Performance Measurement and Member Engagement
PIAC Subcommittee
Minutes

Meeting Information			
Date	Thursday, March 25, 2021	**Time**	3:00 – 4:30 PM
Location	Virtual attendance only	**Call-in Number**	253-215-8782 or 346-248-7799 Meeting ID: 939 1214 7561 Passcode: 385864
		Webinar link	https://zoom.us/j/93912147561?pwd=eG1xR2JLMmZmeDU0VXhwU051dnZjdz09
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) review behavioral health equity data from the revised dashboard (version 2.0); discuss key take-aways and next steps to better understanding the data and how it compares to what is happening in practice; (2) follow up on PMME's CAHPS survey recommendation including ideas for next steps on efforts specific to member engagement and experience.		

Voting Members and Participants
Voting Members Present: Jill Atkinson (Community Reach Center), Eli Boone (Colorado Health Institute), Bob Conkey (Health First Colorado member), Angie Goodger (CDPHE), Valerie Nielsen (CCHN), Ealasha Vaughner (Health First Colorado member), Brandon Ward (Jefferson Center for Mental Health), Janelle Jenkins (Health First Colorado member), Luke Wheeland (The Arc), Kayla Frawley (Clayton Early Learning) **Voting Members Absent:** Gary Montrose (Young People in Recovery) **Co-Chairs:** Bethany Pray (CCLP), Christina Suh (Phreesia/CHCO) **HCPF Staff:** Megan Comer, Sandra Grossman, Milena Guajardo, Amanda Jacquecin, Russ Kennedy, Amy Luu, Liana Major, January Montano, Nicole Nyberg **Other Participants:** Katie Gaffney (Denver Health Medicaid Choice). Lynne Bakalyan (Beacon, RAE 2 & 4), John Mahalik (Beacon, RAE 2 & 4), Kellen Roth (COA, RAE 3 & 5), Melissa Schuchman (Beacon, RAE 2 & 4), Kimberly Phu (Colorado Health Institute), Frank Cornelia (CBHC), Alyssa Rose (Beacon RAE 2 & 4), Colleen Lampron (Caring for CO Foundation), Wilson Araque (Peak Vista Community Health Centers), Jen Hale-Coulson (NHP, RAE 2), Marjorie Champenoy (RMHP, RAE 1), Andrea Cortez (Inner City Health Center), Brace Gibson (Colorado Perinatal Care Quality Collaborative), Lisa Ramey (Peak Vista Community Health Centers), David Keller (CUSOM/CHCO), Katie Mortenson (CCHA, RAE 6 & 7), Camila Joao (CCHA, RAE 6 & 7), Samantha Fields (Health First Colorado member, MEAC, RAE 7 MAC, RAE 7 PIAC)

Speaker(s)	Description
LM	**Updated group conversation guidelines** PMME conversation guidelines were presented. Voting members of the subcommittee were encouraged to engage in conversations following the guidelines. Non-voting members were encouraged to engage in conversations through the chat function or during a public comment period.

BP	**Approval of minutes** Roll call and February meeting minutes approved. No abstention.
Nicole Nyberg	**Request for the groups interest in the APM Workgroup** The Alternative Payment Model (APM) stakeholder process will be starting soon and subcommittee voting members are invited to attend these meetings. This is optional. This group will discuss measurement changes to the 2022 program year. It is the primary care APM and there will be six meetings over the span of six months. The meetings will be more specific to APM 1. There is one meeting dedicated to looking at equity within the program. It would be most valuable to commit to all meetings, but if someone cannot attend them all, it's still possible to participate.
BP/DK/LM	**Behavioral Health Equity Dashboard 2.0 review. Discussion of key take-aways, questions, and next steps.** Dr. David Keller shared the key take-aways from the interim PMME meeting on the data dashboard. • The Overall Screenings measure was broken down by age group. There was a high percentage of teenagers screened in comparison to the other age groups. The percentage of teenagers screened was higher than expected as this population can be difficult to reach. • The group was interested in understanding what happens for members below the age of 12. What screening tools are available, and how are they screening? One PMME member mentioned that for kids younger than 12, screening still happens but it's not done with a validated tool. You have to ask questions and tease it out clinically. • The older adult screening rate is also a concern because of how low it is and suicide risk. • The Overall Screenings measure was also disaggregated by race/ethnicity. Black and Hispanic/Latino had higher screening rates in some regions, but follow up is disproportionately lower. Asian members experience the lowest percentages of follow up care. These disparities in access to care by race/ethnicity are also more visible in the behavioral health engagement measure. The American Indian/Alaska Native population looked better than anticipated. In some regions their screening rates were higher than the White population. • There is a need to figure out what more specific options could be included in the Asian category. Currently, it's not possible to look at the data this way. • There is a lot of variation in screening rates by region. Regional accountable entity (RAE) 7 had the highest rates of depression screening among the other regions while RAE 2 and 5 had the lowest screening rates. It was discussed that this could be due to some providers only screening certain patients and larger provider offices screening all patients. • Another issue is that federally qualified health centers (FQHCs) are getting paid a case rate, so they may not be coding for screenings. RAEs 2 and 5 have a large number of members being seen at FQHCs. The FQHCs are working on improving this as they are made aware of it. • RAE 2 commented that they have been researching to identify reasons regarding why their screening rates are so low, and one reason is the billing codes. They've opted to do a performance improvement project with one of the largest providers that serves a vast majority of the members within their region. They found that screenings are happening significantly more so (based on clinical data) than indicated in the billing of the G codes. This will also be investigated by race/ethnicity and other characteristics. • Are practices generally screening everyone or no one, or picking and choosing? No concrete answer at this time. RAEs are seeing screening rates vary by practice. A question was asked if the subcommittee felt like they had all of the information needed in order to make recommendations.

	• If there are enough interesting research questions, there is a possibility to work with the student group to do a deeper dive.
	• The list of questions that the group is wanting further information on is noted below.
	  ○ Focus on depression screening for kids and teenagers, especially those under 12.
	  ○ To what extent are screenings happening but not getting billed for and how much this is impacting the data?
	  ▪ A possibility to focus on the data already obtained to understand the differences between FQHCs versus other practices.
	  ○ Identify barriers or opportunities for more screening for the age group of 50 and up as it was mentioned that there was a higher rate of suicide among this population.
	  ○ How many different screenings are used, what differentiates them, and what qualifies as a screener?
	  ○ Suggestion of looking at the language data. What does the screening process look like for someone whose primary language is not English?
	  ○ Possibility of picking a few different sites in Colorado working in different parts of the state, for example, one rural and one urban, and a practice that is doing a great job and another practice working on efforts to improve their screening rates for the student group to conduct interviews on.
	  ○ Does reimbursement for screenings vary between the RAEs and what is the range in amounts?

LM/BP	**Member engagement and CAHPS follow up conversation**
	The CAHPS survey is sent to members who have had a primary care visit. There was a discussion on the recommendations made for the CAHPS survey.
	• The following below were the recommendation components.
	  ○ Make RAE reporting on CAHPS-based interventions and outcomes public
	  ▪ It was recommended to think about the level of information being shared. At what point is the level too low to report publicly.
	  ○ Require RAEs to share CAHPS data and work on interventions with Member Advisory Councils
	  ▪ One option is to prioritize one intervention to share and report on.
	  ▪ Some felt that the requirement to work on interventions and prioritizing could be a lot. The group could think about how they can leverage the work the RAEs are doing and aligning that with what is being seen in the CAHPS data.
	  ○ Encourage RAEs to collect more data and information on CAHPS questions about feeling heard and respected. Use this to link members to culturally responsive care and to determine whether provider trainings on cultural competency are effective.
	• The Department shared that RAEs are supposed to share CAHPS results directly with providers (for those that participated). Processes are forgivable but interaction between provider and member is what truly makes the difference in terms of member experience.
	• Need more communications between the regional Member Advisory Councils (MACs) and Program Improvement Advisory Councils (PIACs), and the state Member Experience Advisory Councils (MEACs). There is a need to take the data and turn it into action or else the survey would be useless.
	• Further discussion to occur on ways to integrate the qualitative data coming from regional MACs, PIACs, and the state MEAC in preparation for the next meeting.

BP/CS	**Next steps** • The next meeting is scheduled for Thursday, April 22, 2021. • Dashboard 3.0 is coming (likely for May meeting). • Possibility to review SFY 19-20 BHIP data and measure alignment. • Quarter 1 of KPI data will be available.

Meeting Action Items					
Date Added	**Action No.**	**Owner**	**Description**	**Due Date**	**Date Closed**
3.25.2021	1	HCPF	Continue improving the depression/behavioral health equity dashboard.	5.27.2021	
3.25.2021	2	HCPF	Collaborate with DU students to develop a project proposal.	4.1.2021	

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.