



Adult Focused PIAC Meeting Minutes

Date: August 11, 2026

Time: 4:00pm – 6:00pm

Location: Hybrid

Next meeting: November 10, 2026 (Virtual)

Meeting Attendees

Name	Affiliation	Present
Amy Albrecht	Intermountain Health	
Annie Bacci	TGTHR	v
Ashleigh Phillips	CommonSpirit Health	v
Carolyn Hall	Solari, Heartland Mental Health, Colorado Mental Wellness Network	v
Cassie Williams	Denver Department of Public Health & Environment	v
Chantal Holt	Health First Colorado Caregiver	v
Denise Hosier	WellPower	x
Hiba Muhtar	Health First Colorado Member	x
Jamie Rodriguez	Adams County Public Health	x
Judy Shlay	Public Health Institute at Denver Health	
Laura Brayer-Don	Arapahoe County Public Health	
Laura Ciancone	Douglas County - DHS	v
Lisa Schwartz		v
Lyssa Towl	Vivent Health	
Miriam Garcia		
Rachel Henderson	Health First Colorado Member	v
Robert Conkey	Health First Colorado Member	
Sarah Holt	Health First Colorado Member	v

(x) - In Person attendee; (v) – Virtual attendee; (partial) – Only partially attended the meeting

Other Guests:

Colorado Access Staff: Becky Selig, Dave Aragon, Lauren Brassfield, Bridget Anshus, Jessica Smith, Tyannah Reed, Jamie Zajac, Stacy Stapp, Nancy Viera

Quick Recap

The meeting included introductions, an H.R. 1 policy update, a care coordination discussion focused on reducing duplication and improving role clarity, and a Pay for Performance presentation focused on transitions of care

and prenatal/postpartum care interventions. Members and partners shared feedback throughout the meeting about communication needs, barriers to care, discharge follow-up challenges, care coordination access, transportation, childcare, technology access, and the importance of clear, member-centered outreach.

Agenda and Notes

Time	Activity/Discussion Item	Participation Spectrum and Purpose of Agenda Item
4:00 (20 min)	Welcome & Connection Denise Hosier, PIAC Executive Committee	<i>Connect</i>
4:20 (25 min)	Policy & Emerging Issues: H.R.1 Update Bridget Anshus, Health Policy Analyst, Colorado Access	<i>Inform & Consult</i> Summary - Reviewed H.R. 1 Medicaid changes, including immigration eligibility changes beginning October 1, 2026; six-month renewals, retroactive coverage limits, and work/community engagement requirements beginning January 1, 2027. - Members subject to work requirements may need to earn at least \$580 per month or complete/report at least 80 hours per month of work, volunteering, or school, unless exempt. - Exemptions discussed included people with disabilities, medically frail individuals, parents/caregivers of dependent children, and caregivers of people with disabilities. Self-attestation will be accepted during the first year, but many implementation details are still evolving. Questions Q. How will members be contacted? A. Colorado Access is exploring multiple communication methods, including mail, text, websites, and partner/provider communication. Q. Who decides whether someone qualifies or is exempt? A. Eligibility decisions remain with the state/county eligibility system; Colorado Access cannot determine compliance. Q. Will staff be trained on exemptions? A. Colorado Access expects to provide education internally, but county eligibility staff will need detailed training because they determine eligibility. Q. Will veterans and people with disabilities need six-month redeterminations? A. Yes, some individuals may still need six-month redeterminations, even if exempt from work requirements.

		Q. How can providers support members with serious persistent mental illness? A. Members may qualify as medically frail, but verification and documentation processes are still being clarified. Feedback received - Members and partners need plain-language, proactive, multi-channel communication. - Communication must consider members who are unhoused or do not have reliable mail, email, phone, or internet access. - Providers, case managers, and advocates need clear guidance so they can help members navigate requirements. - Participants emphasized the need for processes that allow trusted support people to help members who cannot complete steps independently.
4:45 (30 min)	Care Coordination: Coordinate, Don't Duplicate Jamie Zajac, Senior Director of Care Coordination, Colorado Access	<i>Consult</i> Summary - Presentation emphasized “one member, one lead, and one shared plan”. - Care coordination should be guided by the member’s goals, preferences, barriers, and choice of who should help lead or participate. - The care coordination ecosystem may include members/caregivers, providers, case management agencies, Colorado Access care coordinators, hospitals, schools, community partners, pharmacies, counties, HCPF, and advocates. - Jamie emphasized warm handoffs, closed-loop referrals, strong communication, clear roles, team calls when needed, and member empowerment. Questions Q. Who decides the lead? A. The member should help decide who leads based on trust, relationship, and current needs; the lead may change over time. Q. How does a provider know if a member has a care manager? A. Providers can call the care coordination resource line or use the referral form and request follow-up. Q. Is care coordination only for high utilizers? A. No. It is available to all Colorado Access members, though higher-acuity members may receive more intensive support. Q. Who organizes team calls? A. Colorado Access may help organize calls when members

		feel overwhelmed or when many people are involved, but the process should start with the member's preferences. Q. When is a team call needed? A. Team calls are most useful when many providers or systems are involved; simpler needs may only require a referral or connection to a provider or resource. Q. Can care coordination help connect members to primary care? A. Yes. Care coordination can help members connect to medical providers, including integrated primary care and behavioral health when available. Feedback received - One member shared that unclear leadership made them feel responsible for arranging everything, which was overwhelming. - Another member shared challenges transitioning from pediatric to adult care, finding adult providers, and coordinating across existing providers. - Participants requested clearer information about what care coordination is, when to use it, how to access it, and how it supports both members and providers. - Feedback emphasized streamlined communication, trust-building, consistent follow-through, stable staffing, support for overwhelmed providers, and stronger connections with community health workers.
5:15 (30 min)	Pay for Performance Metrics and Interventions Tyannah Reed, Senior Quality Improvement Consultant, Colorado Access	<i>Consult</i> Summary - Reviewed Pay for Performance (P4P), a quality improvement program where the state awards incentive funding when Colorado Access meets certain metrics. - The presentation focused on two intervention areas: transitions of care after hospital inpatient discharge and prenatal/postpartum care. - For transitions of care, Colorado Access is working with Goodness Health to call or text adult members after hospital discharge, help schedule follow-up care, confirm primary care connections, identify resource needs, and reduce barriers. - For prenatal/postpartum care, Colorado Access is sending targeted mailers to members who recently had a baby and have not yet had a postpartum visit. The mailer includes education and a reminder to schedule care. - Colorado Access will evaluate interventions using reach rates, workflow performance, care improvement, and metric trends.

		Questions • Q. Does transitions of care include ER or inpatient stays? A. The discussion focused on inpatient hospital stays and follow-up after discharge. • Q. How will Goodness Health know who to contact? A. Colorado Access will provide a feed of adult members discharged from the hospital. • Q. How will Colorado Access know who has not completed a postpartum visit? A. Colorado Access uses delivery/discharge data and claims data, while recognizing that claims data is not perfect. Feedback received: transitions of care • Prioritize post-discharge outreach that confirms members understand next steps, using follow-up calls, teach-back, and clear instructions on who to contact and when. • Help members address common barriers after discharge, including scheduling follow-up appointments, transportation, medications, caregiver support, home health, durable medical equipment, meals, and safe movement at home. • Provide clearer discharge information with provider names, specialties, phone numbers, addresses, and task ownership so members and support people know who is responsible for each next step. • Consider pre-discharge support from a social worker or care team member to review the plan, identify needed supports, and coordinate timely follow-up care. • Use outreach options that work for members with limited technology, language access needs, or unreliable phone, internet, portal, mail, or transportation access, including in-person or physical check-ins when possible. • Gather additional input from community health workers on barriers identified after positive social determinants of health screens. Feedback received: prenatal/postpartum care • Clearly explain which prenatal and postpartum visits are needed, why they matter, what happens during each visit, and whether there are any costs. • Share easy-to-understand information about available postpartum supports, including Family Connects and other parent-focused resources. • Use multiple outreach methods—especially phone calls—to reach members who may not use apps, portals, texts, computers, or the internet.
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		• Include supportive messages that normalize postpartum challenges, encourage follow-up care, and emphasize that caring for the parent also supports the baby. • Share postpartum mental health resources, including information about postpartum depression and when/how to seek help. • Develop culturally responsive outreach by working with community members to understand cultural beliefs, needs, and comfort with asking for support. • Address common barriers directly, including childcare, transportation, appointment availability, after-hours access, limited family support, and uncertainty about postpartum exams. • Provide additional education on parent recovery, baby growth and development, nutrition, vaccines, and what care is available after delivery.
5:45 (5 min)	Question & Wrap-up Denise Hosier, PIAC Executive Committee	
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