COLORADO
Department of Health Care Policy & Financing

MINUTES OF THE MEETING OF THE HEALTH IMPACT ON LIVES: HEALTH IMPROVEMENT SUBCOMMITTEE

303 East 17th Avenue 7th Floor Conference Room 7B
August 26, 2015

Call to Order

The meeting was informally called to order at 3:02pm by Rachel DeShay.

Roll Call

A. Members Present
Bartilotta, Kathy; Bodart, Brooke; Bontrager, Jeff; DeShay, Rachel; Keller, David; Kennedy, Russ; Koltonski, Christian; Mathieu, Susan; Nottingham, Brandi; Rieder, McKenzie;

B. Members on the Phone
Encizo, Becky; Forbes, Elizabeth; Harris, Helen; Hejny, Marilyn; Hudson, Jackie; Lessley, Todd; Nate, Jenny; Neil, Michael; Peck, Alex; Reeder, Lesley; Rich, Anita; Wheeler, Justin

General Announcements

Date and location of the next Health Improvement Meeting: The next meeting is scheduled to be held Wednesday September 23, 2015 beginning at 3:00 p.m. at 303 East 17th Avenue, Denver, CO 80203, Conference Room 7B

Approval of Minutes

There was not a formal motion made to approve the minutes from June 24, 2015. However, as we did not meet in July and the facilitator did not receive edits, the minutes have been unofficially approved.

Discussion

A. PIAC Meeting Report-out

It was noted that not even half of the agenda was addressed in the last PIAC meeting. There was a robust discussion on Primary Care ACO (Accountable Care Organization). The idea of the program is to do more intense case management and have a more robust set of measures all while exploring an alternative payment methodology process. Kaiser group will be assuming risk for primary care and certain primary care codes can be used. The group did not get to the discussion of

care coordination under the new contract. Hopefully this will be talked about at the next PIAC meeting, September 16th.

The Department made a policy decision to change attributions for people when there is a stronger relationship with a PCMP that is not their current PCMP. The existing algorithm will be used for this process and it will be run quarterly (not monthly). There was an agenda item regarding updating the bylaws and adding behavioral health representation to the PIAC. The PIAC will be adding three voting members and two ex-officio (non-voting) members from the behavioral health world. The three voting members will include; a) a behavioral health or substance use clinician from a CMHC, b) a behavioral health or substance use clinician from a provider other than a CMHC, and c) a client representative. The two non-voting members will include; a) a representative from the dental world, and b) a representative from a BHO. The addition of those members was voted on and approved. A bylaw was written to expand the PIAC by 4 members. Finally, the future PIAC meetings will be 3 hours, to allow for discussion of the current ACC and the next version of the ACC.

B. **Colorado Opportunity Project Presentation –** Murielle Romine began her presentation on the project. She shared that this is the second year of this project. The project was a directive from the Governor of Colorado to align and find metrics that could allow for better alignment across State Departments. The tri-agency group (Colorado Department of Public Health and Environment (CDPHE), Department of Health and Human Services (DHS), and the Department of Health Care Policy and Financing (HCPF)), looked for a framework and identified the Brookings Institute's Social Genome Project. A 6 hour meeting occurred August 25th, where the overall goal of "middle class by middle age" was discussed. Middle class is defined as 300% of the federal poverty level and middle age begins at 40 years of age. Three life stages will be added, but the idea is to make sure Coloradoans can be self-sufficient.

The Steering Committee for the project created a draft framework, taking a thoughtful and strategic approach to come up with and agree on indicator metrics. A large part of this effort is to use evidence-based metrics that are able to show that particular outcomes increase opportunity for success. There is a desire to create a definition of what it means to have "evidence-based" interventions in Colorado. The Department is working with the Governor and others to develop this definition. There is an emphasis on leveraging and aligning state resources. HCPF's largest resource is Medicaid funding, for example, and that framework will be used to support all of the work that is currently being done in the communities. A "survey monkey" survey was sent out to assess what these community activities are. The RCCOs have been asked to hire a full-time employee (FTE) to be the Opportunity Liaison. The liaisons have been given the scope of the Family Formation Life Stage. This is the first life stage. Each RCCO will have a geographical focus and work plans

are being drafted. Murielle and the team are looking for thoughts of what this project should look like and who in each community should be involved. Feel free to email coloradoopportunityproject@state.co.us with any questions and/or suggestions. This mailbox is only checked by two Department employees.

Dr. Keller questioned if the group believed that there are robust ways to measure the indicators that have been chosen. It appears very hard to measure and may be something we may have an impact on. Does Colorado have the capacity to tell that success is actually happening? He added that if the focus is on RCCOs and counties, it will be hard to also have an effect statewide. Christian shared that for this reason, many different data sets are being used, such as CDPHE, BRFSS, Colorado Child Health Survey, PRAMS, Medicaid claims data, and vital statistics. The Health Department is on the project steering committee (Dr. Wolk is a member) in hopes of aligning metrics across the board. Further, work is being done with CDPHE to increase utilization of preventative services such as tobacco cessation, obesity, depression screenings, and diabetes.

Jenny added that the challenge is not having the data, as it is hard to get too specific on the location. Is the data really by county or a couple of counties? Anita pointed out that looking only at HCPF claims data is not a necessity. There are data sets from the counties and from school districts, to name a few. Jeff pointed out that Colorado is on the cutting edge with these issues. No other states have done this type of project so there are no best practices or references. In fact, other states are looking to Colorado. Most people want to make changes, but the challenge/barrier is in "how."

C. CAHPS Discussion

Russ shared with the group that February 2016 is when the Quality Health Improvement Section will begin the design for the next iteration of the surveys. As a reminder, only the children's will be surveyed, so there is an opportunity for this workgroup to suggest changes for the children's surveys. Jackie suggested that we think of something different than what has been done in the past. She pointed out that it seems like survey responses are decreasing and people have survey fatigue. She suggest that perhaps a certain section of the survey, preferably 1 page, is chosen to alleviate this fatigue. Russ points out that preliminary review of the most recent CAHPS surveys indicates the response rate was around 30%, which is a good rate. Jeff stated that the fact there are a lot of surveys gets back to the question of how do we want to use the data to maximize utility? Should we prioritize data points? Jeff suggested that the group thinks of a different model—length should be discussed. He gave an example of the RCCOs administering the surveys

Jackie clarified that her mention of the CAHPS survey sections was suggested not if there is an alternation of adult and child surveys every year. The idea was to survey

individuals on one section of the survey each year as it pertains to that one page. The challenge would be that several years go by and gaps between revisiting the sections would be large. Russ added that perhaps the focus could be that of healthcare received in the last 6 months, however demographics would still need to be collected. Rachel added that while a variety of surveys are occurring, nothing is being reported by RCCOs. Russ added that hospitals do this because it is part of their Medicare compliance and to get actionable data, we need to get down to the provider level. But who will do this? What resources do we have? A comment from the phone pointed out that one concern was the order of the questions, and a brief discussion of the strategy of survey question order occurred.

Jeff said that the biggest limitation of the CAHPS is the "actionability" of the data because we don't know which provider the respondent received care from because of the nature of the data capture. Maybe we could consider reinvesting money being spent into a model where a survey is administered at the provider level with a small, core group of standardized questions that providers of RCCOs receive. This information can then be pulled up to the state level. He adds that an opportunity with to make this part of reporting requirements in the RFP is also a possibility.

Russ suggested that the tool be used as a starting point rather than having actions taken from these surveys. It could be a primer for RCCOs to drill down on issues at practices, which can lead to the development of an action plan. Dr. Keller again raised the million dollar question of what do we want to use this data for? Susan shared that the Department was wondering if this data could be a KPI, or perhaps a measure to make incentive payments. She pointed out that NCQA requires that they use the CAHPS data. Russ said that currently, the best use of the survey is the CHP+ plans. If they score below the 50th percentile, a corrective action plan is required.

Rachel asked if the main point of the measure is client activation or improving care coordination. What are some examples of what a focus could be? David shared that Oregon and Rhode Island are using CAHPs to inform incentive payments. Jeff mentioned that he could have CHI look at 3-4 models about how CAHPS data are used. Kathy added that the CAHPS was a policy driven tool meant for reporting at policy levels. We're trying to take this tool and make it actionable, but it is not actionable at an organizational level. Can we use it as a kick-off point, but only to move RCCOs into the mode of having to do further investigation? David shared that he thinks it can be actionable in the use of establishing statewide benchmarks. There needs to be some type of survey tool to bring patient experience into this, however that won't help drive payment. The consensus is that this survey is difficult to use, as is.

Wrap-up

Discussion Take-aways: There were four main ideas regarding this survey process.

1) Parse down the CAHPS survey
2) Reinvest money into a different survey
3) Administer different survey at provider level
4) Use the CAPHS survey data as a tool to redirect quality improvement efforts

Action Items:

1) Murielle to give Rachel framework for CO Opportunity Project to send out to group
2) CHI to look at different models that use CAHPS data

Next Meeting Topic(s): TBD

Adjourn

The meeting was adjourned at 4:32 pm.

Reasonable accommodations will be provided upon request for persons with disabilities. Please notify Rachel DeShay at 303-866-5313 or rachel.deshay@state.co.us or the 504/ADA Coordinator hcpf504ada@state.co.us at least one week prior to the meeting to make arrangements.