A Report on the Remedy for Behavioral Health Reform:

PUTTING PEOPLE FIRST

SEPTEMBER 2020

COLORADO
Behavioral Health Task Force
Department of Human Services

September 2020

Governor Polis,

When you launched the Behavioral Health Task Force in the spring of 2019, you challenged us to design a behavioral health system that works for all Coloradans and lowers costs. Over the past year, we have heard from hundreds of Coloradans who have shared their personal experiences, or those of a loved one, about the barriers they face in our current system. We know that we have to do better. We must have a system in place that puts people first. With implementation of the Blueprint, we will.

You asked us to recommend financing and administrative changes; to identify systemic gaps and enhancements in access, especially for vulnerable or underserved populations; and to evaluate, recommend and adopt proven strategies to drive efficiency. We know that there is good work being done by many providers across the State, and we intend to build from that. There are also evidence-based practices that we can leverage and scale. As you will see in this report, there is a lot of work to do. But we must do it, and we hope that you embrace these recommendations. We are eager to move forward with implementation.

I am incredibly proud to stand with my peers on the Executive Committee, my colleagues on the Task Force, and my allies on the subcommittees to present this report to you. Throughout the course of our work together, we have challenged each other and worked tirelessly to ensure that we identified the most critical recommendations that will need to be implemented to transform our behavioral health system.

Thank you for the opportunity to lead this life-changing work. We are excited to move to the next important phase of implementation so that all Coloradans can have access to affordable, high-quality and patient-centered care.

With gratitude,

Michelle Barnes
Chair, Behavioral Health Task Force
Executive Director, Colorado Department of Human Services

Behavioral Health Task Force Committee Members

The Behavioral Health Task Force is a group of diverse stakeholders who worked together to develop the plan to transform Colorado's behavioral health system. This document is the result of the combined efforts of the individuals listed below, as well as the subcommittees (Appendix A). We are grateful to these stakeholders and content experts who shared their insights, knowledge and perspectives to advance the work of the Task Force.

EXECUTIVE COMMITTEE

Chair, Michelle Barnes, Director, Colorado Department of Human Services

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* denotes a Task Force member who had to step down at some point

EX-OFFICIO MEMBERS

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SUBCOMMITTEE CO-CHAIRS

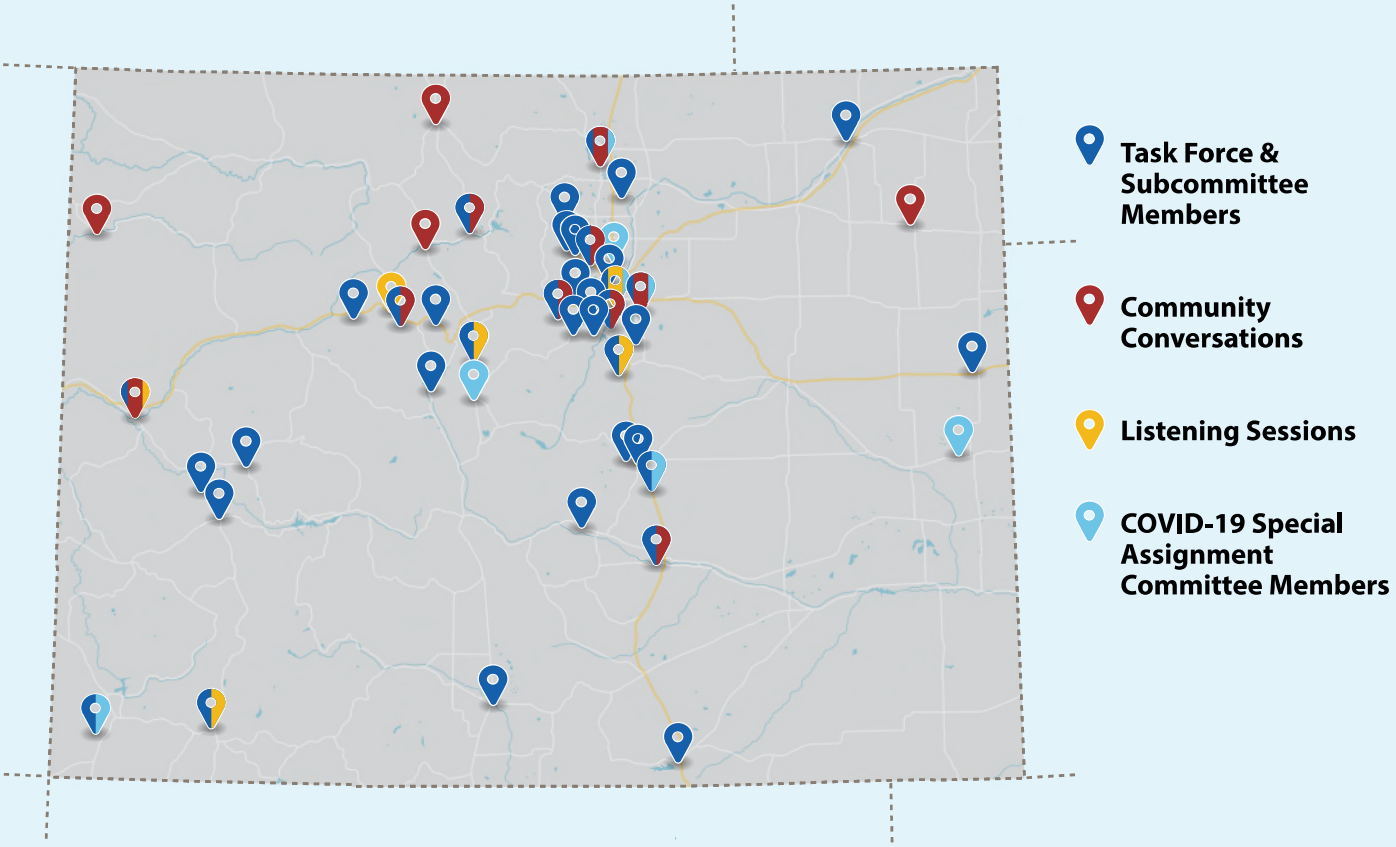
Alison Butler, Disability Law Colorado: Long-Term Competency Subcommittee

Nancy Jackson, Arapahoe County Commissioner: State Safety Net Subcommittee

John Laukkanen, Colorado Department of Health Care Policy & Financing: Children's Behavioral Health Subcommittee

Shannon Van Deman, Children's Hospital Colorado: Children's Behavioral Health Subcommittee

Robert Werthwein, Colorado Department of Human Services Office of Behavioral Health: Long-Term Competency and Safety Net subcommittees



Acknowledgments

The Colorado Department of Human Services gratefully acknowledges the Farley Health Policy Center (FHPC) at the University of Colorado Anschutz Medical Campus. The FHPC works with state agencies and policymakers to understand and inform achievable policy actions to improve the integration of behavioral health across health and healthcare systems. The FHPC was contracted by CDHS in June 2019 to support the Behavioral Health Task Force, and facilitate the three Behavioral Health Task Force subcommittees: Children's Behavioral Health, State Safety Net, and Long-Term Competency, established by Governor Jared Polis.

The Task Force was managed by Summer Gathercole, senior advisor for behavioral health transformation at CDHS, and supported by program assistant Youngsin Joh.

Notes About this Document

The Behavioral Health Task Force and subcommittees met from July 2019 through August 2020. This document reflects the work completed during that period.

Members of the Behavioral Health Task Force had dynamic conversations about whether the terms "consumer" or "person/people" should be used when referencing an individual who is in need of or using services. A consumer often means a person who is currently receiving or formerly received behavioral health services and who self-identifies as a person living in recovery with a mental illness and/or substance use disorder. Many individuals choose to identify with a variety of titles, including patient, consumer and survivor. Not everyone will identify with one of these titles or see themselves or a loved one as a person in need of support. Thus, you will find that, throughout this document, references will be made interchangeable with "Coloradans," "people," "people in need of services," "clients," and "consumers."

Table of Contents

Executive Summary

Colorado has a behavioral health system that works for some people, but not all. The Behavioral Health Task Force heard from hundreds of Coloradans who are continuing to struggle to access the care they need for themselves or a loved one. Tragically, many of these stories ended up in the death of a loved one. In 2018, Colorado had the seventh-highest suicide rate in the nation. Additionally, 15.3% of Coloradans reported poor mental health in 2019, up from 11.8% in 2017.

Many Coloradans report they are not able to access timely care because the services they need are not available in their communities, wait times are too long, or providers can't accommodate their disabilities. The data affirms these concerns: Colorado ranked 29th worst among states by Mental Health America in terms of the prevalence of mental illness and access to care, and close to 95,000 Coloradans with substance use disorder went without treatment in 2019.

With approximately 1 million people in Colorado in need of behavioral health services, Colorado needs a comprehensive system that puts people first.

The Behavioral Health Task Force identified almost 150 recommendations to reform the state's system. Those recommendations fell into six pillars that represent the foundation for a strong behavioral health system, all of which will be addressed in Colorado to achieve the Task Force's vision:

Access

Coloradans will have access to a continuum of behavioral health services, regardless of the severity of need, ability to pay, age, disability, linguistics, geographic location, or racial or gender identity. Coloradans will be connected to the services they need when they need them.

Affordability

Care will be affordable when (1) people get the care they need to keep them healthy; (2) there are administrative efficiencies across Colorado's behavioral health industry; and (3) payment models create the right incentives to also drive improved outcomes.

Workforce & Support

Colorado will have a high-quality, trained, resourced, culturally responsive and diverse behavioral health professional workforce that delivers improved health and access to Coloradans.

Accountability

All stakeholders will work together to ensure that Coloradans are receiving the quality care they need.

Consumer & Local Guidance

Stakeholders from the community will provide feedback and guidance on how best to meet local behavioral health needs.

Whole Person Care

Coloradans are best served — and have the best chances for improved health — when their physical and behavioral health care is integrated and when their social determinants of health are addressed.

THE 3 PHASES OF REFORMING THE SYSTEM

Over three phases, it will take many years for Colorado to reform the behavioral health system. It will require legislative changes to support new policies.

1 Phase One

Create a Behavioral Health Administration (BHA) to ensure a standard of high-quality, integrated, consumer-centric behavioral health care access and services. It will lead and promote the state's behavioral health priorities, ensuring that behavioral health services respond to the changing needs of communities. It will provide the infrastructure to ensure that the recommendations reflected in this document are completed. There is a commitment from the Department of Health Care Policy and Financing (HCPF) and the Division of Insurance to strongly align with the BHA. To what extent Medicaid and private insurance efforts are integrated into the BHA will be studied in Phase One.

Expand and increase tele-behavioral health services across the State to expedite access for people who are seeking behavioral health services.

Review legislation and identify new funding sources to ensure that the recommendations reflected in this report are implemented in the coming years.

2 Phase Two

Colorado will establish a structure for regional support that offers care coordination and management to help people initiate care and navigate to the right crisis supports, mental health and substance use disorder assistance; services that address the social determinants of health; and preventive care services.

Additionally, the 19 prioritized recommendations across the six pillars will be executed. These recommendations are essential in moving the reform of Colorado's behavioral health system to create one that will meet people where they are and help them navigate the different care systems.

3 Phase Three

The Behavioral Health Administration will regularly review the remaining recommendations (i.e., those not prioritized in Phase Two) and assess the environment to determine the next set of recommendations to be implemented.

THE OUTCOME

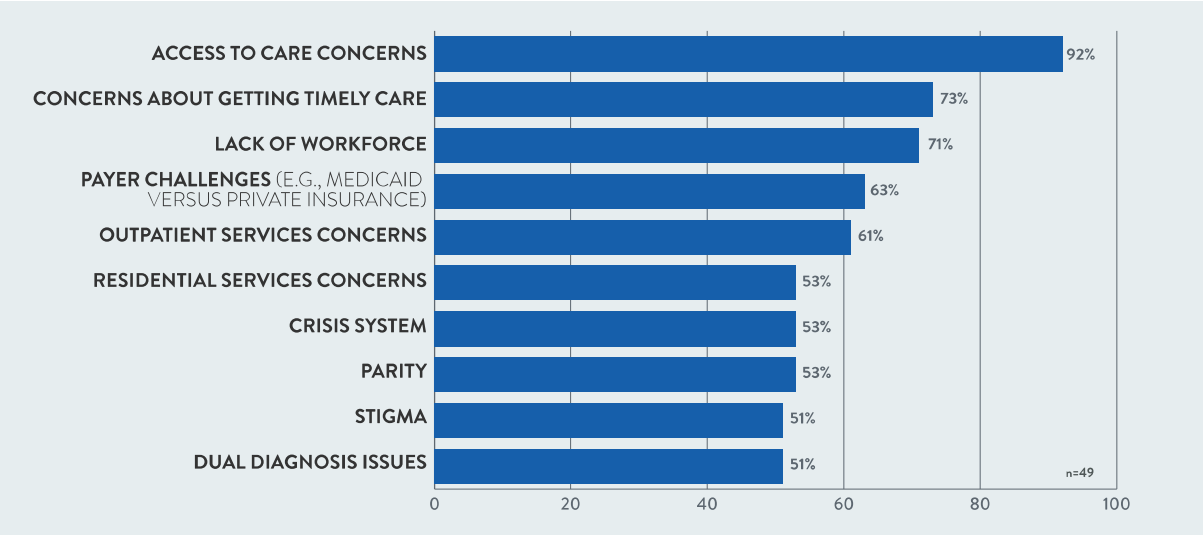
It is clear that significant changes are needed to Colorado's behavioral health system so that people receive the services they need to thrive in their community. By committing to the long-term system changes, and the shorter-term enhancements that will have a more immediate impact on the system and are reflected in this report, Colorado will have a behavioral health system that **puts people first**.

What Coloradans Shared

Data can provide the cold, hard facts, but it does not tell the whole story. Hundreds of courageous Coloradans from across the state shared their experiences with the current system during listening sessions hosted by members of the Task Force's Executive Committee. Some of their stories are shared on these pages. All names in the stories shared have been changed to protect their identities.

The majority of people who participated were parents consumad with worry for their children. Consumers also described their experiences. Nearly everyone expressed frustration at how challenging it is to access timely care. Table 1 depicts the common themes heard. An expanded summary of the listening sessions can be found in Appendix B.

TABLE 1. THEMES TASK FORCE MEMBERS HEARD FROM COLORADANS WHO SHARED THEIR STORIES



THE STORIES BEHIND THE REFORM: JENNY

When Jenny's 11-year-old daughter, Ava, began to receive notes encouraging her to kill herself, Ava began to harm herself. Jenny knew that she needed to get her daughter help, but the school counselor said she did not meet with individual students. Jenny's Employee Assistance Program (EAP) at work allowed three free visits for her daughter, but the available provider would only see new patients two days a week, and would only see the first three people on those days. Finally, able to get in on their third attempt, Jenny and her ex-husband met with the provider without Ava being present. This was not allowed under the EAP, and Jenny received a bill for several hundred dollars and still had no way to get her daughter the care she needed.

Jenny then found a therapist who offered a sliding scale discount, but did not accept private insurance. The therapist wanted to put Ava on medication, but Ava's pediatrician only agreed to do so if a psychiatrist was involved. The wait to see a psychiatrist was two months. While waiting for her appointment, Ava attempted suicide by overdosing. She was treated at an inpatient program for two weeks, but was then released because insurance would not cover a longer stay. Following an appointment with the psychiatrist on Monday and the family counselor on Tuesday, Ava tragically ended her life on Wednesday.

"I feel like my daughter could have been saved," Jenny said, "but she was just another number being pushed through the system that failed us."

The Landscape in Colorado

COLORADO HAS HISTORICALLY NOT BEEN ABLE TO MEET THE COMMUNITY NEED FOR MENTAL HEALTH AND SUBSTANCE USE SERVICES.

COLORADO IS RANKED **29TH** IN TERMS OF THE **PREVALENCE OF MENTAL ILLNESS AND ACCESS TO CARE FOR ADULTS AND CHILDREN**[3]

BETWEEN 2003 AND 2018 **THE PREVALENCE OF SUICIDE DEATHS IN COLORADO INCREASED BY 56.7%**[5]

CLOSE TO **95,000** COLORADANS WITH SUBSTANCE USE DISORDER **WENT WITHOUT TREATMENT** IN 2019, PRIMARILY DUE TO STIGMA[2]

20% OF COLORADANS ARE EXPERIENCING A **MENTAL HEALTH CONDITION**[1]

COLORADO CONSISTENTLY RANKS IN THE **TOP 10** FOR **HIGHEST SUICIDE MORTALITY RATES**[4]

26.9% OF COLORADO ADULTS SAID THAT THEY, A LOVED ONE, OR A CLOSE FRIEND HAVE BEEN **ADDICTED TO ALCOHOL OR DRUGS** IN THEIR LIFETIME[2]

361,000 COLORADANS ARE **UNINSURED**[2]

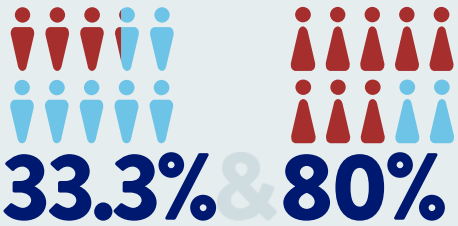
1,200,000 COLORADANS ARE **ENROLLED IN MEDICAID**[7]

IN 2017

11.8% OF COLORADANS REPORTED **POOR MENTAL HEALTH**

IN 2019

15.3% OF COLORADANS REPORTED **POOR MENTAL HEALTH**[2]



33.3% OF MEN & **80%** OF WOMEN CURRENTLY IMPRISONED IN COLORADO **INDICATE THAT THEY HAVE A MODERATE TO CRITICAL MENTAL HEALTH NEED**[6]

The Charge of the Behavioral Health Task Force

In the spring of 2019, Governor Polis asked the Executive Director of the Colorado Department of Human Services (CDHS), Michelle Barnes, to create a Behavioral Health Task Force (the Task Force) to evaluate Colorado's behavioral health system and develop a statewide blueprint to transform the system. The goal is to enable every Coloradan experiencing behavioral health needs to receive timely, high-quality services in their communities.

The Task Force's vision for a behavioral health system in Colorado:

A comprehensive, equitable, effective continuum of behavioral health services that meets the needs of all Coloradans in the right place at the right time to achieve whole-person health and wellbeing.

Coloradans should be connected to the services they need, when and where they need them.

The term "behavioral health" refers to an individual's mental and emotional well-being, development and actions that affect their overall wellness. Behavioral health problems and disorders include mental and substance use disorders, serious psychological distress and suicidal ideation. Problems ranging from unhealthy stress or subclinical conditions to diagnosable and treatable diseases are included.

The Values Underlying the Task Force Work

- All Coloradans — regardless of severity of need, ability to pay, disability, linguistics, geographic location, racial or ethnic identity, socioeconomic status, sexual orientation, age or gender identity — have access that is trauma-informed and culturally and linguistically responsive to a full continuum of behavioral health services in the right place at the right time. This includes access to prevention, treatment and recovery services for behavioral health conditions.
- All stakeholders work together and hold one another accountable to ensure Coloradans are receiving the quality care they need for as long as they need it.
- There is a comprehensive continuum of services available for children, youth and adults.
- People can access services in a variety of methods, such as tele-behavioral health *and* in-person services for all levels of need.
- Colorado has a behavioral health system that distinctly meets the needs of children and youth. Young people have different needs than adults and are offered developmentally appropriate remedies and culturally competent services that an adult system cannot offer.
- Coloradans do not have to engage in the criminal justice system to access behavioral health services. These services are available through their communities.
- All Coloradans have the opportunity to achieve mental wellness.

BEHAVIORAL HEALTH EQUITY

Colorado must do better to address health equity. Findings that resulted from a statewide behavioral health needs assessment[8] completed in 2020 affirmed the need to address health equity:

- Missing data on marginalized populations hides the behavioral health disparity and level of need.
- Provider trainings on priority population-specific needs and cultures is inadequate.
- Most of the behavioral health workforce does not represent the priority population backgrounds or reflect the community within the geography being served.

Marginalized populations include people of color; people with traumatic brain injuries (TBI); Veterans; LGBTQ+ communities; people with disabilities; Deaf, Hard of Hearing, and Deaf Blind Coloradans; older adults; and American Indian/Alaska Native populations.

The Task Force committed to reducing disparities in behavioral health conditions across all populations. Colorado will do better to identify, monitor and respond to behavioral health disparities. This includes expanding workforce capacity to improve outreach, engagement, and quality of care for marginalized populations. A systemic approach to collecting, reporting and analyzing data and demographics will help identify inequities that need to be addressed. There is a significant need to increase awareness about behavioral health disparities and implement strategies to promote behavioral health equity. Health equity will be foundational to all of the work going forward as the Task Force's recommendations are implemented.

Financial Analysis

In early 2020, the Colorado Health Institute conducted a financial analysis of most government-funded adult and children's behavioral health services in Colorado (See Appendices C and D). Approximately $1.4 billion in federal and state funds were identified as supporting behavioral health services — across at least 10 state agencies and over 75 programs. There was additional funding identified after the analysis was complete. With numerous programs and agencies all receiving relatively small funding amounts to provide different services, it is extremely difficult for an individual in need of services to determine a path forward. The administrative burden on community partners is immense, and the analysis identified inefficiencies in contracting for both state agencies and behavioral health providers. The lack of a cohesive statewide approach to addressing the behavioral needs in Colorado does not serve consumers in need of services, state agencies established to support all Coloradans, nor the providers in the behavioral health system.

The analysis highlighted that the current data available reflects who is *receiving* services, but it does not take into account who *needs* services. Additional data is needed to identify which populations may not be getting needed services, and to determine the types of treatment they need. There is also an opportunity to reduce disparities in funding for services provided to marginalized populations. A better data structure could more accurately demonstrate which marginalized populations are receiving services, and identify opportunities to match services with needs.

The financial analysis validated what was already suspected: Colorado does not have an infrastructure in place to understand where and how dollars are being invested, as well as who is being served — or, more importantly, who is *not* being served. Cross-agency data sharing, as well as consolidating non-Medicaid funding and programs under one entity, could generate savings for the State due to reduced administrative costs. It would also allow providers more time for patient care, as they would spend less time on paperwork. Having one entity responsible for overseeing all non-Medicaid public behavioral health could ensure that the changing needs and availability of services across Colorado are monitored. Funding and programs would be coordinated to meet those changing needs.

> **When it comes to retaining valued staff, we have found that administrative burden is the number one reason they leave our organization.**
>
> *-Provider*

THE STORIES BEHIND THE REFORM: CARMEN

Sixteen-year-old Carmen of Colorado Springs loved animals and was an amazing musician and singer. According to her mom, Carmen needed mental health help early in her life, and her family quickly found barriers to getting Carmen the care she needed. Carmen had to wait for weeks for a psychiatrist appointment. The process for admission to a psychiatric hospital was challenging and overwhelming for Carmen's mom, Naomi. The school and therapists and doctors did not communicate with one another, so Naomi took on that role. "I was the go-between and the communicator between everyone," Naomi said. "If I wasn't doing that, I don't think she would have had the care that she did have. There are a lot of parents who work full-time and can't do it."

After many inpatient hospital stays, Carmen had learned how to navigate the system. Her mom said that Carmen learned how to answer the staff's questions the "right" way in order to get discharged. During Carmen's last hospitalization, her mother told the hospital that it was too soon to discharge her daughter. Ten days later, Carmen died by suicide.

The Foundation for a Comprehensive Behavioral Health System

Themes emerged throughout the work of the Task Force. Six pillars reflect these themes and represent the foundation for a strong behavioral health system — all of which need to be addressed.

PILLAR 1: ACCESS

The Aspiration

Coloradans have access to a continuum of behavioral health services, regardless of the severity of need, ability to pay, age, disability, linguistics, geographic location, or racial or gender identity. Coloradans are connected to the services they need when they need them.

Current Challenges

- Coloradans don't know what services exist in their community or where to find them.
- Marginalized populations do not try to access services because those services are not accommodating to them as individuals.
- Access to services, or the type of service needed by the individual or family, is often limited to the form of payment or type of insurance coverage.
- Coloradans are completely confused and overwhelmed about how to navigate the system and have to engage with several types of providers to access services for various conditions (i.e., one provider for therapy and a different provider for drug treatment).
- People are not able to get connected to services due to the lack of providers who can accommodate them (e.g., D/HH/DB Coloradans find few therapists who know American Sign Language).
- There are not enough community behavioral health services or programs available to meet the demand. As a result, Coloradans often wait a long time (i.e., weeks or months) to see a specialist.
- Some people requiring behavioral health services who are facing a significant delay and/or have inadequate services within their communities eventually find themselves inadvertently involved with the criminal justice system. Only under these detrimental circumstances might they receive some type of access to behavioral health services.
- Family members and loved ones are often misdiagnosed – if they even get a diagnosis – due to a lack of complete screening.
- There are still many Coloradans unwilling to access services due to the stigma attached to behavior health issues.

Opportunities for Improvement

Colorado will ensure there is a full continuum of services to address the disparities in access to services. Care coordination – which is the organization of patient care activities and sharing of information among all of the participants concerned with a patient's care to achieve safer, affordable and more effective care – will make it easier for people to navigate the system. It is essential to respond respectfully to culture, languages and other considerations to ensure people feel comfortable actually accessing services. Expanding and enhancing crisis services, co-responder models, and crisis drop-off centers will help to divert people from the criminal justice system. Simultaneously, those initiatives must be expanded in a manner that reduces law enforcement response to emergencies.

> **As a Colorado rural resident, it has been challenging to access higher levels of behavioral health care. Having to leave the area for stabilizing hospitalizations has been a monumental challenge... My daughter's relocation for needed front range services has affected my ability to participate in her care and had a detrimental financial impact.**
>
> *-Parent*

THE STORIES BEHIND THE REFORM: VICTORIA

Victoria of Colorado Springs has been battling mental illness for as long as she can remember. She has a family history of mental health and substance use issues and struggles herself with an eating disorder, borderline personality disorder, self-harm disorder and suicidal ideation. Victoria wants to be a better mother to her three children and a more successful certified nursing assistant, but the mental health resources to help Victoria do not exist in her community. "As a single mother of three who also is a CNA, I have found that there are not many or any resources for most of these disorders. Or for a single mom with these disorders," Victoria said. "And for the ones that do exist, it would cause me to go bankrupt to attend."

Victoria said that she also faces stigma from people who can't understand why she, a mom, would ever consider suicide. That damaging stigma needs to be treated as well, she said. "I ask for more resources and more free resources."

PILLAR 2: AFFORDABILITY

The Aspiration

Care is affordable when (1) people get the care they need to keep them healthy; (2) there are administrative efficiencies across Colorado's behavioral health industry; and (3) payment models create the right incentives to also drive improved outcomes.

Current Challenges

- Coloradans do not get the level of services they need for as long as they need them. This is largely due to the lack of consistency across payer systems. For example, payers have different requirements for people in need of bed at a treatment facility, and different lengths of time that a person can receive care.
- The lack of administrative efficiencies across the behavioral health system drives up the cost of care as providers struggle to complete paperwork and reports for different payers and funding sources.
- Due to the workforce shortage and low reimbursement rates to providers, Coloradans must pay significant out-of-pocket costs to receive services in their community, and/or travel long distances to get the care they need.

Opportunities for Improvement

Colorado cannot retain an adequate network of providers until the rates of reimbursements for the full continuum of services are consistent and fair across all payer systems (and are in compliance with state and federal parity laws). Adequate reimbursements that promote financial sustainability will reflect outcomes. Colorado will streamline and consolidate its funding streams to the degree possible that will ensure taxpayer dollars are used efficiently and effectively. Every effort will be made to maximize federal dollars while not compromising essential services within the service array. Given the State's negative economic outlook in 2020 and the years following, Colorado will identify and secure new funding, such as the community investment funding from not-for-profit hospitals.* Aligning community investment with the statewide behavioral health strategy will help support significant change and reform. A greater investment in prevention efforts, as well as a more streamlined approach, will reduce the need for more expensive higher levels of care later.

* For more information, visit HCPF's Hospital Community Benefit Accountability website: colorado.gov/pacific/hcpf/hospital-community-benefit-accountability

PILLAR 3: WORKFORCE & SUPPORT

The Aspiration

Colorado will have a high-quality, trained, resourced, culturally responsive and diverse behavioral health professional workforce that delivers improved health and access to Coloradans.

Current Challenges

- People have harmed themselves while waiting to see a behavioral health professional due to a weeks- or months-long delay in securing an appointment. Much of this is due to the workforce shortage or a limited number of providers that accept a person's insurance type.
- Professionals are not drawn to the community behavioral health field because they are not reimbursed or paid at a rate that reflects their value.
- Professionals do not receive enough ongoing education or regulation, particularly in the areas of increasing competencies, to meet population-specific needs.
- Coloradans in need of specialty services sometimes have to settle for generic care, as there are no other options in their community.

Opportunities for Improvement

Colorado will expand its workforce and increase competency for marginalized populations and specific conditions — e.g., substance use disorder (SUD), autism spectrum disorder (ASD), etc. Federal dollars will be leveraged to provide training to people passionate about working with these specific populations. Colorado will also expand its workforce from one end of the spectrum to the other. There was consensus that Colorado must increase the number of peer support specialists *and* the number of psychiatrists — and everything in between. Finally, by simplifying the process of adding providers to a payer's network and standardizing guidelines across payer systems, it will be easier for providers to enroll in public and private insurance networks. This will make it easier for patients to access a qualified provider.

THE STORIES BEHIND THE REFORM: BENJAMIN

Benjamin's son was diagnosed with schizo-affective disorder during his sophomore year of high school. Through treatment, his son did well for a few years and was able to graduate high school with his class. "Any pretense of an organized mental health care system was ripped away, once my son reached the age of 18," said Benjamin, who lives in Jefferson County. Benjamin said his son was completely adrift for two years when he became an emancipated adult.

Despite Benjamin's top-notch insurance plan, he could not get his son into a long-term care facility. Finally, at a nurse's suggestion after yet another involuntary mental health hold, Benjamin took his son off his insurance plan and put him on Medicaid, which allowed for longer-term mental health care. His son received care through a local community mental health center and a state mental health institute. Six months of stabilizing behavioral health care let Benjamin's son see that life could be different if he stayed on his medications, Benjamin said.

Today, his son is doing well and is served by the State-funded Assertive Community Treatment program, which helps his son with whatever he needs, including medication and housing. It's been a life-changer for Benjamin's son, and for Benjamin and his wife. "The community-based health care system works if people have consistent access to long-term health care programs," Benjamin says.

PILLAR 4: ACCOUNTABILITY

The Aspiration

All stakeholders will work together to ensure Coloradans are receiving the quality care they need. In a transparent manner, public resources are used efficiently, effectively and equitably.

Current Challenges

- There is not enough focus on producing positive outcomes for people who engage in the behavioral health system.
- Colorado does not have a statewide agreed-upon definition of "quality." Every state agency — as well as payers — defines, collects and uses data differently.
- Various mechanisms and systems are used to track funding.
- Providers are spending an inordinate amount of time submitting data, reports and other paperwork because the different funding sources (i.e., the state agencies) do not share a standardized platform for data collection.
- There is not a standardized tool or process to publicly share data for the purpose of transparency.
- Coloradans are not receiving quality care across all services.

Opportunities for Improvement

Colorado will research, develop and publish population-specific standards of care (inclusive of network adequacy, access measures, wait-time/waitlist limits, and general care considerations) and set clear and reasonable outcomes to measure the quality of the behavioral health system. A single fiscal management system will be used to account for all publicly funded services, and a systemic approach to collecting, reporting and analyzing data and demographics will help identify inequities that need to be addressed. Colorado will address the disparities in care access, delivery and outcomes for marginalized populations.

There must be a continued emphasis to integrate behavioral health and physical health care.

THE STORIES BEHIND THE REFORM: MARIA

"As a parent, there's nothing you wouldn't do for your children. But sometimes, it's not what you wouldn't do, but simply what you can't." Maria's daughter, Sofia, began showing signs of self-harm, auditory hallucinations, and consistent insomnia in middle school. "Trips to the emergency room and crisis clinics were a good start, but they only helped in the immediate." When Sofia began to form serious plans to end her life, Maria took her to get evaluated at an inpatient psychiatric facility. Her daughter was diagnosed with depression and a mild form of schizophrenia. Medication and counseling helped a bit, but it was not enough. Shortly thereafter, Sofia had a psychotic break at school, and officials were unsure of how to manage the situation. Sofia was handcuffed and taken in a patrol car to two different facilities before she was accepted at an Emergency Department.

Because of the incessant advocacy of Maria and her husband, Sofia is doing better today. She was placed in a specialized school and has support from a myriad of professionals. Meanwhile, the medical bills have continued to grow, and the time off from work has become costly as well. Maria has heard countless stories from parents who have not sought help because of the costs. She knows that there has to be a better system. "What I can't do as a parent can be what we can do as a state."

THE STORIES BEHIND THE REFORM: ANTHONY

"He's not a statistic or diagnosis to us. He's a good person with a brain dysfunction who needs help." Samuel and Maya's 35-year old son, Anthony, was diagnosed with schizophrenia at age 16. Local providers could not offer the help that Anthony needed, and he was not able to live successfully on his own. Samuel and Maya took an early retirement to help Anthony. His mental health conditions have worsened over time, and Anthony has begun bingeing on alcohol, marijuana and prescribed anti-anxiety medications. As his behavior has escalated, the Douglas County Sheriff's Community Response Team (CRT) program has helped de-escalate several situations. (The CRT program puts a mental health professional in a car with a trained deputy to respond to suicidal subjects, welfare checks and substance abuse calls for service.) The CRT navigator indicated that the biggest challenge for people like Anthony who have a dual diagnosis is finding an appropriate residential program. A two-week inpatient program has not worked for Anthony. The only program in Colorado that might meet his needs via a 90-day program – and accepts Medicaid – has a two-month waiting list. Samuel and Maya fear for their son's future. "What is going to happen to him when we are older citizens than we are now, and we die? He will end up in jail or die."

PILLAR 5: CONSUMER AND LOCAL GUIDANCE

The Aspiration

Stakeholders from the community will provide feedback and guidance on how best to meet the local behavioral health needs. All Coloradans will have an opportunity to provide feedback on the behavioral health system.

Current Challenges

- The unique needs of rural and frontier areas are not always recognized, understood or prioritized by the State.
- Communities are creating their own programs and solutions because the State is not providing a system that works for them.
- Users of the behavioral health system feel that they are ignored and do not have a voice in sharing the types of services they need and the quality of services they are receiving.
- Coloradans want a clear grievance and appeal process because they do not feel that they have one now.
- With the impact of COVID-19, Coloradans reported an increase in depression and anxiety and expressed an appreciation for tele-behavioral health when in-person services are not available. This was further supported by providers who identified tele-behavioral health as being critical in order to meet the needs of Coloradans during the 2020 pandemic (see Appendix E for COVID-19 Committee Report).

Opportunities for Improvement

The behavioral health system will be built upon the input and ideas of consumers. State and local advisory groups should continuously provide guidance on system improvements. The uniqueness of communities across Colorado will be respected, and the State and local governments will work together to efficiently leverage all resources. All Coloradans will have an opportunity to provide feedback on the behavioral health system.

> **"We don't have a pharmacy in town. When one of us drives an hour over the pass to Steamboat Springs to go to the pharmacy, we let each other know so that we can pick up meds for everyone."**
>
> *-Participant in Listening Session, Walden, CO*

PILLAR 6: WHOLE PERSON CARE

The Aspiration

Coloradans are best served — and have the best chances for improved health — when their physical and behavioral health care is integrated, and when their social determinants of health are addressed. All Coloradans have the opportunity to achieve mental wellness — a state of well-being in which the person realizes their own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to their community.

Current Challenges

People in need of other supports outside of the behavioral health system — such as housing or food assistance — are even more distressed and confused about how to navigate the system.

Coloradans' jobs are jeopardized because of being away from work due to the burden of trying to manage all their care across various systems.

People with intellectual and developmental disabilities (IDD) shared that they are not able to access behavioral health services because there is disagreement about who is responsible for the payment and delivery of those services.

Coloradans with serious behavioral health conditions are entering the criminal justice system because there is a lack of understanding about their needs.

People are not thriving in their communities because they don't have all of the necessary supports.

Opportunities for Improvement

Colorado will better address the social determinants of health through care coordination. Expanding high-intensity treatment programs will ensure that people with the most serious behavioral health conditions have access to treatment, rehabilitation and support services. Offering training and education to professionals who provide services outside of the behavioral health field — such as law enforcement, first responders, judges, court officials and other key partners — will develop the skills and knowledge they need to understand the impacts of behavioral health conditions.

Social determinants of health are the conditions in which people are born, grow, live, work, and age. They include factors like socioeconomic status, education, neighborhood and physical environment, employment, and social support networks, as well as access to health care.

Recommendations

THE PROCESS

In total, the Task Force received almost 200 recommendations from its subcommittees, the COVID-19 Special Assignment Committee, ad hoc work groups and outside stakeholders. There was a fair amount of overlap, and the final list reflected 148 recommendations across the six aforementioned pillars. (See Appendix F for the full list of recommendations and the voting record.) Task Force members were asked to prioritize the recommendations in each pillar using quadratic voting*. The Executive Committee reviewed the voting results, developed a set of priorities for each pillar, and then identified the activities for which implementation should begin in Phase One. Members of the Task Force expressed a strong desire to stay engaged in the next phases of work.

1 PHASE ONE

See Appendix G for the exact language of the recommendation approved by the Task Force.

Goal 1: Create a Behavioral Health Administration

The Task Force voted unanimously to recommend the establishment of a Behavioral Health Administration (BHA). The BHA, which will lead and promote the State's behavioral health priorities, will ensure that behavioral health services respond to the changing needs of communities by convening a Stakeholder Advisory Board at the state level, monitoring state and local data, and evaluating state efforts. This could be a new state agency or an entity housed in an existing agency, and will be accountable for the delivery of behavioral health services in Colorado. The BHA will bestow a streamlined and efficient government approach to support quality care while minimizing the burden to providers so that they can focus on service delivery. State agencies that have non-Medicaid community behavioral health dollars will be asked to re-appropriate their dollars to the BHA and work together to reduce bureaucracy and fragmentation.

In summary, the BHA will ensure a standard of high quality, integrated, consumer-centric behavioral health care that transforms our current system by:

- Promoting a system that revolves around the consumers' needs, a people-first approach.
- Eliminating unnecessary fragmentation of services and taking a whole person approach.
- Promoting transparency of consumer outcomes and spending of taxpayer dollars.
- Offering a streamlined approach to government services that works closely in meeting local community needs.
- Reducing the administrative burden on providers so that they can focus on client care.

Furthermore, the BHA should have a robust infrastructure that includes leadership, staffing, and authority, to oversee and be accountable for the services for all children, youth and young adults, ages 0-26, and their families. This population has unique needs and solutions that require a specific investment throughout the behavioral health system, and starts with an administrative structure that reflects this commitment.

> Shared patient care data among education, behavioral health, and human services systems would be a game-changer to improve care transition.

Designing the BHA is a significant undertaking and will take a few years. Initially, it will require:

1. Continuous, ongoing meetings with stakeholders to develop the infrastructure together.
2. A thorough review of the lines in the Long Bill, relevant legislation, and federal and state regulations to identify changes that need to be made or considered.

* Quadratic voting is a collective decision-making procedure where individuals allocate votes to express the degree of their preferences, rather than just the direction of their preferences

3. The identification of the various funding streams, and determination how best to consolidate them.
4. The initial development of a data integration plan.
5. A massive change-management process to ensure that all of the human elements of the Blueprint are thoughtfully and intentionally addressed.

Finally, there is a commitment from the Department of Health Care Policy and Financing (HCPF), which is the State's Medicaid agency, and the Division of Insurance to strongly align with the BHA. There will be a focus to reduce disparities and promote health equity. To what extent Medicaid and private insurance efforts are integrated into the BHA will be studied over the next year, along with a comprehensive stakeholder process, including consumers, to bring entities into the BHA. By June 30, 2021, the Governor's Office will be presented with the options considered, and a recommendation. HCPF made suggestions on how to improve the system by leveraging the State's investments in data analytics and reporting and billing systems, identifying ways to increase federal funding, aligning on statewide priorities and provider incentives, prioritizing high-need populations, and creating a set of core behavioral health services. These recommendations are outlined in Appendix H.

Goal 2: Expand and Increase Tele-Behavioral Health Services

Thousands of Coloradans are in need of behavioral health services *now*. Many of the recommendations included in this report are systemic changes that will require time and resources to be implemented successfully. As a result of the COVID-19 pandemic, providers in Colorado quickly transitioned to tele-behavioral health so that they could continue to support people in need. Both providers and consumers expressed an ongoing interest in partaking in tele-behavioral health services. The COVID-19 Special Assignment Committee developed recommendations specific to tele-behavioral health (See Appendix I). Some of these recommendations will begin to be implemented in Phase One, as they will help ensure that more Coloradans can immediately access services.

Goal 3: Review legislation and identify new funding sources to implement the Task Force recommendations

Reforming behavioral health in Colorado will require legislative changes to support new policies, and a thorough review of all potentially impacted legislation will be completed.

In the wake of the 2020 economic downturn, Colorado will need to identify new sources of funding to implement some of the recommendations in this report. This includes potential federal funding sources, such as U.S. Department of Labor funding for workforce training and employment. This is an opportunity to grow the peer support specialist workforce across the state.

In addition, there is an opportunity to work with nonprofit hospitals in Colorado to prioritize community investment and funding to support the implementation of the Task Force's recommendations. The federal Patient Protection and Affordable Care Act (ACA)[9] determined that non-profit hospitals needed to engage communities on how to provide a "community benefit." Community benefit programs are designed to provide increased access to care and address population health inequalities for vulnerable patients. [10] In reviewing the major nonprofit health system's community benefit reports in Colorado, most communities have identified behavioral health as a priority for community benefit programs.[11]

Additional Areas of Focus for Phase One

The Task Force identified other areas of work on which to focus in Phase One:

A. Convene subject matter experts to identify specific strategies to strengthen efficiencies and service outcomes for people with disabilities with co-occurring behavioral health conditions, to also include marginalized communities.
B. Develop a full implementation plan for the prioritized Task Force recommendations for Phase Two.

C. Continue extensive stakeholder engagement throughout the system reform.

D. Review all behavioral health legislation and identify opportunities to potentially revise statutes to reflect the vision of the Blueprint.

E. Work with the legislature on implementation of Task Force recommendations.

F. Promote equity throughout all the Task Force recommendations and implementation of the Blueprint.

G. Develop a plan to increase the number of high-intensity treatment programs as well as develop a plan to strengthen and expand the safety net system, per Senate Bill 19-222.

H. Address high suicide incidences via the Suicide Prevention Task Force.

I. Begin addressing the bifurcation of mental health and substance use disorder systems via activities such as the Behavioral Health Entity (BHE) licensing project, which is addressing the licensing and regulation challenges.

J. Begin to determine how to set adequate rates of reimbursement, by all payers and payment sources, for the full continuum of services.

K. Begin to address the workforce shortage by building off the research completed by the Colorado Workforce Development Council (CWDC), which identified behavioral health as a priority career pathway.

2 PHASE TWO

Under the governance of the Behavioral Health Administration (BHA), Colorado will establish a structure for regional support that offers care coordination and management to help clients and families initiate care and navigate to the right crisis supports, mental health, substance use disorder assistance; services that address the social determinants of health; and preventive care services. The regional structures will coordinate care and collaborate with local communities for publicly funded clients and families without available care coordination services. The structure will support providers, as well.

The structures will:

- Exist regionally, reflective of populations and geography, with standards established by the BHA, and customized to the local community
- Have an advisory board, composed of consumers, local government officials and other stakeholders to provide guidance on the needs of community residents and how to meet those needs.

The structures will reduce the duplication and address the bifurcation of services by overseeing and managing contracts with providers that offer mental health, crisis, substance use disorder services, and other community based behavioral health services. This will consolidate community based behavioral health contracts regionally under one structure per region.

The structures will explore alignment and coordination with Medicaid and private insurance markets, which are expected to endorse the

tenets of care coordination. The structures will not be expected to, nor should they, coordinate traditional care for Coloradans receiving behavioral health care through commercial and Medicaid payers. The structures will coordinate and refer Coloradans covered under such programs back to their respective payer's care coordination centers and will be provided with the payer eligibility and referral information to do so. The care coordination structures will, however, manage high need, high-risk populations. This does not restrict future opportunities to improve care coordination across payers if it is in the best interest of Coloradans. People will get connected with enrollment assistants to ensure they get health insurance coverage if they don't have it. The extent to which Medicaid and private insurance efforts are aligned with the proposed care coordination structure will be studied by the agencies who have administrative oversight for Medicaid and private payers along with the Behavioral Health Administration. This process will include a comprehensive stakeholder process, to include consumers and payers. (See Appendix F for the voting record and dissenting opinion.)

My Colorado Journey, a platform supported by the Colorado Department of Higher Education, indicated 422 openings for Social & Human Service Assistants in 2019, which includes Peer Specialists

Additionally, of the 148 recommendations discussed by the Task Force, 19 were identified as priorities across the six pillars (ranked below from top priority to lesser priority *under each pillar*) and will be executed in Phase Two. These recommendations are essential in moving to reform Colorado's behavioral health system to create a system that will meet people where they are and help them navigate the different resources available to them to support the whole person.

Access

1. Develop (and market) a single point of entry (that has "no wrong door") to help high-need, high risk populations navigate the full continuum of services within the behavioral health system in a culturally and linguistically appropriate manner, and link to resources in the community, inclusive of follow-up services. For those Coloradans covered under Medicaid or private insurance, they will be referred back to their respective payer's care coordination centers and will be provided with the payer eligibility and referral information to do so.
2. Expand and enhance the crisis services system, including 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, and explore the right alternative to reduce the reliance on a police/criminal response to a non-threatening behavioral health emergency.
3. Address the bifurcation between mental health and substance use disorder systems and allow for treatment of individuals experiencing a co-occurring crisis to reduce barriers to providing or accessing services (e.g., streamline licensure rules and regulations).
4. Have an adequate, equitable and complete continuum of behavioral health services, and address current disparities, including for people of color, veterans, LGBTQ+ Coloradans, people with disabilities, American Indian/Alaska Native populations, people with TBI, and the aging population. This should include the expansion of high-intensity treatment programs.

Affordability

5. Have adequate rates of payments and reimbursement, by all payers and payment sources, for the full continuum of services.
6. Streamline and consolidate funding streams that include maximizing federal dollars.
7. Prioritize the community investment funding available from not-for-profit hospitals to support implementation of the Task Force recommendations.

Workforce & Support

8. Expand the capacity for a clinically and culturally competent licensed and unlicensed

workforce, especially for specific populations (i.e., LGBTQ+, Tribal communities, deaf/hard of hearing/deaf-blind, etc.) and specific conditions (i.e., SUD, IDD, ASD, etc.).

9. Support and fund the use of non-traditional workforce, especially peers.
10. Simplify the paneling processes and standardize guidelines across payer systems to reduce the administrative burden for providers who are seeking to enroll in private and public health insurance programs.

Accountability

11. Research, develop and publish population-specific standards of care (inclusive of network adequacy and access measures, wait-time/waitlist limits, and general care considerations) and set clear and reasonable outcomes to measure the quality of the behavioral health system.
12. Address high suicide incidences and disparities in care access, delivery and outcomes for vulnerable populations including people of color, people with TBI, veterans, LGBTQ+ Coloradans, people with disabilities, and American Indian/Alaska Native populations.
13. Designate a single fiscal management system to be used to account for all publicly funded services to improve allocations.

Consumer & Local Guidance

14. Complete a comprehensive service gap analysis to identify local, regional and systemic service gaps, and work together to develop a plan to address these gaps.
15. Engage consumers in state- and local-level advisory groups to continuously provide input and guidance on system improvements, including tele-health and children's services.
16. Identify and provide sustainable, flexible funding streams for local communities to prioritize primary prevention, and empower local communities to invest in resources, services and/or materials to support populations that experience mental wellness disparities, and provide support beyond traditional healthcare delivery.

Whole Person Care

17. Offer/expand care coordination with services to address social determinants of health (i.e., housing, transportation, employment, etc.).
18. Expand Assertive Community Treatment (ACT) or other high-intensity case management with treatment for individuals being discharged from a psychiatric hospital to ensure they are receiving the support and treatment they need to be successful after discharge.
19. Create planned and facilitated educational opportunities (i.e., interactive trainings) for law enforcement, first responders, judges and court officials and other partners on how to work with individuals with cognitive disabilities, as well as how to interact in non-crisis situations with them. (Includes best practices to address language and racial disparities.)

> **"When we called the crisis intervention line, we were told they did not have services for children. Twice we were directed to call 911 to bring the Sheriff to our home to transport our son to the hospital. Calling 911 on your own child is distressing to say the least."**
>
> *-Parent*

3 PHASE THREE

The Blueprint and corresponding implementation plan will continue to serve as a guide to reforming Colorado's behavioral health system in future years. The Behavioral Health Administration will regularly review the remaining recommendations (i.e., those not prioritized in Phase Two) and assess the environment to determine the next set of recommendations to be implemented.

In Conclusion

It is rare to have both the opportunity and the political will to make real change happen. Three Coloradans die by suicide every day. Coloradans deserve a behavioral health system that puts people first. One where people can choose from a network of behavioral health providers, one that meets people where they are, and helps them navigate the different resources available to them to support the whole person. One that offers timely services. And, most importantly, a system that meaningfully asks, "How can we help you?"

It is clear that significant changes are needed to Colorado's behavioral health system so that people receive the services they need to thrive in their community.

By committing to the long-term system changes and the shorter-term enhancements that will have a more immediate impact on the system, Colorado will have a behavioral health system that puts people first.

Methodology

When the Behavioral Health Task Force was launched by Governor Polis in the spring of 2019, a multitude of conversations were held with subject matter experts across the U.S., as well as behavioral health commissioners in other states. The conclusion was that there is no single state in the U.S. that has a comprehensive behavioral health system. Many states have components of systems that work well. Colorado studied those various components and considered what could be replicated to ensure those concepts would be successful in this state.

The Task Force had three subcommittees: Children's Behavioral Health, Long-Term Competency, and State Safety Net. Stakeholders, consumers, providers, leaders across tribal, state and local agencies, and related partners — more than 100 people in total from across the state — were selected as members of the subcommittees and Task Force. Those stakeholders all had varying levels of knowledge of Colorado's current behavioral health system — and all had experience with the system. Together, they developed a collective set of recommendations to transform the behavioral health system in Colorado. Subcommittees voted on recommendations and then shared those approved recommendations with the Task Force. The Task Force had final approval and responsibility for the prioritization of recommendations to be presented for Gov. Polis' consideration. Details on the work of each subcommittee can be found in the Subcommittee Report (Appendix A).

> **My wish for the behavioral health system is that it would become more proactive and coordinated. Many "downstream" episodes could be prevented if the system addressed problems "upstream" before they manifest in a crisis.**
>
> *-Participant in listening session*

ADDITIONAL STAKEHOLDER INPUT

Ad hoc work groups formed, and other stakeholders also submitted recommendations for the Task Force to consider.

Task Force Prevention Work Group

Preventing the negative impacts of behavioral health conditions or experiences is critical — as is preventing other experiences/conditions from rising to the level of a behavioral health condition. Strategies developed by this work group included using a public health approach to behavioral health and prioritizing limited resources toward marginalized populations. The work group also recommended enhancing known existing prevention initiatives, as well as integrating screening of behavioral health conditions into a service delivery model. In summary, the work group wants to identify conditions early on, deter substance use, and ensure that strong interventions are in place to lessen the negative impacts of behavioral health conditions. The detailed recommendations can be found in Appendix J.

Task Force Quality Work Group

The quality work group focused on how to ensure all Coloradans receive the level of behavioral health care they need. While the group recommended developing specific standards for network adequacy and using data to measure the overall performance of the behavioral health system, its discussions were mostly focused on how to ensure people have positive outcomes. Coloradans should feel a sense of improved quality of life because of interactions with the behavioral health system, and how that is measured would need to be determined — with input from both consumers and providers. The detailed recommendations presented to the Task Force can be found in Appendix K.

Task Force Parity Work Group

The parity work group wants to achieve the full realization of parity: Behavioral health care is accessible to all Coloradans comparably to physical health. This can be accomplished by ensuring health networks are adequate to serve behavioral health care needs and enhancing workforce capacity and development practices. Additionally, parity can be achieved by

supporting and strengthening entities such as the Behavioral Health Ombudsman. The detailed recommendations presented to the Task Force can be found in Appendix L.

Colorado Daylight Partnership (CDP)

To advance access to linguistically and culturally responsive behavioral health services, Colorado Daylight Partnership (CDP) submitted recommendations based on their Standards of Care that guide the delivery of services for deaf, hard of hearing and deaf-blind (D/HH/DB) Coloradans. Recommendations included significant improvements to communication as well as reviewing the complaint and grievance policies to ensure they address accessibility for D/HH/DB clients. Many of these recommendations can be applied to other populations as well. These recommendations are reflected in Appendix M.

Task Force for the Treatment of Persons with Mental Health Disorders in the Criminal and Juvenile Justice System (MHDCJS)

The Housing Subcommittee of the MHDCJS suggested that the continuum of housing options be broadened and that sufficient support services be provided. It went on to recommend the development of cross-systems data and information sharing assessment tools that effectively and holistically identify needs, remove bias and discrimination, and ensure the appropriate placement. MHDCJS suggested increasing provider capacity for supportive housing and supportive services across the state, and developing measurable outcomes that are informed by local and national evidence. These recommendations are reflected in Appendix N.

Special Section: The Impact of COVID-19

The Behavioral Health Task Force had met for nine months when the COVID-19 pandemic brought a temporary pause to its work. In May 2020, Governor Polis asked the Task Force to establish the COVID-19 Special Assignment Committee. The Special Assignment Committee was asked to (1) create an interim report that highlights the short- and long-term impacts of COVID-19 on the behavioral health system, including access and affordability of behavioral health services, especially for vulnerable and underserved populations; and (2) evaluate the behavioral health crisis response in Colorado to COVID-19.

The Office of Behavioral Health, in partnership with the Colorado Department of Health Care Policy and Financing, completed a survey in August 2020 to examine how COVID-19 impacted factors related to behavioral health treatment. Survey respondents shared that they experienced a significant increase in depression and anxiety between March and July 2020. Many respondents expressed support for using technology to receive care.

TELE-BEHAVIORAL HEALTH

The arrival of COVID-19 significantly altered the delivery of services across the entire healthcare industry. Most notably, there was a shift to tele-behavioral health — which was the first topic of focus by the Special Assignment Committee. Over the course of two months, state and federal leaders established tele-medicine as the new norm for health care during the state of emergency.[12] In Colorado, within two days, the Mental Health Center of Denver went from in-person visits to 100% virtual visits for all of their mental health services. Without recent emergency policy changes to Medicaid reimbursement, this would not be possible. Additionally, Aurora Mental Health provided care to their patients for routine mental health services, crisis, and withdrawal management (detox) using tele-medicine phone calls, which is allowed in Colorado for uninsured and Medicaid clients.[13] Tele-behavioral health quickly proved to be a method to reach Coloradans in need of behavioral health services.

A survey of providers in Colorado confirmed that technology offered several benefits by allowing for the continuation of services that would otherwise need to be shut down completely. Survey respondents reported that technology increased clients' use of, or adherence to, services (38%) and increased efficiency for staff (35%), allowing them more flexibility in scheduling and reduced no-show rates (Table 2). A provider highlighted the essentiality of technology, calling it a "lifeline." Telephone-based service provision was vital for populations with limited or no broadband access, or among clients who were uncomfortable using video. Adolescents and young adults, as well as families with young children, were particularly accepting of technology-based services due, in part, to the new flexibility of services.

TABLE 2. BENEFITS AND BARRIERS OF PROVIDING SERVICES VIA TECHNOLOGY (SURVEY RESPONSES)

BENEFITS		
Increased use of/adherence to services	51	38%
Increased efficiency for staff	47	35%
No benefits that I am aware of	14	10%
Removed transportation barriers to care (i.e., logistically, financially)	8	6%
5% or fewer responses: Client satisfaction, improved service provisions, safely provide services for clients with high COVID-19 risk)		
BARRIERS		
Lack of available and/or adequate technological devices (e.g., smart phones, tablets)	59	44%
Lack of broadband/internet availability for lower income households	54	40%
Lack of internet/computer knowledge for older adults	49	36%
Individual refusal to engage in technology-based services	42	31%
Lack of privacy or safe space to engage	38	28%
Lack of broadband/internet availability in rural areas	36	27%
Decreased efficiency for staff	23	17%
No barriers or challenges that I am aware of	16	12%
5% or fewer responses: Lack of equipment for organizations, some services not possible via technology		

**multiple responses possible*

Acronyms and Definitions

ACRONYMS

ASD	Autism Spectrum Disorder
BHA	Behavioral Health Administration
BHTF	Behavioral Health Task Force
CDHS	Colorado Department of Human Services
CDPHE	Colorado Department of Public Health and Environment
D/HH/DB	Deaf, Hard of Hearing, and Deaf Blind
DOI	Colorado Division of Insurance
IDD	Intellectual or Developmental Disability
HCPF	Colorado Department of Health Care Policy and Financing
MHDCJS	Task Force for the Treatment of Persons with Mental Health Disorders in the Criminal and Juvenile Justice System
OBH	Office of Behavioral Health, Colorado Department of Human Services
SUD	Substance Use Disorder
TBI	Traumatic Brain Injury

DEFINITIONS

Behavioral health
An individual's mental and emotional well-being development and actions that affect his/her overall wellness. Behavioral health problems and disorders include substance use disorders, serious psychological distress, suicidal ideation, and other mental health disorders. Problems ranging from unhealthy stress or subclinical conditions to diagnosable and treatable diseases are included.

Behavioral health disparities
Differences in outcomes and access to services related to mental health and substance misuse which are experienced by groups based on their social, ethnic, and economic status.

Care coordination
The organization and navigation of patient care activities and sharing of information among all of the participants concerned with a patient's care, to achieve safer, affordable and more effective care.

Marginalized populations
Inclusive of people of color; people with traumatic brain injuries (TBI); Veterans; LGBTQ+ communities; people with disabilities; Deaf, Hard of Hearing, and Deaf Blind Coloradans; older adults; and American Indian/Alaska Native populations.

Mental wellness
A state of well-being in which the person realizes their own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to their community.

Social determinants of health
Conditions in which people are born, grow, live, work and age. They include factors like socioeconomic status, education, neighborhood and physical environment, employment, and social support networks, as well as access to health care.

Whole person
A person's health and wellness are not limited to their physical health, but on the well-being of them as the whole person.

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COLORADO
Behavioral Health Task Force
Department of Human Services

Colorado Behavioral Health Task Force

SUBCOMMITTEES' PROCEEDINGS AND RECOMMENDATIONS

Prepared by the Farley Health Policy Center for the
Colorado Department of Human Services

Eugene S. Farley, Jr. Health Policy Center
UNIVERSITY OF COLORADO **ANSCHUTZ MEDICAL CAMPUS**

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About the Authors

The Farley Health Policy Center (FHPC) at the University of Colorado Anschutz Medical Campus strives to advance policy that overcomes fragmented systems and addresses the wholeness of a person – physical, behavioral, and social health in the context of family, community, and the healthcare system. The FHPC works with state agencies and policymakers to understand and inform achievable policy actions to improve the integration of behavioral health across health and healthcare systems. The FHPC was contracted by the Colorado Department of Human Services in June 2019 to facilitate the three Behavioral Health Task Force subcommittees: Children's Behavioral Health, State Safety Net, and Long Term Competency, established by Governor Polis.

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"We can and must do better to transform our system for Coloradans living with a behavioral health condition so that they have access to affordable, high-quality, and patient-centered care."

– Governor Jared Polis

Executive Summary

Introduction

Colorado is home to vibrant and diverse people, reputed to be health conscious with abundant opportunities to thrive in all types of communities. It is therefore discordant that Colorado ranks in the bottom half of all states in prevalence of mental illness and access to mental health care for both adult and youth populations.[1] With an investment of more than $1 billion annually toward Colorado's behavioral health system, the demand for improved health outcomes and accessible, high quality services is universal. Governor Polis set to address Colorado's behavioral health crisis, establishing the Behavioral Health Task Force (BHTF) to develop a blueprint to transform the state's behavioral health system. First and foremost, this process of system reform would be informed by stakeholders from across the state representing those who seek, deliver, administer, and pay for care. Four committees were created to prioritize and address behavioral health needs — a main task force with three subcommittees, Children's Behavioral Health, State Safety Net and Long Term Competency. Their charge from state leadership was to be bold and undeterred by either known or unforeseen barriers. Subcommittee recommendations for improving the behavioral health system are delivered after 12 months of committed work together. Mid-year, upon the global disruption of the COVID-19 public health crisis, subcommittees were encouraged to go forward with presenting the right solutions for reform and not be derailed by ensuing budgetary restrictions. Subcommittees recognize that budget will directly affect implementation, but suggest that these are the reforms required to ultimately address the shortfalls in the behavioral health system. The final blueprint, entitled The Remedy for Behavioral Health Reform, will strive to define and articulate recommendations to meet the behavioral health needs of Coloradans today, with a vision and implementation plan for more secure and equitable behavioral health and wellbeing in the future.

This report, developed and compiled by the Farley Health Policy Center, delineates the work of each of the three subcommittees and describes a comprehensive approach to defining focused recommendations. These recommendations were further vetted and culled by the Main Task Force to determine inclusion in The Remedy for Behavioral Health Reform.

Process

Each subcommittee included representatives from many different sectors and disciplines with experience within the behavioral health system, including direct service providers, managers and directors, system administrators, technical experts, and individuals and family members with lived experience. Subcommittees met for 3-4 hours in-person and virtually each month to discuss critical subject matter, and develop, and vote upon recommendations. Public testimony sessions were held in locations across the state. These testimonies served as a valued component to inform discussion, and to ground and validate recommendations.

The three subcommittees shared common values and guiding principles but were built upon differing mandates. The Children's Behavioral Health Subcommittee articulated the necessity of developmentally appropriate care, engagement and strengthening of family systems, and creation of supports and pathways between the child and adult system and services that specifically address the unique needs of children and youth, ages 0-26. The State Safety Net subcommittee sought to ensure that any Coloradan would have access to quality behavioral health regardless of acuity level, ability to pay, co-occurring disabilities or geographic location. The Long Term Competency subcommittee developed recommendations to address federal requirements that Colorado had previously failed to meet in providing competency evaluations and restoration services, and focused on the intersection between behavioral health and criminal justice systems.

Key Findings

Key findings fell into eight main areas: access, comprehensive continuum of services, workforce, financing, governance, quality, social determinants of health, and specific populations in need for additional focus. To improve the behavioral health and well-being of Coloradans, subcommittees discussed, wrote, and approved recommendations in each of these areas, offering solutions that are specific and tailored to the populations of focus.

ACCESS

Overwhelmingly, the common concern across the three subcommittees is access. All Coloradans deserve equitable access to a full continuum of behavioral health services needed to remain well in their own communities. Access to the right services, in the right place, at the right time. Access to services that are trauma-informed and culturally and linguistically responsive. Access to services to manage crisis, avoid intersection with law enforcement and the criminal justice system, and recover and maintain wellness in community-based settings.

COMPREHENSIVE CONTINUUM OF SERVICES

Both the Children's Subcommittee and the State Safety Net Subcommittee recommend a comprehensive continuum of services be available for children, youth, and adults. Informed by an Institute of Medicine framework[2] and Substance Abuse and Mental Health Services Administration (SAMHSA) service continuum,[3] the subcommittees developed behavioral health service arrays built on promotion, prevention, and early identification, with outpatient treatment, high-intensity treatment, in-patient treatment, crisis system and recovery. Essential supports for these service continuums include care coordination and case management, delivery of services in community-based settings, and investment in expanded access to telehealth services. The experiences and expertise of subcommittee members and stories from public testimonies indicate significant differences in the availability and quality of services across the continuum in different parts of the state. A comprehensive service gap analysis is needed to develop targeted plans to address these gaps and may be informed by the Population In Need study, being conducted for the Office of Behavioral Health (OBH)

concurrently with the work of the BHTF. Additional research may be needed to understand the gaps in publicly-funded and commercial services and future work is needed to develop and implement uniform service definitions across providers and agencies.

The Long Term Competency Subcommittee recommends the inclusion of specific service types, such as Assisted Outpatient Treatment and behavioral health services in jails. While the Long Term Competency Subcommittee had a specific and necessary focus on the competency population and the intersection of the criminal justice system with individuals with behavioral health needs, all recommendations for the subcommittee are couched in the value that the criminal justice system should not serve as the de facto behavioral health system: individuals should not have to be arrested or incarcerated to access behavioral health services. Services provided within the criminal justice system should be available and accessible within the civil behavioral health system and community behavioral health services should be available to those most at risk for incarceration to prevent and divert from detention.

WORKFORCE

The delivery of high-quality behavioral health services is dependent on a high-quality behavioral health workforce. Subcommittees offer recommendations to increase the number, type, and diversity of behavioral health professionals across the state with investments in recruitment, retention, and training. Workforce investments were identified for licensed behavioral health providers, such as psychologists and social workers, and as well as for other direct behavioral health service providers, including peers or program staff, to increase the racial and ethnic diversity of the workforce and improve geographic distribution. Workforce recommendations include strategies for training and other methods to improve the competency to care for specific populations. With an additional emphasis in the safety net systems, the State Safety Net Subcommittee recommends increasing peer support programs across the state, creating pathways for peers to bill Medicaid and other providers, and including peers as part of network adequacy requirements.

FINANCING

To ease access to behavioral health services, subcommittees recommend streamlining funding. Currently, there are over 60 funding streams for publicly funded behavioral health services, which create barriers to individuals and families accessing services. Both the Children's Subcommittee and State Safety Net Subcommittee recommend reimbursement for a set of essential services for children, youth, and adults to support the delivery of a comprehensive service array as well as flexible funding to respond to local and emerging needs.

GOVERNANCE

To inform the BHTF decision about the governance of the state's behavioral health system, discussions occurred in two subcommittees: The State Safety Net Subcommittee calls for a governance structure that streamlines an individual's access to services regardless of payer (i.e., reduces the 60+ "wrong doors"), ensures timely access, offers centralized system navigation services and establishes a core set of essential services that are readily available across the state. The Children's Subcommittee recommends a distinct infrastructure within any governance structure to oversee and be accountable for the services for all children, youth and young adults, ages 0-26. As the largest payer of behavioral health services in the state, subcommittee members call for the Department of Health Care Policy and Financing's (HCPF) alignment with the behavioral health governance structure to reduce administrative burden to providers and coordinate oversight, regulations, and policy.

QUALITY

Subcommittee members recommend a data-driven approach to continuous system improvement. However, the mixed understanding of the current metrics collected and publicly available among subcommittee members underscores the necessity to first assess existing data already collected across the system. Ideally, with an understanding of the current state of data collection and reporting, any development or prioritization of uniform metrics (i.e., a minimal data set) will be consistently defined across the system and will not add administrative

burden on providers or facilities. To enhance care coordination and continuity of care, investment in data infrastructure and health information exchange is needed across providers and systems (e.g., education and healthcare; civil and criminal systems).

SOCIAL DETERMINANTS OF HEALTH.

In all aspects of work, subcommittees considered the impact of social determinants of health including transportation barriers, access to healthy food, and social support systems as necessary components to behavioral health and well-being. Subcommittees call for permanent supported housing and supportive employment programs to ensure basic needs are met, allowing individuals to meaningfully engage in care.

SPECIFIC POPULATIONS.

While the subcommittees each had a population of focus, there were specific subpopulations within and across each subcommittee that members highlighted as needing tailored approaches or additional resources to equitability deliver services and address current population-based health disparities. While this list is not exhaustive, some populations prioritized by subject matter experts and individuals with lived experience for system improvements include: individuals with cognitive or physical disabilities and co-occurring behavioral health needs; individuals with Fetal Alcohol Syndrome; children in the child welfare system; transition-aged youth; LGBTQIA+ youth; communities of color; and the forensic population, or individuals who cycle in and out of the criminal or juvenile justice system.

Legislation

On June 29, 2020, the first piece of legislation derived from work of the BHTF, Senate Bill (SB) 20-181, was signed into law by Governor Polis. SB 20-181 helps ensure individuals are not held in jail when facing low-level charges and competency is in question or when restoration is unlikely due to a severe disability regardless of the charge. The Long Term Competency Subcommittee worked with primary sponsors, Senator Pete Lee and Representative Michael Weissman, on measures to improve outcomes for defendants who may be incompetent to proceed.

Conclusion

There is no quick fix to improve the behavioral health and well-being of Coloradans. A year of focused and extensive work is reflected in the subcommittees' recommendations. Implementation will require continued commitment from diverse and committed stakeholders across Colorado to carry this work forward. The subcommittees' work informs The Remedy for Behavioral Health Reform; implementation will require more discussion, more debate, and more collaboration. Optimistic yet pragmatic leadership will be essential to continue to push stakeholders and state agencies alike towards system reform that will result in better health that includes meeting the behavioral health needs of all Coloradans.

Nancy Jackson, Arapahoe County commissioner and co-chair of the State Safety Net Subcommittee, closed the final State Safety Net Subcommittee meeting reflecting on John F. Kennedy's quote on choosing to go to the moon, likening this endeavor with the resonating truth that we will pursue global improvements in behavioral health:

> "We choose to go to the moon in this decade and do the other things, not because they are easy, but because they are hard, because that goal will serve to organize and measure the best of our energies and skills, because that challenge is one that we are willing to accept, one we are unwilling to postpone, and one which we intend to win."

We are unwilling to let more Coloradans suffer and die because of inadequate access to behavioral health care. The continued work to improve the system to meet the behavioral health needs of all Coloradans will not be easy, and it is up to every one of us to continuously strive for better outcomes. Behavioral health must be at the forefront of the minds of policy makers, legislators, state agency leaders and staff, communities, service providers, and family members so that we never stop paying attention, do not accept the status quo and continuously work towards solutions that meet the behavioral health needs of people living in Colorado.

Introduction

Purpose

Colorado dedicates over $1 billion annually to its behavioral health system,[4] yet in 2020 Colorado was ranked in the bottom half of all US states in prevalence of mental illness and access to mental health care for both adult and youth populations.[1] Moreover, Colorado's suicide rates are among the highest in the country.[5] Consequently, on April 8, 2019, Governor Jared Polis directed the Colorado Department of Human Services (CDHS) to spearhead the BHTF. The BHTF includes four working groups: the governing Main Task Force, the Children's Behavioral Health Subcommittee, the State Safety Net Subcommittee and the Long Term Competency Subcommittee. The Main Task Force and three subcommittees are comprised of interdisciplinary experts representing all regions of the state who were tasked with evaluating and developing a roadmap to improve the state's behavioral health system while optimizing resources.

The strategic vision for this blueprint, to be known as The Remedy for Behavioral Health Reform, is to guide system reform in order to ensure that every Coloradan experiencing behavioral health needs can receive timely, cost effective, and high-quality services in their own communities.

This report delineates work of the three BHTF subcommittees (Children's Behavioral Health, State Safety Net and Long Term Competency), which the Farley Health Policy Center was responsible for facilitating.

Colorado Behavioral Health Task Force Composition

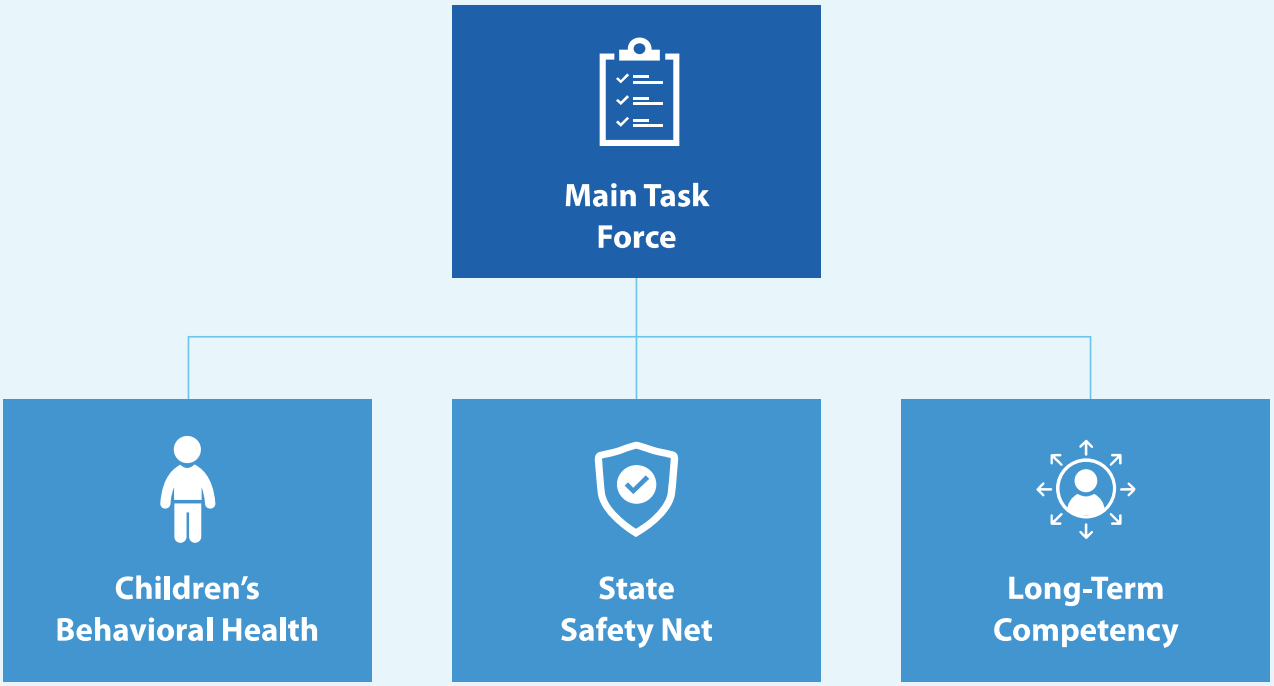
Members of the BHTF (Main Task Force and three subcommittees) were chosen from almost 500 applicants across the State of Colorado to include individuals who represent diverse, multi-disciplinary, multi-sector, and balanced perspectives with respect to behavioral health issues. Members included consumers and families, key executives representing state and local government, criminal justice experts, advocates, clinicians and subject matter experts in behavioral health.

The Main Task Force was comprised of 27 members, plus six ex-officio members. The Main Task Force was led by six Executive Committee members, including a County Commissioner, the Lieutenant Governor, and representatives from CDHS, HCPF, the Colorado Division of Insurance (DOI), the Colorado Department of Public Health and Environment (CDPHE). The Main Task

> *"This new task force will be responsible for developing a statewide, strategic blueprint to reform our system with the goal of improving the efficacy and efficiency of our behavioral health system."*[4]
>
> *– Governor Jared Polis*

Force acted as the governing entity to guide the work of three subcommittees named by Governor Polis: the State Safety Net Subcommittee (24 subcommittee members, plus three ex-officio members), the Children's Behavioral Health Subcommittee (25 subcommittee members, plus one ex-officio member), and the Long Term Competency Subcommittee (25 subcommittee members). Please see Appendix 1 for names of all members of the Main Task Force and subcommittees.

Figure 1. Colorado Behavioral Health Task Force and Subcommittees



Colorado Behavioral Health Task Force Vision

The goal of the BHTF is to provide recommendations that, when implemented, will make behavioral health services in Colorado **comprehensive, equitable,** and **effective**. These three values identified by the Main Task Force are guiding the development of the Remedy for Behavioral Health Reform and are articulated in the Main Task Force vision statement, which is to design a ***comprehensive, equitable, effective*** *continuum of behavioral health services that meets the needs of all Coloradans in the right place at the right time to achieve whole-person health and well-being.* The three BHTF subcommittees considered this overarching vision when developing their individual guiding principles to direct their work.

Subcommittees were encouraged from the start to think big and put forward bold recommendations that they believe are necessary to reform the behavioral health system in Colorado. All recommendations need review to identify whether statutory or budgetary changes will be required to effectively resource and implement.

Subcommittee Processes

Multi-stakeholder groups like the BHTF are brought together because of their differences, with the intent of multiple perspectives being presented. Subcommittees committed to group agreements, including:

- making charitable assumptions,
- allowing space for all members to participate,
- remaining tough on ideas, but soft on individuals,
- staying solution oriented,
- leaving preconceived prejudices outside of subcommittee work,
- acknowledging roles,
- using words thoughtfully, and
- using person-first language.

Members of all three subcommittees had to grapple with bringing both personal and professional experiences to the table while remaining open to listening to and exploring ideas representing very different perspectives. Conflicts arose, differences were expressed, multiple solutions were presented, driving a diverse group to make the best decisions they could with the information they had. Members of the three subcommittees, the Senior Advisor for Behavioral Health Transformation, and the facilitation team remained committed to this often challenging process in order to deliver recommendations to the Governor that they believe will improve the health of Coloradans across the lifespan.

Each subcommittee convened monthly for 3-4 hours. As work progressed, additional in-person meetings and webinars were held to facilitate the work. In-person meetings with remote participation available were held July 2019 through mid-March 2020. All subcommittee meetings April through June 2020 were held virtually due to COVID-19.

All subcommittee meetings were open to the public. Ten minutes were reserved at every meeting for public comment and members of the public were encouraged to participate in small group discussions within meetings. Public testimony opportunities were organized around the state to allow for individuals and families to share personal experiences with behavioral health services in Colorado. These recorded testimonies were often shared at subcommittee meetings to spark discussion and inform recommendations.

Agendas for all subcommittee meetings were set jointly between the Farley Health Policy Center facilitation team, the Senior Advisor for Behavioral Health Transformation and respective subcommittee co-chairs. Meetings combined subject matter expert presentations to inform subcommittee work with facilitated discussions and small group work to accomplish pre-determined meeting objectives. Voting on final recommendations required a quorum of subcommittee members or designated substitutes or proxies. Recommendations were approved with a majority of the quorum. Voting record of approved recommendations is included in Appendix 2.

Significant work occurred between meetings, including drafting and editing of recommendations and completion of surveys to provide feedback and subject matter expertise on evolving work. The Farley Health Policy Center team worked with co-chairs and the Senior Advisor for Behavioral Health Transformation to collect and synthesize data to maintain momentum of work in progress across the subcommittees and inform future agendas.

Subcommittee co-chairs provided monthly updates at the Colorado Behavioral Health Task Force meetings, where feedback on subcommittee progress and final recommendations was solicited.

Meeting minutes including formal results of voting were recorded, approved by subcommittee members and posted publicly. All agendas, recordings and supporting materials for subcommittee meetings are available on the Colorado Behavioral Health Task Force website, https://www.colorado.gov/pacific/cdhs/colorado-behavioral-health-task-force.

Please refer to Appendix 3 for overview of subcommittee meeting dates, meeting objectives, between meeting assignments and subcommittee votes.

COVID-19

In March of 2020 with the onset of the COVID-19 public health crisis and statewide stay at home orders, BHTF work was temporarily paused to support subcommittee members in prioritizing their professional time and attention to meet the needs of their individual employers, organizations and patients. From March 16 through April 18, 2020, formal BHTF meetings were suspended. During that time, subcommittee members were invited to optional web-based workgroup meetings to inform The Remedy for Behavioral Health Reform recommendations, but work on subcommittee specific objectives was paused. Upon return to virtual meetings the week of April 20, 2020, subcommittee timelines were extended by one month and BHTF leadership advised subcommittees to continue work towards drafting recommendations that would best support the redesign of behavioral health services in Colorado, in a time when behavioral health needs were becoming more relevant and urgent to even more Coloradans. Recommendations in this report reflect what the BHTF subcommittees believe needs to be done to improve access, equity, financing, and delivery of behavioral health services in the state, despite budget constraints evolving in the wake of COVID-19.

Of note though not directly addressed in this report, in May of 2020 Governor Polis directed the BHTF to create a new Covid-19 Special Assignment Committee, co-chaired by CDHS and CDPHE. The goal of this special assignment committee is to:

- Evaluate the behavioral health crisis response in Colorado to COVID-19 and provide recommendations for The Remedy for Behavioral Health Reform on improvements of behavioral health services for response during any potential future crisis.
- Create an interim report that highlights the short- and long-term impacts of COVID-19 on the behavioral health system, including access to behavioral health services, especially for vulnerable and underserved populations.

Cross-Cutting Values

Each BHTF subcommittee developed unique value statements and grounding principles, however, fundamental values related to delivery of behavioral health services were cross-cutting and established a foundation for the development of recommendations.

PROVIDE EASY ACCESS TO CARE

Provide equitable and unobstructed access to behavioral health services, including easily accessible options for behavioral health care and related supports in the community regardless of complexity of the presenting problems, ability to pay, criminal history, zip code, payer source, culture, or other factors. Provide "no wrong door" access, in which individuals will be connected to an appropriate level of care in a timely fashion.

ADDRESS SOCIAL DETERMINANTS OF HEALTH

Provide transportation and other accessibility solutions to connect individuals and families with needed services, provide accessible and inclusive housing options that prevent homelessness and rapidly re-house individuals when needed, provide access to food and clean water, and consider community resources including employment, childcare, and high-speed internet access.

PROVIDE A CONTINUUM OF SERVICES

Define and provide a continuum of behavioral health services across the lifespan, including promotion, prevention, early identification, treatment, and recovery.

PROVIDE WHOLE-PERSON CARE

Provide access to whole-person care, including access to care that integrate physical and psychological health. Provide culturally and linguistically responsive care, trauma-informed care, individual- and family-centered care, and emphasize all aspects of health, including wellness.

IMPROVE WORKFORCE

Increase the number, type, diversity, and investment in behavioral health professionals across the state.

Subcommittee Work

Each subcommittee was established based on a unique set of mandates from the Governor and the Colorado General Assembly. Guiding principles aligned the work, but very different goals drove specific efforts and required different approaches to achieve final recommendations. As presented here, each subcommittee had a different purpose and composition. The work of each subcommittee reflects their stakeholder expertise and the differences in activities that resulted in recommendations for the Main Task Force's consideration, prioritization and inclusion in the Remedy for Behavioral Health Reform.

Children's Behavioral Health Subcommittee

As reported in the 2018 Roadmap to Children's Behavioral Health 4-Year Strategic Plan,[6] Colorado ranked 48th in the country when analyzing several indicators including the prevalence of mental illness and access to care for children and youth. Suicide was reported the leading cause of death among Coloradans between 10 and 24 years old, and nearly one in three Colorado high school students reported experiencing sadness or hopelessness that impacted their usual activities for at least two weeks. Colorado ranked 47th in the US for the prevalence of youth with major depression, and was worst for rates of youth alcohol dependence and illicit drug use. The task of the Children's Behavioral Health subcommittee was to improve outcomes by developing a plan to address delivery and management of children's behavioral health.

Mandates from Governor Polis

1. Options to increase and enhance efficient and effective behavioral health services to children and youth
2. Efforts between state agencies and community partners to increase public understanding and awareness of child and youth behavioral health needs
3. Shared children and youth behavioral health policies to remove administrative barriers to facilitate collaboration between communities, Southern Ute Indian Tribe, Ute Mountain Ute Tribe and American Indian/Alaska Native-serving organizations, state departments, and political subdivisions of the state
4. Children and youth behavioral health recommendations, where appropriate, to enhance efficiency and avoid duplication of service delivery, referral, and entry point, and funding mechanisms for behavioral health services for children and youth
5. The need for comprehensive wrap-around services and case management and coordination for children and youth
6. The need for comprehensive screening and early intervention and prevention services for children, youth and families
7. Strategies to promote behavioral health for youth and adolescents in school and community settings, including strategies to protect against mental health challenges, suicide, and substance use
8. Changes in how children and youth behavioral health is governed ensuring services work seamlessly when children and their families are involved in multiple systems
9. Strategies to address the needs of children and adolescents who become "stuck" between systems, including exploring community-based services and other strategies
10. The need for comprehensive support for children and youth who are transitioning out of foster care or out of the custody of the Division of Youth Services

Legislative Mandate - Senate Bill 19-195

Senate Bill 19-195 mandates that HCPF shall seek federal authorization to provide wraparound services for eligible children and youth who are at risk of out-of-home placement or in an out-of-home placement. The act requires HCPF, in conjunction with CDHS, to develop and implement wraparound services for children and youth at risk of out-of-home placement or in an out-of-home placement. The Children's Behavioral Health Subcommittee considered this legislation in their work and aligned recommendations to support the work of HCPF and OBH.

Guiding Principles

To specialize the BHTF value statement to meet the needs of children, youth and families, the Children's Behavioral Health Subcommittee developed the following guiding principles which recognize the necessity of developmentally appropriate care, engagement and strengthening of family systems, and creation of supports and pathways between the child and adult system and services that specifically address the unique needs of children and youth, ages 0-26.

A comprehensive behavioral health system for children and youth must be:

COMPREHENSIVE

- Focuses on individuals and families, respecting the agency of the child and family in solutions and services
- Addresses social determinants of health
- Coordinates for normalization across systems and sectors: social services (housing, employment, food, etc.), public health, health care, education, criminal justice systems
- Provides a continuum of developmentally appropriate services that recognizes wellness across the spectrum of promotion, prevention, treatment, and recovery
- Increases the number, type, diversity, and investment in behavioral health professionals across the state
- Integrates physical and behavioral health services for "no wrong door" access

EQUITABLE

- Provides equitable and unobstructed access to behavioral health services (regardless of zip code, payer source, culture, etc.)
- Provides easy access to culturally and linguistically responsive services
- Insures easy access to trauma-informed care
- Supports a statewide safety-net system that provides services to all individuals regardless of complexity

EFFECTIVE

- Creates a state-wide system tailored for locally driven, community-based, timely solutions
- Ensure accountable and sustainable allocation of financial resources
- Establishes quality assurance processes to support provision of evidence-based services and monitor service outcomes
- Uses data driven continuous quality improvement and evaluation at population and individual levels
- Prevents worsening systems or involvement in the criminal or juvenile justice system

Subcommittee members worked both in small groups and as a whole to refine recommendations that they could support, always prioritizing the consumer experience and meeting the needs of children and youth in Colorado. When grappling with complex and consequential matters of policy and institutional change, such as finance and governance structures, robust debate ensued that at times challenged the group and informed how the subcommittee moved forward, managed timelines or ordered topics of discussion leading to recommendations. As mentioned previously, effective multi-stakeholder processes should be intentionally structured to elicit input from a diverse and knowledgeable group of individuals from differing perspectives. This process pushed and encouraged individuals and the organizations they represent to challenge one another, leading to recommendations that the majority of the subcommittee could ultimately support.

After discussion and debate, the subcommittee decided the population of focus would include children and youth ages 0-26. This upper age limit was decided to reduce "hard breaks" in the system that create gaps for transition-age youth, and is mainly attempting to address distinct populations like foster care youth and youth with disabilities (i.e., intellectual and developmental disabilities (IDD) or Autism Spectrum Disorder (ASD)) where parents may still be actively involved in their care. This age is not a mandate, but rather a range that is intended to dovetail into the adult system. When looking at where system breaks currently exist, and where members fall through the cracks (whether through access, funding, or otherwise), it is helpful to consider the overlaps (former foster care - up to age 26; Clubhouse services range from 15-26, insurance under a guardian stops at age 26, etc.). Additionally, SB 19-195 legislation defined youth as ages 0- 26. High school and college health clinics will deal with similar issues if students remain on their parent's insurance, and these services would benefit from being aligned and informed by a system that considers these ranges. In practice, most individuals 18 and older will seek out and engage in services with an adult system. However, for those who do not, or cannot, setting an upper age limit of 26 will help ensure proper oversight and support to eliminate as many gaps as possible.

Subcommittee work towards final recommendations was also supported by review of foundational documents from previous work completed in Colorado to support transformation of the children's behavioral health service delivery and webinar format presentations to provide context and highlight work happening in Colorado parallel to the BHTF. These provided insight to avoid duplication and optimally encourage alignment across multiple entities and efforts. These included the 2015 report completed by the Colorado Children's Campaign, Young Minds Matter: Supporting Children's Mental Health through Policy Change,[7] and presentations from HCPF and OBH on the current legislative landscape (11/12/2019), and Families First Colorado, highlighting their ongoing work to support legislation allowing local child welfare agencies to use federal funding to pay for services that prevent the removal of a child or teen from their home (1/14/2020).

OBH presented qualitative analysis of 34 public testimonies from children and youth across Colorado (6/9/2020). Outcomes indicate that the top five concerns reported by youth in the testimonies were 1) a need for increased community education, 2) access, 3) timely care, 4) a need for more early intervention, and 5) challenges with payers. These align with and are reflected in the recommendations from the Children's Behavioral Health Subcommittee.

A workgroup assembled to further identify ways to solicit youth voice regarding their experience with the Behavioral Health System created and distributed a survey through youth-serving organizations and advocates across the state. A total of 367 individuals between the ages of 12 and 26 responded. Further synthesis of survey outcomes will be available from OBH after the submission of this report, but identified concerns related to access, timeliness, and stigma support recommendations put forward by the Children's Behavioral Health Subcommittee.

Building from the Roadmap to Colorado's Behavioral Health System for Children, Youth and Families,[6] the Children's Behavioral Health Subcommittee adopted the Building Systems of Care framework[8] to organize and prioritize recommendations. This framework defines a system of care as a broad, flexible array of effective services and supports for a defined multi-system involved population, which is organized into a coordinated

network, integrates care planning and care management across multiple levels, is culturally and linguistically competent, builds meaningful partnerships with families and with youth at service delivery, management and policy levels, has supportive management and policy infrastructure, and is data-driven. Through small group discussions answering the questions, 1) What are the priorities or big issues this subcommittee should focus on; and 2) What will success look like for the Children's Behavioral Health Subcommittee, the subcommittee narrowed to the following categories to make actionable recommendations to the Behavioral Health Task Force: Governance, Quality, Financing, Service Array, Workforce, and Access.

Children's Behavioral Health Subcommittee Recommendations

A small workgroup within the Children's Behavioral Health Subcommittee convened to consider which recommendations passed by majority in the subcommittee should be prioritized, given the budget and implementation implications of the COVID-19 public health crisis. These recommendations have been labeled as COVID-19 priorities in blue font. New recommendations emerging from this workgroup that were not voted on in the Children's Behavioral Health Subcommittee are being presented for approval by the COVID-19 Special Assignment Committee.

GOVERNANCE

COVID-19 priority recommendation: Children and youth are not simply small adults. They have unique needs, experience unique challenges, and require unique supports and interventions. As a result, **WE RECOMMEND** that the State of Colorado design a distinct infrastructure within the Behavioral Health Governance Authority to oversee and be accountable for the services for all children, youth and young adults, ages 0-26, and their families, regardless of level of need or diagnosis. Whatever final design or locus of accountability is chosen by the BHTF, and in line with our mandate as a subcommittee, we believe reforming the current system to include a robust infrastructure, including leadership, staffing, and authority, dedicated to this population is essential.

There is a myriad of reasons why a distinct infrastructure for children and youth is appropriate.

- ***Needs.*** Children and youth require developmentally appropriate remedies and culturally responsive services. They also need high-fidelity wraparound systems. The needs of the family system should be integrated into service provision.
- ***Timeliness.*** Children and youth need a structure that is empowered to direct and respond quickly. Timely intervention is exponentially impactful for children and youth. One example, the appeals process must be simplified so no youth and/or family is left waiting or without services when they need them the most.
- ***Flexibility.*** Children and youth need a system that has adaptability as the landscape constantly changes.
- ***Distinct Systems.*** Children and youth cross multiple sectors (e.g., schools, primary care physicians, foster care, juvenile justice, child welfare, etc.). The behavioral health system needs to coordinate across these sectors and reduce complex navigation needs.
- ***Department of Education.*** The education system must be equipped, engaged, and identified as partners to ensure coordination, alignment, and resources are available to children and youth where they can most easily access help.

- ***Confidentiality and Consent.*** The age of a child/youth creates unique challenges for both parents/caregivers related to access of services and information.
- ***Advocacy.*** Children and youth often do not have a voice in the decision-making process.
- ***Funding.*** Finances can be addressed separately (i.e., different approach). We also recognize that we need to be careful about splitting funding from adult services to ensure one does not rob the other.

Addressing behavioral health wellness early in life can lead to decreases in emotional and behavioral problems, functional impairment, and contact with all forms of law enforcement. It can also lead to improvements in social and behavioral adjustment, learning outcomes, and school performance.[9] We are committed to helping all Colorado children, youth, and young adults flourish and achieve whole-person health and well-being.

The distinct children and youth infrastructure should address the recommendations made by the Children's Behavioral Health Subcommittee of the BHTF, and more broadly:

1. Be accountable for the full scope of system functions which includes, organization and financing of services, improving access, availability of services, and workforce development.
2. Streamline administrative, management, and fiscal functions that shield families from payment disputes between agencies.
3. Be focused on prevention, to earliest possible identification, and to the full range of behavioral health resources.
4. Collaborate with DOI and commercial insurers to establish coverage for an essential benefits package that reflects the Colorado Continuum of Behavioral Health for Children and Youth and supporting service array recommendations.
5. Address the widespread problem of fragmentation and siloed systems to ensure statewide consistency, alignment, and collaboration.
6. Improve collaboration, communication and joint accountability among state, regional, and local child- and youth- serving entities, including the Department of Education and local schools.
7. Reduce duplication and redundancy of work to limit bureaucracy and ensure maximum resources go to services for members and families.
8. Improve quality, outcomes, and resource utilization (e.g., blended and braided funding and maximization of federal dollars).
9. Ensure network adequacy and improve access (i.e., promoting integrated primary care).
10. Ensure adequate stakeholder involvement, including providers as well as family and youth voice in governance.
11. Ensure implementation of a robust child and youth-focused mobile crisis response system and address the intersections of behavioral health and law enforcement.
12. Support expansion of trauma-informed care practices.
13. Recognize cultural-specific needs for children and their families, and respond in culturally responsive ways, which may be different for both.
14. Ensure health equity for all underrepresented groups and those persons furthest away from power (e.g., African Americans, LGBTQIA+, Hispanic/Latino, Tribal, Unsheltered, Refugees, deaf and blind, out of home placement, dual diagnosis, IDD, etc.).

QUALITY

Establishing structures that provide data to system builders and other key stakeholders to measure whether systems are improving the lives of children, youth and families being served in Colorado is essential to measuring outcomes and determining sustainability. These include structures to measure quality, provide feedback loops, and that have response (i.e., quality improvement) capabilities.

1. **WE RECOMMEND** that the State of Colorado determine clear, reasonable, and limited metrics to measure the quality of the Children's Behavioral Health system. This effort should first evaluate existing data points already collected across the system to limit adding more administrative burden on providers/facilities, as well as identify uniform data points, consistently defined, across the system over time. This effort should include metrics to understand statewide awareness of the system, access, unmet need, impact on member functioning and caregiver wellbeing, shared decision making, cost, utilization, and be designed to direct system improvement. This effort should ensure family representation on all quality review teams/initiatives of the behavioral health system.

2. In order to measure and support Colorado's child/youth behavioral health network **WE RECOMMEND** that the State of Colorado research, develop, and publish specific standards of care for children and youth, ages 0-26, that include network adequacy and access measures, wait time/waitlist limits, and general care considerations (time between appointments/services, length of treatment, episode of care, how many touches do members need to get services, efficient use of appointments, integrating multiple appointments in one system – medications, therapy, physical health, etc.). These standards should be aligned with evidence-based best practices, be developmentally appropriate, and specific for respective places of service.

3. **WE RECOMMEND** that the State of Colorado develop and adopt an Outcomes and Performance Dashboard with selected/limited metrics to measure child, youth, and family wellbeing across the state. This effort should align with existing work being done in the Delivery of Child Welfare Services Task Force and other child- and youth-focused systems, as well as help to streamline current quality measurements, and reduce unnecessary and burdensome administrative requirements across the system.

4. **COVID-19 priority recommendation: WE RECOMMEND** that the State of Colorado create a statewide behavioral health strategic plan with clear priorities and measurable goals to help align initiatives and resources across all child and family serving efforts. This strategic plan should include a glossary of common terminology and definitions of terms to promote clarity and consistency in communication and implementation of the plan (for example, suicide prevention efforts that span across state agencies; provider network procurements; align credentialing).

5 In order to promote and ensure transparency and accountability **WE RECOMMEND** that a statewide, unblinded dashboard for payers and behavioral health provider entities be published at least annually using a clear scale/grade and informed by the standards produced by the State of Colorado. This effort should be implemented with robust stakeholder input.

6 In order to address a patchwork of different programs that serve children and families and to determine the ideal distribution of programs along the service continuum, **WE RECOMMEND** that the State of Colorado partner with local stakeholders to create a menu of evidence-informed or promising practices and determine how to invest resources and workforce training for implementation. This should include specific guidelines for early childhood (children 0-8), school-aged children, adolescents, and youth 18+. This standard/model can help inform local communities, counties, and school districts regarding staffing ratios, program offerings, and partnerships, as well as analyze their resources/programs and address gaps as identified.

7 In order to get consistent data across the system and measure true utilization and impact, **WE RECOMMEND** that the State of Colorado create/implement a single identifier for each child, as in a Master Patient Index, to measure utilization throughout the system.

8 **COVID-19 priority recommendation:** In order to remove confusion and support children and families navigating across systems, **WE RECOMMEND** that the State of Colorado publish guidance and training for caregivers and providers to promote easy access to services and protect individuals' rights. This guidance should include information to address situations where parents are necessarily involved in the care of an adult dependent, where legal guidance/practice does not easily translate (e.g., between primary care settings, schools, and behavioral health facilities, as well as HIPAA/FERPA barriers to data sharing), where parents can and cannot access records and/or consent for treatment, and youth's rights to protect their records. This guidance should also address individual/family choice and privacy rights, and help train professionals (including teachers, front line staff, etc.) about the minimum information standards when communicating about a child, youth, or family.

FINANCING

Driven by a recommendation from a 2018 report, *Roadmap to Colorado's Behavioral Health System for Children, Youth and Families: 4-year Strategic Plan*,[6] Partners for Children's Mental Health contracted with the Colorado Health Institute to conduct a financial analysis of the current children's behavioral health system in Colorado. The report was completed in April 2020 and clarifies how state and federal funds are allocated in the current system, the services that these dollars are purchasing, and opportunities to reallocate funding. Key findings of the report indicate between $404 million and $810 million in federal and state funds support child and youth behavioral health services; highlight the complexity of the delivery system and resulting challenges of who is and is not being served; offer opportunities to improve the system through consolidation of funding streams, additional leveraging of federal dollars, and new investments in data collection.[10] The financial analysis report can be found here.

In addition to the financial analysis, the financial recommendations were informed by two other reports: *Risk, Reach, and Resources: An Analysis of Colorado's Early Childhood Mental Health Investments*[11] *and Youth Behavioral Health Services in Colorado School Districts.*[12] The intent of these recommendations is to include all payers that operate within the State of Colorado when feasible and legal.

1 In order to reduce fragmentation, allow for easier system navigation, reduce duplication, increase alignment and efficiencies, prioritize funding of direct services, improve data collection, and improve quality and access to care for children and youth who need it most, **WE RECOMMEND** consolidating children's behavioral health funding streams by eligibility criteria, program size, funding flexibility, and/or services provided across 6 state agencies/offices (i.e., OBH, CDPHE, HCPF, Colorado Department of Education (CDE), Colorado Office of Early Childhood (OEC), Colorado Office of Children, Youth and Families (OCYF)) and the identified 34 distinct programs, as suggested in the financial map.[10]

2 **COVID-19 priority recommendation:** In order to streamline billing and claiming processes; to support meaningful and consistent data collection; and to remove the burden from providers and family members, **WE RECOMMEND** the State of Colorado designate a single, publicly funded, fiscal management system be used to account for funds for all publicly funded services, including HPCF, OBH, and OEC, and to allocate funds as necessary.

3 In order to maximize the use of state dollars by identifying opportunities to increase federal matching funds, **WE RECOMMEND** examining all services provided by state programs that don't get a federal match and changing those that could be provided using funding from Medicaid or Child Health Plan Plus, Individuals with Disabilities Education Act, Title IV-E, etc. while not compromising essential services within the service array. Colorado may be able to get the federal government to pay a greater portion of the cost or be able to deliver more services.

4 **COVID-19 priority recommendation:** Currently, children and youth can wait to receive care while state agencies and commercial carriers debate who is responsible to provide and pay for that care (i.e., the current Creative Solutions process). This happens when children and youth either fall into the gray area regarding populations each state agency is responsible for serving (the child or youth meets criteria for more than one state agency), or is dually insured. These negotiations should not prevent or delay the delivery of care or put at risk payment for the provision of care to the provider or family (beyond their covered benefits or maximum lifetime limits). In order to facilitate the timely provision of clinical services that meet the needs for children, youth, and families, and together with our recommendation to establish an essential services package and statewide utilization management guidelines, **WE RECOMMEND** that the State of Colorado implement a pay and chase model that identifies a single state agency to be responsible for reimbursement to a provider ("pay") for the entire cost of all services rendered up front. The identified single state agency will then be responsible for securing payment from the appropriate payer ("chase") based on an agreed upon funding hierarchy. If they are unsuccessful, this single state agency will maintain complete responsibility for the full payment for all services provided.

5 In order to maximize the dollars that are being deployed and to make informed decisions, **WE RECOMMEND** developing a systematic approach to collect information on children's behavioral health spending across the 6 state agencies/offices (i.e., OBH, CDPHE, HCPF, CDE, OEC, OCYF) to learn where dollars are going, for whom services are being provided, what services are being purchased, number and type of providers involved, where gaps remain, and how to maximize the utilization of resources across the entire array of services. This may include leveraging existing data infrastructure (i.e., Colorado Health Information Exchanges, Office of E-health, All-payers Claims Database) and/or investing in new data infrastructure.

6 In order to support primary care providers (PCPs) throughout the state with the assessment and treatment of behavioral health conditions of children, adolescents and young adults; to address statewide shortages of child psychiatrists throughout Colorado; and to potentially provide the infrastructure for consultation by other specialists related to the needs of children and families, **WE RECOMMEND** that the State of Colorado develop a sustainable funding stream for a statewide behavioral health consultation program.

This program should provide 1) Access for all Colorado families regardless of insurance status (i.e., all payers should contribute to this program), 2) Timely access for peer to peer consultation and education (telephone, e-consults or telehealth), and 3) Support to identify and connect families to local/telehealth mental health resources that provide evidence-based treatment. Based on the experience of programs in other states (e.g., child psychiatry access programs), we estimate that it would cost $2-2.50/child/year to support this program. Given the current population of Colorado, this program would require approximately $2.6-3.2M per year for sustainability.

Based on funding for other states' programs, options for sustaining this program include:

- Funding from the state general fund
- Funding from public and private payers based on proportional utilization of services over time or a per member per month fee for covered lives, ages 0-25, from both public and private payers
- Incorporation into HCPF's Accountable Care Collaborative
- Braided funding from medical, behavioral health and social service budgets
- Creation of an endowment to provide long-term support for the program

7 In order to improve access and authorization of behavioral health services across the state, **WE RECOMMEND** that the State of Colorado create a package of "Essential Services" for children's behavioral health needs that includes an annual mental health exam. The State of Colorado should conduct an annual review to determine which codes cover all essential services and ensure all payers have complied with the requirement to cover these. Additionally, the administrative processes for billing and claiming behavioral health codes should be reviewed to ensure they are at parity with physical health claims.

8 In order to maximize access to care, prevent patient escalation up the care continuum, reduce costs and promote prevention, early intervention, brief interventions, and other services that expedite the appropriate assessment and referral of patients, **WE RECOMMEND** that the State of Colorado open the Health and Behavior Assessment and Intervention codes (96150-96155), eConsult codes (99451, 99452), as well as work to make permanent any of the temporary guidelines related to telehealth services that are clinically appropriate. These codes should be allowed in as many places of service as are clinically appropriate.

9 Financial investment in prevention and promotion is needed for a robust child/youth behavioral health system. In order to support schools, PCPs, and early childhood key partners to prevent mental, emotional and behavioral health problems, **WE RECOMMEND** the State of Colorado consider the following actions:

- Include in the covered Essential Services bundle universal and targeted preventive behavioral health services that do not require a behavioral health diagnosis.
- Ensure that all communities provide access to behavioral health services through school-based providers or health centers or in partnership with other community-based services (Community Mental Health Centers, Federally Qualified Health Centers, etc.) and be required to follow legal confidentiality and consent guidelines as age appropriate.
- Enhance/expand OBH School Based Mental Health Specialist Program, the OEC Early Childhood Mental Health Specialist Program.
- Identify a statewide allocation goal for prevention dollars and move strategically toward that target. This does not have to be new funding, but rather a reallocation of existing funding to continue to invest in promotion and prevention services.

10 In order to equitably meet the needs of all Colorado students, teachers, and schools for a 21st century context that is increasingly tasked with addressing behavioral health needs of students without adequate resources, **WE RECOMMEND** that the State of Colorado evaluate the School Finance Act and modify the School Funding Formula to cover a core set of essential services for every student in the state within TIER 1 resources.

11 While data is limited, findings suggest youth ages 0 to 5 and 18 or older may be disproportionately under-funded compared with school-aged youth, and opportunities exist to reduce disparities in funding among racial, ethnic, and disability groups. In order to promote equity in behavioral health funding and to ensure funds are distributed to services for the youth populations that need them the most, **WE RECOMMEND** tracking spending based on age, gender, sexual orientation, race, ethnicity, primary language, disability, and geographic region, and developing specific programs to address any identified inequities.

12 In order to make the behavioral health system more member-focused and reduce the barriers and complexity of navigating the system, **WE RECOMMEND** that the State of Colorado adopt a single, statewide utilization management guideline for all payers, aligned with an array of essential services. This will promote transparency in the system and reduce some level of grievance and appeals related to disparity in access to services across the state and among payers. This can also address parity issues related to access to physical and behavioral health services.

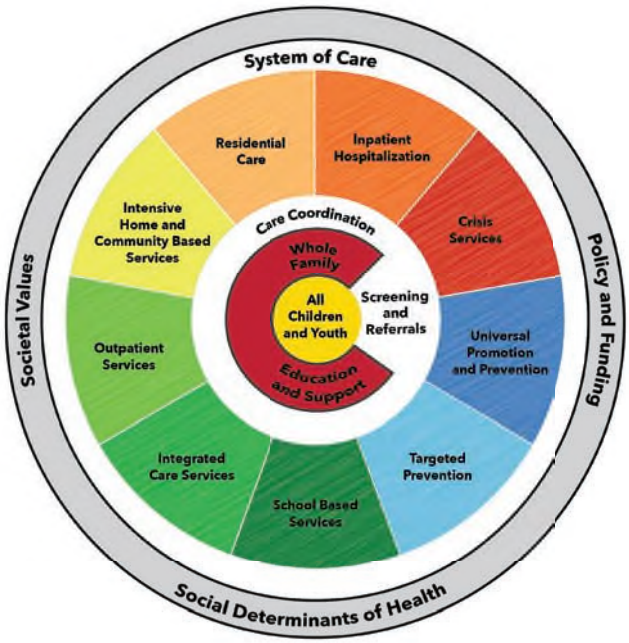
SERVICE ARRAY

To overcome the behavioral health crisis Colorado youth are experiencing, the following recommendations define and support a comprehensive continuum of care considered essential for children and youth across the state, ensuring that children have access to services where, when, and as needed.

1 ***Essential Services.*** **WE RECOMMEND** the State of Colorado adopt the Colorado Continuum of Behavioral Health for Children and Youth (See Figure 2 and Appendix 4). This Continuum defines essential services across the service array (from prevention to treatment and recovery) that should be accessible to all children across the state. The Continuum of care provides support services and interventions in a child and family focused way, across varying levels of intensity that incorporate and address the needs of both children and parents/caregivers. This includes provision of services directly to the child/youth that promote well-being and address behavioral health issues, as well as provision of services directly to adult caregivers in support of the child/youth.

- Reimbursement. **WE RECOMMEND** that essential services, as defined by the Continuum of Children's Behavioral Health Care in Colorado, be universally reimbursed at levels sufficient to cover the actual cost of care by all public and commercial insurance providers in Colorado.
- Service definition. **WE RECOMMEND** that the State of Colorado enforce fidelity of how essential services are defined.
- **COVID-19 priority recommendation:** Flexible funding. **WE RECOMMEND** that state-issued funding for essential children's behavioral health services allow for flexible allocation to respond to local and emerging needs in communities across Colorado**.**

Figure 2. Colorado Continuum of Behavioral Health for Children and Youth



2 ***Gaps.*** To understand where there are gaps in essential services as defined by the Continuum, **WE RECOMMEND** the State of Colorado complete a comprehensive service gap analysis to identify local, regional and systemic service gaps. This analysis would define and assess:

- **Timeliness.** Adequacy of timely access to essential services (timely access to be defined within context of service gap analysis), including entry points that allow services to be offered at the right level of need without requiring an outcome failure to move to the next step of services.
- **Workforce.** Adequacy of trained and competent workforce to support essential services.
- **Financing.** Level and distribution of financing to support essential services
- **Statute and Rules.** Review of legislative and regulatory policies that support or create barriers to access to essential services by all Colorado children and their families.

3 ***Prevention.*** In order to move upstream to prevent intensive and costly behavioral health problems, **WE RECOMMEND** investment in the infusion of promotion and prevention services where children and families seek support, including schools, healthcare and community settings.

4 **COVID 19 priority recommendation: *Integration.*** To support youth and families where they routinely access well-child and healthcare services, **WE RECOMMEND** investment in expanding integrated behavioral health services in primary care settings. This will increase access to screening and provide early intervention for lower acuity conditions, while ensuring strong referral mechanisms and linkages with specialty behavioral health providers for children and families in need of higher levels of care.

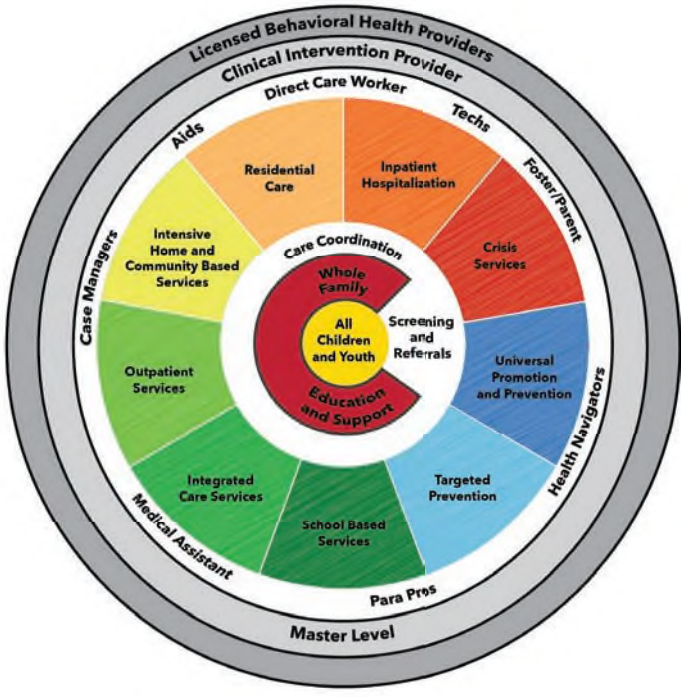
5 ***Care Coordination.*** To assure that youth and families can navigate the Continuum to access the right services at the right time, **WE RECOMMEND** investment in care coordination across the continuum.

1 **COVID-19 priority recommendation:** In order to measure and support Colorado's child/youth behavioral health network, **WE RECOMMEND** that the State of Colorado research, develop, and publish metrics and methods to determine the value and cost of behavioral health services that can inform statewide salary recommendations for the workforce. These metrics should include parity considerations and help inform reimbursement rates and caseload requirements for behavioral health providers.

2 In order to improve workforce retention and quality of care, **WE RECOMMEND** that the State of Colorado develop and adopt a spectrum of core competencies for Direct Care Workers (workers not currently monitored by Colorado Department of Regulatory Agencies (DORA), and who do not already have training and support in their workplace related to behavioral health and wellness), and align these competencies with appropriate scopes of work for each level of acuity/population. This could be modeled after the Youth Health Competency Framework which includes universal and core competencies for variety of individuals and teams working with young people.[13]

These competencies should include pediatric-specific topics such as family engagement, child development, cultural and linguistic inclusivity, and issues surrounding confidentiality and child safety. We believe this will enhance the quality of care for families by expanding the number of competent and trained staff at multiple levels throughout the workforce. We advise that this recommendation be implemented in such a way as to support the workforce and not add additional burden or barriers to participating in the workforce. See Figure 3 for examples of Direct Care Workers, and how they fit with other members of the workforce.

Figure 3. Workforce for the Colorado Continuum of Behavioral Health Care for Children and Youth



3 **COVID-19 priority recommendation:** In order to create a potential career ladder (or Tiered Workforce) that serves as a workforce pipeline, and to focus the work of licensed behavioral health providers on the highest acuity clients as they work at the top of their licensure, **WE RECOMMEND** that the State of Colorado:

- Create a series of endorsements (not certificate or license) supported by a clearinghouse of approved training modules (Motivational Interviewing, Mental Health First Aid, Trauma, Suicide Prevention, etc.) that are aligned with core competencies and best practices for Direct Care Workers, and which follow the worker across child/youth-facing health care roles. This could be modeled after the CO Association for Infant Mental Health (http://coaimh.org/) Endorsement or the Alaska Behavioral Health Aide program.
- Adopt a strong incentive program for employers and educational institutions to recognize these endorsements and support staff training in order to become the cultural expectation for entities that provide behavioral health services. (A system of core competencies or voluntary credentials will not have impact unless paired with a robust incentive system. Colorado Shines, an early childhood multi-level quality rating system, may serve as a model to adapt for behavioral health: professionals can pursue additional levels of training and organizations can achieve higher tiers of reimbursement.)

4 In order to promote/increase competency in the behavioral health workforce for specific populations (LGBTQIA+, Tribal communities, etc.) and specific conditions (Substance Use Disorder (SUD), IDD, ASD, etc.), **WE RECOMMEND** that the State of Colorado:

- Identify specific populations and their needs and identify trainings that would address these needs.
- Work with respective agencies/entities to eliminate unnecessary and duplicative requirements that create barriers to providing and being reimbursed for services to these populations (i.e., OBH certification requirements for SUD providers/services).
- Develop minimum training guidelines for licensed staff to meet and maintain core competency standards (i.e., Licensed Professional Counselors are provided an addiction-specific continuing education seminar).
- Work with DORA and other entities to review and revise requirements to allow for cross discipline supervision within the workforce to open employment opportunities for our diverse workforce.
- Work with medical professionals in primary care settings who could treat lower acuity conditions (like Attention Deficit Hyperactivity Disorder) that would open capacity for child psychiatrists to work with more complex, higher acuity conditions.
- Support the development of a statewide pediatric telepsychiatry consultation program (i.e., Colorado Pediatric Psychiatry Consultation and Access Program).

5 In order to reduce the burden on providers and allow providers to dedicate as much time to clinical care as possible, **WE RECOMMEND** that the State of Colorado consider multiple efforts to support our workforce that include the following options:

- Work with DORA to streamline/implement reciprocity procedures to better facilitate licensed professionals moving into the state from other states or countries (i.e., refugees/immigrants).
- Work with HCPF and other state agencies to simplify and streamline credentialing processes to enroll providers with payers.
- Review and take action to reduce the administrative burden on providers related to billing/claims, reporting, data tracking, etc.

6 In order to attract and retain behavioral health providers to the workforce, **WE RECOMMEND** that the State of Colorado work with the respective agencies/entities to develop incentives that include the following options:

- Improve/strengthen the Colorado Health Service Corps loan repayment program to ensure that awards adequately cover the cost of completing internships and supervised hours required for licensure, that awards incentivize at least 5 years of rural and frontier service, and that award funds can increase to meet the growing need for services.
- Explore Housing supports that could remove barriers to behavioral health providers living in rural/resort communities. This can include partnering with cities who have income-restricted/income-qualified housing programs, or working with the Colorado Housing and Finance Authority to include behavioral health professionals in their preference policy for affordable housing options.
- Use flex funds to create a matching fund to incentivize organizations to offer "sign-on bonuses" for providers in such a way that encourages retention/commitment to these communities (i.e., percentages of bonus paid out for each year a provider extends their service, etc.).
- Identify a pool of licensed behavioral health providers who will offer supervision free of charge to master's level providers in exchange for loan repayment or other cost incentives (i.e., if a Licensed Clinical Social Worker (LCSW) will provide supervision for 2 years to a Licensed Social Worker free of charge, the LCSW will receive a state funded grant of $20,000 toward student loans, or a tax incentive/housing stipend toward rent if serving in a rural/frontier county).

7 In order to support the development of a robust, statewide behavioral health workforce, **WE RECOMMEND**:

- To the extent allowable, prioritize a part of every grant application written by the State be dedicated to workforce development (i.e., training toward core competencies, training toward best practices related to pilot programs, recruiting and skill-building toward new initiatives, etc.).
- **COVID-19 priority recommendation:** Seeking workforce expansion funds (i.e., https://www.hrsa.gov/grants/find-funding/HRSA-19-089).
- Prioritize a portion of state budgets to be used to support "career ladder" efforts.
- **COVID-19 priority recommendation:** Develop and promote workforce cultivation initiatives to reach students looking for career options (i.e., campaign to attract girls in STEM, occupational outlook handbook https://www.bls.gov/ooh/).

ACCESS

Access recommendations from the Children's Behavioral Health Subcommittee are offered in categories of screening, single point of entry, assessment and outreach. Recommendations related to screening, single point of entry, and assessment support the work of SB 19-195 (Figure 4).

SCREENING

1 Because screening and identification of behavioral health needs of children and youth should happen through PCPs, **WE RECOMMEND** a standardized approach to behavioral health screening that is normed to different cultures, languages and for the deaf and blind in primary care settings and schools.

2 To determine appropriate standardized screening tools in primary care as relates to SB 19-195, **WE RECOMMEND**:

- Convening a stakeholder group of PCPs, child and adolescent psychiatrists, and psychologists to identify a set of approved and developmentally appropriate screeners for use in primary care settings. This stakeholder group should:
  - Examine the list of 12 approved screeners from Massachusetts,14 and consider adding the Columbia-Suicide Severity Rating Scale (C-SSRS), Behavior Assessment for Children 3rd Edition, and Conner's Behavior Rating Scale.
  - Evaluate the set of tools periodically and add or remove screeners when appropriate.
  - Develop a workflow or decision tree to help PCPs determine when to use which screener.
  - Provide support / training to those within PCP offices that will be administering the screeners.
- Requiring that public and private payers in Colorado align and reimburse PCPs for a determined set of developmentally appropriate screeners.
- Requiring that identified screenings align with the periodicity schedule, a schedule of screenings and assessments recommended at each well-child visit from infancy through adolescence.

3 **COVID-19 priority recommendation:** Because schools play a critical role in helping identify youth that are struggling with social / emotional wellbeing, **WE RECOMMEND** developing a standardized approach to screening for social / emotional wellbeing in all Colorado schools by:

- Establishing a system where youth ages 12-18 are offered the opportunity to electronically complete a self-report screening tool, making data reporting, tracking, and needs identification possible statewide. For example, a school screening and assessment program in Cañon City uses the Behavior Intervention Monitoring Assessment System 2 (BIMAS-2). Youth in grades 6th – 12th receive the BIMAS-2 to their school email twice per year (assumption of passive consent with an opt out policy). The BIMAS-2 takes 2.5 minutes to complete and examines social, emotional, and behavioral health. It is normed nationally and identifies youth that fall outside the normal distribution and may need help. Youth are referred to a community provider if they ask for care or if a need or risk factor is identified

through the screener. Currently two people coordinate care across nine schools for 900 youth and additional navigation support is needed.

- Convening a stakeholder group of child and adolescent psychiatrists, psychologists, and child development specialists to identify a set of approved and developmentally appropriate screeners to be used in schools.
- Evaluating the set of tools periodically and adding or removing screeners when appropriate.
- Developing a workflow or decision tree to help school professionals determine the best screener for their children and adolescents.
- Providing support / training to those within schools that will be administering the screeners.
- Developing an implementation process for standardized screening in all school districts, including resources for making referrals and warm handoffs to community providers as needed.
- Creating data infrastructure to capture self-report data, analyze data, and flag students in need of supports.
- Identifying a navigator role to help support students with positive screens.
- Identifying an embedded social/emotional curriculum (e.g., Sources of Strength).

4 Because parents are in need of resources to support the emotional and behavioral health of children and youth, **WE RECOMMEND** creating a recognized and credible source to provide parent/care giver education on how to recognize and address behavioral health needs, such as the crisis brand and system, SEE ME Colorado or Children's MD built out for behavioral health.

SINGLE POINT OF ENTRY (SB 19-195)

1 Because of the current behavioral health system's complexity, and burden experienced by children, youth, and families in identifying need and accessing services, **WE RECOMMEND** a single point of entry to help individuals (including PCPs, schools, caregivers, and parents) navigate the behavioral health system. Considerations for a single point of entry include:

- Developing a point of entry so that any service provider administering behavioral health screening has a functional place to refer children and youth for services.
- Potentially leveraging the Colorado Crisis Services Hotline to fulfill this function at a state level, or expanding Crisis Administrative Service Organizations or Care Management Entities responsible for wraparound implementation at the regional level.
- Contributing to creation of a "no wrong door" system by not requiring that all children and youth with a behavioral health need use the single point of entry; that is, if needs are clear and care is accessible, then there is no need to access the single point of entry.

2 **COVID-19 priority recommendation: WE RECOMMEND** that the single point of entry be staffed with family navigators, community health partners, and/or peer specialists as a means to provide further needs assessment and to link families to resources in the community.

3 **WE RECOMMEND** the following considerations and functions of a single point of entry:

- Screening (if not completed already)
- Referral to a consistent assessment process
- System navigation across the multiple systems based on need and eligibility
- Warm handoffs to service provider organizations
- Follow the family and create a feedback loop for 3 months to ensure the link to needed resources was accomplished
- Development of universal consent and information sharing exchanges to facilitate access to care

4 **WE RECOMMEND** extensive marketing so that providers, schools, parents, and others are aware of the single point of entry, know its purpose, and know how to use it.

5 **WE RECOMMEND** measuring the effectiveness of the single point of entry.

ASSESSMENT (SB 19-195)

1 Because standardized approaches to assessment ensure similar levels of quality, equity and access for youth and families and allow for the collection and analyses of systems level data to support data-based decisions, **WE RECOMMEND** exploration of alignment across state agencies to use a single standardized assessment.

For example, there is currently some alignment with the Child and Adolescent Needs and Strengths Assessment (CANS) tool. The CANS is being adopted by Children and Youth Mental Health Treatment Act, the Systems of Care grantees, for SB 19-195 implementation, and through the child welfare Family First Prevention Services Act implementation to access the Qualified Residential Treatment Program level of care. A single standardized assessment tool could also be used by HCPF for implementation of high fidelity wrap around, for any child or youth who receives publicly funded behavioral health treatment and requiring enhanced community-based services or higher levels of care, and as the assessment required by OBH for mental health centers.

2 **WE RECOMMEND** the assessment is re-administered every 3 to 6 months to track progress and measure outcomes.

3 **WE RECOMMEND** standards and approaches to assessment apply to both publicly and commercially insured youth.

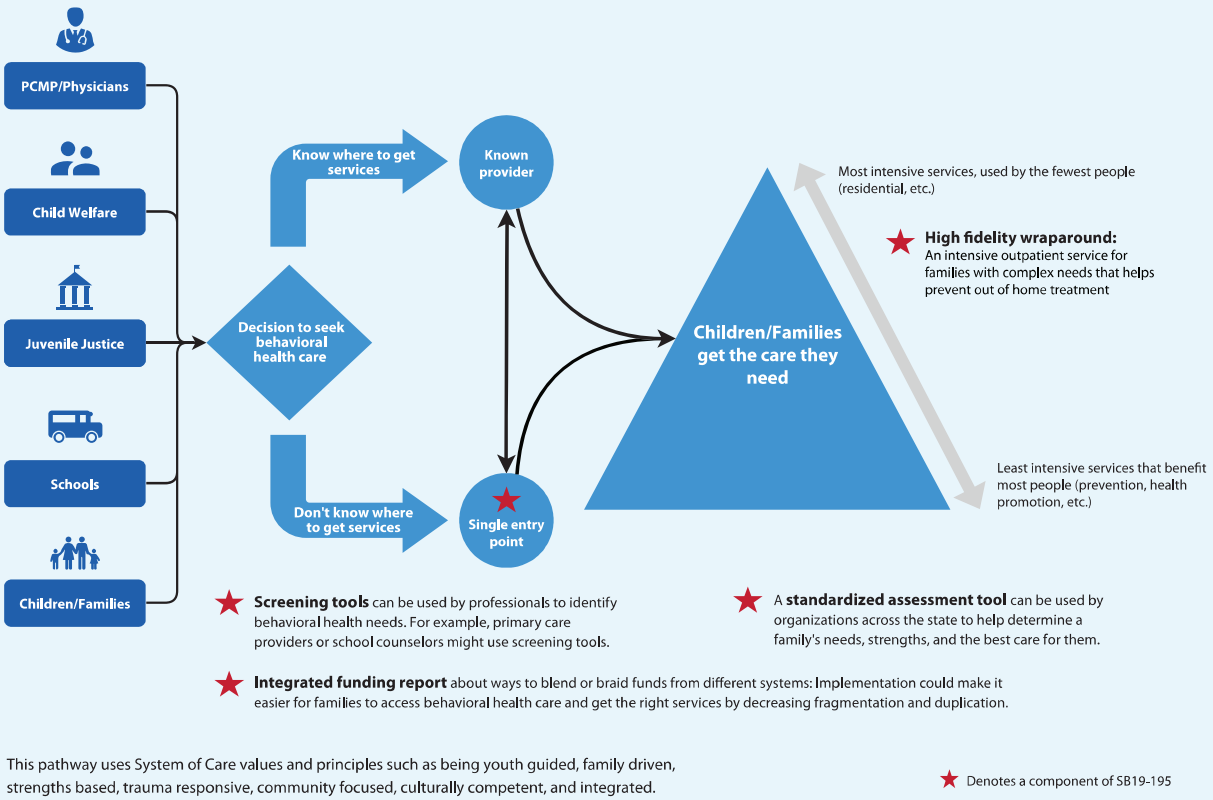
4 **WE RECOMMEND** payment for completing the assessment be required for both publicly and commercially insured youth.

OUTREACH

1 To reach communities that are underserved and underrepresented in the behavioral health system (e.g., LGBTQIA+, Hispanic/Latino, Tribal, unsheltered, refugees, deaf and blind), **WE RECOMMEND** development of specific outreach strategies, including:

- Leveraging organizations already working with these populations and talking with community providers
- Using a community-based approach
- Establishing ambassadors to develop trusted relationships with underrepresented populations and community providers
- Ensuring our care is culturally and linguistically responsive
- Ensuring our workforce reflects the populations we serve
- Analyzing data to understand the reasons that are contributing to underrepresentation (e.g., stigma, lack of a culturally diverse workforce, not enough bi-lingual providers, etc.), and develop and implement specific strategies per population
- Collaborating with underrepresented populations to understand how they would like to engage and then implementing identified strategies

Figure 4. Pathway to Behavioral Health Services For Children, Youth, and Families[15]



State Safety Net Subcommittee

In 2020, Mental Health America ranked Colorado as 33rd in the US for adult mental health and access to mental health care.[1] As reported in the 2019 Colorado Health Access Survey: Behavioral Heath completed by the Colorado Health Institute, 15.3% of Coloradans surveyed reported poor mental health, an increase from 11.8% in 2017.[16] Twenty-seven percent of Colorado adults surveyed reported that they, a loved one, or a close friend have been addicted to alcohol or drugs in their lifetime. Of those surveyed, 72.4% of those who had not sought treatment for their behavioral health concerns reported that they were concerned about someone finding out that they had a problem, a strong indicator that stigma related to behavioral health remains a barrier to care.

Mandate from Governor Polis

This subcommittee shall offer a roadmap to ensure that every Coloradan, regardless of acuity level, ability to pay, or co-occurring disabilities, can obtain appropriate behavioral health services in their community.

Legislative Mandate - Senate Bill 19-222

- Define what constitutes a "high-intensity behavioral health treatment program"
- Understand what services and supports are needed to assist with diversion and release of individuals with behavioral health disorders from the criminal justice and juvenile justice systems

Guiding Principles

The State Safety Net Subcommittee developed a definition for the Colorado Behavioral Health State Safety Net System:

A safe, community-based behavioral health system that provides person-centered and patient-driven access to a continuum of behavioral health services and supports to all Coloradans regardless of severity of need or ability to pay.

Using this definition to guide their work, the State Safety Net Subcommittee developed the following guiding principles:

COMPREHENSIVE

- Assures no one is refused services, regardless of complexity of their presenting symptoms, ability to pay, or criminal history, with criteria and processes for when the needs of an individual exceed treatment capacity or clinical expertise of a provider (SB-222) are developed and implemented so all individuals are served by the system
- Supports locally driven, community-based, culturally informed care
- Supports of multiple pathways to well-being and the role of supportive and peer-based services
- Provides appropriate frequency, duration, and intensity for the needs of the patient

- Addresses social determinants of health
- Provides a continuum of care that recognizes wellness across the spectrum of promotion, prevention, treatment, and recovery comp

EQUITABLE

- Supports inclusive, culturally and linguistically responsive, trauma-informed services
- Provides patient autonomy (client-driven, patient choice in services and/or provider)
- Provides equitable access to behavioral health services across the state

EFFECTIVE

- Remains evidence-informed and focused on patient-centered outcomes
- Provides timely and responsive services, including responsiveness of mobile services, regardless of geographic location or past use
- Commits to the highest levels of quality and patient satisfaction

As the State Safety Net Subcommittee began their work, they reviewed the Western Interstate Commission for Higher Education (WICHE) report completed for CDHS in 2015 which identified and assessed existing state and community resources and made recommendations for strategic future planning to strengthen Colorado's behavioral health system.[17] Recommendations from the WICHE report, including examining funding allocation methodologies for all behavioral health programs and services and exploring alternative payment approaches for the use of indigent funds in Colorado, remain relevant today. WICHE report findings were presented to the subcommittee via webinar to clarify and ground recommendations and provided framing for subcommittee work.

Community Mental Health Centers had the opportunity to present current behavioral health service delivery models to the subcommittee to inform continuum of services and safety net recommendations. Five counties (Douglas, Eagle, Larimer, Park and Summit) also provided overviews of how each county has implemented local behavioral health solutions and recommendations for the subcommittee to consider. Additional readings to ground subcommittee work included The Intersection of Housing and Mental Health in Colorado; Mapping Critical Social Determinants of Health and the Statewide Needs Assessment of Primary Prevention for Substance Abuse (SNAPS) report conducted by the Colorado Health Institute on behalf of OBH.[18,19]

In the recommendations and considerations described below, subcommittee members grappled with defining context and crafting language that represented each of their individual professional organizations and personal experiences. When charged with defining "safety net", subcommittee members debated about who should be included in the definition, ultimately concluding that the safety net should include all Coloradans versus only those who have no access to health insurance. The subcommittee recognized that this increased complexity in defining essential services and program implementation. Of note, subcommittee members repeatedly and conscientiously considered the consumer perspective when refining recommendations, raising questions and having dialogue about how individuals' and families' experiences may improve should certain recommendations be put forward.

When considering potential models for consolidating financing of behavioral health, there were multiple perspectives presented to examine how to best meet the needs of Colorado's safety net population. These perspectives were respectfully considered in drafting of final recommendations and considerations. Generally, across recommendations and areas of discussion, subcommittee members indicated support of final recommendations and considerations, and members were encouraged to provide written synthesis of areas of concern or disagreement with final recommendations for inclusion as addendums to the Remedy for Behavioral Health Reform.

State Safety Net Subcommittee Recommendations

HIGH INTENSITY TREATMENT PROGRAMS

The State Safety Net Subcommittee drafted a definition of "high-intensity behavioral health treatment programs" based on language in SB 19-222, existing definitions in the literature, and subcommittee expertise. SB 19-222 included a list of representation that needed to be consulted within developing the recommendation. Of that list, counties, law enforcement, mental health centers, hospitals, physical health providers, and family advocates were represented by members on the State Safety Net Subcommittee; substance use providers and judicial districts were missing from the subcommittee, and the subcommittee recommended individuals to provide that perspective. The subcommittee identified additional expertise not listed in statute: intellectual and developmental disabilities, traumatic brain injuries, juvenile justice and high-risk youth, child welfare, and social services, including child welfare. Individuals representing these additive perspectives were invited to attend subcommittee meetings and provide revisions and suggestions to the draft definition virtually. A list of individuals who contributed to the definition is included in Appendix 5.

The subcommittee developed and voted on a working definition of high intensity treatment. Using this definition, subcommittee members offered considerations for operationalizing high intensity treatment programs as well as considerations for the state in developing a plan to increase the number of programs, as mandated by SB 19-222.

WORKING DEFINITION OF HIGH INTENSITY BEHAVIORAL HEALTH TREATMENT

High Intensity Behavioral Health Treatment (High Intensity Treatment) is a community-based, client and family centered approach that is specifically designed to engage adults and youth with severe mental health and/or substance use conditions who are at risk for or experiencing complicating problems such as physical health problems, developmental challenges and/or involvement in criminal and juvenile justice systems. This community-based approach to treatment provides individualized support to reduce risk for worsening problems, ensure continuity of care across the service system, and prevent adverse outcomes such as homelessness, criminal justice involvement and physical or behavioral health crisis. High intensity treatment has the following characteristics:

- ***Assertive outreach and engagement:*** The treatment team uses motivational enhancement and other strategies to develop rapport and provides the services that are relevant to the individual and family in order to engage them in care.

- ***Community-based:*** Although some services may be delivered in offices, in general, services are delivered in the community where the individual or family lives.
- ***Multi-disciplinary and team-based:*** The multidisciplinary treatment team needs to have the capacity to meet the needs of and defined by the client. The treatment team may include medical providers, clinicians, case managers, and peer specialists as well as employment and housing navigators and law enforcement who work together in a team-based approach to care.
- ***Recovery-focused:*** Services extend beyond traditional clinical or medical services to include housing and income assistance, employment, social support, education, and daily living skills with the ultimate goal of attaining and maintaining as much independence as possible. This should include any social determinants of health that are necessary for the sustainability of an individual's or family's recovery.
- ***Client driven:*** Service planning is focused on the needs identified by the individual and family and is responsive to their cultural, linguistic and developmental needs and preferences. Treatment is flexible to serve individuals with multiple needs and able to coordinate with other service delivery systems to meet client co-occurring needs.
- ***Flexible in duration and intensity:*** Service intensity and duration are based on the needs and risks of the individual and family; however they are generally more intensive than conventional services and extend over an indefinite period of time.
- ***Coordinates care across settings:*** The team continually assesses need, facilitates access to needed services, and provides continuity across services including emergency and intensive care, and outpatient and recovery support services. The treatment approach is adaptable to other services being provided to the individuals; such as those services related to IDD, brain injuries, etc.
- ***Natural supports:*** The treatment team includes peers and/or recovery coaches and actively works to expand and enhance the natural supports available to the individual and family.
- ***Advocacy:*** The treatment team advocates for the individual and family in accessing needed skills and resources and helps the individual build skills to advocate for themselves.

High Intensity Treatment programs are implemented with fidelity to evidence-based practices such as Assertive Community Treatment, Integrated Dual Disorder Treatment and/or High Fidelity Wrap-around programs and interface with a variety of other evidence-based interventions based on the needs of the individual and family.

To operationalize high-intensity behavioral health treatment definition and ensure services are accessible to individuals who need them, the State Safety Net Subcommittee suggests the following considerations:

1. Identify strategies to make services accessible statewide, including in rural areas, without requiring individuals/families to drive hours for services. This may include mobile services, telehealth, etc.
2. Ensure 24/7 accessibility to manage crisis situations, or ensure programs are connected to a 24/7 crisis system.
3. Connect and coordinate with crisis response systems, including mobile crisis and co-responder teams, e.g., behavioral health providers with law enforcement and paramedics. Explore non-law enforcement response to emergency and urgent mental health and social services needs by dispatching counselors and social workers directly to communities.

4. Connect services with timely access to Crisis Stabilization Units, respite, and/or other residential programs to keep individuals safe during crisis and decrease dependence on Emergency Department services in times of crisis.
5. Ensure natural support services include and are available to families and other caregivers who may need services in order to support the individual in need.
6. Connect behavioral health providers to health information exchange platforms to support compliant sharing of health records across providers and systems.
7. Ensure consumer voice is included in treatment decisions and advance directives.
8. Include in-home and out-of-home respite services when possible.
9. Include flexibility in how services are delivered for rural/mountain communities.

Mandated by SB 19-222, CDHS must create a plan to increase the number of high-intensity treatment programs across the state by November 2020. In addition to the definition and operational considerations above, the subcommittee requests the state consider the following in creation of this plan:

- Ensure culturally appropriate services in all high intensity treatment programs
- Offer guidance to local providers when services are expanded to ensure fidelity with necessary modification that are appropriate given community resources (example, guidance that could address the current differences in Assertive Community Treatment implementation across the state)
- Explore funding sustainability and alternative models, such as hub and spoke
- Support local provider organizations in maintaining service lines (i.e., rural communities may face challenges in maintaining capacity to provide Assertive Community Treatment when caseloads are low and providers may be assigned other responsibilities)
- Invest in peer services as part of high intensity treatment programs
- Include caseworkers in co-responder teams; adding behavioral health expertise and personnel leads to avoided arrests
- Increase availability of services for co-occurring needs in one care setting
- Leverage technology to supplement in-person care (e.g., use technology as a check-in tool)
- Invest in infrastructure to improve telehealth and other technology
- Consider a Housing First strategy, and how a Housing First strategy could be broadened to fund and reimburse services not included under "medical necessity"

The State Safety Net Subcommittee concluded that the definition of high intensity behavioral health services will assist with diversion and release of individuals with behavioral health disorders from the criminal justice system by providing appropriate services to meet the needs of these individuals in the community when combined with the Colorado Continuum of Safety Net Services.

COLORADO CONTINUUM OF SAFETY NET SERVICES

The State Safety Net Subcommittee created the Colorado Continuum of Safety Net Services to display the array of services that should be available as part of the state safety net to promote behavioral health and well-being. The Continuum was developed using a framework from an Institute of Medicine report that identified the need for promotion and prevention, treatment, recovery and maintenance of mental health conditions and shows how each component is interrelated.[2] The framework has been adapted by federal and state agencies, including SAMHSA.[3] The State Safety Net Subcommittee worked from the SAMHSA continuum, identifying behavioral health services necessary to meet Coloradans' needs and informed by public testimony vignettes and consumer perspectives. The continuum is depicted along with service category headers from the Colorado Continuum of Behavioral Health for Children and Youth to display a full continuum of care. In three workgroups, the State Safety Net Subcommittee prioritized the services into three tiers and re-iterated values and considerations for service continuum implementation:

- Develop standardized definitions for services to be used across systems and programs (i.e., care coordination)
- Promotion and prevention include wellness and recover and relapse prevention
- Navigation eases access to and within safety net system
- Care coordination with services to address social determinants of health, like housing, transportation, and employment
- Intensive case management spans and supports multiple service categories
- Services are available in multiple community-based settings
- Decrease wait times
- Invest in telehealth infrastructure
- Improve data sharing between providers and systems
- Address health inequities with specialized outreach, screening, and assessment to engage underserved populations in care

Figure 5. Colorado Continuum of Safety Net Services

Children's Behavioral Health Subcommittee headings	Universal Promotion/ Prevention/Targeted Prevention		Integrated Care Services	Outpatient Services		Across multiple sections of CH array	Across multiple sections of CH array	Intensive Commun Services
State Safety Net Subcommittee headings	**Prevention (including Promotion)**	**Engagement Services**	**Healthcare Home/ Physical Health**	**Outpatient Services**	**Medication Services**	**Community Supports (Rehabilitative)**	**Other Supports (Habilitative)**	**Intensive Services**
Tier 1 (prioritized by 2+ Safety Net Subcommittee workgroups)	- Comprehensive screening in primary care and other community-based settings - Parent/ caregiver skills training and psycho education - Mental Health First Aid - Anti-stigma campaigns - Wellness and recovery; relapse prevention	- Comprehensive case management (including outreach) - Treatment/service planning	- Primary care and behavioral health integration (in fqhcs and other primary care settings and cmhcs) - Centralized care coordination	- Telehealth / telepsych (including phone only) - Mobile services - Primary care and behavioral health integration	- Medication management in community-based settings, ers, outpatient - Pharmacotherapy (including mat) - Laboratory services	- Intensive case management - Co-responder model - Coordination with social service providers	- Interactive communication devices and apps	- Intensiv sud and - High-in treatme both ho commu Assertiv treatme
Tier 2 (prioritized by 1 Safety Net Subcommittee workgroup)	- Expanded use and access to existing programs: Safe Talk, ASSIST, Man Therapy - Screening Brief Intervention and Referral to Treatment (SBIRT) - Social determinants of health - Promotional tools for referral	- Wellness /recovery - All hotlines/ resource lines (streamlined to the extent possible) - Client- and family-centered assessments - Info/education - Specialized evaluations - Referrals and warm-handoffs - Tailored to specific populations - Assertive outreach - Crisis aftercare/ outreach (post-hospitalization) - Peer navigator programs - Safe to tell	- Integration of care with all social determinants of health services - Care navigators - Wrap around services - Peer mentorship - Intensive case management - Comprehensive case management	- Traditional outpatient services, including individual evidence based therapies; group therapy; and family therapy - Supported employment - Treatment for co-occurring disorders	-Increase capacity of med-prescribers -Medication costs -Injectable medication access -Increased used of tech for medication adherence -Psychiatric medication evaluation -Poly-pharmacy services for complex needs	Comprehensive care and intensive case management -Collaboration in schools and with local BH providers - Supports to be successful in other programs; life skills building - Permanent supported housing -Supported employment -Wrap around services -Peer support services -Recovery housing	- Respite - Adaptative rehabilitation services - Nontraditional therapeutic - Long-term supports - Trauma-informed rehabilitative care - Respite - Club houses/ drop in - Partnering with community providers - Job skills training - Care coordination across resources - Supported education - Personal care	- Treatme - Secure off cent refusal) - Intensiv abuse s - Services populat if waitin services - Intensiv manage - Telehea intensiv - Flexibili - Partial h
Tier 3 (other services to	-Brief motivational interviews		-General and specialized	- Consultation to caregivers		-Parent / caregiver support	-Recreational services	- Social d - Multi-sy

IMPLEMENTATION CONSIDERATIONS

Through work developing the Colorado Continuum of Safety Net Services, discussing patient/consumer experience in the system and reflections on public comment and testimonies, a list of barriers and opportunities for the safety net system emerged. To prioritize the work of the subcommittee, members were asked to vote on four "must do" and four "most attainable" opportunities to establish areas of consideration that would both drive and underlie the work of the subcommittee. The multi-vote led to the following areas of focus:

Subcommittee "most attainable" considerations:

1. Telehealth
2. Alignment of licensing
3. Define core safety net services
4. System navigation and Central governance (tied for fourth)

Subcommittee "must do" considerations:

1. Address workforce shortages
2. Central governance
3. Increase access
4. Align funding streams

Workgroups were established to focus on Telehealth, Increased Access, System Navigation, and Workforce Shortages. Subcommittee members decided to defer the work of Alignment of Licensing to DORA's review of the Mental Health Practice Act, the six behavioral health professional boards and the Behavioral Health Entity Implementation and Advisory Committee. Work on Central Governance and Alignment of Funding Streams was incorporated into discussions of CDHS' proposed model for consolidated financing of behavioral health. Defining core safety net services was completed as a full subcommittee.

Due to an increased focus of the State Safety Net Subcommittee on informing a state framework for consolidating behavioral health funding, these identified priority areas did not result in finalized recommendations from the subcommittee. However, the four workgroups drafted considerations for telehealth, system navigation, workforce shortages and increased access that the State of Colorado or a newly established governing behavioral health entity may leverage to guide implementation.

TELEHEALTH CONSIDERATIONS

Expanding the scope of telehealth services will increase access to behavioral health services, particularly to underserved populations in rural demographic and geographic regions. These considerations aim to reduce barriers to treatment for those seeking care, including but not limited to logistical challenges (e.g., schedule/availability, wait lists, transportation, payment) and perceived challenges (e.g., stigma, misconceptions of treatment, negative past experience in therapy). Further, these considerations aim to maximize capacity for clinical services for each clinician, allow for increased flexibility in delivery of services (e.g., groups, more regular brief

check-ins, ongoing periodic assessment of symptom severity) and increase immediacy of service access (i.e., "real time referral"). Most importantly, expanding telehealth may reduce or eliminate the existing health disparities related to both access and outcomes for all community members, especially the most vulnerable populations. Considerations for telehealth expansion should include:

1. Making investments in broadband technology to ensure telehealth and other telemedicine options are available statewide.
2. Considering public-private partnerships and foundation support to improve broadband capacity and pilot expansion of telehealth.
3. Developing policies and rules, as appropriate, for provider training and CME credits that can be made available using online technology.
4. Assessing payment strategies for telehealth services and make recommendations about methods and payments.
5. Maintaining and creating enhanced services using telehealth, with consideration of the following options:
    - Law enforcement co-responder model using telehealth (could also help in areas where there is limited broadband).
    - Home health providers connected to behavioral health providers, for example, psychiatrists for medication assistance.
    - Group therapy, in particular for specific populations, modeled after a successful approach in the Veterans Affairs system.
    - Video chat function for crisis line services.
    - Licensure process for out-of-state telehealth providers.
    - Text-based and app-based platforms.
6. Evaluating and making effective emergency telehealth rules enacted for COVID-19 permanent.

ACCESS CONSIDERATIONS

The primary aim of increased access is to minimize the gap between needing services and acquiring care, such that all individuals with a clinical need, be it basic or essential, receive access that is timely and matches the level of clinical severity. Motivations to expand access also include minimizing degree of distress and burden of mental illness and substance abuse, reducing the number of deaths by suicide, enhancing productivity, quality of life and well-being for all individuals, families and caregivers, and preventing downstream cost and suffering. The following considerations support increased access to behavioral health services in Colorado:

1. Expanding the Co-Responder model of criminal justice diversion. Co-Responder teams consist of two-person teams of law enforcement officers and behavioral health specialists to intervene on mental health-related police calls to de-escalate situations that have historically resulted in arrest, and to assess whether the individual should be referred to immediate behavioral health assessment.

2. Explore new response mechanisms to reduce a police/criminal response to emergency and urgent mental health and social service related 911 calls by dispatching counselors and social workers directly to community; route individuals in need to civil/social service/health systems and not to jail/correctional systems where competency to stand trial issue ever comes into question.

3. Supporting law enforcement management of individuals with behavioral health issues by requiring mental health first aid training for all first responders and law enforcement professionals.

4. Reforming regulations and contract requirements to support trauma-informed and problem-focused assessment.

5. Identifying flexible funding to support minimum intake, assessment, intervention, and referral requirements regardless of payer.

6. Reviewing and, if necessary, reforming regulations to eliminate or streamline requirements for providers to "open" and "close" clients.

7. Expanding transportation services for routine (non-emergency) behavioral health care for all populations and ensuring that transportation models are flexible to encourage behavioral health responsive operations. This includes enhancing the Non-emergent Medical Transportation benefit in Medicaid to include this type of transportation for behavioral health services.

8. Increasing reimbursement and utilization of behavioral telehealth solutions that wrap around and support other services to minimize place as a barrier to care. This includes investigating potential platforms to increase provider capacity, e.g., online forums supporting group telehealth and/or app-based platforms for individuals to engage in treatment between sessions and to allow providers to track outcomes.

9. Expanding and creating additional housing-first models that ensure an individual's basic needs are met and individuals are stabilized prior to expectations to engage in treatment.

10. Creating training opportunities for and invest in two generation (2gen) models to ensure the entire family system is adequately engaged in relevant treatment modalities.

11. Developing a Colorado-focused model of comprehensive care and cost-based reimbursement akin to the Certified Community Behavioral Health Clinic model to facilitate increased access to care, reimbursing providers for the total cost of care, and reducing administrative burden by creating a streamlined and more uniform system of data collection and reporting.

12. Requesting support from the Attorney General's Office and DOI to work with community behavioral health providers to identify access barriers for community members with private insurance, and enforcing network adequacy and parity.

SYSTEM NAVIGATION CONSIDERATIONS

The following considerations will support increased access to behavioral health services and easier navigation of the full continuum of services:

1. Systematically defining, reviewing, and cataloging existing efforts in Colorado to enhance care navigation and assess potential benefits and consequences to consolidating initiatives.
2. Supporting regional expansion of the 211 system and connecting to the 988 national suicide hotline for entry to the behavioral health system.
3. Identifying and supporting a single point of entry to behavioral health services.
4. Supporting navigators that possess knowledge of available behavioral health and developmental disability services and coordinate these services across regional systems in a culturally and linguistically appropriate manner. These navigators will also facilitate navigation in other regions if necessary and appropriate.
    - Establishing a system in which navigators are assigned to a family unit.
    - Developing a certification process for navigators and ensure that peer support is a component.
    - Developing processes for information sharing across systems that ensures compliance HIPAA, FERPA, 42 CFR part 2 (e.g., development of a single consent form).
    - Developing a process to ensure quality of navigation services.
    - Exploring technology-based solutions to support enhanced navigation (i.e., apps for smart phones).

WORKFORCE SHORTAGE CONSIDERATIONS

The issue of workforce shortages which contribute to gaps in access to care across the state was elevated by the Safety Net Subcommittee, identifying the following priorities:

1. Invest in a continuum of workforce strategies, from cultivation (i.e., scholarships and tuition costs to incentivizing supervisors) to retention (i.e., loan repayment programs and care progression opportunities).
2. Modernize the workforce to meet current and future behavioral health needs:
    - Seek feedback from tomorrow's workforce and develop jobs and systems where they want to work
    - Allow more flexibility in funding to respond to community, cultural and market expectations
    - Create training, certification, and reimbursement structures to support peers and non-traditional community health workers
    - Develop workforce for prevention and promotion, and to strengthen integrated care
    - Ensure providers are trained to provide culturally competent care to diverse populations

3. Address low salaries and cover cost of care to ensure value matches priority.
4. Consider workforce needs in the design of any proposed behavioral health authority model to prevent clinician burnout from administrative responsibilities by aligning requirements (credentialing, reimbursement, quality report, documentation standards) with Medicaid.
5. Invest in peer support programs across the continuum of services and create pathways for billing Medicaid and other payers.

The Children's Behavioral Health Subcommittee voted on a set of workforce recommendations as the Safety Net Subcommittee prioritized and began to address safety net workforce needs. In addition to the priorities specified above, State Safety Net Subcommittee members reviewed the Children's Behavioral Health Subcommittee package of workforce recommendations and support those recommendations to invest, build, and retain a robust workforce of licensed and unlicensed behavioral health providers and staff necessary to ensure all Coloradans may access high quality behavioral health services and supports.

PROPOSED SAFETY NET MODEL

Significant meeting time was dedicated to reacting and providing revisions to a proposed Safety Net model developed by CDHS. The proposed model was first introduced to the subcommittee on 1/16/2020 in response to previous discussions of the system's complexity and multiple funding streams. Lessons learned from other states' efforts to redesign their behavioral health systems were also presented. Subcommittee members' input was incorporated for presentation to the full task force and subcommittees on 1/24/2020. The next State Safety Net Subcommittee meeting then focused on discussing further considerations for the proposed model, including consumer experiences captured in public testimony. The Colorado Behavioral Healthcare Council also presented a proposed model to re-appropriate and integrate behavioral health resources. These discussions resulted in the following considerations for CDHS in the redesign of Colorado's behavioral health system.

Highlighted opportunities a new administrative structure should consider:

- Individuals should receive services regardless of payer (reduce the 60+ "wrong doors")
- Care coordination
- Opportunity to establish a minimum set of services
- Timely access
- Centralized navigator that is accessible to individuals/families

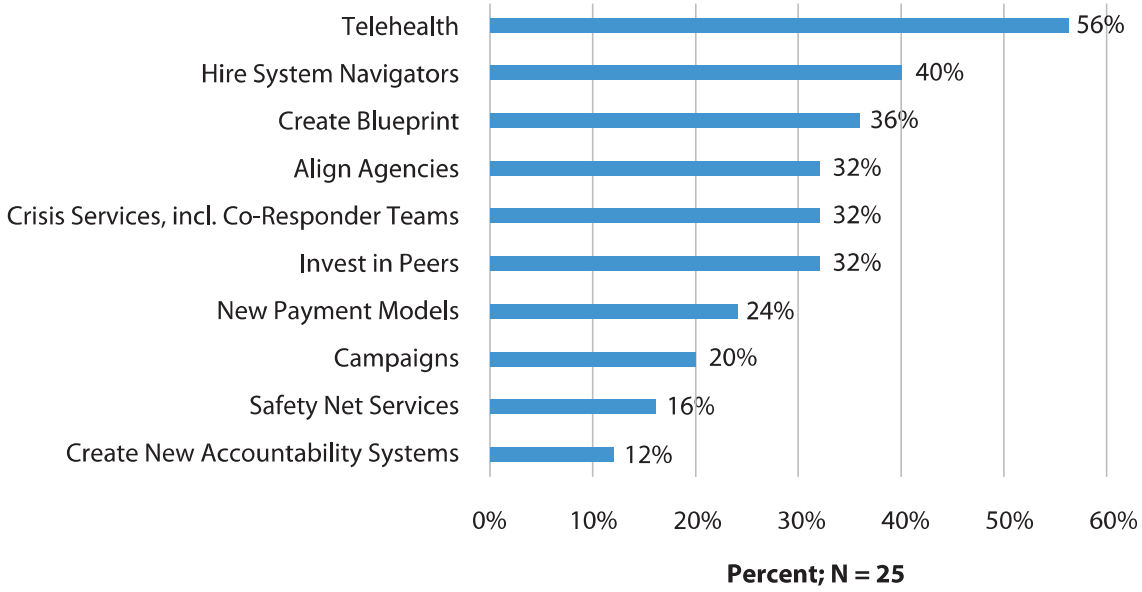
In offering guidance and identifying areas of concern, the State Safety Net Subcommittee suggests the new administrative structure needs to:

- Be integrated with HCPF and the Regional Accountable Entities
- Develop standards and measures for care delivery and provider accountability
- Assure that resources are not taken from direct services to support administrative costs
- Create an external appeals process and accountability system
- Establish a process to ensure the administrative service organization does not become a "dumping ground" for insurance companies
- Define system "guardrails" that are mandates, not guidelines
- Address the experience for individuals with intellectual and developmental disabilities (IDD)

PRIORITIES FOR NEXT 12 MONTHS

Since many of the recommendations proposed by the State Safety Net Subcommittee will require significant time to implement and demonstrate outcomes, members were asked to prioritize actions that could be executed in the next 12 months that would lead to immediate improvements in the behavioral health system. Via survey and in-meeting polling, subcommittee members prioritized actions that were most feasible to implement in the next 12 months and that would yield positive impact for individuals and families.

Figure 6. State Safety Net Subcommittee Priorities for Immediate Focus



Note: percentages reflect number of subcommittee members that indicated this priority in their top three.

Long Term Competency Subcommittee

CDHS is legally responsible for providing competency evaluation or restoration services to individuals who have been court ordered to receive an evaluation of competency to proceed or found incompetent to proceed and are to receive competency restoration treatment. Between FY 2000-01 and FY 2018-19, Colorado has seen a 664% increase in the number of court orders for competency evaluations and a 1,634% increase in the number of court orders for competency restoration services. CDHS has been unable to meet the ever-growing demand for inpatient competency evaluation and restoration services, despite significantly increasing treatment capacity. In 2011, Disability Law Colorado sued the state in federal court alleging the length of time defendants were waiting in jail to receive services violated their constitutional rights. After eight years of litigation, the two parties entered into mediation in March 2019 and reached a Consent Decree, which outlines a comprehensive approach to addressing this crisis.[21]

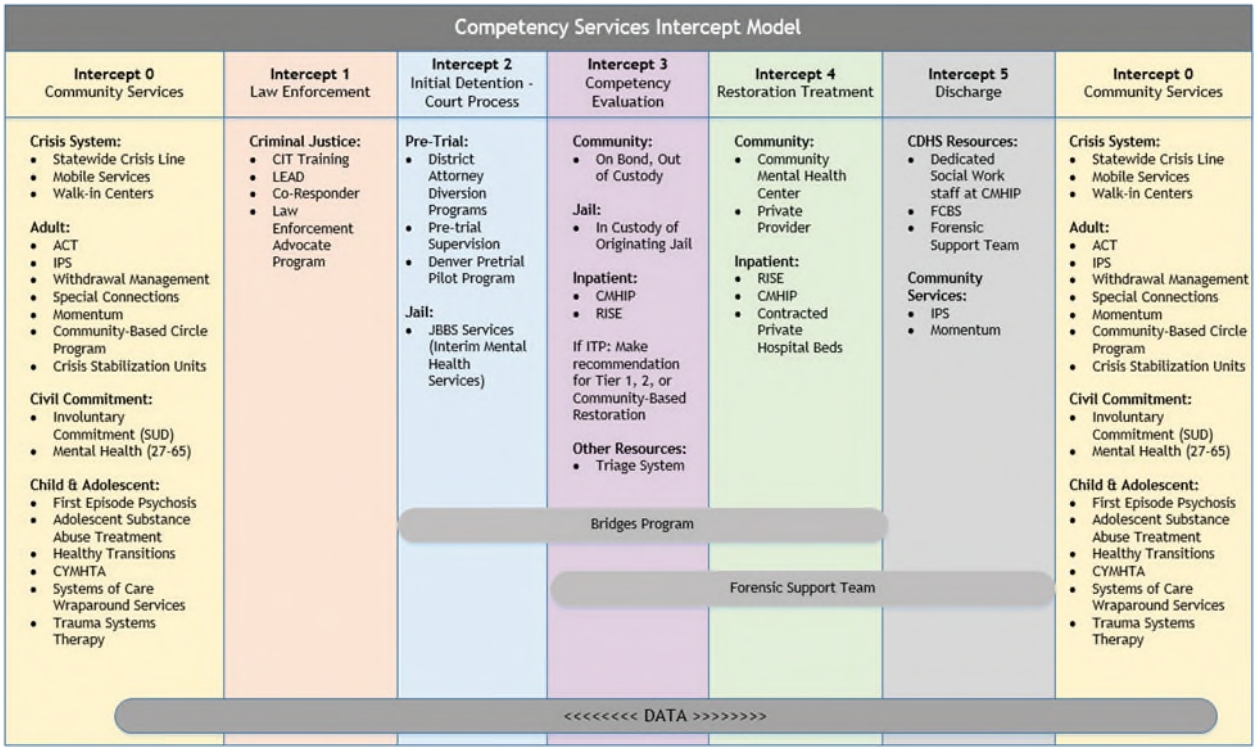
In response to an initial Comprehensive Plan for Compliance submitted in 2018, the Consent Decree required revisions to provide a more comprehensive and cohesive plan by or about January 2020. This second plan, the Long Term Comprehensive and Cohesive Competency Plan,[20] was to result from a long-term visioning process with Disability Law Colorado, the court appointed Special Masters and stakeholders to consolidate pieces of the current plan, along with legislative initiatives into a cohesive package for courts, administrators, service providers and legislators to consider. The aforementioned stakeholder group is represented by members of the Long Term Competency Subcommittee.

Per the Consent Decree, the revised Long Term Comprehensive and Cohesive Competency Plan will address each of the following points:

1. Reducing the emphasis on inpatient beds and increasing the emphasis on community beds
2. Further prioritizing outpatient competency restoration treatment
3. Prioritizing a triage approach (i.e. prioritizing inpatient admissions based on acuity) over a traditional waitlist approach
4. Making better use of data and ensuring reliable access to data
5. Creating a central system of easily accessible information for stakeholders
6. Prioritizing quality, even amid quantity and time pressures

The Long Term Comprehensive and Cohesive Competency Plan uses the framework of the Sequential Intercept Model, a strategic planning tool used to develop a comprehensive picture of how people with behavioral health issues and SUD flow through the criminal justice system along distinct intercept points: Intercept 0: Community Services, Intercept 1: Law Enforcement, Intercept 2: Initial Detention – Court Process, Intercept 3: Competency Evaluation, Intercept 4: Restoration Treatment, Intercept 5: Discharge.[22] Figure 7 describes competency specific services across the Intercept Model. Subcommittee recommendations were made and prioritized across these six individual intercepts of the Sequential Intercept Model, with Intercept 0 (Community Services) represented at both the beginning and the end of the model.

Figure 7. Competency Services Intercept Model



Mandates from Governor Polis

Consistent with a recent consent decree entered into by the Department of Human Services, this subcommittee should address the following:

1. The development of a comprehensive picture of the system of services and resources available for individuals in the criminal justice system who have been found incompetent to proceed (ITP);
2. The framework of a statewide strategic blueprint for competency and the first set of recommendations that aligns with the CDHS' consent decree, to include:
   - A priority emphasis on prevention and diversion efforts;
   - Recommendations on restoration services specifically designed for persons with intellectual or developmental disabilities;
   - Recommendations for short-term and long-term solutions, with an emphasis on expanding community-based solutions first, when appropriate;
   - Projections of competency evaluation and restoration needs over the next 20 years, and an understanding of the trends that impact need;
   - Legislative recommendations (if needed) to implement the plan, along with removing barriers or providing support to aspects of the plan;
   - Costs associated with implementation; and
   - Possible funding mechanisms, including leveraging non-state dollars.

Legislative Mandate - Senate Bill 19-223

Colorado Senate Bill 19-223 addresses issues related to competency to proceed in a criminal trial. When a defendant's competency to proceed is raised, the act:

- Changes the timing of various matters;
- Clarifies where restoration services are to be provided;
- Expands the requirements for a competency evaluation report; and
- Clarifies when defendants are to be released following an evaluation or restoration services.

The act requires the department of human services to:

- Develop an electronic system to track the status of defendants for whom competency to proceed has been raised;
- Convene a group of experts to create a placement guideline for use in determining where restoration services should be provided; and
- Partner with an institution of higher education to develop and provide training in competency evaluations.

On and after January 1, 2020, except for certain certified or certification-eligible evaluators, competency evaluators are required to have attended training. District attorneys, public defenders, and alternate defense counsel are also to receive training on competency to proceed.

The act also provides that a competency evaluator is not liable for damages in any civil action for failure to warn or protect a specific person or persons against the violent behavior of a defendant being evaluated.

The act appropriates general fund dollars to pay for fines, liquidated damages, costs, attorney fees, and special master compensation due to a consent decree agreed to by the state. It also appropriates additional money from the general fund and from reappropriated funds to the department of human services and the judicial department to implement the act.

This legislation guided the work of the Long Term Competency Subcommittee as they considered recommendations to address competency concerns across the Competency Services Intercept Model.

Guiding Principles

The Long Term Competency Subcommittee drafted the following statement of values for inclusion in the Long Term Comprehensive and Cohesive Competency Plan to guide their work and recommendations:

The subcommittee submits the recommendations within our duties and obligations as a subcommittee to the Behavioral Health Task Force to review and recommend solutions to improve the systems related to individuals who are arrested for crimes and present issues of competency. In so doing, the subcommittee prioritized the requirement that CDHS provide the federal court with a cohesive comprehensive plan pursuant to its obligations from the Consent Decree in which Disability Law Colorado sued CDHS over its failings to individuals in the competency process. Thus, this report (Long Term Comprehensive and Cohesive Competency

Plan) focuses on CDHS-directed action steps to resolve the problems identified throughout the course of the lawsuit. We acknowledge the strengths and limitations of such a focused purpose while also advocating for a collaborative, strategic vision to end the criminalization of people living with behavioral health disorders, no matter one's age or identity. Resolution and change toward this vision must be systemic, and the subcommittee discussed the following broad reforms in various areas warranting ongoing improvement and advocacy:

- Early identification of behavioral health concerns (across the lifespan) and criminogenic risk factors, paired with a systems-oriented response to provide preventative healthcare and social support services;
- Guaranteed and easily accessible options for behavioral health care and related supports available in the community prior to and after involvement in the criminal justice system;
- Accessible and inclusive housing options that prevent homelessness and rapidly re-house individuals when needed;
- Transportation and other accessibility solutions to connect individuals and families with needed service, be they healthcare oriented or otherwise, to promote health and wellbeing;
- Telehealth and strong information sharing via health information exchanges to improve access to care and sharing of information between providers; and,
- Collaborations with public health, public safety, corrections, and a wide variety of funding systems to develop a cohesive, health-promotion, recovery oriented, statewide approach.

While these topics generated debate and critical dialogue, the subcommittee finds it important to acknowledge that, despite diverse representation, there are limitations to the scope of what could be accomplished and or addressed. Furthermore, the subcommittee recognizes that such systematic solutions will require cross-departmental collaboration within Colorado's multi-governmental structure and will not always be actionable for CDHS alone.

In acknowledging the importance of the need for strong community-based mental health services to limit the need for criminal justice involvement, the subcommittee is committed to continuing study of these opportunities, engaging with the appropriate stakeholders, and promoting action that is inclusive and reflective of all voices in Colorado beyond the submission of this report. The subcommittee recognizes that for many individuals where competency has been raised, there is an opportunity to divert them away from the criminal justice system with systemic solutions, therefore reducing the demand on the competency services system. To this point, the subcommittee recognizes that the intensity and quality of behavioral health services in the criminal justice system should be matched or exceeded by community-based services to avoid a pipeline to the criminal justice system to obtain essential services.

Additional learning opportunities to support and align recommendations were presented to the subcommittee including a presentation from the court-appointed Special Masters who would review and approve the Long Term Comprehensive Plan, and a webinar to provide an overview of the approach that Los Angeles County is taking to support mental health courts to address delays in competency evaluations and restoration treatment.

Subcommittee members worked diligently together to reach agreement and approval of final recommendations. This group hosted rigorous and respectful debate, reflecting multiple perspectives, including a judge, a district attorney, a public defender, members of law enforcement, consumers of services, and representatives from several advocacy organizations and state agencies. Through thoughtful discussion, this diverse group of individuals focused on client-centered solutions that

considered the rights of those at risk for interaction with the criminal justice system. To this end, the subcommittee heard from a consumer panel prior to the submission of the Long Term Comprehensive and Cohesive Competency Plan to hear directly from individuals who have experienced incarceration or hospitalization on how recommendations and resulting policy directly affect the health and well-being of individuals and families. The subcommittee focused not only on behavioral health services that occur after arrest, but also on how to prevent high risk individuals from entering the criminal justice system by enhancing services available in the community.

The Long Term Competency Subcommittee identified additional priorities to more comprehensively address community-based solutions related to minimizing the likelihood that individuals with behavioral health issues and SUD would interact with the criminal justice system, explicitly focusing on how to appropriately treat these individuals in the community to prevent interactions with law enforcement and the judicial system. The subcommittee also drafted concepts that led to the development of Colorado Senate Bill 20-181, to help ensure that people are not held in jail when competency is in question and they have a low-level crime or if, regardless of charge, due to severe disability, restoration is unlikely.

Long Term Competency Subcommittee Recommendations

LONG TERM COMPREHENSIVE AND COHESIVE COMPETENCY PLAN

In September, October and November of 2019, the Long Term Competency Subcommittee voted on and approved 38 recommendations across the intercept model to be included in the Long Term Comprehensive and Cohesive Competency Plan.[20] At the request of the main Task Force, the subcommittee revisited and prioritized these recommendations in June 2020. Below, recommendations are listed by intercept as prioritized by the subcommittee members. The original recommendation numbers as indicated in the Long Term Comprehensive and Cohesive Competency Plan is reflected within parentheses. The complete Long Term Comprehensive and Cohesive Competency Plan is available here.

INTERCEPT 0: COMMUNITY SERVICES

1. **(Recommendation 1)** Expand and enhance the crisis services system, including crisis drop-off centers, to ensure we are diverting people with behavioral health issues from the criminal justice system to the behavioral health system.

2. **(Recommendation 2)** Enhance, expand, and connect services for individuals at risk of institutionalization or criminal involvement, such as co-responder models, wraparound services, and ACT, to facilitate behavioral health interventions before these individuals come into contact with law enforcement.

3. **(Recommendation 3)** The Department shall ensure that contracts for competency services are bundled with other needed safety net services, and explore opportunities to further fund needed ancillary services that support good restoration outcomes.

INTERCEPT 1: LAW ENFORCEMENT

1. **(Recommendation 6)** The Department shall evaluate models and seek appropriate resources and legislation if necessary to develop secured treatment settings and Behavioral Health Adult Assessment Centers where adults, upon arrest, can be assessed/screened for behavioral health needs and criminogenic risk, and then placed in the appropriate system of care/intervention.

2. **(Recommendation 5)** The Department shall work with the Department of Public Safety and other state agencies to secure resources to expand CIT training (or similar training) for Colorado first responders, court security, and corrections staff, and provide continuing education to ensure officers are well equipped to safely intervene in a mental health crisis and to divert those in crisis to the behavioral health system and away from additional, unnecessary charges and further incarceration.

3. **(Recommendation 7)** The Department shall engage jails to understand and respond to feasibility concerns to developing community-driven and locally responsive interim jail mental health services for defendants.

4. **(Recommendation 4)** The Department shall continue to work with the Long Term Competency Subcommittee to ensure recommendations for legislation so that effective, appropriate, timely and continuous behavioral health services, including medication management, are provided for individuals who are currently in jail.

5. **(Recommendation 8)** The Department shall consider asking the legislature for increased funding for jail-based behavioral services, including medication management and services to maintain competency, to accompany potential legislation to be recommended by the Long Term Competency Subcommittee.

INTERCEPT 2 – INITIAL DETENTION/COURT PROCESSES

1. **(Recommendation 9)** The Department shall explore requesting resources for all jails to have in-person or tele-capacity to conduct screenings and behavioral health services upon intake by qualified behavioral health providers. The Department shall develop standards as to what qualifies as a behavioral health provider. While it is preferred for pretrial defendants to have in-person services, the Long Term Competency Subcommittee recognizes that resource and access limitations may require services to be delivered via tele-health. The Department shall seek to coordinate with other legislative bodies exploring improved telecommunication systems for jail so as not to duplicate efforts and funding.

2. **(Recommendation 10)** The Department shall work with the State Court Administrator's Office to consider seeking additional resources to create and/or expand pretrial supervision and case management services for defendants requiring competency services in an effort to provide services in the least restrictive setting. Services to include court reminders, appointment reminders, and transportation.

3. **(Recommendation 13)** The Department will explore collaborations with local courts to better integrate the availability, access, and delivery of mental health and collateral services by utilizing a community justice center model, where appropriate, in part to divert people with mental illness away from the criminal justice system where their needs can be met and risks mitigated through other community-based resources.

4 **(Recommendation 12)** The Department shall continue to use the Sequential Intercept Model to guide decision making and resource allocation for efforts to enhance the interface and outcomes of the behavioral health and criminal justice systems, and cooperate with the Office of the State Court Administrator and local judicial districts and other state agencies in the use of the model.

5 **(Recommendation 11)** Expand Bridges and Forensic Support teams to provide competency navigation support and stability in the community to meet the needs of released individuals and defendants with potential for release such that judicial officers will increase release decisions. Continue to engage with attorneys in the criminal justice community to maximize the efficacy of Bridges and FST.

6 **(Recommendation 15)** The Department shall continue to work with The Long Term Competency Subcommittee in identifying the need for potential legislation to eliminate unnecessary competency evaluations for people determined Permanently Incompetent to Proceed, those with Intellectual or Developmental Disabilities or Traumatic Brain Injury, or other conditions which result in permanent incompetence.

7 **(Recommendation 14)** The Department shall work with key stakeholders to explore legislation to monitor and continue care for individuals to ensure s/he maintains competency through the court process after a finding that individual is competent or competency has been restored.

8 **(Recommendation 16)** The Department will work with the Long Term Competency Subcommittee in identifying any need for potential legislation for alternatives to the competency process for those with low-level offenses. Any legislation shall address how to meet the behavioral health needs of these individuals.

INTERCEPT 3: COMPETENCY EVALUATION

1 **(Recommendation 17)** The Department shall provide universal training to Judicial Officers, District Attorneys, Defense Attorneys and Guardians Ad Litem to increase understanding of the competency assessment and restoration process, including the availability and extent of services and supports that can be provided in the community versus in jail, and the consequences and cost of using jails to treat and warehouse persons living with mental illness.

2 **(Recommendation 18)** The Department shall collect data, including stakeholder input, on community-based referrals to understand drivers of low referral rates and resources needed to increase court referrals for community restoration.

3 **(Recommendation 20)** The Department shall implement a mandatory annual training in accordance with 16-8.5-122 for evaluators contracted by or managed by the Department in an effort to increase the quality and consistency of evaluations.

4 **(Recommendation 21)** The Department shall continue to provide more information and education to the local courts regarding competency evaluations and community-based options in an effort to increase the number of individuals referred to community-based services if appropriate.

5 **(Recommendation 19)** In an effort to explore opportunities to stabilize an individual prior to the initial court hearing, the Department shall begin by providing subcommittee members with existing jail-based services funding contracts and related statute to facilitate a recommendation to identify individuals who are at risk of being deemed incompetent to proceed as soon as possible.

6 **(Recommendation 22)** The Department shall explore and implement an information sharing process that ensures complete privacy and HIPAA compliance to allow key stakeholders to access information about an individual ordered for competency services.

INTERCEPT 4: RESTORATION TREATMENT

1 **(Recommendation 23)** The Department shall develop comprehensive outpatient restoration treatment programs able to serve higher-risk and higher-need defendants to include a continuum of behavioral health interventions and medication management. Comprehensive programs may include housing, transportation, and other social supports. (Recommendation 29) The Department shall design and implement a quality improvement process for inpatient restoration services that addresses their efficiency, optimum length of stay, and individualized treatment plans.

2 **(Recommendation 25)** The Department shall collect and analyze data to understand the prevalence of housing issues as barriers to success in the community to inform recommendations to the legislature for funding, as appropriate.

3 **(Recommendation 26)** The Department shall actively engage efforts to remove housing as a barrier to completing community restoration services in the community. The Department shall leverage work of the Taskforce Concerning Treatment of Persons with Mental Health Disorders in the Criminal & Juvenile Justice Systems (MHDCJJ) and others in the state, such as Mental Health Center of Denver's pilot program, to develop a strategy for housing for defendants ordered to competency services and for whom housing is the key barrier to success in the community.

4 **(Recommendation 27)** Based on the outcomes of the Denver Pilot, the Department shall request the necessary resources for these services to be available statewide, and, if necessary, the Department shall approach State Court Administrator's Office (SCAO) about jointly seeking resources so that all judicial districts have pretrial services to serve this population. Work with SCAO to ensure pretrial case managers are provided training to work with individuals with mental health needs. The model for outpatient restoration services shall include outpatient competency restoration services such as the Assertive Community Treatment (ACT) model (or similar evidence-supported intensive case management models) and pretrial supervision services.

5 **(Recommendation 24)** The Department shall, with appropriate awareness of civil beds in the state, contract with community or non-state hospitals to provide competency services for individuals with high clinical acuity in order to ensure people are getting the right level of care while the Department retains and provides proper oversight.

6 **(Recommendation 29)** The Department shall design and implement a quality improvement process for inpatient restoration services that addresses their efficiency, optimum length of stay, and individualized treatment plans.

7 **(Recommendation 28)** The Department shall work with HCPF and other stakeholders to explore the development of community-based services and programs dedicated to specific populations in need (IDD, dementia, etc.) to ensure their unique needs are being met and to reduce the number of individuals deemed incompetent to proceed ordered for inpatient services.

8 **(Recommendation 32)** The Department shall encourage judicial districts' interest in developing and piloting court dockets specific to competency (Competency Dockets) to increase the flexibility of court dates so individuals can have their court hearing quickly after being opined competent to proceed or incompetent to proceed. The Department shall support interested judicial districts in developing these specialized dockets, with emphasis on those judicial districts that have the greatest amount of competency examination referrals.

9 **(Recommendation 30)** The Department shall assess the availability of existing transportation services to ensure that individuals in community-based restoration services are able to attend appointments for restoration services, mental health treatment, and court related appointments. Based on this assessment the Department shall consider the request of the necessary resources to eliminate transportation barriers to make these appointments, including the availability to utilize telehealth as an option for individuals to receive services as needed.

10 **(Recommendation 31)** The Department shall work with the Long Term Competency Subcommittee to explore state administered services to fulfill the continuum of care that is less restrictive than inpatient level of care, more restrictive and intensive than outpatient services, and has some security features to account for public safety. This secure treatment level of care should be available for both civil and forensic populations.

11 **(Recommendation 33)** The Department shall work with the court and parties to identify an upcoming discharge date and initiate the discharge process for each patient as early as possible to decrease the time a CMHIP patient waits to discharge due to discharge barriers.

12 **(Recommendation 34)** The Department shall consider legislation that ensures that all safety net providers contracting with the Department have the resources and workforce to provide Community-Based Restoration Treatment and behavioral health services as needed. Specifically, based on the outcomes of the Denver Pilot, that behavioral health services and restoration services shall be paired together in a singular treatment plan and service delivery. The goal is to coordinate restoration services and behavioral health services to restore persons faster while also providing for their ongoing health and maintenance of competency.

INTERCEPT 5: DISCHARGE

1 **(Recommendation 36)** The Department shall collaborate with HCPF to seek resources to expand Assertive Community Treatment (ACT) if clinically indicated for competency individuals being discharged from a psychiatric hospital to ensure they are receiving the support and treatment they need to be successful after discharge. The Department shall develop a workforce strategy to staff ACT teams.

2 **(Recommendation 35)** Based on the outcomes of the housing program with Colorado Coalition for the Homeless, the Department shall seek resources to extend and, based on need, expand housing services and other collateral services beyond the already funded initial five years. The Department shall request funds to evaluate the efficacy and cost of the program and shall consider any such program in future housing strategy.

3 **(Recommendation 38)** The Department shall collaborate with HCPF to seek resources to expand Assertive Community Treatment (ACT) if clinically indicated for competency individuals being discharged from a psychiatric hospital to ensure they are receiving the support and treatment they need to be successful after discharge. The Department shall develop a workforce strategy to staff ACT teams.

4 **(Recommendation 37)** Every three years, the Department shall assess the accessibility and effectiveness of a continuum of treatment services, including for co-occurring disorders, for individuals receiving competency services in the community and assess the impact to non-justice involved citizens requiring community-based care.

As the Long Term Competency Subcommittee drafted recommendations to support equitable access to behavioral health services in jails, the following was approved to improve the efficiency of competency processes. **WE RECOMMEND** a multi-stakeholder process, including behavioral health providers, competency evaluators, judicial representatives, and individuals with lived experience, to develop a more efficient competency process, such as a competency court or docket, or a standard competency report (report from BH providers/comp evaluator) that focuses on increasing quality and decreasing burden, that judges and courts approve in each jurisdiction.

LEGISLATIVE OPPORTUNITIES

On June 29, 2020, the first piece of legislation derived from work of the BHTF, SB 20-181, was signed into law by Governor Polis. SB 20-181 helps ensure individuals are not held in jail when facing low-level charges and competency is in question or when restoration is unlikely due to a severe disability regardless of the charge. The Long Term Competency Subcommittee drafted concepts that were approved by the BHTF, and then worked with primary sponsors, Senator Pete Lee and Representative Michael Weissman, on SB 20-181: Measures to improve outcomes for defendants who may be incompetent to proceed.

CONCEPT 1 (MUNICIPAL COURT):

When a person has been arrested and charged with a municipal offense and competency has been found by the court or where the defendant is civilly committed, the court shall dismiss the charge. These are very low violations, typically traffic offenses.

CONCEPT 2 (MISDEMEANOR CHARGES):

A person who is in jail on a misdemeanor charge and is found ITP and does not meet an inpatient level of care should be ordered for outpatient restoration treatment; the court must presume releasing the individual on a Personal Recognizance bond or demonstrate by clear and convincing evidence why it is an extraordinary circumstance for not doing so. A bond hearing must take place within seven days of being found incompetent.

CONCEPT 3 (MISDEMEANOR CHARGES):

In addition, this legislation expands the current provisions for non-victims' rights misdemeanors to victims' rights misdemeanors, specifically the provisions that state if the defendant is found incompetent, detained on a misdemeanor, and restoration efforts fail after six months, the court shall dismiss the charges. The legislation also allows a court to dismiss charges against a defendant if they are found ITP and are civilly committed, even if the charges involved victim's rights crimes.

CONCEPT 4 (NO PROBABILITY OF RESTORATION):

If a person is arrested, charged with a crime, competency is raised, the court orders a competency evaluation and an evaluator opines the person is incompetent and it is unlikely that the person will be restored within the reasonably foreseeable future based on:

- An evaluation completed in the last 5 years that determined the person is unlikely to be restored within reasonably foreseeable future OR
- A diagnosis of a moderate to severe cognitive disability (IDD, brain injuries, dementia), that alone or together with a co-occurring mental health issue impacts a person's ability to attain or maintain competency OR
- A person who has been found ITP 3 times in the prior 3 years on the current case or another, even if regaining competency at portions of time, but who slips back to incompetency.

Then, the court shall presume that the individual is unlikely to be restored to competency and maintain competency and shall dismiss the pending criminal charges and order the person's release from criminal custody. If the court finds after a hearing that despite the evaluator's findings, there is clear and convincing evidence that the individual may regain and maintain competency and makes findings of fact on record to support that, the court may order restoration services for a maximum period of 91 days. After 91 days of restoration education, if the individual has not been restored, it will be presumed that the individual is unlikely to regain and maintain competency in the reasonably foreseeable future and the individual shall be presumed to be released. If they are not released, periodic reviews will resume, always carrying the presumption of incompetency and dismissal.

DIVERSION

Diversion recommendations are being put forward from the Long Term Competency Subcommittee to support prevention of reoccurring interaction with law enforcement and the criminal justice system for individuals at high risk because of behavioral health concerns.

PRE-ARREST/PRE-CHARGE

1. In order to prevent reoccurring interaction with law enforcement by individuals whose clinical conditions put them at high risk (e.g., those with high intensity needs, medication non-adherence, persistent and severe mental illness, continuous criminal engagement) and connect individuals in need with treatment before a behavioral health crisis begins or at the earliest possible stage of system interaction, **WE RECOMMEND** investment in

a sustainable safety net continuum of behavioral health services that ensures cohesion between substance use and mental health stabilization services that provide timely access to appropriate services and keep individuals engaged in those services, which shall include:

- A full continuum of services as laid out by Substance Abuse and Mental Health Services Administration and supported by State Safety Net Subcommittee, includes supported work, day treatment and comprehensive case management to provide follow up and support adherence.
- Expansion and modification of current crisis stabilization units and withdrawal management licensure requirements that address the bifurcation between the two systems and allow for treatment of individuals experiencing a co-occurring crisis.
- Investment in crisis line expansion and response resources to reduce mental health crisis response wait times. This includes an expanded capacity of crisis line to manage re-routed 911 calls that require a Co-Responder response or does not require a law enforcement or paramedic response.
- In instances in which a law enforcement response is necessary, a statewide expansion of the Co-Responder model of criminal justice diversion to more communities. Co-Responder teams consist of two-person teams of law enforcement officers and behavioral health specialists to intervene on mental health-related police calls to de-escalate situations that have historically resulted in arrest, and to assess whether the individual should be referred to immediate behavioral health assessment.

PRE-PLEA

1. To support individuals to successfully navigate the judicial system and match up the appropriate risk and need to the appropriate supervision and services, **WE RECOMMEND** intensive case management and pre-trial supervision as outlined by recommendation 10 in the Long term Comprehensive and Cohesive Competency Plan to seek additional resources to create and/or expand pre-trial supervision and case management services for defendants requiring competency services in an effort to provide services in the least restrictive setting. Services to include court reminders, appointment reminders, and transportation.

2. In alignment with the Long Term Comprehensive and Cohesive Competency Plan to consistently support diversion to community services when appropriate and not contrary to public safety concerns, **WE RECOMMEND** a safety net system that is required to serve this high risk pre-plea population and provide an adequate level of support, have a defined process by which law enforcement and courts can interact with the safety net system as described above and be assured and informed of services available to help this population to survive and be successful in the community.

3. In lieu of jail, to provide safe alternatives for the appropriate placement of an individual interacting with law enforcement for those that are experiencing behavioral health symptoms and are not appropriate for immediate return into the community and need secure assessment, **WE RECOMMEND** investment in behavioral health assessment centers; secure treatment centers in lieu of jail that provide a mechanism for law enforcement to consult with professionals to stabilize, screen, assess and determine the optimal placement of individuals that may not belong in jail.

4 **WE RECOMMEND** offering an outpatient treatment diversion option pre-plea, with successful completion of treatment plan resulting in dropped charges, per the following Assisted Outpatient Treatment (AOT) pathway produced by the Equitas Model Law Workgroup:

- A petition for involuntary civil commitment for either inpatient treatment or AOT when it is determined that the person meets criteria for involuntary treatment and continues to be unable to participate in needed treatment on a voluntary basis. The decision whether to seek involuntary civil commitment on an inpatient or outpatient basis shall be based on an assessment of the level of care and supervision required by the individual as well as the availability of resources to provide such care. If a civil commitment petition for involuntary inpatient or outpatient mental health treatment for an individual is filed, the individual may remain in the treatment facility pending a hearing (set timeframe). Treatment should continue as allowed by state law.

POST-PLEA

1 In order to effectively process individuals with identified behavioral health concerns through the judicial system and match risk with need with appropriate level of supervision, **WE RECOMMEND** creation or expansion of behavioral health court/dockets with a focus on high risk/high need defendants. Mental health courts provide higher levels of intervention in both misdemeanor and felony charges and based on level of risk to support individuals who may be at risk for incarceration due to underlying behavioral health diagnoses.

2 To provide continuity of behavioral health services post-plea, **WE RECOMMEND** processes be put in place to support a timely warm hand-off to and from Jail-based Behavioral Health Services (JBBS), including case management services with mechanisms for ongoing process improvement with all relevant stakeholders to ensure coordination and collaboration.

CIVIL COMMITMENT

1 Because the under-utilization of involuntary outpatient treatment is likely related to the reliance on the criminal justice system as a mechanism to get treatment, **WE RECOMMEND** reviewing the requirements for pursuing civil commitment filings in Colorado to consider if modifying the standard for civil commitment is needed to minimize the reliance on the criminal justice system. Any consideration for changes to outpatient involuntary treatment should include diverse stakeholder groups, including representation of consumers and consideration of other state models.

ASSISTED OUTPATIENT TREATMENT

As defined by the Treatment Advocacy Center and Northeast Ohio Medical University, October 2019 white paper, Implementing Assisted Outpatient Treatment: Essential Elements Building Blocks, and Tips for Maximizing Results,[23] Assisted Outpatient Treatment (AOT) is the practice of providing community-based behavioral health treatment under civil court commitment, as a means of: (1) motivating an adult with mental illness who struggles with voluntary treatment adherence to engage fully with their treatment plan; and (2) focusing the attention of treatment providers on the need to work diligently to keep the person engaged in effective treatment. AOT has been demonstrated to reduce hospitalization, homelessness, arrests and incarceration, violence, crime, and victimization. It has also been demonstrated to improve treatment compliance, substance abuse treatment outcomes, and caregiver stress.

An AOT program is defined by its "essential elements," as a systematic, organized effort to:

1. identify individuals within the service area who appear to be persistently non-adherent with needed treatment for their behavioral health diagnosis and meet criteria for AOT under state law;
2. ensure that whenever such individuals are identified, the behavioral health system itself takes the initiative to gather the required evidence and apply to the court for AOT, rather than rely on community members to do so (although community members should not be impeded from initiating an AOT petition or investigation where permitted by state law);
3. safeguard the due process rights of participants at all stages of AOT proceedings;
4. maintain clear lines of communication between the court and the treatment team, such that the court receives the clinical information it needs to exercise its authority appropriately and the treatment team is able to leverage the court's powers as needed;
5. provide evidence-based treatment services focused on engagement and helping the participant maintain stability and safety in the community;
6. continually evaluate the appropriateness of the participant's treatment plan throughout the AOT period, and make adjustments as warranted;
7. employ specific, treatment-based protocols to respond in the event that an AOT participant falters in maintaining treatment engagement;
8. evaluate each AOT participant at the end of the commitment period to determine whether it is appropriate to seek renewal of the commitment or allow the participant to transition to voluntary care;
9. ensure that upon transitioning out of the program, each participant remains connected to the treatment services they continue to need to maintain stability and safety.

The following recommendations will support efforts in Colorado to provide and support AOT as defined by these essential elements and ten building blocks of a sustainable AOT program.

WE RECOMMEND

1. Utilizing the Treatment Advocacy Center's, Implementing Assisted Outpatient Treatment: Essential Building Blocks, Elements and Tips for Maximizing Results framework to explain what AOT is and how it can benefit communities, provide a view into the variability of AOT programs, and identify practices considered promising for successful systematic implementation. If a psychiatric advance directive (PAD) exists for the participant, ensure treatment plan incorporates stipulations in the PAD. The model is only effective if adequately resourced to ensure all the appropriate parties and services can be engaged.

2. Continuation of the convening of a multi-disciplinary team building from the Colorado Behavioral Health Task Force Long Term Competency Subcommittee, including the public mental health authority, civil court judge and personnel, mental health professionals representing community-based, inpatient and psychiatric crisis, attorneys representing petitioners and respondents, Sheriff or police agencies, and peer mentors and consumer/family advocates (Building Block 1) to:

   - Explore other state and county models where AOT has been successfully implemented and studied to identify a programmatic mentor to consult and collaborate with as Colorado develops AOT programs across the state (Building Block 10)
   - Review and recommend changes in legislative statute to support the addition of AOT in Colorado to the current structure of civil commitment options (Building Block 2)
   - Develop clear clinical standards based on evidence-based best practices (eliminate variation) for when an individual is eligible or appropriate for AOT services (both through civil and criminal justice avenues)
   - Create written policies, procedures and forms to ensure key elements and principles of AOT are maintained (Building Block 5)
   - Meet periodically for purposes of program improvement and evaluation (Building Block 6)
   - Actively engage stakeholders who may have concerns or opposition to AOT as a violation of civil rights
   - Determine the appropriate level of judicial engagement, for example a specialized court handling AOT (Building Block 3)
   - Empower judges, prosecutors, and defense attorneys to assist in identifying persons appropriate for off-ramping from criminal justice to AOT
   - Provide the appropriate level of funding to provide the capacity to implement the treatment plans that an AOT order would include at a community level.

3. Establishing a mechanism at the state level to provide participants with standardized printed materials to inform them of their rights and responsibilities (Building Block 7) and for monitoring of participants ordered for involuntary treatment to avoid punitive legal measures, as the best outcomes are those that use motivational approaches. (Building Block 4)

4. Tracking data for purposes of program evaluation and improvement, including participant feedback, re-incarceration rates, rehospitalization rates and Emergency Department utilization rates. (Building Block 9)

5 Educating stakeholders and the community at large on AOT processes, procedures, and overview, including healthcare facilities staff, NAMI, peer support, professional organizations, law enforcement, and judicial system stakeholders. (Building Block 8)

INDIVIDUALS WITH COGNITIVE DISABILITIES

Population of focus for these recommendations includes persons with cognitive disabilities, including but not limited to individuals with intellectual and developmental disabilities (IDD), neurodevelopmental disorders (including autism and fetal alcohol syndrome (FAS)), acquired brain injury, and dementia. Hereafter, this population is referred to as "individuals or population with cognitive disabilities."

IMPROVED DATA COLLECTION AND TRANSPARENCY

1 To understand the prevalence of individuals with cognitive disabilities who are arrested and involved in competency evaluations and restoration, **WE RECOMMEND** OBH collects data from jails and other entities within the competency system and publicly report on data collection processes, outcomes, and at what points these individuals are being identified within the system.

- Reports should identify the number of individuals deemed permanently incompetent to proceed who have cognitive disabilities
- Additional data collection and reporting is needed to understand the populations experiences and outcomes at each intercept
- Data will be aggregated as needed based on small numbers
- To support cross-system evaluation, if possible, align with existing codes used by Department of Corrections and other state agencies

INTERCEPT 0: COMMUNITY SERVICES

1 To enable an increased understanding and knowledge of this population and available resources, **WE RECOMMEND** planned and facilitated opportunities for individuals with cognitive disabilities, law enforcement and first responders, and other partners to interact in non-crisis situations. Facilitated opportunities, such as interactive trainings, will be developed with intentional plans to outreach and involve communities of color and majority non-English speaking communities.

2 **WE RECOMMEND** the State create a committee be established to identify partners and develop or review trainings and organized events for best practices.

3 **WE RECOMMEND** Colorado Crisis Services provide the education and infrastructure for individuals, families, and Community Centered Boards and other case management agencies to develop and file crisis plans and register with Smart911.

INTERCEPT 1: LAW ENFORCEMENT

1. **WE RECOMMEND** confirming that Crisis Intervention Team education components include a focus on identification and interaction skills with individuals with cognitive disabilities.

2. **WE RECOMMEND** developing educational opportunities for law enforcement, judges, and court officials to have better understanding and work with populations with cognitive disabilities. Educational opportunities should include best practices to address language and racial disparities. WE RECOMMEND reviewing available trainings through various state and national advocacy partners and experts for opportunities to scale and spread. Trainings will be reviewed and/or developed by a committee with subject matter expertise in law, mental health and behavioral health, and cognitive disabilities.

3. To maximize effectiveness of co-responder teams, **WE RECOMMEND** co-responder teams have access to behavioral health and community centered boards and other case management agencies information to effectively intervene, to respond appropriately, refer to appropriate agenda, and/or divert to appropriate services when necessary.

4. To ensure the co-responder model is effectively interacting with individuals with cognitive disabilities, **WE RECOMMEND** developing uniform and improved data collection, evaluation, and reporting of co-responder model programs and outcomes across the state.

5. **WE RECOMMEND** the expansion and funding of diversion programs to consider and attend to the needs of individuals with cognitive disabilities.

INTERCEPT 2: INITIAL DETENTION - COURT PROCESS

1. **WE RECOMMEND** a study is conducted with a public report to identify which jails are accredited and provide behavioral health and cognitive disabilities screenings and services across the state to better assist the department and legislature in expending JBBS and other similar funds.

2. **WE RECOMMEND** development of screening standards (based on the current accreditation standards of the National Commission on Correctional Health Care and American Correctional Association) and a system for all jails to have access to screening, either in-person or via tele-health services.

3. **WE RECOMMEND** all individuals are initially screened, preferably by JBBS or other health care professionals, at the time of medical/mental health intake or as soon as practical. Screening tools should include measures to identify cognitive disabilities. Screening tools should be culturally competent and available in multiple languages, and attend to common but less likely identified conditions such as FAS and ASD. To support screening efforts, OBH should provide jails with technical assistance to gain access to health care professionals to conduct screenings.

4. **WE RECOMMEND** all individuals are screened for health care coverage at the time of medical/mental health intake or as soon as practical so benefits (Medicaid) can be suspended or eligible unenrolled individuals can also be identified.

INTERCEPT 3: COMPETENCY EVALUATION

1. **WE RECOMMEND** the state conduct assessment of and publicly report on the wait times for competency evaluation, and identify if individuals with cognitive disabilities experiences different lengths of wait times

2. **WE RECOMMEND** a system is developed so that individuals with cognitive disabilities who are deemed ITP and not likely to be restored on the current charge do not have to undergo further restoration efforts. (Note: this recommendation supports following up SB 19-223 with SB 20-181.)

3. **WE RECOMMEND** an independent study of the competency evaluation process to ensure the guidelines and practices currently in place for individuals with cognitive disabilities are equitability being enacted across the state.

INTERCEPT 4: RESTORATION TREATMENT

1. **WE RECOMMEND** OBH contract with restoration providers that have access and ability to provide specialized restoration curriculums for individuals with cognitive disabilities and recognize when curriculum is not "working" because they will not be restored. This includes the ability to individualize curriculum to a person's needs based on core components of restoration curriculum to ensure quality.

INTERCEPT 5: DISCHARGE

1. **WE RECOMMEND** the Forensic Support Team and Bridges navigators be current on available services for individuals with cognitive disabilities, including Community Centered Boards, Community Mental Health Centers, case management agencies, and medical services, so they can navigate clients appropriately.

2. **WE RECOMMEND** the state provide a continuum of placement options to include less restrictive options than hospitals or jails that may include regional centers, group homes, assisted care facilities, etc.

3. **WE RECOMMEND** OBH, for the purpose of promoting a less restrictive setting than hospitals or jail, explore the use of technology for supervision.

BEHAVIORAL HEALTH SERVICES IN JAIL

The following recommendations are presented to assure that individuals currently in jail or transitioning between jail and the community have access to behavioral health services that consider and meet their needs.

1. Because decisions about behavioral health service provision and providers are at the discretion of individual county-run jails, **WE RECOMMEND** statutory changes crafted in collaboration with stakeholders, including law enforcement and JBBS providers, to a) promote uniformity of JBBS standards available across the state and b) ensure the quality of services provided by private correctional corporations and nonprofits are comparable and delivered to fidelity and c) promote collaboration among JBBS, Adult Diversion, Juvenile Diversion, Bridges, and other related state entities.

2. Because jail facilities across Colorado have different space and workforce capacity to deliver behavioral health services in jails, **WE RECOMMEND** that any statutory changes from recommendation number one include flexibility at the jail level to adapt approaches to delivery of behavioral health services in jails based on available resources and assets to deliver uniform goals/standards with technical assistance and consultation from OBH to deliver programming.

3. To improve quality and continuity of care for inmates, **WE RECOMMEND** enhanced collaboration and coordination between services and community resources, or a single provider, to provide behavioral health, physical health and substance use disorder services within a specific facility or county.

4. To support inmates to continue to manage behavioral health conditions upon discharge from jail, **WE RECOMMEND** OBH work with individual vendors and amend contracts as needed to ensure each individual experiences a seamless transition to community services and support continuity of care. Enhancement of transition services may include transition clinics that coordinate with community services to provide medication management, and bridge to community primary care, behavioral health services, and other community resources to address social determinants of health

5. **WE RECOMMEND** continued investment and collaboration between necessary entities to foster health information exchange, both between jails and between jails and community providers, to provide HIPAA-compliant data sharing supporting continuity of care, faster access to lab results and radiology reports, streamlined access to patient histories and discharge summaries, and automated physician referral and consult processes.

6. **WE RECOMMEND** OBH and JBBS work with county jails to develop and implement protocols to screen, assess, treat, and monitor for triage purposes inmates while in custody and in preparation for successful community re-entry. We recommend OBH provide technical assistance and resources that enable jails to meet the basic standards for interim behavioral health services as well as ensure compliance and quality assurance.

CONCLUSION

Three different subcommittees, three different populations, similar priorities, similar calls for action. Across the lifespan, and across a multitude of settings and circumstances, including communities and the criminal justice system, it is clear that reform is needed to better meet the behavioral health needs of Coloradans. And though there are specificities to meet those needs that cannot be ignored, specificities spelled out in the individual subcommittee recommendations, unifying themes sweep across the Children's Behavioral Health, the State Safety Net and the Long Term Competency Subcommittees, demonstrating that opportunities to strengthen the behavioral health system in Colorado are more alike than different across populations.

ACCESS

All Coloradans deserve equitable, locally driven access to the full continuum of behavioral health services they need to remain well in the communities where they live. Access to the right services, in the right place, at the right time that is trauma-informed and culturally and linguistically responsive preserves the opportunity to manage crisis, avoid intersection with law enforcement and the criminal justice system and maintain wellness in the setting of community.

PREVENTION

Coloradans are best served when behavioral health issues are addressed early or even before they present, in such a way that preserves and supports optimal wellness.

WORKFORCE

In order for Coloradans to have access to the behavioral health services that they deserve, behavioral health providers, across the spectrum of licensure and training, must find ways to connect with all communities across the state.

QUALITY

State and local solutions to provide behavioral health services across Colorado should be data informed and maintain a rigorous and transparent process of continuous quality improvement.

SOCIAL DETERMINANTS OF HEALTH

Both the physical and behavioral health of Coloradans are directly tied to the basic needs that allow them to thrive in their communities, including access to food, safe housing in safe neighborhoods, transportation, economic stability and education.

SPECIFIC POPULATIONS

The needs of Coloradans with cognitive or physical disabilities and co-occurring behavioral health needs; individuals with dual diagnoses; children in the child welfare system and foster care; transition-aged youth; LGBTQIA+ youth; communities of color; and the forensic population should be considered in development and implementation of programs and policies to assure that their unique needs are considered and ultimately met.

DIVERSION FROM CRIMINAL JUSTICE SYSTEM

The criminal justice system should not serve as the de facto behavioral health system. Any services provided within the criminal justice system should be available within the civil behavioral health system, and community behavioral health services should be available to those at risk for interface with law enforcement secondary to behavioral health issues to prevent incarceration.

Underpinning these tenants of whole person health that support wellness of both the body and the mind, is the need for statewide infrastructure that provides governance and directs financing for behavioral health services in Colorado. Subcommittees recognized the essential need for these foundations and entered into challenging discussions about how to design an infrastructure that meets the needs of individuals across the state. Both the State Safety Net and Children's Behavioral Health Subcommittees discussed governance and accountability, highlighting the need for integration across state agencies. Both also provided guidance to develop standards and measures for high fidelity services that do not add burden to service providers or take resources away from direct service delivery to support administrative costs. The Children's Behavioral Health Subcommittee in particular emphasized that any reform to the current behavioral health system consider the unique needs of children and youth, highlighting the need for specific staffing, leadership and authority dedicated to this population. Ultimately, it is the hope that the subcommittee recommendations and considerations provide guidance as the Main Task Force continues its work towards designing and implementing a new behavioral health governance structure for the State of Colorado.

The three subcommittees represented a wide array of subject matter expertise from across the State of Colorado, including consumer and family advocates. The groups were high functioning, and members recognized their individual responsibility to participate and contribute. Racial and ethnic diversity across the three subcommittees was limited, and future efforts to engage stakeholders should assure that the diversity of our state is reflected in representation in discussions that guide policy decisions. Focused discussions on specific populations or services highlighted some limitations of the subcommittee membership. On occasion, there simply were not the right people with the right expertise in the room to inform highly actionable recommendations. These instances are reflected in recommendations that ask for future stakeholder processes with the right subject matter experts to focus on specific topics.

A year of focused and extensive work is reflected in the contents of this subcommittee report, but by no means does this represent the end of the work. In fact, the real work starts now. It will require continued commitment from diverse and committed stakeholders across Colorado to carry this work forward. The Remedy for Behavioral Health Reform will represent an implementation plan that will require more discussion, more debate, and more collaboration. Optimistic yet pragmatic leadership will be essential to continue to push stakeholders and state agencies alike towards system reform that will result in better health that includes meeting the behavioral health needs of all Coloradans. Assuring equitable access to high quality behavioral health services when and where Coloradans need them represents work that will never really be complete. Behavioral health must be at the forefront of the minds of policy makers, legislators, state agency leaders and staff, communities, service providers, and family members so that we never stop paying attention, do not accept the status quo and continuously work towards solutions that meet the behavioral health needs of people living in Colorado.

APPENDICES

Appendix 1. Colorado Behavioral Health Task Force Members

*denotes a committee member who had to step down from the BHTF at some point during the course of the year or replaced a subcommittee member

Main Task Force

Executive Committee

Director Michelle Barnes, Colorado Department of Human Services

Lt. Governor Dianne Primavera

Deputy Manager Barbara Drake, Douglas County

Director Jill Hunsaker Ryan, Colorado Department of Public Health & Environment

Director Kim Bimestefer, Colorado Department of Health Care Policy and Financing

Commissioner Michael Conway, Division of Insurance

Ex-Officio Members

*Greg Dorman, Department of Military and Veterans Affairs – Denver

Kate Greenberg, Colorado Department of Agriculture – Denver

*Brey Hopkins, Colorado Department of Military and Veterans Affairs

*Mickey Hunt, Department of Military and Veterans Affairs - Denver

Nancy Ingalls, Douglas County Schools – Douglas County

Debbie Oldenettel, Colorado Department of Public Safety – Denver

Patty Salazar, Colorado Department of Regulatory Agencies – Denver

Dean Williams, Colorado Department of Corrections – Denver

Task Force Members

*Vincent Atchity, Mental Health Colorado – Denver

*Della Cox-Vieira, Alamosa County Public Health – Alamosa

Daniel Darting, Signal Behavioral Health Network – Greenwood Village

Raul De Villegas-Decker, RDV Executive Consulting – Grand Junction

Jill Derrieux, Mesa Youth Services, Inc. dba Mesa County Partners – Grand Junction

Rebecca Ela, Delta County Memorial Hospital – Hotchkiss

C. Neill Epperson, University of Colorado School of Medicine – Aurora

Jennifer Fanning, Grand County Rural Health Network – Hot Sulphur Springs

Michael Fields, Colorado Rising Action – Parker

Rana Gonzales, Colorado Workers for Innovative New Solutions – Manitou Springs

Deidre Johnson, Center for African American Health – Denver

Tracy Kraft-Tharp, General Assembly – Denver

Lois Landgraf, General Assembly – Denver

Glenn Most, Sisters of Charity of Leavenworth Health System – Wheat Ridge

Cory Notestine, Colorado Springs School District 1 – Colorado Springs

Patricia Oliver, Oliver Behavioral Consultants – Broomfield

Byron Pelton, Commissioner Logan County – Sterling

Valerie Schlecht, Colorado Cross-Disability Coalition – Denver

Meg Taylor, Rocky Mountain Health Plans – Greenwood Village

Laura Teachout, National Alliance on Mental Illness, Colorado Springs Board Member – Colorado Springs

Brian Turner, Solvista Health – Cañon City

*Nancy VanDeMark, Mental Health Colorado - Denver

Selwyn Whiteskunk, Ute Mountain Tribe – Towaoc

Children's Behavioral Health Subcommittee

Co-Chairs

John Laukkanen, Colorado Department of Health Care Policy & Financing – Denver

Shannon Van Deman, Children's Hospital Colorado – Aurora

Ex-Officio Member

Jamie Murray, Cañon City School District – Cañon City

Members

Morgan Bruss, Harrison School District 2 – Colorado Springs

Megan Burch, Eagle County Department of Human Services – Eagle

Sarah Davidon, Davidon Consulting – Denver

Samantha Field, Mental Health Professional – Denver

M. Cecile Fraley, Pediatric Partners of the Southwest – Durango

Brook Griese, Judi's House/JAG Institute – Denver

Jennifer Grote, Denver Health – Denver

Camille Harding, Colorado Department of Human Services – Denver

Rebecca Hea, Denver Children's Home – Denver

Melissa Janiszewski, Office of Children's Affairs – Denver

Dawn Khederian, the Vanguard School – Colorado Springs

*Adrianne Maddux, Denver Indian Health & Family Services – Denver

Carol Meredith – The Arc Arapahoe & Douglas Counties – Centennial

Dafna Michaelson Jenet, Colorado General Assembly – Denver

Aaron Miltenberger, Boys & Girls Clubs of the San Luis Valley – Alamosa

Lindsey Myers, Colorado Department of Public Health & Environment – Denver

Leslie Patterson, Envida – Colorado Springs

Jessica Peck, Peck Law Colorado – Denver

Lindsay Reeves, Catholic Charities Diocese of Pueblo – Pueblo

Lenya Robinson, Jefferson Center for Mental Health – Wheat Ridge

Shannon Secrest, Colorado Cross-Disability Coalition – Aurora

Stephanie Villafuerte, Office of Colorado's Child Protection Ombudsman – Denver

Kathryn Wells, Kempe Center for the Prevention and Treatment of Child Abuse and Neglect – Aurora

Lisa Zimprich, Fountain-Fort Carson School District 8 – Fountain

State Safety Net Subcommittee

Co-Chairs

Nancy Jackson, Arapahoe County – Littleton

Robert Werthwein, Colorado Department of Human Services – Denver

Ex-Officio Members

Kristina Daniel, Valley-Wide Health Systems, Inc. – Alamosa

Rickey Gray, Cedar Springs Hospital – Colorado Springs

*Kiara Kuenzler, Jefferson Center for Mental Health – Wheat Ridge

*Jennifer Leosz, Mental Health Partners - Boulder

Members

Aubrey Boggs, Behavioral Health Ombudsman of Colorado – Denver

Traci Bradford-Walker, Aurora Municipal Courts – Aurora

Frank Cornelia, Colorado Behavioral Healthcare Council – Denver

Kevin Duffy, Douglas County Sheriff's Office – Castle Rock

Melissa Eddleman, Colorado Department of Health Care Policy & Financing – Denver

Marilyn Fausset –Family Advocate, Boulder

Alison George, Colorado Department of Local Affairs – Denver

Kimberly Gonzales, Las Animas Huerfano Counties District Health Department – Trinidad

Joy Hart, Colorado Department of Corrections – Denver

*Levon Hupfer, Galvenize Counseling, Commerce City

Carl LoFaro, Clinical Social Worker – Aurora

Meighen Lovelace, Family Advocate – Avon

Tom Manzione, Attention Homes – Boulder

Mike Nugent, Colorado Department of Public Health & Environment – Denver

*Amber Pace, Centura Health Physician Group – Denver

*Kyle Phillips, Valley-Wide Health Systems, Alamosa

*John Pickett III, Larimer County Human Services – Loveland

Aisha Rousseau, Denver Office of Disability Rights – Denver

Deb Ruttenberg, Grand County Department of Human Services – Hot Sulphur Springs

Jessica Schart, Kit Carson County Department of Public Health and Environment – Burlington

Richard Simms, Richard S Simms PC – Littleton

Lauren Snyder, Mental Health Colorado – Denver

*Danette Swanson, Colorado Rural Health Center, Aurora

Sarah Vaine, Summit County Government – Breckenridge

Eva Veitch, Region 10 Low-income Energy Assistance Program – Montrose

Long Term Competency Subcommittee

Co-Chairs

Alison Butler, Disability Law Colorado – Denver

Robert Werthwein, Colorado Department of Human Services – Denver

Members

Lacey Anne Berumen, TRACKtech LLC – Greenwood Village

*Kyle Brown, UC Health – Aurora

Su Coffey, Family Advocate – Denver

Alexis Giese, Colorado Access – Aurora

Brian Gonzales, University of Denver Graduate School of Social Work – Denver

Ravid Moshe "Moses" Gur, Colorado Behavioral Healthcare Council – Denver

Ben Harris, Colorado Department of Health Care Policy & Finance – Denver

Joy Hart, Colorado Department of Corrections – Denver

Daric Harvey, Cañon City Police – Cañon City

Peggy Heil, Colorado Department of Public Safety – Denver

Tim Lane, Colorado District Attorney's Council – Denver

Richard Martinez, University of Colorado School of Medicine – Denver

Lucienne Ohanian, Colorado State Public Defender – Denver

Brenda Pace, Pueblo County Attorney's Office – Pueblo

Sasha Rai, Denver Health – Denver

Cordelia Rosenberg, University of Colorado – Aurora

Jessica Russell, Health Solutions – Pueblo

Carleigh Sailon, Mental Health Center of Denver – Denver

Jonathan Shamis, State of Colorado Judge – Leadville

Rana Shaner – Consumer Advocate, Olathe

Juan Silva, Denver District Attorney's Office – Denver

Cali Thole, SummitStone Health Partners – Fort Collins

Mary Thomas, Consumer Advocate – Longmont

*Laura Warner, San Juan Basin Public Health – Durango

Appendix 2. Subcommittee Voting Record

Long-Term Competency Subcommittee

11/18/2019 LTC Comprehensive Plan – Recommendations Vote (Numbering reflects order in Comprehensive Plan)				
Recommendation or package of recommendations	Voting members present	Approved	Opposed	Abstained
1. Intercept 0-1	23	23	0	0
2. Intercept 0-2	23	23	0	0
3. Intercept 0-3	23	23	0	0
4. Intercept 1-1	23	23	0	0
5. Intercept 1-2	23	23	0	0
6. Intercept 1-3	23	23	0	0
7. Intercept 1-4	23	23	0	0
8. Intercept 1-5	23	23	0	0
9. Intercept 2-1	23	23	0	0
10. Intercept 2-2	23	23	0	0
11. Intercept 2-3	24	24	0	0
12 Intercept 2-4	24	24	0	0
13. Intercept 2-5	24	24	0	0
14. Intercept 2-6	24	24	0	0
15. Intercept 2-7	24	22	2	0
16. Intercept 2-8	24	22	1	1
17. Intercept 3-1	24	24	0	0
18. Intercept 3-2	24	24	0	0
19. Intercept 3-3	24	24	0	0
20. Intercept 3-4	24	24	0	0
21. Intercept 3-5	24	24	0	0
22. Intercept 3-6	24	24	0	0
23. Intercept 4-1	24	23	0	1
24. Intercept 4-2	24	22	0	2
25. Intercept 4-3	24	24	0	0
26. Intercept 4-4	24	24	0	0
27. Intercept 4-5	24	24	0	0
28. Intercept 4-6	24	24	0	0
29. Intercept 4-7	24	24	0	0
30. Intercept 4-8	24	24	0	0
31. Intercept 4-9	24	24	0	0
32. Intercept 4-10	23	23	0	0
33. Intercept 4-11	23	23	0	0
34. Intercept 4-13	23	23	0	0

35. Intercept 5-1	23	22	0	1
36. Intercept 5-2	22	22	0	0
37. Intercept 5-3	21	21	0	0
38. Intercept 5-4	21	17	0	4

2/10/2020 LTC
Legislative Concepts Vote

Recommendation or package of recommendations	Voting members present	Approved	Opposed	Abstained
Municipal Charges	19	17	2	0
Misdemeanor Charges, part 1	19	18	0	1
Misdemeanor Charges, part 2	19	16	2	1
PITP	19	19	0	0

5/27/2020 LTC
Cognitive Disabilities, including Intellectual and Developmental Disabilities Recommendations Vote

Recommendation or package of recommendations	Voting members present	Approved	Opposed	Abstained
Improved data collection and transparency	19	19	0	0
Intercept 0-1	20	20	0	0
Intercept 0-2	20	18	1	1
Intercept 0-3	20	20	0	0
Intercept 1-1	20	20	0	0
Intercept 1-2	20	19	1	0
Intercept 1-3	20	19	0	1
Intercept 1-4	20	12	6	2
Intercept 1-5	20	20	0	0
Intercept 2-1	20	20	0	0
Intercept 2-2	20	20	0	0
Intercept 2-3	20	18	0	2
Intercept 3-1	20	20	0	0
Intercept 3-3	20	20	0	0

6/8/2020 LTC Votes Remaining IDD Recommendations; Diversion and AOT Recommendations				
Recommendation or package of recommendations	Voting members present	Approved	Opposed	Abstained
IDD 2-4	17	16	0	1
IDD 3-2	18	18	0	0
IDD 4-1	18	18	0	0
IDD 4-2	19	11	2	6
IDD 5-1	19	18	0	1
IDD 5-2	19	19	0	0
IDD 5-3	18	18	0	0
Diversion pre-arrest/pre-charge	18	18	0	0
Diversion pre-plea 1	18	18	0	0
Diversion Pre-plea 2	17	17	0	0
Diversion Pre-plea 3	17	17	0	0
Diversion Pre-plea 4	17	17	0	0
Diversion Post-plea 1	17	16	1	0
Diversion Post-plea 2	17	17	0	0
Diversion Civil Commitment	17	17	0	0
AOT #1-5	18	18	0	0

6/22/2020 LTC Votes Behavioral Health Services in Jails Recommendations				
Recommendation or package of recommendations	Voting members present	Approved	Opposed	Abstained
1	19	18	0	1
2	19	18	0	1
3	18	11	6	1
4	17	14	1	2
5	18	17	0	1
8	18	17	0	1

State Safety Net Subcommittee

3/5/2020 State Safety Net Subcommittee Drafted Recommendation to Present to Main Behavioral Health Task Force				
Recommendation or package of recommendations	Voting members present	Approved	Opposed	Abstained
Telehealth Draft Recommendation	20	20	0	0
System Navigation Draft Recommendations	20	19	0	1
High Intensity Treatment Program Draft Definition	20	20	0	0

5/21/2020 State Safety Net Subcommittee High Intensity Treatment Program Definition				
Recommendation or package of recommendations	Voting members present	Approved	Opposed	Abstained
High Intensity Treatment Program Definition	13	12	0	1

Children's Behavioral Health Subcommittee

2/13/2020 Children's Behavioral Health Subcommittee Service Array, Access, and Workforce Recommendations				
Recommendation or package of recommendations	Voting members present	Approved	Opposed	Abstained
Service Array Recommendations	16	15	0	1
Access Recommendations	18	18	0	0
Workforce Recommendations	18	18	0	0

5/28/2020 Children's Behavioral Health Subcommittee Finance Recommendations				
Recommendation or package of recommendations	Voting members present	Approved	Opposed	Abstained
Finance 1: Consolidate Funding Streams	18	18	0	0
Finance 2: Fiscal Management System	19	19	0	0
Finance 3: Federal Match	18	18	0	0
Finance 5: Systematic Approach to Collect Data	19	19	0	0
Finance 6: State-wide Consultation Program	18	18	0	0
Finance 7: Essential Services Package	19	19	0	0
Finance 8: Open H&B Codes	18	17	0	1
Finance 9: Investment in Prevention and Promotion	19	19	0	0
Finance 10: School Finance Act	19	18	0	1
Finance 11: Track Spending Based on Demographics	19	19	0	0
Finance 12: Utilization Management	18	17	1	0

6/11/2020 Children's Behavioral Health Subcommittee Remaining Finance Recommendation				
Recommendation or package of recommendations	Voting members present	Approved	Opposed	Abstained
Finance 4: Pay and Chase Model	14	14	0	0

6/15/2020 Children's Behavioral Health Subcommittee Governance and Quality Recommendations				
Recommendation or package of recommendations	Voting members present	Approved	Opposed	Abstained
Governance Recommendation	15	15	0	0
Quality Recommendations	16	16	0	0

Appendix 3. Subcommittee Meeting Dates and Objectives

Children's Behavioral Health Subcommittee

8/9/19 — 3 HR MEETING

MEETING OBJECTIVE

3 Welcome and introduce members of the Children's Behavioral Health Subcommittee

4 Grounding/level-setting for the work ahead: Discuss priorities and focus for the Children's Behavioral Health Subcommittee

HOMEWORK

Read the following documents and review recommendations to determine if they resonate as a potential starting point for the subcommittee: *Young Minds Matter report and Roadmap to Colorado's Behavioral Health System for Children, Youth, and Families: 4-year Strategic Plan*

VOTE

None

FINAL DOCUMENTS/ OUTCOMES

None

8/23/19 — 2 HR MEETING

MEETING OBJECTIVE

1 Continued work on defining value statements

2 Children's Behavioral Health Governance Structure

HOMEWORK

Refining values

VOTE

1 Input on vision and values (to align with BHTF and add child/youth focus)

2 Feedback on support for Governance and Systems Management recommendations from the Roadmap to Colorado's Behavioral Health System for Children, Youth, and Families: 4-year Strategic Plan

3 Ask for service continuum examples

FINAL DOCUMENTS/OUTCOMES

Values

9/12/19 — 2 HR MEETING

MEETING OBJECTIVE

Governance Structure Discussion-Part 2

HOMEWORK

Survey before next meeting

VOTE

What three transformational ideas would you prioritize for the Children's Behavioral Health Subcommittee?

FINAL DOCUMENTS/OUTCOMES

Draft Governance recs

10/10/19 — 3 HR MEETING

MEETING OBJECTIVE

1. Revisit operating agreements and decision-making process
2. Review Children's Behavioral Health Subcommittee Scope of Work
3. Introduce Children's Behavioral Health Subcommittee Roadmap
4. Small workgroups – System of Care Functions

HOMEWORK

Submit preferences for workgroups

VOTE

None

FINAL DOCUMENTS/ OUTCOMES

None

10/24/19 — 2.5 HR MEETING

MEETING OBJECTIVE

1. Building on existing work
2. Workgroups Session 1: Service Array, Access, Workforce

HOMEWORK

Ongoing homework to refine workgroup recs

VOTE

Input from Workforce, Service Array, and Access workgroups

FINAL DOCUMENTS/ OUTCOMES

Draft workforce and access recommendations

11/14/19 — 3.5 HR MEETING

MEETING OBJECTIVE

Explore a governance structure for children's behavioral health in Colorado

HOMEWORK

Ongoing homework to refine workgroup recs

VOTE

Straw polls for following:

1. As a foundation for this subcommittee's governance recommendations, do we affirm that this list reflects an accurate picture of the needs of the current system, and which we intend our recommendations to address?
2. What population of kids we want to govern. What are the functions that we want to fall under the purview of the governance structure?
3. Decentralized or centralized governance structure?
4. What authority do we want the body to have?
5. Governance Membership and ensuring stakeholder involvement – what group of stakeholders do we want to propose to be engaged?

FINAL DOCUMENTS/OUTCOMES

None

12/12/19 — 4 HR MEETING

MEETING OBJECTIVE

1. Continued work on defining value statements for the BHTF Children's Behavioral Health Subcommittee
2. Children's Behavioral Health Governance Structure

HOMEWORK

Ongoing homework to refine workgroup recs

VOTE

1. Governance – pros and cons of different models
2. Governance – what components are unique to the kid population?

FINAL DOCUMENTS/OUTCOMES

None

1/9/2020 — 2 HR MEETING

MEETING OBJECTIVE

Workgroup time

HOMEWORK

Ongoing homework to refine workgroup recs

VOTE

None

FINAL DOCUMENTS/OUTCOMES

None

1/23/2020 — 2 HR MEETING

MEETING OBJECTIVE

Workgroup time

HOMEWORK

Ongoing homework to refine workgroup recs

VOTE

None

FINAL DOCUMENTS/OUTCOMES

None

2/13/2020 — 3 HR MEETING

MEETING OBJECTIVE

1. Wrap-up recommendations/debrief Main TF
2. Quality Refresher
3. Connecting proposed finance model to proposed Children's Governance Model

HOMEWORK

Ongoing homework to refine workgroup recs

VOTE

Service Array, Access, Workforce Recommendations

FINAL DOCUMENTS/OUTCOMES

Service Array, Access, Workforce Recommendations

2/27/2020 — 2.5 HR MEETING

MEETING OBJECTIVE

Member level - Quality

HOMEWORK

1. Review of recommendations and proposed financing model from consumer perspective, based on case studies from pubic testimonies
2. Ongoing homework to refine quality recommendations

VOTE

None

FINAL DOCUMENTS/ OUTCOMES

None

3/12/2020 — 3 HR MEETING

MEETING OBJECTIVE

System level – Quality

HOMEWORK

Ongoing homework to refine quality recommendations

VOTE

None

FINAL DOCUMENTS/ OUTCOMES

None

4/23/2020 — 3 HR MEETING

MEETING OBJECTIVE

1. Presentations to inform finance recommendations from Children's Subcommittee
2. Launch discussion to begin drafting finance recommendations
3. Update on SB19-195

HOMEWORK

Ongoing homework to refine quality recommendations

VOTE

Discussion regarding parity and finance recommendations

FINAL DOCUMENTS/ OUTCOMES

Finance recommendations

5/14/2020 — 3 HR MEETING

MEETING OBJECTIVE

1. Continue editing finance recommendations
2. Update on service array, access, and workforce recommendations

HOMEWORK

Ongoing homework to refine quality recommendations

VOTE

Refining recs developed in response to financial reports

FINAL DOCUMENTS/ OUTCOMES

Updated finance recommendations

5/28/2020 — 3 HR MEETING

MEETING OBJECTIVE

1 Refine and vote on finance recommendations

2 Revisit governance recommendations and prime for finalizing

HOMEWORK

Provide feedback on finance recommendation #9 and review the governance 1-pager

VOTE

Finance Recommendations

FINAL DOCUMENTS/ OUTCOMES

Finance Recommendations

6/9/2020 WEBINAR — 1 HR MEETING

MEETING OBJECTIVE

Children's Testimony Qualitative Analysis Overview

HOMEWORK

None

VOTE

None

FINAL DOCUMENTS/ OUTCOMES

None

6/11/2020 — 3 HR MEETING

MEETING OBJECTIVE

1 Finalize finance recommendation

2 Revisit governance recommendations

3 Introduce quality recommendations

HOMEWORK

Provide feedback on governance and quality recommendations

VOTE

None

FINAL DOCUMENTS/ OUTCOMES

None

6/25/2020 — 3 HR MEETING

MEETING OBJECTIVE

1 Finalize and vote on governance recommendations

2 Finalize and vote on quality recommendations

3 Child and Youth Survey results

4 Update from COVID-19 workgroup

HOMEWORK

None

VOTE

Governance and Quality recommendations

FINAL DOCUMENTS/ OUTCOMES

Governance recommendation

Quality recommendations

State Safety Net Subcommittee

7/18/19 — 3 HR MEETING

MEETING OBJECTIVE

1 Welcome and introduce members of the Safety Net Subcommittee

2 Grounding/level-setting: Discuss priorities and focus for the Safety Net Subcommittee

HOMEWORK

None

VOTE

None

FINAL DOCUMENTS/OUTCOMES

None

8/15/19 — 2 HR MEETING

MEETING OBJECTIVE

1 Review Operating Agreements and Person-First Language

2 Refine definition of "safety net"

3 Overview of SB 222 and work of the subcommittee

HOMEWORK

SN definition survey

VOTE

Feedback and Review of Safety Net definition

FINAL DOCUMENTS/OUTCOMES

Draft definition of "Safety Net"

9/5/19 — 2 HR MEETING

MEETING OBJECTIVE

1 Finalize "safety net" definitions

2 Safety Net Subcommittee roadmap; work ahead

3 Introduce continuum of care examples

HOMEWORK

None

VOTE

Feedback on Safety Net definition

FINAL DOCUMENTS/OUTCOMES

Updated Safety Net definition

9/19/19 — 2 HR MEETING

MEETING OBJECTIVE

Small group discussion: Safety Net service continuum

HOMEWORK

Provide input on continuum of care

VOTE

Adding details to "protractor" spectrum of care

FINAL DOCUMENTS/OUTCOMES

List to add to continuum of care

10/3/19 — 2 HR MEETING

MEETING OBJECTIVE

1 Synthesis of continuum work to date

2 Small group discussion: Safety Net service continuum

HOMEWORK

None

VOTE

Identify existing, existing but insufficient, and redundant systems in continuum of care

FINAL DOCUMENTS/OUTCOMES

Updated continuum of care

10/17/19 — 2 HR MEETING

MEETING OBJECTIVE

Presentations: Community Mental Health Centers' Role in the Continuum

HOMEWORK

Service continuum from perspective of Colorado families (discussion of case studies)

VOTE

None

FINAL DOCUMENTS/OUTCOMES

None

11/7/19 — 3.5 HR MEETING

MEETING OBJECTIVE

1 Discuss Colorado's financing structure

2 Overview of Ombudsman Office

3 Report out – Service continuum from perspective of Colorado families

4 CMHC presentation

5 Multi-vote: Prioritize work for recommendations

HOMEWORK

Vote on priorities for subcommittee work leading to recommendations and pre-readings

VOTE

Multi-poll: prioritize work for rec's

FINAL DOCUMENTS/OUTCOMES

Prioritized categories for subcommittee recommendations

11/21/19 WEBINAR — 2 HR MEETING

MEETING OBJECTIVE

Counties webinar

1. Overview of five counties that have implemented behavioral health solutions at the local level
2. Learn what is going well
3. Hear recommendations counties think SN subcommittee should consider

HOMEWORK

None

VOTE

None

FINAL DOCUMENTS/OUTCOMES

None

12/5/19 WEBINAR — 1 HR MEETING

MEETING OBJECTIVE

WICHE report webinar

HOMEWORK

None

VOTE

None

FINAL DOCUMENTS/OUTCOMES

None

12/19/19 — 3.5 HR MEETING

MEETING OBJECTIVE

1. Discuss key takeaways from counties and WICHE report webinars
2. Present results of November multi vote on priorities
3. Begin prioritized workgroup discussions

HOMEWORK

None

VOTE

Prioritize top 3 solutions/strategies in workgroups

FINAL DOCUMENTS/OUTCOMES

Prioritization of solutions and strategies

1/16/2020 — 3 HR MEETING

MEETING OBJECTIVE

Overview of state models to consolidate behavioral health financing and structure

HOMEWORK

None

VOTE

None

FINAL DOCUMENTS/OUTCOMES

None

2/6/2020 — 4 HR MEETING

MEETING OBJECTIVE

1 Debrief 1/24 all BHTF and subcommittees meeting

2 Discuss consumer experience in the proposed model

HOMEWORK

Survey: high intensity treatment program definition and recommendations feedback

VOTE

None

FINAL DOCUMENTS/OUTCOMES

None

3/5/2020 — 3 HR MEETING

MEETING OBJECTIVE

1 High Intensity Behavioral Health Treatment Program definition

2 Feedback on recommendations: Telehealth, System Navigation, Access

HOMEWORK

None

VOTE

Feedback and vote on recommendations

FINAL DOCUMENTS/OUTCOMES

Drafted recommendations for Telehealth and System Navigation

5/7/2020 — 4 HR MEETING

MEETING OBJECTIVE

1 Reorient to Subcommittee Work and Timeline

2 Presentation and Discussion of Safety Net Models

HOMEWORK

None

VOTE

Input on model from each individual subcommittee member

FINAL DOCUMENTS/OUTCOMES

Video for main BHTF with input from each safety net subcommittee member

5/21/2020 — 2 HR MEETING

MEETING OBJECTIVE

1 Define high intensity behavioral health services

2 Discussion entities providing behavioral health services in Colorado

HOMEWORK

High intensity behavioral health services

VOTE

Definition high intensity behavioral health services

FINAL DOCUMENTS/OUTCOMES

Definition high intensity behavioral health services

6/4/2020 — 3 HR MEETING

MEETING OBJECTIVE

1 High intensity behavioral health services from consumer perspective

2 Revisit safety net continuum of services

HOMEWORK

Identifying subcommittee priorities

VOTE

Identifying subcommittee priorities

FINAL DOCUMENTS/OUTCOMES

Safety net continuum of services

6/18/2020 — 2 HR MEETING

MEETING OBJECTIVE

1 Connecting Persons in Need Study findings with high intensity behavioral health services

2 Revisiting parking lot items

3 Refining subcommittee priorities

HOMEWORK

None

VOTE

Identifying subcommittee priorities

FINAL DOCUMENTS/OUTCOMES

Subcommittee priorities

Long Term Competency Subcommittee

7/10/19 — 2 HR MEETING

MEETING OBJECTIVE

1 Welcome and introduce members of the Long Term Competency (LTC) Subcommittee

2 Grounding/level-setting for the work ahead for the BHTF

- Determine how we would like to work together
- Define the role of the LTC Subcommittee
- Provide historical narrative of how Subcommittee came to be

HOMEWORK

None

VOTE

None

FINAL DOCUMENTS/OUTCOMES

None

7/22/19 — 2 HR MEETING

MEETING OBJECTIVE

1 Operating Agreements

2 Timelines/deliverables

3 Outpatient Restoration

HOMEWORK

None

VOTE

None

FINAL DOCUMENTS/OUTCOMES

Operating agreements

8/12/19 — 2 HR MEETING

MEETING OBJECTIVE

1 What is the function of this subcommittee - is it just to help improve the competency process to get someone well enough to stand trial or is there more of a role to help improve access to mental health resources in Colorado?

2 What are the priorities or big issue areas this subcommittee should focus on?

HOMEWORK

None

VOTE

Function and priorities of LTC Subcommittee and Competency Evaluation Recommendation

FINAL DOCUMENTS/OUTCOMES

Identification of functions and priorities of LTC Subcommittee and updates for Competency Evaluation Recommendations

8/29/19 — 3 HR MEETING

MEETING OBJECTIVE

1 Special Master's Report - overview and clarification

2 Wrap up discussion - Intercept 3: Competency Evaluation

HOMEWORK

Review and edit recommendations in Intercept 3

VOTE

None

FINAL DOCUMENTS/OUTCOMES

None

9/6/19 — 2 HR MEETING

MEETING OBJECTIVE

Intercept 4 – Restoration Treatment Overview and Discussion

HOMEWORK

Review and edit recommendations in Intercept 4

VOTE

Review Recommendations 1, 2, 3, and 16

FINAL DOCUMENTS/OUTCOMES

Updates for recommendations 1,2,3, and 16

9/23/19 — 3 HR MEETING

MEETING OBJECTIVE

1 Defelonizing Symptoms of Mental Health Conditions

2 Cont. Intercept 4 – Restoration Treatment Overview and Discussion

3 Intro Intercept 5

HOMEWORK

Cont. review and edit recommendations in Intercept 4

VOTE

Review Recommendations in Intercept 4

FINAL DOCUMENTS/OUTCOMES

Updated Recommendations in Intercept 4

10/8/19 — 4 HR MEETING

MEETING OBJECTIVE

1 Intercept 5 – Discharge

2 Intercept 1 – Law Enforcement

3 Intercept 2 – Court Process

HOMEWORK

None

VOTE

Review Recommendations in Intercepts 1 and 5

FINAL DOCUMENTS/OUTCOMES

Updated Recommendations in Intercepts 1 and 5

10/9/19 — 4 HR MEETING

MEETING OBJECTIVE

Intercept 0/6 – Community Services

HOMEWORK

Review and edit recommendations in Intercepts 5, 1, 0, 2, 6

VOTE

Review Recommendations in Intercepts 0, 2, and 4

FINAL DOCUMENTS/OUTCOMES

Updated Recommendations in Intercepts 0, 2, and 4

10/28/19 — 2 HR MEETING

MEETING OBJECTIVE

1 Revisit recommendations after subcommittee survey

2 Value Statements to include in LTC Plan

3 Legislative Recommendations from subcommittee

HOMEWORK

Final review of all recommendations to be included in Comprehensive Plan

VOTE

Review of Recommendations post survey

FINAL DOCUMENTS/OUTCOMES

Updated Recommendations post survey

11/7/19 — 1 HR MEETING

MEETING OBJECTIVE

Legislative Webinar

VOTE

None

HOMEWORK

None

FINAL DOCUMENTS/OUTCOMES

None

11/18/19 — 3 HR MEETING

MEETING OBJECTIVE

Voting on Final Recommendations for Long Term Comprehensive and Cohesive Competency Plan

VOTE

Final recommendations for LTC and Cohesive Competency Plan

HOMEWORK

None

FINAL DOCUMENTS/OUTCOMES

Final recommendations for LTC and Cohesive Competency Plan

12/9/19 — 2 HR MEETING

MEETING OBJECTIVE

Consumer Panel

VOTE

None

HOMEWORK

None

FINAL DOCUMENTS/OUTCOMES

None

1/13/2020 — 2 HR MEETING

MEETING OBJECTIVE

1 Review and discuss plans for legislation related to LTC subcommittee work

2 Wrap up input to Comprehensive Plan

3 Orient and reset for LTC subcommittee Phase 2 work

VOTE

None

FINAL DOCUMENTS/OUTCOMES

None

HOMEWORK

None

1/27/2020 — 2 HR MEETING

MEETING OBJECTIVE

1 Debrief 1/24 meeting and legislative small group

2 Phase 2 Workgroups

HOMEWORK

Review legislative language Google Doc to prepare for vote on 2/10/2020

VOTE

None

FINAL DOCUMENTS/OUTCOMES

None

2/7/2020 — 1 HR MEETING

MEETING OBJECTIVE

Legislative webinar

HOMEWORK

Ongoing review legislative language

VOTE

None

FINAL DOCUMENTS/OUTCOMES

None

2/10/2020 — 2 HR MEETING

MEETING OBJECTIVE

1 Legislative Update

2 Phase 2 Workgroup Time – draft recommendations

HOMEWORK

None

VOTE

Vote on proposed legislative concepts to move forward to BHTF

FINAL DOCUMENTS/OUTCOMES

Proposed legislative concepts

2/24/2020 — 2 HR MEETING

MEETING OBJECTIVE

Phase 2 Workgroups – draft recommendations

Group 1: IDD

Group 2: Diversion and AOT

HOMEWORK

Ongoing review and edits to IDD, Diversion and AOT recs

VOTE

None

FINAL DOCUMENTS/OUTCOMES

None

3/9/2020 — 2 HR MEETING

MEETING OBJECTIVE

Cont. Phase 2 Workgroups – draft recommendations

Group 1: IDD

Group 2: Diversion and AOT

HOMEWORK

Ongoing review and edits to IDD, Diversion and AOT recs

VOTE

None

FINAL DOCUMENTS/OUTCOMES

None

4/27/2020 — 2 HR MEETING

MEETING OBJECTIVE

Final work group time for AOT/Diversion and IDD

HOMEWORK

Review the recommendations submitted to the Federal Court

VOTE

None

FINAL DOCUMENTS/OUTCOMES

None

5/11/2020 — 2 HR MEETING

MEETING OBJECTIVE

1 Transition to jail-based services work

2 Final preparations before voting on IDD, Diversion, and AOT recommendations

HOMEWORK

IDD Recommendations: Review, Prioritizing Comprehensive Plan Recommendations: Survey, and AOT and Diversion Recommendations – continue to refine in Google doc

VOTE

None

FINAL DOCUMENTS/OUTCOMES

None

5/27/2020 — 2 HR MEETING

MEETING OBJECTIVE

1 Final review and vote on IDD recommendations

2 Review and discussion of JBBS recommendations

3 Progress on prioritization of Comprehensive Plan recommendations

HOMEWORK

Review and provide edits to JBBS recommendations and take Prioritizing Comprehensive Plan Survey

VOTE

Recommendations

FINAL DOCUMENTS/OUTCOMES

IDD Recommendations

6/8/2020 — 3 HR MEETING

MEETING OBJECTIVE

1. Vote on remaining IDD recommendations
2. Finalize and vote on Diversion and AOT recommendations
3. Introduce JBBS recommendations

HOMEWORK

Refine and finalize behavioral health services in jails recommendations
Review and provide edits to JBBS recommendations and take Prioritizing Comprehensive Plan Survey

VOTE

Remaining IDD Recommendations, Diversion, AOT recommendations

FINAL DOCUMENTS/OUTCOMES

Final IDD Recommendations, Diversion and AOT recommendations

6/22/2020 — 3 HR MEETING

MEETING OBJECTIVE

1. Finalize and vote on behavioral health services in jails recommendations
2. Prioritize comprehensive plan recommendations

HOMEWORK

None

VOTE

Behavioral health services in jails recommendations

FINAL DOCUMENTS/OUTCOMES

Behavioral health services in jails recommendations

Prioritized comprehensive plan recommendations

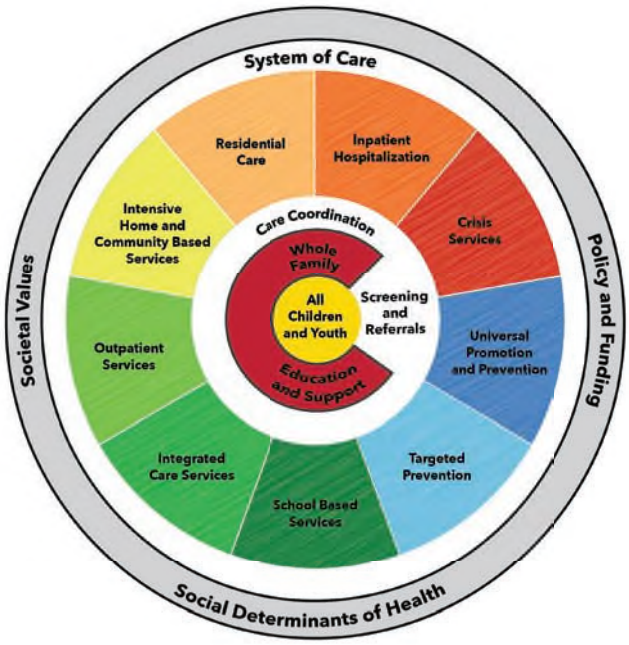
Appendix 4. Colorado Continuum of Behavioral Health for Children and Youth

System of Care: Core Values and Principles

A "system of care" is defined as a spectrum of effective services and supports, organized within a coordinated community network, that partners with individuals and families to meet their cultural and linguistic needs while helping them function better in all aspects of their life.[24] A system of care operates within its larger societal context and is only successful when there is ample public and legislative support for the prioritization and funding of a full continuum of prevention and intervention services. The system relies upon meaningful collaboration and cooperation amongst all agencies and departments, including early childhood, education, human services, child welfare, housing, transportation, public health, law enforcement, corrections, and health and behavioral health care insurers and providers.

The Colorado Behavioral Health Task Force Children's Behavioral Health Subcommittee views the following core values and principles as essential to an inclusive and effective approach to meeting the needs of our state's youth and families:

- Developmentally appropriate services that are individualized and support the whole family through meaningful partnership and collaboration
- Culturally, socially, and linguistically competent and responsive services to reach communities that require additional outreach and those underrepresented in the behavioral health system (e.g., LGBTQIA+, Hispanic/Latin, Tribal, unsheltered, refugees, deaf and blind)
- Trauma-informed services that address the impacts of adverse childhood experiences (ACEs) and other potentially traumatic events
- Accessible, affordable, and inclusive services regardless of diagnostic status
- Strengths-based, resilience, and wellness approaches that include upstream promotion and prevention rather than a singular focus on illness and disorder
- Effective and evidence-informed community-based services that address the full range of social, emotional, physical, and educational needs, including both traditional and nontraditional modalities and informal supports
- Integrated and coordinated care across settings with seamless care transitions and provision of services within the least restrictive environments deemed clinically appropriate
- Advocacy and protection of the rights of all children, adults, and families, with continuous tracking of quality and accountability metrics at the system and practice level



Behavioral Health Service Array

The graphic above is a representation of the comprehensive continuum of care that the Colorado Behavioral Health Task Force Children's Behavioral Health Subcommittee (BHTFCS) deems essential for children and youth across the state to have access to where, when, and as needed. This visual representation highlights the importance of all children and families having access to the right service at the right time through careful assessment and care coordination, with the continuum progressing from lower to higher levels of intensity of need and corresponding service—from promotion and prevention to crisis services. This is not a linear or mutually exclusive continuum, as many youth would benefit from multiple services within the array simultaneously. Rather than continuing to be forced to spin the roulette wheel and land where they might, families should be guided in "dialing in" to the most appropriate and effective services for their children in a timely, accessible, and affordable way.

Below are descriptions of each element of the recommended service array, along with key examples:

All Children and Youth

ALL YOUTH IN COLORADO AGED 0-26 YEARS

For the purpose of addressing the behavioral health needs of Colorado's young people, the Children's Behavioral Health Subcommittee defines "children" as ALL youth, from birth to 26 years old, in line with Colorado Senate Bill 19-195, brain development research, insurance coverage policies, and recent trends in the parenting and living arrangements of young adults. Given alarming increases in behavioral health problems and suicide attempts for youth of all backgrounds, the service array must be accessible to all and not limited to high risk populations. Essentially, all youth are "at risk" during this time in our society's development when technology, social media, and other stressors are contributing to a youth suicide and behavioral health crisis.

WHOLE FAMILY EDUCATION AND SUPPORT

- Psychoeducation on youth's behavioral health issues
- Parenting skills and support

In order for an individual to effectively manage their own behavioral health, it is imperative that their surrounding support system have the knowledge and tools to help provide positive scaffolding for wellbeing. This is particularly true for the young people in our state. Children and youth live, learn, and grow within a family system that profoundly impacts their social, emotional, and behavioral development. Given indisputable evidence of how critical the health, wellbeing, and awareness of parents and caregivers are to the behavioral health of their children, the value and importance of whole family education and support is central to a successful system of care. This includes psychoeducation and parenting support for all caregivers.

EASY ACCESS TO SCREENING AND REFERRALS

- Screening and assessment
- Referral services

Across the board there needs to be increased awareness of and access to screening and referral services in our state—for those in immediate crisis, but also for youth and families who simply need assistance determining what kind of support they need and where to find it. Without broad awareness of resources and ready access to information and early identification services, we will continue to see the startling increase in behavioral health problems and youth suicide rates in our state. Standardized screening assessments are recommended to aid in communication and coordination of care as well as prevention efforts.

CARE COORDINATION

- Care coordination and navigation

Navigating the behavioral health care landscape can be incredibly daunting. Many spend several months trying to find the right service, during which difficulties often worsen, further disrupting lives and developmental trajectories. Timeliness of identification and intervention is particularly crucial for children given how rapidly their brains and behavior patterns are developing. There is a tremendous need for easily accessible and highly trained care coordinators who help individuals and families navigate the system, connect with the right service at the right time, and aid in ensuring continuity of care and collaboration among providers with seamless care transitions. Care coordination is an essential service that should be covered by insurance and other funding sources. This should include linkages and warm hand-offs to services that address social determinants of health, such as food, housing, and transportation. There are opportunities to consider training or certification in care coordination for individuals who do not have advanced degrees in behavioral health.

UNIVERSAL PROMOTION AND PREVENTION

- Awareness campaigns (e.g., public service announcements, behavioral health information and tips shared via media, internet, printed materials, and presentations in schools, primary care offices, and other community settings)
- Safe community spaces and afterschool programs that promote positive youth development
- Social-emotional learning and coping skills development

Intentional integration of social emotional learning and behavioral health education throughout our communities—in classrooms, doctors' offices, workplaces, and the media—can help promote awareness and actions that support mental and physical wellness across the lifespan. In particular, children, adolescents, and young adults are in a critical period of developing social emotional skills and coping strategies that promote lifelong resilience and wellbeing. Providing youth and those who educate and care for them with knowledge and tools is a powerful and cost-effective way to help prevent behavioral health issues from developing or progressing. Awareness building and education should be happening in all settings where youth and families spend their time—especially schools, youth agencies, and primary care settings. Ensuring access to safe community spaces and afterschool programs for children and teens is another important way to promote resilience and support positive youth development.

Upstream prevention efforts begin with universal approaches that are designed for an entire population regardless of individual risk factors. These strategies are generally provided through easily accessible platforms, such as web-based written resources and training, as well as large group outreach and education efforts. These approaches can often be provided at low cost and by trained lay people rather than behavioral health professionals. For example, many schools are implementing resilience and suicide prevention programs, such as Sources of Strength (sourcesofstrength.org), which train students and caring adults to facilitate peer education and support.

TARGETED PREVENTION

- Selective prevention services
- Indicated prevention services/early intervention
- Trauma-informed psychoeducation, coping skills training, and preventive interventions following exposure to potentially traumatic events or other adverse childhood experiences (ACEs), regardless of diagnostic status
- Peer support
- Exercise programs
- Nontraditional therapies
- Group counseling
- Home visitation (e.g., for new or at-risk parents)
- Comprehensive family programs
- Parenting education for caregivers specific to the child's experiences or condition

Targeted prevention includes both "selective" and "indicated" prevention strategies. Selective prevention targets at-risk populations regardless of identified symptoms or problems. For example, providing trauma-informed psychoeducation and supportive services for those who have been exposed to potentially traumatic events or adverse childhood experiences (ACEs). Indicated prevention includes early interventions aimed at individuals with identified behavioral health issues and needs that are designed to reduce symptoms and prevent additional difficulties and life disruption. These are often less intensive and more cost-effective therapeutic approaches, such as

group counseling or peer support, that can help prevent the need for services that are more expensive or difficult to access. Targeted preventive services should be readily accessible and covered by insurance or other funding whether or not the impacted individuals have a diagnosable condition or disorder. We need to move towards including a strengths-based wellness approach to behavioral health and resilience rather than limiting our scope to illness and medical models of care.

SCHOOL BASED SERVICES

- Screening, Assessment, and Referral services
- Social-emotional learning and coping skills development
- Suicide prevention training
- Parenting education and training
- Psychoeducation
- Educational supports and accommodations
- Peer support
- Group counseling
- Individual counseling

As most children and youth are enrolled in an educational setting, early childhood centers, schools, and colleges are key locations for providing behavioral health screening, prevention, and intervention. Students who have unaddressed trauma, loss, and behavioral health needs are less likely to be able to engage successfully in school—academically or socially. In order to fulfill their commitment to whole child education, schools need to have the funding and resources to provide tiered services that meet the diverse needs of their students—whether through behavioral health professionals employed by the school or in close and coordinated partnership with providers in their community. These services should include social emotional and coping skills education, suicide prevention training, behavioral health screening and assessment, individual and group counseling, and referral and care coordination. Training of teachers and school personnel is also key to an informed and supportive environment for all children and families.

INTEGRATED CARE SERVICESS

- Integrated primary care
- Integrated specialty care
- Screening, Assessment, and Referral for behavioral health and substance use issues
- Psychoeducation and coping skills training
- Parenting education and skills training
- Individual counseling/therapy
- Medication management

Increasing the amount of primary care and other health care settings that have behavioral health providers imbedded in the practice is central to attending to mental health and substance abuse needs in a timely manner by removing barriers to this support, such as stigma and lack of understanding of behavioral health needs. Early identification is key to prevention and effective intervention. At a minimum, health care settings need to be trained and equipped to provide screening assessments that help them direct their patients to appropriate care, including warm hand-offs and ongoing care coordination with affordable and accessible behavioral health providers. Given that a large percentage of psychiatric medication management is already provided by primary care physicians, it is essential that continuing education and training in psychiatric care is required. To aid in care integration efforts, behavioral health needs must be covered by insurance at parity with other health conditions.

OUTPATIENT SERVICES

- Screening, Assessment, and Referral services
- Psychoeducation and coping skills training
- Clubhouse Services
- Parenting education and training
- Individual counseling/therapy
- Group counseling/therapy
- Family counseling/therapy
- Substance use disorder treatment (e.g., MAT)
- Psychiatric medication management
- Telehealth (for all of the above services)

A successful system of care requires ample access to outpatient providers with training and specialization in varied behavioral health issues and with demonstrated cultural, developmental, social, and linguistic competence. This includes private practitioners, group practices, nonprofit organizations, and behavioral health organizations. Outpatient providers offer such services as assessments, psychoeducation, parenting support, individual and group counseling or therapy, family therapy, substance abuse treatment, and medication management. There is a particularly large gap in availability of providers in rural and mountain communities in Colorado, requiring financial incentives for professionals to practice in these areas. Telehealth approaches are also a very helpful way to expand access to outpatient care for those who are not able to get to a physical location for services.

INTENSIVE HOME AND COMMUNITY BASED SERVICES

- Frequent psychotherapy sessions
- Frequent medication management sessions
- Intensive family therapy
- Functional Family Therapy (FFT)
- Multisystemic Therapy (MST)
- High Fidelity Wraparound
- Ancillary home-based services, home health care, habilitation
- Rehabilitation and recovery services
- Therapeutic preschools and schools
- Partial hospitalization/day treatment
- Peer support
- Exercise programs
- Nontraditional therapies
- Respite

Youth with behavioral health issues that warrant several hours of intensive community-based services each week need a comprehensive and coordinated treatment plan to prevent escalation to more restrictive and costly levels of care. Youth who are transitioning back from residential or inpatient care to living at home or in the community need services that aid in successful adjustment and maintenance of health in addition to continued behavioral health treatment. Youth and families with this level of need must have access to intensive services, such as frequent psychotherapy and medication management sessions, ancillary home-based services, intensive family therapy, high fidelity wraparound services, peer support, exercise programs, non-traditional therapies, rehabilitation and recovery services, and respite for parents and caregivers. Therapeutic schools, partial hospitalization programs, and day treatment facilities are also essential for those in need of care and supervision throughout the day.

RESIDENTIAL CARE

- Residential psychiatric and substance use disorder treatment facilities
- Therapeutic and rehabilitation group homes
- Therapeutic foster care
- Juvenile justice/corrections therapeutic facilities (e.g., trauma-informed individual and group therapy, substance use disorder treatment, life skills training, social-emotional learning and coping skills development, whole family psychoeducation)

Short- and long-term residential behavioral health care must be available to youth who are not able to live safely in their homes due to mental health, developmental disability, and/or substance abuse issues. This includes treatment facilities, therapeutic and rehabilitation group homes, and therapeutic foster care. For youth who are incarcerated or in juvenile justice facilities, trauma-informed therapeutic services, life skills training, social emotional learning, and whole family education and support are all vital to rehabilitation and prevention of reoffending or exacerbated mental health and substance abuse issues.

INPATIENT HOSPITALIZATION

For individuals who are a danger to themselves or others or whose symptoms are too severe to be managed in the home or community, there must be an adequate number of accessible inpatient beds and providers to accommodate their needs. In particular, our state has seen a tremendous increase in youth arriving at emergency rooms with suicidal ideation and behaviors, and without a corresponding increase in inpatient services we will continue to see our youth suicide rates skyrocket.

CRISIS SERVICES

- 24/7 crisis hotlines
- Mobile crisis services
- Crisis assessment, intervention, and stabilization services
- Co-responder units (police paired with behavioral health and IDD professionals)
- Integrated emergency departments
- Detox services

It is essential that youth and families have ready access to crisis services across the state. These must be effective services that ensure that those in crisis receive the care they need in the moment and ongoing support for continued stabilization. These include 24/7 crisis hotlines, mobile crisis services, co-responder units (police paired with behavioral health and intellectual and developmental disabilities professionals), integrated emergency departments, detox services, and crisis assessment, intervention, and stabilization services. Given disturbing increases in youth anxiety, depression, substance abuse, co-occurring diagnoses, and suicide attempts—with younger and younger children dying by suicide, it is critical that all children, adolescents, young adults, educators, parents and caregivers are aware of crisis services that are easily and immediately accessible throughout Colorado.

Appendix 5. External Experts Who Reviewed the State Safety Net Subcommittee Definition of High Intensity Behavioral Health Services

Kenneth Crawford, LCSW
Wellness Court Coordinator, City of Aurora

Liz Gerdeman, MA, CBIST
Director, MINDSOURCE

Joe Homlar
Director, Division of Child Welfare, Office of Children, Youth & Families, CDHS

Arthur Schut
Principal, Arthur Schut Consulting LLC

Appendix 6. Common Acronyms

AOT - Assisted Outpatient Treatment

ASD - Autism Spectrum Disorder

CDE - Colorado Department of Education

CDHS - Colorado Department of Human Services

CDPHE - Colorado Department of Public Health and Environment

DOI - Division of Insurance

DORA - Department of Regulatory Agencies

FAS - Fetal Alcohol Syndrome

HCPF - Department of Health Care Policy and Financing

IDD - Intellectual and Development Disability

ITP - Incompetent to Proceed

JBBS - Jail-based Behavioral Health Services

LCSW - Licensed Clinical Social Worker

LGBTQIA+ - Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, Intersex, Asexual, Plus other identities

OBH - Office of Behavioral Health

OCYF - Colorado Office of Children, Youth and Families

OEC - Colorado Office of Early Childhood

PCP - Primary Care Provider

SAMHSA - Substance Abuse and Mental Health Services Administration

SUD - Substance Use Disorder

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COLORADO
Behavioral Health Task Force
Department of Human Services

APPENDICES

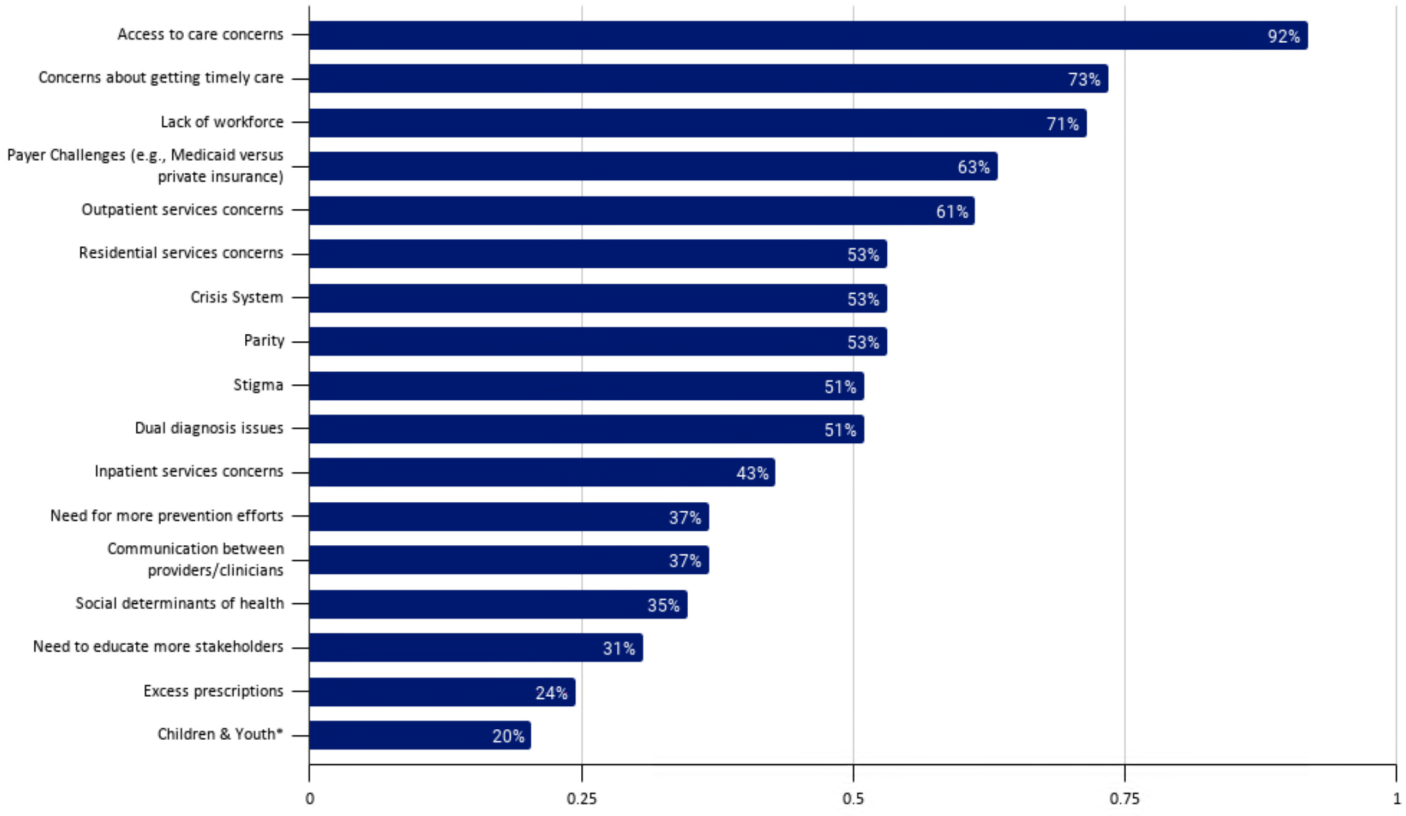
Appendix B. Listening Session Summary

Public Testimony Summary – July 20, 2020

This document reflects a summary of the results from the public testimony surveys sent to Behavioral Health Task Force (BHTF) members as of May 26, 2020. Forty-nine overall responses were received, and summarizes eleven public testimonies (through May 26th, 2020.).

The public testimonies are an opportunity for family members and people with lived experiences to share their stories and offer recommendations to the Behavioral Health Task Force (BHTF). Other stakeholders such as providers and private therapists have also joined these forums. Videos of some of the testimonies can be found on the BHTF webpage: bit.ly/COBHTF

The top theme identified by survey respondents was Access to Care Concerns, with 92% response rate. Concerns About Getting Timely Care (73%) and Lack of Workforce (71%) were the next two ranking themes identified by survey respondents:



* Note that "Children & Youth" were added to the survey as an option for the surveys starting in December 2019 and, thus, is not reflective of all responses.

Douglas County

8/28/2019 5:00-8:00 P.M. **# OF TASK FORCE MEMBER PARTICIPANTS: 8**

Themes shared by BHTF member participants in their own words:

- Need for navigator to help people get in the right door; barriers to families such as not understanding insurance benefits, knowing where treatment is available, struggling to get help or information about treatment for their loved ones
- Difficulty getting treatment; not being able to get the help they need for themselves or their family members
- Difficulty accessing care for Intellectual and Developmental Disability (IDD) population; gap in continuum of care for high-level-needs individuals who are no longer appropriate for hospitalization
- Stigma
- Lack of timely access to providers
- System failures
- Many people were arrested and taken to jail because treament was not available
- Large out-of-pocket expenses due to payment systems that are confusing and inadequate
- Lack of communication between providers/facilities and family members due to Health Insurance Portability and Accountability Act (HIPPA)
- When the Behavioral Health Organization (BHO) capitation program changed to the Regional Accountable Entities (RAEs), certain services are more at risk, such as those programs that are not funded in a traditional Fee-for-Service (FFS) model, or that lack adequate funding

Denver (Colorado Department of Human Services)

9/10/2019 7:30-10:30 A.M. **# OF TASK FORCE MEMBER PARTICIPANTS: 7**

Themes shared by BHTF member participants in their own words:

- Access to care
- Confusing system; frustration with not knowing where or how to access services
- Not enough of the right resources to help people navigate the system
- Not embracing best technology
- Poor communication between the "system" and patients/loved ones
- Need for more upstream services to identify risk factors early, prevent worsening symptoms, prevent initial involvement with the justice system, and provide resources and information to families early on
- Need for supporting what communities are currently doing, and staying oriented around solvable problems; creating a system that gives everyone a voice and opportunity to engage in the design, especially as communities develop solutions that make sense for them
- Issues around cost of care for individuals who seek it, especially individuals who may be depending on their private carrier for coverage
- Workforce shortage: difficulty maintaining capacity especially with affordable and safety net providers; and need for better supports to clinicians and other providers who seek to work in the community at not-for-profit organizations
- The workplace issues seem to extend beyond "lack of workforce" to include a broad range of workforce challenges – that training in trauma-informed care, assertive outreach and current medication advancements are not reaching some of the workforce. The providers tend to see this as a "lack of workforce," but the consumers and family members see it as a lack of preparation of the workforce to do the job at hand

- Family members of adults with serious mental illness are desperate for help – they don't necessarily want to lock up or remove their loved one's rights, but they want assurances from the providers that they are providing outreach and have the same goals as they do – helping people reach their full potential
- Consumers are concerned that they are not taken seriously by the system – providers are not paying attention to advances and warnings related to medications and as a result people are facing grave consequences in terms of functioning
- Stigma
- Need for residential type services
- Care for different disability populations
- Co-occurring substance abuse and mental health treatment needs

Breckenridge (Colorado Behavioral Healthcare Council Conference)

9/27/2019 1:30-3:30 P.M. **# OF TASK FORCE MEMBER PARTICIPANTS: 4**

Themes shared by BHTF member participants in their own words:

- Funding for providers is limited and we are asking for more than we pay for – especially crisis services
- Crisis services are very hard to deliver in rural areas
- Lack of trust between state and provider; direct services providers don't always agree with the leadership
- Providers want to be respected and heard; honor the work of Community Mental Health Centers
- Money/resources/private insurance are not going to make the issues with access and affordability go away
- Need navigators; help navigating the system
- Need for more support of the community system
- Workforce challenges; access to care challenges as a result of workforce issues
- Need to expand specific opportunities to rural and frontier areas of the State, such as transportation
- Moving to a Fee-For-Service (FSS) model away from the more sophisticated capitated system has had negative impacts on the community
- Don't fix what is not broken
- Look to other states/models for system improvement ideas
- System isn't person-centered
- Not enough case managers and peer supports
- Care and response should be tiered to intensity of need
- Need more immediate access
- Solutions need to have flexibility to localize and respond to family needs,
- Integrated care needs
- Need more prevention work
- Major gaps in rural communities – can't simply base funding on numbers/population
- Complex payment systems; find ways to pay for innovative services that work; funding shouldn't pit organizations against each other (drive collaboration, not competition), needs to be transparent
- Public and private insurance don't cover treatments that work but are non-traditional (sports, parenting, self-care, peers)
- Funded service array incomplete to truly meet family needs

Durango

10/01/2019 2:00-5:00 P.M. **# OF TASK FORCE MEMBER PARTICIPANTS: 4**

Themes shared by BHTF member participants in their own words:

- Severe concerns with timeliness and crisis services; folks are having to wait until extreme crisis to get services/care
- Concerns with quality of care (as well as other challenges) with the local community mental health center
- Support groups are critical – not state run
- Workforce issues
- Challenges with provider coordination
- Medicare issues
- Workforce challenges
- The critical role of community and primary care providing foundational supports
- The complexity and challenge of navigating MH/BH supports/services
- Very poor communication from in-patient psych residential services with providers (Physicians/Psychologists) taking care of the patient in their community
- Lack of access to mental health care; lack of providers

Grand Junction

10/22/2019 1:00-4:00 P.M. **# OF TASK FORCE MEMBER PARTICIPANTS: 5**

Themes shared by BHTF member participants in their own words:

- Stigma (focus on men)
- Issues with crisis system
- Lack of communication on what is happening in region
- Workforce issues; provider burnout; lack of reimbursement for services offered in schools; DHS issues with employee turnover
- Concerns about rates; cut in Medicare reimbursement for counseling services
- Access
- Parity
- Need for services
- Lack of ability to share information between providers
- Schools lacking funding to provide crisis services

Denver (Colorado Department of Public Health & Environment)

10/23/2019 1:00-4:00 P.M. **# OF TASK FORCE MEMBER PARTICIPANTS: 6**

Themes shared by BHTF member participants in their own words:

- Social determinants of health
- Stigma
- Access to care; lack of uniform access – publicly funded mental health centers refusing people for reasons that are not apparent to outpatient professionals and family members
- Lack of uniformity in response especially when people are in crisis – no "warm handoffs" or follow-up
- Reluctance of community mental health centers to collaborate with families – losing releases and putting administrative hoops that are not "real" legal barriers between families and providers
- Hospitals and emergency departments are not providing the longer-term care that many people in the community feel that they need
- Finding services for children and adolescents is an even greater challenge than finding those same services for adults
- Affordability; proper funding of services is a huge issue across the board
- Need someone to navigate the system with them – too many wrong doors; families and those with lived experience need advocates as they attempt to navigate a complicated behavioral health system
- Over prescribing
- Crisis and inpatient services; need to provide more services in the community to help people before they reach crisis level
- When there is a crisis and it does not involve police, we need a place/way for people to be treated
- Lack of providers; limits to what providers can be paid make it difficult to attract and keep/pay for good providers
- Lack of services in jails
- Need for expanded intensive outpatient services; psychiatric residential care is a strong need with little availability
- Inappropriate intensity of service for people with serious concerns and people with co-occurring disorders; need for more co-occurring treatment for mental health and substance use disorders
- Need to prioritize certain populations – for example, high need populations
- The absence of intensive services for high need populations, including follow-up after hospitalization or crisis; help for families, with adult children with serious mental illness, find long term and sustainable plans for their loved ones. This seems to be the lack of a person or entity responsible to manage the care with individuals and families – everyone and no one is responsible
- Recent RAE rate cut to the independent provider network

Denver (Colorado Department of Regulatory Agencies - Division of Insurance)

11/18/2019 2:00-5:00 P.M. **# OF TASK FORCE MEMBER PARTICIPANTS: 2**

Themes shared by BHTF member participants in their own words:

- Institutionalization may be appropriate for some people, and our efforts to avoid that have led to a wholly new crisis of homelessness and criminalizing the mentally ill
- Inadequate access to care
- Inability to navigate system
- Fragmented system

- Discrimination by LE and healthcare/hospital staff
- Need for better oversight of quality services
- Need to pay for quality services, not just paying FFS

Denver (Town Hall for Deaf, Deafblind, Hard-of-Hearing)

12/05/2019 5:00-7:30 P.M. **# OF TASK FORCE MEMBER PARTICIPANTS: 4**

Themes shared by BHTF member participants in their own words:

- There is a need in this community, and it must be culturally competent. Rural/urban have different needs. Trauma is real and needs treatment.
- Physical isolation, lack of services, social isolation
- Lack of access is prevalent

Denver (Long-Term Competency Subcommittee)

12/09/2019 9:30-11:30 P.M. **# OF TASK FORCE MEMBER PARTICIPANTS: 21**

Themes shared by BHTF member participants in their own words:

- The individuals on the panel spoke of their trauma that led to involvement in the mental health system as well as trauma they experienced while receiving treatment.
- The LTC asked for specifics how the MH treatment system could improve – unfortunately, there were not the details several of us were hoping for. An area that was in agreement with panel was increased offering of peer support specialist services, in particular peer respite. Other suggestions included: all treatment would be free and at the complete discretion of the client; and services considered augmented or complimentary become first-line interventions. There was no endorsements or support for evidence-based treatment or what professionals would consider best practices.
- The panel was also highly critical of family involvement, based on their negative/traumatic experiences, and were disrespectful when they were invited to stay to listen to other public testimony that was from family.
- The first mother described the experience of her son being held in jail awaiting competency evaluation. Her story was heart wrenching and asked for an apology from the State of Colorado for treating her son in the manner that occurred. The LTC member who offered testimony spoke of the need to intervene at a level that is not currently available to help individuals who are ending up in the criminal justice system when they are not engaging in recommended treatment.
- I understand these testimonies are through personal, emotional filters. The spectrum of citizens that our BHTF and subcommittees are tasked to help improve our behavioral health treatment services is a huge undertaking and not all will be satisfied.
- A common theme - a lack of personal accountability for choices for those who reject and do not engage in recommended treatment. What I mean is, individuals on the panel suggested there should be less or no consequences for violating the law for those who contend with mental illness disorders in crisis.
- Lack of access, housing, transportation, trauma

Eagle County

1/31/2020 11:00 A.M-2:00 P.M. **# OF TASK FORCE MEMBER PARTICIPANTS: 7**

Themes shared by BHTF member participants in their own words:

- Lack of available/consistent help. Issues with meds
- Too many hoops to jump through to get access to care; couldn't afford care; no support that was culturally or linguistically accessible; turned away and given the run around. Stigma preventing people from getting help.

- We were very fortunate to have several Latinx young people speak at the public testimony as well as several Latinx mental health advocates. They bravely articulated challenges around straddling a family's traditional culture and the young person's new US culture compounded with racism, stress around immigration status, etc. with zero resources available to them from a person that looked like them or could communicate with their families. The ACEs scores for these young women would be off the charts and addressing societal factors as well as individual and family factors is critical. Also, several mentioned that culturally relevant services may be religiously based. The high attempted suicide rate among Latinas was presented in personal stories and from one advocate who shared that one study found that 1 out of every 10 Latinas has attempted suicide in the past year, 2 out of 10 have made a suicide plan and half of all Latina teens said they've felt hopeless. To exacerbate the crisis, only 5.5% of U.S. psychologists say they're able to administer mental health care services in Spanish. Additionally, task force members and other groups addresses these needs should be reflective of Colorado's population, including Latinx representation. Healthy kids can't be separate from healthy families and healthy communities. Developmental stages in a child's life are critical for addressing potential behavioral health needs. Early childhood screening coupled with appropriate interventions for children and families is critical. Screenings should happen for child and for the family jointly. Middle school came up as an extremely difficult time with limited resources for multiple stories. Services needed to be integrated into schools. Each stage in a young person's life comes with physical, emotional, and overall developmental needs that are unique. One parent made the point that 12 year olds are very different than 18 year olds (referencing when her child was "bundled away by guards" to point unknown after they went to the ER and ended up with an 18 year old roommate). Parents/caretakers felt excluded from decision-making about their children's/family's needs. Too often, doctors prescribe prescription drugs to address anxiety and depression without full explaining the possible (deadly) side effects and prescribe for decades longer than recommended. Multi-tiered life supports are needed, not prescription-based intervention. The positive impacts and benefits of occupational therapy for young people and adults came up multiple times coupled with the barrier of Medicaid not covering these services for "psycho-social" needs.
- More research - education needed on use of benzodiazepines and their effects. ~Medicaid guidelines should be changed to include payment for outpatient OT services for clients with psychosocial diagnosis. ~Early Childhood Need consistency in early screenings (i.e. ACES or ASQ) Case navigators Universal services - not just income based Increased access to evaluations locally - rather than waiting months to get into Children's Hospital Need to decrease wait times to see therapists Increase school based supports and protocols for all levels - but maybe even more so for middle school aged kids ~Culturally specific BH education and services are desperately needed Increase education and promotion of behavioral health wellness and treatment in SPANISH to help reduce stigma Increase Spanish speaking providers - (Maybe we could do targeted recruitment to first generation citizens with scholarships, loan repayment, etc) ~Veterans have specific needs beyond the general adult population including isolation and long distances to get VA services. (Maybe more peer support services?) ~ Need parity in pay - Behavioral Health Therapists should have similar pay to Physical Therapists
- There are not enough services in Spanish provided by bicultural people. Our spanish speaking community members feel very isolated and cut off from care and support.
- Language access for non-English speakers Culturally appropriate services Age appropriate service Communication with families
- It is apparent with the large crowd at the Edwards testimony that the community wants to see changes and improvements. They are invested in making it a better place.
- The theme of being told to walk in during certain hours and then turned away, waiting way too long to get in to see a provider and hopelessness around these issues.

Note that public testimonies were held in Denver (December 20th), Denver (January 14th), Arvada (January 18th), Colorado Springs (February 26th), and Denver (March 6th) to which no BHTF members responded to provide insights on the themes they heard in the public testimonies. There were BHTF members present at each of these aforementioned testimonies.

Virtual

03/26/2020 1:30-3:30 P.M. **# OF TASK FORCE MEMBER PARTICIPANTS: 6**

Themes shared by BHTF member participants in their own words:

- Very challenging to access services.
- Consumers/Providers confused about where to go.
- Lack of coordination between applied behavioral services and behavioral health.
- Need for Crisis Training for responders related to IDD
- Remove barriers (contracts, billing, regs) that prevent treating physical and behavioral health needs in same setting.
- Allow/reimburse assessments outside of facilities/institutions.
- Require step-down planning as best practice (to replace discharges).
- Identify services only available through DHS (or judicial) and expand access to general population.
- Create bed tracking system.
- Often people were not able to access services in a timely manner or at an affordable price.
- Getting screened and diagnosed correctly is difficult and often off the mark.
- Hearing from people at agencies was not memorable. I thought this would just be for consumers.
- The behavioral health system won't serve I/DD and I/DD system won't serve mental health.
- I heard a lot about autism and care coordination. The START model was mentioned several times as a solution.
- Lack of capacity in services systems, silos between MH and Physical health

Additional information/themes that survey respondents wanted to share:

- Need help navigating the system
- Access; absence or lack of needed or applicable services; inability to access applicable services; continuity of services; lack of services for children in the schools; long wait lists
- Lack of substance use treatment – for children, for people with mental health disorders, for those in jail
- Alignment between Medicaid and strategy (what Medicaid will reimburse doesn't point to parity)
- Workforce; incentives to attract more providers; inadequate training of providers who work with this population
- Lack of empathy for people with dual diagnosis
- Access to higher levels of care, outside of outpatient services
- Parity; we are still trying to make BH look like physical health
- Barriers created by HIPAA
- Legislation according to the exception
- Help people, don't incarcerate people
- Support caregivers and suicide loss survivors
- Lack of beds
- Public guardianship
- Emergency services
- Use our imaginations as if we had all the resources available
- Collaboration in community
- Support providers

Serving Colorado's Adults: A Financial Map of the Behavioral Health System

Prepared for the
Colorado Behavioral Health Task Force

APRIL 2020
(UPDATED JULY 2020)

COLORADO **HEALTH** INSTITUTE
Informing Policy. Advancing Health.

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Introduction

Colorado's behavioral health system is complex, with public services provided by multiple agencies, through multiple funding sources, and to meet multiple objectives. While this complexity can make it hard to understand how funds are being spent, mapping these expenditures is an important step toward evaluating the system's strengths and opportunities for improvement.

An earlier analysis by the Colorado Health Institute (CHI) looked at the system that provides behavioral health services to Colorado's children. This analysis focuses on the service delivery system for adults and provides a detailed financial analysis of seven state organizations that provide these services.

According to one nationwide analysis, Colorado ranks 33rd out of 50 states and the District of Columbia in measures of mental illness and access to care among adults. About one in five Colorado adults (20 percent) has a mental illness, and nearly one in 10 (9 percent) has a substance use disorder.[1]

And though Colorado spends over half a billion dollars on adult behavioral health services, 14 percent of adults report that they are not getting needed treatment.[2] The complexity of the system might be hindering their ability to get the care they need.

That is why Gov. Jared Polis created the Behavioral Health Task Force to overhaul the behavioral health system. The Task Force, led by the Colorado Department of Human Services, is developing a blueprint for improving behavioral health care in the state. The Task Force has partnered with CHI to create a financial map of the adult behavioral health system to answer the following questions:

- ***How are state and federal funds currently allocated in Colorado's adult behavioral health delivery system?***
- ***What services are these dollars purchasing, and who are they serving?***
- ***What opportunities exist to close gaps and maximize investments?***

To answer these questions, CHI requested data from seven state agencies about programs that provide behavioral health services to adults. The time and effort these state agencies took to report these data are greatly appreciated; without them, this analysis would not be possible.

This financial map shows where state and federal funds are supporting Colorado's behavioral health system for adults. Private insurance payments, philanthropic funding, and local funding are not included in this scope of work. This report examines the amount and sources of money spent in Colorado, what programs are funded, how the programs are funded, who these programs serve, and opportunities moving forward.

Key Takeaways

- In state fiscal year 2018-19, $617 million in federal and state funds supported behavioral health services for adults age 27 and older in Colorado.
- The behavioral health delivery system is complex, which can make it difficult to understand who is being served and who is not.
- Opportunities to make this system stronger include the consolidation of funding streams, additional leveraging of federal dollars, and new investments in data collection.

Following the Money

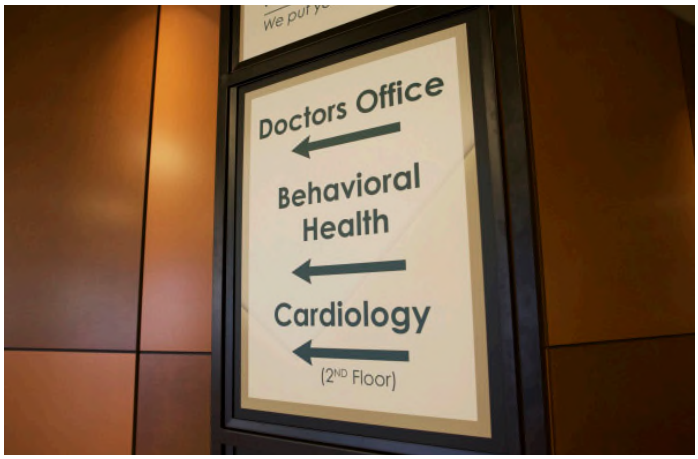
In state fiscal year 2018-2019 (FY 2019), nearly $617 million went to behavioral health services for adults ages 27 and older in Colorado. This represents funding reported to CHI by seven state agencies,

which identified 42 unique funding streams or programs.

To identify state agencies for this analysis, CHI and Behavioral Health Task Force representatives focused on agencies that provide direct services for people with behavioral health conditions. Behavioral health is defined as mental and emotional well-being, development, and actions that affect a person's overall wellness. This can range from unhealthy stress or subclinical conditions to diagnosable and treatable diseases, including substance use disorders, serious psychological distress, suicidal ideation, and other mental health disorders.[3]

There may be other pots of money available within other state agencies that provide direct or indirect behavioral health services. Given the short time frame for this analysis, CHI focused on the seven state agencies that likely provide a majority of this funding (Table 1). This analysis does not factor in funding for behavioral health services that is contributed by county governments. A county-level analysis would provide a detailed look at where in Colorado there are more limited resources; this is an opportunity for future research.

Just over half of all adult behavioral health spending by state agencies ($334 million) is funded by the state of Colorado. This includes both state general funds and other cash funds. Nearly 75 percent of all state funds are spent on programs that are not supported by Medicaid.



The remaining money — nearly $283 million in FY 2019 — is from the federal government. Most of this federal funding comes through Medicaid.

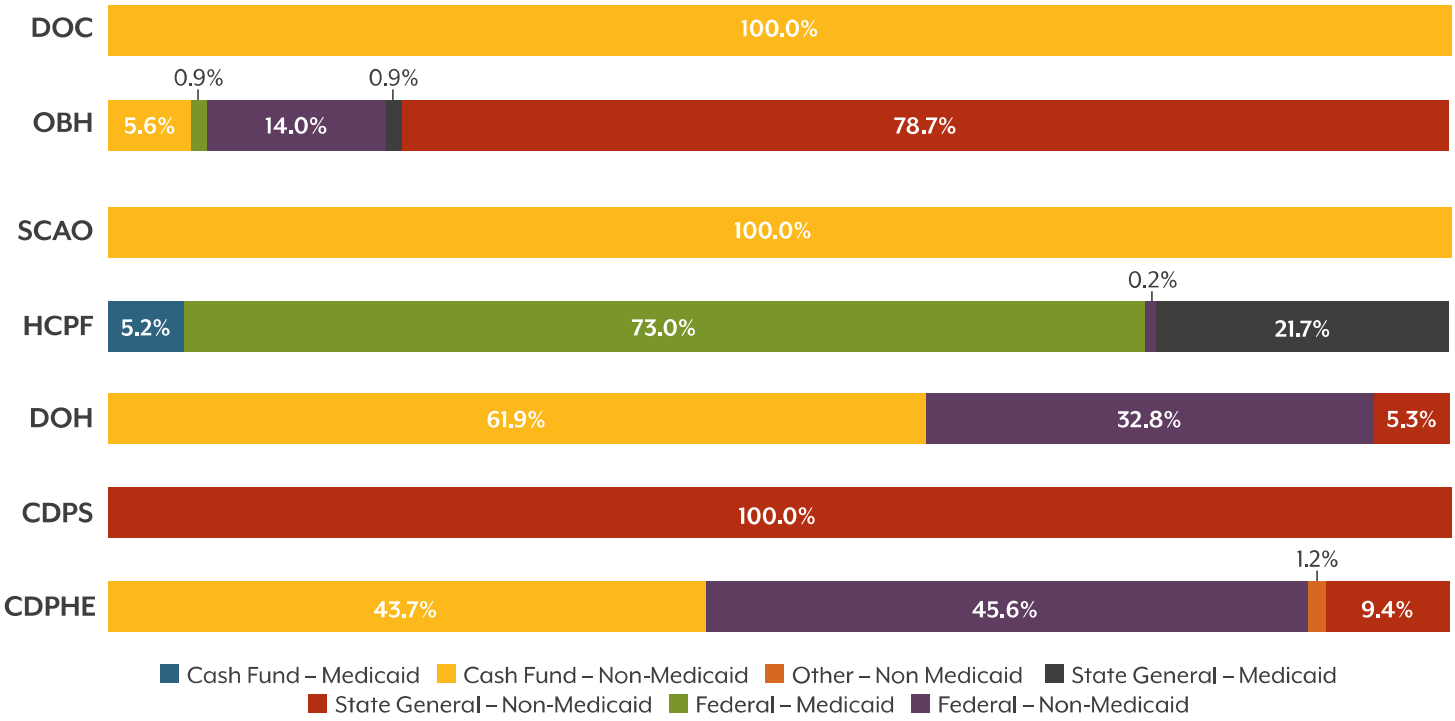
Due to the complexity of the system and different state structures, it is hard to compare Colorado's behavioral health financing with other states'. However, a report by the Substance Abuse and Mental Health Services Administration (SAMHSA) details how much states spend through their State Mental Health Agency (SMHA) and Single State Agency (SSA). In Colorado, the Office of Behavioral Health is both the SMHA and SSA. Data from 2014, the most recent year of available data, indicate that Colorado's agencies spend fewer dollars per capita than other states' agencies — just $133 in Colorado, compared to a national average of $155 per capita.[4] However, this comparison does not include other state funding sources for adult behavioral health services.

Table 1. Adult Behavioral Health Funding by State Agency

State Agency	Total Reported Funding	
Department of Health Care Policy and Financing (HCPF)	$324M	53%
Department of Human Services, Office of Behavioral Health (OBH)	$227M	37%
Department of Local Affairs, Division of Housing (DOH)	$25M	4%
Office of the State Court Administrator (SCAO)	$17M	3%
Department of Public Safety (CDPS)	$14M	2%
Department of Public Health and Environment (CDPHE)	$8M	1%
Department of Corrections (DOC)	$2M	0.4%
Total	**$617 million**	

Figure 1. Some Colorado Agencies Rely Heavily on State Dollars to Fund Behavioral Health Services — for Others, Federal Money Matters More

Distribution of Funding Source by State Agency



Examples of Programs Excluded From This Analysis

In addition to direct services and resources targeting Colorado's behavioral health care delivery system for adults, state agencies spend $7.4 million on data systems, overdose epidemic response efforts, workforce development, and efforts to ensure private insurance carriers cover behavioral health services comparably to physical health coverage. While these programs are not detailed in the overall financial map, they play a critical role in tracking and managing the state's behavioral health services.

The Colorado Behavioral Health Risk Factor Surveillance System collects data on health behaviors and health risks among the adult population through an annual telephone survey. In FY 2019, CDPHE received $1.1 million in federal and state funds to collect and analyze these data.

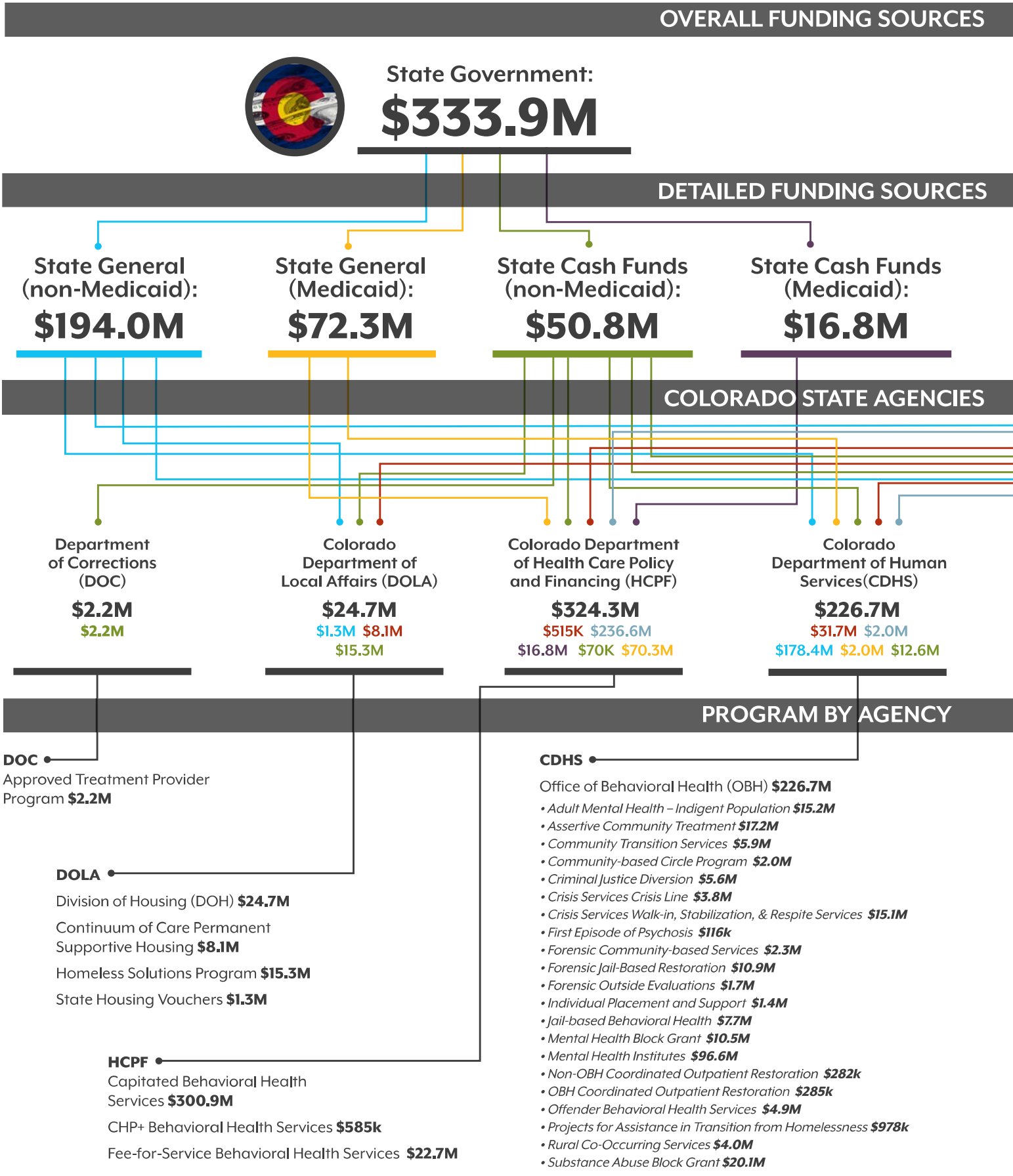
CDPHE also received a $2.6 million federal grant to respond to the overdose epidemic and to scale up prevention and response activities. Additionally, CDPHE administers the Colorado Health Service Corps program, a $3.6 million effort comprised of federal and state funds to increase the capacity of the clinical safety net to respond to primary health care access needs by incentivizing clinicians through educational loan repayment.

The Division of Insurance receives money to implement HB19-1269, a state law to enforce federal and state mental health parity laws. The state general fund contributed $106,000 for this effort.

Finally, the Division of Vocational Rehabilitation spends $1.7 million providing supported employment services, including customized employment, through behavioral health contracts. In FY 2019, an additional $5.8 million was spent on non-contractual vocational rehabilitation services to support individuals with behavioral health impairments, including $786, 000 for psychological services. OBH funds 21.3 percent of these contracts while the other 78.7 percent comes from federal dollars.

Neither the Colorado Department of Agriculture nor the Colorado Department of Higher Education receives funding for direct behavioral health services. The Colorado Department of Military and Veterans Affairs (MVA) assists veterans in signing up with the federal agency (the primary provider of behavioral health to veterans) to ensure there is access to behavioral healthcare, but does not directly receive funds.

Figure 2. Adult Behavioral Health Financial Map Layers and Amounts



Federal Government:
$282.5M

Federal (non-Medicaid):
$44.0M

Federal (Medicaid):
$238.5M

Department of Public Safety (CDPS)
$13.5M
$13.5M

Colorado Department of Public Health and Environment (CDPHE)
$8.0M
$3.7M $757K
$3.5M

State Court Administrator (SCAO)
$17.1M
$17.1M

CDPS
Intensive Residential Treatment **$5.1M**

Residential Dual Diagnosis Treatment **$3.6M**

Therapeutic Communities **$3.1M**

Cognitive Behavioral Treatment Pilot Program **$1.7M**

CDPHE
Alcohol Epidemiology **$150k**

American Foundation for Suicide Prevention **$100k***

Bureau of Justice Assistance – Comprehensive Opioid Abuse Program **$333k**

CDC Overdose Prevention for States Cooperative Agreement **$2.3M**

CDC Preventative Health and Health Service Block Grant **$176k**

Mental Health First Aid **$210k**

Office of Suicide Prevention State General Fund **$547k**

Retail Marijuana Education Program **$3.5M**

SAMHSA Zero Suicide Grant **$725k**

SCAO
Adult and Juvenile Probation **$17.1M**

How to Read the Financial Map

Top Level:
OVERALL FUNDING SOURCES

Funding comes from two overall sources: the federal government and the state government. These are represented in the top level of the financial map.

Second Level:
DETAILED FUNDING SOURCES

The second level specifies six sub-sources: the federal government (non-Medicaid); federal Medicaid; state general funds (non-Medicaid); state Medicaid general funds; state cash funds; and state medicaid cash funds.

Third Level:
COLORADO STATE AGENCIES

This section shows the state agencies that receive these funds. Agencies then distribute funding to programs.

Bottom Level:
PROGRAM BY AGENCY

The seven agencies distribute their funds for behavioral health across 42 distinct programs ranging from direct services to adults in need of behavioral health treatment to targeted training programs aimed at improving services and prevention efforts.

*CDPHE reported receiving $100k in philanthropic funds. This funding is only listed in the fourth level of this financial map.

What We're Funding: Service Array

CHI asked state agencies to report on the types of services these funds provide. Agencies were asked to organize data based on a service array initially developed by the Behavioral Health Task Force Children's Subcommittee. This service array was used to keep the child and adult behavioral health financial mapping reports aligned (see box titled "The Behavioral Health Service Array"). One additional category was used in the adult analysis that was not relevant to the children's analysis: housing and tenancy supports.

All but three percent of funds were allocated to these 11 distinct service categories. The largest single spending category was outpatient care, which accounted for 42 percent of the service costs. This was followed by inpatient hospitalization at 21 percent. The rest of the funds were distributed across the remaining service categories — ranging from one percent of funds spent on universal promotion and prevention to seven percent spent on intensive community- and home-based care (see Figure 3).

It is important to note that state agencies do not define behavioral health services in a uniform way. None of these agencies collect data based on the service array used in this analysis, so each agency had to develop a unique way to report or estimate data toward these categories.

Unfortunately, other national and state reports also do not use the same service array to analyze behavioral health expenditures for adults. Though many reports provide some breakdown of behavioral health expenditures, these are not comparable to the service array reported in this analysis. Therefore, this report does not provide a comparison of Colorado to other states by service area category.

Who We're Serving: Demographics

There are nearly 3.8 million adults age 27 and older in Colorado.[5] While it is unknown exactly how many people need mental health care, it is estimated that nearly one in five Colorado adults has a mental illness.[6]

Together, the seven state agencies included in this analysis reported serving just under 559,000 adults. However, this is likely a significant overcount. Using

The Behavioral Health Service Array

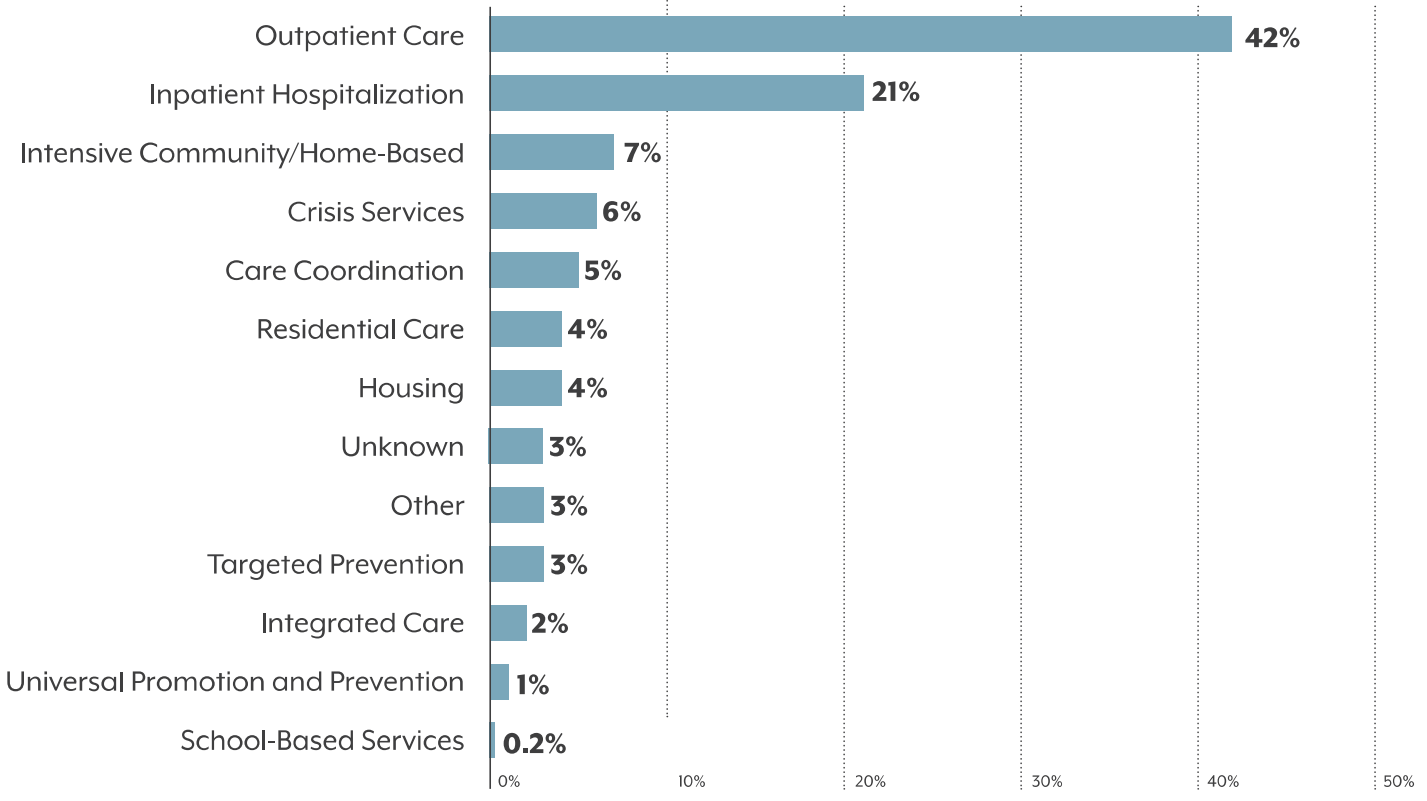
- **Universal Promotion and Prevention:** Awareness and education campaigns, safe community spaces, and programs that promote positive youth development
- **Targeted Prevention:** Preventive services, peer support, counseling (including trauma-informed psychoeducation), comprehensive family programs, and caregiver support and education
- **School-based Services:** Social-emotional learning and coping in classrooms, screening and assessment services, psychoeducation, suicide prevention training, and group and individual counseling
- **Integrated Care:** Integrated primary and specialty care, screening and assessment for behavioral health and substance use treatment, parenting education, and individual counseling
- **Outpatient Care:** Screening and assessment services; outpatient individual, group, and family therapy; substance use disorder treatment; telehealth; and respite care
- **Intensive Community- and Home-Based Services:** Intermediate or ancillary home-based services, multisystemic therapy, functional family therapy, high-fidelity wraparound, therapeutic preschools and schools, and respite care
- **Residential:** Therapeutic group homes and foster care, psychiatric and substance use disorder residential treatment
- **Inpatient Hospitalization:** Hospitalization, inpatient mental health, and substance use services
- **Crisis Services:** Mobile crisis services, crisis intervention or crisis stabilization, detox services
- **Care Coordination:** Execution of a patient-centered approach to facilitate an appropriate, coordinated delivery of health care services
- **Housing and Tenancy Supports:** Rental support and other tenancy supports for people with behavioral health needs

Table 2. Adult Behavioral Health Funding by Service Area Category

	CDPHE	CDPS	DOH	HCPF	SCAO	OBH	DOC	Total*
Universal Promotion and Prevention	$2M					$4M		$6M
Targeted Prevention	$4M		$2M	$12M		$338K		$18M
School-Based Services				$92K				$92K
Integrated Care				$12M				$12M
Outpatient Care				$216M		$42M	$2M	$260M
Intensive Community- and Home-Based Services		$3M		$15M		$22M		$40M
Residential Care		$9M		$10M		$4M		$23M
Inpatient Hospitalization				$25M		$107M		$132M
Crisis Services	$196K			$14M		$20M		$35M
Care Coordination				$14M		$15M		$29M
Housing			$23M					$23M
Other	$2M			$4M		$12M		$18M
Unknown		$2M		$555K	$17M			$19M
Total	**$9M**	**$14M**	**$25M**	**$324M**	**$17M**	**$226M**	**$2M**	**$617M**

*Figures may not sum due to rounding

Figure 3. Distribution of Adult Behavioral Health Funds From State Agencies, by Service Area Category



Colorado's current data systems, there is no way to identify instances where unique adults used services provided by multiple programs.

More than half of the programs were unable to provide demographic information. It is unclear if these data are not collected or if data could not be pulled in the given time frame. In some cases, it is likely that programs do not collect these data in a systematic way that is easily reportable. In other cases, demographic data might not be available because of the nature of a program. For example, prevention programs target a large population indirectly and program coordinators might not be able to track everyone their program reaches.

The following sections analyze the demographic data of programs that were able to provide this information.

Age

Of the adults served whose ages are known, 54 percent were ages 27 to 40, and 44 percent were ages 41 to 64. Just two percent were adults ages 65 and older, perhaps due to high rates of insurance coverage among this group, making them less likely to access publicly funded behavioral health services.

According to the Colorado Health Access Survey (CHAS), 27 percent of adults ages 27 to 40 report not getting needed mental health care, compared with 11 percent of adults ages 41 to 64.[7] The most frequently reported reasons among both age groups are concerns about the cost of treatment and having a hard time getting an appointment.

Sex/Gender

Of the adults receiving behavioral health services whose sex/gender is reported in the data, there was an even split between men and women. However, some smaller, more targeted programs serve a population that is more than 70 percent male. These programs include Adult and Juvenile Probation, Forensic Community-based Services, First Episode Psychosis, Mental Health Institutes, and the Homeless Solutions program. These data indicate that males are more likely to receive high-acuity mental health services.

These limited data suggest that while the overall split between males and females served is about even, further analysis is needed to understand if both men and women are getting the types of services they need.

Race/Ethnicity

Among programs that reported the race/ethnicity of the adults they serve, most clients – just over

Figure 4. Most Adults Served Are Under Age 40
(Among Programs that Reported Ages Served)

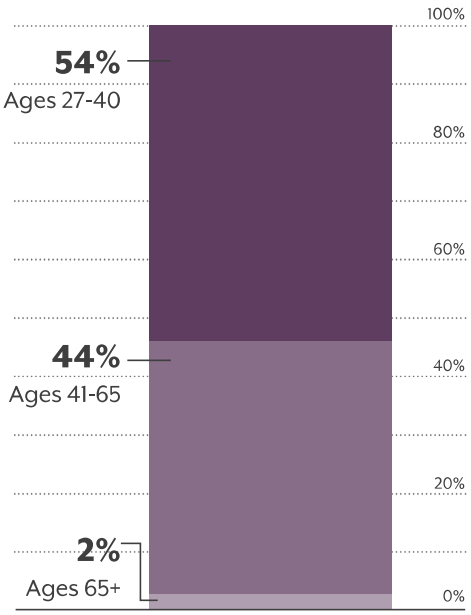
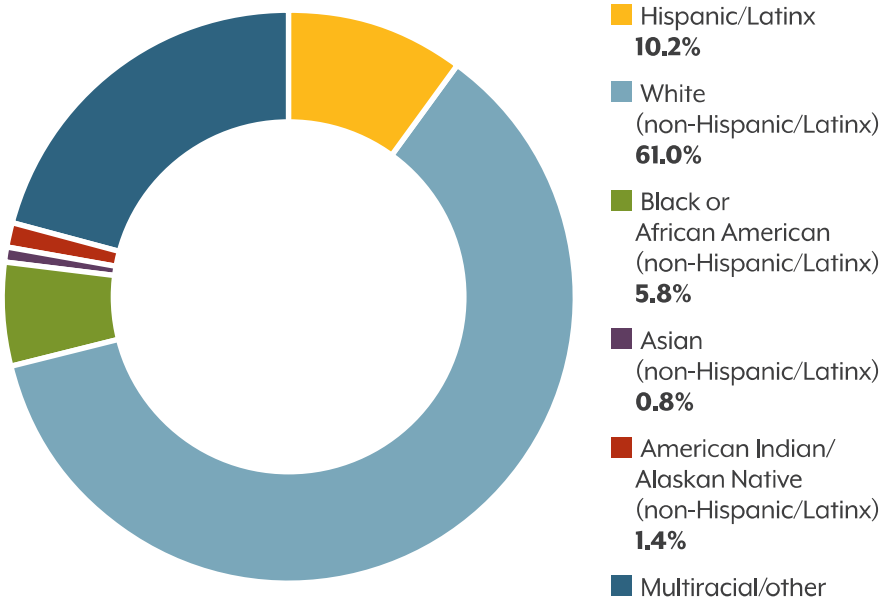


Figure 5. State Agencies Reported Providing Behavioral Health Services to Mostly White (non-Hispanic/Latinx) Adults



* Native Hawaiian/Pacific Islander **0.01%**

60 percent – were white (non-Hispanic/Latinx) Coloradans. Another 21 percent were adults who identified as multiracial or other, and 10 percent were Hispanic/Latinx adults.

Statewide, about 70 percent of Coloradans are white (non-Hispanic/Latinx), just under 22 percent are Hispanic/Latinx, and nearly five percent are black or African American.[8]

The biggest reported difference is for multiracial populations. Statewide it is estimated that three percent of the population is multiracial. However, state agencies report that over 20 percent of the behavioral health services they provide are for people who identify as multiracial or some other race.

How We're Paying: Funding Mechanisms

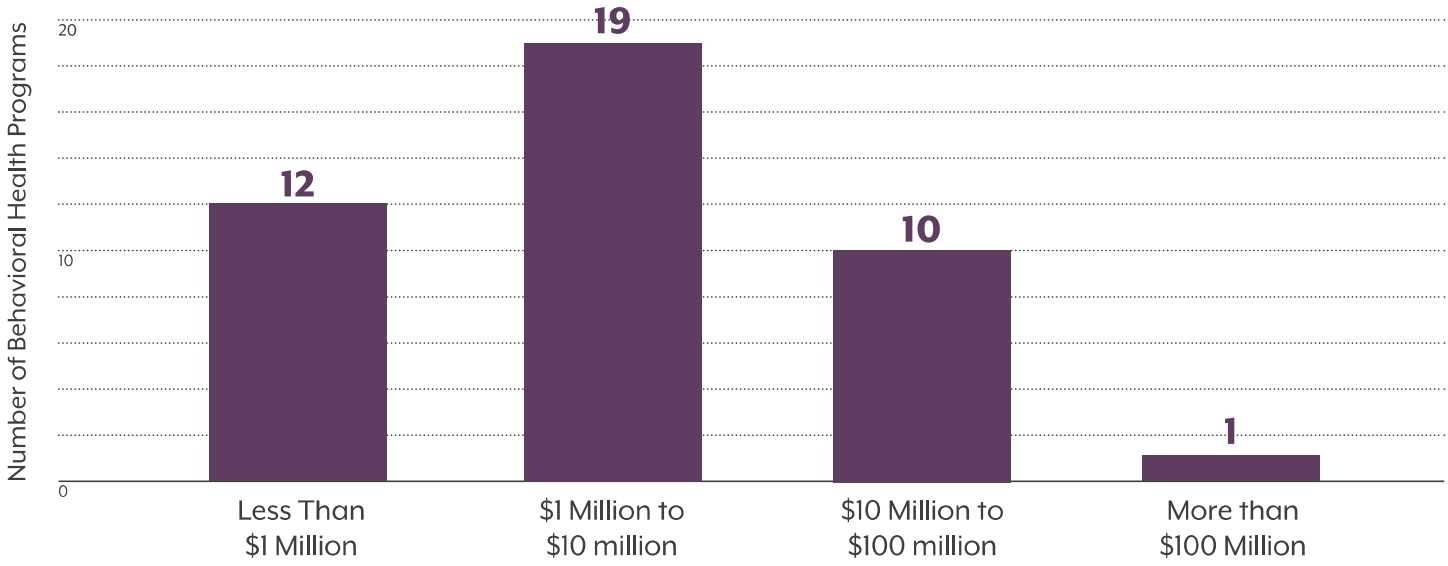
Adult behavioral health services in Colorado are funded through a variety of sources, but also by multiple federal and state mechanisms. Understanding how money comes to the public behavioral health system and how it is used to fund programs can help determine if dollars are being spent effectively.

For example, some federal funds are delivered through block grants, which come to Colorado in one lump sum, regardless of how much state funding is also provided. Other programs receive a federal

Table 3. Federal Funding by Mechanism

Mechanism Type	Amount	Program	State Agency
Medicaid (73 percent federal match)	$219M	Capitated behavioral health	HCPF
	$18M	Fee-for-Service behavioral health	HCPF
	$2M	Mental Health Institutes	OBH
Child Health Plan *Plus* (79 percent federal match)	$515K	CHP+	HCPF
Block Grants	$20M	Substance Abuse Block Grant	OBH
	$11M	Mental Health Block Grant	OBH
	$176K	CDC Preventive Health and Health Services Block	CPDHE
	$116K	First Episode of Psychosis	OBH
Cooperative Agreements	$2.3M	CDC Overdose Prevention for States Cooperative Agreement	CDPHE
	$150K	Alcohol Epidemiology	CDPHE
Other Grants	$8M	Continuum of Care PSH	DOH
	$978K	Projects for Assistance in Transition from Homelessness	OBH
	$725K	SAMHSA Zero Suicide Grant	CDPHE
	$333K	Bureau of Justice Assistance – Comprehensive Opioid Abuse Program	CDPHE

Figure 7. Most Adult Behavioral Health Programs Funded by Colorado State Agencies Have Budgets Under $10 Million



funding match, meaning that for every dollar spent by Colorado for Medicaid, additional money can be obtained from the federal government.

In FY 2019, Colorado received a 73 percent federal match for adult Medicaid services. In other words, for every $100 in Medicaid behavioral health spending, the federal government covered $73 and the state paid $27.

Opportunities to Create a Stronger Adult Behavioral Health System

There are opportunities to create better alignment and reduce complexity in the adult behavioral health system. CHI has identified four such opportunities: Consolidating funding streams and programs across agencies; maximizing federal dollars; promoting equity in behavioral health spending; and investing in data.

These recommendations provide a starting place to begin streamlining the system. They mirror recommendations made in *Serving Colorado's Children: A Financial Map of the Behavioral Health System – Report to the Colorado's Behavioral Health Task Force Children's Subcommittee.* Investing in similar data structures for both adult and children's behavioral health will not only improve systems, but allow for better coordination across the children and youth and adult behavioral health systems, which should in turn improve the quality and continuity of care for many Coloradans.

1. Consolidate Funding Streams and Programs Across Agencies

Colorado's system of behavioral health services is fragmented. Seven agencies manage 42 programs, and over a quarter of these programs have a budget of under $1 million. Collectively, these programs are critical to the behavioral health of Colorado adults. However, consolidating these programs could generate savings for the state due to reduced administrative costs. This in turn could allow agencies to fund more services, which could increase access to and the quality of care provided to adults.

Streamline Programs Across Agencies

One approach for aligning programs would be to organize programs based on their eligibility. Some programs have a very narrow focus on a specific target population. Analyzing each of these programs' criteria for populations served and services offered might identify places for programs to coordinate or become integrated.

There are challenges to aligning programs, especially across state agencies. For example, agencies collect

data differently, and rules and regulations for programs are not uniform.

For instance, the Division of Housing coordinates three housing programs for people with behavioral health conditions. Other state agencies also provide limited funds for housing supports such as rent assistance, and are also likely providing additional behavioral health treatments for this population. This arrangement may lead to a single person receiving different supports from multiple agencies. Finding opportunities to coordinate across state agencies might create a more accessible system for people who need services.

Another potential alignment opportunity involves programs that support justice-involved individuals with behavioral health needs. The Office of Behavioral Health, the Office of the State Court Administrator, and the Colorado Department of Public Safety collectively have 10 programs that provide services for people who have been or are justice-involved. Finding opportunities to consolidate these programs — either in administration, funding, eligibility, or access — may reduce confusion and better serve this population.

Align Funding Streams

One approach to consolidating funding streams is to look at funding flexibility. Non-Medicaid state dollars make up 40 percent of all adult behavioral health spending. These funds are more likely to be flexible than federal funds would be, and they provide an opportunity for Colorado's behavioral health system administrators to streamline and coordinate how the money is spent. For example, many of the programs that support justice-involved individuals receive non-Medicaid state funding. State agencies may be able to use the flexibility of these funds to coordinate the types of services they are providing with other state agencies. This could reduce instances where similar services are being provided by multiple agencies, and possibly expand the reach of their programs due to better alignment.

Transitions From the Child to Adult Behavioral Health System

A similar financial analysis by CHI focused on the child and youth behavioral health system, which identified 38 unique programs across six state agencies. Many have an age requirement to be eligible. As children age out of these programs, there is an opportunity to ensure a seamless transition to the adult behavioral health system. Ensuring that children's behavioral health needs are met as they age can reduce the need for more intensive services down the road.

By using both this analysis and *Serving Colorado's Children: A Financial Map of the Behavioral Health System – Report to the Colorado's Behavioral Health Task Force Children's Subcommittee*, the adult and child and youth financial analyses, Colorado's leaders can coordinate system transition across agencies and programs to ensure transition -aged youth are cared for.

2. Maximize Federal Dollars

It's possible that not all federal funds that would be available to Colorado are being accessed by the state. Just three of the 42 programs analyzed draw down federal Medicaid dollars. Colorado's behavioral health system administrators can use this financial map to identify services that might be missing out on a federal match.

Homing in on these specific opportunities and estimating the size of potential additional Medicaid match dollars requires additional data that are not yet available in Colorado's current data system. Specifically, identifying Medicaid match opportunities requires an understanding of the Medicaid eligibility of people served by various programs and whether the services delivered to them are covered by Colorado's Medicaid benefit.

This report does suggest a way state agencies can work together to discuss possible Medicaid match opportunities. Each individual agency likely has the information that is needed to identify match opportunities within their agency. This map can be a resource to inform conversations about those opportunities.

Recent policy developments may reveal new opportunities to pull down a federal match. For example, Colorado's Medicaid Section 1115 waiver expands the substance use disorder treatment benefit. Any program offering these services may now be able to provide these services through the federal match. This would free up state funds for other services.

3. Promote Equity in Behavioral Health Spending

Changes to spending could lead to a more equitable distribution of resources. While the current data show who is receiving services, they do not take into account who needs services.

Nearly 14 percent of adults report having an unmet mental health need, according to the Colorado Health Access Survey. The current system provides many essential services to those who need them, but there are still gaps in services. Additional data is needed to identify which populations may not be getting needed services, and to determine the types of treatment they need.

The state also has an opportunity to reduce disparities in funding for services provided to people of different racial and ethnic groups. It is possible that certain racial and ethnic groups are more likely to be double-counted in this analysis. This is because data we received from each program did not take into account whether the people they were serving were also receiving services from other organizations. If these data were available, further analysis could show more accurately which racial and ethnic groups are receiving services and identify opportunities to match services with needs.

4. Accountability for Results

Questions remain about where money is being spent and what populations are served. Investing in data infrastructure to learn where dollars are going and who they are serving will help identify gaps in the system.

Increased Efficiency

Data are fragmented across systems and programs. State agencies collect different types of behavioral health and funding data in different ways, so it is difficult to understand the full scope of services being provided to people who need them. Investing in data systems and infrastructure that are supported and used by all agencies would increase the efficiency of behavioral health data sharing and analysis.

Colorado has taken steps to invest in data and technology solutions. The Office of eHealth Innovation, created in 2015, has developed a Health IT Roadmap, which identified opportunities to close the gaps in health care for patients and providers. The efforts of this office might be a starting point for alignment among all state agencies that provide behavioral health services.

Better Understanding of Demographic and Service Gaps

The lack of data infrastructure also impacts the ability to collect demographic data, such as age, gender, and race/ethnicity. Without a better understanding of who is being served, it will be hard to identify where there are gaps in the behavioral health system.

Comprehensive Service Array Information

The types of services being provided to adults with behavioral health conditions are broad. Because there is not a standard service array across the state, each agency took its own approach to estimating how its services fall into the service array categories used in this report. Creating a standard service array that every state agency uses would help provide a structure for analyzing cross-system services.

Individualized Service Provision

Cross-agency data sharing is critical to identify those who are receiving services from multiple agencies. Colorado leaders should adopt a unique identifier for each person accessing services to streamline access to services and ensure appropriate cross-agency communication. This is one place where the Office of eHealth Innovation may be able to support this data sharing approach.

The Governor's Behavioral Health Task Force is considering a single agency to deliver all behavioral health services in Colorado. While this structure might not reduce all inefficiencies in the system, it would facilitate better data sharing and streamlined contracts.

Conclusion

Every year Colorado spends more than half a billion dollars to provide behavioral health services to Colorado's adults. This analysis illustrates that these dollars support a complex system comprised of many agencies, programs, and funding mechanisms. There are opportunities for Colorado leaders to work together to improve the behavioral health system and streamline funding to in order to deliver services more effectively and efficiently, and to ensure that Colorado's adults have access to the behavioral health care they need.

Endnotes

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Serving Colorado's Children: A Financial Map of the Behavioral Health System

Prepared for the Colorado Behavioral Health Task Force Children's Subcommittee

MARCH 2020

COLORADO HEALTH INSTITUTE
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Introduction

Colorado's behavioral health system is highly complex. Services and programs span multiple agencies, objectives, and funding sources, making it difficult to identify exactly how funds are being spent for children and youth. Still, understanding the system is an important step toward evaluating its strengths and opportunities for improvement.

This evaluation is critical because many young Coloradans face mental health challenges. In 2010, 13 percent of children ages 8 to 15 lived with mental illness severe enough to cause significant impairment to their day-to-day lives.[1] The burden is even greater among older children, where 21 percent of youth ages 13-18 experienced this level of mental illness.[2] In Colorado, nearly half of youth with poor mental health (44.9 percent) are insured through a public payer such as Medicaid or Child Health Plan Plus (CHP+), or have no coverage and must rely on other public sources to get behavioral health care.[3] And because private insurance carriers do not uniformly cover the robust array of behavioral health services, people with the most significant needs rely on publicly funded services.[4]

There is no question that Colorado's children, adolescents, and their families need these public services — and they are best served by systems that are effective and efficient.

That's why Partners for Children's Mental Health (PCMH) was created. PCMH is a new center focused on bringing together Colorado communities to improve mental health outcomes for children, youth, and families. In 2018, PCMH convened more than 600 community stakeholders from across the state to develop a strategic plan for change, including a series of recommendations. One recommendation set the foundation for this work: create a financial map to understand the children's behavioral health system in relation to prevalence, need, utilization, and cost.

PCMH contracted with the Colorado Health Institute (CHI) to create this financial map. CHI took direction from the Children's Subcommittee of the Colorado Behavioral Health Task Force, a group convened in 2019 to evaluate and set the official roadmap to improve behavioral health in Colorado, to identify the following questions that guide this report:

Takeaways

- Between $404 million and $810 million in federal and state funds support much-needed child and youth behavioral health services in Colorado.
- The delivery system is complex, which can make it difficult to understand who is — and isn't — being served.
- Opportunities to make this system even stronger include consolidation of funding streams, additional leveraging of federal dollars, and new investments in data collection.

- ***How are state and federal funds currently allocated in Colorado's child behavioral health delivery system?***
- ***What services are these dollars purchasing, and who are they serving?***
- ***What opportunities exist to close gaps and maximize investments?***

To conduct this research, CHI approached six state agencies requesting data on programs providing behavioral health services to children and youth. The time and effort given by these state agencies to report these data are greatly appreciated—without them, this analysis would not exist. Additional details on our research methods are included in Appendix 1.

This report provides a financial map showing where state, federal, and other funds are supporting Colorado's behavioral health system for children and youth. The scope of this work does not include a

Table 1. Funding for Children's Behavioral Health by State Agency, FY 2019

State Agency	Total Reported Funding	
Department of Human Services, Office of Children, Youth, and Families (OCYF)	$381 million*	47.0%
Department of Health Care Policy and Financing (HCPF)	$259 million**	32.0%
Department of Human Services, Office of Early Childhood (OEC)	$66 million	8.2%
Department of Human Services, Office of Behavioral Health (OBH)	$65 million	8.1%
Department of Education (CDE)	$22 million	2.6%
Department of Public Health and Environment (CDPHE)	$17 million	2.1%
Total:	**$810 million**	

* Includes all foster care costs, not just behavioral health services **Excludes $31 million in psychotropic medication

needs assessment identifying the types of services in greatest demand. It also does not include analysis of local or county-level funding, such as local programs available in only one region of the state. Private insurance payments, out-of-pocket spending, and philanthropic funding are also excluded from this scope of work. These are opportunities for future research.

In this report, we look at the amount and sources of money spent in Colorado, what programs are funded, who these programs serve, how the programs are funded, and opportunities moving forward.

Following the Money

In state fiscal year 2018-19 (FY 2019), up to $810 million was spent on Colorado's behavioral health care delivery system for children and youth ages 0 to 26. This represents funding reported to CHI by six state agencies (see Table 1). These agencies provide 34 programs across the state (see Financial Map on page 6).

This figure is inflated. It is likely that only $404 million undeniably support behavioral health services for Colorado children and youth. The remaining $406 million may include behavioral health services as well as related supports such as programs for families, social support services, or other non-behavioral health services. But limitations to the available data — and missing data elements — mean that it is not possible to estimate the portion of these dollars supporting only behavioral health services.

For example, the $381 million in funding through the Office of Children, Youth and Families (OCYF), for instance, includes both child behavioral health services as well as other services such as placements in foster care. Additionally, some CDE and CDPHE funding for school-based health centers includes both physical and behavioral health services.

Despite limitations to these data, this analysis provides a first broad look at a complex behavioral health system.

State funds are the largest source, making up nearly 60 percent ($481 million) of the total expenditure (see Figure 3). This includes both general funds and cash funds such as the Marijuana Tax Cash Fund. Though cash funds are not guaranteed for the long term, no agencies contacted for this research cited concerns about potential changes to funding sources.

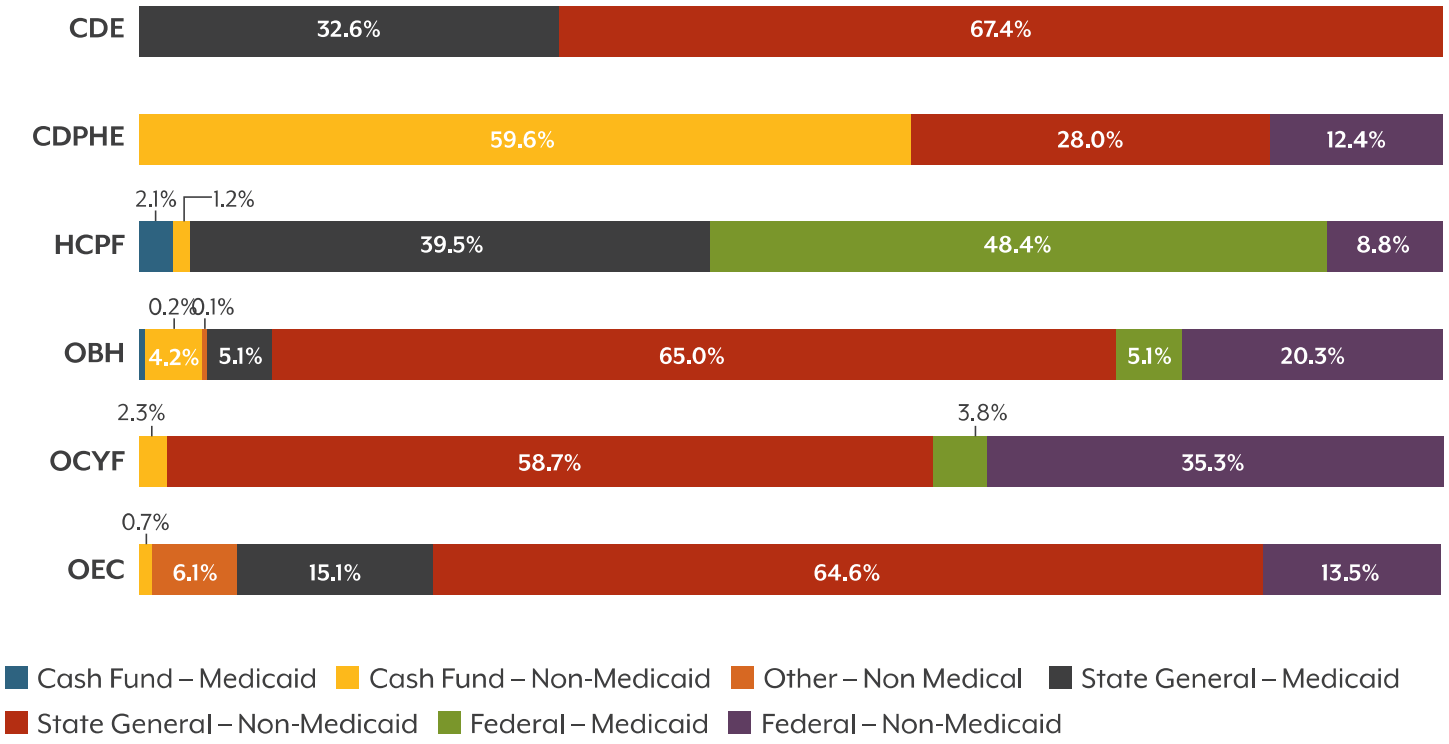
A 2007 Nevada analysis found a similar ratio: about 55 percent of behavioral spending was state funding, compared to 40 percent federal funding. (The Nevada report also included some local funding at 4 percent.) However, the distribution of state and federal funding varies significantly by agency (Figure 1).

Up to $810M

was spent on Colorado's behavioral health care delivery system for children and youth ages 0 to 26 in state fiscal year 2018-19 (FY 2019).

Figure 1. Some Agencies Rely Heavily on Federal Dollars – for Others, State Matters More

Distribution of Funding Source by State Agency



Example Programs Excluded from this Analysis

In addition to direct services and resources targeting Colorado's behavioral health care delivery system for children and youth, $191 million goes to data systems, evaluation efforts, and parent supports. While these programs are not detailed in the overall financial map, they nevertheless are critical components of how behavioral health is tracked and managed.

CDPHE's Healthy Kids Colorado Survey does not directly impact youth or the providers who serve them, but the data collected by this large-scale survey is invaluable in identifying risk factors and tracking mental and other health behaviors. Its $968,000 budget comes from a combination of federal and state funds.

The Colorado Child Fatality Prevention System reviews all child deaths in Colorado, allowing agencies to identify child death trends and patterns and make recommendations for prevention. Its $6.6 million budget comes entirely from the state general fund.

Multiple programs within OEC— SafeCare Colorado, Colorado Community Response, Head Start, Promoting Safe and Stable Families, Nurse Home Visiting Program, Home Instruction for Parents of Preschools Youngsters, and Parents as Teachers — help children by supporting their parents' mental health. Overall, these have a budget of $162.6 million from federal, state, and other sources.

Additionally, the Office of Children, Youth, and Families has a $21 million Child Welfare Staffing Block which is allocated to counties for new county staffing.

How to Read the Financial Map

Top Level:
OVERALL FUNDING SOURCES

Funding comes from three overall sources: the federal government, the state government, and other funds (usually local grants). These are represented in the top level of the financial map.

Second Level:
DETAILED FUNDING SOURCES

The second level specifies six sub-sources: the federal government (non-Medicaid); federal Medicaid; state general funds (non-Medicaid); state Medicaid general funds; state cash funds; and other funding.

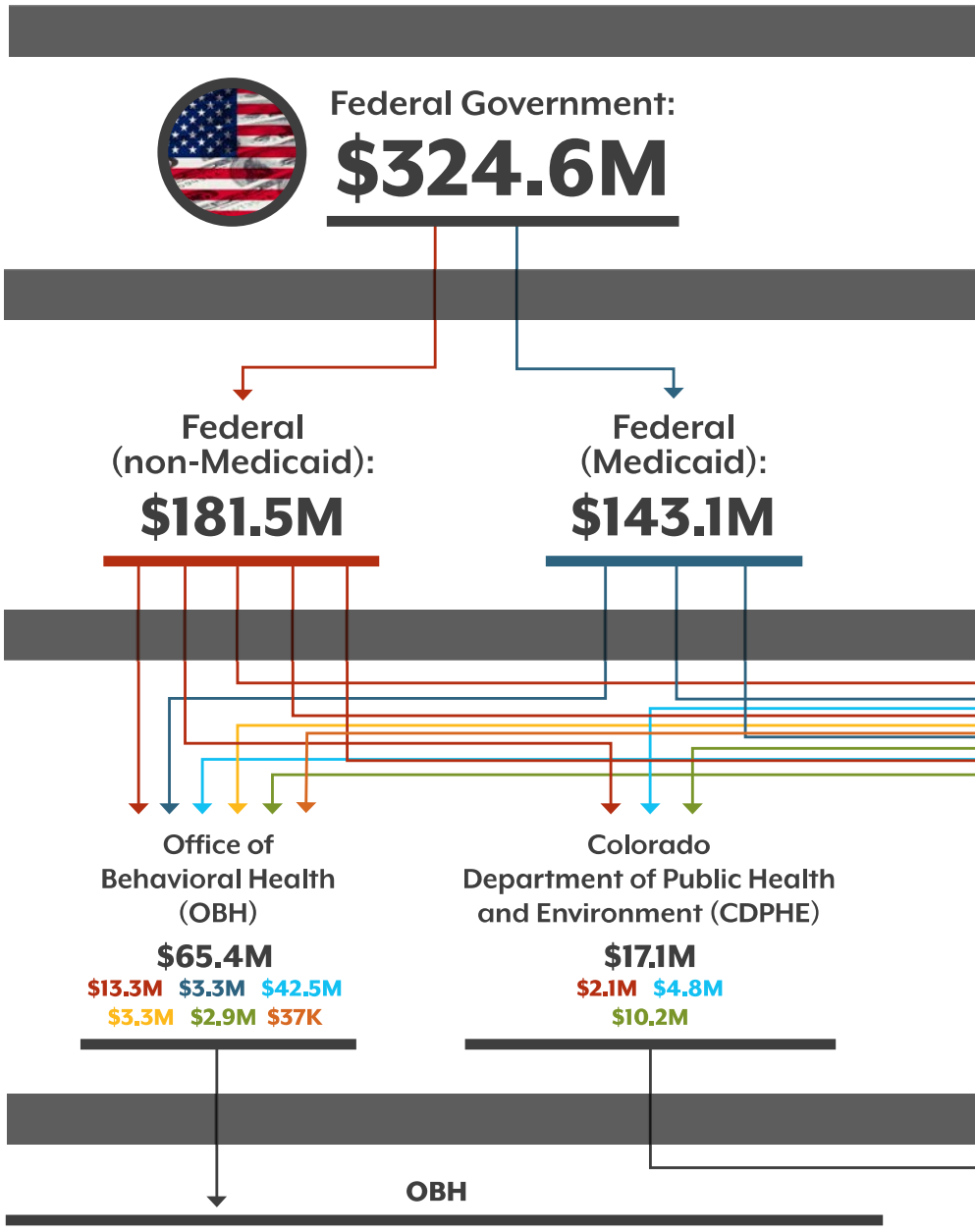
Third Level:
COLORADO STATE AGENCIES

This section shows the state agencies that receive these funds. Agencies then distribute funding to programs.

Bottom Level:
PROGRAM BY AGENCY

The six agencies distribute their funds for behavioral health across 34 distinct programs ranging from direct services to youth in need of behavioral health treatment to targeted training programs aimed at improving services and prevention efforts. The programs with the highest funding by department and office are bolded in the above graphic and detailed in Table 2. For a description of these programs, see Appendix 2.

Children and Youth Behavioral Health Funding



- Child and Youth Mental Health Treatment **$3.0M**
- Children and Adolescent "Indigent Population" **$2.6M**
- Children's Other Community Mental Health Center Hospital Programs **$952k**
- Community Mental Health Center School Based Specialist **$1.1M**
- CO-ACT System of Care Grant **$3.0M**
- Crisis Services Hotline **$941k**
- Crisis Services Walk-in, Stabilization, and Respite Services **$10.0M**
- First Episode of Psychosis **$938k**
- Forensic Community Based Services **$31k**
- Forensic Jail-Based Restoration (RISE) **$2.6M**
- Forensic Outside Evaluations **$2.2M**
- Managed Services Organizations **$5.4M**
- Mental Health Institutes **$24.3M**
- Coordinated Outpatient Restoration **$425k**
- Offender Behavioral Health Services **$660k**
- School Based Mental Health Specialist **$1.1M**
- Substance Abuse Prevention **$7.1M**

in Colorado: A Financial Map

OVERALL FUNDING SOURCES

State Government:
$481.4M

Other:
$4.0M

DETAILED FUNDING SOURCES

State General (non-Medicaid):
$328.0M

State General (Medicaid):
$122.6M

State Cash Funds:
$25.3M

Other:
$4.0M

COLORADO STATE AGENCIES

Colorado Department of Health Care Policy and Financing (HCPF)
$258.9M
$22.8M $125.4M
$102.2M $8.5M

Colorado Department of Education (CDE)
$21.6M
$14.5M
$7.0M

Office of Early Childhood (OEC)
$66.0M
$8.9M $42.7M $10.0M
$481K $4.0M

Office of Children, Youth, and Families (OCYF)
$381.1M
$134.4M $14.4M
$223.5M $8.8M

PROGRAM BY AGENCY

CDPHE

- Communities that Care* **$9.4M**
- Garrett Lee Smith Youth Suicide Prevention **$736k**
- Office of Suicide Prevention School Grants **$318k**
- School-Based Health Center Programs* **$6.6M**

HCPF

- Medicaid Capitated Behavioral Health Services **$211.9M**
- Medicaid Fee-For-Service Behavioral Health **$21.1M**
- Child Health Plan Plus (CHP+) **$25.9M**

CDE

- School Health Professional Grant **$14.5M**
- Medicaid School Health Services* **$7.0M**

OEC

- Early Intervention **$61.3M**
- Early Childhood Mental Health **$2.8M**
- Family Development Services* **$750k**
- The Incredible Years* **$605k**
- Healthy Steps* **$578k**

OCYF

- Children Welfare Services Block Grant (Includes IV-E, IV-B, XX)* **$321.3M**
- Collaborative Management Program* **$4.5M**
- Core Services Block Grant* **$55.3M**

* These programs fund more than just behavioral health services

What We're Buying: Service Array

CHI asked state agencies to report information about the types of services these funds provide. Agencies organized data based on the child and youth behavioral health service array developed by the Behavioral Health Task Force Children's Subcommittee (see box titled "The Behavioral Health Service Array").

The Behavioral Health Service Array

- **Universal Promotion and Prevention:** Awareness and education campaigns, safe community spaces, and programs that promote positive youth development
- **Targeted Prevention:** Preventive services, peer support, counseling (including trauma-informed psychoeducation), comprehensive family programs, and caregiver support and education
- **School-based Services:** Social-emotional learning and coping in classrooms, screening and assessment services, psychoeducation, suicide prevention training, and group and individual counseling
- **Integrated Care:** Integrated primary and specialty care, screening and assessment for behavioral health and substance use treatment, parenting education, and individual counseling
- **Outpatient Care:** Screening and assessment services; outpatient individual, group, and family therapy; substance use disorder treatment; telehealth; and respite care
- **Intensive Community- and Home-Based Services:** Intermediate or ancillary home-based services, multisystemic therapy, functional family therapy, high-fidelity wraparound, therapeutic preschools and schools, and respite care
- **Residential:** Therapeutic group homes and foster care, psychiatric and substance use disorder residential treatment
- **Inpatient Hospitalization:** Hospitalization, inpatient mental health, and substance use services
- **Crisis Services:** Mobile crisis services, crisis intervention or crisis stabilization, detox services
- **Care Coordination:** Execution of a patient-centered approach to facilitate an appropriate, coordinated delivery of health care services

Only 45 percent of $810 million in behavioral health spending could be allocated to these 10 distinct service areas. A small amount ($2.2 million) was reported as "other", but the majority (54 percent) was reported as unknown.

Of the $364 million that could be allocated to service areas, the largest single area of spending was outpatient care, which accounted for 41 percent of service costs (see Figure 2). This was followed by school-based services at 14 percent and targeted prevention at 10 percent.

About nine cents of every dollar spent went to home and community-based services. This included services for youth and families who need multiple hours of services each week, such as frequent psychotherapy, ancillary home-based services, and evidence-based practices such as high-fidelity wraparound services and functional family therapy. However, more funding went toward these services than more intensive care such as crisis services (8 percent), inpatient hospitalization (3 percent), and residential care (3 percent).

Yet with more than half of these funds going to unknown services, there are limits to the conclusions that can be drawn. In addition, state agencies do not define behavioral health services consistently. The lack of uniform data collection methods means that reporting differs greatly between agencies. For example, some reporting systems focus on internal department metrics or funding stream reporting requirements. And none of the agencies track how they spend behavioral health dollars based on this exact service array. So mapping to this analysis' service buckets requires some interpretation and estimation. Finally, many programs contract with external organizations and vendors to provide services, and these organizations may not report this level of service detail back to state agencies. These challenges may indicate a need for better evaluation services or financial accountability to ensure that certain critical service areas are not overlooked.

A national report on Medicaid behavioral health service use and expenditures from 2005 to 2011 suggests that in some ways, Colorado's behavioral health spending is similar to national patterns. Outpatient care was the largest expenditure nationally (see Figure 3). Care coordination and intensive community- and home-based services also

Figure 2. Child Behavioral Health Funding by Service Area Category as a Percent of Known Funding

Less than half (45 percent) of agency expenditures could be mapped to the service array. Of known spending, outpatient and school-based services receive the most.

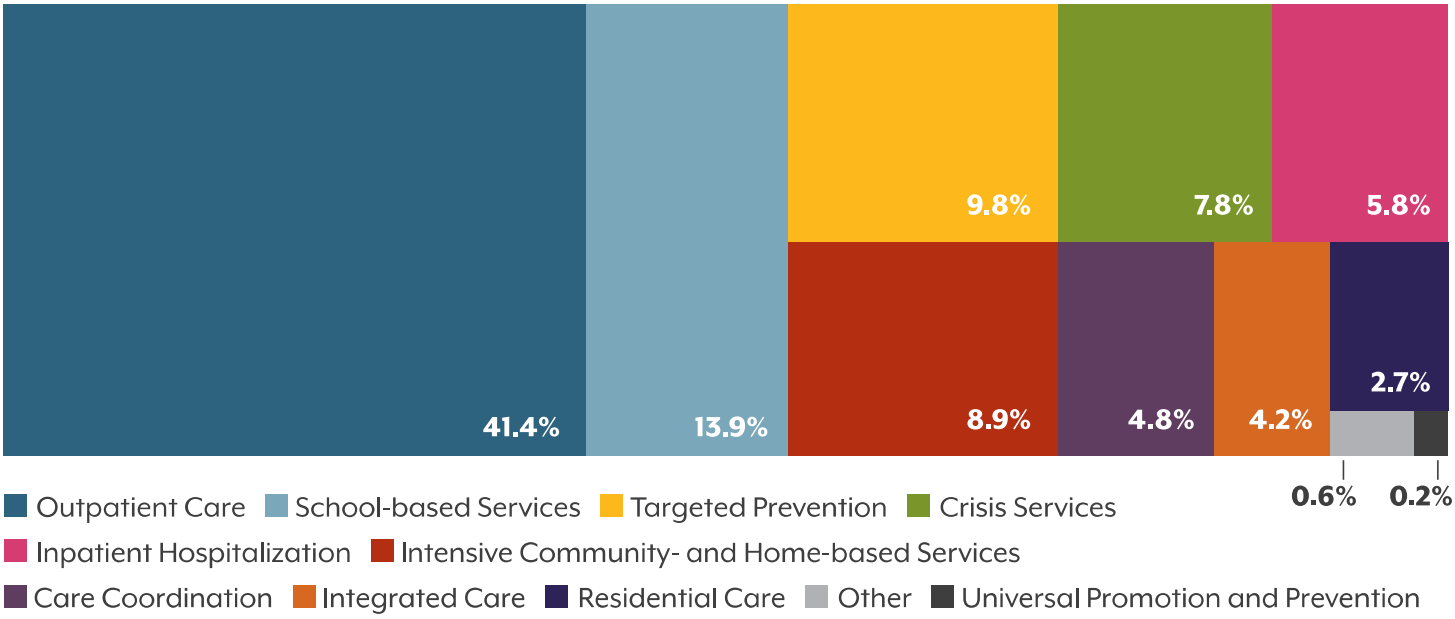


Table 2. Child Behavioral Health Funding by Service Area Category and Agency

	CDE	CDPHE	HCPF*	OBH	OCYF	OEC	Total
Unknown			$26M	$36M	$321M	$61M	$444M
Universal Promotion and Prevention					$563k		$563k
Targeted Prevention		$11M	$6M	$7M	$9M	$4M	$36M
School-based Services	$22M	$7M	$13M	$1M	$9M		$51M
Integrated Care			$7M		$9M		$16M
Outpatient Care			$139M	$4M	$9M		$152M
Intensive Community- and Home-Based Services			$20M	$3M	$9M	$1M	$32M
Residential Care			$9M	$1M			$10M
Inpatient Hospitalization			$22M				$21M
Crisis Services			$9M	$11M	$9M		$28M
Care Coordination			$7M	$2M	$9M		$17M
Other			$2M	$90k			$2M
Total	**$22M**	**$17M**	**$259M**	**$66M**	**$381M**	**$66M**	**$810M**

* Excludes $31 million in psychotropic medication

received about the same percentage of funding in Colorado and nationally — 4 percent and 10 percent, respectively.

However, nearly a quarter of behavioral health expenditures nationally went to residential care, compared to just 3 percent in Colorado. This is likely due to Colorado's focus on reducing the number of children in residential care by providing families with the supports they need to keep families together and interacting with at-risk families before they enter the system.

Further, there are two categories that are notably missing from the national service array — integrated care and school-based services. In Colorado, 4 percent of funding went toward integrated care services, and nearly 14 percent toward school-based services. These are indicative of recent shifts to provide behavioral health care in other clinical settings, such as schools, primary care, and other specialty care facilities.

Some of these discrepancies are likely due to the age of the Medicaid data — these figures are 8 years older than the Colorado data presented in this report. Discrepancies may also result from missing data elements and limitations in available data provided by state agencies. Additionally, it is important to note that the Colorado service array data includes services outside Medicaid.

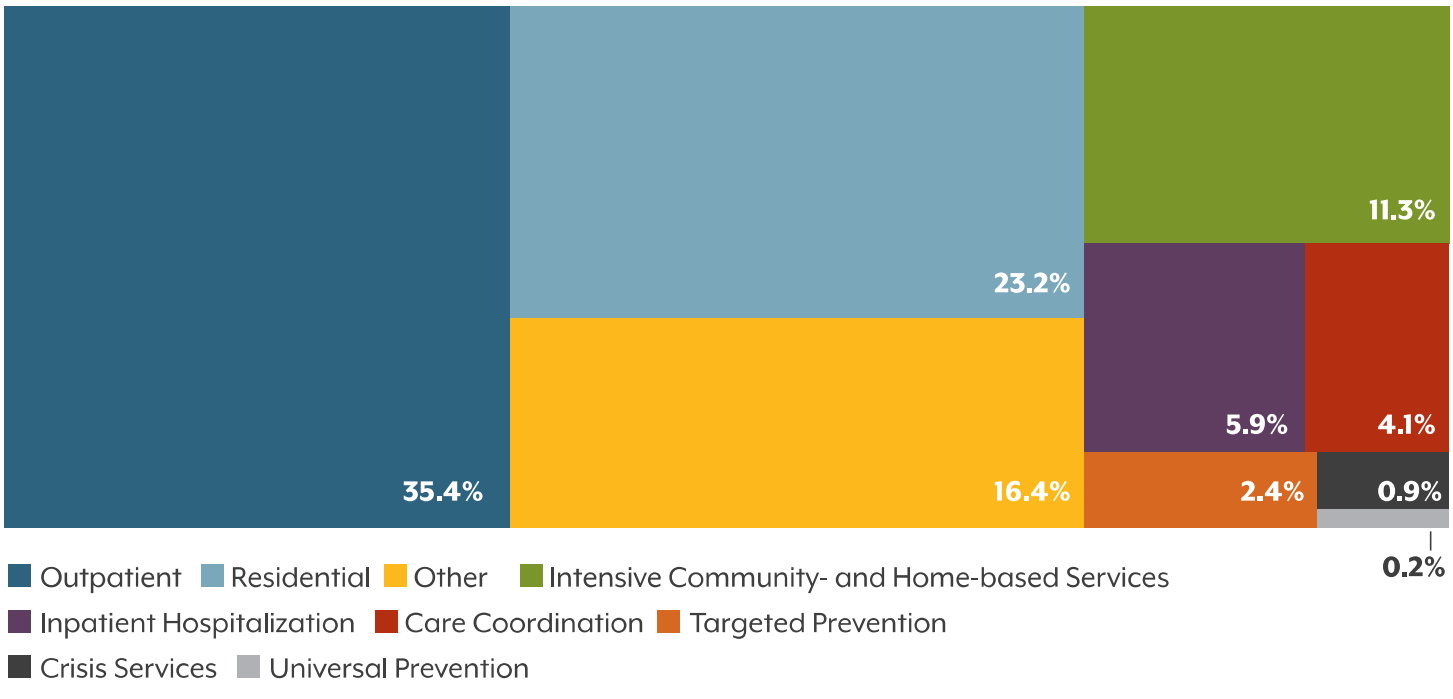
Psychotropic Medications

Psychotropic medications are an important aspect of behavioral health. In FY 2019, psychotropic drug expenditures across Medicaid and CHP+ in Colorado represented just over $31 million — just 15 percent of the total amount HCPF spends on behavioral health services for youth. Half of that money was spent on psychotropic medication for attention deficit hyperactivity disorder, and another 30 percent was spent on antipsychotics.

Yet there are also differences in how services are defined. Just as definitions of behavioral health services are not consistently defined across the state of Colorado, there are no national standards, making it difficult to interpret this comparison. The national report provided data on 30 different service types, which CHI allocated to Colorado's service array (for more details, see Appendix 1).

To better answer the research question, "What services are these dollars purchasing?" state agencies would need to be prepared to attribute their funding to this specific service array.

Figure 3. National Medicaid Expenditures on Behavioral Health Services, 2011



Who We're Serving: Demographics

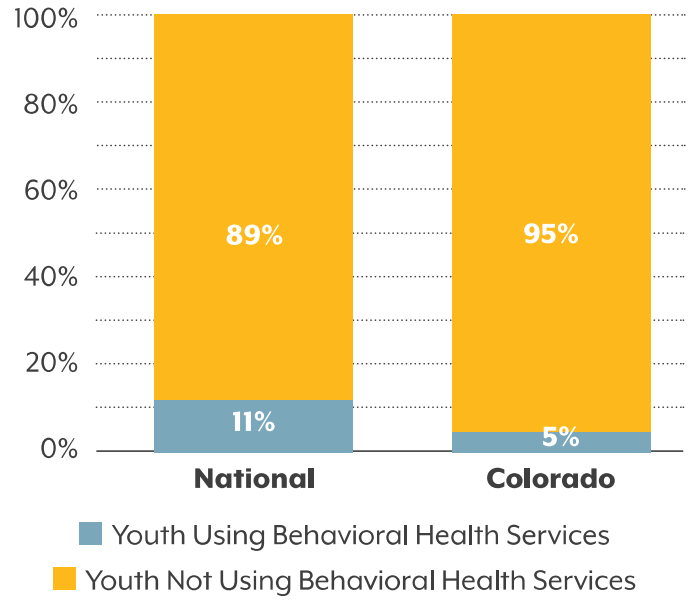
There are over 2 million children and youth between the ages of 0 and 26 in Colorado.[5] As many as 600,000 of them may need behavioral health services.[6]

But in 2019, nearly 14 percent of these Coloradans (200,000) reported that they did not get needed mental health care in the past year.[7] Reasons for not getting this care included concerns about cost of treatment, uncertainty of insurance coverage, and difficulty getting an appointment. This suggests that Colorado's children and youth might use behavioral health services more readily if they understood how they could receive services through different low-cost programs and had an easier time finding behavioral health care providers.

One study focused solely on care within Medicaid found that utilization of behavioral health services among young people is lower in Colorado than the rest of the nation (see Figure 4).[8] While the reasons behind this are unclear, this indicates that there may be room for improvement within Colorado's existing systems of care.

Figure 4. Colorado Youth Use Fewer Behavioral Health Services

Behavioral Health Utilization in Medicaid: National (2011) vs Colorado (FY 2019)



Together, the six state agencies included in this analysis reported serving 1.5 million children. However, there is no way to identify instances where children used services provided by multiple programs, so it is likely that far fewer children were actually served. In order to get an unduplicated count of the number of children and youth using these programs, agencies would need to provide client-level data that could allow children to be identified across programs. This is possible for some services and programs, but not all.

In addition to this limitation, it is hard to paint a full picture of the demographics of young people receiving services. State agencies were unable to report age data for nearly 40 percent of participants, and they could not report gender or race / ethnicity for more than 80 percent.

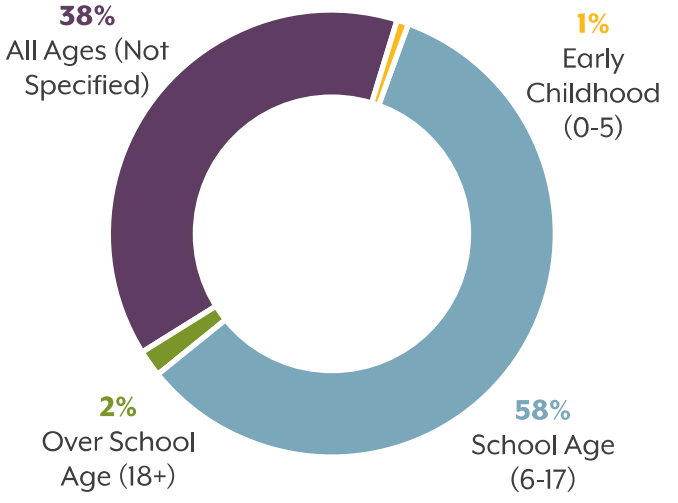
Given these gaps, findings should be interpreted with caution. Better data might change these results considerably. That said, current information can offer insights into the population being served by this system.

Age

Of the children and youth served whose ages are known, the vast majority (94 percent) were school-aged. About 3 percent were young adults, and 2 percent were children in early childhood (see Figure 5).

Figure 5. Among Known Ages, Most Youth Served are School-Age

Children and Youth Served by Age Group

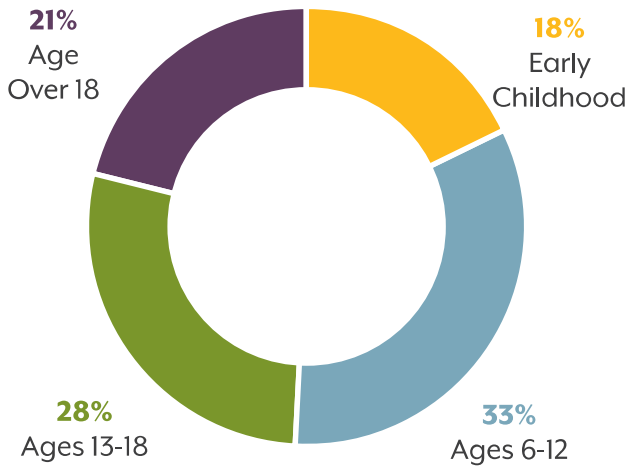


Gaps in policy may explain these findings. While the Affordable Care Act extended parental health insurance coverage to dependents under age 26, programming restrictions for state agencies often limits funding to ages 18 or younger.

For example, OEC only serves children ages 0 to 8, while CDE focuses on school-aged children. Other programs within agencies have age restrictions, such as the Children and Youth Mental Health Treatment Act and Offender Behavioral Health Services, which primarily provide services to kids ages 0 to 18.

There may be opportunities to expand funding to better represent age groups in Colorado, particularly because many of these restrictions are imposed by program, rather than funding source.

Figure 6. Insurance Claims for Youth with a Behavioral Health Diagnosis by Age, 2018



Sex / Gender

Data on sex and gender were reported for just half of children served in FY 2019, but available figures show an even split between males and females. By comparison, 41 percent of national Medicaid behavioral health utilizers between the ages of 0 and 18 are female.[9] This may indicate that Colorado has reached a greater gender parity in service provision than the U.S. as a whole.

However, males do appear more likely than females to receive high-acuity services in Colorado. Some programs use more than 60 percent of their funding for males, including managed service organizations, forensic jail-based restoration, and coordinated outpatient restoration.

Further, the Colorado Health Access Survey (CHAS) estimates that just over 58 percent of the Colorado children and youth who did not get needed behavioral health services in 2019 were female.

Together, the limited data indicate that despite the greater unmet need for behavioral health services among females, most high-acuity spending goes to males. Setting of care — e.g., jail-based services — might be a major reason for this. While the overall split between male and female children and youth receiving behavioral health services is even, these data suggest that further analysis is needed to understand whether young men and women are, in fact, getting the care they need.

What is the Role of Insurance?

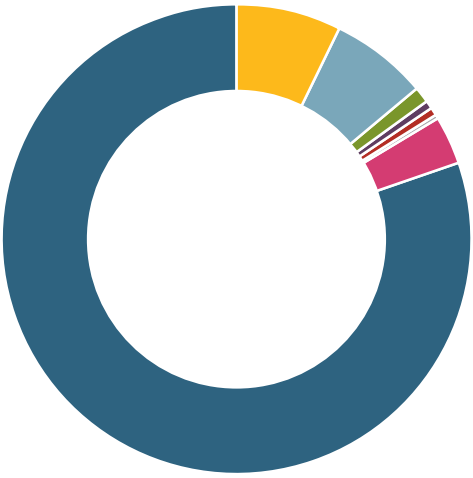
The role played by state agencies and health insurance is different. CHI analyzed data from the All Payers Claims Database (APCD) to help assess what role health insurance plays in providing behavioral health services. APCD reports on services provided by Medicaid and many other private insurers, including some self-insured employer plans.

In 2018, 7,200,000 services were provided to children and youth with a mental diagnosis through both public and private insurance. About a third of were provided in an outpatient setting, and just 1 percent went to inpatient care.

An examination of services provided by age show that services covered by insurance are more equally distributed by age category than those reported by state agencies.

Figure 7. Race / Ethnicity is Not Known for Most

Children and Youth Served by Race / Ethnicity



- Hispanic/Latinx **7.3%**
- White (non-Hispanic/Latinx) **6.5%**
- Black or African American **1.2%**
- Asian (non-Hispanic/Latinx) **0.2%**
- American Indian/Alaskan Native **0.2%**
- Native Hawaiian/Pacific Islander **0.1%**
- Multiracial/other **3.4%**
- Unknown race/ethnicity **81.1%**

Race / Ethnicity

Data on race and ethnicity were reported for less than 20 percent of children and youth receiving behavioral health services. Of those whose race or ethnicity is known, nearly 40 percent were Hispanic / Latinx, and nearly 34 percent were white (non-Hispanic / Latinx). Black or African American Coloradans accounted for 6 percent, and 18 percent were multiracial. Other races and ethnicities account for less than 1 percent each (see Figure 7).

According to the CHAS, 70 percent of children and youth who did not get needed behavioral health services were white (non-Hispanic / Latinx). However, it's important to note that low representation of certain racial and ethnic groups does not equate to lower need. For example, national data showed an overall increase in total expenditures for black or African American youth, despite a decrease in overall representation. This suggests fewer youth were using behavioral health services but at a higher rate.[10] Without the ability to de-duplicate children and youth receiving care across programs, it is difficult to say whether young Coloradans of color are receiving needed services.

Table 3. Federal Funding by Mechanism

Mechanism Type	Amount	Program	State Agency
Medicaid (53 percent average federal match)	$114M	Capitated behavioral health	HCPF
	$14M	Child Welfare Services Block	OCYF
	$12M	Fee-for-service behavioral health	HCPF
	$3M	Mental Health Institutes	OBH
Child Health Plan Plus (79 percent federal match)	$23M	CHP+	HCPF
Block Grants	$131M	Child Welfare Services Block Grant	OCYF
	$7M	Substance Abuse Prevention	OBH
	$2M	Managed Services Organizations	OBH
	$1M	School-Based Health Centers	CDPHE
	$938k	First Episode of Psychosis	OBH
	$3M	Core Services Block Grant	OCYF
	$736k	Garrett Lee Smith Youth Suicide Prevention Grant	CDPHE
Other Grants	$7M	Early Intervention	OEC
	$2M	Early Childhood Mental Health (ECMH) Consultant	OEC
	$3M	CO-ACT System of Care Grant	OBH

How We're Paying: Funding Mechanisms

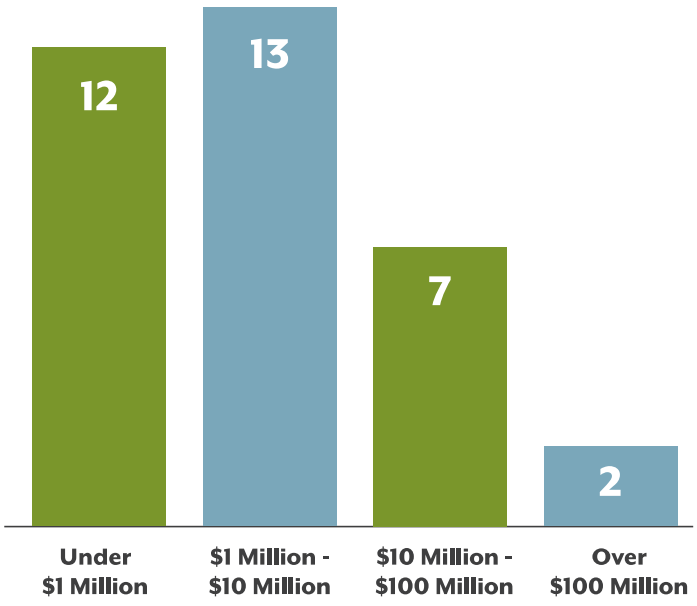
Children's behavioral health in Colorado is funded not only through a variety of sources, but by a variety of funding mechanisms. Understanding differences in how this money enters the state can help determine whether all dollars are being spent effectively.

For example, some federal funds are delivered through block grants, which come to Colorado in one lump sum, regardless of how much state funding is also provided. Other programs receive a federal funding match, meaning that for every dollar spent by Colorado, additional money can be pulled down from the federal government.

Federal match amounts vary depending on the program. In FY 2019, the average federal match rate for Medicaid programs for children and youth was 53 percent.[11] In other words, for every $100 in Medicaid behavioral health expenses, the federal government covered $53 of the cost. In FY 2019, CHP+

Figure 8. Most Programs Have Budgets Under $10 Million

Number of Programs by 2019 Expenditures



was matched by federal dollars at a much higher rate — 79 percent—though this is expected to soon drop to 65 percent.[12] Table 2 summarizes the funding mechanisms that draw down federal dollars in Colorado.

In addition to sources of funding, there is variation in how funding is distributed across programs. Of the 34 programs identified in this financial map, most spend less than $10 million per year (see Financial Map on pages 6 and 7 and Figure 8). Combining smaller programs is a possible opportunity to streamline services and create economies of scale.

Opportunities Moving Forward

Colorado has myriad opportunities to strengthen its system for financing behavioral health services for children and youth ages 0 to 26, and the state faces an urgent need to streamline. CHI identified five opportunities to strengthen this key behavioral health delivery system.

1. Consolidate Funding Streams and Service Delivery

Consolidating programs by their eligibility criteria, program size, funding flexibility, and services provided could reduce duplication, increase alignment and efficiencies, and improve quality and access to care for children and youth who need it most.

One approach to consolidating funding streams may be to align programs by their eligibility criteria. This analysis identified many smaller programs that provide a narrow range of services based on very specific program eligibility requirements. These programs may have similar program-eligibility requirements, populations served, and services offered. But because of small differences in administration through different state agencies, different rules associated with different funding sources, different data infrastructure, and other misalignments, services may not be sufficiently coordinated and comprehensive to reach all children in need.

One example is the interaction between the Collaborative Management Program (CMP) and the CO-ACT System of Care Grant. These programs both offer care coordination and wraparound services, with the CO-ACT grant building on the infrastructure of the CMP. They both serve the behavioral health needs of very similar populations of youth and children. Both are spending less than $5 million annually. But their eligibility requirements are slightly different, they are administered by different state agencies, and their service offerings may not completely align. Consolidating these two programs — either in their administration, funding, eligibility, or other alignment — could reduce confusion and better serve children and their families.

Colorado's leaders may also consider consolidating funding streams by their program size. This analysis identified 12 programs that each spend less than $1 million dollars annually. Collectively, these programs are critical to the behavioral health of the state's youth and children. But for an individual family or provider, consolidating these programs could create economies of scale and increase access to and quality of care provided to youth and children.

Another approach to consolidating funding streams is by funding flexibility. Non-Medicaid state general funds make up 41 percent of all child behavioral health spending. More flexibility in spending of these dollars could allow programs to align with other systems. Colorado's leaders should consider a closer look at the funding restrictions currently limiting these dollars from aligning.

Colorado's leaders should also consider consolidating funding streams by their services provided. One example is the Child and Youth Mental Health Treatment Act funding and the Core Services Block Grant, which provide similar services. Both exist under CDHS. Analyzing these service offerings — as well as who is eligible to receive them — could reveal opportunities to streamline this funding to reach more children.

Recent policy examples also reveal examples of alignment by services provided. Senate Bill 19-195, for instance, requires HPCF to design an integrated funding pilot that would blend and braid federal, state, and local dollars to reduce the duplication and fragmentation of services for multi-system- involved children and youth.[13] Consolidating funding streams across other service areas could similarly reduce duplication across the entire behavioral health system serving children and youth.

2. Maximize Federal Dollars

Colorado's leaders should use this financial map to identify opportunities to increase federal matching funds. If any services currently provided by state programs that don't get a federal match could instead be provided using funding from Medicaid or CHP+, Colorado may be able to get the federal government to pick up a greater portion of the tab.

But homing in on specific opportunities — and estimating the size of potential additional Medicaid match dollars — requires additional data that are not yet available in Colorado's data systems. Specifically, identifying Medicaid match opportunities requires an understanding of the Medicaid-eligibility of individuals served and whether the services delivered are covered by Colorado's Medicaid benefit. For example, identifying matching opportunities requires knowledge of whether the young people being served are eligible for Medicaid in terms of their income, documentation status, and other factors.

That said, this financial map provides a place to start and considerations for policymakers in the future. Colorado's leaders should look for matching opportunities by identifying potential Medicaid-aligned services under state agencies and programs that are not yet using significant Medicaid dollars.

Examples of current non-Medicaid funded programs that could warrant a Medicaid match might include the Early Childhood Mental Health programming within OEC or First Episode of Psychosis within OBH. Again, however, without knowing details on the exact nature of these services or the populations they serve, we can't say this with much certainty.

Additional considerations are described below.

Recent policy developments. Recent policy developments may reveal opportunities to pull down additional federal match dollars. For example, Colorado's Medicaid Section 1115 waiver expanding the substance use disorder treatment benefit creates matching opportunities for any programs already offering these services using existing non-Medicaid dollars.

Funding limitations. The federal government can only use Medicaid or CHP+ dollars to support specific services — and without disruption or complication to the services already available to Colorado's youth. For example, there are currently funding limitations on some inpatient services within Medicaid. Deeply understanding which programs purchase which services is critical to maximizing the federal match.

This is especially true in the child welfare system. Though this analysis is lacking the data needed to investigate, a report by Child Trends identifies opportunities for counties to contribute to ensuring federal dollars are used whenever possible to provide services to children. This report recommends working with counties to ensure Title IV-E eligibility is documented correctly to so that services provided receive a federal match.[14]

3. Promote Equity in Behavioral Health Funding

In addition to securing larger federal matches, changes to spending may lead to a more equitable distribution of resources. An opportunity exists to ensure funds are distributed to services for the youth populations that need them the most. More should be done to ensure all youth are actually aware of services.

Investment in young children and the 18 to 26 population is important. While data are limited, findings suggest youth ages 0 to 5 and 18 or older may be disproportionately under-funded compared with school-aged youth in Colorado and their national counterparts.

Finally, opportunities exist to reduce disparities in funding among racial and ethnic groups. Low representation among communities of color demonstrates a need for targeted outreach.

There also may be racial and ethnic groups that are more likely to be double-counted in this analysis because the data were unable to account for people who use services from multiple programs. If these data were available, further analysis could be conducted to see if certain racial and ethnic groups are more or less likely to receive multiple services, and if so what type of services they are receiving.

4. Focus on Substance Use Treatment

Colorado's leaders should consider consolidating funding streams in ways that promote access to urgently needed services. One example is access to substance use treatment services for children and youth.

This report found that substance use screening and/or treatment services are delivered across the service array — from school-based services to outpatient care and inpatient hospitalization.[15] And multiple funding streams support these different services, such as Managed Services Organizations, Medicaid, Core Services Block, and the Colorado Trauma-Informed System of Care grant. This integration may provide multiple entry points for families — but it may also create fragmentation of funding, eligibility, and access to services.

Conducting additional analysis of Colorado's substance use treatment services for youth may identify inefficiencies and duplication of services.

5. Accountability for Results

Colorado's behavioral health data are fragmented. The state should invest in data infrastructure to learn where dollars are going, who is receiving which services, and where gaps remain.

Increased Efficiency

Investment in data systems and associated governing structures facilitates easier and more accurate tracking of financing streams, services purchased, and populations served. The process of this analysis provides examples of this fragmentation and its implications. For instance, collecting Colorado's behavioral health financing data often required multiple phone calls with multiple staff at a single state agency — and still, interviewees were unable to provide demographic or service information on more than half of the dollars identified.

Better Understanding of Demographic and Service Gaps

As a result of this fragmentation, substantial funding is not attributed to a specific age group, gender, race, or ethnicity. Colorado's leaders should invest in common data infrastructure that allows for multiple agencies and programs to connect their data sets and understand gaps at a population level.

This information is critical not only to understanding gaps in services — but also to determining if programs are maximizing federal match dollars.

Comprehensive Service Array Information

The breadth of services being provided to children and youth with behavioral health issues is vast. Within each of the 10 service areas described on page 8, there are many different types of services. Each state agency provided data broken down by the service array. However, each agency took its own approach to estimate which parts of the service array their funds and programs were supporting.

Colorado's leaders should establish and standardize an array of services to encourage consistent reporting. This would provide a better understanding of what services each dollar is purchasing.

Individualized Service Provision

Cross-agency data sharing is critical to identify those who are receiving services from multiple agencies. Colorado's leaders should consider adopting data infrastructure best practices — such as a unique identifier for all of Colorado's children accessing services — to streamline service access.

The behavioral health task force members are considering ways to better strengthen data sharing. The proposed behavioral health service delivery structure would affect non-Medicaid public programs operating out of many of the agencies interviewed for this analysis. A new or existing singular centralized agency would administer all community-based direct services. This approach could facilitate better data sharing, more aligned service eligibility, and more streamlined contracts.

Conclusion

Every year, Colorado spends at least a half billion dollars on behavioral health services for children and youth. An examination of these finances underscores a complex, yet essential, set of systems and funding mechanisms that goes to providing these important services. Opportunities to expand the equitable, effective, and efficient use of these funds can continue to elevate the behavioral health of all Colorado youth and families.

Appendix 1: Methods

Data for the children's behavioral health financial map were provided by state agencies at the request of the Colorado Health Institute (CHI) and the Behavioral Health Task Force children's subcommittee.

Agencies to include were identified in consultation with taskforce subcommittee representatives and Taskforce leadership. CHI provided one or more representatives at each agency with an Excel spreadsheet to be completed. Once the completed spreadsheet was returned to CHI, it was reviewed for completeness and underwent data validation. CHI engaged with representatives at state agencies before, during, and after this data request to assess the accuracy of submissions and follow up on incomplete or confusing data.

Data represent state fiscal year 2018-2019 (FY 2019). Depending on the state agency, figures provided represent budget or expenditures.

State agencies were often unable to provide all of the information requested. In some cases, those values are not included in this report (see the table below for a summary of demographic data availability by program).

In other instances, CHI made changes to the data in order to report as much information as possible. These are described in more detail by state agency below.

Department of Health Care Policy and Financing (HCPF)

HCPF data came from multiple sources. Medical Services Premiums figures were used to report funding by source (federal, state general, or state cash funds). Data on the types of services provided came through a separate data request, as many behavioral health services are capitated and these claims are not included with the Medical Services Premiums.

Dollar amounts by funding source from the Medical Services Premiums differed from the amounts reported by service type. To reconcile these figures, total funding provided by service type was allocated according to the proportional split of the funds by funding source reported.

Race and ethnicity data were reported separately as well. HCPF used categories that differed slightly from those in the initial data request and included Hispanic / Latinx as both a race and ethnicity category. Hispanic / Latinx enrollees were reported to be 29 percent of the population by ethnicity, and 7 percent of the population by race. In order to align these categories with those reported by other state agencies, CHI assumed that 29 percent was the correct percentage of Hispanic / Latinx enrollees, and that the 22 percent of Hispanic / Latinx enrollees not accounted for in the race breakdown most likely reported as "multiracial" in the race breakdowns provided by HCPF. This lowered the overall percentage of multiracial enrollees reported by HCPF.

Finally, the number of Child Health Plan Plus (CHP+) enrollees was also not reported. CHI used the HCPF 2020-21 budget request to determine the number of CHP+ enrollees in FY 2019.

Spending on psychotropic medications was pulled out of the HCPF funding figures. "Psychotropic" medications included HCPF drug categories of:

- Psychoactive drugs, ADHD
- Psychoactive drugs, depression, anxiety, and other
- Psychoactive drugs benzodiazepines
- Psychoactive drugs antipsychotics
- Analgesics opioid antagonist and withdrawal treatment (SUD treatment)

Data from HCPF reflect expenditures rather than budgeted figures.

Colorado Department of Education (CDE)

It is important to note that CDE was unable to separate behavioral health expenditures from other health expenditures, and so this figure is likely inflated.

CDE was unable to report data on demographics or service array. CHI assumed that 100 percent of

Table 1: Table of Available Demographic Data by Program*

	Age	Sex / Gender	Race / Ethnicity
Healthy Steps	X		
The Incredible Years	X		
Family Development Services through Family Resource Centers		X	X
Early Childhood Mental Health (ECMH) Consultants			
Early Intervention	X	X	X
School Health Professional Grant	X		
School Health Services (Medicaid)	X		
Office of Suicide Prevention School Grants (SB18-272)			
Garrett Lee Smith Youth Suicide Prevention Grant			
Communities that Care			
School Based Health Centers		X	X
Children and Youth Mental Health Treatment Act	X	X	X
Offender Behavioral Health Services (OBHS)	X	X	X
Mental Health Institutes	X	X	X
Forensic Community Based Services (FCBS)			
OBH Coordinated Outpatient Restoration	X	X	X
Non-OBH Coordinated Outpatient Restoration	X	X	X
Forensic Jail-Based Restoration (RISE)	X	X	
Forensic Outside Evaluations	X	X	X
Managed Services Organizations	X	X	X
School-Based Mental Health Specialist			
First Episode of Psychosis	X	X	X
Children and Adolescent "Indigent Population"	X		
Children's Other CMHC Programs Hospital Alternatives	X		
Substance Abuse Prevention	X	X	X
Crisis Services Hotline	X		
Crisis Services Walk-in, Stabilization, & Respite Svcs	X		
COACT System of Care Grant	X	X	X
Core Services Block			X
Collaborative Management Program		X	X
Children Welfare Services block (Includes IV-E, IV-B, XX)			X
CHP+ Behavioral Health			
Behavioral Health Capitation		X	X
Behavioral Health Fee-for-Service		X	X

*An X notes demographic data that was provided by agency.

funding went to school-based services, and that these funds were split equally between all relevant age groups for these school-based services.

CDE did provide data on a Social Emotional Health Grant, but CHI decided not to include these funds, as the implementation cycle of this grant did not occur during FY 2019.

Data from CDE reflect budgeted figures rather than expenditures, with the exception of Medicaid funds under their control.

Colorado Department of Human Services, Office of Behavioral Health (OBH)

OBH was unable to report age data for two programs: Children and Adolescent "Indigent Population" and Children's Other CMHC Programs Hospital Alternatives. For these programs, CHI assumed an even split of funding between the relevant age groups.

In some instances, OBH provided data that had to be parsed out for analysis.

When cells were merged and figures were reported for two groups (e.g., if "70 percent" of clients were said to be in 0 to 5 age category and the 6 to 12 age category), CHI split the figure evenly by age group (e.g., 35 percent were put in the 0 to 5 age bucket and 35 percent in the 6 to 12 age bucket).

When only a high range for a figure was provided in the demographic breakdowns (e.g., "fewer than 2 percent multiracial enrollees"), CHI assumed this percentage was the point estimate (e.g., assumed 2 percent multiracial enrollees).

Data on race and ethnicity often summed to greater than 100 percent. This is likely due to difficulties reporting which racial groups are non-Hispanic / Latinx. In these instances, CHI kept the number of Hispanic / Latinx children served and entered the remaining children as "unknown" race.

Data from OBH reflects budgeted figures rather than expenditures.

Colorado Department of Human Services, Office of Early Childhood (OEC)

OEC data on race and ethnicity often summed to greater than 100 percent. This is likely due to difficulties reporting which racial groups are non-Hispanic / Latinx. In these instances, CHI removed the additional children from the Hispanic / Latinx group. This was handled differently than the same issue in the OBH data set because the size of this gap was relatively small.

Data from OEC reflects budgeted figures rather than expenditures.

Colorado Department of Human Services, Office of Children, Youth, and Families (OCYF)

It is important to note that OCYF was unable to parse out which expenditures went to behavioral health services and which went to other types of services within their purview. Therefore, the total expenditures is an over-estimate.

Data from OCYF reflects budgeted figures rather than expenditures.

Colorado Department of Public Health and Environment (CDPHE)

CDPHE provided data for the Colorado Pediatric Psychiatric Consultation and Access Program (CoPPCAP). CHI did not include in this analysis because FY 2019 was a planning year for the grant.

Data from CDPHE reflects budgeted figures rather than expenditures.

Appendix 2: Description of Children's Behavioral Health Programs by State Agency

Office of Behavioral Health, Colorado Department of Human Services

Children and Youth Mental Health Treatment Act

The Children and Youth Mental Health Treatment Act is an alternative to child welfare involvement. It applies when a dependency and neglect action is not warranted and allows for families to access mental health treatment services for their children.

Offender Behavioral Health Services

Offender Behavioral Health Services provides community-based support for previously incarcerated individuals, jail-based behavioral health, and law-enforcement services such as co-responder services.

Mental Health Institutes

The Office of Behavioral Health operates two mental health institutes, or state-run psychiatric hospitals: the Colorado Mental Health Institute at Pueblo and the Colorado Mental Health Institute at Fort Logan in Denver.

Forensic Community Based Services

Forensic Community Based Services is responsible for the case management of persons found not guilty by reason of insanity, and who are transitioning from an inpatient hospital setting into a community-based outpatient setting. Acquittees on community placement and conditional release have the opportunity for continued independence, recovery, and community reintegration.

Coordinated Outpatient Restoration

The Outpatient Restoration Program serves adults and juveniles in the criminal and juvenile justice systems who are found incompetent to proceed. It provides education and case management services in or near enrollees' communities. This program delivers competency restoration services in the least restrictive setting, increasing a person's ability to engage with local and social support while preventing personal losses such as employment, housing, income, and freedom. Education services are at no cost to the individual and are provided by contracted educators throughout the state. "Non-OBH" restoration refers to those not assigned to the Department of Human Services by the court.

Forensic Jail-Based Restoration (RISE)

The Jail-Based Evaluation and Restoration Program provides jail-based competency restoration services for individuals ordered by a court to receive an initial evaluation of competency to proceed, or those found incompetent to proceed and ordered to undergo competency restoration treatment.

Forensic Outside Evaluations

Competency, sanity, mental, and other examinations done outside of the Department of Human Services.

Managed Service Organizations

Regional organizations who ensure access to a full continuum of quality substance use disorder services for individuals in need.

School-Based Mental Health Specialist

School-based mental health specialists provide consultation, training, support, and mental health resources to schools.

First Episode of Psychosis

First Episode of Psychosis is a high-intensity outpatient program targeting youth with serious mental illness who have or are experiencing psychosis (typically schizophrenia-related disorders). Clients are supported by a multi-disciplinary team consisting of a team lead, therapist, supported employment/education specialist, prescriber/nurse, peer supports, and a case manager.

Children and Adolescent "Indigent Population"

The Office of Behavioral Health provides behavioral health programs and services for individuals designated as "indigent." Qualification as "indigent" is based on uninsured status, severity of diagnosis, and household income.

Children's Other CMHC Programs Hospital Alternatives

Children's Other CMHC Programs Hospital Alternatives provides mentoring programs and other outpatient services for children

Substance Abuse Prevention

Substance abuse prevention efforts include the development of a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program targets both the general population and sub-groups that are at high risk for substance misuse.

Crisis Services Hotline

Hotline, support line, chat, and text services to receive urgent mental health assistance. The hotline can be used by any Coloradan in crisis.

Crisis Services Walk-in, Stabilization, and Respite Services

Mental health evaluations and services via walk-in, crisis stabilization units, mobile crisis response, or respite services.

COACT System of Care Grant

COACT services children and youth with serious behavioral health challenges and their families. They are provided services through High-Fidelity Wraparound with peer support to keep them at home, in school, and out of trouble.

Office of Children, Youth, and Families, Colorado Department of Human Services

Core Services Block

The Core Services Block grant funds therapeutic services focused on family strengths by directing intensive services that support and strengthen the family and protect the child. It aims to prevent out-of-home placement of the child, return children in placement to their own homes, or unite children with their permanent families.

Collaborative Management Program

The Collaborative Management Program is an optional program addressing children, youth, and families involved or at risk of involvement in more than one system.

Children Welfare Services Block

Children Welfare Services Block grant funds are allocated to counties to provide child welfare services. They are generally unrestricted and flexible, being used for more than placement services.

Office of Early Childhood, Colorado Department of Human Services

Healthy Steps

Healthy Steps integrates a child development specialist into the pediatric primary care team to foster positive parenting, strengthen the child's early social and emotional development, and support early literacy. The program pairs a Healthy Steps Specialist with families with children ages birth to three.

The Incredible Years

The Incredible Years is an evidenced-based program for pre-kindergarten and kindergarten classrooms. It supports classroom management for teachers and includes a parenting program. This approach prepares children for school by teaching them how to interact with others and solve problems in a healthy, positive way.

Family Development Services through Family Resource Centers

Family Development Services serve as a single point of entry for providing comprehensive, intensive, and integrated state- and community-based services to families, individuals, children, and youth. State funding supports family development and case management services.

Early Childhood Mental Health Consultants

Early Childhood Mental Health (ECMH) consultants partner with caregivers, teachers, and child care directors to help them understand and respond effectively to children birth to 8 years old. This evidence-based solution reduces challenging behavior in the classroom and helps prevent suspensions and expulsions. ECMH increases teacher retention and helps improve classroom environments.

Early Intervention

Early Intervention provides services for children under age three with developmental delays or disabilities and their families. The program teaches positive relationships, acquisition and use of knowledge and skills, and the use of appropriate behaviors to meet their needs.

Colorado Department of Education

School Health Professional Grant Program

The School Health Professional Grant Program provides funds to eligible education providers to enhance the presence of school health professionals in both elementary and secondary schools.

School Health Services (Medicaid)

Participating school districts can bill Health First Colorado for Medicaid-covered services provided in schools. The Colorado Department of Education provides training on development of the local service plans to support students' mental and physical health needs.

Colorado Department of Public Health and Environment

Office of Suicide Prevention School Grants

Office of Suicide Prevention School Grants help school districts implement comprehensive crisis and suicide prevention strategies. It The program focuses primarily on trainings for school faculty.

Garrett Lee Smith Youth Suicide Prevention Grant

Garrett Lee Smith Youth Suicide Prevention Grants focus on intensive community-level change to strengthen linkages across youth-serving systems and improve the identification, referral, and follow-up supports for youth at risk for suicide. Communities also use grant funds to support Zero Suicide, provider trainings, and gatekeeper trainings for adults working with children.

Communities that Care

Communities That Care guides communities through a proven five-phase change process. Using prevention science as its base, the program promotes healthy youth development, improves youth outcomes and reduces problem behaviors.

School-Based Health Centers

State grant funding supports existing school-based health centers as well as the planning and start-up of new school-based health centers in Colorado.

Department of Health Care Policy and Financing

CHP+ Behavioral Health

Child Health Plan *Plus* (CHP+) is public low-cost health insurance for certain children and pregnant women. It is for people who earn too much to qualify for Medicaid, but not enough to pay for private health insurance.

Behavioral Health Capitation

Most behavioral health services provided to Medicaid enrollees are covered through capitation. HCPF pays a regional entity a monthly amount to provide or arrange for behavioral health services for all Medicaid members.

Behavioral Health Fee-for-Service

Certain behavioral health services for Medicaid enrollees, such as those provided in a primary care setting, are still paid for in a fee-for-service structure.

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11 Most Medicaid costs receive a 50 percent match in Colorado. However, costs for young adults covered as part of Medicaid expansion are given a higher match rate — 90 percent.

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Notes

Notes

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COVID-19 Special Assignment Committee Report

September 17, 2020

COLORADO
Behavioral Health Task Force
Department of Human Services

In May 2020, Governor Polis asked the Behavioral Health Task Force to establish the COVID-19 Special Assignment Committee. This document is the result of the combined efforts of the individuals listed below. We are grateful that these subject matter experts were willing to come together so quickly and develop recommendations that will strengthen Colorado's behavioral health system in a future crisis.

COVID-19 Special Assignment Committee Members

Curt Drennen, Colorado Department of Public Health and Environment, Co-chair

Robert Werthwein, Colorado Department of Human Services, Co-chair

Dianne Primavera, Lt. Governor, Executive Sponsor for the Special Assignment Committee

Yadira Caraveo, State House of Representatives

Cara Cheevers, Colorado Division of Insurance

Lila Cummings, Colorado Hospital Association

Daniel Darting, Signal Behavioral Health Network

Doyle Forrestal, Colorado Behavioral Healthcare Council

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Kim Nordstrom, Colorado Access

Carrie Paykoc, Office of eHealth Innovation

Rod Pelton, State House of Representatives

Susie Walton, Park County Human Services

Leon Wittner, Consumer/Parent

Anthony Young, Association of Black Psychologists

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The COVID-19 Special Assignment Committee was coordinated by Christopher Miller, community programs manager of special projects at CDHS, and supported by program assistant Larena Hatley.

The Office of Behavioral Health, Community Behavioral Health, Evaluation Team who disseminated and analyzed two statewide surveys for this Committee: Matt Best, Elizabeth Brooks, Detre Godinez, Tim Gruzeski, Anoushka Millear, Gregor Rafal, Shaina Riciputi, Stephanie Rogers, Amy Smith, Ari Stillman, Katie TenHulzen, and Heather Tolle.

NOTE ABOUT THIS DOCUMENT

Throughout this document, references are made interchangeably between "Coloradans," "people," "people in need of services," "consumers," and "clients."

Table of Contents

Executive Summary

The COVID-19 pandemic affected the behavioral health needs of Coloradans, leading to increased incidence and prevalence of stress, anxiety, social isolation, and financial hardship accompanied by a concurrent increased demand for behavioral health services and support. The State's crisis hotline experienced a 30% increase in average monthly calls and a record-breaking number of texts. Reports released early in the pandemic by The Colorado Health Foundation, as well as national studies, indicated that COVID-19 is impacting the behavioral health conditions of people across the country, including Coloradans.

After soliciting input from Coloradans across the State, as well as behavioral health providers, reviewing and analyzing data, and identifying the areas in most need of strengthening for future emergencies and pandemics, the Committee developed key recommendations for consideration in a future crisis:

Recommendations

Tele-Behavioral Health

1 Expand/Increase Tele-Behavioral Health Services, including:

- Complete a comprehensive analysis for expanding tele-behavioral health
- Promote tele-behavioral health via training and public awareness
- Promote consumer-centric values for tele-behavioral health
- Review opportunities to permanently enact regulations and administrative flexibilities
- Continue to strengthen the State's broadband infrastructure
- Ensure adequate, flexible resources are available to providers
- Create a proactive outreach plan to identify and reach the most vulnerable populations

Behavioral Health Services

2 Behavioral Health Providers should be recognized as essential health care providers.

3 Ensure the Capacity Tracking System, which is scheduled to launch in January 2021, is adequately resourced to function successfully and address any enhancements.

Outpatient Services

4 Expand services offered by the Colorado Crisis System.

Residential/Inpatient Services

5 Ease specific regulations and oversight standards to increase capacity during an emergency.

6 Ensure clients accessing bed-based services are able to be transferred to facilities to continue their substance use disorder (SUD) treatment even when they are COVID-19 positive.

7 The safety and well-being of patients/clients should not be compromised to respond to a pandemic, disaster, or state emergency.

8 The State Emergency Operations Plan should include continuous quality improvement.

9 During a state of emergency that burdens the inpatient bed capacity, preemptive efforts should be made to reduce the reliance on inpatient beds.

10 Protocols and proper equipment are needed for staff working in substance use and mental health settings, including 24/7 residential and hospital facilities.

Substance Use Disorder Services

11 Ensure all treatment modalities are available to those seeking substance use disorder (SUD) treatment, via telehealth or other forms. This includes establishing different forums for social support groups to help individuals maintain recovery and other interventions that are group-based.

12 Colorado should take steps to ensure that medication-assisted treatment (MAT) services are not interrupted during a pandemic or state emergency.

13 The State should address requirements that create barriers for greater access to transportation services.

Children and Youth

14 The state agency responsible for public health should coordinate with child-serving agencies and educational institutions to prepare a public education strategy to respond to the social/emotional implications that children are experiencing as a result of COVID-19.

15 Develop new strategies and processes to identify and screen children and youth for their behavioral health needs.

16 Ensure evidence-based preventative measures that decrease suicide and other behavioral health concerns are adequately resourced in schools.

17 Ensure there is a strong balance of local and state alignment to have consistent and centralized access to information and coordinate available services between these agencies and educational institutions (i.e., "no wrong door" approach).

18 The State, in conjunction with counties, should ensure that foster children and youth have the behavioral health services they need to successfully navigate the pandemic.

19 As it relates to a pandemic or state emergency, funding agencies of direct and support services for families should adopt flexible funding strategies that ensure all families can access all levels of whole person care and behavioral health services.

20 For children's services, the State should assess which crucial community provider organizations are in jeopardy of closing or laying off their workforce.

Equity

21 Assess and rectify inequitable access for all Coloradans within children, youth and adult behavioral health services during the current pandemic and in future State emergency responses.

Emergency Response

22 Formalize the role of community behavioral health organizations with the capacity and capability to actively participate in the Colorado Department of Public Health and Environment's (CDPHE) emergency preparedness, response, and recovery activities.

23 The State should review the roles of the various state agencies involved in the pandemic response as it impacts behavioral health service delivery and coordinate and align state agencies for emergency responses in meeting the behavioral health needs of individuals and communities.

Funding Flexibility

24 Maintain flexible policies to provide services by telephone and videoconferencing.

25 Explore, with the federal Medicaid agency on expanding the pool of Medicaid providers by allowing non-contracted Medicaid providers to provide services to Medicaid recipients quickly.

Introduction

Special Assignment Committee Purpose

In April 2020, Governor Polis asked the Behavioral Health Task Force (the Task Force) to establish the COVID-19 Special Assignment Committee to:

- Create an interim report that highlights the short- and long-term impacts of COVID-19 on the behavioral health system, including access to behavioral health services, especially for vulnerable and underserved populations;
- Evaluate the behavioral health crisis response in Colorado to COVID-19 and provide recommendations for the Behavioral Health Task Force's Blueprint on improvements to behavioral health services for response during any potential future crisis.

Process

The COVID-19 Special Assignment Committee (The Committee) met between May and September 2020 and explored how COVID-19 impacted the behavioral health of Coloradans and service delivery. A myriad of state-based collection efforts was utilized. Additionally, the Office of Behavioral Health (OBH) solicited input from two key stakeholder groups:

1. A survey was issued in partnership with the Colorado Department of Health Care Policy and Financing (HCPF) to examine how COVID-19 impacted factors related to mental health or substance use treatment for people who needed access to services;
2. A survey, key informant interviews, and focus groups provided insights on the impact of COVID-19 on behavioral health service provision from the providers' perspectives.

This Committee used the Strategies for Managing Behavioral Health Standards of Care During a Crisis developed by the Governor's Expert Emergency Epidemic Response Committee (GEEERC) as the foundation for many of its recommendations (and, in some cases, adopted the exact same recommendations). The GEEERC document lays out actionable standards for the modified practice of behavioral health care during times of crisis, such as a declaration of a "state of emergency." The GEEERC document supports such actions as the expansion of telehealth services and other practice adaptations to meet increased needs during a time when some providers may be unavailable. While the GEEERC document is designed to recommend specific regulatory adaptations to be made during a crisis, this Committee's recommendations speak to broader systemic recommendations that should be made to behavioral health during a crisis, as well as some recommendations to be adopted in non-emergent times.

A strong, accessible behavioral health system is critical to meet the demands for substance use and mental health care during a crisis. The initial phase of the COVID-19 response offers many key lessons that should inform future disaster planning and guide behavioral health system reform over the coming years. Defining behavioral health as an essential service and determining how to better reach the most vulnerable and underserved populations is critical. There are opportunities to enhance outpatient, inpatient, and SUD services and educate Coloradans about pandemic terminology and safety protocols as it relates to behavioral health care, i.e. proper face coverings, social distancing, etc.. Tele-behavioral health can be a powerful mechanism to provide timely services when in-person meetings are not an option.

Additionally, this Committee adopted the recommendations (with some modifications and additions) of the Task Force's Children's Behavioral Health Subcommittee. See the Colorado Behavioral Health Task Force website for meeting agendas, presentations, minutes and related materials located under the COVID-19 Special Assignment Committee meeting resources.

Impact of COVID-19 on Behavioral Health

The COVID-19 pandemic affected the behavioral health needs of Coloradans, leading to increased incidence and prevalence of stress, anxiety, social isolation, and financial hardship, accompanied by a concurrent increased demand for behavioral health services and support.

Even before COVID-19, approximately one million people across the State were in need of behavioral health services, and Colorado was already facing significant behavioral health needs. In 2018, Colorado had the seventh highest suicide rate in the nation, and suicide is the second leading cause of death among Coloradan youth. Close to 95,000 Coloradans with substance use disorder went without treatment in 2019.

Limitations on Findings

The input and data used to analyze the long-term impact of the COVID-19 pandemic on behavioral health are limited. This report in its entirety reflects conversations by Committee members over five months. The limitations of understanding the long term impacts of a pandemic on behavioral health are not limited to this Committee as there exist very few comparable situations. Given that Coloradans are still contracting COVID-19, we have yet to truly understand the direct and indirect long-term impacts. The inadequate information available on COVID-19's long-term impact on behavioral health needs makes it difficult to say with certainty the extent of the expected, forthcoming demand for care. It is also difficult to attest if the reintegration back to previous social norms will mitigate any long-term impacts. However, for the immediate future, there is a clear call from consumers and providers to not neglect the impact of social isolation on the mental wellness of individuals. In addition, the collateral economic impact of the pandemic that has resulted in joblessness will likely have a significant impact on the mental well-being of individuals, and increased suicidal ideation and behavior. There is a relatively large body of literature examining the association between unemployment and all-cause mortality, as well as specific types of deaths. Research focused on suicides is the most established, showing that a one-point increase in unemployment rates increases suicide rates by about 1 to 1.3%.[1]

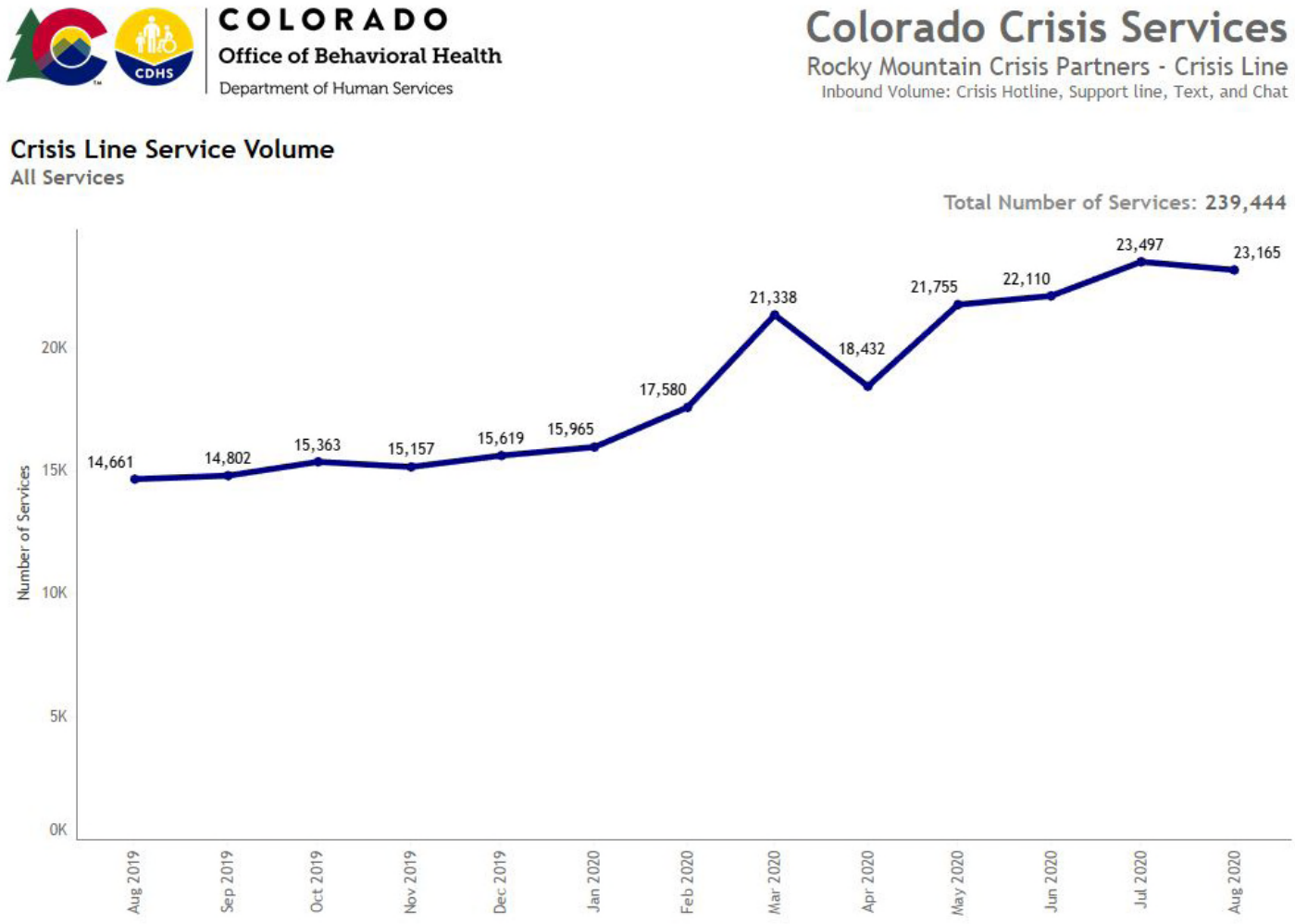
Other than the Colorado Health Foundation August 2020 Survey, the information collected on the pandemic's impact on behavioral health is limited. The committee was unable to obtain a comprehensive analysis on any differences the impact of COVID-19 is having on different groups based on geographic location, race, gender, and other demographics. The data collected by the Colorado Health Foundation found that 20% of minorities reported needing mental health services but were unable to access it. The survey also showed significant differences based on economic status, and that women reported more experiences of increased mental health strain, such as anxiety, loneliness, or stress. One commonality found across all ethnic and racial lines is that about half of the people have been impacted by mental health strain. It is safe to assume that any inequities that existed prior to the pandemic would only be further exacerbated. In addition, it can also be assumed that the pandemic is not impacting everyone the same. While there have been known reports on disparities related to physical health as it relates to COVID-19, this committee was unable to obtain any information specific to behavioral health.

These limitations provide an opportunity for future research and pilot projects to consider the impact of disaster and pandemics on historically marginalized populations and their behavioral health.

Reports and Surveys

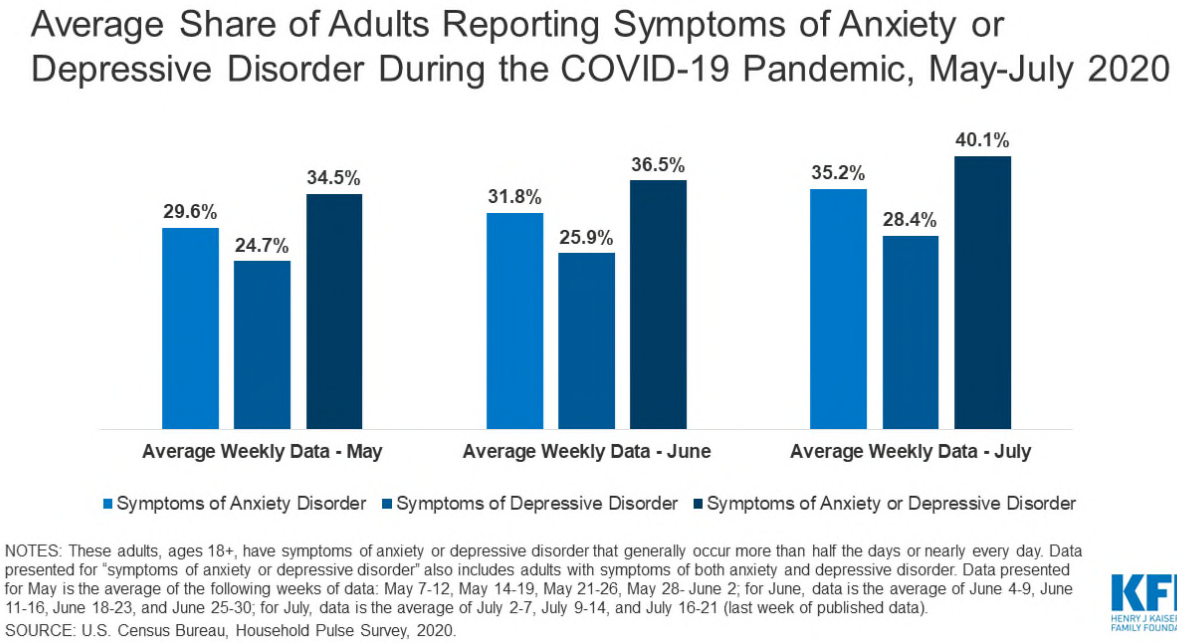
After COVID-19 emerged in Colorado, reports illustrated the negative impact the pandemic and social isolation had on the behavioral health of individuals. This was evident in the 30% increase in average monthly calls to the State's Behavioral Health crisis hotline and a record-breaking number of texts.

Figure 1. The graph below represents the number of Colorado Crisis Services provided each month via the Crisis line from August 2019 - August 2020.



According to a recent survey, released August 21, 2020, conducted by the Kaiser Family Foundations (KFF), more than one in three adults in the U.S. have reported symptoms of anxiety or depressive disorder during the pandemic (weekly average for May: 34.5%; weekly average for June: 36.5%; weekly average for July: 40.1%)[2] (Figure 2). Additionally, a report released by the Centers for Disease Control and Prevention, Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic, found that the public health response to the COVID-19 pandemic should increase intervention and preventions efforts to address associated behavioral health conditions.[3] All of these above studies have amplified the importance of behavioral health in emergency response planning.

Figure 2. Average Share of Adults Reporting Symptoms of Anxiety or Depressive Disorder During the COVID-19 Pandemic, May-July 2020 *Note this is national data.



NOTES: These adults, ages 18+, have symptoms of anxiety or depressive disorder that generally occur more than half the days or nearly every day. Data presented for "symptoms of anxiety or depressive disorder" also includes adults with symptoms of both anxiety and depressive disorder. Data presented for May is the average of the following weeks of data: May 7-12, May 14-19, May 21-26, May 28- June 2; for June, data is the average of June 4-9, June 11-16, June 18-23, and June 25-30; for July, data is the average of July 2-7, July 9-14, and July 16-21 (last week of published data).
SOURCE: U.S. Census Bureau, Household Pulse Survey, 2020.

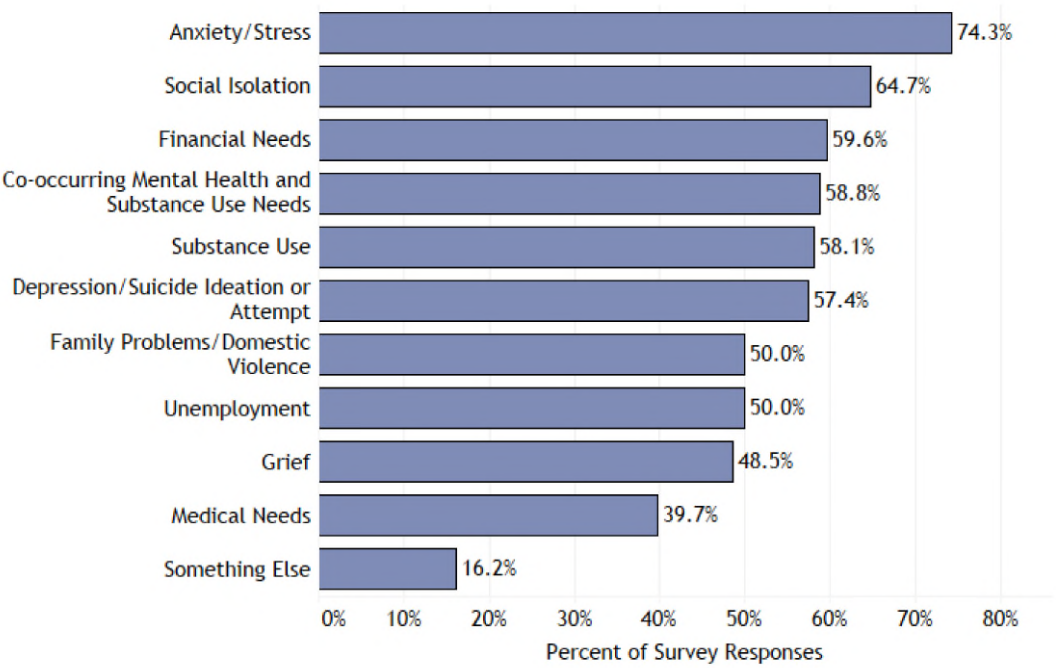
KFF
HENRY J KAISER FAMILY FOUNDATION

Results from a statewide poll completed in August 2020 by The Colorado Health Foundation (CHF) indicated that most Coloradans reported that the COVID-19 pandemic has put a strain on their mental health, contributing to anxiety, loneliness or stress. Coloradans at the lower end of the income spectrum reported more concerns about their mental health. In the CHF survey of 2,275 Coloradans, those reporting financial stressors were most likely to report anxiety, loneliness, or stress (specifically 63% were living on low income, 69% were unemployed and 77% were worried about paying their rent or mortgage). A significant segment of the minority population (80%) who were included in the poll reported that they or a family member were unable to get needed mental health care, and 90% of minorities felt that they needed substance use services, but were unable to get them. Financial considerations were the biggest barrier to accessing services (indicated by 33% of respondents), followed by "Inconvenient/Too distant/Waitlist too long/Didn't know where to go," as indicated by 26% of the respondents.[4]

The Office Behavioral Health (OBH) surveyed behavioral health providers and consumers on how COVID-19 impacted factors related to Coloradans with behavioral health needs. In a survey completed by Coloradans receiving Medicaid (Attachment 1), respondents reported experiencing anxiety and stress "often" at the onset of the pandemic and expressed that depression and anxiety had increased significantly between March and July. Approximately 11% of respondents believed that they used drugs or alcohol "too much" to help them cope with COVID-19. Of those who answered the survey and were caring for children or youth, a majority reported concerns about their children missing major milestones, feeling alone or isolated, experiencing overall mental health challenges, and adapting to new routines.

In a survey completed by behavioral health providers (see Attachment 2), providers shared their observations of behavioral health stressors resulting from COVID-19 in the clients they serve. The most commonly reported stressors were anxiety/stress (74.3%), social isolation (64.7%), and financial needs (59.6%) (Figure 3). Anxiety and stress often stemmed from social isolation and relative lack of contact with clients' usual support systems. Providers reported the prevalence of co-occurring mental health and substance use needs, substance use, and depression/suicidal ideation or suicide attempts.

Figure 3. Client Stressors Due to COVID-19 Crisis as Identified by Providers (Survey Responses)



In addition, specific to telehealth, Colorado's Office of eHealth Innovation and Colorado Health Institute[5] completed research based on clinical documentation by providers in Colorado, and found that behavioral health experienced the highest growth rate in telehealth in comparison to other clinical services and growth in weekly telehealth visits during the pandemic generally decreases as patient age increased. See Attachment 3 for all the findings from the Colorado's Office of eHealth Innovation and Colorado Health Institute's report.

Concerns on Accessing Care During COVID-19

Across the industry, accessing behavioral health care with the sudden changes in how care could be delivered under social distancing protocols was of great concern. Many providers were able to successfully implement tele-behavioral health quickly and offer services to many individuals. While tele-behavioral health helped to mitigate interrupted care for many, it was not a solution for all. This is particularly true for services historically delivered in group settings and dependent on peer social interactions. In addition, geographic location, such as rural and frontier communities, needs to be considered when understanding the utilization of tele-behavioral health services.

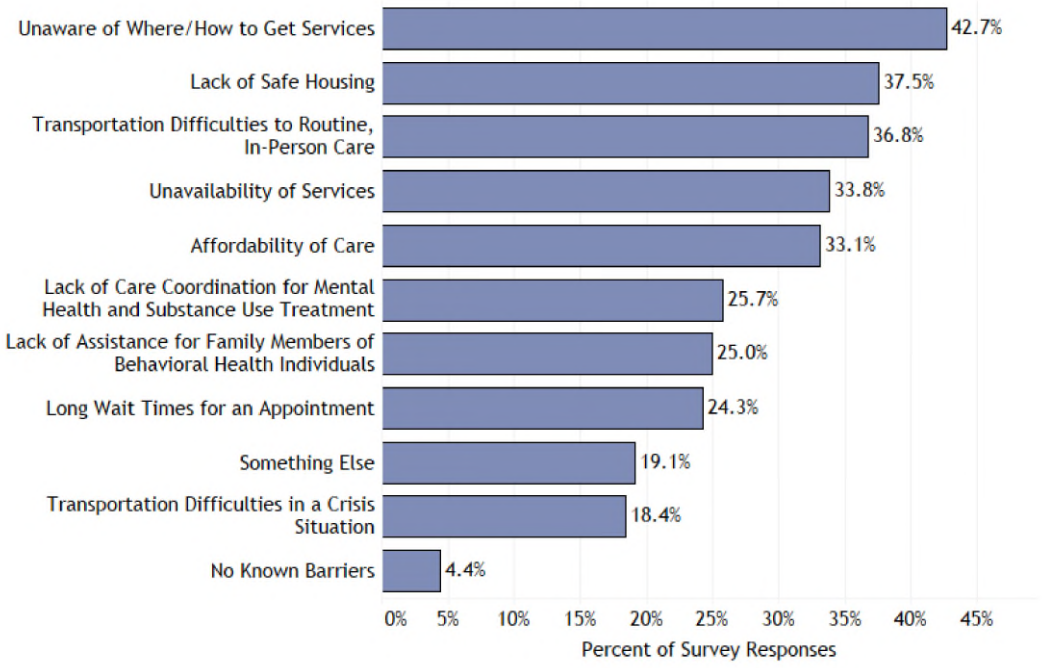
Of the consumers surveyed by OBH, 25% indicated that they had accessed behavioral health services since COVID-19 began (March to August). Treatment was not always available for some individuals; 12% tried to get an appointment after the pandemic began, but were unable. Individuals who sought treatment after the emergence of COVID-19 received care via technology, such as video or telephone (76%) or a combination of technology-based and in-person services (15%). Of those receiving tele-behavioral health care, most believed the care was "good" or "very good" (85%).

Access to care for children was a concern expressed by survey respondents. Over one-third of respondents (35%) were uncertain that children in their home could receive behavioral health care if school was closed. Parents were also concerned about providing for their children. Participants who make less than $30,000 per year were significantly more concerned about being able to meet children's basic needs, such as food or housing, compared to higher-income respondents.

Being able to pay for care was identified as a concern for some survey respondents. Paying for care was harder for one-third of the respondents after COVID-19, but the majority reported no change in their ability to pay.

Providers also identified some concerns for their clients in accessing care (Figure 4). Among the number of concerns listed, they reported many clients were (a) unaware of where or how to get services at the start of the pandemic; (b) lacked safe housing; (c) experienced transportation difficulties to routine, in-person care; (d) found services generally unavailable; and (e) could not afford care.

Figure 4. Client Barriers to Accessing Behavioral Health Services during COVID-19 Crisis as Identified by Providers (Survey Responses)



Associations representing Colorado behavioral health providers reported that providers faced challenges during the pandemic and when responding to other emergencies. For example, bed based care during COVID-19 was significantly reduced in places like withdrawal management and acute treatment units. During COVID-19, providers of these types of treatment modalities had to reduce the bed capacity to accommodate physical distancing standards. With a reduction in bed capacity, there is less revenue generated to ensure these facilities stay viable during such a decline in the amount of care being provided. Also, while the number of people in such 24/7 settings may be reduced, the costs are much higher for providers with additional cleaning protocols (e.g., hazard pay and PPE costs).

What Worked Well

There are initiatives resulting from the pandemic from which Colorado can learn. The identification of these positive learnings contributed to the recommendations of this report as areas to expand upon. Specifically, of the 375 Coloradans surveyed by OBH, 36% reported reduced travel to receive care and 10% reported reduced wait times for scheduling appointments. Some people felt that it was easier to share information with their provider (12%) and believed their care was "better" (11%) using technology.

The success of tele-behavioral health was highlighted by both providers and consumers as an area for continued investment. Specifically, community forum participants stressed the need to continue offering technology-based care "after things returned to normal." However, the Committee did highlight that tele-behavioral health should not be a perpetual substitute for in-person care when clinically appropriate or preferred by the consumer. Tele-behavioral health provides an additional access point for people who are seeking behavioral health services, and it is one tool in the toolbox for providers to assist clients that need access to a continuum of services that are not locally available. However, Coloradans should have the choice to utilize tele-behavioral health and in-person services. While tele-behavioral health was clearly an area that demonstrated success during the pandemic, providers also reported positive experiences in regard to the reduced state and federal regulations on restrictions related to tele-behavioral health service delivery and payment.

The ability of virtual technology to alleviate some social isolation and promote positive mental wellness is another potential area to enhance in the future. Seventy-one percent of consumers surveyed said that they have joined a virtual get-together and believed that it could be a good way to feel less lonely. This finding supports a need for the promotion of social gatherings by professional and community organizations. Over half (53%) of consumers expressed interest in virtual get-togethers sponsored by community organizations.

Additionally, behavioral health stakeholders worked to ensure the needs of Coloradans were met as best as possible in this new environment. At hospitals, behavioral health care workers were brought into the conversation almost from day one, which has not been the case in previous crises. As another example, mental health centers developed creative ways to reach the community, such as offering Facebook live sessions on managing stress, reviewing how to practice meditation, and sharing other resources for the general public. Providers for substance use disorders quickly transitioned to virtual services very quickly to continue client meetings and recovery meetings. State agencies offered unprecedented flexibility, such as allowing workarounds for signatures for consent to treat so that people could get the care they need. The Department of Corrections worked side by side with prison operations and other clinical service providers to adapt how treatment was delivered so that those efforts did not stop. COVID-19 required stakeholders to be innovative, and Coloradans were able to access services under extraordinary circumstances.

Considerations and Recommendations

Tele-Behavioral Health

Many Coloradans are in need of behavioral health services now. As a result of the COVID-19 pandemic, providers in Colorado quickly transitioned to tele-behavioral health so that they could continue to support people in need. When used within comprehensive care plans, tele-behavioral health has the potential to reduce no-shows and cancellations. Although tele-behavioral health has existed in small pockets in Colorado for years, new flexibilities have allowed for increased access for both clinicians and clients who may not have used it before. Colorado's Office of eHealth Innovation reports tele-behavioral health was rarely used prior to the pandemic compared to during the pandemic; Colorado has seen a 700%-500% increase in treatment of anxiety, depression, and substance use via telehealth/telemedicine.

The Committee defined tele-behavioral health as remote treament, via telephone or video conferencing.

Though telehealth provides an additional access point for people who are seeking behavioral health services, it is one tool for providers to assist clients that need access to a continuum of services. Tele-behavioral health can be an important solution to augment resource-dry communities that lack certain types of local services, including specialists and those who serve people with unique needs (e.g., those with limited or no English proficiency, those seeking LGBTQ-affirming care, or those with a preferred language, including sign language). Consumers should have the choice to utilize tele-behavioral health and in-person services.

The reality is that the most vulnerable populations are often hit the hardest during a crisis. Thus, these populations who are at heightened risk for lapses in care or have other disadvantages must be identified to ensure they have access to tele-behavioral health. In addition, Coloradans living in rural areas of Colorado that do not have broadband or lack internet service were at a unique disadvantage to being able to participate in remote service opportunities provided during the pandemic. Many people in these communities did not have the resources to obtain the necessary technology needed to engage in virtual/video tele-behavioral health.

There are limitations to tele-behavioral health. Some clinicians found it difficult to read body language and non-verbal cues from clients, making it easier to potentially hide or mask issues, and more difficult for clinicians to perform assessments. From the 197 respondents surveyed that represented 161 unique behavioral health organizations, the lack of broadband/internet availability was a substantial barrier for rural areas and lower-income households. For older adults who lacked internet/computer knowledge, it created difficulty accessing services.

The expanded use of tele-behavioral health was largely possible due to waivers issued by state and federal agencies. Governor Polis issued an executive order that made a temporary suspension of certain statutes to expand the use of telehealth services due to the presence of COVID-19, including waiving professional licensing limitations and Health Insurance Portability and Accountability Act (HIPAA) technology restrictions. In addition, the state Medicaid agency (HCPF) allowed for flexibility in payments for telehealth services, including the use of telephone only and live chat modalities. In addition the Office of Broadband and the Colorado Department of Local Affairs developed strategy, goals, and approaches for expanding broadband.

Several federal agencies waived regulations, including HIPAA regulations, that created a barrier to accessing care through tele-behavioral health. These agencies also allowed for the sharing of health information between providers without the need for consent to be written. In addition, CMS expanded Medicare telehealth benefits with temporary flexibilities regarding additional telehealth services in rural areas. These changes are proposed to extend permanently through federal Executive Order 13941. Without these critical changes to state and federal policy and regulations, the transition to tele-behavioral health would not have been possible.

RECOMMENDATION 1

Expand/Increase Tele-Behavioral Health Services, including:

A **Complete a comprehensive analysis for expanding tele-behavioral health,** including:

- Review research studies and literature reviews, incorporating current efforts, to determine the quality and effectiveness of tele-behavioral health services (in areas reflective of the Colorado landscape) as an element of the behavioral health service array.
- Continue to study best practices to incorporate tele-behavioral health into the treatment continuum, and develop best practice guidelines on how to coordinate in-person and virtual care.
- Conduct additional analysis to identify outcomes and understand the effectiveness of tele-behavioral health when used with specific populations.
- Engage clients, caretakers, and families who are using tele-behavioral health for their input on how to improve and strengthen tele-behavioral health services.
- Determine how many people have access to tele-behavioral health services (i.e., understand broadband access, access to technology, etc.). Determine how many providers are willing/able to provide tele-behavioral health services to understand the level of services available.
- Quantify cost savings from the payer, provider and patient perspective. Determine any increased cost to payers, if any.

B **Promote tele-behavioral health via training and public awareness,** including:

- Support providers who offer tele-behavioral health in developing campaigns and protocols to raise awareness of the resources.
- Make available accessible and attainable training for best practices in tele- behavioral healthcare delivery that includes how to transition to HIPAA compliant platforms.
- Promote best practice guidelines to help clinicians decide when telephone or video-conferencing methodologies are best in meeting unique client needs.
- Promote the Health at Home website (Healthathome.colorado.gov) and ensure it includes information about how to access behavioral health services.

C **Promote consumer-centric values for tele-behavioral health,** including:

- Ensure tele-behavioral health solutions have a relationship with providers and services that offer in-person and other levels of care to help augment and enhance the needs of the individual client.
- Ensure consumers have access to outpatient on-site care to ensure that clients truly have the option to visit in person, and don't feel restricted to only virtual options.

D **Review opportunities to permanently enact regulations and administrative flexibilities** put into place as a result of COVID-19 that promote the expansion of tele-behavioral health, including:

- Review SB20-212 (i.e., Reimbursement for Telehealth Services) and other legislation; executive orders; public health orders; and state agency rulemaking and administrative changes. Identify areas not addressed and, where needed, conduct a full review to determine which regulations should be made permanent, modified or repealed

E **Continue to strengthen the State's broadband infrastructure** (including internet, cell, satellite, and telephone coverage) for all of Colorado, including rural communities where internet connectivity and broadband are or can be a challenge. A state broadband strategy needs to reach all who need it for mental health and/or substance use disorder treatment and recovery services, with special considerations for vulnerable populations. As such, the State should explore and implement new innovations that support tele-behavioral health solutions without needing broadband or immediate cellular connection.

F **Ensure adequate, flexible resources are available to providers** who proactively conduct outreach to, and work with, the most vulnerable populations. The behavioral health system needs to be able to address disparities in access to care, in order to provide connectivity to individuals in need who otherwise do not have the technology and/or support necessary to engage in tele-behavioral health service. This may include providing technological hardware to clients, developing drop-in tele-behavioral health sites, or any other locally-designed and clinically-informed solutions.

G **Create a proactive outreach plan to identify and reach the most vulnerable populations** prior to and when a crisis arises. Work with the populations to determine how to ensure these populations have access to tele-behavioral health, and how best to operationalize the plan.

Mental Health and Substance Use Disorder Services

During the pandemic, physical distancing significantly altered the manner in which services are provided. In addition to changes to outpatient services being delivered via tele-behavioral health, other examples include modifications to admissions and discharge protocols for inpatient care, as well as to the delivery of medication-assisted treatments for individuals receiving substance use disorder services.

During the onset of the pandemic and "Stay at Home" order, it was not entirely clear which behavioral health services were considered critical under Executive Order D 2020 017, which instructed all businesses to close temporarily other than those qualified as a "Critical Business" under Public Health Order 20-24. The State had to act quickly to explicitly provide guidance on which critical services needed to continue, which included:

- Colorado Crisis Services, including the statewide hotline, walk-in centers, crisis stabilization units and mobile crisis services
- Withdrawal management programs
- Residential programs and services provided in facilities (jails, Youth Services etc.)
- Opioid treatment programs
- Medication-assisted treatment
- Outpatient services should be maintained if at all possible, including use of telehealth

Even with this communication, providers had difficulty being recognized as a critical business and struggled to acquire personal protective equipment (PPE) as suppliers rejected protective and other COVID-19-related equipment orders. This required OBH to issue an ad-hoc letter reiterating that, "behavioral health is an essential service." To best prepare and respond to future pandemics and disasters, it is important that behavioral health is not an afterthought, especially when it comes to needing psychiatric or substance use treatment beds for people with behavioral health conditions.

RECOMMENDATION 2

Behavioral Health Providers should be recognized as essential health care providers.

As a critical business, providers had to evaluate their capacity for any potential increase in demand. One of the pressing questions during the pandemic was in regard to the availability of services. Some providers had to limit their capacity despite an influx of individuals looking to access services, even if medical hospitals and emergency departments became overwhelmed with COVID-19 positive patients. This highlights a need to have a plan for the current pandemic and future state of emergencies that includes a protocol for massive diversion of behavioral health patients from emergency rooms and an ability to track capacity among behavioral health providers for key services.

RECOMMENDATION 3

Ensure the Capacity Tracking System, which is scheduled to launch in January 2021, is adequately resourced to function successfully and address any enhancements.

A Capacity Tracking System helps a hospital or provider understand how patients advance through the system, from admission to discharge. It offers real-time visibility so that staff have immediate knowledge of available beds and/or providers with capacity. In a situation such as COVID-19, where hospitals were expected to be overwhelmed and people were still in need of behavioral health care, a Capacity Tracking System is beneficial in understanding where to send people. Such a system could include key indicators such as the availability of psychiatric inpatient beds; units accepting infectious or symptomatic patients; psychiatric emergency room services; crisis services (including mobile crisis' ability to conduct community evaluations; availability of timely referrals; ability to handle the volume of calls/wait times; volume-to-staffing ratio; changes in where volumes are increasing); and outpatient services for mental health and substance use disorders (including capacity to do intakes, levels and types of care available); and staffing of services. This data is integral in knowing where services are available for new clients. The capacity tracking system will need to share a limited amount of information with the public, so that they are aware of what services are available and the outcomes of the existing services. The capacity tracking system will benefit both individuals needing inpatient services, and those being discharged from a hospital who need to find available services in the community. The System is currently scheduled to launch in January 2021. Once it is in place, it should be continually reassessed to ensure manual, daily entry of provider information is not be mandatory until the system is enhanced in a way that (1) minimizes administrative burden, (2) maximizes usability for both providers and the public (e.g. transitions from lists of providers to data visualization tools), and (3) undergoes stakeholder review and testing to minimize inaccuracies. Adding these additional requirements is a cost driver for providers.

OUTPATIENT SERVICES

Outpatient behavioral health services are those that do not require a prolonged stay in a facility. When there is not an ongoing crisis, these services could include counseling, group therapy, medical consultations, and psychiatry. Many of these services may be delivered via tele-behavioral health. Outpatient services also include crisis services (e.g., mobile response and walk-in-centers), which are available both during non-emergent and emergent times. These services along with other crisis response services can play an integral role in addressing the immediate and acute behavioral needs of Coloradans.

RECOMMENDATION 4

Expand services offered by the Colorado Crisis System. This includes considering the addition of services and scope to crisis services during a state of emergency to allow for:

- follow-up post-hospitalization;
- increased warm line staffing;
- increased peer services;
- care navigation;
- expansion of safe-to-wait services (STW) and use of qualified volunteers;
- divert calls to community providers/ partners;
- expansion of warm hand off; and,
- expansion of ongoing services provided by the Colorado Crisis Services to bridge care (up to 90 days) for delayed access to outpatient care.

This increased reliance on the crisis services system during a state of emergency/disaster illustrates the need to have an adequate plan to successfully increase capacity for the hotline to handle more calls and potential expansion of other crisis services in future emergencies. An expansion will require that the current service capabilities are defined and future state requirements for expanded crisis services are determined. That includes using data to determine if an expansion of the crisis system is truly needed or if existing services can manage demand. If the services offered by the crisis system change during a future crisis, this needs to be clearly communicated. For response services, in addition to crisis mobile services, there is an opportunity to replicate/scale existing programs instead of creating new programs (e.g., Support Team Assisted Response (STAR) program at Mental Health Center of Denver).

RESIDENTIAL, INPATIENT AND INTENSIVE TREATMENT SERVICES

People in need of inpatient and intensive treatment typically are those who are experiencing thoughts that make them dangerous to themselves or others. The group of individuals receiving these services are in need of intensive treatment and likely need additional support to manage the stressors of the current pandemic or other disasters. Per the aforementioned recommendation, the ability to track behavioral health bed availability is going to be key in future state emergencies, particularly if the medical systems become overwhelmed.

The State needs to fully integrate its behavioral health response with more details in Colorado's larger emergency response plan.[6] The plan needs to provide updated options and solutions for treating individuals who need an inpatient level of behavioral health care in the scenario in which the existing bed capacity is not available in regions of the entire state.

There are several regulatory functions that guide a facility's ability to serve clients. If those regulations are modified to be more flexible in Colorado's disaster/emergency response protocols, it could offset any delays in people accessing care.

RECOMMENDATION 5

Ease specific regulations and oversight standards to increase capacity during an emergency, including:

- Permit emergency credentialing at facilities where the licensed professional is not credentialed.
- The State to petition the easing of Joint Commission/CMS standards to allow repurposing of facility space not historically used for behavioral health.

The more easing of regulations and flexibility in the diversity of services a facility can offer, the better it may help to mitigate limited capacity experienced by other providers. Flexibility in permitting facilities to treat for both substance use disorder and mental health is important in meeting the needs of Coloradans with complex needs. Specific to facility-based substance use treatment, the State should ensure clients accessing bed-based services are able to be transferred to facilities to continue their SUD treatment in the event they are COVID-positive (or any infectious-disease-positive). This could be with a facility approved to provide medically monitored high-intensity inpatient substance use services (an American Society of Addiction Medicine 3.7 facility), assuming clients can be isolated, and the staff can be protected. As another example, it could also be with an Institution for Mental Disease[7] (IMD), with ongoing treatment services offered via tele-video by a SUD treatment provider.

RECOMMENDATION 6

Ensure clients accessing bed-based services are able to be transferred to facilities to continue their SUD treatment even when they are COVID-19 positive.

The easing of any regulation needs to ensure it does increase any safety risks for clients, such as ensuring suicide mitigation protocols are sufficient to address the risk for suicidality among clients. In addition, services still need to comply with the Americans with Disabilities Act (ADA), and providers need to ensure patients with disabilities get the required help with the provision of medical or behavioral health care, activities of daily living, speaking for the patient or keeping the patient safe, even during times when a health care facility may need to move to limited-visitor or zero-visitor policies. Patient and client safety have to continue to be the paramount consideration in any practice changes.

RECOMMENDATION 7

The safety and well-being of patients/clients should not be compromised to respond to a pandemic, disaster, or State emergency. This includes:

- Risk assessments should consider the risk of admitting (access, whole-person care, accountability) and not admitting a patient based on the care setting to safely treat them.
- Implement infrastructure and practices that prevent the use of seclusion as a physical distancing practice, given the negative health impacts of seclusion on patients and particularly those with behavioral health conditions.
- To comply with ADA and to ensure the best care possible, providers should have and be reimbursed for a designated assistance person to meet an individual's needs, including during times when a health care facility has limited-visitor or zero-visitor policies. For behavioral health services and supports beyond ADA requirements, facilities should explore other methods of support (e.g. virtual options), while balancing the constraints that led to visitation policy changes.

Any adaptations of regulations or practice that are in response to a State emergency cannot be complacent and should use continuous quality improvement to maintain safety.

RECOMMENDATION 8

The State Emergency Operations Plan should include continuous quality improvement, including:

- Identifying "lessons learned" from discharging patients with barriers to safe discharge.
- Using "lessons learned" to help determine when to expand bed capacity (e.g., convention center) versus when to convert existing facilities into different "beds" (e.g., Freestanding Emergency Departments (FSEDs), Ambulatory Surgical Centers (ASC), other residential providers).

Equally important to increasing bed capacity is (1) increasing intensive services to divert individuals away from an inpatient setting; or (2) increasing the number of discharges from a facility in an effort to free up beds. Preemptively being prepared to reduce the reliance on inpatient services during a surge or diminished capacity will be critical in mitigating collateral consequences. This includes providing post discharge supports to make the transition out of inpatient care successful or increase intensive in-home respite care.

RECOMMENDATION 9

During a state of emergency that burdens the inpatient bed capacity, preemptive efforts should be made to reduce the reliance on inpatient beds, including:

- Leveraging technology to increase post discharge support for patients (support groups, care coordination, Health-at-Home apps, etc.)
- Increasing community respite services and high intensity behavioral health community based treatment for children and adults.

Specifically, under COVID-19, the committee recognizes that the physical health of the provider and staff is equally important to that of patients/clients. Staff need the proper equipment to keep patients/clients well during their care. Mental health and SUD providers are medical providers who need the same access to protective equipment and cleaning services as traditional physical health settings.

RECOMMENDATION 10

Protocols and proper equipment are needed for staff working in substance use and mental health settings, including 24/7 residential and hospital facilities, including:

- Ensure the PPE resources available for medical providers are also available for providers and staff of mental health and substance use treatment facilities.
- Consider the health risks when conducting a welfare check. Ensure that the person doing the welfare check has the protection to be healthy.

TREATMENT OF SUBSTANCE USE DISORDER (SUD)

During a crisis, the treatment of SUD must adapt to a model that supports the person in need, while maintaining the safety of the provider. A number of SUD treatment modalities are reliant on social interaction (e.g., peer services, support groups) and access to medication distribution (e.g., naltrexone, buprenorphine, methadone). This makes them susceptible to significant disruptions of care quality when there are any limitations put on service delivery.

RECOMMENDATION 11

Ensure all treatment modalities are available to those seeking SUD treatment, via telehealth or other forms. This includes establishing different forums for social support groups to help individuals maintain recovery and other interventions that are group-based.

Gaps in intervention can have unfortunate consequences for individuals dependent on services to achieve or maintain their sobriety. In addition, SUD treatments that have a medical component need to continue providing services during a pandemic or State emergency. Ensuring clients' access to Medication Assisted Treatment (MAT) in a time of crisis like the COVID-19 pandemic is critical; ensuring they still are receiving counseling/therapy is also important.

RECOMMENDATION 12

Colorado should take steps to ensure that MAT services are not interrupted during a pandemic or State emergency. This includes creating multidisciplinary rapid response teams ready to deploy and support low staffing of SUD MAT and residential treatment programs throughout the State (this needs feasibility planning, with regional considerations).

OTHER SERVICES

Access to services is not limited to the availability of providers. During the current pandemic, disruptions occurred in other support areas that are critical for individuals accessing their care. Specifically, the interruption to public transportation or private transportation services hinders an ability of a person to access in-person care. Transportation was a barrier for specific populations, such as low-income or rural communities, prior to the start of the pandemic. During the pandemic, transportation barriers substantially increased as buses, Uber, and other ride-share programs essentially stopped, leading to difficulties in accessing services for those without reliable, personal transportation. There needs to be careful consideration given by the State to mitigate barriers to accessing care as it relates to emergent and non-emergent transportation during both the pandemic and non-pandemic times.

RECOMMENDATION 13

The State should address requirements that create barriers for greater access to transportation services.

CULTURALLY-INFORMED CARE

Providers should demonstrate proficiency in delivering culturally-informed care and have an understanding of the CLAS standards (Culturally and Linguistically Appropriate Services). Providing culturally-informed care is fundamental to the provision of quality patient care under any circumstances, particularly during a crisis. The National CLAS Standards were first developed by the HHS Office of Minority Health in 2000, and are intended to advance health equity, improve quality, and help eliminate health care disparities. The Standards establish a blueprint for health and health care organizations to implement and provide culturally and linguistically appropriate services.[8] Behavioral health providers and/or administrators that ignore and/or do not understand the CLAS standards are prone to perpetuate disparities in health care. This includes linguistic access as it relates to the use of sign language for individuals who are deaf or hard of hearing.

Vulnerable and Underserved Populations

The behavioral health impacts of COVID-19 on vulnerable and underserved populations, such as children and youth, older adults and rural Coloradans, can be complex and profound. The first step is to identify those populations who may be in need of services but unable to access them. For instance, once social distancing protocols limited in-person access, it was difficult for individuals experiencing homelessness to access care. Almost all providers had transitioned to telehealth, and many people experiencing homelessness do not have regular access to a phone or computer. Special consideration should be given to addressing the impact of a pandemic or state of emergency on vulnerable populations.

Children and Youth

Children who have previously experienced trauma, economic disparities, separation, loss, anxiety, and depression are at an increased risk for increased behavioral health symptoms according to recent research.[9, 10] Specific to children, the Committee recommends increasing behavioral health screenings, identifying children in foster care who need behavioral health services, and providing funding flexibility where available. (See Attachment 4 for the full list of recommendations from the Children's Behavioral Health Subcommittee.) It is important to note that proactive outreach to children and youth, such as youth and teen mental health first aid, can play a significant role in developing protective coping skills which is important when dealing with a crisis.

BEHAVIORAL HEALTH SCREENING

During a pandemic, children and youth are often isolated and have a reduction of interactions with helping professionals. When those interactions stop, there must be other avenues by which children and youth in need can be identified. In addition, with less professionals engaged in a child's life and a lack of school time, there grows a concern the incidence of identification of behavioral health needs decreases. There needs to be a public health strategy to educate children, youth and families on the social/emotional implications that children are experiencing as a result of COVID-19 (e.g., fear of contracting the disease; advising parents not to go to the playground; avoiding contact with other kids; wearing a mask; and avoiding doctor offices and hospitals) as this could affect their development. The strategy should provide information to parents/guardians/caregivers on how to speak to their children or provide information to youth about the pandemic and how to help them identify a youth that needs help (e.g., what you should look for and what to do if you are concerned). Consider youth both as an audience and a mechanism to spread valuable public health information.

RECOMMENDATION 14

The state agency responsible for public health should coordinate with child-serving agencies and educational institutions to prepare a public education strategy to respond to the social/emotional implications that children are experiencing as a result of COVID-19.

As a result of increased isolation and the risk of increased behavioral health symptoms, widespread screening should occur in settings such as childcare, primary care, educational settings, the home, and other non-traditional venues where children might be. The ability to identify children and youth in need becomes increasingly important for children who lost a parent, family member, or loved one to Covid-19 or were hospitalized themselves for COVID-19. Children and youth's grief and long-term behavioral impact from the pandemic have to be addressed. This includes coordination by all agencies and professionals responsible for ensuring services are provided to the children and youth in need.

RECOMMENDATION 15

Develop new strategies and processes to identify and screen children and youth for their behavioral health needs.

RECOMMENDATION 16

Ensure evidence-based preventative measures that decrease suicide and other behavioral health concerns are adequately resourced in schools.

RECOMMENDATION 17

Ensure there is a strong balance of local and state alignment to have consistent and centralized access to information and coordinate available services between these agencies and educational institutions (i.e., "no wrong door" approach).

CHILDREN IN FOSTER CARE

Children in foster care are more likely to have experienced trauma related to abuse and neglect, distrust of adults, and the removal from peers or schools. Foster youth bring histories that are complicated by prior trauma, as well as potential fracturing of parental, family and sibling relationships related to out-of-home placement, termination of parental rights or post-termination adoption of siblings. In the current pandemic, many youth also experienced an interruption of regular visitations with parents, siblings and other important family members. In all of these circumstances, bereavement may become more complex and require specific interventions to assure children and youth can process and deal with the unexpected death of a sibling, family member or parent. This makes them more vulnerable in a pandemic such as COVID-19.

Without proper identification and support of behavioral health conditions (e.g., psychotherapy, psychiatry, family meetings, outings, support groups, and respite care), child or youth symptoms can escalate, and caregivers can experience burnout. As a result, identifying these children and youth and caregivers at the onset of a crisis and implementing flexible services and supports are necessary. Supportive services should both recognize the unique behavioral health needs of this population and provide targeted assistance for foster families. Preventative or timely caregiver training, telehealth, consistent family meetings, and safe activities are needed to reduce anxiety, depression, isolation, caregiver burnout, and other harmful repercussions.

RECOMMENDATION 18

The State, in conjunction with counties, should ensure that foster children and youth have the behavioral health services they need to successfully navigate the pandemic, specifically:

- Develop a process to identify children and youth in foster care who are receiving mental health therapy or substance use disorder treatment to allow for easy identification for mobile crisis and prioritization of other supportive services.
- Consider developing a protocol that defines youth in foster care as a specific subpopulation of children/youth in need of particular supportive services when dealing with the loss of a parent, family member or sibling.
- Develop virtual foster youth support forums to help mitigate isolation for foster youth.
- Develop a process to identify those youth who will "age out" of the foster care system during times of public health emergencies to assure adequate linkage to adult mental health, SUD, housing and other supportive services when a change of provider is required. Particular attention should be given to navigation and mentoring supports to help these young adults navigate the system and also to decrease isolation.

FUNDING FOR CHILDREN AND YOUTH SERVICES

The initial and prolonged changes that occur during a pandemic can cause sudden and unforeseen consequences for families. This can include but is not limited to economic hardship, family strife, domestic violence, substance misuse, and mental health degradation for one or more members of the family. Families who are commercially insured, under-insured, or non-insured often express in surveys that they go without services because of affordability. There is a need for funders of direct and support services to adopt flexible funding strategies that ensure all individuals and families can access all levels of behavioral health services regardless of their ability to pay. This should also include basic needs such as food and shelter, childcare, respite, crisis interventions, communication, and other necessities.

RECOMMENDATION 19

As it relates to a pandemic or State emergency, funding agencies of direct and support services for families should adopt flexible funding strategies that ensure all families can access all levels of whole person care and behavioral health services.

Given the existing limited number of providers who can provide child and adolescent specific behavioral health care that meets their level of need, it is important that in the current economic environment hindered by the pandemic.

RECOMMENDATION 20

For children's services, the State should assess which crucial community provider organizations are in jeopardy of closing or laying off their workforce or closing their program altogether. Efforts should be made to connect these providers with known resources, federal/state funding, and/or pandemic business loans.

Older Adults

In addition to children and youth, the behavioral health impacts of a pandemic like COVID-19 on older adults can be significant. Because older adults were identified as higher risk for contracting and dying from the virus, proactive measures such as reducing visitors and encouraging social distancing were established to protect these individuals. However, these practices can also lead to social isolation, difficulty engaging in services, and worsened behavioral health symptoms for older adults.

ACCESS TO TECHNOLOGY-BASED SERVICES

During COVID-19, when providers increased their usage of technology-based services, older adults were less able to engage in such services compared to younger populations. Older adults were more likely to have limited access to devices or often experienced difficulty utilizing technology-based services due to lack of skill related to the technological platforms.

Without access to technology-based services, older adults may lack accessible services which might result in the escalation of behavioral health symptoms. Thus, the tele-behavioral health recommendation [Recommendation 1(g)] to create a proactive outreach plan to identify and reach the most vulnerable populations should give consideration to this population.

SOCIAL ISOLATION

As older adults are a vulnerable population for contraction and severe consequences from COVID-19, many of them have experienced increases in social isolation as a result of staying home to reduce contact with others. As a result, many older adults may feel isolated from others and lack access to social engagement. This is exacerbated by the aforementioned difficulties with engagement in technology-based services, as it may be more difficult for older adults to participate in virtual social activities.

Furthermore, due to social distancing guidelines and attempts to keep older adults safe from contracting COVID-19, older adults may experience less support such as reduced contact with caregivers or home-based service providers. Professionals and others should be vigilant in checking in with older adults and probe for behavioral health concerns related to isolation.

In summary, the needs of vulnerable and underserved populations should be a priority in a future crisis. Once the most vulnerable populations are identified, determining how best to support them -- to meet them where they are -- is critical. Furthermore, given the limited data available to assess the disparities that exist in accessing behavioral health care during the pandemic, it is safe to assume that the inequities that existed prior to a pandemic, disaster, or State emergency, exist or are exacerbated during such an event.

RECOMMENDATION 21

Assess and rectify inequitable access for all Coloradans within children, youth and adult behavioral health services during the current pandemic and in future State emergency responses. This includes those factors resulting from structural/institutional racism.

Emergency/Disaster Behavioral Health Response

Colorado must maintain, and enhance, a coordinated behavioral health emergency disaster response and ensure the permanency of robust resources for preparedness. During the COVID-19 pandemic response, some disaster behavioral health response protocols were clearly established as a result of previous state of emergencies and disasters, such as forest fires and floods. However, there were a large number of protocols that were not as clear and required problem solving in the moment. There needs to be a "playbook" of crisis/emergency best practices that should be created and accessible to providers in a centralized location who may activate or have activated crisis standards of care. During a crisis, situations evolve quickly, and a decision tree (as well as the process of creating one) would help providers understand the range of situations that have currently occurred and what could/should be done next. Creating policy decisions now will reduce the confusion and stress during future emergencies.

Communication in an Emergency

During a time of crisis/state of emergency, it is critical for all state agencies to communicate and educate providers on new and evolving policies. While Colorado was quick to distribute relevant updates, the process of communicating information was a learn-as-you-go model. The Provider Survey indicated that the best way to communicate with their clients was to ensure that providers deliver updated information about their services through their website, email communications, and other forms of direct contact with clients.

Many state agencies were quick to establish centralized communication websites for the latest information on COVID-19. CDPHE understood that behavioral health communication was, and is, essential. In particular, under the integration of behavioral health in the joint information center, several web pages, guidance and other communication products were developed, including but not limited to:

- Promotion of the Colorado Crisis Services phone line across the State COVID-19 webpage
- Promotion of the Crisis Counseling Program
- Promotion of behavioral health coping materials
- Guidelines for behavioral health leaders

CDPHE's Emergency Response Protocol

The Colorado Department of Public Health and Environment (CDPHE) is charged with addressing the behavioral health components of the State's emergency preparedness, response, and recovery activities (see Attachment 5). Behavioral health is a critical component of any adequate emergency response plan, and preparedness efforts are enhanced by the inclusion of all behavioral health partners. For comprehensive response to be adequate, behavioral health must be included in the public health mission of addressing population needs, especially following a community crisis. For community behavioral health organizations to be successful contributors in responding during and after a crisis, they must be adequately valued and reimbursed for the role they have in supporting community resilience.

RECOMMENDATION 22

Formalize the role of community behavioral health organizations with the capacity and capability to actively participate in CDPHE's emergency preparedness, response, and recovery activities. This includes:

- Supporting behavioral health disaster response teams as a core service within the provider mission, with funding to allow for:
  - Sustainability through funding.
  - The creation of adequate reimbursement methods within state agencies for community resilience activities and community emergency response activities, which are not tied to individual services.

STATE AGENCIES IN COVID-19 RESPONSE

During the COVID-19 pandemic response, at a minimum, five different state agencies were involved in issuing guidance and updates. These agencies (CDPHE, DORA, HCPF, CDE and CDHS-OBH) had separate mechanisms for communicating with providers. Furthermore, multiple state agencies were independently attempting to secure federal funds without completely strategically aligning efforts. The creation of this Committee did result in an increased coordination across state agencies that proved to be beneficial. If there is a creation of a Behavioral Health Administration in Colorado, as suggested by the Behavioral Health Task Force, that agency may want to review with the aforementioned state agencies' opportunities to better coordinate and align behavioral health efforts.

RECOMMENDATION 23

The State should review the roles of the various state agencies involved in the pandemic response as it impacts behavioral health service delivery and coordinate and align state agencies for emergency responses in meeting the behavioral health needs of individuals and communities.

Funding and Regulation Flexibility

Funding and regulation flexibility for providers is critical during a state of emergency. During the COVID-19 pandemic, providers highlighted the critical benefit that funding and regulation flexibility had in their ability to provide behavioral health care in a rapidly changing environment.

Associations representing Colorado's behavioral health providers reported that when strictly funded in a fee-for-service environment and billable encounters are down, or when 24/7 facilities have to reduce the number of clients served, the cost to run those programs does not also decline. They reported that without adequate base funding for the behavioral health safety net there may not be enough elasticity in the system to have the ability to stay viable and supportive to the clients and community throughout the length of a crisis. In addition, there was concern that the pandemic has stretched already thin resources and without the necessary funding to support the system during such client fluctuating participation in services.

Several state agencies provided funding flexibility for providers. OBH issued Emergency Funding Flexibility guidelines that allowed providers to continue to deliver direct services. Providers were permitted to acquire supplies and tools that were not anticipated at the time of contract budgeting, such as PPE, additional cleaning supplies, and technology/devices for telehealth. In addition, the State Medicaid agency (HCPF) secured state and federal flexibility that focused on eligibility (coverage and processes), provider enrollment, telemedicine, and long-term care services administration and supports. Specific to telemedicine flexibility, in March 2020, HCPF passed emergency rules that allowed a wider array of providers to bill on a fee-for-services (FFS) basis and added new modes including telephone and live chat. (SB 20-212 made these emergency provisions permanent). These telemedicine provisions allowed Medicaid community mental health centers and pediatric behavioral health providers to bill their in-person rates for FFS benefits. Regional Accountable Entities followed suit and liberalized their existing telemedicine policies.

Additionally, Governor Polis ordered the temporary suspension of certain statues to expand the use of telehealth services. The order directs the Colorado Department of Regulatory Agencies' (DORA) Division of Insurance (DOI) to issue emergency rules requiring health insurance carriers regulated by the State to permit providers to deliver clinically appropriate, medically necessary covered services using telehealth services. In early April, DORA released Emergency Regulation 20-E-05 addressing the reimbursement of telehealth services using non-public facing audio or video communication products during the COVID-19 nationwide public health emergency.

The flexibility of funding guidelines and the adjustment of rules and regulations ensured that Coloradans in need of services were able to access them in a timelier manner. In preparing for the next statewide emergency, these steps should be considered and incorporated into plans to enable a more agile response. Maintaining funding flexibility when possible affords providers and the persons receiving care the ability to determine the best mode of treatment.

RECOMMENDATION 24

Maintain flexible policies to provide services by telephone and videoconferencing.

When considering funding flexibility, reimbursements should take into account that facilities provide significant support to providers working remotely. Additionally, the following should accompany reimbursement considerations for tele-behavioral health:

- Provide further clarification on specific funding waivers and exceptions.
- Provide clarification on where/what/how to be flexible in a pandemic or crisis and state that explicitly
- Create a list of services that could be turned "on" (approved) in a pandemic/crisis.

There may also be options for the state to petition waivers from the federal government on funding regulations. During the COVID-19 pandemic, several federal agencies, including that for Medicare and Medicaid, issued regulatory waivers to ease the access to care and reimburse providers for tele-behavioral health services. There may be an opportunity during a future crisis, to quickly expand the workforce if additional federal regulations were waived.

RECOMMENDATION 25

Explore with the federal Medicaid agency on expanding the pool of Medicaid providers by allowing non-contracted Medicaid providers to provide services to Medicaid recipients quickly.

Funding flexibility alone will not ensure that there is an adequate amount of services available for those in need. Budget cuts for behavioral health direct care services result in less resources available during the current and future State emergencies. Minimizing these cuts increases the ability of the State to respond with a sufficient level of behavioral health services to mitigate the impact of pandemics and disasters.

A Healthy Behavioral Health Workforce

The provision of quality behavioral health care is inextricably linked to the health of the workforce. The onset of COVID-19 necessitated rapid change in organizational operations, resulting in significant impacts on behavioral health care workers. Almost immediately, providers were required to alter their approach to delivering care, frequently through the use of technological solutions or, sometimes, cutting back or eliminating services entirely. To complicate matters, changes in care delivery coincided with an increased need for services. Feedback from providers stated that employees engaged in direct client care voiced increased compassion fatigue and feared contracting, or spreading, the virus. The initial lack of personal protective equipment compounded this fear, as did structural issues which limited the ability to maintain social distancing standards. The workforce further struggled with the same personal stressors facing the rest of the nation, such as balancing childcare demands and caring for sick loved ones.

Services for frontline healthcare workers and first responders

Ensuring the identification of, and access to, confidential care is vital for the behavioral health workforce. Information about primary prevention tools and confidential treatment options should be made available. Standardized assessments can prove useful for assessing burnout and other dimensions of well-being (e.g., stress, work-life integration, meaning/purpose in work) in workers. Peer assistance programs offer in-depth assessments, referrals, and sometimes direct treatment, for individuals struggling with behavioral health or medical problems. Using federal funds, OBH was able to contract with the University of Colorado, School of Medicine to provide behavioral health supports for medical professionals, front line workers, and first responders to COVID-19.

Conclusion

A strong, accessible behavioral health system is critical to meet the demands for substance use and mental health care during a crisis. The initial phase of the COVID-19 response offers many key lessons that should not only inform future disaster planning, but also guide behavioral health system reform over the coming years. Providers and stakeholders across Colorado were quick to adapt the provision of services, and their quick responses likely helped thousands of Coloradans. We also learned what we need to do better in terms of emphasizing behavioral health assistance as an essential service, and reaching the most vulnerable and underserved populations. There are opportunities to enhance outpatient, inpatient and SUD services. Tele-behavioral health can be a powerful mechanism to provide timely services when in-person meetings are not an option; however it should never be the only option. Caring for the workforce will help to deliver high-quality services. As is the case with all services available during a crisis, they need to be resourced. This should be considered during the economic downturn and how that impacts the ability to fund direct services and implement the recommendations of this report.

This Committee had a limited timespan of five months to make recommendations to address the impact of COVID-19 pandemic on Coloradans and identify opportunities to improve the behavioral health system in response to future state disasters or emergencies. With that said, there are undoubtedly topics and subject matter areas that were not addressed and need further exploration. For example, although important, this Committee was not able to address the social determinants of health or the use of the Adverse Childhood Experiences Survey as it relates to the pandemic. Strengthening Colorado's behavioral health system, as laid out and recommended in the Governor's Behavioral Health Task Force blueprint (of September 2020), will result in better behavioral health care in times of a pandemic, disaster, or state emergency.

Integrating the recommendations reflected in this report into the implementation plan of the Behavioral Health Task Force will better prepare Colorado for its response during any potential future crisis.

APPENDICES

Appendix 1. Acronyms

ADA	Americans with Disabilities Act
ASAM	American Society of Addiction Medicine
ASC	Ambulatory Surgical Centers
CDE	Colorado Department of Education
CDHS	Colorado Department of Human Services
CDPHE	Colorado Department of Public Health and Environment
CLAS	Culturally and Linguistically Appropriate Services
CMS	Centers for Medicare and Medicaid Services
COVID-19	2019 Novel Coronavirus
DOI	Colorado Division of Insurance
DORA	Colorado Department of Regulatory Agencies
FDA	Food and Drug Administration
FSED	Free Standing Emergency Departments
GEEERC	Governor's Expert Emergency Epidemic Response Committee
HCPF	Colorado Department of Health Care Policy and Financing
HHS	U.S. Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
IMD	Institution for Mental Disease
KFF	Kaiser Family Foundation
LGBTQ	Lesbian Gay Bisexual Transgender Queer
MAT	Medication Assisted Treatment
OBH	Office of Behavioral Health
PPE	Personal Protective Equipment
SB	Senate Bill
STAR	Support Team Assisted Response
STW	Safe to Wait Services
SUD	Substance Use Disorder
The Committee	The COVID-19 Special Assignment Committee
The Task Force	The Behavioral Health Task Force

Appendix 2. Voting Record

COVID-19 Special Assignment Committee

7/22/2020 Tele-Behavioral Health Recommendations				
Recommendation or package of recommendations	Voting members present	Approved	Opposed	Abstained
Recommendation 1	18	18	0	0
Recommendation 2	18	18	0	0
Recommendation 3	18	18	0	0
Recommendation 4	18	18	0	0
Recommendation 5	18	18	0	0
Recommendation 6	18	18	0	0
Recommendation 7	18	18	0	0

9/17/2020 COVID-19 Special Assignment Committee Report				
Recommendation or package of recommendations	Voting members present	Approved	Opposed	Abstained
COVID-19 Special Assignment Committee Report	16*	16	0	0

***Note that one person did not support recommendation #4**

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COLORADO
Behavioral Health Task Force
Department of Human Services

Appendix F. All Recomendations

ACCESS: Coloradans should have access to a continuum of behavioral health services – regardless of the severity of need, ability to pay, age, disability, linguistics, geographic location, or racial or gender identity – to address the disparities in access to services. Coloradans should be connected to the services they need when they need them.

Primary Challenge/Barrier	Recommendations (Listed in order of the quadratic voting results beginning with the top-ranked)	Committee/ Source	Quadratic Vote Result
People are overwhelmed and confused trying to navigate our system.	Develop (and market) a single point of entry (that has no wrong door) to help individuals navigate the full continuum of services within the behavioral health system in a culturally and linguistically appropriate manner,and link to resources in the community, inclusive of follow-up services	Children's, Safety Net, Prevention	54.7
There are not enough community behavioral health services, programs, or funding available.	Expand and enhance the crisis services system, including coresponder 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	Safety Net, LTC	46.0
There are not enough community behavioral health services, programs, or funding available.	Explore new response mechanisms to reduce a police/criminal response to emergency and urgent mental health and social service related 911 calls by dispatching counselors and social workers directly to community; route individuals in need to civil/social service/health systems (and not to jail/correctional systems)	Safety Net, LTC	40.4
There is limited coordination among providers, agencies, and behavioral health stakeholders to support consumers and/or work together cohesively.	Streamline, align and simplify licensure rules and regulations that address the bifurcation between mental health and substance use disorder systems and allow for treatment of individuals experiencing a co-occurring crisis to reduce barriers to providing or accessing services, especially for those individuals experiencing a co-occurring crisis.	Safety Net, LTC	33.7
There are not enough community behavioral health services, programs, or funding available.	Develop a plan to expand high-intensity behavioral health treatment services (as defined in the Blueprint) as part of the service continuum.	Safety Net	30.3
There are not enough community behavioral health services, programs, or funding available.	Expand transportation services for routine (non-emergency) behavioral health care for all populations, including payer flexibility	Safety Net	25.9
We are not reaching marginalized and/or specific populations.	Develop specific outreach strategies to reach communities that are underserved and under-represented in the behavioral health system to address inequities	Children's	25.9
We are not identifying behavioral health conditions early on.	Evaluate models to develop secured treatment settings and Behavioral Health Adult Assessment Centers (in lieu of jail) where adults, upon arrest, can be assessed/ screened for behavioral health needs and criminogenic risk, and then placed in the appropriate system of care/ intervention	LTC	25.9

ACCESS: Coloradans should have access to a continuum of behavioral health services – regardless of the severity of need, ability to pay, age, disability, linguistics, geographic location, or racial or gender identity – to address the disparities in access to services. Coloradans should be connected to the services they need when they need them.			
Primary Challenge/Barrier	Recommendations (Listed in order of the quadratic voting results beginning with the top-ranked)	Committee/ Source	Quadratic Vote Result
We are not identifying behavioral health conditions early on.	Improve and adequately resource jail-based behavioral health services (JBBS) to include standardized screenings for behavioral and cognitive needs during medical intake; screenings for health care coverage during medical/mental intake; strengthening the ability to serve individuals with cognitive disabilities; developing protocols to screen, assess, treat and monitor for triage purposes; establishing follow-up processes; and expanding resources overall	LTC	25.4
There are not enough community behavioral health services, programs, or funding available.	Simplify the paneling processes across payer systems to reduce administrative burden and confusion by providers who are seeking to enroll in private and public health insurance programs	Parity	23.9
We are not identifying behavioral health conditions early on.	Enhance/expand the OBH School Based Mental Health Specialist Program and the OEC Early Childhood Mental Health Specialist Program to prevent mental, emotional and behavioral health problems	Children's, Safety Net	23.5
People are overwhelmed and confused trying to navigate our system.	Coordinate care in school settings as a result of behavioral health screenings and ensure there are resources to coordinate care, support students, and make referrals to community providers	Children's	22.9
There is limited coordination among providers, agencies, and behavioral health stakeholders to support consumers and/or work together cohesively.	Develop a universal consent and information sharing exchange to facilitate access to care	Children's, LTC	21.1
We are not reaching marginalized and/or specific populations.	Improve baseline understanding of true population-specific behavioral health network adequacy needs, as it differs from physical health network adequacy needs	Parity	18.1
People are in need of other supports outside of behavioral health services.	Invest in expanding integrated behavioral health services in primary care settings	Children's	18.0
There is limited coordination among providers, agencies, and behavioral health stakeholders to support consumers and/or work together cohesively.	Review SB20-212, Reimbursement for Telehealth Services and other legislation, executive orders, public health orders, and state agency rulemaking and administrative changes to determine which regulations should be made permanent, modified or repealed	COVID-19 Special Assignment Committee	17.6
People engage with the criminal justice system to access behavioral health services.	Study the incidence and impact of traumatic brain injury on incarceration. Craft approaches to: identify TBI as part of the criminal justice process; create pathways and treaments that reduce incarceration; secure treatment for those with TBI who are incarcerated; create pathwas for those with TBI to be released into the community given more appropriate treatment and supports	Executive Committee	17.1

ACCESS: Coloradans should have access to a continuum of behavioral health services – regardless of the severity of need, ability to pay, age, disability, linguistics, geographic location, or racial or gender identity – to address the disparities in access to services. Coloradans should be connected to the services they need when they need them.

Primary Challenge/Barrier	Recommendations (Listed in order of the quadratic voting results beginning with the top-ranked)	Committee/ Source	Quadratic Vote Result
There is limited coordination among providers, agencies, and behavioral health stakeholders to support consumers and/or work together cohesively.	Create a statewide children's behavioral health strategic plan with clear priorities and measurable goals to help align initiatives and resources across all child and family serving efforts.	Children's	17.0
There are not enough community behavioral health services, programs, or funding available.	Offer an outpatient treatment diversion option pre-plea (via Assisted Outpatient Treatment), with successful completion of treatment plan resulting in dropped charges	LTC	16.5
People are not aware of existing services/programs in their community.	Expand and scale prevention initiatives that have evidence of being successful	Prevention	16.1
Rural and frontier areas of Colorado have unique and different needs.	Continue to strengthen broadband infrastructure to give all Coloradans the option to use tele-behavioral health services	COVID-19 Special Assignment Committee	15.4
People are limited to access based on their form of payment or type of insurance.	Require payers to educate consumers on their rights and protections within health insurance systems	Parity	13.6
There are not enough community behavioral health services, programs, or funding available.	Expand and resource intensive case management and pre-trial supervision services for defendants (pre-plea status) requiring competency services in an effort to provide services in the least restrictive setting	LTC	13.6
There is limited coordination among providers, agencies, and behavioral health stakeholders to support consumers and/or work together cohesively.	Expand the regional 211 system and connect to the 988 national suicide hotline for entry to the behavioral health system.	Safety Net	12.9
There is a lack of coordination between the system serving individuals with IDD and the current MH/SUD system across 10+ state agencies.	Ensure Forensic Support Team, Courts, and Bridges navigators are current on available services for individuals with cognitive disability to help clients navigate the system appropriately	LTC	12.1
There is limited coordination among providers, agencies, and behavioral health stakeholders to support consumers and/or work together cohesively.	Enhance the co-responder model so that there is capacity to access information from behavioral health agencies, the ability to effectively serve individuals with cognitive disabilities, and divert to appropriate services	LTC	11.7
People engage with the criminal justice system to access behavioral health services.	Develop and promote statutory changes for JBBS to promote uniformity of JBBS standars; ensure the quality of services provided; promote collaboration among JBBS, Adult Diversion, Juvenile Diversion, Bridges, and other related state entities; and provide jails with technical assistance	LTC	11.5

ACCESS: Coloradans should have access to a continuum of behavioral health services – regardless of the severity of need, ability to pay, age, disability, linguistics, geographic location, or racial or gender identity – to address the disparities in access to services. Coloradans should be connected to the services they need when they need them.			
Primary Challenge/Barrier	Recommendations (Listed in order of the quadratic voting results beginning with the top-ranked)	Committee/ Source	Quadratic Vote Result
People engage with the criminal justice system to access behavioral health services.	Expand the capacity of the crisis hotline to manage re-routed 911 calls that require a co-Responder response or does not require a law enforcement or paramedic response	Safety Net, LTC	11.5
People are not aware of existing services/programs in their community.	Include recovery and relapse prevention in promotion and prevention to support the continuum	Children's, Safety Net	11.3
We are not identifying behavioral health conditions early on.	Integrate universally accessible social-emotional screening and mental health consultation into early care and learning, primary care and home visitation programs	Prevention	11.2
We are not identifying behavioral health conditions early on.	Create and implement a standardized approach to behavioral health screening (social/emotional wellbeing) that is normed to different cultures and specific populations, and include primary care settings and schools	Children's, LTC	10.2
We are not identifying behavioral health conditions early on.	Establish a comprehensive system of care with a continuum of linguistically and culturally responsive behavioral health services supported by a skilled workforce to expand outpatient behavioral healthcare and supportive services to meet the growing demand of the D/HH/DB population across the state	Executive Committee	9.7
There are not enough community behavioral health services, programs, or funding available.	Develop a comprehensive outpatient restoration treatment program able to serve higher-risk and higher-need defendants across the full behavioral health continuum	LTC	8.9
We are not reaching marginalized and/or specific populations.	Ensure timely and effective communication access of the Deaf, Hard-of-Hearing, and Deafblind in the method requested by the client at no cost to them during normal operating hours and at all points of contact, as required by the ADA	Executive Committee	8.5
Professionals do not receive enough ongoing education or regulation.	Promote best practice tele-behavioral health guidelines to help clinicians decide when telephone or video-conferencing methodologies are best in meeting unique client needs	COVID-19 Special Assignment Committee	8.1
People are not aware of existing services/programs in their community.	Create a recognized and credible source to provide education to and support parents and caregivers on how to recognize and address behavioral health needs	Children's	7.9
People are unwilling to try to access services due to stigma.	Promote programs such as Mental Health First Aid to the general public	Prevention	7.5
We are not reaching marginalized and/or specific populations.	Create a proactive outreach plan to identify and reach the most vulnerable populations prior to and when a crisis arises. Work with the populations to determine how to ensure these populations have access to tele-behavioral health, and how best to operationalize the plan.	COVID-19 Special Assignment Committee	7.4

ACCESS: Coloradans should have access to a continuum of behavioral health services – regardless of the severity of need, ability to pay, age, disability, linguistics, geographic location, or racial or gender identity – to address the disparities in access to services. Coloradans should be connected to the services they need when they need them.			
Primary Challenge/Barrier	Recommendations (Listed in order of the quadratic voting results beginning with the top-ranked)	Committee/ Source	Quadratic Vote Result
Every state agency defines, collects and tracks data and funding differently.	Determine how many people have access to tele-behavioral health services (i.e., understand broadband access, access to technology, etc.). Determine how many providers are willing/able to provide tele-behavioral health services to understand the level of services available	COVID-19 Special Assignment Committee	6.9
We are not identifying behavioral health conditions early on.	Develop and implement a plan to require behavioral health screenings to occur periodically and at well-child visits to identify needs early on	Children's	6.0
There is limited coordination among providers, agencies, and behavioral health stakeholders to support consumers and/or work together cohesively.	Enhance collaboration and coordination for jail-based services to provide behavioral health, physical health and substance use disorder services within a specific facility or county	LTC	5.9
People are unwilling to try to access services due to stigma.	Educate a myriad of audiences (i.e., general public, schools, libraries, area agencies on aging, WIC offices, agricultural businesses, etc.) in order to "normalize" behavioral health	Prevention	5.5
We are not reaching marginalized and/or specific populations.	Develop and disseminate timely, and linguistically and culturally responsive behavioral health promotion and prevention messages, materials, and activities for D/HH/DB Coloradans – especially if/when a crisis emerges	Executive Committee	4.7
There are not enough community behavioral health services, programs, or funding available.	Ensure adequate, flexible resources are available to providers who proactively outreach and work with the most vulnerable populations via tele-behavioral health, ensuring systems address disparities to access to care	COVID-19 Special Assignment Committee	4.6
There are not enough community behavioral health services, programs, or funding available.	Convene stakeholders to study the feasibility and development of an Assisted Outpatient Treatment (AOT) pilot to encourage people with a behavioral health condition to voluntarily engage in adhering to their treatment plan	LTC	4.1
We are not reaching marginalized and/or specific populations.	Inform clients through prominently displayed visual and written information of their right to communication access through hearing assistive technology and interpreters/communication services, as well as sign language fluent providers when available. Also include such information in promotional materials	Executive Committee	4.0
People engage with the criminal justice system to access behavioral health services.	Review the requirements for pursuing civil commitment filings in Colorado to consider if modifying the standard for civil commitment is needed to minimize the reliance on the criminal justice system	LTC	3.3
We are not reaching marginalized and/or specific populations.	Secure appropriate resources to ensure that all populations, including those with a gambling addiction, are targeted for outreach, education and support services	Executieve Committee	3.0
People are not aware of existing services/programs in their community.	Promote the Health at Home website (Healthathome.colorado.gov) and ensure it includes information about how to access behavioral health services	COVID-19 Special Assignment Committee	2.2

ACCESS: Coloradans should have access to a continuum of behavioral health services – regardless of the severity of need, ability to pay, age, disability, linguistics, geographic location, or racial or gender identity – to address the disparities in access to services. Coloradans should be connected to the services they need when they need them.			
Primary Challenge/Barrier	Recommendations (Listed in order of the quadratic voting results beginning with the top-ranked)	Committee/ Source	Quadratic Vote Result
People are limited to access based on their form of payment or type of insurance.	Promote consumer understanding on the integration of behavioral health in health care and insurance overall, and improve consumer education on their rights and protections within the health care and insurance systems	Parity	2.0
People are not aware of existing services/programs in their community.	Publish guidance and training for caregivers and providers to promote easy access to services and protect individuals' rights, in an effort to remove confusion and support children and families navigating across systems	Children's	2.0
Professionals outside of the behavioral health system need education to understand the various components of the system.	Ensure follow-up action is taken after a screening is completed in school settings by providing support/ training to school professionals, offering social/ emotional curriculum, and creating an infrastructure for self-report data	LTC	1.4
There is limited coordination among providers, agencies, and behavioral health stakeholders to support consumers and/or work together cohesively.	Develop and implement a timely, seamless warm hand-off of individuals to and from JBBS, working closely with stakeholders to ensure coordination and collaboration and foster health information exchange	LTC	0.0
There is limited coordination among providers, agencies, and behavioral health stakeholders to support consumers and/or work together cohesively.	Establish a central data repository so that all behavioral health providers have access to consumer data	Quality	-3.8

AFFORDABILITY: Care can be affordable when there are administrative efficiencies across Colorado's behavioral health industry, and payment models create the right incentives to also drive improved outcomes.			
Primary Challenge/Barrier	Recommendations (Listed in order of the quadratic voting results beginning with the top-ranked)	Committee/ Source	Quadratic Vote Result
There is a lack of consistency across payer systems.	Increase reimbursement rates across payer systems to behavioral health providers in compliance with state and federal parity laws	Parity	62.8
There is a lack of consistency across payer systems.	Develop a Colorado-focused model of comprehensive care and implement a cost-based reimbursement plan to universally adjust levels to sufficiently to cover the actual cost of care (examples: PCP screenings, essential Services for behavioral health needs for all public and commercial insurance providers)	Children's, Safety Net	53.1
Public resources are not being used efficiently, effectively and equitably.	Examine and leverage all federal funding opportunities while not compromising essential services within the service array	Children's	47.1
Every state agency defines, collects and tracks data and funding differently.	Consolidate community behavioral health funding streams by eligibility criteria, program size, funding flexibility, and/or services provided across state agencies/offices	Children's	43.7

AFFORDABILITY: Care can be affordable when there are administrative efficiencies across Colorado's behavioral health industry, and payment models create the right incentives to also drive improved outcomes.			
Primary Challenge/Barrier	Recommendations (Listed in order of the quadratic voting results beginning with the top-ranked)	Committee/ Source	Quadratic Vote Result
There are not enough community behavioral health services, programs, or funding available.	Prioritize the community investment funding available from not-for-profit hospitals into behavioral health priorities established by the behavioral health task force and the BHA	Executive Committee	42.9
There is a lack of consistency across payer systems.	Simplify the paneling processes across payer systems to reduce administrative burden and confusion by providers who are seeking to enroll in private and public health insurance programs	Parity	42.5
Public resources are not being used efficiently, effectively and equitably.	Evaluate the School Finance Act and modify the School Funding Formula to ensure any student who wants/ needs access for support can get it regardless of having a known diagnosis, a formal Individualized Educational Plan (IEP), or any other qualifying factor to promote the highest, most accessible support for students	Children's	39.7
Funding sources are not braided or blended to cover costs beyond treatment.	Expand transportation services for routine (non-emergency) behavioral health care for all populations, including payer flexibility	Safety Net	38.2
There is a lack of consistency across payer systems.	Adopt a single, statewide utilization management guideline for all payers to reduce parity issues and disparity in access to services	Children's	34.1
Prevention efforts are not prioritized.	Increase funding so that evidence-based interventions are not cost prohibitive	Prevention	33.8
There is a lack of consistency across payer systems.	Improve consistency across all payers related to the complaints reporting processes to strengthen an "All Doors Open" policy across the behavioral health system	Parity	31.3
Public resources are not being used efficiently, effectively and equitably.	Quantify cost savings from the payer, provider and patient perspective for telebehavioral health services. Determine any increased cost to payers , if any	COVID-19 Speical Assignment Committee	25.9
People cannot access services in a timely fashion.	Implement a pay-and-chase model that identifies a single state agency to be responsible for reimbursement to a provider and securing payment from the appropriate payer	Children's	25.4
There is a lack of consistency across payer systems.	Identify flexible funding to support minimum intake, assessment, intervention, and referral requirements regardless of payer	Safety Net	17.7

WORKFORCE & SUPPORT: Colorado should have a high-quality, trained, resourced, culturally responsive and diverse behavioral health professional workforce that delivers improved health and access to Coloradans.			
Primary Challenge/Barrier	Recommendations (Listed in order of the quadratic voting results beginning with the top-ranked)	Committee/ Source	Quadratic Vote Result
Professionals are not reimbursed or paid at a rate that reflects their value.	Promote/increase competency in the behavioral health workforce for specific populations (LGBTQ+, Tribal communities, etc.) and specific conditions (Substance Use Disorder (SUD), IDD, ASD, etc.) by eliminating unnecessary barriers to providing and being reimbursed for services to these populations; developing minimum training guidelines to maintain core competency standards	Children's, Safety Net	67.8

WORKFORCE & SUPPORT: Colorado should have a high-quality, trained, resourced, culturally responsive and diverse behavioral health professional workforce that delivers improved health and access to Coloradans.			
Primary Challenge/Barrier	Recommendations (Listed in order of the quadratic voting results beginning with the top-ranked)	Committee/ Source	Quadratic Vote Result
People cannot access services in a timely fashion.	Invest in peer support programs and create pathways for billing of Medicaid and other payers to expand the workforce	Children's, Safety Net, Prevention	59.6
Professionals do not receive enough ongoing education or regulation.	Train, recruit and retain specialized clinicians to treat moderate and severe cases in substance use, developmental disorders, special populations, geriatrics, and child psychiatry, among others	Parity	58.2
Workforce expansion in the behavioral health field is not a priority.	Simplify and streamline credentialing processes to enroll providers with payers	Children's, Safety Net	52.8
Workforce expansion in the behavioral health field is not a priority.	Implement reciprocity procedures to have licensed professionals move from other states/countries to improve recruitment	Children's, Safety Net	51.7
Workforce expansion in the behavioral health field is not a priority.	Seek workforce expansion funds	Children's, Safety Net, Prevention	38.1
Professionals are not reimbursed or paid at a rate that reflects their value.	Explore Housing supports that could remove barriers to behavioral health providers living in rural/resort communities	Children's, Safety Net, Prevention	30.7
Professionals do not receive enough ongoing education or regulation.	Develop and adopt a spectrum of core competencies for Direct Care Workers (workers not regulated by DORA) and peers, and align these competencies with appropriate scopes of work for each level of acuity/ population	Children's, Safety Net	27.9
Professionals do not receive enough ongoing education or regulation.	Ensure staff members who provide services to D/ HH/DB clients have specialized training/ experience commensurate to their staff position to work with such clients or shall receive supervision by a staff member with specialized training/experience	Executive Committee	27.1
Professionals do not receive enough ongoing education or regulation.	Implement a mandatory annual training for competency evaluators for quality and consistency of evaluations	LTC	25.2
Workforce expansion in the behavioral health field is not a priority.	Have master's level providers offer supervision for free in exchange for loan repayment or other cost incentives	Children's, Safety Net, Parity	24.6
Workforce expansion in the behavioral health field is not a priority.	Incentivize organizations to offer "sign-on bonuses" for providers in such a way that encourages retention/ commitment to these communities	Children's, Safety Net, Parity	23.1
People cannot access services in a timely fashion.	Expand the workforce by expanding non-licensed workers, including peers.	Children's, Safety Net	22.7
Professionals are not reimbursed or paid at a rate that reflects their value.	Research, develop, and publish metrics and methods to determine the value and cost of behavioral health services that can inform statewide salary recommendations for the workforce	Children's	21.7

WORKFORCE & SUPPORT: Colorado should have a high-quality, trained, resourced, culturally responsive and diverse behavioral health professional workforce that delivers improved health and access to Coloradans.			
Primary Challenge/Barrier	Recommendations (Listed in order of the quadratic voting results beginning with the top-ranked)	Committee/ Source	Quadratic Vote Result
Professionals do not receive enough ongoing education or regulation.	Educate clinicians who are implementing screening, assessment and diagnosis on developmental, environmental or other factors that may impact behavioral health or resemble behavioral health concerns	Prevention	19.9
Workforce expansion in the behavioral health field is not a priority.	Develop and promote workforce cultivation initiatives to reach students	Children's, Safety Net, Prevention	18.4
Workforce expansion in the behavioral health field is not a priority.	Improve/strengthen the Colorado Health Service Corps loan repayment to improve retention	Children's, Safety Net, Prevention	18.0
Workforce expansion in the behavioral health field is not a priority.	Prioritize a portion of the state budget to be used to support "career ladder" efforts	Children's, Safety Net, Prevention	15.1
Professionals do not receive enough ongoing education or regulation.	Offer training for non-licensed direct care workers with a series of endorsements to the training modules and adopt a strong incentive program for employers to recognize those endorsements.	Children's, Safety Net	14.0
Workforce expansion in the behavioral health field is not a priority.	Prioritize a part of every grant application written by the State to be dedicated to workforce development	Children's, Safety Net, Prevention	7.4
Workforce expansion in the behavioral health field is not a priority.	Train, recruit, and retain specialized clinicians to treat moderate and severe cases in substance use, developmental disorders, special populations, geriatrics, and child psychiatry (among others) to cultivate a workforce representative of the community it serves	Children's, Safety Net, LTC, Prevention	0.0

ACCOUNTABILITY: All stakeholders work together to ensure Coloradans are receiving the quality care they need. Public resources should be used efficiently, effectively and equitably.			
Primary Challenge/Barrier	Recommendations (Listed in order of the quadratic voting results beginning with the top-ranked)	Committee/ Source	Quadratic Vote Result
Colorado does not have a state-wide agreed-upon definition for a "quality" behavioral health system/ program.	Research, develop, and publish population-specific standards of care that include network adequacy and access measures, wait-time/waitlist limits, and general care considerations	Children's, Quality	55.7
We are not reaching marginalized and/or specific populations.	Address high suicide incidences and disparities in care access, delivery, and outcomes for vulnerable populations including people of color, Veterans, LGBTQ, people with disabilities, and American Indian/Alaska Native populations.	Executive Committee	51.1
Every state agency defines, collects and tracks data and funding differently.	Designate a single fiscal management system be used to account for all publicly funded services to improve allocations	Children's	43.6
Colorado does not have a state-wide agreed-upon definition for a "quality" behavioral health system/ program.	Determine clear, reasonable, and limited metrics to measure the quality of the behavioral health system	Children's, Quality	42.1

ACCOUNTABILITY: All stakeholders work together to ensure Coloradans are receiving the quality care they need. Public resources should be used efficiently, effectively and equitably.			
Primary Challenge/Barrier	Recommendations (Listed in order of the quadratic voting results beginning with the top-ranked)	Committee/ Source	Quadratic Vote Result
Every state agency defines, collects and tracks data and funding differently.	Standardize the process and explore alignment across state agencies to use a single standardized assessment, and include appropriate payment reimbursement	Children's	40.1
Colorado does not have a standardized tool or process to publicly share data.	Identify what data will inform the public about the quality of the Behavioral Health system (macro and micro level), and review all current data collected to mitigate redundancy	Quality	37.4
There is a lack of consistency across payer systems.	Increase reimbursement rates across payer systems to behavioral health providers in compliance with state and federal parity laws	Parity	35.8
Colorado does not have a state-wide agreed-upon definition for a "quality" behavioral health system/ program.	Measure the effectiveness of the single point of entry to identify opportunities for improvement	Children's	31.8
Every state agency defines, collects and tracks data and funding differently.	Develop a systematic approach to collect information on behavioral health spending across state agencies/ offices, and track spending across demographics to address inequities	Children's	26.9
There is a lack of consistency across payer systems.	Assess provider directories on a continuous basis across payer systems to address issues related to ghost networks	Parity	26.1
Colorado does not have a standardized tool or process to publicly share data.	Produce an annual statewide, unblinded dashboard for payers and behavioral health provider entities to promote and ensure transparency and accountability	Children's, Quality	24.5
There is a lack of consistency across payer systems.	Reform regulations and contract requirements to support trauma-informed and problem-focused assessment	Children's, Safety Net	22.7
Colorado does not have a state-wide agreed-upon definition for a "quality" behavioral health system/ program.	Develop a more efficient competency process via a multi-stakeholder process to decrease the burden on the judicial system and provide a better experience for the consumer	LTC	22.3
Colorado does not have a standardized tool or process to publicly share data.	Develop and adopt an Outcomes and Performance Dashboard with selected/limited metrics to measure wellbeing across the state, effectiveness of interventions, and effectiveness of interventions to serve different populations (including those with cognitive disabilities)	Children's, Safety Net, LTC, Quality	21.2
Colorado does not have a standardized tool or process to publicly share data.	Study and publicly report data for individuals with cognitive disabilities as it relates to competency services to understand prevalence for being arrested, wait times, and equitable competency evaluation services	LTC	20.3
Every state agency defines, collects and tracks data and funding differently.	Develop and improve cross-systems data sharing and assessment tools that effectively and holistically identify needs, remove bias and discrimination, and ensure appropriate placement and access to the whole housing continuum;	MHDCJS	19.5

ACCOUNTABILITY: All stakeholders work together to ensure Coloradans are receiving the quality care they need. Public resources should be used efficiently, effectively and equitably.			
Primary Challenge/Barrier	Recommendations (Listed in order of the quadratic voting results beginning with the top-ranked)	Committee/ Source	Quadratic Vote Result
Colorado does not have a state-wide agreed-upon definition for a "quality" behavioral health system/ program.	Continue to study best practices to incorporate tele-behavioral health into the treatment continuum, and develop best practice guidelines on how to coordinate in-person and virtual care.	COVID-19 Special Assignment Committee	18.0
Professionals do not receive enough ongoing education or regulation.	Make available accessible and attainable training for best practices in tele- behavioral healthcare delivery	COVID-19 Special Assignment Committee	17.2
Colorado does not have a standardized tool or process to publicly share data.	Develop measurable outcomes that are informed by local and national evidence and that help guide resource and funding allocation across the aforementioned recommendations.	MHDCJS	16.5
Colorado does not have a state-wide agreed-upon definition for a "quality" behavioral health system/ program.	Adopt a definition of mental wellness/quality of life as a person maneuvers through the behavioral health system, and determine how best to measure outcomes	Quality	14.6
We are not reaching marginalized and/or specific populations.	Conduct additional analysis to identify outcomes and understand the effectiveness of tele-behavioral health when used with specific populations.	COVID-19 Special Assignment Committee	11.4
Every state agency defines, collects and tracks data and funding differently.	Create/implement a single identifier for each child, as in a Master Patient Index, to measure utilization throughout the system	Children's	9.9
Colorado does not have a state-wide agreed-upon definition for a "quality" behavioral health system/ program.	Review research studies and literature reviews, incorporating current efforts, to determine the quality and effectiveness of tele-behavioral health services	COVID-19 Special Assignment Committee	9.5
Colorado does not have a state-wide agreed-upon definition for a "quality" behavioral health system/ program.	Consider promising practices from past pilots (including the Gap Analysis done by JFK Partners) and study current, respected systems and literature to understand what worked well and how to scale them when appropriate	Quality	9.0
People are not aware of existing services/programs in their community.	Support providers who offer tele-behavioral health in developing campaigns and protocols to raise awareness of the resources available for training and education of providers	COVID-19 Special Assignment Committee	6.7
Colorado does not have a state-wide agreed-upon definition for a "quality" behavioral health system/ program.	Integrate the Standards of Care developed by the Colorado Daylight Partnership Program into existing policies, organizational plans, management, and monitoring activities for providers, and cover them in staff orientations and training	Executive Committee	4.6
Colorado does not have a standardized tool or process to publicly share data.	Collect data, including stakeholder input, on community-based referrals for community restoration to understand drivers of low referral rates	LTC	4.5

CONSUMER & LOCAL GUIDANCE: Stakeholders from the community should be charged with providing feedback and guidance on how best to meet the local behavioral health needs. All Coloradans should have an opportunity to provide feedback on the behavioral health system.			
Primary Challenge/Barrier	Recommendations (Listed in order of the quadratic voting results beginning with the top-ranked)	Committee/ Source	Quadratic Vote Result
Communities are launching their own behavioral health systems.	Complete a comprehensive service gap analysis to identify local, regional and systemic service gaps, and work together to develop a plan to address the gaps	Children's	96.4
Consumers do not feel heard.	Engage consumers in state- and local-level advisory groups to continuously provide input and guidance on system improvements	Executive Committee	73.9
Communities are launching their own behavioral health systems.	Identify and provide sustainable, flexible funding streams for local communities to prioritize primary prevention	Prevention	70.9
Rural and frontier areas of Colorado have unique and different needs.	Empower local communities to invest in resources, services and/or materials to support populations that experience mental wellness disparities and provide support beyond traditional healthcare delivery	Prevention	61.9
Consumers do not feel heard.	Engage clients, caretakers, and families who are using tele-behavioral health for their input in how to improve and strengthen tele-behavioral health services	COVID-19 Special Assignment Committee	58.5
We are not reaching marginalized and/or specific populations.	Develop and implement a grievance process that includes linguistic and cultural accessibility and strategies for identifying, preventing, and resolving conflicts, cross-cultural issues, or complaints by clients	Executive Committee	50.5
Rural and frontier areas of Colorado have unique and different needs.	Convene local stakeholders to create a menu of evidence-informed or promising practices to address the current patchwork of different programs that serve children	Children's	42.9
Rural and frontier areas of Colorado have unique and different needs.	Partner with stakeholders on how to invest resources for evidence-informed or promising practices in their communities	Prevention	39.1

WHOLE PERSON CARE: Coloradans are best served – and have the best chances for improved health -- when their physical and behavioral care coordination is integrated, when their social determinants of health are addressed, and when care is provided in a language they can understand. All Coloradans should have the opportunity to achieve mental wellness --"a state of well-being in which the person realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.			
Primary Challenge/Barrier	Recommendations (Listed in order of the quadratic voting results beginning with the top-ranked)	Committee/ Source	Quadratic Vote Result
People are in need of other supports outside of behavioral health services.	Offer/expand care coordination with services to address social determinants of health (i.e., housing, transportation, employment, etc.)	Safety Net, Prevention	55.8
People are in need of other supports outside of behavioral health services.	Expand Assertive Community Treatment (ACT) or other high-intensity case management with treatment for individuals being discharged from a psychiatric hospital to ensure they are receiving the support and treatment they need to be successful after discharge.	Safety Net, LTC	53.7
There is a lack of coordination between the system serving individuals with IDD and the current MH/SUD system across 10+ state agencies.	Create planned and facilitated educational opportunities (i.e., interactive trainings) for law enforcement, first responders, judges and court officials and other partners on how to work with individuals with cognitive disabilities, as well as how to interact in non-crisis situations with them. (Includes best practices to address language and racial disparities.)	LTC	44.6

WHOLE PERSON CARE: Coloradans are best served – and have the best chances for improved health -- when their physical and behavioral care coordination is integrated, when their social determinants of health are addressed, and when care is provided in a language they can understand. All Coloradans should have the opportunity to achieve mental wellness --"a state of well-being in which the person realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.

Primary Challenge/Barrier	Recommendations (Listed in order of the quadratic voting results beginning with the top-ranked)	Committee/ Source	Quadratic Vote Result
Professionals outside of the behavioral health system need education to understand the various components of the system.	Expand CIT training (or similar training) for Colorado first responders, court security, and corrections staff, and provide continuing education to ensure officers are well equipped to safely intervene in a mental health crisis. (Includes a special focus on identification and interaction skills with individuals with cognitive disabilities)	LTC	38.4
Professionals outside of the behavioral health system need education to understand the various components of the system.	Require mental health first aid training for all first responders and law enforcement professionals	Safety Net	36.3
People are in need of other supports outside of behavioral health services.	Analyze and address housing issues as barriers to success in the community for individuals with behavioral health needs (including those needing competency services). Focus on the housing first model.	Safety Net, LTC	36.2
People are in need of other supports outside of behavioral health services.	Identify specific strategies to strengthen efficiencies and service outcomes for people with intellectual/ developmental/physical disabilities with co-occurring mental health conditions and/or behavioral health needs by convening subject matter experts and developing an implementation plan to be integrated into the blueprint (by 3/31/21)	Executive Committee	35.2
People are in need of other supports outside of behavioral health services.	Study and identify solutions that repurpose resources from inside prisons, jails and law enforcement to create a more holistic means of better addressing behavioral health concerns in a preventive, supportive, community setting.	Executive Committee	31.3
People are in need of other supports outside of behavioral health services.	Support and implement the recommendations adopted by the Suicide Prevention Commission on July 26, 2019 (that includes supporting Gay-Straight Alliances in schools, sexual health education in schools, and an individual's use of gender identity, as well as enforcing non-discrimination policies)	Prevention	30.4
People are in need of other supports outside of behavioral health services.	Bundle contracts for competency services with other safety net services, and explore opportunities to further fund needed ancillary services that support positive restoration outcomes	LTC	30.3
People are in need of other supports outside of behavioral health services.	Support integrated care by "opening" the Health and Behavioral Assessment and Intervention codes, which allow for providers to address behavior factors impacting physical health conditions	Children's	30.0
People are in need of other supports outside of behavioral health services.	Develop an infrastructure and sustainable funding stream for a statewide behavioral health consultation program to access specialists and strengthen primary care provider support	Children's	27.7

WHOLE PERSON CARE: Coloradans are best served -- and have the best chances for improved health -- when their physical and behavioral care coordination is integrated, when their social determinants of health are addressed, and when care is provided in a language they can understand. All Coloradans should have the opportunity to achieve mental wellness – "a state of well-being in which the person realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.

Primary Challenge/Barrier	Recommendations (Listed in order of the quadratic voting results beginning with the top-ranked)	Committee/ Source	Quadratic Vote Result
People are in need of other supports outside of behavioral health services.	Develop a comprehensive outpatient restoration treatment program that is able to serve higher-risk and higher-need defendants to include a full behavioral health continuum and may include housing, transportation, and other social supports	LTC	24.6
People are in need of other supports outside of behavioral health services.	Provide and improve supportive services along the entire housing continuum	MHDCJS	24.0
People are in need of other supports outside of behavioral health services.	Expand intensive case management and support multiple service categories to meet all of an individual's needs	Safety Net	20.3
There is a lack of coordination between the system serving individuals with IDD and the current MH/SUD system across 10+ state agencies.	Empower Colorado Crisis Services with the education and infrastructure to develop and file crisis plans (as well as register with Smart911) for individuals with cognitive disabilities, their families, and Community Centered Boards and other case management agencies to ensure responders have needed info to provide assistance	LTC	17.8
People are in need of other supports outside of behavioral health services.	Increase provider capacity for supportive housing and supportive services across the state	MHDCJS	17.4
People are in need of other supports outside of behavioral health services.	Create training opportunities for and invest in two (2gen) and three generation (3gen) models to ensure the entire family system is adequately engaged in relevant treatment modalities, and a legacy of strength is embedded	Safety Net	15.1
People are in need of other supports outside of behavioral health services.	Develop a strategy and engage efforts to remove housing as a barrier to completing community restoration services	LTC	14.6
Professionals outside of the behavioral health system need education to understand the various components of the system.	Provide universal training to judicial stakeholders to increase understanding of the competency assessment and restoration process	LTC	14.3
People are in need of other supports outside of behavioral health services.	Broaden the continuum of housing options from step down hospital care to bridge housing to family re-integration to rapid rehousing to permanent supportive housing	MHDCJS	10.7
People are in need of other supports outside of behavioral health services.	Create or expand behavioral health court/dockets with a focus on high risk/high need defendants for defendants in which pre-plea diversion is not an option to effectively process individuals with identified behavioral health concerns through the judicial system	LTC	10.1
People are in need of other supports outside of behavioral health services.	Seek resources to extend and, based on need, expand housing services and other collateral services (beyond the already funded initial five years for the program with Coalition of the Homeless)	LTC	8.7

WHOLE PERSON CARE: Coloradans are best served -- and have the best chances for improved health – when their physical and behavioral care coordination is integrated, when their social determinants of health are addressed, and when care is provided in a language they can understand. All Coloradans should have the opportunity to achieve mental wellness -- "a state of well-being in which the person realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.			
Primary Challenge/Barrier	Recommendations (Listed in order of the quadratic voting results beginning with the top-ranked)	Committee/ Source	Quadratic Vote Result
People are in need of other supports outside of behavioral health services.	Encourage, cultivate and incentivize evidence-based professional development in workplaces to support inclusion.	Prevention	5.1
People are in need of other supports outside of behavioral health services.	Standardize Family Friendly Workplace policies and support the family by prioritizing social emotional learning and support	Prevention	2.8
People are in need of other supports outside of behavioral health services.	Bundle contracts for competency services with other safety net services, and explore opportunities to further fund needed ancillary services that support positive restoration outcomes	LTC	0.0
People are in need of other supports outside of behavioral health services.	Expand Assertive Community Treatment (ACT) or other high-intensity case management with treatment for individuals being discharged from a psychiatric hospital to ensure they are receiving the support and treatment they need to be successful after discharge.	Safety Net, LTC	0.0

Behavioral Health Task Force Committee Voting Record

7/30/2020 Behavioral Health Administration				
Recommendation or package of recommendations	Voting members present	Approved	Opposed	Abstained
Behavioral Health Administration	26	26	0	0

8/14/2020 Priorities for current FY, Top 19 Priorities ratification of QV straw votes				
Recommendation or package of recommendations	Voting members present	Approved	Opposed	Abstained
Priorities for current FY	22	22	0	0
Top 19 priorities ratification of QV straw votes	25	25	0	0

8/27/2020 Care Coordination				
Recommendation or package of recommendations	Voting members present	Approved	Opposed	Abstained
Care Coordination	22	14	8	0

8/27/2020 BHTF Report Directional Approval				
Recommendation or package of recommendations	Voting members present	Approved	Opposed	Abstained
BHTF Report Directional Approval	22	20	0	2

Motion to Support a Care Coordination Entity (CCE) Model for Inclusion in the Blueprint: Summation of Dissenting Opinion

On August 27th, 2020, eight voting members of the Behavioral Health Task Force (BHTF) opposed a motion to establish a new regional care coordination structure. In this document we summarize the rationale given by those who voted in opposition. While not every dissenting BHTF member is in consensus on ALL the points made, the summary captures both shared views and unique points that were voiced.

The model was developed in a rushed process, with a top-down approach, and did not arise organically from the work of the Task Force or its subcommittees.

The model was originally presented in January by high level employees of the Colorado Department of Human Services, first to the Safety Net subcommittee and then to the combined subcommittees and BHTF at the large group meeting. While CDHS continued to discuss the model in various settings, it was never voted on by the Safety Net committee nor was it presented to the BHTF again or voted on until August. There was very little shared with the BHTF about alternative models or best practices from other states' systems. When asked if this type of model exists elsewhere, the response was a very brief "no." While there is unanimous desire to be bold and willingness to be unique nationally, there was not adequate research, debate, or compromise afforded to the process leading up to the vote. Suggestions to compile a menu of options and best practices for the Task Force to consider and select the best collection of features were ignored.

It is critical that decisions of this magnitude be thoroughly vetted before expecting individuals to submit a vote. Members of the Task Force were told the Governor needed us to approve the proposal, and that without it the other recommendations would not be attainable. While it is not clear why that would be the case, the emphasis created pressure to support a vaguely described concept so strongly supported by the Governor's Health Cabinet and others on the Task Force Executive Committee. Excluding the Executive Committee, the vote by other members of the Task Force resulted in a tie, eight for and eight opposed. We believe a far less divisive and rushed approach to shaping the future of our state's behavioral health system is not only possible, but indeed paramount to achieving the best possible outcome for Coloradans.

The focus on "care coordination" is misleading.

Between January and August, various words and phrases were altered in the description. For example, "Administrative Services Organization" was changed to "Care Coordination Entity", and ultimately changed to "Care Coordination Structure" which is a misnomer. The structure as proposed is meant to do much more than care coordination and navigation on behalf of individuals seeking services, including provider network contracting and management, billing and credentialing, and provider technical assistance. Utilization management responsibilities were also included in the description, which is a function of risk-based managed care organizations typical to health insurance companies. Additional language was also added indicating these new structures would help address parity concerns related to private insurance and various access and payment issues attributed to Medicaid. Not only do these functions extend well beyond the role of "care coordination", but the Task Force received no detail describing how these new structures will be formed and assume so much administrative responsibility.

In addition, the Task Force received no cost effectiveness analysis or definition of tangible health outcomes by which these proposed administrative structures will be evaluated.

In light of these concerns, we feel it is in the collective best interest of Coloradans to, first, pursue the creation of the Behavioral Health Administration concept, as unanimously supported by the Task Force, and later determine if an additional layer of administrative structure and care coordination services are warranted supports following a robust analysis of available options, best practices and fiscal impact. It is critical to understand what the new Behavioral Health Authority will look like, which funding streams will be blended, how policies will be aligned, and how the BHA will truly function, before we begin discussion on specific administrative, contracting, and coordination mechanisms.

The model does not meet the challenge that Governor Polis laid out for a "bold vision".

It is not clear how, or if, the proposed model will address gaps in needed services, capacity issues in underserved and rural communities, limited behavioral health workforce, parity concerns, or the sustainability of a Colorado safety net. We heard through a resounding number of public testimonials that community members with Medicaid or private insurance have experienced some of the most significant challenges of all populations in getting their mental health and substance use treatment needs met. In no discernable way does the proposed model expand the capacity of local providers, create new investment in direct services to fill specific gaps in care, or rectify network adequacy issues, inadequate reimbursement rates, or other non-quantifiable treatment limitations in private or public insurance. Care coordination and navigation are not novel concepts in our behavioral health or broader healthcare systems, and alone will not achieve the transformative vision contemplated by the Task Force for Colorado.

It is important to note that both the Safety Net and the Children's Subcommittees developed, and the Task Force voted to approve, a full continuum of mental health and substance use prevention and treatment services. Care coordination is only one component of that comprehensive system. An alternative path forward is to take the hard work of the Task Force's subcommittees and invest in a Colorado safety net system from the ground up, based on nationally recognized best practices and models. Rather than simply offering to assist individuals in navigating all the complexity that Coloradans face, we should strive to eliminate the complexity itself.

We must think across systems and move upstream.

The referenced "bifurcation" attempts to address only the split between mental health and substance use services currently funded by the Office of Behavioral Health. This represents just three of the more than fifty fragmented public funding streams identified by the Colorado Office of State Planning and Budget. A specific limitation to this approach is that it does nothing to address the intersection of those with behavioral health needs who also need support for traumatic brain injuries or intellectual or developmental disabilities. Moreover, given that so many folks living with combinations of these disorders are Medicaid recipients, the fact that Medicaid is not integrated with the proposed structure means many identified barriers across systems will continue to be a barrier.

Further, as required under Olmstead v. L.C., the State must ensure the adequacy of community-based services and prevent unnecessary institutionalization. Again, the proposed model does not address the underlying shortage of adequate resources for behavioral health in Colorado. Instead, it should be our highest priority to help Coloradans to thrive in their own communities through a re-imagined behavioral

health safety net, anchored by meaningful systems integration and deep investment in broader social determinants of health.

The Governor's Behavioral Health Task Force, under the charge of its Executive Committee of high-level government leaders should take all Coloradans boldly toward a resetting of our fundamental priorities as a State. We must address health promotion and disease prevention with a shared understanding that there is nothing more important to a human community than human health and wellbeing. By promoting health and applying consistent intelligence to the prevention of all nature of dis-ease, we will spend less on the historically inequitable failures of chronic illness, acute health care interventions, arrest, prosecution, and imprisonment. We will reduce homelessness, violence, and harmful substance use. We will require less crisis management and make it possible to coordinate care for all who need it. To narrowly zero in on care coordination without a major course correction—prioritizing housing, education, economic stability over law enforcement and punishment--is like adjusting the rigging while still sailing toward the rocks.

Medicaid and private insurance are excluded from the model.

The BHTF voted unanimously to approve the Behavioral Health Administration (BHA), a potentially transformative move that would bring together fragmented regulatory and funding authority from many diverse State Agencies under the umbrella of a single, new structure in State government. This vote was made with the understanding that neither the Department of Health Care Policy & Financing (overseeing Medicaid and CHP+) nor the Division of Insurance would be included under the purview of the BHA. However, assurances were made that over the next year, we would work together to determine how alignment would be achieved to make sure we are comprehensively addressing the challenges facing behavioral health in Colorado, rather than reinforcing siloed administration, oversight and funding. It is premature to move ahead with the proposed coordination and administrative structures until the BHA is firmly defined and established.

Further, the exclusion of Medicaid and private insurance effectively means that the new structure will have a very limited scope. The BHA should provide the best possible service to all Coloradans, and work to align, if not integrate, services for all clients regardless of payer source. Ironically, the reference to "publicly insured" individuals in the language of the proposed model should, by definition, be inclusive of those on Medicaid given that Medicaid is a publicly funded program using federal and state dollars.

The language approved does not guarantee that funding for direct services will not be diverted to administrative functions.

Considering COVID-19 and the current budget crisis, it is more important than ever that we work to ensure funding is not diverted from direct prevention and treatment services. There has been no fiscal analysis presented on the new model and given the wide range of responsibilities proposed for the care coordination structure it is challenging to think of where the funding will come from to stand up the new structure. Despite repeated requests, we still have no guarantee that funding will not be taken from the front lines of local prevention and treatment services in order to pay for the proposed administrative structures.

The Care Coordination structure as described is duplicative of other structures and functions, including the coordination function of the Regional Accountable Entities (RAEs), Colorado's largest payer of behavioral health services.

Beyond having no information on how the new administrative structures will be funded, it is also unclear how the structures will coordinate and share data with existing systems and whether they will enhance or expand existing local systems of care rather than duplicate and overlap with them. There is also the likelihood that new data and reporting requirements will be added on to the already untenable expectations put on local care providers. This is unsustainable for communities, especially in rural and frontier Colorado. It also doesn't fix the problem that clients/families/providers are forced to figure out on their own what "other" services are available outside of different payors' lane or scope. The model continues to silo State programs from Federal programs from private insurance, which does not support the "no wrong door" goal that was universally supported by the Task Force. The result will be more confusion and frustration at all levels.

The model does not achieve economies of scale.

There is concern about how Colorado will be regionalized under this model. How will the proposed model avoid many of the same challenges experienced under the State's Medicaid program using Regional Accountable Entities? Proponents of the model discussed potentially using the RAE regions or perhaps even more or smaller regions. We have learned from the Regional Accountable Entities that each region must have sufficient population to be financially viable (i.e. economies of scale). Rural and frontier communities may not have enough "covered lives" to be economically sufficient under the proposed model, which could hurt access to a full continuum of services. Before moving ahead with the proposed model, we should require a complete fiscal analysis that addresses equity and looks at population, need, and other factors such as geography, race, ethnicity and income, to determine where resources need to be allocated. This should not be done based on politically determined geographic regions that may or may not have anything in common or follow natural patterns of service utilization.

The focus should be on getting state policy and financing right at the BHA level.

Some of the dissenting voters believe that contracting should be done on the State level, within the BHA. These voters do not agree that consolidation of mental health and substance abuse services will successfully be accomplished through the proposed administrative and coordination model.

As stated earlier, the Task Force was unanimous in approving the recommendation passed in July – to consolidate and streamline state functions under a Behavioral Health Administration. The dissenting vote on the proposed model does not reflect a lack of support for care coordination services, but recognizes these services are but one component of a comprehensive behavioral health system. Care coordination is meant not only to help navigate people to behavioral health providers, but also to help clients address social determinants of health by educating and empowering them and centering their needs in a care plan.

As appointed Task Force members, we are each accountable to ourselves, to our communities, and to Colorado, to put forward the best possible plan for improving behavioral health in Colorado. We reiterate that while we may not agree with every view articulated above, this summation of dissenting opinion accurately includes the reasons we've expressed for voting in opposition to the recommendation as presented. We sincerely hope the concerns represented will be validated and that alternative solutions put forward continue to be considered and integrated into Colorado's plan.

Thank you to the members of the Executive Committee and the entire Task Force for the opportunity to memorialize these opinions and for ensuring their inclusion in the Blueprint to Governor Polis.

Sincerely,

Behavioral Health Task Force Members Voting in Opposition to Recommendation to Create a Regional Care Coordination Structure:

- Jen Fanning, Grand County Rural Health Network
- Rana Gonzales, Colorado WINS
- Representative Tracy Kraft-Tharp, Colorado House District 29
- Valerie Schlecht, Colorado Cross-Disability Coalition
- Laura Teachout, NAMI – Colorado Springs
- Brian Turner, Solvista Health

Appendix G. BHTF Priorities for Phase One

BHTF Priorities - Phase One

IN THE CURRENT FISCAL YEAR (JULY 2020 - JUNE 2021), COLORADO SHALL:

- Design the Behavioral Health Administration that serves children and adults, including exploring Medicaid/private insurance alignment and collaboration and the integration of physical and behavioral health
- Expand/Increase Tele-Behavioral Health Services
- Identify new funding sources to support the implementation of the BHTF recommendations
- Convene subject matter experts to identify specific strategies to strengthen efficiencies and service outcomes for people with intellectual/ developmental/physical/all disabilities with co-occurring mental health conditions, to include tribal, LGBTQ+, forensic population and marginalized communities
- Develop a full implementation plan for the BHTF recommendations
- Continue stakeholder engagement and launch a change management plan
- Work with legislature on implementation of BHTF recommendations
- Invest in equity throughout all the recommendations and implementation

AND COLORADO SHALL STAY COMMITTED TO ONGOING WORK SUCH AS:

- Develop a plan to increase the number of high intensity treatment as well as develop a plan to strengthen and expand the safety net system
- Address high suicide incidences via the Suicide Prevention Taskforce
- Address bifurcation mental health and substance use disorder systems via activities such as the Behavioral Health Entity (BHE) licensing project, which is addressing the licensing issue

Appendix H. HCPF BH Recommendations

Alignment Across Agencies		
What are we aligning?	How do we do it?	How does this help?
Shared Patient Care Support Data	Insights into provider utilization and history	• Patients do not provide the same information over and over • Accountability to consumers and public to meet outcomes with public dollars
Reporting and Analytics	Shared data repository, analytics software, and analytics team	• Shared data to drive insights, policy, provider incentives, improved patient focus, health
Shared Provider Contracting and Incentives	One provider contract or two contracts with the same terms	• Recruit more providers to Colorado because of higher, aligned payments • Clearer standards for payment for providers that are aligned across programs • Clarifies provider focus to improve patient outcomes • If HCPF and BHA align on contracting requirements and language, it eases burden of compliance on providers • Potentially enables lower administration costs and therefore higher provider reimbursements
Telehealth	Support regulations and programs that increase use of and access to telehealth	• Better access to services, reduces barriers in transportation and child care • Addresses stigma - care from privacy of home • Expanded access to rural communities, people with disabilities, seniors • Convenient for patients; less no-show, more engagement in BH • Providers can see patient home
Federal Funding	Complete a full analysis of federal match opportunity, with a focus on crisis and community-based care	• Improved total funding available for BH services • Potential to look at municipal/county/other funding that is connected to law enforcement
Leadership Alignment on Key Focus Areas	Partner on workstream priorities, such as children, people with disabilities, people of color, BH provider recruitment to CO	• Focused priorities and results • Improved outcomes by community targets • Reduce duplication, costs while improving patient outcomes • Improve expert input and resources for previously under-resourced programs
Policy	Partner with BHA, DOI on finance/ policy innovation, some shared FTE	• Less patient and care variation across payers and programs • More focus on priorities to drive better outcomes
Community Engagement	Shared stakeholder processes like PIAC, grievances, comms	• All BH programs aligned for stakeholder input to present a united front, eliminate duplications seeking same insights, reduce stakeholder frustration • Better transparency and accountability on state's response

Alignment Across Agencies		
What are we aligning?	How do we do it?	How does this help?
Care Coordination Navigation - Getting Coloradans Connected to Support and Care	Partner on a shared navigation line for those who need direction; connects people to their BH care coordinators (all RAEs and the CCEs). Would require a shared data system and shared call center resources	• Improved patient satisfaction • Ease of care access • Earlier care intervention, treatment
Highest Need Patients	Shared funding for single site of inpatient care specifically created for highest risk patients that are difficult to discharge	• Enables discharge of long-residing members at hospitals who are no-longer at appropriate level of care because hospitals, care providers, and RAEs can not find a site who will take/care for them

Leveraging HCPF Systems, Building on HCPF Administration Competencies		
What are we leveraging?	How do we do it?	How does this help?
Medicaid contracting, payment reform and value based payment	Agree to align performance management outcome targets/ KPIs and value based payment for improved results. Potentially align contracts, duplicate language or share contracts Expand value-based contracting (i.e.: Hospital Transformation Program, capitation, incentives, other).	• Providers can focus vs trying to meet multiple priorities from multiple programs • Improved clarity to drive provider performance - quality and affordability • Improved health outcomes for patients • Increase access to high value services, more wellness care
Subject Matter Experts	HCPF subject matter experts are expansive: systems, finance, contracting, policy	• Underfunded programs that can't afford expert insights and lean on shared experts • Improve program results, efficiencies, outcomes
InterChange, (two components of the Medicaid Management Information System (MMIS))	Integrated BH and physical health administration for all state funded services, using interChange BHA can use interChange as their administration technology Integrated reporting, insights, and analytics	• Providers have a single system for claims adjudication and payment • Potential for consolidated BH reporting and analytics through HCPF BIDM (Business Intelligence and Data Management System) and its Data Analytics and Reporting Division • Reporting for BHA to drive priorities, results, improved member health • Insights - provider and member
Provider Credentialing	Work with RAEs to create a shared input for providing credentialing (front end of an already centralized credentialing partner) Expand access to BHA other programs.	• Reduced provider and RAE administration • Ease of credentialing burden on providers • Centralized list of safety net providers available to public and to providers making referrals

Improving HCPF, Evolution of Practices		
What are we changing?	How do we do it?	How does this help?
Payment for Essential BH Services	Create baseline criteria for services provided by safety net programs - identifies core safety net providers Unique incentives for these core providers to drive outcomes and recognize safety net focus	• Clients know what to expect from a safety net provider, and can get essential services services anywhere they go for care • Providers are accountable • Providers are paid according to performance, safety net results and focus
Approval for Payment (Utilization Management)	Create more transparent BH UM criteria among RAEs. This consistency can then be applied across BHA.	• Clients receive timely services, less waiting for approval • Increased provider satisfaction • Providers know what the standards are for reimbursement, instead of separate services by RAE/ payer
Crisis and Post-Crisis Care	Partner with BHA on a continuum of care for high needs patients • Process for addressing barriers to safe discharge and continuity of care • Shared funding for single site to care for patients who can not be discharged to any setting in current environment	• Patients are getting the right care at the right time, not languishing in hospitals • Patients feel supported in care transitions • Addresses challenges of patients that can't be discharged • Opens up needed BH beds
Creative Solutions, Systems of Care	Continue to evolve the creative solutions process for multi-system involved youth. All providers and payers using a single assessment tool for assessing children and youth for service array needs Address system gaps, payer conflict, access to service issues in a timely manner.	• Expedite service delivery for patients while payers argue the policy • Expedite care delivery for patients

Appendix I. Tele-Behavioral Health Recommendations

This set of recommendations is the result of the tele-behavioral health discussion that took place with the COVID-19 Special Assignment Committee on June 10th and June 24th, 2020, and were then edited by Committee members.

Note: Tele-behavioral health is defined as remote treatment, via telephone or video conferencing.

1. Because the telephone (and, now, videoconferencing) is how people connect to friends and family, tele-behavioral health may be an additional tool to deepen the relationship between the patient and the therapist. When used within comprehensive care plans, tele-behavioral health has the potential to reduce no-shows and cancellations. **RECOMMENDATIONS:**
   - Review research studies and literature reviews, incorporating current efforts, to determine the quality and effectiveness of tele-behavioral health services (in areas reflective of the Colorado landscape) as an element of the behavioral health service array.
   - Continue to study best practices to incorporate tele-behavioral health into the treatment continuum, and develop best practice guidelines on how to coordinate in-person and virtual care.
   - Conduct additional analysis to identify outcomes and understand the effectiveness of tele-behavioral health when used with specific populations.
   - Engage clients, caretakers, and families who are using tele-behavioral health for their input in how to improve and strengthen tele-behavioral health services.
   - Determine how many people have access to tele-behavioral health services (i.e., understand broadband access, access to technology, etc.). Determine how many providers are willing/able to provide tele-behavioral health services to understand the level of services available.
   - Quantify cost savings from the payer, provider and patient perspective. Determine any increased cost to payers , if any.
2. Both existing and prospective clients of behavioral health may be unaware of how tele- behavioral health could be embedded into their care plans. Tele-behavioral health has been in use across Colorado for decades, and new flexibilities have allowed for increased access for both clinicians and clients who may not have used it before. **RECOMMENDATIONS:**
   - Support providers who offer tele-behavioral health in developing campaigns and protocols to raise awareness of the resources (such as leveraging the contract with Prime Health to provide focused training and education for Behavioral Health providers, or replicating the training taking place within the RAE system).
   - Make available accessible and attainable training for best practices in tele- behavioral healthcare delivery that include how to transition to HIPAA compliant platforms.
   - Promote best practice guidelines to help clinicians decide when telephone or video-conferencing methodologies are best in meeting unique client needs.
   - Promote the Health at Home website (Healthathome.colorado.gov) and ensure it includes information about how to access behavioral health services.
3. Though telehealth provides an additional access point for people who are seeking behavioral health services, it is one tool in the toolbox for providers to assist clients that need access to a continuum of services that are locally available. Tele-behavioral health can be one important solution to augment resource-dry communities that lack certain types of local services, including specialists and those who serve people with unique needs, like those with limited or no English proficiency or are seeking LGBTQ-affirming care, or the person's preferred language, including sign language. Consumers should have the choice to utilize tele-behavioral health and in-person services. **RECOMMENDATIONS:** As the tele-behavioral health recommendations are implemented, continue to promote the following values:
   - Tele-behavioral health solutions must have a relationship with providers and services who offer in-person and other levels of care to help augment and enhance the needs of the individual client.
   - Consumers should have access to outpatient on-site care to ensure that clients truly have the option to visit in person, and don't feel restricted to only virtual options.

4 Emergency regulations and the flexibilities put into place in the spring of 2020 as a result of COVID-19 are soon going to expire. **RECOMMENDATION:**

- Review SB20-212, Reimbursement for Telehealth Services and other legislation, executive orders, public health orders, and state agency rulemaking and administrative changes. Identify areas not addressed and, where needed, conduct a full review to determine which regulations should be made permanent, modified or repealed

5 Rural communities currently participate in tele-behavioral health, but internet connectivity and broadband can be a challenge. **RECOMMENDATION:**

- The State should continue to strengthen its broadband infrastructure to give all Coloradans the option to use tele-behavioral health services, including internet, cell, satellite and telephone coverage. Explore and implement new innovations that support tele-behavioral health solutions without needing broadband or immediate cellular connection.

6 In times of crisis, vulnerable populations must be identified who are at heightened risk for lapses in care or other disadvantages which access to tele-behavioral health services, when adequately implemented, can help minimize. **RECOMMENDATION:**

- Ensure adequate, flexible resources are available to providers who proactively outreach and work with the most vulnerable populations. The systems need to be able to consistently and constantly address disparities to access to care in order to provide connectivity to individuals in need who otherwise do not have the technology and/or support necessary to engage in tele-behavioral health service. This may include providing technological hardware to clients, developing drop-in tele-behavioral health sites, or any other locally-designed and clinically-informed solution.

7 The most vulnerable populations are often hit the hardest during a crisis. **RECOMMENDATION:**

- Create a proactive outreach plan to identify and reach the most vulnerable populations prior to and when a crisis arises. Work with the populations to determine how to ensure these populations have access to tele-behavioral health, and how best to operationalize the plan.

Appendix J. Prevention Recommendations

Overarching Goal:

Prevent negative impacts of behavioral health conditions or experiences and prevent other experiences/conditions from rising to the level of a behavioral health condition.

Note: Behavioral health is a fundamental component to overall health. Behavioral Health is the integration of genetic, environmental, developmental, social and psychological processes where the Social Determinants of Health are some of the most significant risk factors for a host of behavioral health conditions.

STRATEGY: Use a public health approach to behavioral health, including both (1) treatment/recovery and (2) the intentional prioritization of prevention and promotion of emotional well-being.

Tactics:

- Focus limited resources toward populations that experience mental wellness disparities, and offer flexibility (e.g., funding flexibility) to meet unique needs of individuals beyond traditional healthcare delivery. Local communities should be able to invest in the resources, services, or materials needed.
- "Normalize" behavioral health by educating a myriad of audiences including the general public, and those individuals in trusted settings such as schools, libraries, emergency responders, area agencies on aging, aging and disability resource centers, primary care, WIC offices, agricultural businesses, pre-natal/post-birth clinics, and preschools.
- Identify and provide sustainable, flexible funding streams for local communities to prioritize primary prevention via community-led initiatives, education, screening and early interventions.
- Advocate for a three-generation approach to create a legacy of strength in coping with behavioral health conditions within families.
- Provide access to treatment and recovery services when needed.
- Create opportunities and incentives for treatment service agencies to employ and cultivate a workforce of providers representative of the community it serves.
- Prioritize early social emotional learning and supports for Colorado families.
- Explore options to cultivate and standardize Family Friendly Workplace policies in Colorado to create safe, stable, nurturing environments for families.
- Encourage, cultivate and incentivize evidence-based professional development in workplaces to support inclusion.
- Support the development and equitable enforcement of non-discrimination policies in workplaces and schools, explicitly listing protections for sexual orientation, gender identity, and marital status.
- Affirm an individual's right to the use of their name and pronoun(s) and use of facilities consistent with their gender identity.[1]
- Actively support Gay-Straight Alliances in schools.[1]
- Support comprehensive sexual health education in schools.[1]

[1] Adopted by the Suicide Prevention Commission July 26, 2019 background research and support can be found https://drive.google.com/file/d/1bED3tE40y9kl8Xz-rBNiwU1mtjPABC8cA/view?usp=sharing

STRATEGY: Enhance prevention initiatives.

Tactics:

- Build off of CDPHE's work of identifying opportunities for alignment and collaboration of prevention initiatives at the systems and policy level.
- Expand and scale prevention initiatives that have evidence of being successful.
- Develop a plan to address the Social Determinants of Health.
- Strengthen economic stability and supports for Coloradans, including food security, affordable housing, livable wage and other family-friendly workplace policies.[1]
- Promote programs such as Mental Health First Aid

STRATEGY: Integrate screening of behavioral health conditions into the service delivery model.

Tactics:

- Align with the recommendation that will result from the OBH screening tool workgroup. (Note for context: Per SB 19-195, CDHS is tasked with working with a group of stakeholders to select a developmentally appropriate and culturally competent statewide behavioral health standardized screening tool for primary care providers serving children and youth. The tools will be made available electronically for health care professionals and the public. CDPHE is tasked with creating training modules to educate providers on the available tools.)
  - Build on the work (from the bullet above) and pursue opportunities to embed screening and identification practices into healthcare delivery, social services, and other institutions where individuals gather and connect with their communities.
  - Ensure adequate reimbursement is provided for screening tools.
- Educate clinicians who are implementing screening, assessment, and diagnoses on developmental, environmental, or other factors that may impact behavioral health or resemble behavioral health concerns.
- Require and fund screening for all those entering the justice system.
- When screening is integrated, ensure there are mechanisms for follow-up and those are known by the screener.

STRATEGY: Ease access to therapeutic and supportive interventions.

Tactics:

- Coordinate school-located social-emotional curricula across districts and across other service delivery settings to achieve broader population-based prevention goals.
- Increase funding so that evidence-based interventions are not cost prohibitive.
- Integrate universally accessible social-emotional screening and mental health consultation into early care and learning, primary care and home visitation programs.
- Prioritize peer support models of care across the lifespan.
- Work with AAAs and ARDCs to explore opportunities to embed screening and supportive care into existing service models.
- Incentivize warm handoffs to increase engagement.
- Explore opportunities to use apps for access and for supportive interventions

Appendix K. Quality Recommendations

STRATEGY: Ensure all Coloradans receive the level of behavioral health care they need.

Tactics:

- The State of Colorado will research, develop and publish specific standards for network adequacy. Federal standards will be used to set network adequacy as a baseline, however those standards should be revised across the continuum to best serve Colorado. As Colorado-specific standards are being developed and published, how they are enforced should also be identified.
- The State of Colorado will set standards for access measures, wait time/waitlist limits and general care considerations, and convene all payers and strive for multi-payer alignment.
- These standards will be aligned with evidence-based best practices. Rural and frontier areas will adapt evidence-based practices as needed.

STRATEGY: Ensure Coloradans have a positive outcome(s) and feel a sense of improved quality of life because of those interactions with the behavioral health system.

Tactics:

- The State of Colorado will review findings from pilot programs as well as study current, respected systems and literature to understand how to measure a quality behavioral health system in Colorado.
- The State of Colorado will solicit input from State agencies, contractors, providers, and consumers on data collection and quality metrics.
- The State of Colorado will identify what data will inform stakeholders and the public of the quality of the behavioral health system.
- The State of Colorado will define how to measure if/when a consumer feels that his/her quality of life is improved as a result of their engagement in the behavioral health system, finding a balance between the patient and provider perspectives. Both patients and providers must be engaged in this process.
- The State of Colorado will review all data currently required to be collected by providers and understand how the data is used, and what is absolutely necessary to determine the quality of the behavioral health system.
- The State of Colorado will produce an "Outcomes and Performance Dashboard" that reflects the progress in offering a high-quality behavioral health system to all Coloradans.
- The State of Colorado will produce an annual statewide, unblinded "report card" for payers and behavioral health entities.
- These standards will be aligned with evidence-based best practices. Rural and frontier areas will adapt evidence-based practices as needed.

Appendix L. Parity Recommendations

VISION We envision a future in which every Coloradan - regardless of their socioeconomic status, gender identity, zip code, or race and ethnicity - understands the integration of behavioral health to their overall well-being and has access to a health care system that serves their whole health comprehensively and equitably.

GOAL The full realization of parity: Behavioral health care is accessible to all Coloradans comparably to physical health care.

CURRENT LANDSCAPE Parity in behavioral health is possible. The following recommendations capitalize on the foundation and momentum built in Colorado over the last several years. The Behavioral Health Ombudsman Office of Colorado (BhoCO) was established in 2018 to serve consumers and providers seeking support, navigation, and advocacy in accessing behavioral health services throughout the state and across payer systems. The State Legislature passed the Behavioral Health Care Coverage Modernization Act in early 2019 to further expand state enforcement of mental health parity laws in the commercial insurance market and the state Medicaid program, Health First Colorado. Applicable state agencies - the Division of Insurance and Department of Health Care Policy and Financing - have promulgated rules to ensure covered Coloradans have access to behavioral health care like physical health. The parity workgroup recognizes that this progress affects only a portion of Coloradans, and hopes to convert the following recommendations across payer systems and authority entities, including, but not limited to the commercial insurance market, Medicaid, and federally-regulated plans, like Medicare and ERISA plans.

While we have an unprecedented opportunity to improve access to behavioral health care, it must be noted that the following recommendations will not cure all barriers to behavioral health care in Colorado. The health care system is disjointed - in service provision and by payers systems - creating confusion for consumers and providers doing their best to navigate complex systems. Federal advocacy is also necessary to address parity violations in plans or programs not regulated by the state of Colorado. Finally, the current global pandemic has changed the landscape of healthcare broadly. In doing so, it increases the urgency of the need for behavioral health care that is safe and affordable. These challenges are certainly not insurmountable. Parity can be achieved with increased funding to entities like BhoCO and consumer education, strategic restructuring of the behavioral health system, and the implementation of the following recommendations, put forth by the Behavioral Health Task Force Parity Workgroup.

RECOMMENDATIONS Improve consumers' understanding of their rights and protections in the behavioral health care system.

- Promote consumer understanding on the integration of behavioral health in health care and insurance overall, and improve consumer education on their rights and protections within the health care and insurance systems.
- Require payers to educate consumers on their rights and protections within health insurance systems.
- Improve consistency across payers types, including state and federal programs, related complaints reporting processes, and create a "No Wrong Door" policy across systems.
- Ensure health networks are adequate to serve behavioral health care needs.
- Improve baseline understanding of true population-specific behavioral health network adequacy needs, as it differs from physical health network adequacy needs.
- Assess provider directories across payer systems for quality, accuracy, and adequacy standards to address issues related to ghost networks on a continuous basis.
- Improve behavioral health workforce capacity by reducing administrative burden, improving reimbursement rates and practices, and incentivizing providers to participate in commercial market networks, especially in rural and mountain communities.
- Simplify paneling processes across payer systems to reduce administrative burden and confusion by providers who are seeking to enroll in private and public health insurance programs.

- Increase reimbursement rates across payer systems to behavioral health providers in compliance with state and federal parity laws.
- Enhance workforce capacity and development practices.
- Increase in-person and virtual workforce capacity in rural and mountain communities throughout Colorado through incentives that include loan-repayment programs, reduced administrative burden in telemental health service provision, and reimbursement practices, including but not limited to psychological testing, in compliance with state and federal parity laws.
- Increase training on effective telemental health services provision to providers.
- Train, recruit, and retain specialized clinicians to treat moderate and severe cases in substance use, developmental disorders, special populations, geriatrics, and child psychiatry, among others.

The Colorado Daylight Partnership (CDP) is a collaborative effort led by the Mental Health Center of Denver (MHCD) and the Colorado Commission for the Deaf, Hard of Hearing, and Deaf Blind (D/HH/DB). *Its mission is to advance access to linguistically and culturally responsive behavioral health services for Coloradans who are D/HH/DB.* MHCD is a nationally recognized leader in designing and implementing behavioral health services for the D/HH/DB.

CDP representatives testified before the Governor's Behavioral Health Task Force (BHTF) on September 19, 2019, and January 14, 2020 to advocate for equitable access to behavioral health services for D/HH/DB Coloradans across the lifespan. On December 5th, 2019, the Commission with CDP hosted a town hall where consumers and families, providers and advocates shared their experiences with the BHTF. A summary of the town hall testimonies is attached at Appendix A.

CDP submits the following recommendations to advance access to linguistically and culturally responsive behavioral health services for D/HH/DB Coloradans. These recommendations support the BHTF's charge to develop Colorado's "Behavioral Health Blueprint" to transform the state's current behavioral health care system into one that is *integrated, accessible, accountable, efficient, and of high-quality* for all Coloradans, including those who are D/HH/DB. As experts in the field, CDP would appreciate the opportunity to work with the BHTF to further develop and support implementation of the recommendations. For further information and/or to request assistance, please contact Cliff Moers, Director of the Colorado Commission for the D/HH/DB (cliff.moers@state.co.us), Ric Durity, MHCD's Vice President of Development (ric.durity@mhcd.org) and/or Mary Sterritt, MHCD's CDP Director (mary.sterritt@mhcd.org).

Using data from Colorado's Office of Behavioral Health, CDP documented that less than 1,000 (about 3%) of D/HH/DB Coloradans received services from one of the state's community mental health centers or clinics. In stark contrast, these same methods showed that about 28% of Colorado's general population received services from one of the state's community mental health centers/clinics. Coloradans who are D/HH/DB, and other underserved populations, have the same right to accessible services and improved outcomes as the general population.[1]

In recognition of COVID-19 and its impact on the state's economy, CDP's recommendations are separated into two sets. The first would have a minimal impact on the state's budget and could be implemented in the short term; the second set would have a fiscal impact of about $1.2 million and is submitted as long-term recommendations. All recommendations support the rights afforded to people who are D/HH/DB under §504 of the Rehabilitation Act of 1973, Americans with Disabilities Act of 1990, and §1557 of the Affordable Care Act.

Short Term Recommendations

Recommendations 1-7 are based on CDP's Standards of Care that guide the delivery of behavioral health services for D/HH/DB Coloradans. They were developed with the support of the Colorado Department of Human Services and are posted at www.mhcd.org/cdp. Of importance to COVID-19 and any future pandemics/emergencies is the expanded use of tele-behavioral health to increase

[1] Coen, A.S. (2016). General Colorado Population vs. Deaf and Hard of Hearing: Estimated Population; people with Serious Mental Illness (SMI), Serious Emotional Disorders (SED), or Alcohol/Other Drug Diagnosis (AOD); Served by OBH (Penetration Rate); Population-In-Need (< 300% FPL).

access to behavioral health services found at Recommendation #5. Recommendation #8 is based on community input that informed the design of an integrated health care clinic for D/HH/DB adults.

Recommendations 1-7 ~ The State of Colorado shall require behavioral health providers to:

1. Integrate CDP's Standards of Care into existing policies, organizational plans, management, and monitoring activities, and cover them in staff orientations and training.
2. Ensure timely and effective communication access of the D/HH/DB client's choice at no cost to them during normal operating hours and at all points of contact, including, consent, Colorado Communication Profile, assessment, medication check and adjustment, treatment, social work, recreational, physical, or occupational therapy, psycho-educational classes or groups, and continuing services. Communication access shall include certified sign language interpreters, other communication services such as Computer Assisted Real-time Transcription (CART), captioned video materials, and an array of hearing assistive technology, as well as sign language fluent providers when available.[2]
3. Ensure that complaint and grievance policies address accessibility for D/HH/DB clients, including linguistic and cultural accessibility and strategies for identifying, preventing, and resolving conflicts, cross-cultural issues, or complaints by clients.
4. Ensure adequate time is available for communication with D/HH/DB clients in all settings, including scheduling appointments, consenting to services, and delivery of services.
5. Utilize tele-behavioral health when additional expertise from providers who specialize in services for D/HH/DB clients is needed to ensure linguistic and culturally competent services, including for consultation and/or direct service delivery.
6. Inform clients through prominently displayed visual and written information of their right to communication access through hearing assistive technology and interpreters/ communication services, as well as sign language fluent providers when available. Also include such information in promotional materials.
7. Ensure staff members who provide services to D/HH/DB clients have specialized training/ experience commensurate to their staff position to work with such clients or shall receive supervision by a staff member with specialized training/experience. To do so, CDP recommends that MHCD's statewide technical assistance and training initiative supported by Colorado's Office of Behavioral Health be sustained and expanded to increase statewide capacity to provide linguistically and culturally responsive behavioral health services for D/HH/DB Coloradans.

Recommendation 8 ~ State of Colorado shall develop and disseminate timely, and linguistically and culturally responsive behavioral health promotion and prevention messages, materials, and activities for D/HH/DB Coloradans. This need was highlighted during COVID-19 as there was a delay and limited dissemination of accessible public health information for D/HH/DB Coloradans.[3]

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[2] Recommendation 2 does not generally support the use of Video Remote Interpreting (VRI) except as outlined by the National Association for the Deaf (NAD) as a stop gap measure found at http://www.tararogersinterpreter.com/uploads/1/0/3/7/103709790/nad_advocacy_statement_use_of_vri_in_the_medical_setting.pdf.

[3] See *Perception and misinformation during the COVID-19 pandemic: A cross sectional survey of deaf and hard of hearing adults* at https://preprints.jmir.org/preprint/21103 in *U.S.NAD's position statement outlines emergency management best practices and principles* at https://www.nad.org/about-us/position-statements/position-statement-on-accessible-emergency-management-for-deaf-and-hard-of-hearing-people/

Long Term Recommendations

The State of Colorado shall:

1. Establish a comprehensive system of care with a continuum of linguistically and culturally responsive behavioral health services supported by a skilled workforce to expand outpatient behavioral healthcare and supportive services to meet the growing demand of the D/HH/DB population across the state.
2. Provide for the development and implementation of linguistically and culturally responsive integrated behavioral health and primary care practices/clinics serving D/HH/DB Coloradans to increase access to behavioral health care for this underserved population.

Appendix A

On December 5th, 2019, the Colorado Commission for the Deaf, Hard of Hearing, and DeafBlind (D/HH/DB) with the Colorado Daylight Partnership (CDP) hosted a town hall where consumers and families, providers and advocates shared their experiences with the Governor's Behavioral Health Task Force (BHTF). Several themes emerged that are summarized below with direct quotes in italics.

Equitable Access to Behavioral Health Care (mental health and substance use)

Coloradans who are D/HH/DB deserve equitable access to behavioral health care statewide and across the life span. The needs of Coloradans who are D/HH/DB are often overlooked because the population is relatively small, and the hearing world does not understand that those who are D/HH/DB are *"people just like them"* who are *"wired to communicate"* as a *"basic human need"*.

Hearing people often "*make assumptions about what D/HH/DB people need. It's not [because of] a lack of good intentions. It's because of a lack of exposure to people who are D/HH/DB. Without the ability to communicate there's no opportunity for meaningful understanding or connection…Try to imagine what it is like to be fearful and excluded everywhere because you can't understand what's going on because you can't connect [which can] lead to self-isolation, withdrawal, anxiety, and depression".*

Behavioral Health: Linguistically and Culturally Responsive Behavioral Health Care

"I tell people on any given day, it's easier to deal with being deaf than depressed and dealing with being deaf is hard…Behavioral health care dramatically improved my quality of life. I have seen what happens when people don't receive behavioral health care." We must make it accessible for everyone.

A study of D/HH individuals found that those who were deaf experienced a "*poor quality of life and high distress"* in comparison to those who were hearing. The study also found that deaf participants were "*two times more likely to experience personal trauma than the hearing population including emotional and behavioral and mental health problems associated with low self-esteem and rejection".*

Linguistically Responsive Behavioral Health Care

People who are D/HH/DB are afforded rights under the American with Disabilities Act, the Rehabilitation Act, and the Affordable Care Act. As a national civil rights enforcement law firm in Denver, one area we focus on is *"communication for deaf and hard of hearing people in a number of different situations including medical and behavioral health. We receive requests from the deaf community and from hard of hearing people who have been denied effective communication in the behavioral health system".*

The ADA and Rehabilitation Act apply to most health care providers. These statutes require communication. There's almost no context in which clear and complete communication is as important as behavioral health care. It's one thing to understand or be understood by a salesclerk or a waiter, another thing entirely not to understand or be understood by a mental health clinician or a doctor or someone discussing a serious medical issue. To ensure adequate care for D/HH/DB Coloradans, there are three important things: encouraging and promoting D/HH/DB clinicians who can give direct and clear communication; increasing the number of sign language fluent hearing clinicians who can at least direct communication and be immersed in the deaf community; and ensuring widespread awareness and enforcement of the communications requirements under the law.

Providers have no sense that they have the obligation to provide an interpreter or aids and services. Not true. The ADA and the Rehab Act place the burden directly on the provider to provide that service. I would encourage these best practices. Ask the deaf person how they prefer to communicate as required by Title II of the ADA. Ensure that you hire medically certified interpreters and certified deaf interpreters. Provide interpreters upon request. Don't tell deaf people to bring their own interpreter or a family member. And finally, do not insist on written communication with the exception for next appointment, directions to the rest room.

Ideally there would be no need for sign language interpreters in mental health settings. Instead direct communication between a sign fluent behavioral health consultant and the client is the best practice because mental health information is "*nuanced, contextual, and intimate".* In the interim:

- *No interpreter should set foot into a center without training on the mental health context, both in the therapeutic context and for psychiatric evaluations. That training is available at institutes throughout the country and should be required for those working in mental health settings.*
- Training for hearing providers on the *"limits of interpreting and the impact of interpreting, best practices when using interpreters,* and cultural training. *When possible, creating opportunities for prebriefing and debriefing before and after therapeutic sessions".*

People who have a diagnosis of hearing loss and mental health issues has grown considerably. The reasonable accommodations that are needed by hard of hearing individuals who encounter mental health professionals include face to face communication with limited or no background noise. A way to communicate when parties are not face to face can include Android and I-Phone applications, assistive listening devices, text, email, telephone relay, video conferencing calls such as Skype, any method that makes it easy and less difficult…that's the idea.

When accommodations are not provided serious consequences can follow. *"I had enough clients where I was able to do DUI education as a group and this was their second DUI. They informed me the first go around in treatment and education, they weren't provided interpreters. They went to class, they got their hours in, they met the requirements, and learned nothing. Got a second DUI".*

Culturally Responsive Behavioral Health Care

"Accommodations made with interpreters and flashing alarm clocks, don't address the cultural needs" of deaf clients in residential substance use programs because they were often the only deaf client at the facility. *"Imagine what it would be like for an individual to reach that point in their lives, okay, I have a substance use disorder [and] get in there and be totally isolated...Same is true for outpatient."*

The deaf community is relatively small. *"Everyone knows everyone, who wants to say I got a drug problem? There's a lot of negative stigma with addiction."* A client who was court ordered into treatment requested an interpreter for her assessment. *"[She] knew this interpreter from her professional career and was just mortified that this interpreter would likely connect that, and it would get out in the community".* Direct communication is extremely important. As a CAC, "*I have had clients tell me they have been so traumatized by the hearing in their lives."*

About 10 years ago, I had a full-time job, I had insurance, and I experienced depression. I was seeking counseling services. I reached out to my insurance company and asked if they had counsellors for individuals who are deaf. They said, yeah, sure do. [But they were] hearing interpreters. That's not a

good fit for me. A hearing therapist doesn't necessarily have a working knowledge of deaf culture. I got the runaround for two (2) months while my depression kept getting worse. We *made it happen, but I shouldn't have to fight. I should not have to fight just to get the services that I need to access. I needed to access those services quickly. I shouldn't be asked why do you want this or that? I have personal reasons to ask for a particular type of service*.

The Culturalization Model: You have the hearing world on one end and the deaf world on the other. Hearing interpreters will be more on the hearing world part. By placing a deaf interpreter in that situation, you get close to the real world of the person because they *will have more understanding empathy*. *The [hearing] interpreter and the deaf interpreter working together can make sure that the best communication happens*. *Hearing provider and the hearing interpreter are understanding each other. Deaf interpreter and deaf client would understand each other. That's the optimal situation.*

Oftentimes what happens when deaf people go into counselling, already their mental status can be very confused, emotional, not understand things clearly. When they get faced with a hearing interpreter, they work hard at processing the information. Gives them twice as much trouble trying to understand everything. Sometimes I have to really figure out what it is that the hearing interpreter is doing and making sure that the change in that language is done. I feel like I may not be able to convey my feelings and concerns. I might have thousands of questions I want to bring up and discuss. Because I'm not feeling as sure that the hearing interpreter can do that effectively, I eliminate many of those questions and I have to think very diligently about how am I even going to phrase that? That shouldn't happen.

I am late deafened.[1] *Signing is not my first language. And I still prefer English. I learned sign language…so I could participate in hearing society though I'm a hearing person who can't hear.*

Across the Life Span: Early Childhood, Education and Employment Experiences

Early Childhood

Recent studies demonstrate the harm caused "*when a child does not access language during the period where the brain elasticity is prime for language development resulting in language deprivation syndrome, which is an epidemic in the United States in the deaf community including Colorado".*

What's the end result? The child loses the opportunity to develop language, loses the opportunity to function as they should. If sign language is offered at all, it is taught as a last resort or a complementary intervention. Sign language is secondary to speech with medical and educational professionals resulting in deaf children not developing native like fluency in native American sign language or English. The current literature suggests that cochlear implants are insufficient for language acquisition and the advice not to learn sign language results in language deprivation. With the increased risk of behavioral health problems, this is a unique mental health syndrome that needs to be addressed.

My son doesn't have the English proficiency. His is emerging as a young person. "*He was three when we found out he was deaf. Six months of mental health services to overcome his issues of me adopting before I got him. He slept under my kitchen table for two years with Barney".*

[1] 'Late deafened' usually refers to a person who became deaf as an adult. People who are deafened after early adulthood are likely to communicate in a spoken language such as English. 'Prelingually deaf' typically refers to children who were born deaf or became deaf before they acquired spoken language. People who are deafened prelingually are more likely to communicate using sign language.

Education

The school system has lost its focus in the point of education for deaf kids. Needs are being neglected. Support is not set up. The services they need are difficult and expensive for school districts. They don't provide them. And then, we had to make up our mind if [our son] was going to go to a deaf school and give up his home life or if he was going to go to the area school and give up his deaf culture and his own knowledge of who he should be and who he is and how acceptable he is.

As a parent, your hands are tied. Already knew he had mental health issues. And then when he was graduating, he found alcohol and drugs when he went to college out of state. My son never came home. As in mentally. Physically, he came home. Mentally, he was not okay. When he got back from college, he put himself in at the age of 20, knowing he was the only deaf person in there, knowing they didn't have the resources. He did the best he could. He was isolated. He came out, finally. Ended up with a few DUIs. And put himself in again. Same problem. Kept asking for a deaf counsellor. The only place we could find was Minnesota. And Minnesota would take him. Colorado insurance refused to pay even though they couldn't provide him with any service that he needed. And you guys in Colorado made him do it with his hands tied behind his back. That's not okay. We got to untie their hands.

When individuals are hard of hearing higher education is often not pursued because of language deprivation. College wasn't an option. I am now still set back. I started later with school.

Employment

Came in middle class, now poor. Didn't feel I was disabled to work. But needed an interpreter to work. I gave up. Started doing volunteer work. On the flipside, I was able to finish college, get a master's degree, contribute to society. Proud of that looking back. And yet I've struggled.

The lifetime impact of hearing loss on the income is between $700,000 and $800,000. That's lost revenue for the State of Colorado. That's money we're not earning and paying in taxes. That means retirement savings. Nonexistent. Stunts their lives if they don't have support. They don't get promoted. I lived it. I don't think people should have to go through it and work so hard to learn how to live with it.

System of Care for Coloradans who are D/HH/DB

Hearing people can choose any and every service that they might like to access. For people who are D/HH/DB, their options are limited and almost non-existent. The services needed oftentimes are costly for organizations. Colorado needs to build a system of support that requires education and dedicated funding. Accessibility must be factored into every organization's budget and the system needs to call in a diverse group of people who understand the need. Deaf people themselves are the leaders we need.

A single agency on its own cannot subsidize a system of care for people who are D/HH/DB. Instead, state leadership is needed to establish an adequately funded statewide system of care staffed by a skilled workforce to increase access to a linguistically and culturally behavioral health care. The system also needs to develop and disseminate accessible information for people who are D/HH/DB.

To: Governor Jared Polis's Behavioral Health Task Force
From: Housing Subcommittee of the Task Force for the Treatment of Persons with Mental Illness in the Criminal Justice System
Date: July 2020
Re: Recommendations for Housing, Criminal Justice, and Behavioral Health

Executive Summary: Colorado is experiencing a homelessness crisis that directly intersects with consistent criminal justice system involvement and poor wellbeing, specifically behavioral health, across the state. Housing plays a vital role in reducing engagement with the criminal justice system and promoting excellent behavioral health. In order to advance housing solutions across the state and to amplify the impact of these solutions within their respective communities, the State and its partners must broaden the continuum of housing options, provide supportive services, develop cross-systems data and information sharing, and develop measurable outcomes.

Background: Colorado is experiencing a homelessness crisis due to a combination of rising housing costs, increased behavioral health needs, underfunded re-entry programs, and the lack of a robustly funded supportive housing infrastructure statewide. There is a strong correlation between this crisis and justice system involvement and behavioral health issues. There is also strong evidence supporting housing solutions as effective tactic in combating criminal justice involvement and stabilizing behavioral health needs. Taken together, safe and appropriate housing is a vital element to recovery, community safety, and a healthy and thriving Colorado.

Core Recommendations: In order to address the housing element of the intersection of criminal justice, behavioral health, and housing, we recommend that the State and its partners execute the following actions across five core domains:

1. Broaden the continuum of housing options from step down hospital care to bridge housing to family re-integration to rapid rehousing to permanent supportive housing;
2. Provide and improve supportive services along the entire housing continuum;
3. Develop and improve cross-systems data sharing and assessment tools that effectively and holistically identify needs, remove bias and discrimination, and ensure appropriate placement and access to the whole housing continuum;
4. Increase provider capacity for supportive housing and supportive services across the state; and
5. Develop measurable outcomes that are informed by local and national evidence and that help guide resource and funding allocation across the aforementioned recommendations.

Value Statements: Our recommendations were developed based on the following value assumptions and statements:

- Homelessness is intrinsically linked to sustained deterioration of wellbeing, specifically behavioral health.
- The criminal justice system should not be the default system for individuals living with behavioral health issues.
- Housing solutions must be holistic, culturally responsive, and person specific with the elimination of bias and discrimination, must delivered at the right time and the right place, and must foster community strengths.
- Interventions and solutions for with people experiencing crises must occur before they show up at shelter doors or institutions.
- Cross-system data, particularly on the lived experience of different racial groups, is essential to developing and implementing effective and scalable housing solutions.

Population of Focus: While we acknowledge that housing insecurity can and does affect nearly all segments of society, we have focused our recommendations on the lived experience of individuals with mental health or substance use disorders currently at risk of becoming homeless and who are or have been involved with the criminal justice system.

Partners: Effective and scalable housing solutions will require complex collaborations across sectors and actors. No one sector or actor neither can nor should take on solutions alone. It is critical that any solution build upon the unique strengths of the community in which it is situated. To that end, we recommend that the State use the most inclusive definition of partner as possible. A partner includes but is not limited to:

- individuals with lived experience;
- local organizations, such as faith-based and non-profit organizations, that work with individuals with lived experience;
- housing organizations, authorities, and experts, both public and private; individuals and organizations who have working knowledge of the cross section of mental health, criminal justice, and housing systems;
- local law enforcement agencies;
- county jails;
- social service and behavioral health providers; and
- peer State agencies, such as the Division of Housing at the Department of Local Affairs, the Department of Health Care Policy and Financing, the Department of Corrections.

When referencing partners in our recommendations, we are referring to this definition.

Appendices: Appendix 1 provides expanded recommendations with specific tactics that help achieve success in these core five domains. Appendix 2 provides relevant definitions for key terms. Appendix 3 provides supporting evidence for relevant recommendations. Appendix 4 provides the formal white paper produced for our Legislative Oversight Committee that has served as the basis for these recommendations.

Appendix 1. Expanded Recommendations

1. Housing Continuum: We recommend the State and its partners broaden the continuum of housing options from step down hospital care to bridge housing to family re-integration to rapid rehousing to permanent supportive housing by:
   a. Establishing permanent supportive housing as the goal for all individuals;
   b. Creating housing options that include a more comprehensive array of supportive services and supports that allow for movement up and down the housing continuum as determined by the assessed needs of the person;
   c. Developing and implementing assessment tools that account for all needs, including housing, behavioral health, and criminal justice, of an individual and that help guide allocation of housing resources across the housing continuum accordingly;
   d. Increasing the number of State housing vouchers to serve this population who are presently precluded from federal and local housing authority vouchers;
   e. Refining the definition of homeless and housing instability to include bridge housing;
   f. Ensuring that housing options such as bridge housing must be made available for both immediate and short-term housing needs with no time limits and in lieu of lack of availability for permanent supportive housing due to wait lists and must not affect an individual's vulnerability index score and long-term eligibility for permanent supportive housing; and
   g. Identifying and addressing continued barriers and expanding best practices regarding the use of bridge housing.

2. Supportive Services. We recommend the State and its partners provide and improve supportive services along the entire housing continuum by:
   a. Ensuring adequate access to and inclusion of supportive services in housing solutions;
   b. Re-defining supportive services to include any service found to be essential in keeping a person housed, including services ranging tenancy support services, including but not limited to flex funding, to vocational and life coaching services to case management to high intensity treatment;
   c. Aligning the supportive service continuum with re-entry strategies for individuals re-entering the community from institutions, start with high intensity services then reduce as stability improves and needs decrease;
   d. Developing a cross-system or braided funding approach to delivering supportive services;
   e. Affording the Department of Health Care Policy and Financing the authority to explore strategies to increase federal funding for supportive services, including but not limited to federal waivers;
   f. Using qualitative and quantitative data to assess the delivery models, utilization, and efficacy of supportive services and to guide subsequent policy and resource allocation decisions; and
   g. Providing technical supports, including licensing and billing guidance, to build capacity within community providers to deliver supportive services.

3. Data and Information Sharing. We recommend the State and its partner develop and improve cross-systems data sharing and assessment tools that effectively and holistically identify needs, remove bias and discrimination, and ensure appropriate placement and access to the whole housing continuum by:
   a. Developing and implementing a state-wide information infrastructure that: 1) aggregates cross system data for members that intersect the housing, behavioral health, and justice systems; 2) aggregates qualitative data, both from local initiatives and national evidence, to identify best

practices for interventions; and 3) enhances data sharing across various partners through strategies such as inter-agency data sharing agreements;

b. Developing and implementing accessible, user-friendly, public-facing accountability mechanisms allow for data sharing and cross-community learning, such as dashboards, that describe the effectiveness and outcomes of initiatives across the state;
c. Developing and implementing a statewide database repository that houses standards and best practices, including what housing options exist in Colorado across the continuum, and that aligns with existing housing resources, such as the Behavioral Health Capacity Tracking System;
d. Expanding 211 systems to improve the ability to determine qualifications and availability of appropriate housing continuum services;
e. Modifying the VI-SPDAT tool to reflect the definition of homelessness for individuals with behavioral health disorders and with justice system involvement and the inclusion of bridge housing within the housing continuum; and
f. Re-redesigning the present "point-in time" process and system, including HMIS, to determine the homeless population and to manage housing resources.

4. Provider Capacity. We recommend the State and its partners increase provider capacity to build local infrastructure for supportive housing and supportive services across the state by:
   a. Funding supportive housing pilots across the state to serve as innovation laboratories that develop local solutions for communities that lack the necessary infrastructure for this population;
   b. Providing hands on, in person technical support to communities to conduct needs assessment to determine their community's capacity to develop housing solutions, to leverage state and federal resources, including funding and best practices, to develop those solutions, and to hire and train local personnel to implement and lead these solutions and to develop local infrastructure;
   c. Providing funds for housing solutions during their early stage to ensure solutions have adequate support prior to achieving long-term operational and financial stability;
   d. Providing ongoing education and training, specifically on data systems, landlord recruitment and advocacy, and Medicaid licensing and billing, to recruit, build, and sustain infrastructure within local communities to deliver supportive housing services; and
   e. Developing a learning network of local-based leaders and practitioners to support the ongoing implementation of existing housing pilots and to advance promising practices to underserved communities across the state.

5. Outcomes. We recommend that State and its partners develop measurable outcomes that are informed by local and national evidence and that help guide resource and funding allocation across the aforementioned recommendations. Effective and successful outcomes of each recommendation above require:
   a. that all four areas be enacted and funded in parallel and or in coordinated approaches;
   b. that design and implementation of all four areas be informed by implementation science and developed with and by representatives of impacted communities including those with lived experience;
   c. that data is shared, collected, and used to inform both funding and policy decisions;
   d. that best or promising practices be applied or adapted to the unique strengths of individual communities; and
   e. that learned lessons and outcomes be gathered in a centralized repository and be made readily available to all Colorado stakeholders.

Appendix 2. Definitions

Recommendation 1. Housing Continuum

1. **Supportive housing**, as a practice, is defined as combining affordable housing with access to supportive services. Through these additional supportive services, and a housing-first approach, participants gain the opportunity to live stable, productive, and fulfilling lives. Permanent supportive housing is an intervention that combines affordable housing assistance with voluntary support services to address the needs of chronically homeless people. The services are designed to build independent living and tenancy skills and connect people with community-based health care, treatment and employment services.
2. **Rapid rehousing** provides short-term rental assistance and services. The goals are to help people obtain housing quickly.
3. **Bridge housing** serves as a short-term stay when an individual or household is either waiting to secure permanent housing or has secured permanent housing that is not immediately available. Bridge housing is generally used interchangeably with transitional or interim housing. Bridge housing is the preferred term in our recommendations.

Recommendation 2. Supportive Services

1. **Flex funding** is a gap funding at the provider level typically used to meet immediate needs that would otherwise place a person at risk of losing housing e.g. payment of rent late fees.
2. **Supportive services** include not only all mental, behavioral, and physical health support but also in-reach, outreach, housing search and counseling, engagement, and ongoing supports. The latter four elements, known collectively as 'Tenancy Support Services', are essential to ensuring supportive housing participants have access to the supports they need to secure and retain stable housing.

Recommendation 3. Data and Information Sharing

1. **Coordinated entry** is a process developed to ensure that all people experiencing a housing crisis have fair and equal access and are quickly identified, assessed, referred, and connected to housing and assistance based on their strengths and needs
2. **VI-SPDAT** (Vulnerability Index - Service Prioritization Decision Assistance Tool) is a survey administered both to individuals and families to determine risk and prioritization when providing assistance to homeless and at-risk of homelessness persons.
3. **HMIS** is a local information technology system used to collect client-level data and data on the provision of housing and services to homeless individuals and families and persons at risk of homelessness.

Recommendation 4. Provider Capacity

None.

Recommendation 5. Outcomes

None.

Appendix 3. Supporting Evidence

Recommendation 1. Housing Continuum

1. Permanent supportive housing has the strongest evidence base and is the ultimate goal for this population.
2. Bridge housing is an emerging solution, but a variety of factors have complicated its incorporation within the broader housing continuum and ultimate utilization.
3. Historically, permanent supportive housing has had multiple barriers due to capacity, federal and local requirements regarding access, and long waitlists even in instances where a person qualifies.
    a. For example, the present system, specifically the Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT), has the unintended consequences of incentivizing individuals to remain homeless on the street in order to access permanent supportive housing. The VI-SPDAT considers a person receiving bridge housing as no longer homeless and no longer in need of permanent supportive housing.
    b. This assessment disincentivizes the uses of bridge housing and consequently pushes the number of individuals living with behavioral health disorders deeper into homelessness.

Recommendation 2. Supportive Services

1. Securing adequate local investment for supportive services in certain communities is currently a significant barrier.
2. There exists limited funding for the critical supportive services needed to ensure that people with complex behavioral health needs can stay housed. This is especially true in non-metro communities where there is a shortage of Medicaid funded behavioral health providers.

Recommendation 3. Data and Information Sharing

1. Presently, there is no centralized place to access housing research, outcomes on housing pilots across the state, and availability of and requirements for services across the housing continuum. As a result, a person living with behavioral health disorders does not nor does his/her chosen family even know where to begin looking for housing resources in their community.
2. Currently, the Department of Health Care Policy and Financing and the Department of Corrections have begun to develop a cross agency performance measurement and dashboard to coordinate efforts on shared members who have a behavioral health condition and who are releasing from a state prison. This dashboard should be used as a model for public transparency tools.
3. The present system and tools, specifically the Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT), has the unintended consequences of incentivizing individuals to remain homeless on the street in order to access permanent supportive housing. The VI-SPDAT considers a person receiving bridge housing as no longer homeless and no longer in need of permanent supportive housing. This assessment disincentivizes the uses of bridge housing and consequently pushes the number of individuals living with behavioral health disorders deeper into homelessness.

Recommendation 4. Provider Capacity

1. Since 2017, the Colorado State Legislature has made significant investments in recognized housing best practices and has begun to develop a funding environment to expand these practices. Unfortunately, not all communities across Colorado are able to take advantage of the significant investments that the Colorado state legislature has made in supportive housing due to multiple barriers and challenges. Many communities across the state do not have the programmatic or personnel capacity to take advantage of state or federal funding sources. As a result of these

barriers, these communities have an unequal access to funds, in comparison to the rest of the state, to provide the critical supportive housing interventions for their local populations in need.

2. In addition, many communities also struggle to find providers equipped or authorized to deliver and receive Medicaid reimbursement for supportive services or services within a housing related environment.
3. Division of Housing's housing tool kit is a good resource for communities who have access to basic housing partners and providers for supportive services. Communities which lack this basic infrastructure needs more hands-on technical community support. However, Division of Housing does not have the capacity to offer that level of in depth, in person technical support across the state to meet the high demand. The recommendations outlined in this section will help address those barriers by strengthening local capacity to develop and manage local solutions.

Recommendation 5. Outcomes

1. Currently, the Department of Health Care Policy and Financing and the Department of Corrections have begun to develop a cross agency performance measurement and dashboard to coordinate efforts on shared members who have a behavioral health condition and who are releasing from a state prison. This dashboard should be used as a model for public transparency tools.

Appendix 4. Legislative Oversight Committee White Paper, August 2019

Recommendation

Develop and fund an "innovation pool" to build community capacity in two distinct areas for supportive housing.

1) State supportive services for local communities by a) education, capacity building, and pre-development in supportive housing; and b) data integration and resource collection.

2) COMMUNITY solicitation grants for a) supportive services (tenancy support) for supportive housing programs; and b) evidence-based innovative homeless prevention programs.

This approach will strengthen communities across the state in accessing supportive housing opportunities and resources. It will significantly increase a community's capacity to innovate within an evidence-based framework and sustain programs over time; ensuring homelessness is both rare and brief. The program ultimately gives communities the tools to minimize the possibility of individuals falling into, or recidivating into, the justice system.

Impact of Bill

The impact of this bill is to foster and fund supportive housing opportunities and build capacity through training and technical assistance, seed money, direct funding for program development and technical assistance during implementation. This will allow communities that previously did not have the ability to enter into the housing arena to both prevent homelessness and address their current homeless population. This effort will bolster data collection, evaluation, and access to resource information and availability of supportive housing programming. This data will allow the state to see the potential impacts on housing to some of the hardest to serve -- "frequent utilizers" of local public services, such as jails and emergency rooms, who are released to the street homeless, continuing the cycle of homelessness and contact with first responders. This bill also allows communities to go further upstream to help individuals who are in danger of becoming homeless to remain stable and housed.

Background Research

A. Summary of national research on homelessness and supportive housing

National data shows that the number of Americans caught in a revolving door between the streets, shelters, and jails may reach the tens of thousands. Roughly 48,000 people entering shelters every year are coming nearly directly from prisons or jails. Of the 11 million people detained or incarcerated in jails every year, as many as 15% report having been homeless. (National Alliance to End Homelessness; Homelessness and Incarceration Are Intimately Linked. Mindy Mitchell, March 29, 2018)

People experiencing homelessness are more likely to report having a criminal record than the general public (Burt et al 1999, Metraux and Culhane 2006). In addition, those who have experienced homelessness are overrepresented among those incarcerated in prisons or jails (Greenberg and Rosenheck 2008). Homelessness can be both a cause and consequence of having a criminal record. Among ex-offenders, those with mental illness have higher than average rates of homelessness and housing insecurity (Aidala et al., 2014; Brown et al., 2013; Council of State Governments, 2006; Fries et al., 2014; Herbert et al., 2015; MacDonald et al., 2015). Homelessness is not just a public safety issue but also a public health issue.

Homelessness is intrinsically linked to sustained deterioration of mental and physical health (Oppenheimer, Nurius & Green, 2016), costs communities roughly $30,000 per person experiencing chronic homelessness per year (Gibbs), and tears away at familial ties and community vitality.

Safe and stable housing is viewed as the foundation for individuals to prepare and proactively engage the process of reentry. Housing is important because it can provide a sense of security that gives social and psychological refuge from external threats and enhance overall well-being (Lee, Tyler, & Wright, 2010; Shaw, 2004). A home provides a place of consistency and control to engage in the day-to-day routines important to building social networks and establishing an identity of personal worth (Shaw, 2004). Residential stability provides a base from which to seek employment, focus on treatment, establish a social network within the community, and to comply with community supervision. (Faith Lutz; Jeffrey Rosky; Zachary Hamilton: Homelessness and re-entry; CRIMINAL JUSTICE AND BEHAVIOR, Vol. 41, No. 4, April, 2014, 471–491).

It is clear that incarceration and homelessness are interrelated (Greenberg & Rosenheck, 2008; Kushel et al., 2005; Metraux & Culhane, 2004, 2006; Tsai & Rosenheck, 2012). Housing programs can reduce the cycling of offenders between prison, jail, homeless shelters, and other public services.

Supportive housing as a practice is defined as combining affordable housing with access to supportive services. Through these additional supportive services, and a housing-first approach, participants gain the opportunity to live stable, productive, and fulfilling lives. There are two primary models, rapid rehousing and permanent support housing.

Specifically, ***rapid rehousing*** "provides short-term rental assistance and services. The goals are to help people obtain housing quickly, increase self-sufficiency, and stay housed. It is offered without preconditions (such as employment, income, absence of criminal record, or sobriety) and the resources and services provided are typically tailored to the needs of the person." (https://endhomelessness.org/ending-homelessness/solutions/rapid-re-housing/). ***Permanent supportive housing*** is an intervention that combines affordable housing assistance with voluntary support services to address the needs of chronically homeless people. The services are designed to build independent living and tenancy skills and connect people with community-based health care, treatment and employment services. https://endhomelessness.org/ending-homelessness/solutions/permanent-supportive-housing/. Between these two models, the majority of persons experiencing or at-risk of homelessness can be housed and stabilized.

One of the more enduring paths to ending homelessness–is to address the systemic problems that cause it. Failures of the social safety net is one of the major causes of homelessness. Research shows that it is critical intervene with people experiencing crises before they show up at the shelter door. Studies indicate that prevention is most effective when given to people at highest risk of becoming homeless. People often become homeless after they exit systems that have provided them with a place to stay, including foster care, prisons, hospitals, or military active duty. The key first step to preventing homelessness is to strengthening the social safety net. One such approach is to ensure that supportive services intended to help people maintain stable housing are easily accessible and targeted to address the specific needs of people in the community.http://www.evidenceonhomelessness.com/topic/homelessness-prevention/

Another are that research shows is critical in addressing homelessness is to address the data silos that prevent delivery of coordinated care. Silos make it nearly impossible for providers, pharmacies, and other stakeholders to work together for truly coordinated care. Siloed systems prevent all players from accessing and interpreting important data sets, instead, encouraging each group to make decisions based upon a part of the information rather than the whole. This results in short-term fixes that don't actually do anything to improve the sustainability of operations, or to resolve the root problem. For patients this is really bad news, as it results in delays in diagnosis and delays in access to treatments and appropriate care.

https://healthitanalytics.com/news/healthcare-big-data-silos-prevent-delivery-of-coordinated-care

B. Colorado-specific statistics

Colorado is experiencing a homelessness crisis due to a combination of rising housing costs, increased behavioral health needs, underfunded re-entry programs, and the lack of a robustly funded, statewide supportive housing infrastructure. Currently there over 10,000 persons experiencing homelessness in Colorado (https://endhomelessness.org/homelessness-in-america/homelessness-statistics/state-of-homelessness-report/colorado/?emailsignup&gclid=CjwKCAjwqNnqBRATEiwAkHm2BNgePP0WZKU7u8YaT97LK73vZ48YjZmCIJ0xtW40tLBS4yPYRxkSfxoCOZ0QAvD_BwE). Even more Colorado residents are unstably housed and on the verge of homelessness. Many of these individuals have mental illness, substance abuse challenges, or other disabilities that make it extremely difficult to house them without a coordinated approach that links them to both housing and robust supportive services.

A study of homelessness in seven Colorado jails by Jack Reed, Division of Criminal Justice; Department of Public Safety, 2018: https://cdpsdocs.state.co.us/ors/docs/reports/2018_Jail_Homelessness_Study.pdf found that nearly 40% (39.7%) of 491 inmates across facilities reported that they will be homeless after release from jail. Over 60% of homeless respondents reported needing mental health treatment compared to approximately 45% of non-homeless respondents. Across all facilities, non-homeless respondents were statistically significantly more likely to be charged a violent crime. In contrast, across all facilities, homeless inmates were significantly more likely to be charged with a drug crime and/or trespassing. A larger proportion of inmates reported needing mental health treatment upon release from jail than drug treatment, and the difference in this reported need was significantly greater for homeless than non-homeless respondents. Over 60% of homeless respondents reported needing mental health treatment compared to approximately 45% of non-homeless respondents.

The recently released Colorado Department of Corrections (DOC) Annual Statistical Report for FY2017 (https://drive.google.com/file/d/1opCqREUJL0YboXoJrqZtHkQnV5n9a85k/view) reported the mental health needs of DOC inmates on a scale of 1 to 5. Mental health needs in 2017 for Levels 3 to 5 (moderate to severe) showed 78.7% for the female population has moderate to severe mental health needs; 43.7% of the male inmate population had moderate to severe mental health needs. (pages17&32). The 2017 Report states that mental health needs for both genders have steadily increased over time. The average daily DOC cost per inmate per day is $104.51. The cost of San Carlos mental health facility for men is $265.53 per day. (page 8). Colorado Department of Adult Parole reports, from a point in time review on 7/31/19, that the DOC population paroling to “unsheltered homelessness” is 218 people, and those releasing to “short term, temporary housing” is 903 people, for a total of 1,121 out of the 7,885 people on adult parole.

The Colorado State Legislature has made significant investments in nationally recognized best practices in homeless service provision known as supportive housing. Supportive housing reduces emergency system utilization while increasing health outcomes for participants and is an effective tool in disrupting the cycle of incarceration, hospitalization, and institutionalization that often accompanies homelessness. Supportive housing is one critical element within the continuum of affordable housing options necessary to ensure everyone has a safe place to call home allowing early intervention for homeless prevention and preventing individuals from falling into the justice system.

Colorado's recent legislative investments have increased the number of supportive housing opportunities available to Coloradans experiencing homelessness across the state. The Homeless Solutions Program (HSP) was created through an appropriation of Colorado's Marijuana Tax Cash Fund and the Housing Assistance for Persons Transitioning from the Criminal or Juvenile Justice System Cash Fund. In 2017, the general assembly, based on the support and introduction by this task force's Legislative Oversight Committee sponsorship, enacted a SB17-21 provision requiring that, at the end of the 2016-17 fiscal year, the state treasurer transfer unexpended and unencumbered money appropriated for community corrections programs to a new fund; this fund is dedicated to assisting persons transitioning from the criminal or juvenile justice systems. SB18-016 ensured that the transfer occurs at the end of each state fiscal year. The work by this task force, and its legislative oversight committee, on SB17-21 and SB18-16 lead to the creation and passage of HB19- 1009, which broadens SB17-21 to include housing for people recovering from substance use disorders.

Unfortunately, many communities still struggle to access these funds and replicate housing solutions at the scale needed to make homelessness rare and brief. This bill addresses many of the barriers that communities across the state have in accessing these housing opportunities.

Subcommittee Process

To research the issue of why certain communities did not, or could not, access existing housing opportunities, our MHDCJS Housing Subcommittee convened innumerable meetings over the past year. Members of MHDCJS' housing sub-committee represent the Division of Criminal Justice (DCJ), Health Care Policy and Finance (HCPF), Volunteers of America (VOA), Colorado Coalition for the Homeless (CCH), Equitas, Family member with mental heath issues in the justice system, Metro-Denver Housing Initiative (MDHI- continuum of care/HUD), Latino Coalition, Community Behavioral Health Centers (CBHC), Colorado Dept. of Human Services, Department of Local Affairs (DOLA) Division of Housing (DOH), and attorneys practicing in mental health and justice arena. Other expert stakeholders were brought in where gaps existed and specific topic expertise was needed. Specifically, several subcommittee members attended DOLA/DOH's stakeholder meetings across the state to listen to direct providers, non-profit agency heads, shelters, and multiple housing project directors. The subcommittee is facilitated by DCJ-EPIC (Evidence-Based Practices Implementation Specialists). Part of our subcommittee's process was to list the gaps in housing and a list of actions /solutions to address the gaps from each of our respective positions. These actions/solutions were then rated in terms of level of need and level of impact. As a group, we then rated and prioritized the actions/solutions the committee should address. During this process, we also looked at the priorities that were compiled in the statewide housing stakeholder meetings. It should be noted that our subcommittee's priorities were consistent with the state stakeholder meetings' priorities.

The sub-committee determined that many communities across the state did not have the ability, manpower, or skill set to meet the requirements of the majority of current housing solicitations. Applicants that applied for the housing solicitations were most frequently communities which included large non-profits with housing experience, extensive knowledge and experience in housing voucher management, the Homeless Management Information System (HMIS) re-entry systems, Medicaid billing, supportive services, and staff to carry out the project. Communities without these resources found it an overwhelming task to even begin to learn all these skill sets, let alone address their limited critical resources and staff to coordinate and implement the project.

To allow all communities across the state to make use of the work that Colorado has recently done in the housing arena, it is essential to provide funding for mentorship and technical assistance to increase capacity in the areas of housing navigation, landlord tenant advocacy and recruitment, evidence based supportive services, Medicaid billing, and housing voucher administration. This assistance and increased funding will aid communities in preventing homelessness and decreasing the risk of those individuals falling into the juvenile and criminal justice systems.

Legislative Recommendation

To implement this recommendation, it is recommended that legislation in Title 24 of the Colorado Revised Statutes place the responsibility with the Department of Local Affairs, Division of Housing (DOLA/DOH) to organize collaboration, solicit grants, and to sub-contract as necessary to carry out the "innovation pool" in all four domains, in order to address Colorado communities' barriers in accessing housing grants and funding sources. In addition, the Department of Health Care Policy and Financing may seek any state plan amendments, federal waivers, waiver amendments, or other actions within its authority that may be necessary to implement this bill. Tenancy support services will be defined by DOLA DOH, allowing DOLA DOH to expand providers able to seek re-imbursements, i.e. social workers, case managers, housing counselors/navigators, etc. to carry out the intent of the bill. These professional will aid those individuals who are most needy and at risk of becoming homeless, or are homeless and at risk of falling into the criminal or juvenile justice system or recidivating into it.

Declaration

Therefore, the legislature declares that it is in Colorado's best interest to create assistance and opportunities for communities across the state who are struggling to access federal and state housing and supportive services funds through training and technical assistance, seed money, direct funding for programmatic support, supportive services, housing consulting services for program development, data collection, access to and evaluation of supportive housing programming and its potential impacts on housing some of the hardest to serve; and to provide state level collaboration and funding to interface between data systems, including but not limited to HB19-1287 data system, HMIS, and LINC (linked information network of Colorado).

To accomplish this, there will be developed and funded an "innovation pool" of resources in two distinct areas for supportive housing:

1) State supportive services for local communities by a) education, capacity building, and pre-development in supportive housing; and b) data integration, coordinated entry system, and resource collection.

AND

2) Community solicitation grants for a) Supportive services for supportive housing programs; and b) evidence-based innovative homeless prevention programs.

This effort will strengthen communities across the state in accessing supportive housing opportunities and resources, while significantly increasing capacity to innovate within an evidence-based framework and sustain programs over-time, making homelessness rare and brief, thereby minimizing the possibility of individuals falling into, or recidivating into, the justice system.

Specifically, these areas break down into four domains where communities can apply for assistance and /or funding in any of the four domains:

1). Funding for education, capacity building, and pre-development in supportive housing. This funding would pay for a statewide technical assistance program, modeled after the currently successful Pathways Home Supportive Housing Toolkit launched in 2014, to provide homeless service providers, law enforcement agencies, re-entry programs, municipal court programs, and other grass roots housing entities the ability to increase understanding of supportive housing interventions in their region, better leverage existing state and federal funding sources, and develop and implement a robust, innovative continuum of supportive housing interventions applicable to their community. It is anticipated that a minimum of the equivalent of two full-time positions skilled, and experienced in the below areas to teach and give specific technical support. Cost estimated to be approximately $175,000

a. Tool Kit Training and Technical Assistance: DOLA DOH will ensure qualified and expert technical assistance and training is dedicated to a Toolkit-like training and individualized technical assistance, to engage with community partners through regularly occurring outreach events, trainings, and intensive technical assistance focused on established best practices in homeless service provision. The training and technical assistance will focus on competency in the implementation and utilization of the below areas, but not limited to:

i. Supportive housing; including but not limited to rapid rehousing, Housing first, harm reduction, and trauma-informed care.

ii. Coordinated entry.

iii. Landlord engagement and recruitment.

iv. Input and management of HMIS data.

v. Medicaid system utilization, management, and billing.

vi. Supportive housing program services, implementation and evaluation.

vii. Help to communities to explore feasibility and design programming and services options in an evidence-based, innovative manner fitting the communities' needs.

b. Pre-development: Grants and loans available to support communities as they work to develop supportive housing interventions. This funding source would be used to cover the costs associated with planning and developing supportive housing interventions and programs. A grant fund

solicitation to expand best practices to up to six new projects to be funded with direct technical assistance from supportive housing consultants and approximately $30,000 for the equivalent of halftime position annually to support program coordination at the local community level.

i. All pre-development grant recipients will meet as a group at least one time per year to share their ideas, successes, and barriers with other grant recipients.

ii. All pre-development grant recipients will be required to learn and use HMIS, coordinated entry and Medicaid billing, follow appropriate evidence-based practices, and collect all data as requested by the department.

2). Funding for supportive services (tenancy supportive services) in supportive housing. Presently there exists limited funding for the critical supportive services needed to ensure that people with complex mental and/or behavioral health needs can stay housed. This is especially true in non-metro communities where there is a shortage of Medicaid funded behavioral health services. A recent study conducted for the City of Denver by the Corporation for Supportive Housing, a national expert in the supportive housing field, verified that it costs at minimum $7,200 a year for supportive services funding per supportive housing unit in Colorado. In addition, rural areas also struggle finding providers equipped or authorized to receive Medicaid reimbursement, or who receive adequate Medicaid reimbursement for services provided specifically in a housing related environment. Supportive services include, in-reach/outreach, housing search and counseling, engagement, and ongoing supports. These four elements, known collectively as 'Tenancy Support Services', are essential to ensuring supportive housing participants have access to the supports they need to secure and retain stable housing. Securing adequate local investment for supportive services in non-metro communities is currently a significant barrier in program replication. This bill would authorize the Department of Health Care Policy and Financing to seek any state plan amendments, federal waivers, waiver amendments, or other actions within its authority that may be necessary to implement any part of this bill. Tenancy support services will be defined by DOLA DOH allowing additional providers to be able to seek re-imbursements i.e. social workers, case managers, housing counselors/navigators, etc. to foster tenancy support services to the most needy individuals, at risk of becoming homeless, or are homeless and at risk of falling into the criminal or juvenile justice system, or recidivating into it. This bill would allow for 3 to 6 new projects totaling 1million for each project annually.

i. All grant recipients will meet as a group at least one time per year to share their ideas, successes, and barriers with other grant recipients and to learn from each other.

ii. all grant recipients will be required to learn and use HMIS, coordinated entry, Medicaid, housing voucher administration if appropriate, follow appropriate evidence-based practices, and collect all data as requested by the department.

iii. Supportive services reimbursed under this grant section will focus on non-clinical case management tenancy support services, including but not limited to tenancy supportive services, vocational/occupational training, clinical services, reasonable indirect costs, and daily living activities:(basic personal ***everyday activities*** including, but not limited to, tasks such as eating, toileting, grooming, dressing, bathing, and transferring).

iv. DOLA DOH will collaborate with HCPF to explore the possibility of expansion of new Medicaid providers/contracts and waivers based on the barriers faced by these new projects.

3) Homeless prevention. (3 projects of $500,000 annually each for a total of $1.5 million per year and 4.5million in a total for three years) These dollars will fund expansion of innovative evidence housing projects such as "transformational" housing, focusing on homeless prevention. Limited funding currently exists to support families and other caregivers as they work to keep vulnerable individuals in their homes. Preventing these individuals from entering the homeless system through more intensive interventions would generate cost savings as well as improved health outcomes and housing stability. Potential projects can be rapid rehousing programs and the creation of pilot programs for rural communities. Many communities do not need large supportive housing developments and would like to experiment with innovative models like co-housing; or much smaller apartment complexes, family reunification models, Host Homes, Safe at Home, Circles of Support, co-housing, or other innovative approaches, implemented through evidence-based practices.

Funding in this category would provide for three community-driven new evidence-based programs to analyze and develop smaller scale supportive housing models and interventions. The Department of Health Care Policy and Financing may seek any state plan amendments or federal waivers or waiver amendments that may be necessary to implement this bill and that tenancy support services" will be defined by DOLA/DOH, allowing DOLA/DOH to expand providers able to seek re-imbursements i.e. social workers, case managers, housing counselors/navigators, etc. to carry out the intent of the bill to foster tenancy support services to the individuals most at risk of becoming homeless, or are homeless and at risk of falling into the criminal, or juvenile justice system, or recidivating into it.

i. All grant recipients will meet as a group at least one time per year to share their ideas, successes, and barriers with other grant recipients and to learn from each other.

ii. All grant recipients will be required to learn and use HMIS, coordinated entry, Medicaid, housing voucher administration if appropriate, follow appropriate evidence-based practices, and collect all data as requested by the department.

4) Contract for the design and implementation for data Integration and resource collection. This funding would be used to increase participation in regional homeless data systems, supporting accurate reporting, program evaluation, and needs analysis. This funding would also further the creation of an interface of data systems related to supportive housing best practices, trainings, and resources that could be accessed statewide.

Bill would enable expert individuals to be contracted or hired to assess how Colorado communities can increase the usage of the newly created statewide HMIS and coordinated entry system, to better track populations in need, and those that would be served by this more robust supportive housing programmatic framework. After the initial HMIS assessment the communities receiving technical assistance support would also receive an additional funding to increase their capacity for data collection with the goal of creating a robust program evaluation that can show effectiveness and cost savings for local communities that are using supportive housing with high utilizer populations. This funding would also further the creation of a resource library related to supportive housing best practices, trainings, and resources that could be accessed statewide. Consultant would also work with HMIS administrative teams within the state's Continuum of Care (CoC) regions to determine sufficient funding to augment the new HMIS system to increase HMIS usage and support across the state.

a. Data Integration. Available to support communities working to integrate data systems for those experiencing homelessness with other community resources.

i. Connecting housing resources with Behavioral Health Capacity Tracking System Created by House Bill 19-1287 to help families, law enforcement agencies, counties, court personnel, and emergency room personnel to locate appropriate treatment options for individuals experiencing behavioral health crises.

ii. HMIS is a local information technology system used to collect client-level data and data on the provision of housing and services to homeless individuals and families and persons at risk of homelessness.

a. Each CoC is responsible for selecting an HMIS software solution that complies with HUD's data collection, management, and reporting standards.

b. Coordinated entry is a process developed to ensure that all people experiencing a housing crisis have fair and equal access and are quickly identified, assessed, referred, and connected to housing and assistance based on their strengths and needs.

c. HUD encourages (but does not require) CoCs to use their HMIS as part of their coordinated entry process.

iii. 211 - A simple and easy-to-remember number and web site that people can access when they need help or want to give help.

Database holds information about more than 8,000 services supported by more than 2,800 agencies across the state of Colorado.

Callers can speak live with referral specialists and receive comprehensive community information by dialing the three-digit number 2-1-1, or they may access health and human services online.

Accessible in nearly 100 percent of land-lined home phones and is a free, confidential call.

b. Resource Collection. Establish a resource bank on best practices in homeless service provision, which will be accessible to all statewide community partners. This will be based on existing systems, such as 211 and coordinated with other appropriate systems including but not limited to the data system authorized by HB19-1287.

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