Performance Measurement and Member Engagement
PIAC Subcommittee
Minutes

Meeting Information			
Date	Thursday, August 26, 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 was to (1) review recommendations and key take-aways from the mental health equity work (January – July) for a presentation to PIAC in September; and (2) learn about how and where to access performance results for the ACC program, including COVID equity data.		

Voting Members and Participants

Voting Members Present: Jill Atkinson (Community Reach Center), Brandon Ward (Jefferson Center for Mental Health), Bob Conkey (Health First Colorado member), Janelle Jenkins (Health First Colorado member), Ealasha Vaughner (Health First Colorado member), Valerie Nielsen (CCHN),

Voting Members Absent: Kayla Frawley (Clayton Early Learning), Angie Goodger (CDPHE), Gary Montrose (Young People in Recovery), Luke Wheeland (The Arc)

Co-Chairs: Bethany Pray (CCLP), Christina Suh (Phreesia/CHCO)

HCPF Staff: Liana Major, Audrey Keenan, Erin Herman, Ann Marie Stein, January Montano, Nicole Nyberg

Other Participants: Edward Arnold, Performance Improvement Analyst. Beacon- RAE 2/4, Camila Joao (CCHA RAE 6 & 7),), Nicole Konkoly (RMHP, RAE 1), Chelsea Watkins (RMHP), Dawn Claycomb (RAE 4), Natahsa Lawless NHP, Nayeli Villalobos, Kate Hayes (PPRM), Samantha Fields (Health First Colorado member), Brian Robertson (NHP, RAE 2), Lynne Bakalyan (Beacon, RAE 2 & 4), Emilee Kaminski (CHCO)

Speaker(s)	Description
BP	**Approval of minutes and updates** Roll call and June meeting minutes were approved. No abstentions.

BP	**Discuss and review key take-aways and proposed recommendations on mental health equity and an equity approach to performance measures**
	
	The group reviewed 5 potential recommendations and shared their ideas regarding them. In addition, the group reviewed some key takeaways from the DU student project on depression screening.
	
	Recommendation #1: All performance measures should be broken down by demographics
	• CS added that you don't know what is in the data if you don't look at the data.
	• A few members agreed that this would be a good recommendation.
	    ○ Would direct further research and allow people to focus
	• A member asked if are we recommending how this data should be reviewed and incorporated into operational analysis?
	    ○ BP clarified that this recommendation just refers to how data is reviewed and doesn't specify how it will be used.
	• LM shared that this is a priority for the Department and that the Department is beginning to gear up for this work.
	• BP asked if we could put a timeline on this (e.g. no later than July)?
	• A few members requested to add Rural, Urban, and Frontier in the data disaggregation.
	    ○ LM agreed this would be a good idea but is not done at this time. The Department would need to create this identifier.
	• There was general agreement amongst group members in favor of this recommendation. Needs to be done by Jan 2022 for contract phase (1st choice) or July 2022 (2nd choice).
	
	Recommendation #2: Before selecting new measures, it is essential to analyze whether specific groups of members are excluded from the base population (including high churn members)
	• An important note is that sometimes people are excluded who are not in the data for the entire year.
	    ○ Example: People who are unhoused may not be in the system for a full year
	    ○ Example: In the depression screening measure, anyone who didn't have a primary care visit that year was excluded from the analysis
	• A member shared that if we are using validated measures, they often require a minimum of one year of data. This makes it difficult to act on data that is less than a year.
	    ○ Perhaps, in this case, specify who is excluded from the measure. This would bring transparency to the data. We have to at least be able to name it.
	    ○ In situations where a full year of data isn't mandatory, then efforts should be made to include them.
	    ○ BW: It is hard to operationalize these when the transparency is fuzzy. Need to make sure everyone knows and likes the recommendation.

	○ One member suggested that there could be tracking of which groups have been excluded and a record of which group keeps getting excluded. Perhaps add language about who we have accepted/excluded and then this data could be analyzed separately. *Recommendation #3: For each new performance measure that's considered, evaluate the equity implications broadly* • Where are the disparities, what magnitude are they, are there clear and concrete equity intervention points where accountability is feasible? Give it adequate time to find out. • BP asked if we use research to learn which interventions are effective, do you think this should be a stakeholder process? • CS said that whatever measure we are acting on, we should ask whether it's feasible to reduce the disparity since there is only oversight of the RAEs. • A few members expressed that they liked this recommendation. ○ Helps us think outside the box, offers a different perspective. • One member asked if there are clear definitions and who will identify the concrete and clear? *Recommendation #4: If one RAE is hitting it out of the park in performance, the Department should make it required that the other RAEs also adopt the best practice* • Several members expressed concerns regarding this recommendation. ○ What works for one population may not work for another. ○ Instead of mandating, could the RAE share with the other RAEs? For example, utilize the ACC Learning Collaborative. ○ If a RAE must do one thing, then this takes their energy away from where their RAE may actually need to be focused. ○ One member suggested adding verbiage at the end of the recommendation, "where applicable" ○ There should be development of best practices and encouragement to comply but a that a one size fits all doesn't work and doesn't advance health equity • Based upon feedback in the meeting, group to consider refinements to this proposal. *Recommendation #5: Tie performance dollars to disparity reduction.* For example, for a given measure, half of the dollars could be for overall improvement and half for disparity reduction • A member mentioned that they like this measure because it doesn't require perfection and it incentivizes improvement. • A member cautioned that one potential challenge with this recommendation is that you can reduce disparities in two ways. 1. Improve services to the group that needs it 2. Reduce services to the group that doesn't need it

	• One member asked if the recommendation could be reworded so that it's less punitive because if you might get penalized, you might avoid taking that risk. Is there a way to reward process versus outcome?
	• A member asked if there could be different incentive measures, such as decrease by 10% or 20%?
	• LM shared that other states are doing similar things so we could look elsewhere for guidance. There is time to research and learn about the best way to approach this before it is implemented.
	
	Key Takeaways from the DU student Project on Depression Screening and Follow Up
	The key takeaways include:
	• Expand screening for kids under 12 using the validated tools available
	• Ensure all providers are screening for suicidality and have the tools to effectively support members
	• RAEs could provide training and support to providers on health equity practices & how/why to disaggregate their data by demographics.
	• Make the screening process more meaningful, comfortable (not just a check the box), and track who is opting out
	• Explore a better follow up mechanism to ensure fewer people fall through the cracks when trying to access behavioral health care
	
	• One member expressed a specific desire to focus on bullet #2 and that all providers are screening for suicidality and that they have the tools to effectively support members. For example, if there is no one in the building for a warm handoff, what is the plan? And then afterwards, how do we ensure follow-up with the member? So, perhaps more training is needed on what to do when someone isn't available.
	• RAEs were invited to chime in on this (providing training on the suicidality and make sure they have the resources):
	  ○ LB shared that that there is a new initiative that will implement a behavioral health screen available for everyone (behavioral health well-visit). Goes into effect January 2022 (approximately). This is a state mandate for commercial plans. This isn't Medicaid specific.
	• One member felt this behavioral health screen could be helpful, but how do we improve greater coordination with other agencies etc. and how do we alleviate the burden? In that moment of Member need, if the behavioral specialist isn't available, who can they get on the phone to help?
	• Another member shared that there is a lot of support and training on how to handle Members in need, but the problem is that the providers' time is so tight. There are a lot of services out there so how do we utilize those resources?
	• Group would like to add at least one recommendation from the DU presentation learning (maybe specifically about suicidality (2nd bullet).
	  ○ The recommendation could be shared with the Behavioral Health subcommittee.

LM	**Introduction to where performance results exist on the Department website (public reporting page) and how to interpret the data.** • LM walked the group through data that is available to view on the Department website and shared where the public

	can view the latest ACC program data. • There is always a three to five-month lag for data since this comes from claims. • It is possible to see high level data for each RAE and identify variation across regions. • For example, looking at pediatric well visits, one can see that Covid really impacted the number of visits. The number of visits in most regions has started to climb again. • LM suggested that a smaller group could go through this data for those who are interested. Please let LM know if this is something you would like to do. Regular review of the data • The group discussed options for regularly looking at the performance data. • Options include: The RAEs present the data, could do a quarterly look at the data, or could be a look at the KPIs. • The group landed on quarterly review of performance data. Takeaways can be shared with the PIAC. Well Child Care: New KPI this year starting in July 2021 • This is a standard national measure (CMS Core Measure) which has been validated and will allow us to compare Colorado to other states. • It's a little complicated because there are several age groups. o *Part 1:* ▪ *Ages 0-15 months: 6 or more well visits with a PCMP* ▪ *Ages 15-30 months: 2 or more well visits with a PCMP* o Part 2: ▪ *Ages 3 -21 years old with one or more well visit with a PCMP* • LM presented the baseline data for Part 1 and Part 2. Colorado is a very low performer. Lots of opportunity for improvement. • Several members expressed interested in the PMME committee exploring and evaluating this measure.
BP	**Public Comment** There were no public comments
LM/BP	**Wrap Up** • PMME is recruiting new voting committee members. We would love your suggestions or recommendations of interested individuals. Please contact the committee chairs or Erin Herman (erin.herman@state.co.us) if you have any questions. Applications are due September 15th and the term will begin in October. Applicants can apply using this link • The next meeting is scheduled for September 23, 2021 from 3:00-4:30pm.

Reasonable accommodations will be provided upon request for persons with disabilities. Please notify Erin Herman at 303-866-2246 or

erin.herman@state.co.us or the 504/ADA Coordinator hcpf504ada@state.co.us at least one week prior to the meeting to make arrangements.