HEALTH FIRST COLORADO

REGION 5 PROGRAM IMPROVEMENT ADVISORY COMMITTEE (PIAC)

SEPTEMBER 16TH, 2019 MEETING MINUTES

Name	Organization	Present
AJ Diamontopoulos	Denver Regional Council of Governments	
Allison Romero	Mile High Behavioral Health Care	
Ana Visozo	Servicios de La Raza	X
Angi Wold	Addiction Research & Treatment Services	X
Betsy Holman	Dentaquest	
Damian Rosenberg	Personal Assistance Services of Colorado	
Dede De Percin	Mile High Health Alliance	X
Greg Tung	Colorado School of Public Health	X
Jacquie Stanton	Denver Public Schools, Community Association of Black Social Workers	X
Jeremy Sax	Denver Health	X
Judy Shlay	Denver Public Health	X
Joe Homlar	Denver Human Services	X
Katie Broeren	Health First Colorado	X
Karen Weber	Caritas Clinic, SCL Health	X
Scott Utash	Advocacy Denver	X
Stacey Weisberg	Jewish Family Services	X
Sue Williamson	Colorado Children's Healthcare Access Program	X
Thain Bell	Denver District Attorney Office	

COA Staff Attendees
Cassidy Smith, Senior Program Director, Region 5
Julia Mecklenburg, Community Outreach Specialist
Kellen Roth, Director of Member Affairs
Kelly Marshall, Director of Community and External Relations
Molly Markert, Senior Community Engagement Liaison
Nancy Viera, External Relations Coordinator
Rene Gonzalez, Senior Community Engagement Liaison
Rob Bremer, Vice President of Integration
Sarah Lambie, Quality Program Manager

Guests/Members of the Public
Ben Harris, Health Care Policy & Financing Department

Agenda Item	Meeting Minutes
Welcome to Meeting #4, Introductions, Committee Business (slides 1-4)	Judy Shlay welcomed everyone to the fifth meeting of the Region 5 Program Improvement Advisory Committee (PIAC). The group went around and introduced themselves. **Committee Business:** *Approval of minutes:* The June meeting minutes were presented for approval. Laurie moved to approve the minutes; Karen seconded. Dede abstained. The June meeting minutes were approved unanimously. Kelly Marshall introduced the Fist to Five concept. Fist to five, also called fist of five, is a technique used by agile teams to poll team members and help achieve consensus. Fist to five is similar to thumbs up, thumbs down or thumbs sideways. To use the technique, the team facilitator restates an action the group may make and asks the team to show their level of support. Each team member responds by holding up a closed fist or the number of fingers that corresponds to the level of support. If a team member holds up fewer than three fingers, she is given the opportunity to state her objections and the team may respond. The facilitator continues the fist to five process until the team achieves consensus (everyone holds up three or more fingers) or agrees to move on to the next issue. Closed fist - No. A closed fist is a way to block consensus. 1 finger - I have major concerns. 2 fingers - I would like to discuss some minor issues. 3 fingers - I'm not in total agreement but I feel comfortable enough to let this proposal pass without further discussion. 4 fingers - I think it's a good idea and will work for it. 5 fingers - It's a great idea and would like to take the lead when we implement it.

	Member Advisory Council visit schedule update: Kelly spoke to the committee on dates available for visiting a Member Advisory Council meeting as an observer. Meet and Greet times have been set up from 5:00PM to 5:30PM with the option to stay for the meeting to 7:00PM. The next meeting is scheduled for September 17th.
Regional Performance-Potentially Avoidable Costs/Complications (PAC) **(see slides 1-21)**	Sarah Lambie, Quality Improvement Program Manager from Colorado Access presented on the Potentially Avoidable Costs one of Colorado Access' key performance measures. Other Key Pay for Performance measures were presented by Catherine Morrisey in the previous meeting. Other Pay for Performance measures focus on increasing compliance with member well visits, dental visits, and referrals to mental health care as an appropriate aim to target preventative care. The Potentially Avoidable Cost aims to target the high cost services that are avoidable to reduce costs in Medicaid services. To determine what is avoidable, data to determine this is supplied to the Regions, this data comes from claims. The state implemented this new measure and partnered with an external data analytics and research firm "PROMETHEUS". This firm gathers the data and diagnosis information to form a methodology about what health care costs are "typical" and which are considered "complications'. The PAC looks at the total cost of care and it breaks down by what costs are associated with relevant episodes related to the diagnosis and what costs are not assigned to episodes. The latter are potentially avoidable costs. The PROMETHEUS data allows Colorado Access to sort by high cost episodes and services to target where additional support and interventions are needed in order to drive down avoidable services and costs. The targeted episodes are: <u>Chronic:</u> conditions are long-lasting, or a disease that comes "with time". These are the highest cost episodes across both Region 3 & 5. • Asthma • Diabetes • Mental Illness • Substance Use Disorder <u>System Related Failure:</u> made up of small cost episodes, has not been prioritized by the State at this time for PAC work.

- Routine sick care
- Pancreatitis
- Sepsis

Other:

- Pregnancy (highest cost episode across regions)
- Newborn
- Hepatitis C

Procedural:

- Tonsillectomy
- Gall Bladder Surgery
- Colonoscopy

Acute: something that is severe and sudden

- Stroke
- Pneumonia
- Upper Respiratory Infection

Sarah provided an example of the data Colorado Access receives from PROMETHEUS (slide 7). The example provided demonstrates how total cost, PAC cost, member counts, and episodes are included in one dashboard. For fiscal years 2017 & 2018 (July 2016 to June 2018), asthma, diabetes, and hypertension, have the highest PAC cost episodes. Sarah noted that although Substance Use Disorder appears on the list, the data has been scrubbed out due to privacy sharing and contracts in the state at the time.

Once Colorado Access analyzes the high costs services and episodes a work plan is put in place. The workplan helps with developing meaningful clinical and system interventions that aim to decrease potentially avoidable costs. This means engaging partners like hospitals, clinics, and doctors. To assure this reduction in cost happens, the regions will develop a timeline for completing their work plan. This will include key milestones and clinical interventions that will help address PAC. In future years, measurement of performance may be tied to a dollar amount or percent increase/decrease.

For example, reduce Asthma members utilizing the emergency department for rescue inhalers by X percent.

For Fiscal year 2019 the chronic conditions of Asthma & Diabetes were top costs, selected pediatric asthma as children were the highest sub-group and it is one of the few PROMETHEUS episodes that includes members under 18

	Chronic Obstructive Pulmonary Disease (COPD) had the opportunity to target a smaller population with challenging symptoms SUD was not required in FY19, data was not distributed, and stakeholders agreed to not pursue. Clinical registries for asthma and diabetes were updated to include new research and best practices and also risk stratification. Anxiety and depression were included for pediatric asthma and diabetes. After launching the registries, we analyzed the populations for any further insights into a targeted case management practice. The Care Management workflow for each of the three episodes is as follow: Day 1: Introductory call Week 1: Home Visit Day 14: Telephonic Outreach Day 30: Telephonic Outreach Day 45: Telephonic Outreach Day 60: Telephonic Outreach Day 180: Chart Review. Care Managers use evidence-based practices such as asthma action plans, diabetes education/training, care plan, internal cross-collaboration and collaboration with providers. As a result of these interventions, over 100 members were outreached in two months. A Care Coordinator attended a therapy session with a Member with **COPD** to help them create a care plan with their therapist to find appropriate housing and transportation to medical appointments as well as to get a an order from their primary care provider for home health nursing care and a cane to help them avoid falls. For a Member with **asthma** a Care Coordinator attended his pulmonology appointment and helped him create a care plan with the nurse practitioner to get a CPAP sterilizer and CPAP supplies, start Cooking Matters courses, find a backpack/school supplies for school and follow up with a provider at the Children's Hospital Lifestyles clinic to help him lose weight. Based on feedback from Stakeholders and PAC data, Colorado Access will continue to pursue Asthma and Diabetes and will align milestones to implement interventions. This year will move from the care management level focus to a systems level focus Kelly Marshall instructed the group to break out into small groups of 6 and discuss the questions below.

	• For future report-outs, what would you like to know more about and in what format? (More data? More information about clinical programming interventions?) • Are you aware of programs in the community related to these PAC priorities that Colorado Access should be aware of and learn more about? • What do you think Colorado Access and regional partners can do to have the most impact? • Is there anything you think is missing from this conversation that would make a significant difference? **Questions, Discussion & Feedback:** Question: Age differential, or all ages included? Answer: Most episodes are for adults; some episodes are for children related to asthma Angi: Does this data only contain Region 5? Are pharmacy costs considered? Answer: Typical cost, anything that is prescribed to help with episode is not considered to be avoidable. Question: How are chronic conditions an episode of care? Answer: Capture chronic conditions, procedural diagnosis date and look forward 90 days and that is considered an episode. Sue: Instead of focusing on just Key Performance Indicators, you now must focus on Potentially Avoidable Costs? Answer: Yes, this is a new Key Performance Indicator. Ben: This measure is considered Phase 2 cost control measure, RAEs are compared to Accountable Care Collaboratives that have benchmarks for cost containment, and this is our way to use that member. Slow moving data that has lagged under other Key Performance Indicator. This year the focus is familiarizing with the data and start interventions. In the future we will look at Return on Investment and interventions and look at it as functional measure. Regarding the Substance Use Disorder measure; regulations are astringent. Coming from federal government, we do not have operational procedures to handle the data right now so that requirement has been lifted for this year.

Policy changes from the state – a shift in priorities towards cost containment, avoidance and reduction	Kelly Marshall cited the contract deliverable and role of the committee to provide feedback on Policy changes. We are in the first quarter of year 2. We know that contracts and work evolve. Policies are evolving more quickly than what we expected. This conversation is intended to level set the committee on what the state has shifted and new expectations for the Regional Accountable Entities (RAEs). Ben Harris from the Department spoke regarding the new Policy changes. The state is trying to get more unification through the state PIAC and regional PIACs. The accountable care collaboratives have been an iterative program that members were enrolled in a pilot program at first that evolved pretty quickly. Growth was indicative of a lot of startup around that time. Now we are in phase 2, we are still adapting an evolving approach. Subsequentially approaches with more targeted direction to align with the new governor and office. He emphasized in cost containment around health care. We were tasked to focus on this. Robust analysis on areas of opportunities. That we are not just optimally coordinating. Similar to a lot or national research. Small membership of a lot of services are going. Small portion of our membership. Ben explained that the state is going through a transition. Previously, the focus was to outreach every member using the four-quadrant model that focuses on high or low risk and impact. The state decided this was an ineffective way to reduce cost. So is asking the Regional Accountable Entities (RAEs) to shift towards a population triangle framework. The Triangle has the top five percent of the members that are high cost utilizers in the top of the pyramid and are labeled as Complex Care Management. Members who have chronic conditions and are considered more manageable are in the middle of the triangle. Bottom triangle is the low risk population who are less likely not using the system. The high cost users are costing 50 percent of the costs. The state would like to make more improvement by reducing these costs the state believes that by engaging our members, we can reduce costs. Ben concluded by asking “what would you say sticks out?” Joe: guess that if someone has COPD, they likely have one or more conditions Judy: behavioral health huge problem, anxiety, SUD, and prenatal Ben: A lot of interventions COA has identified high areas that are on the list. Pediatric asthma is not currently on the list but could come later.

	Fab five initials areas of opportunity What are overlapping issues. Aging population and how we will deliver care for that workforce. We are a social health insurance Notes we need to do better with foster care population and justice system and need better partnerships with appropriate stakeholders. Judy: can you use Medicaid for incarcerated folks, it is a gap, when they leave it is a gap in services Greg: people could be contracted to do the work Greg: providers are contracted independently to provide services. Ben: Federal law prohibits Medicaid reimbursement for incarcerated individuals so jails and prisons contract for internal services. Have started to Map out from the population approach. Now we are pivoting to this approach. Pyramid where that top 4 percent and focus on them. Asking RAEs what are they doing. Middle tier is work with PAC good disease management. Bottom of tier, average members who go in for annual checkup. Focus on wellness and general health promotion. What we will focus on is carrying the work form the first year. Pop health interventions focus first year, evolved to interventions on cost containment. Not expecting huge infrastructure changes just aligning to populations. (send out pyramid to group) We are driving outcome-based contact-based expectations, Accountable to delivering better health across the national healthcare landscape. It takes a lot of effort for providers and systems to make changes, some are nimbler than others, performance pool all money not earned by KPIs via incentive structures, developed metrics. Incentivize excellent delivery outcomes. Dede: logical approach to cost containment, worry about access, quality and Social Determinants of Health getting lost on the topic. Ben: with the quality piece perimeters will be set from a lens of delivery that is not focused on health outcomes. Dede: where is the patient experience involved? Do not want to see cost containment at the cost of other things. Ben: high proxy level and drilled down conditions that are key areas of opportunity. Acknowledge that other populations may not arise through that. Social service examples. Justice folks who are getting out of jail are not a big concern based on the data

	because we know there is another type of involvement. Does not rise to the level of concern. It is not as robust as comprehensive. Initial proxy of what we have initial sight. Dede did bring this up at the state PIAC level. Kelly instructed the group on a group activity, what do you like, what concerns you from your perspective and what type of feedback would like to give back.
General Updates and Emerging Issues	Dede: The census: RAEs have a huge role in the census, which is underfunded and faces lots of challenges, housing and government. Talk to people about census. Julia: Together We Count will be presenting at the MAC on 9/17 at 5pm at Colorado Access Molly: There have been reported problems with NEMT, channel 7 ran a news regarding these issues. Judy: applauds work with vulnerable populations, affordable housing, the process to educate individuals who are under informed on ED utilizations.
Public Comment	None at this time.
Action Items /Responsible Party	Nancy will send out the Population Triangle Ben referenced to the PIAC members.
Next Meeting: December 2nd, 2019 at St Joseph's Russell Pavilion	