Issues to be Prepared for When Talking with Legislators

Access to care/wait times

What you might hear

"I saw the latest data showing that Coloradans still struggle to get appointments for mental health care" or a personal/constituent anecdote about wait times/wait lists.

Points to cover when responding

- CMHCs are working hard to ensure that all Coloradans get the behavioral health services they need when they need them.
- Same-day appointments with clinicians are offered but wait times for specialty services like medication evaluations and high-intensity services are sometimes unavoidable. There are many factors that determine access, including medical necessity, program capacity, and provider caseloads. Staffing is always a concern, given the challenging populations safety net clinicians serve and the attractiveness of private practice or telehealth platforms.
- Addressing generalizations about wait times: drill down to learn more
    - Is the issue about getting in to see a prescriber or being admitted to a program? Or is it about access to a counselor for outpatient treatment?
    - What kind of service does someone need? Is there a discrepancy between what the patient and/or family want and what has been recommended based on a clinical assessment?
    - Does the individual have Medicaid or private insurance?
- Factors affecting wait times:
    - Workforce shortages exist, especially for prescribers and high-intensity programs.
    - Evidence-based practice requirements for certain types of care that limit the caseload of the clinicians providing those services.
    - Patient preferences about the location or characteristics of the clinicians they want to see.
    - Resource and referral options may look different depending on geographic location.
- If they cite an issue with your center, offer to look into the circumstances and get back to them with more information within the bounds of patient confidentiality.
    - Explain policy and procedure for making referrals if a need cannot be met in a timely manner due to capacity or expertise.

Violence against health care workers

BACKGROUND: Two bills are expected on this topic. One, from the Colorado Nurses Assn. and Mental Health Colorado, has already been introduced: HB 24-1066. It focuses on prevention and requires covered health facilities to have violence prevention plans, committees, trainings, and reports. One section of the bill applies specifically to comprehensive safety net providers: it lifts out (and in some cases tightens/adds to) violence prevention requirements from the BHE rules.

The Colorado Hospital Association is developing another bill that toughens criminal penalties for assaults against health care workers. At this writing, it is not clear that bill will be introduced.

What you might hear

"What is CBHC's position on HB 1066? What about the idea of enhanced penalties for people who assault health care workers?"

Points to cover when responding

- (add official CBHC position on HB 1066)
- Unfortunately, it's not unusual for our staff to face credible threats and assaults; instances of violence or threats of violence appear to have increased since the pandemic.
    - (Add specific examples from your center.)
- That said, we don't believe that criminalizing behavior stemming from mental health or substance use issues is appropriate.
- Our center and all the others around the state already have violence prevention policies and regularly train our staff in de-escalation techniques.
- And while we prefer the approach in HB 1066, the section that applies to comprehensive safety net providers essentially rewrites existing BHA rules.
- It's better to keep such requirements in rules, which are easier to amend to reflect changing conditions, than embed them in statute.
- We don't believe either of these approaches addresses the root problem: Colorado lacks a full continuum of services needed to address individuals experiencing acute behavioral health crises ("the middle is missing"). Behavioral health crisis teams and co-responder teams need to be supported by the courts and law enforcement so that emergency and involuntary interventions are safe and lead to treatment at a healthcare setting (of the appropriate level).
    - CBHC is focused on working with those partners to identify the policies that would help them feel more confident in their ability to support safety net providers and communities.

BHA: Concerns about effectiveness, funding, commissioner search, duplication with other state agencies

Bear in mind when crafting your response that CBHC and BHA agreed in September not to point fingers at each other. At the same time, though, we have legitimate concerns about the agency's structure, approach and ability to adequately fund the safety net.

<u>What you might hear</u>

"What do you think of the BHA?"

<u>Points to cover when responding</u>

- CBHC supported the creation of the BHA and making it a cabinet-level entity. We have worked closely with BHA staff as they have begun to implement this new structure.
- The legislation that crafted the BHA was some of the most sweeping ever passed in this state, and it's a heavy lift to set up a brand-new administration in a short amount of time.
- We appreciate last year's legislation that extended timeframes for rule implementation and BHASOs. However, there are still a lot of details to be ironed out. We all need to keep a close eye on implementation to guard against unintended consequences.
- We continue to have many concerns about the system the BHA is tasked with developing:
    - Undermining the safety net for adults with serious mental illness and children with serious emotional disturbances by trying to provide all things to all people all the time.
    - Increasing complexity instead of creating a more efficient and streamlined way of regulating and financing community behavioral health.
    - Inadequate financing for this new system which imposes significant new regulatory burdens and is designed to bring on new safety net providers without any new funding. Simply put: the math doesn't work.

General negativity

What you might hear

"You might not like the system that's been created, but it came about because CMHCs weren't taking care of their communities."

Points to cover when responding

- Don't be defensive but provide facts based on your center's experience.
- CMHCs were created to serve the most vulnerable in their communities. It's a calling for us to serve individuals with serious mental illness, those with co-occurring substance use disorder, and children with serious emotional disturbance.
- Nobody is competing to serve those individuals. It's difficult work that can burn out clinicians and is barely financed by the state. Many of the services we provide are not reimbursable by Medicaid or commercial insurance (give examples), so we must be supported by capacity funding from the BHA and other sources, such as grants or investments at the county or municipal level.
- CMHCs offer a tangible return on investment: "Our center serves (number) of clients every year, most of whom need multiple types of services, for an average of $xxxx/client." (NOTE: Average across CMHCs is less than $2000/client/year.)
- Remind them of your mission and reassure them that your organization remains committed to serving as the community mental health center in your region.
- Offer to follow up on any specific issues they identify.

Specific legislation

What you might hear

"What do you think about (X bill)?"

Points to cover when responding:

- Refer to CBHC position document (we'll share with you that morning).
- Talk about how your patients/clinicians are affected by the general issue covered by the bill.
- Ask the legislator how they view it.
- Offer to have CBHC lobby team follow up.