Performance Measurement and Member Engagement
PIAC Subcommittee
Minutes

Meeting Information			
Date	Thursday, February 25, 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: (1) Learn more about HCPF's equity strategy and upcoming efforts; and (2) Collectively analyze and improve a journey map depicting how members obtain access to care for depression and the respective roles of providers and RAEs.		

Voting Members and Participants
Voting Members Present: Jill Atkinson (Community Reach Center), Eli Boone (Colorado Health Institute), Bob Conkey (Health First Colorado member), Kayla Frawley (Clayton Early Learning), Ealasha Vaughner (Health First Colorado member), Angie Goodger (CDPHE), Valerie Nielsen (CCHN), Brandon Ward (Jefferson Center for Mental Health), Luke Wheeland (The Arc), Janelle Jenkins (Health First Colorado member) **Voting Members Absent:** Gary Montrose (Young People in Recovery), Deb Barnett (Connecting Points Advisory) **Co-Chairs:** Bethany Pray (CCLP), Christina Suh (Phreesia/CHCO) **HCPF Staff:** Megan Comer, Sandra Grossman, Milena Guajardo, Maileen Hamto, Russ Kennedy, Amy Luu, Liana Major, Nicole Nyberg **Other Participants:** Marjorie Champenoy (RMHP, RAE 1)**,** Matthew Wilkins (Health Solutions, RAE 4)**,** Dawn Claycomb (Beacon, RAE 2 & 4)**,** Katie Mortenson (CCHA, RAE 6 & 7)**,** Camila Joao (CCHA, RAE 6 & 7)**,** Cindy Jimenez-LCSW (Pueblo Community Health Center), Mary Beckner (RMHP)**,** Melissa Schuchman (Beacon, RAE 2 & 4)**,** Heather Steele (RMHP, RAE 1)**,** Kellen Roth (COA, RAE 3 & 5), Susan Todd (STRIDE Community Health Center)**,** Cynthia Mattingley (RMHP, RAE 1)**,** Alex Scialdone (COA RAE 3 & 5)**,** David Keller-MD (CUSOM/CHCO) Charlie Schneider (BannerHealth, proxy for Dorma Eastman)

Speaker(s)	Description
BP/CS	Roll call and January meeting minutes approved. No abstention.
Maileen Hamto	**Introduction of the Department's EDI Officer and equity efforts** Maileen Hamto provided an introduction on her background and information about the Department's equity, diversity and inclusion (EDI) work. Maileen joined the Department in November 2020 and her task is to lead and support health equity, and workforce diversity and inclusion efforts. Maileen has worked in higher education, health care organizations, and philanthropic foundations tackling anti-poverty efforts. Her educational background includes an MS in Health Care Management and she is currently working on an EdD in Leadership and Educational Equity.

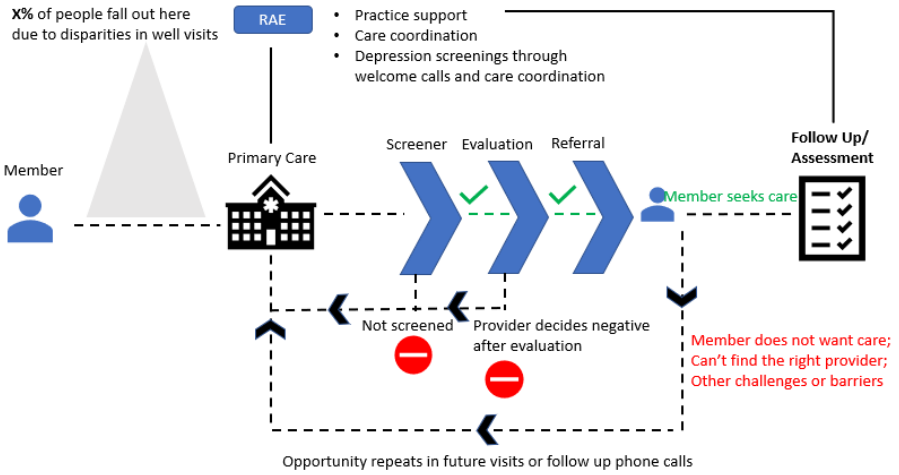
	Within the Department, there is a concentrated effort to ensure that the workforce is diverse as it would help in the collective effort towards advancing health equity. The health equity plan is being developed in collaboration with the Chief Medical Officer, Dr. Pete Walsh. There was discussion around cost control. Equity efforts often require upfront costs, so how is the Department thinking about that? The way the Department views cost control is that it does not always mean cutting costs in areas. There are many times where there is a need to invest in an area, like primary care and depression screening, in order to reduce costs down the road. It doesn't always mean cutting costs in an area but an opportunity to invest in costs that might bring savings in the long-term. The cost control office works to ensure that existing opportunities are used to pay for performance, and how they can connect equity to some of these issues and existing pathways.

CS/RAEs/Providers/ Members	**Analyze and improve the draft journey map for access to care for depression**
	The purpose of this discussion was to walk through three different lenses: member, provider, and RAE, to understand the depression screening and follow up process, specifically, what should happen and in reality, where the gaps or breakdowns occur. An image of the journey map can be found at the bottom of these notes for reference. It should be mentioned that this is a draft and this map will likely be altered to more accurately reflect what happens in practice.
	
	• The journey map represents one of many journeys as to how a member accesses behavioral health services. It varies depending on the member and other conditions. Also, sometimes the process starts backwards, with behavioral health doing the screening. The BHIP measures, though, focuses on primary care access to mental health care so this is why it is drawn this way.
	• The group asked whether we should we look at the concept of depression screenings and follow up care concept more broadly, not limited by how the BHIP measure is constructed which requires someone to have a well visit first. That would provide a fuller picture of screening and follow up. If one of our questions is, "How well is this measuring access," then perhaps we need to think about this differently.
	• Member Lens:
	  ○ A need was identified to focus on the processes between the screener, evaluation and referral. What happens in between these key steps?
	  ○ Patients may feel rushed or may not feel heard. More training for providers would be helpful.
	  ○ One member suggested that we focus on and break down the screening process and how to improve this step. This is where most people begin seeking help. How do we talk about depression? What questions should be asked? Get the screening numbers up first.
	  ○ There could be more education and advocacy to help members become more aware of the signs of depression.
	  ○ Some primary care providers may not necessarily willing to ask questions as they may not know what to do with a specific health concern of a patient.
	  ○ The group talked about the need for an equity and diversity approach to mental health care. There are

	cultural stigmas that can prevent an individual from pursuing care after a positive screening. It was mentioned that the group should be aware of this. ○ How are people being referred to culturally appropriate providers? One member shared that it's about the approach and not who specifically is approaching the member, as in asking the right questions. ○ There was further discussion around addressing cultural stigma and aversion to getting treatment. It was suggested to think about the difficulty that African Americans, Hispanics, and other races and ethnicities have in actually getting diagnosed. There was a study on unconscious bias and the diagnosis of disruptive behavior disorders in Attention-Deficit/Hyperactivity Disorder (ADHD) in African American and Hispanic youth that came out in 2019, that found that African American, Hispanic and other youth were less likely to receive an ADHD diagnosis than non-Hispanic, White youth. ○ There may be an opportunity to actually get useful data from members from the part of the map that leads to "Member does not want care; can't find the right provider; other challenges or barriers." For instance, what do we know about the drop out points along the path? Do we have data on members not being to find the right provider? Or are there other types of data that would help us get at why someone doesn't make it all the way through to care? Providers might have some data, but at the system level there is no data on this. • Provider Lens: ○ Not captured in the map is the frequency of positive depression screenings in which the primary care provider prescribes an anti-depressant and does not refer the member to a behavioral health provider. The BHIP measure does not count this. ○ The screening process is complicated and varies. Multiple screeners can be administered. For example, a majority of practices begin with a PHQ2 depression screener and if this is positive then a PHQ9 depression screening is done. If the PHQ2 is negative, then the process is stopped. ○ Providers sometimes feel rushed to go through all the steps. Sometimes they feel obligated to help but don't know what to do. ○ One provider mentioned that they don't understand the RAE's role. This community mental health clinic refers internally most often. ○ It was noted that primary care is doing a lot of the work for this measure but are not getting credit for the work they are doing. This may be a coding issue. ○ A mental health center commented that they screen every teenager who comes into their clinic. A positive screen doesn't necessarily mean a diagnosis of depression. Just because a screening is positive on a PHQ9, it doesn't give someone a diagnosis of major depression and doesn't mean that a full-blown mental health intervention is needed. All that may be needed at times is a follow up with the patient. This doesn't always result in a treatment process but may result in another screening for that individual and continued watch for any other elevations. ○ Integrated clinics have been able to provide better service where there is both a medical and a behavioral health provider available. Warm hand-offs are effective.

- In practices that are Federally Qualified Health Centers (FQHCs), this measure is not consistent all the way through with the depression measure in the Uniform Data Set (UDS) measure they are required to do. UDS is an annual reporting of various quality measures that FQHCs are required to report on. Some are physical measures. A depression measure was added a few years ago.

- RAE Lens:
  - RAEs said the codes are not adequately capturing all the work that's being done especially in primary care.
  - RAEs involvement may be when a member has a positive depression screen. The RAEs provide indirect care to the member in moving them through the process. For instance, the RAE may have connected the member to a primary care provider. Ideally, the RAE is overseeing and guiding the process, and that members are entering through primary care.
  - One RAE said that their role varies. If the member contacts the RAE to inform them of the issue, they will report it as an access to care issue and offer care coordination to connect the member with a different provider. It was discussed that this member-level data lives in many different sources and that there is not a good way for aggregating all of this different data.
  - Another RAE noted that they check on the primary care attribution status and try to ensure that members always have somewhere they can go to. Sometimes the member will initiate this contact through member support. The information is not captured in one place and is a part of multiple different processes.
  - One member suggested that a place for RAEs to lean in is to support and encourage primary care practices to do the screenings.



	Opportunity repeats in future visits or follow up phone calls
BP/CS	**Next steps** • Review dashboard version 2.0 • Recommendations can be made about the measure and the kind of interaction the group is hoping for, from the RAEs and primary care practices. There is a possibility of pursuing member-level data. • There is a multicultural psychology doctoral student group at the University of Denver available that could provide support to PMME and help dig into any policy implications. The students could provide tips and guidance to providers to reduce some of the disparities due to biases and barriers minorities face when seeking behavioral health care. Dr. Kathryn Fox was seeking opportunities for the students to get involved, learn and apply what they are learning to the community. A possible idea is to have the students propose recommendations to the RAEs, providers and the Department at the end of June. This will be further discussed in the next meeting in March. • The next meeting is scheduled for Thursday, March 25, 2021.

Meeting Action Items					
Date Added	**Action No.**	**Owner**	**Description**	**Due Date**	**Date Closed**
2.25.2021	1	LM	A small group of PMME members will meet before the next meeting to do a live review of the dashboard version 2.0	3.11.2021	3.11.2021

Reasonable accommodations will be provided upon request for persons with disabilities. Please notify Megan Comer at 303-866-2246 or megan.comer@state.co.us or the 504/ADA Coordinator hcpf504ada@state.co.us at least one week prior to the meeting to make arrangements.