upleaf in May of 2015¹⁵. Overall the time spent by Healthy Communities teams on these tasks averaged out as follows:

- Contacting newly enrolled families based on system reports - 26%
- Troubleshooting issues with the health care / Medicaid systems for clients - 18%
- Providing orientation about Medicaid or CHP+ benefits - 15%
- Getting people enrolled in Medicaid or CHP+ - 10%
- Coordinating with providers and other community agencies - 8%
- Organizing and implementing outreach activities - 8%
- Following up with clients regarding well-child visits - 7%
- Helping non-clients navigate Medicaid - 7%¹⁶

Twenty-six percent of Healthy Communities time is spent contacting newly enrolled families, providing orientation about their Medicaid benefits including well-child visits. The Healthy Communities teams feel that the initial

12 Interviews with Kay Johnson, Neva Kaye and Karen VanLandeghem, NASHP. Healthy Communities stakeholder interviews conducted by Upleaf, June 2015.

13 Healthy Communities Research Report. Upleaf, 2015 Annex D.

14 <https://brightfutures.aap.org/Pages/default.aspx>

15 Healthy Communities Team Survey. Upleaf, May 2015. Annex B.

16 Ibid

contact with a newly enrolled client is critical for both raising awareness of well-child visits and building a relationship that facilitates communication for years to come. This is an important approach, and time well-invested. Media Richness Theory confirms that face-to-face interactions are most likely to change behavior.¹⁷

Figure 8. Impact Continuum of Communication Channels - Media Richness Theory



It is noteworthy that only 7% of Healthy Communities time is currently being dedicated to following up with clients regarding well-child visits. That is the same amount of time the teams report spending helping non-clients (ages 21+ and not pregnant) navigate Medicaid. In-depth interviews conducted with the teams revealed that many just don't have time to follow up with families about well-child visits due to the large volume of people needing help resolving issues with their Medicaid application, confusing correspondence, and other systemic challenges.¹⁸ Please refer to the Healthy Communities Team Survey report in **Annex B** for a more robust discussion of the systemic challenges that the Healthy Communities teams face.

E. Healthy Communities Team Priorities

When asked **"What do you think are the most valuable services that Healthy Communities offers to the public?"** the Healthy Communities teams ranked the following activities in order of importance as follows¹⁹:

1. Orientation for newly enrolled
2. Referring clients to health providers and other services
3. Face-to-face customer service
4. Following up with clients about well-child visits and screenings
5. Troubleshooting issues with enrollment or benefits
6. Community awareness about child health
7. Liaison between health providers, clients and Department

The teams were then asked **"What do you believe is the single most important thing that the Healthy Communities program can do to boost EPSDT outcomes?"** The top three responses in order of priority were²⁰:

1. In-person initial orientation for each newly enrolled - 32.4%

¹⁷ Daft, Richard L. and Robert H. Lengel. "Communications: An Inside Look." <http://communicationsinsider.weebly.com/media-richness-theory.html>

¹⁸ Healthy Communities Team Survey. Upleaf, May 2015. Annex B.

¹⁹ Ibid

²⁰ Ibid

2. Statewide educational campaign targeting parents - 27%
3. Automated appointment reminders sent to families (through communication method of their choice) - 21.6%

The stakeholder interviews conducted by Upleaf included multiple Healthy Communities teams, and revealed that while the teams strongly believed initial orientation was critical, as were reminders to families regarding well-child visits, they felt they were no longer able to implement these activities as effectively as they could in the past because their caseloads were so large and staffing levels had not changed. With the inclusion of additional outreach, eligibility and enrollment and troubleshoot client issues to the contract beginning in FY2011; many contractor staff interviewed felt these additional activities were taking much of their time away from the core EPSDT focus. Please see **Annex B** for additional background and discussion of program priorities.

F. RCCO Coordination and Collaboration

Current Coordination. Some Healthy Communities teams and RCCOs are already working together quite well. Through the stakeholder interview process²¹ we learned that some RCCOs often ask Healthy Communities for help tracking down hard-to-reach families. Some RCCOs also rely on Healthy Communities to help meet their well-child Key Performance Indicator (KPI) by producing lists of priority children who have not been in for a well-child visit and asking them to call the families and report back. Healthy Communities often refers children with special needs to RCCOs for closer case management and guidance.²²

The Healthy Communities Team Survey however, revealed that 50% of the teams rarely coordinate with the RCCO in their region. And while 18.4% of survey respondents stated that they coordinate closely with the RCCO in their county, 31.6% reported that they only occasionally coordinate with the RCCO.²³

When asked what that coordination entailed, the responses were:

- We share or coordinate educational / orientation materials given to clients - 30%
- I sit on one or more coordinating committees together with the RCCO - 27%
- I actively support the RCCO by following up on lists that they provide - 19%
- We share lists and intend to share client records where feasible - 13.5%
- We have been contracted by the RCCO to provide services - 13.5%

Contractual Commitments. Upleaf also reviewed both RCCO and Healthy Communities contracts, and found areas of overlap. The areas that both programs were tasked with included:

- Educating providers about Medicaid services and helping to resolve problems related to claims or billing;
- Reaching out to newly enrolled families;
- Creating educational materials;

²¹ Healthy Communities Stakeholder Interviews conducted by Upleaf, April - June 2015. Annex E.

²² Ibid

²³ Healthy Communities Team Survey. Upleaf, May 2015. Annex B.

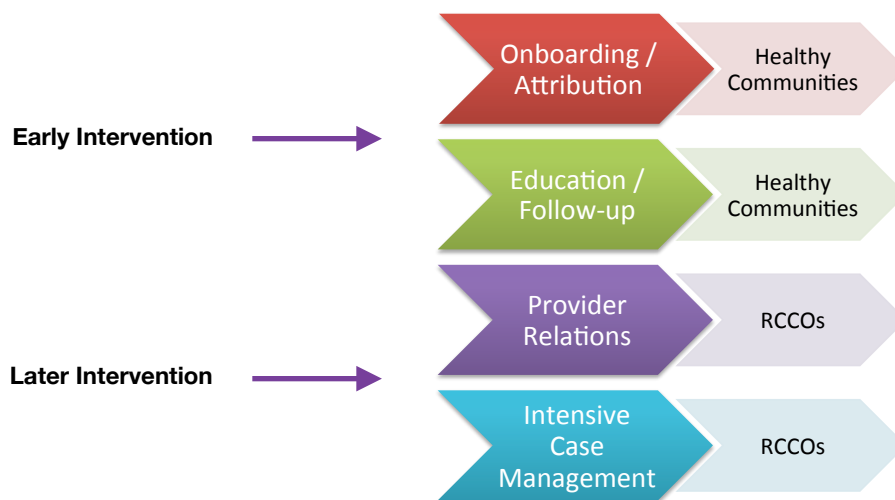
- Providing referrals to a medical home and other community-based services; and
- Maintaining a directory of health care providers and other community services²⁴.

In practice, the RCCOs' well-child KPI has led some RCCOs to make phone calls themselves to remind families that it is time for a well-child visit - a direct duplication of Healthy Communities' role. Other RCCOs are sending letters to families regarding their upcoming visits.

The RCCO and Healthy Communities provider directories are somewhat different - RCCO directories include their member providers while the Healthy Communities directory includes additional primary care providers who are not part of a RCCO as well as other community-based social service agencies. It would be interesting however to explore how the directories can be further integrated.

Avoiding Duplication of Effort. All of the RCCO managers interviewed by Upleaf expressed appreciation for the initial orientation work that Healthy Communities does to reach out to families and explain benefits. They also appreciate that Healthy Communities seems to be the program with the most up-to-date contact information for any family, so they can turn to Healthy Communities to help track down a family that is difficult to reach.²⁵

Figure 9: Intervention Areas and Timing



Some of the managers stated that the most important supporting role Healthy Communities could play for RCCOs is to help ensure that children are all attributed to a Primary Care Medical Provider (PCMP) - a natural role for Healthy Communities to play as they are the "welcome wagon" for all newly enrolled Medicaid families and are already providing referrals to providers as part of the initial Medicaid orientation process. They can continue to follow up with a client until they have completed their first appointment with their primary care physician. Healthy Communities reaches out to families right away, while RCCOs sometimes don't step into the process until 90 days

²⁴ RCCO and Healthy Communities Contract Comparison. Upleaf, 2015.

²⁵ Stakeholder Interviews conducted by Upleaf, April - June 2015.

or so after a child has been enrolled in Medicaid. This early contact can help meet provider attribution goals more quickly.²⁶

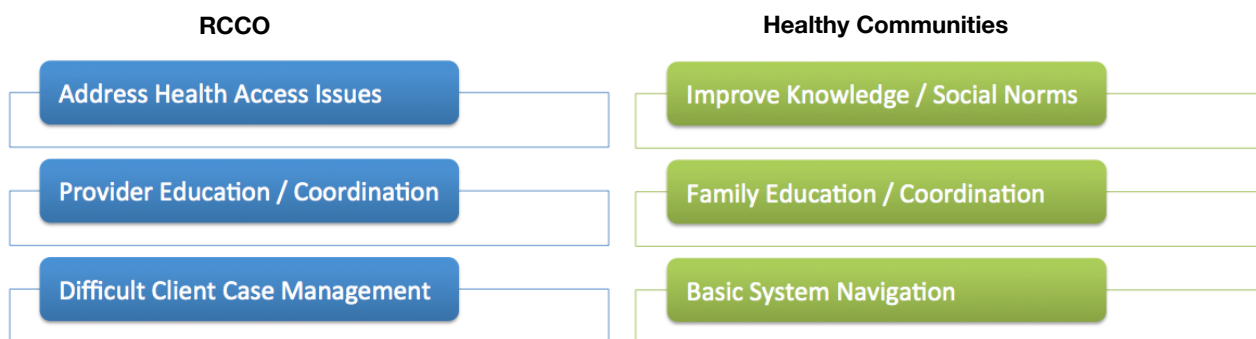
RCCO managers in multiple regions expressed the need for their teams to focus on difficult cases instead of general well-child care. Their care coordinators specialize in working with families who are in dire straits and using the ER or other intensive care services. They feel that Healthy Communities outreach to newly enrolled clients that covers benefits, a medical home and well-child visits is valuable and can enable RCCOs to better focus on special needs and difficult cases. One RCCO manager suggested that responsibilities be delineated as follows:

“Healthy Communities can help the RCCOs by playing more of the upstream prevention role to help people before they’ve fallen off the cliff. RCCOs then take care of the difficult cases once they have [fallen off the cliff].”

Because RCCOs already have the expertise and infrastructure in place to reach health care providers, this is an area that is best left to the RCCOs and removed from the Healthy Communities contracts. This will allow Healthy Communities to focus exclusively on children, educating families and following up on well-child visits.

We recommend that both programs focus on their core missions as outlined in Figure 10 below. This helps to delineate responsibilities and avoid duplication of effort. RCCOs focus on ensuring there are enough Primary Care Medicaid Providers (PCMPs) to serve their region, educating providers, and handling complex client cases that need intensive case management.

Figure 10: Recommended RCCO and Healthy Communities Roles



Healthy Communities focuses on initial orientation regarding Medicaid benefits and informing clients about the importance of well-child visits, ensuring clients are referred to an appropriate medical home (and attributed in the system) and coordinating referrals when necessary, and following up to ensure clients have their well-child visits at the appropriate intervals.

²⁶ Healthy Communities Stakeholder Interviews conducted by Upleaf, May-June 2015. Annex E.

From a broader systems perspective, we recommend that **RCCOs address access to health care while Healthy Communities teams improve knowledge and social norms related to preventive care.** RCCOs can focus on provider education and coordination, while Healthy Communities teams focus on family education and coordination. In terms of client interactions, RCCOs address difficult cases while Healthy Communities teams help all families with basic system navigation.

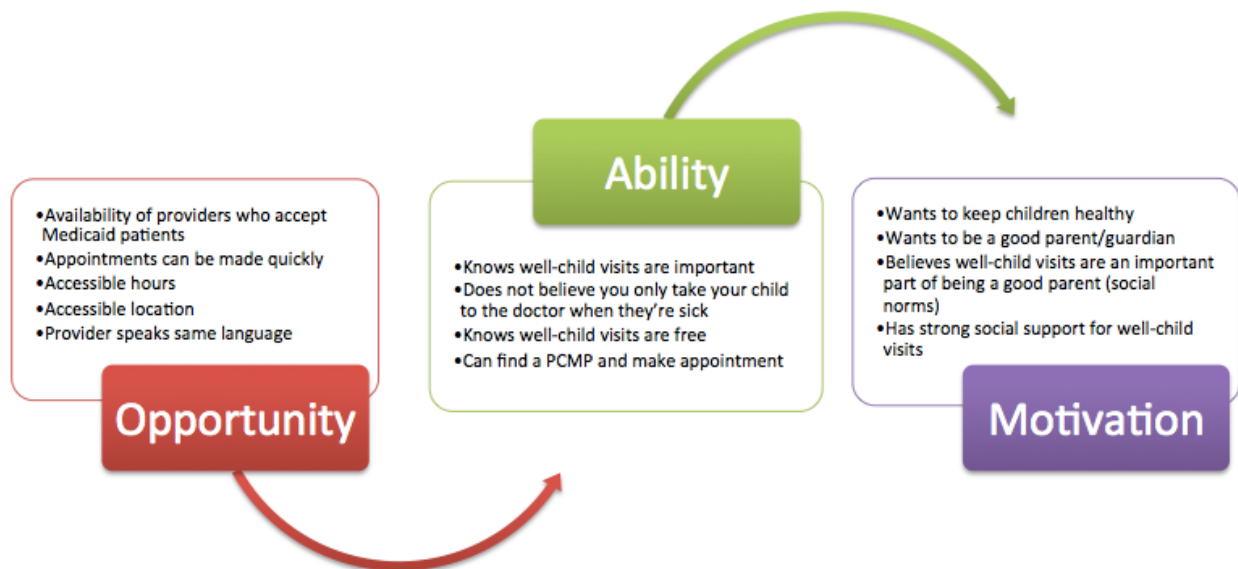
Making these clear distinctions will help avoid duplication of effort and require coordination between the programs to refer clients back and forth depending on the clients’ level of need. The approach should also be accompanied by data integration and shared reporting (or use of a shared system), so that RCCOs can see the results of Healthy Communities’ work and Healthy Communities can see and input RCCO participation and PCMP attribution into the Healthy Communities CRM system.

G. How to Change Individual Behavior

We find Population Services International’s **Opportunity, Ability and Motivation framework**²⁷ to be particularly useful for examining any type of health-seeking behavior, as it draws on reputable health-related behavior change theories such as the Health Belief Model and Theory of Reasoned Action, but also introduces the importance of access issues.

The framework groups the factors that tend to influence behavior into three areas. Examples of the factors within each of these three areas that may impact well-child visits for children on Medicaid are included below:

Figure 11: Opportunity, Ability and Motivation Framework Applied to Well-Child Visits



27 PSI Behavior Change Framework 'Bubbles': Proposed Revision." Concept Paper. Population Services International. 2004. http://www.psi.org/wp-content/uploads/drupal/sites/default/files/publication_files/behaviorchange.pdf

Within the context of this behavior change framework, we recommend that RCCOs focus on issues related to “Opportunity” while Healthy Communities focus on issues that relate to “Ability”. To help further identify which factors most strongly influence well-child visits (Opportunity, Ability or Motivation), Upleaf conducted a Client Survey with the collaboration of the Healthy Communities teams. Key findings from the survey are included below, and the full report can be found in **Annex A**.

H. Barriers to Preventive Care

The Healthy Communities Client Survey questionnaire included one key question: **“When was the last time you took your oldest child to get preventive care? For example they weren’t sick, but went in to get an annual head-to-toe physical, immunizations, or went to dentist or eye doctor?”** Based on the response to that question, the interviewers asked a follow up question - either why did you take your oldest child in for preventive care in the last year or why did you not? The interviewers waited for the client’s parent/guardian to respond spontaneously, and then marked the option that best reflected the spontaneous response or added a note in the comment box at the bottom the questionnaire.

Among the 14% of parents who had not taken their children for preventive care, the top two reasons related to knowledge and social norms: “I just take my kids to the doctor when they’re sick” (57%) and “I didn’t know I should” (20%).²⁸

Figure 12: Barriers to Preventive Care²⁹

Barrier	Percent	Count
I just take my kids to the doctor when they’re sick	57%	110
I didn’t know I should	20.2%	39
I didn’t have health insurance (until recently)	15.6%	30
It’s hard to take time off work	11.4%	22
The clinics aren’t open in the evenings or weekends when I could	6.7%	13
It’s hard to get in to see a Dr. who accepts Medicaid	5.2%	10
Didn’t have transportation	4.7%	9
Didn’t have childcare for other kids	2.1%	4
It’s hard to pull the kids out of school	0.5%	1

Note: Multiple responses were possible so the totals do not equal 100%.

Many of the structural issues that we assumed create barriers to preventive care were not cited as often as the knowledge-based factors. While 11.4% did state that it was hard to take time off work to get to a well-child visit,

²⁸ Healthy Communities Client Survey. Upleaf, June 2015. Annex A.

²⁹ Ibid

other barriers were less significant or ‘top of mind’ for the survey participants.³⁰ These results highlight the importance of more education and information.

In contrast to the Client Survey findings, the Healthy Communities teams who interface with clients every day felt that the top barriers to going in for EPSDT visits were:

1. **Lack of providers who accept Medicaid** (56.8% cited as a significant barrier)
2. **Lack of transportation** (43% cite as significant barrier / 48.7% sometimes a barrier)
3. **Inability to take time off work for well-child appointments** (40.5% say a significant barrier / 48.7% sometimes a barrier)
4. **Lack of initiative from providers to schedule and follow-up on recommended appointments** (37.8% cite as significant / 46% sometimes a barrier)
5. **Lack of child care** (35.1% cite as significant barrier / 64.9% say sometimes a barrier)
6. **Lack of information among families about importance of well-child care** (35.4% cite as significant / 56.8% sometimes a barrier)³¹

The results of the client survey point strongly to the importance of more family education about the importance of annual well-child visits, while the results of the Healthy Communities team survey indicate that structural barriers are likely to also play a role.

I. Motivators of Preventive Care

The 86% of Healthy Communities client parents/guardians who did take their oldest child in for preventive care within the last year were then asked what their main reason was for doing so, in an attempt to understand which factors most motivate parents to go in for well-child visits or other preventive care.

The most popular response (shown in Figure 13 below) reinforces the importance of knowledge in making the decision to go in for a well-child visit; 54.3% of parents responded “I just know you’re supposed to go every year” as their reason for going. The fact that a knowledge-related response is the first spontaneous response both for going and for not going to a well-child visits makes it clear that knowledge is a critical factor.

Doctors also play an important role as influencers of health behavior. They were overwhelmingly cited as the top source for most health information (64%), and cited as the second most important source of information about Medicaid/CHP+ benefits and referrals to other providers after Healthy Communities.

When the Healthy Communities teams were asked which factors were most likely to boost EPSDT outcomes, their top ranking response was “Reminders from the child’s primary care provider to make well-child visit appointments” followed by “More awareness among families of the importance of well-child visits”.³²

30 Healthy Communities Client Survey. Upleaf, June 2015. Annex A.

31 Healthy Communities Team Survey. Upleaf, 2015. Annex B.

32 *ibid*

Figure 13: Motivators of Preventive Care³³

Motivator	Percent	Count
I just know you're supposed to go every year	54.3%	534
I was concerned about my child	23.1%	227
Required by the school	13.9%	137
The doctor told me I had to	13.8%	136
Needed a sports physical	6%	59
The doctor/clinic called me to make an appointment	6%	59
Someone from Healthy Communities told me I had to	3.2%	31
Another health professional told me to	1.9%	19
I took my child in for immunizations	1.7%	17
A friend or family member told me to	1.6%	16
I got information in the mail	1.6%	16
I saw information online	0.8%	8

Note: Multiple responses were possible so the total responses do not equal 100%.

Please see **Annex A** for a more robust presentation and discussion of the Client Survey results.

J. Preferred Client Communication Channels

An important question when seeking efficiencies in the Healthy Communities program is which communication channels should be used to reach out to clients. While there seems to be general consensus across Healthy Communities and RCCO teams that the initial orientation process should be in-depth, in-person (whenever possible) or over a one-on-one phone call, the program must then follow up to remind families of upcoming or late well-child checks. Most Healthy Communities teams are conducting the follow-up reminders by phone, which is often a time-intensive process because many families are hard to reach.

We asked children's parents/guardians this question in the Healthy Communities Client Survey (see Figure 14 below) and the preferred method of communication regarding health plan benefits or well-child visits was overwhelmingly a phone call from a Healthy Communities team member (preferred by nearly 75% of respondents), followed by print mailing (66.3%) and email (47.4%).³⁴ Roughly half of all families liked the idea of receiving reminders by either email or text. Replacing half of the phone calls with automated emails or text messages could offer significant cost savings for the program.

³³ Healthy Communities Client Survey. Upleaf, 2015. Annex A.

³⁴ Ibid

Figure 14: Preferred Contact Method for Clients³⁵

Communication Method	Yes	Okay but Not Preferred	No
Phone call from HC Family Health Coordinator	74.5%	10.8%	14.7%
Print Mailing	66.3%	13.0%	20.7%
Email	47.4%	13.3%	39.3%
Text Message	40.6%	14.7%	44.7%
Pre-Recorded Phone Calls	39.7%	15.6%	44.7%

Older age groups preferred email (more than 50% of respondents ages 30 and over preferred email) as a communication method much more than the 25-29 age group where only 37% would agree to be contacted by email (highly significant difference between age groups, $p < .01$). There was also a tendency for younger age groups to prefer text messaging as a contact method. Nearly 50% of respondents age 24 and under preferred to be contacted via text message.³⁶

Given the disparity in communication preferences among age groups and county type (see **Annex A** for more detail), we recommend asking all families during the initial orientation which communication method they prefer and then using that method to communicate with them. Whenever accepted, email or text message should be used as they are both highly cost-effective and can be automated through the Healthy Communities CRM system.

Figure 15: Client Sources of Health Information³⁷

Information Source	Percent	Count
My doctor	64.3%	731
Online	37.7%	428
Friends or family	16.9%	192
Other medical / health professionals	16.8%	191
Healthy Communities team	9.9%	112
Nurseline	5.5%	63
Magazines / newspapers / printed info	2.9%	33
TV	2.7%	31
Radio	1.4%	16

³⁵ Healthy Communities Client Survey. Upleaf, 2015. Annex A.

³⁶ Ibid

³⁷ Ibid

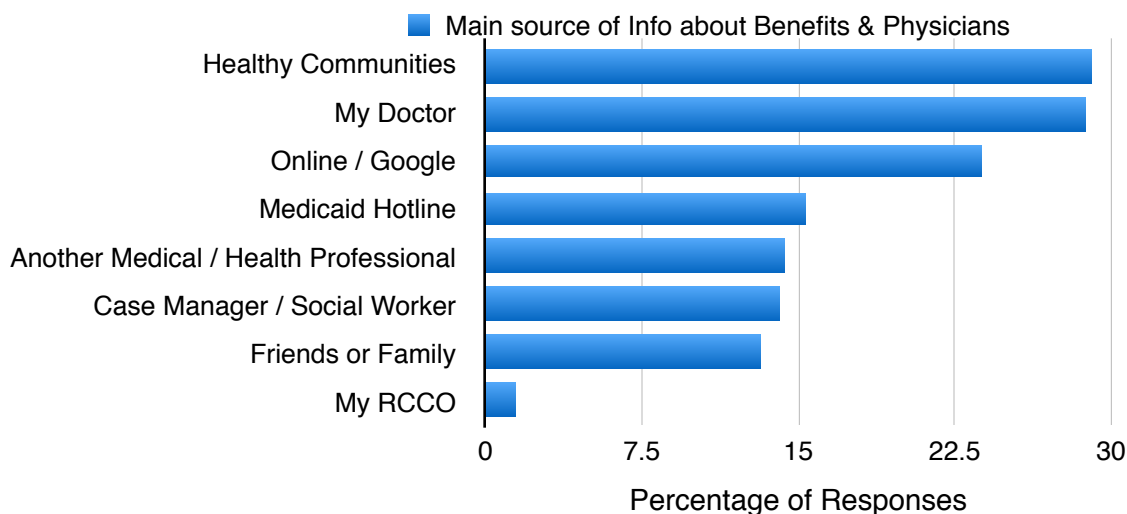
The client survey results also highlighted the influence of doctors as well as the importance of online information, as evidenced in Figure 15 above. When asked **“Where do you get most of your health information?”**, the response **“My doctor”** was by far most popular, with 64.3% of respondents citing their doctor first. The second most popular response was **“Online”** with 37.7% of clients citing this source of information. Younger age groups (25 to 29) and urban county residents were more likely to go online and google questions than residents of other types of counties (25.2% in urban counties versus 15.5% in rural counties and 14.5% in frontier, $p < 0.05$) or age groups. These results highlight the importance of making sure that the right information regarding well-child visits can be found online, and is easily accessible through online searches. This is not currently the case.

K. Healthy Communities Community Presence

Healthy Communities has a strong presence in many counties across the state. The community in these counties values the program as a place to go for real answers from real people, where they don’t have to spend the day in a waiting room or more than an hour on the phone. Because they are a place where people can get an immediate answer, demand for their help troubleshooting has grown.³⁸

The Healthy Communities Client Survey conducted in May/June of 2015 found that when asked **“Who do you turn to when you have questions about your health care benefits or need to find a doctor who accepts Medicaid/CHP+?”** the most popular response was Healthy Communities, as show in Figure 16 below. They were also cited (though less frequently) as the most important source of health information for some families.³⁹

Figure 16: Sources of Information about Medicaid/CHP+ Benefits & Physicians⁴⁰



The older a respondent was, the more likely they were to cite Healthy Communities as the place they turn to for information about their benefits and referrals to providers who accept Medicaid. Because the Healthy

³⁸ Healthy Communities Stakeholder Interviews, April - June 2015. Annex E.

³⁹ Healthy Communities Client Survey. Upleaf, June 2015. See Annex A.

⁴⁰ ibid

Communities program has been around, in one form or another, for more than 35 years, this speaks to the impact the program has had over the years. There was no difference in responses to this question by type of county, indicating the consistent presence the program has had across the state.

Healthy Communities' strong community presence is also well-appreciated by the RCCOs in most regions. During interviews, multiple RCCO managers lauded Healthy Communities for reaching out to families with initial orientation regarding benefits and giving referrals, and going the extra mile to support children on Medicaid.⁴¹ One RCCO manager was particularly appreciative, saying:

"Healthy Communities is there when mom delivers at the hospital. Healthy Communities takes care of the family right away- that's one of the things I love about the program. They follow up until a kid is at an appropriate frequency of visits. I just want to give a shout out to Healthy Communities."

⁴¹ Healthy Communities Stakeholder Interviews conducted by Upleaf, May-June 2015.

5. Program Recommendations

After interviewing stakeholders, analyzing surveys with Healthy Communities clients and staff, conducting background research and speaking at length with RCCO contractors, we present the following recommendations with the goals of increasing the impact of the Healthy Communities program and ensuring the program plays a strong supportive role to the Accountable Care Collaborative and other Department programs.

1. Return to the Basics of EPSDT

We recommend that Healthy Communities refocus on its original and core mission of improving EPSDT outcomes in Colorado. This would mean no longer assisting clients with eligibility and enrollment, or troubleshooting difficult client cases. It also would mean stepping back from the role of educating and liaising with providers. These activities are better left to other agencies and RCCOs, so as to delineate responsibilities and increase impact on the KPI the program was created for.

In returning to the basics of EPSDT, Healthy Communities has the opportunity to directly support the RCCOs by also informing clients about their RCCO and ensuring that they are attributed to a PCMP during the initial onboarding interaction. The core activities of Healthy Communities then become:

- 1.1. **Providing high-quality, in-depth orientation for newly enrolled families on Medicaid.** This includes explaining Medicaid benefits, educating families about the importance of well-child visits, ensuring that each family is attributed to a medical home, and introducing families to their RCCO. It also includes some basic screening for more serious issues, which would then be referred to a RCCO clinical care coordinator. This orientation should be conducted in-person or by phone.
- 1.2. **Following up with families regarding their well-child visits.** Claims data will soon be imported into the Healthy Communities CRM system, so Family Health Coordinators will know who is overdue for a visit and who has a visit coming up, and can prioritize their outreach accordingly. The system will also automate text and email reminders depending on client preferences, to reduce the number of individual follow-up calls that are required.
- 1.3. **Producing high quality educational materials for families on the importance of well-child visits.** These should be produced at the state level following the existing “Bright Futures” materials and messaging from the American Academy of Pediatrics. It should also include online and multimedia messaging, to raise awareness among the population of the importance of well-child visits in all children under 21, and reinforce positive social norms.

2. Codify Program Emphases: RCCOs on Access, Provider Issues and complex cases; Healthy Communities on Outreach, Client Education and Preventive Care

From a behavior change perspective, it is important to address barriers related to both access to care and knowledge. Healthy Communities’ role has long been to inform families on Medicaid about well-child visits and preventive care; the RCCOs are well-positioned to address access issues.

Adding the well-child KPI to the RCCO contracts resulted in RCCO resources being shifted to activities that duplicate the Healthy Communities program responsibilities and activities. The RCCOs interviewed for this evaluation project would prefer that Healthy Communities take care of well-child follow-up with families, but feel compelled to continue to do so themselves because of the incentivized well-child KPI. As a result, we recommend:

- 2.1. Incentivize RCCOs based on objective measures of PCMP access (number of PCMPs accepting new clients, geographic distribution, hours, correct billing procedures, follow-up from doctors offices) instead of EPSDT outcomes.
- 2.2. RCCOs inform providers about well-child visits and EPSDT and ensure their active participation and correct coding of visits. RCCOs can request that their PCMPs regularly reach out to clients to schedule the well-child visits at the appropriate intervals. They are also best placed to address billing and other issues that might arise. It should be made clear that this is the RCCO realm and Healthy Communities can refer providers to the RCCOs with questions. RCCOs should also be a resource for providers who are not yet part of their network.
- 2.3. RCCO care coordinators should focus on the challenging cases and relegate well-child and basic system navigation support to Healthy Communities. RCCOs have clinical care coordinators and case managers who specialize in addressing difficult client cases. This distinction should be recognized at a state level, and Healthy Communities teams directed to refer all difficult cases to the RCCOs.
- 2.4. Shift the responsibility for attributing new clients to PCMPs to the Healthy Communities teams, who will follow up until a family is attributed. This builds on the capabilities and systems Healthy Communities already has in place. It would help alleviate some of the administrative burden RCCOs are facing, and integrate Healthy Communities more clearly with the RCCO mission of bringing Medicaid clients into the ACC and into a medical home.

3. Review Program Funding to Adjust to Larger Caseload

Since 2007 (the last year that Colorado's EPSDT screening ratio was on par with the national average) Healthy Communities' caseload has increased by 159%. The program budget has increased by only 26% in the same time period. Additional resources are necessary to enable Healthy Communities to effectively conduct in-depth initial orientation with the newly enrolled families, and continue to follow up with all families regarding well-child visits.

- 3.1. When state budget climate may allow, seek increased funding for the program to bring the budget up to 2007 funding levels relative to caseload or move to a per member per month (PMPM) compensation model for Healthy Communities, and impose additional requirements on contractors (e.g. must meet technology requirements, hire computer literate employees, meet clearly defined performance expectations, implement activities as prescribed, etc)
- 3.2. Clearly define expectations of each Healthy Communities contractor and require accountability regarding activities so that all Healthy Communities teams invest their time in the activities that will make a difference in EPSDT outcomes and simultaneously support the RCCO's mission.

- 3.3. Allocate a portion of the new funding for incentives tied to EPSDT screening and participant ratios. Upleaf has proposed an incentive structure which can be found in Section 7 of the Healthy Communities Research Report in **Annex D**.
- 3.4. Add an additional full-time or part-time support staff role to the Department team to help meet the caseload demands of the program.

4. Focus Messaging and Activities on Populations that Move the Needle on EPSDT

Eighty-five percent of children on Medicaid in Colorado are found in twelve counties. Sixty percent of children on Medicaid are between the ages of six and eighteen, and these are the children with the lowest EPSDT participation rates. Channeling more attention or resources to counties with high concentrations of children on Medicaid and age groups with low rates of well-child visits could make a big impact on Colorado's EPSDT screening ratio.

- 4.1. Ensure that the twelve counties with highest volume of children on Medicaid have a sufficient number of Family Health Coordinators to do adequate orientation / on-boarding for every new Medicaid family, either in person or by phone, and follow-up regarding well-child visits. Follow progress in these counties closely, and provide additional monitoring, support and supervision as needed.
- 4.2. Clearly define the appropriate messaging for parents of 6-18 year olds. This likely means segmenting messages by 6-10, 11-14, 15-18 year old intervals, and providing training and educational materials to Healthy Communities teams that support the core messages.
- 4.3. Conduct outreach campaigns (preferably online) at a statewide level to educate parents of 6-18 year olds on the importance of well-child visits and what to expect at each year's visit.
- 4.4. Customize the automation of email and text messages to go out to guardians in these age groups to remind them of the visit and also educate them about what happens during a well-child visit for children in their child's age group.
- 4.5. Hold teams accountable for the number of quality interactions they have with priority clients (i.e. not automated messages or RoboCalls) and the overall EPSDT participant ratios and screening ratios for their counties. This can be achieved through an incentive system with clearly identified goals and objectives, outlined in Section 7 of the report found in **Annex D**. We recommend also including incentivized objectives related to data flow to the RCCOs.

5. Maximize Data Integration and CRM Technology

There have been many local efforts to share contact information for clients or share notes on who has been contacted when and by whom between Healthy Communities and RCCOs, but with limited success. Healthy Communities is already pulling newly enrolled data and provider data from the Colorado Benefits Management System and Medicaid Management Information System, and will soon be integrating claims data into the Healthy Communities CRM system so that teams know who has and hasn't already been in for their well-child check. This can also be done at the state level between the Healthy Communities CRM system and the Colorado Statewide Data Analytics Contractor (SDAC) that manages data for the ACC. Alternately, RCCO teams can be given access to view necessary information within the Healthy Communities CRM system.

We recommend utilizing the Healthy Communities CRM System at its full capability to:

- 5.1. **Integrate Healthy Communities data with key data from the SDAC.** At a minimum this would include ACC member and PCMP information for each client. Another option would be to give RCCOs access to view specific data within the Healthy Communities CRM System. Such data sharing/integration, while ensuring HIPAA compliance, would make more sense being addressed one time at the state level rather than having each RCCO and Healthy Communities contractor work out the details separately. Once it is clear which data needs to be shared, it can be scheduled for daily, weekly or monthly integration or RCCO staff can be given access to the HC CRM.
- 5.2. **Allow Family Health Coordinators to attribute (unattributed) clients to a PCMP.** This would be accompanied by a referral to that PCMP that is clearly documented in the data system and could include an automated follow-up confirmation to see whether a client has scheduled their first visit.
- 5.3. Also, allow FHCs to disenroll a client from the ACC if their preferred provider is not PCMP.
- 5.4. **Share data on PCMPs who are still taking new Medicaid patients** and those who are not, for more effective medical home referrals.
- 5.5. **Create dashboards** for each Family Healthy Coordinator, supervisor and client to see at-a-glance their progress toward well-child goals.
- 5.6. **Add new fields to collect a parent/guardian's preferred method of contact** during initial orientation, along with email and cell phone number if they agree to be contacted by text or email or RoboCall.
- 5.7. **Automate well-child visit reminders to go out via text or email** or even RoboCall (whichever medium a client has given their permission to use for contact) with capability to confirm receipt. Messages should be tailored to include what to expect during the visit. Clients who don't accept the automated channels will receive a phone call from a Family Health Coordinator or a letter in the mail, according to their stated preference.

6. Make Information about Well-Child Visits Accessible Online

According to the client survey results, many younger parents are actively searching online for health information and for answers to their questions about Medicaid benefits and physicians who accept Medicaid. They are also passively absorbing health information they're exposed to as they spend time online. Department must therefore ensure that key information about well-child visits, Medicaid benefits, and providers can be easily found through search engines. Recommendations:

- 6.1. Conduct keyword research to identify the terms parents are actually searching for related to Medicaid coverage and well-child visits.
- 6.2. Adjust Department website content to include those terms prominently, in page titles and headings, to reinforce search engine optimization and make sure those key pages are easily found in searches.
- 6.3. Review the website's behind-the-scenes search engine optimization structure to make sure pages are appropriately indexed with all major search engines.

- 6.4. Review the reading level and terminology used in all online information, to make sure it is accessible to Medicaid populations. Ensure content adheres to best practices in writing for the web.
- 6.5. Consider online advertising (Google AdWords, Facebook Advertising) to push key messages out to low-income families around the importance of annual well-child checks, particularly in families with children ages 10 and older.

7. Standardize Activities Across Healthy Communities Contractors

The Healthy Communities teams differ by county in terms of how they are managing their projects. This leads to inconsistent results and can cause confusion or challenges in managing the program. Standardization can be achieved by:

- 7.1. Setting clear goals and priorities for the contractors. Each would be evaluated on the same criteria, and these would be included in their contracts and incentive structures.
- 7.2. Developing an in-depth training manual and standardized training procedure that clearly outlines goals, objectives, priorities, procedures and expectations for all Family Healthy Coordinators.
- 7.3. Closely monitoring monthly reports (volume of quality interactions, outreach to newly enrolled versus targets, EPSDT progress) at the state level to ensure compliance with expected activities.
- 7.4. Clearly communicating the newly defined role of the Healthy Communities program to all RCCOs and other relevant state agencies and programs.

8. Better Integrate the Program into other Department Initiatives

There appears to be a disconnect between the Healthy Communities program and some of Department's other initiatives that also address child or family health. We recommend ensuring that the Healthy Communities program is consulted regarding messaging, referrals and on-boarding activities and integrated into all relevant department discussions. This will help ensure message consistency, improve coordination, and avoid duplication of effort.

More specifically we recommend:

- 8.1. Once Healthy Communities materials are developed, have the FHCs review all member handbooks and relevant educational materials to ensure that all messaging is consistent and includes adequate information about EPSDT benefits.
- 8.2. Ensure that Healthy Communities information and phone numbers are included as a resource in all appropriate RCCO and Department materials.
- 8.3. Share EPSDT information with providers and give them examples of how well-child visits are reported to the federal government and how screening and participant ratios are calculated so that they understand the importance of coding their visits properly. Make sure all provider handbooks are updated with correct information about well-child visits and the periodicity schedule.
- 8.4. Conduct a short audit comparing client survey responses with data in the claims database, to verify whether clients who reported well-child or preventive care visits have corresponding claims data in the

database and if not, what might account for the discrepancy. This will help identify any data-related issues that might be skewing the state's participant or screening ratios.

9. Align Sports Physicals with Well-Child Requirements

Hawaii, Tennessee, and Iowa have successfully aligned sports physicals with well-child visits requirements, which has in turn boosted EPSDT rates in all three states. We recommend that Colorado do the same. This will require coordination between Department leadership and the Department of Education and possibly other departments, in addition to provider outreach.

Specifically, we recommend the Department:

- 9.1. Clearly communicate well-child requirements to physicians and how much more they can bill for a well-child visits and associated screenings versus a sports physical;
- 9.2. Communicate the expectation that all sports physicals conducted in Colorado will now become well-child visits, and why this is so important to overall health of children in Colorado; and
- 9.3. Mobilize all sectors to get the word out to physicians.

10. Examine the Crossover Between HealthColorado and Healthy Communities Onboarding

Similar to Healthy Communities, HealthColorado receives weekly lists from CBMS of all newly enrolled Medicaid and CHP+ clients and then proactively follows up with new clients. In addition to sending out a welcome packet, HealthColorado provides orientation regarding the RCCOs and PCMPs and processes requests to opt out of the ACC program. We believe that there may be some overlap that could cause confusion for the newly enrolled family, and recommend that Department compare the Healthy Communities initial orientation scope of work with that of HealthColorado to see if it makes sense to shift any resources or responsibilities regarding initial orientation to Healthy Communities.

Because each interaction is an opportunity to educate a family about the importance of well-child visits and preventive care, we recommend that whenever possible these initial interactions be handled by Healthy Communities teams.

6. Conclusion

Healthy Communities is a valuable program focused on keeping Colorado's most vulnerable children healthy. The program has a strong local presence in many counties across the state, and offers a unique opportunity for high-value face-to-face education for families. By coupling strong local relationships with clients with additional technology innovations and automated client follow-up, the program can become a dynamic force to increase the state's EPSDT outcomes.

Healthy Communities is well-positioned to serve as the entry point for all families with children enrolled in Medicaid, informing them about their benefits, referring them to a medical home, and educating them about well-child visits and preventive care.

The teams are also well-placed to support the RCCOs by attributing clients to PCMPs during the initial orientation.

We believe that the findings and recommendations offered throughout this report and supporting documents provide a clear, evidence-based path for the way forward. Implementing these recommendations will strengthen the Healthy Communities program, increase its impact, and enable it to become an important partner in improving the health of Colorado's children.