Colorado Health Partnerships, LLC
AspenPointe ♦ SyCare ♦ West Slope Casa ♦ Beacon Health Options

AGENDA
CHP PROGRAM IMPROVEMENT ADVISORY COMMITTEE

October 13, 2016
11 am – 1 pm
GoToMeeting/Call-in Number:
1-877-919-8755
Passcode: 8342477

I. Welcome & Introductions

II. Additions to the Agenda

III. Review April 2016 Meeting Minutes

IV. CEO Update (Arnold S.)

-ACC 2.0
-Payment Reform Portfolio

V. Rate Setting Update (Tina McCrory)

VI. FY17 Performance Measures (Erica Arnold-Miller)

VII. Provider Revalidation (Tina McCrory)

VIII. Integration Report (Tina McCrory/Lisa Clements)

a. Feedback from Committee on Integration Efforts

IX. Zero Suicide (Paul Baranek)

X. IESO – on-line therapy (Tina McCrory)

a. Check out the website! iesohealth.com

XI. Next Meeting – January 12, 2017

a. Requests for future agenda topics from committee

Colorado Health Partnerships, LLC
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Colorado Health Partnerships, LLC
PROGRAM IMPROVEMENT ADVISORY COMMITTEE (PIAC) MINUTES
April 14, 2016

Call to Order: 11:00 am – GoToMeeting: https://www.gotomeeting.com/join/960254229
Dial-in: 1-877-919-8755 PC 8342477

I. Welcome, Roll Call and Introductions

Members Present: Fred McKee/Delta County Sheriff, Pam McManus/Peak Vista, Rebecca Encizo/ICHP/VO, Carol Friedrich/HHS San Miguel/Ouray, Arnold Salazar/CHP and, **Non-Members/Guests:** Erica Arnold-Miller/Quality Management/BHO, Haline Grublak/BHO, Paul Baranek/Education Coordinator/BHO, Catherine Morrisey/BHO, and Kathy Van Gieson, Tina McCrory/CHP

There was not a quorum so items requiring a vote will have a ratified vote at the next meeting with a quorum.

II. Approval of Agenda

The agenda was approved without objection.

III. Approval of Minutes – January 14, 2016

The January 14, 2016 CHP PIAC Minutes were approved without objection.

IV. CEO Update

Arnold reported on State Healthcare System Plans, Changes, and Updates: Kathy will send out the latest Accountable Care Collaborative Phase II Update regarding the new direction in terms of 1. The ACC Phase II procurement timeline (begin the next phase on July 1, 2018), 2. The behavioral health services reimbursement methodology (a modified capitation payment methodology will be retained for core behavioral health service and will be directed to RAEs- Regional Accountable Entity) and, 3. Information on how stakeholders can stay informed.

Tina noted HCPF is moving to a new computer system and is rebranding "Medicaid" in Colorado with a new name, "Health First Colorado" effective June or July 2016. Haline stated other changes going along with the Medicaid rebranding is having a comprehensive one statewide member handbook coming out in June. Paul mentioned that the statewide crisis line now has the option for people to text the statewide crisis line (you can get crisis counseling by text: talk238255).

V. PIAC Member Survey Results & Discussion

Catherine Morrisey reported on the 2015 PIAC Member Survey that was sent out to get input from membership on what areas they might be interested in discussing, what kind of issues agencies are struggling with relative to behavioral health and how Colorado Health Partnerships is doing in the local communities.

Q2. Which BHO-related topics are you interested in learning more about? A. Having more specific trainings/discussions around accessing Medicaid behavioral health services, State Health Care System Plan/Changes/Updates.

Q6. Would you be interested in attending a meeting in-person if it was geographically convenient, and included lunch and a tour of a local facility or program? A. Within an hour or two of Colorado Springs, AspenPointe, Axis Health, Mind Springs.

VI. Transportation Follow Up

Paul reported the State has an annual transportation plan which is a result of information received from 15 different organizations (transportation planning regions or metropolitan planning organizations) around the state. These committees submit an annual report suggesting where they would like the transportation dollars to be used for their region which are then combined into the state annual report. The main focus of the reports are for things like "we need this road or bridge repaired". Possibly the social needs in terms of transportation are not emphasized more are maybe because those people/volunteers on the committees don't tend to be social service type people (businesses, tourism, hospitality services, etc.). The PIAC Committee was asked if there was any interest to have more input into the committees so that the social needs of people in terms of transportation would have higher priority.

Paul noted that each county department of human services has the responsibility for the Medicaid benefit called non-emergency medical transportation program and they have the flexibility to sub-contract that program out to other agencies.

Carol reported on the front-range the State Department is contracting with a third party vendor/ transportation company to do medical transportation. If not part of that geographic area under that contract, it falls to the individual county DSS to administer (without funding) medical transportation and do reimbursements for people that arrange their own personal travel. DSS directors are talking with the state about the system and ways to have more equitable services and help build infrastructure in the rural areas. Folks are not getting equal care/services for medical transportation.

ACTION ITEM: This topic will be moved forward to the State PIAC Committee to talk about any plans to improve the system to have more equitable services and help build infrastructure in the rural areas. At the next meeting Paul will do a more in-depth discussion of the CODOT.gov/programs regulation. Paul noted there are DOT employees assigned to each of the regions to which we could bring to their attention the social needs for transportation aspect and transportation needs in the rural areas.

VII. Behavioral Health Services in Your Community: Strengths & Needs

One of the purposes of this committee is for us, as a BHO to get feedback from stakeholders about how are we doing in terms of providing those behavioral health services for Medicaid members, what are the strengths, weaknesses and places where we can improve.

Fred McKee/Delta County Sheriff reported being involved in the Senate Bill 16-169 Emergency 72-hour Mental Health Procedures dealing with 72 hour hold and conflicts with non-designated facilities and making sure the state legislators have an understanding of the impact of the shortage of beds and transportation issues. Fred noted we need to continue to support the MHCs and crisis services. Summary of Senate Bill 16-169: a bill that would allow rural hospitals to be designated as 27/65 facilities so they can hold mental health patients for up to 72 hours which would take pressure off of the jails. Fred noted the sheriffs' issue is the jails are being required to take patients into the jails without criminal charges and are up against a 24 hour timeline to have them moved to a designated facility and with the shortage of beds the jails frequently find themselves in violation of that 24 hour time period. The sheriffs would like an avenue to petition the courts to increase the initial 24 hour timeline while waiting for a bed. Arnold noted that CBHC is on top of this bill.

ACTION ITEM: A survey will be sent out to the PIAC members to get feedback about how are we doing in terms of providing those behavioral health services for Medicaid members, what are the strengths, weaknesses and places where we can improve. Are the needs being met for older adults in the community or adolescents or that transitional 18-21 age group or, the areas where there could be more programming, etc.?

VIII. Website Demo www.coloradohealthpartnerships.com

The CHP website: www.coloradohealthpartnerships.com has information which includes two tabs: one for providers and one for members. The State is going to send a common member handbook to members and the individual MHCs/BHOs will keep their own member handbooks on their own websites. Calling 800-804-5008 is a way to contact a provider other than the community mental health center since some IPN providers so not return calls. Haline will provide that number on the website. Also on the website: Achieve Solutions, a behavioral health focused (WebMD) self-help tool related to behavioral health and now includes physical health is a great tool for patient education.

IX. Planning for Next Meeting

Meeting in Pueblo – July 14, 2016: Kathy will do a poll of the membership for an in-person meeting (include lunch and a tour of Health Solutions) on July 14, 2016 (teleconference still available for those not able to attend in person). If there is less than a high level of interest it will be a GoToMeeting vs. an in person meeting.

Requests for future agenda topics: July Agenda – 1. CEO Update on State Healthcare System Plans, Changes, and Updates, 2. Medicaid Waiver, 3. Prevention/Intervention/Postvention for Survivors, Family Members Efforts/Activities - Crisis Systems (AspenPointe and Western Slope Crisis Centers staff representative can present). Arnold and Erica will look at other prevention activities in the CHP proposal. 4. Senate Bill 16-169 Update.

X. Adjournment

The April 14, 2016 PIAC meeting was adjourned.

Submitted by: 4.15.16

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Kathy Van Gieson, Executive Assistant Date

EXHIBIT F, PERFORMANCE MEASURES

Heading	Description	Source	Notes
Indicator 1	Child and adolescent major depressive disorder (MDD): Suicide Risk Assessment (see Medicaid Child Core Set)	NQF 1365 Awaiting further specifications from CMS/SAMHSA	The Contractor shall work with each of their network CMHCs and providers that serve 1000 or more unique members annually to develop a plan for collecting data for this measure during this Contract period.
Indicator 2	Adult major depressive disorder (MDD): Suicide risk assessment.	NQF 0104 Awaiting further specifications from CMS/SAMHSA	The Contractor shall work with each of their network CMHCs and providers that serve 1000 or more unique members annually to develop a plan for collecting data for this measure during this Contract period.
Indicator 3	a) Hospital Readmissions: 7,30 & 90 days b) Hospital Readmissions: 180 days	1768/SIM	Will review existing scope document to align with SIM methodology as closely as possible.
Indicator 4	Percent of Members prescribed redundant or duplicated atypical antipsychotic medication	Department Defined	
Indicator 5	Adherence to antipsychotics for individuals with schizophrenia	CMS Core - NQF 1879	
Indicator 6	ECHO Survey	Department Defined	
Indicator 7	Penetration Rates	Department Defined	
Indicator 8	Diabetes screening for individuals with schizophrenia or bipolar disorder who are using antipsychotic medication	1932 NQF	
Indicator 9	Inpatient Utilization	Department Defined	Will review existing scope document to align with SIM methodology as closely as possible.

Indicator 10	Emergency Department Utilization for mental health condition	Department Defined	Will review existing scope document to align with SIM methodology as closely as possible.
Indicator 11	Follow up after discharge from the ED for Mental Health or Alcohol or Drug Dependence	2605 NQF	Will align with SIM whenever possible.
Base Measures- These performance measures will be considered in the rate setting process.			
Indicator 12	Mental Health Engagement	Department Defined	Will review existing scope document methodology.
Indicator 13	a) Initiation of Alcohol and Other Drug Dependence Treatment	0004 CMS - excludes inpatient.	Will review existing scope document.
	b) Engagement of Alcohol and Other Drug Dependence Treatment		
Indicator 14	Follow-up appointments within 7 and 30 days after hospital discharge for a mental health condition- Adult and Child/Adolescent	CMS Core 0576	Will review existing scope document to align with SIM methodology as closely as possible.
Stretch Measures – Each BHO must choose at least one of the stretch measures below to participate in the Performance Incentive Program referenced in Section 2.8.6. of the Contract. These measures/projects will be implemented at large provider sites such as CMHCs. Targets for components of measure implementation will be developed in coordination with the Department.			
Indicator 15	Depression Remission at 12 months using standard PHQ-9	0710/NQF	Measured within each of the CMHCs contracted with the Contractor.
Indicator 16	Substance Use Screening Composite: Screening and Intervention	2597/SIM	Measured within each of the CMHCs contracted with the Contractor.
Indicator 17	Adolescent Health Risk Screening and Referral/coordination of care.	Department Defined	Measured within each of the CMHCs contracted with the Contractor.
Indicator 18	Develop a Person/Family Centered Advisory Council	Upon selection, the Department will work with the Contractor to define this measure.	Developed regionally with CMHCs/BHOs and the Department.

The Department will align performance measures with national measures whenever possible and will continue to work with the Contractor to develop the scope documents.

*New BHO contract requirement

INTEGRATION REPORT
September 30, 2016

Colorado Health Partnership's (CHP) contract with the Colorado Department of Health Care Policy and Financing (HCPF) requires a quarterly Integration Report on the progress of each integration strategy as identified in contract section 2.4.2.3. BHOCompliance@state.co.us The report should include:

- ***Each strategy to increase the integrated care competencies of providers in the network***
- ***Summary of the supporting activities and results of each strategy***
- ***Updated reporting for each measurable goal, as applicable.***
- ***Any new strategies, and/or lessons learned related to integrated care efforts in the region***

Colorado Health Partnerships (CHP) region continues to strive to support providers and encourage the integration of physical and behavioral healthcare. It is believed that when collaborative working relationships are strong, members directly benefit. CHP continues to make deliberate efforts which join the vast geographical regions into a cohesive supportive group as integration best practices are learned. This report will outline the key elements of integration within the CHP region for the time period of July 1 through September 30, 2016.

Colorado Health Partnerships hosted the monthly Chief Clinical Officer / Integrated Care Directors meetings this quarter in July and August of this quarter, September meeting moved to October in lieu of the Colorado Behavioral Healthcare Council Conference. This remains a productive group with each Community Mental Health Center's (CMHC) leadership involved in integration efforts. The focus this quarter involved exploring the data regarding member access, network adequacy and network density data.

Each of the eight CMHCs within the CHP region are actively engaged in individual integration programs. As each of the eight partners cover a variety of communities from frontier, rural, suburban and tourist locations, each community had to find a different way of implementing integration to meet their center's diverse population needs. Each Mental Health Centers (MHC) has submitted individualized plans detailing their integrated care plans and utilize the IPAT rating system to track the progress of their plans. The following is a brief overview of the work each mental health center is engaged in to provide integrated services to meet the needs of their community.

Aspen Pointe has 17 primary integrated care sites and one bi-directional integrated site at Moreno. Aspen Pointe created and launched a new team called Healthcare Transformation, with the focus to specifically work in collaboration with the integrated care leadership. The development and implementation of the Healthcare Transformation team has resulted in an increase of all IPAT scores

ranging from 4-5 at all sites. The Integrated Care Data base (NICE) allows for tracking and analyzing of data resulting in team utilization increases from 20% to nearly 70% since September of last year.

Axis Health Systems operates two integrated community health centers and community mental health centers, Cortez Integrated Health Care (CIH) and La Plata Integrated Healthcare (LPIH). The primary focus of the integration project has been the implementation and revision of the Shared Care Plan Page in the Health Tracker, an internally developed patient health dashboard. They have collected feedback from the staff utilizing the Health Tracker to improve its functions which will be incorporated in to the new version of the Health Tracker, anticipated for fall 2016 moving both locations to an IPAT level 6.

The Center for Mental Health developed in conjunction with Beacon a curbside psychiatric consultation program for adults called PSYCH*Line*. The program is available along with Colorado Psychiatric Access and Consultation for Kids (C-PACK) to all six counties in the Center for Mental Health region. The PSYCH*Line* and C-PACK services allow members to remain with their primary care providers for treatment and for the primary care providers to get support, consultation and training they need to serve their community. The programs also provide an increase of access to psychiatric services for a great number of community members in rural and frontier areas of this region. There are currently seven practices enrolled in the PSYCH*Line* program with active recruitment occurring over the upcoming quarter to enroll additional offices in the service. The new PSYCH*Line* program manager started with Beacon in August and has made several trips in September with additional trips planned in the coming months with the goal of enrolling new practices in the PSYCH*Line* program.

The Center for Mental Health has started a new integration project this quarter with Gunnison Valley Health Systems. A full time behavioral health specialist is working with the PCP practices and Gunnison Valley Hospital which are included in the Gunnison Valley Health System. Additionally The Center for Mental Health has partnered with Community Dental and the Delta Vo-Tech in a combined integrated project called PIC Place (Partners in Integrated Care). All three entities entered into the partnership to purchase a building in Montrose and are remodeling the building to accommodate the fully integrated practice scheduled to open spring 2017. The PIC Place will have full dental services, behavioral health services, family practice and active classroom where students in these fields of education can conduct rounds and have hands on learning opportunities.

Health Solutions opened the Medical Clinic in a renovated former medical building allowing them to make a number of physical plant improvements which increased patient comfort and provider communication with the members. Examples of this include the work flow when seeing members, the members remain in one room and the providers rotate. Additionally in each of the exam rooms the placement of the monitor allows both member and provider to see it creating a collaborative atmosphere. The entire treatment team comprised of multi-disciplinary providers meet daily for a group meeting to prepare for the day and discuss the families scheduled for the day and their needs. The Medical Clinic is working closely with the Integrated Community Health Partners (ICHP), Health

Solutions team; this team is an extension of the ICHP, Region 4 Regional Care Collaborative Organization. Executive staff participated in the University of Massachusetts (UMASS) integrated primary care training, and the behavioral health specialist is scheduled to being UMASS online training on September 1, 2016. The requirements for the IPAT level 1 score have been met, and many of the Level 2 requirements have been meet but not enough to advance from the minimum collaboration score.

Mind Springs has a formal project team for implementing primary care within the Grand Junction Clinic. The team has met regularly and documented potential codes and documents for billing services. The team has also met with Rocky Mountain Health Plans, a managed care agency and begun discussion about potential payment structures and services to the individuals in need. Mind Springs Health has shared client level data with Rocky Mountain Health plans, to examine level of need. Mind Springs Health is also beginning the work of a business pro forma to determine the costs and revenues of starting such a service. Mind Springs Health Grand Junction Clinic remains at an IPAT level 1 at this time with the goal to move to a level 3. We continue to work with our community partners to discuss potential areas for partnership and gaps.

San Luis Valley is currently between levels 2 and 5 in all thirteen clinics they are operating in through six counties of the San Luis Valley. Currently they have staff co-located in three of the primary care sites with consultants and care coordinators in the practice at least half time or more. Which will move the integration level of these two sites from level 2 to level 3. Focused goals include assisting PCP's in recognizing mental health disorders and psychological problems, early identification of at risk patients, and a preventative approach for managing addition specifically related to pain management. SLV has completed training for behavioral health partners, and incorporated the screening process into the clinical work flow which continues to be monitored. Training for the PCP and Clinic staff was completed at the onset of the year and has continued throughout the year. Planned for the fall SLV will establish multi-agency work groups including the consultants to address continued development of the service delivery model, infrastructure systems with in the work groups, and continue to refine data management systems.

Sol Vista choose to identify specific programming to move forward with integrated care goals; their focus is on tobacco cessation and obesity reduction/prevention. New patients are offered an optional health and wellness screening to assist in improvement of their overall health with an incentive for their participation. After the screening patients who were identified as a smoker or as having a BMI over 25 would receive additional outreach to connect them to health and wellness services. Program is not yet implemented as they are in the process of hiring and training staff to start the program. Sol Vista has added medical support professionals, an RN and two Medical Assistances to support daily activities and programming. Sol Vista has implemented a new group each month since February 2016. These group offerings have included pain management, anxiety/symptom management reduction group,

mindfulness bases stress reduction (MBSR), tobacco cessation and Healthy cooking class. The current IPAT level score is at the Pre-coordinated level of engagement.

Southeast Health Group (SHG) identified the area of greatest need in their region is Child Welfare and Adult protection clients in the six county Departments of Human Services (DHS). SHG identified specific areas of focus to measure success, these include Access to Care, Referral Process, Communication Channels, Child Protection Team Meeting Attendance, Adult Protection Team Meeting Attendance, Shared Outcome Measures, Shared Care Plans, and communication regarding interpretations of the LAN Ruling. SHG has hired a part-time DHS Consultant who started on November 1, 2015. The DHS Consultant has allowed them to establish monthly meetings with the DHS directors in each of the 6 counties with the first meeting held on March 1, 2016. SHG was able to set up trainings with three of the six counties (Bent, Crowley and Otero) regarding their referral process they are still working to set dates with the remaining three counties. With the addition of the DHS Consultant SHG and DHS were able to develop a number of reciprocal communication systems which are mutually beneficial. These systems include informing DHS of "show/no show" list and exchanging treatment plans and progress reports between the two entities. All Adult and Child Protection team meetings are attended by a SHG employee as well as a number of collaborative oversight groups and boards, furthering communication. The DHS directors in all six counties have been provided a specific point of contact at SHG for Mental Health and Substance Use respectively. The addition of the DHS Consultant has also provided SHG with insight into the rules, regulations, environment and financial stream associated with DHS offices in their area. Additionally the collaboration highlighted the need for trauma trainings for DHS caseworkers and as a result SHG provides training to the Youth and Family Services teams.

Medicaid members experience the medical and behavioral healthcare systems differently when involved in formal state systems such as criminal justice, child welfare or education. As such, the work of integration needs to be tailored to these situations. All of the integration services employ elements of Intensive Case Management (ICM) for individual members as needed. This is an important aspect of the integrated healthcare work which immediately directly benefits both the provider and the member. Throughout the CHP service region deliberate strategies take place to join efforts with corresponding RCCOs. The integration of physical and behavioral healthcare for Medicaid Members involved in the criminal justice system and those with substance use disorder were coordinated this quarter with other Colorado BHOs and all corresponding RCCOs. This Integration Report will provide highlights with details reported in the CHP CJS Report to HCPF.

This quarter CHP analyzed data through the Incarceration Cross-Match Proof of Concept in order to establish a baseline of all CHP members during a 3-year timeframe. Incarceration trends of these members were analyzed at specific time markings; Pre- Affordable Care Act (2013), ACA Implementation (2014), and ACA Expansion (2013-2015). A total of 228,911 member demographics throughout the CHP

service area but excluding El Paso County specifically were submitted to the Justice Connect vender for a cross match check of booking records for any member during Medicaid eligibility. As a result 48,442 (21%) of CHP members had a jail booking/bookings in the State of Colorado during Medicaid eligibility; and 8,399 (11%) had a mental health claim or encounter 12-months prior to jail booking.

This newly identified population requires unique care coordination and data analysis. Consequently, the information was broken down by mental health center, number of bookings per member per year, and identifying those members with SPMI diagnosis and multiple bookings. The cross match results were separated per mental health center and uploaded for separate Center's review.

Justice Connect is offered to all CHP counties while data sharing formally established in Otero and Delta Counties as a 6 month pilot. These counties benefit from data sharing between the CHP BHO and these particular rural county sheriff offices through signed MOUs. The Sherriff receives information for Medicaid Members who are being booked into the local jails and have identified behavioral healthcare needs. The jail then receives information about the individual's prescription medications, prescriber and last date medications were filled. In return, CHP receives the booking and release date and time for members to ensure treatment resumes upon release. All CHP members are crossed matched with jail booking records throughout the state of Colorado (with the exception of El Paso County).

At this time, Delta and Otero Counties receive care coordination initiated upon booking for each member. The jails also have access to the information collected on members identified as having a behavioral health claim/encounter 12-months prior to booking. This allows for the continuation in medication while incarcerated and upon release. The CHP Criminal Justice Integration Program will continue to define a Criminal Justice Care Coordination approach for those identified as "Super Utilizers" per county per community mental health center; monitor members each month utilizing vendor web-based service adding and/or deleting those identified to be "super utilizers" of the integrated healthcare system; continue to explore areas for improvement or "what works" in a wrap-around service delivery model.

In-Reach services were continued for CHP Medicaid members at the following facilities:

1. Fremont Correctional Facility
2. Arkansas Valley Correctional Facility
3. Denver Women's Prison
4. Limon Correctional Facility
5. Crowley County Correctional
6. Cheyenne Mountain Re-Entry Center
7. San Carlos
8. Territorial (began July 2016)

Specifically related to the integration of physical and behavioral healthcare for Medicaid Members experiencing substance use disorder, the main areas of focus this quarter were on medication assisted treatment and understanding how to support physical health providers as they provide chronic pain management to their patients. These efforts have particularly included RCCOs 4 and 7. The CHP SUD Coordinator attended the ICHP Opioid Epidemic workshop in Alamosa with primary care providers; maintained communications with Community Health Partners about the Opioid Epidemic Community response; provided quarterly round table trainings for SUD providers; provided eight documentation trainings for CHP SUD providers; provided the second two day Peer Specialist training, updated a Peer Specialist training manual; audited four IPN programs and provided feedback related to the documentation needs that includes coordination of care documents.

Related to Long Term Services and Supports, CHP continues to expand integration efforts through consistent participation in state level workgroups and committees. An essential focus with partners and stakeholders centers on the population growth among older Coloradans regarding service capacity and ability to meet their needs. A lack of training among providers in older-adult services and inadequate transportation are primary barriers to providing better services to the older adult population. To enhance the improvements toward the initiative for better Long Term Services and Supports (LTSS), several strategies have been identified, including:

- Improving the coordination and quality of care in the LTSS system by streamlining and simplifying access when possible.
- Providing community and professional education regarding the LTSS program.
- Developing positive relationships and coordinating services with professional groups and agencies by developing knowledge of the roles of other agencies and professional groups, and participating in activities designed to develop an effective working relationship.
- Serving as a helpful and visible advocate for older adults.
- Developing collaborative plans for information systems and utilization of data and participate in joint information sharing and planning interagency organizations.
- Monitoring the coverage of behavioral health services offered by qualified health plans and Medicaid to ensure that individuals with behavioral health conditions have adequate coverage and access to services.
- Identifying federal, state and local programs that could impact services and reduce duplication.

Additionally, the Director of Long Term Services and Supports (LTSS) continues to expand the program through consistent participation in state level workgroups and committees focused on the ACC Phase II, including: The Community Mental Health Stakeholder Workgroup, ACC/MMP, ACC PIAC and other various subcommittees and workgroups that highlight the consideration for the LTSS population. The LTSS director continues to serve on the quality improvement committee that replaced the Community Living Advisory Group (CLAG). The CLQIC (Community Living Quality Improvement Committee) meets monthly and provides feedback regarding policy for the LTSS community in Colorado to HCPF. The LTSS Director has also joined various workgroups/meetings in local CHP communities for the opportunity to meet with providers and change makers to discuss current policy, procedures and focus on the areas that may need more attention in the future within their specific region.

The Director of Long Term Services and Supports in collaboration with CMHCs attended and/or offered the following public trainings and presentations this reporting quarter to improve service capacity and enhance initiatives geared toward LTSS:

- Provided quarterly LTSS meetings to CMHCs, ACFs and ALFs with the specific focus on statewide initiatives regarding LTSS services in addition to offering an open forum for individual questions/concerns. The 2016 schedule has been identified as: January, April, July, and October.
- Monthly LTSS newsletter was initiated in January and provides monthly contact with CMHCs, ACFs and ALFs offering current news/updates and training opportunities.
- Continued involvement with the Colorado Coalition for Senior Behavioral Health and Wellness.
- Ongoing assistance to providers and facilities occurs on a regular basis, often for ICM purposes to enhance Medicaid member care.

CHP employs an Education Coordinator whose presentations often involve integration information and support integrative efforts through connections with various partners. This quarter, educational activities focused on county departments of human services in the last quarter. Live trainings were conducted in Craig (Moffat County), Eagle (Eagle County), Durango (La Plata County), Woodland Park (Teller County), Frisco (Summit County), Pagosa Springs (Archuleta County), and Pueblo (Pueblo County). At these presentations we discuss the functions of the BHO, how to access behavioral health services, what is covered By Health First Colorado and what is not, our treatment philosophy, access to care standards, and answer any questions the DHS case workers might have. These trainings are offered live to all DHS directors in the CHP area annually and webinars are available to be scheduled for the counties who were unable to accommodate a live training.

CHP was privileged to work with Judy Dettmer of the Colorado Department of Human Services Brain Injury Program and Liz Gerdeman of the Brain Injury Alliance of Colorado to arrange a training on working with individuals with brain injuries. Judy and Liz presented this information to a large group of

mental health center clinicians, independent providers, interested community members, and Beacon Health Options staff at the Beacon Health Options office in Colorado Springs.

In June of 2016 Beacon Health Options as well as six of the Colorado Health Partnerships mental health centers sent teams to the Zero Suicide Academy sponsored by the department of Health Care Policy and Financing and the Colorado Department of Public Health and Environment. Following this event we have conducted a number of activities to get this initiative started including networking calls with involved mental health centers to coordinate efforts. On August 30th we held a community wide event with State Senator Linda Newell as the keynote speaker to increase community awareness of the importance of suicide awareness.

The Colorado Health Partnerships Education Coordinator continues to chair the LEARN Lab committee meetings with those responsible for training and education in the partner mental health centers. This monthly meeting allows us to coordinate training and minimize duplication of effort in our widely dispersed area. The Education Coordinator also is the chairperson of the Training and Development Subcommittee of the Colorado Behavioral Healthcare Council. This statewide group brings together multiple stakeholders to share training resources and problem solve issues related to training and educational requirements and needs.

CHP has chosen to employ a variable model of psychiatric access programs to meet the demand and psychiatry workforce shortage through support to primary care. These include the Colorado Psychiatric Access and Consultation for Kids (C-PACK) and PSYCH*Line* programs. Each of these programs operate with the goal of increasing the number of children (C-PACK) and adults (PSYCH*Line*) directly experiencing higher quality behavioral healthcare through a form of integrated services.

The preceding strategies and programs are important to the Colorado Health Partnerships Behavioral Health Organization as the communities require quality healthcare in a focused, integrated and quality way. It is strongly recognized that multiple strategies must be in place to meet a wide variety of member needs in diverse communities. Colorado Health Partnerships looks forward to continued progress with overall integration in the coming calendar year.

Respectfully Submitted,

Christine Andersen, MS, LPC
Director of Integrated Care

WHAT IS ZERO SUICIDE?

Zero Suicide is a commitment to suicide prevention in health and behavioral health care systems, and also a specific set of tools and strategies. It is both a concept and a practice.

» LEAD

» TRAIN

» IDENTIFY

» ENGAGE

» TREAT

» TRANSITION

» IMPROVE

Its core propositions are that suicide deaths for people under care are preventable, and that the bold goal of zero suicides among persons receiving care is an aspirational challenge that health systems should accept. The Zero Suicide approach aims to improve care and outcomes for individuals at risk of suicide in health care systems. It represents a commitment to patient safety—the most fundamental responsibility of health care—and also to the safety and support of clinical staff, who do the demanding work of treating and supporting suicidal patients.

The challenge of Zero Suicide is not one to be borne solely by those providing clinical care. Zero Suicide relies on a system-wide approach to improve outcomes and close gaps rather than on the heroic efforts of individual practitioners. This initiative in health care systems also requires the engagement of the broader community, especially suicide attempt survivors, family members, policymakers, and researchers. Thus, Zero Suicide is a call to relentlessly pursue a reduction in suicide for those who come to us for care.

The programmatic approach of Zero Suicide is based on the realization that suicidal individuals often fall through multiple cracks in a fragmented and sometimes distracted health care system, and on the premise that a systematic approach to quality improvement is necessary. The approach builds on work done in several health care organizations, including the Henry Ford Health System (HFHS) in Michigan. Like other leading health care systems, HFHS applied a rigorous quality improvement process to problems such as inpatient falls and medication errors. HFHS realized that mental and behavioral health care could be similarly improved. This insight led to the development of HFHS's Perfect Depression Care model, a comprehensive approach that includes suicide prevention as an explicit goal. The approach incorporates both best and promising practices in quality improvement and evidence-based care and has demonstrated stunning results—an 80 percent reduction in the suicide rate among health plan members.

Using these successful approaches as the basis for its recommendations, the Clinical Care and Intervention Task Force of the National Action Alliance for Suicide Prevention identified essential elements of suicide prevention for health care systems (i.e., health care plans or care organizations serving a defined population of consumers, such as behavioral health programs, integrated delivery systems, and comprehensive primary care programs). These elements include:

1. **LEAD** » Create a leadership-driven, safety-oriented culture committed to dramatically reducing suicide among people under care. Include suicide attempt and loss survivors in leadership and planning roles.
2. **TRAIN** » Develop a competent, confident, and caring workforce.
3. **IDENTIFY** » Systematically identify and assess suicide risk among people receiving care.
4. **ENGAGE** » Ensure every person has a suicide care management plan, or pathway to care, that is both timely and adequate to meet his or her needs. Include collaborative safety planning and restriction of lethal means.
5. **TREAT** » Use effective, evidence-based treatments that directly target suicidality.
6. **TRANSITION** » Provide continuous contact and support, especially after acute care.
7. **IMPROVE** » Apply a data-driven quality improvement approach to inform system changes that will lead to improved patient outcomes and better care for those at risk.

If we do not set big goals, we will never achieve them. In the words of Thomas Priselac, president and CEO of Cedars-Sinai Medical Center:

"It is critically important to design for zero even when it may not be theoretically possible. When you design for zero, you surface different ideas and approaches that if you're only designing for 90 percent may not materialize. It's about purposefully aiming for a higher level of performance."

Better performance and accountability for suicide prevention and care should be core expectations of health care programs and systems. While we do not yet have proof that suicide can be eliminated in health systems, we do have strong evidence that system-wide approaches are more effective.

To assist health and behavioral health plans and organizations, the Suicide Prevention Resource Center (SPRC) offers an evolving online toolkit that includes modules and resources to address each of the elements listed above. SPRC also provides technical assistance for organizations actively implementing this approach.

Learn more at www.zerosuicide.com.

FOR MORE INFORMATION, PLEASE CONTACT:

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COLORADO HEALTH PARTNERSHIPS
PERFORMANCE IMPROVEMENT ADVISORY COMMITTEE
2017 MEETING SCHEDULE

GoToMeeting: 1-877-919-8755 PC: 8342477

JANUARY 12, 2017	11:00 – 1:00 P.M.
APRIL 13, 2017	11:00 – 1:00 P.M.
JULY 13, 2017	11:00 – 1:00 P.M.
OCTOBER 12, 2017	11:00 – 1:00 P.M.