Member Advisory Council Minutes
Larimer County – 1/12/23

Rocky Mountain Health Plans January Client Council Meeting Meeting Minutes

January 12, 2023, 11:30 am- 1:00 pm

We welcomed people and everyone introduced themselves and spoke about an inclusion, equity, or diversity issue about which they are passionate, but about an identity they do not share. We heard a lot about LGBTQ, people who feel politically marginalized, race and language.

1) Debrief on last meeting on pain management. We discussed upcoming legislation, and it was recommended that **there needs to be language about gatekeepers, preventing pharmacies and front office staff from overriding doctors' orders.** There was also a suggestion to **develop a pain patient's bill of rights that could go with the paperwork** that patients get when they get a prescription. *The group is eager to hear back from HCPF on the physical therapy and finding practices that will serve pain patients including those who have very complex conditions.*

2) Questions from Rocky regarding health equity: Rocky had questions about Health Equity so we reviewed their definition.
Health equity is ensuring high quality and effective services are available, accessible, and acceptable to everyone, removing systemic barriers to equity, with fair and just opportunities to attain their optimal health, regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes.

RMHP has selected to focus on Diabetes as a health equity initiative in 2023. What suggestions do you have for RMHP to meet the needs of Members of vulnerable populations and/or members of your communities who have diabetes? What can providers and their staff do better to support this population?

<u>Responses from the group:</u>

- Lack of providers especially endocrinologists are few and far between,
- Need providers that can look at different lens, such as people with multiple disabilities including mental illnesses and Intellectual or developmental disabilities in tandem with diabetes. In these cases, the family has to monitor blood sugar 24/7 and blood sugar problems must be dealt with immediately,
- endocrinologists need to understand how to work with other disabilities,
- Story of person with bipolar that was let go from 2 endocrinologists who did not understand his behaviors. Once this happens, the person does not get medical care, then this exacerbates his bipolar,
- Food access for low-income people is a huge issue for diabetics. The food bank is mostly not diabetic friendly,

- Need to consider also people older with macular degeneration and diabetes, there is an erroneous assumption that managing low vision and diabetes together is impossible. Technology is available but doctors are not offering it. Instead doctors just tell patients with visual issues to get someone to help. This is not dignified and not always possible. Most Medicare beneficiaries do not have access to glucose monitoring, there are continuous monitors that work through your phone.
- Doctors are not trained to think about accessible technology,
- Increase access to technology is a key,
- Affordability of insulin still an issue as $35 a month is still a lot for people who are low income. People ration due to cost of not only insulin but testing supplies,
- Pharmacies and many doctors do not know that the Free Style Libre, a real time glucometer is available on Medicaid. Patients are told that they must pay out of pocket.
- There are changes all the time and treatment is getting better all the time. The new technology eliminates the need for pricks.
- Medicaid should also cover glucometers and test strips. The -glucometer communicates with pump. Some pumps do small adjustment, but you can control it. The goal is a circular system so the glucometer tells the pump what to do and pump will automatically adjust, this is what our pancreas does. The technology is not there yet but should be there soon.
- Even if you have glucometer people should have glucometer, test strips, and emergency insulin in case it fails.
- Doctors are usually clueless about available resources and what is available through insurance. This is where practices having social workers could be helpful to hook people with diabetes with a social worker who has a clue. There should always be a once-a-year prescription for injectable insulin, supplies, etc.
- They need to understand the technology and timing of prescriptions. People on pumps have a sensor to change every 10 days but they get a month at a time. If something goes wrong, you cannot get replacement quickly. It takes 1-2 weeks to get one. Medicare went to three month supplies of sensors and transmitters. Medicaid should do the same thing if they do not already.
- Enable anyone in the practice to sign off on notes. Prescriptions are denied because the nurse practitioner saw him that day because the doctor was not available, then the script is denied.
- Laws and regulations should prioritize medications for diabetics' overweight loss when there are shortages.

- Food banks should let people take more and not have to come back frequently. Some people are told to come to a food bank three times a week. For people that must find transportation and help to get there this is a big burden.
- People who are diabetic and on LTSS need advocacy to have time allocated to cover cooking for people with restricted diets and more shopping time to find affordable food and manage blood sugar.
- Medicaid and Medicare are unique, other insurance people have for a short time, but we have this forever, lots of diabetes policy is based on private insurance and looks at immediate not long-term costs; if one's blood sugar is out of whack the person needs help with everything else

RMHP has selected to focus on flu and COVID-19 vaccines as a health equity initiative in 2023. What suggestions do you have for RMHP to encourage Members of vulnerable populations and/or members of your communities? What can providers and their staff do better to support this initiative?
Responses from group:

- Veracity gap lots of people do not believe what they hear, see, read, even what their doctor says. This started with COVID but is now spreading to other vaccines. Some sort of veracity improvement program
- People on Medicaid often does not have PCP so finding location for vaccines can seem overwhelming,
- Find those who do not have PCP and reach out with options for vaccinations, especially in u underserved areas,
- Provide more info on why to get vaccinated when the vaccine does not stop one from getting the condition. Advertise about how vaccines work, and how it helps to stop the overall transition.
- Have all Medicaid doctors ask if you have gotten booster like they ask if you got the flu shot. People have misgivings about boosters, and we need to evolve into thinking the COVID shot is like flu shots.
- There are real concerns and different vaccines with different messages and lots of distrust, people listening more to each other than doctor.
- There is a lot of nuance and communicators require knowledge which is hard because you must transmit information in short bursts of time.
- When communicating about this focus on protecting others and herd immunity; Provider education is needed along with more about long COVID. There is even disagreement about what long COVID is with some people wanting to dismiss it saying that it must be people with mental health issues having the problems; It is very important to educate providers not to dismiss people. We need providers to be open

so people will talk to them because that is how is data being gathered and how they are learning about long COVID by tracking symptoms.

3) PIAC Report

Alison was unable to be present because she had a one-day window to get out of a storm burdened area of California and she asked in lieu of the PIAC report to get information from the group on any new (or existing) behavioral health priorities/issues members are experiencing in Larimer county for her to bring up during the PIAC.

Response from the group:

- No one has seen or heard anything new after we gave input.
- The new facility is still supposed to be quick turnaround place, and this would not include a warm transfer and follow up. There is talk that they will do this but members are not able to see how this will be different from the emergency room except maybe being in a nicer building.
- Julie as asked to ask Laurie to come back and share what they did with input this group provided.
- Someone shared a recent story of a local emergency room retraumatizing a patient by not letting them talk with family member that the patient asked to speak with.
- The group feels that there must be transparency on what the actual policies are going to be so expectations are very clear. They want to see the written policies before the facility opens.
- Last we heard they had not locked everything down and the group would like detailed information.
- There was concern that the facility cannot be all things for all people.
- Now is good time to innovate but the group wants to know specifically how they will innovate and not do the same thing again by recreating a system that we have now that does not work.
- They would like to see sample treatment plans. For example, in X scenario we will do Y based on data.
- Currently Summit Stone does not get patient input on the treatment plan. The group wants something in writing that this will change for the new program.

4) Other business:

a) Questions about the training RMHP provided to mental health providers to help them be more able to work with people with IDD.

- Is there a list of people that went through the Oliver training?
- There was a recommendation to ask the trainers if they could have a family member panel where participants could ask questions of family members.

Julie will ask these questions.

b) Mary Michael shared a resource. She often hires students for in home care providers. CSU has two ways they place students or give them job announcements. One way is just noting odd jobs, and another is a way to notice both odd jobs or internships in the students area of interest. This system is called handshake. If you advertise using Handshake employer will be asked more questions such as is this contract or employee, then it gets sponsored by the university and entered into this handshake system. This is brand new https://career.colostate.edu/hire-a-csu-student/ People were excited about this. Cody at CSU is looking for feedback.

The meeting ended a little after 1:00 PM.