Draft Strategic Pillars from Subpanel

Detailed Summary

Integrated and Coordinated Care

Promote easier access to continuum of care through an entry and resource navigation system.

- Develop (and market) a single point of entry that has “no wrong door”
- Easy single entry point: Resource navigation hub with the ability for people to call one number, text, email, or online website to access needed BH supports.
- Increase local access points to avoid reaching crisis
- Flexible access points for people to engage in different ways
- A system that builds trust across underserved communities
- Fill 988 funding gap
- Policy: Immigration status not block receiving health care
- Substance use-informed care
- Accessibility / Treatment and continuum of care
- Continuum of care across service array. Building infrastructure around this continuum
- An easy to navigate and coordinated continuum of care throughout the state with workforce in all areas of need across the state

Support systems navigation with utilization management.

- Utilization management: navigation support system has access to updated availability of BH supports and can book appointments
- Regional Resource Navigation Centers
- Services to improve conditions and needs to be effective. Right Service, Right Place and Right Time. What are the outcomes? Are people getting better and if not what needs to change?
- Getting data to proactively support people who have certain risk factors
- Uniform database, one number to call to navigate our behavioral health system with trained professionals to help place people in treatment across the state, and public education
- System has dashboard indicating what services are locally available for people based on cultural, population, and behavioral health challenges
- Asset mapping - Also understand what is working well now and then build onto the future
- Outcomes dashboards - are people getting better, etc.

Reduce fragmentation and increase integration within health care systems, including mental health and SUD as well as physical health.

- Break down silos and red tape to support individuals across systems, to enable service providers to speak with each other about a client, and to ensure change is sustainable
- Technical supports so local providers can participate in HUB
- Address the bifurcation between mental health and substance use disorder systems and allow for treatment of individuals experiencing a co-occurring crisis
- BH integrated seamlessly into the health system. Brain is part of the body. Reattach the head to the body. BH is health.
- True integration would eradicate distinctions in access & payment between physical versus MH/SU care. BH care access points would be less discriminatory if they were inclusively identified as "health care" access points, inclusive of all types of care.
- Stop fighting for turf - MOU that allows groups to share info without HIPAA requirements.

Integrate behavioral health and community support systems, including housing task force recommendations.

- Streamlined financial system with 202 and local funds to be funded for wrap around, etc.
- More intensive supports to prevent entering a crisis state. Including housing respite, food security, youth services. Close gap between services for those needing a little amount of services to those needing inpatient, not enough in between.
- Integration with other systems and preventative services (e.g., community supports, housing, etc.)
- Care coordination across wrap around services
- Peer support system
- How do we support people to transition into community
- Various tiers of housing that people need - develop this capacity
- Have a spectrum of housing to care for individuals with the level of care and support services

Gaps in Care Across the Continuum

Make one-time investments to fill unique gaps for populations experiencing disparities.

- Unhoused population
- Indigenous/First Nation/American Indian/Alaskan Native Communities
- Racial and ethnic populations experiencing disparities (e.g., Latino/a, Black / African American, etc.)
- Undocumented Individuals, including immigrants and refugees: behavioral healthcare is available without consideration for immigration status
- Monolingual non English speakers
- Deaf / Hard of Hearing / Deafblind
- LGBTQIA+
- Pregnant women and infants
- Veterans
- Older adults
- Co-occurring disabilities
- People with intellectual or developmental disabilities; people with brain injuries
- Survivors of gender-based violence

Make one-time investments to fill regional gaps.

- Harm reduction capacity: sterile syringes, testing strips, naloxone, etc.
- Public education re. harm reduction to reduce stigma/discrimination
- Mobile treatment & outreach services (esp. in rural/frontier communities). Meet people where they are.
- Ensure every county has a detox center (less than 120 miles) (address regulatory barriers)
- Capacity for juvenile and adult substance use care & recovery support
- Increase access to telehealth with broadband across state
- Local drop in crisis center
- No Wrong Door Drop-off/Walk-In Diversion Centers
- Intensive outpatient treatment center
- Capacity building and opportunities for one-time investments in construction
- Flexible in community for urban / rural differences

Identify emergency funding needs.

- Crisis beds to meet the needs across the state
- No gaps in continuum of care - step down care (housing, longer term stays, group homes, supportive living, etc.)
- Local control of funds for programming, and it is not a cookie cutter situation. Communities need are significantly different between communities.

Develop an accountability and transparency system.

- Review and complaint system
- Continuous Improvement / Outcomes Based Evaluation: Feedback loop around what's working and what's not
- Provider participation accountability and incentives (e.g., participation in PDMP)
- Governance Guidance
- Local control, community advisory committees
- Give local govt the money and flexibility to solve BH in their own communities.
- Transparency and accountability with funding
- Report cards for over prescribing - continues indefinitely. Bringing some accountability for providers not using PDPM - and checking for opioid prescriptions.

Identify opportunities to fill gaps across the continuum: Universal prevention, health promotion, and community supports; targeted intervention and crisis management; and high acuity services.

- Overcoming Stigma: Get our society to view mental illness as a disease not a choice or character flaw.
- Fill in the "middle"
- Short term therapies, as well as long-term care
- Intensive and local Care Coordination
- Hospital/clinical capacity for individuals in jail custody who require health care
- Inpatient beds
- Intensive outpatient treatment

Overcome gaps and delays in care due to regulatory and system barriers.

- Address regulatory issues for carrying controlled substances for MAT/withdrawal management on mobile units (policy adjustment)
- Addressing the documentation requirement to providing services
- Streamline processes, reducing administrative burdens on the state level as well as recommendations federally
- It seems like the big policy and funding should be focused on those things that 'grease the skids' to ensure that high-quality, evidence-based services are possible. This would include things like ensuring broadband access for telehealth, focus on creative workforce training (because we all know one time trainings are a non-starter long-term), specialized curricula to help support providers to be able to provide culturally-relevant and competent services, investments in linguistic supports, investments in screening and referral streams knowledge about how to support people getting to services, examining where funding could support enhanced communication and collaboration across systems, etc.

Sustainable Funding, Affordability, and Payer Systems

Identify ongoing sustainable funding.

- Reimbursement for: contingency management for substance misuse, prevention, residential care, telehealth, peer specialist care coordination, actual cost of treatment, all other mental health services
- Additional funding for municipalities to get access to naloxone and fentanyl testing strips. Especially in rural areas. Additional funding for local govs to get behavioral staff in schools and in city halls.
- Ensure Medicaid rates are analyzed annually - set consistent and reasonable rates
- Opportunities for additional Medicaid waivers
- Unlimited funds with the ability to be creative and innovative.
- Pursue other local cost shifting from expenditure on judicial processes for individuals who can be safely diverted to health care
- Sustainable Funding Streams
- Ongoing, sustainable funding for local public health

Evaluate disparities and barriers across payer systems and identify how to maximize public benefit and uniformly pay for integrated health services.

- Conduct a cost/benefit analysis on the funding for BH
- Review current state regulated health plans (ASAM criteria) - how is it going? What can we do within our current systems to make sure the right things are being covered?
- Evaluate whether the RAE system is working
- Evaluation of existing funding - creation of a funding map - then shift funding where it isn't working (outcomes don't exist)
- Shift county-borne costs for health care in jails/youth detention back to Medicaid by creating secure in-patient capacity
- Gaps in insurance coverage
- Use state funds to cover services upfront while we wait for Medicaid reimbursement
- Fair, transparent, streamlined, and easy to use payer system
- Transparency with the funding
- Funding and Affordability, including payer system
- BH premier payer (retention bonuses, signing bonuses, etc.)
- Money and profit out of the system (need one to fund it, but not to drive care).
- Shift costs for crisis intervention team training to individual new recruits by embedding training in POST academy
- Treatment should be given based on patient need, not according to the payment source.
- one stop enrollment for Medicaid, SNAP, WIC

Criminal Justice Reform and Care

Support health outcomes in order to prevent crises. Determine how to divert at first intervention before arrest.

- More MH support for target youth populations with vulnerabilities (IEP, other indicators?)
- End school-to-prison pipeline (harsh disciplinary practices)
- Reduce police presence in schools
- Decriminalize drugs (not legalization or commercialization) (Portugal example)
- Harm reduction and addressing overdose crisis
- Increased availability of supportive housing
- Expand and enhance the crisis services system, including non-LE mobile response, co-responder and crisis drop-off centers, to ensure people with behavioral health issues are diverted from the criminal justice system and to the behavioral health system.
- Training first responders to support health and safety first, rather than to enforce laws (divert rather than arrest & charge)
- Municipal courts

Support alternatives to incarceration before trial as well as post-trial diversion.

- Continuum of supports (with flexibility in communities) to increase diversion opportunities from co-responder/ alternative response to pretrial supports to supports within the justice system/ after hours/ peer support services
- Pre-trial reform - treatment over jail: Co-responder programs for mental health and SUD, treatment vs. criminalization
- Focus on Restorative Justice (Restorative Justice hub?)
- Prosecutor-led Diversion
- Problem-Solving Courts/MH courts
- Evaluate/revise sentencing guidelines & mandatory minimums
- Population awaiting determination of competency to stand trial / restoration
- Diversion, including revising the fail first model and Judicial system
- Probation

Ensure jail, prison, and community corrections mental health and SUD treatment.

- Jail DOES not serve as our default MH/SUD care system
- Medicaid - sign up, continuation of medicaid (ask for state exemption, medicaid start to support transitions
- Address shortage of providers in jails
- Jail-based behavioral health services (audit for outcomes/impact)

- Jail provider contracts
- EHRs in jails
- Continuity of care / medication consistency. Includes connectivity to health information exchanges through electronic health records.
- restoration to competency services, both jail-based and hospital-based
- Mandate jail treatment and care, including medication assisted treatment
- Address regulatory issues associated with emergency and involuntary medicines in jails
- Transportation from jail to community services
- Prison-based behavioral health services
- Access to telehealth
- Peer support services & training
- Health care partnership in-reach
- POLICY: Eliminate requirement that people on parole must get behavioral health services from an Approved Treatment Provider, especially if the person on parole is enrolled in Medicaid.

Support smoother reentry and transitions out of incarceration and into the community.

- Getting people signed up for Medicaid before leaving
- Connection to the services that people need prior to release - medication assisted treatment, community mental health services, housing, etc.
- Re-entry programs and community behavioral health services and supports (housing, employment, recovery supports, etc.)
- Minimize barriers & expenses & enhance supports for individuals transitioning back into the community
- Care, supports, & services for children & families of justice-involved individuals
- Contingency management (tangible reinforcement for abstinence, harm reduction)

Children and Youth

Ensure universal screening and assessment for children and youth.

- Universal screening (SBIRT, etc) procedures for child/youth behavioral risks and symptoms - throughout the school community

Support system of care for infants, children, youth, and their families, including:

1) Universal prevention and community supports,

- Prenatal-Parenting Care
- Funding allocated to prevention education. Start early.
- Develop a set of core service strategies to be available across the state, including services, resources, coordination and supports
- Every child has access
- Define essential health benefits for children's behavioral health

2) Targeted intervention and crisis management,

- Youth suicide prevention
- Lack of SUD services
- Youth of color
- Eating Disorder Services
- Lack of school-based behavioral health services
- Disrupt school-to-prison pipeline and criminalizing childhood behavior; diversion
- Healing & Trauma-responsive care, esp for youth of color
- Foster care & training for foster parents/homes, therapeutic foster homes

3) Intensive intervention.

- Lack of inpatient care
- Expand care coordination for multi-system involved youth
- Child welfare system
- Acute Needs Care (stabilization)
- Community and Home Based Services
- Co-Occurring Issues (MH-Chronic Physical Conditions, MH-SUD, MH-IDD, SUD-IDD, SUD-Chronic Physical Conditions, etc.)
- Cross training of professionals for co-occurring conditions
- Receive services in school setting
- FUNDING: School=primary care, behavioral health care, oral care, vision care
- FUNDING: care for <16 yr with SUD
- FUNDING: hub/spoke model for children/youth; HUB: residential treatment, hospital treatment, IOP --> SPOKES: PCP, Juv Just, SBHC, Boys/Girls Clubs

- POLICY: Gun prevention, universal lethal means assessment
- FUNDING: Diversion - greater access; focus on MH/SUD specifically providing access to treatment
- POLICY: training, billing for universal screening (ex-in SBHCs), incentives for CMHCs/FQHCs
- FUNDING: SBHCs with every school

Workforce

Recruit and retain workers to meet behavioral health needs across the state and for high-need populations. Pipeline development should include a focus on recruitment from those populations experiencing disparities.

- Provide behavioral health outreach staff at the local level so that people who come into city hall can know which services are available.
- Solutions for workforce in gap areas / populations, including rural and co-occurring conditions
- Pay well and other retention solutions, including evaluating pay discrepancies between executives and staff
- Peer supports and nontraditional workforce
- What have we invested in already in the past, and what other incentives can we provide? (Loan repayment program, scholarships, outreach to schools, hiring and training people in recovery for peer support)
- Increase BH capacity through increased workforce
- Pipeline development
- Workforce and pipeline in culturally diverse communities.
- Address licensure barriers while maintaining quality
- Addressing/removing licensure barriers that prohibit the delivery of services (while still maintaining quality)
- Have enough clinicians. Psych nurses. Every child born in CO has access to infant mental health
- Broad spectrum of workforce in areas of substance abuse and behavioral care

Better train the workforce, including more broadly for healthcare workers, as well as for resource navigators and care coordinators.

- Having highly trained care coordinators that know the system (DOC, Child/Family services) that are willing to meet people where they are (under a bridge, local bodega, home) that can help them decide on next steps/resources
- Workforce - curriculum development across the full spectrum of healthcare providers. Include psychiatric nurses. Get folks into rural areas as well.
- SUD-informed care should be as prioritized as trauma-informed care
- Cure for mental illness - would like to figure out what this could be.
- Train providers and insurance on ASAM criteria and the new Medicaid benefit
- Funding those in recovery to help with basic job search services (resumes, etc). Expanded to those with SUD. Like to know more about how the program is doing and if we should fund at a higher level.

- Reduce barriers for those in rural areas - use a prof that steams into a junior college. More innovation around WF training.
- Look at the barriers created around creation of standards.
- Understand how much training is necessary (certified addiction specialist, etc) and are there ops for some interactions to be done by other levels.
- Peers and training of peers to support
- Right training for those working in MH settings - not just MH experts - so things can be addressed and deescalated.
- Lack of consistent education for mental health providers - people are relying on folks with limited ability to detect early signs.
- One stop shop for online trainings. and evidence based practices.
- Application of ECHO for ongoing education - consultant learning model

Ensure cultural competence and linguistically accessible services.

- Culturally responsive services - smaller orgs that have trust in communities and can further their reach.
- Easier process for international BH workers to transfer their license to CO.