COLORADO
Department of Health Care Policy & Financing

Minutes

Transitions Stakeholder Advisory Council

Google Meet Weblink: meet.google.com/gjj-gmae-xff
Google Meet Call-in: +1 347-480-3624
PIN: 515 646 803#

June 1, 2023

2:30 to 4:30 p.m.

COUNCIL MEMBERS

- Meghan Baker, Disability Law Colorado
- Anne Bartels, Sandata
- Monique Flemings, AHOD Services
- Brittany Wright, Atlantis
- Jennifer Giurgila, ACMI
- Fallon Gillespie, RMHS
- Kara Marang, Ombudsman
- Carla Mickelson
- Jennifer Krulewich, Focus Cares
- LaShawn Love, Love Foundation
- Tracy Martinez, Touch of Care
- Jenn Ochs
- Patricia Cook
- Neal Waite, ADRC Region 3B
- Lauren Bell, DRCOG
- Mary Baughman
- Mary Mekbib

1. Welcome and Introductions 2:30 p.m.

- Approval of Minutes - Anne Bartels – Minutes were approved
- Requests for any co-chair interest - Lisa would like to bring on a co-chair to help while she's out on maternity leave. Email Lisa if you're interested: lisa.b.smith@state.co.us
- Suggestions on who to invite to this meeting and council applications

2. Open Forum - Questions or Concerns 2:35 p.m.

a. Renee with Disability Law Colorado-shared they have a survey to inform them where they focus advocacy and legal work for 2024. They are interested in hearing from the group and shared link in chat.
Survey for Disability Law Colorado priority setting - English
Survey for Disability Law Colorado priority setting - Spanish

b. Lisa – shared the Options Counseling form is only in English now and working on getting it translated to Spanish to be more inclusive. Lauren, DRCOG, shared link to HCPF's referral form for options counseling

3. Colorado Coalition for the Homeless Transitions 2:45 p.m.

Carla Mickelson MSN, RN - Nurse Manager Community

a. Colorado Coalition for the Homeless offers many types of health services to care for people experiencing homelessness or at risk of homelessness.

b. Health conditions among people experiencing homelessness are much higher than the general US population. Stout Street Health Center is a one stop shop for integrated health. Services include primary care, dental care, eye, clinic, pharmacy, behavioral health mental health, substance use treatment and case managers. The hospital readmission rate among patients experiencing homelessness is 50.8% with most readmissions occurring within 1 or 2 weeks of hospital discharge. The risk for readmission increases with discharge to streets or shelter.

c. Transition Care Management (TCM) – Link between patients and care partners to educate patients on healthcare plan, what follow up plans are and to remove barriers and red tape. Also, communicate with social workers and nursing/medical staff. Track if people keep follow up appointment to prevent re-hospitalization.

d. Mary Jo - How do people qualify for the program? Carla said they look for people that are part of their Care Transitions Program, mostly people that are already going to Stout Street Health Center.

e. TCM Process – Provide in person and telephonic nurse visits to hospitalized clients. Work to identify SDOH and barriers to care. Provide advocacy, resources and connect to health services. Develop patient centered goals and care plan. Target high risk, vulnerable, high utilizer clients. Mental Health- suicide rate is 10 times higher for people experiencing homelessness.

f. TCM Role - Importance of building rapport and trust, intentionally connecting

with clients and tools including AIDET, commit to sit and Jean Watson's Theory of Human Caring.

g. Rita - Can transitions help a person move from one ACF to another over a hundred miles apart?

    - Carla confirmed they don't serve outside of the Denver Metro Area. They do help clients that are trying to get connected with family that could be in another area.

h. LaShawn – Can they assist with nursing facilities to ensure successful transition to prevent risk of homelessness.

    - Carla - If it is patient that came from Coalition for the Homeless, they can help them to get into long care. Especially if there are concerns about them being successful. Reach out to Carla and they will do what they can to ensure a successful transition.

i. Mary Jo - Spoke to gentlemen that gets care from Stout Street and asked if services are still available to him if he's in independent living situation now.

    - Carla clarified they serve people experiencing homelessness or at risk of experiencing homelessness. Clarified they will continue to go to outpatient center.

j. Mary Jo - Do the Coalition of the Homeless Case Managers know enough about TCM/TC programs to refer to them?

    - Carla - trying to make people more aware of it and will pass on information to the team.

k. Jenny - Can someone enroll based on the risk of experiencing homelessness?

    - Carla - If they have any history of experiencing homelessness, refer them by email or phone call.

l. Lauren - DRCOG connecting with Carla to give info on their program. Would like to learn early in the process about participants that would be good for transitions.

    - Carla - excited for the collaboration and resources shared today.

m. Maria - How does the process work after the individual goes to Stout Street?

    - Carla - someone comes to see them at the clinic, they can talk to them about getting housing vouchers. They are involved more in permanent and transition housing. Case Managers will try to get

people into programs if they can.

n. Jennifer - Are there any plans for Coalition of the Homeless going to Boulder?

- Carla- No branches in Boulder at this time but will pass on to administration that there is a need.

o. Ann Watts - Individuals that go through transitions program can get a housing voucher. Work together for clients to be successful. Jennifer, you might want to connect with the Boulder Shelter for the Homeless - they are the closest thing to CCH in Boulder.

p. Carla Mickelson's email: cmickelson@coloradocoalition.org
Work cell: 720-251-4779

4. PASRR Presentation and Updates 3:15 p.m.

Margaret Anderson, HCPF, PASRR Administrator

a. Pre-admission screening and resident review. Create by CMS in 1987 out of concerns that individuals with disabilities were at risk for institutionalization in restrictive environments.

b. PASRR purpose is to evaluate individuals for serious mental illness or intellectual disability to ensure appropriateness of NF placement. Individuals are offered the most appropriate setting for needs in community, nursing or acute care facility and provide all individuals with services they need.

c. PAS vs RR. PAS= Pre-Admission Screen, Level I Screen submitted prior to SNF admission, usually submitted by hospital or CMA. RR= Residential Review, Level 1 Screen, usually submitted after SNF admission.

d. PASSR documents Level I and Level II for IDD and specialized services recommended. Nursing facilities have to provide services recommended.

e. With the end of PHE on May 11, 2023 the 1135 waivers ended as well. Now it is back to PASRR as normal. Also, back to Level II evaluations being done in person.

f. Mary Jo - In terms of DD and MI, are there other mental conditions that will fall into PASSR too?

- Margaret - Moved to person centered and more individualized now instead of diagnosis, it's case by case. On PASRR, curious to see how many will want to transition to independent living.

g. Rita - In the past, if a person was in the hospital, they would do the PASRR even if they had Medicaid. Why did this change?

- Margaret - if hospital is doing it and accurate that's ok. This hasn't changed.

h. Jenny - Will Transition Coordinator's have access to PASSR assessment information on the new care and case management system?

- Margaret is not sure and will find out and get back to the group.

i. Margaret shared links to all resources:

- PASRR Webpage
- PASRR Training Video (approximately 1 hour)
- Level 1 Entry Demo Video (approximately 20 minutes)
- Link to slide deck
- Link to desk aid
- If you have Level 2 questions for an individual with MMI. Please reach out to: Michelle (Chellie) Voss OBRA/PASRR Program Manager and SMHA State Mental Health Authority - BHA (Behavioral Health Administration), michelle.voss@state.co.us
- PASRR Understanding Specialized Services

5. Open Forum on Wins and Challenges 3:45 p.m.

a. Lauren - Would like to get the bi-monthly mixers for TC and OC's back on the calendar.

- Lisa will work on getting mixers scheduled on calendar.

b. Mary Jo - Recently worked with a client and the outcomes were fantastic. Shared this with Nora and would like to share success story with others as it highlights importance of great work being done

- Lisa will coordinate so the story can be shared to a broader audience.
- Lauren, DRCOG - Asked Mary Jo to connect as they are looking for short stories on transitions and leverage for news media to highlight.

c. Anna – Any updates on Care and Case Management system Go-Live date?

- Currently testing and Phase 1 schedule to go live is July 5, 2023 at 8 a.m. View Case Manager's Corner Newsletter May 2023 for more details.

6. Next Steps and Topic for Next Month 4 to 4:30 p.m.

a. Mary Jo - Suggested getting a Social Security expert to talk to about LTC, disability applications and other challenges having when trying to help individuals with the process.

Next Meeting July 6, 2023
Topic: TBD

Submit Questions, Issues, and Comments:

https://forms.gle/iRZb5zWq5SyMctEe8
or email Lisa.B.Smith@state.co.us

Reasonable accommodations will be provided upon request for persons with disabilities. Please notify John Barry at john.r.barry@state.co.us or the 504/ADA Coordinator at hcpf504ada@state.co.us at least one week prior to the meeting to make arrangements.