Performance Measurement and Member Engagement
PIAC Subcommittee
Minutes

Meeting Information			
Date	Thursday, January 28, 2021	**Time**	3:00 – 4:30 PM
Location	Virtual attendance only	**Call-in Number**	+1 402-364-0128 PIN: 205 793 916#
		Webinar link	meet.google.com/ohd-ofqc-scd
Committee Purpose	Discuss best practices and challenges to improving quality and health outcomes for ACC members and make recommendations for the ACC PIAC and the Department with regard to quality.		
Meeting Purpose	The primary purpose of this meeting is to explore the new behavioral health dashboard that disaggregates data by race/ethnicity, language, age, etc. with the intention of (1) understanding the quality of this data and (2) beginning to identify health disparities and next steps.		

Voting Members and Participants
Voting Members Present: Bob Conkey (Health First Colorado member), Eli Boone (Colorado Health Institute), Kayla Frawley (Clayton Early Learning), Angie Goodger (CDPHE), Gary Montrose (Young People in Recovery), Valerie Nielsen (CCHN), Brandon Ward (Jefferson Center for Mental Health), Luke Wheeland (The Arc), Health First Colorado Member, Jill Atkinson (Community Reach Center) **Voting Members Absent:** Deb Barnett (Connecting Points Advisory), Health First Colorado Member **Co-Chairs:** Bethany Pray (CCLP), Christina Suh (Phreesia/CHCO) **HCPF Staff:** Megan Comer, Sabine Durand, Milena Guajardo, Anne Jordan, Chris Larson, Amy Luu, Liana Major, Nicole Nyberg, Courtney Phillips **Other Participants:** David Keller (CUSOM/CHCO), Agnes Markos (Colorado Access, RAE 3 & 5), Amy Ferris (Pediatric Care Network), Jordan Romeo (Planned Parenthood of the Rocky Mountains), Camila Joao (CCHA, RAE 6 & 7), Katie Gaffney (Denver Health Medical Plan, Medicaid Choice), Andrea Loasby (CUSOM/CHCO), Marjorie Champenoy (RMHP, RAE 1), Cathy Michopoulos (Health Colorado, RAE 4), Detre Godinez (Office of Behavioral Health), Kellen Roth (Colorado Access, RAE 3 & 5), Moses Gur (Colorado Behavioral Healthcare Council), Cynthia Mattingley (RMHP, RAE 1), Katie Mortenson (CCHA, RAE 6 & 7), Randi Addington (Health Colorado, RAE 4), Dawn Claycomb (Beacon RAE 2 & 4)

Speaker(s)	Description
BP/CS	Roll call and December meeting minutes approved. No abstention. Updates were provided from the Department. The Public Health Emergency has been extended through April 20, 2021. For Medicaid members, this means that all who are currently enrolled in Medicaid will be able to maintain their enrollment until at least the end of April. There are thoughts this will be extended further. The new SUD benefit went into effect on January 1, 2021. The Department will be transitioning to using the Zoom web conferencing tool.
BP	**Explore the disaggregated behavioral health dashboard with the intent of understanding health disparities and data quality** The group walked through highlights from the disaggregated data dashboard. The focus was on the BHIP measure, "follow up after positive depression screen within 30 days," and behavioral health engagement rates (a key performance

	indicator or KPI). All demographic data in the dashboard currently comes from the Medicaid application. The slides can be found here.
	
	The following were the guiding questions:
	• Do populations have disparate levels of access to mental health care?
	• If so, where do disparities exist, where are they largest, why do they exist, and what are the impacts?
	  ○ There was discussion about whether the group will be developing recommendations or taking action based on this data. The group agreed that the goal is to eventually get to a place where recommendations about action steps can be made.
	
	A definition of health equity was provided. Due to different barriers often caused by policies and systems, it is fair to give each person what they need to be successful and to acknowledge that what each person's needs may be different. If each person is provided the same thing (equality), then differences in access, for instance, will be perpetuated. The group talked briefly about redlining policies as an example. These policies made it nearly impossible for someone of color to obtain a mortgage, and the outcomes of these policies are still evident today in disparities in intergenerational wealth.
	
	A majority of Medicaid members report their race/ethnicity when completing an application for Medicaid. Only about 6.7% of race/ethnicity data that is missing or unknown. However, there are needed efforts to improve this quality of data, which the Department is now looking at.
	
	The key measure of focus for the discussion is "follow up after positive depression screening." Behavioral health engagement rates are also provided as context for disparities in access to care. A follow up can occur at any place (primary care, behavioral health, emergency department visit) but the follow up needs to be completed by a behavioral health provider. All positive screenings are looked at that were completed during a well visit with the member's primary care provider. The data is from claims and is not clinical data. Providers code the screenings differently depending if they are a positive or a negative screening as there are specific codes for each.
	• Across all Regional Accountable Entities (RAEs) and populations, 49.64% of members who screened positive for depression received a follow up assessment within 30 days.
	  ○ For many populations, the sample size is small, so we can only view right now the percent of people who screened positive. The Department will be adding screening rate data. For example, Native American members have the highest follow up rate, but very small numbers of people are being screened.
	  ○ It was noted that no measure is perfect; for instance, the way that some Federally Qualified Health Centers bill a follow up by a behavioral health provider is not captured in the set of codes that is captured for this measure and so there is follow up occurring that is not seen in this measure. The same was noted for Community Mental Health Centers. There is follow up occurring that is not getting coded in a way that includes them in this measure. The group also wanted to understand why ED visits were an allowed follow up.
	  ○ Similarly, there are some billing issues with screenings, so screenings that we see in the claims data are likely an undercount.
	  ○ The Department will follow up to learn more about billing challenges that impact this data.

	• This measure only includes people who had a well visit in the last year. This means that the data excludes people who may need to be screened or get access to care. Unless everyone is filtered in, it will be difficult to truly see disparities. The Department can provide a broader view in the next dashboard update. • A question was asked if data can be pulled by site. In response, the place of service of where someone completed their follow up can be seen in the Department's behavioral health dashboard. For the follow up, there is a lot of missing data as place of service is not always coded and may not be the most helpful measure. For screenings, there is not much variation with screenings as a majority of them are done within a doctor's office. For the measure, only primary care screenings are counted. Screenings are taking place in other settings but just don't count toward this measure. The Department's behavioral health dashboard was presented. Stakeholders do not have access to this due to member level data being included. • It can be filtered by place of service to allow someone to see what places follow ups were done. The filters also show follow up rates by race/ethnicity and by gender and age. There are other filter options as well, e.g., disability status. • There was a question if the RAEs have access to the dashboard to potentially improve their outreach and allow other groups in their regions help to resolve issues. A response was provided that this has yet to be provided by the RAEs but the goal is to share the data once the next version is developed. • A question was asked about screening for 6-9 year-olds as there is no validated screener for this age group and providers are not reimbursed for this. In response, the Department has not been able to dive into this data and contact providers to determine what is being used to screen children under 9 years-old and so it is unknown what providers are using. However, the sample size is low (30 or less). • As some follow up places were indicated as emergency room admissions, a question was asked if it was possible to pull up this data. In response, this was reviewed but it was a relatively small number that was at about 100. Variation by RAE Region data was presented (slide 14). • The follow up rate, screening rate, and behavioral health engagement rate were shown. The initial goal of looking at the data was to see if members were getting the treatment and care they need in their follow up, after a depression screening. The group discussed if certain communities are being under screened and are these people even receiving care at all. There are variations across the regions. • About 20% of members are getting in for some sort of mental health care each year. 29% of people are getting screened for care on average (significant variation by RAE region). There are no screening rates broken down by race/ethnicity or gender but those are forthcoming. Race and Ethnicity by RAE Region • The data presented shows that race and ethnicity varies by RAE region. Diversity in the RAEs varies substantially. The challenges that the RAEs have in meeting the needs of their population will be specific to each respective RAE. Follow Up by Race/Ethnicity and by RAE (Slide 18) • The "N/A" noted indicates that there was less than 30 members who had a follow up. These are blinded to protect members' identities. • There are striking disparities within regions by race and ethnicity. For example, 38.8% of Hispanic members in Region 1 received a follow up after a positive screen compared to 55% of White members. • The group noted that RAE 7 seems to be performing really well, so what can be learned from them? Follow up

	rates for Hispanic and Black members was higher than for White members. RAE7 agreed to look into this and provide more information. • A thought was shared if modality and the number of follow ups can be captured from each RAE to see if there were multiple attempts made. For example, to see if a follow up was successful after two follow ups as opposed to one. Spoken & Written Language: Behavioral Health Engagement • A comment was provided that it may be helpful to look at overall engagement -- physical health engagement or utilization – by language to see if trends track or if there's a difference would be more helpful and would give the data more context. To look at health system engagement and then to look at the difference would provide more context. Follow Up After Screening by Age • It was noted that the 0-2 age group has been excluded in this measure. The counts of anyone between ages 0-9 are under 100. Further discussion: • Feedback was provided to not limit the data to just well visits and to be able to understand behavioral engagement more broadly would be helpful. • It was recommended for the Department to hold a work session for those interested in discussing the data further. There was agreement and a meeting will be scheduled. • It was shared that having the data exported and possibly having screenshots of the data would be helpful to provide to the RAEs and other groups. This can be used as an alternative method to sharing data while a process is still being determined. • There was interest in seeing what trends took place over COVID and if there were significant changes for some of the minority groups. The Jefferson Center for Mental Health suspects this is true and aligns with their data.
BP/CS/Dept	**Wrap up and next steps** • The next meeting is scheduled for Thursday, February 25, 2021. • Further discussion to occur around the recommendations and questions that can be answered. Interest among group was gauged for those wanting to participate in a working session prior to the next meeting. • It was asked for the RAEs to have a behavioral health representative available in an upcoming meeting that could provide the best insight on the measures. • Additional questions and suggestions can be sent to Liana Major to be included in the next meeting.

Meeting Action Items					
Date Added	**Action No.**	**Owner**	**Description**	**Due Date**	**Date Closed**
2/25/2021	1	Dept	Invite RAEs and a behavioral health provider to the next meeting	2.15.2021	
2/25/2021	2	Dept	Schedule a follow up meeting with PMME volunteers to review the dashboard 2.0 version	3.10.2021	
