COLORADO
Department of Regulatory Agencies
Division of Insurance

Primary Care Payment Reform Collaborative Meeting Minutes

Thursday, January 11, 2024; 10:00 - 1:00 pm
Virtual meeting

Meeting Attendance

Attended
Brandon Arnold
Isabel Cruz
Lauren Hughes
Cassie Littler
Miranda Ross
Lisa Rothgery
Amy Scanlan
Patricia Valverde

DOI
Tara Smith
Laura Mortimer
Cara Cheevers

Absent
Polly Anderson
Josh Benn
Patrick Gordon
John Hannigan
Steve Holloway
Rajendra Kadari
Anne Ladd
Amanda Massey
Kate Hayes for Jack Teter
Pete Walsh

Agenda:

1. Housekeeping & Announcements
2. Annual Report Recommendations
3. Public comment

Introductions:

Tara Smith welcomed participants and briefly outlined the meeting agenda, which was primarily focused on finalizing the recommendations for the 2024 Annual Recommendations Report.

Housekeeping & Announcements:

The following housekeeping issues were addressed:

- **Meeting minutes** - Tara Smith requested approval of the draft Dec meeting minutes.

  ACTION ITEM:

- Meeting minutes from Dec were approved and will be posted on the PCPRC website.

- **Meeting schedule** - The PCPRC meeting schedule for 2024 has been posted on the website, and the Division recirculated the link to register. Members are asked to check their calendars to ensure the meeting dates/times are populated on their calendars and reach out to Tara Smith with any issues.

  ACTION ITEM:
  - Members should ensure they are properly registered for all PCPRC meetings in 2024, and contact Tara Smith with any issues.

- **Member affiliations for annual recommendations report** - Each year, the annual report includes an acknowledgements page that lists the names and organizational affiliation of all members. Members are asked to send their name, credentials, and organizational affiliation, as they would like to have it listed in the report, to Tara Smith (tara.smith@state.co.us) by EOD on 1/15/24.

  ACTION ITEM:
  - Members should email their name, credentials, and organizational affiliation, as they would like to have it listed in the report, to Tara Smith (tara.smith@state.co.us) by EOD on 1/15/24.

Annual Report Recommendations

Tara Smith briefly reviewed the goals for today's meeting, which include finalizing the content in all report sections. She also reviewed the report timeline, noting that the Collaborative had one remaining meeting in Feb prior to the report's release on Feb 15. After today's meeting, the Division and CHI will incorporate feedback and circulate a full, final draft of the report to members, and ask for any final written comments. Any remaining edits, which must be minor in nature, will be discussed and resolved at the PCPRC meeting on Feb 8. At that meeting, members will take a formal vote to approve the report in its entirety, following the voting process outlined in the PCPRC Standard Operating Procedures and Rules of Order. If members know in advance that they will not be able to attend the Feb 8 meeting, they are encouraged to appoint a proxy to participate and vote on their behalf. Members should send the name and contact information for a requested proxy to Tara Smith (tara.smith@state.co.us) prior to the meeting.

Tara Smith then led members through a section-by-section discussion of the report, reviewing feedback that had been received prior to today's meeting, and requesting any additional feedback or edits. In reviewing the overall layout of the report (see slide 9, available here), she noted that a member had provided feedback that the recommendation sections be

ordered, so that the payment section would be followed by the workforce section, then health-related social needs (HRSN)/Housing, and medication-assisted treatment (MAT). She asked members for feedback on this order for the recommendations.

DECISION/ACTION: Members agreed that the report sections should be ordered as: payment, workforce, HRSN/housing, MAT.

Executive Summary & Introduction/Framing Section

Tara Smith reviewed the key discussion points in this section (see slide 11, available here), then paused for group feedback/discussion.

Discussion:

- Tara Smith noted that a member had provided written feedback suggesting the following revision to the sentence at the end of the first paragraph of the Executive Summary:
  - "This focus reflects not only the importance members place on integrated care delivery as a model for increasing access to person-centered, whole person and whole family care, but also the continued rise in behavioral health needs especially among children and youth that are currently being seen and managed in primary care ~~and pediatric~~ settings."
  - **DECISION/ACTION:** Members expressed agreement with this revision, which will be made in the final draft.

- Tara Smith asked members about the current definition of behavioral health integration included in Executive Summary: "Behavioral Health Integration (BHI) is an approach to delivering mental health care that makes it easier for primary care providers to include mental and behavioral health screening, treatment, and specialty care into their practice. It can take different forms, but BHI always involves collaborations between primary care providers and specialized care providers for mental health." She specifically asked members if they felt substance use disorders needed to be explicitly included in a definition of BHI.
  - One member was not against adding SUD, but questioned the implications of this inclusion for the report in its entirety; if the definition is modified or changed here, it would be important to ensure that is appropriate as this term is used throughout each report section- does it widen it too much, particularly at this point in the report process (how much of the report narrative would need to be revised);
  - Another member agreed with this point, and noted that SUD often relates to specialty care that is provided within a practice; in the definition, things should be kept a bit broader, and then we can narrow down into the recommendations;

- Another member noted that they read the definition to be inclusive of SUD as it is currently written, and did not feel changes were needed;
- **DECISION/ACTION:** Members generally supported the inclusion of the definition of BHI as written, so it will remain in the final draft.

- Tara Smith reviewed member comments on the Introduction/Framing section, starting with the "Focusing on Behavioral Health Integration in Primary Care" subsection:
  - This subsection currently begins with the sentence: "The Collaborative recognizes that behavioral health is an essential component of whole person and whole family health, and in previous reports has consistently included support for integrated care models, which address physical and behavioral health needs, as an important dimension of primary care." Tara Smith noted that a member had commented that it is important to specify how this report builds on previous work, and that it could be useful to depict this information visually in a diagram. She asked for member feedback on this suggestion.
    - The member who offered this comment noted that they were a visual person, and that graphics are a good way to break up report content; in addition, with the Collaborative currently scheduled to sunset in Sept 2025, so this might be a way to start building a visual/diagram that features and tells the story of the PCPRC's areas of focus across the different reports, that could be added to next year; it would be a way to provide a synopsis of the Collaborative's work and contributions to primary care in Colorado, both this year and next, to highlight the discussions and achievements of this group;
    - **DECISION/ACTION:** Multiple members supported the idea of a graphic, and the DOI and CHI will take this back and pull something together.
  - In the paragraph discussing stigma (the second paragraph in this subsection, starting with the sentence: "As highlighted in this report, behavioral health integration in primary care is important for many reasons, but foremost among these in a primary care setting is its capacity to address stigma, which remains a significant obstacle for patients with mental health and substance use disorder needs."), a member commented that it is important to emphasize rural and/or underserved settings in this context.
    - **DECISION/ACTION:** Multiple members agreed with this proposed edit, which will be included in the final draft.

- In the "Update on Investment and Primary Care Spending through Alternative Payment Models (APMs)" subsection, Tara Smith noted that members submitted multiple comments related to the discussion of CIVHC's latest Primary Care and APM Spending Report, including:

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- A member had questioned whether the CIVHC report would be included as an appendix, and/or if the report would include a call out box that describes how primary care spending is calculated;
  - Tara Smith noted that the CIVHC report will be included as an Appendix, and contains a detailed description of the full methodology for both defining primary care and how both primary care and APMs spending are calculated;
  - **DECISION/ACTION:** The CIVHC report will be included as Appendix A.
- A member had commented that it would be helpful to note to what extent the inclusion of behavioral spending increased the overall percentage of primary care spending in relation to the sentence: "One such change that had a notable impact on this year's data was one payer's inclusion of integrated behavioral health spending for the first time in 2022, which increased their overall percent of primary care spending."
  - Tara Smith agreed with the sentiment behind this comment, and the desire to get both a better sense of behavioral health spending overall, and its impact on primary care spending, but noted that this is a challenging area to collect good data, and CIVHC has prioritized improving reporting methods/ways to calculate as a focus for the upcoming year;
  - A member noted that it was important that this paragraph also note that the behavioral health spending mentioned is actually behavioral health spending in an integrated care setting- not all behavioral health spending is intended to be included as primary care spending- just that which takes place in the context of an integrated care setting;
  - **DECISION/ACTION:** Tara Smith will check with CIVHC to see if any additional information is available, and the final draft will specify that the integrated behavioral health spending is spending in an integrated primary care setting;
- A member had questioned whether the term "value-based APMs" needed to be defined in the narrative;
  - Tara Smith noted that this was a good flag, as value-based APM in the context of this report has a very specific meaning;
  - **DECISION/ACTION**: A definition of value-based APM will be included in the narrative of the final draft.
- A member had noted that the additional detail should be added to the current sentence: "The Collaborative has also consistently supported increased proportions of prospective payments to providers/practices, which allow for greater flexibility" - flexibility to do what?

        - Tara Smith noted that additional details could be added; a member commented that it was important that the additional details should be offered using a patient-centered lens, rather than from a provider or clinic or system perspective; flexibility to meet what kinds of needs, how care delivered impacts patient experience, etc.
        - **DECISION/ACTION:** A description of the reasons the flexibility of prospective payments is important from a patient-centered perspective will be included in the final draft.
    - Several members questioned the figures reported in the following sentence: "CIVHC reports that prospective payments under APMs accounted for 34.2% of all medical spending across all applicable payers in 2022 and 83.9% of primary care spending in total.", noting that 83.9% seemed too high.
        - Tara Smith said she would double check with CIVHC that is the accurate number, and if they have any additional information;
        - **DECISION/ACTION:** The figures reported in this sentence will be verified with CIVHC, and additional information will be included if available.

- Tara Smith asked for any additional feedback/comments from members on the Executive Summary or Introduction/Framing sections, outside of the written feedback that was just discussed;
    - A member commented that one element currently missing from the discussion of APMs is the lack of APMs for pediatrics, and questioned whether the report should in a call-out noting that while a lot of work is happening in this are (through HCPF's PACK model discussions), opportunities are pediatric practices to participate in APMs are still sparse. The member noted that pediatric spending cannot currently be teased out of the CIVHC data, which seems largely driven by adult numbers, so it may be worth noting all payers (public and private) should put attention toward APMs designed for children;
    - Another member asked a follow-up question, noting that some pediatric practices in their network (3 of 12) had very robust Collaborative Care Models in place, and was curious about the member's experience that pediatric practices were not able to participate in such models;
    - The member reflected that they felt pediatric participation in APMs was variable across the state; models like the Collaborative Care Model are challenging due to the limited number of pediatric psychiatrists in the Denver Metro area, and don't work on the Western Slope. The PCBH model, which integrates therapists and psychologists in a practice, is a little easier to implement and more infused in Western Colorado and other areas of the state; but if a practice only has around 10% of their patients in Medicaid, it is hard to set up a team-based care models in the absence of support from commercial payers with pediatric APMs available.

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Payment Section

Tara reviewed the overall recommendation language (see slide 13, available here), then summarized the key discussion points for each subtopic in this section (see slide 14, available here) and asked for group feedback.

Discussion:

- In terms of the overarching recommendation, a member suggested changing the word "reimbursement" to "payment" in the recommendation language, and elsewhere in the report, as a more appropriate term;
    - Another member (representing Colorado's health plan association) asked for clarification around this request, noting that the report currently uses "reimbursement" throughout. The member questioned the implication(s) of changing this wording, as the word reimbursement is more familiar to many payers, and the language that is generally used (preferred) in state statutes and noted they would take this edit back to their members for feedback.
    - A member commented that "reimbursement" has connotations that work is done/complete, and then reimbursed or paid for after the fact, for that activity; that type of arrangement does not work well to support team-based care delivery, where payment is needed for team-based activities, so the American Academy of pediatrics uses and prefers the word payment, to better capture that component;
    - A member weighed in, noting that they also generally associated the term "payment" with more of a prospective approach, whereas "reimbursement" happens retrospectively, after the work is performed. The member also raised a question around the pairing of the phrase "infrastructure components of care delivery" with the term "reimbursed", noting that when thinking about and talking about infrastructure, it is helpful to draw a distinction between the financing that is needed to support/strengthen the infrastructure (workforce, interoperable data, broadband, etc.- the things you need to provide the care), versus payment to teams for delivering a service. Financing and payment often get conflated, but it is hard to pay for needed high-quality, integrated services for a population or in a clinic setting when the underlying infrastructure is broken; if we don't pay attention to financing what is needed to be able to provide those high-quality services, we can trip ourselves up.
        - Another member agreed with this understanding- you have to finance and fund infrastructure first, and then you have to sustain it with payment; it is hard to reimburse for something that you haven't done yet across the team.
        - A member noted that this parallels the discussion around HRSN, and that while they support screening and referring to services, that cannot

and should not be absent ensuring adequate financing for the infrastructure of services to meet those needs;

- Multiple members expressed support for this framing, and the following suggested revision of the recommendation was entered into chat: "Behavioral health integration should be intentionally/purposefully supported as a key component of increased investment in primary care. While increased investment may flow through various mechanisms, shifting from fee-for-service to prospective, value-based payments for services can increase the sustainability of integrated behavioral health care models and primary care generally. Key infrastructure components that should be prioritized and adequately financed to allow teams to deliver high-quality behavioral health integration services include a diverse array of behavioral health providers, support for developing and sustaining referrals across the spectrum of care, and X [could be data, broadband, other infrastructure elements, etc.]."
  - Several members expressed support for this revision.
  - **DECISION/ACTION:** The suggested revision will be included in the final draft.
- A member pointed out a typo in the sentence regarding public payer support of behavioral health integration, noting that it currently was currently written as "Medicare and Medicare", instead of "Medicare and Medicaid."
  - **DECISION/ACTION:** This typo will be fixed in the final report.

- Tara Smith then walked the group through the written comments the Division had received on this section of the report, including:
  - A member submitted comments on the paragraph related to self-funded plans (currently the third full paragraph in the "Challenges and Opportunities" subsection). One part of the comment was that it is important to quantify the portion of the market in Colorado that self-funded plans currently represent. In addition, the member noted that it would be ideal to include discussion of what actions can be taken in this space to influence self-funded plans, by whom, and how.
    - A member (representing the health plan association) cautioned that health plans would likely be against going into too much detail in the report; plans have expressed concerns about engagement in the ERISA space, both on the legislative and regulatory side, so getting too specific on actions that should be taken, or particular groups that should be influenced, will likely be problematic;
  - A member had flagged that additional details around Kaiser's Primary Care Behavioral Health Model and Collaborative Care approach cited as an example of success in this section, would be helpful to include;

- **DECISION/ACTION:** Tara will contact Kaiser to see if additional details are available to include in the final draft;

- A member asked whether a definition of prospective payments should be in the report; this issue was raised in particular around the current description of pediatric practice payment: "When implementing prospective payments, it's important to ensure that payments are at the correct level for the demand that practices are seeing."
  - Members agreed important to be clear with this term, and it is appropriate to reference the statutory definition of prospective (cite), which has also been incorporated in DOI Regulation 4-2-96.
- A member flagged the current description of considerations around prospective payments for pediatrics, questioning whether this the proper place for this type of comment (should it be removed), or if the language could/should be revised to make a clearer connection to behavioral health integration;
  - A member noted that as written, the statement did seem out of place, but that is because it is currently missing the dimension of whole-family care; they noted that integrated care in pediatrics can support the whole family, including parents who may also need support with behavioral health issues; pediatric care teams can ideally be structured to include infant MH specialists, and other approaches that focus on prevention, such as the Healthy Steps program; currently practices may receive prospective payments for a certain number of patients to receive these services, but a pediatric practice may have 15 babies one week, and 40 the next week, so it is hard to pay prospectively for this care when additional patients and families are constantly added;
  - Another participant (who submitted the comment) noted that their remark was intended to highlight that the first 6 months of life are critical, and retrospective payment doesn't fit well within that year; they echoed the sentiment that pediatric care teams need to including not only early infant mental health specialists, but also team members that can work with the parents on the family-related issues; including language that points out that care must be comprehensive would make sense;
- A member had commented that it might be helpful to supplement the paragraph currently discussing the use of billing codes with a figure or table that lists Collaborative Care Model codes and Health Behavior Assessment and Intervention codes, as a reference for the reader;
  - Members agreed that this would be a helpful addition;
  - **DECISION/ACTION:** The DOI and CHI will review suggestions for tables and graphics, and prioritize those that are most feasible to include;

- A member expressed concern about the current wording of the paragraph recommending that payers should report on their investments in behavioral health integrations to the DOI (a reiteration of a previous recommendation); the member noted that new reporting can be onerous and duplicative, and suggested pointing to existing reporting, such as HEDIS, or the Collaborative is interested in collecting this data; the member further suggested that if the Collaborative was interested in new reporting, it would be better to clarify higher-level priorities, such as annual reporting on the types of integrated behavioral health programs payers have, percent of members eligible to participate in these programs, and the percent of members/patients served by these programs. Detailed metrics, including monthly reporting is onerous and adds administrative burden and cost;
    - A member (representing the health plan association) agreed that any new reporting should be at a higher level; they noted that the association members has recently looked at the effective of depression treatment, and found there are a lot of different metrics that can be used to gauge effectiveness, so clarity around what specific metrics the Collaborative is interested in used will be important for payers;
    - A member noted that if certain data around behavioral health efforts exists, and just needs to be aggregated or integrated in some way to get at what the recommendation is looking to (trying to understand the lay of the land is with regard to investments in behavioral health integration), then it would make sense to point to that data; they noted that it wasn't productive to ask for more data reporting for the purpose of more data, particularly if it already exists; other members agreed with this perspective;
    - **DECISION/ACTION:** Tara Smith will follow-up with the member representing multiple health plans to get a better understanding of existing data that could be leveraged and included in the report;
    - A member requested that if additional information about what payers are currently reporting in this space becomes available prior to the next meeting that it be circulated to members in advance; they noted that it would be helpful to know how many carriers are currently funding integrated behavioral health- if the Collaborative thinks this type of care is important and leads to good outcomes, but that is not a metric we will be looking at, it would be helpful to know that before the report goes out;
    - A meeting participant (former member) offered an additional comment, noting that the way their practice supports IBH would not be evident from looking at claims data; the practice has identified a specific

revenue stream that would not be immediately apparent that it is used for IBH; in addition, money is diverted from prospective payments, and/or bonuses earned for good performance on payment- which are not traceable through claims, and/or it may not come "labeled" that way from a payer; ultimately spending on behavioral health is driven by both payer and provider decisions, and while it is certainly helpful and worthwhile to get insight and understanding how payers are supporting, at the practice level it may be challenging to tease out, because practices use different approaches.

Health-Related Social Needs Screening and Referrals Section

Tara Smith reviewed the overall recommendation language (see slide 16, available here), reviewed the definitions included in this section (see slide 17, available here), then summarized the key discussion points for each subtopic in this section (see slide 18, available here) and asked for group feedback.

Discussion:

- A member commented that they liked the recommendation and this section and did not have any edits; they did note that while the discussion of community health workers is currently contained in the workforce section, CHWs play a role in addressing HRSN, so wondered if there was a need to highlight that role in this section as well.
    - Tara Smith noted that in drafting the recommendations, the DOI/CHI landed on the phrase "clinician and non-clinician providers", which would be inclusive of CHWs, but also additional non-clinician care team roles, and asked if that was in fact the intent of the Collaborative within this recommendation;
    - No members expressed disagreement or concern with the framing of clinician and non-clinician provider or had other suggested edits to the recommendation.
    - **DECISION/ACTION:** The current recommendation language will be included without revisions in the final draft.

- In terms of definitions for this section, Tara Smith asked members for the preference between two proposed definitions of "health-related social needs";
    - A member noted that between the Kaiser and Oregon definitions, they gravitated more toward the Kaiser definition, but felt both conveyed the same content, it was more a matter of wording;
    - Another member agreed, but commented that the Oregon definition included both individuals and families, a component that is missing from the Kaiser definition, which is more narrowly focused on the individual;

        - Another member agreed that Oregon's inclusion of individuals and families was in keeping with the discussion of whole-person and whole-family care in the overall report;
    - Tara Smith noted that in the past, the Collaborative has made amendments (with acknowledgement) to existing definitions, and so the Kaiser definition could be amended to include individuals and families, if people preferred the overall wording;
        - Several members supported this approach;
        - **DECISION/ACTION:** The Kaiser definition will be amended to include individuals and families in the final draft.
    - For the definition of HRSN screening & referral, a member noted that the new Medicare payment rules specifically reference evidence-based tools, which as screening tools that have been tested and validated (such as PREPARE) and wondered if "evidence-based" should be added to the proposed definition;
        - A member commented that evidence-based could be included in the definition, but noted some of the existing tools don't apply to pediatrics; it may be better to just leave it at "evidence-based", and not list specific screeners;
        - **DECISION/ACTION:** The term "evidence-based" will be added to the definition of HSRN screening & referrals in the final draft.

- Tara Smith then walked the group through the written comments the Division had received on this section of the report, including:
    - A commenter questioned whether "health-related social needs" was the proper term to be using, noting that they preferred "social factors that impact health", but acknowledged that the terminology is still evolving in this area;
        - Tara Smith appreciated this comment, but noted that the Collaborative has been fairly consistent in using the terminology HRSN in previous discussions;
        - A participant noted via chat that the word "needs" reflects a deficit-based model, while "factors" embraces both deficits and strengths;
        - A member commented that this is one of instances where the language currently stands and where it should be (to more accurately reflect the concept) are not aligned; they noted they would be okay using HRSN in the report, but suggested the addition of a footnote, that explains why we are using this term, that acknowledges language in this space is evolving; if we create our own term, people may not make the connection between this section and the current conversations/discussions in this area;

        - Another member supported this approach, noting that they are still wrapping their heads around HRSN, and the intersections with social determinants of health (SDOH); they agreed that using terms other than HRSN or SDOH was likely to create confusion among readers;
        - A member offered an interpretation via chat that SDOH is population based, while HRSN in individual/family based; multiple members appreciated this framing/understanding;
        - **DECISION/ACTION:** The report will continue to use the term "HRSN", but will include a flag or footnote indicating that the language is still evolving in this area;
    - Another member had offered a comment in chat about the "promotion of a positive mental health frame"; they offered this both in reaction to the previous comment about the term "factors" including both deficits and strengths, and the comments related to the importance of prevention, and how models/payments that support care delivery in the absence of behavioral health diagnosis or Z codes is also important, particularly in pediatrics (see below);

- Additional member suggestions/comment on this section offered during the meeting include:
    - A member flagged the legislation citations included in the discussion of Medicaid in this section; HB22-1300 and SB23-174 are currently listed, but SB23-174 is related to BH service without a mental health diagnosis, even without an HRSN diagnosis or a Z code; that is really important in pediatrics as a distinction when you are focusing on prevention; the member felt it was okay to leave as written, but it is an important distinction between advancing HRSNs, but some kids don't necessarily have a diagnosis and you are working on prevention, so being able to get MH and BH without any diagnosis is important;
        - A member agreed with this comment, and that the purpose of the legislation was to allow services without a diagnosis or Z code; they noted HCPF has been working through this in the Medicaid space, and noted that another action may be introduced in the legislature this year establishing similar requirements in the commercial space; the member recommended against being more explicit in the report, as these are issues are still actively evolving in the state;
    - A member appreciated the discussion about stigma in this section, but suggested reframing the language in the sentence "in some instances, those with social needs have been the most resistant" to "the most hesitant", to get away from the deficit based perspective; in addition, they suggested including language about the important not just of patient education, but also about the

important of continuing to work with providers on levels of bias related to SUD, class status, etc.
    - Multiple members agreed with this comment;
    - **DECISION/ACTION:** The word resistant will be replaced with hesitant, and the DOI/CHI will add language around needed provider education/training around bias in this section in the final draft.
  - The Division had received a written comment on this section, in regard to the sentence: "Patient education about screening, and why and how the results will be used (and not used), can help address concerns, but is also valuable in building overall trust, communication, and transparency between providers and patients, a hallmark feature of primary care." They suggested adding language about the utility of considering the family, not just the individual in this context, to avoid redundancy (and parental inconvenience.

- Tara Smith reviewed the proposed call-out box on housing, noting that the current discussion is fairly high-level, but reflects the Collaborative's previously discussed suggestions that housing significantly impacts individual and family health issues/needs, particularly in the area of behavioral health, and should be noted in the report, but flagged as an area of future work;
  - Members did not offer specific comments, critiques, or edits on the housing section;
  - **DECISION/ACTION:** The housing call-out box will be included as written in the final draft.

- A member offered an additional comment on the data considerations subsection, noting they appreciated the inclusion of CHAS data, but wondered if data about discrimination based on class status could also be included.
  - **DECISION/ACTION:** The DOI will work with CHI to potentially include this additional data.

Workforce:

Tara Smith reviewed the overall recommendation language (see slide 20, available here), reviewed the definitions included in this section (see slide 21, available here), then summarized the key discussion points for each subtopic in this section (see slide 22, available here) and asked for group feedback.

Discussion:

- In terms of the overarching recommendation, a member commented that they felt it was good, but noted the repeated use of the word "whole";
  - Multiple members agreed, but generally agreed while a lot, the use of the word "whole" multiple times still expressed the concepts appropriately;

    - Another member commented on the substantial interplay between workforce and all things money, be it financing or payment; if adaptations to the first recommendation are made, it would be useful to connect the dots in this section and incorporate the concept that financing for having a team of clinicians and non-clinicians as part of the broader team is an important infrastructure element.

- In terms of the definitions, Tara Smith asked members for feedback on the current list of definitions- were these the right definitions, are any not needed, and are any missing from the list?
    - A member asked if the Collaborative had previously defined what was meant by "whole person care"?
    - Tara Smith responded yes, and referred the group back to the definition offered in the Third Annual Report, which was developed by John Snow, Inc.: "the coordination of health, behavioral health, and social services in a patient-centered manner with the goals of improved health outcomes and more efficient and effective use of resources."
    - A member questioned via chat whether the Collaborative also had a definition of whole family health, and whether it was important to include both;
        - A suggestion was made to modify the JSI definition of whole-person care to include whole-family care, which members support;
        - **DECISION/ACTION:** The definition of whole-person care will be amended to add whole-family care.

- In terms of the subsections included in the report, Tara Smith briefly reviewed the key issues and concepts, then walked through group through written comments received on this section:
    - A member commented that this section notes that the "exact team composition [of an integrated care delivery team] may vary according to the care delivery model"; they questioned whether it would be helpful to include a description/graphic that includes a range of examples;
        - A member agreed that it might be helpful to highlight models outside of the Collaborative Care Model, to show why flexibility is needed to support a variety of models; they suggested it also might be helpful to include access programs, such as the Colorado Pediatric Psychiatry Consultation & Access Program (CoPPAC) program;
        - A member noted that the group had discussed having a graphic earlier in the report that compares different IBH models, and this section of the report could harken back to that; they further noted such a graphic would not need to be comprehensive, but rather highlight 2 or 3 models- the goal is not to be prescriptive, but rather to help people

think about the various models that exist, and better understand the types of clinicians and non-clinicians who are valuable members of different types of care teams; different models require different skill sets and different types of team members, and the type of model that is pursued depends in a variety of factors including the underlying needs of their patients and families, and the local availability of clinician and non-clinician providers;

- On the "Community health workers and other non-clinician providers" subsection, the Division received a comment that outlined the CHW work that CDPHE has been engaged in over the last year, and noted CHW has been and is being used by CDPHE and HCPF as an umbrella term to cover a variety of roles, including a health navigator, patient navigator, and promotores de salud. They noted that it appears in the current draft of the PCPRC report, CHWs and promotores de salud are being considered separately, when for credentialing and reimbursement purposes, based on the CDPHE/HCPF work they will be considered the same. The comment further noted that Peer Support Specialists do not fall under the CHW umbrella, so it makes sense for them to be considered separately. In addition, the commenter recommended a definition of CHW that is inclusive of promotores de salud and is aligned with how CDPHE and HCPF are presenting the definition of CHW: "The American Public Health Association defines "community health worker" as a frontline public health worker who is a trusted member of, and has a close understanding of, the community that worker services. This trusting relationship enables the worker to serve as a liaison between health and social services and improve the quality and cultural competence of service delivery. "Community health worker" is meant to be an umbrella term for individuals who may go by many names, such as: health promoters; community outreach workers; promotores de salud; health navigators; patient navigators."
  - A member agreed with this framing, and the use of CHW as an umbrella term;
  - Another member did not disagree, but noted that it would be important to reference that work, to distinguish how the term CHW is being used in Colorado, which may be different from other states;
  - A member agreed, and supported using this report to reference/support other work in Colorado, and/or previous recommendations from the Collaborative; this helps reinforce the message, and strengthens the signal, rather than adding more noise to ongoing conversations;
  - **DECISION/ACTION:** The DOI/CHI will add language that acknowledges and supports the work in this space by HCPF and CDPHE.

- On the section discussing telehealth, Tara Smith noted that a member has submitted a comment in relation to the sentence about the "lack of adequate infrastructure" being a challenge, it was important to emphasize rural and frontier areas;
    - A member added an additional comment on this section, noting that in addition to adequate technological infrastructure, telehealth has also raised some concerns about quality of care, particularly in relation to vulnerable populations; this member has head concerns that some behavioral health patients, particularly those with SUD, have experienced lower quality of their care with the complete use of telehealth, and so some of the most vulnerable patients may need and respond better to a personal touch with a provider; this member will look for documentation to support this point, and share with the DOI/CHI;
    - Another member agreed with this comment, and additionally noted that telehealth may not be appropriate for all patients that need services, including pediatric patients; as an example: we tell young children not to sit in front of screens, so it is not appropriate to then have them sit in front of a screen for play therapy or other types of care;
    - A member (representing the association of health plans) noted that many carriers are continuing to look for ways to promote health utilization among their members; while these strategies vary based on line of business, carriers see telehealth as a valuable tool for increasing access to care and are interested in findings ways to engage their members through this care modality.

Medication Assisted Treatment (MAT)

Tara Smith reviewed the overall recommendation language (see slide 24, available here), reviewed the definitions included in this section (see slide 25, available here), then summarized the key discussion points for each subtopic in this section (see slide 26, available here) and asked for group feedback.

Discussion:

- In regard to the overarching recommendation, members did not offer any specific questions, comments or suggested revisions.
    - **DECISION/ACTION:** The current recommendation language will be included without revisions in the final draft.

- In regard to the definition, members did not offer any specific questions, comments, or suggested revisions.

- **DECISION/ACTION:** The current definition will be included without revisions in the final draft.

- In regard to the subsections and general contents, members did not offer any specific questions, comments, or suggested revisions.

- Tara Smith then walked the group through the written comments the Division had received on this section of the report, including:
  - Primary care providers face increased pressures on their time in the clinic, and creating enough time to fully address the needs of individuals who are often dealing with both addiction and other behavioral health concerns can be a challenge - important to make sure reflected above with regard to HRSNs
- Brandon- main piece of feedback from members was on the lack of education piece, which we take care of that with the flag for exception; also heard that some carriers do offer like some education pieces that are available, or are able to point to resources that providers can use to assist in the education and training they need to receive;
  - Tara Smith asked if the member would be willing to share the feedback from members, so that additional information on current payer efforts in this area could be incorporated;
  - **DECISION/ACTION:** The Division will follow-up with the member to get additional payer feedback on this section of the report.

Conclusion:

- Adding a specific call-out to housing, in relation to the HSRN, because that was an area of concern that we couldn't get into this super specifically this year, but would be helpful to nod to that specific interest in our work next year;
  - Members approved of this suggestion;
  - **DECISION/ACTION:** Housing will be included in this section as an area of future work.

Next steps:

- DOI/CHI will incorporate comments and circulate a final draft of the report in the next week or two;

- Members will be given as long as possible to provide written comments;
  - Any additional comments need to be very specific in nature (redlines), and at this stage in the process, any revisions will to be restricted to "can't live with" or "can't live without" changes that are relatively minor in terms of adding to or subtracting from the current narrative;

    - If easier for members to provide verbal feedback, they can contact Tara Smith (tara.smith@state.co.us or 720-701-0081);
- If members know they are NOT able to make the meeting on Feb 9, they are encouraged to appoint a proxy; they can do so by emailing the name and contact information of the proxy to Tara Smith (tara.smith@state.co.us);
- The final report must be published by Feb 15, so all content must be completely finalized at the end of the Feb 8 meeting.

Public Comment:

- No public comments were offered.