Member Advisory Council Minutes
Western Slope – 3/13/23

Rocky March Meeting:

March 13, 2023

Present in person:
Henry Grater, Herberta Silas, Bianca Ochoa, Meighen Lovelace, Miala Colorow, Staci Nichols, Ian Engle, Tom Keller, PTISAWQUAH, Janice Curtis, Rochelle Larson, Mary Lou Doke, Tim Hudner, Tracy Klumpker, Monique Terpstra, Susie Richards, Diana Yellow, Nina Kazasian
Online Orchie Baca, Lynn Jolley
Rocky Staff Renae Anderson, Patrick Gordon, Meg Taylor, Sheila Worth in person and Alyssa Rose, Rose Stauffer, David Mok-Lamay, Todd Lesley, Becca Aspray, Sarah Vaie, Dale Renzi online
Guests: Senator Kolker via his aid, Shawn Davis, Josh Montoya, Shawn Bodiker,
Facilitator: Julie Reiskin

The meeting opened with introductions:

Julie explained that she had not been successful in getting any county to participate in meeting with us despite a nice introduction by HCPF to a number of the counties. Both Meg and Ian thought they could get some counties to participate in a meeting with us in June. HCPF is coming to our meeting today to discuss county relationships.

Rocky Management Discussion:

Meg Taylor and Patrick Gordon gave updates from Rocky followed by conversation:

1) David has asked every meeting about neuropsych and psych testing across SW Colorado. Meg said that this has been an issue throughout the region. She found a large practice that continues to grow throughout the region. They are called Integrated Insights. They are Montrose based, they are actively recruiting for this and willing to expand in SW Colorado. They asked what they could do and Meg said we needed this (neuropsych and psych testing)
2) The state is adding autism as a "covered" behavioral health diagnosis beginning July 01. This will mean the RAE or mental health centers can no longer deny people due to autism being a "primary diagnosis". ABA is not being covered but because the clients will be in RAE there will be care coordination with an expectation of coordination. The group thought that we needed to advocate for ABA to be included in future contracts.
3) Meg expects that ACC 3.0 will be more inclusive and they also seem to be actively working to un-silo the office of community living.

4) Members identified a huge need to help with paperwork for disability applications and there will now be a small pilot funded by Rocky to help with this. It will be in Northern Colorado and Larimer. There will be a training component open to case managers and anyone else in the region to increase knowledge.
5) Oliver Consulting did training on treating people with intellectual disabilities who have behavioral health needs. Rocky paid the first 50 providers to enroll. The 2nd round of training is coming up. Rocky is reimbursing providers to attend this training which will be for a whole week. This increases the skill level of providers and providers that work with this population get an enhanced rate. Will inclusion of autism make hospitals more willing to serve this population? The answer is it should but there are still some CPT coding issues to be addressed. We have the same issue with brain injury. This needs to be included also.
6) There is an internal Diversity, Equity, and Inclusion council at Rocky called ABIDE (Ambassadors for Belonging, Inclusion, Diversity and Equity). They are forming an accessibility council to do a variety of tasks including take an inventory of materials.
7) There is a lot happening at the state level especially with the new behavioral health administration. Discussion on this included:
    a) This is an important opportunity that could go either way -improvement or making things worse. Whenever there is big change and reform it creates conflict and confusion. Rocky is standing back, observing, and trying to make sure engagement is constructive and effective.
    b) Members said they do not want to have the “apple cart” upset only to have things be put back exactly the way it is now.
    c) This is hard for providers and we need to “uncluster” this. Providers need to be able to easily serve people on both sides (Medicaid and BHA).
    d) Concern that important issues like peer support, counseling and therapy quality, SDOH get lost while everyone has meetings to figure out how to spend money.
8) The group would like to reach out to local representatives to discuss how things are going with the BHA and discuss the need to align with Medicaid. This would include at least Senator Perry Will, Senator Janice Rich, Speaker Julie McCluskie, and Senator Dylan Roberts.
9) Housing continues to be a huge issue within the community of people with behavioral health needs. Patrick said that one major dynamic is to bring the resources with flexibility of what they can fund under capitated RAE behavioral health benefit. There are many supportive housing programs but what they do not have is integrated behavioral health services. They are set up by accessing behavioral health services. Experiencing housing insecurity may cause people to need access in a different way. They try to fund services in buildings, therapy, peer services, case management, etc. This is so they can do billable and non billable services, can build trust, etc.

Housing supports can be Integrated into services. Practically what this means is different providers with special funding arrangements. When people have affordable housing they also have more access to BH care, more feedback, more assistance towards psychological well being which helps them to maintain housing, also to help prevent eviction. They cannot use Medicaid dollars they receive for housing, the services component is one way to provide support. Discussion included the perspective that services in housing cannot reinforce stigma and oppression. It should never be the " us helping them" deficit approach to cure or fix. Even some peer training promotes a deficit based approach. How do we make sure that does not happen?

10) Janice asked what are contractual requirements for peer services? Peer services throughout behavioral health benefit need to be expanded. It used to be only in CMHC space, but now it is outside of that space. Under BHA under substance abuse program, they have recovery support professionals, with licensed clinician doing supervision. Peer services require certification for substance abuse, but certification is not required under Medicaid. There is a certification for non Medicaid peer services. Meg said that Rocky has a managed service organization for substance abuse—one of the organizations we work with is clear about drawing the line between clinical and peer services. One should not expect a clinician to function as a peer or vis versa. The training and roles are different and produce different results. Mindsprings continues to try to get rid of all peers. Janice shared an email that went out that was giving inaccurate information about why they were laying off peer workers. Rocky had provided a lot of support, put a lot of money into the Mindsprings peer program especially embedding peers in the community (co-responder models, at shelters, etc.) Peers bill fewer hours than providers so make less profit for the companies. The peers are often doing the true and necessary coordination which is not billable. Rocky found alternative payment models to keep Mindsprings whole and address the unreimbursed time. They expanded funding for peers and offered funds but with the stipulation that the funds were for the peer support professionals. Some mental health providers took Rocky up on this, but Mindsprings did not. Peer programs are covered but devalued in legacy mental health systems but there is a ton of evidence about their effectiveness. Rocky has figured out how to pay for them and asked HCPF to recognize this to make it sustainable. This problem is key to the unresponsive existing model of community mental health center funding. They get a lot of extra money to cover those with the greatest needs and this would include providing peers. If they say they "cannot afford" peers despite Rocky figuring out funding, we need to build this model outside of the Community Mental Health Centers. Rocky is happy to share their model with other RAEs. It was noted that how training is delivered is important. Peers will have their own internalized oppression (as we all do) and we need to acknowledge and work ith this in training. We need a model that is strength based. Could we incorporate this? People wanted to know more about training and how it works

and how we can be more involved. Training should also address intersectionality. Rocky is doing some training on gender affirming care. This will be discussed at PIAC tomorrow.

11) Meg also said Rocky is working on an awareness campaign with Mental Health Colorado with real people to address stigma—including circular criminal justice issues which is when people can not get treatment, then end up with criminal system involvement.
12) It was noted that currently mental health providers have to submit a service plan and goals. How does that work with peers and how is this person centered? How can Rocky work with disconnects between requirements and what client needs. The only place this should apply is regarding audits. There always has to be goals, we want to have responsibility to get the client somewhere (as opposed to the old model of doing therapy forever with no real outcome for the client) but there is fluidity needed with people. Where this comes in is when there is an adult who has seen someone for two years. We need to be able to ask what has happened? Prior authorization is more about inpatient care. Rocky does not want documentation to be a barrier, providers are not getting this.
13) Monique mentioned a family member got excellent care at Mindsprings, and people were happy to hear this.
14) Bianca mentioned she is a trained peer support specialist.
15) The lack of services in school and lack of counseling for kids was discussed. Often there are referrals and counseling does not get back to the child or family and when it does often it is not offered in a way that is culturally competent. People are afraid to ask for help because they do not want someone to call the police. Members shared experience about being gaslit by therapists and that if there is no reliability and consistently and cultural competence the experience is traumatic and causes harm
16) Members asked when can we get peer support in high school? Meg is meeting with school districts locally to have peers in schools. There is major shortage, youth supported crisis response can help; Sheila talked about how she has supported a kid based program, Project Butterfly, kids trained to be supportive.https://projectbutterflygj.org Instagram @projectbutterfly.gj Facebook Page – Project Butterfly – Western Colorado
17) Case Management redesign: This is a major effort to redesign Long Term Services and Support through Colorado. Historically case management agencies (CMA) have been able to do both case management and provide services. This violated a federal regulation about conflict free case management. The problems with this were mostly in the Community Centered Boards (CCB)which serve people with intellectual disabilities. Instead of having CCBs and Single Entry Point agencies there will be on case management agency (CMA) in each area to serve all people with disabilities. Rocky bid on two regions Mesa and Costillo/Conejos/Rio Grande/Mineral/Alamosa. They will learn if they won the bid by the end of May. Rocky hopes that by continuing to have these

contracts touching different parts of a person they will help move forward the ideas of blending funding streams, knowledge, staff, etc. Some comments on the segregation of services and how expensive it is included:

a) A 14 year old who had first suicide attempt at 12 and no one would help. Now he is in the criminal system and there is no agency that can serve him.
b) Why are we not doing MRI for brains when someone seems to have a problem that is not responding to treatment. People cannot seem to access this service.
c) Criminal justice does not take into account
d) There is more we can do with food, neurology, and published research that are studying neuro issues re age.
e) There are models that do work we can build on and we can also identify what is working and what is not but not sure how to put this information in a cohesive form.

After our update/discussion with Patrick and Meg we broke for lunch and then reconvened for a meeting with Senator Kolker. He is a metro area Senator but a lead on mental health. After a meeting with Meg he wanted to hear from this group. He was unable to leave the Senate but his aide was there to listen to issues affecting Western Slope Medicaid clients.

Senator Kolker Meeting

1) Nursing facilities
2) Lack of culturally appropriate services
3) Clients really support the idea of vouchers for mental health services. In some areas, especially resort areas, there are plenty of providers but they will not sign up with any insurance including Medicaid. A voucher model would help some clients get services sooner.
4) System is not serving children until they are in need of out of home placement and then they have super high needs. Taking kids away from families is not good but they get so far out of control when they cannot get timely and appropriate help that it is necessary. It then becomes a never ending destructive spiral.
5) There are many older adults who cannot manage paperwork. There is no one that helps people with paperwork such as eligibility paperwork. The systems' people say "just go online" Many do not have access to the internet and even some who have it do not know how to use it or use it safely.
6) There are serious problems with language justice.
7) There is No internet access in rural areas so telehealth cannot be the only option. It does not work for everyone and is not always accessible.

8) We would like accessibility to move away from legalistic compliance driven approaches which are about doing the minimum. Good access is good business. Do not focus on the minimum, the focus should be what is the most I could do? This will help businesses (including healthcare) be more competitive.
9) For health care and mental health care the focus should be on customer service. How do we design systems and programs in a way to focus on customer service instead of wasting time, energy and money.
10) Deaf community issues: This community is very linguistically diverse and it is difficult to satisfy every need. Most have some level of language deprivation. They often need extra explanations to understand the situation. Most cannot do paperwork, they are overwhelmed and throw it out. Language deprivation happens because Deaf do not overhear conversations and miss out on a lot of information. Birth to 3 is a critical time for language development and sometimes Deaf people miss that. Language deprivation creates understanding deprivation and emotional immaturity. People think reading is good enough, any interpreter is good enough. This is not true. We have to ask each person what they need and spend the time to make sure they are able to tell us. Most people do not understand that American Sign Language is not English. If you cannot communicate with your teacher you will not learn.
11) Staffing at the regional center is a problem. They cannot compete with bonuses, salary, or overtime of the private sector, especially for medical staff. There was authorization in 2015 for the Denver Regional Center (Wheat Ridge) to get extra funds and that would be very helpful to get there. People can make more at City Market.

Senator Kolker's email address is chriskolkercosenate@gmail.com if people have other thoughts. Julie will also send a summary of this discussion.

PIAC Updates:

STATEWIDE PIAC met on 2/1. The next one is later this week. HCPF has contracts with RAE that will be up for renewal next year. Members vote on things like what are KPI (key performance indicators) for primary care and behavioral health. There is no coordination with LTSS yet, but will be later. RMHP took over SEP in Mesa which administers LTSS

KPI for Primary care and BH means that providers are told "if you do X this is how you will be paid, and if you hit specific indicators you get paid more". Some have to do with customer service. They are designed around a certain amount of money and changing the KPIs takes so long to set it up because providers have to make major changes to change what they report so it is really bad to change the measures all of the time. This led to a discussion that if the patient advocates and providers get in a room together we

have a lot in common. We also do not want to see measures change constantly, but want to have a say in what is worth reporting and tracking.
We need to measure things like culture and language, this fits in customer service. Right now we need to set up measures that are not too burdensome. Now they spend more time doing paperwork and everyone would prefer a focus on customer service. We need patience, repetition and consistency. It is hard to disagree with common sense.

We need to figure out how to use complaints as a learning tool. This needs to be in contracts instead of a punitive factor which leads to retaliation and under-reporting of complaints.

We need to have more training for cultural sensitivity, we have people from this group capable of providing some of these trainings. We need to provide clients with experience training on how to exercise power in these spaces.

The state will be talking about phase 3 for kids on Wednesday. People can go to open comment. They have a draft of a vision that includes

Improve member experience
Referrals to community partners
Care coordination
BH transformation

<u>Discussion:</u>
We need to figure out how to pay people for all of this work (client engagement)
Patient care and PCP—how to help patient follow through with various orders
Mental health for kids,it is difficult for parents to get help for kids –
Compliance is tied to belief in what they are complying with. Patients need to be bought in and in agreement with the plan.
We have taught people to not take responsibility for their health.
Health coaches help people to take responsibility for their own care.

The PIAC has several subcommittees all of which are open to the public and members were encouraged to participate. Information on all meetings and subcommittees is here
The regional PIAC is meeting tomorrow at the Workforce Center and all members of this council are welcome to attend.

TRIBAL UPDATE:

Monique gave an update on the great working happening at the Ute Mountain Ute Tribe (UMUT) Monique said that they have a full team with Mali, Orchie, Monique, and Herberta. They have gotten the first 2 people on CDASS. They are also helping many get on other services.

Monqiue is filling Tims seat on the housing board representing the disability community and will also represent the Native American community.

MEETING WITH HCPF ON COUNTY ISSUES:

Josh Montoya and Shawn Bodiker from HCPF were introduced. Josh is the county liaison with HCPF and Shawn is the eligibility policy manager for the Department but worked in the LTSS area for years and is very knowledgeable about disability programs. Her job is to oversee all financial rules for department for all eligibility sites include medical assistance sites and application assistance sites and to provide any clarification.

HCPF has fiscal oversight of counties. They can do this best when they have the ability to hear from people who experience service and how to create improvement. They regularly meet with counties and discuss customer service, structure, resources, etc. Some counties are not aware of us and we asked that HCPF connect them to us as direct conversations with clients can help.
HCPF has operational oversight also but there is no rule on federal or state level that says what collaboration should look like. Josh said that we may not be able to say how collaboration should happen, but that it should happen

Shawn said that they try to collaborate with eligibility sites, they have monthly meetings, they are covering the unwind with a smaller group of counties.

One member mentioned a specific concern around Eagle county. The specific case is that the whole family has Medicaid and SNAP. When the family reported income change the county did not understand that having an LLC and DBA are the same and accused the family of dishonesty. They then took SNAP away and that stopped all benefits. The family was told to ask for dispute resolution and the county was very angry. The county then removed a child from LTSS because they were upset about the request for dispute resolution. This left the family without health insurance during the pandemic. When this was brought to the county, they apologized and said they would fix it, but they have flagged this family for fraud. In talking about this case members have heard this is not an isolated incident. People in rural communities hear similar stories.

Staff in some counties are looking at social media to prove families do not need assistance. The group wants to have open and honest conversations on how to have better understanding and not just training directors but supporting staff.

We need to have conversations about clients getting services and case workers being supporters, we want to have open robust conversations about mental models in rural DHS, stopping gatekeeping and starting services. We need to do this without names and case numbers because that puts clients in harm's way

Josh said that he is always open to conversation on how to improve as system and discussed some recent processes. He said there have been decades of challenges in this space.
They have some rule revisions that clarified expectations for non discrimination since 2021. There are some counties that did not have a nondiscrimination policy. They are trying to address these issues and fix decades of problems. There are thousands of workers who do their jobs well. HCPF has created a centralized county complaint process. Clients can submit a form with a statement that triggers follow up. This can be anonymous or with your information. The state can and does use that data to have conversation with counties where there are opportunities for improvement.

HCPF Just did a contract to require member feedback. Starting in July they will have to have a plan to get member feedback and report on what they are doing. HCPFwants to address issues with families quickly when they arise,

Members stated that there is a lot of internalized oppression that comes from being denied or questioned. This keeps people from applying or complaining. We questioned how to measure a negative? In small towns everyone knows everyone and consequences for reporting a person are huge. Retaliation comes in a lot of forms. Members said that sometimes it is easier to go hungry than to continue to be demoralized by the county.

Sometimes it depends on what neighborhood you live in depends on what help you get. For example, if you live on Section 8, or in a mobile home park the message is “my life does not matter”. There is stigma as long as we have an “us helping them” model. We need to change the narrative that Medicaid and other services are a resource and providing them should be a matter of community pride. Do not focus on poor pitiful victim. Can we provide better training led by people who use services on how to provide quality customer service?

Maili spoke about language barriers among the elders in her tribe. She said that they are so overwhelmed with paperwork. She said there is an electronic barrier when they are told to do paperwork online. She said that elders will not do the electronics and electronics do not work
Departments do not assist, people are then just handed a stack of paper, people do not understand paperwork so they give it to someone else or it goes in the trash. There is a lack of communication and support. We need to hire people who are living better lives to support people who want to live better lives so they can see there is hope.

Members mentioned you turn in the packet then wait 45-60 days to see if you get approved, otherwise you get denied if one thing is wrong and you start over. Peer led supporters are important —know what it is like to be denied. We also need to not deny people if one thing is wrong but help them get it right. We also need to get people who have used these programs to speak out on everyone's behalf so that people are more receptive to doing the applications. People are embarrassed to need these things and ashamed of needing medical benefits or SNAP. People are humiliated and workers do not seem to care and it comes down to being a human. One member talked about someone with disabilities whose first experience was you do not quality go away. For 25 years had to fight to keep benefits every year, at end of life was so humiliated they just gave up.

Members said in La Plata county lots of things happen with black and brown families. There is a coalition of BIPOC leaders and they hear horrible things about institutional and interpersonal racism. Staff including leaders talk about clients in meetings until someone says something. The people running the departments are not modeling appropriate behavior.

If state would constantly provide training that would be helpful

Members shared that people are also afraid in Montezuma and Lake Counties.

Members said people cannot understand what the state wants on the applications, and have to rely on others. It is frustrating to have the constant same questions said in a different way over and over. This led to the question: can we eliminate some of the paperwork?

People do not get told what is available. There needs to be more internal education

Can we put ethics or rules for collaboration in the contract?

Josh explained the contractual requirement. They did pass rule revisions to get some of this including customer service that is respectful, timely and culturally appropriate. Contracts provide funding to hire regular staff and the law and state constitution says counties must do eligibility for residents. Retaliation is against regulations and the law, people need to report it to the state because it could result in consequences.

Josh and Shawn wanted to make sure that we understood the signature page in the new renewal packet. It is in the front of the packet. If there are no changes from what is already pre-populated in the packet just check no changes but make sure to sign and return. If you do this online you can sign electronically. Otherwise you have to sign and return by mail. It is very important that all renewal applications are signed. To avoid dropping people who are still eligible they are doing the following:

- 3 outreaches on return mail,
- Working on customer service improvements.
- They are trying to get staff to work on rules and efficiencies for the future. They are looking at ways to make it easier for workers and looking at states like WA and CA to see what they did —how to make it easier for members.
- The feds review application processes each year
- They have been working on a joint application with DHS to make it more efficient.

If no changes do not send whole packet, even if there are changes you can just send those pages
Biggest thing is knowing if there are changes and signature

<u>Feedback:</u>

a) Change the message to workers to support them being proud about helping people get needed benefits.
b) Make sure they know they are eligibility workers not ineligibility workers.
c) Expect that they will tell people about all available programs and provide the income and asset limit with application

NEXT MEETING:

- We discussed having the meeting in either Glenwood or Carbondale but did not come to a conclusion.
- Have a conversation directly with counties.
- Update on end of COVID`
- We will have a presentation by the Butterly kids in September