BHTTF Recommendation Guidance and Lenses

Subpanel Guidance

Funding and policy proposals should meet the following guidance in priority order:

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

Important Considerations Across Pillars

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

- **Regions:** Regional gaps and needs, including rural communities
- **Populations:** Populations experiencing vulnerabilities, including the unique needs or gaps for the following populations:
    - Monolingual non English speakers;
    - LGBTQIA+; BIPOC; Latino/a;
    - Tribal communities;
    - Undocumented individuals;
    - People with intellectual and developmental disabilities;
    - Veterans;
    - Justice involved individuals;
    - Unhoused individuals;
    - Pregnant women and infants;
    - Older adults;
    - People with serious mental illness;
    - Children, youth and families
    - Co-occurring disabilities;
- **Payers:** Specific barriers, gaps and opportunities with payer type
- **Regulations:** Solutions to overcome regulatory constraints / System barriers to access / streamlining processes
- **Integration:** Ensure we are always looking at mental health and SUD
- **Accountability:** Note transparency and accountability with every pillar
- **Leveraging Funding:** Opportunities to leverage local and other dollars
- **Sustainable:** Transformational for the long-term
- **Behavioral Health Task Force:** Keep in mind BHA / Blueprint
    - Affordability
    - Accountability
    - Access to Care
    - Whole Person Care
- **Criminal Justice:** Criminal justice incorporated throughout

Draft Strategic Pillars from Subpanel

Detailed Summary, including Task Force feedback

Note: Feedback statements are denoted by "TF" preceding those bullets

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Integrated and Coordinated Care

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

- Develop (and market) a single point of entry that has "no wrong door"
- Easy single entry point: Resource navigation hub with the ability for people to call one number, text, email, or online website to access needed BH supports.
- Increase local access points to avoid reaching crisis
- Flexible access points for people to engage in different ways
- A system that builds trust across underserved communities
- Fill 988 funding gap
- Policy: Immigration status not block receiving health care
- Substance use-informed care
- Accessibility / Treatment and continuum of care
- Continuum of care across service array. Building infrastructure around this continuum
- An easy to navigate and coordinated continuum of care throughout the state with workforce in all areas of need across the state
- (TF) Promote use of tangential services (MH and SUD professionals), rather than law enforcement or correctional response
- (TF) Specific interest in entry for rural constituents both real and virtual?
- (TF) Navigation has to include human help and help setting up appointments or reaching out to payers and providers. Just setting up a computer system isn't enough.
- (TF) BHA is going to work to get us a no wrong door system and could take on Universal Contract.
- (TF) Complex needs, universal contract- payments, payer and providers, workforce and loan forgiveness
- (TF) Fund bridge services to provide continuity of care when a provider changes, someone is waiting for Medicaid to activate after incarceration, etc.

Support systems navigation with utilization management.

- Utilization management: navigation support system has access to updated availability of BH supports and can book appointments
- Regional Resource Navigation Centers
- Services to improve conditions and needs to be effective. Right Service, Right Place and Right Time. What are the outcomes? Are people getting better and if not what needs to change?
- Getting data to proactively support people who have certain risk factors

- Uniform database, one number to call to navigate our behavioral health system with trained professionals to help place people in treatment across the state, and public education
- System has dashboard indicating what services are locally available for people based on cultural, population, and behavioral health challenges
- Asset mapping - Also understand what is working well now and then build onto the future
- Outcomes dashboards - are people getting better, etc.
- (TF) Crisis victim, DM, 24 hr access
- (TF) Care coordination
- (TF) SIM for rural

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

- Break down silos and red tape to support individuals across systems, to enable service providers to speak with each other about a client, and to ensure change is sustainable
- Technical supports so local providers can participate in HUB
- Address the bifurcation between mental health and substance use disorder systems and allow for treatment of individuals experiencing a co-occurring crisis
- BH integrated seamlessly into the health system. Brain is part of the body. Reattach the head to the body. BH is health.
- True integration would eradicate distinctions in access & payment between physical versus MH/SU care. BH care access points would be less discriminatory if they were inclusively identified as "health care" access points, inclusive of all types of care.
- Stop fighting for turf - MOU that allows groups to share info without HIPAA requirements.
- (TF) More intensive outpatient services (MH and SUD)
- (TF) Some more clarity or vision on this effort - Behavioral Health Task Force, BH Transformational Task Force, Office of Behavioral Health ---> all manifested in BHA?
- (TF) 1 time grant funding to support providers in integrating care under SIM was really popular. Build on that - really important for rural
- (TF) You can't expect a person to have long term housing stability without a job and a living wage.

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

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

- Have a spectrum of housing to care for individuals with the level of care and support services

Other Subcategories

- (TF) Cooperate more with K-12 education system to teach coping skills and suicide prevention to students
- (TF) Ensure every school has partnerships with local mental health services to teach educators the red flags of severe MH needs, signs of suicidal ideation, etc. Facilitate these partnerships, initiated by MH community supports
- (TF) Suicide prevention marketing! Billboards, posters, bus benches - 17 seen messages triggers action - that action could be a call for help, let people know visually and often who to call
- (TF) Employment as part of a person's integrated continuum of "care". Presentation by Vocational Rehabilitation.

Additional *Integrated and Coordinated Care* Priorities:

Please list any additional priorities you believe are still missing:

Gaps in Care Across the Continuum

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

- Unhoused population
- Indigenous/First Nation/American Indian/Alaskan Native Communities
- Racial and ethnic populations experiencing disparities (e.g., Latino/a, Black / African American, etc.)

- Undocumented Individuals, including immigrants and refugees: behavioral healthcare is available without consideration for immigration status
- Monolingual non English speakers
- Deaf / Hard of Hearing / Deafblind
- LGBTQIA+
- Pregnant women and infants
- Veterans
- Older adults
- Co-occurring disabilities
- People with intellectual or developmental disabilities; people with brain injuries
- Survivors of gender-based violence
- (TF) More beds / possible remodel (competency restoration - those who wait). Includes forensic, rural commitment, step down, community based.
- (TF) Create place to place kids with juvenile justice situation and BH needs
- (TF) Expand psych and complex physical care. Child needs dialysis and mental healthcare
- (TF) Public-private partnership where state owns and maintain facility (residential psych treatment center)
- (TF) How do we get kids who are sent out of state to be treated in state?
- (TF) Create a campus to move kids with different issues can be placed
- (TF) Understanding changes in suicide rates by county would be helpful. The state rate is unchanged 2017-2020, are there ares of the state (rural) that are statistically different (worse)?
- (TF) Have an EDI panel presentation to include tribes, deaf and hard of hearing, aging population, as well as other marginalized groups
- (TF) Need sign language interpreters
- (TF) HOUSING--transitional housing on a continuum of intensity of services for people coming out of all facilities. And, supportive housing on a similar continuum for people at risk of entering these systems. Also intensive, cross-systems case management for people transitioning out of facilities and into the community.

Make one-time investments to fill regional gaps.

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

- (TF) Can we expand telehealth services where primary care doctors can coordinate with mental health certified professionals on non-emergency mental health needs for patients? May help increase PCP skills so future calls are reduced?
- (TF) Regional gaps are important to me
- (TF) Beds!
- (TF) Southwest Colorado substance use treatment, especially for tribal communities

Identify emergency funding needs.

- Crisis beds to meet the needs across the state
- No gaps in continuum of care - step down care (housing, longer term stays, group homes, supportive living, etc.)
- Local control of funds for programming, and it is not a cookie cutter situation. Communities need are significantly different between communities.
- (TF) Youth counseling services
- (TF) Transition care for youth coming out of 24-hour care; group home, and transition back to family. Training for family in how to care for youth
- (TF) Crisis intervention in rural areas
- (TF) Youth suicide prevention
- (TF) Transitional housing on a continuum of intensity of services for people coming out of all facilities. And, supportive housing on a similar continuum for people at risk of entering these systems. Also intensive, cross-systems case management for people transitioning out of facilities and into the community.
- (TF) Staffing needs for CMHIP, others—fund hiring incentives, out of state recruitment, etc.

Develop an accountability and transparency system.

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

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

- Overcoming Stigma: Get our society to view mental illness as a disease not a choice or character flaw.
- Fill in the "middle"

- Short term therapies, as well as long-term care
- Intensive and local Care Coordination
- Hospital/clinical capacity for individuals in jail custody who require health care
- Inpatient beds
- Intensive outpatient treatment
- (TF) Telemedicine and broadband
- (TF) Cross-systems case management for youth and adults, and maybe even for families as systems, who otherwise get lost between different agencies/providers pointing the finger and saying "not us"

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

- Address regulatory issues for carrying controlled substances for MAT/withdrawal management on mobile units (policy adjustment)
- Addressing the documentation requirement to providing services
- Streamline processes, reducing administrative burdens on the state level as well as recommendations federally
- It seems like the big policy and funding should be focused on those things that 'grease the skids' to ensure that high-quality, evidence-based services are possible. This would include things like ensuring broadband access for telehealth, focus on creative workforce training (because we all know one time trainings are a non-starter long-term), specialized curricula to help support providers to be able to provide culturally-relevant and competent services, investments in linguistic supports, investments in screening and referral streams knowledge about how to support people getting to services, examining where funding could support enhanced communication and collaboration across systems, etc.
- (TF) Fund bridge services to provide continuity of care when a provider changes, someone is waiting for Medicaid to activate after incarceration, etc.
- (TF) I think the need for capital funding to create space for individuals awaiting a higher level of care through crisis walk in centers. Last week we had 3 adolescents in our walk-in center for 3 days because we could not find bed availability. This occurs in a small space that also has adults and is not ideal.
- (TF) Currently there are onerous requirements on providers and clients, including lengthy intake and assessments that can deter clients from receiving needed services. This is also a parity issue; there is nothing comparable required of safety net providers in the physical health system, such as federally qualified health centers.

Other Subcategories

- (TF) The entirety of all discussions are about <u>after the fact events</u> and there is almost zero discussion about prevention
- (TF) Data on other marginalized groups (Hard of Hearing, various languages, IDD)
- (TF) Training and retaining foster care families and personnel
- (TF) I'd like to see those in foster care as a data set (at-risk, etc)

- (TF) There is a big gap of service for a person who is seen in ER for a suicide attempt or overdose. I heard a presentation that because it takes so long to get follow up treatment, the next time they're often seen is in the morgue
- (TF) Investing in real-estate which can be put in a charity & leased back to public or private rehabilitation agencies for like $1 per year

Additional *Gaps in Care Across the Continuum* Priorities:

Please list any additional priorities you believe are still missing:

Sustainable Funding, Affordability, and Payer Systems

Identify ongoing sustainable funding.

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

- (TF) BHA needs to be lean - shouldn't be top heavy. $ to communities
- (TF) How can we put ARPA $ in BHA now to use through BHA and save general fund $ until ARPA runs out?
- (TF) Partner with local govs for opioid dollars to sustain ongoing costs and AG office
- (TF) Create a new Medicaid waiver for SMI that includes housing

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

- Conduct a cost/benefit analysis on the funding for BH
- Review current state regulated health plans (ASAM criteria) - how is it going? What can we do within our current systems to make sure the right things are being covered?
- Evaluate whether the RAE system is working
- Evaluation of existing funding - creation of a funding map - then shift funding where it isn't working (outcomes don't exist)
- Shift county-borne costs for health care in jails/youth detention back to Medicaid by creating secure in-patient capacity
- Gaps in insurance coverage
- Use state funds to cover services upfront while we wait for Medicaid reimbursement
- Fair, transparent, streamlined, and easy to use payer system
- Transparency with the funding
- Funding and Affordability, including payer system
- BH premier payer (retention bonuses, signing bonuses, etc.)
- Money and profit out of the system (need one to fund it, but not to drive care).
- Shift costs for crisis intervention team training to individual new recruits by embedding training in POST academy
- Treatment should be given based on patient need, not according to the payment source.
- one stop enrollment for Medicaid, SNAP, WIC
- (TF) Gaps in insurance coverage - how do we accomplish parity and no wrong door goal
- (TF) This committee could provide seed money or upfront costs for a number of interventions and then use opioid # for ongoing costs, especially if we're talking about overdose or substance use issues

Other Subcategories

- (TF) For SUD meds - bulk purchasing fund. Increase funding
- (TF) Capital funding to create space for individuals awaiting a higher level of care through crisis walk-in centers
- (TF) Sustainable funding for bulk purchase meds for opioid use disorder
- (TF) Payment to providers for addressing social influences of health and integration of physical/mental/dental/optometric health
- (TF) When it comes to payment the unintended consequence of privacy for 13 year olds is a barrier to ensuring parents can get their 13-17 yo BH and substance use support
- (TF) Will psychiatrists accept in-network payments?

Additional *Sustainable Funding, Affordability, and Payer Systems* Priorities:

Please list any additional priorities you believe are still missing:

Criminal Justice Reform and Care

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

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

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

- Continuum of supports (with flexibility in communities) to increase diversion opportunities from co-responder/ alternative response to pretrial supports to supports within the justice system/ after hours/ peer support services

- Pre-trial reform - treatment over jail: Co-responder programs for mental health and SUD, treatment vs. criminalization
- Focus on Restorative Justice (Restorative Justice hub?)
- Prosecutor-led Diversion
- Problem-Solving Courts/MH courts
- Evaluate/revise sentencing guidelines & mandatory minimums
- Population awaiting determination of competency to stand trial / restoration
- Diversion, including revising the fail first model and Judicial system
- Probation

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

- Jail DOES not serve as our default MH/SUD care system
- Medicaid - sign up, continuation of medicaid (ask for state exemption, medicaid start to support transitions
- Address shortage of providers in jails
- Jail-based behavioral health services (audit for outcomes/impact)
- Jail provider contracts
- EHRs in jails
- Continuity of care / medication consistency. Includes connectivity to health information exchanges through electronic health records.
- restoration to competency services, both jail-based and hospital-based
- Mandate jail treatment and care, including medication assisted treatment
- Address regulatory issues associated with emergency and involuntary medicines in jails
- Transportation from jail to community services
- Prison-based behavioral health services
- Access to telehealth
- Peer support services & training
- Health care partnership in-reach
- POLICY: Eliminate requirement that people on parole must get behavioral health services from an Approved Treatment Provider, especially if the person on parole is enrolled in Medicaid.
- (TF) Create minimum standards for what jails have to provide, mandate that hospitals accept psych patients from jails

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

- Getting people signed up for Medicaid before leaving
- Connection to the services that people need prior to release - medication assisted treatment, community mental health services, housing, etc.
- Re-entry programs and community behavioral health services and supports (housing, employment, recovery supports, etc.)
- Minimize barriers & expenses & enhance supports for individuals transitioning back into the community

- Care, supports, & services for children & families of justice-involved individuals
- Contingency management (tangible reinforcement for abstinence, harm reduction)
- (TF) Jobs and help in employment
- (TF) Bridge funding cited above to support continuity of care
- (TF) One area I'm concerned about is the transition from prison to community. Any investment in transitional housing would be helpful
- (TF) Transitional housing on a continuum of intensity of services for people coming out of all facilities. And, supportive housing on a similar continuum for people at risk of entering these systems. Also intensive, cross-systems case management for people transitioning out of facilities and into the community.

Other Subcategories

- (TF) Transitional housing on a continuum of intensity
- (TF) Intensive cross-systems case management for those transitioning out
- (TF) Community based transition services
- (TF) Expand special needs parole (from DOC) to include more people with SMI whose needs cannot be met in DOC

Additional *Criminal Justice Reform and Care* Priorities:

Please list any additional priorities you believe are still missing:

Children and Youth

Ensure universal screening and assessment for children and youth.

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

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

1) Universal prevention and community supports,

- Prenatal-Parenting Care
- Funding allocated to prevention education. Start early.
- Develop a set of core service strategies to be available across the state, including services, resources, coordination and supports
- Every child has access
- Define essential health benefits for children's behavioral health
- (TF) Two-generation, treat and support whole families/natural supports as systems, not just the "problem" youth

2) Targeted intervention and crisis management,

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

3) Intensive intervention.

- Lack of inpatient care
- Expand care coordination for multi-system involved youth
- Child welfare system
- Acute Needs Care (stabilization)
- Community and Home Based Services
- Co-Occurring Issues (MH-Chronic Physical Conditions, MH-SUD, MH-IDD, SUD-IDD, SUD-Chronic Physical Conditions, etc.)
- Cross training of professionals for co-occurring conditions
- Receive services in school setting
- FUNDING: School=primary care, behavioral health care, oral care, vision care
- FUNDING: care for <16 yr with SUD
- FUNDING: hub/spoke model for children/youth; HUB: residential treatment, hospital treatment, IOP --> SPOKES: PCP, Juv Just, SBHC, Boys/Girls Clubs
- POLICY: Gun prevention, universal lethal means assessment
- FUNDING: Diversion - greater access; focus on MH/SUD specifically providing access to treatment
- POLICY: training, billing for universal screening (ex-in SBHCs), incentives for CMHCs/FQHCs

- FUNDING: SBHCs with every school

Other Subcategories

- (TF) Thoughtful and supportive transition back to home environment with supportive caregivers
- (TF) EPSDI? Presentation especially if we have some wiggle room on expanded services due to SPA. The youth (0-18) suicide rate is very disturbing
- (TF) Divert and refer youth from ALL court systems—delinquency, dependency and neglect, truancy, etc.
- (TF) Equity and parity-- ensure that services provided through BH system are as robust, effective, and intensive as those offered through juvenile justice, child welfare, etc
- (TF) There is also a problem with existing law as the medical privacy laws reach down to early teens while parents are on the hook for liability to 18 and the burden continues to fall on the parents long after a child's 18th birthday.
- (TF) Thinking about adolescents - ensuring there is thoughtful and supportive transition back to the home environment with support to parents/caregivers
- (TF) High Fidelity wraparound is very successful for the step down. Colorado has very strict fidelity and limited coaches to acquire fidelity. It is also an expensive program to run and needs more funding to keep our children in the communities, homes, and local schools.

Additional *Children and Youth* Priorities:

Please list any additional priorities you believe are still missing:

Workforce

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

- Provide behavioral health outreach staff at the local level so that people who come into city hall can know which services are available.

- Solutions for workforce in gap areas / populations, including rural and co-occurring conditions
- Pay well and other retention solutions, including evaluating pay discrepancies between executives and staff
- Peer supports and nontraditional workforce
- What have we invested in already in the past, and what other incentives can we provide? (Loan repayment program, scholarships, outreach to schools, hiring and training people in recovery for peer support)
- Increase BH capacity through increased workforce
- Pipeline development
- Workforce and pipeline in culturally diverse communities.
- Address licensure barriers while maintaining quality
- Addressing/removing licensure barriers that prohibit the delivery of services (while still maintaining quality)
- Have enough clinicians. Psych nurses. Every child born in CO has access to infant mental health
- Broad spectrum of workforce in areas of substance abuse and behavioral care
- (TF) Conduct root cause analysis of the WF challenges - money may not solve issues - may be emerging moral dilemma'
- (TF) Pay clinicians and case managers well and other retention solutions, including evaluating pay discrepancies between executives and staff. Caps on executive salaries and pay staff liveable wages.
- (TF) Provide support and MH for health care workers who've really taken a "hit" with COVID.
- (TF) Retention of diverse clinicians - payment models that better reflect services rendered -> increased pay for clinicians. Leveling up via _____ (more pay, then better care, etc)
- (TF) Identify people with lived experience who have been served in these systems and offer incentives to gain education and licensure in these fields

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

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

- Understand how much training is necessary (certified addiction specialist, etc) and are there ops for some interactions to be done by other levels.
- Peers and training of peers to support
- Right training for those working in MH settings - not just MH experts - so things can be addressed and deescalated.
- Lack of consistent education for mental health providers - people are relying on folks with limited ability to detect early signs.
- One stop shop for online trainings. and evidence based practices.
- Application of ECHO for ongoing education - consultant learning model
- (TF) Reduce licensing barriers for foreign educated licenses - transferred degrees. Work with Office for New Americans to knock down these barriers.
- (TF) Support for supervisors - student loan forgiveness incentives.

Ensure cultural competence and linguistically accessible services.

- Culturally responsive services - smaller orgs that have trust in communities and can further their reach.
- Easier process for international BH workers to transfer their license to CO
- (TF) Starting clinical hrs sooner
- (TF) Clinical SW required LCSW to supervise - don't have enough to supervise
- (TF) Providers who use sign language. MOU with Gallaudet Univ to recruit providers

Other Subcategories

- (TF) Current admin burdens provide barriers - screenings/assessment, intake requirements
- (TF) More promotion of telehealth
- (TF) Role of peers, peer supports, "nontraditional" resources and roles

Additional *Workforce* Priorities:

Please list any additional priorities you believe are still missing: