



# Administrative Burden Report



**COLORADO**  
Behavioral Health  
Administration

## Thank You

We would like to thank each and every individual who participated in providing feedback for the Administrative Burden Report through live sessions, email, and the feedback form. We promise to live our value of co-creation as we continue moving forward with the CCAR/DACODS modernization work.

## Purpose of this Document

In October, BHA shared the Colorado Behavioral Health Administration's (BHA) report on Administrative Burden: Colorado Client Assessment Record (CCAR)/Drug and Alcohol Coordinated Data System (DACODS) Modernization. The report outlines barriers behavioral healthcare providers who care for uninsured, underinsured, and undocumented people face. BHA is committed to addressing the administrative burden and negative impact on provider-client relationships caused by the CCAR/DACODS reports. Through engagement with providers, BHA has created a roadmap to update the data model and technology systems to improve CCAR/DACODS, and we look forward to gathering more feedback from providers to ensure we are co-creating solutions together.

BHA collected feedback from the provider community until October 27th. These form responses will be published with corresponding BHA responses to the project site by early December. The week following the publication of community feedback, we will host three more "Share Out & Discussion Sessions", which are to be scheduled. At this time we will also be promoting additional ways to engage with this effort.

## Contact Information

For general questions, or additional feedback, please contact Megan Lenz at [megan.lenz@state.co.us](mailto:megan.lenz@state.co.us).

To stay updated on Administrative Burden project progress, please visit the [project website](#) and sign up for our [email updates](#).

## Feedback Responses

### Anonymous | 10/11

Thank you and to other BHA staff for the excellent report, "Administrative Burden CCAR/DACODS Modernization at the BHA." It's apparent that a great deal of resources were applied to get stakeholder input and that the BHA is taking this challenge seriously.

Generally the state needs statistics to monitor the system.

COMBINE advocates versus situations that will cause independent outpatient providers to question Medicaid participation, and therefore safety net participation. Margins are tight, reimbursement is low, and expenses are high, so administrative burdens become important. Our clinics do not have administrative staff like CMHC centers do, as you know.

CCAR was always an obstacle to provider recruitment and it was an advance when RAEs, with HCPF support, agreed to not require CCARs. This reduced a serious barrier to recruitment.

In the following years, since then, the RAEs and HCPF have justified the decision by describing the information that is collected through the 1500/837P, which we submit for every clinical session. From page 8, I infer that the BHA understands this. All 837P data winds up in the CIVHC APCD database, as far as we know.

Regarding this document, we would like to see an acknowledgement that a tremendous amount of care has happened since 2019 through the RAEs without any CCAR tracking. Perhaps a paragraph about the RAE situation would be sufficient to acknowledge that a large part of the mental health care system (over 1/2 of outpatient care) has not participated in CCARs for years. HCPF, RAEs, or CIVHC should be able to produce statistics if necessary.

Medicaid and the independent provider network would most likely be moot in this conversation, except for the growing pressure from consumer advocates for our clinics to be licensed by the BHA, which will mean these CCAR policies become our policies (unless there is an exemption). Our larger clinics (e.g., mine, Boulder Emotional Wellness) are already licensed as Community Mental Health Clinics, and more clinics are seeking that licensure.

We request that CCAR is not required for non-SUD outpatient care, as this is essentially the status quo, and data collection happens through 1500/837P.

We appreciate this mention of a consequence of the current system : "Disincentivizing new providers from entering the public behavioral health workforce due to the high and inequitable administrative burden they experience when compared to the private sector."

If data is sought beyond what is collected in the 837P/1500, non-intrusive outcome measures will require creativity and nuance, and will differ at different levels of care and for different types of care. Previous to this career, I was a high school special education teacher in a political environment that wanted to tie my compensation (in part) to my students' academic gains, measured by multiple choice, machine scored exams. This was of course a threat to special education teachers in underfunded environments with students who would react to standardized testing.

COMBINE stands ready to participate and assist in designing processes where quality and safety can be measured and monitored in a fair way, with as little administrative burden as possible, and we are glad to see the commitment to an open process by the BHA. I am reminded of Dr. Medlock's assertion that asking clients a single question, "would you recommend this provider to a family member," is a reliable and valid measure.

In conclusion, I very much appreciate the nod to pragmatism represented here, "At the end of the engagement process we should be left with only data entries that we can solidly defend."

We are very concerned that there is no mention of the current RAE/ HCPF policy that exempts our providers from CCAR participation. Hundreds of thousands of care events have happened with no CCAR, so we're curious about this document and these policy suggestions. Plainly, HCPF and RAEs are fine with no CCAR data for over 1/2 of outpatient care, so that begs the question about CCAR's necessity. If there are federal requirements then HCPF and RAEs are massively in breach. We would like small clinics to consider becoming essential safety net providers, and this added administrative burden will be another

reason to not participate. We will continue to read the associated documents and prepare for participation in the public meetings and in the feedback forms. Perhaps the administrative burden will be reduced to the point where it's not so much of an issue.

### **BHA Response**

Prior to the planned implementation of COMPASS and DII, OBH and HCPF instituted a rule that Independent Provider Network (IPN) providers within the RAE network did not have to submit CCARs, until a new data system was implemented. IPN providers who have had a mental health designation during this time have still been required to submit CCARs to BHA in accordance with current rule and contracting requirements on licensed and designated provider data submission. The scope of this research effort was focused on the BHA data collection requirements but BHA plans to continue working to effectively align the work BHA is doing for all people of Colorado seeking behavioral health with the efforts that HCPF and the RAEs are doing to support behavioral health care.

CCAR/DACODS are data instruments, primarily for federal reporting required by SAMHSA, flowing into the federal data source TEDS. BHA is contractually required to submit data to receive block grant funding from SAMHSA, which allows BHA to administer state-specific programs for mental health and substance use disorder treatment. In order to maintain block grant funding, BHA must submit data on program participation, utilization of block grant funds, and client-level data to SAMHSA annually. 837 Encounters are data collection instruments that capture service and payment level data on all publicly funded behavioral health clients.

A key recommendation from this body of work is to update and minimize the data model, i.e., the amount of questions CCAR/DACODS ask. BHA will engage with providers to create a minimum viable data model that both fulfills federal requirements and collects data that will be useful for monitoring and making system improvements.

While this report does provide recommendations on technology systems and data modeling, our research did not cover licensing and contractual provider requirements dictated by licensing rules and contractual terms.

## **Anonymous | 10/16**

I agree with many of your findings, including that many of the DACODS/CCAR fields are not appropriate for youth clients, that separating mental health from SUD data does not make sense, and that the TMS platform is outdated/ineffective.

Additionally, I would like to share some feedback that I actually didn't hear reflected in the results: Challenges associated with the onboarding process. For our agency, it took us four emails and three phone calls between August 15, 2023 and October 4, 2023 to receive the DACODS training and TMS login. One of the phone numbers listed on the TMS login page or the DACODS manual was no longer active, the voicemail box was full for another phone number, and the last went straight to voicemail. During the training was the first time we were made aware that we were also required to submit CCAR data. So far, I have sent two emails inquiring about how and where to submit this data, and have yet to hear back. Since we have not heard back, and we need to stay operational, our organization has moved forward with current mental health clients without being able to complete data reporting requirements. We have put significant effort into being in compliance with the data reporting requirements, however, it has been incredibly challenging for us to do so. We are a small company, and dedicating an excessive amount of time to follow-up activities diverts our focus from providing care, enhancing the efficacy of our clinical programming, and advancing our mission to ensure every teen in Colorado has access to quality mental healthcare. This process has posed a significant barrier to entry into our industry, and I am deeply committed to its improvement. Given our limited resources as a new business, investing time and energy in this process has had a considerable impact on our overall survival. The statistics on the youth mental health crisis in Colorado are staggering, and I am concerned not only for the well-being of our company but also for the state of the industry as a whole.

### **BHA Response**

BHA plans to support providers through the roll out of new and adapted technologies to ensure that questions are adequately addressed as new technologies are implemented.

As part of this research report, BHA has detailed needed improvements to the onboarding, training, and user experience for providers ([page 23 of Administrative Burden report](#)). This includes re-writing training materials with a trauma-informed lens, developing a new tech system with improved usability, and providing more direct training and customer support opportunities, among other efforts. These improvements to training and onboarding will be co-designed with providers to ensure clear and targeted communications are provided on BHA data reporting processes.

BHA will be evaluating and selecting this new data entry technology system to complement the current data lakehouse vendor Snowflake. A successful technology system will address the timing out of the current system, among other key identified capabilities. The design and development of this new data entry technology system will be done with provider input, including a stakeholdering process to ensure provider questions and needs are addressed.

## **Anonymous | 10/25**

I think you have identified the problems, barriers and impact and necessity of change. I like the human centered design. It sounds good, but I'm not sure what it will actually look like in the revamp and I think it would be important to know the WHY for this at all. Who needs this and why? How does it help the community serving and being served? How does it truly inform clinical care? As a teaching and

training facility serving a lot of medicaid clients we have a hard time answering this and integrating this into training and processes and explaining why folks have to do it. It's duplicative with documentation they have to do in our EHR. And we are one of the low tech/high medicaid impact orgs.

I would also add that there are punitive measures in not meeting these requirements that need to be a significant focus of attention for this reduction of admin burden overall. When we are audited by state agencies, the threat of money being taken back, of loss of license, and the systems of compliance we have to put into place to mitigate risk as an agency create a multilevel oppressive process where the harm to providers is almost a given. Especially for providers with marginalized identities and neuroatypical experiences. We're trying to build and diversify our workforce to serve medicaid population and shooting ourselves in the foot over and over and our efforts and progress seem untenable. While we are waiting for something potentially better, is there opportunity for reprieve from what we are doing now? Guidance or technical assistance to organizations, especially those without these resources, in centering human design in complying with the administrative burden?

### **BHA Response**

As part of the plan to redesign training materials, one of the things BHA will be focusing on is better descriptions of how this data is being used to benefit Coloradans and guidance for how providers should talk with clients about data collection and privacy.

CCAR/DACODS are federally-mandated data instruments required by SAMHSA. BHA is contractually required to submit this data to receive block grant funding from SAMHSA, which allows BHA to administer state-specific programs for mental health and substance use disorder treatment. In order to maintain block grant funding, BHA must submit data on program participation, utilization of block grant funds, and client-level data to SAMHSA annually. [837 Encounters](#) are data collection instruments that capture service and payment level data on all publicly funded behavioral health clients.

A key recommendation from this body of work is to update the data model. Work is currently being done to further understand all data elements that are required by SAMHSA, and how additional data elements are being used. BHA will engage with providers to create a minimum data model, and potential for optional fields beyond federal mandates. Federal requirements are further detailed in the [SAMHSA Federal Rule Detail](#).

The goal through improvement and replacement of technology systems and the refinement of the CCAR/DACODS data model, is that it will be as easy as possible for providers to remain in compliance with data reporting requirements. BHA is also looking for ways to alleviate administrative burden prior to the full relaunch of these new systems and processes. so that value can be released back to providers as quickly as possible.

## **Anonymous | 10/26**

Page 5 - I appreciate referencing the work that was done in the past. I sat on both the DII and COMPASS workgroups and found it quite frustrating that as much time and effort people put into those projects, it really didn't move the dial at all on finding a solution to the state data reporting issues. What safeguards will be put in place to make sure this project is not a repeat and will actually be successful?

Page 18 - It is understood that the current data set is a snapshot in time, however, requiring a clinician to enter additional updates on a patient's progress for state reporting purposes will be an additional burden. Finding a way to pull this information from existing data sources is encouraged.

Page 19 - As a SUD provider with a continuum of services, we completely agree that it is very burdensome to complete new admission and discharge DACOD's for a change in level of care.

Page 24 - It would be beneficial to have a variety of providers involved in this project as it moves forward. Additionally, for providers who have EHR systems that interface directly with the state (or MSO) and who would want to continue interfacing with the state or BHASO to submit data, cost implications MUST be on the forefront. It is not feasible for non-profit, safety net providers to pay for these modifications without funding assistance from the State. It will cost providers over \$100,000 to make these changes to their systems (this is based on estimates during the COMPASS project).

### **BHA Response**

BHA is grateful for the providers and other stakeholders who participated in the COMPASS and DII efforts. The learnings from those projects served as the foundation for this research and roadmap. The recommendations favor small bets (iterative pilots and testing plans) and modern, agile software practices 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.

BHA will release updates around addressing data duplication iteratively so that providers don't have to wait until the full relaunch of the new CCAR/DACODS technologies and processes to see reductions in their administrative burden.

Having representational groups of provider types engaged in co-design efforts is critical. BHA collaborated with a representational sample of providers in this research effort across technology setups, services provided, funding streams, geography, and other factors.

BHA acknowledges that to truly design an equitable solution, the technology system must work as well for providers with Electronic Health Records (EHRs) as it does for providers without EHRs. Providers will be involved and consulted when selecting a technology solution, and BHA will be building a technology system to meet the needs of providers with a variety of technical resources. The implications of iterative change on the provider's EHR costs remain top of mind, and BHA will be strategically testing and validating ahead of publishing the revamped data model.

## **Anonymous | 10/25**

Seeing change regarding the "Key Recommendations" identified would be so meaningful for our providers. Not only is the data entry system archaic, difficult to use, and prone to crashes, but the outdated questions asked are damaging - not only to our clients - but to our providers and staff who see themselves excluded.

An ability to integrate a CCAR/DACODS into our EHR would be very significant and would tremendously increase our compliance with expectations. Our users regularly experience being "locked out" of their CCAR accounts, due to requirements that they log in regularly and we often experience significant

delays in regaining access to accounts. Additionally, providers are required to complete the CCARs/DACODS, save the versions as a PDF, and then upload them to client files, as it is the only way we can reliably audit whether or not CCARs/DACODS have been completed. This is a clunky process and it also takes additional time for providers. That administrative time is unpaid and creates a significant financial strain for a number of our providers who have chosen to prioritize Medicaid clients as a substantial part of their caseloads. As such, our providers are sometimes put in the difficult decision of having to limit the number of Medicaid clients they can see at one time, which creates additional barriers for clients seeking care. I am not sure that I have seen this information anywhere in the slides or reporting, but I also wonder about whether or not RAEs will still have the final say in whether or not CCARs are required? With CCARs being required for some and not all RAEs in the past, I have seen that some providers have to be more selective in determining which RAEs they are able to work with, given the financial difficulties outlined above.

I also wonder about the possibility of requesting a quarterly or biannual report, in which an organization such as ours could pull data from all relevant data forms in our EHR to enter aggregate data regarding information that is of interest to the BHA. Is it necessary that CCARs and DACODS be completed using the clients identity? Could this data be aggregated and collected more easily/seamlessly and provide the same information that is needed by the BHA? Why is this information collected? How is it used?

We have consistently seen that our clients and providers who hold marginalized identities are disproportionately impacted by the systems put into place by oversight agencies such as the BHA and Medicaid RAEs. The studies into the bias of "professionalism" standards highlights a number of concerns that I believe are relevant to CCAR/DACODS expectations, in addition to other compliance expectations adopted by federal, state, and local entities. The information from the BHA regarding recommendations and need for change seem to clearly outline the issues that many have with CCARs/DACODS and yet, these are also part of a larger system which ultimately impacts our BIPOC and neurodivergent providers inequitably. The reliance on and adherence to traditional standards and values, such as perfectionism, worship of the written word, either/or thinking, and paternalism to name a few) are problematic in and of their own right. It's my belief that the findings here are a symptom of this reliance on traditional standards and values.

I am pleased to see progress in moving toward creating actionable, meaningful change, and I feel compelled to continue to advocate further, knowing that these changes will provide temporary reprieve in a system which is structured to maintain the oppression of people who hold marginalized identities.

### **BHA Response**

BHA is actively addressing administrative burden caused by CCAR/DACODS and releasing value to providers as quickly as possible. Documented on the [Administrative Burden roadmap](#), BHA plans to use the remainder of 2023 and 2024 to perform pilot testing, finalize the new data model, and select, build and launch the data entry technology system; all through co-creation with providers. Design and implementation of any provider technology system will be done with provider input, including a stakeholdering process to ensure provider questions and needs are addressed. The intention is for this new technology system to address basic usability issues, such as the lockout issue described above.



A core finding from this research was identifying the need for a broader and more comprehensive EHR research and strategy effort for BHA's technology infrastructure. BHA will be exploring options for EHR automations/APIs as part of this modernization effort. BHA will also be communicating with providers about opportunities to engage with the technology selection process, which will include conversations about EHRs.

Reporting requirements detailing which providers must submit CCARs are based on license, not on RAEs. Prior to the planned implementation of COMPASS and DII, OBH and HCPF instituted a rule that Independent Provider Network providers within the RAE network did not have to submit CCARs, until a new data system was implemented. IPN providers who have had a mental health designation during this time have still been required to submit CCARs to us directly in accordance with rule/statute on licensed and designated provider data submission requirements. CCAR/DACODS are federally-mandated data instruments required by SAMHSA. BHA is contractually required to submit this data to receive block grant funding from SAMHSA, which allows BHA to administer state-specific programs for mental health and substance use disorder treatment. In order to maintain block grant funding, BHA must submit data on program participation, utilization of block grant funds, and client-level data to SAMHSA annually. 837 Encounters are data collection instruments that capture service and payment level data on all publicly funded behavioral health clients. Additional information about SAMHSA Federal Rule is [detailed here](#). Data that BHA submits to SAMHSA is [publicly available here](#).

BHA plans to represent our values of truth, equity, collaboration, community-informed practice, and generational impact. With a mission to co-create a people-first behavioral health system that meets the needs of all people in Colorado, BHA plans to continue the journey of co-creation with providers, people seeking care, and all Coloradans.

## Anonymous | 10/27

*BHA Recommendation: Future research should explore the full breadth of state and federal reporting requirements for behavioral health providers with an eye towards shared data and interoperability.*

HS Feedback: This recommendation is vital and needs immediate action. There is current work being done for the Universal Contract Provisions (UCP) which will rely on the work from DACODS/CCARs BHA

*Recommendation: Create a reporting environment where previously entered data can be used to prepopulate the reports necessary to capture changes in care. Make the process for updating fluid demographic information (ex. address, pregnancy, income) less complicated and duplicative.*

HS Feedback: This is a good step. It is also encouraged to work with Electronic Health Record (EHR) vendors on having the systems available in the EHR. Working with agencies and vendors in the pilots of this change.

*BHA Recommendation: Create core data collection values and principles for the BHA.*

HS Feedback: It is encouraged that the Core data consider federal Certified Community Behavioral Health Clinic (CCBHC), Health Care Policy and Finance (HCPF) as many centers much align with these core data sets as well.

*BHA Recommendation: Finalize unified CCAR/DACDOS data model through relevant stakeholdering and tests into federal systems.*

HS Feedback: This is a good steps and aligns with feedback above

*BHA Recommendation: We need to engage providers in the creation of a minimum data model and the potential for optional fields beyond federal mandates. There are some fields that providers said they wanted us to collect in past modernization efforts (disability, sexual orientation) that aren't federally mandated because they want the state to have data on priority populations. At the end of the engagement process we should be left with only data entries that we can solidly defend.*

HS Feedback: It is encouraged to keep in mind what the data is being collected for and what actionable efforts/support from BHA and their stakeholder will be taken from the data.

Additional HS Feedback:

- BHA training efforts proposed is a good start with ensuring updated materials for training. Training is often homegrown for many agencies, so having training and understanding of data and how it works can help eliminate the data errors that happen for agencies (ex. CSR data errors) Stakeholder engagement meetings, having the EHR cost considerations will be helpful. Thank you for including that.
- Currently CCARs require a Prescriber to do the CCARs for Medication Only clients. This is not feasible in using prescriber time for CCAR entry. Having the option of a nurse who works closely with the prescriber is feasible. It is encouraged that this requirement be looked into further.
- Early intervention codes require a CCAR after 4+ encounters within a Fiscal Year (FY). It is encouraged that this requirement be looked into further, as there are many early intervention services that may not require ongoing treatment such as drop in svcs.
- When an individual is under medication only services, they are only allowed 3 svcs in a FY. There are often times that a client may be in drop svcs to support their care maintenance or have medication management related case management. It is encouraged that this requirement be looked into further as not all individual who received an early intervention svcs require further treatment.

## **BHA Response**

The BHA technology team that prepared this report is working closely with the Universal Contracting Provisions Workgroups to ensure that these findings along with provider feedback on the findings are implemented into that workstream.

A core finding from this research was identifying the need for a broader and more comprehensive EHR research and strategy effort for BHA's technology infrastructure. BHA will be exploring options for EHR automations/APIs as part of this modernization effort.

BHA will also be communicating with providers about opportunities to engage with the technology selection process, which will include conversations about EHRs.

A key recommendation from this body of work is to update the CCAR/DACDOS data model. BHA is working closely with partner agencies like HCPF to further address data duplication and reduce provider administrative burden. There will be additional engagement opportunities for providers and

organizations to provide feedback on the data model updates. At the end of the engagement process, only data entries that can be solidly defended should remain.

BHA plans to update our training materials and processes based on provider feedback. Engagement opportunities will continue to be offered so providers can co-create system improvements.

The requirement for licensed behavioral health professionals to fill out medication only CCARs will be contractually required. BHA will take this feedback to the appropriate teams.

## Anonymous | 10/11

Based on your findings, why continue to require the CCAR and DACODS to be completed while the other program [process improvements] is in the works? Wouldn't it be valuable to find out how much time is saved by providers and how the patient experience improves if they could provide care WITHOUT this admin burden? It seems counterintuitive to continue to do this just because we always have, if in fact the research indicates these surveys are clinically outdated/antiquated and not culturally informed. If there is a requirement by SAMHSA, you could keep that portion and eliminate the BHA additions for the next year.

We should only be collecting data that provides actionable information that will benefit the patient and the system- otherwise we will spend the next year treating patients like data sets when we could focus on the care and free up additional capacity (created by reducing admin burden) to improve access to care. Providers are tired and continue to have to adapt to changing rules and regulations- there is rarely a time that they learn that they DON'T have to do something new, but instead their voices have been heard and they are granted a break from this irrelevant information gathering.

Additionally, why reinvent the wheel at all? Does the BHA truly need data from this patient population? Are you getting information elsewhere? What are you going to do with it to actually improve outcomes/quality of care? If it's about demographics, could it come from some other source, especially if the primary focus is underserved populations that have a significant papertrail and connection systems of care thru Medicaid.

### BHA Response

CCAR/DACODS are federally-mandated data instruments required by SAMHSA. BHA is contractually required to submit this data to receive block grant funding from SAMHSA, which allows BHA to administer state-specific programs for mental health and substance use disorder treatment. In order to maintain block grant funding, BHA must submit data on program participation, utilization of block grant funds, and client-level data to SAMHSA annually.

A key recommendation from this body of work is to update the data model. Work is currently being done to further understand all data elements that are required by SAMHSA, and how additional data elements are being used. BHA will engage with providers to create a minimum data model, and

potential for optional fields beyond federal mandates. This work will also address the culturally and clinically outdated data elements that are currently being collected. BHA is working closely with partner agencies like HCPF to further address data duplication and reduce provider administrative burden. There will be additional engagement opportunities for providers and organizations to provide feedback on the data model updates. At the end of the engagement process, only data entries that can be solidly defended should remain.

Today, data generated by CCAR/DACODS provides limited benefit to the ongoing behavioral health care that an individual is receiving and requires substantial administrative burden to complete. BHA would like to create standard and customizable data analysis dashboards so that providers can view their submitted data in real time, and can track progress towards contractual requirements as well as measures of equity.

A core finding from this research was identifying the need for a broader and more comprehensive EHR research and strategy effort for BHA's technology infrastructure. BHA will be exploring options for EHR automations/APIs as part of this modernization effort, and conducting pilots with providers. BHA will be communicating with providers about opportunities to engage with the technology selection process, which will include conversations about EHRs.

## Anonymous | 10/11

As a front-line psychotherapist, it would be helpful for the state to regularly disseminate population-level findings about the Medicaid clients we serve. Currently, we call the CCAR the "black hole" because data goes in but nothing ever comes back out. It's very discouraging.

Also, is there a way to configure whatever is going to replace the CCAR to just be able to automatically upload the needed client data from Epic and other EHRs, so clinicians don't have to do redundant data entry?

If that is not possible, it would be very helpful to have a smaller amount of client data that clinicians have to input at intake. E.g., it would be wonderful to have computer code written so that if I input the client's address, the system can look up what county the client lives in, and I don't have to do a Google search for this information. It would also be amazing to be able to do keyword searches for things like diagnostic labels and referral source (right now, to get to "self" as the referral source, I have to scroll down through dozens of independent agencies...)

### BHA Response

BHA plans to better utilize and share the data generated by CCAR/DACODS. While our technology team works to generate and share that data analysis plan, take a look at the [Colorado table](#) from SAMHSA which represents the data submitted by BHA to SAMHSA generated from providers like you. Design and implementation of any provider technology system, as well as the data reports output by this system, will be done with provider input, including a stakeholdering process to ensure provider questions and needs are addressed.

A core finding from this research was identifying the need for a broader and more comprehensive EHR research and strategy effort for BHA's technology infrastructure. BHA will be exploring options for EHR automations/APIs as part of this modernization effort, and conducting pilots with providers. BHA will also be communicating with providers about opportunities to engage with the technology selection process, which will include conversations about EHRs.

BHA will be evaluating and selecting a new data entry technology system to complement our data lakehouse vendor Snowflake. A successful technology system will address the timing out of the current system, among other key identified capabilities you mentioned. The evaluation and selection of this new data entry technology system will be chosen with provider input, including a stakeholdering process to ensure provider questions and needs are addressed, such as address lookup enhancements and keyword searching capabilities.

## Anonymous | 10/11

It seems that it would make more sense to align w CCbhc requirements and use NOMS rather than reinvent the wheel w these surveys if the state intends to apply to be a demonstration state. It would reduce duplication for current sites and prepare other sites to become ccbhcs well in advance.

### **BHA Response**

A key recommendation from this body of work is to update the data model. Work is currently being done to further understand all data elements that are required by SAMHSA, and how additional data elements are being used. BHA will engage with providers to create a minimum data model, and potential for optional fields beyond federal mandates. BHA plans to explore NOMS in our additional efforts to reduce reporting duplication and will contact CCBHC about their efforts.

## Anonymous | 10/11

Who needs to submit CCAR/DACODS and is that changing with the BHE changes?

### **BHA Response**

Mental health programs and facilities contracted by the BHA, as well as the Colorado Mental Health Institutes (Pueblo and Ft. Logan), are required to submit CCAR data as specified in their annual contract. All substance use treatment facilities and programs operating with public funds have to fill out DACODS. There are no changes in who is required to do CCAR/DACODS submission with BHE licensing changes.

## Anonymous | 10/11

How long will providers have to implement changes?

### BHA Response

BHA plans to use the remainder of 2023 and 2024 to perform pilot testing, finalize the new data model, and select, build and launch the data entry technology system; all through co-creation with providers. Co-creation encompasses any activity that involves people with lived experience in the process of building products and services. BHA will not be requiring any changes to CCAR/DACODS entry for at least 1 year after our new specifications are released, in order to be respectful of providers' timelines as they update their systems. There will be options for providers to adopt these changes faster, if they so choose.

## Anonymous | 10/11

What is the difference between the data model timeline and the tech system timeline?

### BHA Response

The data model timeline involves updating the data model for CCAR/DACODS through relevant stakeholdering and federal review processes. The technology system timeline involves performing 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. BHA has put updates to the data model and the technology system on different tracks, each with different engagement plans and methods. This is because they are distinct tasks that will require different time commitments, the data model finalization likely moving at a faster pace than the technology selection due to the foundational work of initiatives like COMPASS and DII.

Our recommendations favor small bets (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.

## Anonymous | 10/12

The CCAR serves no clinical purpose and in no way enhances the services provided to patients. Modernization of a system that has clearly been identified as nonfunctional only changes the problem. The administrative burdens, duplications of data submissions, and multisystem management required of service level providers contributes heavily to their professional burden which impacts sustainability of highly skilled clinical staff.

Lastly, the state and federal requirements for reporting places providers in bind wherein they are forced to obtain information that may not be relevant to the services being rendered. There is very low consideration for the provisions of gender affirming care, especially in behavioral health.

### **BHA Response**

BHA acknowledges that the data that the CCAR/DACODS report types collect is clinically outdated, and the state technology systems used to collect the reports are antiquated. Federal requirements can still be met while improving data quality, tech usability, and reducing administrative burden.

CCAR/DACODS are federally-mandated data instruments required by SAMHSA. BHA is contractually required to submit this data to receive block grant funding from SAMHSA, which allows BHA to administer state-specific programs for mental health and substance use disorder treatment. In order to maintain block grant funding, BHA must submit data on program participation, utilization of block grant funds, and client-level data to SAMHSA annually.

A key recommendation from this body of work is to update the data model. Work is currently being done to further understand all data elements that are required by SAMHSA, and how additional data elements are being used. BHA will engage with providers to create a minimum data model, and potential for optional fields beyond federal mandates. This work will also address the culturally and clinically outdated data elements that are currently being collected. At the end of the engagement process, only data entries that represent meaningful, culturally and socially appropriate indicators should remain.

## **Anonymous | 10/12**

Please, please, please know that these are no longer tools of use and are barriers to providers and patient care. We waste at least 3.0 or more clinical FTE on an annual basis filling out CCARs and DACODS. That doesn't count the administrative staff that track the submissions, communicate with clinical staff and monitor for resolution...Of course we will have staff attend and be ready to participate!

### **BHA Response**

As the report details, providers throughout Colorado share your frustration and have identified that some of the data collected to meet CCAR/DACODS requirements are clinically outdated and that the state technology systems used to collect the reports are not user friendly. BHA is actively addressing administrative burden by streamlining the data requirements and improving the data collection methods to provide value as quickly as possible. Documented on the [Administrative Burden roadmap](#), BHA plans to use the remainder of 2023 and 2024 to perform pilot testing, finalize the new data model, and select, build and launch the data entry technology system; all through co-creation with providers.

## Anonymous | 10/16

What type of community outreach for questions around gender and sexuality during intake was done during this research? Are there additional considerations about making this field optional versus required?

### **BHA Response**

BHA engaged with 16 provider organizations across Colorado, and 60 individuals from those organizations. One of these organizations specifically serves the LGBTQIA+ community, while others organizations list “LGBTQIA+ Services” as one of many offerings at their facility. Each data element required by BHA beyond the minimum federal reporting requirements (even for the purpose of informing statewide strategy to improve equitable access to behavioral health care) creates additional work and burden on both providers and the people they serve and should be collected in ways that are both clinically appropriate and culturally sensitive. As such, roadmaps for modernizing CCAR and DACODS include engaging many additional providers and people with lived experience.

## Anonymous | 10/16

At what point will the BHA engage major EHR vendors?

### **BHA Response**

At this time, BHA does not have an explicit plan for engaging major EHR vendors directly; if BHA did engage vendors, it would be through a formal procurement process. A core finding from this research was identifying the need for a broader and more comprehensive EHR research and strategy effort for BHA’s technology infrastructure. BHA will be exploring options for EHR automations/APIs as part of this modernization effort, through [additional research noted in the report](#). BHA will be communicating with providers about any opportunities to engage in technology evaluation process.

## Anonymous | 10/16

Many patients go through primary, secondary and tertiary diagnosis, and need to move fluidly between these different diagnoses. How does this correlate to episodes of care, and how are episodes of care defined?

Is the BHA committed to helping organizations financially for future changes in EHRs?



### **BHA Response**

The “Episodes of Care” concept was explored and validated by past modernization work (COMPASS and DII). The recommendations detailed in this report will build a foundation for a future where additional care coordination possibilities can be explored. Providers are/will be invited to co-create the “Episode of Care” definition so that it will work across different services and settings. The “Episodes of Care” concept is further detailed on [page 18](#) of the Administrative Burden report. SAMHSA Federal Detail speaks to “treatment episodes”, more information [can be found here](#).

A core finding from this research was identifying the need for a broader and more comprehensive EHR research and strategy effort for BHA’s technology infrastructure. BHA will be exploring options for EHR automations/APIs as part of this modernization effort, through [additional research noted in the report](#). BHA plans to take the cost of changes providers and intermediaries must make to align with changing reporting requirements into consideration when modernizing CCAR and DACODS.

## **Anonymous | 10/16**

Could you provide more information on the timeline for technical specification release? It can take 6-8 months for provider technology to make a technical change, depending on complexity.

When these specifications are released, who will be providing support as providers implement these changes?

### **BHA Response**

At a high level, BHA recommends using 2023 and the whole of 2024 to perform pilot testing, finalize the new data model, and select the data entry technology system; all through co-creation with providers. Co-creation encompasses any activity that involves people with lived experience in the process of building products and services. We will not be requiring any changes to CCAR/DACODS entry for at least 1 year after our new specifications are released, in order to be respectful of providers’ timelines as they update their systems. There will be options for providers to adopt these changes faster, if they so choose.

As part of this research report, we’ve detailed how BHA needs to improve the onboarding, training, and user experience for providers. This includes re-writing training materials with a trauma-informed lens, selecting a new tech system with improved usability, among other efforts. These improvements to training and onboarding will be co-designed with providers to ensure we’re providing clear and targeted communications on our data reporting processes.

## **Anonymous | 10/17**

How do these changes apply to agencies that send information to MSO rather than state systems?

### **BHA Response**

There will be minimal changes to when data are reported through MSOs or ASOs rather than directly by the contracted provider to BHA in FY25 in anticipation of BHASOs launching in FY26. BHA is creating guidelines for BHASOs alongside executing on the recommendations detailed in this report.

### **Anonymous | 10/17**

Will there be funding available for providers to update EHR systems to implement the changes?

### **BHA Response**

BHA plans to take the cost of changes providers and intermediaries must make to align with changing reporting requirements into consideration when modernizing CCAR and DACODS.

### **Anonymous | 10/17**

Will regular feedback/reports of items that may be helpful clinically be built in for providers to receive reports?

### **BHA Response**

BHA would like to create standard and customizable data analysis dashboards so that providers can view their submitted data in real time, and can track progress towards contractual requirements as well as measures of equity. Stay tuned for engagement opportunities to inform those dashboards on the [project website](#) and via our [email updates](#).

### **Anonymous | 10/17**

Do you envision that initially you will have an EHR submission version? Or web based solution?

### **BHA Response**

A core finding from this research was identifying the need for a broader and more comprehensive EHR research and strategy effort for BHA's technology infrastructure. BHA will be exploring options for EHR automations/APIs as part of this modernization effort, conducting pilots with providers, and will be communicating with providers about opportunities to engage with the technology selection process, which will include conversations about EHRs. Technology solutions will always be available to providers who do not have EHRs, and who would need a web-based solution to remain in compliance with state reporting.

## Anonymous | 10/16

What LGBTQ groups/community leaders were reached out to help inform the questions on sexuality and gender during intake? seems to me like watering down the data by removing it completely rather than making those questions optional would hide the true necessity for behavioral health needs in that community and affect future funding/programmatic targeting. The excuse of "we don't feel like having an uncomfortable conversation" from a behavioral health provider just sounds- lazy.

### **BHA Response**

BHA engaged with 16 provider organizations across Colorado, and 60 individuals from those organizations. One of these organizations specifically serves the LGBTQIA+ community, while other organizations list "LGBTQIA+ Services" as one of many offerings at their facility. Each data element required by BHA beyond the minimum federal reporting requirements (even for the purpose of informing statewide strategy to improve equitable access to behavioral health care) creates additional work and burden on both providers and the people they serve and should be collected in ways that are both clinically appropriate and culturally sensitive. Plans to modernize CCAR and DACODS include engaging many additional providers and people with lived experience.

## Anonymous | 10/16

Is serious thought being given to designing this from an interoperability standpoint from the ground up and not just as an afterthought. With EHR's being as prevalent as they are, the idea of the web data entry being the primary entry point is a bit antiquated itself.

### **BHA Response**

A core finding from this research was identifying the need for a broader and more comprehensive EHR research and strategy effort for BHA's technology infrastructure.

BHA will be exploring options for EHR automations/APIs as part of this modernization effort, conducting pilots with providers, and will be communicating with providers about opportunities to engage with the new technology system, which will include conversations about EHRs. Technology solutions will be available to providers who do not have EHRs, and who would need a web-based solution to remain in compliance with state reporting.

## Anonymous | 10/18

To what extent have you looked at existing tools as a replacement for CCAR/DACODS? Specifically NOMS.

## BHA Response

A key recommendation from this body of work is to update the data model. Work is currently being done to further understand all data elements that are required by SAMHSA, and how additional data elements are being used. BHA will engage with providers to create a minimum data model, and potential for optional fields beyond federal mandates. BHA plans to explore NOMS in the additional efforts to reduce reporting duplication and will contact CCBHC about their efforts.

## Anonymous | 10/27

How are you engaging EHR vendors?

How is clinical documentation being taken into account for DACODS reporting requirements?

How will data be used to provide outcome measures? How will an analysis be conducted on treatment effectiveness?

Are considerations being made for collecting data that EHRs don't currently support?

—

Overall, we are very pleased and impressed by this work. The issues it raises have long inhibited the effective, available, and affordable care for many individuals. Obviously, solutions come more slowly and are harder to implement than problems. This document holds promise to improve the situation if attention and funding can consistently support it for an adequate duration.

Well done so far! Thank you for taking up this cause and mission!

Creative Treatment Options, Inc. is a privately-owned, for-profit Colorado OBH-licensed behavioral healthcare counseling service that specializes in substance abuse disorder treatment. We were founded in 1998 and have provided treatment to over 20,000 Coloradans. Currently, we have approximately 1,000 active clients who receive care at one of our three Denver-area clinics or through our telehealth/online services. About two-thirds of our clients' care is funded by Medicaid.

p2 - "Our hypothesis" I would add that it negatively impacts the experience of people seeking care in Colorado in several ways, including reducing the amount of actual clinical time spent with clients due to manual note entry into the system.

p2 - I believe "Optimal data validation at the source" should be a top priority.

p3 - The Big Picture. For your information, we are working with CCMCN to enable the transfer of our EHR (ReliaTrax) to Snowflake. The project is funded and in progress.

p4 - "What if BHA could alleviate some of this burden by being more flexible..." Indeed, that's a significant ask of a formidable government healthcare agency. We have developed a suggested model where the same information reaches OBH/BHA but is spread out over departments and time. This allows clinicians more clinical time and improves the fidelity of clinical assessments.

p4 - The lack of a universal definition of terms/terminology is a major contributor to data invalidity. Even for behavioral care, terms like "admission date" are used differently, and data like "first contact" is notoriously and inconsistently recorded.

p4 - 2nd bullet: the "destabilization of trust" is a critical point. Clients not only experience this within the provider environment but also in the referral method/source and the financial aspects of treatment (self-pay, insurance, Medicaid, grant funds, criminal justice vouchers, etc.). My comments on beyond-treatment resources interoperability are outlined below.

p5 - "Why does it matter? - Administrative burden forces providers to spend more time on paperwork than with their clients." While we firmly believe you are on the right track that the administrative burden is responsible for everything outlined in the report, we do not have this ratio of paperwork to clinical work. Some of it is distributed to other departments.

p5 - "Create data mapping options so that..." While cultural competency is now in sharp focus and imperative, as you point out in the document, many other legacy issues with DACODS are clinical and functional in nature, not just cultural. I suggest including the ability to use culturally competent and operationally, financially, and clinically concise terminology with clients.

p5 - "Select and customize..." Certainly, customizing technology will be critical due to the unique and specific tasks at hand. However, bespoke technology could become a long-term liability, as the current system has. I recommend prioritizing the search for a commercially-available "transform" system that can be customized over creating a custom application. Solutions to interoperability and inter-system transfer are emerging everywhere. The era of interoperability has dawned, and legacy systems must reconcile with this.

p9 - In other interoperability task forces, the need for the healthcare community to interoperate (as this one focuses on) is well-known. However, interconnection with family services, school systems, referral systems, insurance, criminal justice, etc. also plays a crucial role. See my comment on p4 regarding the destabilization and intrusion aspects of entering treatment. Interoperability reduces these impacts on the quality of care and increases the accuracy of records/history leading up to the client's behavioral assessment and care. Fundamentally, managing adequate and consistent funding for treatment also affects clinical outcomes, and much of that could be accomplished through better beyond-treatment organization interoperability.

p13 - We largely agree with all of this and have parallel experiences. We also have some practical methods and feasible solutions worth considering for improvements.

p14 - Front desk. To optimize the intake process, CTO has a 3-stage process where administrators can handle non-clinical work, thus reducing clinician burden. We are happy to discuss this further!

p19 - Technical recommendations I want to emphasize earlier points about 1) wider inter-agency interoperability, 2) a more concise definition of clinical and technical capability, and 3) the method used to achieve customization for these specific needs. I'd also add that the technology involved in referral systems needs to be considered. As mentioned earlier, a significant part of the repetition and redundancy you correctly highlighted can start with the referral system.

p23 - Regarding my earlier comments on the consistency of terminology (across technical, financial, clinical, legal, and business domains), perhaps adding a lexicon to the Technology System would be a helpful addition?

Other:

- Considerations should be given to outcome measures (e.g., did the treatment work? How do we know? What measures were used?) and follow-up for the referral source! There is very little data available within the current system to know this information, much less to pass it back up the line to the referral sources.

- The "ReliaTrax" EHR is by far the most common EHR in the state, with around 300 licensed users, of which I believe around 200 are licensed by BHA/OBH. Please don't overlook this extremely important constituency of its treatment agency customers!

\*\*\* In contrast to common perception, these agencies treat the vast majority of people with SUD as compared to the larger-size clinics. \*\*\*

- The users of the above system have a relatively low percentage of technical, financial and managerial resources as compared to a community clinic, hospital, etc. This significantly affects the type of technology they can adopt and manage in order to treat their clients. Large, comprehensive EHR/EMR' such as Epic, Cerner, Athenahealth and others are wonderful systems and capable of addressing many of your modernization ideas, but are unavailable and/or unusable by this provider type.

### **BHA Response**

Regarding how BHA engages EHR vendors: A core finding from this research was identifying the need for a broader and more comprehensive EHR research and strategy effort for BHA's technology infrastructure. BHA will be exploring options for EHR automations/APIs as part of this modernization effort, through additional research noted in the report. BHA will be communicating with providers about any opportunities to engage in technology evaluation process, which will include considerations regarding EHRs. BHA plans to engage with providers who then work with their EHR vendors.

Vendors will be selected through a formal procurement process.

Considerations made for collecting data that EHRs don't currently support: BHA is in the process of establishing a comprehensive EHR strategy for BHA's technology infrastructure.

Regarding clinical documentation being taken into account for DACODS reporting requirements: BHA plans to update training materials and processes based on provider feedback as well as trauma-informed guidance for conversations with clients on data collection. Engagement opportunities will continue to be offered so providers can co-create system improvements, clarity of terminology, and data accuracy.

Regarding how data will be used to provide outcome measures and how an analysis will be conducted on treatment effectiveness: Today, data generated by CCAR/DACODS provides limited benefit to the

ongoing behavioral health care that an individual is receiving and requires substantial administrative burden to complete. BHA would like to create standard and customizable data analysis dashboards so that providers can view their submitted data in real time, and can track progress towards contractual requirements as well as measures of equity.

## Anonymous | 10/23

CCARs are not used for client access of services/admissions into QRTPs. CANS are used. For QRTPs, CCARs should no longer be required.

### **BHA Response**

This research focused on CCAR and DACODS, and BHA is aware of the need for additional exploration specifically into CANS. [SAMHSA Federal Rule Detail outlines](#) that CCARs are required for both adults and children.

CCAR and CANS data instruments collect substantially different information and are used for different purposes. CANS data collection instrument is used to help place youth in appropriate treatment and track response to care over time, but not all youth are in a program that requires CANS. CANS data is not required for SAMHSA and block grant reporting. To ensure experiences of all youth across the state are represented, a standardized collection instrument is needed, which in this case is CCAR.

## Anonymous | 10/24

Please remember that many IPN clinics such as Early Childhood Wellness Place are very small--we have 6 clinicians including myself, and one office manager. We do not have the level of administrative support that larger clinics/Centers have. Administrative burden is a significant barrier to providing services. Please also remember that these same small members of the IPN provide a valuable and needed service. We currently serve over 100 young children (ages 0-12) and around 40 of them are Medicaid members.

### **BHA Response**

BHA understands that in order to promote equity, all providers, from large organizations to individual clinicians, must be supported.

Prior to the planned implementation of COMPASS and DII, OBH and HCPF instituted a rule that Independent Provider Network providers within the RAE network did not have to submit CCARs, until a new data system was implemented.

IPN providers who have had a mental health designation during this time have still been required to submit CCARs to BHA in accordance with rule/statute on licensed and designated provider data submission requirements.

CCAR/DACODS are federally-mandated data instruments required by SAMHSA. BHA is contractually required to submit this data to receive block grant funding from SAMHSA, which allows BHA to administer state-specific programs for mental health and substance use disorder treatment. In order to maintain block grant funding, BHA must submit data on program participation, utilization of block grant funds, and client-level data to SAMHSA annually. 837 Encounters are data collection instruments that capture service and payment level data on all publicly funded behavioral health clients.

A key recommendation from this body of work is to update and minimize the data model, i.e., the amount of questions CCAR/DACODS ask. BHA will engage with providers to create a minimum viable data model that both fulfills federal requirements and collects data that will be useful for statewide advocacy. BHA will also be engaging with providers on a new technology system that will improve the ease of submitting data.

## Anonymous | 10/25

A legend or appendix for all acronyms related to CCAR and DACODS. A breakdown and explanation of reporting from the state submission portal and how to follow up on errors reported and correction process defined. Realtime data reporting if possible. Engaging with EHR vendors sooner than later.

### **BHA Response**

A conclusion in this research report shows the onboarding, training, and user experience for providers needs to be improved. This includes re-writing training materials with a trauma-informed lens, selecting a new tech system with improved usability, among other efforts. These improvements to training and onboarding will be co-designed with providers to ensure clear and targeted communications on data reporting processes are shared.

BHA plans to explore how dashboards can be created so providers to engage with the data they submit. They could then also track contractual requirements and measures of equity.

A core finding from this research was identifying the need for a broader and more comprehensive EHR research and strategy effort for BHA's technology infrastructure. BHA will be exploring options for EHR automations/APIs as part of this modernization effort, and conducting pilots with providers; communicating with providers about opportunities to engage with the technology selection process, which will include conversations about EHRs; and finally, providing technology solutions to providers who do not have EHRs, and who would need a web-based solution to remain in compliance with state reporting.



## Anonymous | 10/25

I have been completing CCARS since I completed my first internship in 2007. This measure has not been updated since its inception (as far as I know) and it is not used to guide or direct treatment. I am not aware of it being an evidenced based measure such as Beck Inventories or used as a pre/posttest to measure effectiveness of treatment. I personally think it is a waste of my clinicians' time to complete this measure. As reimbursement rates have decreased over time and inflation has continued to surge, our profession is being asked to do greater and greater things with fewer and fewer resources. This is not the highest and best use of a clinician's time. If our priority is serving those with the greatest need, then let's have clinician's use their time providing great care, not being a glorified paper pusher.

### BHA Response

BHA acknowledges that the data that the CCAR report types collect is clinically outdated, and the state technology systems used to collect the reports are antiquated. BHA plans to co-create solutions with providers that meet federal requirements while also improving data quality, tech usability, and reducing administrative burden. Co-creation encompasses any activity that involves people with lived experience in the process of building products and services.

CCAR are data instruments federally required by SAMHSA. BHA is contractually required to submit data to receive block grant funding from SAMHSA, which allows BHA to administer state-specific programs for mental health and substance use disorder treatment. In order to maintain block grant funding, BHA must submit data on program participation, utilization of block grant funds, and client-level data to SAMHSA annually.

A key recommendation from this body of work is to update the data model. Work is currently being done to further understand all data elements that are required by SAMHSA, and how additional data elements are being used. BHA will engage with providers to create a minimum data model, and potential for optional fields beyond federal mandates. This work will also address the culturally and clinically outdated data elements that are currently being collected. BHA is working closely with partner agencies like HCPF to further address data duplication and reduce provider administrative burden. Additional engagement opportunities for providers and organizations to provide feedback on the data model updates will be offered. At the end of the engagement process, only data entries that can solidly be defended should remain.

## Anonymous | 10/27

Page 3: “CCAR/DACODS requirements are directly and negatively impacting how people experience behavioral healthcare in Colorado, especially for intake appointments.” • Comment: Additionally, there are different rules for CCAR/DACOD administration further perpetuating the siloing of client’s behavioral health disorders and creates difficulties for providers

Page 3: “Build for Episodic Reporting: Build a reporting environment where we can collect data episodically; aggregating encounters into “Episodes of Care”. “ • Comment: How are we defining an

“episode of care”? Please allow providers to contribute to the creation of this operational definition, nuances in treatment may make this complicated and provider input will be valuable.

Page 3: “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. “ • Does the BHA have outcome measures that would indicate success? Standardization of those measures would allow for comparisons between CMHCs and could provide the whole system with more useful information.

Page 4: “Disincentivizing new providers from entering the public behavioral health workforce due to the high and inequitable administrative burden they experience when compared to the private sector.” • Comment: FTE required for data entry, reporting, and correction could be used toward clinical care if we didn’t have this heavy administrative burden to carry. Ensure the full system alignment needed to implement data and finance protocols including updates or changes, i.e., that MSO, BHASO have the data systems necessary for seamless, uniform data collection. The discharge CCAR is un-client centric and should be reworked.

### **BHA Response**

The “Episodes of Care” concept was explored and validated by past modernization work (COMPASS and DII). These recommendations detailed in this report will build a foundation for a future where additional care coordination possibilities can be explored. BHA would like to work with providers to co-create this definition so that it will work across different services and settings. The “Episodes of Care” concept is further detailed on page 18 of the Administrative Burden report. SAMHSA Federal Detail speaks to “treatment episodes”, more information can be found here.

Today, data generated by CCAR/DACODS provides limited benefit to the ongoing behavioral health care that an individual is receiving and requires substantial administrative burden to complete. BHA would like to create standard and customizable data analysis dashboards so that providers can view their submitted data in real time, and can track progress towards contractual requirements as well as measures of equity.

## **Anonymous | 10/26**

Data and finance protocols aren’t aligned/not match well with our MSO. Example: 6 sessions before the DACOD is due. Signal’s implementation has made this nearly impossible. This shouldn’t be allowable in the future. MSO/BHASO must be required to update their data systems to accommodate changes.

### **BHA Response**

The administrative burden report has recommended future research efforts with ASOs/MSOs (and in the future, BHASOs). BHA is creating guidelines for BHASOs alongside executing on the recommendations detailed in this report.

## Anonymous | 10/26

When I first started dealing with CCARs a year and a half ago, my first thoughts were why are the domain scales and administrative data all part of the same file. 90% of our rejects are due to "unmatched admission", which has nothing to do with a clinician.

Lets look at the errors we get typically:

**\*\*Unmatched admission\*\***(90 to 95% of the rejects)- this is usually due to an incorrect "Admission" date (doesn't match, because the clinician used an incorrect date) -and the document has to be unsigned, corrected and re-signed by the clinician (this should be bumped up against the data you have (to see what is different in both systems-and corrected at the time)- maybe even accept the file-and have an area where we log in to review the error and fix (so file doesn't get rejected, you get the data, and we don't have to submit again)

**\*\*Ethnicity- Ethnicity answers must have at least one selection if declined is false\*\*** This should be allowed- multiple selections

**\*\*Admission date in the future\*\*** again- allow a comparison (usually the year is incorrect) or accept the file and let us log in and correct

**\*\*ICD diagnosis codes- BLANKS\*\*** (5% of the rejects) again another reject that shouldn't need the clinician involvement- not sure why you can't remove blanks in the import

**\*\*Date First Appt Offered- in the future\*\*** again- usually the year-and if we could review the date issues this has nothing to do with the clinician-and we could administratively correct.

The above changes/enhancements would greatly improve the rate of acceptance, and free up at least 1 FTE. Then work on the updating of information that should be collected and remove antiquated fields. Work with the system vendors of EHRs - to have them create areas in their platform that the information can be better integrated with care-so the clinician doesn't have to "Go back " and complete the CCAR section separately.

### BHA Response

BHA will be evaluating and selecting a new data entry technology system to complement the data lakehouse vendor Snowflake. The evaluation and selection of this new data entry technology system will be chosen with provider input, including a stakeholdering process to ensure provider questions and needs are addressed. The intention is for this new technology system to create easier and faster processes for error resolution.

## Anonymous | 10/27

1. Update severity rating for substance use diagnoses to mild, moderate, & severe so in line with DSM-5.

2. Update language to more culturally competent language for gender, race, sexual orientation, etc.
3. Many reasons for discharge do not make sense for forensic population. Wish there were options such as abscond or end of sentence.
4. Often do not know much of the information required in form at the time of discharge, such as client zip code or whether they have used any substances.
5. Timing out of database makes it incredibly difficult to enter data when side tracked from data entry due to clients needing assistance in person.

#### **BHA Response**

A key recommendation from this body of work is to update the data model. Work is currently being done to further understand all data elements that are required by SAMHSA, and how additional data elements are being used. BHA will engage with providers to create a minimum data model, and potential for optional fields beyond federal mandates. This work will also address the culturally and clinically outdated data elements that are currently being collected. BHA is working closely with partner agencies like HCPF to further address data duplication and reduce provider administrative burden. Additional engagement opportunities for providers and organizations to provide feedback on the data model updates will be offered. At the end of the engagement process, only data entries that can be solidly defended should remain.

### **Anonymous | 10/27**

Ensure the full system alignment needed to implement data and finance protocols including updates or changes, i.e., that MSO, BHASO have the data systems necessary for seamless, uniform data collection.

#### **BHA Response**

The administrative burden report has recommended future research efforts with ASOs/MSOs (and in the future, BHASOs). BHA is creating guidelines for BHASOs alongside executing on the recommendations detailed in this report.

### **Anonymous | 10/27**

Recovery Unlimited has approximately 500 SUD clients participating in services. We are also part of the MSO . Our DACODS are entered into the Smart are system which is complicated. It is costly and timely to make these entries for each client. We have 2 near full time positions for DACODS. Unfortunately, these administrative positions do not bring money into the agency by do need to be paid out. This is a burden to the agency and takes away from our ability to stay competitive when attempting to recruit and retain therapists. The less paperwork overall is a benefit to the provider.

### **BHA Response**

The administrative burden report has recommended future research efforts with ASOs/MSOs (and in the future, BHASOs). BHA is creating guidelines for BHASOs alongside executing on the recommendations detailed in this report.

BHA will be evaluating and selecting a new data entry technology system to complement our data lakehouse vendor Snowflake. The evaluation and selection of this new data entry technology system will be chosen with provider input, including a stakeholdering process to ensure provider questions and needs are addressed. Our intention is for this new technology system to create easier and faster processes for error resolution.

## **Anonymous | 10/27**

The CCAR and DACODS manuals dictate administrative discharge from our services when services are not complete within pre-defined timeframes. For example, a client must receive a service within 90 days if they have an open CCAR. If this does not happen, the guidance is to administratively discharge them from services. The timeframe for DACODS is 30 days. These timeframes are imposed upon clients and do not fit what we know about the episodic nature of care that sometimes characterize our population. This framework does not center the patient but rather the administrative needs of the organization/state. Most importantly, the experience of the client is “they fired me.” The experience of our healthcare partners is that “it’s too difficult for our patients to get into the mental health center and too easy for them to be fired”. Further, the need for repeat intake assessments when the patient wants to resume services is a tremendous barrier to continued access to care.

### **BHA Response**

BHA is working to better communicate guidance around reporting timeframes to ensure impact on the client experience is minimized while remaining in compliance with federal requirements, [outlined here](#) within SAMHSA Federal Rule Detail. BHA will release more specific guidance around this scenario as soon as possible.

## **Anonymous | 10/27**

The CCAR is a frustrating administrative load that does not serve to inform our clinical practices or shape the care that the client is receiving. Additionally, the staff who complete the CCAR do not have the answers to the questions that are proposed and as such the data that is recorded is inaccurate. The time spent on reporting CCARs and inevitably correcting them proves to be a heavy burden on an already over-taxed staff,

### **BHA Response**

Today, data generated by CCAR provides limited benefit to the state’s behavioral health ecosystem at large. BHA would like to create standard and customizable data analysis dashboards so that providers can view their submitted data in real time, and can track progress towards contractual requirements as well as measures of equity.

