COLORADO
Department of Health Care
Policy & Financing

Minutes of Behavioral Health Hospital Engagement Forum

Virtual Meeting
Video conference: meet.google.com/bxe-cwag-tdo
Call-in number: (US) +1 219-802-5969
PIN: 792 789 742#

August 9, 2024, 10 – 11 A.M.

1. Call to Order

Jennifer Holcomb called the meeting to order at 10:03 a.m.

2. Welcome and Introductions

Introductions to HCPF staff present at the meeting were done.

3. Discussion Topic 1- Behavioral Health Assessments in a Hospital Setting

Meghan Morrissey, Crisis Services Policy Advisor, led the discussion on what's been happening with behavioral health assessments in hospital settings.

There was a discussion regarding how risk assessments are working in the emergency department (ED). A state agency shared that individuals with psychiatric, and intellectual and developmental disability (IDD) dual diagnoses have been denied having a risk assessment completed in the ED because of the IDD. There's been difficulty with placement because of the co-occurring IDD. A hospital in La Junta shared that risk assessments are initially completed by their nursing staff. The discussion transitioned into how the M1 was working with the new change in regulation that went into effect in January 2024 and who was doing the M1 and voiding it. Per a hospital in La Junta, M1 are initiated by their assessment center that is contracted with the hospital because they are usually evaluated by this outside team for any suicidal ideation and homicidal ideation. There have been rural facilities that usually contract with a Community Mental Health Center (CMHC) do these assessments. Through the rural facility's contract with the local CMHC, they will call the Administrative Service Organization where staff will be sent to the site. A hospital shared that they just implemented tele-psych. There is not much feedback to share at this moment. Though the only issue with tele-psych is that the hospital has no transportation if a patient is recommended for placement.

There are times where the physicians will initiate the M1. Most of the M1's are placed by the contracted provider, if this is not done then the physician will initiate the M1. It was shared that a majority of the metro Denver area uses licensed clinical social workers or professional counselors, which is a shared partnership with the physicians as far as assessing risk. Additionally, telehealth assessments have been done by those who are credentialed. There are a handful of hospitals that have assessments done by the CMHC, particularly in rural communities where there's not resources available internally. So, there is a combination of employed providers and contracted providers to complete risk assessments. It was recommended that the form be components in the electronic health record as there are multiple trained individuals, at different points of contact ensuring safety and continuity of care and so the form can be duplicative, taxing and a disservice. Another hospital was in agreement with this duplication. From the patient perspective, being in a psychiatric crisis is exhausting, confusing, and scary. It is taxing when patients have to repeat themselves with various providers for multiple assessments.

Any questions or concerns can be addressed to hcpf_crisisservices@state.co.us. A podcast was shared on the topic about how regulations view emergency evaluations in an ED. The podcast can be found here[1].

4. Discussion Topic 2- Strategies and Supports for Successful Dispositions

Meghan Morrissey, Crisis Services Policy Advisor, led this brief discussion. Questions were posed about what's working, what's needed, and how people are using ADT software and how that's working.

A hospital noted that the transitional period between an ED visit for behavioral health crisis and accessing follow up care can be a very precarious time for individuals. There was a bridge service like the Rocky Mountain Crisis Partner's hospital follow up program that would help to fill the need while a patient is in transition. It is incredibly helpful and helps improve patient outcomes. The shift to 988 is moving away from the hospitals being able to access this type of service. Rocky Mountain Crisis was for any payor and a great handoff; it made it much more likely to keep that connection. There is a need for inpatient or higher level of psychiatric care as the biggest barrier is when a patient has a comorbid neurologic disfunction or intellectual or developmental disability. It seems like the system is built for one or the other and services become siloed. Another common situation is

[1] https://podcasts.apple.com/us/podcast/the-4-1-1-from-cms-on-emtala-for-bh-emergencies-with/id1063793120?i=1000662976009

when someone has a need for inpatient psychiatric treatment but need oxygen, DME, etc.

Regarding 988, it was recommended for the hospital to reach out to Solari and the BHA. More information about the hospital follow up discussions that are occurring with CDPHE can be found here[2]. There is a roadshow occurring so the hospitals will be contacted about this.

5. Open Topics

Reasonable accommodations will be provided upon request for persons with disabilities. Please notify the Committee Coordinator at amy.luu@state.co.us or the 504/ADA Coordinator hcpf504ada@state.co.us at least one week prior to the meeting.

[2] https://cdphe.colorado.gov/suicide-prevention/the-follow-up-project