COVID-19 Updates for the Disability Community Webinar
Closed Captioning Transcript
September 11, 2020

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>> Please standby for realtime captions.

[Music]

[Captioner standing by]

My name is, Jennifer Larsen, Coordinator for the office of community living. Helping to facilitate the webinar today. We have someone who is a presenter maybe mute their line as we are getting background noise. I will remind you of a few of our webinar procedures. Primarily we're using the chat panel today for managing all of your questions, so please type those in. You can get a copy of the slides. Thank you to Julie for pointing out that I have the wrong version in there, so I reuploaded the version for today. You can download those. They are available for you in the files panel just below the chat box. As always, we make those available on our website as well. With that I will go ahead and turn it over to Bonnie to start the presentation.

Thank so much, Jen my. This is Bonnie Silva. I am the Director of the office of community living here at healthcare Policy and Financing. I would be remiss if I did not remind you all that today is September 11th, and invite you all to remember the thousands of lives that we're lost on this tragic day now nearly 20 years ago. As we talk through today a lot of the important work we are moving forward, I hope each of you take time to grieve but to also remember the courage and sacrifice demonstrated by many heroes and in most impossible circumstances. With that, moving forward if we can go to the next slide.

With me today I have Julie, the Executive Director of the Colorado Cross disability coalition. I want to pause and continue to offer my thanks to Julie and her team. They have been phenomenal partners during this pandemic. I think as you will see it's the future we really have a joint commitment Joining Forces, if you will, too provide communications directly to members, to the Disability Community more broadly. Certainly appreciate her co- presenting today and her efforts and planning this presentation. I also have Melanie Lawson, trainer/Emergency Response Coordinator from the sister State Agency, Colorado Department of public health environment, a Chief Medical Officer, Dr. Lisa Latz here today to give an update on the clinical evidence Advisory Committee. I will spend time today giving a high level update on important work for merely not COVID-19 related that we are moving forward in making sure you all understand the opportunity to engage. And also to participate in the policy work outside of these meetings. With that let's move forward.

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I was so before we get into updates providing you with some high level data around the Medicaid impact resulting from COVID-19. What this graph shows his membership is up about 100,000 people since March of 2020. Not as significant as originally projected, but, certainly, it is having an impact.

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In addition to that we have had more than 200,000 members that a been what open quote, locked into Medicaid coverage due to the continuous coverage was -- provision associated with federal health emergency. We have counties that are taking steps to redetermine eligibility for about 300,000 members total all by the end of October unless our federal partners take action. And currently, really trying to better understand the people who are now without help insurance with response to Covid. We Partner with the Department of Labor and employment to conduct a survey. Those survey results indicated there is almost 20% of those filing for unemployment insurance did not have coverage. Almost 50% of those tend to remain without coverage during the pandemic. Of course, we find this to be very concerning. Addressing these critical issues will be topics of a meeting hosted by our Executive Director, Kim Bimestefer, September 24th from 1:00 to 2:30. She is to work with the disability community in particular, in addition to other health advocates. If you did not receive an invitation and would like to attend this meeting, please contact her Executive Assistant, Jamie Tidwell. Her addresses on the slide. E-mail address to the day. With that I will turn it over to, Julie Reiskin. Are you ready?

I am, thank you, and thank you, body. Thank you for mentioning today is 911. Even though it's a hard day to remember I think everyone knows exactly where they were when we got the news of what had happened and what they were doing that day. I think that what people are also remembering is that was actually a time we came together and reunited as a country, which is something clearly lacking now and something hopefully we will be able to get back to soon. So, I just wanted to add that and thank you, Bonnie, or bringing it up, because it something when we don't remember our history it will be repeated. It's something we shouldn't forget about.

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I'm going to talk about some stuff that has nothing to do with COVID-19 today but something that is important in the Disability Community. I'm going to ask people to put comments in the chat. Electronic Visit Verification, and if you download the slide there will be a link to the top part of the slide there is a link that will take you to an FAQ this department has about that. Electronic Visit Verification for anyone who doesn't know is this new system where for personal care, home health and [Indiscernible] Home Health Agencies you have to have a device on your phone or you can use a landline at a house where the 8:00 in and clock out. Every time they come and go and there's been a lot of controversy about that. And some states they have implemented it in abusive ways where people have cameras in their home watching personal-care. Off. Colorado is not doing that and we are very grateful. Colorado is doing the minimum the feds are making us do. This is something that is a horrible policy but not something the State chose. It was something forced on them, unfortunately, by a Colorado congressperson. It's federal law now so they have to do it or they will lose federal money and we cannot afford to lose federal money.

Some Home Health Agencies have actually been using this for years. But what is important to know is there is what they call a soft implementation until January. What that means is people have to use it but they are not basing payroll on it and claims. After January they well, so they will have to be very specific. Exceptions if someone doesn't use it and there are times when it will be impossible to use like if someone uses their phone and it will be a few days before they get there new phone. You have to register a device number with the phone. There will be times but it's going to be important. People figure this out now I'm not wait until January. I'm interested to know how it's going. I think I know how it's going at CDAS program but how is it going for the people? Is it new? Our their still people who have not heard of it to use the services and do not know what it is? I one point there were going to say DME providers had to use it but they did resend that. Is there anything that is or is it working? I think the CDAS clients are pretty disappointed this was some of the FMS [Indiscernible] that their apps are very clunky. Given the amount of lead-time they have does not where they should be, at least with some of the FMS vendors. We want to hear, how is it going for people?

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One thing that is really important and we believe is being underutilized is there is an exemption for live-in caregivers. A live-in caregiver is someone who lives -- provide paid care for the client and you live with them. Even if you are a family member and does not live with the client doesn't count. You have to be a live in

caregiver. You don't have to be a family member. It's often caregivers are family members. We did want this to be a mandate and if a lot of agencies do not allow it that we might [Indiscernible] legislation but at this point doesn't seem necessary because it seems most agencies that use caregivers or live-in caregivers are allowed live-in care -- live-in and all of the CDAS, FMS vendors are. They have to fill out a form and I think page will drop the link for the form in the chat. You have to fill out a form to do it. We are a little worried that either people do not know they can get exempted or that people might think they are exempted just because they are live-in caregiver. You have to fill out this form and get a process by either FMS or Your Agency to be exempted from using electronic verification. All that means is you do not have to sign in and out on the app. You have to still do timesheets. You are still limited CDAS to 40 hours. If you are a family member but we did want to make sure that people understood it, and then certainly last but not at all least is we're coming up on caregiver appreciation week, which is next week, in the governor has issued a proclamation. I believe Bonnie is going to play a short video from the governor honoring all of the people that provide care to people in Long-term services and supports. I know I tweeted something about it on Labor Day but those are certainly workers that need to be appreciated. I just wanted to take a moment to add thanks our behalf of myself, the staff and Board at sea CDC and I know all of my colleagues in the disability rights movement that we are so grateful to all of the people that provide direct care that make our lives work. Bonnie, again, will share a message from the governor in a little bit.

The other thing I wanted to talk about is the new assessment tool process, and that is not starting right away so right now the way the system works is there are all of these different ways used to assess people. There is the 100.2, the SIS which is horrible, and then there is a different, other systems have different ways of assessing needs, like an CDAS we had the pass sheet. There is all of this stuff all over the place, and it was decided several years ago there should be one way. You shouldn't have one system if you are one waiver to assess needs, when in another when needs are exactly the same, so a group that worked for several years of developing an assessment tool and a pretty top so not the kind of thing you would want to do every single year but it's also not so rigid like the SIS that if there is a change you couldn't redo it when necessary. We looked at what was off the shelf, what you can buy and we didn't like those models. They were very medical, didn't fit are values in Colorado. There was a dual from Minnesota what was closest to what we want too. We took that and adapted it. We work with some consultants who helped. That's done and there has been very, very small pilot seeing how it works. Before gets implemented there is going to have to be a lot of training with Case Managers and everything else, and advocates so everyone understands how this work. Then it has to be integrated with all of the back into systems. But the next piece is really important because the next piece is going to be come up with a way to figure out, so you do this great assessment, which turns into figuring out what you need and then that turns into a care plan. Somewhere you got to figure out how to allocate money, because it all comes down to money. That is what is going on now and there are a number of ways people can be engaged. And I think a link is going to go in there. I hope that I put a link in.

And the resources have to be transparent. We all know we don't have enough resources to meet everyone's needs. Okay, so then let's be honest and not say, we are meeting needs but then were going to make it so impossible to use services that people use services that we need budget goals. That's how it's been an we are not going to keep doing it that way. We well do things in a more transparent way going forward. This plan is person-center, which is what the Federal Government has required and something we want in Colorado. The change is, what got no more S IS. What's this all gets said and done, which is not tomorrow. No more different tools for different waivers. Number secret scoring of processes people do not understand. We'll be something everyone knows what it is. Everyone will be able to understand how to get from point A to B to C. It's a person-centered basis and not one-size-fits-all. This a question in the chat top what is the name of the Minnesota assessment? David is going to answer it, it's Minnesota something. Minnesota choices, thank you. Again, the advocates do have some concerns about this allocation process but we are actively participating and encourage others to participate as well. The only way we are going to come up with something good is if we all work on it and keep it centered on our Colorado values to make sure that we get a product that we can all live with, again, knowing that no one, at least for foreseeable future no one is going to get all of their needs met we can still have something fair and transparent, and that meets the needs copper example people on ventilators who absolutely cannot do without even for a few minutes, and we do the best we can for everyone else.

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Again, change is scary and information is controlled. We put in their, we really encourage people -- David put something in the chat that you can get a link off of this. We encourage people to look at the long-term care assessment tool and support plan. Go to these meetings, there will be a next statewide meeting in November to talk about this, and we all have the power. But we only have the power when we use the power. And so, just one final thing in terms of using are power. We have an election coming up. It's less than two months away now, and if you are not registered to vote you need to get yourself registered because how much of our needs we get met is directly related to holds office. And so, you got the power to educate yourself also. And in terms of how much federal money we get, if you had not filled out the census, please do so. You can go to census .gov and fill out the senses, because that determines how much money we get as a State and how much representation we get in Congress. Again, this is scary but just not paying attention to it doesn't help. What helps us all of us knowing is much as we possibly can about this. We'll take a lot of advocacy want this comes out to be able to explain this widely in our community. That's all I have for today and, thank you, very much.

Thanks, duly, so much. I appreciate that Call to Action, if you will, and usually highlighting the importance of good collaboration and development. All is important, policy work. And I will talk a little more about that later but if I do that I want to and it over to Dr. Lisa Latts, our Chief Medical Officer, to talk about clinical Advisory Committee. Dr.Lisa Latts, are you ready?

I am. Can you hear me okay?

Yes, good to go.

Never know. Sometimes I start -- start talking a to me did -- muted. Take you for giving me a few minutes of your time. I'm here today on a different topic for my usual topic. I'm not here to talk about COVID. I'm here to talk about a new Advisory Committee we are developing at HCPF and seeking public comment called, clinical evidence Advisory Committee or as we commonly say, to 15. The purpose of CEAC is to have a group of clinical experts that can help us determine what the medical evidence is showing and the strength of the medical evidence around issues of clinical safety, efficacy, medical necessity and utility. This would be for things that are new or unique or controversial, and so, the purpose of this group is to help us review what's in the medical evidence, what's the strength of the medical evidence from a scientific perspective, and then weigh in on if something has enough evidence that it has proven it's safety and efficacy. Or if something needs more evidence and at this time we would still want to consider it investigational. Is something has proven it's safe and efficacious, helping us to determine who would benefit from the service. I just want to add that the rest of our processes are all in place and this doesn't change the processes we already have.

Now if there is a new therapy that comes out, a new treatment, there is basically know robust process by which, we, as an Agency determine if something should be covered and under what circumstances. Comes to me as the Chief Medical Officer. I consult with our Clinical Team and would consult with others but there's no robust process. This puts a formal process in place for the front part and then once of the Advisory Committee makes it's recommendation something would still go go to all of the normal processes that we have with the policy team and the benefits team, looking at all of the other components of a particular service, equipment, physician administered drug, et cetera. The idea is this Committee will be cochaired by the Chief Medical Officer at the Department and the Medicaid Director. The Committee will be having on primary care. It will include four primary care physicians and two pediatricians, because potentially more pediatricians that they are part of the primary care group as well. Want to have two subspecialist, physical medicine and rehabilitation Specialist, and so much of our, many of our request are for DME and other like equipment. Somebody who deals with chronic pain. Somebody from the Emergency Department. Pharmacy Specialist, Dr. of Pharmacy, some of the Behavioral Health, and OB GYN, one of the representatives from [Indiscernible]. This is our initial thought around the makeup of the Committee.

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From a logistical perspective all of our Committee members must be licensed and must be in good standing with that license. I must also take Medicaid numbers. We are looking for people who are actively serving our members, serving our population and also population. The meetings will be public pick we don't know how often they will be pick if I were a betting woman I would say somewhere between every two months and quarterly. We will determine internally what topics to bring to the CEAC. That will be based on what we know is coming down the pike, what we are getting a lot of questions or complaints about, things that are making the process coming out soon copper example, than those will go to the Committee. We will present the Committee with a robust round of medical evidence that we accumulate, and then the Committee can also bring their own evidence. If there is a topic that requires expertise for a subspecialty we do not have on the clinic we will bring in subject matter experts to weigh in for Committee members. Again, this is just one component of the policy development process. It will go, it will still go through as I mentioned earlier. Everything else that is going forward before. I'm presenting this to you today because we are seeking public comment. We're seeking thoughts and suggestions of things to make this as robust and as beneficial as possible. I do want to emphasize the reason there are not member representatives on this Committee is it's intended to be a scientific advisory panel with clinician level providers since they are the ones who would be administering providing certain levels of s ervice. I am going to put in the chat box the link where you can give public comment. You can also comment in the chat box here but if you want to go to the link and give it officially, that would be great. We will also be available for questions if you have any questions at the end. Thank you very much. Bonnie, at turn it back to you.

Thank you so much, Dr. Lisa Latts. Next we have sister State Agency, Department of Public Health and Environment from Mel Rossin.

Thanks. I would like to start with surveyor testing to enter the help and safety of the residents whose staff in the Healthcare Communities, are division, health facilities an emergency medical facility -- services is now testing all of our program surveys -- surveyors every two weeks with 24-hour turnaround on the test results. We're also testing all of the life safety code inspectors at the division of fire prevention and control at the Colorado Department of Public Safety. We have three testing locations. One in Pueblo, one in Denver, and one in Grand Junction. As part so far everything is going well with that. EM resource next week I think I'm going to start providing you with a little bit of statistics and information as to what we are finding. I think that will be of interest. We are having increased participation in EM resource. As you can see we are growing in participation levels. We are going to start to contact some of the Healthcare Communities and organizations that are not yet participating to remind staff to report information daily. We are also able to provide technical assistance and I will put that address in the chat box. I think it was on the last slide as well. It's just probably going to start with an e-mail just reminding folks to participate per the public health order.

We're using the information to develop reports related to PPE and other supply needs, staffing needs, and to identify health communities that have open beds for COVID-19 positive patients, as well as COVID free residents. We have been using that data routinely. Recently we started to ask more questions about testing resident, how you were doing it, and at where you are getting the test process. We realize that we have increased the number of questions that we are asking routinely, and we are evaluating them to determine if there is a way that we might be able to combine a few of the questions. With certainly received some concerns and complaints about the frequency of reporting requirements. We say, please, report as frequently as you can. We also know that these folks say there [Indiscernible] doesn't change daily, and so, as long as you log in daily and review your information you don't have to change your information on a daily basis if it hasn't changed. I think that is all we have. I guess, the other thing we had was the Disability Community. We have heard from some providers that are having trouble getting logged into EM resource using the formula that we provided. One tip that has been successful is dropping the 0 in the front of the facility ID. For example, if the ID number is 05431, if you drop off the first 0 that sometimes has helped people with success getting in. We are happy to help anyone, and please feel free to contact us.

Thanks.

Thank you so much, Mel, we appreciate the update and good work in progress, especially on what you have led. Thank you for that. Next slide. I want to talk about some of the work underway within the office of community living not related to COVID, but that it's so important that we continue to move forward even though we had [Indiscernible] one bucket of work is Case Management redesign efforts.

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This work really started in earnest in 2014 with recommendations coming out in the community advisory group where they really set the stage with a variety of recommendations designed to to improve and simplify access to Long-term services and supports for people with disabilities, and to break down silos that existed our system, and to improve the stability within our system by removing subjectivity and replacing that with objectivity in our assessment and case management tools to the extent we were able to [Indiscernible]. We have undertaken a ton of work since 2014. Of course, I would be remiss if I did not also mentioned also in 2014 are federal partners at the Centers for Medicare & Medicaid Services finalized a rule that required complex three case management system. It's a separation of service provision from ongoing active case management as a federal requirement. Of course, when our system here in Colorado was built comprised of community centered and [Indiscernible] point that wasn't a requirement.

It really requires us to work collectively as a community to figure out how we best untangle the system that has been mailed dose build, how we make sure we keep the great things about our system while also really inspiring where we want to be for the next 50 years, if you will. How do we inspire our work to do something great? On the left side of this graph we have highlighted policy and program work underway to redesign how case management is provided. We're working on creating a system where members have one place to go regardless of what particular home waiver. This will make it easier for them to navigate so with less silos. Right now you might have a member who believes that the waiver for persons with developmental disabilities is the best program for them only to really, perhaps, had their needs a better met within the elderly, blind and disabled waiver. Eligible for both. Right now they may start out was community-centered Board but end up having to go to a [I ndiscernible].to get the needs better find out more about the other waivers. Todo that we are planning to send out a request for proposal for all Case Management Agencies. Case Management Agencies will be required to serve all 10 of our home and community-based waiver programs, and member experience is driven by goals, preferences, rather than the specific waiver that they might fit into. The Request for Proposal or RFP process will increase, hopefully, the consistency, accountability and quality across the system. It's our hope to bring more standardization to how long-term care is accessed in Colorado so that if you are a member say in [Indiscernible] County that your experience is very similar to a member who resides in Boulder County in terms of the standardization and what is required. It will also be a significant amount of Stakeholder Engagement dedicated to the left side of this graphic, the program and policy changes. We hold that the value really is the inside of the people who receive services, their family, brands, community and providers that support them.

That is the backbone of our system and it is with direct insight and expertise we create the best policies. A lot of that work is underway and we will find out more here and just a second. On the right side of this graphic on the infrastructure changes. We are implementing a new care and case management IT platform, too streamline processes and increase efficiency for members a Case Managers. This IT platform will create the technology to really actualize the new assessment and support plan Julie talked about in her presentation. That is the by-product of many years of deep work from both part of the Department, but also I know many of you that are on this webinar and our stakeholders, there was a lot of work done to create what we believe to be one of the best care assessments out there nationally, one of the most person-centered plans out there nationally. Our goal is to make this a comprehensive and objective as possible to help best identify what are some of the actual gold, those goals goes preferences and needs. All of this work is the culmination of leading to having a person-centered budget algorithm process. That is built on a new more robust assessment tool. As we move to the next slide I will speak a little more about that individualized budget.

First let me talk about the assessment tool. Like I said on the last slide, after years of development with stakeholders the new Long-term services and supports assessment and support plan are being finalized. These tools will provide a much more comprehensive assessment to inform eligibility and person-centered support planning process. And it will be used for all programs and all people accessing Long-term services and supports. Thus eliminating the need for most other existing tools. Right now in order to get access to services somebody might undergo up to 30 different assessments to get the services that they need. Our hope is to mitigate that wherever possible and to really create a single assessment that will help inform what services our most appropriate. This whole process will be far more objective than the process we have in place now. We have some gray Case Management Agencies and some gray Case Managers but they need to have better tools in order to do their job. This takes a lot of the subjectivity that is embedded within our current process. We are currently incorporating the new tools in our care and case management IT platform that a mentioned earlier, and the plan to implement the new assessment and support plan within the carry case management platform is really to try to launch that by July 1, 2021. I think you will see in this next year to two years, really, combination of the last five years. These are long-standing projects.

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Why a person-centered budget algorithm? As part of a new assessment a person-centered process, this new individualized budget will help identify the right amount of support for members based on assessed needs, and together with strengths and preferences identified during this assessment. This will contribute to a person-centered support plan. Of these individualized budget are an important component of assessment for the planning process and will ensure a consistent method for assigning budget across all members receiving home community-based services. Right now the process is very different if you are can't say, in Supported Living Services waiver versus if you are enrolled in elderly, blind and disabled waiver. This will certainly bring some cohesion and consistency to help funding is allocated across our system. The person-centered budget algorithm is, really will be built on the New Assessment Tool Alona Beal don't be built on the other tool including support and intensity scale. There is a lot of school we would be leveraging that tool and that data. Astutely mentioned got this really was built from scratch to reflect Colorado's values and needs as an objective, perspective budget methodology and we'll be used for all of our programs, breaking down the silos, if you will. A methodology like this is used in about 30 other states, and so, while the person-centered budget algorithm will help determine the members resources, [Indiscernible] only determinant of resource needs. It's a tool in the person-centered toolbox, if you will, along with information gathered as part of the information process.

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I'm going to tell you where you can get more information or how you can plug into this engagement as it moves forward. Here we have webpages for the Long-term services and supports assessment support plan. We have Web page for the person-centered budget algorithm. We also have a Web page for the office of community living Stakeholder Engagement were all of our engagement is posted. Certainly if you haven't, I encourage you to sign up for our constant contact e-mails. We hosted this week a series of statewide meetings. The next one will be in November. Again, if you are interested I want to offer your insight and expertise too this there are avenues for you to do that.

Next slide.

In other news I want to echo some of the information Julie shared around Electronic Visit Verification. On August 3rd we did our soft launch of the electronic very -- Electronic Visit Verification mandate. It is right now today required for all mandated services. Despite that we are only having less than 40% partition -- participate in rate on the part of insiders does providers. It's concerning to us. We're just looking for good faith effort from providers, not perfection. We have training available. There is a link on the slide. It certainly must be completed prior to EVV use. The important part about getting into the system now is claims will continue to pay and errors will appear so that we can identify t hem. If they are sending bumps in implementation now when there is and a financial hardship or a consequence, if you will, associated with it, it's time to start get in

there doing this work. Beginning January 1, 2021, same for Electronic Visit Verification system will be required. Services without the corresponding records will deny and providers will not get paid. We are learning from our past systems launches, trying to give ourselves as long of a runway is possible to make sure that we get this right and that there is an a huge impact on our providers, especially given the current State of the pandemic. I know this call is targeted towards Disability Community but I want to make sure we're elevating the issues for you as well, especially for those [Indiscernible] care. You are very much engaged on what is happening with Electronic Visit Verification, but we definitely want our providers to sign up and work at any kinks now rather than waiting until the January 1st day. Is to -- duly mentioned there is exemptions for live-in caregivers and it's outlined in this slide. They can complete the attestation form also threw a link on this slide. We're surprised to learn there is a low percentage of CCDC does live-in caregivers requesting exception. Again we want to make sure from an educational standpoint that live-in caregivers understand this is out there, it is available. Colorado actually delayed implementation so that we could build a system that would allow for this exemption to a, and so, if you are interested in that certainly work with your Agency. Is duly mentioned those agencies are allowing it. Certainly not all of them are and it is up to them at this point to decide if they want to allow for a live-in caregiver exemption or not. Please make sure to work through the kinks now and having the discussions now and not waiting until the January 1st date.

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Next up I want to remind folks. We talked about a couple of months now engagement around how do we take some of the temporary changes that we have made in response to the pandemic and make them more permanent? We had two areas were focusing on from a benefits perspective pick the first one is around telehealth. The second one is around a programs services. I want to remind people that telehealth and home and community-based waivers our different than telemedicine and our health first Colorado health plan. There are two initiatives within the Department to provide virtual service delivery options but with different approaches. Telehealth is available in HCBS Waivers to our federal approval CMS list of K applications. The Department is working to ensure we can continue to offer telehealth through HCBS Waivers after the explanation of the [Indiscernible] K which now as a reminder slated for January 26, 2020. This would include CMS is approval through waiver action. We actually have to our current HCBS Waivers, we would need to promulgate regulation to the Medical Services Board process. We would need to look at our rates and our systems development to make sure we do not need to change our system or rates. And then, of course, we need to engage stakeholders which is why we are asking the disability community to provide us with FEMA. The next meeting on that is slated September 15 from 1:00 to 3:00 p.m. There is a link again to the OCO Stakeholder Engagement so you could buy details about that should you be interested.

Next up we have day services. The Department is pursuing permanently modifying our day program services across all HCBS waivers to allow for day program services to be provided in various ways to better meet the needs of HCBS Waiver participants. We recognize that the virtual delivery would work well for some members outside of a pandemic setting, where we could offer flexibility and we are working hard to do that. Day Program stakeholder engagement opportunities are being divided into two groups. We have adult day service stakeholders and day habilitation stakeholders. As a reminder, the adult day service stakeholders are for day services that are offered to our elderly, blind and disabled waiver. Our brain injury waiver, spinal cord injury waiver and Community Mental Health support they waiver. Our day habilitation support waivers over day services offered the waivers targeted to people with Intellectual and Developmental Disabilities. The services our different and how they can be built for our different. At this juncture were separating out those engagements. Each group will have two opportunities to provide comments, suggestions, as questions as well as review potential waiver application and regulation changes. There is a link in this slide to an informational memo outlining the date, times the meeting details. I will not spent time at our webinar today going over those in detail, but if you do want to offer your insight and expertise to help inform that work, please click on the link. We certainly look forward to your participation.

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I know, again, this is a webinar targeted to the Disability Community but I wanted to put this up because the deadline is for real happening this time. The Health and Human Services or HHS has again extended the deadline to apply for these provider relief funds to September 13th. If you are connected to a Private Pay or Medicaid certified, Assisted Living got memory care community, please ensure they consider applying for this general distribution. Our health and human service federal partners announced last week that Private Pay, Assisted Living operators are eligible. That non- Skilled Nursing Facilities Medicaid providers are also eligible, but the fairly, believable word on The Street is that will not extend pass September 13, so this is the last time it will be extended.

Last -- next line.

Governor Jared Polis announced September 6 through 12 is long-term care worker appreciation week. Early on in the pandemic we saw hospital workers being elevated as he Rose in the pandemic. That certainly was appropriate. We also saw that did not receive quite as much attention is the fact that COVID really was disproportionately impacting people -- all the people with disabilities and certainly in addition workers in the hospital, long-term care workforce really has shown up as he Rose in this pandemic. They are an amazing workforce outside of what has happened the last six months. Very fitting for Governor Jared Polis and very appreciative of them making this long-term care worker appreciation week Rick I would like to play the video from him directly. I want to note that if you called in to the meeting will not get a video. You must here through your computers. If your mute your phone and unmute the computer or put it directly into a different chat. With that I will let Jen pushed play.

[Governor Polis video] - But the COVID-19 pandemic has been devastating worldwide in Colorado has not been of you. Thanks to the hard work of Coloradans across the worked things are looking better in Colorado compare to our neighboring states. Despite it's I Coloradoans who aging of those with pre-existing conditions, Long-term services and supports in these populations are vulnerable to COVID-19, and many living, you could care caregivers continue to do what you do best, take care of people. As [Indiscernible] evolves it's been the direct care workforce that have been key to implementing changes that save lives, want to personally thank everyone of you who is working hard to do your best to protect and care for those in your chart. Cleaning and all making staff continually disinfect every service to dining step to prepare and serve meals wearing gloves the mascot personal-care workers, certified nurses who wash and regularly, wear gloves and live database directed too absolute minimum to others minimum to others and others and to monitor basis to look for symptoms of COVID and Administrators overseeing implementation of infection control measures, you are all making a difference. You are saving lives. You are getting back to normal quicker rather than later. I want to encourage anyone interested in Jordan is workforce to go to Connected Care jobs.com. If everyone does our part we can reduce the spread of this deadly virus. We must continue to remain vigilant. Washing hands, Learning services, limiting close proximity face-to-face interaction then wearing masks, let's keep on keeping on! [end of video]

I know that many of the people on this webinar echo but Governor Jared Polis just stated during his YouTube video pick we will make sure that the link to the video is also included in the chat. If somebody could put it there. Would encourage you all if you happen to be a provider on this call, please share this. If you [Indiscernible] please be sure that your attendance see it. It's very important that long-term care workforce understand that even at the very highest level of State government that the workforce is seen and appreciated. In addition to the YouTube video there is actual proclamation. We can also put that in the chat, would be great. Sincere thanks to Joss Winkler, who in his new role in the governor's office helped to spearhead this effort and moved to permission. Please share with your team, again, if you are a provider or self-directed, very important that this coveted workforce is recognized and appreciated. If we can now move to the next slide please.

I just checked out the chat box and it looks like Colin Laughlin, Melanie and Ray and I've done a job, good job in addition to David Bolin answering questions. Much appreciated. It's great because we are running short on time. If we can go back to the webinar please.

Next slide.

Just want to again encourage you to stay engaged. Here is a link to our memos, webinar top and FAQs updated regularly. Certainly encourage you to work directly with the Colorado [Indiscernible] coalition with Julie and her staff. I worked weekly with Julie to understand key issues being elevated and how to make sure that we put these webinars together in a way that addresses key issues. You are also certainly welcomed to reach out to us directly. We do have a dedicated inbox for Covid related HCPF related questions. You will see a there. If you have not prescribed to receive updates I encourage you to do so. That means as we draft new guidance it will go to your inbox and you will not have to wait to hear one of us talk about it on a webinar.

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It is our hope that these webinars are a resource for you. Here on a single pages all of the memos that we of issued to date.

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We also have compiled a list of COVID-19 related resources that are really tailored specifically to Long-term services and supports. You can find at them on our LTSS COVID-19 Landing Page. Here is an arrow directing you to that link.

Next slide.

This is just a reminder if you need Personal Protective Equipment to continue to work through your local community Emergency Management, local public health department. If you have issues our sincere thanks to Sadie Martinez with the axis of functionally Coordinator to the office of emergency Emergency Management. Her contact information is here. She has offered to help problem-solve.

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Here is some key websites. I provided them every week for the last six months. The Center for Disease Control, Center for Medicare-Medicaid Services, the COVID-19 Landing Page which is the State Lead Agency on our stay covered response, local public health agencies, are overarching COVID landing page for HCPF. Now we have a new one. We have the residential care Strike Team that has a Landing Page. You can find the link there.

Next slide.

In terms of next steps, the Department, really across all of healthcare we are trying to understand what the new normal is together. We will have many conversations with stakeholders over the coming months and beyond in terms of what is the new normal. We are talking with Medicaid leaders, are peers across the nation to learn from their experiences and how to leverage there expertise. Our service delivery's STEM in a way members interact with it will undoubtedly change given our COVID experience. I think this is the telehealth medicine is a great example of how we see some lasting and permanent changes. I really appreciate your collaboration, helping us navigate this, especially given our current crisis we are facing. We very much appreciate the insights and wonderful questions that you all ask on these webinars. With that I want to remind you all of the new frequency. We are reducing the number of webinars starting in September. This is our first time. The next Disability Community webinar will be October 9, 2020, 2:00 p.m. to 3:00 p.m. We also have an all provide a webinar also held for LTSS Providers from noon to 1:00 p.m. In addition to that there is a deep dive programmatic webinar with HCBS and Case Management Agency providers that are held on the off week. Great opportunities to continue to engage in there. Of course is we're taking some webinars away we added one more on.

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We are now also hosting five weekly webinars on the cross-state Agency response on COVID and residential care setting. The strike team webinar. That is cohosted with Health Care Policy and Financing, CDPHE. Next meeting will be Friday, October 2nd, at 10:30 am. There is of the webinar link and the call in information. We encourage you to participate in that should you be interested.

With that, that is our presentation for today. Again, take you for spending time with us. Thank you for your thoughtful questions. My sincere thanks to Julie, Dr. Lisa Latts and Mel for their presentations today. We look forward to seeing you all in about a month. Take care.

>> [Event Concluded]