	Region 3		Region 5
	Alisia Moreno, International Rescue Committee		Ana Vizoso, Servicios de La Raza
	Angela Wilson, Adams County Government	x	Anthony Moreno, Health First Colorado
	Ashleigh Phillips, Centura Health		Ashleigh Phillips, Centura Health
x	Bipin Kumar, Himalaya Family Clinic		Candy Wolfe, Creative Treatment Options
x	Bob Conkey, Health First Colorado		Carolyn Hall, RM Crisis Centers, CHARG Drop-In Center
x	Carol Tumaylle, Refugee Health Advocate	x	Damian Rosenberg, Personal Assistance Serv of Colorado
	Christina Redwine-Stimson, Aurora Interfaith	x	Heather Schenkel, DentaQuest
	Daniel Darting, Signal Behavioral Health Network		Helen Pattou, International Rescue Committee
x	Elizabeth Snow, Health First Colorado	x	Jacquie Stanton, State of Colorado Dept of Local Affairs
	Jamie Rodriguez, Adams County Health Department		Jeremy Sax, Denver Health
	Jennifer Fierberg, UCHealth Co-Responder Program	x	Jim Garcia, Tepeyac Community Health Center
x	Jessica Courtney, Mile High Behavioral Health	x	Judy Shlay, Public Health Institute at Denver Health
	Jessica Prosser, City of Aurora, Housing & Comm Services		Kraig Burleson, Inner City Health Center
x	Kadi Kouyate, Migrant Response		Matthew Pfeifer, HCPF
x	Laura Ciancone, Douglas County Public Health		Nina Marinello, Intermountain Healthcare
x	Laura Larson, Douglas County Public Health Department		Pamela Bynog, Health First Colorado-ON LEAVE
	Luke Wheeland, ARC of Arapahoe, Douglas	x	Paula Gallegos, Health First Colorado
x	Marc Ogonosky, Health First Colorado	x	Sherri Landrum, Children's Medical Center
	Matthew Pfeifer, HCPF		Ty Smith, Consumer, Health First Colorado
x	Meredith Velasquez, Juvenile Assessment Center		
	Mike Marsico, Behavioral Health Provider		
	Natalie Archuletta, DentaQuest		
	Patty Ann Fontenot, Elbert Collaborative Mgmt Program		
x	Princess Mack, Health First Colorado		
	Scott Adams, The Medical Center of Aurora		
x	Wendy Nading, Tri County Health Department		
x	Whitney Gustin Connor, Kids First Health Care		
	COA Staff		**Guests**
	Ayana Session		Amanda Carter, Jewish Family Service
	Becky Selig		Monica Lintz, Denver Health
	Casey Thomas		Neva Martinez Ortega, Servicios de la Raza
	Dawn Gissender		Rick Thompson, Servicios de la Raza
	Jo Glaviano		
	Julia Mecklenburg		
	Laura Coleman		
	Leah Pryor-Lease		
	Madhu Mallela		
	Mika Gans		

Agenda Items	
Welcome, Introductions	
Well Child Visits	Sarah Thomas, Senior Quality Improvement Consultant • Measures that are required by the state:

	• Well-child visits in first 30 months of life
	• Well-care visits of children ages 3-21 years old
	• Improvement strategies:
	  ○ Provider workgroups: 15 providers meet bi-monthly; collaborate and discuss processes, best practices, successes, challenges
	  ○ Mass Member Ad-Hoc Text Messaging, Postcard Mailing: Sent to all RAE and CHP+ members due for well child visit
	  ○ Discuss feasibility of deploying Mobile Health Units at events
	  ○ Potential underutilization of school-based health centers based on data; brainstorm methods to boost utilization
	
	Questions & Discussion
	Q: Are texts and postcards in different languages?
	A: They are in English and Spanish only
	Local public health organization routinely provide vaccines, often to Medicaid members; we need to ensure that these services are mobile and flexible, especially with schedule to reach the most people.
	It would be helpful to offer well child services at the same time as vaccine clinics, involve providers during mobile events to assist with additional services; important to provide services during evenings and weekends.
	Q: When talking about mobile events, is that data captured?
	A: Our goal with mobile health units is to have them billed through Medicaid so they can be captured; it is captured at contracted schools.
	Q: Chat: Has there been any progress in getting providers to offer well check appointments outside the 9-5, m-f window so parents or students don't have to miss work or school?
	A: It is practice specific, some do offer later night or weekends, but some do not
	Q: Is the numerator and denominator just simply that – visits and population – or is there more dead mining going on?
	A: For metric reporting it is simply that: visit and do they qualify, however, we do look at other factors (demographics, ethnicity, geographic areas)
	Q: Are you looking at any diagnostic coding during visits? If you bring in an infant with jaundice, are you capturing that data? If so, are you using it to create predictability models and if not, why not?
	A: We get the info that is submitted in the claim, which can be limiting, there's a certain amount of diagnostic lines that are allowed in a claim, and sometimes people just do a few; we've done some diagnoses with potentially avoidable costs, do some risk stratification around their population is made up (chronic disease v episodic); predictive modeling would be great, we'd be driving down costs, a lot of it is driven by our data capabilities
	Q: In the data collection itself, when looking at claims, some will be sent back, you can use that to create a pseudo-based cost model, seems it would help the state plan, can leverage AI to get financial picture of future spending; is it heading in that direction? Seems a shame to capture that data and not use it for something. Are we trying to use the data to predict cost and future disease state?
	A: We're looking at that, it's a big thing to do in healthcare
	Q: Concern about the data; are we looking at collaborating with community agencies and organizations to increase the number of individuals getting well child visits? Has there been an effort to collaborate with early childhood education departments to catch the classes of 3 years olds?
	A: We can promote that as an area of opportunity, but when talking about bringing physician to the schools, it works, but just wouldn't be at every school; we're capturing the data when it happens with children who are on Medicaid

	Re: Mobile Vaccinations: Denver Health goes to many places including schools and we connect with school based health centers as needed; we do well child checks, vaccinations, etc.; recommend mobile vans be placed in regional areas that have schools, food banks, provide well checks; school based health centers also provide mental and behavioral health Striking the right balance between technology and in person visits; include dental connections, services Fascinated about well child visits, particularly the communications; heard COA talk about texting and postcards, but there is already so much noise that families are dealing with; we've found that the most effective way of communication is in person events, like back to school events; curious about COA's plans to measure the impact of these new communication methods

Behavioral Health	Mika Gans, Director of Quality Improvement
	• Review of
	  ○ Key Performance Indicator: Depression Screening & Follow-Up
	  ○ Behavioral Health Incentive Measures:
	  ▪ Substance Use Disorder Treatment
	  ▪ Follow-up after Hospitalization for Mental Illness
	  ▪ Follow-up after Emergency Dept visit for Substance Use
	  ▪ Follow-up after positive depression screening
	  ▪ Behavioral Health Screening or Assessment for Children in Foster Care System
	  ○ Performance Pool Measures:
	  ▪ Dept of Corrections Behavioral Health Engagement
	  ▪ Antidepressant Med Management
	
	Questions & Discussion
	Q: Which screening do you use?
	A: PHQ9, but PHQ2 also counts
	Q: What is that difference with children in foster care?
	A: It's the population size; about 20 in region 5 and 80 in region 3, data difference normalizes a little bit more; these are brand new
	Q: Who is screening them and are they taking into consideration these factors; there is no way we have those small numbers of children going into foster care
	A: We work with the counties to get the lists, Region 5 is smaller because there is a carve out for Denver Health; the way the data is filtered looks that way; Denver Health wasn't able to screen just kids in foster care, so we changed procedure to screen all children
	Concerned that in Colorado, the highest number of kids being taken into foster care are black and brown kids.
	The number seems very low and presents that we don't have many kids who rise to the level of meeting secondary and tertiary care; in social services there is bias in the numbers, worried they are being overlooked.
	We work with providers to ensure that every child is getting a depression screening, we've been instituting the care across the population despite what the population says.
	This is an example of the thesis level; the quality metrics that come from HCPF are not exactly the same as quality care; the mechanisms for how the metrics are measured are limited and does not show 100% of the care that is being given.
	Q: Do people who are arrested (and go into custody but not an emergency room) get screened and tracked in the same way?
	A: I can get back to you on that

	I have a team of nurses who are embedded in human services; maybe we can meet with Lauren Showers to dive into the data a bit more; when talking to providers, 30 days is not realistic timing based on the volume of kids who need this care Another example: Newborn babies are part of the denominator, but obviously you can't give a depression screening to them; this doesn't actually capture the full universe of care that is being given. When looking at the numbers, there's no qualifier; maybe in the state system, there's a number of kids that are in foster care; compare it to this number and explain the discrepancy. These metrics can only be determined by billing, not those who are in process or have issues in billing. Seems to be focused on acute care There is network adequacy planning and work happening, maybe bring those folks to a future PIAC meeting.
Behavioral Health Panel	Amanda Carter, Jewish Family Services, Mental Health Kids Success Team Monica Lintz, Administrative Director, Behavioral Health Services, Denver Health
Additional Comments	**Diversifying the PIAC** In an effort to diversify the PIAC to ensure we have expansive and appropriate representation, please take this survey. Information collected will only be used internally to help identify gaps and opportunities and help with recruitment efforts. Personal identification will not be shared externally. **PIAC Meeting Proposal** • Cancel June meetings • Meet together in person/hybrid (combined): ○ Mon, September 9, 2024; 4-6pm ○ Mon, December 9, 2024; 4-6pm ○ Mon, March 10, 2025; 4-6pm ○ Mon, June 9, 2025; 4-6pm **ACC III** Letters of support request will go out starting next week (internal deadline is June 18th)
Next Meeting	Monday, September 9, 2024