COLORADO
Department of Health Care Policy & Financing

1570 Grant Street
Denver, CO 80203

Behavioral Health and Integration Strategies PIAC
April 1, 2020
Meeting Minutes

Introductions:

- **Facilitators:**
  - Jeff Appleman: Dept. of Health Care Policy & Financing *Liaison*
  - Daniel Darting: Signal Behavioral Health Network *Co-Facilitator*
- **Voting Members (Phone):**
  - Sue Williamson: Colorado Children's Health Care Access Program
  - Camille Harding: CDHS: Office of Behavioral Health
  - Terri Hurst: Colorado Criminal Justice Reform Coalition
  - Tom Keller: Region MEAC & PIAC, Statewide PIAC
  - Stephanie Salazar-Rodriguez: Mile High Health Alliance
  - Dr. Vicky Allen-Sanchez Colorado Springs Fire Department
  - Tammy Philips Larimer County
  - Mary Dengler-Frey Colorado Education
  - Heidi Hanies ARC
- **Phone (Non-Voting Members):**
  - Laura Dawn Tri-County Health Department
  - Allen Girard
  - Moses Gur CBHC
  - Kelly Bowman Health Colorado
  - Kristy Callen Imagine
  - Krista Cavataio RMHP (RAE 1 & Crisis Services ASO for same region)
  - Chris RMHP (RAE 1 & Crisis Services ASO for same region)
  - Mindy Klowden CCHA
  - Arnold Colorado BH
  - Karen Levine RMHP
  - Kaylee Meridan
  - Kevin Aspen Point
  - AJ Aspen Point

o Ricky	Aspen Point
o Ashley Philips	Centura Health
o Dom Martin	Colorado Access
o Courtney Todd:	Center of Law and policy
o Doug Meir	Centura Health
o Jeremy White	Beacon Health Options
o Kailey Meardon:	Southeast Health Group
o Kyle Legleiter:	Colorado Health Foundation
o Nicole Konkoly:	RMHP (RAE 1 & Crisis Services ASO for same region)
o Candace Wolf:	Creative Treatment Solutions
o Deb Chandler:	Mathews-Vu Medical Group
o Keith Brown:	
o Alan Girard:	Front Range Health Partners
o Rita Bailey	
o Kat Fitzgerald	Beacon Health Options (works with RAEs 2 & 4)
o Carl Redner	Health Care Consultant
o Pamela Genaro	
o Amanda Wade	San Luis Valley Health
o Tina Gonzales	HPI
o Stacy Allen	
o Tina McCrory:	Beacon Health Options
o Mark Davidson:	Colorado Learning and Behavior Group
o Kevin Porter:	Aspen Pointe
o Jani Walter:	
o Brandon Wart:	Mental Health Center of Denver
o Amanda Wade:	San Luis Valley Health
o Laura Dawn:	Tri-County Health Dept
o Lila Cunningham:	
o Kim Cassidy:	CCHA
o Anna:	RMHP
o Kim Nordstrom:	Colorado Access
o Joanna Martinson:	Colorado Mountain Region 1 & 2
o Colette Martin:	
o Jeremy White:	Beacon Health Options (RAEs 2 & 4)
o Christi Chaudry:	SCL Health
o Kim Fairley	
o Matt Sundeen:	Dept. of Health Care Policy & Financing
o Mike Davis	Dept. of Health Care Policy & Financing
o Ben Harris:	Dept. of Health Care Policy & Financing
o Amanuel Melles:	Dept. of Health Care Policy and Financing
o Jenna Kapp:	Dept. of Health Care Policy & Financing

- John Laukkanen: Dept. of Health Care Policy and Financing
- Morgan Anderson: Dept. of Health Care Policy and Financing
- Victoria Laskey: Dept. of Health Care Policy and Financing
- Susanna Snyder: Dept. of Health Care Policy and Financing

Review Minutes Approval Process:

Sue Williamson motioned to approve the March Meeting Minutes; Terri Hurst then seconded the motion. Daniel Darting moved to call for a vote on the March Minutes, which resulted in all "ayes" and no "nays". The March Meeting Minutes was therefore approved.

COVID-19 Questions:

Jeff Appleman allotted time for COVID-19 related items. First, he directed the attendees to the Department's public website; Jeff specially addressed two recently updated pages on the website, one which contains COVID-19 related materials and a second page which guides recent changes to tele-health services.

Jeff then opened the forum to COVID-19 related questions. Doug, with Centura Health, inquired about the Department's plans to apply for federal waivers, specifically asking if the Department was looking into ways to fund partial mental health hospitalizations and/or Intensive Outpatient Programs (IOP). Melissa, with the Department, stated that it would be best for providers to work directly with their RAEs. As the aforementioned services are under the behavioral health capitation, the RAEs (Regional Accountable Entity) are tasked with adjusting their practices to meet the needs of members in their region(s). She added that specific codes for IOP or partial hospitalizations may not be available due to the current public health emergency but stated that providers may be able to work with their RAEs to address gaps in treatment by offering other services (ex: telehealth) that perform similar functions for our members.

Doug stated that the current this state of emergency has highlighted some longstanding issues in the state and said that now would be a good time to bring together a behavioral health advocacy group that could work with the state, local stakeholders, hospitals, etc. to cohesively address persistent issues that affect behavioral health access, such as regional workforce shortages. Ben Harris, with the Department, asked Doug to submit his recommendations to Jeff Appleman, Sue Williamson, and Daniel Darting; they will then review his materials and decide if/when to present those recommendations to the larger group. If the BHIS voting committee approves of the recommendation, his recommendations can then be presented to the Statewide PIAC (Program Improvement Advisory Committee) for approval. If approved, it would their decision/plan would then be submitted to the Department for implementation. Doug stated that he would send his questions and materials to Jeff and the co-chairs.

Jeff stated that similar to the Listserv for BHIS meeting updates, the Department has created a Listserv for COVID updates, as well. He asked everyone to sign up for the emails and stated that they contain information on how to submit inquiries to the Department.

Crisis System Overview:

Camille Harding from CDHS (Colorado Department of Human Services) presented on the crisis services system and updated the attendees on their current objective of "develop[ing] recommendations regarding the implementation of the crisis service system and collaboration with the RAEs". She then provided background on this programming, stating that the crisis service system was enacted by the State Legislator in 2014 following the Aurora theater shooting. The Legislator originally allotted $21 million which has since increased to $34.5 million (general funding & state block grant funding combined).

Several services fall under the crisis system umbrella, such as the Crisis hotline, Walk-in Crisis Centers (WICs), Crisis Stabilization Units (CSUs), Mobile Crisis Teams (MCTs), and respite services. The services are intended for those across the state, of all ages, regardless of insurance type or ability to pay. Furthermore, the hotline is available to anyone with a 'self-defined crisis', meaning that individuals will not be disallowed from accessing the hotline due to a lack of acuity and/a lack of a particular diagnosis (i.e. there is no acuity test or criteria that would hinder an individual from using the hotline). She added that mobile dispatch programs and peer professionals (i.e. those with lived experience as a mental/behavioral health consumer), were identified as services/workforces they identified as having the most opportunity for growth.

Camille stated that OBH (Office of Behavioral Health) sought stakeholder feedback through a steering committee which included community stakeholders whose work frequently comes into contact with individuals during a mental health crisis (ex: Police, Emergency Medical Services, therapists, etc.). OBH then released an RFP (Request for Proposal) in 2018 to procure the new Administrative Service Organization (ASO) to administer/manage crisis services in each Region.

Camille reviewed the duties of these ASOs, such as, fiscal and data reporting, maintaining a crisis network that ensures access, and management of performance-based payments. Furthermore, she stated that the ASOs were tasked with prioritizing mobile response, due to concerning patterns of Emergency Department (ED) utilization. Additionally, OBH tasked the Crisis ASOs with community-based models and instructed them to work with local hospitals to create MOUs (Memorandum of Understanding) to create more efficient processes, that will improve the quality and cost of care. Since this change, OBH has noticed an increase in innovative programming and an increase in streamlined/standardized protocols between the ASOs and the EDs they work with.

Camille stated that numerous stakeholders emphasized the importance of aligning the work performed by the Crisis ASOs & the RAEs because they frequently encounter the same individuals; because of that feedback, the RAE regions and Crisis ASO regions are now the same (i.e. the ASO and RAE regions overlap). Camille then displayed a chart of the available WICs, stating that the ASOs are required to ensure that there is at least one WIC per region, which must always be staffed by a minimum of 2

employees. Additionally, the ASOs are currently working with Emergency Departments in their region to improve/streamline the medical clearance process for individuals placed solely due to behavioral health concerns (i.e. those without physical concerns).

Camille then reviewed the service that Coloradans most frequently use as their first point of contact with the crisis continuum, the crisis hotline. The hotline receives calls of varying acuity and is tasked with making referrals to the mobile crisis response teams (MCTs), local WICs and can initiate wellness checks with local Emergency Medical Services (EMS)/Police Departments.

Additionally, Camille updated the attendees of important changes that have recently occurred. OBH worked with the American Society of Suicidology, to provide train the hotline staff so that they better screen and provide better support to those that access this service. The hotline system was also updated to allow for text messaging and to track/collect better information (ex: basic geographic information, insurance payor – for referral purposes, etc.) for those that utilize the hotline. Furthermore, OBH is currently funding the development of a similar data tracking module for mobile dispatches and subsequent treatment. Additionally, OBH hired a vendor (HarrisLogic) to develop a safety risk training that focuses on environmental factors, safety risks, and next steps to build out an infrastructure (the vendor's report is due to OBH in May and will be reviewed by the Governor's Behavioral Health Taskforce).

Camille then provided basic information on other aspects of the crisis continuum. She stated that Crisis Stabilization Units are treatment facilities with typical stays of 1 to 5 days and provide a psychiatric prescription, clinical counseling (LPC, LCSW, etc.), case management, and peer specialist services. Treatment in these settings can be voluntary or involuntary (i.e. due to an individual being placed on a 27-65/M-1 Hold). Respite services are short term. Mobile crisis teams have also begun using innovative new programming, such as working with EMS Camille added that, dependent on acuity. Additionally, the Crisis Line is, along with providers, tasked with following up with members following a crisis, those who did not engage in the treatment, and/or others who may need further crisis support.

OBH conducted a focus group that attempted to understand the barriers that exist which hinder crisis services from being utilized as intended. The largest identified barrier, restricting Coloradans from engaging in these services was that they were unaware of available services and they were unaware of the types of referrals the hotline could make. Due to this feedback, there has been a campaign designed to educate the public on when to use to the hotline (i.e. in what circumstances) and what to expect when they do. Lastly, OBH identified the following goals for their Crisis Service System: improve mobile response throughout the state, build-out tele-health capacity, and expand care coordination and follow-up contact with the Crisis Line.

Camille stated that OBH's goal is for the crisis system to seamlessly work with other parts of the treatment continuum. Jeff added that there is language in the RAEs' contacts which requires them to work with the Crisis Line when coordinating care for RAE members and tasks them with educating their members on ASO services.

Camille followed up stating that OBH is completing a Population and Needs study being conducted that will establish areas of growth and focus and the report will be ready by June.

Kim stated that we need to understand gaps in crisis care in the state, especially in rural areas. She added that there is a lack of available nearby services and that the time it takes and distance one has to travel for treatment can be a significant barrier.

Camille stated telehealth has become of greater importance so that they can better ensure coverage, especially in sparsely populated areas; OBH is also looking into internet access issues which could affect the utilization of tele-health services. She also added that House Bill 1287 requires OBH to track bed availability/vacancies in treatment facilities. and tasks them with integrating this information into the data infrastructure. This will assist residential facilities and providers in accessing open beds quickly through an online portal for efficiency and timeliness. ETA: This tool will have a soft launch set for January 2021.

Another participant pointed out that many hospitals in eastern Colorado are critical access hospitals that are rarely full and asked if these beds could be used for respite or psychiatric care has been explored. Camille stated that the ASOs could potentially contract with those facilities if they feel like that could be a worthwhile/cost-efficient expenditure for their region. She added that the Crisis ASOs have also been encouraged to work with to 3rd party insurers to reimburse for the use of services for the crisis system.

A participant asked about the shift of medical clearance from the ERs to community centers. Camille expanded, stating that ASOs were instructed to work with community providers to avoid unnecessary admittance to EDs, as to not hinder their ability to access the most appropriate care without unneeded delays, caused by medical tests for which there is little clinical need.

Doug vocalized his concern for Coloradans, in areas where Non-Emergent Medical Transportation (NEMT) is limited, stating that there are financial barriers associated with travel that will restrict some from accessing treatment. Camille stated that they are currently considering multiple options to address this barrier are being talked through for this barrier.

Terri Hurst asked if the crisis line tracks Health First Colorado-Medicaid as compared to those with other insurers; she added that this data would be helpful to identify service gaps for Medicaid members that are utilizing crisis services. Camille stated that OBH does not require callers to provide their insurance information but that they are looking into other ways to track insurance payor; for example, OBH is also researching which, if any, crisis services can receive Medicaid reimbursement and have a goal of increasing collaboration with these systems.

Behavioral Health Task Force Update:

The Behavioral Health Task Force meetings have been currently suspended due to COVID implications, as have the Behavioral Health Task Force Subcommittees. Some of the workgroups are still meeting so that they do not lose traction on their work.

Subcommittee Housekeeping and Feedback:

The next meeting will be held on May 6, 2020, through a webinar to allow for a single login place. April 10th will be the deadline for voting member submissions and voting member questionnaire turn-in. The final voting member should be established by the next meeting and Jeff will be contacting current voting members about their votes. Meeting adjourned at 10:24 am.