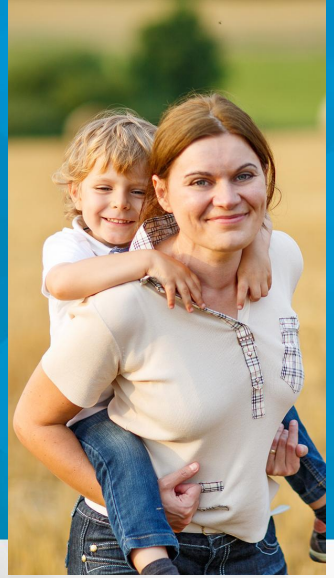
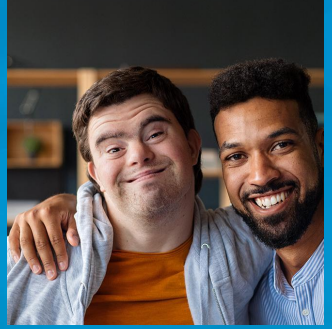




Administrative Burden: CCAR/DACODS Modernization

October 2023

THIS SESSION WILL BE RECORDED AND PUBLISHED ON THE BHA WEBSITE

COLORADO
Behavioral Health Administration

Abigail Fisher (she/her)
BHA Experience Designer

Abigail Fisher is a civic designer living with OCD, who believes her role is to hold space and break down bureaucracy so that communities can design for themselves. Using methods derived from communications design, service design, art, and social justice, Abigail weaves together groups of co-designers with professional and lived/living experience.

Abigail was previously a design lead at New York City's Civic Service Design Studio and is currently working with the Colorado Digital Service focused on improving mental health care through co-created technology and systems.

Technology Team

- Data & Solution Architects
- Procurement Managers
- System Administrators
- Project Managers
- Technical Leads
- Data Technologists
- Front End & Backend Engineers
- Experience Designers
- Engagement & Support Specialists
- Security Specialists
- Product Managers
- Q&A Specialists

Co-authors: Chris Pimlott, Mark Gammon

“[We] honor and acknowledge that the land on which we reside is the traditional territory of the Ute, Cheyenne, and Arapaho Peoples. We also recognize the 48 contemporary tribal nations that are historically tied to the lands that make up the state of Colorado.

We honor Elders past, present, and future, and those who have stewarded this land throughout generations. We also recognize that government, academic and cultural institutions were founded upon and continue to enact exclusions and erasures of Indigenous Peoples.

May this acknowledgement demonstrate a commitment to working to dismantle ongoing legacies of oppression and inequities and recognize the current and future contributions of Indigenous communities in Denver.” - Denver City Council

Share Out Agenda

- **Context** | *Why*
- **Research** | *Who*
- **Findings** | *What*
- **Recommendations** | *How*
- **Roadmap** | *When*
- **Group Discussion** | *45 Min*

Session Purpose

Tactical: To share findings and recommendations from provider research on CCAR / DACODS Modernization.

Emotional: To begin the process of feedback gathering and engagement on these findings to hold true to the BHA's value of co-creation.

Four Ways to Engage!

1. **Open Discussion** — Come off mute and share your thoughts.
2. **Chat** — Put your feedback in google meet chat.
3. **Feedback Form** — Fill out the feedback form after the session.

Acknowledgements

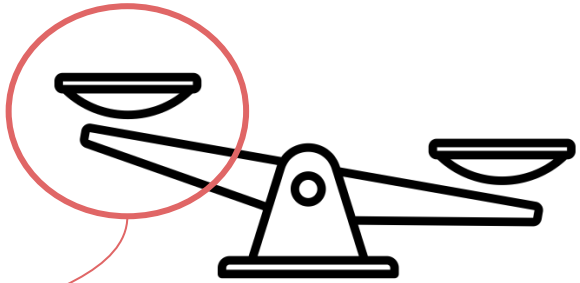
We want to express our deep thanks to the providers and other stakeholders who participated in this research.

We know that every hour spent with us is an hour away from supporting clients. We take this responsibility seriously, and promise to live our value of co-creation. We have expressed the truth as we heard it, and credit the recommendations in this report as solutions created by those closest to the problem.

Key Takeaway

Would these recommendations better balance administrative burden, federal requirements, and measures of quality and access for behavioral health providers in Colorado?

Administrative Burden



Measures of Quality & Access

Federal Requirements

Today, admin burden is proportionally out of balance for providers and for people seeking care.

Icons by the Noun Project

House Bill 22-1278

THE BHA SHALL SET **MINIMUM PERFORMANCE STANDARDS** FOR TREATMENT OF CHILDREN, YOUTH, AND ADULTS THAT ADDRESS KEY METRICS FOR BEHAVIORAL HEALTH PROVIDERS AND BEHAVIORAL HEALTH ADMINISTRATIVE SERVICES ORGANIZATIONS LICENSED BY THE BHA PURSUANT TO PART 5 OF THIS ARTICLE 50, INCLUDING BUT NOT LIMITED TO:

A. **ACCESSIBILITY OF CARE**, INCLUDING:
   a. AVAILABILITY OF SERVICES;
   b. TIMELINESS OF SERVICE DELIVERY; AND
   c. CAPACITY TRACKING CONSISTENT WITH SECTION 27-60-104.5;

B. **QUALITY OF CARE**, INCLUDING APPROPRIATE TRIAGE AND ACCESS BASED ON CLIENT NEED AND FOR PRIORITY POPULATIONS.

C. IN SETTING MINIMUM PERFORMANCE STANDARDS, THE BHA SHALL COLLABORATE WITH STATE AGENCIES TO CONSIDER:
   a. EVIDENCE-BASED AND PROMISING PRACTICES;
   b. THEMES IDENTIFIED THROUGH GRIEVANCES PURSUANT TO SECTION 27-50-108;
   c. INPUT FROM THE BEHAVIORAL HEALTH ADMINISTRATION ADVISORY COUNCIL CREATED PURSUANT TO SECTION 27-50-701;
   d. ALIGNMENT WITH EXISTING STATE AND FEDERAL REQUIREMENTS;
   e. ALIGNMENT WITH THE BHA's COMPREHENSIVE STATE PLAN DEVELOPED PURSUANT TO SECTION 27-50-105 (2); AND
   f. REDUCING THE ADMINISTRATIVE BURDEN OF DATA COLLECTION AND REPORTING FOR BEHAVIORAL HEALTH PROVIDERS.

Establishing Colorado's Behavioral Health Administration

DECISION

JANUARY 2021 – JULY 2021

Executive Committee convenes to discuss and analyze findings from HMA's technical work.

RESEARCH & ENGAGEMENT

FEBRUARY 2021

HMA holds interviews, focus groups and open forums with state departments, stakeholders and consumers on criteria and considerations for the BHA structure and functionality.

LEGISLATIVE

APRIL 2021

BHA Bill (BH21-1097) is signed into law by Governor Polis.

RESEARCH & ENGAGEMENT

APRIL 2021

HMA holds interviews, focus groups and an open forum with state departments, stakeholders, and consumers on draft solutions for BHA structure.

AGREEMENT

SUMMER 2021

Executive Committee agrees on the overall direction of the BHA.

PLANNING

AUGUST 2021 – JULY 2022

Initial Implementation activities to establish the BHA will be underway, including stakeholder engagement.

LEGISLATIVE

NOVEMBER 2021

An implementation plan to establish the BHA via a phased approach will be submitted to the General Assembly.

IMPLEMENTATION

JULY 2022

The BHA will be established within CDHS. It will remain part of CDHS until a permanent location is recommended on or before November 2024.

The BHA is a little over a year old, so we're still very much in the process of resolving our technology debt which has a part to play in reducing administrative burden.

How might we reduce the administrative burden caused by **CCAR/DACODS** reports?

Key Recommendations

1. Update Data Model: Update the data model for CCAR/DACODS through relevant stakeholdering and federal review processes. Map data model to culturally competent best practices (ex. gender, race, ethnicity) for front-end presentation.
2. Select Data Entry System: Perform an analysis of existing internal and external technology systems based on recommended design parameters in order to select a new front-facing data entry system.
3. Build for Episodic Reporting: Build a reporting environment where we can collect data episodically; aggregating encounters into “Episodes of Care”.
4. Create Data Analysis Dashboards: Create standard and customizable data analysis dashboards so providers can track progress towards contractual requirements as well as measures of equity.
5. Prioritize Engagement: Create a robust external communication and engagement plan for providers and other stakeholders to foster trust and transparency.

Context | *Why*

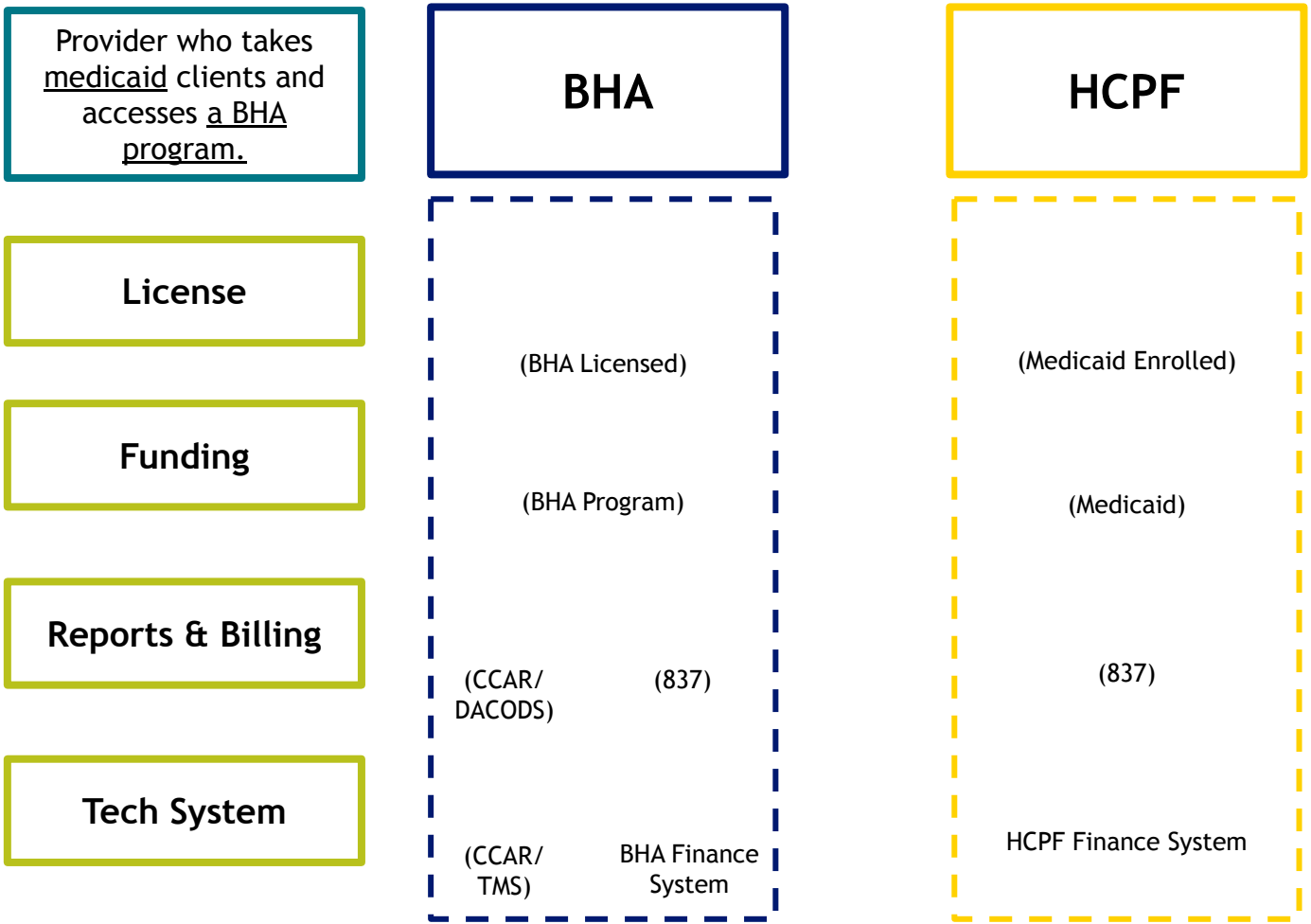
Behavioral health care providers that care for uninsured, underinsured, and undocumented people have to hurdle **extreme bureaucratic barriers.**

Simply to **accept medicaid clients** is a huge task.

1. First a provider organization must **apply to be enrolled** as an approved medicaid provider.
2. Then after they are legally approved by HCPF (the Department of Health Care Policy and Financing) to care for medicaid clients, they must **engage in unique billing and reporting processes** that goes far beyond what a private healthcare provider would experience.

If a provider then wants to **access additional state funding**, for example BHA (Behavioral Health Administration) money to pay for and/or supplement the care of priority populations for the state (ex. pregnant people using substances, justice-involved individuals with severe mental illness), they essentially have to **repeat that process** including:

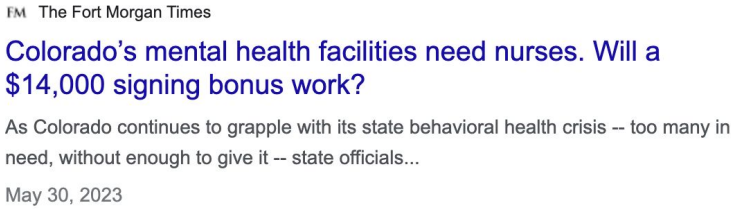
1. Enrollment
2. Applications
3. Contracting
4. Billing
5. Reporting.


Provider who takes medicaid clients and accesses a BHA program.
BHA
HCPF
License
Funding
Reports & Billing
Tech System
(BHA Licensed)
(Medicaid Enrolled)
(BHA Program)
(Medicaid)
(CCAR/ DACODS)
(837)
(837)
(CCAR/ TMS)
BHA Finance System
HCPF Finance System

Private / Public Inequity

Administrative burden refers to the time, effort, and resources required by behavioral health providers to comply with state-mandated reporting, rules, and regulations.

After considering the discrepancies between public and private administrative burden for behavioral health providers, you start to get a clear picture of why there's a **workforce development crisis** in this and many other states.



Administrative Burden State-Wide

There are many initiatives in Colorado aimed at tackling administrative burden.

There are efforts across agencies to standardize contract, data, and reporting requirements so that providers can establish more uniform processes, ultimately saving them time and money.

As the Behavioral Health Administration's technology team, we need to join these efforts by **first tackling our biggest contribution to administrative burden.**

Universal Contracting Provision Workgroup

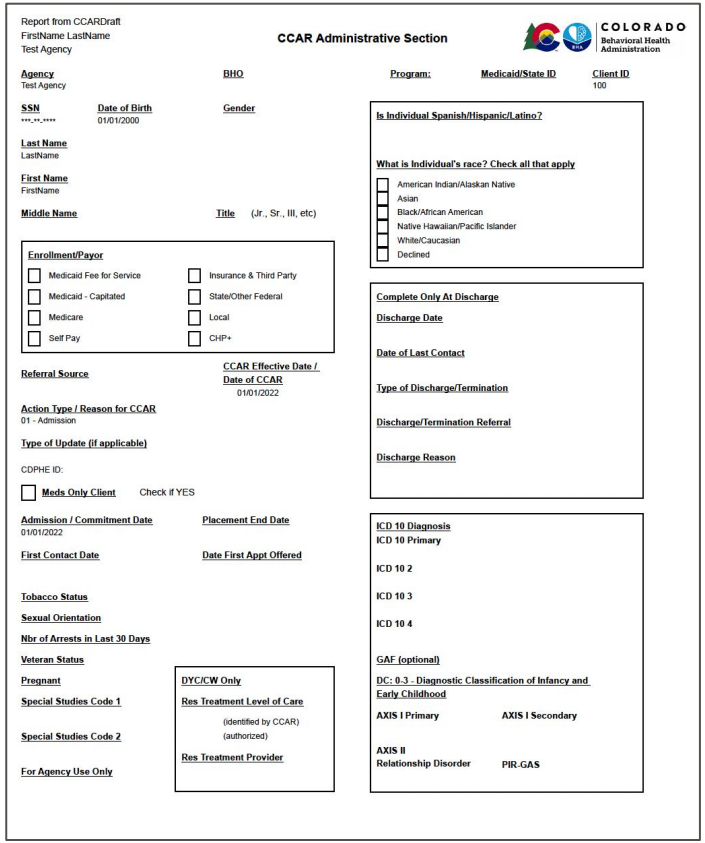
Agency: BHA

Data Model Standardization Groups

Administrative Burden @ the BHA

Providers that engage with the BHA through contracts to **access additional funding** (paid for by federal block grants) to support priority populations and/or **provide opioid treatment programs** (a federally-mandated requirement) have to submit two unique report types:

- **Colorado Client Assessment Record** aka CCARs (for mental health services)
- **Drug and Alcohol Coordinated Data System** aka DACODS (for substance use services).



Report from CCARDraft
FirstName LastName
Test Agency

CCAR Administrative Section

COLORADO Behavioral Health Administration

Agency Test Agency | **BHO** | **Program:** | **Medicaid/State ID** | **Client ID** 100

SSN ***-**-**** | **Date of Birth** 01/01/2000 | **Gender**

Last Name LastName

First Name FirstName

Middle Name | **Title** (Jr., Sr., III, etc)

Is Individual Spanish/Hispanic/Latino?

What is Individual's race? Check all that apply

- American Indian/Alaskan Native
- Asian
- Black/African American
- Native Hawaiian/Pacific Islander
- White/Caucasian
- Declined

Enrollment/Payor

- Medicaid Fee for Service
- Medicaid - Capitated
- Medicare
- Self Pay
- Insurance & Third Party
- State/Other Federal
- Local
- CHP+

Complete Only At Discharge

Discharge Date

Date of Last Contact

Type of Discharge/Termination

Discharge/Termination Referral

Discharge Reason

Referral Source

CCAR Effective Date / Date of CCAR 01/01/2022

Action Type / Reason for CCAR 01 - Admission

Type of Update (if applicable)

CDPHE ID:

Meds Only Client Check if YES

Admission / Commitment Date 01/01/2022 | **Placement End Date**

First Contact Date | **Date First Appt Offered**

Tobacco Status

Sexual Orientation

Nbr of Arrests in Last 30 Days

Veteran Status

Pregnant

Special Studies Code 1

Special Studies Code 2

For Agency Use Only

DYC/CW Only

Res Treatment Level of Care

(identified by CCAR)

(authorized)

Res Treatment Provider

ICD 10 Diagnosis

ICD 10 Primary

ICD 10 2

ICD 10 3

ICD 10 4

GAF (optional)

DC: 0-3 - Diagnostic Classification of Infancy and Early Childhood

AXIS I Primary | **AXIS I Secondary**

AXIS II
Relationship Disorder | **PIR-GAS**

There are many sources of administrative burden caused by the BHA, but we very intentionally began with CCAR/DACODS because those reports are the **most prevalent and harmful** to providers.

We will tackle other sources of admin burden in parallel with the implementation of these recommendations.

Federal

Centers for Medicare & Medicaid Services

SAMHSA

Medicaid

Block Grants

State

CMS Submissions (APCD, TMSIS, others)

HCPF

BHA

SAMHSA Submissions (MHBG, SAPTBG)

BHA Programs

837

Providers

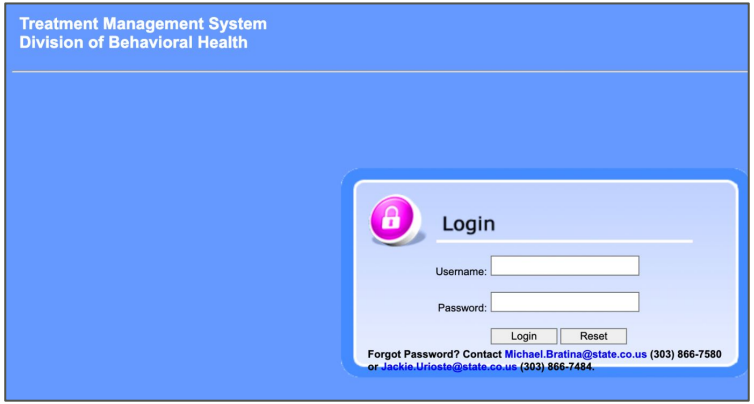
CCAR/DACODS

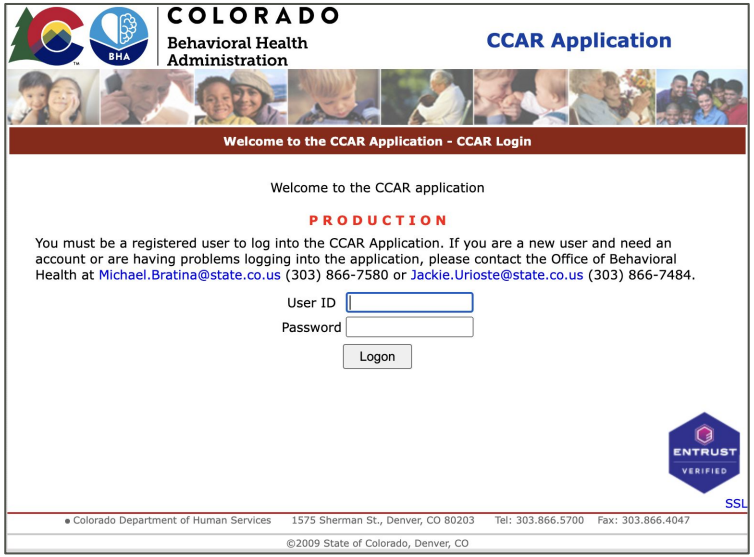
The data that the CCAR/DACODS report types collect is **clinically outdated**, and the state technology systems used to collect the reports are **antiquated**.

We can **still meet federal requirements**, while also improving data quality, tech usability, and reducing admin burden.

Aging Technology

The aging tech used for CCAR/DACODS reports means that providers have to expend additional time and money to comply with reporting requirements, including building bespoke tech systems to more easily translate the data providers already collect through their EHRs into acceptable formats for entry into State systems.





Clinically Outdated Data Model

These reports also cause providers to ask questions to clients that **may make them uncomfortable**. For instance today CCAR/DACODS requires providers to ask clients their sexual orientation, something providers themselves typically would not ask in their intake processes.

There are certain questions that CCAR/DACODS must ask because they are dictated by the federal government. Other questions however were added by the OBH (currently BHA) because they wanted to collect additional demographic information for state data analysis.

Designing forms for gender diversity and inclusion

A little question is a big deal when it comes to shaping people's experience with your product. How do we ask people for their gender in a thoughtful and respectful way?

Sabrina Fonseca · Follow

Published in UX Collective · 12 min read · Apr 24, 2017

"As with any form field, if there isn't a clear benefit to the user, you probably shouldn't ask about it."

By Sabrina Fonseca

The BHA's Responsibility

It's imperative that the BHA address the **administrative burden and negative impact on provider-client relationships** caused by CCAR/DACODS, while also remaining in compliance with federal requirements.

The recommendations that follow in this presentation will address those concerns. The proposed roadmap also considers how this work will integrate and support other administrative burden efforts across the state.

Research | *Who*

Research Focus

Our Hypothesis | Outdated and inefficient state reporting processes create undue administrative burden on behavioral health providers and ultimately negatively impact the experience of people seeking care in Colorado.

Our Goals

- Increased understanding of how BHA reporting requirements (specifically CCAR/DACODS) influence provider processes and operations, and how that carries over into client experience.
- Improvement of data quality and reduction of administrative burden on providers.

Primary & Secondary Research

From March through July of 2023, the Behavioral Health Administration's technology team engaged with **16 provider organizations** across Colorado, which included representation of a variety of tech setups, geographies, mental health settings, services offerings, and population expertise.

We conducted hour-long interviews and virtual site visits with over **60 individuals** from those 16 provider organizations, representing a range of roles including clinicians, administrative staff, data/tech teams, managers, and executive leadership.

We also did extensive secondary research on policy, legislation, and past modernization efforts.

A Breakdown of Facility-Level Representation	
Size / Setting	• Large Organization (multiple locations): **8 orgs** • Medium Organization: **5 orgs** • Small Organization (single location): **1 org** • Hospital: **2 orgs** • CMHC: **6 orgs** • FQHC/Safety Net: **2 orgs** • Walk-In: **4 orgs** • Crisis Stabilization Unit: **3 orgs** • Residential SUD: **8 orgs** • Outpatient SUD: **10 orgs** • DUI/DWI: **3 orgs** • Residential BH: **5 orgs** • Outpatient BH: **9 orgs**
Population Served	• Multi-Lingual Practice: **4 orgs** • Children, Youth & Family: **5 orgs** • Geriatric Care: **3 orgs** • Veterans Care: **3 orgs** • Civic/Criminal/Forensic Services: **7 orgs** • LGBTQIA+: **1 org** • Disability Accommodation: **1 org**

At

For

With

By

These things are transactional at best, harmful, degrading and violent at worst		
Approach	Keywords	Where power is held
Designing at people	Designer, professional or policy-maker as expert, top-down decision-making	*Designing at people* is about what decision-makers and designers think and want.
Designing for people	Design thinking, anything 'centred' e.g. human-centred (HCD), user-centred (UCD), patient-centred, citizen-centred design etc.	*Designing for people* is about what designers and decision-makers want to know and achieve. Good intent usually ends up as system-centred, designer-centred, executive-centred or staff-centred by implementation.
These things are transformational at best, however they are not inherently inclusive or equitable		
Designing with people and planet	Co-design, participatory design, deliberative democracy	*Designing with people* is about what matters to people with lived experience and decision-makers (co-decided).
Led by the people	Co-production, community-led design, citizen movements, design justice*	*Led by the people* is about what people, families and communities want for themselves.

Kelly Ann McKercher, 2020

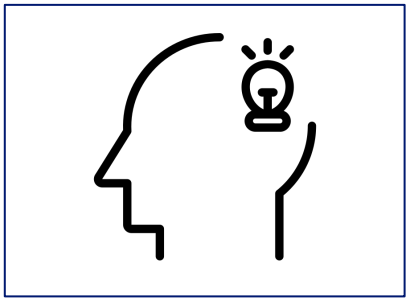
Credit: Beyond Sticky Notes

Findings | *What*

Top Findings

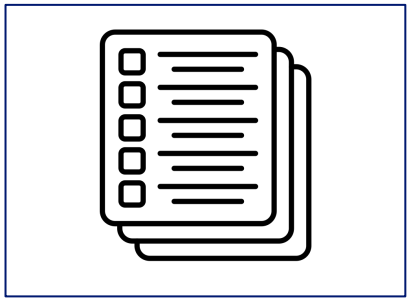
1. The **data model** for CCAR/DACODS is clinically and culturally out of date, especially for data elements like gender, race, and ethnicity.
2. Providers are losing out on **payment and accurate counts towards contractual requirements** due to inflexible data intake into BHA systems and inefficient error resolution processes.
3. The distinction between CCAR (mental health) and DACODS (substance use) perpetuates **siloing of behavioral healthcare** and creates high levels of data duplication for the rising population of dual diagnosis clients.
4. **Basic usability issues** (ex. account management, system time outs, copy/paste functionality) with BHA systems increase the time, effort, and cost required to submit compliant data.
5. Today, the data generated by CCAR/DACODS provides limited benefit to the state's behavioral health ecosystem at large. The data is currently only in active use for contract and funding requirements, **not any larger data analysis** that is publicly shared.
6. CCAR/DACODS requirements are **directly and negatively impacting how people experience behavioral healthcare in Colorado**, especially for intake appointments.

Clinician User Story



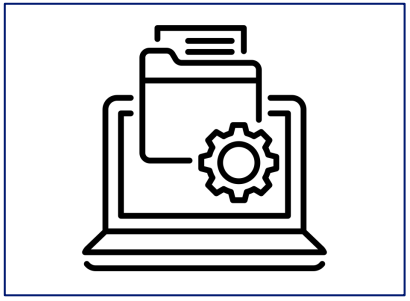
I need to have state-specific reporting requirements in the back of my mind during a client appointment.

At the end of my conversation with a client, sometimes I have to pull out a CCAR/DACODS cheat sheet.



After the appointment, I complete paperwork my org requires, and duplicate much of that information into CCAR/DACODS reports.

Some **larger, high-tech resourced orgs** build EHR modules specifically for CCAR/DACODS, then entered into the state in batch uploads.



Other smaller, **low-tech resourced orgs** have to enter CCAR/DACODS manually, one entry at a time.

The final step I take to submit a CCAR/DACODS successfully is the error resolution process.

Estimated Time Spent on CCAR/DACODS for 1 Client Intake Appointment

- High Tech-Resourced: 30-45 min
- Low Tech-Resourced: 45 min-1 hour

Icons by the Noun Project

Data Strictness

Currently, the BHA is **very strict** about the format in which it will accept CCAR/DACODS data. It requires a customized file format that is not supported by electronic health record systems (EHRs) without customization. It is up to each provider to create unique processes and systems in order to successfully create and submit this file type.

- What if the BHA could alleviate some of this burden by being more flexible about the format of the data we can intake?
- What if we were able to signal errors to providers prior to submission, thereby shortening the error resolution process?
- What if providers were able to see the entire whole-person picture of a client, not just the “moment in time” snapshot currently captured by CCAR/DACODS?

The recommendations in this report detail what tech environment we would need to build in order to make that vision a reality.

Designing For Priority Populations

We've considered equity throughout every stage of research and recommendation creation, and also want to highlight considerations we will be acting on for specific priority population needs related to data model updates.

- **Children, Youth & Families:** The CCAR is not tailored to infants and children, so we need to explore other reporting mechanisms and/or ensure that training materials provide specific clinical guidance for this population.
- **Undocumented People:** Undocumented people can be rightfully reluctant to provide information about themselves or their families due to fear of retribution. We heard several times from providers that they wanted guidance from the state about how to approach reporting requirements with this population.
- **LGBTQIA+:** We heard from providers that the only reason they ask clients about sexuality is because of state reporting. We should consider if this data is absolutely necessary to collect because this type of intrusive question in intake appointments can turn someone off from returning for care.
- **People Who Speak Spanish:** We heard from providers that the race / ethnicity options for Spanish-speakers / Latinx clients were particularly confusing.
- **Unhoused People:** We heard from providers that options for "housing status" in CCAR/DACODS are not at all appropriate for unhoused people.
- **Opioid Treatment Program Participants:** The language for drug types and administration methods are not accurate. For example, there is no option for fentanyl or vapes.

Recommendations | *How*

Key Recommendations

1. Update Data Model: Update the data model for CCAR/DACODS through relevant stakeholdering and federal review processes. Map data model to culturally competent best practices (ex. gender, race, ethnicity) for front-end presentation.
2. Select Data Entry System: Perform an analysis of existing internal and external technology systems based on recommended design parameters in order to select a new front-facing data entry system.
3. Build for Episodic Reporting: Build a reporting environment where we can collect data episodically; aggregating encounters into “Episodes of Care”.
4. Create Data Analysis Dashboards: Create standard and customizable data analysis dashboards so providers can track progress towards contractual requirements as well as measures of equity.
5. Prioritize Engagement: Create a robust external communication and engagement plan for providers and other stakeholders to foster trust and transparency.

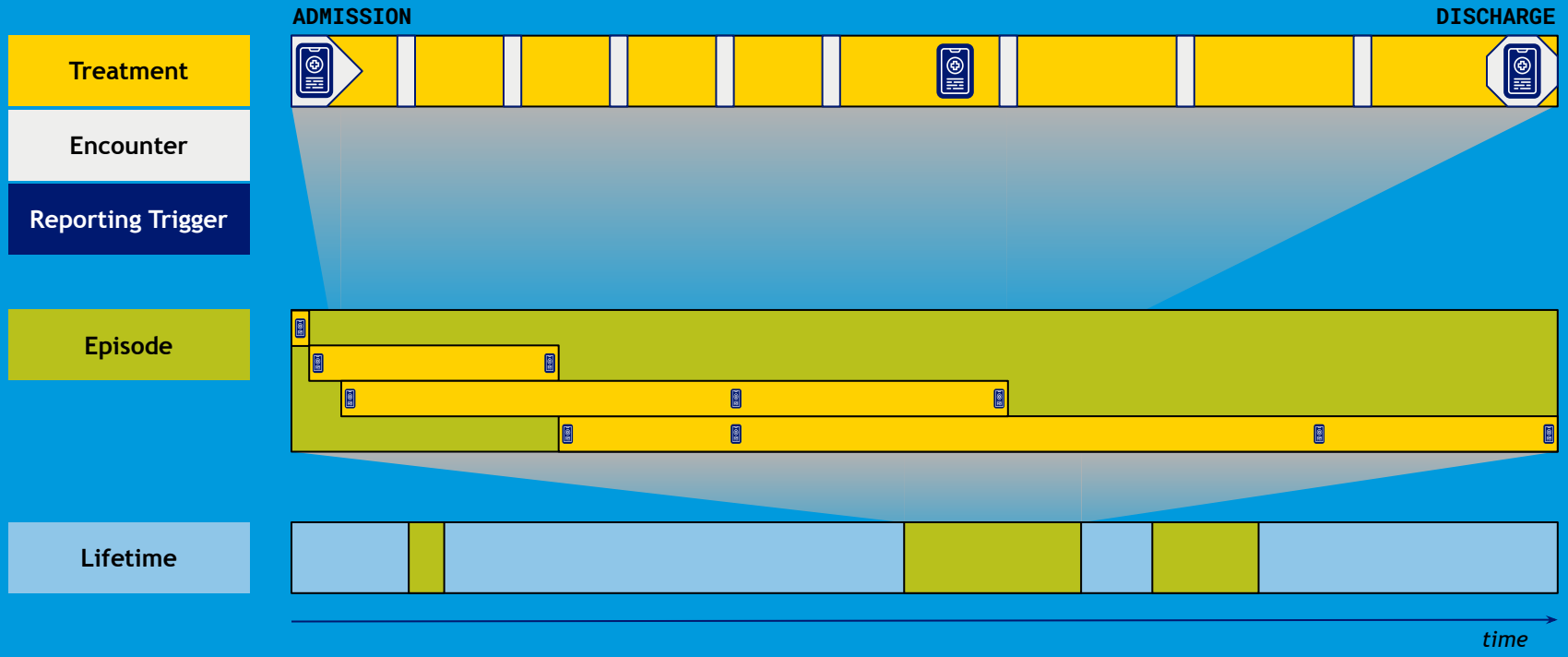
From Encounters to Episodes of Care

Today, when the BHA analyzes CCAR/DACODS data, it's hard to understand an individual's holistic care journey and what impact behavioral health services have had on their lives.

CCAR and DACODS are moments in time, snapshots captured at someone's admission and discharge to a particular service. There's only so many inferences we can make about service and program efficacy through data if we're only looking at a small piece of the puzzle. It would also be useful to providers to know which interventions have and have not worked for someone in the past.

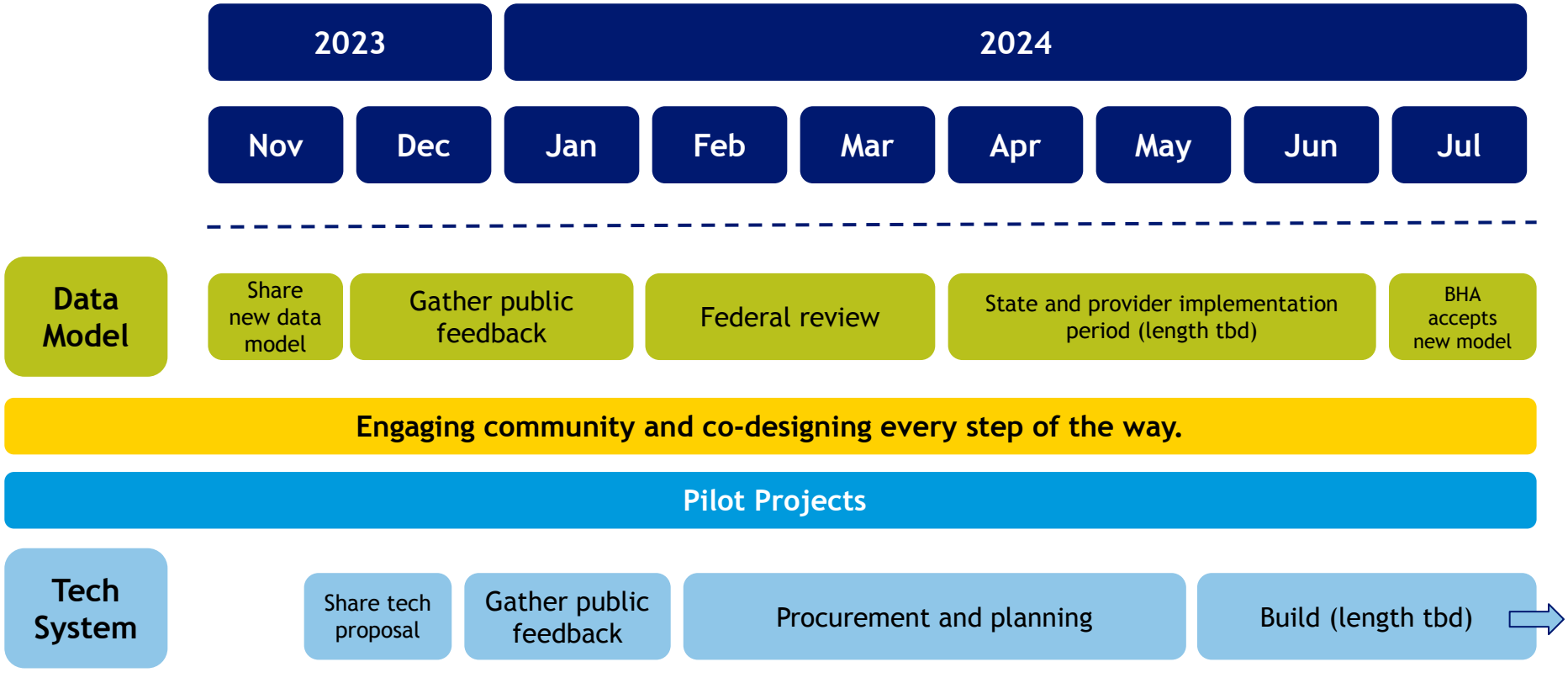
One way recommendations in this report begin to address these concerns is by defining what an "Episode of Care" might look like in a new BHA reporting ecosystem. Stated simply, this means linking together different service-level reports (including CCAR, DACODS and 837 Encounters) for an individual into a holistic data story of their past treatments so that providers can get that more whole-person picture.

Episodes of Care: Moving Towards Whole-Person Data



Roadmap | When

Tentative Timeline*



*This timeline is subject to change, especially because we want to make sure we're giving providers enough time to provide feedback AND implement changes on their own systems.

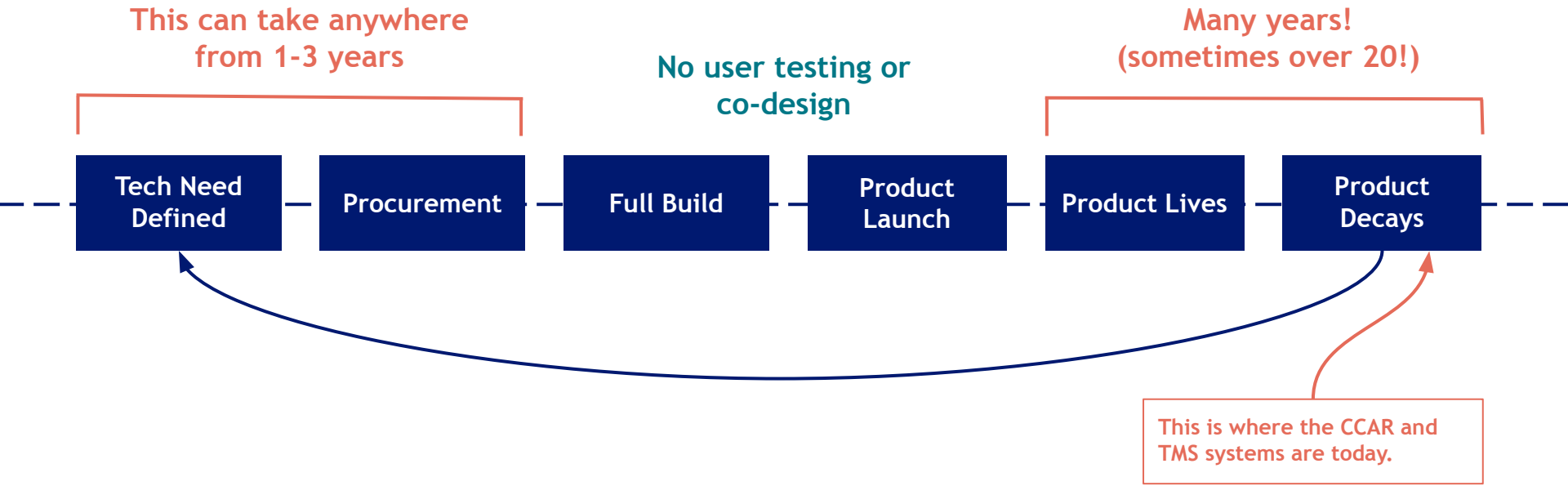
We will not be **requiring** any changes to CCAR/DACODS entry for a least 1 year after our new specifications are released in order to be respectful of providers' timelines as they update their systems.

Iterative Product Design & Management

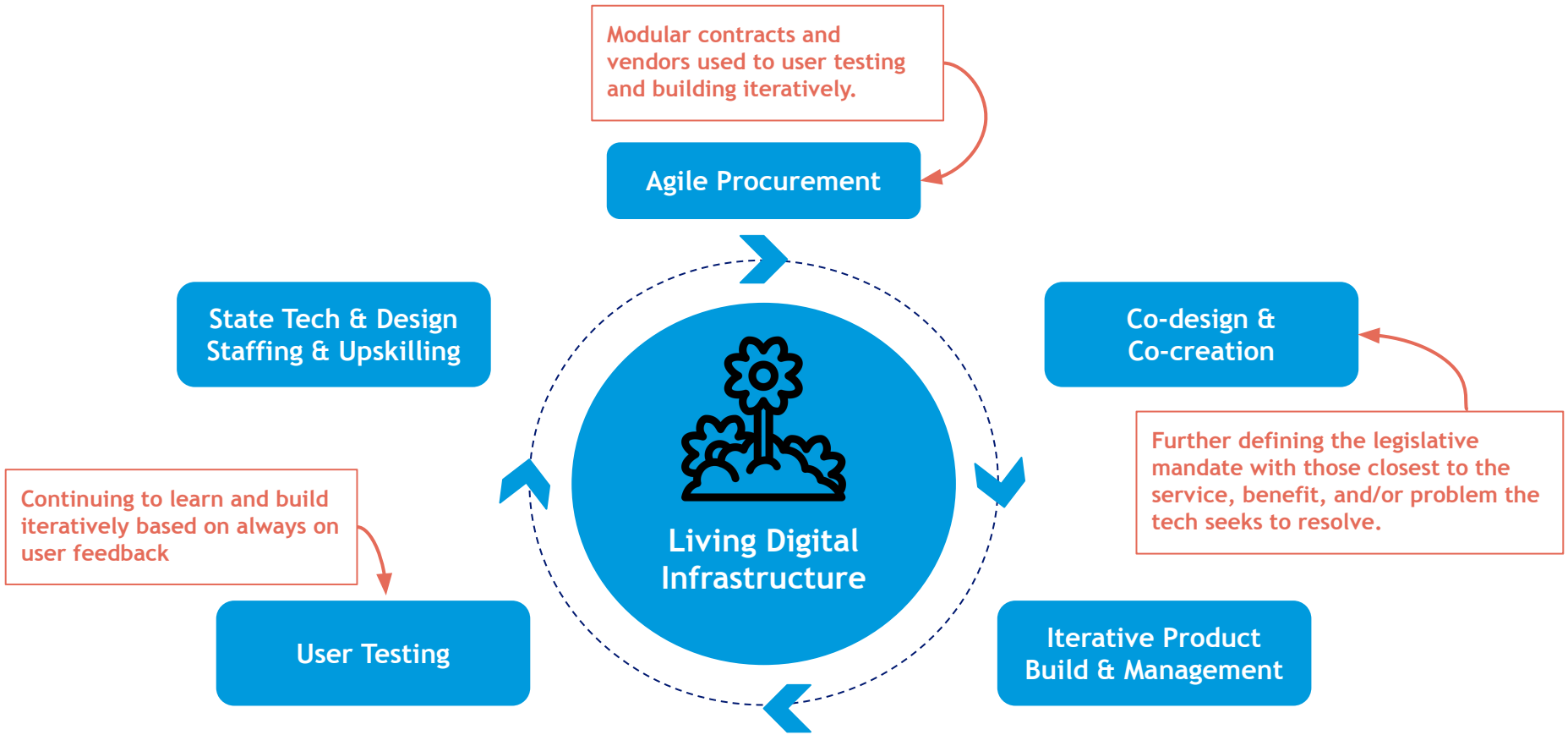
Our recommendations also **favor small bets (i.e., iterative pilots and testing plans)** rather than a magic bullet vendor partnership due to the complexity of this initiative and the risk involved with making definitive decisions too early with too little validation.

This approach also builds trust and momentum with internal and external stakeholders, a critical element ensuring success and buy-in.

Static Product Design & Management



Iterative Product Design & Management



Community Engagement

- **Engage the Behavioral Health Administration Advisory Council (BHAAC)** and other lived experience councils around culturally competent data presentation and how they want this (their) data to be used in Colorado.
- We must continue to understand the impact and opportunities that the **Behavioral Health Administrative Service Organizations (BHASOs)** will have on reporting.
- Engage in **cross-agency collaboration** with the Colorado Department of Health Care Policy and Financing (HCPF) and the Office of eHealth Innovation (OeHI) to share findings and align future research and implementation work (including but not limited to data interoperability and billing processes).
- **Providers need to be kept informed** of rollout activities, timelines, EHR guidance, and cost implications for this effort. This should be accomplished at minimum on a dedicated webpage similar to the Payroll Modernization project. Consider a dedicated monthly public meeting on this initiative.
- The public, especially people seeking or engaged in behavioral health care in Colorado, need consistent communication around the **BHA's data and privacy policies**, this should be built into annual comms plans, website updates, etc.

Calls to Action & Next Steps

Calls to Action

1. **READ** the full report and watch a video of this presentation on the project website.
2. **SUBMIT FEEDBACK** via the form until *October 27th*. All feedback submitted will get a response from the BHA and will be published.
3. **SIGN UP** to get email updates on progress!

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Links in chat and on the project website!

Next Steps

- We will be collecting feedback on the report via the form until **October 27th**.
- These form responses will be published with corresponding BHA responses to the project site by mid-November.
- The week following the publication of community feedback, we will host three more “Share Out & Discussion Sessions” to be scheduled.
- At this time we will also be promoting additional ways to engage with this effort.

Open Discussion

Key Takeaway

Will these recommendations better balance administrative burden, federal requirements, and measures of quality and access for behavioral health providers in Colorado?