Member Advisory Council Minutes
Western Slope – 9/12/22

September West Slope Client Council
Monday September12, 2022
Hybrid meeting at Workforce Center in Grand Junction and Zoom

Present:

Members: Karyn ReNae Anderson, Ian Engle, Jen Oberling, David Nelson, Staci Nichols, Tom Keller, Henry Grater, Herberta Silas, Monique Terpstra, Joe Barrows, Rochelle Larson, Janice Curtis, Diane Prier, Ptisawquah, Noann House, Lynn Jolley, Meighan Lovelace, Tracy Klumker, Tim Hudner
RMHP Staff: Nicole Konkoly, Meg Taylor, Sheila Worth
Guests: Jose Chavez
Facilitator: Julie Reiskin

We did introductions, announcements, check-ins, etc.

Guest Speaker Jose Chavez on Community Building Efforts in Grand Junction & Health Equity Organizing

Jose shared about who he is and the work he has done in the Clifton community in Grand Junction. This community has much more poverty and health disparities than the rest of the community so has been an area of interest for Rocky and other organizations interested in health equity.
The group DEFINITELY wants to continue the conversation.
Jose suggested that in lieu of doing land acknowledgements to research a real person who was Native American and their impact on the community. This makes it more real. Main points of his presentation included but were not limited to:

- Need to have real personal conversations with community members. This will give people a genuine understanding of community needs and wants.
- Need to support community members as leaders. Often people come in and do not really support community leaders.
- He explained a process they went through where they talked to 1,200 members of the Clifton community. Some of the findings from this process include:
    - There are currently no doctors' offices in Clifton, although Marillac plans to open a clinic there in the future.
    - Need Spanish speaking therapists in Mesa County!
- Community engagement takes time and persistence, and one must support leaders, identify issues, solve problems, and stay flexible and supportive.
- The goal is to think upstream. When it comes to projects, sustainability is key.
- Current projects include:
    - Community hall

- Multi-generational, all-inclusive playground
- GOCO planning grant

- 3 key items:
  - People
  - Respect
  - Opportunity

Rocky Management Discussion with Meg

Meg started by reminding the group that she was here to listen and act. She said last year and next will be years of heavy investment in community-based organizations, projects, and initiatives to promote independence and support the opportunity for people to live their healthiest lives – this includes transportation, and other social needs. She wants Rocky to accelerate the ability of clients to get into providers and be served.

Meg had a couple things to bring to this group but wanted to hear the group's issues first. Issues brought up by Members included:

1) David:
   a) There is only one neuropsych provider in SW CO and he is not taking Medicaid and there is nowhere to send people. Need another neuropsych provider for SSD applications. He is trying to find alternative providers in other parts of the state that people could be sent to and requested assistance.
   b) In Purple Cliffs there are over 400 people living in the woods. The county is displacing them on 9/30 with no plans to do anything other than hire more enforcement officers. No vouchers, nowhere to go, etc.
2) Janice: Does Rocky have freedom to implement preventative things? For example, diabetic education is needed. Is there a way to see more things in prevention areas? Rocky's answer is yes, they have done a lot of work with using data to inform and step in at an earlier time--rather than waiting for someone to go to the hospital, for example –and they can do community investment for prevention.
3) Tim: has there been analysis of what benefits will expire at the end of the Public Health Emergency (PHE) and what will happen? He shared some issues about American Rescue Plan Act (ARPA) funding for housing and concerns about one-time funding. Julie explained that the PHE is separate from housing and other programs created through both Coronavirus Aid, Relief, and Economic Security Act (CARES) act and ARPA. Meg said that Rocky has been trying to predict who will lose their Medicaid coverage when the PHE ends, and working on how we can connect them to other coverage options. The state predicts that half a million people statewide and 50-60,000 in Region 1 could lose coverage when the PHE ends. Rocky

and others are advocating for better data so they can do more targeted outreach and education. Some will qualify on the exchange (Connect for Health Colorado) for a highly subsidized health insurance plan where they can keep their provider network. There is concern about how much messaging to do without saturating people and causing them to tune out. Advocacy throughout the process is needed. Members expressed concerns about people not reading mail and other problems with mail and even email. In other words, people felt that mail was not going to cut it. Members said that text outreach works better. The state could make some changes and do this better. Meg explained that Rocky has good mobile data and need to be able to use it. There is a great need for local assisters and navigators, like Hilltop and the Federally Qualified Health Centers (FQHCs), for example. The best guess is that this is likely to start in January. The state is going to take the whole 14 months available to complete the PHE unwind process so that people will stay eligible until their regular renewal time. Jen said that in small communities like Crested Butte, they have had success through the local newspaper and local radio station. She said that they all go through one person, Gary Shondeck - this is where they go with questions. College age kids respond to texts. Other people said in their communities, radio and TV channels and local newspapers are good sources. Any key people who can get to community members who are trustworthy need to be used. Meg said Rocky can prioritize communication with these people who are identified. Other ideas included church outreach/bulletins and libraries. Janice mentioned using peer staff. Meg said they have done this with SUD and in this area have started integrating internally. There is concern that trusted community leaders share information and then the counties contradict them, often with misinformation, and the clients do not know what to do. The group felt HCPF needed to be much stronger with client centered messaging.

4) Janice: Is there a way to track prescriptions by provider and side effects? Meg said that they do not have a proactive way to track, but this is a great idea and something they want to do. There have been different reports in the media about this. They do get pharmacy data so they can see prescription information.

Meg had two questions:

1) There is a policy being drafted about clinical supervision for mental health professionals who are right out of school. There is two years of work one must do in most cases before they can be licensed. Right now they allow unlicensed people to work under the supervision of a licensed person. The RAEs have worked to draft a policy about what this should look like. The policy examines the following questions: *Who can provide supervision? What is the appropriate length of time post license before they are able to provide supervision? Who can provide clinical supervision?* The proposal requiring this person to have two years post license experience was not well received by the provider community.

There was a robust discussion with mixed views by members. Thoughts included:

- What is the protocol when there is an unlicensed person in the role? What is the supervision and how is that written into the policies of the clinic?
- Some people who are just out of school are more open minded and eager to help.
- Sometimes we get subpar care using untrained people. Certain communities like indigenous communities have always been guinea pigs and often without informed consent.
- What is disclosed to patients and is there a real choice?
- Is this a partial answer to the shortage of therapists?
- Would a voucher model be a better alternative?
- Providers are afraid they are going to have to turn people away.
- Choice without options is no choice. This should not be about who bills Medicaid. We do not want the only choice to be an overworked student. We also want to be able to know clinical supervision is available to give students experiential learning. There must be an adequate amount of supervisors and students—make it a *both/and*, not *either/or*.

Julie mentioned disclosure laws for mental health professionals and was not sure if Community Mental Health Center (CMHC) workers were exempt. She said she would research. The laws about disclosure are here. There are some exemptions for social services employees. Mental health center employees have some exemptions from the state database of unlicensed psychotherapists, so it is unclear how they are held accountable and how disclosure works as part of the disclosure is about how to file complaints.

2) All organizations including Rocky use photos in marketing material. Meg asked if those should be generic stock photos or photos of actual Medicaid clients? *The group strongly felt that photos should be real clients so people can see what we look like and celebrate our diversity*. This is a way to actively and meaningfully engage people. We want to be represented without pity and shame. This can be done with informed consent. Using actual clients gets rid of the shame and stigma. The group volunteered and Meg said she would try to set up a photo shoot for our next meeting. This is a way to celebrate diversity and pride. The Medicaid community has a lot to be proud of. Ian mentioned the great diversity in the "My Medicaid matters" campaign.

Case Management Redesign:

We engaged in a case management redesign "world cafe". We had four groups: two in the room and two virtual. Julie shared that HCPF had identified some pillars about what case management redesign should look like. The group was asked to explain what the following terms mean and look like:

1) Accountability
2) Simplicity
3) Integrity
4) Transparency

Below is what people came up with, combining the answers of all of the groups. Most of these answers came up multiple times.

Top ten issues for case management:

1) Adequate caseloads
2) Much more rigorous onboarding and training that is transparent to clients. Hire more peers as case managers and assistants.
3) Integrate disability advocates and peers into the system so there are people that can cut across systems to resolve problems.
4) Have a centralized place for all paperwork/documentation where clients can log in and see their own paperwork.
5) A real person to talk to with an easy phone system (also text and email based on client preference; the point is one person and simple).
6) Knowledge and clarity about rules including HIPAA (stop weaponizing releases).
7) Build trust through relationships, client centeredness, and valuing outcomes over compliance.
8) Dramatic increase in quality and quantity of communication at all levels.
9) Local people to talk to; avoid call centers and third-party contractors.
10) Support case managers to learn from mistakes so they can grow as people and stop blaming clients.

Detailed answers from all groups combined:

1. What would a *simple* case-management system look like?

- Easy to find case managers
- Adequate staffing/balanced caseload
- One person who can cut across all funding streams and make decisions
- Clear, defined rules
- Knowledge about the rules
- Access to information that is up to date
- Highly trained in communication
- Strong teamwork: people communicate with each other
- Resources available on the spot
- Flexible hours (evenings, weekends, etc.)

- Easy access to one's care plan
- Consistent appointments
- Easy process for phone users; no complicated phone tree
- Templates are available
- Single payer system
- All letters and forms tested with diverse client group
- TRUE single entry point that works--one place to go to get through EVERY step in eligibility and enrollment and keep the same people involved.
- Leadership has to be bought into wanting to help the clients, not see themselves as gatekeepers.
- Patient centered care model
- Strong transition plans (for systems and individuals)
- Focus on client and community.

It would **not** include:

- More than one form a year to fill out
- Mail with inaccurate or confusing information
- PEAK SUCKS--have something that works for clients
- Too many different departments (eligibility, enrollment, HCPF, RAE, MH, etc.)
- Obsession about cost effectiveness as this is not good for patients (Example putting EPSDT in loss prevention?)
- Giving money to clinics and corporations
- Focus on profits and providers

2. What would a *transparent* case-management system look like?

- Monthly or quarterly newsletter about case managers, processes, programs, etc.
- Presentations to groups and public
- Collaborative documentation (e.g. the case manager and user both see information as it's being asked, answered, entered, and computed)
- Explanation of the process as it's being conducted and the effects on the user
- Someone who is trusted (not an outsider)
- Easy client access to information including information about them such as appointments (past and future), log notes, forms, etc. This should be like the patient portal in an EHR.
- Better and easier communication between providers for the client so they can work together
- Proper ROI and HIPAA disclosure instead of weaponizing it as is done currently
- WRAP around services that are advertised
- Able to call someone with questions and have an actual conversation with the person answering the phone. Email works for some but not for all.

- Consistent caseworkers
- Warm hand-offs for referrals
- Relatable and equitable communication
- Use social media with updated information
- Individual plans instead of one size fits all
- Build trust with positive, respectful communication--use PEER SUPPORT to do this
- Stop lying and gaslighting clients

3. What would a case-management system *with integrity* look like?

- Following the laws (e.g. confidentiality)
- Only make promises that can be kept
- Admit and state that you don't know, but will find out and get back with the information; Allow case managers to admit what they do not know and give them time and space to learn and get back to the client
- Staff have personal experience with the system
- Staff culture of following through and following up
- Case managers who care and are empowered
- Utilize resources available until the problem is resolved
- Clients and case managers understand the process--it is clear and publicly available.
- Solid onboarding for new case managers which is accessible to clients if they want to review it.
- Skills other than knowing how to document are valued, sought and taught. This includes racial equity, understanding of economic issues, disability competency, cultural understanding of LGBTQ+ community, people that work through a social justice lens
- Hire the right people from the state--current clients are a great source
- Strong communication between the clients and ALL level of staff
- People hired have personal integrity and that is a key quality sought (as opposed to certain degrees or knowing how to use specific computer systems)
- Each level of leadership has dedication to client health and wealth.
- Integrity is dedication to this work, not a job on the way to something better.
- Caseload that is manageable
- Reduction of administration/paperwork so they can fulfill their jobs with integrity.
- Culture of learning with clients and staff.
- Case managers are nurtured by coworkers and supervisors and feel valued, then they will in turn value their clients

4. What would a case-management system with accountability look like?

- Staff are supported to take ownership of problems through their resolution and processes are in place to have supervisors really solve problems with and for clients and case managers. Clear way to report problems with a follow up process that everyone understands and can be tracked. Easy phone process to call to notify people of issues. When you cannot reach anyone, you cannot report concerns.
- Rigorous onboarding for new employees
- Most up-to-date information available to staff and clients
- A way to have everyone (client, providers, case managers) on the same page
- Encourage people to see mistakes as learning opportunities; admit to mistakes and apologize for and rectify errors instead of trying to hide them or blame clients.
- Outcomes (agreed on by client groups) measured
- Sharing best practices
- Paperwork is user friendly--accountability is not just paper compliance. Less time with paper and more with people.
- One on one in person contact is available for ANY issue. Do not send people to call centers.
- More information about needs --not just what they have on the papers. Communication, not checklists.
- ADA/Disability advocates in each case management agency AND peer supporters working as paid staff with case managers
- ONE person to coordinate all of the pieces. Best if this is through an IL center or other advocacy organization.
- Someone identified to take problems who has authority to resolve the problems (this could be the ADA advocate??)
- Peer support
- No third-party vendors (like transportation brokers, choice counselors, etc.) who do not understand our rural communities
- More training on bias and how to treat people with respect--to develop trusting relationships
- Transparency around information sharing and clients have easy access to ALL information including case management forms, training, and completed forms and notes and case plans
- Proper use of releases
- Better wrap around services
- Able to call a person with questions (not just electronic communication)
- Consistency with caseworkers, warm handoffs, and appointments

Closing comments:

- People feel HCPF is using too much money trying to figure out how to spend federal money.
- People need more context and discussion about the clinical supervision issue.

Should Rocky do an anonymous survey about the clinical supervision issues?

- Rocky is doing an update of Member materials and Nicole is looking for testers: Jen, Tracy and Joe volunteered.
- PTISAWQUAH announced a training they were presenting later this week on the school to prison pipeline.
- Nicole announced the Regional PIAC would be held Wednesday of this week and noted members are welcome to attend in person or virtually.
- Monique gave an update on the work she and her team are doing on the Tribal reservations and thanked Rocky for their support. She said it is incremental progress. We fight so hard to get small victories, and when we get one, we need to use it.

December Agenda:

- Photo shoot
- RMHP PRIME presentation, including the recent expansion of PRIME counties and prevention activities
- ACC 3.0 --what may be on the table
- Hear from state about how they plan to address PHE