Regional Program Improvement Advisory Committee (PIAC) - RMHP

Regional PIAC Meeting Minutes 03/14/23
Rocky Mountain Health Plans (RMHP) Regional RAE PIAC Meeting Minutes
Location: Mesa County Workforce Center in Grand Junction and Zoom
Date: Tuesday, March 14, 2023
Time: 10:00am-1:00pm

Attendees- RMHP :
ReNae Anderson ^, Barbara Bishop, Maureen Carney, Sheri Cogley, Becca Espray-Collazo, Jeremiah Fluke, Patrick Gordon ^, Anna Messinger, David Mok-Lamme, Kendra Peters, Meg Taylor^, Sarah Vaine, Sheila Worth

Attendees External: Scott Aker^, Brittany Bear , Paula Belcher,, Kayla Ray Boyd , Maili Colorow ^, Janice Curtis ^, Daniel Darting, Dan Davis,, Shawn Davis ^, Allison Duran ,, Dorma Eastman , Steph Einfeld Ian Engel ^, Jen Fanning , A Franklin , Shaunalee Fruit, Terri Hurst, Kellie Jackson , Jessica Jensen*, Michelle Jonjak , Tyller Kerrigan-Nichols, , Tom Keller *^, , Tracy Klunker^, Rochelle Larson^, Haley Leonard Meighen Lovelace *^, Nancy Mace , Amy Maskie, Ptsaqua McKinney ^, Wade Montgomery , Godwin Namezie, , Rob Nelson,, Hali Nurnberg , Bianca Ochoa *^, Tammy Phillips, Axel and Kaitlyn from Elias Transportation ^, Julie Reiskin^, Allie Richmond *, Stacie Russell, Silvia Santana, Alison Sbrana , Pam Sharratt, , Rebecca Schickling , Namrata Shrestha, Herberta Silas, Jessie Smith, Shelly Spalding, Stacy Starr , Father Tema , Andi tillmann^, Amanda Uehlein , Brandi Vela , Maila^,

^ represents in person. * represents board member

Organizations Represented: Aspen Hospital, Axis Health System, Banner Health, CCCJRC, Colorado Cross Disability Coalition, Community Hospital, Counseling and Education Center, Delta Health, DentaQuest, Family Health West, FIRC, Grand County Rural Health, Grand River Hospital, HCPF, Larimer county DHS, Loving Beyond Understanding, Middle Park Health, Montrose Regional Health, Mountain Family Center, Mountain Family Health Centers, Northwest Colorado Center for Independence, Northwest Colorado Health, PDF Consulting, Quality Health Network, Signal, St. Anthony Summit, WMRHA ,

Agenda Items

1. Call to order: ReNae Anderson, Rocky Mountain Health Plans, called the meeting to order shortly after 10:00am. Participants introduced themselves in the room and via chat in Zoom. Meeting agenda discussed.

A. PIAC Voting Member Update: ReNae Anderson, RMHP

- Three new members

-Bianca Ochoa, bilingual representative
-Meighen Lovelace, family member representative
-Haley Leonard, community mental health center representative

- Vacancies on board: year commitment, with up to three consecutive terms. Commit to 3 hour PIAC and 1 hour strategic planning quarterly.

Criminal justice advocate, private behavioral health provider, family and member, health neighborhood,
Health neighborhood is not a doctor, but assists community in health, i.e. Dentaquest.

2. Update from MAC leaders and Shawn Davis.

Tom Keller from Western slope MAC

- Discussed with Senator Kolkur office and discussed issues facing on western slope.
- Discussed what statewide PIAC is doing getting ready for ACC phase 3.
- Reported on Native American project with CCDC.
- Discussion with HCPF people about county situations and had dialogue regarding county issues between the state and counties and how counties don't have same information that state reports.

Tracy from Deaf Initiative

- Trying to figure out how to broaden our group. Want to be in more counties and other communities.
- Talked about setting up panels to do trainings in two hospitals in Grand Junction.
- Anthony met with fire department and are looking forward to having meeting with fire department. They would like to gradually add in more fire departments. This is to try and understand how in emergencies how to make it work for deaf people. A lot of time fire fighters come yelling that they are here, but deaf people aren't going to hear that. Kind of a similar situation if a person is unconscious, so, we are trying to figure out a way to work with them to help them understand what will work.
- Looking to work with hospitals and doctors, to improve what to do with the deaf people. Hospitals don't often want to provide the resources for translation, etc. Don't know if they don't want to provide or don't want to pay for it. Problems in taking classes and we cannot rely on Sheila to always be there. Center for Independence will assist if we get the word out. There needs to be systemic changes.

Allison Sbrana, Larimer County MAC

- Our themes from this last year have been mostly behavioral health and pain management. We keep coming back to these topics, as they are where there are unmet needs or people are facing barriers to getting care.
- Pain management: Talked about in January. In upcoming legislation there needed to be language about gate keepers preventing pharmacies and office staff from overriding doctor's orders and developing a pain patients bill of rights that they could go to.

Lots of suggestions and would be happy to share it.

- Health equity areas. As rocky has focused on Diabetes as a health equity, we got feedback on that. There are several pages of notes that she is willing to share. There is a lack of providers, especially endocrinologist. We need providers that can look through different lenses to people with multiple disabilities, including mental illness, IDD in tandem with diabetes. Endocrinologists need to know how to work with people with disabilities. We have lots of recommendations that will be willing to share.
- Another health equity area flu and covid vaccines. We have some feedback on that. One point here is that people on Medicaid often don't have primary care providers and finding primary care providers can be difficult. Therefore, finding locations for vaccines can be difficult. There is a whole downstream effect of that.
- Behavioral health: We have the new facility being built. Because we keep talking about the unmet behavioral health needs, Lori, director of behavioral health in Larimer county, came back to talk about the progress of the facility. Had a very grave and lively discussion about what unmet needs are going to be addressed with new facility and how it can be inclusive to all kinds of disabilities, talking about how these providers can meet mental health needs of people with IDD and other disabilities. We had a good conversation about including occupational therapy at this facility, to meet sensory needs and to talk about meeting other needs of people with disabilities, so that they have the ability to stay in treatment at the facility.

Bianca Ochoa: Spanish speaking MAC

- Working on connecting with different counties within our region. Starting to build the Spanish advisory councils. Trying to build it for communities within each county. Working on schedules. Building lots of good communication and are working on a lot of things at the same time.
- Introduced amazing resource in Rifle for Medicaid transportation. Abel and Kaitlin Johnson with Elias Transportation. Nonemergency transportation for Medicaid members. Have been in business for over 8 years. Don't have wheel chair equipped van yet, but will have on esoon. Will cover entire western slope and transport to front range if necessary. Will transport family or caregivers, as well. They do not do nonmedical rides yet, but are hoping to soon.

lets connect too, also about maybe helping you guys get a wheelchair accessible van.

Meg stated that will schedule a meeting with head of care coordination. She will also reach out and discuss how Rocky might help in getting them a wheelchair accessible van.

Julie stated that Millennial is the only service that does wheelchair accessible rides currently.

Abel stated that Millennial does not get a high rating. Elias Transportation strives to be on time, will wait for you during your appointment and focus on privacy. Elias also allows family or others to accompany members to their appointments.

Kaitlyn stated that 24 hours in advance is generally enough time to assure a ride. Preauthorization is not needed in Mesa county, but some other counties require it, especially if going to Denver or other places on the Front Range.

Elias Transportation is aware and makes sure all dirvers understand laws with service animals. They also strive to be attentive if someone requests a female or male driver. They want what is best for the member.

Andi wants to be sure that affirming care is taken into consideration, making sure LGTBQ plus will be safe.

Meighen raised a concern regarding transporting those that display unusual behavior, such as IDD, autism, people on the spectrum, those experienced trauma, etc. How does Elias navigate those situations, as well s those that may be nonverbal.

Abel responded that hiring is of upmost importance, wanting to hire professional and caring people. They get training on specific behaviors, but are always learning. We want to know each specific case, so we can adapt to what the needs are for that particular member.

Maila questioned if Elias would come down to the four corners area and transport all over the sate? Also, will you transport the family, including grandparents that traditionally are involved in health issues, along with the member?

Kaitlyn responded that Elias would see how this can happen, as if the need it there, they would want to be there for those rides. We will allow what ever escorts will be accompanying the member. We just need to know how many, to be sure we bring a large enough vehicle.

Shawn Davis, PDF Consulting:

- Health Equity

Rocky is in process of health equity accreditation. The HEAT team, health equity action team, has a lead representative from each department, making up the HEAT. There is a report last year and have data from the different groups, Spanish speaking, and what we are doing is infusing the work of the PIAC getting to the actual report. Hearing from all the member advisory committees, what there concerns are, and working with the different departments to make sure things are addressed and action is taken. In the next meeting, will walk through the variables and comprehensive focus with member experiences, whether or not members face discrimination, also getting into the health equity.

B. Executive Report from Meg Taylor

- Thanks to the membership advisory council yesterday. I love being a part of that.
- Jeremiah and Kendra are going to talk about the Public Health Emergency Unwind and what this means for our universe, both members and providers.
- Rocky is working on a plan on how to help in some of those gaps in coverage. We are taking this very seriously and what it means for people when they lose coverage, if they lose coverage. We are not only working with Department of Health Care Policy and Finance, on communication and what do we do for people if they might fall off of Medicaid, because they are no longer eligible? Just so you know, it is front and center .

C. Public Health Emergency Unwind from Jeremiah Fluke and Kendra Peters

1. What does continuous unwind mean?

Medical Assistance renewals or MA renewals is the same as redetermination, renewals is the new word for redetermination for all members that are starting for real , because of the past few years, renewal has been on hold, due to the public health emergency.
Starting in May 2023, for all members that have a renewal date, there is a new process in place and action must be taken to be identified to continue to receive eligibility.

- Over the next 12-14 months, all members that have been “locked in” for continuous coverage, due to the Public Health Emergency, will go through the renewal process , each one is a separate for members, per the members renewal date. This is a separate ending from the public health emergency.

2. There are a couple of different processes under the renewal process with the state.

- Phase 1 is called Expert. What this is going to do is working with information already in their system, to verify members eligibility, without the member having to take action. They will do that step first, before any packets are mailed out, and those members that are auto renewed, will receive an approval note of action, and no further action is needed for those that are auto renewed.

- Phase 2 is the process for those who need to confirm additional information , change or verify information, those members will actually receive a renewal packet complete that must be signed and returned by indicated due date for continuation of eligibility, at that point.

- Many people were moved into a Medicaid or CHP during a public emergency, some members will show an over income status and will be moving off of Medicaid and/or CHP. We will be working with those members to help connect them to Connect Colorado. Or exchange plans or other ways to help with continuity of care for those members and their services.

- Phase 2 is the actual renewal packet. For those members that actually receive a renewal packet, there must be action taken. It is going to be different, depending on the individual circumstances. It is not all the same across the board.

- The new process for the MA renewal packet is that a signature must be obtained . If a packet is submitted without a signature, it will be rejected. It will have to be completed before it is accepted and processed through the system. . There will also be due dates indicated for each member's packet. That is the 5th of the month for their renewal date.

- For example, renewal eligibility date in May , there packet must be returned by May 5. That is the actual identified due date. Packets will be accepted up through the end of the month, because the 31st is technically the end of eligibility, if they do not turn in their packet and do not take action. That will be the same for each cohort, IE. June 5, July 5 etc. This will continue for next 12 months.

- There is two exceptions. Former foster care and SSI. If have questions, check with county and long term care.

Scott asked if someone who need to re-certify, can renew early? Kendra stated that they could not. You have to do it when it is the month of your renewal. You can't do it early. You can either do it when you receive a packet or some type of notice from the state.

Meighen asked if there is someone who may be over income to receive Medicaid, however their renewal is not until a few months, are they required to report over income , even though they cannot renew early? Kendra stated that is something you will have to talk to your county office about.

Meighen asked an additional question around the county offices , perhaps, misunderstanding this guidance and taking people off of their Medicaid, prior to the redetermination date that is in their packet. Kendra stated that is our understanding that members will stay on your benefit until it is time for your actual renewal month. Once you are getting close to your renewal month, that is when verification of your income will be verified at that time.

Meighen asked, do you have guidance for individuals whom are being removed from their Medicaid prior to their renewal date, due to a misunderstanding of the county department? Kendra said she would have to follow-up with this answer from the meetings they have with county departments.

Jeremiah continued with thorough explanation.

- For the packets, information that the state already has that needs to be verified or completed will prefill as much as possible, within the packets. Again, that will be specific to each persons circumstances. It could be different, depending on what that is.

- Members will receive a packet according to their preferred communication method. If the member is signed up for online access, or peak access, they will receive an alert from that online format, as well as being able to complete the information in that online format. You can do this through the Peak app. Otherwise, paper packets will be mailed out and they can be completed in several different ways; in going through peak, going through connect Colorado app, actually signing the paper packet and mailing it back or having an in-person visit at the local county department of human services to help with this process.

**Showed screen shots of basic packets and what they looked like. First page shows case number and how to submit the information, how to seek help and how to look for the information in the system.

**The second screen shot shows the signature page. It must be signed and returned. You can do the signature in a couple of different formats, depending on how you are receiving your packet. Electronically, or through county office, there is actually a phone option to take verbal signatures, as well. It depends on how the packet is being completed.

**Third screen shot is gives basic how the packet looks, the different boxes and the different bits of information, the demographic information for the member and household. Health first Colorado also has a designated website for members to go through and helps walk you through the process. It gives you access as to when your renewal month is, how to access your information electronic all your where to find your local county office or assister site and reminder that you must submit your renewal. Sign it and submit your renewal. The link healthfirstcolorado.com//renewal (backslash)

Kendra points out that at the bottom of the page, it says that even if you don't have any changes, that is already in the pre-filled packet, you still have to sign and return it. It is super important to be sure that people realize that. Before, if there were no changes, you didn't have to do anything. But now, you have to sign and submit it.

Chat question: Will other languages be provided for the directions?

Kendra responds with yes, my understanding is that if you are on this page, I think that if you go up to the top, where it says English, you can get other languages. It is my understanding they are also working on the packets in one's preferred language and that is how they will be sent out. You can also change your language if you go into your Peak account. That way, the application will change to that language.

Ian asks that he assumes it has been bedded out for screen reader capability? Kendra assumes so, that they should have all those things working. Ian states that maybe we should ask. Kendra states that she is taking notes and those are things we will bring back to our communications meeting, so she is taking notes on that and will ask.

Meighen asks if there is guidance for those that log into their Peak account, forget their password, put the wrong one in and get locked out and can't get back in? Kendra answers that we don't work with the Peak account, so we really can't help you with that aspect. I know Peak has a customer service number you can call, but I don't know how helpful that is. On our side, we really don't work with the Peak accounts specifically. We are really trying to provide general information, as where to find information about renewals.

Jeremiah states that their PEAK You Tube videos that walks you through some of the different pieces of the renewal process. You will see they are in English and Spanish. This can be accessed through the link on the slide, which will be provided to you. These videos are quick, short videos for the different pieces of the process. This is another helpful resource.

3. What is Rocky doing to assist in this scenario?

- Outreach strategy for members specifically, as well as an outreach strategy for providers and partners.
- follow a timeline, along with the initial communications from HCPF, from the county offices that are going out for those members that are receiving the packet auto renewed through that first phase one.

- To support the process, to answer any questions from the members perspective, what they need to do with their packet and if they are needing help with that. That initial communication is going to be done via text and email campaign that members can reach back out to us if they have specific questions.

    - There is also a follow-up outreach for those members who do not take action in the first week of May, up to that date the at packet is due for May 5.

    - We receive a weekly data file from HCPF and our outreach campaigns will be specifically geared towards those members who are still needing to take action. Members who do take action, will fall off of our outreach list and we will stop those communications at that point, as those members have completed their necessary information.

ReNae asked clarification on some that are automatic renewals? Jeremiah: Yes, that is the first phase that is happening in March for May renewals and will be at the 60-70 day leading up to a members renewal date, where the state is going to work through the system information they already have to determine if a member is eligible to remain enrolled with Medicaid or CHP. Those will be auto renewed at that time. Kendra added that those members will receive what is called a Notice of Action approval. The approval notice saying that you have been approved and no further action is needed.

- We also have a live call campaign for our members that are considered high risk or in a complex category. The care coordination team will be calling members who fit into this particular category to see if there are anything that these may need. Again, for that first week in May, we will be the additional touch point to help members who take an action at that point.

- Our care coordination team will also be doing some in-person visits to local community centers, on a bi-weekly basis, as well as for members that are unhoused or have other support needs . They help educate and help work with those members that may be unaware of the renewal process and need help with those assistance options that are available, etc. We are going to know who still needs to take action and who still is process of renewing. We are going to do everything we can with the outreach process to be sure we have a touchpoint with all members who need team support.

- For our provider and partner process, we will be working with many providers and community partners in working to educate them and support them with the renewal information, to be in their offices and different clinic locations, so you may start seeing different posters and fliers or communication from providers and community partners, as well. They may mention renewals for an office visit, if you go in during that time, just to make sure that we are using every opportunity we have to ensure no one loses coverage when they shouldn't have lost coverage.

- We will be working with community partners to help spread the word, about the importance of members updating their address and any other information and information method preference to make this seamless process possible for everyone involved. It is convoluted and is going to be a long process over the 12-14 months. Hopefully, we can help members through this process, but narrowing it down into monthly chunks of process, so that we can try to work through it as best as possible.

- The renewal timeline we mentioned is looking at the May renewal date. Starting in March, around the 12th of the month, is when that expert or auto renew process is going to run, for the May renewals. Those approval letters Notice of Action will go to members who are auto renewed.

- For those members that are not auto renewed, around March 16, that renewal packet is going to be sent out, again, according to the communication preference. Whether it is an alert on line or in the app or if a paper packet is actually sent out.

- The packets are always due the 5th of the month.

- The official PHE ending is April, that is why the May renewal date or first cohort is starting.

- Between April 20 and May 5, we anticipate receiving the majority of packet returns from members. That is where the processing at the state level and county will be taking place.

- Around May 10, there will be a report to connect for health Colorado, for those members that identify as terminating after the end of the May renewal month, which is May 31.

- If the packet isn't returned or the member is over income, there is going for outreach purposes, to help with continuity of care and get enrolled in an affordable insurance outside of Medicaid or CHP.

- On May 15, a trigger will happen within the state system, for either noncompliance or those over income showing a termination date of May 31. Where those notice of action terminations will actually be sent out to members.

- Another report from connect for health Colorado, for remaining members terminating on 5/31, on a weekly basis to get status of all different members within the process.

Ian stated that in our conversation yesterday with Shawn at HCPF, we talked a little bit about including some information in the notices about income levels and asset limits, to put people at ease a little bit, It says that your eligibility on your income levels and asset limits have not changed. Maybe also, just a quick, couple bullet points what those are. What your income level eligibility is and what your asset limits are and continue to be, particularly for folks who are working adults with disabilities , but pretty much for everybody, might put people at ease. Just a heads up that was the conversation we had yesterday. Andi added people that are self employed and what is considered gross or net? There is a lot of confusion about that, in this community. Which income is taken into consideration. Jeremiah responded with this information, this will come out from HCPF, or county offices, we won't have any leverage on updating those packets. We definitely will take that back, in addition to what you discussed yesterday.

Ptsaqua asked For individuals/families who typically has renewed paperwork that happens the same time as their food stamps, typically, the county will just take your stuff and combine them, without someone having to do two sets . If this applicable in this situation as well, if someone happens to fall upon this renewal timeline? Julie stated that it should do that if you are doing it in Peak. I don't know if you do it in paper, if it is going to connect. It should, because they are just entering it into Peak. That is the whole purpose of the single application, but on the first part, there is a place to check to what you want them to screen for. Sometimes, they screen, even when you don't check, but I am not 100% sure. I know that is generally how they do it, but that gets frustrating sometimes, because someone might just have

done their SNAP and then again it gets redone. There is a lot of concern about SNAP, because it just went down, as the pandemic stuff just ended.

Kendra stated that is a good question. We will take that as a follow up, as well. Basically, when you are doing your renewal papers, for medical assistance benefit, does it also include your renewals for SNAP? Julie added that any other public assistance benefits.

Ian is concerned that after talking with HCPF yesterday, about coordinating with the counties and providing technical assistance with the counties around, particularly keeping new information. One small example is that the upper age limits have been taken out for the buy-in, as of 2022. A lot of our members are in rural frontier county department of human services, for whatever reason, that information doesn't quite make it out into the inter-lands as quickly as we might like. I don't know what role the regional accountable entity can play in providing some level of technical assistance for the counties, as we go through this process, that is an area of interest and concern.

D. Key Performance Indicators presented by David Mok-Lamme
Focus on 5 BHIP measures today. BHIP is Behavioral Health Incentive Programs

1. Substance use disorder engagement measure

- This is the percentage showing members that have 2 or more out patient services, after the initial substance use disorder diagnosis.
- More than half are getting those two visits within 30 days. This is above the target of 49%. It is also 2 or 3% higher than we were a year ago. That is great!

2. Mental Health In-Patient Follow-up

- we were much higher than we were a year ago. Last year we were in the 44-45% range.
- we are in 47, 48% range.
- It is trending down. And is an area of continued focus. We want to get above 48% of follow-up within 7 days from discharge
- This is an identified area for improvement. This is also very important for our members, after experiencing an in-patient stay, that they get timely, quality follow-up care, so they can get ongoing outpatient care, after an acute event.

4. Substance Use Disorder Emergency Room Follow-up

- a member has an outpatient visit within 7 days of discharge.
- This has fallen quite a bit, year after year
- Well below the target.
- Area for major focus

5. Depression Follow-up

- After a positive depression screening, a percentage that have an outpatient visit within 30 days.
- This one hasn't moved a lot. It is mostly as a function of what exists within primary care, since we have so much integrated behavioral health.
- We started off strong and have fallen a little bit.

- May improve when some claims runout
- pretty consistent right around the target, right around our historical average.

- We don't quite have data we can share for foster care, as a result that we have so few foster care children come into the program. We will wait until we get to a credible threshold

Ian questioned that I know you have probably heard me say this before, but I need to say it. How the behavioral health screenings and assessments are being administered? When I go in and when I feel like someone is administering the test, it is really awkward. Especially if I am in a emergency room or at a doctor's office and I just hurt my shoulder, and somebody that I don't know is assessing. It is a lot different if I know you better. It is a lot different than someone coming up and saying "Hey, I went to this therapist and it did a lot for me. Or there's this group of folks with brain injuries that share experience open , you might want to check it out. It did a lot for me. So, we did a lot of talking yesterday and you know I always am about developing trusted relationships with the people we can relate to. When it comes to being screened and assessed, particularly for those that have been screened and assessed, poked and prodded, their whole life, the way we could include peer support with trusted relationships in how these screens are administered at that level. That's my thing on that.

David responded that he thinks that is a great point and hopefully we can screen and administer is really important. It is also really important that members indicate that they do have biggest needs or looking for support in areas where they get that response from a care coordinator that is ideally located where they took the screening. I do know that there is a handful of providers where we are funding peer support to do screenings. It is a very heterogeneous environment as to how screenings happen for many different hospitals, many different care centers and some places do better than others. Your point is very well taken and we have tried to do and we can try to do more broadly to make sure the screening is done in a more culturally sensitive and trauma informed way.

Meighen added to the point, of achieving success, in that particular area, I would say that you are more likely to get honest answers which will lead to that care that that client is seeking, if you have a peer or someone that is trusted n the community administering those screenings that are culturally appropriate and trauma informed way. When you get the results you are looking for, you all are going to have really happy people in the community and less cost because they will then be in acute care, they won't need it. Ian added that we talked a lot about this yesterday because you can have those that are trained to do it in a very sterile manner or even have care coordinators that can develop a trusting relationship with somebody. There is a training element to that too, as far as who is doing the training and how it is being facilitated.

David responded with I completely agree. Along those lines, what we wanted to share about the screenings working on these measures, is we have done a few major things. One, we greatly brought in the number of providers that are paid to do timely follow-up. So, we now have 25 private practices that are signed up to take quick referrals, great timely access and have financial incentives for coordinating with that care. We also have 2 dedicated care coordinators at Rocky that are behavioral health coordinators, that have special training and expertise where they are doing outreach and coordination, so they get that warm, culturally appropriate with outreach. They will schedule and make appointments and having a lot of conversations with those care coordinators and those 25 private practices to sort of discuss barriers, making sure that information can be shared and that access can happen timely. That appointments are available and have reporting so the providers know how they are doing and the financial incentives . This is pretty big changes from where we were historically when we were working with 3 or 4 mental health centers in coordinating care. Now we have a large network of operations that members can choose from and we have those dedicated care

coordinators as opposed to hoping members can figure it out themselves. We are happy to share the names of the coordinators if people have referrals they want to make as well around these sorts of things with their practices.

A question in the chat asked how do we know who to connect patients to. Can we get a list of providers? David responded with yes, I am happy to share the list of providers and the care coordinators in case there other places they need to get urgently and try to make those connections.

Allison asked if the care coordinators only doing follow up for the depression screening or are they doing all of these behavioral health follow up? David answered that they are doing all the measures with other behavioral health access follow-up and are imbedded with utilization management. One of the things that is really important at Rocky is utilization management is what is medically necessary care and what is going to be paid. It is also important as to what is impacting people's lives. When they leave care, after it is funded, or if care is not medically necessary, that is where it shouldn't be just a medical necessity determination, but that determination is actually recognized that it impacts members. , we have care coordinators that can help members through. Is that determination going to impact peoples lives and we want the coordinators that can help do that. That is why we have a single platform where utilization an care coordinators and staff work together. There are 40some providers that use that tool and have that seamless experience to support continuous engagement with members. It is more broad than any one measure and more broad than the behavioral health measures themselves. It is to be sure we have people to support and get timely access to care.

Ian added something for another day. I know others can explain this better than me, but there is a lot to unpack around substance use disorder stuff and feeling like you are a drug seeker and going in there and having somebody say I need this amphetamine this for anxiety, and no, I just hurt my shoulder and all those other drugs make me feel like crap. There is just a lot to that and again, a conversation for another day.

Lunch break

E. Loving Beyond Understanding, Andi Tillman presentation

DR. Jessie Smith started with Thanking Andi for being there in person. She couldn't be there in person. She is physically located in Salt Lake City, and a clinical psychologist who sees clients in Utah, Colorado and all over the country. She and Andi have co-created this curriculum that Andi presented .

Andi began we will walk you through our programs and trainings, especially is an element in this group that is recently funded by Rocky, so that we can offer then for free to a number of agencies here. We have a nice robust schedule and we will be offering them in Grand Junction, and surrounding rural communities, free or deeply subsidized to get every mental health, behavioral health medical practitioner and staff we can get through as we can.

1. Loving beyond understanding is a non profit here in Grand Junction. That addresses social support and safe spaces for LGTBQ people, diverse people of all ages and intersectionality.

Will be presenting own experience

- Safe space to ask questions
- Nothing about us without us is important here

2. Gender Experience
- Important to believe and validate any marginalized groups lived experience. Definitely
- don't question them based on your ideas and opinions
- Pronouns matter and is form of respect
- When not use pronouns, do not validate the person

3. Matter of life and death

Mesa County
- LGTBQ community 45% of youth have considered suicide seriously in the past year
* More than half, 53%, are trans and non-binary youth and have seriously considered suicide
* 42% of all homeless youth are LGTBQ
* 42% identified have been kicked out of their homes
* 78% or that 42% LGTBQ status was a direct factor of being kicked out of their home

4. Matter of Quality of living
- 36% of LGTBQ youth are physically threatened.
- 71% experienced discrimination

**See handout for complete statistics

Janice asked why couldn't youth access care? Andi answered that the biggest number 1 is there isn't enough behavioral health practitioners for adequately culturally competent and trained. They can actually do more harm than help. The other is access. They don't have agency. If parents are not supportive, parents sending their kids for help, and this is the moment , that parents can help so much. Everyone is trying to send their gender diverse kid to get them fixed or get them help and panicking, we have a 18 month to 3 years waiting list for LGTBQ therapists. When facing these suicides rates, that is a really long time. When kids finally get in, after a long waiting list, it is often that they are fine, just a different gender. They are experiencing discrimination.

5. Parents need assistance
- Stressful
- Need support
- Don't want to process doubts on child

Julie stated that parents that are super conservative are who we are talking to. We often make assumptions that we don't need work and is it particular for those over a certain age? Andi responded with we have all been socialized that we are binary, That it doesn't exist and that it is being valiantly enforced and leading to a choice. Believe me, 50% of parent are not conservative.

Meighen stated that I am trying to get my kid the care, actively trying. Even when you are like trying to create the safest environment, it is still hard to find you can't get care. Andi responded that you can get care for you. Meighen stated that even if I can get care for me, I sometimes can't get it for them. Even when I am with their therapist advocating, I am still hitting a brick wall.

ReNae asked if you recommend siblings also get care? Andi responded that she can do free compassionate coaching for all of them and we also have a lot of group services, for parents and all age groups. Siblings are really impacted by this.

6. You can make a difference!

- Youth that live in an accepting community have access to affirming spaces or feel any level of high support from family or friends have significantly lower rates.
- LGTBQ youth report at least one supportive adult in their life and it doesn't mean a parent.
- It cuts the suicide ideation by 40%
- Any trustworthy adult, not just a parent
- Make access to that trustworthy adult
- The way you treat children right now, is the way they will expect others to treat them for the rest of their lives.

7. Gender and gendered Experiences History

**History on handouts

Andi asked everyone to think about when you were told you were not allowed to do something or you had to do something, just because of your gender. Scott answered work. Bianca answered be somebody's mom and wife. Meighen said go to college. Ian asked if that would be that you were told you wouldn't have anything of value to offer in a conversation like in this conversation? Because of my gender, I don't have the experience and being told I don't have anything of value to offer in a situation. Andi responded with she understands why you are getting that message. It is from society telling you that this is hard for men to understand. Now it is even harder. I definitely value what you have to say and know where you are coming from with that.

Tracy asked that my experience is that someone she knows in wanting to be a girl, and in the process, as getting older she wanted to go back to what she was before, that created a great big problem. My question is at what age do you think or I feel they need to have counseling before they do anything. Andi answered that is too deep of a conversation to cover here. I cover it in a training that is touching on an important point of misinformation and will answer it from that place. You start understanding your gender at 3 and 4 years old. These transitions are 1 percent and 90% of the people transitions are not because they got their gender wrong, they have so much discrimination and isolation that they couldn't bear it and they decided to go back to the other. Regrets for gender affirming procedures are 1-3% at most. Most is trans with them because of privilege loss and danger with that intersection and that culture that it is unbearable.

- They face distress not because they have a disorder. It is because of stigma and discrimination.
- What is wrong is a world that punishes for not being normally masculine or feminine.
- Binary means two choices; male or female
- Actually thousands and not just two
- European colonists brought about binary and enforced it
- Cultures all over the world has acknowledged this for Millenia.
- It is in indigenous stories, stating that a two spirit saves the day. Being able to see different
- *perspectives is sacred and necessary , especially in a society that is polarized as we are.

**Handout of identified genders

- There is no gene that makes you LGTBQ doesn't exist
- LGTBQ plus is because there are so many more in the alphabet

8. SIEO
- Sex assigned at birth
- Gender identity -most important. How experience in heart, mind, and soul. It doesn't live in body or brain or anything physical.
- Gender expression -what you wear on your body. Clothes, glasses, etc.

-Says you can be masculine or feminine or gender nonconforming. This is culture stereotypes of gender.

* Sexual orientation

- The first three have to do with gender. Sexual orientation is separate and distinct from gender. It is not the same thing. One doesn't mean the other.

Question from chat asks if there best ways to collect SIEO information? I work in a hospital and want best way to understand and build trust. Andi and Shawn stated that Rocky is adding sexual orientation and gender identity.

- Good to know organ inventory. What parts do you have?
- Sexual orientation has to do about physical.

**See handout for possible sexes

Comment in chat states where I work, I collect information and I ask and they can put down what they feel. It is not mandatory to be one or the other.

Shawn commented that when you talk about the statistics, you have to start talking about safety . I don't think we can look at behavioral health when you have whole communities that are not safe. Their first priority is safe spaces, as opposed to getting care. They are trying to live and they are thinking about dying by suicide and we have got to do a better job.

Ian stated that with people with intersectionality, with those with disabilities, downs syndrome and sort, 4 and 5 are actually abuse and yet, they are also the group that traditionally we have looked to take care of us. (refer to handout) Andi responds with this is the mission of my nonprofit. Identity training and try to help from the outside. Gender diverse people, with safe space and social connection including the intersections, are really trying to get the Latin communities, and create spaces for them.

Shawn states that on your fliers, it is so bad out there, you can't even put the location and time (for meetings) on their. Andi replies with this is another barrier. We rely on spreading word. Only contact is through email.

9. Ask, Validate and Affirm them.
- Love first, understand later
- It is not a comprehension problem, but a compassion problem.

Rochelle asked if LBU Has done a presentation like this to district 51, homeward bound and catholic outreach? 612 children in school district are homeless, suffering, etc. Andi responded that we are happy to do presentations for anyone.

10. Training Available
- 6 hour module series beginning for providers.
- May sign up for train the trainers
- Gender affirming therapy no longer available in Utah. Many coming to Colorado for therapy. Need more trained.

F. Hospital Transformation Program (HTP) presented by Kayla Rae Boyd, Middle Park Health

**Refer to handout

1. What is Middle Park Health doing?

- Located in Kremmling and Granby
- HTP is 5 year program for hospitals to report on Key performance indicators in specific measures.
- Hospital chooses what measures they want to work on
- Quality Improvement Program

2. Measures and community health neighborhood engagement
- Must engage in different groups within community.
- Other things to do with communities.

3. Focusing on readmission rates.
- Costly an unnecessary
- How they relate to frequent chronic conditions.
- Trying to figure out what readmission rates in 30 days.
- Where fill in gaps
- Monitored before with readmission committee.
- Encouraging us to take to next level.
- Talk about this with chronic conditions. How do we address and bridge gap in communities.
- See readmission rate drop over time.

4. Medicaid claim data.
- Only have base line data.
- Show change in year or so.
- 30 day all cause and not just focusing on those areas. This is anything and everything.
- See a lot of second home owners and looking at primary resident.
- Could be two unrelated issues and more challenging to prevent.
- How can we address this.

5. RAE and metric want to make a big difference with gap in care.
- Not a lot of resources.
- Is there follow up care with primary care to manage and keep from coming back unnecessarily.
- Goal is to ensure patients when discharged already set up with follow up appointment as appropriate.
- Make sure RAE is notified within one business day

6. ALTO program alternatives to opiats in ER when not necessary
- We are on EPIC and implemented a long time ago to do this.
- Partnering with Colorado hospital association.
- Provide with alto data and meds all received.
- Have percentage of meds and narcotics and other meds given.
- It is a ratio or ratio percentage to see if increase of pain relievers and narcotics.
- If struggling already, don't want to add to problem.
- Goal is to ensure complete screening for SUD or alcohol use at time of visit.
- Would be addressed in social history and may lead to more questions
- If scored high and need to intervene.
- Refer to treatment.

Found Too much pressure on patient to act and not a partnership
- Need to hit all points to be successful.
- behavioral health navigator just hired and must refer appropriately

7. Telehealth
- Crucial metric
- Shows growth with telehealth
- Rural access and some challenges, mostly with clinical hesitation. Want to have hands on.
- Implement telehealth capabilities.
- Option but not defaulted to or utilized.
- Used with neuro in emergency room
- Speech therapy is also used.

8. Community health needs assessment.
- Community needs and what they said was priorities.

Meighen asked questions around pain management. Have to comply with statutes. A lot of compassion and dignity about asking about substances and nont want to answer. Don't want to feel under investigation. When patients come through, should be able to feel honest about this. Making sure having quality of care, but don't want to marginalize a community that is feeling that way. Kayla responded with hard discussion we have. How do we ensure the patient feels supported and not feeling ridiculed or questioned. Centura questions. Community connect with centura. What questions are asked. Some patients don't mind and others said it did bother them. May make patients feel uncomfortable and makes staff feel bad. Not quite figured out answer for that. Screening is not a questionnaire that has been created by them and don't have a lot of control of what questions are in it.

**See handout for full report

Meeting adjourned at 1:00pm.
Next Regional PIAC on June 13, 2023.

Medicaid/CHP+ Continuous Coverage Unwind

Regional Program Improvement Advisory Committee (PIAC)
Rocky Mountain Health Plans | March 14, 2023

ROCKY MOUNTAIN HEALTH PLANS®
A UnitedHealthcare Company

End of Continuous Coverage

Rocky Mountain Health Plans®
A UnitedHealthcare Company

- **What does End of Continuous Coverage mean?**
  - *Medical Assistance (MA) Renewals* (redeterminations) for ALL members are restarting 'for real' – starting with Members who have a renewal date in May 2023.
    - This is separate from the Public Health Emergency END.
  - The new process for MA Renewals includes 'Ex Parte' as the phase 1 process to auto-determine eligibility for Members.
    - This process includes the State review of information already in their systems to auto-renew Members, without Members needing to take any action. Those Members auto-renewed will receive an APPROVAL Notice of Action (NOA) and no further action is needed.
  - Phase 2 is the process of those who are deemed needing additional information or verification and will receive a Renewal packet to complete, sign and return.
    - Next slide for more detail on Phase 2 – Renewal Packets

End of Continuous Coverage

Rocky Mountain Health Plans®
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- **Phase 2 – Renewal Packets**
  - Members who receive a renewal packet, MUST take action.
    - The action is individually specific to the Member's circumstances.
    - Packet MUST be signed.
    - Packet must be returned by the due date indicated.
    - All information requested in packet must be completed.
      - Any available information from the State will be pre-filled in the packet and must be verified.
  - Members will receive packets according to their HFC/CHP+ communication preference. Members may complete the packet in several ways.
    - PEAK, HFC APP, Paper Mailing, in-person visit to local County DHS or Assister Site.

Renewal Packet – 1st page

ROCKY MOUNTAIN HEALTH PLANS®
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STATE OF COLORADO

Renewal for Health First Colorado/CHP+

Case Number:

It is time to renew your health coverage. We need to see if you and your household members still qualify for Health First Colorado (Colorado's Medicaid Program) or Child Health Plan *Plus* (CHP+). You must take action or you may lose your benefits.

How Can I Submit My Renewal?

- **Online:** Go to CO.gov/PEAK. Log in to your account. Click "Manage my benefits." Then choose "Renew Benefits." If you do not have an account, you can create one at any time. Follow the instructions on CO.gov/PEAK to create an account.
- **Mobile app:** Download the Health First Colorado app and log in with your PEAK account or create an account on the mobile app to complete and electronically sign the renewal form. Use this app to:
  - See if your coverage is active
  - Complete your yearly renewal
  - Learn about your health coverage
  - Update your information
  - Find providers
  - View your member ID card

  Health First COLORADO Colorado's Medicaid Program — Download on App Store — GET IT ON Google Play

  Sign up to get helpful information about your Health First Colorado benefits by text! Text "JOIN" to 66596. Message and data rates may apply.
- **Paper:** Mail, fax, or bring the completed signature page and updated renewal form pages to your local county office:
- **Fax:**
- **Call:** at /State Relay: 711 and tell them you are calling about renewal of your health coverage.

HCPF-6
Med_MAGI_Redetermination_Notice10_EN

Page 1 of 20

Renewal Packet – Signature Page

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Renewal Form Signature Page

Health First Colorado/CHP+ Case Number:

Read and sign this attachment (This page MUST be returned).

Please refer to What I Should Know - Rights & Responsibilities before signing.

Check the box that applies:

☐ I have read all parts of the Renewal Form and Rights and Responsibilities for Health First Colorado/CHP+. All information in the Renewal Form is correct. **I do not need to make any changes or corrections** to the information.

☐ I have read all parts of the Renewal Form and Rights and Responsibilities for Health First Colorado/CHP+. **I need to make changes or corrections** to the information. I will return the Renewal Form with the changes and corrections.

Signature of household contact or Authorized Representative

Date (MM/DD/YYYY): ☐☐ / ☐☐ / ☐☐☐☐

☐ Check here if an authorized representative signed.

If you want to add, change or update an authorized representative, fill out the form that came with this letter.

☐ Check here if you want an authorized representative.

If your household needs to **change its primary phone number**, please update here

Primary Phone Number (Currently On File)		
Primary Phone Number (New)	(☐☐☐) ☐☐☐-☐☐☐☐	☐ Cell ☐ Work ☐ Home

HCPF-6
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Page 4 of 20

Renewal Packet – Pre-filled Info.

ROCKY MOUNTAIN HEALTH PLANS®
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Information for	Health First Colorado/CHP+	Case Number:

1. **Is still in this household?**

☐ YES ☐ NO If "NO," please provide the date they left the household (MM/DD/YYYY): ☐☐ / ☐☐ / ☐☐☐☐

If you marked "NO" above, please skip the remaining questions for this person.

2. If this person has **changes to their name,** please update below:

Full Name (Currently On File)	Date of Birth	What is their new first name?	What is their new middle name?	What is their new last name?

What date did this name change? (MM/DD/YYYY) ☐☐ / ☐☐ / ☐☐☐☐

3. If this person's **relationship to has changed,** please update below:

Relationship to (Currently On File)	What is the new relationship to ?	What date did this relationship change? (MM/DD/YYYY)

4. If this person has **changes to their home address,** please update below:

If your household has moved to a new home address, please also update shelter expenses for null null.

Home Address (Currently On File)	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Street Address

Apartment #

City

State

Zip

What date did this address change? (MM/DD/YYYY) ☐☐ / ☐☐ / ☐☐☐☐

5. If this person has **changes to their mailing address,** please update below:

Mailing Address (Currently On File)	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

SAME AS NEW HOME ADDRESS? ☐ YES ☐ NO

Street Address

Apartment #

City

State

Zip

What date did this address change? (MM/DD/YYYY) ☐☐ / ☐☐ / ☐☐☐☐

HFC Resources –

ROCKY MOUNTAIN HEALTH PLANS®
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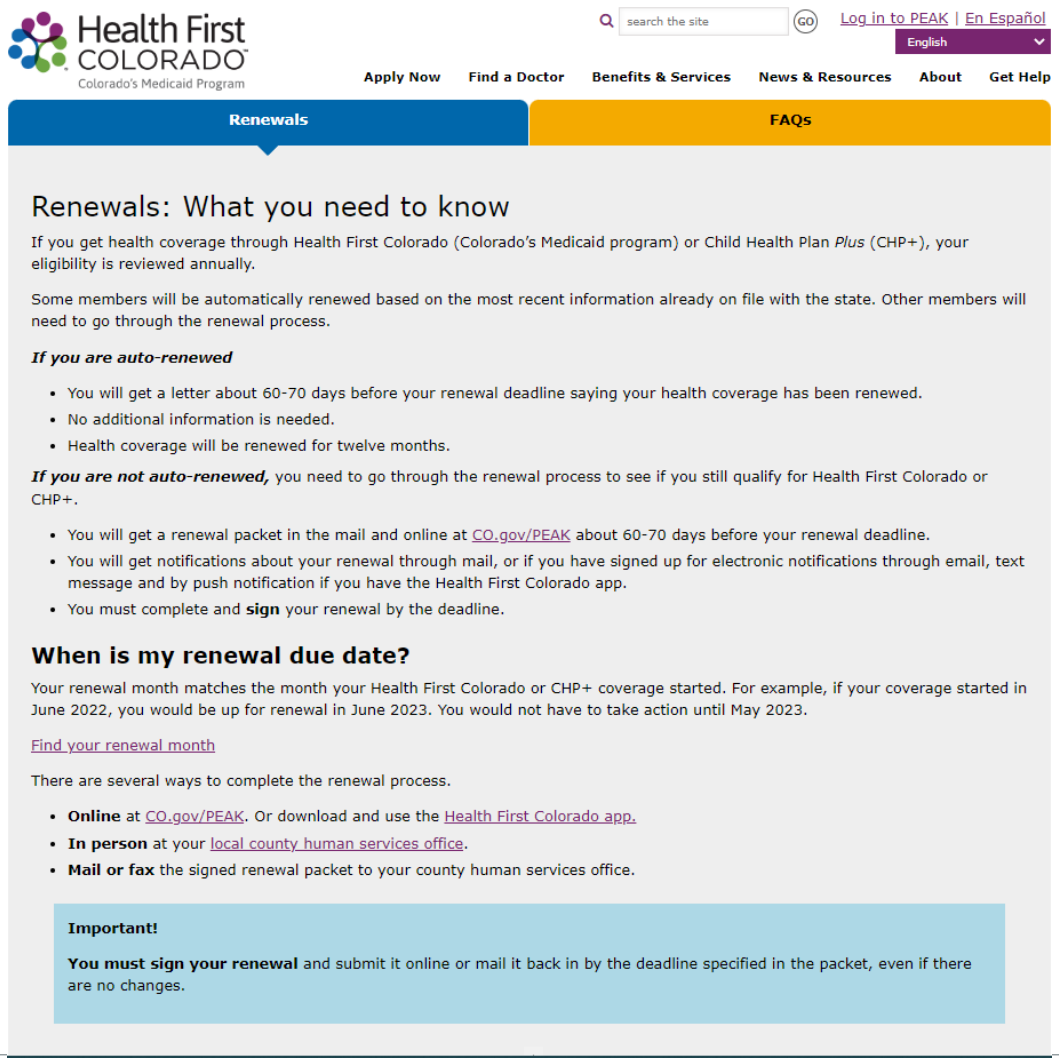
- https://www.healthfirstcolorado.com/renewals/



Health First COLORADO
Colorado's Medicaid Program

search the site GO | Log in to PEAK | En Español | English

Apply Now | Find a Doctor | Benefits & Services | News & Resources | About | Get Help

Renewals | FAQs

Renewals: What you need to know

If you get health coverage through Health First Colorado (Colorado's Medicaid program) or Child Health Plan *Plus* (CHP+), your eligibility is reviewed annually.

Some members will be automatically renewed based on the most recent information already on file with the state. Other members will need to go through the renewal process.

If you are auto-renewed

- You will get a letter about 60-70 days before your renewal deadline saying your health coverage has been renewed.
- No additional information is needed.
- Health coverage will be renewed for twelve months.

If you are not auto-renewed, you need to go through the renewal process to see if you still qualify for Health First Colorado or CHP+.

- You will get a renewal packet in the mail and online at CO.gov/PEAK about 60-70 days before your renewal deadline.
- You will get notifications about your renewal through mail, or if you have signed up for electronic notifications through email, text message and by push notification if you have the Health First Colorado app.
- You must complete and **sign** your renewal by the deadline.

When is my renewal due date?

Your renewal month matches the month your Health First Colorado or CHP+ coverage started. For example, if your coverage started in June 2022, you would be up for renewal in June 2023. You would not have to take action until May 2023.

Find your renewal month

There are several ways to complete the renewal process.

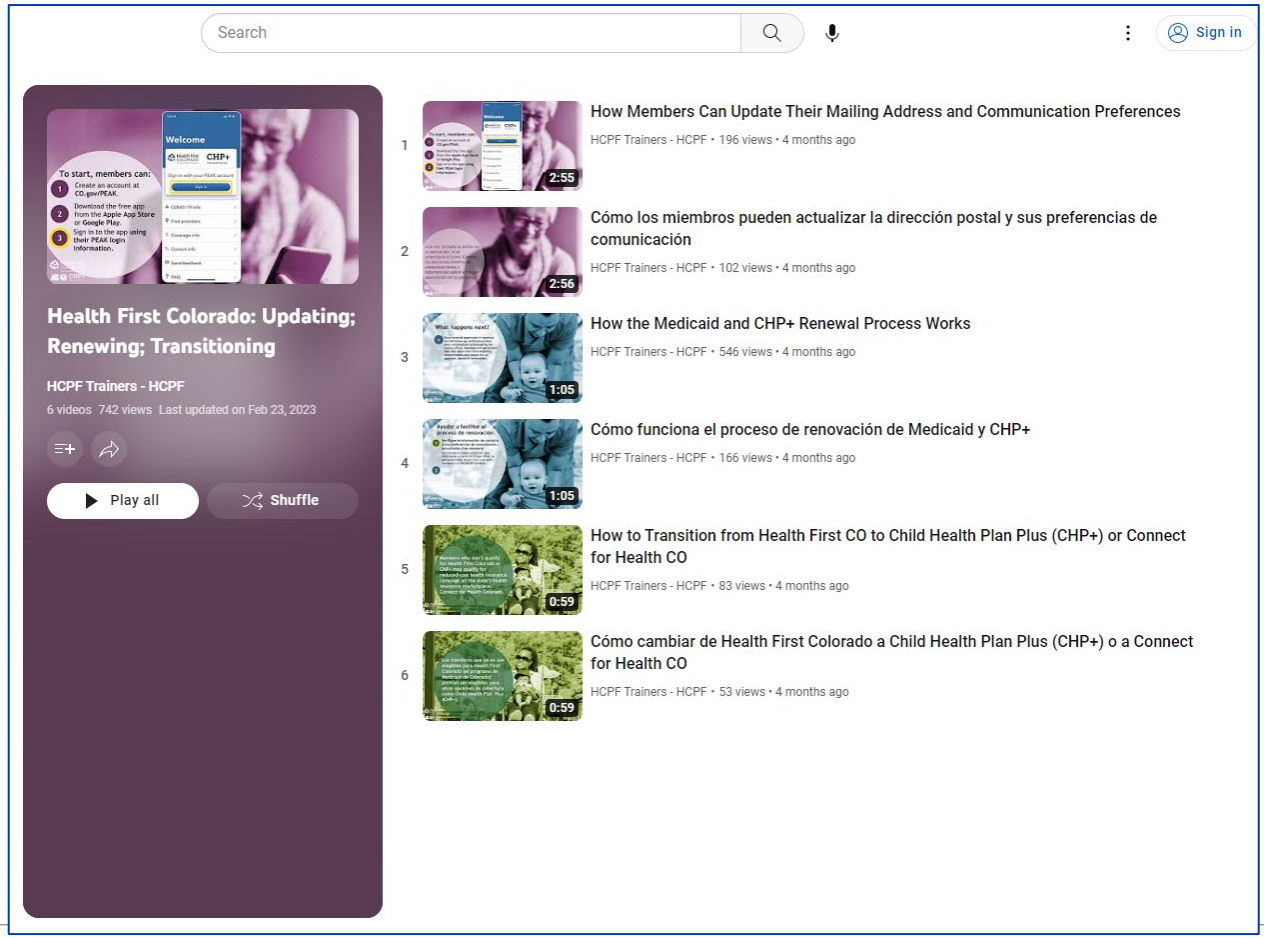
- **Online** at CO.gov/PEAK. Or download and use the Health First Colorado app.
- **In person** at your local county human services office.
- **Mail or fax** the signed renewal packet to your county human services office.

Important!

You must sign your renewal and submit it online or mail it back in by the deadline specified in the packet, even if there are no changes.

HFC Resources –

- https://www.youtube.com/playlist?list=PLFlKrQC_PrCGEuVySAlzoUNN23ihtKrD4



RMHP Outreach Strategy

Rocky Mountain Health Plans®
A UnitedHealthcare Company

Data Driven Strategy: Renewals (per renewal month)

For Members Mailed a Renewal Packet (RAE/Prime/CHP+)

- **Outbound Text & Email Campaign**
  - ✓ Initial outreach – after HCPF initial communications (for May renewals, this RMHP outreach will occur during the month of April 2023)
  - ✓ Follow-up outreach (no action taken) – 1st week of May 2023 for those who have not taken action.
- **Live Calls to Complex Members**
  - ✓ Initial outreach – (for May renewals, this RMHP live call outreach will occur during the month of April 2023)
  - ✓ Follow-up outreach (renewal not completed) – 1st week of May 2023 for those who have not taken action.
- **In Person Visits to Unhoused Members**
  - ✓ RMHP Care Coordinators will coordinate with staff at local community centers to conduct bi-weekly in-person care coordination support
  - ✓ Ensure Members are aware of coverage renewal process, and assistance options available

RMHP Partner/Provider

ROCKY MOUNTAIN HEALTH PLANS®
A UnitedHealthcare Company

- We are working with many of our providers and community partners by providing them with renewal information for their offices and locations.
- Providers may mention renewals when you have an office visit as they want to be sure you do not loose your Medical Assistance benefits.
- We are working with our Community Partners to help them spread the word about the importance of members to update their address and any other information such as their communication preference

Sample Timeline Flowchart

ROCKY MOUNTAIN HEALTH PLANS®
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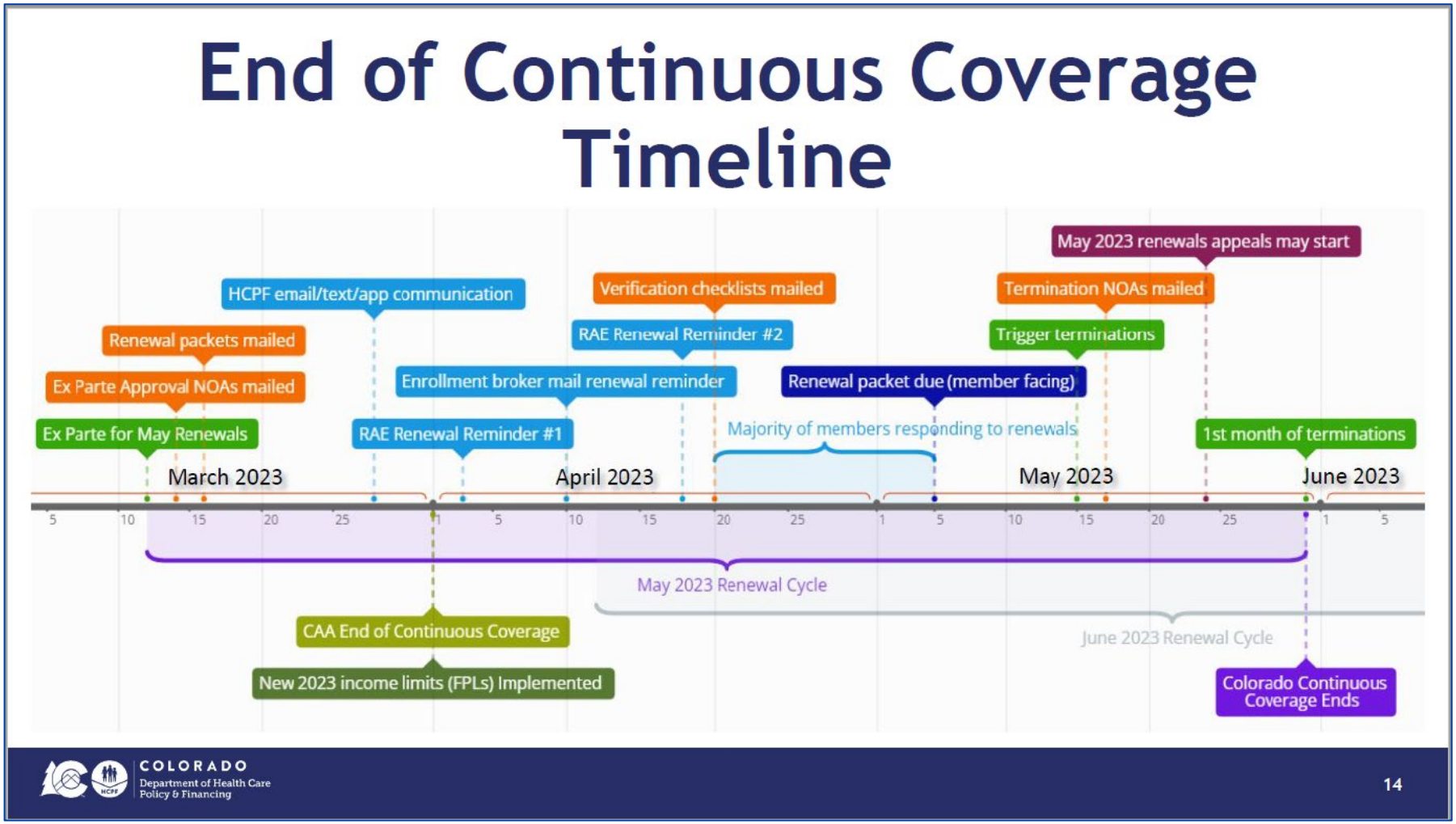

COLORADO
Department of Health Care Policy & Financing

Sample Timeline Flowchart

ROCKY MOUNTAIN HEALTH PLANS®
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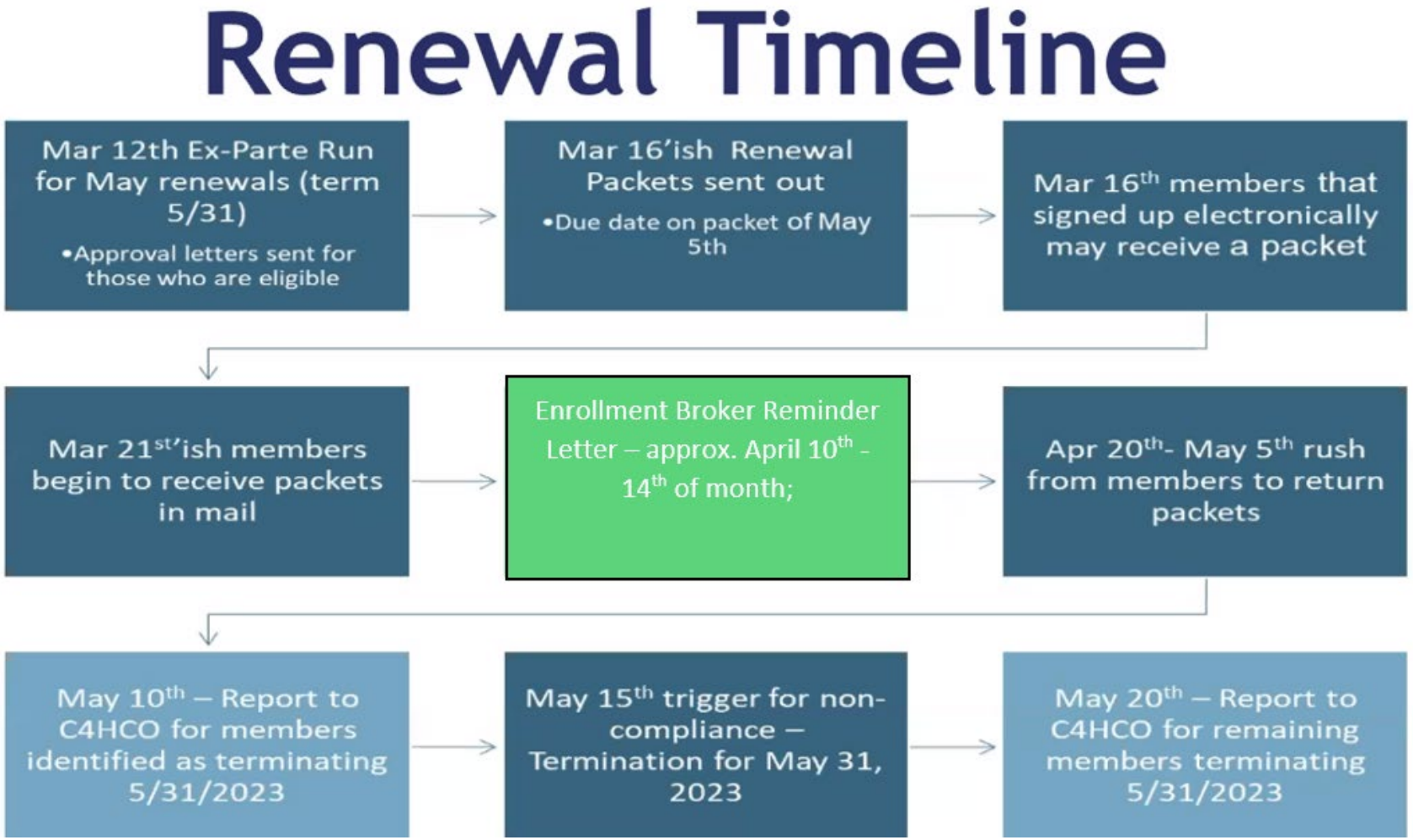


Thank you!

Questions?

Understanding the Trans and Gender Diverse Experience: A Compassionate Dive into Gender, Orientation, Intersectionality, and Self.

Andi Tilmann, MA
Jessie Smith, PhD

Andi Tilmann, MA

They/She/He

LGBTQ+ Solutions, Support and Trainings…

TriUnity Consulting

- LGBTQ+ Cultural Competency Staff Trainings & Workshops

Loving Beyond Understanding

- LGBTQ+ Services & Resourcing
- LGBTQ+ Social Support & Activities
- LGBTQ+ Education & Training
- Private Coaching for Parents of LGBTQ+

Love First. Understand Later.

Acknowledgement

I do NOT represent the experience of any other LGBTQ+ or Nonbinary person!

We acknowledge the work and sacrifices of the LGBQ and Trans and Nonbinary people who came before.

We especially wish to acknowledge Black and Indigenous TNB people, who have so often been at the forefront, while risking the most of all

How to ask questions

And how we will correct

Please ask questions - in the language you have (right now)

Trust my capacity to handle what you ask – I have volunteered to be here

Nothing about us without us…

It is not okay to discuss the needs of any marginalized group without the presence of a member of that group…

"Lived experience” = personal knowledge about the world gained through direct, first-hand involvement in everyday events rather than through representations constructed by other people.”

It is important to believe and validate their lived experience - not question them based upon your ideas or opinions about it

Why Does This Matter?

It matters because it hurts people when you don’t affirm and respect them…

Here’s something to think about….

“Imagine everyone you encounter all day long telling you that you are not real and that there is something fundamentally wrong with you. Being constantly invalidated takes a toll…” -ALOK

And it does….

Statistics for LGBTQ+/TGNCEnby folks

It matters because this is a matter of life & death…

- 45% of LGBTQ youth seriously considered attempting suicide in Mesa County last year, including more than half of transgender and nonbinary youth (53%),
  and 19.9% attempted
- This is 3-5x the average rate. Adjusted for trans youth it skyrockets to a shocking 10x the average rate
- 42% of homeless youth 12-28 are LGBQ+ and Trans-nonbinary.

Why Does This Matter?

This is also a matter of just living….

- 36% of LGBTQ youth reported that they have been physically threatened or harmed due to either their sexual orientation or gender identity
- 71% of transgender and nonbinary youth reported that they have experienced discrimination based on their gender identity.
- 29.4% Trans & Nonbinary people are unemployed (vs. 5% avg)
- 27% do not seek healthcare fearing harassment or culturally incompetent care
- 60% of LGBTQ+ youth on who wanted mental health care last year could not access it (82% report that they need it)

But, You Can Make a Real Difference!

Youth who lived in an accepting community, had access to LGBTQ-affirming spaces, and/or felt high social support from family and friends reported significantly lower rates of attempting suicide in the past year.

- The 2020 Trevor Report

It only takes one….

LGBTQ youth who report having at least one accepting adult were 40% less likely to report a suicide attempt in the past year.

- 2019 Trevor Report Brief

"*The way you treat children is the way that they expect others to treat them the rest of their lives.*"

- Dylan Wylder Quinn, TransIntimate.com founder

Contemplation Question

Try to think about a time when you were told you were or were not allowed to do something because of your gender.

Gender non-conforming people face considerable distress not because we have a disorder, but because of stigma and discrimination. There is nothing wrong with us, what is wrong is a world that punishes us for not being normatively masculine or feminine.

-Alok Vaid-Menon, Beyond the Gender Binary

So, About That Gender Binary ….

The truth about that is…

It Doesn’t Exist!!

There are NOT only two genders…

…never have been.

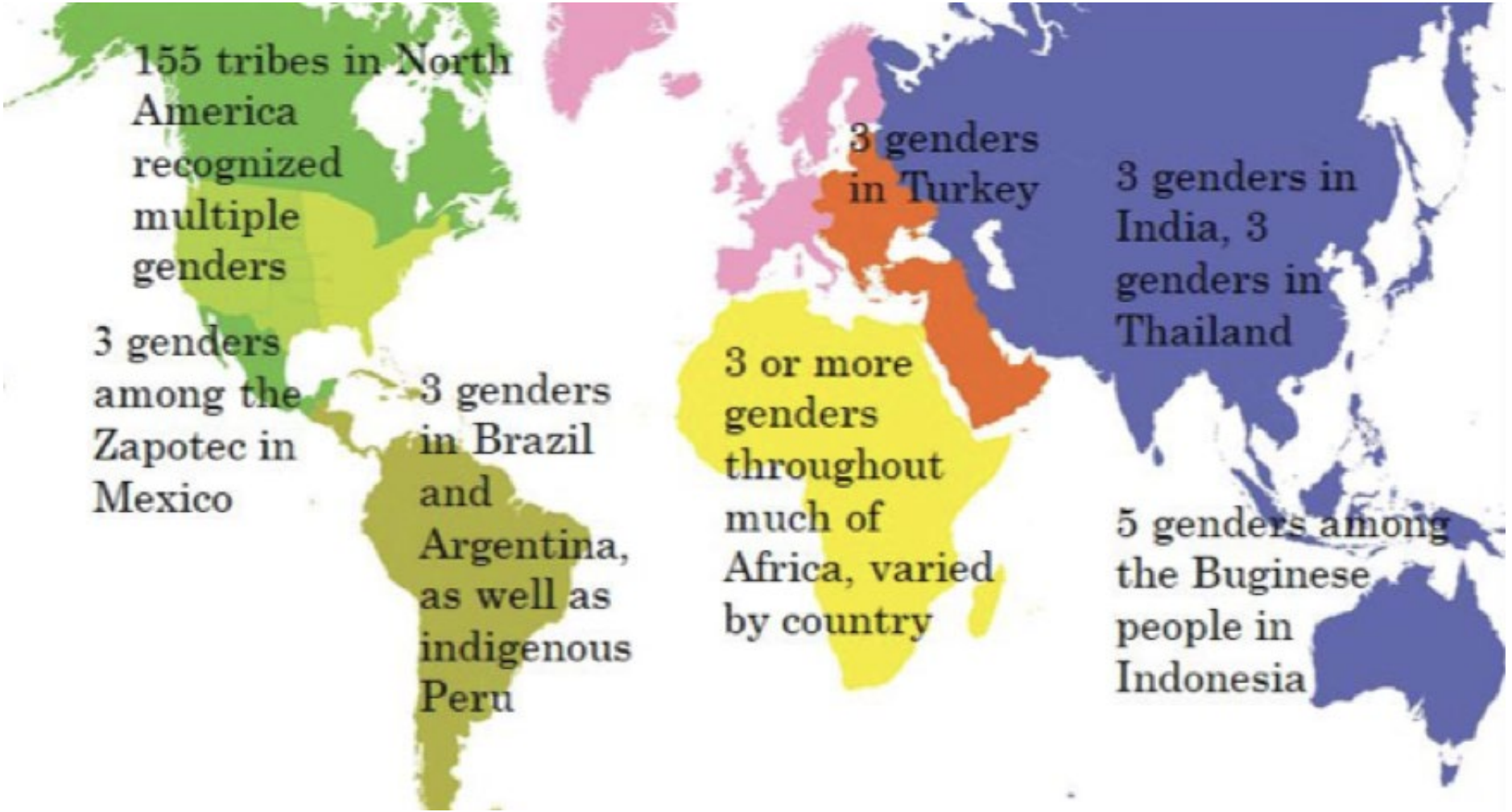
WAIT, WHAT??????

The gender binary is a *social construct* imposed to keep a hierarchical power structure and economic system in place.

It came to this country via European colonists,and was forcibly imposed in a place where no such notion had ever existed.

Cultures all over the world have known and acknowledged gender-diversity for millena - many since the beginning of their time….

…because it is OBSERVABLY SO


155 tribes in North America recognized multiple genders
3 genders among the Zapotec in Mexico
3 genders in Brazil and Argentina, as well as indigenous Peru
3 or more genders throughout much of Africa, varied by country
3 genders in Turkey
3 genders in India, 3 genders in Thailand
5 genders among the Buginese people in Indonesia

Some Native American Multiple Gender Terms…

There are thousands of names for hundreds of genders observed by indignous people…

Blackfoot: (Western Plains of the USA – Montana/Wyomong)

h-oskitsi-pahpyaki, "Manly-hearted-woman." and *a'yai-kik-ahsi*, "Acts like a woman."

•**Crow**: (Also western USA, Rocky Mountains & Plains)

•*batée*. A word that describes both trans-women and homosexual males.

•**Lakota/Dakota**: (Wester USA Plains – North Dakota & South Dakota, Wyoming)

•*wíŋkte* is the contraction of an older Lakota word, *Winyanktehca*, meaning "wants to be like a woman".[23]

•**Navajo**: (Southwestern USA desert “Four Corners” area – Utah, Colorado, Arizona, New Mexico)

•*nádleeh* (also given as *nádleehi*), "One who is transformed" or "one who changes".

•**Ojibwe:** (Mid-western northern USA & Southern Canada – Michgan, Minnesota)

•*ikwekaazo*, "Men who chose to function as women" / "one who endeavors to be like a woman"

ininiikaazo, "Women who functioned as men" / "one who endeavors to be like a man".[

…..and on and on and on

Indigenous Multiple Gender History

Two Spirits were not only recognized, they were honored, celebrated, and held specific cultural roles, seen as having a sacred perspective “between”

Weh-Wah, Zuni Ambassador to DC

Two Spirit Honoring Dance and Two Spirt couples, circa 1850s

Why didn’t I know all this???

“Erasure”

The practice of collective indifference that renders certain people and groups invisible, or imposing ideologies to dismiss inconvenient facts

“The scrutiny on our bodies distracts us from what's really going on here: control. The emphasis on our appearance distracts us from the real focus: power….Power can be defined as the ability to make a particular perspective seem universal…Control is how power maintains itself; anyone who expresses another perspective is punished.”

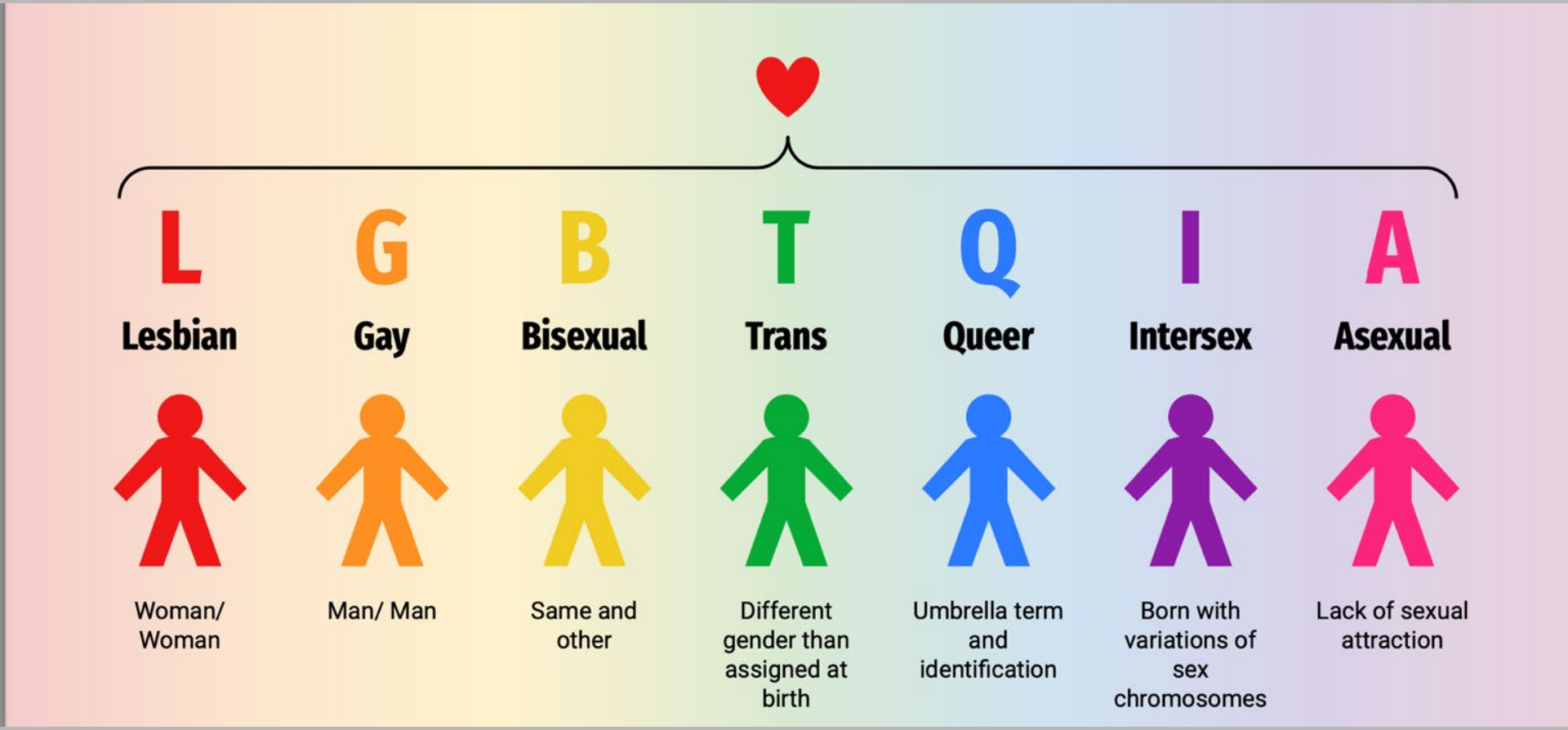
— **Alok Vaid-Menon, Beyond the Gender Binary**

(If the binary is not “real”, how can the patriarchy be justified?)

Over 2,500 distinguished scientists released a statement noting that the idea of the gender binary has no biological basis…

This doesn't reveal much about gender, but it does demonstrate the lengths that people go to in order to distort reality to serve their purposes."

— **Alok Vaid-Menon,** Beyond the Gender Binary

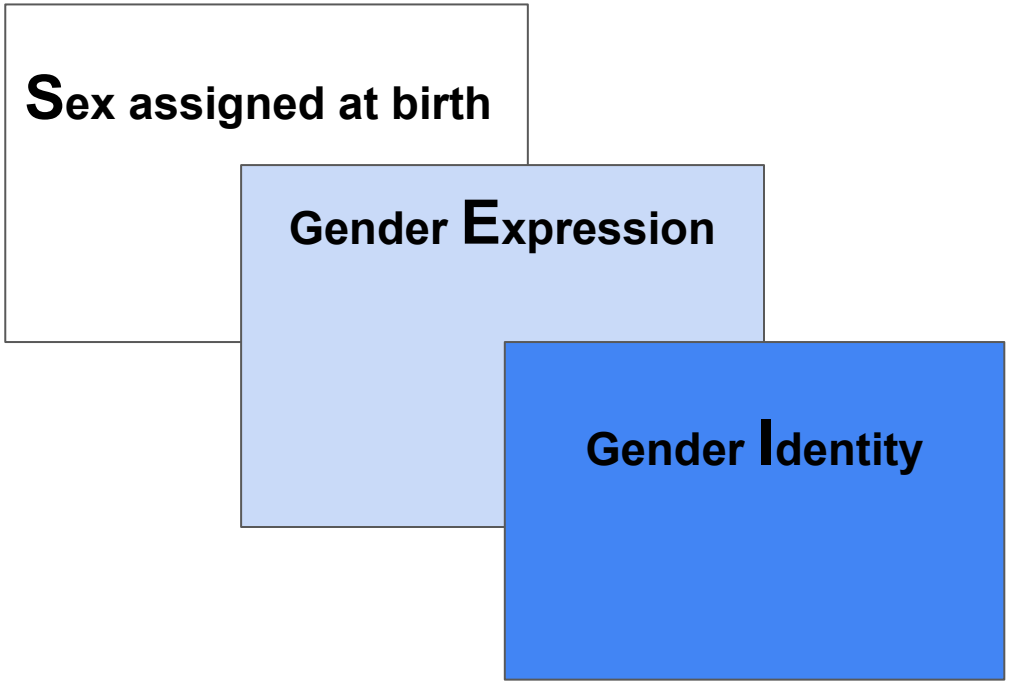

L
G
B
T
Q
I
A
Lesbian
Gay
Bisexual
Trans
Queer
Intersex
Asexual
Woman/ Woman
Man/ Man
Same and other
Different gender than assigned at birth
Umbrella term and identification
Born with variations of sex chromosomes
Lack of sexual attraction

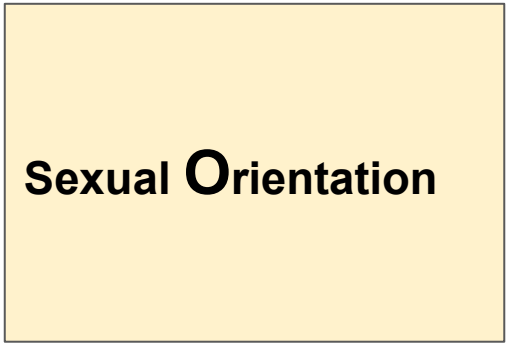
The SIEO Model

Developed by Dr. Eli Green, founder of the Transgender Taining Institute

- **S**ex assigned at birth
- Gender **I**dentity
- Gender **E**xpression
- Sexual **O**rientation

The SIEO Model





Individual Components of Gender

Separate and distinct from Gender

Sex

We are using “sex” to refer to a person’s combination of genitals, chromosomes, hormones and reproductive organs

“Male” or “Female”

= The only two sex/gender markers recognized

The problem is, there are not 2 sexes!

There are at least 29 sexes, meaning combinations of genitals, chromosomes, hormones

Sex Assigned at Birth

A doctor's decision at time of birth to place either a "male" or "female" marker on a person's birth certificate

Sex assigned at birth is different from a person's sex…

The decision to assign "male" or "female" is based solely on external genitalia - with only two options - which impacts a person's entire life in very significant ways

The Gender Binary is created/enforced by assigning sex at birth.

Sex Assigned at Birth

Current terms to refer to one's sex assigned at birth are::

- **"AMAB"** = Assigned Male at Birth
- **"AFAB"** = Assigned Female at Birth

This is private medical info, not to be disclosed or discussed unless legally or medically necessary…

Please do NOT ask people what their sex assigned at birth, or "biological sex" is!

Intersex

Born with different combinations of genitals, chromosomes, hormones, and reproductive organs than only “male” or ”female”

1% of the global population are born “Intersex”

(about the same occurrence as redheads)

Intersex

The Intersex community not the same as the Trans community, but they overlap in that body autonomy is a human right, which is denied them both…

“The surgeries that are performed nonconsensually on intersex infants and children are the same surgeries that

those of us who are transgender and nonbinary are prevented

from having access to as consenting adults.” – Dr Eli Green

More info at Interact.com

Gender Identity

How a person experiences gender in their heart, mind, spirit soul, etc.

The most important aspect of gender

Does not live in brain or genitals, but is all-encompassing

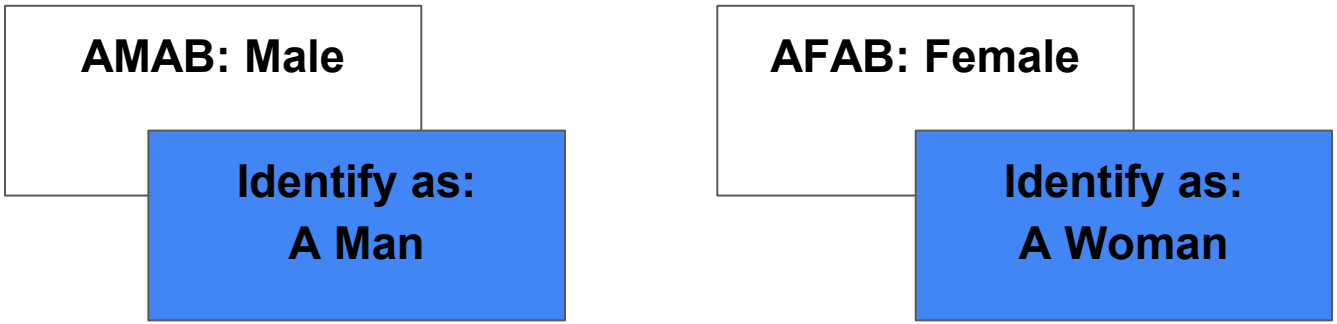
It is deeply intrinsic to how we experience ourselves

Cisgender

A person's gender identity aligns with sex assigned at birth

"Cis" is simply a Latin prefix that means "on the same side" or "on this side"

"Cisgender" refers to congruence between sex assigned at birth and a person's gender identity – *and only that*!

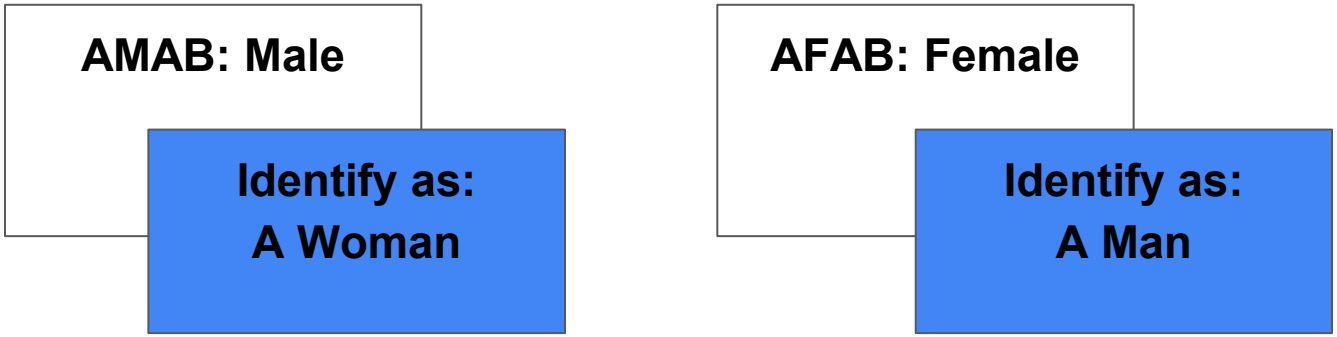


Transgender

A person's gender identity does NOT align with sex assigned at birth

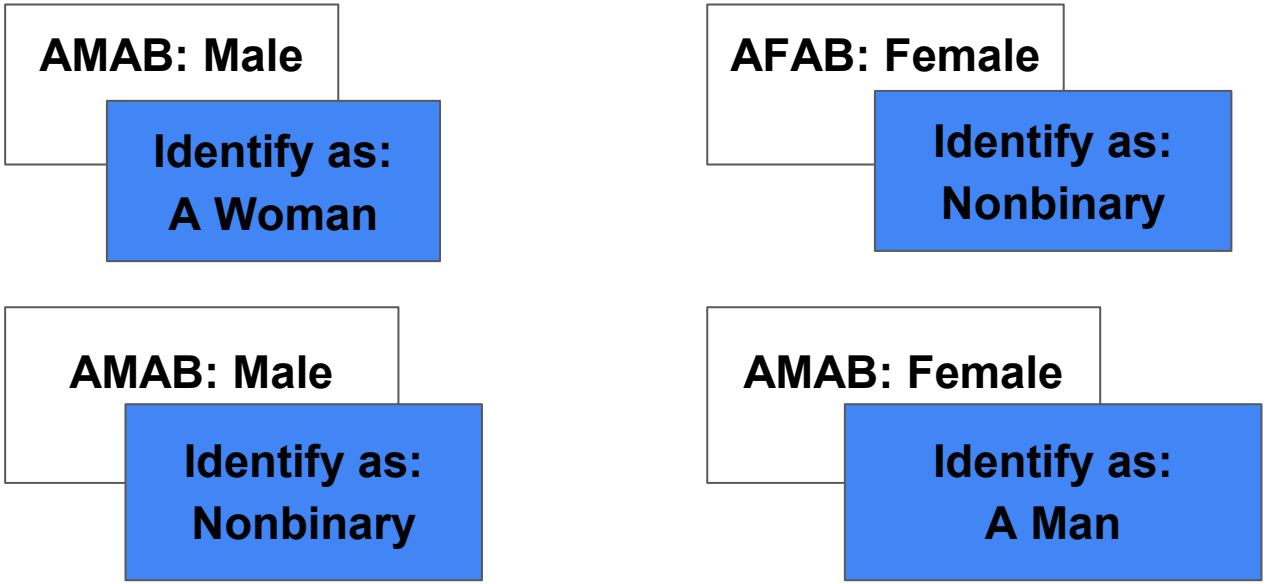
"Trans" is simply a Latin prefix meaning "across from"

"Transgender" refers to a disconnect between sex assigned at birth and a person's gender identity – *and only that*!



Nonbinary

Disconnect between sex assigned at birth and gender identity, AND their gender identity does not fit easily into “boy/man” or “girl/woman” boxes



…and SO many more!

“Nonbinary” is also used as an umbrella term, referring to all other genders besides “man”/”woman”

This is another place where “queer” comes in, or “Gender Queer”, referring to the same thing

Eg. Some nonbinary people ALSO identify as transgender, while others do not…

Gender Expression

How a person communicates their gender to the world

The way we walk, talk, dress, adorn ourselves: jewelry, hair, ,glasses, etc

The Gender Binary comes in again here, saying

you can either be masculine OR feminine

Masculine Expression

Feminine Expression

Gender Non-Conforming

Gender Rules and Roles

“Gender Expression” is really talking about the *stereotypes of gender* AND whether a person is perceived as meeting those or not…

It is about ALL the rules we have around gender…

How “men” and “women” are supposed to act, or not act,

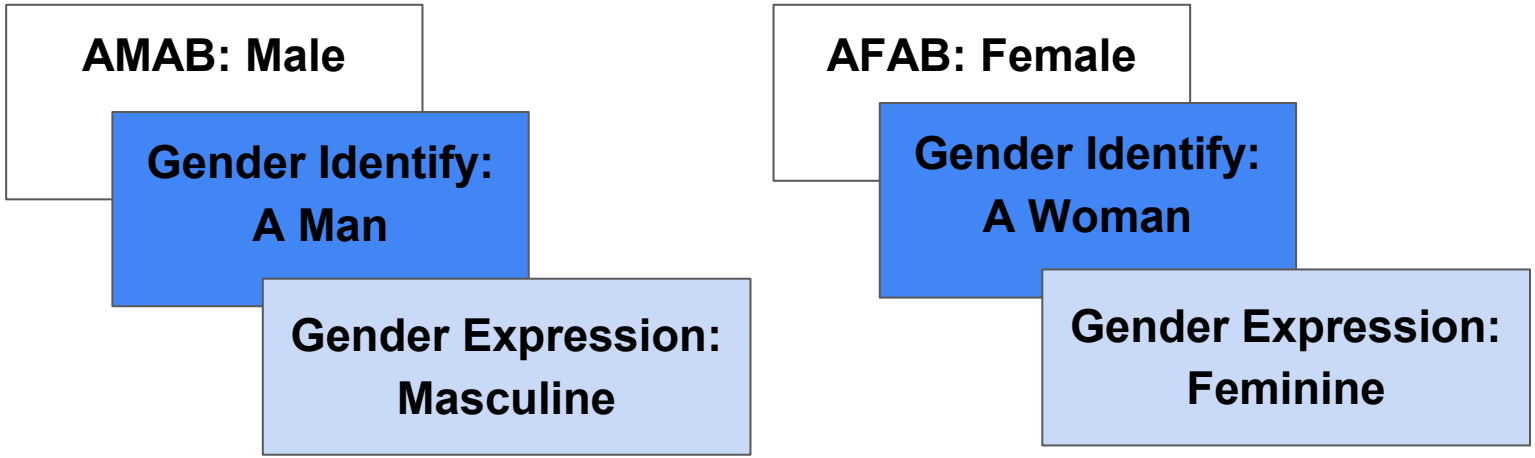
Who is allowed to do what jobs, play with what toys,

Wear what clothes, etc.

All the different things we call “aesthetic/style” often have a gender expression element to them…

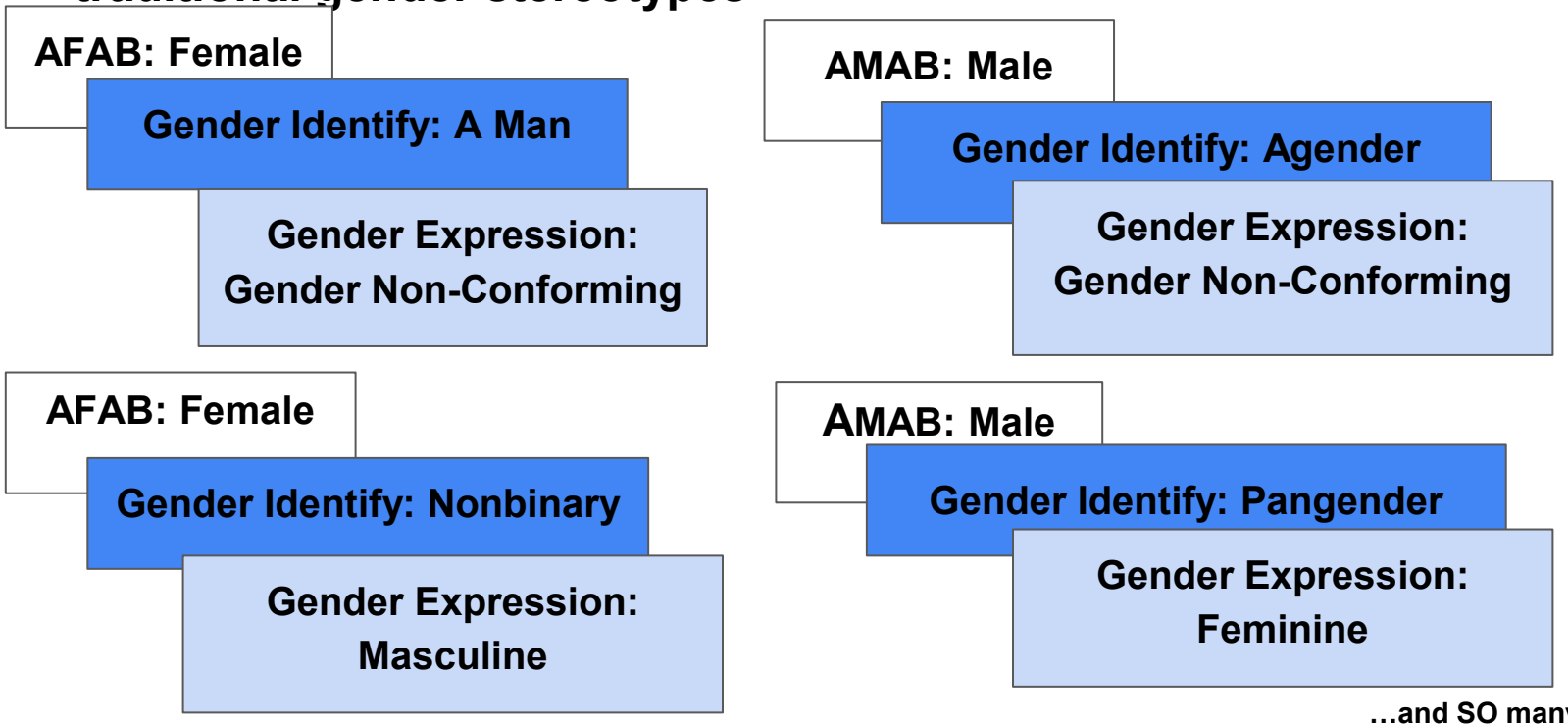
Cisgender Expression / Gender-Conforming

Someone whose gender expression naturally or easily fits into our gender stereotypes



Gender Non-Conforming

Someone whose gender expression naturally DOES NOT fit into traditional gender stereotypes



…and SO many more!

About Being Gender Non-Conforming…

When a person does not fit into those stereotypes, this is the ONE time where somebody else's perception of a person's gender really matters, because…

If someone is perceived as gender non-conforming, that person is much more likely to experience higher levels of discrimination, prejudice, violence, and many other negative outcomes

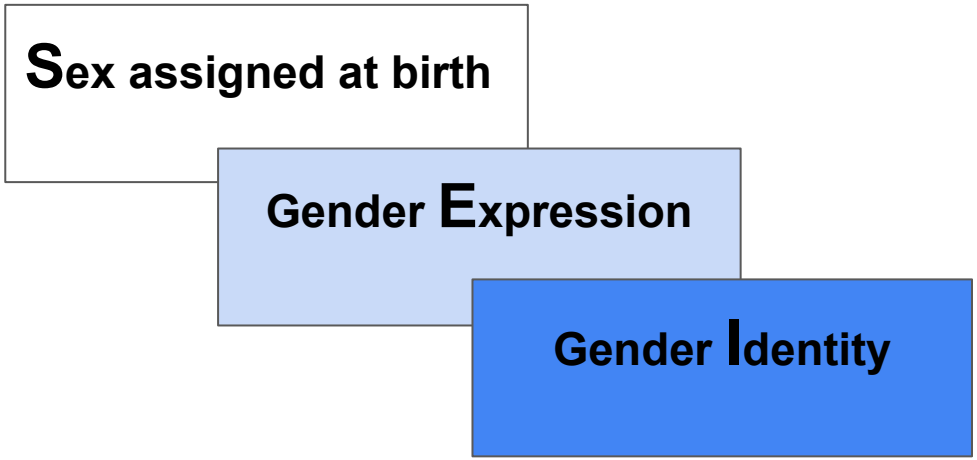
Intersectionality comes in here, because…when we layer on race and class…

The #1 target of violence and murder in the USA is black/POC transgender women

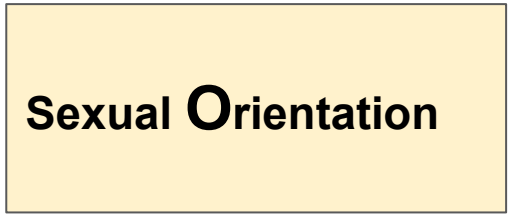
Burning Questions???

Sexual Orientation

Refers to our romantic/sexual attractions



Individual Components of Gender



Separate and distinct from Gender

Sexual Orientation

Refers to our romantic/sexual attractions

Our “orientation” is completely **separate from our “gender” or “sex”**

Sex/Gender Identity/Gender Expression are all about relationship with oneself,

Sexual Orientation is about relationship to others

Sexual Orientation

The LGB, Q, & A…

Some terms for sexual orientations::

Asexual, Heterosexual, Lesbian, Bisexual, Queer, Gay…*and many more*

This is another place where **“queer”** comes in….in the case of orientation, it just holds all things meaning “NOT heterosexual”

But what about …. ?

Every person has their own language for what feels best and most affirming for them…

It's up to them to define themselves, not us.

Listen, Believe, Validate, Affirm.

Overwhelmed Yet?

Great News!

You do not need to understand any of this

to be respectful and affirming!


They come from a binary structure,

Yes, it’s hard, but…

“Speaking up is hard, knowing what to say is hard, receiving critical feedback is hard, too. None of these is as hard as constantly getting excluded by SAE and having people neglect or deny that it is going on.”

- *Dr. Tiffany Jana*


FUSION
Micro
Aggressions

Believe, Validate, Affirm

Just one trustworthy adult can save lives…

Someone has to be the adult.

So, be that adult!

Love first. Understand later.

When slip ups happen….and they will!

Intention vs Impact

Your good intentions do not take away - or absolve you from responsibility for- the impact

“**Ouch” & “Oops”**

Acknowledging the person and the incident is crucial.
Avoiding the topic can cause more pain.

Is it really so bad?

“What does it really cost you to treat people kindly, as they would like to be treated?”

What is your job again?

Believe (they are the expert on their own experience)

Validate (acknowledge that their experience is valid)

Affirm (name, pronouns, and the person - exactly as they are)

“If you’re not transgender it’s natural to be curious and have questions, but remember that your curiosity is never more important than the comfort, privacy and even the safety of your transgender friends and family members.”

-Astroglide


FUSION
“Do You Have a Vagina?”

COLORADO
Department of Health Care Policy & Financing

MIDDLE PARK HEALTH
Keeping Life Grand

Hospital Transformation Program (HTP)

Kayla Ray Boyd MSHCT, BSN, RN

Director of Quality/Risk/Infection Prevention

MIDDLE PARK HEALTH
Keeping Life Grand

COLORADO
Department of Health Care Policy & Financing

What is HTP?

- Over the course of the five-year program, provider fee-funded hospital payments will transition from pay-for-process and reporting to a pay-for-performance structure in an effort to improve quality, demonstrate meaningful community engagement and improve health outcomes over time.

What Are the Goals of HTP?

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Two Parts to HTP

1. Community Health Neighborhood Engagement (CHNE)

2. HTP Measures

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MIDDLE PARK HEALTH
Keeping Life Grand

HTP MEASURES

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CP1 – Readmission Rate for a High Frequency Chronic Condition – 30 Day

- Goal: Reduce rate of readmissions to the hospital within 30 days of discharge for patients with a chronic illness.
- Percentage of Medicaid patients discharged who have a high frequency chronic condition who are readmitted to the hospital within 30 day.
- In the pediatric population, the report will calculate a case-mix-adjusted, 30-day all-condition readmission for patients 18 years old and younger.
- High frequency chronic conditions:
  - Hypertension
  - Diabetes
  - Heart Failure
  - COPD
  - Asthma
- Data source: Medicaid Claims Data

SW-RAH1 30 Day All-Cause Risk Adjusted Hospital Readmission

- Goal: Reduce rate of readmissions to the hospital within 30 days of discharge.
- For Medicaid patients ages 18-64, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.
- This measure is reported as the ratio of actual readmissions to expected readmissions based on risk adjustment for patient severity.
- Data Source: Medicaid claims data

RAH1 – Follow Up Appointment with Clinician Made Prior to Discharge and Notification to the RAE within One Business Day

- Goal: Ensure appropriate follow up for patients discharged from the hospital.
- Percentage of Medicaid patients discharged from an inpatient admission to home with documented follow up appointment with a clinician and notification to the RAE within one business day.
- A documented follow up appointment or notification to the RAE within one business day is not considered adequate for this measure. The measure is reported as one overall score counting in the numerator only those patients who receive both a documented follow up appointment AND notification to their RAE within one business day.
- Data source: Hospital self-report from EMR or medical records.

SW-BH3 Using Alternates to Opioids in Hospital Emergency Departments

- Goal: Decrease use of opioids and increase use of ALTOs and ensure appropriate treatment of pain in the ED.
- Two part measure that will track:
  - 1. Total PO Morphine equivalent units (MEUs) per 1,000 ED visits for patient ages 18 years and older broken down by pain pathway.
  - 2. Total number of listed ALSO drugs of interest medications administered per 1,000 ED visits for patients ages 18 years and older broken down by pain pathway.
- Data source:
  - Numerator: Hospital self-report from EMR, MAR
  - Denominator: EMR data, billing systems, or other tracking systems

BH 1 – Screening, Brief Intervention, Referral and Treatment (SBIRT) in the ED

- Goal: Identify patients with alcohol or SUD in the ED and refer for appropriate treatment.
- Percentage of Medicaid ED patients 12 years and older who are screening for alcohol or other SU at the time of an ED visit and those who score positive have also received a brief intervention during the ED visit.
- Screening alone without brief intervention is not considered adequate for the measure. The measure is reported as one overall score counting in the numerator all patients who are screened and screen negative, and patients with positive screens only is there is a brief intervention.
- Data Source: Hospital self report from EMR

COE2- Implementation/Expansion of Telemedicine Visits

- Goal: Increase patient access to telehealth visits
- The annual number of telemedicine visits supported through the hospital.
- Data Source: Hospital self report.

MIDDLE PARK HEALTH
Keeping Life Grand

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Where Are We Now?

PY/Q	Quarter End Date	Required Report(s)	Report Due Date
PY1/Q1	12/31/2021	N/A	N/A
PY1/Q2	3/31/2022	Rehearsal Measure Data	3/31/2022
PY1/Q3	6/30/2022	Interim Activity & CHNE Report	7/31/2022
PY1/Q4	9/30/2022	Interim Activity & CHNE Report	10/31/2022
PY2/Q1	12/31/2022	Interim Activity & CHNE Report PY1 Performance Measure Data	1/31/2023
PY2/Q2	3/31/2023	Milestone & CHNE Report Milestone Course Correction (if applicable) Milestone Amendment (if applicable)	4/30/2023
PY2/Q3	6/30/2023	Interim Activity & CHNE Report	7/31/2023
PY2/Q4	9/30/2023	Milestone & CHNE Report Milestone Course Correction (if applicable) Milestone Amendment (if applicable)	10/31/2023

Community Health Neighborhood Engagement (CHNE) Requirements

- PY2Q1 (Oct-Dec 2022) Reporting January 31st Requirements:
  - Interim Activity
  - CHNE – Completed on 10/17
  - Baseline Data
- PY2Q2 (Jan – Mar 2023) Reporting April 30th Requirements:
  - Milestone
  - CHNE (PIAC meeting)
  - Milestone Course Correction if needed
  - Milestone Amendment