Behavioral Health Transformational Task Force

Recommendation Report

January 2022

Wellstone Collaborative Strategies

73rd General Assembly

Colorado General Assembly

Developed by the

Behavioral Health Transformational Task Force and Subpanel

with Support by:

Wellstone Collaborative Strategies

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BEHAVIORAL HEALTH TRANSFORMATIONAL TASK FORCE

January 2022

Governor Polis & Members of the Seventy-third General Assembly,

Submitted herewith is the final report on the recommendations from the Behavioral Health Transformational Task Force, pursuant to the direction of the Executive Committee of the Legislative Council, authorized by Section 24-75-230 (4)(b), Co. Revised Statutes, as enacted in Senate Bill 21-137.

This report is the culmination of several months of hard work from both legislative and executive branch members of the Task Force, as well as volunteer citizen members of the Task Force Subpanel, representing many diverse perspectives spanning the behavioral health system. The recommendations received unanimous support from the Task Force. They are intended to use a once-in-a-generation funding opportunity to institute transformational investments in Colorado's behavioral health system that will provide immediate, sweeping, and long-lasting change.

For decades, our fractured and too often ineffective behavioral health system has left the most vulnerable without needed support. As a result, Colorado ranks at or near the bottom of states in meeting our behavioral health challenges. Too many Coloradans are left untreated, resulting in high rates of suicide, harmful substance use, and depression. Children are sent out of state to treat serious behavioral health challenges and suicide rates among young people has gone up over 51% during last decade in Colorado. Hundreds of people are left languishing in jails for months on end, without yet having been convicted of a crime, because we have failed to support them in being competent to stand trial. These disturbing challenges have been exacerbated by the COVID-19 pandemic, increasing domestic violence, isolation and desperation, substance use, anxiety, and depression.

We know that the recommendations in this report will not solve all of the behavioral health challenges Coloradans face, but we believe they will be a transformational step forward. We are confident that if adopted by the General Assembly and implemented in our communities, these investments will make significant strides in expanding our workforce, increasing access to early interventions and care coordination, and meeting the needs of those struggling the most with behavioral health challenges, such as our children, Native Americans, and the staggering number of Coloradans who are caught up in the criminal justice system, often as the result of undiagnosed mental health or substance use disorders. These investments will support Coloradans in every corner of the state.

Thank you for your consideration and we look forward to working with you in the 2022 legislative session and beyond to make these proposals a reality.

Sincerely,

Senator Brittany Pettersen & Representative Serena Gonzales-Gutierrez

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Executive Summary

Colorado has a once-in-a-generation opportunity to transform its behavioral health system and make sure it works for Coloradans in every corner of the state. The $450 million in unallocated funding from the "American Rescue Plan Act of 2021" (ARPA) offers us a chance to make one-time transformational investments that improve access to and the delivery of behavioral health care services across Colorado.

In order to face these challenges, the Governor and General Assembly formed the Behavioral Health Transformational Task Force and Subpanel to develop recommendations in 2021. Comprised of legislators, executive branch representatives, and diverse behavioral health practitioners and experts, the Task Force and Subpanel undertook a deliberative and transparent process. Ultimately, the Task Force came to unanimous consensus on all funding recommendations and allocations, a framework for the Community Behavioral Health Care Continuum Gap Grants, and an inclusion in this report of policy ideas discussed during the process.

The outline below summarizes these transformational investments. Such investments will mean more Coloradans with the highest needs will get the care they need, when they need it, and where they need it, from urban centers to rural communities. People with behavioral health needs will be connected to services across the behavioral health continuum, from primary care visits to inpatient care. The investments will help make our behavioral health system more equitable, culturally responsive, inclusive, and effective. They take on the critical workforce challenges we face by expanding Colorado's trained, qualified, and diverse workforce. With this significant investment, Colorado can and must rise to the challenge. The investments will:

A **Address residential behavioral health needs of Colorado's Native American Tribes.** ($5 to $10M)

B **Meet the needs of children, youth, and families through youth and family residential care, community services, and school and pediatric behavioral health care integrations.** ($110.5 to $141.5M)

C **Invest in increased adult inpatient and residential care.** ($65 to $71M)

D **Integrate primary care and behavioral health.** ($35 to $37.6M)

E **Address gaps in the continuum of care through grants to local governments and community-based organizations.** ($35 to $37.6M)

F **Ensure people aren't arrested and jailed for their behavioral health conditions by using diversion, early interventions, & competency restoration.** ($65 to $70M)

G **Expand and support Colorado's behavioral health workforce.** ($80.3 to $82.7M)

H **Invest in Colorado's behavioral health system through care navigation & coordination, and immediate pandemic relief.** ($44.2 to $50.7M)

Behavioral Health Transformational Task Force

Recommendation Report

Introduction

In January 2022, the Behavioral Health Transformational Task Force reached unanimous agreement on a set of transformational recommendations that will reshape Colorado's behavioral health care system. The Task Force was created to ensure that this once-in-a-generation, one-time investment of $450 million, made possible by the American Rescue Plan Act (ARPA), will bring Colorado from being one of the worst ranked states in meeting behavioral health needs to being an exemplar nationwide. With this report, the Task Force submits its consensus recommendations to the General Assembly and the Governor.

The Opportunity

Colorado has been working hard to improve its behavioral health care system over the past three years, and is on the precipice of major reform. Governor Polis established a Behavioral Health Task Force by Executive Order in 2019, which developed a Blueprint for Reform that recommended, among other things, the creation of a Behavioral Health Administration (BHA). The General Assembly authorized the creation of the BHA in 2021, which will be operational in July 2022. At the same time, the General Assembly passed a number of bills directed at improving access to treatment for Coloradans with substance abuse disorders, building capacity to provide behavioral health services to children, and improving access to peer support. One key ingredient needed for transformational change is the start-up costs for services and infrastructure.

The Task Force

ARPA funds provided the impetus to bring together the legislative and executive branches as well as diverse stakeholders to tackle the behavioral health system and determine where investments would be most impactful. The 16-member Task Force was made up of a bipartisan cohort of ten legislators from Colorado's General Assembly, five executive agency directors, and the Lieutenant Governor. A 25-member Subpanel of diverse behavioral health experts was appointed to advise the Task Force. Additional insights and input were provided through a public survey, stakeholder participation, and public testimony.

The Report

The first section following the introduction describes the challenges we face. The next, envisions a new future with a series of six outcomes. The third section provides a summary of the final set of recommendations agreed upon by the Task Force as well as the policies that were discussed. Following the conclusion are several appendices, including details of the process of developing and finalizing the recommendations.

The Challenges We Face

Colorado ranks at the very bottom of all states in our ability to treat the high prevalence of adults with behavioral health challenges, according to Mental Health America's 2022 report. Approximately 27.5% of Colorado's population, or 1.6 million adults, youth, and children, struggle with mental illness or substance use disorder.

Nearly one third of adults with mental illness report they are not getting the treatment they need. Nationally, Colorado ranks near the bottom for adults, with a high prevalence of suicidal ideation, mental illness, and substance use disorder and low rates of access to care. Colorado was ranked comparatively low for youth, but is doing increasingly well (Colorado ranked 42nd in 2020, and 13th in 2021). Despite this bright spot, Colorado still struggles with substance use disorder among young people, and youth suicide rates increased by more than 51% over the last decade. All of this has been exacerbated by the COVID-19 pandemic, as hospitals are seeing more children and youth in crisis.

The result of these failings are that too many Coloradans die from overdose or suicide. People are arrested for their behavioral health challenges rather than receiving needed care, and by default, the criminal justice system has become the state's largest provider of mental health care. Too often, children are sent out of state to treat complex cases, and people with untreated mental illness wind up homeless. Our dedicated workforce is overworked and understaffed.

Colorado has a moral imperative to improve access to behavioral health services to meet these needs. This infusion of federal funding offers Colorado a unique opportunity to build upon, improve, and reform our behavioral health system so that we can offer all Coloradans the care they need, from prevention and early intervention to long term treatment and support.

Too many Coloradans from different walks of life experience deep disparities and poor outcomes. Recent data reveal significant increases in overdose and suicide among communities of color. Overdose data in 2021 indicate worsening incidence among Black and Native American communities. The pandemic has given rise to increased suicides in Black communities, especially among young Black girls. Communities of color are experiencing the worst outcomes of harmful substance use and mental health disorders, while also experiencing the least reliable access to services. The recommendations in this report have the potential to significantly change these outcomes.

Our workforce struggles to keep up with the ever-growing need. The swell of people who need care, combined with the additional strain of the COVID-19 pandemic, has contributed to a nationwide health care workforce shortage. Colorado's dedicated and compassionate workforce needs to be maintained, supported, and expanded. The current system places intense demands on the profession that contribute to significant burnout among team members. Rural communities often struggle to attract and retain sufficient behavioral health care professionals, while in urban areas, the cost of living makes it difficult for the workforce to afford to live near where they work. Lastly, the workforce is often not representative of the population, leading to poorer outcomes for Black and Latino individuals, Native Americans, those who identify as LGBTQIA+, those with disabilities, and others. The workforce strategy included in the recommendations aims to address these challenges with significant and needed investments to support Colorado's behavioral health workforce.

People don't know where to turn. The public is generally not aware of how and where to access behavioral health services. When it becomes necessary to access such services, there is no well-known means to do so, and in many parts of Colorado there are few, if any, behavioral health care providers. We have a system of care that allows for providers to choose not to provide the needed care or decline certain patients. Furthermore, there are far too many primary care and mental health settings where addiction is not treated at all, creating an incomplete and inaccessible system of care.

"The pandemic has worsened what was already a horrifying trend of young children, teens, and adults suffering increased feelings of anxiety, isolation, depression, and other mental health issues. Colorado needs to take bold action now."

~ Governor Jared Polis

Children, youth, and families are in crisis. Children and families face myriad challenges in accessing care for behavioral health. We have too few providers trained in the treatment of adolescent and child mental health, and even fewer skilled in and willing to treat adolescent and child substance use. When access to care is so delayed, these children, youth, and families become involved in our juvenile justice and/or child welfare systems. We have far too many children who could be cared for at home or in their community if there was an adequate system of respite and therapeutic foster care to support them. Far too many end up in out-of-home placement and inappropriate congregate care settings where children and youth struggle to achieve wellness. Those with complex cases are often sent out of state, a great burden to them and their family. The investments included in these recommendations work to support early intervention, community treatment, and residential care, even for the most complex cases.

We arrest people for their behavioral health conditions. In Colorado, a person with serious mental illness is more likely to be in jail than in a care facility, resulting in jails and prisons acting as the biggest providers of mental health care in our state. People with the most serious mental illnesses often cycle in and out of short-term crisis hospital care and jail, thus exacerbating their mental health challenges. This cycle has shown to be more expensive than preventative harm reduction and public safety investments that keep people healthy and in their communities. Diversion away from the criminal justice system begins with robust community resources, an investment that is integrated into the recommendations.

Colorado falls behind in having enough behavioral health services. For people seeking behavioral health services, and especially for those with severe mental health conditions, there is a serious lack of services and a shortage of behavioral health professionals, especially in rural communities. We have far too many instances where Coloradans attempt to seek care, but are met with a system too complex and with too many challenges for meaningful engagement. Our care coordination system is disjointed and often siloed such that choices for care and support are limited to what a specific organization offers rather than reaching out to all the care services that a community might have to offer. Our community mental health centers are burdened by payment structures and regulatory hurdles that drive uneven access to care, that is dependent on one's payer source. Successful treatment depends on consistent engagement that is difficult for the most disease-burdened patients to attain.

Our behavioral health system is separate from our physical health system, leaving many people without early treatment. While initial attempts at integrating behavioral health care into primary care were promising, we desperately need to invest further in this integration at more practices across the state. Many patients with severe mental health conditions receive care in specialty psychiatry and mental health settings. They deserve to receive behavioral health care where they receive the majority of their physical care, rather than needing to engage with a second or third provider to meet their needs.

Envisioning a New Future

a behavioral health system that puts people first

1

Those with the highest needs get the care they need when they need it.

2

People can access a service when they need it and as early in the continuum as possible.

3

People with behavioral health needs are connected to services across the continuum.

4

Equitable, culturally responsive, inclusive, effective, and high-quality services are available in all regions across Colorado or are connected to the highest acuity needs throughout the state.

5

The state has a trained, qualified, and diverse workforce that is sufficient to meet the needs of Coloradans.

6

There is integration and parity between physical and behavioral health.

Recommendations

Achieving this new future would mean that we met Colorado's behavioral health challenges. To accomplish these outcomes, the Task Force unanimously agreed to a series of transformational recommendations.

While this funding alone will not fully realize the vision for a new future, these investments will bring us much closer to fixing a too often broken behavioral health system. In this section, the funding allocations are summarized, followed by a more detailed description of the recommendations. A summary of the policies discussed by the Task Force comes after, and the section concludes with a description of the framework for the *Community Behavioral Health Continuum Gap Grants*.

All funding recommendations are contingent on a full fiscal analysis. Final funding allocations will not necessarily fall within the ranges provided and could be lower or higher for each recommendation. Further, per federal requirements, ARPA funds must be obligated by December 2024 and spent before the end of 2026. If funds for a particular recommendation are not used at the necessary rate they will be repurposed to other priority areas.

All Behavioral Health Transformational Task Force recommendations are subject to the final guidance issued by the United States Treasury on the use of State and Local Fiscal Recovery Funds. All legislation drafted by the General Assembly will need further fiscal analysis to ensure compliance, and bills based on recommendations may be funded by ARPA or any other revenue source under the discretion of the General Assembly.

Summary of Funding Recommendations

The following is a summary of recommendations discussed and agreed to by the Task Force, highlighting the level of investment being made in each recommendation category (Figure 1).

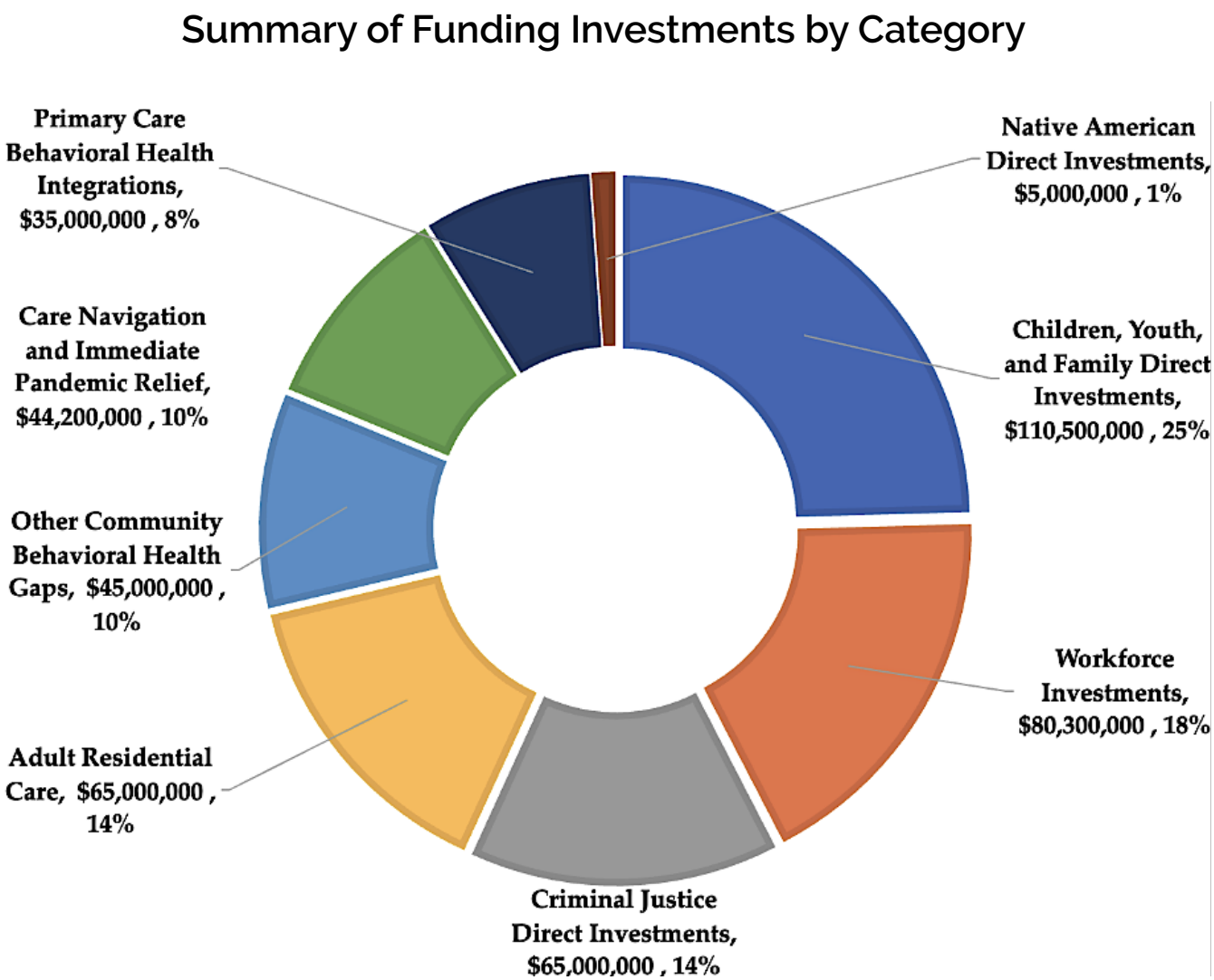

Figure 1. Summary of funding investments by category: Investments are presented by order of investment level, using the low range. Note that the total for the Community Behavioral Health Continuum of Care Gap Grants is approximately $155m, with segments going to address criminal justice and children, youth, and families.

Recommendation Summary

A.

Address the residential behavioral health needs of Colorado's Native American Tribes. ($5 to $10M)

B.

Meet the needs of children, youth, and families through youth and family residential care, community services, and school and pediatric behavioral health care integrations. ($110.5 to $141.5M)

C.

Invest in increased adult inpatient and residential care. ($65 to $71M)

D.

Integrate primary care and behavioral health. ($35 to $37.6M)

E.

Address gaps in the continuum of care through grants to local governments and community-based organizations. ($35 to $37.6M)

F.

Ensure people aren't arrested and jailed for their behavioral health conditions by using diversion, early interventions, & competency restoration. ($65 to $70M)

G.

Expand and support Colorado's behavioral health workforce. ($80.3 to $82.7M)

H.

Invest in Colorado's behavioral health system through care navigation & coordination, and immediate pandemic relief. ($44.2 to $50.7M)

Detailed Funding Recommendations

Below are the detailed recommendations agreed upon by the Task Force. **Note**: the parenthetical numbers following each recommendation indicate that the recommendation addresses one or more of the six outcomes listed in the section titled *Envisioning a New Future*.

Recommendation A.

Tribal Residential Behavioral Health Facility

Provide one-time funding to support the renovation of the existing Southern Ute 16-bed behavioral health facility for inpatient services. This facility would serve tribal members in Colorado with funding support coming from partners in the Four Corners states, and if there is capacity, will serve other Native American and American Indian individuals. The cost of operating the facility would be fully sustainable with Medicaid and Indian Health Services funding after capital cost expenditures. (1)

Funding Allocation: $5m (1%) to $10m (2%)

Recommendation B.

Children, Youth and Family Investments

Meet the needs of children, youth, and families through youth and family residential care, community services, and behavioral health integrations in school and pediatric settings.

B.1. Youth and Family Residential Care

Invest in intensive youth and family residential and outpatient care, ensuring that young people can access the substance use disorder treatment they need and do not need to be sent out of state for residential treatment. Instead, families are able to receive respite across the state through the following strategies: **1)** funds to build and staff a youth neuro-psychiatric facility at Fort Logan with capacity for up to 16 beds; **2)** funds to cover the startup costs to create in-home and residential respite in 10 to 12 regions for children and families across the state; and **3)** operational support for 30 Youth Psychiatric Residential Treatment Facility (PRTF) & Qualified Residential Treatment Program (QRTP) beds across the state. (1)

Funding Allocation: $54m (12%) to $66.5m (15%)

B.2. Children, Youth, and Families Community Services

Through the *Community Behavioral Health Continuum of Care Gap Grants*, ensure there is a youth and family-oriented care access point within a two-hour drive of every community. Wherever possible, such care should augment existing facilities and allow flexibility for communities to co-locate services in order to be efficient. Such access points need to be part of the care navigation/coordination system to ensure people are aware of services. Eligible investments include expanding state-based services, such as the *I Matter* youth telehealth services and grants, for a broad range of community-based services. This includes youth- and family-oriented care navigation and coordination; expansion of evidence-based behavioral health treatment for youth and their families; and intensive outpatient services, including high fidelity wraparound,[1] youth mobile response, and expanded caregiver interventions. (2)

Funding Allocation: $45m (10%) to $55m (12%)

B.3 School and Pediatric Care Behavioral Health Integrations

Expand behavioral health investments in schools, including School-Based Health Centers, school-based services, and school mental health resources. Funding should also build workforce capacity and expertise through short-term support of the Colorado Pediatric Psychiatry Consultation and Access Program and the School Health Professionals grant program. Note that pediatric consultation is also listed in Recommendation D and would also support integrated health practices outside of schools. (2)

Funding Allocation: $11.5m (3%) to $25m (6%)

Recommendation C.
Adult Inpatient and Residential Care

Invest in adult inpatient and residential care across the state that meets gaps for the adult population. The purpose is to provide integrated step-up and step-down care to serve people with serious mental illness or chronic behavioral health needs. This includes individuals with

[1] High fidelity wraparound is an evidenced based intervention that supports young people and their families to develop one plan with a coordinated team across systems, such as behavioral health, education, criminal justice, and child welfare.

co-occurring conditions, substance use disorders, intellectual and/or developmental disabilities, those involved in the criminal justice system, those awaiting competency restoration before standing trial, people experiencing or at risk of homelessness, and other populations experiencing disparities exacerbated by COVID 19. Investments will support **1)** adding 16 beds of capacity at Fort Logan; **2)** residential step-down beds (aim for a minimum of 125 beds); and **3)** recovery services (e.g., sober living homes, peer-run respite homes, club houses, and drop-in centers). Facilities should, wherever appropriate, **a)** address both substance use disorders and mental health diagnoses and **b)** flexibly service both criminal justice competency and civil populations. (1)

Funding Allocation: $65m (14%) to $71m (16%)

Recommendation D.

Primary Care Behavioral Health Integrations

Invest in further integrating physical and behavioral health care in order to increase access to coordinated whole person care for adults and children, provide early behavioral health interventions, and continuation of care after a crisis through primary care practices. This investment increases: **1)** access to mental health and substance use disorder screening and relevant workforce training; **2)** substance use disorder and mental health treatment; and **3)** coordinated referrals to other levels of care and social services. Investments include the psychiatric consultation model (including for over-prescribers), universal contract, practice transformation grants, and practice transformation support. Grants can be used to co-locate and integrate care in outpatient behavioral health and primary care settings and may include funding to address health information technology, social determinants of health, telehealth, care coordination, and sustainable payment and billing practices. Note that pediatric consultation is also listed in Recommendation B3. (2, 6)

Funding Allocation: $35m (8%) to $37.6m (8%)

Recommendation E.

Community Behavioral Health Continuum of Care Gap Grants

Provide funding to local governments and community-based organizations to address identified behavioral health needs. Grant funding should support services along the continuum of behavioral health care that meet regional needs. Specifically, there should be investments in evidence-based programs along the continuum, including prevention, treatment, recovery, harm reduction, care navigation and coordination, transitional housing, supportive housing, and recovery homes. To ensure coordinated and strategic expansion of services and avoid duplication, there should first be a county or regional level assessment that identifies gaps in the service continuum for that community. Areas that need investment should also be identified. Grant funding should also include capacity building as required in SB19-222. Note that recommendations B2 and F will be operated as grants within this program, and are thus included in the larger funding range below. (4)

Funding Allocation: $45m (10%) to $100m (22%) *(All = $155m to $225m)*

Recommendation F.

Criminal Justice Grants: Diversion, Early Interventions, and Competency Restoration

Through the *Community Behavioral Health Continuum of Care Gap Grant*, fund communities to **1)** develop or expand pre-arrest early intervention programs, such as mobile response, co-responder, and community response programs; **2)** increase access to diversion through the judicial branch; **3)** provide intensive community-based services as an alternative to involvement in the criminal justice system; **4)** expand Medication-Assisted Treatment (MAT); **5)** implement behavioral health information and data sharing in the criminal justice system; and **6)** stand up one-stop-shop resource centers to ensure swift connection to and receipt of social support. These resource centers include (but are not limited to) counseling, job placement services, housing assistance, benefits enrollment, medical treatment, childcare subsidy, family counseling, substance abuse treatment, case management services, and peer support. In addition, the recommendation allows judicial districts to apply for additional competency courts for high-need areas for up to 3 years of funding. This recommendation focuses on MAT investments in communities with the highest need, including in jails. Investments should be coordinated with the new 988 behavioral health crisis lifeline as appropriate. (2)

Funding Allocation: $65m (14%) to $70m (16%)

Recommendation G.

Expand and Support Colorado's Workforce

Direct relevant state agencies to develop a plan and invest in workforce expansion, recruitment, training, and retention. The plan should include how to best meet the workforce requirements indicated in the above recommendations. It shall include the following aspects:

1) Expand the workforce by creating more levels of providers; **2)** Encourage rural community members to become and continue to serve as the behavioral health providers in their communities; **3)** Expand telehealth options and reciprocity to immediately expand the eligible workforce and tap providers who represent under-resourced communities; **4)** Increase capacity and training within the behavioral health safety net for existing and newly recruited safety net providers to treat complex needs, substance use disorders (including harm reduction), domestic violence, sexual abuse and assault, and serious mental illness. Trainings should also include how to best use the American Society of Addiction Medicine (ASAM) criteria and Medicaid benefits. Training and potential certification should support providers in becoming more culturally and linguistically competent. Training and workforce development is also needed to serve the population involved in the criminal justice system, including those awaiting competency restoration; **5)** Support peer support professionals through training and a ladder of opportunities; **6)** Reach out to providers to ensure they are aware of all benefits and opportunities; **7)** Ensure that recruitment efforts reflect the community being served and include opportunities to grow in the field, i.e., pipeline and apprenticeship programs; and **8)** Consider loan forgiveness and/or scholarships. The recommendation as a whole should ensure an adequate workforce in each region to meet the above investments, including workforce for children, youth, and family investments; adult residential care, including at Fort Logan, care navigation and coordination, community behavioral health paramedicine; and criminal justice competency and diversion. (4, 5)

Funding Allocation: $80.3m (18%) to $82.7m (18%)

Recommendation H.

Behavioral Health System Investments in Care Navigation & Coordination, and Immediate Pandemic Relief

1.a) Train existing navigators in the safety net system to be able to use the navigation hub funded through SB21-137. Existing navigators include the Regional Accountable Entity (RAE) care managers/coordinators, 988 workers, and those in other safety net provider settings. **1.b)** Use such navigators to help support the technology system, especially for identifying community-based and social determinants of health services and capacity, as well as on the ground local support to encourage participation. **1.c)** Such navigators will have a duty of care to support the safety net system, including those not covered by the RAE and Medicaid (*or* could add additional workforce). **1.d)** Ensure that the technology platform is able to indicate where people can go if they need in-person navigation support. **2)** Support continued maintenance and stabilization after discharge from hospitalization or other behavioral health facilities. **3)** Ensure the system and providers are accountable for connecting people to services and serving those with the highest needs. Results should be reported. **4)** Develop an Electronic Health Record "lite" that interfaces with the health information exchanges. **5)** Direct investments to Naloxone bulk purchase fund for an additional 5 years. **6)** Fund harm reduction through the Colorado Department of Health and Environment's HIV/STI program. **7)** Fund grants for programs supporting survivors of domestic violence and preventing sexual abuse and assault. (1, 3)

Funding Allocation: $44.2m (10%) to $50.7m (11%)

Policy Discussion Items

The following policy items were discussed by the Task Force, many of which received broad support from the Subpanel. While these items were discussed and considerations incorporated, this list does not represent agreement by the Task Force. NOTE: This is not meant to be a comprehensive list, and there are many policy concepts that still need to be addressed. Some discussion items are focused on funds and how to best make those work.

1. **Reciprocity**: Expand reciprocity to domestic and international licensures and encourage providers to move to Colorado. This will help expand the ability to provide culturally competent care. At the same time, continue to invest in Colorado's telehealth infrastructure to reach clinicians and providers nationwide with specialty care. Build and learn from existing models, such as the Interstate Compact for psychiatrists. (Related to Recommendation F.)
2. **1115 Mental Health Waiver**: Explore a Medicaid 1115 waiver for mental health in addition to the one Colorado has for substance use disorder treatment. (Related to C and Ridge View proposal.)

3. **Audit/sunset review of behavioral health line items**: Request that the Legislative Audit Committee identify programs and line items that should be audited or undergo a sunset review, particularly programs that have never undergone an audit and those whose funding has reverted. Items include: **1)** Strategic Individualized Remediation Treatment (STIRT); **2)** Jail Based Behavioral Health Services; **3)** Offender Behavioral Health Services; **4)** Correctional Treatment Cash Fund (CTCF); **5)** Offender Services; **6)** Approved Treatment Provider program; and **7)** Problem Solving Courts (with a focus on accreditation). A broader audit may be needed. The Task Force recognizes that the Audit Committee may be under-resourced and may require additional support.
4. **Decrease Admin Burden**: Without jeopardizing federal funding, reduce the administrative burden that gets in the way of treating patients in a timely manner and overwhelming the workforce, while also ensuring quality & transparency. Colorado's Office of Behavioral Health (OBH) and Department of Health Care Policy and Financing (HCPF) are currently undergoing data consolidation and diminishment processes, and may not require additional legislation to achieve this. (Related to F.)
5. **Judicial diversion**: Explore creating expanded authority for judicial diversion. Allow judicial officers to dismiss charges, divert to programs prior to being charged, and sentence people to treatment rather than incarceration. The need to undergo competency should not impede those eligible for receiving bail to be granted it (see #14). (Related to F.)
6. **988 Behavioral Health line**: Institute legislative policy for using the 988 Suicide Prevention line as a Colorado Behavioral Health Crisis Line, which should include connections to: **1)** the forthcoming Colorado behavioral health resource navigation system with information that more quickly links individuals in crisis with available services; **2)** the forthcoming care coordination system; **3)** peer support services; **4)** information about payer sources and payer funding for services; **5)** diversion programs, such as mobile response, co-responder, and community response programs. (Related to G.)
7. **Certified Addiction Technicians and Specialists**: Adjust requirements of Certified Addition Technicians (CAT) and Certified Addiction Specialists (CAS) hours to be more in line with registered nurses or Licensed Practice Nurses. Currently CAT requires 1,000 hours more than these professions, and CAS, 2,000 more. (Related to F.)
8. **Discharge Strategy**: Allocate minimal funding to examine how to ensure that people are not discharged into homelessness, such as through an evaluation, strategy development, and/or stakeholder consultation. Ensure hospital systems aren't penalized for a lack of available services outside their control or jurisdiction. (Related to G.)
9. **Access to Medication-Assisted Treatment**: For both commercial payers and Medicaid, increase ease of access and reduce limitations, such as requirements for prior authorization to fill buprenorphine products for the treatment of opioid use disorders. Consider other medications such as methadone, vivitrol, and Narcan. Note that costs associated with significantly more expensive forms of medication, such as injectables, will likely still need to be considered. (Related to G.)

10. **Medicaid competency population**: Study how Medicaid can serve the competency population and manage the population with the RAEs. Covering these services could be a requirement of the contracted network adequacy plan and an individual who is bail eligible could not be turned down for receiving community behavioral health services. (Related to F.)
11. **Medicaid in the jails, community corrections, Division of Youth Services, & Department of Corrections**: Ensure adherence to current statutes and clarify the intent of the statute with language indicating that anyone who is eligible for Medicaid in the justice system, whether formerly enrolled or not, is getting enrolled. In addition, maximize Medicaid funding to allow greater flexibility for criminal justice funds and reduce the amount of treatment dollars the criminal justice system needs to access via the state General Fund. Children and youth going into detention under Division of Youth Services would also be included. (Related to F.)
12. **Transparency and accountability**: Request that HCPF submit an annual report to the legislature outlining rates paid to the Community Mental Health Centers (CMHCs) and the independent provider network compared to what they pay fee-for-service providers. Consider reimbursement requirements and higher reimbursements for care coordination. Consider a state-grown solution that works for Colorado and takes into account pertinent accountability elements of the Certified Community Behavioral Health Clinic model. Note that this recommendation ties into work authorized by SB19-222. (Related to G.)
13. **Transform Payer System & Care Coordination**: The Task Force expressed support for the Behavioral Health Administration (BHA) to create a single behavioral health benefit that streamlines and integrates funding, transparency, care coordination, and accountability for mental health, substance use disorder, and crisis. As part of this, the BHA should consider a policy to consolidate Managed Service Organizations (MSOs) and Administrative Services Organizations (ASOs). Money should follow people and services, not organizations. This policy would make sure that those with the highest needs are served with high level of reimbursement rates to providers. Per above, Medicaid should incentivize reimbursement for RAEs doing sufficient care coordination, including being connected to the next set of services. Explore instituting a value-based payment model that incentivizes high success rates and positive outcomes. (Related to G.)
14. **Community Competency Restoration**: Allow for competency restoration in the community when appropriate. Courts should understand that just because an individual is determined incompetent to stand trial, does not mean they should be denied bail. There should be a package for the individual to receive community-based housing and treatment. When appropriate, the judicial system should grant them bail so that they can receive treatment in their community rather than in a jail setting. (Related to F.)
15. **Require Medication-Assisted Treatment**: Require MAT in jails and Department of Correction facilities and provide technical support and outreach. This should be paired with assistance to the counties and funding to support such a mandate. Funding for this

may already exist, as the Jail Based Behavioral Health Services program has reverted funding.

16. **Insurer Therapy Coverage**: Ensure that insurance allows people to see a therapist without requiring a diagnosis. Conduct proactive evaluations of coverage to determine whether the intent of Colorado's parity laws are being achieved. Such work may be connected to the Office of the Ombudsman for Behavioral Health Access to Care.
17. **Social Emotional Learning**: Enact a policy to support the K-5 Social Emotional Act using existing $2.5M. This act supports having enough mental health professionals in a school and a model where these professionals follow students as they move through the grades. (Related to B3.)
18. **Behavioral Health Administration**: Streamline and make more effective disparate programs with overlapping responsibilities.
19. **Community Benefit**: Ensure that hospitals don't count losses from Medicaid reimbursements as their community benefit. Determine what does qualify.

Community Behavioral Health Care Continuum Gap Grant Framework

The *Community Behavioral Health Care Continuum Gap Grant* will provide an opportunity for local governments (counties, tribal governments, municipalities, school districts, law enforcement, and judicial districts) as well as community-based organizations and nonprofits to meet regional gaps and transform behavioral health outcomes. In establishing the grant program, the BHA will consult with local grant-makers and foundations to determine best practices, with the goal of doubling these state allocated dollars. The grant program seeks to balance solutions that are both locally driven while connected to statewide priorities and systems. Key components of the grant program may include:

a. Ensure transparency and accountability mechanisms.
b. Require a county or regional level assessment that identifies gaps in the service continuum for that community, as well as the highest need areas for investment. This will help ensure a coordinated and strategic expansion of services and avoid duplication.
c. Allow for a non-financial match to be used as an addition or alternative to a financial match; waivers in certain instances may be necessary.
d. Incentivize alignment with regional opioid settlement plans and local public health needs assessments.
e. Include a cap on indirect costs.

f. Require that projects be connected with larger state systems (for example, if mobile crisis response is being funded in a community, it would need to respond to 988 calls).
g. Require applicants to demonstrate sustainability for receipt of funds.
h. Encourage applicants to work regionally, such as through the state-established opioid regional boards, or other regional efforts.
i. Demonstrate the need for one-time funding, and provide financial statements.
j. Conduct outreach to communities with an offer to provide grant writing support.

Some of the members of the Behavioral Health Transformational Task Force, Subpanel, and consultant team. Pictured from left to right: Director Cristen Bates, Marisol Rodriguez, Executive Director Michelle Barnes, Jacob Bornstein, Director Robert Werthwein, Senator Brittany Pettersen (Chair), Lieutenant Governor Dianne Primavera, Senator Chris Kolker, Representative Serena Gonzales-Gutierrez (Vice Chair), Representative Judy Amabile, Senator Cleave Simpson, Dr. Vincent Atchity (Subpanel Chair) .

Conclusion

The recommendations agreed to by the Behavioral Health Transformational Task Force will secure transformational change in our behavioral healthcare system across the state. Investments in services across the continuum of care will ensure every Coloradan - regardless of background and zip code - has somewhere to turn to in their community to seek lifesaving services, and are not turned away for lack of ability to pay.

Immediate life-saving investments will mean fewer people die from disease and overdose. Investments in care coordination will mean people will be able to find the services they need. Investments in the criminal justice system and adult residential care will result in those most vulnerable getting the care they need. Integration with primary care practices will result in earlier intervention and prevention. Investments in children, youth and families will mean children will not be sent out of state for treatment and that they will get access to needed services across the behavioral health continuum. Rehabilitating the Southern Ute Indian Tribe facility will mean that both Ute tribes in Colorado will get needed behavioral health care. The flexibility and opportunity to match ARPA funds with local dollars will open pathways for communities across the state to meet specific gaps in the behavioral health continuum. And finally, to support all of this, the significant investment in Colorado's behavioral health workforce will mean we will have the workforce necessary to support these recommendations and the behavioral health system as a whole.

Our behavioral health workforce is experiencing unprecedented demands and challenges, and by increasing access to on-the-job training and incentivizing careers in the field we can overcome urgent staffing shortages felt across our communities while ensuring the highest quality of care.

For the many thousands of Coloradans who struggle with behavioral health, these recommendations will make a difference. Members of the Task Force from both chambers of the General Assembly and the Executive Branch are fully united in taking these critical steps to meet this need, regardless of party affiliation.

This overwhelming level of agreement resulted from a unique process conducted and led by Colorado's General Assembly. While not always simple and easy, it demonstrated that a professionally facilitated Task Force made up of legislative and executive branch members and guided by experts can be a powerful mechanism to build broad consensus and understanding, as it did during this Behavioral Health Transformational Task Force process.

It is with great appreciation of the approximately 1,800 hours of time by Task Force members and volunteer Subpanel members that these recommendations are submitted to the Executive Committee of the Legislative Council and Governor Polis.

Appendix A. Guidance on the Development of Recommendations

Guidance on Establishing Recommendations

The Task Force adopted guidance that funding and policy proposals should meet the following in priority order:

1. Must be transformational for the long run.
2. One-time fund investment can't require additional long-term funding, although seeking funding from other existing sources is encouraged (such as from less effective behavioral health approaches).
3. Leverage local, federal, and private dollars.
4. Fund the gaps in the system that help overcome the disparities.
5. Develop prioritized funding proposals.
6. Identify a few big solutions rather than many small solutions
7. Include transformational legislative and policy changes
8. Be innovative

Each member of the Task Force was asked to define transformational change. This brainstorm was themed and is summarized below. The Subpanel used these themes to consider whether the proposals are truly transformational. Transformational change will:

- **Fill Gaps**: Fill the gaps that have persisted for decades.
- **Be Preventative**: Prevent health problems before they develop and support the whole person by addressing social determinants of health.
- **Be at the Right Time and Place**: Everyone knows where to go and what to do to get timely access to needed care, regardless of geography or population.
- **Provide Access without Obstacles**: Remove all obstacles to accessing care across the continuum of services and ensure treatment no matter the payer or entry point.
- **Put People First**: Support the unique needs of all by providing culturally responsive services that put people first.
- **Integrate Across Systems**: Ensure the integration of behavioral health with schools, hospitals, primary care providers, criminal and juvenile justice, etc. breaking down silos and creating a system of care that is coordinated, seamless, and easy to navigate and supported through data sharing technology.
- **Support Transitions and Long-Term Support**: Ensure people are supported throughout their wellness journey, whether through transitions or when care is needed for the long term.

- **Incentivize Outcomes**: Reconfigure incentives to achieve positive short- and long-term outcomes.
- **Be Affordable**: Be sustainable, affordable, and leverage other funding opportunities.
- **Diversify the Workforce**: Ensure a diverse workforce that includes peers exists to treat those with behavioral health needs.

Lenses

The following aspects, or lenses, should be considered across the pillars when developing solutions:

- **Regions**: Regional gaps and needs, including rural communities
- **Populations**: Populations experiencing vulnerabilities, including the unique needs or gaps for the following populations:
  - Monolingual non-English speakers;
  - Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual (LGBTQIA+);
  - Black, Indigenous, People of Color (BIPOC);
  - Latino/a;
  - Tribal communities;
  - Undocumented individuals;
  - People with intellectual and developmental disabilities;
  - Veterans;
  - Co-occurring disabilities;
  - Justice involved individuals;
  - Unhoused individuals;
  - Pregnant women and infants;
  - Older adults;
  - People with serious mental illness;
  - Children, youth and families.
- **Payers**: Specific barriers, gaps and opportunities with payer type
- **Regulations**: Solutions to overcome regulatory constraints / System barriers to access / streamlining processes
- **Integration**: Ensure we are always looking at mental health and substance use disorder
- **Accountability**: Note transparency and accountability with every pillar
- **Leveraging Funding**: Opportunities to leverage local and other dollars
- **Sustainable**: Transformational for the long-term
- **Behavioral Health Task Force**: Keep in mind the Behavioral Health Administration and the Behavioral Health Blueprint (*Behavioral Health in Colorado:*

Putting People First, A Blueprint for Reform), including the need for affordability, accountability, access to care, and whole person care.

- **Criminal Justice:** Incorporate criminal justice throughout.

American Rescue Plan Act of 2021

SB21-137 directed the executive committee to create the Behavioral Health Transformational Task Force, and also created the behavioral and mental health cash fund. There are roughly $450 million dollars that have not been appropriated. To respond to the public health emergency with respect to COVID-19 or its negative economic impacts, the GeneralAssembly may appropriate money from the fund to a department for mental health treatment, substance misuse treatment, and other behavioral health services. Money in the fund must be obligated by December 31, 2024 and must be expended by December 31, 2026. If the money is not obligated and expended by these dates, it will revert back to the American Rescue Plan Act of 2021 cash fund and then transferred to the unemployment compensation fund.

The Federal interim final rule identifies a non-exclusive list of eligible uses of funding to respond to the COVID-19 public health emergency, one of which is behavioral health. Specifically, the interim final rule states that new or enhanced State, local, and tribal government services may be needed to meet behavioral health needs exacerbated by the pandemic and respond to other public health impacts. These services include mental health treatment, substance misuse treatment, other behavioral health services, hotlines or warmlines, crisis intervention, overdose prevention, infectious disease prevention, and services or outreach to promote access to physical or behavioral health primary care and preventive medicine.

Strategic Pillars

To develop a framework within which to develop recommendations, the Subpanel discussed the following questions at their first meeting: 1) If you had a magic wand, what would your ideal world look like around behavioral health? and 2) If you could manifest two big things to achieve that ideal world, what would they be? Responses to these questions became the basis for ongoing discussions between Subpanel and Task Force members, and led to the development of the following six strategic pillars:

1. Integrated and Coordinated Care

- Promote easier access to continuum of care through an entry and resource navigation system.
- Support systems navigation with utilization management.
- Reduce fragmentation and increase integration within health care systems, including mental health and SUD as well as physical health.
- Integrate behavioral health and community support systems, including Affordable Housing Transformational Task Force recommendations.

2. Gaps in Care Across the Continuum

- Make one-time investments to fill unique gaps for populations experiencing disparities.
- Make one-time investments to fill regional gaps.
- Identify emergency funding needs.
- Develop an accountability and transparency system.
- Identify opportunities to fill gaps across the continuum: a) universal prevention, b) health promotion and community supports, c) targeted intervention and crisis management, and d) high acuity services.
- Overcome gaps and delays in care due to regulatory and system barriers.

3. Sustainable Funding, Affordability, and Payer Systems

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

4. Criminal Justice Reform and Care

- Support health outcomes in order to prevent crises.
- Divert at first intervention before arrest.
- Support alternatives to incarceration before trial as well as post-trial diversion.
- Ensure jail, prison, and community corrections mental health and substance use disorder (SUD) treatment.
- Support smoother reentry and transitions out of incarceration and into the community.

5. Children and Youth

- Ensure universal screening and assessment for children and youth.
- Support system of care for infants, children, youth, and their families, including: a) universal prevention and community supports, b) targeted intervention and crisis management, and c) intensive intervention.

6. 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.
- Better train the workforce, including more broadly for healthcare workers, as well as for resource navigators and care coordinators.
- Ensure cultural competence and linguistically accessible services.

Colorado Behavioral Health Trans

Process Summary

Task Force and Joint Meetings

1. Task Force Kickoff
Purpose: To provide guidance and direction to the BHTTF Subpanel and to begin learning presentations about the current state of behavioral healthcare in Colorado.

2. Strategic Pillars
Purpose: To provide Task Force feedback on draft Strategic Pillars, review the public survey response, learn about the recommendations of the BHTF, and understand the permissible uses and guidelines for ARPA funds.

3. Learning
Purpose: To hear about various aspects of the behavioral health system in Colorado and consider how they might fit within the six strategic pillars.

4. Learning (continued)
Purpose: To hear about various aspects of the behavioral health system in Colorado and consider how they might fit within the six strategic pillars.

5. Recom Review
Purpose: To provide fee recommend by the worl

Working Groups meet

Aug 2021 | Sep | Oct

Subpanel

1. Subpanel Kickoff
Purpose: To kick off the subpanel process by understanding the subpanel's purpose and to identify draft strategic pillars.

2 Strategic Pillar Development
Purpose: To continue to define the strategic pillars to present to the Task Force for approval.

3. Confirm Strategic Pillars
Purpose: To confirm strategic pillars based on TF feedback and organize workgroups for success.

4. Prioritization
Purpose: To deepl subpanel member beginning the pric process for recom to the Task Force.

Working Groups

8. Working Group Meetin
Six working groups were deve around the strategic pillars. Or four times and the rest met thr times for a total of 19 working meetings.

Purpose: To detail recommend for consideration.

Indicates consensus was reached

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kgroups.

7. Recommendation Review (continued)
Purpose: To review and provide feedback on draft recommendations developed by the workgroups.

9. Recommendation Agreements
Purpose: Agree to final set of recommendations.

6. Recommendation Review (continued)
Purpose: To review and provide feedback on draft recommendations developed by the workgroups.

8. Content Agreements
Purpose: To agree to which content should be considered for funding across the Package of Solutions developed by the Subpanel, additional proposals from the Governor's Office, and elevate transformational proposals not already included.

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5. Prioritization
Purpose: To continue to engage the subpanel members in the prioritization process for recommendations to the Task Force.

6. Subpanel Consensus
Purpose: To prepare and reach agreement on a package of recommendations for the Task Force to consider based off the portfolio tool results.

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Figure 2: Summary timeline of the iterative process and coordination between the Task Force,

Appendix B. The Process

The process of developing recommendations to create transformational change in Colorado's behavioral health care system was inclusive of both Task Force and Subpanel members, in addition to outside experts and advocates from a broad swath of the behavioral health field and representing diverse geographies (Figure 2). Supported by the Wellstone Collaborative Strategies facilitation team and Legislative Council Staff, the Task Force and Subpanel took a broad approach to understand and identify historic and current trends in Colorado's behavioral health system, the current state of the behavioral health crisis in Colorado, and the exacerbating impacts of COVD-19.

Given the overwhelming issues identified in the behavioral health system, the Subpanel and Task Force developed six strategic pillars within which to organize potential recommendations (Integrated & Coordinated Care, Gaps in the Continuum of Care, Affordability, Sustainable Funding, Payer Systems, Criminal Justice, Children, Youth, and Families, and Workforce). Working groups comprised of Task Force and Subpanel members were created for each strategic pillar to develop recommendations. Ultimately, the Task Force and Subpanel crafted funding and policy recommendations, which were added to and modified based on public input and testimony. The recommendations were crafted to be flexible, ensuring that those responsible for implementation or fund disbursement could do so in a timely and efficient manner. By the final meeting, the Task Force came to consensus on all funding recommendations and allocations and discussed numerous policy ideas to be further developed in the future.

The Task Force

The Task Force was comprised of 16 members, including legislators from both parties sitting in the House and Senate, as well as six agency directors or their representatives (See Appendix D for full list). They met nine times from August 17, 2021 to January 5, 2022 to deliberate and vote on the final set of recommendations included in this report.

To achieve the final recommendations, the Task Force completed the following:

1. **Defined transformational outcomes and lenses:** During their first meeting, Task Force members collaboratively identified what transformational change in the behavioral health system could look like in Colorado. Based on this definition, they identified six strategic pillars within which to develop and organize potential solutions. Additionally, they identified important lenses through which proposals should be considered and evaluated.
2. **Considered input from the public survey:** The Task Force was presented with the results of the public survey to consider community priorities and new/unique proposed solutions.
3. **Received learning presentations on the state of the behavioral health system**: During two, full-day meetings the Task Force received numerous presentations from various state

agencies, organization leaders, and behavioral health experts and advocates. All presentations can be found on the BHTTF legislative site.

4. **Partnered with the Subpanel to analyze the current state and outline potential solutions:** Working groups, comprised of both Task Force and Subpanel members, were established for each of the six strategic pillars. During weekly meetings, each working group engaged with experts to dive more deeply into specific issues in the behavioral health system and to outline specific solutions.
5. **Listened and considered over 70 recommendations put forth by the working groups:** After the completion of the working groups' work, the Task Force was presented with over 70 specific recommendations for their consideration. Task Force members were able to ask clarifying questions, provide feedback, and request changes/additions/edits to the proposed recommendations.
6. **Heard public testimony**: Following each Task Force meeting, members heard public testimony from both individuals regarding their lived experience, as well as organization leaders currently working to address the many issues in the behavioral health system.
7. **Considered the Governor's behavioral health priorities**: During working group and joint meetings, members of the executive branch presented and advocated for funding and policy priorities of the Governor. These priorities were debated and considered by Task Force members.
8. **Worked with Task Force members to package recommendations**: The Task Force, with support from the Wellstone facilitation team, organized and packaged the Subpanel's recommendations into a series of larger, strategic investments that took into account almost all of the Subpanel's proposals that were considered a high priority for funding (Tier 1). This work also incorporated some proposals that were classified by the Subpanel as Tier 2 () as well as Governor initiated proposals (for more details, see Subpanel steps 7-8).
9. **Checked for general support from Task Force Members**: Task Force members were given an opportunity to better understand each of the recommendation packages and show support or concern for each using a "fist to five" model.[2] Subsequently, Task Force leadership, along with the Wellstone facilitation team, continued to refine the recommendation package based on Task Force feedback to gain additional support from all Task Force members. Ultimately, this led to broad consensus for what should be included in the final package of recommendations.
10. **Voted on the funding recommendations**: In the final meeting, the Task Force unanimously approved a set of 10 funding recommendations and funding allocations. They debated and voted on the content and allocations of the draft funding recommendation packages,

[2] Fist-to-five is a strategy used to gauge general level of support, in which people hold up their hand with 0-5 fingers raised. Zero fingers indicates strong reservations/opposition, and five fingers indicates strong support.

making changes during the discussion. The final funding package incorporated both Subpanel recommendations and Governor's Office budget requests.

11. **Discussed the policy considerations**: The final action of the Task Force was to review and modify the policy discussion items that arose throughout the process. Some of the policy considerations came out of the Subpanel, while others were priorities of Task Force members. While these were discussed by the full Task Force, no vote was taken on whether they should be enacted or not.

The Subpanel

The Subpanel was comprised of 25 members representing various organizations and geographies, and with a breadth of behavioral health expertise and experience (See Appendix D for full list). From August 30 through December 3 2021, the Subpanel met 6 times and participated in 19 workgroup meetings to develop recommendations for consideration by the Task Force. The Subpanel worked alongside the Task Force to create over 50 specific recommendations that are packaged in the approved recommendations section of this report. To achieve this, the Subpanel:

1. **Met as a Subpanel to gain foundational understanding**: During their first meeting, Subpanel members heard the charge of the Task Force and Subpanel, gained an understanding about the appropriate uses and limitations of ARPA dollars, and received Task Force guidance for potential recommendations. Subpanel members took time to re-envision behavioral health in Colorado, with a focus on transformational outcomes the group would like to see because of this work. These outcomes formed the foundation for the six strategic pillars and working groups that would later meet to dive deeper into the current state and potential solutions.
2. **Met with the Task Force to gain a foundational understanding of the challenges of the many aspects of the behavioral health system**: Through a series of two all day meetings the Subpanel listened alongside Task Force members to a variety of speakers and presenters.
3. **Participated in Working Groups**: Working groups, led and facilitated by Subpanel members, were established around each of the six strategic pillars to dive deeper into first identified needs and then to begin discussing and drafting proposed solutions. Each work group met three times throughout October 2021 to further develop recommendations within each Strategic Pillar. Each workgroup was comprised of both Subpanel and Task Force members.
4. **Developed Policy Recommendations**: In addition to funding recommendations, the Subpanel considered various policies to address Colorado's behavioral health crisis and the policy changes needed to support the financial investments described above. During the funding recommendations discussions, if recommendations were identified as being primarily policy related, instead of a good use of this one time funding opportunity, they

were captured by the facilitation team. These recommendations were vetted through Task Force leadership and a list of policy considerations were discussed and revised by the full Task Force at their final meeting.

5. **Presented draft recommendations to the Task Force**: Based on working groups, Subpanel members presented draft recommendation ideas to the Task Force for initial questions and feedback. Based on this feedback, Subpanel members had a chance to revise and build upon and add additional recommendations.
6. **Took temperature checks to rate each of the proposals:** Between meetings, almost all Subpanel members, using a rating scoresheet, analyzed each proposal against the established lenses. These rating sheets were then complied by the consulting team and each proposal was given a score, along with any additional questions or comments provided by Subpanel members. Proposals where then placed into one of three tiers for further discussion.
7. **Analyzed results and made adjustments to recommendations**: During the following Subpanel meeting, results of the temperature check were presented. At that time Subpanel members made adjustments to their recommendations, including agreement on which tiers each recommendation belonged. Tier 1 indicated the recommendation should be prioritized for funding. Tier 2 indicated that the recommendation should only be funded if sufficient funds were available after Tier 1 proposals were funded. Tier 3 proposals were not recommended for funding.
8. **Presented Tier 1 recommendations and their respective scores**: Tier one recommendations were bucketed into themes and were presented to the Task Force for consideration. Task Force members were able to ask questions and ask for clarifications and additions to the recommendations presented. After Tier 1 proposals were discussed, Task Force members were also presented with Tier 2 recommendations.
9. **Provided ongoing support, clarification, and subject matter expertise to the Task Force**: As the Task Force continued its work to shape the recommendations package, Subpanel members joined additional meetings and provided necessary information as requested.

Public Input Survey and Public Testimony

At the outset of this process, a public input survey was developed and deployed by the Colorado Consortium for Prescription Drug Abuse Prevention and Mental Health Colorado to understand the priorities and concerns of the general public regarding Colorado's behavioral health system. The survey was open from August 23 to September 15, 2021 and received 427 responses from across the state (see Appendix C for additional details). Results were presented to the Task Force and incorporated into the development of recommendations.

Public testimony was heard at the majority of Task Force meetings. These testimonies were often deeply moving and represented the behavioral health crisis Colorado faces.

Appendix C. Additional Resources

The following presentations and reports provide extensive context for the historic and current state of behavioral healthcare in Colorado, which was foundational to the Task Force's work of developing recommendations. All additional resources used during the process can be found on the BHTTF legislative website.

Subpanel Recommendations

- Subpanel Recommendation Package and Portfolio Tool Results: This package includes the Subpanel portfolio tool analysis and tier 1, 2, and 3 ranking for each of the recommendations considered. This analysis formed the basis of the final task force recommendations and reflects the consensus reached by the Subpanel.

Public Input Survey

- Presentation to the Task Force. Analysis of the public input survey was presented to the Task Force at their September 23, 2021 meeting, with a focus on how survey responses informed the strategic pillars.

Additional Reports and Presentations

- 2020 Behavioral Health Needs Assessment. Findings of the needs assessment, which was conducted to be responsive to the requirements of the state's Substance Abuse and Mental Health Services Administration (SAMHSA) block grants and to inform a long-term strategic plan for addressing the current and projected behavioral health needs of Coloradans.
- Behavioral Health Task Force Report. Final report of the BHTF, which was convened in April 2019 to evaluate and set the roadmap to improve the current behavioral health system in the state.
- U.S. Department of the Treasury Final SLFRF Guidance. Final Rule from the U.S. Department of the Treasury on allowable uses of State and Local Fiscal Recovery Funds (SLFRF), commonly referred to in this report as ARPA funds.

Appendix D. Task Force & Subpanel Membership

Task Force Member	Affiliation
Sen. Brittany Pettersen (Chair)	CO State Senator
Rep. Serena Gonzales-Gutierrez (Vice Chair)	CO State Representative
Rep. Judy Amabile	CO State Representative
Rep. Mary Bradford	CO State Representative
Sen. Chris Kolker	CO State Senator
Rep. Dafna Michaelson Jenet	CO State Representative
Sen. Kevin Priola	CO State Senator
Sen. Cleave Simpson	CO State Senator
Rep. Tonya VanBeber	CO State Representative
Sen. Faith Winter	CO State Senator
Dean Williams (Leonard Woodson, alt.)	Executive Director, Department of Corrections
Kim Bimestefer (Cristen Bates, alt.)	Executive Director, CO Dept. of Healthcare Policy and Finance
Michael Conway	Commissioner, Division of Insurance
Michelle Barnes	Executive Director, CO Dept. of Human Services
Robert Werthwein (Elizabeth Owens, alt.)	Director, Office of Behavioral Health
Dianne Primavera	Lieutenant Governor, State of Colorado

Subpanel Member	Affiliation
Vincent Atchity (Chair)	President and CEO, Mental Health Colorado
Lesley Brooks (Vice Chair)	Chief of Addition Medicine, SummitStone Health Partners
Michael Allen	CEO, SummitStone Health Partners
Meghan Baker	Facilities Team Leader Attorney, Disability Law Colorado
Nadine Bridges	Executive Director, One Colorado
Harry Budisidharta	Executive Director, Asian Pacific Development Center
Candie Burnham	Executive Director, Atlantis Community, Inc.
Colleen Casper	Executive Director, Colorado Nurses Association

Subpanel Member	Affiliation
Ashley Coram	School Based Health Center Program Manager, Every Child Pediatrics
Jose Esquibel	Director, Colorado Consortium for Prescription Drug Abuse Prevention, University of Colorado Anschutz Medical Campus
Jaime FitzSimons	Sheriff, Summit County
Patrick Fox	American Psychiatric Association Assembly Representative, Colorado Psychiatric Society
Heather Hankins	Chief Behavioral Health Officer, Health Solutions
Terri Hurst	Policy Coordinator, Colorado Criminal Justice Reform Coalition
Suzanne Kerns	Director of Transformative Research, The Kempe Center for the Prevention and Treatment of Child Abuse & Neglect, University of Colorado Anschutz Medical Campus
Lorez Meinhold	Executive Director, Caring for Denver Foundation
Betsy Murray	Retired Lobbyist, Home Care and Hospice Association of Colorado
Byron Pelton	County Commissioner, Logan County
Lisa Raville	Executive Director, Harm Reduction Action Center
Meg Taylor	Vice President of Community Integration, Rocky Mountain Health Plans
Beauclarine Thomas	Legislative & Policy Advocate, Colorado Municipal League
Lora Thomas	County Commissioner, Douglas County
Chris Thurstone	Director of Service of Behavioral Health Services, Denver Health; and Associate Professor of Psychiatry, Colorado School of Medicine
Ana Vizoso	Director of Behavioral Health, Servicios de La Raza, Inc.
Heidi Williams	Director of Opioid Response Unit, Department of Law

Colorado General Assembly
Behavioral Health Transformational Task Force Website

https://leg.colorado.gov/committees/behavioral-health-task-force/2021-regular-session

Wellstone Collaborative Strategies