AdvantagePoint Health Alliance – Laurel Highlands

Practice Managers’ Meeting

June 7, 2023 at 7:15 AM

Teams Meeting

Access via computer or:

1-423-680-7437

Conference ID: 359 664 195#

ADVANTAGEPOINT
HEALTH ALLIANCE
Laurel Highlands

Agenda

• ECCM	Chelsey Speed
• Scoring Updates	Kaitlyn Hickey
• AWV Coding Clarification	Dr. Smith
• Bi-Annual Meeting Recap	Dr. Smith/Kirsten Held
• AWV Visit Data	Kirsten Held
• Kidney Health Evaluation in Diabetes	Kirsten Held
• UPMC Depression Screening Follow-Up	Kirsten Held
• PBCM Documentation Change	Kirsten Held

Highmark Health

Home & Community Services

Enhanced Community Care Management (ECCM)

May 2023

Agenda

- What is Enhanced Community Care Management (ECCM)
- Patient Identification
- How We Partner – Provider Communication
- How to Refer

Enhanced Community Care Management (ECCM)

ECCM is a supportive care solution that provides palliative medical care and specialized care coordination to help people live their best life possible while maintaining their independence in the community.

The ECCM Patient

The high risk, serious ill population that utilizes the most healthcare resources.

- Identified through Highmark advanced analytics
- Advanced illness and frailty are key indicators
- Polypharmacy (10 or more)
- SDOH – unstable housing, food insecurities, financial insecurities, lack of transportation

The ECCM Care Team

An interdisciplinary team of specially trained provider who will meet patients where they are.

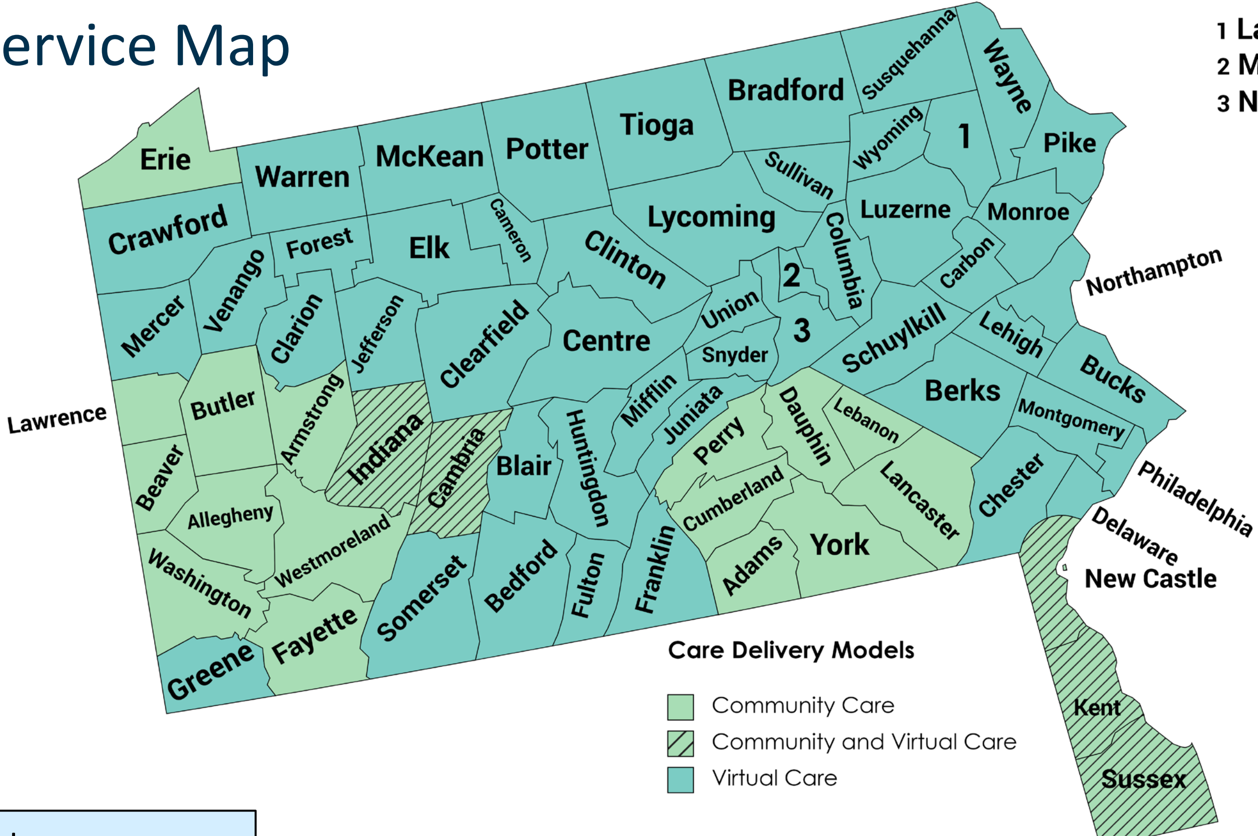
- Physicians
- Advanced Practice Providers (CRNP and PA)
- Registered Nurses
- Licensed Social Workers
- Care Coordinators

The ECCM Goal

Our team is focused on improving health outcomes while lowering the total cost of care and providing a positive patient and provider experience.

- Improve the quality of life for the patient and their family
- Provide relief from the symptoms and stress of the illness
- Clarify the Patient’s Care Priorities
- Advanced Care Planning
- Reduce unnecessary utilization
- Care Coordination across healthcare settings

ECCM Market Service Map



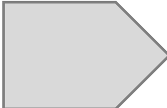
1 Lackawanna
2 Montour
3 Northumberland

ECCM Segment

Highmark Medicare Advantage
Highmark Individual ACA
Highmark Employees/Dependents
Highmark Wholecare (DSNP & Medicaid)
Medicare Fee for Service (Only PPWPA)

Supportive Care Continuum

Disease Progression – Conditions appropriate for Supportive/Palliative Care may or may not progress to death



Care is based on the needs of the patient not the prognosis.
At any stage of a serious illness, ECCM services can be provided along with curative treatment.

Acuity	Low
Care Delivery Method	Telephonic and Virtual (Monthly)
Care Team:	Care Coordinator
Care Provided:	• Goals of Care • Telephonic support to assist with self-management of multiple conditions • Assistance with managing appointments • Support with medication management • Assistance with social determinants of health

Acuity	Moderate - High
Care Delivery Method	Virtual & In-Home – At least once a month (often more)
Care Team:	APP, Nurse, Social Worker, Care Coordinator
Care Provided:	• Whole-person-advanced care planning • Pain & Symptom management through medical and non-medical interventions • More frequent check-ins • Care plan support, including monitoring of conditions and when to take medications • Support family caregiver with education, counseling and/or respite • Assistance with decision making, clarifying care priorities, and helping match treatment and services to those goals • Assistance with social determinants of health

Refer to ECCM

Extra support for your most complex patients.

Care Port

Helion Arc

Epic or Epic Care Link

Email

Phone

Fax

Navinet

Enhanced Community Care Management

REFERRAL FORM: Pennsylvania
Phone Number: 844-438-3226 (844-GET-ECCM)
Email: eccmreferrals@highmark.com
Fax: 844-978-2756

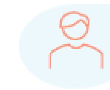
To expedite the engagement of your patient please include the following information with your referral: H&P, Progress Note, OR recent Discharge Summary; and Medication/Allergy List.

Please note that all fields in yellow are required.

Affiliated Health System

☐BHS ☐Conemaugh ☐Excela ☐FPC ☐Genesis ☐HVHS ☐PSH ☐Premier ☐PPWPA ☐WPHO

☐Other:



Patient Information

Is this patient/caregiver aware of this referral? ☐Yes ☐No

Patient Name: Patient DOB:

Insurance: ☐Highmark Medicare Advantage ☐Highmark ACA Member ID:

Street Address: Phone:

City: Zip Code:

Primary Caregiver: Primary Caregiver Phone:

Referring Information ☐PCP ☐Hospital ☐HH/HSP ☐SNF ☐LTAC ☐Specialist

Practice/Facility/Agency Name:

Referring Provider: (☐ same as PCP): Phone:

PCP Information

Patient PCP: PCP Practice:

PCP Phone: PCP Fax:

Referral Information:

Primary Concern:

Last Modified 1.30.2023

Enhanced Community Care Management (ECCM)

- Free Nonbillable Community Palliative Services for
  - Highmark Medicare Advantage
- No LOS requirement
- Does not require a physician's order
- Patient/Member can be receiving home health services and care from an inpatient/outpatient palliative clinical
- Benefits:
  - Patient & Family/Caregivers
  - PCP
  - Hospital

Contact

Contact Me

Chelsey Speed, Strategic Partnership Specialist

Email: Chelsey.l.Speed@HMHCS.com

Phone: 412-215-4896

Thank you!

Refer to ECCM

Clinical picture of how ECCM can support you and your patients.

Enhanced Community Care Management (ECCM) Referral Guide

ECCM is a home-based and virtual supportive and palliative care program delivered by an interdisciplinary team of care coordinators, registered nurses, licensed social workers, advanced practice providers, and physicians.

Patients are appropriate for ECCM if they:

- Have multiple chronic medical conditions affecting quality of life and coordination of care

  and/or

- Have one or more serious illness, such as (but not limited to):
  - Heart failure
  - Cirrhosis
  - Cancer
  - Dementia
  - Chronic pulmonary disease (i.e., COPD, pulmonary fibrosis)
  - End-stage renal disease
  - Parkinson's Disease
  - ALS
  - HIV/AIDS

ECCM can help with:

- Care coordination
- Family and caregiver support
- Social determinants of health
- Avoidable ER/hospital utilization
- Advanced symptom management
- Advance care planning
- Polypharmacy

Supportive and palliative care is **appropriate for anyone with multiple chronic conditions and/or a serious illness.** It is **not the same as hospice** and is appropriate at any stage of a serious illness or advanced chronic disease, including during the receipt of disease-directed care.

Reach us Today

844-438-3226 (844-GET-ECCM)

eccmrererrals@highmark.com

Fax: 844-978-2756

E C C M

E	C	C	M	
Extra layer of support for patients and their families	Connecting patient need to resources in your community	Coordination between healthcare settings	Managing symptoms to avoid crisis care	Simple and seamless to improve quality of life

This is a free/nonbillable service for **Highmark Medicare Advantage.**

Call us Today

844-438-3226 (844-GET-ECCM)

Monthly Lump Sum Quality Summary | Entity Level - Aggregate Summary

ADVANTAGE POINT HEALTH ALLIANCE LAUREL HIGHLANDS LLC TRUE PERFORMANCE - 003499330

Run date: 05/29/2023
Claims Incurred Through: 04/29/2023
Claims Paid Through: 04/29/2023
Attribution Through: 03/31/2023
Measurement Period: 01/01/2023 - 04/29/2023

Population	Lump Sum Threshold*	Population Score	Avg Members	Population Weights**	Lump Sum Score	Points Available	Current Points Earned
Adult		32%	11,275	78%		13	4.1
Pediatric		0%	776	5%	**33%**	9	0.0
Senior		47%	1,211	17%		21	9.9

*Seniors score reflects patients 65+ with commercial plans (MA seniors are now only scored via Stars rating)

Monthly Lump Sum Quality Summary | Entity Level - Aggregate Summary

ADVANTAGE POINT HEALTH ALLIANCE LAUREL HIGHLANDS LLC TRUE PERFORMANCE - 003499330

Run date: 05/19/2022
Claims Incurred Through: 04/30/2022
Claims Paid Through: 04/30/2022
Attribution Through: 03/31/2022
Measurement Period: 01/01/2022 - 04/30/2022

Population	Lump Sum Threshold*	Population Score	Avg Members	Population Weights**	Lump Sum Score	Points Available	Current Points Earned
Adult		28%	11,375	40%		12	3.4
Pediatric		7%	6,670	23%	**30%**	6	0.4
Senior		46%	5,253	37%		26	11.9

2023 STAR MEASURE PERFORMANCE SUMMARY - ENTITY LEVEL

003499330 - ADVANTAGE POINT HEALTH ALLIANCE LAUREL HIGHLANDS LLC TRUE PERFORMANCE

RUN DATE: 22MAY2023

ATTRIBUTION DATE: 31MAR2023

CLAIMS PAID THROUGH: 29APR2023

CURRENT AGGREGATED STAR RATING: 3.06 STARS

Includes Medicare Advantage Members Only

Class	Measure Name	Current Trend Measure Star Rating	5 Star Compliance	5.5 Star Compliance	Current Open Gaps
Dynamic	C15: HbA1c Control for Patients with Diabetes (<=9%)	1.00	89.0%	93.0%	229
Dynamic	C21: All-cause Readmissions	3.75	.71	.58	253
Dynamic	D10: Medication Adherence for Diabetes Medications	5.50	92.0%	93.5%	12
Dynamic	D11: Medication Adherence for Hypertension: RASA	5.50	92.0%	93.0%	22
Dynamic	D12: Medication Adherence for Cholesterol (Statins)	5.50	93.0%	94.5%	31
Dynamic	C16: Controlling High Blood Pressure	1.00	87.0%	91.0%	853
Static	D13: Medication Therapy Management	1.00	92.0%	95.0%	365
Static	C23: TRC Medication Reconciliation Post-Discharge	2.25	89.0%	98.0%	115
Static	C22: Statin Therapy for Patients with Cardiovascular Disease	1.00	91.0%	93.5%	36
Static	D14: Statin Use in Persons with Diabetes	1.00	92.0%	93.5%	55
Static	C13: Eye Exam for Patients with Diabetes	1.00	83.0%	87.0%	164
Static	C01: Breast Cancer Screening	4.00	77.0%	80.0%	135
Static	C02: Colorectal Cancer Screening	2.50	82.0%	86.0%	417
Static	C12: Osteoporosis Management in Women who had a Fracture	2.00	73.0%	82.0%	10
Static	C24: Patient Engagement After Inpatient Discharge	4.00	90.0%	95.0%	40
Static	C25: Follow-up after Emergency Department Visit for Patients with Multiple Chronic Conditions	2.50	74.0%	79.0%	75
Static	HOS1: Fall Risk Assessment	1.00	69.0%	73.0%	2087
Static	C51: Annual Wellness and Initial Preventative Physical Rate				2996
Static	C26: Kidney Health Evaluation for Patients with Diabetes		62.0%	70.0%	514

ADVANTAGEPOINT HEALTH ALLIANCE Laurel Highlands

UPMC Health Plan

Premier Partners Program Performance Scorecard

Advantage Point-Laurel Highlands

Medicare Adult Results

Claims Incurred 01/01/2023 - 03/31/2023, Paid Through 04/30/2023

Quality - Overall Improvement Target

	Current Score	All PPP Score	Tier 1 Target	Tier 1 Opportunity	Tier 2 Target	Tier 2 Opportunity	Tier 3 Target	Tier 3 Opportunity
Overall Stars Rating	2.6	2.8	4.2	$60,000	4.3	$120,000	4.4	$180,000

Risk Adjustment

	Current Rate	CY 2023 Target	All PPP Rate	Target Opportunity	Target + 1% Opportunity	Target + 2% Opportunity	Target + 3% Opportunity
HCC Capture Rate	29.4%	65.1%	28.3%	$100,000	$150,000	$200,000	$250,000

Commercial Risk Adjusted Adult Results

Claims Incurred 01/01/2023 - 03/31/2023, Paid Through 04/30/2023

Quality - Overall Improvement Target

	Current Rate	All PPP Rate	Tier 1 Target	Tier 1 Opportunity	Tier 2 Target	Tier 2 Opportunity	Tier 3 Target	Tier 3 Opportunity
HEDIS Gap Closure %	55.3%	56.7%	73.0%	$10,000	74.9%	$20,000	76.8%	$30,000

Risk Adjustment

	Current Rate	CY 2023 Target	All PPP Rate	Target Opportunity	Target + 1% Opportunity	Target + 2% Opportunity	Target + 3% Opportunity
HCC Capture Rate	26.7%	58.4%	24.5%	$10,000	$20,000	$30,000	$40,000

Commercial Adult Results

Claims Incurred 01/01/2023 - 03/31/2023, Paid Through 04/30/2023

Quality - Overall Improvement Target

	Current Rate	All PPP Rate	Tier 1 Target	Tier 1 Opportunity	Tier 2 Target	Tier 2 Opportunity	Tier 3 Target	Tier 3 Opportunity
HEDIS Gap Closure %	59.2%	59.0%	73.0%	$20,000	74.9%	$40,000	76.8%	$60,000

Medicaid Adult Results

Claims Incurred 01/01/2023 - 03/31/2023, Paid Through 04/30/2023

Quality - Overall Improvement Target

	Current Rate	All PPP Rate	Tier 1 Target	Tier 1 Opportunity	Tier 2 Target	Tier 2 Opportunity	Tier 3 Target	Tier 3 Opportunity
HEDIS Gap Closure %	46.9%	46.4%	65.9%	$30,000	68.2%	$60,000	70.6%	$90,000

Risk Adjustment

	Current Rate	CY 2023 Target	All PPP Rate	Target Opportunity	Target + 1% Opportunity	Target + 2% Opportunity	Target + 3% Opportunity
CDPS Capture Rate	0.0%	27.0%	0.0%	$30,000	$60,000	$90,000	$120,000

Medicaid Pediatric Results

Claims Incurred 01/01/2023 - 03/31/2023, Paid Through 04/30/2023

Quality - Overall Improvement Target

	Current Rate	All PPP Rate	Tier 1 Target	Tier 1 Opportunity	Tier 2 Target	Tier 2 Opportunity	Tier 3 Target	Tier 3 Opportunity
HEDIS Gap Closure %	24.4%	34.2%	59.3%	$7,500	62.8%	$15,000	66.3%	$25,000

Risk Adjustment

	Current Rate	CY 2023 Target	All PPP Rate	Target Opportunity	Target + 1% Opportunity	Target + 2% Opportunity	Target + 3% Opportunity
CDPS Capture Rate	0.0%	19.0%	0.0%	$7,500	$15,000	$22,500	$30,000

*Commercial peds & CHIP are no longer scored due to low population numbers

UPMC Depression Screenings

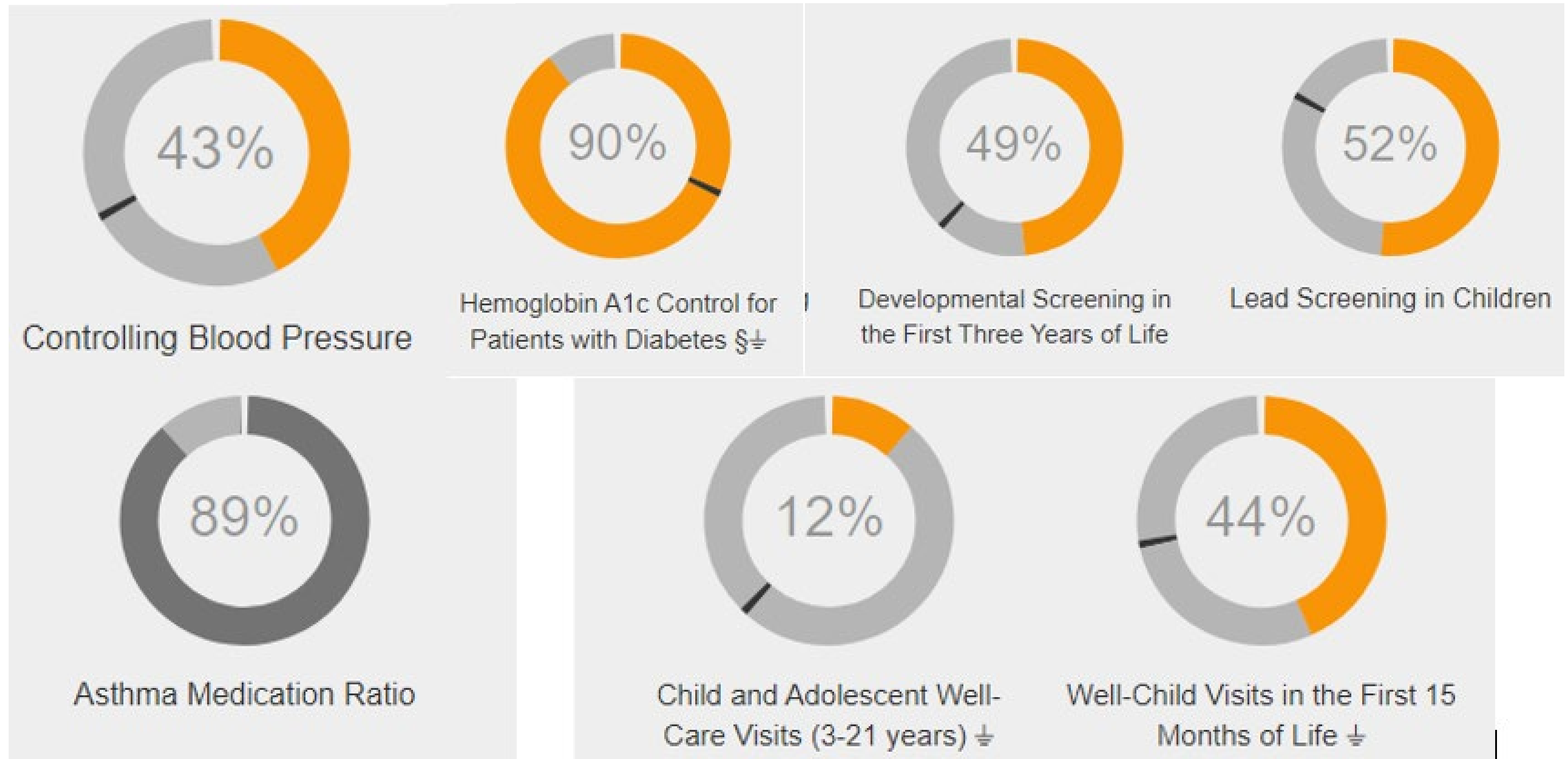
Depression Screening - All Lines of Business

Membership Age Range	Average Membership (a)	Distinct Claim Date Cnt (b)	Screen Rate (b / a)	Tier 1 / Tier 2 Opportunity	Tier 1 / Tier 2 Targets	G8431 (Positive)	G8510 (Negative)	Distinct Members with Pos. / Neg. Code	G0444 (Screen)	96127 (Screen)
Ages 22 & Over Membership	30,109	5,862	19.5%	$2.50 / $6.00	45% / 65%	499	5,178	5,148	4,360	374

Depression Screening - All Lines of Business

Membership Age Range	Average Membership (a)	Distinct Claim Date Cnt (b)	Screen Rate (b / a)	Tier 1 / Tier 2 Opportunity	Tier 1 / Tier 2 Targets	G8431 (Positive)	G8510 (Negative)	Distinct Members with Pos. / Neg. Code	G0444 (Screen)	96127 (Screen)
Ages 12 - 21 Membership	2,498	233	9.3%	$4.00 / $7.00	45% / 65%	23	175	177	90	101

HIGHMARK WHOLECARE



AWV clarification from last month

Medicare AWV Coding

(2023 CMS Physician Fee Schedule for Our Region)

- G0402 – Initial Preventive Physical Exam (IPPE) – Performed within the first 12 months of enrollment in Medicare – ($161.29, 2.6 work RVU)

  ****This is the only traditional physical exam Medicare ever pays for****

  - G0403 – Screening ECG performed as part of IPPE – includes interpretation and report. ($13.96, 0.17 work RVU)
  - G0404 – Screening ECG without interpretation and report. ($6.00, 0 work RVU)
  - G0405 – Interpretation and report of ECG (G0404) ($7.97, 0.17 work RVU)
- G0438 – Annual Wellness Visit, Initial – After 12 months enrollment but did not have an IPPE – ($160.98, 2.6 work RVU)
- G0439 – Annual Wellness Visit, Subsequent – Annually ($125.66, 1.92 work RVU)

Bi-Annual Meeting Recap for Care Model Committee

A legal arrangement that allows hospitals and physicians to collaborate on quality and efficiency improvement while remaining independent entities.

A continuous process of alignment across the care continuum that supports the triple aim of health care or quadruple aim for APLH.

"Clinical Integration" – support from Care Model Committee

Importance of Engaged Clinicians

HEDIS Measures origin and precautions in their use as the "bar" of success

HEDIS Measures role

- Limitations
- APLH expectations from this committee vs payer expectations.

UPMC: Excellent 5 out of 5 stars AGAIN!

October 10, 2022 News

Press Releases

Thursday, October 06, 2022

Highmark's Medicare Advantage plans continue to earn highest score in federal quality program in Pennsylvania

Pennsylvania HMO and PPO plans once again scored 5 out of possible 5 Stars

APLH 4.2x

APLH 4.1x

Engaged Clinician – Expectations/Opportunities

-EHR improvements

Clinical Decision Support?

Coding Support?

Work-flow Best Practices/Ongoing Training

Health Maintenance APLH standardization

- Quality Coding Standards/Expectations

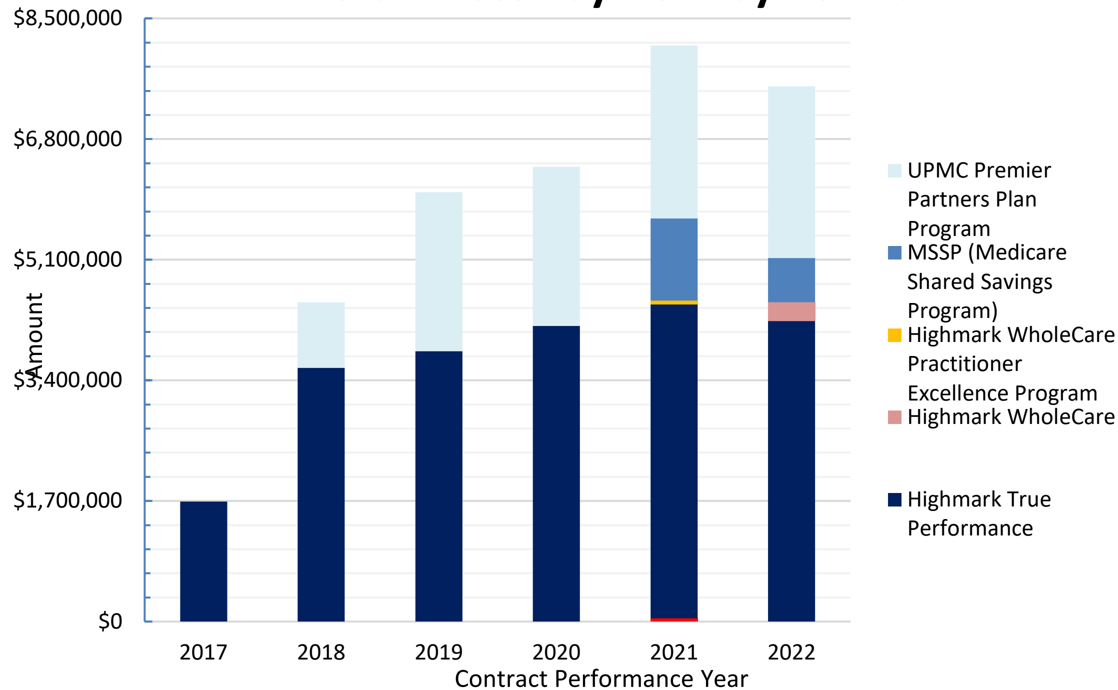
- Staff Training and support – APLH standards
  - APP Committee?

- Citizenship component to funds flow?

ADVANTAGEPOINT HEALTH ALLIANCE Laurel Highlands

Payor	Contract	Population	Earning Opportunity
Aetna	Collaboration 2.1	Medicare Advantage	Quality Lump Sum Shared Savings (Downside risk in 2024)
Medicare FFS	Medicare Shared Savings Program (MSSP)	Medicare	2023 – 3.5% bonus on total billings 2024 and beyond – Fee Schedule Adjustment Exempt from MIPS reporting Shared Savings (Downside risk in 2022)
Highmark	True Performance Plus/Advanced	Commercial Adult and Pediatrics	Care Coordination Quality Lump Sum Shared Savings (Downside risk in 2024)
	Medical Loss Ratio (MLR)	Medicare Advantage	Care Coordination Shared Savings (Downside risk in 2024)
Highmark Wholecare	Practitioner Excellence	Medicare Advantage Medicaid Adult and Pediatrics	Quality Lump Sum
	Shared Savings	Medicaid Adult and Pediatrics	Care Coordination Shared Savings
UPMC	Premier Partners Program	Medicare Advantage Commercial Adult Medicaid Adult & Pediatrics	Care Coordination Quality Lump Sum Shared Savings

Trended Payment Summary



Note: 2022 amounts for the Highmark True Performance, Highmark WholeCare, and UPMC Premier Partners Plan Program contracts represent latest projections.

Contract Performance Year	Total Gross Payment	Total Lives	Per Member Per Year (PMPY)
2017	$ 2,411,056	26,912	$ 89.59
2018	$ 4,502,500	60,384	$ 74.56
2019	$ 6,052,524	65,206	$ 92.82
2020	$ 6,411,063	71,572	$ 89.58
2021	$ 8,119,855	77,868	$ 104.28
2022	$ 7,545,052	84,021	$ 89.80

Clinical Update

Majority of success across contracts has been delivered through improvement in ADK or readmission rates

	MSSP	Highmark	UPMC	HM Wholecare	Aetna	Total
ADK (YTD/Prior)	238 | 254	-	26.2 | 33.6	-	TBD	-
EDK *(YTD/Prior)*	402 | 314	102 | 213	-	-	TBD	-
Readmit Rate *(YTD/Prior)*	19% | 16%	6.3% | 6.8%	8.1% | 8.6%	6.4% | 7.5%	TBD	-
RAF (YTD/Prior)	1.171 | 1.029	1.64 | 1.60	-	-	TBD	-
HCC Recapture Rate (YTD/Prior)	71.21% | 66.42%	-	65.1% | 53.6%	-	TBD	-
OON % (YTD/Prior)	47% | 46%	-	-	-	TBD	-

Quality Update

AWV increase indicates initiatives around standardization and prioritization are occurring

	MSSP	Highmark	UPMC	HM Wholecare	Aetna	Total
AWV Completion (YTD/Prior)	40.8% | 33.6%	73% | 72%	59% | 56%	43.5% | 43.5%	TBD	-
Quality Gap Closure	Met 3 of 3 Measures	Quality Threshold 94%	Met in 5 of 7 LOB	Met 6 of 10 Measures	TBD	-
Quality Star Rating	-	4.19	4.2	-	TBD	-

Quality Committee

- Care Model Updates
- June Meeting – Tuesday, 20th @ 12pm

- Medical Associates of Boswell
- Caring Health Network, Richland
- Cove FP
- CPG Cresson
- CPG Davidsville
- IMC
- CPG Portage
- Dr. Stotler

Microsoft Teams meeting
Join on your computer, mobile app or room device
Click here to join the meeting
Meeting ID: 284 030 585 350
Passcode: NzL5VS
Or call in (audio only)
+1 423-680-7437,,551980856#
Phone Conference ID: 551 980 856#

ADVANTAGEPOINT HEALTH ALLIANCE
Laurel Highlands

	January		February	
Practice Name	ACO	UPMC	ACO	UPMC
Boswell	3%	1%	6%	4%
Claysburg	0%	0%	0%	1%
Cresson	5%	5%	11%	11%
Davidsville	0%	2%	1%	6%
East Hills	8%	9%	12%	19%
Ebandjieff (Nanty Glo)	4%	8%	7%	17%
Ebandjieff Parkhill (Johnstown)	-	7%	-	12%
Ebensburg	10%	4%	16%	10%
FMC	3%	2%	3%	4%
Fockler	2%	6%	8%	10%
Han	1%	0%	5%	8%
Heaton	6%	7%	7%	9%
Hyndman	3%	3%	5%	4%
Hyndman (Bedford)	-	4%	-	7%
Hyndman (Everett)	-	4%	-	0%
Hyndman (Richland)	-	0%	-	1%

IMC	2%	8%	5%	17%
Ligonier	0%	0%	2%	3%
Locke-Cove	8%	5%	12%	8%
Magley	-	1%	-	3%
Maharajh	2%	0%	3%	6%
Massoud	9%	14%	12%	28%
Med Park	5%	9%	13%	19%
Meyersdale	0%	4%	1%	8%
Miller	4%	1%	8%	4%
Portage	1%	4%	1%	8%
Seward	6%	7%	10%	23%
Somerset	4%	2%	6%	9%
St Benedict	2%	2%	4%	4%
Stotler	2%	6%	4%	7%
Wieczorek	0%	0%	0%	3%
Windber	0%	1%	1%	1%

Network Overall ACO YTD 5.92%

Kidney Health Evaluation in Diabetes

American Diabetes Association Standards of Care 2023

- Screening Recommendations:
  - At least annually, **urinary albumin-to-creatinine ratio and eGFR** should be assessed in Type 1 DM with duration of ≥5 years and in all people with Type 2 DM regardless of treatment.
  - In people with established diabetes kidney disease, urinary albumin-to-creatinine ratio and eGFR should be monitored 1-4 times per year depending on stage of disease.

Kidney Health Evaluation in Diabetes

American Diabetes Association Standards of Care 2023

- Treatment Recommendations:
  - Optimize glucose and blood pressure.
  - In patients with HTN and albumin-to-creatinine ratio >30 mg/g, ACE inhibitor or ARB is recommended.
  - In patients with T2DM and diabetes kidney disease, use of SGLT2 inhibitor is recommended to reduce progression and cardiovascular events in patients with eGFR ≥ 20 and normal to elevated urinary albumin-to-creatinine ratio.

UPMC Depression Screening Follow-Up

- UPMC will be tracking positive screening follow-up activities
- Looking for evidence of the following **within 30 days** of a positive screening result:
  - Behavioral health provider engagement
  - Collaborative Care Model
  - Antidepressant medication
  - Any PCP visit, via in-person or telehealth
  - Any Prescription for Wellness referral made via POL or Epic
- 75% completion required to receive depression screening incentives this year

Positive Depression Screen Follow-Up

Membership Age Range	G8431 (Positive)	Distinct Positive Screens with Follow-up (<= 30 days)	Follow-up Rate	Behavioral Health Visit	Follow-up PCP Visit	Antidepressant Medication	Prescription for Wellness	Collaborative Care Model
Ages 22 & Over Membership	499	285	57.1%	247	104	45	3	0

Positive Depression Screen Follow-Up

Membership Age Range	G8431 (Positive)	Distinct Positive Screens with Follow-up (<= 30 days)	Follow-up Rate	Behavioral Health Visit	Follow-up PCP Visit	Antidepressant Medication	Prescription for Wellness	Collaborative Care Model
Ages 12 - 21 Membership	23	16	69.6%	13	6	2	0	0

Open Forum

Next Meeting: August 2, 2023

July 5th meeting will be cancelled due to the holiday