HEALTH FIRST COLORADO
REGION 5 PROGRAM IMPROVEMENT ADVISORY COMMITTEE (PIAC)
JUNE 12, 2023 MEETING MINUTES

	Organization		COA Staff Attendees
	Ana Vizoso, Servicios de La Raza	x	Andrea Swan
x	Anthony Moreno, Health First Colorado	x	Andria Dwyer
	Ashleigh Phillips, Centura Health	x	Bobby King
	Candy Wolfe, Creative Treatment Options	x	Eileen Forlenza
x	Carolyn Hall, RM Crisis Centers, CHARG Drop-In Center	x	Jamie Zajac
	Damian Rosenberg, Personal Assistance Services of Colorado	x	Jared Ward
x	Helen Pattou, International Rescue Committee	x	Jo Glaviano
x	Jacquie Stanton, State of Colorado Dept of Local Affairs	x	Joy Twesigye
x	Jeremy Sax, Denver Health	x	Julia Mecklenburg
	Jessica Courtney, Mile High Behavioral Health	x	Kellen Roth
	Jessica Jensen, DentaQuest	x	Marsha Aliaga-Dickens
x	Jim Garcia, Tepeyac Community Health Center	x	Matt Morrison
	Judy Shlay, Public Health Institute at Denver Health	x	Molly Markert
	Kraig Burleson, Inner City Health Center	x	Nancy Viera
	Matthew Pfeifer, HCPF	x	Phuong Dinh
	Nina Marinello, Intermountain Healthcare		
	Pamela Bynog, Health First Colorado-ON LEAVE		
x	Paula Gallegos, Health First Colorado		
	Patricia Kennedy, Health First Colorado-ON LEAVE		
	Sherri Landrum, Children's Medical Center		**Guests**
	Sue Williamson, American Academy of Pediatrics		
	Tiffany Grays, Black Family Advisory Council, DPS		
	Tria Phuong, International Rescue Committee		
x	Ty Smith, Consumer, Health First Colorado		

Agenda Item	Meeting Minutes
Welcome, Introductions & Committee Business	*Approval of March Minutes*: The March meeting Minutes were approved unanimously. Member Advisory Committee (MAC) Update Anthony Moreno, Kellen Roth • Over the past year, the MAC has created an award to recognize Health First Colorado members who embody dedication to their community, and advocate for the health care system and for Health First Colorado members at large • First annual award that has been voted on by the MAC; anyone can make a nomination, as long as nominated individual is a Health First Colorado Member • MAC has selected three individuals who embody these qualities o Brent P., Laurie G. (In Memory), Katie B. (In Memory)

	• Celebration will take place on June 20th

Health Equity Update & Community of Practice (Slides 7-18)	Phuong Dinh
	• COA's Health Equity (HE) Plan aligns with HCPF's Health Equity Plan, outlines strategies to address disparities for the following focus areas of Vaccinations/COVID-19, Maternity, Behavioral Health, Prevention
	• Centers for Medicare & Medicaid: CMS Framework for Health Equity
	• Health Equity Collaborations:
	    o COA Health Equity Team: Collaborate to advance health equity priorities across COA; diverse representation of executives, department leads, and analysists across member, community and provider facing teams
	    o Statewide HE Task Force: Collaborate to advance HE priorities across Colorado; diverse representation of members, providers, representatives of hospitals, child welfare, etc.
	    o Community Collaborations: Includes DEI Community of Practice, Social Health Information Exchange, CO Public Health Association, and more
	• Overview of Current Efforts through 5 Priorities
	• Community of Practice (COP) Mission: DEI leaders from various organizations connect and work together to share resources and best practices, and provide support to one another.
	• COP Vision: Collaborate on a multi-year health equity initiative with authentic member, community, and clinical partner engagement that aligns with COA's and governing council strategic priorities.
	• Survey to COP: What are your greatest concerns/challenges? Workforce, best practices, alignment, measurement, operation, strategies
	• Survey to COP: Should we work together as a collective on a DEI initiative? Yes: Data informed, shared standards, build trust
	
	Questions & Discussion
	Q: Chat: Are you going to have experts from different communities come in and train on these topics? For example, members of the Independent Living Community who can teach areas of their expertise. My area of expertise is in mental health; having different voices of those with knowledge and experience is very valuable; important to understand the experiences of others.
	A: We understand that having the voice of those with lived experience is crucial for health equity, we need to hear the voices of our members and our communities; one of our teams leading this effort is the member experience director, Kelly Shanahan, designing an overall strategy on how to do this.
	We're always mindful of "nothing about us without us" philosophy of approaching this work; we continuously look for ways to partner with those organizations.
	I recently did a training about how to safely and effectively share your story, will have something coming up this week.
	Q: Are these elements coming from the 2023 improvement activities listed the in Merit-Based Incentive Payment System (MIPS)? Would be logical to find out the providers that subscribe to that system and bring them into the COP.
	A: Yes, my understanding is that MIPS is a variation of valuable based payment reform which is part of the equity plan; there is an element of payment reform to achieve the quintuple aim – achieving care quality, member experience, provider experience, health equity.

Panel Discussion: Serving the Community (Slides 19-27)	Jared Ward, Joy Twesigye, Andria Dwyer, Marsha Aliaga-Dickens
	• Enhanced Clinical Partners (ECP): Provide care mgmt. for all attributed members regardless of complexity and submits care mgmt. data to COA for review • Eligible for higher Per Member Per Month (PMPM)/additional funding, additional rates • Chart Review Audits: Biannual member chart review in Feb and Aug; Feb audits are tied to payment and affect future value-based payment models • Practice Facilitators work internally with Care Mgmt on best practices/training **Questions & Discussion** Q: Are the patients charts randomly selected or can you specify a non-English speaking client member of the refugee community? A: They are randomly selected; we pull random three patients that fall under HCPF chronic condition definition; as far as patient barriers, needs, SDOH, those will be addressed in the care plan Q: So there's no way that you can select a limited English proficiency or refugee specific individual? A: Correct, but I can bring that back to my team Most clients don't know how the referral system works, a primary doctor tells the patient that they are being referred to a specialist, but the patient doesn't get a call and doesn't understand that they have to follow up and make an appointment, easy for them to fall through the cracks Q: I'm a quality-of-life advocate, it seems to be with a satisfaction based system, the patient should have more input on how their services could reduce overall costs and hurtles in the system; do you have anything that checks satisfaction of the consumers receiving services? A: We usually tell the clinics to avoid asking questions about how they can help improve their clients lives because when working with refugees, there is so much need, we don't want to overwhelm our providers and don't want to overpromise We try to stress to our ECPs is the personalization of their care plans, working to improve processes and resources which will help improve patient care plans Chat: I'd like to hear more about the partnership with the YMCA! Chat: The Inner City Health Center's Care manager, Donna Heath, an RN, is the brains behind the YMCA partnership. YMCA has an accredited (approved?) Diabetes program, and Donna helps with the referrals, transportation, and celebrations. Q: When you pick your complex cases and go back to the providers, do you ask for a percentage of the complex cases or how do you go about filtering what you want? A: We do provide a list of our complex patients; as for random selection, our data team pulls based on those conditions Q: Are you pulling or is the provider pushing the data to COA? A: The provider is pushing the data to us; we have a list of complex patients; for COA care mgmt. submission, those practices need to report on extended care plan activities, then we filter those through our internal business intelligence teams, that's how we pull the data for those chart reviews Within systems, like EPIC, anything Oracle-based, there is a way to filter by language so you can get a good demographic of people to sample We are in the process of upgrading our Guiding Care platform at COA, including the platform that use primarily for our care mgmt., but in terms of what should be a push and pull, what makes it easier for the providers, what makes auditing easier and more standard, practices use so many platforms; for some families, there are so many coordinators, so who coordinates the coordinators; there's lot of nuance and pieces; we're aware of these problems and like hearing solutions and options on how we can improve these processes

	Q: What steps would Tepeyac need to take to become an ECP? A: There is a guide on our website on how to ascend to an ECP Andria Dwyer • Interdisciplinary Team (IDT) calls are for anyone, allow for collaboration and coordination between organizations to ensure no duplication of efforts and work together to best meet member's needs; can be facilitated and scheduled by anyone on member's team; do not need to be facilitated by the RAEs, do not involve HCPF or Dept of Human Services staff; if an IDT call has happened, but did not resolve the issue, or the issue is more complex, the next step is: • Creative Solutions Calls: For individuals under the age of 18; HCPF developed this to bring all of funders and programs into a cohesive group to assist members and their families who may be in crisis situation; facilitated by RAEs • Complex Solutions: Way to support members facing challenges, multi system involvement, for adults, member 18 and over; majority are needing skilled nursing placement; facilitated by RAEs • If member needs a Care Manager or care coordination, anyone can send a request to Resource&Referral@coaccess.com. • If a member needs a Creative or Complex Solutions call after completion of IDT meeting, anyone can send a request to CSRequest@coaccess.com **Questions & Discussion** If an established member has a barrier, for example, we don't know how to get them into their mental health provider, transportation – a lower level situation that we need to figure out, that would be appropriate for an IDT call; for IDT calls, the request typically comes from the person who has identified the problem Q: How can someone find a specialist? A: Members can call into care coordinator line to request assistance finding a specialist, there's also a provider tool and a chatbot on the COA website Chat: Our refugee community find it strange when we keep repeating it to them. You have to check with primary care first, you can't schedule appointment with whoever you think you need. Q: What if a person has a high level of need, but is not interested in long term community placement, the want to live independently? Can they still request this to find an appropriate level of services? A: One of the first things we do is see if the member is connected to a case mgmt. agency, if we can get them on a waiver, they can get those extra services, assuming they qualify; might also connect with the provider on their recommendations Q: Would you be willing to do a presentation at Statewide Independent Living Council (SILC) or Atlantis? Many would be interested in this information. A: Yes, we'd love to connect. We do have a lot of these calls happening, the demand is high, so we can't do these calls every day, but sometimes a couple times a week; important to exhaust the lower levels prior to getting HCPF involved We have a mechanism of communicating with HCPF, these calls are not the only ways to escalate issues, we can connect with them in other channels; we report this out to HCPF every week with a status of each case, HCPF takes that spreadsheet and escalates it up their chain of command

	Marsha Aliaga-Dickens • Public Health emergency included continuous coverage; once ended on May 11th, that continuous coverage enrollment stopped; some states started in April, we started in May; everyone who has a May 31st redetermination date is considered part of May cohort of members and each cohort requires a specific type of outreach with specific timelines, member who have not completed their renewal packets in time receive outreach, will continue through April 2024 • Using robocalls, text campaigns, emails, mailers; based on weekly files that we receive from the state and we draw our outreach lists from that data; in the four week timeline, triggers care mgmt. follow up to high risk – have not completed renewal packet (high risk for losing benefits) with digital outreach; high risk based on set of conditions, receive telephonic outreach • Telephonic outreach through the new call center set up specifically for this process • Common challenge: Members have completed the packet, but because of the lag, we don't see it and we are calling to ask about their packet; we suggest people to log into their PEAK account or contact county to check in and ensure that packet was received • Also partnering with our ECP practices to support the continuous coverage outreach work since they have a direct connection with members. **Questions & Discussion** COA is engaging with Open Answer to assist with outreach; we continue to learn how to effectively connect with members about this information; we will report out how that process is going, this is in addition to the efforts of care management call center Q: What was your success rate on the 8,000? A: We just submitted our first deliverable data, which is pulled by a different department; one of the requirements is to report out on head of household instead of individual member; we can get that info to you; we're still understanding the measure of success Chat: We've also partnered with health alliances to work with local trusted community organizations through a community ambassador program for continuous coverage unwind. We've also partnered with our ECPs to outreach their engaged members; also partnered with the case mgmt. agencies so they're outreaching their members Chat: Our public benefits at IRC do their best to help re-apply, but we do have a limited capacity too, because new arrivals need more of our attention Being on the committee has been helpful at my job with Rocky Mountain Crisis Partners; I give out the indigent care program info; also grateful that I can help people with services they need by directing them to their care coordinator; I've referred people to care management and I encourage them to advocate for this Would be good to include this information in the Atlantis newsletter
Additional Comments, State PIAC Update	Still need a Region 5 representative on the State PIAC
	Meeting adjourned at 6:00pm.
Recommendations	Jo: Email State PIAC update with links, July CCDC event Jared: Send info on how to become an ECP Molly: Connect with Ty re: R5 State representation