HMA

HEALTH MANAGEMENT ASSOCIATES

El Paso County Behavioral Health Study
Findings and Priorities

PRESENTED TO

EL PASO COUNTY PUBLIC HEALTH AND THE CRIMINAL JUSTICE COORDINATING COUNCIL OF THE PIKES PEAK REGION

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Research and Consulting in the Fields of Health and Human Services Policy, Health Economics and Finance, Program Evaluation, Data Analysis, and Health System Restructuring

Contents

Overview

Even prior to the 2020 pandemic, El Paso County (EPC) and the Pikes Peak Region experienced high rates of poor mental health, opioid and other substance use, suicide, and rates of incarceration related to mental health and substance use. In recent years, various studies and collaborations were commissioned to understand how to address these worrisome trends.

As part of its strategic planning, El Paso County Public Health (EPCPH) targeted the need to improve mental health and decrease substance misuse, triggered by data from the county's 2017 community health assessment and Health Indicators Report. EPCPH facilitated efforts by the Healthy Community Collaborative (HCC), a stakeholder group of over 60 community partners, to identify a range of behavioral health related strategies that became part of the 2018-2022 EPCPH Community Health Improvement Plan (CHIP). Metrics related to these strategies are tracked on the El Paso County Thriving Colorado Dashboard.[1] Also in response to behavioral health concerns, the Criminal Justice Coordinating Council of the Pikes Peak Region (CJCC) created a Behavioral Health Committee. The committee was charged to identify ways to increase behavioral health prevention and reduce behavioral health-related justice system involvement. The Board of County Commissioners of EPC also signed a "Proclamation Highlighting the Stepping Up Initiative to Reduce Mental Illness Cases in Jails" on October 16, 2015.[2]

Terms of Reference

The term "behavioral health" in this report is intended to be inclusive of mental health and substance use disorder (SUD). The term "behavioral health system" is inclusive and used to refer to the multifaceted continuum of prevention, early intervention, specialty treatment and community supports involving community, health care, and the justice system.

Early in 2020, as behavioral health trends persisted, Health Management Associates (HMA) was asked by both EPCPH and the CJCC to provide an assessment of the behavioral health system in the county and recommendations for strategic action to address gaps and improve behavioral health. In parallel, the Colorado Department of Human Services Office of Behavioral Health contracted with HMA to conduct a federally required statewide behavioral health needs assessment, to be completed in summer 2020. At the same time, the Governor's Behavioral Health Task Force was convened, charged with evaluating and setting a roadmap to improve the current behavioral health system in the state by the fall of 2020. HMA took a collaborative approach to leverage and not duplicate efforts, take advantage of past studies and stakeholder recommendations, provide an updated understanding of countywide behavioral health system capacity, needs and gaps, and help county stakeholders target priorities for action that are feasible and impactful. EPCPH intends to use the results of the assessment to pursue an updated set of strategic CHIP priorities that will improve behavioral health outcomes in the county. The CJCC plans to

[1] The El Paso County Public Health (EPCPH) agency is federally certified and eligible to receive both federal, state and other funds to carry out core public health activities in the county. The EPCPH vision is "to promote and protect public health and environmental quality across the county through people, prevention and partnerships." Its strategic plan outlines specific goals and strategies for how the agency's three major divisions – Health Promotion and Disease Prevention and Control, Health Services, and Environmental Health - address ongoing and critical public health and safety issues.

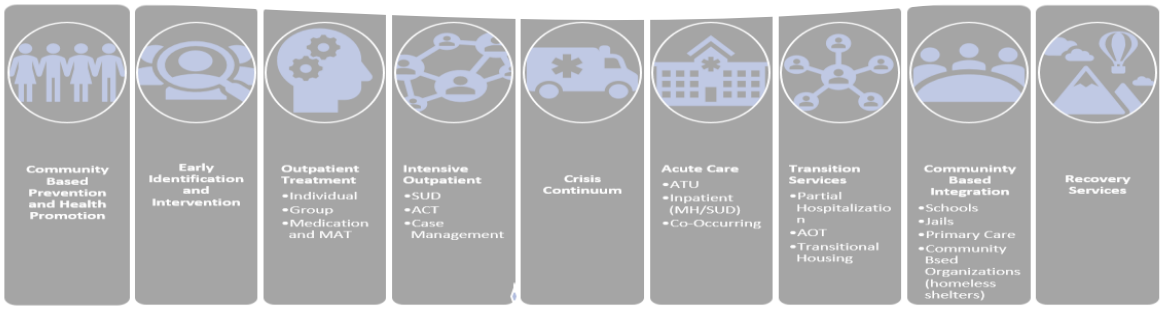
[2] The Stepping Up Initiative is a national initiative to reduce the number of people with mental illness in jails. The initiative asks communities to develop an evidence-based action plan to achieve measurable impact.

use the assessment findings to support the implementation of solutions that will strengthen behavioral health supports for those involved in the justice system, and appropriately divert those individuals who need mental health and substance use disorder (SUD) treatment and supports from becoming involved in the criminal justice system.

Accomplishments, Persistent System Gaps, and Pain Points

The stresses of the current pandemic crisis amplify the urgency to address behavioral health needs and gaps in the county. HMA reviewed over 100 studies and source documents and talked to diverse key informants to collect input regarding the continuum of the county's current behavioral health system. This continuum of interventions and services are part of the behavioral health system represented in the following graphic.

Figure 1 Continuum of Behavioral Health Services



Examining aspects of the current system revealed various strengths and assets moving forward, including the engagement of many key stakeholders, community partnerships, agency leadership, and dedicated resources within EPCPH and CJCC for surveillance and data analytics. At places across the continuum, programmatic innovations have been pursued with positive impact. The successes of the county's crisis intervention programs are examples.

In the context of the pandemic, state policy makers enacted several pieces of 2020 legislation with important implications for addressing heightened behavioral health and substance use concerns. Legislation establishes requirements and provides funding for various aspects of mental health and SUD treatment and supports. Clearly, it is important for the county to act quickly to plan and take advantage of additional resources. However, a common message from study informants is that EPC lacks a coherent vision and shared accountability for addressing major gaps and "pain points" across the continuum, and has not been able to accomplish linking together solutions into an effective BH system aligned with the justice system.

Major pain points include:

- ❑ Widespread and persistent cultural bias or stigma associated with mental health and SUD issues prevents individuals from acknowledging and seeking help for depression, anxiety, suicidality, and substance use and addiction.
- ❑ For individuals needing mental health treatment, barriers prevent timely access to appropriate types of behavioral health treatment and supports. In addition to lack of insurance coverage, barriers include lack of appropriate types of providers, delays in accessing appointments and/or lack of available openings for treatment, administrative complexity, and service fragmentation.

Individuals living in rural areas face geographic hurdles to access behavioral health treatment and recovery supports. Racial and ethnic minorities face barriers to quality care.

- ❑ The number of individuals struggling with substance use and addiction, including opioid and methamphetamine use, and serious mental illness (SMI), has contributed to high rates of justice system involvement and incarceration. Pre and post arrest diversion programs are not available to move individuals to appropriate treatment in the community rather than incarceration. There is a lack of adequate facility placements for detox treatment other than hospital emergency departments. Most individuals incarcerated in the jail receive limited to no behavioral health therapy outside of crisis intervention. Across the county, MAT is a recognized standard of care for opioid use disorder, however across EPC is uneven at best, including within the justice system. MAT is only just beginning to be implemented in the jail.
- ❑ Without more structured formal collaboration and accountability across agencies, current silos and system fragmentation will persist. Individual entities in the behavioral health system are motivated to make improvements. However, study informants emphasize how difficult it is to mobilize resources and sustain efforts to implement more significant reforms.
- ❑ Lack of data is a cross-cutting issue. Data is not available, shared and consistently used for population health management i.e., risk assessment and stratification, planning and treatment, monitoring progress and outcomes, and supporting patients with system navigation. Also lacking is data translated into meaningful information i.e., analysis, program and system evaluation, and reporting. This information serves as a catalyst enabling county stakeholders to support and take actions that improve the system and ultimately decrease avoidable costs to individuals, families, and the county as a whole.

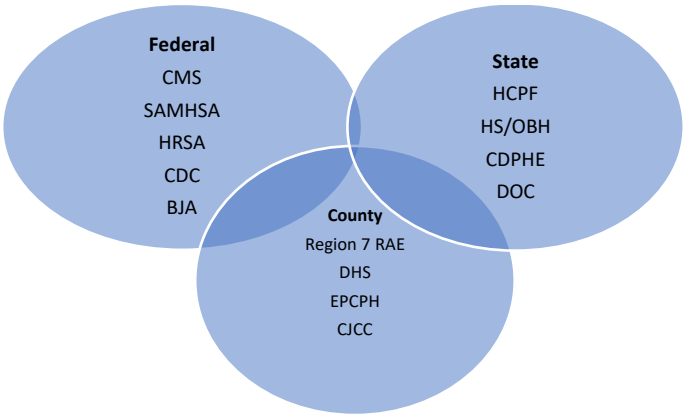
Finding the Way Forward in a Complex Landscape

Like EPC, counties across the nation are grappling with how to address the levels of behavioral health concerns that threaten the well-being of their communities. Addressing the causes and impacts of mental health and SUD issues requires navigating a complex landscape. At all levels, "health" has been historically segmented into domains of **public health** i.e., population health, health prevention, surveillance and epidemiology and **health care** i.e., health insurance coverage, services, and delivery. Within "health care," siloed "sub-systems" exist with extensive rules, eligibility, funding, and provider networks. These include physical medicine, mental health, and substance use. Several health-related programs and services are under the purview of **human services** agencies. **Corrections** i.e., the criminal justice system, represents an additional, distinct "system" with cross-cutting points of intersection with both public health and health care.

Federal and state regulatory/policy frameworks and financing initiatives across these domains significantly influence the availability and deployment of resources to address behavioral health at the county level. A current influx of federal money is targeting opioid use, which is being passed through the state to counties to address local harm reduction and other interventions. Various federal funding initiatives were poised to further address behavioral health needs, however, now are at risk due to pandemic-related economic constraints. In Colorado, funding for mental health and SUD prevention and treatment comes from multiple state agencies. Statewide behavioral health funding cuts are being

enacted due to the economic impact of the pandemic that will have a ripple effect across the county's behavioral health system.[3]

Figure 2: Multiple agencies impact the county level behavioral health system



Against this backdrop, attempts to address current behavioral health issues and gaps in EPC prevention, treatment and supports must consider the interplay between efforts in all of these health and agency domains.

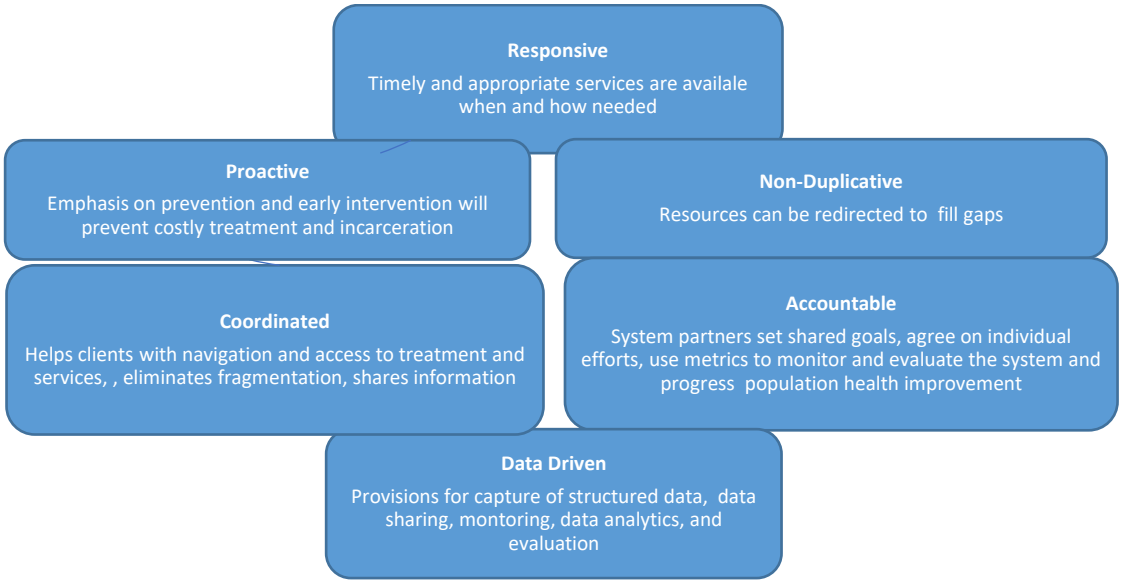
Populations at Risk and System Implications

Many factors impact resilience and behavioral health, including social and economic circumstances, stress and traumatic experiences, genetics, and the extent to which supports are physically available and accessible. Data point to several populations of EPC residents at higher risk for poor mental health, SUD, and suicide. High risk groups include adults with co-occurring disorders, racial and ethnic minorities, pregnant women, youth, active military and veterans, individuals identifying as LGBTQ+, individuals involved in corrections, and individuals without housing. Equity issues cut across all of these populations. Individuals in these groups must access an administratively complex and fragmented system of treatment and services. They are challenged to navigate multiple agency requirements and service access points and grapple with issues such as housing and transportation.

An overwhelming message from county stakeholders is that a way must be found to transcend siloed efforts, identify feasible, cost-effective options, and implement collaborative solutions to significantly move the dial on behavioral health and demonstrate positive outcomes over time. Stakeholders described several desired attributes for a more collaborative and effective system.

[3] A report from the Colorado Health Institute identified that public funds supporting behavioral health in Colorado, for adults alone, are provided by 42 programs across 7 state agencies. HCPF (Medicaid) is the largest funder. Separate pools of federal, state, and local funds support public health and human services.

Figure 3: Desired attributes for the county's behavioral health system



Operationalizing these principles for a better functioning system requires a framework that will braid together efforts to meet the above objectives. The system blueprint must consider not only the services needed, but also the way that different services need to be funded, available and delivered, taking into account levels of health risks, needs and characteristics of different populations.

Organizing around population health, and population health management, avoids a piece meal approach that perpetuates fragmentation and lack of coordination. This system of care focused approach is being broadly advanced and implemented by payers, providers, and governments, and in states and counties across the country. In EPC, it will involve working with federal and state partners that influence policy and funding, while locally establishing multi-level capacity to:

- Systematically monitor the health and identify health risks among the various populations that comprise the residents of the county;
- Collaboratively develop blueprints for how needed treatment and services for various high-risk populations can be enhanced, streamlined and well-coordinated across agencies, taking into account social, cultural, and economic realities; and
- Monitor and measure outcomes and system performance

An organizational infrastructure is necessary to structure and maintain collaboration for leveraging resources and achieving shared objectives and outcomes. Importantly, this includes ensuring reliable and ongoing measurement and accountability for making progress toward agreed upon population health goals. Well-described collaborative models exist for the county to follow (i.e., a collective impact model described later in this analysis).

This Report

This report synthesizes key findings from HMA's assessment of major needs, system gaps and opportunities to address behavioral health and SUD in EPC. The study looked across public health, health care and corrections, and incorporated input from various sources: EPC informants, a

considerable number of resource documents, including EPC and statewide studies; and HMA experts. Findings point to how principles of collective impact, and population health management, provide a framework for addressing specific gaps and strengthening the EPC's behavioral health system as a whole.

Following this Overview, the brief is organized into four major sections along with a set of attachments.

- Section 1 - Profile of Persistent Behavioral Health Issues
- Section 2 - Examination of the Behavioral Health System Assets and Pain Points
- Section 3 - Strategic Priorities
- Section 4 –Recommendations for Next Steps

It should be noted that the attachments provide additional detail accompanying the various sections of the brief, particularly section 2.

Caveats

This study was conducted over five months, during which the SARS-CoV-2 pandemic erupted in full force. The impact of the pandemic is becoming apparent, with worsening behavioral health reported and state cuts to mental health and SUD treatment enacted. Despite this, this study could not account for the effects of the pandemic other than to highlight the increasingly urgent need for resourcefulness and determined efforts to strengthen the behavioral health system.

The stated objectives of the study were to support both EPCPH and the CJCC in further strategic planning. The report itself is designed to be a resource document, an inventory of sorts, with a focus on the entire continuum of the behavioral health system and considerations relative to high risk populations interacting with the system. It was not possible within the limitations of this study to provide exhaustive baseline descriptions of current activities and system functions; to fully explore the needs and system dimensions related to specific high risk populations, including the unhoused, active military/veterans and the LGBTQ+ populations; or provide full development of the solutions that are proposed. The strategic priorities for system improvement that are called out for consideration by EPCPH and CJCC stakeholders require additional investigation, collaborative deliberation, and development of implementation strategies. Effective collaboration is essential for success in doing this. This report urges that cross-cutting infrastructure i.e., a "backbone" as described in the Collective Impact framework, be implemented that will provide structure and processes for collaborative leadership and accountability, define stakeholder roles and resources, identify shared short and longer term outcome goals, and agree upon metrics, data sharing, and provisions for monitoring and evaluation.

Section 1 Profile of Persistent Behavioral Health Issues

EPC residents have experienced increasing rates of poor mental health and SUD, compounded by various barriers to treatment, including physical access, provider availability, lack of insurance coverage and stigma against seeking mental health care. In reaction to the pressures of the current SARS-CoV-2 pandemic, worsening mental health and SUD issues are being reported.

El Paso County Population

The county's population is increasing over time. In 2019, there were a total of 724,685 individuals, growing almost 16% since 2010.[i] The county's population is also diverse – the approximately 30% of the population who consider themselves non-White reside closer to Colorado Springs while the eastern and western parts of the county are more homogenous. This requires tailored approaches to the delivery of behavioral health care and messaging in the county to ensure cultural sensitivity.

The majority of the county is rural while most of the population and providers reside in urban areas, which creates barriers to access for rural-dwelling residents. Families living in poverty are concentrated in south Colorado Springs and south-central and eastern EPC. For example, School District 20 in the northern part of the county only has a 5% poverty rate among students ages 5-17 while Harrison D-2 in Southeast Colorado Springs has a 26% poverty rate.[ii] In a study of youth suicide, kids in Northern Colorado Springs report facing pressures to perform and achieve that negatively impacted their mental health.[iii]

In 2019, approximately 6% of the county population were uninsured while 13% are insured by Medicare, 20% by Medicaid, and the remainder have commercial insurance.[iv] An increase in the number of people insured by Medicaid is anticipated as a result of the global pandemic. In Colorado, poor mental health has been most prevalent among Medicaid insured individuals compared to privately insured individuals.

Prevalence of Mental Health and SUD

Available data suggests that the behavioral health conditions continue to rise in the county relative to statewide benchmarks. The HCC has started to collect data on this topic, with most metrics showing results below or significantly below the target.[v] However, given the fragmented system of payers and providers and lack of standardization, several gaps remain in understanding the full nature of behavioral health needs relative to treatment supply. HMA has provided a Data Book as an appendix that outlines available sources to track key metrics that EPC can use to monitor trends more closely in behavioral health across populations. The Data Book includes and builds on metrics that have already been identified through the HCC. The following sections provide updated summary data on mental health and SUD trends in EPC.

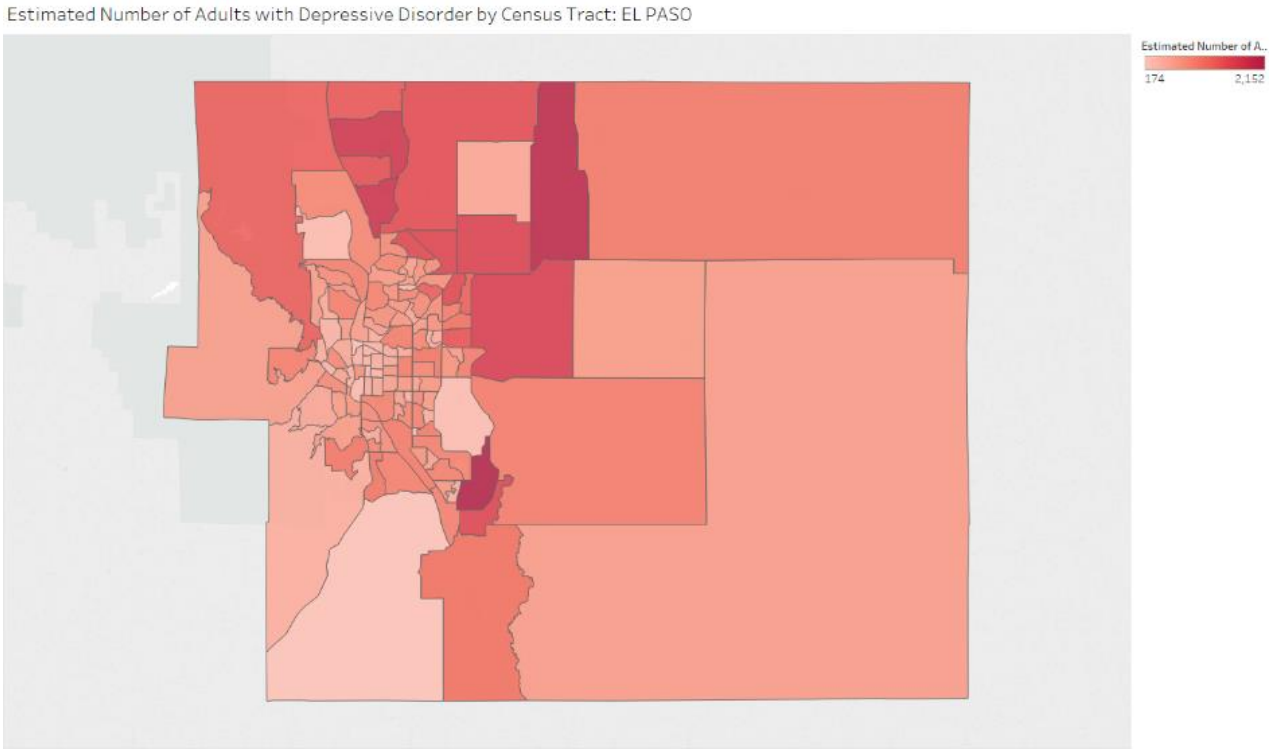
Mental Health Disorders

Almost 18% of adults in EPC have reported depressive disorder between 2016-2018, which is higher than the state average of 17.1%.[vi] Similarly, those over age five reporting eight or more days of poor mental health in the last 30 days have increased from 11% in 2013 to 14.6% in 2019.[vii] Estimates of Serious Mental Illness in the region (EPC, Park and Teller) averages 5.3% which is slightly higher than the state average of 5.23%.[viii]

Suicides have also increased since 2006, from 67 to 180 in 2019.[ix,x] Suicides are primarily among non-Hispanic white males – 37% of all suicides were by armed forces veterans. EPC experiences more suicides among individuals ages 15-34 and ages 55-64 than the state. The most significant contributing circumstance preceding a suicide from 2015-2017 was having a current depressed mood (76% in EPC vs. 60% statewide). The population in EPC was also more likely than those across the state to have opiates present (20.7% in EPC vs. 19.5% statewide), as well as benzodiazepines, antidepressants, and amphetamines. Veterans, in particular, who committed suicide are more likely to have experienced a current depressed mood (78.3%) and have a contributing physical health problem (46.5%).

In the face of potential rising demand for behavioral health treatment, access is also a concern. A rising percentage of individuals over age five reported needing mental health care or counseling but did not receive it in the past year (7.8% in 2013 to 13% in 2019).[xi] The largest number of individuals who have ever been diagnosed with a depressive disorder are in more rural communities of the county, as seen in the map below. The deeper red color reflects a higher estimated number of adults with depressive disorder in a given census tract. The most significant number of adults with depressive disorder reside near Fountain and in the northern part of the county, in addition to pockets in central Colorado Springs. Locations of the largest Community Mental Health Center and crisis provider in the region, AspenPointe, are also placed in those areas of high need.

Figure 4: Concentration of Adults with Depressive Disorder by Census Tract



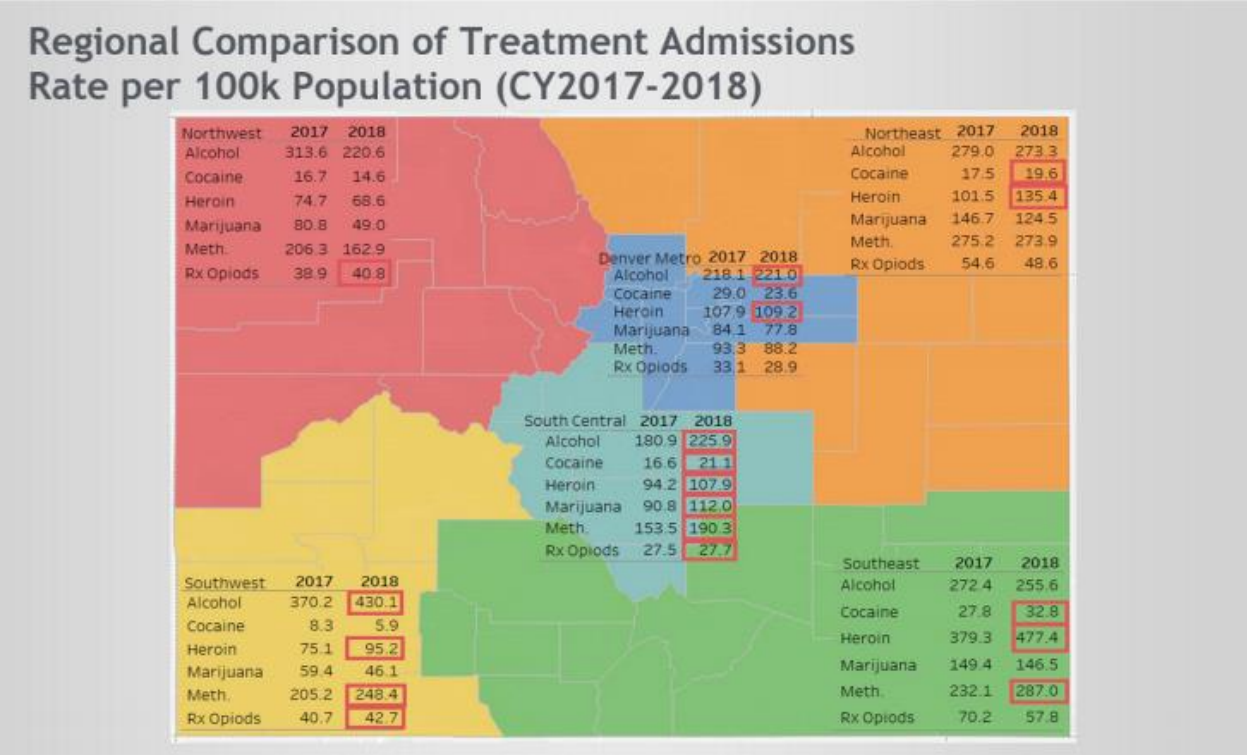
There is also an indication that individuals are not seeking mental health treatment due to stigma. In 2019, only 14% of EPC residents spoke with a mental health provider about their own mental health (ages 5 and older) compared to 20% of the state's residents.[xii]

Substance Use Disorders

SUD continues to be a primary concern for the county. Over nine percent (9.13%) of the population in the region is estimated to have a SUD between 2016-2018, which is an increase over 2015-2017 (8.2%).[xiii]

The map below suggests the South Central region, of which El Paso is a part, is facing increasing treatment admissions to OBH-funded providers for all types of substances – alcohol, cocaine, heroin, marijuana, meth, and prescription opioids - from 2017 to 2018.[xiv] EPC's age-adjusted rate of ED visits for overdose exceeds Colorado's average (213.2 versus 193.8 per 100,000 residents) and the rate has been increasing since 2016.

Figure 5: Regional Comparison of Substance Use Treatment Admissions



Source: OBH Drug Trends Analysis, August 2019

Deaths from drug overdoses are increasing as well, including from 42 deaths in 2000 to 130 deaths in 2018 (Colorado overall increased from 351 to 974 deaths). [xv] EPC accounted for 13.1% of the total deaths from 2000- 2018 drug overdose deaths in Colorado. Almost three quarters of these deaths were unintentional or accidental. Almost 40% of the 332 accidental deaths in the county in 2019 were due to drug-related complications or overdoses.[xvi]

Access to specialty treatment is a challenge for SUD as well as mental health. SAMHSA estimates 8.81% of the population in the region needed treatment at a specialty facility for substance use in the past year but did not receive care in the past year.[xvii]

Statewide, stigma about substance use is on the rise. According to the Colorado Health Access Survey, while there was less concern about the cost of treatment in 2019 compared to 2017, there was more concern about someone finding out they had a problem and more respondents did not feel comfortable talking about personal problems.[xviii]

Population-Specific Behavioral Health Needs

In addition to geographic, socioeconomic, and cultural variation with the county, distinct populations exist that have significant behavioral health needs and can fall through the cracks of a complex system without early intervention.

Active Military and Veterans. The county has five military installations, employing near 40,000 active military and over 13,000 civilians in 2016.[xix] Three quarters of military personnel are estimated to live in communities outside of the military bases.[xx] There is limited recent data on the burden of mental illness

for this population but the Fort Carson Community Health Assessment documented an increase in rates of behavioral health disorders, adjustment disorder, other anxiety disorder, and SUD between 2015-2016. Women had higher rates of all behavioral health diagnosis, excluding SUD.[xxi] Veteran suicide rates are a concern in the state, as veterans of all ages are more susceptible to suicide than the general population and Colorado rates were higher than national rates as recently as 2016.[xxii] Drivers of higher suicide rates are related to higher rates of trauma, depression, untreated traumatic brain injury and SUD in addition to social determinants of health like homelessness.

Criminal Justice Involved. The EPC Jail houses 1,500 inmates on average,[xxiii] of which national estimates suggest around 40% may have a mental health disorder.[xxiv] There are also high rates of co-occurring disorder. An evaluation of Colorado's Jail-Based Behavioral Health Services program found 65% of inmates screened for SUD scored positive for mental health symptoms.[xxv] Effective diversion and re-entry initiatives are needed to prevent worsening burden of disease and recidivism. Key informants reported stigma around housing and treatment of justice-involved individuals.

LGBTQ+ Individuals. In Colorado, the prevalence of ever been diagnosed with a depressive disorder is highest among LGBTQ+ adults at 42.5% compared to heterosexual adults at 14.8%. Four in ten LGBTQ+ individuals in Colorado report feeling down, depressed, hopeless, or having little interest or pleasure in doing things for several days in the past two weeks.[xxvi] Youth who are transgender have the highest risk of suicidal thinking, with 40% admitting to suicidal thinking and 35% admitting to having attempted suicide.[xxvii]

Unhoused Individuals. According to the Pikes Peak Continuum of Care Point-In-Time survey, there was a recent decrease in individuals who identified as homeless – 1,116 in 2020 from 1,562 in 2019. Almost 360 were identified as "unsheltered" or living on the street.[xxviii] Untreated behavioral health challenges and, in particular, Serious Mental Illness can be contributing factors leading to homelessness as well as homelessness leading to greater behavioral health challenges (e.g., emotional distress, substance use, trauma, etc.).[xxix] Key informants identified the lack of affordable housing and lack of public transportation as key challenges to addressing the needs of unhoused individuals in the county.

Pregnant Women with SUD. Key informants report a significant lack of services for pregnant women and their babies in the county. The child (ages 1-14) death rate per 100,000 in EPC is significantly higher (27.6%) than the state (16.1%) and the infant mortality rate is also higher at 5.9% vs. 4.5%.[xxx] Counties with higher substance use indicators in the population tend to have higher foster care entry rates which is also a source of ongoing trauma.[xxxi]

Racial and Ethnic Minorities. Racial and ethnic health disparities are well documented across the nation. Racism contributes to higher mortality rates and a higher burden of disease. People of color remain over-represented in the uninsured population in Colorado and are less likely to receive care compared to white counterparts. There are significant data limitations in tracking the extent of inequity, however limited data suggests, for example, that greater proportions of American Indian / Alaska Natives and Black/African Americans in Colorado report a mental health disability than average.[xxxii] Among racial and ethnic minority youth in 2017, 12.6% of American Indian or Alaska Native students, 10.5% of Native Hawaiian or Other Pacific Islander students, 8.2 percent of Hispanic students and 7.7% of Black students attempted suicide one or more times during the previous 12 months (compared to 7% of all students; 5.9% of White students).[xxxiii] To obtain accurate county-level data will require a concentrated effort to improve race/ethnicity data collection through the behavioral health system and other survey protocols.

Youth with Significant Behavioral Health Needs. Key informants reported that select groups of youth frequently access county crisis resources from the schools. A common risk factor for students experiencing crisis includes use of substances to self-medicate. Alcohol and prescription drugs are used widely. Where students have more resources to access substances, these problems can be greater. An analysis of risk and protective factors showed that youth in the region report significantly more favorable parental attitudes towards substance use (55.9% of students at risk) and favorable peer attitudes towards substance use (51.9%) than the state.[xxxiv]

Individuals with Co-Occurring Disorder. Individuals with both mental illness and SUD often have a difficult time finding treatment that addresses their whole health needs. Literature suggests barriers exist in the identification of co-occurring disorder, service availability, provider training, and insurance coverage.[xxxv] Provider stakeholders in EPC reported particular difficulty placing individuals who have significant medical complications or who are aggressive.

Anticipated Changes in Future Demand for Services

Stresses from isolation during the current pandemic will increase the need for behavioral health supports in the short term. Research points to negative mental health effects from isolation and depression and anxiety from job loss.[xxxvi] Nationwide, federal and local officials are reporting alarming spikes in drug overdoses.[xxxvii] There is also evidence of increases in domestic violence cases in the county.[xxxviii] Gov. Polis has established a new committee within the state's Behavioral Health Task Force (BHTF) that is examining the impacts of the SARS-CoV-2 pandemic on the state's behavioral health system, which will be a good source to better understand the lasting effects on the behavioral health continuum.

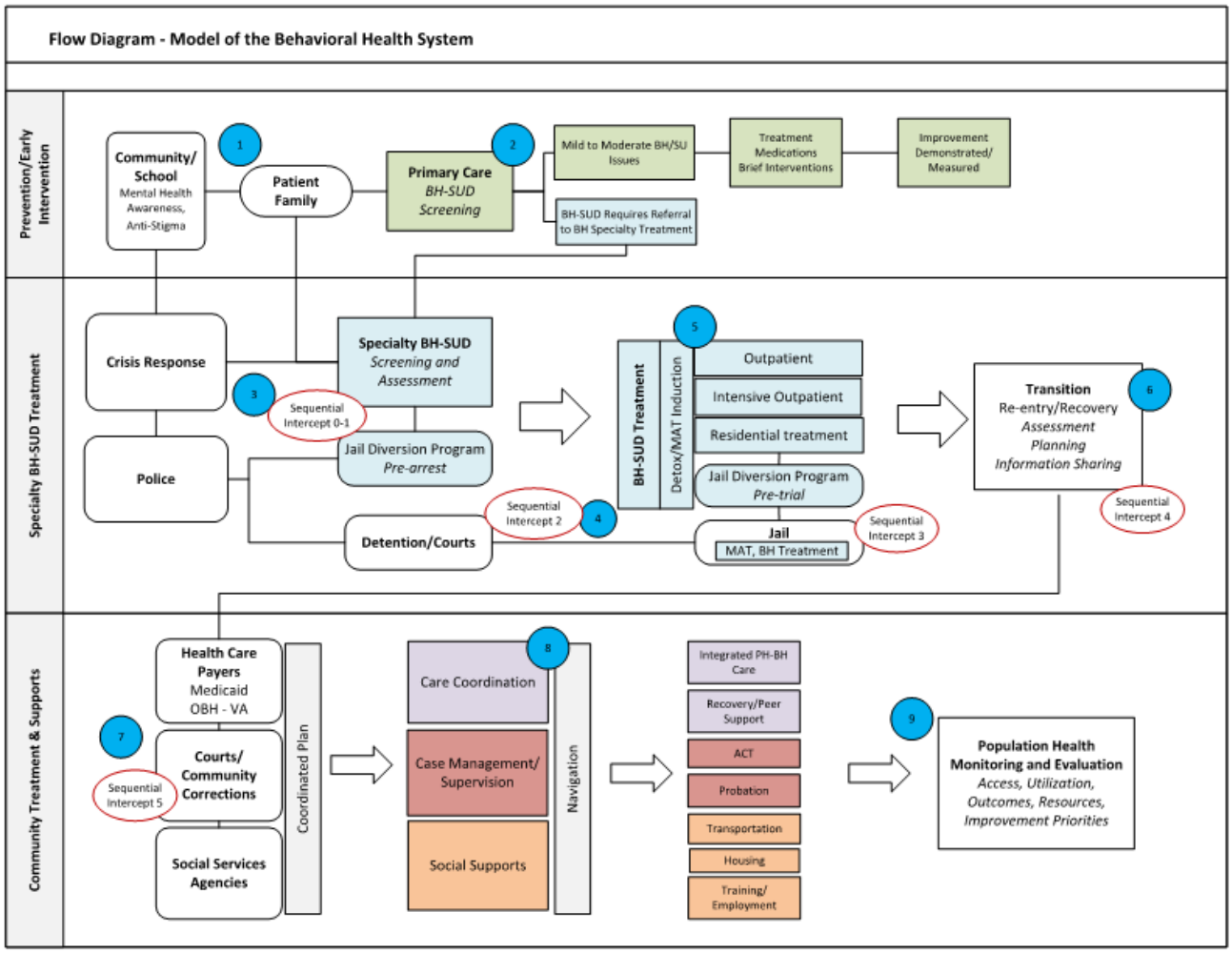
Section 2 Examining the Current EPC Behavioral Health System

As illustrated in Figure 1 above, the EPC behavioral health system is a continuum ranging from prevention and early intervention to various levels of behavioral health treatment and community-based supports. These vital components are all important to meet three behavioral health objectives:

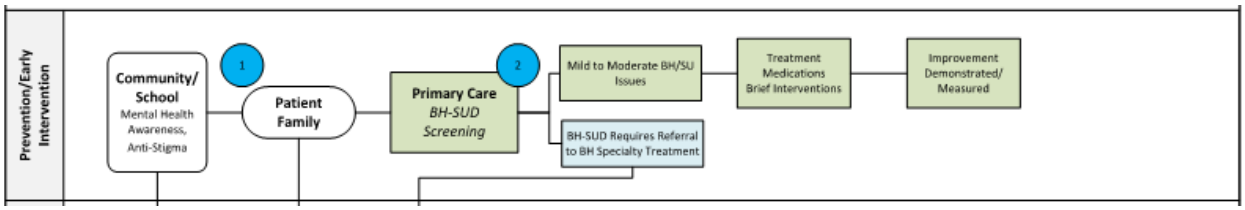
- Foster health and resilience and the earliest possible intervention to avoid negative impacts of mental health and substance use challenges
- Ensure that individuals have access to the most appropriate and timely level of behavioral health treatment well-coordinated services and supports
- Support individuals to recover and maintain their highest level of behavioral health in the context of their community.

The diagram below presents the components of EPC's behavioral health system in a flow diagram to illustrate several critical points of access and connection that are experienced by those in need of services and the public stakeholders at large in the county. This includes touch points with the justice system – acknowledged and described by SAMHSA as Sequential Intercepts (SI) [xxxix] - to highlight the full spectrum of essential system capacity at play especially for high risk populations. The following sections of the brief address each major segment of the system diagram, and highlight what is needed in the way of core capacity, how the EPC system currently functions, and where there are assets, pain points and opportunities for improvement.

Figure 6: Model of the Behavioral Health System in El Paso County



Prevention and Early Intervention



1 Prevention: Community and population-based prevention strategies increase resilience, reduce stigma and foster early intervention for those at risk for serious mental illness, addiction/overdose, justice involvement and/or suicide. In the county, widespread stigma associated with mental illness and SUD leads to avoidable human suffering, system costs and poor outcomes.

Core Capacity for Prevention

"Primary prevention" is a key public health principle – promoting healthy behaviors and resilience in the face of stress or trauma to avoid more costly negative consequences of ill health. Primary prevention activities include:

- Systematically use data to monitor MH/SUD trends and identify at-risk populations
- Health promotion efforts to foster resilience and early mitigation of risks
- Fostering public awareness to reduce stigma about seeking behavioral health treatment and mitigate health inequities

Health promotion – education to foster resilience (positive behaviors and coping strategies) and recognize early signs of difficulty – happens in the context of home, school, workplace and broadly in communities, as well as in primary health care. One of the major threats to early intervention is stigma – negative, societal messages about experiencing mental health issues – that prevent individuals from seeking help. Counteracting stigma requires normalizing seeking help for mental health and substance use concerns, based on shared understanding about depression, anxiety, addiction, and other mental health issues.

Current EPC Prevention Activity and Assets

The mission of Public Health as a core branch of government, is, in the broadest sense, to promote population health. Relative to behavioral health, EPCPH, like other county agencies, prioritizes several core public health functions.

***Surveillance**:* Public health is highly involved in ongoing surveillance of county populations and behavioral health. With dedicated data and analytic resources, various sources of data are compiled, including surveys, that point to rates of poor mental health, risky behaviors including alcohol and drug use, and suicide among priority high risk populations.

***Health promotion*:** Multifaceted efforts target education and awareness about behavioral health, particularly targeting at risk populations and those interacting with them in the community.

Coordinated response: This core role involves convening stakeholders and facilitating activities by partner organizations for a coordinated response to emergent or urgent concerns.

EPC is a partner in the Thriving Colorado Dashboard,[4] a consortium of statewide partners using a common database and common metrics to monitor trends and progress in addressing behavioral health. Locally, EPCPH brought together multiple community partners to form the Healthy Community Collaborative (HCC) as a vehicle to mobilize diverse health promotion efforts in the county responding to trends and alarming county data points revealed in the county's Community Health Assessment. HCC partners represent school districts, business interests, community-based organizations, foundations, heath care providers, social services, among others. Through a strategic planning exercise, the attached blueprint of goals and objectives was generated to be incorporated into EPC 2018-2022 strategic plan and CHIP.

In response to county metrics in the Thriving Colorado dashboard over the past 12 months, EPCPH with the HCC prioritized youth mental health and suicide prevention and engaged in multiple partnership prevention effort with schools, and community partners like NAMI. With grant funding, the agency piloted a youth engagement pilot in Fountain Valley i.e., Fountain Valley Communities that Care. EPCPH participated in "train the trainer" opportunities to help teachers and community stakeholders recognize early childhood behavioral health issues (i.e., the impact of adverse childhood events (ACES)). A behavioral health focused public awareness flyer was published.

From this work, valuable assets to leverage for strengthening prevention including the connections and partnerships created as part of the HCC, the facilitation role that EPCPH played in the past, new resources being added to the EPCPH Planning Office, and agency leadership and dedicated resources for surveillance and analytics.

Pain Points and Opportunities

According to informants, several cross cutting "pain points" in the current behavioral health system must be prioritized to impact behavioral health and the behavioral health system and improve the county's Thriving Colorado dashboard metrics. In the realm of prevention, these include:

Uneven and inadequate data collection and data sharing impede coordinated, population specific prevention strategies. A significant opportunity exists to strengthen data collection and use of shared monitoring and metrics across agencies across the continuum of the behavioral health system, including criminal justice.

Additional prevention activities targeting youth are needed to foster behavioral health awareness and resilience. To date efforts have largely relied on individual school leaders and community organizations and have not reached all districts where lack of equity and mental health risks are high. EPCPH facilitated a community-based youth support pilot in one community, however, greater efforts are needed across the county. Efforts are needed by EPCPH to strengthen the HCC by providing stronger leadership and accountability, engaging current and additional partners, and mobilizing resources to

[4] http://thrivingcolorado.com/partners/el-paso-county-public-health-scorecards

expand prevention efforts. EPCPH expertise is needed to further expand "train the trainer" and other evidence-based approaches in the community to foster mental health awareness and risk identification.

Pregnant women with mental illness and at risk for SUD need upstream supports to identify and address social factors creating health risks, reinforce healthy behaviors that will prevent and/or reduce substance use, foster heathier babies and lead to more positive parenting. An initiative is in progress to develop more transitional housing for expectant mothers suffering with addiction, but significant gaps remain in housing and wraparound supports.

Stigma is a major factor preventing individuals from acknowledging behavioral health issues and seeking early intervention. Informants emphasize that it is persistent and widespread amidst the conservative culture of the county. For example, in the most recent study of youth suicide in Colorado, participants who represented EPC stated there was pressure for parents and youth to appear perfect, and youth felt no one is allowed to show they have problems.[xl] The COVID pandemic has dramatically increased widespread levels of stress, depression and anxiety but also contributed to increased public sharing about personal experiences and challenges e.g., on social media. This presents an opportunity to develop strategies to address stigma, including seeking champions/spokespersons for mental health and targeting population specific communications, particularly targeted to youth, and adults across socioeconomic and ethnic groups.

*See **Attachment A** for a map of strategic priorities incorporated in the EPC 2018-2022 strategic plan and CHIP.*

*See **Attachment B** for a summary of findings: prevention best practices, gaps and opportunities.*

2 **Primary Care: Integrating behavioral health screening and treatment into primary care is a significant opportunity to counteract stigma, provide early intervention for depression, anxiety, and SUD, and ensure timely referrals to higher levels of behavioral health treatment as needed.**

Core Capacity for Early Intervention

Early detection and treatment (referred to in public health as "secondary prevention") supports resilience and interventions for individuals experiencing mild to moderate symptoms. Early interventions rely on screening to identify the level of health risk a patient is experiencing and facilitate timely access to appropriate providers and levels of treatment. As the flowchart illustrates, this may mean that an individual can directly gain access to treatment from a specialty mental health/SUD provider. However, primary care providers can screen for and treat mild to moderate levels of depression, anxiety, and other mental health conditions, preventing worsening health risks of serious mental illness, even suicidality. Making mental health support available in primary care (aka "integrated care") reduces stigma associated with seeking help. Integrated care models have been shown to provide cost effective treatment and improve outcomes.[xli]

Important factors influence early access to screening and behavioral health treatment.

- Federal and state payer policies and practices reduce economic barriers i.e., out of pocket costs and ensure access to provider network.

- Screening and assessment are key to providers picking up on mental health and substance use issues. Well-validated, standardized screening instruments flag levels of depression, anxiety, and substance use. These tools enable ongoing measurement to understand whether symptoms have improved and resolved, or require a different, higher level of treatment. [xlii]
- Provider commitment to and capacity for "advanced primary care" are critical. Primary care providers must incorporate processes to routinely screen, treat and measure progress, consult with psychiatry as necessary, and refer to specialty care if symptoms do not resolve (stepped care). [xliii]
- If screening determines that a patient needs a higher level of behavioral health treatment, processes for referrals and arrangements with mental health clinics and practitioners need to be in place to prevent delays in treatment.

Current Early Intervention Activities and Assets

Numerous practice transformation initiatives have targeted Colorado primary care providers over several years, aiming to build capacity for advanced primary care and value-based payment (i.e., receiving increased payment for demonstrating improved outcomes). Colorado's State Innovation Model (SIM) initiative focused on primary care integration as a core strategy to improve health care. Several philanthropic initiatives also supported development of advanced primary care among select numbers of primary care provider practice grantees. Through its contracts with Regional Accountable Entities (RAE), Medicaid covers specialty behavioral health treatment and capitated payment to behavioral health providers. More recently, Colorado's Medicaid Program implemented payment to primary care providers for a limited number of mental visits.[xliv]

This foundational exposure to integrated care among, at least some portion of the county's primary care providers, is an asset for the county going forward. Additionally, the Medicaid Accountable Care Collaborative (ACC) program is increasing its focus on population health management and value-based care strategies in its contract with its RAEs, including a commitment to foster integrated care.

Pain Points and Opportunities

Study informants report that efforts across the county to strengthen integrated primary care as a source of early behavioral health screening and treatment have lagged and even "gone backward." Yet in the midst of worsening behavioral health, more widespread adoption of integrated primary care and operational collaboration between primary care and behavioral health providers will expand access to critically important early behavioral health treatment.

Providers need to be engaged and motivated to sustain a level of commitment and effort required to redesign primary care team-based roles and processes. Models of integrated care vary in their proven effectiveness and fidelity to core integration practices is often lacking in provider practices. Providers need leadership from among their peers, incentives, and education and technical supports to foster more widespread adoption of robust models of integrated care. This includes strengthening team-based roles and skills in screening, use of brief behavioral health interventions, measurement-based care, psychiatric consultation, and specialty referrals (stepped care).

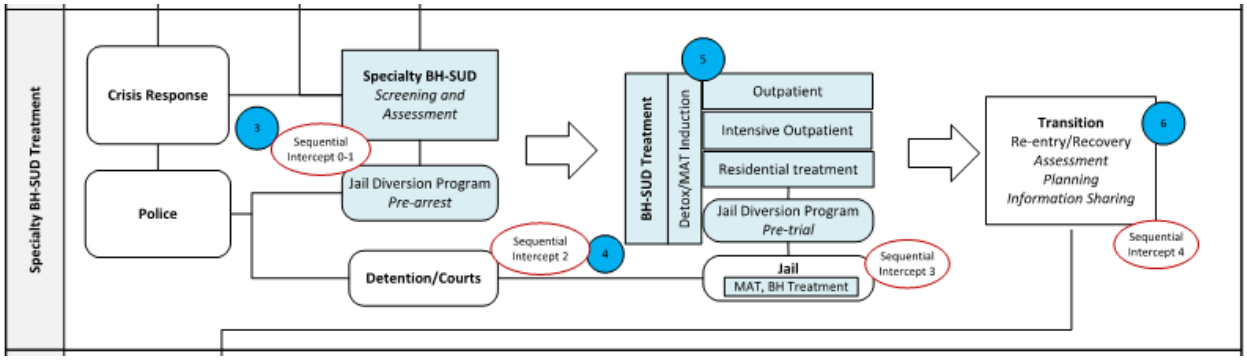
Follow up is needed to further address historically misaligned payment strategies create barriers to adoption, including evaluation of the impact of Colorado Medicaid payment for behavioral health in primary care (i.e., "6 visits"). Colorado Medicaid implemented payment for a limited number of

behavioral health services in primary care (6 visits) but it is unclear the extent to which providers have been able to operationalize them. Many providers are experiencing acute financial strain due to the effects of the pandemic and facing threats to continued operation. At the same time, state budget cuts due to the pandemic are leading to cuts in funding for mental health and SUD treatment. It is unclear how these cuts will be made and potentially impact primary care providers.

An important opportunity exists to use telehealth to expand primary care access to behavioral health interventions. Telehealth is proven to be effective for providing both physical and behavioral health care and providers can benefit from assistance to adopt telehealth strategies.[xlv] In response to the pandemic, federal and state policy now provide greater flexibility and payment for using telehealth. As part of telehealth primary care visits, providers can conduct screening and provide numerous types of interventions for stress, depression, and anxiety.

*See **Attachment C** for a summary of findings: early intervention best practices, gaps and opportunities.*

Specialty Behavioral Health and Substance Use Disorder Treatment



The continuum of what is referred to as "specialty" mental health and SUD treatment represents multi-faceted types of modalities and settings. This system flow diagram illustrates critical interconnections and touchpoints between health care, community services and the justice system Sequential Intercepts. It highlights how various entry points and pathways need to be available for individuals with differing risk profiles, histories, and needs to receive appropriate and timely levels of treatment and supports. One can discern the cross-cutting importance of screening and assessment, data collection and sharing, and how links to community supports and system navigation will play a role to foster recovery among high risk populations.

3 **Crisis Response: Strong evidence points to the value of community team-based crisis response that engages clinical professionals and law enforcement in effective de-escalation, redirection to appropriate treatment and reduction in avoidable costs of emergency room visits and justice involvement. This is especially effective working with individuals with frequent emergency service utilization.**

Core Capacity for Community-based Crisis Response

As represented by Sequential Intercepts 0 and 1 on the above system flow diagram, community crisis response teams (CRT) are recognized as a best practice in achieving harm reduction, public safety, and reduced human and system costs from avoidable emergency and inpatient admissions and justice system involvement. As an alternative to a strict law enforcement response, providing specialized training for law enforcement enables them to recognize individuals manifesting a mental health and/or substance use crisis, participate in what may be life-saving decisions, and divert individuals from the justice system to treatment.

Required CRT skills include the ability to recognize symptoms and distinguish types and levels of mental illness and substance use disorders, effectively apply de-escalation techniques that are key to effective crisis resolution, and conduct rapid, field-based screening regarding levels of treatment needed, level of urgency, criminality, and decisions and plans for next steps. Data plays a critical part in effective CRT services. At the point of crisis intervention, crisis response teams benefit from having access to background information about the individual in crisis to target the most effective crisis response and referrals. Communication and referral pathways and processes between CRTs and mental health and SUD providers are essential to facilitate clients getting to timely treatment. Follow up data is critical to monitor individual client outcomes and analyze the value of CRT, and how well the system is functioning to provide clients with follow up treatment and services.

Current Activities and Assets

Multiple jurisdictions within the county sponsor crisis response interventions. The Behavioral Health Connect (BHCON) crisis co-responder unit was established by the EPC Sheriff's Office in July 2018 and based on its success, has expanded to multiple units. Each response team consists of a deputy trained in crisis intervention and a UCHealth behavioral health clinician. Additional staff include a dedicated sergeant and a case manager. BHCON teams respond to 911 calls and agency referrals, including primarily welfare checks and suicide related calls, as well as disturbance, criminal trespass, domestic violence, and suspicious incidents. Teams have successfully provided treatment in place, referred clients to treatment and/or case management, transported clients to the AspenPointe walk-in clinic, and placed individuals on mental health holds to protect their safety. Statistics demonstrate success in reducing police involvement, diverting calls from the emergency room, and decreasing arrests. In addition to managing crisis response activities, BHCON staff provide mental health training for officers serving on patrol, in the jail, and on the crisis response team.

An additional CRT program is managed under the auspices of the City of Colorado Springs Fire Department, Community and Public Health Division in collaboration with AspenPointe. This program responds to behavioral health crisis calls from 911 and the state crisis line and engages patients with extensive and complicated diagnoses, who have significant barriers to care, and who may pose risks to themselves. Based on demand, an additional unit will be launched in October 2020 to make a total of four. AspenPointe behavioral health center offers an adult-only crisis stabilization center with 16 beds in addition to their walk-in clinic.

How and where individuals are referred from a crisis intervention depends upon assessment and available resources. Information is collected about relevant behavioral health history and treatment as well as current symptoms. BHCON uses a several page assessment form developed by UCHealth; the City's CRT uses a different 20 point assessment. Efforts at placement include AspenPointe as a first

choice for assessment and treatment, and CCHA, the county's Medicaid RAE, for case management. Peak Vista community health center will take referrals of juveniles, but taking adults is more problematic. The CRT is able to directly admit to area facilities, including the Lighthouse Acute Treatment Unit, Peak View Behavioral Health, and Cedar Springs Hospital.

Pain Points and Opportunities

Opportunities exist to build upon current CRT programs to expand geographic access to crisis services, address delays in treatment availability, and improve data that supports the programs. Informants points to several priorities for additional resources, partnerships, and specialized training for law enforcement.

Improving data collection, data sharing and data analytics are important priorities to further strengthen countywide crisis response. Inconsistent data collection and information sharing make it difficult to fully consider client history at the point of crisis.

- Information is not available from the jail regarding client demographics and history of mental health and SUD treatment during incarceration, due to lack of data sharing agreements between agencies and technical data sharing capacity.
- Different assessment forms are used to capture data across BHCON and the CRT
- Limited to no bi-directional information exchange occurs between crisis teams and providers which would enable analysis of longer-range outcomes from crisis interventions linked to referrals and follow up.

Several crisis teams and programs are operating in the county. Much can be learned by analysis of cross program data to understand crisis patterns, evaluate program effectiveness particularly relative to different types of populations e.g., by age, types of disorders, etc. , and develop solutions for how engagement, referrals and treatment availability for these populations can be strengthened. According to informants, current issues include:

- After receiving a referral for follow up treatment, individuals can experience delays of a month or longer gaining access to care.
- Geography poses challenges to effective crisis intervention in outlying areas where current teams cannot travel. For clients seeking follow up after crisis, in areas of the county like the far east there is no reliable transportation to providers.
- Certain schools face challenges in managing students with significant behavioral health issues. This leads to chronic crisis situations when BHCON is repeatedly called in by school personnel in response to the same individual's threats.
- The unhoused population is often difficult to engage and get to the Springs Rescue Mission. If the crisis team cannot take them on a hold, individuals often will not go voluntarily.

Currently, BHCON sheriff's office staff are responsible for specialized training of law enforcement officers. Informants point to opportunities to expand and enhance this training with additional resources. This is particularly relevant given the increasing pressure on law enforcement.

4

Justice System Diversion: Alignment with the justice system is a vital component for addressing the county's behavioral health needs in the most cost-effective manner. As part of the

county's justice system, both pre-arrest and pre-trial diversion programs can benefit individuals and the county by ensuring that individuals with acute and chronic mental illness and SUD avoid undo involvement in the justice system in lieu of treatment and recovery supports.

Core Capacity for Justice System Alignment

In conjunction with crisis response efforts, diversion programs have the potential to generate benefits to individuals and the county as a whole by 1) reducing the number of people coming into the criminal justice system due to behavioral health issues (pre-arrest diversion) and 2) better identifying people with behavioral health issues once they are in the justice system and moving them to community based settings to get treatment needed to stabilize and recover functionality (post-arrest diversion). Models exist for both of these types of programs in counties across the county. Program design requires data analysis to identify target populations, then development of program criteria, resource requirements, accountabilities, and operational planning. Diversion programs involve partnerships between community and jail law enforcement, behavioral health providers, and the courts, as well as community stakeholders such as county commissioners and mental health advocates. Importantly, provisions must be made for ongoing data collection and analysis to determine diversion program outcomes and understand implications for relevant funding, workforce, and policy provisions.

Current Activities and Assets

As part of an analysis of jail health services in the criminal detention center, the EPC Sheriff's Office recognized that a high percentage of inmates demonstrated both mental health and SUD issues contributing to arrest and incarceration. Once in the jail, this population received minimal behavioral health supports and risked decompensation of their mental conditions. In 2017, stakeholders convened by the Community and Public Health Division of the Colorado Springs Fire Department designed a post arrest diversion program, BASIC[5], that would identify individuals with serious mental illness booked into the jail and move them out of the jail into community-based treatment. Despite strong stakeholder buy in and readiness to implement the program, BASIC did not receive funding. However, in the view of informants, BASIC remains a viable program that can be implemented with appropriate funding.

Most recently, under the auspices of the CJCC, a group of multi-agency/multi-disciplinary stakeholders are investigating the robust pre and post arrest behavioral health diversion programs developed by Miami Dade County in Florida. Initial results from this groundwork are generating enthusiasm for how these models could be replicated in EPC.

Pain Points and Opportunities

It is not yet clear how the economic impact of the current pandemic will affect current EPC community and jail-based operations, and the willingness and ability to add new programs. Recently passed law (HB20-1017) states that the Office of Behavioral Health may contract with cities and counties for the creation, maintenance or expansion of criminal justice diversion programs, with the goal of connecting law enforcement and behavioral health providers. In addition, HB 20-1393 added funding for additional mental health pilot programs that divert individuals with low-level offenses into community treatment; El Paso does not currently house one of the existing four pilot programs so may be eligible for a grant. Diversion programs in other counties have demonstrated positive impact. To implement diversion programs like BASIC or a behavioral health crisis diversion center in EPC will require an effort to analyze

[5] Behavioral Accountability through Structured Individual Case Monitoring (BASIC)

the projected savings that can be generated from reduced incarceration and justice system costs, and whether these savings can be used to cover mental health and SUD treatment. At issue is that treatment costs are covered by the state, and the costs of incarceration, including jail health services are paid for by the county. An analysis is needed to understand how costs are braided, where savings and costs will accrue, if and how resources can be redirected and/or obtained from external sources to implement the diversion programs. An example of how other counties have justified and funded the development of crisis diversion centers is provided in Section 3 of this report.

Steps are needed to map criteria related to mental health and SUD diagnoses and develop the processes and procedures needed to operationalize the diversion programs, including screening and assessment impacts on decision making by the District Attorney and problem solving courts, treatment availability, and how implementation will be accomplished.

*See **Attachment E** for a summary of Sequential Intercept best practices, gaps and opportunities.*

5 **Specialty Behavioral Health Treatment Access and Availability: The treatment continuum must support timely access at multiple entry points, recognizing that mental health and substance use treatment must be more integrated, and individuals must be able to move across levels of treatment. Strengthening the behavioral health treatment continuum requires taking a population health – system of care approach to understand population-specific health risks and needs (e.g., age, diagnoses, levels of risk, youth vs adults, individuals with co-occurring conditions, pregnant women), map coordinated pathways to treatment and services, and address gaps in the treatment continuum.**

Core Capacity for Specialty Behavioral Health Treatment

Specialty behavioral health is a continuum of treatment settings and modalities for individuals with mental health disorders, SUD, and co-occurring conditions. The scope of treatment for high risk populations is largely provided by publicly funded providers that strive to serve local needs in the context of long-standing behavioral health system structures and funding flows, dictated by federal and state policy and budgetary resources.

Treatment for mental health conditions and SUD has historically been provided through separate providers and systems of care, making it difficult for individuals with co-occurring mental health and SUD issues to receive a comprehensive, integrated approach to treatment. Community mental health centers are a primary source of outpatient treatment for populations with serious mental illness and in some cases SUD. A recognized continuum of levels of treatment includes outpatient, intensive outpatient, residential treatment in psychiatric treatment facilities, and transitional treatment such as partial hospitalization and supported housing. *The American Society of Addiction Medicine (ASAM)* promulgates a national set of criteria for providing outcome-oriented and results-based care in the treatment of addiction. *The ASAM Criteria* are widely used to arrange for placement, continued stay, transfer, or discharge of patients with addiction and co-occurring conditions.

Jail presents a special challenge for behavioral health and SUD treatment. In Colorado as in counties across the country, jail populations grew in response to the explosion of opioid use with increasing percentages of jail populations being individuals with serious mental illness and/or SUD. Pressures grew

for jails to provide adequate treatment for behavioral health conditions and addiction, while challenging them to mobilize sufficient resources. Widespread privatization of jail health services made it difficult to add behavioral health and substance use treatment to existing vendor contracts.

To meet standards of care for individuals with mental health and SUD, jails grapple with how to administer psychotropic medications, either maintaining existing prescriptions or initiating medications based on behavioral health assessment once in the jail. Managing detox and whether and how to initiate Medication Assisted Treatment (MAT) for opioid use disorder are also significant challenges. Drug addiction is widely recognized as a neurological disease, and MAT is now widely acknowledged as a critically important treatment for opioid use disorder, as well as alcohol abuse. MAT decreases physiologic cravings, fosters physical stability, and enables individuals to benefit from behavioral health treatment. However, understanding of addiction and the promise of MAT is uneven at best across county courts and the justice system, as well as the local mental health and SUD treatment landscape. As part of federal and state campaigns against opioid use, agencies have recognized MAT as a standard of care, including three different medications, each with varying efficacy and appropriateness for specific individuals. Methadone and buprenorphine products are the treatment of choice for stabilization of opioid use disorder during pregnancy, a critical priority for preventing the high system and human costs of neonatal abstinence syndrome, continued maternal addiction and resulting social costs, including foster care and childhood trauma.

The uptake of MAT by jails is being widely advocated, including with grant funding, and was recently mandated. In July 2020, Colorado's Governor signed HB20-1017 that "requires the department of corrections, local jails, multijurisdictional jails, municipal jails, and state department of human services facilities to make available at least one opioid agonist and one opioid antagonist to a person in custody with an opioid use disorder throughout the duration of the person's incarceration or commitment". Research shows benefits from rapid initiation of MAT as early as possible during incarceration so that in the case of a short stay and/or sudden release, inmates have the benefit of MAT to counter cravings and the high risk of drug overdose and death upon return to the community. Each jail must take on the work of culture change required among custody and medical staff to accept MAT rather than abstinence as a preferred route to treat addiction. Also, each jail must figure out processes for how MAT can be administered in way that accommodates the physical layout of the jail, draws upon custody officers in the most efficient way and minimizes concerns about diversion.

Current Activities and Assets

The county's continuum of specialty behavioral health providers includes the behavioral health center, AspenPointe, that provides an extensive array of services for children, adolescences, and adults including SUD treatment. Crisis services are provided daily by two community-based teams, in multiple locations, including a walk-in crisis center. AspenPointe also offers school-based services co-located in 21 schools.

Due to resource constraints and issues with health services vendors over time, the jail has provided limited behavioral health treatment and supports. During the 2019 assessment of jail health services, the opportunity for the Sheriff's Office to partner with community based behavioral health providers gained much interest, however, this has not moved forward for various reasons. Wellpath, the vendor contracted to provide health care services in the jail as of January 2020, is currently responsible to establish policies and procedures and provide behavioral health and SUD screening, assessment, and a

limited amount of treatment to inmates. Psychotropic medications are maintained for inmates when they are booked into the jail if current prescriptions can be verified. Otherwise, medications may be prescribed based on assessment by a behavioral health provider. Also, in 2019, the promise of MAT to reduce justice involvement and prevent recidivism was acknowledged and moving forward with a more robust MAT program in the jail was identified as a priority. The jail's Reintegration and Recovery program was targeted to lead implementation efforts. Legislation and funding from the state to support MAT was expected.

The Division of Criminal Justice contracts with the vendor ComCor, to provide mental health and SUD services for individuals under the auspices of Community Corrections and as a condition of probation or parole. ComCor offers three residential treatment programs for SUD including for individuals dually diagnosed with a significant mental health diagnosis and SUD. These include group treatment, mentoring and peer support and are time limited. ComCor administers MOUs and payment using Correctional Treatment Funds for the provision of outpatient services by external providers. An additional source of outpatient treatment that is funded with monies from the Sheriff's Department is the Jail Mental Health Aftercare Program. This program provides intensive case management and services for individuals under or uninsured with the goal to reduce recidivism. The program, for individuals with mental health and SUD and not already receiving services through ComCor, includes supports for employment, transport, drug testing, rent, medication assistance, and entitlements. Limited MAT is provided but provider capacity to offer MAT is being expanded. Some clients stay long term in the program or are transferred to community providers if that is an option. ComCor is licensed through OBH to provide outpatient services, however, currently provides inpatient treatment.

Most veterans that do not need inpatient treatment go to the VA for outpatient services, or they may seek trauma specific care from AspenPointe.

Expansion of the Bloom Recovery Home, facilitated in part by DHS, is an innovative program providing integrated behavioral health and SUD interventions and supportive services for pregnant women.

Pain Points and Opportunities

Informants point to numerous challenges across the continuum of behavioral health treatment. Resource constraints have impacted the length and breadth of treatment that is available from community providers, including delays in gaining access to treatment following a referral. The state, under recent legislation (SB 20-007), is funding additional studies that will provide EPCPH and CJCC with more insight into the sufficiency of SUD services and MAT provider quantity in the state.

Adequate resources for detox. According to informants, it is "a miracle" getting anyone admitted to the very small detox program that exists. Standards for medical clearance make it difficult to qualify for one of the limited beds and often necessitate going to the ER. In addition, there is limited step-down and recovery management services after detox stays.

Adequate SUD treatment services. Informants also noted gaps in residential and inpatient SUD treatment providers in the region. This is exacerbated by the lack of permanent supportive housing, high quality sober living, and specialized housing.[xlvi] In January 2021, the Department of Healthcare Policy and Financing plans to add inpatient and residential components, including withdrawal management, to the continuum of outpatient SUD services currently available under Medicaid.[xlvii]

Integrated treatment for populations with co-occurring conditions. A high number of high-risk populations have co-occurring conditions whose needs are not met by siloed mental health and SUD treatment. Based on funding, high risk populations must often compete for availability for the treatment and experience delays and suboptimum care that compromises recovery. Because they often present with medication complications or difficult behaviors, placement in a treatment facility is difficult. There are also placement barriers with the homeless population, who often face co-occurring conditions.

Population specific integrated treatment options. Expanding integrated treatment and residential program support for pregnant women via the Bloom program, is a proactive and cost-effective priority with downstream impact on infants, children and decreasing adverse childhood experiences (ACEs). In the face of cuts to expected funding, options for how to otherwise fund and expand the program must be explored. Recently passed Senate Bill 20-007 requires the Colorado Department of Human Services to commission findings and recommendations concerning gaps in family-centered substance use and to identify alternative payment structures for funding childcare and children's services alongside substance use disorder treatment of a child's parent. This may be an opportunity to identify funding structures for an initiative similar to the Bloom program. CJCC explored the feasibility of establishing a Family Resource Center. Initial results were inconclusive, but perhaps warrant being revisited.

Support for MAT and implementation in the jail. Informants point to barriers preventing greater use of MAT in the jail and community. One is historic bias toward abstinence rather than use of any drug to assist with recovery from addiction. Additionally, efforts to ramp up availability of MAT induction in the jail face continued delays. The provision of opioid treatment in jails is now mandated by law in Colorado, with the passage of HB20-1017, along with a requirement that jails provide continuity of care for those being treated with SUD and released from the facility, including post-release resources and Medicaid reenrollment information. The jail's compliance with this law is a significant opportunity for harm reduction, fostering resilience, promoting recovery, and reducing recidivism for inmates with OUD released into the community.

Adequate numbers of providers and workforce. Study informants point to gaps in treatment capacity in the county. Other behavioral health studies have pointed to workforce challenges. Determining the adequacy of the county's provider network via statistics on need and use is difficult and would require more extensive efforts to collect data directly from providers and to conduct system mapping in order to understand capacity challenges and opportunities. This data collection was beyond the limits of this study but is recommended as a priority moving forward. The county may be able to take advantage of SUD network studies recently required by legislation as noted above.

Use of telehealth. Especially during the pandemic, expanding the use of telehealth can be explored as a way to increase outpatient follow up, offer peer support, conduct groups, etc. However, effort is needed to understand which providers have or can add capacity, and what issues must be dealt with to connect clients such as those that may be unhoused or lack digital communication.

*See **Attachment F** for a summary of specialty behavioral health care: best practices, gaps and opportunities.*

6

Support for Community Re-entry*:* Transitions from higher levels of care into the community are periods of heightened risk for relapse and death due to overdose and/or suicide. Adequate planning for continuity of treatment and supports for inmates post release is critically important and cost-effective, which should include robust provisions for harm reduction and warm handoffs.

Core Capacity for Transitional Planning and Re-Entry

Much attention has been paid to the importance of transitional planning for continuity of care to foster recovery and prevent relapse and death. Individuals leaving jails face particular challenges remaining engaged with treatment post release. These include lack of employment and income, transportation, and housing, and difficulties navigating connections to multiple providers and services. Inmates receiving MAT, either continued or initiated while in jail, must be able to access medications without disruption and engage with supportive treatment in order to sustain recovery in the face of social challenges they face as they return to the community. Provisions for harm reduction are essential i.e., ensuring that every inmate is provided with Narcan, given the extremely high risk of overdose and death for the period immediately post release from incarceration. Recently passed law (HB20-1065) further supports harm reduction efforts, by requiring insurer coverage of hospital-administered opiate antagonists and allowing for expansion of locally operated clean syringe programs.

Medicaid enrollment is another critical component of re-entry planning. For individuals with mental health and/or co-occurring conditions involved in the justice system, re-entry plans must consider how case management will be coordinated to ensure effective treatment follow up as well as justice system compliance, and to avoid potentially duplicative case management requirements and processes.

Transitional planning is now an integral component of corrections programs in many counties across the country, where proactive planning prior to discharge occurs through "in reach" by Medicaid and community-based providers. Elements of these transitional programs also include provisions for "warm handoffs" upon discharge. Examples include peer support i.e., someone meeting an inmate upon discharge and providing transportation and a handoff to a provider, transitional housing programs, and transitional residential treatment programs.

Designing effective transitional efforts requires analyzing data about the jail population, examining policy and practices impacting the timing of release, mapping patterns of release for different inmate populations, and making arrangements with community-based organizations and providers.

Current Activities and Assets

In 2019, the EPC Sheriff's Office (EPSO) commissioned an analysis of options to improve its correctional health services. At that time, limited re-entry programming was in place: if it worked out based on the timing of release, an inmate could meet with a representative from DHS to activate Medicaid enrollment. [6] A promising Reintegration and Recovery (R&R) program was in place for a small subset of inmates battling SUD, made possible with Colorado's Jail-Based Behavioral Health Services funding from the Office of Behavioral Health. As a component of the study, the EPSO met with community partners,

[6] Like many states, Colorado's Medicaid program implemented a policy change to enable Medicaid enrollment of incarcerated individuals to be suspended rather than discontinued, eliminating administrative barriers to access for health care upon release.

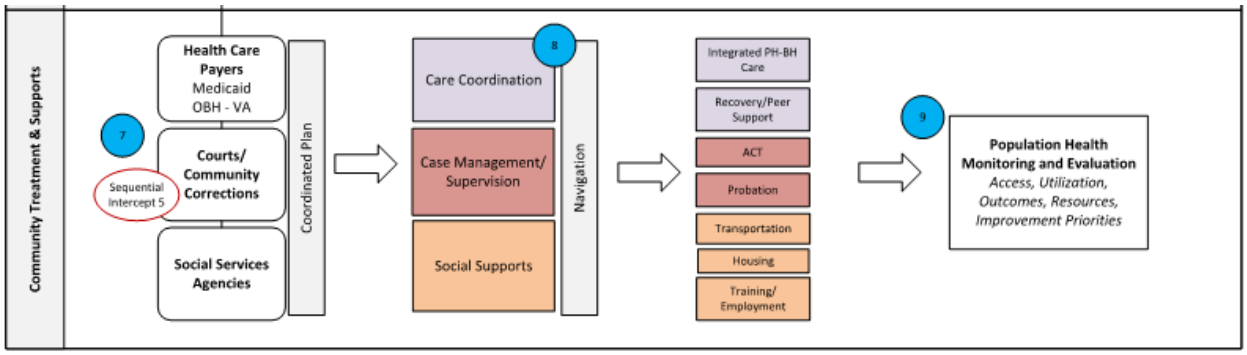
including EPCPH, and recognized that taking a collaborative approach with community partners to strengthen re-entry programming was an important priority. Subsequently, a new vendor was engaged to provide jail health services beginning January 2020. Plans were underway to use additional state funding to expand the jail's R&R program and support inmates to begin MAT during incarceration.

Pain Points and Opportunities

Efforts to strengthen re-entry and the jail's transitions program have been impacted by the timing of bringing on a new health services vendor, and the effects of the pandemic. Efforts to launch a collaborative governance approach called for in the earlier EPSO study that would guide a robust community planning process for re-entry, have not moved forward. Current re-entry provisions that have been instituted call for inmates being released to be enrolled in Medicaid, and to have prescriptions available to them for pick up within a limited timeframe from one designated pharmacy.

Proactively ensuring connections to providers for mental health and SUD treatment, peer supports, and other social supports like housing and transportation immediately post release are vitally important, especially during the pandemic. Although state budget cuts may impact treatment in the jail, the need to strengthen re-entry and transitional programming is all the more important. An opportunity still exists to engage community partners as part of an overarching behavioral health system mapping exercise to provide input and work with the jail to design the best possible options to support inmates in their transitions to the community.

Community Based Treatment and Recovery Support



7 **Alignment of Services across Agencies*:* Purposeful steps to break down silos and reconfigure administration and service delivery based on population specific needs will reduce costs and barriers to recovery caused by administrative complexity and service fragmentation.**

Core Capacity for Cross-Agency Alignment

While living in the community, high risk populations with complex mental health and/or substance use issues, and particularly inmates post release, need an organized array of specific health care and other supports - a "system of care" - to optimize behavioral health recovery and avoid repeated crisis and criminal involvement. Effective plans for re-entry and community-based recovery require purposeful

collaboration across payers, courts, and agencies to streamline and coordinate participation requirements, processes, and services provided.

Populations vary in the services and supports they need depending upon their risk profile – factors that include age, type and level of mental illness and/or addiction, and degree of self-sufficiency. Multiple agencies target services to high risk populations e.g., Medicaid RAEs, mental health and SUD providers, human services organizations, and the courts. However, administrative complexity, and system fragmentation create significant barriers to receiving services.

Coordinating streamlined "systems of care" required by different populations require a purposeful effort to map and operationalize how access to types of treatment and wraparound supports, care coordination and/or case management will be streamlined across multiple providers, organizations and agencies. This is foundational for population health management and to achieve system efficiencies. As Sequential Intercept 5 notes, the courts and community corrections programs can benefit from streamlining and enhancing provisions for sentencing, probation, and community supervision. Opportunities exist to take advantage of MAT treatment, community services and other case management resources outside of the justice system to meet requirements for community supervision, and align parameters for how individuals will manage access to MAT and other recovery and community living supports that will meet court requirements.

Current Activities and Assets

Multiple agencies and community partners participate in the HCC, and the CJCC, demonstrating a level of commitment to collaboratively identify solutions to address the county's behavioral health issues. The City of Colorado Springs through its Fire Department Community and Public Health Division (CPH) is an example of agency innovation and collaboration. As described in the next section about Navigation, CPH created a Community Assistance, Referral and Education Services (CARES) program that fosters stakeholder collaboration to improve system navigation.

During 2019 as part of the Sheriff's Office health services study, robust dialogue took place between public health, health care, key staff from the jail and Sheriff's Office regarding the benefits of a community-based approach to integrated care and population health management with the jail's correctional health care as part of the continuum. A plan to put this approach into operation through a collaborative governance structure involving community providers, public health, and the jail was stalled due to several factors.

More recently, the CJCC participated in the Stepping Up Initiative, and completed a self-assessment of key elements of the EPC justice system, answering several questions about EPC compared to "best practice" system elements outlined by the national Stepping Up Initiative.

Pain Points and Opportunities

System mapping is necessary to understand how high-risk populations interact with the system and encounter points of intersection with various agencies and sponsored services. Medicaid, Human Services, Medicaid and CCHA, and the VA need to participate in order to appropriately consider needs, care management options, and agency interactions pertaining to veterans/military, homeless, foster care, transition age youth, mothers with SUD, and other corrections-involved populations. It is vitally important to foster greater and more consistent understanding of MAT across agencies to fully consider how access to MAT will be supported in cross-agency efforts.

CJCC's Stepping Up Assessment points to the need for more global information sharing among agencies to assist those in the criminal justice system, particularly data sharing between the justice system and behavioral health agencies. Wrap around services for high risk populations are needed to prevent recidivism. However, definitions, screening practices and data collection need to be better standardized to facilitate coordination, tracking and analysis of service utilization, barriers, and outcomes. A mapping process was conducted in years past but did not produce actions beyond establishment of the crisis response program.

System Navigation: **Navigation support provides distinct value by increasing timely access to and engagement in services and strengthening community-based recovery. Deployment of system resources can be more targeted and efficient. Timely supports prevent decompensation, leading to reduced demand on crisis and emergency services, and helps avoid potential justice system involvement.**

Core Capacity for Navigation Support

High risk populations with complex health need services from multiple agencies and programs to optimize recovery. This requires navigating complex cross-agency administrative requirements in addition to social challenges, such as lack of reliable transportation and housing, to access services. Lack of consistent supports can lead to decompensation, resulting in otherwise avoidable crisis and emergency services. Communities are recognizing the need for community wide resources that help to organize and facilitate access to an integrated set of services required by high risk populations, such as unhoused individuals with serious mental illness (SMI), and individuals living with SMI and addiction. Approaches include innovative use of emergency medical services and other public safety resources to support individuals in need of non-emergency services.

Current Activities and Assets

The Colorado Springs Fire Department Community and Public Health Division (CPH) acted in 2012 to establish a Community Assistance, Referral and Education Services (CARES) program. Under the CARES umbrella, the program developed an array of navigation supports for different residents, including older adults, individuals experiencing homelessness, and individuals with complex needs and frequent utilization of services, and also sponsors Crisis Response Teams (CRT). A technology platform, Julota, supports data exchange in support of CARES programs. CARES assists frequent users of the 911 and emergency departments. Referred patients are offered the opportunity to voluntarily participate and receive assistance to find resources and address barriers to healthcare access; this intervention can last for up to 12 months. The CARES team consists of intake providers, medical navigators, and behavioral health clinicians. The navigation teams are designed to provide integrated intensive interventions to members who consent to treatment. CARES is supported by community partners and blended funding streams including contributions from tax revenues, and nonprofit and for-profit organizations.

The CARES Homeless Outreach Program (HOP) was launched as a pilot in August 2019 and transitioned to a full program in 2020. It provides intensive outreach to high needs individuals unhoused in the downtown area that demonstrate high acuity behaviors and frequently access emergency and other services. HOP staff work to build rapport, identify needs, coordinate medical and behavioral health services, assess and coordinate housing resources. As an example of the type of cross -agency

coordination that is so necessary to streamline and strengthen system navigation, the HOP program represents an active collaboration between the Colorado Springs Police Department Homeless Outreach team, Downtown Area Response Team, the City of Colorado Springs Homelessness Prevention and Response Coordinator Homeward Pikes Peak, The Place and Coordinated Entry through Pikes Peak Community Health Partnership.

Pain Points and Opportunities

CARES serves as a valuable umbrella for programmatic efforts to overcome system fragmentation, bringing together multiple streams of services within the City of Colorado Springs where an unhoused, high need population is concentrated. At issue is sustaining and expanding program capacity and data sharing supported by the navigation platform to serve additional high-risk individuals within and outside the city's jurisdiction. The effects of the pandemic are expected to destabilize housing that may lead to additional homelessness. Individuals released from the jail, already a high-risk population, face challenges securing resources within the community. Many outside the boundaries of the city that interact with crisis response teams, would benefit from navigation support.

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Population Health Management: The design of the behavioral health system is fragmented and duplicative and allows high risk populations to fall through the cracks. By aligning agencies and providers around population health management, expanding data availability, and strengthening operational capacity to use data, the county will be better equipped to identify high-risk populations, connect them to needed care pathways, prioritize resources

Core Capacity for Population Health Management

Data aggregation and population stratification are key elements of a population health model. Data aggregation is required to collect information from different data sources and partners to understand and monitor the health of the population. To do this, common definitions are required to ensure partners are collecting data that can be compared and analyzed. This includes common definitions of mental health, substance use disorder and social determinants of health like homelessness and transportation.

Data can then be used to identify high-risk populations, such as those with co-occurring mental illness and SUD, stratify them by health risks and need, and develop a pathway for care that addresses their needs and avoids unnecessary use of high-cost services such as ED or inpatient settings. This stratification occurs at key levels in the system:

- By CCHA for Medicaid population health management
- EPCPH for monitoring against population health metrics (e.g. the Thriving Colorado dashboard)
- Crisis programs for referrals and follow-up
- Providers for population-specific outcomes and identifying effective treatment pathways
- Stakeholders for system performance and quality improvement

Performance reporting is a critical component to ensure accountability in improving the behavioral health system. Common metrics must be identified that are linked to behavioral health improvement goals and are actionable in terms of understanding what interventions are needed to meet the goal.

Current Activities and Assets

Individually among agencies, some steps are being taken to better exchange and aggregate data for reporting and evaluation. An example is the Department of Human Services implementing its *HS Connects* workflow management system which connects regions to locate an individual's history with Human Services, demographics, vital records, and more.

EPCPH is partnering with the Colorado Springs CARES program to explore navigation platform *Julota* which can interface with the EMS system and assist in navigation of 9-1-1 patients to appropriate care.

CORHIO is an ongoing resource for county providers and entities that need to fill information gaps about patient health care history from hospitals, labs, and other entities.

The County has pursued data sharing agreements such as MOUs to facilitate the movement of data between entities. For example, CJCC is working to advance adoption of a data sharing agreement, using a template adopted by Arapahoe County, that would allow for better data communication between justice system parties.

Pain Points and Opportunities

Past studies about behavioral health in the county and most informants to this study identify that having more and better data is an urgent priority. This includes robust data sharing to support individualized treatment and coordinate supports, as well as to measure and evaluate programs and health outcomes.

As part of the CJCC justice system Stepping Up assessment, the lack of data was acknowledged as a major system deficit. In particular, little data is shared from the jail about inmate health histories and treatment and services during incarceration. Lack of data about inmate diagnoses and treatment creates barriers for community partners seeking to ensure continuity of care, and for system partners to understand the interrelated impact of jail and community prevention and treatment efforts. Behavioral health and substance use providers treating individuals referred from crisis, or the courts, report difficulty tracking patients after discharge to evaluate program effectiveness based on longer range outcomes, including relapse and justice system recidivism.

A systems view of data needs, assets and gaps is needed to break down current data silos. Such a systemwide data plan would address the need for:

- Common definitions and metrics linked to common goals
- Requirements for complete data collection and data sharing to meet the common goals and track progress, including needed data sharing agreements
- Additional data systems or integration needed to support gaps in data for certain high-risk populations

Attempts to strengthen the county's data system must include establishing data sharing agreements based on understanding key data sharing needs across entities.

Section 3 Strategic Priorities

Observations

Analysis of the EPC behavioral health system points to many strengths upon which to build in addressing opportunities for a stronger, more effective system for behavioral health.

As a manifestation of its core roles in the realm of community-based prevention, EPCPH joined a collaborative approach toward surveillance – monitoring and measuring progress on population health priorities – represented by participation in Thriving Colorado dashboard. A clear outline of priorities for health promotion efforts was included in the EPCPH strategic plan, especially targeting youth and schools, with notable efforts to address education and awareness. EPCPH played a role in these activities helping to facilitate content and partnerships cultivated through the HCC. However, it is not clear how much effort has been made to address what informants describe as a persistent culture of stigma against mental health that keeps adults from seeking help for behavioral health concerns. However, opportunities exist to expand current community-specific initiatives via the HCC and CJCC and for EPCPH to play a strong, formal leadership role. Recent workforce additions to staff in the agency Program/planning Office may make this possible.

Beyond surveillance and health promotion, opportunities exist to build on current approaches and models in play. The City of Colorado Springs, collaborating with EPCPH and others as part of CARES actively collaborated to develop and operate a community navigation resource, and is continuing to lead efforts to develop a robust community navigation platform (Julota). EPCPH actively collaborates with the EPSO, providing input to an assessment of jail health services, and plan to strengthen correctional health care, MAT, community re-entry and system governance. Additionally, EPCPH is represented on the CJCC and its behavioral health committee, seeking to align efforts toward broad system improvement.

The CJCC itself is a valuable resource that is facilitating engagement and advancing numerous initiatives to reduce justice system involvement and strengthen behavioral health supports for justice involved populations. The Council brings together critical parties that can influence the lives of those involved in criminal justice in the Pikes Peak Region including representatives from the Police Department, Sheriff's Department, the District Attorney and Public Defender Offices, county commissioners, behavioral health providers, and community-based organizations. The CJCC also maintains several committees focused on aspects of the system including pretrial services, strategic planning, behavioral health, financial resources, transition to workforce and legislative affairs. The CJCC has initiated several important initiatives, based on their 2019-2021 Action Plan[7], including holding a Behavioral Health/Criminal Justice Summit, taking actions to support data sharing, and exploring opportunities for diversion and co-located behavioral health supports.

At the same time, efforts to address gaps across other aspects of the behavioral health system have not been as targeted or robust. Needs exist across the continuum of early intervention and specialty behavioral health, where the interests of EPCPH and CJCC converge.

Critical considerations lead to several cross-cutting priorities for action.

- ❑ Current siloes contribute to duplication, fragmentation, missed opportunities across the continuum
    - Lack of system design, processes, workflows, information sharing
    - Duplicative, inefficient services

[7] https://assets-communityservices.elpasoco.com/wp-content/uploads/Community-Outreach-Division/CJCC/CJCC-Action-Plan-2019-2021.pdf

- ❑ "System alignment" is a key goal and task, to blueprint behavioral health related policy, definitions, standards, and models of care across health and criminal justice systems
- ❑ Organizing for population health management is the answer to alignment. Population specific pathways and approaches must guide the organization and provision of needed services to ensure that they are coordinated and accessible in practical ways.
- ❑ A data plan is critical. It must address:
    - consistent collection of structured data
    - ability to track individuals in the system
    - agreed upon information sharing protocols and provisions e.g. HIPAA
    - data needed to evaluate overall system ROI
- ❑ Given alarming trends in poor mental health and SUD, addressing stigma as a barrier to treatment is a vitally important prevention priority.
- ❑ Efforts to foster broader understanding of addiction and the value of MAT are vitally important to provide individuals with BH/addiction every opportunity to stabilize and recover. MAT is a proven and recognized treatment for opioid disorder; not providing it is considered to be substandard care.
- ❑ Leadership and defined and measured accountabilities for making progress toward improved outcomes are essential. The county's behavioral health system "infrastructure" must include provisions for collaborative governance structure and processes. Currently, the HCC is informal, data reporting is lacking, and progress is uneven.
- ❑ Roles and resources must be examined, along with necessary investments needed to improve the behavioral health system. These include the level of investment in the public health agency, as well as productive options for how public health and CJCC will collaborate, along with other stakeholders to prioritize, plan, invest, lead, monitor, and continue to innovate.

Strategic Priorities

This analysis points to several impactful strategies that stakeholders can pursue to leverage the county's assets and address specific gaps in the county's behavioral health system. The strategies listed in the table below vary in level of effort and timing and in where and how they will impact the behavioral health system and its outcomes. Certain of these strategies, like the recommended data initiative, are multi-faceted and longer term, involving diverse stakeholders. However, in this effort and others listed in the table, there are incremental steps that can begin immediately.

Each of the following options warrant consideration to address priorities for the county's behavioral health system. In the discussion that follows the summary table, examples are provided of where these various strategies have been implemented, as evidence to illustrate the feasibility and potential value of these efforts to the county.

Figure 7. Strategic Priorities to Strengthen the EPC Behavioral Health System

Strategic Priority	Components	Considerations
Cross-Cutting System Infrastructure – to support collaboration, accountability, integration across silos and systems of care, population health management, monitoring/evaluation		
1. Adopt Collective Impact Model and "backbone" entity	▪ Backbone entity staff ▪ Participation plan and commitments (Steering Committee, work groups) ▪ Charter and governance provisions ▪ Financing	Discussion is needed to consider best option to serve as the backbone entity with appropriate dedicated resources, staff. HCC/ CJCC members and staff can be leveraged for participation.
2. Conduct system mapping	▪ Facilitation ▪ Agreed upon methodology and structured processes ▪ Dedicated staff time	A critical and foundational activity to update past mapping based on current realities and find and address areas to streamline. Justice system sequential intercept mapping is a component.
3. Develop and implement integrated data plan	▪ Defined data elements to be collected across continuum ▪ Information sharing provisions ▪ System metrics ▪ Analytics/reporting	EPCPH and CJCC have data expertise. Lead for work plan/work group facilitation must be identified. Work involves: convene partners, identify priorities, develop aspects of overall plan, align capacity expansion efforts by individual agencies
4. Standardize screening and assessment data collection/ tools	▪ Consistent set of data elements ▪ Aligns risk assessment/supports for treatment across the continuum ▪ Data for pop. health management, system evaluation	Requires convening key informants (jail, courts, health care) to examine current tools and practices, identify core data/tools, plan for how to implement.
Prevention		
5. Expand school & community-based training	▪ Planning ▪ Resources (subject matter experts) ▪ BH/SUD curriculum ▪ Buy in from school districts, community stakeholders	Requires expanding scope of activity, targeting high risk schools and communities. Can continue to leverage the train the trainer approach, building on successful HCC partnerships.
6. Social marketing to address stigma among adults	▪ Champions ▪ Message development ▪ Marketing strategy in conjunction with community partners	Requires a strong partnership approach, with resources contributed by key stakeholders willing to serve as champions
Early Intervention		
7. Integrated care expansion	▪ Champions in the community	Requires a strong partnership approach with advocacy from and

Strategic Priority	Components	Considerations
	▪ Survey/assessment of current practices ▪ Payment/financing strategies ▪ Technical assistance re: integration practices	collaboration with providers, provider organizations and payers
Specialty Behavioral Health / Substance Use Disorder Treatment		
8. Crisis system enhancement	▪ Expand data sharing / links to navigation ▪ Identify options to better reach rural residents	The county's crisis system is a best practice but can be enhanced to better address the needs of rural residents and high-utilizers.
9. Telehealth expansion	▪ Technical capacity ▪ Provider workflows ▪ Workforce training/skills	Timely opportunity to take advantage of new flexible policies and funding. Steps involve taking stock of current provider telehealth capacity, targeting sites to expand/train
10. Expand/ enhance training for law enforcement	▪ Curriculum ▪ Trainers ▪ Planning: logistics for office participation; competency evaluation strategy ▪ Related policy changes as appropriate	Very significant for all law enforcement (CSPD, EPSO) given current environment. Opportunity to build on and enhance current training.
11. BH/SUD residential treatment options	• Conduct system mapping / provider capacity survey • Identify gaps and develop case for funding • Target provider gaps and develop treatment models, financing options • Cross-agency/provider plan for implementation	SUD treatment are major gaps, but also options for co-occurring treatment. Expanding the treatment network needs to take into account new legislation, system mapping, and provider input to identify policy/administrative gaps that are driving treatment delays or overutilization of higher levels of care.
12. Detox expansion	▪ Identify expanded bed capacity ▪ Staffing plan	Detox is a cost-effective alternative to emergency department treatment and current capacity is insufficient.
13. Programming for high risk pregnant women	▪ Residential housing ▪ Integrated BH/SUD/PH treatment ▪ Parenting supports	Recent agency budget cuts currently prevent anticipated expansion of the DHS initiative Project Bloom. Other options to address this population should be explored in light of new legislation/#11 above.

Strategic Priority	Components	Considerations
14. Jail Diversion	▪ Targeted population/ eligibility criteria ▪ Arrangements with providers ▪ Policies and procedures ▪ Operational processes	Pre-trial diversion program (BASIC) needs funding, could be a pilot using new CO funds. Miami-Dade County approach being explored for additional programs
15. Expand use of MAT including induction in jail	▪ Jail health vendor policies/procedures for assessment, induction, administration ▪ Data sharing w/community providers	MAT in the jail has been mandated in recent CO legislation. MAT plays a critical role to stabilize individuals with addiction, reduce harm of overdose, and promote BH recovery. Rapid benefit can be achieved from induction soon after incarceration and ensuring continuity of care immediately post release.
16. Re-entry Post incarceration	▪ Jail policies and procedures for in-jail prior to and at release ▪ Arrangements with community partners, Medicaid, agencies for in-reach, planning, warm handoffs	Provisions for continuity of care post release are required per recent CO legislation. Re-entry provisions are critically important for harm reduction and to optimize community recovery. Planning for each inmate needs to begin at booking to ensure that connections to support services, medications and community providers are accessible without delay.
Community-Based Treatment and Recovery Support		
17. Community Navigation	▪ Plan for ongoing staff and operation of technical platform, ▪ Alignment with system mapping ▪ Partnership arrangements for data sharing, referrals	Use of the current technical platform can be expanded to additional community partners, in conjunction with system mapping efforts.
18. Community Supports	▪ Facilitate cross-agency dialogue, planning to enhance services such as housing, transportation, and case management/ supervision.	Addressing social determinants of health will help lessen the cycle of emergency room and jail churn and help stabilize high-risk community members.

Priority 1: "Backbone" - Governance for Sustained Planning, Progress, Accountability

To combat the siloed, fragmented nature of the current behavioral health prevention and treatment system in the county, entities will need to come together to share a common vision for change and take responsibility in implementation and measuring success.

EPC should consider a Collective Impact Model[xlviii] that will foster trust and accountability across sectors, backed with diversified funding, to execute community-wide strategies to address population mental health and SUD needs over the long term. EPCPH has initiated collective work through the Healthy Community Collaborative (HCC) but could benefit from a formal Collective Impact Framework to establish stronger governance and shared accountability for work moving forward.

Empowering a Backbone Entity to Provide Structure and Processes

As noted in earlier sections, a strong governance structure is required to execute a population health management model for the county. Successful Collective Impact initiatives have five essential components: a common agenda, a backbone organization, mutually reinforcing activities, shared measurement, and continuous communication.[xlix]

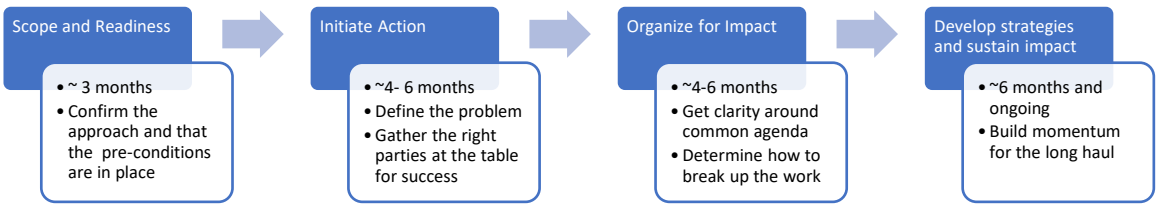
The backbone entity, which should be appointed by the collective community, would guide the initiative's vision and strategy, promote mutually reinforcing activities, support establishment and tracking of shared measures, build public will, advance policy, and mobilize resources. As implementation begins, workgroups will be formed that best support implementation of the goals and prioritized activities.

The backbone entity requires dedicated staff, including a project manager, data manager and facilitator, to support the initiative. EPCPH would likely have a role to play in establishing a community-wide vision for behavioral health, compiling data from partners and reporting trends to support population health management, and tracking progress in addressing behavioral health needs.

The first step in the process will be an assessment of readiness for implementation of the model:

- Are there influential champions in the community who will highlight these issues and lead collaborative work forward?
- Are there turf issues or issues of inequity among the community participants that need to be addressed before change can be made?
- Are there sufficient resources in place to support the planning process and infrastructure for at least one year and over the longer term? This includes funding and time up-front to support the process of convening, mapping out key players, and building shared measurement systems.
- Is there urgency to address behavioral health issues in the county in new and different ways and invest time and resources in a process for developing infrastructure?

If these conditions are not met, they will ideally be developed before major system change can move forward. The following is a generalized timeline of activities to illustrate the commitment required:



Source - Collective Impact Forum

The Collective Impact Forum provides a Backbone Starter Guide that includes detail on the ideal setup of a backbone entity and the resources required to establish a Collective Impact. The guide states initial backbone operations budgets typically range from $400,000 to $600,000 in the first few years.

Best Practice: Douglas County Collective Impact Framework

The Douglas County Mental Health Initiative (DCMHI) is a partnership of over 40 organizations committed to finding solutions to provide effective, coordinated mental health and substance use healthcare service for Douglas County.[l] DCMHI is currently using a Collective Impact Framework as a governance model and Douglas County Administration serves as the backbone entity. Goals include creating a networked system of care, rebranding mental health and SUD, developing programs and interventions to address current gaps, working on policy and systems improvements, and developing the workforce. While the county is still in the process of finalizing the structure of the collective impact model, it is a good local case for EPCPH to follow.

Best Practice: Larimer County Community Master Plan for Behavioral Health

Larimer County, Colorado passed a sales tax initiative in the 2018 general election that includes funding for development of a behavioral health crisis diversion facility. The effort began in 1999, with 20 behavioral health providers and organizations who formed the Mental Health and Substance Use Alliance. This group encompasses 53 people representing 35 agencies. The group produced an initial analysis that paved the way for educating the community about the need for funding to address gaps in the behavioral health continuum. The community then pursued a 5-year community strategic planning process to identify top priority needed services. The plan includes a three-pronged approach: expand and enrich local BH services across the county; facilitate connections between community-based services and services/providers in a centralized facility to provide a stronger care coordination system; and building transition bridges across providers and services.[li]

Best Practice: Connecticut Health Enhancement Communities

Health Enhancement Communities, a strategy of the Connecticut State Innovation Model, are community hubs designed to work collaboratively across sectors to improve the social, economic, and physical conditions affecting the health and well-being of community members.[lii] Initially, the HECs are focusing on (1) improving child well-being pre-birth to age 8 years and (2) improving healthy weight and physical fitness for all residents. Each HEC has a governance structure, a backbone organization, and partners who implement interventions. Each HEC identifies process and outcome measures for each of their interventions, using validated measures where they exist. They develop and release periodic, easy-to-understand updates about HEC progress and performance throughout their network and communities, including at community meetings where they can get additional design and implementation feedback.[liii] Preliminary analysis shows that HECs in conjunction with primary care reforms have the potential to reduce state Medicare spending by 2.4 percent over the 10-year demonstration period 2021-2030.[liv]

Funding Collective Impact Strategies

The Collective Impact Model is a method to collaboratively identify creative ways of blending funds to support behavioral health system improvements. As noted earlier, no single funding source will be

sufficient to fund the strategies identified by EPCPH and its partners. Any solution will require blending Federal, state, local and private dollars. Examples of creative funding strategies and sources include:

- State BH-focused grants and contracts: Several bills were passed in the most recent legislative session that create funding opportunities for EPC to address opioid and other SUD in the region. Opportunities range from CARES funds for COVID-19 (HB20-1411), to leveraging grant writers to obtain state and local funds for addressing SUD (SB20-007), to funding for pilot mental health diversion pilot programs (HB20-1393), to developing SUD recovery support services (SB20-028).
- Social impact bonds: partnerships between private funders, non-profits, and government agencies where upfront private dollars are used to fund proven interventions that have a long-term return on investment.
- Blended grant opportunities: the Partnership Pilots for Disconnected Youth, for example, is a national program that allows grantees to blend discretionary funds from the Departments of Education, Housing and Urban Development, Justice, and Health and Human Services and creates flexibility for grantees to test comprehensive, outcomes-based strategies to achieve improvements in educational, employment, and other key outcomes for disconnected youth.
- Wellness trusts, or Community Health Funds: mechanisms that aggregate funds to support community-based population health or prevention activities. In one recent example, the Massachusetts Department of Public Health administered the Prevention and Wellness Trust Fund from 2012-2016, funded by a one-time $60 million assessment on insurance and hospital revenue. The fund provided grants to nine community-based prevention initiatives focused on pediatric asthma, hypertension, tobacco use, and elder falls.
- Diverse billing: Larimer County's Behavioral Health Services Center, referenced above, is initially funded through a voter-approved tax initiative. However, the health center provider must leverage funding from multiple payers to cover services, including Medicaid, private insurers, block grants and local resources.

Priority 2: System Map to Address Fragmentation

EPC should complete a system map to clarify how individuals with mental health and substance use conditions can access and move through the system. County stakeholders will not have to start from scratch – maps have been completed in the past for portions of the system such as the criminal justice system populations and the CRT response. However, this updated comprehensive system map would identify current resources' capacity and knowledge (e.g. fire department, police department, schools, corrections, crisis, RAE) as well as gaps and redundancies in services. The map would identify current referral resources and patterns and target where and how MOUs and processes for referrals and follow-up between primary care and BH/CMHCs can be strengthened. Mapping should also address how high-risk populations move through the system and where there are gaps in assistance. Once the map is complete, partners will have a much clearer sense of interventions that are needed to fill gaps across the community and reduce duplication. The mapping effort should include a process for keeping services accurate and up to date.

In addition, sequential intercept mapping is a key element of the Stepping Up Initiative to which the county has committed. A comprehensive sequential intercept map identifies gaps, resources, and opportunities at each intercept point in the criminal justice system. HMA has used this intercept framework to identify opportunities for the CJCC.

Best Practice: Douglas County

To meet its goal of creating a networked system of care, the Douglas County Mental Health Initiative identified the following mapping activities:[lv]

- Assess and map current resources for individuals with mental health and substance use conditions and other social determinants of health needs in the community
- Map current and future state mental health/primary care referral processes and develop referral protocols

Best Practice: Santa Clara Public Health Department

The Santa Clara County (California) Community Health Improvement Plan for 2015-2020 focuses on behavioral health as a priority. One of the strategies to meet its goal of increasing utilization of behavioral health services was to assess and map current referral sources' capacity and knowledge.[lvi]

Best Practice: Chester County, PA Sequential Intercept Mapping

Chester County convened a key leadership group to address priority issues in their system, including challenging emergency department cases and a developing relationship with law enforcement. The leadership group conducted a Sequent Intercept Map that resulted in recommendations across the continuum. The mapping involved collection of 911 data and crisis team and police data, as well as data from the prison, treatment courts and parole/probation. Recommendations from the latest mapping exercise pointed to the need for cross system training, public outreach, peer support expansion, and use of involuntary commitment, among others. They were able to obtain a grant for Crisis Intervention Training.[lvii]

Priority 3: Integrated Data Plan

An integrated data plan has been recommended in prior studies. This is because such a plan is foundational to any effort to improve care and demonstrate progress. Establishing interoperable data systems will enable the county to identify and stratify high risk populations to connect them to effective services and care pathways across the system. It will allow for improved handoffs across system entry points, reducing duplication of services and assessments. Importantly, data sharing will allow the county to evaluate the effectiveness of interventions and to better make the case for future funding. In the short term, this will require agreement on data elements to be collected and shared. Data elements that will help monitor health care disparities and social determinants of health should be included.[lviii] Part of this includes aligning definitions of mental health, behavioral health, SUD, social determinants, recidivism, and more across county entities so that data can be uniformly collected and compared. Sharing data will require completion of data sharing agreements to exchange mental health, substance use disorder, risk screenings and assessment data. An MOU is currently being drafted for sharing judicial information and the county is already pursuing data sharing initiatives such as DHS' investment in HSConnects. Longer term efforts will include building additional interfaces across systems to support data transfer outside of agency walls.

Best Practice: Weld County Inter-Agency Agreement

Weld County has developed a coordinated system agreement for its "inter-agency treatment group" that establishes open lines of communication among entities targeting individuals at high risk of being

chronically arrested or hospitalized. Such a universal agreement confirms organizational commitment to share critical information to manage an individual's care and to use a standard Consent to Release Information Form to ensure confidential information is protected.[lix]

Best Practice: Allegheny County, PA

The Allegheny County data warehouse consolidates data from human services, including behavioral health, child welfare, intellectual disability, homelessness, and aging. Some information is shared by external sources, such as school districts and public benefits. The county uses this data warehouse to develop and implement plans to divert, treat and support people with behavioral health conditions who are at risk of returning to jail.[lx]

Priority 4: Standardized Screening and Assessment Data

Encouraging community partners and providers to use standardized, valid mental health / SUD / SDOH screening tools (or to include standard elements in their own tool) will assist in the comparability of data across the county and therefore help to highlight important trends in the need for prevention and treatment. It will also strengthen referral pathways and connection to needed treatment and resources. This includes screenings across entry points - in primary care settings, health fairs, outpatient and inpatient behavioral health, schools, public health, and corrections. While agreement on a tool may need to be a part of the Collective Impact approach, EPCPH can begin to identify potential tools and required data elements that need to be collected and draft needed data sharing agreements. An element of these screening standards will be developing a common definition of behavioral health conditions, as noted above.

Best Practice: Fountain Valley Communities that Care

As a local example, in their Community Action Plan, FV-CTC identified key risk and protective factors that are linked to targeted health and behavior problems. They established baseline data in 2017, using the Healthy Kids Survey and public health data, which was used to create a profile to monitor changes in poverty indicators.[lxi]

Best Practice: Pathways HUB Approach

Pathways HUB is a population health model that activates the community response to social determinants. The model is used to identify individuals at greatest risk, and provide a comprehensive assessment of all health, social, and behavioral risk factors to identify needed evidence-based treatment pathways and measure treatment outcomes.[lxii] The hub is a community-led collective, which serves as a single point of access for healthcare partners to refer people for care and share administration functions. The model supports Community Health Workers to screen and mitigate risks. The HUB model includes:

- Standardized risk assessment
- Standardized documentation
- Standardized performance metrics
- Coordinated CBO engagement
- Standardized pay for performance

The assessments are used to assess risk, assign pathways of care, and monitor risk factors.

Priority 5: Expanded Resilience Training for School and Community

One of the HCC strategies included increasing evidence-based programming in schools such as Sources of Strength, RULER, Pyramid Plus, Parenting Classes and Restorative Justice. While some schools have implemented these programs, there are still significant gaps and disparities in access. Schools without significant grant supports and without military supports should be prioritized. While the Youth Suicide Prevention Workgroup has successfully increased the focus on suicide, there is a parallel need to address youth substance use.

Best Practice: Train the Trainer

EPC's School District 20 received a grant to fund Sources of Strength training. The school has trained trainers who now can train others, which helps with cost. Other train-the-trainer initiatives could be funded to improve sustainability of these evidence-based resilience programs. The school also uses Safe Counselors for students at risk of truancy which has demonstrated effectiveness for addressing issues with SUD. These counselors help identify at-risk kids, screen them, and connect them to resources, leveraging evidence-based programming such as Teen Intervene.[lxiii]

Best Practice: Co-Location of Youth Services

While schools are out of session or remote, it may be beneficial to co-locate mental health services in community-based organizations where children already go to recreate. As an example, Larimer County contributed funding for the Boys & Girls Club of Larimer County to hire a behavioral health specialist for their summer youth programming.[lxiv]

Priority 6: Social Marketing to Address Stigma

In addition to broader training on Mental Health First Aid and other evidence-based mental health education and training opportunities, emphasis needs to be placed on changing the public mindset about the value of treating mental health and SUD. This can be done through media campaigns as well as working with community-based organizations to educate the community around the importance of behavioral health and social emotional wellness. The goal of these campaigns is to increase public understanding of mental illness and SUD, to normalize mental health and substance use issues, improve the likelihood of high-risk populations seeking treatment, and to build public will for funding solutions. Messages should build on existing campaigns like *Let's Talk Colorado*, a media campaign funded through the State Innovation Model, that underscores the importance about talking about and seeking help for mental health concerns.[lxv]

Best Practice: NAMI In Our Own Voice Program.

EPCPH could consult with their local NAMI chapter on the most effective campaigns to reduce stigma in the community. One example is the In Our Own Voice presentation which pairs in-person interaction from a person with a mental health disorder with standard training materials. Studies have found significant increases in attitude scores from pre-test to posttest.[lxvi]

Best Practice: Care Not Cuffs Campaign

The Equitas Project is driving a **Care Not Cuffs** campaign, a national public health awareness campaign designed to bring awareness to the problem of defaulting to law enforcement and build demand for a mental health care first responder system.[lxvii] The campaign will inform the public that when they reach

out for help, there should be a health response instead of law enforcement response. In so doing, the campaign hopes to increase the demand for real, tangible change starting with the public and also targeting those with the power to improve crisis response systems and coordination among community leaders, health care providers, and legislatures.

Priority 7: Integrated Care Expansion

Lowering barriers to care for individuals to access mental health supports will be a benefit as poor mental health rates rise. As the safety net primary care hub in the county, Peak Vista and other primary care providers could expand resources to screen for and treat mild to moderate mental health and SUD for those seeking primary care services. EPCPH could engage primary care partners and identify interest in advancing integration in the county, in addition to identifying potential funding or technical assistance sources. Mapping efforts above will also identify partnerships between primary care and behavioral health entities that could benefit the population.

Best Practice: Collaborative Care Model

Collaborative Care has been identified as one of the "five inter-related opportunities to stem the tide of access issues".[lxviii] It is an evidence-based practice in primary care that can be scaled. In addition to over 90 randomized control trials (RCTs), plus many non-academic large-scale implementations, it is the only integration model that has a specific billing code and strong evidence of cost savings.[lxix]

Priority 8: Crisis System Enhancement

The county's crisis and co-responder infrastructure is a major asset. However, more can be done to ensure that all areas of the region can access crisis resources. The county can leverage telehealth and other technologies to reach a broader audience outside of Colorado Springs. In addition, it will be important to more strongly connect the crisis system into the rest of the behavioral health continuum through data sharing to better address needs of frequent users of the crisis system. Improved data collection and data sharing will also improve the ability to track outcomes of crisis interventions.

Best Practice: Grand Lake Mental Health Center

Mobile tablets are provided to hospitals and law enforcement agencies to expedite the delivery of services to individuals who are in a law enforcement encounter. These tablets quickly link first responders and law enforcement with licensed mental health professionals. GLMHC also provides mobile tablets to people with high-risk needs or significant transportation barriers to increase access to services. These efforts have led to a reduction in inpatient stays and emergency department use, resulting in cost savings.[lxx]

Priority 9: Expand Telehealth Capacity

Governor Polis recently signed a bill requiring health insurers to cover telehealth sessions that are conducted through a HIPAA-compliant platform, including for behavioral and mental health consultations and diagnoses.[lxxi] EPCPH could play a role in identifying where telehealth services should be expanded in the county and selecting tools which may best address gaps in the continuum, such as crisis services and specialty care in rural parts of the county and for high-risk populations.

Best Practice: Guidelines for State and Local Agencies

State and local territorial agencies can play a role in expanding telehealth access by:[lxxii]

- Building telehealth infrastructure
- Leveraging federally qualified health centers as hubs of a telehealth network
- Leveraging state partnerships, such as between behavioral health and SUD services to increase program capacity and increase access to resources and services that can aid in prevention and control of disease
- Reforming telehealth policy and governance structures

*See **Attachment D** for a summary of how telehealth can be leveraged in behavioral health.*

Priority 10: Expand Training for Law Enforcement

El Paso has already initiated trainings for law enforcement, including evidence-based practices such as Mental Health First Aid and Crisis Intervention Training. However, best practice states that 100 percent of officers and First Responders should be trained with the full 40 hours of training.[lxxiii] Any ability to expand this training will likely enhance access to and treatment for behavioral health needs in the community and reduce avoidable incarcerations.

Priority 11: Expand Residential Treatment Access

Stakeholders reported significant gaps in the behavioral health continuum of care in the region. Completing priorities above, including developing a formal collaborative and completing system mapping, would help clearly define priorities for developing additional services, target populations, and identifying funding opportunities for advocacy at the state and local levels.

Priority 12: Detox Service Expansion

Stakeholders consistently noted the lack of adequate detox services / facilities with a medical component. EPCPH could convene a conversation with stakeholders about how to identify a funding source for additional detox beds in the community.

Best Practice: Larimer County Behavioral Health Project

Larimer County conducted a robust year and a half public awareness campaign identifying the costs of mental illness to the county in lost earnings, absenteeism and reduced productivity and the positive return on investment from funding mental illness and addiction treatment. As a result, voters passed a quarter-cent sales tax hike and raises $15 million a year, which is going to fund a new $25 million treatment and detox facility.[lxxiv]

Priority 13: Programming for High-Risk Pregnant Women

Both stakeholders and data point to the need to identify interventions to support high-risk pregnant women, who suffer from mental health issues and SUD, to avoid poor birth outcomes and long-term health effects on mother and child. The planned Project Bloom was intended to provide up to 20 beds for pregnant women, which would help fill a temporary housing gap, however funding was not available, and more beds are needed to meet the demand. Best practices point to quick identification of at-risk mothers-to-be and robust wraparound services to support addiction treatment and parenting skills.

Best Practice: San Antonio Mommies Program[lxxv]

In 2014, Bexar County accounted for 36% of the reported NAS cases in Texas. The Mommies Program was originally developed in 2007 with a $2.5 million SAMHSA grant but was continued by community partners in 2013 after the program demonstrated success. Any pregnant woman with a diagnosed SUD being treated at the local mental health authority (CHCS) is eligible for the program. University Health System staff provide education classes so the participating women are familiar with the hospital staff they may encounter at the time of delivery. Methadone is also provided free of charge and conveniently located at CHCS. Transportation to and from the center is provided by a van that was purchased with initial grant funds and women who are able to take public transportation are provided bus passes. At one point in the program, an outreach specialist and case manager were included to provide targeted outreach and wraparound service coordination, but these positions had to be cut due to budget constraints. Participants do have access to a patient navigator to serve as an advocate as for the mother as she navigates other services or referral agencies. Specialized evidence-based services are provided to participants in need, such as the Trauma Recovery and Empowerment Model (TREM). Participation has resulted in a 33% reduction in NICU length of stay due to Neonatal Abstinence Syndrome. Annual costs range from $175,000 to $400,000 with funding coming from the University Health System, Medicaid reimbursement, and the Texas Department of State Health Services.

Best Practice: Staten Island Project LAUNCH[lxxvi]

Staten Island saw a 165 percent increase in the number of babies born with neonatal abstinence syndrome over the past decade. In response, the Richmond University Medicaid Center will implement Project LAUNCH with funding from a five-year SAMHSA grant. According to SAMHSA, Project LAUNCH (Linking Actions for Unmet Needs in Children's Health) is intended to promote the wellness of young children ages birth to 8 years of age by addressing the physical, social, emotional, cognitive, and behavioral aspects of their development. The long-term goal of Project LAUNCH is to ensure that children enter school ready to learn and able to succeed.

In addition to initiatives to support the children, the project will also increase public awareness of the risks of untreated maternal and infant health and mental health conditions and improve connections to care for high risk mothers and infants. This includes screening pregnant women for opioid/addiction, buprenorphine induction, and providing specialized wraparound supports to support infant and maternal health.

Priority 14: Crisis Diversion

EPC has the opportunity to better coordinate and deliver targeted, effective treatment to individuals in crisis to avoid justice system involvement and incarceration. One consideration is to develop a crisis diversion facility, which co-locates and coordinates healthcare, law enforcement and first responders in a central facility. While this is an emerging best practice, EPC can build on existing diversion programming, such as specialized law enforcement training and specialty courts (Recovery, Veteran Trauma, DV and DUI Courts). The county can also identify funding to support the BASIC pre-trial program, which would connect individuals to treatment who cannot afford bond but have behavioral health needs.

Best Practice: Crisis Diversion Facility

A crisis diversion facility is a physical hub for a community's crisis continuum of care. Services include a crisis line, walk-in crisis services, mobile crisis teams, and crisis stabilization units. In one of the most cited examples, the Restoration Center in San Antonio, Bexar County, Texas, was built with investment and involvement from county, city, state, and private entities including community hospitals and a local private hospital foundation. In its first eight years (2008-2015) close to $97 million have been documented as cost avoidance for City and County jails, emergency rooms and court rooms. Arnold Ventures published a community guide on the development of a crisis diversion facility, including case studies from Pima County, AZ, Pennington County, SD, and Knox County, TN in addition to Bexar County.[lxxvii]

Best Practice: Mentoring Program

Another program in Bexar County is a partnership between Big Brothers and Big Sisters of South Texas and the Bexar County Juvenile Probation Program. The focus is providing mentoring services to youth screened as being low risk to public safety but who have experienced adverse childhood events and are exhibiting delinquent behavior. The goal is to prevent youth who have experienced adverse childhood events from entering the juvenile justice system and preventing recidivism among those who are already engaged in the system. The program was grant-funded by the Department of Justice Office of Juvenile Justice and Delinquency Prevention.[lxxviii]

Best Practice: Criminal Mental Health Projects

Miami-Dade County implemented the Eleventh Judicial Circuit Criminal Mental Health Project (CMHP) ten years ago to divert those with serious mental illness or co-occurring illness to community-based treatment and support services. The program operates two components: pre-booking diversion consisting of Crisis Intervention Team (CIT) training for law enforcement officers and post-booking diversion serving individuals booked into the jail and awaiting adjudication.[lxxix] The county is investing $42 million on a "one-stop shop" for pre- and post-trial detainees that offers psychiatric, primary care, dental, and ophthalmic treatment, tattoo removal, job training, and trauma services, as well as a courtroom.[lxxx]

Priority 15: Medication Assisted Treatment to Address Corrections Service Gap

Medication Assisted Treatment (MAT) is a standard of care for opioid use disorder and a significant gap that is likely contributing to fatal and non-fatal overdoses both inside and outside the jail. Quickly ramping up both jail-based MAT and expanding community-based MAT access will improve public health and the county will save money from fewer days of incarceration due to recidivism as one metric.[lxxxi]

Best Practice: County Touchpoints Project – MAT Training

HMA has developed a set of materials for group or individual training about the use of Medication Assisted Treatment (MAT) for Opioid Use Disorder in justice and human service systems. Resources are available here: https://addictionfreeca.org/California-MAT-Expansion-Project/County-Touchpoints-in-Access-to-MAT-for-Justice-Involved-Populations/Training-Site

Priority 16: Reentry Programming

There are opportunities to formalize reentry programs for inmates coming out of the EPC Jail and state prison to ensure continuation of medication and to address social determinants of health that may improve stability and reduce recidivism. The Reintegration & Recovery program in the jail has a robust reentry program but is limited to inmates enrolled in that program.

Best Practice: Transitions Clinic Program

The Transitions Clinic Program started in San Francisco, provides a patient-centered medical home for chronically ill returning prisoners. The program leverages community health workers with a history of incarceration as part of an integrated medical team and has shown results in lower ED utilization.[lxxxii]

Best Practice: Aurora Second Chance Center

The Second Chance Center provides employment, mentorship, social services, addiction counseling, and more for individuals on parole or under intensive supervision.[lxxxiii]

Priority 17: Community Navigation

EPC has already begun the groundwork to bring parties together to support navigation of individuals engaged in the criminal justice system, supported with the Julota platform. It is important that these efforts are sustained to ensure clients are connected to appropriate services and supports to avoid returning to the jail or emergency room. Staff from EPCPH have been identified to facilitate the navigation effort. Additional planning is required to establish current and future requirements for Julota, to ensure requirements are aligned with the system map, and to develop necessary arrangements and agreements for data sharing and referrals.

Priority 18: Community Supports

To address social determinants of health that are driving behavioral health crisis demand and limiting access to regular treatment, county agencies need to coordinate on a plan to enhance services. Particular gaps identified across informants included affordable housing and transportation. Supervision and case management for those involved in the Problem Solving Court system is also a gap. One solution to explore is co-located transitional housing, legal support services and case management. CJCC has started to explore a Family Resource Center with peer supports.

Best Practice: Lane County FUSE

Frequent User System Engagement (FUSE) combines systems collaboration with stable housing and support services to achieve better outcomes, reduced inefficiencies and increased cost savings. Lane County and its community partners use data to identify the highest users of the hospital, jail, police, and other crisis services, all of whom are homeless. Navigators work directly with FUSE participants to provide services such as street outreach and rental assistance, assistance and payment for required identification, assistance with housing searches, advocacy with property managers and others, and referral to appropriate supports. The results of a small pilot revealed a decrease in average health care costs, fewer emergency room visits and hospitalizations, and a decrease in average arrests.[lxxxiv]

Section 4 Recommendations for Next Steps

This report is intended to serve as a resource for EPC leadership and stakeholders as they seek to confront levels of poor mental health and SUD across the county. HMA was asked to shine a light on a path forward toward feasible solutions and tangible impact by pulling together input from recent studies conducted in the county, as well as validating issues and priority concerns from the point of view of key informants. The findings that are compiled serve to update and provide a focus on issues that are not new to the county, except for the current COVID-19 pandemic and its profound and evolving impact on behavioral health and the economy.

By looking at the continuum of the entire behavioral health system, encompassing the full gamut of mental health and addiction prevention, treatment, and community recovery, clear and urgent priorities emerge. In response, options for behavioral health system improvement are available for EPCPH and the CJCC stakeholders to consider, along with examples of how they have been implemented in counties in Colorado and across the country. However, a range of additional steps are needed to pursue these options moving forward. These include gathering more detail through system process mapping, identifying how resources can be deployed, and developing implementation plans.

In such a stressed and constrained pandemic environment, mobilizing the energy and resources to pursue innovations may seem impractical, even impossible. However, the county is fortunate to have valuable assets within public health, health care, corrections, as well as philanthropy, upon which to build.

Most of all, EPC stakeholders face the challenge to work together differently in order to achieve meaningful progress - to truly break down silos, mobilize available resources across the system to the best advantage, and maintain accountability for making progress toward improved behavioral health across the county.

Using the Report

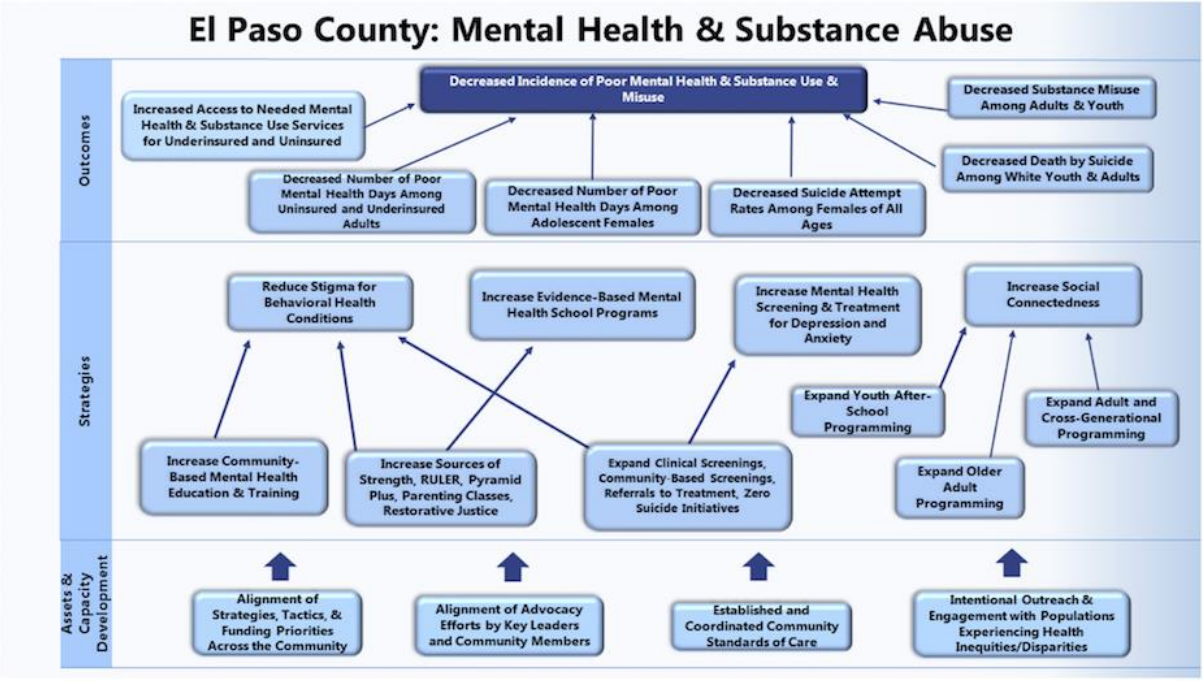
As the obvious first step in using the results of this study, both EPCPH and CJCC need to dedicate time to formulate questions, clarify understanding of the options presented, then consider the implications for stakeholders that would be involved in addressing the solutions.

Also critical is a plan for ongoing communication regarding how each entity views its next steps.

- To begin, feedback in response to the report findings from public health and CJCC stakeholders should be shared.
- A discussion needs to take place to plan how the collective impact model can be embraced, including the identity of and resources to support a backbone entity.
- An entity and person assigned to facilitate should be identified to provide interim leadership, serving to convene and guide initial discussions and maintain momentum in collaboratively responding to this study.
- As a first step towards embracing a collective impact model in the county, workgroups can be formed to begin work to examine the scope of what needs to be addressed and organize a work plan. A data workgroup is one example where initial steps include developing a blueprint of current data collection, interoperability, reporting etc.

- As quickly as possible, an initiative should be undertaken to conduct system mapping, including the justice system Sequential Intercepts. In the context of the current public health crisis and its cascading impact on behavioral health and the behavioral health system, mapping will be the most productive way to locate points of cross-cutting fragmentation, duplication and inefficiencies in the system, and target cost-effective interventions that can expand and strengthen behavioral health services. Identifying specific points of action will be useful in developing financial plans and expectations for return on investment.

Attachment A: EPCPH Strategy Map



Attachment B: Analysis – Opportunities targeting Community-Based Prevention

Analysis: Public Health Framework – Primary Prevention

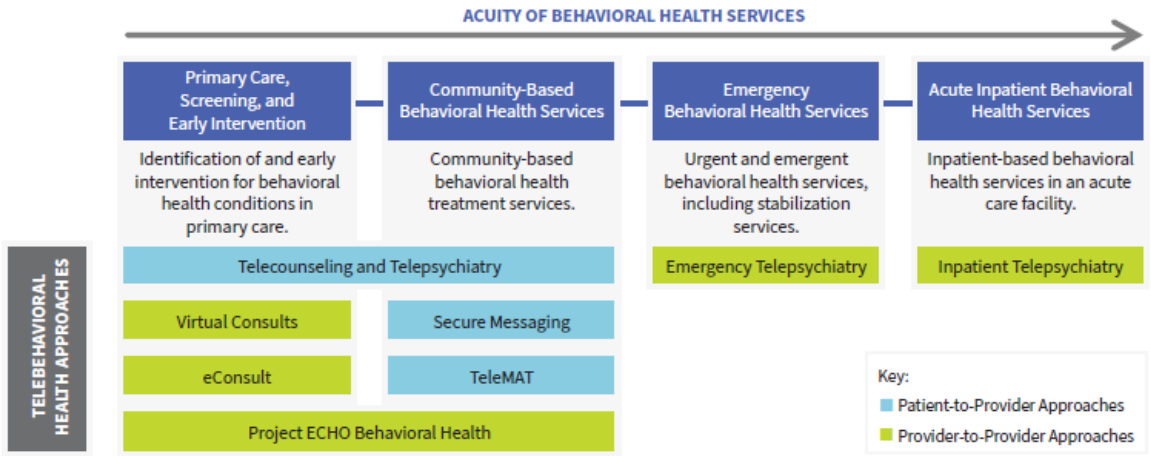
Best practice	EPCPH Strategic Plan/CHIP	Gaps/Opportunities
Systematically use data to identify, target and monitor MH/SUD trends and at-risk populations	☐ Un/underinsured (increase access to mental health and SU services) ☐ Un/underinsured adults (decrease # poor mental health days) ☐ White adults and youth (decrease death by suicide) ☐ Adults and youth (decrease substance misuse) ☐ Adolescent females (decrease # of poor mental health days) ☐ Females of all ages (decrease suicide attempt rates)	☐ Develop integrated dataset including standardized data elements to support identification and monitoring of high-risk populations across agencies, systems ☐ Engage, develop consensus among relevant data sources and data users for data collection and data sharing including jail, courts/justice system, DHS, ECPH, health care ☐ Examine and identify options to enhance and expand public reporting
Provide early supports to foster resilience	☐ Increase social connectedness o Expand adult/older adult/cross-population programming ☐ Increase evidence based mental health school programs o Increase Sources of Strength, RULER, PyramidPlus o Expand youth after school programming ☐ Expand parenting classes ☐ Expand restorative justice programming	☐ Prioritize interventions for high risk pregnant women with both mental health and SU, to foster more effective parenting and early childhood/family development. ☐ Continue and expand collaborative efforts across all county school districts to enable implementation/sustainability of programming designed to help youth recognize and address ACES, depression, anxiety, and substance use, foster well-being, decrease stigma associated with help-seeking ☐ Leverage partnerships (e.g., NAMI) to address priority areas of the county with high risks and lack of resources. ☐ Address supportive housing and affordable living solutions ☐ Homeless children and those living in poverty need early intervention and support.
Training for early identification of risks	☐ Increase community based mental health education and training	☐ Expand train the trainer programming targeting key stakeholders – Target efforts across all school districts, different subregions in the county. – Develop data driven educational materials and approaches to make concerns locally relevant – Strategically involve community level "influencers" e.g., faith, business leaders – Continue and expand focus on ACEs, youth and Mental Health First Aid ☐ Engage with major primary care providers/health systems to educate regarding MH/SUD risks, neuroscience of addiction and approaches to pain management
Foster public awareness to reduce stigma, increase support for seeking BH and SUD treatment including MAT, and foster health equity	☐ Increase community based mental health education and training	☐ Identify champions across the region ☐ Develop social marketing strategies designed to impact cultural acceptance and understanding about BH and SUD as chronic diseases, including the neuroscience of addiction and MAT as effective treatment o Replicate current efforts that have been most effective across the county and region ☐ Facilitate solutioning with community stakeholders to address homelessness and heightened risks for BH/SUD

Attachment C: Analysis – Opportunities targeting Early Intervention in Primary Care

Analysis: Public Health Framework – Secondary Prevention

Best practice	EPCPH Strategic Plan/CHIP	Gaps/Opportunities
Remove barriers/facilitate access for treatment of mild to moderate and emerging BH/SUD risks	☐ Increased access to needed mental health and SU services for under and uninsured ☐ Increase mental health screening and treatment for depression and anxiety	☐ Engage with provider/payer/and community leaders/stakeholders to assess implications of gaps in insurance coverage for high risk populations and identify potential approaches to mitigate impacts. (Coloradoans between the ages of 19 and 29 that have had the highest uninsured rate of any age group). ☐ Identify what telehealth solutions can be deployed where to address locations in the county/region where high risk populations lack access to primary care and BH
Population health management approaches across agencies, payers, and providers use data to identify high risk patient populations and coordinate appropriate care	☐ Intentional outreach and engagement with populations experiencing health inequities/disparities	☐ Engage stakeholders in a structured effort to identify data needs, and steps necessary to address current fragmentation and mobilize data for effective population health management. ○ HCPF, DHS, OBH, CHHA, public health, CHHA/RAE, etc. ☐ Identify options for innovative resources and approaches (e.g., telehealth, CARES, CORHIO/Ute Pass H.O.M.E. Program) that can be leveraged to target gaps in primary care (e.g., rural, justice system involved) ☐ Engage HCPF, CHHA/RAE, BH/SUD/primary care providers and EPSO to develop county/regionwide blueprint for re-entry for inmates post release that connects them with primary care/pharmacy/BH-SUD treatment
Identification and referrals for early intervention are streamlined and made from multiple points across systems	☐ Expand clinical screenings, community-based screenings, referrals to treatment and zero suicide initiatives. ☐ Decrease substance misuse among adults and youth	☐ Address current system fragmentation and administrative complexity by mapping out points aka "intercepts" where potential referrals for MH/SUD treatment should be initiated across early childhood, youth to adolescent development, and adulthood. ☐ Take steps to develop and disseminate screening and referral protocols/ communications appropriate for different populations and system "intercepts."
Widespread use of BH/SUD screening tools and approaches (including across community and justice system settings) that enable measurement based care (MBC)	☐ Expand clinical screenings, community-based screenings, referrals to treatment and zero suicide initiatives.	☐ Promote widespread use of appropriate MH/SUD screening, tools and approaches i.e., using standardized and validated instruments appropriate for children, youth, adults ☐ Address current gaps in screening including for older adults and in rural areas ☐ Incorporate enhanced BH assessment, collecting consistent data elements, as part of risk--based pretrial release programs
Primary care practices across the county/region are meaningfully "integrated" conducting screening and MBC/treat to target for mild to moderate BH and SU (SBIRT).	☐ Increase mental health screening and treatment for depression and anxiety	☐ Engage health integrated care is still in infancy (need to validate); minimal co-location, full integration at FQs ☐ Engage with major primary care providers/health systems to develop and deploy initiatives targeting education and training about assessment and management of pain, BH and SU
Primary care providers effectively practice "stepped care" including having productive arrangements for specialty consultation, treatment referrals and coordination.	☐ Increase mental health screening and treatment for depression and anxiety	☐ Work with provider associations, major health systems and provider groups to map current referral resources and patterns and target where and how MOUs and processes for referrals and follow up between primary care and BH/CMHCs can be strengthened. ☐ Engage with HCPF and CHHA/RAE regarding ways in which KPI's relevant to integrated care can be strengthened

Attachment D: Behavioral Health Services via Telehealth



APPROACH	DESCRIPTION
Telecounseling and Telepsychiatry	Patient connects to a behavioral health provider via phone or video to receive routine counseling or therapy.
TeleMAT	Patient connects via phone, video, and/or secure message to a behavioral health provider to receive Medication Assisted Treatment (MAT).
Secure Messaging	Patient uses a secure messaging platform to communicate with their provider about a behavioral health issue, request a prescription refill, or ask the provider a question.
Virtual Consult	A non-behavioral health provider uses phone or video to connect to a behavioral health provider to discuss a patient case and receive treatment and/or referral guidance. Video is sometimes used to visually assess the patient.
eConsult	A non-behavioral health provider sends a structured and formatted message to a behavioral health provider to ask a question or receive treatment advice for a patient.
Project ECHO Behavioral Health	"Hub-and-spoke" telementoring model that provides community-based providers ("spokes") with access to specialists at a "hub" via phone and video to conduct virtual case reviews with and discuss treatment recommendations.
Emergency Telepsychiatry	Emergency medicine provider in an emergency department uses phone or video to consult with a remote psychiatrist who assesses the patient and makes treatment plan recommendations to the emergency medicine provider.
Inpatient Telepsychiatry	Inpatient medicine provider in a hospital uses phone or video to consult with a remote psychiatrist who assesses the patient and makes treatment plan recommendations to the inpatient provider.

Source: Manatt Health. Expanding Access to Behavioral Health Care in Massachusetts through Telehealth: Sustaining Progress Post-Pandemic. July 2020.

Attachment E: Analysis – Opportunities targeting Sequential Intercepts

Intercept	Action Plan 2019-2021	Gap/Opportunity
Intercept 0 Community Services (Crisis/Diversion)		
Mobile crisis teams/co-responders, response centers ED diversion Police/BH collaborations	❑ Expand BH services ❑ Utilize jail diversion opportunities ❑ Explore data sharing opportunities ❑ Explore innovative CJ strategies	❑ Build on current crisis response programs to expand geographic reach of crisis response teams ❑ Address increasing school-based crisis response, training needs ❑ Address gaps in referrals/treatment availability and reduce wait times: detox, residential, pregnant women, rural ❑ Leverage telehealth ❑ Build integrated data system to strengthen coordinated crisis response, referrals, share pertinent health history, assessment, navigation to track individuals and outcomes
Intercept 1 Law Enforcement (911/Arrest)		
Dispatcher training Specialized police training Frequent utilizer interventions	❑ Utilize jail diversion opportunities	❑ Enhance training with feasible options to strengthen 1st responder awareness, strategies and skills ❑ Collaboratively develop criteria and options for population-based pre-arrest diversion programs (e.g. frequent utilizer, homeless)
Intercept 2 Initial Detention/Court Hearings		
Screening prior to 1st court appearance Data matching (jail/community providers) Pre-trial supervision and diversion services	❑ Reduce jail population through pretrial services ❑ Improve pretrial supervision and case management ❑ Explore data sharing opportunities	❑ Blueprint continuum of supervision/supports for indivs with BH/SUD across community, pretrial, detention, release ❑ Develop standardized screening and assessment to collect and share consistent data elements ❑ Address fragmentation e.g., substance testing without referrals to treatment ❑ Address silos that limit effectiveness of wraparound services ❑ Assess and plan for implications of rapid pretrial release e.g., data sharing capability ❑ Assess/pursue risk-based pre-trial programs e.g. work release, LEAD, Angel program

Intercept	Action Plan 2019-2021	Gap/Opportunity
Intercept 3 Jails/Courts		
Treatment courts for high risk/high need Jail based programming, health care services, MAT Collaboration with veteran's justice outreach specialists	❑ Reduce jail population through pretrial services ❑ Utilize jail diversion opportunities ❑ Explore innovative CJ strategies ❑ Family justice center development ❑ Expand BH services	❑ Enhance BH/SUD assessment with standardized instruments ❑ Pursue implementation of BASIC program/release detainees with serious BH/SUD issues to community treatment ❑ Pursue implementation of comprehensive jail MAT induction and maintenance program, including increasing x-waivered providers ❑ Examine and develop coordinated approach across problem solving courts for BH/SUD assessment, population/risk-based dispositions ❑ Continue to expand jail R&R program to broader jail population ❑ Develop data system/metrics to monitor and evaluate outcomes across courts/programs ❑ Collaborate with EPCPH and stakeholders to expand needed treatment capacity e.g., inpatient rehab ❑ Develop workforce plan to support specialty court dispositions to community programs/supervision
Intercept 4 Re-entry		
Transition planning by jail/in reach providers Medication/prescription access Warm handoff jail – community providers	❑ Explore innovative CJ strategies ❑ Expand BH services	❑ Bring together courts and jail to identify ways to strengthen coordination, information sharing, priorities for resource development ❑ Convene jail/vendor/community partners to address transition pathways for different populations of jail detainees and design provisions for timely in-reach, access to medications, transportation, housing and warm handoffs from jail to community. ❑ Develop provisions for sustainable comprehensive community navigation infrastructure
Intercept 5 Community Corrections (Parole/Corrections)		
Specialized community supervision/caseloads Access to MAT Access to recovery supports (benefits, housing, employment)	❑ Expand BH services ❑ Reduce employment barriers for indivs w/criminal history ❑ Research/support resources for community CJ projects	❑ Pursue additional funding for BH, drug/alcohol treatment in community corrections settings ❑ Develop co-located/one-stop source for treatment and case management ❑ Foster acceptance and diffusion of standard practices regarding MAT across community continuum of treatment and recovery support providers/settings ❑ Address lack of affordable housing and needed placements ❑ Address workforce needs to ensure adequate probation / supervision

Attachment F: Analysis - Opportunities targeting Tertiary Prevention

Analysis: Public Health Framework – Tertiary Prevention

Best practice	Strategic Plan/CHIP	EPCO - Themes
Crisis intervention and diversion programs support stabilization and linking individuals to timely, appropriate levels of treatment, avoiding justice system involvement for BH/SUD populations as much as possible	☐ Increase mental health screening and treatment for depression and anxiety ☐ Decrease suicide attempts among females ☐ Decrease death by suicide among white youth and adults	☐ Explore data sharing options to provide crisis response teams access to relevant patient info/history, past utilization at the point of care and to monitor and analyze patient outcomes. ☐ Pursue efforts to develop true diversion program modeling after successful efforts (e.g., Miami Dade County FL). Unclear about subsequent referrals, treatment and recidivism.
Continuum of treatment levels/settings (ASAM) available as needed by at risk populations (children, youth, pregnant women, adults, older adults)	☐ Increase mental health screening and treatment for depression and anxiety	☐ Take steps to structure and facilitate a collaborative effort (involving state and regional stakeholders) to address major gaps in the county's BH treatment continuum across the county/region – Detox facility – Residential treatment for pregnant women with co-occurring SUD and BH (including for those transitioning from jail) – Intensive outpatient treatment – Qualified SUD treatment providers – Timely access to BH providers in follow up to crisis referrals and for at risk individuals outside of crisis – In the justice system, pre-trial screening for BH/SUD is happening but unclear that referrals to treatment are being made.

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Analysis: Public Health Framework – Tertiary Prevention

Best practice	Strategic Plan/CHIP	EPCO - Themes
MAT accepted and integrated as a health care standard of care in the community and across justice system	☐ Decrease substance misuse among adults and youth	☐ Work with EPSO and current vendor to accelerate implementation of full MAT program in the CJC, including maintenance, buprenorphine induction, in jail BH supports as appropriate, and naloxone for all inmates upon release ☐ Provide leadership and expertise, in collaboration with CJCC, to facilitate shift in cultural understanding, acceptance of and provisions for MAT among pre-trial, problem-solving courts, CJC leadership and custody, probation staff, and justice system stakeholders.
Re-entry transitions include provisions for harm reduction and to ensure the continuity of MAT and BH treatment/ supports in the community	❑ Decrease substance misuse among adults and youth	☐ Work with EPSO and current vendor to ensure that all detainees are provided naloxone upon release ☐ Structure a collaborative initiative with SO/Wellpath, community SUD/BH providers and pharmacies to blueprint and arrange provisions to ensure access to medications, peer support and BH treatment – Take into account transportation and regions of the county – Address telehealth capacity
Population specific systems of care in place with well defined collaborative protocols across agencies, providers		☐ Develop community blueprint showing access/pathway for population health management – Gaps in case management/wraparound services across populations – Transportation is an immediate need for CJ-involved population – No evidence regarding if and what screening, treatment is available for older adults, and in rural areas.

[i] Community Catalyst, 2019 and Census, 2013-2017.
[ii] https://gazette.com/news/census-bureau-wide-gaps-in-haves-and-have-nots-among-el-paso-county-school-districts/article_7a1b0780-1df2-11ea-9e7a-c3d5d73e6b9e.html
[iii] Health Management Associates. Community Conversations to Inform Youth Suicide Prevention. 2018. https://www.healthmanagement.com/wp-content/uploads/Final-Colorado-Suicide-Report-with-Appendices_February-2019.pdf
[iv] Colorado Health Access Survey (CHAS), 2019.
[v] http://thrivingcolorado.com/partners/el-paso-county-public-health-scorecards/el-paso-county-healthy-mind-spirit/
[vi] CDPHE. VISION: Visual Information System for Identifying Opportunities and Needs. El Paso Area Profile.
[vii] CHAS, 2019.
[viii] SAMHSA. National Survey on Drug Use and Health: 2016-2018. Model-Based Substate Estimates for Colorado. July 8, 2020.
[ix] CDPHE, Center for Health & Environmental Data. "Suicides in Colorado: Counts." *Colorado Violent Death Reporting System.* https://cohealthviz.dphe.state.co.us/t/HSEBPublic/views/CoVDRS_12_1_17/Story1?:embed=y&:showAppBanner=false&:showShareOptions=true&:display_count=no&:showVizHome=no#4
[x] https://krdo.com/news/2020/06/23/el-paso-county-coroner-releases-2019-report-increases-in-suicide-and-fentanyl-deaths/
[xi] CHAS, 2019.
[xii] CHAS, 2019.
[xiii] SAMHSA, 2020.
[xiv] OBH Drug Trends Report. August 2019. https://drive.google.com/file/d/1yt2jr9W9_4B5MvxVWMoNcAf5V1znPrq3/view
[xv] https://cohealthviz.dphe.state.co.us/t/PSDVIP-MHPPUBLIC/views/DrugOverdoseDashboard/LandingPage?iframeSizedToWindow=true&:embed=y&:showAppBanner=false&:display_count=no&:showVizHome=no&:origin=viz_share_link
[xvi] https://krdo.com/news/2020/06/23/el-paso-county-coroner-releases-2019-report-increases-in-suicide-and-fentanyl-deaths/
[xvii] SAMHSA, 2020.
[xviii] CHAS, 2019. https://www.coloradohealthinstitute.org/sites/default/files/file_attachments/CHAS%20Storybook%202019%20for%20Web.pdf
[xix] Summit Economics. The Economic Impact of Department of Defense, Veterans and Military Retirees, and the Department of Veterans Affairs Activities in Colorado. 2018. https://coloradospringschamberedc.com/wp-content/uploads/2018/08/18colomilstudyabr.pdf
[xx] https://www.elpasocountyhealth.org/sites/default/files/files/WhoWeAre.pdf
[xxi] Fort Carson Department of Public Health Community Health Assessment 2019.
[xxii] https://www.mentalhealth.va.gov/docs/data-sheets/2016/Colorado_2016.pdf
[xxiii] https://krdo.com/health/coronavirus/2020/04/08/el-paso-county-jail-reduces-population-in-last-3-weeks-to-control-spread-of-coronavirus/
[xxiv] https://www.bjs.gov/content/pub/pdf/imhprpji1112_sum.pdf
[xxv] Office of Behavioral Health (2018). Initial evaluation of Colorado Jail based behavioral health services. https://drive.google.com/file/d/1TFK0LZmM_f10Uyao2QppRdoaNGu4llc5/view?pli=1
[xxvi] https://one-colorado.org/wp-content/uploads/2017/06/OneColorado_HealthSurveyResults.pdf
[xxvii] Colorado Department of Public Health and Environment (CDPHE). Health Kids Colorado Survey. Denver: CDPHE, 2015.
[xxviii] https://www.outtherecolorado.com/news/el-paso-county-homeless-population-sees-dramatic-decrease-survey-says/article_4728a97d-20d9-5837-b4b0-e88b11f289c0.html
[xxix] CDPHE Homelessness and Health https://www.colorado.gov/pacific/sites/default/files/PSD_SDOH_Homelessness_long.pdf

[xxx] Colorado Children's Campaign. Kids Count in Colorado. 2019. https://www.coloradokids.org/wp-content/uploads/2019/08/2019-KidsCount-8-22-19-Low-Res.pdf
[xxxi] https://aspe.hhs.gov/system/files/pdf/258831/SubstanceUseCWCaseloads.pdf
[xxxii] OBH 2015 Behavioral Health Equity Report. https://drive.google.com/file/d/1Hbd306oYkTGMs8R9GUseaEgKF-vsNaCv/view.
[xxxiii] Colorado Department of Public Health and Environment. (n.d.). Healthy Kids Colorado Survey Data, 2017. Retrieved May 15, 2020 from https://www.colorado.gov/pacific/cdphe/healthy-kids-colorado-survey-data
[xxxiv] CDPHE. Healthy Kids Colorado Survey 2017. HSR 4. https://drive.google.com/drive/folders/1ejQHT67grRegRcqwlARKSlvJgtvCh08I
[xxxv] Priester, M, et. al. "Treatment Access Barriers and Disparities Among Individuals with Co-occurring Mental Health and Substance Use Disorders: An Integrative Literature Review". J Subst Abuse Treat. 2016 Feb; 61: 47–59.
[xxxvi] https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/
[xxxvii] https://www.washingtonpost.com/health/2020/07/01/coronavirus-drug-overdose/
[xxxviii] https://gazette.com/news/isolation-during-pandemic-leading-to-more-severe-domestic-violence-in-el-paso-county-da-says/article_2bd7e16c-83fd-11ea-883f-9f1d4208a28a.html
[xxxix] Sequential intercepts
[xl] HMA. Community Conversations to Inform Youth Suicide Prevention. 2018.
[xli] Evidence collaborative care model
[xlii] Measurement based care
[xliii] Advanced primary care – stepped care
[xliv] https://www.colorado.gov/pacific/sites/default/files/Short-term%20Behavioral%20Health%20Services%20in%20Primary%20Care%20Fact%20Sheet%20Jan%202019.pdf
[xlv] Evidence of BH screening and brief interventions delivered via telehealth
[xlvi] SUD Regional Capacity Stakeholder Meeting. Colorado Springs. February 2020. https://www.colorado.gov/pacific/sites/default/files/SUD%20Stakeholder%20Meeting%20Summary%20Colorado%20Springs%20February%202020.pdf
[xlvii]https://www.colorado.gov/pacific/sites/default/files/Frequently%20Asked%20Questions%20SUD%20Benefit%20Expansion%20July%202020.pdf
[xlviii] https://ssir.org/articles/entry/collective_impact#
[xlix] https://www.collectiveimpactforum.org/
[l] https://www.douglas.co.us/documents/blue-print-for-a-community-based-mental-health-system-in-douglas-county-prepared-by-health-management.pdf/
[li]https://www.larimer.org/sites/default/files/uploads/2019/2018_lc_master_plan_for_behavioral_health.digital_1.pdf
[lii] https://www.chdi.org/our-work/health/health-reform/health-enhancement-communities/
[liii] https://portal.ct.gov/-/media/OHS/HEC/CT-SIM-HEC-Framework.pdf
[liv] Analysis conducted by Health Management Associates and Airam Actuarial Consulting in collaboration with OHS and DPH.
[lv] https://www.douglas.co.us/documents/blue-print-for-a-community-based-mental-health-system-in-douglas-county-prepared-by-health-management.pdf/
[lvi] https://www.sccgov.org/sites/phd/collab/chip/Documents/cha-chip/cha-chip.pdf
[lvii] https://stepuptogether.org/wp-content/uploads/2017/07/Stepping-Up-June-Webinar-Slides.pdf
[lviii]https://sirenetwork.ucsf.edu/sites/sirenetwork.ucsf.edu/files/Data%20Sharing%20and%20the%20Law_July%202020_.pdf
[lix] https://www.joinbuiltforzero.org/wp-content/uploads/2020/03/NoCo-Coordinated-Agency-System-Agreement.pdf
[lx] https://www.naco.org/resources/allegheny-county-pa-integrating-justice-and-human-services-data
[lxi] https://www.elpasocountyhealth.org/sites/default/files/Fountain%20Valley_CAP_2.0_final.pdf
[lxii] https://innovations.ahrq.gov/sites/default/files/Guides/CommunityHubManual.pdf
[lxiii] https://www.hazeldenbettyford.org/addiction/intervention/teen-intervene
[lxiv] https://www.reporterherald.com/2020/05/05/larimer-county-gives-115545-to-9-behavioral-health-programs/

[lxv]https://www.denvergov.org/content/dam/denvergov/Portals/771/documents/CH/Road_to_Wellness_Framework.pdf
[lxvi] Acosta, Joie D., Amariah Becker, Jennifer L. Cerully, Michael P. Fisher, Laurie T. Martin, Raffaele Vardavas, Mary Ellen Slaughter, and Terry L. Schell, Mental Health Stigma in the Military. Santa Monica, CA: RAND Corporation, 2014. https://www.rand.org/pubs/research_reports/RR426.html.
[lxvii] https://www.equitasproject.org/2020-strategic-vision/
[lxviii] https://aims.uw.edu/path-forward-case-collaborative-care-during-covid-19
[lxix] https://higherlogicdownload.s3.amazonaws.com/NAHPC/3d988744-80e1-414b-8881-aa2c98621788/UploadedImages/The_Path_Forward_Case_for_Collaborative_Care_During_COVID-19_FINAL_6_17.pdf
[lxx] https://store.samhsa.gov/sites/default/files/d7/priv/pep19-crisis-rural.pdf
[lxxi] https://leg.colorado.gov/bills/sb20-212
[lxxii] Kearly A., Oputa, J and Harper-Hardy, P. Telehealth: An Opportunity for State and Territorial Health Agencies to Improve Access to Needed Health Services. Journal of Public Health Management and Practice. January/February 2020. 26 (1): 86-90.
[lxxiii] http://www.cit.memphis.edu/information_files/CoreElements.pdf
[lxxiv] https://www.cpr.org/2018/11/19/successful-local-tax-measures-are-unlocking-opportunities-for-mental
[lxxv] https://hhs.texas.gov/sites/default/files/documents/services/mental-health-substance-use/mommies-toolkit-neonatal-abstinence-syndrome.pdf
[lxxvi] https://www.rumcsi.org/rumcinthenews/richmond-university-medical-center-awarded-4m-to-i-244
[lxxvii] https://www.healthmanagement.com/wp-content/uploads/AVCrisisFacilityGuidebook_v6.pdf
[lxxviii] https://ojjdp.ojp.gov/funding/awards/2019-ju-fx-0031
[lxxix] https://www.jud11.flcourts.org/Criminal-Mental-Health-Project
[lxxx] https://www.floridaphoenix.com/2019/08/28/florida-leaders-consider-better-approaches-to-handle-the-mentally-ills-revolving-jail-door/
[lxxxi] Horn, B et. al. “Cost-effectiveness analysis of a large jail-based methadone maintenance treatment continuation program in New Mexico”. Journal of Substance Abuse Treatment. 115 (2020).
[lxxxii]http://transitionsclinic.org/
[lxxxiii] https://www.scccolorado.org/
[lxxxiv]https://www.lanecounty.org/UserFiles/Servers/Server_3585797/File/Government/County%20Departments/Health%20and%20Human%20Services/Human%20Services/HMIS%20ServicePoint/Fight%20Homeless%20wth%20Data%20handout%201.pdf

HEALTH MANAGEMENT ASSOCIATES

Behavioral Health Needs Assessment Interim Report

Criminal Justice Coordinating
Council of the Pikes Peak Region
May 19, 2020

TOPICS

- About the study
- Overview
  - Data
  - Analysis
  - Preliminary findings
- Next steps

ABOUT THE STUDY

Our charge

Support development of a feasible CJCC action plan

Target priority BH/SUD related solutions to prevent and reduce justice system involvement.

Support development of an updated EPCPH BH strategic plan

Target priorities to prevent and address county-wide BH/SUD

Three phases

Needs and gaps

Collaborative effort with EPCPH BH study – June 2020

Best practices and potential solutions

Summer 2020

Action plan recommendations

Late fall 2020

Approach

Frameworks for analysis

Public health and justice system

Leverage existing resources

EPC and OBH statewide studies, supplement with key informant input

Identify county needs, strengths, gaps and potential solutions

Develop strategic/action plan options for consideration

Incorporate county-level best practices, EPC specific factors

Stakeholder prioritization

Develop action plan implementation considerations and recommendations

Public Health Prevention Framework to Assess the BH Continuum

Population	Primary Prevention Self Management/Early Identification		Secondary Prevention Early intervention Access to Tx for Mild /Moderate BH/SUD			Tertiary Prevention Maintaining Stability /Recovery Specialty BH/SUD Care for Higher Acuity				
	Community		Primary Care			Specialty BH/Recovery				
	BH/SUD skill development	Awareness/ anti-stigma campaign Education Screening	Screening	Referral/ Referral networks	Integrated model (BH tx/ MAT)	Treatment network	Crisis response	CJ/Jail BH tx/MAT	Commumty Recovery programs	Case mgmt./ wrap
Children										
At risk children: **Parents w/SUD/OUD** **Trauma** **Poverty** **Homeless**										
Youth										
At risk youth: **LBGTQ** **Trauma**										
Young Adults										
At risk young adults **Foster care transition** **LBGTQ** **Trauma** **Homeless**										
Adults										
At risk adults **Domestic abuse** **Homeless**										
Older adults										

EPC Analysis Using the Sequential Intercepts Framework

Intercept	Goals/status	Gap/Opportunity
Intercept 0 Community Services (Crisis Lines/ Care Continuum)		
Mobile crisis outreach teams and co-responders (clinics, response centers, care teams		
ED Diversion (triage w/imbedded BH/crisis/peer staff)		
Police - BH collaborations/partnerships		
Intercept 1 Law Enforcement (911/Arrest)		
Dispatcher training		
Specialized police training		
Frequent utilizer interventions/follow up		
Intercept 2 Initial Detention/Court Hearings		
Screening BU/SUD prior to 1st court appearance		
– At booking, holding cells, court lock ups		
– Screening instruments		
Data matching (jail – community based BH providers)		
Pre-trial supervision and diversion services (risk based, pre/post sentencing)		
Intercept 3 Jails/Courts		
Treatment courts for high risk/high need		
Jail based programming, health care services, MAT		
Collaboration with veteran's justice outreach specialists		
Intercept 4 Re-entry		
Transition planning by jail/in reach providers		
Medication/prescription access		
Warm handoff jail – community providers		
Intercept 5 Community Corrections – Parole/Corrections		
Specialized community supervision/caseloads for indivs w/MH		
Access to MAT		
Access to recovery supports (benefits, housing, employment)		

STATUS OF INITIAL PHASE

Data collection

Updated BH/SUD trends

Data sources: OBH surveys, public health, CHI

Synthesized findings

Over 80 relevant source documents

Key informant interviews

7 completed and several pending

Analysis

Preliminary set of themes

EPC BH challenges and opportunities

Justice system challenges and opportunities

Cross-cutting system gaps/issues

DATA OVERALL BH TRENDS IN THE COUNTY

DEPRESSION / ANXIETY

17.9% of adults in EPC have been diagnosed with a depressive disorder, slightly higher than the state's average of 17.1% (2016-2018) *Source: CDPHE*

Rising percentage of individuals over age 5 in the county reporting 8 or more days of poor mental health during the past 30 days (11% in 2013 to 14.6% in 2019) *Source: CO Health Access Survey (CHAS)*

Rising percentage of individuals over age 5 in the county reporting they needed mental health care or counseling but did not receive it in the past year (7.8% in 2013 to 13% in 2019). *Source: CHAS*

SUICIDE

Upward trend since 2006, from 67 to 153, but recent decline between 2016 and 2019 *Source: CDPHE*

Age-adjusted suicide rate per 100,000 in EPC is higher than the state's (20.3 vs. 18.1) *Source: CDPHE*

SUBSTANCE USE

ACC Region 7 has second highest density of SUD cases in the state (15,855). *Source: HCPF*

ED visits for opioid OD on the rise since 2016 and higher than the state's rate. *Source: CDPHE*

Binge drinking rate of 15.6% - lower than CO's rate of 19.1%. *Source: BRFSS*

Regionally there has been an increase in the rate of treatment admissions for SUD, driven by overuse of alcohol, meth, heroin, marijuana, opioid prescriptions and cocaine from 2017-18. *Source: OBH*

Drug overdose deaths have been increasing from 42 deaths in 2000 to 130 deaths in 2018 – EPC sees a higher rate of meth and heroine related overdose deaths than the state. *Source: CDPHE*

JUSTICE INVOLVEMENT

Jail population over 1,600 in 2019

Over 40% of those incarcerated have mental health / IDD needs. *Source: BJS/Census*

Lacking accurate data on mental health, substance use diagnoses with inmates

High utilizers cycling through crisis, courts, jail *Source: HMA Assessment of Jail Health Services for EPSO, 2019*

DATA POPULATION SPECIFIC CONCERNS

YOUTH

Suicide rate; SUD rates; hopelessness

MILITARY / VETERANS

Women with higher rates of diagnosed BH conditions; Suicide rates disproportionately high among vets

CHILDREN

Substance-exposed infant mortality rate; adverse events related to SUD; depression/anxiety rates among foster children; gaps in preschool access

ADULTS

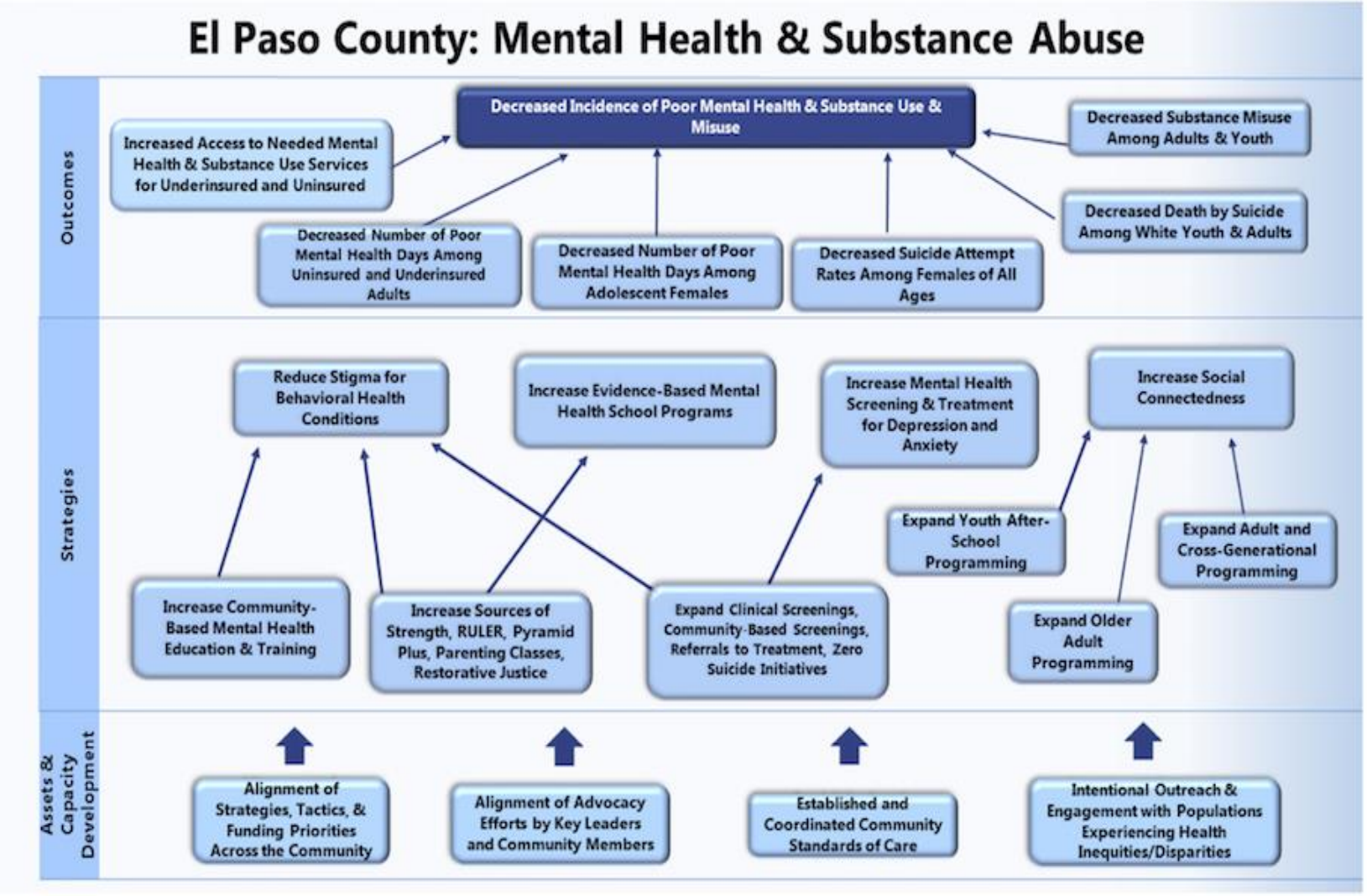
Poor access due to lack of insurance; poor mental health; depressive disorder among LGTBQ; pregnant women with co-occurring disorders

RURAL

Most people who have ever been diagnosed with a depressive disorder are in communities with low population density or more rural communities

ANALYSIS EPCPH STRATEGIC FOCUS ON BH

EPCPH PRIORITIES AND PROGRESS 2018-2022



ANALYSIS EPCPH BH/SUD PRELIMINARY OBSERVATIONS

Achievements include multiple programs and partnership efforts targeting "primary prevention"

Train the trainer
Participation in collaborative discussions and initiatives
Advocacy/information
Partnerships (e.g., CARES, EPC Sheriff's Office)

Major Targets

Youth mental health, suicide prevention
Fountain Valley Communities that Care
Community navigation
Schools
Maternal/child health

Less tangible efforts to impact secondary and tertiary prevention

Promoting integrated primary care
Expanding access to specific treatment providers
Expanding treatment resources e.g. detox, residential treatment for pregnant women

Strengths/Assets

Community connections/partnerships, especially leadership for building navigation partnership and data

Opportunities to expand current community-specific initiatives

Gaps/Opportunities

Continued/expanded efforts targeting mental health/SUD/suicide with youth

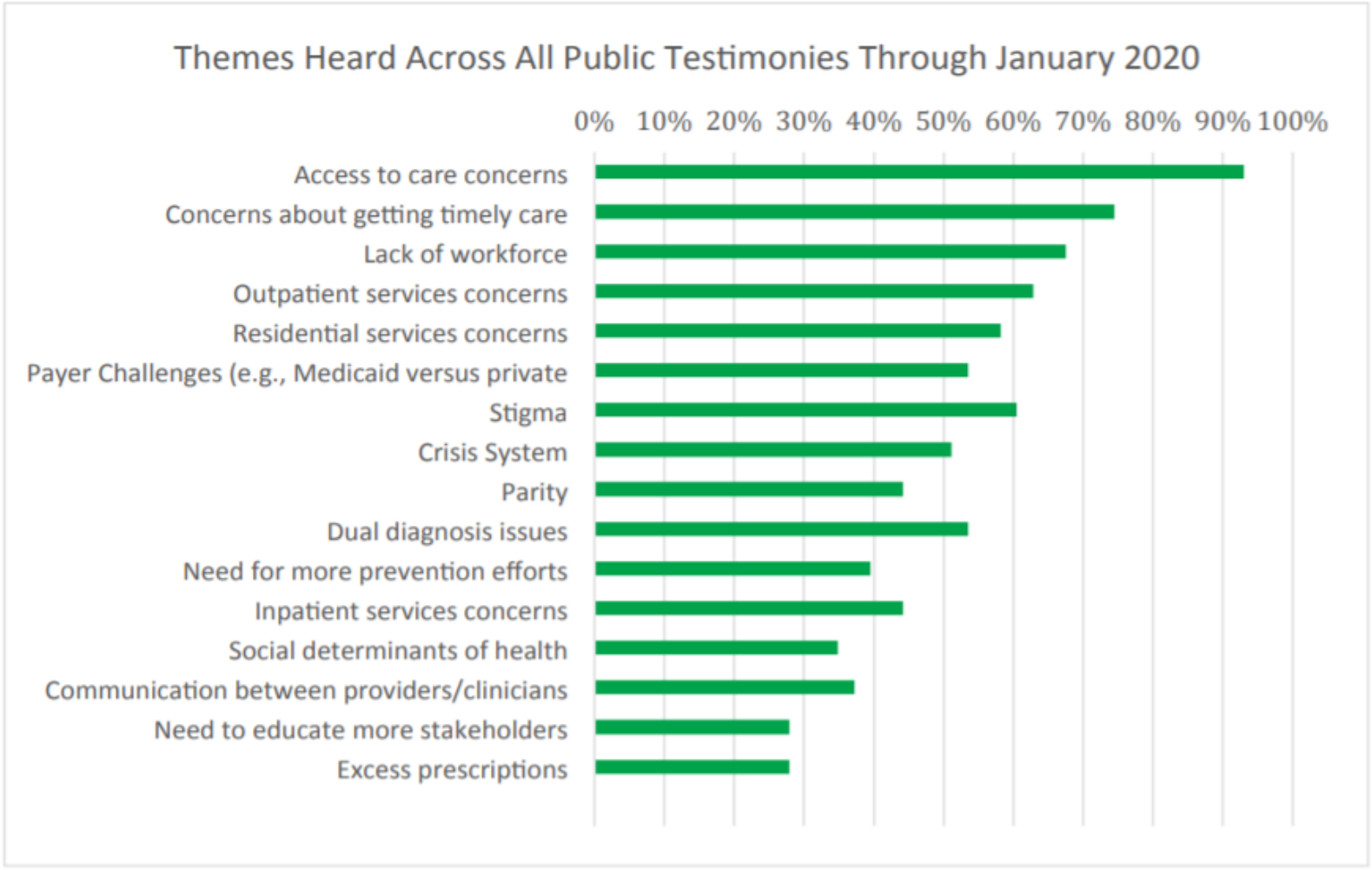
Expansion of efforts addressing mental health/SUD/stigma for adults

Opportunity to support community resource development linked to integrated primary care network, resources/access to mental health treatment via telehealth, etc

Lack of hard numbers on outcomes

Lack of program evaluation data

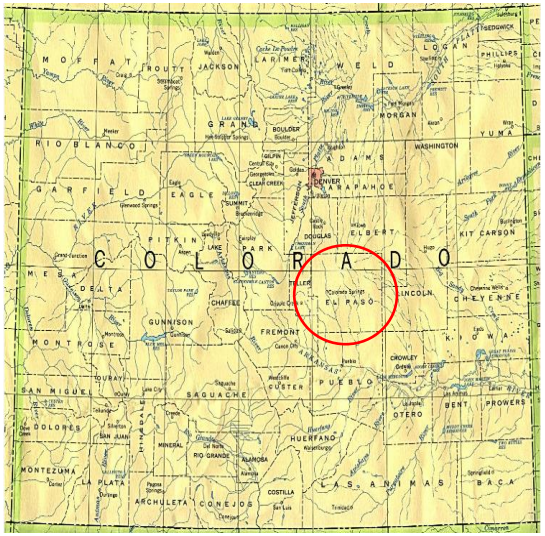
PRELIMINARY THEMES SYSTEM CHALLENGES STATEWIDE AND IN EPC



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

PRELIMINARY THEMES CROSS CUTTING CONSIDERATIONS

- Gaps in treatment/service continuum
  - Inpatient and higher levels of care, intensive care management and programs like Assisted Outpatient Treatment, transitional programs and housing, recovery housing / sober living, MAT and intensive outpatient treatment
- Cultural competence for priority populations
- Rural and frontier areas as a disparity population
- Fragmentation of services
  - Physical-BH health
  - Mental health – SUD
- Data
  - Different metrics, different timelines
  - Not shared
  - Incomplete
- Workforce shortages, retention, and training



- Systems/silos
  - Mixed authority
  - Lack of program connection
  - Regulatory challenges
  - Funding
- Administrative burden

[HMA presentation to BHTF (March 11, 2020) and summary findings from the CJCC Criminal Justice and Behavioral Health Summit (March 2019)]

CJCC FRAMEWORK

A framework with which to analyze and identify options to advance community-based solutions for justice involved people with mental and substance use disorders

THE SEQUENTIAL INTERCEPT MODEL

- Cross system collaboration and coordination of initiatives
- Routine identification of people with mental and substance use disorders
- Access to treatment for mental and substance use disorders
- Linkage to benefits to support treatment success, including Medicaid and Social Security
- Information sharing and performance measurement among BH, CJ & housing/homelessness service providers

Source: SAMHSA GAINS Center brochure; https://www.samhsa.gov/gains-center

ANALYSIS USING THE SEQUENTIAL INTERCEPT FRAMEWORK

Intercept	Action Plan 2019-2021	Gap/Opportunity
Intercept 0 Community Services (Crisis/Diversion)		
Mobile crisis teams/co-responders, response centers ED diversion Police/BH collaborations	❑ Expand BH services ❑ Utilize jail diversion opportunities ❑ Explore data sharing opportunities ❑ Explore innovative CJ strategies	❑ Build on current crisis response programs to expand geographic reach of crisis response teams ❑ Address increasing school-based crisis response, training needs ❑ Address gaps in referrals/treatment availability and reduce wait times: detox, residential, pregnant women, rural ❑ Leverage telehealth ❑ Build integrated data system to strengthen coordinated crisis response, referrals, share pertinent health history, assessment, navigation to track individuals and outcomes
Intercept 1 Law Enforcement (911/Arrest)		
Dispatcher training Specialized police training Frequent utilizer interventions	❑ Utilize jail diversion opportunities	❑ Enhance training with feasible options to strengthen 1st responder awareness, strategies and skills ❑ Collaboratively develop criteria and options for population-based pre-arrest diversion programs (e.g. frequent utilizer, homeless)
Intercept 2 Initial Detention/Court Hearings		
Screening prior to 1st court appearance Data matching (jail/community providers) Pre-trial supervision and diversion services	❑ Reduce jail population through pretrial services ❑ Improve pretrial supervision and case management ❑ Explore data sharing opportunities	❑ Blueprint continuum of supervision/supports for indivs with BH/SUD across community, pretrial, detention, release ❑ Develop standardized screening and assessment to collect and share consistent data elements ❑ Address fragmentation e.g., substance testing without referrals to treatment ❑ Address silos that limit effectiveness of wraparound services ❑ Assess and plan for implications of rapid pretrial release e.g., data sharing capability ❑ Assess/pursue risk-based pre-trial programs e.g. work release, LEAD, Angel program

ANALYSIS SEQUENTIAL INTERCEPT FRAMEWORK, CONT

Intercept	Action Plan 2019-2021	Gap/Opportunity
Intercept 3 Jails/Courts		
Treatment courts for high risk/high need Jail based programming, health care services, MAT Collaboration with veteran's justice outreach specialists	❑ Reduce jail population through pretrial services ❑ Utilize jail diversion opportunities ❑ Explore innovative CJ strategies ❑ Family justice center development ❑ Expand BH services	❑ Enhance BH/SUD assessment with standardized instruments ❑ Pursue implementation of BASIC program/release detainees with serious BH/SUD issues to community treatment ❑ Pursue implementation of comprehensive jail MAT induction and maintenance program, including increasing x-waivered providers ❑ Examine and develop coordinated approach across problem solving courts for BH/SUD assessment, population/risk-based dispositions ❑ Continue to expand jail R&R program to broader jail population ❑ Develop data system/metrics to monitor and evaluate outcomes across courts/programs ❑ Collaborate with EPCPH and stakeholders to expand needed treatment capacity e.g., inpatient rehab ❑ Develop workforce plan to support specialty court dispositions to community programs/supervision
Intercept 4 Re-entry		
Transition planning by jail/in reach providers Medication/prescription access Warm handoff jail – community providers	❑ Explore innovative CJ strategies ❑ Expand BH services	❑ Bring together courts and jail to identify ways to strengthen coordination, information sharing, priorities for resource development ❑ Convene jail/vendor/community partners to address transition pathways for different populations of jail detainees and design provisions for timely in-reach, access to medications, transportation, housing and warm handoffs from jail to community. ❑ Develop provisions for sustainable comprehensive community navigation infrastructure
Intercept 5 Community Corrections (Parole/Corrections)		
Specialized community supervision/caseloads Access to MAT Access to recovery supports (benefits, housing, employment)	❑ Expand BH services ❑ Reduce employment barriers for indivs w/criminal history ❑ Research/support resources for community CJ projects	❑ Pursue additional funding for BH, drug/alcohol treatment in community corrections settings ❑ Develop co-located/one-stop source for treatment and case management ❑ Foster acceptance and diffusion of standard practices regarding MAT across community continuum of treatment and recovery support providers/settings ❑ Address lack of affordable housing and needed placements ❑ Address workforce needs to ensure adequate probation / supervision

PRELIMINARY THEMES CJCC OPPORTUNITIES

- Leverage current assets, including approaches and models in play
  - Crisis response, pre-trial and post-sentencing initiatives
  - Fund and deploy BASIC, a promising best practice program already developed
- Develop and deploy a true pre-arrest diversion program with adequate resources
  - Treatment partner(s)
  - Police training
- Address options to expand resources in the MH/SUD treatment continuum impacting justice involved populations
  - Intensive outpatient, residential treatment, detox
- Advocate to ensure that standards of care for individuals with substance addictions are being met across the criminal justice system
  - Buy in and operationalizing MAT based on understanding of neuroscience of addiction
- Collaborate with EPCPH to support strategic initiatives targeting equity and access
  - Health insurance, telehealth, community navigation
- Engage CJ stakeholders to develop an integrated data system for collecting and sharing information
  - Agree on approach and tools for standardized screening and assessment to capture and be able to use individual and population specific information e.g. MH and addiction history, patterns, etc.
  - Gain agreement on information sharing agreements and protocols
  - Foster agency efforts to achieve data system adaptations

PRELIMINARY THEMES CROSS CUTTING CONSIDERATIONS

- Risks for not meeting standards of care for individuals with BH/addiction
- Current siloes contribute to duplication, fragmentation, missed opportunities across the continuum
  - Lack of system design, processes, workflows, information sharing
  - Example: Jail lacking defined communication/navigation/info sharing with community
- Population specific approaches must be considered
  - Identify subpopulations, then align interventions and resources
  - Homeless and safe surrender, workforce delivering BH services
- Without an integrated data system, lack of data and information sharing will continue to impede evidence-based resource investments and ability to substantiate return on investment
  - Lack of consistent collection of structured data (common data definitions, interoperable data systems)
  - Lack of ability to support population health management
  - Lack of ability to track individuals in the system
  - Lack of data needed to evaluate overall system ROI, including population and program specific outcomes
- Leadership and accountability is essential for achieving improvements
  - Need for empowerment of a collaborative governance entity with accountability to lead and demonstrate outcomes from countywide initiatives

NEXT STEPS

The implications of COVID!

- Complete data collection
  - including interviews and updates from OBH study and state policy developments
- Identify targeted opportunities and best practices/county models for consideration
  - including possible funding sources
- Prepare for CJCC input and prioritization
  - Summer 2020

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HEALTH MANAGEMENT ASSOCIATES

EL PASO COUNTY

El Paso County Public Health and
Criminal Justice Coordinating Council of the Pikes Peak Region

Behavioral Health Study
Findings and Strategic Priorities

Presentation to the Criminal Justice Coordinating Council
Behavioral Health Committee
August 14, 2020

OBJECTIVES AND AGENDA

1. In advance of CJCC, prepare BH Committee to understand and advocate for next steps to use the study findings
2. Provide BH committee with overview of study findings, recommended strategic priorities and next steps
3. Provide opportunity for input, questions and discussion

RECAP: ABOUT THE STUDY

Our charge

Support development of an updated EPCPH BH strategic plan

Target priorities to prevent and address county-wide BH/SUD

Support development of a feasible CJCC action plan

Target priority BH/SUD related solutions to prevent and reduce justice system involvement

Three phases

1. Needs and gaps

Collaborative effort with CJCC BH study – July 2020

2. Best practices and potential solutions

Summer 2020

3. Action plan recommendations

Late fall 2020

We are here

Where we are headed

Approach

Frameworks for analysis

Public health and justice system

Leverage existing resources

EPC and OBH statewide studies, supplement with key informant input

Identify county needs, strengths, gaps and potential solutions

Develop strategic/action plan options for consideration

Incorporate county-level best practices, EPC specific factors

Stakeholder prioritization

Develop action plan implementation considerations and recommendations

PHASE TWO: FINDINGS, PRIORITIES AND POTENTIAL SOLUTIONS

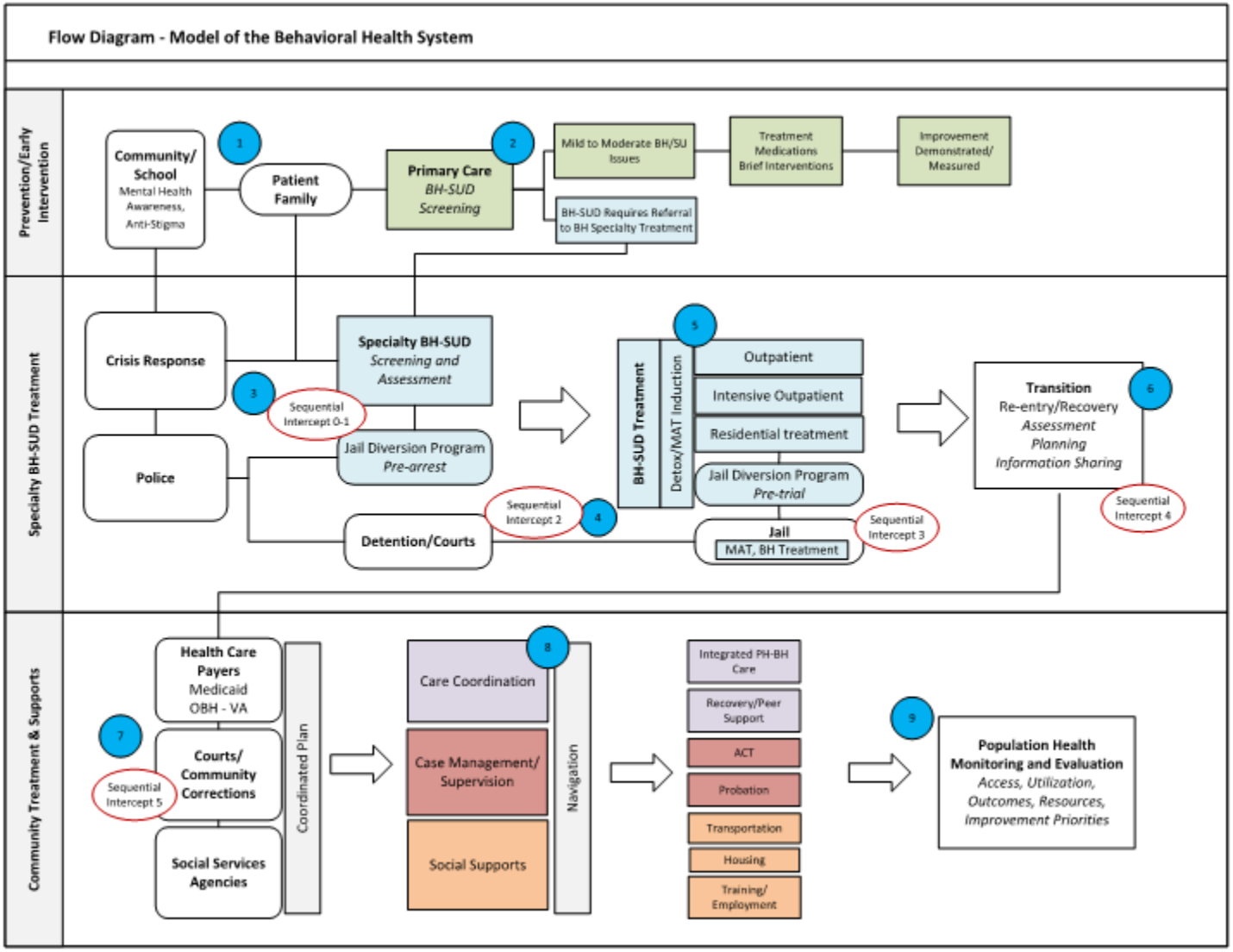
- Report in 4 sections, with overview/introduction and attachments
- Report tells a story, serves as a resource for county stakeholders, and both EPCPH and CJCC
  - The analysis is based on a "systemwide" view: system capacity needed, current gaps, and opportunities
  - Priorities and related solutions are outlined: cross-cutting and targeted
  - A way to start forward is proposed, including steps to organize, start work on priorities

SECTION 1 WHAT THE DATA SHOW (PAGES 7-12)

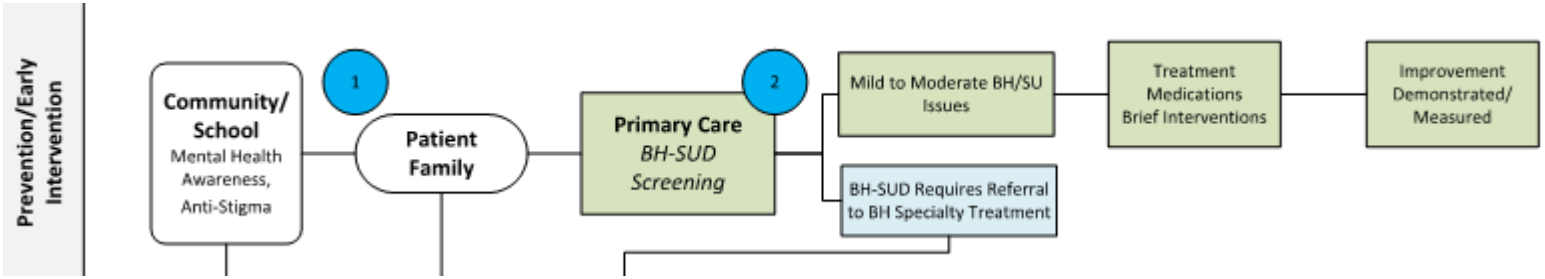
- **The problems are worsening**
  - **Persistent and worsening depression, anxiety, SUD, suicide**
  - **Several high-risk populations: Youth, Military/veterans, Minorities, Pregnant Women, LGBTQ+, Unhoused, CJ involved**
  - **Stigma about behavioral health prevents early intervention and treatment, compounding the need for acute treatment and risk of death**

    "Rates of stigma against SUD treatment are reportedly increasing across the state – 72% said they were concerned about what would happen if someone found out they had a problem in 2019". Source: Colorado Health Access Survey

SECTION 2 EXAMINING THE CURRENT BH SYSTEM (Pages 12-31)

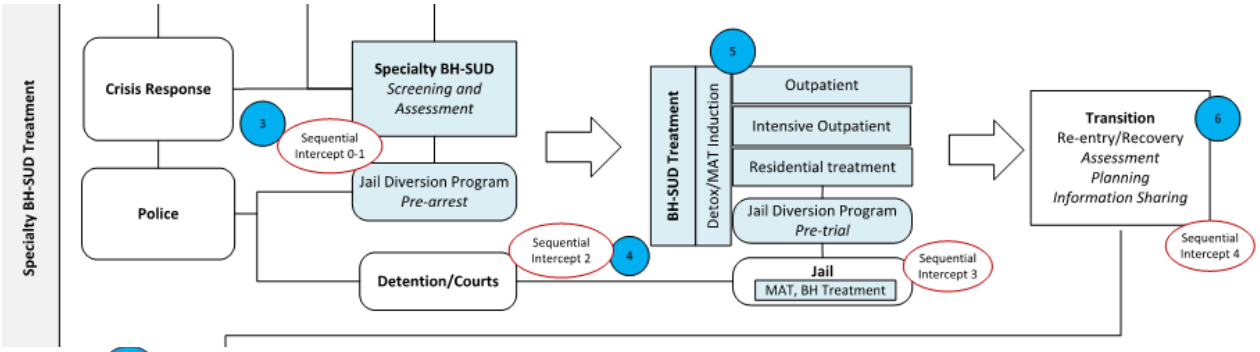


SECTION 2 PREVENTION AND EARLY INTERVENTION (Pages 14-18)



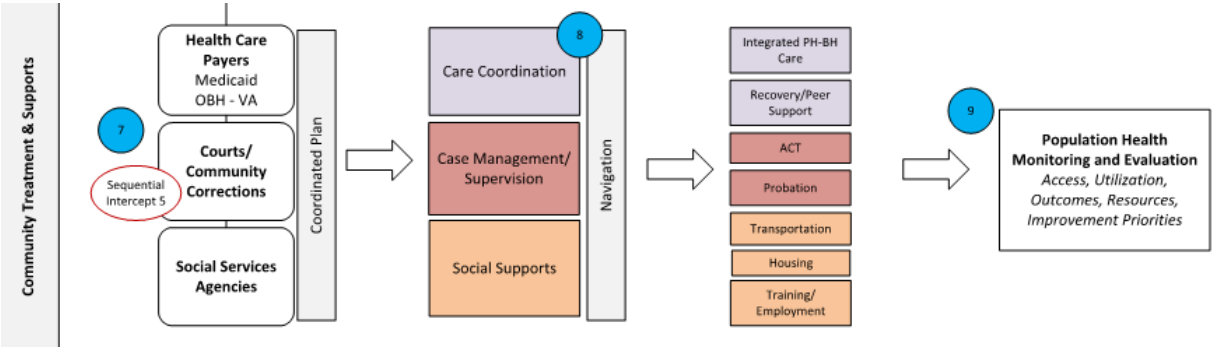
- **Prevention** 1 **(Pages 14-16)**
  - *Especially given negative BH/SUD impact of the pandemic, more widespread and diverse prevention efforts are needed focused on youth, high risk school districts and communities, and targeting stigma.*
- **Early Intervention** 2 **(Pages 16-18)**
  - *Integrated primary care is critically important to overcome stigma, expand access to BH/SUD treatment and support BH/SUD recovery in the community e.g., with MAT and telehealth. Pushing primary care providers to adopt integrated care practices is a priority, taking advantage of new policy flexibility.*

SECTION 2 SPECIALTY BH-SUD TREATMENT (Pages 18-27)



+ **Crisis intervention 3 (Pages 18-20)**
  + *Enhanced and expanded law enforcement training is needed to build law enforcement skills in crisis intervention. Additional crisis resources and approaches are needed to address gaps in reach and increased demand, including use of telehealth, improved data/data sharing to track outcomes, recidivism.*
+ **Justice system treatment alignment 4 (Pages 20-22)**
  + *Alignment with BH and SUD screening and treatment standards, including MAT, is needed across courts, jail and BH treatment continuum.*
  + *The county will benefit from pre and post arrest diversion programs, which are cost-effective best practices to increase BH treatment and decrease justice system involvement and incarceration. Significant support among stakeholders and opportunity created by state legislation need to be acted upon to implement programs.*
+ **Treatment continuum 5 (Pages 22-25)**
  + *Recently enacted legislation adds urgency system mapping and addressing gaps in the treatment continuum including detox capacity, residential SUD options, treatment for co-occurring conditions, and Jail MAT, BH treatment.*
+ **Re-entry supports 6 (Pages 26-27)**
  + *Development of a robust jail re-entry program is an urgent priority, now mandated by legislation, including in-reach, and provisions for continuity of care i.e., warm handoffs for MAT, primary and specialty BH care.*

SECTION 2 COMMUNITY TREATMENT AND RECOVERY SUPPORT (Pages 27-31)



- **Cross –Agency Alignment** 7 **(Pages 27-29)**
  - *There is an important opportunity for agencies, the courts and community organizations to align policy, requirements and programmatic resources around population-based needs (aka "systems of care"). System mapping is first necessary to identify pathways for high-risk populations, reveal points of administration and process complexity across multiple agencies and guide collaborative re-design and resources.*
- **System navigation** 8 **(Page 29-30)**
  - *CARES Homeless Outreach Program illustrates type of population specific programs that are needed, e.g., for pregnant women with co-occurring conditions. The CARES program with navigation platform and dedicated staff is a model for coordinating community supports that should be considered for expansion by the county as part of a comprehensive approach to population health management.*
- **Population health management – data** 9 **(Page 30-31)**
  - *Data plan to enhance information sharing across the continuum, including criminal justice, must be developed, including steps to standardize data collected as part of enhanced screening and assessment.*
  - *Various individual information platforms in play (HS Connects, Julota). Work needed to blueprint interoperability, institute comprehensive data sharing agreements*
  - *Metrics, measurement and reporting strategies needed to monitor progress and outcomes among high-risk populations*

SECTION 3 CROSS CUTTING OBSERVATIONS

Current siloes contribute to duplication, fragmentation, missed opportunities across the continuum due to lack of system design, processes, workflows, information sharing.

- **"System alignment"** is a key goal and task, to blueprint behavioral health related policy, definitions, standards, and models of care across health and criminal justice systems.
- **Organizing for population health management** is the answer to alignment. Population specific pathways and approaches must guide the organization and provision of needed services to ensure that they are coordinated and accessible by high risk populations in practical ways.
- A **multifaceted data plan** is critical. It must address consistent collection of structured data, agreed upon information sharing protocols and provisions e.g. HIPAA, metrics and measurement for monitoring, analytics for evaluation, determining ROI.
- Given alarming trends in poor behavioral health and substance abuse, **targeted and global prevention strategies to address stigma** and encourage seeking help are vitally important priorities.
- Efforts to foster **broader understanding of addiction and the value of MAT** are vitally important to provide individuals with BH/addiction every opportunity to stabilize and recover. MAT is a proven and recognized treatment for opioid disorder; not providing it is considered to be substandard care.
- **Leadership and defined and measured accountabilities** for making progress toward improved outcomes are essential. The county's behavioral health system "infrastructure" must include provisions for collaborative governance structure and processes. Currently, the HCC is informal, data reporting is lacking, and progress is uneven.
- **Roles and resources** must be examined, along with necessary investments needed to improve the behavioral health system. These include the level of investment in the public health agency, as well as productive options for how public health and CJCC will collaborate, along with other stakeholders to prioritize, plan, invest, lead, monitor, and continue to innovate.

SECTION 3 STRATEGIC PRIORITIES

- 18 strategic priorities identified
- Examples provided for most priorities to show implementation and funding strategies
- Selected to directly address pain points / opportunities across system continuum:
  - Prevention
  - Early Intervention
  - Specialty BH/SUD Treatment
  - Community-based Treatment/Supports
  - Cross-Cutting Infrastructure
- Some more directly link to public health scope and priorities while others are more tied to the criminal justice system but all relevant to improve population behavioral health

SECTION 3 STRATEGIC PRIORITIES – TASKS AND STAKEHOLDERS

Prevention

Early Intervention

School & Community-based Training

- Planning and resources (subject matter experts) for train the trainer and other events
- BH/SUD curriculum appropriate for students, teachers, parents, other stakeholders: resilience, recognizing crisis, etc.
- Identified community and school champions, buy in from targeted school districts, community stakeholders

Major Stakeholders

- ✓ EPCPH
- ✓ Schools
- ✓ BHCON/CARES
- ✓ Youth-serving CBOs
- ✓ HCC partners e.g., NAMI

Social Marketing to Address Stigma

- Research and develop social marketing strategies in conjunction with community partners
- Identify champions
- Message development
- Resources

Major Stakeholders

- ✓ EPCPH
- ✓ City and County leadership
- ✓ NAMI
- ✓ CCHA
- ✓ Community partners e.g., CHP
- ✓ Providers/associations
- ✓ Citizens

Integrated Primary Care

- Develop partnership strategy
- Identify champions among providers, community
- Survey/assessment of current practices
- Payment/financing strategies
- Technical assistance re: integration practices, telehealth

Major Stakeholders

- ✓ CCHA
- ✓ Peak Vista
- ✓ AspenPointe
- ✓ Grantmakers/ Community partners e.g., CHP,

Specialty Behavioral Health/SUD

Crisis/Response

- Plan, curriculum, resources/expertise to support expanded officer training
- Develop options/plan to expand data sharing, links to navigation
- Identify options for expansion e.g., rural areas potentially with telehealth, community partners

Major Stakeholders
- ✓ BHCON
- ✓ CARES
- ✓ AspenPointe
- ✓ CSPD
- ✓ EPSO

Treatment Continuum

- Research/develop options for treatment continuum i.e., detox, co-occurring treatment, MAT in SUD treatment
- Financing/payment strategies
- Assistance to inform, develop jail best practice policies/procedures
- Support to develop provider partnerships

Major Stakeholders
- ✓ DHS
- ✓ BH/SUD Providers
- ✓ CCHA
- ✓ EPSO
- ✓ Courts/Comm Corrections
- ✓ Justice contractors e.g., Wellpath, Comcor, other

Jail Alignment/Diversion

- Input, expertise to develop data metrics, monitoring, evaluation of diversion outcomes
- Research, data support for model development
- Implementation planning: policies, provider arrangements, training
- Strategic communications for advocacy, buy-in

Major Stakeholders
- ✓ CSPD/EPSO
- ✓ Courts
- ✓ DA, County Attorney
- ✓ Providers
- ✓ CBOs
- ✓ BHCON/CARES

SECTION 3 STRATEGIC PRIORITIES – TASKS AND STAKEHOLDERS

Specialty BH/SUD

Community-based Treatment & Recovery Supports

Re-Entry

- Convene/facilitate planning with SO, vendor, CBOs, Medicaid, VA, other
- Agree on policies, arrangements for re-entry continuum from in-reach to warm handoffs
- Training

Major Stakeholders
- ✓ EPCPH
- ✓ CCHA/Medicaid
- ✓ VA
- ✓ DHS
- ✓ EPSO/Wellpath
- ✓ Courts/Probation
- ✓ BH/SUD Providers
- ✓ CBOs
- ✓ CARES

Navigation

- Participate in/leverage system mapping to identify needs for service expansion
- Plan for sustainability, expanded use of CAREs technical platform, staffing
- Formulate expanded partnership arrangements for data sharing, referrals

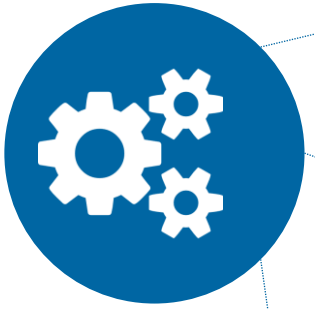
Major Stakeholders
- ✓ EPCPH
- ✓ CARES
- ✓ EPSO/Wellpath
- ✓ VA
- ✓ CCHA

Community Supports

- Leverage system mapping to identify population system of care needs
- Cross agency dialogue, planning to enhance services e.g., case mgmt/supervision, housing, transportation
- Partnership arrangements for data sharing, referrals

Major Stakeholders
- ✓ EPCPH
- ✓ CARES/HOP
- ✓ DHS
- ✓ VA
- ✓ CCHA/Medicaid
- ✓ Courts/Comm Corrections
- ✓ CBOs

SECTION 3 STRATEGIC PRIORITIES - CROSS-CUTTING TASKS, STAKEHOLDERS



CROSS-CUTTING INFRASTRUCTURE

Major Stakeholders

- ✓ EPCPH
- ✓ DHS
- ✓ Medicaid/CCHA
- ✓ VA
- ✓ Justice system: SO, CSPD, Courts, Comm Corrections
- ✓ Providers
- ✓ CBOs

SYSTEM MAPPING: An important activity to blueprint services and pathways of high risk populations and address areas to streamline

- Facilitation
- Agreed upon methodology and structured processes
- Dedicated staff time

INTEGRATED DATA PLAN: Supports population health monitoring, provision of services, system evaluation, and support for resource investments

- Defined data elements to be collected across continuum
- Information sharing provisions
- System metrics
- Analytics/reporting

STANDARDIZED SCREENING AND ASSESSMENT: Comparable data elements, understanding of high-risk populations across agencies, providers, CBOs

- Required to align risk assessment, stratification, levels of treatment,
- Use of standardized data collection and validated screening tools enables measurement of progress, outcomes across continuum/justice

Data Book attachment identifies key metrics, sources to monitor

Collective Impact Model: To support collaboration, accountability, integration across silos and systems of care, population health management, monitoring/evaluation

Entity to be determined after weighing local options

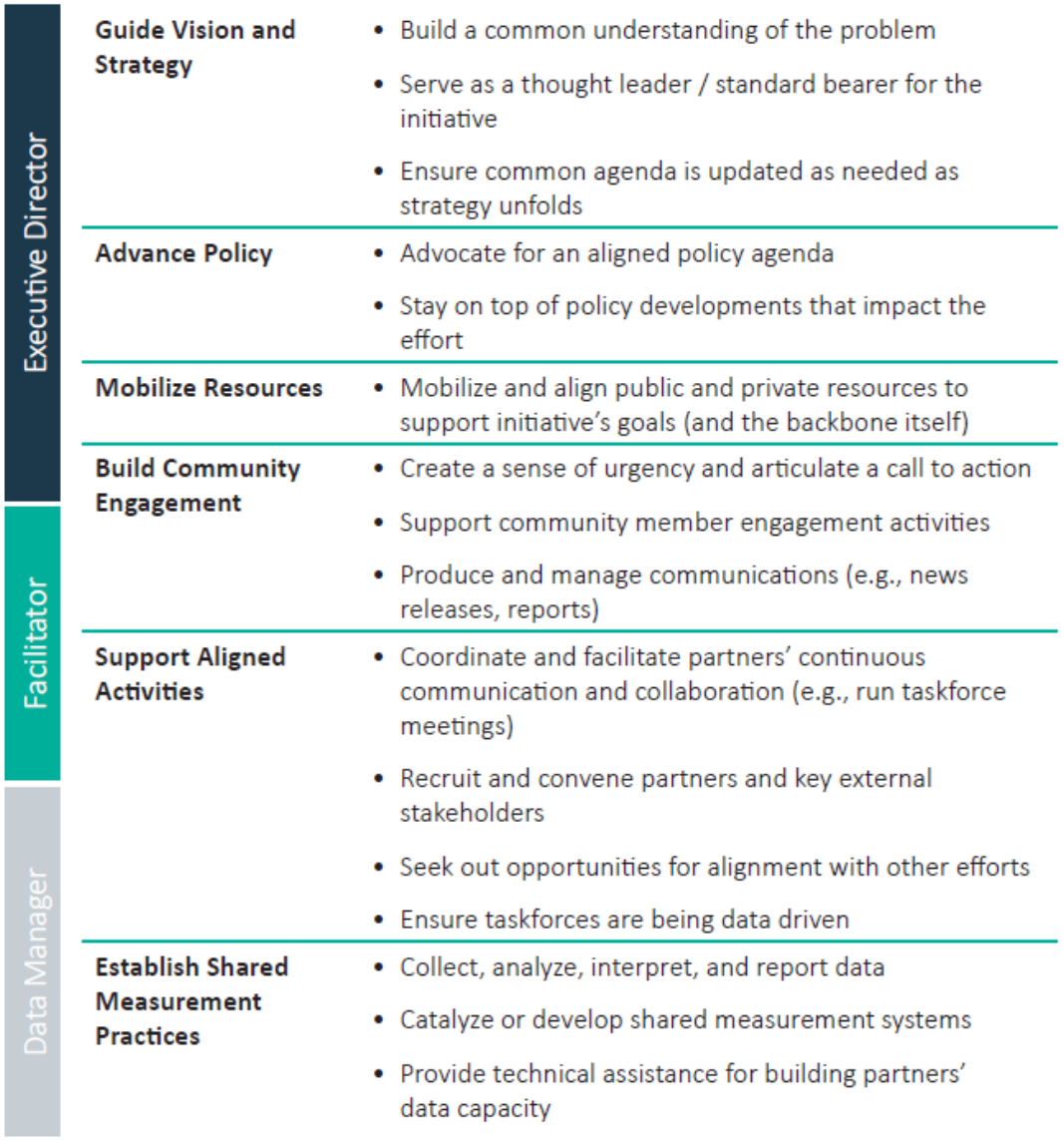
An Approach Backed by Evidence

Backbone Outcomes

Activity	Short-term Outcomes (Illustrative)	Intermediate Outcomes (Illustrative)
Guide vision and strategy	Partners share a common understanding of the need and desired result	Partners' individual work is increasingly aligned with the initiative's common agenda
Support aligned activities	Partners increasingly communicate and coordinate their activities toward common goals	Partners collaboratively develop new approaches to advance the initiative
Establish shared measurement practices	Partners understand the value of sharing data	Partners increasingly use data to adapt and refine their strategies
Build public will	Guide vision and strategy	More community members feel empowered to take action on the issue(s)
Advance policy	Partners increasingly communicate and coordinate their activities toward common goals	Policy changes increasingly occur in line with initiative goals
Mobilize funding	Funding is secured to support initiative activities	Philanthropic and public funds are increasingly aligned with initiative goals

Source: Stanford Social Innovation Review.

Backbone Staffing Options Vary



Turner, Merchant, Kania, and Martin, 2012.

Source: Collective Impact Forum.

CI INITIATIVE INFRASTRUCTURE Involves Stakeholders in Aligned Activities

Leaders with authority to commit to shared agenda

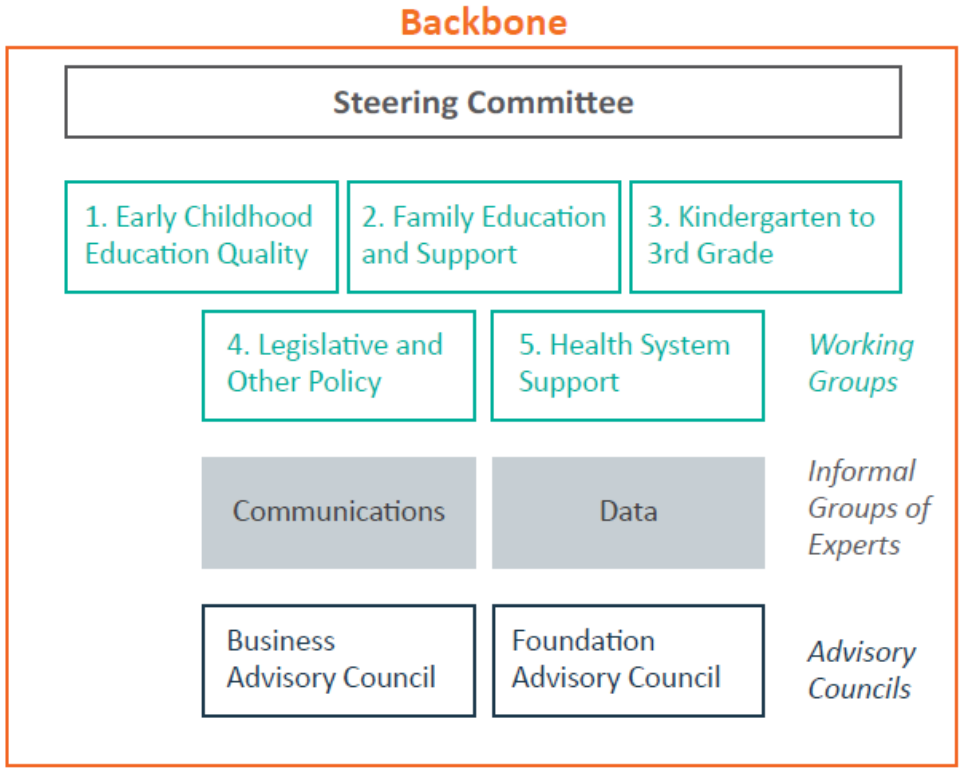


Figure 1

Example Structure of Collective Impact Effort—Early Matters in Houston, Texas

CJCC and HCC participants would be engaged in work groups for solution development

DOUGLAS COUNTY CI MODEL: Dept of Administration Backbone, Matrix of Roles/Staffing

In the grid below, indicate which staff person is responsible for an aspect of the backbone's role in the Collaborative
Suggested Key

✓+ = Primary responsibility / Accountable for the Work Getting Done

✓ = Significant Supporting Role

ROLES OF THE BACKBONE																	
		Guide Vision and Strategy			Advance Policy		Mobilize Resources	Build Community Engagement			Support Aligned Activities				Establish Shared Measurement Practices		
DOUGLAS COUNTY STAFF	Backbone Position	*Build a common understanding of the problem*	*Serve as a thought leader / standard bearer for the initiative*	*Ensure common agenda is updated as needed as strategy unfolds*	*Advocate for an aligned policy agenda*	*Stay on top of policy developments that impact the effort*	*Mobilize and align public and private resources to support initiative's goals (and the backbone itself)*	*Create a sense of urgency and articulate a call to action*	*Support community member engagement activities*	*Produce and manage communications*	*Coordinate and facilitate partners' continuous communication and collaboration (e.g., run Steering Committee meetings)*	*Recruit and convene partners and key external stakeholders*	*Seek out opportunities for alignment with other efforts*	*Ensure taskforces are being data driven*	*Collect, analyze, interpret, and report data*	*Catalyze or develop shared measurement systems*	*Provide technical assistance for building partners' data capacity*
	Leader & Convener																
	Director/Internal Facilitator																
	External Facilitator																
	External Facilitator/ Administrative Support																
	Communications																
	Policy Analyst																
	Development																
	Data Analyst																

AN EFFECTIVE BACKBONE: KEY CHARACTERISTICS

+ One or more organizations with committed staff designated to perform backbone functions
+ Well-functioning leadership structure established, responsible for governance & decision-making
+ Backbone infrastructure coordinates & supports core initiative activities
+ Backbone staff have appropriate skills & credibility to perform backbone functions

Two parallel tracks

I. **Organize to transcend silos of effort and maintain accountability for shared vision, solutions, activities**
   i. Adopt Collective Impact approach
   ii. Identify and establish initial backbone entity
   iii. Identify initial Steering Committee

II. **Begin to tackle solutions to address specific gaps and opportunities across the system continuum**
   i. Constitute workgroups
      a. Draw from CJCC BH, other committees, HCC
   ii. Launch work on cross cutting priorities
      i. System mapping
      ii. Data plan development
   iii. Leverage HMA expertise and support for best practices research, solution development

NEXT STEPS IMMEDIATE PRIORITIES

- We are requesting feedback from entities represented on the BH Committee about the report and its implications for each entity to confirm the path forward
  - BH Committee members should review report findings with their leadership
- We plan to include BH Committee member feedback when reviewing the report with the CJCC at large
- A survey will be sent via email
  - Seeking feedback on the proposed priorities, solutions, the collective impact approach, and your involvement
  - Return comments by COB Friday 8-21-20

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HEALTH MANAGEMENT ASSOCIATES

HEALTH MANAGEMENT ASSOCIATES

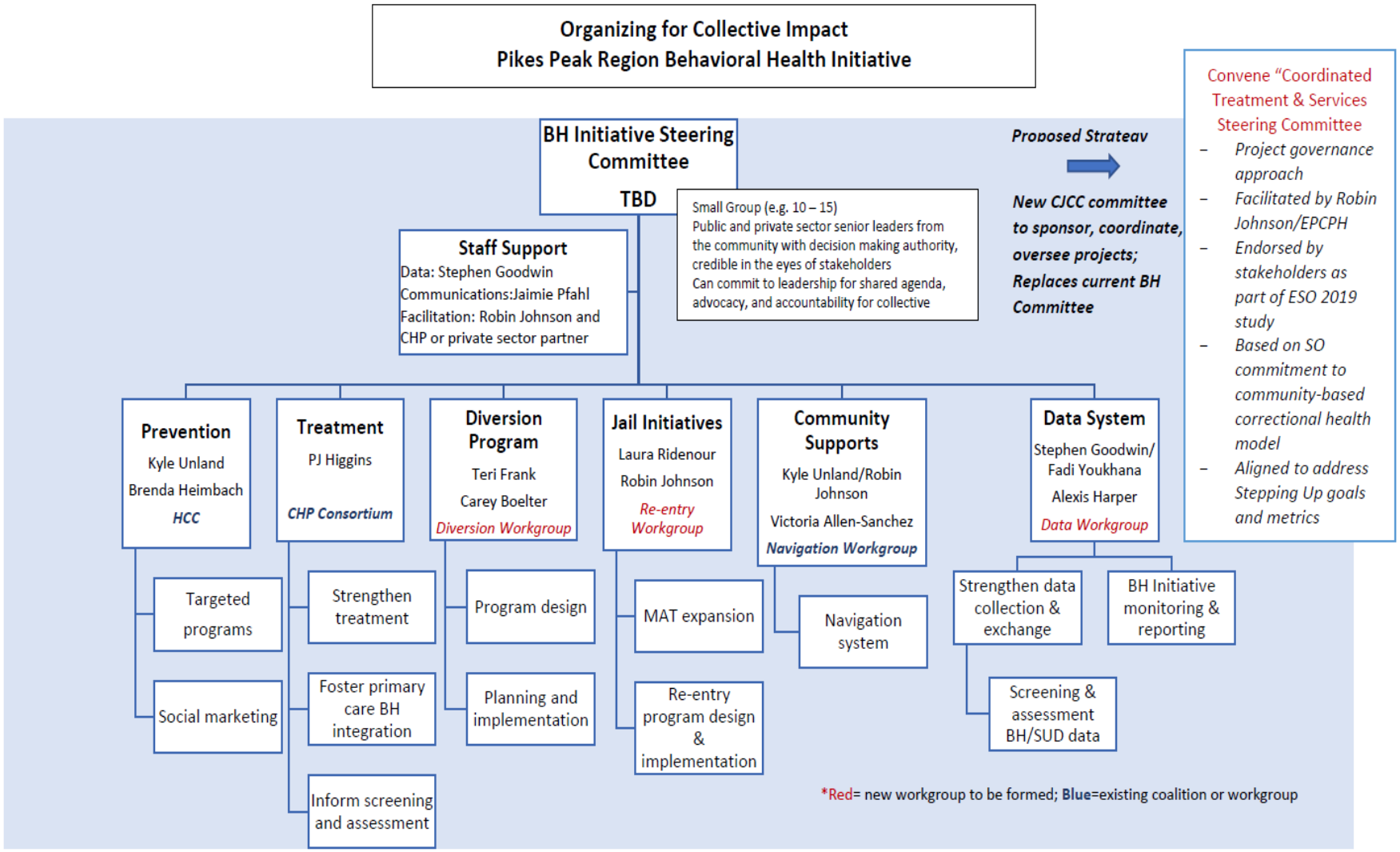
Addressing Behavioral Health: Update and Recommendations

December 1, 2020
Criminal Justice Coordinating Council
Pikes Peak Region

PROGRESS ON KEY PRIORITIES FROM BH STUDY

- **Community navigation and system mapping to coordinate supports for population exiting jail**
  - Existing multi-stakeholder workgroup meeting
  - Inventory of community-based MH/SUD services compiled
  - HMA facilitating development of initial current and future state maps
- **Screening and assessment background work (in conjunction with navigation, mapping) to improve MH/SUD data collection, sharing**
  - Diverse MH/SUD screening tools currently in use across jail, courts, providers and gaps in data collection/sharing being identified
  - HMA met with CHP provider consortium to solicit engagement for input on screening and assessment, strengthening treatment models in line with the Stepping Up Initiative recommendations
- **Jail diversion program background work (HMA)**
  - Compilation of relevant program models for consideration
  - Compilation of potential funding sources
  - Template to analyze value proposition/ROI
  - Identifying data needs and what's available

PRIORITY: AN ORGANIZATIONAL STRATEGY TO ADVANCE SOLUTIONS



STEPS TAKEN TO DISCUSS, VALIDATE APPROACH

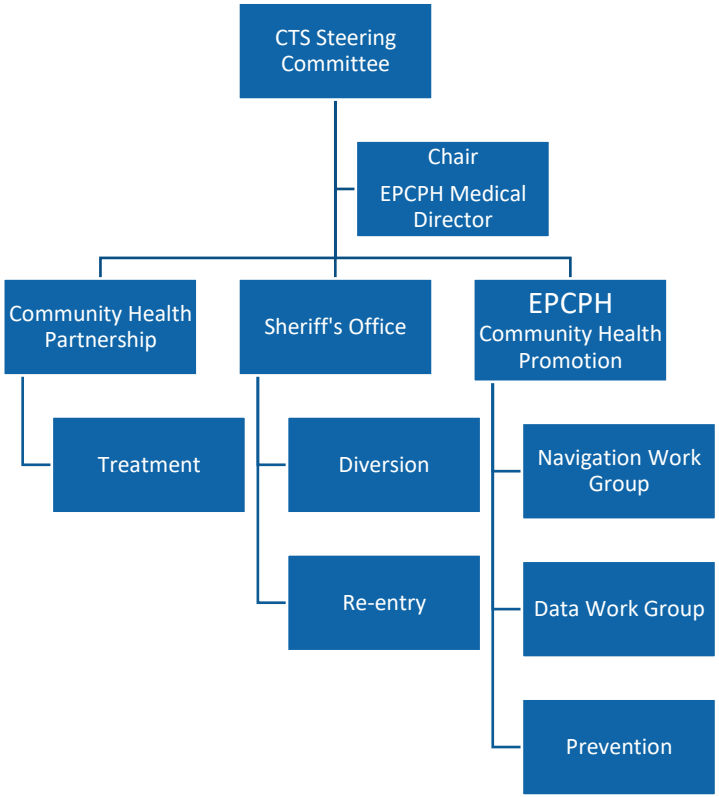
- **Organizational approach shared with key entities**
  - CJCC Behavioral Health Committee
  - EPCPH
  - Sheriff's Office
  - Community Health Partnership
- **Initial workgroup co-leads identified**
- **Workgroup charters drafted to outline key aspects of accountability, scope and participation, including:**
  - Project goals and objectives
  - Deliverables
  - Workplan tasks and timeline
  - Accountabilities and participation
  - Potential work group members

WORKGROUP ORGANIZATION AND LOGISTICS

- **The workgroups intended to address targeted CJCC priorities**
  - Recommended by BH study
  - Aligned with Stepping Up Initiative
  - Build on current initiatives and sources of leadership (e.g., current EPCPH/CARES navigation taskforce, jail re-entry efforts, CHP consortium)
- **Initial workgroup co-chairs are highly invested and empowered by their agencies**
  - Currently in roles directly related to the solutions under development
  - Solutions/topics of workgroup directly relevant to agencies, populations served, ROI, etc.
- **Core workgroups small to stay nimble**
  - Blend of individuals with appropriate expertise, time and commitment
  - Identified and convened by workgroup leaders
- **Iterative workgroup process for solution development with additional stakeholder input**
  - Workgroup meets at least monthly to pursue workplan
  - Workgroup develops initial models, questions for additional input and decisions
  - Workgroups engages additional informants for input, to validate assumptions and aspects of solution development, implementation considerations
- **Workgroup collaboration and coordination overseen by CTS Steering Committee**
  - Standing agenda for project leads to all report, discuss, problem solve

PROPOSED FOR CJCC ENDORSEMENT

1. Replace current BH Committee with a newly constituted "Coordinated Behavioral Health and SUD Treatment and Services Steering Committee" aka "CTS Steering Committee"
    i. CTS Steering Committee to be comprised of senior executives/decision makers
2. Under the auspices of the CTS Steering Committee:
    i. Workgroups chartered to pursue BH priorities recommended by the BH study; and
    ii. Workgroup/project chairs appointed by Sheriff's Office and EPCPH convene, communicate and collaborate.
3. Work group leads will engage individuals from among the BH Committee to either be part of specific work groups, or to serve as informants to the work of the committees, as appropriate.



ROLE OF THE CTS STEERING COMMITTEE

Purpose

Provide a reliable structure and processes for collaboration, decision making and accountability among multiple partners to support implementation of solutions addressing BH/SUD gaps and opportunities.

Scope

- **Prioritize efforts necessary to identify and implement solutions** that address gaps in existing services and decrease avoidable incarceration, connect individuals with SMI/SUD to appropriate treatment, and reduce rates of recidivism.
- **Sponsor and oversee efforts by collaborative subcommittees/workgroups on projects** led by the Sheriff's Office, EPCPH, and other partners to strengthen the continuum of behavioral health/substance use treatment and services within the jail and community
- **Provide recommendations as appropriate to Jail leadership** about strengthening jail policies and programs as part of executing the broader community-based continuum of care.
- **Provide ongoing input and recommendations to the CJCC, EPCPH and stakeholders** regarding the BH status and needs of jail populations, and the continuum of resources and interventions that will impact justice system involvement and outcomes.
- **Collaborate with CJCC to identify potential resources to fund system improvements, develop an evaluation framework, define performance metrics and data sources, and monitor the impact of system changes.**
- **Charter additional subcommittee(s) as needed** on an ongoing basis for further development of resources/programs.

CTS STEERING COMMITTEE: WHO, WHAT, HOW

Chair:
- EPCPH Medical Director

Accountabilities:
- Keep CJCC stakeholders informed on workgroup progress, accomplishments
- Identify & address barriers to implementing solutions, including policy, funding needs
- Make recommendations regarding BH related needs, opportunities and projects

Logistics:
- Quarterly meetings
- Standing agenda
- Workgroup leads will report
  - ✓ Diversion
  - ✓ Re-entry
  - ✓ Navigation/mapping
  - ✓ Data system
  - ✓ Community prevention
  - ✓ Treatment
- Documentation maintained/ongoing reports to CJCC

Proposed CTS Steering Committee Membership

Participants	Affiliation
Sheriff/Designee	Sheriff's Office
JC Health Services Administrator	Sheriff's Office
Public Health Medical Director	EPCPH
COO/Senior Executive	Peak Vista
VP Transformation/Senior Level Executive	Aspen Pointe
Senior Executive for MH/SUD Treatment/Services (e.g., inpatient, ED)	UCHealth Penrose
Lead Data and Evaluation	EPCPH
CCHA Senior Level Executive	Medicaid RAE
4th Judicial District Justice System representative(s)	Pre-trial, Courts, Probation, Community Corrections
Senior Level City Leads: Housing, Employment, Public Safety	CSFD, CARES CSPD
Crossroads Recovery Programs/ Residences	Detox
Senior Executives/Directors Community Treatment	MAT/Methadone Services Hep C-HIV testing
Leads	Projects/workgroups

NEXT STEPS ON PROPOSED ORG. STRATEGY

1. **Proceed with reconfiguration of BH Committee to CTS Steering Committee**
   i. Outreach to potential CTS members
   ii. Develop charter
   iii. Convene initial meeting (target late December or January 2021)

2. **Proceed with workgroup organization and work plan development:**
   i. Confirm project leads, core work group members
   ii. Adopt charters, work plan tasks and timeline
   iii. Coordinate with CJCC to incorporate workplans as part of annual planning

3. **First quarter 2021 and ongoing: reports to CJCC from the CTS Steering Committee**
   i. Update on relevant work plan progress, barriers
   ii. Recommendations and requests, as appropriate, for policy and/or funding support

HMA

HEALTH MANAGEMENT ASSOCIATES

Criminal Justice and Behavioral Health Gaps and Needs Analysis and Action Plan Recommendations

PREPARED FOR THE
CRIMINAL JUSTICE COORDINATING COUNCIL OF THE PIKES PEAK REGION

FEBRUARY 23, 2021

Research and Consulting in the Fields of Health and Human Services Policy, Health Economics and Finance, Program Evaluation, Data Analysis, and Health System Restructuring

Building upon the results of its 2020 Behavioral Health Gaps and Needs Analysis of the Pikes Peak Region, Health Management Associates (HMA) outlined a set of potential solutions. These have been followed by recommended action steps for stakeholders, steps that will strengthen the continuum of behavioral health interventions for at risk and justice involved populations and address CJCC objectives for reduced justice system involvement.

The following provides brief background information and presents recommended 2021 priorities and action steps endorsed by the CJCC on February 23, 2021.

Background

Grant funding enabled the Criminal Justice Coordinating Council (CJCC) to contract with consulting firm Health Management Associates (HMA) in early 2020 to study and identify options to strengthen the region's behavioral health system serving at risk and justice involved populations. At about the same time, El Paso County Public Health (EPCPH) also contracted with HMA for a study to identify priorities for improving behavioral health (including substance use) across the county. With support from CJCC and EPCPH leadership, HMA pursued a three-phased scope of work that began by leveraging a collaborative approach to synthesize earlier research into the region's behavioral health issues, gather input from key informants, and generate assessment findings about the region's behavioral health system needs and gaps that would be applicable to CJCC, EPCPH and the region at large. During the second phase, HMA focused on compiling a set of priority solutions for consideration by the CJCC and its stakeholders, then worked in phase three to develop recommendations and provide additional research and organizational support to advance implementation.

Recommended Priorities and Actions

The behavioral health study recommended organizational structure and processes necessary to ensure successful implementation of targeted solutions to strengthen access to appropriate behavioral health treatment and supports.

Priorities include establishing a collective impact governance model and workgroups to target specific solutions recommended by the study.

1.Establish a Collective Impact Governance Model

One key finding of the study pointed to the need for a more robust overall governance structure that would maintain leadership and accountability for the implementation of behavioral health related solutions across multiple sectors and organizations. Based on its research and experience, including with other Colorado counties, HMA formulated recommendations for how El Paso County could leverage its work to date and adopt an evidence-based, collective impact organizational approach. This would more effectively channel stakeholder efforts and make progress on addressing specific behavioral health issues and solutions.

Action Steps

Recommendations to re-align elements of the CJCC organizational structure with a collective impact governance approach include:

1.1 Disband the existing Behavioral Health Committee and establish a Behavioral Health Steering Committee.

The newly constituted Behavioral Health Steering Committee, chaired by the EPCPH medical director, Dr. Robin Johnson, will be made up of executive level leaders in a position to embrace a shared agenda for strengthening the behavioral health system for at risk and justice involved populations. The steering committee will serve as a governance body to oversee the work of several workgroups focused on specific areas of work. It will meet regularly and report progress toward addressing behavioral health system solutions to the CJCC.

The model for this new, multi-sector governance committee, was first discussed and endorsed by stakeholders in 2019 as part of an earlier study HMA conducted for the El Paso County Sheriff's Office (EPSO). That study produced recommendations to promote a community based, continuity of care model of health services for the justice involved population.

HMA worked with Dr. Johnson to identify potential steering committee members and hosted information meetings to provide background and confirm participation.

(See Attachment A: Steering Committee Roster)

2.Establish and charge workgroups to advance development and implementation of targeted solutions

The study identified key gaps that need to be filled to build a continuum of services in the region that would prevent individuals with mental illness and substance use disorder from entering or returning to correctional settings and, instead, obtain more cost-effective and quality treatment in the community. Several priority areas include:

- Expanding prevention activities such as school & community-based training and social marketing to address stigma
- Building out the treatment continuum including adequate medication-assisted treatment, detox and recovery services as well as jail-based behavioral health treatment
- Developing more robust pre-trial diversion programming
- Formalizing a jail re-entry program with warm handoffs to community behavioral health and substance use disorder treatment services
- Streamlining coordinated navigation supports, including data sharing, care planning and case management, to strengthen recovery and prevent recidivism
- Developing data capacity that supports population health monitoring, provision of services, system evaluation, and support for resource investments

Action Steps

2.1 Establish and charge workgroups, as outlined below, to advance projects implementing solutions under the auspices of the Behavioral Health Steering Committee.

HMA worked with stakeholders of the existing CJCC Behavioral Health Committee to organize six workgroups to advance the development and implementation of these interrelated, multiple reinforcing solutions. Charters are drafted and chairs or co-chairs for each are identified as noted. Each workgroup will engage stakeholders with appropriate expertise and experience to advance the development and implementation of multiple reinforcing solutions identified by the study. The workgroups will involve members of the former CJCC Behavioral Health Committee as appropriate. The outputs of these workgroups will be incorporated into strategic planning that is now underway to develop the CJCC's 2022-2024 Action Plan.

The workgroups, chairs, and their charges include:

Prevention Workgroup: *Charged to facilitate collaborative efforts by community stakeholders participating in the Healthy Community Collaborative, to accelerate and expand prevention initiatives targeting at risk youth, communities and other populations that will improve behavioral health and prevent justice system involvement.*

Chair: Kyle Unland, Director, Division of Community Health Promotion, EPCPH.

Treatment: *Charged to design and support implementation of behavioral health treatment models (mental health, substance use and co-occurring disorders) and resources that will expand access to appropriate and timely treatment prior to, during, and following incarceration and lead to decreased justice system involvement. This will include development of a plan to provide expanded behavioral health treatment and supports in the criminal justice center. Chairs: TBD*

Diversion Workgroup: *Charged to design and recommend a program to be implemented as part of EPC/Pikes Peak region justice system that will divert individuals with serious mental illness and substance use disorders from incarceration to treatment in the community.*

Chairs: Carey Boulter, BH Program Manager/BHCON Co-Responder Unit, EPSO; and Teri Frank, 4th Judicial District Liaison, EPSO.

Re-entry/Jail Initiatives Workgroup: *Charged to design and support implementation of an effective, well-coordinated EPC Justice Center re-entry program in conjunction with community partners, that proactively plans for and organizes delivery of transitional behavioral health and substance use disorder treatment and services required by each inmate as he or she transitions from the jail to the community.*

Chairs: Laura Ridenour, Detention Behavioral Health Manager, EPSO; and Dr. Robin Johnson, Medical Director, EPCPH.

Community Supports / Navigation Workgroup: *Charged to design and support implementation of an effective, well-coordinated navigation program in conjunction with community partners, that builds clear pathways that populations with MH/SUD conditions can follow to receive timely, coordinated treatment and supports.*

Chairs: Kyle Unland, Director, Division of Community Health Promotion, EPCPH; and Dr. Victoria Allen-Sanchez, BH Coordinator, Community and Public Health Division, CSFD.

Data Workgroup: *Charged to lead efforts to mobilize data required to identify and address behavioral health/SUD among populations at risk or actively involved in the justice system and monitor and evaluate the outcomes of the projects of the behavioral health initiative.*

Chairs: Stephen Goodwin, Chief Data Scientist, EPCPH; and Fadi Youkhana, Chief Epidemiologist, EPCPH.

2021 Work planning

The plan for the Behavioral Health Steering Committee is to convene in March 2021, to review its charter and the scope of workgroup charters and efforts in progress. The committee will be provided with background information and materials in support of the agenda. The Steering Committee will continue to meet on a quarterly basis to inform solution development, including resource needs and funding strategies, and report progress, barriers, and requests to the full CJCC . HMA will continue to provide support to stand up the committee under a new contract with the EPSO.

Workgroups are in the process of developing detailed workplans, outlining their activities for the year to meet their objectives. Activities to be part of the workplans include:

- **Reentry/Diversion Workgroups:** A small pilot is currently underway to provide intensive case management for individuals who are eligible for outpatient competency restoration. This pilot will be monitored and evaluated to understand how it could form the basis of an expanded pre-trial diversion program. Working collaboratively, the two workgroups will map and explore options to streamline and strengthen the continuum of pre-trial and post incarceration community- based services for targeted populations, including case management, access to medications and treatment, transportation, referrals and data sharing. Input will be solicited from justice, health and social services partners.

- **Navigation Workgroup:** Mapping of current and future state community navigation pathways has been undertaken. Using the results, efforts are currently underway by the workgroup to develop a proof of concept pilot for a new, streamlined navigation model, including establishing clear requirements for data sharing across entities providing navigation, care coordination and treatment services.

- **Data Workgroup:** The workgroup will work across the various workgroups to understand data needed to support an enhanced continuum of behavioral health and substance use disorder treatment and services for different populations of at risk and justice involved individuals. Steps

will be taken to profile system users, outline a data architecture, then target priorities to enhance data collection and data sharing across health care, justice system, social services to implement, monitor and evaluate cost-effective solutions and their outcomes. The data workgroup will play an active role to support the Behavioral Health Steering Committee to monitor progress.

- **Treatment:** Efforts are underway to stand up this committee, including identifying co-chairs and the scope of 2021 priorities. Under a contract with the EPSO, HMA will be working to develop a plan for how behavioral health treatment and supports can be enhanced for the population within the Criminal Justice Center. This will include active involvement of community providers, and projections for workforce and budget.

ATTACHMENT A: EL PASO COUNTY BEHAVIORAL HEALTH STEERING COMMITTEE
ROSTER

Name	Affiliation
PHILANTHROPY	
Amber Ptak, CEO	Colorado Health Partnership
Cari Davis	Colorado Springs Health Foundation
Deb Mahon, Executive Director	Gazette Charities, Anshutz Foundation
CITY/COUNTY GOVERNMENT	
Brett Waters	City of Colorado Springs
Jayme McConnellogue, Chief	Colorado Springs Fire Department Regional EMS (including fire depts, CARES, CRT, detox)
Todd Evans	City of Fountain
JUSTICE SYSTEM	
Bill Elder, Sheriff	El Paso County
Joe Roybal, Bureau Chief	El Paso County Sheriff's Office Administrative Bureau
Daphne Burlingame, Magistrate	Recovery Court 4th Judicial District
PROVIDERS	
Mark Mayes MHA, BSN, RN, CEN Associate Chief Nursing Officer	UCHealth, Memorial North Hospital
Doug Muir, Director, Behavioral Health Services	Centura, Penrose Hospital
Rob Nartker, COO	Peak Vista Community Health Centers
Adam Roberts. CEO	Diversus Mental Health (formerly AspenPointe)
Trudy Hodges, CEO	Springs Recovery Connection
MEDICAID/INSURANCE	
Gelissa Garcia Diaz, Director, Behavioral Health	CCHA Regional Accountable Entity
PUBLIC HEALTH	
Susan Wheelan, Director	El Paso County Public Health

STEERING COMMITTEE LEADERSHIP AND SUPPORT	
Robin Johnson, MD, Steering Committee chair	EPCPH Medical Director
Jamie Pfahl	EPCPH, Public Health Planner
Lynn Dierker, BSN, RN	Health Management Associates
Laquisha Grant, MPA	Health Management Associates
Alexis Harper, PhD	CJCC Liaison

As of 2-2-21

CJCC Behavioral Health Study Alignment with Stepping Up Initiative

Stepping Up Action **(County Self-Assessment Question 5 –** **Have we prioritized policy, practice, and funding improvements?)**	**Related BH Study Workplan Activities**

Step 1: Programs, policies, and practices that address the four key measures (the number of people who have SMI booked into jail, their average length of stay, the percentage of people who have SMI that are connected to treatment, and their recidivism rates) that address gaps in existing services have been identified and prioritized for implementation and potential funding.	• **HMA identified the need for programs and practices that address existing service gaps and align with current priorities:**
	• **<u>Develop Diversion Workgroup and plan</u>**
	  ○ **Goals:**
	  ▪ **Reduce number of people who have SMI booked into jail**
	  ▪ **Reduce length of stay in jail**
	  ▪ **Reduce recidivism rates**
	• **<u>Strengthen jail initiatives: Re-entry Workgroup/MAT program; Develop Treatment Workgroup Plan</u>**
	  ○ **Goals:**
	  ▪ **Improve percentage of people with SMI/SUD who are connected to treatment**
	  ▪ **Reduce recidivism rates**
	• HMA is currently convening leads in these areas to (1) define workgroup members, (2) identify plan to identify specific solutions/connections, and (3) discuss funding sources
	• Two other workgroups are developing plans to reduce the number of people who have SMI booked into jail, although more upstream. They include <u>prevention</u> efforts and <u>treatment expansion</u> efforts geared toward improving screening and assessment efforts to identify individuals before they become involved in the criminal justice system and develop an adequate continuum of treatment.

Step 2: Strategies have been developed that target people who have SMI who are also at the highest risk of reoffending (based on a validated criminogenic risk assessment) and encourage collaboration between behavioral health care providers and supervision staff.	• **<u>Community supports: Prevention Workgroup and Navigation Workgroup</u>**
	  ○ **Goals:**
	  ▪ In addition to the existing CARES and Homeless Outreach Programs to prevent justice involvement, HMA is supporting the existing community navigation workgroup , to ensure information is being shared across entities involved in the care of those who are at the highest risk of reoffending
	• HMA is currently facilitating a meeting of navigation entities and kicking off an overall system map that will highlight capabilities, gaps, and data connectivity needs

Step 3: Strategies for addressing the needs of people who have SMI who are at a lower risk of reoffending have been developed collaboratively between the jail and community-based behavioral health care providers.	**See Re-entry/MAT program and navigation programs above**
Step 4: A plan has been submitted to the county leaders that provides a clear description of needs based on data and evidence-based practices, as well as justifications for new staff and/or programming.	A final report with recommendations was submitted for stakeholder review to conclude HMA's contract with the CJCC. (Feb. 2021)
Step 5: The plan estimates the number of people to be served and the impact that the proposed programs, policies, or practices will have on one or more of the four key measure (the number of people who have SMI booked into jail, their average length of stay, the percentage of people who have SMI that are connected to treatment, and their recidivism rates).	• **<u>Data System Workgroup</u>** ○ **Goals:** ▪ Strengthen data collection and exchange to be able to understand the impact of interventions ▪ Improve BH initiative monitoring and reporting HMA will work with data workgroup leads to identify a process for developing baseline data in coordination with the jail and community-based entities. In addition, each workgroup (diversion, reentry, data, navigation) will be tasked with estimating the potential impact of a given solution. HMA will support these estimates based on other programs around the country and the unique characteristics of the El Paso County region.
Step 6: The plan includes estimated costs of proposed interventions to the county and it is clear how these resources will address and impact the four key measures (the number of people who have SMI booked into jail, their average length of stay, the percentage of people who have SMI that are connected to treatment, and their recidivism rates).	Each workgroup (diversion, reentry, data, prevention, navigation, treatment) will be tasked with estimating the potential cost (and cost avoidance) of a given solution. HMA will support these estimates based on data from other programs around the country and the unique characteristics/resources of the El Paso County region.

CJCC Behavioral Health Study Alignment with Stepping Up Initiative

Step 7: The plan describes the extent to which external funding streams can support proposed programs, policies, or practices that address the four key measures	Each workgroup (diversion, reentry, data, prevention, navigation, treatment) will be tasked with estimating the potential funding sources for a given solution. HMA will support these estimates based on other programs around the country and the unique characteristics/resources of the El Paso County region.