

Member Advisory Council Minutes

Larimer County – 11/10/22



Larimer County Client Council

November 10, 2022

Present: ReNae Anderson, Madison Johnson, Corina Lane, Alison Sbrana, [Alison Dawson](#), Kim Jackson, Jessica Benson, Mary Micheal Justice, [George Cunninngham](#), Owen Kent, [Dave Hejde](#),

Facilitator Julie Reiskin

Guests: Ingrid Betts, [Jim Leonard - HCPF](#)

The meeting began at 11:30 am. Introductions were made and Owen and George as new members were welcomed.

Julie re-introduced the guests from HCPF (Ingrid and Jim) who are back to further discuss pain management issues after hearing from the group in the past. The two topics for today are physical therapy as ongoing pain management and prescribing opioids for pain management.

Jim and Ingrid both expressed appreciation for this group and being open about issues and said that the group information has informed their thinking and policy work.

Ingrid spoke first about **therapy**.

PT is a huge issue and can be helpful in managing pain. Ingrid recalled that in this group we had determined that getting year round therapy would be helpful in controlling pain and maintaining function and should be made available to people who will not improve in a traditional way. She said people in her unit agreed and as a result she has been researching how this could happen. She said that they are not the benefit experts but have been doing research, this is what they learned so far:

- 1) All clients get 12 hours a year and anything beyond that requires PAR from PCP/PT , Included is a letter of medical necessity, With this, therapy could be authorized for even a. Year
- 2) She is optimistic but not 100% sure about getting it approved solely for maintaining and not approving. She said it will take time to get this done.
- 3) She reviewed the PT billing manual which is what is required to get something approved and they think they can make it work however what she needs is to hear stories about experiences in trying to get a PAR

Julie shared and the group agreed that the problem is not denials of PARS because people are not getting to PAR because providers just say it is not available.

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Another issue raised by Alison is that providers only have 7 days to respond and if HCPF says there is more info needed then PT has to contact the PCP to get the info and this is too small of a window realistically especially with many PCP's only in the office a day or two a week.

Alison D. mentioned that she was not able to get PT post surgery because she had PT on a different issue later in the year. Even though the post surgical therapy was for a new issue it was still looked at as part of 12 hours and applied as an annual cap.

The "narrative" for providers is that it is only 12 hours and there is no way around it. When clients try to say "no..HCPF will approve more if you do a PAR" providers do not believe us.

Could we have official letter clients could bring to both their PCP and PT providers from HCPF to let them know what the state would actually support?

There was more discussion about the amount of time and energy to invest in convincing HCPF that a service for a person with a chronic pain issue is necessary and that leads to provider burnout. Another issue is that the gap in care is really significant. Right now one will have a course of therapy, finish that authorization, then to have an appointment with a doctor and get another authorization. While that goes through the process it is a couple months and the client gets worse, then spends the time in the new authorization getting back to baseline and it is a vicious circle. In the interim, people end up in ED, urgent care and other crisis situations.

Dr.Jackson asked If you call HCPF member services do you get information? She has heard from providers they do not get accurate information and she has herself experienced a hard time getting accurate information on issues pertaining to disability and chronic illness.

Others all said it would be great if there was a letter outlining what can happen and how it should happen with a reference to any needed documents in a place that is easy to find and search for on the HCPF website.

Alison S and her PT both tried and could not find the needed information anywhere on the HCPF site. It was also mentioned that the health care system in general is not friendly for people who have systemic issues. The health care system is siloed out and they want you to focus on one body part. There are some PTs know how to work with people holistically. The lack of looking at people holistically is also embedded in the issues regarding pain medications.

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The financial incentives are different between Medicaid and private insurance. The private insurance is incented to push people to more disability to get on government insurance so they no longer have to pay, but in government insurance we are on it for life so the incentive should be to help people be as healthy as possible.

So the summary is that PT can be approved for a year which is great if all right info is included, but things are missing and then there is a request for more info and then it gets into a loop and extended time and providers give up or get frustrated as patients lose what they have gained. We need the process made easier. Someone asked if medical necessity language could include the term “ameliorate” as it does in some other areas of regulation.

Some asked what is the problem with just saying everyone has 24 hours a year or 30 minutes a week? Could that work? Would this be abused?

Ingrid said she appreciated this information and discussion, and has written this down and will look at each area and get back to us and figure out how to get this resolved. She said that HCPF has heard over and over from other groups that they cannot get long term PARS approved. Benefits are available but people cannot get them and this is not acceptable. Ingrid again asked If anyone has other stories or info to please reach out. She has secure voice mail and email—but said not to send super personal information that way, she would rather do that in a call.

Some providers know their way around the system better. Jim brought ingrid onto the team to assist people with working through the system. She has been doing research on these issues. There seem to be some specific criteria in the PT manual and the word ameliorate is in there so they are not sure why this is a problem. She will help with specific problems.

Jim said that the letter is a good idea and they will get going on this. Re the issue of PARs -they are interested. Is there a black box at Keypro (the agency that processes PARs)? He is not sure why there are denials when maintaining functionality is a problem that they cover. An example is important. People suggested that he could also ask Keypro if they would deny under these circumstances (chronic problem, goal is to manage pain, not improve functioning, need will be ongoing). The group also would like to get a list of specific criteria. Jim said there may be potential to just expand hours as suggested earlier. They are also looking to see what other states are doing.

Pain Medication:

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Providers are afraid to prescribe pain meds. They have neither comfort nor education about how to do it. How can we help to educate newer doctors who have not learned about this because they were in school after the stigma against prescribing opioids had already started. How we help educate so that opioids are not demonized? They need to better understand the consequence of untreated pain. HCPF have had an idea to establish centers of excellence for pain management. They are working with CU school of pharmacy. The model is that there is a Pharm D and pain management doctor available but mostly to consult with PCP when the PCP feels over their head. This team is available to the PCPs. HCPF will ask them to do a monthly training. Jim was not sure if this will be rolled out by RAE or hospital/clinic systems. HCPF will do educational programs to talk about different topics, how to prescribe and how to enter into conversations to adequately analyze benefits and risks for example. They want this to a patient centered approach

Jim has read but not completely digested the new CDC guidelines. He thinks that what has changed the most is that it moved from being directive -telling providers “do X in this situation” to now understanding and directing that everything has to include patient perspectives, and benefits vs risks and what to do if there is disagreement between patient and provider. There is a focus on how to avoid abandonment. Tapers –only OK if the patient agrees and understands that some situations should not be tapered . Tapering can be harmful and can increase suicide, overdose, and decrease function.

Some of the need is education for providers and not demonizing –providers need to be protected from DEA, etc.

Some providers are pressured internally. Clinics set limits and do not take into account the needs of chronic pain patients in that provider's subsets. The way the new guidelines are written is going to give providers more leeway. He hopes the center of excellence will help protect doctors, if there is scrutiny and they consulted with the center that will protect providers.

Jim said that educating the PCP seems to be the best way to meet the need because they cannot find enough specialist to cover the need, so focus on PCP as the place to go for prescribing and monitoring. Increased anxiety depression sleep disorders also is a problem

This focuses on the whole person. There have been a few stakeholder meetings, there are issues around substance use disorder and this is tough.

Jim would love the member perspective on behavioral health. Should there be a screen for depression or anxiety to take actions to help

Are the screenings for depression a problem?

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Kim is part of a group working on a bill modeled after Minnesota, to protect doctors and patients and this could be addressed in the bill.

It was raised that there may be a history of depression on medical records, some people are honest some are not. Depression is worse due to unmanaged chronic pain, people feel the pain is blamed on depression not the other way around.

A member talked about a situation where they finally got into a pain clinic and now has to go somewhere once a month just to do a depression screen and they ask the same questions and not get help. At least before the pain clinic the member was able to get some medications from the primary care system. There was one medication that actually helped and they lost access to that medication. Jim asked if telehealth would work and the answer was YES if the system they use for telehealth is usable and accessible it works great. That would be much easier than having to go somewhere.

A member said that they were really glad HCPF was setting up a consultation process for PCPs.

A member said the area's largest office locally has system wide policies that limit prescribing. Even if a doctor thinks someone needs an opioid the clinic has a ban on prescribing.

Other ideas included that the RAE needs to talk to the consult people so they can make sure the PCPs they work with know this is available when it is available. Also, many mental health needs are due to lack of health care

Dave supported the concerns about depression screenings. He said it makes it worse when they ask then do nothing.

Kim said some doctors make too big a deal over someone admitting depression or do nothing when they hear someone in obvious distress.

It was noted that CBT (cognitive behavioral therapy) can help some pain patients, however this is based on a part of your symptoms are based on your pain and problematic thinking, but this is over simplified And CBT cannot fix it all, providers need to be able to make distinction and understand nuances.

Jim said he wanted to wrap up with a couple thoughts:

- 1) A more comprehensive depression screen could be more valuable. Maybe ask if there is an underlying condition that is affecting the depression then that could cause a referral to medical care for medical intervention.
- 2) Some studies say you get better answers if people can take it on their phone or computer instead of right before an appointment. People liked this idea!

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- 3) Also issue of inability to get treatment especially in marginalized communities is very hard. Mary Michael said that there are some good diverse therapists at the neurofeedback center and this is covered by Medicaid. They use multiple modalities for therapy other than medication.

OTHER COMMENTS:

Pat said providers often require check ins and each time they require signatures on privacy agreements. She read one and it said that by agreeing to them they can look at websites you have visited and this is a problem.

People are afraid to mention mental health or addiction issues because of a history or fear.

Stim mechanisms not currently covered. Is there any more info about this and why this is the case? No more info—but Jim will get the right person to get info.

Dave said that the fear of providers is their license. We need to address this level of fear.

There are also many issues regarding medical (or regular) marijuana. We did not have time to discuss in detail.

The meeting ended a few minutes after 1:00 PM

The next meeting is scheduled for January 12, 2023.

PROPOSED SCHEDULE FOR REMAINDER OF 2023: All meetings 11:30-1:00

Moving to the first Thursday for better coordination with PIAC so we always meet ahead of the PIAC.

- March 2, 2023
- May 4, 2023
- July 6, 2023
- September 7, 2023
- November 2, 2023

We will discuss in January if we want to do some meetings hybrid and if so if we alternate between Loveland and Fort Collins?