



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

September 23, 2015

Call to Order

David Keller called the meeting to order at 3:01pm

Roll Call

A. Members Present

Bontrager, Jeff; Brown, Ashlie; Cummings, Lila; DeShay, Rachel; Encizo, Becky; Keller, David; Kennedy, Russ; Koltonski, Christian; Lamb, Chavanne; Mathieu, Susan; Rieder, McKenzie

B. Members on the Phone

Bueler, Ryan; Forbes, Elizabeth; Harris, Helen; Hejny, Marilyn; Hudson, Jackie; Lessley, Todd; Reeder, Lesley; Rich, Anita; Taylor, Meg; Wheeler, Justin

General Announcements

Date and location of the next Health Improvement Meeting: The next meeting is scheduled to be held Wednesday October 28, 2015 beginning at 3:00 p.m. at 303 East 17th Avenue, Denver, CO 80203, Conference Room 7B.

Due to the holiday season: **November and December meetings are rescheduled.** Meeting times are as follows: Wednesday November 18, 2015 beginning at 3:00 p.m. and Wednesday December 16, 2015 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 August 26, 2015. The motion was seconded and the minutes were approved.

Discussion

A. PIAC Meeting Report-out

The last meeting was 3 hours long and the entire time was filled with discussion. The Provider and Community Issues Subcommittee proposed some recommendations around care coordination. These were discussed, approved, and sent to the Department. In addition, outcomes and indicators and the need to address specific

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population was discussed. Department is requesting recommendations for outcomes and indicators for ACC 2.0. In regards to ACC 1.0, the group talked about the number of issues that still need to be addressed. There will be a calendar to outline the topics to be discussed in PIAC moving forward.

Payment reform and the Kaiser Access and RCCO 3 project was also discussed. The nitty gritty details of how the pilot is going to work were shared. There was a concern that providers would not know what this project was or how it interacts with the current work flow of their practice. In addition, it was expressed that consumers also may not understand the changes and this may add another level of confusion to operationalizing the project. Susan ended the PIAC report discussion by informing the group that Access Kaiser, which was scheduled to roll-out 1/1/2016 has been delayed. No current timeline information has been discussed.

B. ACC 2.0 Outcome and Indicator Presentation

Lila Cummings addressed the PIAC earlier this month with a draft proposal of possible outcomes and indicators that should be addressed in ACC 2.0. She attended the meeting to share with the group a draft of what areas the Phase II measures are and is requesting feedback. (See handout). Currently, Katie Mortenson is putting together a list of the measures that are currently being tracked by the Department. The first outcome discussed was Improved Health. The section was further broken down to Health Management, Population Health, and Social Well-being. Lila asked what measures could address these areas. It was brought up that there currently are no Institute of Medicine (IOM) core measures that address this topic. David Keller pointed out that he believes this is because IOM is focused on health, while the State Innovation (SIM) is focused on disease management.

Jeff brought up the 5 point scale that asks, "How would you rate your health?" This is a self-report health status question and the majority of the factors are related to social factors. Jeff added that the CAHPS measures well-being and access. Christian posed the question if a new data source was being created or if we are limited to current data sources. Lila clarified that the purpose of the document and discussion is to cross-walk the existing indicators with the intent to see where everything shakes out. This will help inform what is measured in ACC 2.0. David Keller then added an example that a measure of wellbeing might be if a child is ready for kindergarten.

Justin Wheeler then shared with the group some measures he is using. One is the HARMS 8 Care Oregon's Hospital Admission Risk Monitoring System to identify intervention needs for high risk patients, as well as a Care Team Assessment. This measures whether the team feels the client can follow a care plan. This measures not only wellbeing, but also the client's confidence in maintaining those items in the plan. Justin has found that these assessments have been very helpful. The question was raised about how fluid this process of asking for the data is blended into the workflow is. Justin answered that the care team assessment can also be done outside of the



visit; it can be completed telephonically. He then said the Care Team Assessment was the best predictor of high utilization, morbidity and mortality. The best predictor was the question, “would you be surprised if the patient died in the next year?” Anita then questioned if there was a pediatric portion to the assessment. Justin answered that this was an adult measure, but it may be possible to administer in various development stages in order to reach children. David added that this topic matches the assessment around health literacy that has become a part of discharge planning.

Todd asked if a plan exists to identify data sources outside of claims data for wellbeing and health management. Susan shared that the scope of sources has been broadened, but there still is further need to get data from providers to send to us. The example shared was EHR information that isn’t currently required to be given to us. She continued that the requirements for BIDM were designed to take data feeds. The Department is not trying to make the process burdensome. Todd said he would be interested to know the capabilities of the broader system to report consistently throughout the system.

Access to care was the next topic and David shared that he is a fan of the access questions in CAHPS. It doesn’t matter how many hours you are open if the patient doesn’t believe there is access. The classic measure is time until third next available appointment. David suggested “mystery shopping.” Russ shared that some HSAG access and availability questioning does occur with the managed care plans. This included different type of access: first and third next available appointment measures, however, the “mystery shopper” has been an issue because a Medicaid ID is required to make an appointment. He continued that the Department hasn’t looked specifically at the specific question, “has your doctor told you of where you can get care after hours or on the weekends?” and this may help to give a larger picture of how folks are doing on a RCCO level. David pointed out that the problem of who wants to take responsibility becomes a problem. The challenge is that we have to be able to show the variation across providers.

Jeff stated that there are other questions to address this. Christian shared that access may be addressed in the HEIDIS measures to care for adults and children. David clarified if we were only talking about primary care providers and Jeff answered that all types of sub-specialties could be included, such as dental care, behavioral health, and others. Anita added that this should cover access to both child and adult services. Jeff then raised the importance of how these metrics are going to be used. Are we really trying to hone down to ACC enrollees or all those who use the system—all Medicaid patients? These questions need to be answered in order to answer this question. Lila said she would take this question back to her team to find out numerator and denominator in this analysis.

Jeff added that currently we can’t tell where the clients get care or didn’t get care so there is no way to follow-up. Russ pointed out that while it is difficult to look at the



results and be actionable, trends can be found at the RCCO level that can be brought to their attention. The key is a metric that is trying to be moved and can show variability. A suggestion for a focus measure for patient safety was listed as medical error rate. David shared that he recently read an IOM report that found about 10% of deaths are caused by incorrect diagnoses. Elizabeth Forbes added that part of the report also included late diagnosis as a cause. Todd questioned how the broader ACC community could impact hospital metrics, as he does not feel RCCOs have control over this. David noted the comment and reminded the group that our focus today was on the last two columns of the document: ACC Phase II Measures and Measure Type.

The group moved to discussing population health and Helen Harris shared that RCCO 7 has been working with agencies in the community that handle a population with significant disabilities. She continued that one of the important questions being asked is the opportunity for younger people with disabilities to communicate and also access spiritual resources, where they are encouraged to socialize. David asked how to measure the engagement of certain populations. Helen answered that it is purely self-reported, like Quality of Life measure. David added that another population to look into might be new mothers and tie into depression screenings. Next the group continued the conversation and David Keller shared that perhaps the terminology "substance use disorder" should be used instead of "addictive behavior." Justin then noted the importance of including prescription drugs as well as illicit drugs. David further added that prescription drug abuse does not just occur with schedule 1 drug. Just because it isn't schedule 1, doesn't mean that it is legal to use--frequent abuse of off-brand drugs does occur. The next topic raised was obesity and it was stated that this measure is pretty straight forward. However, the accuracy of child measurements for obesity was raised and that the measures are the most accurate way to get a child's growth trajectory. David added that skin fold fat thickness is a reasonable measure for obesity and BMI is definitely better than using weight.

The group then moved on to the next outcome: More Value. David pointed out the issue of dealing with "cost" is tricky. Lila shared that value was more about evidence-based cost efficiency, not necessarily cost measures and we may want to provide more of some services to a population, even though they cost more. For example, the foster care population may need more mental health services. Next, personal burden and the question of how to capture it was then raised. It was raised that a report was recently released about the cost-shifting that has been occurring over the past 5 years. Acknowledging this is one thing, but measuring it is a challenge. This burden, however, may be able to be measured in the All-Payers Claims Database, because private insurers have to track it.

Due to time constraints, the workgroup moved on to the last outcome in the chart: Better Experience. Chavanne brought up the need to coordinate the coordinators and mentioned the pilot that was occurring in RCCO 3 with Healthy Communities and CDPHE's HCP team. Leslie Reeder shared the work RCCO 1 is doing in Mesa County. A



pilot is using Crimson Care Management software but they are not necessarily married to that particular platform. The key they have found is that it is necessary to make the information brief and/or high-level. David added that CMMI is supposed to have a shared care plan, however every agency looks at a person with a different lens. The Department of Health and a primary care provider also have different ways of looking at info. He continued that he does not prefer the term “health literacy.” This is because it may not necessarily be linked to literacy; it may be health knowledge and health information. Usually the health literacy of the family is put in the child’s chart.

Justin added that as a standalone, health literacy is not as powerful to a provider unless it is coupled with patient engagement. Regardless of how you present the data, if the patient isn’t engaged, you are missing the boat. Lila asked how Justin measures patient engagement. He told the group that you could address engagement in a formal way, when self-management goals are set. This makes it easier to measure the patient’s confidence in being able to engage in the activity, understand the barriers, and bring in elements of motivational interviewing to the visit and discussion. He continued that then a long view should be taken—how is the patient following up with services? Is the patient coming back for appointments, engaging in education materials, and/or increasing their level of knowledge of their condition? Michael Neil from CCDCC added that it is imperative to include in this conversation, those clients who don’t have a communication strategy. This population will be of utmost importance to include.

Wrap-up

Decision Items: November and December meetings to be rescheduled to the week before—look for an updated invitation

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

Next Meeting Topic(s): Discussion of draft recommendation regarding outcomes and indicators to be submitted to PIAC in November.

Adjourn

The meeting was adjourned at 4:35 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.

