Key Findings Report

Community Mental Health Center (CMHC) Interviews

Final Submission: June 18th, 2024

The Colorado Department of Health Care Policy and Financing P24-187455

Introduction

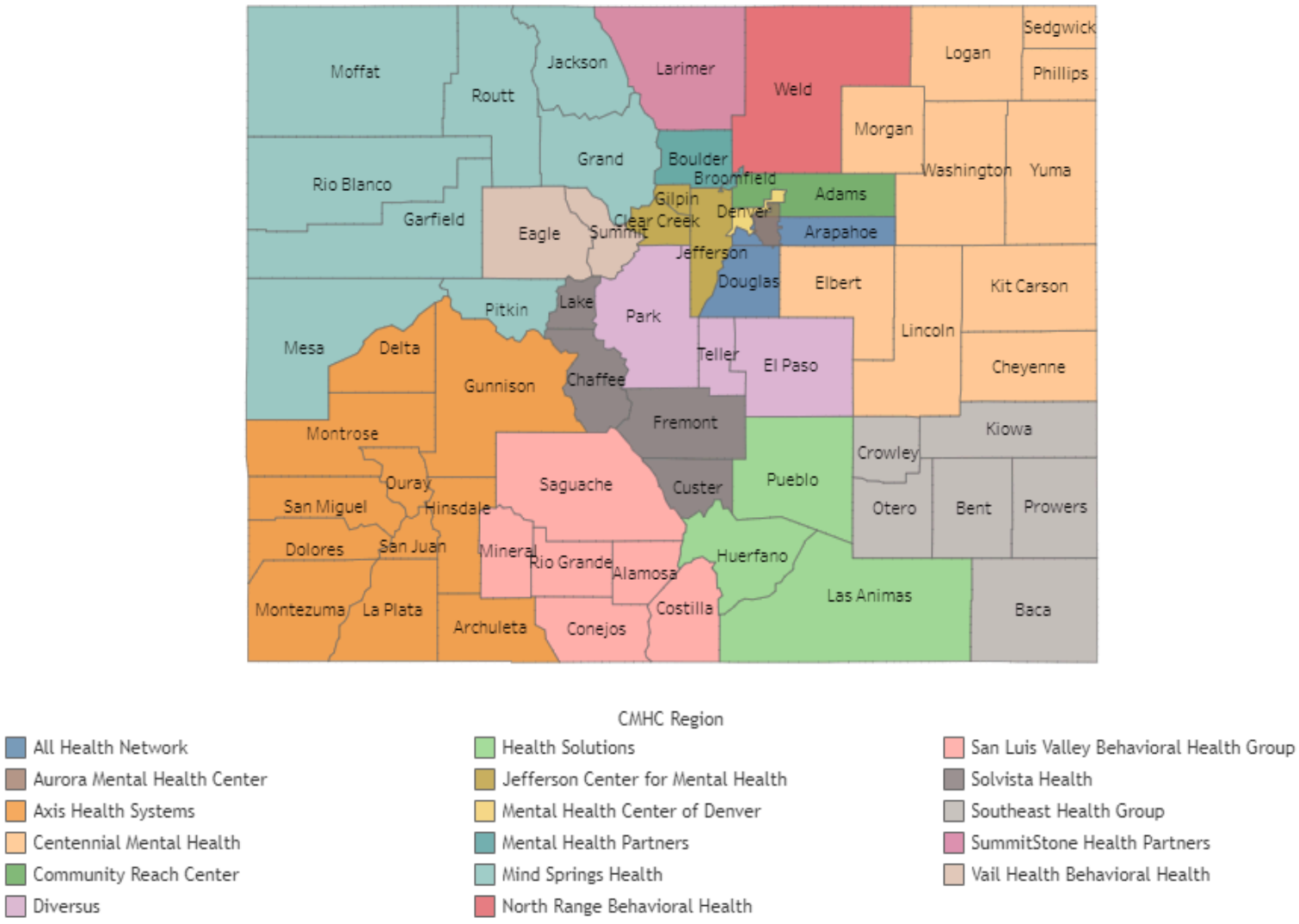
The Colorado Department of Health Care Policy and Financing (HCPF) contracted with CCMCN to evaluate the present state of electronic health records (EHR) interoperability within Community Mental Health Centers (CMHCs) focusing on data capacity, data sharing, data security and privacy, quality improvement and analytics. The results of this environmental scan and analysis were intended to facilitate a deeper understanding of each Colorado CMHC's technological capabilities and needs in a meaningful way that supports and aligns with current State priorities including the transition of many CMHCs to Certified Community Behavioral Health Clinics (CCBHCs). The information gathered during these interviews may be used to assist HCPF in guiding priorities and resource allocation for assisting CMHCs. It should be noted that while the participating entities were called CMHCs during the time of the interviews and subsequent analysis, the designation of CMHC was sunsetted as of July 1, 2024, and replaced by Comprehensive and Essential Safety Net Providers. Most CMHCs became Comprehensive Providers.

This process included 17 virtual interviews completed during March and April of 2024. The following Community Mental Health Centers were interviewed as part of this process:

1) AllHealth Network
2) Aurora Mental Health and Recovery
3) Axis Health System
4) Centennial Mental Health Center
5) Community Reach Center
6) Diversus Health
7) Health Solutions
8) Jefferson Center for Mental Health
9) Mental Health Partners
10) Mind Springs Health
11) North Range Behavioral Health
12) San Luis Valley Behavioral Health Group
13) Solvista Health
14) SummitStone Health Partners
15) Vail Health Behavioral Health
16) Valley-Wide Health
17) WellPower

The following graphic depicts the counties that are served by each respective CMHC. It should be noted that the Mental Health Center of Denver changed their name to WellPower in 2022 and Southeast Health Group merged with Valley-Wide Health in 2023.

Historical Community Mental Health Centers Map FY 2023-24[1]



[1] Colorado Behavioral Health Administration. "Community Mental Health Centers (CMHCs)". Accessed March 20th, 2024. https://bha.colorado.gov/get-behavioral-health-help#cmhc-so.

Executive Summary

CCBHC Model Adoption

The Colorado Department of Health Care, Policy & Financing is interested in learning about the technology investments that would need to be made by current Community Mental Health Centers (CMHCs) in Colorado to be able to become Certified Community Behavioral Health Clinics (CCBHCs). CCBHC is a federally designated model of care developed in 2014 to improve community behavioral health services.[2] There is varied adoption currently of the CCBHC model among Colorado's CMHCs with five centers already certified, two centers with implementation grants working toward certification, eight prospective centers, and two centers who are currently not interested in becoming certified. Although fourteen of the centers interviewed received American Rescue Plan Act (ARPA) monies with 50% using their funds to update their EHR systems, the majority of CMHCs (58%) cited needing resources to upgrade existing technologies (including, but not limited to, their Electronic Health Record (EHR) systems) to meet the requirements of CCBHC certification.

Data & Technology: Challenges and Identified Needs

In addition to each CMHCs EHR, numerous technology solutions are in use to meet the program requirements and specific needs of each CMHC, including care coordination systems and analytics software. These solutions are crucial to meeting both the business needs of each organization and improving patient experience and health outcomes. There are many systems that CMHCs are wanting to implement within their centers with the most commonly cited being patient-facing portals, Artificial Intelligence tools, and software to support internal operations. Additionally, 71% (12/17) of CMHCs are receiving health information through a Health Information Exchange (HIE), while only 5% (1/17) are sending information via an HIE. This mostly one-sided connectivity poses challenges to the ability of centers to contribute to a holistic patient record.

[2] Congressional Research Service. Certified Community Behavioral Health Clinics (CCBHCs). September 15, 2023. https://sgp.fas.org/crs/misc/IF12494.pdf

Due to the complexity and existing regulations tied to healthcare data, health information silos are common and interoperability of health IT between key stakeholders is often lacking, which decreases efficiency, undermines coordination of care, and increases costs[3]. There was consensus across CMHC interview participants that there is a need for more interoperable technology solutions to increase staff capacity by reducing the administrative burden of data collection felt by providers that is often a by-product of State reporting requirements. The standardization of metrics and reporting requirements across systems was also mentioned by participants as a way to ameliorate this burden. Additionally, there was a strong call to action for improving data sharing capabilities between CMHCs and the stakeholders they touch (including funders, payors, and community partners). Information sharing is critical to the provision of safe, appropriate, effective health care for consumers. A significant contributing factor to reported medical errors is poor information management practices.[4]

Access to quality health information is needed to support providers in reducing health disparities, ensuring health equity, containing costs, providing access to quality care, and improving the health of populations.[4] CMHCs greatly value data transparency and need improved access to their own outcome data that is often submitted as part of State reporting requirements. This would allow them to benchmark the outcomes of their services to other CMHCs across the State and create the opportunity for conversations around strengths and areas of growth. The ability to have a more holistic view of clients needs is crucial to complete additional analyses and to inform interventions and subsequent funding. Access to this data could be incredibly beneficial to client outcomes as big data analytics have shown moderate to high accuracy for the diagnosis and classification of mental disorders; prediction of suicide attempts and behaviors; and the diagnosis, treatment, and

[3] Hermes, S., Riasanow, T., Clemons, E.K. *et al.* The digital transformation of the healthcare industry: exploring the rise of emerging platform ecosystems and their influence on the role of patients. *Bus Res* 13, 1033–1069 (2020). https://doi.org/10.1007/s40685-020-00125-x

[4] Wager, K., Lee, F., Glaser, J. Health Care Information Systems: A Practical Approach for Healthcare Management. Jossey-Bass & Pfeiffer/Wiley, (2017).

prediction of important clinical outcomes of several chronic diseases[5]. Additionally, central to an evidence-based model of care coordination for patients with co-occurring behavioral and physical health diagnoses, is the need for all care teams members to have access to relevant and appropriate information through technology, and health system information.[6]

Another salient issue faced by CMHCs is how challenging it is to recruit, hire, and retain qualified behavioral health data analysts and other business intelligence support staff. These positions are often difficult to fill, especially in rural areas, and can be costly to retain although they are often essential to CMHC operations and the need to complete copious required reporting deliverables that stem from complex funding mechanisms. Staffing was cited by interview participants as the number one barrier that impacts internal data collection and analysis efforts, followed by the cost of products to manage data, data integrity, and interoperability barriers that inhibit data sharing.

Advocacy & Investment Opportunities

Past and prospective safety net providers and their clients would likely benefit from resources that support improved IT infrastructure, which would also support the implementation of the CCBHC model statewide. Additionally, CMHCs are an important stakeholder to include as the State invests more into the Social Health Information Exchange (S-HIE) and funds initial use cases as part of this work. The targeted data sources that could be brought in as part of the S-HIE work would complement existing programming in some centers and help expand the holistic client view that many centers desire having to support targeted interventions and improved outcomes. Additionally, streamlining business intelligence resources to provide support to CMHCs could be particularly beneficial, including innovative models to split or share employees across centers.

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[5] Borges do Nascimento IJ, Marcolino MS, Abdulazeem HM, Weerasekara I, Azzopardi-Muscat N, Gonçalves MA, Novillo-Ortiz D. Impact of big data analytics on people's health: overview of systematic reviews and recommendations for future studies. J Med Internet Res 23:4 (2021). doi: 10.2196/27275

[6] Williams MD, Asiedu GB, Finnie D, Neely C, Egginton J, Finney Rutten LJ, Jacobson RM. Sustainable care coordination: a qualitative study of primary care provider, administrator, and insurer perspectives. BMC Health Serv Res. 2019 Feb 1;19(1):92. doi: 10.1186/s12913-019-3916-5.

There are additional projects underway to support CMHCs desire to aggregate behavioral health data across the State to improve visibility into collective outcome metrics such as the Behavioral Health Data Exchange (BHX) Project, spearheaded by the Colorado Behavioral Health System, Inc. (CBHS). The BHX could help solve many of the barriers and challenges faced by CMHCs such as improving data sharing and analysis to then support streamlining resources and improving capacity for CMHCs.

In summary, there are several opportunities for investments and support that would improve technological advancements to improve data sharing, efficiency, and capacity within the behavioral health safety net. Improving efficiencies that can increase provider capacity are important as they will allow more patients to receive timely access to services. Additionally, data sharing amongst care team providers can improve a clients experience by decreasing the amount of time they will spend re-telling their history and ensuring providers have a comprehensive understanding to facilitate safe and appropriate treatment options.

Interview Guide

Each Community Mental Health Center that participated in an interview was asked a series of questions that were written and approved first as part of the scope of this project. The Community Mental Health Center (CMHC) Interview Guide served as the template to facilitate each interview. Each interview sought to deepen the understanding of each Colorado CMHC's current data ecosystem and technologies, priorities and strategies, barriers and pain points, care coordination, use of state-owned technology products, reporting and analytics, and privacy and security.

Key Findings Summary

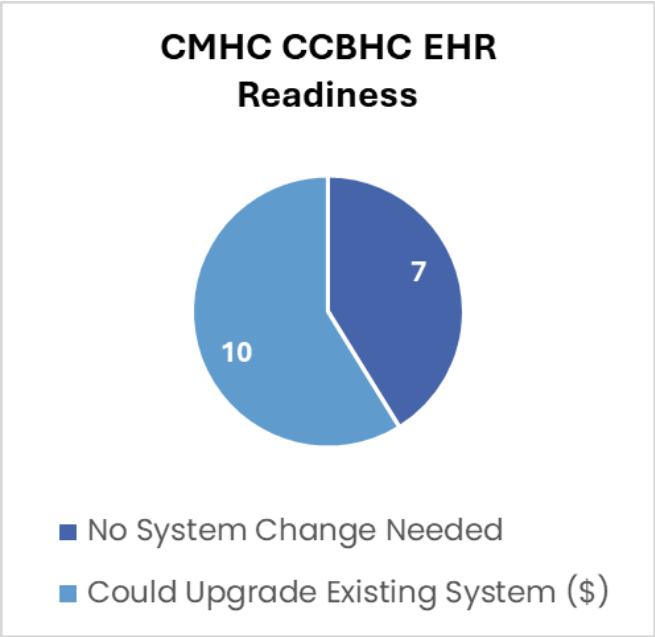
The following Key Findings Summary provides high-level trends and takeaways from the 17 Community Mental Health Center (CMHC) interviews. The feedback provided from each center is based directly on the expertise and opinions of the staff who participated in each interview and is not a representation of the State or of CCMCN.

CCBHC Status Summary

The table below identifies the current EHR being used by each CMHC and the CCBHC status for each organization:

CMHC	Current EHR	CCBHC?
AllHealth Network	SmartCare	No
Aurora Mental Health & Recovery	SmartCare	Yes
Axis Health System	NextGen, transitioning 10/2024	Yes
Centennial Mental Health Center	myAvatar	No
Community Reach Center	NextGen, transitioning 7/2024	Not interested
Diversus Health	SmartCare	No
Health Solutions	myAvatar, Next Gen, Methasoft	No
Jefferson Center for Mental Health	myAvatarNX	Not yet
Mental Health Partners	SmartCare	Yes
Mind Springs Health	myAvatar	No
North Range Behavioral Health	myAvatarNX	Yes
San Luis Valley BHG	myAvatar	No
SolVista Health	myAvatarNX	Yes
SummitStone Health Partners	EPIC	Not yet
Vail Health Behavioral Health	Oracle Health	Not interested
Valley-Wide Health	NextGen	No
WellPower	myAvatar	No

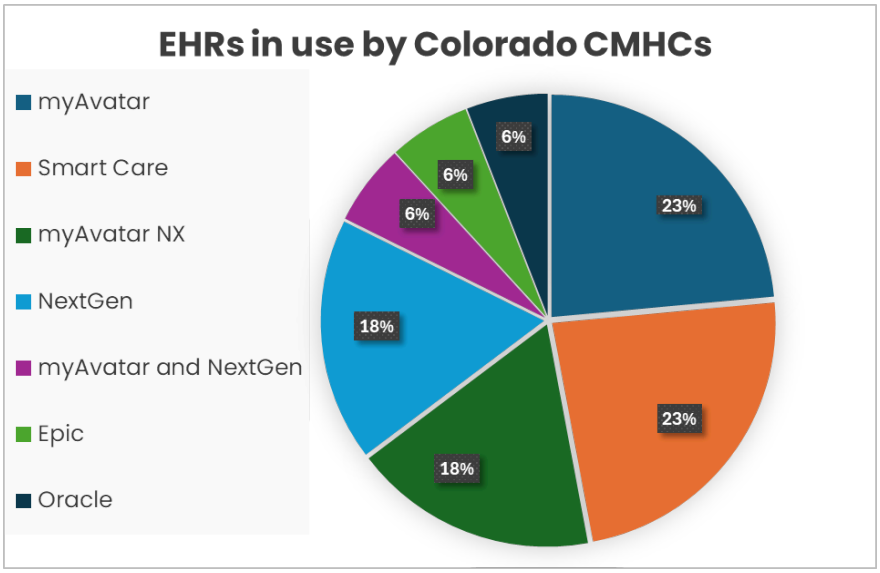
CMHC CCBHC EHR Readiness



When it comes to whether or not CMHCs EHR systems *could* support becoming a CCBHC, ten centers could upgrade their existing EHR systems at a cost and seven have EHR systems that are ready to support becoming a CCBHC. Whether or not they anticipate adoption of new technologies, need additional infrastructure to support the adoption or are considering upgrading existing systems is explained in detail above in the *CCBHC Status and EHR Details* section.

Electronic Health Records of Use

The graphic to the right depicts the EHRs being used by Colorado's CMHCs. MyAvatar and SmartCare are the most commonly used, each by four centers, followed by myAvatar NX and NextGen which are each used by three centers. Epic and Oracle are each used by one center and one center is using both myAvatar and NextGen to deliver services.



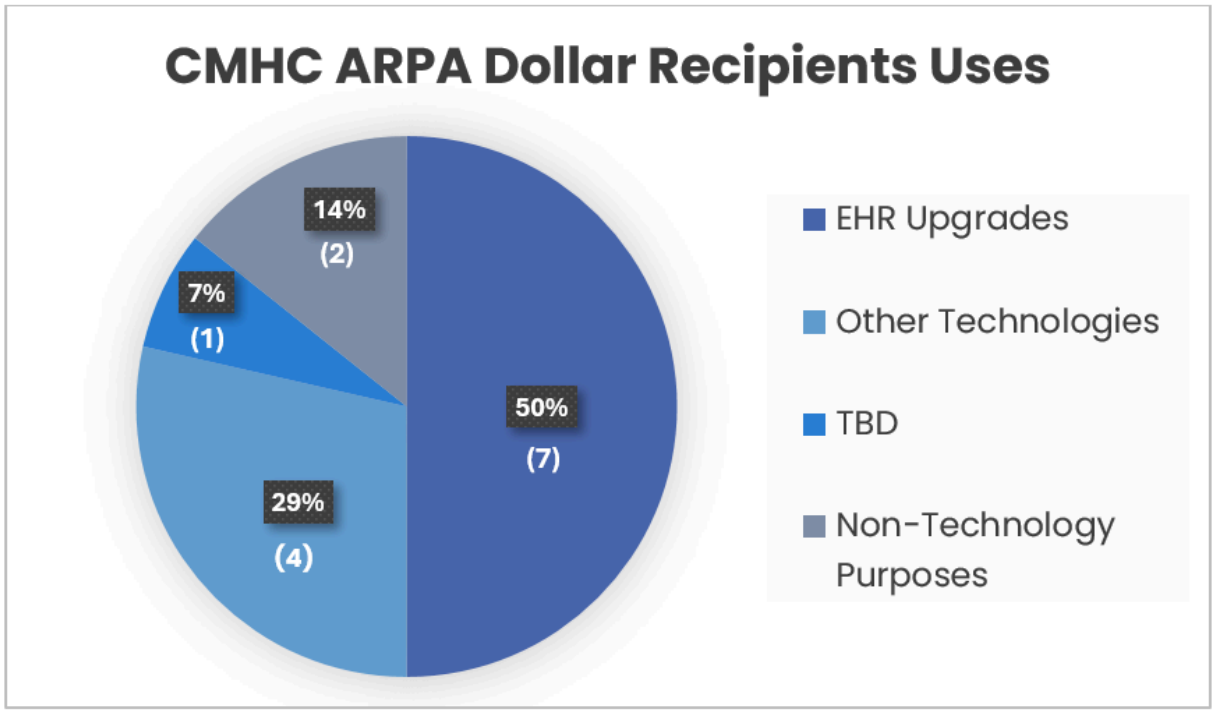
ARPA Grant Funding Recipients and Usage

For each CMHC, the table below identifies whether or not the center received ARPA dollars and what the funding was used for. Overall, fourteen centers received ARPA dollars and twelve were eligible to use their monies to support technology upgrades or implementations.

CMHC	ARPA Funding Recipient?	Usage
AllHealth Network	No	N/A
Aurora Mental Health & Recovery	Yes	EHR Upgrades
Axis Health System	Yes	EHR Upgrades
Centennial Mental Health Center	Yes	EHR Upgrades
Community Reach Center	No	N/A
Diversus Health	Yes	Technology upgrades TBD
Health Solutions	Yes	EHR Upgrades
Jefferson Center for Mental Health	Yes	Telehealth platform "Mend" implementation and EHR upgrade at Jefferson Hills
Mental Health Partners	Yes	Eleos Health "Scribe" implementation
Mind Springs Health	Yes	EHR Upgrades
North Range Behavioral Health	Yes	Patient Facing Portal
San Luis Valley BHG	Yes	EHR Upgrades, Patient Facing Portal, Cloud transition
SolVista Health	Yes	EHR Upgrades

SummitStone Health Partners	Yes	ARPA monies not eligible to support technology upgrades
Vail Health Behavioral Health	Yes	ARPA monies not eligible to support technology upgrades
Valley-Wide Health	No	N/A
WellPower	Yes	Technology upgrades for reporting requirements

Below is a visual depicting what ARPA monies were used for by recipients:

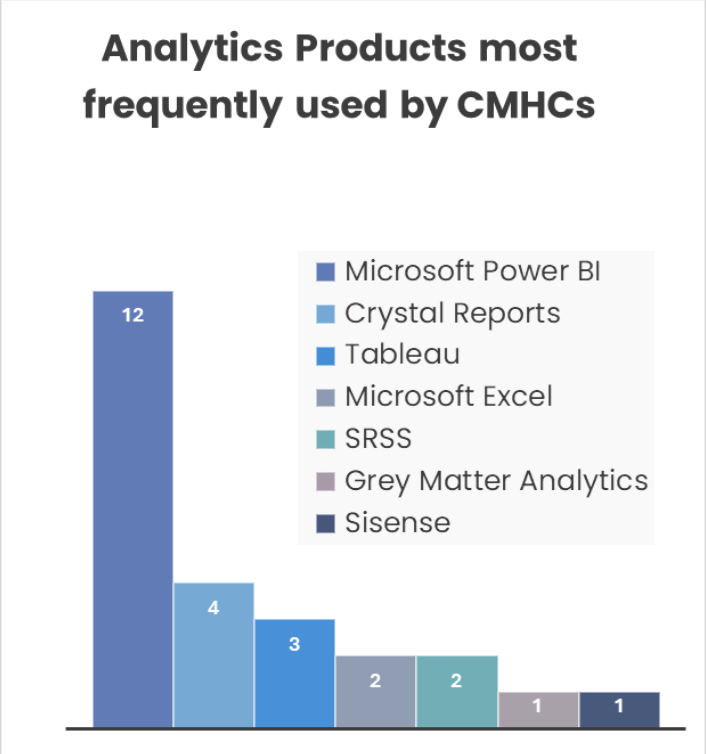


The centers that are using ARPA funding to support EHR Upgrades are: Aurora Mental Health & Recovery, Axis Health System, Centennial Mental Health Center, Health Solutions, Mind Springs Health, San Luis Valley Behavioral Health Group, and Sol Vista Health. The centers that are using ARPA funding to support the upgrade or implementation of other technologies are: Jefferson Center for Mental Health, Mental Health Partners, North Range Behavioral Health, and Well Power. SummitStone Health

Partners and Vail Health Behavioral Health both received ARPA funding that was not eligible to be used for technology support. Finally, Diversus Health has not yet determined what specific technology upgrades they will be using their ARPA grant funding for

Analytics Products and Barriers

Numerous analytics products are being used by CMHCs to support their various business lines. The most common products in use include Microsoft Power BI, which is being used by twelve different centers, and Crystal Reports, which is being used by four centers.



Microsoft Power BI was mentioned to be "affordable" compared to other analytics technologies and "easy to customize and adjust." Crystal reports was described as an "antiquated technology" that requires a specific skill-set. However, the product is still in use by many centers because they don't currently have access to alternative technologies to meet their needs.

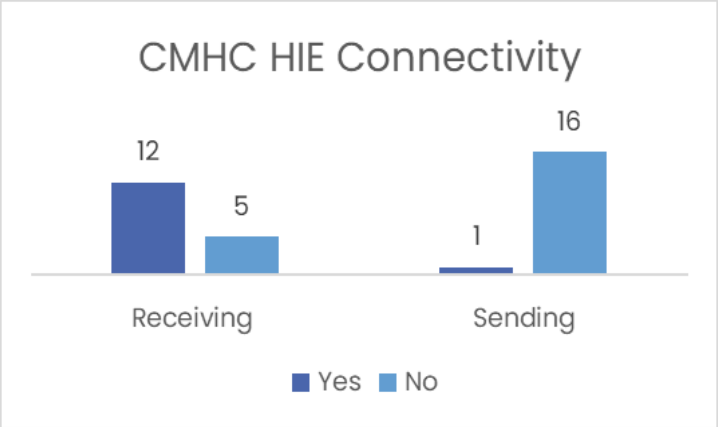
There were several barriers mentioned by CMHCs that impact the data collection, storage, and analysis efforts of each center. Challenges with the staffing needed to effectively complete activities in support of data collection, storage and analysis was the most frequently mentioned barrier followed by the funding or cost associated with these activities. Additional barriers include data integrity, interoperability, reporting requirements,

and EHR functionality. The table below outlines all mentioned barriers and the frequency they were mentioned by the CMHC participants.

Barriers that Impact Data Collection, Storage, and Analysis	Total
Staffing (Reporting Burden/Time Allocation)	7
Funding/Cost	6
Data Integrity (Cleanliness)	6
Interoperability Barriers (Data Sharing)	5
Reporting Requirements (Complexity)	4
EHR Functionality (Upgrades, Interoperability)	3
Training	2
Business Intelligence Resources	2
State Systems	1
State Communication	1
Need for AI/Automation to improve efficiency with data collection	1
Consent	1
Data Governance	1
Claims Data	1
Security	1

Information Exchange: Feedback and Opportunities

CMHCs have widely adopted HIE solutions from Contexture and QHN, however, they predominantly receive information in a unidirectional data flow rather than engaging in bidirectional exchanges. This one-sided connectivity poses challenges in constructing comprehensive patient records, particularly concerning essential CMHC data. The unidirectional data feeds limit the potential for developing longitudinal patient records necessary for a holistic understanding of each patient's health journey. Additionally, challenges with governance policies, regulatory requirements, and the ability to ensure privacy and the proprietary control of data also influence the extent to which CMHCs engage in bidirectional data exchanges.



Additionally, CMHCs might be constrained by technological limitations or financial considerations that affect their ability to establish bidirectional data exchange capabilities. Despite these challenges, efforts to promote awareness and education about the benefits of bidirectional HIE data exchange could encourage CMHCs to explore and implement such solutions more extensively.

While some CMHCs remain unaware of how their organizations utilize HIE data, others leverage it for enhancing care coordination efforts or individual patient care decisions. CMHCs have explored other opportunities to consume HIE data outside of the 2 State HIEs, including HIE feeds provided by their EHR (like Epic's Care Everywhere or CommonWell).

It's important to note that the information gathered regarding CMHCs' utilization of HIE solutions and the nature of their data exchange might not fully reflect the current status of their subscriptions or practices.

The Colorado Client Assessment Record (CCAR)

The Colorado Client Assessment Record (CCAR) is a clinical instrument that is designed to assess the behavioral status of a consumer in treatment.[7] All licensed and designated behavioral health providers, including CMHCs, are required to submit CCAR data.[7] Additionally, the Drug and Alcohol Coordinated Data System (DACODS) is also utilized as the primary SUD client level treatment data collection instrument required by the Behavioral Health Administration.[8] Although centers were not asked specific questions about DACOD completion and reporting, it should be mentioned as a required tool that is used to monitor service quality, utilization, and effectiveness, and to report to the legislature on treatment outcomes and service needs in Colorado.[8]

As part of this interview project, CMCHs were asked to describe their process for CCAR reporting and any barriers or areas of improvement. The following highlights the key themes or areas of improvement mentioned by participants:

13 centers mentioned the *administrative burden* of the CCAR process. This included mentioning the process for completing and reporting on CCARs being time intensive, manual, and/or using excessive staff resources

9 centers mentioned that addressing issues with CCAR *submission errors* was a challenging and cumbersome process

6 centers mentioned concerns with the *validity* of the CCAR tool and/or the *objectivity* and *accuracy* of the data produced by the CCAR

5 centers mentioned challenges with *matching existing data fields* in their systems with data fields that are required for CCAR reporting

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[7] Colorado Behavioral Health Administration. "Final FY23 CCAR Manual." Accessed April 30th, 2024. https://bha.colorado.gov/sites/bha/files/documents/FINAL%20FY23%20CCAR%20User%20Manual.pdf.
[8] Colorado Behavioral Health Administration. "DACODS User Manual (Drug and Alcohol Coordinated Data System)." FY 22/23, Version 2022.1, July 1, 2022-June 30, 2023. https://bha.colorado.gov/sites/bha/files/documents/FINAL%20FY23%20DACODS%20User%20Manual.pdf

5 centers mentioned the need for the State to *automate* the CCAR reporting process to ease the burden placed on centers

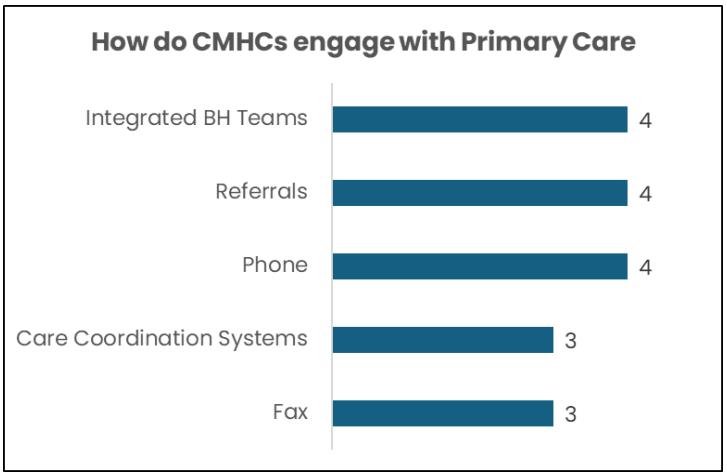
4 centers mentioned the need for *aggregated outcome data* from CCARs for their center and others around the State to inform patient care or population health

3 centers mentioned that there is *no perceived value* for patients and/or providers to complete CCARs

2 centers mentioned the portal used to accept CCAR data is of *antiquated* technology and *needs modernized* to support more automated processes

Interoperability Challenges between CMHCs and Primary Care

CMHCs recognize the significance of integrating with primary care providers (PCPs) to enhance patient outcomes. Some CMHCs have incorporated Behavioral Health teams within Primary Care settings to foster collaboration and improve patient care. However, CMHCs and PCPs are faced with numerous technological barriers when it comes to the interoperability of existing systems, impeding the establishment of automated communication methods. Several CMHCs indicated their reliance on traditional communication channels like phone and fax to engage with PCPs, underscoring the deficiency in efficient interoperability solutions.



The CMHC challenges faced in achieving interoperability with PCPs likely mirror those documented in the absence of bidirectional connectivity between HIEs and CMHCs.

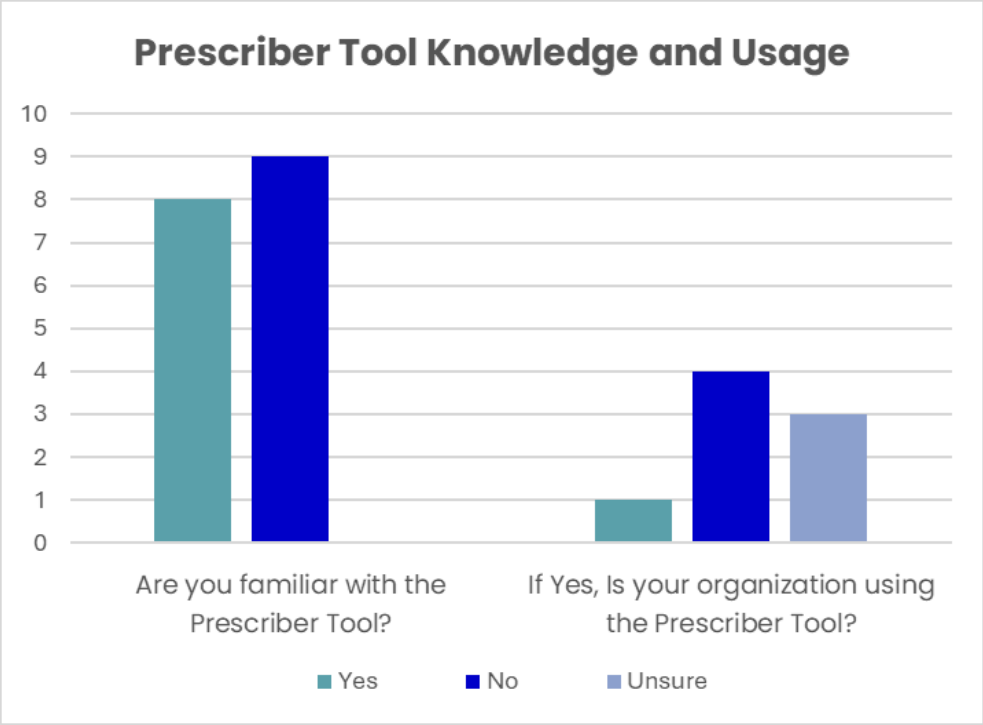
Despite these obstacles, some CMHCs are actively pursuing automated solutions through other methods. CMHCs reported utilizing care coordination systems or

resources to enhance communication with Primary Care. These endeavors aim to bridge the gap between services provided by CMHCs and the broader ecosystem represented by PCPs.

Enhancing interoperability between CMHCs and PCPs is pivotal for improving patient care outcomes and addressing individuals' holistic health needs. Streamlining communication channels through automated interoperability solutions can facilitate timely information exchange, enabling better-informed treatment decisions and coordinated care efforts across different healthcare providers. As CMHCs navigate these challenges, prioritizing interoperability initiatives can facilitate more effective collaboration, ultimately enhancing the quality of care for patients.

Prescriber Tool Knowledge

Each CMHC was asked if they were familiar with the State's Prescriber Tool platform and, if yes, whether or not their organization was using the tool. Additionally, they were asked what the perceived benefits or barriers of the tool are and how HCPF could improve the experience of the end-user. There were eight CMHC's that stated



they were familiar with the Prescriber Tool, and of those, one stated they were using the tool, four were not, and three were unsure if the tool was being used internally. The majority of CMHCs who had not heard of the Prescriber Tool were interested in learning more about the platform and how it could be used inside their organization.

Additional Feedback

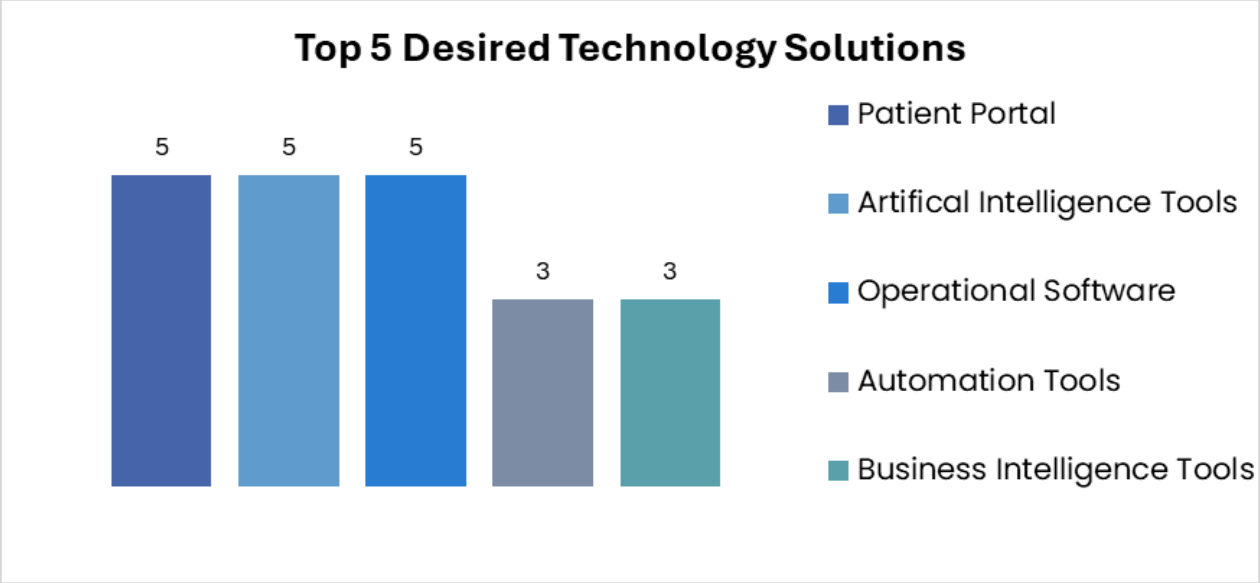
CMHC's who are aware of the Prescriber Tool but not using it offered the following additional feedback related to why it is currently not being used inside their organization:

- "Time is the problem."
- We need to better understand what the global benefits of these tools are other than saving costs Statewide. It is hard to get provider buy-in without this directly benefiting the individual patient.
- "Newer, more modern medications are prescribed for psychiatric conditions because of side effects and this should be a consideration above costs."
- The State has not done well communicating effectively about the Prescriber Tool, overall. Recently an email was received asking organizations to complete a survey and start using the tool to be eligible for incentive payments. Maybe this will help adoption.
- A barrier to using the tool is that providers have their autonomy diminished when using this so more education for them would be helpful.
- The issue with the Prescriber Tool is that it doesn't fit well into workflows and it doesn't provide robust information, specifically for prescribers. It shows the cost, but if the patient is on Medicaid it has no bearing on the person themselves since their medications are typically covered.
- The tool could be improved by adapting to individual workflows better with Single-Sign-On capability.

Technology Wish List

Below you will find the top desired technology solutions identified by CMHCs. Most commonly cited are patient portals, Artificial Intelligence tools, and software to

support internal operations. Patient Portals are needed to reduce administrative burden and improve client access to pay bills, schedule appointments, and access their records. Artificial Intelligence tools were mentioned to be helpful in assisting providers with dictation and documentation and to improve other organizational efficiencies. Operational software was also frequently mentioned as a need to assist with project management, human resources, and accounting.



The following technology needs were also mentioned one time each:
a Health Information Exchange solution, point of service information, off-site patient kiosks, referral tracking, 24/7 emergency response technology, a Statewide centralized reporting system, and technology that is interoperable with current systems.

Additionally, it was mentioned that the most common form of access in the behavioral health industry is telemedicine so it would be helpful for provider's to understand what client's access to broadband or cellular service is and what is needed for clients who are primarily in rural areas to access services.

CCBHC Certified Centers

Aurora Mental Health & Recovery

This center received their first CCBHC expansion grant in 2020 and then received funding again in 2022. They are currently in year two of a four year grant cycle. The CCBHC module of their EHR, SmartCare, costs an additional $12,000 per year on top of core functionality fees which could fluctuate over time. This cost includes biannual updates to the product. The NOMS module has a stand-up fee and a $1,000 per-year ongoing cost. Currently, Aurora Mental Health & Recovery are evaluating moving to a cloud-based structure for their organization which could double their annual costs as they are currently self-hosted. Any sort of customization of their EHR incurs significant costs unless it is a change that could potentially impact the entire Colorado SmartCare group which could lead to a cost-sharing discussion.

There is a large administrative burden attached to gathering and reporting metrics to regulatory agencies. Many require similar but different metrics which means staff are asking clients similar things over and over again. It was also mentioned that "you can't move information easily in systems if it doesn't match," which alludes to the process and difficulty of data matching between various systems to create a unified client view for analysis and reporting purposes. Better ways to gather information automatically are needed so that staff don't have to move it manually.

Axis Health Systems

This organization was recently CCBHC certified and did not need to replace their EHR to do so, however, they are transitioning to NextGen in October to streamline behavioral health service records, physical health service records, and dental records. Currently they are working to develop web-based forms to capture National Outcome Measures (NOMs).

If the State mandates reporting requirement changes then typically these will need to be completed by the vendor which will then incur additional costs. However, changes in reporting requirements that come from the federal government are typically included in system upgrades.

Mental Health Partners

This organization was the first CCBHC in Colorado. They reported a minimal lift to become a CCBHC because their EHR, SmartCare by Streamline, had the functionality needed to do so. However, interoperability has been a challenge. This is not necessarily an issue with the platform itself, but they are unable to optimize the user interface (UI) due to the amount of customizations they have done.

Hosting fees are predicated on user numbers which scale in cost for what they have to build out in their infrastructure. They also pay for the rights to use the software and the fees go up and down depending on "what they have consumed." Additionally, there is a maintenance agreement for customizations. For State-required changes that the entire Colorado user group needs they are able to share costs collectively, but for changes specific to them there is an hourly rate incurred based on needs.

Mental Health Partners would like to see a way to simplify the burden of effort for reporting such as a State-wide centralized reporting system created in collaboration between State partners and the entities that will be required to use it. Other ways to decrease administrative burden such as a user-friendly client portal that could feed data back into the system would also be helpful.

North Range Behavioral Health

This organization became CCBHC certified three years ago which was a very “large lift” as multiple modifications to their EHR, myAvatar NX, were needed. The myAvatar NX product costs NRBH more than $500,000 per year. Typical costs associated with modifications for this product are between $5,000-$10,000 which each require an associated Scope of Work and addendum and often create recurring fees. To become a certified CCBHC likely cost the organization “millions of dollars” although some of these costs were offset by the ARPA grant monies received. ARPA dollars supported building out and standing up the client-facing portal. Additional high-costs associated with becoming a CCBHC have been related to hiring staff.

The wait associated with changes or modifications needing to be done to the EHR based on new requirements is a challenge and creates a large administrative

burden. They are still working to figure out how to make modifications to the EHR quickly to address changes. One modification could take between 90 days and 6 months. The organization is also limited in funding to purchase add-ons because they are expensive.

SolVista Health

To become certified as a CCBHC, SolVista was able to use Dollars to Digitize funding (funding from 9817 HCBS ARPA) to help cover some of the associated costs. The core functionality of their current EHR, myAvatar NX, met CCBHC certification requirements. However, the reporting metrics for the CCBHC accreditation required more of an investment than the infrastructure itself.

The current cost structure for the EHR is a hybrid model with both subscription-based costs and platform-based costs. The costs associated with upgrades and modifications needed for State requirements are "outrageous" for them as a small but critical safety net provider in rural and frontier Colorado. The EHR has to have the same functionality as really large centers to meet the requirements for insurance, the State, and the Federal government. Implementation costs, upgrades, building data connections, integrating with systems and other developments needed to keep up with industry standards are challenging. Being paid retrospectively for services rendered is difficult as a small center.

CCBHC Implementation Grantees

Jefferson Center

This organization is currently in year one of four of an implementation grant that has awarded them $1 million each year for four years to support becoming a CCBHC. Their current EHR, myAvatar NX, will be able to support the organization as a CCBHC. A significant portion of the CCBHC implementation grant monies awarded to Jefferson Center are being used to improve infrastructure and technology.

Additional costs that are incurred due to State required modifications or upgrades are considered a "sore spot" for the organization. This stems from the failed launch of Compass 2.0 and the costs associated with the required changes for this program

which cost Jefferson Center “hundreds of thousands of dollars” to prepare for something that never happened. When the State or other funders ask for supplemental files or codes to be changed this is a direct cost from either internal staff or the vendor, Netsmart.

There is a hesitation to jump into any additional Health Information Exchange (HIE) endeavors because there is no return-on-investment from a care or cost perspective. For CCBHC there will be a need to further HIE but there is skepticism of the market and a need to understand how consent will be managed at the State level.

SummitStone Health Partners

SummitStone is working toward CCBHC accreditation and is currently in year two of a CCBHC implementation grant. They recently transitioned their EHR from myAvatar to EPIC in December of 2023 and are working to build out the appropriate assessments to capture needed data to support both National Outcome Measures (NOMs) and Government Performance and Results Act (GPRA) outcome measures. CCBHC planning and implementation work has included specific strategic plans for both technology and data with internal work groups and committees that assess data needs, evaluate potential technology vendors, and determine areas for improvement.

SummitStone paid a one-time implementation fee to UCHealth and now pays a monthly service fee to have access to all EPIC applications. Additional fees are incurred if SummitStone wants an application that is new to UCHealth and not pre-existing in the system but there are no anticipated significant additional costs. This pricing structure is very different from the previous arrangement with Netsmart which included user and licensing fees and separate charges for cloud hosting. This was challenging, complex and hard to budget for due to unexpected fees.

There is a lot of needed review and customization for State reporting data requirements, therefore, the standardization of reporting elements would greatly improve the need for internal resource dedication to this. Simplification and anything to improve ease-of-use would be best. Funders and payors all want different but

similar metrics.

Prospective CCBHCs

All Health Network

This organization has a goal to become a CCBHC and are currently meeting some of the CCBHC requirements. Their existing EHR, SmartCare, offers a CCBHC module that they feel will support additional required functionality. This module has an annual subscription fee of $12,000 per year for four years and a one time implementation fee of $4,000. There is an expected 3% increase annually.

Funding is the largest barrier in getting new technologies implemented which is an industry-wide challenge due to CMHC payment mechanisms. The organization is not revenue generating and IT is an indirect patient care cost. The way reimbursement is structured barely covers the cost of services. When it comes to the process of inputting and extracting data for various purposes, the most valuable component for success is being able to create interoperability between systems. Although interoperability is part of the organization's IT roadmap, there is a large cost associated with it. Additionally, funding is needed to implement automation that could ease administrative burden but there is a need to build a strong and scalable infrastructure first.

Centennial Mental Health Center

This organization looks to the CCBHC framework as a "guiding star" for anticipated upgrades. Clinically they are able to meet CCBHC standards but their current technology does not support this so the organization is working to build out and modernize organizational and technological infrastructure. This includes selecting a new EHR (or possibly upgrading their current EHR). They want an EHR vendor that has the flexibility to meet CCBHC requirements, as well as being a single place to tie data together and get the analysis that is needed.

There needs to be more standardization from the State when it comes to reporting requirements. Colorado tends to adopt a national standard and then makes Colorado-specific tweaks which requires everyone to amend their systems. CMHCs

need to be able to benchmark to their peers across the State which they are currently unable to do. Accessibility and transparency of data to support reporting in a timely and meaningful way is also needed. The volume of disparate audits the CMHCs have to do is very challenging because everyone wants something similar but different which creates a need for multiple custom reports.

Diversus Health

This organization has applied for grant funding to become a CCBHC but has not been selected as a recipient. They plan to complete a CCBHC readiness assessment soon and are exploring EHR vendors who have included CCBHC modules. The money they have received through the Dollars to Digitize program will be used to upgrade their current EHR. The organization is interested in any product that uses automation and/or can improve efficiencies through its adoption. Current reporting structures are sound but it would be ideal to update back-end interfaces once future State data requirements are better understood.

Health Solutions

This organization applied for funding two years ago to support becoming a CCBHC but was not awarded. However, they did receive ARPA funding that was used to upgrade and purchase new modules for their previous EHR, myAvatar, to move to the enhanced product, myAvatar NX.

When it comes to costs incurred for upgrades or modifications for Netsmart products, if something needs "reprogrammed" then a per-hour billable cost is typically incurred. Many CMHCs in Colorado use Netsmart and this group has made changes collectively before such as splitting the costs for a form that needed completed for the now defunct COMPASS project that was going to combine CCARs and DACODS. The largest ongoing costs for technologies are the cloud costs to host everything in that environment.

Mind Springs

This organization applied for implementation grant funding to support becoming a CCBHC but was not awarded. Upgrades to their current EHR, myAvatar, would be

needed to meet CCBHC requirements such as collecting all of the required demographic information. Currently, the organization is exploring other platforms to interface with their EHR to support the required bidirectional flow of data needed for CCBHC, and to address issues related to data collection, submission, and analysis. Additionally, the system is not agile or flexible and it is quite costly to make modifications based on State requirements which typically cost around $20,000, not including internal staff time and training needed.

Concerns exist that there are not enough primary care providers in the region to support the CCBHC model. On the Western Slope, community members often visit urgent care facilities while they are waiting to establish care with a PCP where the average wait time is 3 months for an appointment.

San Luis Valley Behavioral Health Group

This organization is familiar with the CCBHC model and is considering applying to be one in the future. Their understanding is that they will be able to retain their current EHR, myAvatar NX, to become a CCBHC but will need to make some upgrades. The annual cost of myAvatar NX is $350,000 per year. When it comes to additional costs incurred with upgrades or modifications to the EHR, there is a clause in their contract saying that required State changes must be covered by the vendor, Netsmart. However, since the Colorado Psych-care Consortium recently ended, this may no longer be in effect so that is yet to be determined.

Valley-Wide Health Systems

This organization is not currently a CCBHC but knows that their current EHR, NextGen, has the functionality to support becoming one. They have applied for additional funding to support becoming a CCBHC in the past but were not awarded at that time. However, Southeast Health Group and Valley-Wide merged companies in 2023 and Southeast Health Group received a CCBHC planning grant a few years ago.

The current pricing structure for Next Gen is based on a “per-provider” monthly licensing fee and the majority of needed modifications based on State requirements or otherwise are able to be completed internally.

WellPower

This organization has applied for a CCBHC planning grant but has not been awarded. They are hopeful that Colorado will implement a Statewide CCBHC designation as it is felt that CCBHC is the "model of the future" with beneficial standardization for behavioral health services. Currently, WellPower is in the process of preparing their EHR, myAvatar, to support CCBHC certification. The product is highly configurable and able to support the model as the vendor, Netsmart, has already supported the CCBHC model in other states

The pricing structure for their EHR is a per-user licensing agreement with an economy of scale. Costs are incurred for modifications and the biggest challenge with this is when the State introduces new requirements without sufficient lead time for the organization to make changes and so it ends up costing more because it needs to be rushed.

Centers Not Interested in CCBHC Adoption

Community Reach Center

This organization is very familiar with the CCBHC model and received grant funding in 2015 to develop a cost proposal for CCBHC. They would like to see a fee structure that helps CMHCs pay for CCBHC certification. Community Reach Center feels that the current unit costing method for CCBHC that was developed by CMS puts providers at risk. They do not see the need to transition EHRs or any significant costs to becoming a CCBHC in the future as their EHR, NextGen, has already configured their system to support CCBHC in other states.

Overall, there is a large administrative burden associated with collecting data at the organization level and CRC would like to see data used for analyzing outcomes together as a larger system instead of "just to fulfill a contract". The State may request a specific piece of information but the system is not designed to collect this metric so it makes sense to approach this together and develop a solution that meets everyone's needs instead of making expensive one-off changes. Strong, positive reciprocal relationships between the State and provider organizations are needed whereby KPI's are developed together thoughtfully.

Vail Health Behavioral Health

This organization does not plan to become a CCBHC after working with a consultant to determine their interest. They found too many pain points related to the mandated intake structures and barriers with reporting for the CCBHC model. Additionally, it is felt the CCBHC model is inequitable for clients who have Health First Colorado insurance because of the assessments that are required to be completed with them versus clients with commercial insurance. The time needed for these assessments takes away from direct patient care during the initial phases of engagement which are critical for establishing a positive provider-client relationship.

The current EHR being used by Vail-Health Behavioral Health, Oracle, is meeting their needs from a functional standpoint, although there have been challenges with external reporting due to State requirements. This product was selected because of its ability to be used across service lines, its interoperability across the system, and its customization capabilities for behavioral health-specific needs. This product is also used by the largest hospital system in the region. EHRs are not designed to meet State reporting requirements so there are continued costs to extracting data from the EHR and reporting it to the State via the method requested.

The Colorado Behavioral Healthcare Council and the Behavioral Health Data Exchange (BHX)

As part of this interview project, the former CEO of the Colorado Behavioral Healthcare Council and current consultant leading the Behavioral Health Data Exchange (BHX) Project, also participated in an interview to discuss the work being done to improve and expand the shared behavioral health data environment in Colorado through a Behavioral Health Data Exchange.

The Colorado Behavioral Healthcare Council (CBHC) serves as the statewide membership association for Colorado's network of community behavioral health providers. Membership of the council includes 16 Community Mental Health Centers (CMHCs) and one specialty clinic.[2]

The CBHC participates in numerous specialty projects to support their members. One such project, the BHX Project, was conceptualized in response to CBHC members' desire to bring their data together in a more comprehensive way and to leverage that collective data to support policy and advocacy opportunities in State and National arenas. The founding stakeholders and current supporters of the BHX Project include the members of the Colorado Behavioral Health System, Inc. (CBHS). This entity is separate from CBHC but has the same Board of Directors.

Data sharing in the behavioral health world has reportedly been perceived as challenging due to specific regulations that differ from other privacy laws. Individuals who suffer from mental illness face higher levels of stigma and discrimination in health care and this, among other things, has historically contributed to provider trepidation in data sharing due to the possible unintended ramifications of the sharing of data that is considered highly sensitive and stigmatizing[9]. However, in addition to the interest at the State level for CMHCs to begin collecting Center for Medicare & Medicaid Services (CMS) core measure data and with the advent of the Certified Community Behavioral Health Clinic (CCBHC) movement, it became clear that to efficiently serve clients best interests there is a need to holistically understand their physical, social, and behavioral health needs. Colorado's State Innovation Model and House Bill 22-1302 have also impacted the trajectory of data sharing in the State in support of more integrated models of care.

There are numerous metrics that CMHCs mentioned they would like to analyze collectively, including, but not limited to, patient demographics, services rendered, depression and anxiety inventories, and Behavioral Health Incentive Program Measures outcomes. These reasons, among others, helped to define the need for a behavioral health data environment where CBHC members could bring their data together in a shared, centralized place. This would also allow them to complete analyses on both individual and aggregate level data that could support State reporting requirements and allow for benchmarking to other centers both in Colorado and nationally to better understand how to improve outcomes. Coming

[9] National Library of Medicine. "Mental health professionals' perceptions on patients' control of data sharing." Accessed June 3rd, 2024. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9310561/

together to make decisions as a collective partnership will improve advocacy opportunities and organizational capacity.

Long term, the biggest need that could be met with a Behavioral Health Data Exchange is the need for CMHCs to have the ability to easily share data with each other to collectively support State reporting requirements and standardization. However, there is also a desire to be able to share patient level information with hospitals, other community partners, the State, Regional Accountable Entities (RAEs), and anywhere else real-time collaboration could improve client care and outcomes without having to extract this from disparate systems. This could be especially helpful to support the holistic view of a patient's journey and continuum of care if they are accessing behavioral health services across various providers in the State.

The BHX project is set to begin a six-month Proof-of-Concept phase in May of 2024. If this goes as anticipated, they will begin onboarding organizations and move into the Minimum Viable Product (MVP) phase. Leadership is working to secure additional funding to support the project.

Opportunities for System Improvements

The following recommendations and suggested opportunities are a summary of feedback based on the information gathered during CMHC interviews.

Interoperable Solutions to Reduce Provider Burden

There was consensus across centers that the need for more interoperable applications and other technology solutions is critical for providing person-centered services in a timely and efficient way. Improving interoperability can benefit both the organizations delivering services and the clients receiving services. Interoperability reduces the administrative burden of duplicate entry and the potential for errors associated with it. It also can improve client care by enabling more efficient communication and referral practices and leave more time for direct client care.

Each CMHC is using various technology solutions and applications to meet their needs. For example, Vail Health Behavioral Health has 160 applications currently in use. For many centers the resource and complexity of managing numerous solutions is unsustainable, leading to prioritizing core functionality in place of innovation like many would like to do.

EHRs, care coordination systems, and analytic solutions need the ability to appropriately ingest and send several data sources to reduce the administrative burden felt by CMHCs.

Improve Data Sharing

CMHCs value and understand the importance of sharing data and how doing so can greatly benefit both client care and improve organizational efficiencies. However, it was mentioned often that there is a general trepidation about sharing data and what is allowable, specifically for behavioral health data. Patient information specific to SUD has additional protections in place and specific requirements needing to be met that enable the sharing of this information under Title 42 of the Code of Federal Regulations Part 2: Confidentiality of Substance Use Disorder Patient Records (often referred to as "42 CFR Part 2"). Part 2 is intended to ensure that patients who are receiving treatment for SUD in a Part 2 program do not face adverse consequences in relation to issues such as criminal or domestic proceedings[10]. In general, Part 2 programs are prohibited from disclosing any information that identifies a person as having or having had a SUD unless that person provides specific written consent[3]. Part 2 program regulations differ from HIPAA privacy laws and this was mentioned as a challenge for CMHCs to navigate. Improved clarity around consent mechanisms and sensitive information sharing are needed to support CMHCs so they can focus on providing services and supporting the continuum of care for their clients.

It was also mentioned that there are anticipated changes related to the sharing of CMHC client data and a better understanding and level-setting around the HIEs capabilities to support CMHC data sharing would be helpful.

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[10] The Office of the National Coordinator for Health Information Technology. "Disclosure of Substance Use Disorder Patient Records: *How Do I Exchange Part 2 Data?*". Accessed May 28th, 2024. https://www.samhsa.gov/sites/default/files/how-do-i-exchange-part2.pdf

Additionally, CMHCs greatly value data transparency and would like to improve this by gaining access to more real-time data to inform client interventions and understand where else clients are seeking services, data related to performance programs monitored by RAEs, data from Human Services, and other outcome data from State agencies. There are often discrepancies between data sets and CMHCs want to see actionable outcome data that can be validated internally to ensure that data is being captured and received accurately. Improving visibility into shared data and outcome reporting and the adoption of shared data definitions would help to strengthen trust in data across organizations.

CMHC Stakeholder Advocacy for the S-HIE Roadmap

As the State invests more into infrastructure that will support service delivery to Coloradoans in addressing their Social Determinants of Health (SDoH) needs, it is important that CMHCs have a place at the table during these discussions. The Social Health Information Exchange (S-HIE) is meant to serve as a Statewide Unifying Architecture to improve information sharing for providers and community-based organizations. CMHCs are an important stakeholder in this work and could benefit from participation. The initial priority use cases that the S-HIE is planning to support align directly with the work being done by CMHCs with their clients in communities across Colorado. This includes individuals with disabilities, individuals in need of housing support, individuals with substance use disorder, and individuals exiting incarceration. The targeted data sources that could be brought in as part of the S-HIE work would complement existing programming in some centers and help expand the holistic client view that many centers desire having to support targeted interventions and improved outcomes.

Enhanced Care Coordination Systems

The majority of referrals between primary care entities and CMHCs are currently happening via manual methods such as phone, fax, or email. This can be an inefficient process that poses administrative burden on staff and trickles down to longer wait times for clients needing other services. Many CMHCs have developed

innovative solutions to meet the needs of their programs and clients but do not have access to the resources to implement larger technology-based solutions.

Addressing Reporting Burden and Staffing Challenges

Completing required reporting is a challenge felt across all CMHCs. Many have complex funding mechanisms in place which correlate to numerous reports needing to be generated and sent to payors and programs in varying requested formats. There is a widespread need to reduce required manual reporting by implementing automated data transfer mechanisms to reduce the administrative burden felt by CMHCs. Other considerations are creating less complex reporting specifications, data standardization for requested metrics and opportunities for alignment in data collection fields across systems, or simplified data standards.

Competing for, recruiting, hiring, and retaining qualified behavioral health data analysts and other business intelligence support staff was a global challenge and barrier mentioned by CMHCs. Behavioral health data analysts are described as a niche role that is difficult to recruit for, especially in rural areas. Additionally, business intelligence staff can be "expensive" to retain. Streamlining business intelligence resources to provide support to CMHCs could be particularly beneficial, including innovative models to split or share employees across centers to provide support. Other ways to improve business intelligence capacity at CMHCs should also be explored.

Support for the BHX Project

The BHX Project aims to coalesce behavioral health data across the State and serve as a mechanism to improve visibility into outcome metrics for CMHCs collectively. This would greatly benefit CMHCs to help drive policy and bring a voice to behavioral health providers Statewide. Additionally, the BHX could help solve many of the aforementioned barriers and challenges such as improving data sharing and streamlining resources to improve capacity for CMHCs.