COLORADO
Department of Health Care Policy & Financing

1570 Grant Street
Denver, CO 80203

Behavioral Health and Integration Strategies PIAC
August 5th Meeting Minutes

Introductions:

Facilitators:

- Jeff Appleman: HCPF - Dept. Liaison
- Daniel Darting: Signal Behavioral Health Network Co-Facilitator

Voting Members:

- Sue Williamson: Colorado Children's Health Care Access Program
- Tom Keller: Region MEAC & PIAC, Statewide PIAC
- Camille Harding: CDHS: Office of Behavioral Health
- Amanda Jones: Center for Mental Health
- Stephany Salazar-Rodriguez: Mile High Health Alliance
- Dr. Heidi McMillion: Pediatric Partners of the Southwest
- Heidi Haynes: ARC of Colorado
- Dr. Vicky Allen-Sanchez: Colorado Springs FD
- Tammy Philips: Larimer DHS
- Mary Dengler-Frey: Southwestern Colorado Area Health Education
- Stacee DeLisle A Kidz Clinic
- Terri Hurst CCJRC

Other Attendees:

- Tammy Arnold Northeast Health Partners (RAE 2)
- Mindy Klowden Colorado Behavioral Health Council
- Catherine Morrissey Northeast Health Partners, RAE Region 2
- Kim Fairly Centennial Health

• Lila Cummings	Colorado Hospital Association
• Tina Gonzales	Beacon Health Options
• Frank Cornelia	Colorado Behavioral Health Council
• Jen Hale-Coulson	RAE 2 & RAE 4
• Marty Jansen	Colorado Access (RAE 3)
• Amber Kochevar	Community Care Alliance/ Western Healthcare Alliance
• Christopher Garcia	DHMP
• Alyssa Rose	Beacon Health Options
• Clay Cunningham	Community Reach Center
• Elizabeth Richards	Beacon Health Options (RAE 2 & RAE 4)
• Amanda Berger	Colorado Access (RAE 3 & RAE 5)
• Camila Joao	CCHA (RAE 6 & 7)
• Jenn Conrad	Signal Behavioral Health Network
• Taylor Thompson	Colorado Community Health Network.
• Ashley Philips	
• Victoria Laskey	
• Pat Cook	
• Louisa Wren	
• Shingo Ishida	HCPF
• Melissa Eddleman	HCPF
• Benjamin Harris	HCPF
• Jeff Helm	HCPF
• Amanuel Melles	HCPF
• Brooke Powers	HCPF
• Matthew Pfeifer	HCPF
• Megan Comer	HCPF
• Sandra Grossman	HCPF
• John Laukkanen	HCPF

Minutes Approval

Daniel solicited a motioned to approve the July meeting meetings. Terri Hurst motioned to approve the minutes and Heidi Haynes seconded the meeting minutes. The motion received all ayes and no nays.

Jeff then reviewed the Department's mission statement and displayed the links to the Department's COVID websites. Next Jeff recapped the previous month's meeting which looked to understand the incentives used to encourage positive health outcomes for the RAEs' work, related to behavioral health. This meeting we will shift directions to look at how the RAEs build out their care coordination

processes and procedures and how they have built their systems to address the needs of members utilizing the crisis system.

RAE Presentations

Rocky Mountain Health Plan – Louisa Wren

Rocky Mountain Health Plan (RMHP) is both the RAE and the Crisis ASO for their regions which allows for unique opportunities. Rocky can use this overlapping work to more effectively reach out to members and to work with local partners with a combined focus; they listed several possible ways to utilize this overlapping work. Additionally, Louisa has identified important on the ground resources, providers, etc. and has worked on communicating with them in shared forums and have been more able to identify and address opportunities that overlap for their RAE contact and the Crisis ASO contract. RMHP has been able to capitalize on existing CMHC, care coordination, etc. programs, particularly for high utilizers.

Rocky utilizes a breadth of comprehensive assessments to meet the health needs of its members, across social, cultural, and linguistic spectrums. They have a workflow that effectively refers members to the services they need; they then use that workflow to track the efficiencies of their work and their areas of improvement. RMHP uses the same case management workflows whether someone is accessing the Crisis System or if a member is being referred for another reason; Rocky focuses on building relationships and having a provider pool that can meet the needs of their region.

Rocky stated that delays in receiving data and a lack of sharing data can cause on the ground issues. Additionally, RMHP stated that common goals, shared by the Department and OBH, could more effectively be enjoined and that common incentive could be used. Additionally, RMHP identified improved communication, such as joint meetings and further building more effective and efficient workflows between Mobile Crisis, the Crisis Hotline, etc. Rocky continues to work to track the work they are doing and are mindful to track and remedy any overlapping work. Furthermore, Rocky reaches out to providers, agencies, etc. they come in contact with to improve processes. Additionally, RMHP has created unique processes for ATUs and CSUs in their region and has other workflows for those being treated outside of the region; this ensures the member receives a follow-up call within 24 hours of their discharge.

Rocky identified geography as a barrier as their region contains 20+ counties and is less populated than other parts of Colorado; they, therefore, have formed unique workflows to address this. RMHP suggested that the State align various incentives since many have common goals.

• **Northeast Health Partners – (**Kim Coleman & Elizabeth Richards**)**

Similar to Region 1, both the Crisis ASO (Administrative Service Organization) and RAE have some overlapping structures as both are affiliated with Beacon. This has helped ease their ability to build out shared workflows. For members accessing mental health services, RMHP has created a format where a

CMHC takes the lead in creating a plan to address the member's mental health needs and RMHP builds on their plan to address their other, ancillary needs, such as SDOH (Social Determinateness of Health). NHP identified several 'Barriers Identified & Gaps in Care' which hinder their ability to reach out to members. Although they have strived to reduce duplication, there could be more done by the state to better differentiate between the roles and responsibilities of the RAEs and Crisis ASOs. Additionally, the lack of member level information and the lack of real-time data sharing has delayed their ability to reach out to members more quickly.

Elizabeth also identified areas of opportunities for the future, such as reaching out to on-the-ground providers for their input and utilizing information those providers to improve health outcomes. Additionally, they added that further communication between providers, ASOs, OBH, etc. on overlapping work.

• **Colorado Access –** (Marty Jansen, Amanda Berger & Jenn Conrad)

Colorado Access presented on the successes and growth opportunities for the work that overlaps with the Crisis ASO's.

COA identified numerous 'successes' that they have identified while working with the Crisis ASOs. They worked to collaborate at the early stages of the contract and have worked to not overlap duties while also ensuring to fill any gaps that are not being addressed. COA has had ongoing collaboration about the members they share with the Crisis ASOs and have worked well with the other organizations in their region. For example, RMCP (Rocky Mountain Crisis Partners) updates COA on any interactions they have with members they share; they also update COA on any needs those members to have. COA also works with RMCP when they're informed about Bi-directional information sharing has helped streamline communication and has helped members get their needs met more quickly.

Colorado Access also identified areas of opportunity for the future. Marty identified data-sharing as a growth opportunity and stated that COA will continue to build relationships/partnerships involving shared work and shared information. He added that a statewide bi-directional information system would be helpful so that everyone has access to the available information (preferably, providing the RAE, ASO, etc. with their clinical information at the point of contact).

Additionally, COA employees are assigned to ATUs (Acute Treatment Units) in which COA members are frequently treated. These shorter stays (typically between 3 and 7 days), have required COA to develop a process where they begin working with the member on their discharge planning at the time of admission to better transition back into the community, following their treatment.

Members in Residential/IMD facilities often have longer stays and are more likely to need outpatient/wrap-around services. As such, COA's focus is on ensuring that all members of the discharge team (including those in other organizations/agencies) are on the same page through cross-system collaboration to not overlap work and to develop the most effective treatment strategy, following

discharge. Since Crisis Stabilization Units (CSUs) are not authorized through the RAE, COA is working with the Crisis ASOs to better connect CSU providers to a member's RAE when they require further ongoing treatment; COA is currently developing pilot programs with on-the-ground providers, to this end.

With the transition to virtual services due to the COVID public health emergency, COA has worked to develop quicker communications with providers and is continuing to make alterations to their programming to address the "new normal."

• Health Colorado Inc Presenter(s): (Tina McCroy)

Health Colorado is both the RAE and the Crisis ASO for the regions they cover; they administer these services in a total of 19 counties (14 rural, 4 frontier, and 1 Urban county). They have similar procedures to those of RAE 2 due to their relationship with Beacon. Their ownership is divided between 4 different organizations which each have a vested interest in their region; this helps allow for improved care coordination and understanding of the ground resources. Tina named coordination of work (example: with local police departments) and sharing of information through their EHR (Electronic Health Records) system as positive developments that could use further improvement. Lastly, she stated that they are developing Memorandums of Understanding (MOUs) with various agencies/organizations (such as local Fire Departments and Police Departments) to improve the work they do for those in their region.

Tina listed several barriers to care as well as potential solutions. One large mitigating factor is the recent Public Health emergency due to the novel Coronavirus. She stated that the Department's 'Complex Member' list has been helpful but that making real-time data available could streamline the process and help them to respond more quickly to the needs of their members. Furthermore, her RAE has utilized on the ground resources such as the 'Directing Others to Services' Grant, which despite COVID-19, has been able to perform more in-home outreach to meet the needs of members, before their needs become more acute and costly.

Tina then discussed Health Colorado's Work Flow and how it is designed to react to their region's needs. To identify 'trigger points' and care coordination processes, Health Colorado uses a care coordination tool, . Their goal is to use this across their region and have worked on developing relationships with providers in their region. One way they do this is by having recurring care coordination with other organizations/agencies where they discuss sharing resources and to define clear roles, responsibilities, and best practices especially for 'complex/high-needs' members. Getting out of Emergency Room/Department and into treatment as quickly as possible, especially those with a Substance Use Disorder (SUD).

• CCHA: (Gelissa Diaz-Garcia)

Gelissa stated that one major, overarching goal of Colorado Community Health Alliance (CCHA) is to identify consistent, structural issues within their organization and in their regions so that they can continue to make improvements and build on those improvements. Although they have different plans to address the different needs of each region they cover (RAE 6 & RAE 7), there are common practices between each Region.

In each region they hold 'Integration' meetings with their region's ASOs, to better understand the opportunities they must work together, for the betterment of the regions they administer. Additionally, the two work together to develop co-branded teams, so that they can streamline their workflow while getting as many treatment supports involved. Additionally, CCHA has a quarterly meeting with outside care coordinators from outside agencies/organizations so that they can discuss common issues and improve the work they are doing for the members they treat. Additionally, they have a sub-group meetings where they discuss particular populations, specifically those with more acute needs.

Furthermore, in both regions any member that enters an Acute Treatment Unit (ATU) and up to get assigned either an Outreach Specialist, Peer Specialist, or Care Manager for their discharge and treatment planning. The largest area of improvement Gelissa identified was the lack of data which makes it more difficult to track the work of providers and hinders their ability to track trends.

Their Quality Team is working to develop 'Quality Insurance scorecards' to better reinforce the feedback loop. CCHA is open to feedback from providers in their region and is investigating ways to provide similar feedback to their providers (although developing measures to track has been difficult). Gelissa identified data-sharing as a barrier since it hinders their ability to integrate treatment and implement different strategies. Additionally, they attempt to identify areas for improvement and training needs for their providers so that they can consistently strengthen their provider group.

CCHA uses community partnerships and community/member education to improve their workflows. Namely, they have created a "Cheat Sheet" which provides a basic breakdown of various resources in their region. Additionally, this awareness of services has helped CCHA address issues such as over-utilization of the Emergency Department. Furthermore, CCHA has attempted to build out a provider group that is in line with their community and has looked for unique opportunities for collaboration with providers that did not previously engage.

Wrap-Up

Jeff stated that he appreciated the time everyone put into their presentations and re-capped some common themes from the discussion, such as the need to improve data-sharing and the goal of aligning metrics and incentives. Camille added that there are numerous opportunities to align the Crisis' System metrics and RAE metrics. She added that there is also an opportunity to work with Emergency Services because for other opportunities, such as clearing members medically in the field to avoid hospital admissions that would be much more expensive and maybe unneeded.

Amanda Jones asked if we could create some action items that derive from the common statements by the different RAEs and ASOs. Daniel stated that we could take time to develop questions and to organize our thoughts. Jeff stated that

PIN Survey

Camille provided an update on the Population In Need (PIN) Study. Health Management Associates created a draft that will be released in the next two weeks. The study provides recommendations on the public Mental Health System. They leveraged data from the State and various providers and agencies and were able to break down the data based on locales; for example, there is a good deal of data on the rural and frontier communities, specifically related to their lack of access to health services.

Behavioral Health Task Force Update

Daniel provided an update on the Behavioral Health Task Force, stating that they are wrapping up on their work and they are near completion of determining their specific recommendations; recently they voted on the creation of a statewide team that would provide oversight, but the specifics have not yet been determined.

Housekeeping

Jeff stated that the next meeting would be September 2, 2020. He thanked everyone for attending the meeting and ended the meeting.