

## Experiences of Members with Disabilities in Primary Care Settings Public Listening Session Part 1 Transcript

This document has been lightly edited to make minor corrections to names or references.

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(Live Captioner standing by.)

SUMAN MATHUR: Good morning, everyone! It looks like some folks are still joining in so we will get started and just a short moment. Thank you. It looks like the folks joining our starting to slow down so I'm going to go ahead and turn it over to a Della from the department of financing to kick us off this morning. Thank you.

ADELA FLORES-BRENNAN: Good morning everyone hello, my name is a Della Floris Brennan. I wanted to take a few moments to thank you for being here this morning and for joining us for this important conversation. I hope that it is a first of more than one, that we can have this opportunity to hear from our community about how we can be making improvements in access for people with disabilities.

We are cohosting this with the department and the Colorado health Institute. Who will be presenting a little information about the accountable care collaborative which is how we administer care through the Medicaid program. They have been great partners in helping us conduct are state engagement. We will also be joined by my colleague John Berry who will help facilitate the agenda.

The purpose of today's meeting is to share some background information on our accountable care collaborative also known as the ACC and how we are planning for the future. We are currently in phase two of our care collaborative and we're planning for phase three.

Since we are in that planning process it is a really good opportunity for us to reach out to the community and understand from you where you have been seeing problems or gaps in accessing care and collect ideas for how we can improve access and disability competency under the ACC part three.

So, our agenda for today, first we are welcoming you. We would do this review of the agenda. We will do some housekeeping, and then just to bring everyone up to speed some history and background of the accountable care collaborative so you will have a good understanding. We will talk about how we are moving forward and some of the plans that we currently have or ideas that we currently have for phase three.

Then, we will take your questions. Any questions about the accountable care collaborative, and then we will move into a discussion and this is really your opportunity to share with us, your experiences, and any ideas that you have for how we can improve as we move forward.

I want to emphasize that this is not the last opportunity to share. There will be other opportunities both through the stakeholder engagement process with the accountable care collaborative, but also to other opportunities that the department is creating.

The other thing before we get started and I turn it over to John to do some housekeeping, I really wanted to thank our advocates and in particular Chanda Hinton for really advocating and holding the department accountable for doing this work. To make sure that we are making improvements and that we are engaging the community to understand how we can do that so that our efforts are member driven and more equitable.

So, much appreciation for your advocacy and for continuing to hold us accountable as a department. So, with that, I'm going to turn it over to John to go through some housekeeping.

JOHN BARRY: Thank you, Della, and hello everyone! My name is John Barry if you're wondering who I am I worked in the office of community living. We will be offering American sign language interpretation and live captions. They are available. So, please make use of them. I would be tracking the time for each agenda item. You saw the agenda before, I have those times written down on my little cheat sheet.

I will be making sure that we keep the time available to hear from you. Within that, we also hear from as many people as possible. We will ask for ACC related questions between 9:25 a.m. and 9:35 a.m. I will be using the speakers queue at that point and then during the later discussion.

De speakers queue, or any of you familiar with it? It's really simple. It's a way to gather names so that we know who wants to speak in the way that you get your name into that queue, is go to the reaction button on the bottom of the screen. Click that and then click raise your hand. If you change your mind you can click, lower your hand as well.

I will be tracking those, they pop up on my screen in the order that they came. I will make sure that I call on everyone as time allows. We have a lot of time later in the meeting. Everyone will have up to 2-minutes. So please be prepared to make your point or comment in 2-minutes.

We are asking people to have one comment or question part-time that they actually raise their hand. I will be giving -- jumping in as delicately as I can give you a 15-seconds alert to say, you have 15-seconds left. If that seems a little abrupt, my apologies beforehand.

It is really important now, especially giving the content of this meeting that we ask you to really avoid -- making any statements that will give any PHI which is protected health information, or PII, personal identifying information. We are looking for experience is in primary care.

I believe it's possible to do that without sharing the name of the patient. When that happens, I will pause the speaker politely, and I will ask to see if we are doing that and if we can stop doing that. With that, I just want to say that I will do everything I just said as well as I can.

I make mistakes, I will be tracking people raising their hands, I would do that as well as I can. Please bear with me. If you want to make follow-up comments you can always get yourself back into the queue. We are hoping to hear from everyone in the meeting. So, that is the intent.

All right everyone, thank you! And I will talk to later.

SUMAN MATHUR: Thank you, John. Thank you, and welcome everyone! I think you heard from you shortly at the beginning. My name is Suman. As a Della mentioned my organization the Dorado health Institute or see HI has been working with the department to talk to folks across the state about the phase three of the ACC. While I'm certainly not an expert in all things HEPA or all things ACC, what I'm here today to do is to provide some context about what it means when we say ACC phase three.

On what to provide some background and share a little more information about this process. Then, we will pause to take some questions, any clarifying questions you might have about ACC phase three and then we definitely want to leave plenty of time for some discussion at the end of our conversation today.

The accountable care collaborative with or the ACC, is responsible for a few things. The first is that the ACC is really the delivery system for cost-effective and quality healthcare for Colorado Medicaid members. The ACC, the system here in Colorado that is responsible for coordinating regional, physical, and behavioral health services.

To really make sure that members have access to care that is appropriate in their region. So, we note that many of you will likely have comments and questions around this but again, I just want to keep in mind that this is really the role is to think about, how this looks at a regional level here in Colorado.

Some of you are likely familiar with something called a ray or -- regional accountable entity. The RAE's are really what the -- looks like here in Colorado. The Rae's have a few different rules. The first is to build a network of care providers. To do this, raise contract with primary care providers or PC MPs within the region to make sure that those services are offered.

They also contract with behavioral health providers and administer something known as a capitated behavioral health benefit which is partially the payment system. The way the dollars go to behavioral health providers to cover the cost of the care they provide.

The Rae's also provide care coordination, care programs, in case management. This might look a bit different from the Ray to the Ray. In some regions some the Rae's do this himself while others might contract it out.

The Rae's also assist with practice transformation. This means that they work with providers that are within the region to help them think about ways that they can improve their practice. That's might be things like integrative care or making sure that they have appropriate technology, but this is just another thing that they are doing is help support Mary care practices.

Though, they have a certain number of resources to help support this. Finally, and I apologize, these are all ranked number one here on my slide. The last bullet for the last point that I want to discuss here is that, they respond to local community needs in order to best support Medicaid members.

Sometimes we think of the Rae's as being the eyes and ears on the ground. And are able to respond to needs in their communities. This is what the current system looks like here in Colorado. Again, we have a regional system here so their are currently 7 the raise or reasonable -- regional accountable entities. Illustrates how these seven entities are broken down here in Colorado.

I won't get into the detail of the specific counties within specific regions right now but just again, want to emphasize right in our current system is set up so that there is seven regions. I want to share a little more background before talking a bit more about phase three. The first piece I want to clarify is, what the department of healthcare department in financing relationship is to raise providers.

HEPA helps with these administrative pieces that raise are responsible for. Eight CPF rule when it comes to doctors offices directly reimburses a physical health providers with a fee-for-service payment. RAEs has contract with health providers in which they reimburse health providers for there services. Rae's also has contract with physical health providers where they pass on some of that p.m. p.m. money to providers and they can also be a little innovative and think about ways to provide bonuses or alternative payments to providers for achieving certain goals.

I recognize that this is sort of a complicated payment structure but I think it's important to recognize that there are different tiers here. Now, I would like to talk a little bit about what it is we mean by phase three. Phase three of the accountable care collaborative is really referring to a new contract that are going to go into effect between the department or HCPF or the Rae's. That will happen on July 1, 2025. Right now we are in phase two.

Phase three will go into effect in July of 2025. That might be a little ways away but there's actually a lot of work that needs to happen before now and then and a lot of that involves talking to folks like yourself. Many of you I think a person participated in many of our discussions as well. Right now we are listening in learning from folks who our Medicaid members who are providers, who are family members and caregivers, to really understand what is working well in the current phase two system and some opportunities for improvement in phase three.

This information will help inform something called a request for proposal or an RFP. That is basically the applications that the new RAEs will have to fill out to have their application judge. It's for determination as to whether they will be a ray in phase three. Soon we're going to have some more information on the department in terms of -- some of what they are learning and what they're thinking about for phase three.

That will go will to inform what is in the school box here on the screen. I'm displaying a timeline that illustrates some of these steps between where we are currently two when phase three goes into effect on July 1. There's a gold box that outlines a proposal that will be coming out in November of 2023.

After that draft Request For Proposal comes out we will talk to folks again and get more feedback. We will see what's missing, we need to be clarified, what people's questions are. Then, the department will release the actual, formal request for proposal next April of 2024. At that point, applications or bidding are open and that process will take us through next fall when those awards will be given out.

Then, of course, there would be a lot of work to be done to make sure these rays are ready to go live July 1st of 2025. There are a few considerations that the department is keeping in mind as they are building and thinking about creating phase three. One is to build on the strengths of phase two. We are here today to hear feedback and to hear about your experiences. After a while we surely know that some of those experiences may be critical or more negative experiences, it's also really important that the department understands what is working well.

If there are strengths in the current system that you think are absolutely important to continue, we want to make sure here about those too. We have that many of the advocates and members joining us today have been part of these conversations for years and years. Certainly, that input you have been providing over the years is going into consideration as well.

We also know that there are other state agencies that are coming on board or who are also doing really important work to improve the health of Coloradans. Thinking of the work of the ministration as well as others. The department wants to make sure that they are being good partners and thinking about alignment.

Not just from the state level but really so that members in providers are able to have a more streamlined experience when working through all of our different systems here in Colorado. Identifying opportunities for improvement are obviously a very important piece. The department has been focused on a few priorities to really think through this next phase -- phase three.

That is some of the information that will be coming out in more detail some of these concept papers and other materials. I'd say the most important piece is that we really need your post. We are grateful for everyone for joining us today and those of you who have joined in previous sessions as well.

Before we close for questions I just want to share with some of the high-level goals are for phase three. The first and perhaps one of the most important here is to improve quality care for members. Part of

that involves thinking about what does quality care mean to you? Those are some of the questions that we would love to hear some answers to today.

Closing health disparities and promote health equity I think ties into this first goal nicely. Thinking about improving care and access, let's think about that from an equity perspective. Improving care access. Improving the member and provider experience. Again, this is something we are really interested in hearing about more today. To think about how the department can be effective in reaching this goal.

Finally, there is an important piece around money in cost. How can those costs be managed so that members coverage in benefits are protected. And that providers are continued to be reimbursed for their work and the services that they provide. I know that was a lot of information. I appreciate everyone bearing with me through that.

At this point I'm going to turn it over to John to check our speakers Q around whether there are any clarifying questions related to the material I just shared.

JOHN BARRY: We are going to have some time later to talk about your experiences. For the moment if you have any questions about the ACC itself and/or phase three itself, you can go into the speakers Q are going to the reactions button at the bottom of your screen. Click it open and click RAEs hand. Looking for any clarifying questions or comments that anyone has about ACC.

Just about the speakers Q while anyone is making a comment you can always click to RAEs your hand. That won't interrupt them. You can always do that at any point. One more time, if anyone has a question or comment about ACC itself?

SUMAN MATHUR: Does ACC apply to both waivers HCBS or only Medicaid? I'm going to see if there's anyone from the department who is on that can respond to that. John, maybe you know the answer to this question?

JOHN BARRY: I do know, I'm a facilitator to person, I just play the piano at these meetings. I'm not policy person. It is a great question and Kelly, why don't we see during the course of this meeting if we can get the answer to that and pop it into the Chat. Does that sound okay?

SUMAN MATHUR: That sounds great. I think you, Kelly, for that question. Will see if we can get a response for you soon, so, thank you.

JOHN BARRY: With that, I think we can move forward. Suman?

SUMAN MATHUR: I am seeing another question. How does the ACC work with the CCB's or SCP's? I am similar to John in that I am a bit of a piano player in this world but Idella?

ADELA FLORES-BRENNAN: For those of you who don't know -- they are separate entities from the RAEs. The RAEs do make an effort to try to coordinate with the CCB's or SCP's.

SUMAN MATHUR: Thank you Adella, and thank you Deanna for that question. I see one question about how the ACC maybe overlap with the new behavioral health administration. I can share that this is something that I think a huge priority for the department to understand in phase three. Part of that involves a more clear understanding as to some of the roles of the BHA. What I can say, if you are on Medicaid your behavioral health services will still come from the Medicaid side.

However, it is important that there is that connection point if folks access behavioral health services through the BH -- side. So that connection is made and then secondly, the behavioral health administration will have some administrative oversight over behavioral health providers across the state including behavioral health providers that see Medicaid patients.

It's important that there is an understanding and communication from the administrative perspective as well so that when folks are Medicaid providers are setting up their systems, that they work for everyone. I would to see if there's anyone else from the department would like to add anything there?

JOHN BARRY: If there's any other comments now would be the time before we move forward.

SUMAN MATHUR: Adella?

ADELA FLORES-BRENNAN: Yes, the current thinking is that we would continue decapitated process or decapitated rates for behavioral health and then still continue with fee-for-service -- the physical health benefits without additional payment for care coordination.



ADELA FLORES-BRENNAN: Thank you, Sherry, for that question. And Adella for that response.

JOHN BARRY: Anything else before we move forward? These have been great questions so far. Anything else? We have questions in the chat, we hope people will use the speakers queue to jump in and speak out loud, that would be wonderful. Looks like we have no more ACC questions right now, Suman.

We move forward. We have a little more time because we are early. With the next session in the movie about hearing from you about your experiences and what I think of the Medicaid primary care system. The first question, is what are some of the barriers or changes -- challenges excuse me, that you've experienced when accessing care?

Then there is a sub bullet to that. The one that is highlighted. The one is the one we were focusing on at the moment. How can you providers improve your experiences accessing care? We are really looking to hear from you at this point and again using the reactions button at the bottom of your screen, click it, then click RAEs hand. (correction) raise hand.

We are wanting to hear about things that work, things that have not worked, barriers, challenges, and how providers can improve experiences. We have three people. Thank you. Please, I'm going to start calling on folks so go ahead and RAEs your hand if you are another person who wants to during like you. Let's start with Ginger Stringer. Ginger, thank you for being the first.

SPEAKER: One of the barriers I find is when people with disabilities, it's hard to get them into the doctor's office to start with. There is a list of things that you need to cover. There have been many times that I am told we can only talk about one thing and have to schedule an appointment to talk about the other thing.

So, if I have a list of concerns or things that need to be addressed with the individual with disabilities, scheduling, rescheduling, having multiple times especially for someone who has anxiety on top, and has medical trauma, it is very difficult and I've been told that it is an insurance driven thing that we can not talk about anything except for what we have scheduled. So, that's a barrier to be.

Because other things fall by the wayside. Because I'm not going to schedule, reschedule, in schedule again.

JOHN BARRY: Ginger, thank you so much. That makes sense and that's a great point to make. I will move us now next to Oliver. Oliver, good to see you in this meeting. You have 2-minutes.

SPEAKER: Thank you, John. My name is Oliver. Accessibility in the doctor's office. Anything from physical space to exam tables. X-ray equipment, all of that stuff I have definitely encountered barriers. Just having general access ability, that's my thought.

JOHN BARRY: Thank you so much, Oliver. Folks, before I move us forward to Deeann want to point out there's a response from Adella and Chat. Regarding a question that was asked earlier, you might want to look at it. Next up is Deeann major.

SPEAKER: I work with children and adults with intellectual in developmental disabilities. It's a very specific area but we do work with a lot of people with intellectual disabilities and mental health needs and I'm finding this gap were someone younger is on EPSDT and the community center board has is trying to find resources and has reached out to RAEs because there seems to be no providers.

We have people with significant mental health needs that are on the HCPF waiver but they can't get any treatment rather than going to an emergency room which is a cycle that doesn't work and is in productive. I was also wondering, I'm not that familiar with the ACCs, and trying in his presentation to understand more, my experience has been when I'm working with someone who is getting surfaces on a Medicaid waiver and we've reached out to the Ray -- I'm sorry the ACC, there's a circular conversation.

They say well, you need to refer that back to the CCB, then there's other times when we have wonderful collaboration. I don't want to duplicate services. I want to be able to use that service effectively, that's all.

JOHN BARRY: Thank you, Deanna. I realize we have a lot of time left in the meeting, I am sticking to the 2-minutes limit so we can hear from as many people as we can. Please, people who have spoken before you can jump back in the queue if you have another comment to make. Shayna?

SPEAKER: I work with individuals with intellectual and develop mental disabilities as well. I applaud all the comments so far. They are very applicable. I think we just need to emphasize that the actual access to care is our biggest barrier. When we have people who are looking for psychiatrists, they are not available. There's a long waiting list. They are not providing documentation which we are required to have per state relation.

There's a lot of barriers in place and I really appreciate Deanna's comment as well about just not being able to find the things we need. Even as simple as dental care -- is a huge barrier. For our folks, dental is one of the -- probably the most dramatic areas of care because many are very sensitive to that experience.

If we could just do something a little better about getting those things even doubt and having more care available for our folks.

JOHN BARRY: Thank you very much, Shanna. Folks, we are looking for more comments. We have one hand raised in the queue, please go ahead. With one hand raised in the Chat. Also, you can certainly let us know that you concur with someone's comment. You can RAEs and cupped her hand, say yes. Morgan?

SPEAKER: Thank you, I want to greet with everyone who was spoken so far as well. We encounter those barriers as well. We work with adults with intellectual and physical disabilities. I would agree that one of the biggest barriers is access to care as far as available providers who have confidence in working with our folks.

I think as far as psychiatric services that we brought up as well, we just don't have availability is first treatment centers that will take our folks as well. I really don't know what that care coordination should look like but often times as someone spoke earlier, I forgot who said this, are people wait in the ER up to I've seen six-months waiting in the ER because our regional centers are full and want to and the psychiatric facilities say --

We see this is a huge problem as well as far as accessing care in psychiatric care.

JOHN BARRY: Thank you. Thank you very much. We will move next to Chanda Hinton.

SPEAKER: Thank you, Barry. Sorry I raised my hand the Chat. Agreeing with a lot of things, I think availability limited providers. I think Limited providers obvious Lee then lead ability to accessing surfaces when upon arriving at any particular provider, if there's not physical access that is a direct limitation to getting care.

If you can get into the building but you are not able to get proper examinations on the treatment table, I think the limited time is very concerning and it can definitely feel for providers choosing to not have -- or

choosing to have limited time based on how much they may get paid. That is something we can work with on providers. As we get to all of those barriers, then and get into the room I think the lack of awareness around disabilities and our needs are then very hard to understand.

If we look through those particular steps in those ongoing barriers, we can often times just give up or go to the emergency as someone said. Over utilizing resources that are not really essential, then there are times where people don't access care at all which is then increasing the health disparity of the population overall.

I just want to share that linear model and with the outcomes are and I'm really grateful for the department having the conversation to improve this.

JOHN BARRY: Thank you, Chanda, very much. Next, we have Sherry. Please go ahead.

SPEAKER: Chandra theory fully mentioned getting to the provider. I don't know how that might work into a contract but especially in a rural area where it's 45 minutes just to get to the provider. This is a serious barrier. We will have situations where our consumers simply can't find one of the Medicaid transportation companies willing to get them there.

Even if they can get them there, the provider has given a 3:00 o'clock appointment, the provider's running mate, now they can't get back home again.

JOHN BARRY: Thank you very much, Sherry, that's really important point. So, we have no more hands raised for the moment. Suman, there has been some activity in the Chat. Certainly people can read that. If there's anything anyone wants to call out, usually can. I will call one more time for any comments about the first item which is the highlighted question, how can your providers improve your experiences accessing care?

Anything else on this? We could certainly come back to it is not like we are not going to be open to hearing more comments about that. I think things just blend together. Anything else right now on this first one? Suman, we will use to the second bullet, thank you. How can your RAEs, regional accountable entity, support providers in improving your experiences? Or those of whom you love.

Any comments about this one? You can RAEs your hand in the queue. We have one so far. Anyone else? Okay, please feel free to RAEs your hand at any point if you have a comment in this area. Shanna go ahead.

SPEAKER: I think we already kind of talked about with adding with the barriers are, what the gaps are. Which we need is that support to go in and be that actual bridge between those barriers. Help support and fix them. Communicate with people and really having our providers understand all the people that we serve in there current needs.

JOHN BARRY: Thank you very much, Shanna. Shannon Seacrest?

SPEAKER: Thanks. I sat on the member advisory committee for the CCHA which is my local entity and having done that I would say that most people don't even know who they are. Or what their purposes. I know they've done extensive outreach and is difficult to get their name out there. Again, it's not pointing fingers but I would say most people don't even know who or what array is and what their purposes. So that's the first thing.

When you talk about care coordination with talking about needing super Coordinators. For like my kid who was a severe need whether it's physical, emotional, behavioral, police involved, just as involved, things like that. Super coordinators. Also as far as a RAEs, I think there needs to be an awareness they hand out like a propensity to hand out a list. If you are in crisis, if you find them and you are calling them, these don't hand us a list.

The idea is that you need someone often times to hold your hand and walk you through it and make some of those connections. Do the warm handoffs because if you are reaching out, you don't know what you are doing most of the time or what you need or how it works, payment, PM PMs, you don't know that stuff. And if you are in crisis, you don't want to do it anyway.'S, that's it. Do the warm handoffs, don't just hand us a list.

JOHN BARRY: Thanks so much, Shannon. We have one hand up in the queue, again feel free to RAEs your hand

SPEAKER: I would echo what Shannon has just shared. I'm sure that the rate has done (correction) the Ray so it doesn't duplicate with the case manager is doing. I do have a question -- in case -- where the community center boards are going to be rearranging perhaps what areas they serve and they're going to be going to single entry points, there's going to be a certain case load size that certain entry point.

There's tremendous concern for there not being enough managers to handle the changing volume for some of these single entry points. What is the caseload number for a case manager who is providing this type of overall super coordination, like Shannon said, because these are very complex located, difficult cases. I'm wondering what is the caseload side? That's all.

ADELA FLORES-BRENNAN: I may have an answer to that based on what I heard yesterday during the children's with disability advisory committee. I understand I sought caseload number of one to 65. So it can be any more than 65. (correction) can't be any more than 65. I will confirm that but that is what I recall hearing yesterday during that meeting.

JOHN BARRY: Thank you, before I move us forward, I just want to say the end referenced case management redesign which is a huge project and efforts like ACC, multiyear, if you don't know about it or haven't heard of it, I will try to get a link to that page into the Chat before the meeting is over.

Failing that though, because I'm doing the queue here, if you go to the department website and type in the search bar, case management redesign, it will pop up that page and you might want to check it out. It is very important and a lot of work going on there. A lot of stakeholder input. Chanda Hinton?

SPEAKER: Thank you, John, this is Chanda. I want to go back to what the providers can do to improve the access and I think there is often -- words I'm not the doctor for you. I think there's a lot of information that comes for that. For me it's when providers and not the doctor for you it's limited around disability or expanded to disability and I think we could maybe go into ways of, why is that existing for providers?

Answer the question in terms of why they feel they are not adequate to serve people with disabilities. A lot of them will say I'm not educated enough, expertise, there's a level of services that can be provided. I would love providers to come forward and advocate for their needs. A little bit more. We have the systems in which providers are inside of.

I really open up that opportunity or request that opportunity for providers to come forward and really ensure that they are advocating for what they need in order to serve disabilities on Medicaid. We understand that Medicaid is limited funding in the person with disabilities take a longer time, we need to know what that barrier is for them so we can really start to address it.

That would be my primary recommendation on that area.

JOHN BARRY: Thank you, Chanda, thank you, very much. Shanna?

SPEAKER: I appreciate the last comment very much, thank you for that. To go back to case management redesign, I know that's not necessarily what we are talking about here. However, it's going to impact greatly the access into care. I know it's supposed to be more person centered, I'm finding that it is not.

A lot of people are feeling like they are being left in the cold. I know as a -- we are feeling like we are not receiving our information quickly enough to be able to then go find care. I have a lot of concerns about this case management redesign and how that's going to look in this process for our people moving forward.

JOHN BARRY: Thank you, very much, Shanna. Oliver?

SPEAKER: Thank you, John. Again, this is all over. Somebody mentioned earlier I like Chanda's comment about providers advocating for themselves. I think also that the RAEs can provide some accountability in hold our providers accountable for some of these service gaps. For example, excess ability issues.

I've asked that the RAEs can get back to the providers.

JOHN BARRY: Thank you, Oliver. There's a link in the Chat if you want to grab that. Morgan?

SPEAKER: I just wanted to speak out on the provider side of things. I'm currently an associate director of nursing for people with intellectual in developmental disabilities. I am school of see you for psychiatric nurse practitioner. Through my experience, this is my third degree. There isn't a lot of teaching as far as working with people with intellectual and his abilities. I think it's a huge barrier as far as providers being able to provide Access. I don't know if that something the RAEs can do in improving the experience as far as, here's some training. Peers person centered care. I am often educating my colleagues on this type of care.

Secondly, a suggestion is financial access to be able to provide those simple things so people can remove barriers and often times we go to primary care offices in the provider doesn't even have a wheelchair scale so we can't even weigh the person. We are providing -- how are you providing the type of care for

someone with it the necessary means to deliver it? That's my experience from the nursing side of things that I have seen.

JOHN BARRY: Thank you, very much. It seems like we are having a bit of two conversations here. One in the Chat and one verbally in the main meeting. I would ask you if you can, and are willing, please bring your comments in and speak them out loud so we can all hear them. Chanda?

SPEAKER: I wanted to agree with, all over, on that enforcement piece. The race, the department, I see this as an amazing opportunity for us to be looking at those particular contracts in the sense that what is the RAEs ability to have it in their contract with the department in terms of what they're doing enforcement or accountability around.

I'm in agreement with that I just think there needs to be an additional level of accountability. I'm thinking, what is that accountability live? That would be really great opportunity to identify those pieces.

JOHN BARRY: Thanks, Chanda. Folks, again, reminder. Join the conversation, RAEs your hand, get into the queue, we appreciate it.

SPEAKER: One other comment about the RAEs, as a provider, when the RAEs are all named something different in all the different counties, it's like CCB's, they'll have a a different name. It is difficult for parents to know where to go. Especially when they are all called something different and you don't quite understand what they are doing anyway. I think that might be something to consider.

JOHN BARRY: Thank you very much, Ginger. That's an excellent point. Sherry?

SPEAKER: I'd like to quote the nurse that I know who worked for many years and then became disabled and she said, after becoming disabled, if I knew then what I know now, I would've been much more empathetic. You cannot teach people how to live with a disability. Only people who are living it know how to live with a disability. Only people who are living it know how to live with neurodiversity and so on.

I think it would really help providers if they had access to people who actually know what they are doing. What it is like living with a disability. I think that would be my suggestion, if the rays new to hire people



with the life experiences to act as patient advocates, to act as provider advocates to improve their ability to really connect with the disability community.

Maybe using that model. I don't think we can require half but using that model to help the RAEs increase their diversity in hiring would probably really, really improve the situation.

JOHN BARRY: Thank you, very much. Again, folks, please join the queue if you have a comment to make. We really appreciate it.

SPEAKER: Thank you, John. I just want to bring up that I've been hearing a lot about community center boards, single entry point providers, case management agencies. The case management redesign. Also, community first choice is also rolling out which is supposed to be -- is going to change the way the waiver services are developed And implemented.

I want to encourage the department and the RAEs to have a lot of medication and coordination because when the salt rolls out it's going to happen right around the same time. I can foresee a lot of potential lack of understanding and a lot of confusion, I can see that coming down the way. I really encourage everybody to really coordinate and make sure the message is coming from a central point.

JOHN BARRY: Thank you, Oliver. we currently have no more hands in the queue for people to make comments. People are chiming in on the Chat. It's important to know the sentiments of the group. Anything else? Now's the time, folks. We really appreciate it. We like to hear from more people if you haven't made a comment yet. Adella?

ADELA FLORES-BRENNAN: I just wanted to get back to the question about caseload erasures. Did confirm that case management agencies are going to have a one to 65 ratio. There's currently no no racial planned for the RAEs moving forward. We talked about how we have a draft RFP coming out, your welcome to comment on that, and we are appreciating all this feedback.

JOHN BARRY: Thank you, Adella. Anyone else, folks? We have these two questions. The second one is highlighted but so far, these questions really inform each other so could be either one. Any other comments or thoughts at this point? DN?

SPEAKER: Thank you for confirming it was a one to 65 ratio. I know that they are looking at one to 65 as a baseline and when this change happens they would look at possibly reducing that caseload ratio but being such highly complex cases I would really hope that that ratio is much, much lower. Adult protective services has believe a mandated ratio of one to 25.

From the trainings that I have attended because they are such complicated cases I think it's very difficult to do them justice when the caseload is one to 65. Understand their looking at that as a baseline but I would hope through the RFP process that is not the ratio being considered. Is my personal experience.

JOHN BARRY: Thank you, Deanne. I've asked Cody to come on. It's sometimes hard to listen verbally to the audio and also follow the Chat and vice versa. Trying to have one conversation. Cody, thanks for coming out, please go ahead.

SPEAKER: For those of you who don't know me my name is Cody Hickman I'm an adult support specialist from the office of community living. I actually get to work on his cases on that side of things. What I was saying in the Chat and what I wanted the group to know is first and foremost, thank you so much for being willing to share your left experience with us because we just don't know -- we never want to determine the needs of the community.

Only ways that we can get everybody to those. In that vein I wanted to share that we currently are developing thanks to ARPA the American Rescue Plan Act. A disability cultural competency for behavioral health providers. More or less building off of a co- occurring that came out during the behavioral health task force. That's a lot of words. More or less was driven by stakeholder engagement. Personal with lived experience or those organizations who represent those persons.

It is very much from the perspective of the community. It was a report that summarizes how they defined cultural competence. The importance of adopting surfaces and supports so the clinicians known for providing the services isn't a matter of a political specialty.

As someone mentioned, I'm not the doctor for you, rather that these are cultural competencies that every clinician needs to have to provide the services. They just don't get a lot of training on this when they get their degrees so they don't know, what they don't know. This training that we are developing is going to providing this cultural competence.

Again, informed by people with lived experience. Best practices from the experts and we are going to be making this available to all behavioral health providers. And all honesty, we are looking at a much wider

audience because we think everybody ought to have some of this information and as this comes to be, we will let everyone know.

JOHN BARRY: Thank you, Cody, thank you very much, sir. There's a bunch of information in the Chat including a link to the report, so thank you very much. Again, a lot of activity in the Chat. Let me check in with Suman.'S or anything you want to mention?

SUMAN MATHUR: Some really great comments. Chanda, thank you for your recommendation that you put into the Chat. We will make note of all of that. It is specific to some criteria thinking about monitoring and reimbursement.

JOHN BARRY: Anyone else at this point was a comment? Especially anyone who has not spoken yet we would love to hear from you in the meeting. In the meantime, Suman, let me call on Chanda in the sec here. We can jump back to the previous one, folks, no problem. Chanda?

SPEAKER: Thank you, John. I wanted to thank Cody for sharing that feedback. I would recommend that the department look at a lot of education and criteria that is existing already. What I continue to see is a lot of grants and dollars going to these types of efforts. There's a lot of curriculums out there but we all keep creating more and people are not taking the ones that currently exist but we continue to spend money on developing more. I throw that out there as an opportunity to take in what is already there in addition to what you might be developing.

JOHN BARRY: Thank you, very much, Chanda. Folks, the final question and again these questions to blend together, we recognize that. What are some best practices that you have seen in the community that you would like to see replicated? Any comments along those lines? Responses to that? Anybody?

SPEAKER: Thank you, John. Spinal cord injury clinic they focus on having disability competent care and they give us longer time to meet with our Doctor and they are very aware of some accessibility issues and I think if that could be replicated I know a lot of people don't have the resources but I think it is a good model.

JOHN BARRY: Next up we have, Sherry.

SPEAKER: To follow up on that, a brain injury alliance called Prado hired mental health counselors with specific competence in working with people with brain injury. One of the big issues with a severe

disability is that it affects you emotionally. It affects when you have a major loss of self and you have to deal with that as a mental health issue. Since many of their consumers couldn't get that kind of competency Adam medical health facility they just hire counselors that can do that.

JOHN BARRY: Thank you, Sherry. Ginger?

SPEAKER: I think in Colorado Springs, there's a developmental disabilities health clinic that is incorporated into fairly qualified health center or entity. I think the model of that is great. In having doctors that you feel a passion and competence to serve individuals with disabilities. They also have the mental health component within that same office.

They have extra time, they have a wheelchair scale, their sensory room for waiting table. But for implementations into that the difficulty is, the doctors that have been there have come in gone. They think it is a great model, it just needs to be supported more so to support the doctors that come in and devote that kind of time to those entries.

JOHN BARRY: Thank you, very much. Again, we really appreciate all of these comments today. Very thoughtful.

SPEAKER: I have often found that one of the biggest barriers to comprehensive, medical, mental care, is SSI or SSDI. That can be the biggest barrier is being able to access these waivers that are encompassing and much more supportive. I don't know if it is possible that if raised can get training so the Social Security penetration has special training to assist people to get SSI or SSDI quickly and is called the SO AR. Having people trained and certified in getting a SO AR through SSI or SSDI, they have a higher rate of awarding the benefit versus denial.

That can be the beginning point for someone who is experiencing homelessness or housing instability. At least having that knowledge that that is a possibility and perhaps having people specially trained or dealing with these complex cases because that is a big piece of the puzzle, that's my thought

JOHN BARRY: At the risk of being dumb here, SSI, SSDI? If you could just say.

SPEAKER: SSI is an entitlement program through Social Security administration. Social Security disability insurance is if someone has put in so many quarters of work history that is money that they have already paid into the system. So Social Security disability insurance and then SSI is the total amount of money

that someone can get monthly at this point is \$914 which is not very much but it has been an increase. There is programs that have run to the social cute security administration and many people on waiver programs rely on that as the funding source for the programs.

JOHN BARRY: That's the benefit I have in my position, I can pretend to not know anything. Which is often true! I'm going to: More time for any responses to the question that is on the screen. Best practices. Then I'm going to ask Suman to flip to the prior screen. Anyone else? Best practices that come to mind? And might be a thing, maybe a provider, it might be an area.

They only health equity clinic that has that competence of service and is able to provide head to toe assessments being able to take time with patients, provide everything they need. I agree there needs to be more care models exactly like that in the community where people are trained. They take the time, they know what to do, they have accessibility.

I just wanted to speak from a nursing perspective, we are actually -- the able and a dozen recognize intellectual disability as a specialty yet. We have been fighting to be able to get that certification. Specialty from a nursing perspective that we are not recognized as specialist nurses. From the American nurses Association. We just need to keep pushing and advocating and having these open dialogs. We really appreciate everyone's feedback because it also helps me in my role in thinking about policy change, I appreciate it.

JOHN BARRY: Again, not as a policy person, I want to reflect one thing that I'm hearing today which is, getting training. Getting input from people with lived experience, we are sort of doing that today here. I'm hearing people say that on the provider level, on the RAE level, subtheme in hearing. Hire people with experience.

Either of these sub bullets, either of these questions, if you have any thoughts about these. How can your providers improve experiences. Your experience, accessing care, how can your RAEs support those providers? Any thoughts or comments along these lines? Again the prior one was about best practices. We are moving towards the end of this discussion period. It is 1019 by my clock.

Anyone else? After this we will be talking about next steps. But for the moment, we are still here. Anything else? Especially anyone who hasn't spoken up today? Anyone who has made a comment in the Chat that you feel is important enough that you want to speak it out to the group? Your time to do that. Shannon?

SPEAKER: I just want to give one caution. One of the things I'm finding lately men not only my work but my personal life. We have really changed the behavioral health system to allow young people some autonomy in seeking treatment and I certainly absolutely support that 1000 percent. I think my caution comes in that when you have 14-year-old -- again, I won't give PHI, blah blah blah.

Your providers that can essentially closeout parent and say, I don't need to talk to you. I don't need to involve you because your child is 14 and has the behavioral health system. That child now has autonomy and can make decisions. Well, when asked a child for the Medicaid number and they don't even know what that is or where to find it, then the parent has to be involved.

So, when you talk about payments and payment methodologies and things like that, it becomes a dichotomy of -- you want children to seek treatment and get treatment and have the availability but they are not adults. They do not have -- some of them, do not have the ability to make that kind of decision. They can drive themselves to an opponent. They can schedule appointments.

I want to throw that out that as maybe a bigger discussion. When we are talking to providers and about provider implementation in policies, specifically in the behavioral health because it is at age 14 now. What it does to families and some of the barriers that it creates. Just the conversations in difficulties it can create, thank you.

JOHN BARRY: Thank you very much, Shannon. With that, I will thank everybody for all of your comments. Both in the Chat and also in the webinar. I will turn it over to the rest of the team. 90.

ADELA FLORES-BRENNAN: Suman, do you want to talk about compensation?

SUMAN MATHUR: Before we close out today want to take a moment to thank everyone for their participation. I want to note that we are able to provide monetary compensation for folks who joined today who our Medicaid members or who are caregivers or family members of helpers Colorado or Medicaid members. There are few ways that you can request that. The first is by an online form that I'm going to put in the Chat.

(Off mic.)

My colleague Kendra has a ready put that in the Chat. If you are unable to provide -- complete that form for any reason, I will also share out at the end of our conversation my email address as well as a phone number and you're welcome to return by email, phone, and we will be sure to send out all of these materials to folks by email after today.

Certainly, if you are a Medicaid member, or a family member, you are eligible for compensation for your time today. You just need to fill out that form or be judged by email and we will get that squared away.

ADELA FLORES-BRENNAN: Everyone, I'm so appreciative for you taking the time to join us today and to share your thoughts, ideas, in experiences. I have found this conversation to be very rich and I'm hopeful that we can do it at least one more time. I would also like to extend the invitation that, if you would like to have a small group of us come to an existing meeting just to have these conversations, collector ideas, we would be happy to do that as well.

Please stay tuned for another instance of this meeting and I will definitely be needing you all to spread the word. We're trying to figure out how to pull the community and the providers together for a conversation. I would like to think about that for the future, as well. I wanted to call attention to the website or ACC 3.0. or phase three is we are calling it. This is where you can go to sign up for the newsletter.

If you're interested in staying informed about phase three, please use that website for further information. We also have a feedback form. We are constantly soliciting feedback in addition to collecting all of your thoughts and comments of today, you are able to submit comments via a written form. Thank you to Kendra who is dropping his links in the Chat if you wanted to capture them, you are welcome to also submit your feedback in writing.

There are some other meetings that I wanted to call attention to. As part of our health equity plan a series of meetings with various communities that are coming up or have already been ongoing. That is part of our commitment to ongoing and sustained health equity for all of our members. We are on a journey as a department to ensure that we are delivering more equitable care. As part of that we are meeting with members of the community to solicit their input. We have one that is specific for members of the community -- people with disabilities. That is coming on August 22 from 12:00 p.m. until 1:00 p.m.

There's a link here, I'm hoping someone can grab that link and drop it in the chat before. We will be doing a health equity with respect to people's disabilities and we invite you to attend that, as well. Here is our contact information. This is my email, if you would like to reach out to me at the department.

Suman's email at sea HI. Please reach out with thoughts, comments, invitations to come to your meetings. We will look forward to hearing from you. Thank you, all for your time. Was a great opportunity, we appreciate it.

SUMAN MATHUR: Like I said, we will be sending out the slides from today along with the Chat which is chock-full of great links and other resources. Keep an eye out on that we will be sending it to the email address that folks registered with. Of course, you can send those materials out to other folks as well. And the gift card compensation link is for those who attended here today. Thank you all very much, I hope you have a lovely rest of your day!

Meeting concluded at 12:28 PM EST)