Performance Measurement and Member Engagement
PIAC Subcommittee
Minutes

Meeting Information			
Date	Thursday, August 27, 2020	**Time**	3:00 – 4:20 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 purpose of this subcommittee meeting is to prepare for onboarding of new members, to continue to determine the PMME scope of work, and to follow-up on the prenatal KPI and other relevant topics.		

Voting Members and Participants
Voting Members Present: Eli Boone (Colorado Health Institute), Bob Conkey (Health First Colorado member), Kayla Frawley (Clayton Early Learning), Angie Goodger (CDPHE), Valerie Nielsen (CCHN), Luke Wheeland (The Arc) **Voting Members Absent:** Jill Atkinson (Community Reach Center), Deb Barnett (Connecting Points Advisory), Jerry Evans (Community Health Initiatives), Gary Montrose (Young People in Recovery), Brandon Ward (Jefferson Center for Mental Health) **Co-Chairs:** Bethany Pray (CCLP), David Keller (Children's Hospital) **HCPF Staff:** Morgan Anderson, Megan Comer, Amy Luu, Liana Major, Nicole Nyberg **Other Participants:** Tammy Arnold (NHP), Lynne Bakalyan (Beacon), Marjorie Champenoy (RMHP), Kate Hayes (Planned Parenthood of the Rocky Mountains), Camila Joao (CCHA), Nicole Konkoly (RMHP), Catherine Morrisey (NHP), Katie Mortenson (CCHA), Tim Morton (Mile High Health Alliance), Tony Olimpio (CCHA), Kellen Roth (COA), Jen Hale-Coulson (Regions 2 and 4)

Speaker(s)	Description
BP/DK	Roll call and July's meeting minutes approved. No abstention.
BP/DK/LM	**Discuss member orientation** • New and current voting members provided an introduction. Members were asked to share the organization/perspective they are representing and what brought them to PMME. • 3 new voting members were unanimously approved.
BP/DK/LM	**Review priority survey responses from PMME members and discuss PMME scope of work** • Conversation initiated about finalizing the PMME scope of work, with the reminder that nothing is set in stone as sometimes it's necessary to revise based on changing needs or circumstances. • One-half of the respondents were in favor of PMME focusing on reducing health disparities this year with a particular emphasis on racial justice. It was noted that some of the respondents that indicated they were not in

favor interpreted the survey question to be asking if racial justice should be the primary or only focus. They said it should be one of many topics PMME works on.

- The survey topics felt broad and it would've been helpful to have been more specific.
- The group discussed the top-ranking topics from the survey as well as two write in responses which did not receive votes:

Highest Ranking Topics	
Select 1-3 measures to analyze and explore based on largest disparities, including by race/ethnicity	9 votes
Find ways to measure and improve cultural competency in the system to benefit member experience	9 votes
Find ways to better measure care coordination for members	6 votes
Guide public reporting efforts and alignment of measures	5 votes
Use CAHPS survey to add questions, analyze data, or consider paying on member experience measure	5 votes
Write in: Changes in the incidence of people with BH AND SUD paid / requests for diagnoses and recovery services, by age, race, and geographic areas.	1 vote
Write in: Advocating for the disaggregation of data based on race, prioritizing metrics of quality and performance that show which providers are focusing on addressing racial disparities, if need be creating metrics, support a racial data lens to quality improvement.	1 vote

- Support was offered for the second write-in topic. Someone added that they have always been surprised that HCPF doesn't look at disparity data and that it's important to do so. This group may also want to eventually discuss whether to focus on RAEs or providers as it pertains to disparity data, since there are measure sets for both.
- A member shares that the focus should be on providers since changes will more directly impact the person receiving care (more accountability and benefit to members). RAEs do have some influence over providers because of the way the ACC is designed with incentives for performance. But there is still not enough impact to the member. Perhaps Medicaid members could provide disparity data or information directly and make that tied to payments. A member discussed something they could fill something out after an appointment that could go directly to Medicaid so results about their experience wouldn't be skewed by providers.
- It was acknowledged that finding better ways to bring the member experience into the discussion is important and

	there needs to be better ways to do this. • From a voting member's experience, relying on patients to complete surveys may not be doable as some may not want to complete these surveys. It is important to inform patients how the data will be used before they take the survey. Some patients may not understand why surveys are being given to them. It would be helpful to include a statement on the purpose and use of the data. Lastly, some Medicaid members have not felt heard and do not feel like changes are being made from the feedback they provide, which influences whether they want to take a survey in the first place. Members want to ensure that if they're taking the time to fill something out, that they will experience better care as a result. • For Medicaid members with developmental disabilities, surveys are typically a low priority for them because they are seen as more paperwork. • To summarize, there is an interest in doing a better job at measuring and engaging with Medicaid members in a way where they understand that their feedback is meaningful, and also finding ways to obtain disaggregated data by race for existing measures. There is interest in pursuing both paths simultaneously. • A suggestion was made to form a team of advocates, assign them to Medicaid recipients so they may be a sounding board to help direct the recipients. These advocates would be paired by similarity of culture, language, and family unit so there would not be any barriers to communication and to prevent people from falling through the cracks. It could also increase the amount of information we can collect from the community. o To obtain quick and meaningful responses, it should be face-to-face where the Medicaid members are engaged. o It was mentioned that the Department and the Regional Accountable Entities (RAEs) have member advisory/ambassador groups that are intended to increase direct member participation. • Additionally, it would be helpful to break the stigma Medicaid members experience and focus on racial disparities that are most important to BIPOC communities. • What is needed is data that reflects the issues of disparities and trying to come up with ways to incentivize providers to do something about this. The notion of trying to figure out the best way to bring the member voice into these discussions. A task may be to think about a practical way, as a subcommittee, to make recommendations. • A thought was shared that Medicaid members may not know what good care is if they haven't experienced it or don't have anything to compare their experience to. Members need to know what they should expect so they can provide helpful feedback. For example, when should someone expect a referral to a specialist? There is always going to be some variation across providers but teaching people to know when and how to advocate for themselves is important. • Northeast Health Partners (region 2) said their Member Experience Advisory Council (MEAC) has worked on defining what is "good care." Members were asked for input about their idea of good care and not-so-good care as well as expectations from their provider. o Good care: ▪ Not having the money for a co-pay and still being seen.

	▪ Not having a long wait. ▪ Having a provider that listens to me, not one that just hears. When providers actually listen, they ▪ provide better care. ▪ Having a provider that helps me get better, not just prescribe medication ○ Not-so-good care: ▪ Not seeing me on time. ▪ Not listening. ▪ Just prescribing medication. ▪ Specialists just line people up. The more people, the more money. ○ Expectation: ▪ Expect to be treated like a person and not a number. ▪ Address health concerns timely. ▪ Be attentive. • The group talked briefly about what a Regional Accountable Entity (RAE) is. The state of Colorado pays organizations in 7 regions of the state to manage Medicaid. These organizations are RAEs, and they receive money from the state to do this work in exchange for creating a network of providers, for instance, and coordinating care for members, and ensuring all members are connected to a PCMP and have access to mental health and SUD treatment (among other activities). • Northeast Health Partners also said that they are interested in an accountability metric to address these more systemic issues in the health care system. Working with race data is complicated as data aren't always complete. Sometimes this is because members have not wanted to disclose this information. There is a sizeable refugee and immigrant population in their region who do not want to report their race. So, RAE2 has used vital statistics provider-level data to try and supplement for the data they're unable to obtain. • Beacon Health Options (region 2 and 4): MEAC summaries are available on Health Colorado, Inc. and Northeast Health Partner's websites. These websites are regularly updated. The goal has been to educate to all members on what a "RAE" is.
BP/DK/Dept	**Subcommittee updates:** • These updates were postponed and will be discussed at a later meeting. • The group discussed potentially covering APM during the September meeting.
DK/BP/Dept	**Wrap up and Next Steps** • The group will have a chance to look at onboarding materials at the next meeting. • Next meeting: ○ Thursday, September 24 from 3 – 4:20 PM