Summaries of the BHIS Breakout Discussions on March 3, 2021 to Identify Future Subcommittee Priorities

Breakout group 1:
The priorities discussed were an interest in seeing care coordination as a critical issue and helping unify how it is prioritized within health delivery systems, as now it's mostly on the member to follow up on their care plan. Additionally, priority was noted around technology and technological parity, especially considering the rural nature of many communities, whether it's not having an electronic health record (EHR) or the whole state having 14 EHRs making it difficult for data sharing.

Breakout group 2:
A goal they discussed was movement forward in continuing to look at access to care for members seeking behavioral health care and continuing to look at integration strategies. An example of the things that still seem complicated in the current system is that individuals seek treatment but often times there is a delay in being able to get access to initial behavioral health care and that there is fragmentation about the process of being able to enroll in services. There is a desire to look at efforts of streamlining how quickly people get access to care when they seek it and looking at streamlining processes to be able to actively engage in treatment.

Breakout group 3:
The group made general observations of the difficulty to fully integrate behavioral health when the payment structures are misaligned. The funding streams are siloed where there is capitation for behavioral health and FFS for physical health. There was uncertainty if this was something the group could work on and discuss. It was mentioned that until the funding streams are better aligned to create the right incentives for providers and members, then it will continue to be a challenge. Another observation was made that the conversations appear to be very urban Denver-centric focused. There is a need to remember that resources, access to care and the delivery system looks very different on a regional basis, especially in rural and remote areas. There was a discussion about data and how to learn from one another to create best practices to a whole centric health as there's an overlap in physical, behavioral and oral health measures. In order to achieve health equity, there is a need to think of behavioral health as a component of family health, population health, and neighborhood health. This holistic approach will lead to improved equity. A thought was shared that there are opportunities around foster care, early childhood and the programs that operate out of the Colorado Department of Human Services (e.g., early intervention), and where there are intersections with Medicaid for children and youth.

Breakout group 4:
An area discussed for consideration of focus were services for the IDD population and integrating this. Access for children's services, understanding children's behavioral health needs and what further integration should look like was discussed. There was a brief discussion about the SUD residential expansion benefit and what this means for the mental health residential benefit and the IMD exclusion and if there should be some consideration for alignment. Also discussed was technology, HIE, and how EHRs are connected with HIEs.

Breakout group 5:
They discussed barriers to access behavioral health care, particularly for low income communities of color. There was also a discussion around how the COVID crisis has exacerbated the need for behavioral

health care in these communities. Additionally, they discussed the possibility of a model, rather than bringing people to behavioral health care services or facilities, bringing health care to them as a way to be effective and aware. This is similar to what is happening with physical health with using a Promotora model. There were thoughts that the DOC and crisis services work has only been scratched on the surface and wanting to potentially look more upstream in terms of prevention. It was discussed if there was a possibility for overlap with what hospitals are doing around the Hospital Quality Incentive Payment (HQIP). In regard to the Zero Suicide framework with crisis services, are there other opportunities across the behavioral health care continuum and outside of it to ensuring all are looking at zero suicide? Lastly, it was discussed of a focus on children, youth and families.

Breakout group 6:

Access to care issues were mainly discussed. There was agreement that access to care is an ongoing challenge that doesn't seem to have a one size fits all answer. It's much more than just checking a box and there's a need to get out of this mentality of just checking boxes when helping to link members with the services needed. Some of the conversations did identify that outside of urban areas looked different and would need to be thought through in different ways, such as rural and frontier areas. Data sharing and having a central platform of being able to communicate are the big dream vision. It is wanted to not duplicate efforts and to identifying who is in charge of what.

Breakout group 7:
They discussed promoting diversity in health care professions, specifically in behavioral health. Each participant shared their experiences such as, educating others on Native American cultural awareness.