# BEHAVIORAL HEALTH TRANSFORMATION

# IN

# COLORADO

## 2010 Annual Report

Submitted by the
Colorado Department of Human Services
on behalf of the

## Behavioral Health Cabinet
## and
## Behavioral Health Transformation Council

This report is submitted to the House of Representatives Health and Environment and Senate Health and Human Services Committees of the Colorado General Assembly pursuant to section 27-61-102 (2), (c), C.R.S.

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## Behavioral Health Cabinet and Behavioral Health Transformation Council
## List of Representatives: August 2009- August 2010

| **BEHAVIORAL HEALTH CABINET** | |
|---|---|
| Department of Corrections | Aristedes (Ari) Zavaras |
| Department of Health Care Policy and Financing | Joan Henneberry |
| Department o f Human Services | Karen L. Beye |
| Department of Labor and Employment | Don Mares |
| Department of Local Affairs | Susan Kirkpatrick |
| Department of Public Health and Environment (Chief Medical Officer) | Dr. Ned Calonge |
| Department of Public Safety | Peter Weir |
| Governor's Office of Policy and Initiatives | Ken Weil |
| | |
| **BEHAVIORAL HEALTH TRANSFORMATION COUNCIL** | |
| Advocates for Recovery | Don Rothschild |
| Blue Ribbon Policy Council on Early Childhood MH | Claudia Zundel |
| Child Welfare Action Committee | George Kennedy |
| Colorado Behavioral Healthcare Council | George DelGrosso |
| Colorado Commission on Criminal and Juvenile Justice | Diane Pasini-Hill |
| Colorado CURE | Kathie Izor |
| Colorado Department of Corrections | Joanie Shoemaker |
| Colorado Department of Health Care Policy and Financing | Marceil Case |
| Colorado Department of Human Services | Joscelyn Gay/Janet Wood |
| Colorado Department of Labor and Employment | Booker Graves |
| Colorado Department of Local Affairs | Clarke Becker |
| Colorado Department of Public Health and Environment | Shannon Breitzman |
| Colorado Department of Public Safety | Jeanne Smith |
| Colorado Governor's Office of Policy and Initiatives | Leslie Herod |
| Colorado Governor's Office of State Planning and Budgeting | Ann Renaud |
| Colorado Multi-Ethnic Cultural Consortium | Deborah Ward-White |
| Colorado Provider Association | Carmelita Muniz |
| Federation of Families for Children's Mental Health | Tom Dillingham |
| Mental Health America of Colorado | Jeanne Rohner |
| Mental Health Planning and Advisory Council (MHPAC) | Ty Smith |
| Silverprint Colorado (Older Adults) | Vicki Rodgers |
| National Alliance on Mental Illness (NAMI) Colorado | Lacey Berumen |
| Prevention Leadership Council | José Esquibel |
| Professional Provider Associations:<br>▪ Colorado Psychiatric Society<br>▪ Colorado Psychological Association<br>▪ National Association of Social Workers | Renee Rivera |
| University of Colorado School of Medicine – Family Medicine | Frank deGruy |
| University of Colorado School of Medicine – Psychiatry | Thomas Crowley |
| WE CAN! | Amanda Kearney-Smith |

**Introduction**

The Behavioral Health Transformation Project began in 2007 with the creation of the House Joint Resolution 07-1050 Task Force (HJR 1050 Task Force), which was charged with studying mental health and substance abuse services in order to coordinate the efforts of state agencies, streamline the services provided and maximize federal and other funding sources.

At the same time, Governor Bill Ritter, Jr. called a meeting of key Cabinet members and other experts to discuss methods to improve behavioral health services (i.e. mental health and substance use disorder services) in Colorado. Out of this meeting the Governor created a "Behavioral Health Cabinet (BHC)" to oversee a process for increasing the efficiency and effectiveness of behavioral health services in Colorado.

In 2009, Colorado received a federal planning grant to develop a process for the transformation of the behavioral healthcare system in Colorado, from a system that is fragmented and difficult to navigate to one that is streamlined and effective. This initiative was led by the Behavioral Health Cabinet, which included the Executive Directors of the Departments of Corrections, Health Care Policy and Financing (the state's Medicaid agency), Human Services, Labor and Employment, Local Affairs, and Public Safety. Other members included the state's Chief Medical Officer (Dept. of Public Health and Environment) and the Director of the Governor's Office of Policy and Initiatives.

The Behavioral Health Cabinet, using the recommendations of the HJR 1050 Task Force as a blueprint, developed an infrastructure for continued progress toward transformation of Colorado's behavioral healthcare system by accomplishing three things:

1. Developing a process for ongoing, meaningful input from consumers and other stakeholders. The Behavioral Health Cabinet **formed the Behavioral Health Transformation Council (BHTC) to advise the work of the Behavioral Health Cabinet,** with responsibility to set priorities to guide behavioral health transformation efforts, define annual objectives to guide implementation, and assemble subject matter experts (including substance use disorder providers, community mental health centers, consumers, advocates, state staff, and physical healthcare providers) across multiple work groups to implement system transformation;
2. **Developing coordinated implementation/work plans** to integrate Colorado's behavioral healthcare system; and
3. **Securing a multi-year commitment of Colorado's executive, judicial, and legislative branches of government** to ensure that the Behavioral Health Cabinet's planning and implementation efforts are institutionalized and are both ongoing and productive, resulting in true system transformation.

The Behavioral Health Cabinet contracted with *TriWest Group, Inc.* and *Advocates for Human Potential* to facilitate this planning process.

The implementation plans detailed in this Annual Report were developed from the feedback of regional stakeholder forums convened in April and May 2009. Overall, 75 in-person forums were conducted involving over 500 participants. Forums were conducted in major urban areas (Denver Metro, Colorado Springs, Grand Junction, Fort Collins, and Pueblo). Forums for rural and frontier areas were conducted using a network of videoconference sites (Craig, Durango, Lamar, Sterling, and Trinidad), and additional telephone conferences were conducted for some mountain communities and other areas. Additional forums requested by stakeholders were conducted with American Indian/Native American service providers in the Denver Metro area and with members of the Child Welfare Action Committee.

Participants identified 1,149 local issues across 12 overall categories, which were used to rank potential state-level changes. These forums resulted in the selection of four top priorities for system transformation (See "The 2009 Colorado Behavioral Health Transformation Transfer Initiative: Final Grant Report: February 2010" for a full description of the community forums and resulting implementation plans):

1) Financing reform;
2) Streamlined rules and regulations;
3) Increased spending on services; and
4) The establishment of a solid process to guide implementation and ensure consumer and family involvement.

In addition, high-risk/high-needs adults, criminal justice, and youth populations received the most interest and concern for focusing transformation efforts. Based on these priorities, the Behavioral Health Transformation Council developed implementation/work plans for behavioral health system transformation in the following prioritized areas:

- Sustain behavioral health system transformation through joint efforts of the executive, legislative, and judicial branches of Colorado State Government;
- Better coordinate prevention and intervention services for children, adolescents and young adults;
- Improve continuity of care and ultimately reform financing for people using multiple or high cost services across state agencies; and
- Improve assessment and medication access for people with behavioral health needs in the criminal and juvenile justice systems.

The four implementation plans included in this report focus primarily on changes to the behavioral health prevention, intervention, and treatment service delivery systems funded and regulated by state agencies (primarily the Colorado Department of Corrections, Colorado Department of Health Care Policy and Financing, Colorado Department of Human

Services, Colorado Department of Public Health and Environment, and Colorado Department of Public Safety). Just as critical are the broader sets of non-medical supports essential to the prevention of and recovery from behavioral health disorders, including the employment and workforce development supports of the Colorado Department of Labor and Employment and the housing and community development resources of the Colorado Department of Local Affairs. Key supports from the Colorado Department of Education and the Colorado State Judicial Branch were also incorporated.

The Behavioral Health Cabinet and Transformation Council placed a premium on data-driven decisions and where possible, the evidence of effectiveness. Therefore, the implementation plans included in this report emphasize using evidence-based, promising and best practices wherever feasible, building on existing efforts, and coordinating with other task forces and interagency collaboratives to both promote and make use of the work that preceded this initiative.

Under the leadership of the Behavioral Health Cabinet and the Behavioral Health Transformation Council, a consensus-based framework to support this process across the years is now in place through the passage of Senate Bill 10-153.

Behavioral health system transformation was created out of a widespread and commonly shared commitment to respond to the needs and strengths of people across Colorado involved in the delivery and receipt of behavioral health services. In 2011, the Behavioral Health Cabinet and Behavioral Health Transformation Council will continue these efforts while incorporating and integrating key aspects of the federal Patient Protection and Affordable Care Act (March 2010) and identifying new key issues to move the transformation of the behavioral healthcare system forward for the people of Colorado.

## EXECUTIVE SUMMARY OF SUB-COMMITTEE ACTIVITIES

### Sustainability of Behavioral Health Transformation Sub-Committee

This sub-committee was charged with expanding the involvement of the three branches of government in behavioral health system transformation and developing options for a public-private partnership to guide transformation over a multi-year period. This included defining a vision for behavioral health transformation and the development of a policy framework with goals and objectives to guide this work.

These activities culminated in the passage of Senate Bills 10-153 and 10-175 during the 2010 legislative session. Senate Bill 10-153 defined the membership of the Behavioral Health Cabinet and Transformation Council and included a comprehensive policy framework to guide this effort. Senate Bill 10-175 consolidated into one title of statute, all statutes governing publicly funded alcohol and drug use disorder and mental health services administered by the Department of Human Services. Previously, these statutes were spread across three different titles, which contributed to the fragmentation and varying requirements governing these services.

In addition, the Behavioral Health Transformation Council was awarded a $750,000 Transformation Grant to provide supported employment for adults and transition-age youth with mental illness. The Council was anticipating the release of this grant opportunity and was hoping it would support the work of the Behavioral Health Cabinet and Transformation Council. However, this transformation grant was very targeted in its approach requiring the use of specific evidenced-based practices for specific populations, as opposed to systemic change activities. The Behavioral Health Cabinet and Transformation Council worked with the Mental Health Center of Denver to secure this grant and is excited that Colorado was awarded this grant and looks forward to the results of this effort for consumers of mental health services in Colorado.

In 2011, this group will continue to identify opportunities to make the law and regulations governing the behavioral healthcare system more consistent and efficient.

### Prevention and Intervention for Persons Under 26 Years of Age Sub-Committee

The Prevention and Intervention Under 26 sub-committee is in the process of developing a "white paper" to examine the service gaps and challenges in serving transition age youth between the ages of 14 and 25 years. The white paper will offer recommendations to meet the needs of this population in the public behavioral health system.

Over the past several months, the Under 26 sub-committee surveyed an estimated 80 providers within multiple departments, divisions and agencies to identify how those agencies are providing services to transition-age youth and young adults. The group received information from approximately 50 agencies including: the CDHS/Division of Youth Corrections, the CDHS/Division of Vocational Rehabilitation, local Boards of Cooperative

Educational Services (BOCES) and School-to-Work Alliance Programs (SWAP), the Workforce Development Council, County Departments of Human Services/Child Welfare programs, CDHS/Division of Supportive Housing and Homeless Programs, Community Mental Health Centers, Community Centered Boards, the Colorado Coalition for the Homeless, the National Alliance on Mental Illness (NAMI) Colorado Chapter, and 2 school districts.

Survey results indicate providers serve a wide range of transition-age clients. Services provided include job readiness/employment training and counseling, behavioral health/therapy services, disability counseling, Web-based support groups, life skills development, physical health services, and preparation for secondary education. Many entities indicated that they apply a system of care and goals-oriented/goals-driven approach to service delivery. A number of providers noted client participation in decision-making. Several providers indicated that they are following the nationally recognized, evidence-based "Transition to Independence Program (TIP)" developed by Hewitt B. (Rusty) Clark, Ph.D., of the University of South Florida. Several also noted that they have no knowledge of the TIP model.

The Under 26 sub-committee and the Youth and Young Adult Transition Committee of the Mental Health Planning and Advisory Council (MHPAC) will make further efforts to collect information on the various transition-age service models, promising practices and resources within the counties and communities of Colorado as well as nationally. The goal is to promote effective service delivery to the transition-age population through the development of a standards guide for service providers. This standards guide will include strategies for active consumer and family involvement and give the transition-age population the best chance at becoming productive independent adults.

This group was also charged with adapting and establishing social and emotional standards for Colorado schools and then expanding those standards to include early childhood and other systems, such as child welfare and the youth corrections populations. The Colorado Board of Education adopted standards on emotional and social wellness and prevention and risk management in December of 2009.

In 2011, this workgroup will use the findings from the survey on the transition-age population to create models of service delivery for this population and adapt the social and emotional standards used in schools for use in other systems.

**Continuity of Care Sub-Committee**

This sub-committee was very active in 2010 and has substantial overlap with the Under 26 sub-committee. The Continuity of Care sub-committee was charged with systematically examining the population with the highest level of service utilization to identify alternative strategies to prevent this high-level of expense and service utilization for future populations. This sub-committee identified 299 people in this high-risk/high-need category, many of who were youth in the child welfare system, and is proceeding with examining a sample of

individual cases. Using individual case studies, the group is identifying intervention points that will change the course of service utilization for this population resulting in better outcomes and lower public expense.

This group was also charged with streamlining processes and paperwork across these public systems. Areas of examination included client assessments, treatment plans and data collection. Over the past six months, the Departments of Health Care Policy and Financing and Human Services have been meeting to compare and streamline the performance measures that each agency is required to collect for federal reporting and billing purposes. The two agencies have developed the minimum set of required indicators and will modify provider contracts accordingly.

**Criminal Justice Sub-Committee**

This group is a joint sub-committee of the Behavioral Health Cabinet and the Commission on Criminal and Juvenile Justice that is looking at behavioral health service provision for offenders as a strategy to reduce recidivism. Over 20% of offenders entering the criminal justice system have a significant behavioral health issue. The provision of appropriate behavioral health services has been shown to reduce recidivism and prevent deeper penetration and/or continued involvement with the criminal justice system.

In a joint venture between multiple state departments, the Division of Criminal Justice received a $2.1 million federal grant to provide comprehensive, evidenced-based training for law enforcement personnel to use when they encounter individuals with significant behavioral health issues. This training provides tools to identify and appropriately respond to these individuals rather than simply taking them to jail. Law enforcement personnel receive training in motivational interviewing, cognitive behavioral therapy, and mental health first aid. The training uses the *Level of Supervision Inventory Risk and Needs Assessment*, which is a validated tool for measuring offender risk. These tools allow law enforcement personnel to accurately assess risk and apply appropriate intervention techniques. Since May 2010 more than 360 individuals have been trained.

In 2011, this sub-committee will be looking at developing a common screening tool to be used in county jails to allow jails to share information about offenders who may cross county jurisdictions. The group will also promote and develop a common pharmaceutical formulary to increase the likelihood that offenders will receive access to medications across the county corrections system. State departments already use common screening and assessment tools and a common formulary. These common tools greatly improve the continuity and compliance with care for offenders. The Behavioral Health Cabinet and Commission on Criminal and Juvenile Justice would like to develop the same types of common systems at the county level so counties may share this information across counties as well as with the state in an effort to increase compliance with care and thereby reduce recidivism.

## Behavioral Health Cabinet and Behavioral Health Transformation Council Annual Report 2010

| Number | Goal | Activities and Entities Involved | 2010 Accomplishments | 2011 Next Steps/Decision Points |
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| **SUSTAINABILITY OF BEHAVIORAL HEALTH INTEGRATION** | | | | |
| S -1 | Expand the involvement of the State Judicial and Legislative Branches and the Department of Education in the BH Cabinet and BH Transformation Council processes. | Develop options for a sustainable public-private partnership to guide transformation efforts over a multi-year period. Promote collective leadership to improve the quality of life of Colorado citizens. Sustain a continual focus on behavioral health as a public policy issue of paramount importance. Promote the recognition that no single entity can address the complexity of behavioral health issues within Colorado. | SB-153: Designated the Commissioner of Education or his representative, two members of the Judicial Branch and four members of the Legislature to serve on the BH Transformation Council along with a group of Cabinet members representing the Departments of Corrections, Health Care Policy and Financing, Human Services, Labor and Employment, Local Affairs, Public Health and Environment and Public Safety. Executive Order B 2010-011 creates the BH Transformation Council and outlines the membership pursuant to statute: State Staff (9), Legislative (4), Judicial (2), and Stakeholders (17). Executive Order A 2010-209 appointed members to the BH Transformation Council. | Develop and examine opportunities to fund the activities of the BH Transformation Council and Cabinet. Those opportunities may include but are not limited to private foundations, grants, and individual donors who may have a special interest in behavioral health transformation outcomes. |
| S - 2 | Set forth a declaration of the vision and intent for comprehensive behavioral health transformation, formally establish the Behavioral Health Cabinet and direct it to continue the transformation work. | Develop options for a sustainable public-private partnership to guide transformation efforts over a multi-year period. Promote collective leadership to improve the quality of life of Colorado citizens. Sustain a continual focus on behavioral health as a public policy issue of paramount importance. Promote the recognition that no single entity can address the complexity of behavioral health issues within Colorado. | SB-153: Establishes an infrastructure compiled of the above listed entities, which will assist in further examining the way behavioral health funding and treatment are provided in Colorado. SB-153 provides for a collaborative effort around continuity of care and reform of financing, improved access and workforce development, better coordinated prevention and intervention services, and sustainability through the sunset of SB-153 in 2020. | The Behavioral Health Transformation Council will conduct a 1-2 day retreat to establish and affirm priorities for 2011. |

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| **Number** | **Goal** | **Activities and Entities Involved** | **2010 Accomplishments** | **2011 Next Steps/Decision Points** |
| S - 3 | Recodification of existing statute to consolidate behavioral health related statutes where appropriate. | Develop options for a sustainable public-private partnership to guide transformation efforts over a multi-year period. Promote collective leadership to improve the quality of life of Colorado citizens. Sustain a continual focus on behavioral health as a public policy issue of paramount importance. Promote the recognition that no single entity can address the complexity of behavioral health issues within Colorado. | The statutes related to behavioral health were previously contained in Titles 25, 26 and 27 of the Colorado Revised Statutes. Senate Bill 10-175 moved all of the statute pertaining to behavioral health services administered by the Department of Human Services into Title 27. This consolidation will allow the Behavioral Health Transformation Council to streamline current statute to improve the behavioral health services system. | The Behavioral Health Transformation Council has not identified any statutory changes for 2011, but will identify additional opportunities to modify statute to streamline service delivery. |

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| Number | Goal | Activities and Entities Involved | 2010 Accomplishments | 2011 Next Steps/Decision Points |
| S - 4 | Establish a commitment from each of the three branches of government to work together to carry out the goals, objectives, and values of the behavioral health policy framework. This process would ensure that consumers, families, and other stakeholders provide meaningful involvement, and would designate that the Executive Directors of the Departments of Corrections, Education, Health Care Policy and Financing, Human Services, Labor and Employment, Local Affairs, Public Health and Environment, and Public Safety would dedicate staff to assist with the fulfillment of the behavioral health policy framework. | Develop options for a sustainable public-private partnership to guide transformation efforts over a multi-year period. Promote collective leadership to improve the quality of life of Colorado citizens. Sustain a continual focus on behavioral health as a public policy issue of paramount importance. Promote the recognition that no single entity can address the complexity of behavioral health issues within Colorado. | The Behavioral Health Cabinet and Transformation Council received a Transformation Transfer Initiative Grant from the federal government to conduct a number of focus groups across the state to establish the Behavioral Health Cabinet and Transformation Council's priorities for 2010. The Behavioral Health Cabinet and Transformation Council established an ongoing process for implementing behavioral health integration, which included joint decision-making with stakeholders, consumers, and relevant state government representatives. In the 2010 legislative session, the Behavioral Health Cabinet and Transformation Council facilitated the passage of S.B. 10-153, which outlined a behavioral health policy framework to guide Colorado's integration efforts. It also established the formal creation of the Behavioral Health Cabinet and Transformation Council as the process for completing these activities. | The Behavioral Health Cabinet and Transformation Council have not received grant funding to allow for dedicated staff for this project. In 2011, the Behavioral Health Cabinet and Transformation Council will continue to identify and apply for grant funding to support this effort. |

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| Number | Goal | Activities and Entities Involved | 2010 Accomplishments | 2011 Next Steps/Decision Points |
| S - 5 | Implementation of specific provisions of the Transformation Transfer Initiative implementation plans as appropriate. | Develop options for a sustainable public-private partnership to guide transformation efforts over a multi-year period. Promote collective leadership to improve the quality of life of Colorado citizens. Sustain a continual focus on behavioral health as a public policy issue of paramount importance. Promote the recognition that no single entity can address the complexity of behavioral health issues within Colorado. | Implementation of the provisions of the Transformation Transfer Initiative are captured in this Behavioral Health Transformation 2010 Annual Report. | The Behavioral Health Transformation Council will hold a 1 or 2 day retreat to discuss priorities for behavioral health integration for 2011, including items associated with the federal Patient Protection and Affordable Care Act. |

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| **Number** | **Goal** | **Activities and Entities Involved** | **2010 Accomplishments** | **2011 Next Steps/Decision Points** |
| S - 6 | Align the myriad groups, taskforces, and commissions that are working on some aspect of behavioral health coordination across agencies in order to consolidate and strengthen transformation efforts. Focus on the development of priorities across the groups and build consensus as to which items move forward and are implemented in legislation and practice. In this time of scarce resources, behavioral health stakeholders, advocates and state staff are spread thin with the number of groups working on this topic, and improved coordination is needed to maximize efficiency, effectiveness, and transparency across groups. | Develop options for a sustainable public-private partnership to guide transformation efforts over a multi-year period. Promote collective leadership to improve the quality of life of Colorado citizens. Sustain a continual focus on behavioral health as a public policy issue of paramount importance. Promote the recognition that no single entity can address the complexity of behavioral health issues within Colorado. | In 2010 the Behavioral Health Transformation Council reviewed a number of committees which govern the distribution of offender fees designated for alcohol and drug use services These groups have shown a willingness to explore the consolidation of their efforts. This coordination and consolidation will be explored further with the help of the Criminal and Juvenile Justice Commission in 2011. | The Behavioral Health Transformation Council will establish a date for a 1 or 2 day retreat to discuss priorities for the integration of behavioral health. |

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| **PREVENTION AND INTERVENTION FOR PERSONS UNDER AGE 26** | | | | |
| PI - 1 | Support local communities in their efforts to leverage prevention and intervention resources by implementing processes to update and expand available funding information within the Colorado BRAID database, and develop system utilization guidance documents for dissemination to state program managers and technical assistance providers to enhance the use of the database. | Leverage prevention/intervention programs to maximize resources and funding by examining Colorado BRAID (Braiding Revenue Across Interagency Departments), an existing online database that identifies federal and state behavioral health program funding primarily for early childhood programs, to include federal and state behavioral health program funding information for all children and youth prevention and intervention programs. | The sub-committee drafted a letter to be sent to Department and Division Directors requesting the assignment of relevant staff to review and update the specific funding streams included in this database. The letter also requests identification of any new federal or state funding related to behavioral health prevention and treatment for inclusion in the database. | In 2011, the Behavioral Health Transformation Council will approve and finalize the request letter and send it to Department and Division Directors. In addition, the Council will design a protocol for updating funding streams and training for data utilization. |
| PI - 2 | Coordinate with the Lt. Governor's Race to the Top initiative to implement social and emotional standards in education systems. | Implement social and emotional standards for schools to contribute to increased academic performance, school retention, increased graduation rates and other positive behavioral outcomes for youth. | The Colorado State Board of Education adopted Colorado Academic Standards: Comprehensive Health and Physical Education Standards in December 2009 These standards included: Standard # 3 - Emotional and Social Wellness and Standard and # 4 - Prevention and Risk Management | In 2011, the Behavioral Health Transformation Council will adapt these standards for utilization within other systems, such as early childhood programs, child welfare, youth corrections, etc. |

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| Number | Goal | Activities and Entities Involved | 2010 Accomplishments | 2011 Next Steps/Decision Points |
| PI - 3 | Coordinate with the Lt. Governor's Office and Colorado's Early Childhood Framework to develop standards for professionals providing mental health services for young children, defining competencies across departments and disciplines. | Establish standards for children and have standard competencies across departments and disciplines in order to improve the quality of early childhood mental health services, preventing or mitigating long-term negative outcomes. | The Behavioral Health Cabinet recommended not developing an implementation plan for this area and instead work with the Race to the Top initiative within the Lt. Governor's office. The Cabinet also recommended that implementation planning should coordinate with the standard development process underway through the Child Welfare Action Committee's newly formed Child Welfare Training Academy, following a similar format and model to the Academy's standard development process. No planning activity has taken place since Colorado was not chosen for the Race to the Top grant. | The Behavioral Health Transformation Council will conduct a 1 or 2 day retreat to establish and affirm priorities for 2011. This implementation item will be revisited at that time. |
| PI - 4 | Complete a review of youth transition plans across state and provider agencies to identify principles/values and common elements as standards to guide system transitions for youth in transition, ages 14 to 25. | Develop standards to guide system transitions for youth ages 14 to 25 with behavioral health needs who are transitioning out of child and youth serving systems in order to enhance opportunities for employment and education, secure adequate housing, and promote sustainability and livability within communities. | The committee developed and administered a survey with various youth systems in order to determine common elements and processes for transition planning. Many providers have some components of evidenced-based practices for transition-age youth. | The committee is currently reviewing the survey results in order to make recommendations to the Council on standard or common elements. |

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| **CONTINUITY OF CARE FOR HIGH-RISK, HIGH-NEED INDIVIDUALS** | | | | |
| CC - 1 | Streamline processes and associated paperwork across systems. Reform assessment requirements to avoid duplicate assessments in different systems; develop a common treatment plan across agencies with a greater awareness of referral/admission criteria in different systems. Ensure continued access to essential data needed for performance management and federal funding stream compliance (Medicaid and federal block grants) while reducing duplication, building on efforts such as the multi-year DBH/HCPF joint statewide performance indicator matrix for mental health and substance use disorders. | Joint data and paperwork streamlining workgroup established by HCPF and DBH in October 2009. | The Behavioral Health Transformation Council workgroup on this item convened mutiple stakeholders in 2009 and 2010 to examine options to reduce paperwork to increase efficiencies in the behavioral health system. The group focused on examining the current Client Care Assessment Record (CCAR) requirements and implementation practices. The group identified the following efficiencies and improvements: 1) Develop processes and improve understanding of state rules/contracts whereby initial treatment contact by providers is focused on meeing consumers treatment needs first and secondarily focusing on State data gathering needs; 2) Clearly distinguish differences in State requirements and provider data practices with regard to clients with brief behavioral needs and those with longer term needs; and 3) Continue to collect information that is necessary for reporting outcomes and other information to State agencies and State and federal stakeholders. | Once implemented, the following policy changes will be monitored over 2011: 1) A CCAR must be completed upon receiving 4 or more service encounters during a 6 month period. 2) For providers under contract with the Division of Behavioral Health, the above requirement does not exempt the provider from meeting any of its DBH contract targets such as "Indigent", SB 07-97, AIM etc. 3) Providers may voluntarily provide CCARs for clients with fewer than 4 service encounters. 4) Certain procedure codes enumerated in the "Service Encounters that are exempt from the CCAR Implementation Policy" table do not count toward meeting the "4 or more service encounters during a 6 month period." |

| Number | Goal | Activities and Entities Involved | 2010 Accomplishments | 2011 Next Steps/Decision Points |
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| CC - 2 | Streamline processes and associated paperwork across systems to develop other uniform intake forms and/or electronic records across systems. Establish cross-agency common consent forms. Remove the requirement that releases expire after one year and instead add the option of setting whatever date the consumer chooses (including "until revoked"). | For data sharing across behavioral health systems, build on the Colorado Behavioral Healthcare Council's, "Health Information Exchange for Behavioral Health", coordinating with the Colorado Regional Health Information Organization (CORHIO) and the Governor's Office for Information Technology. | The Colorado Regional Health Information Organization (CORHIO) was awarded $178,290 to work with a variety of partner organizations, including the Colorado Behavioral Healthcare Council, to examine the differing laws, rules, and practices regulating the exchange of mental health and substance use disorder treatment information. Health information exchange is a cornerstone of health care reform and this effort will remove barriers and pave the way for the appropriate exchange of behavioral health information. | The progress of this grant will be monitored in 2011. Any proposed legislation and rule changes involved will be reviewed, assessed and considered for endorsement by the Behavioral Health Cabinet and Transformation Council. |
| CC - 3 | Streamline processes and associated paperwork across systems to develop other uniform intake forms/electronic records across systems. Reform assessment requirements to avoid duplicate assessments in different systems. Develop a common treatment plan across agencies with a greater awareness of referral/admission criteria in different systems. | For data sharing across child/youth-serving systems: Colorado Children and Youth Information Sharing (CCYIS) initiative. | The Colorado Children and Youth Information Sharing Collaborative received almost $500,000 in federal funds to advance their work through the Governor's Office of Information Technology. The grant is funding the completion of data assessments of children and youth data systems in various state departments. The next big area of focus is privacy and confidentiality constraints in data sharing. The Government Data Advisory Committee and the Governor's Office of Information Technology are pulling together representatives from various data and information sharing efforts to form a Privacy Committee. Some newly received federal funds will assist in moving the work of the privacy committee forward. | S.B. 153 added the Governor's Office of Information Technology to the membership of the Behavioral Health Transformation Council. In early 2011, the Governor's Office of Information Technology will provide an overview of their initiatives and collaborations to the Transformation Council to assist in the Transformation Council's prioritization of projects for 2011. |

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| CC - 4 | Identify the "Top 400" utilizers of services across state agencies to serve as a benchmark for cost effectiveness and quality improvement, as well as to inform efforts to improve continuity of care. Compile an initial inventory of funding silos, gaps, opportunities for integration, and identify potential indicators for a prevention risk profile related to the "Top 400" service utilizers. | Ensure employment, housing, and local services are appropriately addressed in treatment/continuity of care plans. | The Continuity of Care work group identified clients receiving mental health services and their relationship to other service systems. This analysis was conducted through the examination of data collected through the Client Care Assessment Record (CCAR) and the Drug/Alcohol Coordinated Data System (DACODS). This data was then compared to clients served in corrections and child welfare systems. Of the 299 clients identified as using multiple services, 166 were eligible for Medicaid and 140 had actual Medicaid claims. The average cost for these 140 clients was almost $24,000 per person. The next step for this sub-committee is to perform an indepth case analysis of a sample of these high-need service utilizers. | In 2011, this sub-committee will examine a sample of actual cases to determine the services utilized and identify possible intervention points along the service utilization trajectory. The outcome of this review will be discussed by the Transformation Council to consider policy and programmatic changes designed to prevent this high level of service utilization for future populations. |

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| **Number** | **Goal** | **Activities and Entities Involved** | **2010 Accomplishments** | **2011 Next Steps/Decision Points** |
| CC - 5 | Identify indicators and develop an initial baseline report for a performance dashboard across state agencies to track BH transformation, with at least one key performance indicator per agency and at least one indicator each related to cultural congruence and consumer/family voice. | Improve quality of life outcomes and more efficiently use public and private resources for people with the highest needs served by multiple systems. Improve outcomes and increase efficiency through the integration of service systems, implementation of processes to enhance continuity of care, and reform of financing approaches across systems. | The Continuity of Care sub-committee prioritized other areas for work in 2010. | This item was under discussion by the Behavioral Health Transformation Council in late 2010. This item will be reviewed and prioritized by the Transformation Council in early 2011. |

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| **Number** | **Goal** | **Activities and Entities Involved** | **2010 Accomplishments** | **2011 Next Steps/Decision Points** |
| CC - 6 | Compile an initial inventory of existing evidence-based practices (EBPs) and related services that support Recovery, Systems of Care, and Cultural Congruence. | Improve quality of life outcomes and more efficiently use public and private resources for people with the highest needs served by multiple systems. Improve outcomes and increase efficiency through the integration of service systems, implementation of processes to enhance continuity of care, and reform of financing approaches across systems. | The Division of Behavioral Health within the Department of Human Services is in the process of cataloging fact sheets on evidenced-based and promising practices in the field of behavioral health. | In 2011, the Behavioral Health Transformation Council will review these practices and identify methods for distribution throughout the behavioral health system. |

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| Number | Goal | Activities and Entities Involved | 2010 Accomplishments | 2011 Next Steps/Decision Points |
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| **BEHAVIORAL HEALTH ISSUES IN THE CRIMINAL JUSTICE POPULATION** | | | | |
| CJ - 1 | Implement a standardized behavioral health screening process across the adult and juvenile justice systems and upon admission to city/county jails, probation, community corrections, and DOC for individuals charged with a municipal or state offense. | Improve the availability and quality of behavioral health services for people at risk. Use behavioral health services to reduce recidivism. Divert people better served in clinical settings from involvement in the criminal and juvenile justice systems. | In spring and fall 2010, the Behavioral Health Transformation Council explored the feasibility of county jails developing and implementing a common screening tool. The state agencies already use a common instrument, but no such instrument exists at the local level. The Criminal and Juvenile Justice Commission is also interested in pursuing this common instrument, therefore it will likely be pursued as a collaboration between the Behavioral Health Transformation Council and the Commission in 2011. | This initiative will likely be pursued in some form in 2011. Counties are concerned that the state will create an unfunded mandate for this tool, as well as the infrastructure cost associated with such a change. These issues will have to be reconciled and addressed if this initiative is to move forward. |
| CJ - 2 | Improve access to medications across correctional settings and the service systems that coordinate with them by finalizing recommendations regarding continuity of care issues as they relate to medication transfer between systems. | Improve the availability and quality of behavioral health services for people at risk. Use behavioral health services to reduce recidivism. Divert people better served in clinical settings from involvement in the criminal and juvenile justice systems. | This item was an initiative of the Mentally Ill in the Criminal Justice System Task Force, a subgroup of the Task Force for the Continuing Examination of the Treatment of the Mentally Ill in the Criminal Justice System. This group was suspended for one year during the 2010 session. | This initiative is still viewed as a high priority to develop a common formulary within the criminal justice system to improve the likelihood that offenders can maintain their current medication regimen once they leave the corrections system. This item will be reviewed and reprioritized during the retreat of the Behavioral Health Cabinet and Transformation Council in early 2011. |

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| **Number** | **Goal** | **Activities and Entities Involved** | **2010 Accomplishments** | **2011 Next Steps/Decision Points** |
| CJ - 3 | Develop a comprehensive, evidence-based training model for service providers across systems serving people at risk of becoming or involved in Colorado's criminal and juvenile justice systems that creates a cohesive approach to the behavioral health and criminal justice systems. | Improve the availability and quality of behavioral health services for people at risk. Use behavioral health services to reduce recidivism. Divert people better served in clinical settings from involvement in the criminal and juvenile justice systems. | The Division of Criminal Justice in the Department of Public Safety was awarded a $2.1 million Justice Assistance Grant to reduce recidivism among adult offenders by training criminal justice practitioners in evidence-based practices. This grant was endorsed by the Criminal and Juvenile Justice Commission and the Behavioral Health Cabinet and Transformation Council. It is being implemented through a collaboration of the Departments of Public Safety, Corrections, Human Services and Judicial. The evidence-based practices funded by the grant include motivational interviewing, cognitive behavioral therapies and mental health first aid. More than 360 individuals have been trained since May 2010. The grant employs the *Level of Supervision Inventory-Revised* instrument, which provides a validated risk and needs assessment. | This grant will be monitored by the Commission on Criminal and Juvenile Justice and the Behavioral Health Cabinet and Transformation Council. This grant utilizes a train-the-trainer model; therefore, the primary outcome measure of recidivism can be measured and evaluated after the grant period is over. |
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## Additional Collaborations/Activities Facilitated by the Behavioral Health Cabinet and Transformation Council

The creation of the Behavioral Health Cabinet and Transformation Council facilitated a number of other collaborations, which resulted in positive changes in the behavioral health system. These collaborations were not initiated by the Behavioral Health Cabinet and Transformation Council; however, the working relationships fostered through this process presented additional opportunities for collaboration on other projects, grants and initiatives occurring in the state. Summaries of these collaborations are highlighted below:

- The **Department of Local Affairs** contributed $600,000 to assist the **Colorado West Regional Mental Health Center** with its efforts to build three group homes for individuals with severe mental disabilities. The three homes will house up to 24 individuals in community group homes based on the closure of the Grand Junction Regional Center skilled nursing unit.

- The **Department of Local Affairs (DOLA)** is currently working with the **Department of Corrections** on developing transitional housing for offenders. The U.S. Department of Justice awarded the Department of Local Affairs $750,000 to provide supportive services to discharged inmates. DOLA's Division of Housing is pledging two years of rental assistance for up to 60 former felons to complement these services. The Mental Health Center of Denver (MHCD) and Arapahoe/Douglas Mental Health Network (ADMHN) will create Assertive Community Treatment (ACT) teams to provide forensic treatment for these 60 Department of Corrections (DOC) offenders who are suffering from co-occurring substance use disorders and serious mental illness and are being released "as homeless" to Denver and Arapahoe Counties. The ACT teams will utilize a comprehensive array of community-based services that provide substance abuse treatment, psychiatry, psychotherapy and wrap-around case management, including housing search and placement, transportation, medication, vocational and job placement assistance, and family counseling to assist these former offenders.

- The **Department of Local Affairs' Division of Housing** will sponsor a training program for affordable housing property managers to learn to identify tenants with behavioral conditions that can be attributed to mental illness or other medical conditions. Many tenants labeled "troubled tenants" face possible eviction or nonrenewal of leases due to a pattern of conflicts with property managers or other tenants. Resources like Mental Health First Aid will be included in the curriculum.

- The **Department of Local Affairs' Division of Housing** applied Neighborhood Stabilization Program 1 funds (federal stimulus money for foreclosed properties) to **three multi-family acquisition/rehabilitation projects**:

- Aspen Leaf Apartments, Aurora
  Grantee: Arapahoe/Douglas Mental Health Network (ADMHN)
  Grant Funds: $918,000
  Acquisition and rehabilitation of a 12-unit multi-family property in Aurora, Colorado. Upon completion of rehabilitation on the property, ADMHN provides subsidized rental housing in a community environment to clients of the Arapahoe Mental Health Court. One unit will be set aside for an on-site manager earning up to 120% of Area Median Income (AMI), and the remaining 11 units will serve households at 50% of AMI or lower. ADMHN has staff dedicated to management of the organization's residential facilities and independent living apartments. Their in-house property management provides services such as administration of the Section 8 program, screening of potential residents, and ongoing maintenance and repairs of the facilities owned by the organization.

- Fox Street Apartments, Littleton
  Grantee: Arapahoe/Douglas Mental Health Network (ADMHN)
  Grant Funds: $1,609,675
  Acquisition and rehabilitation of a 16-unit multi-family property in Littleton, Colorado. A two-building property with eight units each, one unit will be set aside for an on-site manager earning up to 120% of Area Median Income, and the remaining 15 units will serve households at 50% of AMI or lower. Some of these apartments will be available to those who receive services at ADMHN and who have demonstrated their readiness for independent living. ADMHN management will provide building supervision, and in particular, support for ADMHN clients to ensure their success in this environment. Rehabilitation work will include new boilers and new windows to improve the buildings' energy efficiency.

- 1700 7th Avenue, Greeley
  Grantee: Greeley Urban Renewal Authority (GURA) and partnering contractor North Range Behavioral Health
  Grant Funds: $1,020,000
  Approximately half of the contracted funds will be used to acquire and rehabilitate the property on 7th Avenue, and half will be used for a separate 4-plex property in Evans. Greeley Urban Renewal Authority (GURA) acquired a nine-bedroom house in Greeley to rehabilitate and house clients of North Range Behavioral Health, an organization providing services for persons with mental disabilities. Each resident will have a permanent long-term lease for an individual bedroom and personal storage space in a shared-living residence, and all units will serve households (primarily individuals) at or below 50% of the Area Median Income.

- Persons with behavioral health issues who have safe, decent housing and access to services are more likely to experience positive outcomes. To that end, the **Department of Local Affairs** (DOLA) contracted with the **Department of Human Services** to receive

**Temporary Assistance for Needy Families (TANF) Supplemental Program funds.** This program provides financial assistance, housing relocation and stabilization services to prevent individuals and families from becoming homeless and those who are experiencing homelessness to be quickly re-housed and stabilized.

**The Department of Local Affairs** contracted with **Colorado Coalition for the Homeless** to serve the Metro Denver area and the balance of the state in an award totaling just over $4.0 million. Over 4,000 persons were served. DOLA contracted with the City of Colorado Springs to serve El Paso County in an award of $451,506, and 303 persons were served.

- **Metro Crisis Services** opened its Crisis Line during the summer of 2010. Initially, the service provided immediate professional support and consultation only to members of law enforcement while they intervened with individuals and families affected by mental health or substance abuse issues. By the end of the summer, the Crisis Line became a 24/7 operation, open to the whole seven-county Denver Metro community. Any resident of the region can call Metro Crisis Line for help with any mental health or substance abuse problem, including immediate suicide intervention; all calls are answered 24/7 by licensed mental health professionals.

- The **Department of Human Services** conducted meetings throughout 2010 on **improving the service continuum for geriatric, adolescent and child mental health services** following the closure of these units at the Colorado Mental Health Institute at Ft. Logan. These meetings resulted in identifying a model for short-term respite services for youth as a diversion from inpatient psychiatric hospitalization. This model will be shared with community providers and hospitals as an option for diversion or step-down from inpatient care.

  A separate workgroup is exploring the feasibility of a secure residential placement for the geriatric population with behavioral health needs who do not need extensive nursing care. This group has only begun meeting on service options for this growing population.

  Both groups represent collaborations between the Departments of Human Services, Health Care Policy and Financing and Public Health and Environment with local providers including acute care hospitals, therapeutic residential child care facilities, psychiatric residential child care facilities, behavioral health organizations and community mental health centers.

- **The Colorado Commission on Criminal and Juvenile Justice** is a statutorily created commission to study and make recommendations concerning multiple facets of the justice and correctional systems to ensure public safety, reduce recidivism of offenders, and enhance victim protections. The 26 members represent state and local agencies as well as legislators and other interest groups. The Commission **identified offenders' behavioral health needs as a critical issue** and made recommendations relating to

funding, agency practices, and legislative changes to encourage appropriate identification of needs and delivery of treatment services.

- The **Governor's Child Welfare Action Committee** prioritized a workgroup to develop strategies to enhance county child protection workers' ability to address domestic violence, mental health and/or substance use disorder issues when encountered on a child protection case. This group was composed of law enforcement, judicial, and other representatives of the criminal justice system in addition to service providers. The committee's recommendations were submitted to the Governor in early 2010 and were approved for implementation.

- **Colorado Children's Trust Fund:** The Colorado Children's Trust Fund (CCTF) is a statutorily mandated child abuse and neglect prevention program at the **Colorado Department of Public Health and Environment.** The CCTF utilizes state and federal funds to support local communities in their efforts to provide research-based curricula to the parents and children in their area. These programs include the Nurturing Parenting and Incredible Years programs, both of which are offered in a group setting. The CCTF also funds the SafeCare program in Denver County; this program is provided in a home-visitation modality.

  Some grantees of the Colorado Children's Trust Fund also coordinate service provision with their local mental health centers, but needs are typically communicated to county departments of human and social services which then refer clients to local mental health centers.

- **Family Resource Center Program:** The Family Resource Center program at the **Colorado Department of Public Health and Environment** coordinates federal funding for local family centers' activities designed to prevent child abuse and neglect. These services utilize many curricula and are offered in both group and home visitation settings. Most family resource centers across the state coordinate their services and referrals with other child and family-serving agencies in their community. These include referrals to and from local mental health centers, where available.

- **Injury Prevention:** The Office of Suicide Prevention in the **Department of Public Health and Environment** funds:
  - Communities to organize and host gatekeeper training programs, which teach community members how to recognize the risk factors and warning signs for suicide, intervene with suicidal individuals, and refer them to life saving services.
  - The Pueblo Suicide Prevention Center to staff calls to the National Suicide Lifeline, a 24/7 hotline for those in suicidal crisis. Funds also support the collection of caller data throughout the year.
  - The design and dissemination of educational and awareness materials statewide.

- The Program Manager of the Office of Suicide Prevention serves on the advisory board of the School Safety Resource Center and Safe2Tell, both agencies work on safety among school-aged children/youth.

➢ **Interagency Prevention Systems Program:** The Interagency Prevention Systems Program oversees the coordination of prevention, intervention and treatment programs and services across multiple state departments, as outlined in C.R.S. 25-20.5(101-109).

The Director of Interagency Prevention Systems assists with the coordination of children and youth behavioral health initiatives, including Colorado LINKS for Mental Health, Care Coordination Work Group, Colorado System of Care Collaborative, Blue Ribbon Policy Council on Early Childhood Mental Health, and the Medical Home Initiative. The director also chairs the Colorado Prevention Leadership Council.

The work of the Interagency Prevention Systems program has fostered improved coordination across state programs and state agencies and is instrumental in implementing the strategies of the State Plan for Prevention, Intervention and Treatment Services for Children and Youth, 2010-2030, which includes strategies for improving coordination and integration of state-managed children and youth behavioral health services.

➢ **Screening, Brief Intervention and Referral to Treatment (SBIRT):** SBIRT Colorado is a grant to the Office of the Governor that is being implemented as a collaborative public-private partnership. The state government partners include the Office of the Governor, the Division of Behavioral Health (Colorado Department of Human Services), Interagency Prevention Systems Program (Colorado Department of Public Health and Environment/Prevention Services Division) and the Medicaid Program (Health Care Policy and Financing). The non-state partners are Peer Assistance, Inc., Health TeamWorks (formerly the Colorado Clinical Guidelines Collaborative), Colorado Association of Alcohol and Drug Service Providers, and OMNI Institute.

- SBIRT is an evidence-based, public health approach to preventing risky substance use behavior. Patients are screened for levels of substance use risk behaviors using standardized screening tools in primary healthcare settings. SBIRT Colorado is currently providing services to a broad range of patients in 26 clinical settings within 12 healthcare sites in urban, rural, and frontier healthcare settings across Colorado.

- As of November 1, 2010, over 95,000 screens were completed with about 3,000 screens occurring per month. The efficacy of SBIRT in reducing the substance use of patients is supported by results from six month follow-up with patients that screened positive for high-risk substance use:

- Days of alcohol use fell by 48% and overall days of illicit substance use fell by 44%.
- Days of binge drinking (consuming 5 or more drinks in a single sitting) fell by 51%.
- Days of cannabis and cocaine use fell by 43% and 88%, respectively.

➢ **Colorado Prevention Leadership Council:** The State Plan for Prevention, Intervention and Treatment Services for Children and Youth, 2010-2030, signed by Governor Bill Ritter, Jr., includes a goal for state agencies that fund children and youth programs to utilize a system of care approach that fosters more efficient use of resources and more effective, integrated responses to needs children and youth, inclusive of behavioral health needs.

The Colorado System of Care Values and Principles, adopted by the Colorado Prevention Leadership Council and ten other interagency groups that address children and youth issues, serves as a common guide and foundation for creating a more coordinated, integrated continuum of services.

The Colorado Prevention Leadership Council consists of representatives of ten state agencies and two universities and is formed by inter-departmental memoranda of agreement and supported by state statute. The Council promotes coordinated planning, implementation, and evaluation of quality prevention, intervention and treatment services for children, youth and families (www.colorado.gov/plc).

➢ **Colorado LINKS:** The mission of the Colorado LINKS is to promote partnerships among state agencies and key stakeholder groups by weaving together existing efforts to create a more coordinated continuum of mental health services for Colorado children, youth, and families.

The Colorado LINKS partnership consists of broad-based representation of family organizations, behavioral health professionals and advocates, and six state departments.

- The partners are representatives of the Colorado Department of Human Services, Colorado Department of Public Health and Environment, Colorado Department of Education, Colorado Department of Health Care Policy & Financing, Colorado Department of Public Safety, Colorado Judicial Department, Colorado Prevention Leadership Council, Colorado Systems of Care Collaborative, the Federation of Families for Children's Mental Health ~ Colorado Chapter, the Mental Health Planning & Advisory Council, and the Center for Systems Integration.

- Accomplishments of Colorado LINKS include:
    - Integration Efforts: The Repository for Systems Transformation (ReST) is an on-line toolkit for communities and state agencies to utilize in undertaking cross-system transformation efforts on behalf of children, youth, and their families (www.cdphe.state.co.us/ps/ipsp/ReST).

- Development and Dissemination of the Family and Youth Involvement: The Colorado LINKS for Mental Health Family and Youth Involvement: A Workbook for Policy and Governance Boards and Planning Groups.
- LINKING *YOU to Important System Integration News* is an on-line newsletter of Colorado LINKS that communicates current activities related to children and youth behavioral health issues to over 500 stakeholders.(www.csi-policy.org/linkingyou/sept10.html).

➢ **Building Bridges for Children's Mental Health:** Building Bridges for Children's Mental Health (Building Bridges,) initially funded by a U.S. Department of Education Grant, is focused on building a statewide system to support increased access to behavioral health services and improved outcomes for school-aged children and youth. It integrates two complementary approaches currently in place in many Colorado communities: Positive Behavioral Interventions and Supports (PBIS) and Systems of Care (SOC.)

Key partners in the Building Bridges Grant include the Colorado Department of Education, Colorado Department of Human Services/Division of Behavioral Health, Colorado State Judicial Department, and the Federation of Families for Children's Mental Health – Colorado Chapter. The state cross-system Leadership Team is the Grant Implementation Group (GIG) of the Colorado LINKS for Mental Health Initiative. Mesa County Valley School District #51, along with their community partners replicating the above agencies, served as the grant demonstration site.

Accomplishments include:

- Development of a referral protocol between school systems and behavioral health services that includes parent consent and a system for communication to ensure access to services;
- Development of a series of behavioral health fact sheets designed specifically for families and educators;
- Assisted in the development of the Social and Emotional Learning (SEL) components of the Comprehensive Health and Physical Education Standards that were adopted by the Colorado Board of Education in December 2009. Sample grade-specific K-12 benchmarks were also developed.
- Collaborated with the School Safety Resource Center within the Department of Public Safety and the Office of Suicide Prevention within CDPHE to provide two Youth Suicide Prevention Symposia (May and October, 2010) designed to educate school and community mental health professionals regarding evidence-based and best practices for prevention, suicide risk assessments and 'postvention'. A majority of attendees planned to use the information presented in their work.
- These and additional resources are available at http://www.cde.state.co.us./cdesped/BuildingBridges.asp and at http://www.csi-policy.org/buildingbridges/

# APPENDIX 1

## Questions on the implications of recent legislative changes on the behavioral health care landscape

The Behavioral Health Cabinet and Transformation Council are actively responding to initiatives underway as the State of Colorado responds to laws that are impacting health care, and more specifically, behavioral health care. The behavioral health legislative landscape has been changed significantly over the past three years by both state and federal laws. We now stand at an intersection with many possible scenarios for future development to enhance behavioral health treatment for the citizens of Colorado. There are four major legislative changes that have led to an overall change in the landscape for the delivery of these services:

1. Wellstone-Dominici Mental Health Parity Act of 2008 is a federal law that became effective in 2010. It requires that when behavioral health services are a plan benefit, they must be treated in a similar (at parity) manner to medical conditions.

2. The Medicare Improvements for Patients and Providers Act was signed into federal law in 2008. One of its provisions is to change the 50% co-payment for mental health services, which has been required for over 40 years, to 20%, consistent with other Medicare Part B co-payments for medical visits. This change will occur gradually with full implementation expected in 2015.

3. The Colorado Healthcare Affordability Act was signed into state law in 2009. This Act directs the Colorado Department of Health Care Policy and Financing to assess a fee on all Colorado hospitals for the purposes of expanding Medicaid to new populations in Colorado, including low income childless adults, and expanding eligibility for CHP+ to more low-income children and pregnant women.

4. Finally, the Patient Protection and Affordable Care Act was signed into federal law in 2010 and will be implemented through 2018. It expands health insurance coverage through a combination of Medicaid expansion and individual coverage requirements. For the first time, behavioral health benefits will be included in a basic benefit package commensurate with physical health.

Additional issues and questions to consider as the BHTC moves forward include:

1. Behavioral Health Care will be included as an equal benefit to physical health care under the Patient Protection and Affordable Care Act. However, it is not yet known what will be included in the federally mandated minimum benefit package for behavioral health care. The BHTC will need to continue to monitor and evaluate its activities against any changes to the behavioral health care system brought about by federal or state health care reform.

2. The Department of Health Care Policy and Financing will be expanding Medicaid eligibility to Adults Without Dependent Children (Aw/oDC) up to 100% of the federal poverty level in 2012. Behavioral health benefits for this previously uninsured population will need to be designed in relation to the new minimum benchmark benefit that will be required in 2014.

3. As a huge number of individuals with mental health issues are treated in the juvenile/correctional system, how can we utilize healthcare reform to better bridge the gap in services when this population transitions back into the community?

4. Can we find a way to utilize (and pay for) peer support specialists, with/without a history of involvement in the correctional system, to assist with navigation and other recovery services for the juvenile justice/correctional population?

5. Will a Primary Care Medical Provider (PCMP) or case managers serve as "gatekeepers" for substance use disorder treatment, now or in the future?

6. Will PCMPs be responsible for approving or denying care by "specialty providers?" How will PCMPs identify substance use disorder needs and refer to the appropriate level of care?

7. Can Colorado consider implementing a "no wrong door" policy for clients seeking behavioral health treatment?

8. What can we do to prevent clients with a SUD (Substance Use Disorder) from facing a complex system in which they must first obtain Medicaid, then locate a PCMP; disclose substance use/abuse, which is particularly challenging for pregnant women, adolescents, etc; and then trust that the primary care physician will assess their needs and refer them to appropriate treatment?

9. What happens when a Medicaid Member who is passively enrolled in the Regional Care Coordination Organization (RCCO) pilot is already an enrolled client in a 'specialty' substance use disorder treatment provider organization? Will that Member/client need to be discharged and/or transferred to a provider who is in the RCCO network, or will the PCMP authorize the treatment in the provider organization in which the client is currently enrolled?

10. Similarly, what happens to adolescents in Therapeutic Residential Child Care Facilities (TRCCFs) if they are passively enrolled in the RCCO pilot? Will these adolescents need a referral from the PCMP or authorization for this level of care? What, if any, roles will county social services departments play in making these referrals for adolescents?

11. Who will manage the Medicaid program for pregnant substance using women (Special Connections) benefit and what relationship, if any, will that entity have to the RCCOs and PCMPs? Will the Special Connections benefit continue to be managed by DBH? How will the 12 months post-partum portion of the benefit be administered? What is the plan for pregnant women in residential or outpatient SUD treatment through Special Connections if they are passively enrolled in the pilot RCCO? Will their referrals or continuation in treatment require authorization by the PCMP?

12. What role, if any, will Managed Service Organizations (MSOs) and Behavioral Health Organizations (BHOs) play in the future?

13. Many Colorado Criminal Justice clients, particularly those in Community Corrections, are unable to access Medicaid. How will they be covered? Clients in other states are eligible; can we make efforts to ensure Colorado clients are also eligible?

14. What can we do if primary care physicians do not refer to behavioral health care?

15. What can Colorado do to collect data about primary care's referral rate to behavioral healthcare and how can we measure this against state prevalence data?

16. How will we ensure that at-risk and priority populations continue to be served?

17. What will happen to residential treatment for adolescents and pregnant women in Colorado

18. What will happen to the Block grant funds when Medicaid covers most people?

19. Will methadone or other Medication Assisted Therapies be covered under the Medicaid substance abuse benefit?

20. What can Colorado do to ensure that there are CPT codes available and open for all of the behavioral health services that need to be billed?