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

AGENDA
CHP PROGRAM IMPROVEMENT ADVISORY COMMITTEE

April 13, 2017
11:00 am – 1:00 pm
GoToMeeting: https://global.gotomeeting.com/join/885767437

Call-in Number: 1-877-668-4493 Passcode: 79878011

I. Welcome & Introductions

II. Additions to the Agenda

III. Review January 2017 Meeting Minutes

IV. CEO Update (Arnold S.)

-ACC 2.0

V. Rate Setting Update (Tina McCrory)

VI. FY17 Performance Measures (Erica Arnold-Miller)

a. Preliminary Analysis of CHP Performance Based on FY16 Measures
b. List of New Performance Measures

VII. Office of Member and Family Affairs Update (Lynne Bakalyan)

VIII. Integration Report (Christine Andersen)

a. Feedback from Committee on Integration Efforts

IX. Next Meeting – July 13, 2017

a. Requests for future agenda topics from committee

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

Colorado Health Partnerships, LLC
PROGRAM IMPROVEMENT ADVISORY COMMITTEE (PIAC) MINUTES
January 12, 2017

Call to Order: 11:00 am – GoToMeeting: https://global.gotomeeting.com/join/887756349
Dial-in: 1-877-919-8755 PC 8342477

I. Welcome, Roll Call and Introductions

Members Present: Mike Van De Casteele/Beth Haven, Inc., Reverend Linda Stetter/Centura, Rebecca Encizo/ICHP/VO, Carol Friedrich/HHS San Miguel/Ouray, Arnold Salazar/CHP and, **Non-Members/Guests:** Erica Arnold-Miller/Quality Management/BHO, Lynne Bakalyan/BHO, Paul Baranek/Education Coordinator/BHO, Christine Andersen/BHO, Jennifer Hale-Coulson/BHO and Kathy Van Gieson, Tina McCrory/CHP

A quorum was declared.

II. Approval of Agenda

The agenda was approved without objection.

III. Approval of Minutes – April 14, 2016

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

IV. CEO Update

ACC 2.0 - Arnold reported on the State Healthcare System (HCPF) new direction in terms of the re-procurement of the current RCCO (Regional Care Collaborative Organization) contracts where it will combine the RCCOs and BHOs (Behavioral Health Organizations) into RAEs (Regional Accountable Entities). The deadline for comments on the draft ACC Phase II RFP is Friday January 13, 2017 and can be submitted online.

CHP's responses/concerns: 1. the draft RFP focus too heavily concentrates on primary care to the exclusion of behavioral health. CHP will provide the input that HCPF needs to place more attention around the fact that 87% of the resource dollars is for behavioral health with that portion continuing to be at risk and the focus of the bid is about primary care. We don't want to see our limited behavioral health resources going to fund additional primary care, particularly in the area of primary care management. 2. The program doesn't focus enough on integrated care where we have sites that have full time practitioners, and they are integrated at a level where you can't tell the difference between a primary health clinic and a mental health center.

3. There is the requirement that contractors have a physical office located in the awarded region. If a contractor is awarded multiple regions, will they be required to have fully operational offices in all regions that are awarded including rural regions or will those contractors be allowed to consolidate their office locations in urban areas as is currently allowed with the BHO contractors? 3. HCPF has been overly prescriptive with a lot of extraordinary oversight never seen before. 4. The contractor cannot subcontract more than 40% of the award. Clarification needed that 40% does not apply to joint owners of partnerships performing the work. 5. There is the requirement that the contractor operate the two federal waivers (1915 B Waiver - PCMP healthcare coordination and PIHP behavioral health) in an integrated program. HCPF should award points for proposals based on how thoroughly these waivers are integrated. 6. There is a section that requires attribution to RAEs be based on the member's enrollment with a primary care provider. This shifts the burden of dealing with multiple RCCOs to families when there are different primary care providers for different family members or when the bulk of their care is with behavioral health. 7. The additional requirement for network development is that there are 2 providers for each member available within 30 miles of the ZIP code in which they live which will be difficult and maybe unachievable in some rural and frontier areas. 8. The requirement for one mental health provider and one substance use disorder provider for each 1500 members would be difficult in trying to meet the additional requirements of the network development above. 9. Explain how the health neighborhood concept will work with the PCMP model, Population Health and the various community engagement requirements of the RFP in light of the requirement to integrate the program with behavioral health. 10. Clarification on whether Population Health Management and Care Coordination is to be addressed at the RAE regional level or whether the requirement is for individual providers to manage the health of the members attributed to their practice. 11. The incentives for the contractors as they are outlined are spread out throughout the proposal, are hard to consolidate and difficult to understand how they will all work together. More thought needs to be put into how the incentives are working. 12. Concern with an oversight that needs to be fixed around primary care providers billing 6 sessions per episode in primary care settings, which can be multiple episodes, will not be managed and will not be integrated. Members can receive a significant amount of care without having any contact with the RAE since the services will be billed to fee for service. If Members continue to have ongoing episodes of behavioral health problems, they should be referred. 13. Make sure HCPF is clear about what the capitation rates are going to be so that Contractors can understand what kind of risk they need to take in applying for the contracts. 14. The MLR target incentive effectively reduces the administrative fee to 11% and brings into question whether the administrative fee is adequate to cover the added administrative requirement of the RAE RFP.

Comments on the draft ACC Phase II RFP will be posted on the web and a copy will be sent if requested.

V. Rate Setting Update

Tina noted that July 1, 2017 – June 30, 2018 is the last year of the CHP contract period before ACC 2.0 begins. Due to new managed care regulations, payments to the mental health centers and independent other providers (including hospitals, etc.) may be reduced. Rate setting for the last year will include our actuary certifying that a rate point versus a rate range is appropriate and adequate to cover the contract. The federal government is now requiring that each of the seven rate categories have to be sufficient in order to cover the services in that category instead of doing the overall blending of the rates as in the past. Analysis is being done by evaluating non-covered services so they can be included in the rates. The first draft of the rates is due by March 17, 2017. The challenge is how to make the rates work for this last year and then carry forward to the new contracts with the RAEs when they combine the RCCOs with the BHOs starting July 1, 2018.

VI. FY17 Performance Measures

Erica reviewed the Exhibit F, Performance Measures which are part of the contract with the last amendment and are evaluated annually on our performance. Many of the measures align across the RCCOs, OBH, SIM grants and other programs that cross over to behavioral health and support the future direction of the State. The Performance Base Measures will be considered in the rate setting process and each BHO must choose at least one of the Stretch Measures to participate in the Performance Incentive Program. CHP selected Indicator 15 Depression Remission at 12 months using standard PHQ-9 and are in the first year of data collection.

VII. Provider Revalidation

Tina reported the State is going to a new MMIS system (Colorado Interchange) that will be going live March 1, 2017 which required that all providers with a Medicaid ID to re-enroll and complete revalidation. CHP is reaching out to help those providers who have not completed the revalidation process.

VIII. Integration Report

Christine Andersen, Director of Integrated Care reviewed the FY17Q2 Integration Report which includes the activity for each of the eight CMHCs within the CHP region in their individual integration programs and the following activities which were highlighted: PSYCH*Line*, C-PACK, Justice Connect and, Long Term Services and Supports by Jenn Hale-Coulson/LTSS Director and, Education and Training by Paul Baranek/Education Coordinator (training is available to providers, MHCs and PIAC member organizations). The next Quarterly Integration Report will have integration plan details for the coming calendar year.

IX. Zero Suicide

Paul Baranak presented the Zero Suicide Power Point. Erica noted the Performance Measures Indicators 1 and 2 are suicide risk assessment indicators for child/adolescent and adults for individuals who are diagnosed with major depressive disorder showing that the State is also putting measures in place because of the high suicide rates in Colorado. Lynne Bakalyan/Director of OMFA commented that the Office of Member and Family Affairs are putting together a presentation on non-demand caring contacts for the Suicide Prevention Coalition of Colorado which is hosting a 2 day conference in May and are hoping to partner with other MHCs/agencies and get feedback on success. Paul commented that the research in other states that have passed assisted suicide measures shows that the suicide rate after that measure is passed usually increases, not for those people utilizing assisted suicide but for people in other categories. There is a connection that seems like when states pass assisted suicide measures it gives other people not falling into the assisted suicide category the idea that it may be a more acceptable alternative. This is something we need to get on our radar screen to look at how it may impact that category.

X. IESO – On-Line Therapy

Website: iesohealth.com – Tina reported IESO is a company from the UK that is starting this one to one behavioral health therapy online program with CHP.

In rural areas this is a great solution for providers that are not available, is good for college students (must be 18 year old, Medicaid member), very easy to use, secure and available all hours, goes against the stigma, etc. CHP is working with the State on how to get this as an approved modality and for now CHP gets reimbursed out of our administrative fund. Committee members were encouraged to look at the website.

XI. Next Meeting – April 13, 2017

Recommendations and requests for future agenda topics from community members should be referred to Kathy. Kathy asked the committee members to send recommendations for new PIAC members and Lynne Bakalyan will email the Advocates and Peer Specialists for suggestions. Lynne also suggested a Member Survey to help shape the CHP webpage and CHP Facebook Page.

The next meeting will be on Thursday April 13, 2017 by teleconference/GoToMeeting.

XII. Adjournment

The January 12, 2017 PIAC meeting was adjourned.

Submitted by: 1.18.17

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Kathy Van Gieson, Executive Assistant Date

Colorado Health Partnerships

Preliminary Analysis of FY16 Performance Measures

Below is a preliminary summary analysis of CHP's performance during FY16 on key measures. Measures identified for further evaluation may change based on Quality Committee input and recommendations.

Areas of Strong Performance

- Reducing Hospital Readmission Rates
- Reducing Redundant/Duplicate Prescription of Atypical Antipsychotics
- Reducing Preventable Emergency Department Utilization
- Follow up after MH and SUD ED visits

Areas of Focus

- Continue focus on improving Ambulatory Follow-Up Rates
- Continue focus on improving mental health engagement
- Continue focus on improving SUD engagement

Penetration Rate

During FY16, the BHO saw an increase in the number of members served. CHP's penetration rate rose slightly to 14.86%, compared to 14.83% in FY15. In FY15, CHP served 58,162 members. In FY16, CHP served 66,085 members. This increase of 7,923 equates to 13% more members served during FY16. Increases in members served were observed across all age groups.

Hospital Readmissions

The rate of inpatient readmissions to non-state hospitals declined slightly during FY16; it dropped from 3.44% in FY15 to 3.06% in FY16 for all age groups. The all-hospitals rate decreased slightly for seven-day readmits (from 3.41% to 2.99%), and declined slightly for 30-day readmissions (from 9.83% to 9.66% re-admissions). 90-day recidivism also decreased when compared to FY15. In FY15 the 90-day recidivism rate was 16.29% and decreased to 15.92% in FY16. 180-day readmissions for all-hospitals also decreased slightly when compared to FY15. The rate went from 21.22% in FY15 to 21.14% in FY16. CHP's performance on the readmission rate measure was positive when compared to FY15; in relation to the FY16 rate, CHP's rates was higher than the weighted average.

Inpatient Utilization

CHP experienced a small increase in non-state hospital utilization during FY16 compared to the prior year. However, the utilization rate for all hospitals was consistent with FY15. CHP experienced a decrease in inpatient utilization for the age 0-12 category as compared to 2015; an increase for ages 13-17 also was observed. While utilization for CHP's adult population increased as well, it remained below the weighted average for all BHOs.

Ambulatory Follow-up after Inpatient Hospitalization

During FY16, CHP experienced a slight decrease in completed follow-up appointments for both non-state and all hospital discharges. CHP's 30-day follow up rates decreased, and will continue to be a focus for improvement for CHP during the upcoming year. Inpatient discharges were up 18% this year for CHP. This increase, along with the growth in members accessing services, may have contributed to the decline in follow-up rates. CHP's rates remain above the HEDIS average for Medicaid, at about the 75th percentile for 30-day follow-up. Ambulatory follow-up rates using only licensed providers were lower than the statewide average for the seven-day rate. However, CHP's performance climbed significantly at the 30-day point. Feedback indicates the seven-day rate may be affected by the limited availability of licensed providers in some CHP rural and frontier regions designated as Heath Professional Shortage areas. While members are treated post-hospitalization, the treatment may more often occur with a non-licensed provider working under the supervision of a licensed provider.

Emergency Department Utilization

A small decrease was observed in CHP's overall Emergency Department utilization rate (10.22% in FY15 decreasing to 9.81% in FY16), and CHP remains below the statewide average for the third straight year for all age categories. CHP continues to support providers in efforts to decrease emergency department use. One intervention that may have contributed to the decrease in CHP's rate was Health Solutions' implementation of a plan to continue increasing the use of available community crisis services, such as the Crisis Living Room, the Mobile Early Intervention Team, and the 23-hour Observation Unit. In the last year, the Crisis Living Room provided approximately 1,000 outreach services to the community. CHP continues its outreach to ED users, informing them of crisis alternatives and providing contact information for additional information or treatment.

Engagement Measures

Initiation and Engagement of Alcohol and other Drug Dependence Treatment: These two measures are in their second year of measurement. For the Initiation measure, in FY15 CHP's baseline rate was 43.04%. In FY16, CHP's rate decreased slightly to 41.04%. While there was a slight decrease in the measure, it is important to note that CHP initiated treatment of 36% (629) more members in FY16 than was done in FY15. CHP's performance for the initiation of AOD treatment was 41.40%. This rate was in line with the five BHO average of 41.40% Engagement in AOD treatment was slightly lower than the BHO average at 30.40%. When compared to the HEDIS rates, CHP performed very well, scoring at or above the 75th percentile for the initiation measure. For the engagement measure, CHP scored at or above the 90th percentile. It is important to note, however, that comparisons must be made with caution, as the methodology used to calculate these measures varies somewhat from the HEDIS methodology. Mental Health Engagement: for the FY16 measurement year, Medicaid members who had a mental health diagnosis only were included in this calculation. CHP's performance on this measure was above average compared to the statewide BHO performance. In FY15, CHP's rate was 43.73% and dipped slightly to 42.68% in FY16. Engagement with the older adult population continues to be lower than expected; a focused evaluation is planned for this subgroup.

Follow up after MH and SUD ER Visits

These two measures were new for the BHOs this year. Consequently, there is no history is available for comparison purposes. However, CHP's rates for both 7 and 30-day follow up were higher than the statewide average for both measures.

Redundant/Duplicate Prescriptions for Antipsychotic Medication

CHP continues to perform well on this measure, with one of the lowest rates in the state for members who have been prescribed two or more atypical antipsychotics for 120 days or more. CHP's rate has slightly increased over the past year as indicated below:

FY16 Rate	FY15 Rate	FY14 Rate
3.33%	3.14%	4.02%

Adherence to Antipsychotics for Individuals with Schizophrenia

This measure is new for the BHOs, so comparison data from the previous year was not available. A review of performance on this measure via HEDIS does not provide a Medicaid-specific benchmark. However, CHP's performance is slightly above the HEDIS 50th percentile for the "all lines of business" category. We will continue to monitor performance, as this is a key measure for our population.

ECHO Satisfaction Survey

Results of the FY16 ECHO Survey were helpful in understanding our Members' perceptions of treatment and services. On the adult survey, it is notable that CHP increased their score on the "perceived improvement" question in FY16. CHP's Quality Committee reviewed the survey results and plans to continue to examine data trends to further evaluate areas for focused improvement and any others areas where survey results show a decrease in performance.

EXHIBIT L, PERFORMANCE INCENTIVE PROGRAM

The Department may institute a Performance Incentive Program allowing the Contractor to receive incentive payments for the improvement of key performance indicators. The implementation of the Performance Incentive Program is contingent on the availability of funds, as well as state and federal approval.

Under the Performance Incentive Program, the overall incentive funds available to the Contractor are proportionally contingent on the Contractor's performance as it relates to the following three (3) participation measures:

1. All corrective action plan submissions and activities shall be in accordance with the provisions of the Contract, for the duration of the Contract term.
    - 25% of the overall incentive funds are allocated to this participation measure.
    - To qualify for the portion of overall incentive funds allocated for this participation measure, the Contractor shall demonstrate 100% compliance.
2. Encounter data shall be submitted monthly in accordance with the provisions of the Contract, for the duration of the Contract term.
    - 25% of the overall incentive funds are allocated to this participation measure.
    - To qualify for 100% of the portion of overall incentive funds allocated for this participation measure, the Contractor shall submit flat file data that is 100% accurate for a minimum of ten (10) months for the duration of the Contract term.
    - In the event of a submission beyond the due date, up to two (2) months, the Contractor shall remain eligible for participation in the performance incentive program at a 10% reduction for each month beyond the due date. Inaccurate flat file submissions will be rejected by the Department and the Contractor shall continue to resubmit until the data is accurate.
3. The Contractor shall demonstrate documentation accuracy in the 2018 Contractor reported 411 audit.
    - 50% of the overall incentive funds are allocated to this participation measure.
    - The portion of overall incentive funds allocated for this participation measure is adjusted based on the average percentage of compliance achieved by the Contractor for the following six (6) documentation categories:
        - Procedure Code
        - Diagnosis Code
        - Place Service
        - Service Program Category
        - Units
        - Staff Requirements.
    - The percentage of total incentive payments for which the Contractor qualifies is determined by the accuracy of the above six (6) measures as follows:
        - 90% accuracy qualifies the Contractor for 100% of the portion of overall incentive funds allocated for this participation measure;
        - 85% accuracy qualifies the Contractor for 90% of the portion of overall incentive funds allocated for this participation measure;
        - 80% accuracy qualifies the Contractor for 80% of the portion of overall incentive funds allocated for this participation measure.

If the Contractor meets the abovementioned minimum requirements, the Contractor can qualify for incentive payments based on minimum improvements in incentive performance measures and by percentage of compliance with incentive process measures.

Minimum improvement for each incentive performance measure is defined as the Contractor "closing their performance gap by 10%" from a respective benchmark (based on FY 15-16 rates) and Fiscal Year 2016-2017 performance. The table below lists each of the incentive performance measures and the percentage of incentive funding allocated for each measure. The benchmark for each measure is established by adding 10% to the highest validated FY15-16 Behavioral Health Organization score for associated measures.

	Incentive Performance Measure	**Percentage of Funding Allocated for Measure**
Indicator 1	Mental Health Engagement (all members excluding Foster Care)	15%
Indicator 2	Mental Health Engagement (Foster Care)	5%
Indicator 3	Engagement of SUD Treatment	10%
Indicator 4	Follow-up Appointment within 7 days after a hospital discharge for a mental health condition	5%
Indicator 5	Follow-up Appointment within 30 days after a hospital discharge for a mental health condition	5%
Indicator 6	Emergency Department Utilization for mental health condition	7.5%
Indicator 7	Emergency Department Utilization for substance use disorder condition	7.5%

The table below lists each of incentive process measures, the percentage of funding allocated for each measure, and the percentage of compliance that is required to qualify for an incentive payment.

	Incentive Process Measure	**Percentage of Compliance**	**Percentage of Funding Allocated for Measure**
Indicator 8	Suicide Risk Assessment	80%	10%
Indicator 9	Documented Care Coordination Agreements	100%	15%
Indicator 10	Denials: Dual Diagnosis	80%	20%

In accordance with 42 CFR 438.6(b)(2) incentive payments may not provide for payment in excess of 105% of the approved capitation payments. Incentive payments must be considered when determining the cost effectiveness of the Community Behavioral Health Services Program.

The incentive arrangements specified in the Performance Incentive Program are necessary to support program initiatives as specified in the state's behavioral health quality strategy, in accordance with 42 CFR 438.6(b)(2)(v).

Incentive payments may only be available for a fixed period of time and incentive performance must be measured during the rating period under the contract in which the performance incentive program is applied, in accordance with 42 CFR 438.6(b)(2)(i). The Department must remit qualifying incentive payments earned during the performance period on July 1, 2017 and June 30, 2018 to the Contractor between July1, 2018 and December 31, 2018.

In accordance with 42 CFR 438.6(b)(2)(ii) - (iv) Performance Incentive Program arrangements:

- Are not renewed automatically.
- Are made available to both public and private contractors under the same terms of performance.
- Are not conditioned on the Contractor entering into or adhering to intergovernmental transfer agreements.

LONG RANGE 2017 OFFICE OF MEMBER AND FAMILY AFFAIRS RECOVERY WORK PLAN

Colorado Health Partnerships' OMFA goals were originally developed in 2009. Modifications were made using subsequent RFPs & proposals. The BHO Advocates' and OMFA staff across the CHP region incorporated their ideas and individual MHC goals into this work plan. The work plan is presented to the Class B Board for review and approval annually.

OMFA	KEY OBJECTIVES	TARGETED ACTIVITIES	RESPONSIBLE PERSON	DUE DATE	Mid-year Status/OUTCOME	FOLLOW-UP
1. Promote visionary thinking.	**1a.** Hold ongoing training for consumers/families. The training will improve leadership skills & will use local and national Beacon trainers.	1. Identify trainers. 2. Plan & hold leadership training.	BHO Advocate Representatives Consumer leadership Family leadership CHP/Beacon	Ongoing-will reassess feasibility in June, 2018		Continue to provide topics on leadership development through the use of. Webinars and/or trainings. Work with CHP Education Coordinator to provide leadership topics and materials.
	1b. keep current with research and accomplishments in behavioral health service delivery so that we continue to be progressive and visionary	1. Share research articles in OMFA meetings; regularly review new research	BHO Advocate Representatives	January 2018		Continue to send articles to CMHC advocates and peer specialists on trends in behavioral health services.
2. Strengthen advocacy function within the BHO	**2a**. Provide training for consumers/family members who will take on an active leadership role in the CMHC, community	2. Conduct additional training to consumer/family leadership (4x at each service center)	National Recovery Resource; CHP Service Center; CMHC Executive staff	Ongoing through-out the contract		OMFA will continue to provide training for CMHC advocates and peer specialists 1-2 times per year from Beacon national staff.
	2b. Increase the Customer service functions of the OMFA.	1. Offer customer service training modules for staff, consumers and family members.	CMHC advocates	complete		Send customer service training modules to CMHC advocates and discuss at bi-monthly meetings.
	2c. Increase staff knowledge about the value of peer-run services.	1. Training/ reinforcement training in recovery models (at least 4 times throughout CHP)	CHP National Recovery Leaders Advocates	Ongoing		Continue to promote the value of peer-run services through articles and discussion.

Submitted to Class B Board on February 22, 2017

3. Empower Consumers and Family Members/Client Advisory Committee	**3a.** Implement a client advisory committee with formal communication mechanisms with the Board.	1. Establish formal communication between committee and Board.	CMHC advocates CHP	Ongoing		OMFA staff will visit CMHCs to meet with Members. OMFA will develop a separate Member and Family Advisory committee to obtain feedback about behavioral health services.
4. Develop and expand peer run services at the CMHC's	**4a.** Increase work and vocational opportunities for consumers and families.	1. Develop recovery oriented self-determined vocational programs and job opportunities. 2. Offer training that is consistent with the IC and RC requirements and the state core competencies.	CMHC advocates	Ongoing		Provide continued education needed for peer specialist credentialing required by the State. Collaborate with CMHCs about the types of work opportunities that are available for peers.
	4b. Increase education and information available to consumers and families about mental illness, wellness and recovery.	1. CHP Website, Newsletters that include successes stories and solutions. 2. Newsletters that include successes and solutions. 3. Achieve Solutions	CMHC advocates	Ongoing		Continue to provide educational information including resources such as NAMI for CMHC advocates. Place educational articles on website and Facebook.
	4c. Develop supports for adolescents and their families.	2. Develop a plan to expand or partner for these services.	CMHC advocates	July 2018		Provide Beacon resource guide to CMHC advocates. Discuss what support systems are already in place at CMHCs.

	4d. Ensure that peer specialists employed by the CMHC's have the appropriate level of support to be successful in their employment.	1. Assess policies and practices to ensure they do not create barriers to wellness for peers.	CMHC advocates Engagement center	Ongoing		Discuss what needs have been identified for peer specialists to be successful at the Advocate's meeting. Discuss ways to meet these needs and OMFA will provide support as needed.
5. Strengthen advocacy function with external systems	**5a.** Formalize community based integrated coalitions with a philosophy of recovery.	1. Outreach to judicial, school, medical, faith-based communities. (ongoing) 2. Get feedback from community partners via surveys, other outreach activities.	CMHC advocates	Ongoing		Identify what current outreach practices that the CMHCs have within the community. OMFA to discuss at Advocate's meeting.
6. Decrease stigma about mental illness through education and outreach	**6a.** Train faith community on recovery and mental illness.	1. Identify at least 2 sites and provide training and education to the faith community.	CMHC advocates	Ongoing		Provide educational materials for CMHC advocates to provide to faith based communities.
	6b. Higher education.	1. Identify avenues for providing recovery training to colleges, universities and other higher education institutions. 2. Bring Youth MHFA to college, high school and middle school teaching staff.	CMHC advocates	Ongoing		Youth MHFA training has been provided at the high school and middle school teachers, administration and paras through Beacon staff. Identify CMHC MHFA instructors and obtain list of classes that have been taught.
	6c. Suicide prevention agencies	1. Identify avenues for recovery training through suicide prevention	CMHC advocates	Ongoing		Beacon has a Zero Suicide Implementation team that works quarterly with CMHCs on suicide

		initiatives at CMHC's and with Suicide Task Group				prevention efforts.
7. Demonstrate thru data the effectiveness of OMFA Services	**7a.** Get recognition for our work (i.e. journal articles, books, awards)	1. Research available awards. 2. Identify exemplary programs in the CMHC's 3. Apply for local/national awards	CMHC advocates	July 2018		Assign OMFA to research what awards are available and if appropriate, apply for award.
	7b. conduct a study of peer services in the CHP region	1. Develop a survey tool 2. Distribute the tool 3. Analyze the responses	Advocates	July 2018		OMFA has been completing surveys at the CMHCs on efficacy of peer specialists. Review bi-annually at the Advocates meeting.
8. Promote holistic recovery through wellness and health	**8a.** Develop wellness program at each center	1. Implement local programs that includes but are not limited to yoga, smoking cessation, stress reduction, etc. 2. Include wellness training for integrated models.	CMHC Advocates CHP	June 2018		Each CMHC has a wellness program in place. Complete, but continue to monitor as needed or requested by the Department.
	8b. Increase peers' knowledge of integrated systems. Increase their knowledge about methods to promote health and wellness.	1. Increase Peers' knowledge of RCCO's and health Colorado to connect peers with a PCP when indicated.	Advocates, peers.	July, 2018		Offer a peer specialist training for Whole Health Management with Beacon national staff.
9. Ensure the Advocacy function is in compliance with regulations, laws, and contract.	**9a.** Ensure members and family members have access to an effective grievance/appeal system.	1. When appropriate, get involved at the state level decision making around complaints.	QISC CMHC advocates Advocate's Forum	Complete and ongoing		OMFA has updated CMHC Advocates on regulation 1557 to ensure compliance with federal law.
	9b. Monitor complaints/ grievances.	1. Review complaints data quarterly 2. Conduct training and	CHP CMHC Advocates QISC	Ongoing		OMFA will continue to review quarterly complaints at the bi-

		remediation as necessary.				monthly Advocates meeting.
10. Promote Mental Health First Aid (MFA)in the community	**10a.** Increase awareness of community resources available to address mental health issues.	1. Identify trainers through OMFA and CMHC's 2. Continue to identify rural areas with limited MH resources and schedule MHFA trainings to community members.	CMHC advocates	December 2018		Identify the number of staff trained at each CMHC and have staff report on trainings that they have completed.
11. Incorporate Zero Suicide philosophy within CHP	11a. Educate staff on Zero Suicide model.	1. Evaluate use of IP discharge report at MHCs	CMHC advocates	December 2018		

Beacon Colorado presents

Health Promoter
Peer Specialist Training
(Whole Health Management)

This two-day course is for peers who are interested in supporting those who have both behavioral and physical health issues. Instructors are Clarence Jordan, Vice-President of Wellness and Recovery and Cindy Goulding, Licensed Behavioral Counselor. Cindy is also a certified personal fitness trainer and certified health and wellness coach. Registrants must attend both days.

- The training is designed for Peer Specialists within Colorado Health Partnerships. It is not appropriate for clinicians or other professionals.
- There is a minimum of **8** participants required to hold the training. We are limited to a maximum of **20** participants.
- Registrants will be accepted on a first-come, first-serve basis.
- Returned Registration Form Deadline: Friday, April 14, 2017
- Continental breakfast and lunch are provided

Training Dates and Times

Tuesday and Wednesday, April 25 & 26th 8:30 am to 4:30 pm

Training Cost

Beacon is offering this class for **free** for in-network Peer Specialists with CHP
Travel/Lodging: Beacon Health Options will not be able to provide lodging or travel

Meeting Location

Beacon Health Service Center
9925 Federal Drive, Suite 100
Colorado Springs, CO 80921
1-800-804-5040, ext 361483

Training Registration Form

Name: _____

Organization: _____

Mailing Address: _____

City/State/Zip Code: _____

Work Phone: _____ **Fax Number:** _____

Cell Phone: _____

E-Mail Address: _____

If you have dietary restrictions, what are they? _____

If you need an accommodation for a disability, what is it? _____

Liability

The Applicant agrees that Beacon Health Options (the "Certification Body"), in performance of its duties, consideration and review under this application does not assume or undertake to discharge any responsibility to any other party or parties. The Applicant acknowledges that the opinions and findings of the Certification Body represent its judgment given with due consideration to the necessary limitations of practical operation and in accordance with performance of its duties, and agrees that the Certification Body does not warrant or guarantee the correctness of its opinions or that its findings will be recognized or accepted by any third party. For these and other reasons, the Applicant agrees to hold the Certification Body harmless and to defend and indemnify the Certification Body against any loss, expense, liability or damage, including reasonable attorney's fees, arising out of any malpractice, tort, willful acts, negligence, or gross negligence by the Applicant; or misuse by the Applicant of the Certification Body certification: or arising out of any violation by the Applicant of the terms and conditions of this application.

Supervisor Name: _____ _____

Supervisor Signature: _____
(Required)

Return Deadline: Friday, April 14, 2017

Please send your registration form to: D'Anne.Goldstein@beaconhealthoptions.com

Colorado Health Partnerships invites you to join our

MEMBER AND FAMILY ADVISORY FORUM

Your story matters. . .

Take time to share what is helpful in your treatment and recovery.

Your advice matters. . .

How easy is it to read and understand our letters, tip sheets, and website?

How would you change our Member handbook?

What training is important for your recovery?

What would you like providers and mental health centers to know?

Your time matters. . .

One hour. Four times a year. Will you join us on the phone to share your story and your advice?

Take time to call. . .

Please call us if you will be a part of our forum. **Call 1-800-804-5040 ext. 361483**. This is a free call and will not cost you anything.

INTEGRATION REPORT
March 28, 2017

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 January 1 through March, 2017.

Colorado Health Partnerships hosted the monthly Chief Clinical Officer / Integrated Care Directors meetings this quarter in January, February and March. This remains a productive group with each Community Mental Health Center's (CMHC) leadership involved in integration efforts. In January's meeting the individual centers provided a summary on the previous year's integration efforts and presented their upcoming integration projects. The team was also presented with the upcoming policy and rate setting changes as well as review of the density reports which are submitted quarterly. February's meeting was an introduction to the Performance Measures used to determine performance of CHP and individual centers within the CHP region. Discussion was conducted regarding how the measures are calculated and validated. March's meeting was a continued discussion regarding performance measures and the implications for performance incentives in FY2018. Next steps will be continued review of validated measures and creating workgroups comprised of clinical and quality staff from all the partner regions.

Each of the eight CMHCs within the CHP region are actively engaged in individual integration programs. As each of the 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 previous quarter's report provided an overview of the work each mental health center is

engaged in to provide integrated services to meet the needs of their community. Each CMHC has submitted a final report January 9th detailing their progress with the previous year's integration report as well as their plans for their 2017 Integration Projects which are outlined below.

Aspen Pointe

There have been many iterations of the service delivery model over the past 16 years in an effort to move each partnered location toward a Level 6 on the integration continuum. Aspen Pointe currently has 17 primarily integrated care sties and one bi-directional integrated site on the Moreno specialty campus, and employs 17 full time Behavioral Health Providers.

In an effort to align the core components of integration, Aspen Pointe has increased its primary cross organizational focus and supports. Part of this ongoing work ash been developing the right infrastructure, systems and processes to further each core component and associated goals. To do so, Aspen Pointe as created and laughed in 2016 a new team, Healthcare Transformation, to specifically work in collaboration with the Integrated Care leadership and staff. Over the course of 2016, the Healthcare Transformation Team has been able to provide process improvement and project management supports to the Integrated Care Team. This has assisted with increases in almost all IPAT scores ranging form 4-5. Aspen Pointe's Integrate Care database (NICE) has played an integral part in their ability to track, analyze, and share data with each of their partners, resulting in team utilization increase from 20% to nearly 80% to date. Since the mid-year report, they also continue to expand their integrated Care footprint with the addition of 1 new integrated care partnership with Summit Medical Clinic. Three additional clinics are engaged in partnership negotiations for 2017.

Axis health System

Axis Health System (Axis) operates two clinics that are integrated Community Health Centers and Community Mental Health Centers combined. The first incentive project focused on developing a Shared Care Plan Page in the *Health Tracker*, an internally developed patient health dashboard. This page was developed and made available to the care teams at La Plata Integrated Healthcare (LPIH). This project moved La Plata Integrated Healthcare to a Level 6, as measured on the IPAT and improved the Shared Care Plan and Follow-Up areas of the Vermont Integration Profile (VIP).

The current project focused on the further development of the *Health Tracker* by revisiting the set-up of the information contained in the dashboard display, with simplification and alignment to better support higher levels of integrated practice. This project also included a staged rollout of enhanced *Health Tracker* functions to Cortez Integrated Healthcare (CIH), which would allow that clinic to move to Level 6 integration, as has La Plata Integrated Healthcare.

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Axis Health System expected this project would take until January 2017 to fully implement, with another quarter devoted to data collection for evaluation and outcome measurement. As it turns out, they would like to continue this project through June, 2017. The additional project time would be to refine the Health Tracker post roll-out that has just occurred in January. They propose to set up data collection for utilization in the first quarter and to be able to collect this data through the end of June. In addition, Axis Health System is opening a third integrated clinic in Pagosa Springs at the end of April. As part of this clinic opening, they will train the staff on the Health Tracker and open with the availability of this technology at Archuleta Integrated Healthcare. Axis would then have all three integrated clinics using the new version of the Health Tracker by the end of the project period, which would represent the completion of work on this project.

The Center for Mental Health

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. The number of enrolled practices has doubled from last quarter due to active recruitment efforts. The training program was initiated during this quarter. Training modules were created by the Beacon Program Manager to educate primary care providers in recognizing, assessing and diagnosing the most commonly occurring mental health issues. The second part of the training modules is an in person or virtual training with the teleconsultants specific to medications recommended for treating the commonly occurring mental illnesses.

The PSYCH*Line* program manager will continue to develop and expand the library of training modules allowing practices to request specific trainings as they identify a need in their practices. The Program Coordinator employed through Beacon Health Options has made multiple site visits with enrolled practices and working to recruit more practices. The reception from PCP practices has been very positive and the program coordinator continues to work to build more ways to gain data.

Previously implemented integration programs continue in CMH region with the goal of improving IPAT scores for each location. Locations include:

- Gunnison Valley Health Systems- IPAT 3
- Partners in Integrated Care (PIC Place- partnership between Center for Mental Health, Community Dental and Delta Vo-Tech) – IPAT Pending Opening Spring 2017

- Pediatric Associates- IPAT 4

Health Solutions

Building upon previous integration efforts, Health Solutions designed a fully integrated primary care center for Pueblo. For inaugural venture into primary medicine, the Executive team worked closely with major architectural firm to construct a unique whole person care center. Pueblo county has a population of approximately 162, 891 residents 37.6% or 61,323 of whom are Medicaid members. Additionally, 20.1% of the population lives below the Federal poverty line, compared to 13% statewide. Illustrating the unique and specific needs of Pueblo county. The Health Solutions Medical Center team is comprised of multi-disciplinary members under the direction of the Deputy Healthcare officer. The Medical clinic works 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 (RCCO). This provides Medicaid members full coordination of healthcare services.

The original Integration Incentive Plan Proposal to CHP was to achieve the IPAT Level 3 by June 30, 2017. Level 3 was readily achieved one year early on June 30, 2016. Continued improvement and refining of the processes has enabled Health Solutions Medical Clinic to reach IPAT level 5 on December 31, 2016. One of the original goals of the Medical Clinic was to increase the number of underserved Pueblo County citizens who receive integrated health care. The clinical recorded 4,627 patient services for the twelve months. Though Health Solutions met this goal as well as other goals outlined in their previous Integration plan they maintain that there are many more Puebloans who could benefit from these services. Emphasis on the Key Performance Indicators will be an instrument al part of their improvement plan for 2017. Additional Key Performance Indicators for behavioral health will be added to the improvement plan to demonstrate their effectiveness at achieving full healthcare integration objectives.

Mind Spring Health

The overall goal of the project is to provide efficient and effective coordination of care with Primary Care Physicians for individuals receiving Behavioral Health Care. Mind Springs Health has been working closely with the Health Information Exchange (HIE) in Western Colorado, Quality Health Networks (QHN) for the past couple of years. The HIE's purpose is to allow nurses and doctors to access and share a patient's vital medical information electronically. The aim is to improve the speed, quality, safety and cost of patient care. Having the patient's vital health information stored electronically in one central location can improve care. The HIE works with the physical health providers and their electronic medical records so that information is pulled from and pushed to the primary care provider. MSH had worked with QHN for many years and that work had allowed the MSH psychiatrists and prescribers to pull

information from the HIE such as all current medications and lab results. However, this was a one-way communication.

As we know, behavioral health providers are often seen and thought of by physical health providers as a "black hole" of information. The confidentiality issues surrounding Mental Health and Substance Use Disorder treatment create issues for sharing information that all too often do not make sense to primary care providers and leaves them feeling that, and in reality not having the information they need to treat their patient. Due to these issues and the importance of coordinating care for individuals in an integrated, efficient way QHN and MSH worked together to find a way to honor 42 CFR Part 2 and HIPPA regulations and enter Mental Health and Substance Use Disorder treatment information into the QHN HIE system. In 2016 MSH began sharing information regarding psychiatric medications prescribed, lab orders and lab results as well as psychiatric hospital discharge information for an individual into the QHN system when a release of information/authorization is in place to the primary care doctor.

Goals for this project: Increase efficiency and sharing of information between Primary Care Physicians and Behavioral Health services at Mind Springs. MSH will track the number of clients who report having a Primary Care Physician as well as those that then agree to sign a release of information. MSH will track the number of reports we enter into the HIE (QHN) and report on progress being made with sharing information. The overall goal of this project is to move from an IPAT level 1 to an IPAT level 3 in the Grand Junction Clinic of Mind Springs Health.

San Luis Valley Behavioral Health Group

The San Luis Valley Behavioral Health Group (SLVBHG), Behavioral Health Integration Program provides services utilizing holistic treatment and preventative approaches that supports people's lives, strengthens families, nurtures our youth and empowers people.

The purpose of this program is to develop and expand behavioral health services within primary care clinics in the San Luis Valley. SLVBHG currently has strong relationships and integrated settings, this year will focus on improving levels of integration. They are currently at levels between 2 and 5 in all 13 clinics SLVBHG is in. This project will improve access to those who cannot or have difficulty accessing needed behavioral healthcare, improve behavioral health workforce capacity and improve treatment quality and effectiveness by implantation of best practices in the field of behavioral health integration. The overall goal is to improve access and effectiveness of healthcare services in the San Luis Valley. The core of this approach is working with the primary care partners towards a whole person orientation where the health care system supports team-based care (shared care) and provides case management/care coordination and supports to individuals to meet their self-management goals.

While SLVBHG will continue to strengthen all of our integrated sites throughout this year, the primary focus for this funding will be to expand and strengthen services in the three SLV Health sites (Alamosa, La Jara, and Antonito). To continue to move integration efforts forward and take the next step in integration they will continue to expand the services and level of integration at medical sites that they have staff co-located to provide consultation and care coordination. Currently, SLVBHG has a staff co-located in 3 of the primary care sites, with consultants and care coordinators in the practice at least half time or more. This will move SLVBHG's level of integration in these two sites from a level 2 to a level 3.

Solvista Health

Solvista Health has increased integrated care programming over the last 18 months, including opening up a new primary care clinic onsite with behavioral health services in Fremont County. In addition to the new clinic, specific program goals were set to increase support services for medical and behavioral health patients to assist them in pursuit of healthier lifestyles. Solvista's overall goal is to provide care in an environment that fully integrates physical and behavioral healthcare and offers a variety of options that are practical to meet their clients where they are, whether they are ready to make small or large changes to improve their health. Solvista's overall project goals focused on smoking cessation, and reduction of obesity. In summary, the project goals related to tobacco cessation were met, and the efforts to reduce obesity will continue.

Solvista has future plans to imbed their care coordinators more fully into their medical clinic to help improve the daily functioning of all of their clients. They plan to use a formal assessment tool, such as the DLA 20 to review overall functioning on admission and to help highlight areas where clients need assistance. Connecting them to a care coordinator to help with issues related to social determinants for health will result in overall improved functioning of their clients and better health. Solvista will measure our outcomes by improvements in the DLA 20 or other validated tool from baseline at admission to another result after 90-180 days of participation in services.

Southeast Health Group (SHG)

Southeast Health Group (SHG) has identified an area of need in their six county region, specific to Child Welfare and Adult Protection clients, who would benefit from a strengthened collaboration with our six county Departments of Human Services (DHS).

When a treatment plan is developed as mandated by Colorado Statute and a need for services provided by SHG is identified, a referral is made by DHS. After the referral process has taken place, communication with DHS is severely lacking. The treatment plan, though requested, is never provided to SHG. Additionally, SHG provides sporadic treatment progress notes**.** Therefore, the goals of each provider become unaligned, unclear, and do not serve the client effectively.

SHG has not consistently communicated to DHS dates of intake appointments and whether the client had shown for such appointment. This creates frustration by DHS as their awareness of the clients' non-compliance is often weeks late. Additionally, SHG's different referral options (mail, fax, phone, website, Signal MSO, EHR) seem to have created confusion by caseworkers and makes it difficult for SHG staff to provide feedback in such manners regarding intake attendance.

SHG has been successful in strengthening collaboration with our area DHS offices. As part of the Integration Project, SHG hired a part-time DHS Consultant that was a DHS Director before retiring. Because of his knowledge and understanding of processes, SHG has been better able to accommodate DHS and facilitate some integration of the systems. We still experience some difficulty in the areas of Shared Outcome Measures, as our goals may align, but the communication isn't flowing. Likewise, we cannot currently say that we have Shared Care Plans with DHS—though the document has been created, it is not necessarily being used as intended.

SHG will continue to work toward progressing with some counties that the DHS Consultant has identified as priorities because of their investment in collaboration. After we've experienced success in those counties, we will work to replicate those successes to the entire region.

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.

The previous CHP analyzed data through the Incarceration Cross-Match Proof of Concept, continues to be utilized 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.

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

stakeholder's 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.

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.

CHP employs an Education Coordinator whose presentations often involve integration information and support integrative efforts through connections with various partners. Colorado Health Partnerships continues to promote awareness and education regarding the BHO, Health First Colorado behavioral health benefits and more general mental health issues throughout the region. On January 12th we gave a presentation regarding our Zero Suicide initiative to the Performance Improvement Advisory Committee. This group is composed of community members from various walks of life such as members, sheriffs, department of human service directors, pastors, assisted living facility directors and others. Beacon Health Options, the administrative partner in the BHO, has a national as well as a Colorado Zero Suicide initiative. On January 17th a day long Motivational Interviewing training was given in Alamosa to care managers from Valley Wide, the Federally Qualified Health Center serving the San Luis Valley area. This presentation was also given to care managers from Solvista mental health center in Canon City on March 15th.

Colorado Health Partnerships continues to reach out to the educational community. On February 9th a presentation on the functions of the BHO and how to access behavioral health services through Health First Colorado was given to the statewide meeting of the Board of Cooperative Educational Services. This group serves special needs students throughout the state and CHP region. CHP also provided a Youth Mental Health First Aid training to staff of school districts around the Pikes Peak region on February 17th.

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March 28, 2017

Colorado Health Partnerships recently became a Leadership Partner in Healthy Transitions Colorado. This group problem solves problems with transitions from health care systems and levels of care through education and training. On March 23rd CHP presented to a large group of health care representatives from around the state and region on the functions of the BHO and how to access behavioral health services through Health First Colorado. We also discussed our innovative Child Psychiatric Access and Consultation for Kids program and our text therapy program for rural areas called IESO. By involvement in statewide groups such as Healthy Transitions Colorado and chairing the Training and Development Subcommittee of the Colorado Behavioral Healthcare Council, Colorado Health Partnerships promotes better utilization of Heath First Colorado behavioral health services.

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

COLORADO HEALTH PARTNERSHIPS
PERFORMANCE IMPROVEMENT ADVISORY COMMITTEE
2017 MEETING SCHEDULE

GoToMeeting: 1-877-668-4493 PC: 79878011

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.