COLORADO
Department of Health Care Policy & Financing

MINUTES
Accountable Care Collaborative
Provider and Community Experience (P&CE) Subcommittee

December 8, 2022, 8:00-9:30 A.M.

1. Introductions & Approval of October Minutes (handout)

Kathie Snell, P&CE Co-Chair, called the meeting to order. The following people were in attendance:

Voting members: Kathie Snell (P&CE CO-Chair, Aurora Mental Health), Jenny Munthali (CYSHCN Director, CDPHE), Theresa Anselmo (Delta Dental of Colorado Foundation), Carolyn Green, MD (retired), Andrea Loasby (CU School of Medicine and Children's Hospital Colorado), Pat Cook (RN, BSN, MA. Colorado Gerontological Society), Marc Ogonosky (Medicaid member), and Karma Wilson (Southeast Colorado District Hospital). A quorum was established.

Non-Voting Members: Brooke Powers (HCPF, liaison to P&CE), Callie Kerr (HCPF), Erin Herman (HCPF), Nicole Konkoly (RMHP/RAE1), Violet Willett (RMHP/RAE1), Jen Hale-Coulson (NHP/RAE2), Ashley Clement (NHP/RAE2), Laura Johnson (CCHA/RAE6), Sarah Hamilton (MSN, RN, Care Coordination Director North Colorado Health Alliance), Marissa Kaesemeyer (Director of Provider Affairs, COA) Marsha Aliaga-Dickens (COA/RAE3/5), Angie Goodger (CDPHE), Tina Gonzales (Health Colorado/RAE4), Ashley Clement (NHP/RAE2), Jessica Zaiger (CCHA, RAE7), Nikole Mateyka (CCHA, RAE6), Katie Mortenson (CCHA, RAE6/RAE7), Mona Allen (RAE4), Hannah Sieben (Prevention Services Division, CDPHE), Emilee Kaminski (University of Colorado Department of Peds & CHCO), Mark Levine, MD (PIAC member), Alyssa Rose (RMHP/RAE1), Tina McCrory (Health Colorado/RAE4), Dede de Percin (Mile High Health Alliance), Joseph Anderson (RAE3/5), Chesley Sterling (Health Colorado/RAE4), Andrea Skubal (CCHA, RAE6/7), Christina Brown (Health Colorado/RAE4), Allie Morgan (Director, CHI), Suman Mathur (Project Manager, CHI), Kendra Neumann (Analysist, CHI), and Susan Mathieu (Medicaid Policy Director, Eugene S. Farley, Jr. Health Policy Center).

Kathie Snell asked for a motion to approve the October Meeting Minutes. A quorum was established, and the meeting minutes were approved.

2. P&CE Follow-up items and Housekeeping

Kathie Snell, P&CE CO-Chair

- Voting Membership (voting member terms are 4-year terms with no more than 2 consecutive terms allowed)
    - Three open voting member seats: Family Practice; Behavioral Health; and Long-term Services and Supports. Voting member application

- Free Educational Opportunities for Coloradans: Please help us grow the health care workforce as well as the childcare workforce. Please print and display these time-limited training opportunity communications in your patient waiting rooms, exam rooms, staff break rooms and other related areas. The links below include a poster that can be printed and a digital display that can go on TV screens in patient or staff areas. Print and digital resources are here: hfcgo.com/assistance.

3. State ACC PIAC Update

Kathie Snell, P&CE Co-chair

November 2022 meeting:

- PMME subcommittee updates: presented recommendations on well-child visit data, a KPI. Recommendations on interviews and data analysis. Recommendations such as education on well-child visits, partnering with schools and parents by informing members on NEMT to access well-child visits easier, extended hours in physicians' offices to offer after-hours dedicated to well-child visits so parents and legislation requiring well-child visits. There will be a vote on these recommendations.
- Adela Flores-Brennan and Mark Queirolo came and spoke about planning and implementation of ACC Phase III. Visit the Department ACC Phase III webpage.
  - Focusing on 8 priority initiatives
- PIAC requested an overview of APM1/APM2 at a future meeting.
- Upcoming retreat for State ACC PIAC to onboard new members into PIAC, ACC phase 3, and topics for next year.

4. ACC Phase III Discussion

Allie Morgan, Suman Mathur, and Kendra Neumann, Colorado Health Institute (CHI), and Susan Mathieu, Farley Center

1. Preparing for ACC Phase III
2. ACC Phase III Overview
3. Priority Initiatives:
   a. Care Coordination
   b. Referrals to Community Partners
4. Discussion
5. Next Steps

Accountable Care Collaborative overview

- Delivers cost-effective, quality health care services to Colorado Medicaid members to improve the health of Coloradans (1 in 4 Coloradans have Medicaid).

- Coordinates regional physical and behavioral health care services to ensure member access to appropriate care.

Creating ACC Phase III

- Build on strengths on Phase II
- Align with advances made by other state agencies
- Incorporate input received over the past several years
- Identify opportunities for improvement
    - Focus on priority initiatives
    - We need your input!

ACC Phase III Goals

- Improve quality car for members
- Close health disparities and promote health equity
- Improve care access
- Improve the member and provider service experience
- Manage costs to protect member coverage and benefits, and provider reimbursements

Commitments to Continuity

- Compliance with federal guidance supporting paying for value
- Coordinated behavioral, physical and community-based services through a regional delivery system with the existing seven regions
- A hybrid managed care model to allow for robust benefits and member supports by improving the capitated behavioral health benefit and innovating the managed fee-for-service infrastructure for physical health
- Collaboration with state agencies to provide high quality, whole-person care that improves health equity and overall health of Medicaid members

Priority Initiatives to Address Opportunities

- Member Communication and Support
- Accountability for Equity and Quality
- Improving Referrals to Community Partners
- Alternative Payment Methodologies
- Care Coordination
- Children and Youth
- Behavioral Health Transformation
- Technology and Data Sharing

Discussion and *Feedback*

- **Which populations have the greatest need for care coordination?**
    - *Lived experience as a parent or caregiver is important.*
    - *Children 0-5 and older adult individuals with unmet oral care needs*
    - *Children and youth-care coordination is imperative for youth to avoid rising risk and prevent chronic issues from becoming out of control late in life. This is also important to happen at the PCP/practice level as opposed to a centralized level.*
    - *Members with chronic illness, especially with multiple conditions that often include behavioral health. Primarily adults but crosses to children and youth with behavioral health conditions.*
    - *As we learn about long haul covid and crossovers in other chronic conditions we need to have a plan to capture impact for all ages.*
    - *People living in the rural areas that need more assistance may lack the needed people to help them get to appointments and the home care that they need due to lack of workforce availability.*
    - *Understanding how CC for CYCHCN differs from CC.*
    - *Individuals with co-morbidities.*
    - *Care coordinators should have a solid understanding of their community.*
    - *Appreciate focus on children and youth. Providers and their office staff need to be kept aware, educated, and supported about care coordination resources. The desperate needs on one hand and marry similar-surrounding services bewildering at times.*
    - *Individuals outside of urban and suburban areas—rural and frontier specifically.*
    - *Members where English is not the primary language.*
    - *People living in areas that have no resources.*
    - *Requirements for CC include understanding the networks community organizations and providers to refer to.*
    - *Pre-natal members, members with top five health conditions, child/youth in foster care.*
    - *Families involved with county services.*
    - *Youth with serious emotional disorders.*
    - *Hard to coordinate care when there are no caregivers to coordinate.*
    - *Clarification about who what why where do referrals go to the RAE. I have heard in my area that specific instances are referred, but they don't know who or how to refer?*
    - *Care coordination that is integrated with behavioral health and primary care works best: team-based care rather than passing the patient around.*

- *Newly arrived immigrant populations that may not understand navigating the system.*
- *Newly enrolled members who may not know benefits and are fearful.*
- *Elders voice is different than the normal audience.*
- *Telehealth barriers.*
- *Anxiety of having money for basics like rent.*
- *Understanding EPSDT.*
- *Improve experience by relying on community organizations that already have the relationships rather than build new networks from untrusted agencies.*
- *Immigrants providers need to be compensated for additional costs they incur, or services will not be broadly available and coordination therefore difficult.*
- *People who move ending up changing RAEs loosing their care management team.*
- *Decentralized care coordination to ensure it happens at the practice level, where the patient/family has continuity and relationships with the folks who serve them.*
- *Newly enrolled particularly those that were newly eligible based on status.*
- *Better data systems and in real time. Example senior dental under old age person.*
- *When RAEs are incentivized for specific core measures, focus on those areas naturally improve. Need to carefully consider which measures to incentivized to have the greatest impact on the population of focus.*
- *Care coordination and the agency must practice language justice—have info and communication in multiple.*
- *Rosters on who is engaged with complex care needs.*
- *Having a network is useful and that work together well for care coordination for people.*
- *RAEs not notified by clinics that staff changes have occurred and/or no longer providing the service which end up impacting the care management.*
- *Need data at the provider level, not just the RAE level.*
- *Workforce and peer supports. Unlicensed supports are very important.*

- **What role should care coordinators play in screening for health-related social needs?**
  - *Referrals are most effective when someone actively helps folks navigate to the resource. If that can't happen there at minimum needs to be a warm handoff.*

- *Maybe not primary screening, but follow-up or more detailed screening. Not sure if there is a standard quick screen that may warrant a referral to the CC that then they follow-up with more detail.*
- *Care coordination across the RAEs and provider entities could use a standard screening tool and share data so that all are coordinated in approach to accessing providers that focus on social needs. Need a central place for data.*
- *Care coordination at the practice level is engaged in connecting patients with resources once screening has been complete. They also keep a pulse on what changes happen in the patient/family's life and act as the glue that holds everything together.*
- *Partner with community health workers, social work, etc. To ensure nothing falls through the cracks—best addressed at the practice level with embedded care coordination.*
- *Duplication or overuse of screening at different levels—standardization to relieve burden on care coordination.*
- *Connection to partners is important but follow through is critical. Health navigators are in a great position to walk members through such processes.*
- *The gaps are the upstream preventing measures. Medicaid and organizations will "help" when people are sick but there is little to no work to prevent these things from happening.*
- *looking at a person holistically it makes sense that the CC would be screening and referring for these needs.*
- *Everyone in the community is dedicated at all levels and is screening now. Feedback from patients is irritation with the duplication at all levels. let's have standardized screens and somewhere to record it. Also pay community partners for doing it.*
- *Standard SDoH.*
- *Gaps between HCPF programs. RAE metrics don't align with HTP metrics.*
- *Recognizing that screening is not enough- we need to understand the story as well. Also, screening is different for children, youth and elders. Screening must take family and developmental stage into account.*
- *Prioritizing patient priorities. The screening may reveal food insecurity but if it's not a priority for the patient, listen to that.*
- *Screening is best done by interpersonal communication, much more effective than a screening survey.*
- *I feel like a lot of the changes are meant to broaden the scope or allow more individuals access or provide care, but I see a lot of limitations … like some of the things add more limitations.*

- *Need data on CBO caseloads & waiting lists. Also need to assure funding of CBOs sufficient to meet the demands of increasing referrals.*
- *Figure out how RAE screening and referrals interact with and synergize HTP screening and referrals.*
- *Time and reimbursement.*
- *Support communications.*
- *Need companions within health neighborhoods to work 1:1 with beneficiaries and their families.*
- *Supporting and coaching care coordinators around equity.*
- *Importance of care coordination working with patient care team to work on the areas of need other than medical resources if needed for housing, utilities, etc.*
- *Escalate issues with workforce community resources availability, etc. If/when identified—PDN is a great example.*
- *To focus on follow through, need to connect care coordinators, navigators, community health workers, etc. to determine the best path for each to ensure alt coordinate as availability of resources to support members beyond the initial referral vary.*
- *Care coordinators need support from the Department when the area they are working in lack the local resources to assist the patient with care coordination and other SDoH needs.*
- *Navigators are trusted voice. It is more processes oriented over opinion.*
- *Care coordinators are great at linking both mental/behavioral health needs and physical health needs when embedded in the practice.*
- *Ask members, "what are you concerned about or working on?"*
- *Some hospitals and clinics are now doing SDoH screening, and this would be helpful as resources if it could be shared with RAE care coordinators.*

- **What expectations should there be for RAEs to facilitate referrals to community partners? Or to make sure these are completed?**
  - *Going with members to a referral and not just sending them. Allowing people to have the time with the client. Making the initial phone call with the member support.*
  - *RAEs should have access to easily searchable lists of community partners, including a simple way to add resources and comments based an experience.*
  - *Stop sending a list and help folks match their vision to agencies who can blend home care under waivers. Really are struggling in this area in elderly care.*
  - *If standardization tool is in use, RAEs could be required to*

demonstrate that specific needs identified have been addressed through a referral. Ultimately, health outcomes are the most important factor but are difficult to tie directly.

- *Having a process that PCP goes through with the member and standardization would be very helpful. The member needs to be wrapped up in the experience.*
- *Application for services can be very complicated and many people struggle to fill out the form and need assistance or support for this.*
- *Barriers for there not being time to help members who are most vulnerable. Time and reimbursement*
- *HCPF needs to pay the RAE to pay sufficiently for the time and experience for comprehensive needed support.*
- *Barriers to providing a greater support in follow through include insufficient funding and lack of workforce. One program in my organization has 20 refugee health navigators that must be partially grant funded to sustain.*

- **Additional comments**
  - *worry about sustainability and how we financially can do it. Also, what data exists showing SDoH is highly prevalent in the Medicaid populations? Is it a certain age or correlation with certain health issues?*

Upcoming ACC Phase III Stakeholder Activities

- Feedback Survey: https://www.surveymonkey.com/r/ACCMeetingFeedback
- Public Listening Session: January 10: (6:00-7:30 pm) via Zoom

Next meeting: January 12, 2023 **8:00-9:30 A.M.**

Reasonable accommodations will be provided upon request for persons with disabilities. Please notify Brooke Powers at 303-866-2184 or brooke.powers@state.co.us or the 504/ADA Coordinator hcpf504ada@state.co.us at least one week prior to the meeting to make arrangements.

Acronym Key:
ACC-Accountable Care Collaborative
ARPA- American Rescue Plan Act
BH-Behavioral Health
CCHA-Colorado Community Health Alliance
CBO-Community Based Organizations
CC-Care Coordination
CDPHE-Colorado Department of Public Health & Environment
CHCO-Children's Hospital of Colorado
CHI-Colorado Health Institute
COA-Colorado Access
CYCHCN-Children and Youth with Special Health Care Needs
DHMP-Denver Health Medical Plan

FFS-Fee-For-Service
HCBS-Home and Community Based Services
HCPF- Department of Health Care Policy and Finance
HTP-Hospital Transformation Program
HQuIP-Healthcare Quality Improvement Platform
LTSS-Long Term Supported Services
MAT-Medication Assisted Treatment
MCE-Managed Care Entity
MCO-Managed Care Organization
MPH-Master's in Public Health
NEMT-Non-Emergency Medical Transportation
NHP-Northeast Health Partners
OCL-Office of Community Living
OOS-Out of State
P&CE-Provider and Community Experience Subcommittee
PMME-Performance Measurement and Membership Engagement Subcommittee
PHQ-9-Patient Health Questionnaire
PIAC-Program Improvement Advisory Committee
RAE-Regional Accountable Entity
RMHP-Rocky Mountain Health Plans
SDoH-Social Determinants of Health