SENATE BILL 19-222: COMPREHENSIVE PLAN TO STRENGTHEN AND EXPAND THE BEHAVIORAL HEALTH SAFETY NET SYSTEM

COLORADO
Office of Behavioral Health
Department of Human Services

Table of Contents

Acknowledgements

The development of the recommendations to implement a behavioral health safety net model and framework relied on significant contributions and recommendations from stakeholders across the state. CDHS and OBH conducted over 30 presentations in the Spring of 2021 and was able to incorporate feedback from the following organizations:

Colorado Crisis Services Administrative Service Organizations, including the Substance Use Disorder and Crisis Services Integration Workgroup
Colorado Directors Human Services Association
Colorado Counties and Community Partners
Colorado County Commissioners
Colorado Providers Association
Colorado State Parole Board
Colorado Judicial Branch- Correctional Treatment Board
Colorado Behavioral Health Care Council
Colorado Accountable Care Collaborative- Performance Improvement Advisory Committee-Behavioral Health Integration Subcommittee & Operations Workgroup
Health Care Policy and Financing Hospital Forum
Health Care Policy and Financing, Regional Accountable Entities and Counties Collaborative Forum
Mental Health Colorado
Colorado Community Health Network
Single Entry Points and Community Center Board
Children's Services Steering Committee
Colorado Center on Law and Policy
Colorado Hospital Association
Children's Hospital Colorado
Colorado Safety Net Collaborative
Colorado Health Care Policy and Financing IMD Forum
Health Management Associates
Healthier Colorado
Co-Occurring Disabilities Workgroup

Special Thanks to individual contributors:

Carrie Paykoc, Office of eHealth Innovation
Rachel Dixon, Prime Health
Yumiko Dougherty, Director of Strategic Planning & Implementation Community Partnerships, CDHS
Mollie Bradlee, Deputy Director, Office of Children Youth and Families, CDHS
Glenn Tapia, Director Division of Probation, Colorado Judicial Branch
Chad Dilworth, Vice Chair, Colorado State Board of Parole
Shelly Solopow, OBH Tribal Liaison, CDHS
Kathryn Redhorse, Executive Director, Colorado Commission of Indian Affairs
Jenifer Lewis, Interagency Tribal Liaison, Colorado Commission of Indian Affairs
Dr. Darlene Tad-Y, Colorado Hospital Association
Sylvia Park, Colorado Hospital Association
Patrick Gordon, CEO, Rocky Mountain Health Plans
Meg Taylor, Vice President of Community Integration, Rocky Mountain Health Plans

Daniel Darting, CEO, Signal Behavioral Health
Nancy VanDeMark, Innovela Consulting
Lauren Snyder, State Policy Director, Mental Health Colorado
Dr. David Keller, Vice Chair, Clinical Strategy & Transformation, Department of Pediatrics, Children's Hospital Colorado
Dr. Kimberly Nordstrom, Colorado Access

Colorado Department of Human Services-Office of Behavioral Health:
Andrew Gabor, CDHS
Christopher Miller, CDHS
Deb Hutson, CDHS
Jennifer Wood, CDHS
Larena Hatley, CDHS
Lindsay Sandoval, CDHS
Liz Owens, CDHS
Victoria Gallegos, CDHS
Jagruti Shah, CDHS
Carie Gaytan, CDHS
Ryan Templeton, CDHS
Dr. Robert Werthwein, CDHS
Summer Gathercole, CDHS

Colorado Department of Health Care Policy and Financing:
Ben Harris, HCPF
Ling Cui, HCPF
Michelle Craig, HCPF
Gina Robinson, HCPF
Melissa Eddleman, HCPF
Colin Laughlin, HCPF
Jenn Barr, HCPF
Laurel Karabatsos, HCPF
John Laukknen, HCPF
Sandra Grossman, HCPF
Amy Luu, HCPF
Matt Pfifer, HCPF
Morgan Anderson, HCPF
Jeff Eggert, HCPF
Josh Winkler, Colorado Governor's Office
Elisabeth Arenales, Colorado Governor's Office

And primary authors:

Camille Harding, Strategy and Innovation Officer, Office of Behavioral Health, Colorado Department of Human Services
Cristen Bates, Senior Advisor on Affordability Partnerships, Colorado Department of Health Care Policy and Financing

Introduction and Purpose

Senate Bill 19-222 (SB 19-222) requires that the Colorado Departments of Human Services (CDHS) and Health Care Policy and Financing (HCPF) address systemic issues to developing a behavioral health safety net for Colorado. The bill requires CDHS and HCPF to strengthen and expand the safety net system so that individuals with behavioral health disorders will *not be allowed to be turned away from treatment or discharged without help and coordination unless or until the individual no longer requires behavioral health services*.[1]

In service to this goal, and in accordance with the statutory requirements of SB 19-222 (C.R.S. 27-63-104 (2)), CDHS and HCPF have developed a comprehensive proposal that strengthens and expands the safety net system that provides behavioral health services to individuals with severe behavioral health disorders, including individuals with co-occurring mental health and substance use disorders (SUD).

According to SB19-222, the proposal must:

1. Identify which behavioral health services each community must have access to in each region of the state, including intensive community-based treatment and supportive services to ensure that individuals with the most difficult-to-treat disorders are receiving services.
2. Develop a funding model to ensure the ongoing viability of the safety net system. The funding model must supplement and not supplant any state funding to complement Medicaid, federal substance abuse prevention and treatment block grants, federal mental health services block grants, and private pay funding.
3. Provide locally responsive recommendations, including legislative recommendations, to address behavioral health provider licensing and regulations, housing, transportation, workforce, and any barrier that curbs access to care.
4. Set forth criteria and processes, in collaboration with behavioral health providers, for when the needs of an individual referred to a safety net provider exceed the treatment capacity or clinical expertise of that provider.

This proposal outlines a new comprehensive safety net system for behavioral health in Colorado that is to be implemented by the state in January of 2024 to improve the health and lives of Coloradans with behavioral health needs.[2]

Description of Need

The need for a comprehensive behavioral health system in Colorado was solidified by SB19-222 and was confirmed by multiple reports, stakeholder feedback, and an advisory body.[3] *Putting People First: A Blueprint for Reform,* developed by Governor Polis's Behavioral Health Task Force (BHTF), identified that Colorado has "historically struggled to consistently and equitably meet the overarching community needs for mental health and substance use services."[4] This

statement reflects the persistent and prevalent problems of behavioral health care in the state of Colorado.

- From April 28-May 10, 2021, 30.8% of Coloradan adults reported symptoms of anxiety and/or depressive disorder.[5]
- Between 2018-2019, 23.2% of Coloradans reported mental illness in the previous year.[6]
- In 2019, more than one in 10 Coloradans (13.5%) said they were unable to get mental health care that they needed, up from 7.6% in 2017.
- Substance use disorders (SUDs) are a particularly critical problem in Colorado. Between 2017 and 2018, 11.9% of people age 18 and older in Colorado reported an SUD in the past year, higher than the national rate of 7.7%.[7]
- In a 2019 study, over 95,000 Coloradans 18 and older (2.3%) did not get treatment or counseling to address their dependencies.[8]

Overall, Colorado has a higher need for behavioral health services and higher than average national rates of tragic outcomes that can result from untreated behavioral health conditions, including suicide and addiction-related deaths. The stressors of the COVID-19 pandemic, the associated economic fallout, and the disproportionate impact those events had on already-marginalized communities are worsening behavioral health and access to care in the state. [9] As behavioral health reform progresses, it is absolutely vital for the wellbeing of Coloradans to ensure that every Coloradan can access the behavioral health care they need when they need it.

2020 Behavioral Health Needs Assessment

The Office of Behavioral Health's (OBH) *2020 Behavioral Health Needs Assessment*[10] (the Needs Assessment) identified several key areas within Colorado's behavioral health care delivery system as causes for concern: fragmentation of responsibility; lack of integration of services; and inadequate services for individuals who need a higher level of care than routine services.[11] Key findings of the Needs Assessment include:

Fragmentation in the system impacts client care
Mental health and substance use programs are overseen by multiple state agencies and are funded by many separate sources. As a result, there are silos in behavioral health services which create gaps in care for individuals in need. One of the results of a system with silos and fragmentation is there is no shared vision for behavioral health in the state. Instead, there are many visions in silos. *A shared vision across state agencies would support the state in building a stronger system of care*.

Treatment integration is lacking across the continuum of delivery system
Stakeholders identified that poor integration of services impacts a client's ability to access the right level of care. In the Needs Assessment, integration is described as "treating behavioral

health and physical health together; treating mental health and substance use together." Additionally, integration involves integrating oversight, licensing, standards of care, and accountability for a core set of services across the state.

The middle is missing

Subacute services, or those that fall between traditional outpatient and the more intensive inpatient services, are limited. Many of these programs that previously existed have been cut due to budgetary concerns, lack of Medicaid funding, and other considerations such as regulatory requirements. Stakeholders described a need for greater focus on intensive outpatient programs, especially those that can be tailored to priority populations, such as Assertive Community Treatment, Intensive Case and Care Management, High Intensity Wrap-around, Dialectical Behavior Therapy and Intensive Outpatient Programs for substance use. They highlighted the need for more transitional step down and recovery settings and sober and recovery living environments.

The Comprehensive Safety Net Service Model and Framework for Colorado

Developing the Model and Framework

Prior to preparing a final proposal, SB19-222 required CDHS and HCPF to develop a draft implementation plan to increase the number of high-intensity behavioral health treatment programs, including programs that serve youth statewide. CDHS and HCPF worked collaboratively and used this implementation plan, the recommendations from the BHTF (including the Safety Net Subcommittee), data and policy research, and a review of evidence-based best practices to create a model titled the *Comprehensive Safety Net System Model and Framework*, which

- addresses systemic fragmentation, aligns policies, accountability, and regulatory oversight, and reduces the silos that are present in the current delivery system
- outlines specific steps to re-define what a core set of behavioral health services should deliver in order to achieve the goal of a comprehensive and coordinated behavioral health safety net system
- includes new value based funding opportunities for comprehensive behavioral health provider agencies that increase client access to High Intensity

The Comprehensive Behavioral Health Safety Net Model and Framework serves as the shared vision across state agencies to support the state in building a stronger system of care.

Behavioral Health Treatment Services that keep clients healthy and support a coordinated transition following an acute episode of care, such as a hospitalization or residential treatment stay

- supports behavioral health integration in primary care settings
- creates new standards for comprehensive safety net providers requiring them to provide services for mental health, substance use, and co-occurring disorders

Incorporating Stakeholder Recommendations

In Spring 2021, the initial draft of the framework was presented to a variety of stakeholders in over twenty five public stakeholder feedback sessions which included primary care providers, Regional Accountable Entities (RAEs), Managed Service Organizations (MSOs), community mental health centers (CMHCs), Health First Colorado members and families, behavioral health advocates, substance use disorder providers, justice system personnel, and other stakeholders. Coupled with the findings from the Behavioral Health Needs Assessment, CDHS and HCPF directly incorporated stakeholder feedback on plan elements concerning priority populations, value-based payments, and care coordination. An overview of the stakeholder feedback and the state's response can be found in Appendix A.

Providing Culturally and Linguistically Competent Services for Priority Populations

Disparities in care grow and are experienced more acutely for individuals with membership in multiple priority population groups (e.g., individuals who experience homelessness who also have a history of criminal justice involvement; LGBTQ+ youth who are also BIPOC; or individuals with disabilities who also have justice involvement). Delivering services in a culturally and linguistically competent manner is critical to the successful implementation of the Comprehensive Safety Net Model and Framework and to the long-term improvement of behavioral health outcomes for these populations.

The Safety Net system must effectively and proactively engage with underserved populations and individuals with the most difficult-to-treat disorders. The following priority populations have been identified through stakeholder conversations, the *Behavioral Health Needs Assessment*[12], and recommendations from the BHTF as critical opportunities to improve care:

1. Children, Youth, and Families, including those involved in the Child Welfare system and those with complex treatment needs
2. Individuals with justice involvement
3. Individuals with disabilities
4. Black and indigenous people of color (BIPOC)
5. Individuals experiencing homelessness and housing instability
6. Individuals with Serious Mental Illness

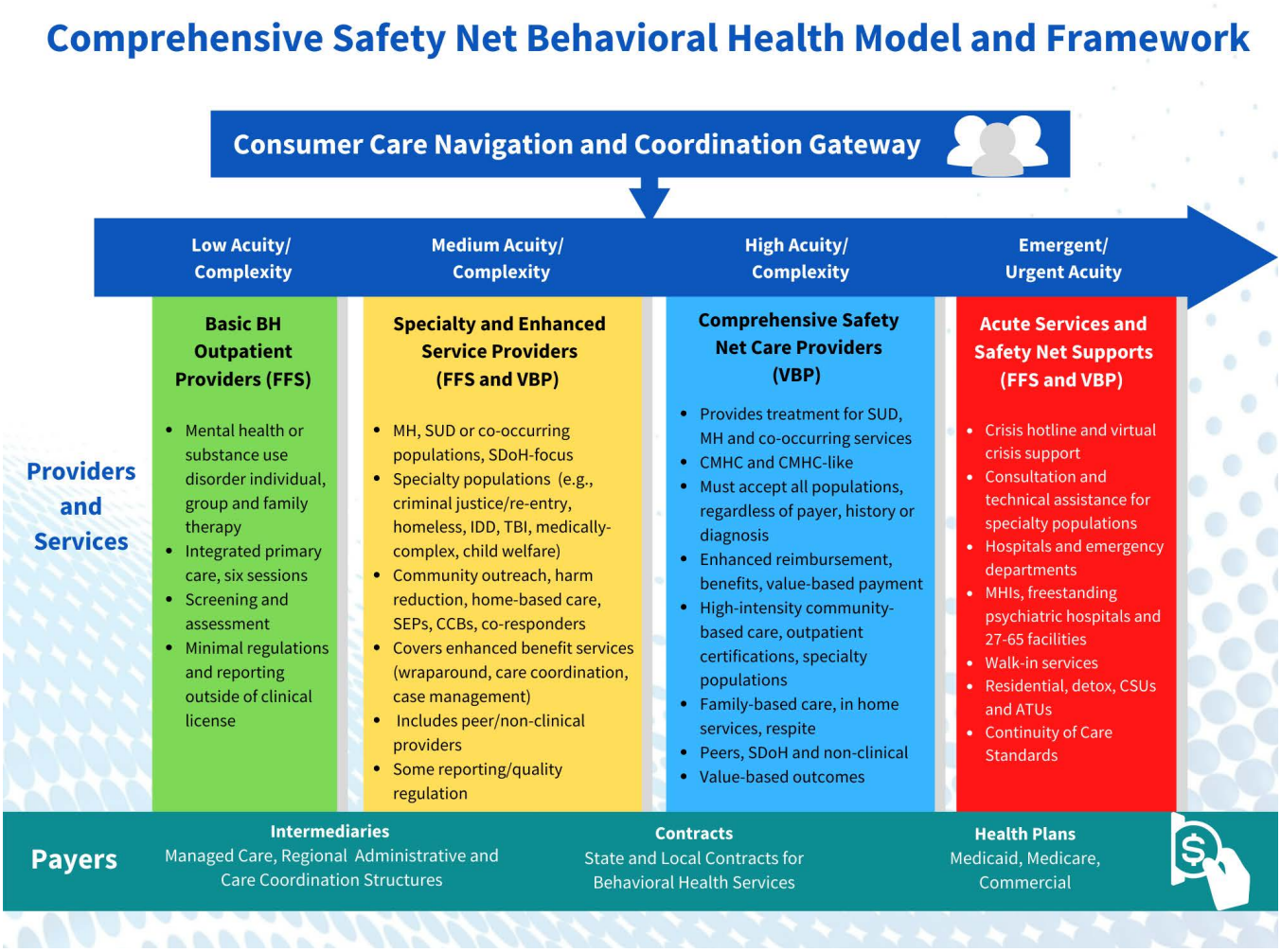
7. Veterans
8. Lesbian, Gay, Bisexual, Transgender, Queer+ (LGBTQ+)

Overview of the Comprehensive Safety Net Model and Framework

The Comprehensive Safety Net Model and Framework identifies behavioral health services that each community must have access to in each region of the state. These services include intensive community-based treatment and supportive services to ensure individuals with the most difficult-to-treat disorders are receiving services.

The Comprehensive Safety Net Model and Framework is organized along a continuum to address the need described in the legislation for SB 19-222 for "improved access to a high-quality behavioral health system that serves individuals regardless of payer type or acuity level and that has a full continuum of behavioral health treatment services".[13] The model is designed with the acknowledgement that an individual's need for treatment is based both on acuity (how severe are a client's symptoms) and complexity (how a client's behavioral health needs intersect with medical and social needs).

Comprehensive Safety Net Behavioral Health Model and Framework



The Comprehensive Safety Net Model and Framework Addresses Core SB19-222 Aims

At its core, SB19-222 is focused on "improvement of access to behavioral health services for individuals at risk of institutionalization." Its aim is to increase access and system capacity to provide community-based and High Intensity Behavioral Health Treatment Services. The Comprehensive Safety Net Model and Framework addresses this aims by:

Expanding Community-Based Services. The model and framework provide better community-based care that can help prevent the need for institutionalization and ensure that individuals can step down gently from an institution with the proper supports to maintain wellness and recovery. Improving community-based resources can help decrease use of inpatient resources by those who can be served in the community, creating more inpatient capacity for those who need it.

Ensuring Treatment Access for all. The model and framework require comprehensive safety net providers to serve individuals with mental health and substance use needs, as well as those who have co-occurring conditions. This reduces the fragmentation and reliance on primary vs.

secondary diagnostic criteria that keep people from getting the care they need. The model also brings specialty providers into the network more directly, requires a higher standard for cultural competency among all providers, and offers technical assistance to help small, medium, and large providers meet this standard.

- By creating new specialty and enhanced provider types and providing statewide technical assistance to providers who want to do the right thing and serve the safety net population, the model lowers the barriers of entry into the system for small and medium sized providers.
- By creating new standards for comprehensive safety net providers that include SUD services and higher standards for cultural competency and population-specific care in every community, the model ensures access for individuals seeking care.

Promoting Flexible Funding. The model provides additional opportunities for sustainable funding for essential safety net providers, more funding for high-benefit low cost services that keep people healthy, and more flexibility to provide whole person care.

Addressing Social Determinants. The model requires the state to expand reimbursement opportunities for proactive and alternative support programs, such as connection to social benefits, housing supports and support for homeless service providers, transportation services, and in-home behavioral health services.

Creating a Unified Network and Full Continuum of Care. Currently, the state has many different ways to pay for services and different providers accepting public payments, making it hard for clients to find the "right provider" that accepts their coverage. The Comprehensive Safety Net Model and Framework, in conjunction with the upcoming expansion of the Medicaid financial operation system to include other state payers, will create a single network of providers for all state-funded behavioral health services. Safety net providers will be able to receive public funds from any state source, though services they are eligible to provide might differ. This offers an opportunity to create a single network of public providers, shared credentialing, and connection to a publicly available directory. The Comprehensive Safety Net Model and Framework meets the statutory requirements that "the safety net system must have a network of behavioral health care providers", and builds on the foundation of "community mental health centers, managed service organizations, contractors for the statewide behavioral health crisis response system, and other behavioral health community providers as key elements in the safety net system". The model includes:

- **New Provider Definitions.** The model outlines new provider definitions, the set of services they offer, and the payment model and level of client need associated with each provider type. As the needs of the client increase, the access to flexible funding increases and the state requirements for reporting and credentialing increase.

    - The current definitions of behavioral health providers in statute and regulation have not kept pace with the population needs and alignment of substance use and mental health programs. The definitions also do not reflect the innovation many of the providers have implemented including telehealth, co-responder and mobile crisis response, changes to Medicaid through the Affordable Care Act, and specialized models of care that serve priority populations.
- **Expanded Provider Network.** The model addresses access into services through expanding the provider network to include additional providers in different sectors, such as primary care, the justice system, and the housing system.
    - In some cases, these providers may be more effective in outreaching and engaging populations that experience barriers to care.
    - Aligning providers into a cohesive continuum of care will improve clinical quality of the services provided and will ensure that culturally competent services are more fully developed to address disparities in care.
- **Minimum Set of Services.** The model establishes the minimum set of behavioral health services that must be provided in each community and is developed as part of the regulatory framework for the behavioral health administration.
    - This will mitigate access issues and address the fragmentation that exists due to siloed provider networks across CDHS, HCPF, and other state agencies.

Value-Based Care and Funding Model

To establish a sustainable, high quality system of care for all communities, it is important that the payment models respond to and incentivize this care, balancing accountability, and flexibility.

Fee-for-Service and Value-Based Care in Colorado

Currently, most health care in Colorado is paid for with a "fee for service" (FFS) or a "pay for volume" model. Fundamentally, the FFS model provides an incentive structure that rewards volume and process over quality and outcomes. FFS models reward health care providers for doing *more* tests and procedures, instead of rewarding health care providers for making and keeping their clients *healthy*. This model of care has contributed to the steep growth of health care spending in the United States, with the U.S. spending more on health care compared to similar high-income countries while maintaining the lowest life expectancy.[14]

FFS payment does not inherently reward or even hold providers accountable for outcomes. Treatments or practices that may be effective in improving client well-being may be disincentivized because they are reimbursed at low or non-existent rates. The FFS model

particularly impacts rural providers. Because they do not have a high volume of clients, they are unable to build up or maintain the financial stream necessary to expand services, to innovate, or to deliver the full spectrum of care vital to maintaining a safety net.

Value-based Payment (VBP) or Alternative Payment Models (APM) refer to the diverse range of financial and accountability models that tie provider payments to client outcomes and care quality. Colorado's Medicaid program, Health First, has implemented APMs within the Accountable Care Collaborative (ACC) framework implemented in 2011. The ACC is the dominant program which oversees member health care delivery and care coordination for Health First Colorado. In this framework, Regional Accountable Entities (RAEs) are accountable to the CDHS for coordinating both the physical and behavioral health of their members. Financial incentives, RAE requirements, and increased accounting methods work to improve health care delivery, quality, and transparency for Health First Colorado members. Within the ACC framework, the CDHS has implemented successful APMs for both primary care[15] and maternity care[16]. The past successes of these programs will act as a springboard to facilitate and launch future APMs.

Moving Forward

The Comprehensive Safety Net Model and Framework will be pursuing a tiered approach that deploys different payment models depending on the intensity and level of care that is being provided. This approach creates additional opportunities for flexible, value-based payments that will ensure the viability of the safety net system.

- Fee for Service payments will cover specific billable services, such as an hour of individual therapy or completing an assessment. Any licensed provider that is registered and enrolled could potentially bill for basic services, including those who work in primary care practices.
- Under VBP, enhanced, specialty and comprehensive care providers will qualify to be reimbursed for an expanded set of services. These providers will deliver population-specific services and/or the ability to serve more complex clients. VBP requires a higher level of reporting to ensure accountability for improved client care. These providers might include:
    - Federally Qualified Health Centers
    - Small and medium-sized clinical practices that specialize in providing services to individuals with co-occurring disabilities, individuals experiencing homeless, criminal justice services, LGBTQ+ communities or even social service providers
    - Comprehensive behavioral health providers who are equipped to serve all clients in a complete continuum of outpatient behavioral health services
- The model will also consider the need for enhanced, specialty and comprehensive service providers in every community, including smaller rural communities where there is not

sufficient volume to cover all costs, including the cost of effectively providing services to clients with the highest need.

To fully develop a funding model that emphasizes value and outcomes as opposed to volume, CDHS and HCPF have identified and begun developing the following elements as part of the aligned alternative payment approach.

Population and Service-Specific Provider Payments. Communities and individuals need providers who are able to provide services that are specific to their needs and operate seamlessly across the care continuum. CDHS and HCPF will develop financial models that give high performing providers the flexibility to cover services that are hard to bill for, or don't fit into a specific encounter, such as

- Street outreach and in-home visits
- Peer and non-clinical support staff
- Treatment planning meetings with families and schools
- Addressing social determinants such as transportation, food security, employment, and financial counseling

Reliable population-based payments help providers to build or sustain these systems, while reporting the outcomes helps the state retain accountability. These services and payments are essential for the highest need and most complex clients, especially those who have a history of institutionalization.

For many Coloradans, meeting and sustaining their behavioral health needs might require more short term or less comprehensive care. In this case, more service-specific needs, not population specific payment, is more appropriate. CDHS and HCPF will continue working with providers, clients and families, and payers and intermediaries to use the Comprehensive Safety Net Model and Framework to develop, budget, and implement an integrated, blended funding model that meets the needs of clients across the continuum.

Regional Flexibility. While the model represents a continuum of services required for all communities, the manner in which each community implements these services will vary across Colorado. CDHS and HCPF will implement flexible payment and network policies, in collaboration with their intermediary and health plans, to allow communities to develop provider networks and arrangements that meet the needs of the safety net population. These will be tied to more specific standards in network adequacy that require clients to have access to specialty providers.

Improved Data Infrastructure to Measure Outcomes: Reliable and comprehensive data is an essential component of value-based payment. Systems, providers, and communities often only

see and address a portion of an individual's needs, leading to a disjointed and fragmented approach to care and suboptimal outcomes. To address this, CDHS and HCPF will work with other state agencies to create a shared information infrastructure between themselves, intermediary contractors, health plans and, where appropriate, providers and other partners. This infrastructure will not only support payment and contracting methodologies on the front end but will also ensure effective monitoring of outcomes on the back end. The development of improved health information technology is largely funded through the 2021 legislative session and will begin July 1, 2021.

Contracting

The Comprehensive Safety Net Model and Framework is designed to withstand ongoing payment methodology changes and administrative structures by focusing on service availability, client level needs, and provider responsibilities. The model can be effective in managed care environments, such as the current Medicaid managed care system, or with direct payment contracts, which is more aligned with how CDHS and many other state agencies directly purchase care.

In creating this model, stakeholders had a lot of questions about how contracting would work from the RAEs who are responsible for managing networks and paying providers, with CDHS who pays providers directly or through intermediaries like the Managed Care Organizations (substance use intermediary) and the Administrative Service Organizations (crisis system intermediaries). The stakeholders also wanted to know about the expectation for providers to contract with each other (See Appendix A for details).

- The Comprehensive Safety Net Model and Framework does NOT require providers to contract with one another to be reimbursed for services. However, there are opportunities for providers to create partnerships with one another in order to meet the standards of a specialty/enhanced service provider or to become a comprehensive behavioral health provider.
- For managed care systems or similar infrastructure that requires intermediaries to manage and contract with regional provider networks, the intermediaries are still the primary payer for providers and will be required to contract directly with multiple provider types to meet network adequacy standards.
    - To meet these requirements, intermediaries are also expected to provide business and billing support to ensure smaller providers are able to be reimbursed for care. The Behavioral Health Administration (BHA) will also play a role in providing technical assistance and master contracting support to ensure that the system is truly more streamlined and efficient, with reduced provider burden.

Financial Responsibility and Supplementing not Supplanting Funds

The authorizing legislation for this proposal requires that the state "develop a funding model to ensure the viability of the safety net system. The funding model *must supplement and not supplant any state funding* to complement Medicaid, federal substance abuse prevention and treatment block grants, federal mental health services block grants, and private pay funding." CDHS and HCPF have interpreted this language to mean that the state must increase the total investment in behavioral health and ensure there is funding set aside specifically for the implementation and maintenance of this model. The legislation also requires that CDHS include" funding and legislative recommendations needed to appropriately implement the plan." These recommendations can be found in the table below.

Current Funding Increase Requests to Support the Comprehensive Safety Net System
State general funds to be used to align the state's data collection, reporting, claims processing, and eligibility determination systems by 2024 (decision item R-23).
Over $100M in funding from marijuana cash tax fund and the American Rescue Plan Act (ARPA) to increase capacity of existing substance use and mental health programs and to create "a statewide care coordination infrastructure to drive accountability and more effective behavioral health navigation to care that builds upon and collaborates with existing care coordination services."
Over $100M in ARPA funds available through an increased federal Medicaid match to improve the behavioral health system, including approximately $30M specifically to implement the recommendations of SB19-222.
Approximately $400M in ARPA funds identified by the Governor's Office to promote system transformation.

For additional funding, CDHS and HCPF will work with the state budget office to determine the appropriate funding requests for the legislature for additional ongoing support of the Comprehensive Safety Net Model and High Intensity Behavioral Health Treatment Programs. In order to determine the actual amount, federal match, and payment methodology, CDHS and HCPF need time to test and explore the actual costs of approved value based payments, care coordination infrastructure, enhanced services provision, additions of social determinants of health, and other supports to provide the legislature with as much detail as possible on funding requests. However, the intent of this model is to go beyond supplementing budgets.

The Comprehensive Safety Net Model and Framework includes significant changes in the way the state pays for behavioral health services, as CDHS and HCPF have identified a funding model that will support system reform and make more efficient use of the state's existing budget which is between $1.5 and $2 billion annually. HCPF and OBH have a responsibility to make the most appropriate use of our state and federal funds and in some cases existing resources may need to be realigned to ensure expansion of new programs or of existing programs that more closely align with the intent of a behavioral health safety net. Previous efforts to increase the state's investment in behavioral health by hundreds of millions of dollars has not led to improved outcomes. We must change the way we pay for care and put the client at the center of our funding model, focusing on consumer outcomes and population health instead of service volume or dollars spent.

Goals, Next Steps, and Recommendations Needed to Address Barriers to Care

In the tables that follow, CDHS and HCPF have identified a comprehensive set of steps to address the major systemic barriers at the statewide level, followed by recommendations that address safety net services for populations that frequently receive inadequate services and often have the most difficult-to-treat disorders. The areas covered are:

I. Statewide Systemic Barriers to Care: Fragmentation in Regulations and Funding that impact Care.
II. Barriers to Culturally and Linguistically Competent Services for Priority Populations
III. Barriers for Children, Youth and Families
IV. Barriers for Individuals with Justice Involvement
V. Barriers for Co-Occurring Services for Individuals with Disabilities
VI. Barriers for Individuals with Serious Mental Illness
VII. Barriers for Individuals experiencing homelessness or housing instability

These recommendations establish clear standards for high intensity treatment programs in the Safety Net Framework. The structure allows CDHS, HCPF, and all other stakeholders to simultaneously establish clear long-term goals and priorities for the safety net framework while creating tangible short-term improvements to the care continuums of priority populations. These goals and tactics include activities such as creating standards of care, establishing clear regulatory criteria, and aligning payment models that reflect and execute the critical steps to implementing the overall safety net framework.

I. Statewide Systemic Barriers to Care: Fragmentation in Regulations and Funding that Impact Care.

Goal 1: *Align regulatory framework to allow for an endorsement(s) by the Behavioral Health Administration based on services and provider type.*

Current Gaps:

- ➔ Current regulations are fragmented and inhibit the state's ability to establish standards of care for access, coordination of care, clinical quality, and outcomes.
- ➔ High Intensity Behavioral Health Services are not adequately defined to ensure populations who have increased complexity or acuity can access services that meet their needs.

Steps 1.1	Review current mental health and substance use regulations and compare to current clinical guidelines and established national certification models to design a single behavioral health regulatory schema.
1.2	Establish a work plan that delineates statutory, regulatory or rulemaking steps to improve accountability, and clear standards of care.
1.3	Partner with Colorado Department of Public Health and Environment CDPHE to define when a facility license is required.
1.4	Define what an adequate network of High Intensity Behavioral Health Treatment providers is by community and region.
1.5	Convene a workgroup to define provider endorsement criteria for comprehensive High Intensity Behavioral Health Treatment Programs.
1.6	Establish process and criteria for providers to pursue when an individual exceeds their clinical capacity or clinical expertise.
1.7	Develop a standardized provider self-assessment tool for providers to identify gaps in meeting newly established certification criteria in alignment with the Comprehensive Safety Net Framework.
1.8	Synthesize provider self-assessment information in order to identify major gaps in the safety net and for high-intensity treatment programs. Consolidate information into a public directory.
1.9	Identify training and technical assistance needs for providers and identify local and regional gaps and prioritization for further investments.

Goal 2: *Establish infrastructure to provide technical assistance and training to support the implementation of EBPs and other best practices in the delivery system.* **Current Gaps:** ➔ No standard infrastructure to establish consistent training and technical assistance to implement evidence-based practices.	
Steps 2.1	Develop centralized infrastructure to support providers across the state that includes training, technical assistance, business process supports, practice transformation and implementation science expertise.
Goal 3*: Develop and scale innovative solutions.* **Current Gaps:** ➔ No standard way to scale innovation to address systemic challenges such as rural capacity, or telehealth and workforce solutions	
Steps 3.1	Develop an innovation model to support new approaches that address intractable problems to strengthen and expand workforce, rural capacity, and clinical expertise in order to scale solutions and cultivate best practices.
Goal 4: *Establish Quality Health Improvement Framework for the behavioral health safety net.* **Current Gaps:** ➔ No consistent framework that promotes quality improvement and is aligned with national standards.	
Steps 4.1	Form a workgroup to recommend a quality framework that aligns disparate measure sets to create a unified behavioral health core measure set and prioritized opportunities to conduct quality improvement efforts.
Goal 5: *Establish a cohesive care coordination strategy to support care coordination activities at the client, provider, payer, and state level including clear opportunities to link social determinants of health to behavioral health services.* **Current Gaps:** ➔ Without effective linkage of activities that support whole person care, health care organizations operating in silos are unable to achieve the intended outcomes. ➔ Lack of cohesive strategy to support care coordination activities at the client patient, provider, payer, and state level leads to diffuse responsibilities and inadequate support for clients. ➔ Diffuse accountability for care coordination that leads to poor outcomes.	

Steps 5.1	Establish a care coordination workgroup/subcommittee to review the recent Health management Associates (HMA) care coordination report in order to develop standards of care and requirements for navigation, care coordination and care management at the provider, regional and state levels.
5.2	Establish intentional linkages between providers, and community resources and social service organizations to improve population health outcomes and to empower clients and families and improve health literacy.
Goal 6: *Implement Alternative Payment Model strategies to adequately support the delivery system.* **Current Gaps:** ➔ Payment models are outdated and do not fully align with the service array offered at the provider level. ➔ Value based payments are limited and do not adequately support service intervention for increased client acuity or complexity. ➔ Payment models are not connected to the intensity of client needs or outcomes for clients.	
Steps 6.1	HCPF and CDHS to engage contractors to identify and recommend alternatives to current cost reporting.
6.2	HCPF and CDHS to facilitate workgroups in an effort to develop payment incentives and measures that support providers in meeting cost, quality, and outcomes.
6.3	HCPF and CDHS to develop value-based payment models that align with the safety net continuum of care and address Medicaid, uninsured, and underinsured populations.
6.4	HCPF and CDHS to develop technology infrastructure to ensure Medicaid-covered services are being reimbursed, using Medicaid's eligibility, data, and financial processing systems.
6.5	HCPF and CDHS to identify policies to cover services for individuals that are uninsured or uninsured.
Goal 7: *Establish Workforce Standards to effectively strengthen the workforce and increase opportunities to leverage unlicensed behavioral health aides.*	

Current Gaps: ➔ Significant workforce shortages exist across the state that may be addressed by leveraging non-traditional workforce. Opportunities to leverage unlicensed staff and individuals with lived experience are not clearly delineated in the safety net framework. Providers are not adequately reimbursed for services provided and supported with training and supervision opportunities.	
Steps 7.1	Convene workgroup to establish workforce standards and prioritize training opportunities for licensed and unlicensed staff that aligns with the Safety Net continuum.
7.2	Establish standards of practice for unlicensed staff working in various roles within the safety net continuum.
7.3	Workgroup to consider clear criteria and strategies for safety net providers to address burnout, training and supervision and career pathways for staff.
Goal 8: *Implement technology and centralized resources for aligned data collection across state agencies in order to develop clear behavioral health reporting for cost, quality, and outcomes and to reduce provider burden reporting to multiple state agencies in various ways.* **Current Gaps:** ➔ Across state agencies standards for data collection are outdated, siloed, misaligned, and fragmented, impacting the ability for the state to report on costs and quality outcomes of the behavioral health safety net system. ➔ Redundancies in data collection and high administrative burden for provider organizations.	
Steps 8.1	Establish a technology sub-committee that reports to the eHealth Commission and Office of eHealth Innovation (OeHI) composed of cross agency leaders to ensure a coordinated technology infrastructure for behavioral health data collection and reporting that aligns with state agencies business needs.
8.2	Engage sub-committee members to participate in user design and product demos as the technology vision is implemented to ensure goals are achieved and products meet the business needs of state agencies and providers.
8.3	Leverage efforts underway with OeHI and partner with legal and privacy experts to ensure data interoperability that protects personal health information.

Goal 9: *Implement aligned partnerships with local and regional communities to ensure that community planning efforts for identification of needs, gaps, and cost sharing models are aligned and supported by the Comprehensive Safety Net Model.* **Current Gaps:** ➔ Community level planning efforts are siloed and fragmented which impacts opportunities to develop local prioritization and planning of needed behavioral health services, address zoning, transportation solutions, law enforcement needs, housing, and community cost sharing opportunities for existing resources and infrastructure.	
Steps 9.1	Review multiple regional assessments such as local public health needs assessments, community health needs assessments conducted by hospitals, and collaborative management programs.
9.2	Establish a process to consolidate information from local needs assessments in order to address solutions for prioritization and planning of needed behavioral health services; zoning; transportation solutions; law enforcement needs; housing; and community cost sharing opportunities for existing resources and infrastructure.
9.3	Recommend an approach for local communities and regions to conduct behavioral health planning and partnering in areas that align with state priorities.
9.4	Consider developing a regulatory framework to ensure alignment and process for strategic funding. Specifically review the community benefit funding opportunities with nonprofit hospitals and health systems.
Goal 10: *Implement shared input into regulatory standards and develop a client advocacy framework into the behavioral health delivery system to decrease stigma, improve outcomes and engage families in care.* **Current Gaps:** ➔ Engaging with clients and families with lived experience for systematic decision making and governance is voluntary, inconsistent, and under-utilized. ➔ Lack of meaningful information to support individuals identifying best practices, options for treatment, and stigma reduction	
Steps 10.1	Create statewide standards that incorporate the expertise of those with lived experiences into the behavioral health safety net to streamline access, reduce stigma, improve client education and self-advocacy into governance models at the state, local, intermediary, and provider level.

10.2	Convene a group of experts to develop a framework for incorporating shared decision making into the regulatory schema for the behavioral health safety net.

II. Barriers to Culturally and Linguistically Competent Services for Priority Populations

Goal 1: *Integrate policy and systemic approaches into the safety net framework to successfully organize services that meet the social, cultural, and linguistic needs of clients. Develop standards of care to ensure that services are equitable, culturally competent and meet the unique needs of populations that are historically underserved.*

Current Gaps:

- ➔ Multiple populations are unable to access care that is specifically tailored to meet their unique treatment needs including developmentally appropriate services, culturally competent care, and evidenced based models that are clinically specialized to address symptoms, improve functioning, and achieve wellbeing.
- ➔ Race and ethnicity data that exists indicates that Hispanic, Black, and American Indian individuals are least likely to get the services they need.[17]
- ➔ Bilingual/bicultural services are limited.
- ➔ Stakeholders have expressed that frequently small numbers of a population mean certain populations are not prioritized and which impacts adequate funding for culturally competent services.
- ➔ Targeted outreach and engagement strategies do not exist for populations that are least likely to access care and incidence and prevalence data indicate higher rates of suicide and overdose.

Steps 1.1	Engage community members and representatives from priority populations to participate in the design and development of the safety net system regulations and standards of care across the Safety Net Continuum.
1.2	Develop policies in partnership with underserved populations to improve equity and address systemic barriers to care in the delivery system.
1.3	Improve and invest in data collection and analysis to improve monitoring of trends and facilitate ongoing quality and health outcome improvement efforts. Develop best practices to disaggregate data that lead to identification of disparities in care. Provide additional training for providers to understand how improved demographic data is central to member engagement and treatment.

1.4	Develop and integrate best practices and identify standards of care for BIPOC that may lead to an endorsement or other rating system indicating an organization's ability to respond to cultural differences.
1.5	Develop coordination criteria and standards for providers and intermediaries (RAEs, MSOs, ASOs) to support alignment with federal policies by partnering with Indian Health Services (IHS), tribes, and other tribal operated community organizations.
1.6	Develop a strategy to improve capacity to provide culturally competent High Intensity Behavioral Health Treatment Programs to BIPOC including tribally operated organizations in rural and urban settings. Leverage input from communities as well as recommendations from respected sources or other experts.
1.7	Improve accessible crisis services by ensuring hotline staff are culturally competent to address the diverse needs of Coloradans and ensure that crisis services are LGBTQ+ friendly
1.8	Develop a more streamlined and accessible grievance process for LGBTQ+, BIPOC consumers who have been denied behavioral health services at state and regional levels.
1.9	Implement expanded demographic options on provider forms in order to collect additional information such as sexual orientation, gender identity, sex assigned at birth and relationship status.
Goal 2: *Develop centers of excellence to deliver culturally competent services and provide training and technical assistance for smaller provider organizations to fully build this capacity.* **Current Gaps:** ➔ Inadequate services for populations that are culturally and linguistically responsive leads to individuals delaying care or not receiving care. Strategies to support providers in developing care and improving culturally competent services are lacking. Resources and strategies to support existing organizations to develop consultation models and become “centers of excellence” are not available.	
Steps 2.1	Establish targeted recommendations and criteria for creation of provider organizations that are centers of excellence to ensure culturally competent service delivery that support client choice.
2.2	Monitor the number of providers able to provide services in a culturally competent manner to ensure an adequate, accessible, and culturally competent network. Include diverse models of engagement and modes of service delivery that may include peers or mobile technologies.

2.3	Increase expertise and competency of providers into safety net workforce strategies to improve access and cultural competency.
2.4	Develop standards for culturally and linguistically responsive treatment programs to improve opportunities for early engagement for clients in need of services.

Goal 3: *Ensure delivery of adequate culturally competent safety net services including High Intensity Behavioral Health Treatment Programs for Black, Indigenous and People of Color (BIPOC).*

Current Gaps:

- ➔ BIPOC are more likely to receive care through public human service and justice system settings (90% for Black people and 50% for Hispanic[18] people) as opposed to the larger public health care system.
- ➔ Data indicates that BIPOC may not be accessing early intervention and more routine services that could prevent involvement in human service and justice settings.
- ➔ Early intervention strategies that ensure that services meet the needs of the intended populations are not widely disseminated in the Safety Net Continuum.
- ➔ Most regions in Colorado report lacking adequate bilingual and bicultural providers and services for non-English speaking, immigrant, and refugee populations.
- ➔ Shared decision-making tools are often not offered in an individual's native language.

Steps 3.1	Build out services in the service array to improve cultural competencies for providers.
3.2	Diversify the behavioral health profession (both traditional and non-traditional providers) and improve recruitment and retention of individuals representing priority populations. Consider supports for individuals of color to address barriers that may impact retention.
3.3	Develop tailored behavioral health services that may include behavioral health aides to support outreach and engagement to priority populations.
3.4	Develop improved outreach and engagement strategies to support screening, early intervention, and treatment.
3.5	Address workforce by building statewide collaborations with critical community partners to recruit diverse clinical and non-clinical providers into the behavioral health workforce.

III. Barriers for Children, Youth and Families

Goal 1: *Ensure adequate and culturally competent High Intensity Behavioral Health Treatment Programs that meet the needs of children, youth and families across Colorado including those involved in the Child Welfare system.*

Current Gaps

- ➔ Current capacity to deliver wraparound services and intensive clinical interventions for families is limited. Limited statewide services for children and youth with co- occurring physical, IDD and/or behavioral health diagnoses, youth that exhibit sexually acting out behaviors, and youth with a history of aggression.
- ➔ Youth with the most complex needs are often sent out of state for services due to current residential and psychiatric residential treatment programs having limited clinical expertise and staffing to support these youth.
- ➔ There are inadequate and uncoordinated psychiatric beds and/or residential programs and no youth criteria for "27-65[19]" that establishes clear standards for involuntary care for youth placed in facilities.
- ➔ There are no standard criteria for High Intensity Behavioral Health Treatment Program for youth that includes in-home respite that considers caregiver capacity and establishes standards for delivering services in the home, foster home or other community-based settings and that is evaluated and monitored to ensure the services meet population/community needs.
- ➔ No regulatory criteria with clear timelines to ensure coordination across child serving organizations including child welfare, youth services, Medicaid/EPSDT/Waivers, CYMHTA, Momentum, and school districts are coordinated to develop a plan of care and payment responsibilities.
- ➔ Clinical models of care such as Child First, Parent-Child Interaction Therapy, Multisystemic Therapy, Functional Family Therapy, Dialectical Behavioral Therapy, and substance use treatment programs for youth are not adequately scaled in Colorado to ensure statewide coverage.
- ➔ Lack of access to High Intensity Behavioral Health Treatment Programs that support youth with co-occurring treatment needs including those with autism, intellectual/developmental disabilities, and youth with aggressive or sexually acting out including occupational therapy, behavioral interventions, parent coaching and respite services.

Steps 1.1	Identify existing capacity of High Intensity Behavioral Health Treatment Programs and assess opportunities to more fully provide services for youth with co-occurring treatment needs including autism, intellectual and/or developmental disabilities,

	physical disabilities, and aggressive/sexually acting out behaviors and mental health and substance use treatment.
1.2	Assess if any programs offer structured Intensive Outpatient and residential elements in the youth service array including in-home services for respite, parenting supports and family therapy.
1.3	Convene a work group of experts to develop a High Intensity Behavioral Health Treatment Program endorsement in order to fully establish an expected standard of care for communities. Include personnel that oversee child serving programs including child welfare, youth services, Medicaid/EPSDT/Waivers, CYMHTA, Momentum, and school districts.
1.4	Establish a work group to recommend a regulatory framework to ensure timelines and accountability for developing a plan of care and shared payment responsibilities for complex youth. Develop criteria for when a "patient exceeds the clinical capacity of a treatment provider."
1.5	Consider a "27-65" provider designation for youth to integrate services more fully for youth with complex needs and align payment models for programs that address co-occurring treatment needs and services offered in the program.
1.6	Establish a clinical best practices workgroup to recommend the service array options and best practice options for community-based providers across the continuum of care for children and youth that should be established in communities and in regions.
1.7	Identify opportunities for the BHA to expand additional evidence-based models of care by implementing pilots in care and coordination for children, youth, and families.
1.8	Include best practices to leverage telehealth and alternative staffing models that can be integrated into the standards of care and address the significant gaps for co-occurring treatment needs for youth and families.

IV. Barriers for Individuals with Justice Involvement

Goal 1: *Ensure adequate safety net services including High Intensity Behavioral Health Treatment Programs and services that meet the needs of those individuals with justice involvement including opportunities for diversion and re-entry services.*

Current Gaps:

➔ Current services and clinical interventions for individuals with justice involvement are siloed and often do not consider criminogenic risk.[20] ➔ Community-based treatment programs and providers do not adequately assess criminogenic risk and/or understand the criminal justice system. ➔ Coordination between community behavioral health providers and the justice system is fragmented with diffuse responsibilities and no coordination between behavioral health and judicial to align assessment tools and treatment planning.	
Steps 1.1	Convene a workgroup of subject matter experts and providers to address the criminogenic risk factors and behavioral health treatment needs of individuals in the criminal justice system.
1.2	Conduct a regulatory review to align different criteria that exist in the justice and behavioral health systems to coordinate a plan of care more effectively for clients receiving services in multiple systems.
1.3	In collaboration with justice system personnel, develop program standards and endorsement criteria for comprehensive criminal justice programs and services including High Intensity Behavioral Health Treatment Programs and criteria and processes for when a client exceeds provider capacity
1.4	Develop a comprehensive training curriculum of evidence-based treatment approaches for staff working in programs that obtain a "Criminal Justice Treatment provider endorsement." Include training to ensure cross-system alignment around a proactive, coordinated, and pre-release care plan.
1.5	Establish strategy to ensure cross-system partnerships between payers, providers, local Criminal Justice treatment boards, judicial districts, problem solving courts, Forensic Navigators, and other stakeholder groups.
1.6	Work with a team of experts to develop standardized risk assessment tools that include mental health, substance use and criminogenic risk in order to improve treatment matching and outcomes.
1.7	Identify opportunities to leverage and expand additional evidence-based models of care by implementing pilots and include best practices to leverage telehealth and alternative staffing models that can be integrated into the standards of care.

V. Barriers for Co-Occurring Services for Individuals with Disabilities

Goal 1: *Build capacity and tailored interventions in the behavioral health safety net to ensure access to services for individuals with disabilities. Address systemic barriers resulting from the "primary behavioral health diagnosis" that impacts access to care for individuals with disabilities.*

Current Gaps:

- ➔ Current capacity to deliver services and clinical interventions for individuals with disabilities are inadequate and do not meet the unique cultural and linguistic competency standards for individuals with disabilities.
- ➔ Treatment programs and providers do not adequately coordinate between systems to ensure comprehensive treatment planning processes that include behavioral health providers, behavioral analysts, education, Single Entry Points, Community Centered Boards, developmental specialists, or other relevant participants.
- ➔ Primary mental health diagnosis is often a basis for denying behavioral health services for individuals with co-occurring disabilities.
- ➔ Opportunities to leverage telehealth and further develop staffing models that ensure alignment around a coordinated plan of care can be improved.

Steps 1.1	Conduct a regulatory review to align different criteria that exist in programs serving individuals with disabilities to ensure effective coordination of a plan of care for clients receiving services in multiple systems.
1.2	Convene a workgroup of experts and individuals with lived experience to review the co-occurring disabilities workgroup report and establish the safety net endorsement criteria for behavioral health providers to adequately treat clients with co-occurring disabilities. Establish safety net criteria for a "co-occurring disabilities provider endorsement."
1.3	Develop program standards and program criteria for comprehensive services including High Intensity Behavioral Health Treatment Programs and criteria for when a client exceeds provider capacity.
1.4	Work with a team of experts and individuals with lived experience to develop standardized risk assessment tools that include mental health, substance use and other criteria to ensure services are culturally competent and match the needs of the individual.
1.5	Establish minimum training criteria for staff and providers working in a program that is endorsed as a "co-occurring disabilities'' treatment provider. Identify best practices and evidence-based models to integrate into the safety net continuum to

	ensure quality and outcomes.
1.6	In coordination with the proposed "Implementation and Innovation" model proposed in Section I, identify opportunities to pilot and expand additional evidence-based models of care. Include best practices to leverage telehealth and alternative staffing models that can be integrated into the standards of care.

VI. Barriers for Individuals with Serious Mental Illness

Goal 1: *Ensure adequate access to High Intensity Behavioral Health Treatment Programs that meet the needs of Individuals with a Serious Mental Illness.*

Current Gaps:

- ➔ Current capacity to deliver Assertive Community Treatment (ACT) is limited and primarily offered in communities with higher population density. Many of the current programs do not meet fidelity to the model and meet standards for contact and community-based engagement.
- ➔ Inadequate and uncoordinated Adult Care Facilities (ACF) beds and/or residential and housing programs addressing transition services for those leaving institutional settings or needing increased support for a period of time.
- ➔ Intermediate Care Facilities for clients that may need this level of community-based support but do not meet criteria for inpatient level of care do not exist.
- ➔ Inadequate assertive outreach and engagement that effectively engages with the "hard-to-serve" population that would benefit from this model of care.
- ➔ Models such as Assisted Outpatient Therapy, Critical Time Intervention have not been piloted or scaled in Colorado to evaluate other models to support the population of individuals needing High Intensity Behavioral Health Treatment Programs.
- ➔ Opportunities to leverage telehealth and staffing models that ensure adequate outreach and engagement and/or leverage a behavioral health aide model have not been evaluated.

Steps 1.1	Identify existing capacity of High Intensity Behavioral Health Treatment Programs and assess if program meets the following criteria including evidence-based approach, staffing, frequency of contact with the individual (e.g., multiple times per week); location of services (e.g., home, community, work and clinic); and counties these services are offered.
1.2	Assess if any programs offer structured living and residential elements in a service array.

1.3	Establish an expected standard of care and service array for communities that includes psychiatric rehab supports, housing and residential needs for individuals with Serious Mental Illness (SMI), Co-occurring treatment needs, and individuals experiencing homelessness in collaboration with housing system personnel
1.4	Identify opportunities to expand additional evidence based models of care by implementing pilots in coordination with the proposed "Implementation and Innovation" model proposed in Section I. Include best practices to leverage telehealth and alternative staffing models that can be integrated into the standards of care.
1.5	Work with a team of experts to develop standardized risk assessment tools and training for engaging with individuals that may exhibit aggressive behaviors and develop a comprehensive curriculum of required training for staff working in a program that obtains a "High Intensity Behavioral Health Treatment Program endorsement."

VII. Barriers for Individuals experiencing homelessness or housing instability

Goal 1: *Ensure adequate access to High Intensity Behavioral Health Treatment Programs that meet the needs of Individuals experiencing homelessness or housing instability.*

Current Gaps:

- ➔ Current capacity to provide services in the community that includes assertive outreach and engagement and provides co-located supportive services to help people struggling with mental health and substance use issues maintain stable housing and receive appropriate health care services is limited.
- ➔ Individuals who are homeless also have a high prevalence of SUD. The Housing and Urban Development January 2019 report identified almost a quarter of individuals who were homeless in Colorado have chronic substance use disorder.
- ➔ Specialized providers that can address mental health and substance use treatment needs and coordinate services for individuals experiencing homelessness or housing instability are limited.

1.1	Develop and integrate best practices and identify standards of care for individuals experiencing homelessness or housing instability into the safety net framework to ensure coordinated care and an improved continuum of care.
1.2	Identify and develop endorsement criteria for providers that specialize in working with individuals experiencing homelessness or housing instability.

Criteria and Processes for When Client Needs Exceed Provider Capacity

The following section meets the requirement that the proposal must "set forth criteria and processes, in collaboration with BH providers, for when the needs of an individual referred to a safety net provider exceed the treatment capacity or clinical expertise of that provider." When determining the criteria and processes below, CDHS and HCPF also reviewed the section of SB19-222 that outlines required service standards. Included in this safety net model and framework is the expectation that comprehensive safety net providers are held to a higher standard, which includes accepting clients that are hard to serve.

27-63-105. Safety Net System Implementation - Safety Net System Criteria

The safety net system must not refuse to treat an individual, including youth, based on the following.

(i) the individual's insurance coverage, lack of insurance coverage, or ability or inability to pay for behavioral health services;
(ii) the individual's clinical acuity level related to the individual's behavioral health disorder, including whether the individual has been certified pursuant to article 65 of this title 27;
(iii) the individual's readiness to transition out of the Colorado Mental Health Institute at Pueblo, the Colorado Mental Health Institute at Fort Logan, or any other mental health institute because the individual no longer requires inpatient care and treatment;
(iv) the individual's involvement in the criminal or juvenile justice system; (v) the individual's current involvement in the child welfare system;
(vi) the individual's co-occurring mental health and substance use disorders, physical disability, or intellectual or developmental disability; or
(vii) the individual's displays of aggressive behavior, or history of aggressive behavior, as a result of a symptom of a diagnosed mental health disorder or substance intoxication;"

The safety net criteria above raised some questions among stakeholders about who could deny care--is it the system or the providers? CDHS and HCPF interpret this section to mean that the system must ensure there are providers who will accept all individuals in every condition and

circumstance listed. Therefore, this list shall serve as the essential requirements for any provider identified as a Comprehensive Behavioral Health Provider.

CDHS and HCPF recommend that, in order to meet these goals, and further reduce fragmentation between mental health and substance use treatment services, the state should consider legislation to update the definitions for a community behavioral health providers that aligns with the Comprehensive Safety Net Model.

Considering that Comprehensive Behavioral Health Providers have a higher standard to meet when denying clients care, below are the recommended processes for Comprehensive Service Providers that will be further developed in drafting the standards of care and requirements for Safety Net providers as outlined in Section 1.2.

New and Returning Clients Initiating Treatment with a Comprehensive Behavioral Health Provider

1. When a client reaches out to a Comprehensive Behavioral Health Provider to initiate treatment, prior to the intake, the provider will complete an initial screening and triage process to determine urgency and appropriateness of the provider.
2. If the client's needs exceed the capacity of the Comprehensive Behavioral Health Provider, the provider is responsible for ensuring that individual has access to interim behavioral health services in a timely manner up until the point the client is connected to the most appropriate provider for ongoing care. This may include use of the state's crisis system for clients in crisis or at risk.
3. The comprehensive behavioral health provider will provide a warm hand off by assisting the client in identifying a new provider, using the state's care coordination and navigation infrastructure as appropriate.
    a. For individuals who need alternative services outside the scope of the safety net system, such as services for housing, food insecurity, and transportation, the comprehensive behavioral health provider will ensure the client is able to use the online care coordination and navigation system to initiate those services.
4. Comprehensive Behavioral Health Providers must report ongoing to the BHA a list of all individuals who were triaged to alternative services and a standard description of the needs of the client that could not be met and required the client to be referred to another provider.

For all other providers, those that are part of the safety net system but not providing comprehensive services, the following process is recommended for circumstances in which the provider does not have the capacity to serve that individual due to a lack of expertise or availability.

New Clients Initiating Treatment with Basic, Specialty, and Enhanced Providers

1. When a client reaches out to a provider to initiate treatment, prior to the intake, the provider will ask the client about their primary concerns and complete a triage process to determine the timeliness and appropriate provider type.
2. If the client's needs exceed the provider's capacity to serve this individual, the provider will refer the client to the state's care coordination and navigation site.
3. If the client is in crisis, the provider will complete a warm hand-off to the state's crisis system for immediate access to a services provider.
4. For individuals who need alternative services outside the scope of the safety net system, such as services for housing, food insecurity, and transportation, the provider will ensure the client is able to use the online care coordination and navigation system to initiate those services.

Existing and Returning Client that Require a Different Level of Expertise

1. When an existing client or returning client reaches out to a provider for a service that exceeds the capacity of the provider, the provider is responsible for connecting the client to a new provider and continuing to provide interim behavioral health services up until the point that the client is connected to the most appropriate provider for ongoing care.
2. The existing provider will provide a warm hand off by assisting the client in identifying a new provider, using the state's care coordination and navigation infrastructure as appropriate.
3. For individuals who need alternative services outside the scope of the safety net system, such as services for housing, food insecurity, and transportation, the provider will ensure the client is able to use the online care coordination and navigation system to initiate those services.

These criteria and processes are to be used for when an individual or family member reaches out directly to a provider to initiate care. For individuals and families that reach out using their health plan, such as the RAEs, or through the care coordination and navigation infrastructure, the BHA will also provide recommendations on the process to ensure client choice, timely

access, and screening to determine treatment needs. This process may include use of telehealth, the state's crisis system, and any additional statewide support as appropriate.

Complex Clients that Need Services from Multiple Providers

In addition to these triage efforts, the state would like to build a more comprehensive process for individuals with complex needs that are often served by multiple providers and alternative funding sources. Several examples of these complex processes exist, including Creative Solutions, intensive care planning managed by Rocky Mountain Human Services, and the Child and Youth Mental Health Treatment Act (CYMHTA).

The existing various groups and funding sources for developing treatment plans and funding the necessary services are not unified in a way that requires all probable payers to come to the table and develop a comprehensive plan of care and subsequent strategy to pay for the set of services in order to cohesively and decisively address options. Current state procedures and policies encourage collaboration between counties, payers, providers, and school districts. The challenge is there is no regulatory authority to require or compel payment for services when a determination is made that a client needs medically necessary services. This collaborative process can drag on for months at a time leaving clients and their families without services which results in poor outcomes for individuals and impacts the developmental trajectory of youth.

- This plan proposes a regulatory review be recommended and that a board be developed that includes clinical experts to determine the acuity and treatment needs of a youth and is based on objective criteria obtained from assessments of the individual and family.
- Once the plan of care and set of recommendations is developed with a finite time frame, the decision should move to a funding board comprised of all the relevant stakeholders and payers to determine the how payment needs to occur and the portioned responsibilities of the respective parties.
- Built into this process should be a process for appeal that will address many of the current challenges that impact the treatment needs for our highest and most complex youth and families. This process also must include strict timeliness standards to ensure individuals are not suffering while awaiting access or are not languishing in inpatient settings when they could be better served in the community.
- The process should also include standard processes that fit within federal and state standards regarding eligibility determination and identifying the primary, secondary, and tertiary payers and payer of last resort.

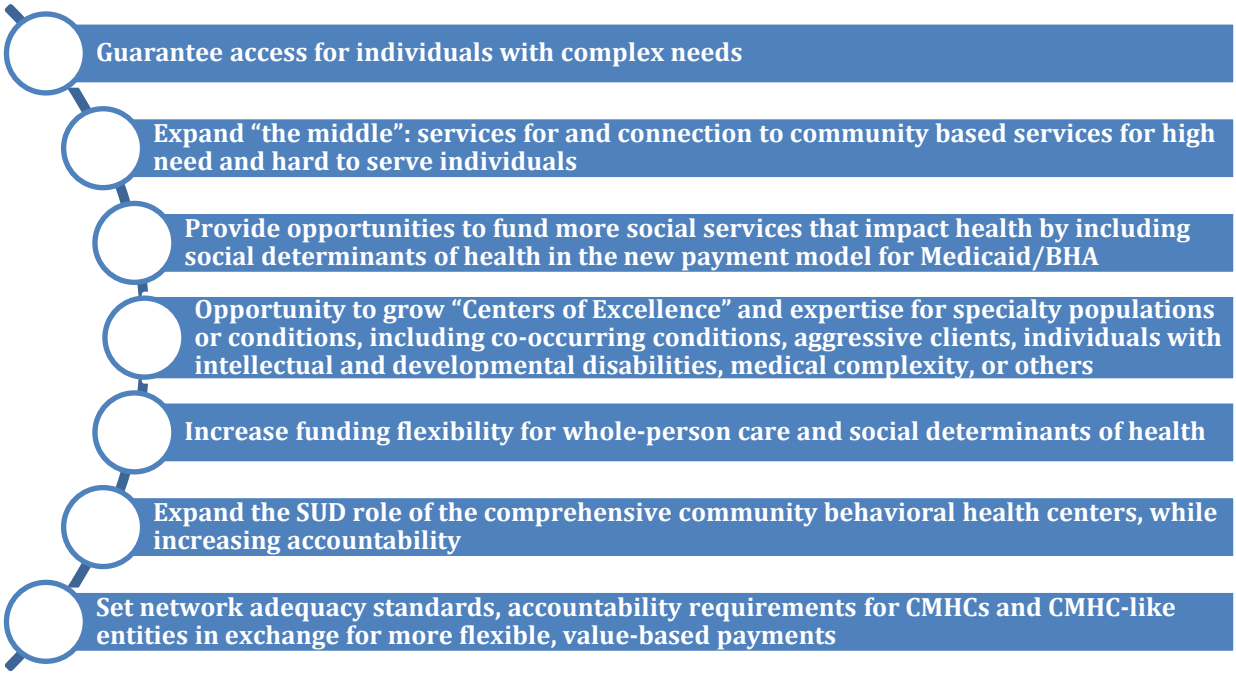
The processes outlined above will need to be reviewed and approved before being implemented through regulation or contracts. Each process must also include documentation and reporting, so the state is able to identify where there are gaps in provider capacity, and address concerns regarding a safety net providers' ability to meet standards and regulations. During this process, the stakeholders should ensure that processes are not so prescriptive that they would prevent adjustment to better meet the needs of an individual client. The use of validated screening and assessment tools could significantly improve this process and should be considered during the implementation process.

Finally, in discussions about the state's overall capacity to meet the needs of individuals in every population, the state agencies and other stakeholders identified that in addition to these processes, the state must also prioritize workforce development, education, training, and technical assistance to continuously strive to increase provider capacity and reduce the need for these processes.

Conclusion and Recommendations

This proposal is the result of an extraordinary level of effort and commitment in Colorado to make true reforms to our behavioral health system. For years, as Colorado's economy has grown and prospered, the state has invested more dollars into the behavioral health system. The state and federal response to the opioid crisis expanded access to and brought more funding. Legislators and state agencies worked fervently to close gaps in the systems, and put more money in behavioral health, only to see new gaps appear. Without a comprehensive delivery reform, the state will not be able to purchase our way out of this problem. The Comprehensive Safety Net Model and Framework outlined in this proposal is the state's recommendation for how to make sustainable and foundational changes to the behavioral health system that builds on the strengths of the current system.

Stakeholders wanted to know, what does this model change? The model and framework for the comprehensive safety net system will:



Recommendations and Needed Investments to Implement the Model

This proposal outlines a set of recommendations to improve the quality and access to care in Colorado and addresses the steps that are needed to create a behavioral health safety net system for the state. What follows is a summary of the recommendations to address the goals and gaps that have been identified above and estimates on funding to fully implement these recommendations. These recommendations will be matched with the steps and timelines in Appendix D. These recommendations are complete, but as the BHA is established, it will continuously review these steps and assess the need for additional resources and necessary revisions to the steps based on legislative and other changes within the state and national environment.

Recommendations and Funding Considerations to Address Systemic Barriers to Care

★ **Recommendation 1.** Establish and operate a center for innovation and technical assistance within the BHA or through a public-private partnership that can support implementation of evidence based models of care, develop and scale innovative solutions and quality improvement strategies, facilitate ongoing learning and

development opportunities for the behavioral health safety net system for including creation of methods to create staffing endorsements such as a behavioral health aide, and telehealth solutions that address workforce shortages, and assist in the development of centers of excellence and access for providers to connect to immediate consultation and support for complex high needs capacity.

- **Funding Considerations:** One-time funding to establish a center for innovation and technical assistance that could pilot and scale solutions, establish best practice and training infrastructure. Funding to provide support for providers in meeting the increased standards of care for the safety net and ongoing technical assistance to effectively meet the diverse needs of clients in the delivery system. Ongoing operational support would be required.
- **Estimated Initial Investment: TBD**

★ **Recommendation 2.** Centralize statewide infrastructure, such as a learning management system and care navigation platform, that will address staffing and workforce, scaling standardized training, and best practice training for the behavioral health workforce.

- **Funding Considerations:** Infrastructure for a learning management system and behavioral health workforce support is funded under Senate Bill 21-137: Behavioral Health Recovery Act.

★ **Recommendations 3**. Creation of a robust care coordination platform that establishes a "front door" for clients to find resources and connect with providers will effectively link the silos in our current system and address the fragmentation that leads to poor outcomes for clients.

- **Funding Considerations:** Infrastructure for a care coordination platform is funded under Senate Bill 21-137: Behavioral Health Recovery Act.

★ **Recommendation 4:** CDHS and OBH to work on aligned payment strategies and invest in aligned infrastructure to be able to develop payment models, align reimbursement with services offered and pay providers for improved client outcomes.

- **Funding Considerations**: Technology infrastructure funded in a CDHS decision item (R-23) will support this effort. Additional ongoing investments to support incentive payments for providers and cover service costs for clients who are uninsured or underinsured may be needed.

★ **Recommendation 5**: Facilitation to consolidate the multiple strategic plans that are produced by hospitals, local public health, and collaborative management programs to support communities in prioritization of needs and investments at the regional

level may be helpful to communities. Develop delivery system policies and practices that connect and align areas of local control, such as jails and school districts, with resources and programs that impact behavioral health access.

- **Funding Considerations:** One-time funding to support communities in identification and prioritization of gaps and opportunities for cost sharing could support improved alignment with statewide strategies.
- **Estimated One-time Investment: TBD**

★ **Recommendation 6:** Engage with clients, advocates, and families in creation of the care coordination platform and public facing resources to ensure that information is useful and appropriate. Engage with stakeholders throughout design of the behavioral health safety net to ensure that the system meets the needs for all Coloradans.

★ **Recommendation 7.** Support specialty providers to develop capacity and telehealth infrastructure to effectively become centers of excellence for the safety net system and support smaller communities with consultative services and telehealth services in areas of the state that lack specialized services.

- **Funding Considerations:** One-time funding to support development of centers of excellence for scaling infrastructure to become centers of excellence to support clients in accessing culturally competent services.
- **Estimated One-time Investment: TBD**

★ **Recommendation 8**: Research and identify strategies and best practices to effectively engage and outreach populations in care that supports earlier identification of needs to mitigate child welfare and criminal justice involvement.

- **Funding Considerations:** Fund pilots and evaluation of programs to effectively outreach and engage priority populations and engage BIPOC, veterans, and LGBTQ+ individuals in culturally competent ways.
- **One-Time Investment: $4 Million**

★ **Recommendation 9:** Implement High Intensity Treatment Service options for children and youth in every county across Colorado that are delivered in the home and community that offer parenting support and include in-home respite services, are adequate to serve youth and families including those with autism or intellectual and/or developmental disabilities;

- **Funding Considerations:** One-time funding to support implementation of programs to ensure statewide access to best practice models of care to create additional capacity for High Intensity Behavioral Health Treatment Programs

that include telehealth strategies and alternative staffing strategies to address workforce. Ongoing investments to support funding of services for non-Medicaid covered services and necessary services to support youth with complex treatment needs may be necessary to ensure services are available for youth that are not involved with the child welfare system.

- **One-time Investment: $2 Million**

★ **Recommendation 10:** Implement child and adolescent in-home crisis response/assessment team to improve responses for children and families in need of services in an effort to avoid out of home placements.

- **Funding Considerations**: Implement one-time funding to pilot and evaluate effectiveness of the intervention. Ongoing investment may be needed if the pilot proves effective in avoiding out of home placements.
- **One-Time Investment**: $**2 Million**

★ **Recommendation 11**: Implement capacity building for High Intensity Behavioral Health Treatment Programs for Criminal Justice Involved individuals that integrate criminogenic risk with behavioral health treatments to ensure that populations are receiving adequate interventions. Pilot best practice models of care to create additional capacity for High Intensity Behavioral Health Treatment Programs that include telehealth strategies and alternative staffing models to address workforce shortages

- **Funding Considerations:** Expanded one-time investments to support implementation of high-intensity treatment programs and evidenced based models of care to ensure adequate services statewide.
- **One-Time Investment: $2 Million**

★ **Recommendation 12:** Implement capacity building for High Intensity Behavioral Health Treatment Programs that integrate behavioral health treatment with best practice interventions for individuals with disabilities and including individuals diagnosed with autism/neurodiversity, intellectual developmental disabilities, brain injury, dementia, fetal alcohol exposure, and individuals who are deaf, hard of hearing, deaf-blind, or physical disabilities to ensure that populations are receiving adequate interventions.

- **Funding Considerations:** Expanded one-time investments to support implementation of high-intensity treatment programs and evidenced based models of care to ensure adequate services statewide for individuals with disabilities.
- **One-Time Investment**: $**2 Million**

★ **Recommendation 13:** Implement capacity building for High Intensity Behavioral Health Treatment Programs that integrate behavioral health treatment with best practice interventions for individuals with complex treatment needs to ensure that populations are receiving adequate high intensity behavioral health interventions.

- **Funding Considerations:** Expanded one-time investments to support implementation of high-intensity treatment programs and evidenced based models of care to ensure adequate services statewide for individuals
- **One-Time investment: $2 Million**

★ **Recommendation 13:** Consider regional intermediate care facilities or more standard criteria for respite services in the crisis system to ensure adequate support for individuals that do not meet criteria for a mental health hold but are still in need of services.

- **Funding Considerations:** One-time funding to invest in regionalized infrastructure to support individuals with behavioral health needs in an intermediate care facility or respite setting.
- **One-Time Investment: $2 Million**

Legislative Recommendations

Fortunately, many of the actions and plans outlined in this model are allowable under state and federal authorities, including the initial authorizing statutes for the comprehensive safety net behavioral health system outlined in SB19-222. However, the existing policy, like the system, is fragmented and spans multiple areas of focus. The legislation needed to implement this model is not extensive but does require alignment and review of existing policy.

- Combine authority for essential oversight and state accountability for the success of the behavioral health system in the soon to be created Behavioral Health Administration (BHA). The BHA will be operational prior to the implementation deadline for this model. CDHS and HCPF recommend that the legislation that determines the governance, specified purpose, and direction for the BHA also include directives on the implementation of SB19-222, including:
  - New definitions for providers to align mental health and substance use statutes and create new and updated regulatory authorizations for the behavioral health safety net that include the BHA;
  - Review for any potential changes needed for the role of current CDHS intermediaries;
  - Updated definitions of network adequacy definitions;
  - Review and update required behavioral health services needed for a robust behavioral health safety net;

    - Identify requirements for behavioral health providers to participate in the behavioral health safety net in the Colorado statute and determine if the requirements are unnecessarily limited;
    - Review and update statutory and funding policy to establish requirements for when an individual exceeds clinical capacity or clinical expertise of a provider and establish clear timelines and payment options to ensure clients receive the necessary services.
- Other legislative recommendations include:
    - Identify Complex eligibility requirements for clients in the Colorado statute that create barriers to care that need to be collapsed wherever possible.
    - Identify any payment methodologies specifically listed in statute and determine if the requirements would prevent more flexible payment methodologies such as value-based payment.
    - Identify any data reporting and data sharing requirements that would prevent a move to outcome-based payments or care coordination infrastructure.

Recommendations to Supplement the Safety Net

In addition to the implementation and legislative recommendations listed above, CDHS and HCPF have identified other opportunities that support and advance a more robust safety net within Colorado. These recommendations came from subcommittee meetings and work of the BHTF, conversations with stakeholders, and exploratory research during the development of this comprehensive plan. These efforts are not required to implement the plan but could greatly enhance the capacity of the comprehensive behavioral health system.

- In partnership with OeHI develop common data standards, legal frameworks, and consent policies to support whole person care coordination which includes access to social determinants of health services and supports such as housing, food, etc.
- Establish state standards for how nonprofit hospitals meet federal requirements to provide community benefits based on their community's needs. Nonprofit hospitals are exempt from paying taxes but have federal requirements to provide community benefits based on their community's needs. Setting state standards for how nonprofit hospitals meet this requirement could potentially include directives to expand hospital provision of behavioral health services or to directly support providers in their community.
- Reduce the wait time for clients with an identified need for an institutional level of care by increasing the total number of publicly run beds available in the state.

Appendix A: Overview of Stakeholder Feedback and How it was Incorporated

Throughout the stakeholder engagement process, including presentations, discussions, and requests for written feedback, CDHS and HCPF documented feedback and have consolidated this information into themes. Under each theme we have listed how the feedback was incorporated into the model.

Broad System Reform v. Reform for Specific Populations
Stakeholders expressed concern regarding CDHS and HCPF's commitment to reforming the entire behavioral health system while addressing systemic challenges and gaps in care for specific populations, including individuals with justice involvement, children, youth, families, and individuals with a disability. Stakeholders shared that both are essential, and that the system needs to ensure individuals will be able to access culturally and linguistically responsive services that are both specialized and part of the whole.

RESPONSE:
CDHS and HCPF continuously updated the Comprehensive Safety Net Behavioral Health Model and Framework to include populations and service array considerations for the different identified populations.

- This model and framework require the state to review current regulations and create new standards of care that align with best practices to ensure that the provider network is able to serve specialty populations. It also standardizes the services that need to be available based on the type of provider and the population being served.
- This process will require the state to continue to engage stakeholders on the service array and endorsement standards, and to align these standards so the network of providers meet the needs of all Coloradans.
- This model is designed specifically to better incorporate the needs of priority populations and existing specialty providers to be brought into the system, while simultaneously increasing the requirements of every provider regarding cultural and linguistic competency.

Provider Networks and Capacity
Stakeholders expressed interest in how provider networks would deliver services outlined within the safety net framework. Specifically, stakeholders were interested in how primary care providers would be involved in the behavioral health networks, the balance between smaller, independent providers and comprehensive behavioral health centers, the ability of all providers to deliver services within the scope of their practice and to fidelity, and the funding mechanisms to adequately support providers. Federally Qualified Health Centers, hospitals, and substance use treatment providers all expressed interest in opportunities to connect with

funding for services that promote whole person care, along with some concern about the level of administrative burden that would be required.

RESPONSE:
The Department continuously updated the types of providers that were specifically included in the model, and better articulated that these different provider types would be better incorporated into the safety net system. In addition to the provider requirements, CDHS and HCPF felt the need for technical assistance was much more significant than originally envisioned. The updates to the model and implementation plan include a significant investment in identifying technical assistance needs and providing business and clinical practice support, especially for small and medium providers. The technical assistance support should also include a clear onboarding and credentialing process.

Care Coordination Across the Care Continuum
This topic was brought up in letters, feedback forms, and in stakeholder discussions among almost every group. Stakeholders were concerned as to how individuals would be supported across the care continuum from one level of care to another, when they tried to enter the system for the first time, and if they wanted to get care coordination services that connected them to a different provider. Stakeholders were concerned for individuals with justice involvement, children, youth, families, individuals with an intellectual and developmental disability, individuals residing in mental health institutes, and individuals who enter the system at a higher level of care than what is appropriate. Stakeholders were also concerned about the division of labor between the intermediary and providers to address these coordination challenges.

RESPONSE:
Due to the timing and planning of some of the other behavioral health reform initiatives throughout the state, including the Behavioral Health Blueprint recommendation for region care coordination services, this a key area of focus for the implementation plan.

- The passage of the Behavioral Health Recovery bills (SB21-137) included some direction and funding for this purpose, and state that CDHS, in collaboration with HCPF "shall develop a statewide care coordination infrastructure to drive accountability and more effective behavioral health navigation to care that builds upon and collaborates with existing care coordination services. The infrastructure must include a website and mobile application that serves as a centralized gateway for information for clients, providers, and care coordination and that facilities access and navigation of behavioral health-care services and support."
- The Comprehensive Safety Net Behavioral Health Model and Framework was designed to be able to function with different types of administrative structures and supports, including care coordination and payment structures.

- CDHS and HCPF recognize that this system will benefit significantly from other reforms in progress, including the creation of a BHA, the care coordination and navigation gateway, and the statewide improvements anticipated through federal COVID recovery funding.

Specific Treatments and Services
Many stakeholders proposed specific treatment and service modalities be included in the Comprehensive Safety Net Behavioral Health Model and Framework such as alternative medications, residential services, and additional substance use disorder treatments.

RESPONSE:
The Comprehensive Safety Net Behavioral Health Model and Framework was designed to provide a comprehensive infrastructure that would fund and support effective and evidence-based treatment models. The regulatory and standard setting process led by CDHS and in the new BHA will provide stakeholders the opportunity to ensure such specific models are not excluded. In the implementation plan, the state has included ongoing engagement with relevant stakeholders to determine the standard service array for different types of providers and populations.

Provider Contracting with Intermediaries and with Other Providers
Stakeholders had a lot of questions about how contracts would be managed with the state, intermediaries, (i.e. Regional Accountable Entities, Managed Service Organizations, Administrative Service Organizations) and from provider to provider. The Comprehensive Safety Net Behavioral Health Model and Framework allows for providers to create arrangements with other providers or social service agencies to become an agency that meets the definition of a Comprehensive Behavioral Health Provider. This encourages strong local community partnerships, data sharing, and allows for smaller specialty providers to access value-based payments and reimbursements for wrap around services, such as those that address social determinants of health. Providers were concerned about managing multiple contracts, and about risk sharing. The Comprehensive Safety Net Behavioral Health Model and Framework will be most successful when paired with strong technical assistance from the state to support sustainable business practices for providers.

RESPONSE:
CDHS and HCPF's initial presentations and draft led to the inaccurate assumption that all contracting must go through a comprehensive behavioral health provider, which is not the intention of the model. We understand that the state's presentation and this proposal needed to directly state that this was not the intention.

- The report has been updated to provide clarity on contracting expectations, which do not require contracting between providers.

- We included in the plan an expanded effort for technical assistance within the BHA to support small and medium providers.
- This technical assistance could be completed by the state agency and/or an intermediary who will be tasked with recruiting and expanding the number of providers and access points across the system.
- We foresee accomplishing new network adequacy standards in several ways including through value-based payment incentives and expect new providers and provider groups to emerge to contract with the state and/or intermediaries.

Additional Comments
Stakeholders provided smaller but by no means less important feedback on other topics ranging from definitions, specific provider types, additional payers, case mix, and administrative burden of providers.

RESPONSE:
CDHS and HCPF will continue to reach out to our stakeholders, with a focus on clients and families, in the coming years through the implementation process. We are hopeful to find the same level of robust stakeholder engagement through implementation.

Appendix B. Safety Net Definitions

The following definitions were created by the BHTF and the Safety Net Subcommittee to clarify and define SB 19-222 terms.

Behavioral health
According to SB 19-222, behavioral health "refers to an individual's mental and emotional well-being development and actions that affect an individual's overall wellness. Behavioral health problems and disorders include substance use disorders, serious psychological distress, suicidal ideation, and other mental health disorders. Problems ranging from unhealthy stress or subclinical conditions to diagnosable and treatable diseases are included in the term 'behavioral health.' An intellectual or developmental disability is insufficient to either justify or exclude a finding of a behavioral health disorder."[21]

Behavioral health safety net
The behavioral health safety net is a safe, community-based behavioral health system that provides person-centered and client-driven access to a continuum of behavioral health services and supports to all Coloradans regardless of severity of need or ability to pay. The behavioral health safety net is intended to support and treat people who struggle to access other systems of care.

Care coordination
Care coordination is "the organization of patient care activities and sharing of information among all of the participants concerned with a patient's care to achieve safer, affordable, and more effective care."[22]

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

For additional details, please refer to Appendix C.

Priority Populations: The Colorado behavioral health needs assessment highlights priority populations that have long-standing behavioral health disparities and have been historically underserved. For the purpose of this report priority populations are "Inclusive of people of color; Veterans; LGBTQ+ communities; people with disabilities; Deaf, Hard of Hearing, and Deaf Blind Coloradans; older adults; and American Indian/Alaska Native populations."[23]
Other populations that have been historically underserved include people with a serious mental illness, have criminal justice involvement, traumatic brain injuries, individuals with a history of aggression or a history of a sexual offense,

Mental wellness

"A state of well-being in which the person realizes their own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to their community."[24]

Safety net population

The safety net population is the population that the Comprehensive Safety Net Behavioral Health Model and Framework is intended to reach. The safety net population struggles to access the traditional behavioral health system for a host of reasons, including poverty; social barriers; lack of health coverage; complex health needs; unstable living situation; geographic challenges of access; criminal justice involvement; or other related attributes. This population is characterized by the following factors:

- Incomes below 300 percent of the federal poverty level (FPL);
- Lack of health coverage.
- Inadequate health coverage for behavioral health needs (e.g., high-deductible health plan or inadequate behavioral health benefits);
- Public health coverage (Medicaid or Medicare);
- More significant behavioral health need (high risk);
- Co-occurring and/or co-morbid health and behavioral health conditions; and
- Significant barriers to care as a result of geographic region, cultural competence considerations and other social determinants of health.

Safety net providers

Safety net providers are behavioral health providers (including [types of BH providers]) who specialize in treating and caring for the defined safety net populations. Exact criteria and qualifications will be defined by state agencies. In order to create the safety net, state agencies will identify safety net providers who specialize in addressing the needs of the safety net populations.

Social determinants of health (SDOH)

Social determinants of health are the "conditions in which people are born, grown, live, work and age. They include factors like socioeconomic status, education, neighborhood, and physical environment, employment, and social support networks, as well as access to health care."[25]

Understanding and addressing the social underpinnings and factors in an individual's wellbeing is particularly important for the safety net population that SB 19-222 is aimed to protect, as many people in the safety net population are unhoused or are suffering from severe poverty.

Whole person care

Whole person care considers the biopsychosocial factors that promote either health or disease and build resilience. "A person's health and wellness are not limited to their physical health, but to the wellbeing of them as a whole person."[26]

Appendix C. High-Intensity Behavioral Health Services

SB 19-222 mandates that CDHS in collaboration with the HCPF define what constitutes a High Intensity Behavioral Health Treatment Program. The Safety Net Subcommittee defined and explained what "High Intensity Behavioral Health Treatment Services" refers to. The following definition is the result of committed discussion and engagement among the Subcommittee members and reflects the principles by which the safety net plan will move forward.

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

- Distinctive services with higher intensity which are often tailored to specific subpopulations or specific behavioral health risk factors. Individuals may need these services episodically for short acute periods of time or for longer periods to reach stability. The goal for all high-intensity treatment services is to meet individual needs and support recovery with an ultimate return to less intensive levels of care.
- High-Intensity Treatment is often provided in the community; however, some programs include structured living and residential elements.
- High-Intensity Treatment Services:
    - combine evidence-based and best practice modalities;
    - often include an interdisciplinary team approach;
    - increase frequency of contact with the individual (e.g., multiple times per week);
    - expand location of services (e.g., home, community, work, and clinic);
    - utilize targeted interventions that are evidenced-based for severe mental illness and complex need;
    - prevent poor outcomes and divert individuals from needing acute care or alternative systems (e.g., emergency department utilization, inpatient hospitalization, short term and long-term residential treatment, criminal justice, or juvenile justice involvement, etc.);
    - include care coordination and/or care management functions including:
        - comprehensive and whole person assessment of need
        - identification of risk factors and plan for mitigation

        - standardized screening and assessment tools such as the Adult Needs and Strengths Assessment (ANSA) and Child and Adolescent Needs and Strengths Assessment (CANS)
        - an individualized care plan
        - coordinated team/provider treatment planning
    - use of flexible services and interventions to meet specific individual needs
    - involve assertive community outreach and ongoing engagement;
    - track progress and rapid adaptation of treatment plan to address needs;
    - assess of social determinant of health barriers and connection to services;
    - monitor progress and risk and scale services as needed to meet changing risk and need and;
    - meet a threshold of quality and effectiveness for the target population.

Qualities of a High-Intensity Behavioral Health Service

The following qualities, like the above discussion, were also developed by the Safety Net Subcommittee.

Assertive outreach and engagement

The High-Intensity behavioral health treatment team uses motivational enhancement and other strategies to develop rapport and provides the services that are relevant to the individual and family in order to engage them in care.

Community-based

Although some services may be delivered in offices, in general, services are delivered in the community where the individual or family lives.

Multi-disciplinary and team-based

The High-Intensity behavioral health treatment team is multidisciplinary and needs to have the capacity to meet the client's needs, as defined by the client. The treatment team may include medical providers, clinicians, case managers and peer specialists as well as employment and housing navigators and law enforcement who work together in a team-based approach to care.

Recovery-focused

Services extend beyond traditional clinical or medical services to include housing and income assistance, employment, social support, education, and daily living skills with the goal of attaining and maintaining as much independence as possible. This should include any social determinants of health that are necessary for the sustainability of an individual's or family's recovery.

Client-driven

Service planning is focused on the needs identified by the individual and family and is responsive to their cultural, linguistic, and developmental needs and preferences. High Intensity Treatment is flexible to serve individuals with multiple needs and is able to coordinate with other service delivery systems to meet client co-occurring needs.

Flexible in duration and intensity
Service intensity and duration are based on the needs and risks of the individual and family; however, they are generally more intensive than conventional services and extend over an indefinite period of time.

Coordinates care across settings
The High Intensity Treatment team continually assesses need, facilitates access to needed services and provides continuity across services including emergency and intensive care, and outpatient and recovery support services. The High Intensity Treatment approach is adaptable to other services being provided to the individuals, such as those services related to individuals with Intellectual and Developmental Disabilities (IDD), traumatic brain injuries, etc.

Natural supports
The High Intensity Treatment team includes peers and/or recovery coaches and actively works to expand and enhance the natural supports available to the individual and family.

Advocacy: The High Intensity Treatment team advocates for the individual and family in accessing needed skills and resources and helps the individual build skills to advocate for themselves. High Intensity Treatment Programs are implemented with fidelity to evidence-based practices such as Assertive Community Treatment, Integrated Dual Disorder Treatment and/or High-Fidelity Wraparound programs and interface with a variety of other evidence-based interventions based on the needs of the individual and family.

Appendix D. Implementation Workplan

Goals	Steps		2021				2022				2023			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Goal 1: Align regulatory framework to allow for an endorsement(s) by the Behavioral Health Administration based on services and provider type.	1.1	Review current mental health and substance use regulations and compare to current clinical guidelines and established national certification models to design a single behavioral health regulatory schema.		X	X	X								
	1.2	Establish a work plan that delineates statutory, regulatory or rulemaking steps to improve accountability, and clear standards of care.		X	X	X								
	1.3	Partner with Colorado Department of Public Health and Environment CDPHE to define when a facility license is required.		X	X	X								
	1.4	Define what an adequate network of High Intensity Behavioral Health Treatment providers is by community and region.		X	X	X								

	1.5	Convene a workgroup to define provider endorsement criteria for comprehensive High Intensity Behavioral Health Treatment Programs.			X	X									
	1.6	Establish process and criteria for providers to pursue when an individual exceeds their clinical capacity or clinical expertise.				X	X								
	1.7	Develop a standardized provider self assessment tool for providers to identify gaps in meeting newly established certification criteria in alignment with the Comprehensive Safety Net Framework.				X	X	X							
	1.8	Synthesize provider self assessment information in order to identify major gaps in the safety net and for high-intensity treatment programs. Consolidate information into a public directory.					X	X							
	1.9	Identify training and technical assistance needs for providers, and identify local and regional gaps and prioritization for further investments.					X	X	X	X	X	X	X	X	
Goal 2: Establish infrastructure to provide technical assistance and training to support the implementation of EBPs and other best practices in the delivery system.	2.1	Develop centralized infrastructure to support providers across the state that includes training, technical assistance, business process supports, practice transformation and implementation science expertise.							X	X	X	X	X	X	

Goal 3: Develop and scale innovative solutions.	3.1	Develop an innovation model to support new approaches that address intractable problems to strengthen and expand workforce, rural capacity, and clinical expertise in order to scale solutions and cultivate best practices.				X	X	X	X	X	X	X	X	X
Goal 4: Establish Quality Health Improvement Framework for the behavioral health safety net.	4.1	Form a workgroup to recommend a quality framework that aligns disparate measure sets to create a unified behavioral health core measure set and prioritized opportunities to conduct quality improvement efforts.			X	X	X	X						
Goal 5: Establish a cohesive care coordination strategy to support care coordination activities at the client, provider, payer, and state level including clear opportunities to link social determinants of health to behavioral health services.	5.1	Establish a care coordination workgroup/subcommittee to review the recent Health management Associates (HMA) care coordination report in order to develop standards of care and requirements for navigation, care coordination and care management at the provider, regional and state levels.			X	X	X							
	5.2	Establish intentional linkages between providers, and community resources and social service organizations to improve population health outcomes.			X	X	X							
Goal 6: Implement Alternative Payment Model strategies to adequately support the delivery system.	6.1	HCPF and CDHS to engage contractors to identify and recommend alternatives to current cost reporting.			X	X	X							
	6.2	HCPF and CDHS to facilitate workgroups in an effort to develop payment incentives and measures that support providers in meeting cost, quality and outcomes.	X	X	X	X	X							

	6.3	HCPF and CDHS to develop value based payment models that align with the safety net continuum of care and address Medicaid, uninsured, and underinsured populations.					X	X	X	X	X	X	X	X
	6.4	HCPF and CDHS to develop technology infrastructure to ensure Medicaid-covered services are being reimbursed, using Medicaid's eligibility, data, and financial processing systems.	X	X	X	X	X	X	X	X	X	X	X	X	X
	6.5	HCPF and CDHS to identify policies to cover services for individuals that are uninsured or uninsured.					X	X	X	X	X	X	X	X
Goal 7: Establish Workforce Standards to effectively strengthen the workforce and increase opportunities to leverage unlicensed behavioral health aides.	7.1	Convene workgroup to establish workforce standards and prioritize training opportunities for licensed and unlicensed staff that aligns with the Safety Net continuum.			X	X	X	X						
	7.2	Establish standards of practice for unlicensed staff working in various roles within the safety net continuum.			X	X	X	X						
	7.3	Workgroup to consider clear criteria and strategies for safety net providers to address burnout, training and supervision and career pathways for staff.			X	X	X	X						

Goal 8: Implement technology and centralized resources for aligned data collection across state agencies in order to develop clear behavioral health reporting for cost, quality and outcomes and to reduce provider burden reporting to multiple state agencies in various ways.	8.1	Establish or leverage an existing a technology commission composed of cross agency leaders to ensure a coordinated technology infrastructure for behavioral health data collection and reporting that aligns with state agencies business needs.			X	X	X	X	X	X	X	X		
	8.2	Engage commission to participate in user design and product demos as the technology vision is implemented to ensure goals are achieved and products meet the business needs of state agencies and providers.			X	X	X	X	X	X	X	X	X	X
	8.3	Partner with legal and privacy experts to ensure data interoperability that protects personal health information.			X	X	X	X	X	X	X	X	X	X
Goal 9: Implement aligned partnerships with local and regional communities to ensure that community planning efforts for identification of needs, gaps, and cost sharing models are aligned and supported by the Comprehensive Safety Net Model.	9.1	Review multiple regional assessments such as local public health needs assessments, community health needs assessments conducted by hospitals, and collaborative management programs.					X	X	X	X				
	9.2	Establish a process to consolidate information from local needs assessments in order to address solutions for prioritization and planning of needed behavioral health services; zoning; transportation solutions; law enforcement needs; housing; and community cost sharing opportunities for existing resources and infrastructure.							X	X				
	9.3	Recommend an approach for local communities and regions to conduct behavioral health planning and partnering in areas that align with state priorities.									X	X	X	X

	9.4	Consider developing a regulatory framework to ensure alignment and process for strategic funding. Specifically review the community benefit funding opportunities with nonprofit hospitals and health systems.			X	X	X	X						
Goal 10: Implement shared input into regulatory standards and develop a client advocacy framework into the behavioral health delivery system to decrease stigma, improve outcomes and engage families in care.	10.1	Create statewide standards that incorporate the expertise of those with lived experiences into the behavioral health safety net to streamline access, reduce stigma, improve client education and self advocacy into governance models at the state, local, intermediary, and provider level.			X	X	X	X	X	X	X	X	X	X
	10.2	Convene a group of experts to develop a framework for incorporating shared decision making into the regulatory schema for the behavioral health safety net.			X	X	X	X	X	X				

Statewide Systemic Barriers to Care: Fragmentation in Regulations and Funding that impact Care.

Goal 1: Integrate policy and systemic approaches into the safety net framework to successfully organize services that meet the social, cultural and linguistic needs of clients. Develop standards of care to ensure that services are equitable, culturally competent and meet the unique needs of	1.1	Engage community members and representatives from priority populations to participate in the design and development of the safety net system regulations and standards of care across the Safety Net Continuum.			X	X	X	X	X	X	X	X	X	X
	1.2	Develop policies in partnership with underserved populations to improve equity and address systemic barriers to care in the delivery system.			X	X	X	X	X	X				

populations that are historically underserved.	1.3	Improve and invest in data collection and analysis to improve monitoring of trends and facilitate ongoing quality and health outcome improvement efforts. Develop best practices to disaggregate data that lead to identification of disparities in care. Provide additional training for providers to understand how improved demographic data is central to member engagement and treatment.			X	X	X	X	X	X				
	1.4	Develop and integrate best practices and identify standards of care for BIPOC that may lead to an endorsement or other rating system indicating an organization's ability to respond to cultural differences.			X	X	X	X						
	1.5	Develop coordination criteria and standards for providers and intermediaries (RAEs, MSOs, ASOs) to support alignment with federal policies by partnering with Indian Health Services (IHS), tribes, and other tribal operated community organizations.			X	X	X	X	X	X				
	1.6	Develop a strategy to improve capacity to provide culturally competent High Intensity Behavioral Health Treatment Programs to BIPOC including tribally operated organizations in rural and urban settings. Leverage input from communities as well as recommendations from respected sources or other experts.			X	X	X	X	X	X				
	1.7	Improve accessible crisis services by ensuring hotline staff are culturally competent to address the diverse needs of Coloradans and ensure that crisis services are LGBTQ+ friendly			X	X	X	X						
	1.8	Develop a more streamlined and accessible grievance process for LGBTQ+, BIPOC consumers who have been denied behavioral health services at state and regional levels.			X	X	X	X						

	1.9	Implement expanded demographic options on provider forms in order to collect additional information such as sexual orientation, gender identity, sex assigned at birth and relationship status.			X	X	X	X							
Goal 2: Develop centers of excellence to deliver culturally competent services and provide training and technical assistance for smaller provider organizations to fully build this capacity.	2.1	Establish targeted recommendations and criteria for creation of provider organizations that are centers of excellence to ensure culturally competent service delivery that support client choice.			X	X	X	X							
	2.2	Monitor the number of providers able to provide services in a culturally competent manner to ensure an adequate, accessible, and culturally competent network. Include diverse models of engagement and modes of service delivery that may include peers or mobile technologies.			X	X	X	X							
	2.3	Increase expertise and competency of providers into safety net workforce strategies to improve access and cultural competency.						X	X	X	X	X	X	X	
	2.4	Develop standards for culturally and linguistically responsive treatment programs to improve opportunities for early engagement for clients in need of services.			X	X	X	X							
Goal 3: Ensure delivery of adequate culturally competent safety net services including High Intensity Behavioral Health Treatment Programs for Black,	3.1	Build out services in the service array to improve cultural competencies for providers.							X	X	X	X	X	X	

Indigenous and People of Color (BIPOC).	3.2	Diversify the behavioral health profession (both traditional and non-traditional providers) and improve recruitment and retention of individuals representing priority populations. Consider supports for individuals of color to address barriers that may impact retention.					X	X	X	X	X	X	X	X
	3.3	Develop tailored behavioral health services that may include behavioral health aides to support outreach and engagement to priority populations.									X	X	X	X
	3.4	Develop improved outreach and engagement strategies to support screening, early intervention and treatment.									X	X	X	X
	3.5	Address workforce by building statewide collaborations with critical community partners to recruit diverse clinical and non-clinical providers into the behavioral health workforce.									X	X	X	X

Barriers to Culturally and Linguistically Competent Services for Priority Populations, BIPOC, and LGBTQ+

Barriers for Children, Youth and Families

Goal 1: Ensure adequate and culturally competent High Intensity Behavioral Health Treatment Programs that meet the needs of children, youth and families across Colorado including	1.1	Identify existing capacity of High Intensity Behavioral Health Treatment Programs and assess opportunities to more fully provide services for youth with co-occuring treatment needs including autism, intellectual and/or developmental disabilities, physical disabilities, and aggressive/sexually acting out behaviors and mental health and substance use treatment.			X	X	X	X						

those involved in the Child Welfare system.	1.2	Assess if any programs offer structured Intensive Outpatient and residential elements in the youth service array including in-home services for respite, parenting supports and family therapy.			X	X	X	X	X	X				
	1.3	Convene a work group of experts to develop a High Intensity Behavioral Health Treatment Program endorsement in order to fully establish an expected standard of care for communities. Include personnel that oversee child serving programs including child welfare, youth services, Medicaid/EPSDT/Waivers, CYMHTA, Momentum, and school districts.			X	X	X	X						
	1.4	Establish a work group to recommend a regulatory framework to ensure timelines and accountability for developing a plan of care and shared payment responsibilities for complex youth. Develop criteria for when a "patient exceeds the clinical capacity of a treatment provider."			X	X	X	X						
	1.5	Consider a "27-65" provider designation for youth to more fully integrate services for youth with complex needs and align payment models for programs that address co-occuring treatment needs and services offered in the program.			X	X	X	X						
	1.6	Establish a clinical best practices workgroup to recommend the service array options and best practice options for community-based providers across the continuum of care for children and youth that should be established in communities and in regions.			X	X	X	X	X	X				
	1.7	Identify opportunities for the BHA to expand additional evidence-based models of care by implementing pilots in care and coordination for children, youth and families.							X	X	X	X	X	X

	1.8	Include best practices to leverage telehealth and alternative staffing models that can be integrated into the standards of care and address the significant gaps for co-occurring treatment needs for youth and families.							X	X	X	X	X	X

Barriers for Individuals with Justice Involvement

Goal 1: Ensure adequate safety net services including High Intensity Behavioral Health Treatment Programs and services that meet the needs of those individuals with justice involvement including opportunities for diversion and re-entry services.	1.1	Convene a workgroup of subject matter experts and providers to address the criminogenic risk factors and behavioral health treatment needs of individuals in the criminal justice system.			X	X	X	X							
	1.2	Conduct a regulatory review to align different criteria that exist in the justice and behavioral health systems to more effectively coordinate a plan of care for clients receiving services in multiple systems.			X	X	X	X							
	1.3	In collaboration with justice system personnel, develop program standards and endorsement criteria for comprehensive criminal justice programs and services including High Intensity Behavioral Health Treatment Programs and criteria and processes for when a client exceeds provider capacity			X	X	X	X							
	1.4	Develop a comprehensive training curriculum of evidence based treatment approaches for staff working in programs that obtain a "Criminal Justice Treatment provider endorsement." Include training to ensure cross-system alignment around a proactive, coordinated, and pre-release care plan.					X	X	X	X	X	X	X	X
	1.5	Establish strategy to ensure cross-system partnerships between payers, providers, local Criminal Justice treatment boards, judicial districts, problem solving courts, Forensic Navigators, and other stakeholder groups.			X	X	X	X	X	X					

	1.6	Work with a team of experts to develop standardized risk assessment tools that include mental health, substance use and criminogenic risk in order to improve treatment matching and outcomes.					X	X	X	X	X	X	X	X
	1.7	Identify opportunities to leverage and expand additional evidence-based models of care by implementing pilots and include best practices to leverage telehealth and alternative staffing models that can be integrated into the standards of care.					X	X	X	X	X	X	X	X

Barriers for Co-Occurring Services for Individuals with Disabilities

Goal 1: Build capacity and tailored interventions in the behavioral health safety net to ensure access to services for individuals with disabilities. Address systemic barriers resulting from the "primary behavioral health diagnosis" that impacts access to care for individuals with disabilities.	1.1	Conduct a regulatory review to align different criteria that exist in programs serving individuals with disabilities to ensure effective coordination of a plan of care for clients receiving services in multiple systems.			X	X	X	X							
	1.2	Convene a workgroup of experts and individuals with lived experience to review the co-occuring disabilities workgroup report and establish the safety net endorsement criteria for behavioral health providers to adequately treat clients with co-occuring disabilities. Establish safety net criteria for a "co-occuring disabilities provider endorsement."			X	X	X	X							
	1.3	Develop program standards and program criteria for comprehensive services including High Intensity Behavioral Health Treatment Programs and criteria for when a client exceeds provider capacity.			X	X	X	X							
	1.4	Work with a team of experts and individuals with lived experience to develop standardized risk assessment tools that include mental health, substance use and other criteria to ensure services are culturally competent and match the needs of the individual.					X	X	X	X					

	1.5	Establish minimum training criteria for staff and providers working in a program that is endorsed as a “co-occuring disabilities'' treatment provider. Identify best practices and evidence based models to integrate into the safety net continuum to ensure quality and outcomes.			X	X	X	X	X	X	X	X	X	X
	1.6	In coordination with the proposed “Implementation and Innovation” model proposed in Section I, identify opportunities to pilot and expand additional evidence based models of care. Include best practices to leverage telehealth and alternative staffing models that can be integrated into the standards of care.							X	X	X	X	X	X

Barriers for Individuals with Serious Mental Illness

Goal 1: Ensure adequate access to High Intensity Behavioral Health Treatment Programs that meet the needs of Individuals with a Serious Mental Illness.	1.1	Identify existing capacity of High Intensity Behavioral Health Treatment Programs and assess if program meets the following criteria including evidence-based approach, staffing, frequency of contact with the individual (e.g., multiple times per week); location of services (e.g., home, community, work and clinic); and counties these services are offered.			X	X	X	X						
	1.2	Assess if any programs offer structured living and residential elements in a service array.			X	X								
	1.3	Establish an expected standard of care and service array for communities that includes psychiatric rehab supports, housing and residential needs for individuals with Serious Mental Illness (SMI), Co-occuring treatment needs, and individuals experiencing homelessness in collaboration with housing system personnel			X	X	X	X						
	1.4	Identify opportunities to expand additional evidence based models of care by implementing pilots in coordination with the proposed “Implementation and Innovation” model proposed in Section I.Include best practices to leverage telehealth and alternative staffing models that can be integrated into the standards of care.							X	X	X	X	X	X

	1.5	Work with a team of experts to develop standardized risk assessment tools and training for engaging with individuals that may exhibit aggressive behaviors and develop a comprehensive curriculum of required training for staff working in a program that obtains a "High Intensity Behavioral Health Treatment Program endorsement."			X	X	X	X	X	X	X		X	

Barriers for Individuals experiencing homelessness or housing instability

Goal 1: Ensure adequate access to High Intensity Behavioral Health Treatment Programs that meet the needs of Individuals experiencing homelessness or housing instability.	1.1	Develop and integrate best practices and identify standards of care for individuals experiencing homelessness or housing instability into the safety net framework to ensure coordinated care and an improved continuum of care.			X	X	X	X	X	X				
	1.2	Identify and develop endorsement criteria for providers that specialize in working with individuals experiencing homelessness or housing instability.			X	X	X	X						

[1] Individuals at Risk of Institutionalization: Concerning the improvement of access to behavioral health services for individuals at risk of institutionalization, and, in connection therewith, making an appropriation. SB19-222, Senate, 2019 Regular Session (2019). https://leg.colorado.gov/bills/sb19-222

[2] Per statute 7-63-101, "Behavioral Health" refers to an individual's mental and emotional well-being development and actions that affect an individual's overall wellness. Behavioral health problems and disorders include substance use disorders, serious psychological distress, suicidal ideation, and other mental health disorders. Problems ranging from unhealthy stress or subclinical conditions to diagnosable and treatable diseases are included in the term "behavioral health." An intellectual or developmental disability is insufficient to either justify or exclude a finding of a behavioral health disorder.

[3] Per the statute in C.R.S. 27-63-104, the BHTF Safety Net Subcommittee was established to determine what an adequate network of behavioral health services should include and define the characteristics of a High Intensity Behavioral Health Treatment Program

[4] Behavioral Health Task Force. (2020). *Behavioral Health in Colorado: Putting People First: A Blueprint for Reform*. Colorado Department of Human Services. https://drive.google.com/file/d/1lWVIG3IHPM8OUgVFgLuqWFn8waggUseZ/view

[5] Kaiser Family Foundation. (2021). *Mental Health and Substance Use State Fact Sheets* [Fact Sheet]. https://www.kff.org/statedata/mental-health-and-substance-use-state-fact-sheets/

[6] Kaiser Family Foundation. (2021). *Adults Reporting Mental Illness in the Past Year* [State Health Facts]. KFF. https://www.kff.org/other/state-indicator/adults-reporting-any-mental-illness-in-the-past-year/

[7] Whittington, L. (2020). *Going Without: Many Coloradans Not Getting Needed Treatment for Substance Use Disorder*. Colorado Health Access Survey. https://www.coloradohealthinstitute.org/sites/default/files/file_attachments/2019%20CHAS%20Substance%20Use%20Brief_1.pdf

[8] Whittington, L. (2020). *Going Without: Many Coloradans Not Getting Needed Treatment for Substance Use Disorder*. Colorado Health Access Survey.

[9] Docherty, M., Spaeth-Rublee, B., Scharf, D., Ferenchick, E. K., Humensky, J., Goldman, M. L., Chung, H., & Pincus, H. A. (2020). *How Practices Can Advance the Implementation of Integrated Care in the COVID-19 Era*. Commonwealth Fund. https://doi.org/https://doi.org/10.26099/4rmr-xs37.

[10] Office of Behavioral Health. (2020). *2020 Behavioral Health Needs Assessment*. Colorado Department of Human Services. https://drive.google.com/file/d/1lln7LrH8f7vaYy7DVh53PkxaN4Zb9LlB/view.

[11] Office of Behavioral Health. (2020). *2020 Behavioral Health Needs Assessment*. Colorado Department of Human Services.

[12] Office of Behavioral Health. (2020). *2020 Behavioral Health Needs Assessment*. Colorado Department of Human Services. https://drive.google.com/file/d/1lln7LrH8f7vaYy7DVh53PkxaN4Zb9LlB/view.

[13] Individuals at Risk of Institutionalization: Concerning the improvement of access to behavioral health services for individuals at risk of institutionalization, and, in connection therewith, making an appropriation., SB19-222, Senate, 2019 Regular Session (2019). https://leg.colorado.gov/bills/sb19-222.

[14] Tikkanen, R., & Abrams, M. K. (2020). *U.S. Health Care from a Global Perspective, 2019*. Commonwealth Fund. https://doi.org/https://doi.org/10.26099/7avy-fc29.

[15] Colorado Department of Health Care Policy and Financing (2021) *Primary Care Payment Reform*. https://hcpf.colorado.gov/primary-care-payment-reform-3.

[16] Colorado Department of Health Care Policy and Financing (2021) *Bundled Payments*. https://hcpf.colorado.gov/bundled-payments.

[17] https://drive.google.com/file/d/1c7KRvR19bcAPlEidmI1ynxWBs2m-U7b6/view. Page 8- BH needs assessment.

[18] https://drive.google.com/file/d/1ELU6GREoHVCl7SHl_dW7UlqZ4n88c21F/view. Page 8 of priority populations section- Racial and Ethnic Minorities

[19] *Colorado's system of care and involuntary treatment for mental health is established in Colorado statute (Title 27, Article 65, C.R.S., commonly referred to as "27-65") and further defined in OBH rule (Volume 2 CCR 502-1). It establishes provider standards for navigating the laws and rules on mental health care and involuntary treatment in our state.*

[20] Criminogenic risk is the likelihood that an individual will engage in future illegal behavior in the form of a new crime or failure to comply with conditions of probation or parole. Criminogenic needs are factors that increase an individual's likelihood of re-offense, such as lack of

employment or livable wages, or the presence of a substance use disorder. Criminogenic risk and need factors are malleable and responsive to intervention.

[21] Individuals at Risk of Institutionalization: Concerning the improvement of access to behavioral health services for individuals at risk of institutionalization, and, in connection therewith, making an appropriation., SB19-222, Senate, 2019 Regular Session (2019). https://leg.colorado.gov/bills/sb19-222

[22] Behavioral Health Task Force. (2020). *Behavioral Health in Colorado: Putting People First: A Blueprint for Reform*. Colorado Department of Human Services. https://drive.google.com/file/d/1lWVIG3IHPM8OUgVFgLuqWFn8waqgUseZ/view

[23] Behavioral Health Task Force. (2020). *Behavioral Health in Colorado: Putting People First: A Blueprint for Reform*. Colorado Department of Human Services. https://drive.google.com/file/d/1lWVIG3IHPM8OUgVFgLuqWFn8waqgUseZ/view

[24] Behavioral Health Task Force. (2020). *Behavioral Health in Colorado: Putting People First: A Blueprint for Reform*. Colorado Department of Human Services. https://drive.google.com/file/d/1lWVIG3IHPM8OUgVFgLuqWFn8waqgUseZ/view

[25] Behavioral Health Task Force. (2020). *Behavioral Health in Colorado: Putting People First: A Blueprint for Reform*. Colorado Department of Human Services. https://drive.google.com/file/d/1lWVIG3IHPM8OUgVFgLuqWFn8waqgUseZ/view

[26] Behavioral Health Task Force. (2020). *Behavioral Health in Colorado: Putting People First: A Blueprint for Reform*. Colorado Department of Human Services. https://drive.google.com/file/d/1lWVIG3IHPM8OUgVFgLuqWFn8waqgUseZ/view