PIAC Members		Colorado Access Staff	
	Angela Wilson, Adams County Government	x	Alexandria Dienstbier
x	Ashleigh Phillips, Centura Health	x	Andrea Swan
	Bipin Kumar, Himalaya Family Clinic	x	Bobby King
x	Bob Conkey, Health First Colorado	x	Brittany Romano
x	Carol Tumaylle, Refugee Health Advocate	x	Erin Friedman
	Courtney Tassin, City of Aurora, Housing & Comm Services	x	Jamie Zajac
	Daniel Darting, Signal Behavioral Health Network	x	Jo Glaviano
x	Erin Metz, Kids in Need of Dentistry	x	Joy Twesigye
	Genene Duran, The Arc Arapahoe & Douglas	x	Julia Mecklenburg
	Harry Budisidharta, Asian Pacific Development Center	x	Kellen Roth
	Ingrid Kolstoe, Parent, Health First Colorado	x	Marty Janssen
	Jennifer Fierberg, UCHealth Co-Responder Program	x	Molly Markert
x	Jessica Jensen, DentaQuest	x	Nancy Viera
	Jessica Prosser, City of Aurora, Housing & Comm Services	x	Nicki Howey
	Joseph Prezioso, Health First Colorado		
	Juan Marcano, Aurora City Councilmember		
	Laura Larson, Douglas County Public Health Department		
x	Marc Ogonosky, Health First Colorado		**Guests**
x	Maria Zubia, Adelante Community Development		
	Matthew Pfeifer, HCPF		
	Natalie Archuletta, DentaQuest		
	Patty Ann Maher, Elbert Cnty Collaborative Mgmt Program		
	Scott Adams, The Medical Center of Aurora		
x	Wendy Nading, Tri County Health Department		
x	Whitney Gustin Connor, Kids First Health Care		

Agenda Items	

Welcome, Introductions & Committee Business	*Approval of December Minutes*: The December meeting Minutes are approved.
	
	Member Advisory Committee (MAC) Update
	Marc Ogonosky
	• Departments and Organizations Engaged
	  ○ Internal: Population Health, Quality, Community Engagement, Diversity Equity & Inclusion, Evaluation and Health Informatics, and Member Affairs.
	  ○ External: Colorado Health Institute
	• TeleHealth Survey being completed by COA
	  ○ The MAC was able to provide their lived experience to shape this survey.
	• Colorado Health Institute joined the MAC
	  ○ Completing an eHealth Environmental Scan for COA
	  ○ An update on ACC 3.0 and what members may want to see in new contracts. This interaction came from the direction of HCPF.
	• We are always looking for new MAC members!

State PIAC Update	Wendy Nading
	• February:
	  ○ Subcommittee Updates:
	  ▪ Performance Measurement & Member Engagement (PMME)
	  ▪ Provider & Community Experience (P&CE)

	▪ Behavioral Health & Integration Strategy (BH&I) ○ Executive Director Presentation ○ ACC Phase III Vision ○ See additional attachment "State PIAC notes 2.15.2023" • March: ○ Subcommittee updates ○ PIAC Department Updates & Amendments ○ ACC Phase III: Children & Youth; stakeholder survey for feedback ○ ACC Phase III: Key Performance Indicators • Health Cabinet Affordability Summit this morning included an update on direction of department • Need Region 5 representative on the State PIAC
PIAC Member Update	Molly Markert • Representation needed: Foster care, criminal justice system, Elbert County, district attorney; more providers in substance use, behavioral health, physical health **Questions & Discussion** Chat: I am also a dental hygienist and happy to provide dental input!
Care Management & Breakout Groups	Joy Twesigye • Human-Centered Design ensures that the member experience informs our approaches and that social determinants of health are a focus from the start • Care Management: Real, tangible, responsive, provide services where members are • Everyone gets a health risk assessment, which helps COA understand your health needs; assistance with health management and care increases with higher needs • Primary Care Medical Provider (PCMP): Primary care providers contracted with Colorado Access that also provide care coordination for complex members; PCMP+ R3: 6 sites • Enhanced Clinical Partners (ECP): Primary care providers contracted with Colorado Access to also provide enhanced care coordination for physical health and population management services; R3: 37 sites • All Population Care Coordination: R3: 29.75%; Extended Care Coordination R3: 25,317 • PCMP+ & ECP Care Management: Patient education, care plan, medication reconciliation, risk stratify patient and ensure support matches need, communication across system & specialties • Care Management Overview: Complex Members, Transitions of Care, Priority Subpopulations & Health Equity; Community & Population Level Partnerships • Community Navigation Team: Being explicit about how COA connects with community and brings services as close to members as possible ○ Intentional service delivery, member centered, flexible inter-departmental collaboration, culturally responsive services, responsive feedback loop ○ Core Members: Community Engagement, Care Coordination/Comm health Worker ○ Rotating Members: Case Managers, AMES, Customer Service **Questions & Discussion** Q: What is your thought on how the number of PCMP+ matches the "demand" or needs for care coordination? A: I have no data, but assume there's more demand than what we have; we are looking at how to standardize our language and promote it Q: Can we get a list of PCMP+ and ECP partners in R3? We see complex families in WIC, we can address some of the system barriers if we know what practices offer what supports; help folks find a medical home A: I will see if we can share it out

	A: The list is on the COA website, but we are aware that they change daily with openings and availability. Chat: Jamie with COA- happy to circle back with our practice supports group to get most current list of ECP/PCMP+ sites Q: What do care management tiers/standards look like for pediatrics? A: There's a definition of what constitutes a complex pediatric case which recently changed, pulling from multiple diagnoses and focusing on vulnerability versus cost; we also have priority sub-populations in a category with assigned care managers; historically, haven't focused on prevention, usually care mgmt. comes after something has been identified; looking to add population health module that shows more specific data so we can tailor the message specifically to those members/families Q: Are there efforts that specifically support/are adjusted for members who speak a language other than English? A: We do have an interpreter process so providers can request an in-person interpreter for visits; we have internal processes, including a program for care managers to use for calls and to coordinate telehealth visits; COA internal committee focused on DEI initiatives for providers to be more member focused Q: Which of those PCMP/ECP are the ones that get extra dollars for care mgmt.? A: Both get dollar amounts, but there are different requirements for different levels, ECP is physical care for all members, whether complex or not; PCMP+ is paid more to focus on providing care coordination for complex members Q: Hard to send people to providers if they're not getting that service. How do you know it's working? Want to ensure that those receiving enhanced payment for care coordination are doing it. A: There are opportunities for growth; right now, there is an accountability process with folks who audit the charts at these practices to ensure they are doing what they're supposed to be doing, may add more details to these audits; we're creating internal dashboards to compare what ECPs/PCMPs are doing versus what COA is doing to hold us all accountable and to the same standards Chat: We (Arapahoe county public health) hear the same feedback from families that Maria is sharing. Q: What's been put into place to ensure equitability when it comes to cultural relevance? A: There aren't specific standards in place for that, it's practice dependent, we've also contracted with family voices to help us put some of those things in place Q: How do you obtain more accurate data? A: No data set is perfect, but there are multiple ways that people come to us (advocacy groups, self referral, community referrals, community events, etc.), we also receive the clinical data from hospitals for both physical and behavioral health, there's a tiering system for physical health and we narrow which folks we can reach out to, we contact all behavioral health folks to see how we can be helpful; claims-based data also drives information; how do we continue to assess members' needs and let them know that we're still here to help, especially when needs change AMES Program Main contact: appassist@accessenrollment.org **Breakout groups** What was provided in care mgmt. pre-covid is different now Folks don't know what they don't know Better define and improve clarity care mgmt. / care coordination and what COA offers What exactly are networks providers providing Checklist for providers so everyone is on the same page, consistency Importance of the connection between dentistry and whole health, insufficient dental coverage Can takes years to reach health goals to fit into dental coverage Distinguish what members need to know, how do we inform them Trauma in community Essential needs beyond what member is there for; receive one service while other needs are present Adults navigating dental care, where do we go, lack of resources

	Importance of more community based and peer-to-peer individuals to help members connect to care management Trusted people for messaging Members don't know who COA is and what it does Important of health care literacy for different cultures, diverse languages, necessary to build trust Peer to peer, especially with difficult to place folks, i.e. dual diagnosis Work force development
End of PHE & Continuous Coverage	Erin Friedman • Digital Engagement for All Members: All Members who need to complete renewal; includes text, email, and robocalls depending on Member's stated communication preference. • Care Managers will focus outreach on High-Risk Members • For Members transitioning to COA or Non-COA CHP+ Plans: COA staff will be educating Members on how this transition will be communicated by Health First Colorado/CHP+. • Members whose income disqualifies them for Medicaid and are transitioning to Connect for Health Colorado (C4HC), COA will send a letter providing information about how to connect with a C4HC Enrollment Broker • Current definition of "High-Risk" during Continuous Coverage Unwind outreach (Complex +) • COA Complex member definition: 4 of 8 chronic conditions (Adults) OR 3 of 11 conditions (Children) OR Pregnant OR Unhoused OR 65+ transitioning to Medicare OR Client Overutilization Program (COUP) / high utilizers • AND individuals with serious health conditions who have a care plan and may experience negative health outcomes if they do not have continuity of coverage. • Provider and Community Partner Resources, COA is/will: o Distribute flyers to provider offices and community partners outlining resources o Including providers in Continuous Coverage Unwind messaging (newsletters, webinars) o Sharing Department's Renewals Toolkit with providers and community partners o Contracting with the Health Alliances and Colorado Coalition for the Homeless for direct outreach to vulnerable and unhoused populations. • Additional Resources: o COA developing Medical Assistance (MA) Renewal Frequently Asked Questions (FAQ) video shorts better understand and follow the MA Renewal process. o Customer service hold messaging will include information on renewal. o Customer service staff will be trained to direct callers to appropriate resources. o COA updating website and social media content to include information on how to renew MA benefits and where to get assistance with renewals. **Questions & Discussion** Q: Can we get updates on how well Colorado is doing with reenrollment as the next year rolls out? I really want to know if lots of folks are falling off and becoming uninsured.
Accountable Care Collaborative (ACC) 3.0	Marty Janssen • Concept Papers for Priority Initiatives: Spring - Summer 2023 • Draft Request for Proposals for Public Comment: November 2023 • Request for Proposals Published: April 2024 • Awards Announced: Late Summer - Fall 2024 • ACC Phase III Begins: July 2025 • HCPF Priority Initiatives: o Enhance Primary Care and BH accountability for providers and RAEs

	○ Implement member incentives and advance alternative payment models across spectrum to enhance quality, reduce disparities, improve health, and ensure accountability ○ Align with and support the Behavioral Health Administration; increase culturally competent community-based behavioral health services
Additional Discussion, Public Comment	Reminder that the next meeting is May 24th combined PIAC meeting which will be hybrid – in person with a virtual option.
	Meeting adjourned at 6:01 pm.
Recommendations	Provide a list of the practices that do their own care coordination/ECP's. How do we assure cultural competency and implement accountability in practices?