Performance Measurement and Member Engagement
PIAC Subcommittee
Minutes

Meeting Information			
Date	Thursday, April 23, 2020	**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	Update from the Department on COVID-19, review data that indicates which Medicaid members may be at higher risk for contracting COVID-19, and provide feedback on the Department's proposed COVID-19 Performance Pool measures		

Voting Members and Participants

Voting Members Present: Jill Atkinson (Community Reach Center), Deb Barnett (Connecting Points Advisory), Eli Boone (Colorado Health Institute), Bob Conkey (Health First Colorado member), Jerry Evans (Community Health Initiatives), Angie Goodger (CDPHE), Valerie Nielsen (CCHN), Brandon Ward (Jefferson Center for Mental Health), Luke Wheeland (The Arc), Kayla Frawley (Clayton Early Learning)
Voting Members Absent: Gary Montrose (Healthcare Strategies)
Co-Chairs: Bethany Pray (CCLP), David Keller (Children's Hospital)
HCPF Staff: Jessica Bass, Megan Comer, Sabine Durand, Emily Ebner, Ben Harris, Anne Jordan, Dr. Lisa Latts, Amy Luu, Liana Major, Nicole Nyberg, Brooke Powers, Matt Sundeen
Other Participants: Renzo Amaya, Lynne Bakalyan (Beacon), Byron Burton, Clara Cabanis (CCHA), Lindsey Carnick (Beacon), Jeani Frickey Saito (SCL Health), Moses Gur (CBHC), Jen Hale-Coulson (Beacon), Lynette Johnson (Laradon), Lynne Jones, Anne Jordan, Agnes Markos (CO Access), Dom Martin (CO Access), Amy Moore (CCHA), Katie Mortenson (CCHA), Julie Nutter (Chaffee County Health Department), Anna Ouzts, Rachel Wisdom, Randi Addington (HCI), Tammy Arnold (NHP), Michopoulos (HCI), Alyssa Rose (Beacon), additional phone participants not captured

Speaker(s)	Description
Dr. Lisa Latts and Dept staff	**Department update on COVID-19 response** Overview • Dr. Latts shared the latest case data. As of April 23, there are currently about 11,000 COVID-19 cases, about 500 deaths, and 123 outbreaks in Colorado. • She also discussed Safer at Home and what is and is not changing as Colorado moves into the next phase of social distancing. • Enrollment has begun to increase but official projects are not available. Disenrollment from Medicaid is not allowed under most circumstances during the emergency time period, and the Department has increased its staff to handle the increased enrollment volume. • Dr. Latts briefly talked about the state's forecasted revenue shortfall due to COVID-19. • Regarding telemedicine, practices are utilizing telemedicine with the codes that are listed on the HCPF website. In

	particular, the Department is allowing Federally Qualified Health Centers, Rural Health Clinics, and Indian Health Services to bill for telemedicine visits. There has also been specific physical therapy and occupational therapy services that can be done via telemedicine. • There is a residential care strike force, per the request of the Governor. Its goals consist of trying to reduce the percentage of COVID-19 related deaths in residential care settings, reduce the spread of the COVID-19 illness once it occurs in a setting, and to increase the number of settings that have been COVID-19 free for 60 days. Q&A • There was a question about whether the emergency order will be extended since it's currently scheduled to expire on May 1. This will impact providers and their use of telemedicine. o The current telehealth expansion is set for 90 days from the date the Stay-at-Home order went into effect. • A question was posed about any insights on readmission policies for post-partum care and utilization of emergency rooms (ERs). o Obstetric (OB) care has been in discussion as the state has been hearing from advocates that women have not been wanting to go into these health care settings. The Department has been meeting with OB clinics. ERs are making efforts to separate COVID and non-COVID patients; however, people are still reluctant to be in these spaces. • There was a question about the denominator for the facilities' outbreak data. o The denominator (number of cases in facilities) is believed to be around 1,000. For Medicaid contracted facilities it is around 400. • A question was asked about having enough tests. o The current testing capacity for health departments is about 1,500 a day. The National Guard will be deployed to assist with testing.
DK, BP and Dept staff	Roll call and March's minutes approved. No abstention.
DK, BP	**Adding Medicaid members to the voting membership** There's an interest in having more Medicaid members participate in this subcommittee. Co-chairs requested feedback from the subcommittee. • Currently, there are 11 total members, and one active Medicaid member. • Kayla noted that Clayton Early Learning has a parent ambassador program that could be helpful in recruiting. • It was asked whether there will be a budget available to compensate members for participating. Currently, there is no budget for this. • The addition of adding up to four additional Medicaid members was proposed and approved. Dr. David Keller asked current voting members, with some expertise in data, to contemplate taking on the role as co-chair in the fall as his term will end then.
HCPF/CCHA/ DK/BP	**High risk COVID-19 list discussion: Review the data and learn how RAEs are applying the data** Overview of risk indicators • In response to COVID, the Department has come up with several risk indicators. Most risk indicators have come from research and has been updated as more information has been obtained. Additional indicators are added as more evidence becomes available. The RAEs receive a list of members at risk of COVID monthly and, at the member level, it identifies which member falls into which indicator bucket that is applicable to them.

	• The risk indicators mainly come from CDC data which are based on hospitalization rates.
	• A question was asked about older adults and if there is any way to differentiate older adults who are healthy and those less healthy.
	  o The age indicators (risk levels 1-3) do pull in a lot of members that may be healthy but not have other underlying conditions that put them at higher levels of risk. But higher risk levels can indicate people who are both older and unhealthy.
	• There was a question asked if the Department has considered also adding the risk of exposure as a factor. For example, those who work on the front-line, and their exposure to high-risk family members, their inability to isolate, etc.
	  o Per Colorado Community Health Alliance (CCHA), this category has not been included in their data.
	  o Risk factors beyond medical conditions have not be included so far in the Department's analysis.
	• There were further thoughts if the Department can add race and ethnicity data to the risk indicator.
	  o In a response from HCPF, the reason it has not been added is due to the research showing that certain races and ethnicities have more underlying health conditions and that is why they've been more at risk. These underlying health conditions are included in the risk indicator.
	  o It was also mentioned that access is also an issue by race and ethnicity. In response, CDPHE has been including race and ethnicity in their data.
	CCHA provided an overview of their utilization on how the COVID-19 risk data is being utilized and how they are engaging members.
	• Their member outreach goals were to support members' health care needs, mitigate risk, and educate members on applicable and available resources.
	• They tiered their member outreach campaign. The tiers were based on risk stratification, current engagement with CCHA, current engagement with Single Entry Point agencies/Community Centered Boards (SEP/CCBs), behavioral health and physical health needs, and the members already outreached by the Accountable Care Network. CCHA used the following methods of communication like, outbound calls, text messaging and social media. They also used their call center and website for COVID-19 resources.
	• Outbound calls began to members with a risk level of 9+ and members with a transplant. Calls were also made to members in corrections, foster care and maternity. (For CCHA's full approach, please view their presentation slides.)
	• SEP, CCB and nursing facility support included, the CCHA Population Health Nurse reaching 40 facilities via phone to offer support, and complex case reviews with SEP/CCBs occurring monthly and includes reviewing outreach and case management plans for COVID-19 high risk members.
	• Behavioral health provider support has included efforts such as, telemedicine webinars with more than 250 participants, telehealth town halls, and COVID email alerts with a more than 50% open rate.
	• In collaboration with community partners, CCHA developed a care coordination workflow for positive COVID-19 cases with public health.

Dept staff	**Update on changes to performance pool measures considering COVID-19** This is an opportunity to use performance pool money to support regional needs and reward the RAEs for their current work regarding COVID. • The metrics are COVID specific.

	o The first part of the proposed metric asks RAEs how they are conducting outreach and engaging members, and on how they are supporting providers financially and through practice support. The RAEs would be required to document their efforts. o The second part of the proposed metric would have the RAE report demonstrate an XX% successful engagement of members on the COVID member risk list. The report will be similar to that used for the Complex Care Report. • Feedback from the RAEs has been requested by the Department for proposed COVID metrics parts one and two. • The goal is to get money out to providers. • The Department proposed two different activities for what could constitute as outreach and engagement. It was proposed for the RAEs or providers, to conduct outreach by mail and uni-directional electronic communications (e.g., IVR calls, texts, email) to their members. The RAEs and providers need to have a plan that offers at least three different ways of contacting members. For engagement, they need successful, bi-directional electronic communications (e.g., live calls, telehealth, two-way texting, apps, etc.). • The RAEs may risk stratify their population as they see fit using the new high-risk list and as clinical guidance evolves. RAEs must offer outreach services to all high-risk members. And RAEs must offer engagement services to at least some percentage of higher risk members. • The Department proposed a performance targets of having RAEs do 100% of outreach to members, possibly just members on the high-risk list. The 22% floor for engagement has been suggested based on existing care coordination data. • Lastly, the Department suggested what could constitute as provider practice and financial support. It can be through operational support by allowing services for continued care provision (e.g., practice support, direct supplies, etc.), or through financial support by doing direct financial payments to providers. All of the money is required to go into one of these categories. The RAEs are asked to report on money and providers served in each category. o A comment was made that private practices are running at about 20% of their volume and are not generating enough revenue. Discussion and Feedback on the Metrics • Of PMME members who spoke, it was generally agreed that the goal of outreach should be to connect members with providers as opposed to the RAE. There is a need for RAEs to help providers. It would be helpful to spell out the objectives of what this entails such as, what's the benefit of connecting with higher risk members in terms of COVID-19, and what we're wanting to see happen. Some assurance that high risk members are actively connected with their PCP is ideal. • It was also mentioned that there is no incentive for connecting with behavioral health providers. There is a desire to see mental health centers considered as well. • It was suggested for the RAEs to assist with preventive care and to discuss how the RAEs can assist providers. Next steps • The Department will request additional written feedback by Tuesday.
DK/BP/Dept	**Housekeeping and Wrap-up** • Next meeting: o Thursday, May 28 from 3 – 4:30 PM

Meeting Action Items					
Date Added	**Action No.**	**Owner**	**Description**	**Due Date**	**Date Closed**
4/23/2020	1	LM	Begin recruitment of up to 4 Health First Colorado Members. Schedule a meeting with Kayla and Sarah Eaton.	TBD	
4/23/2020	2	LM	Collect additional feedback on COVID-19 performance pool measures from PMME and stakeholders to share with Department leadership.	4/28/2020	