Integrated and Coordinated Care

4 Preliminary Draft Recommendations

This set of recommendations focus on:

1. improving care coordination to better support access to behavioral health services
2. instituting a certified Community Behavioral Health Clinic Model in Colorado
3. ensuring safe discharge from hospitals and reducing preventable readmissions, and
4. increasing the number of access points for short term behavioral health services and increasing the number of primary care providers embedded in mental health clinics and centers.

1. Care Coordination: Complete a single point of entry and technology platform to allow care coordinators to connect clients with behavioral health providers and multiple human service organizations in order to coordinate care and establish a single point of access for individuals to find local resources for behavioral health and other local community based organizations that address social determinants of health. (Funding)

A. **Resource Navigation Hub and technology investments:** Supplement the existing $26M from HB21-137 to further support data integration with an additional $15M to do the following:

1. Align and leverage investments and policies established through Colorado's Health IT Roadmap, led by the Office of eHealth Innovation and eHealth Commission to accelerate this work. This includes prior investments and policy recommendations in care coordination/social health information exchange (S-HIE), health information exchange, identity resolution, consent, and information governance.

2. Leverage the eHealth Commission to advise and steer health IT approaches and recommendations once vetted by the Office of Behavioral Health led sub-committees.

3. Connections to connect to the use of a statewide shared care coordination system, also known as social health information exchange (S-HIE) and Health Information Exchanges (HIEs) at scale for providers.

4. An EHR Lite that is compatible for S-HIE and HIE connections--meaning a single platform for paper based organizations to participate in the ecosystem for care

coordination. User fees may be limited and support ongoing maintenance of the system.

5. Data model upgrades for providers to improve local provider to provider exchange of information through a standard data model such as HL7. This would allow for more community coordination across different types of behavioral health providers.

6. Review with Department of Public Safety on Criminal Justice information platform piece (currently have funding for $20M over 5 yrs) opportunities to align and connect resources into the single statewide platform to ensure improved coordination of care for justice involved populations.

7. HCPF has prioritized $15M for interoperability for SDOH (social determinants of health) platforms (6 or 7 in the state); $12M will go to platforms being interoperable; supplemental funding for increasing effectiveness. Micro-grants for local partners.

8. Ensure each system follows agreed upon standards to support interoperability at all levels of maturity from EHR lite to more sophisticated integrations.

9. Ensure each system can talk to one another; honeycomb of each build on one another.

10. Integrate an accountability system, including review requests, evaluation, outcomes dashboard, and complaint system into the resource navigation hub and service models.

11. The resource navigation should have filters like AirBnB or Zillow, so that people can identify providers that have the language access they need or level of inclusion, such as for LGBTQIA and cultural sensitivity.

B. **Resource Navigation and Care Coordination human and regional investments:** Funding of up to $25M to augment and where necessary build regional walk-in centers for crisis management and care coordination walk-in centers with integrated care for co-occurring conditions, paying special attention to meeting gaps by geography and population, including young people. Such a system should be part of a hub and spoke model that provides “hot handoffs” between the center’s offered community based services and beds when necessary.

Recommended funding: $40 million

2. Require the State of Colorado to develop a Certified Community Behavioral Health Clinic (CCBHC) Model in Colorado and provide capacity building funds for providers meeting criteria. (Funding and Policy)

A. All community providers that can meet certification criteria should gain access to recognition as a CCBHC and qualify for an alternative payment methodology that better supports population health and value-based care. To accomplish this, Colorado should enact a statewide CCBHC model.

   1. Invest in one-time capacity building funds for Community Health Centers and other providers meeting criteria for certification, to expand their data infrastructure, population health management competencies, and care coordination agreements within their local communities.

   2. Activities to build out the nine required core services and meet all certification requirements may include but are not limited to: hiring new staff and training staff in required competencies, such as evidence-based practices; establishing care coordination agreements and protocols; and/or enhancing existing Electronic Health Record (EHR) systems to support care coordination, adequate data collection, and quality reporting.

B. Policy Recommendation: This may require legislative action directing the Department of Health Care Policy and Financing to obtain all necessary CMS approvals, and to require HCPF and OBH to work in partnership with CBHC to define the certification criteria and process.

Recommended funding: $200,000 in one time capacity building grants to each of the 17 Community Mental Health Centers and up to 3 additional community providers who meet certification criteria. Total of $4,000,000.

3. Create policies to ensure a safe discharge from hospitals and reduce preventable readmissions. (Policy)

A. Contractual language to hold hospitals accountable when unsafe discharges happen and readmissions occur.

B. Ensure that psychiatric hospitals and residential treatment settings provide intensive pre-discharge, care coordination services to help transition beneficiaries out of these settings and into appropriate community-based outpatient services - as well as requirements that community-based providers participate in these transition efforts.

C. Assess the housing situation of individuals transitioning to the community from psychiatric hospitals and residential treatment settings and connect those who are homeless or have unsuitable or unstable housing with community providers that coordinate housing services where available.

D. Psychiatric hospitals and residential treatment settings have protocols in place to ensure contact is made by the treatment setting with each discharged beneficiary within 72 hours of discharge and to ensure follow-up care is accessed by individuals after leaving those facilities by contacting the individuals directly and by contacting the community-based provider the person was referred to.

E. Explore options allowed by Medicaid that remove the limitations imposed by the Institutions for Mental Disease exclusion to include reviewing the possibility of an 1115 waiver similar to what Colorado has for substance use disorders (SUD) treatment.

F. In the event options through Medicaid do not address the issue, create a fund to allow for extended stays, up to five days, beyond what is authorized by insurance to ensure safe and appropriate discharge.

G. Implementation of strategies to develop and enhance interoperability and data sharing between physical, SUD, and mental health providers with the goal of enhancing care coordination.

H. Evaluate the possibility of an Assisted Outpatient Treatment model to increase the standard of care and intensive community based treatment that exceeds services provided through Assertive Community Treatment. Safeguards should be established within models of service that limit rights and choices of individuals.

4. State Innovation Model (SIM) 2.0: Increase the number of access points for short-term behavioral health services, for individuals with multiple chronic conditions, for children and youth, and for those with disabilities and increase the number of primary care providers embedded in mental health clinics and centers. (Funding)

A. Practice Transformation Grants + Support Teams:

1. Small grants program for 400+ health care providers (up to $200,000 each) to be used as seed funding to integrate physical and behavioral health care. These grants could support workforce development, infrastructure, Healthcare Information Technology (HIT) investment, community engagement, and/or business development for sustainability. Focus areas could include:

pediatric behavioral health, co-occurring disorders, substance use disorders, social determinants of health, and care coordination. Support team should include clinical and sustainable billing.

B. Payer Transformation Grants
    1. Grant program for health care payers (up to $2 million each) to be used to incentivize payers to transition their business models to alternative payment models that better sustain integrated practices. These grants could support cost analytics, infrastructure, HIT investment, business analysis and development, and/or workforce training.

C. Connecting Patients to Social Services
    1. Invest in methods that assist care teams in identifying and connecting patients to resources that help meet patient needs; one example could be to build on the regional health connect program that was initiated through SIM.

D. Healthcare Information Technology Investments:
    1. Connect remaining providers to the health information exchanges, social health information exchange ecosystem, and technology systems that support integrated care models.

Recommended funding: $45 million