Date: Aprill 23, 2026
Time: 12:00 to 2:00pm
Location: In-Person/Virtual
Facilitator: Nancy Viera
Recorder: Monique Bowler

Shared Resources for Meeting (links)

- Relevant Terminology for this Meeting
- PowerPoints
- Table with relevant documents (Charter, Agreements, Action Item Tracker)
- Feedback Form

Meeting purpose: Q-2 Regional Healthy CO for All Committee, Meeting

- X
- y

Next meeting: July 23, 2026

Meeting Attendees:

Name	Role	Present
Alexa Diaz		V
Amy Peters Hill		V
Becky Selig		V
Brittany Goldstien		V
Bridget Anshus	HR1 Prep	X
Christine Giesing		V
Christina Bejarano		V
Claire Peters	Follow-up from January 2026 meeting	V
Dominique Rosendo		V
Donaven Smith		V
Elizabeth Snow		X
Francesca Maes		V
Gabrielle Jablonski		V
Gabriel Motter	(Spanish Interpreter)	V
George Roupas	Telehealth Presentation	X
Ian Milby		V
Jacquelyn Stanton		V
Jaime Moreno	Follow-up from January 2026 meeting	V
Jamie Zajac	Care Coordination process Presentation	V
Jessica Smith		V

Jesus Trevino		X
Joy Twesigye		X
Judith Watts		V
Judy Shlay		V
Lexi Deinstbier		V
Lori Banks		V
Lucia Francis	(Spanish Interpreter)	V
Lucy Guereca		V
Marsha Aliaga-Dickens		V
Mary Doran		V
Miriam Garcia		V
Monique Bowler	Recorder	X
Mordy Cukier		V
Nancy Viera	Facilitator	X
Patty Garcia		V
Robert Franklin		X
Shanice Sims		V
Shannon Godbout		Y
Shelley Cooper		V
Simret Kahsai		V
Sophia Alires		V
Stephanie Segal	Land & People Acknowledgement	V
Tyler Woody		V
William Wright		V

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

Action Item Tracker

Item	Owner	Status	CLEF	Due Date
Share progress on the delayed timeline for the health equity plan.	Claire Peters	In progress		07/23/26

Agenda/Discussion Item	Participation Spectrum and Purpose of Agenda Item
Land/Acknowledgement (Stephanie Segal)	Land & People Acknowledgement

Agenda/Discussion Item	Participation Spectrum and Purpose of Agenda Item
Welcome / Introductions **(Nancy Vera)**	Welcome to the Regional Healthy Colorado for All Committee! Thanks for your continued dedication to advancing healthcare for members and the community
Check-in	Everyone
Agenda/Discussion Item	Participation Spectrum and Purpose of Agenda Item
Follow-up From January meeting (Jaime/ Claire)	Jaime reported on an action item from the January meeting. The following are on track with making contact. • Independent Living Council Connection • AsiaCultural Development and Education/ Aurora Mental health • Partner with schools at different grades/ages • Aurora and Denver public schools • Jewish family services to connect with the Russian Population • Secor • Denver Commissions Denver Commissions was the first group contacted, and we have already established a relationship while continuing to connect with other community leaders; additionally, a key outcome from the meeting is that they plan to host one of their in-person meetings in fall 2026 at our offices at Colorado Access. African Leadership Group in Aurora, and Spiritual communities/spiritual leadership have communication through WhatsApp, newsletters, and community meetings. Western Slope Native American Resource Center is part of the PIAC We have not made connect yet • Native American Housing Circle DIFC • Populations from Marshall Islands Claire shared an update on her action item, noting that delays at the state level have postponed the timeline for the health equity plan, and the team has only recently received the necessary data and analytical resources; consequently, there is no meaningful analysis to present at this time, but they intend to bring findings to the next

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	committee meeting to support a more informed discussion on strategy and solicit feedback. Amy asked: Given everything currently happening at the Capitol that is outside of your control, what key pain points are you experiencing, particularly beyond just budget constraints and how are these factors impacting your ability to carry out your work? Claire answered: It comes down to logistical steps that HCPF is needing to take to get the data to us, including the fact that they are working with an external vendor, which creates additional potential barriers for HCPF in the process. It is important to ensure access to members' specific language preferences, however, if that information cannot be obtained externally, internal member files may need to be used to identify it.
Agenda/Discussion	Participation Spectrum and Propose of Agenta Item
Care Coordination Processes (Jamie)	Jamie Zayas, Senior Director of Care Coordination at Colorado Access, provides an overview of how care coordination is structured and delivered. There are two primary models: an internal, health plan-led team and external Care Coordination Partners (CCPs) embedded within provider clinics. The internal team supports Medicaid and CHP+ members who are not connected to a provider, as well as all behavioral health coordination, while CCPs focus on physical health, chronic condition management, and care within clinical settings. The internal department includes approximately 62 staff, with a range of roles from care navigators to intensive care coordinators, supported by leadership and administrative staff. They also manage specialized populations, including youth through the Colorado Systems of Care (COSOC) initiative and members with high behavioral health needs, often in collaboration with Denver Health Medical Plan. Care coordination is organized using a three-tier model based on member acuity: • Tier 1 focuses on prevention, • Tier 2 on chronic condition management, • Tier 3 on high-acuity members needing intensive support. Although all members are eligible, the tier system helps prioritize resources and interventions. Unlike traditional case management, care coordination is event-driven, with members entering through triggers such as hospital

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	admissions, referrals, or identification through clinical data. Outreach typically occurs within two business days.
	
	The care coordination process includes assessing member needs, developing a care plan, connecting members to resources, collaborating with care teams, and ensuring follow-through ("closing the loop"). A strong emphasis is placed on avoiding duplication of services, improving communication across providers, and empowering members to better manage their health and navigate the healthcare system.
	
	Overall, care coordination at Colorado Access focuses on connecting, supporting, and guiding members, rather than providing direct medical care, with the goal of improving outcomes and ensuring members receive the right care at the right time.
	
	What Care Coordination CAN Do
	
	• Connect members to appropriate healthcare providers
	• Assist with appointment scheduling
	• Communicate with providers and care teams
	• Coordinate across multiple agencies and services
	• Help members access:
	  ○ Benefit application assistance
	  ○ Community resources (housing navigation, financial support programs)
	• Support non-emergency medical transportation
	• Provide care plan development and goal setting
	• Educate and empower members on managing their health
	• Escalate issues when there are delays or barriers
	• Collaborate with other insurers when not primary
	• Support behavioral health needs across all populations
	• Assist with system navigation (healthcare and social services)
	What Care Coordination CANNOT Do
	• Provide medical care:
	  ○ No diagnosing, treating, or prescribing
	  ○ No medical advice (not a nurse advice line)
	• Override provider decisions
	• Provide emergency services or crisis care
	• Complete disability paperwork
	• Update member information in state systems (e.g., income, eligibility, address)
	• Provide:

Agenda/Discussion Item	Participation Spectrum and Purpose of Agenda Item
	○ Housing or emergency housing placement ○ Direct financial assistance • Move members up waitlists or force provider/facility acceptance • Guarantee access to providers accepting new patients • Provide transportation directly (only coordinate it) • Act as a personal assistant for members • Take over full responsibility from care coordination partners (collaborative role only) Key Clarifications / Common Misconceptions • Care coordination is not limited to Tier 3, though Tier 3 receives the most intensive services • CCPs are team-based, not a single individual handling all needs • The RAE (Colorado Access) does not replace providers or CCPs, but collaborates with them Care coordination focuses on navigation, connection, and support, not direct service delivery
Agenda/Discussion Item	Participation Spectrum and Purpose of Agenda Item
Access Care Telehealth Survey (George Roupas)	The objective of this initiative is to improve telehealth patient experience and equity by providing context on the importance of collecting telehealth feedback, identifying and prioritizing key telehealth equity signals and indicators, refining a post-telehealth patient experience survey, and gathering stakeholder input to inform the final pilot design. **Background & Context** Colorado Access operates a virtual behavioral health telehealth program, serving members through: • Primary care provider referrals • Internal care coordination This model provides direct insight into real-time access and experience barriers in telehealth delivery. **Key Points:** • Telehealth is a major access point, especially for behavioral health services • Barriers (technology, language, privacy, trust) are not evenly distributed

Agenda/Discussion Item	Participation Spectrum and Purpose of Agenda Item
	• The goal is to identify early, actionable signals to address inequities proactively **Alignment with Strategic Goals** This initiative aligns with Healthy Colorado for All, specifically: • Goal 2.2: Use data-driven signals to detect disparities early • Goal 3.2: Improve understanding of member experience and health literacy Both goals emphasize: • Co-design with stakeholders • Continuous feedback loops • Equity-focused improvements **Telehealth Equity Indicators (Discussion)** The group reviewed potential indicators to track inequities in telehealth. The goal is to select three actionable and feasible indicators for Year 1. **Candidate Indicators:** • Visit completion vs. no-show/cancellation rates • Successful technology connection on first attempt • Time to complete consent/guardianship forms • Interpreter use and language-concordant visits • Follow-through on interventions or referrals • Time to first successful telehealth visit • Visit disruptions or modality switches **Key Discussion Highlights** **Technology Access** • Many patients struggle with telehealth platforms • Staff provide guidance (including Spanish-language support) to improve access **No-Show Rates** • Telehealth no-show rates remain high (approx. 25–30%) • Participants noted provider no-shows should also be tracked **Access Timeliness**

Agenda/Discussion Item	Participation Spectrum and Purpose of Agenda Item
	• Stakeholders emphasized time to first successful visit as a critical metric • Delays in care (weeks to months) remain a concern in some settings **Follow-Up Effectiveness** • Strong support for tracking follow-through on interventions/referrals • Important for populations with disabilities or communication barriers **Defining Metrics** • Discussion on clearly defining constructs like "completion" and "engagement" • Consideration of factors like time of day and patient availability **Population Considerations** • Youth engagement may differ from adults • Some stakeholders noted challenges building rapport via telehealth for teens **Preliminary Indicator Selection (Consensus Direction)** Emerging priority indicators: 1. Time to first successful telehealth visit 2. Follow-through on interventions/referrals 3. Interpreter use and language access **Equity Lens Prioritization** The group discussed which population factors ("equity lenses") to prioritize analysis. **Options Considered:** • Language preference • Race and ethnicity • Disability and accessibility needs • Age group (youth vs. adults) • Geography • Gender

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	Key Themes:
	• Overlap between language and race/ethnicity
	• Importance of accessibility and disability considerations
	• Value of broader reporting beyond just 1–2 lenses
	Outcome Direction:
	• Prioritize language preference and accessibility/disability needs
	• Consider adding gender as an additional lens
	• Develop dashboards to track all variables more comprehensively
	
	Telehealth Survey Design
	
	A short 3-question post-visit survey will be implemented to capture patient experience.
	
	Final Question Themes:
	
	Clarity of Next Steps
	• Selected: *"I know what to do next and how to get help if needed."*
	Usability/Experience
	• Selected: *"Telehealth worked well for me today."*
	Respect & Responsiveness
	• Selected directions:
	  ○ Focus on respect, cultural responsiveness, and accessibility
	  ○ Incorporate feedback on accommodations and accessibility needs
	
	Survey Design Considerations
	• Use a 5-point Likert scale (strongly agree → strongly disagree)
	• Add:
	  ○ "Not applicable" or "prefer not to answer" option
	  ○ Optional open-text comments
	• Ensure:
	  ○ Plain language (approx. 6th-grade reading level)
	  ○ Clear definitions (e.g., "telehealth")
	• Consider "select all that apply" for complex questions

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	Survey Distribution Plan
	• Sent after:
	  ○ First telehealth visit
	  ○ Then quarterly or at final session
	• Delivery methods:
	  ○ Primarily email
	  ○ Alternative methods (phone, text) when needed
	• Translated based on language preference
	
	Data & Reporting
	• Data captured through electronic health records (EHR)
	• Plan to develop dashboards for:
	  ○ Internal reporting
	  ○ Stakeholder review
	• Feedback loops will:
	  ○ Inform leadership decisions
	  ○ Drive workflow improvements
	
	Key Challenges Identified
	• Digital access limitations
	• Survey accessibility and response rates
	• Balancing simplicity with meaningful data collection
	• Ensuring inclusive design across diverse populations
	
	Next Steps
	• Finalize:
	  ○ 3 pilot indicators
	  ○ Survey questions and format
	• Develop reporting dashboards
	• Incorporate plain language revisions
	• Explore flexible survey delivery methods
	• Present updated pilot design in future meeting
	
	Additional Notes
	• No fees are charged for missed appointments
	• Strong emphasis on care coordination (differentiators from other telehealth models)

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	• Potential expansion to rural areas and other regions • Interest in sharing findings externally (e.g., conferences) **Contact Information** For follow-up questions or additional input: **George Roupes** Email: george.roupas@accesscare.com
Agenda/Discussion Item	**Participation Spectrum and Purpose of Agenda Item**
HR1 Prep (Bridget Anshus)	Bridget Anshus, a health policy analyst at Colorado Access gave an overview of HR1, a major federal law passed in July that significantly changes Medicaid, CHIP, and Affordable Care Act programs. While the law increases federal funding for areas like border security and defense, it offsets costs through roughly $1 trillion in healthcare cuts over the next decade. Most major Medicaid-related changes will take effect in January 2027. **Key Medicaid Changes** **Work Requirements** Starting January 2027, certain Medicaid expansion members ages 19–64 will need to earn at least $580 per month, or complete 80 hours per month of work, school, or volunteering. **Exemptions include:** • People with disabilities • Medically frail individuals • Parents with children age 13 or younger Colorado estimates it can automatically verify compliance or exemptions for about 60% of impacted members, while approximately 155,000 people may require additional review or outreach. **More Frequent Renewals** Medicaid expansion members will need to renew eligibility every six months instead of annually. State officials acknowledged this will

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	create significant administrative burden and increase the risk of people losing coverage due to paperwork or reporting issues. **Immigration-Related Eligibility Changes** Beginning October 1, 2026, certain lawfully present immigrants, including refugees, asylees, and some domestic violence survivors will lose Medicaid eligibility unless they are pregnant or children. Colorado estimates about 7,000 individuals will be affected. **State Preparation Efforts** The Colorado Department of Health Care Policy and Financing (HCPF) is: • Hosting webinars and public education sessions • Developing online screening tools • Upgrading IT systems • Hiring additional staff • Requesting about $100 million for implementation support The state is also awaiting additional federal guidance from CMS, expected later this year. **Timeline** • Summer 2026**:** notices begin for immigration-related eligibility changes • August 2026: work requirement notices begin • November 2026: six-month renewal notices begin • January 1, 2027: major HR1 provisions take effect **Colorado Access Response** • Advocating with state and federal policymakers • Coordinating with providers and community organizations • Developing outreach campaigns to reduce coverage loss "Stay Connected, Stay Covered" campaign encourages members to: • Update contact information

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	• Stay informed • Respond quickly to renewal notices The organization is also exploring outreach strategies such as QR codes and hotline information placed in community locations like schools, grocery stores, and recreation centers. **Behavioral Health Concerns** Participants expressed concern that many behavioral health patients could temporarily lose Medicaid coverage during the transition. Colorado Access stated it is coordinating with the Behavioral Health Administration (BHA) to help maintain continuity of care. One representative shared that Colorado Access's telehealth program has chosen not to immediately terminate behavioral health services when members unexpectedly lose Medicaid coverage, allowing clinicians and patients time to transition care appropriately. **Overall Takeaways** The discussion emphasized: Administrative complexity may cause eligible people to lose coverage, and strong communication, community partnerships, and flexible implementation will be critical to reducing harm.
Adjourn Nancy Viera	Nancy thanked everyone for attending. The meeting was adjourned at 2:01 p.m.