



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

303 East 17th Avenue 7th Floor Conference Room 7B
December 16, 2015

Call to Order

David Keller called the meeting to order at 3:20pm

Roll Call

A. Participants Present

Bontrager, Jeff; DeShay, Rachel; Encizo, Becky; Harder, Amy; Keller, David; Kennedy, Russ; Koltonski, Christian; Mathieu, Susan; Mortenson, Katie; Ponicsan, Heather; Roumell, Nina

B. Participants on the Phone

Harris, Helen; Hejny, Marilyn; Henrichs, Rachel; Hudson, Jackie; Lessley, Todd; Nate, Jenny; Rich, Anita; Sanchez, Jessica; Terry, Betsy

General Announcements

Date and location of the next Health Improvement Meeting: The next meeting is scheduled to be held Wednesday January 27, 2016 beginning at 3:00 p.m. at 303 East 17th Avenue, Denver, CO 80203, Conference Room 7B.

Approval of Minutes

There was a motion made to approve the minutes from October 28, 2015. The motion was seconded and the minutes were approved.

Discussion

A. PIAC Meeting Report-out

At the PIAC meeting held earlier today our subcommittees' feedback/recommendations regarding ACC 2.0 Indicators and Outcomes were discussed. The overall sense was that there was no need for turning them into formal recommendations. By and large, all of the contents were agreed upon. Next the committee discussed the idea of a "health care team," who should be on it and what the term means. As the Department has a highlighted focus on person-centeredness, it was stated that health team should be defined by the client and their family. A concern of reaching families arose and it was suggested that a mechanism be developed to put the client in the center of the team.



For example, data sharing is important across systems, but especially important on the level between practitioners on a team. It is also important to discuss how to arrange this team. Helen Harris questioned if there was a discussion in PIAC regarding the minimum number of people who should be on a health care team. Members noted that ideally the smallest team would be the client and their primary care provider and then other practitioners, providers, etc., added as needed. David pointed out that not everyone needs a team, but could agree that the minimum number of people on a health team is two.

Next it was shared that there was a release of a statement regarding SIM and the RCCOs. It was announced that the RCCOs would be putting more money into the pot to help Medicaid providers connect with SIM. To date there has been no announcement of private payers and their involvement in SIM. Susan Mathieu clarified that the money was coming from the pool of money created from the \$.50 reduction in the RCCO's base PMPM and the reduction in PMPM for members who remained unattributed for 6 or more months.

B. Research on Client Assessment of Healthcare Providers & Systems (CAHPS) survey use

Currently, client experience is not being measured in the ACC and the Health Improvement Subcommittee has been tasked with wrestling over how to best capture client experience. Jeff suggested the subcommittee could revise client experience measures for the future. He then introduced his Colorado Health Institute colleague, Nina, and student Heather, who both helped him take a scan of what is currently happening both locally and nationally with CAHPS. Nina did research around Colorado to ask RCCOs if they are using CAHPS (or any survey) and if so, how often and how it was being used. Nina found that most folks she talked to use a vendor to administer the CAHPS survey. She found that some surveys were administered face-to-face. While having a live person to take the survey leads to a higher rate of surveys taken, it may also lead to a less random sample. In addition, clients might find it hard to answer truthfully in fear of upsetting the survey administrator, or losing coverage, etcetera. Russ added that this concern is not surprising when compared to administering the survey via phone or email.

Current uses of the CAHPS survey are to monitor member experience. Colorado Access has used findings to train customer service representatives on calls. Rocky Mountain Health Plans (RMHP) looks at the responses of wait times to inform the client experience. In addition, CAHPS can be used for care management and process improvement. RMHP results showed that clients expressed frustration with the lack of payment options. RMHP used this feedback and now members are able to make payments online. Another use of CAHPS is to use survey results to make comparisons across clinics or regions, which can help drive improvements. Finally, Primary Care Medical Home Certification requires that CAHPS be administered. Jeff reminded the group that CAHPS is a complimentary tool. Colorado Community Health Network



(CCHN) attempted to standardize the survey questions across the regions Federally Qualified Health Centers. Moreover, some entities are collecting a different survey than CAHPS. For example, RCCO 7 has a patient satisfaction survey that can be accessed on their website. Denver Health was contacted and results are forthcoming. Overall, the use of surveys and CAHPS is on a spectrum.

Findings suggest much of the same that has been discussed in this subcommittee—It is challenging to drill down in the current ACC CAHPS survey to locate where care was actually received. This ability to drill down allows results to become more actionable. Unfortunately, the current sample size is low and the survey is long—making it difficult to focus on one particular area of experience. David added that Children’s Hospital is using the CAHPS patient satisfaction and experience survey, where they call the family a few days after a visit. Jessica Sanchez questioned if all FQHCs hire their own vendors to administer the CAHPS and it was clarified that the Department’s external quality reviewer, HSAG administers the surveys. Todd shared that his practice is set up to give the client an iPad to complete the survey on their way out the door.

Heather reminded the group that there are many versions of the CAHPS and some look at questions surrounding hospitals, insurance, providers, etc. She also noted that most other states use a mixed approach for survey questions. Three states that Heather found used the CAHPS were Rhode Island, Oregon, and Michigan. Rhode Island has a relatively high response rate (about 40%) and will do up to six follow-up calls to reach clients. The use of CAHPS is successful because there is buy in. Providers actually apply to be a part of the program and benchmarks are developed based on a learning collaborative (CTC) that gets together to discuss the matter. Guidelines for the number of surveys to be given exist, something like for a group of 4-9 providers, 343 surveys need to be completed and a group of 20-28 providers require 643 surveys, etc. Furthermore, Rhode Island administers the CAHPS at the practice level and subscales reviewed by the CTC (committee) and becomes part of setting a practice’s Per Member Per Month (PMPM) payment. Jeff pointed out that timing of the results may be a factor. For example, survey times have changed in some states and some are looking at giving the survey every 18 or 24 months, as a year isn’t enough time to use information found from the previous survey period.

Jackie Hudson asked a clarification of the focus of the research that was done. Heather answered that she narrowed in on states that had “actionable use” of the CAHPS survey and other criteria, such as similarities between states (Colorado and Oregon). She also shared that Oregon is unique in its use of posters and brochures related to the CAHPS survey. A great deal of marketing efforts go in to letting folks in the communities know that the survey is coming. This helps promote a higher survey completion rate. In addition, after results are collected, marketing is once again used to share the responses that were received. These posters are shared to indicate to the community that their voices are being heard. Similarly, Michigan has a consumer guide that includes information on taking the CAHPS survey.



C. Discussion of possible recommendations

Dr. Keller refocused the conversation due to a limited amount of time being left in the meeting. He posed the question, "what would this subcommittee recommend for client/patient experience?" Attendees stated that whatever survey that is used, it is important for it to be brought down to the provider and/or practice level. A need to standardize the surveying across regions to allow comparability was shared. Jeff posed the question of who would be funding the survey in the future and Russ recommended that the new Regional Accountable Entities (RAEs) be responsible for the survey. RAEs could partner and coordinate with the Department and HSAG to administer the surveys. David reminded the group that funding depends on what we want to collect this data for: are we interested in making CAHPS (or another survey) a measure? A program improvement tool or outcome measure? Or do we want to use the information gathered for feedback on performance. David suggested that the subcommittee look at the answers to these questions in sequence.

Wrap-up

Decision Items: Subcommittee to draft and vote on CAHPS recommendations for/in January meeting

Action Items: Think about recommendations regarding CAHPS in ACC 2.0 and feel free to send to Rachel DeShay.

Next Meeting Topic(s): Discussion of and vote on recommendations on client experience. ACC Evaluation Presentation by CSPH.

Adjourn

The meeting was adjourned at 4:28 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.

