COLORADO
Department of Human Services

Person-Driven Solutions for Behavioral Health Transformation & Care Coordination

Generated by:
People with Lived Experience from across the State

Supported by:
Civic Consulting Collaborative

Acknowledgements:
We greatly appreciate the time, dedication, and deep insights of our participants from across the state who shared their lived experience to envision an ideal behavioral health system and generate solutions to achieve that vision.

We also thank our volunteer facilitators at the summit, Elizabeth Brooks, Ricardo Matthias, Shelly Solopow, and Yolanda Dandridge, as well as our behavioral health support volunteer, Danielle Culp.

Citation:
Engelman, A., Bornstein, J., Becker, J., Drumm, K., & Vitello, J. (June 2021) *Person-Driven Solutions for the Behavioral Health Transformation & Care Coordination*. Civic Consulting Collaborative on behalf of Colorado Department of Human Services and people with lived experience of the behavioral health system.

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Executive Summary

In order to offer a behavioral health system that puts people first, the system needs to be built upon the input and ideas of Coloradans. In the first half of 2021, a community engagement effort was launched with a two-fold purpose:

Short term: To bring together people with lived experience of Colorado's behavioral health system working poorly and begin to discuss solutions for safe, affordable, effective care coordination that puts people first.

> *It was overwhelming to see so many people of color on a Zoom call, I have not experienced this. To hear a language translated/interpreted that I was raised with and shared with those in attendance to discuss issues relating to our community struggles we have had trying to care for those we love or have lost, touched my heart."*
> ~ Participant post-summit survey comment

Long term: To bring together the existing infrastructure for coordinated "local and consumer guidance" that centers people who experience the most disparities within the behavioral health system from across the state.

Thus, the engagement design aimed to gather people to discuss aspects of care coordination that seemed most pertinent to their shared identity or experience in addition to gathering people to discuss other aspects that seemed most pertinent to a shared regional perspective. Therefore, the engagement design included two phases:

1. Statewide Summit - focus on shared identity/experience
2. Regional Meeting - included participants from the prioritized identities/experiences in six regions across the state

Person-Driven Success Measures

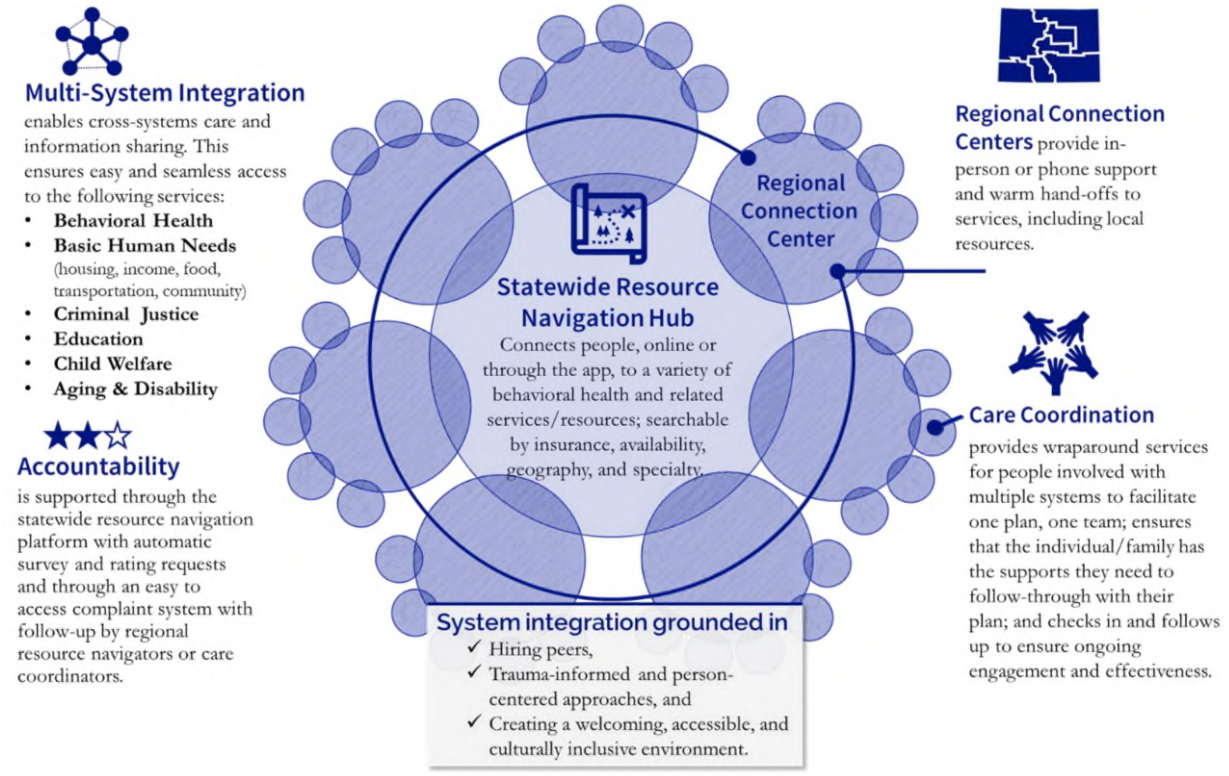
People with lived experience of the behavioral health system identified the following broad indicators for the ideal desired state during the summit. During the regional meetings, these success measures were refined by participants and used for quality control to ensure the solutions being generated led to this desired state.

1. Human-forward
2. Compassionate, humane, & trustworthy
3. Culturally relevant & respectful of others regardless of background, belief, or ability
4. Trauma informed throughout the system
5. Easily accessible, timely service options for all
6. Affordable service options available to all
7. Preventative & proactive
8. Grounded in peer support
9. Coordinated at all levels & across systems
10. Accountable

Participant Recommended, Person-Driven Structure for Care Coordination and Resource Navigation

Across all identity groups and regions, the need for a centralized system to learn about and access services, specific to behavioral health and also broader social and economic wellness needs was paramount. Therefore, many of the participants' suggestions are integrated into a Statewide Resource Navigation Hub with Regional Connection Centers (see Figure ES-1).

Figure ES-1: Statewide Resource Navigation Hub with Regional Connection Centers



A Statewide Resource Navigation Hub offers a single point of entry through a comprehensive, searchable, user-friendly website and app.

Regional Connection Centers provide an in-person option to ensure accessibility and that people feel supported in initiating care.

Care Coordination uses quality wraparound service models for individuals/families working with multiple systems.

Multi-System Integration enables cross-systems care and information sharing

Accountability is managed by a central agency at the state level that is responsible for review, complaint, and evaluation systems.

Additional Participant Recommended, Person-Driven Solutions

While still connected and relevant to the overarching solution of a Statewide Resource Navigation Hub & Regional Connection Centers described above, the following recommendations and solutions are separate and achievable outside the creation of a hub as they pertain to workforce development, training and standards, transitions in care, and specific system integration. The headline solutions are indicated below:

- Workforce: Invest in an expanded, more diverse, and better trained workforce;
- Training & standards: Develop, train, and monitor clear standards throughout the system;
- Transitions: Sustain support through care provision transitions; and
- System integration solutions: Align policies and practices for a seamless experience of care across the continuum.

Civic Consulting Collaborative's Recommended Next Steps

Below is a summary of our recommended next steps:

1. Continue meaningful engagement with people who have lived experience;
2. Consider majority-representation of people with lived experience for all advisory/accountability boards;
3. Invest in engagement infrastructure for the San Luis Valley and other rural areas;
4. Design safe, inclusive, culturally respectful, and meaningful future engagements;
5. Employ strategies for community-wide engagement; and
6. Align within and across systems.

> *I'm encouraged and inspired by the Polis administration and those facilitating this process that we can, as a compassionate statewide community, end so much needless suffering.*
> ~ Participant post-summit survey comment

Section 1: Introduction

Background & Purpose

On April 8, 2019, Gov. Jared Polis directed the Colorado Department of Human Services to spearhead Colorado's Behavioral Health Task Force. The mission of the Task Force was to evaluate and set the roadmap to improve the current behavioral health system in the state. In September 2020, the Task Force released its blueprint for reform, "Behavioral Health Reform in Colorado: Putting People First." The 148 recommendations fell into six pillars that represent the foundation of a strong behavioral health system (See Figure 1). The local and consumer guidance pillar recognizes that engagement with community stakeholders is critical for feedback and guidance on how best to meet local behavioral health needs. One of the key opportunities the Task Force identified to improve this pillar was "activate local community advisory groups and consumers to continuously provide guidance on system improvements."

Figure 1: The 6 Pillars of a Strong Behavioral Health System

The focus of the reform efforts to date have been on the first of the "Big 3" recommendations: create a Behavioral Health Administration (BHA). To plan for the second "Big 3" recommendation, people with lived experience were asked to provide guidance on solutions for implementing care coordination.

Moreover, the Task Force committed to behavioral health equity as foundational to all the system reform work and turned to the concurrent needs assessment that identified priority populations that the system needs to be transformed to better engage, serve, and gets results for, which include[1]:

- Black/African Americans
- Indigenous
- People of color, particularly those who speak Spanish
- Refugees
- LGBTQIA+
- Deaf, hard of hearing, deafblind
- People with intellectual/developmental disabilities
- People with brain injuries
- Veterans
- People who have been incarcerated, including for sex offenses
- People who have experienced houselessness
- Survivors of gender-based violence
- Pregnant or new parents with behavioral health challenges
- Parents/caregivers of children with complex behavioral health challenges
- Youth and young adults
- Older adults

Note: The use of the term "culture" is used throughout this report to encapsulate the myriad of identities, abilities, and life experiences that the system needs to more equitably include and support as participants and as part of the workforce, as outlined above.

Thus, the purpose of this community engagement effort was two-fold:

Short term: To bring together people with lived experience of Colorado's behavioral health system working poorly and begin to discuss solutions for safe, affordable, effective care coordination that puts people first

Long term: To bring together the existing infrastructure for coordinated "local and consumer guidance" that centers people who experience the most disparities within the behavioral health system from across the state

Details on the engagement methods and results can be found at the end of this report in Section 4.

[1] The priority populations identified include the marginalized populations that the Task Force enumerated: people of color; people with traumatic brain injuries; veterans, LGBTQ+ communities; people with disabilities; Deaf, Hard of Hearing and Deaf Blind Coloradans; older adults; and American Indian/Native populations.

Some of the Statewide Summit Participants

Section 2: Participant-Generated Solutions

This section contains the ideal experience for participants in the behavioral health system and their recommended solutions to achieve their ideal state. For a detailed description about how participants were recruited and engaged to generate these solutions and their demographic representation, see Section 4: Engagement Methods & Results.

Person-Driven Success Measures for the Behavioral Health System

Statewide summit participants shared how they defined a successful care coordination experience based on their shared identity/experience. At the regional meetings, participants refined a draft of their success measures that illustrated their collective vision for the behavioral health system they desired. These success measures were used for quality control to ensure the solutions they were generating would result in this desired state. The final draft of their success measures follows.

Human-forward: The behavioral health system is designed from the perspective of the person or family, not the providers or insurance companies. Care and success are defined by the person seeking care, and, if appropriate, family or caregivers. The system is easy to navigate and addresses the whole person/family - mind, body, spirit, heart, and culture - and their basic needs first (e.g., safety, shelter, food). This person/family first approach is tailored to them and meets them where they are, honoring their full humanity, agency, desires, culture, and potential. The individual/family is supported in becoming increasingly engaged in their health and wellness and are provided the support they need to be able to access services, understand their provider, and remember what they need to do.

Compassionate, humane, & trustworthy: A system that is supportive rather than punitive, connective rather than isolating (even in criminal justice settings), where appointments aren't rushed, money is not the driver to care received, and people across all ages feel heard and respected. People don't have to repeat their story over and over again. The system is designed to validate and support the diversity of people's suffering, trauma, life circumstances, co-occurring disabilities, and diagnoses, and where root causes are acknowledged, and harm reduction approaches are embraced. Feelings of welcome, joy, inclusivity are conveyed through both the physical environment and the disposition and use of accessible language by all staff. People feel listened to when staff remain curious, ask for clarification, and dig into the meaning of people's words, letting them into the most intimate aspects of their lives.

Culturally relevant & respectful of others regardless of background, belief, or ability: The system employs strategies to diversify and expand the behavioral health workforce at all levels so that people can work with providers who are culturally aligned. While the system works toward that desired state, regardless of geographic location, people are able to access a range of providers and home healthcare workers, who are open-minded, respectful, and sensitive to culture, language, religious beliefs, ability, neuro-diversity, and life circumstance, and who promote self-worth and social and community connection. Racism, xenophobia, homophobia, transphobia, anti-immigrant, religious discrimination, and disability prejudice are not tolerated, and training is provided to ensure staff are aware of and manage their internal biases and inherent power dynamics. Accountability measures are in place for when discriminatory issues arise. Policies and practices are intentional about advancing equity. At a minimum, this includes providing visual cues of commitments to safe spaces, access for people with a variety of disabilities, providing a variety of communication mechanisms, and language interpretation. Visual cues include indicators of LGBTQIA+ allyship such as pins, posters, or pamphlets, so that all feel welcome upon walking through the door.

Trauma informed throughout the system: Staff trust people's lived experience, seek to understand the person's whole self and story, drop all judgements to create safety and trust, and understand the signs, symptoms, and dynamics of trauma, including historical, generational, systemic oppression and violence. They see the person seeking care as being on a hero's journey and join their journey by uplifting the person's responsibility and ability to work toward healing and their goals and vision for wellness. Staff start with validating their challenge or loss and acknowledging their courage in seeking support. As the relationship matures, the provider is accepting of different rates of progress, including regression.

Easily accessible, timely service options for all: The right service options are available in a timely manner regardless of age, justice system status, or military benefits. This includes prevention, early intervention, and diversion. Crisis services should be available 24/7, in both rural and urban settings, using telehealth and mobile services when necessary. Timely includes filling the current lag between crisis intervention, such as in the emergency room, and time to the next appointment. All Coloradans know where to go when a behavioral health concern arises, and they have accessible pathways for getting the support they choose.

Affordable service options available to all: In lieu of universal healthcare, the system has a uniform payment system across Medicaid regions and private payers so that a multitude of service options are available regardless of insurance.

Preventative & proactive: People do not have to be in a life-or-death situation to receive behavioral

health services. For instance, those involved in the criminal justice system are incentivized to increase charges in order to be able to access needed treatment through diversion programs. Instead of this fail first model, universal prevention is provided throughout the community, including behavioral health education, stigma reduction, and public awareness campaigns. Early identification, including recognizing co-occurring behavioral health concerns, is built into the system to ensure those at an early age get the care they need to avoid longer, more intensive care in the future. Out-patient therapy, support groups, and educational opportunities are accessible without a referral or diagnosis.

Grounded in peer support: A successful behavioral health system includes peer specialist/advocates, who reflect the community, throughout the system, particularly with resource navigation and care coordination. Employing peers to work within the system recognizes the power of peers' shared experience and provides multiple benefits to the specialist and the peer for early intervention, recovery, and maintenance.

Coordinated at all levels & across systems: The system is cohesive and supported through local partnerships and coordinated between providers, close-by jurisdictions (including tribes), and other necessary medical and non-medical services. This means increased partnership, workforce development, communication, integration, and coordination at the local level and also between local and state systems across sectors. Continuity of care, including medications, is achieved. Behavioral health and social services are coordinated on behalf of the individual/family to reduce burden and increase follow-through.

Accountable: Providers, organizations, and the behavioral health system as a whole must be evaluated and accountable to achieving outcomes that are defined by and meaningful to those who use behavioral health services. Communities, particularly where disparities exist and persist, realize improvements, and see how the issues that they have identified are being addressed.

Person-Driven Structure for Care Coordination and Resource Navigation

Overview of the Statewide Resource Navigation Hub with Regional Connection Centers Solution

Across all identity groups and regions, the need for a centralized system to learn about and access services, specific to behavioral health and also broader social and economic wellness needs was paramount. Websites, apps, and databases were discussed with enthusiasm. Participants added that there also needs to be hard copy and in-person options locally. One participant likened the system to the national park system, which has multiple engagement options. There is a centralized online hub, searchable by key criteria, with online and phone reservation options. The national park system also staffs a visitor center at each park with staff members welcoming guests and supporting them in the process of making a reservation or just dropping in for more information. Visitors can also connect in-person with tour guides if they need specialized support or are going on a longer excursion. Although the national park system was only an example, it encompasses many of the qualities and features that all participants discussed. Therefore, we integrated many of the participants'

suggestions into a similar model, a Statewide Resource Navigation Hub with Regional Connection Centers (see Figure 2). An important next step will be hearing from participants on how this model fits with their thinking.

National Park Model

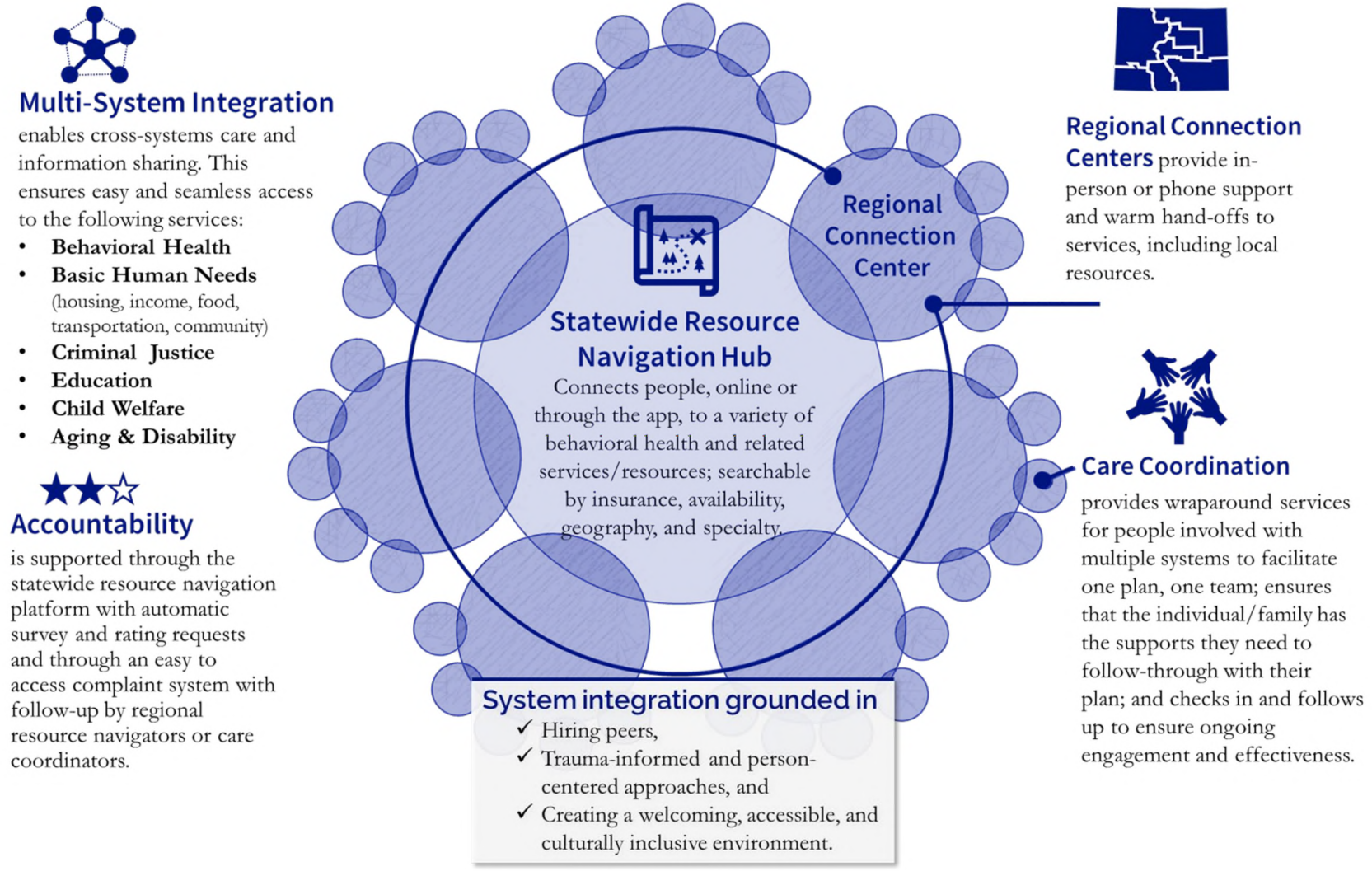
1. **Recreation.gov:** People can learn information, connect to resources, and book their trips using the app or website.
2. **Visitor Centers:** People can get the support they need for their trip to the park by calling or showing up to a visitor center.
3. **Trail Guides:** Visitors who need extra support or are embarking upon a more difficult journey can receive hands-on support with a guide.

In this model and throughout this report, we offer a clear distinction between resource navigation and care coordination. We heard two very distinct contexts (state vs regional/local) and solutions (resource identification vs care sensemaking) for each of these uniquely important roles. We also distinguish the different roles that state and regional/local navigators can provide. By the nature of care coordination being very hands-on and longer-term, a state level role for care coordination is not included in this model.

Critical Roles

- **Statewide resource navigators** are responsible for managing the website, researching federal and state resources, ensuring all the information is up-to-date, and that the website is functioning as designed. They provide technical support as needed by phone, email, or chat. Referring to the National Park Service metaphor, they are the people behind recreation.gov.
- **Regional resource navigators** provide short-term support to connect individuals/families to behavioral health, basic needs, and other system services (e.g., criminal justice, education, child welfare). They provide warm handoffs and support the application and appointment process to ensure everyone has access to timely and relevant services. Referring to the National Park Service metaphor, they are the visitor center staff.
- **Care coordinators** work directly with individuals and families, who are involved with multiple systems, as their primary point of contact throughout their wellness journey. They facilitate the care team to ensure information is shared, the plan is coordinated, and the individual/family is engaged with all aspects of their plan. Referring to the National Park Service metaphor, care coordinators are the tour guides.

Figure 2: Statewide Resource Navigation Hub with Regional Connection Centers



Statewide Resource Navigation Hub: Offer a single point of entry through a comprehensive, searchable, user-friendly website and app

Any Coloradan can access this statewide resource through their phone or computer at any time to search for behavioral health resources in addition to other wellness related services, including basic needs (e.g., housing, employment, food). State-level resource navigator staff continuously research resources to ensure the website/app is up to date with federal, state, and local resources and relevant eligibility information. They are also available to support people through the process by chat, text, email, or phone 24/7. State-level resource navigators communicate changes to regional resource navigators and care coordinators and support and train them in accessing new or complex resources. This ensures regional navigators and care coordinators have updated information and support to connect individuals and families to services in a timely fashion.

A public awareness campaign ensures every Coloradan knows that this website/app is the place to go when they have a behavioral health challenge. The campaign has a destigmatizing message, such as behavioral health is like physical health - *we all have it, so we all know where to go when there's a problem*. The campaign will need to adjust messages to help reduce stigma in a way that works for different cultures and geographies.
The website/app includes the following features:

- Providers are searchable based on payer, eligibility, current availability, geographic location, and specialization.
- Descriptions of the providers, their approach, including its evidence-base, and user reviews to facilitate choice and fit.
- Applications and insurance forms can be filled out immediately so appointments can be made through the website by anyone at any time. They are securely saved to minimize paperwork burdens.
- The system provides automated check-ins, reminders, and follow-up to support the individual/family in between sessions.
- When treatment is delayed due to availability, the system supports finding telehealth options or other short-term community supports to help in the interim.
- The system connects people to local and online peer support groups, including for young people and parents /caregivers.
- The system supports access to a robust home health care system, including Consumer-Directed Attendant Support Services (CDASS), where individuals/families can hire their own home health workers using the website or app.
- Behavioral health supports and respite care resources for families/caregivers are accessible through this website.
- Care coordinator matches are made through the app to guide people through the entire process, short or long term. (A more in-depth description of care coordination follows).
- The website/app is available in multiple languages.

- If a person wants to follow a practitioner when they leave an agency, they can use the website/app to determine where the provider is now working and easily transition their care to their practitioner's new agency.

Regional Connection Centers: Provide an in-person option to ensure accessibility and that people feel supported in initiating care

Regional, and local satellites to ensure accessibility, connection centers are welcoming, inclusive, and joyful; however, they also have private/hidden entry and exits available for those who need to remain discreet about their inquiry, particularly in small towns. Connection centers employ people with cognitive and physical disabilities to lead classes and host events for the whole community to decrease stigma and increase connection and joy. Regional resource navigators are employed and trained to welcome and support people in using the website/app to find the right fit for them in their geographic region, whether they walk in or call. Regional resource navigators understand how difficult the process is and make the experience easier and more effective, "like going into the Apple Store." They achieve this by providing:

Supports to individuals/families:

- Immediate access to certified interpreters, including ASL, to support anyone who comes through the door;
- Help filling out forms and making the appointment or provide a hard copy of the available resources if the person is not ready to make a decision at that moment;
- Follow-up to ensure they received the information they need to initiate or enhance their care; and
- Outreach to the community, particularly those which are hard to reach due to mistrust or stigma, to break down cultural barriers and educate people about what behavioral health means, the resources and services available in the community, and their rights as consumers, including the ability to refuse care if it's not a fit. Work with community leaders and navigators in immigrant/refugee communities and religious organizations so they can support the cultural interpretation and meaning making with their community.

Connections with providers:

- Research on local, community-based resources to include on the website/app and make sure the information is up-to-date;
- Orientations to new providers and frontline workers about what is available in the community to facilitate referrals through the website; and
- Meetings for service providers to connect, learn about, and coordinate with one another.

Care Coordination: uses quality wraparound service models for individuals/families working with multiple systems

Connected, yet separate, from the resource navigation and connection system are regional/local care coordinators, who provide specialized, individualized support and guidance throughout the behavioral health care process. While resource navigation is available to everyone, care coordination is reserved for individuals/families who are engaging with multiple systems. Quality care coordination supports individuals/families in the following ways:

1. **Basic human needs:** Care coordinators start with basic needs and ensure people's safety, housing, and food are addressed, so they can focus on their behavioral health, including harm reduction. Care coordinators are experts in accessing social services that support basic human needs, Medicaid/Medicare, disability waivers, and local employment. They ensure continuity of these services when people are in crisis.
2. **Understanding the process:** Care coordinators support the individual/family with clear and proactive communication, so the individual/family knows what to expect during the process and are equipped with the information to make decisions about their care. This includes providing access and authority to family members as appropriate and being clear about how behavioral health will be maintained through any transition processes. Care coordinators may also send out reminders about next steps.
3. **Full participation:** Care coordinators ensure that the individual/family can participate as fully as possible in their care by securing interpreters, child/older adult care, appointments, and transportation for all appointments. As needed, additional supports are employed with people who are neurodiverse to help them manage their time and calendar effectively.
4. **Cross system coordination:** Care coordinators share all relevant information with service providers across systems and facilitate communication to ensure continuity of care.
5. **Whole person/family care:** Care coordinators facilitate a team-based approach to care where all service providers develop and implement a seamless care plan that reduces burdens such as communication, eligibility, and time. The plan increases a holistic understanding of the individual/family's needs and services, including specialized medical management. The team supports the care coordinator in recognizing when additional specialists are needed and brings them on to the team.
6. **Coordinated handoffs:** Care coordinators provide warm or hot handoffs[2] to providers and resources to ensure a successful connection. Depending on needs, handoffs may include the referring party participating in the connection (warm) or remaining involved until the person is connected to the resource

[2] Hot handoff - A process that all service systems and service providers utilize when referring an individual between systems and services. Rather than providing the individual with contact information and the onus being on the individual, the referring party leads and participates in the connection. The referring party remains involved until the person is connected to the resource or declines services.

or declines services (hot), rather than simply providing contact information (cold) and the onus being on the individual.

7. **Regular check-ins:** Care coordinators check-in with individuals and families regularly to support their wellness journey. If they are not responsive, they knock on their doors to support their safety and re-engagement. This is done at least annually, though individuals/ families are able to determine the frequency. Follow-up check-ins are standard when an individual leaves the hospital or other facility within a week to make sure they are well and have transitioned to community-based services. Primary care physicians also follow-up after recommending behavioral health treatment. Follow-up could also extend care, such as extending prescription times so that there isn't a lapse.
8. **Clear and honest support:** Care coordinators also have hard, honest conversations with individuals and families. This includes an active role in supporting the individual/family's plan and progress, giving tools to practice moving toward their goals, and holding them accountable to acting in alignment with their commitments.
9. **Support self advocacy:** Care coordinators support individuals/families to develop self-advocacy skills so they can articulate their needs to others and potentially move beyond the need for a care coordinator or advocate.
10. **Care coordination specialists:** Care coordinators can specialize in working with specific populations so that they can have in-depth understandings of specific systems. For example, coordinators working with children and youth will need specialized expertise in the education system, including individualized education plans (IEPs) and how to advocate for the necessary supports, accommodations, and safety plans. Coordinators working with people involved in the criminal justice system need to be experts in navigating court requirements, particularly when they do not align with the behavioral health system's rules and regulations. They also need to have knowledge of the community resources people involved with the criminal justice system can access.

Multi-System Integration: Enable cross-systems care and information sharing

Integration and coordination across systems were discussed as critical in each regional group. The two primary areas needing coordination are cross-systems care and information sharing to ensure that individuals, families, and providers have the resources and information needed to be successful.

1. **Cross-systems care supports continuity:** Individuals/families are supported with a cross-system approach so that they have one coordinated support system for their whole health.
    - **All paths lead to care:** Systems integrate funding so that the multitude of potential resources are accessible to an individual/family regardless of which system they are primarily connected with initially. Systems do the difficult work in the background so that people easily access the supports

they need.

- **Trauma informed intakes and assessments:** Firstly, people are asked about their current struggle in a manner that is compassionate and validating. Additionally, the intake process is standardized across systems, so people don't have to tell their story more than once. Intakes implement comprehensive screenings and assessments early, after the person/family has had an opportunity to talk about their immediate crisis and feels heard and any previous intake and assessment data has been carefully reviewed. Providers use the information to design and enhance care while not asking clients to repeat their story. All assessments, particularly initially, need to be conducted from a trauma-informed lens and with extreme care and concern for the person(s).
- **Trauma informed transitions:** In partnership with transitioning individuals, jails, prisons, congregate living, in-patient, and other high-intensity treatment settings are required to work with community providers and supports to create person-centered transition plans prior to exiting the program or facility.

2. **Information sharing supports seamless care:** The necessary cross-system information sharing and communication is enabled to ensure seamless care provision across geographic and systems boundaries in the state.
   - **Medical information:** Medical information needs to be shared within the bounds of privacy laws and the choice of individuals. Although the health information exchanges were not mentioned explicitly, participants expressed this type of service is needed more broadly in the behavioral health system.
   - **Cross-systems information:** A set of data is needed to help coordinate across systems to support individuals/families, including between providers in the behavioral health system and across systems addressing basic human needs, education, criminal justice, and child welfare. In general, such systems will help ensure continuity of care, individual access, and be a support to providers.
   - **Records are available to people seeking care:** All records are accessible to the individual/family wherever they go, which is especially important for people to engage in their own care and reduce barriers for referrals.

Accountability: A central agency at the state level is responsible for review, complaint, and evaluation systems

Participants across all regional groups also made clear that a centralized system of accountability is absolutely necessary. As authors of the report, we recognize that this discussion overlaps with deliberations related to the Behavioral Health Administration and its role. Participants in the regional sessions were clear that providers should be protected in the case of small issues or nonissues, as their removal without serious cause could decrease access and support. Aspects of accountability as part of this hub model are discussed below as it relates to the creation of a central agency and includes the following elements, as depicted in Figure 3: 1) review, 2) complaint, and 3) evaluation systems at the state and regional level.

Central agency: A central agency is responsible for overseeing resource navigation and care coordination statewide with a high level of accountability, including a centralized location to file a complaint. Complaints are a means to jump start needed care. This agency also acts as a central watchdog entity that handles complaints and neglected care. Therefore, it needs a multi-stakeholder oversight board composed of people with lived experience or a panel of licensed providers, peers, and advocates for accountability and quality control. Here people can voice their complaint to determine if it is justified and next steps.

Figure 3: Central Agency Accountability Solutions

1. **Provider review system:** People are automatically given the opportunity to review a provider immediately after all appointments. Reviews are visible for others to see through the website/app, like google reviews. Similar to google reviews, participants recognized the system should protect providers from unfair reports. How to do this needs to be carefully considered and participants offered some ideas - the system could rule out chronic complainers, especially when their complaints are outliers; and fact checking reviews. Recognizing the complications, people still want to be aware of which providers can effectively work with particular communities and diagnoses. The reviews need to be analyzed and plans made to ensure the feedback meaningfully contributes to positive changes at the provider and systems levels.
2. **Complaint system:** People know who to make a complaint to and are able to follow a clear time-bound and timely process, regardless of English language ability, and without retribution, even in rural communities where anonymity can be difficult. Those who file a complaint need follow-up to understand what is happening during the process and what happened as a result of their complaint. When an individual is going through a behavioral health crisis, handling a complaint is just another level of trauma that has to be dealt with, so resource navigators or care coordinators are available to advocate for the person filing a complaint. Thus, resource navigation and care coordination positions must be independent of industry. Participants recognize the workforce shortage and want careful consideration prior to license removal; however, they do not want unqualified and unethical providers providing life-saving care.
3. **Outcome-based evaluation system:** Statewide standards, outcomes, and measurements aligned with the success measures are developed for each of the care coordination touchpoints. This formal evaluation of the system is used to improve delivery of all aspects of care, determine where interventions need to occur, and where progress is being made. By having a standards-based evaluation, the onus of accountability is moved from the people seeking care to the system providing care. The following accountability metrics were discussed covering most of the success measures.

- **Human-forward:** Person receiving care indicates that they are moving toward or achieving their definition of success.
- **Compassionate and trauma informed:** Person receiving care indicates that they don't have to get angry to resolve an issue and that they are treated as a human being without providers making assumptions. District attorneys, probation officers, and others adjacent to the behavioral health system also need to be held accountable, not just providers.
- **Culturally relevant and respectful:** Staff are held accountable to overcoming their biases to treat human beings. The system supports license removal when providers give biased and dangerous information. Providers are held accountable to ensuring equal language access, including for American Sign Language, braille, and a variety of other languages.
- **Easily accessible & timely service options for all:** Community-based options that don't require a crisis first exist across county lines. The system sets standards for the first appointment after a behavioral health crisis (e.g., after first overdose, after use of the emergency room, etc.). It measures the time that initial transition takes and for any transition to a new provider, with the goal of having no gaps in transitions.
- **Affordable service options for all:** Services provided are the services billed. Providers with limited in-patient space choose the individuals that need care the most rather than those for whom it will be easier to provide care.
- **Preventative & proactive:** Providers prevent complaints from happening in the first place, including asking if the individual or family has a substance-use problem in advance of prescription.
- **Grounded in peer support:** People seeking care have access to peers when they need them. Peers are hired as care coordinators and patient navigators most of the time.
- **Coordinated at all levels & across systems:** Disconnects between systems, such as the courts and the behavioral health system, are held to account by this system, so that those who need it have access to wraparound services to ensure they are supported from one place to another.

Participants recognized that it will be challenging to find the right metrics that are meaningful to those with lived experience and are available even in the face of privacy laws. One participant explained that they "would love to see more focus on exactly what 'should be' measured, what 'can be' measured, and how those outcome measures can really be used to baseline today, measure improvement, and inform future continuous improvement." Participants indicated that the qualitative aspects of the success measures could be identified through surveys or a "secret shopper." The evaluation system pays people who take a detailed survey minimum wage to fill it out. Such an evaluation not only covers system and regional issues, but also goes to the provider level and providers could lose accreditation if they consistently do not meet the standards. CHARG was held up as an example of providers and consumers setting standards together and working together to ensure and improve quality.

Person-Driven Workforce, Training & Standards, Care Transitions, System Integration Solutions

While still connected and relevant to the overarching solution of a Statewide Resource Navigation Hub & Regional Connection Centers described above, the following recommendations and solutions are separate and achievable outside the creation of a hub as they pertain to workforce development, training and standards, transitions in care, and specific system integration.

Workforce, Training & Standards

Workforce: Invest in an expanded, more diverse, and better trained workforce

For the behavioral health system to meet the success measures described earlier, state-level workforce development strategies are needed, such as:

- Provide sufficient training and compensation to incentivize and support people choosing a career in the behavioral health system, including providers, medication managers, home health workers, care coordinators, peer advocates, and resource navigators, that diversifies the workforce throughout the system;
- Tap into existing community infrastructure for natural supports, such as community navigators and Promotoras, to ensure that existing infrastructure includes behavioral health training and peer support;
- Incentivize providers, particularly those who identify with the prioritized populations, to stay in under-resourced communities and community mental health centers;
- Consider standards and mechanisms for paid leave to ensure providers' wellness and continuity in the workforce;
- Increase training and personnel to support people in crisis, even if they are considered dangerous, including co-responder such as Support Team Assisted Response (STAR) programs;
- Work with insurance providers to expand who can be reimbursed for mental health related services, including peer respite centers, peer specialists/advocates, community navigators, and religious leaders;
- Hire and train more peer advocates/specialists and community navigators to work throughout the behavioral system and with community agencies, including law enforcement. Train those agencies on the mutually beneficial relationship of having peers as part of their team;
- Create a clear path for reciprocity, so providers with licenses in other states can practice in Colorado;
- Expand addiction treatment options and availability; and
- Expand screening and counseling services in jail so that everyone is properly identified and supported for true rehabilitation.

Training & Standards: Develop, train, and monitor clear standards throughout the system

For the behavioral health system to meet the success measures described earlier, behavioral health staff need ongoing training, support, and reinforcement along with ethical standards, performance monitoring, quality

control, and accountability measures to uphold those standards and best practices. Training and standards for all behavioral health professionals need to include:

- Diversity, equity, and inclusion practices that address historical and internalized oppression and trauma, internal biases, stigma, and power dynamics;
- Cultural education about the communities/identities/abilities they work with and the skills to ask non-judgmental questions when they do not know something so that they can provide holistic support;
- Trauma-informed care, from assessment and diagnosis to evaluation and transitions
- Protocols and accountability for crisis response, including when the person denies/hides that there is a threat;
- Protocols and accountability for supporting transitions with continuous care, particularly from in-patient to out-patient, and developing safety plans for anyone with suicidality concerns;
- Confidentiality and boundaries; and
- Demonstration that providers have done, and continue to engage in, their own self-development and wellness work.

Additional needed training and standards for medical, licensed professionals includes:

- Careful and precise diagnoses and treatment plans, including for those with brain injuries, dual diagnoses, or co-occurring disabilities;
- Talking to individuals/families early about the possibility of medication and its side effects for specific diagnoses;
- Evidence-based practices for specific diagnoses, including medication assisted treatments and harm reduction, while also recognizing that evidence for effectiveness is often only conducted on people who identify as white and that these approaches may not work for other populations;
- Ensure competence, awareness, and understanding of dual diagnoses and substance use;
- Early intervention to break intergenerational cycles; and
- Training for primary care providers on not rushing to medication, especially without therapy

Transitions: Sustain support through care provision transitions

Transitions are a reality of life and can complicate wellness. Examples of care provision changes include:

- Crisis to management;
- In-patient to out-patient;
- Incarceration into the community;
- Insurance provider transitions;
- Legally being a child to legally being an adult;
- Primary health provider to behavioral health provider;
- Provider transitions due to moving; and
- Provider transitions due to turnover.

Many of these transitions are predictable. As such, the behavioral health system is responsible for proactively planning for these situations in partnership with individuals and families to ensure the following key elements.

1. **Care & medication consistency across settings:** Prior to a transition, the care coordinator ensures care and medication consistency within and across settings, including geographical locations, community agencies, schools, hospitals, jails, and Veteran medical facilities. Medical management exists at all levels and for all types of transitions, not just for those in crisis. This includes for the aging populations

and through insurance changes.

2. **Reentry to community out of in-patient and congregate settings:** Reentry support is available to continue progressing an individual's care, whether they are returning to the community after being hospitalized or incarcerated. Discharge plans include how the individual will reconnect with the community and access necessary services, including those for housing and employment, which may have been lost.
3. **Reduce and improve transitions due to turnover in the workforce:** As depicted in Figure 4 below, participants identified several opportunities to improve transitions due to turnover and even improve care. To reduce difficult transitions, create a commitment timeline in contracts with chargebacks if the practitioner leaves before their commitment is finished and even more so if they leave without ample notice. In addition, providers should implement hiring practices and incentives so that practitioners will stay in the community for more than two years. Ideas related to connecting people to a new provider include having a transition party where people can meet potential providers, a joint session with both providers that insurance pays for, opportunity to interview a provider, or at least a letter to inform people that a transition is happening. Once a transition has occurred, have the new provider ask what worked about care from the previous provider.

Figure 4. Reducing and improving transitions due to turnover.

System integration solutions: Align policies and practices for a seamless experience of care across the continuum

With behavioral health impacting many other areas of a person/family's life, a multitude of opportunities to better coordinate and integrate across systems exist beyond those articulated in the hub model. Participants called out the following specific solutions for focused attention to achieve the success measures described above.

- **Children, Youth, & Family Specific Prevention & Early Intervention:** Universal behavioral health screeners are employed in all school, primary and pediatric care settings and that

behavioral health education is provided to all children and families, preschool through graduation, focused on coping skills, resilience, and connection.

- **Behavioral Health First Aid:** Frontline staff in every state system, including at the regional and local levels, needs basic, trauma-informed, behavioral health training. This training should include signs, symptoms, basics of trauma, how to respond, and where to refer and get connected to support. People who work at the nexus of commonly triggering life changes, such as work to retirement, good health to poor health, able-bodied to disabled, loss of employment, and aging, need to be trained to identify potential risk factors so they can refer individuals to behavioral health services early to avoid crisis.
- **Care Co-location:** Models where primary care and behavioral health providers share facilities and work together, such as school-based health centers, are scaled, so hot handoffs and transitions are easy, and information is seamlessly shared across providers and systems.
- **Align rules to be family oriented:** When it is in the best interest of the individual receiving care, family and caregivers are afforded opportunities to support their children and adults in getting the care they need by loosening regulations restricting the ability to make an appointment, apply for waivers, and help coordinate care. For many family members, it can be confusing when they are asked to leave the room; thus, clear explanations as to why and when it is necessary are important.
- **Payer advocacy for better person-centered care policies:**

  Support Providers: Support providers in receiving payment and supports needed for improved person-centered care by:
  - Paying providers for their preparation time to review existing intakes, histories, notes, and other records;
  - Reducing paperwork burden required by insurance; and
  - Allowing the provider and individual to determine the appropriate care as opposed to care being determined by insurance limitations on medications, days in-patient, location, number, or time of appointment (even if outside typical work hours).

  Support individuals and families: Payer modifications are also important for individuals and families to receive the care they need, including:
  - Transparency about the cost of specific medications for various insurance plans;
  - Establishing access across insurance providers to decrease time delays and disruptions in care due to a move or change in employment;
  - Payment models for the Regional Accountability Entities and private insurers tie payment to achieving defined outcomes and excellence in care; and
  - Individuals have the right to refuse care if a provider is not a good fit, including a cultural, stylistic, or approach mismatch.
- **Expanded and integrated crisis system:** The crisis system is able to respond to behavioral health crises appropriately, even in rural and tribal communities. Opportunities exist to braid emergency funding at the local level, increase the ability for behavioral health professionals to respond to relevant 9-1-1 calls, and expand jurisdiction regulations, particularly with and around tribal communities. The crisis system also needs to expand its language access with more interpreters.

Section 3. Civic Consulting Collaborative's Recommended Next Steps

> *I felt heard and acknowledged which brings me a sense of fulfillment.*
> ~ Participant post-regional meeting survey comment

The Civic Consulting Collaborative team was honored to facilitate hearing and understanding the brilliant ideas of those with lived experience. We are thrilled with the planned investment Colorado is making into care coordination and the behavioral health system in ways that are closely aligned with the ideas of the community. We recognize that much work remains with the reform effort and strongly believe that continuing authentic engagement with those who have deep lived experience, particularly those with identities/experiences that suffer the most disparities from the system not working, will be critical to the success of the transformation of the behavioral health system. Continuing this effort will ensure the Local and Consumer Guidance pillar for the new behavioral health system is strong (refer to Figure 1). To that end, we recommend the following next steps.

1. **Continue meaningful engagement with people who have lived experience.** For decades people with lived experience and diverse identities, experiences, and geographic locations have been advocating to be at decision-making tables for the behavioral health system. Of those who took our survey after the regional sessions, 85% indicated that they wanted to participate in behavioral health transformation working groups and 82% in regional groups. The people who contributed to this report are the right people to be engaging in future design, implementation, and evaluation discussions. After participating in these discussions, 75% of participants felt optimistic about Colorado's behavioral health system. Thus, we strongly recommend continued meaningful engagement at the collaboration or shared leadership levels (see Figure 5) in partnership with this amazing set of individuals in the near future.

Figure 5: Community Engagement Continuum

Increasing Level of Community Involvement, Impact, Trust, and Communication Flow

Outreach	Consult	Involve	Collaborate	Shared Leadership
Some Community Involvement	More Community Involvement	Better Community Involvement	Community Involvement	Strong Bidirectional Relationship
Communication flows from one to the other to inform	Communication flows to the community and then back, answer seeking	Communication flows both ways, participatory form of communication	Communication flow is bidirectional	Final decision making is shared with the community
Provides community with information	Gets information or feedback from the community	Involves more participation with community on issues	Forms partnerships with community on each aspect of project from development to solution	Entities have formed strong partnership structures

Reference: Modified from the International Association for Public Participation

The momentum and infrastructure built to engage these community members is exciting and should not be wasted. As part of this recommendation, a second statewide summit should be planned within 12 to 24 months of the first one held in April 2021 to share ideas and enthusiasm across regions.

2. **Consider a majority representation of people with lived experience for all advisory/accountability boards.** While the groups we engaged with were 100% made up of people with lived experience using the behavioral health system, it may be appropriate to integrate participants from organizations at the provider, nonprofit, and systems levels. In our experience, multi-stakeholder groups bring tremendous insight and understanding across those who need services and those who are working to support those individuals and family members. If and when advisory or decision-making bodies are formed at the statewide or regional level as part of the behavioral health reform, such groups should be at least 51% made up of those with lived experience to ensure broad representation of identities, experiences, and geographic locations. This will also demonstrate an acknowledgement in the power differential and a strong commitment to honoring lived experience expertise. We recommend these groups' engagement extends beyond care coordination and applies to the behavioral health reform work in general.
3. **Invest in engagement infrastructure for the San Luis Valley and other rural areas.** Ultimately, participants resided in 24 of Colorado's 64 counties. Although this represented every region of the state, including many rural areas, large areas of the state were not represented, particularly in the San Luis Valley. This is in part due to a lack of infrastructure in these areas for connecting people to the behavioral health system in general, and even more so due to the lack of advocacy, peer support, and community leadership organizations and infrastructure. This creates a cycle of continuing not to get the care needed in many parts of rural Colorado because it is difficult to hear their voices. Thus, we recommend that an investment be made in building infrastructure for community voice in the San Luis Valley and other rural areas. Although foundations and universities have been making investments and efforts to pull stakeholders together in the San Luis Valley, of which we tried to tap into, we were only able to engage one community member with lived experience from the Valley. While our approach worked well in most regions, it did not in the Valley because as we learned, statewide advocacy organizations have little to no infrastructure there. In addition, engaging virtually only increases the known cultural, internet access, and trust barriers to state-led and statewide events. One small investment that could be made is to host mixed meetings where people could participate virtually or in person using some of the latest mixed meeting technologies that allow virtual participants to see the individual people talking.
4. **Design safe, inclusive, culturally respectful, and meaningful future engagements.** We applaud the Task Force in prioritizing marginalized populations and behavioral health equity in the blueprint and recommend intentional recruitment and retainment strategies and budgets to achieve these aspirational goals. For the first step of

> *Great facilitators who respected and listened to all and, also validated what was written was correct.*
> ~ Participant post-regional meeting survey comment

recruitment, we suggest that future community engagement opportunities continue to build authentic relationships with some of the harder to engage priority populations, such as Black/African American, Indigenous, monolingual Spanish speakers, and refugees. To build trust and authentic community engagement, we recommend the following practices:

- **Partner organization or community liaison approach:** Build strong relationships with statewide and local organizations and people, especially those who have deep connections with harder to engage priority populations indicated above. Work with them to identify people and the supports people will need to engage.
- **Partner organization compensation:** Compensate partner organizations at acceptable rates for the time they invest in developing trust and leadership among their constituents.
- **Participant compensation:** Participants continue to be compensated for their time at rates that respect their time and expertise.
- **Participant accessibility:** Ask partner organizations and participants what supports are needed to support full engagement and accessibility. Provide live captioning at all future meetings and Spanish, ASL, and any other language interpretation as needed. For in-person meetings, food, transportation, and childcare should also be provided.
- **Clear expectations:** Provide clear, honest communication with follow-through and follow-up in order to sustain community engagement and build authentic relationships with individuals and partner organizations. Be clear about how participant ideas will or will not be used; and be honest about any limitations.
- **Materials in advance:** Provide participants with all the meeting materials and the questions being asked of them in advance, so they can be prepared. This is especially important for blind participants and those who need more time to process the material.
- **Feedback loop:** Engage in best practices for community-engaged research, which provides participants the opportunity to correct, clarify, or add anything to the researcher's analysis. We also recommend post-meeting surveys to understand what worked and what could be improved upon. Participants will notice when their feedback is acted upon.
- **Ground rules for Emotional Safety:** In order to ensure participants engage in future meetings that are inclusive, safe, and meaningful, we recommend future meeting design starts with the ground rules we developed with some of our organizational partners and verified during the Summit (see Appendix B).

5. **Employ strategies for community-wide engagement:** While work with smaller groups is critical to making decisions and progress, getting a broader representation of the community is also critical to ensure no one feels left behind and voiceless in such an important and far-reaching reform process. We recommend the development and implementation of community-wide conversations that build off the connective infrastructure this project launched. For instance, current participants could be supported to guide conversations with their community or to gain feedback or be liaisons in engaging their peers in an online forum.

6. **Align within and across systems:** The suggested Statewide Resource Navigation Hub with Regional Connection Centers models vertical integration from local to state geographic levels as well as horizontal integration across systems. Whatever future structures exist, we recommend they integrate across both of these levels in decision making structure, accountability, and communication to, ultimately, achieve parity for the needed services.

> *I'm encouraged and inspired by the Polis administration and those facilitating this process that we can, as a compassionate statewide community, end so much needless suffering.*
> ~ Participant post-summit survey comment

Section 4: Engagement Methods and Results

Engagement Design

In addition to the priority populations having shared experiences that would inform their perspective on care coordination solutions, where people live within Colorado was also another important perspective. The regional approach was developed based on several geographic considerations. At the root of the geography is a concept we are calling "care sheds." This is similar to the concept of a hospital catchment area, but more broadly based off where people go when they have higher intensity needs. To influence the map, we also considered the Regional Accountability Entities and Office of Behavioral Health regions for substance use disorder. The result was seven regions which are listed below and in the Figure 6 map on page 30.

- Region 1: Western Slope
- Region 2: Southwest
- Region 3: Northeast
- Region 4: Denver Metro
- Region 5: Pikes Peak
- Region 6: Southeast
- Region 7: San Luis Valley/South

Thus, the engagement design aimed to gather people to discuss aspects of care coordination that seemed most appropriate to their shared identity or experience in addition to gathering people to discuss other aspects that seemed most pertinent to a shared regional perspective. Therefore, the engagement design included two phases:

1. Statewide Summit - focus on shared identity/experience
2. Regional Meeting - included participants from the prioritized identities/experiences

Statewide Summit

The virtual statewide summit was held on April 14, 2021, with the goals of providing all participants an orientation to the behavioral health reform work and care coordination specifically, and for shared identity/experience groups to come together to define successful care coordination and brainstorm solutions for a successful experience with a provider. Colorado Department of Human Services' care coordination vision video was shown, and then the care coordination process was broken down into five key touchpoints:

1. **Initiating Care:** Reaching out for help, identifying service providers, filling out eligibility paperwork, and getting an appointment or into a program
2. **Experience with Provider:** The educational, intervention, or treatment program and the person(s) facilitating the therapeutic environment/relationship
3. **Connection to Other Services:** Coordination of additional non-medical supports, such as housing, family supports, transportation, school, and employment
4. **Transitions:** Sustaining support through life or care provision changes
5. **Accountability Process:** Making a complaint; what to do if things go wrong

With the support of volunteer facilitators from the Colorado Department of Human Services and a community partner, participants were able to self-select a breakout group that reflected one of eight potential aspects of their identity/experience that they feel is most important to their wellness. Facilitators, who also shared a connection to the identity group, guided breakout discussions about what successful care coordination means to them, generally, and then solutions for touchpoint #2, a successful experience with a provider, based on their shared identity/experience. A follow-up survey was provided to glean additional thoughts from participants.

Regional Meeting

Throughout May 2021, virtual, 3-hour, regional meetings were conducted to review the findings from the statewide summit on success measures and develop solutions for each of the care coordination touchpoints. A follow-up survey was provided to glean any additional thoughts from participants.

Participant Outreach Process & Results

Process

The long-term goal of building off of the existing infrastructure for geographically representative and diverse community engagement representing the prioritized identities/experiences called for an outreach approach grounded in warm hand-offs. Fortunately, Colorado has a long history of advocacy and community leadership for behavioral health and within many of the prioritized populations. Thus, the outreach approach relied on this robust, existing statewide infrastructure wherever possible to provide warm hand-offs to their constituents:

- With lived experience of the behavioral health system, though not in crisis at the time;
- Who identify with one of the priority populations described on page 31; and
- And, ideally, someone from each of the seven regions.

After statewide organizations and networks were tapped, we reached into the regional and local infrastructure to identify organizations that worked with the subpopulations that the state infrastructure left gaps in within each region to ensure diverse representation of the prioritized populations within each region. (See Appendix A for the list of organizations that made this work possible.)

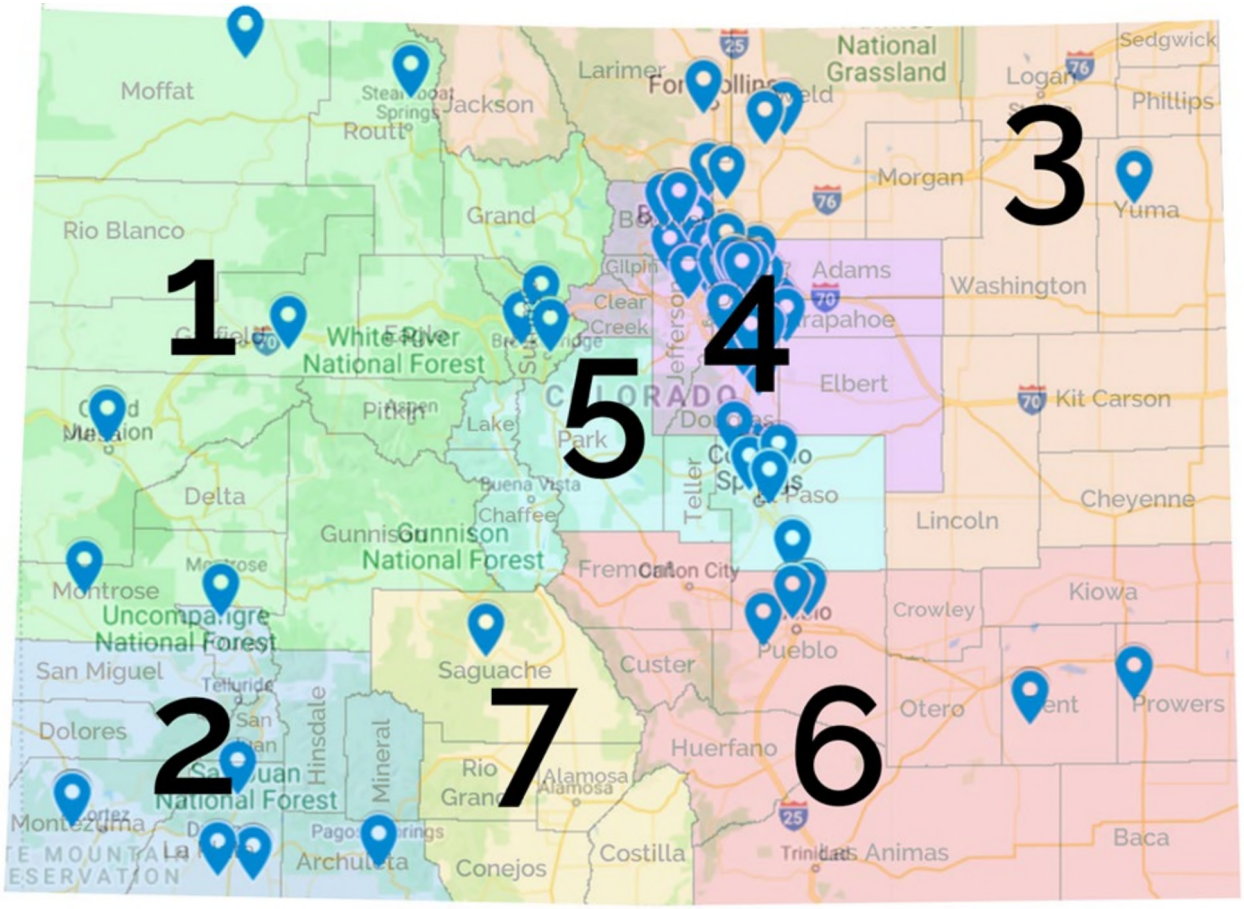
Rightfully so, some partners were very protective of their members; thus, we worked closely with those partner organizations to ensure that any necessary accommodations or supports were provided to engage their constituents in a respectful and safe manner. One Colorado helped to ensure our meeting norms were inclusive of the LGBTQIA+ community (see Appendix B). Additionally, because any conversation about behavioral health can potentially be triggering, during the summit, we had a volunteer psychologist in a separate breakout room in the event someone needed support that facilitators of such a large virtual group could not notice or provide.

Results

Outreach was conducted to approximately one hundred statewide and local organizations, which yielded 78 summit participants with robust statewide representation, from Yuma to Archuleta, Saguache to Routt, and Prowers to Moffat in addition to the many Front Range and I-70 mountain corridor community participants.

Unfortunately, even after extensive local outreach efforts to fifteen regional and community organizations focused on behavioral health in the San Luis Valley, only two people from the Valley registered. One person from Saguache County participated in both the Summit and what became the South/Southeast regional meeting (a combination of regions 6 & 7, see the map below for participants' geographic representation).

Figure 6: Regional Approach - Participants' Location Map



Outreach also ensured diverse representation in terms of cultural identity (i.e., Black/African American, Indigenous, Latino/a, LGBTQIA+, deaf, hard of hearing, deafblind, youth/young adult, veteran, older adults) and lived experience (i.e., immigrant/refugee, houselessness, violence survivor, former incarceration, brain injury, intellectual/developmental disability, parent/caregiver of a child/adult with significant behavioral health challenges). American Sign Language, Spanish, and Pashto interpretation were provided as well as closed captioning to ensure equitable engagement at the summit and regional meetings, as needed.

Table: Participants' Self-Identified Representation of Priority Populations by Region

Priority Population	1	2	3	4	5	6	7
Black/African American	✓			✓	✓	✓	
Indigenous		✓	✓	✓		✓	✓
Mono/bilingual Spanish speakers	✓	✓	✓	✓	✓	✓	
Refugees				✓			
People who identify as LGBTQIA+	✓	✓	✓	✓	✓	✓	
People who are deaf, hard of hearing, or deafblind	✓		✓	✓		✓	
People with intellectual/developmental disabilities	✓	✓	✓	✓	✓	✓	
People with brain injuries	✓	✓	✓	✓	✓	✓	
Veterans	✓	✓	✓	✓	✓	✓	
People who have been incarcerated	✓	✓	✓	✓	✓	✓	
People who have been houseless	✓	✓	✓	✓	✓	✓	
Survivors of violence	✓	✓	✓	✓		✓	
Pregnant or new parents with behavioral health challenges		✓		✓			
Parents/caregivers of children with behavioral health challenges	✓	✓	✓	✓	✓	✓	
Youth and young adults		✓	✓	✓		✓	
Older adults	✓	✓	✓	✓	✓	✓	✓

It was overwhelming to see so many people of color on a Zoom call, I have not experienced this. To hear a language translated/interpreted that I was raised with and shared with those in attendance to discuss issues relating to our community struggles we have had trying to care for those we love or have lost, touched my heart.
~ Participant reflections after summit in a follow-up email

Appendix A

Partner Organizations for Outreach & Engagement

We are immensely grateful to the following organizations who worked to identify and connect us with their constituents to ensure a broad representation of geographies, identities, and experiences.

Axis Health System
BIPOC Alliance
Boys & Girls Club of San Luis Valley
Brain Injury Alliance of Colorado
Center for Restorative Programs
Center for Rural School Health and Education
Children's Hospital Colorado
Colorado Association of Black Social Workers
Colorado Black Health Collaborative
Colorado Children's Campaign
Colorado Coalition for the Homeless
Colorado Commission of Indian Affairs
Colorado Criminal Justice Reform Coalition
Colorado Health Foundation
Colorado Mental Wellness Network
Colorado Opioid Response grant partners
Colorado Trust community partners
Colorado Veterans Health & Wellness Agency
Colorado Youth Leadership Network
Commission for the Deaf, Hard of Hearing, & Deaf Blind
Commission on Aging
Community Resource Center
Denver Foundation partners/grantees
Disability Law Colorado
Envision You
Family Resource Center Association
Family Voice Council
Federation of Families
Four Corner Rainbow Youth
Friendly Harbor
Health Management Associates
Illuminate Colorado
Independent Living Centers
International Rescue Committee
La Puente
Lake County Build a Generation
Latino Coalition
Latino Foundation partners/grantees
Mental Health Colorado
Mental Health Partners
MINDSOURCE
National Alliance for Mental Illness - CO
One Colorado
Parent to Parent
Project Worthmore
Pueblo Community College Disability Resource Center
Refugee Speakers Bureau
Rocky Mountain Prevention Research Center
San Luis Valley Housing Coalition
San Luis Valley Prevention Center
Second Chance Center
Servicios de la Raza
Sexual Offender Management Board
Southeast Health Group
Strategic Action Planning Group on Aging
The Arc of Colorado
The Civic Canopy
University of Colorado - Center for Public Health Practice
Various County Commissioners
Violence Free Colorado
WarriorNow
Young People in Recovery
Youth Move & COACT

Appendix B

Behavioral Health Transformation Summit & Regional Meetings
Ground Rules for Emotional Safety

1. **Respect** each individual for who they are, how they show up, and the contributions they make to the group, including their race, color, religion, gender expression, age, ancestry, ability, marital status, sexual orientation, or military status. Use each other's preferred pronouns - include pronouns on participant name tag.
2. **Share the air** - make space AND take space in the conversation. The only bad ideas are the ones that aren't shared. Respect each other's time and stay on topic.
3. **Assume positive intent** of everyone in the group.
4. **Listen to understand first** - seek to understand another's intention or meaning when unclear.
5. **Confidentiality** - "What's heard here, stays here. What's learned here, leaves here."
6. **Use "Oops / Ouch"** - to note when we've said or done something that might have been insensitive or harmful to others OR when something said or done hurt us and call for a pause to discuss it or use it as a learning moment.
7. **Stay solution focused** - Focus on the future as opposed to the past.
8. **Take care of yourself first.**
9. **Zoom etiquette** - mute when not talking, would love to see your face and understand if that isn't appropriate in this moment for you.