# PMME Update

## Program Improvement Advisory Committee

August 19, 2020

# Agenda

**10:45 – 11:00** PMME Updates and Recommendation to PIAC

**11:00 – 11:05** Context and Background: The COVID Performance Pool Measure

**11:05 – 11:15** PMME Feedback and Results

**11:15 – 11:30** RAE Response to the Pandemic

**11:35 – 12:00** Discussion about RAE Response & What's Next

# PMME Update

- Provided feedback on a COVID APM measure, emphasis on telehealth adoption and lessons learned
- Brainstormed options for improving the prenatal KPI
- Developed onboarding and engagement strategies for new members, and in particular Health First Colorado members
- In the process of finalizing a scope of work for SFY20-21 including a focus on racial equity and health equity

# Recommendation to PIAC

**Goal:** To improve the prenatal KPI measure which currently does not accurately measure timeliness and frequency of prenatal care

**Option 1**
Long term: Changes to global billing
Short term: Prenatal check list

**Option 2**
Lab series tied to trimesters

**Option 3**
Depression Screens

**Option 4**
Maternal Morbidity

Most similar to current measure → Most different

Recommendation:

- Consider the outcome that matters most to members
- Report data by race/ethnicity if possible
- If the current measure cannot be improved, consider depression screens. It aligns with key health disparity indicators.
- Interest in making a second recommendation to PIAC based on HCPF's proposal (in development)

# COVID Response

## An Overview of RAE Efforts to Address the Pandemic

# Our Mission

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

# Core Questions

- Given what was known about the pandemic, how adequate was the Department's response via the COVID deliverables?

- Given how the pandemic has evolved, how does the Department need to approach a potential second wave?

# Overarching Goal

Send direct support to the provider network early in the pandemic

&

Outreach and engage members at highest risk of being impacted by COVID-19 to ensure health needs were met

70% of PCMPs nationwide were reporting a >50% decline in patient volume

*Source: The Larry Green Center, May 1-4, 2020*

# PMME & Stakeholder Feedback

- Connect members with providers
- Promote health equity
- Ensure members receive specific communication, such as the crisis services hotline
- Evaluate the success of efforts

# COVID Part 1 and Part 2

Key Targets:

(1) Outreach: 100% to all high-risk members

(2) Engagement: 25% of members, defined out of 10% of the high-risk base

(3) 100% of incentive dollars to providers

High-Risk Members defined by:

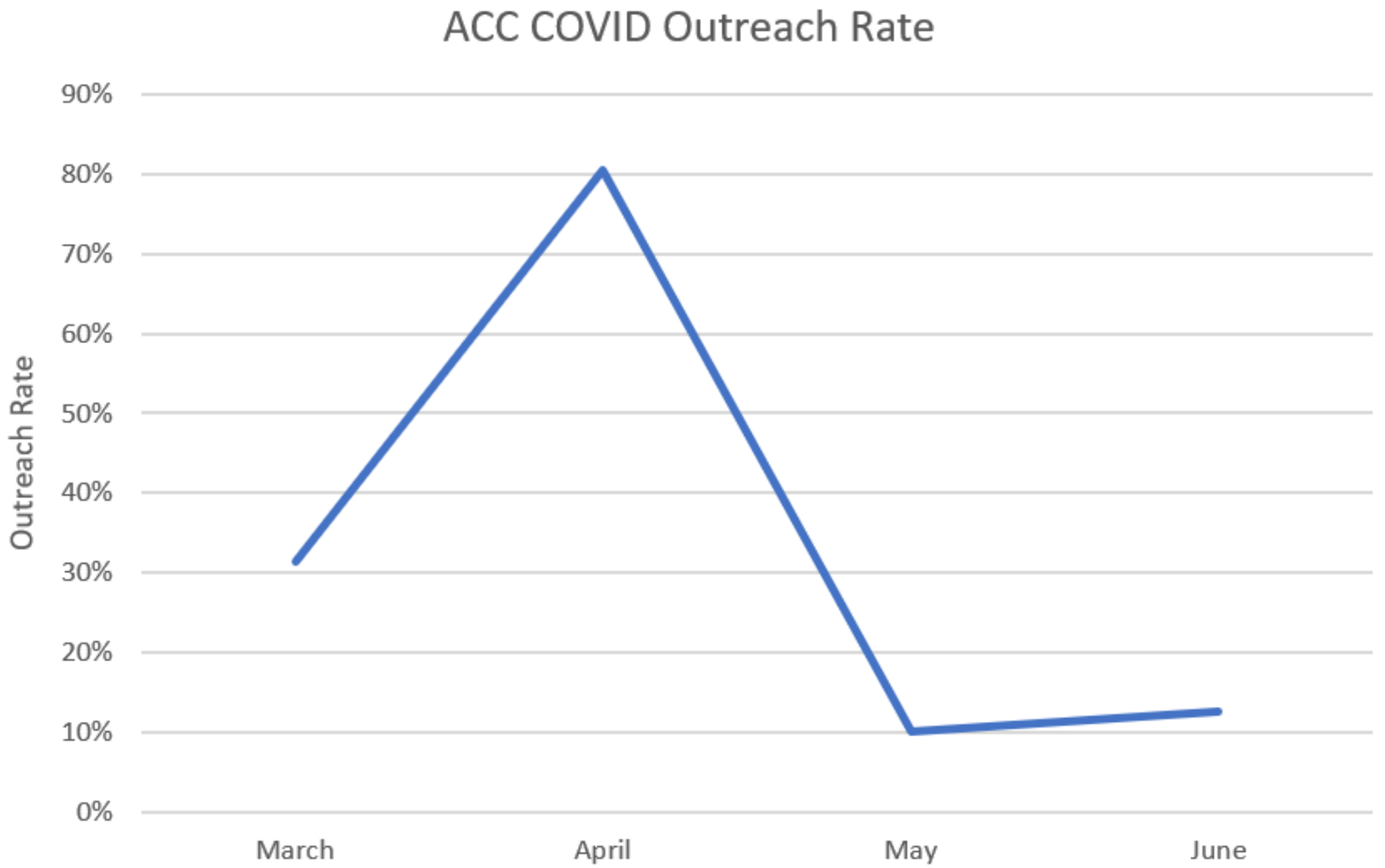
Age, heart disease, COPD, cancer, diabetes, asthma, hypertension, lung disease, chronic respiratory disease, coagulation disorder, immunosuppressives, etc.

Each factor weighted equally.

# COVID Part 1 and Part 2

- All RAEs earned 100% of eligible performance payments
- RAEs initiated outreach early on in pandemic
- RAEs exceeded engagement thresholds and engaged 100% of high risk members
- Department and RAEs released ~$7.6 million

# COVID Part 1 and Part 2



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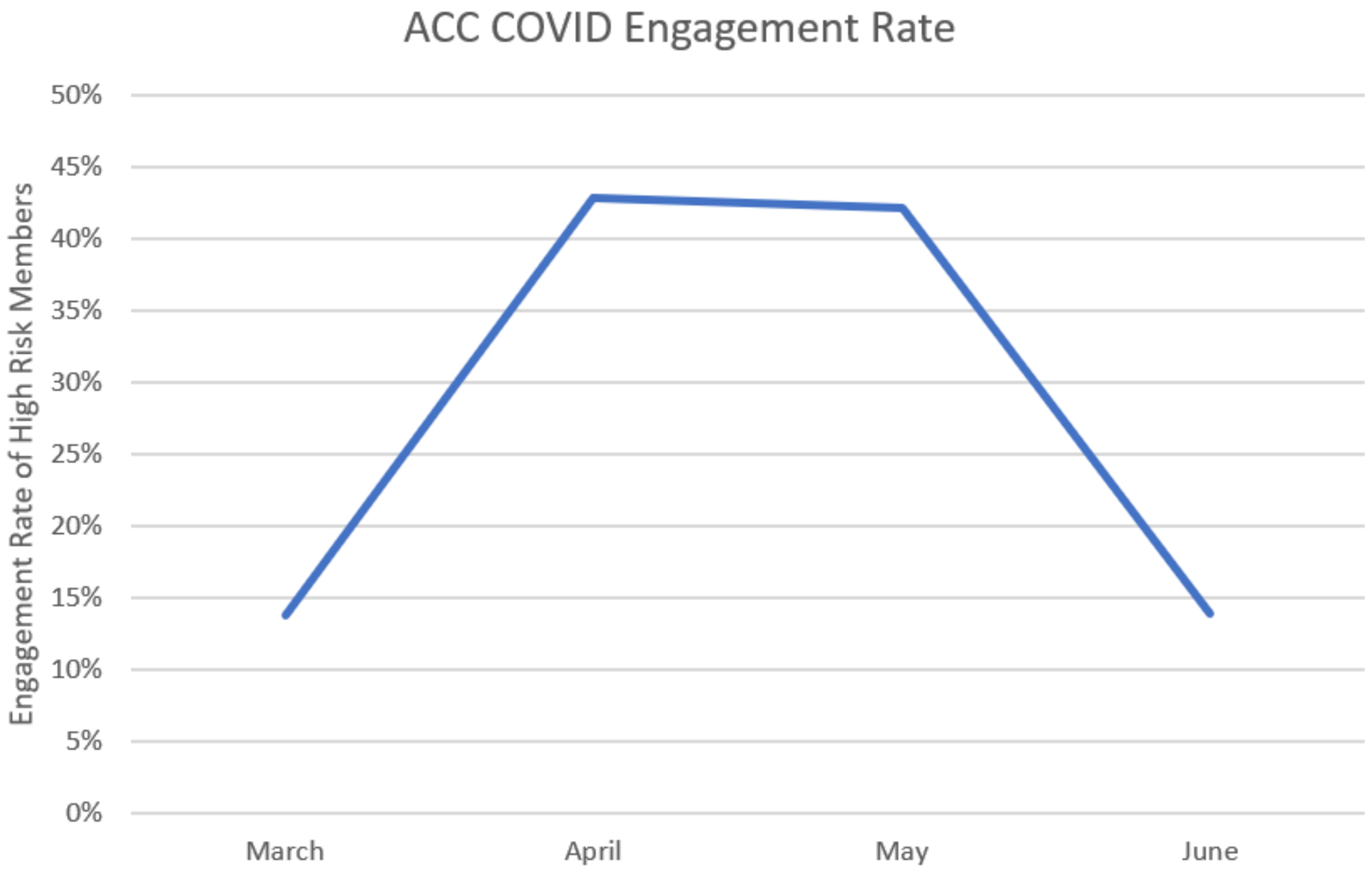

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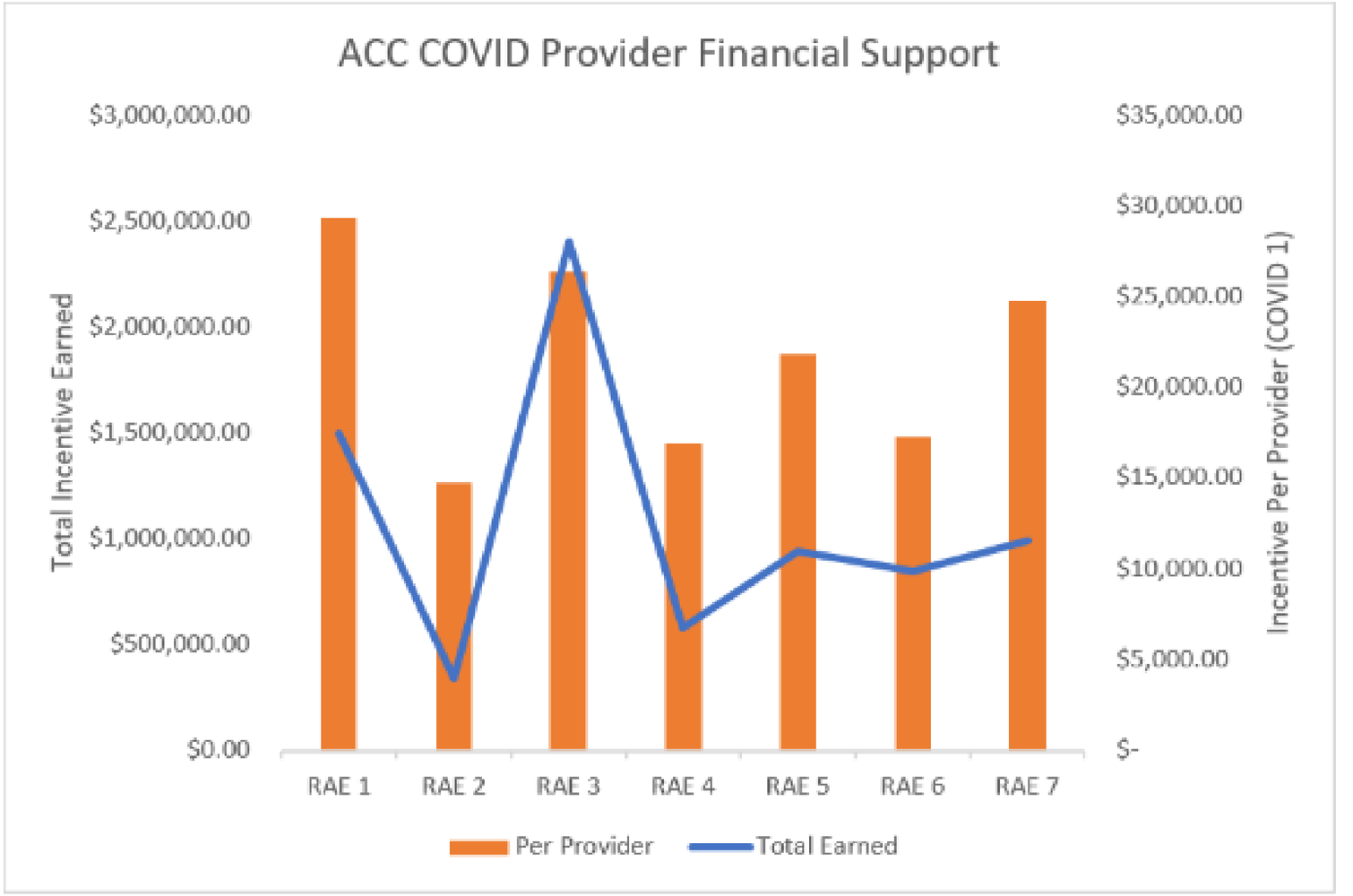
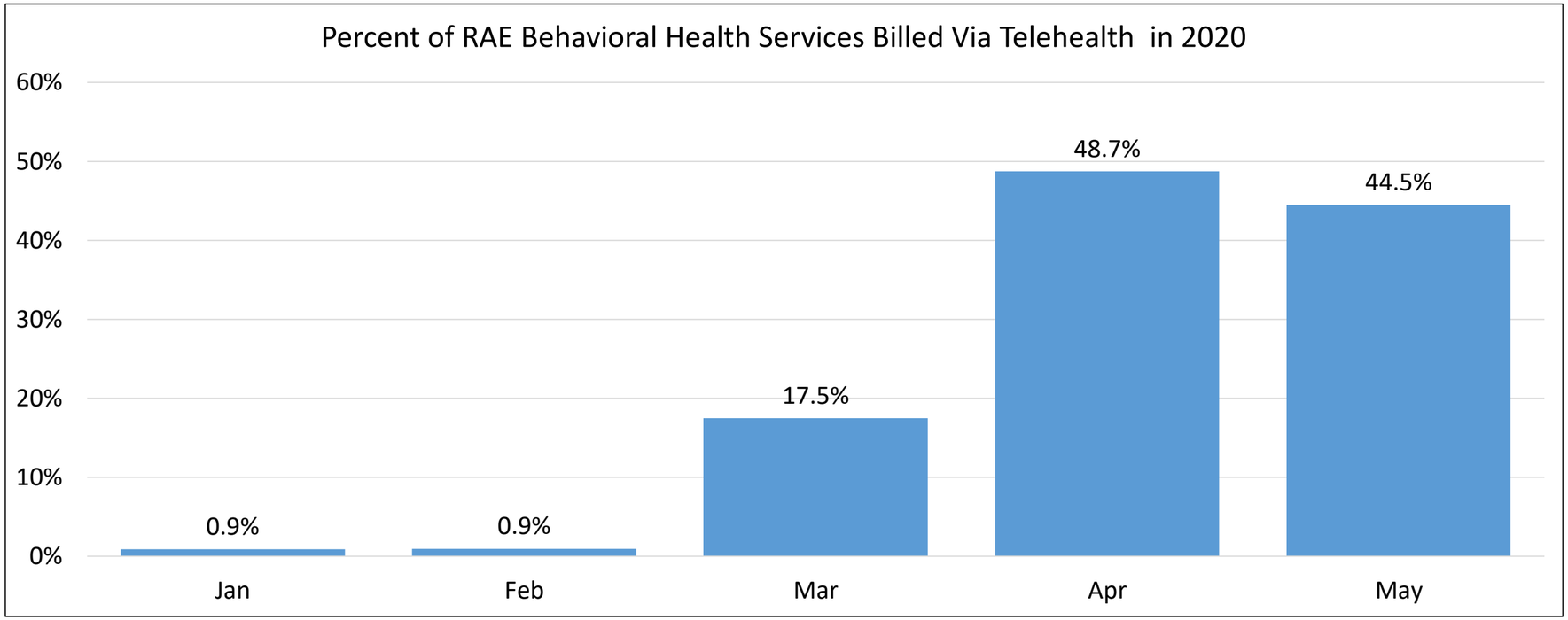


**Question 1:** How have you measurably improved the connections between members (particularly high risk members) and providers during the early months of the pandemic?

# Connecting Members and Providers

*RMHP **contacted 53,465** Members via text and phone call and had **conversations with 5,054 Members** about how to access medical, behavioral health, and social services*



# Measurable Improvements on Connections Between Members* & Providers

| | |
|---|---|
| Members identified as high risk for complications | • 135,399 members identified as at-risk |
| Member Support Services – Outreach & Education | • 5,256 inbound calls<br>• 20,886 outbound calls (33% increase)<br>• 22,676 automated calls<br>• 300,454 texts through 5 campaigns |
| Care Coordination | • 10,440 members engaged March 25 – June 30 |
| Health Neighborhood & Community – Education | • Collaboration with schools, hospitals, public health<br>• 60 + emails sent to educate and inform |
| Network Providers Accountable Care Network Rural Contractors | • Identified members for prioritization, helped to create messaging & ramp up telemedicine efforts |
| Telemedicine – PH & BH | • CYQ1 versus Q2—Claims increased by 670%, with BH claims being 53% of this increase |

** Particularly high risk*

Question 1: **How have you measurably improved the connections between members (particularly high-risk members) and providers during the early months of the pandemic?**

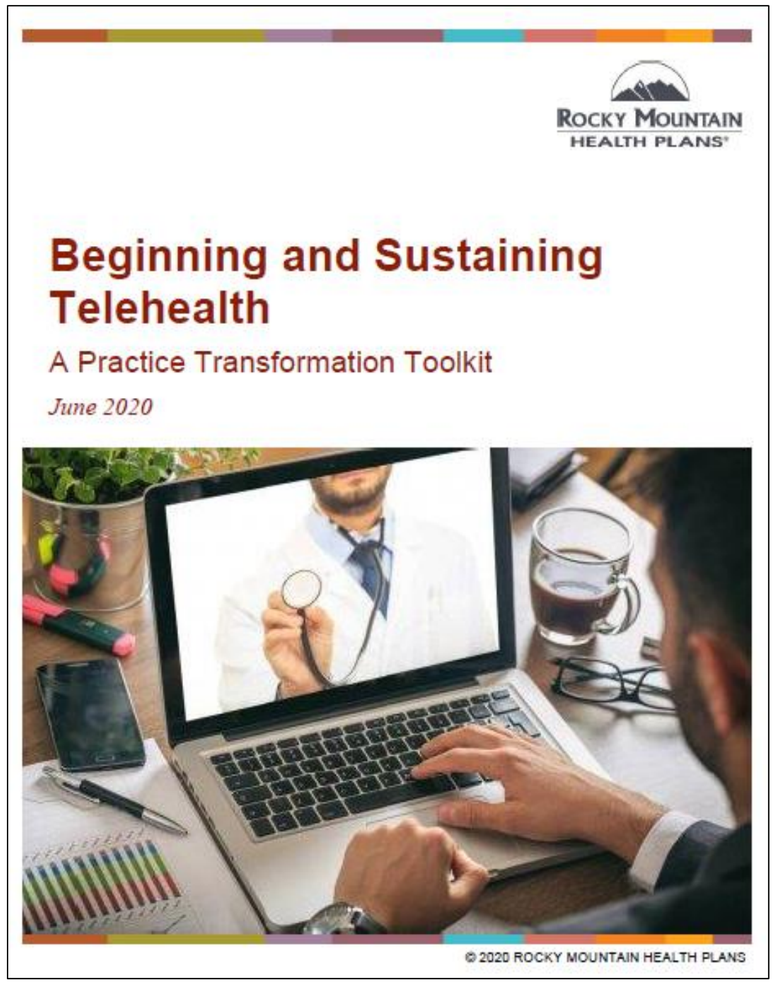
# HEALTH COLORADO ENGAGEMENT STRATEGY

- **(27.5% of Members with a COVID Risk Level 6+ were engaged in bi-directional communication with Health Colorado).**
- **Automated Calls**- prioritization (most at risk first) with live agent transfer option. Members provided information about how Health Colorado can connect them to their provider, help them find a provider.
- **Bi-directional text campaign**- interactive, auto-response campaign as a targeted follow-up to a COVID educational campaign. Help identify Members with barriers to care, finding and reaching providers, and making appointments.
- **Care Coordination Live Call Outreach**- live call outreach starting with Members with the highest COVID risk scores. Objective to review and answer questions about COVID-19, Stay at Home Order, Safer at Home Guidelines, connect and assist them with reaching providers, address any social determinant of health issues, etc.

Health COLORADO

**Question 2:** Tell us about your efforts to support providers, including behavioral health, shifted as they adapted to the pandemic.

# Promoting Telehealth in Practices




- Held weekly **technical assistance** with practices
- Developed **toolkit** with guidance on payer regulations, workflows, consent, technology, and other telehealth policies and procedures
- Provide **individual practice consultation** for implementing and improving telehealth workflows
- Focus on maintaining **whole person health**

# Pivoting to Quickly Deploy Interventions to Support Providers in Response to the Pandemic

| | |
|---|---|
| Communication | • Telemedicine webinars on 3/24 & 3/26 for all providers offering a comprehensive explanation of changes; more than 250 participated live. 6 provider alerts with 40% average open rate. |
| Survey | • Practices indicated themes of financial strain and significant changes to operations |
| Funding | • Over $3.8 million was distributed in addition to flexible & accelerated performance payouts |
| Connection & Education | • Regular, at a minimum monthly often weekly, virtual meetings with providers to brainstorm innovative approaches. Created telemedicine guides. |

**Question 2: Tell us about how your efforts to support providers, including behavioral health, shifted as they adapted to the pandemic.**

## HEALTH COLORADO PHASED APPROACH TO OUTREACH AND ENGAGEMENT

- **Phase 1**- Focus on risk management and rapid response to the COVID-19 public health crisis. This includes efforts to provide Member education about COVID-19, symptoms, spread, and resources for those who may be affected. Focus on Provider changes, information hub, alerts.
- **Phase 2**- Focus on supporting and managing conditions in the changing environment. Between financial pressures and limited accessibility, we want to ensure Providers had the resources and support they needed to continue to help Members follow treatment plans and take medications. Prevent unmanaged conditions and risk of high-cost hospitalization. Emergency funding, support calls
- **Phase 3**- Focus on managing the demand and backlog of preventative screenings. Well-care had been limited and we wanted to provide the most up to date information on adult and child wellness and prevention, as well as immunizations. Individual support outreach, Facebook

Health COLORADO
A system of integrated healthcare providers.

**Question 3:** This pandemic continues to disproportionately impact populations that are at higher risk of exposure to COVID, particularly communities of color, those without stable housing and those living in facilities. What has your RAE done to address health disparities so far?

# Members with Elevated Risk

| Population | Strategy |
| --- | --- |
| 3,207 Members experience housing insecurity | (1) Prioritize housing resources for high risk Members; (2) Support funding apps.; (3) Facilitate services; (4) Expand supportive housing programs |
| 913 Members experience interpersonal violence | Educate providers about high rates of interpersonal violence among Men and Boys and provide gender specific training and resources |
| 1,324 Members live in congregate settings | Outreach nursing homes and other congregate living programs to promote telehealth services and connect programs to RAE resources |

# Recognizing Health Disparities within Populations Existing During the Pandemic

| | |
|---|---|
| At-risk for Homelessness | • Ascending to Health Respite Care – 43 members<br>• Motel Voucher Program – 3 members<br>• Springs Rescue Mission – 70 members enrolled, 607 referrals to programs, 1,673 referrals to PH/BH |
| Complex Youth | • Collaborative Management Program Partnership<br>• Worked with families to find alternatives to placements |
| Justice Involved | • Identified providers ready for released members<br>• Telepsychiatry |
| Long Term Service & Support Waivers | • SEP/CCB partnership<br>• Sharing of High Risk Members & ADT Data<br>• 47 High Risk Members Identified & Complex Case Reviews were appropriate for half. |

**Question 3: This pandemic continues to disproportionately impact populations that are at higher risk of exposure to COVID, particularly communities of color, those without stable housing and those living in facilities. What has your RAE done to address health disparities so far?**

## HEALTH COLORADO HIGH RISK BREAKDOWN

Identification of the role age and co-morbidities played in the risk algorithm.

- **CCB/SEP communication plan**- emails, virtual meetings, individual Member care plans and interventions. Make the connections with the CMA agencies, determine roles and responsibilities, connect them to the appropriate accountable provider providing care coordination.
- **Live Call Outreach**- Localized care coordinator outreach, strength in live person-to-person engagement. Feedback from care coordinators indicated that Members, particularly at-risk older adults, were receptive to outreach and generally willing to engage once they were reached. Social determinant of health issues addressed.
- **Bi-directional text outreach**- ability to reach high risk members requesting follow-up sooner.
- **Automated Calls**- Voice recording in English, translation to Spanish and the recording of a Spanish translation, list set up and prioritization (most at risk first).

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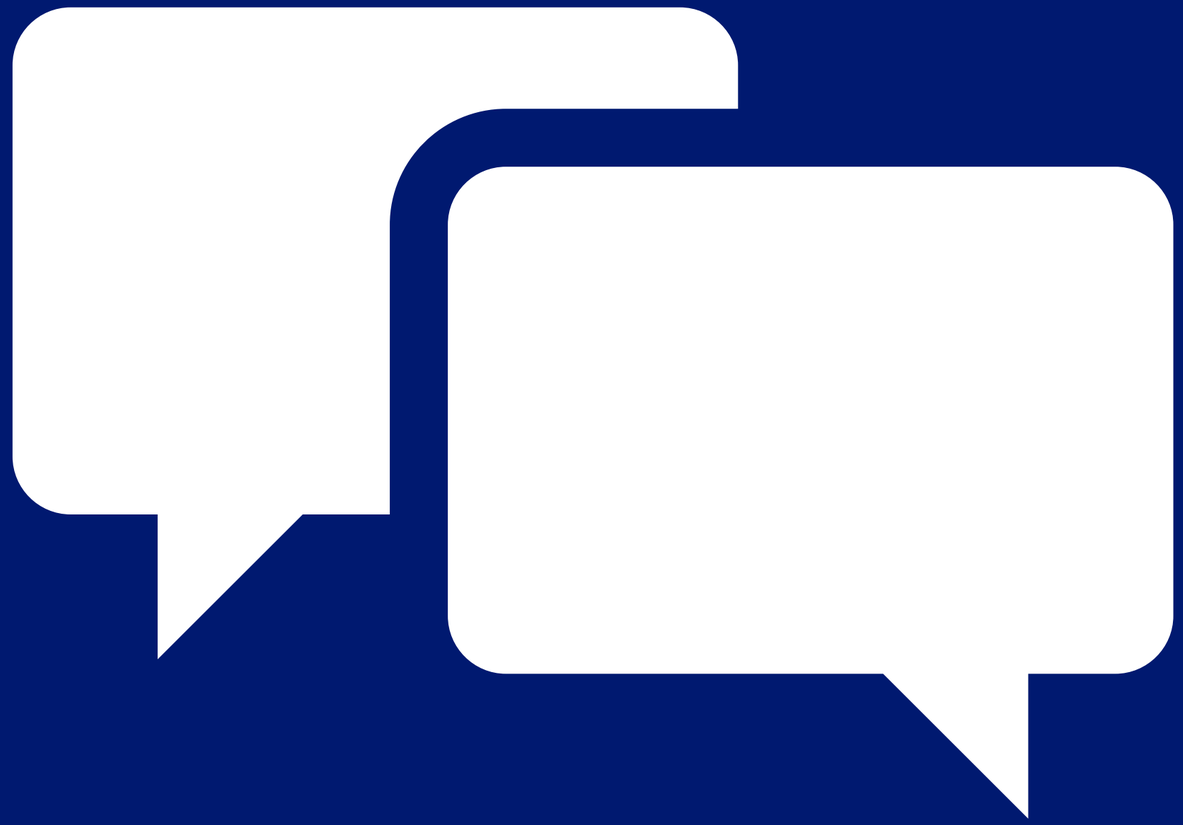

# Questions for RAEs?

# Contacts


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# Core Questions

- Given what was known about the pandemic, how adequate was the Department's response via the COVID deliverables?

- Given how the pandemic has evolved, how does the Department need to approach a potential second wave?

- What should the next steps be?