Alignment and Conversation to Ensure Members Get Access to Crisis Services

Summary of BHIS Discussion on 11/9/20

Ideal State:

To have behavioral health systems (Medicaid, crisis services, providers, community resources, etc.) working together to ensure Medicaid members have appropriate access to all levels of behavioral health services as needed. **Behavioral health systems will appreciate, understand, communicate, collaborate and align with each other.**

Items needed to reach the ideal state

- Communication and follow up for members that is clear, efficient, helpful, and comes from trusted sources.
- Aligned metrics between Regional Accountable Entities (RAEs/Medicaid) and Administrative Services Organizations (ASOs/Crisis Services).
- Routine Data Sharing between RAEs and ASOs

Recommendations: Concrete Steps

- Regular meetings between RAEs and ASOs to understand and align performance monitoring as it relates to Medicaid members.
    - Because ASOs and RAEs are regional entities shared agenda items can help create consistency.
    - Standing agenda items could include:
        - data sharing
        - metric alignment
        - performance measurement
        - member communication
        - best practices and processes for local communities
    - Map out how follow-up from crisis services should be managed and delegated. This helps increase role clarity and minimize duplication.
- Duplicate what is working
    - CARES model in Colorado Springs use CORHIO and MOU between hospitals to streamline process. There are similar systems with the Community Action Collaborative in Greeley and in Douglas County.
    - All programs have extensive data sharing agreements that include law enforcement, the fire department, community health centers, RAE, and municipal courts.
    - Community case reviews include RAEs, FQHCs, CMHCs, etc. to ensure an organized system.
    - Initial funding is critical to the success of systems working. The cost savings of these community programs is evidence-based.
    - Example metrics from these programs are decreased ED utilization and decreased 911 calls.
- Participate in Behavioral Health Task Force implementation work to:
    - improve care coordination
    - support crisis co-responder models
    - increase workforce diversity (in terms of background and provider type)
    - Develop a statewide behavioral health authority that supports RAE and ASO alignment

Additional Context: Status and ways to gather more information

- Member Communication and Follow-Up
  - Follow-up can be duplicative, overwhelming and confusing.
  - Written communication to members can include vague and unfamiliar terminology.
  - Members are uncertain about what each of the involved entities are doing.
  - Involved entities have a hard time knowing what one another are doing and when things are being done.
  - Members don't understand that crisis services and other care coordination (from RAEs or other providers) might be linked.
  - More info: Case studies by an ASO and RAE could help obtain the member experience. What is happening? What can be improved? What can be streamlined? Where can responsibility be delegated?
- Metrics
  - Some metrics are regionally specific (e.g. ASO POP plans)
  - Measuring some transition from crisis contact to engagement in care would be an ideal measure.
  - There is no metric for members leaving jails like there is for members leaving prison
  - More info: An in-depth review of ASO and RAE metrics might be needed.
- Data Sharing
  - There is some access to encounter data.
  - Separating Medicaid Members from other crisis service utilizers can be difficult.
  - When crisis providers are CMHCs, it has helped with sharing data in a region.
  - More info: Identify gaps and hurdles in confidentiality and information sharing between RAEs and MSOs