



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

303 East 17th Avenue 7th Floor Conference Room 7B

June 24, 2015

Call to Order

David Keller called the meeting to order at 3:03pm.

Roll Call

A. Members Present

Bartilotta, Kathy; Bodart, Brooke; Bontrager, DeShay, Rachel; Forbes, Elizabeth; Hejny, Marilyn; Keller, David; Kennedy, Russ; Koltonski, Christian; Lamb, Chavanne; Lessley, Todd; Mills, Gretchen; Montrose, Gary; Rieder, McKenzie; Schum, Hanna; Taylor, Meg

B. Members on the Phone

Encizo, Becky; Hudson, Jackie; Miller, Melissa; Rich, Anita; Vivian, Kelley

General Announcements

The July meeting is cancelled. Date and location of the next Health Improvement Meeting: The next meeting is scheduled to be held Wednesday August 26, 2015 beginning at 3:00 p.m. at 303 East 17th Avenue, Denver, CO 80203, Conference Room 7B

Approval of Minutes

A motion was made to approve the minutes from May 27, 2015. Motion was seconded and the minutes were approved.

Discussion

A. PIAC Meeting Report-out

PIAC discussed David Keller now serving as a Pediatric Consultant to the Department. The idea of a possible conflict of interest led to a long discussion of the process. It was decided, however, that at this time he will continue to be a co-chair of the Health Improvement Subcommittee. The report out of the former Payment Reform Subcommittee was the next topic. It was noted that this subcommittee lost steam last year and its actual purpose was unclear. The topic of payment reform will now be dealt with through PIAC and workgroups may be formed as needed. The Provider and Community Issues Subcommittee report out followed, where they



discussed transportation. The subcommittee expressed concerns with the performance of Total Transit, the Department's Non-emergent Medical Transportation (NEMT) agency. They recommended that HCPF take action and the discussion began about the process and a development of a template. It was suggested that two separate meetings be set-up.

At the last PIAC, on the topic of enrollment and program operations, everything came down to the topic of attribution. David pointed out that the original methodology doesn't allow enough time to establish a relationship with the patients. Some methods look back 2-3 years for this. He talked about his personal work example of issues with his panel. The inconsistencies suggest that reattribution be done on a more regular basis. Russ asked for clarification on how often this process is happening now. Currently, the reattributions are being run monthly. It was stated that there has not been much consensus around the issue moving forward on changing attributions quarterly, and PIAC will take the subject back to committee after a discussion with their subcommittee. David indicated that this topic is also of interest to our subcommittee and so it will be necessary to keep the two groups in communication.

Hanna Schum shared that it was important to talk about attribution at this point in time, as well as talk about attribution in the next iteration of the ACC. She continued to clarify that these are two separate, but parallel, paths and the information is helpful in the design of the program's next phase. Todd then shifted to the path of future attribution and suggested a discussion of "auto enrollment." There was discussion at the last PIAC meeting about what this might look like in the future. David added that the idea of how SIM plays a role needs to be addressed in how we move forward and we will want to discuss the issue in both the Health Improvement and PCI Subcommittees. We will look to Anita and Todd them to champion this communication, as they are members on both subcommittees.

B. Follow-up from environmental scan of survey data used – After our last meeting, Russ Kennedy sent out an email in an effort to do an environmental scan of how RCCOs and providers are currently using CAHPS data, or any other survey data. He shared some information he received, like RCCO 6 using CAHPS data with 6 practices. It was noted that this program is targeting all of their lines of business. Meg Taylor added that RCCO 6 is also doing surveys on their own, while others do have a more specific Medicaid focus.

Colorado Access talked about Denver Health using survey data in their Intensive Case Management Pilot. The survey has approximately 13 questions. RCCO 7 shared that they also have a survey that was created on their own. It is done quarterly and they attach it to the invitation for the Bi-annual Stakeholder Meetings. RCCO 4 discussed a survey that they have online that is accessible through the ICHP website. They are currently looking to change how the survey is administered, and



want to have more in depth questions. RCCO 1 shared that Jackie Hudson would be in contact with the Department on a response for Russ's environmental survey scan request. Jeff questioned if the providers were able to see the survey info at a practice level. RCCO 1 shared they have a 1 page document that asks about satisfaction with appointment wait times and shared decision making. They then compile the responses and send out to the provider for review. Russ pointed out that with CAHPS, answering one question is counted as a complete form.

David noted that the discussion brings up the fact that there are so many variations of how surveys are being used from RCCO to RCCO. He question if here needed to have a survey that is more standard across the state. Elizabeth Forbes then asked about that participation rates in the survey, including the one Colorado just finished collecting. Russ stated that the rate over the last few years has been from 20-30%. He shared that there are NCQA standards that exist and that the sample size this year was 1350 for adults and 1650 for children. While he has the most recent data, he has not had a chance to look at this year's response rates. He will be doing this and also breaking the information down to a RCCO level. His best guess, however is 50%. David asked if these surveys were by email or by phone. Russ stated that the process is to send letter and make two phone calls. However, there continues to be an issue with inaccurate client contact information. In addition, it is hard to get at that problem because tracking this would threaten the anonymity of the survey. David suggested/questioned the use of text messages and or a link on the internet. Regardless, the real question is, "what do we get out of this survey data?"

Meg shared that in RCCO 6 they give their providers feedback and offer a comparison across the network. Based on the analysis, they make a process improvement plan, if needed. This is to try to align the KPIs and incentives. Russ asked if there were any requirements for the practices to put those plans in place. Meg answered that there is not, however it is strongly suggested that they do. She added that issue may also be addressed through various client interventions. Kelley Vivian shared that RCCO 7 uses the data in the same way. One example is that her practice transformation team identified an issue with a provider and the survey score he received on his appointment wait times. They then worked with the provider to re-vamp their scheduling process and discovered a way to improve this process. In addition, it raised the discussion of how to lessen clients no showing up to their appointments. Rachel interjected with the fact that there really hasn't been much talk about what the consumer side of this issue. Do we know what the client actually thinks of these surveys? To that point, Kelley looped back to the survey standardization suggested and reminded the group that RCCO 7's survey was created by the local PIAC committee, which includes Medicaid members and as such they would not want to develop another survey.

David then took the time to highlight that the subcommittee is describing surveys that are linked to the individual practices, but it appears the Department's data is



not captured in this way. He then shared that his surveys were put together with a group of advocates. Russ suggested the possibility of having one survey for communities, perhaps per RCCO. David pointed out that this could lead to something that may require a recommendation! Subcommittee members were unsure of this suggestion because of a concern with what happens when the RCCOs are given general outlines from the Department. Jeff Bontrager then brings up that the priorities of the Department have also got to be kept in mind and so questioned how the Department is using the CAHPS data. He suggested that we examine this. Rachel then made an announcement that since we are not meeting in July, the "ask is for the subcommittee to use the time off to analyze these surveys. Gary Montrose shared that this process seems to be the right opportunity; one that the subcommittee should take. David added that he would like to more specifically ask that each RCCO also take a look at their data and be prepared to discuss how/what can be learned from the data in relation to the survey in order to inform this subcommittee.

C. KPI Discussion

David posed the questions, "What would be helpful to know? What info do the RCCOs want? Member level data? A visual representation?" Kelley points out that RCCOs have met the ER KPI in the past. RCCO 7 looks at the detail and also get trend reports. David said that this information is helpful, as he was not aware of this. He added that it seemed like the RCCOs were getting enough data. Kelley responded that their RCCO doesn't see an issue with the quality or quantity of the data. Her providers have an issue with the delay in that data. It is difficult to see if interventions are having an impact. Kathy Bartilotta shared that in other states, various plans negotiated different ED rates, so it didn't matter as much where people chose to get their care. David asked what the percent (%) difference is.

Hanna shared that they targets are based on a budgeted expected amount based on 11-12 utilization data and accounting for regional population differences. Gretchen Mills added that the budget expected amount is not seasonal. David then questioned how well the potentially preventable measure parses out which visits were actually avoidable. Jeff also questioned if the measures that capture ambulatory data sensitive conditions and Russ asked if the visits that end in admissions are counted. The answer to the last inquiry was no. David then asked why there is such variation between RCCOs. Todd shared that he has clinics in two Colorado Access regions and some variation could be due to the metro versus rural differences. Hanna stated that the Department is constantly examining appropriate budgets. David posed a homework assignment: Think about what is changeable. 1) The budget? 2) Should we look at a subset of ER visits? Potentially preventable visits or ambulatory or some other more accountable segment of the population?

Hanna stated that it is important to keep in mind that there are exclusions from this population. For example, the expansion population is not included in this metric



because there was no baseline data. The expansion population will be included next year. Meg shared that RCCO 6 outreach is similar to what RCCO 7 described. They work with practices to do patient education and diversion programs with people located at the ER. Kelley added that RCCO 7 is interested in a potentially preventable metric and focusing on those that are open to change. Russ added that Colorado Access also seems to be focusing on a smaller segment of their population to reduce ER use. David points out that the well child check measure has changed; the age category was narrowed. His own practice data analysis showed that their numbers are similar to the RCCO rates; this was shocking. It was suggested that perhaps there are a practice of doctors maybe telling their patients that they are okay for the next year, since there are no shots to do at that next visit. David said that this has not been his practice's experience. They have seen that children with chronic conditions come in for other visits often and don't get a physical.

Meg added that she has found that having a good EHR (electronic health record) and a good recall process is the most effective method. Kelley asked if the subcommittee would be interested in discussing benchmarking for KPIs and moving to percent (%) difference to keep people engaged. David asked what the appropriate amount of change would be. Kelley shared that other measures are between 1-5% and over 5%. Russ stated that he will bring this to the Quality Unit. David then asked if any of the RCCOs do prizes or incentives to their practices. Jackie Hudson shared that they have begun giving gift card incentives to parents who bring their children in for well visits, but they think a practice level intervention might work better.

Meg shared that they do a member-level incentives for the postpartum visits. Clients can get diapers and other incentives. Hanna noted that the postpartum measure is a blended rate of data from the past 2 fiscal years. David added that "winning" or meeting targets is important to keep people interested. Hanna said that a worry is what would happen to the RCCOs that are close to meeting the current targets if we change the targets. David suggested thinking about ER visits and different metrics. Think of well child checks and if we should set a different benchmark. Postpartum appears to be working but also keep in mind what the next "big thing" might be. Hanna reminded everyone that the Department is also tracking on other metrics on SDAC that are not paid on, so it could be helpful to take a look at those when thinking about where to go next.

Wrap-up

Decisions: July meeting is cancelled

Action Items: 1) Review CAHPS documents
2) Look at own data and prepare for discussion how/what can be learned from the data in relation to the survey



Next Meeting Topic(s): The group will continue to discuss how to use the CAHPS most effectively and KPIs

Adjourn

The meeting was adjourned at 4:30 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.

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